EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**24 APRIL 2015**
SUBJECT:	**CLINICAL QUALITY & PATIENT SAFETY**
REPORT FROM:	**CHIEF NURSE & DIRECTOR OF QUALITY**
PURPOSE:	**Discussion** **Information**

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 94.3% of our inpatients were deemed 'harm free' which is lower than last month (95%) but meets the national figure which is 94%. 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 98.1%, similar to last month (98.7%). However, KCH performance is of particular note, being the only site to achieve 99% harm free care of new harms. Further analysis of these data show that the prevalence of patients with a catheter and a new urinary infection or who have developed a new VTE had decreased this month, the remainder were slightly increased.

- Nurse Sensitive Indicators – In March there were 20 reported incidents of pressure ulcers developing in hospital (21 in February). These include 16 Category 2 pressure ulcers and four Category 3 ulcers. Five 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. Due to the good progress of the improvement plan, the reduction targets of a 25% reduction of avoidable category 2 ulcers and a 50% reduction internal stretch target for avoidable deep ulcers has been achieved. Both trajectories have finished the year below their set limit.

- There were 185 patient falls recorded for March (153 in February). One fall resulted in a hip fracture (Fordwich Ward, QEQM). This is reported on STEIS. Data outlining falls per 1000 patient bed days are now available and demonstrate a slight rise in falls rate during March. The link worker audit tool is live on ward iPads and enables assessment of compliance with the Falls Risk Assessment and Care Plan and highlights areas to focus improvement. The new Falls Steering Group will meet in April in order to steer a Trust wide improvement plan and to share and implement Trust wide learning. The Trust CQUIN target to reduce falls by 25% was achieved with a total number of 42 against a limit of 94 as measured by the monthly snapshot Safety Thermometer.

- Infection Prevention and Control –Trust wide mandatory Infection Prevention and Control training compliance for February was 79.9%, similar to January (80.2%). The March data will be reported in May -15. Divisions are working on a phased improvement trajectory to meet the 95% standard.

- HCAI – There were no cases of MRSA bacteraemia in March. There has been 1 Trust assigned case for the year 2014/15.

- There were four cases of C. difficile occurring within the Trust during March resulting in 47 cases for the year, An additional case that occurred under Hospital at Home was not recognised by the PHE as being attributed to the Trust as it was community acquired. We have thereby reached but not exceeded our limit. Two of the cases were deemed unavoidable at RCA with no lapses in care.

- There were 39 cases of E.coli bacteraemia in March. Thirty-five cases occurred pre-48h and 4 occurred post-48h. None met the criteria for RCA. There were 11 cases of MSSA bacteraemia in March. Seven cases occurred pre-48h and 4 cases post 48h. One case met the criteria for RCA.

- Mortality Rates – The most recent HSMR performance was reported in

December 2014 and equalled 78.6 compared to 83.7 in December 2013. Crude mortality for non-elective patients shows a seasonal trend with deaths higher during the winter months. Performance in Mar -15 continues to show a reduction on January's elevated position, but similar to February 15. Elective crude mortality rose in March compared to the previous month and is similar to that of January. 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 Q1 2014/15 indicate a SHMI value of 95.3 lower than the position reported in Q4 2013/14.

- 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 was seen over the first months of reporting. 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. March fill rates have seen a reduction at the QEQM and WHH due to slightly higher annual leave taken at year end. March has seen a slight fall in actual fill rates at QEQM and at WHH. Analysis of the quality indicators does not show a correlation with the staffing levels reported, although Harbledown and Richard Stevens Wards reported the highest number of falls. Please see the attached Appendix 1 for greater detail on nursing staffing.

- Risk Management – In Mar-15 a total of 1091 clinical incidents including patient falls were reported. Eight serious incidents were required to be reported on STEIS in March. Six cases have been closed since the last report. There remain 70 serious incidents open at the end of March. Incidents may be re-graded following investigation. Update Never Event and Serious Incident guidance has been released by NHS England for implementation from 1 Apr-15. This guidance firmly places the focus on a case by case approach to identify serious incidents in order to focus resources on learning from the most serious of incidents. The AIR (Adverse Incident Reporting) policy is currently being updated to reflect this new guidance.

- During March there was an increase in the number of incidents relating to delays in providing treatment. One incident has been graded as death and one as severe harm. Both are under investigation. The remaining metrics reported show similar levels to previous months.

CLINICAL EFFECTIVENESS

- Bed Occupancy – The bed occupancy metric looks only at adult inpatient beds and excludes any ring fenced wards such as Maternity. In Mar-15, bed occupancy equalled 93.2% similar to the levels reported in Oct-14, and is lower than the position reported in Mar-14 (i.e. 99.7%).

- In Mar-15 the degree of extra beds used within the Trust recorded at 6.7%. This is similar to February's figure (7%), and is higher than that recorded in Mar-14.

- Readmission Rates – Readmission rates (reported 2 months in arrears) for Feb-15 is lower than this time last year. The 30-day readmission rate for February is below the target set within month, similar to last month.

- CQUINs – March 2015 data shows a significant increase in the percentage of Friends and Family Test responses received in A&E areas to 27.9%. Response rates in inpatient areas have also increased to over 45%, and all Friends and Family Test CQUINs have therefore been met. NHS Safety Thermometer data demonstrate a year to date reduction in the prevalence of falls, catheter associated urinary tract infections and also Category 2- 4 pressure ulcers. All have exceeded the required reduction targets. Development of the Integrated Care Heart Failure, COPD, Diabetes and Over 75s pathways are progressing and will continue into 2015/16 as local CQUINs.

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. The new policy has been agreed and implemented.

- During March there were 2 reportable mixed sex accommodation breaches to NHS England via the Unify2 system, occurring in the CDU at WHH. The remaining cases occurred in the Stroke Units which is a justifiable mixing based on clinical need. There were 3 mixed sex accommodation occurrences in total, affecting 16 patients. (Last month there were 7 occurrences affecting 26 patients).

- Compliments & Complaints – During March we received 73 complaints, which is similar to February. One formal complaint has been received for every 1178 recorded spells of care in comparison to February's figures where 1 formal complaint was received for every 1099 recorded spells of care. During March there were 73 informal concerns, 251 PALS contacts and 2755 compliments received. This represents a ratio of compliments to formal complaints of 37:1, and one compliment being received for every 31 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 similar to last month with WHH showing the lowest number of formal complaints per 1000 bed days.

  The number of returning clients seeking further resolution of their concerns during March was 15 (7 in February and 15 in January). Surgical Services Division have the highest number of returning clients.

  This month the Trust achieved the standard of responding to 85% of formal complaints within the agreed date with the client. We sent 95% of the responses out on time to clients during February (64% in February, 67% in January). Every Division achieved the required standard this month. Focussed work continues with the teams to address themes, reduce the number of complaints and ensure compliance to the response time standard.

  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 Mar-15 were concerns about clinical management, problems with discharge arrangements and issues around nursing care and Doctor communication.

- Friends and Family Test – This month we received 4397 responses from inpatients and A&E patients. Maternity services achieved 440 responses. The response rates and satisfaction scores are depicted in the table below:

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

Department	Standard	Response Rate		Percentage recommended	
Inpatients	40%	45.8%	↑	93%	↓
A&E	20%	27.9%	↑	79.4%	↓
Maternity	15%	19.7%	↑	95.7	-
Outpatients	-	22.8%	-	89.8%	-
Day Case	-	37.2%	↑	94%	↑

The reportable Trust response rate (A&E and inpatients combined) is 35.4% with 93% of respondents who would recommend the Trust to their friends and family. 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. We have exceeded this standard. Comparison of response rates for February across Kent & Medway (the most recent county data validated) are shown in the Table 2:

Table 2 - Kent & Medway Comparison Response Rate Data

NB: February 2015 Data		
	A&E	**Inpatients**
EKHUFT	21.6%	36.9%
Dartford	2.8%	24.9%
MTW	18%	39.4%
Medway	20.3%	52.6%
NATIONAL	**21.2%**	**39.8%**

It is encouraging to see that our A&E 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. In the meantime the Trust is preparing for our re-inspection on the 15th July 2015.

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 although we met 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. This is reported sepaparetly;
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.

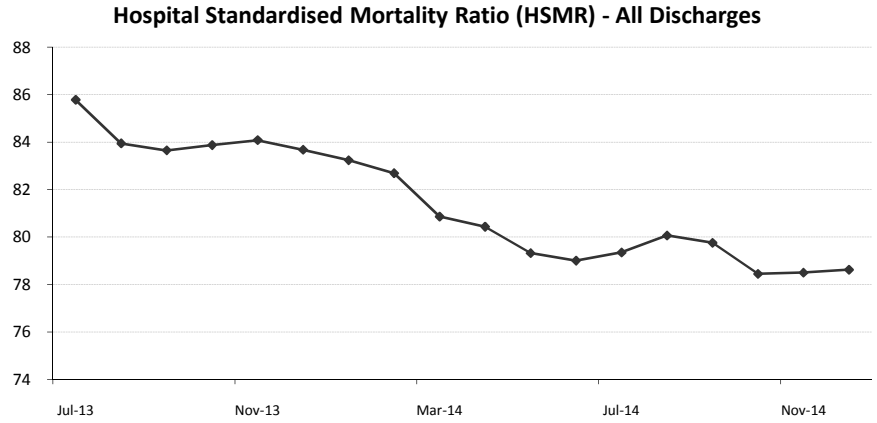
CLINICAL QUALITY & PATIENT SAFETY PERFORMANCE SUMMARY

Introduction

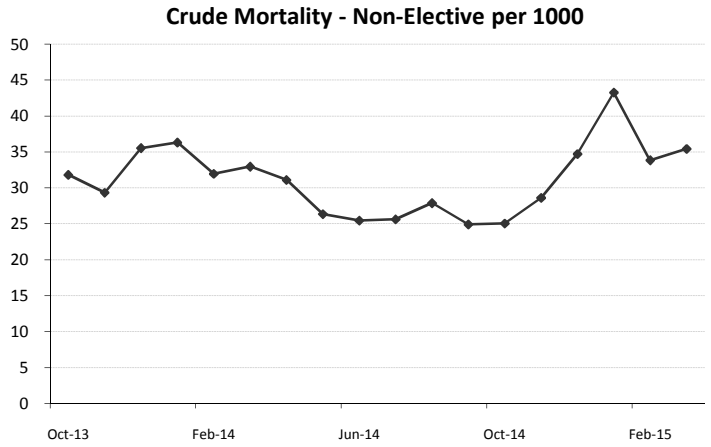
A summary of key trends and actions of the Trust's performance against the clinical quality and patient safety indicators is provided together with supporting narrative. The report is structured around the key themes of the annually published Quality Report/Account; Patient Safety, Patient Experience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

	Measure	Improvement Metric		Target 14/15	Dec-14	Dec-13	vs Dec-13	YTD
Patient Safety	Mortality Rates	HSMR		-	78.6	83.7	↓	79.3
					Q1 14/15	Q1 13/14	vs Q1 13/14	YTD
		SHMI (%)		-	95.30%	95.51%	↓	-
					Mar-15	Mar-14	vs Mar-14	YTD
		Crude Mortality: All Ages (Per 1000)	Non-Elective	-	35.429	32.965	↑	30.190
			Elective	-	0.615	0.439	↑	0.429
	Risk Management	Serious Incidents (STEIS)	New Incidents	-	8	8	↔	-
			Open Incidents	-	70	33	↑	Cumul.
	HCAI	MRSA	Attributable	5	1	8	↓	Cumul.
		C. difficile	Post 72h	47	47	49	↓	Cumul.
	Infection Prevention				Feb-15	Feb-14	vs Feb-14	YTD
		Mandatory Training Compliance (%)		95.0%	79.9%	82.7%	↓	82.1%
	Harm Free Care (HFC)				Mar-15	Mar-14	vs Mar-14	YTD
		Safety Thermometer HFC (%) - Old & New Harm	EKHUFT	93.0%	94.3%	94.9%	↓	93.5%
			National	-	94.0%	93.6%	↑	-
	Nurse Sensitive Indicators	Pressure Ulcers: Category 2,3 and 4	Acquired	-	20	26	↓	265
			Avoidable	99	8	10	↓	81
		Falls		-	185	167	↑	1973
	Clinical Incidents	Total Clinical Incidents		-	1091	1148	↓	13258
Patient Experience	Compliments and Complaints	Compliments:Complaints		-	37:1	29:1	↑	-
		No. Care Spells per Formal Complaint		-	1178	1141	↑	-
	Experience	Friends and Family Test (Star Rating)		5.0	4.5	4.4	↑	-
		Adult Inpatient Experience (%)		80.00%	88.28%	87.57%	↑	-
		Mixed Sex Accommodation Occurrences		-	3	8	↓	90
Clinical Effectiveness	Readmission				Feb-15	Feb-14	vs Feb-14	YTD
		7 Day (%)		2.00%	4.05%	4.66%	↓	4.19%
		30 Day (%)		8.32%	7.88%	9.45%	↓	8.62%
	CQUIN				Mar-15	Mar-14	vs Mar-14	YTD
		Standard Contract CQUIN		Multiple			↔	
		Specialist CQUIN		Multiple			↔	
	Bed Usage	Bed Occupancy (%)		-	93.24%	99.77%	↓	-
		Extra Beds (%)		-	6.87%	6.27%	↑	6.02%
		Outliers		-	35.03	28.42	↑	420.32
		Delayed Transfers of Care (Average)		-	37.75	35.75	↑	36.18
Care Quality Commission	Intelligent Monitoring Report	Outcome Measures	Risks	-	3	-		-
			Elevated Risks	-	2	-		-

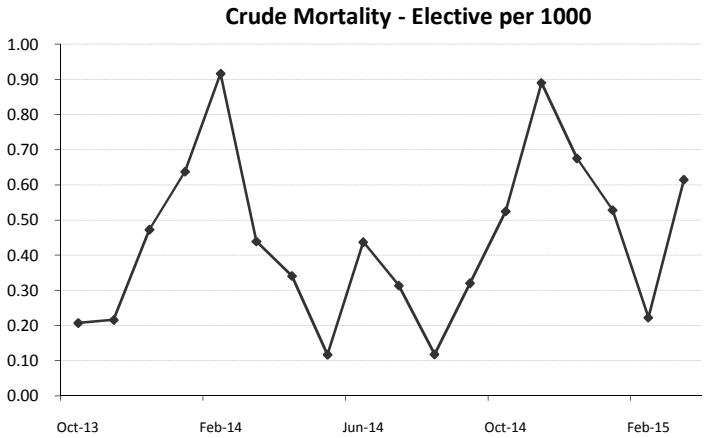
CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: MORTALITY RATES



As defined by data provider CHKS, Hospital Standardised Mortality Ratios (HSMR) 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 Dec-14 equalled 78.6, that is, approximating the value reported in Nov-14 (78.5) and compares with an elevated position of 83.7 in Dec-13.

