Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

'You matter, we care'

Trust Board Meeting (Part 1)	Date: 24th September 2014

Title:	**Quality & Performance Report**
Item:	**BD/14/156**

Executive Director lead and presenter	**Director of Operations**
Report author(s)	**Head of Information & Performance, Head of Quality Information & Systems, Workforce Planning Manager, Clinical Director (leading on Safer Staffing)**

History:	ET

This report is for:	
Decision	
Discussion	
To Note	X

The following impacts have been identified and assessed in relation to this report:	
Equality	None identified
Quality	None identified
Privacy	None identified

Executive Summary of key issues

The report address the quality and performance of the Trust across a number of metrics included in the IQ system and reports on the submission via NHSE on 'Safer Staffing' requirements

The report details the emerging and Known performance challenges across some indicators and describe the immediate actions in place and those planned to address these.

This report addresses these Strategic Priorities:	
We will deliver the best care	X
We will support and develop our staff	X
We will continually improve what we do	X
We will use our resources wisely	X
We will be future focussed	X

1. Introduction

This report provides commentary on the most recent position for each of the seven 'domains of quality' reported in the scorecard (and within the Trust's IQ system). Appendices A and B provide the Trust level scorecard and the Monitor Compliance Dashboard for reference. The body of this report is organised under the seven domain headings, with information provided separately on 'safer staffing', as required by NHS England. The final section of the report provides information on the 'areas of greatest focus' currently in place.

2. Friends and Family Test (Quality and Standards Committee)

Service users are asked if they wish to respond to the following question: "**how likely are you to recommend this service to friends and family if they needed similar care and treatment**"

Indicator	Month				Commentary
	03	04	05	Q2 forecast	
Data Quality Assessment			GREEN		See Appendix H below for full DQ assessment.
Score Trust total	50	60	55	Remains positive	The result for August is +55. Community scores remain higher than those for inpatient services. National benchmark scores in Mental Health will not be available until 2015, however other settings are scoring as follows: • A&E +54 • Acute inpatient +72 • Maternity +67
Inpatient	19	28	42		
Community	56	64	57		
Response Rate (Target 15%)	11.5%	12.3%	12.8%	c12%	The response rate is continuing to improve; however by smaller increments each month. Responses can now be made via SMS messaging and email which should support on-going improvement. <u>Link to CQUIN</u> The Trust has agreed an improvement target as part of the national FFT CQUIN to increase rates of response for community based services. Moving from a baseline in March 2014 (c9%), to 12% at the end of Q3 (Dec 2014). Based on improvements seen in the last six months, the Trust is currently on track to deliver this.
Community	10.3%	11.1%	11.6%		
Inpatient	36.1%	32.2%	31%		

3. CQC Compliance (Quality and Standards Committee)

Indicator	Month				Commentary
	03	04	05	Q2 forecast	
Data Quality Assessment			Amber		Small numbers of teams continue to miss the submission deadline each month, impacting on the overall completeness of the dataset. See Appendix H below for full DQ assessment.
CQC Compliance	92.8%	92.8%	92.8%	c95%	The overall level of compliance is at 93%, sustained at a similar level to the previous six months. Five outcomes stand out at Trust level as scoring lower than average on a consistent basis. These are included here for reference. <u>IQ Review</u> As noted last month, there is a plan developing to update this element of IQ during 2014-15, most likely during October 2014, using experience gained from the recent CQC inspection and feedback from operational managers and clinicians as part of the IQ review. These changes are likely to include realignment under the headings now used by the CQC (outstanding, good, requires improvement and inadequate), away from the KPI type approach currently in place.
Outcome 1: respecting & involving people	90.6%	89.%	90.6%		
Outcome 2: consent to care and treatment	87.1%	88.2%	87.8%		
Outcome 7: safeguarding	90%	88.9%	89.3%		
Outcome 13: staffing	90.7%	90.8%	90.7%		
Outcome 14: Supporting Workers	90.4%	89.3%	87.9%		
Submission rate	89.6%	92.4%	87.9%		Small numbers of teams continue to miss the submission deadline, albeit different teams each month. This is impacting on the overall Data Quality Assessment noted above, holding it to Amber.

4. Records Management (Quality & Standards Committee)

<table>
<tr><th rowspan="2">Indicator</th><th colspan="3">Month</th><th colspan="2">Commentary</th></tr>
<tr><th>2</th><th>3</th><th>4</th><th>Q1 forecast</th><th></th></tr>
<tr><td>Data Quality Assessment</td><td></td><td></td><td>Amber</td><td></td><td>Small numbers of teams continue to miss the submission deadline each month, impacting on the overall completeness of the dataset.

See Appendix H below for full DQ assessment.</td></tr>
<tr><td>Records Management

(Target 75%)</td><td>87.4%</td><td>86.9%</td><td>85.7%</td><td>Green</td><td rowspan="4">The July audit scores all ten elements at >75%, 6 out of 10 scoring over >85% at Trust level. The three lowest scoring elements are noted here, see left.

This month sees the release of several new indicators in the Monitor / Contract section, two of which allow for triangulation between the different sections of IQ.

<u>Risk assessment</u>

The new indicator shows that 99% of service users on CPA have a risk assessment available in RiO. Records Management provides evidence that 89% of these to be of good quality based on the audit criteria. This means that whilst all service users have a risk assessment, some 10% of these are lacking in some detail, e.g. historic or current risk, or the consequence of risk taking. Furthermore, Records Management also judges 20% of risk assessments as lacking sufficient involvement from the service user. Taken together, this evidence suggests that risk assessments within the Trust are of good quality in the vast majority of cases, but that there remain some areas for improvement.

<u>Crisis, relapse and contingency plans</u>

The new indicator shows that 80% of service users on CPA have a crisis plan available on RiO. This is consistent in the last six months and triangulates with the evidence gathered via Records Management – which also consistently reports a figure of c80%. Further work is required in this area to ensure all service users have a high quality crisis plan.</td></tr>
<tr><td>Risk assessment has involved the service user</td><td>79.3%</td><td>81.3%</td><td>80%</td><td></td></tr>
<tr><td>Crisis, relapse and contingency plans</td><td>83.9%</td><td>84.5%</td><td>80.2%</td><td></td></tr>
<tr><td>Formulation / summary</td><td>80.5%</td><td>77%</td><td>79.3%</td><td></td></tr>
<tr><td>Submission rates</td><td>92.7%</td><td>95%</td><td>92.5%</td><td></td><td>Small numbers of teams continue to miss the submission deadline, albeit different teams each month. This is impacting on the overall Data Quality Assessment noted above, holding it to Amber.</td></tr>
</table>

5. Contract / Monitor (Finance & Planning Committee)

This section sets out the Trust's governance and financial risk ratings (using Monitor's Risk Assessment Framework) and also details of any indicators included in the Quality Schedule of the Mental Health contract that are below the required standard.

