CLINICAL QUALITY & PATIENT SAFETY PERFORMANCE SUMMARY

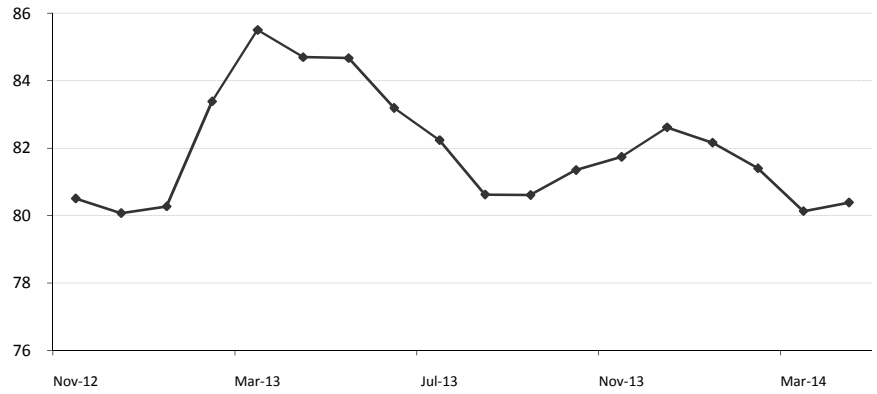
Introduction

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

	Measure	Improvement Metric		Target 14/15	Mar-14	Mar-13	vs Mar-13	YTD
Patient Safety	Mortality Rates	HSMR		-	80.4	84.7	↓	80.4
					Q2 13/14	Q2 12/13	vs Q2 12/13	YTD
		SHMI (%)		-	86.32%	88.78%	↓	-
					Jun-14	Jun-13	vs Jun-13	YTD
		Crude Mortality: All Ages (Per 1 000)	Non-Elective	-	25.147	27.205	↓	27.545
			Elective	-	0.442	0.351	↑	0.303
	Risk Management	Serious Incidents (STEIS)	New Incidents	-	7	4	↑	-
			Open Incidents	-	52	31	↑	Cumul.
	HCAI	MRSA	Attributable	5	1	1	↔	Cumul.
		C. difficile	Post 72h	47	15	18	↓	Cumul.
	Infection Prevention and Control				May-14	May-13	vs May-13	YTD
		Mandatory Training Compliance (%)		95.0%	83.2%	87.7%	↓	82.9%
	Harm Free Care (HFC)				Jun-14	Jun-13	vs Jun-13	YTD
		Safety Thermometer HFC (%) - Old & New Harm	EKHUFT	93.0%	94.4%	88.8%	↑	93.9%
			National	-	93.6%	92.7%	↑	-
	Nurse Sensitive Indicators	Pressure Ulcers: Category 2,3 and 4	Acquired	-	17	28	↓	54
			Avoidable	99	8	10	↓	23
		Falls		-	177	165	↑	507
	Clinical Incidents	Total Clinical Incidents		-	1095	998	↑	3178
Patient Experience	Compliments and Complaints	Compliments:Complaints		-	29:1	16:1	↑	-
		No. Care Spells per Formal Complaint		-	842	1640	↓	-
	Experience	Friends and Family Test (Star Rating)		5.0	4.4	4.6	↓	-
		Adult Inpatient Experience (%)		80.00%	88.33%	87.47%	↑	-
		Mixed Sex Accommodation Occurrences		-	11	3	↑	26
Clinical Effectiveness	Readmission				Apr-14	Apr-13	vs Apr-13	YTD
		7 Day (%)		2.00%	4.21%	4.47%	↓	4.21%
		30 Day (%)		8.32%	9.03%	9.11%	↓	9.03%
					May-14	May-13	vs May-13	YTD
		7 Day (%)		2.00%	4.44%	4.37%	↑	4.33%
		30 Day (%)		8.32%	8.99%	9.07%	↓	9.02%
	CQUIN				Jun-14	Jun-13	vs Jun-13	YTD
		Standard Contract CQUIN		Multiple			↔	
		Specialist CQUIN		Multiple			↔	
	Bed Usage	Bed Occupancy (%)		-	92.35%	91.27%	↑	-
		Extra Beds (%)		-	6.31%	5.30%	↑	5.90%
		Outliers		-	24.57	27.63	↓	74.21
		Delayed Transfers of Care (Average)		-	36.75	36.25	↑	36.52
Care Quality Commission	Intelligent Monitoring Report	Outcome Measures	Risks	-	4			-
			Elevated Risks	-	1			-

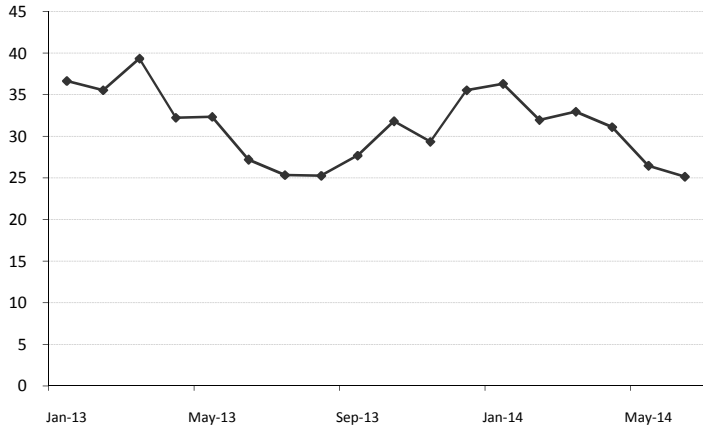
CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: MORTALITY RATES

Hospital Standardised Mortality Ratio (HSMR) - All Discharges



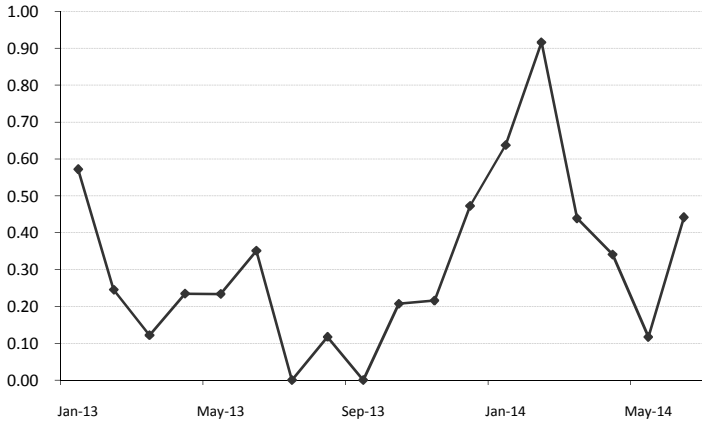
Performance at Trust level remains good across all mortality indicators with the 12 month rolling HSMR equalling 80.4 at the end of Apr-14 (that is, showing a 0.3 increase against March), and is in line with the trend demonstrated by the crude mortality metric. This also is a reflection of seasonal fluctuations, although it is hoped rates will be more consistent during Q4. HSMR for May is not yet reported due to the change in systems from Dr Foster to CHKS, however this will be updated when available.

Crude Mortality - Non-Elective per 1 000



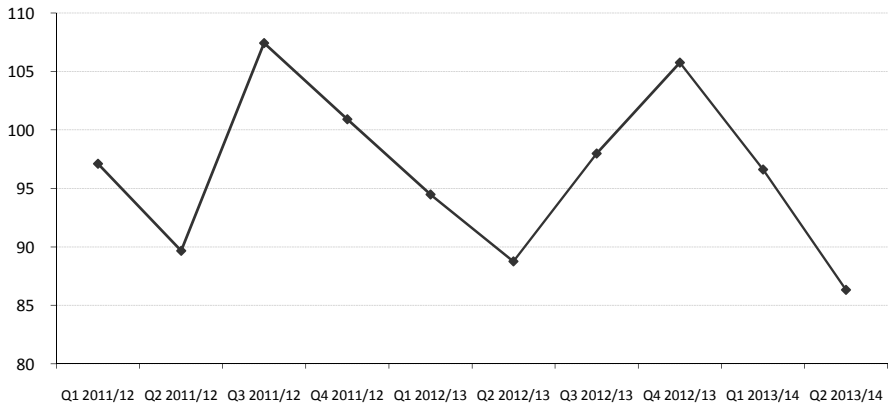
Crude mortality for non-elective patients shows a fairly seasonal trend with deaths higher during the winter months. The winter peak during 2012/13 extended further into the spring than normal, with a reduction to expected levels occurring in June rather than in April/May. Following this trend, May-14 performance equalled 26.471 deaths per 1 000 population, and June's position again dropped to 25.147.

Crude Mortality - Elective per 1 000



During February elective crude mortality was 0.916 deaths per 1 000 population, which dropped back to expected levels seen in March at a rate of 0.439. April's position stabilises this once more, achieving 0.341 and again in May, achieving 0.117. As predicted it is expected that the levels will reduce to those seen pre Nov-13 and follow seasonal trends. However, June shows an unexpected increase to 0.442 which is being investigated.

Summary Hospital Mortality Indicator (SHMI)



