CLINICAL QUALITY & PATIENT SAFETY PERFORMANCE SUMMARY

Introduction

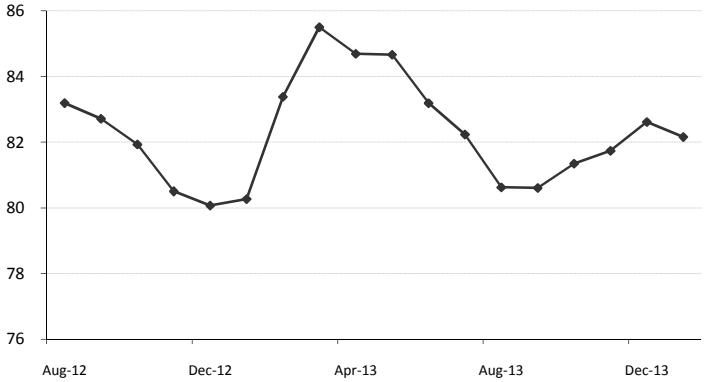
A summary of key trends and actions of the Trust's performance against the clinical quality and patient safety indicators is provided together with supporting narrative. The report is structured around the key themes of the annually published Quality Report/Account; Patient Safety, Patient Experience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

	Measure	Improvement Metric		Target 13/14	Jan-14	Jan-13	vs Jan-13	YTD
Patient Safety	Mortality Rates	HSMR		-	82.2	80.3	↑	82.4
		RAMI		-		94.0		-
					Q1 13/14	Q1 12/13	vs Q1 12/13	YTD
		SHMI (%)		-	94.96%	93.49%	↑	-
					Mar-14	Mar-13	vs Mar-13	YTD
		Crude Mortality: All Ages (Per 1 000)	Non-Elective	-	32.400	39.343	↓	30.713
			Elective	-	0.443	0.122	↑	0.319
	Risk Management	Serious Incidents (STEIS)	New Incidents	-	8	10	↓	-
			Open Incidents	-	33	28	↑	Cumul.
	HCAI	MRSA	Attributable	0	8	4	↑	Cumul.
		C. difficile	Post 72h	29	49	39	↑	Cumul.
	Infection Prevention	Mandatory Training Compliance (%)		95.0%	87.2	87.9%	↑	85.8%
	Harm Free Care (HFC)	Safety Thermometer HFC (%) - Old & New Harm	EKHUFT	93.0%	94.9%	89.6%	↑	91.0%
			National	-	93.6%	92.5%	↑	-
	Nurse Sensitive Indicators	Pressure Ulcers: Grades 2,3 and 4	Acquired	-	27	34	↓	324
			Avoidable	135	10	10	↔	126
		Falls		1788	166	209	↓	2019
	Clinical Incidents	Total Clinical Incidents		-	1120	1018	↑	12460
Patient Experience	Compliments and Complaints	Compliments:Complaints		-	25:1	13:1	↑	-
		No. Care Spells per Formal Complaint		-	1140	756	↑	-
	Experience	Friends and Family Test (Star Rating)		5.0	4.4			-
		Adult Inpatient Experience (%)		80.00%	87.57%	89.12%	↓	-
		Mixed Sex Accommodation Occurrences		-	8	9	↓	79
Clinical Effectiveness	Readmission Rate				Feb-14	Feb-13	vs Feb-13	YTD
		7 Day (%)		2.0%	4.86%	4.70%	↑	4.54%
		30 Day (%)		8.3%	9.42%	8.96%	↑	9.13%
	CQUIN				Mar-14	Mar-13	vs Mar-13	YTD
		Standard Contract CQUIN		Multiple			↔	
		Specialist CQUIN		Multiple				
	Bed Usage	Bed Occupancy (%)		-	95.34%	95.49%	↓	92.84%
		Extra Beds (%)		-	5.77%	8.83%	↓	6.02%
		Outliers		-	25.06	43.90	↓	368.13
		Delayed Transfers of Care (Average)		-	35.75	39.75	↓	38.56
Care Quality Commission	Intelligent Monitoring Report	Outcome Measures	Risks	-	4			-
			Elevated Risks	-	1			-

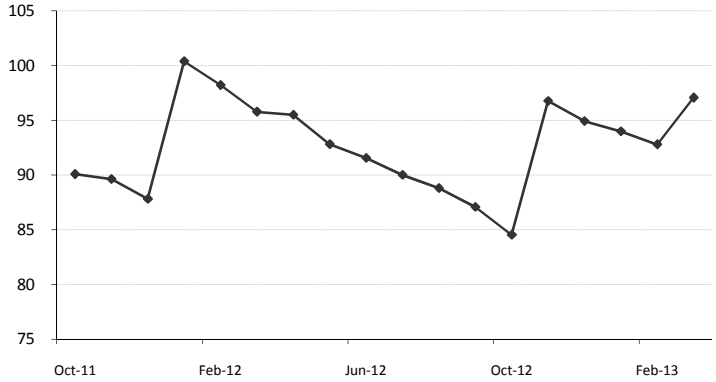
NB: RAMI - Data sharing agreements with CHKS have now been resolved. An up to date RAMI position will be published in the near future.

CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: MORTALITY RATES

Hospital Standardised Mortality Ratio (HSMR) - All Discharges



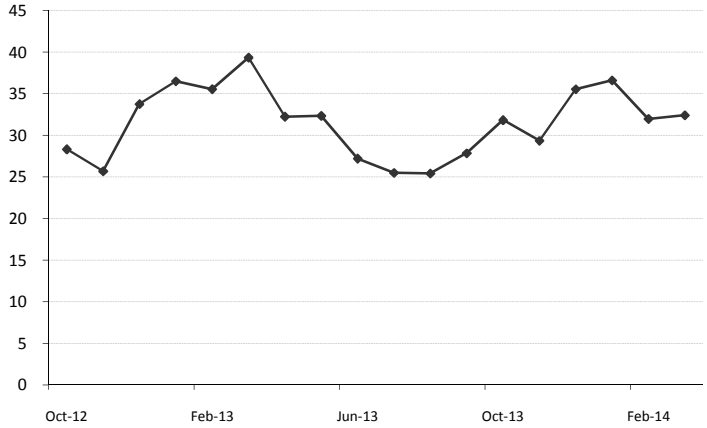
Risk-Adjusted Mortality (RAMI) - All Discharges



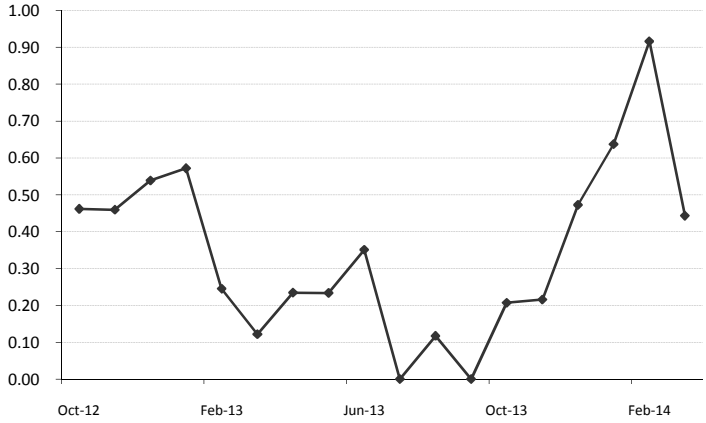
Performance at Trust level remains good across all mortality indicators with the 12 month rolling HSMR equalling 82.2 at the end of Jan-14 (that is, showing a 0.4 decrease upon Dec-13), and is in line with the trend demonstrated by the crude mortality metric. This also is a reflection of seasonal fluctuations, although it is hoped rates will be more consistent during Q4.

Data sharing agreements with CHKS have now been resolved and data are being uploaded for the current financial year. It is hoped that an up to date RAMI position will be published in the near future.

Crude Mortality - Non-Elective per 1 000



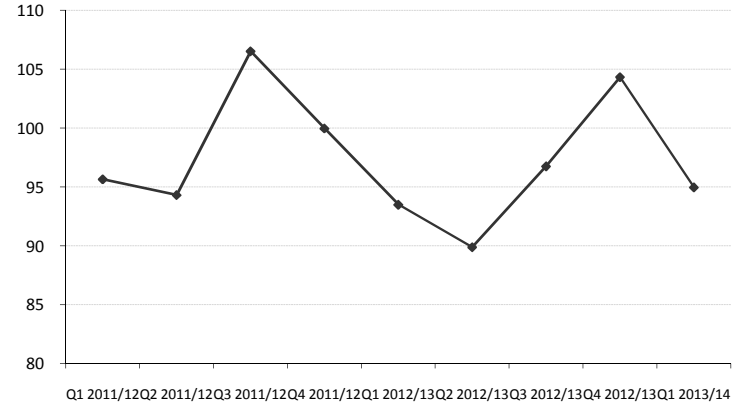
Crude Mortality - Elective per 1 000



Crude mortality for non-elective patients shows a fairly seasonal trend with deaths higher during the winter months. The winter peak during 2012/13 extended further into the spring than normal, with a reduction to expected levels occurring in June rather than in April/May. Following this trend, Feb-14 performance equalled 32.156 deaths per 1 000 population, with March consistent at 32.400, and as such shows a constant decrease on the previous months.

During February elective crude mortality was 0.923 deaths per 1 000 population, which dropped back to expected levels seen in March at a rate of 0.443. This stopped the increase evident during previous months, and it is expected that the levels will reduce to those seen pre Nov-13 and follow seasonal trends. This increase, however, is currently under review and is being investigated.

Summary Hospital Mortality Indicator (SHMI)



The Summary Hospital Mortality Indicator (SHMI) includes "in hospital" and "out of hospital" deaths within 30 days of discharge. These data are supplied by an external party and are updated on a quarterly basis. During the latter part of 2011/12 SHMI for EKHUFT was higher than other mortality indicators at over 100. Improvements have been made over the last year, and the data up to the end of Q2 2012/13 show an improved position, reducing to 90 over the period of 3 quarters. The most recent data to be published (Q1 2013/14) show a decrease against Q4 2012/13 and are in line with levels last seen at Q1 2012/13.

Serious Incidents - Open Cases

Date		Summary of Serious Incident & Remedial Action Taken	IX lv	Division	Timely Submit?
Incident	STEIS Report				
10-Mar-14	24-Mar-14	Suboptimal care of the deteriorating patient	1	Surgical	Not Due
7-Mar-14	20-Mar-14	Unexpected Death	1	UCLTC	Not Due
19-Mar-14	20-Mar-14	Neonatal Death - home birth	2	Specialist	72h Report Sent
27-Jan-14	19-Mar-14	Grade 4 hospital acquired pressure ulcer (avoidable)	1	Surgical	Not Due
1-Mar-14	19-Mar-14	Grade 3 hospital acquired pressure ulcer (avoidable)	1	UCLTC	Not Due
19-Feb-14	13-Mar-14	Unexpected Death - pericardial effusion	1	UCLTC	Not Due
1-Mar-14	10-Mar-14	Never Event - wrong site pleural aspiration	2	UCLTC	72h Report Sent
28-Feb-14	3-Mar-14	Medication Administration Error - administered via wrong route	0	Surgical	Not Due
9-Jan-14	25-Feb-14	Unexpected Death - venous thomboembolism at 6 weeks postoperative		Surgical	Not Due
19-Feb-14	25-Feb-14	Neonatal Death - at 24 weeks		Specialist	Not Due
10-Dec-13	5-Feb-14	Unexpected Death - retroperitoneal haematoma	1	Surgical &	Not Due
18-Jan-14	24-Jan-14	Unexpected Death - sepsis	1	UCLTC	Not Due
24-Jan-14	24-Jan-14	Neonatal Death - unexpected breach delivery at home, taken to QEH	2	Specialist	Not Due
21-Nov-13	16-Jan-14	Unexpected Death - myasthaenia gravis		UCLTC	Not Due
17-Jul-13	10-Jan-14	Radiological Error - missed reporting of carotid stenosis in 2 patients		Clinical	Not Due
12-Dec-13	19-Dec-13	Unexpected Death - epileptic patient with ischaemic bowel		UCLTC	Not Due
14-Aug-09	12-Dec-13	Failure to Act - abnormal test results, missed grade 3 leiomyosarcoma		Surgical	Not Due
15-Oct-13	15-Nov-13	Unexpected Death - a subdural haematoma following a fall	2	UCLTC	Yes
6-Nov-13	11-Nov-13	Never Event - misplaced nasogastric tube	2	UCLTC	Not Due
11-Oct-13	30-Oct-13	Allegation against a member of staff	1	UCLTC	Not Due
28-Aug-13	3-Oct-13	Unexpected Admission - term baby admitted to NICU from MLU via labour ward at QEH	2	Specialist	Yes
Aug-13	14-Aug-13	Media Interest - delayed implementation of PACS/RIS replacement resulting in a backlog of patient bookings across all modalities	0	Clinical Support	Not Due
22-Jan-13	24-Jan-13	Never Event - wrong site surgery: pleural aspiration	2	UCLTC	Yes
7-Jan-13	11-Jan-13	Never Event - wrong site surgery: Ophthalmology	2	Surgical	Yes
3-Jan-13	8-Jan-13	Neonatal Death - term baby	2	Specialist	Yes
8-Aug-11	13-Sep-12	Media Interest - re: DNR and patient with learning disabilities	1	Corporate	Yes
4-Sep-12	13-Sep-12	Neonatal Death - following shoulder dystocia	1	Specialist	Yes

