CLINICAL QUALITY & PATIENT SAFETY PERFORMANCE SUMMARY

Introduction

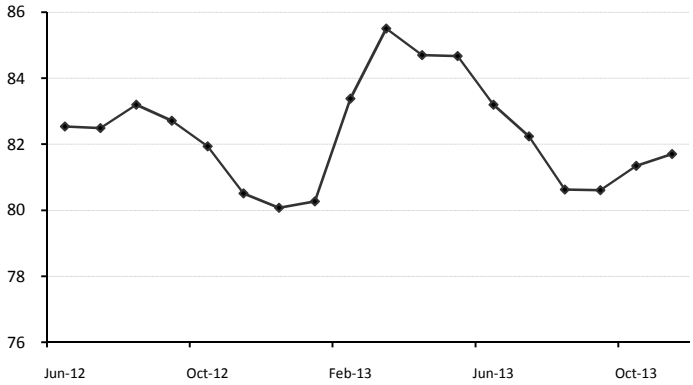
A summary of key trends and actions of the Trust's performance against the clinical quality and patient safety indicators is provided together with supporting narrative. The report is structured around the key themes of the annually published Quality Report/Account; Patient Safety, Patient Experience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

	Measure	Improvement Metric		Target 13/14	Nov-13	Nov-12	vs Nov-12	YTD
Patient Safety	Mortality Rates	HSMR		-	81.7	80.5	↑	82.4
		RAMI		-		96.8		-
					Q1 13/14	Q1 12/13	vs Q1 12/13	YTD
		SHMI (%)		-	94.96%	93.49%	↑	-
					Jan-14	Jan-13	vs Jan-13	YTD
		Crude Mortality: All Ages (Per 1 000)	Non-Elective	-	36.358	36.500	↓	30.394
			Elective	-	0.858	0.572	↑	0.271
	Risk Management	Serious Incidents (STEIS)	New Incidents	-	5	8	↓	-
			Open Incidents	-	26	23	↑	Cumul.
	HCAI	MRSA	Attributable	0	7	4	↑	Cumul.
		C. difficile	Post 72h	29	42	34	↑	Cumul.
	Infection Prevention	Mandatory Training Compliance (%)		95.0%	83.5%			86.1%
	Harm Free Care (HFC)	Safety Thermometer HFC (%) - Old & New Harm	EKHUFT	93.0%	91.6%	90.7%	↑	90.5%
			National	-	93.5%	92.3%	↑	-
	Nurse Sensitive Indicators	Pressure Ulcers: Grades 2,3 and 4	Acquired	-	23	29	↓	267
			Avoidable	135	9	10	↓	106
		Falls		1788	149	183	↓	1657
	Clinical Incidents	Total Clinical Incidents		-	1042	1032	↑	10250
Patient Experience	Compliments and Complaints	Compliments:Complaints		-	28:1	19:1	↑	-
		No. Care Spells per Formal Complaint		-	1417	1091	↑	-
	Experience	Friends and Family Test (Star Rating)		5.0	4.5			-
		Adult Inpatient Experience (%)		80.00%	89.16%	89.32%	↓	-
		Mixed Sex Accommodation Occurrences		-	12	12	↔	63
Clinical Effectiveness	Readmission Rate				Dec-13	Dec-12	vs Dec-12	YTD
		7 Day (%)		2.0%	4.53%	4.46%	↑	4.42%
		30 Day (%)		8.3%	9.30%	9.30%	↓	9.10%
	CQUIN				Jan-14	Jan-13	vs Jan-13	YTD
		Standard Contract CQUIN		Multiple			↔	
		Specialist CQUIN		Multiple				
	Bed Usage	Bed Occupancy (%)		-	97.97%	99.78%	↓	92.89%
		Extra Beds (%)		-	5.53%	8.68%	↓	-
		Outliers		-	25.06	40.81	↓	318.53
		Delayed Transfers of Care (Average)		-	42.60	50.40	↓	38.55

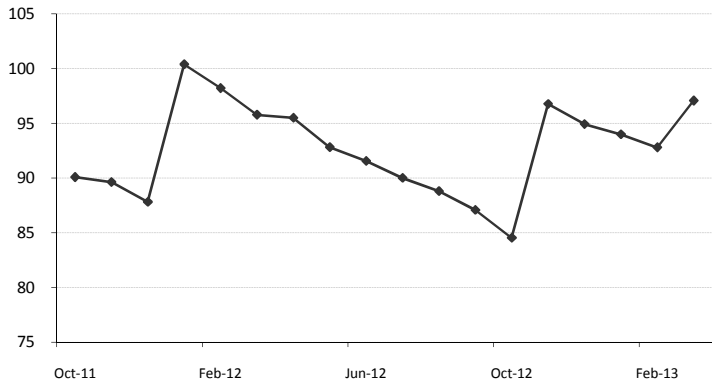
NB: RAMI - Data sharing agreements with CHKS have now been resolved. An up to date RAMI position will be published in the near future.

CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: MORTALITY RATES

Hospital Standardised Mortality Ratio (HSMR) All Discharges

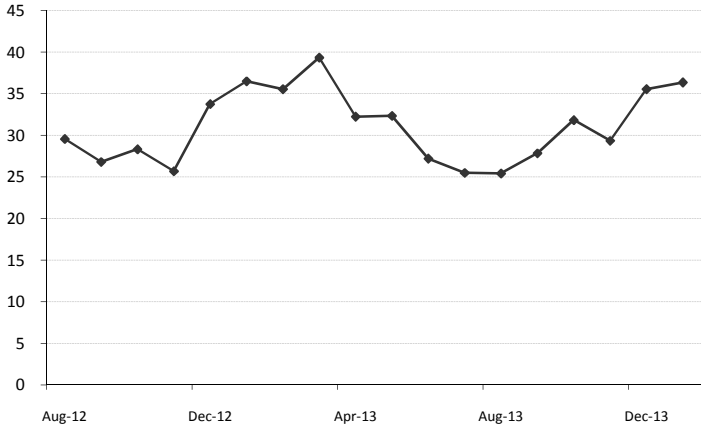


Risk-Adjusted Mortality (RAMI) - All Discharges



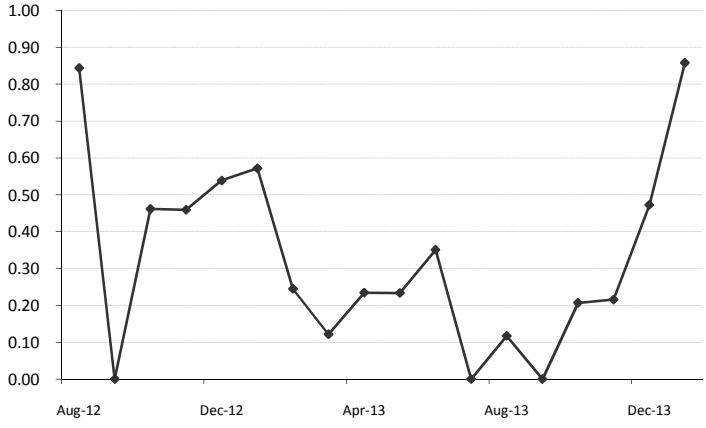
Performance at Trust level remains good across all mortality indicators with the 12 month rolling HSMR equalling 81.7 at the end of Nov-13 (that is, a 0.4 increase upon Oct-13), and is in line with the trend demonstrated by the crude mortality metric.
Data sharing agreements with CHKS have now been resolved 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 1 000



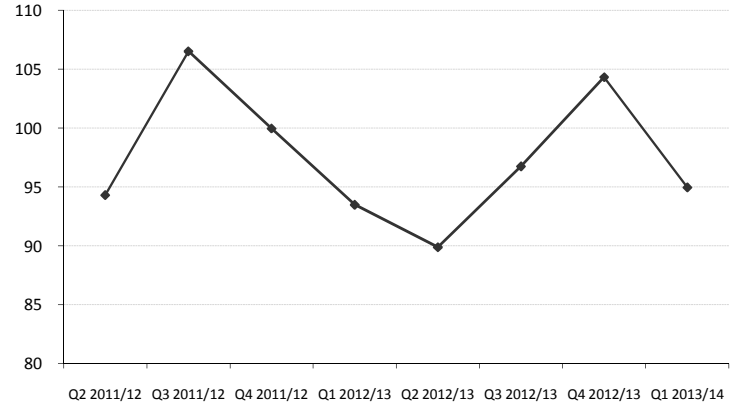
Crude mortality for non-elective patients shows a fairly seasonal trend with deaths higher during the winter months. The winter peak during 2012/13 extended further into the spring than normal, with a reduction to expected levels occurring in June rather than in April/May. Following this trend, Jan-14 performance equalled 36.358 deaths per 1 000 population and as such shows a very slight increase on the previous month. This is in line with previous year's performance and it is expected that this trend will continue.

Crude Mortality - Elective per 1 000



During January elective crude mortality was 0.858 deaths per 1 000 population. Although another sharp increase in month, it remains in line with previous good performance and follows seasonal trend. However, this increase is currently under review and is being investigated.

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 (Q1 2013/14) show a decrease against Q4 2012/13 and are in line with levels last seen at Q1 2012/13.

