Kingston Hospital NHS Foundation Trust

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Clinical Quality Report
Aug-15 (Month 5)

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.

Throughout August 2015 bed numbers have been de-escalated and the trolleys for assessment in the Acute Assessment Unit have been protected enabling ambulatory pathways of care to be adopted. The medical model to deliver ambulatory emergency care is being developed in one of the work streams under the Transformation Board which has been re-named Faster Flow, Safer Care Board using the strap line adopted in the Trust's 'Breaking the Cycle Week' in April 2015.

New nurses recruited over recent months both from the UK and abroad are now being inducted and starting to work in clinical areas. This process is ongoing. The surgical wards, orthopaedic wards and ITU had fill rates of trained staff over 95% both for day and night shifts. Where the fill rate remains low in trained staff HCA fill is increased to achieve overall safe staffing levels.

The unadjusted mortality rate in August 2015 is 1.0% and Quarter 2 SHMI 0.88 both indicative of good performance in the Trust.

The safety KPIs are generally good with a total of 3 pressure ulcers this month, the lowest number year to date. All of the pressure ulcers were grade 3/4 pressure . It is unlikely that the Trust will meet the reduced target set for Grade 3/4 pressure ulcers for the year, as year to date there have been 11 with a target of 15. The cumulative rate for grade 2 pressure ulcers is well below that of 2014/15. Continuing efforts to prevent pressure ulcers are in place and details of the cases are outlined in the exception report. The Trust now determine whether a pressure ulcer is unavoidable in line with national advice when undertaking the investigation. The level of harm free care as seen through the Patient Safety Thermometer results have improved further in August 2015 at 94.98%.

There were no cases of MRSA bacteraemia or of C.difficile. The Board will note that this report shows the actual number of reported cases of C.difficile as well as the number of lapses of care. The incidence the Trust reports externally are those of lapses of care though the report will continue to identify all cases as an induction of the overall activity in infection prevention. Continued efforts to achieve good hand hygiene compliance are in place and peer audits are being undertaken more frequently to give greater assurance. The reported performance fro August 2015 is 92.5% so further improvement is required.

There were 4.9 falls per 1000 bed days in August 2015, 4 falls being with harm, all fractured neck of femur . The falls with harm were not related to a particular area of the hospital and do not correlate with staffing levels or type of ward. Serious incident investigations have demonstrated that there are opportunities to improve falls prevention intervention however the Serious Incident Group has noted that harm has occurred even when patients are receiving appropriate supervision and assistance.

The improved performance with responses to complaints within 25 days continued in August 2015 with 84% of responses meeting the target time. A number of complicated complaints haven taken longer than the response time in order to provide an adequate response and the additional management support to address the issue in the Emergency department is yet to see improvement.

The Trust-wide FFT score has remained over 95% (95.6%) this has been achieved by a significant improvement in A and E and slight fall in out patients. The Board should note the high scores for both maternity and day cases and the new indicator; support for carers of patients with dementia (96.7% for Q1 2015).

Post Partum Haemorrhage (PPH) of greater than 2000ml remains higher than target although there has been a reduction in incidence of blood loss greater than 1500mls. Through August 2015 following specific focus on the management of PPH in vaginal delivery this has significantly reduced. The action plan will be fully implemented by the end of October.

