CLINICAL QUALITY & PATIENT SAFETY PERFORMANCE SUMMARY

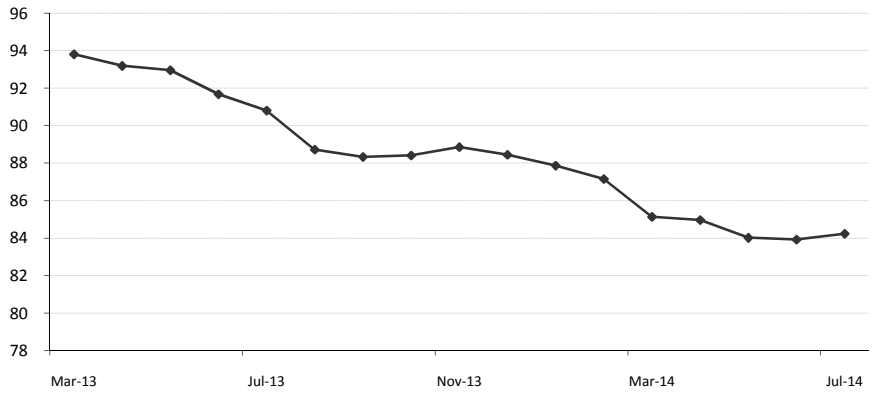
Introduction

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 14/15	Jul-14	Jul-13	vs Jul-13	YTD
Patient Safety	Mortality Rates	HSMR		-	84.2	90.8	↓	84.3
					Q4 13/14	Q4 12/13	vs Q4 12/13	YTD
		SHMI (%)		-	106.44%	103.67%	↑	-
					Oct-14	Oct-13	vs Oct-13	YTD
		Crude Mortality: All Ages (Per 1 000)	Non-Elective	-	25.116	31.819	↓	26.614
			Elective	-	0.529	0.207	↑	0.315
	Risk Management	Serious Incidents (STEIS)	New Incidents	-	5	8	↓	-
			Open Incidents	-	60	28	↑	Cumul.
	HCAI	MRSA	Attributable	5	1	5	↓	Cumul.
		C. difficile	Post 72h	47	36	35	↑	Cumul.
	Infection Prevention	Mandatory Training Compliance (%)		95.0%	82.6%	85.1%	↓	83.0%
	Harm Free Care (HFC)	Safety Thermometer HFC (%) - Old & New Harm	EKHUFT	93.0%	93.2%	89.0%	↑	94.0%
			National	-	93.9%	93.4%	↑	-
	Nurse Sensitive Indicators	Pressure Ulcers: Category 2,3 and 4	Acquired	-	21	29	↓	130
			Avoidable	99	4	10	↓	44
		Falls		-	163	186	↓	1146
	Clinical Incidents	Total Clinical Incidents		-	1091	1047	↑	7660
Patient Experience	Compliments and Complaints	Compliments:Complaints		-	22:1	14:1	↑	-
		No. Care Spells per Formal Complaint		-	707	1055	↓	-
	Experience	Friends and Family Test (Star Rating)		5.0	4.4	4.6	↓	-
		Adult Inpatient Experience (%)		80.00%	89.20%	88.70%	↑	-
		Mixed Sex Accommodation Occurrences		-	9	7	↑	61
Clinical Effectiveness	Readmission				Sep-14	Sep-13	vs Sep-13	YTD
		7 Day (%)		2.00%	3.84%	3.94%	↓	4.28%
		30 Day (%)		8.32%	8.54%	8.19%	↑	8.87%
	CQUIN				Oct-14	Oct-13	vs Oct-13	YTD
		Standard Contract CQUIN		Multiple			↔	
		Specialist CQUIN		Multiple			↔	
	Bed Usage	Bed Occupancy (%)		-	91.03%	99.78%	↓	-
		Extra Beds (%)		-	4.32%	7.27%	↓	5.47%
		Outliers		-	21.52	41.00	↓	166.15
		Delayed Transfers of Care (Average)		-	29.40	37.80	↓	35.31
Care Quality Commission	Intelligent Monitoring Report	Outcome Measures	Risks	-	6	-		-
			Elevated Risks	-	2	-		-

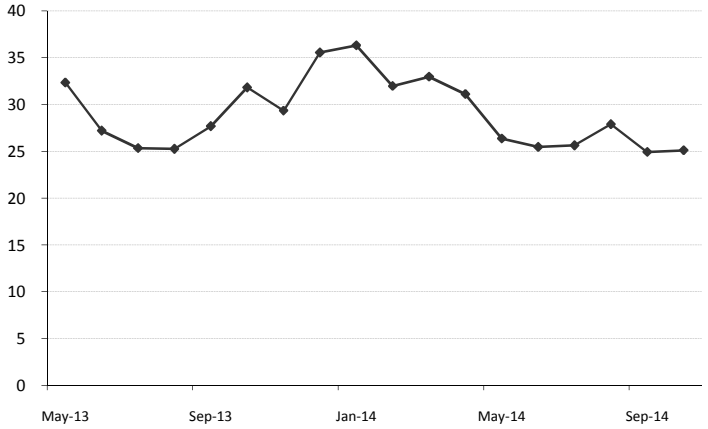
CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: MORTALITY RATES

Hospital Standardised Mortality Ratio (HSMR) - All Discharges



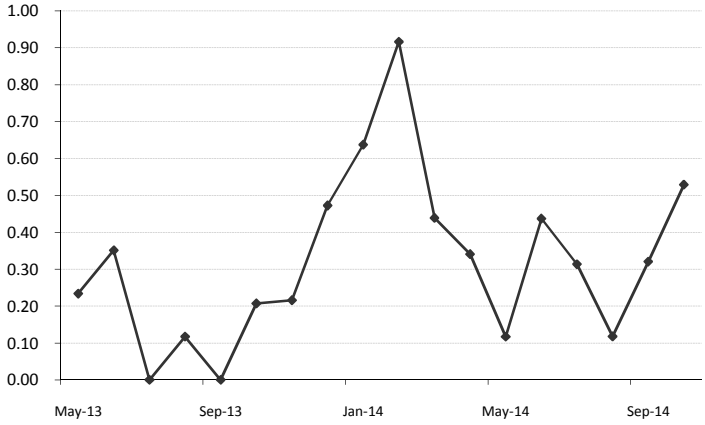
The Trust has changed HSMR data providers from Dr Foster to CHKS. As defined by CHKS, Hospital Standardised Mortality Ratios (HSMRs) compare the number of expected deaths with the number of actual deaths, in hospital. The data are adjusted for factors statistically associated with hospital death rates. Severity of illness is an important factor on mortality and the methodology acknowledges this by using a measure of co-morbidity called the Charlson index, which looks at a number of secondary diagnoses and scores them according to severity.
HSMR performance at Trust level remains good. HSMR in Jul-14 equalled 84.2 (that is, showing a 0.3 against Jun-14) and compares with a position of 90.8 in Jul-13.

Crude Mortality - Non-Elective per 1 000



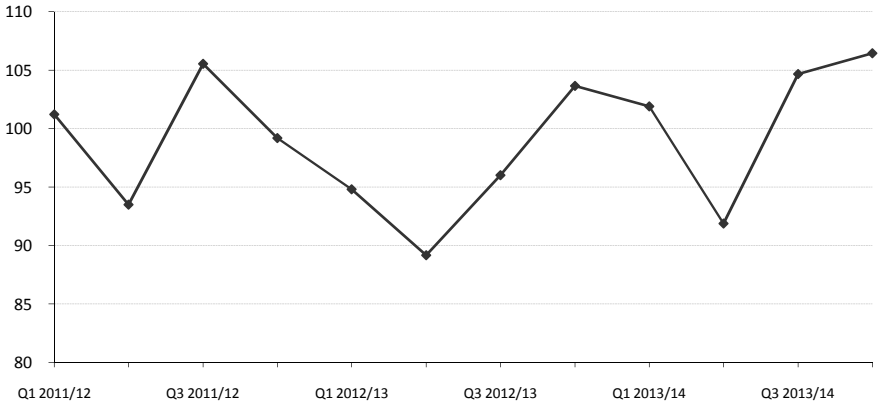
Crude mortality for non-elective patients shows a fairly seasonal trend with deaths higher during the winter months. The winter peak during 2013/14 has since faded, and following this trend the performance in Oct-14 equalled 25.116 deaths per 1 000 population approximating September's position of 24.933. This trend appears to have stabilised over the past 6 months.

Crude Mortality - Elective per 1 000



During February elective crude mortality was 0.916 deaths per 1 000 population, which dropped back to expected levels as seen in March at a rate of 0.439. April's position stabilised this once more, achieving 0.341 and again in May, achieving 0.117. Since May levels appear to be following seasonal trends with the position in Oct-14 equalling 0.529 deaths per 1 000 population, which is higher than the previous month (i.e. 0.320 deaths per 1 000 population).

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 (CHKS) and are updated on a quarterly basis.
The most recent data for Q4 2013/14 indicate a SHMI value of 106.44 in line with a value last reported in Q3 2011/12.

Serious Incidents - Open Cases

Date		Summary of Serious Incident & Remedial Action Taken	IX lv	Division	Timely Submit?
Incident	STEIS Report				
25-Oct-14	31-Oct-14	Unexpected Admission - NICU	2	Specialist	72h report sent
26-Sep-14	17-Oct-14	Category 3 hospital acquired pressure ulcer (avoidable)	1	UCLTC	Not Due
10-Oct-14	15-Oct-14	Unexpected Admission - NICU	2	Specialist	72h report sent
8-Jun-14	9-Oct-14	Fall	1	Surgical	Not Due
8-Oct-14	9-Oct-14	Unexpected Death	1	Surgical	Not Due
11-Aug-14	12-Sep-14	Fall - arm weakness	1	UCLTC	Not Due
25-Aug-14	12-Sep-14	Delayed Diagnosis	1	UCLTC	Not Due
29-Aug-14	12-Sep-14	Unexpected Admission - NICU	2	Specialist	72h report sent
2-Sep-14	5-Sep-14	Hospital Transfer Issue	1	UCLTC	Breach
3-Jul-14	2-Sep-14	Category 3 hospital acquired pressure ulcer (avoidable)	1	Surgical	Extension
15-Jun-14	1-Sep-14	Delayed Diagnosis	1	UCLTC	Not Due
21-Aug-14	29-Aug-14	Unexpected Admission - NICU	2	Specialist	72h report sent
24-Aug-14	29-Aug-14	Delayed Diagnosis	1	Surgical	Extension
27-Aug-14	29-Aug-14	Intrapartum Death - term infant	2	Specialist	72h report sent
3-Aug-14	13-Aug-14	Unexpected Admission - NICU	2	Specialist	72h report sent
13-Aug-14	13-Aug-14	Adverse Media Coverage - CQC report and breach of licence as Foundation Trust	2	Trust	Stop the
23-Jul-14	30-Jul-14	Category 3 hospital acquired pressure ulcer (avoidable)	1	UCLTC	Breach
19-Jul-14	23-Jul-14	Unexpected Death - neonatal	2	Specialist	Stop the Clock
7-Jul-14	18-Jul-14	Category 3 hospital acquired pressure ulcer (avoidable)	1	UCLTC	Breach
7-Apr-14	10-Jul-14	Fall - resulting in permanent harm	1	UCLTC	Yes
27-Jun-14	4-Jul-14	Category 3 hospital acquired pressure ulcer (avoidable)	1	UCLTC	Yes
26-Jun-14	27-Jun-14	Unexpected Death - neonatal	2	Specialist	Stop the Clock
16-Jun-14	26-Jun-14	C. diff and Healthcare Acquired Infections	1	UCLTC	Yes
28-May-14	16-Jun-14	Category 3 hospital acquired pressure ulcer (avoidable)	1	Surgical	Yes
20-Mar-14	13-Jun-14	Fall - resulting in subdural haematoma	1	UCLTC	Yes
20-May-14	2-Jun-14	Missed Diagnosis - meningitis	2	Specialist	Yes
27-May-14	2-Jun-14	Unexpected Death	1	UCLTC	Breach
19-May-14	21-May-14	Unexpected Admission - NICU	2	Specialist	Extension
7-Mar-14	13-May-14	Unexpected Death - endoscopic bleed	1	UCLTC	Yes
11-May-14	12-May-14	Suboptimal Care - deteriorating patient	1	UCLTC	Breach
6-May-14	8-May-14	Unexpected Death - displacement of tracheostomy tube	1	UCLTC	Breach
31-Mar-14	1-May-14	Serious Injury - upper limb infarction following cannulation	1	UCLTC	Yes
28-Apr-14	29-Apr-14	Surgical Error - agency surgeon	1	Surgical	Breach
13-Jan-14	24-Apr-14	Category 3 hospital acquired pressure ulcer (avoidable)		UCLTC	Breach
18-Mar-14	11-Apr-14	Unexpected Death - transfer/missed diagnosis	1	UCLTC	Breach
7-Apr-14	11-Apr-14	Category 3 hospital acquired pressure ulcer (avoidable)	1	UCLTC	Breach
8-Apr-14	10-Apr-14	Unexpected Death - post debridement	1	Surgical & UCLTC	Breach
3-Apr-14	3-Apr-14	Never Event - retained vaginal swab post delivery		Specialist	Breach
10-Mar-14	24-Mar-14	Suboptimal Care - deteriorating patient	1	Surgical	Breach
19-Feb-14	13-Mar-14	Unexpected Death - pericardial effusion	1	UCLTC	Breach
1-Mar-14	10-Mar-14	Never Event - wrong site pleural aspiration	2	UCLTC	Breach
9-Jan-14	25-Feb-14	Unexpected Death - venous thomboembolism at 6 weeks postoperative		Surgical	Yes
11-Oct-13	30-Oct-13	Allegation against a member of staff	1	UCLTC	Extension
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	Stop the Clock
22-Jan-13	24-Jan-13	Never Event - wrong site surgery: pleural aspiration		UCLTC	Yes
7-Jan-13	11-Jan-13	Never Event - wrong site surgery: Ophthalmology	2	Surgical	Yes