5.1. New Indicators for 2014-15

As noted in last month's report, the 2014-15 contracts include a number of new performance metrics that the Trust is required to monitor. Development is now complete on all but one indicator and results are shown below (the two indicators released and reported last month have been removed and will be exception reported along with all other indicators as required).

Indicator	Reports available	Trust performance
Allocation of care coordinator for service users on CPA	September Board	Reports now complete and performance included in IQ. All areas are above target, hence not exception reported below, with Trust performance at 99.9%. *England average 99.8%*
Allocation of diagnosis for service users on CPA	September Board	Reports now complete and performance included in IQ. The Trust is required to baseline performance and establish a trajectory during Q2, hence not exception reported below. The M5 Trust level result is 68.1%.
Risk assessment available for all service users on CPA	September Board	Reports now complete and performance included in IQ. All areas are above target, hence not exception reported below, with Trust performance at 99.7%.
Crisis, relapse and contingency plan in place for all service users on CPA	September Board	Reports now complete and performance included in IQ. Trust level performance at 81% for M5 which is below the 85% level agreed in the Contract – seen below for further commentary.
Weight assessment undertaken for all inpatients with dementia	TBC	Not available, confirmation still required as to whether RiO will be the source of information.

5.2. Monitor Compliance Dashboard

The Trust's most recently published governance and financial risk scores are noted below. Detailed breakdown is included as appendix B.

As can be seen in appendix B, two indicators in the governance section are showing as red at M5, commentary is provided below on the trajectory for improvement. In August 2014, Monitor released a revised version of their Risk Assessment Framework and an initial review suggests that some work will be required to IQ and the dashboard to incorporate the changes. All the KPIs remain the same, with the same thresholds and risk scoring, however the CQC compliance indicators are revised and scored differently. Work will be done in September to detail the changes that are required to make the Trust compliant with the new framework and an estimated delivery date confirmed (this will be shared at the October Board)

This notwithstanding, those indicators that are red as per the old approach, will still be red in the new, albeit presented in a slightly different way.

Area	M12	M1	M2	M3	M4	M5	Q2 forecast
Governance risk							
Finance risk score	4	4	3	3	3		See separate Finance paper.

5.3. Nationally and locally defined key quality indicators off target

Indicator	Month				Commentary
	03	04	05	Forecast (Q2 2014-15)	
Data Quality Assessment			Green		Assessed as green, see Appendix H below for details.
Delayed Transfers of Care (Target: 7.5%)	A 7.7 %	Red 9%	Red 9.7%	Red	Rates of DTOC have been increasing over recent months, monitored by the Trust via the Quality Huddle and with Commissioners via CQMP. Since M4, levels have risen sufficiently to move from Amber to Red and this triggers a risk score of 1 within Monitor's Risk Assessment Framework. <u>Cost of DTOC</u> As noted last month, the cost of bed days 'lost' to DTOC is significant. In physical terms this equates to the equivalent of a 32 bedded unit full all month, and in financial terms (using an average day rate of £359 sourced from the Trust's Reference Costs) the annualised total would be c£4m.
Referral to assessment – memory services Target: 95%	R 56 %	R 59%	R 63%	R	New target for 2014-15. N Somerset, Swindon and Bristol are well below 95% (all other areas above). Area level commentary as follows: **N Somerset**: show continued improvement, as planned, up a further 12% to 54%. **Bristol**: the new model for memory services will go live in October 2014 and from then on AWP will no longer be operating those services. This will impact on the Trust's overall compliance as a significant area of under-performance will be removed. **Swindon**: no improvement in waiting times since last month, with less than 5% of service users being assessed within 4 weeks of referral. As reported previously, a paper has been shared with Commissioners that suggests that there is insufficient capacity within the Swindon team to cope with demand. To date, the CCG has given no indication of an intention to alter the service model, or fund additional staff to meet the demand. By way of further context on the wider quality of services provided in Swindon, it should be noted that: • Sickness rates are low (0.5% for July) • Appraisal rate at August = 100% • Supervision dipped in July and August, but

					previously at 100% • CQC compliance and Records Management do not show any areas of concern • Family and Friends: month on month improvement in response rate (now well above the community average at c19%) and that the Net Promoter Score has been >50 for the last six months. Taken together, this suggests that despite a poor result against one quality metric, the service provided remains of high quality and that the majority of service users are happy with the support they receive.
Service users on CPA with a crisis plan			R	R	This is a new indicator for 2014-15 and was only developed and released into IQ in late August. The Trust's overall position is 81% which triangulates with evidence obtained through the Records Management audit which also indicates that crisis, relapse and contingency plans are in place 80% of the time. In some areas, e.g. N Somerset and Wiltshire, the results look very similar between the different sources of evidence. In other areas, the results are quite different (e.g. B&NES). Whilst a small difference between the indicators is possible (given the construction of each), high levels of compliance across both would give strong evidence of good clinical practice in this area. To support improvement, team level information is available in IQ to show managers their position and later in September an additional report will be provided to report those service users where a crisis plan is not yet available on RiO so targeted action can be taken.
CQC: enforcement action					This indicator has been shown as red following the Chief Inspector's visit and subsequently released report. Details contained within the report will be known to the Board and thus will not be detailed here.

6. Supervision & Appraisal (Employee Strategy & Engagement Committee)

Measure	Month				Commentary
	03	04	05	Q2 forecast	
Data Quality Assessment			Amber		Assessed as amber as no formal internal or external audit has been undertaken on the results. See Appendix H below for details.
Supervision (Average for permanent staff)	81.6%	84.4%	71.7%	75%	A chart showing the trend in recorded supervision is included as Appendix C. As previously noted, the rates for Bank staff are lowest across the Trust, with permanent staff receiving more consistent supervision. August saw a dip in supervision across all parts of the organisation, both in the front line and in corporate services. As expected, significant amount of annual leave was taken during August interrupting some routine supervision processes; which will revert to normal in September and beyond. This notwithstanding, the Q2 forecast is revised to amber as despite expected improvement in most areas, no movement has been seen in supervision of bank staff, and until resolved, this will prevent movement above 85%.
Supervision (Bank staff)	50.9%	55.1%	51.3%		
Appraisal Target = 85% (stretch to 90%)	88.9%	89.5%	89.3%	85%	The Trust's appraisal rate was above target in August 2014 for the fourth month in a row. The Trust is considering a stretch target to 90% and M5 performance for each LDU is included as Appendix D below and shows the current and stretch targets. As can be seen, all localities currently exceed the 85% target, with some also exceeding 90%.

