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

TRUST BOARD
27 October 2016

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 September 2016[1]. Mortality review completion at 64% is below target of 90% and is lower than 67% last month. The 2 C.difficile cases in September are due to be reviewed by the CCG to determine whether there were any lapses in care. Stroke performance increased significantly from 65.4% last month to 75% although it remains below target. FFT satisfaction score for maternity touchpoint 2 was below the expected level and may reflect bias due to low feedback response rates. Falls with harm of 1.11% were above the national average of 0.60% and relate to 5 low harm falls on AMU, BACU and May wards. Maternity Safety Thermometer was not submitted in September 2016; in future,	

[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).

	the ward manager will be responsible for data submission. Patients with reconciliation started within 24 hours of admissions at 70.00% were lower than the national average of 77.29%. Pharmacy is working through a redesign of its service with implementation to be undertaken by the end of 2016. 20% reduction in falls target has been missed, with an average of 35 falls per month to date. Comprehensive actions are in place. In Q2, screening of 98% of eligible inpatients for diabetes was not achieved, but increased to 94% from 89% last quarter; this is likely to be due to embedding of the new ANA document. Complaints responded to within the agreed timescale with the complainant, was 93% for September. The action plan measure from the Fix Dementia Care report is to be discussed and reviewed as it is not feasible to collate data quarterly - biannual or annual collation would be more appropriate. In Q2 the Trust achieved Safety Thermometer performance better than the national average apart from 2 months: new pressure ulcers in July 2016 and falls with harm in September 2016. 15% reduction in pressure ulcers was narrowly missed for July but was achieved in August and September. The focus for the next quarter will be ensuring that wards which consistently report hospital acquired pressure damage develop localised initiatives to reduce patient harms. Approval is being sought from patient representatives for the patient information leaflet on ward moves. Appendix 3 summarises results from the 2015 CQC National Cancer Patient Experience Survey.
RECOMMENDATION:	Review the paper and seek additional assurance as necessary.
SPECIFIC ISSUES CHECKLIST:	
Quality and safety	Y
Patient impact	Y
Employee	Y
Other stakeholder	Quality priorities are set following consultation with internal and external stakeholders.
Equality & diversity	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	Not applicable.

Legal	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	Dr Erica Heppleston, Assistant Director Regulation and Improvement
PRESENTED BY	Dr David Fluck, Medical Director and Mrs Heather Caudle, Chief Nurse
DATE	27 October 2016
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 pages 6 to 7. 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 – September clinical quality data

Mortality reviews
Mortality review completion rates increased for MES from 59% to 64%; rates decreased for TASCC from 100% to 77%, and DTTO and WH&P did not complete any reviews this month. The overall completion rate fell to 63% from 67%.

C.difficile
The CCG is due to review the 2 cases of C.difficile to determine whether they were avoidable.

Emergency 30-day readmissions
Readmissions within 30 days at 12.9% was significantly improved from previous months.

Direct stroke unit admission
September stroke performance increased to 75% but is below the target of 90%; the majority of breaches were due to lack of ring-fenced beds.

FFT satisfaction score
FFT satisfaction score for maternity touchpoint 2 was below the expected level and may reflect bias due to low feedback response rates.

Safety thermometer
Falls with harm of 1.11% were above the national average of 0.60% and relate to 5 low harm falls on AMU, BACU and May wards.

Maternity Safety Thermometer was not submitted in September 2016; moving forward, the ward manager will be responsible for data submission.

Patients with reconciliation started within 24 hours of admissions at 70.00% were lower than the national average of 77.29%. Pharmacy is working through a redesign of its service with implementation to be undertaken by the end of 2016.

Complaints performance
Complaints responded to within the agreed timescale with the complainant, was 93% for the month of September. 2 complaints did not leave the Trust within the agreed timeframe with the complainant; both left the Trust 2 days later than agreed and were for MES and DTTO. Attempts were made to contact the complainants but were unsuccessful. The average response time for September was 26.5 days for grades 1 & 2 complaints. Grades 3 & 4 complaints have an average response time in September of 65 days. One complaint has skewed the figure for September as there was also a SIRI process running and the complaint was not closed until the

whole process had been completed. This case took 231 days to close. Follow-up complaints in September have dropped to below the 10% threshold at 8.4% in September with 3 follow-up complaints received. The year to date figure of 6.5% remains below the 10% limit.

PHSO[2] cases
In September the Trust has not been notified of any new cases to be investigated by the PHSO. The Trust currently has 4 open cases. No cases were closed in September.

Claims
2 new claims were reported in September; 1 for DTTO and 1 for TASCC. 2 claims were intimated with DTTO (1) and WH&P (1).

Patient safety alerts
One new patient safety alert was received in September 2016.

1.2 Performance by exception – Q2 Quality Account and Business Plan review

The majority of priorities are on track. Areas slipped or at significant risk are outlined below by exception. For more information refer to the dashboard in Appendix 2 on pages 9 -12.

