CLINICAL QUALITY & PATIENT SAFETY PERFORMANCE SUMMARY

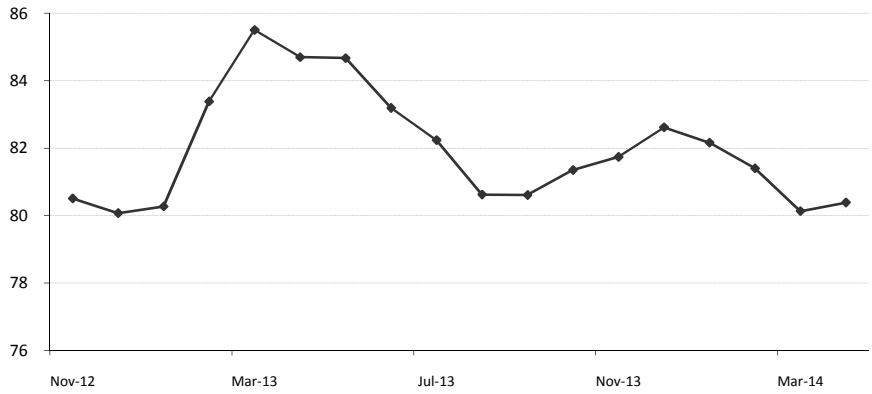
Introduction

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

	Measure	Improvement Metric		Target 14/15	Apr-14	Apr-13	vs Apr-13	YTD
Patient Safety	Mortality Rates	HSMR		-	80.4	84.7	↓	80.4
					Q2 13/14	Q2 12/13	vs Q2 12/13	YTD
		SHMI (%)		-	86.32%	88.78%	↓	-
					May-14	May-13	vs May-13	YTD
		Crude Mortality: All Ages (Per 1 000)	Non-Elective	-	26.277	32.335	↓	28.599
			Elective	-	0.118	0.234	↓	0.231
	Risk Management	Serious Incidents (STEIS)	New Incidents	-	8	1	↑	-
			Open Incidents	-	47	32	↑	Cumul.
	HCAI	MRSA	Attributable	5	0	1	↓	Cumul.
		C. difficile	Post 72h	47	7	13	↓	Cumul.
	Infection Prevention	Mandatory Training Compliance (%)		95.0%	83.2%	87.7%	↓	82.9%
	Harm Free Care (HFC)	Safety Thermometer HFC (%) - Old & New Harm	EKHUFT	93.0%	93.5%	90.2%	↑	93.7%
			National	-	93.5%	92.4%	↑	-
	Nurse Sensitive Indicators	Pressure Ulcers: Category 2,3 and 4	Acquired	-	19	22	↓	35
			Avoidable	99	9	10	↓	16
		Falls		-	171	156	↑	329
	Clinical Incidents	Total Clinical Incidents		-	1074	1044	↑	2070
Patient Experience	Compliments and Complaints	Compliments:Complaints		-	20:1	20:1	↔	-
		No. Care Spells per Formal Complaint		-	864	1268	↓	-
	Experience	Friends and Family Test (Star Rating)		5.0	4.4	4.5	↓	-
		Adult Inpatient Experience (%)		80.00%	88.92%	88.31%	↑	-
		Mixed Sex Accommodation Occurrences		-	7	5	↑	15
Clinical Effectiveness	Readmission Rate				Mar-14	Mar-13	vs Mar-13	YTD
		7 Day (%)		2.00%	4.19%	4.57%	↓	4.21%
		30 Day (%)		8.32%	8.09%	9.26%	↓	8.91%
	CQUIN				May-14	May-13	vs May-13	YTD
		Standard Contract CQUIN		Multiple			↔	
		Specialist CQUIN		Multiple			↔	
	Bed Usage	Bed Occupancy (%)		-	96.21%	90.56%	↑	92.70%
		Extra Beds (%)		-	5.57%	5.77%	↓	5.49%
		Outliers		-	20.81	34.26	↓	45.87
		Delayed Transfers of Care (Average)		-	39.80	37.20	↑	36.40
Care Quality Commission	Intelligent Monitoring Report	Outcome Measures	Risks	-	4			-
			Elevated Risks	-	1			-

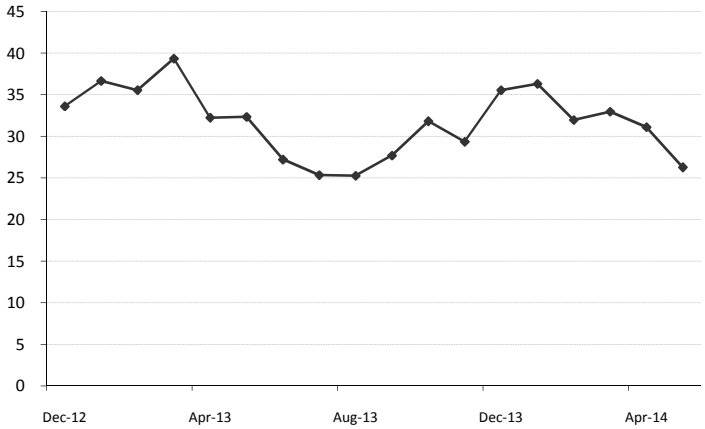
CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: MORTALITY RATES

Hospital Standardised Mortality Ratio (HSMR) - All Discharges



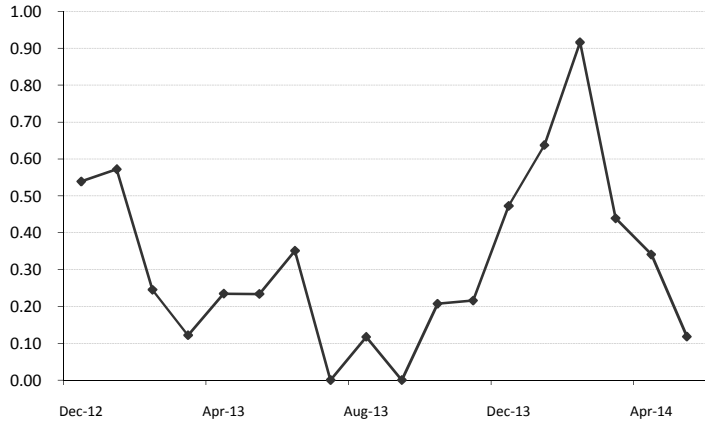
Performance at Trust level remains good across all mortality indicators with the 12 month rolling HSMR equalling 80.4 at the end of Apr-14 (that is, showing a 0.3 increase against March), and is in line with the trend demonstrated by the crude mortality metric. This also is a reflection of seasonal fluctuations, although it is hoped rates will be more consistent during Q4.

Crude Mortality - Non-Elective per 1 000



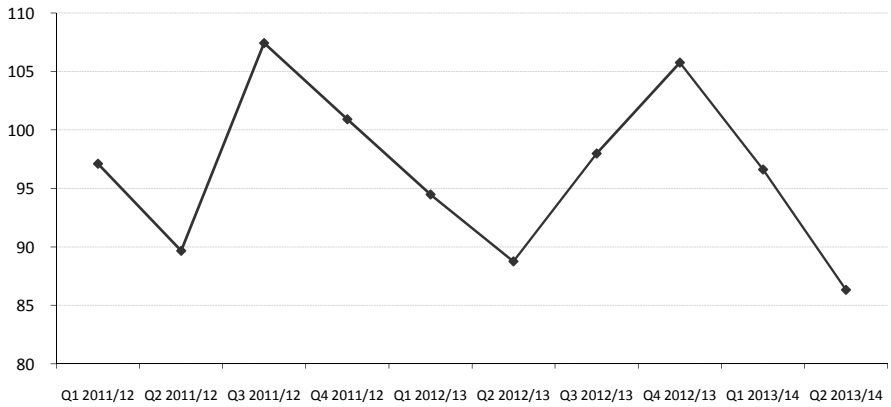
Crude mortality for non-elective patients shows a fairly seasonal trend with deaths higher during the winter months. The winter peak during 2012/13 extended further into the spring than normal, with a reduction to expected levels occurring in June rather than in April/May. Following this trend, May-14 performance equalled 26.277 deaths per 1 000 population, which again shows an improved position against both the last quarter and last month (at 31.093).

Crude Mortality - Elective per 1 000



During February elective crude mortality was 0.916 deaths per 1 000 population, which dropped back to expected levels seen in March at a rate of 0.439. April's position stabilises this position once more, achieving 0.341 and again in May, achieving 0.118. As predicted it is expected that the levels will reduce to those seen pre Nov-13 and follow seasonal trends.

Summary Hospital Mortality Indicator (SHMI)



The Summary Hospital Mortality Indicator (SHMI) includes "in hospital" and "out of hospital" deaths within 30 days of discharge. These data are supplied by an external party and are updated on a quarterly basis. During the latter part of 2011/12 SHMI for EKHUFT was higher than other mortality indicators at over 100. Improvements have been made over the last year. Data for Q2 2013/14 data has now been published and shows a decrease on Q1, achieving 86.32% which demonstrates an improvement against previous quarters and is in line with the achievement of the other metrics.

Serious Incidents - Open Cases

Date		Summary of Serious Incident & Remedial Action Taken	IX lv	Division	Timely Submit?
Incident	STEIS Report				
19-May-14	21-May-14	Unexpected Admission - NICU	2	Specialist	72h Report Sent
7-Mar-14	13-May-14	Unexpected Death - endoscopic bleed	1	UCLTC	Not Due
8-Mar-14	13-May-14	Missed Diagnosis - meningitis	2	UCLTC	72h Report Sent
10-Mar-14	13-May-14	Unexpected Admission - term baby to NICU	2	Specialist	Not Due
11-May-14	12-May-14	Suboptimal care of the deteriorating patient	1	UCLTC	Not Due
5-May-14	9-May-14	Unexpected Admission - NICU	2	Specialist	80.3875269
6-May-14	8-May-14	Unexpected Death - displacement of tracheostomy tube	1	UCLTC	Not Due
31-Mar-14	1-May-14	Serious Injury - upper limb infarction following cannulation	1	UCLTC	Not Due
28-Apr-14	29-Apr-14	Surgical Error - locum surgeon	1	Surgical	Not Due
27-Mar-14	28-Apr-14	Category 4 hospital acquired pressure ulcer (avoidable)	1	UCLTC	Not Due
13-Jan-14	24-Apr-14	Category 3 hospital acquired pressure ulcer (avoidable)	1	UCLTC	Not Due
17-Mar-14	24-Apr-14	Category 3 hospital acquired pressure ulcer (avoidable)	1	Surgical	Not Due
16-Apr-14	22-Apr-14	Unexpected Admission - NICU	2	Specialist	72h Report Sent
18-Mar-14	11-Apr-14	Unexpected Death - transfer/missed diagnosis	1	UCLTC	Not Due
7-Apr-14	11-Apr-14	Category 3 hospital acquired pressure ulcer (avoidable)	1	UCLTC	Not Due
5-Apr-14	10-Apr-14	Unexpected Admission - NICU	2	Specialist	72h Report Sent
8-Apr-14	10-Apr-14	Unexpected Death - post debridement	1	Surgical & UCLTC	Not Due
3-Apr-14	3-Apr-14	Never Event - retained vaginal swab post delivery	2	Specialist	72h Report Sent
3-Apr-14	3-Apr-14	Intrapartum Death - placental abruption	2	Specialist	72h Report Sent
10-Mar-14	24-Mar-14	Suboptimal care of the deteriorating patient	1	Surgical	Extension
7-Mar-14	20-Mar-14	Unexpected Death	1	UCLTC	Extension
19-Mar-14	20-Mar-14	Neonatal Death - home birth	2	Specialist	72h Report Sent
27-Jan-14	19-Mar-14	Category 4 hospital acquired pressure ulcer (avoidable)	1	Surgical	Yes
1-Mar-14	19-Mar-14	Category 3 hospital acquired pressure ulcer (avoidable)	1	UCLTC	Yes
19-Feb-14	13-Mar-14	Unexpected Death - pericardial effusion	1	UCLTC	No
1-Mar-14	10-Mar-14	Never Event - wrong site pleural aspiration	2	UCLTC	72h Report Sent
28-Feb-14	3-Mar-14	Medication Administration Error - administered via wrong route	1	Surgical	Yes
9-Jan-14	25-Feb-14	Unexpected Death - venous thomboembolism at 6 weeks postoperative		Surgical	Yes
19-Feb-14	25-Feb-14	Neonatal Death - at 24 weeks		Specialist	Yes
10-Dec-13	5-Feb-14	Unexpected Death - retroperitoneal haematoma	1	Surgical & UCLTC	Yes
18-Jan-14	24-Jan-14	Unexpected Death - sepsis	1	UCLTC	Yes
24-Jan-14	24-Jan-14	Neonatal Death - unexpected breach delivery at home, taken to QEH	2	Specialist	Yes
12-Dec-13	19-Dec-13	Unexpected Death - epileptic patient with ischaemic bowel		UCLTC	No
11-Oct-13	30-Oct-13	Allegation against a member of staff	1	UCLTC	Not Due
Aug-13	14-Aug-13	Media Interest - delayed implementation of PACS/RIS replacement resulting in a backlog of patient bookings across all modalities	0	Clinical Support	Not Due
22-Jan-13	24-Jan-13	Never Event - wrong site surgery: pleural aspiration	2	UCLTC	Yes
7-Jan-13	11-Jan-13	Never Event - wrong site surgery: Ophthalmology	2	Surgical	Yes
3-Jan-13	8-Jan-13	Neonatal Death - term baby	2	Specialist	Yes
8-Aug-11	13-Sep-12	Media Interest - re: DNR and patient with learning disabilities	1	Corporate	Yes

