TRUST BOARD
27 April 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 March 2017[1.] The monthly dashboard is on Appendix 1 page 8. 116 in-hospital deaths increased from 114 deaths in February. Mortality review rates of 61% were up from 70% in February. 1.39 pressure ulcers per 1000 bed days is below the limit of 1.98. Emergency readmissions of 14.0% exceeds Q4 target of 12.5%. Stroke performance of 57.5% is below target of 90%. The FFT Inpatient recommended score for March of 95.1% is down from 96.6% in February and year to date result of 95.0% was in line with target. FFT satisfaction score for ED of 83.5% is low and will be reviewed for contributing factors to guide improvement. Maternity touchpoint 2 FFT score was 100% however 96.8% ytd narrowly missed target of 97% owing to dips in September and December. Outpatients FFT March score of 95.7% remains above target of 92%. Dementia case finding score of 29% is incompletely recorded on RealTime and next 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).

	Safety Thermometer new harms of 0.99% in March were below national average of 2.15% and ytd harms of 1.21% were well below average of 2.14%. Data for the Maternity and Medications Safety Thermometers is still unavailable from the national provider and no timescale has been provided. 49 new complaints were received in February of which 27 complaints pertained to MES (including ED), 8 pertained to TASSC, 8 pertained to DTTO, 4 pertained to WH&P and 1 pertained to Estates and Facilities and 1 pertained to Quality. Of the 37 February complaints requiring a response 9 (28%) met the timescale agreed with the complainant. Performance against the Business Plan and Quality Priorities for Q4 and the Year Ended 31 March 2017 is outlined in summary in Section 2.0 on page 6 and in detail in the Appendix 2 dashboard on page 10. Pending data will be submitted in the Annual Quality Report to be submitted to Board in May.
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	21 April 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 8. Results by exception by either the ratings below or significance are summarised in Section 1.1.

Rating table

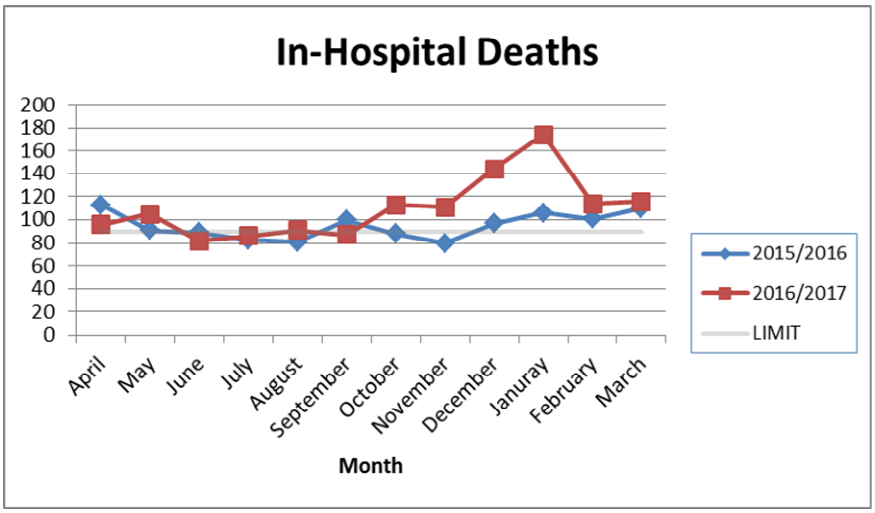
Delivering or exceeding target		Improvement month on month
Underachieving target		In line with or just below last month
Failing target		Below target

1.1 Performance by exception – March clinical quality data

In-hospital deaths

116 recorded deaths in March is above seasonal trend.