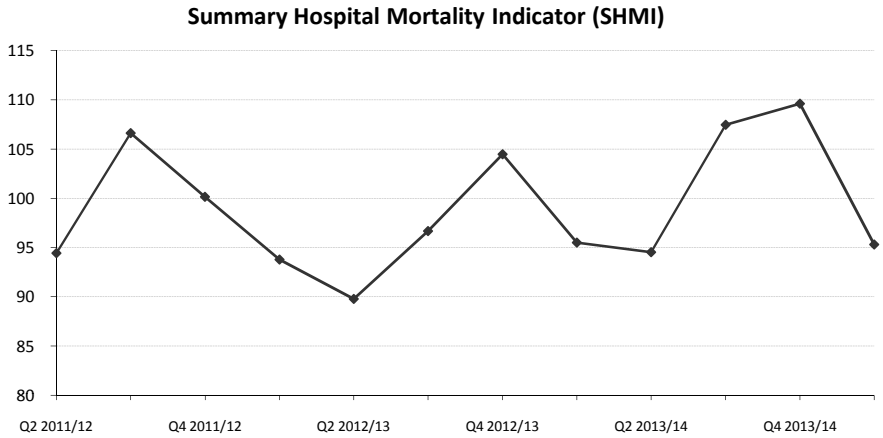


Crude mortality for non-elective patients shows a fairly seasonal trend with deaths higher during the winter months. Performance in Mar-15 equalled 35.429 deaths per 1000 population, thus showing an approximate 8 point reduction on January's elevated position (cf. 43.265), and is slightly higher than the level reported in Mar-14 where 32.965 deaths per 1000 population were recorded.



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 1000 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 0.222 deaths per 1000 population. This value increased in Mar-15 to 0.615 deaths per 1000 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 9 Apr-15.



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				
20-Nov-14	26-Mar-15	Serious Injury - child	2	Specialist	Not Due
28-Feb-15	16-Mar-15	Suboptimal Care - deteriorating patient	1	UCLTC	Not Due
12-Feb-15	13-Mar-15	Unexpected Death - general	1	Specialist	Not Due
12-Mar-15	13-Mar-15	Allegation Against HC Professional - assault	1	UCLTC	Not Due
7-Mar-15	10-Mar-15	Fall	1	UCLTC	Not Due
21-Feb-15	9-Mar-15	Category 3 hospital acquired pressure ulcer	1	UCLTC	Not Due
3-Mar-15	4-Mar-15	Death - child	2	Specialist	Not Due
1-Mar-15	2-Mar-15	Unexpected Death - neonatal (Maternity Services)	2	Specialist	Not Due
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	Breach
23-Jan-15	26-Jan-15	Fall	1	UCLTC	Breach
9-Jan-15	23-Jan-15	Category 4 hospital acquired pressure ulcer (avoidable)	1	UCLTC	Extension
7-Jan-15	19-Jan-15	Suboptimal Care - deteriorating patient	1	Surgical	Breach
22-Dec-14	16-Jan-15	Category 3 hospital acquired pressure ulcer (avoidable)	1	Surgical	Breach
7-Apr-14	15-Jan-15	Unexpected Death - general	1	UCLTC	Breach
22-Dec-14	15-Jan-15	Unexpected Death - general	1	Surgical	Breach
31-Dec-14	15-Jan-15	Unexpected Death - general	1	UCLTC	Extension
6-Jan-15	15-Jan-15	Unexpected Death - general	1	UCLTC	Breach
5-Jan-15	9-Jan-15	Fall	1	UCLTC	Extension
24-Dec-15	9-Jan-15	Category 3 hospital acquired pressure ulcer (avoidable)	1	Surgical	Breach
30-Dec-14	30-Dec-14	Category 3 hospital acquired pressure ulcer (avoidable)	1	UCLTC	Breach
21-Dec-14	23-Dec-14	Unexpected Admission - NICU	2	Specialist	Breach
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		Specialist	Extension
10-Nov-14	3-Dec-14	Mislabelling of Sample - breast biopsy	1	Clinical Support	Breach
19-Nov-14	25-Nov-14	Medication Incident - wrong dose of Clexane administered	1	UCLTC	Breach
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	1	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		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
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

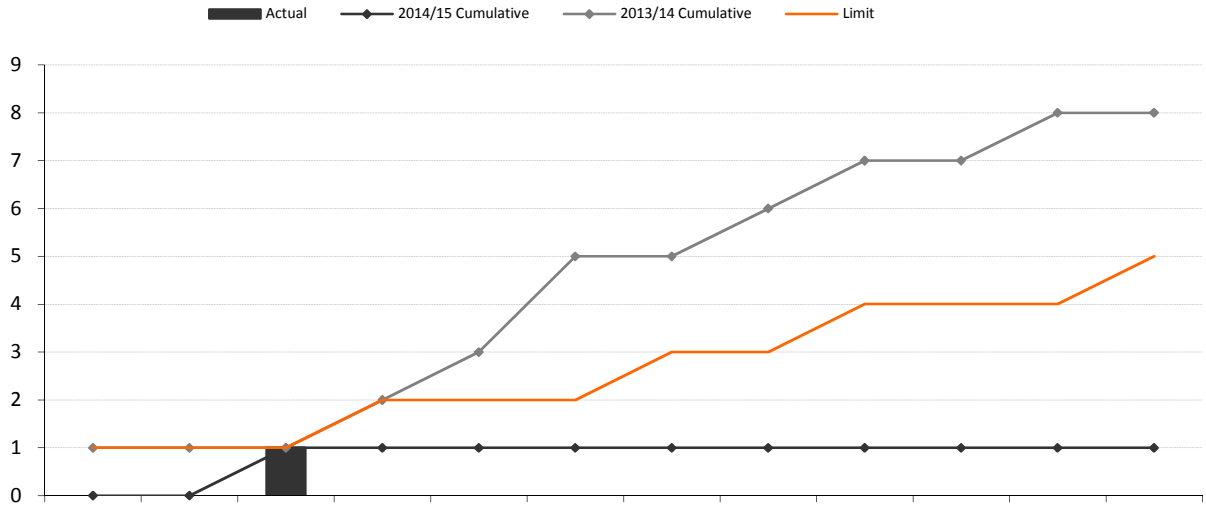
Serious Incidents - Partially Closed Cases

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			
26-Jun-14	27-Jun-14	Unexpected Death - neonatal	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
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
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
7-Jan-13	11-Jan-13	Never Event - wrong site surgery: Ophthalmology	2	Surgical

Eight serious incidents were reported on STEIS during Mar-15. These were: a neonatal death, a child death, a child serious injury, an unexpected death, a suboptimal care of a deteriorating patient, an allegation against a healthcare professional, a fall and a pressure ulcer. Six incidents have been closed on STEIS by the CCG or Area Team. At the end of Mar-15, there remain 10 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 Mar-15 there were 70 serious incidents open on STEIS. Update Never Event and Serious Incident guidance has been released by NHS England for implementation from 1 Apr-15. This guidance firmly places the focus on a case by case approach to identify serious incidents in order to focus resources on learning from the most serious of incidents. The AIR (Adverse Incident Reporting) policy is currently being updated to reflect this new guidance.

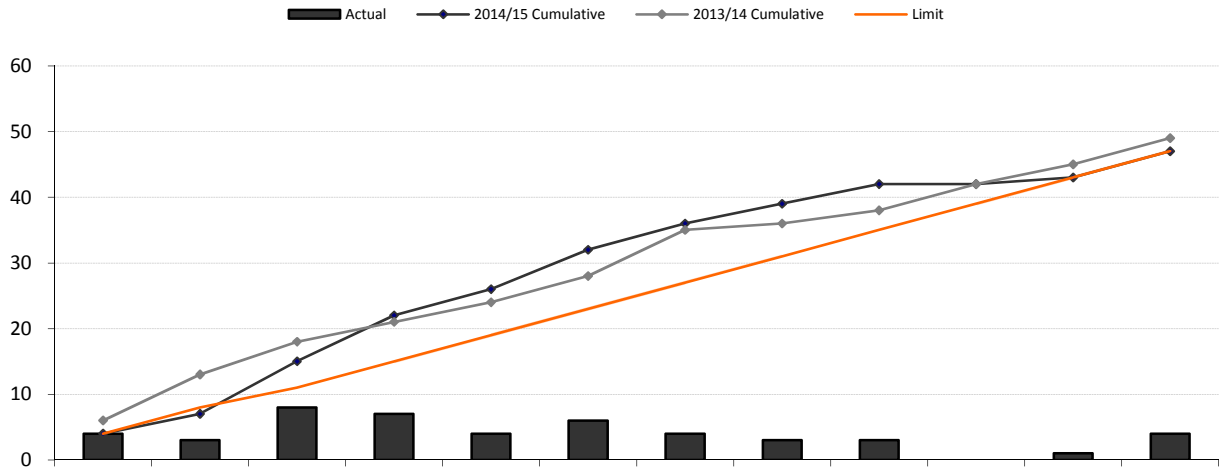
MRSA Bacteraemia - Trust Assigned Case



	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	0
2014/15 Cumulative	0	0	1	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 Mar-15. There has been 1 Trust assigned case for the year 2014/15.

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	3	3	0	1	4
2014/15 Cumulative	4	7	15	22	26	32	36	39	42	42	43	47
2013/14 Cumulative	6	13	18	21	24	28	35	36	38	42	45	49
Limit	4	8	11	15	19	23	27	31	35	39	43	47

There were 4 cases of C. difficile in March resulting in a total of 47 cases for 2014/15 against a limit of 47. Two cases were within the UCLTC Division; 1 each at KCH (Harbledown Ward) and QEH (Deal Ward). The remaining 2 cases were within the Surgical Services Division (i.e. in ITU at KCH and Kings D Male Ward at WHH). RCAs for the 2 cases at KCH are outstanding. The cases on Deal Ward and Kings D Male were both deemed at RCA to be unavoidable and non-compliant, with no lapses in care.
NB: Public Health England has considered that the Hospital at Home C. diff case recorded in Nov-14 should not be Trust Attributed. The total number of C. diff cases recorded in 2014/15 therefore reflect this change.

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

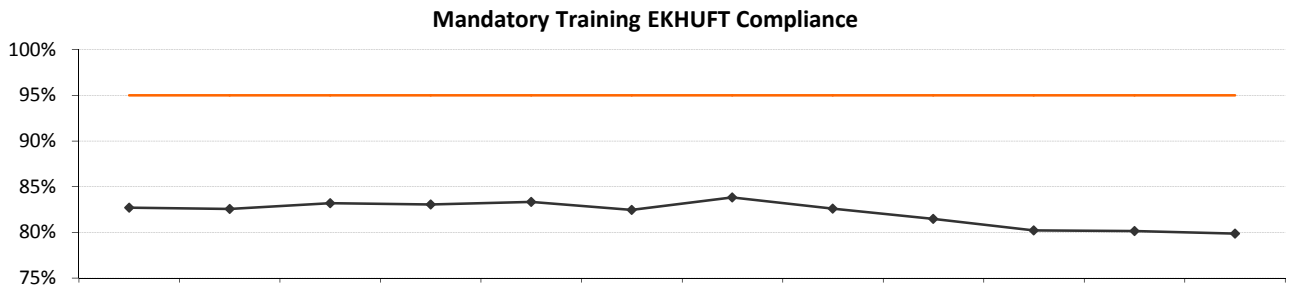
There were 39 E.coli bacteraemias cases recorded in March; 35 cases occurred pre-48h, and 4 occurred post-48h. None met the criteria for RCA.

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 11 cases of MSSA bacteraemia in March. Seven cases occurred pre-48h, and 4 cases occurred post-48h. Only 1 case (which occurred pre-48h) met the criteria for RCA.