Clinical Quality Dashboard - August-15						Actual										
	Strategic objective	KPI description	Exec Owner	Reported in	Target/ Benchmark	2014-15	Jun-15	Jul-15	Aug-15	2015-16 Q1	2015-16 Q2	YTD	Qtr Trend	Month Trend	Forecast	Comments
Safety	1	Number of patients with hospital acquired pressure ulcers (Grade 3-4)	DB	Board - CPR, CQIC, CRC	<=1	16	1	2	3	6	5	11	↓	↑		Target set as 10% reduction on 2014/15 outturn. Target is to have =<14.4 cases in 2015/16.
	1	Number of patients with hospital acquired pressure ulcers (Grade 3&4) per 1000 beddays	DB	CQIC, CRC	<=0.06	0.12	0.09	0.17	0.27	0.17	0.22	0.19	→	↑		
	1	Number of patients with hospital acquired pressure ulcers (Grade 2)	DB	Board - CPR, CQIC, CRC	<=3	67	5	2	0	12	2	14	↓	↓		
	1	Number of patients with hospital acquired pressure ulcers (Grade 2) per 1000 beddays	DB	CQIC, CRC	<=0.51	0.40	0.44	0.17	0.00	0.35	0.09	0.24	↓	↓		
	1	Number of Patient Safety Incident (PSI) Falls	JW	CQIC, CRC	<=58	730	70	54	53	178	107	285	↓	↓		Benchmark against Trust performance - 10% reduction on year end rate
	1	Number of Patient Safety Incident Falls where moderate or severe harm occurred	JW	CQIC, CRC	<=6	19	1	1	4	4	5	9	↑	↑		
	1	Number of Patient Safety Incident Falls per 1000 G&A beddays	JW	Board - CPR, CQIC, CRC	<=4.7	5.6	6.1	4.6	4.9	5.1	4.7	5.0	↓	↑		Benchmark against Trust performance - 10% reduction on year end rate.
	1	MRSA Bacteraemias - Post 48hour (Hospital Acquired)	DB	Board - CPR, CQIC, CRC	<1	0	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, CRC		17	3	2	0	6	2	8	↓	↓		
	1	Clostridium difficile Infections - Post 72hours (Hospital Acquired) due to Lapse in Care **CONFIRMED**	DB	Board - CPR, CQIC	<1	1	2	0	0	2	0	2	↓	→		Target set by NHS England. Full year target is <= 9 cases. This has been profiled evenly over the year. Cases of CDIFF resulting from a lapse in care are provisional. Once allocation has been confirmed by the Commissioning Support Unit and following a Post-Infection Review, cases will be confirmed and amended on the report as necessary.
	1	MSSA Bacteraemias - Post 48hour (Hospital Acquired)	DB	CQIC, CRC	<=1	7	2	1	1	2	2	4	→	→		
	1	Completed Patient Observations	DB	CQIC, CRC	>=97%	93.5%	91.7%	94.1%	90.8%	92.0%	92.4%	92.1%	↑	↓		NEWS data
	1	Medication Incidents	JW	CQIC, CRC		701	79	45	37	195	82	277	↓	↓		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, CRC	<=4%	0.5%	0.00%	0.00%	0.00%	0.53%	0.00%	0.32%	↓	→		
	1	Number of Serious Untoward Incidents	JW	CQIC, CRC		55	7	3	5	15	8	23	↓	↑		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, CRC	0	2	0	0	0	0	0	0	→	→		
	1	Patient Safety Thermometer - % Harm Free Care	DB	CQIC, CRC		91.7%	94.26%	94.98%	96.41%	94.5%	95.7%	95.0%	↑	↑		
Effectiveness	1	SHMI	JW	Board - CPR, CQIC, CRC	<=95	89.6				0.87	0.88		↑			SHMI score < 100 is lower than expected mortality, taking into account age, gender, comorbidity and diagnosis grouping of patients. Q1 score is for Oct 2013 to Sep 2014, published in Apr 2015. The Q2 score is for Jan 2014 to Dec 2014, published in Jul 2015.
	1	Unadjusted Mortality Rate	JW	CRC		1.2%	1.2%	1.0%	1.0%	1.1%	1.0%	1.1%	↓	↓		
		% Emergency Readmissions following elective admission - 30 days	DB	CQIC, CRC		2.1%	2.0%	2.1%	2.5%	2.5%	2.3%	2.4%	↓	↑		Local data has been used to give an indication of performance.
	1,4	% Emergency Readmissions following emergency admission - 30 days	DB	CQIC, CRC		13.7%	12.7%	11.7%	14.1%	13.6%	12.8%	13.3%	↓	↑		Local data has been used to give an indication of performance.
	1,4	% Emergency Readmissions following all admissions - 30 days	DB	Board - CPR, CRC	<= 6.1%	5.1%	5.7%			6.0%			↓	↑		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, CRC	>=95%	95.2%	98.2%	98.6%	98.7%	98.5%	98.7%	98.6%	↑	↑		Target is national CQUIN.
	1	Hand Hygiene	DB	CQIC, CRC	>=95%	93.1%	94.6%	85.4%	92.5%	93.1%	89.6%	91.8%	↓	↑		Target is locally set.
	1	Open Incidents - % of Managers Reports Completed within 10 days	DB	CQIC		Not Available	54%	45%	52%				→	↓		