Chart 1 – In-hospital deaths April 2015 onwards



Mortality reviews

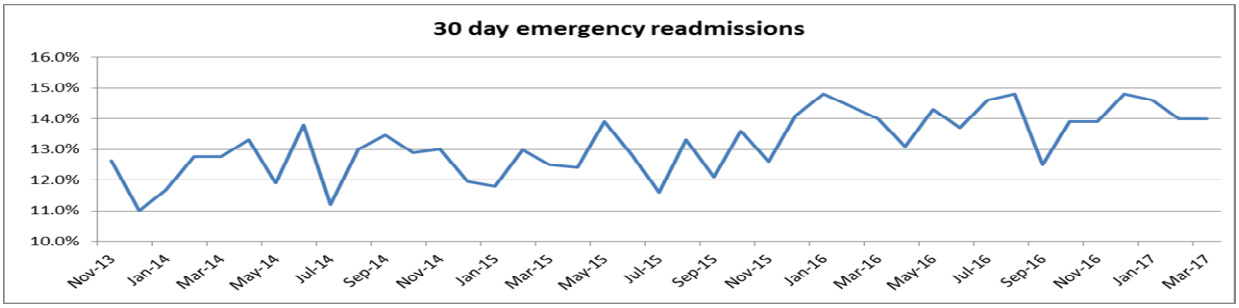
MES mortality review rates have decreased from 70% in February to 61% in March. Mortality review completion rates were 89% for TASCC, 59% for MES, and 0% for both WH&P and DTTO. All December deaths were scheduled for review and performance is currently at 81% (120/149 case reviews) reflecting MES 80%, TASCC 82%, WH&P 83% with DTTO having no reviews required.

Pressure ulcers

The monthly CCG target of 18.2 stage 2 and above hospital acquired ulcers was achieved this month with 5 ulcers 2 of which were stage 3 ulcers. This is a significant improvement on 21 ulcers for February, however, a longer timescale is needed to ascertain whether the improvement seen is sustainable going forward. The Trust did not achieve its annual limit agreed with CCG of 218 ulcers with a total of 240 ytd for 2016/17. New improvement initiatives for next year include implementing a wedge foot protector, taking learning to the frontline wards on Worldwide Stop the Pressure Day and deepening use of Datix at ward level to analyse pressure damage mapped at body level.

Emergency 30-day readmissions
30 day readmissions of 14.0% remains above the Q4 target of 12.5%. Significant areas by volume are General Medicine at 17.1% (180 from 1052) and A&E at 18.0% (44 from 245) which together represent 62% by volume of March non-elective readmissions. By absolute percentage value significant areas included Vascular Surgery at 31.3% (5 from 16) and Critical Care 25% (3 from 12).

Chart showing 30 day emergency readmissions from October 2013



Direct stroke unit admission
Stroke performance ranged between 65% to 75% from April to November 2016 then dipped to around 40% in December and January. March performance increased to 58% up from 56% in February but remains below the 90% target. Breaches reflect a combination of ring fenced bed lack, stroke pathway disruption and medical need.

Medication errors per 1000 bed days
The rate of reported medication errors of 2.6 in March is below the year to date average of 3.0 cases per 1000 bed days. It is impractical to distinguish if this is random variation, an increase in drug errors, or increased reporting.

FFT satisfaction score
The FFT Inpatient recommended score of 95.1% is in line with target as is 95.0% year to date.

ED FFT satisfaction score ranged between 87% to 94% from August 2016 to February 2017. The March result of 83.5% is similar to Q1 2016/17 and will be reviewed for contributing factors to guide improvement.

Maternity touchpoint 2 score increased in March to 100% from 98.3% last month, however, the year to date target was narrowly missed at 96.8% owing to dips in September and December 2016.

Outpatients FFT score of 95.7% remains consistently above target of 92%.

Dementia
It is impractical to analyse the dementia case finding measure score of 29% 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 electroically in 2017/18 which is expected to significantly improve this issue.

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

Safety Thermometer
New harms of 0.99% were below national average of 2.15%. New pressure ulcers of 0.5% is below national average of 1.04% which is much improved compared with 1.28% last month. Catheter associated urinary tract infections (CAUTIs) of 0.5% exceeded national average of 0.28% in March but 0.04% year to date remains well within limits. No falls with harm occurred on the March spot test day.

Data for the Maternity and Medications Safety Thermometers remains unavailable from the national data team and no firm date for provision has been obtained from the national co-ordinators.

Learning from new complaints
49 new complaints were received in March with the largest Division by volume being MES with 27 complaints and TASCC and DTTO with 8 each. WH&P received 4 complaints and both Estates and Facilities and Quality 1 complaint each. There was a clear trend in clinical treatment being the main cause for complaint in these specialties. Communication is the next largest theme in formal complaints

1.2 Complaints performance

Performance against timescale agreed with complainant
Of the 35 February complaints requiring a response 9 (28%) met the timescale agreed with the complainant.

Follow-up complaints
The follow-up complaint rate of 4%[2] for March and year-to-date of 6.8% are below the 10% threshold.

PHSO[3] cases

There was 1 case referred or opened by the PHSO in March, this adds to the 3 cases already open from February. No cases were closed in March.