Serious Incidents - Partially Closed Cases

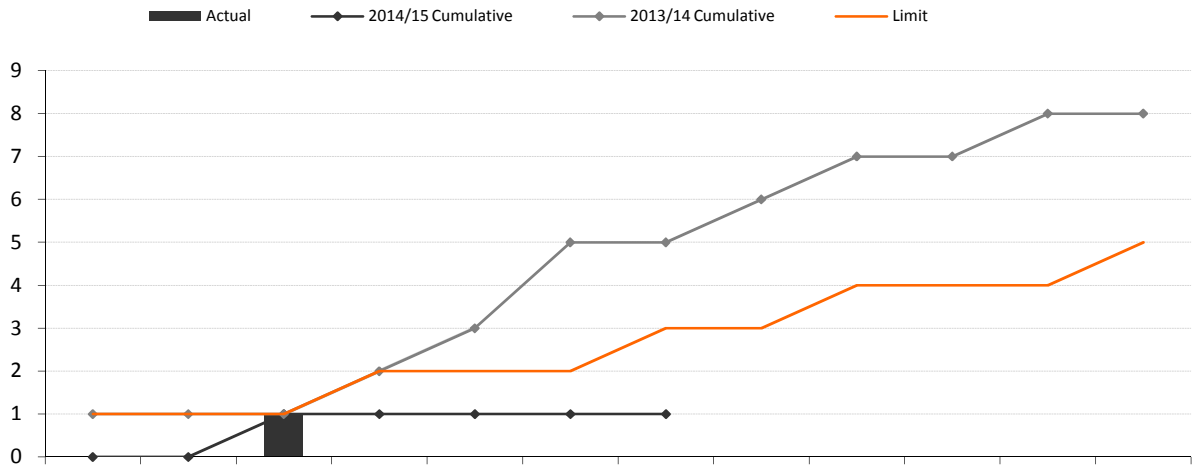
Serious Incidents closed by KMCS but remaining open on STEIS pending review by external bodies.

Date		Summary of Serious Incident & Remedial Action Taken	IX lv	Division
Incident	STEIS Report			
17-Jun-14	1-Jul-14	Intrauterine Death	2	Specialist
8-Mar-14	13-May-14	Missed Diagnosis - meningitis	2	UCLTC
10-Mar-14	13-May-14	Unexpected Admission - term baby to NICU	2	Specialist
5-May-14	9-May-14	Unexpected Admission - NICU	2	Specialist
16-Apr-14	22-Apr-14	Unexpected Admission - NICU	2	Specialist
5-Apr-14	10-Apr-14	Unexpected Admission - NICU	2	Specialist
3-Apr-14	3-Apr-14	Intrapartum Death - placental abruption	2	Specialist
19-Mar-14	20-Mar-14	Neonatal Death - home birth	2	Specialist
19-Feb-14	25-Feb-14	Unexpected Neonatal Death	2	Specialist
24-Jan-14	24-Jan-14	Neonatal Death - unexpected breach delivery at home, taken to QEH	2	Specialist
6-Nov-13	11-Nov-13	Never Event - misplaced nasogastric tube	2	UCLTC
17-Jun-13	27-Jun-13	Screening Issue - diabetes eye screening programme and Hospital Eye Services (HES)	1	UCLTC
28-Nov-12	14-Feb-13	Unexpected Death	1	Surgical
4-Sep-12	13-Sep-12	Neonatal Death - following shoulder dystocia	1	Specialist

Five serious incidents were reported on STEIS during Oct-14. These were: 2 unexpected admissions to NICU, an unexpected death, an avoidable hospital acquired Category 3 pressure ulcer and a Fall. The Trust has had 3 incidents closed on STEIS by the CCGs and 1 pressure ulcer incident removed from STEIS as it was found to be an avoidable Category 2 (not 3 or 4) hospital acquired pressure ulcer. At the end of Oct-14, there were 14 incidents awaiting Area Team or other external body review; 1 of which was reopened as the Area Team had not reviewed prior to closure. Root Cause Analysis (RCA) reports have been presented either to the Trust Quality Assurance Board, Patient Safety Board or to the site based Pressure Ulcer Panels. These included the findings of the investigations and action plans to take forward recommendations, including mechanisms for monitoring and sharing learning. At the end of Oct-14 there were 60 serious incidents open on STEIS.

CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: HOSPITAL ACQUIRED INFECTIONS

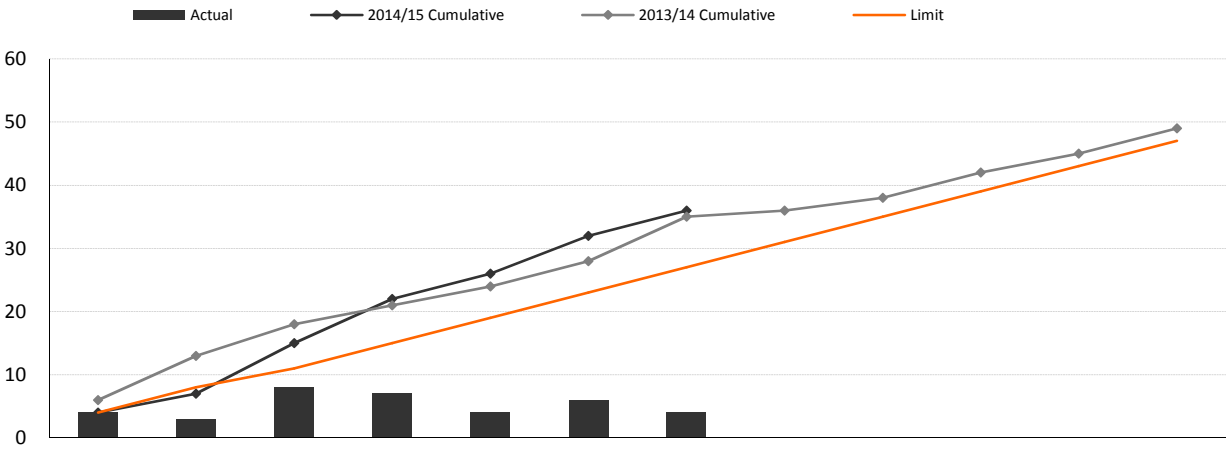
MRSA Bacteraemia - Trust Assigned Cases



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual	0	0	1	0	0	0	0					
2014/15 Cumulative	0	0	1	1	1	1	1					
2013/14 Cumulative	1	1	1	2	3	5	5	6	7	7	8	8
Limit	1	1	1	2	2	2	3	3	4	4	4	5

There were no cases of MRSA bacteraemia in October. The number of Trust assigned cases to date is 1.

Clostridium difficile - Incidents Post 72h



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual	4	3	8	7	4	6	4					
2014/15 Cumulative	4	7	15	22	26	32	36					
2013/14 Cumulative	6	13	18	21	24	28	35	36	38	42	45	49
Limit	4	8	11	15	19	23	27	31	35	39	43	47

There were 4 cases of C. difficile infection in October, bringing the YTD total to 36 against an annual objective of 47 cases, and breaching the trajectory for Apr-14 to Oct-14 by 9 cases. Three cases occurred with UCLTC (QEH, KCH and WHH), and 1 within Surgical Services (QEH). Of those within UCLTC, 1 case was on St Margaret's Ward at the QEH (RCA pending), 1 was on Harbledown Ward at KCH (i.e. avoidable and non-compliant and a decision is awaited from the CCG regarding lapses of care around stool specimen collection and isolation which did not affect the outcome; the Ward remains in "Special Measures" as reported last month), and 1 case was on Richard Stevens Ward at WHH. The latter was the first case of C. difficile on the ward to date this financial year, and a decision is awaited from the CCG as to avoidability and lapses of care associated with prescribing. The RCA for the case on Seabathing Ward at QEH (the first case of C.difficile on the ward to date this financial year) is pending.
"Deprox" for the high-level disinfection of the environment (using hydrogen peroxide vapour) has been implemented at WHH during October. The third phase of the rollout/6 month trial will commence mid-November with implementation at KCH.

PATIENT SAFETY: HOSPITAL ACQUIRED INFECTIONS

Escherichia coli Bacteraemia - Incidents Pre and Post 48h

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly Average	Total YTD
2014/15	Pre 48h	32	36	32	37	25	39	40						34.4	241
	Post 48h	9	1	8	7	6	5	6						6.0	42
2013/14	Pre 48h	30	33	41	37	28	42	36	36	26	31	29	33	33.5	30
	Post 48h	4	3	4	12	3	12	10	4	8	8	6	11	7.1	4

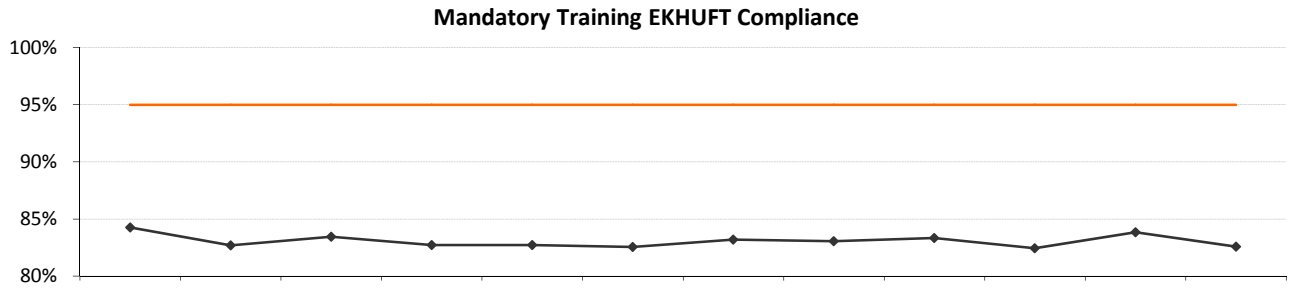
There were 46 cases of E.coli bacteraemia in October, that is, 40 pre 48h (of which only 1 requires RCA), and 6 post 48h (none of which require RCA).
RCAs held to date for all cases of E.coli and MSSA bacteraemia have highlighted the need for improvements to be made regarding the recording of line related interventions and on-going care on VitalPAC.

Meticillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly Average	Total YTD
2014/15	Pre 48h	7	6	6	7	7	9	9						7.3	51
	Post 48h	1	1	3	0	4	2	0						1.6	11

There were 9 cases of MSSA bacteraemia, all occurring pre 48h. None require RCA.

