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

TRUST BOARD
28 July 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 June 2016[1] and an update on Q1 Quality Account and Business Plan Priorities. **June clinical quality data – refer to Appendix 1 page 7** Mortality review completion at 55% is below target of 90%, mainly from MES at 47%. The Divisional Director is informed of specialties not meeting requirements. The 90% rate has been referred to the Mortality Surveillance Group for review. Emergency 30-day readmissions of 14.1% exceeds the Q4 stretch target of 12.5% with significant areas by volume being General Medicine at 19.6% and Cardiology at 17.2%. Data review at governance meetings will guide action setting. Direct stroke unit admission performance of 62.2% has been around this level throughout Q1 and is under 90% reflecting ring fenced bed gaps, cases treated	

[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).

	elsewhere for medical need and pathway disruption. Medication errors per 1000 bed days is 3.40. The aim is to improve reporting to support learning so there is no target. Improvement actions from an internal audit review of medicines management are being progressed. FFT Inpatient satisfaction score of 94.3% fell 1% this month thus is narrowly below target of 95% so areas are reviewing performance to identify actions and learning. FFT ED satisfaction score of 79% has dropped significantly from 84.1% the previous month. Thematic feedback analysis is under review by ED senior leadership. Reported dementia case finding dropped significantly from 88% in May to 50% in June due to data collection limitations from staff capacity gaps and screening results not entered into Realtime. VitalPAC use for data recording will be evaluated later this year. Combined maternity harm-free care improved significantly by 9 percentage points in June to reach 72.2% which is marginally below the national average of 72.4%. Medicines reconciliation rates at 48.6% is below national average of 75.7%. Pharmacy is to redesign its service with the aim of implementing medicines reconciliation 7 days a week at the main admission points by the end of 2016. Complaints response to timescale rose from 54.5% in May to 70.4% in June with an average response time of 30.5 days for grades 1 & 2 complaints. No grades 3 & 4 complaints were issued to timescale and response time averaged 65.6 days. Follow-up complaints in June were 5.5% and 6.5% for Q1 which remain below the 10% limit. 3 new claims were reported from TASCC, all were previously complaints. 10 claims were intimated with DTTO (4), TASCC (3), WH&P (2) and MES (1). **Q1 Quality Account and Business Plan review – refer to Appendix 2 page 9** The majority of priorities are on track. Areas slipped or at significant risk are outlined below by exception. 15% reduction in pressure ulcers was narrowly missed with 58 ulcers (56 stage 2 and 2 stage 3) which narrowly exceeded the quarterly limit of 54.6. In Q2 focus will be on the heel wedge pilot and correct surface reviews for patients. VTE risk assessment is provisionally just below the 97% Quality Account target but above 95% national limit. Q1 data validation is underway with April 97.1%, May 98.2% and June 95.9% currently. The VTE data process is under urgent

	review as an absence of risk assessments for a cohort of ambulatory patients was found in June following a service reconfiguration. VTE performance for audit of the documentation of the prescription for chemical thromboprophylaxis with a Q1 score of 83% is marginally below the 85% target. The tool will be reviewed to ensure validity. Root cause analysis of HAT[2] cases is amber rated as no cases of HAT were identified in Q1. Due to services pressures no diagnostic screening review was undertaken. 98% spot screening of eligible inpatients – In Q1 screening increased from 83% in April, 91% in May to 95% in June resulting in 89% for Q1, below the 98% target. As the new Adult Nursing Assessment embeds results should keep improving. Under clinical effectiveness the divisional NICE guideline status update and gap analysis is under review by divisions, but is not yet completed. Regarding national audits a review for key recommendations for action planning has not progressed. Refreshing the 15 steps tool for outpatient experience has slipped slightly, this will be recovered in Q2.
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

[2] HAT: Hospital acquired thrombus

	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 July 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 7 to 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 – June clinical quality data

Mortality reviews
Mortality review completion rates dipped in all divisions compared with last month: TASCC (88% to 79%), WH&P (100% to 66%), MES (62% to 47%) and DTTO (100% to 33%). MES has a process in place for most specialties to review the mortality forms and the Divisional Director is informed of any specialties which do not meet the deadlines.

