Kingston Hospital NHS Foundation Trust

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Clinical Quality Report
October 2014 (Month 7)

Executive Summary

The Trust Clinical Quality Report provides the Board with an overview of clinical quality. The metrics should be considered in the context of the overall performance of the Trust and in particular to determine if there are any changes in quality that might be due to the productivity programme.

There are several areas of improvement in safety KPIs but there remain some concerns regarding quality of care in the Trust in October 2014. Mortality rates are maintained at a low level, with the most recent in-hospital SHMI (Apr2013- March 2014) being 89.6 and the unadjusted mortality for Q2 1.2%.

The October 2014 falls rate is 5.0 per 1000 bed days. There have been some particularly good improvements in specific wards where SWARM is being rolled out. There were 2 falls associated with harm, where the patients suffered a fractured neck of femur. These are subject to serious incident investigations.

The position with pressure ulcers in October 2014 has deteriorated with 11 pressure ulcers recorded (6 x grade 2; 3 x grade 3 & 2 x grade 4). The specific reasons for 3 pressure ulcers related to BIPAP masks have been addressed. Two of the pressure ulcers were deemed unavoidable. Actions are in place and are detailed in the exception report. Some of the concerns about evidence are due to recording in CRS which is requires additional training in the use of electronic pressure ulcer documentation. All grade 3 & 4 pressure ulcers are investigated as serious incidents.

Recording and accurate reporting of VTE risk assessment is now above the required 95% performance at 96.1%. In November 2014 it became mandatory to complete this field on CRS prior to any electronic prescribing. A reduction in performance in completed patient observations has varied between wards in month. Staff are being reminded of the importance of this within the areas identified as requiring improvement. An exception report is provided for this on a quarterly basis if the performance remains below target.

The Trust had two cases of C.difficile in October 2014. This brings the total to 7 year to date which continues to be an improved position from 13/14. Actions to maintain this position continue. As per new guidance from 14/15 cases of hospital acquired C.difficile have to be agreed with commissioners if they are due to lapses of care. 5 of the 7 cases year to date have been reviewed with the Trust by the CSU infection control nurse and have been deemed not due to lapses of care. The other two cases are currently being reviewed. Although there was one case of MRSA bacteraemia in the Trust in October 2014 it is not shown in the figures on the Clinical Quality Report because the Trust has declared it as a third party acquisition rather than a hospital acquired case. It is thought that the current MRSA bacteraemia is an ongoing bacteraemia from that diagnosed in June 2014. The Trust has therefore commenced the third party acquisition process with support from the Commissioning Support Unit (CSU) Infection control nurse. Hand hygiene compliance remains below the 95% threshold. Actions are in place in areas with poor compliance which are bringing the overall performance of the Trust to a lower position. The 'hand hygenius' campaign run by the infection control nurses continues. Hand hygiene audits are being conducted more frequently in poorly performing areas to drive improvement.

Response rate to complaints in a timely manner has reduced to 50% in September 2014. It is acknowledged that this is not at an acceptable level of performance and actions to address this are outlined in the exception report. As a result of these actions the performance is expected to improve in coming months.

The exception report provides a breakdown of FFT score by ward for October 2014. The Inpatient FFT is 56 in October 2014. A&E FFT scores have continued to improve. The exception report details the progress being made to address concerns regarding food from the FFT. It also describes the changes that have been made to national guidance and reporting which is likely to mean a change from the FFT score on the performance report. In future the percentage of people likely or extremely likely to recommend the hospital will be reported as this is now the measure being looked at nationally.

The percentage of women with a primary postpartum haemorrhage of 2000ml has continued to reduce. A joint study day was run in October 2014 for maternity, with transfusion services which enabled shared learning about major haemorrhage. The latest quarterly perinatal mortality per 1000 births was made available as the Clinical Quality Report is released. Further work is therefore taking place to understand the higher rate. This follows a higher rate in Q1, which upon investigation found no areas of concern.

The safe nursing & midwifery staffing information in October 2014 shows a stable position and further detail is provided in the Nursing, Midwifery & Care staffing report to the Trust Board.

Clinical Quality Dashboard - October 14

	Strategic objective	KPI description	Exec Owner	Reported in	Target	Actual 2013-14	Aug-14	Sep-14	Oct-14	2014-15 Q2	2014-15 Q3	YTD	Qtr Trend	Month Trend	Forecast	Comments
Safety	1	Number of patients with hospital acquired pressure ulcers (Grade 3-4)	DB	Board - CPR, CQIC	<=1	11.7	0	1	5	1	5	9	↑	↑		Target set as 10% reduction on 2013/14 outturn. Target is to have =<11.7 cases in 2014/15
	1	Number of patients with hospital acquired pressure ulcers (Grade 3&4) per 1000 beddays	DB	CQIC	<=0.06	0.1	0.00	0.10	0.47	0.03	0.47	0.12	↑	↑		
	1	Number of patients with hospital acquired pressure ulcers (Grade 2)	DB	Board - CPR, CQIC	<=3	53	4	6	6	13	6	37	↓	→		Corporate objectives set target as reduction of 10% on 2013/14 Outturn but this would be higher than the 2013/14 target so keeping 2013/14 target of 36. See Exception Report 1.
	1	Number of patients with hospital acquired pressure ulcers (Grade 2) per 1000 beddays	DB	CQIC	<=0.5	0.4	0.38	0.58	0.57	0.41	0.57	0.50	↑	↓		
	1*	Number of Patient Safety Incident (PSI) Falls	JW	CQIC	<=51	770	68	50	53	182	53	408	↓	↑		Benchmark against Trust performance - 20% reduction on year end rate
	1*	Number of Patient Safety Incident Falls where moderate or severe harm occurred	JW	CQIC	<=14	7	1	1	2	3	2	10	↓	↑		Target is a reduction of 15% on last year's outturn
	1*	Number of Patient Safety Incident Falls per 1000 G&A beddays	JW	Board - CPR, CQIC	<=4.7	5.9	6.5	4.8	5.0	5.8	5.0	5.5	↓	↑		Benchmark against Trust performance - 20% reduction on year end rate. See Exception Report 2.
	1*	MRSA Bacteraemias - Post 48hour (Hospital Acquired)	DB	Board - CPR, CQIC	<1	4	0	0	0	0	0	0	→	→		Target is zero tolerance as per national guidance and contract
	1*	Clostridium difficile Infections - Post 72hours (Hospital Acquired)	DB	Board - CPR, CQIC	<=2	22	2	1	2	3	2	7	↓	↑		Target set by NHS England. Full year target is <= 24 cases. This has been profiled evenly over the year.
	1*	MSSA Bacteraemias - Post 48hour (Hospital Acquired)	DB	CQIC	<=1	14	0	1	0	1	0	2	↓	↓		
	1*	E.coli Bloodstream Infections (Hospital Acquired)	DB	CQIC	<=2	24	2	0	3	5	3	15	↓	↑		
	1	Nutrition - compliance with MUST assessment	DB	CQIC	>=85%	91.7%					94.3%	90.1%				Data is collected bi-annually as part of nutrition audit. The audit assesses whether or not the MUST score for a patient is accurate. The Oct-14 audit showed 105 patients were assessed, 99 of which had an accurate MUST score.
	1	Completed Patient Observations	DB	CQIC	>=97%	94.9%	96.1%	93.2%	89.8%	95.2%	89.8%	94.3%	↓	↓		NEWS data. 595 of 656 observations completed in Oct-14.
	1	Medication Incidents	JW	CQIC		633	70	52	57	181	57	423	↓	↑		No target set. Reporting of incidents is important and should not be discouraged by setting a ceiling target
	1	% of Medication Incidents Where Moderate or Severe Harm Occurred	JW	CQIC	<=4%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	→	→		
	1	Number of Serious Untoward Incidents	JW	CQIC		45	3	2	9	10	9	31	↓	↑		No target set. Reporting of incidents is important and should not be discouraged by setting a ceiling target
	1	Number of Never Events	JW	CQIC	0	2	0	0	0	1	0	1	↓	→		
	1	Patient Safety Thermometer - % Harm Free Care	DB	CQIC		91.7%	94.62%	93.01%	92.43%	93.4%	92.4%	92.4%	↓	↓		
Effectiveness	1	SHMI	JW	Board - CPR, CQIC	<=95	92.8				93.2	89.6		↓			SHMI score < 100 is lower than expected mortality, taking into account age, gender, comorbidity and diagnosis grouping of patients. The score for the previous year is for the period Jul 12 to Jun 13 as published by the Information Centre in Jan 2014. Q3 score is for Apr 2013 to Mar 2014 as published by the Information Centre in Oct 2014 (latest available data)
	1	SHMI (In hospital Mortality)	JW	CQIC	<=73	55				57		53				Data from CHKS and reported in arrears.
	1	Unadjusted Mortality Rate	JW			1.2%				1.2%		1.1%	↓			Data from CHKS and reported in arrears.
		% Emergency Readmissions following elective admission - 30 days	ST	CQIC		2.0%	2.2%	1.9%	2.7%	1.9%	2.7%	2.0%	↑	↑		Local data has been used to give an indication of performance.
	1,4	% Emergency Readmissions following emergency admission - 30 days	ST	CQIC		11.4%	13.8%	14.2%	12.6%	13.5%	12.6%	13.4%	↓	↓		Local data has been used to give an indication of performance.
	1,4	% Emergency Readmissions following all admissions - 30 days	ST	Board - CPR	<= 5.7%	5.5%						5.1%	↓	↑		Data reported from CHKS and therefore in arrears. Target based on national peer upper quartile from CHKS.
	1	Prevention of hospital acquired VTE - % patients risk assessed	JW	CQIC	>=95%	86.6%	93.9%	93.3%	96.1%	94.1%	96.1%	92.9%	↑	↑		Target is national CQUIN.
	1	Hand Hygiene	DB	CQIC	>=95%	94.2%	93.9%	90.4%	90.3%	91.7%	90.3%	92.9%	↓	↓		Target is locally set.
	1	% of patients with a fractured neck of femur that went to theatre within 24 hours for repair of the fractured femur	JW	CQIC	>=70.0%	84.0%				81.3%		89.8%				Data from CHKS and will be reported 3 months in arrears.