Claims
There were 4 new claims reported in March 2017 with 1 for MES and 3 for WH&P of which 2 were re-opened cases from prior years. 6 claims were intimated with 2 each in MES and WH&P and 1 each for TASCC and DTTO.

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

[3] PHSO: Parliamentary and Health Service Ombudsman

2.0 Business Plan and Quality Priorities Q4 and Year Ended 31 March 2017

Performance is outlined in detail in the dashboard in Appendix 2 page 10 and in summary below.

2.1 Patient Safety

The following patient safety measures were achieved:

Medication Safety Thermometer performance was collected and baselined, however, data beyond November 2016 is not available nationally owing to a change in data provider. Classic safety thermometer harm free care was below national average for the third year.

97.6% of hospital inpatients risk-assessed for VTE exceeded both our local 97% target and the national 95% target and the Trust was awarded VTE Exemplar Status by NHS England.

Quarterly audits of duty of candour were completed and the Manchester Safety Framework divisional action plans were reviewed for progression in Q3. The KSS AHSN safety culture and leadership pilot programme has been implemented by Q4.

Nursing revalidation timescales have been met.

The Reducing Variation Programme has been progressed and performance was reported to Board in February.

2 fronline training workshops on patient safety root cause analysis took place.

The following patient safety measures were not achieved:

Combined maternity harm free care was less favourable than national average at November ytd, however, subsequent data is not available nationally for benchmarking as explained above.

Falls reduced by 8% which was below the 20% target compared to last year per our Sign up to Safety Plan Year 2 trajectory.

Hospital acquired stage 2 and above pressure ulcers increased 11.1% this year thus the Trust did not achieve the 20% reduction compared to last year in Sign up to Safety Plan Year 2.

Root cause analysis (RCA) of 100% of identified cases of hospital associated thrombus (HAT) in 2 months was not achieved and neither was achieving 85% regarding documentation of the prescription of appropriate chemical thromboprophylaxis for VTE with a score of 83.7%.

Implementation of National Standards for Invasive Procedures by September 2016 was substantially but not fully demonstrated as complete.

2.2 Clinical effectiveness

Data is pending regarding whether these clinical effectiveness measures were achieved:

Data on national audit participation is being collated and will be disclosed in the Annual Quality Account.

Whilst significant work has progressed per NICE Guideline NG 31, Care in the Last Days of Life, it is to be confirmed whether the gap analysis and action plan was in place by Q3.

The following clinical effectiveness measures were not achieved:

Whilst Divisional NICE Guidance plans have been reviewed gaps were identified in a minority of areas which will be monitored through the designated clinical effectiveness committee.

98% of patients did not receive capillary blood glucose testing within 24 hours of admission with a score of 93%.

2.3 Patient Experience

The following patient experience measures were not achieved:

Whilst the dementia clinical environment was reviewed feedback is still ongoing and an improvement action plan was not in place by Q3.

Data is pending regarding whether these patient experience measures were achieved:

Whether clinician level data for outpatients and inpatients was captured, published and fed back by Q4.

The Adopt a Grandparent Scheme continued to recruit staff during the year, however, it is not yet ascertained whether the feasibility analysis was undertaken in Q4.

The following patient experience measures were achieved:

The Mental Health Act training scheme has been reviewed.

Patient records, privacy and dignity was included in a campaign by Q2.

The dementia carers survey was undertaken and the report to Board is in Appendix 3 page 14.

98.7% of patients in the Urgent Care Cenre achieved the 4 hour wait which was above 95% target.

Our new communication programme for promoting patient involvement with research opportunities at the Trust was implemented.

Follow-up complaints were consistently below 10%.

The following patient experience measures were not achieved:

Patient move information was prepared, however, the January 2017 completion date was minor slippage against the September 2016 timescale.

Three always events were not implemented this year so this measure will continue next year.

Whilst face to face feedback with general practitioners has been implemented at the Urgent Care Centre this was not consistently undertaken quarterly therefore this is only partially met.

The action plan for the Fix Dementia Care report was not undertaken by Q2.

Refresh of the 15 Steps tool to capture Outpatient experience was not undertaken owing to lack of capacity.

