TRUST BOARD
27 July 2017

AGENDA ITEM NUMBER	5.2	
TITLE OF PAPER	Quality Report	
Confidential	**NO**	
Suitable for public access	**YES**	
PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN VIEWED		
None		
STRATEGIC OBJECTIVE(S):		
Best outcomes	✓	
Excellent experience	✓	
Skilled & motivated teams	✓	Safety is improved when teams actively engage with care quality improvement.
Top productivity	✓	Performance is improved with effective pathways and safe care.
EXECUTIVE SUMMARY		
	This report summarises clinical quality data for June 2017[1.] The monthly dashboard is on Appendix 1 on page 7. The 99 in-hospital deaths in June decreased from 112 in-hospital deaths in May but remains higher than monthly targets. Mortality review rates this month of 69.0% remain below target. There were 4 hospital acquired cases of C.difficile in June. We are currently above our monthly trajectory to be within our limit of 17 cases in 2017/18. Emergency readmissions of 15.9% exceeds target of 12.5%. Stroke performance of 44.4% is significantly below target of 90%. FFT satisfaction score for ED of 81.4% is decreased from 86.3% last month and is below target of 87%. Maternity touchpoint 2 FFT score was 92.7% and is below the monthly target of 97%. Dementia case finding score of 38.5% is incompletely recorded on RealTime and in the forthcoming year VitalPac is planned to track this measure electronically.	

[1] Abbreviations used: Diagnostics, Therapies, Trauma & Orthopaedics (DTTO); Emergency Department (ED); Medicine and Emergency Services (MES); Theatres, Anaesthetics, Surgery & Critical Care (TASCC); Women's Health and Paediatrics (WH&P), Intensive Care Unit (ICU). CHKS is explained on page 5 in the footnote. Friends and Family Test (FFT). Summary Hospital-level Mortality Indicator (SHMI). Risk Adjusted Mortality Index (RAMI). Care Quality Commission (CQC).

	May and June 2017 data for the Medications Safety Thermometer is still unavailable from the national provider and June data for the classic Safety Thermometer has not yet been published. Of the June complaints requiring a response 72.0% met the timescale agreed with the complainant. The quarterly dashboard is on Appendix 2 on page 9. Please refer to the commentary on section 2.0 on page 5 regarding red rated items. The National Audit of Dementia results published recently are summarised in Appendix 3 on page 16. Areas for improvement include refining our discharge strategy and supporting carers.
RECOMMENDATION:	Review the paper and seek additional assurance as necessary.
SPECIFIC ISSUES CHECKLIST:	
Quality and safety	Y
Patient impact	Y
Employee	Y
Other stakeholder	Y Quality priorities are set following consultation with internal and external stakeholders.
Equality & diversity	Y All of our services give consideration to equality of access, taking into consideration disability and age and all matters are dealt with in a fair and equitable way regardless of the ethnicity or religion of patients.
Finance	N Not applicable.
Legal	Y Poor quality care for patients can lead to potential litigation, non-compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and could affect the Care Quality Commission registration and NHS Improvement licences.
Link to BAF principal risk	Vulnerable groups care is part of Board Assurance Framework (BAF) risk 2.2.
AUTHOR NAME/ROLE	Russell Wernham, Deputy Chief Nurse
PRESENTED BY	Dr David Fluck, Medical Director and Mrs Heather Caudle, Chief Nurse
DATE	24July 2017
BOARD ACTION	Assurance.

1.0 Background and Scope

The Board receives assurance and information on key clinical quality and improvement measures from the performance dashboard in Appendix 1, page 6. Results by exception by either the ratings below or significance are summarised in Section 1.1.

Rating table

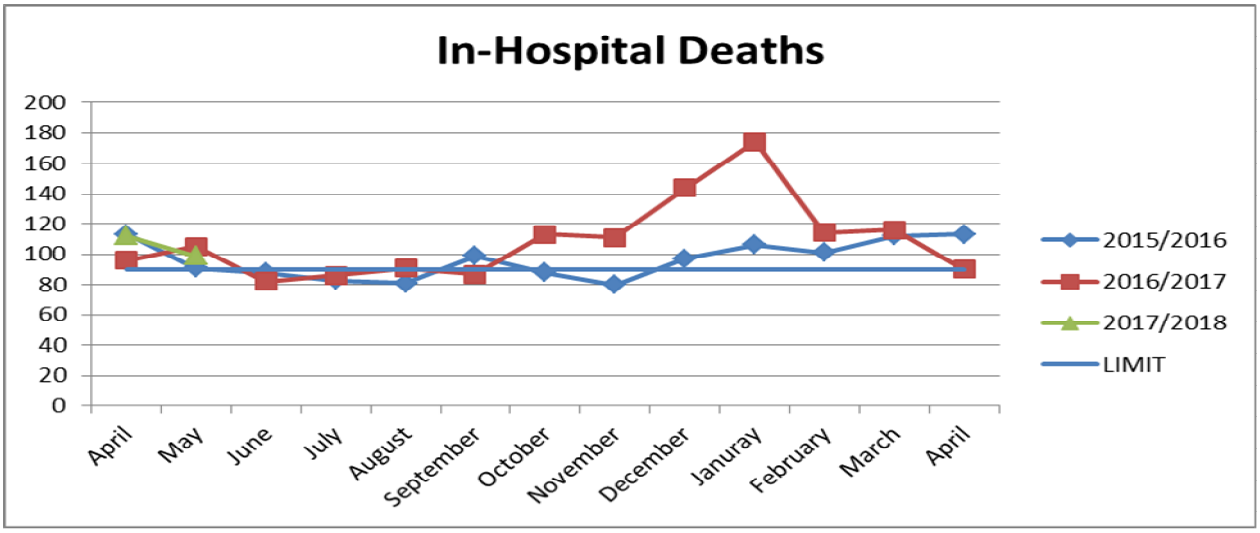
Delivering or exceeding target		Improvement month on month
Underachieving target		In line with or just below last month
Failing target		Below target

1.1 Performance by exception – June clinical quality data

In-hospital deaths

99 recorded deaths in June is above the monthly target.