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

Serious Incidents - Open Cases

Date		Summary of Serious Incident & Remedial Action Taken	IX lv	Division	Timely Submit?
Incident	STEIS Report				
26-Jun-14	27-Jun-14	Unexpected Death - neonatal	2	Specialist	Not Due
16-Jun-14	26-Jun-14	C. Diff and Healthcare Acquired Infections	1	UCLTC	Not Due
23-Jun-14	26-Jun-14	Category 3 hospital acquired pressure ulcer (avoidable)	1	UCLTC	Not Due
28-May-14	16-Jun-14	Category 3 hospital acquired pressure ulcer (avoidable)	1	Surgical	Not Due
20-Mar-14	13-Jun-14	Fall - resulting in subdural haematoma	1	UCLTC	Not Due
20-May-14	2-Jun-14	Missed Diagnosis - meningitis	2	Specialist	Not Due
27-May-14	2-Jun-14	Unexpected Death	1	UCLTC	Not Due
19-May-14	21-May-14	Unexpected Admission - NICU	2	Specialist	Not Due
7-Mar-14	13-May-14	Unexpected Death - endoscopic bleed	1	UCLTC	Not Due
8-Mar-14	13-May-14	Missed Diagnosis - meningitis	2	UCLTC	Not Due
10-Mar-14	13-May-14	Unexpected Admission - term baby to NICU	2	Specialist	Not Due
11-May-14	12-May-14	Suboptimal Care - deteriorating patient	1	UCLTC	Not Due
5-May-14	9-May-14	Unexpected Admission - NICU	2	Specialist	Not Due
6-May-14	8-May-14	Unexpected Death - displacement of tracheostomy tube	1	UCLTC	No
31-Mar-14	1-May-14	Serious Injury - upper limb infarction following cannulation	1	UCLTC	Yes
28-Apr-14	29-Apr-14	Surgical Error - locum surgeon	1	Surgical	No
27-Mar-14	28-Apr-14	Category 4 hospital acquired pressure ulcer (avoidable)	1	UCLTC	Yes
13-Jan-14	24-Apr-14	Category 3 hospital acquired pressure ulcer (avoidable)	1	UCLTC	No
17-Mar-14	24-Apr-14	Category 3 hospital acquired pressure ulcer (avoidable)	1	Surgical	Yes
16-Apr-14	22-Apr-14	Unexpected Admission - NICU	2	Specialist	Not Due
18-Mar-14	11-Apr-14	Unexpected Death - transfer/missed diagnosis	1	UCLTC	Extension granted
7-Apr-14	11-Apr-14	Category 3 hospital acquired pressure ulcer (avoidable)	1	UCLTC	No
5-Apr-14	10-Apr-14	Unexpected Admission - NICU	2	Specialist	Not Due
8-Apr-14	10-Apr-14	Unexpected Death - post debridement	1	Surgical & UCLTC	Yes
3-Apr-14	3-Apr-14	Never Event - retained vaginal swab post delivery	2	Specialist	Yes
3-Apr-14	3-Apr-14	Intrapartum Death - placental abruption	2	Specialist	Yes
10-Mar-14	24-Mar-14	Suboptimal Care - deteriorating patient	1	Surgical	Not Due
7-Mar-14	20-Mar-14	Unexpected Death	1	UCLTC	No
19-Mar-14	20-Mar-14	Neonatal Death - home birth	2	Specialist	Not Due
1-Mar-14	19-Mar-14	Category 3 hospital acquired pressure ulcer (avoidable)	1	UCLTC	Yes
19-Feb-14	13-Mar-14	Unexpected Death - pericardial effusion	1	UCLTC	No
1-Mar-14	10-Mar-14	Never Event - wrong site pleural aspiration	2	UCLTC	No
28-Feb-14	3-Mar-14	Medication Administration Error - administered via wrong route	1	Surgical	Yes
9-Jan-14	25-Feb-14	Unexpected Death - venous thomboembolism at 6 weeks postoperative		Surgical	Yes
10-Dec-13	5-Feb-14	Unexpected Death - retroperitoneal haematoma	1	Surgical & UCLTC	Yes
18-Jan-14	24-Jan-14	Unexpected Death - sepsis	1	UCLTC	Yes
24-Jan-14	24-Jan-14	Neonatal Death - unexpected breach delivery at home, taken to QEH	2	Specialist	Yes
12-Dec-13	19-Dec-13	Unexpected Death - epileptic patient with ischaemic bowel		UCLTC	No
11-Oct-13	30-Oct-13	Allegation against a member of staff	1	UCLTC	Not Due
Aug-13	14-Aug-13	Media Interest - delayed implementation of PACS/RIS replacement resulting in a backlog of patient bookings across all modalities	0	Clinical Support	Not Due
22-Jan-13	24-Jan-13	Never Event - wrong site surgery: pleural aspiration	2	UCLTC	Yes
7-Jan-13	11-Jan-13	Never Event - wrong site surgery: Ophthalmology	2	Surgical	Yes
3-Jan-13	8-Jan-13	Neonatal Death - term baby	2	Specialist	Yes
8-Aug-11	13-Sep-12	Media Interest - re: DNR and patient with learning disabilities	1	Corporate	Yes

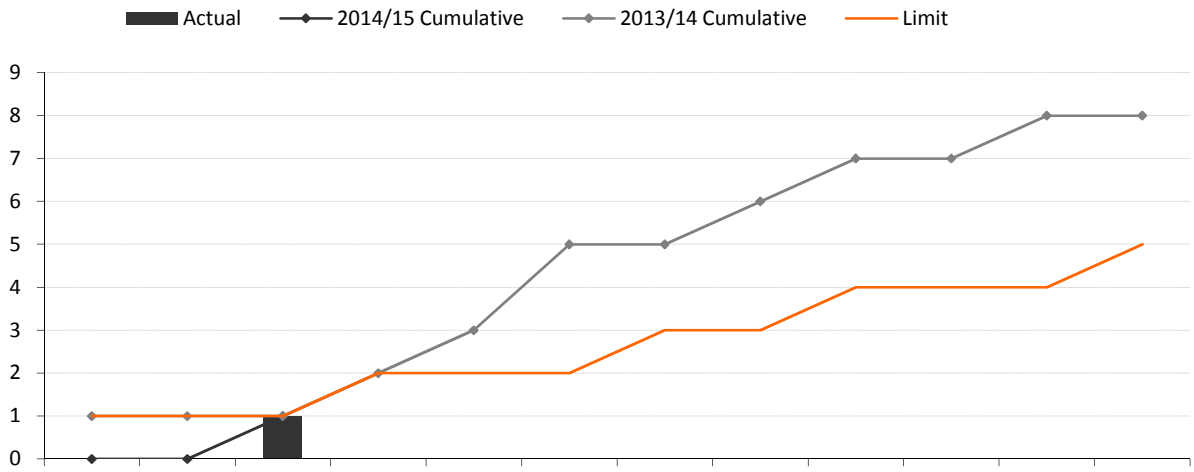
Serious Incidents - Partially Closed Cases

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

Date		Summary of Serious Incident & Remedial Action Taken	IX lv	Division
Incident	STEIS Report			
19-Feb-14	25-Feb-14	Neonatal Death - at 24 weeks	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
21-May-13	21-Jun-13	Induction of Labour - term baby developed seizures at 36h	2	Specialist
27-Feb-13	1-Mar-13	Maternal Death - 6 days postpartum	1	Specialist
28-Nov-12	14-Feb-13	Unexpected Death	1	Surgical
22-Nov-12	22-Nov-12	Unexpected Admission - NICU	2	Specialist
4-Sep-12	13-Sep-12	Neonatal Death - following shoulder dystocia	1	Specialist

Seven serious incidents were reported on STEIS during Jun-14. These were: 2 Category 3 pressure ulcers, 1 neonatal death, 1 C. difficile outbreak, 1 fall resulting in death, 1 unexpected death and 1 serious incident (outpatient with missed meningitis diagnosis). The Trust has had 1 notification of closure from the CCGs. There were 8 incidents awaiting Area Team review. The Root Cause Analysis (RCA) reports have been presented to the Risk Management Governance Group by the Divisions responsible. These included the findings of the investigation and action plans to take forward recommendations, including mechanisms for monitoring and sharing learning. At the end of Jun-14 there were 52 serious incidents open on STEIS.

MRSA Bacteraemia - Trust Assigned Cases



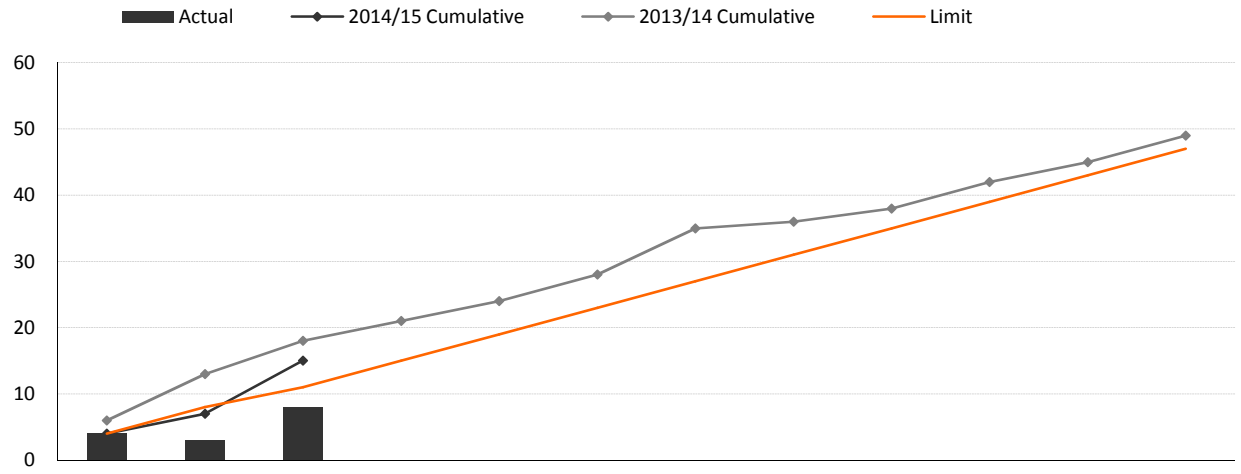
	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual	0	0	1									
2014/15 Cumulative	0	0	1									
2013/14 Cumulative	1	1	1	2	3	5	5	6	7	7	8	8
Limit	1	1	1	2	2	2	3	3	4	4	4	5

There was 1 MRSA bacteraemia in June, which was assigned to the Trust (KCH) at the Post Infection Review (PIR) Meeting on the 30 Jun-14. There were various non-compliances within the Surgical Pre-Assessment Clinic and also on Clarke Ward that could have contributed to the development of the bacteraemia, and the final decision is that this was an avoidable infection. Work is currently being undertaken within the Pre-Assessment Team Trust wide to review how MRSA positive results are managed and escalated to the medical teams prior to the patient's admission for surgery. This work forms part of the PIR Action Plan, which is being led by the Surgical Services Division, and includes actions for Clarke Ward.

The MRSA bacteraemia case from May, which was provisionally assigned to NHS Thanet CCG, remains unassigned following PIR, and has been referred to the Public Health England (PHE) Regional Team for arbitration, as it falls under the new NHS England heading/assignment of "third party/intractable infection". The Arbitration Panel is meeting on the 14 Jul-14 and the outcome will be reported next month.

PATIENT SAFETY: HOSPITAL ACQUIRED INFECTIONS

Clostridium difficile - Incidents Post 72h



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

The C. difficile target for the end of quarter 1 was 11. There were 8 post 72 hour cases of C. difficile infection in June, 3 at the QEH, 2 at KCH, and 3 at WHH. Of these, 4 were within UCLTC and 4 were within Surgical Services. Five of the 8 cases were determined to be unavoidable at Root Cause Analysis; RCA meetings for the remaining 3 cases are pending. The Q1 target has been exceeded by 4 cases (15 cases in total).

A Period of Increased Incidence (PII) and a Serious Untoward Incident (SUI) was declared on the 16 Jun-14 on Minster Ward (which was re-located onto St Augustine's as part of the QEH decant and refurbishment programme) following 3 post 72h cases which occurred over a 28 day period in May to June. There were 2 patients with pre72h C. difficile infection on the ward during this period, making a total of 5 patients with C. difficile on Minster Ward. Ribotyping of 4 C. difficile isolates has identified 2 belonging to ribotype 015, and 2 belonging to ribotype 0126. Sub-typing has been requested in order to see if the strains are indistinguishable (i.e. identical and therefore associated). An action plan is in place, and there have been no new cases of C. difficile on the ward since the 15 Jun-14. The Quality Lead and IPC Specialist Nurse Advisor from NHS Thanet and South Kent Coast CCG undertook a Quality Visit to the ward on the 1 Jul-14, and were reassured by the measures that are in place. The ward is being supported daily by the site-based IPC Specialist Nurses and remains under infection control "Special Measures". Kent wide agreements regarding "lapses of care" definitions are soon to be finalised.

Escherichia coli Bacteraemia - Incidents Pre and Post 48h

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly Average	Total YTD
2014/15	Pre 48h	32	36	32										33.3	100
	Post 48h	9	1	8										6.0	18
2013/14	Pre 48h	30	33	41	37	28	42	36	36	26	31	29	33	33.5	30
	Post 48h	4	3	4	12	3	12	10	4	8	8	6	11	7.1	4

The IPCT are now undertaking RCA for all E. coli bacteraemia cases occurring within 30 days of a surgical procedure undertaken in EKHUFT, in order to identify causes and address as necessary. There were 40 cases of E.coli bacteraemia in June, that is, 32 pre and 8 post 48h. Only 1 case (on Kent at KCH) met the criteria for RCA, and this will be undertaken in July.