PATIENT SAFETY: INFECTION PREVENTION & CONTROL



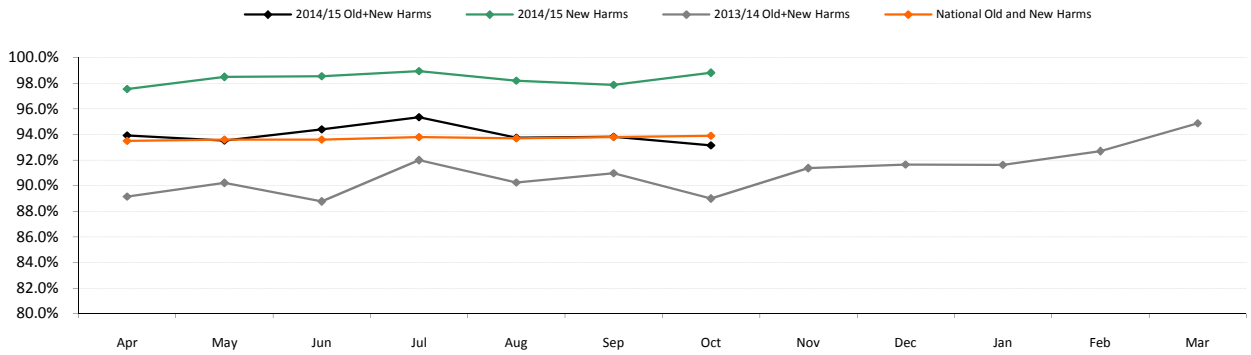
	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14
Compliance	84.3%	82.7%	83.5%	82.7%	82.7%	82.6%	83.2%	83.1%	83.3%	82.5%	83.9%	82.6%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

	Oct-14								
	Target	Trust	Clinical Support Services	Corporate	Specialist Services	Strat Dev & Capt Pln	Surgical Services	UCLTC	SERCO
Mandatory Comparative Data for Biennial Training Compliance	95%	82.6%	89.1%	84.5%	76.5%	92.0%	82.7%	79.4%	87.0%

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

Trust compliance has decreased marginally from 83.9% in September, to 82.6% in October. Clinical Support Services are the only Division to have increased their compliance (from 88.9% to 89.1%). Decreases have been seen in all other Divisions as follows; Corporate Services (from 84.8% to 84.5%); Specialist Services (from 77.9% to 76.5%); Strategic Development (from 93.0% to 92.0%); Surgical Services (from 84.5% to 82.7%); UCLTC (from 81.6% to 79.4%) and SERCO (from 90.6% to 87.0%).
All Divisions are required to achieve 95% compliance by the end of Q4 2014/15 (Mar-15) via a phased attainment approach, achieving 91% by the end of Q3 (Dec-14).

Safety Thermometer Harm Free Care



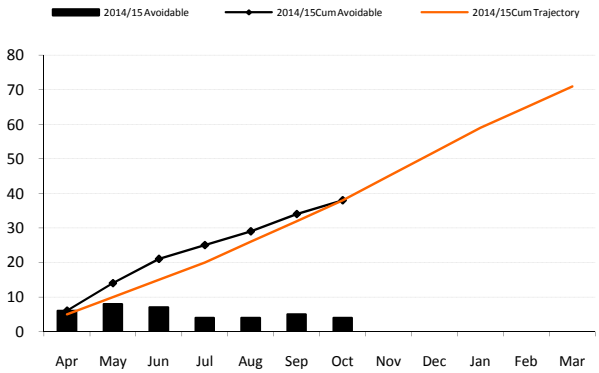
The chart above shows the percentage of Harm Free Care expressed as a one-day snapshot in each month. It is known as the NHS Safety Thermometer and is a quick and simple method for surveying patient harms. The aim of the Safety Thermometer is to identify, through a monthly survey of all adult inpatients,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

- All categories of pressure ulcers whether acquired in hospital or before admission;
- All falls whether they occurred in hospital or before admission;
- Urinary tract infection (inpatients 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 in order to count all occurrences of harms.

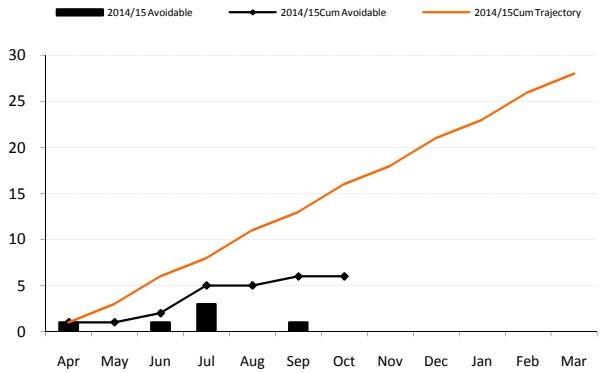
Harm Free Care includes both harms acquired in hospital ("new harms") and those acquired before admission to hospital ("old harms"). There is limited ability to influence "old harms" if a patient is admitted following a fall at home, or with a pressure ulcer, but these are included in the overall performance 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 Oct-14, 93.2% of our inpatients were deemed "harm free" which is a similar percentage of harm free care to the national average of 93.9%. The percentage of patients receiving harm free care during their admission with us (which we are able to influence) is 98.8%, an improvement to last month (97.9%). Further analysis of these data show that the prevalence of VTE, all falls and catheters with urinary tract infections were slightly raised. The remaining areas had reduced or remained the same. Given the Trust's higher Harm Free Care percentage, this emphasises the importance of the work we are undertaking with the Area Team to develop Kent and Medway wide improvements that should positively impact on these indicators across the whole of the patient pathway prior to their admission with the Trust.

Category 2 Incidence Trajectory 2014/15 25% Reduction



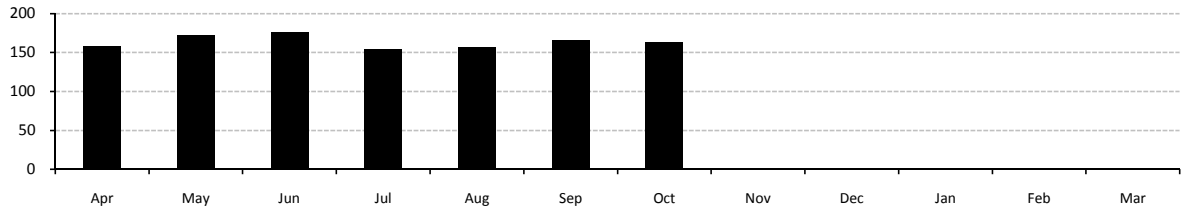
In October there were 17 acquired category 2 pressure ulcers of which 4 were avoidable. This has brought the pressure ulcer outcome figures back in line with 25% reduction trajectory and demonstrates improvements in quality standards. Two of the 4 avoidable pressure ulcers were related to medical devices i.e. catheter tube, NG tube and all reflected lack of documentation. These ulcers occurred on Kingston, Seabathing, Cambridge J and ITU/WHH. In October, campaign events were undertaken at all 3 sites with exhibitions to raise awareness of pressure ulcer prevention and management.

Category 3 and 4 Incidence Trajectory 2014/15 25% Reduction



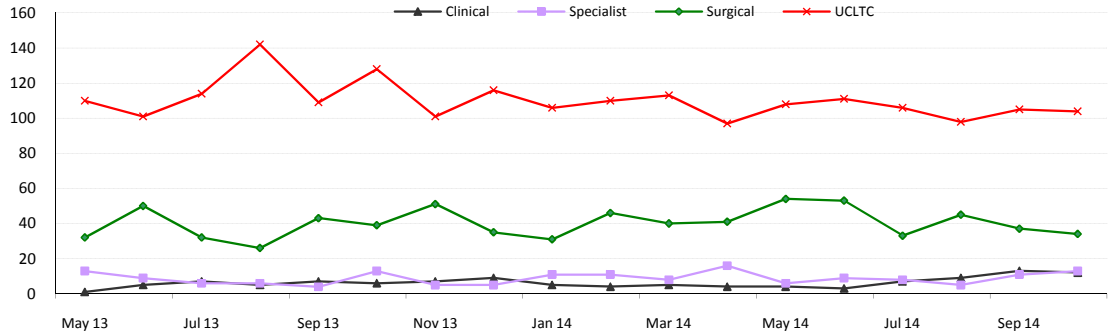
In October there were 4 category 3 pressure ulcers, all being assessed as unavoidable due to improvements in documentation which demonstrate patients have received full preventative care. Deep investigation audits were undertaken on 5 wards at the WHH and support improvements in compliance with quality standards. These were Cambridge L, Cambridge K, Clinical Decisions Unit, CCU and Cambridge J. Monthly Pressure Ulcer Panels are underway to ensure learning from root cause analysis is fully embedded in practice, taking place at KCH in October. Seventy two tissue viability link nurses (representing 44 wards/departments) participated in the Autumn learning event which included generating a shared vision for tissue viability care.

Patient Falls - Injurious and Non-Injurious



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
■2014/15	158	172	176	154	157	166	163					
2014/15 Cum	158	330	506	660	817	983	1146					

Patient Falls - Injurious and Non-Injurious By Division

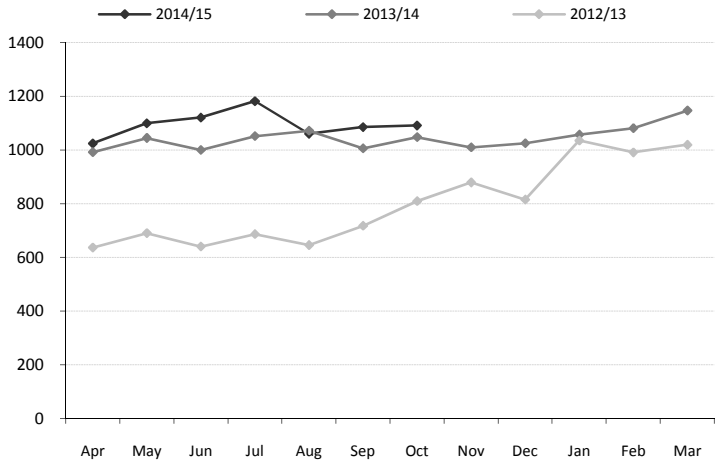


Of the 163 falls in October, 39 occurred at KCH, 64 at QEH and 59 at WHH. Of this total, 13 happened outside of ward areas, such as car parks. Therefore, there were 150 inpatient falls. Wards with the most falls were Sandwich Bay (10), Fordwich (8), Cambridge L (10) and Cambridge M2 (9). Two falls resulted in hip fractures; 1 on Cambridge M1 where a RCA has found that all measures were taken to minimise risk and the fall was unavoidable, and the other on CDU at QEH were the RCA report is pending. The Trust has now taken delivery of an additional 30 low level beds following (i.e. the outcome of a previous RCA) and is on target to achieve the current quarter's CQUIN target of 95% of link workers trained in use of the Falls Risk Assessment and Care Plan. The annual Falls Assessment and Intervention Audit is planned for November.

CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: CLINICAL INCIDENTS

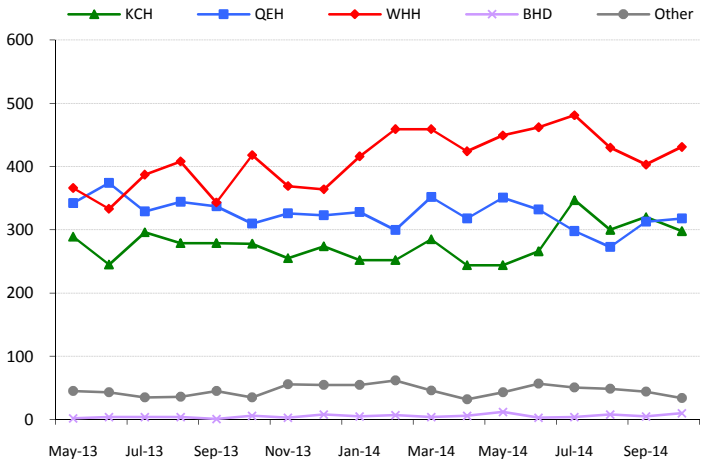
In Oct-14 a total of 1091 clinical incidents including patient falls were reported. This includes 1 incident of post-operative complications (which is under investigation) graded as death, and 2 unexpected admissions to NICU (which are under investigation) graded as severe. Incidents may be re-graded following investigation. In addition to these 3 serious incidents, 12 incidents have been escalated as serious near misses, of which all are under investigation.
Five serious incidents were required to be reported on STEIS in October. Four cases have been closed since the last report; there remain 60 serious incidents open at the end of October.

Overall Incident Rates by Year



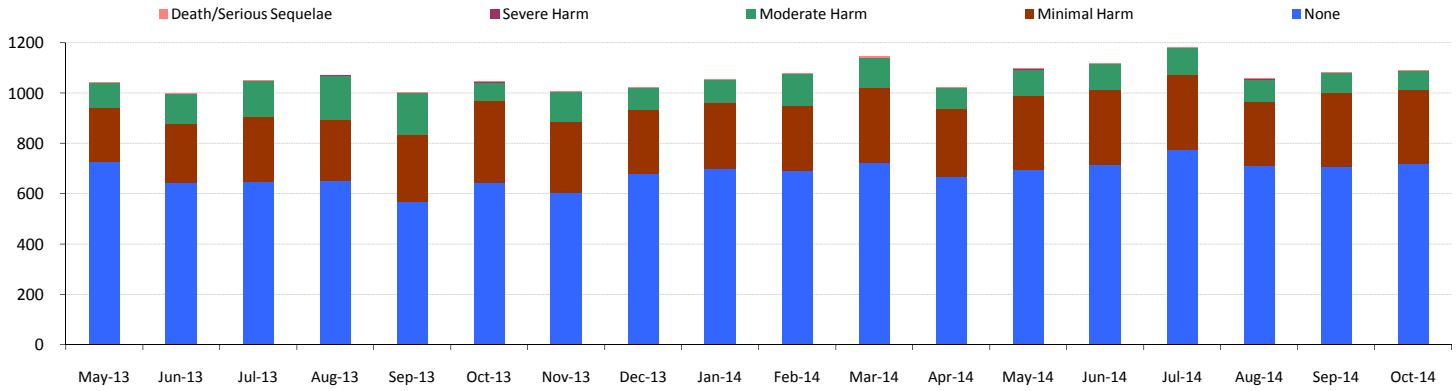
A total of 1091 clinical incidents have been logged in as occurring in October compared with 1085 recorded for Sep-14.

