CLINICAL QUALITY & PATIENT SAFETY PERFORMANCE SUMMARY

Introduction

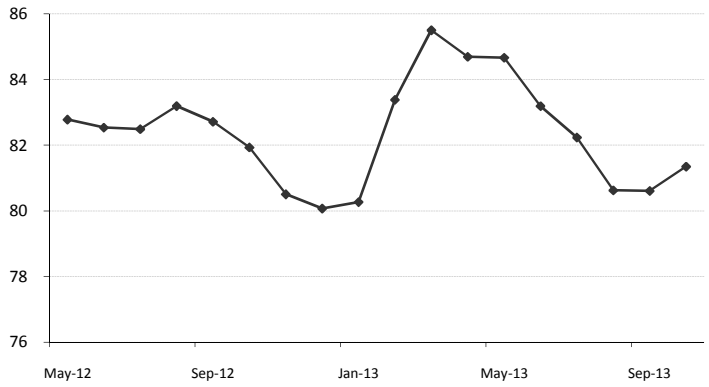
A summary of key trends and actions of the Trust's performance against the clinical quality and patient safety indicators is provided together with supporting narrative. The report is structured around the key themes of the annually published Quality Report/Account; Patient Safety, Patient Experience and Clinical Effectiveness.

	Measure	Improvement Metric		Target 13/14	Oct-13	Oct-12	vs Oct-12	YTD
Patient Safety	Mortality Rates	HSMR		-	81.3	81.9	↓	82.4
		RAMI		-		84.5		-
					Q4 12/13	Q4 11/12	vs Q4 11/12	YTD
		SHMI (%)		-	103.34%	98.93%	↑	-
					Dec-13	Dec-12	vs Dec-12	YTD
		Crude Mortality: All Ages (Per 1000)	Non-Elective	-	35.238	33.752	↑	29.662
			Elective	-	0.476	0.539	↓	0.202
	Risk Management	Serious Incidents (STEIS)	New Incidents	-	2	0	↑	-
			Open Incidents	-	30	20	↑	Cumul.
	HCAI	MRSA	Attributable	0	7	0	↑	Cumul.
		C. difficile	Post 72h	29	38	32	↑	Cumul.
	Infection Prevention	Mandatory Training Compliance (%)		95%	82.7%			86.4%
	Harm Free Care (HFC)	Safety Thermometer HFC (%) - Old & New Harm	EKHUFT	93%	91.7%	89.1%	↑	90.4%
			National	-	93.5%	92.4%	↑	-
	Nurse Sensitive Indicators	Pressure Ulcers: Grades 2,3 and 4	Acquired	-	28	30	↓	243
			Avoidable	135	10	10	↔	96
		Falls		1788	154	153	↑	1499
	Clinical Incidents	Total Clinical Incidents		-	998	815	↑	9192
Patient Experience	Compliments and Complaints	Compliments:Complaints		-	43:1	29:1	↑	-
		No. Care Spells per Formal Complaint		-	1602	1541	↑	-
	Experience	Friends and Family Test (Star Rating)		5.0	4.5			-
		Adult Inpatient Experience (%)		80%	87.58%	89.77%	↓	-
		Mixed Sex Accommodation Occurrences		-	11	9	↑	51
Clinical Effectiveness	Readmission Rate				Nov-13	Nov-12	vs Nov-12	YTD
		7 Day (%)		2.0%	4.11%	4.25%	↓	4.44%
		30 Day (%)		8.3%	8.52%	8.72%	↓	9.02%
	CQUIN				Dec-13	Dec-12	vs Dec-12	YTD
		Standard Contract CQUIN		Multiple			↔	
		Specialist CQUIN		Multiple				
	Bed Usage	Bed Occupancy (%)		-	94.55%	83.70%	↑	92.71%
		Extra Beds (%)		-	5.22%	6.46%	↓	-
		Outliers		-	32.35	37.81	↓	294.59
		Delayed Transfers of Care (Average)		-	33.00	32.75	↑	38.09

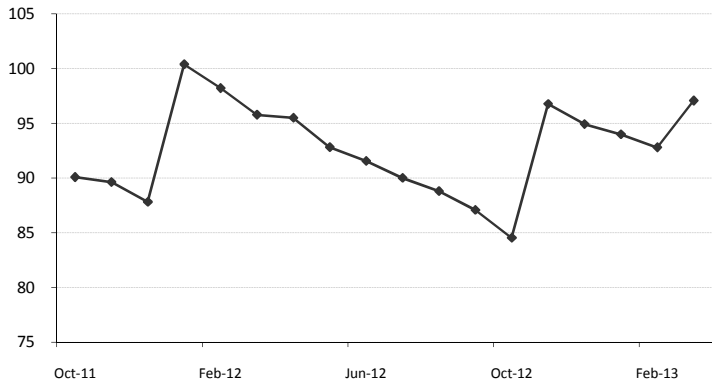
NB: RAMI - Data sharing agreements with CHKS have now been resolved. An up to date RAMI position will be published in the near future.

PATIENT SAFETY: MORTALITY RATES

Hospital Standardised Mortality Ratio (HSMR) - All Discharges

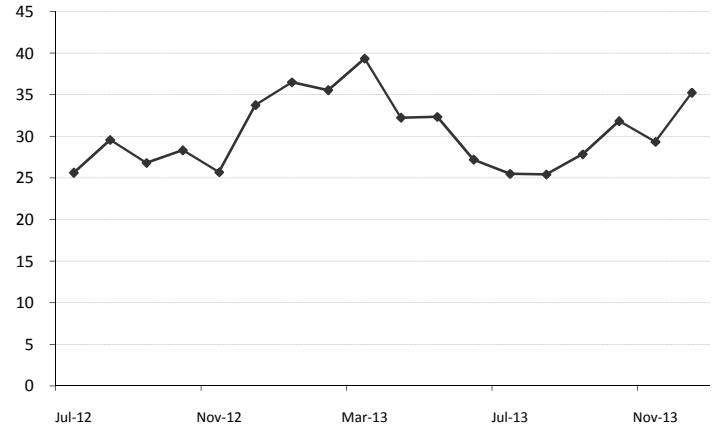


Risk-Adjusted Mortality (RAMI) - All Discharges

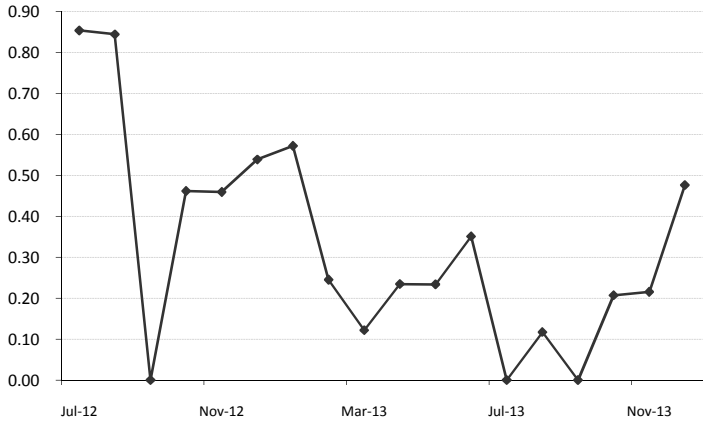


Performance at Trust level remains good across all mortality indicators with the 12 month rolling HSMR equalling 81.3 as at the end of Oct-13, and this is in line with the trend demonstrated by the crude mortality metric.
Data sharing agreements with CHKS have now been resolved and data are being uploaded for the current financial year. It is hoped that an up to date RAMI position will be published in the near future.

Crude Mortality - Non-Elective per 1000



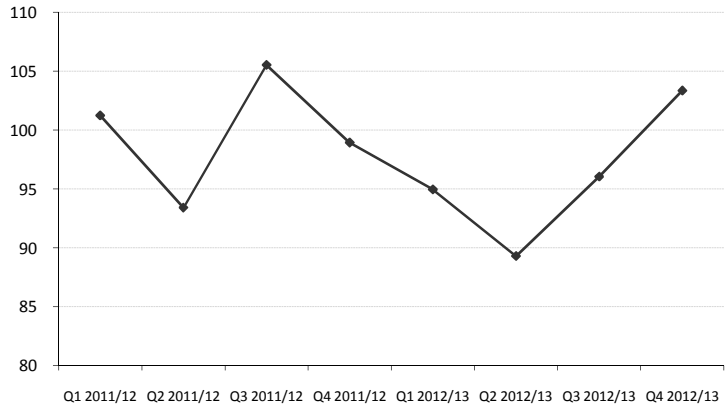
Crude Mortality - Elective per 1000



Crude mortality for non-elective patients shows a fairly seasonal trend with deaths higher during the winter months. The winter peak during 2012/13 extended further into the spring than normal, with a reduction to expected levels occurring in June rather than in April/May (as seen in previous years). December performance, following this trend, equalled 35.238 deaths per 1000 population, an increase on the previous month. This is in line with previous year's performance and it is expected this trend will continue.

During December elective crude mortality was 0.476 deaths per 1,000 population. Although a sharp increase in month, this remains in line with previous good performance and follows seasonal trend.

Summary Hospital Mortality Indicator (SHMI)



The Summary Hospital Mortality Indicator (SHMI) includes "in hospital" and "out of hospital" deaths within 30 days of discharge. These data are supplied by an external party and are updated on a quarterly basis. During the latter part of 2011/12 SHMI for EKHUFT was higher than other mortality indicators at over 100. Improvements have been made over the last year, and the data up to the end of Q2 2012/13 show an improved position reducing to 90 over the period of 3 quarters. The most recent data to be published, Q4 2012/13, show a further increase compared with Sep-13. This is currently being reviewed.

Serious Incidents - Open Cases

Date		Summary of Serious Incident & Remedial Action Taken	IX lv	Division	Timely Submit?
Incident	STEIS Report				
12-Dec-13	19-Dec-13	Unexpected Death - epileptic patient with ischaemic bowel		UCLTC	Not Due
14-Aug-09	12-Dec-13	Failure to Act - abnormal test results, missed grade 3 leiomyosarcoma		Surgical	Not Due
15-Oct-13	15-Nov-13	Unexpected Death - a subdural haematoma following a fall	2	UCLTC	Not Due
6-Nov-13	11-Nov-13	Never Event - misplaced nasogastric tube	2	UCLTC	Yes
30-Oct-13	8-Nov-13	Unexpected Death - post operative AAA repair	1	Surgical	Not Due
28-Aug-13	31-Oct-13	Unexpected Admission - term baby admitted to NICU from MLU via labour ward at QEH	2	Specialist	Not Due
26-Sep-13	31-Oct-13	Intrauterine Death - at term	1	Specialist	Not Due
11-Oct-13	30-Oct-13	Allegation against a member of staff	1	UCLTC	Not Due
2-Jun-13	17-Oct-13	Never Event - retained swab post caesarean section	2	Specialist	Not Due
8-Aug-13	11-Oct-13	MRSA bacteraemia	1	UCLTC	Yes
8-Aug-13	20-Sep-13	Grade 4 hospital acquired pressure ulcer (avoidable)	1	Surgical	Yes
Aug-13	14-Aug-13	Media Interest - delayed implementation of PACS/RIS replacement resulting in a backlog of patient bookings across all modalities	0	Clinical Support	Not Due
18-Jun-13	5-Aug-13	Unexpected Death - post-operative emergency following gallbladder surgery	1	Surgical	Yes
22-Mar-13	9-Apr-13	Unexpected Death - adult with small bowel obstruction	1	Surgical	Yes
16-Mar-13	27-Mar-13	Intrauterine Death - at 24 weeks	1	Specialist	Yes
12-Mar-13	22-Mar-13	Grade 3 hospital acquired pressure ulcer (avoidable)	1	UCLTC	Yes
19-Feb-13	6-Mar-13	Suboptimal care of deteriorating patient	1	Surgical	Yes
27-Feb-13	1-Mar-13	Maternal Death - 6 days postpartum	1	Specialist	Yes
28-Nov-12	14-Feb-13	Unexpected Death - post nephrectomy	2	Surgical/ UCLTC	Yes
22-Jan-13	24-Jan-13	Never Event - wrong site surgery, pleural aspiration	2	UCLTC	Yes
7-Jan-13	11-Jan-13	Never Event - wrong site surgery: Ophthalmology	2	Surgical	Yes
3-Jan-13	8-Jan-13	Neonatal Death - term baby	2	Specialist	Yes
5-Nov-12	6-Nov-12	Intrauterine Death - at 41+2 weeks	1	Specialist	Yes
8-Aug-11	13-Sep-12	Media Interest - re: DNR and patient with learning disabilities	1	Corporate	Yes
4-Sep-12	13-Sep-12	Neonatal Death - following shoulder dystocia	1	Specialist	Yes

Serious Incidents - Partially Closed Cases

Serious Incidents closed by KMCS but remaining open on STEIS pending review by external bodies.

