Kingston Hospital
NHS Foundation Trust

Kingston Hospital NHS Foundation Trust

Clinical Quality Report
Oct-15 (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.

The Trust is beginning to to experience days of high bed pressure and admissions and consequently the number of beds opened has been flexed on a day by day basis. The Faster Flow Safer Care programme continues with a focus on safe efficient discharge and bed utilisation. Further new nurses are commencing work in the Trust and improvement in recruitment KPIs indicate this stream will continue. Fill rates of trained staff in the day are improving month on month and many areas are now achieving their targets, as in previous months where trained staff fill rates are not adequate non-trained staff levels are over filled to compensate.

The unadjusted mortality rate in October 2015 is 0.8% and the Quarter 3 Standardised Hospital Mortality Index (SHMI) was 0.91, both indicative of good performance in the Trust.

The safety KPIs are generally good with a total of only 3 pressure ulcers this month, none of which were grade 3/4. The cumulative rate for grade 2 pressure ulcers continues to be 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 strategy to further reduce pressure ulcers was launched on 19th November, National Stop the Pressure day. The level of harm-free care as seen through the Patient Safety Thermometer results have remained high in September 2015 at 92.14%.

The infection control safety KPIs are particularly good this month with no C.Difficile lapses in care, MSSA or MRSA bacteraemias. Hand Hygiene audits however still demonstrate that specific areas of the Trust need to improve. The particularly low scores were identified in Maternity and on Astor ward, which affected the overall Trust rate and are being addressed specifically.

There were 6.3 falls per 1000 bed days in October 2015, 1 fall being with harm. The Trust received data from the first national falls audit this month which has demonstrated that at an organisational level there is good performance and benchmarking shows the incidence of falls is mid point compared with other Trusts. The audit did however demonstrate that greater focus on the issues at the bedside level might improve the overall incidence of falls. This will be addressed within the Falls Group chaired by the Medical Director.

The performance with responses to complaints within 25 days has deteriorated in September 2015 with 73% of responses meeting the target time. A number of complicated complaints haven taken a long response time and there is a plan in place to get this back on track. The details are described in the exception report.

The Trust-wide FFT score has remained over 95% (95.34%) particularly good performance has been seen in A&E.

Post Partum Haemorrhage (PPH) of greater than 2000ml remains below the target in October 2015. The action plan to reduce PPH was fully implemented by the end of October. The Sign up to Safety improvement project continues with specific actions to increase the number of normal deliveries. The Caesarean Section rate was the lowest this year in October at 25.7% although it is recognised that there is significant monthly variation in this KPI.

The Board should review progress with delivery of the Quality Goals appended to this report.

The Board are asked to note and discuss the contents of the report.