Serious Incidents - Partially Closed Cases

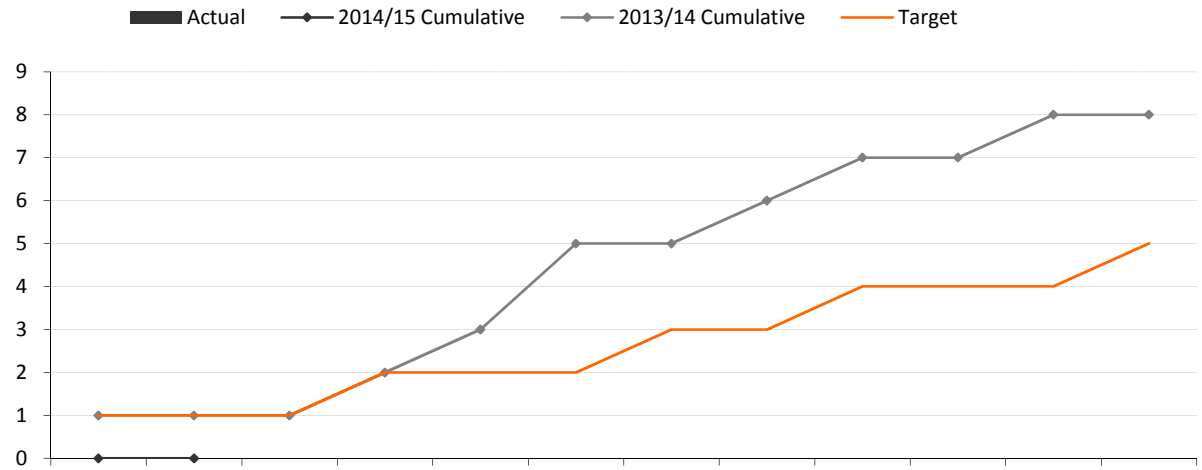
Serious Incidents closed by KMCS but remaining open on STEIS pending review by external bodies.

Date		Summary of Serious Incident & Remedial Action Taken	IX lv	Division
Incident	STEIS Report			
6-Nov-13	11-Nov-13	Never Event - misplaced nasogastric tube	2	UCLTC
2-Jun-13	17-Oct-13	Never Event - retained swab post caesarean section	2	Specialist
17-Jun-13	27-Jun-13	Screening Issue - diabetes eye screening programme and Hospital Eye Services (HES)	1	UCLTC
21-May-13	21-Jun-13	Induction of Labour - term baby developed seizures at 36h	2	Specialist
22-Mar-13	9-Apr-13	Unexpected Death - adult with small bowel obstruction	1	Surgical
27-Feb-13	1-Mar-13	Maternal Death - 6 days postpartum	1	Specialist
22-Nov-12	22-Nov-12	Unexpected Admission - NICU		Specialist
4-Sep-12	13-Sep-12	Neonatal Death - following shoulder dystocia	1	Specialist

Eight serious incidents were reported on STEIS during May-14. These were: 3 unexpected admissions to NICU, 2 unexpected deaths (a displaced tracheostomy and a bleed post endoscopy), 1 suboptimal care of a deteriorating patient, 1 serious incident (an outpatient with a missed case of meningitis), and 1 serious incident (an inpatient with a limb infarct). The Trust has had 6 notifications of closure from the CCGs, 1 of which remains open on STEIS pending Area Team review. The Root Cause Analysis (RCA) reports have been presented to the Risk Management Governance Group by the Divisions responsible. These included the findings of the investigation and action plans to take forward recommendations, including mechanisms for monitoring and sharing learning. At the end of May-14 there were 47 serious incidents open on STEIS.

CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: HOSPITAL ACQUIRED INFECTIONS

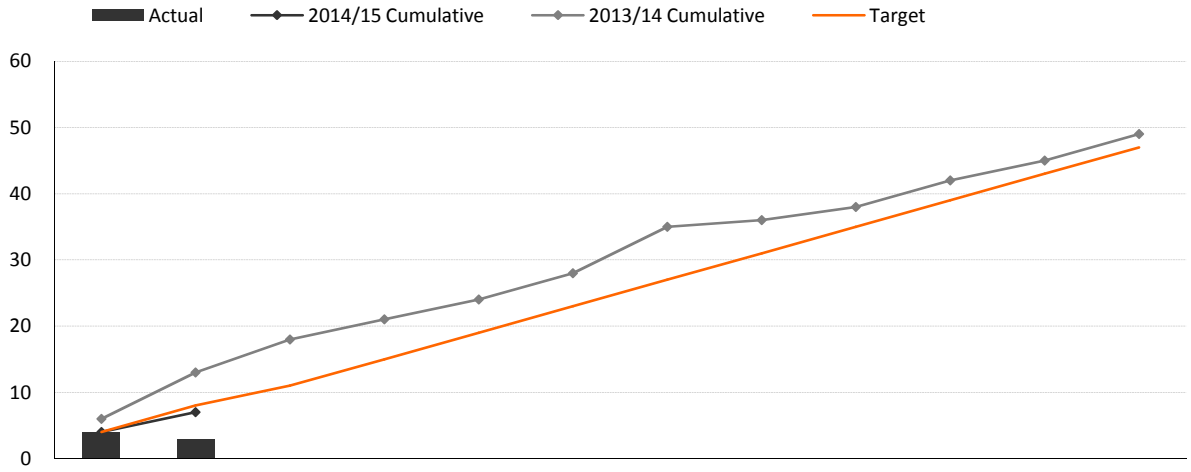
MRSA Bacteraemia - Trust Assigned Cases



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual	0	0										
2014/15 Cumulative	0	0										
2013/14 Cumulative	1	1	1	2	3	5	5	6	7	7	8	8
Target	1	1	1	2	2	2	3	3	4	4	4	5

There was 1 MRSA bacteraemia in May, provisionally assigned to the CCG. The Post infection Review (PIR) held on the 12 Jun-14 determined that the case should be referred to the PHE HCAI Team for arbitration as it is an “intractable infection” (as per revised NHS England guidance).

Clostridium difficile - Incidents Post 72h



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual	4	3										
2014/15 Cumulative	4	7										
2013/14 Cumulative	6	13	18	21	24	28	35	36	38	42	45	49
Target	4	8	11	15	19	23	27	31	35	39	43	47

There were 3 post 72h C. difficile cases in May-14, against a trajectory of 4 for the month. The year to date total for April-May was seven cases against a trajectory of 8. Two of the 3 cases in May appear to be associated with Minster Ward. A Period of Increased Incidence meeting is arranged for the 16 Jun-14 to establish the facts. The ward has been under "Special Measures" for Infection Prevention and Control since February due to increased incidences of ward acquired MRSA colonisation and failing to meet the required environmental and clinical practice standards when audited. Since these cases have occurred, the ward has been supported daily by the IPC Specialist Nurses to monitor practice and support the improvement in compliance with Infection control standards.
Decisions with regard to whether there were "lapses of care" described in the Clostridium difficile infection objectives for NHS organisations in 2014/15, and guidance on sanction implementation will be made when the precise definitions for "lapses of care" have been agreed, Kent wide, with the Commissioners. This is currently being discussed.

PATIENT SAFETY: HOSPITAL ACQUIRED INFECTIONS

Escherichia coli Bacteraemia - Incidents Pre and Post 48h

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly Average	Total Apr - May
2014/15	Pre 48h	32	36											34.0	68
	Post 48h	9	1											5.0	10
2013/14	Pre 48h	30	33	41	37	28	42	36	36	26	31	29	33	33.5	30
	Post 48h	4	3	4	12	3	12	10	4	8	8	6	11	7.1	4

The IPCT are now undertaking Root Cause Analysis (RCA) for E.coli bacteraemia cases occurring within 30 days of a surgical procedure undertaken in EKHUFT to identify the causes and address as necessary. During April and May there were 5 cases in total that met the definition, all occurring at KCH and associated with the urology ward, i.e. 1 case in May and 4 in April. Root Cause Analysis have been completed on 3 of the cases so far. All were considered clinically significant and unavoidable.

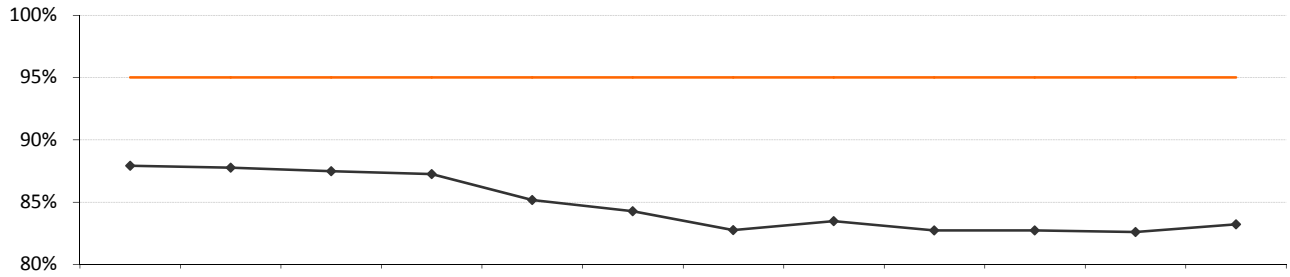
Meticillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly Average	Total Apr - May
2014/15	Pre 48h	7	6											6.5	13
	Post 48h	1	1											1.0	2

The IPCT are now undertaking Root Cause Analysis for all Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases occurring within 30 days of a surgical procedure undertaken in EKHUFT, or associated with an intravenous line. So far this financial year there has only been 1 case that fits this criteria and it occurred in May. The RCA will be completed shortly.