Chart 1 – In-hospital deaths April 2015 onwards



Mortality reviews

Mortality review completion rates were 74% for MES, 73% for TASCC and 0% for both DTTO and WH&P which each had 4 deaths in May. There were 4 deaths in DTTO in May which will be reviewed at the next QUASH meeting on 26 September, together with all deaths that occur in the intervening period. Of the WH&P deaths, 1 review has now been completed after the deadline; there is a new network mortality review tool in use and the remaining 3 cases are planned to be reviewed on 21 July.

C.difficile

Of the 4 C.difficile cases in June, 1 has been reviewed with the CCG and was not deemed a lapse in care. The remaining 3 cases are awaiting root cause analyses and will be reviewed by the CCG in the next quarter.

Pressure ulcers

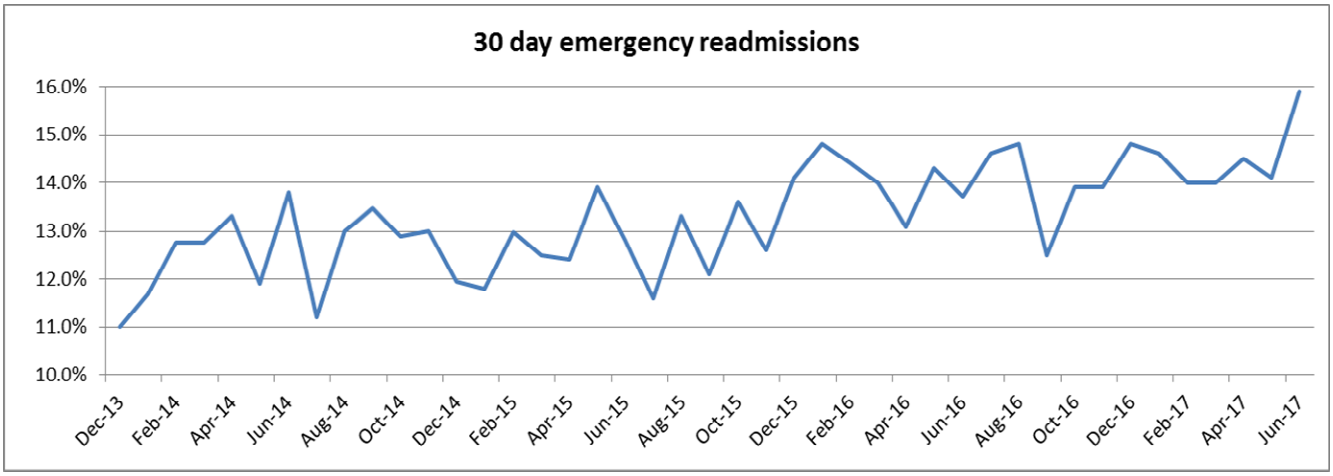
The monthly CCG target of 11.7 stage 2 hospital acquired ulcers was not achieved this month with 14 stage 2 pressure ulcers. ITU and Swift both had 4 stage 2 pressure ulcers; Maple had 2 stage 2 pressure ulcers and AMU, Aspen, Cedar and Heron Annexe each had 1 stage 2

pressure ulcer. Swift continues with the pressure ulcer Quality Improvement project; areas of concern have been identified and reflections and root cause analyses have been requested of the staff. Swift ward staff identified as requiring training have been booked onto the pressure ulcer study day planned on 28 July. It should be highlighted that the patient caseload was challenging due to contractures and difficulties in repositioning; new Heel Up protection boots were used in these patients. The Tissue Viability Service Team continue to provide mandatory training on a monthly basis. The first order of Repose Wedges has been received in the Trust and ward based training on their use and ordering has commenced.

Emergency 30-day readmissions

30 day readmissions of 15.9% remains above the annual target of 12.5%. Significant areas by volume were Urology at 21.9%, General Surgery at 20.6%, General Medicine at 20.5%, Upper Gastrointestinal Surgery at 20.3%, A&E at 18.3%, Colorectal at 15.4% and Cardiology at 14.7%.

Chart 2 - 30 day emergency readmissions from December 2013 onwards



Direct stroke unit admission

Stroke performance increased from 53% in April to 68% in May, but has decreased to 44% in June. The majority of breaches were due to medical need requiring specialty input, followed by disruptions in the stroke pathway.

FFT satisfaction score

ED FFT satisfaction score results were 84.7% in April and 86.3% in May but is below target in June at 81.4%. Further detail is that adult satisfaction was 80.5% with a response rate of 1.8% and for paediatric A&E the satisfaction score was 88.9% with a response rate of 0.5%. An action plan is in place to improve the response rate.

Maternity touchpoint 2 score has increased slightly in June to 92.7% from 91.3% last month although still below target of 97%. The response rate was 27.7% and continues to be significantly increased from rates before April 17.

Dementia

It is impractical to analyse the dementia case finding measure score of 38.5% for scorecard item 3.11a as recording is incomplete on the RealTime system due to limited capacity to collect this data from manual assessments in clinical records. It is planned to use VitalPAC to track this data electronically in 2017/18 which is expected to significantly improve this issue.

Patient safety alerts
In June no new safety alerts were received. Open alerts are being actioned and no alerts are overdue.

Safety Thermometer
National Safety Thermometer data for June is not yet available from the national data provider and Medications Safety Thermometer data for May and June is also not published.

Learning from new complaints
38 new complaints were received in June; the largest Divisions by volume being MES with 13 complaints, TASCC with 11 and WH&P with 7. DTTO had 6 complaints and 1 was assigned to the Chief Executive.

1.2 Complaints performance

Performance against timescale agreed with complainant
Of the complaints requiring a response, 72.0% met the timescale agreed with the complainant.

Follow-up complaints
The follow-up complaint rate of 8.1%[2] for June is below the 10% threshold.

PHSO[3] cases
There was 1 new case opened by the PHSO in June and no closed cases.