Serious Incidents - Partially Closed Cases

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

Date		Summary of Serious Incident & Remedial Action Taken	IX lv	Division
Incident	STEIS Report			
2-Jun-13	17-Oct-13	Never Event - retained swab post caesarean section	2	Specialist
17-Jun-13	27-Jun-13	Screening Issue - diabetes eye screening programme and Hospital Eye Services (HES)	1	UCLTC
21-May-13	21-Jun-13	Induction of Labour - term baby developed seizures at 36h	2	Specialist
22-Mar-13	9-Apr-13	Unexpected Death - adult with small bowel obstruction	1	Surgical
27-Feb-13	1-Mar-13	Maternal Death - 6 days postpartum	1	Specialist
22-Nov-12	22-Nov-12	Unexpected admission to NICU		Specialist

Serious Incidents - Closed Cases

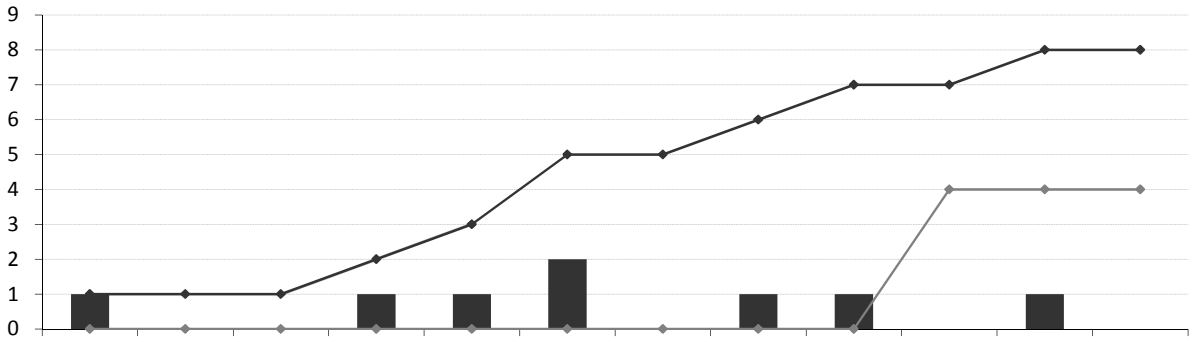
Date		Summary of Serious Incident & Remedial Action Taken	IX lv	Division
Incident	STEIS Report			
28-Nov-13	3-Jan-14	Unexpected Death - hospital associated venous thromboembolism (pulmonary embolism)		UCLTC
18-Jun-13	5-Aug-13	Unexpected Death - post-operative emergency following gallbladder surgery	1	Surgical
16-Mar-13	27-Mar-13	Intrauterine Death - at 24 weeks	1	Specialist

Eight serious incidents were reported on STEIS in Mar-14. These were 2 unexpected deaths, 1 drug incident in which PCA medication was given via epidural route, 2 pressure ulcers, 1 Never Event, 1 unexpected neonatal death and 1 suboptimal care of a deteriorating patient. The Trust has been notified that 3 incidents have been closed; 2 unexpected deaths and 1 intrauterine death. Root Cause Analysis (RCA) reports have been presented to the Risk Management Governance Group by the Divisions responsible. These included the findings of the investigation and action plans to take forward recommendations, including mechanisms for monitoring and sharing learning. At the end of Feb-14 there were 33 serious incidents open. The CCGs have agreed closure of 6 of these serious incidents pending review by the area team.

PATIENT SAFETY: HOSPITAL ACQUIRED INFECTIONS

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

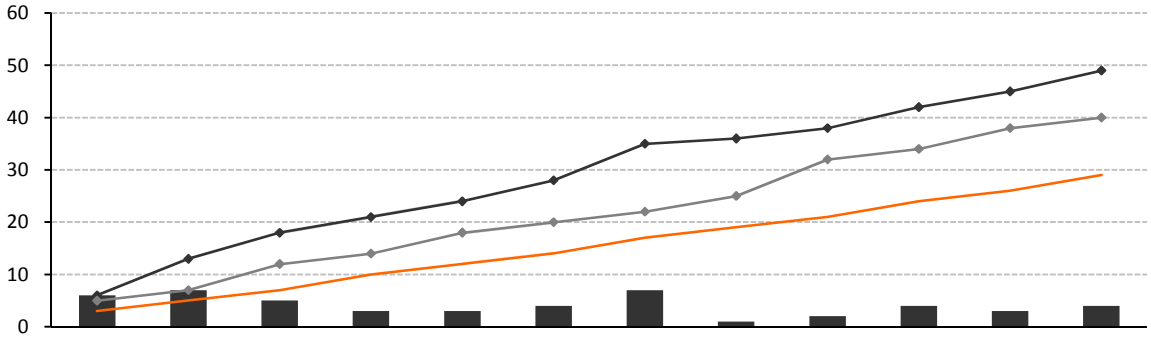
MRSA Bacteraemia - Trust Assigned Cases



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Actual	1	0	0	1	1	2	0	1	1	0	1	0
2013/14 Cumulative	1	1	1	2	3	5	5	6	7	7	8	8
2012/13 Cumulative	0	0	0	0	0	0	0	0	0	4	4	4

There were no MRSA bacteraemias in Mar-14. The cumulative total of Trust assigned MRSA bacteraemia cases for 2013/14 is 8, of which 2 were categorised as "contaminants". This represents an increase in the number of cases seen in the 2 previous years where 4 post 48h cases, each year, were attributed to EKHUFT. The Lyon clone of MRSA, which has been present in East Kent since 2011, was responsible for 4 other MRSA bacteraemia cases during the past 11 months (Trust and community cases, combined).

Clostridium difficile - Incidents Post 72h



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Actual	6	7	5	3	3	4	7	1	2	4	3	4
2013/14 Cumulative	6	13	18	21	24	28	35	36	38	42	45	49
2012/13 Cumulative	5	7	12	14	18	20	22	25	32	34	38	40
2012/13 Cumulative Target	3	5	7	10	12	14	17	19	21	24	26	29

There were 4 post 72h C. difficile cases in Mar-14, and the end of year total equalled 49 cases. The increase in the number of cases during Q1 2013/14 (i.e. 18) returned to the baseline of the previous 2 years of 10 per quarter, with the exception of Q4 2013/14 where there were 11 cases. The target for the forthcoming year is 47 cases.

Escherichia coli Bacteraemia - Incidents Pre and Post 48h

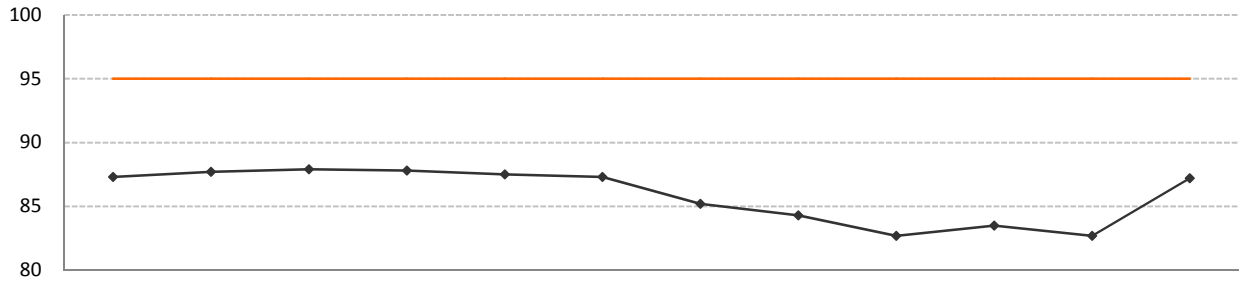
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly Average	Total Apr - Mar
2013/14	Pre 48h	30	33	41	37	28	42	36	36	26	31	29	33	33.5	402
	Post 48h	4	3	4	12	3	12	10	4	8	8	6	11	7.1	85
2012/13	Pre 48h	30	27	20	33	34	37	39	22	28	30	25	34	29.9	325
	Post 48h	11	8	3	9	6	5	5	5	2	4	8	8	6.2	66

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

More than 80% of cases of E. coli bacteraemia are present at the time of admission to hospital and, therefore, in most cases represent community acquired infection. There were 33 pre 48h and 11 post 48h E. coli bacteraemias in Mar-14. Cases were evenly distributed between hospital sites. The trend for increased pre and post 48h cases in 2013/14 is reflected in both national and local E. coli totals for NHS Trusts in England (Public Health England data). The IPCT will be undertaking Root Cause Analysis (RCA) of cases occurring within 30 days of a surgical procedure at EKHUFT during 2014/15 in order to better understand the causes.

PATIENT SAFETY: INFECTION PREVENTION & CONTROL

Mandatory Training Compliance



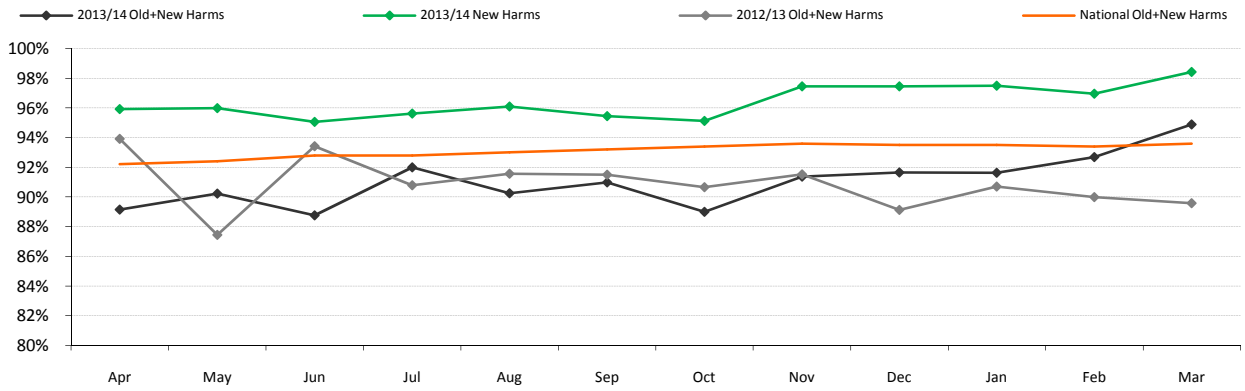
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Complinace (%)	87.3	87.7	87.9	87.8	87.5	87.3	85.2	84.3	82.7	83.5	82.7	87.2
Target	95	95	95	95	95	95	95	95	95	95	95	95

	Mar-14							
	Target	Trust	Clinical Support Services	Corporate	Specialist Services	Strat Dev & Capt Pln	Surgical Services	UCLTC
Mandatory Comparative Data for Biennial Training Compliance	95%	87.2%	83.4%	87.0%	79.1%	93.4%	83.0%	82.3%

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

Trust compliance increased from 82.7% in February to 87.2% in March. Increases have been seen in Clinical Support Services (from 83.0% to 83.4%); Corporate Services (from 83.4% to 87.0%), and Surgical Services (from 82.3% to 83.0%). However, there have been slight decreases in compliance within Specialist Services (down to 79.1% from 80.1%); Strategic Development and Capital Planning (down to 93.4% from 94.1%), and Urgent Care and Long Term Conditions (down to 82.3% from 82.7%). Special attention needs to be given to raising compliance within these be given to raising compliance within these Divisions.

Safety Thermometer Harm Free Care



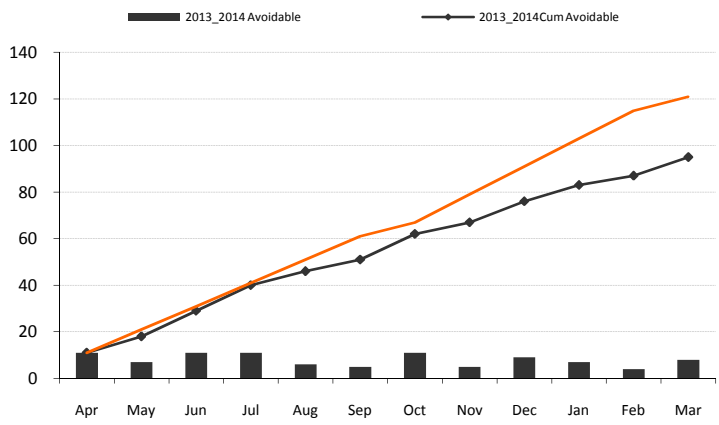
The chart above shows the percentage of Harm Free Care expressed as a one-day snapshot in each month. It is known as the NHS Safety Thermometer and is a quick and simple method for surveying patient harms. The aim of the Safety Thermometer is to identify, through a monthly survey of all adult inpatients,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

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

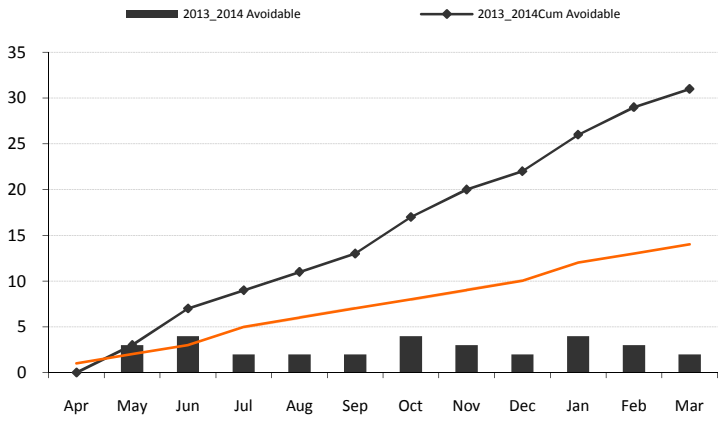
The strength of the NHS Safety Thermometer lies in allowing front line teams to measure how safe their services are and to deliver improvement locally. There are several different ways in which harm in healthcare is measured and there are strengths and limitations to the range of approaches available.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

Harm Free Care includes both harms acquired in hospital ("new harms") and those acquired before admission to hospital ("old harms"). There is limited ability to influence "old harms" if a patient is admitted following a fall at home, or with a pressure ulcer, but these are included in the overall performance reported to the Health and Social Care Information Centre. "New harms only" are included separately when reporting performance to Divisional teams to enable success to be celebrated and to incentivise improvement. Harm Free Care performance is incorporated within the monthly ward quality dashboard and is triangulated with the existing funded establishment, acuity and dependency of patients, and effectiveness of rostering to enable analysis of influencing factors and thereby focusing improvement actions. In Mar-14, the Trust's own score was 98.4% showing that those patients in our care have a greater harm free experience. This is above the national figure of 93.6% and is the area we can influence the most. This value has improved since last month. The total percentage of Harm Free Care ("old and new harms") has also improved since Feb-14 (92.7%) and is 94.9%. This is above the national figure for the first time. Both the Tissue Viability Team and the Falls Prevention Team are working towards developing action plans to reduce these incidents occurring in our care. The way we collect these data has been reviewed to ensure greater accuracy so that we can make the necessary quality improvements.

