EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**21 MAY 2015**
SUBJECT:	**CLINICAL QUALITY & PATIENT SAFETY**
REPORT FROM:	**ACTING 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 2015. 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 2015/16 is provided in the dashboard and supporting narrative.

PATIENT SAFETY

- Harm Free Care – This month 92.3% of our inpatients were deemed 'harm free' which is lower than last month (94.3%) 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 98.5%, similar to last month (98.1%). Further analysis of these data show that the prevalence of patients with new ulcers, falls or who had developed a new VTE had decreased (improved) this month, the remainder were slightly increased or similar this month.

- Nurse Sensitive Indicators – In April there were 23 reported incidents of pressure ulcers developing in hospital (20 in March). These include 22 Category 2 pressure ulcers and 1 Category 3 ulcer. Two of the Category 2 ulcers have been assessed as avoidable. There are 2 potential Category 3 and 1 potential Category 4 ulcers reported. All are currently unstageable until debrided and depth may be fully established. This is in line with new national and local recommendations. The Pressure Ulcer Steering group will be targeting sacral ulcers to make further reduction in incidents during the forthcoming financial year, and further analysis is required to update the Trust Action Plan.

- There were 160 patient falls recorded for April (185 in March). Two falls resulted in a hip fracture (Birchington and Sandwich Bay Wards, QEQM), and one resulted in a head injury (Harbledown). This is reported on STEIS. Data outlining falls per 1000 patient bed days are now available and shows a reduction compared to March. Work is ongoing to support Harbledown with a programme of training as the ward has consistently had the highest rate of falls Trust wide. The ward have seen a marked reduction in falls during April due to the focussed work. The Falls Prevention Team have expressed interest in a multi-centred research trial to evaluate the efficacy of a flooring system, designed to reduce injuries from falls. The newly formed Prevention of Falls and Injuries Steering Group met for the first time in April and will be setting a trajectory for reduction in falls and injuries.

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- Infection Prevention and Control –Trust wide mandatory Infection Prevention and Control training compliance for March was 80.5%, an increase on February (79.9%). The April data will be reported in June.

- HCAI – There were no cases of MRSA bacteraemias in April. There were four cases of C. difficile occurring within the Trust during the month against a trajectory of four. The outcomes of the RCAs are pending.

- There were 39 cases of E.coli bacteraemia in April. Thirty cases occurred pre-48h and 6 occurred post-48h. Two cases met the criteria for RCA which are pending. The learning will be reported next month. There were 14 cases of MSSA bacteraemia in April. Thirteen cases occurred pre-48h and 1 case post 48h. Two of the pre-48 hours cases met the criteria for RCA which are also pending.

- 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 April-15 continues to show a reduction on January's elevated position and also March-15. Elective crude

mortality has decreased returning to expected seasonal levels. 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 – There was a reduction in incidents recorded due to staffing levels in April. 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, and March due to annual leave being taken at the end of the financial year. Fill rates have improved during April. This correlates with a reduction of incident reporting around staffing difficulties. Two wards who reported lower than expected fill rates of RNs during the day did report falls and pressure ulcers. The remaining wards with similar fill rates did not show any correlation with these metrics. Please see the attached Appendix 1 for greater detail on nursing staffing.

- Risk Management – In April a total of 1026 clinical incidents including patient falls were reported. Seven serious incidents were required to be reported on STEIS in April. Four cases have been closed since the last report. There remain 73 serious incidents open at the end of April. Incidents may be re-graded following investigation. Work is in progress with the CCGs to close the cases in a more timely way. Updated 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.

CLINICAL EFFECTIVENESS

- Bed Occupancy – The bed occupancy metric looks only at adult inpatient beds and excludes any ring fenced wards such as Maternity. In April-15, bed occupancy equalled 88.3% demonstrating a reduction for the third consecutive month. The number of extra beds in use also reduced during April.

- Readmission Rates – Readmission rates are reported 2 months in arrears. The 7 day and 30 day readmission rates for Mar-15 continue to show an improved position from the same period last year, and this position has been replicated for 3 consecutive months. The Service Improvement Team have been working with clinical teams to ensure safer and timely discharge from hospital.

- CQUINs – The 15/16 CQUINs have yet to be finalised with our CCG colleagues but include nationally a CQUIN for sepsis, acute kidney injury and dementia. Development of the Integrated Care Heart Failure, COPD, Diabetes and Over 75s pathways are progressing and 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. A key area was to refresh the justifiable agreed clinical scenarios that were previously agreed with the PCT. Reporting to date has been in line with this policy. During April there were 7 reportable mixed sex accommodation breaches to NHS England via the Unify2 system, occurring in the CDUs at WHH and QEQM. The remaining cases occurred in the Stroke Units which is a justifiable mixing based on clinical need. There were 14 mixed sex accommodation occurrences in total, affecting 71 patients. (Last month there were 3 occurrences affecting 16 patients).

- Compliments & Complaints – During April we received 76 complaints, which is similar to March. One formal complaint has been received for every 1019 recorded spells of care in comparison to March's figures where 1 formal complaint was received for every 1178 recorded spells of care. During April there were 81 informal concerns, 237 PALS contacts and 2513 compliments received. This represents a ratio of compliments to formal complaints of 33:1, and one compliment being received for every 30 recorded spells of care, similar to last month.

  The number of returning clients seeking further resolution of their concerns during April was 17 (15 in March). Surgical Services Division recorded the highest number of returning clients. This is being addressed through the Complaints Management Steering Group where performance is discussed and managed.

  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 April (96% in March). Every Division achieved the required standard this month. From April we are also monitoring response rates against the Trust Policy of 30 working days as part of our improvement work to reduce the length of time complaints remain open. Compliance to this local standard is 48%. Focussed work continues with the teams to address themes, reduce the number of complaints and ensure compliance to the response time standard. This is performance managed through the Complaints Steering Group.

  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 April-15 were concerns about clinical management, problems with communication and attitude and concerns about surgical management.

- Friends and Family Test – During April we received 12105 responses from our patients. This includes inpatients, A&E, maternity, outpatients, day cases and paediatrics. The response rates and satisfaction scores are depicted in the table overleaf:

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

Department	Response Rate		Percentage recommended	
Inpatients*	37%	↓	92%	↓
A&E	25.4%	↓	80%	↑
Maternity	29.8%	↑	96.3%	↑
Outpatients	25.9%	↑	90.4%	↑

* Now includes day case wards and paediatrics.
It is encouraging to see that satisfaction rates have improved in 3 of the 4 areas. The reduction in inpatient rates is marginal with a 2% reduction this month. Our star rating for this month equals 4.5 out of 5.0, similar to last month. We await the detailed satisfaction scores for each area but these will be shared with the wards and departments where the individual comments are being scrutinised so that we can make improvements in response to the feedback. The A&Es continue to be an area where improvement work continues. The key theme for the lower scores in the feedback is the length of time patients are waiting to be seen in the Depts. Local action plans are in place across all areas.

CARE QUALITY COMMISSION

The latest Intelligent Monitoring Report was received on the 1st December. The draft has been released and will be reported next month. The staff survey is flagged as an elevated risk in the draft report. 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 13th 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: AO1: Deliver the improvements identified in the Quality and Improvement Strategy in relation to patient safety, patient experience and clinical effectiveness.

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. 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;
3. The consistent achievement of the response rate standard for formal complaints. The Complaints Steering Group oversees the delivery of the Improvement Plan;
4. 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;
5. 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

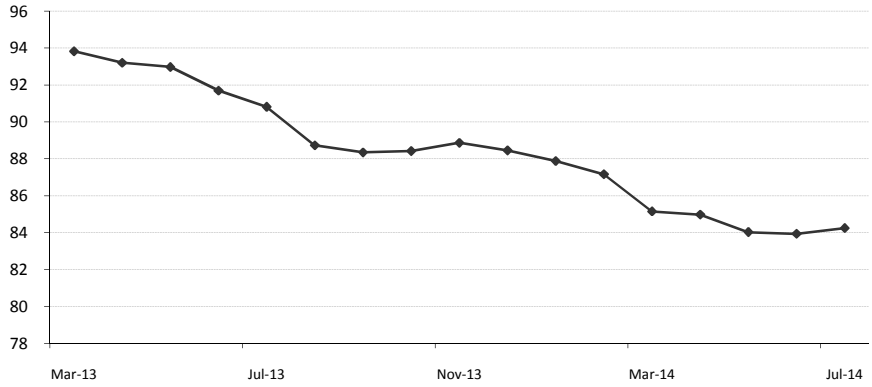
Introduction

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 15/16	Jul-14	Jul-13	vs Jul-13	YTD
Patient Safety	Mortality Rates	HSMR		-	84.2	90.8	↓	
					Q1 14/15	Q1 13/14	vs Q1 13/14	YTD
		SHMI (%)		-	95.30%	95.51%	↓	-
					Apr-15	Apr-14	vs Apr-14	YTD
		Crude Mortality: All Ages (Per 1000)	Non-Elective	-	31.582	31.106	↑	31.582
			Elective	-	0.346	0.341	↑	0.346
	Risk Management	Serious Incidents (STEIS)	New Incidents	-	7	11	↓	-
			Open Incidents	-	73	44	↑	Cumul.
	HCAI	MRSA	Attributable	0	0	0	↔	Cumul.
		C. difficile	Post 72h	45	4	4	↔	Cumul.
	Infection Prevention				Mar-15	Mar-14	vs Mar-14	YTD
		Mandatory Training Compliance (%)		95.0%	80.5%	82.7%	↓	81.9%
	Harm Free Care (HFC)				Apr-15	Apr-14	vs Apr-14	YTD
		Safety Thermometer HFC (%) - Old & New Harm	EKHUFT	93.0%	92.5%	93.9%	↓	92.5%
			National	-	93.8%	93.6%	↑	-
	Nurse Sensitive Indicators	Pressure Ulcers: Category 2,3 and 4	Acquired	-	26	16	↑	26
			Avoidable	79	2	10	↓	2
		Falls		-	160	158	↑	160
	Clinical Incidents	Total Clinical Incidents		-	1026	1030	↓	1023
Patient	Compliments and Complaints	Compliments:Complaints		-	36:1	22:1	↑	-
		No. Care Spells per Formal Complaint		-	1019	1143	↓	-
	Experience	Friends and Family Test (Star Rating)		5.0	4.5	4.4	↑	-
		Adult Inpatient Experience (%)		80.00%	88.94%	88.12%	↑	-
		Mixed Sex Accommodation Occurrences		-	14	8	↑	90
Clinical Effectiveness	Readmission				Mar-15	Mar-14	vs Mar-14	YTD
		7 Day (%)		2.00%	3.81%	4.27%	↓	4.16%
		30 Day (%)		8.32%	7.75%	8.89%	↓	8.83%
	CQUIN				Apr-15	Apr-14	vs Apr-14	YTD
		Standard Contract CQUIN		Multiple			↔	
		Specialist CQUIN		Multiple			↔	
	Bed Usage	Bed Occupancy (%)		-	88.33%	91.08%	↓	-
		Extra Beds (%)		-	6.29%	5.70%	↑	6.29%
		Outliers		-	37.73	34.97	↑	37.73
		Delayed Transfers of Care (Average)		-	31.60	33.00	↓	31.60
Care Quality Commission	Intelligent Monitoring Report				Apr-15	Apr-14	vs Apr-14	YTD
		Outcome Measures	Risks	-	3	-		-
			Elevated Risks	-	2	-		-

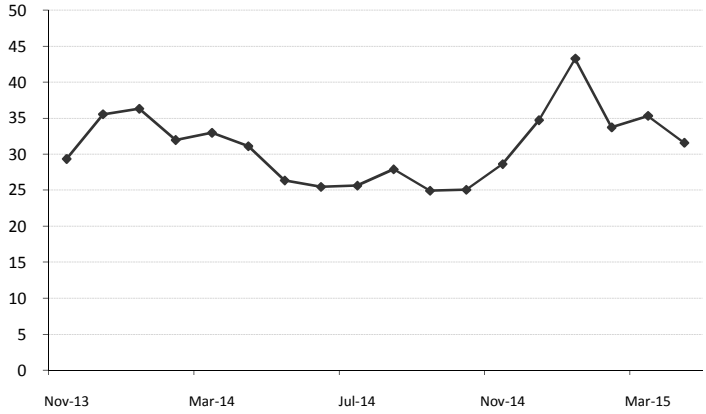
CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: MORTALITY RATES

Hospital Standardised Mortality Ratio (HSMR) - All Discharges



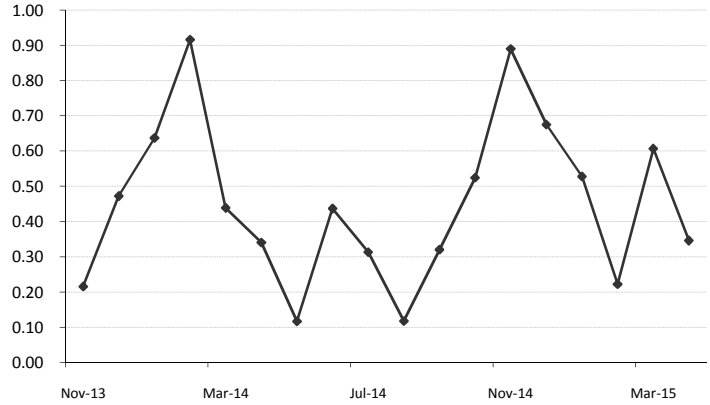
As defined by data provider CHKS, Hospital Standardised Mortality Ratios (HSMR) compare the number of expected deaths with the number of actual deaths, in hospital. The data are adjusted for factors statistically associated with hospital death rates. Severity of illness is an important factor on mortality 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 - Non-Elective per 1000



Crude mortality for non-elective patients shows a fairly seasonal trend with deaths higher during the winter months. Performance in Apr-15 equalled 31.582 deaths per 1000 population, thus showing an approximate 12 point reduction on January's elevated position (cf. 43.265), and is of a similar order to the level reported in Apr-14 where 31.106 deaths per 1000 population were recorded.