PATIENT SAFETY: INFECTION PREVENTION & CONTROL

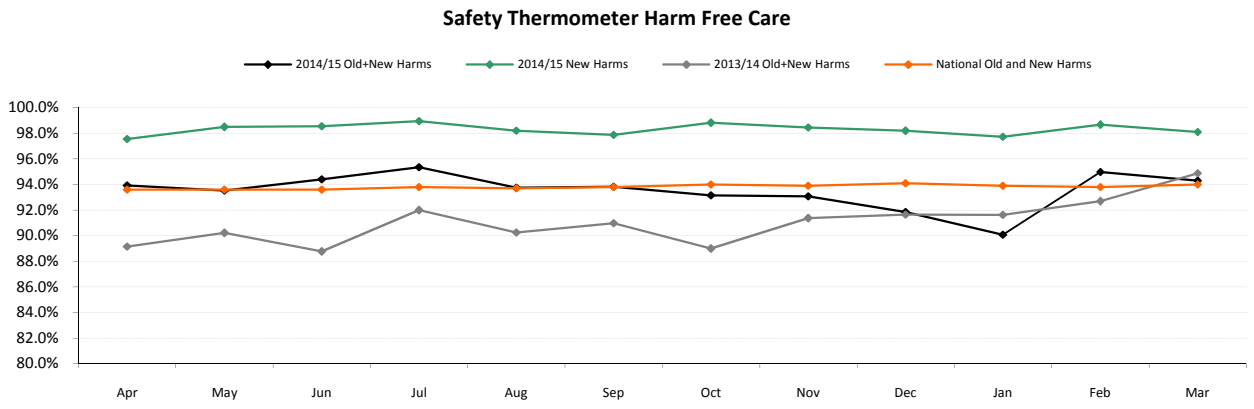


	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Compliance	82.7%	82.6%	83.2%	83.1%	83.3%	82.5%	83.9%	82.6%	81.5%	80.2%	80.2%	79.9%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

	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.
NB: Infection prevention and control mandatory training data for Mar-15 will be reported in May-15.



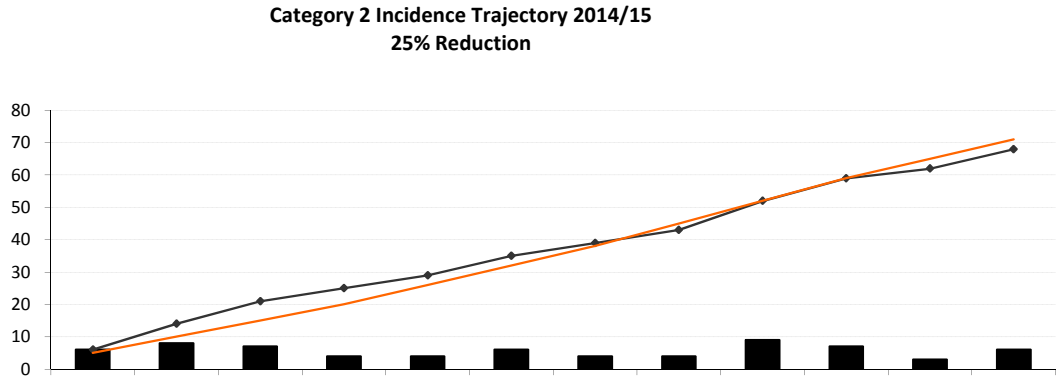
The chart above shows the percentage of Harm Free Care expressed as a one-day snapshot in each month. It is known as the NHS Safety Thermometer and is a quick and simple method for surveying patient harms. The aim of the Safety Thermometer is to identify, through a monthly survey of all adult inpatients,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

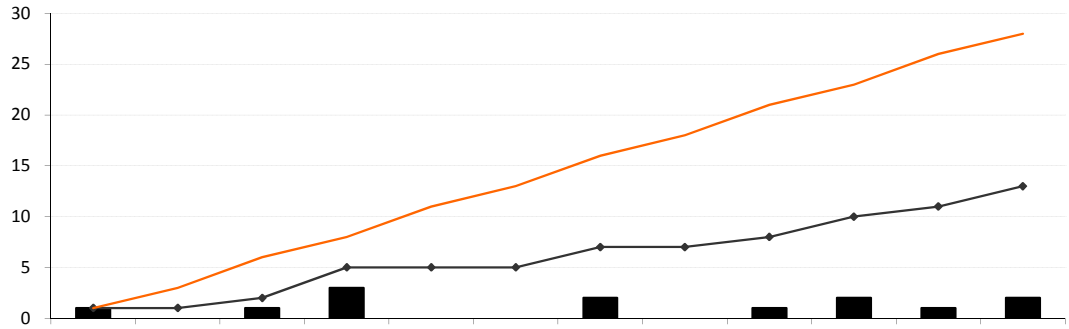
This month 94.3% of our inpatients were deemed "harm free" which is slightly lower than last month (95.0%) but equals the national figure which is 94.0%. This figure includes those patients admitted with harms and those who suffered harm whilst with us. The percentage of patients receiving harm free care during their admission with us (which we are able to influence) is 98.1%, similar to last month (98.7%). Further analysis of these data show that the prevalence of patients with a catheter and a new urinary infection or who had developed a new VTE had decreased this month, the remainder were slightly increased this month.



	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	6
2014/15Cum Avoidable	6	14	21	25	29	35	39	43	52	59	62	68
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	0.19

In March-15, a total of 16 acquired Category 2 pressure ulcers were reported, of which 6 were avoidable. This represents a slight increase of 3 avoidable ulcers from the previous month. Two avoidable ulcers occurred at KCH, 3 at QEH and 1 at WHH. Lack of, and consistency of, documentary evidence of care remains a significant factor in avoidable ulcers and actions plans continue to address these challenges. Eleven of the Category 2 pressure ulcers occurred on the sacrum, 4 being avoidable. Five occurred at the heel, 2 being avoidable. A campaign to reduce heel ulcers has proved effective during the year and a "Keep Moving" campaign has launched to target sacral ulcers. Good progress has been made, demonstrated by the achievement of greater than the proposed 25% reduction trajectory, finishing the year 3 incidents under the set limit.

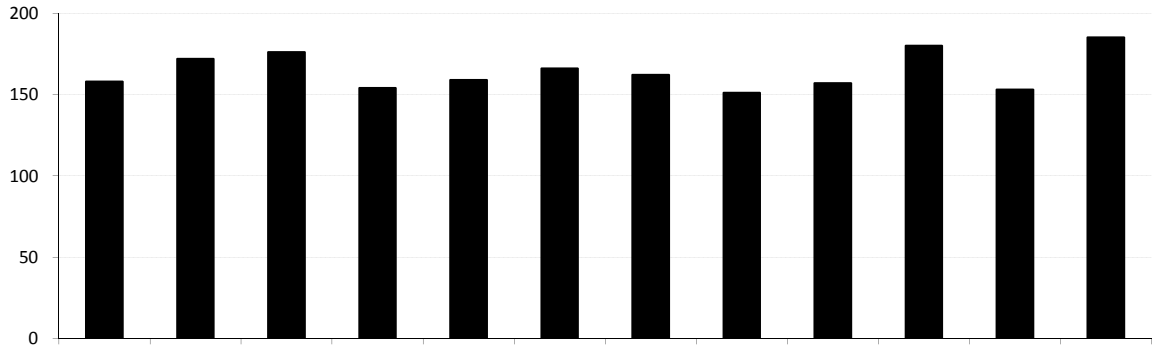
Category 3 and 4 Incidence Trajectory 2014/15
25% Reduction



	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	1	2	1	2
2014/15Cum Avoidable	1	1	2	5	5	5	7	7	8	10	11	13
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	0.03	0.06	0.03	0.06

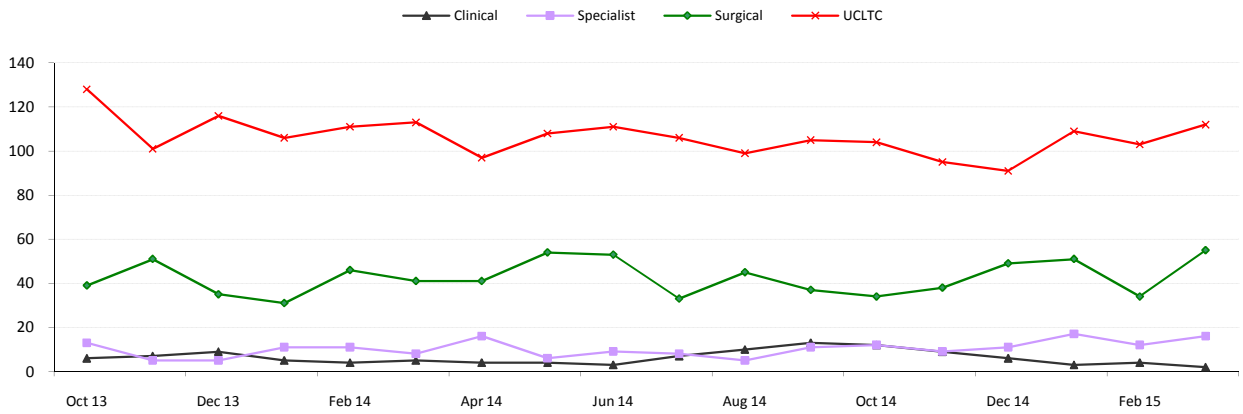
In March, there were 4 reported deep ulcers, with 2 of these ulcers being avoidable. The avoidable ulcers were both classified as Category 3. One avoidable pressure ulcer case (affecting the heel) occurred at WHH, and 1 (affecting the ankle and associated with the wearing of a leg brace) was reported at QEH. Following the "Think Heel" campaign in May-14, excellent progress has been made by reducing heel ulcers by 31%, and avoidable heel ulcers by 69% at the end of 2014/15. This has been instrumental in the Trust achieving greater than the 50% stretch reduction trajectory in the development of Category 3 and/or 4 pressure ulcers, being 5 incidents under the set limit at year end.

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	180	153	185
2014/15 Cum	158	330	506	660	819	985	1147	1298	1455	1635	1788	1973
per 1000 bed days	5.11	5.42	5.79	4.98	5.36	5.72	5.28	5.19	5.17	5.45	5.23	5.84

Patient Falls - Injurious and Non-Injurious By Division



In Mar-15 there were 185 falls in EKHUFT which included 50 at KCH, 67 at QEH and 67 at WHH. One fall resulted in a hip fracture (Fordwich). The wards with the highest total falls were Harbledown (11), Bishopstone (8), CDU QEH (8), and CDU WHH (8). There has been an increase in falls this month compared to February although March is a slightly longer month. The link worker audit tool is live on ward iPads and audits are underway to enable measurement and areas for improvement. The Trust has enrolled in the National Audit of Inpatient Falls which will be undertaken in May. The Trust CQUIN target to reduce falls recorded on the Safety Thermometer by 25% was achieved easily with the cumulative number being 42 versus a limit of 94.

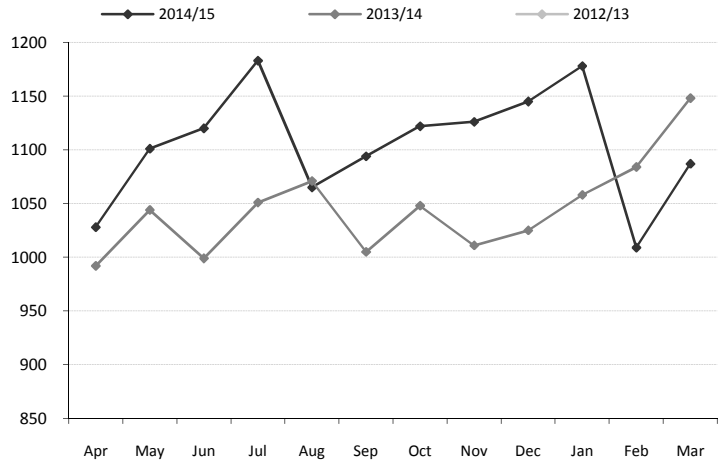
PATIENT SAFETY: CLINICAL INCIDENTS

In Mar-15 a total of 1091clinical incidents were reported. This includes 3* incidents graded as death and 3 incidents graded as severe harm. One of the 6 serious Incidents has been reported on STEIS and, following review by the Executive SI Group, 4 more are being reported on STEIS and 1 is to be downgraded to low harm. In addition to these 6 incidents, 1 incident has been escalated as a serious near miss and is awaiting final approval. There continues to be a reduction in the proportion of moderate harm incidents reported during Mar-15 (i.e. Mar-15: 57 compared with Feb-15: 48 and Mar-14: 115) 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.

Eight serious incidents were required to be reported on STEIS in March. Six cases have been closed since the last report and there remain 70 serious incidents open at the end of March.

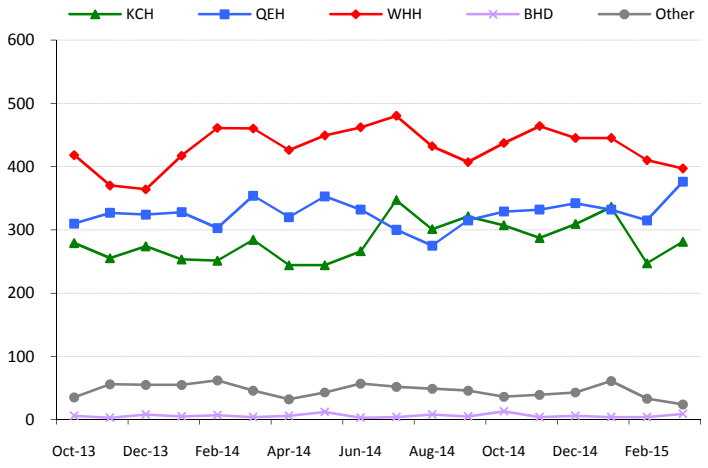
*Plus 1 duplicate as relates to the same patient (to be merged).

