EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**26 JUNE 2015**
SUBJECT:	**CLINICAL QUALITY & PATIENT SAFETY**
REPORT FROM:	**ACTING CHIEF NURSE & DIRECTOR OF QUALITY** **MEDICAL DIRECTOR**
PURPOSE:	**To note**

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, which is a requirement to report planned staffing versus actual staffing levels to the Board of Directors; an appendix outlining detailed complaints themes and trends and a heatmap of wards and departments in relation to quality indicators.

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 94.4% of our inpatients were deemed 'harm free' which is a 2% improvement on last month 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 98.9%, similar to last month (98.5%). Further analysis of these data show that the prevalence of patients who had developed a new VTE had slightly increased this month, the remaining indicators similar this month.

- Nurse Sensitive Indicators – In May there were 32 reported incidents of pressure ulcers developing in hospital (27 in April). These include 27 Category 2 pressure ulcers and 4 ulcers categorised as unstageable, and 1 deep tissue injury. Six of the Category 2 ulcers have been assessed as avoidable. The unstageable ulcers will be categorised when they are debrided and the 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 150 patient falls recorded for May (160 in April) of which 81 resulted in no injury. None were graded as severe or death, the remaining were reported as low or moderate harm. The top reporting wards were Cambridge M2 ward (WHH) with 9 falls; CDU (WHH) with 8 falls. Harbledown Ward continues to make good progress with falls reduction for the second month running. The Falls Team have undertaken some focused work with this team.

- Infection Prevention and Control –Trust wide mandatory Infection Prevention and Control training compliance for May was 78.5% and 81% for April. The online training link is now active and staff are being advised to complete this as soon as possible.

- HCAI – There were no cases of MRSA bacteraemias in May, and 3 cases of C. difficile occurring within the Trust during the month (against a trajectory of four). The earlier cases reported on Harbledown Ward identified lapses of care that may have contributed to the development of the cases. The Ward remains on special measures around infection prevention and control practices, supported by the Infection, Prevention and Control Team. There were 44 cases of E.coli bacteraemia in May. Thirty nine cases occurred pre-48h and 5 occurred post-48h. There were 13 cases of MSSA bacteraemia in May. All cases occurred pre-48h.

- Mortality Rates – The most recent HSMR performance was reported in December 2014 and equalled 78.6 compared to 83.7 in December 2013. Next month we are hoping to have the full 14/15 data up to March. Crude mortality for non-elective patients continues to show a reduction on January's elevated position. 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 May. 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, then slight reductions seen in December to March that reflected the requirement for additional shifts during winter pressures not always being filled by NHSP, and due to annual leave being taken at the end of the financial year. Fill rates improved during April and are similar this month in May. This correlates with a reduction of incident reporting around staffing difficulties reported this month. Please see the attached appendix for greater detail on nursing staffing and the 'heatmap' for correlation of patient safety and quality of care against the fill rates.

- Risk Management – In May a total of 1101 clinical incidents were reported. Five serious incidents were required to be reported on STEIS in May. Eight cases have been closed since the last report. There remain 71 serious incidents open at the end of May. Incidents may be re-graded following investigation. The team are working closely with the CCGs and the Divisions to complete the investigations and share the learning as soon as possible.

CLINICAL EFFECTIVENESS

- Bed Occupancy – The bed occupancy metric looks only at adult inpatient beds and excludes any ring fenced wards such as Maternity. In May a further reduction in bed occupancy was reported, including a reduction in the number of extra unfunded beds in use, and patients bedded in a ward outside of their Division (Outliers).

- Readmission Rates – Readmission rates are reported 2 months in arrears. The 7 day and 30 day readmission rates for April-15 continues to show an improved position from the same period last year.

- CQUINs – The 2015/16 CQUINs have yet to be finalised with our CCG colleagues but will include national quality improvements for Sepsis, Acute Kidney Injury and dementia. Development of the integrated Heart Failure, COPD, Diabetes and Over 75s pathways 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 May there were 9 reportable mixed sex accommodation breaches to NHS England via the Unify2 system, occurring in the CDU at WHH. The remaining cases occurred in the Stroke Units which is a justifiable mixing based on clinical need.

- Compliments & Complaints – During May we received 75 complaints, which is similar to April. One formal complaint has been received for every 1010 recorded spells of care similar to April. During May there were 77 informal concerns (81 in April), 231 PALS contacts (similar to last month) and 2175 compliments (compared to 2513 in April). This represents a ratio of compliments to formal complaints of 29:1, and one compliment being received for every 29 recorded spells of care.

  The number of returning clients seeking further resolution of their concerns during April was 19 (17 in April). 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 97% of the responses out on time to clients during May (95% in April). Every Division achieved the required standard this month with this being the third consecutive month we have achieved this standard. 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 40% with the average length of time a complaint was open during May as 39 days. UC&LTC is the only Division who achieved the 30 day standard. 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 Management 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 May were, problems with communication, concerns about clinical management and problems with attitude.

Appended is a more detailed review of complaints and offers the Board of Directors a detailed overview of the complaints performance as of the end of Q4 14/15, and pulls through current hotspots and trends as of May-15.

- Friends and Family Test – During May we received 14597 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 below:

Table 1 - Response Rates and Percentage Recommended – May 2015

Department	Response Rate		Percentage recommended	
Inpatients*	54%	↑	95%	↑
A&E	29%	↑	84%	↑
Maternity	20%	↓	98%	↑
Day Cases**	39%	-	39%	-
Outpa□i□nts	27%	↑	94%	↑

* Now includes paediatrics.
** Was included last month in the inpatient total.

It is encouraging to see that satisfaction rates have improved in all areas that we are able to compare to last month. Our star rating for this month equals 4.7 out of 5.0, improving on 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.

The Staff FFT takes place during June and we are hoping for an improved

score given the cultural change and staff engagement work that is in progress. The previous score showed a 2% improvement with 47% of staff recommending the Trust as a place to work and 72% said they would recommend the Trust to friends and family as a place to be treated.

CARE QUALITY COMMISSION

The latest Intelligent Monitoring Report (IMR) was received on the 21st May 2015. The draft has been released and will be reported next month. This report shows four elevated risks in areas which have not previously flagged and which will remain in the IMR until the results of national surveys improve. The staff survey is flagged as an elevated risk along with our Monitor governance rating and snapshot of whistleblowing.

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 are currently meeting the limit set by NHS England. 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. Although we have achieved this for 3 consecutive months, the length of time complaints are open now needs focus to maintain our improvement journey. The Complaints Management 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. The maintenance of safe staffing levels given the vacancy factors and occasions where extra beds are opened due to operational pressures. A robust recruitment and retention action plan is in place including an overseas recruitment drive to ensure our war staffing remains safe;
6. Successful delivery of the CQC Improvement Plan. Divisions are progressing the actions and monthly meetings with Monitor are in place.

FINANCIAL AND RESOURCE IMPLICATIONS:

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

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

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

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

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

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

None

ACTION REQUIRED:

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

CONSEQUENCES OF NOT TAKING ACTION:

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

CLINICAL QUALITY & PATIENT SAFETY PERFORMANCE SUMMARY

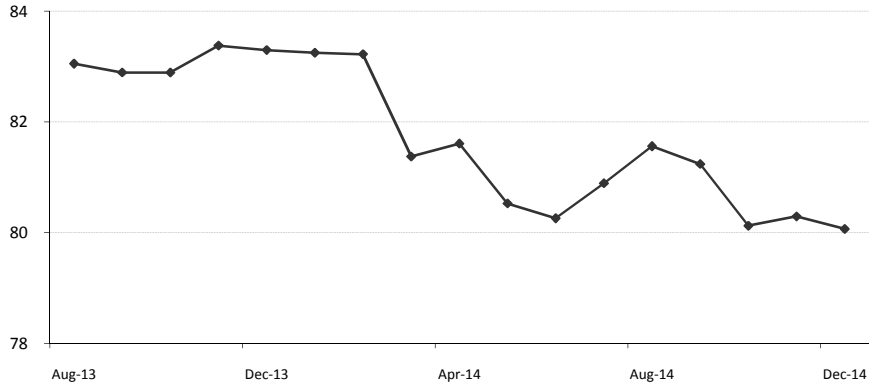
Introduction

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

	Measure	Improvement Metric		Target 15/16	Dec-14	Dec-13	vs Dec-13	YTD
Patient Safety	Mortality Rates	HSMR		-	80.1	83.3	↓	
					Q1 14/15	Q1 13/14	vs Q1 13/14	YTD
		SHMI (%)		-	95.30%	95.51%	↓	-
					May-15	May-14	vs May-14	YTD
		Crude Mortality: All Ages (Per 1000)	Non-Elective	-	28.940	26.365	↑	30.244
			Elective	-	0.117	0.117	↓	0.232
	Risk Management	Serious Incidents (STEIS)	New Incidents	-	6	8	↓	-
			Open Incidents	-	71	47	↑	Cumul.
	HCAI	MRSA	Attributable	0	0	0	↔	Cumul.
		C. difficile	Post 72h	45	7	7	↔	Cumul.
	Infection Prevention				Apr-15	Apr-14	vs Apr-14	YTD
		Mandatory Training Compliance (%)		95.0%	81.0%	82.6%	↓	81.0%
					May-15	May-14	vs May-14	YTD
		Mandatory Training Compliance (%)		95.0%	78.5%	83.3%	↓	79.9%
	Harm Free Care (HFC)				May-15	May-14	vs May-14	YTD
		Safety Thermometer HFC (%) - Old & New Harm	EKHUFT	93.0%	94.4%	93.5%	↑	93.4%
			National	-	94.0%	93.6%	↑	-
	Nurse Sensitive Indicators	Pressure Ulcers: Category 2,3 and 4	Acquired	-	26	22	↑	56
			Avoidable	79	7	10	↓	10
		Falls		-	150	172	↓	313
	Clinical Incidents	Total Clinical Incidents		-	1101	1102	↓	2172
Patient Experience	Compliments and Complaints	Compliments:Complaints		-	29:1	21:1	↑	-
		No. Care Spells per Formal Complaint		-	1010	864	↑	-
	Experience	Friends and Family Test (Star Rating)		5.0	4.7	4.4	↑	-
		Adult Inpatient Experience (%)		80.00%	89.20%	88.92%	↑	-
		Mixed Sex Accommodation Occurrences		-	14	7	↑	28
Clinical Effectiveness	Readmission				Apr-15	Apr-14	vs Apr-14	YTD
		7 Day (%)		2.00%	4.06%	4.24%	↓	4.06%
		30 Day (%)		8.32%	8.42%	9.12%	↓	8.42%
	CQUIN				May-15	May-14	vs May-14	YTD
		Standard Contract CQUIN		Multiple			↔	
		Specialist CQUIN		Multiple			↔	
	Bed Usage	Bed Occupancy (%)		-	81.77%	98.30%	↓	-
		Extra Beds (%)		-	5.35%	6.04%	↓	5.85%
		Outliers		-	22.42	30.26	↓	60.95
		Delayed Transfers of Care (Average)		-	35.50	39.80	↓	33.55
Care Quality Commission	Intelligent Monitoring Report	Outcome Measures	Risks	-	3	4	↓	-
			Elevated Risks	-	6	1	↑	-

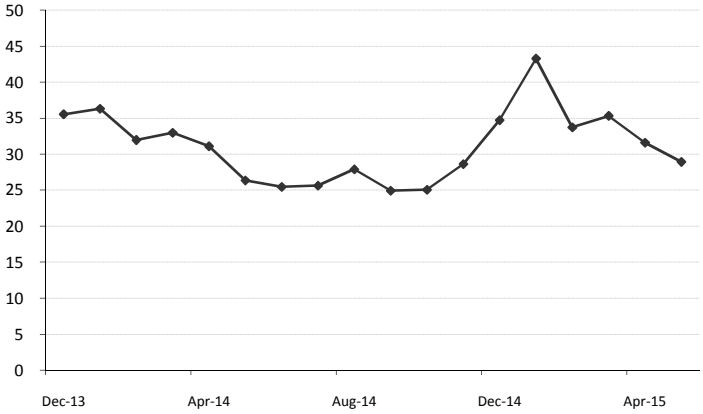
CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: MORTALITY RATES

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 80.1, that is, approximating the value reported in Nov-14 (80.3) and compares with an elevated position of 83.3 in Dec-13.

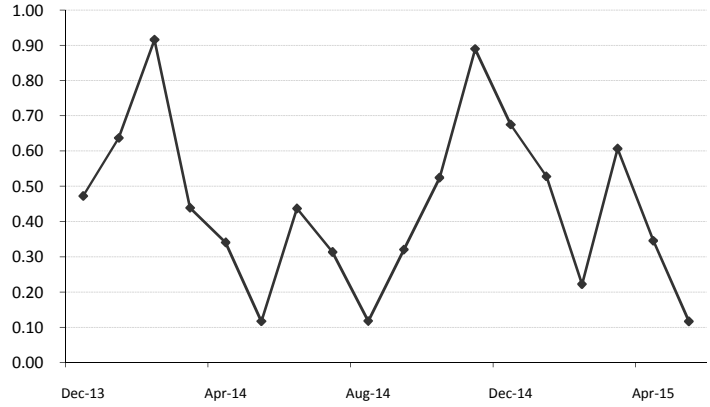
Crude Mortality - Non-Elective per 1000



Crude mortality for non-elective patients shows a fairly seasonal trend with deaths higher during the winter months. Performance in May-15 equalled 28.940 deaths per 1000 population, thus showing an approximate 14 point reduction on January's elevated position (cf. 43.265), and is slightly greater than the level reported in May-14 where 26.365 deaths per 1000 population were recorded.

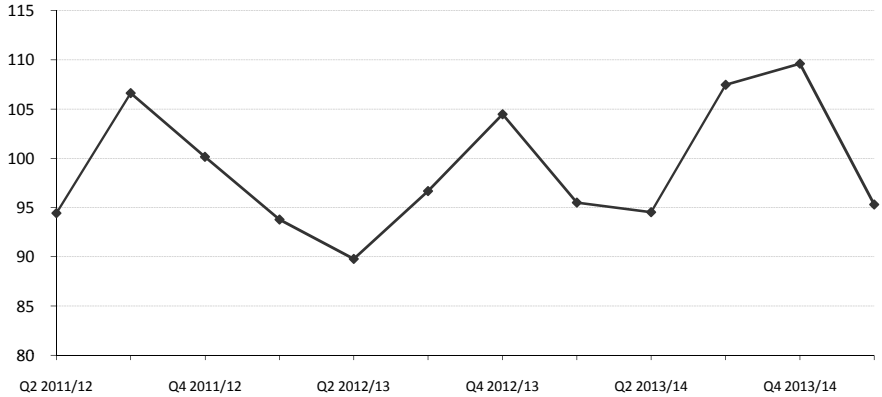
NB: Crude Mortality data are sourced from the Trust's Balanced Scorecard as of 4 Jun-15.

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 May-15 (i.e.0.117 deaths per 1000 population, equivalent to the position in May-14). 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.