Clinical Quality Dashboard - October 14					Actual										
Strategic objective	KPI description	Exec Owner	Reported in	Target	2013-14	Aug-14	Sep-14	Oct-14	2014-15 Q2	2014-15 Q3	YTD	Qtr Trend	Month Trend	Forecast	Comments
1	Open Incidents - % of Managers Reports Completed within 10 days	ST	CQIC		Not Available	57.2%	49.5%	51.3%					↑		

Clinical Quality Dashboard - October 14	Strategic objective	KPI description	Exec Owner	Reported in	Target	Actual 2013-14	Aug-14	Sep-14	Oct-14	2014-15 Q2	2014-15 Q3	YTD	Qtr Trend	Month Trend	Forecast	Comments
Patient Experience	1	Number of Complaints received this month	DB	CQIC		403	25	30	32	102	32	263	↓	↑		
	1	Number of Complaints reopened this month	ST	CQIC		59	7	5	7	18	7	43	↓	↑		
	1	Number of Complaints referred to ombudsman this month	ST	CQIC		6	0	0	1	0	1	1	↑	↑		
	1	% Complaints responded to within 25 working days	ST	CQIC	>=90%	67.6%	56.0%	50.0%		59.8%		62.8%		↓		Data reported 1 month in arrears. See Exception Report 3.
	1	Friends and Family Score - Trust	DB	CQIC		63	62	65	68	64	68	63	↑	↑		
	1	Friends and Family Score - Adult Inpatient	DB	CQIC	78	60	62	57	56	60	56	58	↓	↓		The Inpatient Response Rate was 47.7% for October 2014. See Exception Report 4. Please note that Patients with a 0 LOS are currently being included in the Inpatient data. Once this data can be collected separately they will be included in the A&E data. The target for FFT has been based on achieving the current top 25th Percentile score for acute trusts. NHS England has reported that FFT Scores should not be used to compare performance of individual Trusts, however the benchmark is still used for internal reporting.
	1*	Friends and Family Score - Outpatient	DB	CQIC		71	72	74	77	72	77	73	↑	↑		
	1	Friends and Family Score - A&E	DB	CQIC	68	52	58	60	63	58	63	55	↑	↑		The A&E Response Rate was 9.1% for October 2014. The target for FFT has been based on achieving the current top 25th Percentile score for acute trusts.
	1	Friends and Family Score - Maternity	DB	CQIC		63	68	69	65	67	65	67	↓	↓		The overall score has been collated from responses to the 4 maternity touch points. This covers the patients experience of antenatal, delivery and postnatal wards/community care.
	1	Friends and Family Score - Paediatric Inpatient	DB	CQIC		79	69	70	71	72	71	65	↓	↑		Includes scores from Sunshine Ward, Dolphin Ward and Neonates
	1	Number of Mixed Sex accommodation breaches	ST	CQIC	0	0	0	0	0	0	0	0	→	→		This is based on a national directive.
Safer Staffing	1	Day - Registered Midwives/Nurses Fill Rate	DB	CQIC			94.1%	95.1%	94.3%	95.1%	94.3%	95.7%	↓	↓		This is a new dataset.
	1	Day - Assistant Fill Rate	DB	CQIC			110.7%	107.8%	110.1%	109.3%	110.1%	108.1%	↑	↑		
	1	Night - Registered Midwives/Nurses Fill Rate	DB	CQIC			97.4%	96.8%	96.5%	97.3%	96.5%	97.5%	↓	↓		
	1	Night - Assistant Fill Rate	DB	CQIC			124.2%	115.2%	106.5%	118.7%	106.5%	113.0%	↓	↓		
	1	Overall Trust Fill Rate	DB	CQIC			101.0%	100.0%	99.2%	100.7%	99.2%	100.2%	↓	↓		
Maternity	1	Caesarean section rate	JW	CQIC	<=26%	27.5%	26.7%	28.9%	26.8%	27.5%	26.8%	28.5%	↓	↓		
	1	% women with a primary postpartum haemorrhage of 2000ml or more	JW	CQIC	<=1.0%	1.5%	1.1%	0.7%	0.4%	1.1%	0.4%	1.0%	↓	↓		
	1	Significant Perineal Trauma	JW	CQIC		3.3%	3.4%	2.0%		2.0%		2.5%		↓		Data reported 1 month in arrears as requires coding to be completed
	1	Perinatal Mortality Rate per 1000 births	JW	CQIC	<=3.7	2.1				6.6		6.7				Data from CHKS. Target is National Peer rate from CHKS Data will be reported quarterly.
	1	Number of Red Maternity Escalations	JW	CQIC	0	0.0%	0	0	0	0	0	0	→	→		

Key: 1* Quality Account Objective

Qualitative Summary - October 2014

National Patient Surveys

The Trust is participating in a number of national surveys at present and the progress with these is detailed below.

Paediatric Inpatient Survey - the field work for this survey is currently taking place and surveys have been sent out to the sample of parents
National Neonatal survey - this is an optional and the Trust has opted in to better understand the experience of parents using neonatal services. The field work of this is currently taking place.
A&E Survey - the CQC survey results will be published on 2nd December 2014. Picker are hosting an event on Tuesday 25th November with staff and patients to review the results received so far and priority actions in response to the feedback.
Cancer Survey - The Trust has received the quantitative analysis of the 2014 National Cancer Patient Experience Survey, and is awaiting the patient free text feedback. .The Trusts results are based upon the 175 patients who responded to the survey from the Trust. Whilst there has been progress, these results for the Trust demonstrate the need for us to have a more joined-up cancer system along the whole pathway of care; from diagnosis through to specialist treatment and ongoing care. This would allow patients to experience seamless care no matter where they are first diagnosed or treated. It has been noted that patients treated within the haematology pathway had particularly low scores for within the survey. It was noted that significant improvements were needed in the areas of staff giving an explanation of purpose of test(s), providing easy to understand written information about test sand being given complete explanation of test results in an understandable way. For other tumour groups the Trust was close to or above the national level for patients reporting their rating of care as either 'excellent'/'very good'.. Cancer Improvement Plan is in place already in the Trust and this will be supplemented in light of the cancer patient experience results.

The Trust has formally announced the appointment of the new Lead Cancer Nurse Manager to the Trust. and will commence work in February 2015. They will undertake a significant leadership role alongside the new Clinical Director for Cancer in improving the cancer patient experience across the Trust.

Quality Account Mid-Year progress report

Appended to the Clinical Quality Report this month (Appendix 1) is a 6 month progress report on the 9 Quality Account 2013/14 objectives. This was received by QAC on 29th October 2014.

Clinical Audit & Quality Improvement Projects

In December 2013 a quality improvement project was initiated to establish a formal Peripherally Inserted Central Catheter (PICC) service. The project was born from a NCEPOD assessment, interest from Consultant Anaesthetists and a Serious Incident which highlighted the need for a robust and well documented pathway. Initial discussions and a clinical audit indicated that lines needed to be replaced soon after insertion and that the procedure was not always coded correctly. Line insertions were also delayedtand the choice of lines did not follow a protocol

The need was estimated and the project group recommended that the service be implemented in two phases; first phase to implement a midline service and second phase to introduce the PICC line. The project has progressed well and included re-procurement of consumables, design and implementation of referral forms, patient information, guidelines and training sessions for Clinicians in Anaesthetics and General Surgery. Training in aftercare for the ward based nursing teams, ASPs and Infection Control nurses begins at the end of November 2014 and will run for several weeks. There are two midline lists per week with the first list undertaken on 30th June 2014. A clinical audit is underway but initial assessment of the service is that Clinicians are finding it easier to place the lines and there have been very few issues with lines blocking or needing replacement. It is estimated that the PICC line service will commence in early 2015.

Complaints

The Trust received 32 formal complaints in October 2014 compared to 40 in October 2013. Emergency Services received the highest amount of complaints accounting for 50% of the total, followed by Specialist Services (44%), Clinical Support Services and Trust (3% each). The most frequent complaint subject within the complaints that were received, related to care and treatment which accounted for 28%, followed by appointments (22%), communication (16%), diagnosis (9%), admission/discharge and procedure (6% each) of the total.

Reopened complaints

Seven complaints were reopened in October 2014, arising from complaints first received in April 2014 (1), June 2014 (1), July 2014 (4) and September 2014 (1)

The reasons for these complaints reopening were:
Further Questions – 4
Facts Challenged – 1
Facts Inaccurate - 1
Issues not responded to adequately - 1

Ombudsman Referrals

There was one complaint referred to the Ombudsman in October 2014.

Clinical Quality Report **Author: Alison Williams**

Exception Report 1: Pressure Ulcer Stage 3&4

In October 2014, a total of 6 patients were reported as having developed Trust acquired stage 2 pressure ulcers (1 x AAU, 1 x Blyth Ward, 1 x Hamble Ward and 1 x Kennet Ward, 1 x Cambridge Ward and 1 x ITU). 3 patients were identified with Trust acquired stage 3 pressure ulcers (1 x AAU, 1 x Hamble and 1 x Derwent Ward) and 2 patents were identified with stage 4 pressure ulcers (1 x Blyth Ward and 1 x Hamble Ward). This equates to 11 patients with Trust acquired pressure ulcers in October.

Hamble Ward identified 3 patients in October who acquired pressure ulcers (1 x stage 2, 1 x stage 3 and 1 x stage 4) on the nose whilst on BIPAP (Bi-level Positive Airway Pressure) therapy. Hamble have developed and implemented an action plan including hourly skin observation for patients on BIPAP therapy, ward based training and use of pressure redistributing dressing. Hamble Ward has a new Senior Sister who is being supported by Senior Practice Development staff. Since 12/10/2014, no other pressure ulcers have been reported from Hamble Ward.

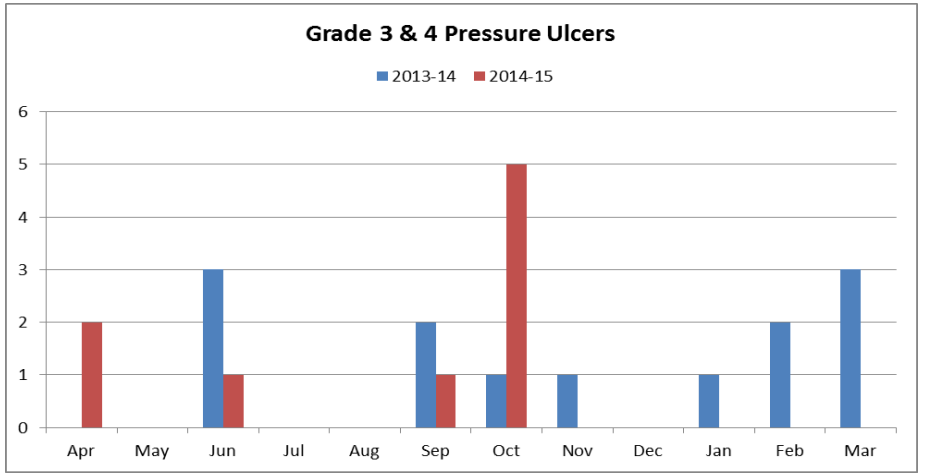
Blyth Ward identified 2 patients with Trust acquired pressure ulcers (1 x stage 2 and 1 x stage 4). Investigation of the patient with a stage 2 pressure ulcer showed that there was a lack of documentation regarding the deterioration from stage 1 to 2. It was also identified that there were inaccuracies with the risk assessment and delays in specialist referral. Actions include education and weekly audit of Waterlow and food charts. Serious incident investigation has commenced for the patient identified with a stage 4 pressure ulcer. Initial investigations suggest that this is an unavoidable pressure ulcer in a patient receiving palliative care.