Date		Summary of Serious Incident & Remedial Action Taken	IX lv	Division
Incident	STEIS Report			
20-Sep-13	4-Oct-13	Screening Issue - amniocentesis SCD	1	Clinical Support
17-Jun-13	27-Jun-13	Screening Issue - diabetes eye screening programme and Hospital Eye Services (HES)	1	UCLTC
21-May-13	21-Jun-13	Induction of Labour - term baby developed seizures at 36h	2	Specialist
13-Sep-12	11-Jan-13	Neonatal Death - term baby born at home to a 16 year old	2	Specialist
17-Jun-10	1-Jul-10	Child Death - pneumococcal meningitis	3	Specialist

Serious Incidents - Closed Cases

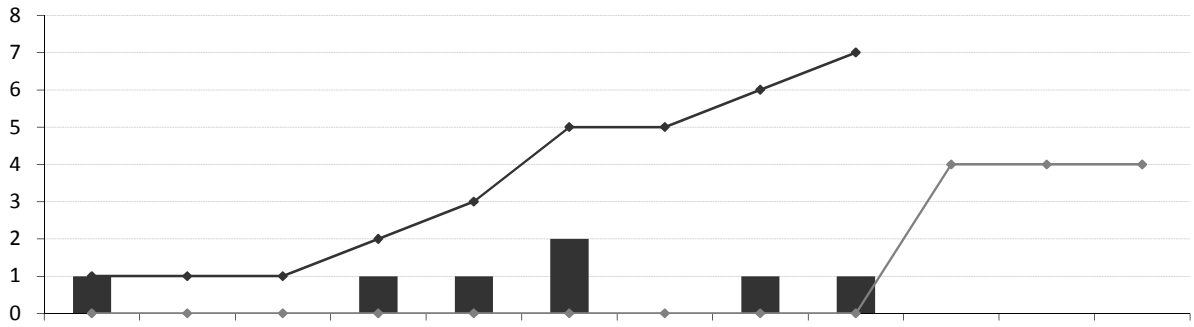
Date		Summary of Serious Incident & Remedial Action Taken	IX lv	Division
Incident	STEIS Report			
29-Jan-13	31-Oct-13	Unexpected Admission - term baby admitted to NICU. CTG and gases normal.	2	Specialist
17-Sep-13	1-Oct-13	Grade 4 hospital acquired pressure ulcer (avoidable)	1	UCLTC
11-Jun-13	30-Aug-13	Unexpected Death - adult patient	1	Surgical
15-Aug-13	20-Aug-13	Suboptimal care of deteriorating patient	2	Specialist
25-May-13	19-Jun-13	Grade 3 hospital acquired pressure ulcer (avoidable)	1	UCLTC

Two serious incidents were reported on STEIS in Dec-13. These were an unexpected death of a 48 year old epileptic lady with ischaemic bowel following deterioration and an emergency operation, and the missed diagnosis in 2009 of leimyosarcoma leading to inoperable lung metastases lung spread. These are all currently under investigation. Five incidents were closed: 2 pressure ulcers, 1 unexpected admission to NICU, 1 unexpected adult death and 1 suboptimal care. Root Cause Analysis (RCA) reports have been presented to the Risk Management Governance Group by the Divisions responsible. These included the findings of the investigation and action plans to take forward recommendations, including mechanisms for monitoring and sharing learning. There are currently 30 serious incidents open. The CCGs have agreed closure of 5 of these serious incidents pending an area team review.

CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: HOSPITAL ACQUIRED INFECTIONS

Both MRSA and C difficile numbers have increased during 2013/14 compared with the previous year, and in response the Infection Prevention and Control Team (IPCT) have launched a comprehensive programme of education and support in all clinical areas. Areas addressed include compliance with MRSA and C difficile infection control policies and close supervision of broad spectrum antimicrobial prescribing.

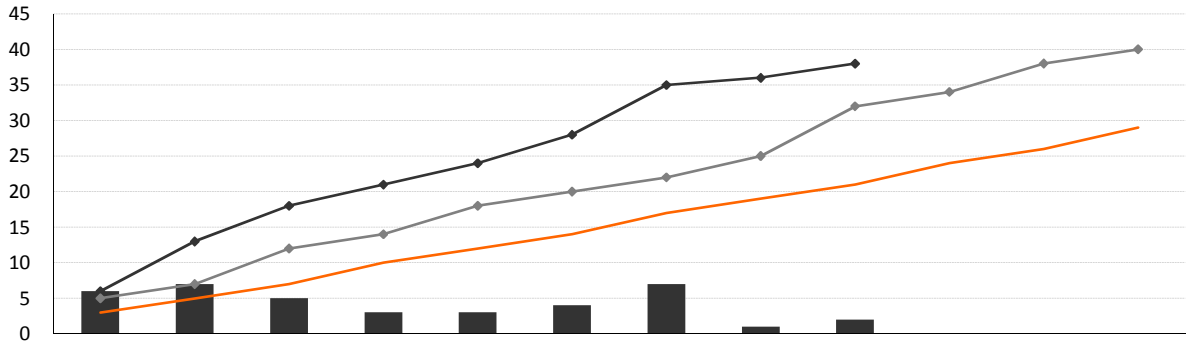
MRSA Bacteraemia - Trust Assigned Cases



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Actual	1	0	0	1	1	2	0	1	1			
2013/14 Cumulative	1	1	1	2	3	5	5	6	7			
2012/13 Cumulative	0	0	0	0	0	0	0	0	0	4	4	4

There was 1 post 48h MRSA bacteraemia in December. The Post Infection Review has assigned the case to EKHUFT. The cumulative total of EKHUFT assigned cases for Apr-Dec is 7 and represents an increase in cases compared with the 2 previous years (when the 12 month total of post 48h cases was 4). It is unclear whether the increase in cases in 2013/14 represents a real trend or results from random statistical variation in low numbers. Three cases of MRSA bacteramia (2 CCG assigned and 1 EKHUFT assigned case) belong to the Lyon clone of MRSA which is unusual in the UK, but has been seen locally for several years. It is possible that the increase in cases may be due to spread of the Lyon clone in the community.

Clostridium difficile - Incidents Post 72h



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Actual	6	7	5	3	3	4	7	1	2			
2013/14 Cumulative	6	13	18	21	24	28	35	36	38			
2012/13 Cumulative	5	7	12	14	18	20	22	25	32	34	38	40
Target	3	5	7	10	12	14	17	19	21	24	26	29

There were 2 post 72h C difficile cases in December. This is the second consecutive month with very low numbers. Following the high numbers seen in Q1 2013/14, the Q2 and Q3 totals of 10 cases per quarter represent a return to the low baseline achieved in 2012/13, and provide evidence that the C difficile recovery plan is working.

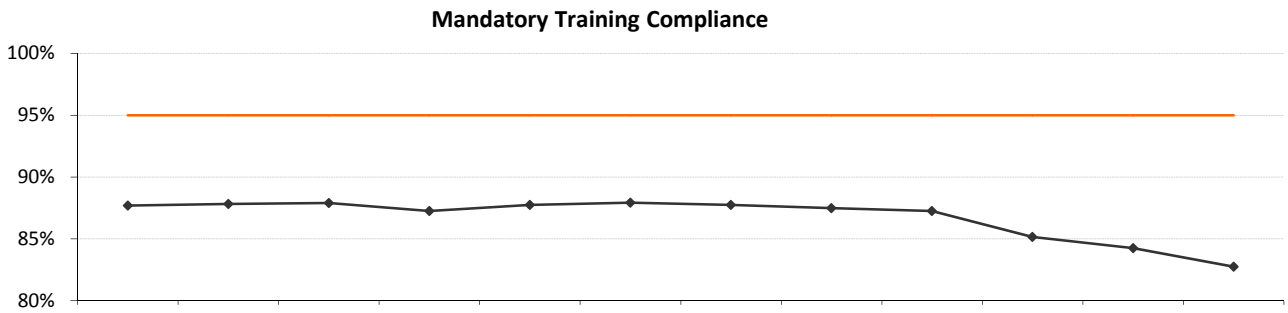
Escherichia coli Bacteraemia - Incidents Pre and Post 48h

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly Average	Total Apr-Dec
2013/14	Pre 48h	30	33	41	37	28	42	36	36	26				34.3	309
	Post 48h	4	3	4	12	3	12	10	4	8				6.7	60
2012/13	Pre 48h	30	27	20	33	34	37	39	22	28	30	25	34	29.9	270
	Post 48h	11	8	3	9	6	5	5	5	2	4	8	8	6.2	54

Ecoli is the most frequent cause of blood stream infection locally and nationally. All cases are reported to the Public Health England mandatory database each month which provides an opportunity for comparison with other trusts. The Ecoli rate/100,000 occupied bed days is high in East Kent (123 compared with the NHS average of 93). The reason for this high rate is unknown, but may be due to differences in population demographics. (In contrast to the high Ecoli rate/bed-day the Ecoli rate/head of population is close to, or below, the national average).

More than 80% of cases of Ecoli bacteraemia are present at the time of admission to hospital and, therefore, in most cases represent community acquired infection. This can be seen in the accompanying EcoliEcoli table which shows an average of 34.3 Pre 48h Ecoli cases per month during 2013/14, compared with only 6.7 Ecoli cases/month occurring more than 48h after admission. A high proportion of Ecoli blood stream infections are complications of either urinary tract infection or biliary sepsis. The Infection Prevention and Control Team are undertaking enhanced surveillance to determine the contribution made by urinary tract catheterisation, and this information will be included in subsequent reports when the data are available.

PATIENT SAFETY: INFECTION PREVENTION & CONTROL

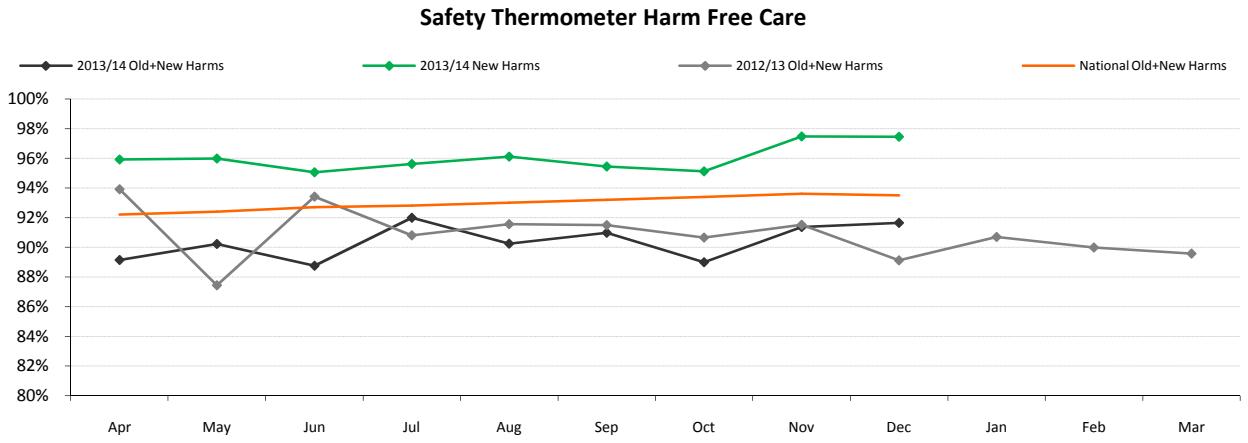


	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Compliance	87.7%	87.8%	87.9%	87.3%	87.7%	87.9%	87.8%	87.5%	87.3%	85.2%	84.3%	82.7%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

	Dec-13							
	Target	Trust	Clinical Support Services	Corporate	Specialist Services	Strat Dev & Capt Pln	Surgical Services	UCLTC
Mandatory Comparative Data for Biennial Training Compliance	95%	82.7%	83.7%	85.7%	82.4%	91.6%	82.5%	80.1%

Compliance Against Performance	
	Achieving or exceeding performance metric
	0-10% underperformance against metric
	10-20% underperformance against metric

Trust wide mandatory Infection Prevention and Control training continues to decline, that is, from 84.3% in Nov-13 to 82.7% in Dec-13. All Divisions have reduced compliance rates this month. There are plans to report this metric via the QlikView platform in the near future, and it is anticipated that this will support improved compliance.



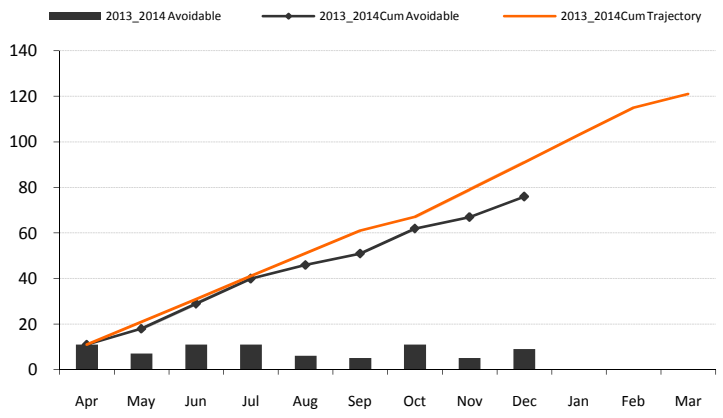
The chart above shows the percentage of Harm Free Care expressed as a one-day snapshot in each month. It is known as the NHS Safety Thermometer and is a quick and simple method for surveying patient harms. The aim of the Safety Thermometer is to identify, through a monthly survey of all adult inpatients, the percentage of patients who receive Harm Free Care. Four areas of harm are currently measured:

- All grades of pressure ulcers whether acquired in hospital or before admission;
- All falls whether they occurred in hospital or before admission;
- Urinary tract infection (in patients with a catheter);
- Venous thromboembolism, risk assessment and appropriate prevention.

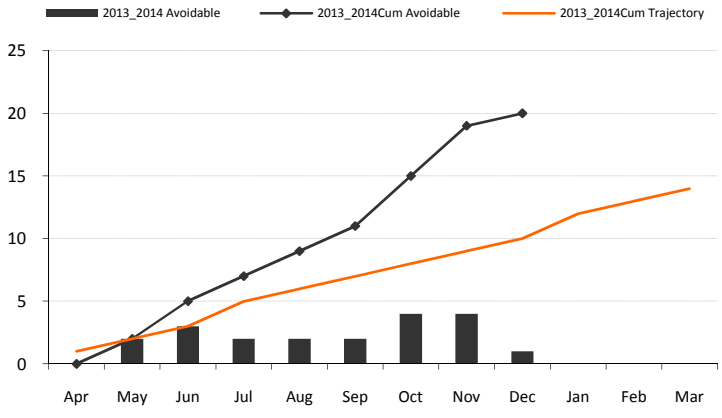
The strength of the NHS Safety Thermometer lies in allowing front line teams to measure how safe their services are and to deliver improvement locally. There are several different ways in which harm in healthcare is measured and there are strengths and limitations to the range of approaches available. The NHS Safety Thermometer measures prevalence of harms, rather than incidence, by surveying all appropriate patients on one day every month to count all occurrences of harms.