Overall Incident Rates by Site



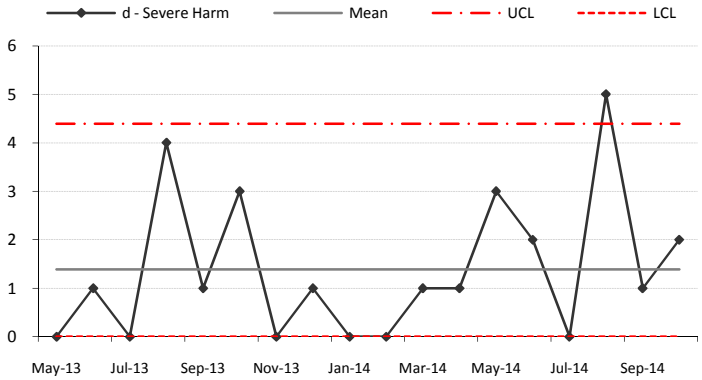
There has been a slight increase in the number of clinical incidents reported at WHH and QEH, but a decrease at KCH.

Clinical Incidents by Severity

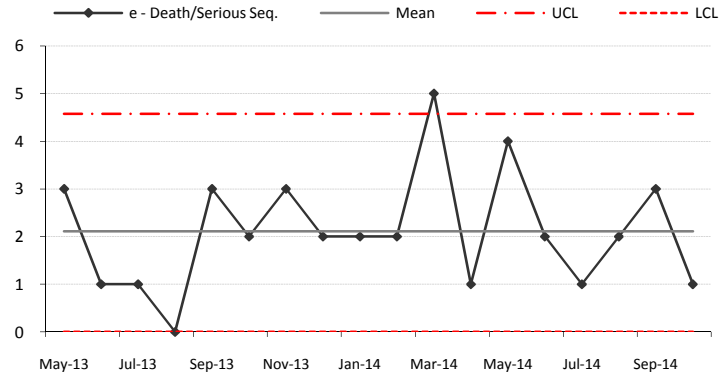


The incidents graded as moderate, serious and death have all been subject to review in order to confirm the consistency of the grading of harm across the Trust. The Board of Directors may see a change in this report to reflect the re-categorisation process undertaken. This is consistent with the data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

Severe Harm

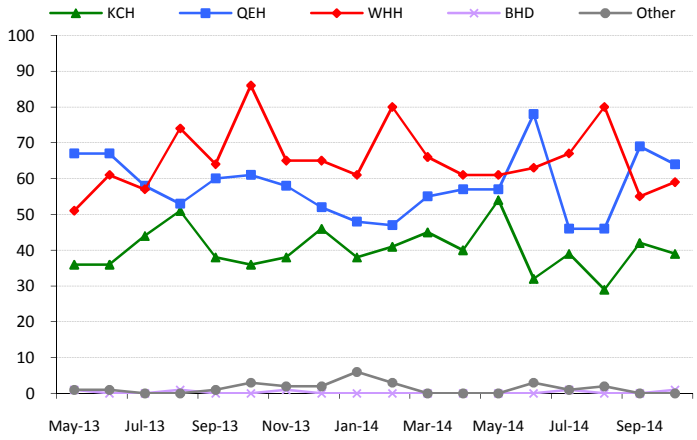


Death/Serious Sequelae



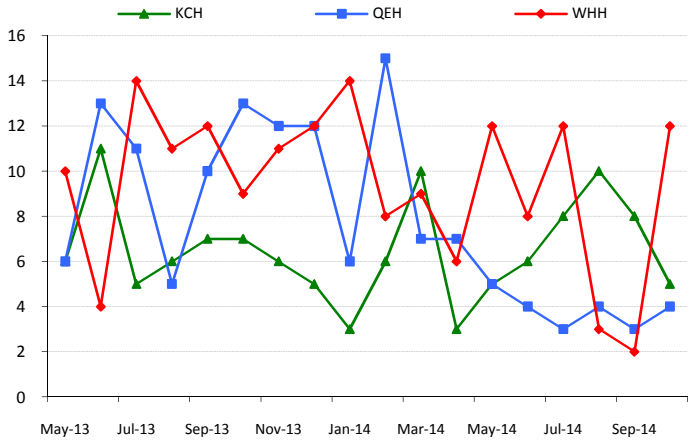
The number of death/serious and severe harm incidents reported in Oct-14 remains subject to the usual RCA investigation and review. It is possible that the severity of these cases will be downgraded once the investigation process is completed. In Oct-14, the number of incidents graded as death or severe are on a par with previous months; these are currently under investigation.

Patient Slips, Trips and Falls



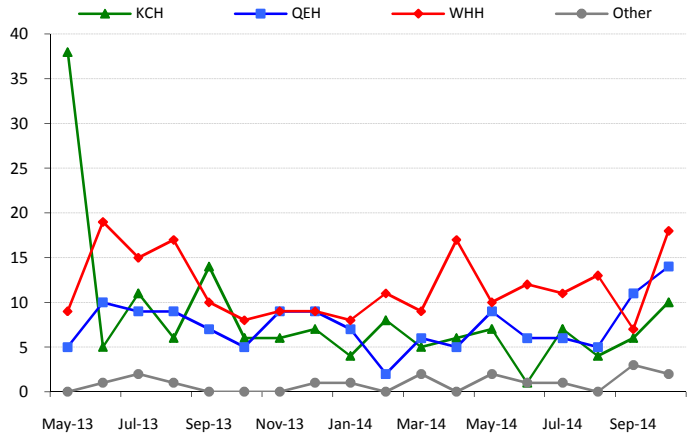
Of the 163 patient falls recorded for October (166 in September), no incidents were graded as severe or death. There were 97 falls resulting in no injury, 64 in low harm and 2 in moderate harm. The top reporting wards were Sandwich Bay (QEH)and Cambridge L (WHH) with 10 falls each; Cambridge M2 (WHH) with 10; CDU (WHH) with 8; Kingston Stroke Unit (KCH), Cambridge M2 (WHH) with 9 falls; Fordwich Stroke Unit (QEH) with 8 falls; Cheerful Sparrows Male (QEH) and Deal (QEH) with 7 falls each; CDU (QEH) with 6 falls. The remaining wards reported 5 or less falls. The 2 moderate harm falls both resulted in fractures (an extracapsular to left hip and right neck of femur) and occurred on CDU (QEH) and Cambridge M1 (WHH). A RCA is carried out for all falls resulting in serious harm or fracture.

Hospital Acquired Pressure Ulcers



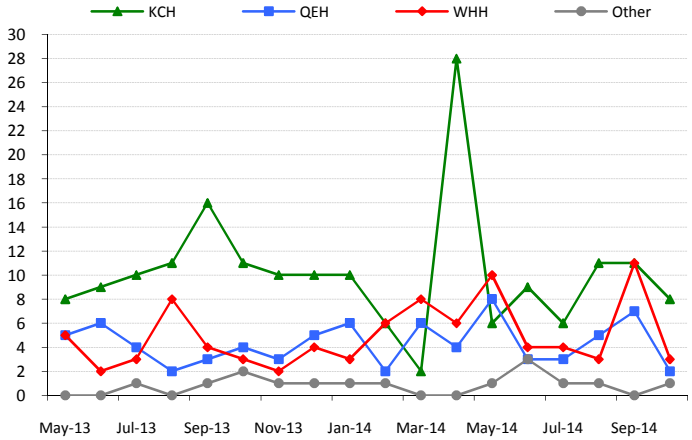
In October there were 21 reported incidents of pressure ulcers developing in hospital (13 in September); there were 29 in the same period last year. This included 17 Category 2 pressure ulcers and 4 Category 3. No Category 4 ulcers were reported. Four (all Category 2 ulcers) have been assessed as avoidable and 17 as unavoidable. The highest reporting wards were Seabathing (QEH), ITU (WHH) and Richard Stevens Stroke Unit (WHH) with 3 incidents each.

Delay in Providing Treatment



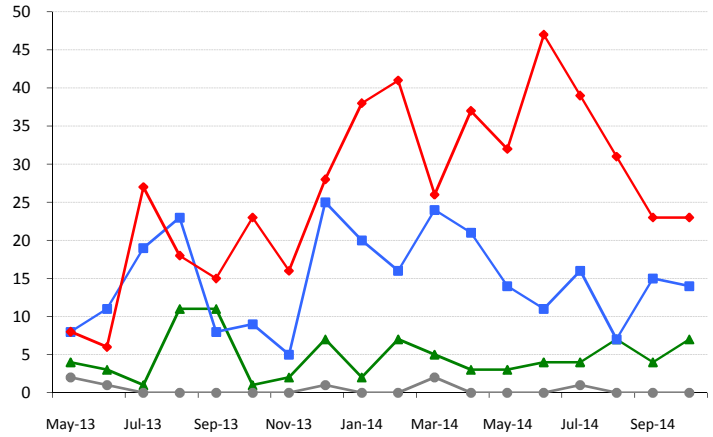
There were 43 incidents resulting in delay in providing treatment during October compared with 27 in September. No incidents have been graded as death or severe harm. Two have been graded as moderate harm, 7 have been graded as low and 34 resulted in no harm. Themes in location: 7 incidents in A&E (QEH), 4 on Folkestone (WHH) and 3 incidents on Kings D Male (WHH) ; all other areas reported 2 or fewer incidents.

Incorrect Data in Patient Notes



There were 14 incidents of incorrect data in patients' notes reported as occurring in October (29 in September), all of which were graded as no harm. Twelve incidents related to incorrect data in paper notes and 2 to incorrect data in electronic patient record (PAS). Of the incidents reported, 8 were identified at KCH, 2 at QEH and 3 at WHH. Themes in the location of these incidents: 4 occurred in Outpatients (KCH).

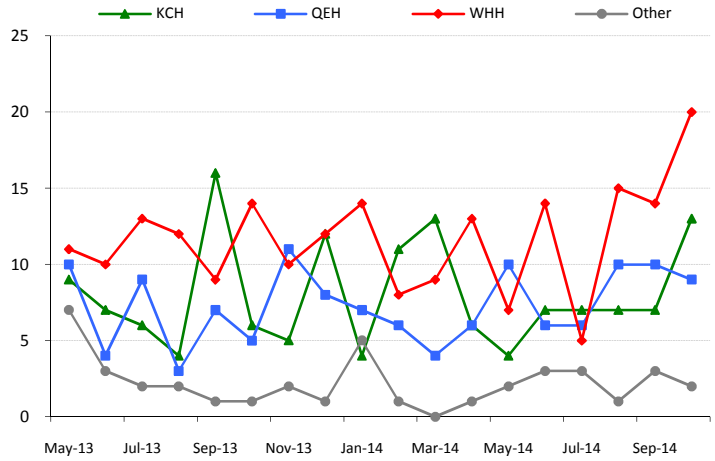
Staffing Level Difficulties



There were 44 incidents relating to staffing difficulties recorded in October (42 in September). These included 24 incidents relating to insufficient nurses, 5 to inadequate skill mix, 1 to insufficient doctors and 14 to general staffing level difficulties. Top reporting locations were Kings D Male (WHH) and CDU (QEH) with 5 incidents each; Kennington (WHH) with 4 incidents; A&E (QEH) and Cheerful Sparrows Male (QEH) with 3 incidents each. Other areas reported 2 or fewer incidents.

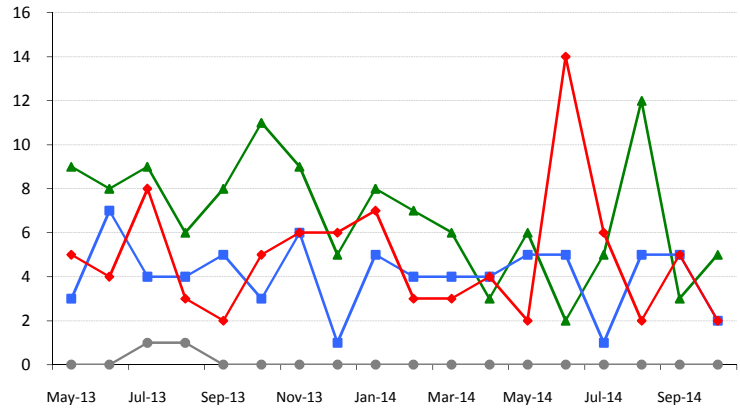
Seven incidents occurred at KCH, 14 at QEH and 23 at WHH. One incident has been graded as moderate and 7 as low harm due to delays in providing treatment and suboptimal care being identified. The remaining 36 incidents have been graded as no harm.