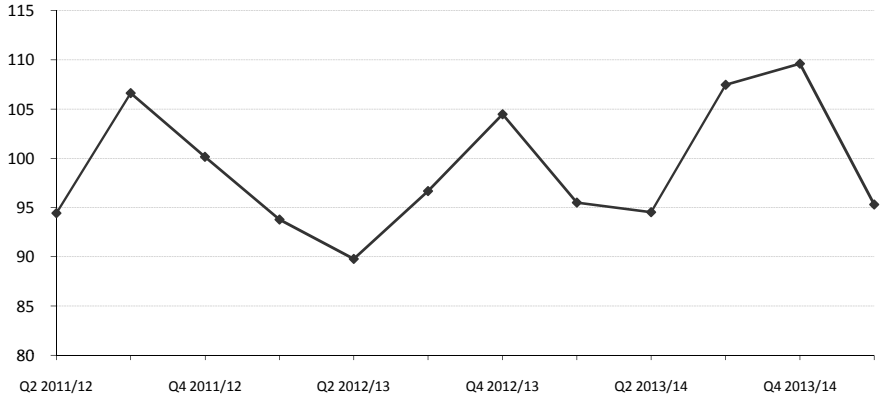
Crude Mortality - Elective per 1000



During Feb-14 elective crude mortality was reported at 0.916 deaths per 1000 population, which dropped back to expected levels as seen in March, and stabilised further over the summer period. A month on month increase in elective crude mortality was, however, evident from Aug-14 and peaked at a level of 0.890 deaths per 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 0.607 deaths per 1000 population, but declined to expected seasonal levels in Apr-15 (i.e.0.346 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 7 May-15.

Summary Hospital Mortality Indicator (SHMI)



The Summary Hospital Mortality Indicator (SHMI) includes "in hospital" and "out of hospital" deaths within 30 days of discharge. These data are supplied by an external party (CHKS) and are updated on a quarterly basis. The most recent data for Q1 2014/15 indicate a SHMI value of 95.30 which is lower than the position reported in Q4 2013/14 (i.e. 109.59), but approximates the value reported in Q1 2013/14 (i.e. 95.51).

Serious Incidents - Open Cases

Date		Summary of Serious Incident & Remedial Action Taken	IX lv	Division	Timely Submit?
Incident	STEIS Report				
18-Apr-15	22-Apr-15	Suboptimal Care - deteriorating patient	2	UCLTC	Not Due
30-Mar-15	15-Apr-15	Unexpected Death - neonatal	2	Specialist	Not Due
13-Mar-15	10-Apr-15	Suboptimal Care - deteriorating patient	2	Surgical	Not Due
25-Mar-15	10-Apr-15	Delayed Diagnosis	2	UCLTC	Not Due
26-Mar-15	10-Apr-15	Unexpected Death	2	Surgical	Not Due
27-Mar-15	0-Jan-00	Delayed Diagnosis	2	Surgical	Not Due
30-Jan-15	2-Apr-15	Intrauterine Death - Maternity Services	2	Specialist	Not Due
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	Extension
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	Breach
11-Feb-15	16-Feb-15	Maternal unplanned admission to ITU	2	Specialist	Not Due
7-Jan-15	13-Feb-15	Fall	1	UCLTC	Breach
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	Breach
3-Feb-15	6-Feb-15	Category 3 hospital acquired pressure ulcer (avoidable)	1	UCLTC	Breach
28-Jan-15	5-Feb-15	Fall	1	Surgical	Breach
16-Dec-14	4-Feb-15	Venous Thromboembolism (VTE)	1	UCLTC	Breach
1-Feb-15	3-Feb-15	Fall	1	Surgical	Breach
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	Breach
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	Breach
6-Jan-15	0-Jan-00	Unexpected Death - general		UCLTC	Breach
5-Jan-15	9-Jan-15	Fall	1	UCLTC	Breach
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	Breach
11-Dec-14	18-Dec-14	Unexpected Admission - NICU	2	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		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	2	Specialist	Extension
2-Sep-14	5-Sep-14	Hospital Transfer Issue	1	UCLTC	Breach
3-Jul-14	2-Sep-14	Category 3 hospital acquired pressure ulcer (avoidable)	1	Surgical	Extension
15-Jun-14	1-Sep-14	Delayed Diagnosis	1	UCLTC	Extension
27-Aug-14	29-Aug-14	Intrapartum Death - term infant	2	Specialist	Yes
13-Aug-14	13-Aug-14	Adverse Media Coverage - CQC report and breach of licence as Foundation Trust	2	Trust	Stop the Clock
19-Jul-14	23-Jul-14	Unexpected Death - neonatal	2	Specialist	Extension
7-Apr-14	10-Jul-14	Fall - resulting in permanent harm	1	UCLTC	Yes
27-May-14	2-Jun-14	Unexpected Death	1	UCLTC	Breach
7-Mar-14	13-May-14	Unexpected Death - endoscopic bleed	1	UCLTC	Yes

Date		Summary of Serious Incident & Remedial Action Taken	IX lv	Division	Timely Submit?
Incident	STEIS Report				
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

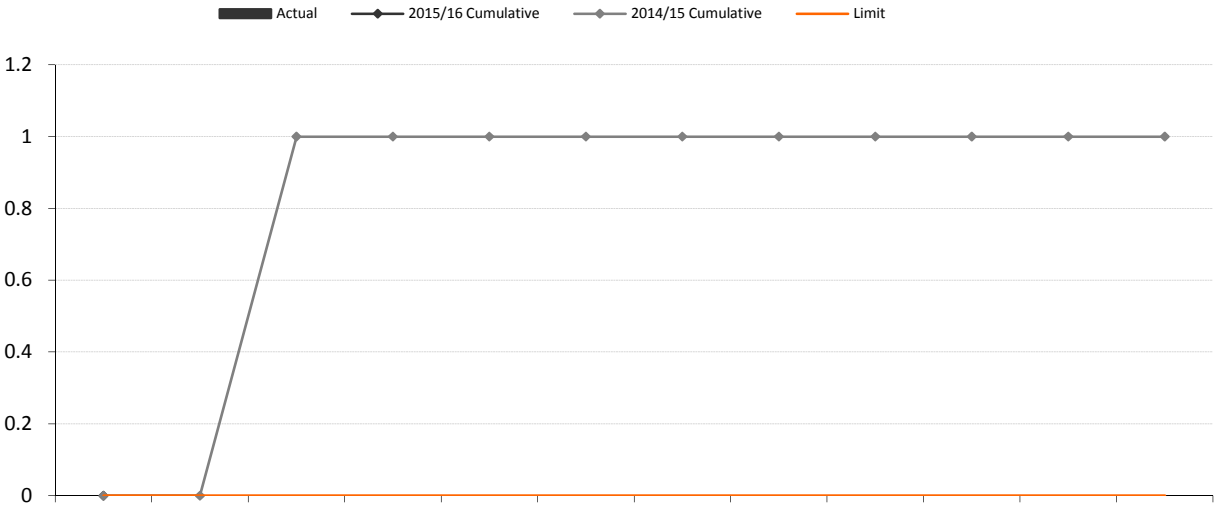
Serious Incidents closed by KMCS but remaining open on STEIS pending review by external bodies.

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
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

Seven serious incidents were reported on STEIS during Apr-15. These were: 2 delayed diagnosis incidents, 2 suboptimal care of deteriorating patients, an intrauterine death, a neonatal death and an unexpected death. Four incidents have been closed on STEIS by the CCG or Area Team. At the end of Apr-15, there remain 7 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 Apr-15 there were 73 serious incidents open on STEIS. The Adverse Incident Reporting policy and investigation templates are under review and being updated in line with the new Never Events guidance and Serious Incident Framework. 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.

CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: HOSPITAL ACQUIRED INFECTIONS

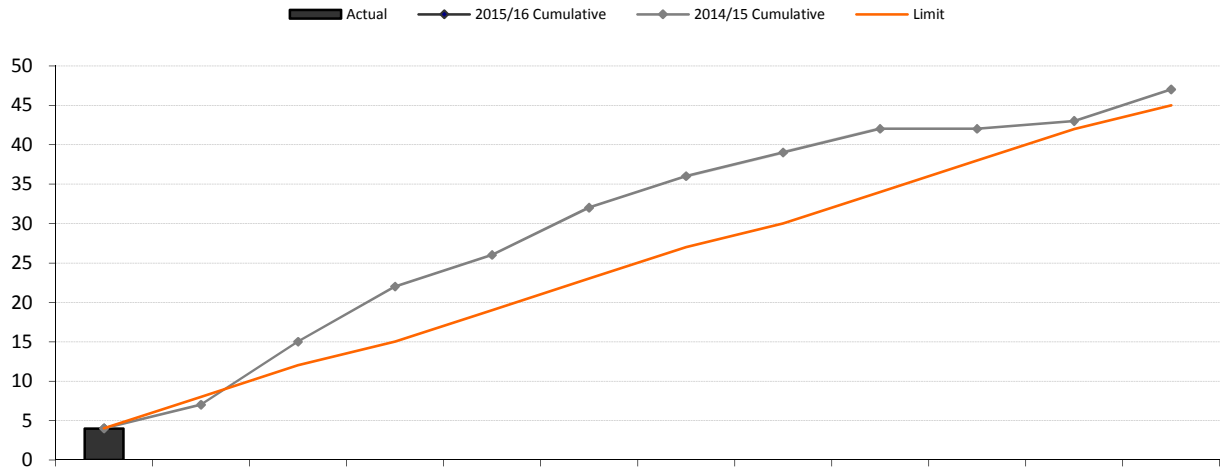
MRSA Bacteraemia - Trust Assigned Case



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Actual	0											
2015/16 Cumulative	0											
2014/15 Cumulative	0	0	1	1	1	1	1	1	1	1	1	1
Limit	0	0	0	0	0	0	0	0	0	0	0	0

There were no cases of MRSA bacteraemia in Apr-15. The NHS England objective for 2015/16 remains zero avoidable cases.

Clostridium difficile - Incidents Post 72h



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Actual	4											
2015/16 Cumulative	4											
2014/15 Cumulative	4	7	15	22	26	32	36	39	42	42	43	47
Limit	4	8	12	15	19	23	27	30	34	38	42	45

There were 4 cases of C. difficile in Apr-15 against a monthly trajectory of 4 cases, and a year end limit for 2015/16 of 45 cases. Three cases were within UCLTC Division (Minster and St Augustine's Wards at QEH, and Harbledown Ward at KCH), and 1 within Surgical Services Division (King's B at WHH). Outcomes of RCAs are pending; decisions regarding lapses of care are to be formally agreed with the CCGs.

A Period of Increased Incidence (PII) was declared on Harbledown Ward in April following 1 case at the end of March followed by a second case at the beginning of April, with both cases occurring within 28 days. The ward was closed due to Norovirus at the time both cases were confirmed. Ribotyping results to identify the strains and determine whether or not they are indistinguishable are pending. There have been no further cases; an Action Plan is in place.

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
2015/16	Pre 48h	33												33.0	33
	Post 48h	6												6.0	6
2014/15	Pre 48h	32	36	32	37	25	39	40	35	29	30	30	35	33.3	32
	Post 48h	9	1	8	7	6	5	6	4	9	6	3	4	5.7	9

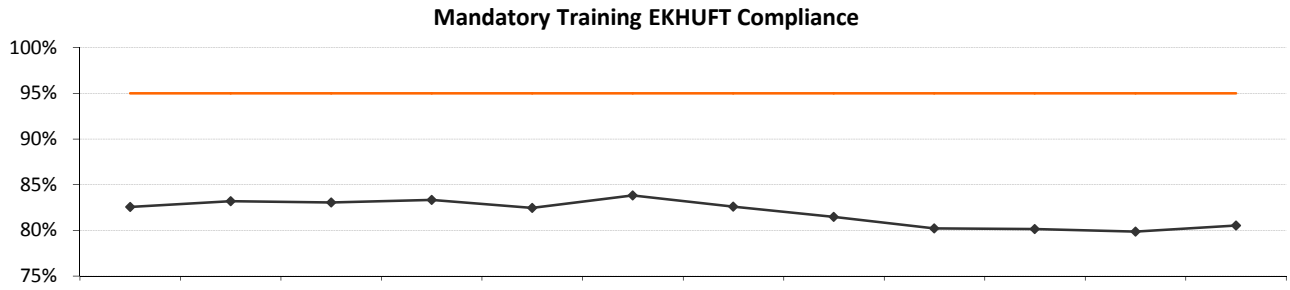
Provisional data indicate that there were 39 cases of E.coli bacteraemia in April. Thirty three cases occurred pre 48h, and 6 cases occurred post 48h. Two cases met the criteria for RCA (1 pre 48h and 1 post 48h), which are pending.

Meticillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly Average	Total YTD
2015/16	Pre 48h	13												13.0	13
	Post 48h	1												1.0	1

Provisional data indicate that there were 14 cases of MSSA bacteraemia in April. Thirteen cases occurred pre 48h, and 1 case occurred post 48h. Two pre 48 hour cases met the criteria for RCA, which are pending.