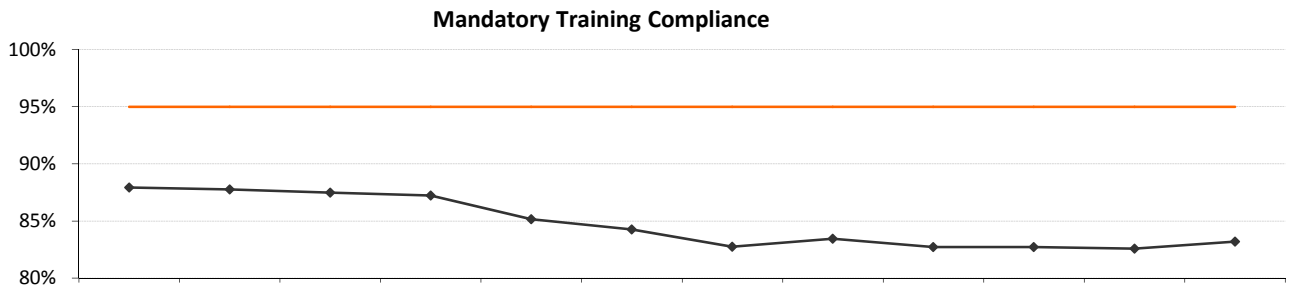
Meticillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly Average	Total YTD
2014/15	Pre 48h	7	6	6										6.3	19
	Post 48h	1	1	3										1.7	5

The IPCT are now undertaking RCAs for all cases of MSSA bacteraemia occurring within 30 days of a surgical procedure undertaken in EKHUFT, or associated with an intravenous line. In June there were 9 cases of MSSA bacteraemia, 6 pre and 3 post 48h. Three cases met the criteria for RCA, 1 at each at KCH, QEH and WHH. RCAs are to be held in July.

At QEH a RCA was held for the case that occurred in May and which was associated with the management of a peripherally inserted central catheter (PICC line) on Viking Day Unit. A Trust wide action involves improving documentation in relation to line insertion and management through use of the newly launched "PICC Passport" by the Vascular Access Team, in addition to education for staff on the Ambulatory Care Unit at QEH on the management of PICCs.

PATIENT SAFETY: INFECTION PREVENTION & CONTROL

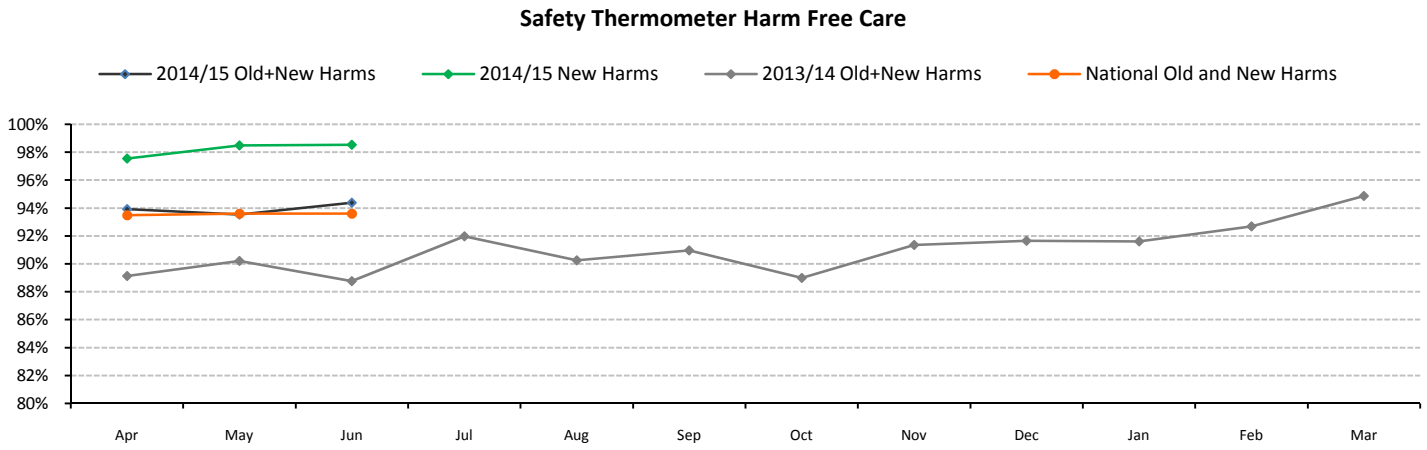


	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14
Compliance	87.9%	87.8%	87.5%	87.2%	85.2%	84.3%	82.7%	83.5%	82.7%	82.7%	82.6%	83.2%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

	May-14								
	Target	Trust	Clinical Support Services	Corporate	Specialist Services	Strat Dev & Capt Pln	Surgical Services	UCLTC	SERCO
Mandatory Comparative Data for Biennial Training Compliance	95%	83.2%	86.1%	84.2%	78.3%	89.6%	83.8%	82.7%	97.0%

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

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



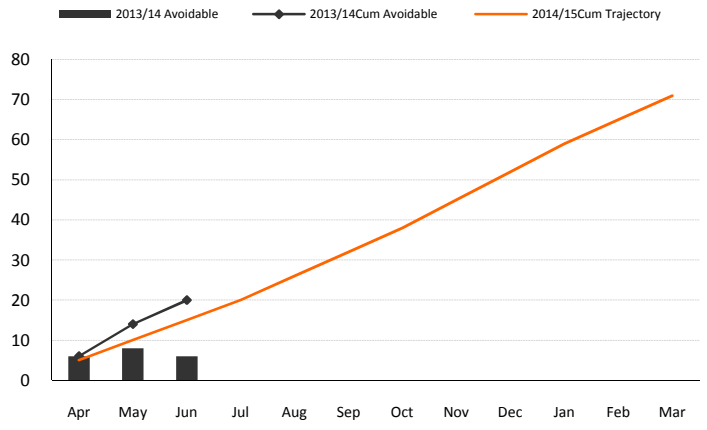
The chart above shows the percentage of Harm Free Care expressed as a one-day snapshot in each month. It is known as the NHS Safety Thermometer and is a quick and simple method for surveying patient harms. The aim of the Safety Thermometer is to identify, through a monthly survey of all adult inpatients,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

- All 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.

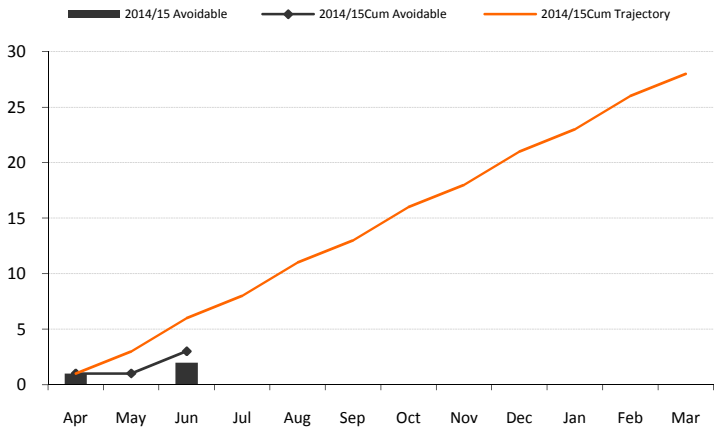
The strength of the NHS Safety Thermometer lies in allowing front line teams to measure how safe their services are and to deliver improvement locally. There are several different ways in which harm in healthcare is measured and there are strengths and limitations to the range of approaches available. 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 all occurrences of harms.

Harm Free Care includes both harms acquired in hospital ("new harms") and those acquired before admission to hospital ("old harms"). There is limited ability to influence "old harms" if a patient is admitted following a fall at home, or with a pressure ulcer, but these are included in the overall performance reported to the Health and Social Care Information Centre. "New harms only" are included separately when reporting performance to Divisional teams to enable success to be celebrated and to incentivise improvement. Harm Free Care performance is incorporated within the monthly ward quality dashboard and is triangulated with the existing funded establishment, acuity and dependency of patients, and effectiveness of rostering to enable analysis of influencing factors and thereby focusing improvement actions. In Jun-14, the Trust's own score was 98.5% showing that those patients in our care have a greater harm free experience. This is above the national figure of 93.6% and is the area we can influence the most. The total percentage of Harm Free Care ("old and new harms") is 94.4%, and is in line with the national figure. We are working closely with the Area Team to develop Kent and Medway wide improvements that should positively impact on these indicators across the whole of the patient pathway. This is via the Kent and Medway Patient Safety Collaboratives.

Category 2 Incidence Trajectory 2014/15
25% Reduction



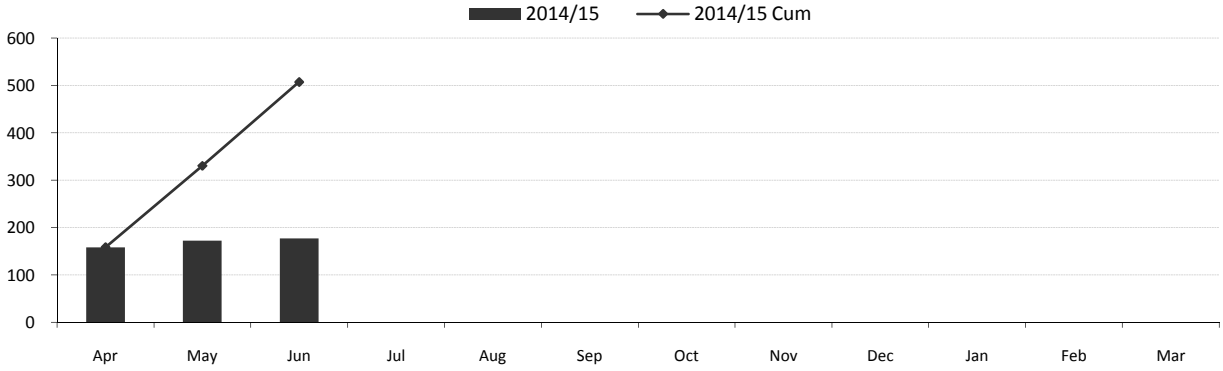
Category 3 and 4 Incidence Trajectory 2014/15
25% Reduction



In June there were 13 hospital acquired Category 2 pressure ulcers; 5 were recorded at KCH, 2 at QEH and 6 at WHH. Six Category 2 pressure ulcers were deemed avoidable. Five of these were heel ulcers, 1 of which was due to the lack of offloading. Thirty three wards have developed and returned specific action plans to eliminate avoidable heel ulcers. The main learning identified as contributing to avoidable Category 2 pressure ulcers was insufficient evidence of repositioning, and 1 incident related to the position of the feet in the bed which caused toe pressure damage.

In June, there were 4 reported deep acquired ulcers (Categories 3 and 4); 1 at KCH and 1 at QEH and 2 at WHH. Of these ulcers, 2 were agreed as avoidable due to insufficient evidence of repositioning and Root Cause Analysis meetings are being arranged to identify learning points. The Deep Pressure Ulcer Working Group is continuing to support the Trust wide "Think Heels" campaign and has set a stretch target of 50% reduction in deep ulcers. The first intensive multidisciplinary investigation is underway with 2 wards at QEH. This is being held together to allow for peer support. Both wards are formulating their action plans at this time. An additional TVN has been employed at WHH to help with education and prevention measures.