Appendix 1 Quality Performance Dashboard March 2017

Table 1: Quality Performance Dashboard 31 March 2017

REF	Quality Scorecard Measures	Outturn 15/16	Monthly Target / Limit	Annual Target / Limit	Feb	Mar	6 month trend	YTD 16/17	Current month commentary
1.01	In-hospital SHMI	64	<72	<72	73	74		70	Mortality indices above expectation.
1.02	RAMI	62	<70	<70	82	66		69	See below.
1.03	In-hospital deaths	1139	90	<1082	114	116		1319	March in-hospital deaths of 116 inccreased from 114 in February but are lower than 174 in January and remain above target.
1.04	Proportion of mortality reviews (data 1 month in arrears)	56%	>90%	>90%	70%	61%		56%	Mortality review completion rates were 89% for TASCC, 59% for MES, and 0% for both WH&P and DTTO. All December deaths were scheduled for review and performance is currently at 81%.
1.05	Number of cardiac arrests not in critical care areas	56	-	-	5	10		62	An update is awaited on whether the Treatment Escalation Plan pilot in 2 medical wards at the end of February occurred as planned. There were 3 arrests on Aspen respiratory ward and 4 on the Acute Medical Unit this month which is significantly above usual levels and is under review by the Resuscitation Services Manager.
1.06	Methicillin Resistant Staphlococcus Aureus (MRSA) -	0	0	0	0	0		0	No cases.
1.07	C. Difficile (hospital only)	15	1.4	17	1	5		20	20 cases year to date was outside the limit set by NHS England of 17 cases. The CCG has reviewed the 5 cases and confirmed that there were no lapses in care.
1.08	Falls (per 1000 beddays)	2.59	2.46	2.46	2.7	1.99		2.36	Falls per 1000 bed days of 2.36 year-to-date is below the annual limit of 2.46 and lower than last year's rate of 2.59. Next year the following items are planned: updating the doctors' risk assessment form, spreading Baywatch 24/7 campaigning, focussing on surgical and orthopaedic wards, and taking action on polypharmacy where applicable.
1.09	Pressure ulcers (per 1000 beddays)	2.08	1.98	1.98	2.34	1.39		2.24	The monthly CCG target of 18.2 stage 2 hospital acquired ulcers was achieved this month with 5 ulcers. There were 2 stage 3 pressure ulcers. This is much improved on 21 stage 2 pressure ulcers for February. A longer timescale is needed to ascertain whether the improvement seen is sustainable going forward. The Trust did not achieve its annual limit with the CCG of 218 cases with a total of 240 cases. New improvement initiatives for next year include implementing a wedge foot protector, taking learning to the frontline wards on Worldwide Stop the Pressure Day and deepening use of Datix at ward level to analyse pressure damage mapped at body level.
1.10	Readmissions within 30 days - emergency only	13.1%	12.5%	12.5% by Q4	14.0%	14.0%		14.0%	30 day readmissions of 14.0% remains above the Q4 target of 12.5%. Significant areas by volume were A&E at 18.0% and General Medicine at 17.1%.
1.11	Stroke patients (% admitted to stroke unit within 4 hours)	65.0%	90%	90%	55.9%	57.5%		58.3%	Stroke performance in March increased to 57.5% up from 55.9% in February and 39.1% in January but remains below the 90% target. Breaches reflect a combination of ring fenced bed lack, stroke pathway disruption and medical need.
1.12	Medication errors (rate per 1000 beddays)	2.92	-	-	2.9	2.6		3.0	In line with expectations.
1.13	Sepsis screening audits - % of eligible patients that were screened in ED	70.5%	90%	90%	-		-		The Q4 and year-to-date data reported in arrears is pending.
1.14	Sepsis - antibiotics administered on ED patients and day 3 antibiotic review performed	-	-	80% Q2; 90% Q3	-		-		The Q4 and year-to-date data reported in arrears is pending.
1.15	Inpatient sepsis - % eligible patients screened for sepsis	-	-	Dec 90%; Q4 90%	-		-		The Q4 and year-to-date data reported in arrears is pending.
1.16	Inpatient sepsis - % eligible patients receiving timely antibiotics and day 3 antibiotic review performed	-	-	Dec 90%; Q4 90%	-		-		The Q4 and year-to-date data reported in arrears is pending.
3.03	Serious Incidents Requiring Investigation (SIRI) reports overdue to CCG	8	-	-	5	9		9	Under progression by the Safety Team.
3.04	Serious Incidents Requiring Investigation (SIRI) reports submitted to CCG	116	-	-	10	6		104	Under progression by the Safety Team.
3.07	Friends and Family Satisfaction Score - Inpatients including Daycase	96.2%	95%	95%	96.6%	95.1%		95.0%	The FFT Inpatient recommended score of 95.1% is in line with monthly target of 95% and has reached year-to-date target overall with 95.0%.
3.08	Friends and Family Satisfaction Score - Accident and Emergency Department (ED) including Paediatrics	84.3%	87%	87%	91.2%	83.5%		86.4%	ED FFT satisfaction score ranged from 87% to 94% between August 2016 and February 2017. The March result of 83.5% is similar to Q1 2016/17 and will be reviewed for contributing factors to guide improvement.
3.09	Friends and Family Satisfaction Score - Maternity Touch Point 2	96.3%	97%	97%	98.3%	100.0%		96.8%	Maternity touchpoint 2 score for FFT increased in March to 100% from 98.3% last month, however, the year to date target was narrowly missed at 96.8% owing to dips in September and December 2016.
3.09a	Friends and Family Satisfaction Score - Outpatients	0.9	92%	92%	96.4%	95.7%		95.8%	Outpatients FFT score of 95.7% remains consistently above target of 92%.
3.10	Follow-up complaints - complaint rate per rolling 12 month average	8.3%	<10%	<10%	2.8%				Follow up complaints in March were below target of 10%.
3.11a	Dementia case finding	96%	>90%	>90%	0.2%	29.0%		42.2%	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 electroically in 2017/18 which is expected to significantly improve recorded results.
3.11b	Dementia diagnostic assessment	99%	>90%	>90%	91%	100%		99.4%	Dementia diagnostic assessment at 100% in March was up compared with 91% in February.
3.11c	Dementia referral	87%	>90%	>90%	100%	100%		96.0%	In line with expectations.

