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

TRUST BOARD
24th September 2015

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report format is being streamlined this quarter to present information in a tabular format; see pages 3-4. Significant improvement in complaints performance across the divisions apart from Medicine and Emergency Service (MES) at 80%, hence Trust-wide performance on timeliness is 87.7%.
BOARD ASSURANCE (RISK) / IMPLICATIONS	The Quality Report provides assurance that quality indicators are being monitored and assessed and that mitigating actions are being put in place as required.
ALIGN TO TRUST RISK REGISTER	Refer to Risk Scrutiny Committee submissions.
LINK TO STRATEGIC OBJECTIVE	**SO1**: Best outcomes. **SO2**: Excellent experience.
STAKEHOLDER / PATIENT IMPACT AND VIEWS / STAFF VIEWS	Patients' views are included via the reporting mechanisms for quality. The clinical quality metrics indicate where poor care and poor experience are occurring. Where appropriate staff views are included.
EQUALITY AND DIVERSITY ISSUES	All of our services give consideration to equality of access taking into consideration disability and age. All matters are dealt with in a fair and equitable way regardless of ethnicity or religion of patients.
LEGAL ISSUES	Poor quality for patients can lead to potential litigation. Poor quality care can lead to non-compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Compliance with these regulations is a legal requirement and failure to do so could affect the Trust's Care Quality Commission registration and Monitor licence.
The Trust Board is asked to:	Review the paper and discuss the contents seeking additional assurance as necessary.
Submitted by:	Dr David Fluck, Medical Director and Mrs Heather Caudle, Chief Nurse
Date:	24 September 2015
Decision:	For Assurance

Quality Report

Contents

1 Scorecard

Scorecard

The Quality Report format is being streamlined this quarter to present information in tabular format. Scorecard definitions are on pages 12-13.

Table 1: Quality Performance Dashboard

REF	Quality Scorecard Measures	Outturn 14/15	Monthly Target	Annual Target	July	Aug	6 month trend	YTD 15/16	Current month commentary
1.01	In-hospital SHMI	58	<72	<72	63	67		66	The mortality indices are reflecting the expected improvement associated with season variation.
1.02	RAMI	60	<70	<70	49	61		66	The mortality indices are reflecting the expected improvement associated with season variation.
1.03	In-hospital deaths	1111	86	<1033	83	81		456	There has been no significant change in in-hospital deaths.
1.04	Proportion of mortality reviews (measured at the cut-off date for Board reporting)	38%	>90%	>90%	45%	61%		50%	TASCC achieved 100% for the 5th consecutive month by improving clinician engagement and robust monitoring. DTTO undertook 0% of mortality reviews; due to changes in the timings of QUASH meetings the regular detailed reviews of mortality have not occurred and the next one is in November. MES has increased increased to 55% in August from 39% in July. There was no NICU Morbidity and Mortality Review meeting in August which may account for the WHP figure of 25%.
1.05	Number of cardiac arrests not in critical care areas	72	-	-	3	3		23	The Treatment Escalation Plan form is currently under review and once agreed will be trialled on Aspen and Swan wards following doctor education and training.
1.06	Methicillin Resistant Staphlococcus Aureus (MRSA) - hospital only	1	0	0	0	0		0	On target this month.
1.07	C. Difficile (hospital only)	18	1.4	17	1	0		5	On target.
1.08	Falls (per 1000 beddays)	3.29	3.00	3.00	2.43	2.47		2.76	No serious falls injuries occurred in August and the rate of falls per 1000 beddays has been declining since June. Continued falls prevention strategies include the rollout of the "yellow prevention toolkit", medical and nursing documentation to help identify and reduce falls and the establishment of e-learning packages for junior doctors and nurses.
1.09	Pressure ulcers (per 1000 beddays)	2.03	1.19	1.19	1.94	2.20		2.10	The Trust had 22 stage 2 hospital acquired pressure ulcers in August affecting 19 patients; the number is just below the agreed target with the CCG of 22.4 per month. There were no stage 3 or 4 hospital acquired pressure ulcers. The Tissue Viability Service is providing focused "pop up" training in those areas needing it, as well as continuing with actions against the Trust corporate action plan for the reduction of pressure ulcers. In addition, ward/department managers are implementing local actions. Cedar ward had the highest number of pressure ulcers in August, all of which were attributed ot oxygen tubing. the nurse in charge now checks all patients on oxygen at the start of the shift.
1.10	Readmissions within 30 days - emergency only	12.60%	12.2%	12.2%	11.6%	13.30%		12.5%	The divisional approach to monitoring readmissions is continuing. The Trust is actively working with community partners on the Locality Hub Project which involves set up of a new targeted facility to provide co-located high level community services to a patient cohort at higher risk of readmission.
1.11	Stroke patients (% admitted to stroke unit within 4 hours)	52.80%	90%	90%	71.7%	65.1%		58.1%	Trajectory to achieve 90% to be reviewed by the Division.
1.12	Medication errors (rate per 1000 beddays)	2.04	2.01	2.01	3.61	2.41		2.96	Medication Safety Thermometer has been piloted on 4 wards in August and the data submitted nationally. Manchester Patient Safety Framework (MaPSaF) is due to be rolled out in Pharmacy in September. Pharmacy action plans are in place including a focus on promoting reporting.
1.13	Sepsis audits undertaken (placeholder - to be added in Q3)	-	-	-	-			-	Baseline data is being collected in Q2; initial results for August showed 60% compliance with sepsis screening in the Accident and Emergency Department.
3.03	Serious Incidents Requiring Investigation (SIRI) reports overdue to CCG	-	-	-	30	33		33	The 11 September deadline for clearance of overdue SIRIs has not been met. A revised trajectory is in place with only 8 outstanding reports for submission by 18 September. It is anticipated that the progress to date will be sustained.
3.04	Serious Incidents Requiring Investigation (SIRI) reports submitted to CCG	-	-	-	20	13		53	This reflects the progress with submission of outstanding SIRIs.
3.07	Friends and Family Satisfaction Score - Inpatients including Daycase	93.9%	95%	95%	95.8%	97.0%		96.4%	August shows improvement in satisfaction on previous month and is above the monthly target.
3.08	Friends and Family Satisfaction Score - Accident and Emergency including Paediatrics	83.6%	87%	87%	82.9%	87.0%		85.7%	August shows significant improvement from the previous month and is at the target level.
3.09	Friends and Family Satisfaction Score - Maternity composite score	95.8%	TBC	TBC	100.0%	93.1%		96.5%	August shows a drop in satisfaction from the previous month. The maternity team are looking into the unfavourable comments in order to initiate improvements where possible.
3.09a	Friends and Family Satisfaction Score - Outpatients	NEW	TBC	TBC	94.4%	95.7%		94.2%	August shows ongoing month on month improvement and the Outpatients Improvement Project is continuing.
3.10	Follow-up complaints (measure of quality of response)	85	7	81	2	4		15	August follow ups remain under set limit of 10% at 8.9%.
3.11	Dementia screening (composite score)	96.6%	>90%	>90%	99.2%	99.2%		97.4%	On track.