Communication Breakdowns



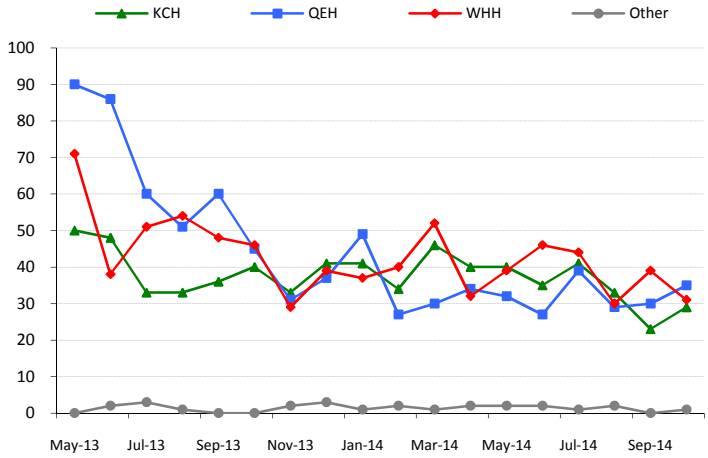
In Oct-14 there were 44 incidents of communication breakdown (34 in September). Of these, 28 involved staff to staff communication failures, 15 were staff to patient and 1 staff to relative or other visitor. Of the 44 incidents reported, 13 were reported as occurring at KCH, 9 at QEH, 20 at WHH, 1 at BHD and 1 in the community. Themes by location: Outpatients (WHH) reported 7 incidents; Dermatology (KCH) and Day Surgery (KCH) reported 3 incidents each; other areas reported 2 or fewer. Incidents in October were graded as follows: 35 as no harm, 7 as low harm and 2 as moderate harm, which included an incident where post procedural care information was not provided and the patient's skin blistered requiring further treatment. The other moderate harm incident may be downgraded as no harm is evidenced.

Blood Transfusion Errors



In October, there were 9 blood transfusion errors reported (13 in September). One theme was evident during that period, namely 5 incidents were categorised as communication. Seven incidents were graded no harm, 1 as low harm and 1 as moderate harm relating to a possible reaction to blood transfusion (and is under investigation). Reporting by site: 5 incidents occurred at KCH, 2 at QEH and 2 occurred at WHH.

Medicines Management



Medicines Management

Category	Oct-14
Prescribing	24
Dispensing	19
Administering	33
Missing (lost or stock discrepancy)	10
Shortage (drug unavailable)	3
Suspected adverse reaction	3
Infusion problems (drug related)	0
Infusion injury (extravasation)	4
TOTAL	**96**

There were 96 medication incidents reported as occurring in October (92 in September). Of those, 79 were graded as no harm including 3 serious near misses, 14 as low harm and 3 as moderate harm (i.e. delayed administration of chemotherapy, adverse reaction to Midazolam and incorrectly prescribed dose of insulin leading to hypoglycaemia). Top reporting areas were: Cheerful Sparrows Male (QEH) and Pharmacy (QEH) which reported 7 incidents each; Celia Blakey Centre (WHH), Cathedral Day Unit (KCH) and Marlowe (KCH) with 4 incidents each; Clarke (KCH), Pharmacy (KCH), CDU (QEH), ITU (QEH), CDU (WHH), Cambridge M2 (WHH) and Padua (WHH) with 3 incidents each; other areas reported 2 incidents or fewer. Twenty nine incidents occurred at KCH, 35 at QEH, and 31 at WHH.

* Missing drugs are broken down as follows: 4 incidents where drugs had been dispensed by Pharmacy but could not be found on the ward, with the patient or in Pharmacy, 3 stock discrepancies, 1 missing but later found as sent to the wrong ward, 1 where an emergency drug box had not been restocked with adrenaline, and 1 drug incorrectly stored (5ml syringe amongst 10 ml syringes).

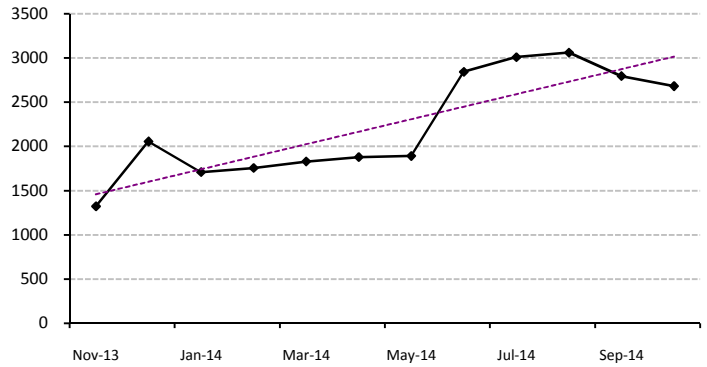
CLINICAL QUALITY & PATIENT SAFETY
PATIENT EXPERIENCE: CONCERNS, COMPLAINTS & COMPLIMENTS

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 during Oct-14. The information reported is for cases received in October and formal cases with target dates due that month. A more detailed report can be found in Appendix 2.

• Activity: Formal complaints - 120; informal concerns - 66; compliments - 2681; PALS contacts - 248.

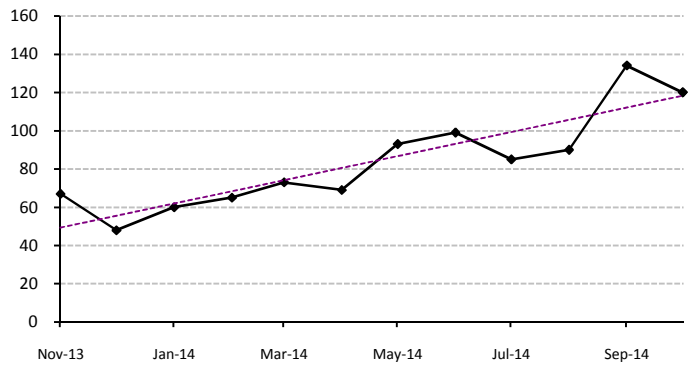
The charts below show the number of complaints and compliments received on a monthly basis. One formal complaint has been received for every 707 recorded spells of care in comparison with September's figures where 1 formal complaint was received for every 627 recorded spells of care.

Number of Compliments



The number of compliments received has slightly decreased by 4% compared to the previous month. The ratio of compliments to formal complaints received for the month is 22:1. There has been 1 compliment being received for every 31 recorded spells of care.

Number of Formal Complaints



The number of complaints received has decreased by 10% compared to Sep-14. The number of formal complaints has significantly increased by 45% compared to Sep-13 (83 compared to 120). The number of concerns has slightly increased by 3% compared to last month.

Top Five Concerns Expressed in Formal Complaints
October 2014

Concerns		No.
Problems with Communication	Doctor communication issues	16
	Misleading or contradictory information given	7
	Nursing communication issues	7
	Lack of information/explanation of procedure outcome	6
	Unable to contact department/ward	3
	A&C staff communication issues	3
	Other staff communication issues	1
	Therapist communication issues	1
	Unhappy with information on medical records	1
Problems with Clinical Management	Unhappy with treatment	22
	Incomplete examination carried out	8
	Lack of/inappropriate pain management	5
	Referral issues	2
	Scans/X-rays not taken	2
	Blood tests not carried out	1
Delays	Delays in receiving treatment	8
	Delays in allocation of outpatient appointment	6
	Delay in receiving X-ready results	5
	Delay in being seen in outpatient department	4
	Delay in going to theatre	4
	Delays being seen in A&E	3
	Delay with elective admission	3
	Delay with emergency admission	1
Problems with Attitude	Problems with nurse's attitude	13
	Problems with other staff attitude	10
	Problems with doctor's attitude	8
Problems with Nursing Care	Problems with nursing care	7
	Delay in receiving treatment	6
	Nitrition	4
	Staffing level difficulties	3
	Lack of response to call button	2

The common themes raised within the top 5 informal concerns are led by delays, problems with appointments, problems with attitude, problems with communication, and cancellations.

With regards to formal complaints, the highest recurring subjects raised in Oct-14 were problems with communication, concerns about clinical management, delays, problems with attitude, and problems with nursing care.
In comparison to Sep-14, problems with communication have remained the top concern. Problems with nursing care has replaced problems with diagnosis. Problems with clinical management, attitude and delays all remain in the top 5 subject areas.

Concerns, Complaints and Compliments - Divisional Performance

October 2014

Division	Divisional Activity				Divisional Performance	
	Formal Complaints	Compliments	Informal Concerns	Compliments: Complaints	Response Date Agreed with Client	Returning Complaints
Clinical Support	10	115	6	11:1	8 of 8	0
Specialist Services	23	938	10	40:1	19 of 22	4
Surgical Services	40	470	39	11:1	38 of 47	4
UCLTC	44	1127	7	25:1	39 of 48	4
Corporate	2	31	4	15:1	1 of 3	0
Other	1	0	1	0:1	0	0
TOTAL	**120**	**2681**	**67**	**22:1**	**105 of 128**	**12**

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

The table above shows the monthly Divisional activity and performance for Oct-14, reporting on the percentage of cases where target dates falling within the month have been met. The 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. During Oct-14 the data show that 81% of responses due to be sent out on target compared to 78% in September.
Clinical Support sent out 100% of their responses on target, Specialist Services sent out a minimum of 85% of their responses on target, whilst UCLTC and Surgical Services sent out a minimum of 75% of their responses on target. Corporate Division sent out less than 75% of responses on target.

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

Status of Cases	Actions in Oct-14
Cases carried over from previous month	20 *
New cases referred to the Trust	1
Cases closed by PHSO	0
Current open cases with the PHSO	21

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 October, the PHSO have been in contact with the Trust with regards to 1 new case brought to their attention which is related to the UCLTC Division (General Medicine). No cases were closed by the PHSO in Oct-14.

* The 2 oldest PHSO cases currently open with the Trust were first received from the PHSO in Dec-13. The Trust has received the final report on 1 case and is in the process of completing the PHSO's recommendations. The Trust awaits the final report from the PHSO regarding the other case.

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 have been measured using the Net Promoter Score (NPS) where a score of approximately 50 is deemed good. Feedback from the public and staff has said that the NPS is difficult for people to understand, so we are also reporting the percentage of people who would recommend the Trust to friends and family which is easier to understand. The Trust's NPS was 62 in October which is an increase on September (i.e. 49 in September). This is the combined satisfaction from 3738 responses from inpatients and A&E. Maternity services achieved 543 responses. The NPS for inpatients was 71, for A&E it equalled 52, both markedly higher than in September where they were 66 and 28 respectively. Maternity was 79. The percentage of inpatients that would recommend the Trust to their friends or family was 91%, for A&E 78% and for Maternity 89.5%. These data have been shared with the wards and departments where the individual comments are being scrutinised so that we can make improvements in response to the feedback. Local action plans are in place across all areas, with a specific focus on A&E at WHH.

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 October was 4.4 stars out of 5 stars which is higher than last month.

The response rate for Inpatients and A&E combined in Oct-14 achieved 29.4%. Inpatients achieved 38.4% this month, and the A&E departments achieved 22.6%. Maternity services achieved 22.5% combined which is higher than last month. FFT for Outpatients and Day Cases have been implemented. The number of responses for Outpatients was 5572 with a 23.1% response rate. The number of Day Case responses were 1479 with a 24.6 % response rate. Of the Outpatient responders 88% said they would recommend the service to their friends and family resulting in an NPS of 62. Of the Day Case responders 92.7% said they would recommend the service to their friends and family which yielded an NPS of 75.

As reported last month staff FFT has been implemented with 70% of the 2442 responses saying they would recommend the Trust to their family or friends if they required care or treatment. Only 45% said they would recommend the Trust as a place to work. This is a reduction on the last survey.

We Care Programme

The Trust is embarking in a culture change programme in response to the CQC Report. Within this the We Care Programme will be encompassed. The Trust values and behaviours are in place and the We Care Steering Group continues to meet to take forward the embedding of these values across the organisation. Events have taken place across the Trust during the past 12 months led by frontline staff. These have sought feedback from patients and families, as well as having discussions about the We Care values within teams. Further "We Care" Champion events have taken place during September and October with a plan to undertake more work on the values and behaviours leading up to Christmas. This includes a Market Place Event across the Trust in the first week of December. In the meantime the Tender document for the culture change programme has gone out to market and a number of bidders were met with in order to appoint an external partner to take forward the programme. This will progress apace and will enable the embedding of the values and behaviours into everyday practice.