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



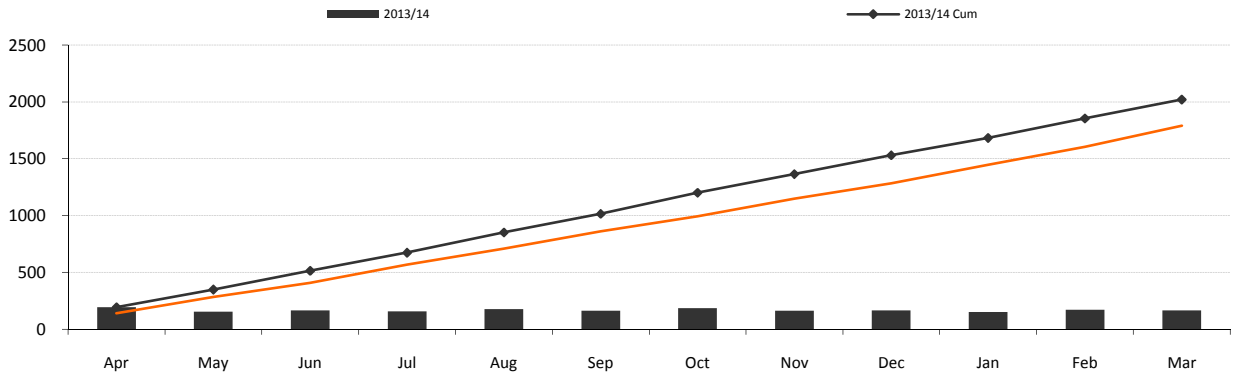
Grade 3 and 4 Incidence Trajectory 2013/14
50% Reduction



In March, 16 hospital acquired grade 2 pressure ulcers were reported of which 8 were deemed as avoidable; 4 were recorded at KCH, 2 at QEH and 2 at WHH. Learning included ensuring early intervention is taken, and that patients are repositioned regularly and appropriately. The Tissue Viability team are working with high risk areas to support quality improvements and facilitating bespoke action plans to address particular needs of the client group.

In March, there were 11 reported deep acquired ulcers (grades 3 and 4); 3 at KCH, 4 at QEH and 4 at WHH. Root cause analyses of 3 of these incidents has occurred and 2 were classed as avoidable. Learning points identified include improving documented evidence of sufficient pressure relief. Specific action plans include improving tools to raise both the awareness and ease of recording actions. Urgent actions (to be overseen by the Task and Finish Group) are underway to eliminate avoidable heel pressure damage. A protocol to ensure availability of high risk equipment has been issued and 21 new active mattresses purchased.

Patient Falls - Injurious and Non-Injurious

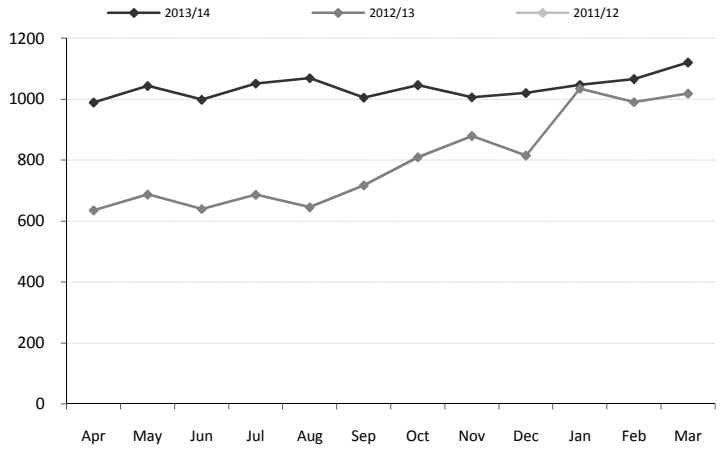


During Mar-14, 166 falls were reported which is a decrease on Feb-14 (171). None were graded as severe or death. Work continues with the Harm Prevention Action Group to streamline the Risk Assessment Booklet in order to reduce duplication of assessments and the time taken to complete them. The focus will then be to ensure interventions are put in place to minimise risk and harm, therefore driving up standards. Although there have been more falls, and more falls resulting in fractures, over the last year, data for the past 5 years shows a downward trend in the number of falls in total and falls resulting in fractures. Over the coming year a proposed Safety Thermometer CQUIN target will be aimed at reducing harm from falls. Areas for action are full implementation of the new Falls Risk Assessment and Care Plan, compliance with link worker mandatory training, and compliance with the risk assessment (focus on assessment and management of postural hypotension and strength and balance assessment and exercise interventions). Alongside this the Harm Prevention Action Group are beginning to plan educational awareness events to inform frontline staff of the need to consider all "risks" to the patient as many patients have multiple risks. For example, patients with Dementia are more likely to fall and are also more prone to nutritional problems whilst patients with movement problems have an increased risk of pressure ulcers.

CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: CLINICAL INCIDENTS

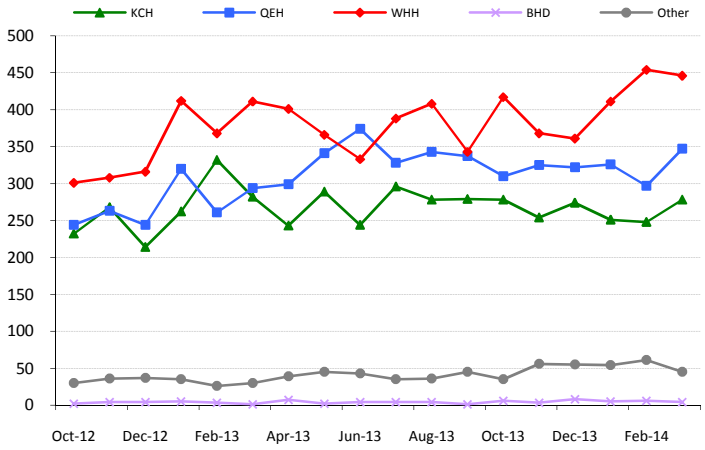
In Mar-14 a total of 1120 clinical incidents including patient falls were reported. This includes 6 incidents (which are under investigation) graded as death and 1 (which is under investigation) graded as severe. Unapproved incidents may be downgraded following investigation. In addition to these 7 serious incidents, 18 incidents have been escalated as serious near misses, of which 7 have been finally approved.
Eight serious incidents were required to be reported on STEIS in March. Three cases have been closed since the last report; there remain 33 serious incidents open at the end of March of which 6 have been closed by the KMCS pending review of external bodies before closure on STEIS.

Overall Incident Rates by Year



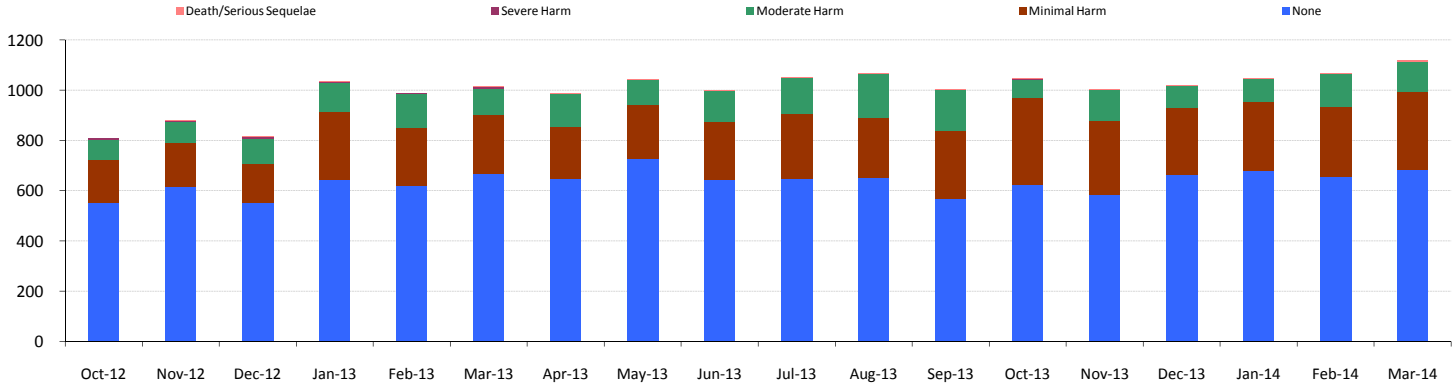
A total of 1120 clinical incidents have been logged in March compared with 1066 recorded for Feb-14.

Overall Incident Rates by Site



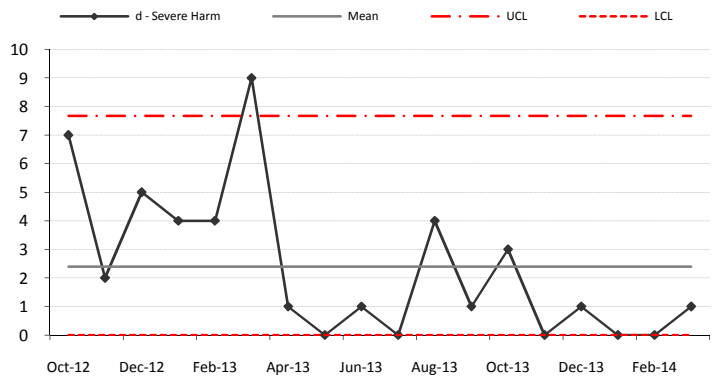
Incident numbers for March at WHH have remained constant, whereas an increase in clinical incidents is evident at KCH and QEH.

Clinical Incidents by Severity

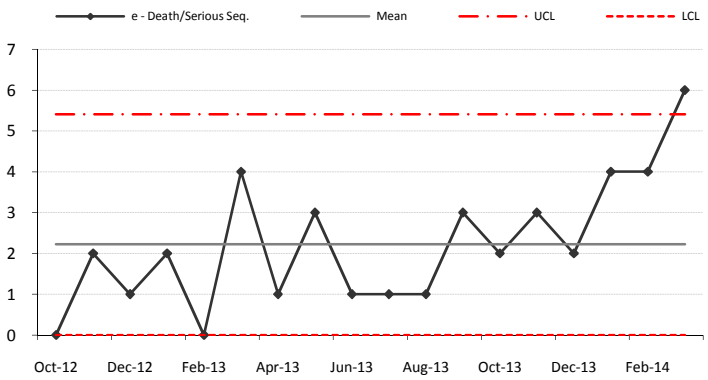


The incidents graded as moderate, serious and death have all been subject to review in order to confirm the consistency of the grading of harm across the Trust. The Board of Directors may see a change in this report to reflect the re-categorisation process undertaken. This is consistent with the data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

Severe Harm

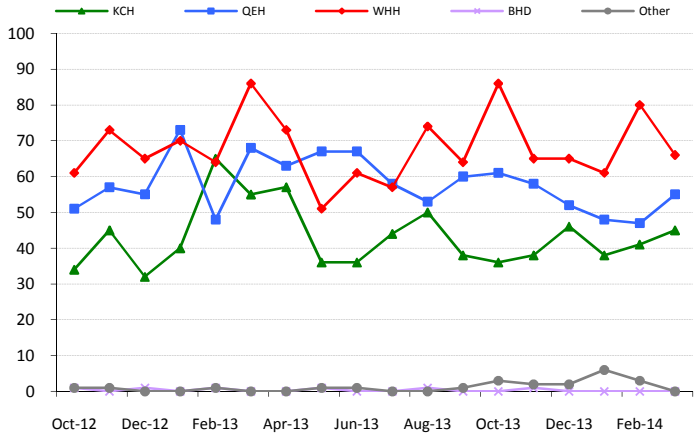


Death/Serious Sequelae



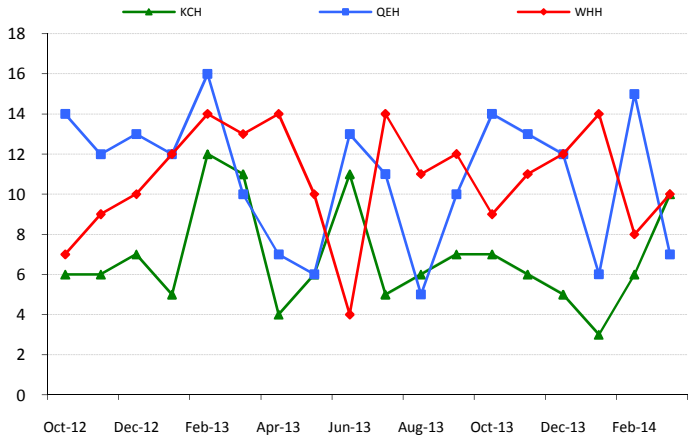
The number of death/serious and severe harm incidents reported in Mar-14 remains subject to the usual RCA investigation and review. It is possible that the severity of these cases will be downgraded once the investigation process is completed. In Mar-14, the number of incidents graded as death has risen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