Safety thermometer
Medications Safety Thermometer data collection is ongoing and results are compared with the national position. Pharmacy is working through a redesign of its service with implementation to be undertaken by the end of 2016; this will include amending the inpatient medication chart to include high risk medicines, an administration section to document actions taken if a drug is unavailable and plans to keep the charts in the clinical area. Pharmacy clinical services will be prioritised to ensure that all patients on any high risk medicines will have a formal clinical review by a suitably experienced pharmacist.

Maternity Safety Thermometer performance better than the national average: July and September data was not submitted. The ward manager has agreed to take responsibility for this in future. The Maternity governance team is reviewing cases for improvement actions where appropriate and progress is reported on a weekly basis to the Chief Nurse.

In Q2 the Trust achieved Safety Thermometer performance better than the national average apart from 2 months: new pressure ulcers in July 2016 and falls with harm in September 2016.

Falls
20% reduction in falls target has been missed, with an average of 35 falls per month to date. Actions which have been implemented to reduce falls include a colour coded poster with specific instructions for different locations including ward areas and bathrooms, ongoing development of a colour coded patient mobility status tool and a trial of fluorescent walking frames. Red blankets for patients with cognitive impairment will also be used.

Pressure ulcers
15% reduction in pressure ulcers was narrowly missed for July but was achieved in August and September. Training in pressure ulcer prevention is now mandatory and teaching is occurring monthly. The Trust has implemented new alternating air mattresses with training from company representatives being undertaken. The focus for the next quarter will be ensuring that wards

[2] Parliamentary and Health Service Ombudsman

which consistently report hospital acquired pressure damage develop localised initiatives to reduce patient harms.

VTE
In Q2, no cases of HAT were identified. Due to service pressures, no diagnostic screening review was carried out. If service pressures reduce, this will be addressed in Q3.

Diabetes
In Q2, screening of 98% of eligible inpatients for diabetes was not achieved, but increased to 94% from 89% last quarter; this is likely to be due to embedding of the new ANA document.

NICE guidance
Divisional NICE guidance status report and gap analysis is under view by divisions but regular updates to the plans are necessary, particularly by WH&P. The Trust is participating in a variety of national audits.

Dementia
The action plan measure from the Fix Dementia Care report is to be discussed and reviewed as it is not feasible to collate data quarterly - biannual or annual collation would be more appropriate.

Ward moves
Approval is being sought from patient representatives for the patient information leaflet on ward moves.

Outpatient experience
Refreshing the 15 steps tool for outpatient experience is planned for Q3.

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Appendix 1 - Quality Performance Dashboard September 2016