Patient Falls - Injurious and Non-Injurious

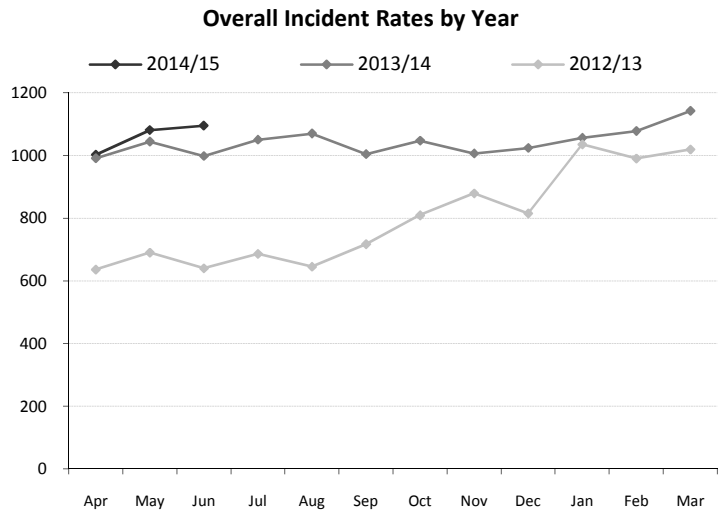


There has been an increase in falls since Apr-14 resulting in fractures and head injuries at WHH. This is across UCLTC and Surgery Divisions. A meeting was held on 10 Jul-14 to discuss this issue and explore the underlying reasons. A meta analysis of these incidents is planned for 25 Jul-14 to be chaired by the Head of Nursing for Surgery. There is also a plan to implement an increased focus and responsibility for RCAs on Ward Managers with an aim to improve ward level engagement in the RCA process, and most importantly, the action plan. The Falls Team have relocated one of the CNSs from KCH to WHH for 2 days per week to support the site at this time.

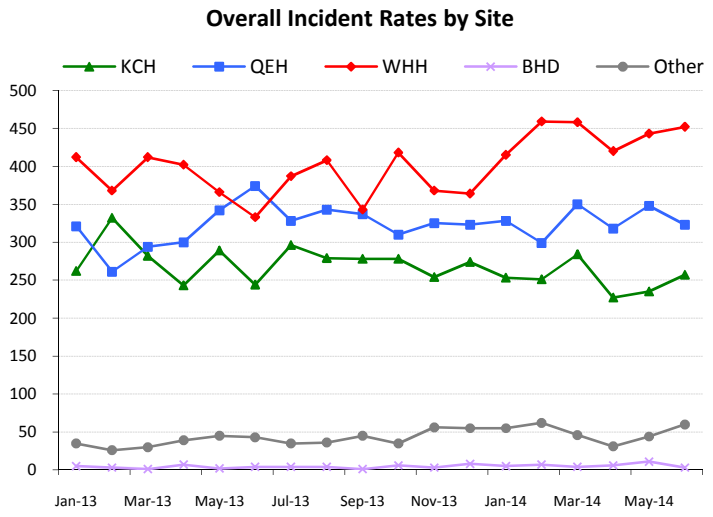
PATIENT SAFETY: CLINICAL INCIDENTS

In Jun-14 a total of 1095 clinical incidents including patient falls were reported. This includes 1 incident (which is under investigation) graded as death and 3 (which are under investigation) graded as severe. Unapproved incidents may be downgraded following investigation. In addition to these 4 serious incidents, 26 incidents have been escalated as serious near misses, of which all are under investigation.

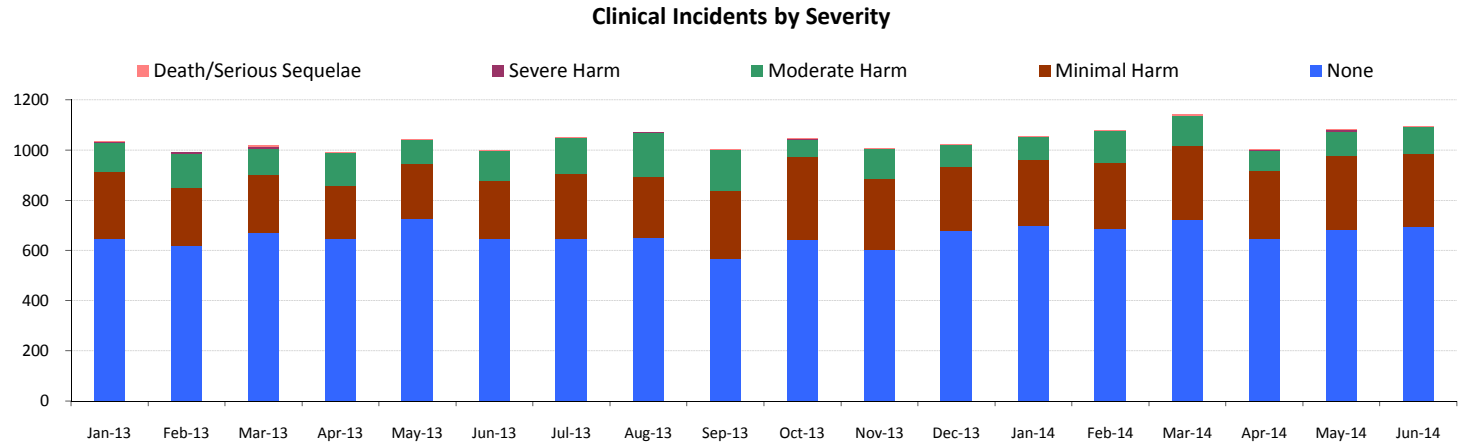
Seven serious incidents were required to be reported on STEIS in June. One case has been closed and one re-opened (closed in error by KMCS) since the last report; there remain 52 serious incidents open at the end of June.



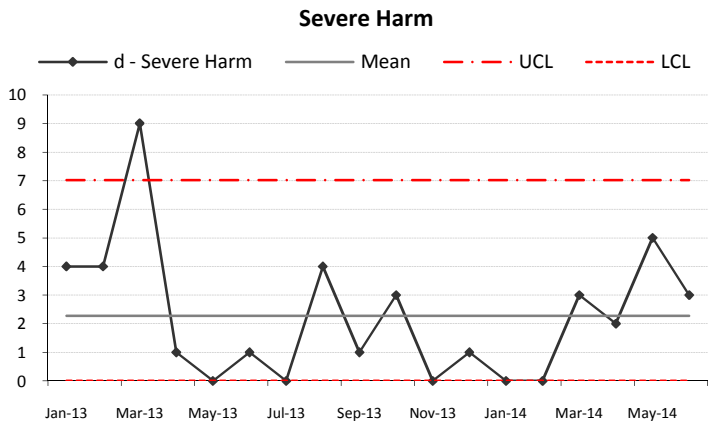
A total of 1095 clinical incidents have been logged in June compared with 1081 recorded for May-14.

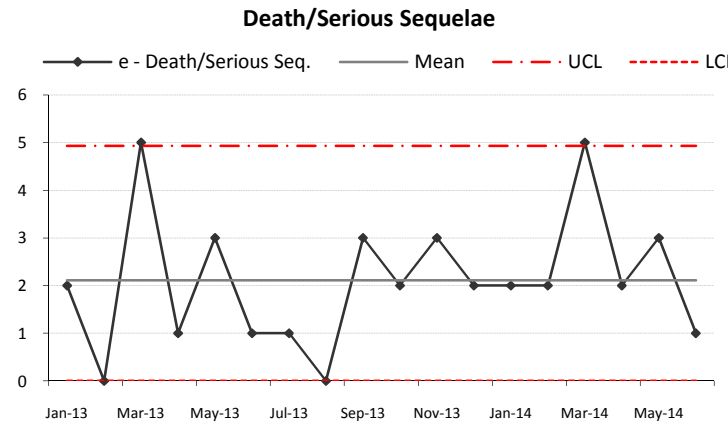


Numbers of clinical incidents have risen slightly at KCH and WHH.

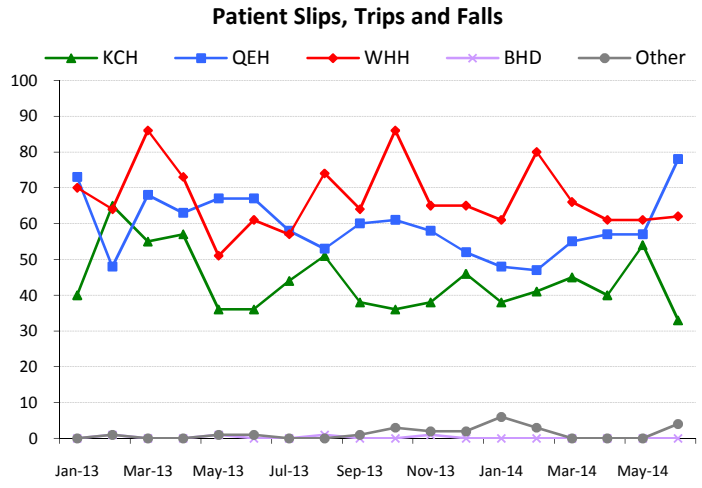


The incidents graded as moderate, serious and death have all been subject to review in order to confirm the consistency of the grading of harm across the Trust. The Board of Directors may see a change in this report to reflect the re-categorisation process undertaken. This is consistent with the data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

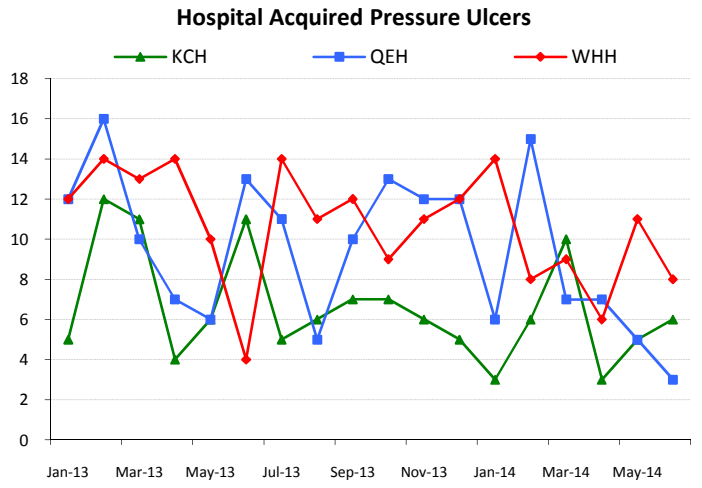




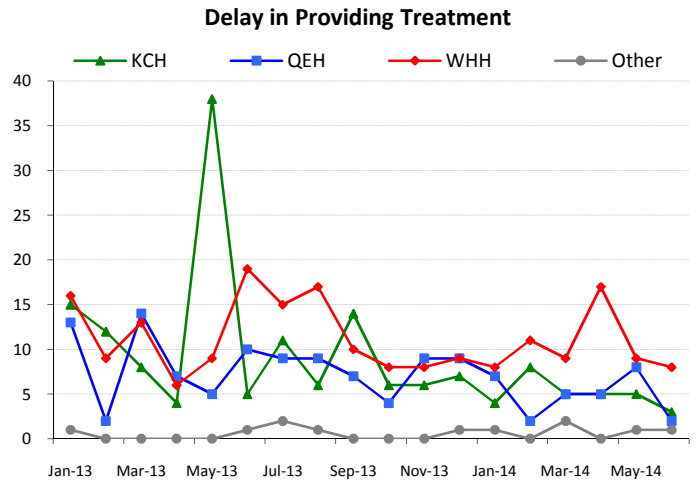
The number of death/serious and severe harm incidents reported in Jun-14 remains subject to the usual RCA investigation and review. It is possible that the severity of these cases will be downgraded once the investigation process is completed. In Jun-14, the number of incidents graded as death or severe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