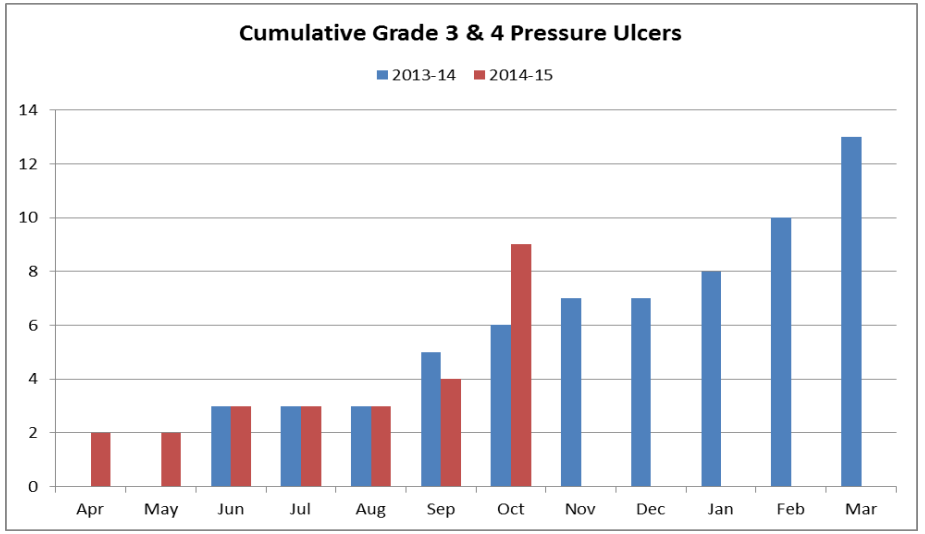
AAU identified 2 patients with Trust acquired pressure ulcers (1 x stage 2 and 1 x stage 3). Investigation for the patient with a stage 2 pressure ulcer showed incomplete and inaccurate risk assessment and a lack of evidence regarding regular skin checks. AAU are implementing ward based training regarding documentation and risk assessments. Serious Incident investigation has commenced for the patient with a stage 3 pressure ulcer. Initial investigations show that the skin damage was caused by pressure from bandaging.

Kennet ward identified a patient with a stage 2 pressure ulcer. Following investigation it was found that all appropriate strategies had been implemented and ulcer deemed unavoidable.

ITU identified a patient with a stage 2 pressure ulcer. Following investigation it was found that despite all appropriate measures being implemented they were unable to prevent skin breakdown. This was deemed unavoidable.

Early investigations show that of the 11 patients who developed Trust acquired pressure ulcers 2 were unavoidable. The tissue viability link nurse meeting in October focussed on the care of the skin of patients who are incontinent. Research shows that there is a close link between patients who are incontinent and the development of pressure ulcers. Incontinence audits have been commenced to identify the number of patients using incontinence products in the Trust as well as strategies to maintain patients' skin. Tissue Viability are looking at devices to offload pressure from heels as it has been acknowledged that there has been a high volume of pressure ulcers from this body site. Feedback of both of the audit and evaluation will be given via the PUMP group.





	Person Responsible	Date	Committee monitoring delivery
1. Serious Incident Report - AAU	Ward Sister	31/12/2014	Service line governance meeting
2. Serious Incident Report - Blyth Ward	Ward Sister	31/12/2014	Service line governance meeting
3. Serious Incident Report - Derwent Ward	Ward Sister	31/12/2014	Service line governance meeting
4. Serious Incident Report - Hamble Ward (stage 3)	Ward Sister	31/12/2014	Service line governance meeting
5. Serious Incident Report - Hamble Ward (stage 4)	Ward Sister	31/12/2014	Service line governance meeting
6. Monitoring and implementation of pressure area care in Paeds, Maternity and Neonatal Unit	Tissue Viability Nurse Specialist	31/12/2014	Service line governance meeting

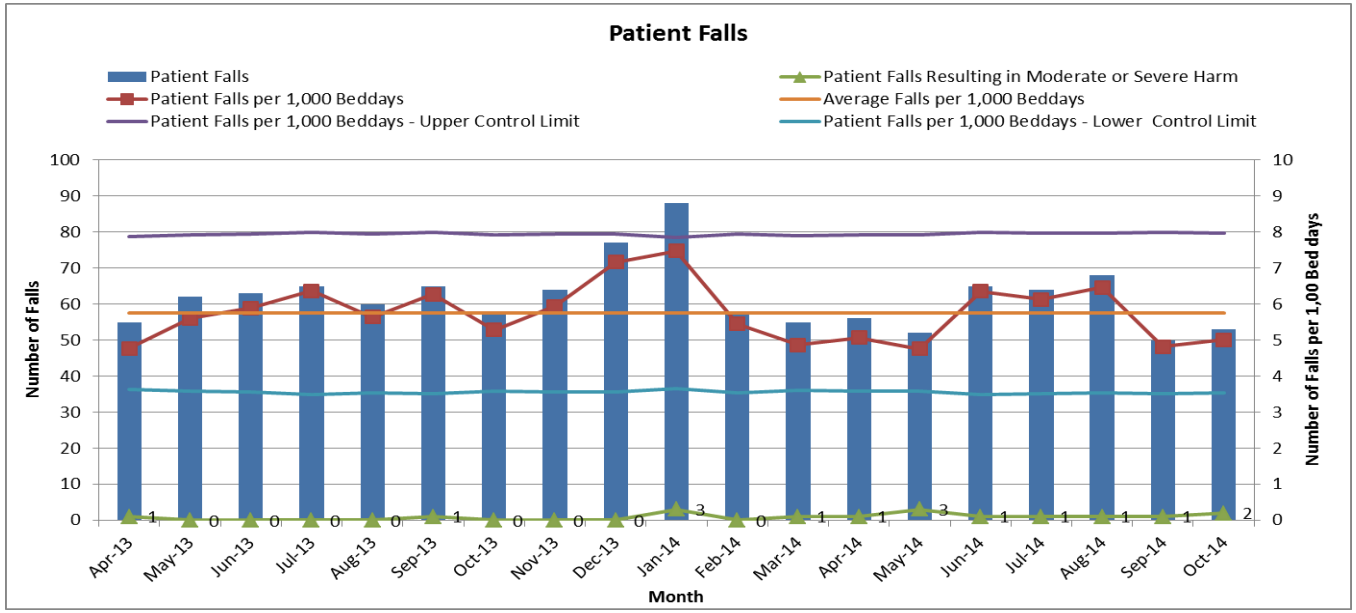
Clinical Quality Report **Author: Fergus Keegan**

Exception Report 2: Patient Safety Incident Falls

The falls rate for October is 5.0 falls per 1,000 bed days. This is a marginally higher figure than in the previous month, but September and October performance has been the two lowest rates for consecutive months in the last 18 months. The highest number of falls for October were on A&E and Bronte Ward (6 falls). Previously reported high rates in Alex and Astor Wards have reduced significantly to 1 per ward in the last month.

There have been two falls resulting in serious harm on Hardy and Kennet Wards. Both were unwitnessed falls in the toilet and resulted in a fractured neck of femur injury requiring surgery for the patients. These are being investigated as part of the serious incident process and will be reported in November. Canbury, Cambridge and Kennet Wards have continued to embed the SWARM pilot and have identified a 40% reduction in falls rate since implementation. Hardy Ward will commence this approach in the last week of November as part of the rollout of this approach to falls prevention. The nursing team have developed a Falls Prevention Checklist which is being introduced in four wards and has been picked up by other NHS QUEST Trusts to support their approach to falls prevention.

Work to change toilet seats to coloured ones has commenced.



	Person Responsible	Date	Committee monitoring delivery
1. Continue implementation of actions arising through Trust Falls Group	Medical Director	Ongoing	Trust Falls Group
2. Extend falls alarm provision for bathrooms to other wards	Chris Simms/Paul Kirkby	30/09/2014	Trust Falls Group
3. Replace signage and toilet seats in bathrooms on medical wards	Medical matrons and ward sisters on medical wards Chris Simms, Estates manager	30/05/2014	Trust Falls Group
4. Commence SWARM approach to falls prevention on Hardy Ward	Sarah Joseph, Matron	31/11/2014	Trust Falls Group
5. Implement falls prevention checklist on Cambridge, Canbury, Kennet, Hardy Wards	Sarah Joseph, Matron	30/09/2014	Trust Falls Group

Clinical Quality Report **Author: Clare Parker**

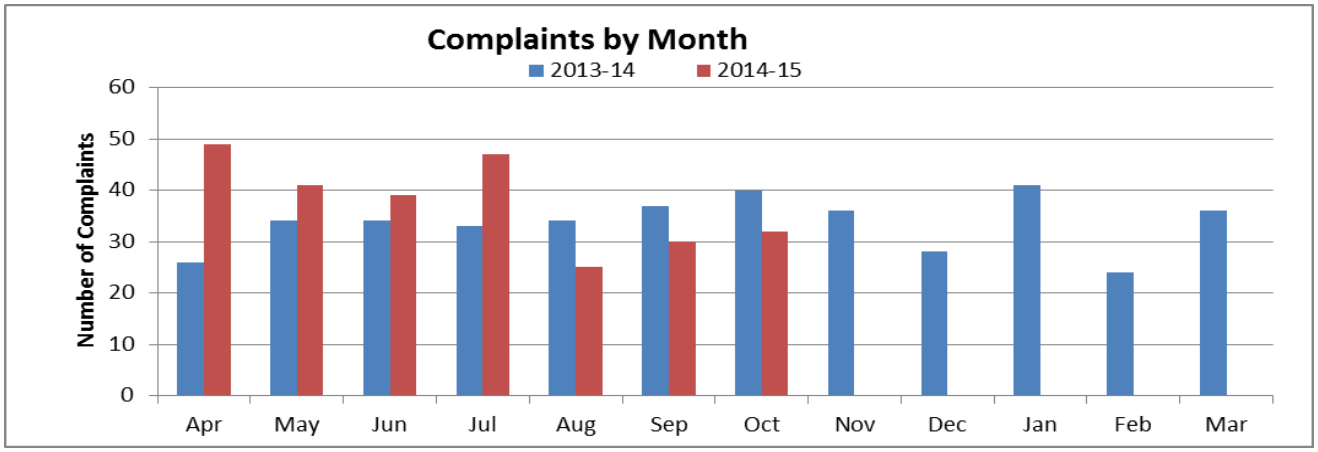
Exception Report 3: Complaints responded to within 25 working days

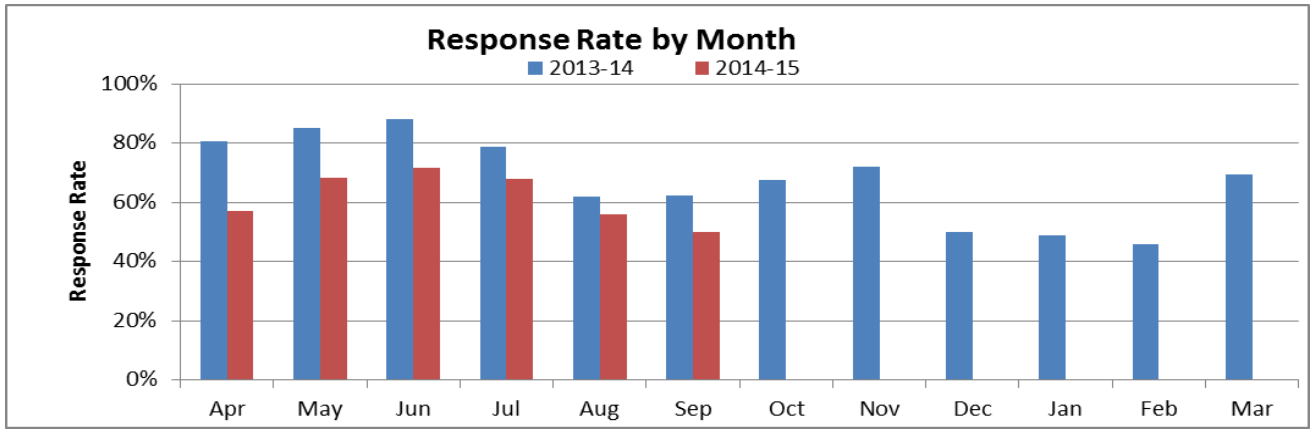
The response rate in September was 2014 was 50%, which remains below the 90% target and demonstrates a further reduction in performance.