Overall Incident Rates by Year



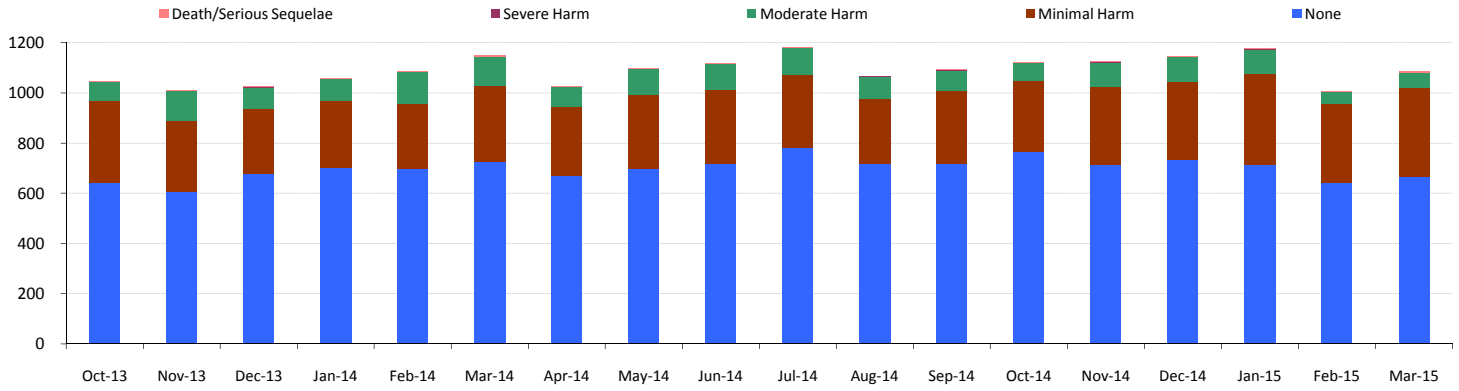
A total of 1091 clinical incidents have been logged in as occurring in Mar-15compared with 1009 recorded for Feb-15 and 1148 in Mar-14.

Overall Incident Rates by Site



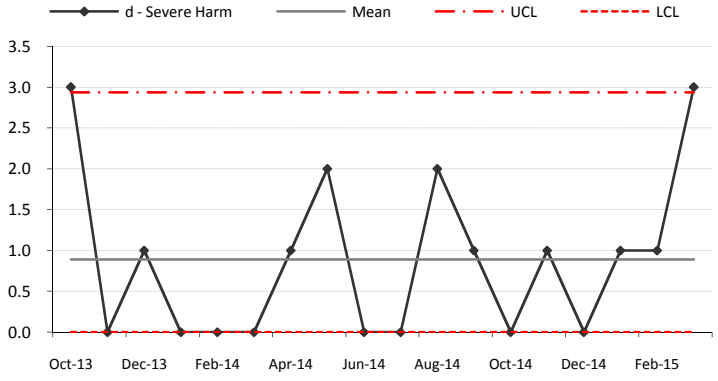
There has been a drop in reporting at WHH, but an increase at KCH and QEH. Overall there is a trend increase in the number of incidents reported in the Trust.

Clinical Incidents by Severity

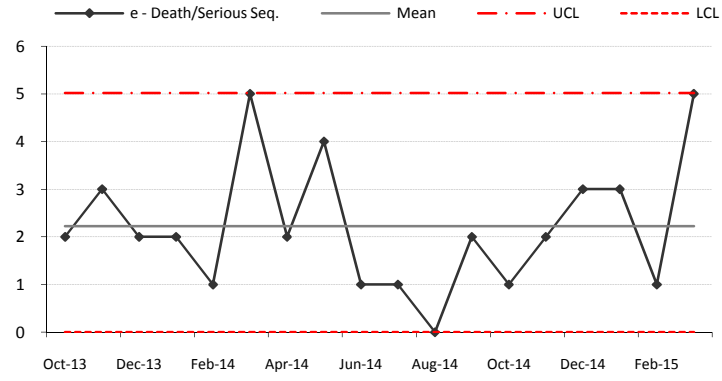


The incidents graded as moderate, serious and death have all been subject to review in order to confirm the consistency of the grading of harm across the Trust. The Board of Directors may see a change in this report to reflect the re-categorisation process undertaken. This is consistent with the data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

Severe Harm

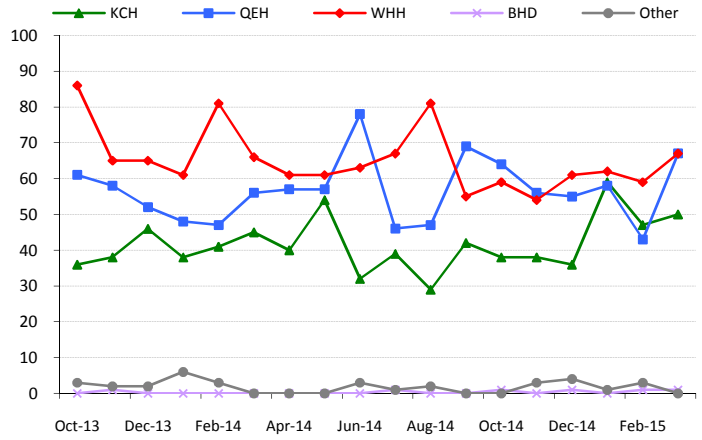


Death/Serious Sequelae



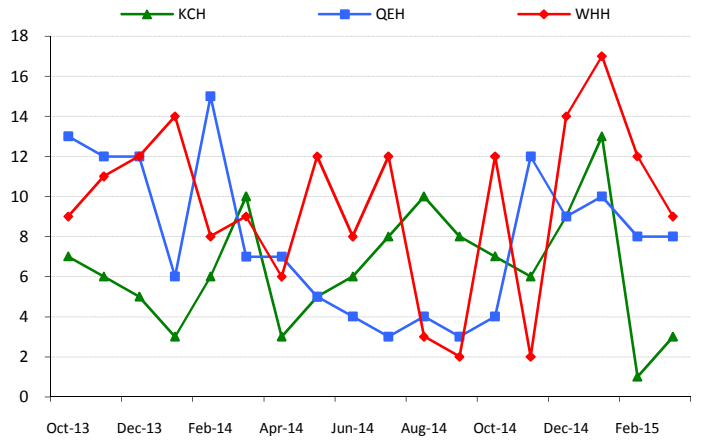
The number of death/serious and severe harm incidents reported in Mar-15 remains subject to the usual RCA investigation and review. It is possible that the severity of these cases will be downgraded once the investigation process is completed in line with national guidance to ensure the actual harm caused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

Patient Slips, Trips and Falls



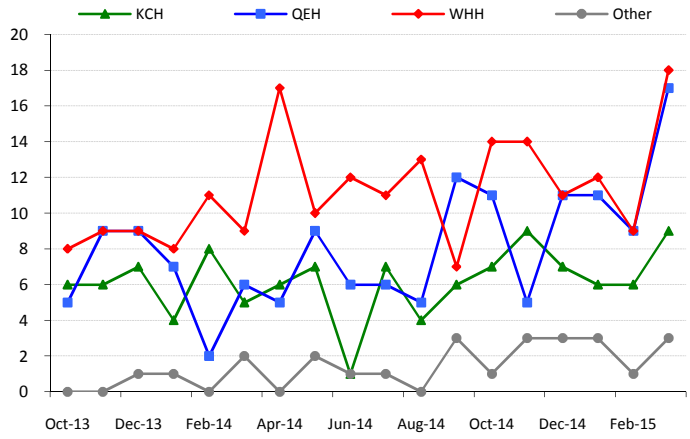
Of the 185 patient falls recorded for March (153 in Feb-15 and 167 in Mar-14), 2 incidents were graded as moderate, no incidents were graded as severe or death. There were 100 falls resulting in no injury and 83 in low harm. The top reporting wards were Harbledown (KCH)with 11 falls; Bishopstone (QEH), CDU (QEH) and CDU (WHH) with 8 each; Kingston Stroke Unit (KCH), Cheerful Sparrows Male (QEH), St Margaret's (QEH), Kings D Female (WHH) and Richard Stevens Stroke Unit (WHH) with 7 falls each; and Mount and McMaster (KCH) with 6 falls. 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



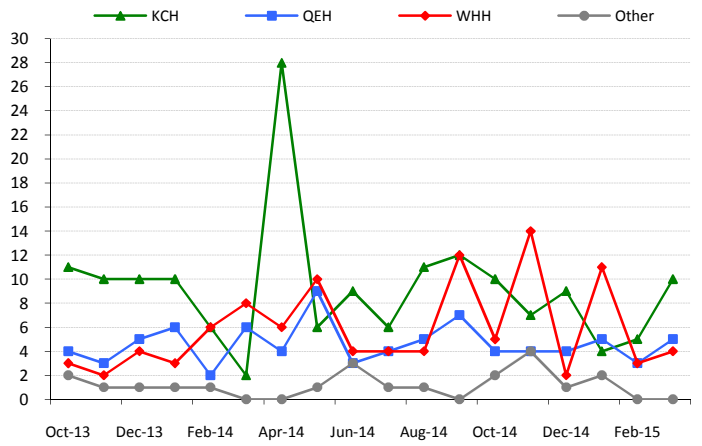
In March there were 20 reported incidents of pressure ulcers developing in hospital (21 in Feb-15 and 26 inMar-14). March's incidents included 16 Category 2 pressure ulcers and 4 Category 3; no Category 4 ulcers were reported. Two Category 3 and 6 Category 2 pressure ulcers have been assessed as avoidable. The avoidable Category 3 incident will be assessed in line with the new SI framework (from 1 Apr-15) to judge whether it is STEIS reportable. The highest reporting wards were Seabathing (QEH)and Bishopstone (QEH)with 2 incidents each; 16 other wards or departments reported 1 incident each.

Delay in Providing Treatment



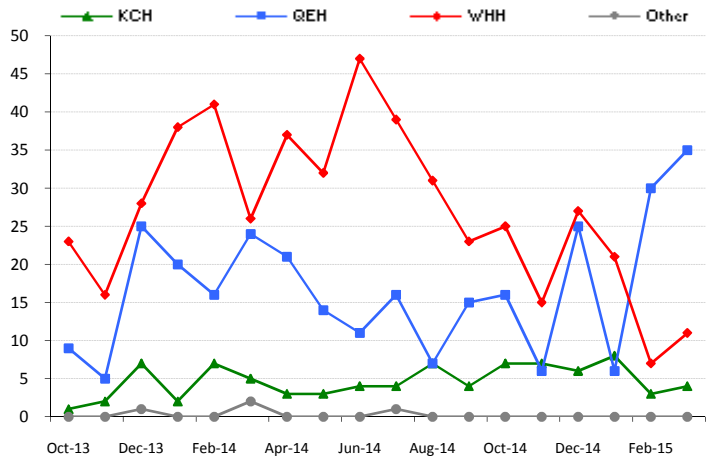
There were 47 incidents resulting in delay in providing treatment during March compared with 25 in Feb-15 and 22 in Mar-14. One incident has been graded as death and 1 has been graded as severe harm (both are under investigation and relate 1) to a failure to escalate a deteriorating patient and 2) delayed diagnosis of probable cancer (both incidents are being reported on STEIS)). Six have been graded as moderate harm, 10 have been graded as low harm and 29 resulted in no harm. Themes in location were: 9 in the Celia Blakey Centre (WHH) and 5 incidents occurred on A&E (QEH).

Incorrect Data in Patient Notes



There were 19 incidents of incorrect data in patients' notes reported as occurring in March (11 in Feb-15 and 16 in Mar-14), all 19 were graded as no harm and related to incorrect data in paper notes. Of the incidents reported, 10 were identified at KCH, 5 at QEH and 4 at WHH. There was 1 theme in the location of these incidents: 5 incidents occurred in Outpatients (KCH).

Staffing Level Difficulties

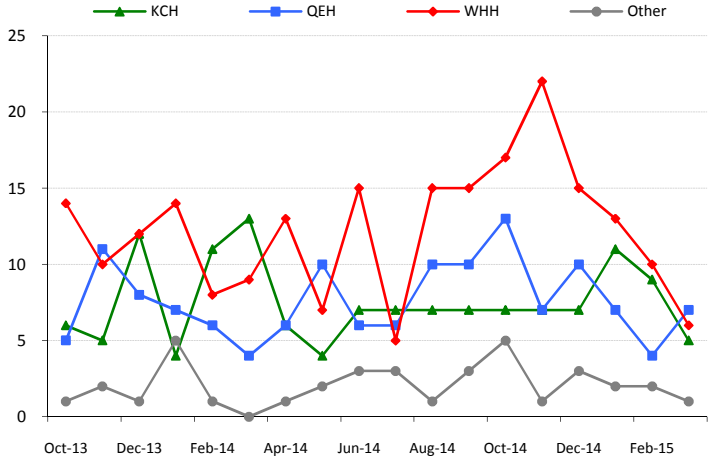


There were 50* incidents recorded in Mar-15 (40 in Feb-15 and 57 in Mar-14). These included 38 incidents relating to insufficient nurses, 3 to inadequate skill mix, 1 to insufficient doctors, 3 to insufficient doctors/nurses and 5 to general staffing level difficulties. Top reporting locations were CDU (QEH) with 20 incidents; A&E (QEH) with 8 incidents and Ambulatory Care (WHH) with 4 incidents. Other areas reported 2 or fewer incidents.