PATIENT SAFETY: INFECTION PREVENTION & CONTROL



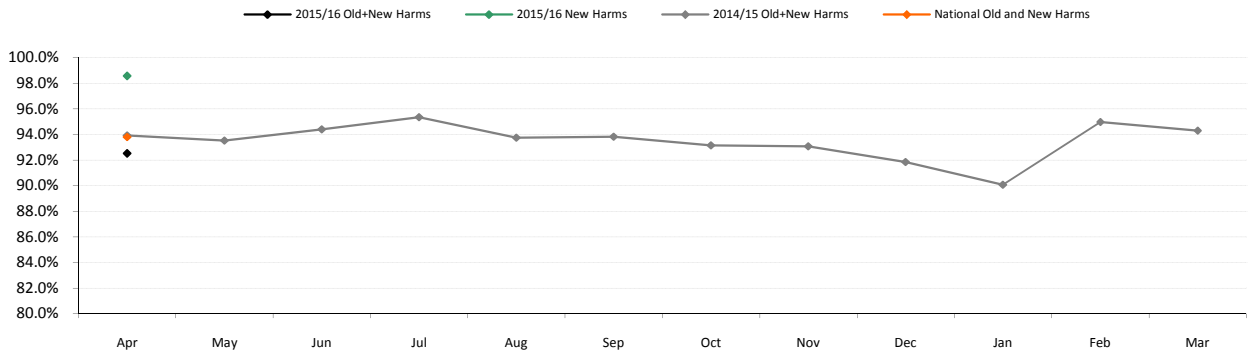
	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Compliance	82.6%	83.2%	83.1%	83.3%	82.5%	83.9%	82.6%	81.5%	80.2%	80.2%	79.9%	80.5%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

	Mar-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%	80.5%	87.5%	80.7%	76.3%	85.0%	79.0%	78.6%	80.0%

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

Trust compliance increased from 79.9% in Feb-15 to 80.5% in Mar-15. Increases have been seen in Clinical Support Services (from 86.8% to 87.5%); Corporate (from 80.6% to 80.7%); Specialist Services (from 74.7% to 76.3%), Strategic Development and Capital Planning (from 84.8% to 85.0%)and UCLTC (from 77.4% to 78.6%). A minor decrease has been seen in Surgical Services, from 79.4% to 79%. Compliance within SERCO remains the same as 80%. Infection prevention and control mandatory training data for Apr-15 will be reported in Jun-15.

Safety Thermometer Harm Free Care



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

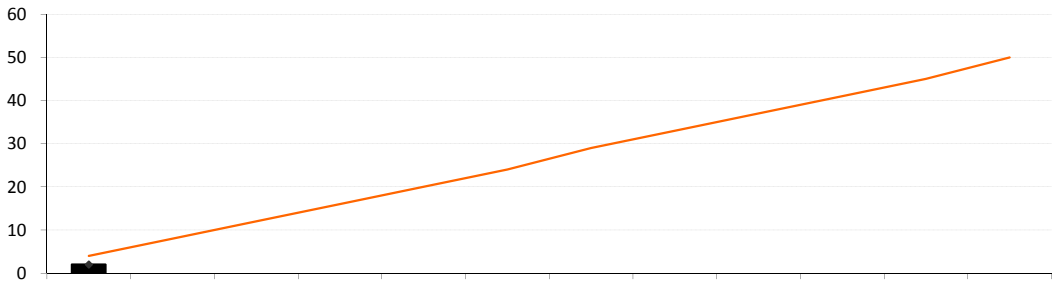
- All categories of pressure ulcers whether acquired in hospital or before admission;
- All falls whether they occurred in hospital or before admission;
- Urinary tract infection (inpatients with a catheter);
- Venous thromboembolism, risk assessment and appropriate prevention.

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

Harm Free Care includes both harms acquired in hospital ("new harms") and those acquired before admission to hospital ("old harms"). There is limited ability to influence "old harms" if a patient is admitted following a fall at home, or with a pressure ulcer, but these are included in the overall performance reported to the Health and Social Care Information Centre. "New harms only" are included separately when reporting performance to Divisional teams to enable success to be celebrated and to incentivise improvement. Harm Free Care performance is incorporated within the monthly ward quality dashboard and is triangulated with the existing funded establishment, acuity and dependency of patients, and effectiveness of rostering to enable analysis of influencing factors and thereby focusing improvement actions.

This month 92.5% of our inpatients were deemed "harm free" which is slightly lower than last month and is lower than the national figure which is 93.8%. 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 98.6%, which is higher than last month (98.1%). Further analysis of these data show that the prevalence of patients with new ulcers, falls or who had developed a new VTE had decreased (improved) this month, the remainder were slightly increased or similar this month.

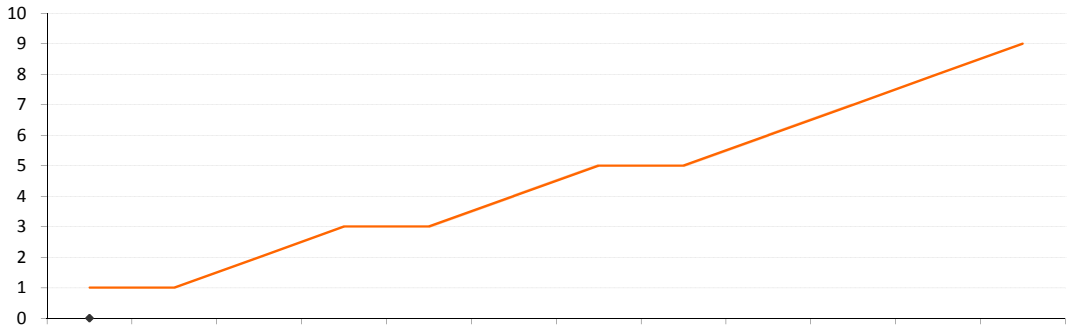
Category 2 Incidence Trajectory 2015/16
25% Reduction



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
2015/16 Avoidable	2											
2015/16Cum Avoidable	2											
2015/16Cum Trajectory	4	8	12	16	20	24	29	33	37	41	45	50
per 1000 bed days	0.07											

In Apr-15, a total of 22 acquired Category 2 pressure ulcers were reported, of which 2 were avoidable. This represents an increase of 6 acquired ulcers but a reduction of 3 avoidable ulcers from the previous month. Of the 2 avoidable ulcers, 1 was due to delays in appropriate intervention at WHH, and 1 due a patient's foot resting on the end footboard. Of the remaining unavoidable ulcers, 11 occurred on the sacrum/buttocks and although all known care was in place, further work is required to investigate and address this issue. Five occurred at the ankle/heel and 4 were located at the nose or ear (and related to tubing from medical devices). The Pressure Ulcer Steering group will be targeting sacral ulcers to make further reduction in incidents during the forthcoming financial year, and further analysis is required to update Trust Action Plan.

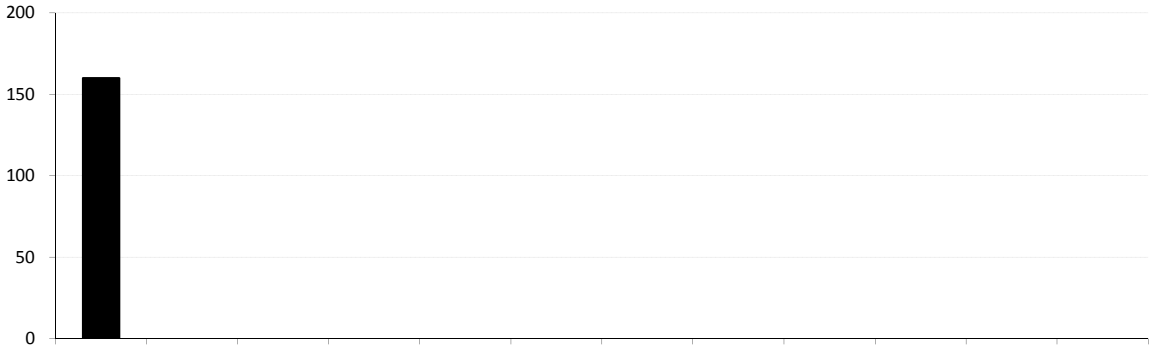
Category 3 and 4 Incidence Trajectory 2015/16
25% Reduction



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
2015/16 Avoidable	0											
2015/16Cum Avoidable	0											
2015/16Cum Trajectory	1	1	2	3	3	4	5	5	6	7	8	9
per 1000 bed days	0.00											

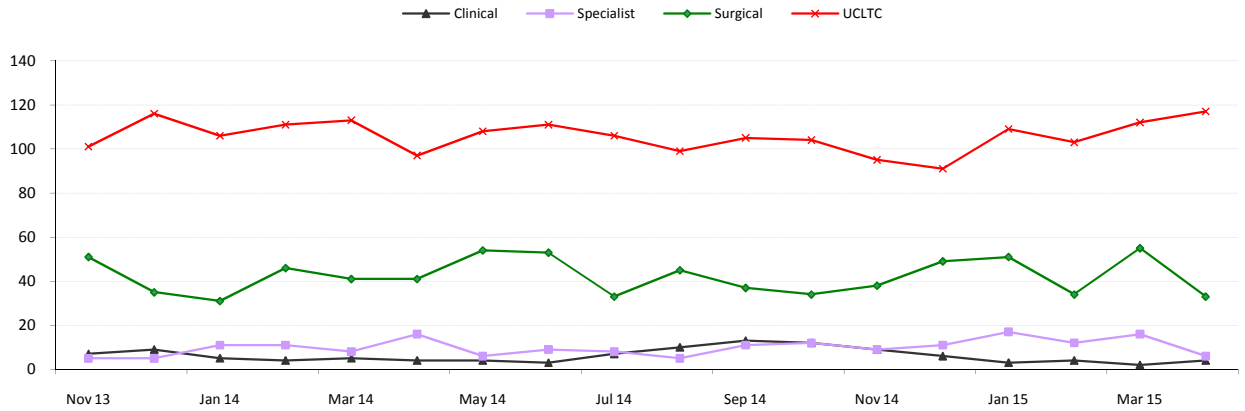
In Apr-15, there was one confirmed Category 3 pressure ulcer where further information has been requested to determine avoidable/unavoidable decision. There are 2 potential Category 3 and 1 potential Category 4 ulcers reported. All are currently unstageable until debrided and depth may be fully established. This is in line with new national and local recommendations. Two of these incidents have been agreed as unavoidable as full preventative care was already in place whilst the other incident is awaiting further information. Following the success of the heel campaign, efforts will be directed at maintaining and pursuing further improvements.

Patient Falls - Injurious and Non-Injurious



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
2015/16	160											
2015/16 Cum	160											
per 1000 bed days	5.36											

Patient Falls - Injurious and Non-Injurious By Division

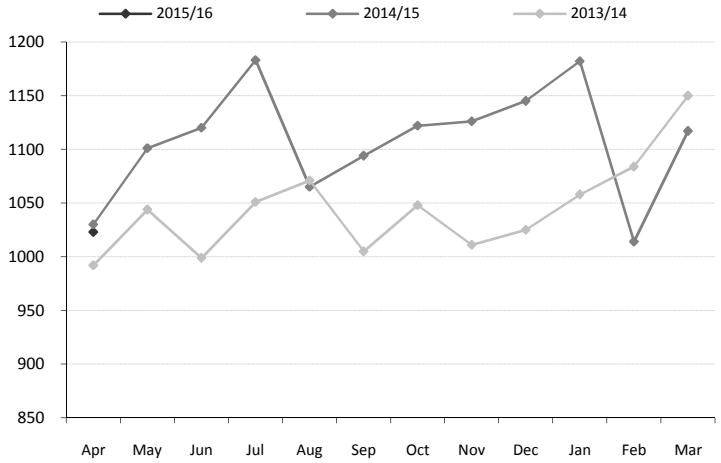


In Apr-15 there were 160 falls in EKHUFT which included 35 at KCH, 48 at QEH and 76 at WHH. Two falls resulted in a hip fracture (Birchington and Sandwich Bay) and 1 resulted in a head injury (Harbledown). The wards with the highest total falls were Kingston (9), Harbledown (8), Deal (8), CDU QEH (8), and Oxford (15), Cambridge L (8) and Kings D Male (8). There has been an decrease in falls this month compared with March. Work is ongoing to support Harbledown with a programme of training as the ward has consistently had the highest rate of falls Trust wide. The Falls Prevention Team have expressed interest in a multi-centred research trial to evaluate the efficacy of a flooring system, designed to reduce injuries from falls. The newly formed Prevention of Falls and Injuries Steering Group met for the first time in April and will be setting a trajectory for reduction in falls and injuries.

CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: CLINICAL INCIDENTS

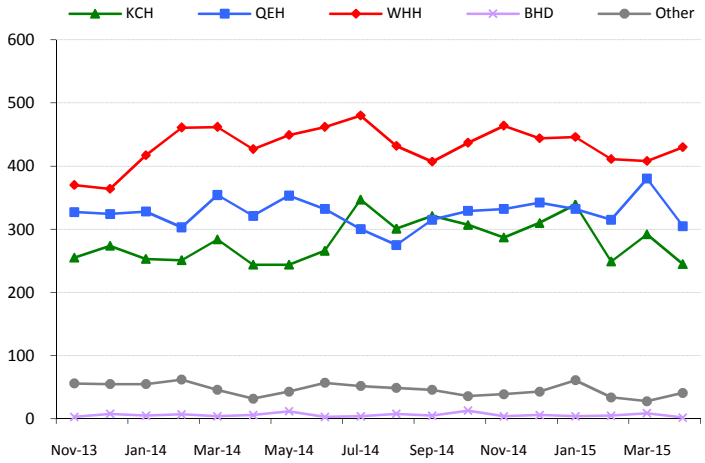
In Apr-15 a total of 1026 clinical incidents were reported. This included 3 incidents graded as death and 2 incidents graded as severe harm. Two of the five Serious Incidents have been reported on STEIS; 2 deaths have been subsequently downgraded following review as the deaths were unrelated to the incidents; and 1 severe harm incident of a baby born with multiple amniotic bands is currently under review; initial impression is that the incident will be downgraded as no errors or omissions occurred. In addition to these 5 incidents, 7 incidents have been escalated as a serious near miss of which 1 has been finally approved. There continues to be a reduction in the proportion of moderate harm incidents reported during Apr-15 (i.e. Apr-15: 59 compared with Mar-15: 59 and Apr-14: 83) 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, evidence of compliance with the Duty of Candour requires significant improvement.
Seven serious incidents were required to be reported on STEIS in April. Four cases have been closed since the last report and there remain 73 serious incidents open at the end of April.