Clinical Quality Dashboard - August-15						Actual											
	Strategic objective	KPI description	Exec Owner	Reported in	Target/ Benchmark	2014-15	Jun-15	Jul-15	Aug-15	2015-16 Q1	2015-16 Q2	YTD	Qtr Trend	Month Trend	Forecast	Comments
Patient Experience	1	Number of Complaints received this month	DB	CQIC		473	42	63	32	110	95	205	↓	↓		
	1	Number of Complaints reopened this month	DB	CQIC		71	3	5	11	12	16	28	↑	↑		
	1	Number of Complaints referred to ombudsman this month	DB	CQIC		6	2	0	0	3	0	3	↓	→		
	1	% Complaints responded to within 25 working days	DB	CQIC	>=90%	74.6%	81.0%	81.0%		77.3%	81.0%	78.6%	↑	→		Data reported 1 month in arrears.
	1	Friends and Family Score - Trust	DB	CQIC		94.38%	93.65%	95.26%	95.60%	94.42%	95.76%	95.08%	↑	↑		The FFT score is calculated by determining the number of people who are "extremely likely" or "likely" to recommend the Trust, as a proportion of the number of people who responded to the question.
	1	Friends and Family Score - Adult Inpatient	DB	CQIC		92.05%	90.45%	91.88%	92.40%	91.78%	92.50%	92.12%	↑	↑		The Adult Inpatients response rate was 27.3% for Aug 2015. 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		96.40%	93.75%	97.29%	95.64%	93.97%	96.90%	95.62%	↑	↓		
	1	Friends and Family Score - A&E	DB	CQIC		92.99%	91.06%	91.32%	96.55%	91.14%	94.29%	92.59%	↑	↑		The A&E response rate was 3.4% for August 2015.
	1	Friends and Family Score - Maternity	DB	CQIC		96.17%	97.80%	92.76%	96.72%	96.98%	95.26%	96.19%	↓	↑		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 - Daycases	DB	CQIC			96.50%	98.52%	98.64%	97.71%	98.65%	98.17%	↑	↑		
	1	Friends and Family Score - Support for Carers of Patients With Dementia	DB	CQIC						96.67%			↑			
	1	Number of Mixed Sex accommodation breaches	DB	CQIC	0	0	0	0	0	5	0	5	↓	→		This is based on a national directive.
Safer Staffing	1	Day - Registered Midwives/Nurses Fill Rate	DB	CQIC			92.1%	89.7%	91.1%	91.5%	90.4%	91.1%	↓	↑		
	1	Day - Assistant Fill Rate	DB	CQIC			119.6%	126.8%	125.9%	123.6%	126.4%	124.7%	↑	↓		
	1	Night - Registered Midwives/Nurses Fill Rate	DB	CQIC			98.3%	96.3%	97.0%	97.5%	96.7%	97.2%	↓	↑		
	1	Night - Assistant Fill Rate	DB	CQIC			114.3%	108.6%	112.3%	119.0%	110.4%	115.6%	↓	↑		
	1	Overall Trust Fill Rate	DB	CQIC			101.7%	100.9%	101.9%	102.6%	101.4%	102.1%	↓	↑		
	1	% of Registered Nurse and Midwife Expenditure on Agency Staff	DB	FIC			12.4%	15.1%	14.8%	12.6%	15.0%	13.5%	↑	↓		The threshold for Q3 is 10%
Maternity	1	Caesarean section rate	JW	CQIC	<=26%	27.5%	29.57%	30.57%	27.44%	29.95%	29.13%	29.82%	↓	↓		
	1	% women with a primary postpartum haemorrhage of 1500ml or more	JW	CQIC	<3.1%		5.42%	4.37%	2.85%	3.37%	3.10%	3.24%	↓	↓		Target added in July-15 due to new London Quality Standards
	1	% women with a primary postpartum haemorrhage of 2000ml or more	JW	CQIC	<=1.0%	1.5%	2.06%	1.38%	1.83%	0.88%	1.27%	0.07%	↑	↑		
	1	Significant Perineal Trauma	JW	CQIC		3.29%	2.62%	2.99%	2.24%	2.36%	0.91%	1.65%	↓	↓		Data reported 1 month in arrears as requires coding to be completed

Qualitative Summary - August 2015

Clinical audit

Kingston Hospital takes part in the National Emergency Laparotomy Audit (NELA) which aims to collect information on all patients undergoing emergency laparotomy surgery in order to drive improvement in clinical care. Over 30,000 patients undergo emergency laparotomy surgery every year in England and Wales with the majority of patients undergoing bowel surgery for potentially life threatening conditions.

The first patient outcome data for this national audit was published in July 2015. Alongside this, clinical staff from Anaesthetics, Colorectal Surgery and ITU are taking part in a national quality improvement project entitled 'Enhanced Peri-Operative Care for High-Risk Patients' (EPOCH). This project uses the national audit data to drive change and aims to reduce overall mortality for patients undergoing emergency laparotomy. As a result of changes to the patient pathway made by clinical staff at Kingston Hospital in the past year, patient mortality has significantly reduced in all age groups but particularly in patients over 80 years of age. This equates to around 25 lives saved per year with a reduction in mortality from 25% to 5.8%. Comprehensive medical assessment of patients undergoing this major surgery is essential to patient outcome and further developments in the coming year include a new consultant post to lead on pre-operative medical assessment. Improving surgical care in the elderly was a priority in the Trust 2014/15 Quality Account which was not met as the improvement was against a national quality standard of staffing which could not be achieved in year. This audit demonstrates that there have been significant improvements in outcome despite this and the staffing gap has now been addressed with all consultant staff now recruited and start dates imminent.