Four incidents occurred at KCH, 35 at QEH and11 at WHH. Two* incidents have been graded as death, however these relate to the same patient and the incident is currently under investigation. One incident has been graded as moderate harm and is under investigation. It relates to an overwhelming increase in admissions to A&E (QEH). Eight incidents have been graded as low harm and 39 incidents have been graded as no harm. Investigations evidence continued active management of bed, staffing situation and escalation to senior staff.

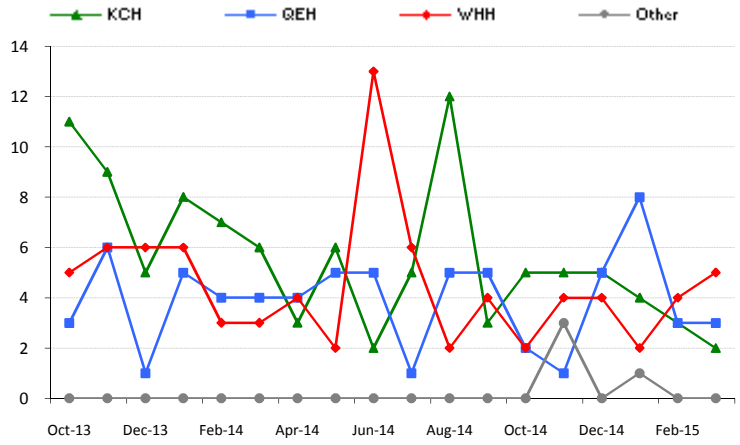
*Includes 1 duplicate.

Communication Breakdowns

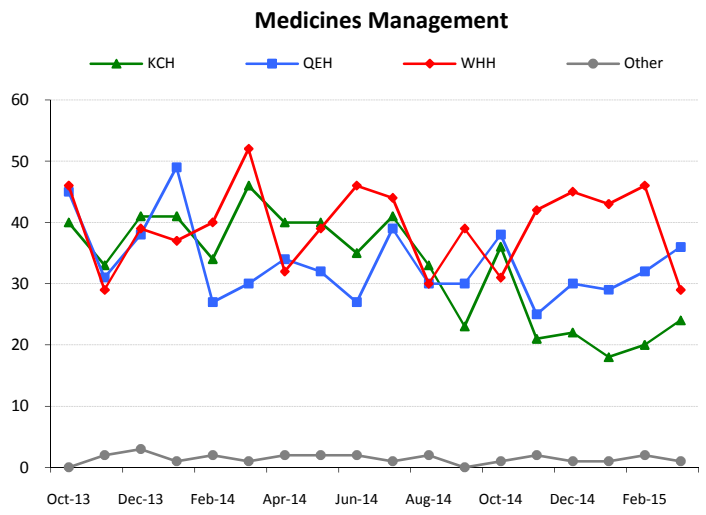


In Mar-15 there were 19 incidents of communication breakdown (38 in Feb-15 and 26 in Mar-14). Of these, 16 involved staff to staff communication failures and 3 were staff to patient. Of the 19 incidents reported, 5 were reported as occurring at KCH, 7 at QEH, 6 at WHH and 1 in the community. Themes by location: Celia Blakey Centre (WHH) reported 3 incidents; Labour Ward (QEH) and Invicta (KCH) each reported 2 incidents; other areas reported 1 or none. Incidents in March were graded as follows: 18 as no harm and 1 as low harm.

Blood Transfusion Errors



In March, there were 10 blood transfusion errors reported (10 in Feb-15 and 13 in Mar-14). There were 2 themes arising in the period: 2 incidents relating to delay in providing blood products and 2 incidents of inappropriate transfusions given: both relate to units recalled by NHSBT which had already been transfused. All 10 incidents were graded no harm. Reporting by site: 2 at KCH, 5 at WHH and 3 at QEH.



Medicines Management

Category	Mar-15
Prescribing	19
Dispensing	22
Administering	40
Missing (lost or stock discrepancy)	4
Shortage (drug unavailable)	0
Suspected adverse reaction	3
Infusion problems (drug related)	1
Infusion injury (extravasation)	1
TOTAL	**90**

There were 90 medication incidents reported as occurring in March (100 in Feb-15 and 129 in Mar-14). The reporting of medication incidents has increased at both QEH and KCH, but dropped at WHH.
Of the 90 reported, 69 were graded as no harm including no serious near misses and 20 as low harm. There was 1 medication incident graded as moderate harm, relating to a patient being delivered medicine by an external pharmacy which was intended for another patient. However, this should be downgraded to no harm as it occurred outside the Trust. Top reporting areas were: ITU (KCH), Rainbow (QEH) and Pharmacy (QEH) with 5 incidents each; Bishopstone (QEH) reported 4 incidents; Harbledown (KCH), A&E (QEH) and ITU (QEH) reported 3 incidents each; other areas reported 2 incidents or fewer. Twenty four incidents occurred at KCH, 36 at QEH, 29 at WHH and 1 in the community.

*Missing Drugs are broken down as follows: all 4 incidents relate to stock discrepancies in both patients' own medications and ward stock occurring on Harbledown (KCH), Cambridge J (WHH), Kings B (WHH) and Kings D Female (WHH). Two of the discrepancies were explained as 1) failure to document administration and 2) missing drug found under fridge, but the other 2 were of unknown cause.

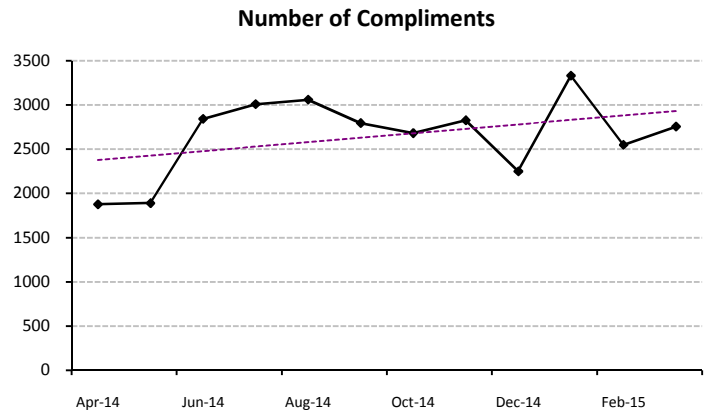
CLINICAL QUALITY & PATIENT SAFETY

PATIENT EXPERIENCE: CONCERNS, COMPLAINTS & COMPLIMENTS

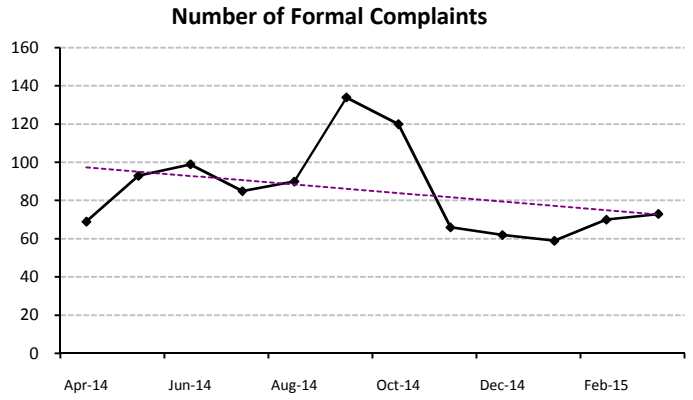
The experience of the patients and their families is of paramount importance to the Trust. Patient views are sought via a number of ways including the Patient Opinion website, the Friends and Family Test, via NHS Choices and also through the Trust's formal systems. This report provides the Board of Directors with activity and performance information about the complaints, concerns, comments and compliments during Mar-15. The information reported is for cases received in February and formal cases with target dates due that month.

• Activity: Formal complaints (received) - 73; informal concerns - 69; compliments - 2755; PALS contacts - 251.

The charts below show the number of complaints and compliments received on a monthly basis. In March, 1 formal complaint has been received for every 1178 recorded spells of care (0.08%) in comparison with February's figures where 1 formal complaint was received for every 1099 recorded spells of care (0.09%).

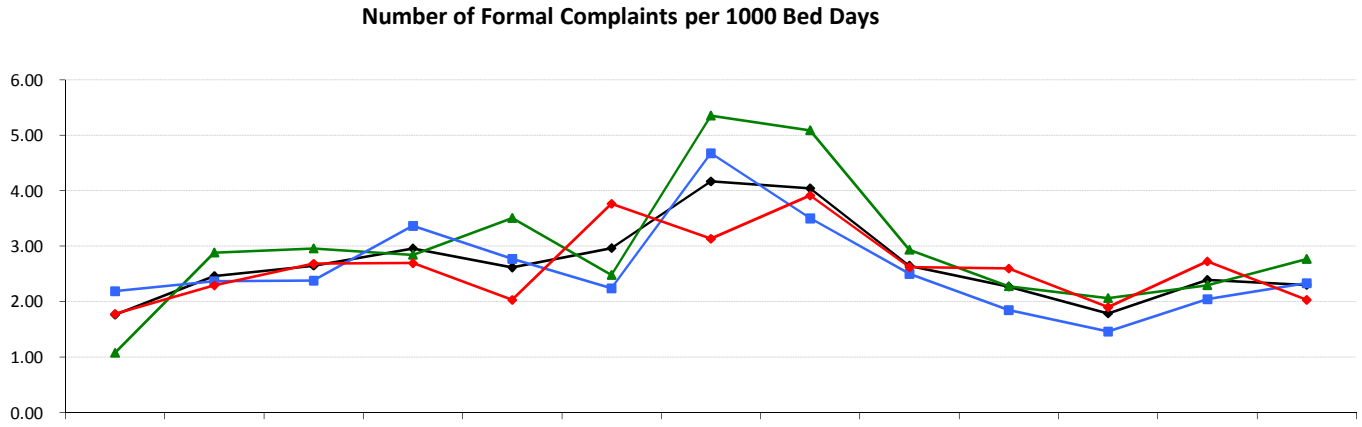


The number of compliments received has increased by 8% compared with the previous month. The ratio of compliments to formal complaints received for the month is 37:1. There has been one compliment being received for every 31 recorded spells of care.



In Mar-15, the number of complaints received has very slightly increased by 4% compared with Feb-15 (i.e. 73 compared to 70). The number of complaints is the same as reported in Mar-14. Fourteen complaints were received via the website during Mar-15.

The number of concerns has decreased by 12% compared with last month (cf. 69 with 78 respectively).



	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trust	1.76	2.46	2.65	2.96	2.62	2.97	4.17	4.04	2.65	2.27	1.79	2.39	2.30
KCH	1.08	2.89	2.96	2.85	3.51	2.48	5.36	5.09	2.94	2.28	2.07	2.30	2.77
QEH	2.19	2.37	2.38	3.37	2.77	2.24	4.68	3.50	2.50	1.85	1.46	2.04	2.33
WHH	1.78	2.30	2.69	2.70	2.03	3.77	3.14	3.92	2.62	2.60	1.90	2.73	2.03

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. WHH 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.

PATIENT EXPERIENCE: CONCERNS, COMPLAINTS & COMPLIMENTS

Top Five Concerns Expressed in Formal Complaints

March 2015

Concerns		No.
Problems with Clinical Management	Unhappy with treatment	18
	Incomplete examination carried out	6
	Lack of/inappropriate pain management	2
	Blood tests not carried out	1
	Scans/x-rays not taken	1
Problems with Communication	Doctor communication issues	8
	Misleading or contradictory information given	7
	Lack of information/explanation realting to procedure	3
	Nursing communication issues	2
	A&E staff communication issues	1
	Unable to contact ward/department	1
Problems with Discharge Arrangements	Unfit for discharge / or poor arrangements	13
	Unhappy about follow up arrangements	4
	Lack of information given upon discharge	4
	Incomplete/illegible discharge letter	1
Delays	Delay in referral	4
	Delays in receiving treatment	3
	Delays being seen in A&E	3
	Delays in allocation of outpatient appointment	3
	Delay with elective admission	3
	Delay in being seen in Outpatient Department	1
	Delay in going to theatre	1
	Delay in receiving x-ray results	1
Problems with Nursing Care	Problems with nursing care	9
	Nutrition	4
	Lack of response to call button	3
	Inappropriate physical handling	2
	Pressure ulcer care	1

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

With regards to formal complaints, the highest recurring subjects raised in Mar-15 were concerns about clinical management, problems with communication, problems with discharge arrangements, delays and problems with nursing care.

In comparison with Feb-15, delays has dropped from the top subject, and clinical management, communication and discharge arrangements remain in the top 5. Problems with nursing care has replaced problems with attitude.

Concerns, Complaints and Compliments - Divisional Performance

March 2015

	Divisional Activity				Divisional Performance	
Division	**Formal Complaints**	**Compliments**	**Informal Concerns**	**Compliments: Complaints**	**Response Date Agreed with Client**	**Returning Complaints**
Clinical Support	3	100	7	33:1	3 of 3	0
Specialist Services	13	1089	9	83:1	11 of 11	3
Surgical Services	27	522	34	19:1	13 of 15	8
UCLTC	27	1037	15	38:1	17 of 17	3
Corporate	3	7	4	2:1	0	1
Other	0	0	0	0:0	0	0
TOTAL	**73**	**2755**	**69**	**37:1**	**44 of 46**	**15**

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

The table above shows the monthly Divisional activity and performance for Mar-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 Mar-15, the data show that 96% of responses due to be sent out the clients were on target and compared with 64% last month.
UCLTC, Specialist Services and Clinical Support Divisions sent out 100% of their responses on target. The Surgical Services Division sent out a minimum of 85% of their responses on target, whilst the Corporate Division did not have any responses due in Mar-15.
The Patient Experience Team (PET) implemented a new process during Mar-15 whereby extensions are no longer sought from the complainant. The PET now contacts the complainant to renegotiate a timeframe for responding to complaints. With the aim of providing more meaningful data from Apr-15, the PET are aiming to include data indicating the number of complaints open for 30, 60 and 90 days.