7. Sickness / absence (Employee Strategy & Engagement Committee)

Measure	Month				Commentary
	02	03	04	Q2 Forecast	
Data Quality Assessment			Amber		Assessed as amber as no formal internal or external audit has been undertaken on the results. See Appendix H below for details.
Sickness Target = 4.6% (3.5% stretch)	4.0%	4.28%	4.53%	Green	<u>Overall position</u> Rates of sickness / absence declined in the last quarter of 2013/14 but have risen slightly across the first quarter of 2014/15. They remain below the 4.6% target. <u>Analysis</u> Appendix E provides a series of charts that can be used to better understand the Trust's position. The key things to note are: • **Annual pattern**: a similar rise in sickness / absence was seen during the same period of 2013/14 (i.e. a rise across the summer months). This suggests that rates will begin to fall in September / October 2014. • **Short-term / Long-term split**: the increase in 2014 is driven by rises in long term sickness. This differs from 2013 where the rise was split between short and long term sickness. • **Benchmark**: the trend within AWP matches closely with trends seen in the wider MH Trust community and also within the NHS in general. Furthermore, whilst AWP has levels higher than the NHS average, the Trust is now tracking below the MH average.

8. Finance (Finance & Planning Committee)

This indicator within IQ shows the budget variance month on month.

Measure	Month						Commentary
	11	12	01	02	03	04	
Finance	A	G	G	G	G	A	See detail in separate Finance report.

9. Safer Staffing

In 2014-15 the Trust is required to monitor staffing levels on each inpatient ward, to ensure that the actual number of staff on each shift was at the planned level (i.e. at the level of staff deemed to be clinically safe for that particular ward environment). *The Trust's agreed date range for the July submission is included for reference in Appendix F.*

The Trust's results submitted in early August 2014 are included in Appendix G. The following comments are made:

- **Registered vs. un-registered staffing**: for a number of wards, the total registered staff working on some shifts is significantly below the planned level for that ward. In most cases, the number of un-registered staff is sufficient to compensate and the overall total staff is at, or very close to, the agreed level.

- **Medium Secure services**: there remain significant staffing challenges in the Medium Secure service, with a large number of incidents relating to staffing being raise during August. The overall number of incidents raised in August significantly increased, from 22 to 58, with Medium Secure as the source of the increase. The volume of 'high' level incidents remained small, however the number of 'moderate' level incidents increased, reflective of the challenges experienced by the service.

Table 1: Staffing related incidents raised (Trust)

Type	May 2014	June 2014	July 2014	August 2014
Low, very low	21	8	15	22
Moderate	15	22	5	33
High	0	0	2	3
Total	36	30	22	58

10. Areas of greatest focus

The Board is aware that a quality triangulation process is being tested which brings together all available data on each delivery unit, examining aspects of quality, performance and finance. This process is designed to be taken to the Operational Senior Management Team (Ops SMT) meeting to establish additional measures both from a locality perspective and a Trust wide perspective that need to take place to provide further assurance across all indicators. This will also enable Ops SMT to coordinate and monitor the actions needed,

either locally or Trustwide, to ensure improvements are made. Currently the areas of greatest focus are listed below and current position against each area is detailed.

Local Delivery Unit	Service name / type	Trigger	Update
North Somerset	Juniper Ward	Serious Incidents	A number of serious incidents have taken place on Juniper Ward over the last 3 months. The locality has requested additional Trustwide support to address the range of issues identified. A 360° service review involving internal and external stakeholders is planned.
B&NES	Sycamore (Adult Acute ward)	2 x serious incidents	• RCAs undertaken • Action plan following CQC visit in place. Monitored weekly • 8 beds closed • Changes to ward environment in relation to lines of sight complete
Secure Services	All services	Re-design consultation closing, sickness levels, appraisal levels	Outcome paper published and assessment and selection processes about to commence. Some staff continue to be dissatisfied with the outcome and on-going engagement continues. Outcome implementation brought forward to 1st September and progressing.
Secure Services	All services	Staffing numbers	Secure services have a number of vacant posts across all wards. It is increasingly challenging to fully staff ward rotas required to deliver required care. Plans in place to reduce capacity and maximise available nursing resource. Closure of Wellow ward agreed with NHSE and will be complete by 10th October
Trustwide	On-going bed pressure across the Trustwide bed base	Continued high levels of occupancy. Continued high levels of DTOC in Wilts and Swindon, and increasingly high in B&NES.	• Bed pressures action plan in place and monitored weekly. • Local teams reviewing all individual DTOCs with partners weekly • Commissioners fully sighted on issues and discussed at CQPM • Local teams working with LA and CCG partners

Wiltshire	All services	Recruitment challenges	• Significant challenges in recruitment across Wiltshire • Locality working with HR to development a range of actions to address recruitment • Recruitment strategy under development
Bristol	All retendered services	Scale of Transition required	• Financial pressures being identified • Impact on staff moral during this period

11. Actions to address emerging performance challenges

There are a number of actions in hand to address both the emerging and known performance challenges.

11.1 The CQC action plans in each locality and Trust wide addresses the issues identified via the records management audit in IQ. In particular this particularly addresses:

- Risk assessments
- Person centred care planning
- Physical health care needs
- Supervision

Additionally Locality specific actions are required against crisis and contingency planning. This is reported via the Quality Huddle, Triangulation meeting and performance reviews.

11.2 To further support the supervision level improvements email alerts are being established to prompt supervisees that their supervision is due within the next 5 days as well as to team and ward managers detailing that the supervision levels for their team is at 80% and corrective action is now required.

11.3 The quarterly Locality performance and quality reviews are scheduled for October where the main focus will be on the 'seat belt' requirements of the Trust:

- Supervision levels
- Appraisal levels
- Compliance with statutory and mandatory training requirements

