EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS**

DATE: **27 MARCH 2015**

SUBJECT: **CLINICAL QUALITY & PATIENT SAFETY**

REPORT FROM: **CHIEF NURSE & DIRECTOR OF QUALITY**

PURPOSE: **Discussion**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

- The clinical metrics programme was agreed by the Trust Board in May 2008; the strategic objectives were reviewed as part of the business planning cycle in January 2014. Alignment with the corporate and divisional balanced scorecards has been reviewed.

- Performance is monitored via the Quality Assurance Board, Clinical Advisory Board and the Integrated Audit and Governance Committee.

- This report covers

    - Patient Safety
        - Harm Free Care
        - Nurse Sensitive Indicators
        - Infection Control
        - Mortality Rates
        - Risk Management
    - Clinical Effectiveness
        - Bed Occupancy
        - Readmission Rates
        - CQUINS
    - Patient Experience
        - Mixed Sex Accommodation
        - Compliments and Complaints
        - Friends and Family Test
    - Care Quality Commission
        - CQC Intelligent Monitoring Report.

- This report also appends data relating to nurse staffing (Appendix 1). This is a requirement that planned staffing versus actual staffing levels are reported to the Board of Directors.

SUMMARY:
A summary of key trends and actions of the Trust's performance against clinical quality and patient safety indicators in 2014/15 is provided in the dashboard and supporting narrative.

PATIENT SAFETY

- Harm Free Care – This month 95% of our inpatients were deemed 'harm free' which is higher than last month (90.1%) and lower than the national figure which is 93.7%. This figure includes those patients admitted with harms and those who suffered harm whilst with us. The percentage of patients receiving harm free care during their admission with us (which we are able to influence) is 98.7%, similar to last month (97.7%). Further analysis of these data show that the prevalence of patients with a new catheter and a urinary infection or who had fallen rose this month, the remainder were improved this month.

- Nurse Sensitive Indicators – In February there were 21 reported incidents of pressure ulcers developing in hospital (40 in January); there were 29 in the same period last year. For February these include six Category 2 pressure ulcers and five Category 3 ulcers. Three Category 2 and two Category 3 pressure ulcers have been assessed as avoidable. Both of the avoidable Category 3 incidents have been reported on STEIS. The improvement trajectory remains on track.

- There were 153 patient falls recorded for January (179 in January). One fall resulted in a wrist fracture (Cambridge L Ward, WHH), and 1 in an ankle fracture (Rotary Suite, WHH). Data outlining falls per 1000 patient bed days are now available and indicate that rates of falls are lowest at WHH, despite it having the highest frequency of falls resulting in moderate and severe injuries. It has enabled the Falls Team to identify areas to prioritise interventions. A link worker audit tool is also going live on ward iPads to enable assessment of compliance with the Falls Risk Assessment and Care Plan.

- Infection Prevention and Control –Trust wide mandatory Infection Prevention and Control training compliance for February was 79.9%, similar to January (80.2%). All Divisions are expected to improve their compliance and achieve 95% by March 2015. To enable improved compliance across the Divisions, the Director of Infection Prevention and Control is working with the Director of Human Resources to review the systems in place that staff use to undertake this training.

- HCAI – There were no cases of MRSA bacteraemia in February. There has been 1 Trust assigned case to date.

- There was one case of C. difficile occurring within the Trust in February. The year to date total is 44 against a limit of 47 cases. The case was within UCLTC at QEH and was deemed at RCA to be unavoidable. A decision on whether there were any lapses of care will be made following a meeting with the Clinical Commissioning Group in March.

- There were 33 cases of E.coli bacteraemia in February. Thirty cases occurred pre-48h and 3 occurred post-48h. None met the criteria for RCA. There were 3 cases of MSSA bacteraemia in February. All cases occurred pre-48h and did not meet the criteria for RCA.

- Mortality Rates – There has been no HSMR available since July 14 when it equalled 84.2. Crude mortality for non-elective patients shows a seasonal trend with deaths higher during the winter months. Performance in Feb-15 showed a decrease on the previous month. Elective crude mortality fell in Feb-15 for the third consecutive month and is lower than the value reported in Feb-14. All elective deaths are reported on Datix and discussed at the Morbidity and Mortality meetings.
  Any points of learning are highlighted as part of this process. The most recent data for Q4 2013/14 indicate a SHMI value of 95.3.

- Staffing – The revised National Quality Board guidance published in May 2014 outlined the requirement for % fill of planned and actual hours to be identified by registered nurse and care staff. This is expressed by day and by night, and also by individual hospital site. Gradual improvement has been seen over the first 9 months of reporting. However, February has seen a slight fall in actual fill rates with 91% of the actual hours at K&C, over 96% at QEQM and 98% at WHH. Analysis of the quality indicators does not show a correlation with the staffing levels reported. However, Harbledown and Treble wards report the highest number of falls against a reported high percentage of absence among their registered staff. Please see the attached Appendix 1 for greater detail on nursing staffing.

- Risk Management – In Feb-15 a total of 989 clinical incidents including patient falls were reported. Ten serious incidents were required to be reported on STEIS in February. Seven cases have been closed since the last report; and two incidents removed. There remain 68 serious incidents open at the end of February. Incidents may be re-graded following investigation.

CLINICAL EFFECTIVENESS

- Bed Occupancy – The bed occupancy metric looks only at adult inpatient beds and excludes any ring fenced wards such as Maternity. In Feb-15, bed occupancy equalled 96.9% similar to the levels reported in Dec-14, and is higher than the position reported in Feb-14 (i.e. 94.8%).

- In Feb-15 the degree of extra beds used within the Trust recorded at 6.9%. This is a reduction compared with the previous month (8%), and similar to that recorded in Feb-14. January's elevated position was a result of the difficulty in discharging long stay patients who were admitted over the Christmas and New Year period.

- Readmission Rates – Readmission rates (reported 2 months in arrears) for Jan-15 has improved for the 7-day readmission rate compared to this time last year. The 30-day readmission rate for January is below that expected for the month, but year to date remains above the annual target. Attendances at ECC KCH are recorded as admissions and therefore patients who return to ECC within 7-30 days will show as readmissions. This is also the case for the E-Beds in A&E at QEH.

- CQUINs – February 2015 data shows a decrease in the percentage of Friends and Family Test responses received in inpatient areas to just under 37%, slightly lower than last month. Response rates from A&E remain fairly stable at just over 21%. Actions are in place to ensure we achieve the 40% response rate for March, which was exceeded in Jan-15. NHS Safety Thermometer data continues to demonstrate a year to date reduction in the prevalence of falls, catheter associated urinary tract infections and also Category 2- 4 pressure ulcers. Both are exceeding the required reduction targets. Development of an Integrated Care Heart Failure and COPD pathway are progressing.

PATIENT EXPERIENCE

- Mixed Sex Accommodation – The Trust has been working closely with the CCG Chief Nurses to agree the new Delivering Same Sex Accommodation Policy. A key area was to refresh the justifiable agreed clinical scenarios that were previously agreed with the PCT. Reporting to date has been in line with this policy.

- During Feb-15 there was 1 reportable mixed sex accommodation breach to NHS England via the Unify2 system, occurring in the CDU at KCH. The remaining cases occurred in the Stroke Units which is a justifiable mixing based on clinical need. The CCGs have requested that the new policy removes the current justifiable criteria, apart from critical care areas and Stroke Units. There were 7 mixed sex accommodation occurrences in total, affecting 26 patients. (Last month there were 4 occurrences affecting 18 patients).

- Compliments & Complaints – During February we received 70 complaints, which is higher than January. One formal complaint has been received for every 1099 recorded spells of care in comparison to January's figures where 1 formal complaint was received for every 1371 recorded spells of care. During February there were 78 informal contacts (concerns), 236 PALS contacts and 2548 compliments. This represents a ratio of compliments to formal complaints of 36:1, and one compliment being received for every 30 recorded spells of care. We are now showing the number of formal complaints related to activity, i.e. complaints per 1000 bed days. This allows a comparison to be made across sites as well a rate throughout the year. It can be seen that the rate of formal complaints is reducing. QEH are showing the lowest number of formal complaints per 1000 bed days. We are aiming to compare our rates with other Trusts.

  The number of returning clients seeking further resolution of their concerns during February was 7 (15 in January). Three of these were for the Surgical Services Division; two were for Urgent Care and Long Term Conditions Division, and Specialist Services.

  This month the Trust did not achieve the standard of responding to 85% of formal complaints within the agreed date with the client. We sent 64% of the responses out on time to clients during February (67% in January). Specific actions are in place with the Divisions who are not meeting this standard and an improvement trajectory being set with the teams.

  Themes remain similar to previous months and are being triangulated with other patient feedback data and addressed at Divisional level. With regards to formal complaints, the highest recurring subjects raised in Feb-15 were delays, concerns about clinical management, and problems with communication. Problems with discharge arrangements and staff attitude were the fourth and fifth most common theme.

- Friends and Family Test – This month we received 3077 responses from inpatients and A&E patients. Maternity services achieved 339 responses. The response rates and satisfaction scores are depicted in the table overleaf:

  Table 1 - Response Rates, Net Promoter Score and Percentage Recommended – February 2015

Department	Standard	Response Rate		NPS	Percentage recommended	
Inpatients	20%	36.9%	↓	75	94%	↑
A&E	15%	21.6%	-	60	83.2%	-
Maternity	15%	16.5	↓	75	95.6	↑
Outpatients	-	22.7	↓	65	90%	-
Day Case	-	35.8	↑	76	93.8%	↑

In February we have received the highest percentage recommended and NPS so far for inpatients and outpatients. The reportable Trust response rate (A&E and inpatients combined) is 28.4% and a Trust NPS of 68. Our star rating for this month equals 4.5 out of 5.0, similar to last month. 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.

This year our target is to achieve 20% response rates in A&E and 40% response rates for inpatients, both by Quarter 4. Comparison of response rates for January across Kent & Medway (the most recent county data validated) are shown in the Table 2:

Table 2 - Kent & Medway Comparison Response Rate Data

NB: January 2015 Data		
	A&E	**Inpatients**
EKHUFT	21.9%	41.32%
Dartford	3.5%	21.1%
MTW	17.7%	22.88%
Medway	21.9%	38.58%
National	**20.1%**	**35.8%**

It is encouraging to see that our inpatient response rates remain the highest in Kent & Medway and are above the national average.

The staff FFT will be repeated at the end of this quarter and will be reported when the results are received.

CARE QUALITY COMMISSION

The latest Intelligent Monitoring Report was received on the 1st December. 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. Monthly reports on progress are submitted to NHS Choices and are published on our website.

RECOMMENDATIONS:

The Board of Directors are invited to note the report and the actions in place to continue patient safety and quality improvement.

NEXT STEPS:

None. The metrics within this report will be continually monitored.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

Clinical quality, the patient safety programme and patient experience underpin many of the Trust's strategic and annual objectives. Continuous improvements in quality and patient safety will strengthen the confidence of commissioners, patients and the public.

LINKS TO BOARD ASSURANCE FRAMEWORK:

This report links to AO1 of the BAF: Implement the third year of the Trust's Quality Strategy demonstrating improvements in Patient Safety, Clinical Outcomes and Patient Experience / Person Centred Care.

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

Identified risks include:

1. Ability to maintain continuous improvement in the reduction of HCAIs in particular C-difficile and not meeting the limit set by the Department of Health. An action plan is in place which is being monitored via the Infection Prevention and Control Committee;
2. Achieving all of the standards set out in the Quality Strategy Year 3. Mitigation is assured via close monitoring of all of the metrics; specific action plans in place to address the individual elements which are being monitored via Divisions and also corporately;
3. The delivery of same sex accommodation in all clinical areas in the Trust given the change in reporting due to CCG concerns of the previously agreed justifiable criteria based on clinical need. Work is in progress within the Divisions to ensure we meet these standards;
4. The consistent achievement of the response rate standard for formal complaints. The Complaints Steering Group oversees the delivery of the Improvement Plan;
5. The maintenance of the improvement in patient satisfaction as depicted by the FFT. Divisions are addressing specifically the feedback and developing plans to address patients' concerns;
6. Successful delivery of the CQC Improvement Plan. Divisions are progressing the actions and monthly meetings with Monitor are in place.

FINANCIAL AND RESOURCE IMPLICATIONS:

Continuous improvement in quality and patient safety will make a contribution to the effective and efficient use of resources.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

Reduction in clinical quality and patient safety will impact on NHSLA activity and litigation costs.

Most of the patient outcomes are assessed against the nine protected characteristics in the Equality & Diversity report that is prepared for the Board of Directors annually.

The CQC embed Equality & Diversity as part of their standards when compiling the Quality Risk Profile.

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

None

ACTION REQUIRED:

(a) Discuss and agree recommendations.
(b) To note

CONSEQUENCES OF NOT TAKING ACTION:

Pace of change and improvement around the patient safety programme and patient experience will be slower. Inability to deliver a safe, high quality service has the potential to affect detrimentally the Trust's reputation with its patients and within the wider health economy.

CLINICAL QUALITY & PATIENT SAFETY PERFORMANCE SUMMARY

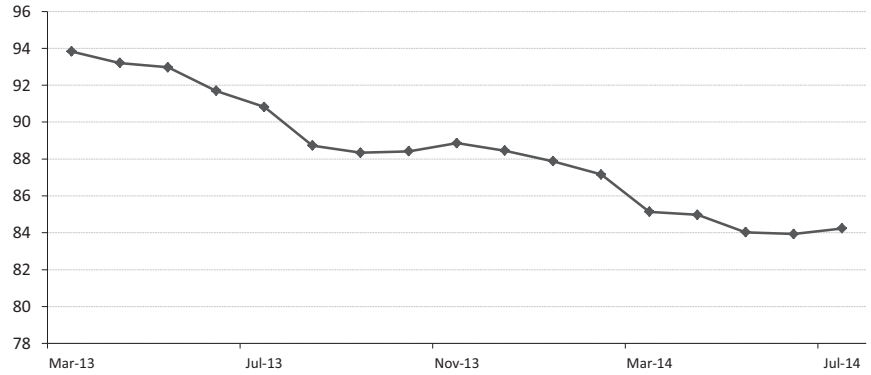
Introduction

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
					Q1 14/15	Q1 13/14	vs Q1 13/14	YTD
		SHMI (%)		-	95.30%	95.51%	↓	-
					Feb-15	Feb-14	vs Feb-14	YTD
		Crude Mortality: All Ages (Per 1000)	Non-Elective	-	33.645	31.967	↑	29.697
			Elective	-	0.224	0.916	↓	0.411
	Risk Management	Serious Incidents (STEIS)	New Incidents	-	10	3	↑	-
			Open Incidents	-	68	28	↑	Cumul.
	HCAI	MRSA	Attributable	5	1	8	↓	Cumul.
		C. difficile	Post 72h	47	44	45	↓	Cumul.
	Infection Prevention	Mandatory Training Compliance (%)		95.0%	79.9%	82.7%	↓	82.1%
	Harm Free Care (HFC)	Safety Thermometer HFC (%) - Old & New Harm	EKHUFT	93.0%	95.0%	92.7%	↑	93.4%
			National	-	93.7%	93.4%	↑	-
	Nurse Sensitive Indicators	Pressure Ulcers: Category 2,3 and 4	Acquired	-	21	29	↓	245
			Avoidable	99	5	10	↓	73
		Falls		-	153	172	↓	1787
	Clinical Incidents	Total Clinical Incidents		-	989	1084	↓	12133
Patient Experience	Compliments and Complaints	Compliments:Complaints		-	36:1	26:1	↑	-
		No. Care Spells per Formal Complaint		-	1099	1175	↓	-
	Experience	Friends and Family Test (Star Rating)		5.0	4.5	4.5	↑	-
		Adult Inpatient Experience (%)		80.00%	89.76%	87.68%	↑	-
		Mixed Sex Accommodation Occurrences		-	7	8	↓	87
Clinical Effectiveness	Readmission				Jan-15	Jan-14	vs Jan-14	YTD
		7 Day (%)		2.00%	3.86%	4.28%	↓	4.20%
		30 Day (%)		8.32%	7.78%	8.48%	↓	8.66%
	CQUIN				Feb-15	Feb-14	vs Feb-14	YTD
		Standard Contract CQUIN		Multiple			↔	
		Specialist CQUIN		Multiple			↔	
	Bed Usage	Bed Occupancy (%)		-	96.96%	94.86%	↑	-
		Extra Beds (%)		-	6.90%	6.60%	↑	5.90%
		Outliers		-	39.86	36.14	↑	384.58
		Delayed Transfers of Care (Average)		-	39.75	41.50	↓	36.04
Care Quality Commission	Intelligent Monitoring Report	Outcome Measures	Risks	-	3	-		-
			Elevated Risks	-	2	-		-

CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: MORTALITY RATES

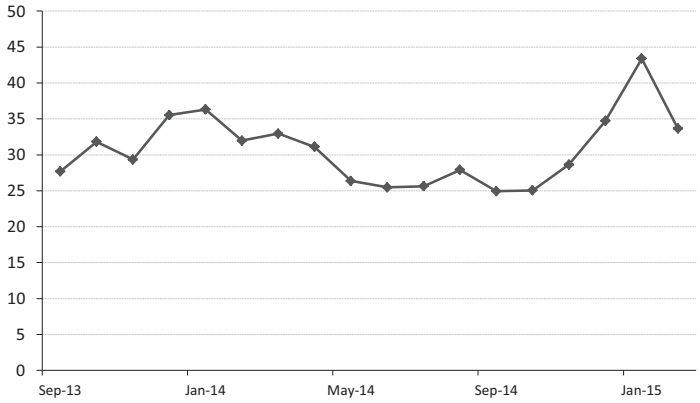
Hospital Standardised Mortality Ratio (HSMR) - All Discharges



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 increase against Jun-14) and compares with a position of 90.8 in Jul-13.

