EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS**

DATE: **7 AUGUST 2015**

SUBJECT: **CLINICAL QUALITY & PATIENT SAFETY**

REPORT FROM: **CHIEF NURSE & DIRECTOR OF QUALITY**
MEDICAL DIRECTOR

PURPOSE: **Discussion**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

- The clinical metrics programme and annual and 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 Committee 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 and a heatmap of wards and departments in relation to quality indicators is included.

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 93.5% of our inpatients were deemed 'harm free' which is a slight decrease on last month, and is also slightly below the national figure of 94%. This figure includes those patients admitted with harms and those who suffered harm whilst with us. The percentage of patients receiving harm free care during their admission with us (which we are able to influence) is 98.5%, similar to last month (98.9%). Further analysis of these data show that the prevalence of patients who had developed a VTE, a pressure ulcer or had a fall had slightly increased this month, the remaining indicators are similar to the previous month.

- Nurse Sensitive Indicators – In June there were 28 reported incidents of pressure ulcers developing in hospital (32 in May). These include 23 Category 2 pressure ulcers and 2 ulcers categorised as unstageable (covered in slough or eschar), and 3 deep tissue injury ulcers (discolouration of the skin). Seven of the Category 2 ulcers have been assessed as avoidable, two of the unstageable ulcers and 3 of the deep tissue injury ulcers were deemed avoidable. These 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. Further campaigns are being planned to refresh heel care and to focus on protecting the sacral area.

- There were 171 patient falls recorded for June (151 in May) of which 95 resulted in no injury. None were graded as severe or death, the remaining were reported as low or moderate harm. The top reporting ward was CDU (WHH) with 10 falls.

- Infection Prevention and Control –Trust wide mandatory Infection Prevention and Control training compliance for June was 83.1%, 78.5% for May 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 June, and 1 case of C. difficile occurring within the Trust during the month (against a trajectory of 3 for the month). This case was deemed unavoidable and did not identify any lapses in care. The Trust is currently 3 cases under trajectory. There were 36 cases of E.coli bacteraemia in June. Thirty one cases occurred pre-48h and 5 occurred post-48h. There were 4 cases of MSSA bacteraemia in June (13 in May), with 3 cases occurring pre-48h, and 1 case post-48hr.

- Mortality Rates – The most recent HSMR performance was reported in December 2014 and equalled 78.6 compared to 83.7 in December 2013. We are still awaiting 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 an increase in incidents recorded due to staffing levels in June compared to 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 NHS-P, and due to annual leave being taken at the end of the financial year.

Reported data is derived from the E-Rostering and NHS-Professionals systems and aggregated fill rates in June are over 98% at WHH and over 94% at QEQM and K&C. The lower fill rates during the day reflect the priority to ensure night shifts are properly covered. During the day Matrons and other RNs are able to assist on the wards to ensure safe staffing. This isn't always reflected on the E-Rostering system. The fill rates this month reflect the vacancy position. A number of recruitment and retention initiatives are in progress with overseas recruitment having commenced and an open day for a 'one stop shop' recruitment day planned for August the 8th. We are also expecting around 40 newly qualified nurses to commence with us in September. 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 June a total of 1128 clinical incidents were reported. Ten serious incidents were required to be reported on StEIS in June. Three cases have been closed since the last report. There remain 77 serious incidents open at the end of June. 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 June a slight increase in bed occupancy was reported. However, a further reduction in the number of extra unfunded beds in use was reported, but the number of patients bedded in a ward outside of their Division (Outliers) rose slightly.

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

- CQUINs – The 2015/16 CQUINs were finalised with our CCG colleagues in late July and 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. Implementation of all quality initiatives are underway and all required milestones negotiated for Q1 have been met. Full reporting will be available in the next report.

PATIENT EXPERIENCE

- Mixed Sex Accommodation – During June there were 5 reportable mixed sex accommodation breaches to NHS England via the Unify2 system, occurring in the CDU at WHH and Fordwich Ward at QEQM. The remaining cases occurred in the Stroke Units and Coronary Care which are deemed a justifiable mixing based on clinical need.

- Compliments & Complaints – During June we received 77 complaints, which is similar to May. One formal complaint has been received for every 1091 recorded spells of care similar to May. During June there were 68 informal concerns (77 in May), 251 PALS contacts (231 last month) and 2527 compliments (compared to 2175 in May). This represents a ratio of compliments to formal complaints of 32:1, and one compliment being received for every 33 recorded spells of care.

The number of returning clients seeking further resolution of their concerns during June was 13 (19 in May). Surgical Services Division recorded the highest number of returning clients. This is being addressed through the Complaints Management Steering Group where performance is discussed and managed.

This month the Trust achieved the standard of responding to 85% of formal complaints within the agreed date with the client. We sent 95% of the responses out on time to clients during June (97% in May). Every Division achieved the required standard this month with this being the fourth 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 47% (an improvement on May – 40%), with the average length of time a complaint was open during June as 37 days compared to 39 days last month. 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 June were, problems with communication, concerns about clinical management and problems with attitude.

- Friends and Family Test – During June we received 15311 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 – June 2015

Department	Response Rate		Percentage recommended	
Inpatients*	40%	↓	95%	-
A&E	26%	↓	80%	↓
Maternity	36%	↑	98%	-
Day Cases	36%	↓	94%	↑
Outpatients	28%	↑	90%	↑

* Now includes paediatrics.

Satisfaction rates have improved or stayed the same in 4 out of the 5 areas compared to last month. Our star rating for this month equals 4.7 out of 5.0, the same as 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 took place during June with improved scores reported against both areas. Our staff FFT has shown a 7% increase over the past 6 months in those staff who would recommend the Trust as a place to work (45% - 52%), and a 4% rise in recommending the Trust for treatment (72% - 76%).

CARE QUALITY COMMISSION

The latest Intelligent Monitoring Report (IMR) was received on the 21st May 2015. 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.

TRIANGULATION OF THE HEATMAP

Included in the Board report is a heatmap of the wards across the Trust with safety, staffing and quality metrics displayed and RAG rated. The key is outlined at the foot of the heatmap. A number of patterns are evident in the heatmap for further exploration with the Ward Managers, Matrons, Divisional Heads of Nursing and clinical teams. As a 'status at a glance' it can be seen that the Cambridge Wards, Kings Wards and Treble Ward report a lower patient satisfaction in involvement with care, privacy in care discussions and the patients perceiving that staff were available to discuss their concerns.

We have commenced improvement work with the three CDUs as an action from the Quality Committee. The Matrons are theming their FFT feedback, triangulating this with complaint themes and developing plans of action to make improvements. Other patterns that emerge from the heatmap include:

Of the 9 wards which had a fill rate of less than 80% registered nurse hours, 7 reported falls and 5 received complaints;

Of the 2 areas reporting Harm Free Care of less than 93%, only 1 ward (Bishopstone) had less than 80% registered nurse fill rate;

14 wards reported more than 12 compliments in June and all but 3 of these wards had positive patient feedback in relation to privacy and staff availability to discuss concerns;

22 wards received complaints and most of these wards (17) also demonstrated patient feedback below the standard expected in relation to patient involvement in care and privacy in care discussions;

There is some correlation between patient feedback on poor staff availability to discuss concerns and registered nurse shift fill of less than 80%;

On the 8 wards which had a fill rate of less than 80% registered nurse hours, 5 were due to parenting leave of between 6 – 33% and 2 were due to sickness of more than 6%.

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 4 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 ward 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) Discussion
(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

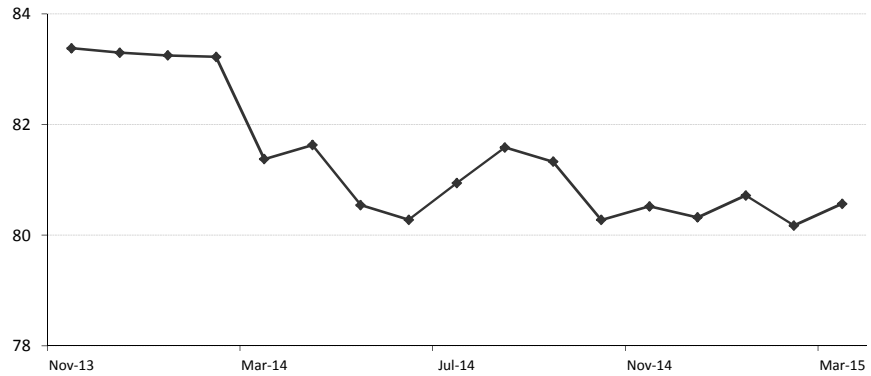
Introduction

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	Mar-15	Mar-14	vs Mar-14	YTD
Patient Safety	Mortality Rates	HSMR		-	80.6	81.4	↓	
					Q1 14/15	Q1 13/14	vs Q1 13/14	YTD
		SHMI (%)		-	95.30%	95.51%	↓	-
					Jun-15	Jun-14	vs Jun-14	YTD
		Crude Mortality: All Ages (Per 1000)	Non-Elective	-	29.081	25.465	↑	29.831
			Elective	-	0.210	0.437	↓	0.224
	Risk Management	Serious Incidents (STEIS)	New Incidents	-	10	7	↑	-
			Open Incidents	-	77	52	↑	Cumul.
	HCAI	MRSA	Attributable	0	0	1	↓	Cumul.
		C. difficile	Post 72h	45	8	15	↓	Cumul.
	Infection Prevention				Jun-15	Jun-14	vs Jun-14	YTD
		Mandatory Training Compliance (%)		95.0%	83.1%	83.1%	↑	81.9%
	Harm Free Care (HFC)				Jun-15	Jun-14	vs Jun-14	YTD
		Safety Thermometer HFC (%) - Old & New Harm	EKHUFT	93.0%	93.5%	94.4%	↓	93.5%
			National	-	94.1%	93.6%	↑	-
	Nurse Sensitive Indicators	Pressure Ulcers: Category 2,3 and 4	Acquired	-	23	18	↑	80
			Avoidable	79	7	10	↓	18
		Pressure Ulcers	Unstageable	-	2		↑	8
		Falls		-	171	176	↓	485
	Clinical Incidents	Total Clinical Incidents		-	1128	1122	↑	3327
Patient Experience	Compliments and Complaints	Compliments:Complaints		-	32:1	30:1	↑	-
		No. Care Spells per Formal Complaint		-	1091	842	↑	-
	Experience	Friends and Family Test (Star Rating)		5.0	4.7	4.4	↑	-
		Adult Inpatient Experience (%)		80.00%	89.12%	88.33%	↑	-
		Mixed Sex Accommodation Occurrences		-	18	11	↑	46
Clinical Effectiveness	Readmission				May-15	May-14	vs May-14	YTD
		7 Day (%)		2.00%	4.41%	4.51%	↓	4.24%
		30 Day (%)		8.32%	8.62%	9.19%	↓	8.56%
	CQUIN				Jun-15	Jun-14	vs Jun-14	YTD
		Standard Contract CQUIN		Multiple			↔	
		Specialist CQUIN		Multiple			↔	
	Bed Usage	Bed Occupancy (%)		-	88.12%	96.39%	↓	-
		Extra Beds (%)		-	5.26%	6.60%	↓	5.85%
		Outliers		-	27.43	37.13	↓	90.29
		Delayed Transfers of Care (Average)		-	35.75	36.75	↓	34.28
Care Quality Commission	Intelligent Monitoring Report	Outcome Measures	Risks	-	3	4	↓	-
			Elevated Risks	-	6	1	↑	-

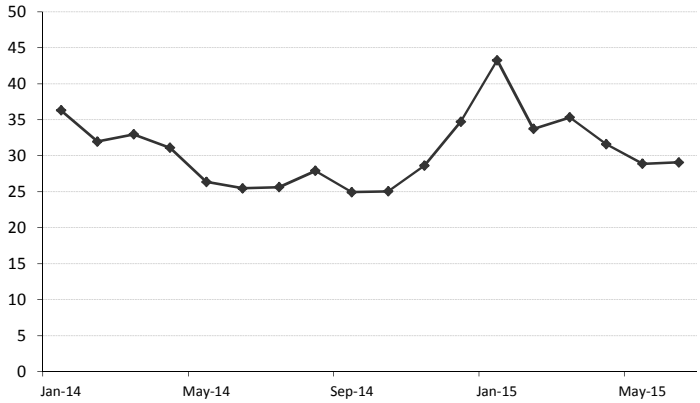
CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: MORTALITY RATES

Hospital Standardised Mortality Ratio (HSMR) - All Discharges



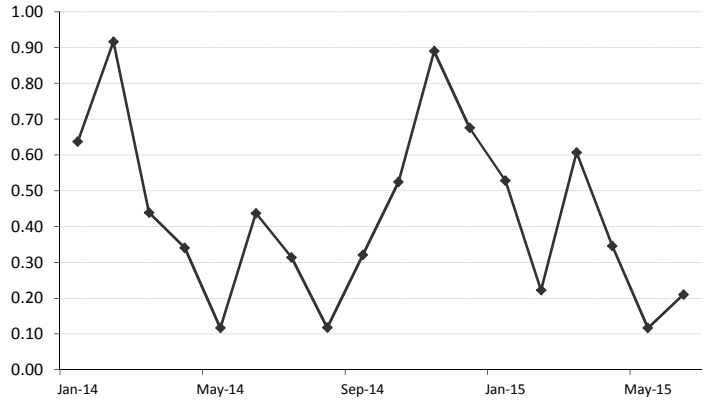
As defined by data provider CHKS, Hospital Standardised Mortality Ratios (HSMR) compare the number of expected deaths with the number of actual deaths, in hospital. The data are adjusted for factors statistically associated with hospital death rates. Severity of illness is an important factor on mortality 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 Jun-15 equalled 29.081 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.