Table 1: Quality Performance Dashboard 30 September 2016

REF	Quality Scorecard Measures	Outturn 15/16	Monthly Target / Limit	Annual Target / Limit	Aug	Sep	6 month trend	YTD 16/17	Current month commentary
1.01	In-hospital SHMI	64	<72	<72	64	62		63	Mortality indices in line with expectation.
1.02	RAMI	62	<70	<70	66	55		60	Mortality indices in line with expectation.
1.03	In-hospital deaths	1139	90	<1082	92	87		547	In hospital deaths are below the monthly limit of 90.
1.04	Proportion of mortality reviews (data 1 month in arrears)	56%	>90%	>90%	67%	63%		52%	Completion rates were 77% for TASCC, 64% for MES and 0% for DTTO and WH&P. All specialties are due to attend quarterly mortality review meetings.
1.05	Number of cardiac arrests not in critical care areas	56	-	-	1	3		18	Review of the 3 cases has been undertaken; the patients were in the appropriate areas but deteriorated rapidly. There did appear to be a delay in calling the doctor for 1 case and discussion with the ward staff is planned.
1.06	Methicillin Resistant Staphlococcus Aureus (MRSA) -	0	0	0	0	0		0	On track with zero cases.
1.07	C. Difficile (hospital only)	15	1.4	17	1	2		6	The 2 C.difficile cases will be reviewed by the CCG to determine whether there were any lapses in care.
1.08	Falls (per 1000 beddays)	2.59	2.46	2.46	3.03	2.21		2.35	Falls per 1000 beddays for September are below the monthly target and falls prevention strategies continue.
1.09	Pressure ulcers (per 1000 beddays)	2.08	1.98	1.98	2.21	1.67		2.04	The monthly target of 18.2 stage 2 hospital acquired pressure ulcers (PUs) was met in September 2016 with 12 stage 2 ulcers. 1 palliative patient on AMU developed 3 stage 2 pressure ulcers which were probably due to SCALE (skin changes at life's end) and unavoidable. Internal and external discussion is currently ongoing regarding reporting such cases in the future, but possibly excluding them from the reduction strategy. Swan had 3 stage 2 pressure ulcers; ongoing action plans include being more vigilant with repositioning and documentation. The ward manager is to identify any extra training requirements. ITU had 2 stage 2 pressure ulcers; due to the increase in device related pressure ulcers, training will focus on skin monitoring around devices. The 2 stage 3 pressure ulcers on Aspen and Maple wards occurred on 1 palliative care and 1 paraplegic patient respectively and root cause analyses are in progress.
1.10	Readmissions within 30 days - emergency only	13.1%	12.5%	12.5% by Q4	14.9%	12.9%		13.9%	Readmisions within 30 days was close to the monthly target of 12.5%. Significant areas by volume were in MES with A&E at 21.7% and general medicine at 17.1%. Specialty readmissions data continues to be reviewed at governance meetings.
1.11	Stroke patients (% admitted to stroke unit within 4 hours)	65.0%	90%	90%	65.4%	75.0%		63.9%	September stroke performance increased to 75% from 65.4% the previous month, with 8 breaches. 3 of these were due to lack of ring fenced beds, 2 were due to disruptions in the stroke pathway and 2 were complex cases to diagnose.
1.12	Medication errors (rate per 1000 beddays)	2.92	-	-	2.95	3.21		2.92	The Trust continues to promote notifying and investigating medication errors which is driving increased reporting.
1.13	Sepsis screening audits - % of eligible patients that were screened in ED	70.5%	90%	90%	-	-	-		Data is reported quarterly.
1.14	Sepsis - antibiotics administered on ED patients and day 3 antibiotic review performed	-	TBC	TBC	-	-	-		Data is reported quarterly.
1.15	Inpatient sepsis - % eligible patients screened for sepsis	-	TBC	TBC	-	-	-		Data is reported quarterly.
1.16	Inpatient sepsis - % eligible patients receiving timely antibiotics and day 3 antibiotic review performed	-	TBC	TBC	-	-	-		Data is reported quarterly.
3.03	Serious Incidents Requiring Investigation (SIRI) reports overdue to CCG	8	-	-	3	3		3	The Safety Team continue to actively progress completion of overdue SIRI reports.
3.04	Serious Incidents Requiring Investigation (SIRI) reports submitted to CCG	116	-	-	16	9		56	Under review by the Safety Team.
3.07	Friends and Family Satisfaction Score - Inpatients including Daycase	96.2%	95%	95%	91.6%	94.4%		94.6%	The inpatient recommended score has improved in September compared to August and is just below target of 95%.
3.08	Friends and Family Satisfaction Score - Accident and Emergency Department (ED) including Paediatrics	84.3%	87%	87%	87.7%	87.8%		83.0%	The ED recommended score remains higher than the national average for the second month running. The response rate remained low in September, however significant efforts are underway to improve this over the coming months and increase staff engagement.
3.09	Friends and Family Satisfaction Score - Maternity Touch Point 2	96.3%	97%	97%	95.5%	87.5%		96.7%	The recommended score for touchpoint 2 is below the expected level in September. This may be partly due to a skewed result as there was only a small amount of feedback. This has been raised with the division who will make efforts to increase feedback response rate moving forwards.
3.09a	Friends and Family Satisfaction Score - Outpatients	0.9	92%	92%	96.6%	96.5%		95.9%	The Outpatient recommended score remains above the national average and stable.
3.10	Follow-up complaints - complaint rate per rolling 12 month average	8.3%	<10%	<10%	11.1%	8.4%		6.5%	There were 3 follow-up complaints received in the month of September, of which 1 was a grade 3 complaint for WH&P, 1 a grade 2 complaint for MES and the last a grade 1 complaint for DTTO. The latter is the second follow-up for this particular complaint and the complainant has been advised to contact the PHSO should they remain dissatisfied.
3.11a	Dementia case finding	96%	>90%	>90%	73%	TBC		79%	Dementia data is not available until near the end of the month, thus will be reported 1 month in arrears.
3.11b	Dementia diagnostic assessment	99%	>90%	>90%	100%	TBC		100%	As above.
3.11c	Dementia referral	87%	>90%	>90%	92%	TBC		98%	As above.