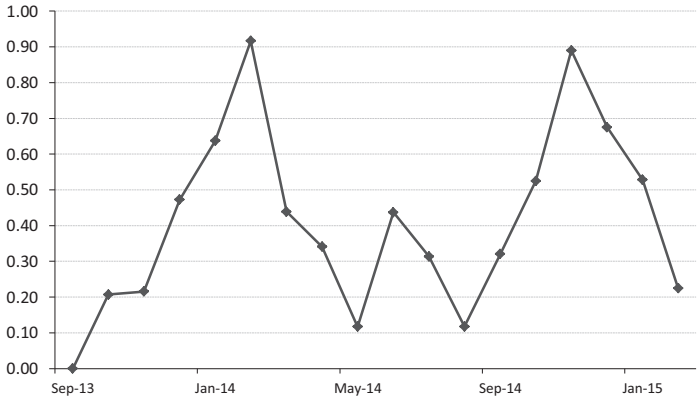
Crude Mortality - Non-Elective per 1000



Crude mortality for non-elective patients shows a fairly seasonal trend with deaths higher during the winter months. Performance in Feb-15 equalled 33.645 deaths per 1 000 population, thus showing an approximate 10 point reduction on January's position (cf. 43.399), and is in line with the level reported in Feb-14 where 31.967 deaths per 1 000 population were recorded.

The Specialist, Surgical and UCLTC Divisions each reported a reduction in NEL crude mortality in Feb-15 compared with the previous month, with the latter demonstrating the greatest reduction i.e. 51.221 and 65.139 deaths per 1 000 population respectively.

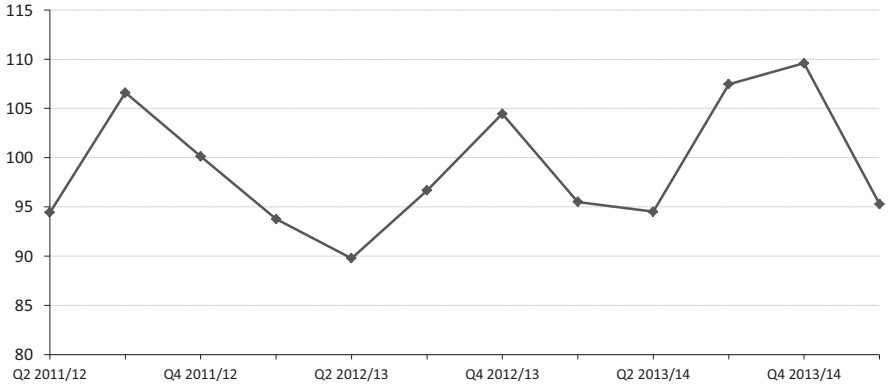
Crude Mortality - Elective per 1000



During Feb-14 elective crude mortality was reported at 0.916 deaths per 1000 population, which dropped back to expected levels as seen in March, and stabilised further over the summer period. A month on month increase in elective crude mortality was, however, evident from Aug-14 and peaked at a level of 0.890 deaths per 1 000 population in Nov-14 (i.e. a value comparable with the position reported in the previous February). Thereafter, a month on month fall has been reported with the position in Feb-15 equalling 0.224 deaths per 1 000 population. All elective deaths are reported on Datix and discussed at the Surgical Morbidity and Mortality meetings. Any points of learning are highlighted as part of this process.

NB: Crude Mortality data are sourced from the Trust's Balanced Scorecard as of 5 Mar-15.

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 Q1 2014/15 indicate a SHMI value of 95.30 which is lower than the position reported in Q4 2013/14 (i.e. 109.59), but approximates the value reported in Q1 2013/14 (i.e. 95.51).

Serious Incidents - Open Cases

Date		Summary of Serious Incident & Remedial Action Taken	IX lv	Division	Timely Submit?
Incident	STEIS Report				
23-Feb-15	25-Feb-15	Suboptimal Care - deteriorating patient	1	Surgical	Not Due
20-Jan-15	24-Feb-15	Fall	1	UCLTC	Not Due
11-Feb-15	16-Feb-15	Maternal unplanned admission to ITU	2	Specialist	Not Due
7-Jan-15	13-Feb-15	Fall	1	UCLTC	Not Due
26-Jan-15	13-Feb-15	Unexpected Admission - NICU	2	Specialist	Not Due
8-Jan-15	6-Feb-15	Category 3 hospital acquired pressure ulcer (avoidable)	1	Specialist	Not Due
3-Feb-15	6-Feb-15	Category 3 hospital acquired pressure ulcer (avoidable)	1	UCLTC	Not Due
28-Jan-15	5-Feb-15	Fall	1	Surgical	Not Due
16-Dec-14	4-Feb-15	Venous Thromboembolism (VTE)	1	UCLTC	Not Due
1-Feb-15	3-Feb-15	Fall	1	Surgical	Not Due
15-Jan-15	27-Jan-15	Appointment Delay - outpatient	1	Surgical	Not Due
23-Jan-15	26-Jan-15	Fall	1	UCLTC	Not Due
9-Jan-15	23-Jan-15	Category 4 hospital acquired pressure ulcer (avoidable)	1	UCLTC	Not Due
7-Jan-15	19-Jan-15	Suboptimal Care - deteriorating patient	1	Surgical	Not Due
22-Dec-14	16-Jan-15	Category 3 hospital acquired pressure ulcer (avoidable)	1	Surgical	Not Due
7-Apr-14	15-Jan-15	Unexpected Death - general	1	UCLTC	Not Due
22-Dec-14	15-Jan-15	Unexpected Death - general	1	Surgical	Not Due
31-Dec-14	15-Jan-15	Unexpected Death - general	1	UCLTC	Not Due
6-Jan-15	0-Jan-00	Unexpected Death - general	1	UCLTC	Not Due
5-Jan-15	9-Jan-15	Fall	1	UCLTC	Not Due
24-Dec-15	9-Jan-15	Category 3 hospital acquired pressure ulcer (avoidable)	1	Surgical	Not Due
30-Dec-14	30-Dec-14	Category 3 hospital acquired pressure ulcer (avoidable)	1	UCLTC	Not Due
21-Dec-14	23-Dec-14	Unexpected Admission - NICU	2	Specialist	72h report sent
29-Nov-14	18-Dec-14	Delayed Operation	1	Surgical	Yes
11-Dec-14	18-Dec-14	Unexpected Admission - NICU	2	Specialist	Extension
11-Dec-14	18-Dec-14	Unexpected Admission - NICU	2	Specialist	72h report sent
10-Nov-14	3-Dec-14	Mislabelling of Sample - breast biopsy	1	Clinical Support	Extension
19-Nov-14	25-Nov-14	Medication Incident - wrong dose of Clexane administered	1	UCLTC	Extension
26-Oct-14	17-Nov-14	Suboptimal Care - deteriorating patient (child cardiorespiratory arrest)	2	Specialist	Breach
13-Sep-14	13-Nov-14	Fall	1	UCLTC	Yes
27-Oct-14	13-Nov-14	Category 4 hospital acquired pressure ulcer (avoidable)	1	UCLTC	Yes
25-Oct-14	31-Oct-14	Unexpected Admission - NICU	2	Specialist	Breach
10-Oct-14	15-Oct-14	Unexpected Admission - NICU	2	Specialist	Yes
8-Jun-14	9-Oct-14	Fall		Surgical	Breach
8-Oct-14	9-Oct-14	Unexpected Death	1	Surgical	Breach
25-Aug-14	12-Sep-14	Delayed Diagnosis	1	UCLTC	Breach
29-Aug-14	12-Sep-14	Unexpected Admission - NICU	2	Specialist	Extension
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	Extension
27-Aug-14	29-Aug-14	Intrapartum Death - term infant	2	Specialist	Yes
13-Aug-14	13-Aug-14	Adverse Media Coverage - CQC report and breach of licence as Foundation Trust	2	Trust	Stop the Clock
19-Jul-14	23-Jul-14	Unexpected Death - neonatal	2	Specialist	Extension
7-Apr-14	10-Jul-14	Fall - resulting in permanent harm	1	UCLTC	Yes
26-Jun-14	27-Jun-14	Unexpected Death - neonatal		Specialist	Stop the Clock
20-Mar-14	13-Jun-14	Fall - resulting in subdural haematoma	1	UCLTC	Yes
27-May-14	2-Jun-14	Unexpected Death	1	UCLTC	Breach
7-Mar-14	13-May-14	Unexpected Death - endoscopic bleed	1	UCLTC	Yes
6-May-14	8-May-14	Unexpected Death - displacement of tracheostomy tube	1	UCLTC	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
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
7-Jan-13	11-Jan-13	Never Event - wrong site surgery: Ophthalmology	2	Surgical	Yes

Serious Incidents - Partially Closed Cases

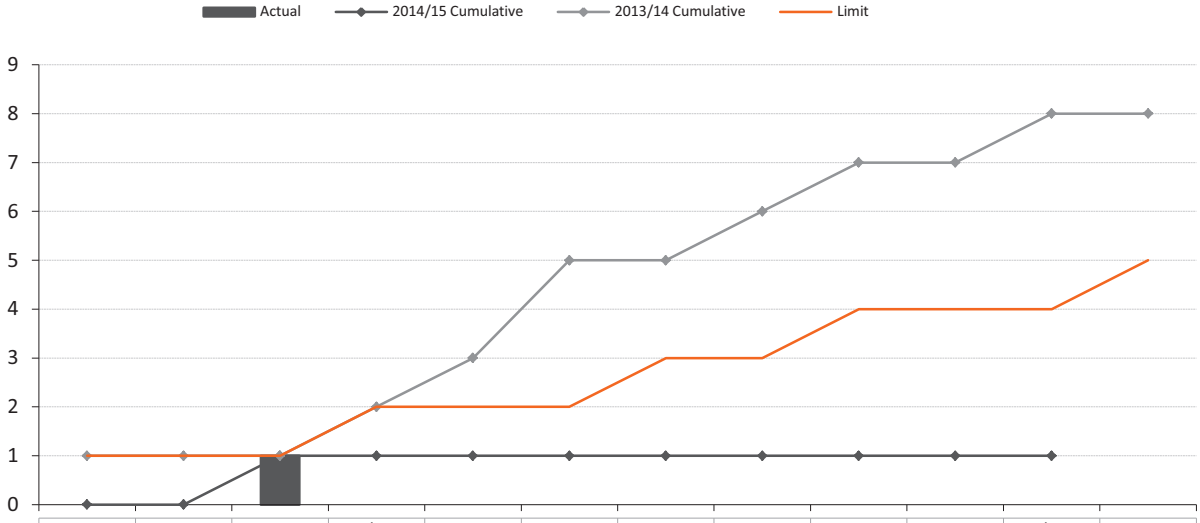
Serious Incidents closed by KMCS but remaining open on STEIS pending review by external bodies.

Date		Summary of Serious Incident & Remedial Action Taken	IX lv	Division
Incident	STEIS Report			
21-Aug-14	29-Aug-14	Unexpected Admission - NICU	2	Specialist
3-Aug-14	13-Aug-14	Unexpected Admission - NICU	2	Specialist
17-Jun-14	1-Jul-14	Intrauterine Death	2	Specialist
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
3-Apr-14	3-Apr-14	Never Event - retained vaginal swab post delivery	2	Specialist
19-Mar-14	20-Mar-14	Neonatal Death - home birth	2	Specialist
1-Mar-14	10-Mar-14	Never Event - wrong site pleural aspiration	2	UCLTC
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

Ten serious incidents were reported on STEIS during Feb-15. These were: 4 falls resulting in serious fracture or head injury, 2 avoidable hospital acquired Category 3 pressure ulcers, 1 Venous Thromboembolism resulting in death, 1 unexpected admission to NICU, 1 unplanned maternal admission to ITU and 1 suboptimal care resulting in paralysis. The Trust has had 2 incidents removed from STEIS as following initial investigation it was agreed the incidents did not meet STEIS criteria. Seven incidents have been closed on STEIS by the CCG or Area Team. At the end of Feb-15, there remain 14 incidents awaiting Area Team or other external body review. Root Cause Analysis (RCA) reports have been presented either to the Trust Quality Assurance 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. In addition, in order to facilitate closure of incidents on STEIS, the Trust has presented RCA reports to the Ashford and Canterbury CCG closure panel and discussed specific incidents with the Heads of Quality for Thanet and South Kent Coast CCGs. At the end of Feb-15 there were 68 serious incidents open on STEIS.