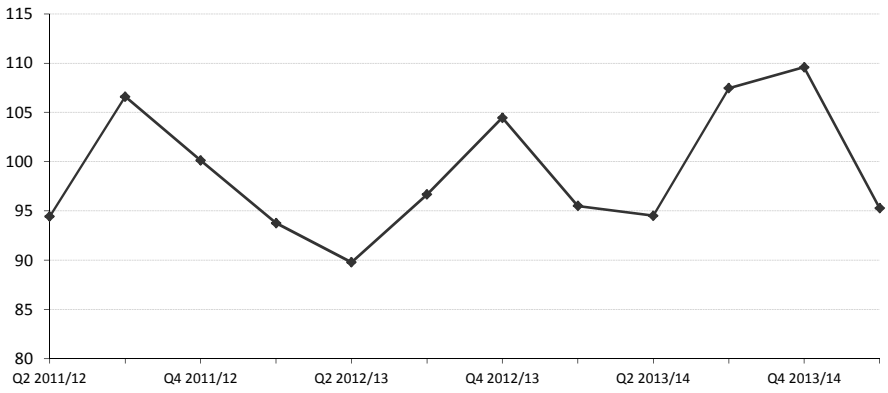
Crude Mortality - Elective per 1000



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 increased in Jun-15 (i.e. 0.210 deaths per 1000 population, lower than the position in Jun-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.

NB: Crude Mortality data are sourced from the Trust's Balanced Scorecard as of 16 Jul-15.

Summary Hospital Mortality Indicator (SHMI)



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

Serious Incidents - Open Cases

Date		Summary of Serious Incident & Remedial Action Taken	IX lv	Division	Timely Submit?
Incident	STEIS Report				
18-Jun-15	1-Jul-15	Medication Incident - ACS protocol	2	Surgical	Not Due
22-Jun-15	23-Jun-15	Surgical/Invasive procedure - Never Event	2	Surgical	Not Due
20-May-15	22-Jun-15	Surgical/Invasive procedure - Never Event	2	Surgical	Not Due
7-Jun-15	19-Jun-15	Maternity/Obstetric Incident: Baby only	2	Specialist	Not Due
27-Apr-15	16-Jun-15	Surgical/Invasive procedure - Never Event	2	Surgical	Not Due
11-Jun-15	12-Jun-15	Treatment Delay meeting SI criteria	2	UCLTC	Not Due
10-Dec-14	11-Jun-15	Diagnostic Incident including delay	2	Specialist	Not Due
1-May-15	11-Jun-15	HCAI/Infection Control incident	2	UCLTC	Not Due
9-May-15	11-Jun-15	Slips/Trips/Falls	2	UCLTC	Not Due
29-Apr-15	3-Jun-15	HCAI/Infection Control incident	2	UCLTC	Not Due
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	Yes
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	Extension
27-Mar-15	0-Jan-00	Delayed Diagnosis	2	Surgical	Not Due
30-Jan-15	2-Apr-15	Intrauterine Death - Maternity Services	2	Specialist	Yes
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-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
1-Mar-15	2-Mar-15	Unexpected Death - neonatal (Maternity Services)	2	Specialist	Breach
23-Feb-15	25-Feb-15	Suboptimal Care - deteriorating patient	1	Surgical	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)		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
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	1	Surgical	Breach
22-Dec-14	16-Jan-15	Category 3 hospital acquired pressure ulcer (avoidable)	1	Surgical	Breach
7-Apr-14	15-Jan-15	Unexpected Death - general	1	UCLTC	Breach
22-Dec-14	15-Jan-15	Unexpected Death - general	1	Surgical	Breach
31-Dec-14	15-Jan-15	Unexpected Death - general	1	UCLTC	Breach
6-Jan-15	0-Jan-00	Unexpected Death - general		UCLTC	Breach
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	1	UCLTC	Breach
26-Oct-14	17-Nov-14	Suboptimal Care - deteriorating patient (child cardiorespiratory arrest)	2	Specialist	Breach
13-Sep-14	13-Nov-14	Fall	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	Stop the Clock

Serious Incidents - Open Cases (continued)

Date		Summary of Serious Incident & Remedial Action Taken	IX lv	Division	Timely Submit?
Incident	STEIS Report				
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
13-Aug-14	13-Aug-14	Adverse Media Coverage - CQC report and breach of licence as Foundation Trust	2	Trust	Stop the Clock
19-Jul-14	23-Jul-14	Unexpected Death - neonatal	2	Specialist	Extension
7-Apr-14	10-Jul-14	Fall - resulting in permanent harm	1	UCLTC	Yes
27-May-14	2-Jun-14	Unexpected Death	1	UCLTC	Breach
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
19-Jul-14	23-Jul-14	Unexpected Death - neonatal	2	Specialist	Extension
7-Apr-14	10-Jul-14	Fall - resulting in permanent harm	1	UCLTC	Yes
27-May-14	2-Jun-14	Unexpected Death	1	UCLTC	Breach
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

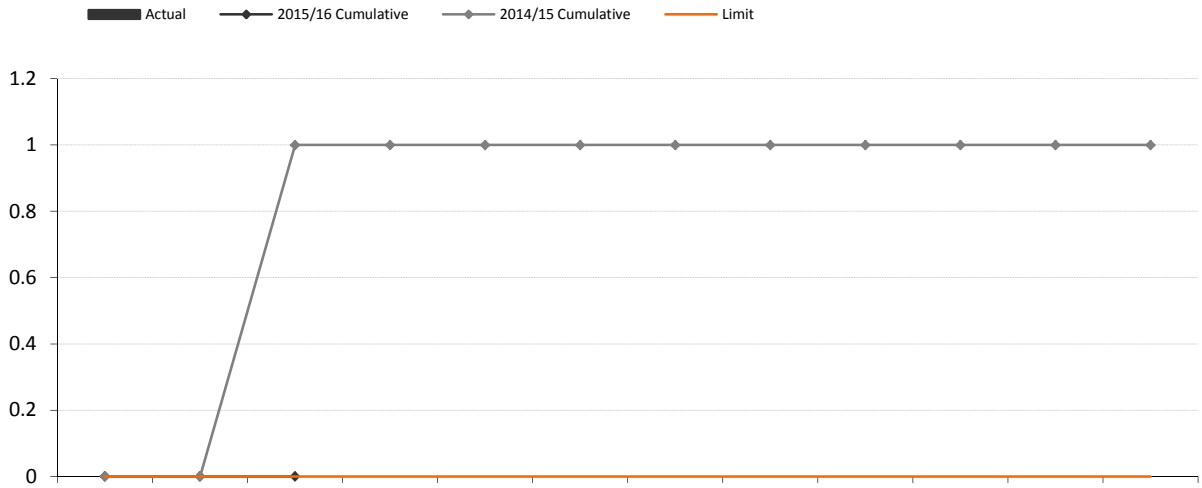
Serious Incidents closed by KMCS but remaining open on STEIS pending review by external bodies.

Date		Summary of Serious Incident & Remedial Action Taken	IX lv	Division
Incident	STEIS Report			
3-Mar-15	4-Mar-15	Death - child	2	Specialist
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

Ten serious incidents were reported on STEIS during Jun-15. These were: 3 Never Events – wrong site regional blocks, 2 HCAI/Infection Control incidents, a fall, a medication incident, a maternity incident, a treatment delay and a diagnostic incident. At the end of Jun-15, there remain 8 incidents awaiting Area Team or other external body review. The governance arrangements regarding the presentation of Root Cause Analysis (RCA) reports is currently under review. These included the findings of the investigations and action plans to take forward recommendations, including mechanisms for monitoring and sharing learning. The findings from investigations and learning continues to be shared via Divisional Governance Boards. At the end of Jun-15 there were 77 serious incidents open on STEIS. The Adverse Incident Reporting policy and investigation templates were ratified at the QAB on 3 Jun-15.

PATIENT SAFETY: HOSPITAL ACQUIRED INFECTIONS

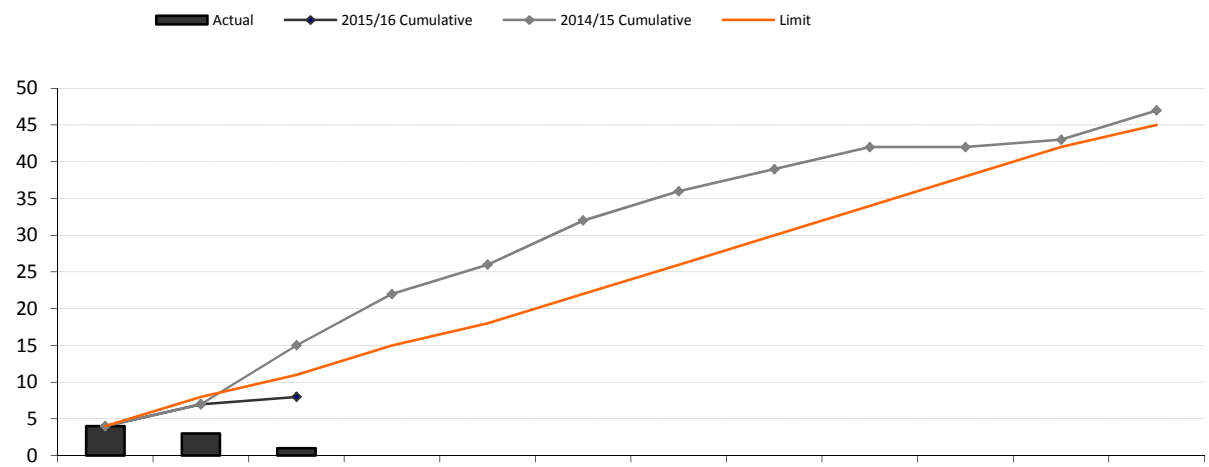
MRSA Bacteraemia - Trust Assigned Case



	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	0									
2015/16 Cumulative	0	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 Jun-15. The NHS England objective for 2015/16 remains zero avoidable cases. There were no Trust assigned MRSA bacteremia cases at EKHUFT during Q1 2015. The monthly rate per 1000 occupied bed days for the year 2014/2015 was 0.3 against national average of 0.75. For Q1 2015, the monthly rate per 1000 occupied bed days is zero against the national average of 0.79.

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	1									
2015/16 Cumulative	4	7	8									
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 was only one case of C.difficile in Jun-15. We have had 8 cases for Jun-15 against a total 2015/2016 DH target of 45 cases. The monthly C.diff rate per 1000 occupied bed days is 9.59 in comparison to the national average of 12.31 and KSS average of 13.40 cases. Root cause analyses of June 2015 case concluded that this case was unavoidable and did not identify any major lapse in care.

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	31										34.3	103
	Post 48h	6	5	5										5.3	16
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

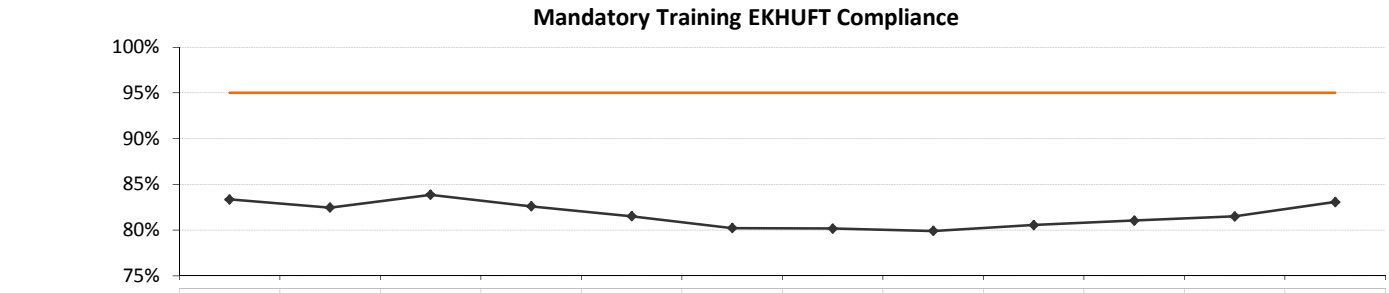
In Jun-15 there were 36 cases of E.coli bacteremia in total (31- Pre 48 hour and 5 post 48 hour bacteremia). There were 120 E.coli bacteremia cases in Q1 2015. Annual epidemiological commentary from PHE shows that nationally there has been an increase in E.coli bacteremia rates. The English average is 66.2 per 1000 population, the Kent and Medway Area average is 68.3. The highest rate of 94.9 has been reported from Merseyside. The reported rates for East Kent CCGs are as follows : NHS Ashford CCG-59.11, South Kent Coast CCG- 65.52, Canterbury/Coastal CCG-71.88 and Thanet CCG- 75.92. The last 2 CCGs are above the national average. We are currently conducting a case note review of 110 patients from Jan-15 to Mar-15 to identify any avoidable risk factors. Urinary catheter use is a risk factor for Urinary tract infections and E.coli bacteremia. The HOUDINI project has been implemented Trustwide and will be reaudited in Aug-15.

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	3										9.7	29
	Post 48h	1	0	1										0.7	2

In Jun-15 there were 4 cases of MSSA bacteremia (3- Pre 48 hour and 1 Post 48 Hour bacteremia). The monthly rate per 1000 occupied bed days in 2014/2015 was 6.32 against a national average of 6.52. The 2015/2016 average for Q1 2015/2016 is 2.4 compared to the national average of 6.35 cases per 1000 occupied bed days. We conduct RCAs for all MSSA bacteremia cases related to intravascular devices or within 30 days after surgery. Lessons from these RCAs have led to improvements in device insertion and care.