Overall Incident Rates by Year



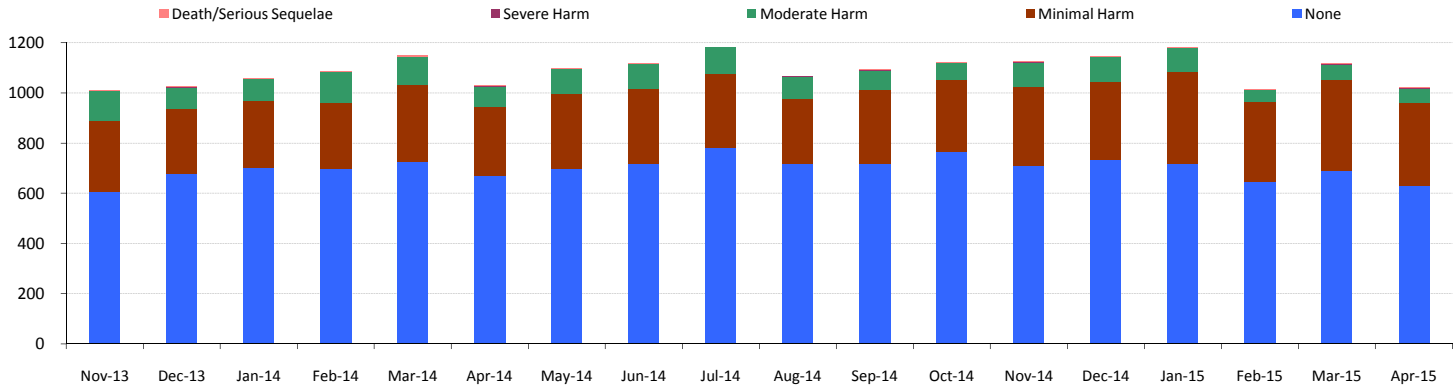
A total of 1026 clinical incidents have been logged in as occurring in Apr-15 compared with 1117 recorded for Mar-15 and 1030 in Apr-14.

Overall Incident Rates by Site



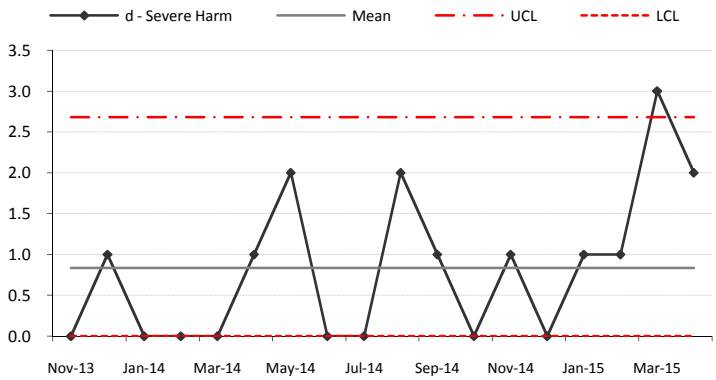
There has been a drop in reporting at KCH and QEH, but an increase at WHH. Overall the number of incidents reported in the Trust appears to have plateaued at an average of 1100 per month.

Clinical Incidents by Severity

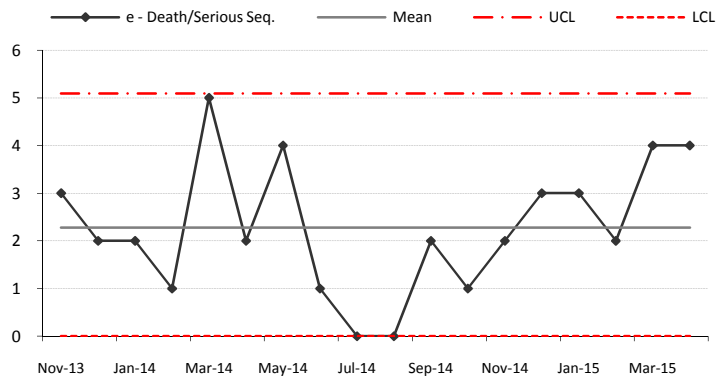


The incidents graded as moderate, serious and death have all been subject to review in order to confirm the consistency of the grading of harm across the Trust. The Board of Directors may see a change in this report to reflect the re-categorisation process undertaken. This is consistent with the data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

Severe Harm

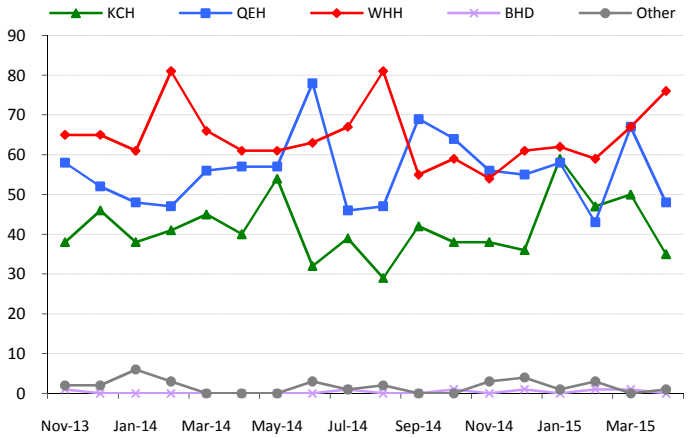


Death/Serious Sequelae



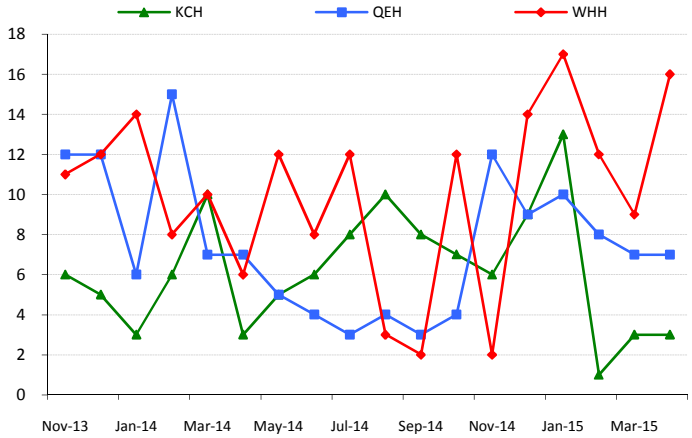
The number of death/serious and severe harm incidents reported in Apr-15 remains subject to the usual RCA investigation and review. It is possible that the severity of these cases will be downgraded once the investigation process is completed in line with national guidance to ensure the actual harm caused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

Patient Slips, Trips and Falls



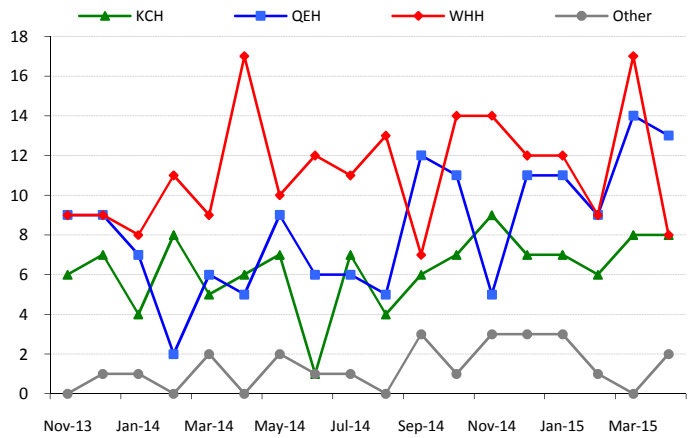
Of the 160 patient falls recorded for April (185 in Mar-15and 158 in Apr-14), 4 incidents were graded as moderate, no incidents were graded as severe or death. There were 94 falls resulting in no injury and 62 in low harm. The top reporting wards were Oxford (WHH)with 15 falls; Kingston Stroke Unit (KCH) with 9 falls; Harbledown (KCH), CDU (QEH), Deal (QEH), Cambridge L (WHH) and Kings D Male (WHH) with 8 each; Sandwich Bay (QEH) and CDU (WHH) with 7 falls each; and Cambridge J (WHH)and Richard Stevens Stroke Unit (WHH) with 6 falls each. The remaining wards reported 5 or less falls. The falls team are undertaking a review of the high number of falls on Oxford (WHH).

Hospital Acquired Pressure Ulcers



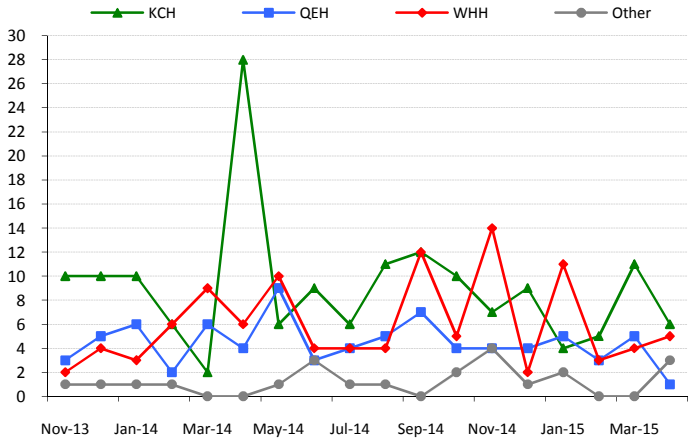
In April there were 26 reported incidents of pressure ulcers developing in hospital (19 in Mar-15 and 16 inApr-14). The Apr-15 incidents included 22 Category 2 pressure ulcers, 2 of which have been assessed as avoidable. Three Category 3 and 1 Category 4 have been reported, none of which are currently classified as avoidable, however 1 Category 3 is yet to be assessed and 1 Category 4 is currently unstageable. The highest reporting wards were Richard Stevens Stroke Unit (WHH) with 3 incidents; Cheerful Sparrows Male (QEH), Seabathing (QEH), ITU (WHH) and Kings D Male (WHH) with 2 incidents each; 14 other wards or departments reported 1 incident each.

Delay in Providing Treatment



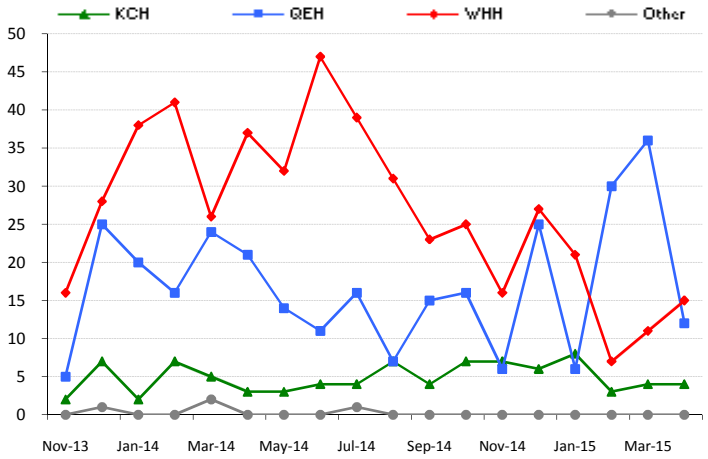
There were 31 incidents resulting in delay in providing treatment during April compared with 39 in Mar-15 and 28 in Apr-14. No incidents were graded as death or severe harm. Two have been graded as moderate harm and are currently under investigation, 13 have been graded as low harm and 16 resulted in no harm. Themes in location were: three incidents occurred in CDU (QEH) and 2 incidents each occurred in A&E (WHH), Kings D Male (WHH), Endoscopy (QEH) and Cathedral Day Unit (KCH).

Incorrect Data in Patient Notes



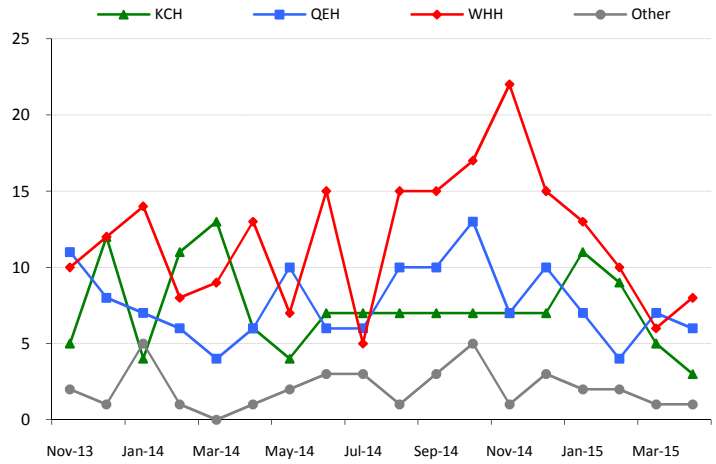
There were 15 incidents of incorrect data in patients' notes reported as occurring in April (20 in Mar-15 and 38 in Apr-14). All 15 were graded as no harm; 13 related to incorrect data in paper notes, 1 to eDNs and 1 to Patient Centre. Of the incidents reported, 6 were identified at KCH, 1 at QEH, 5 at WHH and 3 at RVHF. Themes in the location of these incidents: 5 incidents occurred in Outpatients (KCH), 3 in Outpatients (RVHF), 2 each in Celia Blakey Centre (WHH) and Outpatients (WHH).