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REF	Reference items	Target description & limit		Aug	Sep	6 month trend	YTD 16/17	Current month commentary
1	Overdue safety alerts	<1 overdue	<1	0	0		n/a	There was 1 new stage 3 safety alert received on 7 September 2016 on the restricted use of open systems for injectable medication. This alert requires Trusts to revise policies and protocols to ensure an 'open system' of injectable medicines from containers such as gallipots is not used, with the exception only of embolization procedures involving embolic agents that need to be prepared openly. This alert builds on a previous NHS England Patient Safety Warning alert. This alert has been actioned and is underway. Alerts received prior to September are all either actioned and underway or closed.
2.1	NHS Safety Thermometer - % of patients on spot day with new harms	< National av.	2.20%	1.17%	1.99%		1.13%	New harms of 1.99% were below the national average of 2.20%.
2.2	NHS Safety Thermometer - % of patients on spot day with new CAUTIs	< National av.	0.35%	0.00%	0.00%		0.08%	There were no new CAUTIs on the September audit day.
2.3	NHS Safety Thermometer - % of patients on spot day with new pressure ulcers	< National av.	0.89%	0.47%	0.88%		0.50%	New pressure ulcers of 0.88% were below the national average of 0.89%.
2.4	NHS Safety Thermometer - % of patients on spot day with falls with harm	< National av.	0.60%	0.47%	1.11%		0.34%	Falls with harm of 1.11% were above the national average of 0.60% and relate to 5 low harm falls on AMU, BACU and May wards.
2.5	NHS Maternity Safety Thermometer - % of patients with combined harm free care (physical harm and women's perception of safety)	> National av.	72.10%	50.00%	0.00%		65.66%	The Maternity Safety Thermometer was not submitted in September 2016.
2.6	NHS Medications Safety Thermometer - % of patients with reconciliation started within 24 hours of admission	> National av.	77.29%	57.78%	70.00%		64.5%*	*YTD actual is rolling median in line with national charts. Patients with reconciliation started within 24 hours of admissions at 70.00% were lower than the national average of 77.29%. Pharmacy is working through a redesign of its service with implementation to be undertaken by the end of 2016. This will consist of a high risk medicines section is to be included on the inpatient medication chart and pharmacy clinical services will be prioritised to ensure that all patients on any high risk medicines will have a formal clinical review by a suitably experienced pharmacist.
2.7	NHS Medications Safety Thermometer - % of patients with an omitted critical medicine in the last 24 hours	< National av.	8.22%	13.33%	2.50%		9.4%*	*YTD actual is rolling median in line with national charts. Critical medicine omission of 2.50% is better than the national average of 8.22%. Triangulation with other audits indicates missed doses and incomplete administration documentation, contributed in part by inpatient charts in transit to Pharmacy. The Pharmacy redesign will keep charts in the clinical area and a redesign of the inpatient chart is under consideration which will include an administration section to document actions taken if a drug is unavailable.
3	Best care audits undertaken this month	Level 3 ward count	-			-		Quarterly best care audits are currently in progress and results will be available in the November report.
4	WOW awards	-	n/a	62	47		n/a	MES received 19 WOW nominations, WH&P received 9 and TASCC had 8 proposals. DTTO was nominated for 7. Business Development, Estates & Facilities, Health Informatics and Occupational Health all received 1 nomination each.
5.1	Complaints % Responded to timescale as agreed with complainant	Timeliness	>95%	90.0%	93.0%		90.0%	2 out of 27 closed complaints left the Trust after the agreed date with the complainant. 1 of these complaints was for MES and 1 for DTTO. Both complaints responses were 2 days later than agreed and attempts to contact the complainants were made but were not successful.
5.2	Complaints % Responded to timescale (Grade 1 & 2 in 25 days)	Timeliness	No target	59.4%	43.0%		51.6%	21 grade 1 or 2 complaints were closed in September. 6 of these were allocated a longer time period due to the need for additional scrutiny. 9 complaints left the Trust within a 25 day timeframe. 6 complaints allocated a 25 day turnaround left the Trust in more than 25 days.
5.3	Complaints % Responded to timescale (Grade 3 & 4 in 35 days)	Timeliness	No target	25.0%	67.0%		22.0%	6 grade 3 or 4 complaints were closed in September. Of the 6 cases, 4 of these left the Trust within the target timeframe of 35 days. 1 left the Trust after 38 days and the complainant was informed of the small delay. 1 complaint was also part of a SIRI process and the complainant was fully informed of time frames throughout the period. The case took 231 days to close.
5.4	Complaints mean response time in days: variance from 25 day target (Grade 1 & 2)	Responsiveness	No target	0.2	1.5	-	4.6	The average number of days to respond to a grade 1 or 2 complaint in the month of September was 26.5 days.
5.5	Complaints mean response time in days: variance from 35 day target (Grade 3 & 4)	Responsiveness	No target	20.6	30	-	33.7	The average number of days to respond to a grade 3 or 4 complaint in the month of September was 65 days.
5.6	PHSO (Ombudsman) cases open - total number	Response quality	No target	4	4		-	There are currently 4 open cases with the PHSO.
5.7a	PHSO (Ombudsman) cases closed but not upheld	Response quality	No target	1	0		4	0 cases were closed in September.
5.7b	PHSO (Ombudsman) cases closed and partially upheld	Response quality	No target	1	0		2	0 cases were closed in September.
5.7c	PHSO (Ombudsman) cases closed and upheld	Response quality	No target	0	0		0	0 cases were closed in September.
5.8	PHSO (Ombudsman) new cases received	Response quality	No target	0	0		5	0 new cases were received in September.