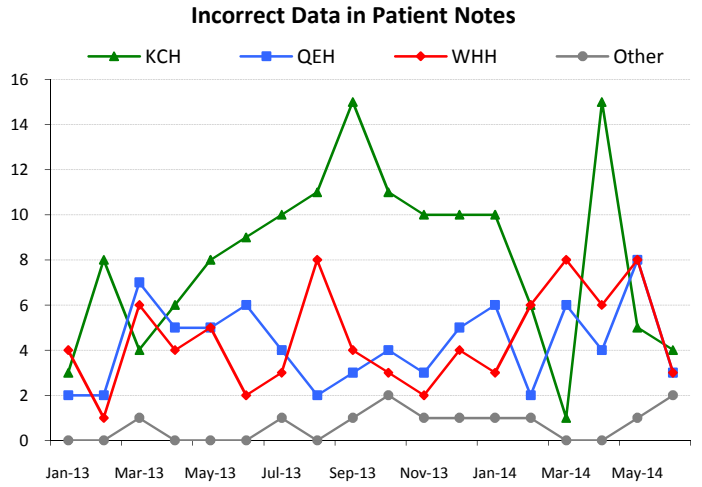
Of the 176 patient falls recorded for June (172 in May), none were graded as severe or death. There were 98 falls resulting in no injury, 73 in low harm and five in moderate harm. The top reporting wards were CDU (QEH) with 11 falls; CDU (WHH) with 10 falls; Richard Stevens Stroke Unit (WHH), St. Margaret's (QEH), Sandwich Bay (QEH) with 9 falls each; Deal (QEH) with 8 falls; Bishopstone (QEH), Fordwich (QEH), Seabathing (QEH) and Kings C1 (WHH) with 6 each. The remaining wards reported 5 or less falls. Of the 5 moderate harm falls, 3 resulted in fracture on Cambridge L (WHH), Richard Stevens Stroke Unit (WHH) and Seabathing (QEH); 2 resulted in head injuries on Richard Stevens Stroke Unit (WHH) and Kings C1 (WHH). A Root Cause Analysis is carried out for all falls resulting in serious harm or fracture.



In June there were 17 reported incidents of pressure ulcers developing in hospital (21 in May). This included 13 Category 2 pressure ulcers and 4 Category 3. No Category 4 ulcers were reported. Eight have been assessed as avoidable and 9 as unavoidable. The highest reporting wards were CDU (WHH) and Clarke (KCH) with 3 incidents each.

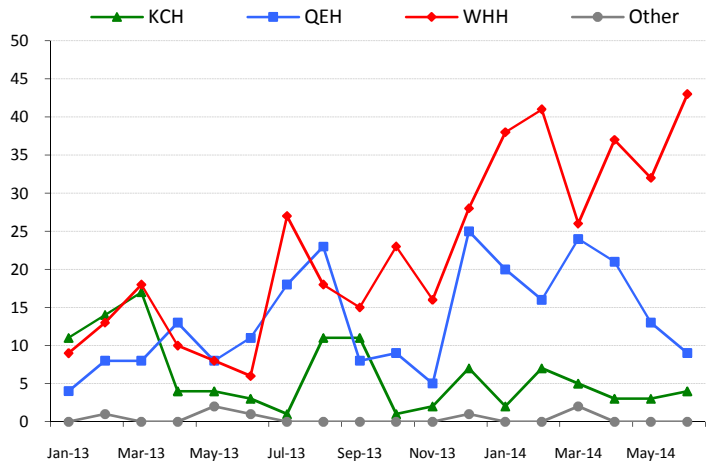


There were 14 incidents resulting in delay in providing treatment during June compared with 23 in May. No incidents have been graded as severe harm or death. One has been graded moderate harm, 5 have been graded as low and 8 resulted in no harm, which included 1 serious near miss. Themes in location: 2 incidents occurred in A&E (WHH); all other areas reported 1 or no incidents.



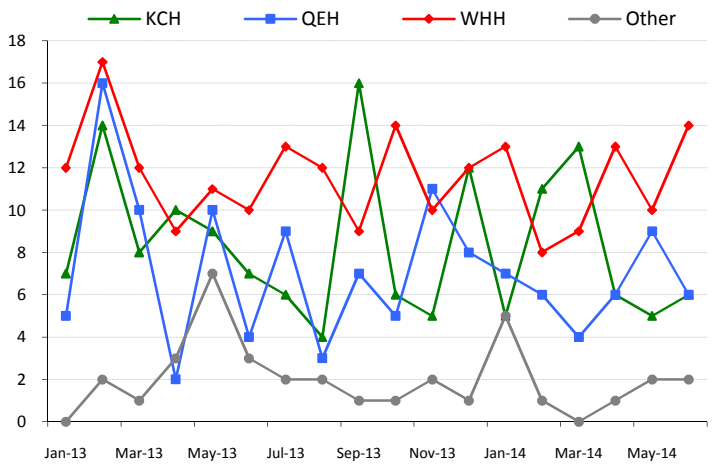
There were 12 incidents of incorrect data in patients' notes reported as occurring in June (22 in May), all of which were graded as no harm. Five incidents related to incorrect data in paper notes, 4 to incorrect data on patient's electronic record (Patient Centre/Euroking) and 3 to incorrect data in the electronic discharge notification (eDN). Of the incidents reported, 4 were identified at KCH, 3 at QEH, 3 at WHH, 1 at RVHF and 1 at Seabrook Children's Centre. There were no themes in the location of these incidents.

Staffing Level Difficulties



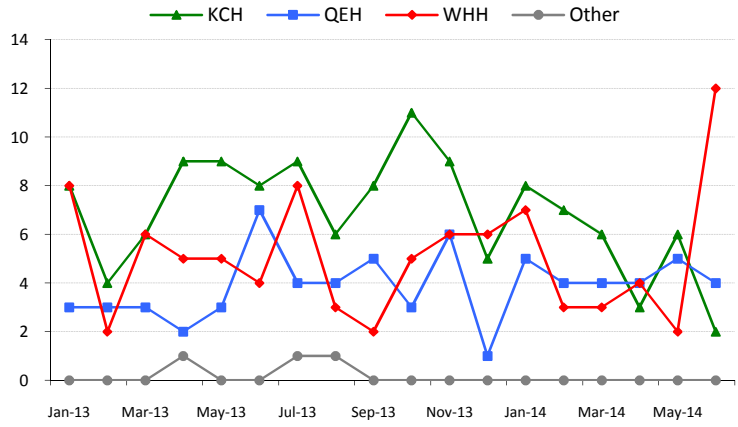
There were 56 incidents recorded in June (48 in May). These included 40 incidents relating to insufficient nurses and midwives, 6 to inadequate skill mix, 1 to insufficient doctors and nurses, 2 to insufficient doctors and 7 to general staffing level difficulties. Top reporting locations were ITU (WHH) with 14 incidents; Kennington (WHH) with 10; A&E (QEH) with 6; and the following areas reporting 4 incidents each: Singleton MLU (WHH) and Haematology (WHH). Other areas reported 2 or fewer incidents. Four incidents occurred at KCH, 9 at QEH and 43 at WHH. One incident has been graded as moderate and 3 as low harm due to delays in providing treatment and suboptimal care being identified. The remaining 52 incidents have been graded as no harm.

Communication Breakdowns



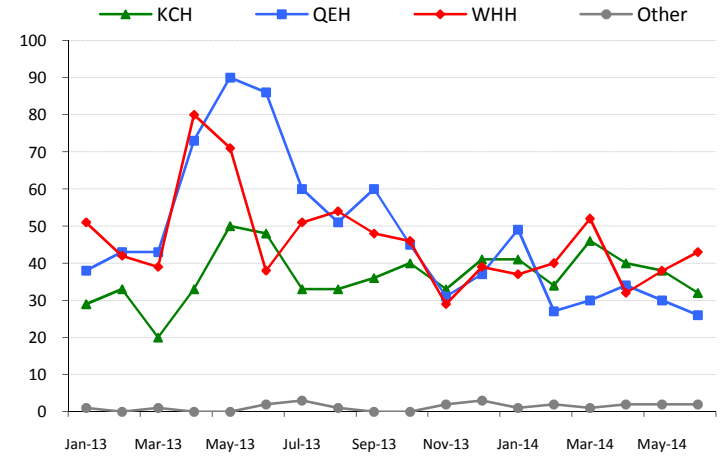
In Jun-14 there were 28 incidents of communication breakdown (26 in May). Of these, 22 involved staff to staff communication failures and 6 were staff to patient. Of the 28 incidents reported, 6 were reported as occurring at KCH, 6 at QEH, 14 at WHH, 1 at RVHF and 1 at BHD. Themes by location: Cambridge M (WHH) and Deal (QEH) reported 2 incidents each; other areas reported 1 or none. Incidents in June were graded as follows: 23 as no harm, 2 as low harm and 3 as moderate harm.

Blood Transfusion Errors



In June, there were 18 blood transfusion errors reported (13 in May). Three main themes arose in the period: 6 incidents related to phlebotomy process errors (sampling and labelling), 3 incidents of prescription/documentation errors (including traceability) and 3 incidents related to inappropriate/wrong treatment or procedure. Of the 18 incidents reported, 16 were graded no harm and 2 as low harm. Reporting by site: 2 at KCH, 4 at QEH, and 12 occurred at WHH, of which 5 were in A&E.

Medicines Management



There were 103 medication incidents reported as occurring in June (108 in May).

Medicines Management

Category	Jun-14
Prescribing	26
Dispensing	25
Administering	36
Missing (lost or stock discrepancy)	12
Shortage (drug unavailable)	3
Suspected adverse reaction	1
Infusion problems (drug related)	0
Infusion injury (extravasation)	0
TOTAL	**103**

Of the 103 reported, 86 were graded as no harm including 5 serious near misses, 16 as low harm and 1 as severe harm. Top reporting areas were: Cathedral Day Unit (KCH) with 13 incidents, Pharmacy (WHH) with 6; St. Margaret's (QEH) with 5; ECC (KCH), Cheerful Sparrows Male (QEH), Celia Blakey Centre (WHH) and Folkestone (WHH) with 4 each; 3 incidents occurred on Rainbow (QEH), CDU (WHH), ITU (WHH), Kings A2 (WHH), Padua (WHH) and in Aseptics (KCH); other areas reported 2 incidents or fewer. Thirty two incidents occurred at KCH, 26 at QEH, 43 at WHH, 1 attributed to Maidstone Hospital (not EKHUFT) and 1 at Maidstone renal satellite unit.

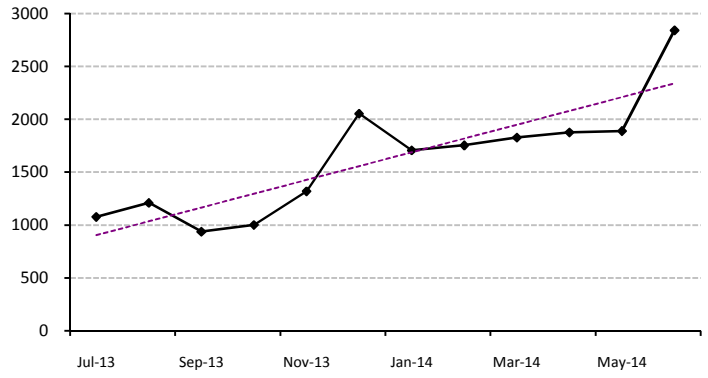
PATIENT EXPERIENCE: CONCERNS, COMPLAINTS & COMPLIMENTS

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

• Activity: Formal complaints - 99; informal contacts - 67; compliments - 2842; PALS - 205.