Sepsis Mortality Alert

The Trust received an alert fro CQC regarding an increase in deaths at the hospital due to Sepsis fro the period November 2014 to March 2015. The alert is triggered by Dr Foster intelligence as performance against the background Trust mortality rate for this condition had deteriorated. A clinical audit is being undertaken for this period and the Board will receive the report on completion. The sepsis quality improvement programme is continuing as a 2015 Quality Goal.

Complaints

The Trust received 32 formal complaints in August 2015 compared to 25 in August 2014. Emergency Services received the highest amount of complaints accounting for 50% of the total, followed by Specialist Services (25%), Clinical Support Services (19%) and Corporate Services (6%).

The most frequent complaint subjects that were received related to appointments (25%), followed by care & treatment (19%), communication (16%), procedural issues (9%), infrastructure & resources, security and tests/investigations (6% each), admission/discharge, diagnosis, infection and transfer (3% each).

Reopened complaints

Eleven complaints were reopened in August 2015, arising from complaints first received in February 2015 (1), June 2015 (2), July 2015 (8).

The reasons for these complaints reopening were:

Further Questions – 9
Facts Challenged – 2

Our reopened rate is currently 10% for the year to date, which is an improvement on the previous two years where it was 15%.

Ombudsman Referrals

There were no complaints referred to the Ombudsman in August 2015.

Clinical Quality Report **Author: Alison Williams**

Exception Report 1: Pressure Ulcer Stage 3

In August 2015, 3 patients were identified as having developed Trust acquired pressure ulcers (Derwent Ward, Bronte Ward and Cambridge Ward). All 3 patients have been raised as serious incidents and investigations are taking place. Interim actions have been presented at the Intermediate PUMP meeting and await formal presentation at SIG.

Derwent Ward

The patient was admitted with poor dietary and fluid intake and general deterioration. This very frail immobile patient had lower limb contractures and already had severe pressure ulcers on admission. Despite a multi-disciplinary approach to pressure area management, regular tissue viability reviews and use of specialist products to aim to reduce risk of skin breakdown further pressure damage occurred. The pressure ulcers acquired during admission were deemed unavoidable by the PUMP group with no further actions required of the ward.

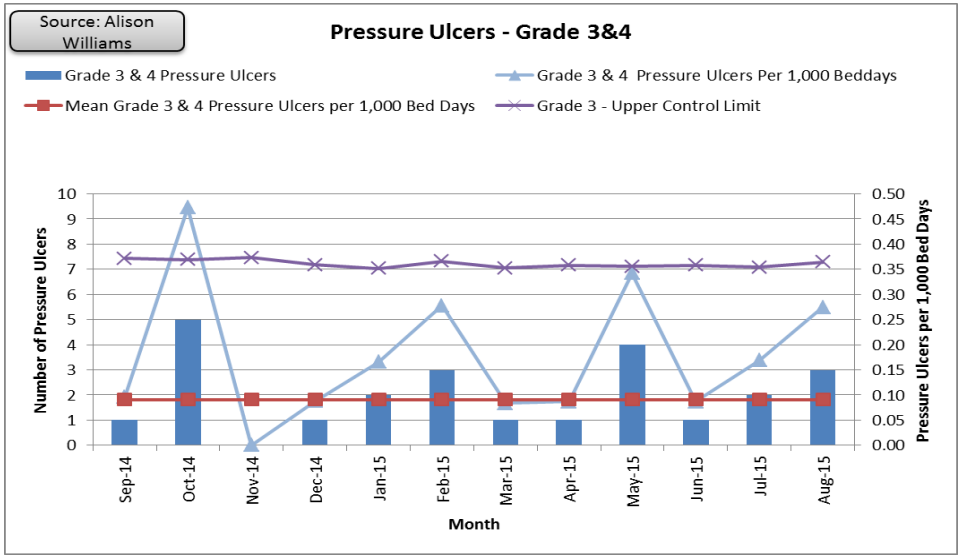
Cambridge

The severely cognitively impaired patient who was non-concordant with treatment was admitted with a distal femoral fracture. Traction was the first choice of treatment but was not tolerated by the patient and a back slab plaster was applied. Two areas of skin damage were identified as Stage 3 pressure ulcers over the Achilles tendon when the plaster was removed. No actions were identified from initial investigations which will be reviewed on completion of the serious Incident report.