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Appendix 2 – Quality Account and Business Plan Dashboard

Quality Priority Dashboard 2016-17

REF	2016/17 Quality Account Measure	Q2	Quarter 2 Narrative
	Safety - Improving harm free care		
1.1	Medication Safety Thermometer data collected and position against national position is baselined.		The Medication Safety Thermometer data collection is ongoing and results are compared with the national position. Pharmacy is working through a redesign of its service with implementation to be undertaken by the end of 2016. This will consist of a high risk medicines section is to be included on the inpatient medication chart, as well as an administration section to document actions taken if a drug is unavailable. There are also plans to keep the charts in the clinical area. Pharmacy clinical services will be prioritised to ensure that all patients on any high risk medicines will have a formal clinical review by a suitably experienced pharmacist.
1.2	Maternity Safety Thermometer performance better than national average.		In Q2, the Trust did not submit data for July and September 2016; the division has reviewed the submission process and the ward manager has agreed to submit the data moving forward. In August 2016, combined harm-free care of 50.0% was below the national average of 70.4%.
1.3	Classic Thermometer performance better than national average.		In Q2, the Trust has achieved Safety Thermometer performance better than the national average apart from 2 months: new pressure ulcers in July 2016 and falls with harm in September 2016.
1.4	20% reduction in falls compared to last year.		In 2015/16 there were 457 falls and the target to reduce falls by 20% this year to 365 falls using the Sign up to Safety Trajectory equates to less than 30 falls per month. To date, the Trust has had an average of 35 falls per month, which is higher than the desired monthly limit. Review of the data revealed that the orthopaedic wards had high levels of falls during July and August 2016 and an action which has been implemented to support patients is a colour coded poster with specific instructions for different locations including ward areas and bathrooms. The physiotherapy team are developing a colour coded patient mobility status tool. Fluorescent walking frames are to be trialled, as well as red blankets for patients with cognitive impairment.
1.5	15% reduction in stage 2 and above hospital acquired pressure ulcers compared to last year.		The Trust has a monthly target of 18.2 hospital acquired pressure damage for stage 2 pressure ulcers which was not achieved in July but was achieved in August and September 2016. There were 6 hospital acquired stage 3 pressure ulcers. Training in pressure ulcer prevention is now mandatory and teaching is occurring monthly. The Trust has implemented new alternating air mattresses with training from company representatives being undertaken. The focus for the next quarter will be ensuring that wards which consistently report hospital acquired pressure damage develop localised initiatives to reduce patient harms.
1.6	Risk assess 97% of adult inpatients for VTE on admission.		July - 97.05%, August - 97.53%, September - 97.80%. The average figure for Q2 is 97.46%.
1.7	Root cause analysis (RCA) of 100% of identified cases of hospital associated thrombus (HAT) in 2 months.		No cases of HAT were identified in Q2. Due to service pressures, no diagnostic screening review was carried out. If service pressures reduce, this will be addressed in Q3.
1.8	Audited documentation of the prescription of appropriate chemical thromboprophylaxis with the aim of achieving 85%.		Q2 average for documentation of appropriate chemical prophylaxis was 86%, with July at 83%, August at 88% and September at 87%.
1.9	Achieve VTE Exemplar Centre Status by 31 March 2017.		The Trust was awarded VTE Exemplar Centre Status by NHS England on the 24th August 2016. This is a huge achievement as it recognises our commitment to patient safety and VTE prevention at the Trust.

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	Safety - Embedding and measuring safety culture	Q2	
2.1	Quarterly audits of duty of candour with exeception reporting to QAPC.		Achieved. The audits are underway and results being collated for feedback.
2.2	Review MaPSaF divisional action plans by Q3 ensuring evidence of action implementation.		This work is progressing.
2.3	Implement KSS AHSN safety culture and leadership pilot programme by Q4.		The pilot programme is progressing and team members have attended offsite events by the regional programme as part of the engagement and learning exercise.
2.4	Implement National Standards for Invasive Procedures by September 2016.		A priority action communicated to divisions to report on progress by end of October 2016.
	Safety standards		
3.1	NMC revalidation timescales met.		All revalidation applications have been submitted to date. Attendance at Training has diminished significantly and less people are uptaking portfolio support, indicating that the process is embedding within the organisation and there are significantly more people around that are able to support staff. Professional Registration Policy and Procedure being updated to incorporate nursing and midwifery revalidation.
3.2	Reducing Variation Programme progressed, including national data collection exercise.		The national data collection exercise was undertaken in September and October 2016 in line with the national requirements.
	Clinical Effectiveness - Diagnosis of diabetes		
4.1	Screen 98% eligible inpatients for diabetes (spot audit).		The percentage of patients who had CBG testing within 24 hours of admission remained below the target of 98% in Q2. However, the percentage tested rose from 89% in Q1 to 94% in Q2 as the new ANA document becomes embedded.
	Clinical effectiveness - Audits and NICE guidance		
5.1	Implementation NICE Clinical Guidelines – monthly status report and gap analysis.		Divisional NICE Guidance plans were reviewed during the September 2016 CENARG meeting; there had been recent work on plans for DTTO, MES and TASCC but not for WH&P. Ongoing action is for regular updates to the plans. The difficulty with cross-divisional NICE guidance was noted but should be referred to the MD to identify the lead.
5.2	Gap analysis of NICE Guideline NG 31, Care in the Last Days of Life: gap analysis and action plan by Q3.		A guidance priorities document and communication sheet for use by patients and relatives has been designed and implemented. A training package for ward staff on the priorities of care and individualised care planning has been developed and implemented on 4 wards and staff training, mentoring and embedding continues on these wards. Implementation and embedding continues on a further 3 wards. An audit of notes to demonstrate quality improvements is ongoing, with 60% completed and analysis progressing. Trustwide teaching of junior doctors has been achieved; with Trust induction planned. A staff questionnaire had been developed and implementation and analysis are planned.
5.3	Participate in all applicable mandatory national audits and implement action plans for key recommendations from the national bodies.		It was confirmed in July 2016 that the Trust will participate in the re-audit of blood management in scheduled surgery which is due to start in October 2016. At the end of August 2016, TASCC were requested to support new Breast Implant Registry. In September 2016, a pilot for the new COPD audit was completed and the Trust registered for national COPD audit from 1 Feb 2017.