Harm Free Care includes both harms acquired in hospital ("new harms") and those acquired before admission to hospital ("old harms"). There is limited ability to influence "old harms" if a patient is admitted following a fall at home, or with a pressure ulcer, but these are included in the overall performance reported to the Health and Social Care Information Centre. "New harms only" are included separately when reporting performance to Divisional teams to enable success to be celebrated and to incentivise improvement. Harm Free Care performance is incorporated within the monthly ward quality dashboard and is triangulated with the existing funded establishment, acuity and dependency of patients, and effectiveness of rostering to enable analysis of influencing factors and thereby focusing improvement actions. In Dec-13, the Trust's own score is 97.4% showing that those patients in our care have a greater harm free experience. This is above the national figure of 93.0% and is the area we can influence the most. It has remained similar to last month. The total percentage of Harm Free Care ("old and new harms") is also similar to last month and is 91.7%. However, this remains below the national figure and both the Tissue Viability Team and the Falls Prevention Team are working towards developing action plans to reduce these incidents occurring in our care. In addition, we are also reviewing in January the way we collect these data to ensure accuracy so that we can make the quality improvements we need to.

Grade 2 Incidence Trajectory 2013/14
20% Reduction (CQUIN)



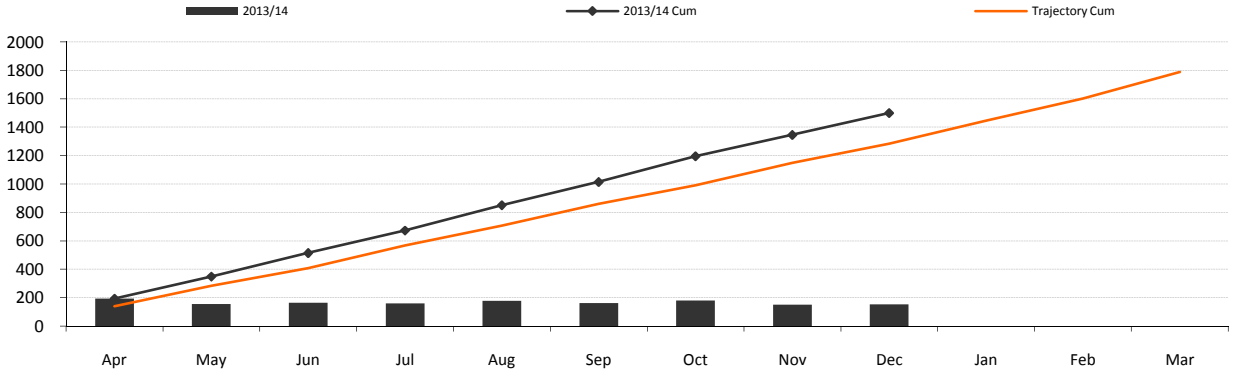
Grade 3 and 4 Incidence Trajectory 2013/14
50% Reduction



In December, of the 22 reported hospital acquired grade 2 pressure ulcers, 9 were agreed as avoidable. These ulcers may have been avoided with sufficient repositioning or heel pressure off-loading. The Trust remains within the set trajectory for CQUINs 20% reduction and the Trust's own 25% reduction of avoidable grade 2 pressure ulcers. However, the Trust Wide Action Plan has been reviewed and updated to support continued improvement. A further 17 wards have now achieved 100 consecutive avoidable pressure ulcer free days, and 7 wards have attained 200 consecutive avoidable pressure ulcer free days.

In December 6 deep ulcers were reported (grades 3 and 4). Following multidisciplinary investigations 1 incident was agreed as avoidable due to lack of pressure off-loading at the heel, 1 was found to be present on admission and in another, the origin of pressure ulcer development was unclear pending further information. Two incidents were unavoidable due to the deteriorating condition of the patient even with full prevention in place. There are 2 outstanding investigations, 1 booked for January and the other awaiting patient's notes. It is encouraging that there was a reduction in deep heel ulcers and actions to address these issues remain in progress.

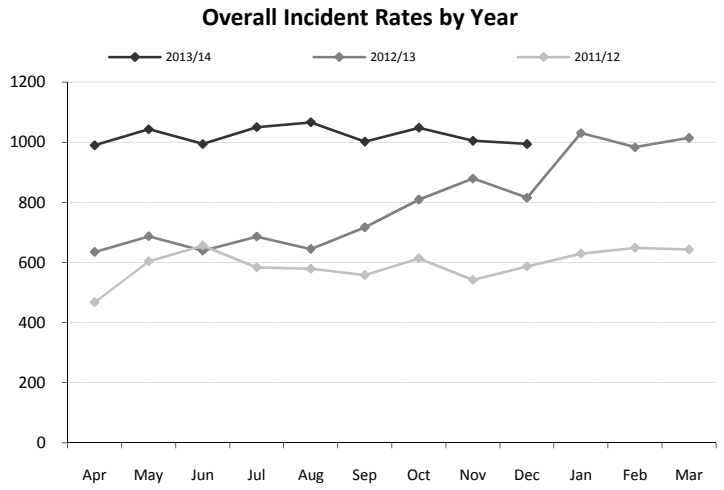
Patient Falls - Injurious and Non-Injurious



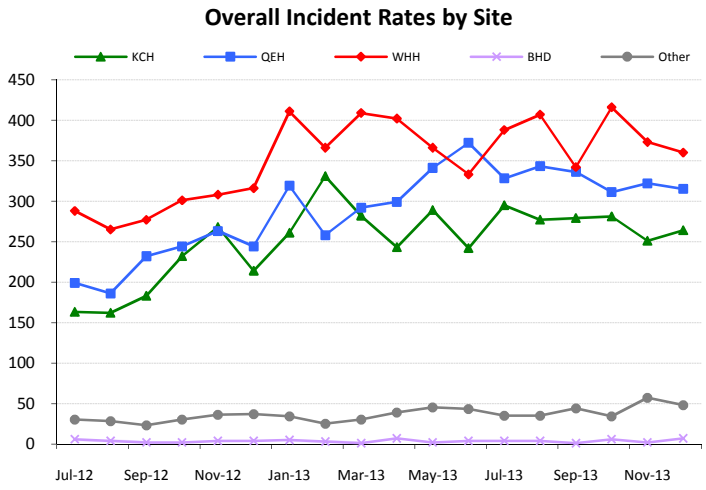
There has been a similar trend in the total number of falls over the past 2 months, which is less than the number recorded in Oct-13. A Root Cause Analysis (RCA) of all falls which result in significant harm is undertaken, and the Falls Team is currently continuing its analysis of all serious falls to enable a focus on the recurring themes. It is clear that there are several areas of concern which include lack of escalation during "out of hours", inadequate risk assessment, poor communication and handover, staff shortages and heavy workload, lack of recognition of change in condition, and acute delirium. A change register is being developed to manage common themes and actions against these criteria. The Falls Team is working with other specialty services to triangulate data and identify high risk areas in order to work jointly to improve patient safety and quality of care. An example of this is a RCA for a patient fall which involved representatives from Movement and Handling, Dementia, Nutrition and Clinical Governance. By undertaking the RCA in this way issues were identified, such as "labelling" a patient with a diagnosis of Dementia without a formal investigation process and poor movement and handling assessment.

PATIENT SAFETY: CLINICAL INCIDENTS

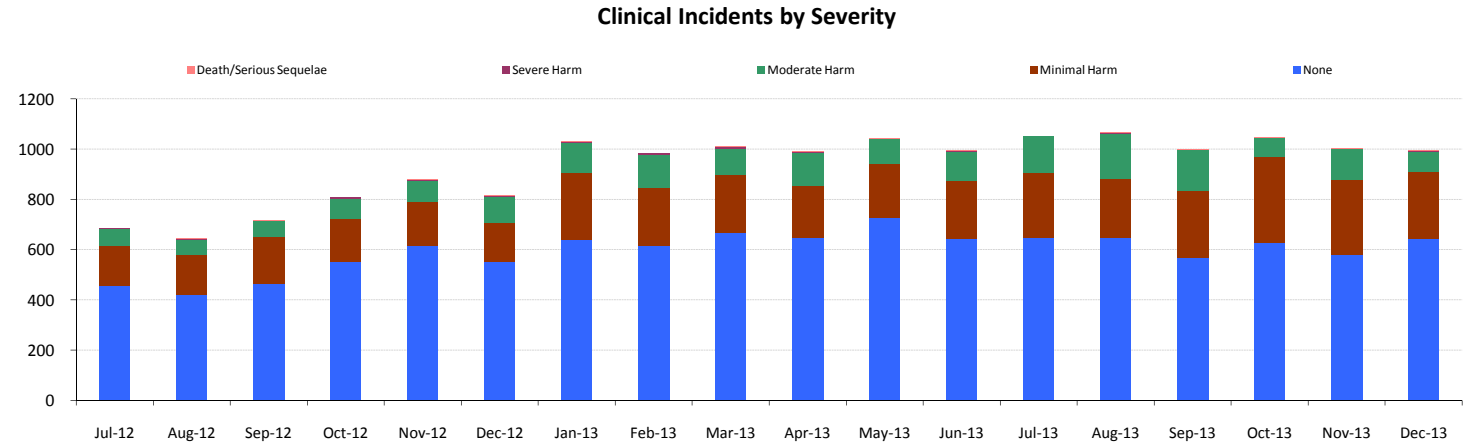
In Dec-13 a total of 998 clinical incidents and patient falls were reported. This includes 2 incidents (which are under investigation) graded as death/serious sequelae, and 1 (which is also under investigation) graded as severe. Unapproved incidents may be downgraded following investigation. In addition to these 3 serious incidents, 39 incidents have been escalated as serious near misses, of which 7 have been finally approved.
Two serious incidents were required to be reported on STEIS in December. Five case has been closed since the last report; there remain 30 serious incidents open at the end of December of which 5 have been closed by the KMCS pending review of external bodies before closure on STEIS.



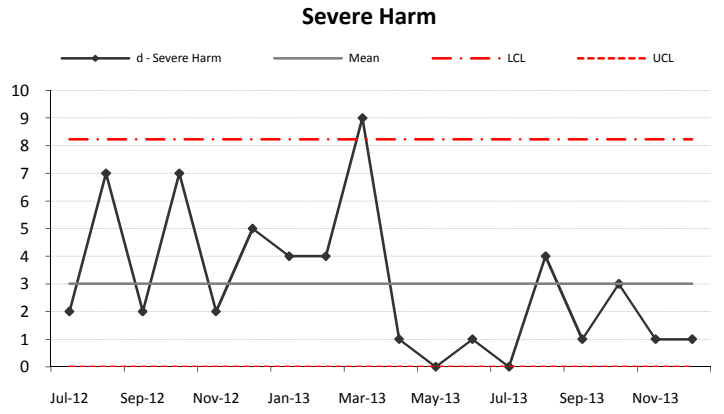
A total of 998 clinical incidents have been logged in December compared with 1006 recorded for Nov-13.

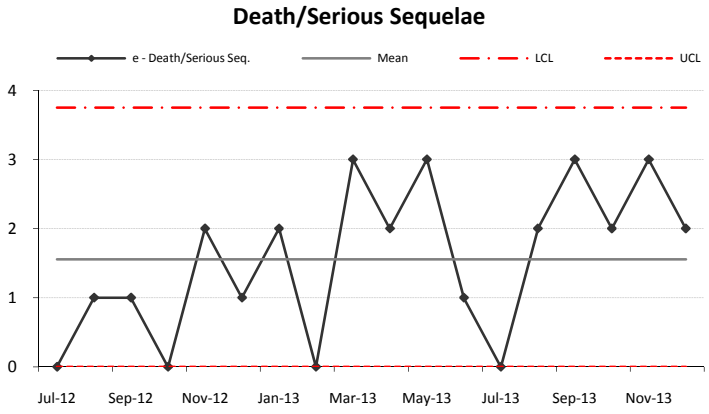


Incident numbers for December at KCH have risen slightly, whereas a decrease in clinical incidents is evident at other sites.



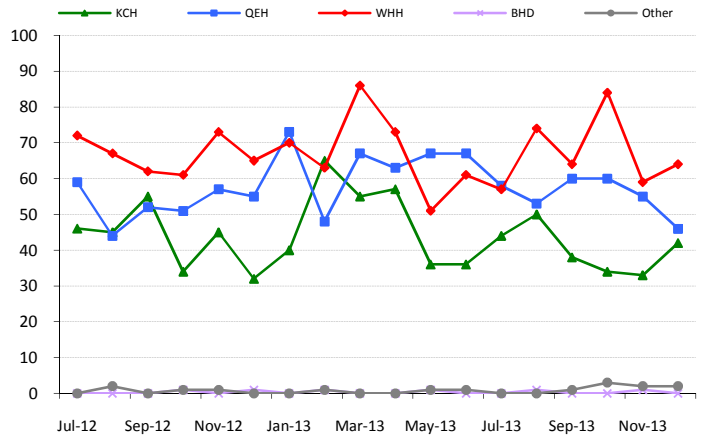
The incidents graded as moderate, serious and death have all been subject to review in order to confirm the consistency of the grading of harm across the Trust. The Board of Directors may see a change in this report to reflect the re-categorisation process undertaken. This is consistent with the data presented in the Quality Account and Quality Report.