PATIENT SAFETY: HOSPITAL ACQUIRED INFECTIONS

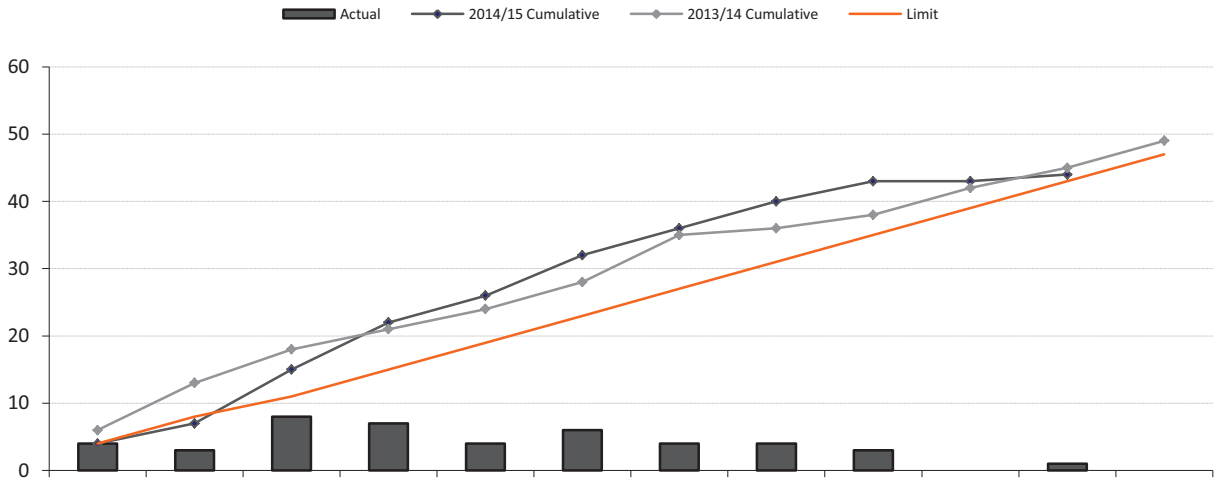
MRSA Bacteraemia - Trust Assigned Case



	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	0	0	0	0	
2014/15 Cumulative	0	0	1	1	1	1	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 Feb-15. There has been 1 Trust assigned case to date.

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	4	3	0	1	
2014/15 Cumulative	4	7	15	22	26	32	36	40	43	43	44	
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 was 1 case of C. difficile in February (44 cases to date against an objective of 47). The case was within UCLTC at QEH and was deemed at RCA to be unavoidable, clinically significant and non-compliant. A decision on whether there were any lapses of care will be made following a meeting with the Clinical Commissioning Group in March.

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	35	29	30	30		33.2	365
	Post 48h	9	1	8	7	6	5	6	4	9	6	3		5.8	64
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 33 E. coli bacteraemias in February. Thirty cases occurred pre-48 h, and 3 occurred post-48 h. None met the criteria for RCA.

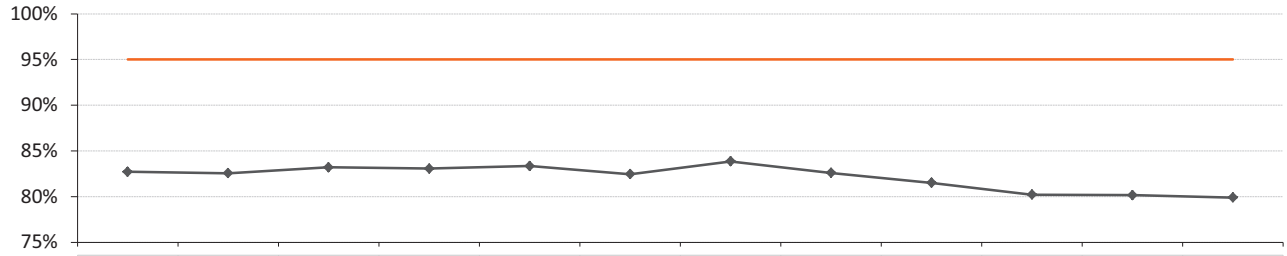
Meticillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia

		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	10	8	11	3		7.5	83
	Post 48h	1	1	3	0	4	2	0	2	2	1	0		1.5	16

There were 3 cases of MSSA bacteraemia in February, all of which occurred pre-48h. None met the criteria for RCA.

PATIENT SAFETY: INFECTION PREVENTION & CONTROL

Mandatory Training EKHUFT Compliance



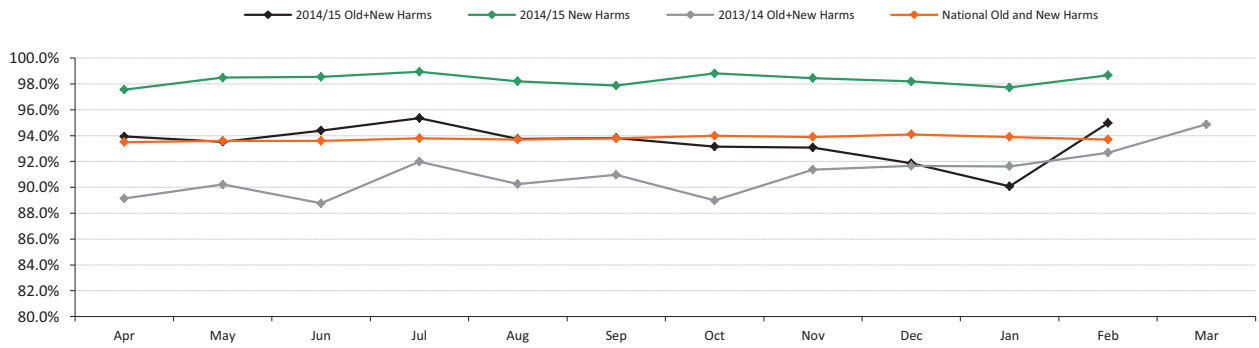
	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Compliance	82.7%	82.6%	83.2%	83.1%	83.3%	82.5%	83.9%	82.6%	81.5%	80.2%	80.2%	79.9%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

	Feb-15								
	Target	Trust	Clinical Support Services	Corporate	Specialist Services	Strat Dev & Capt Pln	Surgical Services	UCLTC	Serco
Mandatory Comparative Data for Biennial Training Compliance	95%	79.9%	86.8%	80.6%	74.7%	84.8%	79.4%	77.4%	80.0%

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

Trust compliance in Feb-15 remains similar to the position seen in Jan-15 (79%).
All Divisions are required to achieve 95.0% compliance by the end of Q4 2014/15 (Mar-15) via a phased attainment approach.

Safety Thermometer Harm Free Care

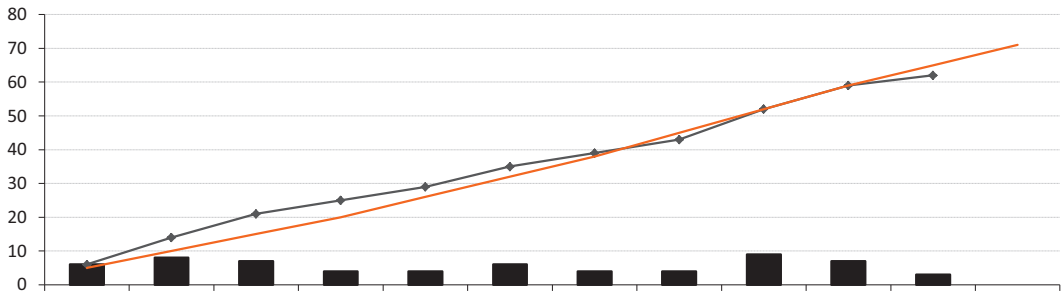


The chart above shows the percentage of Harm Free Care expressed as a one-day snapshot in each month. It is known as the NHS Safety Thermometer and is a quick and simple method for surveying patient harms. The aim of the Safety Thermometer is to identify, through a monthly survey of all adult inpatients, 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 the 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. This month 95.0% of our inpatients were deemed "harm free" which is higher than last month (90.1%) and higher than the national figure which is 93.7%. This figure includes those patients admitted with harms and those who suffered harm whilst with us. The percentage of patients receiving harm free care during their admission with us (which we are able to influence) is 98.7%, higher than last month (97.7%). Further analysis of these data show that the prevalence of patients with a new catheter and a urinary infection or who had fallen rose this month, whilst the remainder were improved.

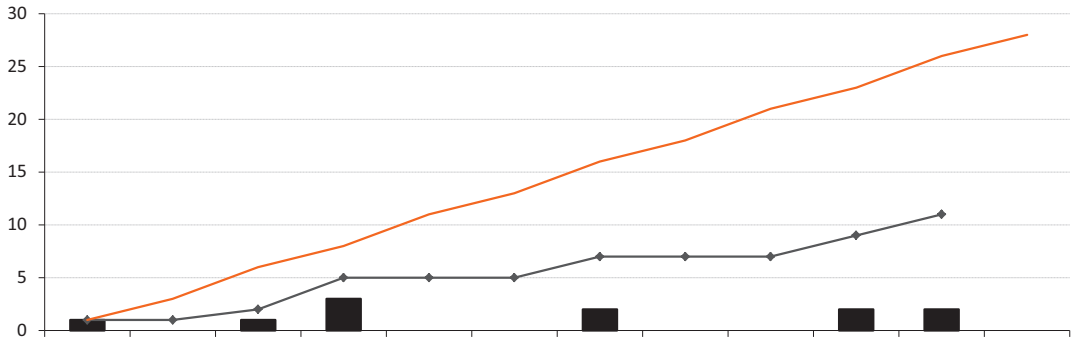
Category 2 Incidence Trajectory 2014/15
25% Reduction



	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 Avoidable	6	8	7	4	4	6	4	4	9	7	3	
2014/15Cum Avoidable	6	14	21	25	29	35	39	43	52	59	62	
2014/15Cum Trajectory	5	10	15	20	26	32	38	45	52	59	65	71
per 1000 bed days	0.19	0.25	0.23	0.13	0.13	0.21	0.13	0.14	0.30	0.21	0.10	

In Feb-15,a total of 16 acquired Category 2 pressure ulcers were reported, of which 3 were avoidable. This represents a decrease of 4 avoidable ulcers and 14 in total from the previous month. One unavoidable incident occurred at KCH, and 7 occurred at QEH where 2 were classified as avoidable ulcers due to insufficient evidence of repositioning. Seven Category 2 pressure ulcers occurred at WHH, 1 of which was classified as avoidable given that it was related to poor positioning of a catheter tube. Eleven of the Category 2 avoidable pressure ulcers occurred on the sacrum, 2 at the heel and 2 related to medical devices i.e. naso-gastic tubes. The Trust 25% reduction trajectory remains on target.

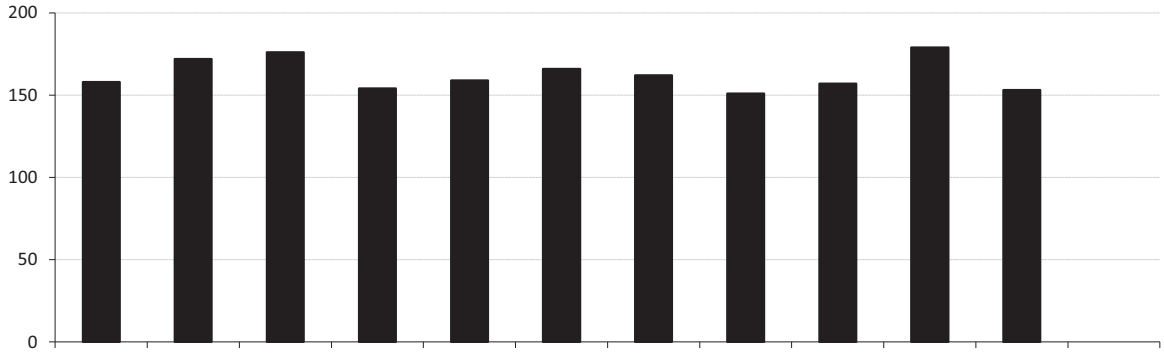
Category 3 and 4 Incidence Trajectory 2014/15
25% Reduction



	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 Avoidable	1	0	1	3	0	0	2	0	0	2	2	
2014/15Cum Avoidable	1	1	2	5	5	5	7	7	7	9	11	
2014/15Cum Trajectory	1	3	6	8	11	13	16	18	21	23	26	28
per 1000 bed days	0.03	0.00	0.03	0.10	0.00	0.00	0.07	0.00	0.00	0.06	0.07	

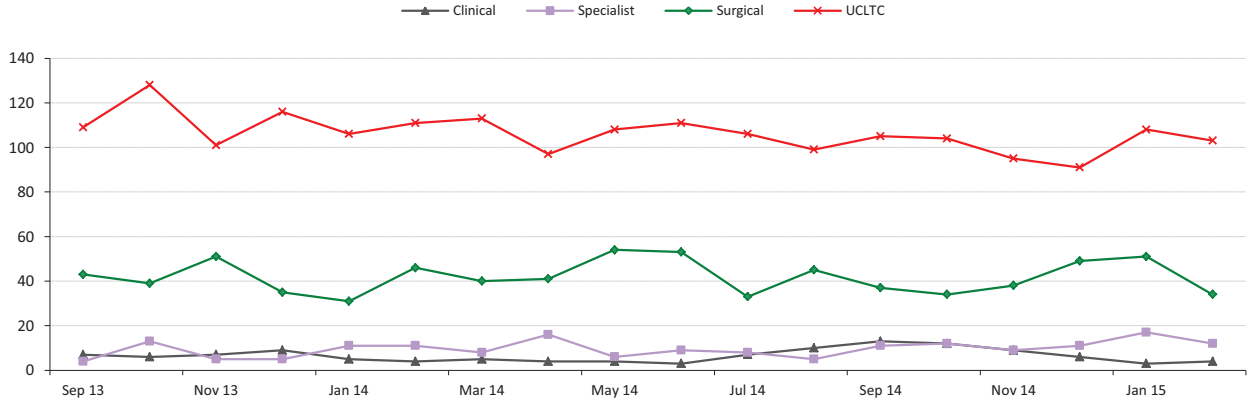
In February, there were 5 reported deep ulcers, a reduction of 4 from the previous month. All were identified at WHH and 2 of these have been identified as avoidable. Four of the ulcers occurred at the heel and 1 at the sacrum. Lack of sufficient evidence for repositioning has been cited as a main reason for this and RCA investigations are underway. However, trajectory reductions are maintained at below 50%. A repositioning project group has commenced and aims to undertake a peer review exercise in March to identify and promote best practice.

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	159	166	162	151	157	179	153	
2014/15 Cum	158	330	506	660	819	985	1147	1298	1455	1634	1787	
per 1000 bed days	5.12	5.42	5.79	4.98	5.36	5.72	5.29	5.20	5.17	5.42	5.23	

Patient Falls - Injurious and Non-Injurious By Division

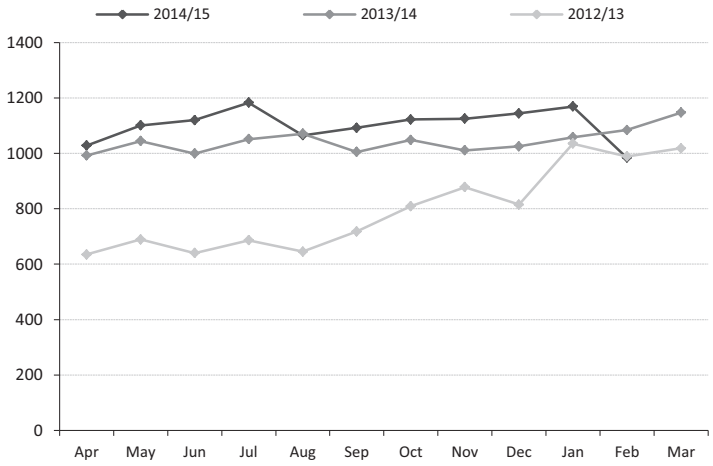


In Feb-15 there were 153 falls in EKHUFT which included 47 at KCH, 43 at QEH and 59 at WHH. One fall resulted in a wrist fracture (Cambridge L WHH), and 1 in an ankle fracture (Rotary Suite WHH). The wards with the highest total falls were Harbledown (16) and Richard Stevens Stroke Unit (9). All other areas had considerably fewer, or no falls. Data outlining falls per 1000 patient bed days are now available and indicate that rates of falls are lowest at WHH, despite it having the highest frequency of falls resulting in moderate and severe injuries. It has enabled the Falls Team to identify areas to prioritise interventions. A link worker audit tool is also going live on ward iPads to enable assessment of compliance with the Falls Risk Assessment and Care Plan.

CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: CLINICAL INCIDENTS

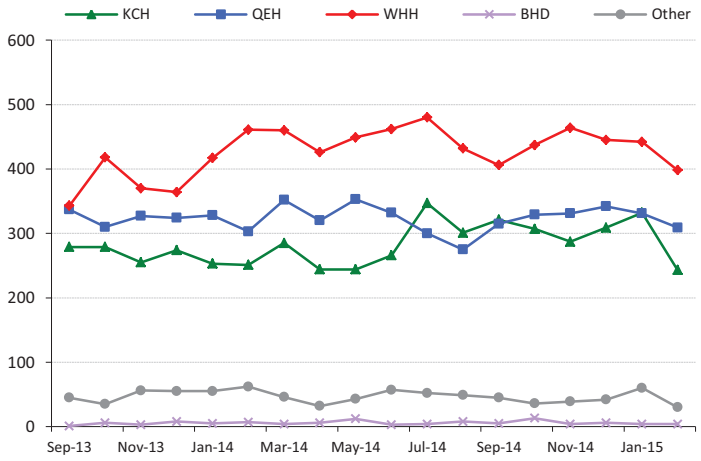
In Feb-15 a total of 989 clinical incidents were reported. This includes 1 incident graded as death and 2 incidents graded as severe harm. One of the 3 Serious Incidents has been reported on STEIS and 2 are under review by the Executive SI Group. Incidents may be re-graded following investigation. In addition to these 3 incidents, 6 incidents have been escalated as serious near misses, of which 5 are under investigation. There has been a reduction in the proportion of moderate harm incidents reported during Feb-15 (i.e. Feb-15: 25 compared with Jan-15: 94 and Feb-14: 128), and thus the number of incidents subject to the legal Duty of Candour responsibilities. This is due to greater scrutiny of actual harm caused by actions or omissions in care/treatment. Overall compliance with Duty of Candour requires significant improvement. Current data since Oct-14 indicate 53% patients informed and 18% of relatives informed (when staff were unable to inform the patient).
Ten serious incidents were required to be reported on STEIS in February. Two incidents have been removed from STEIS as they were assessed as not meeting the reporting criteria and 7 cases have been closed since the last report; there remain 68 serious incidents open at the end of February.

Overall Incident Rates by Year



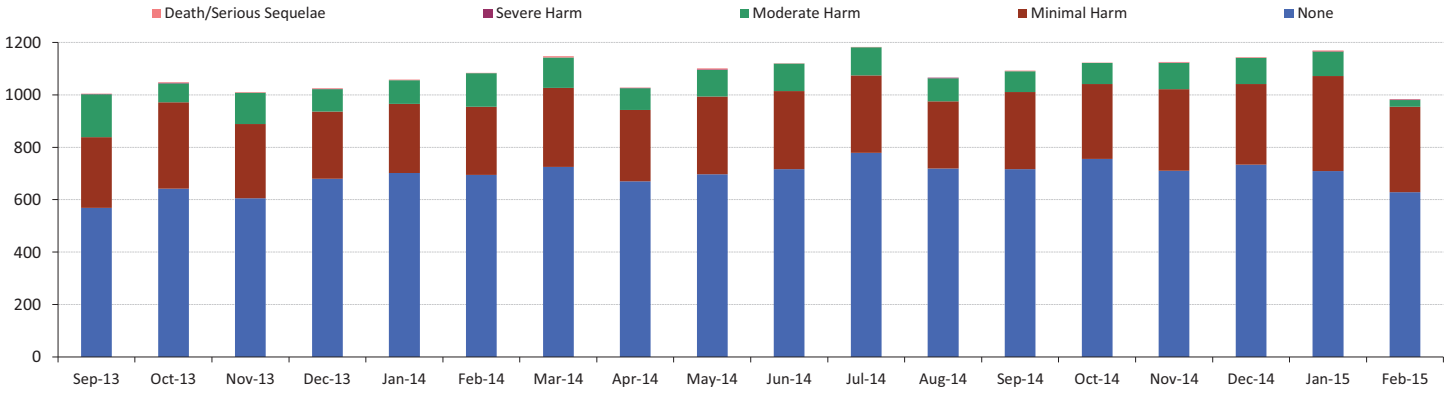
A total of 989 clinical incidents have been logged in as occurring in Feb-15 compared with 1169 recorded for Jan-15 and 1084 in Feb-14

Overall Incident Rates by Site



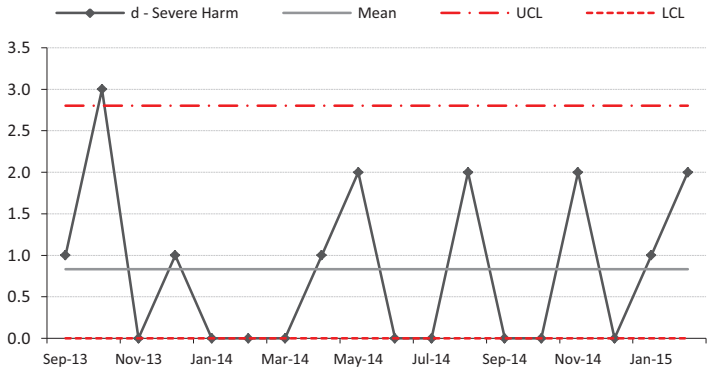
There has been a drop in reporting at all 3 main sites, particularly at KCH. Overall there is a trend increase in the number of incidents reported in the Trust.

Clinical Incidents by Severity

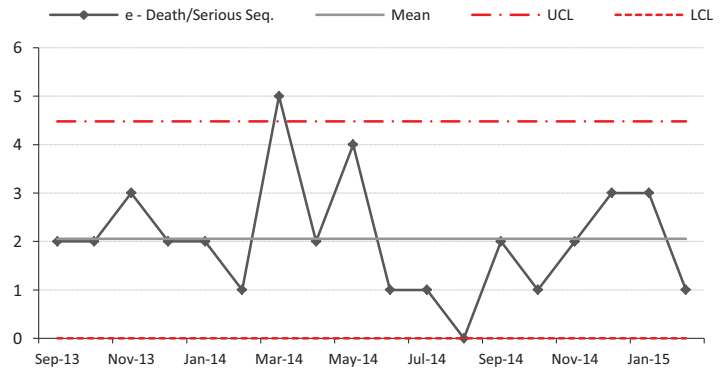


The incidents graded as moderate, serious and death have all been subject to review in order to confirm the consistency of the grading of harm across the Trust. The Board of Directors may see a change in this report to reflect the re-categorisation process undertaken. This is consistent with the data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

Severe Harm

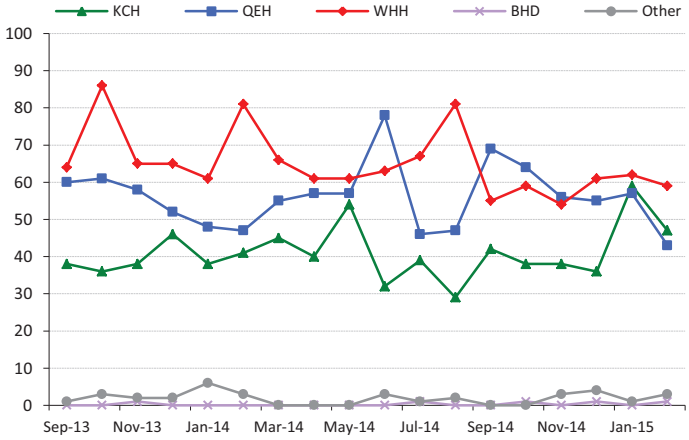


Death/Serious Sequelae



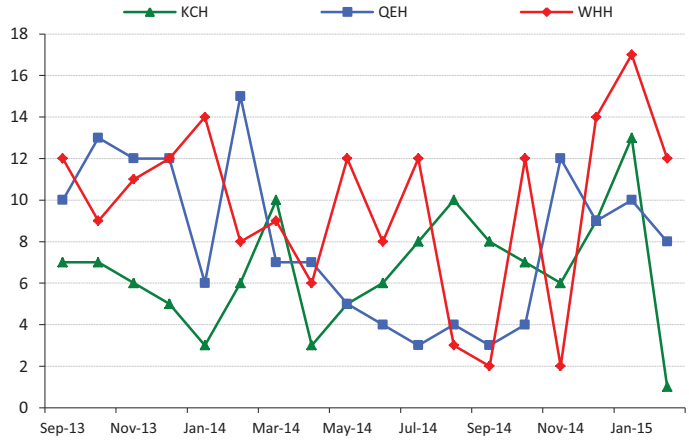
The number of death/serious and severe harm incidents reported in Feb-15 remains subject to the usual RCA investigation and review. It is possible that the severity of these cases will be downgraded once the investigation process is completed in line with national guidance to ensure the actual harm caused by any act or omission is recorded. In Feb-15, the number of incidents graded as death or severe is on a par with previous months.

Patient Slips, Trips and Falls



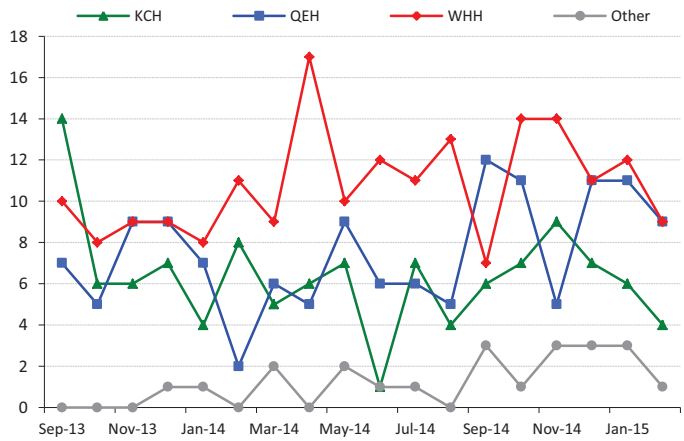
Of the 153 patient falls recorded for February (179 in Jan-15 and 172 in Feb-14), no incidents were graded as moderate, severe or death. There were 88 falls resulting in no injury and 65 in low harm. The top reporting wards were Harbledown ward (KCH) with 16 falls; Richard Stevens Stroke Unit (WHH) with 9;Treble ward (KCH) with 7 falls; Kingston Stroke Unit (KCH), CDU (WHH) and Oxford ward (WHH) with 6 falls each. The remaining wards reported 5 or less falls. A RCA is carried out for all falls resulting in a head injury or fracture. As of 1 Jan-15 all falls resulting in a fracture of a major long bone which requires surgery have been reported on STEIS.

Hospital Acquired Pressure Ulcers



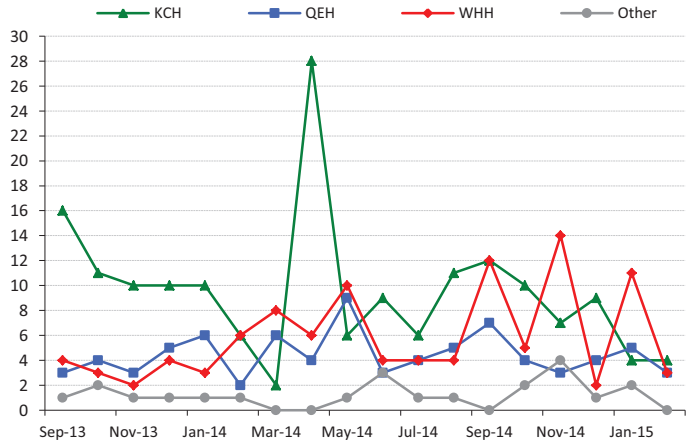
In February there were 21 reported incidents of pressure ulcers developing in hospital (cf. 40 in Jan-15 and 29 in Feb-14). February's incidents included 16 Category 2 pressure ulcers and 5 Category 3; no Category 4 ulcers were reported. Three Category 2 and 2 Category 3 pressure ulcers have been assessed as avoidable. Both of the avoidable Category 3 incidents have been reported on STEIS. The highest reporting wards were Seabathing (QEH), Cambridge M1 (WHH), ITU (WHH), Kings D Female (WHH) and Kings B (WHH) with 2 incidents each; 11 other wards reported 1 incident each.

Delay in Providing Treatment



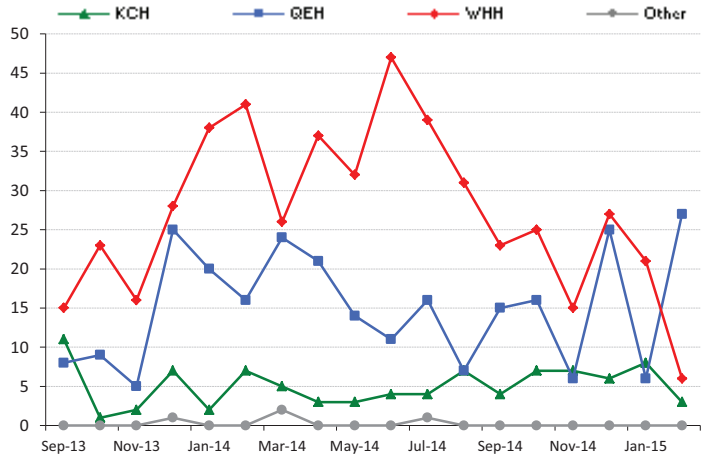
There were 23 incidents resulting in delay in providing treatment during February compared with 32 in Jan-15 and 21 in Feb-14. No incidents have been graded as death, but 2 have been graded as severe harm. Both are under investigation and relate 1) to a failure to review a deteriorating patient over the weekend (and is on the Executive SI Group schedule) and 2) delayed diagnosis leading to paralysis (and is reported on STEIS). Four have been graded as moderate harm, 8 have been graded as low harm and 9 resulted in no harm. Themes in location were: 5 incidents occurred on CDU (QEH) and 3 in the Celia Blakey Centre (WHH).

Incorrect Data in Patient Notes



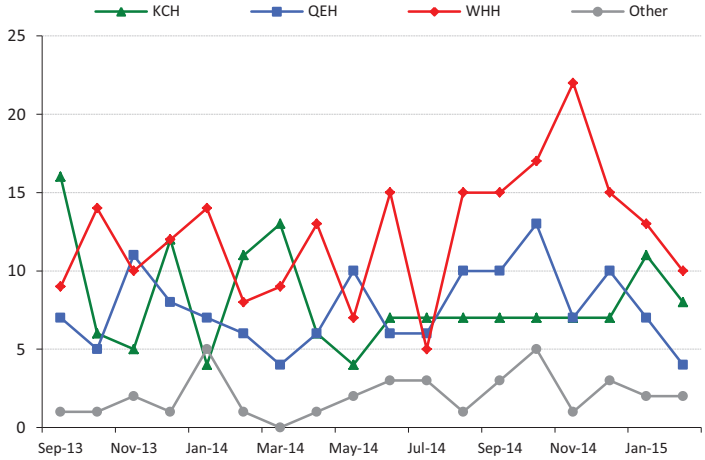
There were 10 incidents of incorrect data in patients' notes reported as occurring in February (22 in Jan-15 and 15 in Feb-14), all 10 were graded as no harm. Eight incidents related to incorrect data in paper notes and 2 to incorrect data in electronic patient records (PAS). Of the incidents reported, 4 were identified at KCH, 3 at QEH, and 3 at WHH. There were no themes in the location of these incidents.