PATIENT SAFETY: INFECTION PREVENTION & CONTROL

Mandatory Training Compliance

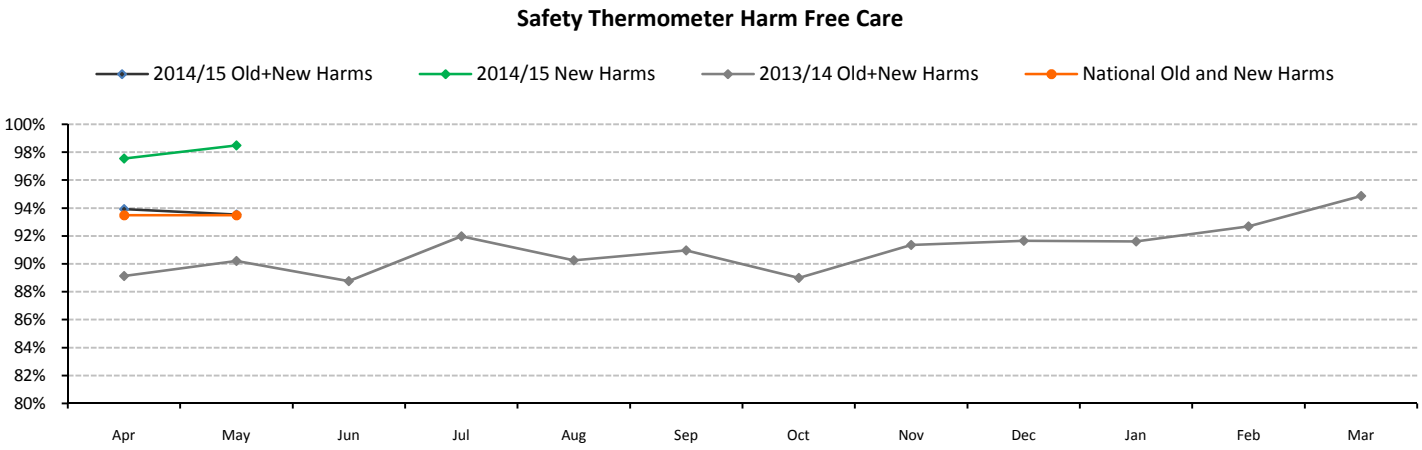


	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14
Compliance	87.9%	87.8%	87.5%	87.2%	85.2%	84.3%	82.7%	83.5%	82.7%	82.7%	82.6%	83.2%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

		Target	Trust	Clinical Support Services	Corporate	Specialist Services	Strat Dev & Capt Pln	Surgical Services	UCLTC	Serco
Mandatory Comparative Data for Biennial Training Compliance	Apr-14	95%	82.6%	84.4%	84.0%	77.5%	91.8%	83.9%	81.9%	96.0%
	May-14	95%	83.2%	86.1%	84.2%	78.3%	89.6%	83.8%	82.7%	97.0%

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

Trust Compliance has increased from 82.6% in Apr-14, to 83.2% in May. Within the Divisions, increases have been seen within Clinical Support Services (from 84.4% to 86.1%); Corporate Services (from 84.0% to 84.2%); Specialist Services (from 77.5% to 78.3%), and Urgent Care and Long Term Conditions (from 81.9% to 82.7%). Compliance within Serco has increased from 96.0% to 97.0%, exceeding the performance metric of 95%. However, compliance within Strategic Development and Capital Planning has decreased from 91.8% to 89.6%, and therefore requires impro 91.8% to 89.6%, and therefore requires improvement, and within Surgical Services from 83.9% to 83.8%.



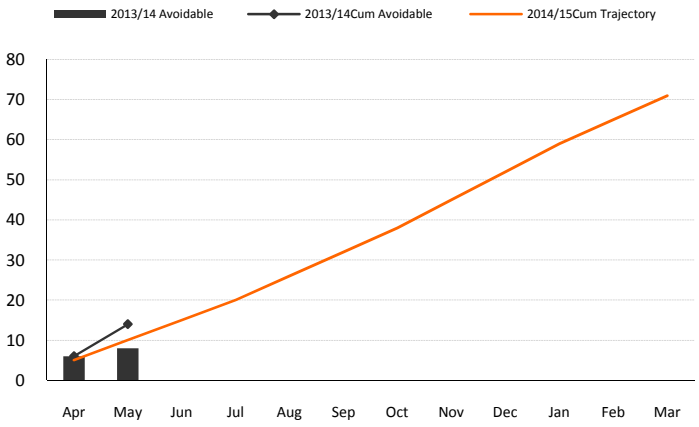
The chart above shows the percentage of Harm Free Care expressed as a one-day snapshot in each month. It is known as the NHS Safety Thermometer and is a quick and simple method for surveying patient harms. The aim of the Safety Thermometer is to identify, through a monthly survey of all adult inpatients,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

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

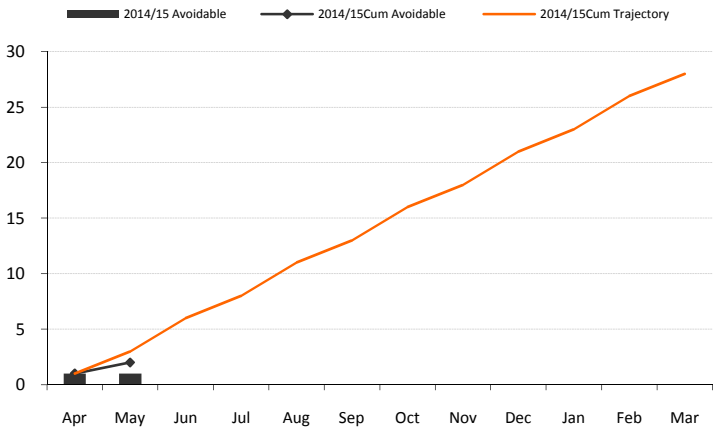
The strength of the NHS Safety Thermometer lies in allowing front line teams to measure how safe their services are and to deliver improvement locally. There are several different ways in which harm in healthcare is measured and there are strengths and limitations to the range of approaches available.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

Harm Free Care includes both harms acquired in hospital ("new harms") and those acquired before admission to hospital ("old harms"). There is limited ability to influence "old harms" if a patient is admitted following a fall at home, or with a pressure ulcer, but these are included in the overall performance reported to the Health and Social Care Information Centre. "New harms only" are included separately when reporting performance to Divisional teams to enable success to be celebrated and to incentivise improvement. Harm Free Care performance is incorporated within the monthly ward quality dashboard and is triangulated with the existing funded establishment, acuity and dependency of patients, and effectiveness of rostering to enable analysis of influencing factors and thereby focusing improvement actions. In May-14, the Trust's own score was 98.5% showing that those patients in our care have a greater harm free experience. This is above the national figure of 93.5% and is the area we can influence the most. The total percentage of Harm Free Care ("old and new harms") is 93.5%, and is in line with the national figure. We are working closely with the Area Team to develop Kent and Medway wide improvements that should positively impact on these indicators across the whole of the patient pathway. This is via the Kent and Medway Patient Safety Collaboratives.

Category 2 Incidence Trajectory 2014/15
25% Reduction



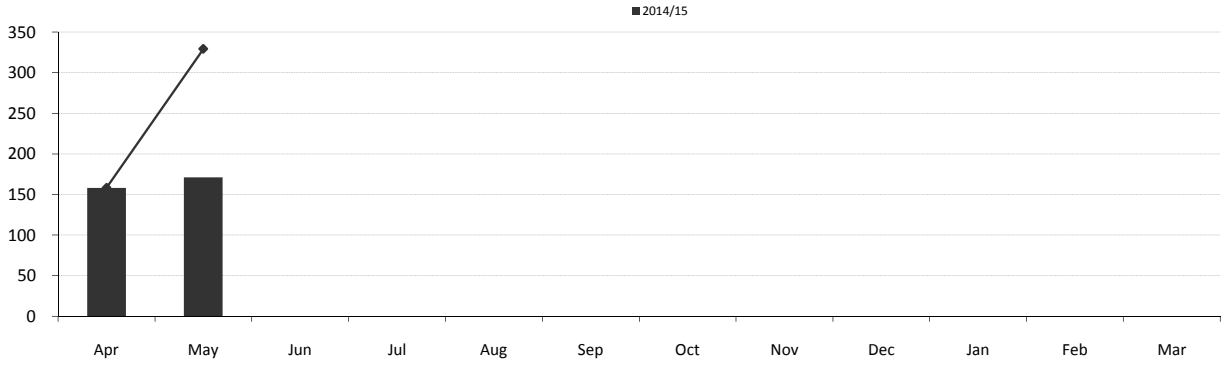
Category 3 and 4 Incidence Trajectory 2014/15
25% Reduction



In May, 14 hospital acquired Category 2 pressure ulcers were reported of which 8 were deemed as avoidable; 3 were recorded at KCH, 2 at QEH and 9 at WHH. Seven of these were heel ulcers and of these 5 were avoidable. Twenty seven wards have developed and returned specific action plans to eliminate avoidable heel ulcers. The main learning identified as contributing to avoidable Category 2 pressure ulcers was insufficient evidence of repositioning and 1 incident was related to the care a naso-gastric tube.

In May, there were 5 reported deep acquired ulcers (Categories 3 and 4); 2 at KCH and 2 at QEH and 1 at WHH. Of these ulcers, 1 was agreed as avoidable due to insufficient evidence of consistent repositioning and a Root Cause Analysis meeting is being arranged to identify learning points. The Deep Pressure Ulcer Working Group is continuing to support the Trust wide "Think Heels" campaign and is taking further actions to address areas of concern. These actions involve identifying areas for intensive multidisciplinary investigation, and support to assure an improvement plan which addresses their specific issues and promotes a zero tolerance of avoidable pressure ulcers.

Patient Falls - Injurious and Non-Injurious

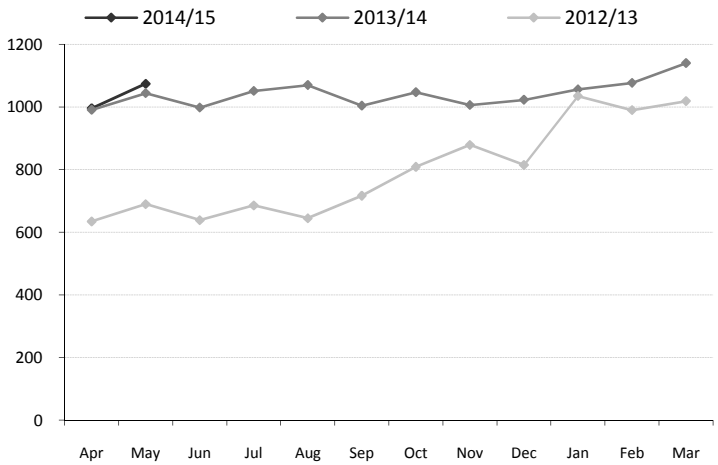


in May-14 there were a total of 171 inpatient falls; 53 were at KCH, 57 at QEH and 61 at WHH. There has been a steady increase in the number of falls resulting in fractures at WHH, both within UCLTC and Surgical Services Divisions. An engagement event is planned for 10 Jul-14 which is to be facilitated by the Deputy Chief Nurse and aims to raise this issue in detail, examine contributory factors and develop solutions.

CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: CLINICAL INCIDENTS

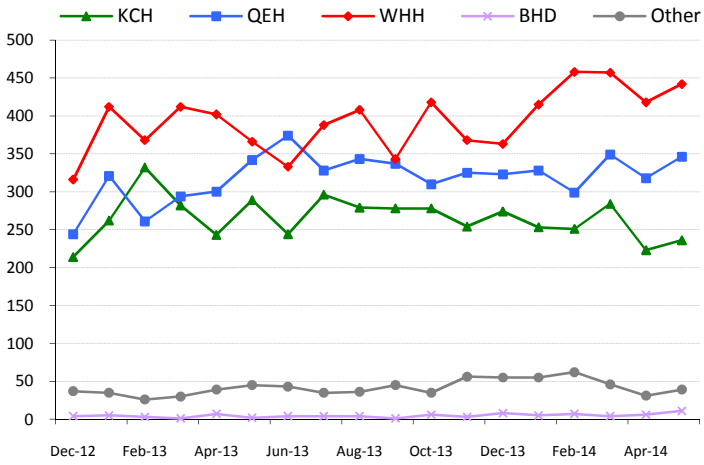
In May-14 a total of 1074 clinical incidents and patient falls were reported. This includes 3 incidents (which are under investigation) graded as death and 5 (which are under investigation) graded as severe. Unapproved incidents may be downgraded following investigation. In addition to these 8 serious incidents, 19 incidents have been escalated as serious near misses, of which all are under investigation.
Eight serious incidents were required to be reported on STEIS in May. Five cases have been closed since the last report; there remain 47 serious incidents open at the end of May of which 8 have been closed by the KMCS pending review of external bodies before closure on STEIS.