Claims
There were 2 new claims reported in June 2017 with 1 each for DTTO and WH&P. 11 claims were intimated with 4 for WH&P, 3 for DTTO and 2 each for MES and TASCC.

2.0 Quarterly Quality Account Priorities and Business Plan Q1

Performance is outlined in detail in the dashboard in Appendix 2 on page 8 and by exception below.

Sign up to Safety Falls Trajectory of 50% Cumulative Reduction by end of 2017/18 (319 in total)
The Sign up to Safety falls reduction trajectory of 50% was not achieved in Q1. The quarter total for falls was 116 against a target of 79.75 for the quarter based on the annual target of 319. A review of training and development is being undertaken to increase compliance.

Sign up to Safety Hospital Acquired Stage 2 and above Pressure Ulcers Trajectory of 50% Cumulative Reduction by end of 2017/18 (140.5 in total)
The Sign up to Safety hospital acquired stage 2 and above pressure ulcers reduction trajectory of 50% was not achieved in Q1. The quarter total for hospital acquired pressure ulcers stage 2 and above was 45 against a target of 35.1 for the quarter based on the annual target of 140.5. The wards/clinical areas provide monthly commentary and action plans to reduce pressure ulcers. The Tissue Viability Team continues to verify all hospital acquired pressure damage at stage 2 and above. A centralised database of pressure ulcer damage has been created to

[2] Denominator is rolling 12 month average new complaints per month

[3] PHSO: Parliamentary and Health Service Ombudsman

enable wards/clinical areas to monitor pressure ulcer levels and trajectories of improvement or slippage are displayed. The Tissue Viability Heel SOS campaign continues to promote heel elevation for all patients in addition to the introduction of a heel wedge. The 100 day stage 2 and above pressure ulcer-free campaign will be introduced in the next quarter by the Tissue Viability Team to acknowledge those areas that have achieved the target. The corporate action plan continues to be a live document with 6 monthly review and updating based on analysis, trends and serious incident reports in relation to pressure damage.

Appendix 1 Quality Performance Dashboard June 2017

Table 1: Quality Performance Dashboard 30 June 2017

REF	Quality Scorecard Measures	Outturn 16/167	Monthly Target / Limit	Annual Target / Limit	May	June	6 month trend	YTD 17/18	Current month commentary
1.01	In-hospital SHMI	64	<72	<72	72.71	72.8		68.4	Mortality indices close to monthly target.
1.02	RAMI	62	<70	<70	53.7	51.9		67.4	See below.
1.03	In-hospital deaths	1139	90	<1082	112	99		301	June in-hospital deaths are above target.
1.04	Proportion of mortality reviews (data 1 month in arrears)	56%	>90%	>90%	68.5%	69.0%		68.8%	Mortality Review completion rates were 74% for MES, 73% for TASCC and 0% for both DTTO and WH&P. There were 4 deaths in both DTTO and WH&P in May. DTTO will review the 4 May deaths together with all other deaths in the intervening period at the next QUASH day on 26 September. WH&P reviewed 1 of the cases after the deadline and the remaining 3 are planned to be reviewed on 21 July.
1.05	Number of cardiac arrests not in critical care areas	56	-	-	3	3		8	Finalisation of the Treatment Escalation Plan (TEP) document is imminent; Trustwide rollout will then be implemented.
1.06	Methicillin Resistant Staphlococcus Aureus (MRSA) - hospital only	0	0	0	0	0		0	No cases.
1.07	C. Difficile (hospital only)	15	1.4	17	0	4		4	One case has been reviewed with the CCG and was not deemed a lapse in care. The remaining 3 cases are awaiting root cause analyses and will be reviewed by the CCG in the next quarter.
1.08	Falls (per 1000 beddays)	2.59	2.46	2.46	3.28	2.07		2.65	Falls per 1000 beddays of 2.07 is below target.
1.09	Pressure ulcers (per 1000 beddays)	2.08	1.98	1.98	1.25	2.07		1.67	The monthly CCG target of 11.7 stage 2 hospital acquired ulcers was not achieved this month with 14 stage 2 pressure ulcers. ITU and Swift both had 4 stage 2 pressure ulcers; Maple had 2 stage 2 pressure ulcers and AMU, Aspen, Cedar and Heron Annexe each had 1 stage 2 pressure ulcer. Swift continues with the pressure ulcer Quality Improvement project; areas of concern have been identified and reflections and root cause analyses have been requested of the staff. Swift ward staff identified as requiring training have been booked onto the pressure ulcer study day planned on 28 July. It should be highlighted that the patient caseload was challenging due to contractures and difficulties in repositioning; new Heel Up protection boots were used in these patients. The Tissue Viability Service Team continue to provide mandatory training on a monthly basis. The first order of Repose Wedges has been received in the Trust and ward based training on their use and ordering has commenced.
1.10	Readmissions within 30 days - emergency only	13.1%	12.5%	12.5%	14.1%	15.9%		14.8%	30 day readmissions of 15.9% remains above the annual target of 12.5%. Significant areas by volume were Urology at 21.9%, General Surgery at 20.6%, General Medicine at 20.5%, Upper Gastrointestinal Surgery at 20.3%, A&E at 18.3%, Colorectal at 15.4% and Cardiology at 14.7%.
1.11	Stroke patients (% admitted to stroke unit within 4 hours)	65.0%	90%	90%	67.5%	44.4%		56.1%	The majority of breaches were due to medical need requiring specialty input, followed by disruptions in the stroke pathway.
1.12	Medication errors (rate per 1000 beddays)	2.92	-	-	3.3	2.96		2.81	Medication errors at 2.96 were lower than last month.
1.13	Sepsis screening audits - % of eligible patients that were screened in ED	70.5%	90%	90%	-		-		Sepsis data is reported quarterly and results are reported in arrears; Q1 results should be available next month.
1.14	Sepsis - antibiotics administered on ED patients and day 3 antibiotic review performed	-	-	80% Q2; 90% Q3	-		-		Sepsis data is reported quarterly and results are reported in arrears; Q1 results should be available next month.
1.15	Inpatient sepsis - % eligible patients screened for sepsis	-	-	Dec 90%; Q4 90%	-		-		Sepsis data is reported quarterly and results are reported in arrears; Q1 results should be available next month.
1.16	Inpatient sepsis - % eligible patients receiving timely antibiotics and day 3 antibiotic review performed	-	-	Dec 90%; Q4 90%	-		-		Sepsis data is reported quarterly and results are reported in arrears; Q1 results should be available next month.
3.03	Serious Incidents Requiring Investigation (SIRI) reports overdue to CCG	8	-	-	9	13		13	Under progression by the Safety Team.
3.04	Serious Incidents Requiring Investigation (SIRI) reports submitted to CCG	116	-	-	8	2		17	Under progression by the Safety Team.
3.07	Friends and Family Satisfaction Score - Inpatients including Daycase	96.2%	95%	95%	95.7%	97.3%		96.6%	The FFT Inpatient recommended score of 97.3% is above the monthly target of 95%. The response rate of 18.9% has returned to usual levels after an increase during May. Of note, 100% of patients were likely to recommend include Urology (response rate 66.7%), Wordsworth (response rate 36.2%) and Cedar (response rate 25.9%).
3.08	Friends and Family Satisfaction Score - Accident and Emergency Department (ED) including Paediatrics	84.3%	87%	87%	86.3%	81.4%		84.5%	The FFT satisfaction score for ED is below target at 81.4%. Further breakdown is that adult satisfaction was 80.5% with a response rate of 1.8% and for paediatric A&E the satisfaction score was 88.9% with a response rate of 0.5%. An action plan is in place to improve the response rate.
3.09	Friends and Family Satisfaction Score - Maternity Touch Point 2	96.3%	97%	97%	91.3%	92.7%		92.1%	Maternity touchpoint 2 score was below target of 97%. The response rate was 27.7% and continues to be significantly increased from rates before April 17.
3.09a	Friends and Family Satisfaction Score - Outpatients	0.9	92%	92%	95.3%	95.2%		95.1%	Outpatients FFT score was above target. Response rate of 2.6% has returned to usual levels after introduction of mobile boxes saw exceptional rises in April.
3.10	Follow-up complaints - complaint rate per rolling 12 month average	8.3%	<10%	<10%	8.2%	8.1%		7.2%	3 follow ups were received which were all grade 3, of which 2 were for MES and 1 for TASCC. 38 new complaints were received in June.
3.11a	Dementia case finding	96%	>90%	>90%	37.3%	38.5%		35.6%	Dementia case finding data reporting is incomplete due to limited staff capacity to manually collate this data. It is planned to use VitalPAC to track this data electronically in 2017/18 which is expected to significantly improve recorded results.
3.11b	Dementia diagnostic assessment	99%	>90%	>90%	100.0%	94.9%		98.4%	In line with expectations.
3.11c	Dementia referral	87%	>90%	>90%	100.0%	100.0%		100.0%	In line with expectations.