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				
16-May-15	22-May-15	Maternity/Obstetric Incident: Baby only	2	Specialist	Not Due
14-May-15	21-May-15	Suboptimal Care - deteriorating patient	2	UCLTC	Not Due
4-May-15	14-May-15	Suboptimal Care - deteriorating patient	2	UCLTC / Surgical	Not Due
3-May-15	12-May-15	Unexpected Death	2	Surgical	Not Due
12-May-15	12-May-15	Fall	2	UCLTC	Not Due
20-Apr-15	5-May-15	Suboptimal Care - deteriorating patient	2	Surgical	Not Due
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	Breach
12-Feb-15	13-Mar-15	Unexpected Death - general	1	Specialist	Stop the Clock
12-Mar-15	13-Mar-15	Allegation Against HC Professional - assault	1	UCLTC	Stop the Clock
7-Mar-15	10-Mar-15	Fall	1	UCLTC	Breach
21-Feb-15	9-Mar-15	Category 3 hospital acquired pressure ulcer	1	UCLTC	Breach
3-Mar-15	4-Mar-15	Death - child	2	Specialist	Yes
1-Mar-15	2-Mar-15	Unexpected Death - neonatal (Maternity Services)	2	Specialist	Extension
23-Feb-15	25-Feb-15	Suboptimal Care - deteriorating patient	1	Surgical	Breach
20-Jan-15	24-Feb-15	Fall	1	UCLTC	Breach
11-Feb-15	16-Feb-15	Maternal unplanned admission to ITU	2	Specialist	Breach
7-Jan-15	13-Feb-15	Fall	1	UCLTC	Breach
26-Jan-15	13-Feb-15	Unexpected Admission - NICU	2	Specialist	Breach
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
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		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	1	UCLTC	Breach
24-Dec-15	9-Jan-15	Category 3 hospital acquired pressure ulcer (avoidable)	1	Surgical	Breach
21-Dec-14	23-Dec-14	Unexpected Admission - NICU	2	Specialist	Breach
29-Nov-14	18-Dec-14	Delayed Operation	1	Surgical	Yes
11-Dec-14	18-Dec-14	Unexpected Admission - NICU	2	Specialist	Extension
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		UCLTC	Breach
26-Oct-14	17-Nov-14	Suboptimal Care - deteriorating patient (child cardiorespiratory arrest)	2	Specialist	Breach
13-Sep-14	13-Nov-14	Fall	1	UCLTC	Yes
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
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
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

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

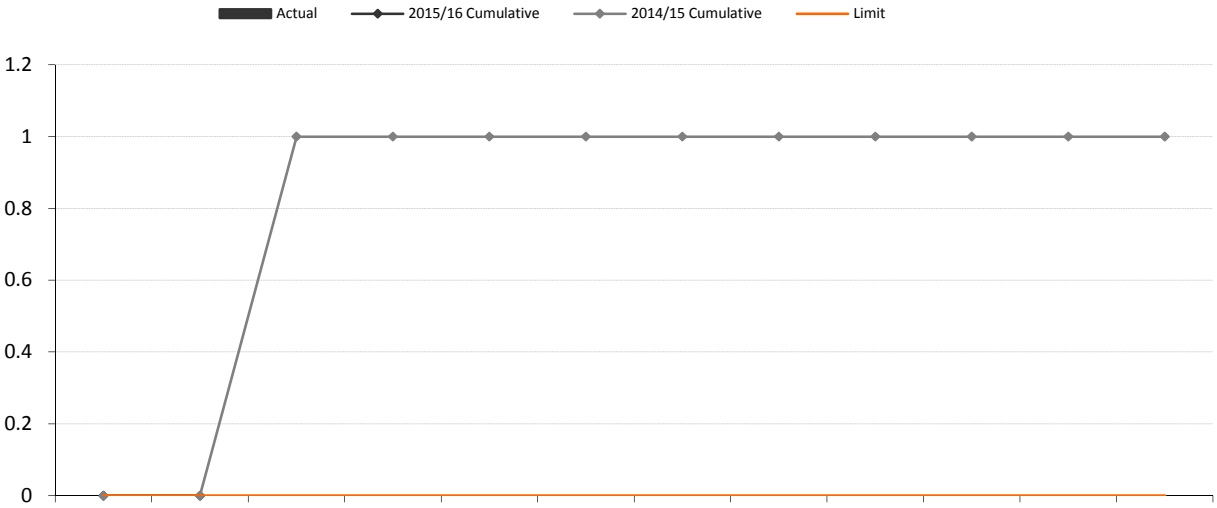
Serious Incidents closed by KMCS but remaining open on STEIS pending review by external bodies.

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

Six serious incidents were reported on STEIS during May-15. These were: 3 suboptimal care of deteriorating patients, a maternity incident (baby only), an unexpected death and fall incident. Eight incidents have been closed on STEIS by the CCGs. At the end of May-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 (QAB) 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 May-15 there were 71 serious incidents open on STEIS. The Adverse Incident Reporting policy and investigation templates have been updated and are due to be ratified at the QAB on 3 Jun-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.

PATIENT SAFETY: HOSPITAL ACQUIRED INFECTIONS

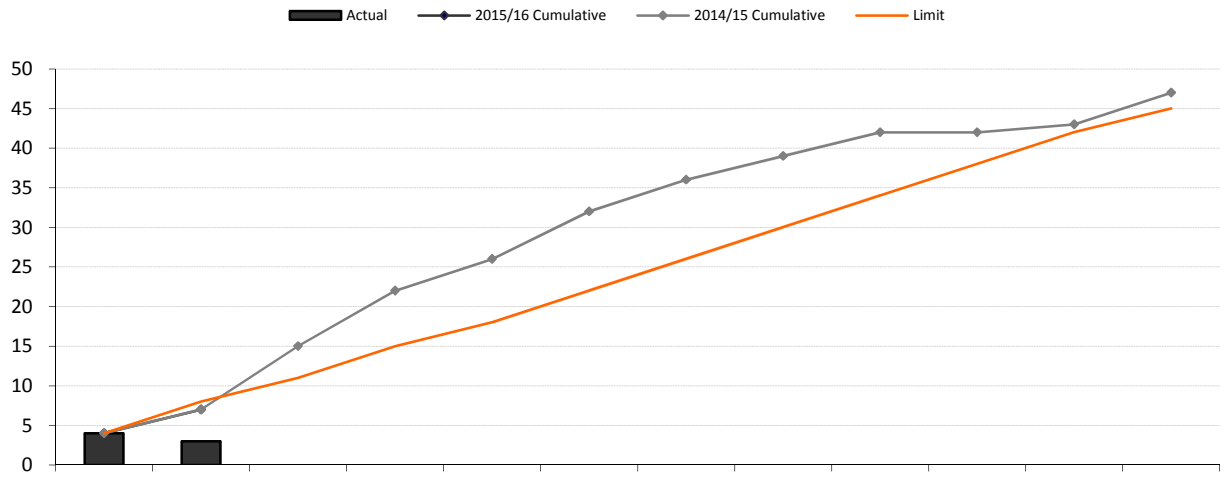
MRSA Bacteraemia - Trust Assigned Case



	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	0										
2015/16 Cumulative	0	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 May-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	3										
2015/16 Cumulative	4	7										
2014/15 Cumulative	4	7	15	22	26	32	36	39	42	42	43	47
Limit	4	8	11	15	18	22	26	30	34	38	42	45

There were 3 cases of C. difficile in May-15 against a monthly trajectory of 4 cases, and a year end limit for 2015/16 of 45 cases. One case within UCLTC Division (Oxford), 1 within Surgical Services Division (ITU, WHH) and 1 within Specialist Services Division (Marlow). RCAs are pending for the cases recorded in May-15.
Outcomes of the Harbledown Period of Increased Incidence (PII) cases RCA and discussions at the Lapses in Care meeting with CCG identified lapses of care that could have contributed to the development of C. difficile infection in both patients for the following reasons:

- Ribotyping: Ribotyping could only be undertaken for 1 of the patients; it failed in the other. This means that we do not know whether or not the strains were the same.
- Four out of 5 commodes were found to be soiled on a spot inspection by the Infection Prevention and Control Specialist Nurse. A curtain in 1 of the toilets was also found to be soiled.
- Hand hygiene compliance was below the minimum threshold.

Therefore, it is possible that lapses of care occurred where different management may have made a difference to the outcome. Harbledown has been in Special Measures and an action plan is in place to address the above issues.

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	39											36.0	72
	Post 48h	6	5											5.5	11
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

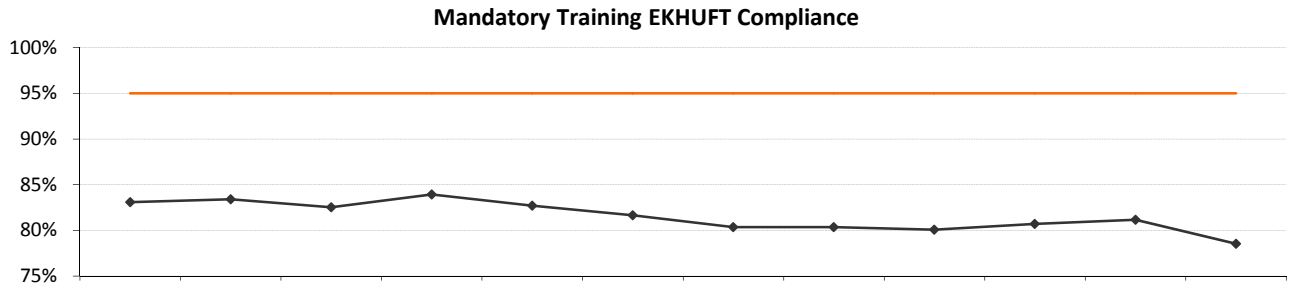
Provisional data indicate that there were 44 cases of E.coli bacteraemia in May-15. Thirty nine cases occurred pre 48h, and five cases occurred post 48h.

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											13.0	26
	Post 48h	1	0											0.5	1

Provisional data indicate that there were 13 cases of MSSA bacteraemia in May-15. All 13 cases were pre 48h bacteremia.

CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: INFECTION PREVENTION & CONTROL



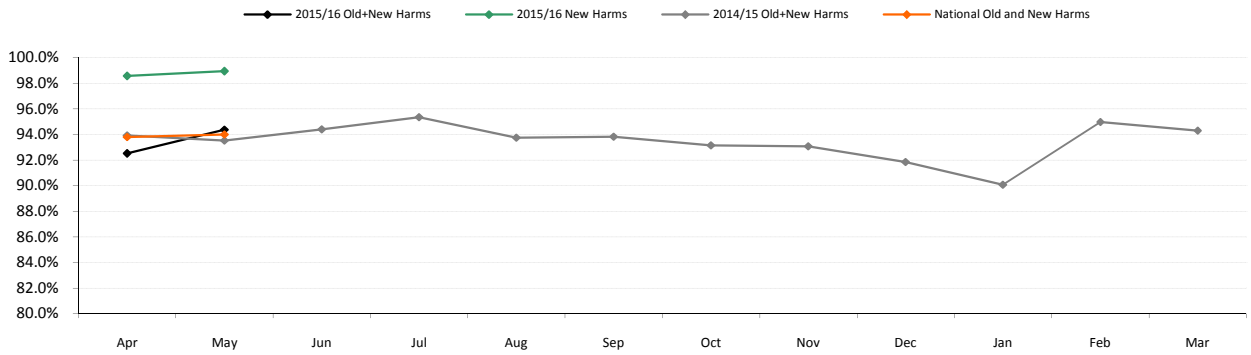
	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Compliance	83.1%	83.4%	82.5%	84.0%	82.7%	81.7%	80.4%	80.4%	80.1%	80.7%	81.2%	78.5%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

	Target	Trust	Clinical Support Services	Corporate	Specialist Services	Strat Dev & Capt Pln	Surgical Services	UCLTC	Serco
	Apr-15								
Mandatory Comparative Data for Biennial Training Compliance	95%	81.2%	87.6%	82.9%	77.5%	87.4%	78.7%	79.4%	86.0%
	May-15								
	95%	78.5%	83.6%	80.7%	74.3%	87.1%	75.8%	78.3%	85.0%

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

Trust compliance decreased slightly from 81.2% in Apr-15 to 78.5% in May-15.
Decreases have been seen in both the Clinical Support Services Division (from 87.6% to 83.6%), and the Specialist Services Division (77.5% to 74.3%).
Minor decreases have been seen in the Corporate Division (from 82.9% to 80.7%), Strategic Development and Capital Planning (from 87.4% to 87.1%), Surgical Services Division (from 78.7% to 75.8%), and UCLTC (from 79.4% to 78.3%).
Serco compliance decreased by 1.0% from 86.0% to 85.0%.

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:

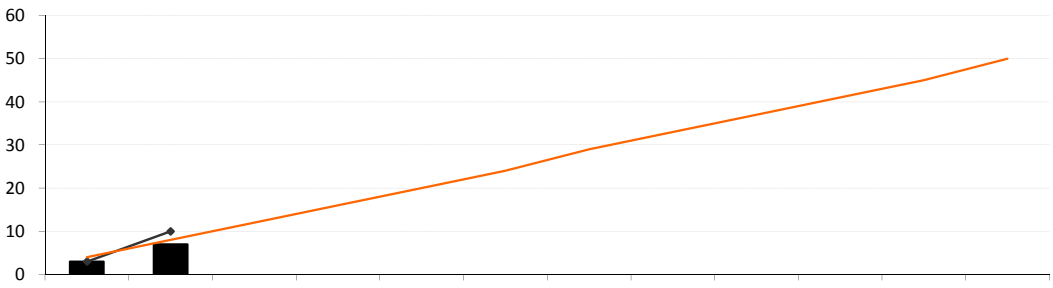
- All categories of pressure ulcers whether acquired in hospital or before admission;
- All falls whether they occurred in hospital or before admission;
- Urinary tract infection (inpatients with a catheter);
- Venous thromboembolism, risk assessment and appropriate prevention.

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 94.4% of our inpatients were deemed "harm free" which is a 1.9% improvement on last month, and is also slightly greater than the national figure i.e. (94.0%). This figure includes those patients admitted with harms and those who suffered harm whilst with us. The percentage of patients receiving harm free care during their admission with us (which we are able to influence) is 98.9% which is increase on last month (98.7%). Whilst all 3 sites demonstrated "New Harms Only" harm free care of >98.0% in month, the performances of QEH and WHH equalled 99.0% and 99.3% respectively. Further analysis of these data show that the prevalence of patients who had developed a new VTE had increased worsened by 0.3% this month, the remainder were either improved or similar to last month.

Category 2 Incidence Trajectory 2015/16
25% Reduction

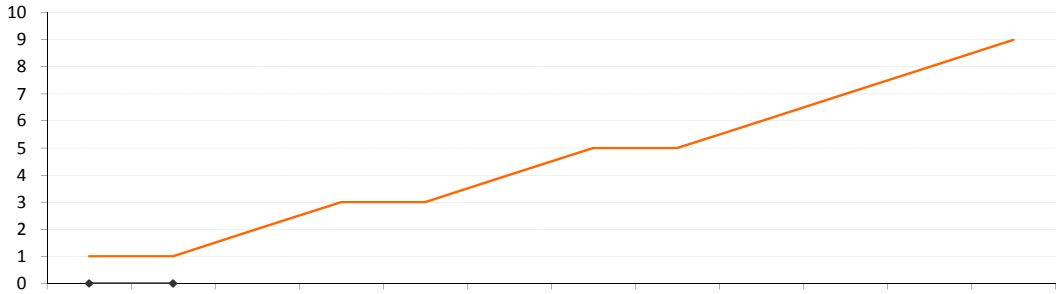


	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
2015/16 Avoidable	3	7										
2015/16Cum Avoidable	3	10										
2015/16Cum Trajectory	4	8	12	16	20	24	29	33	37	41	45	50
per 1000 bed days	0.10	0.23										

In May-15, a total of 26 acquired Category 2 pressure ulcers were reported, 7 of which were avoidable. This represents an increase compared with the previous month. Three avoidable ulcers occurred at QEH; 2 on Cheerful Sparrows Female due to lack of evidence of repositioning, and 1 on Bishopstone due to lack of evidence of risk assessment and heel offloading. Three cases were recorded at KCH, 1 instance each on Marlowe (i.e. a sacral ulcer due to delay in risk assessment), Kingston (i.e. a heel ulcer which lacked appropriate reassessment to high risk when the patient became unwell), and Harbledown (i.e. a sacral ulcer following incorrect risk assessment on admission). A sacral ulcer was recorded on Richard Stevens Stroke Unit (WHH) and resulted because of delays, lack of repositioning, and sitting too long in a chair.

The majority of avoidable Category 2 pressure ulcers in month were recorded at the sacrum, and the Trust's Action Plan is focusing on reducing avoidable sacral ulcers by 25%.

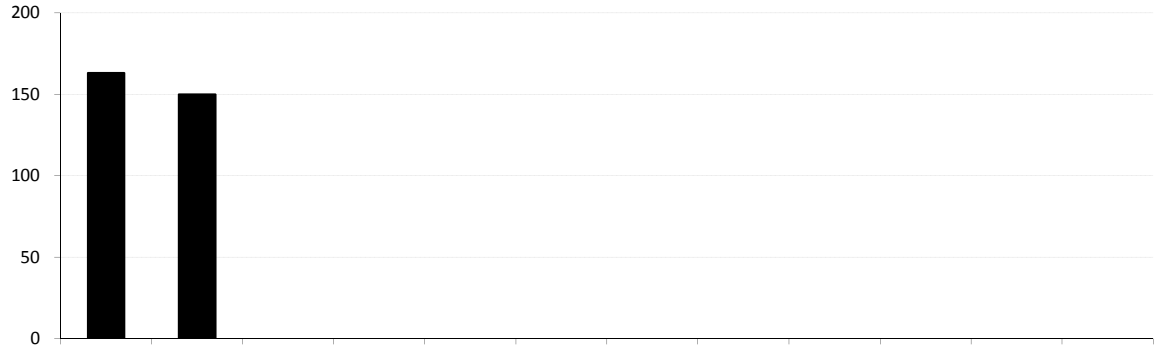
Category 3 and 4 Incidence Trajectory 2015/16
25% Reduction



	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	0										
2015/16Cum Avoidable	0	0										
2015/16Cum Trajectory	1	1	2	3	3	4	5	5	6	7	8	9
per 1000 bed days	0.00	0.00										

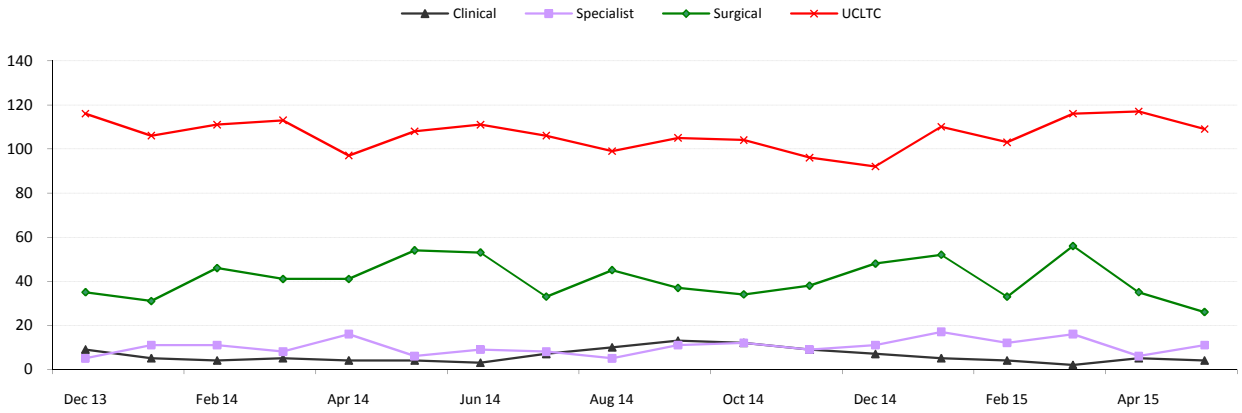
In May-15, there were 4 acquired pressure ulcers categorised as unstageable. Three heel ulcers occurred at WHH (A&E, Kings D and ITU), and 1 sacral ulcer on Minster (QEH). All ulcers are classified as unstageable as the depth of the ulcer is either obscured by necrotic tissue or discolouration. One ulcer was found to be avoidable and will be reported when categorised. This patient had a discoloured heel noted on first skin assessment within 24h of admission. Following review the discolouration appeared to be resolving and was unlikely to develop into a deep ulcer. The ulcer is awaiting an in depth investigation in order to decide whether more could have been done to prevent this incident. Following from last year's achievements a further 25% reduction trajectory for heel ulcers has been set.