Overall Incident Rates by Year



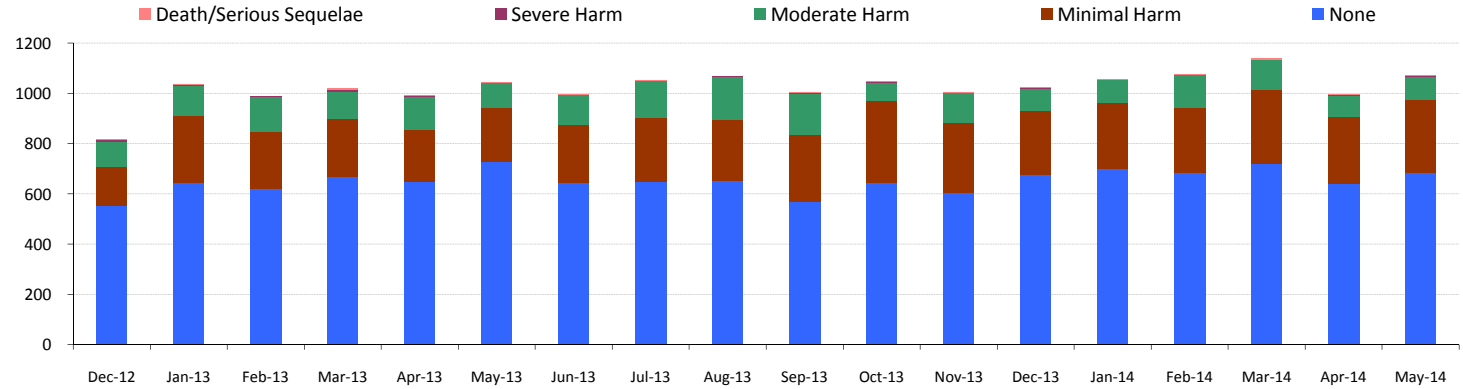
A total of 1074 clinical incidents have been logged in May compared with 996 recorded for Apr-14.

Overall Incident Rates by Site



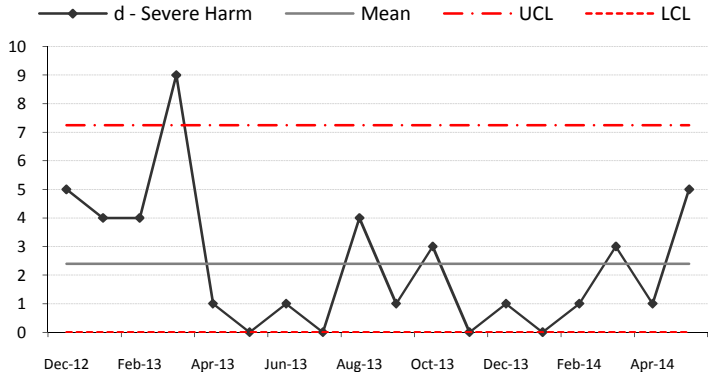
The number of clinical incidents have risen slightly at all 3 main sites.

Clinical Incidents by Severity

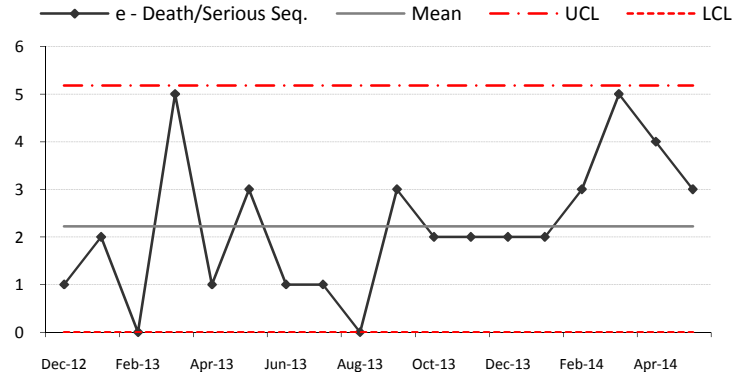


The incidents graded as moderate, serious and death have all been subject to review in order to confirm the consistency of the grading of harm across the Trust. The Board of Directors may see a change in this report to reflect the re-categorisation process undertaken. This is consistent with the data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

Severe Harm

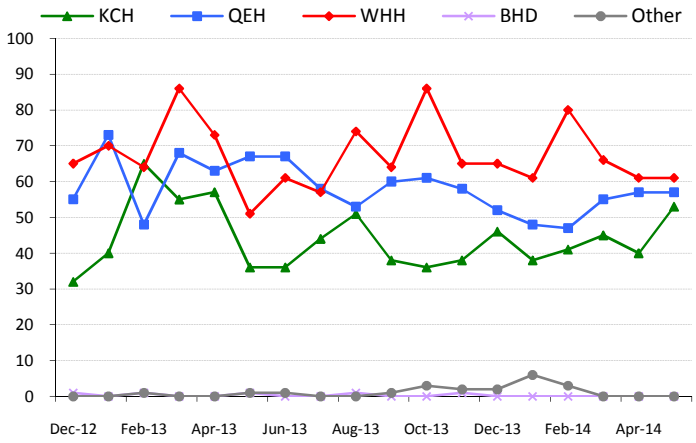


Death/Serious Sequelae



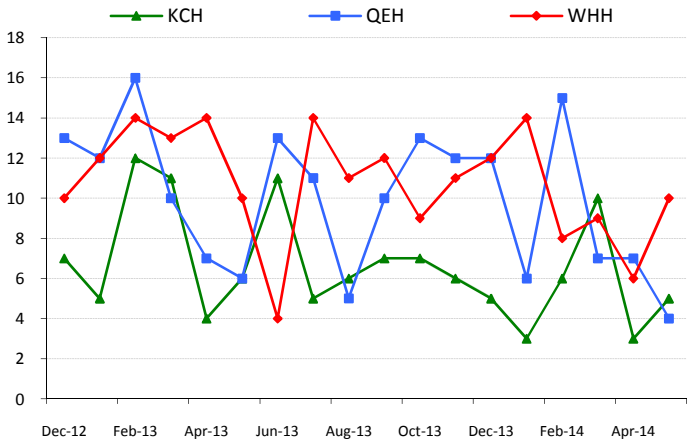
The number of death/serious and severe harm incidents reported in May-14 remains subject to the usual RCA investigation and review. It is possible that the severity of these cases will be downgraded once the investigation process is completed. In May-14, the number of incidents graded as death or severe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

Patient Slips, Trips and Falls



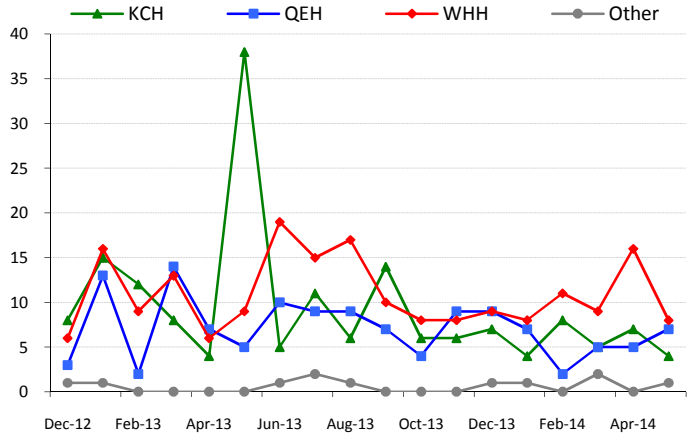
Of the 171 patient falls recorded for May (158 in April), none were graded as severe or death. There were 101 falls resulting in no injury, 64 in low harm and 6 in moderate harm. The top reporting wards were Cambridge M2 (WHH) with 14 falls; Treble (KCH) with 10 falls; Seabathing (QEH) with 9; Clarke (KCH), Harbledown (KCH), Fordwich (QEH), Sandwich Bay (QEH) and Kings D Male (WHH) with 7 each; Harvey (KCH), Cambridge L (WHH) and Richard Stevens stroke unit (WHH) with 6 each. The remaining wards reported 5 or less falls. Of the six moderate harm falls, five resulted in fracture on CDU (WHH), Cambridge L (WHH), Kings A2 (WHH), Kings C1 (WHH) and Richard Stevens Unit (WHH); 1 resulted in dislocation on Kings C1 (WHH). A Root Cause Analysis (RCA) is carried out for all falls resulting in serious harm or fracture.

Hospital Acquired Pressure Ulcers



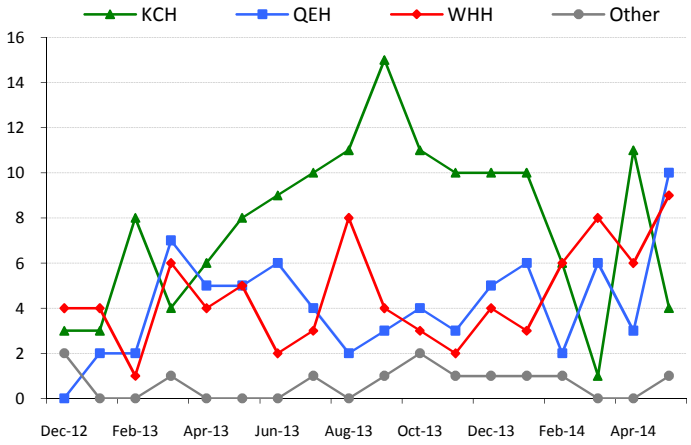
In May there were 19 reported incidents of pressure ulcers developing in hospital (16 in April). This included 14 Category 2 pressure ulcers and 5 Category 3. No Category 4 ulcers were reported. Nine have been assessed as avoidable, 10 as unavoidable. The highest reporting wards were ITU (QEH) and Kent (KCH) with 3 incidents each and Cambridge L (WHH) with 2.

Delay in Providing Treatment



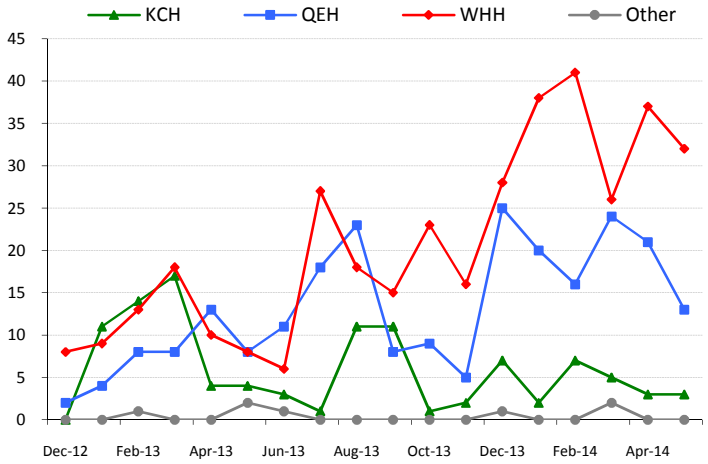
There were 20 incidents resulting in delay in providing treatment during May compared with 28 in April. No incidents have been graded as death; 1 has been graded severe and is currently under investigation. Five have been graded moderate harm, 4 have been graded as low and 10 resulted in no harm, which included 1 serious near miss. Themes in location: 3 incidents occurred on Padua (WHH) and A&E (QEH); 2 incidents occurred on St Margaret's (QEH); all other areas reported 1 or no incidents.

Incorrect Data in Patient Notes



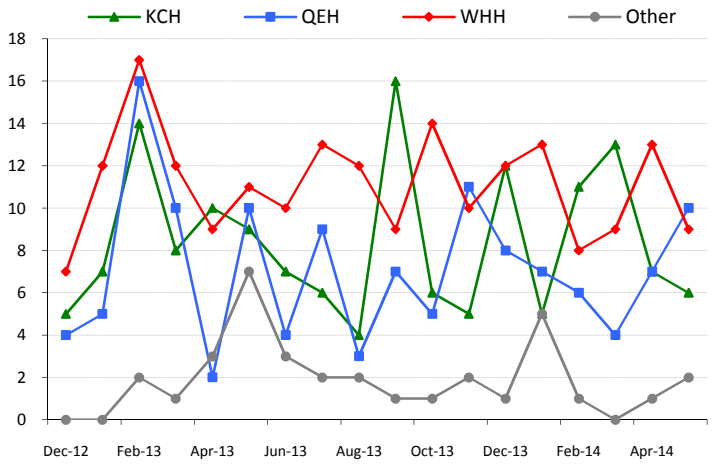
There were 24 incidents of incorrect data in patients' notes reported as occurring in May (20 in April), of which 23 were graded as no harm and one as low harm. Fifteen incidents related to incorrect data in paper notes, 8 to incorrect data on patient's electronic record (Patient Centre/Euroking) and 1 to incorrect data in the electronic discharge notification (eDN). Of the incidents reported, 4 were identified at KCH, 10 at QEH, 9 at WHH and 1 at RVHF. The highest reporting areas were Outpatients (KCH), Outpatients (WHH) and Seabathing (QEH) with 2 incidents each.