Patient Slips, Trips and Falls



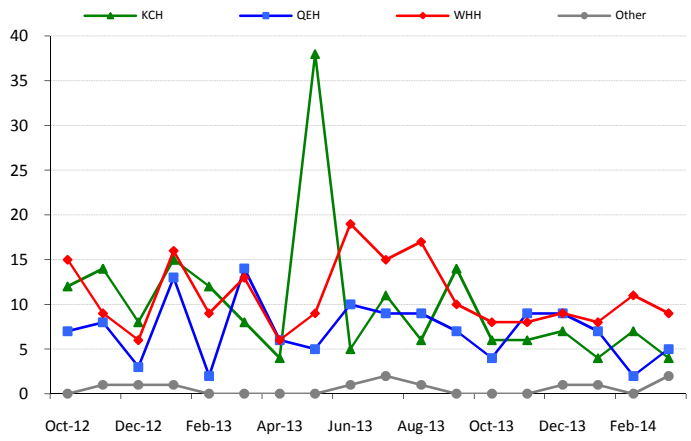
Of the 166 patient falls recorded for March (171 in February), none were graded as severe or death. There were 98 falls resulting in no injury, 65 in low harm and 3 in moderate harm. The top reporting wards were Richard Stevens Stroke Unit (WHH) with 12 falls; CDU (WHH), Cambridge L (WHH) and Cambridge M2 (WHH) with 9 each; Deal ward (QEH) with 8; Treble (KCH), Fordwich Stroke Unit (QEH) and St Margaret's (QEH) with 7 each; Harvey (KCH) and Marlowe (KCH) with 6 each. The remaining wards reported 5 or less falls. Of the 3 moderate harm falls, 1 resulted in fractured neck of femur and a head injury on Cambridge K (WHH); a fractured wrist was sustained on CDU (QEH); a head injury on Deal (QEH). A root cause analysis (RCA) is carried out for all falls resulting in serious harm or fracture.

Hospital Acquired Pressure Ulcers



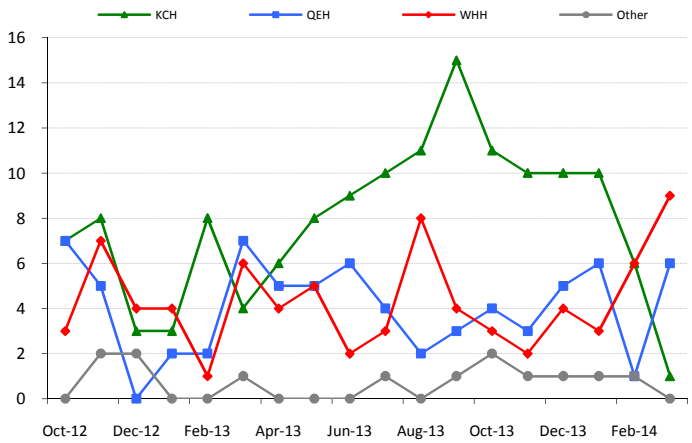
In March there were 27 reported incidents of pressure ulcers developing in hospital (29 in February). This included 16 grade 2 pressure ulcers, 10 grade 3 and 1 grade 4. Ten have been assessed as avoidable, 8 as unavoidable and 9 not yet assessed (awaiting RCAs). The highest reporting wards were Seabathing (QEH) and Cambridge J (WHH) with 3; Harbledown (KCH), Kingston Stroke Unit (KCH) and Cambridge L (WHH) with 2 incidents each.

Delay in Providing Treatment



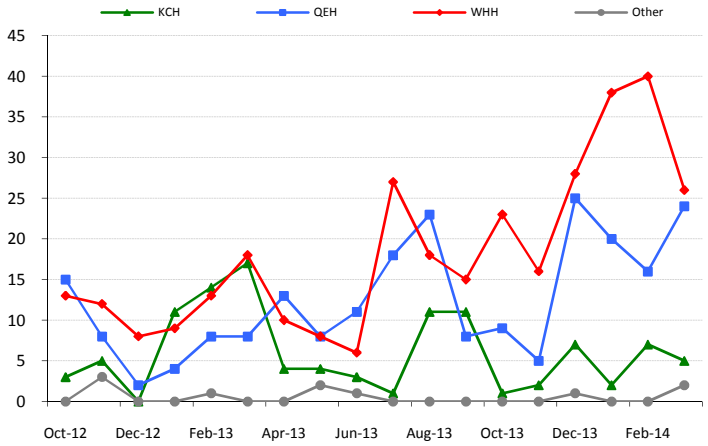
There were 20 incidents resulting in delay in providing treatment during March compared with 20 in February. One incident has been graded as death, which is currently under investigation, and none have been graded as severe harm. One incident was graded as moderate, 4 graded as low and 14 resulted in no harm, which included 2 serious near misses. Themes in location: 5 incidents occurred at QEH, of which 2 occurred in A&E; 9 incidents occurred at WHH, of which 3 occurred in A&E; 4 incidents occurred at KCH and 2 in the community.

Incorrect Data in Patient Notes



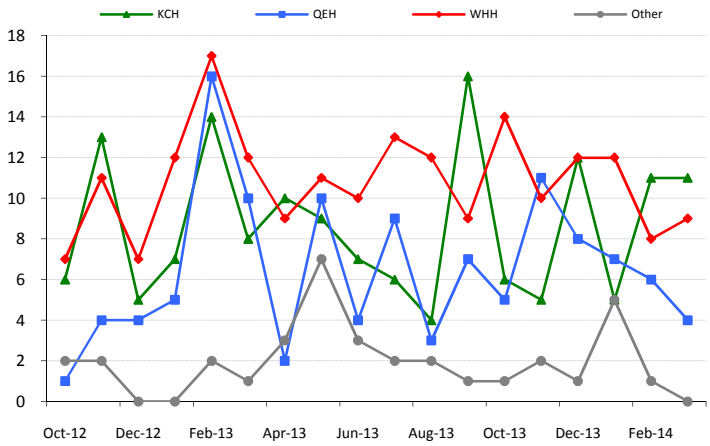
There were 16 incidents of incorrect data in patients' notes reported as occurring in March (14 in February), of which 15 were graded as no harm and one as low harm. Nine incidents related to incorrect data in paper notes, 6 to incorrect data on patient's electronic record (Patient Centre/Euroking) and 1 to incorrect data in the electronic discharge notification (eDN). Of the incidents reported, 1 was identified at KCH, 6 at QEH and 9 at WHH. The highest reporting area was Outpatients (WHH) and A&E (WHH) with 2 incidents each.

Staffing Level Difficulties



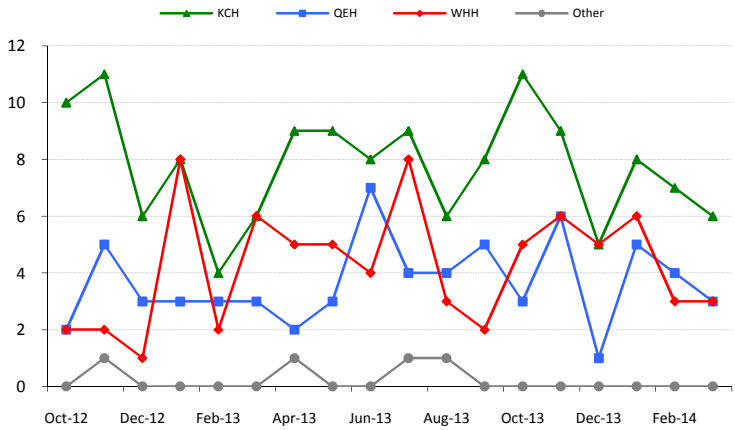
There were 57 incidents recorded in March (63 in February). These included 27 incidents relating to insufficient nurses and midwives, 4 to inadequate skill mix, 3 to insufficient doctors and 23 to general staffing level difficulties. Top reporting locations were A&E (QEH) with 14 incidents; Singleton Unit (WHH) with 8, Kennington (WHH) with 3; and the following areas reporting 2 incidents each: at WHH A&E, Cambridge J, Kings B and Pharmacy; at QEH St Augustine's and Theatres; at KCH Clarke.
Five incidents occurred at KCH, 24 at QEH, 26 at WHH and 2 at RVHF. All incidents were graded as no harm.

Communication Breakdowns



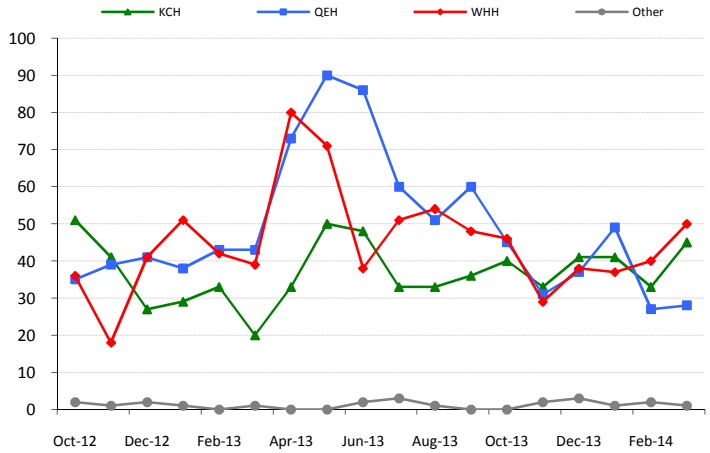
In Mar-14 there were 24 incidents of communication breakdown (26 in February). Of these, 17 involved staff to staff communication failures, 6 were staff to patient and 1 was staff to relative (or other visitor). Of the 24 incidents reported, 11 were reported as occurring at KCH, 4 at QEH and 9 at WHH. Themes by location: Outpatients (KCH) reported 2 incidents. Incidents in March were graded as follows: 19 as no harm, 3 as low harm, 1 as severe harm and 1 graded death. The 2 serious incidents both related to handover issues on transfer of deteriorating patients and are under investigation.

Blood Transfusion Errors



In March, there were 12 blood transfusion errors reported (14 in February). Two main themes arose in the period: 4 incidents related to prescription/documentation errors (including traceability) and 2 incidents related to communication. Of the 12 incidents reported, 11 were graded no harm and 1 as low harm. Reporting by site: 6 at KCH, 3 at QEH, and 3 occurred at WHH.

Medicines Management



There were 124 medication incidents reported as occurring in March (102 in February).

Medicines Management

Category	Mar-14
Prescribing	15
Dispensing	33
Administering	51
Missing (lost or stock discrepancy)	10
Shortage (drug unavailable)	7
Suspected adverse reaction	1
Infusion problems (drug related)	3
Infusion injury (extravasation)	4
TOTAL	**124**

Of the 124 reported, 97 were graded as no harm including 3 serious near misses, 26 as low harm and one as moderate harm. No serious incidents were reported. Top reporting areas were: Celia Blakey Centre (WHH) reported 9; Hospital at Home (virtual ward) reported 6; Ambulatory Care Unit (QEH) reported 5; Brabourne Ambulatory Care Unit (KCH), CDU (KCH), Kent (KCH), Pharmacy (QEH), Kings B (WHH) and Kings C2 (WHH) each reported 4 incidents; other areas reported 3 incidents or less. Twenty eight were reported at QEH, 45 at KCH, 50 at WHH and 1 in the community.

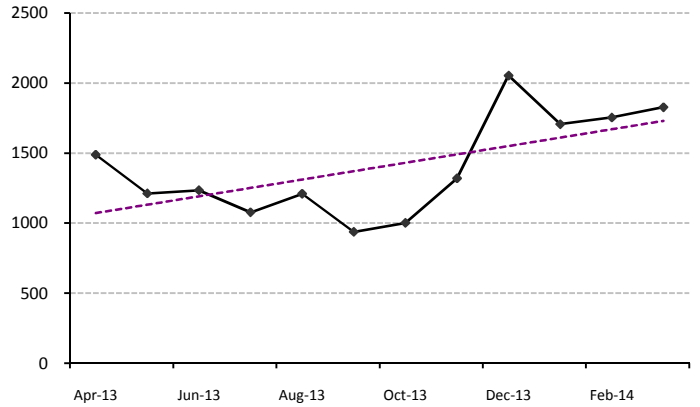
PATIENT EXPERIENCE: CONCERNS, COMPLAINTS & COMPLIMENTS

The experience of the patients and their families is of paramount importance to the Trust. Patient views are sought via a number of ways including the Patient Opinion website, the Friends and Family Test, via NHS Choices and also through the Trust's formal systems. This report provides the Board of Directors with activity and performance information about the complaints, concerns, comments and compliments in Mar-14. The information reported is for cases received in month and formal cases with target dates due that month.

• Activity: Formal complaints - 73; informal contacts - 301; compliments - 1828.