- Financial grip

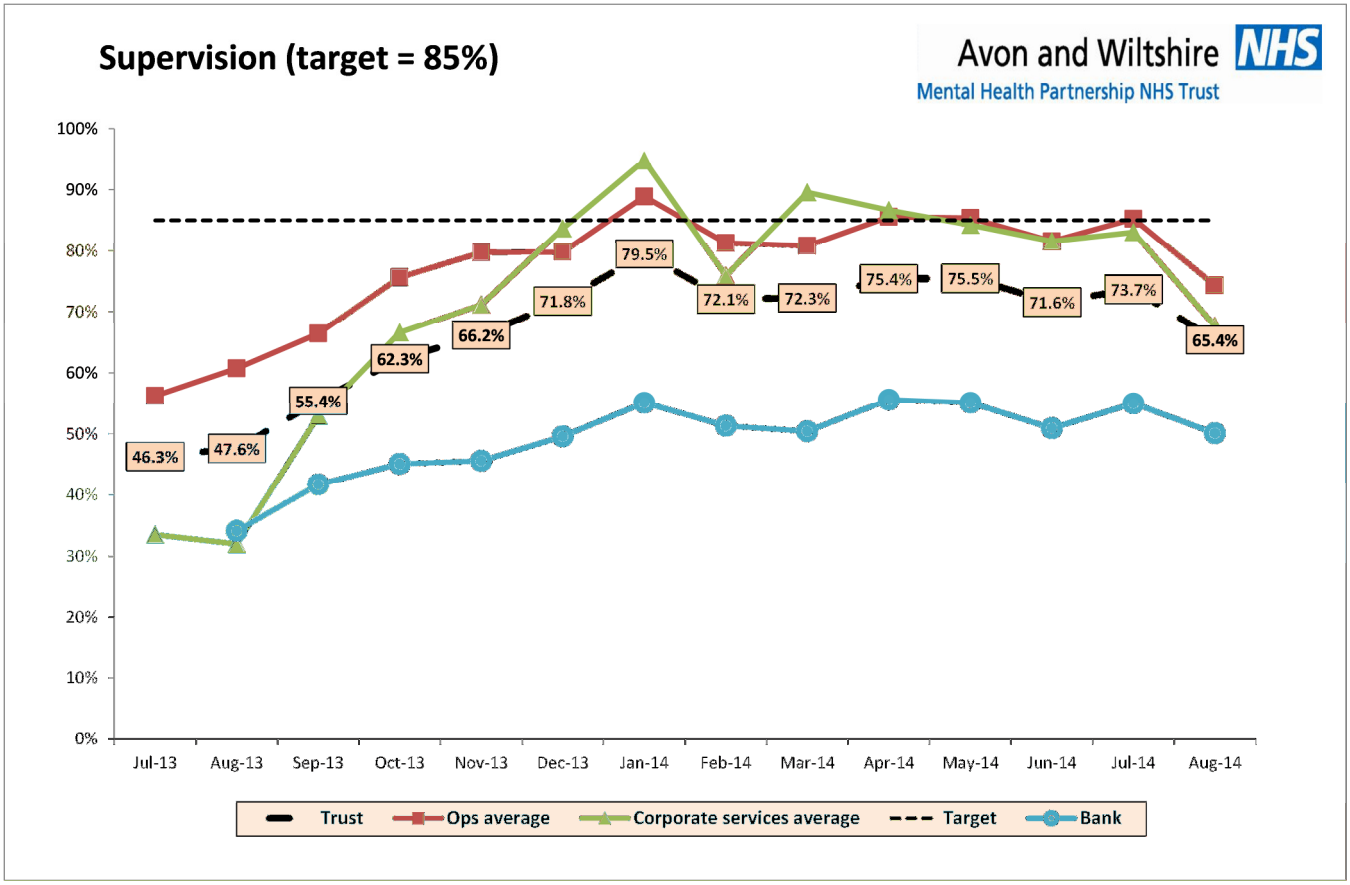
Through Learning and Development plans are in place to enable staff to be compliant with statutory and mandatory training requirements available via e-learning by the end of September and compliance with face to face training by the end of December 2014. This is monitored via the CQC weekly action and progress meeting.

11.4 In relation to DTOC and the on-going work on immediate actions regarding bed pressures, a paper was presented to Quality and Safety Committee on 16th September 2014 detailing progress against actions to date. A verbal brief was provided on the next stage of this process and is presented to Board part 2.

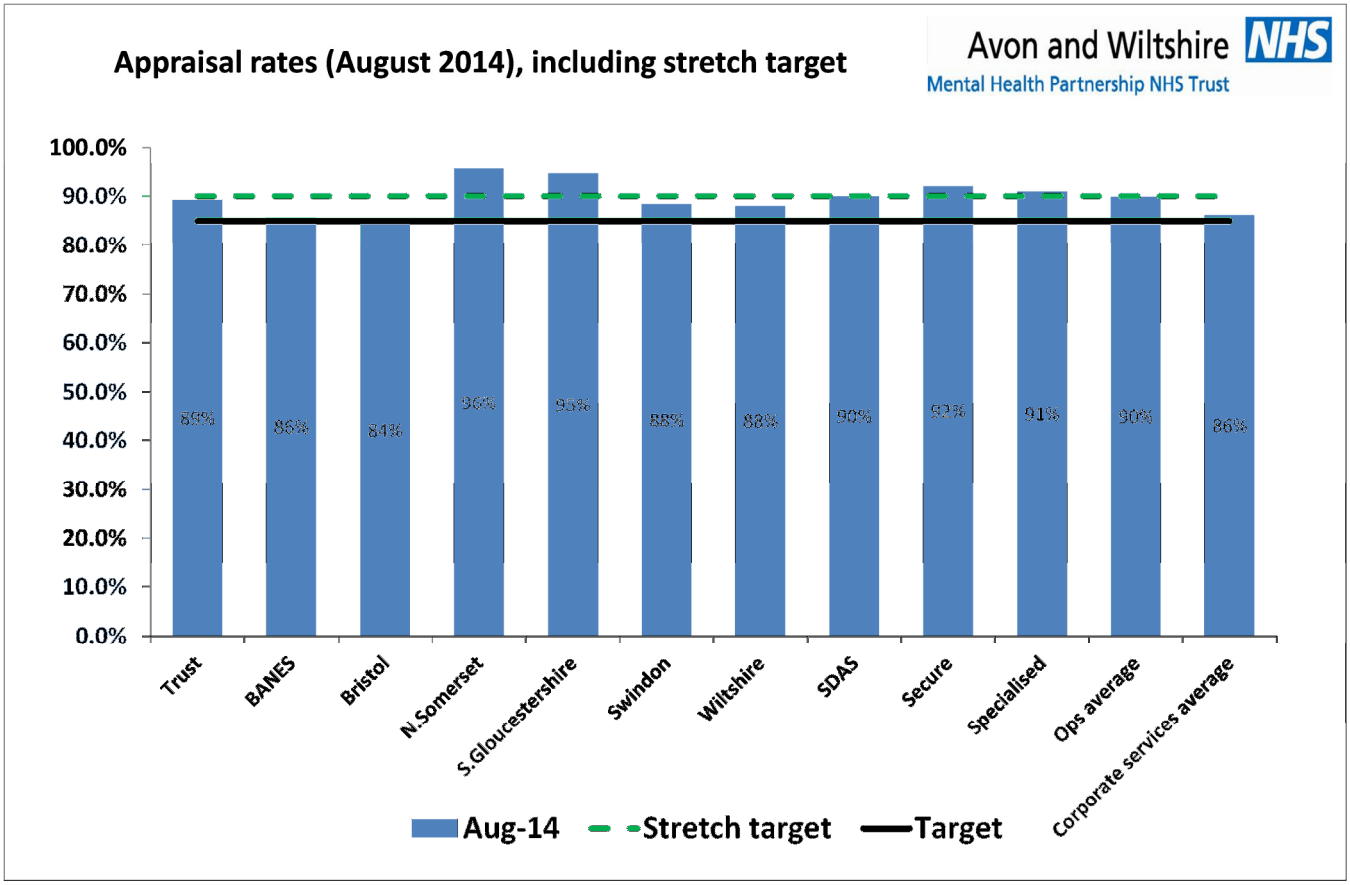
11.5 In relation to memory service waiting times, papers were presented to Finance and Planning committee on 22nd August 2014 by both the Bristol and Swindon Localities.