The reasons for the delays in completing responses from complaints have been due to delays in obtaining the comments from the staff involved; complex cases have slowed down the process; and issues with service line internal distribution which has delayed investigations. In addition in specific places general management support to complaints has not been available consistently.

It is acknowledged that this has reached an unacceptable level of performance. Actions taken include the Chief Executive writing to the Trust in the weekly message regarding this, and to specific staff where complaints are outstanding. A weekly tracker is in place and is being provided to Executive & Divisional Directors to improve performance with service lines, and to ensure the outstanding complaints in the system are completed as a matter of urgency.

The Complaints Policy has now been updated to include the requirement of service line senior leaders to contact complainants by telephone at the point of making a complaint, so as to better understand the complaint.





	Person Responsible	Date	Committee monitoring delivery
1. Twice weekly review of complaints list in Emergency Care	Associate Directors	On-going	Executive Management Committee
2. Escalation of delays in receiving statements to relevant manager.	Associate Directors	On-going	Executive Management Committee
3. Weekly report of progress against for each complaint sent to Service lines, Divisional & Executive Directors	Head of Complaints, Claims & Litigation	On-going	Executive Management Committee
3. Roll out of new complaints process to all service lines	Head of Complaints, Claims & Litigation	01/11/2014	Executive Management Committee
4. Implement changes to the complaints policy	Head of Complaints, Claims & Litigation	30/11/2014	Executive Management Committee

Clinical Quality Report **Author: Fergus Keegan**

Exception Report 4: Friends and Family Test Inpatient

The inpatient FFT response rate for October 2014 was 47.7%. This is an improvement over the previous month and remains in excess of the required rate of 40%. Our overall inpatient FFT score for October was 56, the September score was 57.

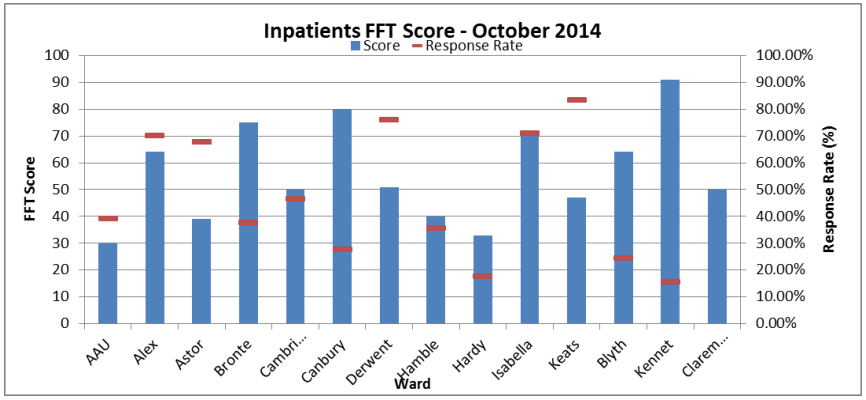
Following last months very low score on Hamble Ward, the new nursing leadership team have improved the response rates and will continue to focus on this in the coming month. Overall, 85% of patients gave a positive response for the month on Hamble Ward. Kennet Ward had the highest score for the month at 91.

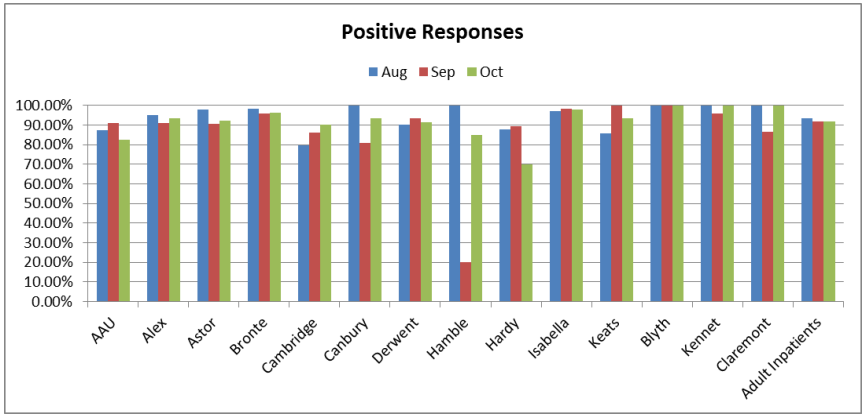
All Surgery and Orthopaedic wards have improved their scores compared with the previous month and the sisters and charge nurses continue to implement local action plans based on the analysis of the FFT each quarter, and this is being reported and monitored via the Patient Experience Committee.

Further to the update in September Trust Board, progress has been made in making improvements to the food offered to in-patients. This is in response to patient feedback through the FFT which shows this as the highest area comments for improvement are made about. The Trust has now approved new menus which will be introduced during the week of 19th January 2015. There will be an improved selection of choice for all meals to include; an egg option, fruit and yoghurt for breakfast with the addition of sausages and bacon at the weekend, a light meal option and main course option that will better meet the requirements of the patients. Included in this will be homemade soup and new options of food in general. Wards will use this as an opportunity to fix the main meal to be either at lunchtime or in the evening depending on that that aligns with their patient population's needs and choice. In addition to this a new 'plated' service will be introduced into Maternity that will be able to offer greater flexibility for the women using this service. A programme of menu familiarisation sessions will be held with key Trust and ISS staff in the weeks before the introduction. This progress is in addition to the changes already made such as the warm fresh cake in the afternoon, additional ward based snacks and finger foods for patients most at risk.

The NHS England review of the patient Friends and Family Test (FFT), published in July 2014, recommended a move away from the Net Promoter Score (NPS) and the introduction of a simpler scoring system in order to increase the relevance of the FFT data for NHS staff, patients and members of the public. Based on the findings of the review, NHS England is now calculating and presenting the FFT results as a percentage of respondents who would/would not recommend the service to their friends and family. NHS Choices is undertaking ongoing user testing of the presentation of the FFT results on the NHS Choices website. Further details will be provided at a later date, following the completion of the user testing. The Trust score for October was 92% of patients would recommend the Trust, based on 568 responses. The Trust is considering changing how it presents its performance in the Clinical Quality Report going forward in order to come into line with how this measure is reported nationally. A further analysis of how the Trust compares to other acute Trusts is underway in view of percentage scores and will be reported once completed.

The Trust has appointed a replacement Patient Experience Quality Improvement Lead and will commence in post in early December.





Actions	Person Responsible	Date	Committee monitoring delivery
1. Introduce new menus for patients	Director of Estates and Facilities	19/01/2015	Nutrition Steering Group
2. Implement Food improvement plan	Director of Estates and Facilities	31/12/2014	Patient Experience Committee
3. Fully implement action plan for improving inpatient experience	Director of Nursing & Patient Experience	31/03/2015	Patient Experience Committee

Clinical Quality Report - Action Log

Action Number	Date	KPI	Action	Owner	Action by	Status
1	Feb-13	C diff	2. Complete implementation of t the C. diff action plan in response to the peer review visit.	DB	31/03/2014	
2	Dec-13	MSSA	3. Complete intravenous catheter Quality Improvement Project	JW	30/10/2014	
3	May-14	Falls	4. Replace signage and toilet seats in bathrooms on medical wards	DB	30/05/2014	
4	Oct-14	Falls	1. Continue implementation of actions arising through Trust Falls Group	DB	Ongoing	
5	Oct-14	Falls	2. Extend falls alarm provision for bathrooms to other wards	DB	30/09/2014	
6	Oct-14	Falls	3. Replace signage and toilet seats in bathrooms on medical wards	DB	30/05/2014	
7	Oct-14	Falls	4. Commence SWARM approach to falls prevention on Hardy Ward	DB	31/11/2014	
8	Oct-14	Falls	5. Implement falls prevention checklist on Cambridge, Canbury, Kennet, Hardy Wards	DB	30/09/2014	
9	Jun-14	Inpatient FFT	2. Implement Food improvement plan	DB	31/12/2014	
10	Jun-14	Inpatient FFT	4. Fully implement action plan for improving inpatient experience	DB	31/03/2015	
11	Sep-14	Inpatient FFT	2. Implement Food improvement plan	DB	31/12/2014	
12	Sep-14	Inpatient FFT	3. Fully implement action plan for improving inpatient experience	DB	31/03/2015	
13	Oct-14	Inpatient FFT	1. Introduce new menus for patients	DB	19/01/2015	
14	Aug-14	Complaints	1. Twice weekly review of complaints list in Emergency Care	DB	On-going	
15	Aug-14	Complaints	2. Escalation of delays in receiving statements to relevant manager.	DB	On-going	
16	Oct-14	Complaints	3. Weekly report of progress against for each complaint sent to Service lines, Divisional & Executive Directors	DB	On-going	
17	Oct-14	Complaints	3. Roll out of new complaints process to all service lines	DB	On-going	
18	Oct-14	Complaints	4. Implement changes to the complaints policy	DB	On-going	
19	Oct-14	Pressure Ulcer Stage 3	1. Serious Incident Report - AAU	DB	31/12/2014	
20	Oct-14	Pressure Ulcer Stage 3	2. Serious Incident Report - Blyth Ward	DB	31/12/2014	
21	Oct-14	Pressure Ulcer Stage 3	3. Serious Incident Report - Derwent Ward	DB	31/12/2014	
22	Oct-14	Pressure Ulcer Stage 3	4. Serious Incident Report - Hamble Ward (stage 3)	DB	31/12/2014	
23	Oct-14	Pressure Ulcer Stage 3	5. Serious Incident Report - Hamble Ward (stage 4)	DB	31/12/2014	

Clinical Quality Report - Action Log

Action Number	Date	KPI	Action	Owner	Action by	Status
24	Oct-14	Pressure Ulcer Stage 3	6. Monitoring and implementation of pressure area care in Paeds, Maternity and Neonatal Unit	DB	31/12/2014	