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

Status of Cases	Actions in Mar-15
Cases carried over from previous month	17 *
New cases referred to the Trust	4
Cases closed by PHSO	1
Current open cases with the PHSO	20

In March the PHSO has been in contact with the Trust in regards to 4 new cases, 3 of which related to the Surgical Services Division (i.e. 2 cases were linked with Trauma and Orthopaedics, and 1 case related to General Surgery). The remaining case was linked with General Medicine within the UCLTC Division.
Two cases were closed by the PHSO in Mar-15. One case related to the Specialist Services Division (Oncology and Cancer Services). The complainant felt that the Trust had failed to investigate and diagnose the patient's leukaemia. The PHSO found that the Trust took appropriate steps to confirm the diagnosis and did not uphold the complaint. The other case related to the Surgical Services Division (General Surgery) and was upheld by the PHSO. The complaint primarily related to the care and treatment given to the patient following admission to A&E at WHH in Mar-13, namely that the Trust did not act quickly enough to provide emergency surgery and that the patient's death was avoidable.

* The oldest PHSO cases currently open with the Trust were first received from the PHSO in May-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 4397 responses from inpatients and A&E received in Mar-15, 86.8% 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 440 responses this month. The percentage of inpatients that would recommend the Trust to their friends or family was 93.0%, for A&E 79.4%, Maternity 95.7%, Outpatients 89.9% and for Day Cases 94.0%. 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 Mar-15 achieved 35.4%. Inpatients achieved 45.8% this month, and the A&E departments achieved 27.9%. Maternity services achieved 19.7%. Outpatients received 6643 responses with a 22.8% response rate. The number of Day Case responses was 2396 with a 37.2% 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 continues 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 meets on a monthly basis. We are on track to deliver the first phase by the end of March and have received the draft behavioural framework for staff and report on the outcome of the diagnostics from our external partner.

CLINICAL QUALITY & PATIENT SAFETY

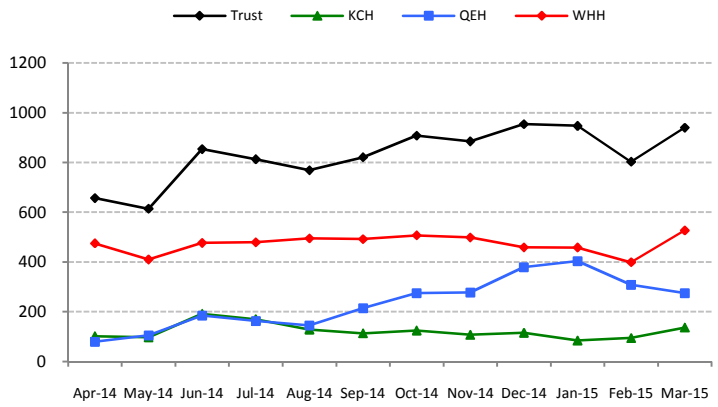
PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

Real time patient experience monitoring using iPads have captured data since 1 Apr-13. During Mar-15, 940 adult inpatients were asked about their experiences of being an inpatient; 137 responses were received from patients treated at KCH, 276 from QEH patients, and 527 responses from patients based at WHH. (Compared with the previous month the number of responses were 95, 309 and 399 respectively). The combined result from all submitted questionnaires in Mar-15 was that of 88.28% satisfaction.

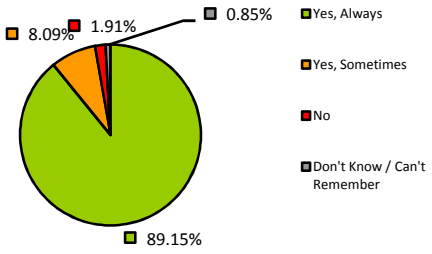
Overall Adult Inpatient Experience March 2015

Experience (%)	No. of Responses
88.28	940

Number of Adult Inpatient Survey Responses

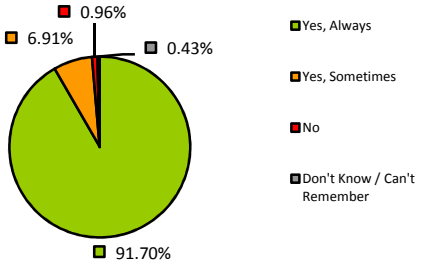


Were you given enough privacy when discussing your treatment?



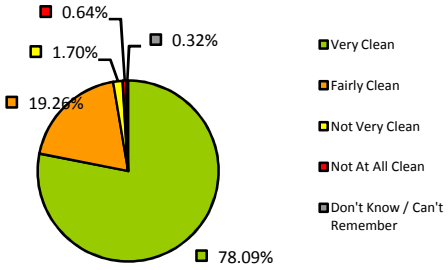
Overall Score = 93.99%

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



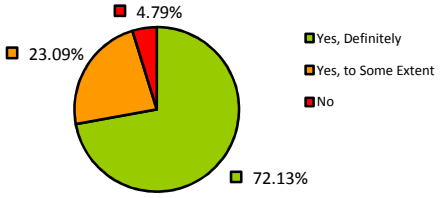
Overall Score = 95.57%

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



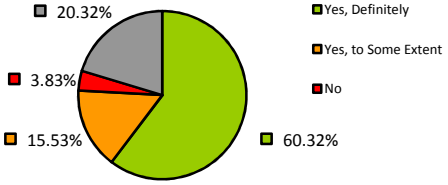
Overall Score = 91.78%

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



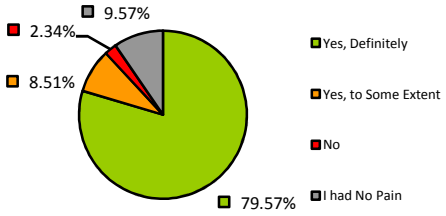
Overall Score = 83.67%

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



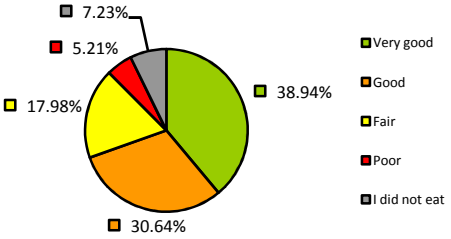
Overall Score = 85.45%

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



Overall Score = 92.71%

How would you rate the hospital food?

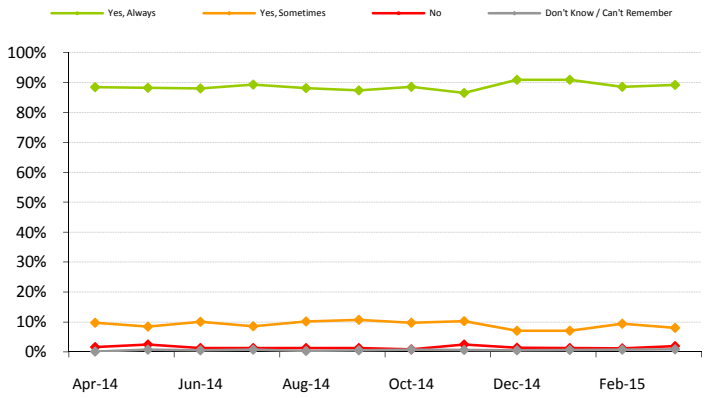


Overall Score = 70.45%

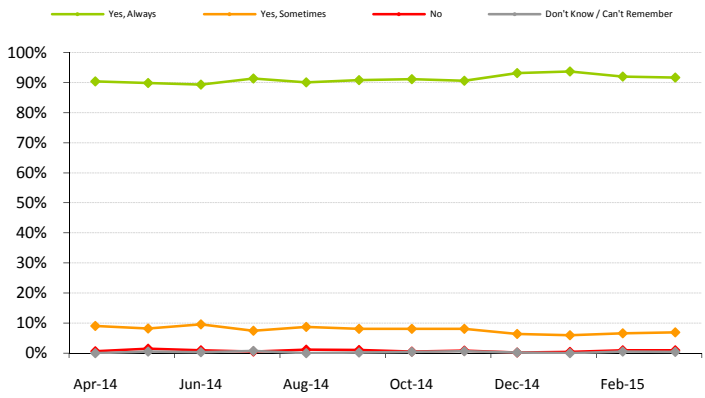
Each ward reviews their real-time monitoring data regularly. They are also shared as "heat maps" with other teams. From this actions are taken to address the themes which are considered with the Friends and Family Test feedback, and compliments and complaint information. A particular focus at present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

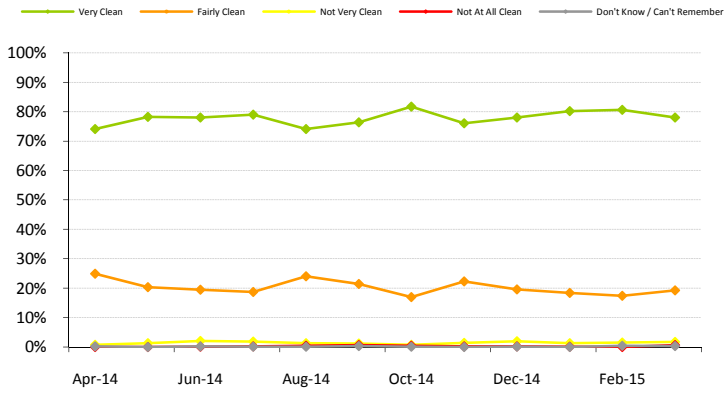
Were you given enough privacy when discussing your treatment?



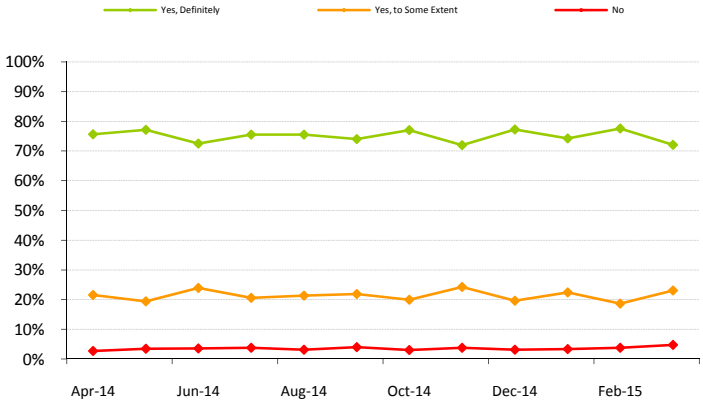
Overall, did you feel you were treated with respect and dignity while you were in hospital?



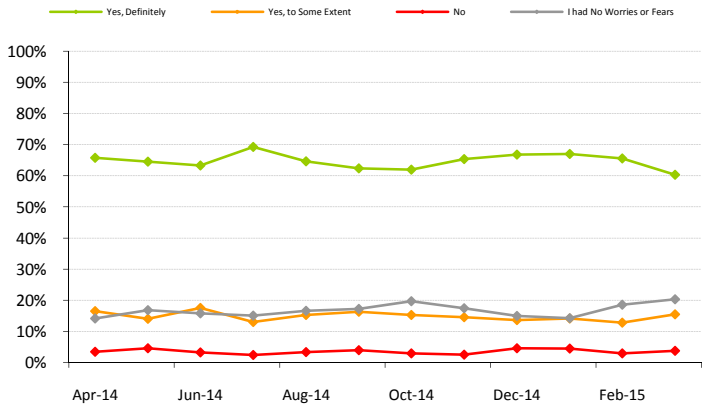
In your opinion, how clean was the hospital room or ward that you were in?



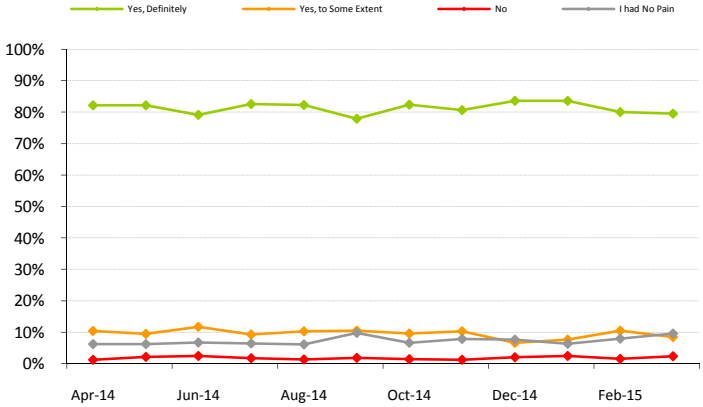
Were you involved as much as you wanted to be in the decisions about your care and treatment?



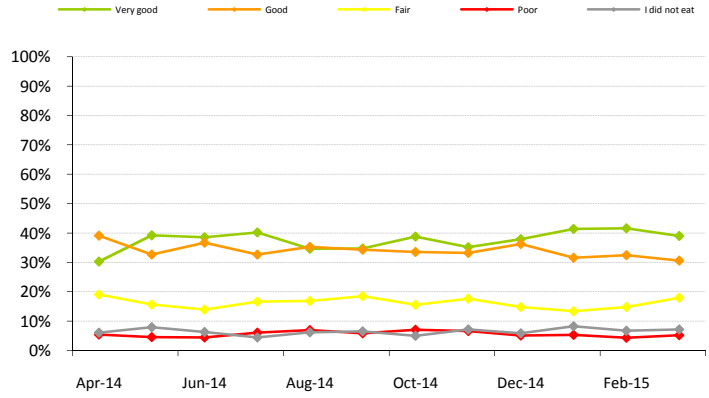
Did you find someone on the hospital staff to talk about your worries and fears?