Staffing Level Difficulties



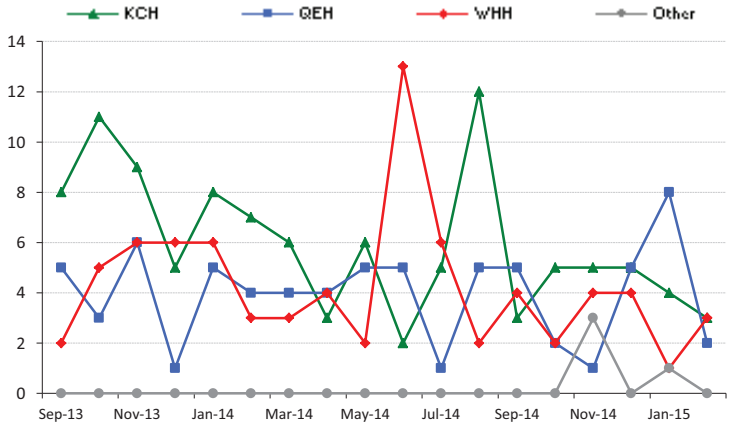
There were 36 incidents recorded in Feb-15 (with 35 in Jan-15 and 64 in Feb-14). These included 28 incidents relating to insufficient nurses, 1 to inadequate skill mix, 2 to insufficient doctors and 5 to general staffing level difficulties. Top reporting locations were CDU (QEH) with 10 incidents; A&E (QEH) and Cheerful Sparrows Male (QEH) with 5 incidents each; Deal (QEH) with 4 incidents. Other areas reported 2 or fewer incidents.
Three incidents occurred at KCH, 27 at QEH and 6 at WHH. Twelve incidents have been graded as low harm and 24 incidents have been graded as no harm.
Investigations evidence continued active management of bed, staffing situation and escalation to senior staff.

Communication Breakdowns



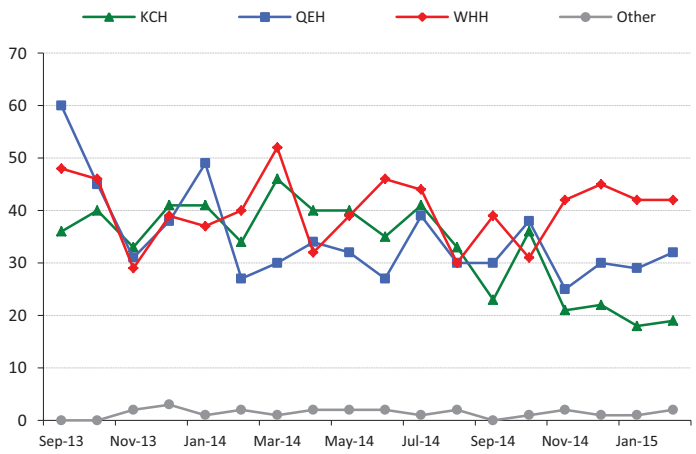
In Feb-15 there were 23 incidents of communication breakdown (compared with 33 in Jan-15 and 26 in Feb-14). Of these, 17 involved staff to staff communication failures and 6 were staff to patient. Of the 23 incidents reported, 8 were reported as occurring at KCH, 4 at QEH, 9 at WHH and 2 at BHD. Themes by location: A&E (QEH), Ultrasound (BHD), ECC (KCH), Celia Blakey Centre (WHH) and Harbledown (KCH) each reported 2 incidents; other areas reported 1 or none. Incidents in February were graded as follows: 19 as no harm, 3 as low harm and 1 as moderate harm: this involved a patient being sent an appointment for an ultrasound which should have been cancelled due to a recent miscarriage.

Blood Transfusion Errors



In February, there were 8 blood transfusion errors reported (14 in Jan-15 and 14 in Feb-14). There were 2 themes arising in the period: 3 incidents relating to delay in providing blood products and 2 incidents of wrong blood in tube (patient ID). Six incidents were graded no harm and 2 as low harm. Reporting by site: 3 at KCH, 2 at QEH and 3 at WHH.

Medicines Management



Medicines Management

Category	Feb-15
Prescribing	17
Dispensing	19
Administering	40
Missing (lost or stock discrepancy)	9
Shortage (drug unavailable)	2
Suspected adverse reaction	5
Infusion problems (drug related)	2
Infusion injury (extravasation)	1
TOTAL	**95**

There were 95 medication incidents reported as occurring in February (90 in Jan-15 and 103 in Feb-14). The reporting of medication incidents appears to have plateaued. Of the 95 reported, 81 were graded as no harm including no serious near misses and 14 as low harm. There were no medication incidents graded moderate harm or above. Top reporting areas were: Cheerful Sparrows Male (QEH) with 7 incidents; Folkestone (WHH) and CDU (WHH) each reported 5 incidents; CDU (QEH), Cambridge L (WHH) and ITU (WHH) reported 4 incidents each; Pharmacy (QEH), Channel Day Surgery (WHH), ITU (KCH) and Kent (KCH) reported 3 incidents each; other areas reported 2 incidents or fewer. Nineteen incidents occurred at KCH, 32 at QEH, 42 at WHH, 1 at RVHF and 1 at Maidstone renal satellite unit.

*Missing Drugs are broken down as follows: all 9 incidents relate to stock discrepancies in both patients' own medications and ward stock occurring in ITU (KCH), 2 incidents on Rotary (WHH), Kings A2 (WHH), Birchington (QEH), CDU (QEH), Cheerful Sparrows Female (QEH),Minster (QEH) and Pharmacy (QEH).

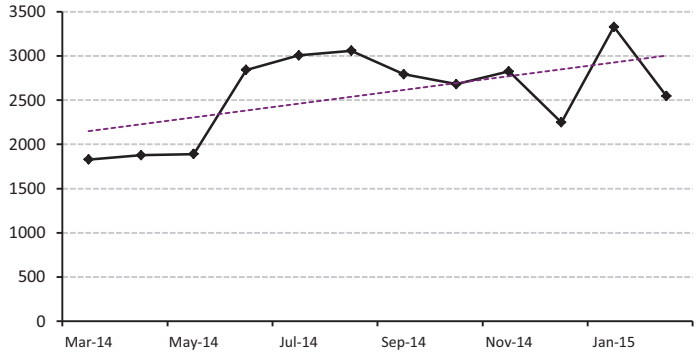
PATIENT EXPERIENCE: CONCERNS, COMPLAINTS & COMPLIMENTS

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 Feb-15. The information reported is for cases received in February and formal cases with target dates due that month.

• Activity: Formal complaints (received) - 70; informal concerns - 78; compliments - 2548; PALS contacts - 236.

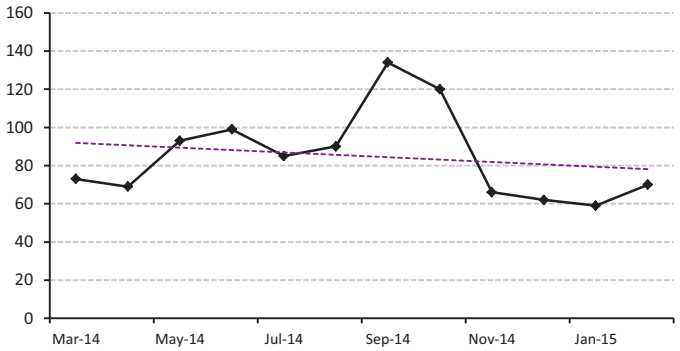
The charts below show the number of complaints and compliments received on a monthly basis. In February, 1 formal complaint has been received for every 1099 recorded spells of care (0.09%) in comparison with January's figures where 1 formal complaint was received for every 1371 recorded spells of care (0.07%).

Number of Compliments



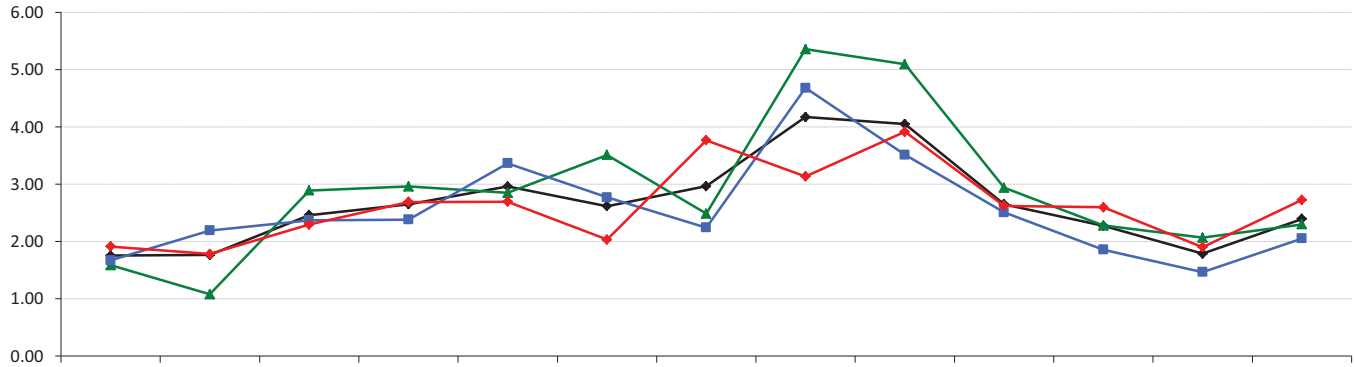
The number of compliments received has significantly decreased by 23% compared with the previous month. The ratio of compliments to formal complaints received for the month is 36:1. There has been 1 compliment being received for every 30 recorded spells of care.

Number of Formal Complaints



In Feb-15, the number of complaints received has increased by 19% compared with Jan-15 (i.e. 70 compared with 59). The number of complaints has slightly increased by 8% compared with Feb-14 (i.e. 70 compared with 65).
The number of concerns has slightly decreased by 9% compared with last month, namely 86 and 78 respectively.

Number of Formal Complaints per 1000 Bed Days



	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Trust	1.75	1.76	2.46	2.65	2.96	2.62	2.97	4.17	4.05	2.65	2.27	1.79	2.39
KCH	1.59	1.08	2.89	2.96	2.85	3.51	2.48	5.36	5.09	2.94	2.28	2.07	2.30
QEH	1.67	2.19	2.37	2.38	3.37	2.77	2.24	4.68	3.51	2.51	1.86	1.47	2.05
WHH	1.91	1.78	2.30	2.69	2.70	2.03	3.77	3.14	3.92	2.62	2.60	1.90	2.72

We are now showing the number of formal complaints related to activity, i.e. complaints per 1000 bed days. This allows a comparison to be made across sites as well a rate throughout the year. It can be seen that the rate of formal complaints is slightly higher than last month. QEH are showing the lowest number of formal complaints per 1000 bed days. Benchmarking with other Trusts is in progress to compare our performance with others and ascertain where we can make further improvements.

Top Five Concerns Expressed in Formal Complaints
February 2015

Concerns		No.
Delays	Delays in receiving treatment	8
	Delays being seen in A&E	4
	Delay in referral	4
	Delay in receiving x-ray results	4
	Delay with elective admission	3
	Delay in going to theatre	3
	Delays in allocation of outpatient appointment	2
	Delay in emergency admission	1
	Delay in being seen in Outpatient Department	1
Problems with Clinical Management	Unhappy with treatment	14
	End of life/palliative care issues	4
	Referral issues	4
	Incomplete examination carried out	3
	Scans/x-rays not taken	1
Problems with Communication	Doctor communication issues	4
	Nursing communication issues	3
	Misleading or contradictory information given	3
	Unhappy with information on medical records	2
	Other staff communication issues	1
	A&E staff communication issues	1
	Other communication issues	1
Problems with Discharge Arrangements	Unfit for discharge / or poor arrangements	8
	Unhappy about follow up arrangements	5
	Lack of information given upon discharge	1
	Waiting for documentation	1
Problems with Attitude	Problems with doctor's attitude	6
	Problems with other staff attitude	4
	Problems with nurse's attitude	2

The common themes raised within the top 5 informal concerns are led by delays, problems with attitude, problems with communication, concern about clinical management and problems with discharge arrangements.

With regards to formal complaints, the highest recurring subjects raised in Feb-15 were delays, concerns about clinical management, problems with communication, problems with discharge arrangements, and problems with attitude.
In comparison with Jan-15, the top 3 subjects remain the same. Problems with discharge arrangements and problems with attitude have replaced concerns about surgical management and problems with nursing care.

PATIENT EXPERIENCE: CONCERNS, COMPLAINTS & COMPLIMENTS, & PHSO

Concerns, Complaints and Compliments - Divisional Performance

February 2015

Division	Divisional Activity				Divisional Performance	
	Formal Complaints	Compliments	Informal Concerns	Compliments: Complaints	Response Date Agreed with Client	Returning Complaints
Clinical Support	5	153	7	30:1	4 of 4	0
Specialist Services	8	982	13	122:1	6 of 10	2
Surgical Services	24	425	26	17:1	11 of 25	3
UCLTC	30	984	26	32:1	16 of 19	2
Corporate	3	2	6	0:1	0	0
Other	0	0	0	0:0	0	0
TOTAL	**70**	**2546**	**78**	**36:1**	**37 of 58**	**7**

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

The table above shows the monthly Divisional activity and performance for Feb-15, 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 complaint; this will either be via a letter or at a meeting.
During Feb-15, the data show that 64% of responses due to be sent out the clients were on target and compared with 66% last month.
Clinical Support Division sent out 100% of their responses on target, UCLTC sent a minimum of 75% of their responses on target, and Specialist Services and Surgical Services Divisions sent out less than 75% of their responses on target. Corporate did not have any responses due in Feb-15.
The PET has identified that some target dates have been missed due to extensions not being agreed prior to the target date. A process was implemented in early Oct-14 to ensure that these should be kept to a minimum in future.

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

Status of Cases	Actions in Feb-15
Cases carried over from previous month	17 *
New cases referred to the Trust	1
Cases closed by PHSO	2
Current open cases with the PHSO	18

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 February, the PHSO has been in contact with the Trust in regards to 1 new case relating to Surgical Services Division (Urology).
Two cases were closed by the PHSO in Feb-15, both of which were partly upheld. One case related to the Surgical Services Division (Trauma and Orthopaedics), whilst the other case was linked to UCLTC Division (A&E).

* The oldest PHSO cases currently open with the Trust were first received from the PHSO in Mar-14.

Friends and Family Test (FFT)

The Friends and Family Test asks the patient how likely they are to recommend the ward, A&E department, Maternity Services, Day Case Services and Outpatient Departments 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 by the percentage of people recommending the service. From 3077 responses from inpatients and A&E received in Feb-15, 89.4% of responders said they would recommend the Trust to family or friends. Only inpatient and A&E are reported on Unify as the Trust percentage. Maternity services achieved 339 responses this month. The percentage of inpatients that would recommend the Trust to their friends or family was 94.0%, for A&E 83.2%, Maternity 95.6%, Outpatients 89.9% and for Day Cases 93.8%. These data are 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. The Trust star rating this month is 4.5.

The response rate for inpatients and A&E combined in Feb-15 achieved 28.4%. Inpatients achieved 36.9% this month, and the A&E departments achieved 21.6%. Maternity services achieved 16.5%. Outpatients received 4941 responses with a 22.7% response rate. The number of Day Case responses was 2087 with a 35.8% response rate.

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.

Cultural Change Programme

The Trust has commenced its cultural change programme ‘a great place to work’ in response to the concerns raised by the CQC. The culture change programme will encompass the We Care Programme and accompanying values that were agreed by the Board last year. The Cultural Change Programme Steering Group has been set up and work has begun in earnest with the appointed external partner with focus groups taking place during February. We are on track to deliver the first phase by the end of March when we anticipate receiving the behavioural framework for staff.