Clinical Quality Report - Glossary

Strategic Objectives	
1	To Deliver Quality Patient Centred Healthcare Services with an Excellent Reputation
2	To Deliver Care by Competent and Caring Staff Working in Effective and Supportive Teams who Feel Valued by the Trust
3	To Work with Partners to Consolidate and Strengthen the Healthcare we Deliver Together to our Local Community
4	To Work with GPs and Other Providers to Support the Delivery of More Care in Primary and Community Settings
5	To Deliver Well Managed, Quality Services Which are Value for Money for the Tax Payer

KPI definitions

KPI	KPI Name	KPI Definition	Source of Benchmark/target	Exception Report Criteria	Data Source	RAG Colour	RAG_Score
1	Number of patients with hospital acquired pressure ulcers (Grade 3-4)	Number of patients with a newly hospital acquired pressure ulcers (Grade 3-4)	Target set as 10% reduction on 2013/14 outturn. Target is to have =<14.4 cases in 2014/15	Year to date performance is red	Data Source: Ulysses	Green Red	Full year < = 14.4 Full year > 14.4
2	Number of patients with hospital acquired pressure ulcers (Grade 3&4) per 1000 beddays	Number of patients with a newly hospital acquired pressure ulcers (Grade 3-4) divided by number of General and Acute occupied beddays	Target is calculated based on the reduction of actual numbers as set out in the Trust's Corporate Objectives	Year to date performance is red	Data Source: Ulysses and internal bedstate summary	Green Red	<= 0.06 >0.06
3	Number of patients with hospital acquired pressure ulcers (Grade 2)	Number of patients with hospital acquired pressure ulcers (Grade 2)	Corporate objectives set target as reduction of 10% on 2013/14 Outturn but this would be higher than the 2013/14 target so keeping 2013/14 target	Year to date performance is red	Data Source: Ulysses	Green Red	Full year <= 36 Full year > 36
4	Number of patients with hospital acquired pressure ulcers (Grade 2) per 1000 beddays	Number of patients with a newly hospital acquired pressure ulcers (Grade 2) divided by number of General and Acute occupied beddays	Target is calculated based on the reduction of actual numbers as set out in the Trust's Corporate Objectives	Year to date performance is red	Data Source: Ulysses and internal bedstate summary	Green Red	<= 0.5 > 0.5
5	Number of Patient Safety Incident (PSI) Falls	Number of falls reported on Ulysses		An exception report will be generated each month there is an occurrence.	Data Source: Ulysses	Green Red	<=51 >51
6	Number of Patient Safety Incident Falls where moderate or severe harm occurred	Includes falls resulting in moderate harm to severe harm/death	Target is a reduction of 15% on last year's outturn	Exception reports to be produced when severe fall has been reported.	Data Source: Ulysses	Green Red	
7	Number of Patient Safety Incident Falls per 1000 G&A beddays		Benchmark against Trust performance - 20% reduction on year end rate		Data Source: Ulysses	Green Red	<=4.7 >4.7
8	MRSA Bacteraemias - Post 48hour (Hospital Acquired)	Number of hospital acquired MRSA bacteraemia (admission to positive test >48 hours)	Target is based on Department of Health set objective (maximum of 1) and Monitor Compliance Framework (de minimis of 6 cases).	An exception report will be generated each month there is an occurrence.	Data Source: Infection Control team - as reported to HPA	Green Amber Red	Full year =< 1 Full year > 1 and =< 6 Full year > 6
9	Clostridium difficile Infections - Post 72hours (Hospital Acquired)	Number of hospital acquired C diff bacteraemia (admission to positive test >72 hours)	Target set by NHS England. Full year target is <= 24 cases. This has been profiled evenly over the year.	Year to date performance is red	Data Source: Infection Control team - as reported to HPA	Green Red	Full year < =24 Full year > 24
10	MSSA Bacteraemias - Post 48hour (Hospital Acquired)	Number of hospital acquired MSSA bacteraemia (admission to positive test >48 hours)	Target is based on Department of Health set objective (maximum of 1) and Monitor Compliance Framework (de minimis of 6 cases).	An exception report will be generated each month there is an occurrence.	Data Source: Infection Control team - as reported to HPA	Green Amber Red	Full year =< 1 Full year > 1 and =< 6 Full year > 6
11	E.coli Bloodstream Infections (Hospital Acquired)	E.coli Bloodstream Infections (Hospital Acquired). Note HPA have not defined 'Hospital Acquired' so using post 72 hrs as with C diff	Target based on last year's outturn and set at <24 for full year, profiled evenly across the year.	Quarterly when year to date performance is red	Data Source: Infection Control team - as reported to HPA	Green Red	<=2 >2
12	Nutrition - compliance with MUST assessment	Compliance with the Malnutrition Universal Screening Tool (MUST); a five step screening tool to identify adults who are malnourished, at risk of malnutrition or obese		Year to date performance is red	Data Source: Clinical Audit	Green Amber Red	>=85% >=70% and <85% <70%

KPI definitions							
KPI	KPI Name	KPI Definition	Source of Benchmark/target	Exception Report Criteria	Data Source	RAG Colour	RAG_Score
13	Completed Patient Observations		Target is Locally set	Year to date performance is red	Data Source: Clinical Audit	Green Amber Red	> =97% < 97% and > 94% < 94%
14	Medication Incidents	The number of incidents which actually caused harm or had the potential to cause harm involving an error in administrating, prescribing, preparing, dispensing or monitoring medication.	No target set. Reporting of incidents is important and should not be discouraged by setting a ceiling target		Data Source: Ulysses		
15	% Medication Incidents Where Moderate or Severe Harm Occurred	Numerator: Medication Incidents Where Moderate or Severe Harm Occurred Denominator: Total Number of Medication Incidents	Set following Deep Dive into medication Incidents	Exception report required whenever red in month	Data Source: Ulysses		
16	Number of Serious Untoward Incidents	Total number of serious untoward incidents reported to the Risk Management Team	No target set. Reporting of incidents is important and should not be discouraged by setting a ceiling target		Data Source: Ulysses		
17	Number of Never Events	"Never events" are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place.		Exception reports will not be produced for never events but instead the comment should reference the SI report.		Green Red	=0 >0
18	% Harm Free Care	% of patients audited on Patient Safety Thermometer where no harm recorded.	tbc based on CQUIN	Year to date performance is red	Data Source: Patient Safety Thermometer		
19	In-Hospital Summary Hospital-level Mortality Indicator 2013	SHMI calculated where observed deaths only include deaths in hospital.	National Peer Apr 12 to Mar 13	Exception Report if above target for month	Data Source: CHKS		
20	Unadjusted Mortality Rate	Number of Deaths / Number of discharges (excludes Well Babies)			SSRS Discharge Report		
21	% Emergency Readmissions following elective admission - 30 days						
22	% Emergency Readmissions following emergency admission - 30 days	The percentage of emergency admissions that were subsequently re-admitted to the Trust (via A&E) within 30 days of discharge					
23	% Emergency Readmissions following all admissions - 30 days		Thresholds are based on national upper quartile performance, CHKS analysis for Apr 2013 - Feb 2014.	An exception report will be generated on red performance at YTD.		Green Red	<= 5.7 > 5.7
24	Prevention of hospital acquired VTE - % patients risk assessed	Percentage of admitted patients receiving a VTE risk assessment.	Threshold from NHS Performance Framework 2013/14			Green Amber Red	>= 95% < 95% and > 90% < 90%
25	Hand Hygiene	Number of times hands were washed / number of observed opportunities hand should have been washed. Shown as a percentage.	Target is locally set.	Year to date performance is red	Data Source: Infection Control team - Monthly Audit	Green Amber Red	>= 95% >= 90% and < 95% < 90%
26	% of patients with a fractured neck of femur that went to theatre within 24 hours for repair of the fractured femur		Data benchmarked against CHKS national peer top 25th percentile performance for 2012/13 - to be reviewed. Uses National Hip Database Audit data for targer		Data Source: CHKS		
27	Open Incidents - % of Managers Reports Completed within 10 days				Data Source: KHT Datix/Ulysses		
28	Number of Complaints received this month	The number of complaints received during the reporting month	No target set		Data Source: Ulysses		

KPI definitions							
KPI	KPI Name	KPI Definition	Source of Benchmark/target	Exception Report Criteria	Data Source	RAG Colour	RAG_Score
29	Number of Complaints reopened this month	The number of complaints that were re-opened during the reporting month	No Target set		Data Source: Ulysses		
30	Number of Complaints referred to ombudsman this month	Total number of complaints received that were referred to the Ombudsman	No Target set		Data Source: Ulysses		
31	% Complaints responded to within 25 working days	Percentage of the received complaints which were responded to within the 25 day deadline. Data are reported 1 month in arrears to allow 25 day deadline.	Target Locally Set	An exception report will be generated when monthly performance red.	Data Source: Ulysses	Green Amber Red	>=90% <90% and >80% <80%
32	Friends and Family Score - Trust	The Friends and Family Test is a simple, comparable test. The Friends and Family Test (FFT) score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent.			Data Source: FFT - RaTE		
33	Friends and Family Score - Inpatient	The Friends and Family Test is a simple, comparable test. The Friends and Family Test (FFT) score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent.	National data - top 20%		Data Source: FFT - RaTE	Green Amber Red	>=78 <78 and >72 <72
34	Friends and Family Score - Outpatient	The Friends and Family Test is a simple, comparable test. The Friends and Family Test (FFT) score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent.	National data - top 20%		Data Source: FFT - RaTE		
35	Friends and Family Score - A&E	The Friends and Family Test is a simple, comparable test. The Friends and Family Test (FFT) score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent.	National data - top 20%		Data Source: FFT - RaTE	Green Amber Red	>=68 <68 and >54 <54
36	Friends and Family Score - Maternity	The Friends and Family Test is a simple, comparable test. The Friends and Family Test (FFT) score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent.	National data - top 20%		Data Source: FFT - RaTE	Green Amber Red	TBC
37	Friends and Family Score - Paediatric Inpatient	The Friends and Family Test is a simple, comparable test. The Friends and Family Test (FFT) score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent.	National data - top 20%		Data Source: FFT - RaTE	Green Amber Red	TBC
38	Number of Mixed Sex Accommodation breaches	Number of breaches of mixed sex accommodation	NHS 2011/12 Operating Framework	An exception report will be generated for any mixed sex breach		Green Red	=0 >0
39	Day - Registered Midwives/Nurses Fill Rate	Day Staffing Rate - Percentage of actual hours worked by Registered Midwives/Nurses compared to the planned hours.	TBC	TBC	Data Source: Local staff survey collection	Green Red	TBC
40	Day - Assisstant Fill Rate	Day Staffing Rate - Percentage of actual hours worked by Assistants compared to the planned hours.	TBC	TBC	Data Source: Local staff survey collection	Green Red	TBC
41	Night - Registered Midwives/Nurses Fill Rate	Night Staffing Rate - Percentage of actual hours worked by Registered Midwives/Nurses compared to the planned hours.	TBC	TBC	Data Source: Local staff survey collection	Green Red	TBC
42	Night - Assisstant Fill Rate	Night Staffing Rate - Percentage of actual hours worked by Assistants compared to the planned hours.	TBC	TBC	Data Source: Local staff survey collection	Green Red	TBC