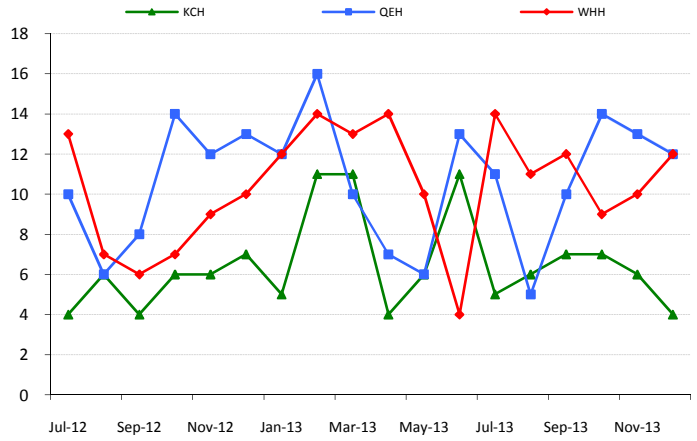
The number of death/serious and severe harm incidents reported in Dec-13 remains subject to the usual Root Cause Analysis (RCA) investigation and review. It is possible that the severity of these cases will be downgraded once the investigation process is completed. December's data is on a par with last month's.

Patient Slips, Trips and Falls



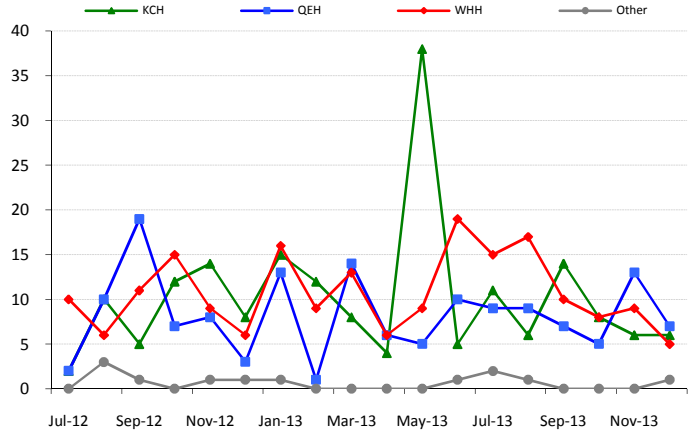
Of the 154 patient falls recorded for December (150 in November), none were graded as severe or death/serious sequelae. There were 95 falls resulting in no injury, 54 in low harm and 5 in moderate harm. The top reporting wards were CDU (WHH) with 13 falls, Deal (QEH) with 11, Kingston Stroke Unit (KCH) with 9; Harbledown (KCH), Cambridge M2 (WHH), and Richard Stevens Stroke Unit (WHH) with 8 each. The remaining wards reported 6 or less falls. All 5 moderate harm falls resulted in fracture and occurred on Cambridge J2 (WHH), Deal (QEH), Sandwich Bay (QEH), St. Margaret's (QEH) and Harbledown (KCH). A Root Cause Analysis is carried out for all falls resulting in serious harm or fracture.

Hospital Acquired Pressure Ulcers



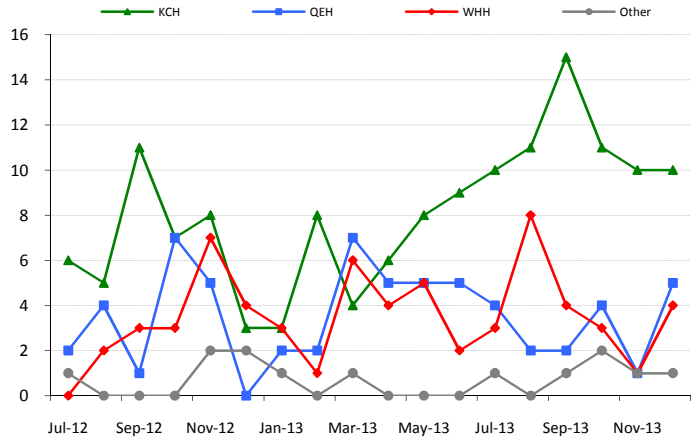
In December there were 28 reported incidents of pressure ulcers developing in hospital (29 in November). This included 22 grade 2 pressure ulcers, 6 grade 3 pressure ulcers and no grade 4. Ten have been assessed as avoidable, 14 as unavoidable and 4 not yet assessed (awaiting RCA). The highest reporting wards were Kings C1 (WHH) with 4 incidents, Deal (QEH) and Seabathing (QEH) with 3 incidents each, followed by Kings A2 (WHH), Richard Stevens Stroke Unit (WHH), Bishopstone (QEH), Cheerful Sparrows Male (QEH) and Clarke (KCH) each with 2 incidents.

Delay in Providing Treatment



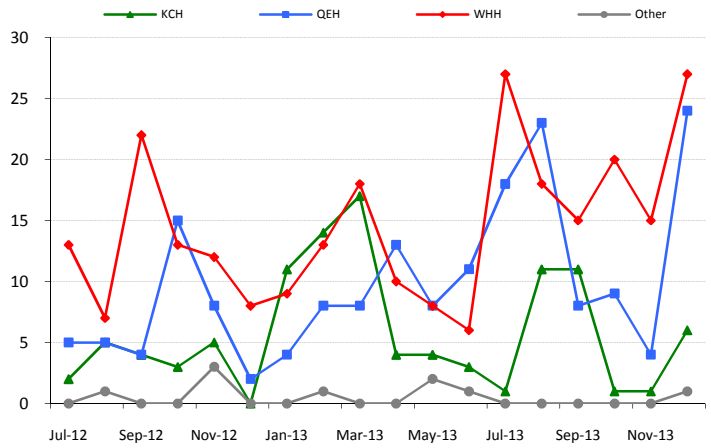
There were 19 incidents resulting in delay in providing treatment during December compared with 28 in November. No incidents have been graded as death/serious sequelae or severe harm. One incident was graded as moderate, 3 graded as low, and 15 (including 3 serious near misses) resulted in no harm. Themes in location: 5 incidents occurred at WHH, of which Celia Blakey Centre (chemotherapy) reported 2 incidents; 7 incidents occurred at QEH, including 2 on Fordwich Stroke Unit and 2 in A&E; 6 incidents occurred at KCH, including 4 in Cathedral Day Unit. One incident occurred at BHD.

Incorrect Data in Patient Notes



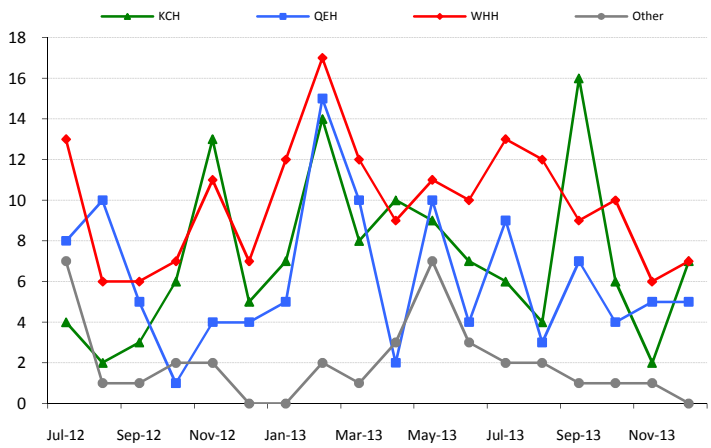
There were 20 incidents of incorrect data in patients' notes reported as occurring in December (13 in November), of which 19 were graded as no harm and 1 as low harm. Seventeen incidents related to incorrect data in paper notes, 2 to incorrect data on patient's electronic record (Patient Centre/Euroking), and 1 to incorrect data in Electronic Discharge Notifications (eDN). Of the incidents reported, 10 were identified at KCH, 5 at QEH, 4 at WHH and 1 at RVHF. The highest reporting area was Outpatients (KCH) with 5 incidents.

Staffing Level Difficulties



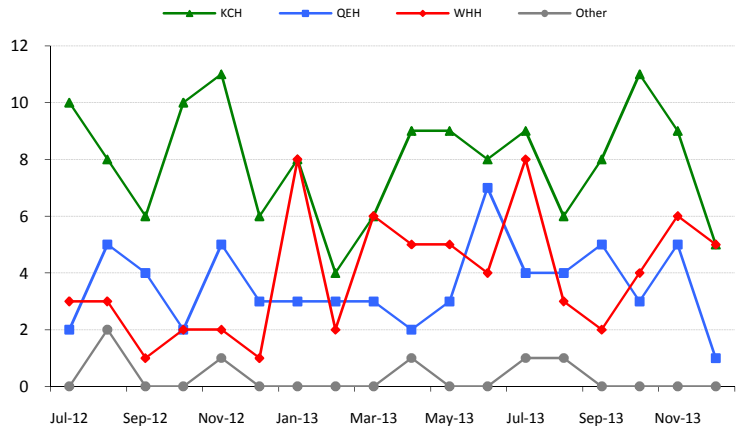
There were 60 incidents recorded in December (20 in November). These included 35 incidents relating to insufficient nurses and midwives, 1 to inadequate skill mix and 24 to general staffing level difficulties. Top reporting locations were Singleton Unit (WHH) with 18 incidents, Cheerful Sparrows Male (QEH) with 8, Coronary Care Unit (QEH) with 5, and Fordwich Stroke Unit (QEH) with 4 incidents each.
Six incidents occurred at KCH, 25 at QEH, 28 at WHH and 1 at Maidstone Renal Satellite unit. Fifty four incidents were graded as no harm, 5 as low harm and 1 as moderate harm.

Communication Breakdowns



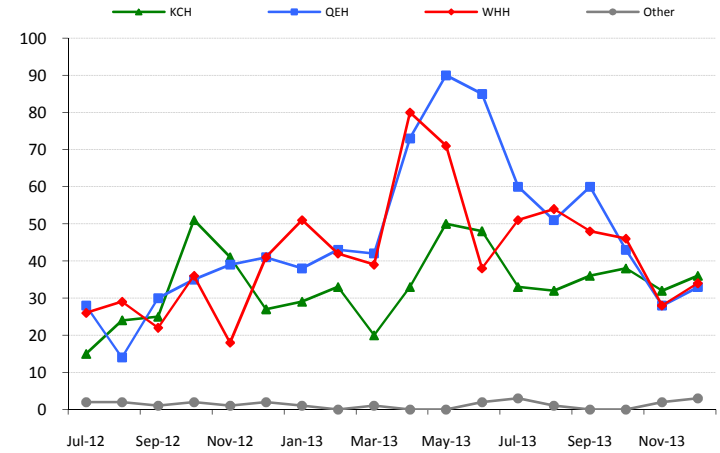
In Dec-13 there were 19 incidents of communication breakdown (14 in November). Of these, 15 involved staff to staff communication failures, 3 were staff to patient, and 1 was staff to relative (or other visitor). Of the 19 incidents reported, 7 were recorded as occurring at KCH, 5 at QEH and 7 at WHH. No area reported more than one incident. Incidents in December were graded as follows: 15 as no harm, 3 as low harm and 1 as moderate harm.

Blood Transfusion Errors



In December, there were 11 blood transfusion errors reported (20 in November). Two main themes arose in the period: 2 incidents of blood products being recalled by NHS Blood and Transplant Authority (already transfused), and 4 adverse reactions to blood transfusion, which included 2 allergic reactions (i.e. 1 haemolytic and 1 febrile non-haemolytic reaction). Of the 11 incidents reported, 7 were graded no harm and 4 as low harm. Reporting by site: 5 at KCH, 1 at QEH and 5 occurred at WHH.

Medicines Management



There were 106 medication incidents reported as occurring in December (90 in November).

Medicines Management

Category	Dec-13
Prescribing	31
Dispensing	14
Administering	43
Missing (lost or stock discrepancy)	8
Shortage (drug unavailable)	4
Suspected adverse reaction	1
Infusion problems (drug related)	2
Infusion injury (extravasation)	3
TOTAL	**106**

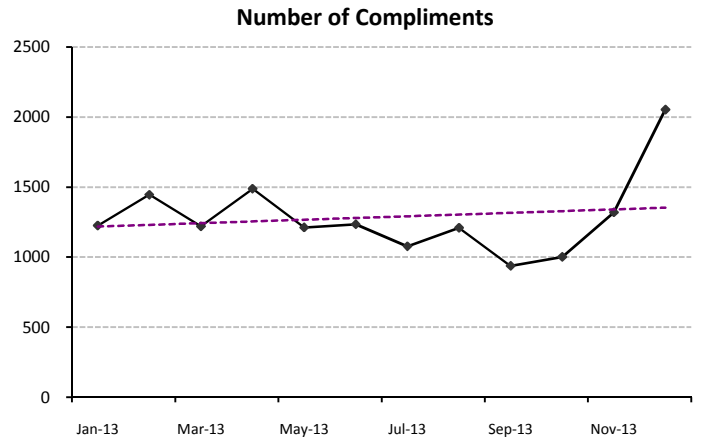
Of the 106 reported, 95 were graded as no harm including 10 serious near misses, 9 as low harm and 2 as moderate harm. No serious incidents were reported. Top reporting areas were: Folkestone (WHH) and Pharmacy (KCH) each reported 7 incidents; Viking Day Unit (QEH) reported 6; Seabathing (QEH), Celia Blakey Centre (WHH) and Cathedral Day Unit (KCH) reported 5 incidents each. Other areas reported 4 or less incidents. Thirty six were reported at KCH, 33 at QEH, 34 at WHH, and 3 incidents at another sites.