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	163	150										
2015/16 Cum	163	313										
per 1000 bed days	5.47	4.90										

Patient Falls - Injurious and Non-Injurious By Division

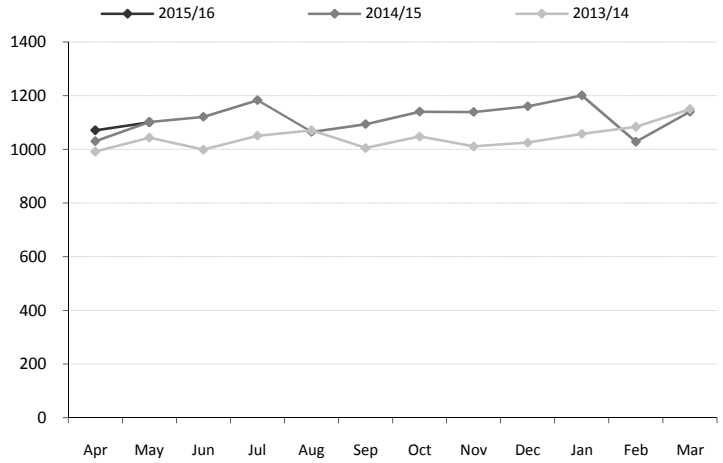


In May-15 there were 150 falls across the Trust, a significant decrease on the previous month. Of these, 38 were at KCH, 52 at QEH and 58 at WHH. Wards with the highest reported number of falls were Kingston (6), Fordwich (7), CDU WHH (9) and Cambridge M2 (7). Four falls at QEH resulted in fractures, 2 wrist fractures on Bishopstone and CCU (both unavoidable), 1 ankle fracture on Fordwich (unavoidable), and 1 hip fracture on Seabathing which was avoidable and an RCA is underway. Over the previous year Harbledown at KCH has had consistently the highest number of falls Trust wide. However, with extensive measures to improve the workplace culture and provision of safe care, the falls this month reduced to 5. The Falls Team will continue to support Harbledown to consistently reduce falls.

CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: CLINICAL INCIDENTS

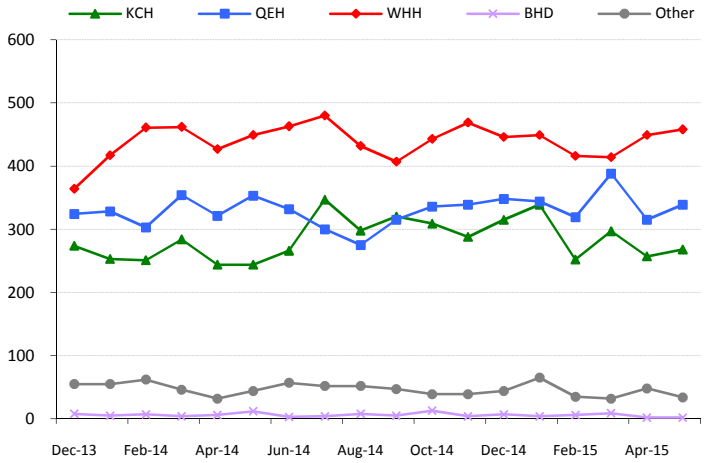
In May-15 a total of 1101 clinical incidents (excluding duplicates) were reported. This included 5 incidents graded as death and no incidents graded as severe harm. Four of the 5 serious incidents have been reported on STEIS and the other incident will be discussed at the Executive SI Group and related to delayed diagnosis of possible splenic haematoma. In addition to these 5 incidents, 7 incidents have been escalated as a serious near miss and all of which are under investigation. There continues to be a reduction in the proportion of moderate harm incidents reported during May-15 (i.e. May-15: 45 compared with Apr-15: 55 and May 2014: 98) 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. A Duty of Candour section has been added to the incident form to monitor compliance.
Six serious incidents were required to be reported on STEIS in May. Eight cases have been closed since the last report; there remain 71 serious incidents open at the end of May.

Overall Incident Rates by Year



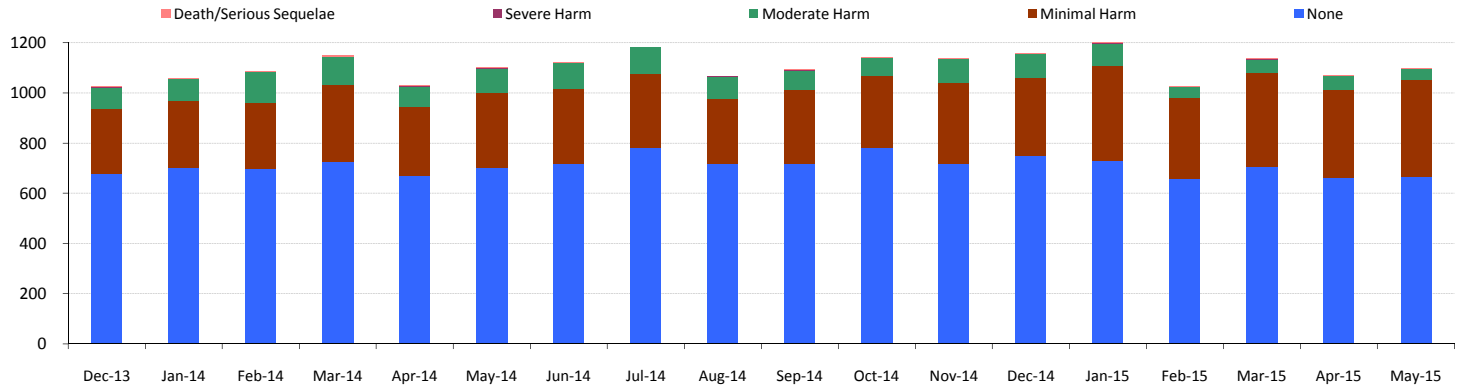
A total of 1101 clinical incidents have been logged in as occurring in May-15 compared with 1071 recorded for Apr-15 and 1102 in May-14.

Overall Incident Rates by Site



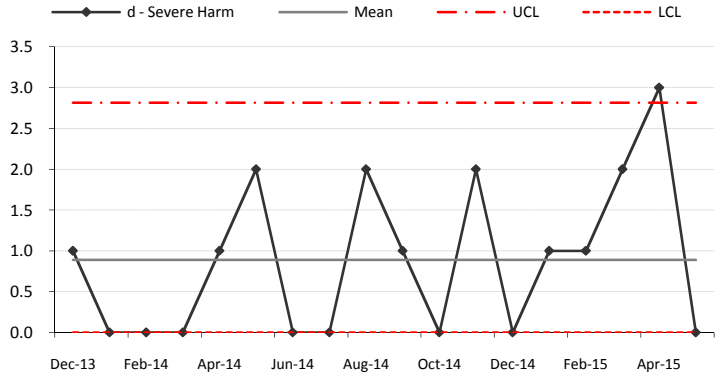
Incident reporting has increased at all 3 main sites.

Clinical Incidents by Severity

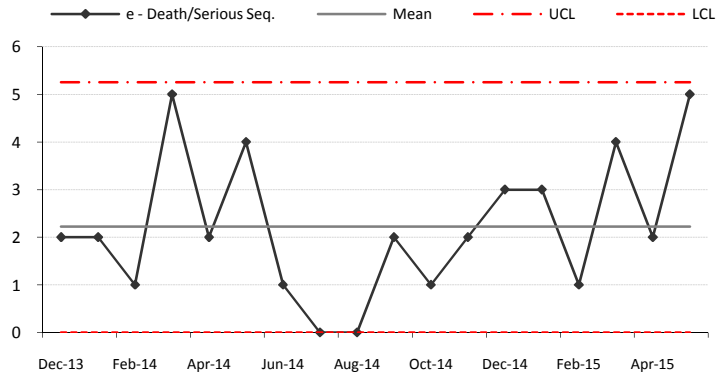


The incidents graded as moderate, serious and death have all been subject to review in order to confirm the consistency of the grading of harm across the Trust. The Board of Directors may see a change in this report to reflect the re-categorisation process undertaken. This is consistent with the data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

Severe Harm

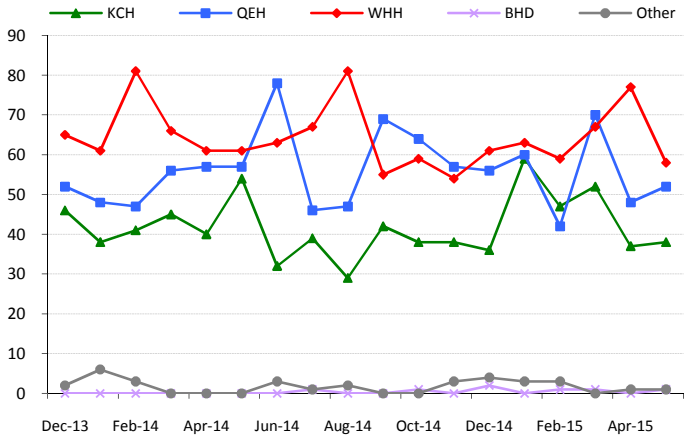


Death/Serious Sequelae



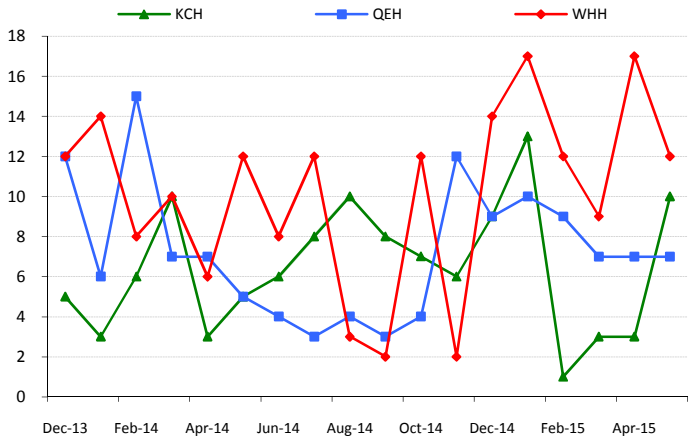
The number of death/serious and severe harm incidents reported in May-15 remains subject to the usual RCA investigation and review. It is possible that the severity of these cases will be downgraded once the investigation process is completed in line with national guidance to ensure the actual harm caused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

Patient Slips, Trips and Falls



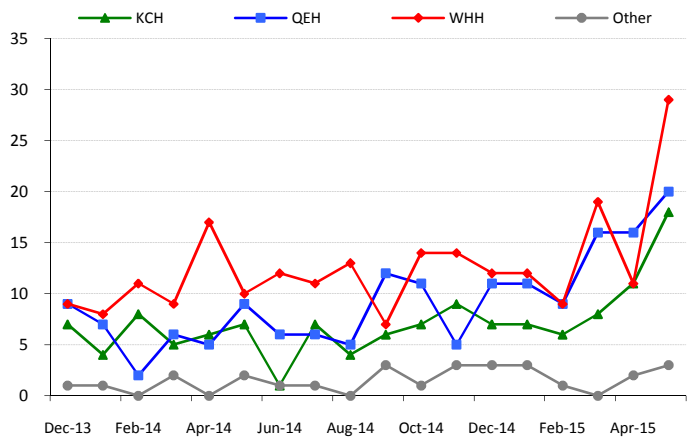
Of the 150 patient falls recorded for May-15 (163 in Apr-15 and 172 in Apr-14), 4 incidents were graded as moderate, no incidents were graded as severe or death. There were 81 falls resulting in no injury and 65 in low harm. The top reporting wards were Cambridge M2 (WHH) with 9 falls; CDU (WHH) with 8 falls; Cambridge M1 (WHH) and Fordwich Stroke Unit (QEH) with 7 each; Deal (QEH), Kingston Stroke Unit (KCH) and Cambridge L (WHH) with 6 falls each; the remaining wards reported 5 or less falls.

Hospital Acquired Pressure Ulcers



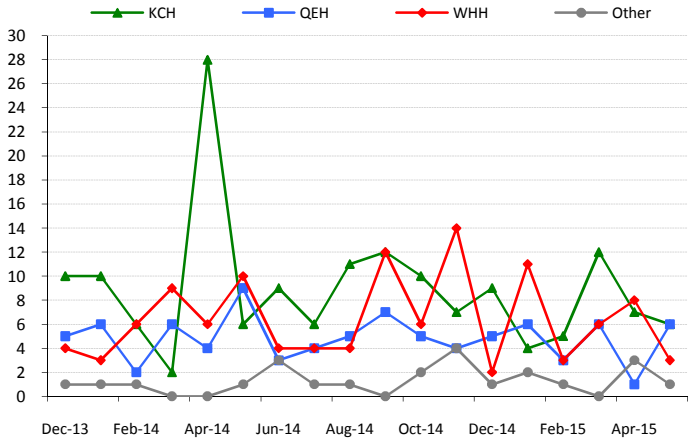
In May there were 30 reported incidents of pressure ulcers developing in hospital (27 in Apr-15 and 22 in May-14). The May-15 incidents included 26 Category 2 pressure ulcers, 7 of which have been assessed as avoidable. No Category 3 or 4 ulcers have been reported. In addition, there are 4 ulcers assessed as unstageable. The highest reporting wards with regards to the Category 2 ulcers were Cheerful Sparrows Female (QEH), Treble (KCH), Seabathing (QEH), Cambridge J (WHH), Cambridge M2 (WHH) and Kings D Male (WHH) with 2 incidents each; 14 other wards or departments reported 1 incident each.

Delay in Providing Treatment



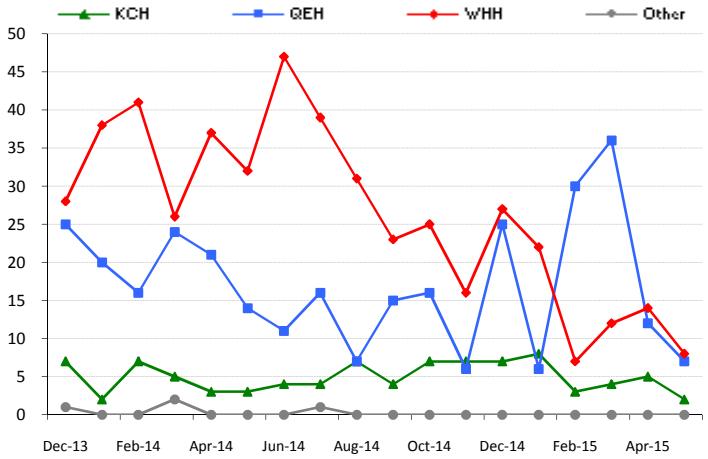
There were 69 incidents resulting in delay in providing treatment during May compared with 40 in Apr-15 and 28 in May-14. Two incidents were graded as death and have both been reported on STEIS; none were graded as severe harm. Four have been graded as moderate harm and are currently under investigation, 24 have been graded as low harm and 39 resulted in no harm. Themes in location were: 5 incidents occurred in Celia Blakey unit (WHH); 4 in A&E (WHH); 3 each in Ambulatory Care (WHH), Waiting List (WHH) and ECC (KCH); and other areas reported 2 incidents or fewer.