Staffing Level Difficulties



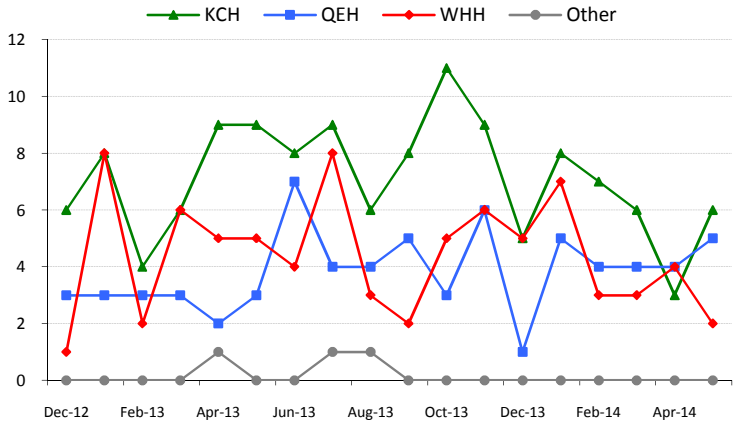
There were 48 incidents recorded in May (61 in April). These included 26 incidents relating to insufficient nurses and midwives, 4 to inadequate skill mix, 1 to insufficient doctors and nurses, 5 to insufficient doctors and 12 to general staffing level difficulties. Top reporting locations were Kennington (WHH) with 7 incidents; Haematology (WHH) with 5; Singleton MLU (WHH) and Kings D Male (WHH) with 4 each; and the following areas reporting 3 incidents each: Kings C2 (WHH) and Cheerful Sparrows Female (QEH). Other areas reported 2 or fewer incidents. Three incidents occurred at KCH, 13 at QEH and 32 at WHH. Four incidents have been graded as moderate and 8 as low harm due to delays in providing treatment and suboptimal care being identified. The remaining 36 incidents have been graded as no harm.

Communication Breakdowns



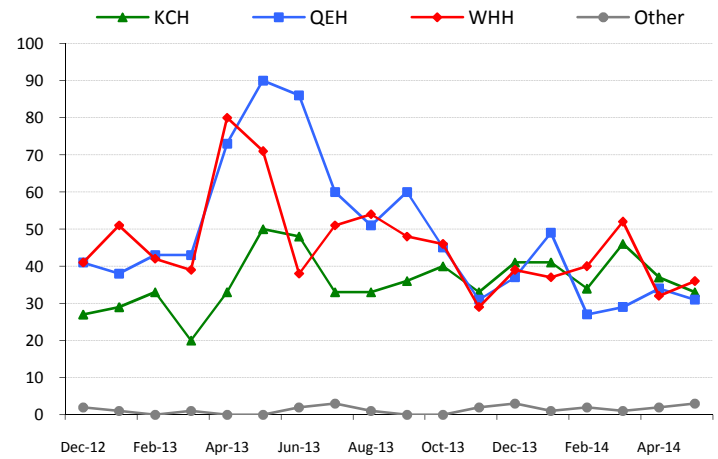
In May-14 there were 27 incidents of communication breakdown (28 in April). Of these, 18 involved staff to staff communication failures, 7 were staff to patient and 2 were staff to relative (or other visitor). Of the 27 incidents reported, 6 were reported as occurring at KCH, 10 at QEH, 9 at WHH, 1 at RVHF and 1 at Medway renal satellite unit. Themes by location: A&E (WHH) reported 3 incidents; Theatres (QEH), Cheerful Sparrows Male (QEH) and Clarke (KCH) reported 2 incidents each; other areas reported 1 or none. Incidents in May were graded as follows: 19 as no harm, 7 as low harm and one as severe harm, pertaining to failure to escalate a deteriorating patient.

Blood Transfusion Errors



In May, there were 13 blood transfusion errors reported (11 in April). Two main themes arose in the period: 3 incidents related to phlebotomy process errors (sampling and labelling) and 3 incidents related to suspected reactions to blood products. Of the 13 incidents reported, 10 were graded no harm and 3 as low harm. Reporting by site: 6 at KCH, 5 at QEH, and 2 occurred at WHH.

Medicines Management



There were 103 medication incidents reported as occurring in May (105 in April).

Medicines Management

Category	May-14
Prescribing	23
Dispensing	23
Administering	33
Missing (lost or stock discrepancy)	13
Shortage (drug unavailable)	3
Suspected adverse reaction	2
Infusion problems (drug related)	5
Infusion injury (extravasation)	1
TOTAL	**103**

Of the 103 reported, 92 were graded as no harm including 4 serious near misses, 10 as low harm and 1 as moderate harm. No serious incidents were reported. Top reporting areas were: Cathedral Day Unit (KCH) with 10 incidents, ITU (WHH) with 5; Celia Blakey Centre (WHH) and Cheerful Sparrows Female (QEH) with 4 each; 3 incidents occurred on CDU (KCH), Kent (KCH), Sandwich Bay (QEH), Cambridge M2 (WHH), Kings D Female (WHH) and Kings B (WHH); other areas reported 2 incidents or fewer. Thirty one incidents occurred at QEH, 33 at KCH, 36 at WHH, 1 at Buckland Hospital Dover, 1 in the Community and 1 at Maidstone renal satellite unit.

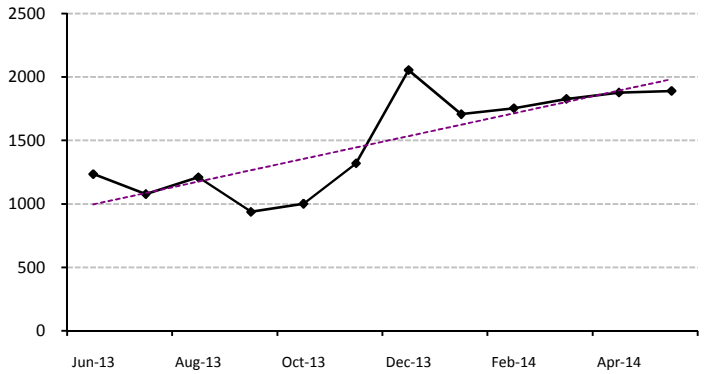
PATIENT EXPERIENCE: CONCERNS, COMPLAINTS & COMPLIMENTS

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

• Activity: Formal complaints - 93; informal contacts - 58; compliments - 1890; PALS - 228. There were 20 returning clients who are seeking greater understanding to their concerns.

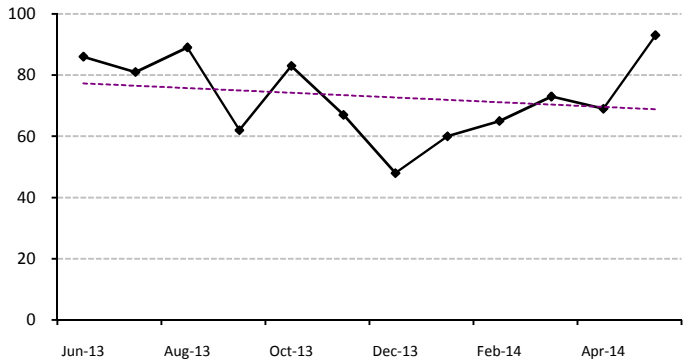
The charts below show the number of complaints and compliments received on a monthly basis. One formal complaint has been received for every 864 recorded spells of care (0.12%) in comparison to April's figures where 1 formal complaint was received for every 1143 recorded spells of care (0.09%).

Number of Compliments



In May-14 the number of compliments received increased by 0.7% compared to the previous month. The ratio of compliments to formal complaints received for the month is 20:1. There has been 1 compliment being received for every 43 recorded spells of care.

Number of Formal Complaints



The number of formal complaints received has increased by 35% compared to Apr-14, and has increased by 43% since May-13.

Top Five Concerns Expressed in Formal Complaints May 2014

Concerns		No.
Delays	Delays in receiving treatment	12
	Delay in receiving x-ray results	3
	Delay in referral	3
	Delays in being seen in A&E	3
	Delay with elective admission	2
	Delays in allocation of outpatient appointments	1
Problems with Communication	Doctor communication issues	7
	Nursing communication issues	6
	Misleading or contradictory information given	5
	Lack of information/explanation of procedure outcome	3
	A&E staff communication issues	1
	Therapist communication issues	1
Problems with Attitude	Problems with Doctor's attitude	10
	Problems with other staff attitude	6
	Problems with nurse's attitude	5
Problems with Discharge Arrangements	Problems with discharge arrangements	12
	Waiting for medication	3
	Lack of information given on discharge	1
	Problems with going to another hospital	1
	Unhappy about follow-up arrangements	1
Concerns about Clinical Management	Incomplete examination carried out	6
	Lack of/inappropriate pain management	4
	End of life/palliative care issues	3
	Referral issues	3
	Scans/x-rays not taken	1

The common themes raised within the top 5 informal concerns are led by problems with delays, followed by problems with communication, problems with appointments, cancellations, and concerns about surgical management.

With regards to formal complaints, the highest recurring subjects raised within formal complaints for May-14 were delays, problems with communication, problems with attitude, problems with discharge arrangement, and concerns about clinical management.

Concerns, Complaints and Compliments - Divisional Performance

May 2014

Division	Divisional Activity				Divisional Performance	
	Formal Complaints	Compliments	Informal Contacts	Compliments: Complaints	First Response Met	Returning Complaints
Clinical Support	9	92	6	10:1	1 of 1	0
Specialist Services	12	861	5	71:1	5 of 7	0
Surgical Services	36	440	33	12:1	22 of 25	6
UCLTC	35	495	14	14:1	27 of 31	14
Corporate	1	2	0	2:1	0	0
Other	0	0	0	0:0	0	0
TOTAL	93	1890	58	20:1	55 of 64	20

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

The table above shows the monthly Divisional activity and performance for May-14, 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 complaints; this will either be via a letter or at a meeting. During May-14 the data show that 85.9% of these responses were sent out on target, and 4 out of 5 Divisions sent out a minimum of 75% of their responses on time.

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

Status of Cases	Actions in May-14
Cases carried over from previous month	16
New cases referred to the Trust	3
Cases closed by PHSO	0
Current open cases with the PHSO	19

The PHSO is the second and last stage of the National Complaints process and it is open to all clients to approach the Office if they are dissatisfied with the way their formal complaint has been handled.
In May, the PHSO have been in contact with the Trust with regards to 3 new cases brought to their attention, that is, 1 case relating to the Specialist Division (Renal), 1 case relating to the Surgical Division (T&O), and 1 case relating to UCLTC Division (A&E). No cases were closed by the PHSO in May-14.

Friends and Family Test (FFT)

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

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

There is also a "don't know" option which isn't scored, and an opportunity to write further comments. Nationally, Trusts are measured using the Net Promoter Score (NPS) where a score of approximately 50 is deemed good. The Trust's NPS was 53 in May, similar to April. This is the combined satisfaction from 3573 responses from inpatients and A&E. Maternity services achieved 470 responses. The NPS for inpatients was 70, for A&E it equalled 38, and for Maternity it was 78. The inpatient score is at the national average, but the A&E score is below national average (55). Further work is underway regarding the low A&E NPS to take a close look at the feedback and to also set an improvement plan to address the issues our patients are telling us about regarding waiting times, pain management, staff attitude, and food and drink availability.

The company iWantGreatCare which reports FFT data on behalf of the Trust have converted the NPS into a "star score" value (ranging from 0 to 5) thus making the interpretation of FFT results easier. The star score is calculated using an arithmetic mean, so a ward that scores 4 stars has an overall average rating of "likely" to be recommended. The Trust score for May was 4.42 stars out of 5 stars and is similar to last month.

The response rate for May-14 for inpatients and A&E combined achieved 22.59%. This awaits Unify2 validation. This year the wards have a 20% standard for Q1 which they exceeded with a 29.65% response rate. The A&E departments achieved 18.66% this month exceeding their 15% standard. Maternity services achieved 20.27% combined.

Staff FFT is being implemented and FFT for Outpatients and Day Cases is being planned for October this year.