REF	Reference items	Target description & limit		Feb	Mar	6 month trend	YTD 16/17	Current month commentary
1	Overdue safety alerts	<1 overdue	<1	0	0		0	In March no new safety alerts were received. Open alerts are being actioned and no alerts are overdue.
2.1	NHS Safety Thermometer - % of patients on spot day with new harms	< National av.	2.15%	1.71%	0.99%		1.21%	Measure favourably below national average for both month and year-to-date.
2.2	NHS Safety Thermometer - % of patients on spot day with new CAUTIs	< National av.	0.28%	0.00%	0.50%		0.04%	Measure above the monthly national average but below national year-to-date average.
2.3	NHS Safety Thermometer - % of patients on spot day with new pressure ulcers	< National av.	1.04%	1.28%	0.50%		0.66%	Measure favourably below national average for both month and year-to-date.
2.4	NHS Safety Thermometer - % of patients on spot day with falls with harm	< National av.	0.49%	0.21%	0.00%		0.35%	Measure favourably below national average for both month and year-to-date.
2.5	NHS Maternity Safety Thermometer - % of patients with combined harm free care (physical harm and women's perception of safety)	> National av.					64.18%	No national data currently available due to a change in the data provider. YTD figure is for last published national data (November data).
2.6	NHS Medications Safety Thermometer - % of patients with reconciliation started within 24 hours of admission	> National av.					64.5%*	No national data currently available due to a change in the data provider. YTD figure is for last published national data (November data) and is the rolling median in line with national charts.
2.7	NHS Medications Safety Thermometer - % of patients with an omitted critical medicine in the last 24 hours	< National av.					10.30%*	No national data currently available due to a change in the data provider. YTD figure is for last published national data (November data) and is the rolling median in line with national charts.
3	Best care audits undertaken this month	Level 3 ward count	-	-	-	-	-	The Quality Improvement Dashboard Update Report is due to be presented to Quality & Performance Committee on 20 April and outlines the removal of the Best Care Audit and QEWS Dashboard and replacement with a new performance dashboard consisting of run charts for 12 indicators in Patient Experience, Outcomes and Safety. In addition, wards have chosen between 1 -3 Quality Improvement Measures to focus on for a period of 3 months, with weekly data collection by Multi-Disciplinary Teams, which has commenced in the first week of April.
4	WOW awards	-	n/a	23	23		-	MES received 9 WOW nominations, WH&P received 8 and TASCC received 4. DTTO was nominated for 2 proposals.
5.1	Complaints % Responded to timescale as agreed with complainant	Timeliness	>95%	57.0%	28.0%		**	Response rates have dropped significantly in March. This is being addressed by a new team design
5.2	Complaints % Responded to timescale (Grade 1 & 2 in 25 days)	Timeliness	No target	79.0%	32.0%		**	On average grade 1 complaints took 31 days to respond to and grade 2 complaints took 35 days to respond to.
5.3	Complaints % Responded to timescale (Grade 3 & 4 in 35 days)	Timeliness	No target	17.0%	0.0%		**	On average grade 3 complaints took 61 days to respond to, the one grade 4 complaint took 182 days to respond to. No Grade 3 and 4 complaints were answered in the required timeframe in March
5.4	Complaints mean response time in days: variance from 25 day target (Grade 1 & 2)	Responsiveness	No target	15.5	8.5	-	**	On average grades 1 and 2 complaints took 33.5 days to respond to.
5.5	Complaints mean response time in days: variance from 35 day target (Grade 3 & 4)	Responsiveness	No target	47.1	56	-	**	On average grade 3 and above (including grades 1 and 2 addressed to CEO) took 56 days to respond to.
5.6	PHSO (Ombudsman) cases open - total number	Response quality	No target	2	3		-	3 cases are open with the PHSO and the February brought forward total now reflects the 2 open cases from then.
5.7a	PHSO (Ombudsman) cases closed but not upheld	Response quality	No target	0	0			No change.
5.7b	PHSO (Ombudsman) cases closed and partially upheld	Response quality	No target	0	0			No change.
5.7c	PHSO (Ombudsman) cases closed and upheld	Response quality	No target	0	0			No change.
5.8	PHSO (Ombudsman) new cases received	Response quality	No	1	1			One new complaint was received from the PHSO.