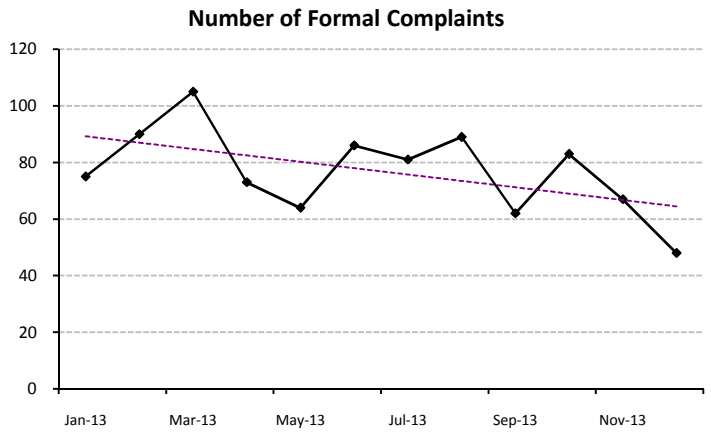
PATIENT EXPERIENCE: CONCERNS, COMPLAINTS & COMPLIMENTS

The experience of the patients and their families is of paramount importance to the Trust. Patient views are sought via a number of ways including the Patient Opinion website, the Friends and Family Test, via NHS Choices and also through the Trust's formal systems. This report provides the Board of Directors with activity and performance information about the complaints, concerns, comments and compliments in Dec-13. The information reported is for cases received in month and formal cases with target dates due that month.

• Activity: Formal complaints - 48; informal contacts - 213; compliments - 2054.

The charts below show the number of complaints and compliments received on a monthly basis. One formal complaint has been received for every 1602 recorded spells of care (inpatient, outpatient and A&E attendances) in comparison with November's figures where 1 formal complaint was received for every 1221 recorded spells of care.





In Dec-13 the number of compliments received has increased by 56% compared to the previous month. The ratio of compliments to formal complaints received for the month is 43:1. There has been 1 compliment received for every 37 recorded spells of care. In addition to these data, compliments are also received via the Friends and Family Test, inpatient survey, and letters and cards sent directly to wards and departments. During December there were 26 compliments posted on patient opinion and NHS Choices and 17 concerns. These were all responded to by the Chief Nurse and Director of Quality and Operations and followed up as necessary.

The number of formal complaints received has decreased by 28% compared to Nov-13. The number of informal contacts has decreased by 24% compared to the previous month, and has also increased by 10% compared to Dec-12.

Top Five Concerns Expressed in Formal Complaints
December 2013

Concerns		No.
Problems with Attitude	Problems with doctor's attitude	7
	Problems with nurse's attitude	1
Concern about Clinical Management	Incomplete examination carried out	4
	Liverpool Care Pathway	1
	Lack of/inappropriate pain management	2
	Scans/X-rays not taken	1
Concern about Surgical Management	Unexpected outcome/post-operative complications	8
Problems with Discharge Arrangements	Unfit for discharge/poor arrangements	4
	Unhappy about follow up arrangements/care	2
Problems with Nursing Care	Delay in receiving treatment	1
	Problems with nursing care	2
	Nutrition	1

The common themes raised within the top five issues for informal concerns are led by delays, followed by problems with communication, problems with appointments, problems with attitude, and problems with cancellations.

With regards to formal complaints, concerns regarding clinical management and concerns regarding surgical management have entered the top 5 catergory when compared with Nov-13, and thus replacing problems with discharge arrangements and problems with delays. The other 3 subjects have remained in the top 5 formal subjects from November to December.

Concerns, Complaints and Compliments - Divisional Performance

December 2013

Division	Divisional Activity				Divisional Performance	
	Formal Complaints	Compliments	Informal Contacts	Compliments: Complaints	First Response Met	Returning Complaints
Clinical Support	2	116	30	58:1	4 of 4	0
Specialist Services	10	1162	12	116:1	11 of 14	0
Surgical Services	20	522	81	26:1	19 of 27	0
UCLTC	16	254	56	15:1	38 of 42	3
Corporate	0	0	34	0:0	4 of 4	0
Other	0	0	0	0:0	0	0
TOTAL	48	2054	213	43:1	76 of 91	3

Compliance Against First Response Met	
	85 - 100%
	75 - 84%
	<75%

The table above shows the monthly Divisional activity and performance for Dec-13, reporting on the percentage of cases where target dates falling within the month have been met. The first response date is the date agreed with the client for the receipt of a substantive response to their complaints; this will either be via a letter or at a meeting.
In Dec-13, there were a total of 80 responses sent out to clients, and 9 extensions to the response date were obtained. The data show that 83% of these responses were sent within the 30 working days target, and as such show an increase over the Nov-13 position (i.e 77%).

Parliamentary and Health Service Ombudsman (PHSO) Cases - Latest Action

Status of Cases	Actions in Dec-13
Cases carried over from previous month	15
New cases referred to the Trust	5
Cases closed by PHSO	4
Current open cases with the PHSO	16

The PHSO is the second and last stage of the National Complaints process and it is open to all clients to approach the Office if they are dissatisfied with the way their formal complaint has been handled.
In December, the PHSO have been in contact with the Trust with regards to 5 new cases brought to their attention. The Ombudsman have asked the Patient Experience Team for a status update on 2 of the new referrals to determine whether local resolution had been completed and the Ombudsman may then begin their pre-assessment. The remaining 3 new referrals have had papers requested from the Trust and comments from the Divisions involved. One of these 3 new referrals relate to Clinical Support Services, 1 to Surgical Services, and the remaining case to UCLTC.
One case which was under pre-assessment and referred from the PHSO in Nov-13 has been formally taken forward. Final reports have been received by the Trust regarding 4 cases; 1 was partially upheld and the PHSO advised that an apology letter be sent to the client, and the remaining 3 cases were not upheld.

Friends and Family Test (FFT)

The Friends and Family Test asks the patient how likely they are to recommend the ward or A&E department to their friends or family. The scoring ranges from:

- Extremely likely;
- Likely;
- Neither likely nor unlikely;
- Unlikely;
- Extremely unlikely.

There is also a “don't know” option which isn't scored, and an opportunity to write further comments. Nationally, Trusts are measured using the Net Promoter Score (NPS) where a score of approximately 50 is deemed good. EKHUFT’s NPS was 56.5 in December. This is the combined satisfaction from 3335 responses from inpatients, A&E and maternity services.

The company iWantGreatCare which reports FFT data on behalf of the Trust have converted the NPS into a "star score" value (ranging from 0 to 5) thus making the interpretation of FFT results easier. The star score is calculated using an arithmetic mean, so a ward that scores 4 stars has an overall average rating of "likely" to be recommended. The Trust score for Dec -13 was 4.48 stars out of 5 stars and is an improvement on last month.

The response rate for Dec-13 for inpatients and A&E achieved the 15% standard this month at 19.3%. This is a continued increase on previous months and awaits Unify2 validation. Once again the wards exceeded the 15% standard with a 26.9% response rate. The A&Es achieved 15% in December reaching the standard for the first time. Maternity services achieved 18.7% combined.

We Care Programme

In order to improve the experience for patients and their visitors, as well as ensuring we look after one another, the Trust is working on the "We Care" Programme. After listening to over 1500 patients and members of staff 3 new Trust values and behaviour standards have been developed. They describe how the Trust employees aim to interact with patients, family members and each other. These values and standards also outline the Trust's ambition to "show that we care" and to provide an excellent experience for everyone who works within the Trust. They will become an integral part of the Trust's working practices and will be used to guide staff recruitment and appraisal processes, illustrate how both patients and colleagues will be cared for, and how improvements in their experience will be measured.

The draft values and standards are listed below. Each of these will be evidenced through a more detailed description of the behaviours that staff and patients want to see.

- CARING: People will feel cared for as individuals. Because we are welcoming and polite; attentive and helpful; we respect people, their dignity and their time, and we have the courage to speak up when others don't.
- SAFE: People will feel safe, reassured and involved. Because we are consistently safe and reassuringly professional, we listen and communicate clearly, and we work as an effective team.
- MAKING A DIFFERENCE: People will feel confident we are making a difference. Because we take responsibility for delivering the best outcomes, act as leaders where we can, and we look to improve and develop ourselves and our services.

In August a summer campaign was undertaken which focused on the following areas:

- Week 1: Mealtime Experience - currently patients score as mainly fair and good rather than excellent.
- Week 2: Pain Management and Hand Hygiene - relating to safety and value number 2.
- Week 3: Seeking and Giving Feedback - making sure we care for each other. The FFT and complaints were the key focus during this time, concentrating on making a difference to each other and the patients.

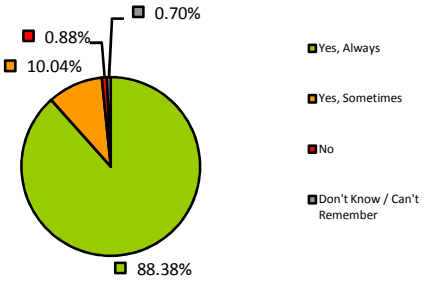
Events took place across the Trust during October by frontline staff. These have sought feedback from patients and families, as well as having discussions about the We Care values within teams. The Steering Group are currently working on the development of the We Care Programme going forward. This includes designing a Trust wide organisational development plan and embedding the values and behaviours into everyday practice.

We have undergone a "branding" piece of work that ensures our communications with each other and the public are empathetic and sensitive. This has been labelled the 'Tone of Voice' work led by Human Resources. In addition, work is in progress to embed the values as part of job

PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

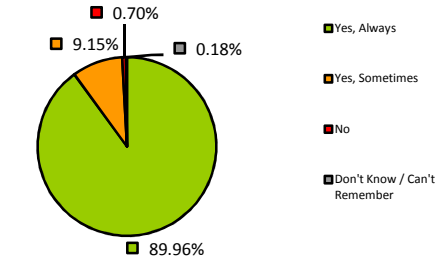
Real time patient experience monitoring using iPads have captured data since 1 Apr-13. During Dec-13 568 adult inpatients were asked about their experiences of being an inpatient; 55 responses were received from patients treated at KCH, 103 from QEH patients, and 410 responses from patients based at WHH. (Compared with the previous month the number of responses were 79, 182 and 430 respectively). The combined result from all submitted questionnaires in Dec-13 was that 87.58% satisfaction.

Were you given enough privacy when discussing your treatment?



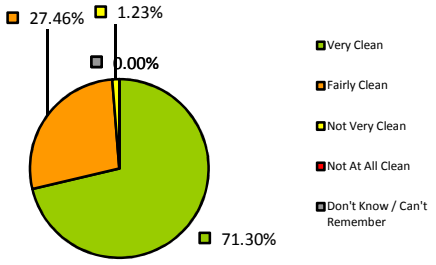
Overall Score = 94.06%

Overall, did you feel you were treated with respect and dignity while you were in hospital?



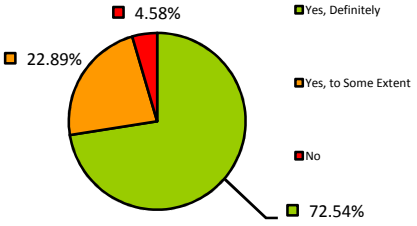
Overall Score = 94.71%

In your opinion, how clean was the hospital room or ward that you were in?



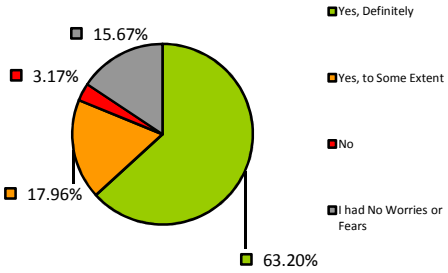
Overall Score = 90.02%

Were you involved as much as you wanted to be in the decisions about your care and treatment?



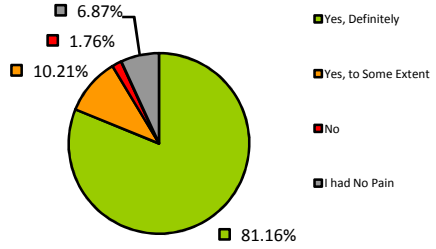
Overall Score = 83.98%

Did you find someone on the hospital staff to talk about your worries and fears?



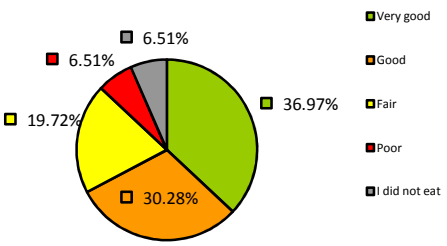
Overall Score = 85.50%

Do you think the hospital staff did everything they could to help control your pain?



Overall Score = 92.63%

How would you rate the hospital food?