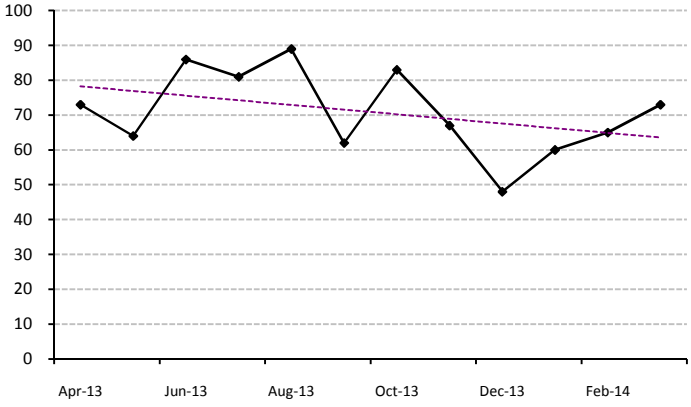
The charts below show the number of complaints and compliments received on a monthly basis. One formal complaint has been received for every 1140 recorded spells of care (inpatient, outpatient and A&E attendances) in comparison with February's figures where 1 formal complaint was received for every 1175 recorded spells of care.

Number of Compliments



In Mar-14 the number of compliments received increased by 4% compared to the previous month. The ratio of compliments to formal complaints received for the month is 25:1. There has been 1 compliment being received for every 46 recorded spells of care.

Number of Formal Complaints



The number of formal complaints received has increased by 12% compared to Feb-14, and has decreased by 30% since Mar-13. The number of informal contacts has increased by 5% compared to the previous month, and has also increased by 44% compared to Mar-13.

Top Five Concerns Expressed in Formal Complaints
March 2014

Concerns		No.
Problem with Attitude	Problem with doctor's attitude	5
	Problems with nurse's attitude	5
	Problems with other staff attitude	2
Delays	Delay with elective admission	6
	Delays in receiving treatment	2
	Delay with emergency admission	1
	Delay in being seen in Outpatient Department	1
	Delay in referral	1
	Delays in being seen in A&E	1
Concern about Clinical Management	Incomplete examination carried out	6
	Lock of/inappropriate pain management	3
	Inappropriate ward	1
Problems with Communication	Doctor communication issues	2
	Lack of information/explanation of procedure outcome	2
	Nursing communication issues	2
	Misleading or contradictory information given	1
	Unhappy with information on medical records	1
Problems with Diagnosis	Missed fracture/or other medical problem	5
	Mis-diagnosis	2
	Delay in receiving diagnosis	1

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

With regards to formal complaints, the highest recurring subjects raised in Mar-14 were problems with attitude, problems with delays, concerns about clinical management, problems with communication, and problems with diagnosis.

Concerns, Complaints and Compliments - Divisional Performance

March 2014

Division	Divisional Activity				Divisional Performance	
	Formal Complaints	Compliments	Informal Contacts	Compliments: Complaints	First Response Met	Returning Complaints
Clinical Support	2	150	45	75:1	3 of 4	0
Specialist Services	8	910	42	**113:1**	9 of 9	2
Surgical Services	29	635	130	**21:1**	24 of 27	4
UCLTC	34	133	66	**3:1**	15 of 18	3
Corporate	0	0	18	**0:0**	1 of 1	0
Other	0	0	0	**0:0**	0	0
TOTAL	73	1828	301	**25:1**	52 of 59	9

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

The table above shows the monthly Divisional activity and performance for Mar-14, reporting on the percentage of cases where target dates falling within the month have been met. The first response date is the date agreed with the client for the receipt of a substantive response to their complaints; this will either be via a letter or at a meeting.
During Mar-14 the data show that 88.1% of these responses were sent out on target, and every Division sent out a minimum of 75% of their responses on time.

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

Status of Cases	Actions in Mar-14
Cases carried over from previous month	17
New cases referred to the Trust	2
Cases closed by PHSO	3
Current open cases with the PHSO	16

The PHSO is the second and last stage of the National Complaints process and it is open to all clients to approach the Office if they are dissatisfied with the way their formal complaint has been handled.
In March, the PHSO have been in contact with the Trust with regards to 2 new cases brought to their attention, that is, 1 case relating to the Surgical Division and 1 case linked to Specialist Services. The PHSO have requested comments from the Trust. During the month 3 cases, all under formal investigation, were closed by the PHSO, 2 cases were not upheld, and 1 upheld with a recommendation for redress.

Friends and Family Test (FFT)

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

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

There is also a "don't know" option which isn't scored, and an opportunity to write further comments. Nationally, Trusts are measured using the Net Promoter Score (NPS) where a score of approximately 50 is deemed good. EKHUFT's NPS was 48 in March and lower than in Feb-14. This is the combined satisfaction from 3444 responses from inpatients and A&E. Maternity services achieved 363 responses. The NPS for inpatients was 68, for A&E 25 and for Maternity 74. Further work is underway regarding the low A&E NPS to take a close look at the feedback and set an improvement plan to address the issues our patients are telling us.

The company iWantGreatCare which reports FFT data on behalf of the Trust have converted the NPS into a "star score" value (ranging from 0 to 5) thus making the interpretation of FFT results easier. The star score is calculated using an arithmetic mean, so a ward that scores 4 stars has an overall average rating of "likely" to be recommended. The Trust score for March was 4.4 stars out of 5 stars and is similar to last month.

The response rate for Mar-14 for inpatients and A&E combined achieved the 15% standard this month at 22.03%, which is the highest to date. This awaits Unify2 validation. Once again the wards exceeded the 15% standard with a 32.59% response rate. The A&E departments achieved 16.01% this month exceeding the 15% standard. Maternity services achieved 16.68% combined.

We Care Programme

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

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

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

In August a summer campaign was undertaken which focused on the mealtime experience, pain management, hand hygiene and seeking and giving feedback.

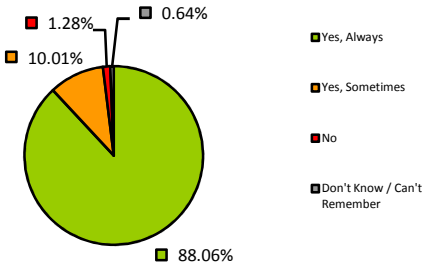
Events took place across the Trust during October by frontline staff. These have sought feedback from patients and families, as well as having discussions about the We Care values within teams. The Steering Group are currently working on the development of the We Care Programme going forward. This includes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

We have undergone a "branding" piece of work that ensures our communications with each other and the public are empathetic and sensitive. This has been labelled the 'Tone of Voice' work led by Human Resources. In addition, work is in progress to embed the values as part of job advertisements, the recruitment process, and our engagement with staff. The roll out of the "We Care" Champions has commenced following the approval by the Board of Directors of the Trust values. "Market Place" events took place during March to engage staff and patients in the delivery of the values. This feedback has been collated ready for analysis against the Trust values.

PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

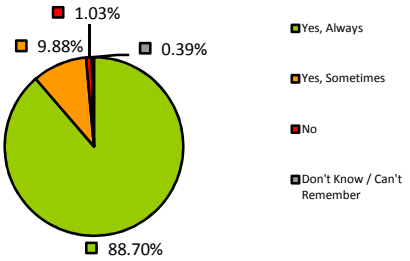
Real time patient experience monitoring using iPads have captured data since 1 Apr-13. During Mar-14, 779 adult inpatients were asked about their experiences of being an inpatient; 141 responses were received from patients treated at KCH, 150 from QEH patients, and 488 responses from patients based at WHH. (Compared with the previous month the number of responses were 116, 172 and 376 respectively). The combined result from all submitted questionnaires in Mar-14 was that 87.57% satisfaction.

Were you given enough privacy when discussing your treatment?



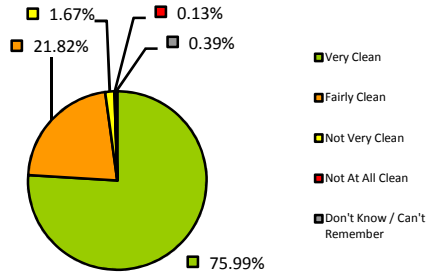
Overall Score = 93.67%

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



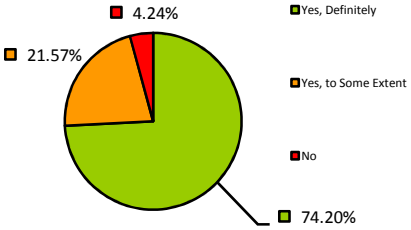
Overall Score = 94.01%

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



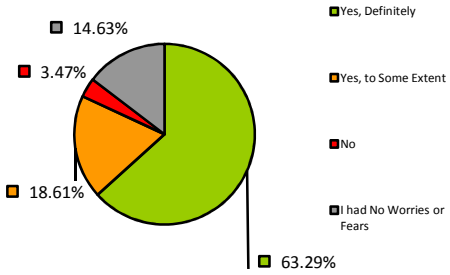
Overall Score = 91.45%

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



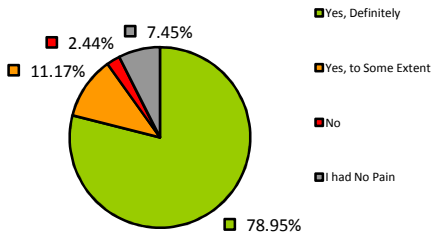
Overall Score = 84.98%

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



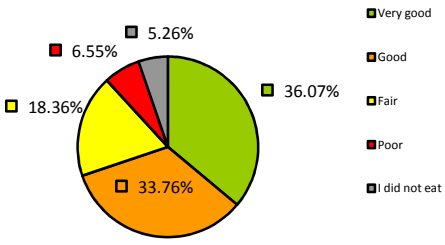
Overall Score = 85.00%

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



Overall Score = 91.33%

How would you rate the hospital food?



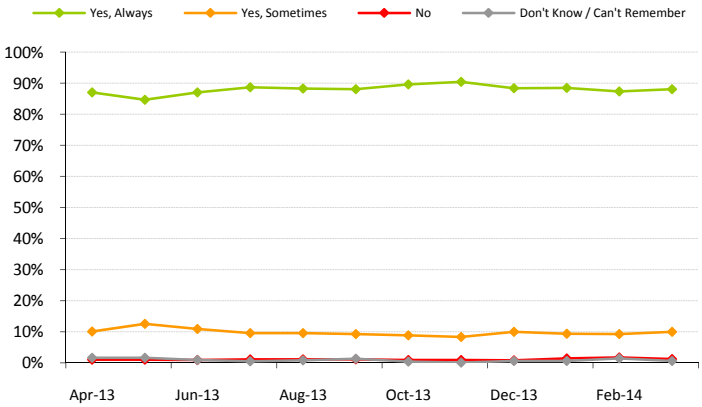
Overall Score = 68.29%

Overall Adult Inpatient Experience Mar-14	
Experience (%)	**No. of Responses**
87.57	779

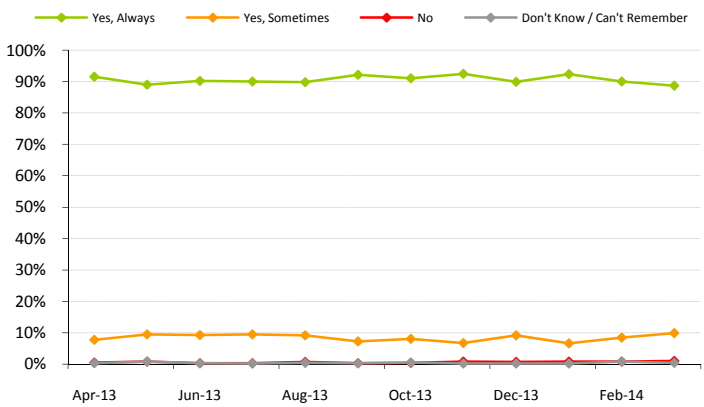
In response to the question "How would you rate the hospital food?" patients are able to answer "very good, good, fair, poor, or I did not eat". This replicates the methodology of the annual national CQC inpatient survey which respectively canvases the opinion of 850 EKHUFT inpatients. In 2012 the results of the national survey indicated that patients rated EKHUFT hospital food below average (52%) when compared with other Trusts. Countrywide the top 20% of Trusts achieved scores of 64 - 79% in response to "How would you rate the hospital food?", suggesting that the survey methodology does not produce very high scores. In the 3 month period form Jan-14 to Mar-14 the real-time monitoring of inpatient experience at KCH, QEH and WHH rated hospital food as 68%, 72% and 70% respectively, and the Trust overall scored 70%. Therefore, if the results of the national CQC inpatient survey in 2013 follow the trend displayed by EKHUFT real-time patient experience monitoring, EKHUFT hospital food will potentially be rated in the top 20%.

PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

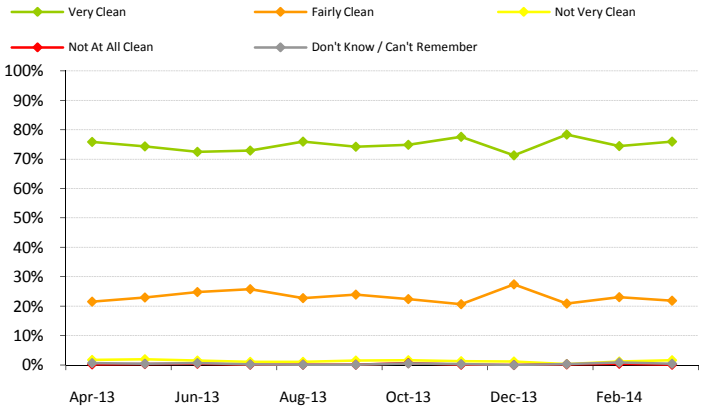
Were you given enough privacy when discussing your treatment?