Incorrect Data in Patient Notes



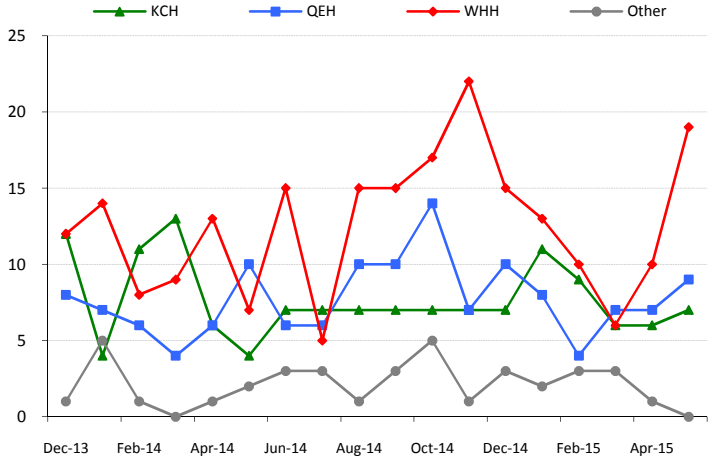
There were 16 incidents of incorrect data in patients' notes reported as occurring in May (19 in Apr-15 and 26 in May-14). Fourteen were graded as no harm and two as low harm; 10 related to incorrect data in paper notes and 6 to Patient Centre. Of the incidents reported, 6 were identified at KCH, 6 at QEH, 3 at WHH and 1 at RVHF. Themes in the location of these incidents: 3 incidents occurred in Outpatients (KCH), 2 in Endoscopy (QEH) and 2 in NICU (WHH).

Staffing Level Difficulties



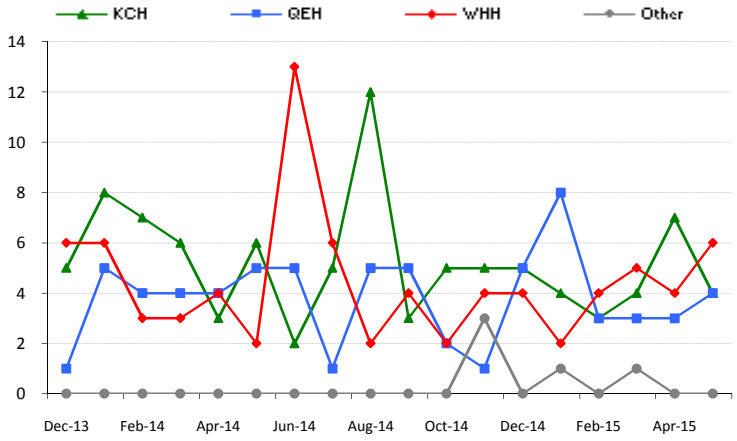
There were 17 incidents recorded in May-15 (31 in Apr-15 and 49 in May-14). These included 9 incidents relating to insufficient nurses, 2 to inadequate skill mix, 1 to insufficient doctors, 1 to recruitment issues (new category) and 4 to general staffing level difficulties. Top reporting locations were WACU (WHH) with 3 incidents; 2 incidents each in theatres (QEH), St Augustine's (QEH) and Kings D Male (WHH). Eight other areas reported 1 incident each.
Two incidents occurred at KCH, 7 at QEH and 8 at WHH. No incidents have been graded as moderate harm, severe harm or death. Fourteen incidents have been graded as no harm and 3 incidents have been graded as low harm. Investigations evidence continued active management of bed, staffing situation and escalation to senior staff.

Communication Breakdowns



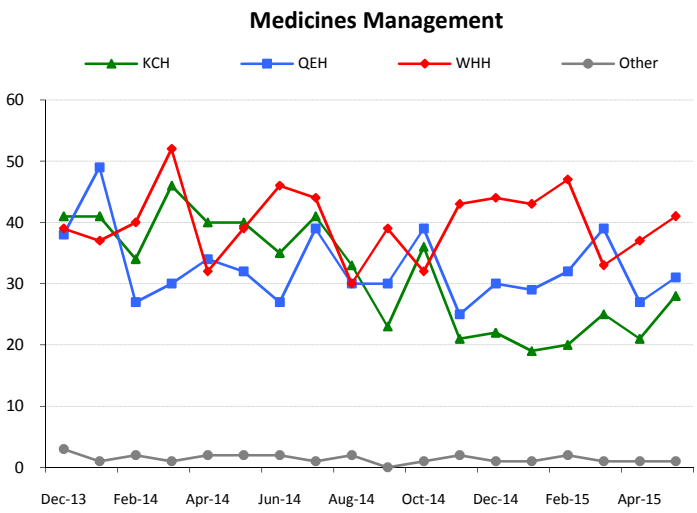
In May-15 there were 35 incidents of communication breakdown (24 in Apr-15 and 23 in May-14). Of those reported, 24 involved staff to staff communication failures, 10 were staff to patient and 1 was staff to relative (or other visitor). Seven were reported as occurring at KCH, 9 at QEH and 19 at WHH. Themes by location: Celia Blakey Unit (WHH) reported 4 incidents; 6 wards/departments reported 2 incidents; 19 other areas reported 1 incident. Incidents in May were graded as follows: 28 as no harm, 6 as low harm and 1 as moderate harm: this related to a breach of patient confidentiality and will be re-categorised as such.

Blood Transfusion Errors



In May, there were 14 blood transfusion errors reported (14 in Apr-15 and 13 in May-14). There were 2 themes arising in the period: 2 incidents relating to delay in providing blood products and 3 incidents of wrong blood in tube. Nine incidents were graded no harm, 4 were graded low harm and 1 moderate harm, which related to a 30 minutes delay in provision of blood for a trauma call in A&E (QEH). Reporting by site: 4 at KCH (2 of which occurred on Marlowe), 6 at WHH and 4 at QEH.

CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: CLINICAL INCIDENTS



Medicines Management

Category	May-15
Prescribing	13
Dispensing	24
Administering	36
Missing (lost or stock discrepancy)	12
Shortage (drug unavailable)	4
Suspected adverse reaction	3
Infusion problems (drug related)	7
Infusion injury (extravasation)	2
TOTAL	**101**

There were 101 medication incidents reported as occurring in May (86 in Apr-15 and 113 in Apr-14). The reporting of medication incidents has increased at all 3 main sites. Of the 101 reported, 79 were graded as no harm including one serious near miss and 20 as low harm. There were 2 incidents graded moderate harm which related to 1) administering of 10 times the correct dose of insulin and 2) adverse reaction to anaesthetic (possible anaphylaxis) requiring admission to ITU. Top reporting areas were: Viking Day Unit (QEH) with 8 incidents; Cambridge M2 (WHH) with 7; Harbledown (KCH) with 5; Pharmacy (QEH), Clarke (KCH), ITU (KCH), Cambridge K (WHH) and Pharmacy (WHH) with 4 incidents each; other areas reported 3 incidents or fewer. Twenty eight incidents occurred at KCH, 31 at QEH and 41 at WHH.

*Missing drugs are broken down as follows: 6 incidents relating to stock discrepancies, 4 to delayed dispensing/drugs missing between Pharmacy and ward/unit, 1 to wastage where a bottle was dropped and 1 to a missing drug chart (to be re-categorised to missing medical notes).

CLINICAL QUALITY & PATIENT SAFETY

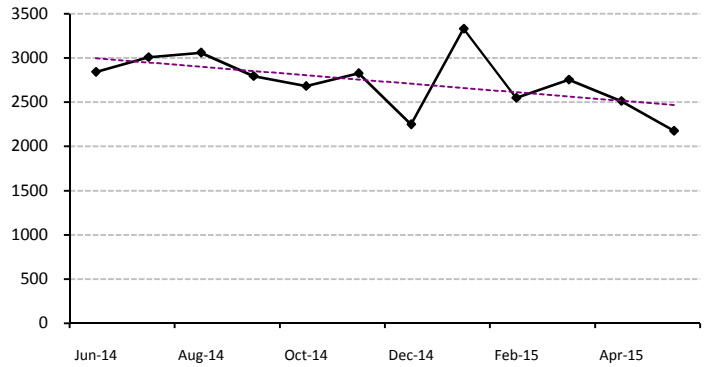
PATIENT EXPERIENCE: CONCERNS, COMPLAINTS & COMPLIMENTS

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

• Activity: Formal complaints (received) - 75; informal concerns - 77; compliments - 2175; PALS contacts - 231.

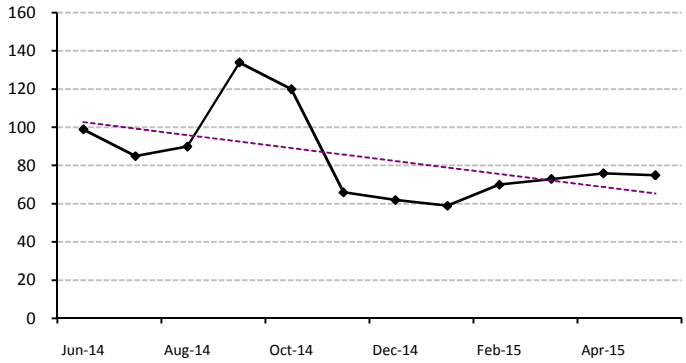
The charts below show the number of complaints and compliments received on a monthly basis. The total number of recorded episodes of care for May-15 was 75,787. In May, 1 formal complaint has been received for every 1010 recorded spells of care (0.09%) in comparison with April's figures where 1 formal complaint was received for every 1019 recorded spells of care (0.09%).

Number of Compliments



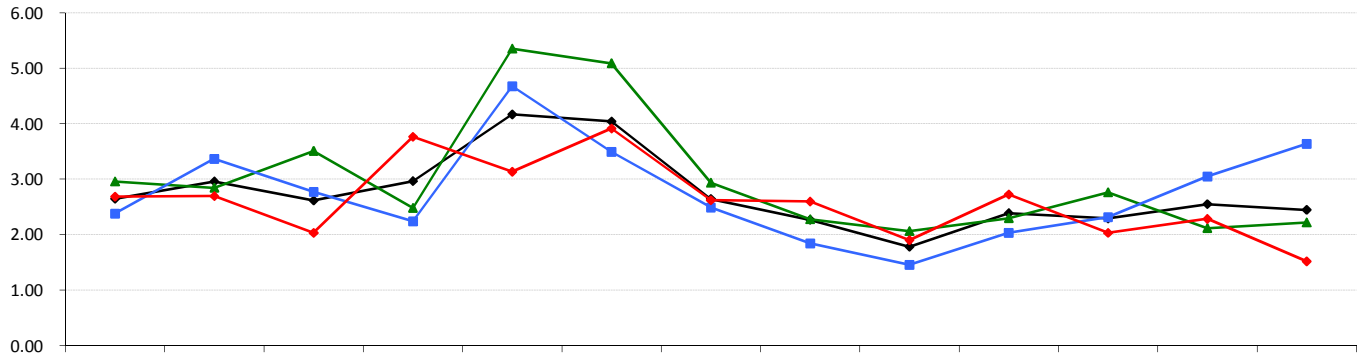
The number of compliments received has decreased by 13% compared with the previous month. The ratio of compliments to formal complaints received for the month is 29:1. There has been 1 compliment being received for every 34 recorded spells of care.

Number of Formal Complaints



The number of complaints received in month has very slightly decreased by 1% compared with Apr-15 (i.e. 75 compared to 76). The number of complaints received during May-15 compared with May-14 has increased by 9% (i.e. 75 compared with 69). The number of concerns has decreased by 4% compared to last month (cf. 77 compared with 81).

Number of Formal Complaints per 1000 Bed Days



	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Trust	2.65	2.96	2.62	2.97	4.17	4.04	2.64	2.27	1.78	2.39	2.29	2.55	2.45
KCH	2.96	2.85	3.51	2.48	5.36	5.09	2.94	2.28	2.07	2.30	2.76	2.12	2.22
QEH	2.38	3.37	2.77	2.24	4.68	3.50	2.49	1.84	1.46	2.03	2.32	3.05	3.64
WHH	2.69	2.70	2.03	3.77	3.14	3.92	2.62	2.60	1.90	2.73	2.03	2.28	1.52

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 lower than last month. WHH is showing the lowest number of formal complaints per 1000 bed days.

PATIENT EXPERIENCE: CONCERNS, COMPLAINTS & COMPLIMENTS

Top Five Concerns Expressed in Formal Complaints
May 2015

		No.
Problems with Clinical Management	Incomplete examination carried out	1
	Lack of / inappropriate pain management	1
	Scans / X-rays not taken	1
	Unhappy with treatment	8
Problems with Communication	Doctor communication issues	3
	Lack of information of how procedure went	1
	Misleading or contradictory information given	4
	Nursing communication issues	1
	Other communication issues (e.g. phones not working)	1
Delays	Delay in allocation of outpatient appointment	1
	Delay in being see in outpatient department	1
	Delay in receiving x-ray results	1
	Delay with elective admission	2
	Delays in being seen in A&E	4
	Delays in receiving treatment	1
Problems with Appointments	Problems with administration	1
	Problems with department appointment	3
	Problems with outpatient appointments	3
Problems with Discharge Arrangements	Lack of information given upon discharge	1
	Unfit for discharge / or poor arrangements	2
	Unhappy about follow-up arrangements / care	1
	Incomplete / illegible discharge letter	1
	Waiting for medication on discharge	1

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

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

Concerns, Complaints and Compliments - Divisional Performance

May 2015

Division	Divisional Activity				Divisional Performance	
	Formal Complaints	Compliments	Informal Concerns	Compliments: Complaints	Response Date Agreed with Client	Returning Complaints
Clinical Support	5	26	7	5:1	8 of 8	0
Specialist Services	14	877	11	62:1	10 of 10	1
Surgical Services	27	433	29	16:1	18 of 20	11
UCLTC	28	822	26	29:1	17 of 17	6
Corporate	1	17	3	17:1	3 of 3	1
Other	0	0	1	0:0	0	0
TOTAL	**75**	**2175**	**77**	**29:1**	**56 of 58**	**19**

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

The table above shows the monthly Divisional activity and performance for May-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 May-15, the data show that 97% of the responses sent out to the clients were sent out on target compared with 95% last month.
UCLTC, Specialist Services, Clinical Support and Corporate Divisions sent out 100% of their responses on target. Surgical Services Division sent a minimum of 85% of their responses on target.
From Apr-15, the Patient Experience Team (PET) have implemented 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 May-15, 40% of responses were sent out to clients within 30 working days (cf. 48% in Apr-15). UCLTC Division took on average 30 working days to respond, whilst the average number of working days for the Trust to deliver a first response was 39 working days.

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

Status of Cases	Actions in May-15
Cases carried over from previous month	17
New cases referred to the Trust	1
Cases closed by PHSO	2
Current open cases with the PHSO	16

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 May the PHSO has been in contact with the Trust in regards to 1 new case relating to Specialist Services (Women's Services (Gynaecology)). This complaint was not upheld.
Out of the 16 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.

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 May we received 14597 responses in total. This includes inpatients, A&E, maternity, outpatients, day cases and paediatrics. The total number of inpatients, including paediatrics who would recommend our services was 94.5%, an increase on April which equalled 91.8%. For A&E it was 84.4% (an approximate 4% increase on April), maternity 98.0% (96.3% in April), day cases 92.8% and for outpatients it was 93.7% (April's figure was 90.4%). The Trust star rating in May is 4.7 which is slightly greater than the star rating in April.

The response rate for inpatients was 53.7% (37.0% in April), A&E 29.0% (25.4% in April), maternity 20.2% (29.8% in April), day cases 39.3% and for outpatients 26.7% (25.9% in April).

The staff FFT takes place during June and we are hoping for an improved score given the cultural change and staff engagement work that is in progress. The previous score showed a 2% improvement with 47% of staff recommending the Trust as a place to work and 72% said they would recommend the Trust to friends and family as a place to be treated.

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. These are commencing during June.

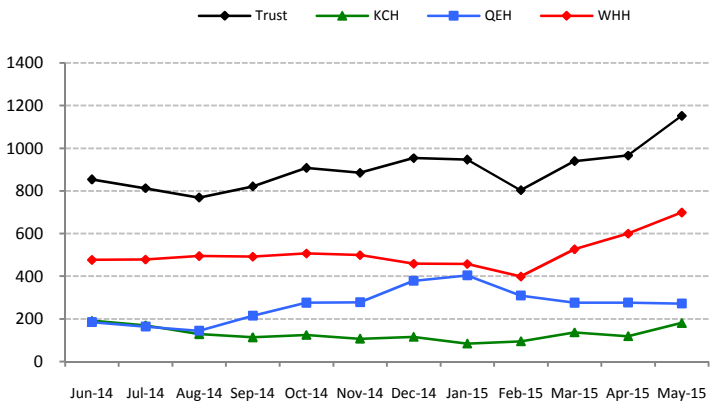
PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

Real time patient experience monitoring using iPads have captured data since 1 Apr-13. During May-15, 1152 adult inpatients were asked about their experiences of being an inpatient; 181 responses were received from patients treated at KCH, 272 from QEH patients, and 699 responses from patients based at WHH. (Compared with the previous month the number of responses were 119, 277 and 600 respectively). The combined result from all submitted questionnaires in May-15 was that of 89.20% satisfaction.