PATIENT SAFETY: INFECTION PREVENTION & CONTROL



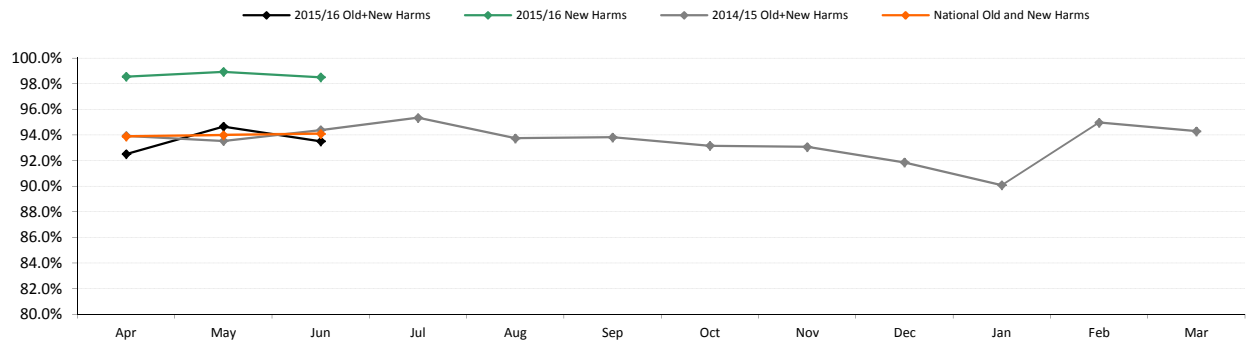
	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Compliance	83.3%	82.5%	83.9%	82.6%	81.5%	80.2%	80.2%	79.9%	80.5%	81.0%	81.5%	83.1%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

	Jun-15								
	Target	Trust	Clinical Support Services	Corporate	Specialist Services	Strat Dev & Capt Pln	Surgical Services	UCLTC	Serco
Mandatory Comparative Data for Biennial Training Compliance	95%	83.1%	87.7%	82.7%	80.5%	81.1%	80.4%	84.1%	85.0%

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

Trust compliance has increased from 78.5% in May-15 to 83.1% in Jun-15. Increases have been seen within the Divisions as follows. Clinical Support Services (from 83.6% to 87.7%); Corporate (from 80.7% to 82.7%); Specialist Services (from 74.3% to 80.5%); Surgical Services (from 75.8% to 80.4%), and Urgent Care and Long Term Conditions (from 78.3% to 80.4%). Compliance within Strategic Development and Capital Planning has decreased from 87.1% to 81.1%. Compliance within SERCO remains unchanged at 85%.

Safety Thermometer Harm Free Care

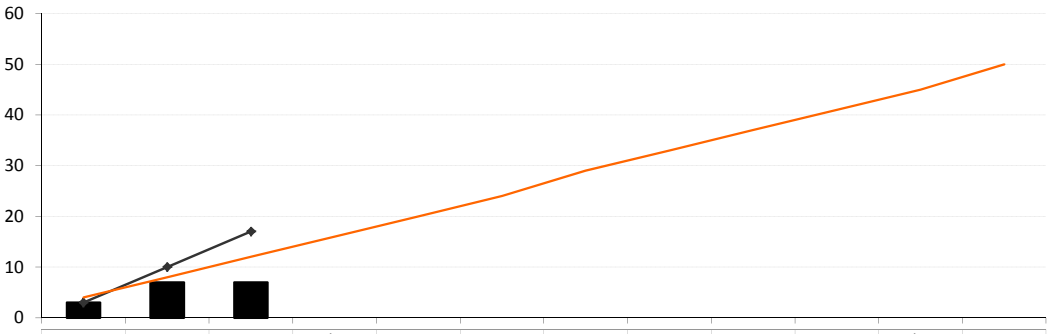


The chart above shows the percentage of Harm Free Care expressed as a one-day snapshot in each month. It is known as the NHS Safety Thermometer and is a quick and simple method for surveying patient harms. The aim of the Safety Thermometer is to identify, through a monthly survey of all adult inpatients, 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 93.5% of our inpatients were deemed "harm free" which is a reduction on last month, and is also slightly below the national figure i.e. (94.1%). 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 98.51% which is similar to last month (98.9%). Whilst all 3 sites demonstrated "New Harms Only" harm free care of >98.0% in month, the performances of K&C and WHH equalled 98.6% and 98.8% respectively. Further analysis of these data show that the prevalence of patients who had developed a VTE, a pressure ulcer or who had a fall increased this month, the remainder were either improved or similar to last month.

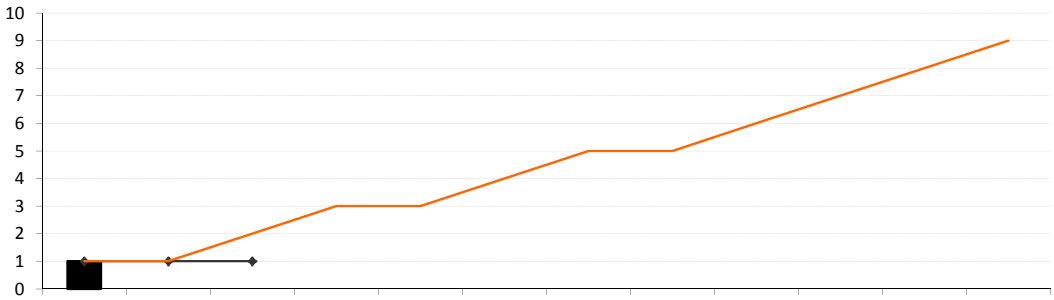
Category 2 Incidence Trajectory 2015/16
25% Reduction



	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	7									
2015/16Cum Avoidable	3	10	17									
2015/16Cum Trajectory	4	8	12	16	20	24	29	33	37	41	45	50
per 1000 bed days	0.10	0.23	0.24									

In Jun-15, a total of 23 acquired Category 2 pressure ulcers were reported, 7 of which were avoidable which equals last month. Three avoidable ulcers occurred at QEH; Seabathing, St Augustine's and Cheerful Sparrows Male wards, all were heel ulcers which lacked evidence of sufficient pressure relief. Two avoidable ulcers occurred at KCH, on CCU and CDU, both sacral ulcers and related to lack of evidence of repositioning. Two avoidable ulcers developed at WHH, on Cambridge J and M2, both related to tubing from medical devices causing pressure on the ear and nose. The majority of these superficial ulcers occurred on the sacrum or buttocks and full preventative care was already in place. However, 3 incidents were due to medical device tubing rubbing the ears/nose. Further campaigns are being planned to refresh the heel campaign and focus on protecting sacrums.

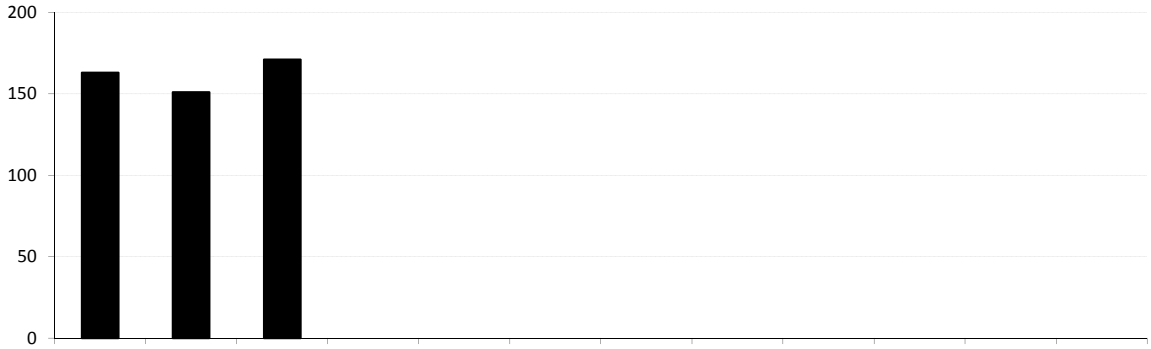
Category 3 and 4 Incidence Trajectory 2015/16
25% Reduction



	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	1	0	0									
2015/16Cum Avoidable	1	1	1									
2015/16Cum Trajectory	1	1	2	3	3	4	5	5	6	7	8	9
per 1000 bed days	0.03	0.00	0.00									

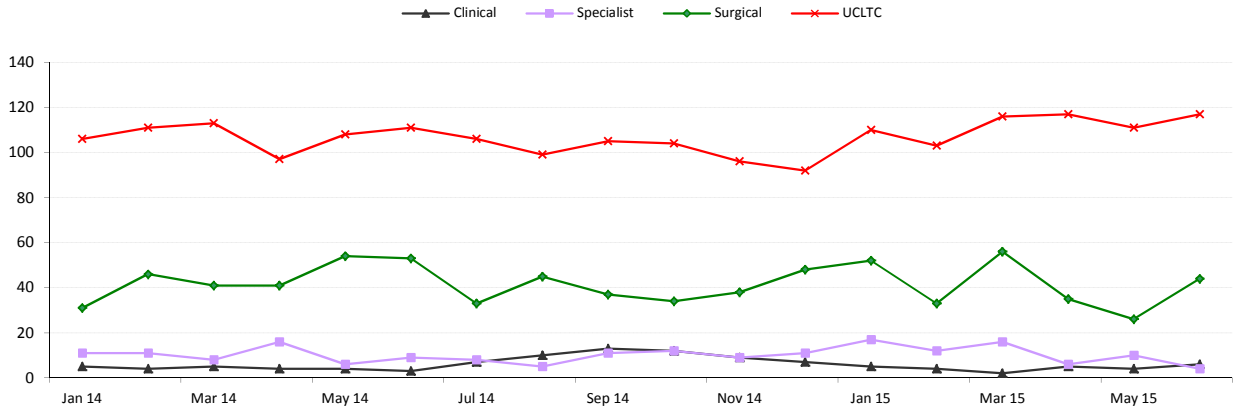
In Jun-15, there were 4 acquired potential deep pressure ulcers, 2 classified as suspected deep tissue injury (discolouration of skin) and 2 classified as unstageable (covered with slough or eschar). Two ulcers occurred at WHH, both considered avoidable. On Kings B one patient's unstageable sacral ulcer was considered avoidable due to incomplete entries for repositioning with lengthy chair sitting. The other avoidable ulcer occurred on CM2 where the tubing from oxygen therapy had rubbed the ears and there was lack of evidence of regular skin inspection. The other 2 cases occurring at QEH were both heel ulcers. One was avoidable and developed on St Margaret's ward due to lack of heel offloading evidence.

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	151	171									
2015/16 Cum	163	314	485									
per 1000 bed days	5.44	4.91	5.76									

Patient Falls - Injurious and Non-Injurious By Division



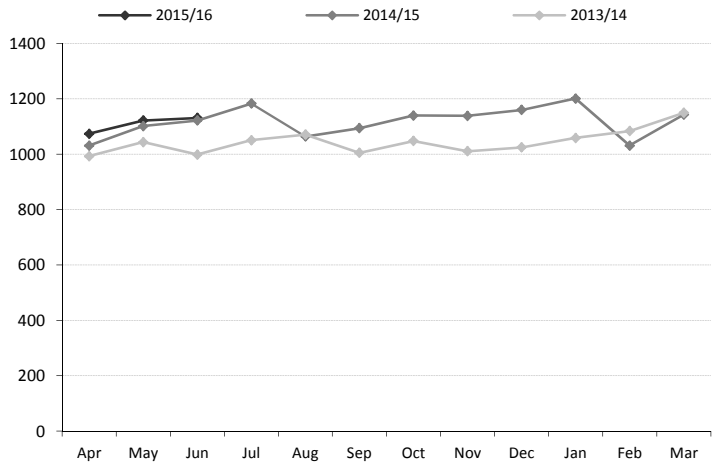
In Jun-15 there were 171 falls across the Trust, a significant increase on the previous month. Of these, 48 were at KCH, 53 at QEH and 88 at WHH (30 more than during May 2015). The falls per 1000 patient bed day rate was 5.09 which is well below the national average of 5.6. Wards with the highest reported number of falls at WHH were CJ2, CK, M2, Oxford, RSU (8 on all) and CDU and CL (10 on each). Nineteen falls at WHH occurred in 8 patients who were repeat fallers. These were all seen by the Falls Team and although most had appropriate strategies in place, where they did not have these were implemented by the Falls Nurse. Wards with the highest reported number of falls at KCH were Harbledown and Kingston (6 on each). The ward with the highest reported number of falls at QEH was Deal (7). Of these 1 fall resulted in a hip fracture on Deal ward. This was deemed unavoidable as all appropriate assessments and interventions were appropriately in place. A fall on CSF resulted in a sub dural haematoma and was also deemed unavoidable. A programme of 'high impact actions' is being reimplemented to support wards in a rolling programme over 2 months per ward. This will be launched officially in September. The national annual audit of inpatient falls was completed in May and the as yet unpublished results indicate that KCH and QEH both performed well against other Trusts.

CLINICAL QUALITY & PATIENT SAFETY
PATIENT SAFETY: CLINICAL INCIDENTS

In Jun-15 a total of 1128 clinical incidents (excluding duplicates) were reported. This included two incidents graded as severe harm. There were no incidents graded as Death. Both of the severe harm incidents have been reported on STEIS (see the STEIS narrative for details). In addition to these two incidents, eight incidents have been escalated as a serious near miss, of which six are under investigation and two are closed. There continues to be a reduction in the proportion of moderate harm incidents reported during Jun-15 [Jun-15: 47 compared with May-15: 43 and Jun-14: 103] 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.

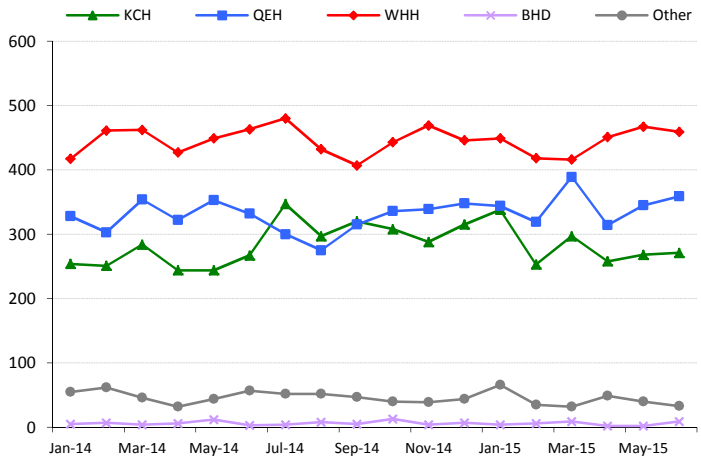
Ten serious incidents were required to be reported on STEIS in June. Three cases have been closed and one downgraded since the last report; there remain 77 serious incidents open at the end of June.