We Care Programme

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

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

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

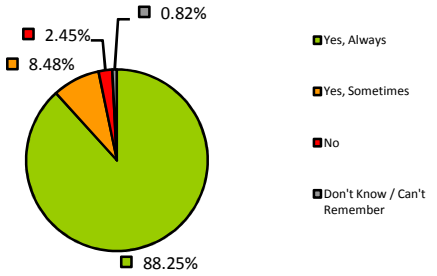
Events have taken place across the Trust during the past 12 months led by frontline staff. These have sought feedback from patients and families, as well as having discussions about the We Care values within teams. The Steering Group are currently working on the development of the We Care Programme going forward. This includes designing a Trust wide organisational development plan and embedding the values and behaviours into everyday practice. "Market Place" events took place during March to engage staff and patients in the delivery of the values. This feedback has been collated ready for analysis against the Trust values.

We have undergone a "branding" piece of work that ensures our communications with each other and the public are empathetic and sensitive. This has been labelled the "Tone of Voice" work led by Human Resources. In addition, work is in progress to embed the values as part of job advertisements, the recruitment process, and our engagement with staff. The roll out of the "We Care" Champions has commenced following the approval by the Board of Directors of the Trust values with many Champions in place. A second event focusing on developing listening skills has been scheduled in June. In addition, the behaviours linked to the values are due to be shared with staff during June in a separate publication.

PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

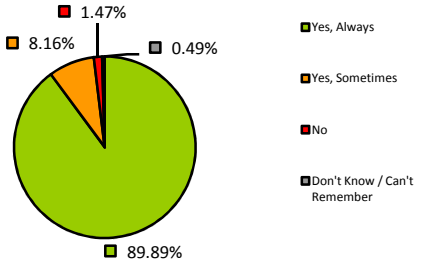
Real time patient experience monitoring using iPads have captured data since 1 Apr-13. During May-14, 613 adult inpatients were asked about their experiences of being an inpatient; 98 responses were received from patients treated at KCH, 106 from QEH patients, and 409 responses from patients based at WHH. (Compared with the previous month the number of responses were 102, 80 and 475 respectively). The combined result from all submitted questionnaires in May-14 was that of 88.92% satisfaction.

Were you given enough privacy when discussing your treatment?



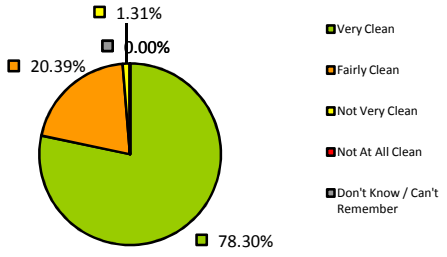
Overall Score = 93.26%

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



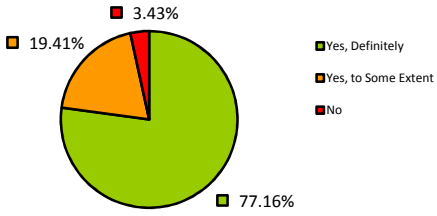
Overall Score = 94.43%

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



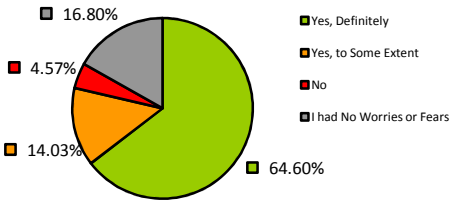
Overall Score = 92.33%

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



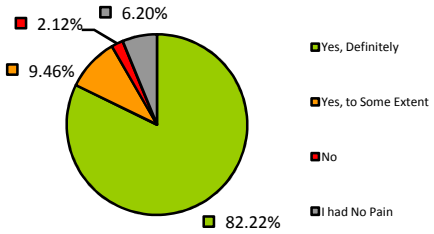
Overall Score = 86.87%

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



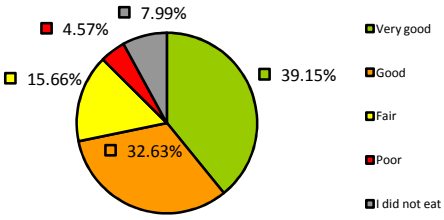
Overall Score = 86.08%

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



Overall Score = 92.70%

How would you rate the hospital food?



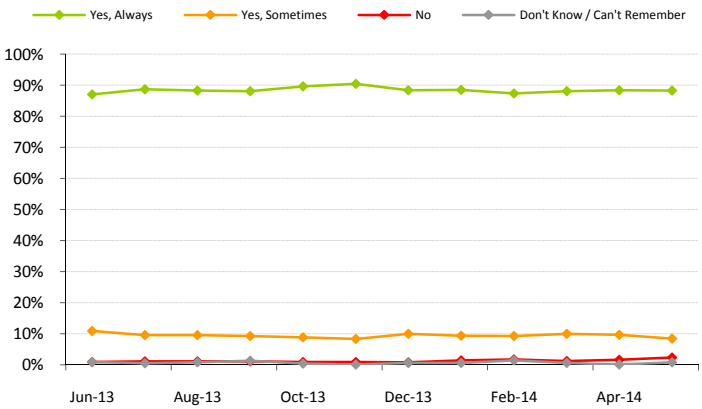
Overall Score = 71.87%

Overall Adult Inpatient Experience May-14	
Experience (%)	No. of Responses
88.92	613

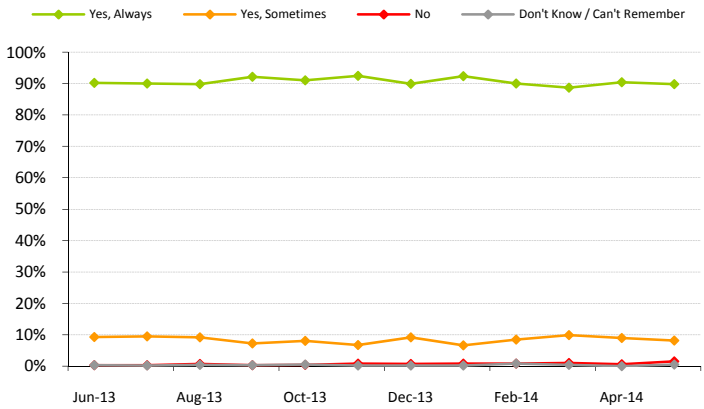
In response to the question "How would you rate the hospital food?" patients are able to answer "very good, good, fair, poor, or I did not eat". This replicates the methodology of the annual national CQC inpatient survey which respectively canvases the opinion of 850 EKHUFT inpatients. In 2012 the results of the national survey indicated that patients rated EKHUFT hospital food below average (52%) when compared with other Trusts. Countrywide the top 20% of Trusts achieved scores of 64 - 79% in response to "How would you rate the hospital food?", suggesting that the survey methodology does not produce very high scores. In the 3 month period form Mar-14 to May-14 the real-time monitoring of inpatient experience at KCH, QEH and WHH rated hospital food as 65%, 74% and 69% respectively, and the Trust overall scored 69%. Therefore, if the results of the national CQC inpatient survey in 2013 follow the trend displayed by EKHUFT real-time patient experience monitoring, EKHUFT hospital food will potentially be rated in the top 20%.

PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

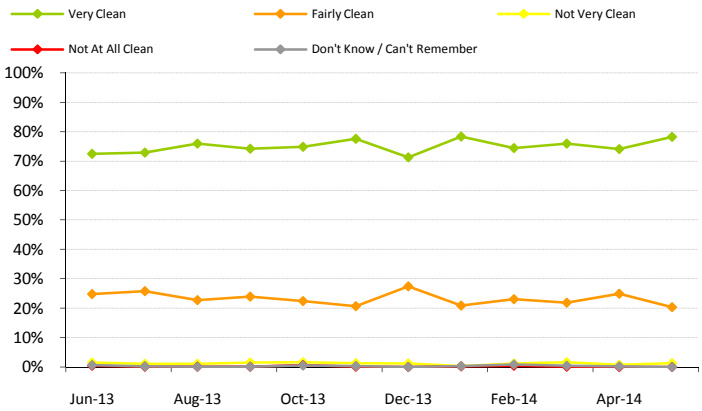
Were you given enough privacy when discussing your treatment?



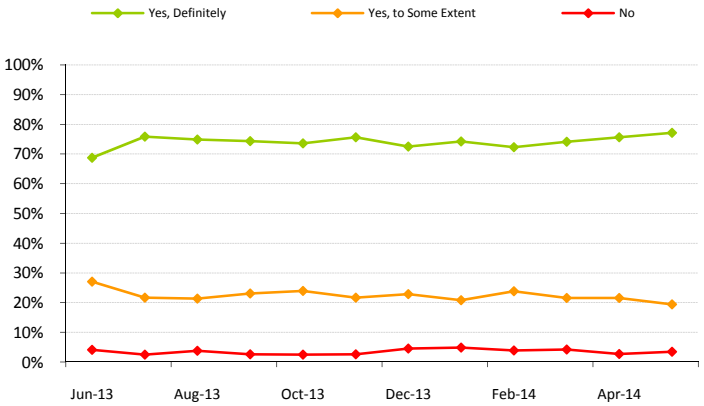
Overall, did you feel you were treated with respect and dignity while you were in hospital?



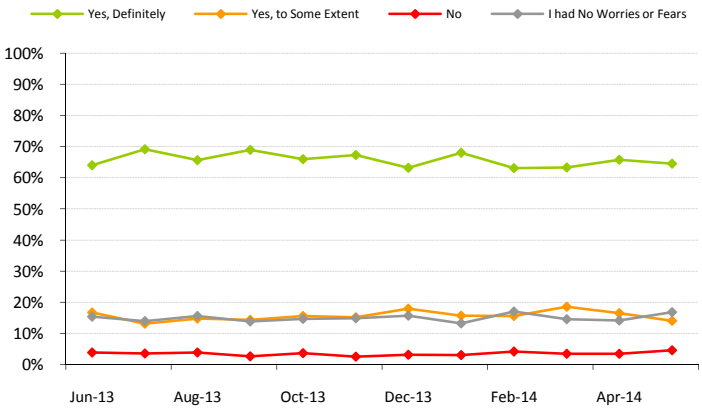
In your opinion, how clean was the hospital room or ward that you were in?



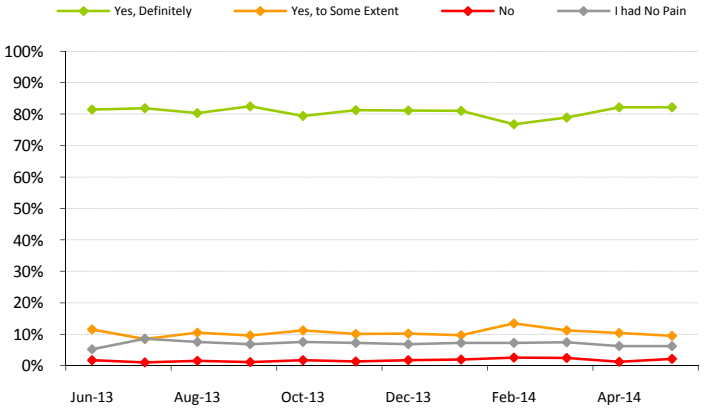
Were you involved as much as you wanted to be in the decisions about your care and treatment?



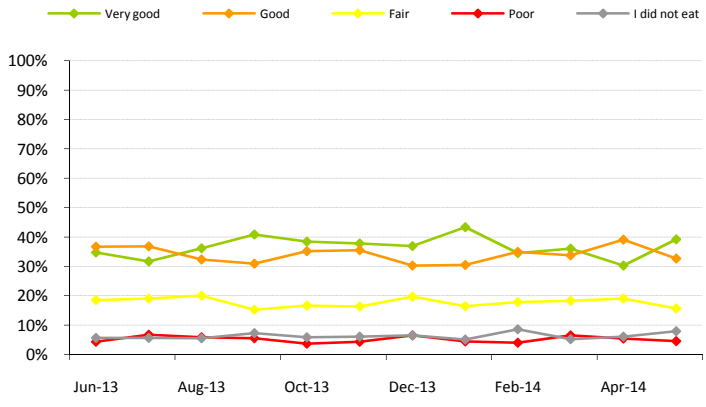
Did you find someone on the hospital staff to talk about your worries and fears?