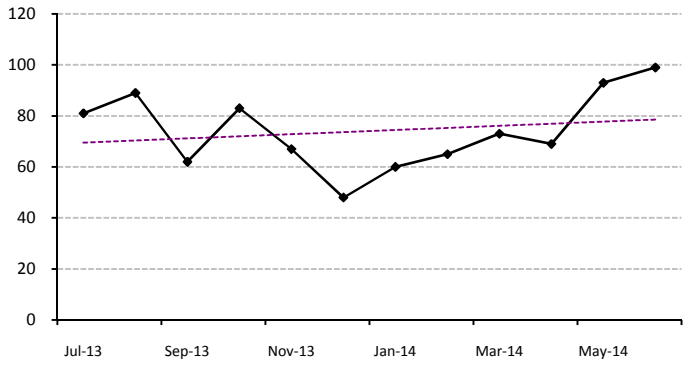
The charts below show the number of complaints and compliments received on a monthly basis. One formal complaint has been received for every 842 recorded spells of care (0.1%) in comparison to May's figures where 1 formal complaint was received for every 864 recorded spells of care (0.1%).

Number of Compliments



The number of compliments received increased by 50% compared to the previous month. This significant increase is primarily due to the department actively encouraging the Divisions to report on compliments received. The ratio of compliments to formal complaints received for the month is 29:1. There has been 1 compliment being received for every 29 recorded spells of care.

Number of Formal Complaints



The number of formal complaints received has increased by 7% compared to May-14, and has increased by 15% since Jun-13.

Top Five Concerns Expressed in Formal Complaints
June 2014

Concerns		No.
Problems with Communication	Doctor communication issues	10
	Nursing communication issues	5
	Misleading or contradictory information given	4
	Other staff communication issues	3
	Lack of information/explanation of procedure outcome	2
Delays	Delay in going to theatre	5
	Delay with elective admission	5
	Delays in receiving treatment	5
	Delay in referral	3
	Delays in allocation of outpatient appointments	2
	Delay in receiving x-ray results	1
	Delays in being seen in A&E	1
Problems with Attitude	Problems with doctor's attitude	7
	Problems with nurse's attitude	7
	Problems with other staff attitude	5
Problems with Nursing Care	Problems with nursing care	11
	Lack of response to call button	3
	Inappropriate physical handling	1
Problems with Diagnosis	Misdiagnosis	6
	Delay for results	2
	Missed fracture/or other medical problem	2
	Delay in receiving diagnosis	1

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

With regards to formal complaints, the highest recurring subjects raised in Jun-14 were problems with communication, delays, problems with attitude, problems with nursing care, and problems with diagnosis.
In comparison with May-14, problems with communication have returned to being the top concern. Problems with discharge arrangements and concerns about clinical management have been replaced by problems with nursing care and problems with diagnosis.

Concerns, Complaints and Compliments - Divisional Performance

June 2014

Division	Divisional Activity				Divisional Performance	
	Formal Complaints	Compliments	Informal Contacts	Compliments: Complaints	Response Date Agreed with Client	Returning Complaints
Clinical Support	6	96	9	16:1	1 of 2	0
Specialist Services	14	1349	13	96:1	12 of 13	0
Surgical Services	37	706	27	19:1	27 of 32	6
UCLTC	39	689	17	18:1	18 of 23	4
Corporate	3	2	1	0:1	0	0
Other	0	0	0	0:0	0	0
TOTAL	**99**	**2842**	**67**	**29:1**	**58 of 70**	**10**

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

The table above shows the monthly Divisional activity and performance for Jun-14, reporting on the percentage of cases where target dates falling within the month have been met. The response date is the date agreed with the client for the receipt of a substantive response to their complaints; this will either be via a letter or at a meeting. During Jun-14 the data show that 82.9% of these responses were sent out on target, and 4 out of 5 Divisions sent out a minimum of 75% of their responses on time. Although there has been a slight increase in the number of formal complaints received in June (7%), there has been a significant decrease in the number of returning complaints received during the same period (50%).

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

Status of Cases	Actions in Jun-14
Cases carried over from previous month	20
New cases referred to the Trust	2
Cases closed by PHSO	0
Current open cases with the PHSO	22

The PHSO is the second and last stage of the National Complaints process and it is open to all clients to approach the Office if they are dissatisfied with the way their formal complaint has been handled.
In June, the PHSO have been in contact with the Trust with regards to 2 new cases brought to their attention, that is, 2 cases relating to the UCLTC Division (A&E and Neurology). No cases were closed by the PHSO in Jun-14.

Friends and Family Test (FFT)

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

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

There is also a "don't know" option which isn't scored, and an opportunity to write further comments. Nationally, Trusts are measured using the Net Promoter Score (NPS) where a score of approximately 50 is deemed good. The Trust's NPS was 54 in June similar to May. This is the combined satisfaction from 3631 responses from inpatients and A&E. Maternity services achieved 456 responses. The NPS for inpatients was 72 for A&E it equalled 30, and for Maternity it was 79. The inpatient score is at the national average, but the A&E score is below national average (54). Further work is underway regarding the low A&E NPS to take a close look at the feedback and achieve the improvement plan to address the issues our patients are telling us about regarding waiting times, pain management, staff attitude, and food and drink availability.
The company iWantGreatCare which reports FFT data on behalf of the Trust have converted the NPS into a "star score" value (ranging from 0 to 5) thus making the interpretation of FFT results easier. The star score is calculated using an arithmetic mean, so a ward that scores 4 stars has an overall average rating of "likely" to be recommended. The Trust score for June was 4.42 stars out of 5 stars and is similar to last month.
The response rate for June-14 for inpatients and A&E combined achieved 28.31%, which is higher than May. This awaits Unify2 validation. This year the wards have a 20% standard for Q1 which they exceeded with a 34.36% response rate. The A&E departments achieved 23.86% this month exceeding their 15% standard, and their highest response rate to date. Maternity services achieved 20.03% combined. Staff FFT is being implemented and FFT for Outpatients and Day Cases is being planned for October this year.

We Care Programme

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

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

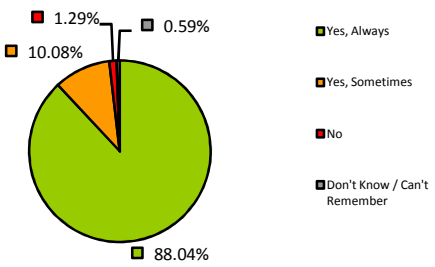
Events have taken place across the Trust during the past 12 months led by frontline staff. These have sought feedback from patients and families, as well as having discussions about the We Care values within teams. We have undergone a "branding" piece of work that ensures our communications with each other and the public are empathetic and sensitive. This has been labelled the "Tone of Voice" work led by Human Resources. In addition, work is in progress to embed the values as part of job advertisements, the recruitment process, and our engagement with staff. The roll out of the "We Care" Champions has commenced following the approval by the Board of Directors of the Trust values with around 85 Champions in place. A second event focusing on developing listening skills took place in June. In addition, the behaviours linked to the values were shared with staff during June in a separate publication.
The Steering Group are currently working on the Tender document in order to go out to market and appoint an external partner to take forward the programme in order to ensure the embedding of the values and behaviours into everyday practice.

CLINICAL QUALITY & PATIENT SAFETY

PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

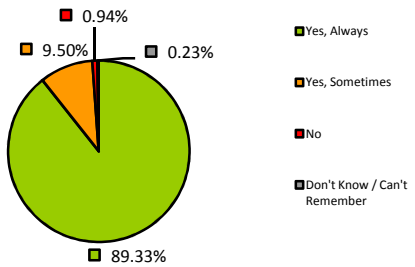
Real time patient experience monitoring using iPads have captured data since 1 Apr-13. During Jun-14, 853 adult inpatients were asked about their experiences of being an inpatient; 192 responses were received from patients treated at KCH, 185 from QEH patients, and 476 responses from patients based at WHH. (Compared with the previous month the number of responses were 98, 106 and 409 respectively). The combined result from all submitted questionnaires in June-14 was that of 88.33% satisfaction.

Were you given enough privacy when discussing your treatment?



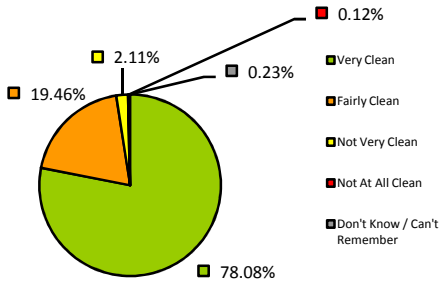
Overall Score = 93.63%

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



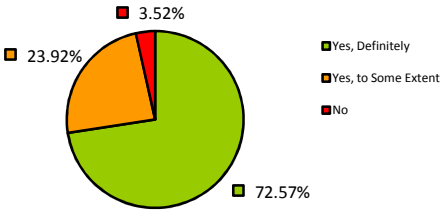
Overall Score = 94.30%

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



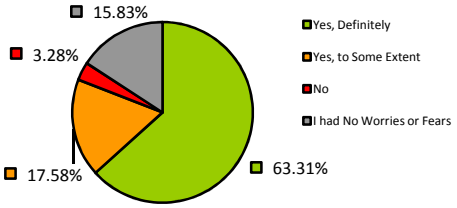
Overall Score = 91.97%

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



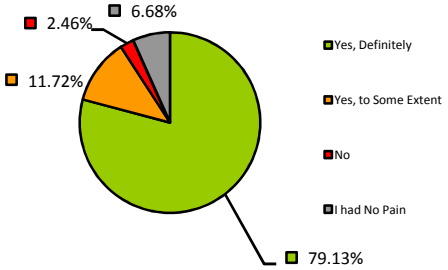
Overall Score = 84.53%

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



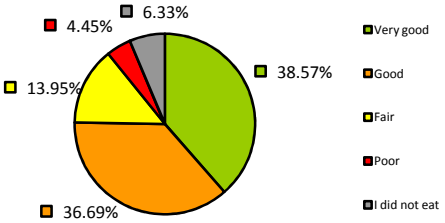
Overall Score = 85.60%

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



Overall Score = 91.08%

How would you rate the hospital food?