Overall Incident Rates by Year



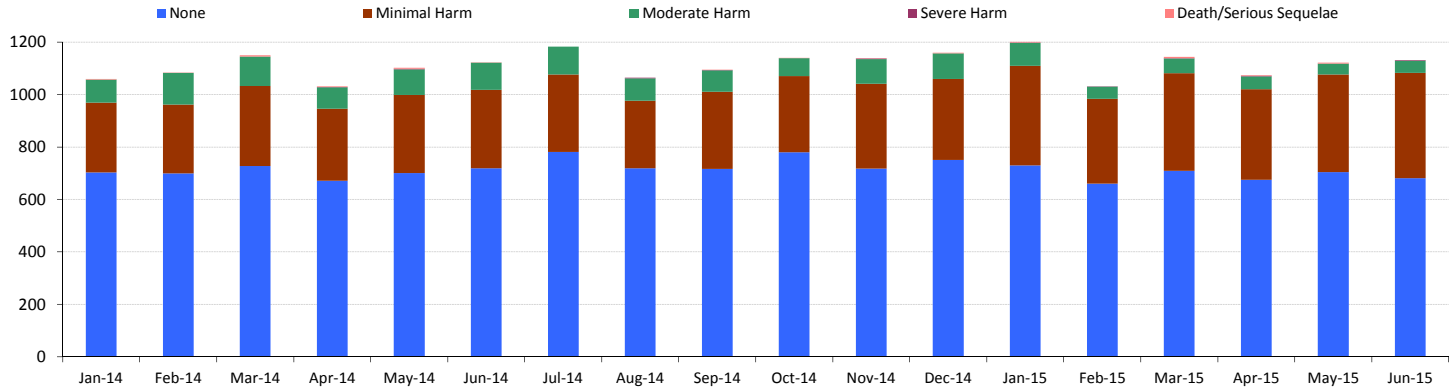
A total of 1128 clinical incidents have been logged in as occurring in Jun-15 compared with 1122 recorded for May-15 and 1122 in Jun-14.

Overall Incident Rates by Site



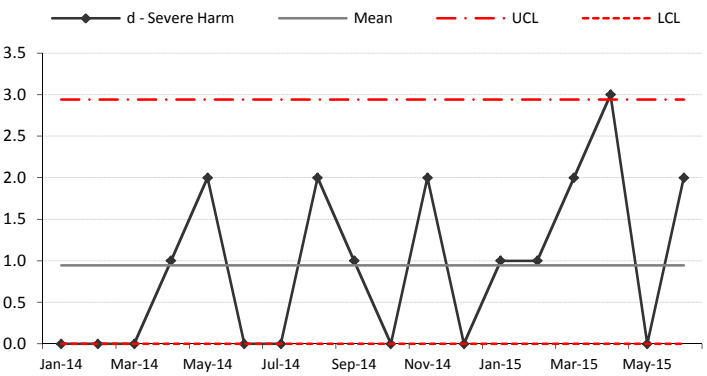
Incident reporting has increased marginally at QEH and KCH. There has been a slight decrease at WHH.

Clinical Incidents by Severity

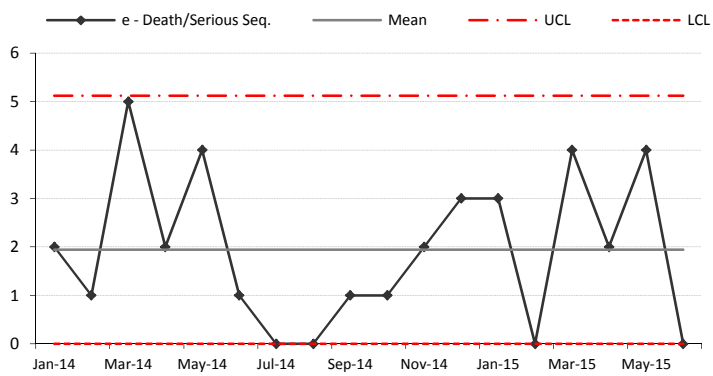


The incidents graded as moderate, serious and death have all been subject to review in order to confirm the consistency of the grading of harm across the Trust. The Board of Directors may see a change in this report to reflect the re-categorisation process undertaken. This is consistent with the data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

Severe Harm

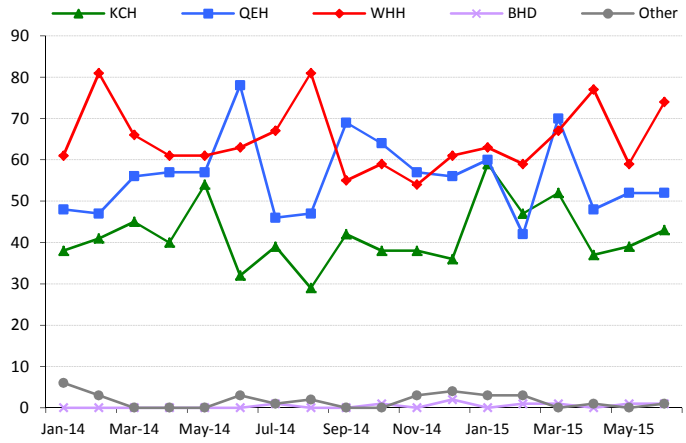


Death/Serious Sequelae



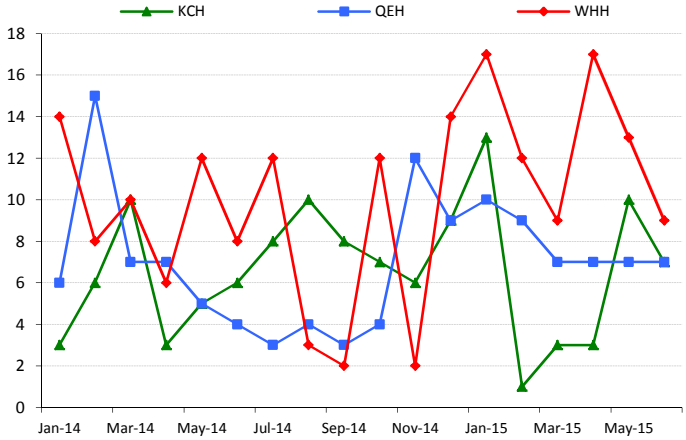
The number of death/serious and severe harm incidents reported in Jun-15 remains subject to the usual RCA investigation and review. It is possible that the severity of these cases will be downgraded once the investigation process is completed in line with national guidance to ensure the actual harm caused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

Patient Slips, Trips and Falls



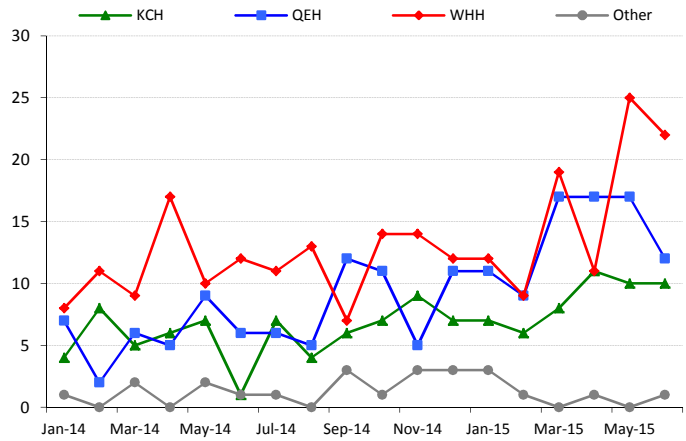
Of the 171 patient falls recorded in Jun-15 (151 in May-15 and 176 in Apr-14), 3 incidents were graded as moderate, no incidents were graded as severe or death. Two of the moderate harm falls resulted in fractures (wrist and femur) and the third resulted in a head injury: awaiting post mortem results to ascertain whether the patient's death was attributable to the fall. There were 95 falls resulting in no injury and 73 in low harm. The top reporting wards were CDU (WHH) with 10 falls; Cambridge L (WHH) with 9 falls; Cambridge M2 (WHH) with 8 falls; Deal ward (QEH), St. Margaret's (QEH), Oxford ward (WHH), Richard Stevens stroke unit (WHH) and Cambridge J (WHH) with 7 falls each; Kingston stroke unit (KCH) with 6 falls; the remaining wards reported 5 or less falls.

Hospital Acquired Pressure Ulcers



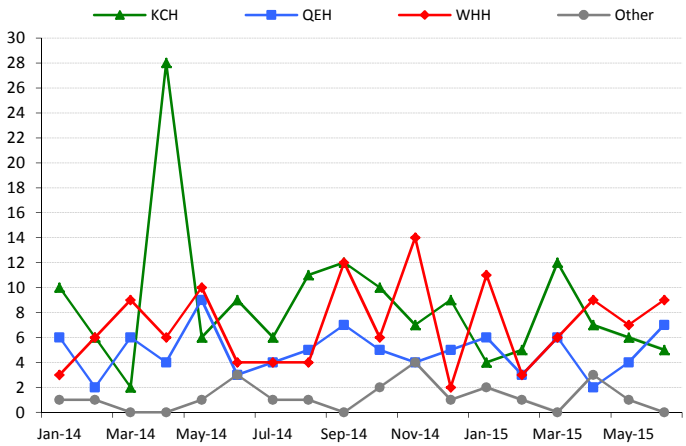
In Jun-15 there were 28 reported incidents of pressure ulcers developing in hospital (36 in May-15 and 18 in Jun-14). Jun-15 incidents included 23 category 2 pressure ulcers, seven of which have been assessed as avoidable, one not yet assessed and 15 unavoidable. No category 3 or 4 ulcers have been reported. In addition, there are 2 ulcers assessed as unstageable (both avoidable) and 3 deep tissue injuries (two avoidable, one unavoidable). The highest reporting wards were Cambridge J (WHH) and Cambridge M2 (WHH) with 3 incidents; Marlowe ward (KCH), St.Margaret's ward (QEH), and Kings C2 (WHH) with 2 incidents each; 16 other wards or departments reported 1 incident each.

Delay in Providing Treatment



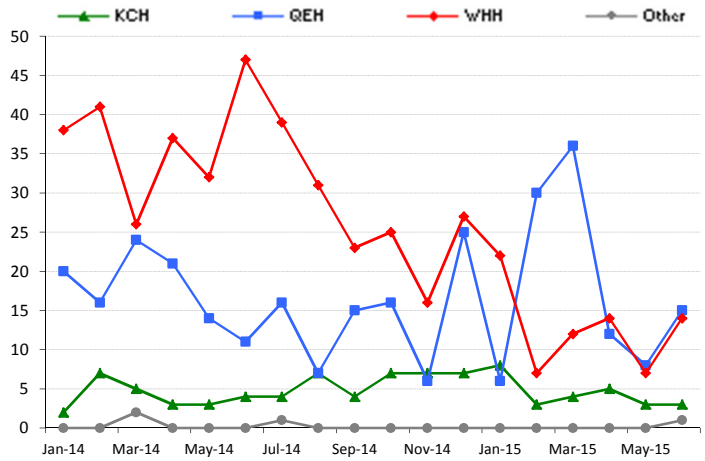
There were 45 incidents resulting in delay in providing treatment during June compared with 52 in May-15 and 20 in Jun-14. One incident was graded as severe harm and has both been reported on STEIS; none were graded as death. 4 have been graded as moderate harm and are currently under investigation, 15 have been graded as low harm and 25 resulted in no harm. Themes in location were: 5 incidents occurred in Celia Blakey chemotherapy unit (WHH); 3 each in A&E (WHH), Cambridge M1 (WHH), A&E (QEH) and Rainbow ward (QEH); and other areas reported 2 incidents or fewer.

Incorrect Data in Patient Notes



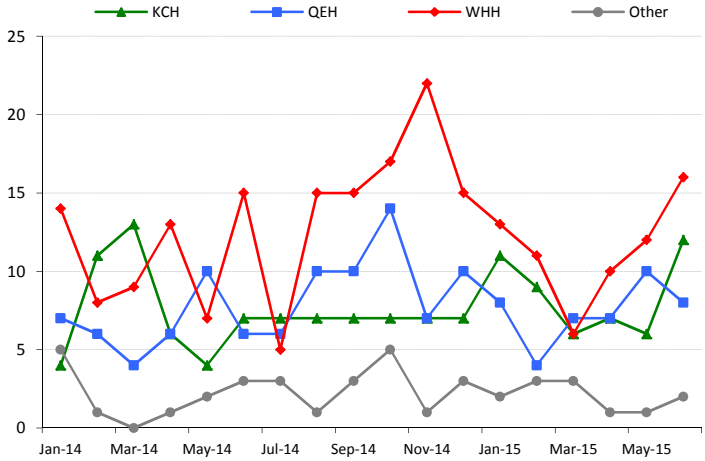
There were 21 incidents of incorrect data in patients' notes reported as occurring in June (19 in May-15 and 19 in Jun-14). 20 were graded as no harm and one as low harm; 16 related to incorrect data in paper notes, 3 to Patient Centre and two to EDN. Of the incidents reported, 5 were identified at KCH, 8 at QEH and 8 at WHH. Themes in the location of these incidents: 3 incidents occurred in Outpatients (WHH); 2 each in Outpatients (QEH), Walmer A (QEH) and Outpatients (KCH).

Staffing Level Difficulties



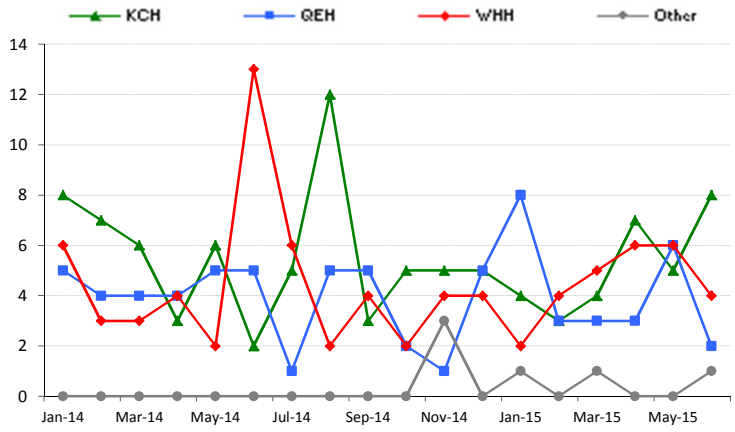
There were 33 incidents recorded in Jun-15 (18 in May-15 and 62 in Jun-14). These included 14 incidents relating to insufficient nurses, 8 to inadequate skill mix, one to insufficient doctors and 10 to general staffing level difficulties. Top reporting locations were Deal ward (QEH) with eight incidents; 2 incidents each in Kings D male (WHH) and NICU (WHH). 21 other areas reported one incident each.
3 incidents occurred at KCH, 15 at QEH, 14 at WHH and 1 at BHD. No incidents have been graded as moderate harm, severe harm or death. 26 incidents have been graded as no harm and 7 incidents have been graded as low harm. Investigations evidence continued active management of bed, staffing situation and escalation to senior staff.