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



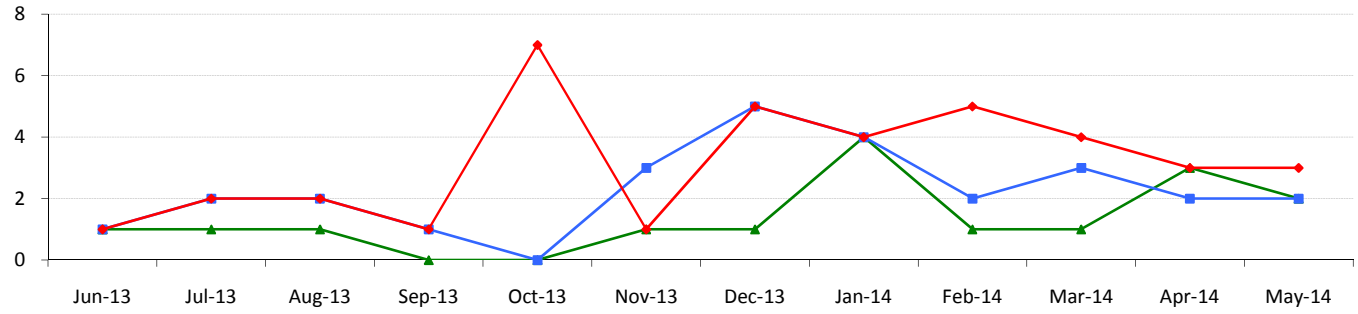
How would you rate the hospital food?



Initiatives are in place to improve nutrition for the Trust's patients, such as a choice of 23 different hot meal options per lunchtime menu, finger foods for those who can not use cutlery, puréed meals, picture menus and assistance when needed. We are working closely with our cleaning teams to ensure that the environment, both clinical and communal, are of a high standard.

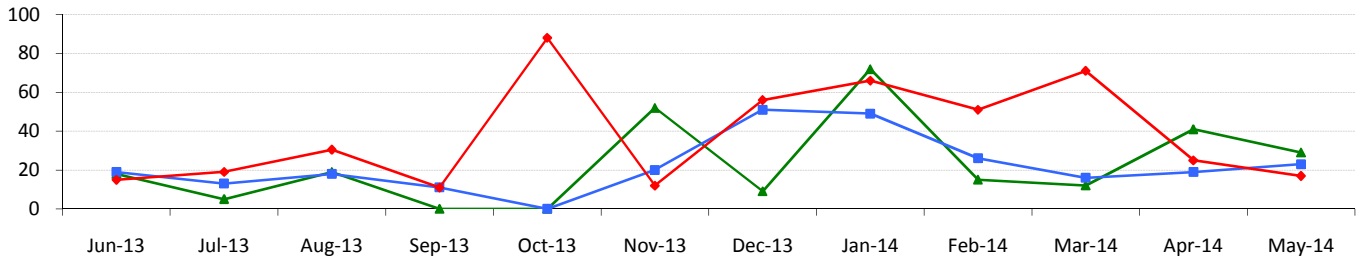
CLINICAL QUALITY & PATIENT SAFETY
PATIENT EXPERIENCE: MIXED SEX ACCOMMODATION

Number of Episodes of Mixed Sex Occurrence



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

Number of Hours of Mixed Sex Occurrence



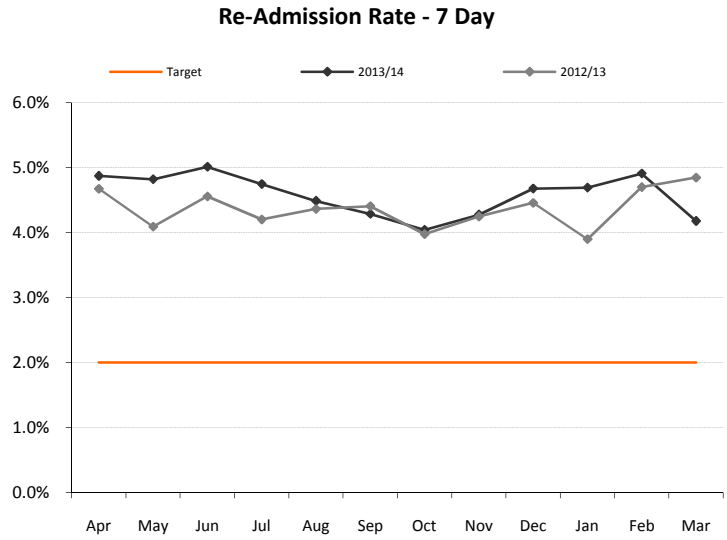
	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14
KCH	18	5	19	0	0	52	9	72	15	12	41	29
QEH	19	13	18	11	0	20	51	49	26	16	19	23
WHH	15	19	30.5	11	88	12	56	66	51	71	25	17

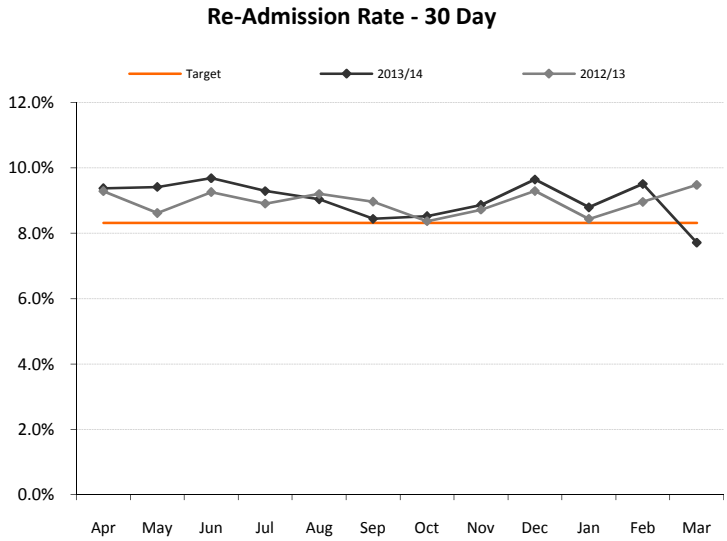
Mixed Sex Accommodation Occurrrences May 2014

Site	Clinical Area	Total No. of Occurrences	Total No. of Patients Affected
KCH	Kingston	2	8
QEH	CDU	1	6
QEH	Fordwich	1	5
WHH	CDU	3	20
TOTAL		**7**	**39**

During May-14 there were no reportable mixed sex accommodation breaches to NHS England via the Unify2 system. These were not reported as they complied with CCG criteria, such as clinical need. There were 7 clinically justified mixed sex accommodation occurrences affecting 39 patients. The Trust is working closely with the CCGs in order to ensure that mixed sex accommodation occurrences are minimised as much as possible. This includes reviewing the local policy for delivering same sex accommodation and refreshing the acceptable justifiable criteria as outlined in the 2010 national guidance. Collaborative work continues with the CCGs where the policy scenarios are being revised. This is due to be discussed at the Quality Meeting with the CCGs where the policy will be refreshed and agreed collaboratively.

CLINICAL QUALITY & PATIENT SAFETY
CLINICAL EFFECTIVENESS: READMISSION RATES





The readmission data shown this month is the Trust's 30 day readmission rate as at the end of March. This has achieved an 8.09% performance against a goal of 8.32%. The Information Team are embedding a new process which requires realignment of the data sources. We will report both April and May's readmission data in next month's report due to delays in implementing the new validation process.

Going forward into 2014/15 a goal to further reduce the Trust's readmission rates through improvement work is underway. Accurate data analysis and the identification of specialities where support to reduce readmission rates would be beneficial are key aspects of this improvement work.

			CQUIN	2013/14 Baseline	2014/15 Target	YTD Status	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Q1	Q2	Q3	Q4	Year End Position
			National CQUINS																				
Performance	Friends and Family Test	1a	Implementation of FFT to staff	N/A	Implemented by Jul-14																		
		1b	Implementation to Outpatient and Day Case Units	N/A	Implemented by Oct-14																		
		1c	Increased Response Rates in A&E	Q1 2014/15 - TBC	Improvement from at least 15% in Q1 to at least 20%, or higher than Q1 baseline if higher than 20% by Q4	19.2%	19.6%	18.7%															
		1d	Increased Response Rates in Inpatient Areas	Q1 2014/15 - TBC	Improvement from 25% in Q1 to 30% by Q4, or maintaining a response rate of 30%	32.4%	35.2%	29.6%															
		1e	Reduced Negative Responses in A&E, Inpatient and Maternity Areas (Aggregate Measure - Full Payment)	Q4 2013/14 - 9%	Reduction in negative responses as a proportion of total responses in A&E, Inpatient and Maternity areas	7.0%	7.0%	7.0%															
		1e	Partial Payment - Negative Responses in Inpatient Areas	Q4 2013/14 - 1%	No increase in negative responses in Inpatient areas	1.0%	1.0%	100.0%															
		1e	Partial Payment - Negative Responses in A&E Areas	Q4 2013/14 - 16%	Reduction in negative responses in A&E areas	13.0%	13.0%	13.0%															
		1e	Partial Payment - Reduction in Negative Responses in Maternity Areas	Q4 2013/14 - 1%	No increase in negative responses in Maternity areas	1.0%	1.0%	1.0%															
	NHS Safety Thermometer	2a	Reduction in Falls - Risk Assessment/Care Plan	2013/14 audit - 20%.	50% compliance with completion of falls risk assessment and care plan																		
		2a	Reduction in Falls - Improvement in Prevalence	Apr-13 to Jan-14 - 1.13%	25% improvement in prevalence of falls with harm - NHS Safety Thermometer in Q4	3	2	1															
		2b	Reduction in UTIs in Patients with Urinary Catheters	Apr-13 to Jan-14 - 1.98%	25% improvement in prevalence of UTIs in patients with urinary catheters - NHS Safety Thermometer in Q4	17	5	12															
		2c	Reduction in Pressure Ulcers - New	Apr-13 to Jan-14 - 1.09%	5% improvement in prevalence of new pressure ulcers - NHS Safety Thermometer in Q4	26	16	10															
		2c	Reduction in Pressure Ulcers - Old	Apr-13 to Jan-14 - 5.01%	Leading the Pressure Ulcer Work Stream																		
	Improving Diagnosis of Dementia		Dementia Case Finding	98.8%	Average of 90% in each of the elements of the indicator each month for any 3 consecutive months	99.7%	99.7%																
		3.1	Dementia Assessment within 72h	90.1%		94.7%	94.7%																
			Appropriate Referral	100.0%		100.0%	100.0%																
		3.2	Staff Training/Leadership	20.0%	35% of appropriate staff trained	22.3%	22.3%																
		3.3	Care for People with Dementia	N/A	Self assessment of person-centred care in wards																		
Commentary	Friends and Family Test	1a	Implementation of FFT to staff	An approved supplier has been identified and method agreed(3x p.a.). Due to be launched this month.																			
		1b	Implementation to Outpatient and Day Case Units	Task and Finish group in place. Draft DH guidelines available, final guidelines not due from DH til end of June. This makes implementation by 1 Oct-14 challenging, but plans have already commenced to ensure we are in a position to roll out by September at the latest. Project has been scoped on draft guidelines factoring at worst expectations.																		
		1c	Increased Response Rates in A&E	Reporting includes A&E areas at WHH and QEH.																			
		1d	Increased Response Rates in Inpatient Areas	ECC at KCH included within inpatient areas.																			
			Reduced Negative Responses in A&E, Inpatient and Maternity Areas	Month 1 (Apr-14) data show a reduction from 9% in Q4 2013/14 to 7%.																			
		1e	Negative Responses in Inpatient areas	Month 1 (Apr-14) data remain static at 1% compared to Q4 2013/14.																			
		1e	Negative Responses in A&E Areas	Month 1 (Apr-14) data show a reduction from 16% in Q4 2013/14 to 13%.																			
		1e	Reduction in Negative Responses in Maternity Areas	Month 1 (Apr-14) data remain static at 1% compared to Q4 2013/14.																			
	NHS Safety Thermometer	2a	Reduction in Falls - Risk Assessment/Care Plan	The risk assessment/care plan has been updated and has been implemented as part of the Risk Assessment Booklet. Link workers plus other staff are to be trained in Jul-14. An audit of compliance with risk assessments is planned for Q3.																			
		2a	Reduction in Falls - Improvement in Prevalence	YTD NHS Safety Thermometer data - 3 falls with harm, against a trajectory of up to 16.																			
		2b	Reduction in UTIs in Patients with Urinary Catheters	YTD NHS Safety Thermometer data - 26 UTIs in patients with catheters, against a trajectory of up to 21.																			
		2c	Reduction in Pressure Ulcers - New	YTD NHS Safety Thermometer data - 17 new Category 2 - 4 pressure ulcers, against a trajectory of up to 10.																			
			Lead Pressure Ulcer Work Stream	The first meeting of the Work stream Collaborative group was planned for later in May-14.																			
	Improving Diagnosis of Dementia		Dementia Case Finding	Month 1 exceeded 90%.																			
		3a	Dementia Assessment within 72h	Month 1 exceeded 90%.																			
			Appropriate Referral	Month 1 exceeded 90%.																			
		3b	Staff Training/Leadership	This measure will be reported one month retrospectively. Numbers remain provisional; reporting will include appropriate non-clinical staff to be trained (and not yet incorporated).																			
		3c	Care for People with Dementia	Initial discussions have taken place on how to approach this and a plan is due to be developed.																			