REF	Reference items	Target description & limit		May	Jun	6 month trend	YTD 17/18	Current month commentary
1	Overdue safety alerts	<1 overdue	<1	0	0			In June no new alerts were received. Open alerts are being actioned and are underway and include the nasogastric tube misplacement alert received in July 2016; the restricted use of open systems for injectable medication received in September 2016 and the safety of girls and women who are being treated with valproate received in April 2017. There are no overdue alerts.
2.1	NHS Safety Thermometer - % of patients on spot day with new harms	< National av.	%	0.41%				National data for June not yet available from the national data provider.
2.2	NHS Safety Thermometer - % of patients on spot day with new CAUTIs	< National av.	%	0.00%				National data for June not yet available from the national data provider.
2.3	NHS Safety Thermometer - % of patients on spot day with new pressure ulcers	< National av.	%	0.21%				National data for June not yet available from the national data provider.
2.4	NHS Safety Thermometer - % of patients on spot day with falls with harm	< National av.	%	0.21%				National data for June not yet available from the national data provider.
2.5	NHS Maternity Safety Thermometer - % of patients with combined harm free care (physical harm and women's perception of safety)	> National av.	73.63%	88.24%	86.67%			Combined maternity harm-free care of 86.67% was above the national average of 73.63%. YTD data is unavailable.
2.6	NHS Medications Safety Thermometer - % of patients with reconciliation started within 24 hours of admission	> National av.						National data for May and June not yet available from the national data provider.
2.7	NHS Medications Safety Thermometer - % of patients with an omitted critical medicine in the last 24 hours	< National av.						National data for May and June not yet available from the national data provider.
3	Best care audits undertaken this month	Level 3 ward count	-			-	-	From 1 April 2017, wards/areas have been completing weekly data collection for between 1 - 3 measures using Quality Improvement methodology; these measures are undertaken for a 3 month period. The next phase of new/continuing measures is currently being decided.
4	WOW awards	-	n/a	32	36		-	WH&P received 15 WOW nominations, MES received 9 and DTTO received 8. TASCC received 2 nominations and Estates & Facilities and Health Informatics each received 1.
5.1	Complaints % Responded to timescale as agreed with complainant	Timeliness	>95%	61.5%	72.0%		-	30 complaints were closed in June. Of these, 5 were grade 1, 16 were grade 2, 8 were grade 3 and 1 was grade 4.
5.2	Complaints % Responded to timescale (Grade 1 & 2 in 25 days)	Timeliness	No target	25.0%	52.0%		-	11 out of 21 complaints were responded to within the target timescale. 9 were allocated 35 working days for review by the Chief Executive. Ther were 2 grade 2 follow ups, of which 1 was completed in 58 days and 1 in 302 days.
5.3	Complaints % Responded to timescale (Grade 3 & 4 in 35 days)	Timeliness	No target	29.0%	56.0%		-	5 of the 9 closed complaints were completed within the timescale.
5.4	Complaints mean response time in days: variance from 25 day target (Grade 1 & 2)	Responsiveness	No target	23.00	10.00	-	-	This month there were no major outliers and 3 complaints were closed in under 10 days.
5.5	Complaints mean response time in days: variance from 35 day target (Grade 3 & 4)	Responsiveness	No target	36.00	0.00	-	-	The mean response was 35 days. 2 complaints were closed in under 6 days as they were amended to SIRIs. In addition, there were no major outliers.
5.6	PHSO (Ombudsman) cases open - total number	Response quality	No target	4	5		-	There are 5 PHSO cases open, of which 1 remains open from 2015-16.
5.7a	PHSO (Ombudsman) cases closed but not upheld	Response quality	No target	0	0			
5.7b	PHSO (Ombudsman) cases closed and partially upheld	Response quality	No target	0	0			
5.7c	PHSO (Ombudsman) cases closed and upheld	Response quality	No target	0	0			No cases closed in June.
5.8	PHSO (Ombudsman) new cases received	Response quality	No	1	1			There was 1 new PHSO case in June regarding treatment of a confused elderly patient.