Communication Breakdowns



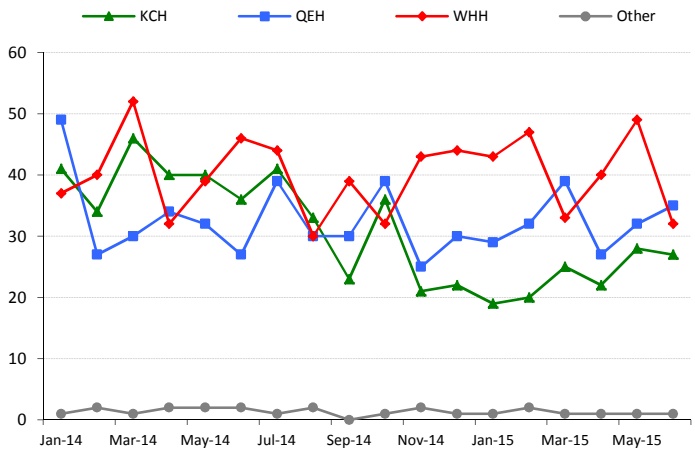
In Jun-15 there were 38 incidents of communication breakdown (29 in May-15 and 31 in Jun-14). Of the 38 reported, 31 involved staff to staff communication failures, 6 were staff to patient and one was staff to relative (or other visitor). 12 were reported as occurring at KCH, eight at QEH and 16 at WHH. Themes by location: Celia Blakey chemotherapy unit (WHH), Cathedral day unit (KCH) and Outpatients (WHH) reported three incidents each; Rainbow ward (QEH), A&E (WHH) and Cambridge L (WHH) reported two incidents each; 23 other areas reported one incident. Incidents in June were graded as follows: 35 as no harm and three as low harm.

Blood Transfusion Errors



In June, there were 15 blood transfusion errors reported (17 in May-15 and 20 in Jun-15). There were no real themes arising in the period, however, there were 3 incidents relating to prescription or documentation errors (including traceability). 11 incidents were graded no harm and four were graded low harm. Reporting by site: 8 at KCH, 4 at WHH, 2 at QEH and one at Pilgrim's Hospice Thanet (traceability documentation).

Medicines Management



Medicines Management

Category	Jun-15
Prescribing	21
Dispensing	15
Administering	34
Missing (lost or stock discrepancy)	10
Shortage (drug unavailable)	3
Suspected adverse reaction	4
Infusion problems (drug related)	3
Infusion injury (extravasation)	5
TOTAL	**95**

There were 95 medication incidents reported as occurring in June (110 in May-15 and 111 in Apr-15). The reporting of medication incidents has increased at QEH, but decreased at KCH and WHH.

Of the 95 reported, 73 were graded as no harm including one serious near miss and 21 as low harm. There was one incident graded moderate harm, which related to a post op patient being treated under the acute coronary syndrome protocol (ACS) who suffered significant blood loss; this incident has been reported on StEIS. Top reporting areas were: Kingsgate ward (QEH) and Pharmacy (QEH) with five incidents each; Cathedral day unit (KCH), ITU (KCH), Cheerful Sparrows female (QEH), Celia Blakey Centre (chemo unit WHH) and Pharmacy (WHH) with four incidents each; other areas reported 3 incidents or fewer. 35 incidents occurred at QEH, 27 at KCH, 32 at WHH and one at BHD.

CLINICAL QUALITY & PATIENT SAFETY

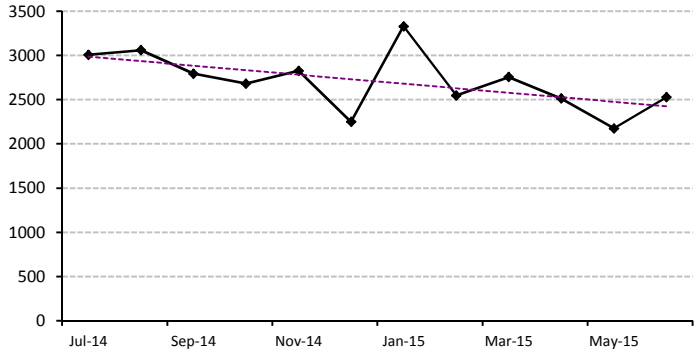
PATIENT EXPERIENCE: CONCERNS, COMPLAINTS & COMPLIMENTS

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

• Activity: Formal complaints (received) - 77; informal concerns - 68; compliments - 2527; PALS contacts - 251.

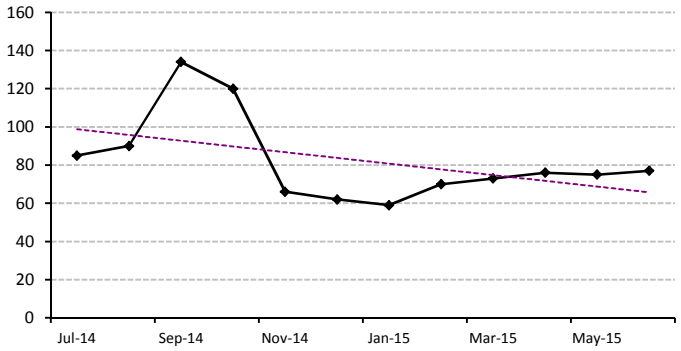
The charts below show the number of complaints and compliments received on a monthly basis since June 2014. The total number of recorded episodes of care for June 2015 was 84,019. In June 2015, one formal complaint has been received for every 1091 recorded spells of care (0.09%) in comparison to May's figures where one formal complaint was received for every 1010 recorded spells of care (0.09%).

Number of Compliments



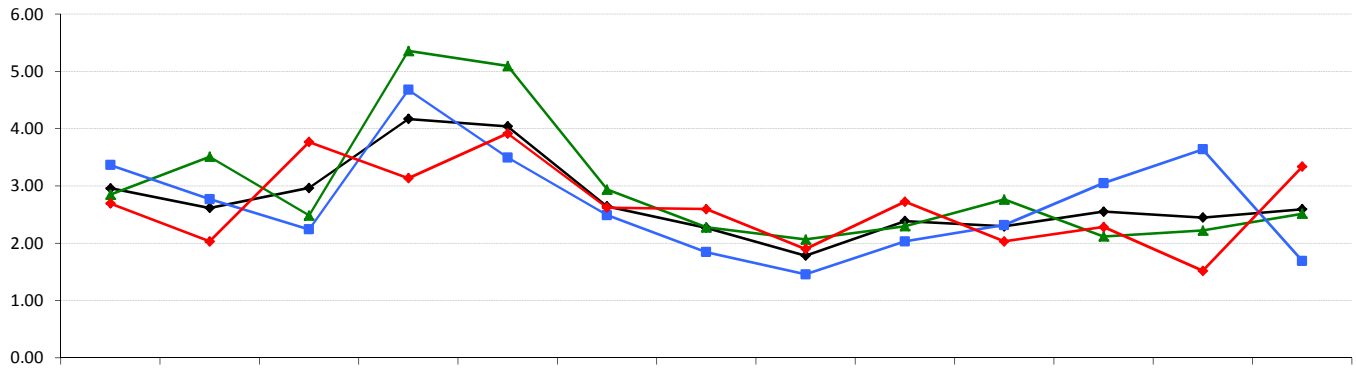
The number of compliments received has increased by 16% compared to the previous month. The ratio of compliments to formal complaints received for the month is 32:1. There has been one compliment being received for every 33 recorded spells of care.

Number of Formal Complaints



The number of complaints received has very slightly increased by 3% compared to May 2015 (77 compared to 75). The number of complaints received from June 2015 compared to June 2014 has decreased by 22% (77 compared to 99). The number of concerns has decreased by 12 % compared to last month (68 compared to 77).

Number of Formal Complaints per 1000 Bed Days



	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Trust	2.96	2.62	2.97	4.17	4.04	2.64	2.27	1.78	2.39	2.29	2.55	2.45	2.59
KCH	2.85	3.51	2.48	5.36	5.09	2.94	2.28	2.07	2.30	2.76	2.12	2.22	2.51
QEH	3.37	2.77	2.24	4.68	3.50	2.49	1.84	1.46	2.03	2.32	3.05	3.64	1.69
WHH	2.70	2.03	3.77	3.14	3.92	2.62	2.60	1.90	2.73	2.03	2.28	1.52	3.34

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. QEH is showing the lowest number of formal complaints per 1000 bed days.

PATIENT EXPERIENCE: CONCERNS, COMPLAINTS & COMPLIMENTS

Top Five Concerns Expressed in Formal Complaints
June 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 appointments, and problems with attitude.

With regards to formal complaints, the highest recurring subjects raised in Jun-15 were problems with communication, concerns about clinical management, problems with attitude, problems with discharge arrangements, and problems with nursing care.
In comparison to May 2015, communication and clinical management remain the top two subjects. Problems with attitude remain in the top five.
Problems with nursing care have replaced concerns about delays.

PATIENT EXPERIENCE: CONCERNS, COMPLAINTS & COMPLIMENTS, & PHSO

Concerns, Complaints and Compliments - Divisional Performance

June 2015

Division	Divisional Activity				Divisional Performance	
	Formal Complaints	Compliments	Informal Concerns	Compliments: Complaints	Response Date Agreed with Client	Returning Complaints
Clinical Support	3	85	10	28:1	4 of 4	1
Specialist Services	13	822	5	63:1	13 of 13	0
Surgical Services	32	586	32	18:1	28 of 31	8
UCLTC	28	1025	19	36:1	25 of 25	4
Corporate	1	9	0	9:1	0	0
Other	0	0	2	0:0	0	0
TOTAL	**77**	**2527**	**68**	**32:1**	**70 of 73**	**13**

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

The table above shows the monthly Divisional activity and performance for Jun-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.
The data shows 95% of responses sent out to clients in June were sent out on target compared to 97% last month. UCLTC, Specialist and Clinical sent out 100% of their responses on target. Surgery sent a minimum of 85% of their responses on target.
The PET have implemented a new process from April 2015 whereby the target response date relates to the number of complaints responded to within 30 working days (as set out in the Complaints Policy) rather than 'within agreed timescales' which we consider to be more meaningful data. We also monitor the average number of working days to respond to complaints for each division to gain a better understanding of the time being taken by each division to respond to complaints.
The data shows 47% of responses sent out the clients in June were sent out on target (within 30 working days) compared to 38% last month.
The average number of working days for the Trust overall to respond was 37 working days compared to 39 last month.

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

Status of Cases	Actions in Jun-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.
The PHSO has been in contact with the Trust in regards to four new cases in June 2015; two relating to UCLTC, Gastroenterology, one relating to Surgical Services, Vascular and one relating to UCLTC, Cardiology.

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;
- Don't Know.

The percentage measures for patients that would and would not recommend our services are then calculated.

The FFT does not provide results that can be used to directly compare providers because of the flexibility of the data collection methods and the variation in local populations. This means it is not possible to compare like with like with other trusts. There are other robust mechanisms for that, such as national patient surveys and outcome measures. The real strength of the FFT lies in the follow up questions that are attached to the initial question, and a rich source of patient views can be used locally to highlight and address concerns much faster than more traditional survey methods.

During Jun-15 we received 15311 responses in total. The total number of inpatients, including paediatrics who would recommend our services was 95%, which is better than the score in May-15 which was 94%. For A&E it was 80% (81% in May), maternity 98% (97% in May), day cases 94% (93% in May) and for outpatients it was 90% (90% in May). The Trust star rating in June is 4.7 which is equal to the star rating in May.

The response rate for inpatients was 32% (31% in April), A&E 26% (29% in May), maternity 36.4% (30.6% in May)(Please note as per DH guidelines only Q2 Birth is given a response rate, the other 3 questions reponses are not calculated or required nationally). The response rate for day cases was 36% (37% in May), and for outpatients it was 28% (28% in May).

All areas receive their indivudal reports to display each month, containing the feedback left by our patients which will assist staff in identifying areas for further improvement. This is monitored and actioned by the Division Governance Teams.

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 encompasses 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 which commenced during June. Our staff FFT has shown a 7% increase over the past 6 months in those staff who would recommend the Trust as a place to work (45% - 52%), and a 4% rise in recommending the Trust for treatment (72% - 76%).

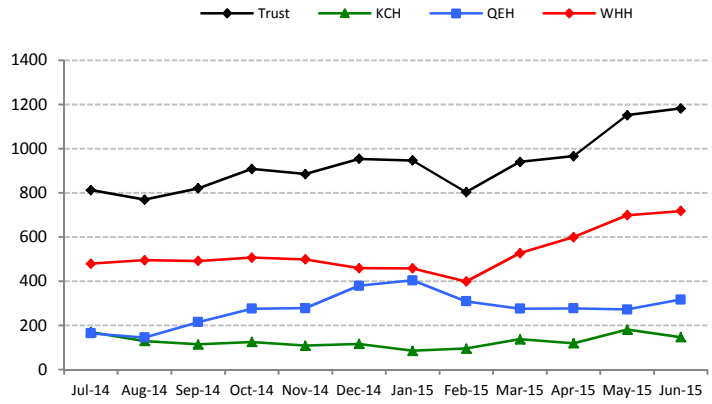
PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

Real time patient experience monitoring using iPads have captured data since 1 Apr-13. During Jun-15, 1182 adult inpatients were asked about their experiences of being an inpatient; 147 responses were received from patients treated at KCH, 317 from QEH patients, and 718 responses from patients based at WHH. (Compared with the previous month the number of responses were 181, 272 and 699 respectively). The combined result from all submitted questionnaires in Jun-15 was that of 89.12% satisfaction.