Bronte

Patient admitted with stage 2 pressure ulceration. A patient admitted with Ischaemic heart disease had stage 2 pressure ulceration on admission. The pressure ulcer developed to stage 3 on the ward. As a change in mobility and weight loss prior to admission was not full appreciated and the skin inspection assessments were incomplete staff involved will meet with the Head of Nursing.

Pressure ulcer strategy pathway almost complete and ready for launch. Poster developed depicting the elements of the strategy and the progress of achievements. The updated pressure area management and wound care policy will be ratified in October.



	Person Responsible	Date	Committee monitoring delivery
1. Serious Incident Report - Bronte	Ward Sister	14/10/2015	Service line governance meeting
2. Serious Incident Report - Cambridge	Ward Sister	21/10/2015	Service line governance meeting
3. Serious Incident Report - Derwent	Ward Sister	14/10/2015	Service line governance meeting

Clinical Quality Report **Author: Fergus Keegan**

Exception Report 2: Patient Safety Incident Falls

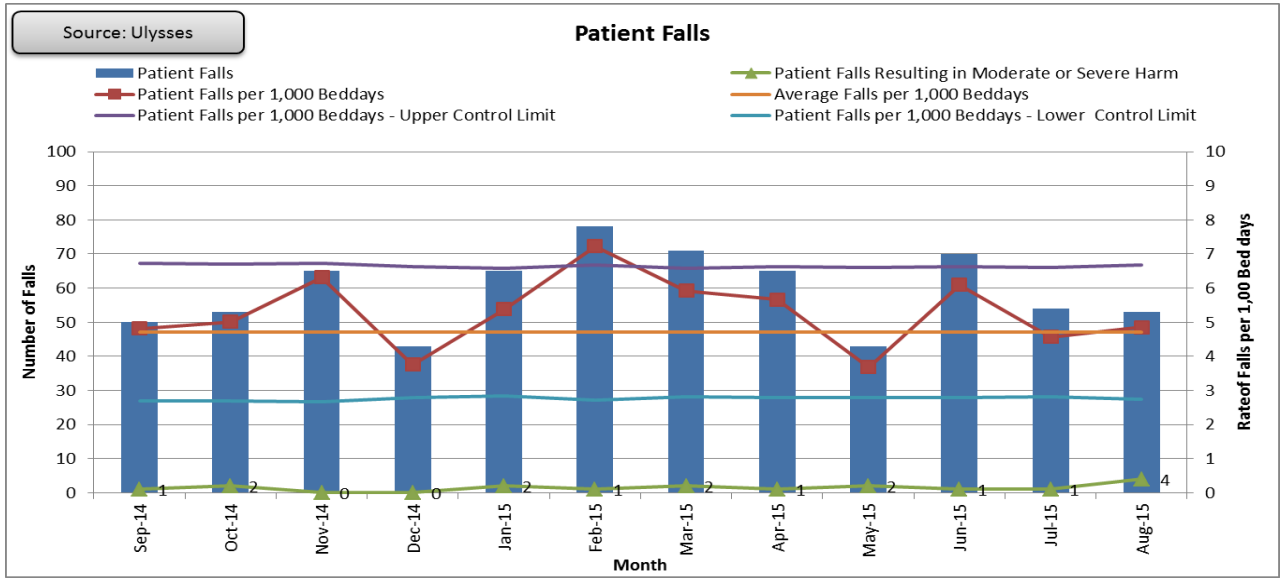
The rate of falls continues at a steady rate and it is proving difficult to reduce the frequency below the NPSA benchmark from 2010. The rate has not exceeded the control limit on the trend graph since February 2015. Falls occur most frequently on the Medical Wards but their is no individual ward that has an outlying rate. The number of falls are highest on the wards with high bed numbers and patient turnover with AAU having the most falls. Over the past 3 months AAU have reduced the falls from, 12 in June 2015 to 8 in July 2015 and 5 in August 2015.

There were 4 falls with harm in August 2015. The falls with harm are all investigated as serious incidents and actions identified as a result tracked to completion through the Serious Incident Group.

The programme of rolling out SWARM in its original form was abandoned as the resource required was too great. Local SWARMs are continuing within the ward teams.

The serious incident group has noted that falls with harm have occurred where all the necessary prevention interventions were in place although there have been omissions in assessments and failure to use all the available falls prevention initiatives in some cases. There is no evidence that there is a lack of equipment but timely application of falls alarm was identified in one case.

Some improvements in the environment have been made in line with the dementia Strategy but further improvements might limit the likelihood of falling.