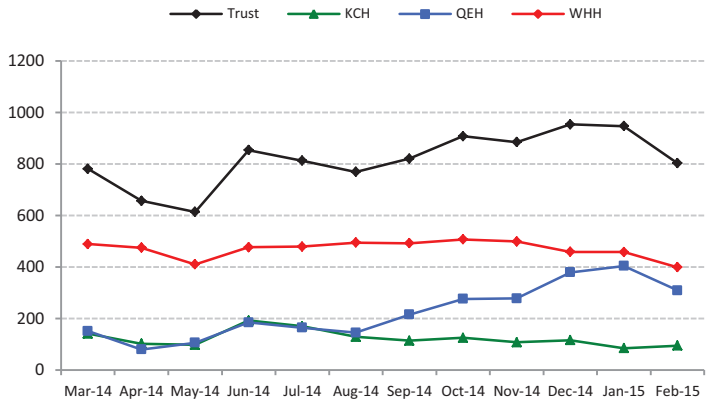
PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

Real time patient experience monitoring using iPads have captured data since 1 Apr-13. During Feb-15, 803 adult inpatients were asked about their experiences of being an inpatient; 95 responses were received from patients treated at KCH, 309 from QEH patients, and 399 responses from patients based at WHH. (Compared with the previous month the number of responses were 85, 404 and 485 respectively). The combined result from all submitted questionnaires in Feb-15 was that of 89.76% satisfaction.

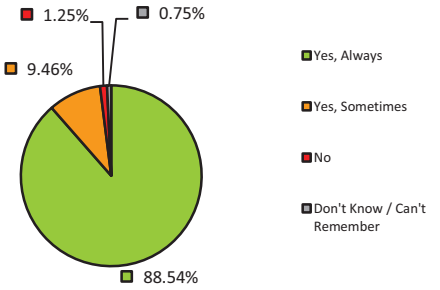
Overall Adult Inpatient Experience February 2015

Experience (%)	No. of Responses
89.76	803

Number of Adult Inpatient Survey Responses

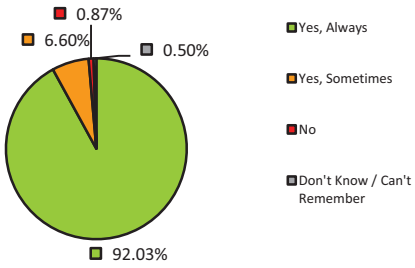


Were you given enough privacy when discussing your treatment?



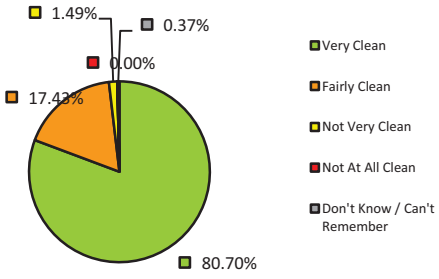
Overall Score = 93.98%

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



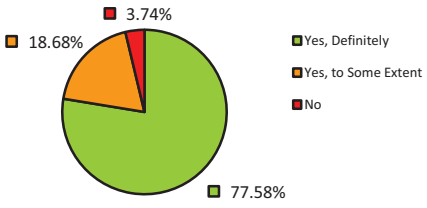
Overall Score = 95.81%

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



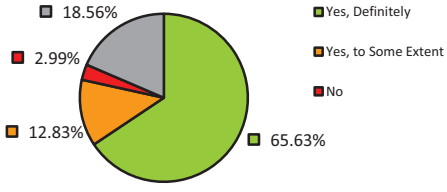
Overall Score = 93.17%

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



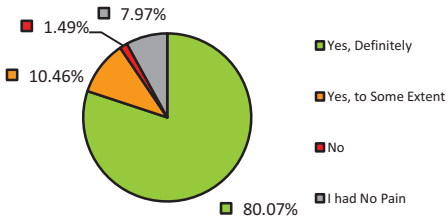
Overall Score = 86.92%

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



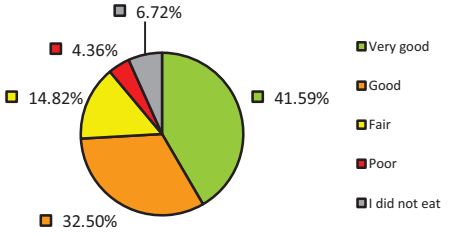
Overall Score = 88.46%

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



Overall Score = 92.69%

How would you rate the hospital food?

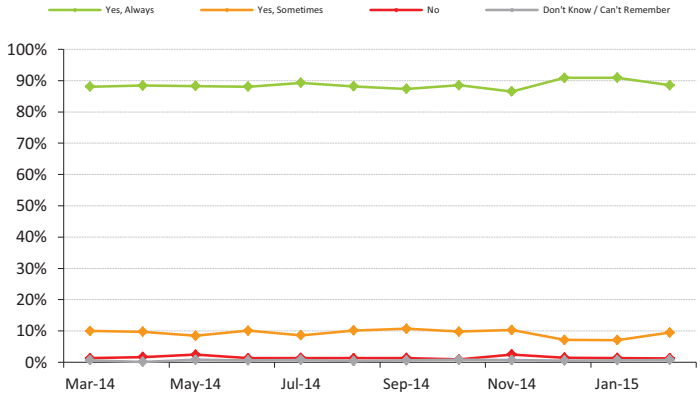


Overall Score = 73.12%

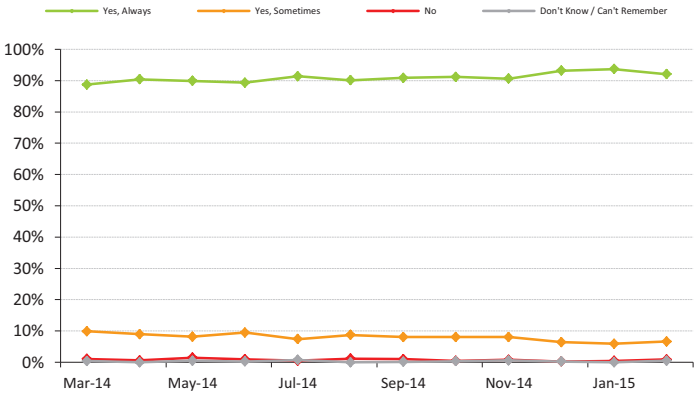
Each ward reviews their real-time monitoring data regularly. They are also shared as "heat maps" with other teams. From this actions are taken to address the themes which are considered with the Friends and Family Test feedback, and compliments and complaint information. A particular focus at present 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.

PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

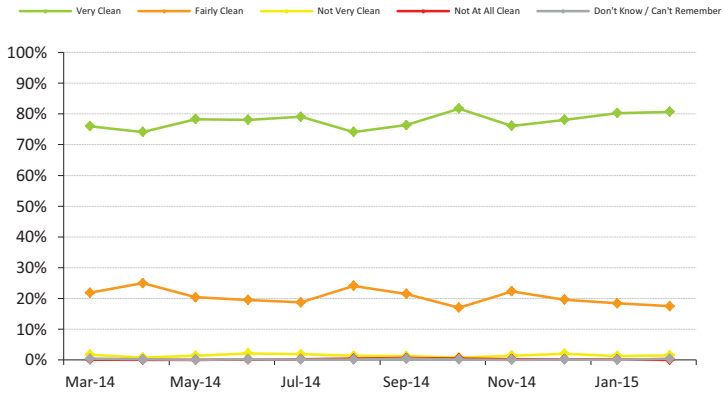
Were you given enough privacy when discussing your treatment?



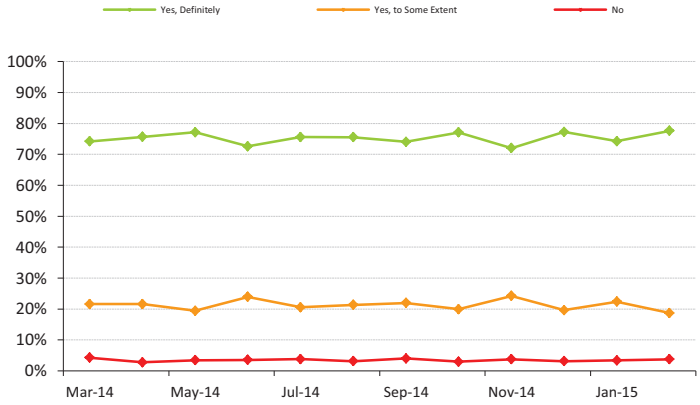
Overall, did you feel you were treated with respect and dignity while you were in hospital?



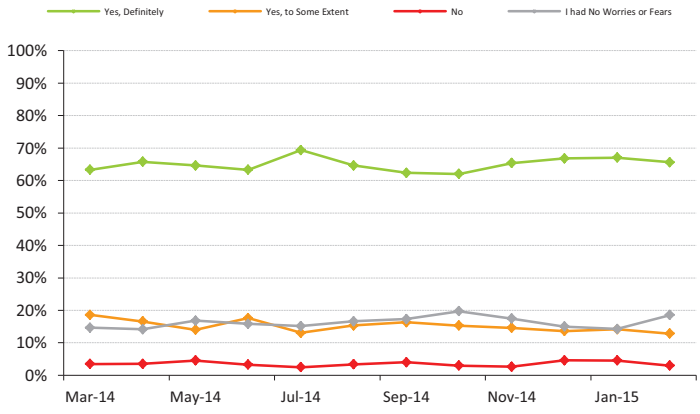
In your opinion, how clean was the hospital room or ward that you were in?



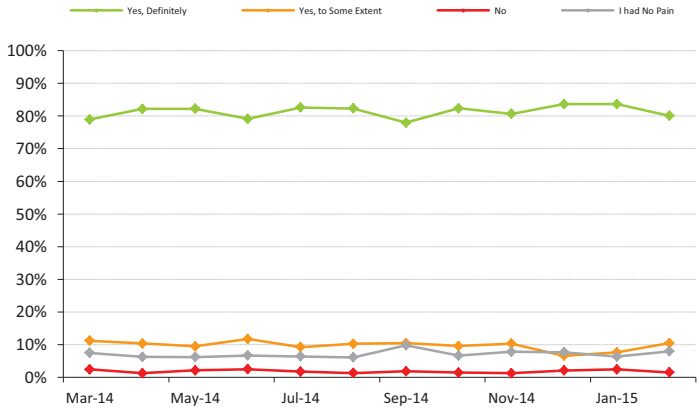
Were you involved as much as you wanted to be in the decisions about your care and treatment?



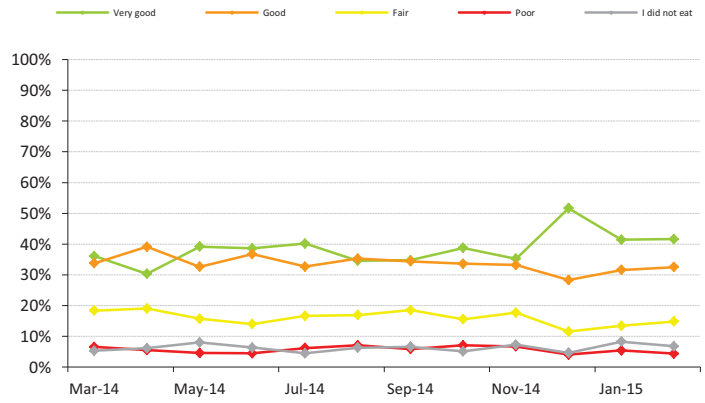
Did you find someone on the hospital staff to talk about your worries and fears?



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



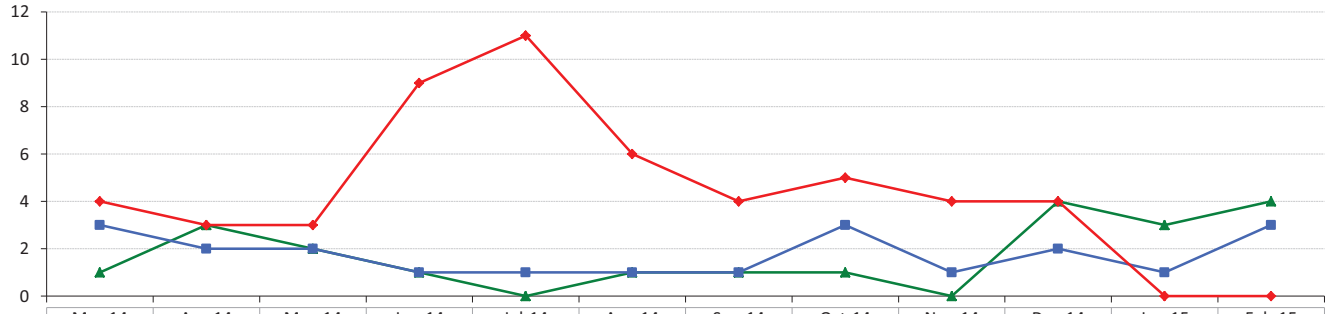
How would you rate the hospital food?



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 that 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. It is encouraging to see the number of patients who felt they were able to talk about worries and fears were slightly improved this month. Wanting to be involved in decisions about care and treatment and help with pain control were slightly lower during February. The remaining metrics are similar to the previous month.

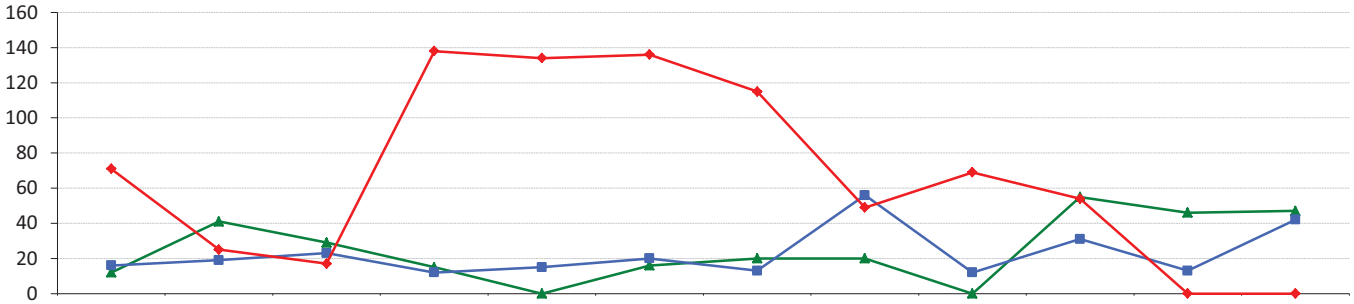
CLINICAL QUALITY & PATIENT SAFETY
PATIENT EXPERIENCE: MIXED SEX ACCOMMODATION

Number of Episodes of Mixed Sex Occurrence



	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
KCH	1	3	2	1	0	1	1	1	0	4	3	4
QEH	3	2	2	1	1	1	1	3	1	2	1	3
WHH	4	3	3	9	11	6	4	5	4	4	0	0

Number of Hours of Mixed Sex Occurrence



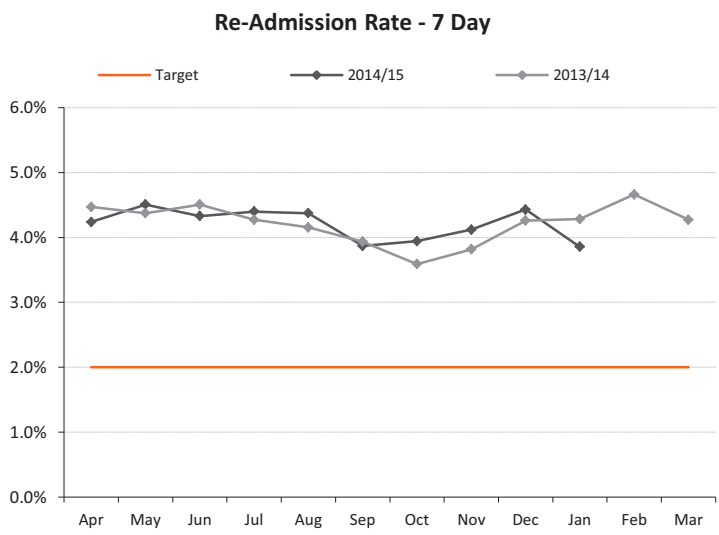
	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
KCH	12	41	29	15	0	16	20	20	0	55	46	47
QEH	16	19	23	12	15	20	13	56	12	31	13	42
WHH	71	25	17	138	134	136	115	49	69	54	0	0