Appendix 2 Quality Account and Business Plan Dashboard Q4 and Year Ended 31 March 2017

Quality Priority Dashboard year end 2016-17

REF	2016/17 Quality Account Measure	YTD Result	Quarter 4 Narrative
	Safety - Improving harm free care		
1.1	Medication Safety Thermometer data collected and position against national position is baselined.	☑	Achieved. National data has not been available since November 2016 owing to a change in the national external database provider. Baselining commenced in August 2015.
1.2	Maternity Safety Thermometer performance better than national average.	☒	Combined maternity harm free care was less favourable than national average at November ytd however subsequent data is not available nationally for benchmarking. This priority will continue in 2017/18. In 2015/16 combined harm free care in maternity was 75.0% which exceeded 71.4% nationally.
1.3	Classic Thermometer performance better than national average.	☑	This is the third consecutive year for which performance has exceeded national average. Year to date new harms of 1.21% was below national average of 2.14%. [2015/16 new harms 1.20% vs. national average 2.18%].
1.4	20% reduction in falls compared to last year.	☒	2016/17 annual falls reduction of 20% down to 365 falls was not achieved with 421 falls occurring which was 36 fewer than last year and an 8% reduction. In 2015/16 the 15% planned total falls reduction was surpassed with 457 falls which is better than target giving a 28% reduction. Next year the following items are planned: updating the doctors' risk assessment form, spreading Baywatch 24/7 campaigning, focussing on surgical and orthopaedic wards, and taking action on polypharmacy where applicable.
1.5	15% reduction in stage 2 and above hospital acquired pressure ulcers compared to last year in Year 2 of the Sign up to Safety Plan.	☒	The Plan Year 2 target reduction of 15% (32.4 fewer ulcers) was not achieved with 56 additional ulcers arising and 240 total ulcers for 2016/17 which is an 11.1% overall increase in ulcers compared with the prior year. In Plan Year 1 during 2015/16 the intended 20% reduction of 56.2 ulcers was improved upon with a reduction of 65 ulcers (23% reduction) and only 216 total ulcers. New improvement initiatives for next year include implementing a wedge foot protector, taking learning to the frontline wards on Worldwide Stop the Pressure Day and deepening use of Datix at ward level to analyse pressure damage mapped at body level.
1.6	Risk assess 97% of adult inpatients for VTE on admission.	☑	Performance for Q4 was 98.5% and for the year was 97.6%. Sample testing during the year did however indicate gaps in assurance regarding the accuracy of this measure surrounding the timeliness of the initial risk assessment and a revised pro-forma is being submitted to the Documentation Group along with modifications to the Patient Medication Chart.
1.7	Root cause analysis (RCA) of 100% of identified cases of hospital associated thrombus (HAT) in 2 months.	☒	This measure was not achieved. Of 156 HATs identified this year 76 (48%) now have RCAs completed, however, these have not met the 2 month timescale owing to capacity factors. Diagnostic screening for HATs is now being undertaken weekly to improve the timeliness of this measure.
1.8	Audited documentation of the prescription of appropriate chemical thromboprophylaxis with the aim of achieving 85%.	☒	Result was 83.7% this year and 81.7% last year. This measure tests whether the prescription of chemical thromboprophylaxis is appropriate according to the outcome of the risk assessment tool. The audit tool has been reviewed to optimise testing going forward.
1.9	Achieve VTE Exemplar Centre Status by 31 March 2017.	☑	Exemplar Status was awarded by NHS England in August 2016 which is a significant achievement. The measure was not applicable last year as the outcome of the submission made was unknown at the time of the Quality Account submission.
	Safety - Embedding and measuring safety culture		
2.1	Quarterly audits of duty of candour with exception reporting to QPC.	☑	Audited performance for this year was 100%, which was significant improvement compared with last year when capacity prevented audits being undertaken.
2.2	Review MaPSaF divisional action plans by Q3 ensuring evidence of action implementation.	☑	Divisional action plans were reviewed in Q3 and improvement is being progressed as outlined in measure 2.3 below.
2.3	Implement KSS AHSN safety culture and leadership pilot programme by Q4.	☑	Safety Culture Measurement has been refocussed using the adapted Safety Climate Survey Tool of Yorkshire and Humber Academic Health Science Network piloted in Urgent Care Centre/Clinical Decision Unit, Medicine's Respiratory Ward and the Maternity Ward. Improvements are being delivered by group safety huddles which involve regular focused frontline team discussions of specific patient harms supported by improvement skills, coaching, data and feedback.
2.4	Implement National Standards for Invasive Procedures by September 2016.	☒	Inside theatre standards were implemented as required through updating the WHO Surgical Checklist to include implant and prosthesis checks. Whilst substantially implemented several additional procedures outside theatres remain under review to determine whether the guidance is applicable to them and thus if standard operating procedures need implementing and testing.