Emergency 30-day readmissions
Emergency 30-day readmissions of 14.1% exceeds the Q4 stretch target of 12.5% with significant areas by volume being General Medicine at 19.6% and Cardiology at 17.2%. Data review at governance meetings will guide action setting.

Direct stroke unit admission
Direct stroke unit admission performance of 62.2% has been around this level throughout Q1 and is under 90% reflecting ring fenced bed gaps, cases treated elsewhere for medical need and pathway disruption.

Medication errors per 1000 bed days
Medication errors per 1000 bed days is 3.40. The aim is to improve reporting to support learning so there is no target. Improvement actions from an internal audit review of medicines management are being progressed.

FFT satisfaction score
FFT Inpatient satisfaction score of 94.3% fell 1% this month thus is narrowly below target of 95% so areas are reviewing performance to identify actions and learning.

FFT ED satisfaction score of 79% has dropped significantly from 84.1% the previous month. Thematic feedback analysis is under review by ED senior leadership.

Dementia case finding
Reported dementia case finding dropped significantly from 88% in May to 50% in June due to data collection limitations from staff capacity gaps and screening results not entered into Realtime. VitalPAC use for data recording will be evaluated later this year.

Safety thermometer
Combined maternity harm-free care improved significantly by 9 percentage points in June to reach 72.2% which is marginally below the national average of 72.4%.

Medicines reconciliation rates at 48.6% are below national average of 75.7%. Pharmacy is to redesign its service with the aim of implementing medicines reconciliation 7 days a week at the main admission points by the end of 2016.

Sepsis screening
Sepsis screening data is pending; audits are undertaken in arrears and are still in progress for Q1.

Complaints performance
Complaints response to timescale rose from 54.5% in May to 70.4% in June with an average response time of 30.5 days for grades 1 & 2 complaints. No grades 3 & 4 complaints were issued to timescale and response time averaged 65.6 days. Follow-up complaints in June were 5.5% and 6.5% for Q1 which remain below the 10% limit.

PHSO[3] cases
This month the Trust has been notified of 1 new case from MES which will be investigated by the PHSO. The Trust currently has 8 open cases. 1 case pertaining to the TASCC division was closed in June and was not upheld.

Claims
3 new claims were reported from TASCC, all were previously complaints. 10 claims were intimated with DTTO (4), TASCC (3), WH&P (2) and MES (1).

Patient safety alerts
No new patient safety alerts were received in June 2016.

1.2 Performance by exception – Q1 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 pages 9 to 12.

Pressure ulcers
15% reduction in pressure ulcers was narrowly missed with 58 ulcers (56 stage 2 and 2 stage 3) which narrowly exceeded the quarterly limit of 54.6. In Q2 focus will be on the heel wedge pilot and correct surface reviews for patients.

VTE
VTE risk assessment is provisionally just below the 97% Quality Account target but above 95% national limit. Q1 data validation is underway with April 97.1%, May 98.2% and June 95.9% currently. The VTE data process is under urgent review as an absence of risk assessments for a cohort of ambulatory patients was found in June following a service reconfiguration.

[3] Parliamentary and Health Service Ombudsman

VTE performance for audit of the documentation of the prescription for chemical thromboprophylaxis with a Q1 score of 83% is marginally below the 85% target. The tool will be reviewed to ensure validity.

Root cause analysis of HAT[4] cases is amber rated as no cases of HAT were identified in Q1. Due to services pressures no diagnostic screening review was undertaken.

Diabetes screening
98% spot screening of eligible inpatients – In Q1 screening increased from 83% in April, 91% in May to 95% in June resulting in 89% for Q1, below the 98% target. As the new Adult Nursing Assessment embeds results should keep improving.

Clinical effectiveness
Under clinical effectiveness the divisional NICE guideline status update and gap analysis is under review by divisions, but is not yet completed. Regarding national audits review key recommendations for action planning have not progressed sufficiently.

Outpatient experience
Refreshing the 15 steps tool for outpatient experience has slipped slightly but this will be recovered in Q2.