Clinical Quality Dashboard - October-15

	Strategic objective	KPI description	Exec Owner	Reported in	Target/ Benchmark	Actual 2014-15	Aug-15	Sep-15	Oct-15	2015-16 Q2	2015-16 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, CRC	<=1	16	3	1	0	6	0	12	↓	↓		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	0.27	0.09	0.00	0.18	0.00	0.15	→	↓		
	1	Number of patients with hospital acquired pressure ulcers (Grade 2)	DB	Board - CPR, CQIC, CRC	<=3	67	0	3	3	5	3	20	↓	→		
	1	Number of patients with hospital acquired pressure ulcers (Grade 2) per 1000 beddays	DB	CQIC, CRC	<=0.51	0.40	0.00	0.26	0.25	0.15	0.25	0.25	↑	↓		
	1	Number of Patient Safety Incident (PSI) Falls	JW	CQIC, CRC	<=58	730	54	72	76	180	76	434	↓	↑		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	2	2	1	5	1	10	↓	↓		
	1	Number of Patient Safety Incident Falls per 1000 G&A beddays	JW	Board - CPR, CQIC, CRC	<=5.3	5.6	4.9	6.3	6.3	5.3	6.3	5.4	↑	↑		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	1	0	1	0	1	↓	↓		Target is zero tolerance as per national guidance and contract
	1	Clostridium difficile Infections - Post 72hours (Hospital Acquired)	DB	Board - CPR, CQIC, CRC		17	0	4	2	6	2	14	↓	↓		
	1	Clostridium difficile Infections - Post 72hours (Hospital Acquired) due to Lapse in Care **CONFIRMED**	DB	Board - CPR, CQIC	<1	1	0	1	0	1	0	3	↓	↓		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	1	1	0	3	0	5	↓	↓		
	1	Completed Patient Observations	DB	CQIC, CRC	>=97%	93.5%	90.8%	87.5%	90.8%	90.7%	90.8%	91.3%	↑	↑		NEWS data
	1	Medication Incidents	JW	CQIC, CRC		701	41	63	64	149	64	408	↓	↑		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%	0.00%	0.00%	0.23%	→	→		
	1	Number of Serious Untoward Incidents	JW	CQIC, CRC		55	5	6	0	14	0	29	↓	↓		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%	96.41%	95.15%	92.14%	95.5%	92.1%	94.6%	↓	↓		
Effectiveness	1	SHMI	JW	Board - CPR, CQIC, CRC	<=95	89.6				0.88	0.91		↑			SHMI score < 100 is lower than expected mortality, taking into account age, gender, comorbidity and diagnosis grouping of patients. The Q2 score is for Jan 2014 to Dec 2014, published in Jul 2015. The Q3 score is for Apr 2014 to Mar 2015, published in Oct 2015.
	1	Unadjusted Mortality Rate	JW	CRC		1.2%	1.0%	1.2%	0.8%	1.0%	0.0%	1.1%	↓	↓		
		% Emergency Readmissions following elective admission - 30 days	DB	CQIC, CRC		2.1%	2.5%	1.7%	2.3%	2.1%	2.3%	2.3%	↑	↑		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%	14.1%	13.2%	14.4%	12.9%	14.4%	13.4%	↑	↑		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%							→	→		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%	98.6%	98.8%	98.5%	98.7%	98.5%	98.6%	↓	↓		Target is national CQUIN.
	1	Hand Hygiene	DB	CQIC, CRC	>=95%	93.1%	92.5%	93.0%	88.2%	90.9%	88.2%	91.6%	↓	↓		Target is locally set.
	1	Open Incidents - % of Managers Reports Completed within 10 days	DB	CQIC		Not Available	52%	58%	53%				→	↑		