REF	Reference items	Target description & limit		July	August	6 month trend	YTD 15/16	Current month commentary
1	Overdue safety alerts	<1 overdue	<1	1	1		n/a	The laboratory has finished live testing of the AKI algorithm in the pathology system. Sector treatment of the AKI safety alert parameters is under review in order to guide the closure process for this alert. The antimicrobial resistance alert received on 18 August has been actioned and is underway.
2.1	NHS Safety Thermometer - % of patients on spot day with new harms	< National av.	2.23%	1.56%	1.31%		1.30%	New harms at 1.31% are well below the national average of 2.26%.
2.2	NHS Safety Thermometer - % of patients on spot day with new CAUTIs	< National av.	0.30%	0.22%	0%		0.09%	There were no new CAUTIs in August.
2.3	NHS Safety Thermometer - % of patients on spot day with new pressure ulcers	< National av.	0.99%	0.67%	0.65%		0.50%	New pressure ulcers at 0.65% are below the national average of 0.94% for the fifth consecutive month.
2.4	NHS Safety Thermometer - % of patients on spot day with falls with harm	< National av.	0.59%	0.67%	0.44%		0.43%	Falls with harm at 0.44% reflect 2 falls and are below the national average of 0.64%.
3	Best care audits undertaken this month	Level 3 ward count	-	2	4		n/a	In August 2015 8 wards were audited. 4 wards retained accreditation level 3: Holly, May, OPD ASH and ITU. Kingfisher and NICU both improved from level 1 to level 2, with gaps in patient observations for Kingfisher and nutrition and skin integrity for NICU. Maple decreased from level 3 accreditation to level 1, with gaps in manual handling and falls. Paediatric Emergency Department dropped accreditation level to 2 from 3; skin integrity, manual handling and falls and nursing documentation were all RAG rated as red and patient observations was amber rated. Improvement will be monitored via the Best Care Surveillance Panel.
4	WOW awards	-	n/a	31	58		n/a	There were 21 WOW nominations for Diagnostics & Therapies, Trauma & Orthopaedics and Acute Medicine and Emergency Services received 12 proposals. Theatres, Anaesthetics, Surgery and Critical Care and Women's Health and Paediatrics each had 9 nominations. There were 2 proposals each for Estates and Facilities, Health Informatics and Quality, Research, Medicine, Nursing and Midwifery. Human Resources received 1 recommendation.
5.1	Complaints % Responded to timescale (pre April 2015)	Timeliness	>95%	n/a	83.0%		88.00%	The target response time based on grade has been discontinued as agreed with our Commissioners. This measure is a continuation of complaint responded to in a timescale agreed with the complainant (as per 2014-15).
5.2	Complaints % Responded to timescale (Grade 1 & 2 in 25 days)	Timeliness	>95%	69%	58%		73.00%	Measure discontinued - timescale agreed with complainant is the ongoing measure (see above).
5.3	Complaints % Responded to timescale (Grade 3 & 4 in 35 days)	Timeliness	>95%	50%	53%		60.00%	As above.
5.4	Complaints mean response time in days: variance from 25 day target (Grade 1 & 2)	Responsiveness	<0	+4	-6		+3	As above.
5.5	Complaints mean response time in days: variance from 35 day target (Grade 3 & 4)	Responsiveness	<0	-4	+9		-5	As above.
5.6	PHSO (Ombudsman) cases open - total number	Quality of response	nil	16	16		n/a	To date there are 16 cases. 1 case that was closed was not upheld.
5.7	PHSO (Ombudsman) cases not upheld	Quality of response	All	1	1		n/a	Year to date, there has been 1 case that was not upheld.

Scorecard notes:

Rating table

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

2.1 Patient Experience

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

There has been a small decrease in PALS cases received in August and a notable decrease in concerns pertaining to the Outpatient Department from 38 in July to 13 in August. Other themes remain consistent with communication issues being the highest reported concern.

Formal complaints have reduced in August to 31 compared with 46 in July. This level is more in line with seasonal trends and is indicative of the efforts being made to resolve issues and concerns immediately they are first raised.

Follow-ups remain low with 4 follow-ups received in August and a percentage of 8.9%. This measure continues to indicate that the quality of response is high and complainants are satisfied with the responses they receive.

Complaint Performance Against Timescale

The average time to respond to a complaint across the Trust was 34 days in August. This includes closure of one complaint with a parallel SIRI process running which therefore took an extended time to close.The Trust continues to aim for Grade 1 and 2 responses in 25 working days and Grade 3 and 4 responses in 35 working days, although timeliness is measured against the date agreed with the complainiant.

The MES August figure of 80% for responses sent within agreed timeframe is low due to a transitional period where staff were being made aware of the target reverting back to that of an agreed timeframe with complainant. Whilst complainants were being made aware of delays in early August, staff were not immediately aware that extended dates could be agreed with complainants and therefore the decision was made by the Head of Patient Experience to leave the original agreed dates in place for reporting purposes in the knowledge that complainants had been made aware of any delays. Moving forwards all staff are now aware that where necessary and appropriate, an extended deadline may be agreed with a complainant if there are valid reasons. Therefore it is expected that there will be an improvement in September.

Parliamentary and Health Service Ombudsman (PHSO) Cases

There has been 1 new request for information received by the PHSO in August bringing the total cases since April 2015 to 5. 1 case has been closed in August and was not upheld.

Friends and Family Test (FFT)[1]

Inpatients recommending the service remains stable and above the national average at 97%. The Accident and Emergency Department recommended score has recovered in August to 87% in line with the national average. Maternity Touchpoint 2 has dropped to 95.7% but remains high and stable. The Outpatient Department's percentage recommended score[2] is displaying gradual improvement at 95.7%, an increase on July. The first month for national submission was April 2015, however there is no national data available for benchmarking.

It was recognised in August that previously not all daycase episodes have been included in the denominator figure such as Endoscopy, Opthalmology and Maxillofacial. These have

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

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

now been included increasing the denominator for August inpatients and daycase's considerably. This has resulted in a low percentage of 17.1% for August within the daycase and inpatient submission as feedback commenced collection from September. This is therefore expected to recover in September.