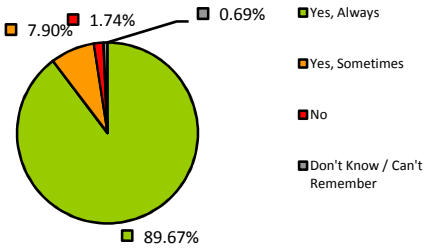
Overall Adult Inpatient Experience May 2015

Experience (%)	No. of Responses
89.20	1152

Number of Adult Inpatient Survey Responses

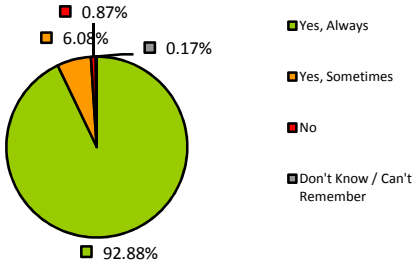


Were you given enough privacy when discussing your treatment?



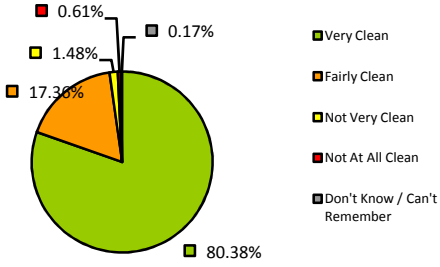
Overall Score = 94.27%

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



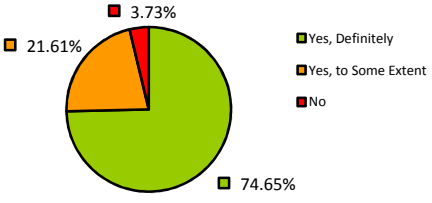
Overall Score = 96.09%

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



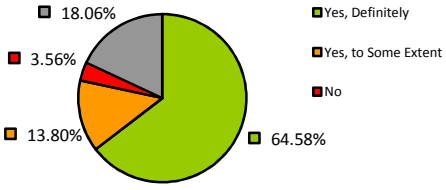
Overall Score = 92.61%

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



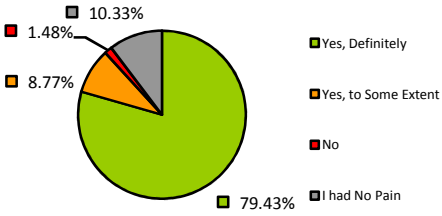
Overall Score = 85.46%

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



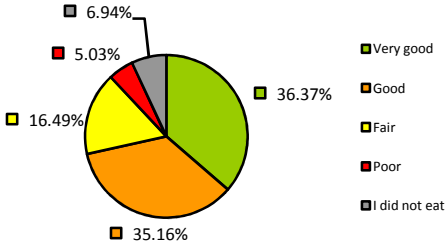
Overall Score = 87.24%

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



Overall Score = 93.47%

How would you rate the hospital food?

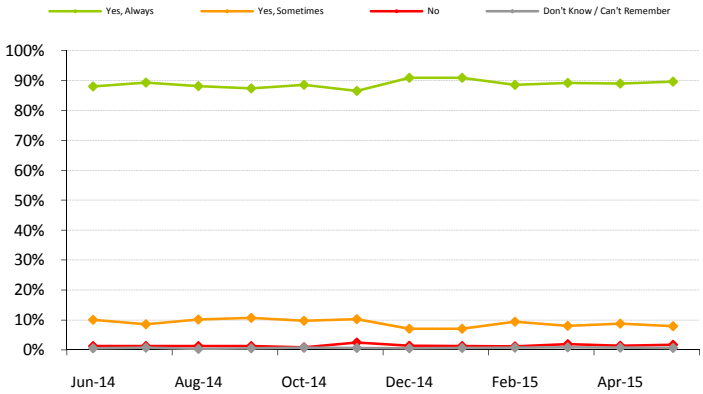


Overall Score = 70.18%

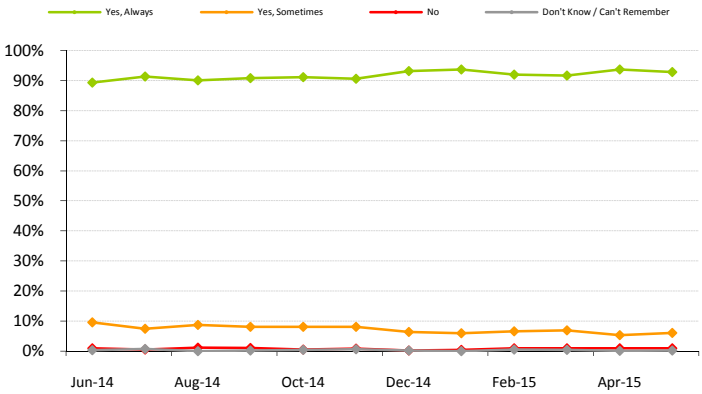
Each ward reviews their real-time monitoring data regularly. They are also shared as "heat maps" with other teams. From this actions are taken to address the themes which are considered with the Friends and Family Test feedback, and compliments and complaint information.

PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

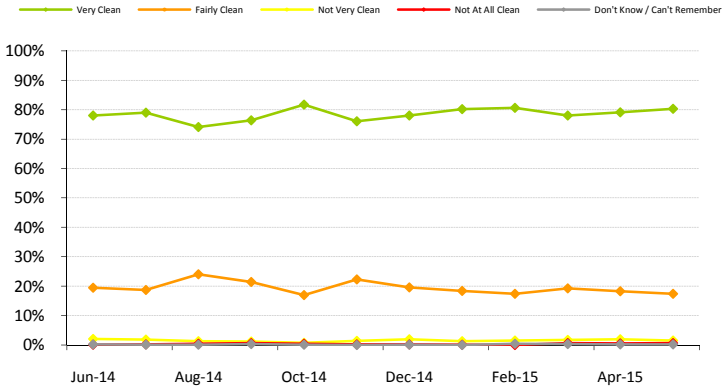
Were you given enough privacy when discussing your treatment?



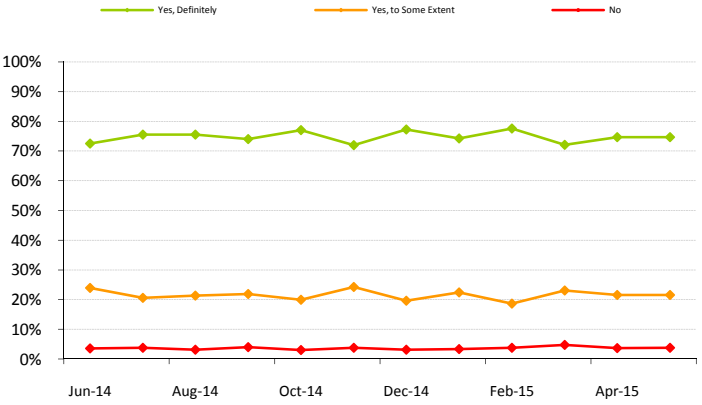
Overall, did you feel you were treated with respect and dignity while you were in hospital?



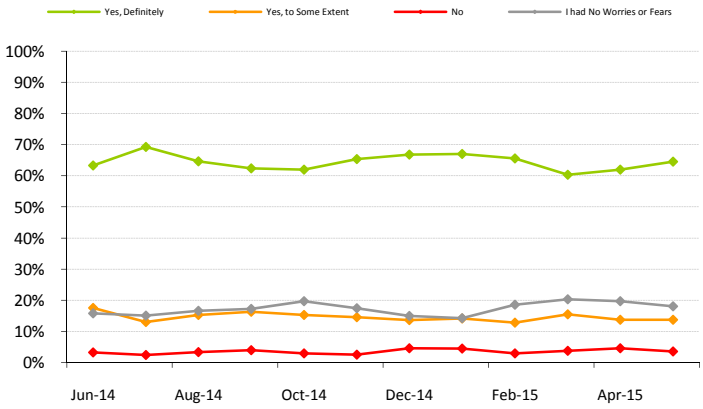
In your opinion, how clean was the hospital room or ward that you were in?



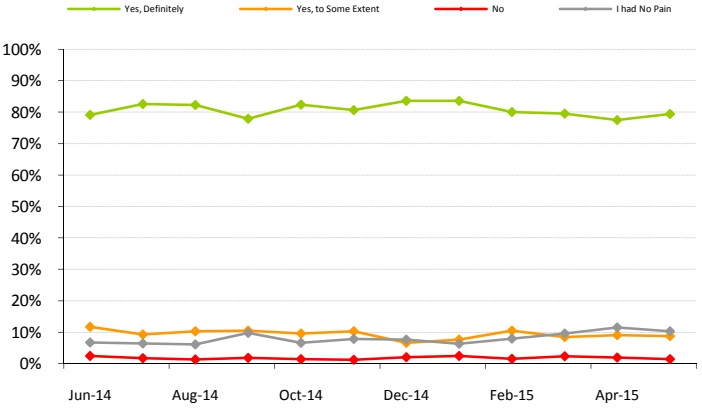
Were you involved as much as you wanted to be in the decisions about your care and treatment?



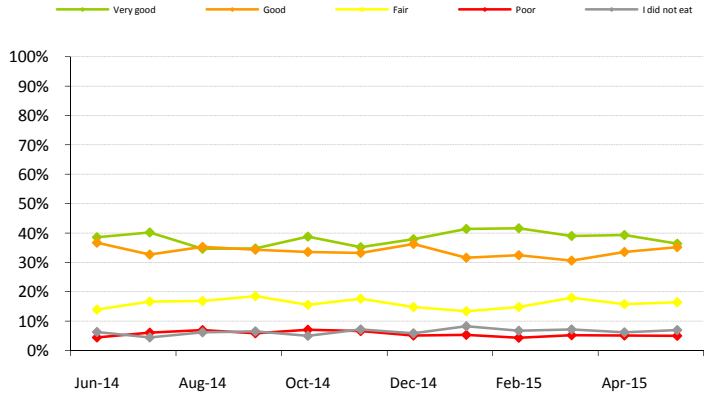
Did you find someone on the hospital staff to talk about your worries and fears?



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



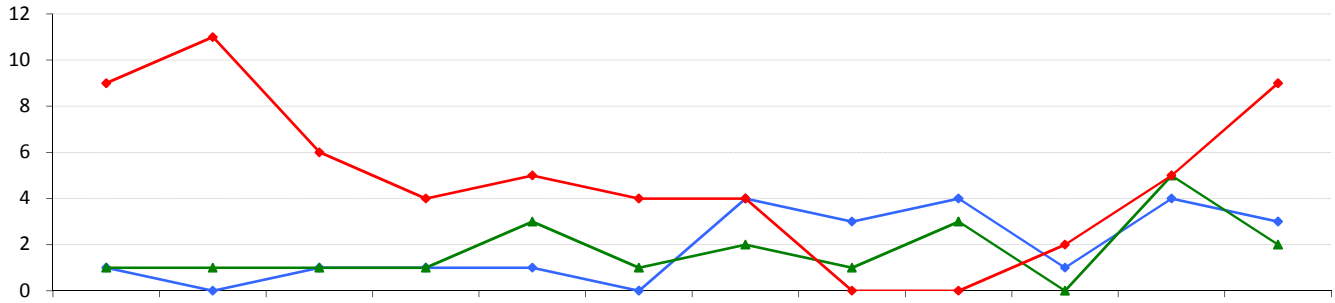
How would you rate the hospital food?



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 able to talk about their worries and fears, and slight increase in help with pain control. The remaining metrics are similar to last month.

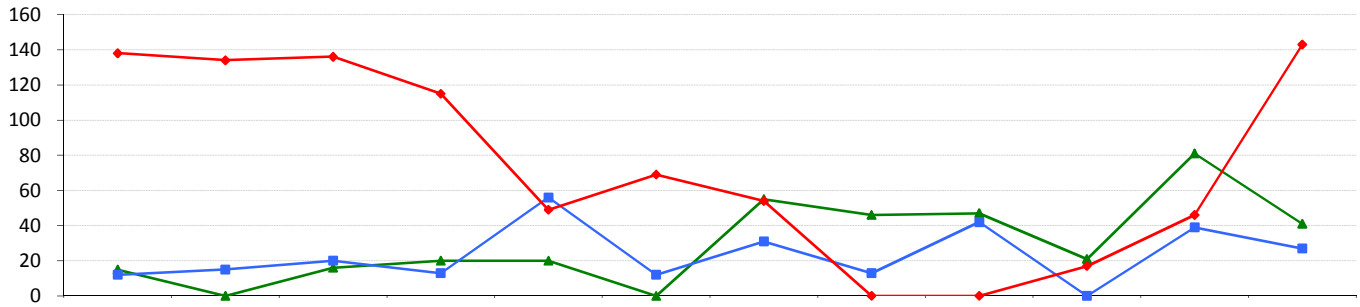
CLINICAL QUALITY & PATIENT SAFETY
PATIENT EXPERIENCE: MIXED SEX ACCOMMODATION

Number of Episodes of Mixed Sex Occurrence



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

Number of Hours of Mixed Sex Occurrence



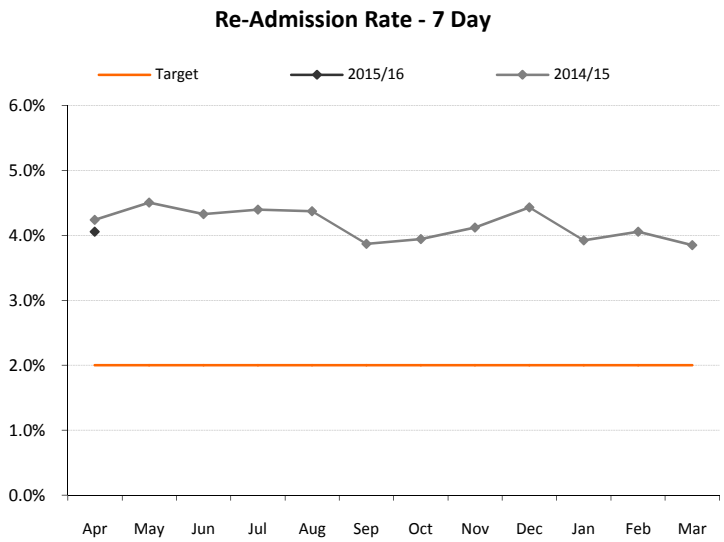
	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
KCH	15	0	16	20	20	0	55	46	47	21	81	41
QEH	12	15	20	13	56	12	31	13	42	0	39	27
WHH	138	134	136	115	49	69	54	0	0	17	46	143

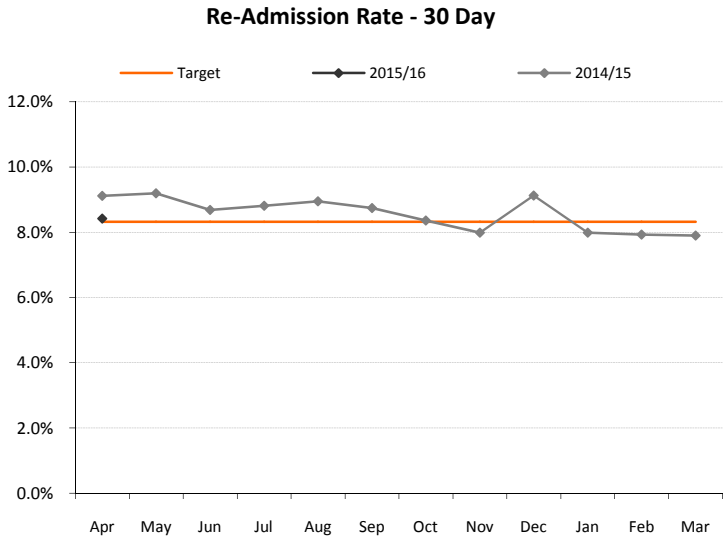
Mixed Sex Accommodation Occurrrences May 2015

Site	Clinical Area	Total No. of Occurrences	Total No. of Patients Affected
KCH	Kingston	3	11
QEH	Fordwich	2	9
WHH	CDU	9	71
TOTAL		**14**	**91**

During May-15, 9 non-justifiable incidents of mixed sex accommodation breach occurred and affected 71 patients located in the CDU. 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 current policy removes all previously agreed justifiable criteria, apart from critical care areas and stroke units. There were 14 mixed sex accommodation occurrences in total, affecting 91 patients. (Last month there were a total of 14 occurrences affecting 71 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





Whilst the 7d and 30d readmission rates have increased slightly between Mar-15 and Apr-15, performance overall continues to improve against the same position as last year.

With the exception of Dec-14, the Trust has consistently achieved the 30d readmissions target of 8.32% since Oct-14.

Performance around the 7d target (internally set) is consistently around 4.00 - 4.50%, partly driven by the way we record activity around the Emergency Care Centre at KCH, Ambulatory Care Pathways and the use of the "e-beds" at QEH, therefore the target of 2.00% is unachievable without agreeing some exclusions.