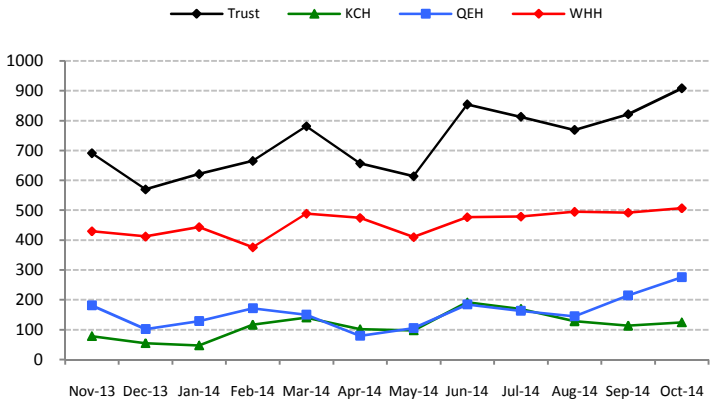
PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

Real time patient experience monitoring using iPads have captured data since 1 Apr-13. During Oct-14, 908 adult inpatients were asked about their experiences of being an inpatient; 125 responses were received from patients treated at KCH, 276 from QEH patients, and 507 responses from patients based at WHH. (Compared with the previous month the number of responses were 114, 215 and 492 respectively). The combined result from all submitted questionnaires in Oct-14 was that of 89.20% satisfaction.

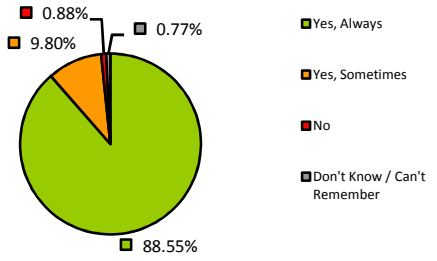
Overall Adult Inpatient Experience October 2014

Experience (%)	No. of Responses
89.20	908

Number of Adult Inpatient Survey Responses

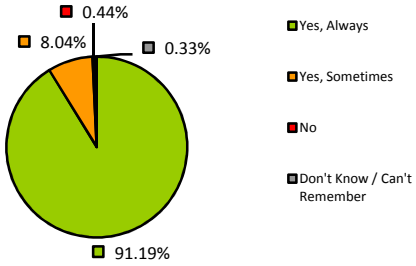


Were you given enough privacy when discussing your treatment?



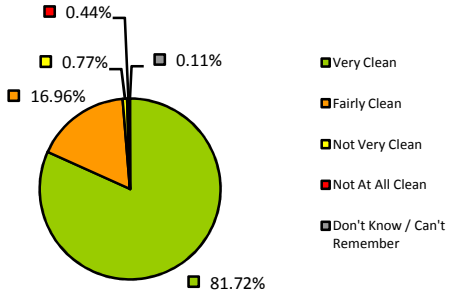
Overall Score = 94.17%

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



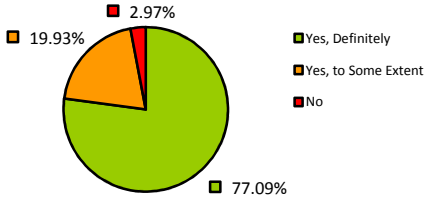
Overall Score = 95.52%

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



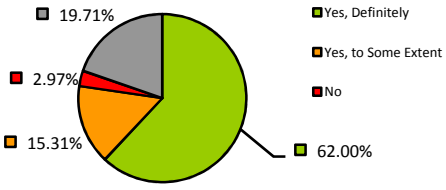
Overall Score = 93.38%

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



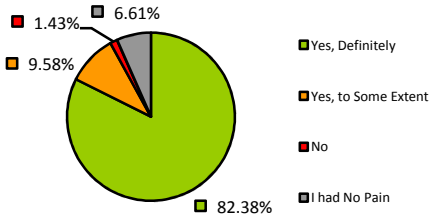
Overall Score = 87.06%

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



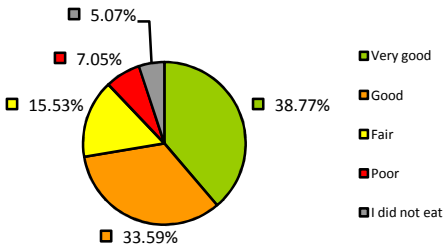
Overall Score = 86.76%

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



Overall Score = 93.34%

How would you rate the hospital food?

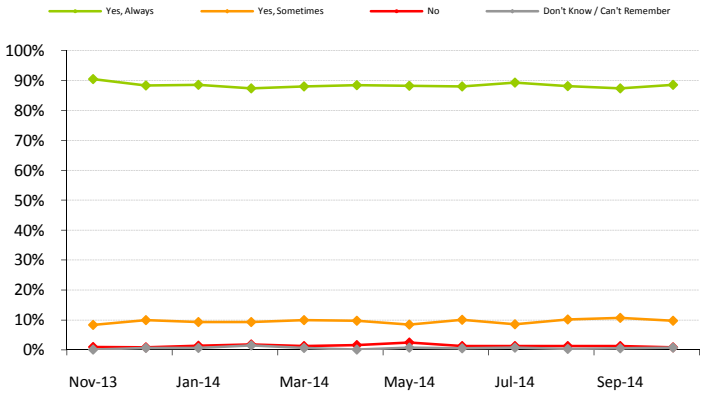


Overall Score = 69.88%

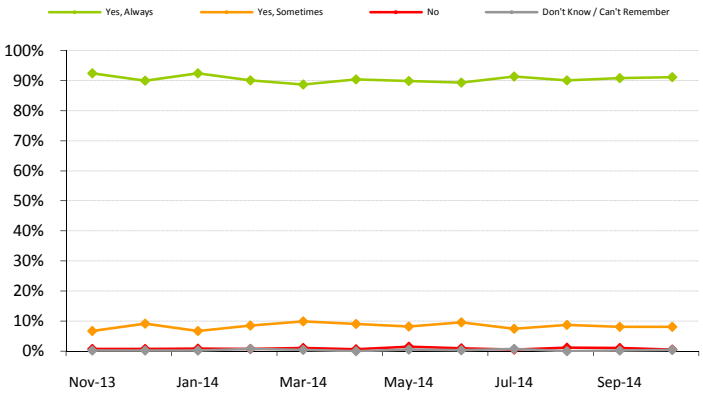
Each ward reviews their real-time monitoring data regularly. They are also shared as "heat maps" with other teams. From this actions are taken to address the themes which are considered with the Friends and Family Test feedback, and compliments and complaint information. A particular focus at present is around improving the catering and cleaning standards. The Trust is working closely with Serco to ensure high standards are maintained at all times. The Pain Team are working closely with ward teams to improve this aspect of care, and the wards continue their comfort rounds to ensure that at all times patients and families have their needs met. A meeting to explore further ideas for improving patient experience has taken place with a plan to strengthen Frontline Fridays, Intentional Rounding, and the use of 'Emotional Touch-Points' as a tool for seeking feedback from patients and visitors.

PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

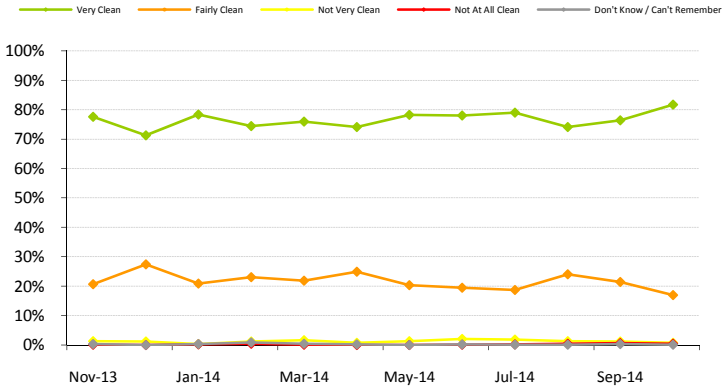
Were you given enough privacy when discussing your treatment?



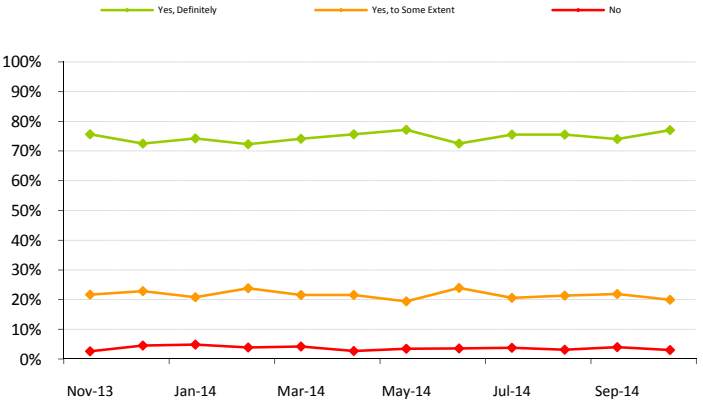
Overall, did you feel you were treated with respect and dignity while you were in hospital?



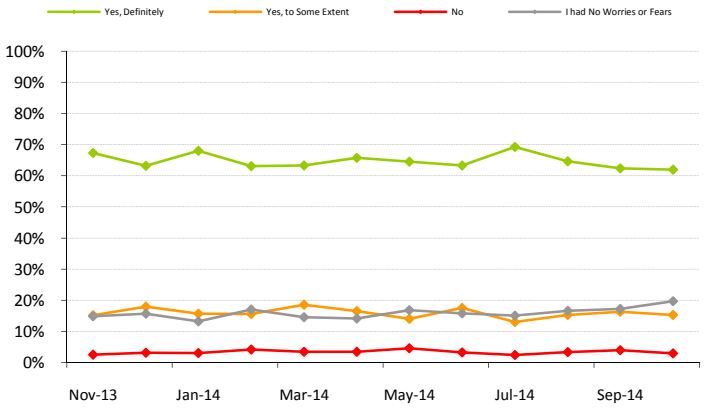
In your opinion, how clean was the hospital room or ward that you were in?



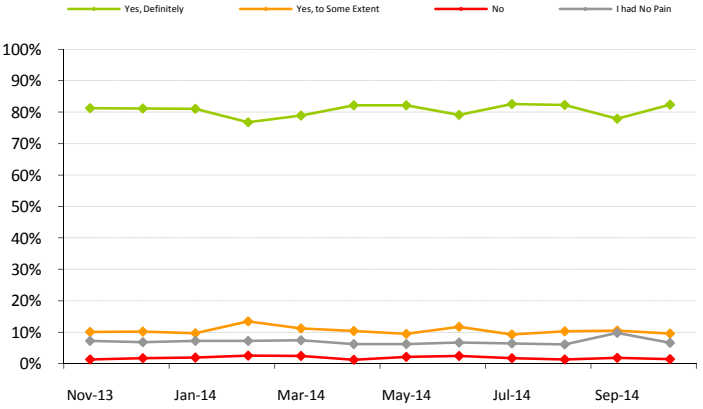
Were you involved as much as you wanted to be in the decisions about your care and treatment?



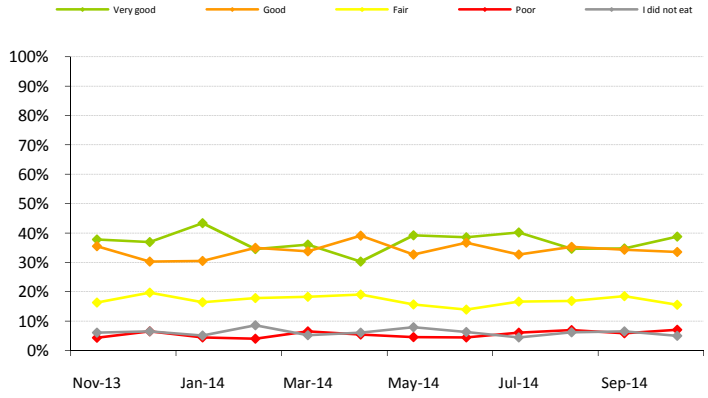
Did you find someone on the hospital staff to talk about your worries and fears?



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



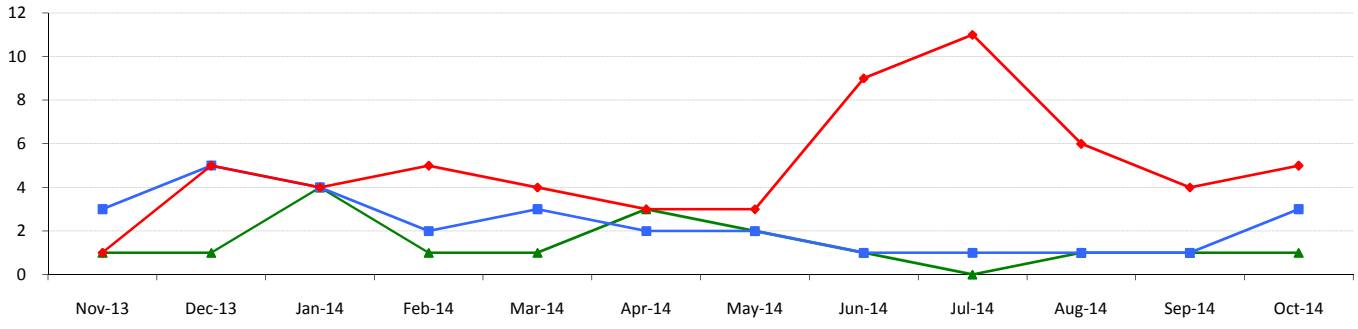
How would you rate the hospital food?