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REF	2016/17 Quality Account Measure	Q2	Quarter 2 Narrative
	Patient experience - Vulnerable groups		
6.1	Review the MHA training scheme by Q1, action plan by Q2 to Mandatory Training Committee.		Training day starting as planned in October 2016. MHA training for doctors for discussion at Psychiatric Liaison Meeting.
6.2	Introduction to MHA Training within Safeguarding Training for Clinical Staff by Q2.		Training day starts in October 2016.
6.3	Campaign covering patient records and privacy by Q2.		The video promoting privacy and dignity of patient records is due to be completed soon.
6.4	Dementia clinical environment review by Q2, action plan by Q3.		The dementia friendly bays on Swift and Holly wards (phase 1) are completed. Phase 2 is to be included on the business case for 2017 which will include bathrooms/toilets in patient and public areas.
6.5	Continue dementia carers' local survey: implement improvement actions, 6 monthly updates to Board.		Work continues with the always event communication tool; the take up for the carers surveys for the national dementia audit was poor.
	Patient Experience - Outpatients		
7.1	Capture, publish and feedback clinician level data for outpatients and inpatients by Q4.		The Head of Patient Involvement and Experience is actively determining how to optimise the use of clinician level patient feedback data. There are plans for a Trustwide launch on 7 December 2016.
	Patient Experience - Inpatients		
8.1	Communicate to inpatients potential for ward transfers by Q2		Patient information leaflet needs patient representative approval which is being sought. Baseline audit has been undertaken with the following criteria: 1. Adult patients on the medical wards during the month of June 2016 (may have been admitted prior to this). 2. Have had more than 3 moves for non medical reasons (assumed that ED - MAU-Specialty ward is appropriate) 3. Have included any patient admitted to CDU in the first instance and any patient admitted to Cherry Annexe. Audit showed there were 63 patients who met the above criteria. Agreed that decisions to move patients for non medical reasons sit with the MDT with the support of the Integrated Care Bureau.
8.2	Implement framework for using Always Events toolkit, and have 3 Always Events by Q4.		The Paediatric Team is considering an Always Event in the young persons age group.
8.3	95% of patients in the UCC achieve the 4 hour wait		99% achieved for patients seen and discharged by the UCC.
8.4	Implement face-to-face feedback process at UCC quarterly from Q2; set improvement actions.		Continued local dialogue. Started 3 sessions per week GP care in UCC.
	Patient Experience - Research involvement		
9.1	Research opportunities communication programme: explore options by Q2; in place by Q3; feedback from patients in Q4, feedback to Research Committee.		**1. Information Sharing -** our Summer newsletter has been well received, especially as the focus for our front page interview was with a Mother and her daughter who was recruited to a clinical trial. The webiste has been recently updated reflecting our team profiles. Other matters such as our CTP DH data, study updates and educational information, are updated in real time. **2. Education and Knowledge -** we are part of the Trust Induction market stalls, but are exploring the opportunity again to present on the day. We have examples of exemplary engagment in our Women's Services Division, regarding presentations for new starters. External events need further work. **3 Targeted awareness -** recent press release for our Radiology study. Need to be seen as ongoing though. **4 Electronic data capture -** a lot of work has been done with the Evolve team and we went live with our research specific documents on 6th October 2016. Further work now to look at how Evolve can be used to help with screening for our studies.