Plans are progressing in Swindon regarding the development of Shared Care but this has not as yet commenced. The Bristol service transfers to the new provider on 1st October2014 allowing no opportunity for the current team to influence current performance

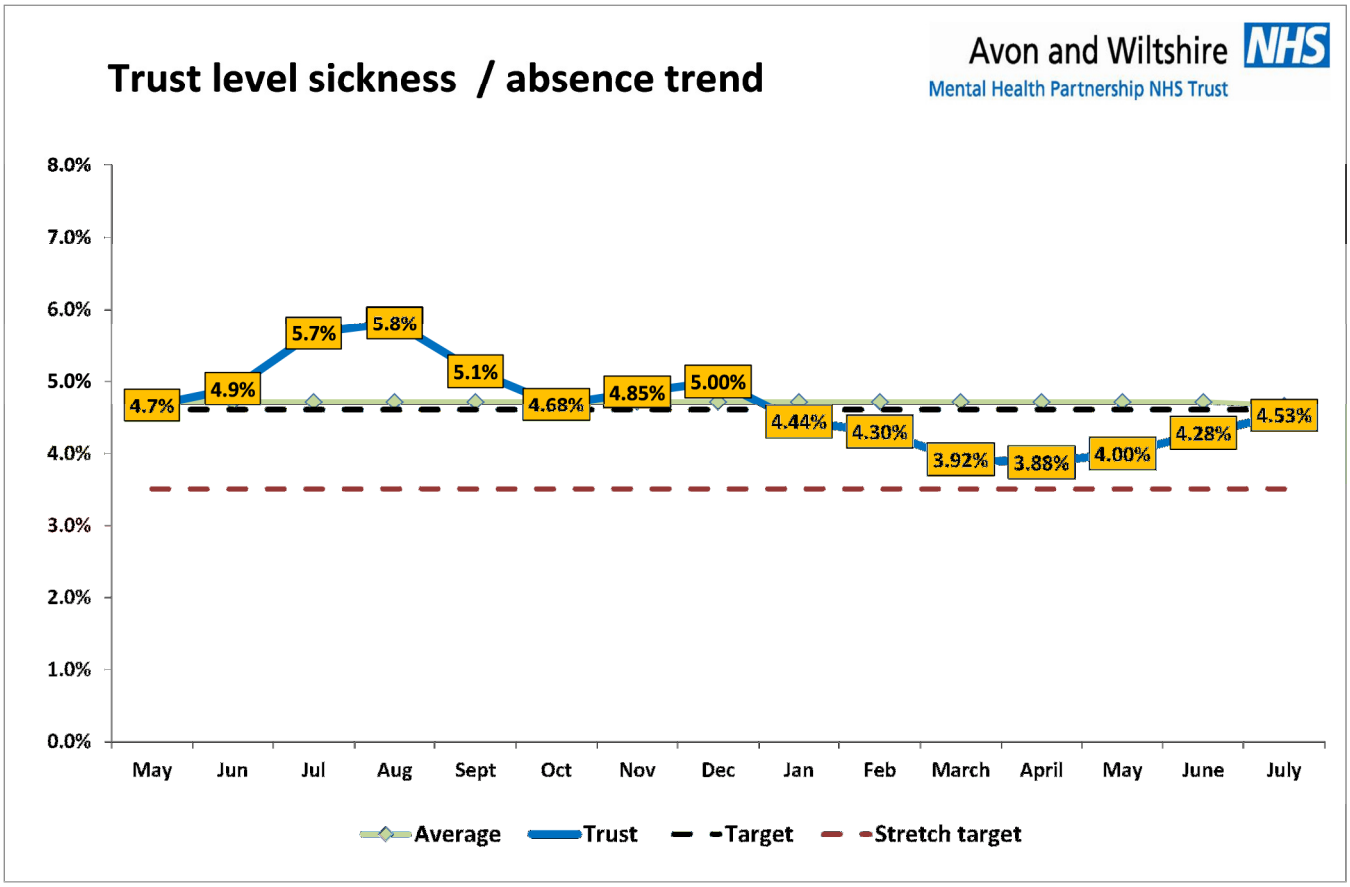
Appendix C: Monthly supervision rates



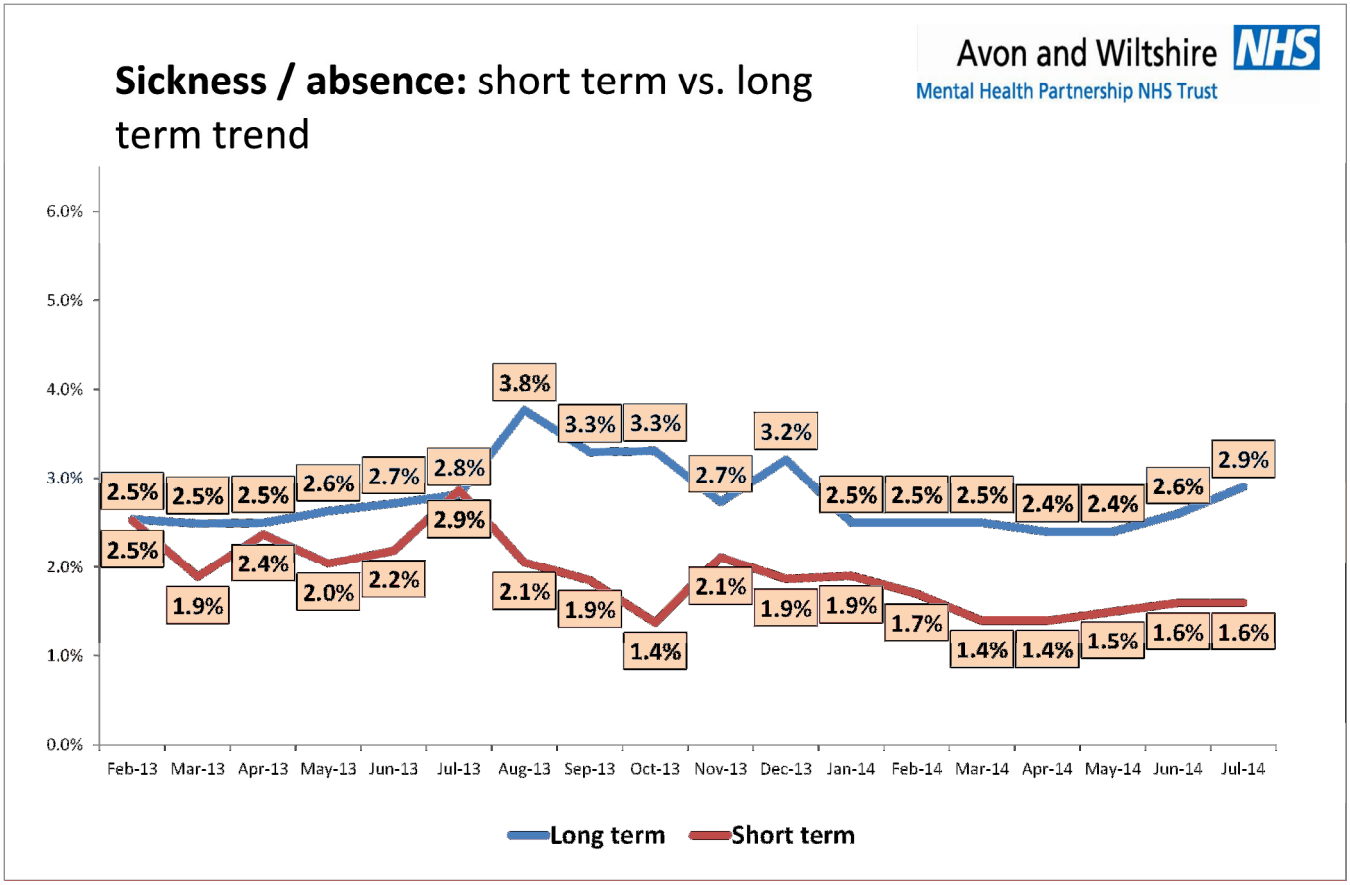
Appendix D: August Appraisal Rates, By Locality (including stretch target)



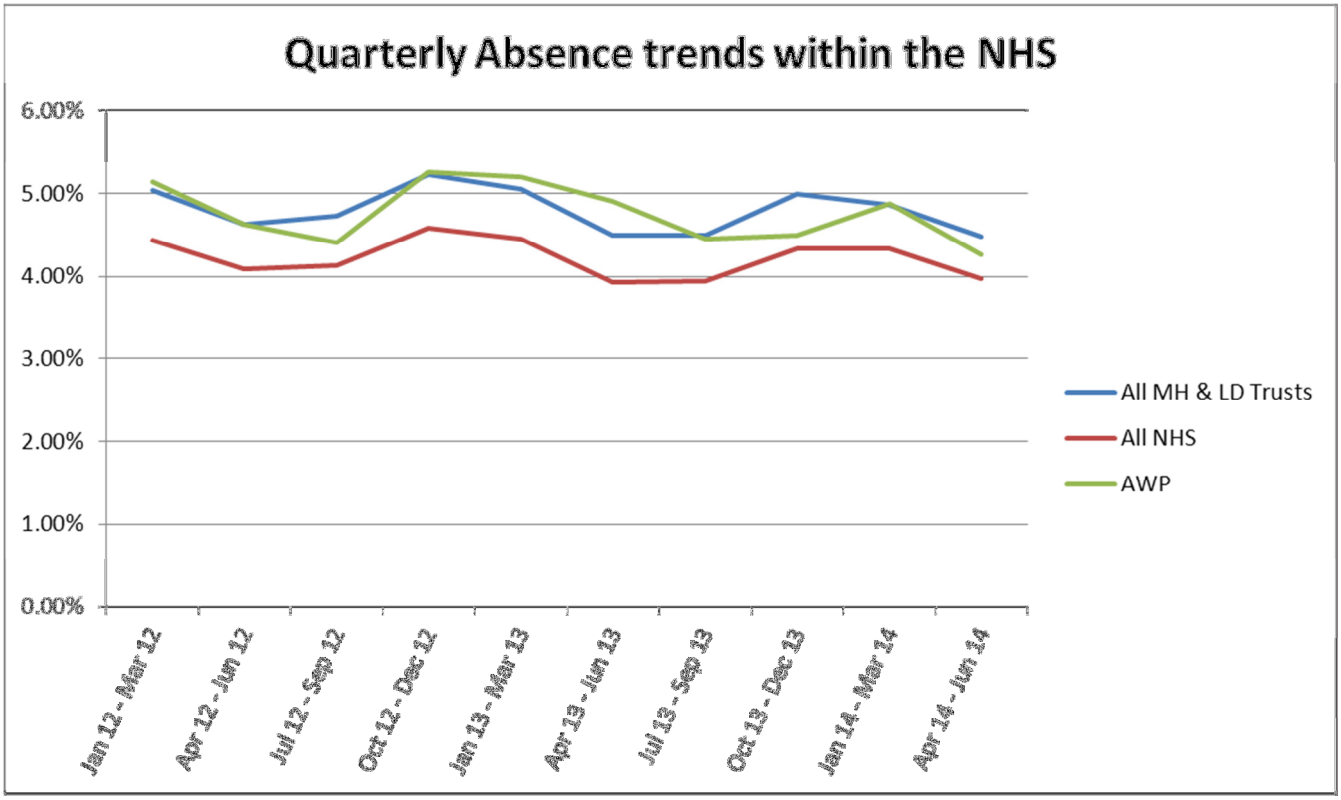
Appendix E: Monthly sickness rates



Appendix E: Short-term and long-term sickness rates



Appendix E: National Benchmark



Appendix F: revised date ranges for 2014-15 Safer Staffing submissions

Month	Start date	End date	Total days
April 14	25 Mar 2014	23 Apr 2014	30
May 14	24 Apr 2014	24 May 2014	31
June 14	25 May 2014	23 Jun 2014	30
July 14	24 Jun 2014	24 Jul 2014	31
August 14	25 Jul 2014	24 Aug 2014	31
September 14	25 Aug 2014	23 Sep 2014	30
October 14	24 Sep 2014	24 Oct 2014	31
November 14	25 Oct 2014	23 Nov 2014	30
December 14	24 Nov 2014	24 Dec 2014	31
January 15	25 Dec 2014	24 Jan 2015	31
February 15	25 Jan 2015	21 Feb 2015	28
March 15	22 Feb 2015	24 Mar 2015	31
Total days for 2014-15			**365**