Serious Incidents - Open Cases

Date		Summary of Serious Incident & Remedial Action Taken	IX lv	Division	Timely Submit?
Incident	STEIS Report				
18-Jan-14	24-Jan-14	Unexpected Death - sepsis	1	UCLTC	Not Due
24-Jan-14	24-Jan-14	Neonatal Death - unexpected breach delivery at home, taken to QEH	2	Specialist	Not Due
21-Nov-13	16-Jan-14	Unexpected Death - myasthaenia gravis		UCLTC	Not Due
17-Jul-13	10-Jan-14	Radiological Error - missed reporting of carotid stenosis in 2 patients		Clinical Support	Not Due
28-Nov-13	3-Jan-14	Unexpected Death - hospital associated venous thromboembolism (pulmonary embolism)		UCLTC	Not Due
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	Yes
6-Nov-13	11-Nov-13	Never Event - misplaced nasogastric tube	2	UCLTC	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	Yes
28-Aug-13	3-Oct-13	Unexpected Admission - term baby admitted to NICU from MLU via labour ward at QEH	2	Specialist	Yes
26-Sep-13	3-Oct-13	Intrauterine Death - at term	1	Specialist	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
16-Mar-13	27-Mar-13	Intrauterine Death - at 24 weeks	1	Specialist	Yes
27-Feb-13	1-Mar-13	Maternal Death - 6 days postpartum	1	Specialist	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
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			
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
22-Mar-13	9-Apr-13	Unexpected Death - adult with small bowel obstruction	1	Surgical
22-Nov-12	22-Nov-12	Unexpected admission to NICU		Specialist

Serious Incidents - Closed Cases

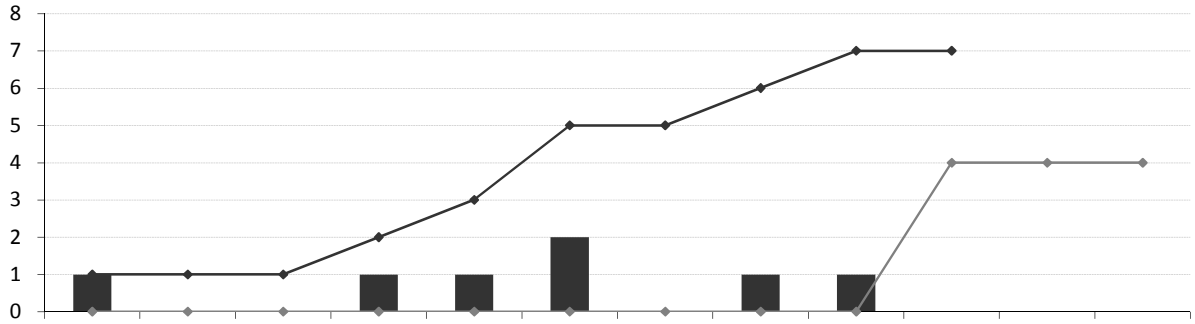
Date		Summary of Serious Incident & Remedial Action Taken	IX lv	Division
Incident	STEIS Report			
30-Oct-13	11-Nov-13	Unexpected Death - post operative AAA repair	1	Surgical
8-Aug-13	11-Oct-13	MRSA bacteraemia	1	UCLTC
8-Aug-13	20-Sep-13	Grade 4 hospital acquired pressure ulcer (avoidable)	1	Surgical
19-Feb-13	6-Mar-13	Suboptimal care of deteriorating patient	1	Surgical
5-Nov-12	6-Nov-12	Intrauterine Death - at 41+2 weeks	1	Specialist
17-Jun-10	1-Jul-10	Child Death - pneumococcal meningitis	3	Specialist

Five serious incidents were reported on STEIS in Jan-14. These were: an unexpected death due to a hospital associated pulmonary embolism; misreporting of carotid stenosis resulting in potentially avoidable strokes in 2 patients; an unexpected death due to myasthenia gravis crisis (joint with GP); a neonatal death following an unexpected breech delivery at home (joint with SECAmb); and the death of a 41 year old woman with sepsis. Six incidents were closed: 1 suboptimal care, 1 intrauterine death; 1 child death - pneumococcal meningitis; 1 pressure ulcer; 1 MRSA bacteraemia; and 1 unexpected adult death. 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. At the end of Jan-14 there were 26 serious incidents open. The CCGs have agreed closure of 4 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.

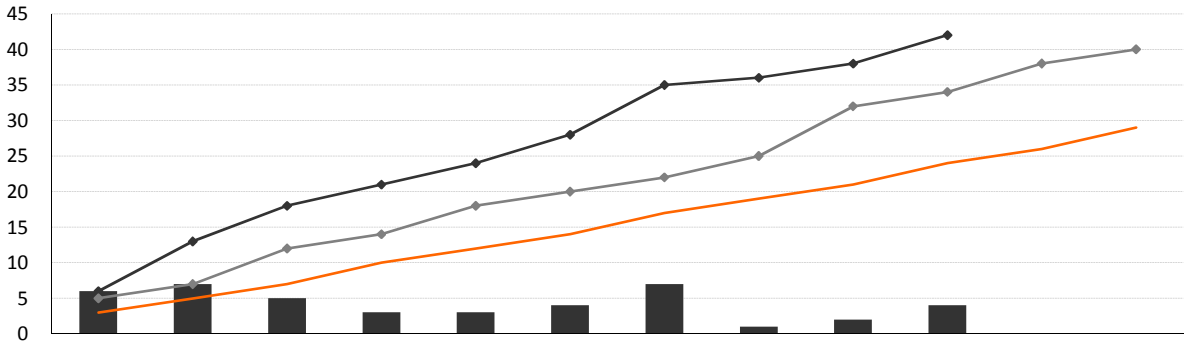
MRSA Bacteraemia - Trust Assigned Cases



	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	0		
2013/14 Cumulative	1	1	1	2	3	5	5	6	7	7		
2012/13 Cumulative	0	0	0	0	0	0	0	0	0	4	4	4

There were no Trust assigned MRSA bacteraemia cases during Jan-14. One pre 48h MRSA bacteraemia was assigned to the CCG. The cumulative total of MRSA cases that are Trust assigned remains at 7 and represents an increase on the number of cases seen in the 2 previous years when 4 post 48h cases each year were attributed to EKHUFT. The increase in 2013/14 may represent random fluctuation in small numbers, or a true increase reflecting the presence of the Lyon clone of MRSA which has been present in East Kent since 2011 and has been responsible for 3 MRSA bacteraemia cases during the past 10 months.

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	4		
2013/14 Cumulative	6	13	18	21	24	28	35	36	38	42		
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 4 post 72h C difficile cases in January, a slight increase on numbers seen in November and December. However, the overall trend since Q2 has been a return to the low baseline established in the 2 previous years. The Infection Prevention and Control Team expect that the Q1-Q4 total will be below the NHS average rate for acute Trusts despite being above the Department of Health local target.

PATIENT SAFETY: HOSPITAL ACQUIRED INFECTIONS

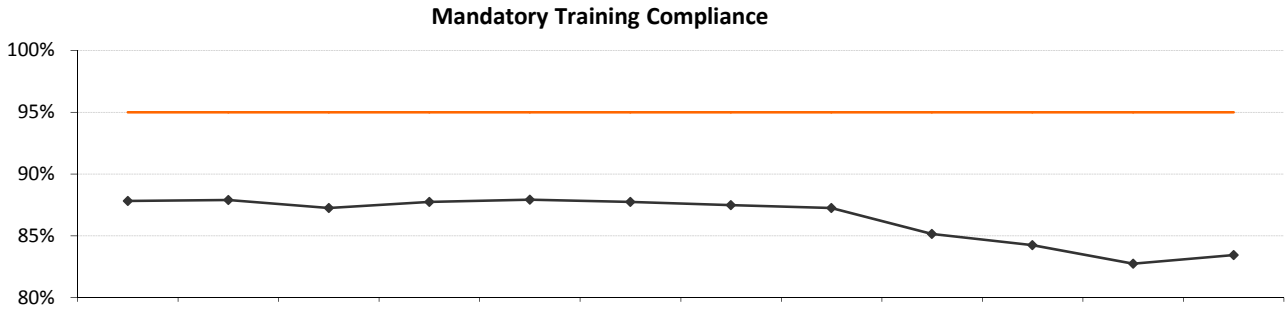
Escherichia coli Bacteraemia - Incidents Pre and Post 48h

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly Average	Total Apr - Jan
2013/14	Pre 48h	30	33	41	37	28	42	36	36	26	31			34.0	340
	Post 48h	4	3	4	12	3	12	10	4	8	8			6.8	68
2012/13	Pre 48h	30	27	20	33	34	37	39	22	28	30	25	34	29.9	300
	Post 48h	11	8	3	9	6	5	5	5	2	4	8	8	6.2	58

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. There were 31 pre 48h and 8 post 48h Ecoli infections in Jan-14. This is similar to the monthly totals reported during the previous 9 months. Cases were evenly distributed between hospital sites and provide no evidence of hospital acquired infection. The trend for increased pre and post 48h cases in 2013/14 is reflected in both national and local Ecoli totals for NHS Trusts in England (Public Health England data).

PATIENT SAFETY: INFECTION PREVENTION & CONTROL



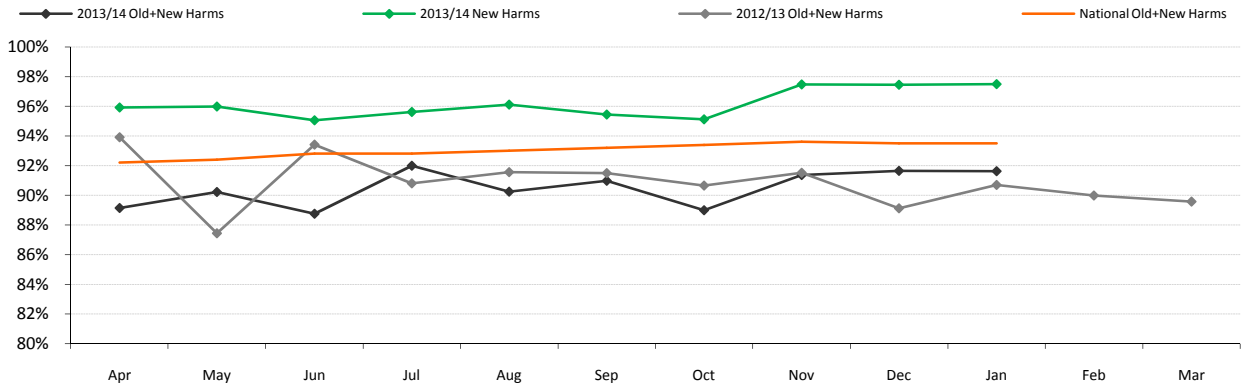
	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14
Compliance	87.8%	87.9%	87.3%	87.7%	87.9%	87.8%	87.5%	87.3%	85.2%	84.3%	82.7%	83.5%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

	Jan-14							
	Target	Trust	Clinical Support Services	Corporate	Specialist Services	Strat Dev & Capt Pln	Surgical Services	UCLTC
Mandatory Comparative Data for Biennial Training Compliance	95%	83.5%	84.3%	86.8%	81.3%	93.2%	82.6%	82.8%

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 compliance has improved slightly this month from 82.7% in December to 83.5% in January. This is encouraging as there had been a month on month decline over the previous 3 months. All Divisions have improved apart from Specialist Services who had 81.3% compliance in January compared with 82.4% in December.