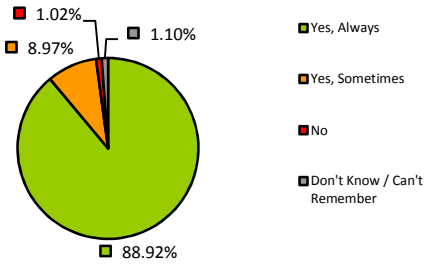
Overall Adult Inpatient Experience June 2015

Experience (%)	No. of Responses
89.12	1183

Number of Adult Inpatient Survey Responses

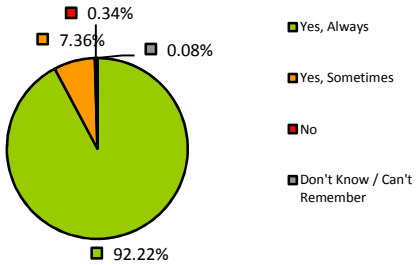


Were you given enough privacy when discussing your treatment?



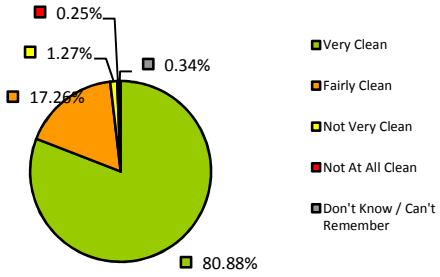
Overall Score = 94.40%

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



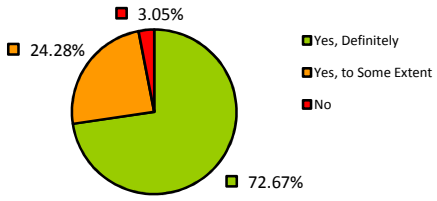
Overall Score = 95.94%

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



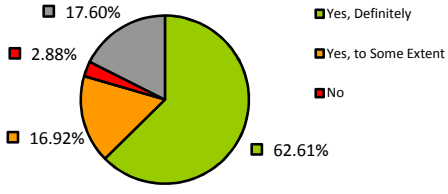
Overall Score = 93.13%

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



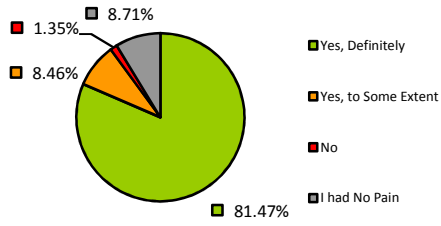
Overall Score = 84.74%

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



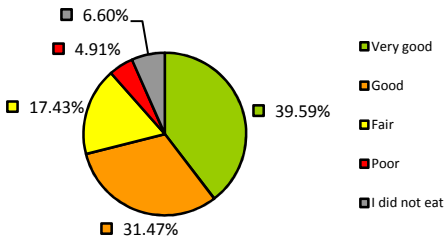
Overall Score = 86.15%

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



Overall Score = 93.84%

How would you rate the hospital food?

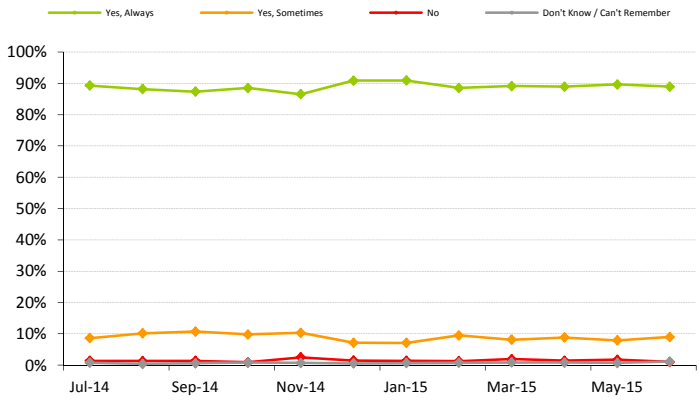


Overall Score = 71.01%

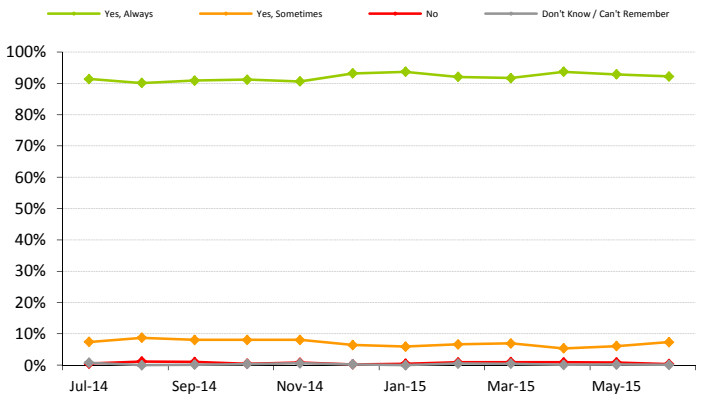
Each ward reviews their real-time monitoring data regularly. They are also shared as "heat maps" with other teams. From this actions are taken to address the themes which are considered with the Friends and Family Test feedback, and compliments and complaint information. This is monitored and actioned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

PATIENT EXPERIENCE: REAL-TIME MONITORING QUESTIONNAIRE

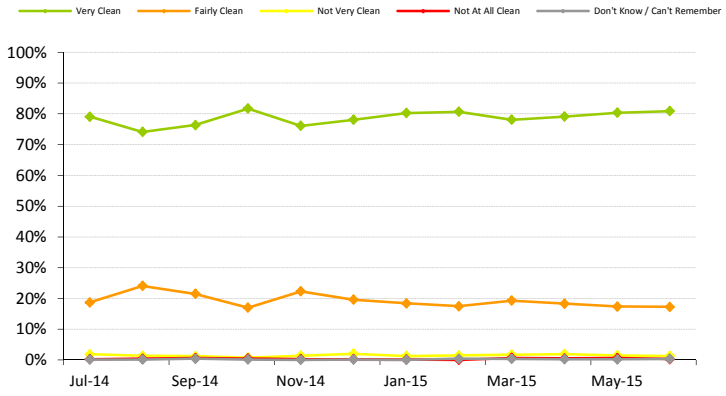
Were you given enough privacy when discussing your treatment?



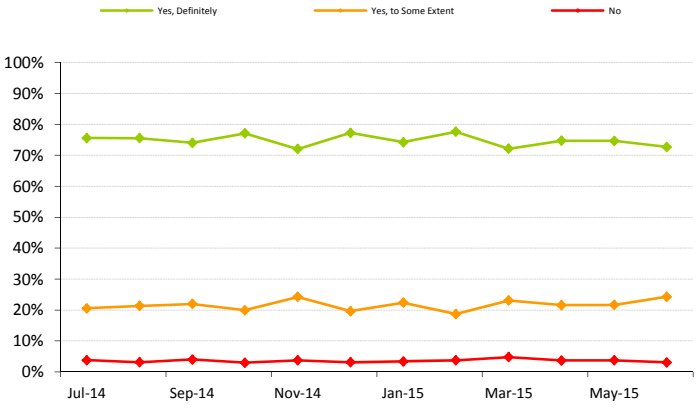
Overall, did you feel you were treated with respect and dignity while you were in hospital?



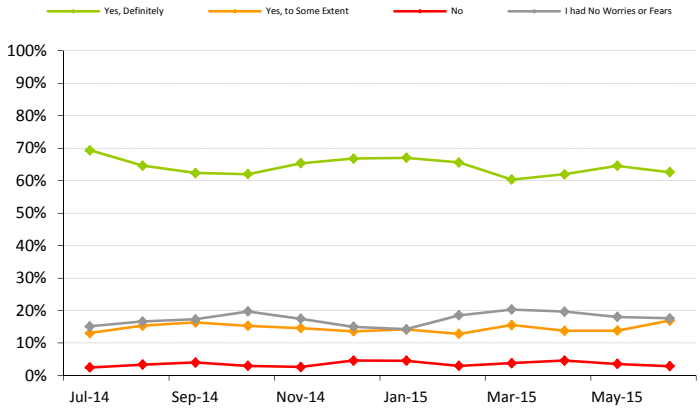
In your opinion, how clean was the hospital room or ward that you were in?



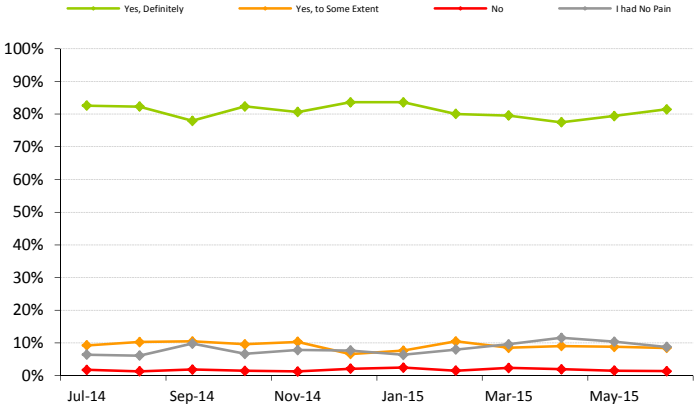
Were you involved as much as you wanted to be in the decisions about your care and treatment?



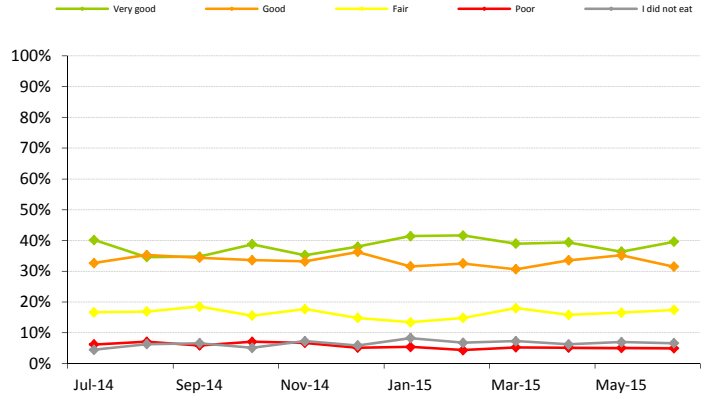
Did you find someone on the hospital staff to talk about your worries and fears?



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



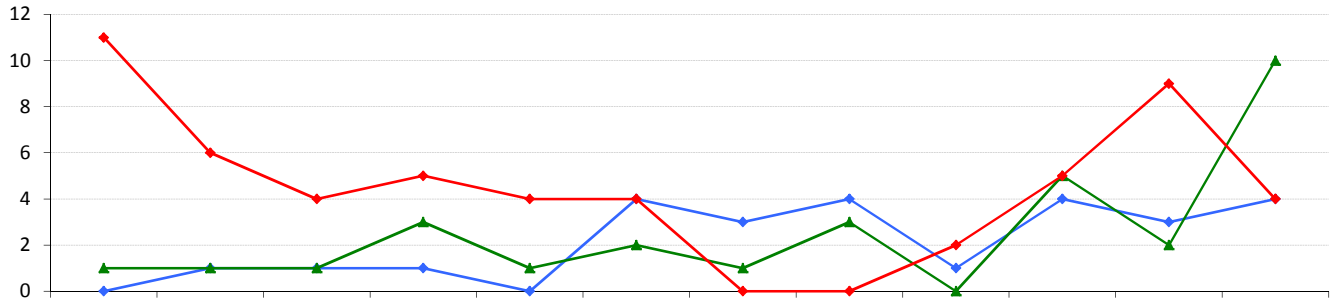
How would you rate the hospital food?



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 majority of lower scores at KCH and QEH relate to the UCLTC Division, where as at WHH they relate to the UCLTC and Surgical Divisions almost equally. The remaining metrics are similar to last month. Improvements are being led by the senior matrons using the data from the survey and the data they recieve from the Friends and Family Test to ensure it is all triangulated. St Augustine's has commenced collecting data this month. The response rate is higher at WHH compared with the other 2 sites.