Appendix G: Safer Staffing submission (September submission of August period)

	Day			
	Registered		Un-registered	
Ward	**Actual**	**Planned**	**Actual**	**Planned**
BANES Acute IP Sycamore	885:00	930:00	1615:30	1395:00
BANES LL IP St Martins Ward 4	1149:39	930:00	1149:00	1162:30
Bristol Acute IP Lime	1195:30	1027:30	1607:00	1395:00

Bristol Acute IP Oakwood	996:15	1020:00	1850:00	1860:00
Bristol Acute IP Silver Birch	1209:15	1020:00	1650:50	1395:00
Bristol LL IP Aspen	1170:00	1230:00	1544:31	1860:00
Bristol LL IP Laurel	1659:00	1657:30	2467:15	2325:00
Bristol PICU Elizabeth Casson	1360:45	960:00	2262:50	1395:00
Bristol PICU Hazel	1185:45	990:00	1933:10	1860:00
Bristol Rehab Alder	538:30	465:00	616:00	465:00
Bristol Rehab Blaise View	684:15	465:00	455:45	465:00
Bristol Rehab Larch	584:45	465:00	919:30	465:00
Nsom Acute IP Juniper	869:45	930:00	1466:00	1395:00
NSom Long Fox Unit LL IP Unit	1721:48	1860:00	2128:11	1860:00
NSom Rehab Elmham Way	480:00	465:00	505:30	465:00
SGlos Rehab Whittucks Road	692:30	525:00	1026:00	1027:30
Specialised DAS Bristol IP Acer Unit	549:30	573:45	567:30	667:30
Specialised Eating Disorders Clifton	698:15	960:00	1020:20	930:00
Specialised LSU Wickham IP Cromwell	864:00	1125:00	1074:00	1200:00
Specialised LSU Wickham IP Fairfax	1180:00	1155:00	1620:00	1170:00
Specialised LSU Wickham IP Hopton	940:30	697:30	1528:30	930:00
Specialised M Secure IP Avon	1140:30	930:00	1841:00	2790:00
Specialised M Secure IP Bradley Brook	884:00	930:00	1523:30	1860:00
Specialised M Secure IP Kennet	620:30	930:00	1143:30	1162:30
Specialised M Secure IP Ladden Brook	1148:00	1395:00	1682:59	1395:00
Specialised M Secure IP Teign	1174:15	1395:00	1690:45	1395:00
Specialised M Secure IP Wellow	1535:30	1860:00	2239:20	1860:00
Specialised Mother & Baby IP Unit	671:35	532:30	433:30	787:30
Swindon Acute IP Applewood	985:00	930:00	2158:00	2325:00
Swindon LL IP Hodson	965:30	930:00	1156:30	1087:30
Swindon LL IP Liddington	1233:30	930:00	1721:30	1860:00
Swindon Rehab Windswept	813:30	622:30	767:00	772:30
Wiltshire Acute IP Beechlydene	1073:00	1162:30	2235:00	1860:00
Wiltshire Acute IP Imber	918:15	1087:30	1683:45	1470:00
Wiltshire LL IP Amblescroft North	1149:15	930:00	1938:00	1695:00
Wiltshire LL IP Amblescroft South	976:30	1252:30	2550:14	2467:30
Wiltshire PICU Ashdown	1188:30	930:00	1363:30	1395:00

	Night			
	Registered		Un-registered	
Ward	**Actual**	**Planned**	**Actual**	**Planned**
BANES Acute IP Sycamore	610:00	620:00	940:00	930:00
BANES LL IP St Martins Ward 4	660:30	310:00	560:00	620:00
Bristol Acute IP Lime	430:00	620:00	780:00	620:00
Bristol Acute IP Oakwood	610:00	620:00	910:00	930:00
Bristol Acute IP Silver Birch	430:00	620:00	880:00	620:00
Bristol LL IP Aspen	440:00	620:00	660:00	620:00
Bristol LL IP Laurel	550:00	620:00	1090:00	620:00
Bristol PICU Elizabeth Casson	871:00	620:00	1623:00	620:00
Bristol PICU Hazel	580:00	620:00	1072:30	930:00
Bristol Rehab Alder	310:00	310:00	300:00	310:00
Bristol Rehab Blaise View	315:00	310:00	310:00	310:00
Bristol Rehab Larch	330:00	310:00	290:00	310:00
Nsom Acute IP Juniper	600:00	620:00	931:45	930:00

NSom Long Fox Unit LL IP Unit	622:30	620:00	1111:00	930:00
NSom Rehab Elmham Way	310:00	310:00	309:30	310:00
SGlos Rehab Whittucks Road	320:00	310:00	350:00	310:00
Specialised DAS Bristol IP Acer Unit	371:45	348:45	348:45	348:45
Specialised Eating Disorders Clifton	310:00	310:00	321:00	310:00
Specialised LSU Wickham IP Cromwell	360:00	310:00	680:00	620:00
Specialised LSU Wickham IP Fairfax	630:00	620:00	940:00	620:00
Specialised LSU Wickham IP Hopton	410:00	310:00	840:00	620:00
Specialised M Secure IP Avon	638:30	589:00	1201:30	1178:00
Specialised M Secure IP Bradley Brook	449:30	589:00	928:00	589:00
Specialised M Secure IP Kennet	353:00	589:00	560:30	589:00
Specialised M Secure IP Ladden Brook	335:00	589:00	889:30	589:00
Specialised M Secure IP Teign	514:30	589:00	621:00	589:00
Specialised M Secure IP Wellow	729:30	589:00	1276:00	1178:00
Specialised Mother & Baby IP Unit	300:00	310:00	320:00	310:00
Swindon Acute IP Applewood	590:00	620:00	1528:00	1550:00
Swindon LL IP Hodson	310:00	310:00	340:00	310:00
Swindon LL IP Liddington	590:00	620:00	650:00	620:00
Swindon Rehab Windswept	310:00	310:00	309:30	310:00
Wiltshire Acute IP Beechlydene	601:30	620:00	1149:30	930:00
Wiltshire Acute IP Imber	610:30	620:00	1231:00	930:00
Wiltshire LL IP Amblescroft North	310:00	310:00	930:00	620:00
Wiltshire LL IP Amblescroft South	621:45	620:00	860:00	620:00
Wiltshire PICU Ashdown	400:00	620:00	920:00	620:00