Safety Thermometer Harm Free Care



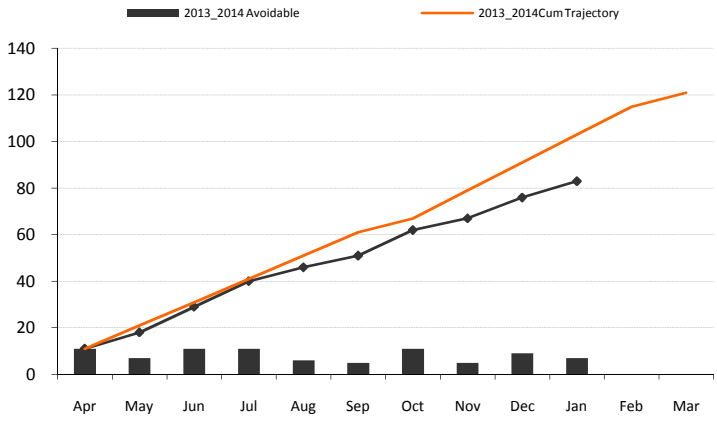
The chart above shows the percentage of Harm Free Care expressed as a one-day snapshot in each month. It is known as the NHS Safety Thermometer and is a quick and simple method for surveying patient harms. The aim of the Safety Thermometer is to identify, through a monthly survey of all adult inpatients,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

- All 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.

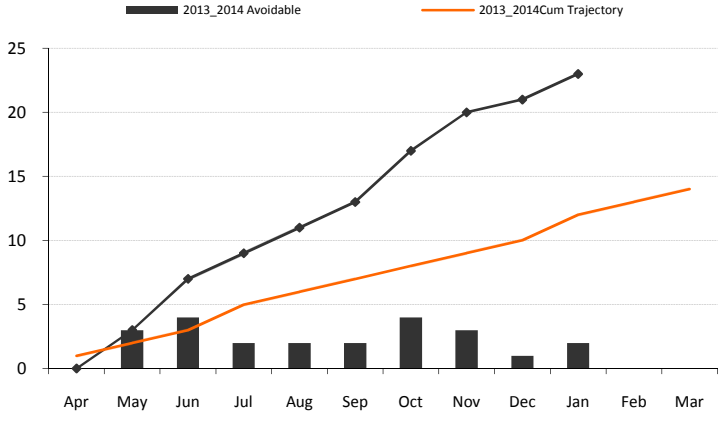
The strength of the NHS Safety Thermometer lies in allowing front line teams to measure how safe their services are and to deliver improvement locally. There are several different ways in which harm in healthcare is measured and there are strengths and limitations to the range of approaches available. 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 Jan-14, the Trust's own score is 97.5% showing that those patients in our care have a greater harm free experience. This is above the national figure of 93.5% 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 91.6%. 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, during Jan-14 we have also reviewed 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)



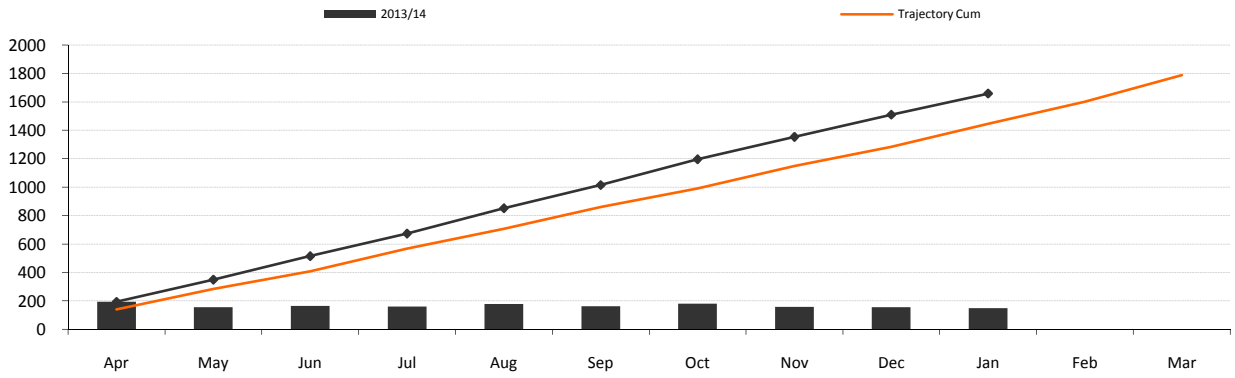
Grade 3 and 4 Incidence Trajectory 2013/14
50% Reduction



In January, 15 hospital acquired grade 2 pressure ulcers were reported, of which 7 were avoidable. This is a reduction of 7 and 2 respectively from the previous month and reflects improvements in meeting best practice standards. There has been significant progress towards the Trust Wide Action Plan. This includes enhancing multidisciplinary team working to improve patient pressure ulcer prevention plans and commencing roll out of the SKINS bundle to all other areas, such as A&E.

In January, there were 8 deep ulcers reported (grades 3 and 4). Two of these were agreed as avoidable, but 6 are awaiting planned multidisciplinary investigations. Six heel ulcers developed at WHH, with 3 developing in T&O, 1 in Stroke, and 2 in UCLTC. At QEH, UCLTC reported 2 deep ulcers affecting the lower limb. Both were classified as avoidable due to the lack of documented evidence of a prevention plan. KCH did not report any acquired deep ulcers this month. In addition a task and finish group has been set up to undertake a meta-analysis of all deep ulcers during 2013/14. Learning and actions from this review will be rolled out.

Patient Falls - Injurious and Non-Injurious

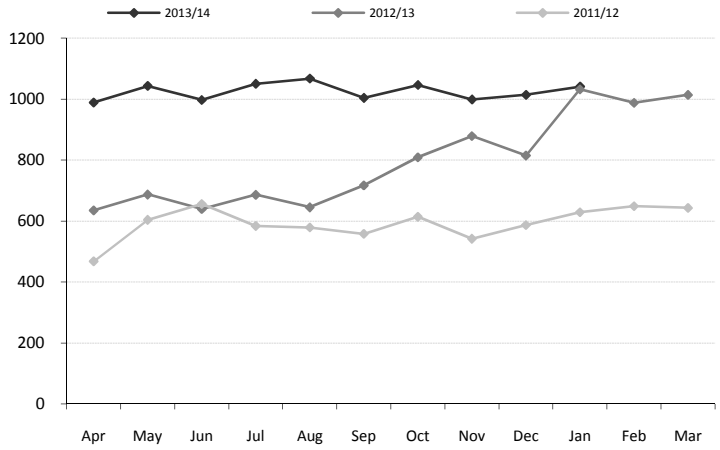


Work to understand the increase in falls incidences this year has identified that a refocus on thorough assessment is needed at the point of admission. The Falls Team has worked with the ward based Falls Link Workers to revise the current falls screening tools in response to NICE 161 (Jun-13) "Prevention of Falls in Older People", and the Trust Falls Screening and Intervention Audit 2013. A new Falls Risk Assessment and Care Plan was produced with their engagement and has been extensively piloted in several areas. The tool will "go live" on 11 Feb-14. The Falls Team are working with colleagues in movement and handling, and tissue viability to streamline the entire Risk Assessment Booklet as part of the work undertaken by the Harm Prevention Action Group. The purpose of this work is to prevent duplication of assessments and enhance the accuracy of the risk assessment and intervention. Alongside this, joint working during Root Cause Analysis is helping to identify common themes when patients suffer falls with significant harm, including movement and handling issues and Dementia care.

CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: CLINICAL INCIDENTS

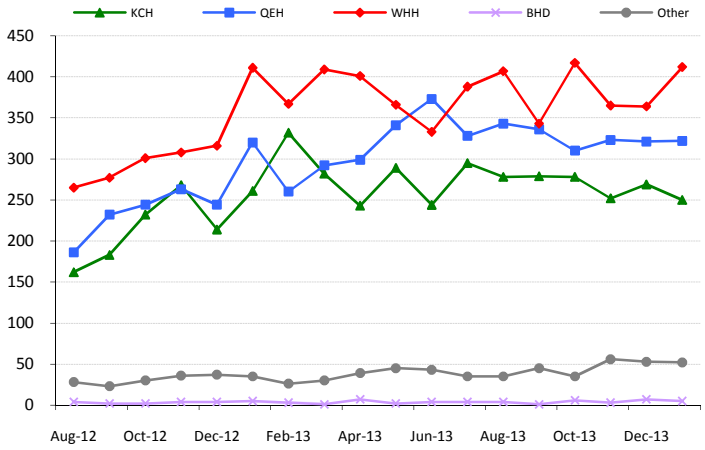
In Jan-14 a total of 1042 clinical incidents and patient falls were reported. This includes 5 incidents (which are under investigation) graded as death and 1 (which is under investigation) graded as severe. Unapproved incidents may be downgraded following investigation. In addition to these 6 serious incidents, 48 incidents have been escalated as serious near misses, of which 6 have been finally approved.
Five serious incidents were required to be reported on STEIS in January. Six cases have been closed since the last report; there remain 26 serious incidents open at the end of January of which 4 have been closed by the KMCS pending review of external bodies before closure on STEIS.

Overall Incident Rates by Year



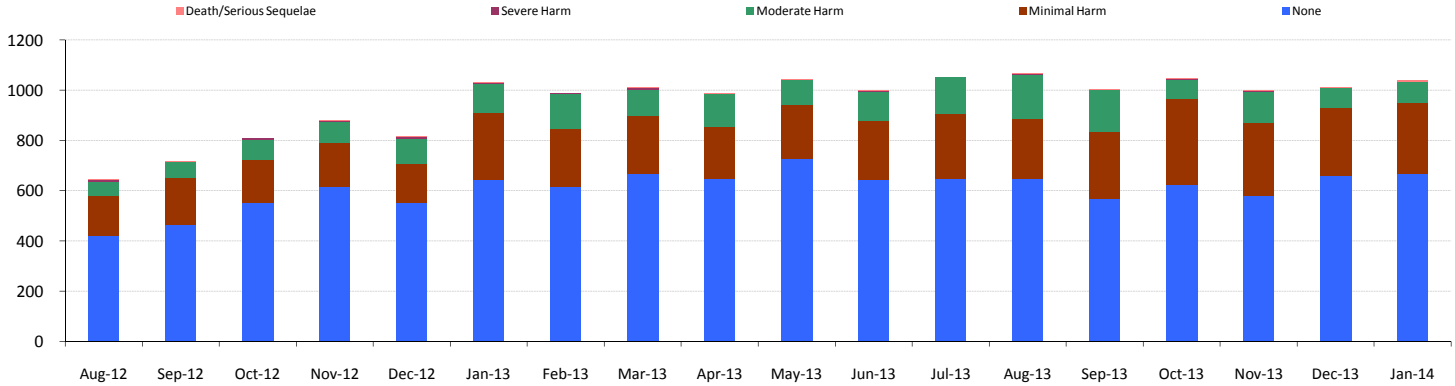
A total of 1042 clinical incidents have been logged in January compared with 1014 recorded for Dec-13.