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

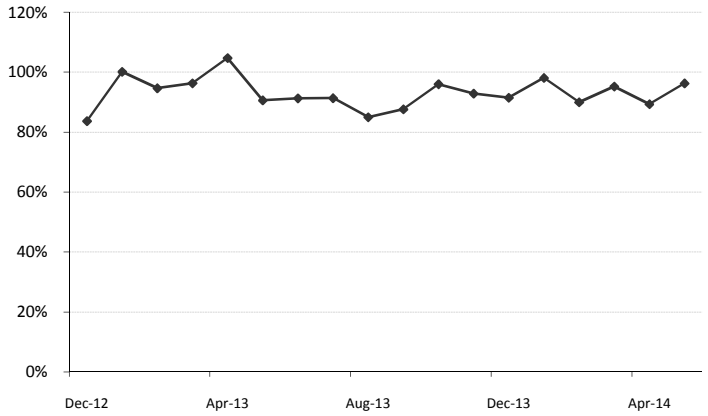
	Local CQUIN			2013/14 Baseline	2014/15 Target	YTD Status	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Q1	Q2	Q3	Q4	Year End Position
Performance	Heart Failure	4	EQ Pathway Measures	74.21%	Maintain 2013/14 levels	78.3%	78.3%																
	COPD	5a	Improved referral rate to the Stop Smoking Service	9%	Improved referral rate - Improvement rate TBA		8.1%	13.3%															
		5b	Improved referral rate to the Community Respiratory Team	4.6%	Improved referral rate - Improvement rate TBA	4.3%	`																
	Diabetes	6	Develop an Integrated Care Pathway	N/A																			
	Over 75 Frailty Pathway	7	Develop an Integrated Care Pathway	N/A																			
Commentary	Heart Failure	4	EQ Pathway Measures	This measure will be reported Month 1 - 12, Jan-14 to Dec 14. Data will be reported 1 month retrospectively.																			
	COPD	5a	Improved referral rate to the Stop Smoking Service	Month 2 shows an improvement in the referral rate.																			
		5b	Improved referral rate to the Community Respiratory Team	The reporting processes for these referrals continues to be investigated to ensure all data is being captured. Data will be reported 1 month retrospectively.																			
	Diabetes	6	Develop an Integrated Care Pathway	A CCG led Project group has been developing an Integrated Diabetes Pathway. A shared meeting took place 20 May-14 and discussions are ongoing as to the best way forward to progress the pathway development.																			
	Over 75 Frailty Pathway	7	Develop an Integrated Care Pathway	The first CCG led multi provider Pathway Development meeting is planned for 29 May-14. A Trust wide internal group will also be established to feed into this group, and in the meantime inout is being gathered from WMs as to their view of frailty and the care currently provided. Regular CCG led meetings have been planned up to Mar-15.																			

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

	Specialist CQUIN		2013/14 Baseline	2014/15 Target	YTD Status	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Q1	Q2	Q3	Q4	Year End Position
	National CQUINS																					
Performance	**ODNs**	Support the Operational Delivery Networks (ODNs)	N/A	Provide financial support to ODNs																		
Performance	**Quality Dashboard**	Regular Submission of Data via a Specialised Services Quality Dashboard	N/A	Submit data to Specialty Dashboard as per reporting schedule																		
Commentary	**ODNs**	Support the Operational Delivery Networks (ODNs)																				
Commentary	**Quality Dashboard**	Regular Submission of Performance Data via a Quality Dashboard																				
	Local CQUINS																					
Performance	**Dental Dashboard**	Submit Data to the Dental Dashboard	N/A	Submit data to Dental Dashboard as per reporting schedule																		
Performance	**Hand Held Patient Records**	TBC	TBC																			
Performance	**Neonatal**	TBC	TBC																			
Performance	**Public Health Screening**	TBC	TBC																			
Commentary	**Dental Dashboard**																					
Commentary	**Hand Held Patient Records**																					
Commentary	**Neonatal**																					
Commentary	**Public Health Screening**																					

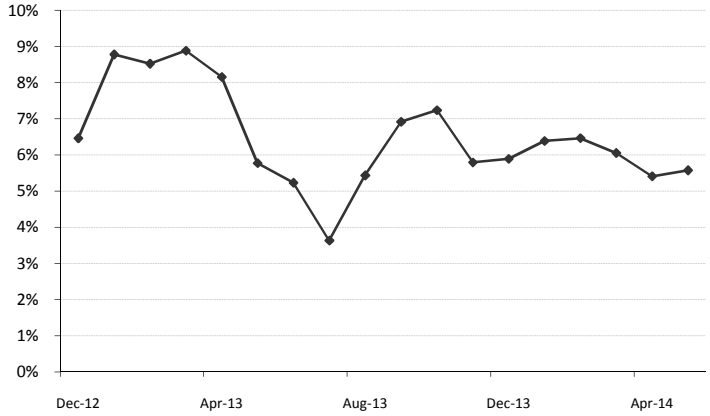
Compliance Against Performance
On target
Monthly target missed; quarterly/annual target at risk
Monthly target missed; annual target at risk

Bed Occupancy



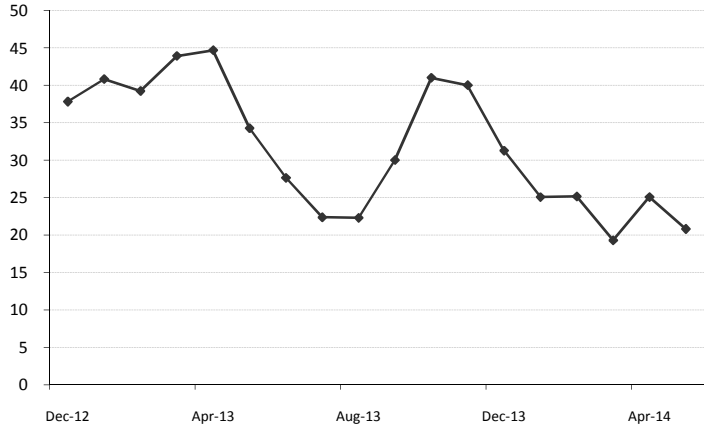
The bed occupancy metric looks only at adult inpatient beds and excludes any ring fenced wards such as Maternity. Occupancy peaked at over 100% during Apr-13, but has since reduced. However, since Aug-13 occupancy has steadily increased with levels becoming static in the last couple of months. Occupancy for May-14 shows an increased position at 96.21% against that seen in April (89.61%), and returns to the level seen in March.

Extra Beds



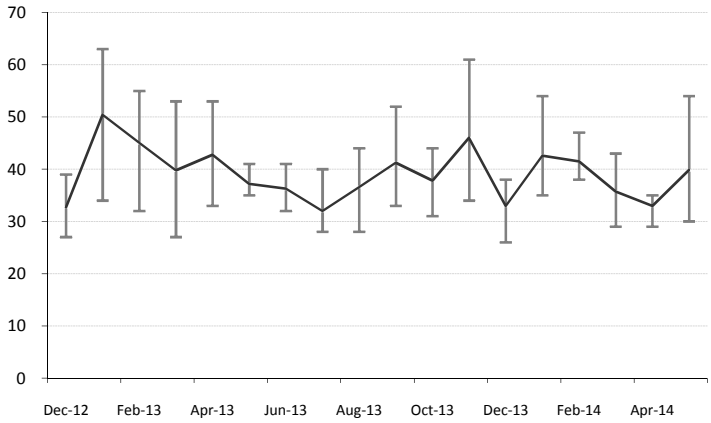
This metric is built up using the number of funded beds on each ward and reviewing those occupied on a daily basis. Where the number of occupied beds exceeds the funded bed base for the ward these are classified as "extra". Following on from months of fluctuation, May's position shows consistency against April, increasing slightly to 5.57% and again indicates the position and use of extra beds is stabilising.

Outliers



The outliers data show the average number of patients bedded in a ward outside of the relevant Division over a given month. In line with the number of extra beds, the number of outliers peaked in Apr-13 when the Trust, and local health economy, was under extreme pressure with unseasonably high emergency flows. The position has now been stable at approximately 25 for the last 3 months. May shows another improvement achieving 20.81, and it is hoped this position will stabilise further moving into 2014/15 being, as it is, underpinned by a reduction in extra beds and the current stable bed occupancy performance.

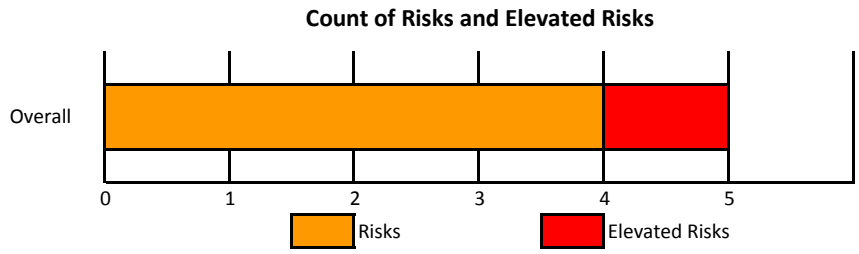
Average Delayed Transfers of Care



In May-14, the number of patients on the Delayed Transfer of Care (DToC) list has increased slightly, linked to the increased bed occupancy, and increase in non-elective admissions through A&E, resulting in a position of 39.80.
The Trust now provides 60 reablement beds, 20 of which became operational on 31 Jan-14. The primary issues for DToC remain, that is, continuing health care, pending assessment by Social Services, and care provision and community resources.

CARE QUALITY COMMISSION: INTELLIGENT MONITORING REPORT

Trust Summary



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

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

The Trust was rated as a Band 3 organisation based on the risk scores calculated by the CQC in the first Intelligent Monitoring Report published in Oct-13. The banding process is no longer being adopted by the CQC. Two further reports have been issued since this time; the most recent being on 13 Mar-14. There are 5 areas showing as a risk; 1 of these is classified as "elevated". This is the Cumulative Sum (CUSUM) for an emergency readmission following an elective admission; the comparative data shows the Trust is performing in line with indicator. The control limits set by the CQC for CUSUM alerting are not clear within the methodology and this alert may have triggered as a result of random variation, particularly as the other indicator is within the expected range.
The remaining areas are classified as "risk". The number of Never Events occurring is calculated by calendar year, rather than financial year; this gives the number as 4. The remaining 3 areas are the same as previous Reports, but with a reduced level of risk. There is an improving position for the Friends and Family Test, the Patient Reported Outcome Measures (PROM) for primary knee replacement is alerting for the composite of the Visual Analogue Scale only. This relates to general patient well-being rather than any functional improvement following the surgery. The GMC enhanced monitoring risk is invoked when there is one or more entries where the GMC status is not closed over a period from 1 Mar-09 to 4 Oct-13. We have sought clarification on 2 of the reported Never Events from NHS England. The chest aspiration is not considered to fulfil the criteria, as this was undertaken outside an operating theatre environment. The retained pack, because it was knowingly inserted as a pack, rather than an unaccounted item during surgery, is not considered a Never Event either. We have alerted the commissioners and are awaiting a response.