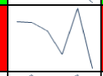
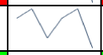
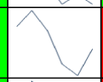
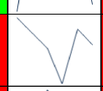
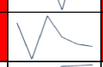
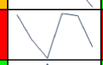
2.0 Strategic issues and options

Quality measures are those deemed strategically important to the Trust. The next Quality Account and Business Plan update is scheduled for Q2.

[4] HAT: Hospital acquired thrombus

Appendix 1 - Quality Performance Dashboard June 2016

Table 1: Quality Performance Dashboard 30 June 2016

REF	Quality Scorecard Measures	Outturn 15/16	Monthly Target / Limit	Annual Target / Limit	May	June	6 month trend	YTD 16/17	Current month commentary
1.01	In-hospital SHMI	64	<72	<72	64	66		64	Mortality indices in line with expectation.
1.02	RAMI	62	<70	<70	60	65		61	Mortality indices in line with expectation.
1.03	In-hospital deaths	1139	90	<1082	105	82		283	In-hospital deaths for the month are in line with expectations.
1.04	Proportion of mortality reviews (data 1 month in arrears)	56%	>90%	>90%	68%	55%		61%	Completion rates dipped in all divisions compared with last month: TASCC (88% to 79%), WH&P (100% to 66%), MES (62% to 47%) and DTTO (100% to 33%). MES has a process in place for most specialties to review the mortality forms and the Divisional Director is informed of any specialties which do not meet the deadlines.
1.05	Number of cardiac arrests not in critical care areas	56	-	-	6	2		13	A national Resuscitation Council Treatment Escalation Plan (TEP) is due in mid 2016 so TEP implementation of deferred until this guidance is released.
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	0		1	On track with zero cases.
1.08	Falls (per 1000 beddays)	2.59	2.46	2.46	1.75	2.18		2.59	Absolute falls of 88 in Q1 remains low with 28 in April, 27 in May, 33 in June. Falls prevention strategies including completion of the medical assessment and intervention for all admitted patients using the electronic documentation in patient centre are continuing.
1.09	Pressure ulcers (per 1000 beddays)	2.08	1.98	1.98	2.22	1.7		2.08	The CCG limit of 18.2 pressure ulcers (PUs) of stage 2 and above was narrowly exceeded in June with 19 PUs; 17 stage 2 and 2 stage 3. Root cause analyses are progressing. ITU had 6 stage 2 PUs and their action plan includes initial risk assessment for pressure relieving products, MUST scoring, and promoting regular positioning changes. Swan had 4 stage 2 PUs and the Repose wedge for heel pressure offloading is being piloted from June.
1.10	Readmissions within 30 days - emergency only	13.1%	12.5%	12.5% by Q4	14.5%	14.1%		13.8%	Significant areas for emergency readmissions by volume are general medicine at 19.6% and cardiology with 17.2%; since June 2016 specialty readmissions data is being reviewed at governance meetings to guide action plan setting.
1.11	Stroke patients (% admitted to stroke unit within 4 hours)	65.0%	90%	90%	63.0%	62.2%		63.5%	June stroke performance at 62% has been constant across Q1. In June 14 breaches reflected factors including 7 ring fence beds being unavailable and 4 cases of differing presenting complaint or medical opinions being awaited.