Overall Incident Rates by Site



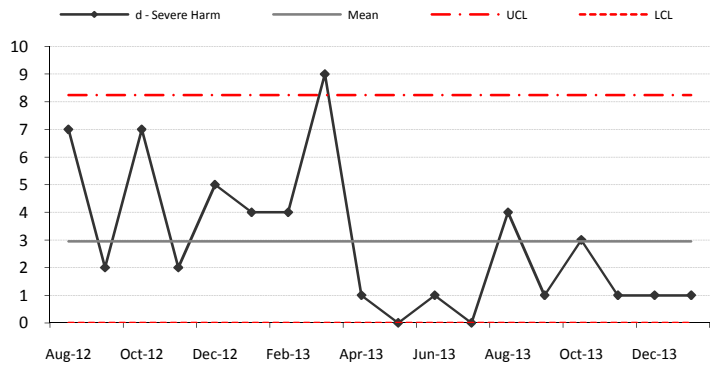
Incident numbers for January at WHH have risen slightly, whereas no change in clinical incidents is evident at other sites.

Clinical Incidents by Severity

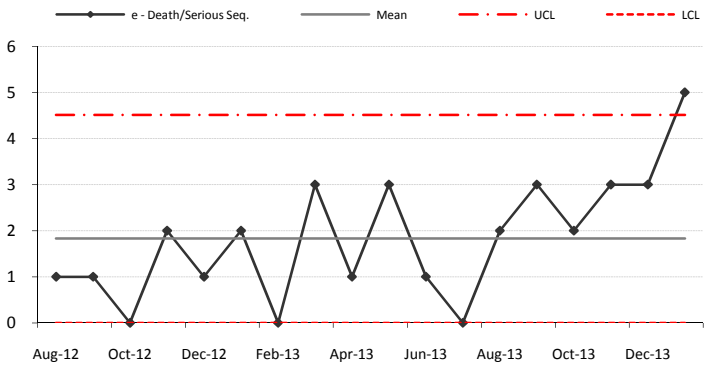


The incidents graded as moderate, serious and death have all been subject to review in order to confirm the consistency of the grading of harm across the Trust. The Board of Directors may see a change in this report to reflect the re-categorisation process undertaken. This is consistent with the data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

Severe Harm

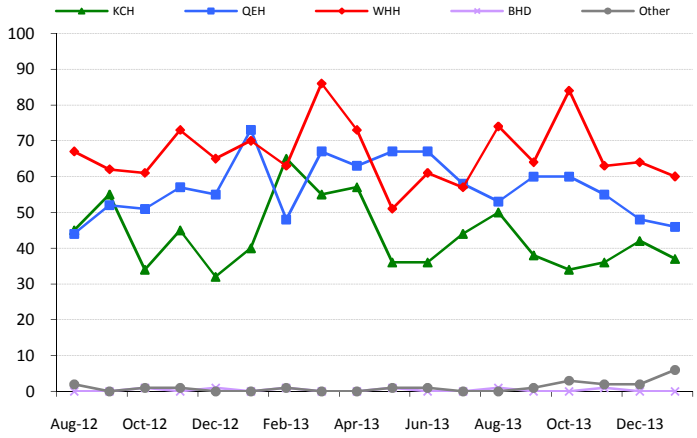


Death/Serious Sequelae



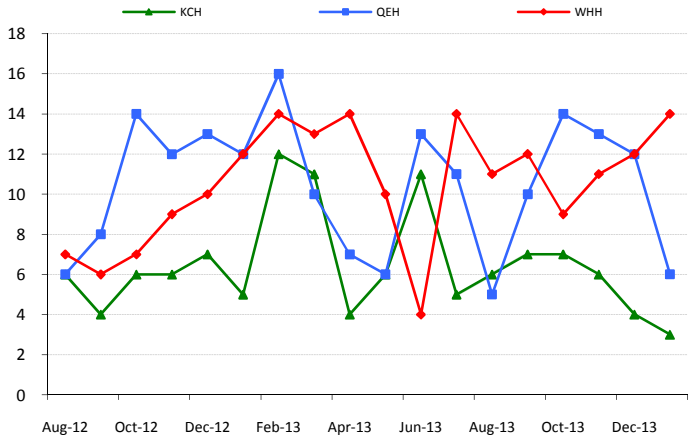
The number of death/serious and severe harm incidents reported in Jan-14 remains subject to the usual Root Cause Analysis (RCA) investigation and review. It is possible that the severity of these cases will be downgraded once the investigation process is completed. In Jan-14, the number of incidents graded as death is higher than in previous months, but are still under investigation.

Patient Slips, Trips and Falls



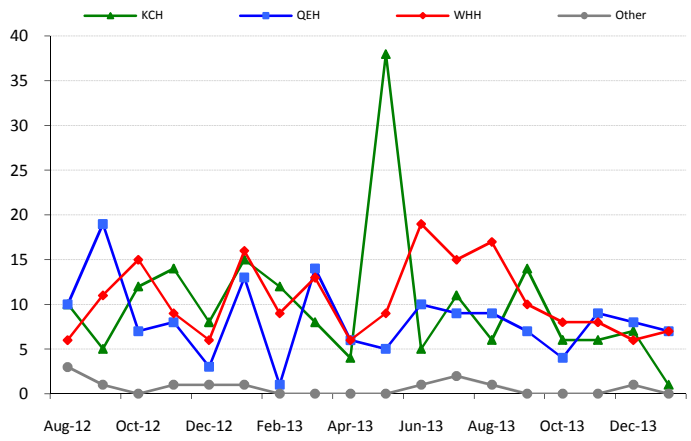
Of the 149 patient falls recorded for January (156 in December), none were graded as severe or death. There were 84 falls resulting in no injury, 58 in low harm and 7 in moderate harm. The top reporting wards were CDU (WHH) with 12 falls; Mount/McMaster (WHH) and Cambridge L (WHH) with 9 each; Fordwich Stroke Unit (QEH) with 8; CDU (QEH) and Minster (QEH) with 7 each. The remaining wards reported 6 or less falls. Of the 7 moderate harm falls, 3 resulted in fractures and occurred on Kings C1 (WHH), Richard Stevens Stroke Unit (WHH) and CDU (WHH). A Root Cause Analysis is carried out for all falls resulting in serious harm or fracture.

Hospital Acquired Pressure Ulcers



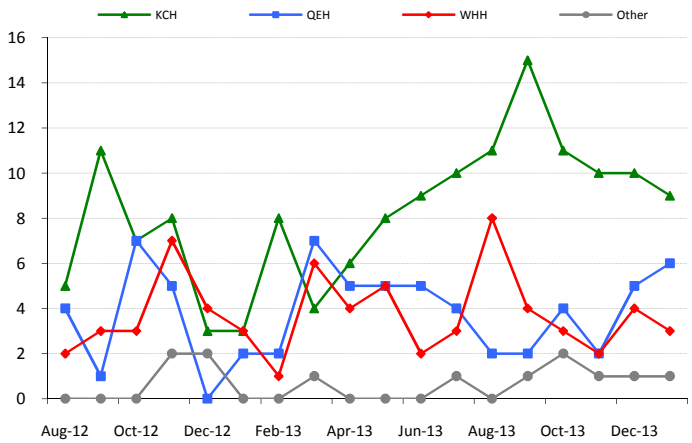
In January there were 23 reported incidents of pressure ulcers developing in hospital (28 in December). This included 15 grade 2 pressure ulcers, 7 grade 3, and 1 grade 4. Nine have been assessed as avoidable, 8 as unavoidable and 6 not yet assessed (awaiting RCAs). The highest reporting wards were Cambridge L (WHH) and Cambridge M1 with 3 incidents each; Kings D Male (WHH) and Richard Stevens Stroke Unit (WHH) with 2 incidents each.

Delay in Providing Treatment



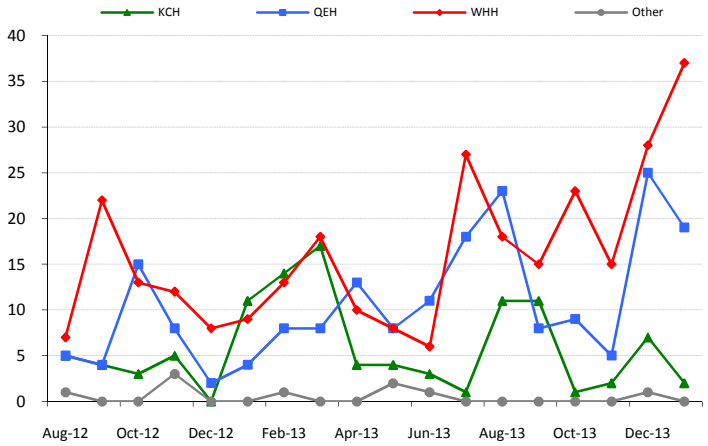
There were 15 incidents resulting in delay in providing treatment during January compared with 22 in December. One incident, graded as death, has been reported on STEIS and is under investigation. No incidents have been graded as severe harm. One incident was graded as moderate, 5 graded as low, and 8 resulted in no harm (which included 5 serious near misses). Themes in location: 7 incidents occurred at QEH, of which Viking Day Unit (chemotherapy) reported 3 incidents and A&E reported 2; 7 incidents occurred at WHH (where there were no themes in the exact location); 1 incident occurred at KCH.

Incorrect Data in Patient Notes



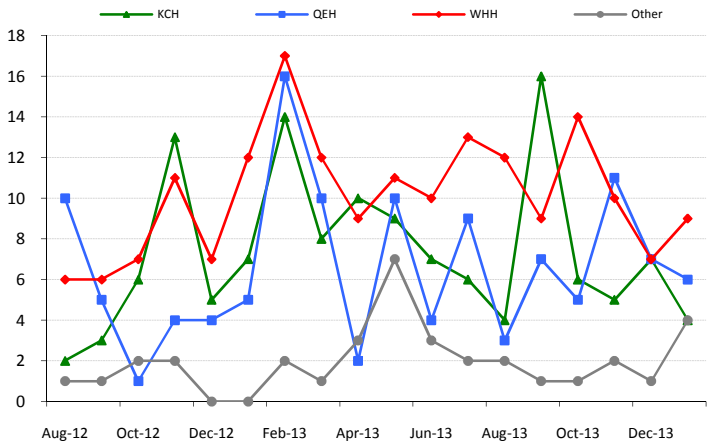
There were 19 incidents of incorrect data in patients' notes reported as occurring in January (20 in December), of which 18 were graded as no harm and 1 as low harm. Fifteen incidents related to incorrect data in paper notes, 3 to incorrect data on patient's electronic record (Patient Centre/Euroking), and 1 to incorrect data in Electronic Discharge Notifications (eDN). Of the incidents reported, 9 were identified at KCH, 6 at QEH, 3 at WHH and 1 at RVHF. The highest reporting area was Outpatients (KCH) with 6 incidents.