Appendix 2 Quality Account Priorities and Business Plan Dashboard

Quality Priority Dashboard 2017-18

REF	2017/18 Quality Account Measure	Q1	Quarter 1 Narrative
	Priority 1 - Safety - Improving harm free care		
1.1	Strengthen governance of medication errors and learning from these by improving year on year Medication Safety Thermometer performance.		Monthly Medication Safety Thermometer data has been collected, however there has been a change in the data provider and national data has been made available up to April 2017 only.
1.2	Maternity Safety Thermometer performance to be better than the national average.		In Q1 combined maternity harm free care was better than the national average.
1.3	Continue the Sign up to Safety falls trajectory with the reduction of falls to be set to achieve a 50% cumulative reduction by end of 2017/18 (Plan Year 3). Reduce falls by 102 per annum in 2017-18, with no more than 319 total falls in 2017-18.		The quarter total for falls was 116 against a target of 79.75 for the quarter based on the annual target of 319. A review of training and development is being undertaken to increase compliance.
1.4	Continue the Sign up to Safety hospital acquired stage 2 and above pressure ulcer reduction trajectory with the reduction to be set to achieve a 50% cumulative reduction by end of 2017/18 (Plan Year 3). Reduce PU stage 2 and above hospital acquired by 99.5 per annum in 2017-18, with no more than 140.5 total stage 2 and above hospital acquired PUs in 2017-18.		The quarter total for hospital acquired pressure ulcers stage 2 and above was 45 against a target of 35.1 for the quarter based on the annual target of 140.5. The wards/clinical areas provide monthly commentary and action plans to reduce pressure ulcers. The Tissue Viability Team continues to verify all hospital acquired pressure damage at stage 2 and above. A centralised database of pressure ulcer damage has been created to enable wards/clinical areas to monitor pressure ulcer levels and trajectories of improvement or slippage are displayed. The Tissue Viability Heel SOS campaign continues to promote heel elevation for all patients in addition to the introduction of a heel wedge. The 100 day stage 2 and above pressure ulcer-free campaign will be introduced in the next quarter by the Tissue Viability Team to acknowledge those areas that have achieved the target. The corporate action plan continues to be a live document with 6 monthly review and updating based on analysis, trends and serious incident reports in relation to pressure damage.
1.5	Risk assess 97% of adult inpatients for VTE on admission.		April 2017 - 98.56%, May - 98.90% and June figures will be available later in July. To date the quarter the average is 98.73% and the target has been achieved.
1.6	Root cause analysis (RCA) of 100% of identified cases of hospital associated thrombus (HAT) in 2 months.		All diagnostic screening for VTE for Q1 is up to date. Screening is completed weekly and HATs are identified and notified on the same day. In Q1 27 HATS were identified, of which 17 have had RCAs completed, all within the 2 month deadline. The RCA review group has reviewed 9 of these. After further review, 3 of the 27 were not actually HATs. There are 10 RCAs awaiting completion.
1.7	Audited documentation of the prescription of appropriate chemical thromboprophylaxis with the aim of achieving 85%.		April - 82%, May - 90%, June - 76%. The quarter average is 83%. A review of the audit tool is planned for 17/18 to ensure data validity, and to reduce duplication of data. It is important to note that this measure is looking at whether the prescription of chemical thromboprophylaxis is appropriate according to the outcome of the risk assessment tool. It does not measure whether patients have received thromboprophylaxis or whether thromboprophylaxis has been prescribed in general.
1.8	Work towards the national target limits for E. Coli bacteraemia infection, with trajectories to reduce these in 2017.		It has been agreed with the CCG that the Trust will undertake an in depth review of a sample of cases; most of which are community cases. The Surrey Infection & Prevention Committee was in agreement.
1.9	Trustwide rollout of the National Aseptic Non Touch Technique (ANTT) protocol as part of the overall drive to reduce hospital acquired infection and thus length of stay.		New equipment (trays) for intravenous drug administration has been implemented and resources have been secured for the Aseptic Non Touch Technique. A meeting is planned with Clinical Practice Educators and Clinical Nurse Leader on 27 July to progress training of ANTT which will replace the current aseptic training technique.