KPI definitions							
KPI	KPI Name	KPI Definition	Source of Benchmark/target	Exception Report Criteria	Data Source	RAG Colour	RAG_Score
43	Overall Trust Fill Rate	Overall Staffing Rate - Total hours worked as a percentage of the planned hours	TBC	TBC	Data Source: Local staff survey collection	Green Red	TBC
44	Caesarean section rate	The percentage of deliveries performed as a C section Numerator: Number of C-section deliveries Denominator: Total number of deliveries	CHKS - SHA London Peer 75th Percentile	Exception report if latest 3 months are red	CRS	Green Amber Red	<= 26% 26% - 29% >= 29%
45	% women with a primary postpartum haemorrhage of 2500ml or more	Numerator: The number of women with a primary post partum haemorrhage of 2000ml or more Denominator: The total number of deliveries	HCC Review of Maternity Services 2008 median of 1.9 per 1,000 births ranging from 0.1 per 1,000 to 8 per 1,000.	Exception report if latest 3 months are red	CRS	Green Red	< =1% > 1.5%
46	Significant Perineal Trauma	The percentage of women with 3rd or 4th degree tears					
47	Perinatal Mortality Rate per 1000 births	The rate per 1000 births Numerator: The number of stillbirths + neonatal deaths Denominator: Total number of births	Last Year's Performance = 3.7 2011 National Data = 7.5	When Quarterly performance is red	CRS		
48	Number of Red Maternity Escalations						

Clinical Quality Report - Action Log

Action Number	Date	KPI	Action	Owner	Action by	Status
1	20/06/2012	Pressure Ulcers G3&4	1. Meeting with all Cambridge Ward registered nurses to ensure all staff are aware of their accountability to patients, NMC and to the Trust.	JP	Completed	
2	20/06/2012	Pressure Ulcers G3&4	2. Implement process of identifying patients at risk of developing a pressure ulcer on the Cambridge Ward RAG board (black dot)	JP	Completed	
3	20/06/2012	Pressure Ulcers G3&4	3. Cambridge Ward Sister to conduct daily patient/relatives ward round	JP	Completed	
4	20/06/2012	Pressure Ulcers G3&4	4. Reintroduce and embed two hourly rounding on Cambridge Ward	JP	Completed	
6	20/06/2012	Pressure Ulcers G3&4	5. Develop and embed a process to escalate skin integrity deterioration to the nurse in charge	JP	Completed	
7	20/06/2012	Pressure Ulcers G3&4	6. UndertAle training on waterlow assessment and Pressure ulcer management for all registered nurses on Cambridge and Astor.	JP	Completed	
8	20/06/2012	Pressure Ulcers G3&4	7. Presentation of Cambridge/ Astor Ward action plan outcomes	JP	Completed	
9	25/07/2012	Pressure Ulcers G3&4	8. Complete Serious Incident investigations, identifying actions.	JP	Completed	
10	25/07/2012	Pressure Ulcers G3&4	9. Present results to Director of Nursing and Divisional Risk Boards	JP	Completed	
11	06/09/2012	Pressure Ulcers G3&4	10. Hamble Ward to complete Serious Incident investigations, identifying actions.	JP	Completed	
13	06/09/2012	Pressure Ulcers G3&4	12. Claremont Ward to complete Serious Incident investigations, identifying actions.	JP	Completed	
14	06/09/2012	Pressure Ulcers G3&4	13. Present results from Claremont Ward to EMC	JP	Completed	
15	26/09/2012	Pressure Ulcers G3&4	14. Implementation of the Pressure Ulcer Care Bundle	JP	Completed	
17	26/09/2012	Pressure Ulcers G3&4	16. Quality Assurance Committee to conduct a “deep dive” review of pressure area care	JP	Completed	
18	06/09/2012	C diff	1. Progress Clostridium difficile action plan and monitor implementation via Nursing Quality Assurance Framework; Frontline Focus Friday, Infection Control Group and Divisional Risk Board Meetings	JP	Completed	
19	06/09/2012	C diff	2. Establish an antibiotic stewardship task and finish group	JP	Completed	
21	26/09/2012	C diff	4. Ribotyping [identifies the strain(s) of Clostridium difficile causing the infection] for all Hardy ward CDT patients (to ascertain if cross-infection has occurred)	JP	Completed	
22	26/09/2012	C diff	5. C. difficile RCA template revised to capture information on patient placement and other colonised/ infected patients on same ward	JP	Completed	
29	20/06/2012	Patient Observations	1. Communication of performance to senior nurses	JP	Completed	
ıation scree	20/06/2012	Patient Observations	2. Ward Sister to conduct daily patient/ relatives ward round	JP	Completed	
31	20/06/2012	Patient Observations	3. UndertAle monthly documentation audit on ward to identify where any actions to improve standards are required	JP	Completed	
32	20/06/2012	Patient Observations	4. Attendance at Acute Response Group	JP	Completed	
33	20/06/2012	Patient Observations	5. Monitoring of training plan and remedial action where needed	JP	Completed	
35	25/07/2012	Patient Observations	7. Head of Nursing to meet with ward manager to agree improvement plan for Hamble/ Kennet and AAU	JP	Completed	

Clinical Quality Report - Action Log

Action Number	Date	KPI	Action	Owner	Action by	Status
42	20/06/2012	Percentage of Normal Deliveries	3. A water birth study day was undertAlen in July to encourage uptAle of waterbirth and use of Malden suite and home birth	JW	Completed	
48	25/07/2012	NPS	2. Develop team and Divisional patient experience action plans to include improvement actions based on patient feedback in the NPS survey.	JP	Completed	
49	25/07/2012	NPS	3. Review the target response rates to ensure they are appropriate.	JP	Completed	
1	06/09/2012	Pressure Ulcers G3&4	1. Present results from Hamble Ward to EMC	JP	19/09/2012	
2	26/09/2012	Pressure Ulcers G3&4	2. Executive Team Department/ Ward visits to include a focus on pressure area care	JP	01/10/2012	
6	26/09/2012	C diff	1. Hardy ward Clostridium difficile action plan devised and implemented (hand hygiene awareness; weekly hand hygiene audits; deep clean throughout ward; equipment cleaning & think clean afternoon.)	JP	24/10/2012	
7	18/10/2012	C diff	2. A task and finish group chaired by the DON/DIPC has been set up to monitor progress with the C. difficile action plan, RCA summary, exception report and isolation / hand hygiene audit results	JP	Completed	
8	18/10/2012	C diff	3. Carry out a deep clean on Hardy ward	JP	Completed	
10	18/10/2012	C diff	5. Carry out an point prevalence isolation audit	JP	Completed	
11	18/10/2012	C diff	6. Information sheet on C. diff given out to the wards - to be read and signed by all nursing staff.	JP	Completed	
12	18/10/2012	C diff	7.When patients are GDH positive but toxin negative (colonised but not infected with C diff) medical staff will be notified by a Microbiology Consultant, in order to ensure optimal management.	JP	Completed	
15	20/06/2012	Medication Incidents	1. Assessments for all F1 doctors to be completed before end of September each year and arrangements for prescribing assessments to be confirmed	JW	Completed	
16	20/06/2012	Medication Incidents	3. Include responsibility for reporting medication errors in Junior doctor induction	JW	Completed	
17	20/06/2012	Medication Incidents	4. Further work to be undertAlen on drug administration through Frontline Focus Friday	JW	Completed	
19	20/06/2012	Medication Incidents	6. Produce comprehensive reports with greater granularity and analysis drug incident data to Medicine Safety Group, Patient Safety Committee and Divisional Risk Boards	JW	Completed	
20	25/07/2012	Never Event	1. Grade 2 Investigation	JW	Completed	
25	26/09/2012	Complaints	Consolidate the timings in the response process to reduce the initial response time available and increase the available review time	ST	Completed	
26	18/10/2012	Complaints	1. Head of Nursing (Surgery) has responsibility for coordinating responding to complaints in a timely fashion	ST	Completed	
28	20/06/2012	Percentage of Normal Deliveries	1. A Consultant midwife led clinic was established in Jan 2012 to encourage woman who have had a previous traumatic experience, requesting an elective C section, to have a normal delivery.	JW	Completed	
29	20/06/2012	Percentage of Normal Deliveries	2. An action plan has been developed to support increase in deliveries on the Midwife Led Unit.	JW	Completed	
30	20/06/2012	Percentage of Normal Deliveries	3. A water birth study day was undertAlen in July to encourage uptAle of waterbirth and use of Malden suite and home birth	JW	Completed	

Clinical Quality Report - Action Log

Action Number	Date	KPI	Action	Owner	Action by	Status
34	18/10/2012	Percentage of Normal Deliveries	4. A weekly normal birth forum has been introduced by the consultant midwife as part of the action plan,to review and disseminate learning for midwives. It is antispated that this will help to increase the number of women who go on to have a normal birth.	JW	Completed	
35	20/06/2012	PPH	1. Audit all PPHs over 2litres between april 2012- June 2012.	JW	Completed	
36	20/06/2012	PPH	2. UndertAle an audit of small volume PPH	JW	Completed	
37	27/06/2012	PPH	3. Agree recommendations and actions	JW	Completed	
38	28/06/2012	Still Birth	1. Review each still birth to identify any contributing factors.	JW	Completed	
1	18/10/2012	Pressure Ulcers G3&4	3. Weekly audit on Blyth Ward of the Pressure Ulcer Care Bundle	JP	Completed	
2	18/10/2012	Pressure Ulcers G3&4	4. Ward Sister supervision of care using new handover checklist	JP	Completed	
3	18/10/2012	Pressure Ulcers G3&4	5. Serious incident investigation	JP	Completed	
4	18/10/2012	C diff	1. Hardy ward action plan to be tAlen to Divisional Risk Board meeting	JP	Completed	
5	18/10/2012	C diff	2. Executive Team walkabouts to focus on isolation	JP	Completed	
6	18/10/2012	C diff	3. Weekly hand hygiene audits will occur in all areas where scores are low until improvement is demonstrated (Bronte, A&E, Hamble, Hardy, Keats, Cambridge, Isabella, Delivery Suite, Radiology)	JP	Completed	
9	30/11/2012	C diff	6. Additional audits to be undertAlen - pilot Hardy ward (isolation audits)	JP	Completed	
10	01/12/2012	C diff	7. HCAI Peer review	JP	Completed	
13	25/07/2012	Patient Observations	6. Revised ward handover procedures (to include SBAR) in Medical Wards to aid (Hamble outstanding)	JP	Completed	
14	20/06/2012	Complaints	Complaints team will continue to chase the outstanding information.	ST	Completed	
15	20/06/2012	Complaints	Weekly Chief Operating Officer (COO) meeting with DMs tracks complaints performance	ST	Completed	
16	20/06/2012	Complaints	Include a standing item regarding complaints on Divisional Risk Board	ST	Completed	
22	25/07/2012	Open Incidents	1. Divisions to focus on timely return of the Managers Report in accordance with the policy and to monitor this monthly within the Divisional Risk Boards	ST	Completed	
23	25/07/2012	Open Incidents	2. The Divisional Risk Managers are to ensure prompt inputting of incidents and sending weekly summaries of all incidents reported by Area to the relevant Manager	ST	Completed	
27	18/10/2012	Falls	2. Review training for new staff to the department to ensure a standardised approach.	JW	Completed	
3	28/11/2012	C diff	3. Audit of stool charts, laxative use, PPI prescriptions, antibiotic use on Hardy ward.	JP	28/11/2012	
4	19/12/2012	C diff	4. Chlorclean to be used for routine daily cleaning in medicine, ITU & Sunshine	JP	30/11/2012	
5	19/12/2012	C diff	3. Use of stool charts, laxative use, rapid isolation of patients with diarrhoea and collection of stool samples discussed at ICLP meeting and FFF	JP	07/12/2012	
6	19/12/2012	C diff	4. Monthly isolation audits in medicine	JP	Ongoing	
7	19/12/2012	C diff	5. Appropriate collection of stool samples to be raised with nursing & medical staff	JP	10/12/2012	
1	28/11/2012	C diff	1. Antibiotic stewardship group to be set up, twice weekly ward rounds, antibiotic awareness day (19.11.12)	JP	01/12/2012	