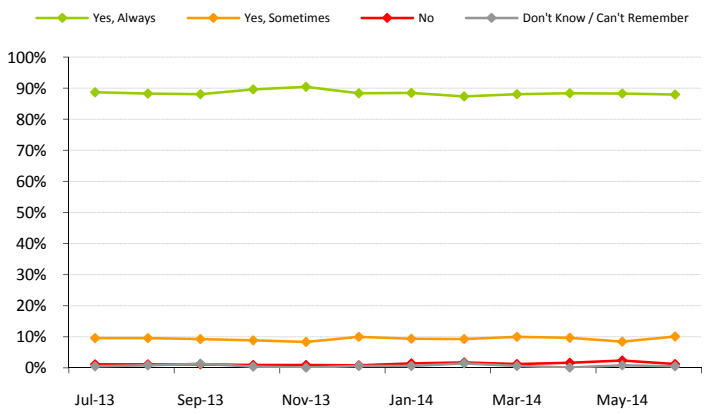


Overall Score = 72.26%

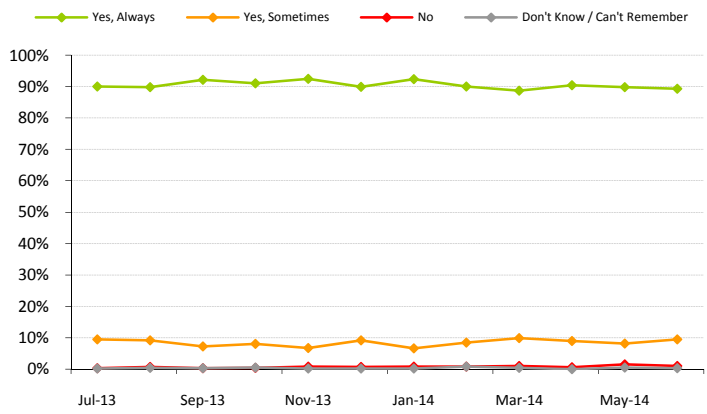
Overall Adult Inpatient Experience Jun-14	
Experience (%)	No. of Responses
88.33	853

PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

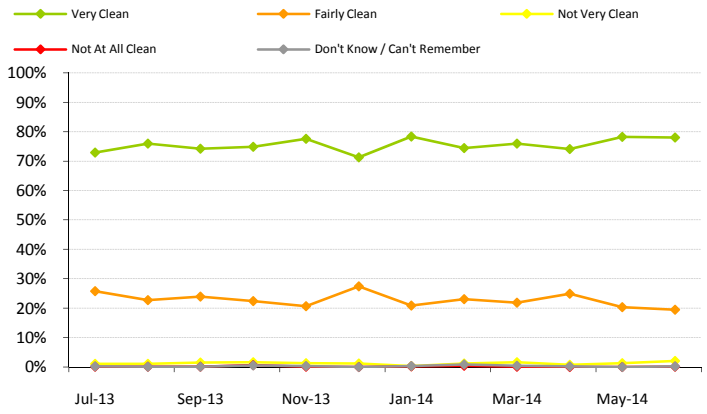
Were you given enough privacy when discussing your treatment?



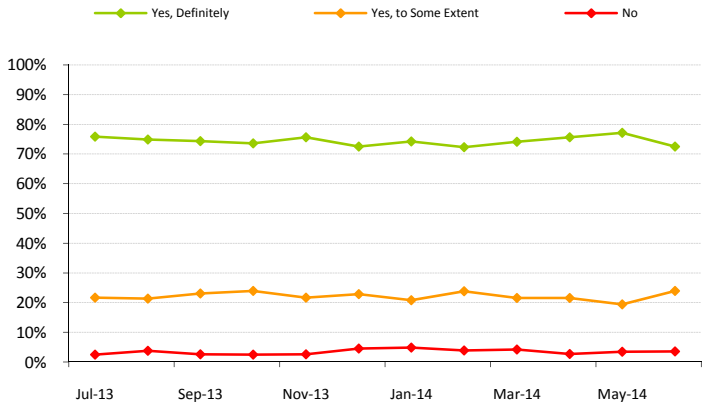
Overall, did you feel you were treated with respect and dignity while you were in hospital?



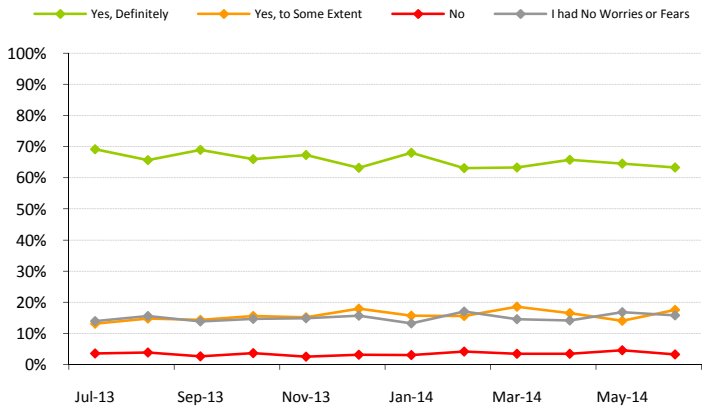
In your opinion, how clean was the hospital room or ward that you were in?



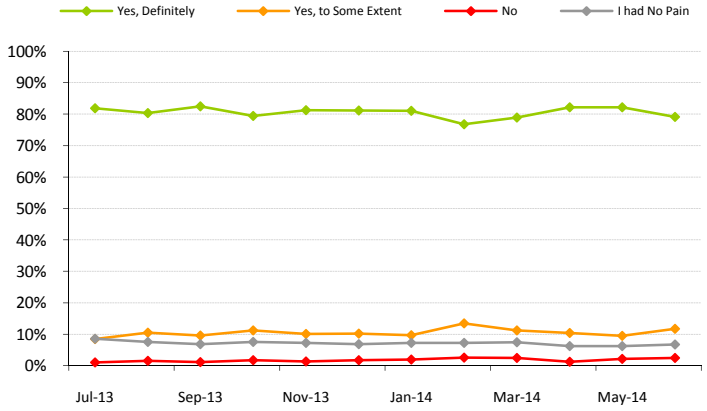
Were you involved as much as you wanted to be in the decisions about your care and treatment?



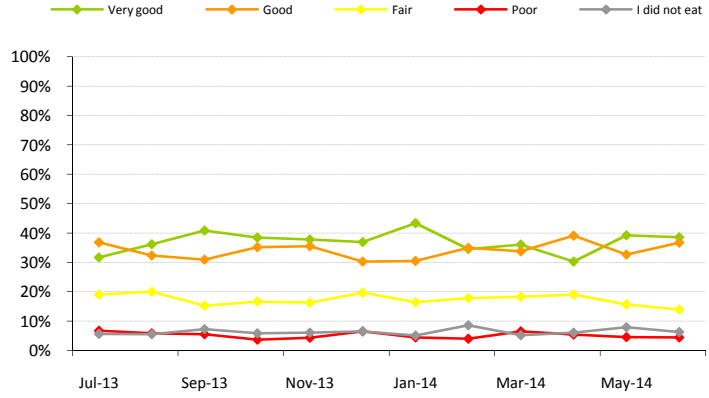
Did you find someone on the hospital staff to talk about your worries and fears?



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



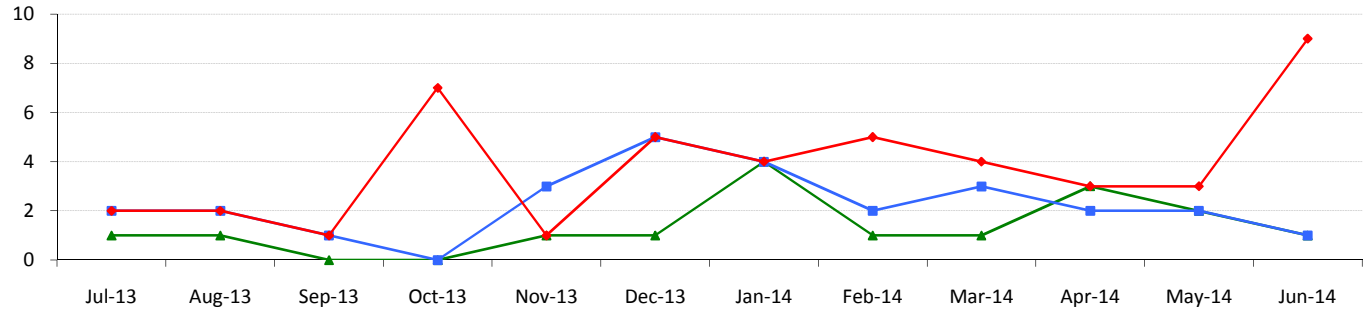
How would you rate the hospital food?



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

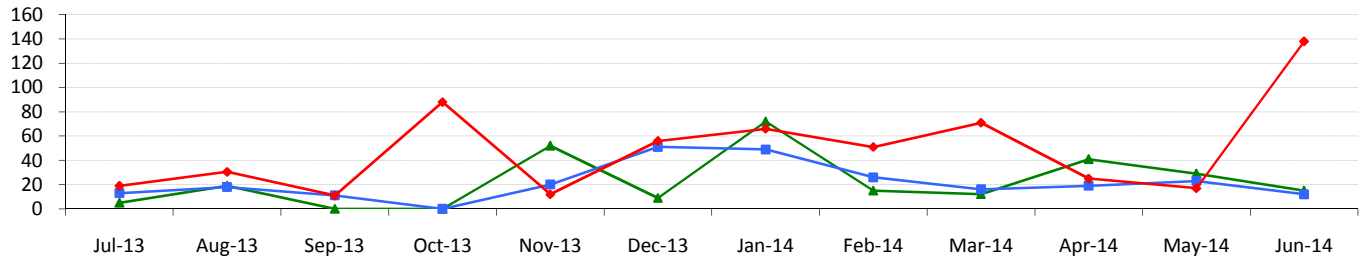
PATIENT EXPERIENCE: MIXED SEX ACCOMMODATION

Number of Episodes of Mixed Sex Occurrence



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
KCH	1	1	0	0	1	1	4	1	1	3	2	1
QEH	2	2	1	0	3	5	4	2	3	2	2	1
WHH	2	2	1	7	1	5	4	5	4	3	3	9

Number of Hours of Mixed Sex Occurrence



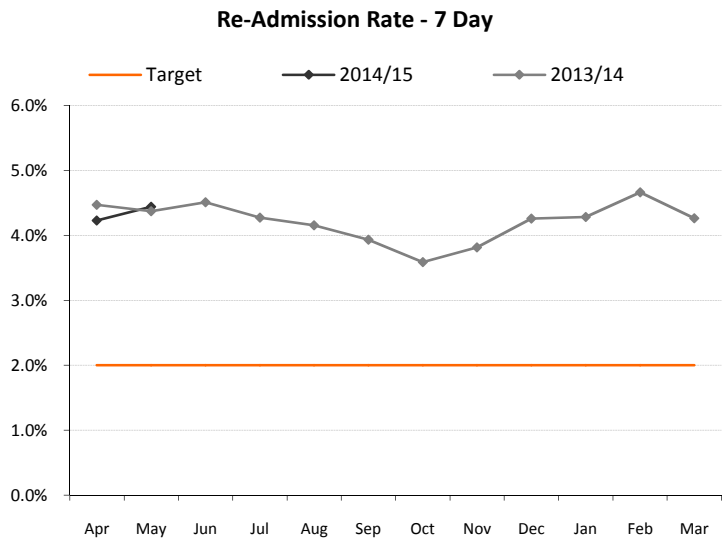
	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
KCH	5	19	0	0	52	9	72	15	12	41	29	15
QEH	13	18	11	0	20	51	49	26	16	19	23	12
WHH	19	30.5	11	88	12	56	66	51	71	25	17	138