Staffing Level Difficulties



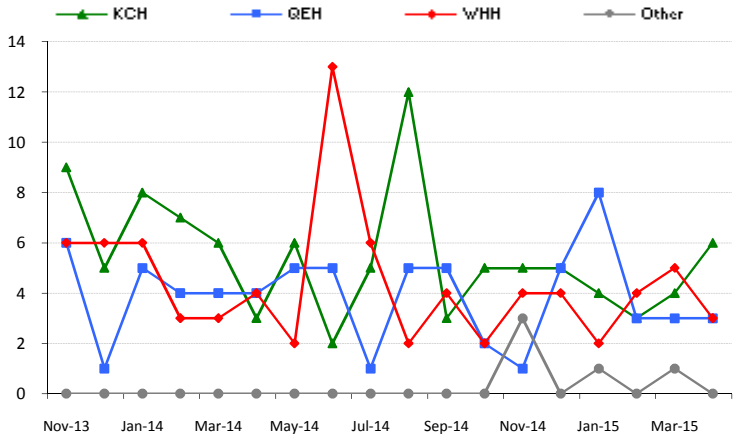
There were 31 incidents recorded in April 2015 (51 in Mar-15 and 61 in Apr-14). These included 17 incidents relating to insufficient nurses, 3 to inadequate skill mix, 3 to insufficient doctors, 1 to insufficient doctors/nurses and 7 to general staffing level difficulties. Top reporting locations were WACU (WHH) and CDU (QEH) with 4 incidents each. Other areas reported 2 or fewer incidents.
Four incidents occurred at KCH, 12 at QEH and 15 at WHH. No incidents have been graded as death or severe harm. Two incidents have been graded as moderate harm, relating to uncovered shifts and sickness on Kings D Male (WHH) and A&E (QEH); these are likely to be downgraded to low harm as relate to delays only. Eight incidents have been graded as low harm and 21 incidents have been graded as no harm. Investigations evidence continued active management of bed, staffing situation and escalation to senior staff.

Communication Breakdowns

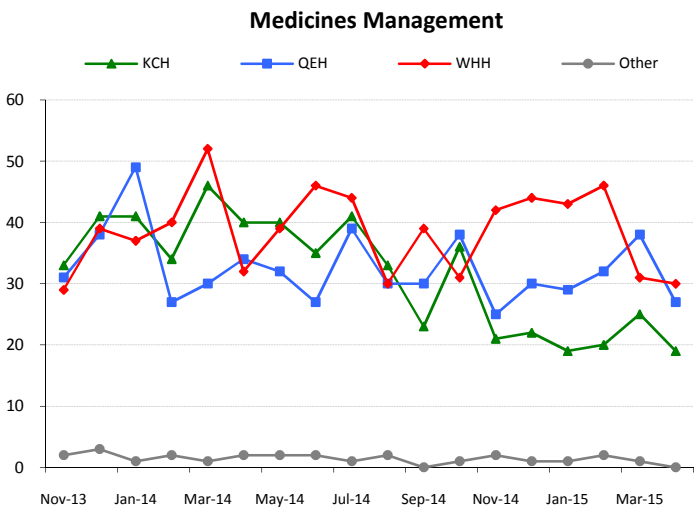


In Apr-15 there were 18 incidents of communication breakdown (19 in Mar-15 and 26 in Apr-14). Of these, 11 involved staff to staff communication failures, 6 were staff to patient and 1 was staff to relative (or other visitor). Of the 18 incidents reported, 3 were reported as occurring at KCH, 6 at QEH, 8 at WHH and 1 in the community. Themes by location: A&E (WHH) and ITU (WHH) each reported 2 incidents; other areas reported 1 or none. Incidents in April were graded as follows: 14 as no harm, 3 as low harm and 1 as moderate harm: this related to failures in handing over a deteriorating patient, compounded by a missing DNAR form which was eventually located in another patient's notes.

Blood Transfusion Errors



In April, there were 12 blood transfusion errors reported (13 in Mar-15 and 11 in Apr-14). There were 2 themes arising in the period: 4 incidents relating to delay in providing blood products and 2 incidents relating to testing and processing errors. Ten of the 12 incidents were graded no harm and 2 were graded low harm. Reporting by site: 6 at KCH, 3 at WHH and 3 at QEH.



Medicines Management

Category	Apr-15
Prescribing	15
Dispensing	21
Administering	30
Missing (lost or stock discrepancy)	6
Shortage (drug unavailable)	4
Suspected adverse reaction	0
Infusion problems (drug related)	1
Infusion injury (extravasation)	1
TOTAL	**78**

There were 78 medication incidents reported as occurring in April (95 in Mar-15 and 108 in Apr-14). The reporting of medication incidents has decreased at both QEH and KCH, but remained level at WHH.
Of the 78 reported, 66 were graded as no harm including 2 serious near misses and 12 as low harm. There were no incidents graded moderate harm or above. Top reporting areas were: Celia Blakey Centre (WHH) with 6 incidents; Cathedral Day Unit (KCH), Seabathing (QEH) and Pharmacy (QEH) with 4 incidents each; ITU (KCH), Cheerful Sparrows Female (QEH), A&E (WHH), Cambridge M2 (WHH), Folkestone (WHH) and Pharmacy (WHH) reported 3 incidents each; other areas reported 2 incidents or fewer. Twenty seven incidents occurred at QEH, 19 at KCH and 32 at WHH.

*Missing drugs are broken down as follows: all 6 incidents relate to stock discrepancies in both patients' own medications and ward stock occurring on Kent (KCH), Cheerful Sparrows Female(QEH), 2 incidents in A&E (WHH), Seabathing (QEH)and Padua (WHH). A questionnaire has been developed with support from Pharmacy to ascertain the level of knowledge about the responsibilities of nurses when checking and dispensing controlled drugs. This has been circulated to all trained staff and results will be used to identify training requirements in this area.

CLINICAL QUALITY & PATIENT SAFETY

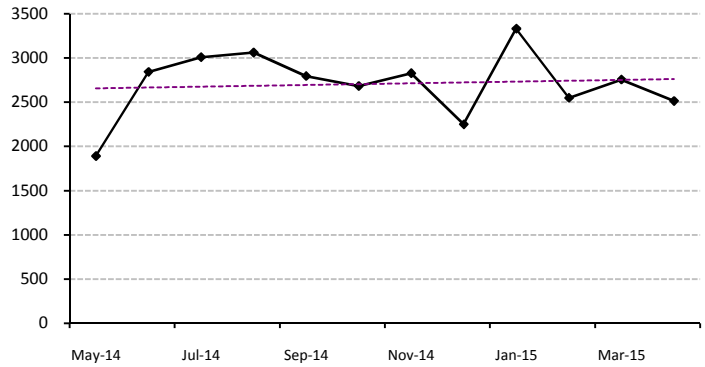
PATIENT EXPERIENCE: CONCERNS, COMPLAINTS & COMPLIMENTS

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

• Activity: Formal complaints (received) - 76; informal concerns - 81; compliments - 2513; PALS contacts - 237.

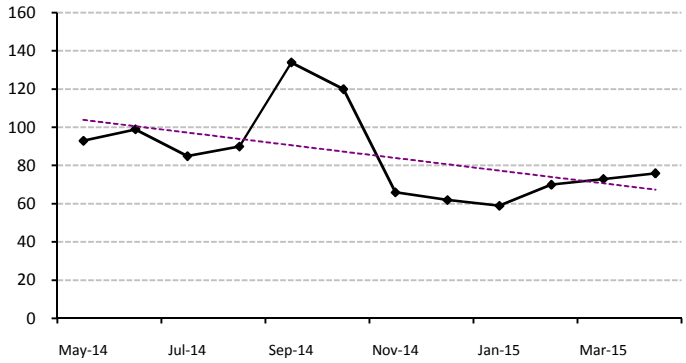
The charts below show the number of complaints and compliments received on a monthly basis. The total number of recorded episodes of care for Apr-15 was 77,518. In April, 1 formal complaint has been received for every 1019 recorded spells of care (0.09%) in comparison with March's figures where 1 formal complaint was received for every 1178 recorded spells of care (0.08%).

Number of Compliments



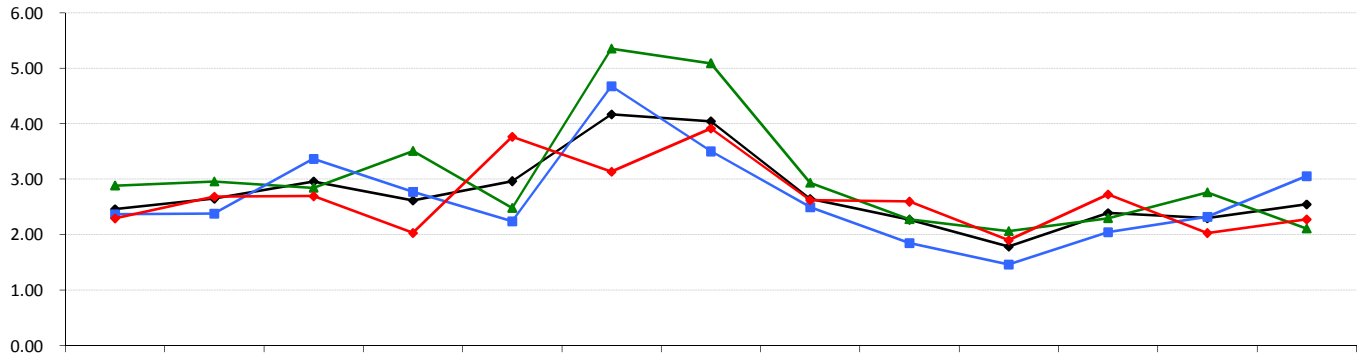
The number of compliments received has increased by 8% compared with the previous month. The ratio of compliments to formal complaints received for the month is 33:1. There has been 1 compliment being received for every 30 recorded spells of care.

Number of Formal Complaints



In Apr-15, the number of complaints received has very slightly increased by 4% compared with Mar-15 (i.e. 76 compared to 73). The number of complaints received during Apr-15 compared with Apr-14 has increased by 10% (76 compared with 69). The number of concerns has increased by 17% compared with last month (cf. 81 and 69 respectively).

Number of Formal Complaints per 1000 Bed Days



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
Trust	2.46	2.65	2.96	2.62	2.97	4.17	4.04	2.65	2.27	1.79	2.39	2.30	2.55
KCH	2.89	2.96	2.85	3.51	2.48	5.36	5.09	2.94	2.28	2.07	2.30	2.76	2.11
QEH	2.37	2.38	3.37	2.77	2.24	4.68	3.50	2.50	1.85	1.46	2.04	2.32	3.05
WHH	2.30	2.69	2.70	2.03	3.77	3.14	3.92	2.62	2.60	1.90	2.73	2.03	2.28

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. KCH is 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
April 2015

Concerns		No.
Problems with Clinical Management	Unhappy with treatment	16
	Incomplete examination carried out	5
	Scans/x-rays not taken	2
	Lack of/inappropriate pain management	1
	Inappropriate ward	1
	Referral issues	1
	End of life/palliative care issues	1
Problems with Communication	Misleading or contradictory information given	9
	Doctor communication issues	6
	Lack of information/explanation procedure outcome	5
	Nursing communication issues	4
	Other staff communication issues	2
Concerns about Clinical Management	Unexpected outcome / post op complications	10
	Difficulties during procedure	5
	Preassessment Issues	3
	Consent issues	1
Problems with Attitude	Problems with doctor's attitude	9
	Problems with nurse's attitude	8
	Problems with other staff attitude	2
Delays	Delay in referral	7
	Delays in receiving treatment	2
	Delays being seen in A&E	2
	Delays in allocation of outpatient appointment	2
	Delay with elective admission	2
	Delay in going to theatre	1
	Delay in receiving x-ray results	1

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

With regards to formal complaints, the highest recurring subjects raised in Apr-15 were concerns about clinical management, problems with communication, concerns about surgical management, problems with attitude, and delays. In comparison with Mar-15, clinical management and communication remain the top 2 subjects. Delays remain in the top 5. Problems with attitude and concerns about surgical management have replaced problems with nursing care and problems with discharge.

Concerns, Complaints and Compliments - Divisional Performance

April 2015

Division	Divisional Activity				Divisional Performance	
	Formal Complaints	Compliments	Informal Concerns	Compliments: Complaints	Response Date Agreed with Client	Returning Complaints
Clinical Support	5	52	13	10:1	2 of 2	0
Specialist Services	15	895	7	59:1	10 of 10	1
Surgical Services	33	397	25	12:1	26 of 29	11
UCLTC	23	1140	32	49:1	31of 32	5
Corporate	0	29	3	29:0	4 of 4	0
Other	0	0	1	0:0	0	0
TOTAL	**76**	**2513**	**81**	**33:1**	**73 of 77**	**17**

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

The table above shows the monthly Divisional activity and performance for Apr-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 Apr-15, the data show that 95% of responses due to be sent out the clients were on target and compared with 96% last month.
Specialist Services, Clinical Support and Corporate Divisions sent out 100% of their responses on target. The Surgical Services and UCLTC Divisions and sent out a minimum of 85% of their responses on target.
From Apr-15, the Patient Experience Team (PET) will implement a new process whereby the target response date also relates to the number of complaints responded to within 30 working days (as set out in the Trust's Complaints Policy). This is aimed at providing more meaningful data and incentivising Divisions to reduce the length of time a complaint remains open; part of the Improvement Plan. During April 48% of responses were sent out to clients within 30 working days. Clinical Support Services Division took on average 28 working days to respond, whilst the UCLTC Division took an average time of 31 working days, almost meeting the standard. The average number of working days for the Trust to deliver a first response was 41 working days.

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

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

The PHSO is the second and last stage of the National Complaints process and it is open to all clients to approach the PHSO if they are dissatisfied with the way their formal complaint has been handled. In April the PHSO has been in contact with the Trust in regards to 1 new case relating to Specialist Services (Acute Paediatrics). This complaint was not upheld.
Out of the 17 cases currently held with the PHSO, 15 are awaiting action from the PHSO rather than the Trust. One case is currently on hold pending the outcome of a RCA, and 2 cases are awaiting action from the Trust. The oldest PHSO case open with the Trust was first received from the PHSO in May-14. Action from the PHSO is awaited.