	Safety standards		
3.1	NMC revalidation timescales met.	☑	Following supported staff training on portfolios revalidation applications have been submitted per national timescales and nursing revalidation is now well embedded Trustwide.
3.2	Reducing Variation Programme progressed, including national data collection exercise.	☑	The Trust scores from October 2016 were generally favourable regarding emergency patients being seen within 14 hours of arrival, emergency admission patients' access to diagnostic tests and access to Consultant directed interventions. Twice daily Consultant review of those emergency admission patients needing two reviews during weekends requires improvement.
	Clinical Effectiveness - Diagnosis of diabetes		
4.1	Screen 98% eligible inpatients for diabetes (spot audit).	☒	Capillary blood glucose testing within 24 hours of admission was 95% in Q4 and 93% 2016/17 ytd [2015/16 91%]. This item is now a designated section of the Adult Nursing Assessment protocol to improve performance.
	Clinical effectiveness - Audits and NICE guidance		
5.1	Implementation NICE Clinical Guidelines – monthly status report and gap analysis.	☒	Divisional NICE Guidance plans have been reviewed and gaps were identified in a minority of areas which will be monitored through CENARG Committee. An Executive led process to ensure cross-divisional guidance is taken forward smoothly is now in place.
5.2	Gap analysis of NICE Guideline NG 31, Care in the Last Days of Life: gap analysis and action plan by Q3.	TBC	Guidance for use by staff and patients is in place and individualised care planning training is being rolled out to wards. Quality improvement auditing to demonstrate progress is underway along with a staff questionnaire. Update is pending on whether the gap analysis and action plan were in place by end Q3.
5.3	Participate in all applicable mandatory national audits and implement action plans for key recommendations from the national bodies.	TBC	This data is still in the process of being collated and will be reported in the Annual Quality Report.
REF	**2016/17 Quality Account Measure**		**Quarter 4 Narrative**
	Patient experience - Vulnerable groups		
6.1	Review the MHA training scheme by Q1, action plan by Q2 to Mandatory Training Committee.	☑	From October 2016 a designated training day has been in place.
6.2	Introduction to MHA Training within Safeguarding Training for Clinical Staff by Q2.	☑	Achieved as outlined in measure 6.1 above.
6.3	Campaign covering patient records and privacy by Q2.	☑	Detailed campaigning took place throughout 2016.
6.4	Dementia clinical environment review by Q2, action plan by Q3.	☒	Feedback on the environment is still being obtained from clinical areas and thus this was not achieved. A future initiative is piloting coloured crockery on Cherry Ward in May 2017.
6.5	Continue dementia carers' local survey: implement improvement actions, 6 monthly updates to Board.	☑	75 carers were surveyed with staff attitude being described as excellent, and communication being an area for improvement.
	Patient Experience - Outpatients		
7.1	Capture, publish and feedback clinician level data for outpatients and inpatients by Q4.	TBC	Update pending.