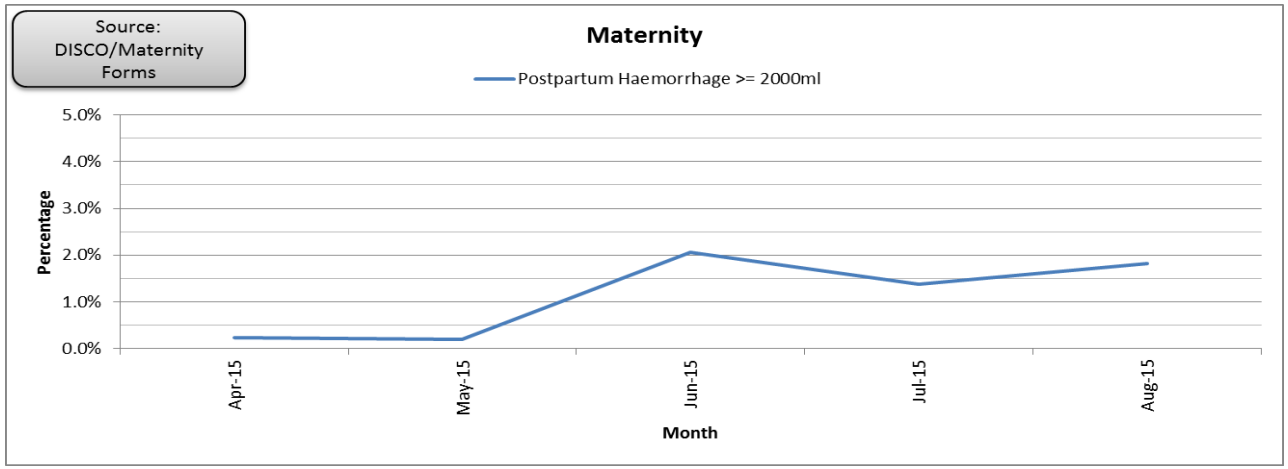


Actions	Person Responsible	Date & RAG status	Committee monitoring delivery
Continue to implement actions from Falls group and SI investigations	Medical Director	Ongoing	Falls Group/SI Group
Implement local SWARM	Managers	01/11/2015	Falls Group/SI Group

Clinical Quality Report **Author: Anna Dellaway**

Exception Report 3: Maternity PPH

The PPH rate of both >1500 mls and >2000mls rate was raised above target in June and July 2015. A review of all PPHs greater than 2 litres has been undertaken and it was indentified that PPH was associated with vaginal delivery more frequently than expected. An action plan is in progress which will be completed by end of October 2015. There was particular focus on managing bleeding following vaginal delivery with both doctors and midwives. In August 2015 most PPHs were associated with caesarean section nad there were no particluar features of the cases that required specific action or identified particular risk. Of note the rate of 2ltr PPH has reduced below the target benchmark in August 2015. The unit has recruited an additional 28 midwives and a dedicated labour ward lead consultant has been appointed. Targeted teaching to junior medical staff has been carried out to highlight good practice to decrease blood loss at delivery. This is expected to maintain the focus on fast action with early senior involvement to control the frequency of PPH following vaginal delivery and caesrean section.



Action	Person Responsible	Date	Committee monitoring delivery
1. All midwives recruited will be in post by end of October 2015	Anna Dellaway	31/10/2015	Maternity Risk Group/SLM
2. The action plan from findings of PPH audit will be fully implemented by end of October.	Diana Fleming	31/10/2015	Maternity Risk Group/SLM

In August 2015 there was a higher rate of Healthcare Assistants and lower registered nurse availability compared to expected figures. The reasons for this are below:

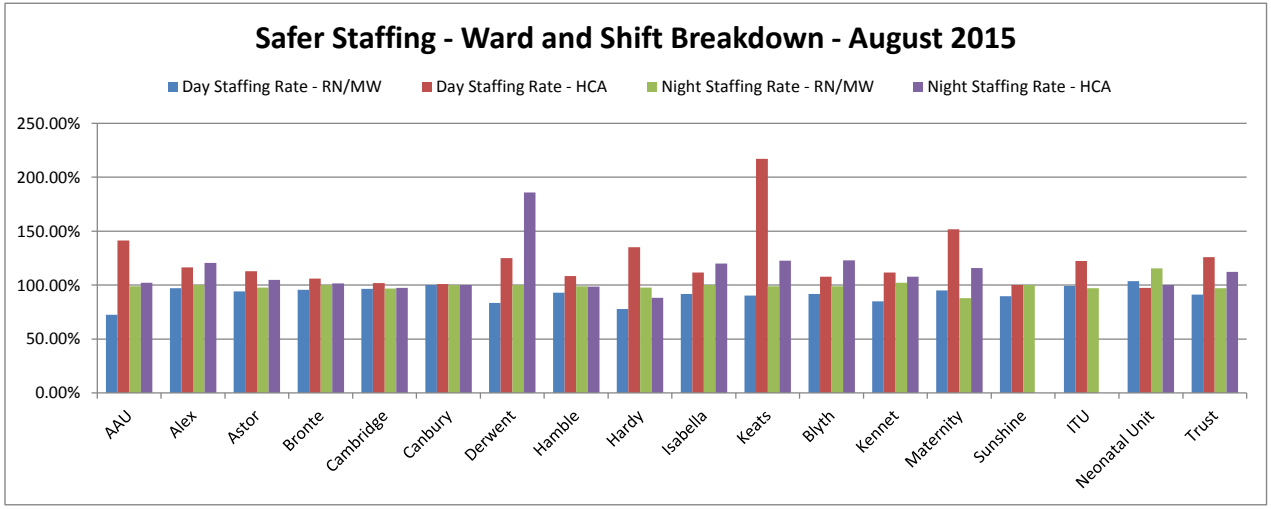
• Escalation capacity during the month leading to a higher requirement for registered nurses (from bank and agency). In circumstances where an RN was unavailable, a nursing assistant sourced to support nursing care on a number of wards.