2. 2 Best Care Audits

The Best Care Audit is an on going accreditation scheme used to assess wards against 14 quality and safety indicators. The frequency of Best Care Audits is aligned with performance. Wards may be reassessed every 2, 3, 4 or 6 months dependent upon achievement of accreditation levels of 0, 1, 2 or 3 respectively. In August 8 wards were audited. The accreditation levels are shown below with detailed results in Appendix 4.

Table 2 Best Care Accreditation Levels August 2015

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

3 Classic NHS Safety Thermometer Charts

The Classic NHS Safety Thermometer programme aims to achieve significant reductions in 4 types of avoidable harm: pressure ulcers, falls, Catheter Associated Urinary Tract Infection (CAUTI) and Venous Thromboembolism (VTE). Data is collected on inpatients on 1 day per month. [3] Safety Thermometer performance for these harms is shown on Charts 1 to 4 on pages 10-11. Charts 1 to 4 have not contained Frimley Healthcare NHS Foundation Trust (FPH) data since April and the Health and Social Care Information Centre (HSCIC) has confirmed previously that the data has not been available.

Chart 1 Percentage of Patients with New Harms

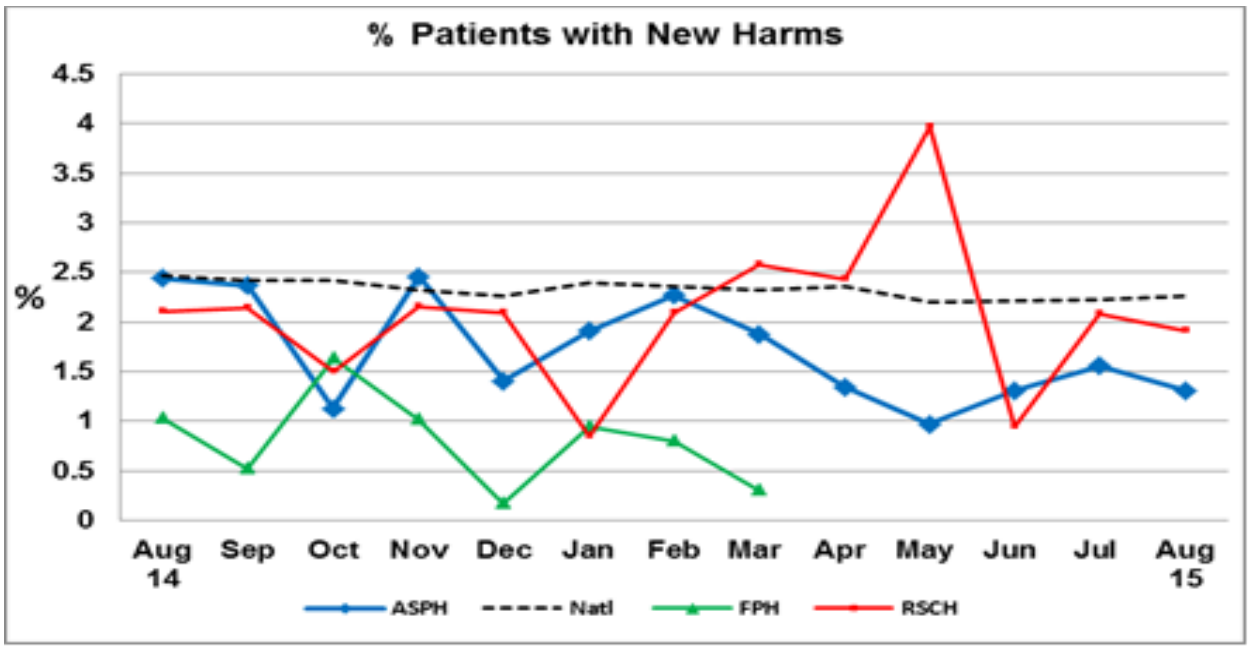
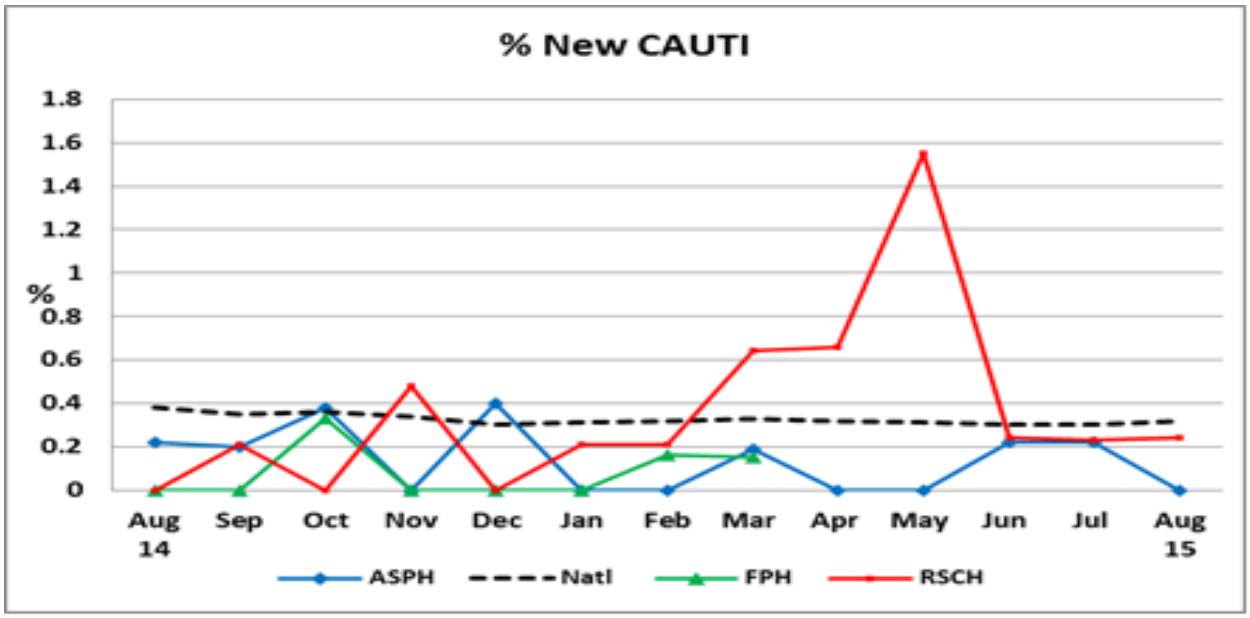


Chart 2 Incidence of new Catheter Associated Urinary Tract Infection (CAUTI)