	Priority 2 - Caring for patients in a safe way, without delay		
2.1	Implement a process to improve early diagnosis of cancer through sharing upfront learning with clinical teams quarterly as new claims arise (with focus on missed/delayed diagnosis).		Learning points are often covered under the Root Cause Analysis (RCA) and Serious Incident Requiring Investigation (SIRI) processes under the care of the patient safety team. Any action points or process issues highlighted by such SIRI reports will then be added to the cancer risk register and reviewed via cancer board. Cancer risk register yet to be formalised, currently underway and to be ratified by cancer board.
2.2	Increase completion rates and improvement opportunities for learning from mortality reviews within the Clinical Divisions, in line with national guidance documents. Target to be set in Q2 once guidance has been assimilated, with improvement trajectory for achievement by Q4.		A business case has been written and is due to be presented to the Trust Executive Committee in August 2017 to secure funding for the new process. This process will incorporate RCP/NHS England guidance.
	Priority 3 - Safety standards and our clinical workforce		
3.1	Progress the Reducing Variation Programme including participating in the external data collection exercise. This programme will continue throughout 2017/18.		At the beginning of July the Trust hosted a visit from Professor Tim Briggs from the *Get it Right First Time* Programme focusing on improving clinical quality and efficiency by reducing unwarranted variations in care. Trauma & Orthopaedics has embedded this methodology and this will be rolled out to other divisions.
3.2	Formulate a Clinical Workforce Strategy and develop demand/capacity modelling for the medical workforce by Q4.		Meetings for the Medical Workforce Group chaired by the Medical director have commenced.
3.3	Commence a nursing associate test pilot in conjunction with Health Education England and the Nursing Associate Implementation Programme.		The Nursing Associate programme has commenced and we have 13 members of staff signed up to the pilot. The Trust is part of a wider consortium called Surrey Heartlands and we lead on the scrutiny panel and placement development aspect of the pilot.
3.4	Communication campaign to promote staff awareness of the Freedom to Speak up Guardian role by Q2.		The communication campaign continues with the following in place: new intranet website; e-training available; launch on Aspire via CEO message; poster campaign, talks in clinical areas and on junior doctors' training day and a new policy ratified by the Trust Executive Committee. Second Board report is due in September 2017. Ongoing plan for Q2 includes visits to clinical areas and a stand at Junior Doctors' induction in August. An aim is for Compliance in Practice Audit scores to improve regarding knowledge of Freedom to Speak up.
	Priority 4 - Clinical effectiveness: work to improve diagnosis for patients with diabetes		
4.1	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 be set at 98% which is consistent with the target set from 2014/15 onwards.		The percentage of patients undergoing capillary blood glucose testing within 24 hours of admission was 93% in Q1, falling from 95% in Q4 2016 - 17. It is thought that staffing and ward management changes may have impacted some areas. This will be investigated further and the diabetes specialist nurse will visit the areas having difficulties.

5.1	Implementation of relevant NICE Clinical Guidelines – monthly status report on progress including a gap analysis with reasons for non-compliance identified.		Checks have been made on Trust Formulary and approved lists for Technology Appraisals and all were compliant. As further guidance was published at the end of June, evidence on compliance needs to be considered at a later date. Ongoing work by divisional teams to disseminate guidance for review by clinical teams. It is noted that there have been recent updates to all divisional plans.
5.2	Set up an extranet site to share learning openly to both staff and the wider public learning from a range of areas including external reviews, audits, serious incidents and complaints.	TBC	This initiative is pending.
5.3	Participate in all applicable mandatory national audits and implement action plans based on key recommendations from the national bodies.		CENARG meeting on 5 July 17 reviewed participation in applicable mandatory audits. Some updates are awaited. CENARG now has a programme for review of recommendations from national studies; the NCEPOD self-assessment on Alcohol Related Liver Disease was reviewed at the meeting.
	Priority 6 - Patient experience: work to improve the experience of vulnerable groups		
6.1	Feasibility test and develop specialty volunteers to support named areas, with first pilot in dementia.		Recruitment plan is underway supported by David Sills, Admiral Nurse Lead and Diana Sheridan, Occupational Therapist. The aim is to recruit and train a cohort of 10 volunteers by the end of Q3. Two volunteers have been booked for corporate induction at the end of July 2017.
6.2	Either adopt or locally adapt the principles of the *NHS England Quality Checkers Programme for Patients with Learning Disability and Autism.*		Peer review has been discussed at the Surreywide partnership group and is planned to be completed in Quarter 4. The young ambassadors Learning Disability group has completed a pilot site visit and review of another trust and they have been requested to review ASPH.
	Priority 7 - Promote patient empowerment		
7.1	Pilot a patient awareness empowerment initiative as part of planned care pre-admission to promote, where appropriate, patient 'self care' and encourage challenging poor care.		The Patient Panel has been consulted on how they can help with this action.
7.2	Develop in-house a Trustwide *#InvolveMe* programme encompassing involving patients in planning their care incorporating service level consideration of patient equality characteristics.		Pending.
	Priority 8 - Improve patient experience		
8.1	Continue to develop a means of communicating to inpatients the potential for transfers between wards as part of their expected care pathway and implement this communication process by Q2.		Booklet has been developed by the Division.
8.2	Further embed *Always Events* by introducing 2 new always events covering the areas of (1) medications safety and (2) patient involvement (including shared decision making) and understanding of care planning.		(2) Always Event planning is underway for "addressing young carers" with Eileen White, Named Nurse for Safeguarding Children and Young People. Initial preparation on patients' experience of care planning/shared decision making is underway with Quality Improvement team interviewing patient case studies.
8.3	A minimum of 95% of patients in the Urgent Care Centre to achieve the 4 hour wait target.		The 95% target was achieved in Q1.

	Priority 9 - opportunities for patient involvement in research		
9.1	Continue to meet the Department of Health requirements to increase our recruitment of patients to clinical research studies by 20% year on year.		In the first quarter of the year we are already well on track and above our target requirements in recruitment to our clinical studies.
9.2	Enhance Trustwide communication to staff promoting research publications and studies, to include signposting to the Knowledge and Research Hub.		In June we held a very successful R&D Open Event which was opened by our Chairman, and jointly chaired during the afternoon by our CEO and Medical Director. Suzanne Rankin made this event the subject of her weekly message. Our Summer newsletter is currently being printed; all copies of our Winter one have been distributed.
	Priority 10 - Transformational cross-boundary working		
10.1	Actively participate in the Surrey Heartlands Sustainability and Transformation Programme (STP). Specific objectives to be set 6 monthly as the STP progresses.		The Trust is an active participant in Surrey Heartlands Sustainability and Transformation Programme (STP). Members of the Executive Team and clinicians from the Trust lead a number of significant workstreams in the STP (MSK, Cardiovascular, Workforce and Digital). Direction and specific milestones for progress are set and monitored by the Surrey Heartlands Transformation Programme Board. Surrey Heartlands STP has been successful in securing devolution, a major step forward which will lead to integrated commissioning.