Clinical Quality Dashboard - October-15

Section	Strategic objective	KPI description	Exec Owner	Reported in	Target/ Benchmark	Actual 2014-15	Aug-15	Sep-15	Oct-15	2015-16 Q2	2015-16 Q3	YTD	Qtr Trend	Month Trend	Forecast	Comments
Patient Experience	1	Number of Complaints received this month	DB	CQIC		473	32	37	30	132	30	272	↓	↓		
Patient Experience	1	Number of Complaints reopened this month	DB	CQIC		71	11	5	3	21	3	36	↓	↓		
Patient Experience	1	Number of Complaints referred to ombudsman this month	DB	CQIC		6	0	1	0	1	0	4	↓	↓		
Patient Experience	1	% Complaints responded to within 25 working days	DB	CQIC	>=90%	74.6%	84.4%	73.0%		79.5%		78.5%		↓		Data reported 1 month in arrears.
Patient Experience	1	Friends and Family Score - Trust	DB	CQIC		94.38%	95.60%	96.58%	95.34%	95.76%	95.34%	95.13%	↓	↓		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.
Patient Experience	1	Friends and Family Score - Inpatient	DB	CQIC		92.05%	92.40%	93.30%	91.50%	92.50%	91.50%	92.05%	↓	↓		The Inpatients response rate was 18.6 for Oct-15 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. NHS England has also specified that FFT should be inclusive of all patients regardless of age, therefore paediatric FFT responses are now included in the overall inpatient figures.
Patient Experience	1	Friends and Family Score - Paediatric Inpatient					93.33%	100.00%	90.00%	94.29%	90.00%	96.05%	↓	↓		Paediatric inpatient FFT data is included in the main Inpatient FFT score, though the score is also reported and reviewed separately.
Patient Experience	1	Friends and Family Score - Outpatient	DB	CQIC		96.40%	95.64%	97.20%	94.81%	96.90%	94.81%	95.41%	↓	↓		
Patient Experience	1	Friends and Family Score - A&E	DB	CQIC		92.99%	96.55%	96.82%	97.96%	94.29%	97.96%	93.06%	↑	↑		The A&E response rate was 1.9% for Oct-15
Patient Experience	1	Friends and Family Score - Maternity	DB	CQIC		96.17%	96.72%	96.63%	93.14%	95.26%	93.14%	95.75%	↓	↓		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.
Patient Experience	1	Friends and Family Score - Daycases	DB	CQIC			98.64%	98.86%	98.63%	98.65%	98.63%	98.27%	↓	↓		
Patient Experience	1	Friends and Family Score - Support for Carers of Patients With Dementia	DB	CQIC						83.33%			↓			
Patient Experience	1	Number of Mixed Sex accommodation breaches	DB	CQIC	0	0	0	0	0	0	0	5	→	→		This is based on a national directive.
Safer Staffing	1	Day - Registered Midwives/Nurses Fill Rate	DB	CQIC			91.1%	92.4%	94.3%	91.1%	94.3%	91.7%	↑	↑		
Safer Staffing	1	Day - Assistant Fill Rate	DB	CQIC			125.9%	121.6%	114.5%	124.8%	114.5%	122.8%	↓	↓		
Safer Staffing	1	Night - Registered Midwives/Nurses Fill Rate	DB	CQIC			97.0%	100.7%	99.8%	98.0%	99.8%	98.0%	↑	↓		
Safer Staffing	1	Night - Assistant Fill Rate	DB	CQIC			112.3%	108.7%	103.9%	109.9%	103.9%	112.9%	↓	↓		
Safer Staffing	1	Overall Trust Fill Rate	DB	CQIC			101.9%	102.2%	100.9%	101.6%	100.9%	102.0%	↓	↓		
Safer Staffing	1	% of Registered Nurse and Midwife Expenditure on Agency Staff	DB	FIC			14.8%	14.8%	16.7%	14.9%	16.7%	14.2%	↑	↑		The threshold for Q3 is 10%
Maternity	1	Caesarean section rate	JW	CQIC	<=26%	27.5%	27.44%	29.68%	25.79%	29.13%	25.79%	29.82%	↓	↓		
Maternity	1	% women with a primary postpartum haemorrhage of 1500ml or more	JW	CQIC	<3.1%		2.85%	2.39%	3.35%	3.15%	3.35%	3.27%	↑	↑		Target added in July-15 due to new London Quality Standards
Maternity	1	% women with a primary postpartum haemorrhage of 2000ml or more	JW	CQIC	<=1.0%	1.5%	1.83%	0.80%	0.98%	1.33%	0.98%	0.06%	↓	↑		
Maternity	1	Significant Perineal Trauma	JW	CQIC		3.29%	2.24%	1.79%	2.17%	2.31%	2.17%	2.26%	↓	↑		Data reported 1 month in arrears as requires coding to be completed

Qualitative Summary - October 2015

Clinical Audit

As part of the process when a patient undergoes a procedure, the clinician will provide information and discuss the risks and benefits of this prior to the procedure being carried out. The patient is given an opportunity to ask questions and both clinician and the patient sign the consent form. This process of consent is audited as part of the Trust's rolling audit programme. Over the past year audits have been carried out in Orthopaedics, Gynaecology, Ophthalmology, Pain Clinic and Radiology. Generally, the results showed that the Trust's Policy for taking consent was being followed. A few minor issues are being addressed via action plans. Currently, audits are underway in Breast Surgery and Maternity and other specialties are planned within our rolling programme.

Complaints

The Trust received 30 formal complaints in October 2015 compared to 32 in October 2014. Emergency Services received the highest amount of complaints accounting for 53% of the total, followed by Specialist Services (43%) and Trust (3%).

The most frequent complaint subjects that were received related to communication (27%), followed closely by care and treatment (23%), appointments (20%), diagnosis, medication, test/investigation (7% each), information governance, surgical procedural issues and security (3% each).

Reopened complaints

Three complaints were reopened in October 2015, arising from complaints first received in October 2014 (1), August 2015 (1) and September 2015 (1).

The reasons for these complaints reopening were:

Facts Challenged – 1
Further Questions – 2

Ombudsman Referrals

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

Clinical Quality Report — **Author: Jane Wilson**

Exception Report 1: 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 statistical process control charts.