1.12	Medication errors (rate per 1000 beddays)	2.92	-	-	3.34	3.4		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%					The sepsis measures and targets for items 1.13 to 1.16 are provisional - pending finalisation of the audit later this month. Q1 results will be provided in the August report.
1.14	Sepsis - antibiotics administered on ED patients and day 3 antibiotic review performed	-	TBC	TBC					-
1.15	Inpatient sepsis - % appplicable patients screened for sepsis	-	TBC	TBC					-
1.16	Inpatient sepsis - % appplicable patients receiving timely antibiotics and day 3 antibiotic review performed	-	TBC	TBC					-
3.03	Serious Incidents Requiring Investigation (SIRI) reports overdue to CCG	8	-	-	12	12		12	The Safety Team continue to actively progress completion of overdue SIRI reports.
3.04	Serious Incidents Requiring Investigation (SIRI) reports submitted to CCG	116	-	-	3	1		11	1 report was submitted to Panel this month.
3.07	Friends and Family Satisfaction Score - Inpatients including Daycase	96.2%	95%	95%	95.2%	94.3%		95.1%	FFT satisfaction rate dipped narrowly by 1 percentage point in June and inpatient areas are reviewing to identify actions and learning.
3.08	Friends and Family Satisfaction Score - Accident and Emergency Department (ED) including Paediatrics	84.3%	87%	87%	84.1%	79.0%		82.7%	The ED satisfaction score dropped 5 percentage points from 84% in May to 79% in June and thematic feedback analysis is under urgent review by ED senior leadership to guide improvement actions.
3.09	Friends and Family Satisfaction Score - Maternity Touch Point 2	96.3%	97%	97%	98.1%	98.1%		97.5%	The maternity satisfaction rate remains above national average in June and reflects benefits from the ongoing service improvement work programme.
3.09a	Friends and Family Satisfaction Score - Outpatients	0.9	92%	92%	95.5%	96.2%		95.9%	Outpatient feedback continues to be stable and above average. The Outpatient improvement project continues to enhance the experience for outpatients and any negative feedback is used to inform future initiatives.
3.10	Follow-up complaints - complaint rate per rolling 12 month average	8.3%	<10%	<10%	8.4%	5.5%		6.5%	The 2 June follow-up complaints from DTTO were grade 1 and 2 complaints which have subsequently been reviewed by the complaints panel for learning. Grade 1 and 2 complaints are not part of the Chief Nurse quality review process and this group of follow-up complaints is being monitored closely in Q2.
3.11a	Dementia case finding	96%	>90%	>90%	88%	50%		77%	Reported dementia case finding dropped significantly from 88% in May to 50% in June and is thought to reflect a combination of data collection limitations from staff capacity gaps and screening results not being entered into the Realtime system. Consideration of VitalPAC for data recording will be evaluated later this year.
3.11b	Dementia diagnostic assessment	99%	>90%	>90%	100%	100%		100%	All eligible patients received a diagnostic assessment.
3.11c	Dementia referral	87%	>90%	>90%	100%	100%		100%	All eligible patients were referred to appropriate specialist services.