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

REF	Business Plan Measure	Q2	Quarter 2 Narrative
	Business plan - Best outcomes		
1	20% reduction in falls compared to last year (Sign up to Safety)		In 2015/16 there were 457 falls and the target to reduce falls by 20% this year to 365 falls using the Sign up to Safety Trajectory equates to less than 30 falls per month. To date, the Trust has had an average of 35 falls per month, which is higher than the desired monthly limit. Review of the data revealed that the orthopaedic wards had high levels of falls during July and August 2016 and an action which has been implemented to support patients is a colour coded poster with specific instructions for different locations including ward areas and bathrooms. The physiotherapy team are developing a colour coded patient mobility status tool. Fluorescent walking frames are to be trialled, as well as red blankets for patients with cognitive impairment.
2.1	Medication Safety Thermometer data collected and position against national position is baselined.		The Medication Safety Thermometer data collection is ongoing and results are compared with the national position. Pharmacy is working through a redesign of its service with implementation to be undertaken by the end of 2016. This will consist of a high risk medicines section is to be included on the inpatient medication chart, as well as an administration section to document actions taken if a drug is unavailable. There are also plans to keep the charts in the clinical area. Pharmacy clinical services will be prioritised to ensure that all patients on any high risk medicines will have a formal clinical review by a suitably experienced pharmacist.
2.2	Maternity Safety Thermometer performance better than national average.		In Q2, the Trust did not submit data for July and September 2016; the division has reviewed the submission process and the ward manager has agreed to submit the data moving forward. In August 2016, combined harm-free care of 50.0% was below the national average of 70.4%.
2.3	Classic Thermometer performance better than national average.		In Q2, the Trust has achieved Safety Thermometer performance better than the national average apart from 2 months: new pressure ulcers in July 2016 and falls with harm in September 2016.
3	Implement KSS AHSN safety culture and leadership pilot programme by Q4.		The pilot programme is progressing and team members have attended offsite events by the regional programme as part of the engagement and learning exercise.
4	Run 2 training workshops on patient safety RCAs for frontline staff by end Q4.		No workshops have yet been held, however, it is planned for this work to commence in Q3. Plans are on track to deliver this.
5	Reducing Variation Programme progressed, including national data collection exercise.		As above, the national data collection exercise has been undertaken in September and October per national timescales.
6	Implement National Standards for Invasive Procedures by September 2016.		A priority action communicated to divisions to report on progress by end of October 2016.
7	NMC revalidation timescales met.		All revalidation applications have been submitted to date. Attendance at training has diminished significantly and less people are uptaking portfolio support, indicating that the process is embedding within the organisation and there are significantly more people around that are able to support staff. Professional Registration Policy and Procedure being updated to incorporate nursing and midwifery revalidation.
	Business plan - Excellent experience		
8	Evaluate 'Adopt a Grandparent' pilot by Q1, if deemed feasible to implement by Q4.		The scheme is continuing to recruit new staff and has created business cards for clinicians to pro-actively contact the scheme when they feel a patient will benefit from it.
9	Action plan for Fix Dementia Care report by end Q2.		Measure to be discussed and reviewed as not feasible to collate data quarterly - biannual or annual collation would be more appropriate.
10	Capture, publish and feedback clinician level data for outpatients and inpatients by Q4.		As above, this work is progressing.
11	Follow-up complaints < 10% on average. RCA and action plan if exceeded.		Q2 achieved a threshold of under 10%.
12	Refresh 15 Steps tool to capture outpatient experience by Q2, action plan by Q3.		Refresh has not taken place in Q2 and will be planned for Q3.

Appendix 3 – National Cancer Patient Experience Survey 2015

The National Cancer Patient Experience Survey 2015 is the fifth iteration of the survey first undertaken in 2010. It has been designed to monitor national progress in cancer care and to provide information to drive local quality improvements. The survey includes all adult NHS patients with a confirmed primary diagnosis of cancer discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment in the months of April, May and June 2015. Outlined below is a summary of the Trust's performance.

The Trust achieved a response rate of 71% (250/392) which was above the national average of 66% and a significant increase on the previous survey of 58%. Of those who responded 106 male and 144 female respondents respectively.

The survey questions are not identical year on year and there were 63 questions in 2014 and 59 questions in 2015.

The survey scoring method rates each question as the percentage of patients who have reported a positive experience.

Results summary

Table 1

	2014	2015
Number of questions	63	59
Number above average	0	1
Number below average	43	10

The 2015 survey has seen a significant improvement when compared with the previous survey. However it is important to note that many of the questions have changed and it is therefore difficult to directly compare the two surveys.

Key areas that have improved are:

<u>Name of Clinical Nurse Specialist (CNS) and ease of contacting:</u>

Table 2 – 2015 "CNS" Section results compared nationally

				2015 Case-mix Adjusted			
Question		Number of respondents	2015 Unadjusted Score	2015 Score	Expected range - lower	Expected range - upper	National Average Score
Q17	Patient given the name of the CNS who would support them through their treatment	228	86%	87%	85%	94%	90%
Q18	Patient found it easy to contact their CNS	179	86%	86%	81%	93%	87%
Q19	Get understandable answers to important questions all or most of the time	170	88%	87%	84%	93%	88%

When compared with the same questions in the 2014 survey, two questions have improved significantly and all are within the national average range, compared to being below average in 2014. Whilst Q19 has not changed, the national percentage has declined therefore the same score in 2015 leaves the Trust within average range and not lower range as in 2014.