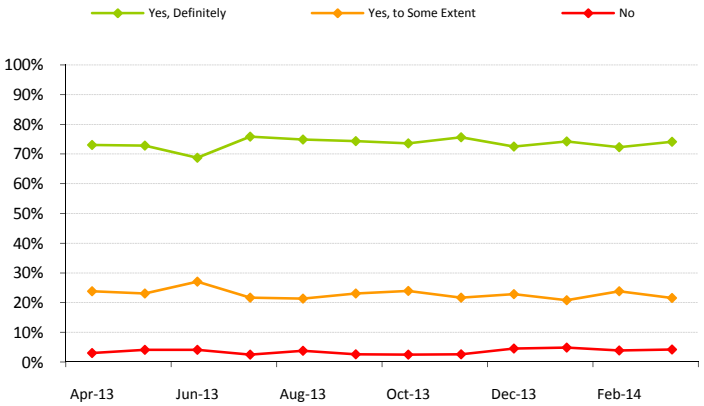
Overall, did you feel you were treated with respect and dignity while you were in hospital?



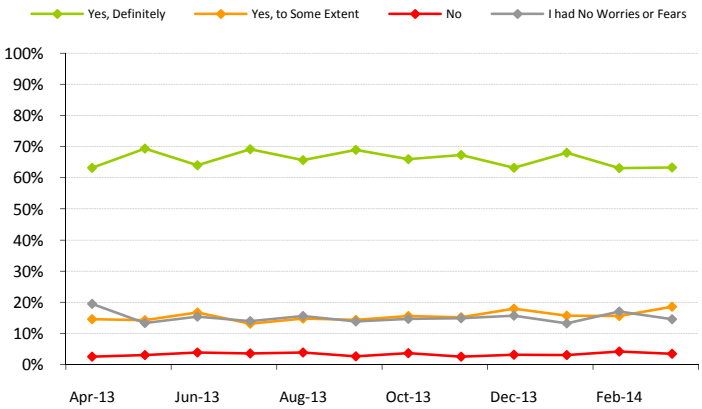
In your opinion, how clean was the hospital room or ward that you were in?



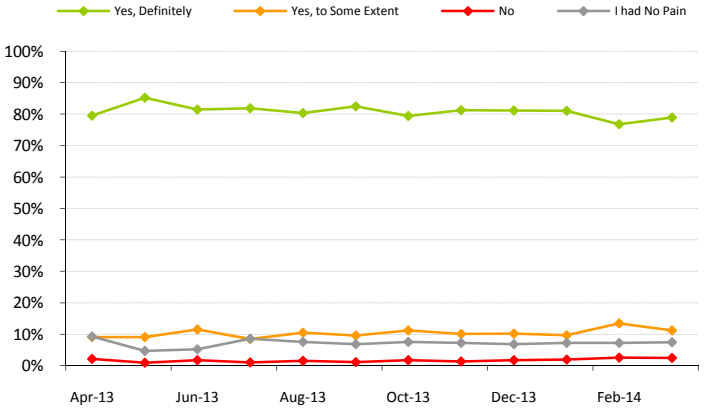
Were you involved as much as you wanted to be in the decisions about your care and treatment?



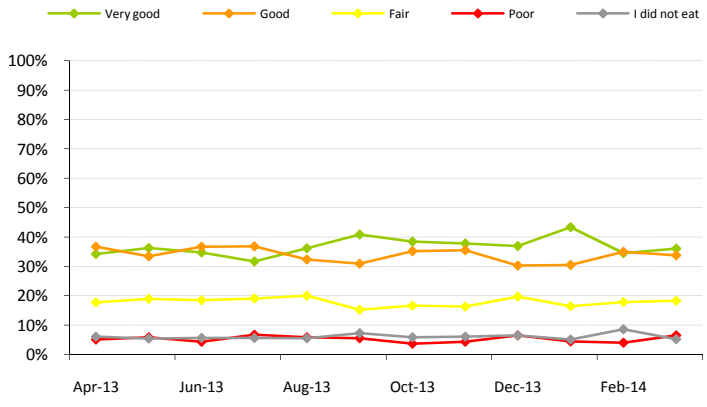
Did you find someone on the hospital staff to talk about your worries and fears?



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



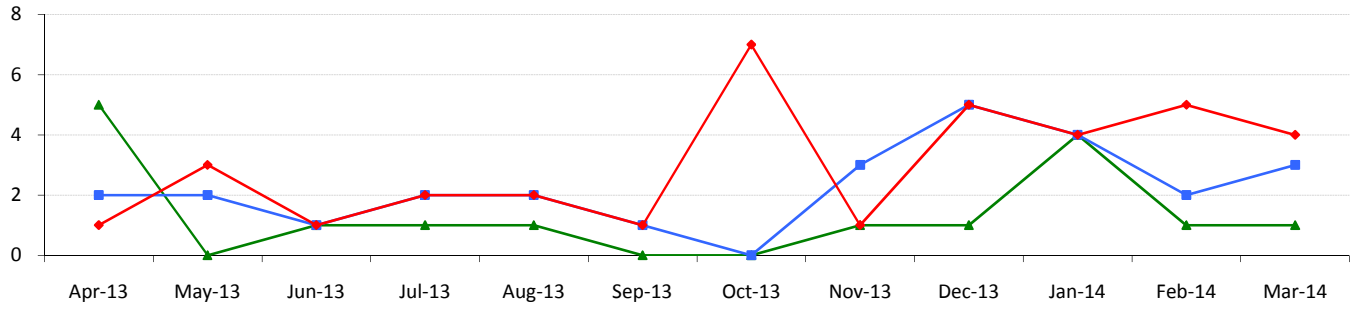
How would you rate the hospital food?



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

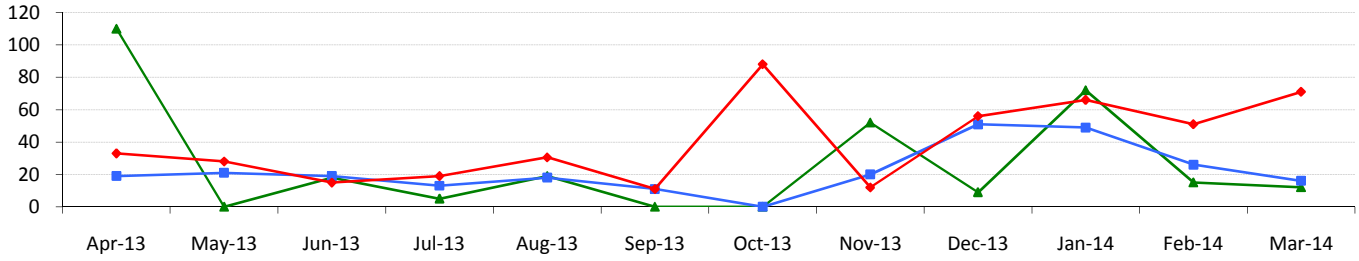
CLINICAL QUALITY & PATIENT SAFETY
PATIENT EXPERIENCE: MIXED SEX ACCOMMODATION

Number of Episodes of Mixed Sex Occurrence



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

Number of Hours of Mixed Sex Occurrence



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
KCH	110	0	18	5	19	0	0	52	9	72	15	12
QEH	19	21	19	13	18	11	0	20	51	49	26	16
WHH	33	28	15	19	30.5	11	88	12	56	66	51	71

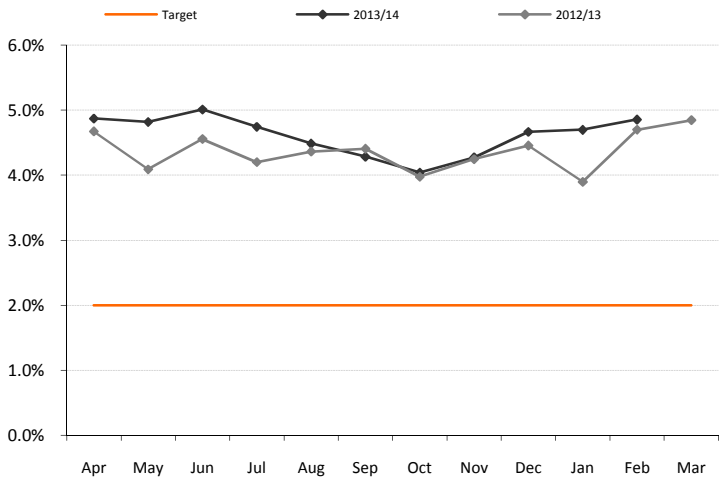
Mixed Sex Accommodation Occurrrences March 2014

Site	Clinical Area	Total No. of Occurrences	Total No. of Patients Affected
KCH	Kingston	1	4
QEH	CDU	2	9
QEH	Fordwich	1	5
WHH	CDU	4	31
TOTAL		**8**	**49**

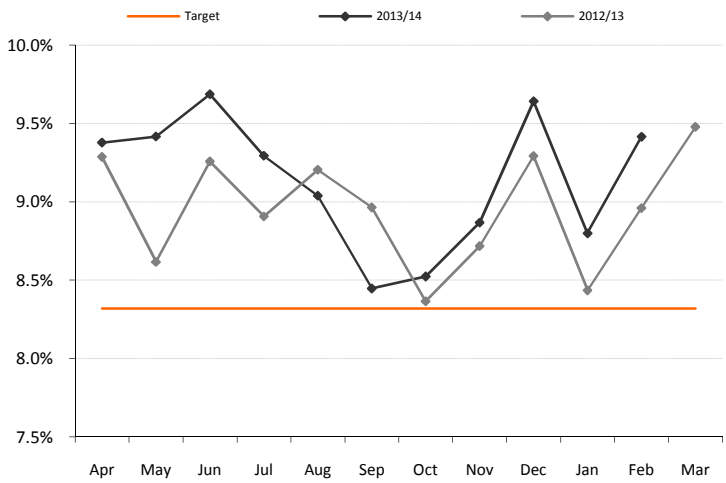
During Mar-14 there were no reportable mixed sex accommodation breaches to NHS England via the Unify2 system. These were not reported as they complied with CCG criteria, such as clinical need. There were 8 clinically justified mixed sex accommodation occurrences affecting 49 patients. The Trust is working closely with the CCGs in order to ensure that mixed sex accommodation occurrences are minimised as much as possible. This includes reviewing the local policy for delivering same sex accommodation and refreshing the acceptable justifiable criteria as outlined in the 2010 national guidance. Building works are continuing in the CDU at KCH in order to provide additional toilet and shower facilities. It is worth noting that none of March's occurrences were in the CDU at KCH. Collaborative work continues with the CCGs where the policy scenarios are being revised. This is due to be discussed at the Quality Meeting with the CCGs where the policy will be refreshed and agreed collaboratively.

CLINICAL QUALITY & PATIENT SAFETY
CLINICAL EFFECTIVENESS: READMISSION RATES

Re-Admission Rate - 7 Day



Re-Admission Rate - 30 Day



An increase in readmissions is evident for the month of February. The 30d readmission rate equalled 9.42%, displaying a seasonal spike very similar to that of 2012/13. The readmission goal of 8.32% by the end of Mar-14 will be a challenge. A meeting has taken place with Julie Pearce and Paul Stevens and a plan to analyse the data to ensure the correct target groups are identified is in place, in addition to the identification of similar Trusts in England who fall below the national average for readmissions so that shared learning can be achieved.