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



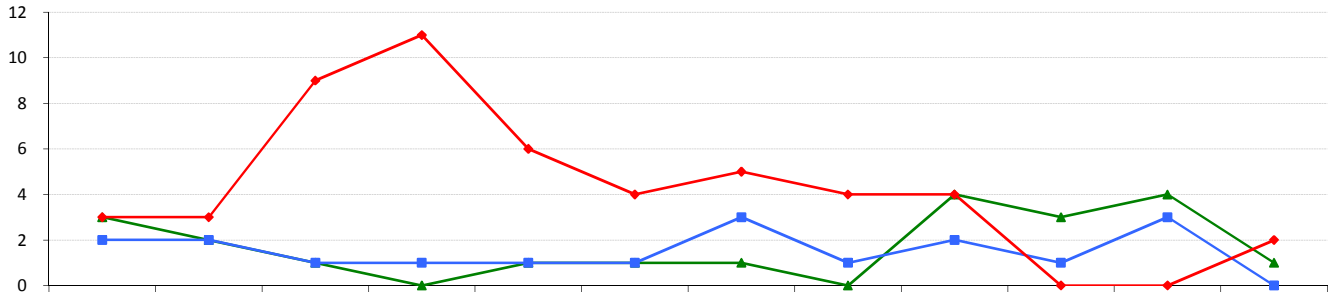
How would you rate the hospital food?



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 use "Emotional Touch-Points" methodology to interview patients about their experiences and discuss their worries and fears. The standard of hospital food is monitored, and improvements are made periodically in response to feedback. This month all the metrics have been rated similarly to the previous month. We await our results from the recent PLACE assessment at KCH.

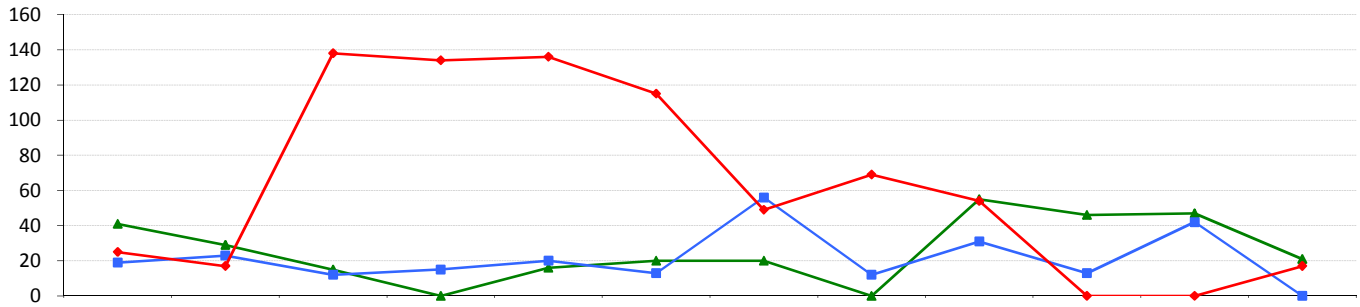
PATIENT EXPERIENCE: MIXED SEX ACCOMMODATION

Number of Episodes of Mixed Sex Occurrence



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

Number of Hours of Mixed Sex Occurrence



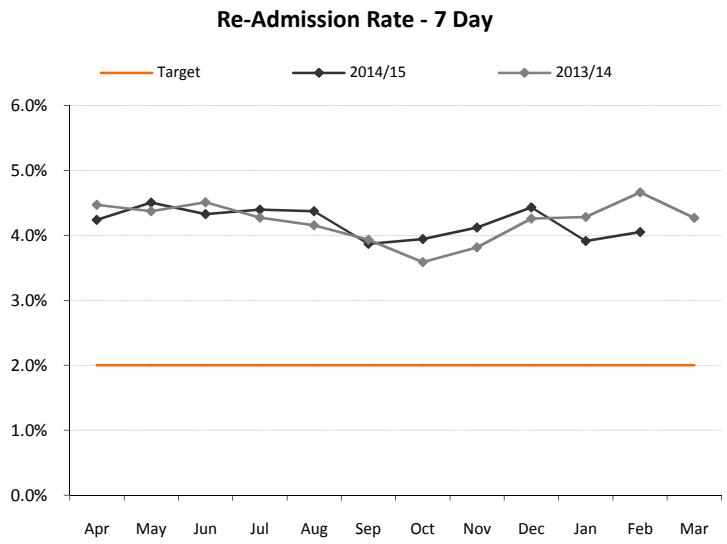
	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
KCH	41	29	15	0	16	20	20	0	55	46	47	21
QEH	19	23	12	15	20	13	56	12	31	13	42	0
WHH	25	17	138	134	136	115	49	69	54	0	0	17

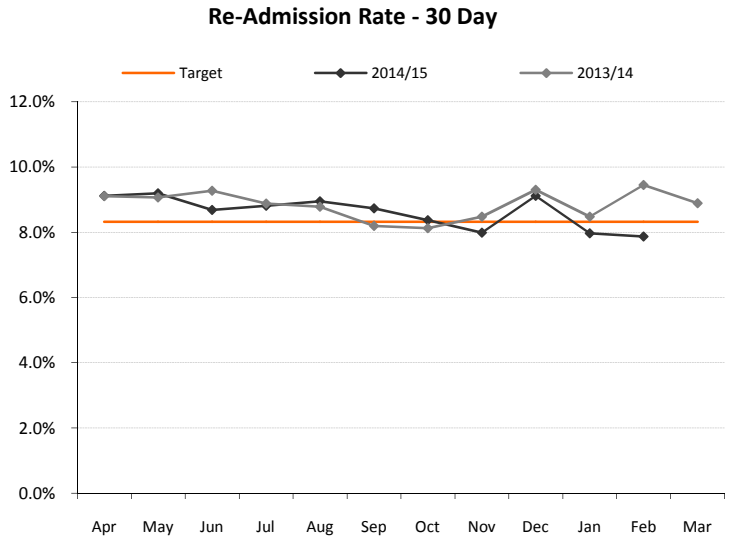
Mixed Sex Accommodation Occurrrences March 2015

Site	Clinical Area	Total No. of Occurrences	Total No. of Patients Affected
KCH	Kingston	1	3
WHH	CDU	2	13
TOTAL		**3**	**16**

During March-15, 2 non-justifiable incidents of mixed sex accommodation breach occurred and affected 13 patients located in the CDU, WHH. 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 3 mixed sex accommodation occurrences in total, affecting 16 patients. (Last month there were a total of 7 occurrences affecting 26 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 7d and 30d readmission rates for Feb-15 were lower than the same period last year.
The year to date position for both metrics is also lower than the Feb-14 position, which suggests improvements have been made and are ongoing. This is reassuring against the backdrop of 2 "Perfect Weeks" in January and March. The aim of the Perfect Week is to "reset the system" by encouraging a whole systems focus on facilitating early discharge, which itself could have resulted in an unplanned increase in readmissions. The fact that this does not appear to be the case would indicate that discharge was both timely and safe.
The detailed audit around patient records has been completed by the Service Improvement and Innovation Team. Whilst discharge appears to be safe, this audit clearly demonstrates that the quality and comprehensiveness of information provided at the point of discharge, is extremely variable. This will therefore be an ongoing area of improvement, with the Service Improvement Team working alongside the Divisions over the coming months, to enhance communication and move towards a more sustainable picture.

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

			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	22.7%	19.6%	18.7%	23.9%	28.5%	21.1%	19.4%	22.6%	24.0%	22.8%	21.9%	21.6%	27.9%	20.7%	23.0%	23.1%	23.8%	
		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%	36.8%	35.2%	29.6%	34.4%	35.0%	39.5%	34.6%	38.4%	34.1%	36.7%	41.3%	36.9%	45.8%	33.1%	36.4%	36.4%	41.3%	
		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	36.8%	35.2%	29.6%	34.4%	35.0%	39.5%	34.6%	38.4%	34.1%	36.7%	41.3%	36.9%	45.8%	33.1%	36.4%	36.4%	41.3%	
	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	42	2	1	0	3	5	7	5	2	4	1	4	8	3	15	11	13	42
		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	140	5	12	12	7	13	8	18	13	19	18	5	10	29	28	50	33	14
		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	73	16	10	3	3	2	5	0	3	9	13	3	6	29	10	12	22	73
		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%	99.1%	98.8%	99.6%	99.4%	99.9%	99.0%	
			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%	90.9%	90.2%	94.0%	93.2%	96.0%	90.7%	
			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%	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%	35.0%	36.0%	25.0%	24.0%	32.0%	36.0%	
		3.3	Care for People with Dementia	N/A	Self assessment of person-centred care in wards																		

			CQUIN	Commentary
Commentary	Friends and Family Test	1a	Implementation of FFT to staff	FFT for staff implemented in Jun-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 12 shows a significantly improved response rate of 27.9% (22.7% YTD).
		1d	Increased Response Rates in Inpatient Areas	ECC at KCH included within inpatient areas. Month 12 shows a reduction in response rates to 45.8% (36.8% YTD).
		1e	Increased Response Rates in Inpatient areas	A response rate of 40% has been achieved in both Aug-14 and Jan-15, and exceeded in March 2015 at 45.8%.
	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 - 42 falls with harm, against a trajectory of no more tha 94. Prevalence equalled 0.80% in Month 12, and Q4 2014/15 prevelance of 0.44% 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 - 140 UTIs in patients with catheters, against a trajectory of no more than 154. Prevalence equalled 1.00% in Month 12, and Q4 2014/15 prevelance of 1.11% 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 - 73 new Category 2-4 pressure ulcers, against a trajectory of no more thatn 126. Prevalence equalled 0.60% in Month 12, and Q4 2014/15 prevelance of 0.74& 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. By Feb-15 35% of staff were trained.
		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

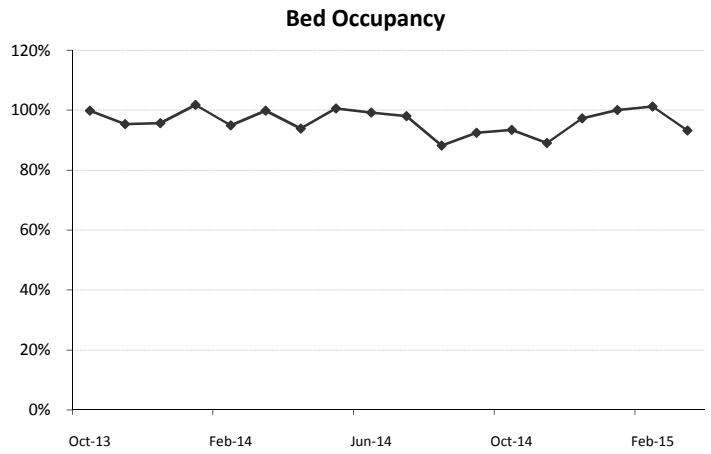
CLINICAL QUALITY & PATIENT SAFETY

CLINICAL EFFECTIVENESS: CQUIN MONTHLY MONITORING AND PERFORMANCE

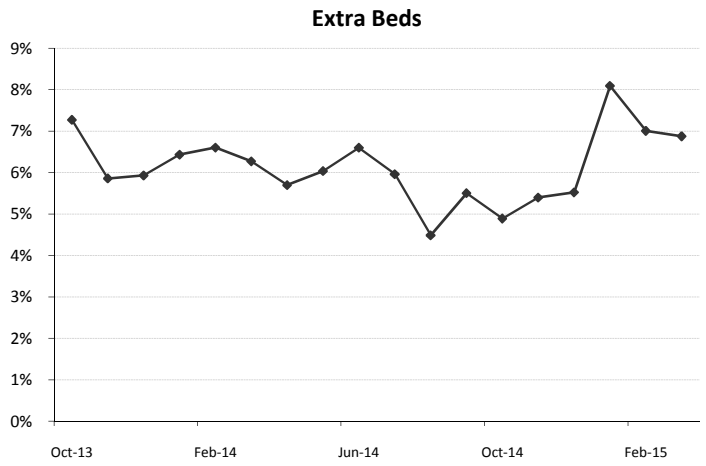
	Local CQUIN			2013/14 Baseline	2014/15 Target	YTD Status	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Q1	Q2	Q3	Q4	Year End Position
Performance	Heart Failure	4a	Develop an Integrated Care Pathway	N/A	Develop Integrated Care Pathway																		
		4b	EQ Pathway Measures (Jan-14 to Dec-14)	74.21%	Maintain 2013/14 levels	94.4%	78.3%	81.1%	70.6%	66.7%	92.9%	92.9%	93.6%	84.6%	94.1%	95.7%	100.0%		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	22.9%	25.4%	25.7%	23.3%	22.1%	21.9%	20.3%	20.3%	21.0%	23.9%	24.7%	23.0%		24.8%	21.5%	21.7%	23.9%	
		5c	Improved referral rate to the Stop Smoking Service	7.8%	Improved referral rate in 2014/15 - Improvement rate TBA	7.6%	8.9%	10.5%	7.3%	9.3%	8.4%	9.3%	8.0%	5.0%	5.2%	7.4%	4.7%		8.9%	9.0%	6.1%	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 94.4% 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