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

Chart 3 Incidence of New Pressure Ulcers

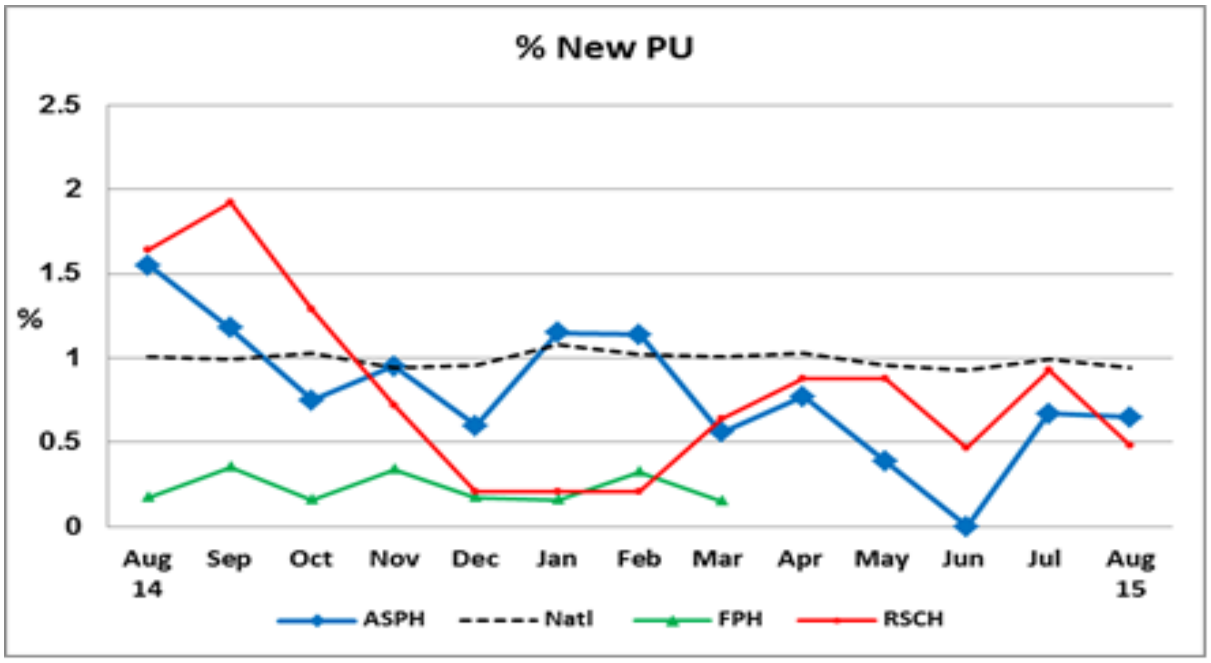
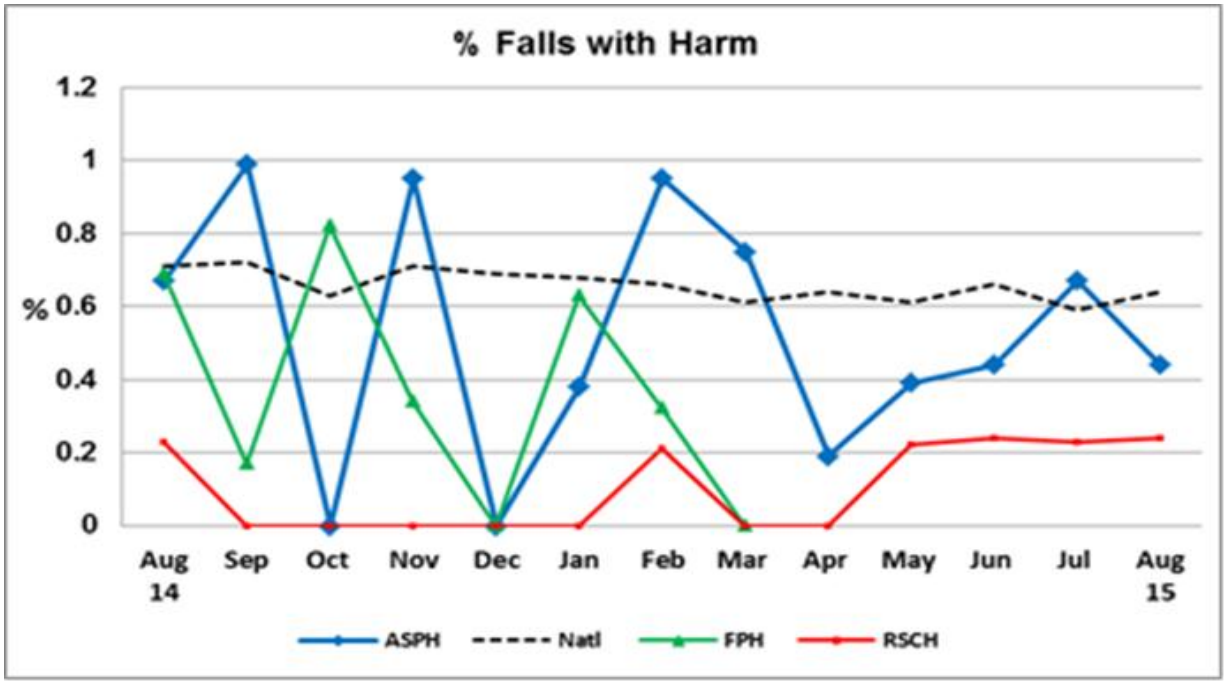
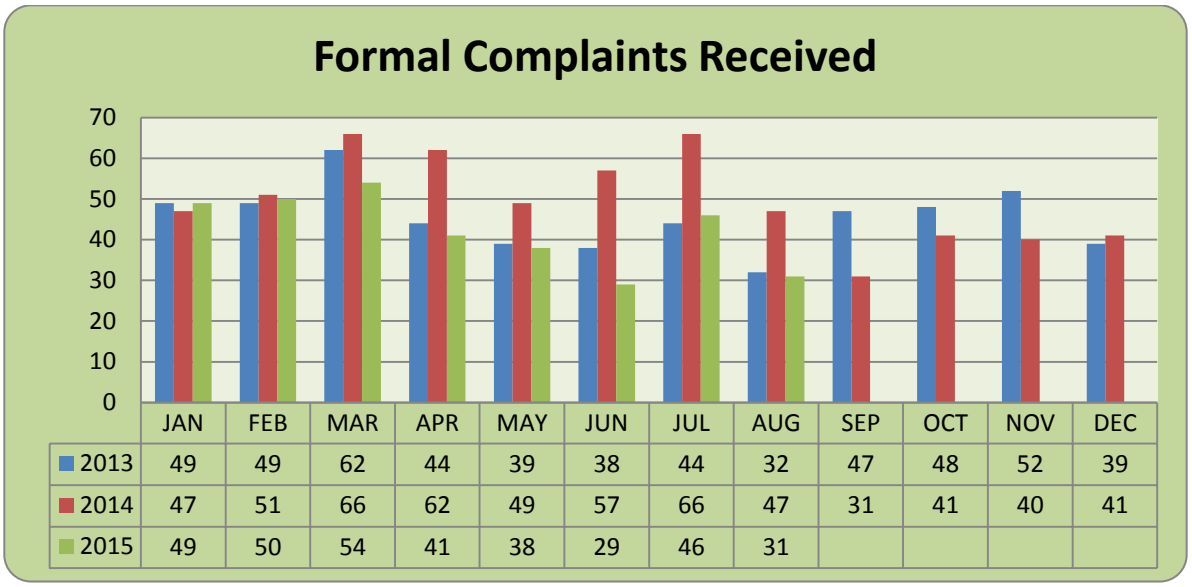