			CQUIN		2012/13 Baseline	2013/14 Target	YTD Status	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Q1	Q2	Q3	Q4	Year End Position
Performance	Pre-Qualification Criteria		3 Million Lives: Use of Teleheatlh/Telecare Technologies		Zero	Baseline and trajectories in place																		
			International and Commercial Activity		NA	Process in place																		
			Digital First		Various	Baseline & trajectories in place																		
			Support for Carers of Dementia Sufferers		NA	Signposting carers																		
Commentary			3 Million Lives: Use of Teleheatlh/Telecare Technologies		Response to Commissioners sent Apr-13 containing a summary of baseline and trajectories for 3 Million Lives (Telehealth) and Digital First activity. The response also includes commentary on the other Pre-Qualification Criteria applicable this year (International and Commercial Activity), and providing support to carers of patients with dementia (signposting). The Pre-Qualification Criteria do not include targets, but next steps will include the Divisions developing and monitoring growth in Telehealth and Digital First activity. For the signposting carers of dementia sufferers the Trust already provide patients with literature signposting them to support organisations. Performance will be available following implementation of the monthly audit of carers described in the individual CQUIN.																	
			International and Commercial Activity																					
			Digital First																					
			Support for Carers of Dementia Sufferers																					
	National CQUINS																							
Performance	Friends and Family Test	1.1	Increased Response Rate for Inpatients and A&E	Inpatients	1.3%	Increased response rate	32.8%	0.5%	0.6%	2.7%	9.1%	18.4%	23.3%	24.3%	26.5%	26.9%	26.5%	32.8%	32.6%	2.5%	16.9%	25.9%		32.6%
				A&E	3.9%	Increased response rate	13.6%	4.6%	4.0%	3.1%	1.7%	5.4%	6.5%	5.8%	7.6%	15.0%	13.4%	13.6%	16.0%	3.1%	4.5%	9.5%		16.0%
		1.2	Phased Expansion		NA	Rollout to maternity by Oct-13	16.7%								1.8%	18.7%	28.4%	17.7%	16.7%					16.7%
		1.3	Improved Performance on Staff Survey		55%	Improvement												57.0%					57.0%	
	Safety Thermometer	2.1	Monthly Safety Thermometer Data Collection		100% submitted	100% each quarter	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%	100.0%	100.0%	100%	100%	100.0%	100.0%	100.0%
		2.2	Incidence of Avoidable Grade 2 Pressure Ulcers		151	20% reduction in avoidable grade 2 pressure ulcers from 12/13 baseline - no more than 121 in year	95	11	7	11	11	6	5	11	5	9	7	4	8	29	22	25	19	95
	Improving Diagnosis of Dementia	3.1	Dementia Case Finding		95.8% Q4 12/13	Average of 90% in each of the elements of the indicator each month for any 3 consecutive months		96.6%	96.9%	97.4%	99.3%	98.8%	100.0%	99.2%	99.6%	98.7%	99.5%	99.8%	99.5%	96.9%	99.4%	99.1%	99.6%	
			Dementia Assessment within 72h		87.2% Q4 12/13			79.5%	75.7%	79.5%	90.7%	95.1%	95.0%	92.5%	95.4%	95.7%	93.0%	93.2%	95.4%	78.2%	93.6%	94.5%	93.9%	
			Appropriate Referral		100%			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		8.5%	20% of appropriate staff trained	21.6%	11.4%	11.4%	13.1%	13.4%	13.3%	14.9%	17.6%	17.9%	20.4%	21.7%	21.7%	21.6%	13.1%	14.9%	20.4%	21.6%	21.6%
		3.3	Supporting Carers		NA	Monthly audit of support for carers																		
	VTE	4.1	Risk Assessment		95.2%	95.0%	96.3%	98.0%	97.0%	97.0%	97.0%	95.0%	95.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	97.3%	95.7%	96.0%	96.0%	96.3%
		4.2	Root Cause Analyses of PE and DVT		40.2% (Jan-13 to Mar-13)	60.0% by Q4	69.8%	78.1%	75.6%	70.0%	60.0%	73.3%	60.0%	68.0%	58.0%	85.0%				74.6%	64.4%	70.3%		
Commentary	Friends and Family Test	1.1	Increased Response Rate for Inpatients and A&E		Combined response rates are meeting 15% national requirements.																			
		1.2	Phased Expansion		Roll out to maternity went live 30 Sept-13 with the first data submitted to Unify Nov-13.																			
		1.3	Improved Performance on Staff Survey		Survey results have confirmed an increase in staff who would recommend the Trust as a place to work or receive treatment, from 55% in 2012/13 to 57% in 2013/14.																			
	Safety Thermometer	2.1	Monthly Safety Thermometer Data Collection		Monthly safety thermometer data collection is in place from last year and has been 100% throughout the year.																			
		2.2	Incidence of Avoidable Grade 2 Pressure Ulcers		The target for the year was a 20% reduction (i.e. no more than 121 grade 2 pressure ulcers). The end of year position was 95 grade 2 pressure ulcers, and as such was well within target.																			
	Improving Diagnosis of Dementia	3.1	Dementia case finding		Performance continues to meet the requirement to have an average of 90% or greater each month for any 3 consecutive months. Now eligible for partial payment of 1/3 related to 1 of the 3 measures.																			
			Dementia assessment within 72h		Performance now meets the requirement to have an average of 90% or greater each month for any 3 consecutive months. Now eligible for partial payment of 1/3 related to 1 of the 3 measures.																			
			Appropriate referral		Performance continues to meet the requirement to have an average of 90% or greater each month for any 3 consecutive months. Now eligible for partial payment of 1/3 related to 1 of the 3 measures.																			
		3.2	Staff training		Plans are in place to ensure that training continues to be conducted, and the year end target of 20% has been achieved 1 quarter early.																			
		3.3	Supporting Carers		The definition of a carer has been documented and process methodology designed and implemented. An audit of 10 carers per site per month was conducted for 3 months. Of those, many were already receiving support with only 17% agreeing to have their details forwarded to a Carers Support Organisation. The audit is continuing and its findings and recommendations will be reported later in the year.																			
	VTE	4.1	Risk Assessment		Performance has met or exceeded the target of 95% of inpatients assessed (eDN reported).																			
		4.2	Root Cause Analyses of PE and DVT		The target is RCAs to be conducted on 60% of Hospital Acquired Thrombolysis (HAT). A more efficient way of identifying VTEs (via Radiology) will be explored once the migration to the new radiology system is complete. This measure will always have a time lag of at least 3 months, and quarterly reporting has been agreed 1 quarter retrospectively. The first, second and third quarter results confirmed that the 60% target was exceeded. Quarter 4 will be reported in Jul-14.																			

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

		Local CQUIN		2012/13 Baseline	2013/14 Target Minimum	2013/14 Target Maximum	YTD Status	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Q1	Q2	Q3	Q4	Year End Position
Performance	Enhancing Quality and Recovery Programme (EQRP)	5.1	AKI (EQ)	Pilot	Establish pathway																			
		5.2	#NoF (EQ)	NA	Establish pathway																			
		5.3	Heart Failure (EQ) (Jul to Dec-13)	40.8%	48.3%	52.8%	73.7%	68.5%	46.4%	50.0%	46.9%	70.7%	65.0%	57.7%	71.0%	90.0%	73.9%	90.9%						
		5.4	CAP (EQ) (Jul to Dec-13)	48.6%	48.1%	58.7%	58.5%	41.0%	46.9%	44.6%	46.7%	47.8%	50.8%	59.0%	53.7%	61.5%	53.6%	62.6%						
		5.6	H&K (ER) (Sept-13 to Feb 14)	8.3%	26.2%	38.3%	92.6%	93.1%	91.7%	42.9%	78.8%	91.9%	93.9%	92.9%	93.7%	90.0%	90.6%			75.9%	88.2%	92.2%		
		5.7	Colorectal (ER) (Sept-13 to Feb-14)	13.7%	12.6%	36.2%	63.4%	38.2%	42.4%	52.9%	34.5%	52.2%	63.2%	77.8%	55.0%	57.7%	46.2%			44.5%	49.9%	63.5%		
		5.8	Gynaecology (ER) (Sept-13 to Feb-14)	15.5%	14.4%	35.5%	94.4%	84.8%	87.2%	87.8%	94.6%	90.7%	94.7%	97.4%	93.8%	91.7%	90.9%			86.6%	93.3%	94.3%		
		5.9	Improve Readmission Rate HF (EQ)		Develop a joint action plan with KCHT																			
		5.10	Patient Experience HF/H&K (EQ/ERP)	Pilot	Submit patient experience data																			
		5.11	Prescribing of Anti-psychotic Drugs (EQ)	33.3%	95% from Sep-13 data			40.0%	80.0%	80.0%	100.0%	75.0%	87.5%	100.0%		100.0%	100.0%	100.0%		66.7%				
	Respiratory Disease	6.1	Referral for Smoking Cessation Service	Q1 13/14 - 7.1%	Process, baseline, trajectories and improvement		9.0%	7.7%	4.2%	9.1%	9.1%	6.9%	10.5%	7.7%	14.5%	7.2%	10.8%	9.0%	5.1%	7.0%	8.8%	9.8%	8.3%	9.0%
		6.2	Referral for Pulmonary Rehabilitation Services	Q1 13/14 - 3.6%	Process, baseline, trajectories and improvement		4.5%	3.8%	3.6%	3.5%	4.1%	3.6%	2.5%	5.6%	4.2%	5.2%	5.8%	4.3%	5.1%	3.6%	3.4%	5.0%	5.1%	4.5%
	Stroke	7.1	Door to Needle Time	13.0% of patients	23% of patients by Q4		25.4%	25.0%	19.0%	33.0%	28.6%	18.0%	27.0%	33.3%	25.0%	20.0%				25.7%	24.5%	26.1%		
		7.2	Admission to Stroke Unit	80.2% - To be re-baselined	85.0% acute stroke patients by Q4		65.3%	54.0%	55.6%	71.8%	76.7%	61.0%	56.2%	67.3%	69.1%	65.9%	69.0%	71.8%		60.4%	64.6%	67.5%		
		7.3	Quarterly Audit of Brain Scans <12h	NA	Quarterly audit of brain scans conducted within 12h		Audit Only	89.0%	91.0%	83.0%	88.0%	87.0%	91.0%	85.0%	87.0%	88.0%	91.0%	91.0%						
		7.4	Stroke Pathway/Supported Discharge	NA	Measure pathway		Audit Only																	
	Breastfeeding/ Smoking Cessation Referral	8.1	Referral to Smoking Cessation Service	46.0%	TBA		54.8%	58.0%	57.0%	62.0%	54.6%	56.0%	50.8%	54.0%	50.0%	52.0%	55.0%	53.0%		59.0%	55.3%	52.0%		
		8.2	Breast feeding within 48h of Birth	67.4%	TBA		68.8%	66.3%	68.8%	68.5%	69.3%	69.6%	71.0%	69.3%	64.2%	70.9%	70.4%	68.0%		67.9%	69.5%	68.1%		
		8.3	Breastfeeding at 10 days after Birth	55.7%	TBA		57.9%	54.5%	57.8%	59.4%	59.1%	59.3%	57.1%	57.3%	54.9%	59.7%	59.3%	58.4%		57.6%	56.4%	57.3%		
	Post Op Complications	9.1	Post Operative Complications of Joint Replacement Surgery	NA	Audit																			

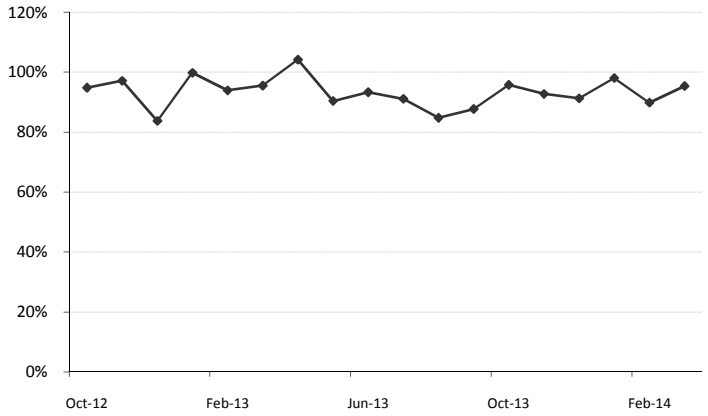
Commentary	Enhancing Quality and Recovery Programme (EQRP)		General	Targets have now been published with a partial payment being possible if a minimum target is achieved. The level of this partial payment is currently being clarified. Minimum scores for the improvement targets have been updated as per recent advise from the EQ Team. ERP targets will apply for the period Sep-13 to Feb-14 and success is measured on the Trust's average performance over that period. There is therefore a transition period between Apr-Sep to introduce data collection of the new measures included in the care bundles. EQP targets apply for the period Jul13 to Dec-13 and success is measured on the Trust's average performance over that period.
		5.1	AKI (EQ)	This is a measurement pathway with no targets currently set. The EQ team have indicated that as more providers demonstrate their ability to collect data, they may choose to introduce a target part way through the year. A response to this would need to be considered if published. They have also indicated a desire to consider measuring the AKIM 3 patient group and discussions are taking place.
		5.2	#NoF (EQ)	There are no targets for the #NoF pathway, this is an establishing pathway measure.
		5.3	Heart Failure (EQ)	A meeting to discuss the coding process has taken place. Improved record keeping/coding and regular MDM meetings, alongside other improvements, appear to have had a positive impact with this pathway exceeding the target.
		5.4	CAP (EQ)	This pathway has previously experienced poor performance around recording of CURB 65, referral to the Smoking Cessation Team and antibiotics within 6 hours. A full action plan has been applied to ensure that this pathway improves and the impact of this has been seen in improved results in the last 2 months (ie June data 50.8% and July data 59.0%) with the 58% target being exceeded for the first measurement month of Jul-13. Ongoing focus will remain to help ensure that these pathway improvements are sustained and continue to grow. November data show the target has been exceeded, but further improvement is required to achieve target for the year.
		5.6	H&K (ER)	The Trust is already performing significantly above target (ie Jan-14 is 90.6% against a target of 38.3%).
		5.7	Colorectal (ER)	The Colorectal Pathway is impacted by a low usage of IOFM within the pathway. A review of IOFM usage for all procedures has been completed. Performance continues to improve since a dip in July, and is exceeding the target of 36.2% (ie Jan-14 is 46.2%).
		5.8	Gynaecology (ER)	The Trust is already performing significantly above target (ie Jan-14 is 90.9% against a target of 35.5%).
		5.9	Improve Readmission Rate HF (EQ)	A joint action plan with KCHT is required to address improving the readmission rate for HF patients. Baseline data on the patient group are being obtained. The Community Heart Failure Nurse is attending the regular internal HF meetings. An initial RCA meeting has taken place and further RCA work planned.
		5.10	Patient Experience HF/H&K (EQ/ERP)	Submission of Heart Failure patient experience data is up-to-date. Some of the H&K patient experience data collected is being clarified internally. Response rates are above target, and responses to the data received are being developed.
		5.11	Prescribing of Anti-psychotic Drugs (EQ)	The period of Jan to Jul-13 was a non target driven audit of APD GP follow up within 30 days of discharge. From September the Trust will be measured against a 95% target for the period Sep-13 to Mar-14. A small population increases the risk to achieving this target consistently.
	Respiratory Disease	6.1	Referral for Smoking Cessation Service	Referral to the Smoking Cessation Service is recorded in PAS. Improvement targets for this measure are still to be agreed, but year to date figures show an improvement, that is, 9..0% against a Q1 baseline of 7.1%.
		6.2	Referral for Pulmonary Rehabilitation Services	Baseline data is sourced from PAS. However, a COPD section has been launched within the eDN to enable referrals to be sent automatically to the Community Team. There has been an increase in referrals year to date, from a Q1 baseline of 3.6% to 4.5%. The reporting processes for these referrals continues to be investigated to ensure all data is being captured.
	Stroke	7.1	Door to Needle Time	The 2012/13 baseline equalled 13% with an agreed target of 23% by Q4. Data will always be reported 1 month retrospectively, and validated data for January and February will be available shortly.
		7.2	Admission to Stroke Unit	The 2013/14 data has been revalidated and now demonstrates a lower performance than previously reported. Current figures take into account the patient's time spent in A&E. The 2012/13 baseline data will be re-run on the same basis to fully understand the level of improvement achieved in 2013/14.
		7.3	Quarterly Audit of Brain Scans <12h	The data show a consistently high performance in providing brain scans within 12h, achieving 91% in Feb-14.
		7.4	Stroke Pathway/Supported Discharge	Collaboratively working with Community Early Supported Discharge team and auditing patient pathway including functional ability and return to usual place of residence. Second and third quarter audit data are available, and Q4 audit data will be available mid Apr-14. A full audit report with commentary will be completed by the end of Apr-14.
	Breastfeeding/ Smoking Cessation Referral	8.1	Referral to Smoking Cessation Service	An improvement target is still to be agreed. Current data reported is on the number of smoking mothers who take up a referral to the Smoking Cessation Service. Rates on the number of smoking mothers offered a referral are also available, and in Feb-14 equalled 95%.
		8.2	Breast feeding within 48h of Birth	An improvement target is still to be agreed. Monthly performance will be reported 1 month retrospectively. Year to date there has been improvement in the referral rate.
		8.3	Breastfeeding at 10 days after Birth	An improvement target is still to be agreed. Monthly performance will be reported 1 month retrospectively. Year to date there has been improvement in the referral rate.
	Post Op Complications	9.1	Post Operative Complications of Joint Replacement Surgery	An audit has been conducted and an action plan will be shared with CCG Clinical Lead. No further response has been received. CQUIN measure achieved.