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. During April we received 12105 responses in total. This includes inpatients, A&E, maternity, outpatients, day cases and paediatrics. The total number of inpatients, including paediatrics and day cases who would recommend our services was 91.8%. For A&E it was 80.0%, maternity 96.3% and for outpatients it was 90.4%. The Trust star rating in Apr-15 equalled 4.5.

The response rate for inpatients was 37.0%, A&E 25.4%, maternity 29.8% and for outpatients 25.9%.

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 have delivered the first phase as planned by the end of March and have received the draft behavioural framework for staff, the analysis of bullying and harassment, and a report on the outcome of the diagnostics from our external partner. We are now embarking on a leadership development programme for all people managers, and divisional and senior management teams.

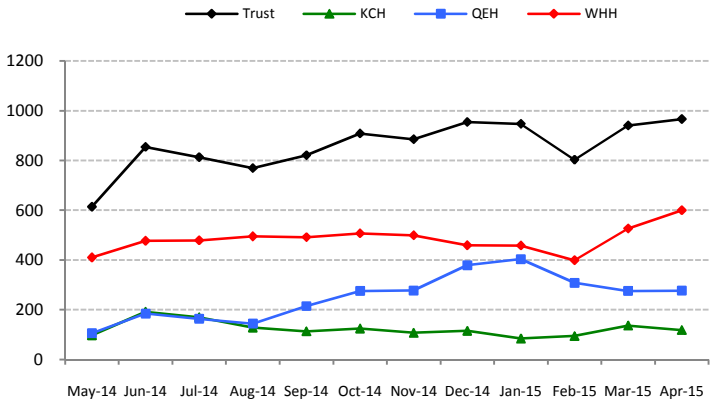
PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

Real time patient experience monitoring using iPads have captured data since 1 Apr-13. During Apr-15, 996 adult inpatients were asked about their experiences of being an inpatient; 119 responses were received from patients treated at KCH, 277 from QEH patients, and 600 responses from patients based at WHH. (Compared with the previous month the number of responses were 137, 276 and 527 respectively). The combined result from all submitted questionnaires in Apr-15 was that of 88.94% satisfaction.

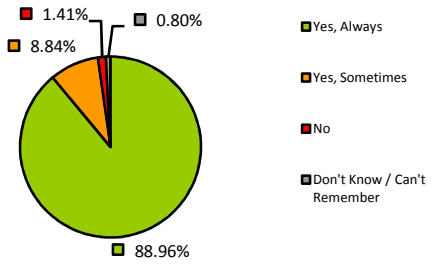
Overall Adult Inpatient Experience April 2015

Experience (%)	No. of Responses
88.94	996

Number of Adult Inpatient Survey Responses

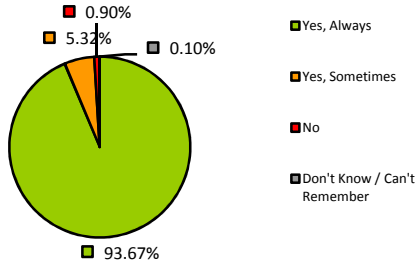


Were you given enough privacy when discussing your treatment?



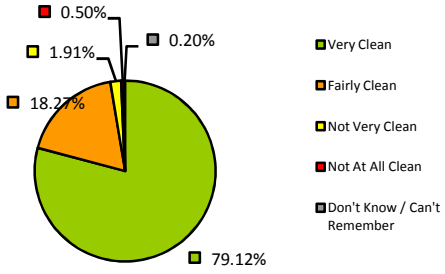
Overall Score = 94.13%

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



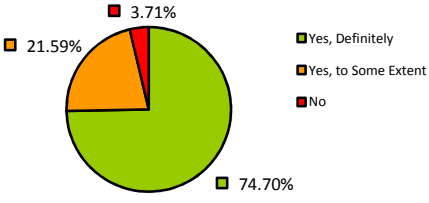
Overall Score = 96.43%

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



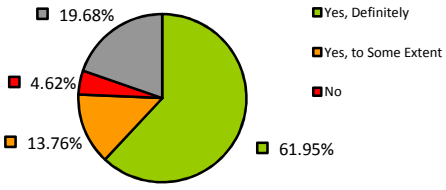
Overall Score = 92.12%

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



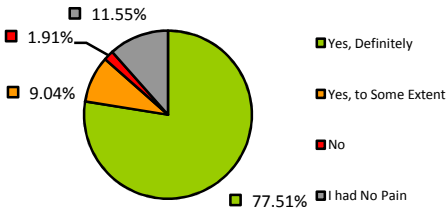
Overall Score = 85.49%

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



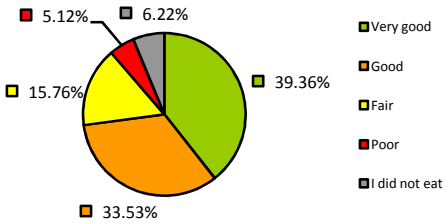
Overall Score = 85.69%

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



Overall Score = 92.74%

How would you rate the hospital food?

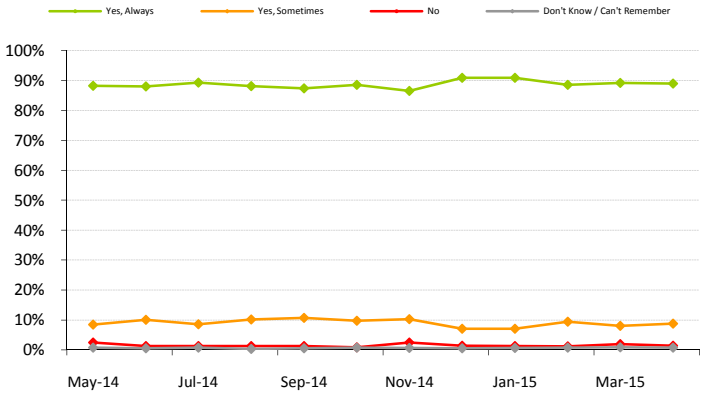


Overall Score = 71.41%

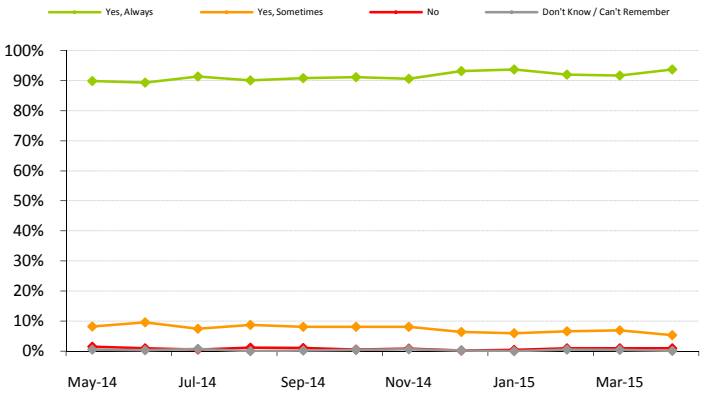
Each ward reviews their real-time monitoring data regularly. They are also shared as "heat maps" with other teams. From this actions are taken to address the themes which are considered with the Friends and Family Test feedback, and compliments and complaint information.

PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

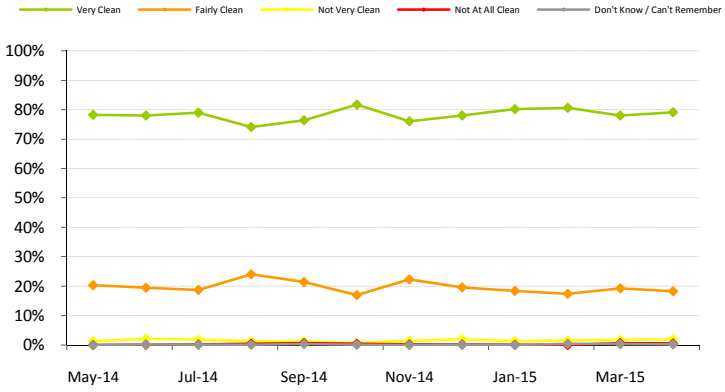
Were you given enough privacy when discussing your treatment?



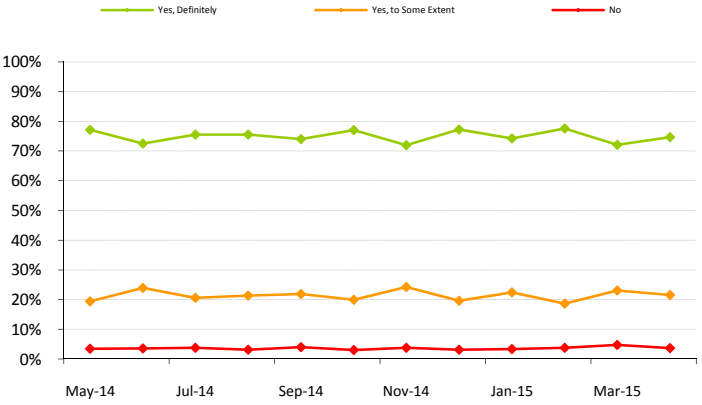
Overall, did you feel you were treated with respect and dignity while you were in hospital?



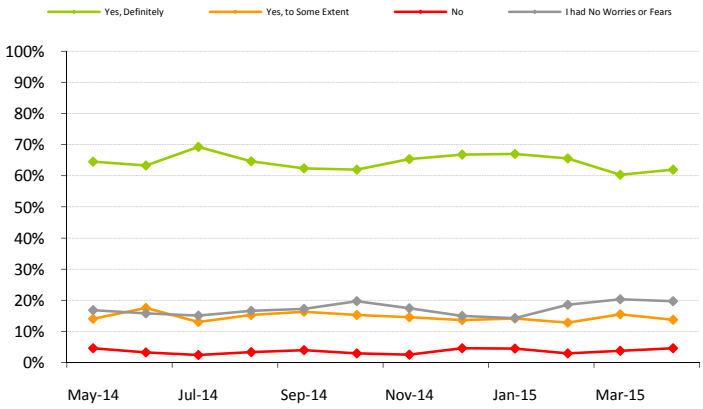
In your opinion, how clean was the hospital room or ward that you were in?



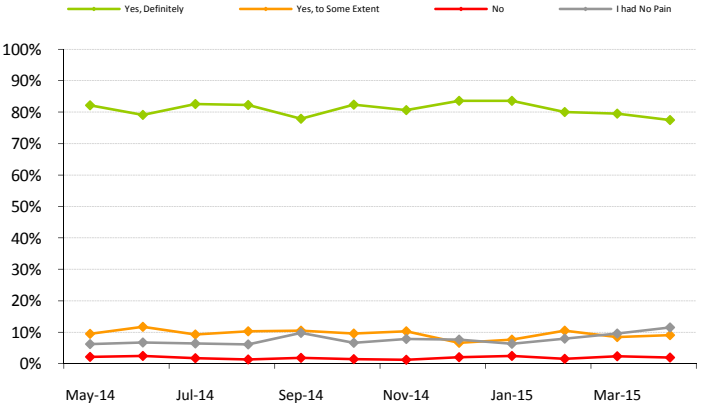
Were you involved as much as you wanted to be in the decisions about your care and treatment?



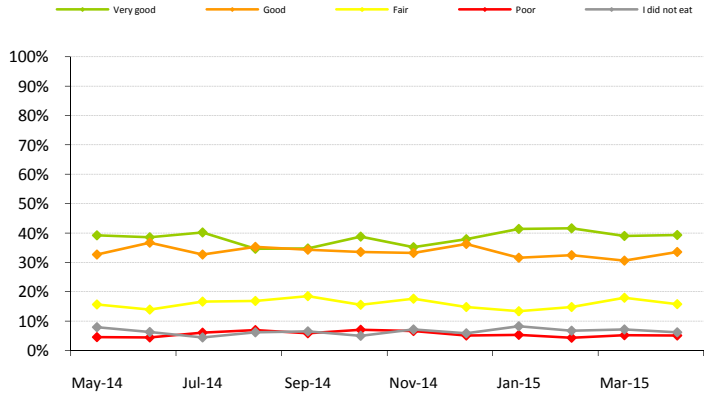
Did you find someone on the hospital staff to talk about your worries and fears?



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



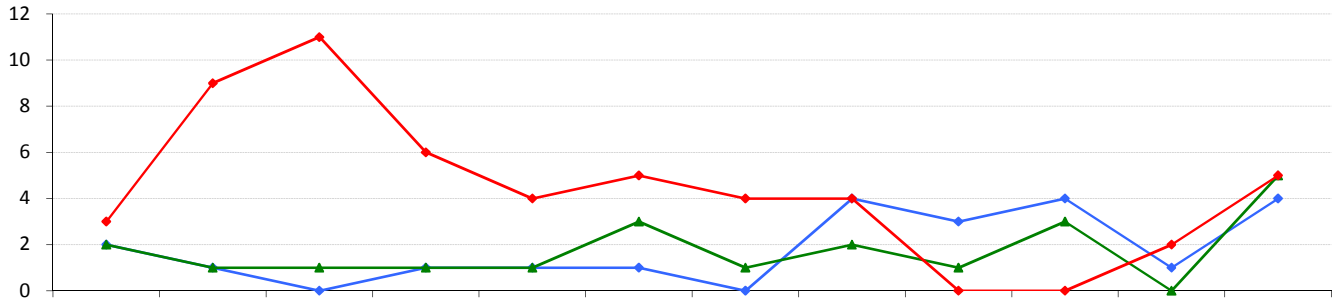
How would you rate the hospital food?



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. This month we see an improvement in patients feeling treated with dignity and respect, and feeling able to talk about their worries and fears. Hospital food and feeling involved in decisions is slightly lower this month. The remaining metrics are similar to last month.