REF	Business Plan Measure	Q1	Quarter 1 Narrative
1	Actively participate in the Surrey Heartlands Sustainability and Transformation Programme (STP). specific objectives to be set 6 monthly as STP progresses		The Trust is an active participant in Surrey Heartlands Sustainability and Transformation Programme (STP). Members of the Executive Team and clinicians from the Trust lead a number of significant workstreams in the STP (MSK, Cardiovascular, Workforce and Digital). Direction and specific milestones for progress are set and monitored by the Surrey Heartlands Transformation Programme Board. Surrey Heartlands STP has been successful in securing devolution, a major step forward which will lead to integrated commissioning.
2	Further embed Aways Events by introducing 2 new always events covering the areas of (1) medications safety and (2) patient involvement (including shared decision making) and understanding of care planning.		(2) Always Event planning is underway for "addressing young carers" with Eileen White, Named Nurse for Safeguarding Children and Young People. Initial preparation on patients' experience of care planning/shared decision making is underway with Quality Improvement team interviewing patient case studies.
3	Continue Adopt a Grandparent programme with rollout to selected new wards in 2017/18. Measure impact via feedback from service users.		Around 10 staff volunteers are signed up and active on Holly, Swift, Cherry and Maple wards. Adopt a Grandparent Diaries on the wards monitor activity. Increase in activity is planned and expected in the autumn.
4	Develop an in-house Commitment to Carers patient engagement and information programme.		Carers plan approved by the Trust Executive Committee. Planned roll out via a task and finish group lead by the Deputy Chief Nurse. Carers lead appointed and in post working with medical Matrons.
5	Clinical strategy rollout emphasising working practices and behaviours by clinicians which promote our philosophy of care.	TBC	No update received.
6	Continue iWant Great Care rollout of clinician level data; uptake and impact assessment mechanism to be developed to guide improvement action plan.		New promotional activity is planned following soft launch in December 16. New monitoring is in progress. During the quarter there were 65 reviews for 20 clinicians.
7	Continue to meet the Department of Health requirements to increase our recruitment of patients to clinical research studies by 20% year on year.		In the first quarter of the year we are already well on track and above our target requirements in recruitment to our clinical studies.
8	Refresh Quality, Safety, and Risk Management Strategy and supporting strategies where applicable (e.g., Patient Experience Strategy).		Strategy due for refresh in Q3 2017/18. The plan for this has been discussed and a delivery schedule is required that will include focus groups, Divisions and the MDT.

9	Formulate Clinical Workforce Strategy with demand / capacity modelling for the medical workforce.	TBC		No update received.
10	Adapt the principles of the NHS England Open and Honest Care Driving Improvements Programme (OHCP) to share key elements of monthly Quality Report or other applicable safety, experience, and effectiveness information more widely among staff and the public.	TBC		No update received.
11	Either adopt or locally adapt the principles of the NHS England Quality Checkers Programme for Patients with Learning Disability and Autism.			Peer review has been discussed at the Surreywide partnership group and is planned to be completed in Quarter 4. The young ambassadors Learning Disability group has completed a pilot site visit and review of another trust and they have been requested to review ASPH.
12	Develop in-house Trustwide #InvolveMe programme encompassing involving patients in planning their care incorporating service level consideration of patient equality characteristics.	TBC		No update received.
13	Feasibility test and develop specialty volunteers to support named areas, with first pilot in dementia.			Recruitment plan is underway supported by David Sills, Admiral Nurse Lead and Diana Sheridan, Occupational Therapist. The aim is to recruit and train a cohort of 10 volunteers by the end of Q3. Two volunteers have been booked for corporate induction at the end of July 2017.
14	Pilot a patient awareness empowerment initiative as part of planned care pre-admission to promote, where appropriate, patient 'self care' and encourage challenging poor care.			The Patient Panel have been consulted on how they can help with this action.
15	Develop a long term integrated Chaplaincy strategy with Royal Surrey County Hospital based on the model of a Spiritual Health and Wellbeing Centre.			The Lead Chaplain has been in his part-time post at the Trust since January 2017 and was unaware of the proposed long term integrated chaplaincy strategy with Royal Surrey County Hospital (RSCH), particularly in light of the discontinued merger. The chaplaincy's priority is to continue developing in becoming an excellent centre of spiritual health and wellbeing, including modernising and making services more personal and compassionate and increasing chaplaincy activity and diversity.
16	Improve early diagnosis of cancer through sharing upfront learning with clinical teams quarterly as new claims arise (with focus on missed/delayed diagnosis).			Learning points are often covered under the Root Cause Analysis (RCA) and Serious Incident Requiring Investigation (SIRI) processes under the care of the patient safety team. Any action points or process issues highlighted by such SIRI reports will then be added to the cancer risk register and reviewed via cancer board. Cancer risk register yet to be formalised, currently underway and to be ratified by cancer board.
17	Build on the work of the Mortality Review Group to increase completion rates and improvement opportunities regarding learning from mortality reviews within the Clinical Divisions.			A business case has been written and is due to be presented to the Trust Executive Committee in August 2017 to secure funding for the new process. This process will incorporate RCP/NHS England guidance.
18	Work towards the national target limits for E. coli bacteraemia infection, with trajectories to reduce these in 2017/18.			It has been agreed with the CCG that the Trust will undertake an in depth review of a sample of cases; most of which are community cases. The Surrey Infection & Prevention Committee was in agreement.
19	Trustwide rollout of the National Aseptic Non Touch Technique (ANTT) protocol as part of the overall drive to reduce hospital acquired infection and thus length of stay.			New equipment (trays) for intravenous drug administration has been implemented and resources have been secured for the Aseptic Non Touch Technique. A meeting is planned with Clinical Practice Educators and Clinical Nurse Leader on 27 July to progress training of ANTT which will replace the current aseptic training technique.