• Increased registered nurse vacancies which will reduce as new starters from newly qualified nurses and overseas nurses start from August 2015 through to December 2015

• Requirements for 1:1 nursing care during the period (to support patients identified at high risk e.g. falling, confusion).

Ward	Day Staffing Rate - RN/MW	Day Staffing Rate - HCA	Night Staffing Rate - RN/MW	Night Staffing Rate - HCA
AAU	72.51%	141.48%	98.89%	102.15%
Alex	97.11%	116.38%	100.00%	120.59%
Astor	94.25%	112.90%	97.87%	104.84%
Bronte	95.76%	106.03%	100.00%	101.61%
Cambridge	96.46%	101.74%	96.77%	97.30%
Canbury	100.00%	101.09%	100.00%	100.00%
Derwent	83.45%	125.00%	100.00%	186.00%
Hamble	92.96%	108.51%	98.92%	98.77%
Hardy	77.89%	135.17%	97.80%	88.24%
Isabella	91.70%	111.56%	100.00%	120.00%
Keats	90.32%	217.17%	98.92%	122.76%
Blyth	91.89%	107.87%	98.92%	122.81%
Kennet	84.97%	111.54%	102.24%	107.85%
Maternity	95.14%	151.65%	87.91%	115.88%
Sunshine	89.82%	100.00%	100.00%	-
ITU	99.15%	122.22%	97.23%	-
Neonatal Unit	103.54%	97.50%	115.52%	100.00%
Trust	**91.13%**	**125.89%**	**97.01%**	**112.30%**

Key	
RN	Registered Nurse
MW	(Registered) Midwife
HCA	Healthcare Assistant



Clinical Quality Report - Action Log						
Action Number	Date	KPI	Action	Owner	Action By	Status
1	Jun-15	CDIFF	1. The importance of correct antibiotic prescribing (following Trust policy and having discussions with Microbiology where necessary) to be re-enforced.	DB	01/08/2015	
2	Jun-15	Complaints	1. Ensure all service lines meeting timelines for complaints response	DB	30/08/2015	
3	Jun-15	Complaints	2. Provision of targeted support to specific areas where risk of performance decline noted	DB	30/09/2015	
4	Oct-14	Falls	1. Continue implementation of actions arising through Trust Falls Group	JW	Ongoing	
5	Oct-14	Falls	4. Commence SWARM approach to falls prevention on Hardy Ward	JW	30/11/2014	
6	Jun-15	Falls	2. Complete SI investigation into case on Blyth Ward	DB	20/08/2015	
7	Jun-15	Falls	3. Complete August 'focus on falls' month	DB	01/09/2015	
8	Jun-15	FFT	1. Complete Team Development Programme by all Inpatient Wards	DB	30/11/2015	
9	Jun-15	FFT	2. Implement Food improvement plan	DB	30/09/2015	
10	Jun-15	FFT	3. Weekly monitoring of FFT response rates in inpatient areas to be escalated as required to service line management teams	DB	30/09/2015	
11	Jun-15	Maternity PPH	1.Review all PPH's for June 2015 >2 litres. Identify any recurrent themes and make & implement an appropriate action plan.	JW	01/09/2015	
12	Jun-15	Maternity PPH	2. Implement actions from recent audit on PPH	JW	01/08/2015	
13	Jun-15	Maternity PPH	1. All midwives recruited will be in post by end of October 2015	DB	01/10/2015	
14	Jun-15	Maternity PPH	2. The action plan from findings of PPH audit will be fully implemented by end of October.	DB	01/10/2015	
15	Dec-14	Pressure Ulcers	2. Develop pressure area management strategy	DB	31/03/2015	
23	Jun-15	Pressure Ulcers	1. Development of the Pressure Ulcer Prevention Strategy	DB	01/10/2015	
24	Jun-15	Pressure Ulcers	2. Update and Review of Pressure Ulcer Management Policy	DB	30/09/2015	
25	Jun-15	Pressure Ulcers	3. Review of Continence Products on all adult inpatient wards to reduce incidence of moisture lesions	DB	30/09/2015	
19	Aug-15	Pressure Ulcers	1. Serious Incident Report - Bronte	DB	14/10/2015	
20	Aug-15	Pressure Ulcers	2. Serious Incident Report - Cambridge	DB	21/10/2015	
21	Aug-15	Pressure Ulcers	3. Serious Incident Report - Derwent	DB	14/10/2015	