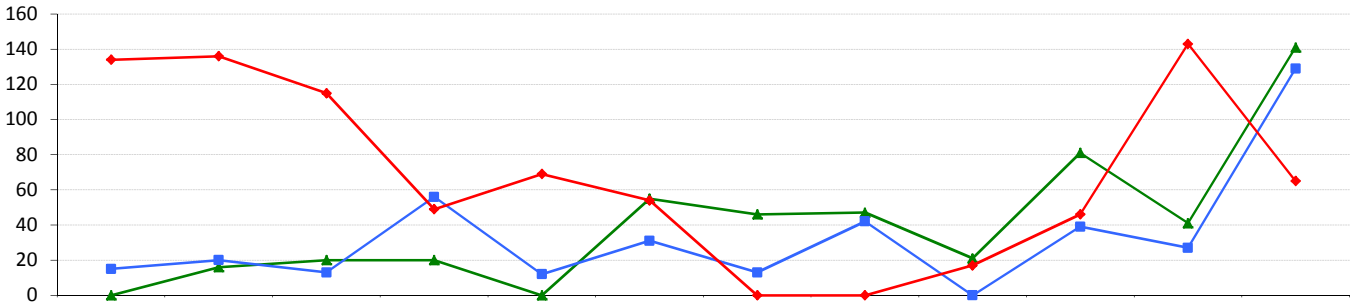
CLINICAL QUALITY & PATIENT SAFETY
PATIENT EXPERIENCE: MIXED SEX ACCOMMODATION

Number of Episodes of Mixed Sex Occurrence



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
KCH	0	1	1	1	0	4	3	4	1	4	3	4
QEH	1	1	1	3	1	2	1	3	0	5	2	10
WHH	11	6	4	5	4	4	0	0	2	5	9	4

Number of Hours of Mixed Sex Occurrence



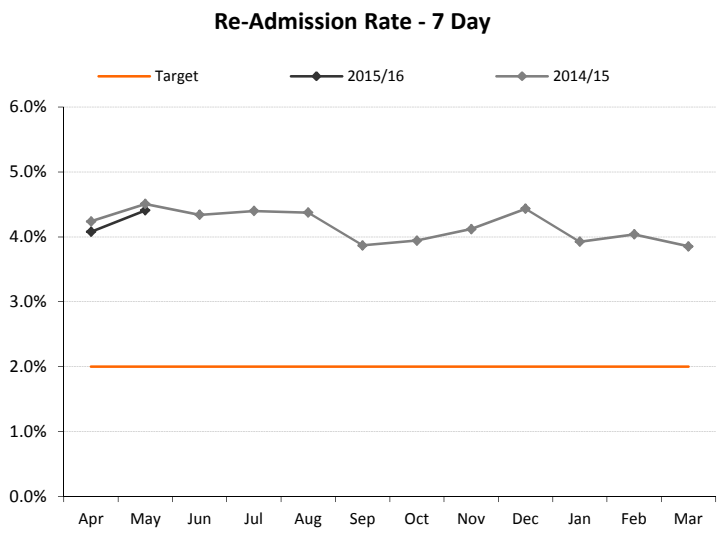
	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
KCH	0	16	20	20	0	55	46	47	21	81	41	141
QEH	15	20	13	56	12	31	13	42	0	39	27	129
WHH	134	136	115	49	69	54	0	0	17	46	143	65

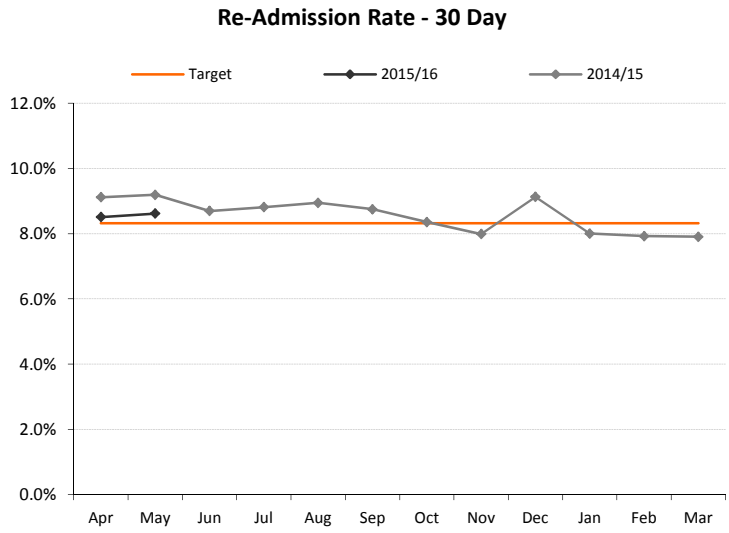
Mixed Sex Accommodation Occurrrences June 2015

Site	Clinical Area	Total No. of Occurrences	Total No. of Patients Affected
KCH	Kingston	4	16
QEH	CCU	5	20
QEH	Fordwich	5	20
WHH	**CDU**	**4**	**31**

During Jun-15, 5 non-justifiable incidents of mixed sex accommodation breaches occurred and affected 34 patients. This information has been reported to NHS England via the Unify2 system. These were due to capacity issues. There were 4 incidents at WHH CDU and 1 incidence at QEQM Fordwich ward. The remaining incidents occurred in the Coronary Care and 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 18 mixed sex accommodation occurrences in total, affecting 87 patients. (Last month there were a total of 14 occurrences affecting 91 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





In Jun-15 readmission rates for both 7 and 30 days are showing an improved performance against the same period last year, for the fifth consecutive month. The outcome of the Patient Records Audit (undertaken by the Service Improvement & Innovation Team) has been shared with the Chief Operating Officer and Divisional Directors; five key workstreams have been identified to continue to improve performance and further enhance a coordianted and person-centred approach to discharge. The Readmission Audit will now be presented to Divisional Board meetings throughout August.

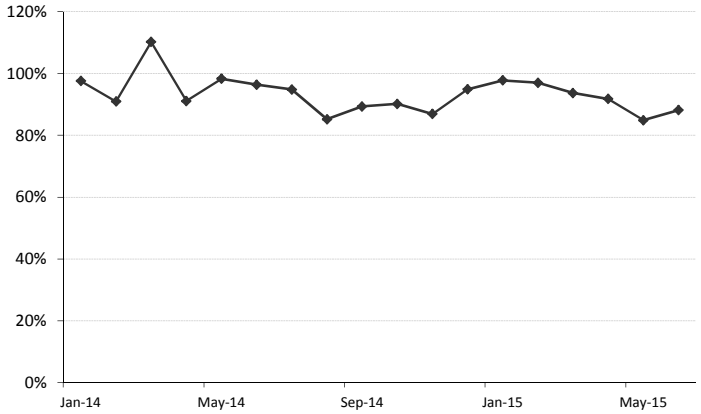
			CQUIN	2014/15 Baseline	2015/16 Target	YTD Status	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Q1	Q2	Q3	Q4	Year End Position
	National CQUINS																						
Performance	Acute Kidney Injury (AKI)	1a	Audit Established and Baseline Data Gathered	N/A	Audit established 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. We are waiting for the CCGs to sign off the CQUIN measures by the end of the month.																			
		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. We are waiting for the CCGs to sign off the CQUIN measures by the end of the month.																			
		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. We are waiting for the CCGs to sign off the CQUIN measures by the end of the month.																			
			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.																			

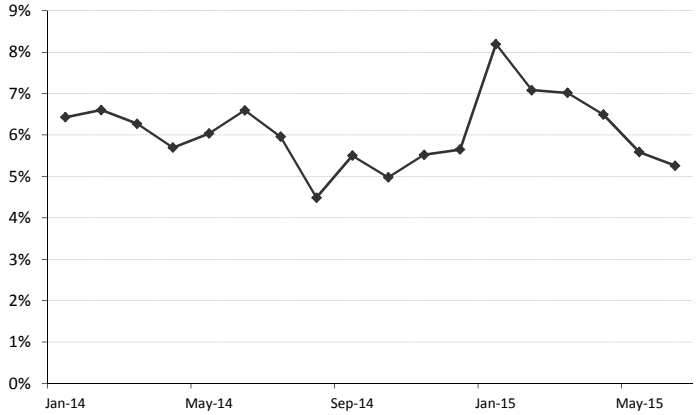
Compliance Against Performance	
	On target
	Monthly target missed; quarterly/annual target at risk
	Monthly target missed; annual target at risk

Bed Occupancy



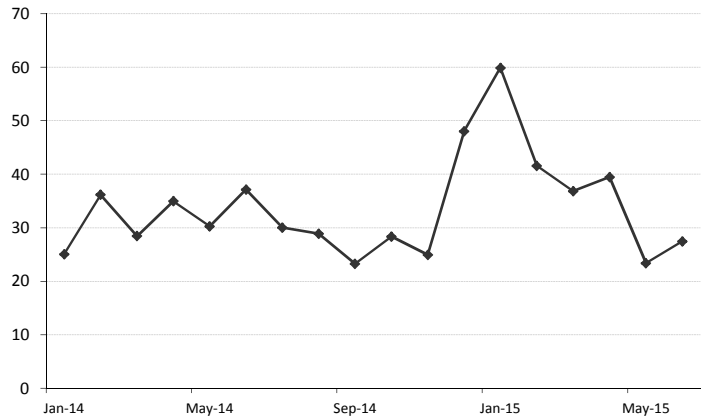
The bed occupancy metric looks only at adult inpatient beds and excludes any ring fenced wards such as Maternity. Occupancy levels peaked in Mar-14 at 110.20%, thereafter fluctuating between 98.301% and 85.2% between Apr-14 and Apr-15. The position in Jun-15 (i.e. 88.12%) demonstrated an increase in bed use for the four months.
NB: Data are sourced from the Trust's Balanced Scorecard as of 10 Jun-15.

Extra Beds



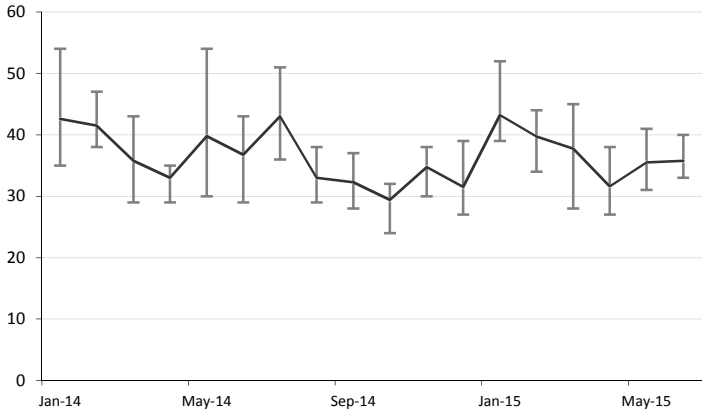
This metric is built up using the number of funded beds on each ward and reviewing those occupied on a daily basis. Where the number of occupied beds exceeds the funded bed base for the ward these are classified as "extra". In Jun-15 the degree of extra beds used within the Trust equalled 5.26%, and lower than the position reported in May-15 (i.e. 5.59%), and is lower than the value recorded in Jun-14 (cf. 6.60%). The degree of extra beds reported in Jun-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. The outlier position in Jun-15 equalled 27.43, which is slightly higher than the values recorded in May-15 (23.39).

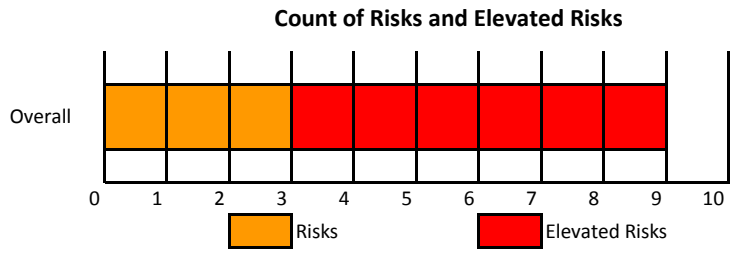
Average Delayed Transfers of Care



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. Jun-15 shows a slightly raised value of 35.75 and although continuing the upward trend seen since Jan-15, 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.

CLINICAL QUALITY & PATIENT SAFETY
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 – June 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 June are over 98% at WHH and over 94% at QEQM and K&C, shown in Figure 1.

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

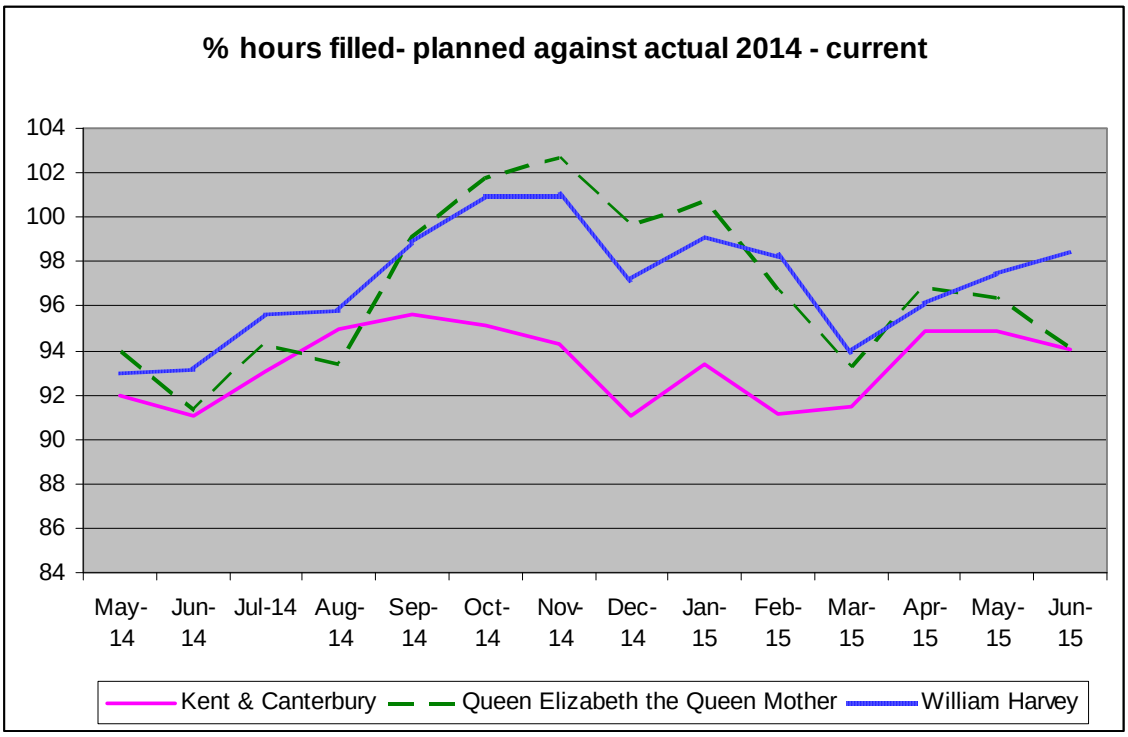
	% Hours filled - planned against actual June 2015				
	DAY		NIGHT		
Hospital site	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Overall % hours filled
Kent & Canterbury	83.8%	97.3%	100.0%	117.1%	94.05
Queen Elizabeth the Queen Mother	87.5%	98.7%	98.7%	99.5%	94.07
William Harvey	91.9%	105.5%	97.4%	111.8%	98.42

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 an overall 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 NHS-P. 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 June 2015



The fall in fill rate at the QEQM in June reflects the vacancy position and the prioritisation of safely covering RN night shifts.

Figure 3. % hours filled for RNs / HCAs by site for day / night shifts - June 2015

	RN Day	HCA Day	RN Night	HCA Night
QEQM	88.32	90.99	102.18	81.14
K&C	89.26	79.91	99.19	182.20
WHH	88.76	103.39	93.78	93.68

Senior nursing leaders have reported that:

- It is not possible 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 4 shows total monthly hours actual against planned and % fill during June 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 4. Comments relating to the main root cause of <80% fill rates are provided and detail on annual leave, sickness and parenting leave rates by ward. The RAG rating for these elements are provided below. Detail on key quality indicators are included by ward within the heat map within the main report.