Wards have received their own results and are being asked to address the issue of involving patients in decisions about their care as well as ensuring the comfort rounds take place to enable patients to have the opportunity to discuss their worries and fears. The Ward Peer Review process and We Care Events use 'Emotional Touch-Points' methodology to interview patients about their experiences and discuss their worries and fears. This helps us to develop and put in place the specific improvements required.

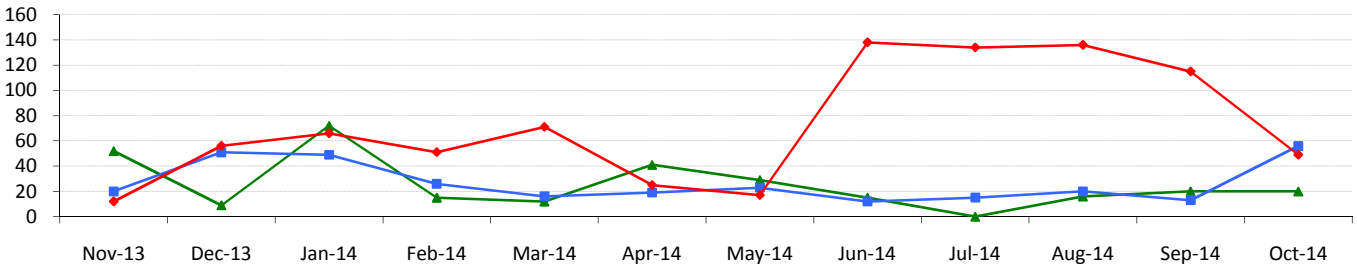
CLINICAL QUALITY & PATIENT SAFETY
PATIENT EXPERIENCE: MIXED SEX ACCOMMODATION

Number of Episodes of Mixed Sex Occurrence



	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14
KCH	1	1	4	1	1	3	2	1	0	1	1	1
QEH	3	5	4	2	3	2	2	1	1	1	1	3
WHH	1	5	4	5	4	3	3	9	11	6	4	5

Number of Hours of Mixed Sex Occurrence



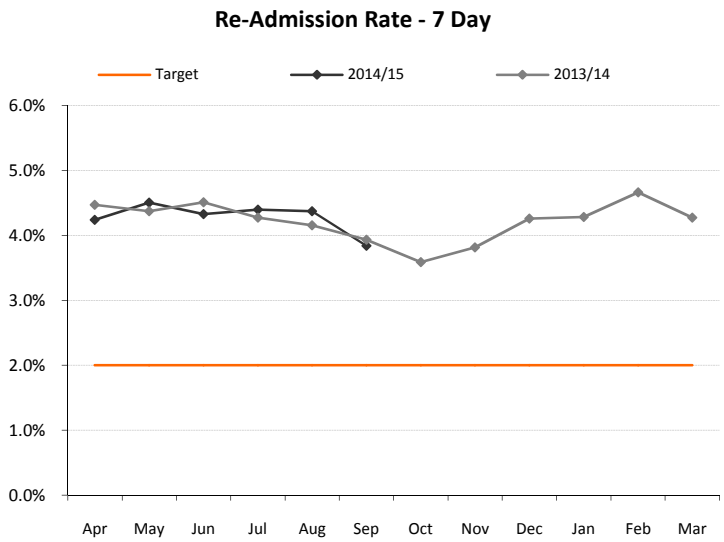
	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14
KCH	52	9	72	15	12	41	29	15	0	16	20	20
QEH	20	51	49	26	16	19	23	12	15	20	13	56
WHH	12	56	66	51	71	25	17	138	134	136	115	49

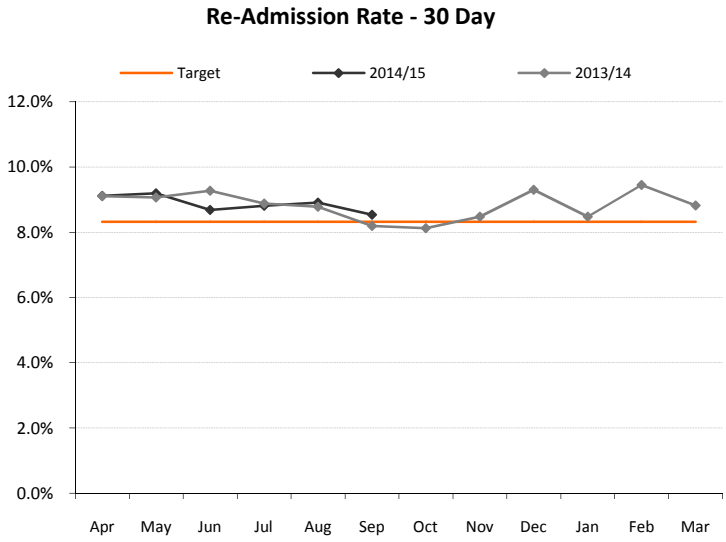
Mixed Sex Accommodation Occurrrences October 2014

Site	Clinical Area	Total No. of Occurrences	Total No. of Patients Affected
KCH	Kingston	1	4
QEH	CDU	2	14
QEH	Fordwich	1	3
WHH	CDU	5	35
TOTAL		**9**	**56**

During Oct-14 there were no reportable mixed sex accommodation breaches to NHS England via the Unify2 system. These were not reported as they complied with current agreed criteria, such as clinical need. There were 9 clinically justified mixed sex accommodation occurrences affecting 56 patients. (Last month there were 6 occurrences affecting 47 patients). The Trust is working closely with the CCGs in order to ensure that mixed sex bathroom occurrences are minimised as much as possible. Collaborative work continues with the CCGs where the policy scenarios have been revised. The new policy and revised justifications are due to be ratified collaboratively. In addition, a review of the way we measure and report our mixed sex accommodation data was undertaken during October by external auditors. We await the final report.

CLINICAL QUALITY & PATIENT SAFETY
CLINICAL EFFECTIVENESS: READMISSION RATES





In Oct-14, 7 day readmissions have reduced slightly whilst 30 day readmissions have increased, however the general seasonal trend remains the same.
Following the completion of a "deep dive" into readmissions data, a number of recommendations have been made regarding "short, medium and long term" service improvements. The data clearly demonstrate that the day of discharge is a contributory factor for patients readmitting, i.e. patients discharged on a Friday, Saturday and Sunday are more likely to readmit than those discharged on a Monday, Tuesday, Wednesday and Thursday. The age of patients is a further dynamic which contributes towards readmissions; i.e. the older the patient, the higher the incidence of readmission.
Service Improvement and Clinical Audit are working jointly to undertake a Patient Record Audit, with a view to applying the patient's voice to the data regarding readmissions.
Links have also been established with the Integrated Discharge Teams to review patients who are readmitted in order to ensure that discharge arrangements and communication is constantly reviewed and improved as required.
The clinical Divisions are involved with service improvements moving forward and readmissions will be a key priority within the Transformation Redesign Service Improvement Programme.

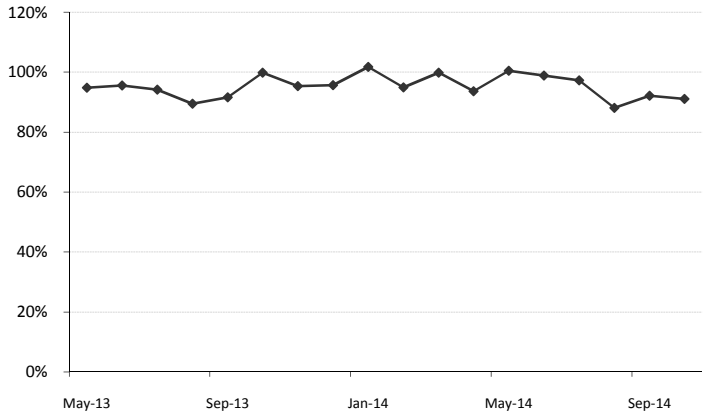
			CQUIN	2013/14 Baseline	2014/15 Target	YTD Status	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Q1	Q2	Q3	Q4	Year End Position
	National CQUINS																						
Performance	Friends and Family Test	1a	Implementation of FFT to staff	N/A	Implemented by Jul-14																		
		1b	Implementation to Outpatient and Day Case Units	N/A	Implemented by Oct-14																		
		1c	Increased Response Rates in A&E	Q1 2014/15 - 20.7%	Improvement from at least 15% in Q1 to at least 20%, or higher than Q1 baseline if higher than 20% by Q4	22.0%	19.6%	18.7%	23.9%	28.5%	21.1%	19.4%	22.6%						20.7%	23.0%			
		1d	Increased Response Rates in Inpatient Areas	Q1 2014/15 - 33.1%	Improvement from 25% in Q1 to 30% by Q4, or maintaining a response rate of 30%	35.5%	35.2%	29.6%	34.4%	37.0%	39.5%	34.6%	38.4%						33.1%	37.0%			
		1e	Increased response rates in Inpatient areas to 40% in March 2015	Q1 2014/15 - 33.1%	Improvement in response rate to 40% in Mar-15	35.2%	35.2%	29.6%	34.4%	35.0%	39.5%	34.6%	38.4%						33.1%	36.4%			
	NHS Safety Thermometer	2a	Reduction in Falls - Risk Assessment/Care Plan	2013/14 audit - 20%.	50% compliance with completion of falls risk assessment and care plan																		
		2a	Reduction in Falls - Improvement in Prevalence	Apr-13 to Jan-14 - 1.13%	25% improvement in prevalence of falls with harm - NHS Safety Thermometer in Q4	23	2	1	0	3	5	7	5						3	15			
		2b	Reduction in UTIs in Patients with Urinary Catheters	Apr-13 to Jan-14 - 1.98%	25% improvement in prevalence of UTIs in patients with urinary catheters - NHS Safety Thermometer in Q4	75	5	12	12	7	13	8	18						29	28			
		2c	Reduction in Pressure Ulcers - New	Apr-13 to Jan-14 - 1.09%	5% improvement in prevalence of new pressure ulcers - NHS Safety Thermometer in Q4	39	16	10	3	3	2	5	0						29	10			
		2c	Reduction in Pressure Ulcers - Old	Apr-13 to Jan-14 - 5.01%	Leading the Pressure Ulcer Work Stream																		
	Improving Diagnosis of Dementia	3.1	Dementia Case Finding	98.8%	Average of 90% in each of the elements of the indicator each month for any 3 consecutive months	99.5%	99.7%	99.4%	99.7%	99.4%	99.2%	99.6%							99.6%	99.4%			
			Dementia Assessment within 72h	90.1%		94.1%	94.7%	94.7%	93.2%	93.3%	94.5%	91.7%							94.2%	93.2%			
			Appropriate Referral	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%							100.0%	100.0%			
		3.2	Staff Training/Leadership	20.0%	35% of appropriate staff trained	24.0%	22.3%	23.5%	25.0%	25.0%	25.0%	24.0%	24.0%						23.5%	24.7%			
		3.3	Care for People with Dementia	N/A	Self assessment of person-centred care in wards																		
Commentary	Friends and Family Test	1a	Implementation of FFT to staff	FFT for staff implemented in June 14 via a Picker Survey. All staff will receive the survey 3 times/year and the second survey was completed at the beginning of September.																			
		1b	Implementation to Outpatient and Day Case Units	Implementation of FFT to Outpatients and Day Case Surgery is completed.																			
		1c	Increased Response Rates in A&E	Reporting includes A&E areas at WHH and QEH. Month 7 shows an improvement in response rates.																			
		1d	Increased Response Rates in Inpatient Areas	ECC at KCH included within inpatient areas. Month 7 response rates have risen to >38%.																			
		1e	Increased response rates in Inpatient areas	Month 7 response rates have risen to >38%.																			
	NHS Safety Thermometer	2a	Reduction in Falls - Risk Assessment/Care Plan	The risk assessment/care plan has been updated and has been implemented as part of the Risk Assessment Booklet. Link workers plus other staff were trained in Jul-14. An audit of compliance with risk assessments is planned for Q3.																			
		2a	Reduction in Falls - Improvement in Prevalence	YTD NHS Safety Thermometer data - 23 falls with harm, against a trajectory of up to 56. Prevalence equalled 0.46% in Month 7, against a 1.13% 2013/14 baseline prevalence and against a Q4 target of no more than 0.85% prevalence.																			
		2b	Reduction in UTIs in Patients with Urinary Catheters	YTD NHS Safety Thermometer data - 75 UTIs in patients with catheters, against a trajectory of up to 91. Prevalence equalled 1.65% in Month 7, against a 1.98% 2013/14 baseline prevalence and against a Q4 target of no more than 1.49% prevalence.																			
		2c	Reduction in Pressure Ulcers - New	YTD NHS Safety Thermometer data - 39 new Category 2 - 4 pressure ulcers, against a trajectory of up to 73. Prevalence equalled 0% in Month 7, against a 5.01% 2013/14 baseline prevalence and against a Q4 target of no more than 4.76% prevalence.																			
			Lead Pressure Ulcer Work Stream	The first meeting of the Work stream Collaborative group took place in May-14, with a further meeting on 24 Jun-14, and regular meetings have taken place since to progress this work.																			
	Improving Diagnosis of Dementia	3a	Dementia Case Finding	Q1 has met the year target for average of 90% for 3 consecutive months.																			
			Dementia Assessment within 72h	Q1 has met the year target for average of 90% for 3 consecutive months.																			
			Appropriate Referral	Q1 has met the year target for average of 90% for 3 consecutive months.																			
		3b	Staff Training/Leadership	This measure will be reported 1 month retrospectively. From September reporting now includes Pharmacy and SERCO staff. Provisional numbers for Month 7 indicate that 24% of staff are trained.																			
		3c	Care for People with Dementia	he ability to survey carers of dementia sufferers via the Meridian web based system is being launched (paper based) in Oct-14.																			