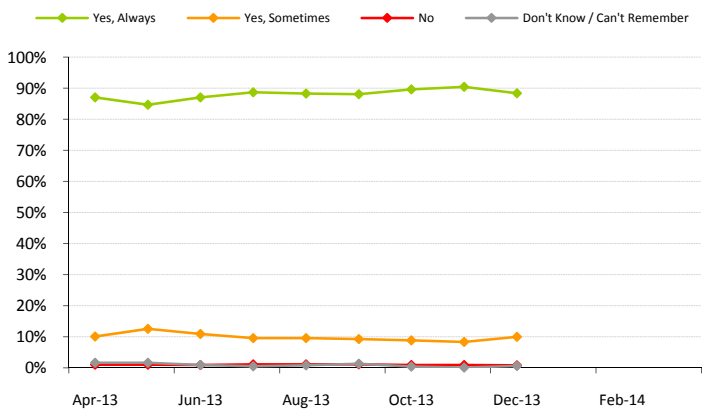
Overall Score = 68.17%

Overall Adult Inpatient Experience Dec-13	
Experience (%)	No. of Responses
87.58	568

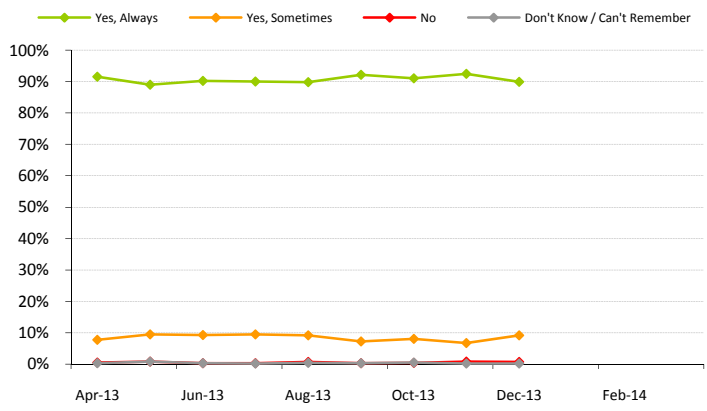
In response to the question "How would you rate the hospital food?" patients are able to answer "very good, good, fair, poor, or I did not eat". This replicates the methodology of the annual national CQC inpatient survey which respectively canvases the opinion of 850 EKHUFT inpatients. In 2012 the results of the national survey indicated that patients rated EKHUFT hospital food below average (52%) when compared with other Trusts. Countrywide the top 20% of Trusts achieved scores of 64 - 79% in response to "How would you rate the hospital food?", suggesting that the survey methodology does not produce very high scores. In the 3 month period form Oct to Dec-13 the real-time monitoring of inpatient experience at KCH, QEH and WHH rated hospital food as 68%, 76% and 69% respectively, and the Trust overall scored 71%. Therefore, if the results of the national CQC inpatient survey in 2013 follow the trend displayed by EKHUFT real-time patient experience monitoring, EKHUFT hospital food will potentially be rated in the top 20%.

PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

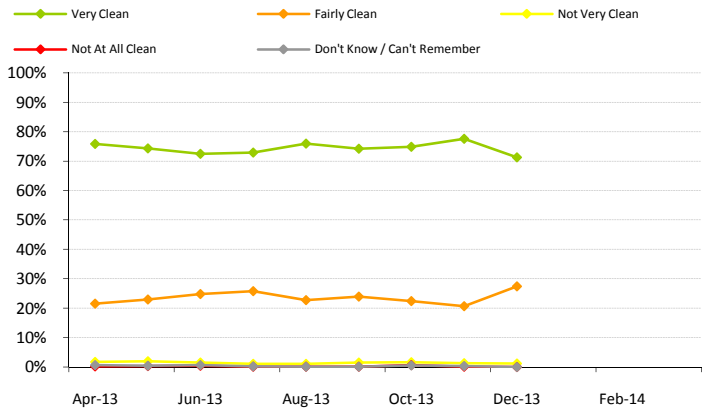
Were you given enough privacy when discussing your treatment?



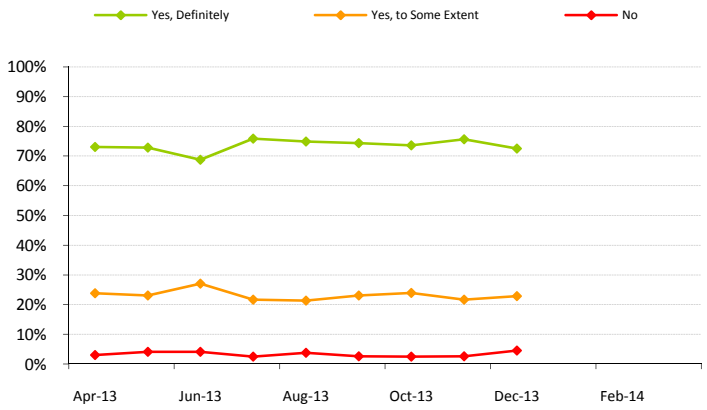
Overall, did you feel you were treated with respect and dignity while you were in hospital?



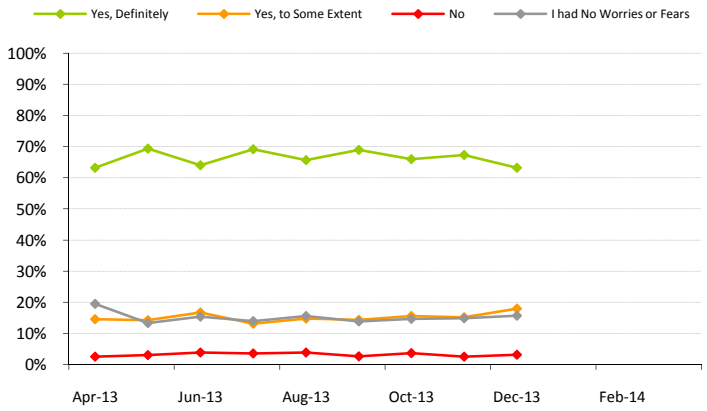
In your opinion, how clean was the hospital room or ward that you were in?



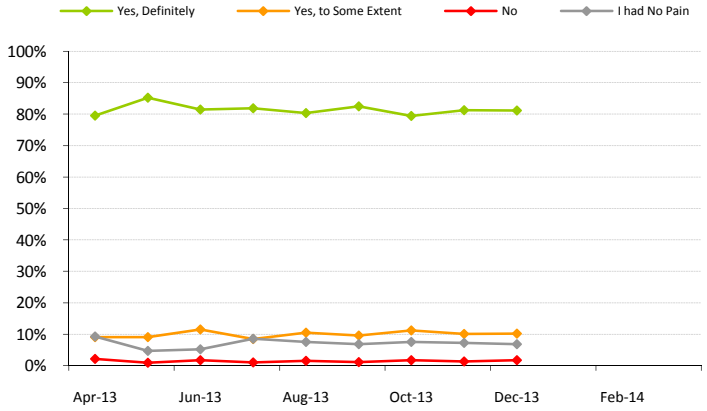
Were you involved as much as you wanted to be in the decisions about your care and treatment?



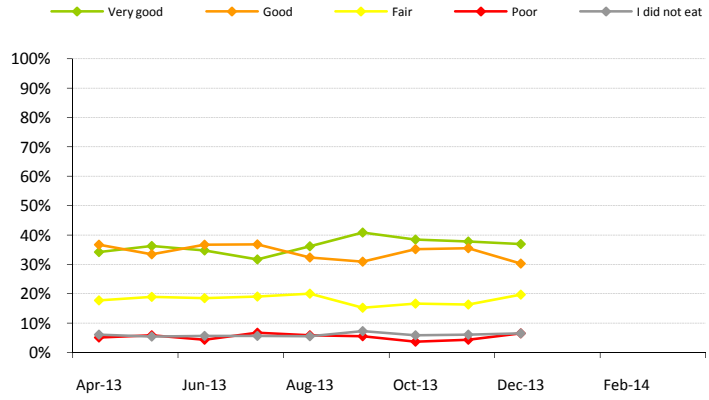
Did you find someone on the hospital staff to talk about your worries and fears?



Do you think the hospital staff did everything they could to help control your pain?



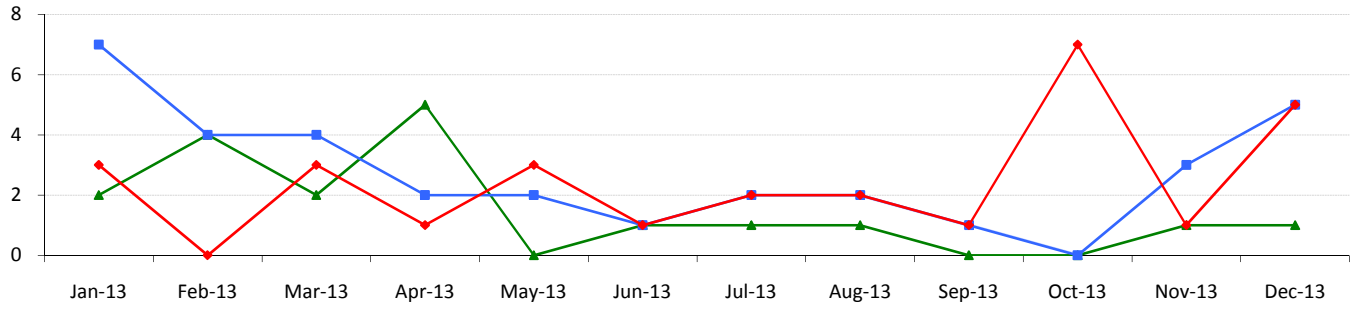
How would you rate the hospital food?



Initiatives are in place to improve nutrition for the Trust's patients, such as a choice of 24 different hot meal options per lunchtime menu, finger foods for those who can not use cutlery, puréed meals, picture menus and assistance when needed. We are working closely with our cleaning teams to ensure that the environment, both clinical and communal, are of a high standard.

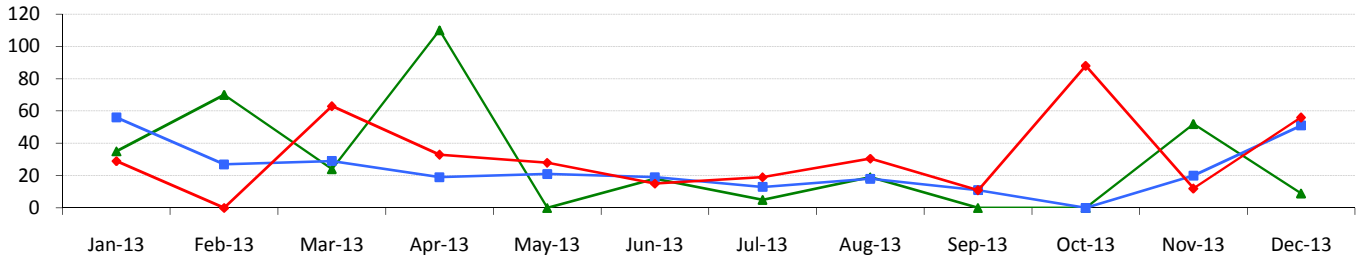
PATIENT EXPERIENCE: MIXED SEX ACCOMMODATION

Number of Episodes of Mixed Sex Occurrence



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
KCH	2	4	2	5	0	1	1	1	0	0	1	1
QEH	7	4	4	2	2	1	2	2	1	0	3	5
WHH	3	0	3	1	3	1	2	2	1	7	1	5

Number of Hours of Mixed Sex Occurrence



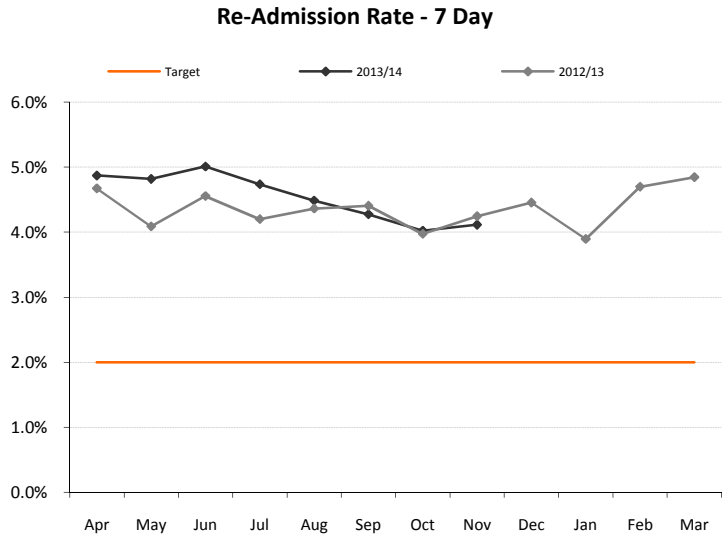
	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
KCH	35	70	24	110	0	18	5	19	0	0	52	9
QEH	56	27	29	19	21	19	13	18	11	0	20	51
WHH	29	0	63	33	28	15	19	30.5	11	88	12	56

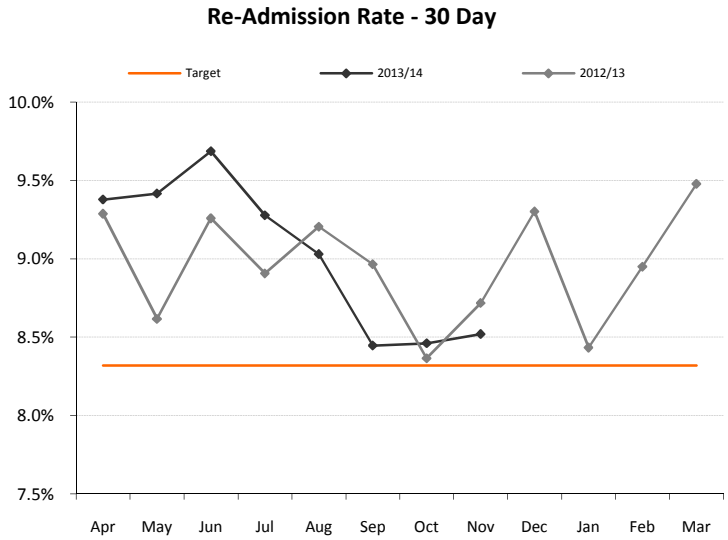
Mixed Sex Accommodation Occurrences December 2013

Site	Clinical Area	Total No. of Occurrences	Total No. of Patients Affected
KCH	Kingston	1	6
QEH	CDU	5	31
WHH	CDU	5	35
TOTAL		**11**	**72**

During Dec-13 there were no reportable mixed sex accommodation breaches to NHS England via the Unify2 system. These were not reported as they complied with CCG criteria, such as clinical need. There were 11 clinically justified mixed sex accommodation occurrences affecting 72 patients. The Trust is working closely with the CCGs in order to ensure that mixed sex accommodation occurrences are minimised as much as possible. This includes reviewing the local policy for delivering same sex accommodation and refreshing the acceptable justifiable criteria as outlined in the 2010 national guidance.