Chart 4 Percentage of Falls With Harm



Patient Experience Charts

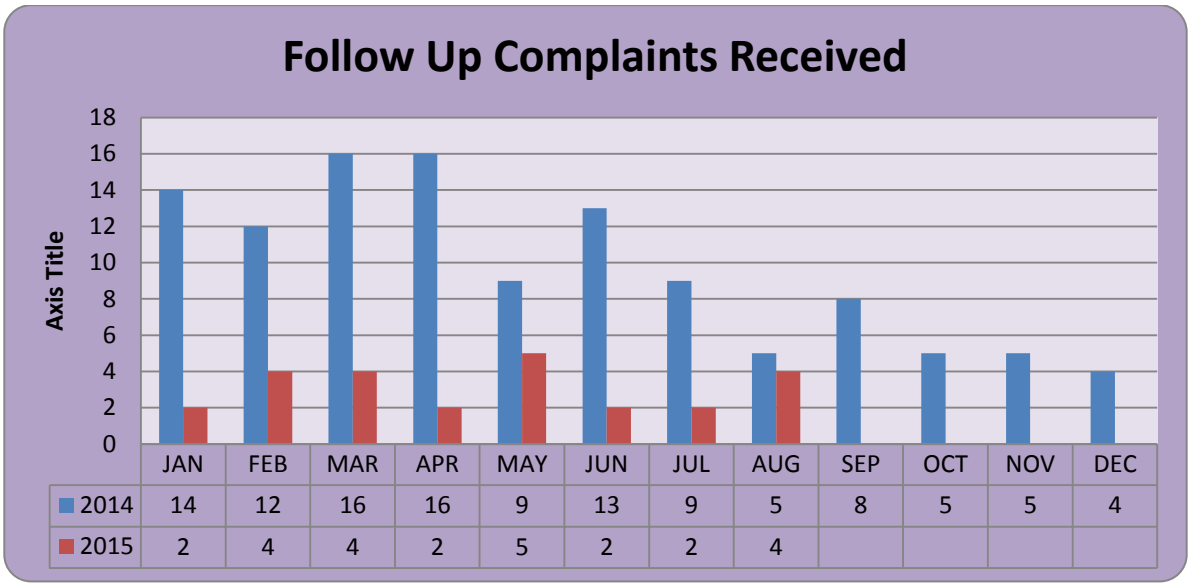
Chart 5a: Complaints Received by Month



	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
2013	49	49	62	44	39	38	44	32	47	48	52	39
2014	47	51	66	62	49	57	66	47	31	41	40	41
2015	49	50	54	41	38	29	46	31				

Chart 5a displays a reduction in formal complaints in 2015

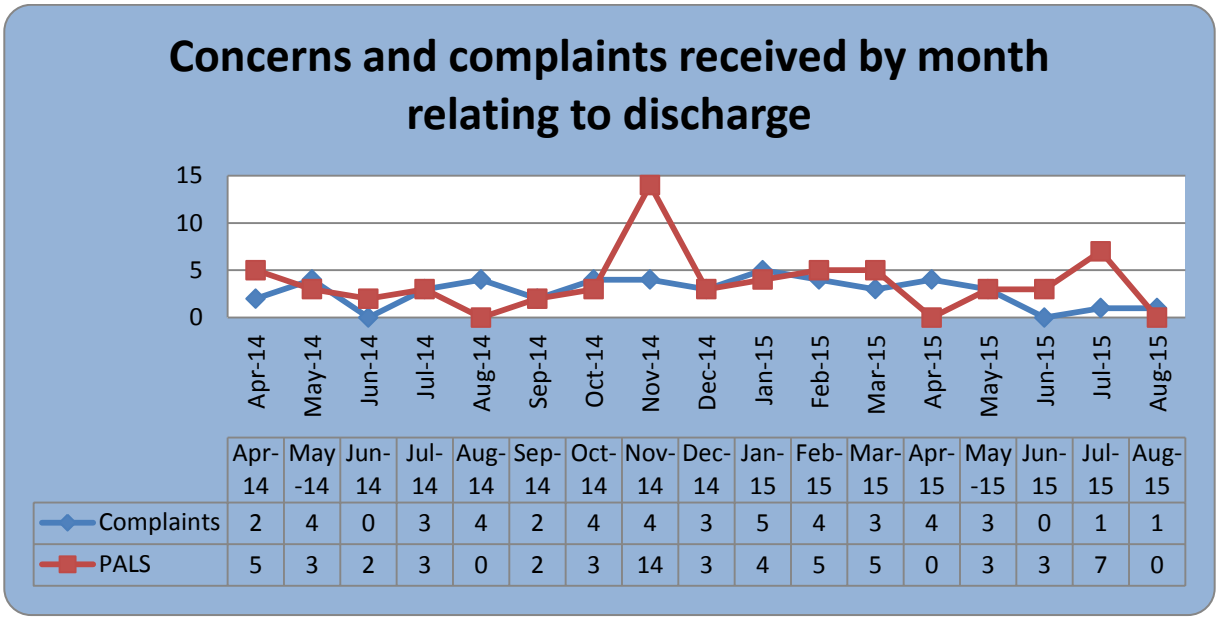
Chart 5b: Follow-up Complaints Received



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

Chart 5b displays a consistent reduction in follow-up complaints received highlighting a much improved experience and satisfaction for complainants.