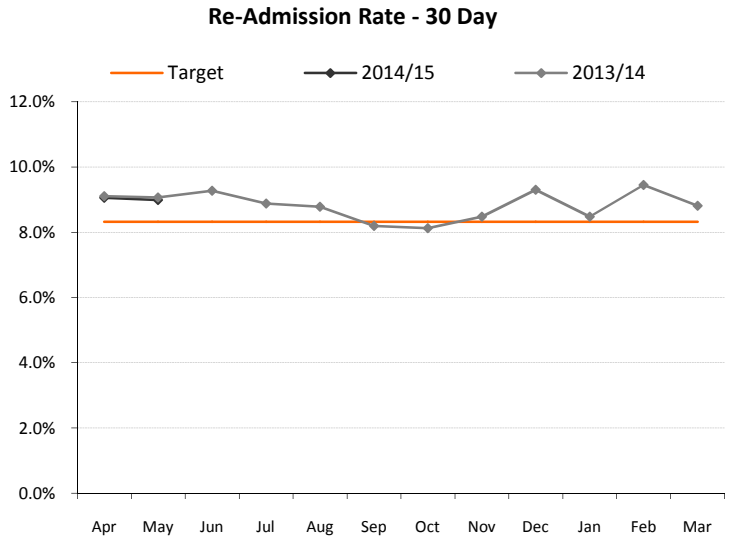
Mixed Sex Accommodation Occurrrences June 2014

Site	Clinical Area	Total No. of Occurrences	Total No. of Patients Affected
KCH	Kingston	1	3
QEH	CDU	1	6
WHH	CDU	9	60
TOTAL		**11**	**69**

During June-14 there were no reportable mixed sex accommodation breaches to NHS England via the Unify2 system. These were not reported as they complied with CCG criteria, such as clinical need. There were 11 clinically justified mixed sex accommodation occurrences affecting 69 patients. The Trust is working closely with the CCGs in order to ensure that mixed sex accommodation occurrences are minimised as much as possible. This includes reviewing the local policy for delivering same sex accommodation and refreshing the acceptable justifiable criteria as outlined in the 2010 national guidance. Collaborative work continues with the CCGs where the policy scenarios having been revised. This is due to be signed off at the Quality Meeting in July with the CCGs where the policy will be ratified collaboratively.

CLINICAL QUALITY & PATIENT SAFETY
CLINICAL EFFECTIVENESS: READMISSION RATES





The 30 day readmission rates for April and May 2014 are consistently lower in comparison to that of last year and this is replicated with the 7 day readmission rates for Apr-14, compared to Apr-13. There was a slight increase in May-14, compared to May-13, however the downward trend for 7 day readmissions overall continues, with the exception of the predictable seasonal variation in February. Technical difficulties with data validation experienced for March and April's data have since been resolved.
A full "End of Year" review of Readmissions is underway and this will inform service improvement going forward. Key specialities are being identified and specific interventions to address high readmission rates within the elderly and Care Home population are also being evaluated.

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

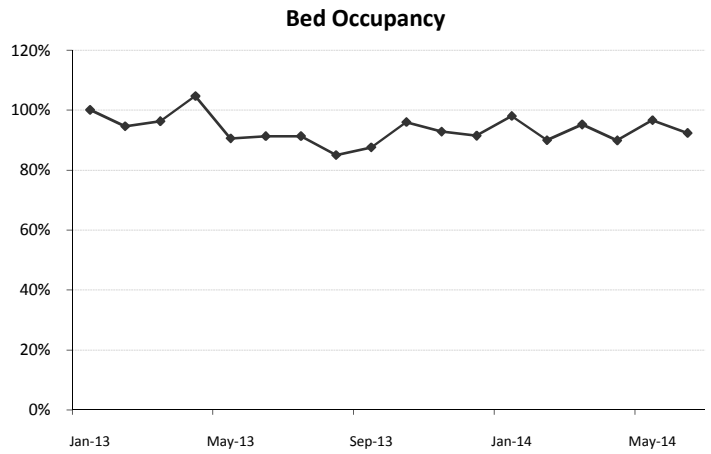
	Local CQUIN			2013/14 Baseline	2014/15 Target	YTD Status	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Q1	Q2	Q3	Q4	Year End Position
Performance	Heart Failure	4	EQ Pathway Measures (Jan-14 to Dec-14)	74.21%	Maintain 2013/14 levels	79.7%	78.3%	81.1%															
	COPD	5a	Improved referral rate to the Stop Smoking Service	9%	Improved referral rate - Improvement rate TBA	10.3%	8.1%	13.3%	9.5%										10.3%				
		5b	Improved referral rate to the Community Respiratory Team	4.6%	Improved referral rate - Improvement rate TBA	5.6%	4.5%	6.7%															
	Diabetes	6	Develop an Integrated Care Pathway	N/A																			
	Over 75 Frailty Pathway	7	Develop an Integrated Care Pathway	N/A																			
Commentary	Heart Failure	4	EQ Pathway Measures	This measure will be reported Month 1 - 12, Jan-14 to Dec 14. Data will be reported 1 month retrospectively. Data from Jan-14 and Feb-14 confirm ongoing improvements in this pathway.																			
	COPD	5a	Improved referral rate to the Stop Smoking Service	Months 2 and 3 shows an improvement in the referral rate.																			
		5b	Improved referral rate to the Community Respiratory Team	The reporting processes for these referrals continues to be investigated to ensure all data is being captured. Data will be reported 1 month retrospectively.																			
	Diabetes	6	Develop an Integrated Care Pathway	A CCG led Project group has been developing an Integrated Diabetes Pathway. A shared meeting took place 20 May-14 and implementation planning is due to start.																			
	Over 75 Frailty Pathway	7	Develop an Integrated Care Pathway	The second CCG led multi provider Pathway Development meeting took place 3 Jul-14. A Trust wide internal group has been established and has had its first meeting to feed into the CCG led group. Regular CCG led meetings have been planned up to Mar-15.																			

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

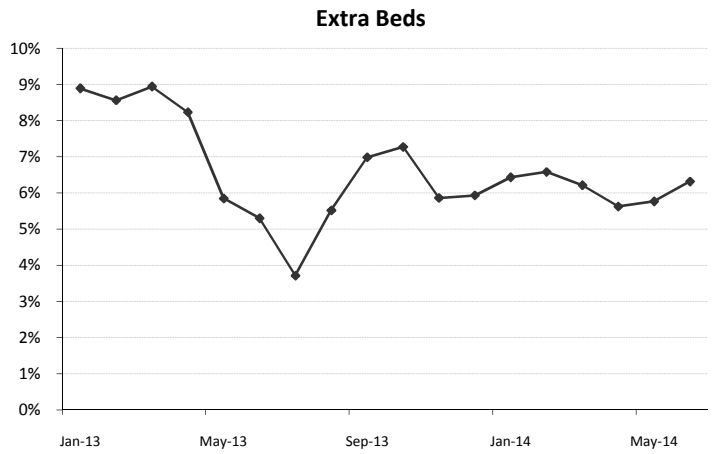
CLINICAL EFFECTIVENESS: SPECIALIST CQUINS MONTHLY MONITORING AND PERFORMANCE

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

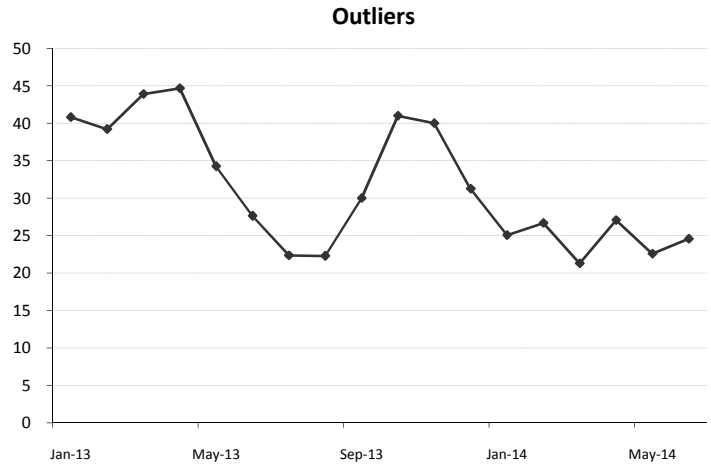
Compliance Against Performance	
	On target
	Monthly target missed; quarterly/annual target at risk
	Monthly target missed; annual target at risk



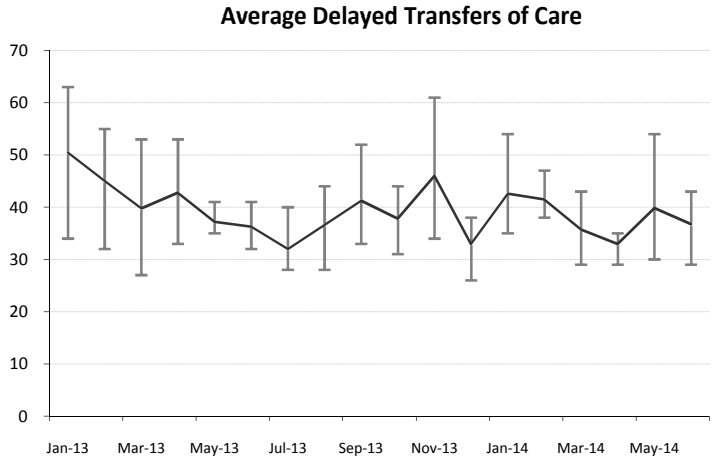
The bed occupancy metric looks only at adult inpatient beds and excludes any ring fenced wards such as Maternity. Occupancy peaked at over 100% during Apr-13, but has since reduced. However, since Aug-13 occupancy has steadily increased with levels becoming static since Oct-13 onwards. Occupancy for Jun-14 shows a decreased position at 92.35% against that seen in May (96.61%), and returns to the level seen in late 2013.



This metric is built up using the number of funded beds on each ward and reviewing those occupied on a daily basis. Where the number of occupied beds exceeds the funded bed base for the ward these are classified as "extra". Following on from months of fluctuation, May's position showed consistency against April, however June has increased to 6.31% and again indicates that the position and use of extra beds is fluctuating.



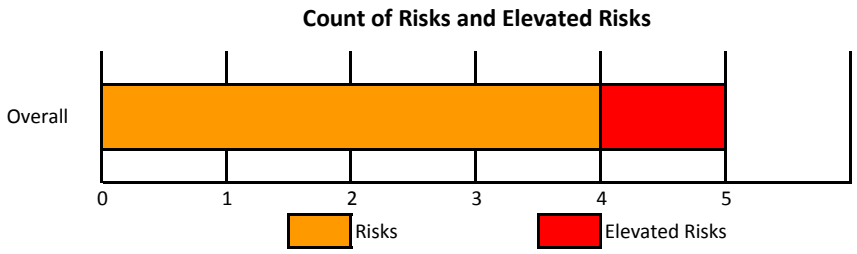
The outliers data show the average number of patients bedded in a ward outside of the relevant Division over a given month. In line with the number of extra beds, the number of outliers peaked in Apr-13 when the Trust, and local health economy, was under extreme pressure with unseasonably high emergency flows. The position has now been stable at approximately 25 for the last 6 months. June shows another stable month at 24.57, and it is hoped this position will stabilise further moving into 2014/15 being, as it is, underpinned by a reduction in extra beds and the current stable bed occupancy performance.



In June-14, the number of patients on the Delayed Transfer of Care (DToC) list has decreased slightly resulting in a position of 36.75.
The Trust now provides 60 reablement beds, 20 of which became operational on 31 Jan-14. The primary issues for DToC remain, that is, continuing health care, pending assessment by Social Services, and care provision and community resources.

CARE QUALITY COMMISSION: INTELLIGENT MONITORING REPORT

Trust Summary



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

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

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