Annual Leave	<11.0%
	>17.0%
Sickness	>2.5%
Parenting	>3.0%

Data validation and sign-off steps have been implemented and the data has been reported externally via Unify/NHS Choices on 15th July. The national data will be published representing each hospital site on the NHS Choices website.

Figure 4. Total monthly hours actual against planned and % fill by ward during June 2015

Division / Ward	DAY		NIGHT			Unavailability %					
						A/L		Sickness		Parenting	
Urgent Care & LongTerm Conditi	Average fill rate - registered midwives (%)	Average fill rate - nurses/ care staff (%)	Average fill rate - registered midwives (%)	Average fill rate - nurses/ care staff (%)	Comments	Registered	Unregistered	Registered	Unregistered	Registered	Unregistered
Cambridge J	104.53	160.60	97.39	145.00		19.00%	12.40%	0.50%	12.10%	0.0%	0.0%
Cambridge K	86.32	118.22	100.14	96.67		14.40%	10.30%	2.90%	4.40%	0.50%	7.90%
Cambridge M2	104.54	91.81	99.80	95.28		16.70%	16.00%	3.50%	5.20%	0.0%	10.10%
Coronary Care Unit (K&C)	58.49	N/A	100.22	N/A	RN sickness	12.00%	0.0%	10.70%	0.0%	0.0%	0.0%
Coronary Care Unit (QEQMH)	83.41	62.60	104.08	93.83	HCA AL	15.30%	39.10%	0.0%	0.80%	0.0%	0.0%
Coronary Care Unit (WHH)	101.61	124.31	98.01	78.48	HCA AL	17.60%	14.00%	0.90%	0.0%	4.00%	0.0%
Minster	87.07	86.10	96.82	95.00		15.90%	15.90%	6.10%	0.40%	0.0%	3.10%
Oxford	108.05	116.54	98.91	147.83		17.10%	16.00%	0.50%	0.80%	8.60%	11.90%
Sandwich Bay	92.90	159.82	100.45	154.24		11.00%	18.40%	2.00%	0.80%	17.80%	0.0%
St Margarets	106.35	88.84	100.95	100.12		17.00%	12.00%	0.90%	5.50%	0.40%	0.0%
Deal	89.92	88.71	102.83	98.33		16.10%	10.10%	2.90%	4.10%	7.10%	6.50%
Harvey	96.71	103.27	100.00	197.54		13.40%	17.50%	8.60%	0.0%	0.0%	0.0%
Invicta	86.92	93.21	96.67	180.14		9.80%	15.90%	3.10%	15.10%	4.40%	1.80%
Cambridge L	41.71	181.10	88.41	174.28	RN sickness / parenting	11.10%	10.50%	8.50%	5.90%	6.20%	4.40%
Treble	79.09	85.58	98.33	97.25	RN parenting	14.70%	19.40%	1.80%	6.00%	6.00%	0.0%
Mount/McMaster	77.46	102.14	98.33	178.75	RN parenting	16.10%	17.00%	1.70%	3.50%	8.40%	0.0%
Fordwich Stroke Unit	90.68	109.36	97.14	101.67		15.50%	6.20%	6.80%	16.00%	0.40%	0.0%
Kingston Stroke Unit	83.26	147.62	97.76	99.86		13.20%	15.90%	4.70%	9.80%	0.0%	0.0%
Richard Stevens Stroke Unit	68.12	61.25	71.69	124.20	RN 4.27 wte vacancy	17.30%	12.20%	6.20%	4.30%	4.40%	7.10%
Harbledown	92.34	81.66	98.50	99.58		17.90%	18.60%	6.90%	14.10%	0.0%	0.0%
QE CDU	71.14	92.25	96.42	130.87	RN sickness / parenting	12.00%	16.30%	9.40%	12.70%	10.20%	2.20%
WH CDU/Bethersden	114.58	98.26	112.50	95.07		15.60%	13.80%	5.70%	7.60%	2.80%	5.10%
Surgical Services											
Rotary Suite	109.59	98.08	100.00	103.33		13.70%	16.30%	0.0%	0.0%	0.0%	0.0%
Cheerful Sparrows Female	98.05	117.23	106.74	90.15		17.70%	18.60%	4.90%	7.70%	0.0%	0.0%
Clarke	81.31	107.28	93.75	93.60		18.00%	8.90%	4.90%	8.00%	0.0%	0.0%
Cheerful Sparrows Male	67.57	138.82	97.99	115.15	RN parenting	17.40%	15.90%	0.0%	0.0%	33.20%	0.0%
Kent	87.12	118.12	100.11	95.07		19.10%	15.40%	0.20%	0.0%	12.20%	10.60%
Kings B Ward - WHH	110.95	103.59	105.58	178.26		18.10%	9.20%	1.60%	5.70%	0.0%	6.20%
Kings A2	105.11	143.59	100.29	265.94		15.80%	13.00%	4.20%	4.70%	0.0%	0.0%
Kings C1	82.24	126.17	100.00	100.58		17.20%	11.50%	0.80%	2.30%	0.0%	3.80%
Kings C2	80.34	92.28	88.33	101.64		13.40%	16.50%	4.60%	7.00%	0.0%	7.90%
Kings D	86.42	124.36	93.16	119.72		14.10%	13.00%	3.50%	5.40%	0.0%	0.0%
Quex	83.88	129.51	100.00	90.00		19.50%	28.70%	0.0%	3.70%	0.0%	1.60%
Bishopstone / Seabathing	71.22	103.50	90.76	98.41	RN sickness	17.90%	14.80%	7.30%	7.80%	2.40%	0.0%
Critical Care - WHH -	122.50	83.51	111.45	38.46	HCA sickness	11.70%	13.10%	6.30%	8.10%	5.30%	0.0%
Critical Care - KCH	93.44	94.93	106.98	N/A		14.80%	17.40%	3.30%	11.80%	4.10%	0.0%
Critical Care - QMH	81.05	54.59	95.04	N/A	HCA AL	16.10%	19.90%	3.30%	0.0%	1.60%	0.0%
Specialist Services											
KC Marlowe Ward	85.20	74.53	95.75	92.78	HCA 4.49wte vacancy	10.80%	16.30%	2.40%	8.30%	6.20%	6.20%
WH NICU	82.89	128.59	91.30	N/A		15.80%	16.90%	4.10%	0.0%	3.50%	0.0%
WH Padua Ward	103.04	78.61	99.17	76.67	HCA sickness / parent	17.00%	15.70%	0.70%	6.60%	0.0%	10.40%
QE Rainbow Ward	87.56	77.41	98.48	N/A	Impact HCA AL	23.90%	16.20%	8.90%	2.90%	4.10%	0.0%
QE Birchington Ward	80.02	109.89	99.96	97.50		16.90%	13.70%	3.60%	8.30%	14.10%	0.0%
WH Kennington Ward	80.62	99.37	96.61	N/A		9.70%	12.00%	12.60%	4.10%	8.70%	0.0%
KC Brabourne Haematology Ward	70.84	83.00	103.96	N/A	RN parenting	17.50%	10.30%	3.60%	25.70%	15.20%	0.0%
WH Maternity Labour and Folkest	89.68	78.13	97.87	58.91	HCA sickness	10.70%	9.50%	14.70%	6.20%	8.40%	1.30%
MLU WHH	104.96	55.09	100.91	53.33	HCA sickness	11.80%	37.20%	0.60%	10.70%	6.70%	2.10%
QE Maternity Wards + MCA	101.48	84.82	92.59	95.56		10.70%	9.40%	8.60%	6.30%	0.30%	8.20%
QE MLU	103.33	60.00	160.37	70.00	HCA sickness	11.50%	20.80%	12.40%	15.10%	8.10%	0.0%
QE SCBU	92.91	94.75	101.11	N/A		11.80%	6.50%	1.30%	0.0%	0.0%	25.30%

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CLINICAL QUALITY & PATIENT SAFETY PERFORMANCE HEAT MAP

East Kent Hospitals University NHS
NHS Foundation Trust

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%	0	0	0	100%	100%				71%	104%
Clarke Ward - KCH	1	2	0	0	100%	1	0	1	29%	98%	88%	88%	97%	81%	94%
Critical Care - KCH	0	2	0	0	100%	0	0	0	91%	97%				93%	107%
Emergency Care Centre - KCH (CDU only)	2	6	0	0	100%	0	1	2	27%	86%	75%	96%	81%		
Coronary Care Unit (Taylor) - KCH	0	32	1	0	100%	0	1	3			93%	100%	95%	59%	100%
Harbledown Ward - KCH	3	21	0	0	100%	1	0	6	23%	94%	75%	100%	100%	92%	99%
Harvey Ward - KCH	2	0	0	0	100%	0	0	3	71%	100%	50%	94%	69%	97%	100%
Invicta Ward - KCH	0	0	0	0	96%	0	0	2	46%	100%	94%	97%	96%	87%	97%
Kent Ward - KCH	0	66	0	0	93%	1	0	5	51%	98%	92%	96%	100%	87%	100%
Kingston Stroke Unit - KCH	0	1	0	0	100%	0	0	6	107%	98%	93%	93%	88%	83%	98%
Marlowe Ward - KCH	0	0	0	0	95%	1	0	3	28%	93%				85%	96%
Mount & McMaster Ward - KCH	0	9	0	0	100%	0	0	3	51%	96%				77%	98%
Treble Ward - KCH	2	1	0	0	100%	1	0	5	37%	83%	83%	89%	79%	79%	98%
Birchington Ward - QEH	0	21	0	0	100%	1	0	0	35%	97%				80%	100%
Bishopstone Ward - QEH	0	0	0	0	88%	0	0	3	79%	94%	99%	100%	98%	71%	91%
CDU - QEH	1	0	0	0	100%	0	0	5	30%	88%	91%	90%	75%	71%	96%
Cheerful Sparrows Ward Female - QEH	2	7	0	0	91%	0	0	1	49%	95%	80%	90%	100%	98%	107%
Cheerful Sparrows Ward Male - QEH	1	12	0	0	100%	0	1	5	47%	97%	100%	100%	92%	68%	98%
Coronary Care Unit - QEH	0	17	0	0	100%	0	0	2	42%	100%	86%	100%	100%	83%	104%
Critical Care - QEH	0	1	0	0	100%	1	0	1			100%	100%		81%	95%
Deal Ward - QEH	1	0	0	0	96%	1	0	7	15%	100%	86%	93%	98%	90%	103%
Fordwich Stroke Unit - QEH	0	20	0	0	100%	0	0	5	36%	100%	100%	100%	100%	91%	97%
Hospital at Home - QEH	0	0	0	0	100%	0	0	0							
Kingsgate Maternity & Labour Ward - QEH	0	0	0	0	100%	0	0	0							
Minster Ward - QEH	0	0	0	0	100%	0	0	0	84%	100%				87%	97%
Quex Ward - QEH	0	0	0	0	100%	0	0	2	84%	100%	88%	96%	92%	84%	100%
Rainbow Ward - QEH	0	150	0	0	100%	0	0	0	36%	99%				88%	98%
Sandwich Bay Ward - QEH	1	0	0	0	95%	0	0	2	49%	97%	90%	93%	96%	93%	100%
Seabathing Ward - QEH	1	0	0	0	100%	0	1	4	29%	94%	98%	100%	100%		
Special Care Baby Unit - QEH	0	0	0	0	100%	0	0	0						93%	101%
St Augustine's Rehab Ward - QEH	1	0	0	0	0%	0	0	1							
St Margaret's Ward - QEH	0	0	0	0	100%	0	0	0	28%	86%	63%	83%	60%	106%	101%
Cambridge J2 Ward - WHH	1	2	0	0	100%	2	1	8	48%	93%				105%	97%
Cambridge K Ward - WHH	0	13	0	0	97%	0	0	8	88%	98%	80%	86%	83%	86%	100%
Cambridge L Ward - WHH	2	1	0	0	100%	0	0	10	43%	90%	55%	70%	64%	42%	88%
Cambridge M2 Ward - WHH	1	14	0	0	100%	1	1	8	45%	95%	82%	91%	79%	105%	100%
CDU - WHH	5	0	0	0	93%	0	0	10	26%	81%				115%	113%
Coronary Care Unit - WHH	0	8	0	0	100%	0	0	0	65%	100%	94%	100%	100%	102%	98%
Critical Care - WHH	0	3	0	0	100%	0	0	0			100%	100%	100%	122%	111%
Folkestone Maternity & Labour Ward - WHH	0	0	0	0	100%	0	0	0			100%	100%	100%	90%	98%
Hospital at Home - WHH	0	0	0	0	100%	0	0	0							
Kennington Ward - WHH	1	1	0	0	100%	0	0	0	14%	100%	84%	93%	77%	81%	97%
Kings A2 Ward - WHH	2	69	0	0	100%	0	0	1	104%	96%	92%	91%	91%	105%	100%
Kings B Ward - WHH	1	52	0	0	96%	0	0	4	51%	98%	72%	93%	74%	111%	106%
Kings C1 Ward - WHH	0	1	0	0	100%	1	0	5	44%	100%	87%	99%	90%	82%	100%
Kings C2 Ward - WHH	0	70	0	0	100%	2	0	3	57%	98%	91%	96%	86%	80%	88%
Kings D Ward Male - WHH	0	6	0	0	100%	1	0	4	59%	92%	83%	92%	88%	86%	93%
Kings D Ward Female - WHH	0	12	0	0	94%	0	0	3	42%	91%	83%	92%	88%		
Neonatal Intensive Care Unit - WHH	0	0	0	0	100%	0	0	0							
Oxford Ward - WHH	1	0	0	1	100%	0	0	8	56%	100%	95%	100%	94%	108%	99%
Padua Ward - WHH	0	1	0	0	100%	0	0	0	6%	100%				103%	99%
Rotary Suite - WHH	2	105	0	0	100%	0	0	5	64%	100%	91%	99%	92%	110%	100%
RSU Unit - WHH	1	0	0	0	95%	0	0	8	84%	96%	83%	100%	82%	68%	72%

Criteria

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