Appendix H – Data Quality Assurance

1. Friends and Family Test		
Completeness	All records entered into Meridian are used in the monthly results and all teams and wards across the Trust complete FFT with their service users	Green
Timeliness	Results are collated and presented immediately after the end of the month and service users are selected for involvement based as their most recent episode of care fell into that month (i.e. they're able to feedback in a timely way based on their recent experience of service).	Green
Accuracy	The Net Promoter Score uses the nationally defined methodology and this was tested as accurately calculated during the IQ development phase.	Green
Audit	No formal internal or external audit has taken place on the Friends and Family process that corroborates the numbers presented. Teams and wards are recommended to keep paper surveys and to complete random audits quarterly.	Amber / Green
Validation	Results are presented at team and ward level (as well as aggregated to LDU and Trust) within IQ on a monthly basis, including both the Net Promoter Score as well as	Green

	the number of responses (split into positive and negative) – they are also presented on a chart in the inpatient dashboard. Locality scorecards are reviewed at internal and external (with Commissioners) meetings monthly, which includes review and validation of FFT results. Trust level results are reviewed twice per month at the Quality Huddle.	
Overall		Green

2. CQC Compliance		
Completeness	All teams and wards are expected to submit the self-assessment on a monthly basis, making the aggregated results a genuine reflection of the full range and number of services provided. However, each month, there continue to be a small number of teams that fail to submit which represents a gap in knowledge at local level. LDU and Trust level results are still consider to be reliable sources of evidence as the aggregated results from the teams / wards that did submit represents a sufficiently large volume of data to draw broad assurance from.	Amber
Timeliness	Results are collated and presented immediately after the end of the month and the audit parameters are focussed on the current position at the time of the audit.	Green
Accuracy	The indicator is based on a self-assessment by each team and ward, using a standard electronic data entry tool, supported by standardised guidance documents. In the past the relative subjectivity of the process was questioned and revised (more explicit) guidance was developed and published.	Green
Audit	Some areas operate a peer review process, where one team completes the audit for another and visa versa. The clinical academy also undertakes independent audits of teams across the Trust, either responding to concerns raised, or as part of a systematic programme.	Green
Validation	CQC compliance is a self-assessment process and as such operational validation is implicit within the process. In addition results are scrutinised at monthly internal and external quality / performance meetings, with twice monthly review of the Trust and LDU level results at the Quality Huddle.	Green
Overall		Amber

3. Records Management		
Completeness	All teams and wards are expected to complete and submit the audit on a monthly basis, making the aggregated results a genuine reflection of the full range and number of services provided. However, each month, there continue to be a small number of teams that fail to submit which represents a gap in knowledge at local level. LDU and Trust level results are still consider to be reliable sources of evidence as the aggregated results from the teams / wards that did submit represents a sufficiently large volume of data to draw broad assurance from.	Amber
Timeliness	Results are collated and presented immediately after the end of the month and the service user records audited relate to service users active within the most recent month.	Green
Accuracy	The indicator is based on a self-assessment of service user records, which are randomly selected centrally and provided to each team and ward. Managers then complete their audit of the clinical record, supported by standardised guidance, and submit their results using an electronic data entry tool.	Green
Audit	Some areas operate a peer review process, where one team completes the audit for another and visa versa. The clinical academy also undertakes independent audits of the RiO record, either responding to concerns raised, or as part of a systematic programme.	Green
Validation	Records Management is a self-assessment process and as such operational validation is implicit within the process. In addition results are scrutinised at monthly internal and external quality / performance meetings, with twice monthly review of the Trust and LDU level results at the Quality Huddle.	Green
Overall		Amber

4. Contract and Monitor		
Completeness	All indicators included in this section are generated using all applicable service users on the electronic record.	Green
Timeliness	All indicators are refreshed on a daily basis using the electronic record as it was at 9pm the night before and as such, each indicator uses up to date information. In addition, the Trust has a data quality: timeliness standard of three working days for community services and 'by end of shift' for crisis and inpatient services. This standard is	Green

	monitored via the Trust's timeliness indicator which consistently shows performance at c95% across all localities.	
Accuracy	All indicators are developed in line with relevant definitions and rigorously tested against that definition prior to release into IQ.	Green
Audit	Each year, two or three indicators are externally audited as part of the Quality Accounts process and have always been passed as an accurate reflection of the detailed definition.	Green
Validation	Team and ward level information is available in IQ for all indicators in this section, with further 'patient level' data also available to allow teams / wards to review potential breaches and prospectively manage key elements of care (e.g. waiting times or annual reviews). These reports, and their active use, ensure that the mechanics of each indicator are thoroughly investigated as individual records are reviewed and updated by clinical and administrative staff. Occasionally this leads to slight amendments / revisions as unusual cases arise and this is deemed to be a central part of the data quality management cycle.	Green
Overall		Green

5. Supervision & Appraisal		
Completeness	Both supervision and appraisal indicators are calculated using the whole workforce for which AWP has responsibility for supervising / appraising. The records are extracted monthly from the Trust's electronic staff record (which feeds payroll).	Green
Timeliness	Results are collated and presented immediately after the end of the month and the service user records audited relate to service users active within the most recent month.	Green
Accuracy	The Trust developed it's own electronic system to allow staff to monitor and enter their supervision and appraisal data. So events are not derived, but entered by the staff that undertook them – supported by reports that highlight prospectively where events have not (or appear not) to have taken place.	Green
Audit	No formal internal or external audit has taken place on either supervision or appraisal figures that corroborates the numbers presented. Testing was undertaken as part of system and IQ development, but this only validates the calculation, not the veracity of the data entered into the system.	Amber

Validation	As noted, staff enter their own supervision and appraisals into the system, so validation is implicit in the process. In addition results are scrutinised at monthly internal and external quality / performance meetings, with twice monthly review of the Trust and LDU level results at the Quality Huddle.	Green
Overall		Amber

6. Sickness		
Completeness	Sickness results are calculated using the whole workforce for which AWP has responsibility for managing sickness absence. The records are calculated using information from return to work forms completed and submitted by staff.	Green
Timeliness	Results are collated and presented immediately as soon as possible following the close of the month. Due to data entry processes, publication within the scorecard / IQ is always one month behind as internal processing cannot be completed until after the publication date. However, this still represents timely information as it is released and analysed at the earliest opportunity.	Green
Accuracy	The calculation that created the percentages reported was thoroughly tested as part of IQ development and confirmed as accurately reflecting the underlying data.	Green
Audit	No formal internal or external audit has taken place on sickness figures that corroborates the numbers presented.	Amber
Validation	As noted, staff submit the return to work paperwork as part of sickness / absence management and this information is used to calculate the results presented here. So validation is implicit in the process. In addition results are scrutinised at monthly internal and external quality / performance meetings, with twice monthly review of the Trust and LDU level results at the Quality Huddle.	Green
Overall		Amber