Staffing Level Difficulties



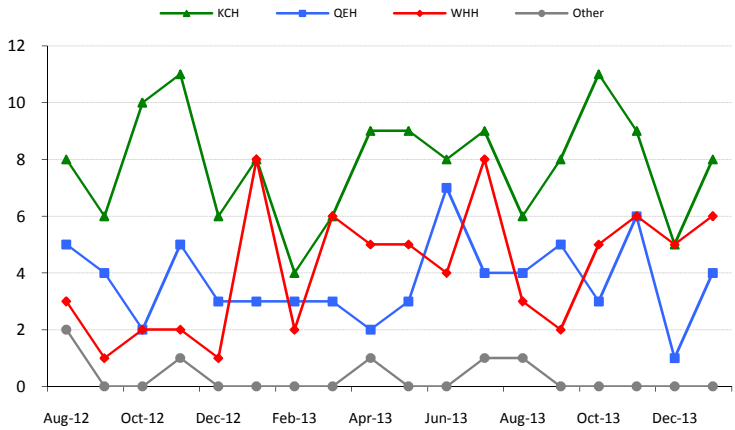
There were 58 incidents recorded in January (61 in December). These included 21 incidents relating to insufficient nurses and midwives, 3 to inadequate skill mix, 2 to insufficient doctors, 1 to insufficient doctors and nurses, and 31 to general staffing level difficulties. Top reporting locations were Singleton Unit (WHH) with 16 incidents, Cheerful Sparrows Male (QEH) with 6, Folkestone (WHH) with 5, and Quex (QEH) with 4 incidents.
Two incidents occurred at KCH, 19 at QEH and 37 at WHH. Fifty six incidents were graded as no harm and 2 as low harm.

Communication Breakdowns



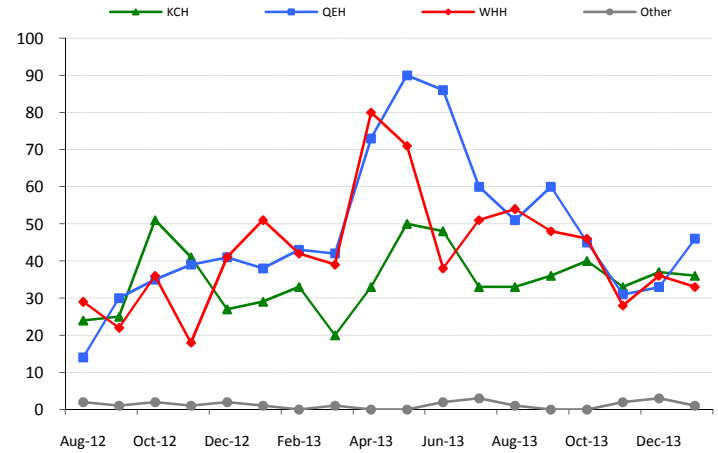
In Jan-14 there were 23 incidents of communication breakdown (22 in December). Of these, 15 involved staff to staff communication failures, 7 were staff to patient and 1 was staff to relative (or other visitor). Of the 23 incidents reported, 4 were reported as occurring at KCH, 6 at QEH, 9 at WHH, 1 at Medway Renal Satellite Unit, and 3 in the community. No area reported more than 1 incident. Incidents in January were graded as follows: 19 as no harm and 4 as low harm.

Blood Transfusion Errors



In January, there were 18 blood transfusion errors reported (11 in December). No main themes arose in the period, however 2 incidents in each of the following categories were reported: communication, delay in provision of component/product, prescription/documentation error (including traceability), testing and processing error, and wastage (clinical/laboratory). Of the 18 incidents reported, 13 were graded no harm, 3 as low harm and 2 as moderate harm. Reporting by site: 8 at KCH, 4 at QEH (of which 3 occurred on Seabathing), and 6 occurred at WHH.

Medicines Management



There were 116 medication incidents reported as occurring in January (compared with 109 in December).

Medicines Management

Category	Jan-14
Prescribing	24
Dispensing	29
Administering	41
Missing (lost or stock discrepancy)	11
Shortage (drug unavailable)	1
Suspected adverse reaction	3
Infusion problems (drug related)	3
Infusion injury (extravasation)	4
TOTAL	**116**

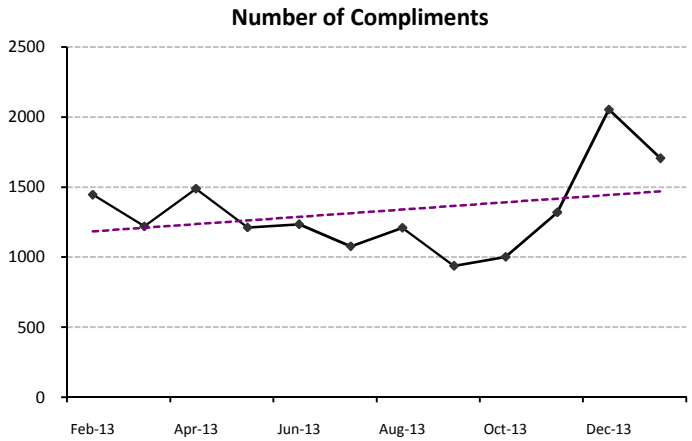
Of the 116 incidents reported, 103 were graded as no harm (including 17 serious near misses), and 13 as low harm. No serious incidents were reported. Top reporting areas were: Viking Day Unit (QEH) reported 17; Folkestone (WHH) and Pharmacy (KCH) each reported 7 incidents; CDU (KCH) reported 5; Treble (KCH), Sandwich Bay (QEH), and CDU (QEH) reported 4 incidents each. Other areas reported 3 or less incidents. Forty six incidents were reported at QEH, 36 at KCH, 33 at WHH, and 1 incident at another site.

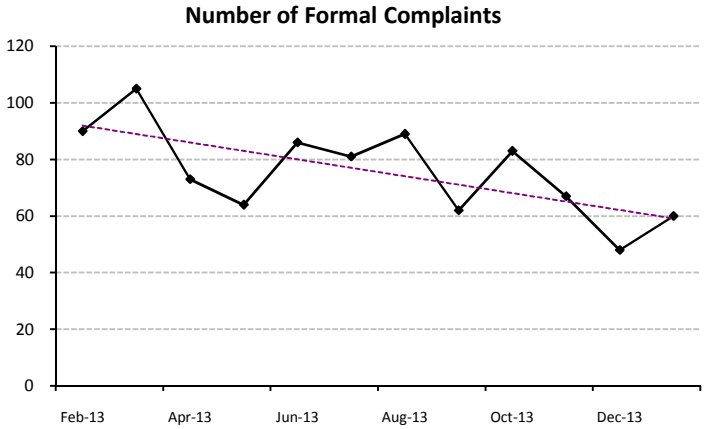
PATIENT EXPERIENCE: CONCERNS, COMPLAINTS & COMPLIMENTS

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 Jan-14. The information reported is for cases received in month and formal cases with target dates due that month.

• Activity: Formal complaints - 60; informal contacts - 277; compliments - 1707.

The charts below show the number of complaints and compliments received on a monthly basis. One formal complaint has been received for every 1417 recorded spells of care (inpatient, outpatient and A&E attendances) in comparison with December's figures where 1 formal complaint was received for every 1602 recorded spells of care.





In Jan-14 the number of compliments received has decreased by 17% compared to the previous month. The ratio of compliments to formal complaints received for the month is 28:1. There has been 1 compliment received for every 50 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.

The number of formal complaints received has increased by 25% compared to Dec-13, and has decreased by 20% since Jan-13. The number of informal contacts has increased by 30% compared to the previous month, and has also increased by 34% compared to Jan-13.

Top Five Concerns Expressed in Formal Complaints
January 2014

Concerns		No.
Problems with Attitude	Problems with nurse's attitude	6
	Problems with doctor's attitude	4
	Problems with other staff's attitude	2
Problems with Nursing Care	Problems with nursing care	8
	Delay in receiving treatment	1
	Inappropriate physical handling	1
Concern about Clinical Management	Lack of/inappropriate pain management	4
	Incomplete examination carried out	3
	End of life/palliative care issues	1
	Scans/X-rays not taken	1
Problems with Communication	Doctor communication issues	3
	Nursing communication issues	3
	Misleading or contradictory information given	2
Problems with Discharge Arrangements	Unfit for discharge/or poor arrangements	6

The common themes raised within the top 5 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, the highest recurring subjects raised in Jan-14 were problems with attitude, problems with nursing care, concerns about clinical management, problems with communication , and problems with discharge arrangements.

Concerns, Complaints and Compliments - Divisional Performance

January 2014

Division	Divisional Activity				Divisional Performance	
	Formal Complaints	Compliments	Informal Contacts	Compliments: Complaints	First Response Met	Returning Complaints
Clinical Support	4	97	29	24:1	4 of 5	0
Specialist Services	9	1095	27	121:1	8 of 10	0
Surgical Services	16	337	116	21:1	27 of 33	2
UCLTC	29	176	66	6:1	31 of 35	1
Corporate	2	0	34	0:1	1 of 1	0
Other	0	2	5	2:0	0	0
TOTAL	60	1707	277	28:1	71 of 84	3

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

The table above shows the monthly Divisional activity and performance for Jan-14, 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 Jan-14, there were a total of 84 responses sent out to clients. The data show that 84.5% of these responses were sent within the 30 working days target, and as such show a 1% increase over the Dec-13 position (i.e. 83.5%).

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

Status of Cases	Actions in Jan-14
Cases carried over from previous month	16
New cases referred to the Trust	1
Cases closed by PHSO	1
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 January, the PHSO have been in contact with the Trust with regards to 1 new case brought to their attention, and have requested papers from the Trust and comments from the Division involved (UCLTC). The Trust also received 1 draft from the PHSO requesting Divisional comments, and 1 case under formal investigation was closed and 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 54 in January This is the combined satisfaction from 2870 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 Jan-14 was 4.5 stars out of 5 stars and is similar to last month.

The response rate for Jan-14 for inpatients and A&E combined achieved the 15% standard this month at 18.32% and awaits Unify2 validation. Once again the wards exceeded the 15% standard with a 26.53% response rate. The A&Es achieved 13.45% this month. Maternity services achieved 28.37% 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.