REF	Reference items	Target description & limit		May	June	6 month trend	YTD 16/17	Current month commentary
1	Overdue safety alerts	<1 overdue	<1	0	0		n/a	No new safety alerts were received in June 2016. Alerts received prior to June are all either actioned and underway or closed.
2.1	NHS Safety Thermometer - % of patients on spot day with new harms	< National av.	2.11%	1.05%	0.65%		0.65%	New harms of 0.65% were below the national average of 2.11%.
2.2	NHS Safety Thermometer - % of patients on spot day with new CAUTIs	< National av.	0.31%	0.42%	0.00%		0.15%	There were no new CAUTIs on the June audit spot day.
2.3	NHS Safety Thermometer - % of patients on spot day with new pressure ulcers	< National av.	0.90%	0.63%	0.43%		0.36%	New pressure ulcers of 0.43% were below the national average of 0.63%.
2.4	NHS Safety Thermometer - % of patients on spot day with falls with harm	< National av.	0.54%	0.00%	0.22%		0.07%	Falls with harm of 0.22% were below the national average of 0.54%.
2.5	NHS Maternity Safety Thermometer - % of patients with combined harm free care (physical harm and women's perception of safety)	> National av.	72.40%	63.0%	72.2%		73.9%	Combined maternity harm-free care improved significantly by 9 percentage points in June to reach 72.2% which is now only marginally below the national average of 72.4%.
2.6	NHS Medications Safety Thermometer - % of patients with reconciliation started within 24 hours of admission	> National av.	75.70%	52.86%	48.57%		58.8% *	*YTD actual is rolling median in line with national charts. Patients with reconciliation started within 24 hours of admissions at 48.57% were lower than the national average of 75.70%. Currently Pharmacy undertakes Medicines Reconciliation on all adult wards Monday to Friday and limited service to AMU on weekends and Bank Holidays. Pharmacy targets the admission areas Monday to Friday to maximise the number of patients seen but the multiple areas to which patients are admitted means the resource is currently stretched for scope and capacity. Pharmacy is working through a redesign of its service with implementation to be undertaken by the end of 2016. The redesign is to ensure that the Pharmacy service primarily operates at ward level and that we are resourced to undertake Medicines Reconciliation 7 days a week at the main admission points.
2.7	NHS Medications Safety Thermometer - % of patients with an omitted critical medicine in the last 24 hours	< National av.	7.26%	21.43%	5.70%		7.9% *	*YTD actual is rolling median in line with national charts. Critical medicine omission of 5.70% is better than the national average of 7.26%. 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.
3	Best care audits undertaken this month	Level 3 ward count	-	-	-	-	n/a	The quarterly Best Care Audits are in progress and results will be available in the August report.
4	WOW awards	-	n/a	56	28		n/a	DTTO had 8 WOW nominations and MES and TASCC both received 7 proposals each. WH&P were nominated for 4 awards and Estates & Facilities received 2 proposals.
5.1	Complaints % Responded to timescale as agreed with complainant	Timeliness	>95%	89.0%	92.0%		89.0%	3 out of 38 closed complaints left the Trust after the agreed date with the complainant. The 3 exceptions 3 were from within the WH&P division.
5.2	Complaints % Responded to timescale (Grade 1 & 2 in 25 days)	Timeliness	No target	54.5%	70.4%		57.0%	33 grade 1 or 2 complaints were closed in June. 6 of these were allocated a longer time period due to additional scrutiny before despatch. Of the 27 remaining complaints 19 were issued within 25 days.
5.3	Complaints % Responded to timescale (Grade 3 & 4 in 35 days)	Timeliness	No target	14.0%	0.0%		12.0%	5 grade 3 or 4 complaints were closed in June. One of these was also a Serious Incident and therefore was not expected to achieve a 35 day turnaround. Of the 4 remaining cases, none of these left the Trust within the target timeframe of 35 days.
5.4	Complaints mean response time in days: variance from 25 day target (Grade 1 & 2)	Responsiveness	No target	7	5.5	-	7	The average number of days to respond to a grade 1 or 2 complaint in the month of June was 30.5 days.
5.5	Complaints mean response time in days: variance from 35 day target (Grade 3 & 4)	Responsiveness	No target	12	31	-	20	One of these complaints was also a SIRI and the longest timeframe for response was 121 days which has led to a high average number for response time.
5.6	PHSO (Ombudsman) cases open - total number	Response quality	No target	8	8		-	There was 1 new case and 1 closed case in June. 8 cases remain open with the PHSO.
5.7a	PHSO (Ombudsman) cases closed but not upheld	Response quality	No target	0	1		2	The PHSO closed 1 case in June from TASCC which was not upheld.
5.7b	PHSO (Ombudsman) cases closed and partially upheld	Response quality	No target	0	0		1	-
5.7c	PHSO (Ombudsman) cases closed and upheld	Response quality	No target	0	0		0	-
5.8	PHSO (Ombudsman) new cases received	Response quality	No target	1	1		5	1 new MES case was accepted for investigation by the PHSO.