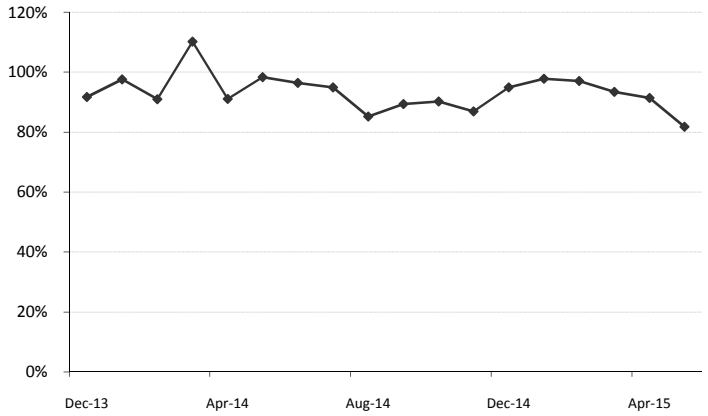
			CQUIN	2014/15 Baseline	2015/16 Target	YTD Status	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Q1	Q2	Q3	Q4	Year End Position
	National CQUINS																						
Performance	Acute Kidney Injury (AKI)	1a	Audit Established and Baseline Data Gathered	N/A	Audit established 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 agree, 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 1 month retrospectively.																			
			Dementia Assessment within 72h	This measure when agreed will be reported 1 month retrospectively.																			
			Appropriate Referral	This measure when agreed will be reported 1 month retrospectively.																			
		3b	Staff Training/Leadership	From Sep-14 reporting 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

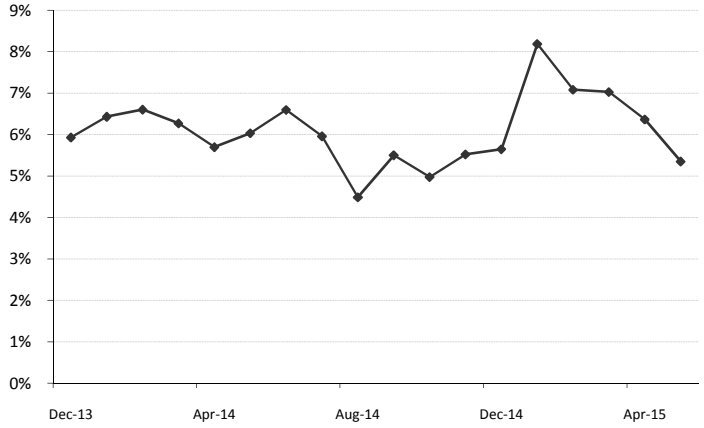
Bed Occupancy



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 110.20%, thereafter fluctuating between 98.301% and 85.2% between Apr-14 and Apr-15. The position in May-15 (i.e. 81.77%) demonstrated a reduction in bed use for the fourth consecutive month.

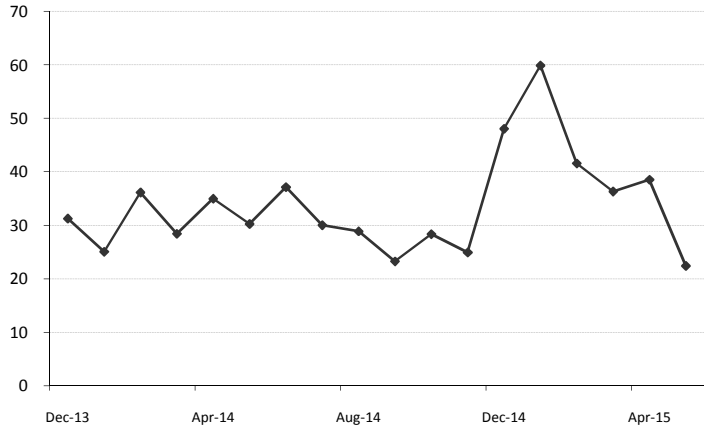
NB: Data are sourced from the Trust's Balanced Scorecard as of 4 Jun-15.

Extra Beds



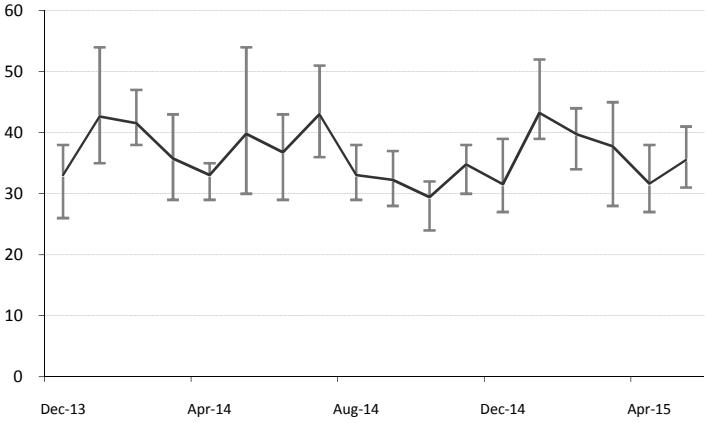
This metric is built up using the number of funded beds on each ward and reviewing those occupied on a daily basis. Where the number of occupied beds exceeds the funded bed base for the ward these are classified as "extra". In May-15 the degree of extra beds used within the Trust equalled 5.35%, and lower than he position reported in Apr-15 (i.e. 6.37%), and is lower than the value recorded in May-14 (cf. 6.04%). 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 May-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, 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 May-15 equalled 22.42, significantly less than the values recorded in Apr-15 (38.53).

Average Delayed Transfers of Care

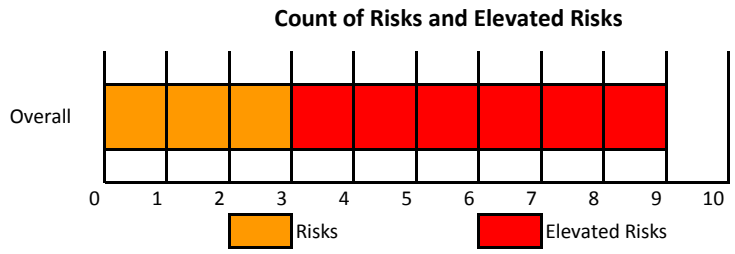


In Jan-15, the average number of patients on the Delayed Transfers of Care (DToC) list increased resulting in a position of 43.20 and was driven by the difficulty in discharging long stay patients admitted over the Christmas period. However, this value dropped in Feb-15 and has seen consistent trend since this point. May-15 shows a slightly raised value of 35.50 and although it is the first upward trend since January, it is not statistically significant and within control limits.

The primary issues for DToC remain, that is, continuing health care pending assessment by Social Services 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	6
Overall Risk Score	15
Number of Applicable Indicators	96
Percentage Score	7.81%
Maximum Possible Risk Score	192

Safe	Composite of Central Alerting System (CAS) - Dealing with CAS safety alerts in a timely way	Risk
	NHS Staff Survey - The proportion of staff who stated that the incident reporting procedure was fair and effective (KF 14-2014)	Elevated Risk
Effective	NHS Staff Survey - The proportion of staff reported receiving support from immediate managers (KF 9)	Elevated Risk
Well-led	Monitor - Governance risk rating	Elevated Risk
	NHS Staff Survey - The proportion of staff who would recommend the trust as a place to work or receive treatment	Risk
	NHS Staff Survey - The proportion of staff reporting good communication between senior management and staff (KF 21)	Elevated Risk
	Composite Indicator - NHS staff survey questions relating to abuse from other staff	Elevated Risk
	Snapshot of whistle blowing alerts	Elevated Risk
	GMC - Enhanced monitoring	Risk

The latest Intelligent Monitoring Report (IMR) was published on 21 May-15. The high level summary of risk areas is shown below:

• Composite of Central Alert System (CAS) reports - This flagged due to a delay in closure of 15 Estates and Facilities alerts. Whilst these have now all been closed, following the required action being taken, the composite score includes an historic look-back at the activity over the past year. This has gone from an elevated risk to a risk in the most up to date report and should not flag in subsequent alerts. A report is received monthly by the Quality Assurance Board on CAS activity.

• Monitor governance risk rating - Being a Trust in Special Measures means an automatic elevated risk in this section.

• Whistle blowing incidents reported by staff directly to the CQC - Any alert raised directly with the CQC automatically places organisations in an elevated risk category. There has been more than 1 alert reported in the time period.

• The GMC enhanced monitoring has improved to the level of "risk". The GMC website confirms the position, and it also confirms that most concerns raised following the Royal College of Surgeons visit in 2012 have been addressed.

• This report shows 4 elevated risks in areas which have not previously flagged and which will remain in the IMR until the results of national surveys improve. There is a fifth area which is flagging as a "risk area". The majority of these new indicators are within the "well-led" section of the IMR.

East Kent Hospitals University NHS
NHS Foundation Trust

The Publication of Nurse staffing Data – May 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.

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 May are over 97% at WHH, over 96% at QEQM and almost 95% across K&C, shown in Figure 1.

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

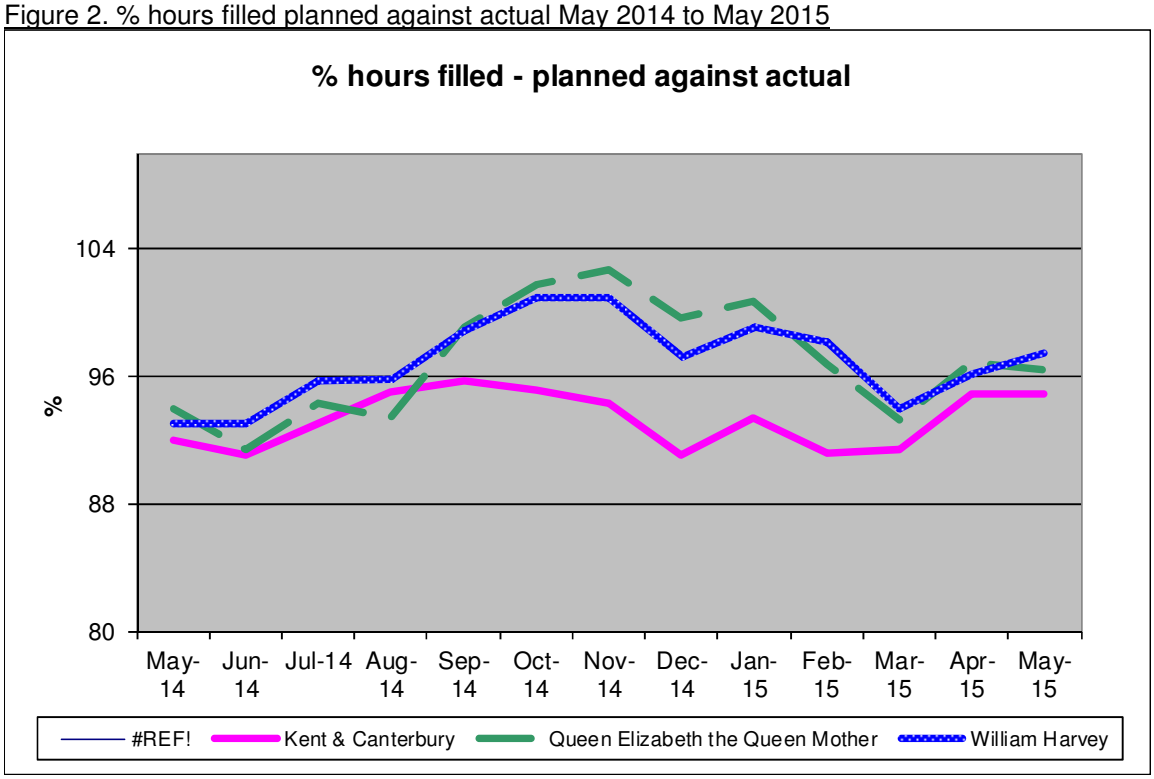
	% Hours filled - planned against actual May 2015				
	DAY		NIGHT		
Hospital site	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Overall % hours filled
Kent & Canterbury	84.8%	99.6%	96.5%	122.5%	94.86
Queen Elizabeth the Queen Mother	90.1%	104.1%	97.4%	101.4%	96.41
William Harvey	91.7%	101.6%	97.7%	110.7%	97.45

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 May 2014 to May 2015



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.

Figure 3 shows total monthly hours actual against planned and % fill during May 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. Detail on key quality indicators are included by ward within the heat map within the main report.

Data validation and sign-off steps have been implemented and the data will be reported externally via Unify/NHS Choices on 15th June. 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 May 2015

Division / Ward Urgent Care & LongTerm Conditions	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Comments
Cambridge J	90.63	128.38	88.20	136.92	
Cambridge K	88.32	98.87	100.00	93.69	
Cambridge M2	107.71	102.72	103.94	114.98	
Coronary Care Unit (K&C)	62.51	N/A	100.28	N/A	RN sickness 4.0%
Coronary Care Unit (QEQMH)	85.35	84.22	98.51	93.95	
Coronary Care Unit (WHH)	93.87	102.02	100.67	70.97	HCA parenting leave
Minster	88.77	82.80	100.00	87.10	
Oxford	111.74	111.54	102.21	119.64	
Sandwich Bay	96.06	173.37	103.23	171.55	
St Margarets	107.30	102.66	107.37	114.27	
Deal	106.24	101.01	100.81	110.16	
Harvey	83.33	103.15	100.00	195.23	
Invicta	102.36	96.36	102.15	188.04	
Cambridge L	48.97	158.68	88.85	204.17	1.08 WTE RN Vacancy, 11% SL
Treble	72.93	97.62	96.77	135.76	
Mount/McMaster	97.92	100.38	96.77	184.95	
Fordwich Stroke Unit	89.33	114.48	99.10	110.52	
Kingston Stroke Unit	80.75	138.72	93.64	101.61	
Richard Stevens Stroke Unit	75.65	58.78	77.51	127.98	3.69 WTE RN Vacancy
Harbledown	76.44	107.61	100.27	91.60	1.79 WTE RN Vacancy
QE CDU	77.02	82.11	106.49	127.70	
WH CDU	138.74	88.23	126.94	96.55	
Cambridge M1					
Surgical Services					
Rotary Suite	103.38	106.80	100.00	100.00	
Cheerful Sparrows Female	90.22	133.44	89.59	84.24	
Clarke	89.81	89.74	91.98	99.33	
Cheerful Sparrows Male	65.17	138.22	89.20	93.55	2.77 WTE RN Vacancy, 29% ML
Kent	80.21	118.37	100.00	91.07	
Kings B Ward - WHH	112.62	98.50	117.39	158.32	
Kings A2	111.01	134.71	111.08	211.50	
Kings C1	87.20	127.08	100.00	103.37	
Kings C2	79.03	94.24	92.22	97.30	4.28 WTE RN Vacancy
Kings D Female	85.26	115.75	94.02	115.77	
Kings D Male					
Quex	80.02	116.39	100.00	87.10	
Bishopstone - split	80.98	108.32	98.68	105.50	
Seabathing -split					
Critical Care - WHH -	112.86	95.17	109.62	56.26	1.86 WTE HCA Vacancy
Critical Care - KCH	91.61	96.00	90.05	N/A	
Critical Care - QMH	87.55	55.28	92.61	N/A	0.92 WTE HCA Vacancy, 14% SL
Specialist Services					
KC Marlowe Ward	92.32	78.65	97.08	94.09	3.69 WTE HCA Vacancy
WH NICU	87.73	133.27	88.51	N/A	
WH Padua Ward	97.33	94.72	97.57	77.42	10% HCA ML
QE Rainbow Ward	93.49	69.77	100.00	N/A	
QE Birchington Ward	92.86	102.74	98.79	100.00	
WH Kennington Ward	89.58	100.86	97.38	N/A	
KC Brabourne Haematology Ward	68.63	82.10	102.42	N/A	7% RN sickness, 13% ML
WH Maternity Labour and Folkestone+	90.31	71.48	97.44	59.54	6% sickness. 7% ML
MLU WHH	108.60	59.76	101.75	61.29	1.45 WTE MCA Vacancy
QE Maternity Wards + MCA	96.92	89.65	89.31	92.47	
QE MLU	102.55	69.46	187.10	83.87	1.60 WTE MCA Vacancy, 8% SL
QE SCBU	83.75	90.93	88.31	N/A	