	Patient Experience - Inpatients		
8.1	Communicate to inpatients potential for ward transfers by Q2	☒	Following a patient move criteria audit and patient representative approval the patient information leaflet on ward moves was available for rollout to patients from end January 2017 reflecting minor slippage past the September 2016 timescale set.
8.2	Implement framework for using Always Events toolkit, and have 3 Always Events by Q4.	☒	By Q3 an Always Event on patient experience and dementia care support was implemented in 1 ward involving a communication diary between carers and the ward yielding greater understanding of carers' perspective and learning on staff involvement in scoping Always Events. The three planned measures were not implemented and this action continues as a priority area next year.
8.3	95% of patients in the UCC achieve the 4 hour wait	☑	Performance this year was 98.7% which is significantly above the required level. The Urgent Care Centre opened on 7 March 2016 so comparative data of 98.5% is for that month only.
8.4	Implement face-to-face feedback process at UCC quarterly from Q2; set improvement actions.	☒	Feedback topics have included referral process back to general practitioners after UCC attendance. Feedback has occurred however has not consistently been quarterly so this was only partially met.
	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.	☑	In 2016/17 the Trust implemented our new communication programme for promoting patient involvement with research opportunities at the Trust. Information sharing is via the Research and Knowledge Hub, education sharing included presenting at a Members' Monthly Event and electronic data capture is progressing well.

REF	Business Plan Measure	Q4	Quarter 4 Narrative
	Business plan - Best outcomes		
1	20% reduction in falls compared to last year (Sign up to Safety)	☒	2016/17 annual falls reduction of 20% down to 365 falls was not achieved with 421 falls occurring which was 36 fewer than last year and an 8% reduction. In 2015/16 the 15% planned total falls reduction was surpassed with 457 falls which is better than target giving a 28% reduction. Next year the following items are planned: updating the doctors' risk assessment form, spreading Baywatch 24/7 campaigning, focussing on surgical and orthopaedic wards, and taking action on polypharmacy where applicable.
2.1	Medication Safety Thermometer data collected and position against national position is baselined.	☑	Achieved. National data has not been available since November 2016 owing to a change in the national external database provider. Baselining commenced in August 2015.
2.2	Maternity Safety Thermometer performance better than national average.	☒	Combined maternity harm free care was less favourable than national average at December ytd however subsequent data is not available nationally for benchmarking. This priority will continue in 2017/18. In 2015/16 combined harm free care in maternity was 75.0% which exceeded 71.4% nationally.
2.3	Classic Thermometer performance better than national average.	☑	This is the third consecutive year for which performance has exceeded national average.
3	Implement KSS AHSN safety culture and leadership pilot programme by Q4.	☑	Safety Culture Measurement has been refocussed using the adapted Safety Climate Survey Tool of Yorkshire and Humber Academic Health Science Network piloted in Urgent Care Centre/Clinical Decision Unit, Medicine's Respiratory Ward and the Maternity Ward. Improvements are being delivered by group safety huddles which involve regular focused frontline team discussions of specific patient harms supported by improvement skills, coaching, data and feedback.
4	Run 2 training workshops on patient safety RCAs for frontline staff by end Q4.	☑	These sessions were held in November 2016.
5	Reducing Variation Programme progressed, including national data collection exercise.	☑	The Trust scores from October 2016 were generally favourable regarding emergency patients being seen within 14 hours of arrival, emergency admission patients' access to diagnostic tests and access to Consultant directed interventions. Twice daily Consultant review of those emergency admission patients needing two reviews during weekends requires improvement.
6	Implement National Standards for Invasive Procedures by September 2016.	☒	Inside theatre standards were implemented as required through updating the WHO Surgical Checklist to include implant and prosthesis checks. Whilst substantially implemented several additional procedures outside theatres remain under review to determine whether the guidance is applicable to them and thus if standard operating procedures need implementing and testing.
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.	TBC	The Scheme continued to recruit staff during the year. Feasibility analysis was due for Q4 and update is pending on whether this occurred.
9	Action plan for Fix Dementia Care report by end Q2.	☒	This was not achieved.
10	Capture, publish and feedback clinician level data for outpatients and inpatients by Q4.	TBC	Update pending.
11	Follow-up complaints < 10% on average. RCA and action plan if exceeded.	☑	Achieved.
12	Refresh 15 Steps tool to capture outpatient experience by Q2, action plan by Q3.	☒	This has not been refreshed owing to lack of capacity.