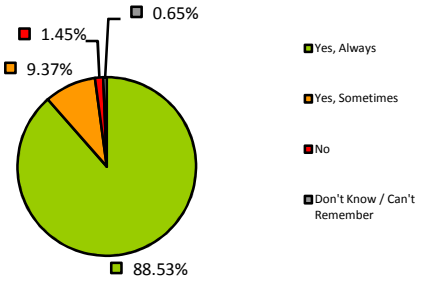
Events took place across the Trust during October by frontline staff. These have sought feedback from patients and families, as well as having discussions about the We Care values within teams. The Steering Group are currently working on the development of the We Care Programme going forward. This includes 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 advertisements, the recruitment process, and our engagement with staff. The roll out of the "We Care" Champions has commenced following the approval by the Board of Directors of the Trust values. More events are also scheduled for March to engage staff and patients in the delivery of the values.

PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

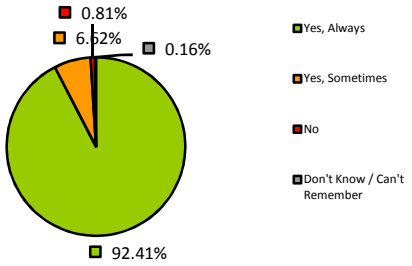
Real time patient experience monitoring using iPads have captured data since 1 Apr-13. During Jan-14, 619 adult inpatients were asked about their experiences of being an inpatient; 47 responses were received from patients treated at KCH, 129 from QEH patients, and 443 responses from patients based at WHH. (Compared with the previous month the number of responses were 55, 103 and 410 respectively). The combined result from all submitted questionnaires in Jan-14 was that 89.16% satisfaction.

Were you given enough privacy when discussing your treatment?



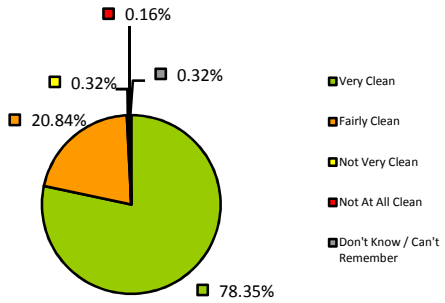
Overall Score = 93.82%

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



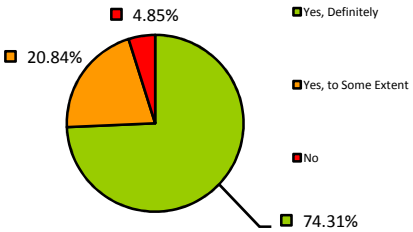
Overall Score = 95.87%

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



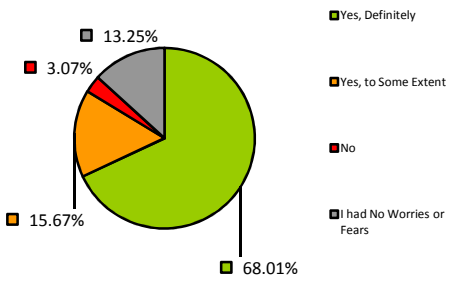
Overall Score = 92.65%

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



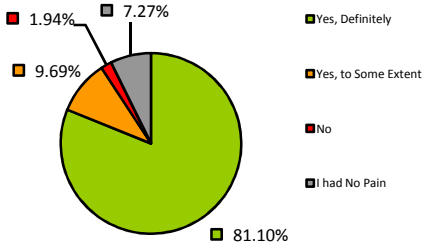
Overall Score = 84.73%

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



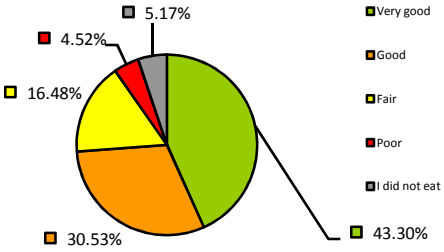
Overall Score = 87.40%

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



Overall Score = 92.68%

How would you rate the hospital food?



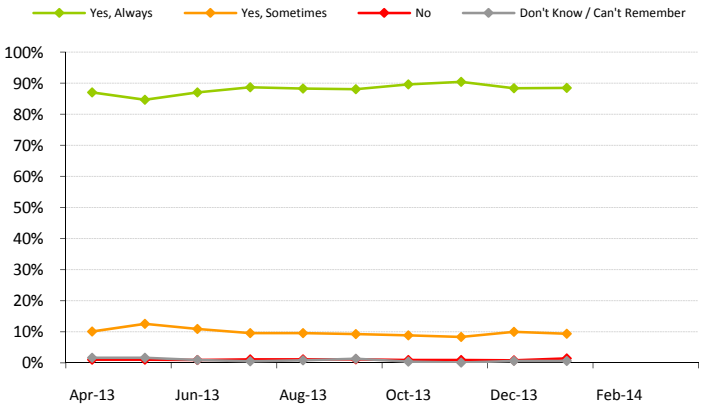
Overall Score = 72.91%

Overall Adult Inpatient Experience Jan-14	
Experience (%)	**No. of Responses**
89.16	619

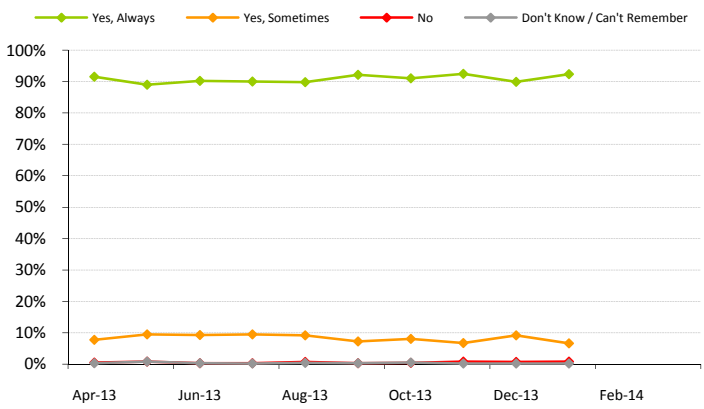
In response to the question "How would you rate the hospital food?" patients are able to answer "very good, good, fair, poor, or I did not eat". This replicates the methodology of the annual national CQC inpatient survey which respectively canvases the opinion of 850 EKHUFT inpatients. In 2012 the results 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 Nov-13 to Jan-14 the real-time monitoring of inpatient experience at KCH, QEH and WHH rated hospital food as 66%, 73% and 71% 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

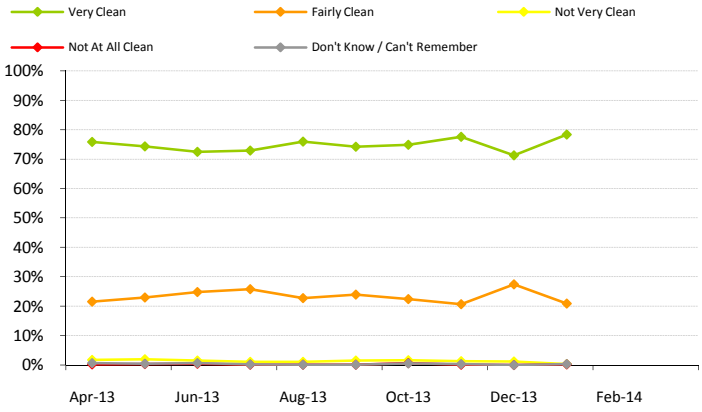
Were you given enough privacy when discussing your treatment?



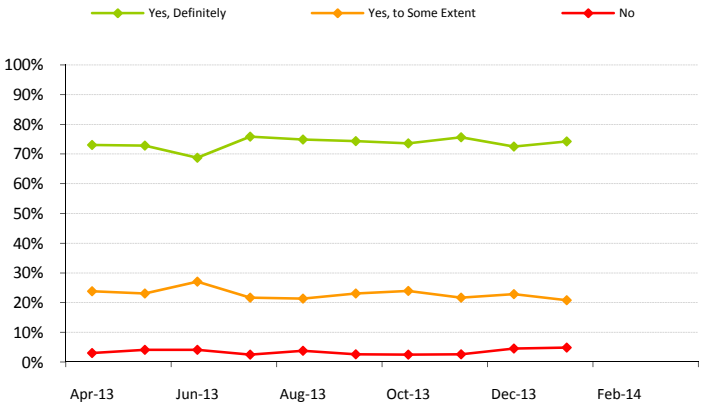
Overall, did you feel you were treated with respect and dignity while you were in hospital?



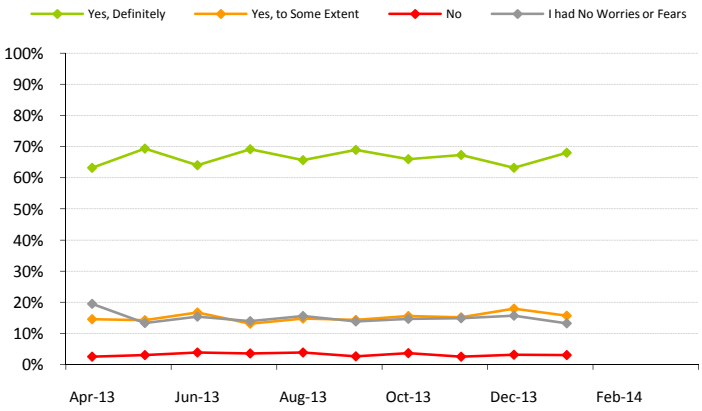
In your opinion, how clean was the hospital room or ward that you were in?



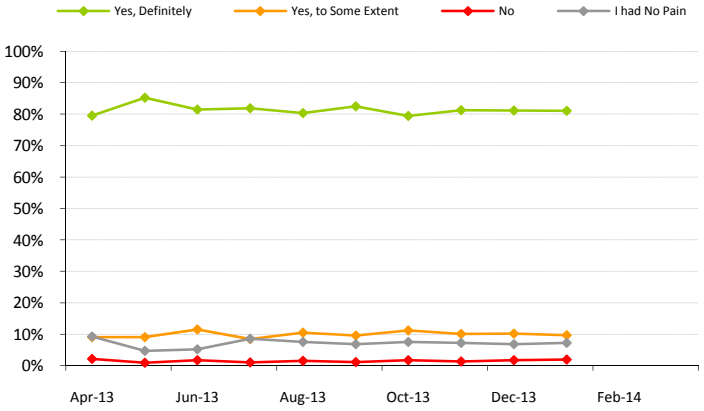
Were you involved as much as you wanted to be in the decisions about your care and treatment?