Ward/Site	Patient Safety								Patient Experience					Clinical Effectiveness	
	Risk Management		HCAI		Harm Free Care	Nurse Sensitive Indicators			Experience					Nurse Staffing	
	Complaints	Compliments	MRSA	C. diff	Safety Thermometer HFC - New Harms (%)	Pressure Ulcers: Category 2, 3 and 4		Falls	FFT: Response Rate(%)	FFT: Recommend (%)	Involvement with Care%	Privacy in Care Discussions %	Staff Available to Discuss Concerns %	Day - Staff Fill Rate (%)	Night - Staff Fill Rate (%)
						Unavoidable	Avoidable								
Brabourne Ward - KCH	0	2	0	0	100%	1	0	0	6%	100%				69%	102%
Clarke Ward - KCH	1	53	0	0	100%	0	0	2	37%	97%	64%	93%	92%	90%	92%
Critical Care - KCH	0	0	0	0	100%	1	0	0						92%	90%
Emergency Care Centre - KCH (CDU only)	1	1	0	0	100%	0	0	0			84%	92%	80%		
Harbledown Ward - KCH	1	47	0	0	100%	0	1	7	91%	98%	95%	90%	85%	76%	100%
Harvey Ward - KCH	0	0	0	0	84%	1	0	6	135%	100%	75%	100%	94%	63%	100%
Invicta Ward - KCH	1	8	0	0	100%	0	0	4	55%	100%	78%	89%	100%	102%	102%
Kent Ward - KCH	0	45	0	0	100%	1	0	2	121%	100%	88%	94%	79%	80%	100%
Kingston Stroke Unit - KCH	0	0	0	0	95%	0	1	6	79%	93%	88%	100%	86%	81%	94%
Marlowe Ward - KCH	1	10	0	1	100%	0	1	5	39%	97%				92%	97%
Mount & McMaster Ward - KCH	0	14	0	0	100%	0	0	0	39%	96%				98%	97%
Treble Ward - KCH	2	13	0	0	100%	2	0	4	64%	97%	88%	97%	90%	73%	97%
Birchington Ward - QEH	1	24	0	0	100%	0	0	1	10%	100%				93%	99%
Bishopstone Ward - QEH	2	0	0	0	100%	1	1	4	63%	93%	94%	96%	88%	81%	99%
CDU - QEH	1	16	0	0	100%	0	0	2	34%	84%	85%	93%	81%		
Cheerful Sparrows Ward Female - QEH	2	16	0	0	100%	1	2	2	51%	98%				90%	90%
Cheerful Sparrows Ward Male - QEH	0	3	0	0	100%	0	0	5	47%	96%				65%	89%
Coronary Care Unit - QEH	0	17	0	0	100%	0	0	4	116%	100%	89%	94%	100%	85%	99%
Critical Care - QEH	0	1	0	0	100%	0	0	0						88%	93%
Deal Ward - QEH	0	0	0	0	89%	0	0	6	31%	100%	84%	92%	95%	106%	101%
Fordwich Stroke Unit - QEH	0	11	0	0	100%	0	0	7	64%	97%	96%	100%	100%	89%	99%
Hospital at Home - QEH	0	0	0	0	100%	0	0	0							
Kingsgate Maternity & Labour Ward - QEH	1	1	0	0	100%	0	0	0							
Minster Ward - QEH	0	2	0	0	100%	0	0	0	61%	96%				89%	100%
Quex Ward - QEH	1	0	0	0	100%	0	0	1	80%	97%	89%	94%	87%	80%	100%
Rainbow Ward - QEH	1	145	0	0	100%	0	0	1	5%	100%				93%	100%
Sandwich Bay Ward - QEH	1	1	0	0	100%	0	0	2	32%	100%	75%	90%	77%	96%	103%
Seabathing Ward - QEH	1	15	0	0	100%	2	0	2	28%	100%	100%	100%	100%	81%	99%
Special Care Baby Unit - QEH	0	0	0	0	100%	0	0	0						84%	88%
St Augustine's Rehab Ward - QEH	1	0	0	0	0%	0	0	1							
St Margaret's Ward - QEH	0	130	0	0	100%	0	0	0	17%	100%	83%	100%	89%	107%	107%
Cambridge J2 Ward - WHH	4	4	0	0	97%	2	0	4	69%	84%				91%	88%
Cambridge K Ward - WHH	0	24	0	0	96%	0	0	2	75%	95%	89%	94%	79%	88%	100%
Cambridge L Ward - WHH	0	20	0	0	100%	0	0	6	59%	88%	75%	100%		49%	89%
Cambridge M2 Ward - WHH	1	135	0	0	95%	2	0	7	51%	94%	81%	92%	93%	108%	104%
CDU - WHH	1	0	0	0	100%	1	0	9	27%	72%					
Coronary Care Unit - WHH	0	14	0	0	100%	0	0	1	82%	100%	100%	100%	100%	94%	101%
Critical Care - WHH	0	6	0	1	100%	0	0	1			100%	100%		113%	110%
Folkestone Maternity & Labour Ward - WHH	2	32	0	0	100%	0	0	0						90%	97%
Hospital at Home - WHH	0	0	0	0	100%	0	0	0							
Kennington Ward - WHH	0	0	0	0	100%	0	0	1	45%	97%				90%	97%
Kings A2 Ward - WHH	0	1	0	0	100%	0	0	1	43%	97%	84%	91%	80%	111%	111%
Kings B Ward - WHH	1	15	0	0	100%	0	0	2	74%	93%	83%	98%	89%	113%	117%
Kings C1 Ward - WHH	1	10	0	0	100%	1	0	1	51%	95%	84%	85%	79%	87%	100%
Kings C2 Ward - WHH	2	86	0	0	100%	0	0	2	64%	97%	96%	96%	92%	79%	92%
Kings D Ward Male - WHH	0	1	0	0	100%	3	0	2	57%	96%	81%	95%	87%	85%	94%
Kings D Ward Female - WHH	0	0	0	0	100%	0	0	0	54%	97%					
Neonatal Intensive Care Unit - WHH	0	0	0	0	100%	0	0	0							
Oxford Ward - WHH	0	0	0	1	100%	1	0	6	56%	96%	89%	100%	100%	112%	102%
Padua Ward - WHH	1	156	0	0	100%	0	0	1	16%	97%				97%	98%
Rotary Suite - WHH	2	102	0	0	100%	0	0	0	71%	98%	87%	95%	83%	103%	100%
RSU Unit - WHH	2	0	0	0	100%	0	1	6	78%	95%	87%	97%	85%	76%	78%

Criteria

The Heat Map uses May-15 data, except for Compliments and the Experience section, which uses Apr-15 data.

Data are sourced from the Ward Dashboard* and therefore only relate to Inpatient Care, not Trust-wide numbers which the Clinical Quality and Patient Safety Report will include.

* With the exception of FFT data, sourced form the FFT Dashboard, and Safe Staffing data, taken from the CQC Action Dashboard.

Where applicable, RAG ratings are assigned to the data using thresholds taken from the Ward Dashboard and the CQC Action Plan. FFT threshold for Recommended % taken from the NHS England average. Where complaints are over 1, the RAG is marked red.

For the purposes of this Heat Map, the RAG is either red or green, to help with simplified alerting and emerging patterns.

APPENDIX - Complaints, Concerns, Comments and Compliments – May 2015

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**26 JUNE 2015**
SUBJECT:	**COMPLAINTS, CONCERNS, COMMENTS AND COMPLIMENTS –MAY 2015**
REPORT FROM:	**ACTING CHIEF NURSE & DIRECTOR OF QUALITY**
PURPOSE:	**Information**

SUMMARY:

This Appendix offers additional detail in the trends in activity and themes of the complaints received in the Trust from January 2015. Presented are:

- Activity Information;
- Quarter 4 activity and themes compared to Quarter 4 of the previous year;
- Themes and trends by site and speciality;
- Complaint performance information.

The key areas to highlight are:

- The variation in the number of formal complaints over the year;
- The specialities that have the highest number of complaints. These are currently the Emergency Departments, General Surgery, Trauma and Orthopaedics and Obstetrics;
- The improved response rate performance against the date agreed with the client;
- The work of the Complaints Management Steering Group to improve the complaints process being led by the Patient Experience Team with the Divisions;
- The on-going work in place.

This Appendix explains and describes the progress and actions in place to improve the process and ensure a responsive service to our patients and their families and friends.

Introduction
The experience of the patients and their families is of paramount importance to the Trust. Patients' views are sought via a number of ways including the Patient Opinion website, the Friends and Family Test, NHS Choices and also through the Trust's formal systems. This report provides the Board of Directors with the top theme mapped by Division, by Speciality and by Site. The actions in place to improve the whole complaints process are described.

Activity Information
Since January 2015 we have seen a very slight increase in the number of formal complaints received each month by the Trust. Complaints are described in different ways:

Formal complaints are those where communication received is of sufficient concern that it is designated as a formal complaint. This is assigned a realistic timeline that is agreed with the client depending on the complexity of the complaint. If a complaint becomes very complex an extension is agreed with the client to ensure a thorough and robust response that answers all of their concerns.

Concerns are the informal contacts that a client may have with a Trust. We aim to turn these around within 10 working days. We now have the Patient Advice and Liaison Service (PALS) in place across each of the acute sites. The role of this team is to provide an on-the-spot point of contact for patients, their families, and their carers who need confidential advice, support, and information on health-related matters. This service helps to prevent people needing to escalate their concern to a formal level and is operationalised in a very person-centred way.

The Patient Experience Team (PET) manage all of the telephone enquiries and email enquiries that are received centrally. Currently the team are managing between 30 to 35 emails, calls and letters per day in addition to processing and supporting the Divisions with the existing workload and formulation of responses. The team respond to 100% of the telephone calls within 1 working day. Every email receives an immediate acknowledgement of receipt within 1 working day. Both these areas are demonstrating improved performance are meeting our internal standard. Formal complaints receive an acknowledgement letter or verbal acknowledgement. The internal metric for this is 3 working days and we are monitoring our compliance against this metric. For May this was 100% achieving the standard.

As part of the complaints process we also record the number of compliments we receive each month. These far outweigh the number of complaints and concerns received. The charts below show the number of complaints and compliments received on a monthly basis since May 2014. It can be seen that in September 2014 we saw an increased number of formal complaints which was following the publication of the CQC Report in August 2014. Similarly we also saw an increase in compliments at the same time until the publication of the CQC report in August where the number have decreased, and the number of formal complaints has increased. The number of complaints then continues to decrease between October 2014 and January 2015. There is a very slight increase from February to May 2015.

Figure 1: Number of complaints received

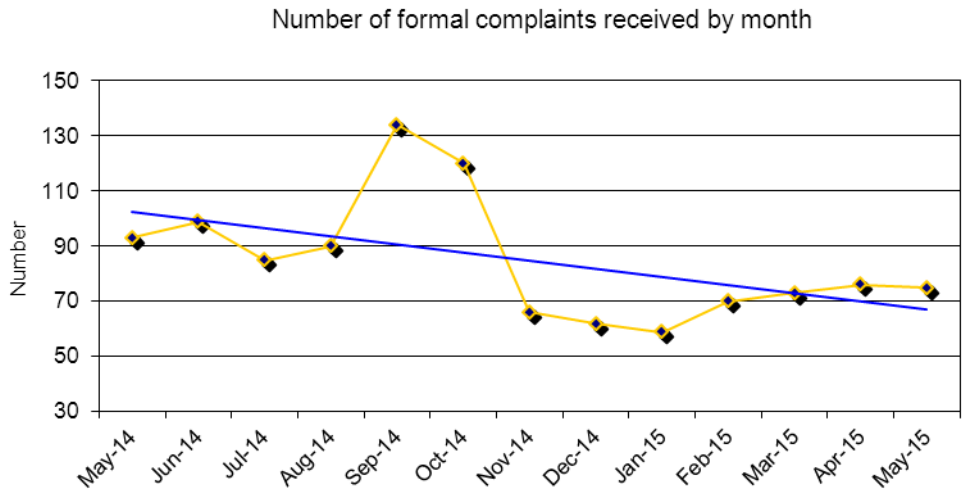
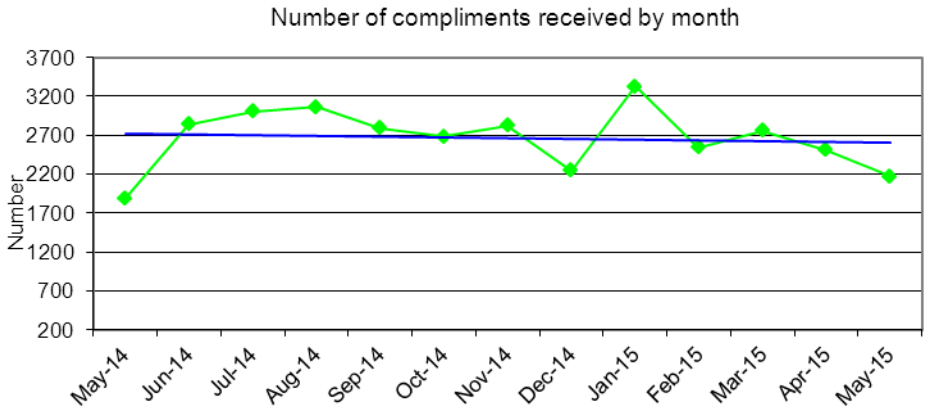


Figure 2: Number of compliments received



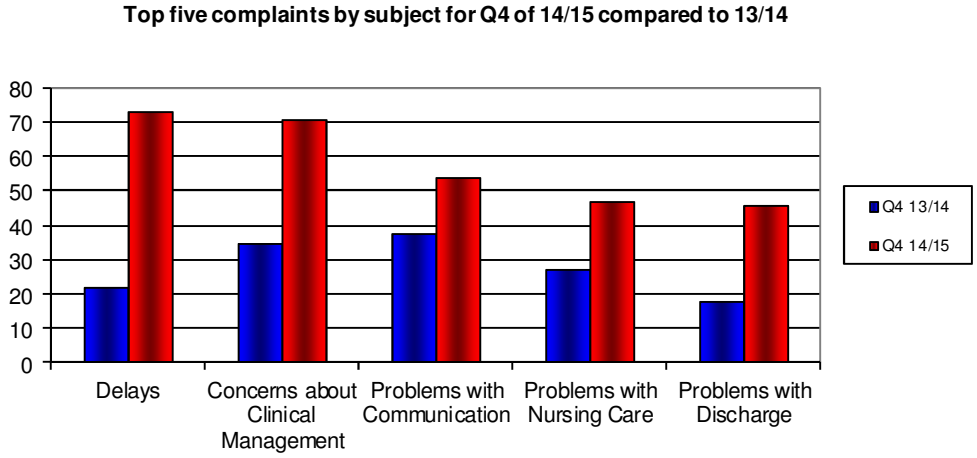
Divisional leads are reporting that some of the complaint activity is relating to people complaining about their experience in the Trust as far back as 2012 and 2013. This may be in response to the CQC report and has caused the Divisions additional workload. At the time of writing the number of complaints and concerns open were 218. Table 1 overleaf shows the distribution across the Divisions. It can be seen that Surgical Services Division has the greatest number open.

Table 1: Current Open Cases by Division

Division	Complaints	Concerns	Total
Urgent Care and Long Term Conditions	52	10	62
Surgical Services	83	15	98
Specialist Services	32	6	38
Clinical Support	11	7	18
Corporate	0	2	2
TOTAL	**178**	**40**	**218**

Themes and Trends of the Concerns and Complaints
This section outlines the most common themes and trends of complaints received during the last reported quarter, this being Q4 of 2014/15 (January – March 2015) with comparisons to May 2015. There is a concern that these themes are recurrent and work has commenced with the Divisions to address the root cause of the themes and also to proactively place strategies in place to prevent a person's concern becoming a formal complaint.

The chart below depicts the top five subjects arising from formal complaints received in Q4 of 2014/15, compared with those received in the same quarter in 2013/14 for the same topics.



The top three themes for complaints received in Q4 of 2014/15 were:

1. Delays
2. Concerns about Clinical Management
3. Problems with Communication.

Themes and Trends in May 2015 – Complaints for all of Trust

The breakdown of the top three themes by sub-subject are shown in Table 2 below:

Table 2: Top Three Themes of complaints received in May 2015

Problems with Communication	
Misleading or contradictory information given	12
Lack of information / explanation of how procedure went	8
Doctor communication issues	7
A&C Staff communication issues	3
Nursing communication issues	2
Unhappy with info on medical records	1
Other communication issues (i.e. old literature, phones not working	1
TOTAL	**34**
Concerns about Clinical Management	
Unhappy with treatment	20
Incomplete examination carried out	3
Scans/x-rays not taken	1
Lack of / Inappropriate pain management	1
Referral issues	1
TOTAL	**26**
Problems with Attitude	
Problems with doctor's attitude	10
Problems with nurse's attitude	10
Problems with other staff attitude	5
TOTAL	**25**

In comparison to Q4 2014/2015, problems with communication has now become the top theme. Concerns with clinical management remains in the top three themes. Problems with attitude has replaced delays.

Problems with Communication

The top theme, problems with communication, has been broken down by speciality within each Division for the purpose of identifying any 'hot spot' areas:

Table 3 - Urgent Care and Long Term Conditions

Speciality	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Total**
A&E	0	3	1	2	2	8
Cardiology	2	1	0	4	1	8
Gastroenterology	2	0	2	3	0	7
HCOOP	1	1	2	3	0	7
Respiratory medicine	0	2	0	0	0	2
Neurology	0	0	0	1	0	1
General Medicine	1	0	0	0	0	1
TOTAL	**6**	**7**	**5**	**13**	**3**	**34**

Communication concerns are most prevalent in the Emergency Department, Cardiology, Gastroenterology and Health Care of the Older Person Specialty.