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Appendix 2 – Q1 Quality Account and Business Plan Dashboard

Quality Priority Dashboard 2016-17

REF	2016/17 Quality Account Measure	Q1	Quarter 1 Narrative
	Safety - Improving harm free care		
1.1	Medication Safety Thermometer data collected and position against national position is baselined.		Data is being collected and baselined in Q1. The Pharmacy service redesign will be implemented by December 2016 to include 7 day medicines reconciliation at key admission points and minimising removal of charts from wards to improve missed doses. Inpatient chart redesign to promote improved documentation is under consideration.
1.2	Maternity Safety Thermometer performance better than national average.		Q1 performance dipped slightly below national average. Maternity Safety Thermometer performance was better than the national average for April, lower in May and almost the same as the national average in June. The Division is reviewing the submission process and the Maternity Governance Team is reviewing cases for improvement actions where applicable.
1.3	Classic Thermometer performance better than national average.		In Q1, the Trust has achieved Safety Thermometer performance better than the national average apart from an incorrect submission in May for a new CAUTI. This will be re-classified in the next submission and will take the Trust to above national average for all months and measures.
1.4	20% reduction in falls compared to last year.		The monthly falls limit is 30.5 per month (365 per year) reflecting a 20% reduction on 2015/16 falls of 457. In Q1 the 88 falls is thus below the target of 91.5 per quarter, which is a significant achievement. The ongoing falls corporate prevention strategy uses an improvement methodology model and includes training, engagement, sensor alarms and other clinical improvements.
1.5	15% reduction in stage 2 and above hospital acquired pressure ulcers compared to last year.		For Q1 there were 58 PUS (56 stage 2 and 2 stage 3) which narrowly exceeded the quarterly limit of 54.6. Training in pressure ulcer prevention is now mandatory. The Trust is piloting a new wedge to elevate patients' heels from the mattress. The Q2 focus is ensuring that patients are on the correct surface to meet their needs.
1.6	Risk assess 97% of adult inpatients for VTE on admission.		April - 97.05% , May - 98.18% , June - 95.87. Q1 result - pending. VTE data process following a service reconfiguration is under urgent validation and review following identification of an absence of risk assessments for a cohort of ambulatory patients.
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 Q1. Due to service pressures, no diagnostic screening review was carried out. If service pressures reduce, this will be addressed in Q2.
1.8	Audited documentation of the prescription of appropriate chemical thromboprophylaxis with the aim of achieving 85%.		Q1 average for documentation of appropriate chemical prophylaxis was 83%, with April at 81%, May at 83% and June at 84%. A review of the audit tool is planned for 16/17 to ensure data validity. 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.
1.9	Achieve VTE Exemplar Centre Status by 31 March 2017.		VTE Exemplar Centre Status is awarded by VTE Prevention England, which is a programme of NHS England. There are six requirements that need to be fulfilled, each with their own indicators. An application to NHS England was made in March, with a site visit due to take place in August.

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	Safety - Embedding and measuring safety culture		
2.1	Quarterly audits of duty of candour with exeception reporting to QAPC.		Q1 duty of candour compliance was 100% based on Datix records of grade 3,4 and 5 incidents requiring a response to the patient or family. A more detailed record is outlined in the monthly SIRI report to QPC Committee.
2.2	Review MaPSaF divisional action plans by Q3 ensuring evidence of action implementation.		To review in Q2.
2.3	Implement KSS AHSN safety culture and leadership pilot programme by Q4.		The Trust has attended MaPSaF training and development events to progress the programme.
2.4	Implement National Standards for Invasive Procedures by September 2016.		To review in Q2.
	Safety standards		
3.1	NMC revalidation timescales met.		All relevant revalidation applications have been submitted to date.
3.2	Reducing Variation Programme progressed, including national data collection exercise.		Progressing, detailed update pending.
	Clinical Effectiveness - Diagnosis of diabetes		
4.1	Screen 98% eligible inpatients for diabetes (spot audit).		In Q1 screening increased from 83% in April, 91% in May to 95% in June resulting in 89% for Q1, below the 98% target. As the new Adult Nursing Assessment embeds results should keep improving.
	Clinical effectiveness - Audits and NICE guidance		
5.1	Implementation NICE Clinical Guidelines – monthly status report and gap analysis.		All divisions are reviewing guidelines, update awaited.
5.2	Gap analysis of NICE Guideline NG 31, Care in the Last Days of Life: gap analysis and action plan by Q3.		Currently the Trust lacks a structured approach to ensure compliance with this guidance. A PMO supported implementation plan was commenced in 2014 aiming to provide an individual approach based on NICE guidance and the Leadership Alliance for Care of Dying People. The Supportive and Palliative care team is progressing the remaining areas including staff training and mentoring along with quality improvement audits.
5.3	Participate in all applicable mandatory national audits and implement action plans for key recommendations from the national bodies.		Work underway to participate in mandatory audits. Lack of progress regarding review of recommendations.