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

	Specialist CQUIN		2012/13 Baseline	2013/14 Target	YTD Status	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Q1	Q2	Q3	Q4	Year End Position
	National CQUINS																					
Performance	**ODNs**	Support the Operational Delivery Networks (ODNs)	N/A	Provide financial support to ODNs																		
Performance	**Quality Dashboard**	Regular submission of data via a Specialised Services Quality Dashboard	N/A	Submit data to Specialty Dashboard as per reporting schedule																		
Commentary	**ODNs**	Support the Operational Delivery Networks (ODNs)	EKHUFT currently support the Cancer Network, including hosting. The Trust has also expressed interest in there being ODNS for Renal and Vascular and the Commissioner has responded positively to these suggestions. Rebates for the charge to support the ODNS will be available to acknowledge the delays by Commissioners in putting ODNs into place.																			
Commentary	**Quality Dashboard**	Regular submission of performance data via a Quality Dashboard	Concern has been expressed to the Commissioners as to the security of the data submission process and they have assured that this is currently being improved. Data submission will not take place until this has been addressed. A reporting schedule and confirmed process has not yet been provided. Active work streams for the three key elements of the Quality Dashboards (Neonatal, Renal, Haemophilia) have all been identified. Still awaiting data from Renal and Haemophilia, and work is on going to make the Neonatal data source a more automated process to remove burden on the consultant workload.																			
	Local CQUINS																					
Performance	**Renal**	AKI pathway data collection	N/A	Data collection and submission																		
Performance	**Cancer Services**	To assess the impact of CNS support on the patients' experience of their cancer journey and agree action plan to improve experience	N/A	Gather patient feedback and produce action plan			Await National Cancer Survey results (Jul-13)															
Performance	**Cardiac Inpatient Pathway**	Audit Cardiac Inpatient Pathway and publish improvement plan	N/A	Audit and action plan implemented																		
Performance	**Haemophilia**	At least 50% of registered severe and moderate haemophilia A and B patients aged 4 years and over receiving a Joint Score Assessment by a trained physiotherapist in the last 12 months	70.0%	50.0%	62.0%	1.0%	17.0%	25.0%	30.0%	46.0%	51.0%	54.0%	56.0%	59.0%	61.0%	62.0%	66.0%	28.0%	51.0%	59.0%	66.0%	66.0%
Performance	**Neo Natal**	Timely administration of total parenteral nutrition (TPN) for preterm infants	36.5%	TBA Q1	79.6%	100.0%	100.0%	33.0%	71.0%	80.0%	100.0%	100.0%	100.0%	100.0%	67.0%	33.0%	71.0%	77.7%	100.0%	100.0%	57.0%	79.6%
Commentary	**Renal**	AKI Pathway data collection	AKI pathway data is already captured, and the Trust has been participating in a pilot submitting baseline data since Sep-12.																			
Commentary	**Cancer Services**	To assess the impact of CNS support on the patients' experience of their cancer journey and agree action plan to improve experience	The National Cancer Survey has confirmed <10 patients with rarer cancers. The CCG has indicated that gathering further patient feedback may not be required and this needs confirming in writing.																			
Commentary	**Cardiac Inpatient Pathway**	Audit Cardiac Inpatient Pathway and publish improvement plan	A working party has been formed, and development of methodology for auditing the pathway is underway. (The working party includes General Manager, Service Improvement and Cardiology Matron). A Cardiac Pathway dashboard has now been developed and will be the source of all performance data for all patients. Service Improvements have been identified and are being progressed in some areas of the pathway.																			
Commentary	**Haemophilia**	At least 50% of registered severe and moderate haemophilia A and B patients aged 4 years and over receiving a Joint Score Assessment by a trained physiotherapist in the last 12 months	Performance is measured against trajectories set for both 100% achievement, and 50% target agreed. The 2013/14 performance to date exceeds the 50% target for the year , and achieved 66% in Mar-14.																			
Commentary	**Neo Natal**	Timely administration of total parenteral nutrition (TPN) for preterm infants	Due to the small number of eligible babies involved (usually 0 - 10), performance (%) can heavily fluctuate. An improvement target was due to be set at the end of Q1. Full year performance is 79.6% against a 2012/13 baseline of 36.5%.																			

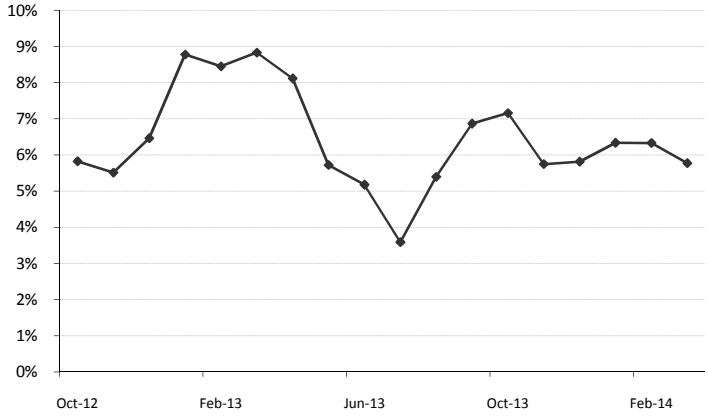
Compliance Against Performance
On target
Monthly target missed; quarterly/annual target at risk
Monthly target missed; annual target at risk

Bed Occupancy



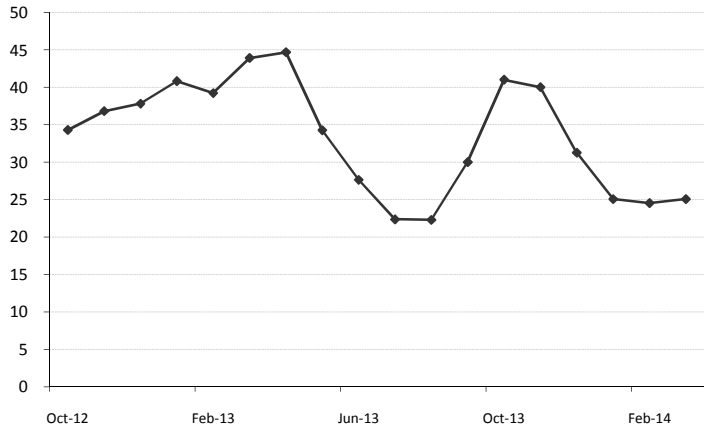
The bed occupancy metric looks only at adult inpatient beds and excludes any ring fenced wards such as Maternity. Occupancy peaked at over 100% during Apr-13, but has since reduced. However, occupancy has been steadily increasing since Aug-13, but in Feb-14 decreased on the previous month with a position of 90.94% (against 97.97% in Jan-14), and sits above the Trust target of 85%. Occupancy in March has increased again slightly to 95.34%, in line with January and October positions.

Extra Beds



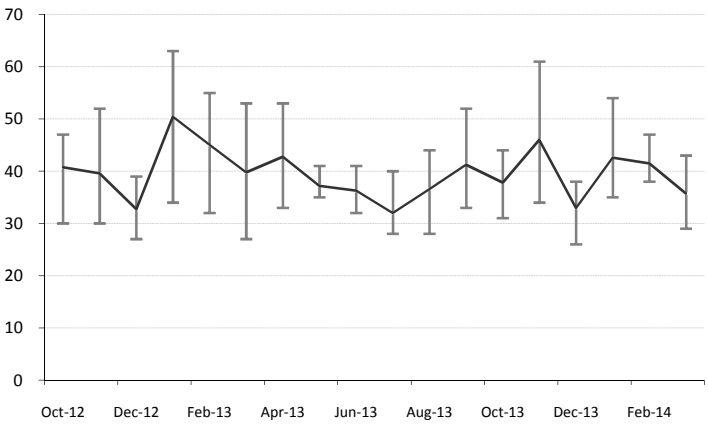
This metric is built up using the number of funded beds on each ward and reviewing those occupied on a daily basis. Where the number of occupied beds exceeds the funded bed base for the ward these are classified as "extra". During January, 5.53% of the Trust's bed days were delivered using extra "unfunded" beds. This position increased slightly to 6.34% in February (thus demonstrating a slight increase on the previous 3 months and is linked to extra capacity being re-opened to meet demand), but again dropped to a March position of 5.77%, in line with Nov-13 and Dec-13.

Outliers



The outliers data show the average number of patients bedded in a ward outside of the relevant Division over a given month. In line with the number of extra beds, the number of outliers peaked in Apr-13 when the Trust, and local health economy, was under extreme pressure with unseasonably high emergency flows. Performance in Jan-14 dropped further with a position of approximately 25 (mirroring achievement from Aug-13), and stabilised in March at 25.06. It is hoped this position will stabilise further moving into 2014/15, underpinned by a reduction in extra beds and the current stable bed occupancy performance.

Average Delayed Transfers of Care

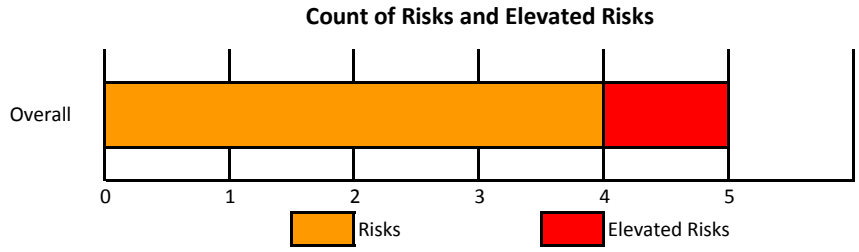


In Mar-14, the number of patients on the Delayed Transfer of Care (DToC) list is similar to that seen in Oct-13 and has reduced on February's position, with overall reportable delays being lower when compared to the same period last year.

The Trust now provides 60 reablement beds, 20 of which became operational on 31 Jan-14. The primary issues for DToC remain, that is, continuing health care, pending assessment by Social Services, and care provision and community resources.

CARE QUALITY COMMISSION: INTELLIGENT MONITORING REPORT

Trust Summary



Priority Banding for Inspection	Recently Inspected
Number of Risks	4
Number of Elevated Risks	1
Overall Risk Score	6
Number of Applicable Indicators	93
Proportional Score	3.23%
Maximum Possible Risk Score	186

Elevated Risk	Composite Indicator: Emergency readmissions following an elective admission
Risk	Never Event Incidence
Risk	PROMs EQ-5D Score: Knee Replacement (PRIMARY)
Risk	Inpatients Response Percentage Rate: NHS England Friends and Family Test
Risk	GMC: Enhanced Monitoring

The Trust was rated as a Band 3 organisation based on the risk scores calculated by the CQC in the first Intelligent Monitoring Report published in Oct-13. The banding process is no longer being adopted by the CQC. Two further reports have been issued since this time; the most recent being on 13 Mar-14. There are changes to the risk reported in the previous iterations of this document.

There are 5 areas showing as a risk; 1 of these is classified as "elevated". This is the Cumulative Sum (CUSUM) for an emergency readmission following an elective admission; the comparative data shows the Trust is performing in line with indicator. The control limits set by the CQC for CUSUM alerting are not clear within the methodology and this alert may have triggered as a result of random variation, particularly as the other indicator is within the expected range.

The remaining areas are classified as "risk". The number of never events occurring is calculated using the calendar, rather than the financial year; this gives the number as 4. The remaining 3 areas are the same as in the previous Reports, but with a reduced level of risk. There is an improving position for the Friends and Family Test, the Patient Reported Outcome Measures (PROM) for primary knee replacement is alerting for the composite of the Visual Analogue Scale only. This relates to general patient well-being rather than any functional improvement following the surgery. The year end figures are currently being compiled. The GMC enhanced monitoring risk is invoked when there is one or more entries where the GMC status is not closed over a period from 1 Mar-09 to 4 Oct-13.