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	Clostridium difficile Infections - Post 72hours (Hospital Acquired)						
11	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
12	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

KPI definitions							
KPI	KPI Name	KPI Definition	Source of Benchmark/target	Exception Report Criteria	Data Source	RAG Colour	RAG_Score
13	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%
14	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%
15	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		
16	% 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		
17	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		
18	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
19	% 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		
20	SHMI	SHMI is the national hospital-level indicator used for reporting mortality across the NHS. The SHMI indicator gives an indication of whether the mortality ratio of a provider is as expected, higher than expected or lower than expected when compared to the national baseline (England). The SHMI is a ratio of the observed number of deaths to the expected number of deaths for a provider. The observed number of deaths is the total number of patients who died in hospital plus those who died within 30 days of discharge from the hospital. The expected number of deaths is calculated from a risk adjusted model using patient age, gender, admission method, Charlson Comorbidity Index and diagnosis grouping.	Figure calculated is based on benchmark across hospitals	Exception report if above target	Data shown are from NHS Information Centre	Green Amber Red	< =95 >95 and < 105 >105
21	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		
22	Unadjusted Mortality Rate	Number of Deaths / Number of discharges (excludes Well Babies)			SSRS Discharge Report		
23	% Emergency Readmissions following elective admission - 30 days						
24	% 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					
25	% 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

KPI definitions							
KPI	KPI Name	KPI Definition	Source of Benchmark/target	Exception Report Criteria	Data Source	RAG Colour	RAG_Score
26	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%
27	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%
28	% 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		
29	Open Incidents - % of Managers Reports Completed within 10 days				Data Source: KHT Datix/Ulysses		
30	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
31	Number of Complaints reopened this month	The number of complaints that were re-opened during the reporting month	No Target set		Data Source: Ulysses		
32	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		
33	% 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%
34	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 are "Extremely Likely" or "Likely" to recommend the Trust, as proportion of the total responses to the test.			Data Source: FFT - RaTE		
35	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 are "Extremely Likely" or "Likely" to recommend the Trust, as proportion of the total responses to the test.	National data - top 20%	An exception report will be generated when monthly performance red.	Data Source: FFT - RaTE	Green Amber Red	>=96 <96 and >91 <91
36	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 are "Extremely Likely" or "Likely" to recommend the Trust, as proportion of the total responses to the test.	National data - top 20%		Data Source: FFT - RaTE		
37	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 are "Extremely Likely" or "Likely" to recommend the Trust, as proportion of the total responses to the test.	National data - top 20%		Data Source: FFT - RaTE	Green Amber Red	TBC
38	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 are "Extremely Likely" or "Likely" to recommend the Trust, as proportion of the total responses to the test.	National data - top 20%		Data Source: FFT - RaTE	Green Amber Red	TBC
39	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 are "Extremely Likely" or "Likely" to recommend the Trust, as proportion of the total responses to the test.	National data - top 20%		Data Source: FFT - RaTE	Green Amber Red	TBC
40	Friends and Family Score - Carers of Patients with Dementia	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 are "Extremely Likely" or "Likely" to recommend the Trust, as proportion of the total responses to the test.	National data - top 20%		Data Source: FFT - RaTE	Green Amber Red	

KPI definitions							
KPI	KPI Name	KPI Definition	Source of Benchmark/target	Exception Report Criteria	Data Source	RAG Colour	RAG_Score
41	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
42	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
43	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
44	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
45	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
46	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
47	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%
47	% women with a primary postpartum haemorrhage of 1500ml or more	Numerator: The number of women with a primary post partum haemorrhage of 1500ml or more Denominator: The total number of deliveries	TBC	TBC	CRS	Green Red	TBC
47	% women with a primary postpartum haemorrhage of 2000ml 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%
47	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	Green Red	TBC
47	Number of Red Maternity Escalations						