CLINICAL QUALITY & PATIENT SAFETY
CLINICAL EFFECTIVENESS: READMISSION RATES





Since Sep-13, 30 day readmission rates have stabilised and there have been 3 consecutive months of improvement. The 30 day readmission rate for Oct-13 was 8.46% and is similar to the September position. November showed a slight increase at 8.52%, and whilst this may be expected due to the start of seasonal pressure, this value is 0.20% lower than that evident in Nov-12.

A seasonal peak during Nov-13 to Feb-14 is expected as a result of this year's unprecedented level of patient activity during the winter months. The year end forecast for Mar-14 will be revised against the 8.32% target. There is a reasonable risk that this target will be missed, and a more accurate projection is currently being prepared. The Medical Director and new Project Manager will refresh the project and governance arrangements. The initial diagnostic will include identifying interventions that will impact on readmission rates and ensure sustainability. It is envisaged that the diagnostics will be complete with an options appraisal and action plan in place by the end of Mar-14. This will include the proposed rate of improvement for discussion and agreement with Medical Director, Chief Nurse and Divisions.

	CQUIN				2012/13 Baseline	2013/14 Target	YTD Status	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Q1	Q2	Q3	Q4	Year End Position
Performance	Pre-Qualification Criteria		3 Million Lives: Use of Teleheatlh/Telecare Technologies		Zero	Baseline and trajectories in place																		
			International and Commercial Activity		NA	Process in place																		
			Digital First		Various	Baseline & trajectories in place																		
			Support for Carers of Dementia Sufferers		NA	Signposting carers																		
Commentary			3 Million Lives: Use of Teleheatlh/Telecare Technologies		Response to Commissioners sent Apr-13 containing a summary of baseline and trajectories for 3 Million Lives (Telehealth) and Digital First activity. The response also includes commentary on the other Pre-Qualification Criteria applicable this year (International and Commercial Activity), and providing support to carers of patients with dementia (signposting). The Pre-Qualification Criteria do not include targets, but next steps will include the Divisions developing and monitoring growth in Telehealth and Digital First activity. For the signposting carers of dementia sufferers the Trust already provide patients with literature signposting them to support organisations. Performance will be available following implementation of the monthly audit of carers described in the individual CQUIN.																		
			International and Commercial Activity																					
			Digital First																					
			Support for Carers of Dementia Sufferers																					
	National CQUINS																							
Performance	Friends and Family Test	1.1	Increased Response Rate for Inpatients and A&E	Inpatients	To be baselined Q1	Increased response rate	23.5%	0.5%	4.4%	2.7%	9.1%	18.4%	22.5%	23.5%	26.5%	31.8%				2.5%	16.7%			
				A&E	To be baselined Q1	Increased response rate	6.5%	3.7%	2.4%	3.1%	1.7%	5.4%	6.5%	5.8%	7.6%	15.0%				3.1%	4.5%			
		1.2	Phased Expansion		NA	Rollout to maternity by Oct-13									1.8%									
		1.3	Improved Performance on Staff Survey		61%	Improvement																		
	Safety Thermometer	2.1	Monthly Safety Thermometer Data Collection		100% submitted	100% each quarter	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%	100%			
		2.2	Incidence of Avoidable Grade 2 Pressure Ulcers		151	20% reduction in avoidable grade 2 pressure ulcers from 12/13 baseline - no more than 121 in year	67	11	7	11	11	6	5	11	5					29	22			
	Improving Diagnosis of Dementia	3.1	Dementia Case Finding		95.8% Q4 12/13	Average of 90% in each of the elements of the indicator each month for any 3 consecutive months		96.6%	96.9%	97.4%	99.3%	98.8%	100.0%	99.2%	99.6%					96.9%	99.4%			
			Dementia Assessment within 72h		87.2% Q4 12/13			79.5%	75.7%	79.5%	90.7%	95.1%	95.0%	92.5%	95.4%					78.2%	93.6%			
			Appropriate Referral		100%			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					100%	100%			
		3.2	Staff Training		8.5%	20% of appropriate staff trained	17.6%	11.4%	11.4%	13.1%	13.4%	13.3%	14.9%	17.6%	17.9%	20.4%				13.1%	14.9%			
		3.3	Supporting Carers		NA	Monthly audit of support for carers																		
	VTE	4.1	Risk Assessment		95.2%	95.0%	96.4%	98.0%	97.0%	97.0%	97.0%	95.0%	95.0%	96.0%	96.0%	96.0%				97.3%	95.7%	96.0%		
		4.2	Root Cause Analyses of PE and DVT		N/A	60.0% by Q4	69.5%	78.1%	75.6%	70.0%	60.0%	73.3%	60.0%							74.6%	64.4%			
Commentary	Friends and Family Test	1.1	Increased Response Rate for Inpatients and A&E		Response rates are meeting 15% national requirements.																			
		1.2	Phased Expansion		Roll out to maternity went live 30 Sept-13 with the first data submitted to Unify Nov-13.																			
		1.3	Improved Performance on Staff Survey		Survey results will be available Feb-14.																			
	Safety Thermometer	2.1	Monthly Safety Thermometer Data Collection		Monthly safety thermometer data collection is in place from last year.																			
		2.2	Incidence of Avoidable Grade 2 Pressure Ulcers		These data are usually reported 1 month retrospectively, and November data are within trajectory.																			
	Improving Diagnosis of Dementia	3.1	Dementia case finding		Performance continues to meet the requirement to have an average of 90% or greater each month for any 3 consecutive months. Now eligible for partial payment of 1/3 related to 1 of the 3 measures.																			
			Dementia assessment within 72h		Performance now meets the requirement to have an average of 90% or greater each month for any 3 consecutive months. Now eligible for partial payment of 1/3 related to 1 of the 3 measures.																			
			Appropriate referral		Performance continues to meet the requirement to have an average of 90% or greater each month for any 3 consecutive months. Now eligible for partial payment of 1/3 related to 1 of the 3 measures.																			
		3.2	Staff training		Plans are in place to ensure that training continues to be conducted, and the year end target of 20% has been achieved 1 quarter early.																			
		3.3	Supporting Carers		The definition of a carer has been documented and process methodology designed and implemented. An audit of 10 carers per site per month was conducted for 3 months. Of those, many were already receiving support with only 17% agreeing to have their details forwarded to a Carers Support Organisation. The audit is continuing and its findings and recommendations will be reported later in the year.																			
	VTE	4.1	Risk Assessment		Performance has met or exceeded the target of 95% of inpatients assessed (eDN reported).																			
		4.2	Root Cause Analyses of PE and DVT		The target is RCAs to be conducted on 60% of Hospital Acquired Thrombolysis (HAT). A more efficient way of identifying VTEs (via Radiology) will be explored once the migration to the new radiology system is complete. This measure will always have a time lag of at least 3 months, and quarterly reporting has been agreed 1 quarter retrospectively. First quarter results are now available and confirm that the Trust is currently exceeding the 60% target. Second quarter performance will be reported in Jan-14.																			

Compliance Against Performance	
	On target
	Monthly target missed; quarterly/annual target at risk
	Monthly target missed; annual target at risk

CLINICAL QUALITY & PATIENT SAFETY
CLINICAL EFFECTIVENESS: CQUIN MONTHLY MONITORING AND PERFORMANCE

	Local CQUIN			2012/13 Baseline	2013/14 Target Minimum	2013/14 Target Maximum	YTD Status	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Q1	Q2	Q3	Q4	Year End Position
Performance	Enhancing Quality and Recovery Programme (EQRP)	5.1	AKI (EQ)	Pilot	Establish pathway																			
		5.2	#NoF (EQ)	NA	Establish pathway																			
		5.3	Heart Failure (EQ) (Jul to Dec-13)	40.8%	48.3%	52.8%	71.9%	68.5%	46.4%	50.0%	46.9%	70.7%	65.0%	57.7%	71.0%	90.0%								
		5.4	CAP (EQ) (Jul to Dec-13)	48.6%	48.1%	58.7%	58.1%	41.0%	46.9%	44.6%	46.7%	47.8%	50.8%	59.0%	53.7%	61.5%								
		5.6	H&K (ER) (Sept-13 to Feb 14)	8.3%	26.2%	38.3%	93.9%	93.1%	91.7%	42.9%	78.8%	91.9%	93.9%	92.9%						75.9%	88.2%			
		5.7	Colorectal (ER) (Sept-13 to Feb-14)	13.7%	12.6%	36.2%	77.8%	38.2%	42.4%	52.9%	34.5%	52.2%	63.2%	77.8%						44.5%	49.9%			
		5.8	Gynaecology (ER) (Sept-13 to Feb-14)	15.5%	14.4%	35.5%	94.7%	84.8%	87.2%	87.8%	94.6%	90.7%	94.7%	97.4%						86.6%	93.3%			
		5.9	Improve Readmission Rate HF (EQ)		Develop a joint action plan with KCHT																			
		5.10	Patient Experience HF/H&K (EQ/ERP)	Pilot	Submit patient experience data																			
		5.11	Prescribing of Anti-psychotic Drugs (EQ)	33.3%	95% from Sep-13 data			40.0%	80.0%	80.0%	100.0%	75.0%	87.5%	100.0%						66.7%				
	Respiratory Disease	6.1	Referral for Smoking Cessation Service	Q1 13/14 - 7.1%	Process, baseline, trajectories and improvement		7.2%	7.7%	4.2%	9.1%	9.1%	6.9%	10.5%	7.7%	14.5%	4.4%				7.1%	7.2%			
		6.2	Referral for Pulmonary Rehabilitation Services	Q1 13/14 - 3.6%	Process, baseline, trajectories and improvement		4.5%	3.8%	3.6%	3.5%	4.1%	3.6%	2.5%	5.6%	4.5%					4.1%	3.4%			
	Stroke	7.1	Door to Needle Time	13.0% of patients	23% of patients by Q4		25.1%	25.0%	19.0%	33.0%	28.6%	18.0%	27.0%	33.3%						25.7%	24.5%			
		7.2	Admission to Stroke Unit	80.2%	85.0% acute stroke patients by Q4		82.9%	77.0%	76.0%	87.0%	90.0%	86.0%	81.0%	83.0%	89.0%					80.3%	85.7%			
		7.3	Quarterly Audit of Brain Scans <12h	NA	Quarterly audit of brain scans conducted within 12h		Audit Only	38.0%	41.0%	62.4%	82.9%	86.9%	86.0%	85.7%	84.0%									
		7.4	Stroke Pathway/Supported Discharge	NA	Measure pathway		Audit Only																	
	Breastfeeding/ Smoking Cessation Referral	8.1	Referral to Smoking Cessation Service	46.0%	TBA		56.4%	58.0%	57.0%	62.0%	54.6%	56.0%	50.8%	54.0%	50.0%					59.0%	55.3%			
		8.2	Breast feeding within 48h of Birth	67.4%	TBA		68.9%	66.3%	68.8%	68.5%	69.3%	69.6%	71.0%	69.3%	64.2%					67.9%	69.5%			
		8.3	Breastfeeding at 10 days after Birth	55.7%	TBA		57.8%	54.5%	57.8%	59.4%	59.1%	59.3%	57.1%	57.3%	54.9%					57.6%	56.4%			
	Post Op Complications	9.1	Post Operative Complications of Joint Replacement Surgery	NA	Audit																			