Chart 6: Concerns and Complaints about Discharge



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Complaints	2	4	0	3	4	2	4	4	3	5	4	3	4	3	0	1	1
PALS	5	3	2	3	0	2	3	14	3	4	5	5	0	3	3	7	0

Chart 6 shows a reduction in concerns and complaints pertaining to discharge issues.

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

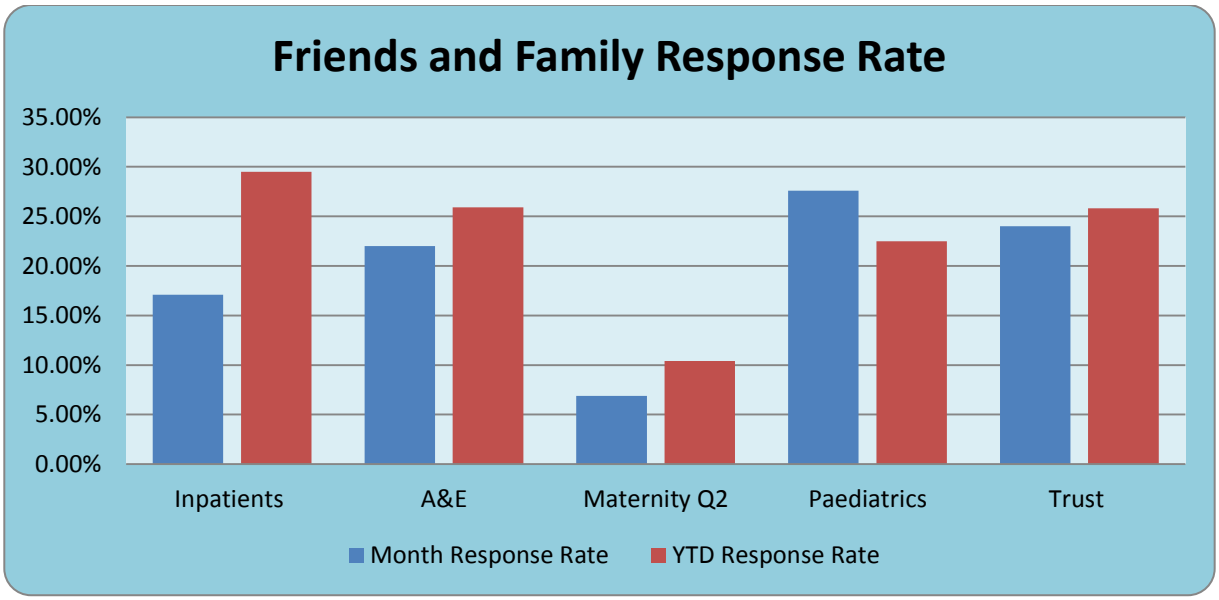
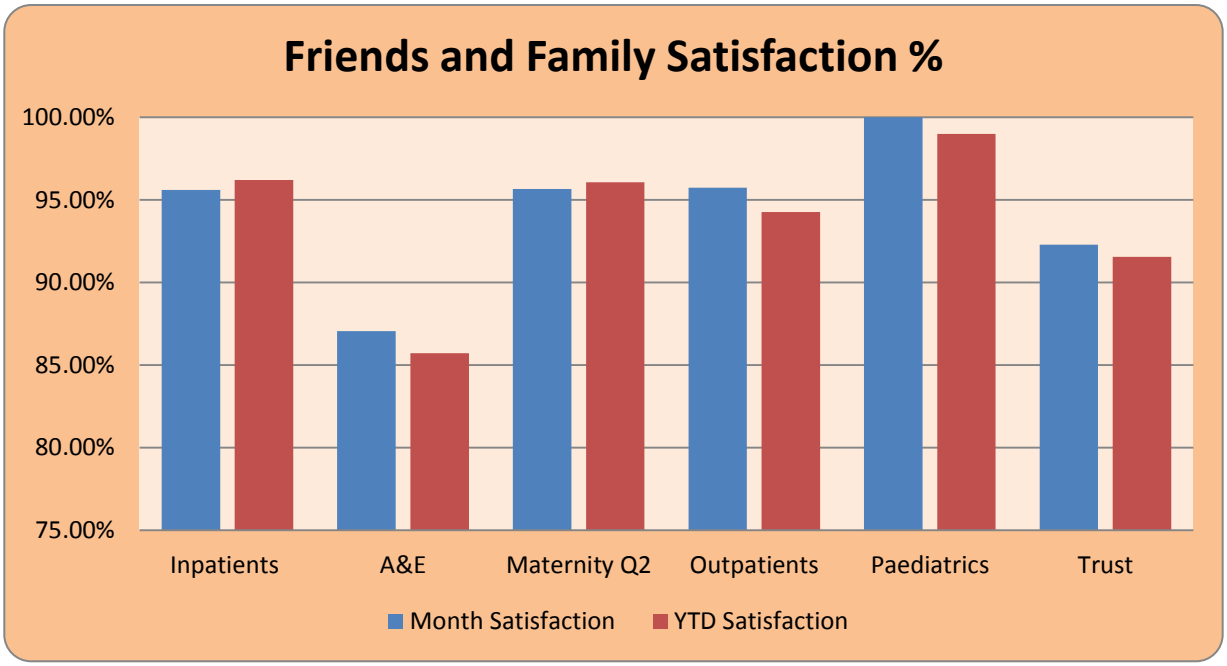


Chart 8: Friends and Family Test Satisfaction Percent



4 APPENDICES

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

1-01 The SHMI (Summary Hospital-Level Mortality Indicator) is a ratio of the observed number of deaths to the expected number of deaths for a provider. The observed number of deaths is the total number of patient admissions to the hospital which resulted in a death either in-hospital or within 30 days post discharge from the hospital. The expected number of deaths is calculated from a risk adjusted model with a patient case-mix of age, gender, admission method, year index, Charleston Comorbidity Index and diagnosis grouping. A 3 year dataset is used to create the risk adjusted models. A 1 year dataset is used to score the indicator. The 1 year dataset used for scoring is a full 12 months up to, and including, the most recently available data. The 3 years used for creating the dataset is a full 36 months up to, and including, the most recently available data. The data source is CHKS. The monthly figure shown is a rolling 6 month position, reported one month in arrears and the YTD figure shown is a rolling 12 month position, reported one month in arrears.
1-02 The RAMI is the Risk Adjusted Mortality Index from CHKS. RAMI (Risk Adjusted Mortality Index) uses a method developed by CHKS to compute the risk of death for hospital patients on the basis of clinical and hospital characteristic data. The model calculates the expected probability of death for each patient based on the experience of the norm for patients with similar characteristics (age, sex, diagnoses, procedures, clinical grouping, and admission type) at similar hospitals (teaching status). After assigning the predicted probability of death for each patient, the patient-level data is aggregated. The data source is CHKS. The monthly figure and YTD are reported 1 month in arrears.
1-03 In-Hospital deaths as per the former CQUIN definition, with exclusions for age <18, maternity. The total number of in-hospital deaths (CQUIN definition, excludes age<18, maternity and ICD10 codes that relate to trauma - V01, X*, W*, Y*, O*).
1-04 Proportion of deaths for which mortality reviews are completed. Number of mortality reviews (numerator) divided by total number of deaths (denominator). Unlike 1-03, the denominator has no exclusions, i.e. all deaths are counted. This measure is reported 1 month in arrears to account for the time lag to carry out and record the mortality review.
1-05 Number of cardiac arrests which occurred other than in critical care areas, i.e. not in MAU, CCU, SDU, SAU, Endoscopy, Cardiac Catheter Laboratory, A&E, ICU, Theatres, MHDU, Paediatrics A&E.