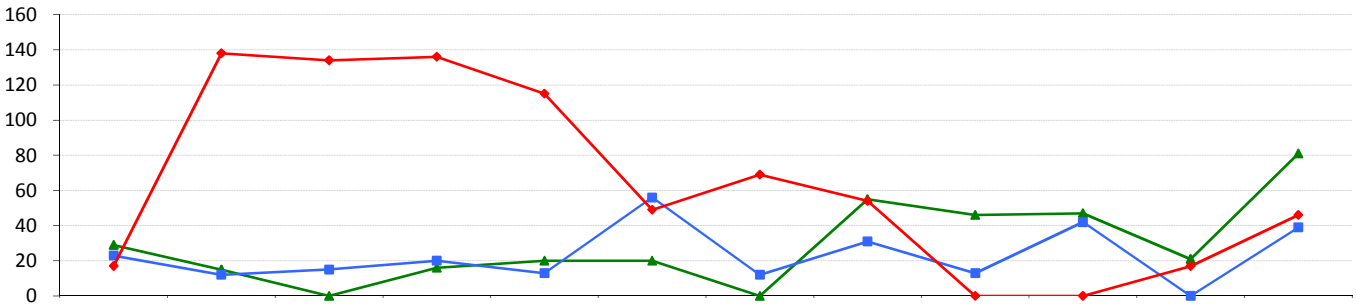
CLINICAL QUALITY & PATIENT SAFETY
PATIENT EXPERIENCE: MIXED SEX ACCOMMODATION

Number of Episodes of Mixed Sex Occurrence



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

Number of Hours of Mixed Sex Occurrence



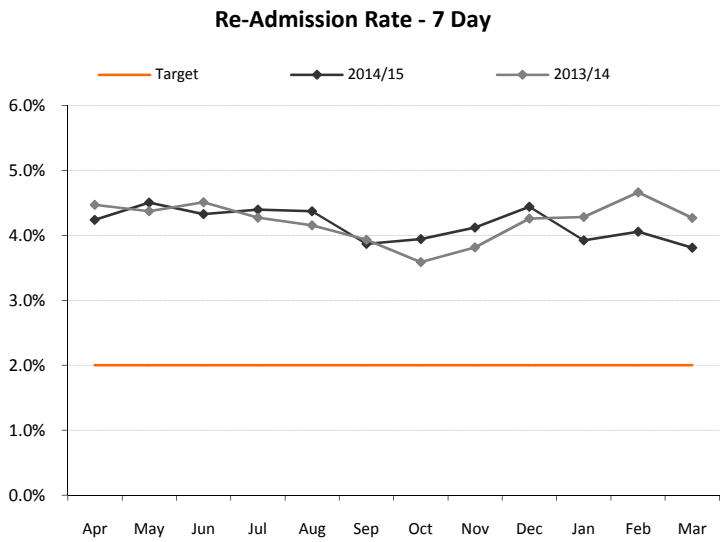
	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
KCH	29	15	0	16	20	20	0	55	46	47	21	81
QEH	23	12	15	20	13	56	12	31	13	42	0	39
WHH	17	138	134	136	115	49	69	54	0	0	17	46

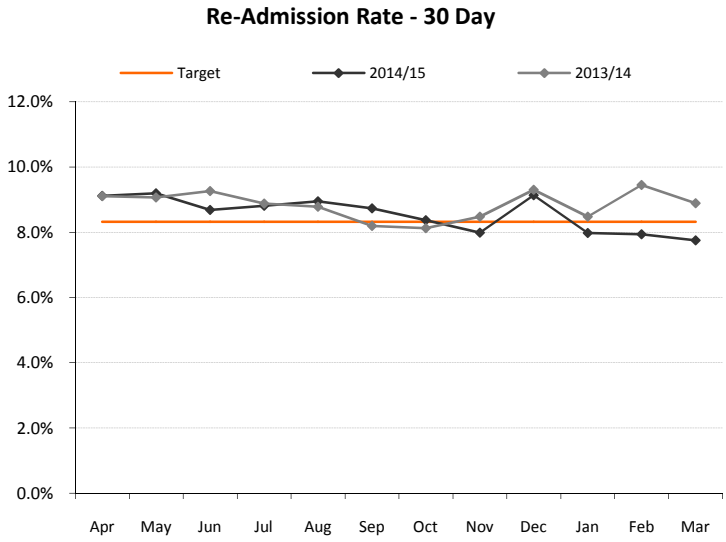
Mixed Sex Accommodation Occurrrences April 2015

Site	Clinical Area	Total No. of Occurrences	Total No. of Patients Affected
KCH	Kingston	4	16
QEH	CCU	3	11
QEH	CDU	2	8
WHH	CDU	5	36
TOTAL		**14**	**71**

During Apr-15, 7 non-justifiable incidents of mixed sex accommodation breach occurred and affected 44 patients located in the CDU, 5 episodes at WHH affecting 36 patients and 2 episodes at QEH affecting 8 patients. 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 14 mixed sex accommodation occurrences in total, affecting 71 patients. (Last month there were a total of 3 occurrences affecting 16 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 Mar-15 continue to show an improved position from the same period last year, and this position has been replicated for 3 consecutive months.

As previously stated, the Service Improvement and Innovation Team have completed an audit of inpatient records to demonstrate some of the more patient-centred reasons which drive readmissions, and these include the inconsistencies regarding the level of detail provided on discharge via the eDN. Information for patients with regards "who to contact" or "what to expect" following discharge could be improved in some areas and the various tools developed and introduced by the Service Improvement and Innovation Team (e.g. Tick It Home or the comprehensive Discharge Checklist) are not routinely used. Therefore, whilst it is encouraging that the readmission rates are continuing to reduce, there are still opportunities for improvement especially in relation to patients with more complex care needs or specific issues such as catheterisation.

NB: The eDN has recently been revised to include a mandatory field relating to the "Catheter Passport", jointly developed with Community colleagues.

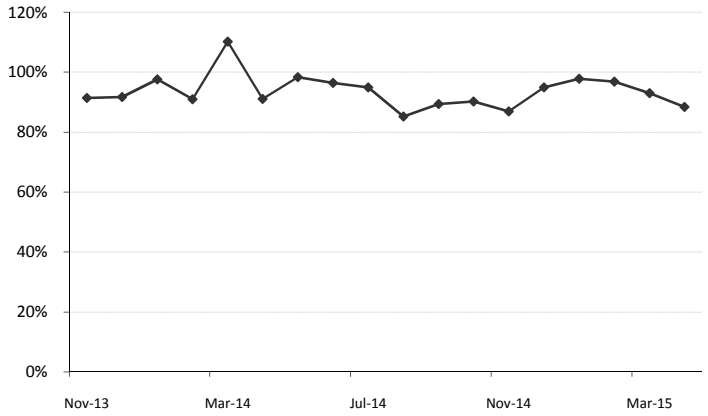
			CQUIN	2014/15 Baseline	2015/16 Target	YTD Status	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Q1	Q2	Q3	Q4	Year End Position
	National CQUINS																						
Performance	Acute Kidney Injury (AKI)	1a	Audit Established and Baseline Data Gathered	N/A	Audit established in Q1 2015/16 - TBA																		
		1b	Achieve Improvement Target for AKI Measures	N/A	Locally agreed improvement target reached - TBA																		
		1c	Achieve Improvement Target for AKI Measures	N/A	Locally agreed improvement target reached - TBA																		
		1d	Achieve Improvement Target for AKI Measures	N/A	90%																		
	Sepsis	2a	Monthly Audit of Sepsis Screening	N/A	Audit conducted - TBA																		
		2b	Performance Against Sepsis Measures	N/A	TBA																		
	Improving Diagnosis of Dementia	3a	Dementia Case Finding	N/A	TBA																		
			Dementia Assessment within 72h	N/A																			
			Appropriate Referral	N/A																			
		3b	Staff Training/Leadership	36.0%	Maintain current training levels - TBA																		
		3c	Inpatient Survey Carer Perspective	N/A																			
Commentary	Acute Kidney Injury (AKI)	1a	Audit Established and Baseline Data Gathered	The detail of this quality improvement is not yet agreed but implementation is being progressed.																			
		1b	Achieve Improvement Target for AKI Measures	The detail of this quality improvement is not yet agreed but implementation is being progressed.																			
		1c	Achieve Improvement Target for AKI Measures	The detail of this quality improvement is not yet agreed but implementation is being progressed.																			
		1d	Achieve Improvement Target for AKI Measures	The detail of this quality improvement is not yet agreed but implementation is being progressed.																			
	Sepsis	2a	Monthly Audit of Sepsis Screening	The detail of this quality improvement is not yet agreed but implementation is being led through the Sepsis Collaborative Group.																			
		2b	Performance Against Sepsis Measures	The detail of this quality improvement is not yet agreed but implementation is being led through the Sepsis Collaborative Group.																			
	Improving Diagnosis of Dementia	3a	Dementia Case Finding	This measure when agreed will be reported one month retrospectively.																			
			Dementia Assessment within 72h	This measure when agreed will be reported one month retrospectively.																			
			Appropriate Referral	This measure when agreed will be reported one month retrospectively.																			
		3b	Staff Training/Leadership	From Sep-14 reporting now includes Pharmacy and Serco staff. Maintenance of current percentage of staff trained is proposed for 2015/16.																			
		3c	Inpatient Survey Carer Perspective	The ability to survey carers of dementia sufferers via the Meridian web based system was launched (paper based) in Oct-14 and will continue in 2015/16																			

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

	Local CQUIN			2014/15 Baseline	2015/16 Target	YTD Status	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Q1	Q2	Q3	Q4	Year End Position
Performance	COPD	4a	Establish Baseline Performance EQ Data and Implementation Integrated Pathway	N/A	Establish baseline performance EQ data and implement integrated pathway																		
		4b	Agree methodology of audit of implemented pathway	N/A	Agree audit criteria, methodology and sample size with commissioning lead and authorised by chief nurse first quarter following go live of new pathway																		
		4c	Conduct Audit of Implemented Pathway	N/A	Produce audit report and associated action plan																		
		4d	EQ Measures	Q1 2015/16 - TBA	Achieve COPD Appropriate Care Score (ACS) target set by EQ team - TBA																		
	Diabetes	5a	Audit of Implementation of Integrated Care Pathway	N/A	Audit report Q3 2015/16																		
		5b	Audit of Implementation of Integrated Care Pathway		Audit report Q4 2015/16																		
	Heart Failure	6a	Training	N/A	Train Heart Failure Nurses on new integrated care pathway																		
		6b	EQ measures	Q1 2015/16 - TBA	Publish HF pathway ACS																		
		6c	EQ measures	Q1 2015/16 - TBA	Achieve Heart Failure Pathway ACS target published by Central EQ Team																		
		6d	EQ measures	N/A	Achieve Heart Failure Pathway ACS target published by Central EQ Team																		
	Over 75 Frailty Pathway	7a	Business Case and Pathway Implementation	N/A	Contribute to business case and implement pathway																		
		7b	Audit of Pathway	N/A	Conduct sample audits																		
Commentary	COPD	4a	Establish Baseline Performance EQ Data and Implementation Integrated Pathway	A collaborative COPD Task and Finish Group has come to a close. Discussions are due to take place with the CCGs to understand the plan to agree the integrated pathway. Internal meetings are in place. Rapid progress on the pathway development is needed.																			
		4b	Agree methodology of audit of implemented pathway	The audit of the proposed pathway has yet to be agreed with CCGs.																			
		4c	Conduct Audit of Implemented Pathway	The audit of the proposed pathway has yet to be agreed with CCGs.																			
		4d	EQ Measures	Appropriate Care Score EQ measure target will be implemented in 2015/16. The target has yet to be confirmed with central EQ Team and CCGs.																			
	Diabetes	5a	Audit of Implementation of Integrated Care Pathway	A CCG led project group has been developing an Integrated Diabetes Pathway. A mobilisation group is in place to lead the pilot and subsequent implementation of the new pathway. This group commenced in Feb-15.																			
		5b	Audit of Implementation of Integrated Care Pathway	The audit of the proposed pathway has yet to be agreed with CCGs																			
	Heart Failure	6a	Training	A collaborative Cardiology Task and Finish Group is in place and meet regularly. The integrated pathway will be agreed through this group in Q1 2015/16.																			
		6b	EQ measures	Appropriate Care Score EQ measure will continue into 2015/16. The target has yet to be confirmed with central EQ Team and CCG.																			
		6c	EQ measures	Appropriate Care Score EQ measure will continue into 2015/16. The target has yet to be confirmed with central EQ Team and CCG.																			
		6d	EQ measures	Appropriate Care Score EQ measure will continue into 2015/16. The target has yet to be confirmed with central EQ Team and CCG.																			
	Over 75 Frailty Pathway	7a	Business Case and Pathway Implementation	A CCG working group is leading the development and agreement of a business case which will be finalised on 18 May-15 and agreed through the Whole Systems Delivery Board on 22 Jun-15.																			
		7b	Audit of Pathway	The audit of the proposed pathway has yet to be agreed with CCGs.																			