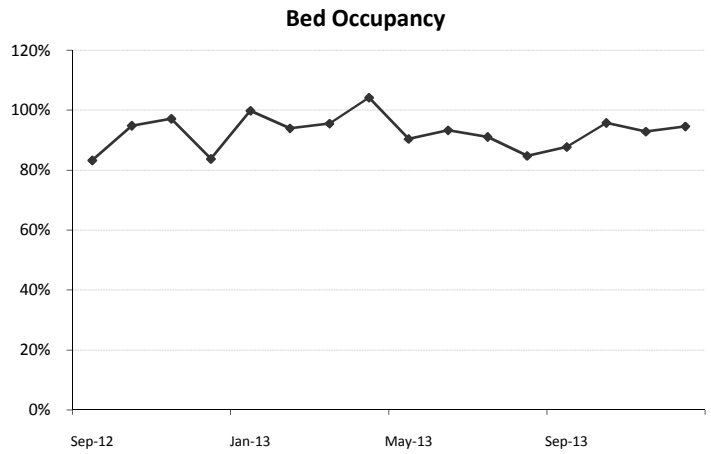
Commentary			General	Targets have now been published with a partial payment being possible if a minimum target is achieved. The level of this partial payment is currently being clarified. Minimum scores for the improvement targets have been updated as per recent advise from the EQ Team. ERP targets will apply for the period Sep-13 to Feb-14 and success is measured on the Trust's average performance over that period. There is therefore a transition period between Apr-Sep to introduce data collection of the new measures included in the care bundles. EQP targets apply for the period Jul13 to Dec-13 and success is measured on the Trust's average performance over that period.
	Enhancing Quality and Recovery Programme (EQRP)	5.1	AKI (EQ)	This is a measurement pathway with no targets currently set. The EQ team have indicated that as more providers demonstrate their ability to collect data, they may choose to introduce a target part way through the year. A response to this would need to be considered if published. They have also indicated a desire to consider measuring the AKIM 3 patient group and discussions are taking place.
		5.2	#NoF (EQ)	There are no targets for the #NoF pathway, this is an establishing pathway measure.
		5.3	Heart Failure (EQ)	A meeting to discuss the coding process has taken place. Improved record keeping/coding and regular MDM meetings, alongside other improvements, appear to have had a positive impact with this pathway exceeding the target. September results are provisional.
		5.4	CAP (EQ)	This pathway has previously experienced poor performance around recording of CURB 65, referral to the Smoking Cessation Team and antibiotics within 6 hours. A full action plan has been applied to ensure that this pathway improves and the impact of this has been seen in improved results in the last 2 months (ie June data 50.8% and July data 59.0%) with the 58% target being exceeded for the first measurement month of Jul-13. August data has only exceeded the minimum target, and ongoing focus will remain to help ensure that these pathway improvements are sustained and continue to grow.
		5.6	H&K (ER)	The Trust is already performing significantly above target (ie Oct-13 is 92.3% against a target of 38.3%).
		5.7	Colorectal (ER)	The Colorectal Pathway is impacted by a low usage of IOFM within the pathway. A review of IOFM usage for all procedures has been completed. Performance continues to improve since a dip in July, and is exceeding the target of 36.2% (ie Oct-13 is 77.8%).
		5.8	Gynaecology (ER)	The Trust is already performing significantly above target (ie Oct-13 is 97.4% against a target of 35.5%).
		5.9	Improve Readmission Rate HF (EQ)	A joint action plan with KCHT is required to address improving the readmission rate for HF patients. Baseline data on the patient group are being obtained. The Community Heart Failure Nurse is attending the regular internal HF meetings. An initial RCA meeting has taken place and further RCA work planned.
		5.10	Patient Experience HF/H&K (EQ/ERP)	Submission of Heart Failure patient experience data is up-to-date. Some of the H&K patient experience data collected is being clarified internally. Response rates are above target, and responses to the data received are being developed.
		5.11	Prescribing of Anti-psychotic Drugs (EQ)	The period of Jan to Jul-13 was a non target driven audit of APD GP follow up within 30 days of discharge. From September the Trust will be measured against a 95% target for the period Sep13 to Mar-14. A small population increases the risk to achieving this target consistently.
	Respiratory Disease	6.1	Referral for Smoking Cessation Service	Referral to the Smoking Cessation Service is recorded in PAS. Improvement targets for this measure are still to be agreed, but YTD figures show an improvement against Q1 baseline. the figures for December are provisional and are likely to increase in final reporting.
		6.2	Referral for Pulmonary Rehabilitation Services	Baseline data is sourced from PAS. However, a COPD section has been launched within the eDN to enable referrals to be sent automatically to the Community Team, and it is intended to replace the current PAS/paper process. For a temporary period there will be dual reporting from eDN and PAS. December data are not yet available.
	Stroke	7.1	Door to Needle Time	The 2012/13 baseline equalled 13% with an agreed target of 23% by Q4. Data will always be reported 1 month retrospectively, and Nov-13 data will not be available until later in Jan-14. Year to date data confirm improvement in performance.
		7.2	Admission to Stroke Unit	The 2013/14 data demonstrate improvement. Data are reported 1 month retrospectively.
		7.3	Quarterly Audit of Brain Scans <12h	This measure is now sourced from the Radiology Information System and will be reported 1 month retrospectively.
		7.4	Stroke Pathway/Supported Discharge	Collaboratively working with Community Early Supported Discharge team to audit patient pathway including functional ability and return to usual place of residence. Much of the data is contained within the National Stroke Audit (SSNAP).
	Breastfeeding/ Smoking Cessation Referral	8.1	Referral to Smoking Cessation Service	An improvement target is still to be agreed. Current data reported is on the number of smoking mothers who take up a referral to the Smoking Cessation Service. Rates on the number of smoking mothers offered a referral are also available, and in Nov-13 equalled 94%.
		8.2	Breast feeding within 48h of Birth	An improvement target is still to be agreed. Monthly performance will be reported 1 month retrospectively. Year to date there has been improvement in the referral rate, with improved performance against baseline consistently since May-13.
		8.3	Breastfeeding at 10 days after Birth	An improvement target is still to be agreed. Monthly performance will be reported 1 month retrospectively. Year to date there has been improvement in the referral rate.
	Post Op Complications	9.1	Post Operative Complications of Joint Replacement Surgery	An audit has been conducted and an action plan will be shared with CCG Clinical Lead.

Compliance Against Performance	
	On target
	Monthly target missed; quarterly/annual target at risk
	Monthly target missed; annual target at risk

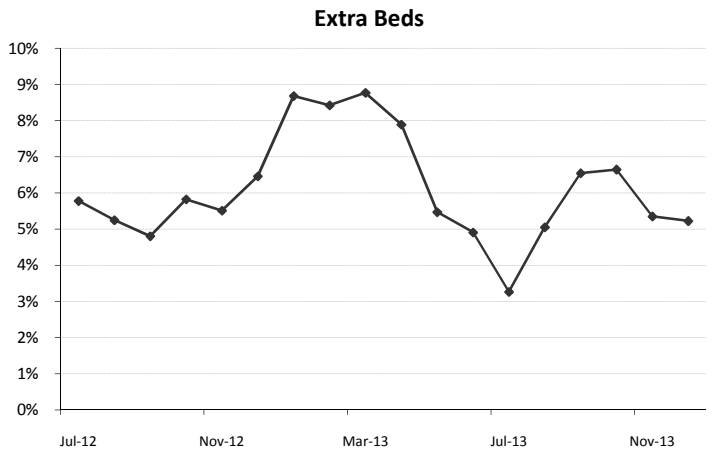
CLINICAL QUALITY & PATIENT SAFETY
CLINICAL EFFECTIVENESS: SPECIALIST CQUINS MONTHLY MONITORING AND PERFORMANCE

	Specialist CQUIN		2012/13 Baseline	2013/14 Target	YTD Status	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Q1	Q2	Q3	Q4	Year End Position
	National CQUINS																					
Performance	**ODNs**	Support the Operational Delivery Networks (ODNs)	N/A	Provide financial support to ODNs																		
Performance	**Quality Dashboard**	Regular submission of data via a Specialised Services Quality Dashboard	N/A	Submit data to Specialty Dashboard as per reporting schedule																		
Commentary	**ODNs**	Support the Operational Delivery Networks (ODNs)	EKHUFT currently support the Cancer Network, including hosting. The Trust has also expressed interest in there being ODNS for Renal and Vascular and the Commissioner has responded positively to these suggestions. Rebates for the charge to support the ODNS will be available to acknowledge the delays by Commissioners in putting ODNs into place.																			
Commentary	**Quality Dashboard**	Regular submission of performance data via a Quality Dashboard	Concern has been expressed to the Commissioners as to the security of the data submission process and they have assured that this is currently being improved. Data submission will not take place until this has been addressed. A reporting schedule and confirmed process has not yet been provided. Active work streams for the three key elements of the Quality Dashboards (Neonatal, Renal, Haemophilia) have all been identified. Still awaiting data from Renal and Haemophilia, and work is on going to make the Neonatal data source a more automated process to remove burden on the consultant workload.																			
	Local CQUINS																					
Performance	**Renal**	AKI pathway data collection	N/A	Data collection and submission																		
Performance	**Cancer Services**	To assess the impact of CNS support on the patients' experience of their cancer journey and agree action plan to improve experience	N/A	Gather patient feedback and produce action plan			Await National Cancer Survey results (Jul-13)															
Performance	**Cardiac Inpatient Pathway**	Audit Cardiac Inpatient Pathway and publish improvement plan	N/A	Audit and action plan implemented																		
Performance	**Haemophilia**	At least 50% of registered severe and moderate haemophilia A and B patients aged 4 years and over receiving a Joint Score Assessment by a trained physiotherapist in the last 12 months	70.0%	50.0%	56.0%	1.0%	18.0%	28.0%	32.0%	52.0%	56.0%	59.0%	62.0%					28.0%	56.0%			
Performance	**Neo Natal**	Timely administration of total parenteral nutrition (TPN) for preterm infants	36.5%	TBA Q1	80.7%	100.0%	100.0%	33.0%	71.0%	80.0%	100.0%	100.0%	100.0%					77.7%	100.0%			
Commentary	**Renal**	AKI Pathway data collection	AKI pathway data is already captured, and the Trust has been participating in a pilot submitting baseline data since Sep-12. National detail on EQ requirements still being finalised.																			
Commentary	**Cancer Services**	To assess the impact of CNS support on the patients' experience of their cancer journey and agree action plan to improve experience	The National Cancer Survey has confirmed <10 patients with rarer cancers. The CCG has indicated that gathering further patient feedback may not be required and this needs confirming in writing.																			
Commentary	**Cardiac Inpatient Pathway**	Audit Cardiac Inpatient Pathway and publish improvement plan	A working party has been formed, and development of methodology for auditing the pathway is underway. (The working party includes General Manager, Service Improvement and Cardiology Matron). A Cardiac Pathway dashboard has now been developed and will be the source of all performance data for all patients.																			
Commentary	**Haemophilia**	At least 50% of registered severe and moderate haemophilia A and B patients aged 4 years and over receiving a Joint Score Assessment by a trained physiotherapist in the last 12 months	Performance is measured against trajectories set for both 100% achievement, and 50% target agreed. The 2013/14 performance to date exceeds the 50% target for the year.																			
Commentary	**Neo Natal**	Timely administration of total parenteral nutrition (TPN) for preterm infants	Due to the small number of eligible babies involved (usually 0 - 10), performance (%) can heavily fluctuate. An improvement target was due to be set at the end of Q1.																			

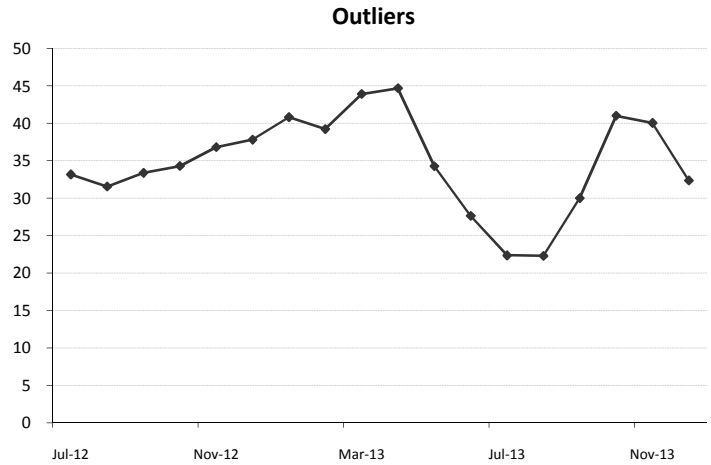
Compliance Against Performance	
	On target
	Monthly target missed; quarterly/annual target at risk
	Monthly target missed; annual target at risk



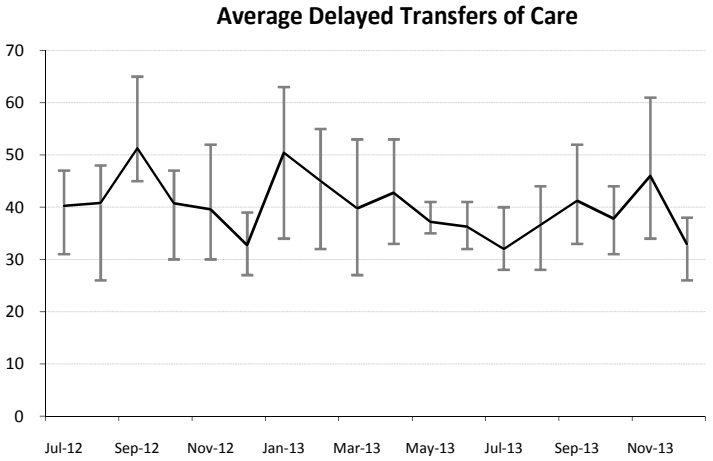
The bed occupancy metric looks only at adult inpatient beds and excludes any ring fenced wards such as Maternity. Occupancy peaked at over 100% during Apr-13, but has since reduced. Occupancy in December has increased slightly on the previous month with a position of 94.55% and still sits it above the Trust target which is to achieve 85% bed occupancy.



This metric is built up using the number of funded beds on each ward and reviewing those occupied on a daily basis. Where the number of occupied beds exceeds the funded bed base for the ward these are classified as "extra". During December, 5.22% of the Trust's bed days were delivered using extra "unfunded" beds. This is a slight reduction on the previous couple of months, and when reviewed in conjunction with the stability of the bed occupancy in month it could suggest an alleviation of the pressure previously on EKHUFT hospital sites. However, towards the end of the month extra capacity was re-opened to meet demand, and this may be evidenced in the Jan-14 data.



The outliers data show the average number of patients bedded in a ward outside of the relevant Division over a given month. In line with the number of extra beds, the number of outliers peaked in April when the Trust, and the local health economy, was under extreme pressure with unseasonably high emergency flows. After 2 consecutively high months, performance in December dropped to levels previously seen in September. It is hoped this position will stabilise moving into 2014, underpinned by a reduction in extra beds and the current stable bed occupancy performance.



In Dec-13, the number of patients on the Delayed Transfers of Care (DToC) list has decreased to levels previously seen in Jul-13. This follows months of increases which culminated in the high November position.
Average DToC decreases were due, in part, to the action plans put in place to help improve this situation. The UCLTC Division has introduced "whole systems" board rounds to support early identification of patients who can be discharged back to Community or Primary Care. Work is continuing to identify patients who can be cared for in the community earlier in their care journey, and also to ensure that discharge planning is commenced on admission.