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Action Number	Date	KPI	Action	Owner	Action by	Status
2	28/11/2012	C diff	2. Augmentin audit and audit of 48 hour antibiotic review	JP	01/01/2013	
3	30/01/2013	C diff	3. Time to isolate audit (process in place, tAIen through EMC and FFF)	JP	31/01/2013	
7	30/01/2013	C diff	7. Equipment cleaning audit implemented	JP	10/12/2012	
10	19/12/2012	Pressure Ulcers	2.Matron to be based on ward to support development of ward sister and team	JP	Commenced Nov 2013	
11	19/12/2012	Pressure Ulcers	3. Serious incident investigation	JP	01/02/2013	
14	19/12/2013	Never Event	1. Grade 2 investigation	JW	17/12/2013	
15	18/10/2012	Complaints	1. Follow up with individuals who do not reply in a timely way	ST	30/11/2012	
16	19/12/2012	Complaints	2. Chief Operating Officer to investigate the causes of the poor performance	ST	Completed	
18	18/10/2012	Percentage of Normal Deliveries	1. The VBAC clinic is now established and uptAIe is increasing, outcomes are being monitored and will be presented at Clinical Governance.	JW	31/12/2012	
24	19/12/2012	Percentage of Normal Deliveries	7. A weekly normal birth forum has been introduced by the consultant midwife as part of the action plan, to review and disseminate learning for midwives. It is anticipated that this will help to increase the number of women who go on to have a normal birth.	JW	Forum Established	
25	25/07/2012	NPS	1. Completion of the Outpatient Redesign project, for main outpatient areas. This involves mapping and improving the patient flow through the system. 2 year programme on track	JP	Completed	
28	18/10/2012	Falls	1. Validation of PSI Falls incidents with Falls Lead for June and July data. Following this a validation of data from April to Present to ensure correct definition of NRLS is used. A look back exercise of PSI incidents for 2011 to review to validate falls data.	JW	Completed	
34	28/11/2012	Never Event	Grade 2 Investigation	JW	18/03/2013	
35	28/11/2012	C Section	1. Audit of Robson group 1 Caesarean section. Singleton Cephalic presentation >37 weeks spontaneous labour with presentation of findings at Clinical governance meeting.	JW	01/01/2013	
36	28/11/2012	C Section	2. CS rate Discussion at consultant O&G 'away day	JW	23/11/2012	
39	30/01/2013	VTE	1. Highlight poor performance to Divisional Directors.	JW	Completed	
12	20/02/2013	Pressure Ulcers	3. New band 7 Charge Nurse appointed to Blyth Ward	DB	01/01/2013	
16	18/10/2012	Percentage of Normal Deliveries	3. A Consultant midwife led clinic was established in Jan 2012 to encourage woman who have had a previous traumatic experience, requesting an elective C section, to have a normal delivery. Maternal request CS remains a challenge and alternative pathways/management are being explored with Obstetric team.	JW	31/12/2012	
20	19/12/2012	Percentage of Normal Deliveries	7. A weekly normal birth forum has been introduced by the consultant midwife as part of the action plan, to review and disseminate learning for midwives. It is anticipated that this will help to increase the number of women who go on to have a normal birth.	JW	Ongoing	
24	18/10/2012	Falls	2. QA process to be implemented for all incidents	JW	31/10/2012	
25	19/12/2012	Falls	3. Continue Falls audit and report to the Patient Safety Committee	JW	18/02/2013	
26	19/12/2012	Falls	4. Analyse the increased falls incidents on AAU and Claremont to establish if there is any new learning	JW	18/01/2013	
28	20/02/2013	Falls	6. Further deep dive into Octobers, Novembers and Decembers falls data required	JW	20/02/2013	
30	28/11/2012	C Section	2. Presentation of VBAC team audit and Consultant MW audit Jan/Feb. Normality MW study days commencing March 2013	JW	01/02/2013	
31	30/01/2013	VTE	1. Re-emphasise and remind medical teams to undertAIe assessment on ward rounds.	JW	31/01/2013	
5	30/01/2013	C diff	5. Diarrhoea Care Bundle implementation - IPCT to include in training and send global email	DB	16/01/2013	
6	27/02/2013	C diff	6. Implement a '5 key pieces of equipment' audit	DB	28/12/2012	

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Action Number	Date	KPI	Action	Owner	Action by	Status
7	27/02/2013	C diff	7. IPCT spot check on '5 key pieces of equipment'	DB	12/02/2013	
2	30/01/2013	C diff	2. KPI Report for EMC, Divisions and ward scorecard	DB	14/01/2013	
3	30/01/2013	C diff	3. Antibiotic Management Group to meet	DB	07/02/2012	
20	27/03/2013	Normal Birth (Non instrumental delivery)	6. The Big Push campaign. For five weeks in January and February the CM and LW lead are ran a campaign to improve second stage management. The aim was to enhance clinical decision mAling and promote normality using the five 'P's Powers, Passage, Passanger, Psyche and Partogram. A second stage management tool has been developed to support clinical decision mAling and will be launch in March.		29/03/2013	
26	41360	Falls	3. Merge Task and Finish and Falls group. Re-energised falls	JW	Completed	
28	41304	VTE	2. Check risk assessment completed when undertAling surgi	JW	31/01/2013	
31	41360	C Section - Primip	3. Feedback to staff at labour ward forum, department O&C	JW	Completed	
1	30/01/2013	C diff	4. Augmentin use audit and review of antibiotic use at 48 hours	DB	Completed	
2	27/02/2013	C diff	8. Commence a review of antibiotic use at 48 hours	DB	Completed	
3	27/02/2013	C diff	9. Raise awareness of and promote use of diarrhoea care bundle	DB	Ongoing	
4	27/03/2013	C diff	IPCT to clarify guidance on stool specimen tAling	DB	Completed	
5	28/03/2013	C diff	IPCT to report innappropriate transfer as clinical incident and to relevant people including HPA and SGH ICN's.	DB	Completed	
3	May-13	C diff	3. Stool charts changed, with specific messages regarding timely specimens and the fact that specimens mixed with	DB	Completed	
4	May-13	C diff	4. IPCT to clarify guidance on stool specimen tAling - posters put into all sluice areas, information given at team	DB	Completed	
8	Jan-13	Pressure Ulcers	1. Serious incident investigations	DB	Completed	
9	Apr-13	Pressure Ulcers	2. Serious incident investigation -ITU	DB	Completed	
11	Feb-13	Pressure Ulcers	4. Blyth Ward four week audit of pressure area management documentation	DB	01/04/2013	
17	Mar-13	Falls	2. Development and implementation of revised falls action plan as following amalgamations of groups & QAC deep dive	JW	Completed	
1	May-13	C diff	1. Antibiotic audits continue in medicine and surgery and include audit on compliance with antimicrobial policy.	DB	Ongoing	
2	May-13	C diff	2. IPCT ward rounds continue 3 times a week, to re-iterate messages around stool specimens, isolation and antibiotics.	DB	Ongoing	
5	Jun-13	C diff	5. Staff education on Bristol stool form scale - revised educational posters to be rolled out	DB	Completed	
6	Jun-13	C diff	6. New posters on diarrhoea and when to tAle a sample were installed in sluice rooms; key messages were sent via global email.	DB	Completed	
7	Jun-13	C diff	7. A 'deep clean' took place on Blyth ward on May 24th and chlorclean is used for all cleaning in all wards.	DB	Completed	
8	Jun-13	C diff	8. Weekly hand hygiene audits in Blyth ward.	DB	Completed	
9	Jun-13	C diff	9. Two new infection control link nurses to be recruited and trained in Blyth ward.	DB	Ongoing	
10	Jun-13	C diff	10. Nursing handover sheets to include more information on infection	DB	Completed	
12	Jun-13	C diff	12. Ensure correct stool sample pots are available	DB	Completed	
1	May-13	C diff	1. Antibiotic audits continue in medicine and surgery and include audit on compliance with antimicrobial policy.	DB	Ongoing	
2	May-13	C diff	2. IPCT ward rounds continue 3 times a week, to re-iterate messages around stool specimens, isolation and antibiotics.	DB	Ongoing	
6	Jul-13	C diff	6. Blyth ward action plan in place to address potential cross infection including 'fogging'of the ward.	DB	Completed	
8	Jul-13	C diff	8. infection Control column added to handover sheet in Blyth ward	DB	Completed	
12	Jul-13	C diff	12. New posters on diarrhoea and when to tAle a sample were installed in sluice rooms; key messages were sent via global email.	DB	Completed	