20	Refresh Sign up to Safety Plan Year 3 – falls trajectory to determine a revised target reduction of falls in 2017/18.			The quarter total for falls was 116 against a target of 79.75 for the quarter based on the annual target of 319. A review of training and development is being undertaken to increase compliance.
21	Refresh Sign up to Safety Plan Year 3 – stage 2 (and above hospital acquired) pressure ulcers trajectory to determine a revised target reduction of stage 2 pressure ulcers in 2017/18.			The quarter total for hospital acquired pressure ulcers stage 2 and above was 45 against a target of 35.1 for the quarter based on the annual target of 140.5. The wards/clinical areas provide monthly commentary and action plans to reduce pressure ulcers. The Tissue Viability Team continues to verify all hospital acquired pressure damage at stage 2 and above. A centralised database of pressure ulcer damage has been created to enable wards/clinical areas to monitor pressure ulcer levels and trajectories of improvement or slippage are displayed. The Tissue Viability Heel SOS campaign continues to promote heel elevation for all patients in addition to the introduction of a heel wedge. The 100 day stage 2 and above pressure ulcer-free campaign will be introduced in the next quarter by the Tissue Viability Team to acknowledge those areas that have achieved the target. The corporate action plan continues to be a live document with 6 monthly review and updating based on analysis, trends and serious incident reports in relation to pressure damage.
22	Set up an extranet site to share learning openly to both staff and the wider public learning from a range of areas including external reviews, audits, serious incidents and complaints.	TBC		This initiative is pending.
23	Commence a nursing associate test pilot in conjunction with Health Education England(HEE) and the Nursing Associate Implementation Programme.			The Nursing Associate programme has commenced and we have 13 members of staff signed up to the pilot. The Trust is part of a wider consortium called Surrey Heartlands and we lead on the scrutiny panel and placement development aspect of the pilot.
24	Explore learning and training opportunities such as through the apprenticeship scheme.			The Apprenticeship scheme for clinical staff is under developemnt and we have had an open evening to assess the level of enthusiasm for this model of training. The Trust is looking at a model to recruit HCA's
25	Rollout multiprofessional integrated Education Strategy for all staff.			This is being evaluated currently.
26	Develop additional training courses or events with a view to both improving our staff's development opportunities whilst simultaneously promoting the Trust and gaining revenue from external attendees.			To date we have run courses for Tissue Viability and Educational mentoring
27	Quality Department learning needs analysis and training programme formulation.			This is pending development.
28	Communication campaign to promote staff awareness of the Freedom to Speak up Guardian role.			The communication campaign continues with the following in place: new intranet website; e-training available; launch on Aspire via CEO message; poster campaign, talks in clinical areas and on junior doctors' training day and a new policy ratified by the Trust Executive Committee. Second Board report is due in September 2017. Ongoing plan for Q2 includes visits to clinical areas and a stand at Junior Doctors' induction in August. An aim is for Compliance in Practice Audit scores to improve regarding knowledge of Freedom to Speak up.
29	Expand use of a variety of quality improvement tools (such as run charts) thereby improving or expanding data presentation to improve the quality of care.			The re-designed Best Care Audits with Quality Improvement methodology use run charts for presentation of data to help identify if and when changes in care have been sustained.

30	Develop a personalised solution to providing relatives with patients' personal possessions following a bereavement.			The Bereavement Office has sourced large green plastic patient property bags which are now being used to replace inappropriate carriers such as bin bags or poor quality bags.
31	Enhance Trustwide communication to staff promoting research publications and studies, to include signposting to the Knowledge and Research Hub.			In June we held a very successful R&D Open Event which was opened by our Chairman, and jointly chaired during the afternoon by our CEO and Medical Director. Suzanne Rankin made this event the subject of her weekly message. Our Summer newsletter is currently being printed; all copies of our Winter one have been distributed.
32	In November 2016 the CQC issued the results of its review into its NHS National Patient Survey Programme - 1 annual Inpatient Survey plus rolling 2 yearly surveys in Urgent and Emergency Care, Maternity, and Children and Young People. Implement new survey regime as per national timescales when released.			The 2017 Inpatient Survey programme is underway. Data will be captured at the end of July. Resources have been secured to ensure timely reporting of data. Promotion of the survey to inpatients is underway.
33	Strengthen governance of medication errors and learning from these; improve year on year Medication Safety Thermometer performance.			Monthly Medication Safety Thermometer data has been collected, however there has been a change in the data provider and national data has been made available up to April 2017 only .

Appendix 3 Summary of National Audit of Dementia 2017 – results for Ashford & St. Peter's Hospitals NHS Foundation Trust

Theme	Description	Hospital average	National average
Governance	Data from the organisational checklist. This looks at the involvement of hospital leads and the Executive Board in leading, planning and monitoring care for people with dementia including delayed discharges, complaints and carer engagement strategies.	81.3%	65%
Nutrition	Data from the organisational checklist. This looks at how hospitals organise and monitor nutritional needs for patients with dementia including protected mealtimes, the provision of appropriate foods and allowing carers to visit at all times.	100%	84%
Discharge Planning	Data from the casenote audit. This looks at evidence in patient notes about discharge planning including whether discussion about the place of discharge and support needs took place with the patient, carer and members of the multidisciplinary team.	58.3%	73%
Assessment	Data from the casenote audit. This looks at whether people with dementia admitted to hospital received a comprehensive assessment including assessments of mobility, nutritional status, pain, pressure ulcer, continence, functioning and screening for delirium.	86%	84%
Staff and Carer ratings of information and communication	Data from the carer and staff questionnaires. These two scores rate the quality of information and communication in the hospital from the point of view of staff and carers. This includes asking the carer about recording and effective sharing of personal information about the patient with dementia.	65.8%	65%
Carer rating of patient care	Data from the carer questionnaire. Carers were asked to rate the quality of care overall on a five-point scale ranging from Excellent to Poor.	Insufficient feedback	72%