1-06 Number of Hospital acquired MRSA cases.

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

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

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

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

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

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

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

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

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

3-07 Friends and Family Test Satisfaction: Percentage recommended score for Inpatients (Test asks following standardised question: "how likely are you to recommend our ward to friends and family if they needed similar care or treatment?"). Includes Daycase and Paediatric activity.
3-08 Friends and Family Test Satisfaction: Percentage recommended score for A&E (Test asks following standardised question: "how likely are you to recommend our A&E Department to friends and family if they needed similar care or treatment?"). Includes Paediatric activity.

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

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

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

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

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

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

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

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

8. Performance - Monthly Trend Indicator - The arrows represent 1 of 3 states, improvement on the previous month, deterioration on the previous month, or the same. It must be noted that this does not necessarily mean that higher numbers are represented by an 'up' arrow as higher numbers may be worse and thus will be represented by a 'down' arrow.

APPENDIX 2 Patient Experience Dashboards – August 2015

Aug-15	AMES	YTD		TASCC	YTD		TODT	YTD		WH & Paeds	YTD		Fac &IS	YTD		HR & Other	YTD		Monthly Total	YTD	YTD target	Annual target
COMPLAINTS AND PALS DATA																						
Complaints Rec'd	11	87	▼	11	45	▲	4	25	▼	5	25	▼	0	1		0	2		31	185		
Discharge related complaints	1	8		0	0		0	1		0	0								1	9		
Follow ups received	1	5		1	2	▲	1	6		1	2	▲							4	15		
PALS Concerns	63	284	▼	36	172	▼	30	158	▼	8	44		4	21		2	10	▲	143	691		
COMPLAINT TIMESCALE PERFORMANCE																						
% Response timescales met within agreed timeframe	80.0%	87.5%		100.0%	97.0%		n/a	100.0%		100.0%	67.0%		n/a	n/a		n/a	100.0%		83.0%	88.0%	95.00%	>95%
CLAIMS DATA																						
Intimations of claims	2	9	▲	1	11	▼	2	9		1	8		0	0		0	0		6	32		
Reported claims	0	3	▼	1	5		1	5	▲	0	1		0	0		0	0		2	12		

Aug-15	FFT Returns	YTD	FFT Rec Score	YTD	Annual Target Returns	Annual Target Rec Score
Inpatients inc Daycase	17.1%	30.0%	97.0%	96.2%	30.0%	95.0%
Maternity Touchpoint 2	6.9%	10.4%	95.7%	96.1%	30.0%	97.0%
A&E	22.0%	25.9%	87.0%	85.7%	20.0%	87.0%
Outpatients	N/A	N/A	95.7%	94.3%	N/A	TBC - no national data
Trust	N/A	N/A	92.60%	91.55%	N/A	N/A

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

APPENDIX 3 Patient Experience Schedules – August 2015

Complaint Response Time

Mean response time to complaint							
Month	AMES	WHPAED	TODT	TASCC	Facilities	Info/Fin/HR	Trust
April	23	22	21	26	22	18	23
May	27	21	16	31	21	-	25
June	24	29	20	40	29	-	28
July	25	26	19	50	16	61	33
August	22	21	19	41	19	-	26
September	33	35	36	32	14	28	33
October	32	26	34	49	-	-	39
November	38	40	37	37	-	-	36
December	34	44	38	39	15	-	38
January	41	31	29	32	-	31	35
February	30	34	38	30	26	-	32
March	34	35	32	29	24	-	32
April	28	31	39	27	-	-	28
May	31	32	37	23	-	28	32
June	36	44	40	30	31	-	39
July	31	24	29	31	-	-	31
August	35	37.5	45	20	-	-	34

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

Mean response time by grade			
MONTH	Grade 1&2	Grade 3&4	COMBINED
April	24	37	28
May	31	32	32
June	26	30	28
July	29	31	31
August	19	44	34

Complaint Response Time Against Target Days (post April 2015)

Percent response within timeframe for grade (complaints received after 01 April 2015)		
MONTH	Grade 1&2 within 25 working days	Grade 3&4 within 25 working days
April	N/A	N/A
May	86%	100%
June	67%	53%
July	69%	50%
August	This timeframe target is no longer being used	This timeframe target is no longer being used