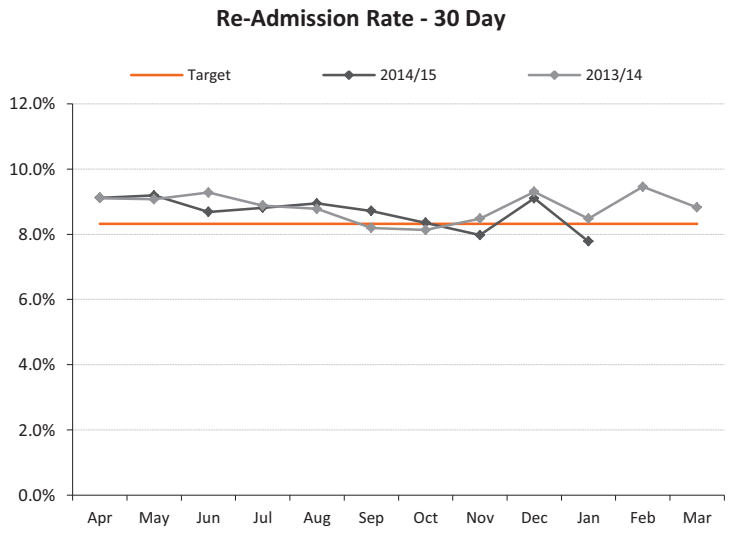
Mixed Sex Accommodation Occurrrences February 2015

Site	Clinical Area	Total No. of Occurrences	Total No. of Patients Affected
KCH	CDU	1	4
KCH	Kingston	3	10
QEH	Fordwich	3	12
TOTAL		**7**	**26**

During Feb-15, 1 non-justifiable incident of mixed sex accommodation breach occurred and affected 4 patients located in the CDU, KCH. This information has been reported to NHS England via the Unify2 system. The remaining incidents occurred in the stroke units which is a justifiable mixing based on clinical need. The CCGs have requested that the new policy removes all justifiable criteria, apart from critical care areas and stroke units. They have requested this change to be invoked immediately. There were 7 mixed sex accommodation occurrences in total, affecting 26 patients. (Last month there were a total of 4 occurrences affecting 18 patients). A review of bathroom mixed sex compliance has been performed and is being taken forward by the Trust.

CLINICAL QUALITY & PATIENT SAFETY
CLINICAL EFFECTIVENESS: READMISSION RATES





The position for both the 7 day readmission rate and the 30 day readmission rate has improved in Jan-15 compared with the same period last year.
In Jan-15, the 7 day readmission rate equalled 3.86%. The corresponding year to date (YTD) value was reported at 4.20%, and as such, both positions indicate that 7 day readmissions rates are greater than the 2014/15 target of 2.00%. Delivery of the 7 day readmission rate objective is challenging and this may, in part, be the result of the methodology used to record activity in the Surgical Assessment Unit (WHH), and the E-beds in A&E at QEH. An analysis to understand the impact of the reporting process is due for completion in March.
The 30 day readmission rate in Jan-15 (i.e. 7.78%) was below the 2014/15 objective of 8.32%, but conversely the YTD position reported in month (8.66%) is above the year end target. However, if the 30 day readmission rate stays on its current trend, it is on trajectory to achieve Mar-15 end target.
Work is being undertaken by the Service Improvement Team to establish whether patients receive the appropriate level of information at the point of discharge from hospital in order to enable them to access services outside of hospital, and thereby avoiding the need to be readmitted to hospital. The outcome of this investigation will be available at the end of March.

			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	22.2%	19.6%	18.7%	23.9%	28.5%	21.1%	19.4%	22.6%	24.0%	22.8%	21.9%	21.6%		20.7%	23.0%	23.1%		
		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%	35.9%	35.2%	29.6%	34.4%	35.0%	39.5%	34.6%	38.4%	34.1%	36.7%	41.3%	35.7%		33.1%	36.4%	36.4%		
		1e	Increased response rates in Inpatient areas to 40% in Mar-15	Q1 2014/15 - 33.1%	Improvement in response rate to 40% in Mar-15	35.9%	35.2%	29.6%	34.4%	35.0%	39.5%	34.6%	38.4%	34.1%	36.7%	41.3%	35.8%		33.1%	36.4%	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	34	2	1	0	3	5	7	5	2	4	1	4		3	15	11		
		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	130	5	12	12	7	13	8	18	13	19	18	5		29	28	50		
		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	67	16	10	3	3	2	5	0	3	9	13	3		29	10	12		
		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	99.6%	99.7%	99.4%	99.7%	99.4%	99.2%	99.6%	100.0%	99.8%	99.8%	99.3%			99.6%	99.4%	99.9%		
			Dementia Assessment within 72h	90.1%		94.3%	94.7%	94.7%	93.2%	93.3%	94.5%	91.7%	93.6%	98.8%	95.6%	90.9%			94.0%	93.2%	96.0%		
			Appropriate Referral	100.0%		100.0%	100.0%	100.0%	100.0%	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	32.0%	22.3%	23.5%	25.0%	25.0%	25.0%	24.0%	24.0%	31.0%	32.0%	33.0%			23.5%	24.7%	32.0%		
		3.3	Care for People with Dementia	N/A	Self assessment of person-centred care in wards																		

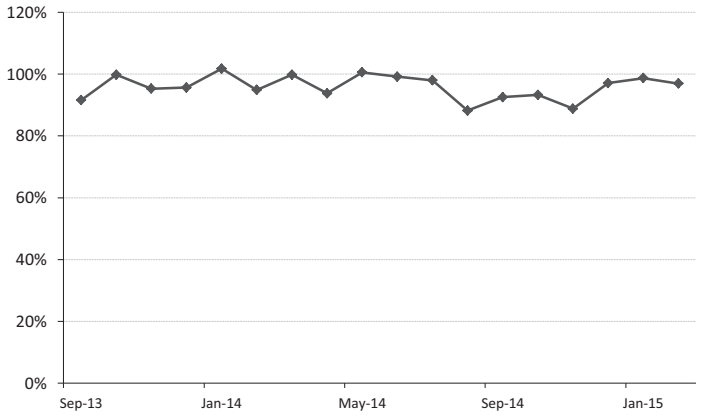
			CQUIN	
Commentary	Friends and Family Test	1a	Implementation of FFT to staff	FFT for staff implemented in June 14 via a Picker Survey. All staff will receive the survey 3 times/year and the second survey was completed at the beginning of September, and a further issued in Mar-15.
		1b	Implementation to Outpatient and Day Case Units	Implementation of FFT to Outpatients and Day Case Surgery has been completed.
		1c	Increased Response Rates in A&E	Reporting includes A&E areas at WHH and QEH. Month 11 shows a response rate of 21.6% (and 22.2% YTD).
		1d	Increased Response Rates in Inpatient Areas	ECC at KCH included within inpatient areas. Month 11 shows a reduction in response rates to 35.8% (35.9% YTD).
		1e	Increased Response Rates in Inpatient areas	Month 9 shows a response rate of 36.7%. A response rate of 40% has been achieved in both Aug-14 and Jan-15 and is achievable in Mar-15.
	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. This measure has been RAG rated as amber for although the reduction target for falls is being exceeded, the Q3 2014/15 audit has confirmed that the Q3 milestone has not been achieved (i.e. 42% risk assessments completed against a target of 50%). This may result in a partial payment for this measure.
			Reduction in Falls - Improvement in Prevalence	YTD NHS Safety Thermometer data - 34 falls with harm, against a trajectory of up to 88. Prevalence equalled 0.41% in Month 11, 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 - 130 UTIs in patients with catheters, against a trajectory of up to 143. Prevalence equalled 0.51% in Month 11, 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 - 67 new Category 2-4 pressure ulcers, against a trajectory of up to 115. Prevalence equalled 0.31% in Month 11, 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, 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 and performance continues to be at a very high standard throughout the year.
			Dementia Assessment within 72h	Q1 has met the year target for average of 90% for 3 consecutive months and performance continues to be at a very high standard throughout the year.
			Appropriate Referral	Q1 has met the year target for average of 90% for 3 consecutive months and performance continues to be at a very high standard throughout the year.
		3b	Staff Training/Leadership	From Sep-14 reporting includes Pharmacy and Serco staff.
		3c	Care for People with Dementia	The 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	Develop Integrated Care Pathway																		
		4b	EQ Pathway Measures (Jan-14 to Dec-14)	74.21%	Maintain 2013/14 levels	92.6%	78.3%	81.1%	70.6%	66.7%	92.9%	92.9%	93.6%	84.6%	94.1%	95.7%			YTD 76.3%	YTD 80.3%	YTD 87.6%		
	COPD	5a	Develop an Integrated Care Pathway	N/A	Develop an Integrated Care Pathway																		
		5b	Improved referral rate to the Community Respiratory Team	22.0%	Improved referral rate in 2014/15 - Improvement rate TBA	22.8%	25.4%	25.7%	23.3%	22.1%	21.9%	20.3%	20.3%	21.0%	23.9%	23.7%			24.8%	21.5%	21.7%		
		5c	Improved referral rate to the Stop Smoking Service	7.8%	Improved referral rate in 2014/15 - Improvement rate TBA	8.0%	8.9%	10.5%	7.3%	9.3%	8.4%	9.3%	8.0%	5.0%	5.4%	7.5%			8.9%	9.0%	6.1%		
	Diabetes	6	Develop an Integrated Care Pathway	N/A	Develop an Integrated Care Pathway																		
	Over 75 Frailty Pathway	7	Develop an Integrated Care Pathway	N/A	Develop an Integrated Care Pathway																		
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.																			
		4b	EQ Pathway Measures	Results continue to improve and the target is being exceeded with a YTD value of 92.6% against an objective to sustain 2013/14 level of 74.21%.																			
	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. Internal meetings are in place. Rapid progress on the pathway development is needed.																		
		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 have been refreshed further as the process of ensuring that all referrals are being captured in the reporting process has progressed.																			
		5c	Improved referral rate to the Stop Smoking Service	Current data indicate that greater stability in improved referral rates is required.																			
	Diabetes	6	Develop an Integrated Care Pathway	A CCG led Project group has been developing an Integrated Diabetes Pathway. A mobilisation group is in place to progress a pilot pathway (which commenced in Feb-15) and the subsequent implementation of the new pathway.																			
	Over 75 Frailty Pathway	7	Develop an Integrated Care Pathway	A CCG led meeting will take place on 5 Mar-15 to continue to progress the development of the pathway. This CQUIN measure requires Project, Clinical and Information Team support to ensure that it remains on track.																			

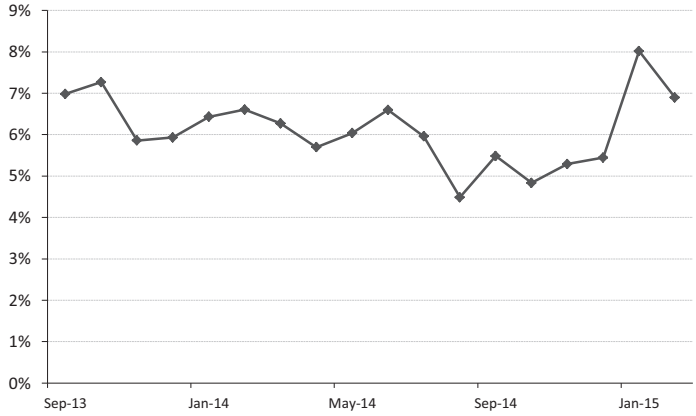
Compliance Against Performance	
	On target
	Monthly target missed; quarterly/annual target at risk
	Monthly target missed; annual target at risk

Bed Occupancy



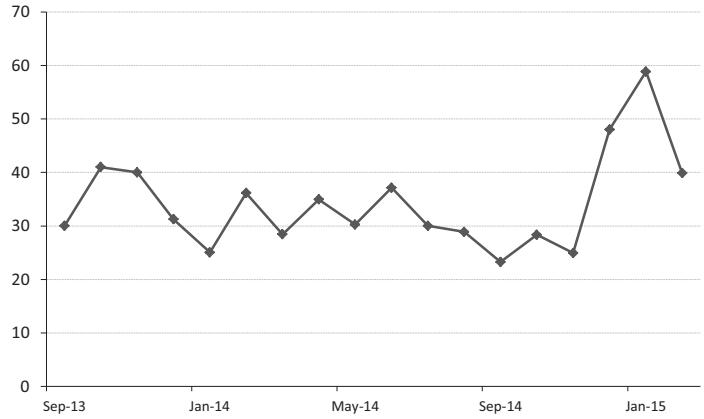
The bed occupancy metric looks only at adult inpatient beds and excludes any ring fenced wards such as Maternity. Occupancy levels were static from Oct-13 (99.78%) to May-14 (100.56%), decreasing thereafter to a position of 88.21% in Aug-14. In Feb-15, bed occupancy equalled 96.96% approximating the levels reported in Dec-14, and is higher than the position reported in Feb-14 (i.e. 94.86%).
NB: Data are sourced from the Trust's Balanced Scorecard as of 5 Mar-15.

Extra Beds



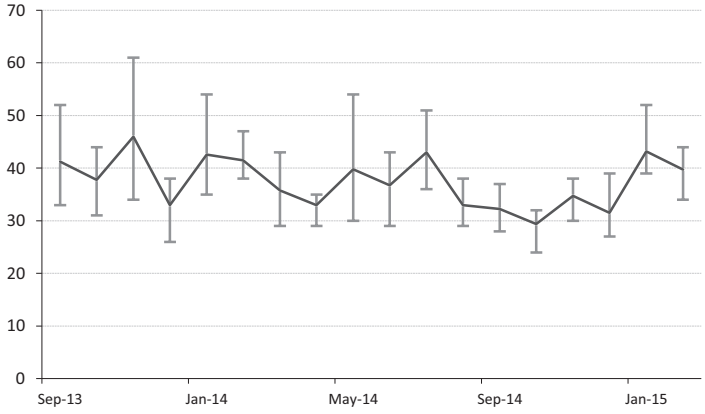
This metric is built up using the number of funded beds on each ward and reviewing those occupied on a daily basis. Where the number of occupied beds exceeds the funded bed base for the ward these are classified as "extra". In Feb-15 the degree of extra beds used within the Trust equalled 6.90%, thus showing a greater than a 1% reduction compared with Jan-15 (i.e. 8.02%), and is of the order reported in Feb-14 (cf. 6.60%). January's elevated position was a result of the difficulty in discharging long stay patients who were admitted over the Christmas and New Year period. However, the degree of extra beds reported in Feb-15 was in line with expected seasonal 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 Jan-15 a marked increase was evident over the Dec-14 position given that the outlier value equalled 58.87, that is, more than 2 fold higher than the value recorded in Jan-14 (25.06) and as such represented the highest level reported in at least 18 months. This trend was in line with the number of extra beds used in month, for although Trust activity in Jan-15 matched the expected seasonal level, the difficulty in discharging patients throughout the early part of the month resulted in a high level of operational pressure on beds. However, in line with the decreased use of additional beds, the outlier position in February fell to a value of 39.86, and is of a similar order to the position reported in Feb-14 (36.14).