Table 3 – CNS Section results compared with previous year ASPH results

	2014	2015	Change
Q17	81%	87%	+6%
Q18	74%	86%	+12%
Q19	87%	87%	+0%

Support for people with cancer:

Table 4 – 2015 "Support" Section results compared nationally

	Question	Number of respondents	2015 Unadjusted Score	2015 Case-mix Adjusted 2015 Score	2015 Case-mix Adjusted Expected range - lower	2015 Case-mix Adjusted Expected range - upper	National Average Score
Q20	Hospital staff gave information about support groups	164	79%	79%	77%	89%	83%
Q21	Hospital staff gave information about impact cancer could have on day to day activities	148	75%	75%	74%	87%	81%
Q22	Hospital staff gave information on getting financial help	111	58%	58%	44%	65%	55%
Q23	Hospital staff told patient they could get free prescriptions	114	82%	78%	72%	88%	80%

When compared to the same questions in 2014, three questions have improved significantly and all four questions are now within the average range compared to only Q23 being in the average range in the 2014 survey.

The changes are detailed below in Table 5:

	2014	2015	Change
Q20	77%	79%	+2%
Q21	68%	75%	+7%
Q22	43%	58%	+15%
Q23	79%	78%	-1%

Overall NHS Care

Of the comparable questions there was a significant improvement in patients being given care plans

Table 6 – Overall NHS Care

	Question	Number of respondents	2015 Unadjusted Score	2015 Case-mix Adjusted 2015 Score	2015 Case-mix Adjusted Expected range - lower	2015 Case-mix Adjusted Expected range - upper	National Average Score
Q54	Hospital and community staff always worked well together	235	59%	58%	54%	68%	61%
Q55	Patient given a care plan	182	32%	34%	25%	41%	33%

Table 7 – Overall Section results compared with previous year ASPH results:

	2014	2015	Change
Q54	59%	58%	-1%
Q55	15%	34%	+19%

Table 8 shows all questions that fell either above or below the expected range:

Questions which scored outside expected range

	Question	Number of respondents for this Trust	2015 Case-mix Adjusted 2015 Percentage for this Trust	2015 Case-mix Adjusted Lower limit of expected range	2015 Case-mix Adjusted Upper limit of expected range	National Average Score
Finding out what was wrong with you						
Q8	Patient told they could bring a family member or friend when first told they had cancer	195	67%	72%	85%	79%
Deciding the best treatment for you						
Q13	Possible side effects explained in an understandable way	221	66%	67%	79%	73%
Q14	Patient given practical advice and support in dealing with side effects of treatment	225	59%	60%	73%	66%
Q16	Patient definitely involved in decisions about care and treatment	226	71%	72%	83%	78%
Hospital care as an inpatient						
Q28	Groups of doctors or nurses did not talk in front of patient as if they were not there	137	75%	75%	88%	81%
Q38	Given clear written information about what should / should not do post discharge	121	77%	78%	91%	84%
Hospital care as a day patient / outpatient						
Q47	Beforehand patient had all information needed about chemotherapy treatment	97	76%	77%	92%	84%
Q48	Patient given understandable information about whether chemotherapy was working	90	57%	58%	77%	68%
Your overall NHS care						
Q57	Length of time for attending clinics and appointments was right	233	76%	57%	75%	66%
Q58	Taking part in cancer research discussed with patient	236	15%	19%	38%	28%
Q59	Patient`s average rating of care scored from very poor to very good	238	8.5	8.5	8.9	8.7

Key	
	Below average
	Above average

Improvement work

Since the 2014 survey results were released the Lead Cancer Clinician/Lead Nurse for Cancer and Palliative Care has led a programme of improvement work with key focuses on areas such as:

- Support for people with cancer
- Support from the Clinical Nurse Specialist and Establishment review
- Cancer research
- Conducting local surveys and introducing FFT for Haematology day unit and Ashford infusion Suite
- Patient Engagement with Improving '*Cancer Care Action Group'*
- Working with NHS improvement Buddy Hospital
- Information and sign posting improvement
- Development of the Urology Centre
- Close working with third sector voluntary organisations, Macmillan, Prostate UK, Beating Bowel Cancer as well as other local groups

Since the publication of the 2015 survey the Cancer Board has met to analyse the results in detail and to prepare a continuing action plan focusing on some of the remaining key areas for improvement.

Action plan governance

Once finalised the 2015 Cancer Patient Experience Survey improvement plan will be presented on a monthly basis to the Cancer Board with exception reporting to The Executive Committee (TEC).