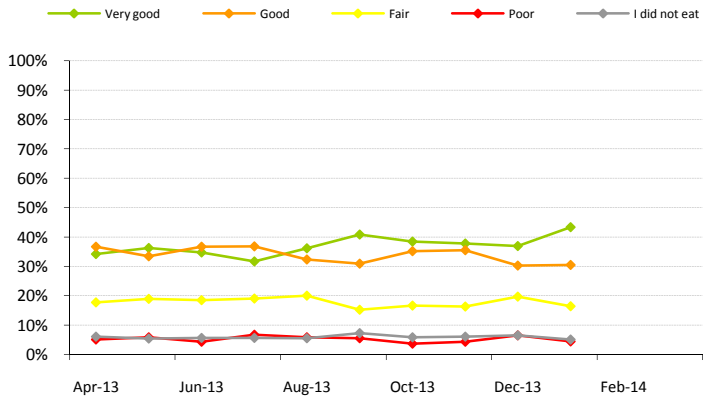
Did you find someone on the hospital staff to talk about your worries and fears?



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



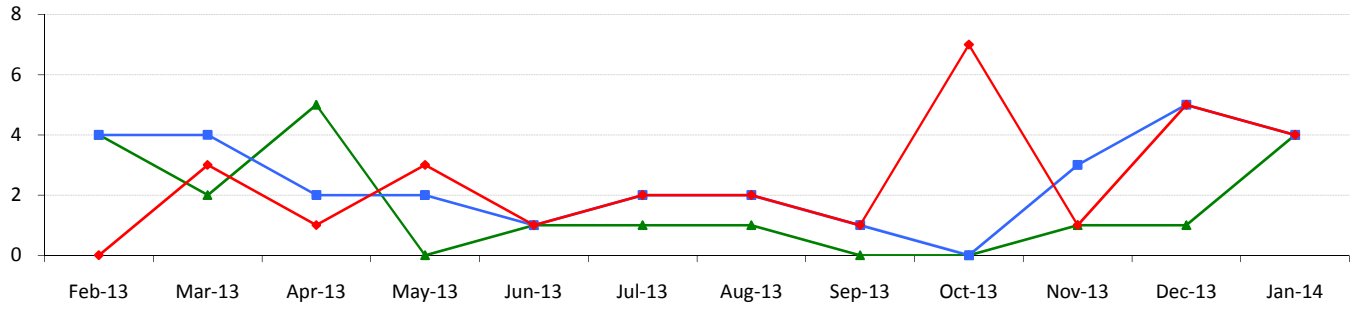
How would you rate the hospital food?



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.

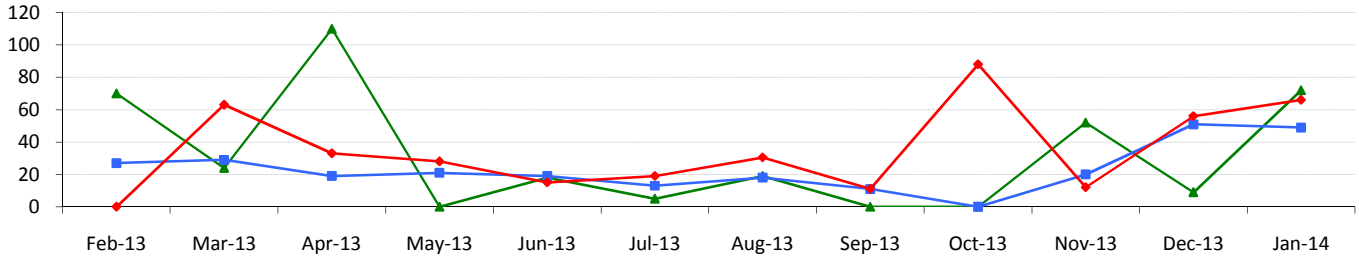
CLINICAL QUALITY & PATIENT SAFETY
PATIENT EXPERIENCE: MIXED SEX ACCOMMODATION

Number of Episodes of Mixed Sex Occurrence



	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14
KCH	4	2	5	0	1	1	1	0	0	1	1	4
QEH	4	4	2	2	1	2	2	1	0	3	5	4
WHH	0	3	1	3	1	2	2	1	7	1	5	4

Number of Hours of Mixed Sex Occurrence



	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14
KCH	70	24	110	0	18	5	19	0	0	52	9	72
QEH	27	29	19	21	19	13	18	11	0	20	51	49
WHH	0	63	33	28	15	19	30.5	11	88	12	56	66

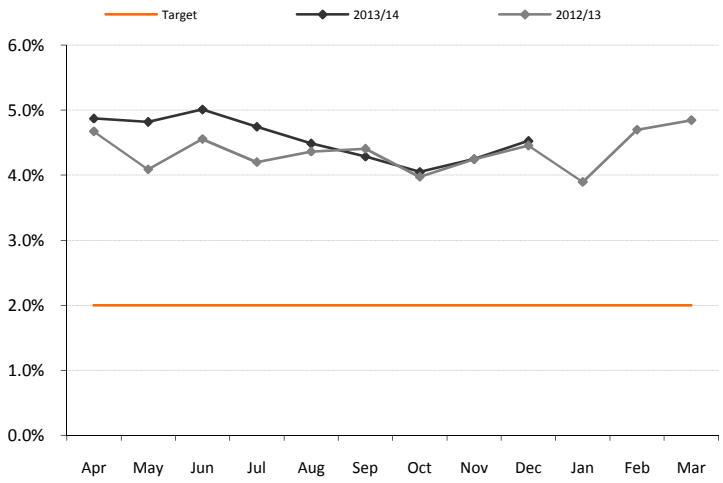
Mixed Sex Accommodation Occurrrences January 2014

Site	Clinical Area	Total No. of Occurrences	Total No. of Patients Affected
KCH	Kingston	4	15
QEH	CCU	1	4
QEH	CDU	2	10
QEH	Fordwich	1	4
WHH	CDU	4	30
TOTAL		**12**	**63**

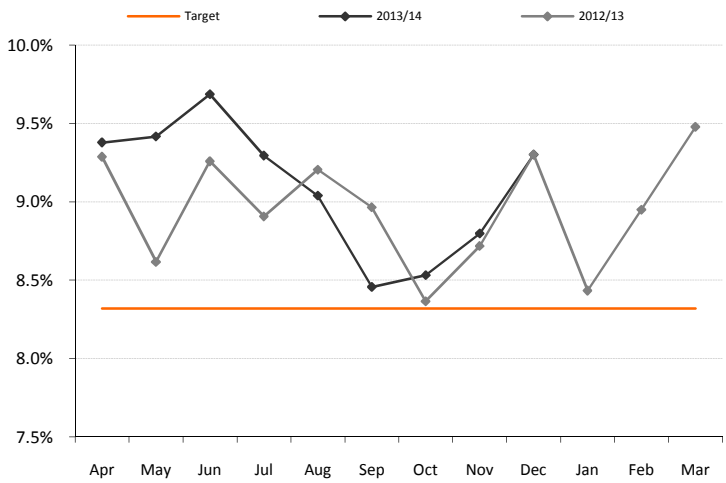
During Jan-14 there were no reportable mixed sex accommodation breaches to NHS England via the Unify2 system. These were not reported as they complied with CCG criteria, such as clinical need. There were 12 clinically justified mixed sex accommodation occurrences affecting 63 patients. The Trust is working 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. Building works are commencing in the CDU at KCH in order to provide additional toilet and shower facilities. It is worth noting that none of January's occurrences were in the CDU at KCH. Collaborative work continues with the CCGs where the policy scenarios are being revised. This is due to be discussed at the Quality Meeting in February where the policy will be refreshed and agreed collaboratively.

CLINICAL QUALITY & PATIENT SAFETY
CLINICAL EFFECTIVENESS: READMISSION RATES

Re-Admission Rate - 7 Day



Re-Admission Rate - 30 Day



The 9.30% increase in 30 day readmission rates for December is in line with seasonal patterns and can be attributed to the start of seasonal pressures.
The meeting is planned for the end of March with Paul Stevens and Julie Pearce to review the opportunities to further reduce the 30 day readmission rate. This will be achieved through anticipated improvements the Trust will be making to bring the organisation in line with the national readmission rate.

			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	31.8%	0.5%	4.4%	2.7%	9.1%	18.4%	22.5%	23.5%	26.5%	31.8%	26.5%			2.5%	16.7%	27.3%		
				A&E	To be baselined Q1	Increased response rate	15.0%	3.7%	2.4%	3.1%	1.7%	5.4%	6.5%	5.8%	7.6%	15.0%	13.4%			3.1%	4.5%	9.5%		
		1.2	Phased Expansion		NA	Rollout to maternity by Oct-13									1.8%	18.7%	12.9%					16.0%		
		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%	100.0%			100%	100%	100.0%		
		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	83	11	7	11	11	6	5	11	5	9	7			29	22	25		
	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%	98.7%				96.9%	99.4%	99.1%		
			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%	95.7%				78.2%	93.6%	94.5%		
			Appropriate Referral		100%			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	100.0%	100.0%				100.0%	100.0%	100.0%		
		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%	21.7%			13.1%	14.9%	20.4%		
		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%	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		Combined 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 January data are within trajectory (i.e. 83 against a trajectory of 103).																			
	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 and second quarter results confirmed that the 60% target was exceeded.																			