REF	2016/17 Quality Account Measure	Q1	Quarter 1 Narrative
	Patient experience - Vulnerable groups		
6.1	Review the MHA training scheme by Q1, action plan by Q2 to Mandatory Training Committee.		MHA training is provided by Surrey and Borders Partnership (SABP). Training for medical staff is under consideration. MHA awareness is to be provided for all clinical staff on a new training day starting from October.
6.2	Introduction to MHA Training within Safeguarding Training for Clinical Staff by Q2.		MHA awareness for all clinical staff will be through the new training day commencing from October.
6.3	Campaign covering patient records and privacy by Q2.		A video is currently being designed promoting privacy and dignity of patient records.
6.4	Dementia clinical environment review by Q2, action plan by Q3.		Work on the dementia friendly bays on Swift and Holly wards is complete and training sessions for staff will be carried out on the bays. The Dementia Lead will work with colleagues from capital projects on future initiatives.
6.5	Continue dementia carers' local survey: implement improvement actions, 6 monthly updates to Board.		In response to carer feedback from events an improvement area identified was communication therefore a staff/carer diary is to be piloted on an elderly care ward. 75 carers will be surveyed via the upcoming National Dementia Audit with feedback when published later this year.
	Patient Experience - Outpatients		
7.1	Capture, publish and feedback clinician level data for outpatients and inpatients by Q4.		Clinical level data rollout is underway with an oversight steering group in place.
	Patient Experience - Inpatients		
8.1	Communicate to inpatients potential for ward transfers by Q2		A draft patient leaflet is under consultation which incorporates expectations regarding the patient journey, how patient moves are determined and occasional use of escalation areas. A baseline audit of multiple patient moves is scheduled for Q2.
8.2	Implement framework for using Always Events toolkit, and have 3 Always Events by Q4.		The initial Always Event is underway in dementia care and the second event is to be progressed in A&E during Q2.
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.		Face to face feedback meetings have been held with 2 GPs reviewing establishing UCC support and referral process back to GPs after UCC attendance. Further sessions are planned.
	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.		Our communication plan principally consists of four areas: **1. Information sharing** - ensuring we produce a twice yearly newsletter, regularly update on our news boards around the Trust, ensure our comprenehensive website is kept up to date. The aim is to ensure that Trust staff and patients are aware of research activities across the Trust, along with specifc studies in pertinent areas and specialities. **2. Education and knowledge** - to include presentations (both internal and external events), education opportunities with local and national stakeholders, open events and meetings (again internal and external). **3. Targeted awareness** - area and study specific. Explore the opportunities of social media to enhance research engagement, specifically for patient recruitment. **4. Electronic data capture** - to link our research source data and patient specific documents onto Evolve. Identify research patients and key details onto PAS.

REF	Business Plan Measure	Q1	Quarter 1 Narrative
	Business plan - Best outcomes		
1	20% reduction in falls compared to last year (Sign up to Safety)		Achieved as explained in section 1.4 above.
2.1	Medication Safety Thermometer data collected and position against national position is baselined.		Achieved as explained in section 1.1 above.
2.2	Maternity Safety Thermometer performance better than national average.		Not yet achieved as explained in section 1.2 above.
2.3	Classic Thermometer performance better than national average.		Achieved as explained in section 1.3 above.
3	Implement KSS AHSN safety culture and leadership pilot programme by Q4.		Progressing as per section 2.3 above.
4	Run 2 training workshops on patient safety RCAs for frontline staff by end Q4.		To review in Q2.
5	Reducing Variation Programme progressed, including national data collection exercise.		Progressing, detailed update pending.
6	Implement National Standards for Invasive Procedures by September 2016.		To review in Q2.
7	NMC revalidation timescales met.		All relevant revalidation applications have been submitted to date.
	Business plan - Excellent experience		
8	Evaluate 'Adopt a Grandparent' pilot by Q1, if deemed feasible to implement by Q4.		Implementation underway with 5 wards officially onboard with the programme and further development planned for Q2.
9	Action plan for Fix Dementia Care report by end Q2.		Local figures from the Fix Dementia Care report will be collated for a quarterly report.
10	Capture, publish and feedback clinician level data for outpatients and inpatients by Q4.		Rollout of the project is underway with a steering group set up to monitor progress.
11	Follow-up complaints < 10% on average. RCA and action plan if exceeded.		Follow-up complaints were 5.5% in June and 6.5% for the quarter thus in Q1 complaints follow-ups remained below the threshold of 10%.
12	Refresh 15 Steps tool to capture outpatient experience by Q2, action plan by Q3.		Minor recoverable slippage - refresh of tool to take place in Q2.