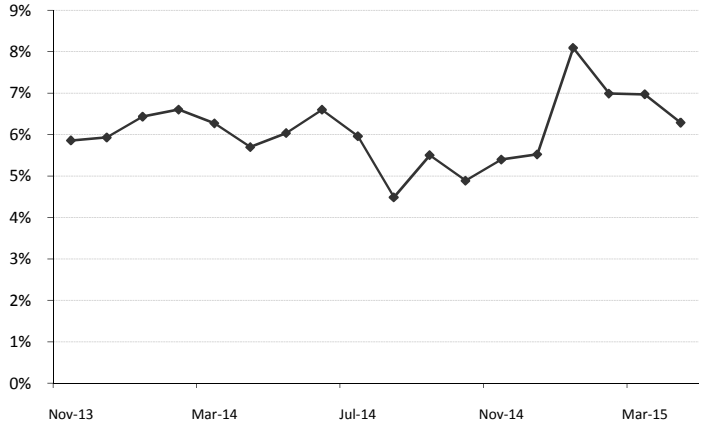
Compliance Against Performance	
	On target
	Monthly target missed; quarterly/annual target at risk
	Monthly target missed; annual target at risk

Bed Occupancy



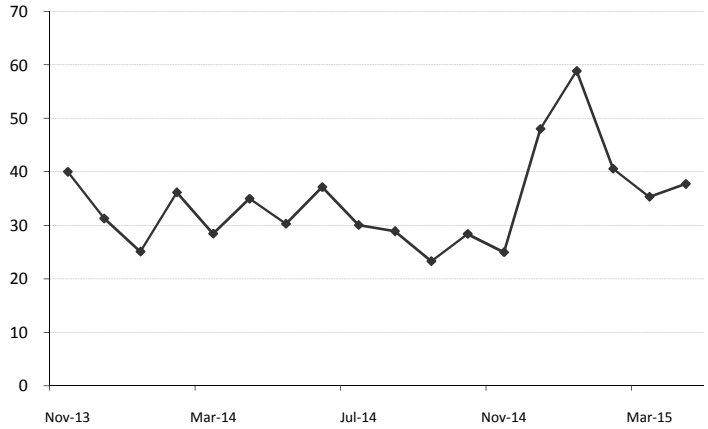
The bed occupancy metric looks only at adult inpatient beds and excludes any ring fenced wards such as Maternity. Occupancy levels peaked in Mar-14 at 110.2%, thereafter fluctuating between 85.2% and 98.3% between Apr-14 and Apr-15. The position in Apr-15 (i.e. 88.3%) demonstrated a reduction in bed use for the third consecutive month.
NB: Data are sourced from the Trust's Balanced Scorecard as of 7 May-15.

Extra Beds



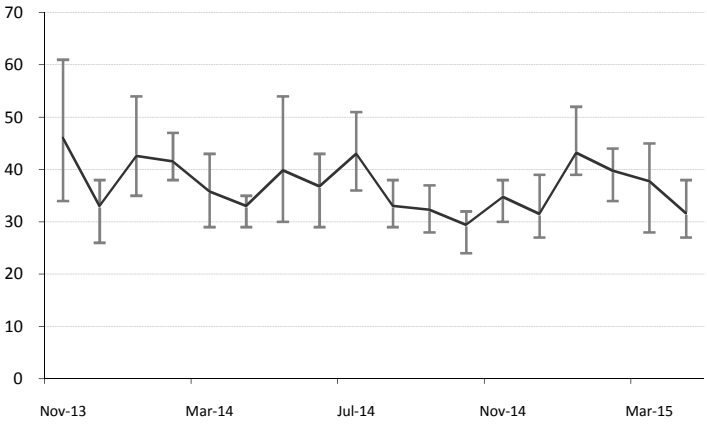
This metric is built up using the number of funded beds on each ward and reviewing those occupied on a daily basis. Where the number of occupied beds exceeds the funded bed base for the ward these are classified as "extra". In Apr-15 the degree of extra beds used within the Trust equalled 6.29%, approximating the position reported in Mar-15 (i.e. 6.97%), and is higher than the value recorded in Apr-14 (cf. 5.70%). 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 Apr-15 appears to be reducing in line with expected seasonal demand.

Outliers



The outliers data show the average number of patients bedded in a ward outside of the relevant Division over a given month. In Jan-15 a marked increase was evident over the Dec-14 position given that the outlier value equalled 58.87, that is, more than 2 fold higher than the value recorded in Jan-14 (25.06) and as such represented the highest level reported in at least 18 months. This trend was in line with the number of extra beds used in month, for although Trust activity in Jan-15 matched the expected seasonal level, the difficulty in discharging patients throughout the early part of the month resulted in a high level of operational pressure on beds. The outlier position in April equalled 37.73, which is slightly greater than the values recorded in Mar

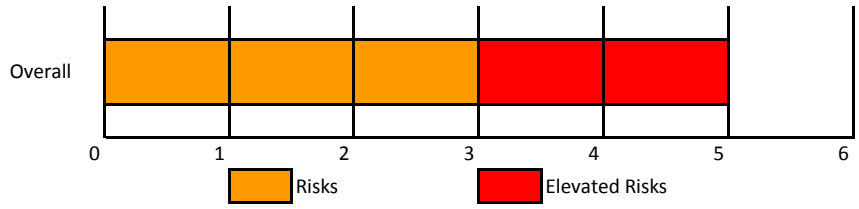
Average Delayed Transfers of Care



In Jan-15, the average number of patients on the Delayed Transfers of Care (DToC) list increased resulting in a position of 43.20 against 31.50 in December, and was driven by the difficulty in discharging long stay patients admitted over the Holiday period. However, this value returned to expected levels in Feb-15, that is, 39.75, and decreased further in April to a position of 31.60. This compares with a value of 33.00 reported in Apr-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. The draft report for May-15 has been released and will be reported on next month. The staff survey is flagging as elevated risks.
In the meantime, 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 monthly progress reports continue to be submitted to NHS Choices and have 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 – April 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 2014. 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 April are almost 97% at QEQM, 96% at WHH and almost 95% across K&C, shown in Figure 1.

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

	% Hours filled - planned against actual April 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	88.0%	94.1%	99.0%	116.9%	94.85
Queen Elizabeth the Queen Mother	89.8%	103.5%	99.7%	103.7%	96.89
William Harvey	92.2%	99.4%	95.1%	107.0%	96.12

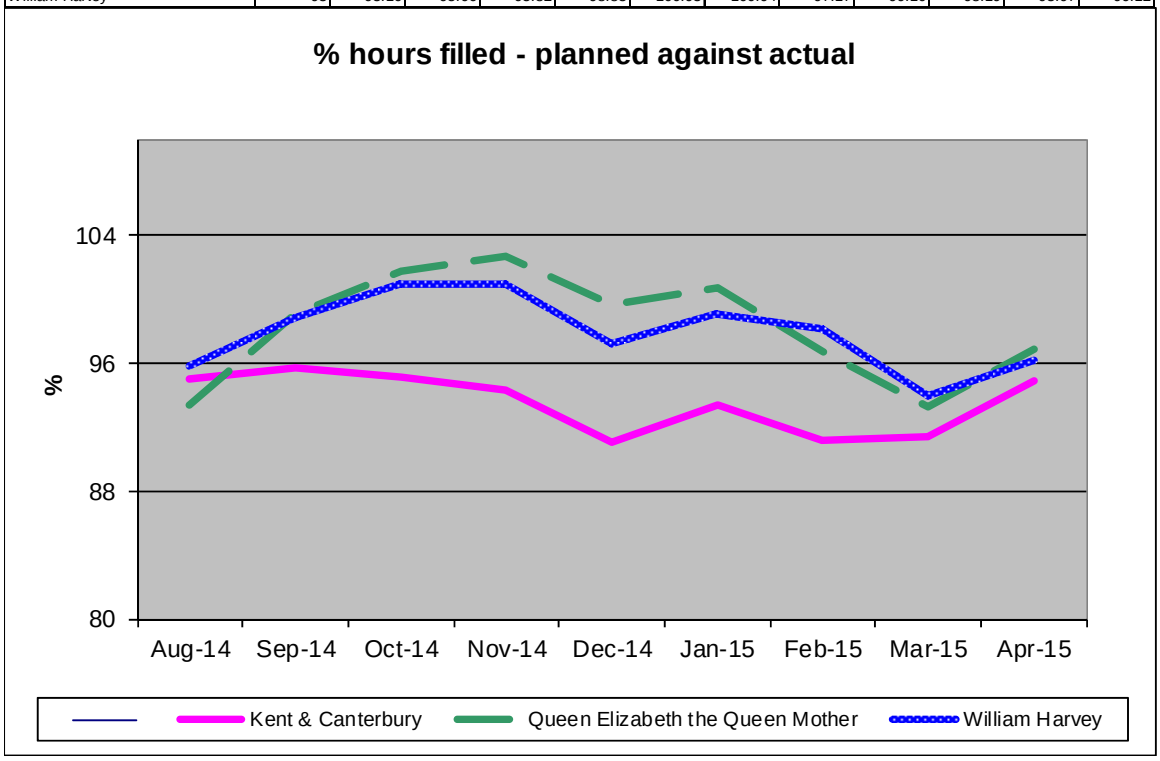
It should be possible to fill 100% of hours if:

- 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 from December to March reflect the requirement for additional shifts during winter pressures not always being filled by NHSP. The reduction in March also 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	Apr-15
Kent & Canterbury	92	91.08	93.05	94.97	95.65	95.14	94.31	91.09	93.40	91.15	91.44	94.85
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	96.89
William Harvey	93	93.16	95.66	95.82	98.83	100.93	100.94	97.17	99.10	98.19	93.97	96.12



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 April 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. FFT results were not available at the of reporting.
Data validation and sign-off steps have been implemented and the data will be reported externally via Unify/NHS Choices on 15th May. 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 April 2015

Division / Ward						Quality Indicators April 2015		
Urgent Care & LongTerm Conditions	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Comments	Harm Free Care (%) - New Harms	All Falls	All Pressure Ulcers
Cambridge J	99.26	147.46	92.07	155.16		97.1	5	1
Cambridge K	93.40	96.49	100.43	88.62		100	3	1
Cambridge M2	99.97	102.98	100.01	102.55		100	2	4
Coronary Care Unit (K&C)	69.01	N/A	100.22	N/A	RN 2.42 wte vacancy	100	2	0
Coronary Care Unit (QEQMH)	85.80	72.99	100.00	100.50	HCA 11%sickness	100	1	0
Coronary Care Unit (WHH)	92.82	120.00	92.95	73.33	Only 4 wte in establishment	100	0	1
Minster	70.48	89.77	100.49	93.33	RN 5% sick and 6% parenting leave	100	0	0
Oxford	104.91	104.93	84.06	113.48		100	13	1
Sandwich Bay	98.23	164.30	100.53	174.92		95.2	8	3
St Margarets	103.95	86.72	108.37	103.15		100	0	0
Deal	102.26	105.25	94.08	117.92		96.4	8	0
Harvey	69.15	90.53	93.33	173.91	RN 13% sickness	100	2	0
Invicta	104.43	93.76	101.67	151.53		100	2	0
Cambridge L	55.40	129.26	95.00	163.53	RN 9% sickness	96.2	7	1
Treble	79.19	82.76	103.33	155.07	RN 8% sickness	100	2	0
Mount/McMaster	95.11	77.15	98.40	168.89	HCA 13% sickness	100	1	1
Fordwich Stroke Unit	93.01	128.88	90.61	100.00		90.9	5	2
Kingston Stroke Unit	82.82	141.09	101.79	103.48		100	9	0
Richard Stevens Stroke Unit	68.09	45.95	85.65	122.68	RN 3.0 wte vacancy, HCA 11% sickness, 12% parenting	87.5	7	4
Harbledown	93.47	95.46	100.28	94.51		100	6	0
QE CDU	81.95	113.04	105.89	136.22		100	8	13
WH CDU/Bethersden	114.14	104.47	122.65	99.40		95.8	0	0
Surgical Services								
Rotary Suite	97.47	93.68	88.33	93.51		100	0	0
Cheerful Sparrows Female	99.56	112.30	98.37	95.64		100	1	0
Clarke	82.66	108.93	101.31	98.37		100	3	4
Cheerful Sparrows Male	70.74	117.76	119.89	98.48	RN 1.7 wte vacancy, 27% parenting	100	3	7
Kent	87.00	101.74	96.59	88.24		100	0	4
Kings B Ward - WHH	104.58	99.77	107.39	154.44		100	3	0
Kings A2	111.99	109.48	97.25	130.72		95	0	2
Kings C1	80.88	140.86	100.00	98.30		95.7	2	2
Kings C2	71.47	104.68	95.29	96.52	RN 3.48 wte vacancy	100	3	1
Kings D Female	91.28	117.05	94.55	119.23		100	4	3
Kings D Male						95.8	7	3
Quex	71.54	181.66	98.50	100.00	RN 1.2 wte vacancy, 7% sickness	100	1	0
Bishopstone - split	91.37	106.16	111.02	104.43		100	1	3
Seabathing -split						100	1	4
Critical Care - WHH -	113.38	85.93	107.70	65.79	HCA 2.9 wte vacancy	100	0	2
Critical Care - KCH	104.64	129.19	99.60	N/A		100	0	2
Critical Care - QMH	77.46	38.30	95.54	N/A	RN 11% sickness, HCA 39% (2 wte in establishment)	100	1	2
Specialist Services								
KC Marlowe Ward	91.33	80.39	92.75	90.73		100	3	2
WH NICU	91.64	143.88	80.24	N/A		100	0	0
WH Padua Ward	92.60	87.42	99.96	80.00		100	0	0
QE Rainbow Ward	96.03	73.10	98.38	N/A	HCA 1.4 wte vacancy	100	0	0
QE Birchington Ward	81.25	116.61	99.77	97.05		100	1	0
WH Kennington Ward	114.59	96.06	83.13	N/A		100	0	0
KC Brabourne Haematology Ward	79.49	78.13	102.02	N/A	RN 15% parenting, HCA parenting 17%	100	0	0
WH Maternity Labour and Folkestone+	94.92	79.67	101.38	61.50	MCA vacancies	100	0	0
MLU WHH	96.87	70.61	99.35	56.38	MCA 35% sickness	na	0	0
QE Maternity Wards + MCA	99.62	90.04	85.30	94.44		100	0	0
QE MLU	109.81	98.44	183.70	100.37		na	0	0
QE SCBU	93.88	90.91	100.29	N/A		100	0	0