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

	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%	93.7%					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%	55.0%					44.5%	49.9%			
		5.8	Gynaecology (ER) (Sept-13 to Feb-14)	15.5%	14.4%	35.5%	97.4%	84.8%	87.2%	87.8%	94.6%	90.7%	94.7%	97.4%	93.8%					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%		100.0%				66.7%				
	Respiratory Disease	6.1	Referral for Smoking Cessation Service	Q1 13/14 - 7.1%	Process, baseline, trajectories and improvement		9.3%	7.7%	4.2%	9.1%	9.1%	6.9%	10.5%	7.7%	14.5%	7.2%	9.8%			7.1%	7.2%	9.8%		
		6.2	Referral for Pulmonary Rehabilitation Services	Q1 13/14 - 3.6%	Process, baseline, trajectories and improvement		4.2%	3.8%	3.6%	3.5%	4.1%	3.6%	2.5%	5.6%	4.2%	5.2%	6.0%			4.1%	3.4%	5.0%		
	Stroke	7.1	Door to Needle Time	13.0% of patients	23% of patients by Q4		26.3%	25.0%	19.0%	33.0%	28.6%	18.0%	27.0%	33.3%	25.0%					25.7%	24.5%			
		7.2	Admission to Stroke Unit	80.2%	85.0% acute stroke patients by Q4		82.2%	77.0%	76.0%	87.0%	90.0%	86.0%	81.0%	83.0%	86.0%	71.0%	82.0%			80.3%	85.7%	83.3%		
		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		54.9%	58.0%	57.0%	62.0%	54.6%	56.0%	50.8%	54.0%	50.0%	52.0%				59.0%	55.3%	52.0%		
		8.2	Breast feeding within 48h of Birth	67.4%	TBA		68.7%	66.3%	68.8%	68.5%	69.3%	69.6%	71.0%	95.0%	64.2%	70.9%				67.9%	69.5%	68.1%		
		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
	Enhancing Quality and Recovery Programme (EQRP)	5.1	AKI (EQ)
		5.2	#NoF (EQ)
		5.3	Heart Failure (EQ)
		5.4	CAP (EQ)
		5.6	H&K (ER)
		5.7	Colorectal (ER)
		5.8	Gynaecology (ER)
		5.9	Improve Readmission Rate HF (EQ)
		5.10	Patient Experience HF/H&K (EQ/ERP)
		5.11	Prescribing of Anti-psychotic Drugs (EQ)
	Respiratory Disease	6.1	Referral for Smoking Cessation Service
		6.2	Referral for Pulmonary Rehabilitation Services
	Stroke	7.1	Door to Needle Time
		7.2	Admission to Stroke Unit
		7.3	Quarterly Audit of Brain Scans <12h
		7.4	Stroke Pathway/Supported Discharge
	Breastfeeding/ Smoking Cessation Referral	8.1	Referral to Smoking Cessation Service
		8.2	Breast feeding within 48h of Birth
		8.3	Breastfeeding at 10 days after Birth
	Post Op Complications	9.1	Post Operative Complications of Joint Replacement Surgery

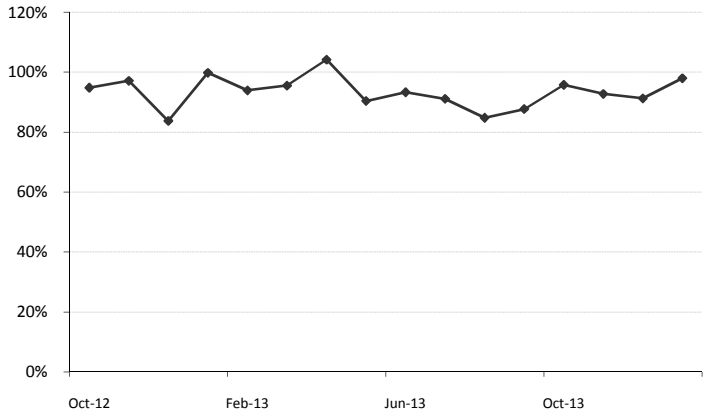
Targets have now been published with a partial payment being possible if a minimum target is achieved. The level of this partial payment is currently being clarified. Minimum scores for the improvement targets have been updated as per recent advise from the EQ Team. ERP targets will apply for the period 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.
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.
There are no targets for the #NoF pathway, this is an establishing pathway measure.
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.
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.
The Trust is already performing significantly above target (ie Nov-13 is 93.7% against a target of 38.3%).
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 Nov-13 is 55.0%).
The Trust is already performing significantly above target (ie Nov-13 is 93.8% against a target of 35.5%).
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.
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.
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.
Referral to the Smoking Cessation Service is recorded in PAS. Improvement targets for this measure are still to be agreed, but year to date figures show an improvement against Q1 baseline. The figures for January are provisional and are likely to increase in final reporting.
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.
The 2012/13 baseline equalled 13% with an agreed target of 23% by Q4. Data will always be reported 1 month retrospectively, and Dec-13 data will not be available until later in Feb-14. Year to date data confirm improvement in performance.
The 2013/14 data demonstrate improvement. There was a drop in performance in Dec-13 but this has been improved upon in Jan-14 with a performance of 82.0%.
This measure is now sourced from the Radiology Information System and will be reported 1 month retrospectively. Validated December data will be available shortly.
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).
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 Dec-13 equalled 98%.
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.
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.
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

	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%	100.0%	100.0%			77.7%	100.0%	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 are 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. Service Improvements have been identified and are being progressed in some areas of the pathway.																			
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.																			

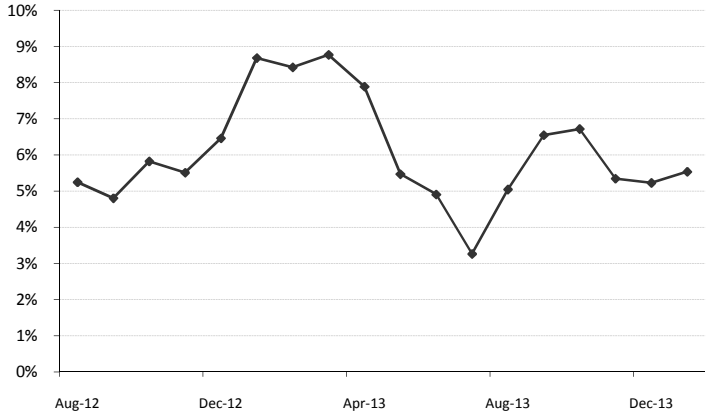
Compliance Against Performance
On target
Monthly target missed; quarterly/annual target at risk
Monthly target missed; annual target at risk

Bed Occupancy



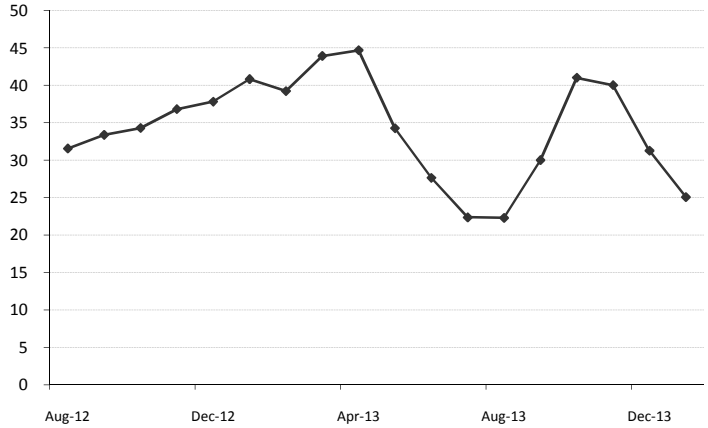
The bed occupancy metric looks only at adult inpatient beds and excludes any ring fenced wards such as Maternity. Occupancy peaked at over 100% during Apr-13, but has since reduced. However, occupancy has been steadily increasing since Aug-13, and in January increased slightly on the previous month with a position of 97.9% (against 91.2% in Dec-13), and sits above the Trust target of 85%.

Extra Beds



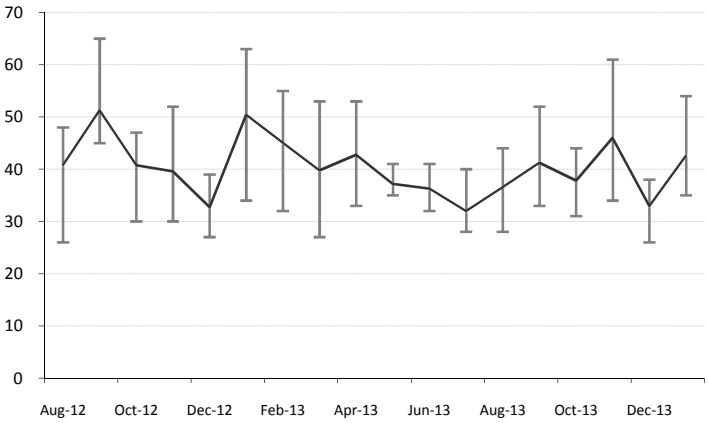
This metric is built up using the number of funded beds on each ward and reviewing those occupied on a daily basis. Where the number of occupied beds exceeds the funded bed base for the ward these are classified as "extra". During December, 5.22% of the Trust's bed days were delivered using extra "unfunded" beds. This position increased slightly to 5.53% in January thus demonstrating a a slight increase on the previous 2 months and is linked to extra capacity being re-opened to meet demand.

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 Apr-13 when the Trust, and the local health economy, was under extreme pressure with unseasonably high emergency flows. After 2 consecutively high months, performance in Dec-13 dropped. This decrease continued in January and mirrors achievement from Aug-13. It is hoped this position will stabilise moving into 2014, underpinned by a reduction in extra beds and the current stable bed occupancy performance.

Average Delayed Transfers of Care

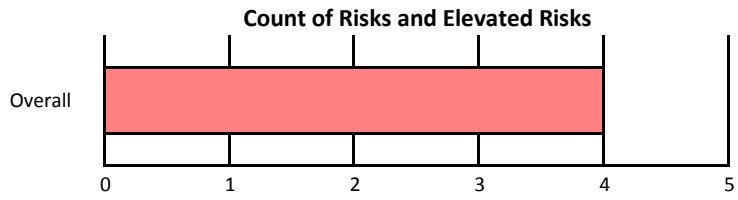


In Jan-14, the number of patients on the Delayed Transfers of Care (DToC) list has increased to levels previously seen in Sept-13.
Average DToC decreases were due, in part, to the action plans put in place to help improve this situation. The UCLTC Division has introduced "whole systems" board rounds 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.

CLINICAL QUALITY & PATIENT SAFETY

CARE QUALITY COMMISSION: INTELLIGENT MONITORING REPORT

Trust Summary



Band	3
Number of Risks	0
Number of Elevated Risks	4
Overall Risk Score	8
Number of Applicable Indicators	86
Proportional Score	0.05
Maximum Possible Risk Score	172

Elevated Risk	Composite Indicator: In-hospital mortality - Trauma and Orthopaedic conditions and procedures
Elevated Risk	PROMs EQ-5D score: Knee replacement
Elevated Risk	Inpatients response rate from NHS England Friends and Family Test
Elevated Risk	Serious education concerns

The Trust was 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. This gave the Trust an overall score of 8, with each of the following risks being counted twice.
There were four areas assessed as showing a risk. These were:

- Mortality following hemi-arthroplasty repair of a fractured neck of femur - HMSR 125
- Patient experience and functional outcome following elective knee arthroplasty (PROMs)
- Response rate against the Friends and Family test
- Educational concerns reported to the CQC by the General Medical Council (GMC).

There is a multidisciplinary team programme of action to address mortality following fractured neck of femur, performance against PROMs is scheduled for publication at the end of the financial year and the response rate for the Friends and Family Test is now in line with the national reporting requirement. No response has yet been received from the GMC about the nature or scope of any educational concerns. Subsequent Intelligent Monitoring Reports will be published by the CQC on a quarterly basis. The Trust looks forward to the forthcoming CQC visit at the beginning of March. Preparations for this visit are underway.