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

	Local CQUIN			2013/14 Baseline	2014/15 Target	YTD Status	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Q1	Q2	Q3	Q4	Year End Position
Performance	Heart Failure	4a	Develop an Integrated Care Pathway	N/A																			
		4b	EQ Pathway Measures (Jan-14 to Dec-14)	74.21%	Maintain 2013/14 levels	80.3%	78.3%	81.1%	70.6%	66.7%	92.9%	92.9%							YTD 79.3%	YTD 80.3%			
	COPD	5a	Develop an Integrated Care Pathway	N/A																			
		5b	Improved referral rate to the Community Respiratory Team	24.6%	Improved referral rate - Improvement rate TBA	23.4%	26.1%	28.3%	28.9%	19.4%	19.3%	18.2%							27.8%	19.0%			
		5c	Improved referral rate to the Stop Smoking Service	8%	Improved referral rate - Improvement rate TBA	9.6%	8.6%	12.0%	9.9%	9.8%	7.6%	10.4%	9.5%						10.2%	9.0%			
	Diabetes	6	Develop an Integrated Care Pathway	N/A																			
	Over 75 Frailty Pathway	7	Develop an Integrated Care Pathway	N/A																			
Commentary	Heart Failure	4a	Develop an Integrated Care Pathway	This measure was agreed within the CQUIN programme after the start of the financial year. A collaborative Cardiology Task and Finish Group is in place and are meeting regularly. HF and AF have been identified as separate work streams. The development of an Integrated Care Heart Failure Pathway is underway with audit of the existing pathway planned for later this year.																			
		4b	EQ Pathway Measures	This measure will be reported Month 1 - 12, Jan-14 to Dec-14. March and April data indicate lower compliance with LV function evaluation, and issuing of discharge instructions. This is being reviewed. A failed measures case review has identified cases where the required care was provided leading to an outcome of 71.43% for April. Further improvement is still required.																			
	COPD	5a	Develop an Integrated Care Pathway	This measure was agreed within the CQUIN programme after the start of the financial year. A collaborative COPD Task and Finish Group has come to a close. Discussions are due to take place with the CCGs to understand how this work should progress. The development work will need an internal working group and this CQUIN measure requires Project, Clinical and Information Team support to ensure that it will progresses. A meeting is planned on 26 Nov-14 to progress internal discussions.																			
		5b	Improved referral rate to the Community Respiratory Team	All previous months referral rates are revised as patient data is updated. Both 2013/14 baseline and 2014/15 data has been refreshed further as the process of ensuring that all referrals are being captured. Current data indicate that the referral rates have reduced and this is being explored.																			
		5c	Improved referral rate to the Stop Smoking Service	All previous months referral rates are revised as patient data is updated. Both 2013/14 baseline and 2014/15 data has been refreshed further as the process of ensuring that all referrals are being captured. Current data indicate that greater stability in improved referral rates is required. This is likely to tie in with the COPD integrated pathway development work.																			
	Diabetes	6	Develop an Integrated Care Pathway	A CCG led Project group has been developing an Integrated Diabetes Pathway. CCG led meetings took place on 3 Sep-14 and 24 Oct-14 to discuss the many outstanding issues that need to be resolved to enable the pathway development to progress including resolution of the contractual structure, specific details around the new pathway delivery, development of implementation plans and funding. The Trust is due to identify numbers of diabetic patients who would fall into each level of service within the new pathway. The Clinical Audit Team are fully supporting an audit and results are about to be published.																			
	Over 75 Frailty Pathway	7	Develop an Integrated Care Pathway	A third CCG led multi-provider Pathway Development meeting took place on 2 Sept-14. The Trust conducted an audit to identify the proportion of patients who would be identified as frail if the Prisma frailty tool was applied, and greater than 80% of patients were identified as frail. Further data collection in other areas (A&E and Outpatients) is planned, and a further internal meeting is scheduled for 18 Nov-14. Also, and additional CCG led meeting is due to take place 26 Nov-14 to agree how to progress the development of a pathway. This CQUIN measure requires Project, Clinical and Information Team support to ensure that it remains on track.																			

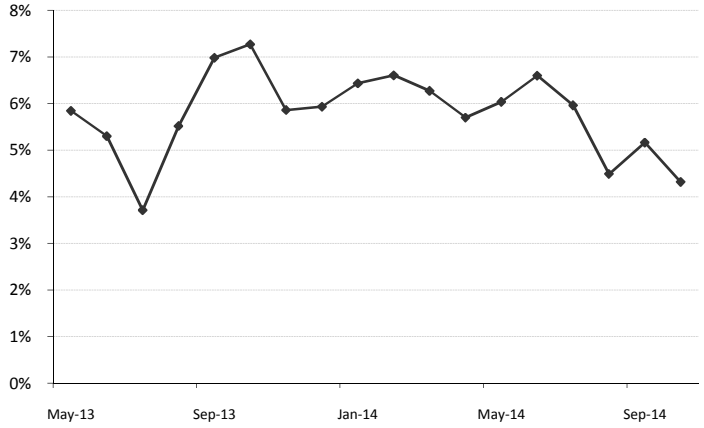
Compliance Against Performance	
	On target
	Monthly target missed; quarterly/annual target at risk
	Monthly target missed; annual target at risk

Bed Occupancy



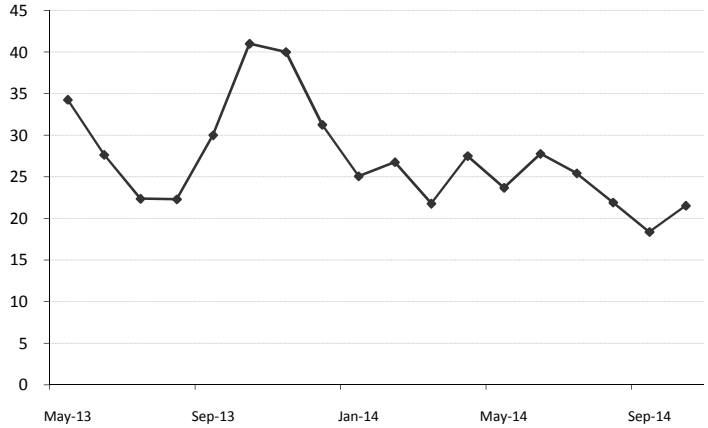
The bed occupancy metric looks only at adult inpatient beds and excludes any ring fenced wards such as Maternity. Since Aug-13 occupancy steadily increased with levels becoming static from Oct-13 (99.78%) to May-14 (100.44%). However, occupancy for Oct-14 shows a continued decreased position at 91.03% (as at 27 Nov-14 and sourced from the Trust Balanced Scorecard).

Extra Beds



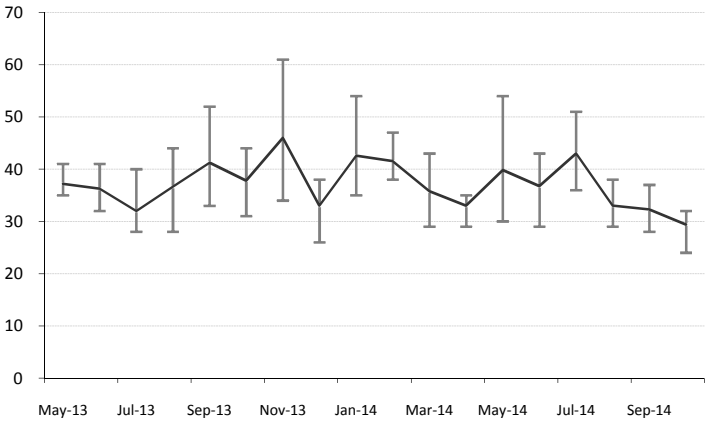
This metric is built up using the number of funded beds on each ward and reviewing those occupied on a daily basis. Where the number of occupied beds exceeds the funded bed base for the ward these are classified as "extra". Following on from months of fluctuation the position in May-14 showed consistency against Apr-14. In Jun-14 however, this value increased to 6.60%, subsequently dropping thereafter to a value of 4.32% in Sep-14 mirroring the reduction seen in bed occupancy.

Outliers



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 Oct-13. However, the position stabilised at approximately 25 extra beds per month from Jan-14 to Jul-14 and subsequently reduced to an 18 month low in Sep-14 (i.e. 18.37). In Oct-14 the outlier value increased at 21.52.

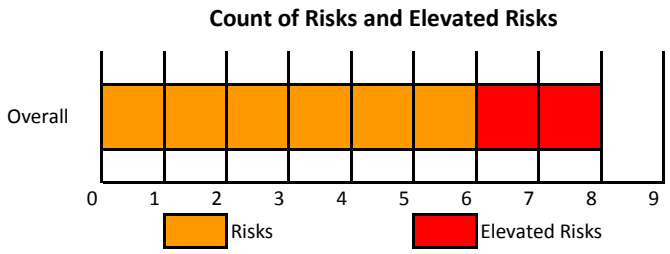
Average Delayed Transfers of Care



In Oct-14, the number of patients on the Delayed Transfers of Care (DToC) list decreased resulting in a position of 29.40, against 32.25 in September. This value is markedly lower than the trust's position in Oct-13, that is, 37.80. The Trust now provides 60 reablement beds, 20 of which became operational on 31 Jan-14. The primary issues for DToC remain, that is, continuing health care, pending assessment by Social Services, and care provision and community resources.

CLINICAL QUALITY & PATIENT SAFETY
CARE QUALITY COMMISSION: INTELLIGENT MONITORING REPORT

Trust Summary



Priority Banding for Inspection	Recently Inspected
Number of Risks	6
Number of Elevated Risks	2
Overall Risk Score	10
Number of Applicable Indicators	96
Percentage Score	5.21%
Maximum Possible Risk Score	192

Elevated Risk	Composite of Central Alerting System (CAS) safety alerts indicators (1 Apr-04 to 30 Apr-14)
Elevated Risk	Whistle blowing alerts (22 Mar-13 to 2 Jun-14)
Risk	Never Event incidence (1 May-13 to 30 Apr-14)
Risk	Composite indicator: In-hospital mortality: Trauma and Orthopaedic conditions and procedures
Risk	SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator (1 Oct-13 to 31 Dec-13)
Risk	All cancers: 62 day wait for first treatment from NHS cancer screening referral (1 Jan-14 to 31 Mar-14)
Risk	Composite of PLACE indicators (1 Apr-13 to 30 Jun-13)
Risk	GMC: Enhanced Monitoring (1 Mar-09 to 21 Apr-14)

The Trust was initially rated as a Band 3 organisation based on the risk scores calculated by the CQC in the first Intelligent Monitoring Report published in Oct-13. The banding process is no longer being adopted by the CQC. Three further reports have been issued since this time; the most recent being in Jul-14. There were 8 areas showing as a risk; 2 of these are classified as "elevated". These are the composite scores for the Central Alert System (CAS) where at the time, the Trust had 15 outstanding Estates and Facilities alerts and the number of whistle-blowing alerts from Trust staff made directly to the CQC. The outstanding CAS alerts have been closed and, this will not flag as a risk in the next iteration of the Intelligent Monitoring Report. This is a new indicator in the Jul-14 report. The whistle-blowing alerts are not quantified by the CQC. The Trust was placed in "Special Measures" by Monitor at the end of August following publication of the CQC Report. This has been added as an additional risk. We have received the draft Intelligent Monitoring Report; the full one is not scheduled for release until beginning of December. The High Level CQC Improvement Plan was submitted to the CQC on 23 Sep-14 which is being progressed. The Trust's Improvement Director Sue Lewis has been appointed by Monitor to provide us with advice, to observe progress on the implementation and embedding of the improvements, and to liaise with the Monitor Regional Team as part of the performance review requirements. The second monthly report on progress has been submitted to NHS Choices and has been published on our website.