Table 4 - Surgical Services Division

Speciality	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Total
General Surgery	2	1	5	2	3	13
T&O	4	3	1	0	3	11
Colorectal Surgery	0	2	0	1	4	7
Ophthalmology	2	0	1	1	1	5
Urology	1	1	1	1	1	5
ENT	0	0	0	1	2	3
Maxilo Facial	0	2	1	0	0	3
Anaesthetics	0	1	0	0	0	1
TOTAL	**9**	**11**	**9**	**6**	**14**	**48**

General Surgery and Trauma and Orthopaedics have the greatest number of complaints around communication.

Table 5 - Specialist Services Division

Speciality	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Total
Obstetrics	2	1	4	1	5	13
Gynaecology	1	0	0	3	1	5
Acute paediatrics	0	0	1	1	2	4
Clinical Oncology	0	0	0	1	1	2
Dermatology	0	1	0	1	0	2
Neonatal	0	0	0	1	0	1
Community Paediatrics	0	0	0	1	0	1
TOTAL	**3**	**2**	**5**	**9**	**9**	**28**

Obstetrics received the greatest number of complaints in the Division.

Concerns about Clinical Management

Table 6- Urgent Care and Long Term Conditions

Speciality	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Total
A&E	0	5	2	3	5	15
Respiratory medicine	0	3	2	0	2	7
Gastroenterology	3	0	0	3	1	7
Cardiology	0	1	0	2	3	6
HCOOP	0	0	2	2	2	6
Stroke	0	2	2	0	0	4
Neurology	0	1	0	2	0	3
Rheumatology	0	0	0	0	2	2
General Medicine	0	0	2	0	0	2
Haematology	1	0	0	0	0	1
TOTAL	**4**	**12**	**10**	**12**	**15**	**53**

Concerns about clinical management in UCLTC are most prevalent in the Emergency Department, Respiratory Medicine, Gastroenterology, Cardiology and Health Care of the Older Person Specialty.

Table 7 - Surgical Services Division

Speciality	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Total
T&O	6	3	1	8	4	22
General Surgery	1	0	2	3	0	6
Colorectal Surgery	0	1	1	2	2	6
ENT	0	1	0	0	0	1
Urology	0	1	0	0	0	1
Maxilo Facial	0	0	1	0	0	1
Pain Services	0	0	0	0	1	1
TOTAL	**7**	**6**	**5**	**13**	**7**	**38**

The greatest number of complaints regarding clinical management in Surgery relate to Trauma and Orthopaedics.

Table 8 - Specialist Services

Speciality	Jan-15	Feb-15	Mat-15	Apr-15	May-15	Total
Obstetrics	1	4	4	0	3	12
Acute paediatrics	0	1	0	2	1	4
Gynaecology	1	1	0	1	0	3
Dermatology	0	1	0	1	0	2
Haematology (Clinical)	0	1	0	0	0	1
TOTAL	**2**	**8**	**4**	**4**	**4**	**22**

Obstetrics received the greatest number of complaints in Specialist Services regarding clinical management.

Themes by Site
Table 9 shows how the themes are distributed across the three acute sites for May only. Greater analysis is presented in Tables 10, 11 and 12 overleaf for the top reporting theme, problems with communication.

Table 9 – Top Three Themes by Site – May 2014

Problems with Communication	**KCH**	**QEQM**	**WHH**
Misleading or contradictory information given	1	8	2
Lack of information / explanation of how procedure went	0	5	3
Doctor communication issues	1	4	2
A&C Staff communication issues	0	2	1
Nursing communication issues	0	1	1
Unhappy with info on medical records	0	0	1
Other communication issues (i.e. old literature, phones not working	0	1	0
TOTAL	**2**	**21**	**10**
Concerns about Clinical Management			
Unhappy with treatment	6	9	5
Incomplete examination carried out	0	3	0
Scans/x-rays not taken	0	1	0
Lack of / Inappropriate pain management	0	0	1
Inappropriate ward	0	0	0
Referral issues	0	1	0
TOTAL	**6**	**14**	**6**
Problems with Attitude			
Problems with doctor's attitude	4	3	3
Problems with nurse's attitude	0	8	1
Problems with other staff attitude	1	3	1
TOTAL	**5**	**14**	**5**
GRAND TOTAL	**13**	**49**	**21**

It can be seen from this snapshot taken from the May data that QEQM has the greatest number of complaints in each of the three top themes.

Table 10, 11 and 12 show the highest recorded complaint theme by site and speciality from January 2015. This allows the Board of Directors to see a snapshot of where the issues and 'hot spots' are across the Trust with our most commonly reported theme, which is problems with communication .

Table 10 - KCH – Problems with Communication

K&C							
Division	**Speciality**	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Total**
UCLTC	**Gastroenterology**	1	0	0	1	2	4
	HCOOP	1	0	1	0	0	2
	A&E	0	0	1	0	0	1
Surgery	**Ophthalmology**	1	0	0	0	0	11
	Urology	0	2	1	1	0	4
	ENT	0	0	0	1	1	2
	General Surgery	0	0	1	0	0	1
Specialist	**Dermatology**	0	1	0	1	0	2
	Gynaecology	1	0	0	0	0	1
	Community Paediatrics	0	0	0	1	0	1
Clinical	**Radiology**	0	1	0	0	0	1
	Orthotics	0	0	1	0	0	1
TOTAL		**4**	**4**	**5**	**5**	**3**	**41**

At K&C, it can be seen that Ophthalmology, receive the greatest number of complaints, followed by Gastroenterology and Urology.

Table 11 – QEQM – Problems with Communication

QEQM							
Division	**Speciality**	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Total**
UCLTC	**A&E**	0	0	0	0	1	1
	HCOOP	0	0	0	1	0	1
	Cardiology	0	0	0	0	1	1
	General Medicine	0	0	1	0	0	1
	Gastroenterology	0	0	1	0	0	1
Surgery	**T&O**	0	0	0	0	5	5
	General Surgery	1	0	0	0	4	5
	Colorectal	0	1	0	1	1	3
	Ophthalmology	0	0	0	2	0	2
	Urology	0	0	0	0	1	1
	ENT	0	0	0	0	1	1
Specialist	**Obstetrics**	1	0	3	1	4	9
	Gynaecology	0	0	0	3	1	4
	Clinical Oncology	0	0	0	1	0	1
Clinical	**Radiology**	1	0	0	1		2
TOTAL		**3**	**1**	**5**	**10**	**19**	**38**

At QEQM, the Table shows that Obstetrics received the greatest number of complaints about communication. Trauma and Orthopaedics and General Surgery also received a fairly high number of complaints for the period. The greatest number of complaints was received in May 2015 compared to the other months.

Table 12 – WHH – Problems with Communication

WHH							
Division	**Speciality**	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Total**
UCLTC	**Cardiology**	0	4	0	2	2	8
	A&E	0	3	2	1	1	7
	HCOOP	0	0	1	1	2	4
	Gastroenterology	1	0	1	0	0	2
	Resp. Medicine	0	2	0	0	0	2
	Neurology	0	0	0	1	0	1
Surgery	**General Surgery**	1	1	4	0	0	6
	T&O	1	2	0	1	0	4
	Colorectal	0	1	0	0	3	4
	Maxillo Facial	0	3	0	0	0	3
	Ophthalmology	1	0	0	0	1	2
	Anaesthetics	0	1	0	0	0	1
Specialist	**Obstetrics**	1	1	1	0	0	3
	Acute Paediatrics	0	0	1	1	0	2
	Neonatal	0	0	0	1	0	1
	Clinical Oncology	0	0	0	0	1	1
Clinical	**Radiology**	1	0	1	0	0	2
	Physiotherapy	0	0	0	1	0	1
	Therapies	0	0	0	0	1	1
TOTAL		**6**	**18**	**11**	**9**	**11**	**55**

At WHH, the Table shows that Cardiology, the Emergency Department and General Surgery received the greatest number of complaints about communication. The greatest number of complaints was received in February 2015.

Table 13, 14 and 15 show the second highest recorded complaint theme, concerns about clinical management, by site and speciality from January 2015.

Table 13 – K&C – Concerns about Clinical Management

K&C							
Division	**Speciality**	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Total**
UCLTC	**Gastroenterology**	3	0	0	1	1	5
	HCOOP	1	0	0	0	0	1
	Rheumatology	0	0	0	0	1	1
Surgery	**Urology**	0	1	0	0	0	1
	ENT	0	1	0	0	0	1
	T&O	0	0	0	0	1	1
	Pain Services	0	0	0	0	1	1
Specialist	**Dermatology**	0	1	0	1	0	2
	Stroke	0	2	0	0	0	2
	Haematology	0	1	0	0	0	1
	Neurology	0	0	0	1	0	1
	Cardiology	0	0	0	0	1	1
Clinical	**Interventional Radiology**	0	0	0	0	1	1
	Orthotics	0	0	1	0	0	1
TOTAL		**4**	**6**	**1**	**3**	**6**	**20**

At K&C, the Table shows that Gastroenterology received the greatest number of complaints about clinical management. Complaints are received fairly evenly since January 2015.

Table 14 - QEQM – Concerns about Clinical Management

QEQM							
Division	**Speciality**	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Total**
UCLTC	**A&E**	0	3	0	0	5	8
	Gastroenterology	0	0	0	2	0	2
	General Medicine	0	0	2	0	0	2
	Stroke	0	0	2	0	0	2
	HCOOP	0	0	0	1	0	1
Surgery							
	T&O	3	1	1	3	2	10
	General Surgery	1	0	1	2	0	4
	Colorectal	0	1	1	0	1	3
Specialist	**Obstetrics**	0	1	3	0	3	7
	Respiratory Medicine	0	0	2	0	2	4
	Gynaecology	1	1	0	1		3
	Acute Paediatrics	0	0	0	1	1	2
TOTAL		**5**	**7**	**12**	**10**	**14**	**48**

At QEQM, the Table shows that the Emergency Department and Trauma and Orthopaedics received the greatest number of complaints about clinical management.

Table 15 – WHH – Concerns about Clinical Management

WHH							
Division	**Speciality**	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Total**
UCLTC	**A&E**	0	2	2	3	0	7
	HCOOP	0	0	2	1	1	4
	Cardiology	0	1	0	2	1	4
	Maxillo Facial	0	0	1	0	0	1
Surgery	**T&O**	3	2	0	5	1	11
	Colorectal	0	0	0	2	1	3
	General Surgery	0	0	1	1	0	2
Specialist	**Obstetrics**	1	3	1	0	0	5
	Respiratory Medicine	0	3	0	0	0	3
	Acute Paediatrics	0	1	0	1	0	2
	Neurology	0	1	0	1	0	2
	Rheumatology	0	0	0	0	1	1
Clinical	**Radiology**	1	0	0	0	1	2
TOTAL		**5**	**13**	**7**	**16**	**6**	**47**

At WHH, the Table shows that Trauma and Orthopaedics and the Emergency Department received the greatest number of complaints about clinical management.

Summary and Actions of the Themes

The Surgical Services Division have the greatest number of complaints in the top theme. The William Harvey site appear to have the greatest number of complaints across all of the acute sites in these areas. This may reflect the pressure the site has experienced in recent months with the numbers of patients attending the hospital for urgent care. All Divisions are aware of these themes. They have also been triangulated with the feedback from the Friends and Family Test and inpatient surveys which mirror some of the themes around communication.

There are a number of initiatives in place to proactively address the issues that we are seeing. The Specialist Services Division presents complaints and Friends and Family themes to their teams via a monthly presentation at the relevant meetings. They also have a system whereby every returning complainant is offered a meeting. The Surgical Services Division are working on their backlog and have engaged all staff in the complaints process. They now have in post a dedicated Matron, similar to the other Divisions. This person works with the clients and teams and has developed an improvement trajectory in order to reduce the backlog and the number of returning clients. All of these teams work closely with the Patient Experience Team (PET). The Head of PET and her Deputy also triage all formal complaints and undertake central management of simple complaints in order to provide a more timely response to clients. This commenced in November and at the time of writing we are able to demonstrate achievement against most of the metrics.

As well as complaint and Friends and Family themes, we formally review the ward heat maps (inpatient survey), Patient Opinion website, ward dashboard and Ward Peer Review feedback. As part of the Ward Peer Reviews we seek feedback from patients and visitors using the 'Emotional Touchpoints' tool. The We Care 'Market Place' events that focus on the Trust values and behaviours continue and the Matrons undertake their regular 'walk-about' meeting patients and visitors.

Performance by Site

This month's Trust wide performance is shown in the main Clinical Quality & Patient Safety report. Last year, the KPMG audit reported an anomaly in our reporting where the standard was reported as having been met, when in fact the extension had been agreed with the client after the agreed date. PET have put in place a system where extensions target dates are mapped closely and Divisions are notified of all responses due with a week's notice so that we can ensure either that an extension is requested or the draft response is completed ahead of the target date. PET also check every response due when providing the performance report to ensure no case is reported as compliant if the extension was not being agreed prior to the target date. Table 15 shows performance according to site.

Table 15 – Site Performance – May 2015

	Site activity in May 2015					Site Performance in May 2015			
Site	**Complaints**	**Compliments**	**Concerns**	**PALS Contacts**	**Compliments: Complaints ratio**	**First response target met (within agreed timescales)**	**First response target met (30 working days)**	**Average Number of Working Days to Respond**	**No. of returning complaints**
KCH	15	945	21	103	63:1	17 of 17 (100%)	6 of 17 (35%)	38	4
WHH	20	647	31	60	32:1	18 of 20 (90%)	9 of 20 (45%)	40	10
QEQM	39	481	20	58	12:1	19 of 19 (100%)	7 of 19 (37%)	36	5
BHD	1	0	2	3	0:1	1 of 1 (100%)	1 of 1 (100%)	25	0
RVHF	0	0	2	2	0	1 of 1 (100%)	0 of 1 (0%)	83	0
Other (non-site specific)	0	102	1	5	102:0	0	0	0	0
TOTAL	**75**	**2175**	**77**	**231**	**29:1**	**56 of 58 (97%)**	**23 of 58 (40%)**	**39**	**19**

Key

Rating	% of first responses met
	85 – 100%
	75-84%
	< 75%

Performance by Site has been given a red, amber or green indicator for the month (see key above).

The data shows 97% of responses due to be sent out the clients in May were sent out on target.

- KCH and QEQM sent out 100% of their responses on target;
- WHH sent out a minimum of 85% of their responses on target;

In order to continue our improvement journey around the complaints process, from April we report the percentage of complaint responses that meet the 30 working day standard, as per our policy. It can be seen that compliance to this is 40% against an 85% standard. Although we have achieved the target response rate agreed with clients, the Complaints Management Steering Group now wishes to reduce the length of time complaints are open. Divisions are developing an improvement trajectory in order to achieve the 30 working day standard. For greater visibility, we monitor the length of time complaints are open. Table 16 overleaf shows this per Division.

Table 16 - Divisional Performance – 30/60/90 day metrics

Division	Open 30-60 days	Open 60-90 days	Open >90 days	TOTAL
UCLTC	5	2	0	7
Surgical Services	11	5	1	17
Specialist Services	5	0	0	5
Clinical Support	4	1	0	5
Corporate	3	0	0	3
TOTAL	**28**	**8**	**1**	**37**

The remaining complaints are open within the 30 day timeframe. This metric as well as continuing to reduce the number of returning clients is a key focus for the Divisions currently and relates to the timeliness of the response as well as ensuring that it answers all the clients queries to their satisfaction first time.

The Complaints Management Steering Group
The management of complaints continues to be a focus for the Trust. This is managed via the Complaints Management Steering Group. The group is working to an action plan which is currently being refreshed. The team meet every month. Membership is representative from PET and the Divisions. Reporting is monthly to the Board of Directors via the Clinical Quality & Patient Safety Report, and also to the Quality Assurance Board.

Training – The PET has reinstituted training packages for Trust staff of all levels, including customer care, how to identify and deal with complaints and an understanding of the role of the PET.

Learning from Complaints Newsletter
A complaints newsletter has been produced with a view to disseminating the learning from complaints to staff in the Trust. The first issue went out in June 2015 and is also attached to Trust News. The newsletter contains the complaints and compliments data for the quarter for each division and 2-3 case studies identifying service improvements within the Trust as a result of complaints. PHSO cases are also presented on the Trust website for learning.

Customer Complaints Satisfaction Questionnaire
The PET is trialling the use a customer satisfaction questionnaire from 1 June 2015. Complainants are invited to complete either an online or paper questionnaire on their experience of making a complaint with the Trust. The feedback from the questionnaires will be reviewed after a period of 3 months to decide whether this is a useful exercise.

Monthly Reports to Divisions
The PET now sends the Divisions a monthly report detailing the complaints received and closed in that particular month. The Divisions are also provided with a themes and trends table for each month in order that each Division are aware of their ‘hot spots’ and are able to make improvements where necessary.

PHSO Visit
The Parliamentary and Health Service Ombudsman visited the Trust in April 2015 to update the Trust on the new approach of the PHSO, as well as sharing learning and good practice. This was attended by Divisional staff, as well as the PET.

Summary
This Appendix has described in greater detail the current status of the complaints process within the Trust across the Divisions. The top two themes have been presented by Division and also by site. Actions that are in place to address the recurrent themes and improve the complaints process are described.