APPENDIX 4

Best Care Dashboard - August 2015

		Accreditation			Quality & Safety																			Experience					
		Best Care Accreditation Level	Month Assessed	Reassessment Month	Process: Patient Observations	Outcome: Cardiac Arrest calls	Process: Nutrition	Process: Skin Integrity	Number of Pressure ulcers inherited grade 2>=	Outcome: Hospital Acquired PU stage >=2	Process: Falls and Manual Handling Assessments	Outcome: Number of Falls no harm	Process: Medication	Outcome: No of Administration Errors	Process: Nursing Documentation	Outcome: Wards Self Assessment	Process: Environment & Infection Control	Outcome: Hand Hygiene Audits	Outcome: Saving Lives	Process: Safeguarding	Process: End of Life Care	Process: Mental Health	Privacy & Dignity	Complaints	Family & Friends Test	Communication	Consent	Leadership
Medicine & Emergency Services	Aspen	2	MAY	SEP	88%	2	95%	92%	0	2	95%	4	98%	0	92%		100%	100%	100%	91%	100%	100%	100%	0	27.9%	100%	98%	100%
	Birch	2	JUN	OCT	85%	5	89%	100%	0	0	76%	0	96%	0	90%		89%	100%	99%	100%	NA	100%	100%	0	37.1%	100%	100%	100%
	Cedar	2	MAY	SEP	77%	2	91%	98%	0	4	97%	2	100%	0	81%		99%	100%	100%	100%	100%	100%	100%	1	31.7%	99%	96%	94%
	Holly	3	**AUG**	FEB	100%	2	95%	92%	2	0	98%	5	95%	0	95%		97%	100%	100%	100%	NA	NA	100%	0	69.8%	99%	100%	100%
	May	3	**AUG**	FEB	100%	3	100%	100%	0	3	98%	3	97%	0	88%		100%	93%	100%	100%	NA	100%	100%	2	22.6%	100%	100%	100%
	MAU	3	JUL	JAN	95%	2	99%	100%	16	0	100%	1	95%	3	100%		96%	97%	96%	94%	NA	NA	97%	0	24.4%	99%	97%	98%
	MSSU	2	JUN	OCT	100%	3	100%	95%	5	2	99%	5	86%	1	88%		99%	100%	100%	94%	78%	100%	93%	2	11.1%	98%	98%	100%
	Maple	1	**AUG**	NOV	96%	0	86%	83%	1	0	76%	1	91%	1	86%		100%	100%	100%	90%	NA	NA	98%	1	54.0%	100%	97%	100%
	Chaucer	3	JUL	JAN	99%	0	100%	100%	0	1	89%	2	100%	0	85%		98%	100%	100%	99%	NA	NA	100%	0	53.8%	98%	100%	100%
	Swift	1	JUN	SEP	79%	0	90%	95%	0	1	81%	1	92%	0	64%		100%	100%	100%	100%	89%	100%	100%	0	19.0%	100%	100%	100%
	ED	3	JUN	DEC	98%	12	90%	93%	86	0	95%	4	93%	0	85%		100%	94%	20%	98%	100%	100%	100%	2	28.3%	100%	100%	100%
	Endoscopy	2	APR	TBC	83%	0	100%	NA	NA	0	NA	0	100%	0	96%	NA	100%	100%	100%	78%	NA	NA	100%	0	NA	100%	83%	100%
T & O	Dickens	2	JUN	OCT	91%	0	93%	93%	0	2	89%	1	99%	1	97%		94%	100%	0%	96%	NA	88%	99%	0	39.6%	100%	99%	92%
	Swan	1	JUL	NOV	83%	1	80%	89%	3	1	72%	2	90%	5	78%		92%	88%	69%	94%	NA	75%	95%	2	14.0%	93%	98%	93%
Theatres, Anaesthetics, Surgery & Critical Care	**Kingfisher**	2	**AUG**	DEC	79%	0	91%	94%	0	0	85%	0	85%	0	95%		100%	100%	94%	87%	NA	NA	94%	2	39.9%	98%	96%	93%
	Falcon	2	JUN	OCT	86%	0	96%	77%	0	2	92%	1	97%	0	93%		97%	100%	100%	83%	NA	NA	98%	1	24.8%	94%	98%	100%
	SDU	3	APR	OCT	100%	0	92%	100%	0	0	100%	1	100%	2	100%		100%	0%	0%	100%	NA	NA	100%	1	NA	100%	100%	100%
	Heron	2	JUN	OCT	86%	0	83%	99%	2	1	92%	0	99%	0	97%		94%	100%	92%	95%	NA	NA	95%	1	52.6%	94%	99%	94%
	SAU	2	JUL	NOV	86%	0	100%	63%	4	0	100%	1	96%	0	98%		94%	100%	100%	97%	NA	NA	85%	2	37.7%	90%	99%	89%
	ITU	3	**AUG**	FEB	100%	0	98%	96%	1	2	98%	0	100%	0	100%	NA	100%	100%	100%	99%	100%	NA	100%	0	NA	100%	100%	97%
	HDU	3	APR	OCT	100%	0	100%	100%	0	0	100%	0	83%	0	100%	NA	100%	100%	100%	100%	NA	NA	100%	0	NA	100%	100%	100%
	DSU ASH	1	JUL	OCT	84%	0	92%	57%	0	0	*	NA	89%	0	98%		88%	99%	100%	88%	*	NA	100%	0	27%	97%	100%	89%
	Theatres ASH	1	JUN	SEP	74%	0	100%	100%	0	0	*	NA	100%	0	86%	NA	75%	100%	100%	54%			100%	0	NA	100%	82%	52%
	Theatres SPH	2	JUN	OCT	81%	0	100%	100%	0	1	*	NA	96%	0	80%	NA	92%	98%	100%	79%	*	NA	100%	0	NA	100%	95%	90%
Women's Health & Paediatrics	Oak	3	MAY	NOV	100%	0	100%	100%	0	0	100%	0	88%	0	97%		95%	0%	NA	100%	NA		100%	1	14.9%	100%	100%	98%
	Ash	2	MAY	SEP	99%	0	71%	100%	0	0	100%	0	76%	1	87%		88%	100%	0%	94%	80%		100%	1	10.7%	100%	100%	96%
	NICU	2	**AUG**	DEC	87%	0	76%	75%	0	0	NA	NA	98%	3	91%		97%	100%	100%	97%	96%		98%	0	26%	98%	92%	99%
	Paeds ED	2	**AUG**	DEC	75%	0	95%	22%	0	0	50%		97%	0	69%		95%	94%	43%	100%	100%		100%	0	0.5%	100%	NA	100%
	Labour Ward	2	APR	AUG	95%	0	90%	74%	0	0	63%		99%	1	97%		100%	98%	100%	91%	100%		100%	1	6.9%	100%	100%	95%
	Joan Booker	3	MAY	NOV	96%	0	96%	73%	0	0	80%	0	98%	1	95%		100%	100%	100%	94%	100%		100%	0	21.1%	100%	100%	100%

Outpatients	Accreditation Level	Audit	Re-audit	Manual Handling/Falls		Medication		Documentation		Environment & Infection Control		Safeguarding		Privacy & Dignity		Communication		Consent		Leadership	
OPD ASH	3	AUG	FEB	95%		100%		98%		100%		98%		100%		100%		100%		100%	
OPD SPH	2	JUN	OCT	92%		93%		94%		100%		78%		100%		100%		100%		100%	

LEVEL 3 (12-14 Green Indicators in total) — Re-assess in 6 Months

LEVEL 2 (9-11 Green Indicators in total) — Re-assess in 4 Months

LEVEL 1 (6-8 Green Indicators in total) — Re-assess in 3 Months

LEVEL 0 (0-5 Green Indicators in total) — Re-assess in 2 Months

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

The Sparkline incorporates the reassessment audits since April 2013

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