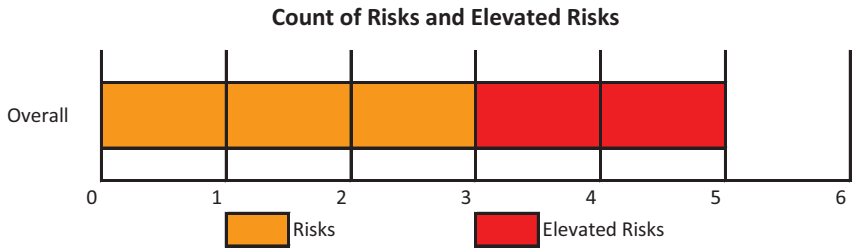
Average Delayed Transfers of Care



In Jan-15, the average number of patients on the Delayed Transfers of Care (DToC) list increased resulting in a position of 43.20 against 31.50 in December, and was driven by the difficulty in discharging long stay patients admitted over the Holiday period. However, this value returned to expected levels in Feb-15, that is, 39.75, and compares with a value of 41.50 reported in Feb-14.
The primary issues for DToC remain, that is, continuing health care pending assessment by Social Services, and care provision and community resources.

CARE QUALITY COMMISSION: INTELLIGENT MONITORING REPORT

Trust Summary



Priority Banding for Inspection	Recently Inspected
Number of Risks	3
Number of Elevated Risks	2
Overall Risk Score	7
Number of Applicable Indicators	95
Percentage Score	3.68%
Maximum Possible Risk Score	190

Elevated Risk	Monitor - Governance Risk Rating (9 Sep-14 to 9 Sep-14)
Elevated Risk	Whistle blowing alerts (18 Jul-13 to 29 Sep-14)
Risk	Composite of Central Alerting System (CAS) safety alerts indicators (1 Apr-04 to 31 Aug-14)
Risk	SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator (1 Apr-14 to 30 Jun-14)
Risk	GMC: Enhanced Monitoring (1 Mar-09 to 2 Jul-14)

The latest Intelligent Monitoring Report was received on 1 Dec-14. Following the CQC Report the High Level Improvement Plan has been submitted to the CQC and Monitor (23 Sep-14) and continues to be progressed. Our Improvement Director Sue Lewis has been appointed by Monitor and continues to work with the Trust 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 fourth monthly report on progress has been submitted to NHS Choices and has been published on our website.

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. Four further reports have been issued since this time; the most recent being in Dec-14. The risk score overall is 7. There were 5 areas showing as a risk; 2 of these are classified as "elevated". These are the number of “whistle blowing” reports made by Trust staff directly to the CQC from 18 Jul-13 to 29 Sep-14 being more than 1 and the Trust being placed in special measures following the publication of the CQC inspection report in August. The other risk areas reported are unchanged. These are the:

1. Composite scores for the Central Alert System (CAS.) The outstanding CAS alerts have been closed and this is unlikely to flag as a risk in the next iteration of the Intelligent Monitoring Report.
2. Stroke national audit overall team rating results for Q1 2014/15.
3. Enhanced monitoring by the GMC.

The risk alert relating to mortality following the procedure for hemi-arthroplasty was closed by the CQC and no longer triggers in the report.

East Kent Hospitals University NHS
NHS Foundation Trust

The Publication of Nurse staffing Data – February 2015

Introduction

In accordance with National Quality Board requirements to provide assurance on safe staffing the Trust is now publishing staffing data in the following ways:

- Information about nurses, midwives and care staff deployed, by shift, against planned levels has been displayed at ward level since April. The levels are displayed using a red, amber green status; green depicts staffing levels are as planned; amber depicts that the ward is slightly short staffed but not compromised; red rag rating depicts an acute shortage for that shift. The display allows staff to explain the reasons for any shortage and also what actions they have taken to mitigate the situation, thereby offering assurance to patients and visitors.
- Ward staffing reviews are repeated every 6 months and the October review was reported to the Trust Board in January 2015.
- Monthly reports detailing planned and actual staffing on a shift by shift basis for the previous month has been presented monthly to the Board since May. This report is also published on the Trust website and to the relevant hospital webpage on NHS choices. Nurse sensitive quality metrics are now included, shown in figure 3.

Planned and actual staffing

Revised National Quality Board guidance published in May 2014 outlined the requirement for % fill of planned and actual hours to be identified by registered nurse and care staff, by day and by night, and by individual hospital site. Reported data is derived from the E-Rostering and NHS-Professionals systems and aggregated fill rates in February are 98% at WHH, over 96% at QEQM and 91% across K&C, shown in Figure 1.

Figure 1. % hours filled planned against actual by site during February 2015

	% Hours filled - planned against actual Feb 2015				
	DAY		NIGHT		
Hospital site	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Overall % hours filled
Kent & Canterbury	87.8%	85.6%	96.8%	106.3%	91.15
Queen Elizabeth the Queen Mother	90.8%	101.1%	100.5%	102.2%	96.72
William Harvey	95.8%	99.9%	97.0%	106.9%	98.19

It should be possible to fill 100% of hours if:

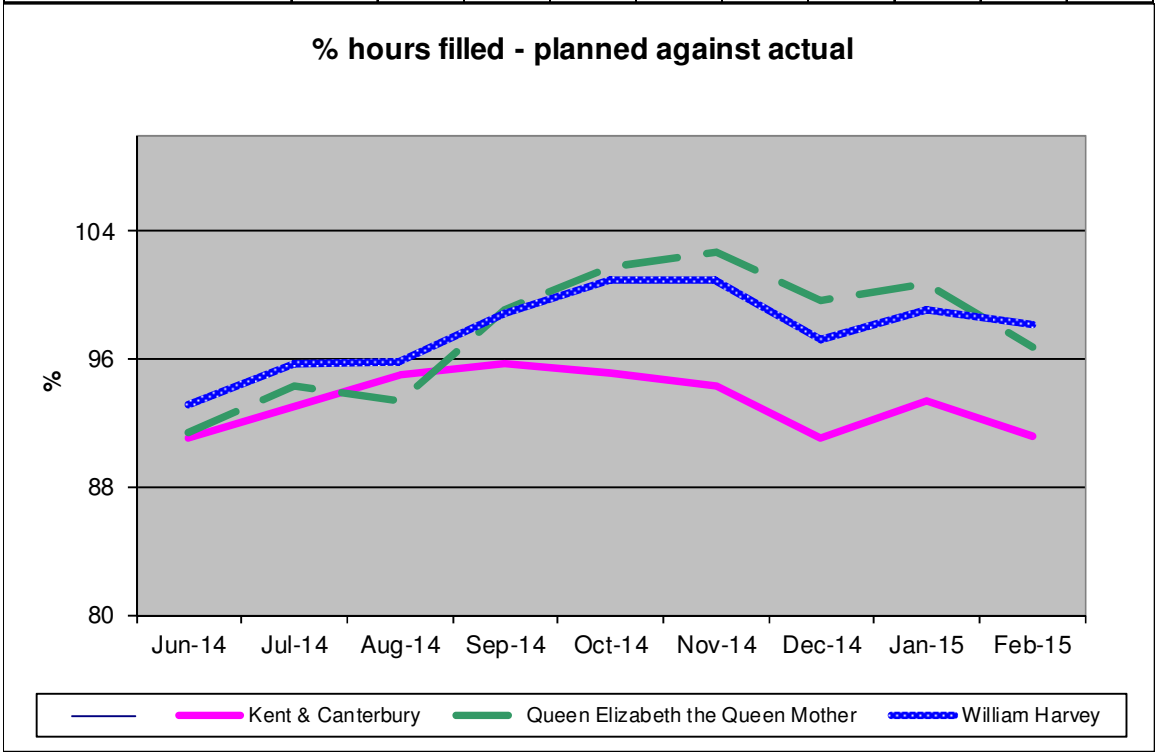
- There are no vacant posts
- All vacant planned shifts are covered by overtime or NHS-P shifts
- Annual leave, sickness and study leave is managed within 22%

Gradual improvement was seen over the first months of reporting, shown in figure 2. The slight reductions seen in December and February reflect the requirement for additional

shifts during winter pressures not always being filled by NHSP. Work to ensure that roster templates closely reflect the budgeted establishments and include shifts necessary for additional beds has supported the increased fill rates seen over time.

Figure 2. % hours filled planned against actual 2014/15

% Hours filled - planned against actual 2014/15										
Hospital site	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Kent & Canterbury	92	91.08	93.05	94.97	95.65	95.14	94.31	91.09	93.40	91.15
Queen Elizabeth the Queen Mother	94	91.34	94.26	93.37	99.09	101.80	102.70	99.63	100.65	96.72
William Harvey	93	93.16	95.66	95.82	98.83	100.93	100.94	97.17	99.10	98.19



Senior nursing leaders have reported that:

- It is still too soon to say which organisations have concerning levels of staffing using this data;
- Some Trusts may achieve high % fill rates but have planned for what are already sub-optimal levels;
- Many Trusts reporting the lowest fill rates have invested in to nursing in the last year;
- There may be inconsistencies in the methodology as those Trusts using E-Rostering tend to report lower fill rates.

Work to evaluate care contact time, one of the recommendations made by NICE, will be undertaken in 2015/16 to identify the % time spent by nursing staff on activities related to direct care, indirect care and also non patient care, by ward. This will provide a baseline to enable detailed understanding of how nurses spend their time and enable strategies to be developed to support and optimise patient benefit.

Figure 3 shows total monthly hours actual against planned and % fill during February by ward. Work has been undertaken to explore the reasons for the gap, the impact and the actions being taken to address the gap. Some wards achieve higher than 100% due to additional shifts worked through NHS-P during times of increased demand and additional bed use.

No national RAG rating tolerances have been determined, but wards achieving under 80% have been RAG rated Red, in Figure 3, and detail is provided on contributory factors. Key quality indicators have also been included by ward although there does not appear to be a clear link between actual fill <80% and patient experience and safety. Data validation and sign-off steps have been implemented and the data will be reported externally via Unify/NHS Choices on 16th March. The national data will be published representing each hospital site on the NHS Choices website.

Figure 3. Total monthly hours actual against planned and % fill by ward during February 2015

Division / Ward						Quality Indicators Feb 2015			
Urgent Care & LongTerm Conditions	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Comments	Friends & Family Test - % who would recommend	Harm Free Care (%) - New Harms	All Falls	All Pressure Ulcers
Cambridge J	111.87	190.72	153.40	137.58		100	96.8	5	2
Cambridge K	76.85	80.22	98.21	91.68	18.8% RN A/L. 6.3% RN Sickness.	95	100	4	0
Cambridge M2	130.58	95.27	98.49	84.20		84	100	5	2
Coronary Care Unit (K&C)	80.87	N/A	100.00	N/A	0.66 WTE HCA Vacancy. No HCA's in post.	100	100	1	0
Coronary Care Unit (QEQMH)	86.32	61.50	100.00	114.46	27.7% HCA Sickness.	100	100	2	1
Coronary Care Unit (WHH)	95.62	121.43	91.15	60.71	3.8% HCA Sickness.	97	100	0	0
Minster	78.18	94.54	96.67	102.11	21.3% RN A/L. 5.5% RN Parenting.	94	100	0	0
Oxford	106.44	94.70	95.73	105.51		95	100	6	0
Sandwich Bay	109.52	158.94	101.34	128.90		92	100	4	5
St Margarets	118.03	78.65	103.78	113.31	13.7% HCA Sickness.	80	95.5	0	0
Deal	95.61	94.81	95.59	94.15		79	96.4	5	0
Harvey	63.44	81.80	93.01	103.57	11.2% RN Sickness. 7.5% RN Parenting.	78	100	0	0
Invicta	98.31	99.15	92.86	120.83		100	100	0	0
Cambridge L	78.15	94.30	100.00	173.84	Extra Beds Shifts?	77	100	3	1
Treble	73.93	81.67	99.96	169.02	17.1% RN Sickness. 5.7% RN Parenting.	100	100	9	0
Mount/McMaster	92.36	75.38	96.43	146.90	23.4% HCA Sickness.	93	100	3	0
Fordwich Stroke Unit	87.49	120.27	98.73	105.57		97	95.8	3	1
Kingston Stroke Unit	77.45	124.59	97.21	96.43	5.56 WTE RN Vacancy.	91	100	6	0
Richard Stevens Stroke Unit	74.17	90.86	89.49	100.78	6.7% RN Sickness. 4.5% RN Parenting. 1.91 WTE RN Vacancy	96	100	9	2
Harbledown	105.63	71.62	102.08	76.19	27.8% HCA Sickness.	86	100	16	2
QE CDU	78.01	103.71	93.57	109.38	18.5% RN A/L. 9.1% RN Parenting.	80	100	5	6
WH CDU/Bethersden	115.78	98.71	133.31	120.10		81	100	6	15
Surgical Services									
Rotary Suite	88.52	99.22	100.00	103.41		97	100	3	1
Cheerful Sparrows Female	117.25	119.69	114.03	93.43		100	100	3	1
Clarke	75.93	102.63	101.79	87.50	9.7% RN Sickness. 3.24 WTE RN Vacancy.	100	95.8	1	1
Cheerful Sparrows Male	87.47	110.16	116.70	97.36		100	95	4	3
Kent	119.85	77.48	100.93	89.03	4.7% HCA Sickness. 1.01 WTE HCA Vacancy.	95	100	3	4
Kings B Ward - WHH	109.19	90.66	106.29	179.19		100	88.9	3	4
Kings A2	96.92	94.44	95.11	121.74		98	100	1	4
Kings C1	103.89	128.05	101.94	107.45		96	91.7	3	3
Kings C2	69.21	97.66	84.08	105.98	19.8% RN A/L. 4.29 WTE RN Vacancy.	99	100	1	0
Kings D Female						96	100	1	5
Kings D Male	94.97	112.95	87.26	116.65		97	95.8	3	1
Quex	76.70	165.41	97.62	96.96	10.7% RN Sickness. 1.18 WTE RN Vacancy.	98	100	0	1
Bishopstone - split						96	100	4	2
Seabathing -split	98.35	109.60	107.14	102.96		100	100	5	5
Critical Care - WHH -	120.18	104.14	112.42	97.22		N/A	100	1	5
Critical Care - KCH	100.65	96.49	97.84	N/A		N/A	100	0	0
Critical Care - QMH	77.20	89.58	94.16	N/A	7.2% RN Sickness. 3.86 WTE RN Vacancy.	N/A	100	0	1
Specialist Services									
KC Marlowe Ward	80.73	76.99	85.46	103.94	5.8% HCA Sickness. 3.27 WTE HCA Vacancy.	100	100	7	0
WH NICU	81.78	112.31	79.27	N/A	6.9% RN Sickness.	N/A	100	0	0
WH Padua Ward	107.12	103.98	107.20	58.54	9.3% HCA Parenting.	N/A	100	1	0
QE Rainbow Ward	94.16	83.20	97.62	N/A		N/A	100	1	0
QE Birchington Ward	78.87	139.83	93.55	114.77	13.9% RN Parenting. 1.28 WTE RN Vacancy.	95	100	2	0
WH Kennington Ward	114.28	100.25	85.86	N/A		93	100	1	0
KC Brabourne Haematology Ward	88.02	61.82	101.86	N/A	35.7% HCA Parenting. 6.9% HCA Sickness.	100	100	0	0
WH Maternity Labour and Folkestone+	96.33	63.59	97.76	65.95	8.5% MCA Sickness. 5.3% MCA Parenting.	N/A	100	0	0
MLU WHH	85.72	57.19	89.67	67.86	24.6% MCA A/L. 12.1% MCA Sickness.	N/A	N/A	0	0
QE Maternity Wards + MCA	87.49	67.71	87.04	96.43	10.7% MCA Parenting. 4.1% MCA Sickness.	N/A	100	0	0
QE MLU	102.30	79.45	196.83	85.71	14.3% MCA Sickness.	N/A	N/A	0	0
QE SCBU	86.59	95.95	101.76	N/A		N/A	100	0	0