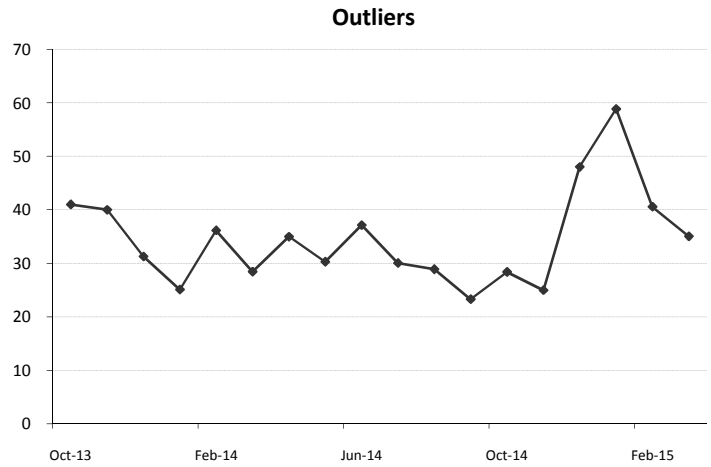
CLINICAL QUALITY & PATIENT SAFETY
CLINICAL EFFECTIVENESS: BED USAGE



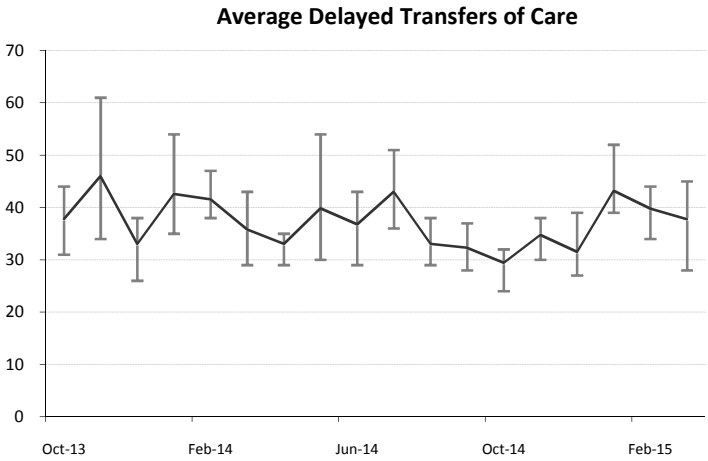
The bed occupancy metric looks only at adult inpatient beds and excludes any ring fenced wards such as Maternity. Occupancy levels were static from Oct-13 (99.78%) to May-14 (100.56%), decreasing thereafter to a position of 88.21% in Aug-14. In Mar-15, bed occupancy equalled 93.24% approximating the levels reported in Oct-14, and is lower than the position reported in Mar-14 (i.e. 99.77%).
NB: Data are sourced from the Trust's Balanced Scorecard as of 8 Apr-15.



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 Mar-15 the degree of extra beds used within the Trust equalled 6.87%, approximating the position reported in Feb-15 (i.e. 7.00%), and is higher than the value recorded in Mar-14 (cf. 6.27%). 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 Mar-15 appears to be reducing in line with expected seasonal demand.



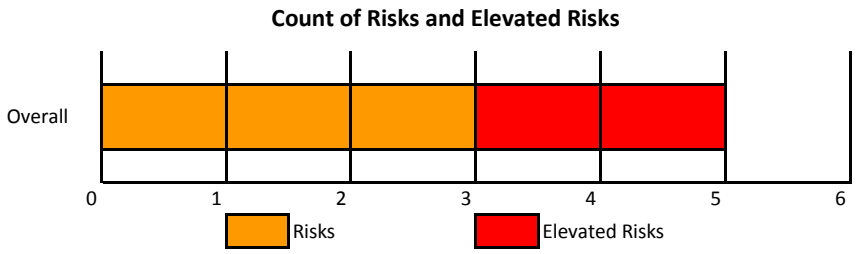
The outliers data show the average number of patients bedded in a ward outside of the relevant Division over a given month. In Jan-15 a marked increase was evident over the Dec-14 position given that the outlier value equalled 58.87, that is, more than 2 fold higher than the value recorded in Jan-14 (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 March further fell to a value of 35.03, and is greater than the position reported in Mar-14 (28.42).



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 decreased further in March to a position of 37.75. This compares with a value of 35.75 reported in Mar-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 – March 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 March are 94% at WHH, over 93% at QEQM and over 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 March 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	83.1%	90.9%	97.8%	113.7%	91.44
Queen Elizabeth the Queen Mother	85.9%	95.5%	98.9%	104.5%	93.24
William Harvey	90.7%	94.2%	95.5%	102.2%	93.97

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

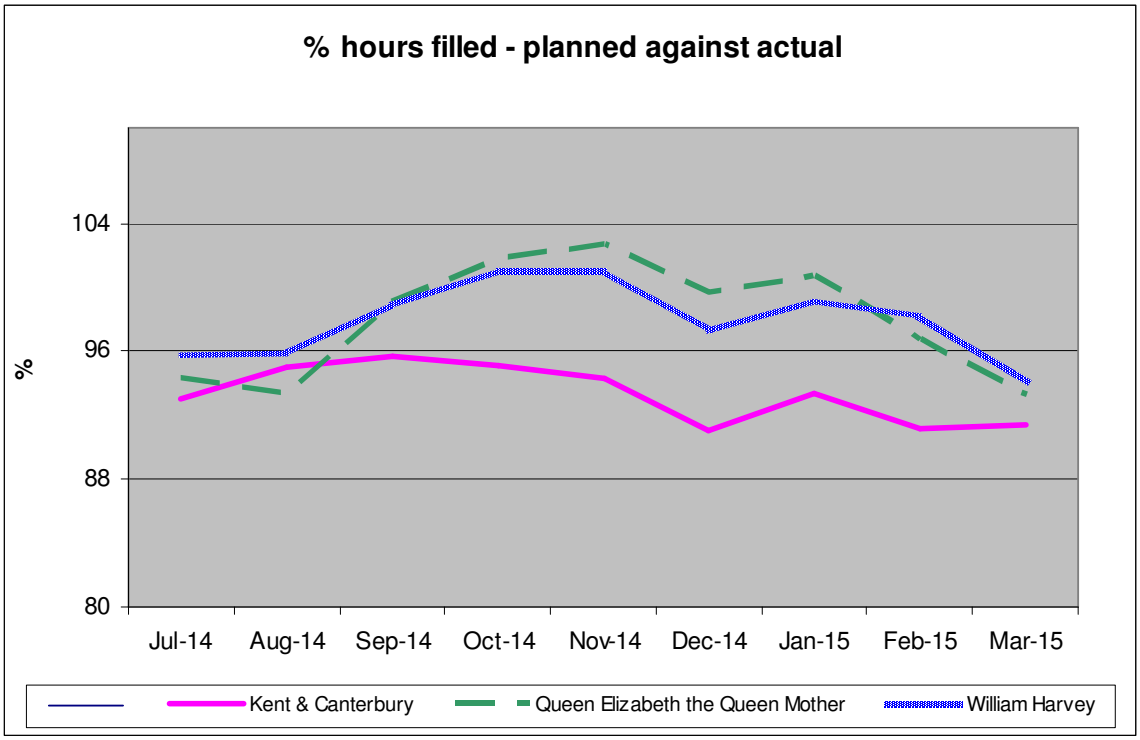
- There are no vacant posts
- All vacant planned shifts are covered by overtime or NHS-P shifts
- Annual leave, sickness and study leave is managed within 22%

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. The reduction in March reflects annual leave taken at year end. 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	Mar-15
Kent & Canterbury	92	91.08	93.05	94.97	95.65	95.14	94.31	91.09	93.40	91.15	91.44
Queen Elizabeth the Queen Mother	94	91.34	94.26	93.37	99.09	101.80	102.70	99.63	100.65	96.72	93.24
William Harvey	93	93.16	95.66	95.82	98.83	100.93	100.94	97.17	99.10	98.19	93.97



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 March 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 15th April. 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 March 2015

Division / Ward

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	Quality Indicators March 2015			
						Friends & Family Test - % who would recommend	Harm Free Care (%) - New Harms	All Falls	All Pressure Ulcers
Cambridge J	97.94	189.48	131.45	147.90		90	97.1	2	1
Cambridge K	76.03	88.63	100.00	92.50	18.9% RN A/L. 1.24 WTE RN Vacancy.	96	100	3	0
Cambridge M2	105.17	107.77	96.94	99.60		97	95	5	0
Coronary Care Unit (K&C)	61.48	N/A	100.63	N/A	0.66 WTE HCA Vacancy - No HCA's in post. 2.42 WTE RN Vacancy	100	100	0	0
Coronary Care Unit (QEQMH)	86.96	52.77	100.12	98.87	28.7% HCA Sickness.	100	100	0	0
Coronary Care Unit (WHH)	96.34	113.04	90.60	87.10		96	100	0	0
Minster	70.05	88.18	99.19	93.84	8.4% RN Sickness. 6% RN Parenting.	93	100	0	0
Oxford	99.32	84.76	91.80	111.50		94	92.9	4	2
Sandwich Bay	101.38	151.15	103.67	190.10		93	100	5	2
St Margarets	105.09	70.08	104.61	126.27	13.5% HCA Sickness. 7.5% HCA Parenting.	95	100	0	0
Deal	94.54	93.19	93.55	104.64		88	92.9	2	3
Harvey	65.15	80.42	95.30	156.52	9.3% RN Sickness. 7.8% RN Parenting. 1.0 WTE RN Vacancy	100	100	3	0
Invicta	96.66	97.46	99.60	178.09		100	100	5	0
Cambridge L	89.53	98.02	100.00	159.19		86	95.8	6	2
Treble	69.64	82.36	100.14	159.19	16.8% RN Sickness. 1.0 RN vacancy	97	100	6	0
Mount/McMaster	95.11	84.58	98.39	150.20		95	95.8	8	0
Fordwich Stroke Unit	78.78	127.74	96.03	108.53	20.4% RN A/L. 7.8% RN Sickness.	100	86.4	3	1
Kingston Stroke Unit	72.05	130.86	87.00	96.77	4.15 WTE RN Vacancy.	96	95.7	7	1
Richard Stevens Stroke Unit	76.34	49.99	77.51	102.17	10.9% RN Sickness. 14.5% HCA Parenting. 1.9 WTE RN Vacancy	100	100	8	2
Harbledown	87.15	77.77	101.61	91.06	10.3% HCA Sickness.	85	100	12	1
QE CDU	99.41	100.63	170.05	140.62		79	100	8	10
WH CDU/Bethersden	90.28	111.24	85.24	99.06		82	100	8	19
Surgical Services									
Rotary Suite	84.40	93.01	97.29	117.08		93	92.9	4	1
Cheerful Sparrows Female	103.35	107.77	100.65	98.75		89	95.5	4	2
Clarke	73.18	107.33	100.00	87.10	4.24 WTE RN Vacancy.	98	100	3	4
Cheerful Sparrows Male	78.62	104.59	114.13	88.42	23.3% RN Parenting.	97	100	10	6
Kent	109.96	93.98	100.84	79.63	6.2% HCA Parenting.	96	100	5	3
Kings B Ward - WHH	97.08	94.13	115.81	165.71		96	96.3	3	0
Kings A2	96.56	95.50	100.91	87.38		89	100	1	1
Kings C1	110.62	102.71	100.00	98.53		100	100	3	4
Kings C2	69.32	112.01	93.69	99.72	3.68 WTE RN Vacancy. 18% RN A/L	100	100	2	0
Kings D Female	85.13	116.15	91.32	115.04		100	94.4	7	2
Kings D Male						98	100	3	1
Quex	76.90	163.27	98.39	87.10	20.6% RN A/L. 10.6% RN Sickness.	99	100	4	0
Bishopstone - split	91.65	117.44	109.71	102.51		86	95	8	2
Seabathing -split						78	91.7	2	7
Critical Care - WHH -	113.19	90.70	104.85	82.05		n/a	100	0	3
Critical Care - KCH	93.98	125.78	100.69	N/A		n/a	100	0	0
Critical Care - QMH	73.22	28.00	91.67	N/A	10.5% RN Sickness. 41.3% HCA Sickness (Only 2.8 WTE in post).	n/a	100	0	2
Specialist Services									
KC Marlowe Ward	85.68	80.86	92.03	96.97		96	100	5	2
WH NICU	76.67	135.04	82.56	N/A	21.3% RN A/L. 7.6% RN Sickness.	n/a	100	0	0
WH Padua Ward	83.47	83.15	100.07	70.97	9.8% HCA Parenting.	n/a	100	2	0
QE Rainbow Ward	96.40	83.25	100.00	N/A		n/a	100	1	0
QE Birchington Ward	79.52	119.38	98.83	100.44	21% RN A/L. 8.9% RN Parenting.	97	94.4	2	0
WH Kennington Ward	102.65	90.91	88.27	N/A		95	100	0	0
KC Brabourne Haematology Ward	80.01	68.41	101.61	N/A	35.5% HCA Parenting.	100	100	1	0
WH Maternity Labour and Folkestone+ MC	93.57	65.27	95.82	46.00	13.2% MCA Sickness. 5.3% MCA Parenting.	n/a	100	0	0
MLU WHH	88.87	68.31	88.90	35.48	47.9% MCA Sickness (Only 4.35 WTE in post).	n/a	n/a	0	0
QE Maternity Wards + MCA	81.02	51.35	83.23	95.70	9.2% RM Sickness.	n/a	100	0	0
QE MLU	98.04	84.32	187.10	93.55		n/a	n/a	0	0
QE SCBU	84.97	117.28	100.28	N/A		n/a	100	0	0