Clinical Quality Report - Action Log

Action Number	Date	KPI	Action	Owner	Action by	Status
1	May-13	C diff	1. Internal Audit of Compliance with the antimicrobial prescribing policy	DB	tbc	
3	Jun-13	C diff	3. Diarrhoea algorithm to be reviewed and re-issued	DB	01/07/2013	
4	Jul-13	C diff	4. Improve documentation on stool charts and laxative use	DB	31/07/2013	
8	Aug-13	C diff	8. IPCT review of transfers from other Trusts within 24 hours of admission	DB	Completed	
15	Apr-13	Pressure Ulcers	1. Serious incident investigation - Kennet Ward	DB	tbc	
16	May-13	Pressure Ulcers	2. Skin Awareness Training, AAU	DB	30/06/2013	
17	May-13	Pressure Ulcers	3. Development of strategies to reduce PU numbers in orthopaedics meeting	DB	31/05/2013	
18	Jun-13	Pressure Ulcers	4. BIPAP Awareness Training	DB	31/07/2013	
19	Jun-13	Pressure Ulcers	5. Highlighted pressure relieving strategies implemented in Orthopaedics	DB	30/06/2013	
20	Jun-13	Pressure Ulcers	6. Stage 2 pressure ulcer checklists to be presented at Skin HIA meeting	DB	15/07/2013	
27	Jun-13	Falls	2. Review June 2013 NICE guidance and undertAIe GAP analysis identifying any areas for focus within the Trust .	DB	28/06/2013	
29	Jul-13	Falls	4. Complete Falls Audit	DB	20/07/2013	
35	Aug-13	A&E FFT	1. The volume of respondents will be split over the 3 areas: Majors/ Minors/ Paeds. This can be subdivided over the day/ night. Team have a target of a minimum of 8 per shift per area to achieve. Allows identification of responsible individuals.	DB	22/07/2013	
36	Aug-13	A&E FFT	2. Daily reports of volume compliance to be sent to Mike Walker & Emma Duffy so that the progress can be tracked, and managers can intervene should there be a risk of not achieving the target.	DB	22/07/2013	
37	Aug-13	A&E FFT	3.Agenda item at the following; Senior nurse Meeting, Staff Meeting, ED Governance Meeting for monitoring.	DB	22/07/2013	
3	Jul-13	C diff	3. High fibre diet clarification for patients on menus to be commenced in Autumn 2013	DB	01/09/2013	
4	Jul-13	C diff	4. Exploration into the use of sporicidal wipes that are now available, for cleaning equipment.	DB	31/07/2013	
5	Aug-13	C diff	5. Staff training and assessment package developed to promote timely stool sample collection, improve awareness of diarrhoeal stool types, improve documentation of bowel activity using appropriate terminology, requirement for isolation within two hours of onset of suspected infective diarrhoea	DB	23/08/2013	
6	Aug-13	C diff	7. Monitoring of adherence to Hand Hygiene and PPE and standards of environmental cleanliness	DB	12/08/2013	
17	Jul-13	Pressure Ulcers	7. RCA Investigation - Cambridge Ward	DB	21/08/2013	
18	Jul-13	Pressure Ulcers	8. RCA Investigation - Keats Ward	DB	21/08/2013	
19	Jul-13	Pressure Ulcers	9. RCA Investigation - Bronte Ward	DB	21/08/2013	
31	Aug-13	Falls	8. Disseminate falls audit results	DB	Completed	
34	Aug-13	A&E FFT	2. Daily reports of volume compliance to be sent to Mike Walker & Emma Duffy to track progress & intervene as required.	DB	Ongoing	
36	Aug-13	Inpatient FFT	1. Weekly tracking of response rate compliance	DB	01/09/2013	
37	Aug-13	Inpatient FFT	2. FFT to be agenda item and NMAC,sisters' meeting	DB	20/08/2013	

Clinical Quality Report - Change Log

Change Number	Date	KPI	Change	Request Owner	Action by
1	Apr-13	Number of patients with Hospital acquired pressure ulcers (Grade 3 and 4)	10% reduction to 2012/13 target. Annual target for 2013/14 is now 6	DB	CO
2	Apr-13	Number of patients with Hospital acquired pressure ulcers (Grade 2)	10% reduction to 2012/13 outturn. Monthly target for 2013/14 is now <=3	DB	CO
3	Apr-13	E.coli Bloodstream Infections (Hospital Acquired)	Amend target to be reduction on 2012/13 outturn (18) Monthly target <=1.5	DB	CO
4	Apr-13	% of Medication Incidents Where Moderate or Severe Harm Occurred	Amend target to be % of all medication incidents rather than number and set target <4% following Deep Dive into medication Incidents.	JW	CO
5	Apr-13	Patient Safety Thermometer - % Harm Free Care	Indicator added. Need to calculate target based on CQUIN	DB	CO
6	Apr-13	% Emergency Readmissions following elective admission - 30 days	Add indicator and base on local data	ST	CO
7	Apr-13	% Emergency Readmissions following all admissions - 30 days	Amended target to be top 25th percentile for Apr to Feb 2013/12 from CHKS and use CHKS data to compare	ST	CO
8	Apr-13	SHMI (In hospital Mortality)	Amended target to be based on Apr to Feb 13	JW	CO
9	Apr-13	Prevention of hospital acquired VTE - % patients risk assessed	Amend target for 2013/14 CQUIN green>95% amber between 95% and 90%	JW	CO
10	Apr-13	Hand Hygiene	Amended Score required for amber to 90%	DB	CO
11	Apr-13	Net Promoter Score	All indicators removed as replaced by FFT in February	DB	CO
12	Apr-13	Caesarean section rate	Target amended based on CHKS - SHA London Peer 75th Percentile	JW	CO
13	Apr-13	Caesarean section rate - primip	Indicator removed	JW	CO
14	Apr-13	% women with a primary postpartum haemorrhage of 2500ml or more	target based on HCC Review of Maternity Services 2008 median of 1.9 per 1,000 births ranging from 0.1 per 1,000 to 8 per 1,000.	JW	CO
15	Apr-13	Significant Perineal Trauma	Previously % of 3rd and 4th degree tears. Target to be agreed.	JW	CO
16	Apr-13	Perinatal Mortality Rate per 1000 births	New Indicator to be reported quarterly. (previously reported still birth rate)	JW	CO
17	Apr-13	Number of Red Maternity Escalations	New Indicator	JW	CO
18	Apr-13	Spontaneous Vaginal Delivery Rate	Indicator removed	JW	CO
19	Apr-13	Breast Feeding Initiation Rate	Indicator removed	JW	CO
20	Apr-13	Number of post operative PE or DVT	Indicator removed	JW	CO
21	Apr-13	A&E - % of A&E Attendances for Cellulitis + DVT that end in Admission	Indicator removed	JW	CO
22	Apr-13	Number of Intensive Care Unit patients who are readmitted into ICU after fit for transfer	Indicator removed	JW	CO
23	Jun-13	% women with a primary postpartum haemorrhage of 2500ml or more	Amended to 2000ml in line with sector scorecard	JW	CO
24	Jul-13	Friends and Family Score - Inpatient	Amended to include only Adults as submitted to DH	DB	CO
25	Jul-13	Friends and Family Score - Paediatric Inpatient	Include a new indicator to show Paediatric data previously included in inpatient score	DB	CO
26	Aug-13	Friends and Family Score - Inpatient & A&E	Rag rating included following publication of national data	DB	CO
27	Sep-13	Number of patients with hospital acquired pressure ulcers (Grade 3-4)	Amended 2012/13 Pressure Ulcer Figure from 14 to 16 following additional data from Alison Williams	DB	CO
28	May-14	E.coli Bloodstream Infections (Hospital Acquired)	Removed indicator as it is being monitored locally by the Infection Control team	DB	SO
29	May-14	MSSA Bacteraemias - Post 48hour (Hospital Acquired)	Removed indicator as it is being monitored locally by the Infection Control team	DB	SO

	KPI description	Exec Owner	Indicator also reported in	Target	RAG Green	RAG Amber	RAG Red
	Number of patients with pressure ulcers (Grade 3-4)	JW	Board - CPR, CQR	1	1		
	Number of patients with pressure ulcers (Grade 2)	JW	Board - CPR, CQR	<=3	3		
	Number of patients with pressure ulcers (Grade 3&4) per 1000 beddays	JW	CQR	<=0.06	0.06		
	Number of patients with pressure ulcers (Grade 2) per 1000 beddays	JW	CQR	<=0.5	0.500		
	Number of Patient Safety Incident Falls	JW	CQR	<=51	51		
	PSI Patient Falls per 1000 G&A beddays	JW	Board - CPR, CQR	<=4.7	4.7		4.7
	MRSA Bacteraemias - Post 48hour (Hospital Acquired)	JP	Board - CPR, CQR	<=0	0		1
	Clostridium difficile Infections - Post 36hours (Hospital Acquired)	JP	Board - CPR, CQR	<=2	2		2
	E.coli Bloodstream Infections (Hospital Acquired)	JP	CQR	<=2	2		2
	Nutrition - compliance with MUST assessment*	JP	CQR	>=85%	85%		70%
	Medication Incidents	JP	CQR	<=30	30		
	Number of Serious Untoward Incidents	JP	CQR				
	Number of Never Events	JP	CQR	0	0		
	Completed Patient Observations	JP	CQR	>=97%	97%		94%
	Number of Post Operative PE or DVT	JW	CQR				
	Improve percentage completion of early cognitive assessments of patients aged over 65 admitted to Kingston	JP	CQR				
	SHMI	JW	Board - CPR, CQR	<95	95		
					71		105
	% Emergency Readmissions following emergency admission - 30 days	ST	CQR				
	% Emergency Readmissions following all admissions - 30 days	ST	Board - CPR	< 5.7%	5.70%		5.70%
	Prevention of hospital acquired VTE - % patients risk assessed	JW	CQR	>95%	95%		90%
	Hand Hygiene	JP	CQR	>95%	95%		90%
	A&E - Percentage of A&E Attendances for Cellulitis + DVT that end in Admission	JW	CQR				
	A&E - Patients presenting in High Risk Groups	JW	CQR				
	Certification against compliance with requirements regarding patients with learning disabilities	JP	CQR	0	0		>0
	Number of Complaints	JP	CQR				
	Number of Complaints reopened	ST	CQR				
	Number of Complaints referred to ombudsman	ST	CQR		4		8
	% Complaints responded to within 25 working days	ST	CQR	>=90%	90%		80%
	FFT - Trust	DB	CQR				
	FFT Score - Inpatient	DB	CQR		78.00		72.00
	FFT Score - A&E	DB	CQR		68.00		54.00
	FFT Score - Maternity	DB	CQR		70.00		
	A&E - Service Experience	ST	CQR				
	Number of Mixed Sex accommodation breaches	ST	CQR	0	0		
	Average Number of Preoperative bed days for patients with fractured neck of femur	JW	CQR	<=1.5	74.10%		

	KPI description	Exec Owner	Indicator also reported in	Target	RAG Green	RAG Amber	RAG Red
	Reduce the number of Intensive Care Unit patients who are readmitted into ICU after fit for transfer	JW	CQR				
	Open Incidents	JP	CQR		60%		20%
	Caesarean section rate	JW	CQR	<=26%	26%		29%
	Caesarean section rate - Primip	JW	CQR	<=28%	28%		30%
	Normal delivery Rate	JW	CQR	>58%	58%		
	% women with a primary postpartum haemorrhage of 2500ml or more	JW	CQR	<1%	1%		1.5%
	% of 3rd and 4th degree tears	JW	CQR	<5%	5%		
	Number of stillbirths	JW	CQR	<=1	0.49%		
	Perinatal mortality rate	JW	CQR				
	Term admissions to Neonatal unit	JW	CQR				
	Maternal Admissions to ITU	JW	CQR				
	1:1 Care in established labour	JW	CQR				
	Breast Feeding Initiation Rate	JW	CQR	>=86.5%	86.50%		85.50%
	Nursing establishments	DG	CQR				