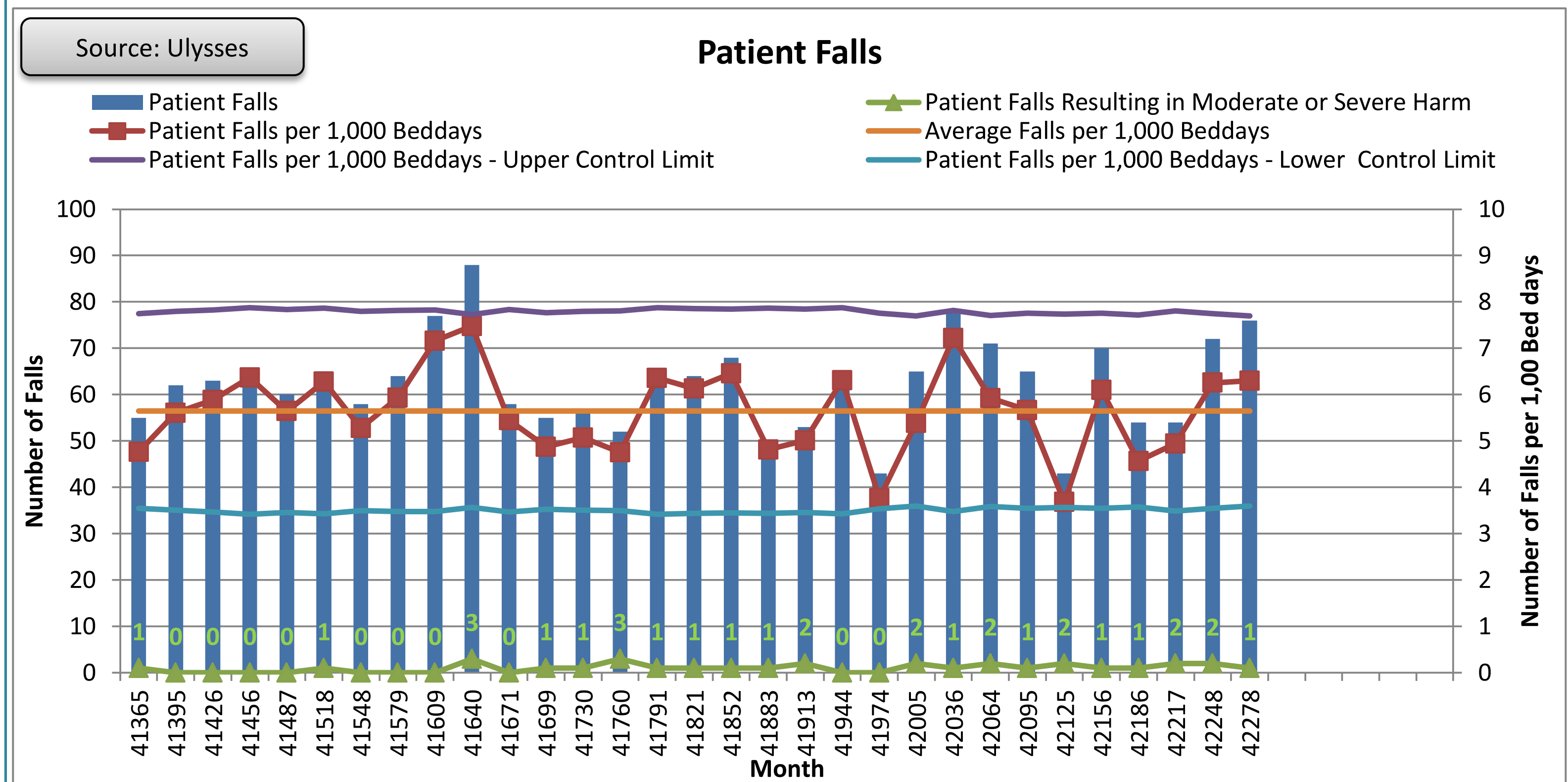
Falls occur most frequently on the Medical Wards but their is no individual ward that has an outlying rate. The number of falls are highest on the wards with high bed numbers and patient turnover, with AAU having the highest number at 15 falls in October-15.

There was 1 fall with harm in October 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: Fran Brooke-Pearce**

Exception Report 2: Hand Hygiene

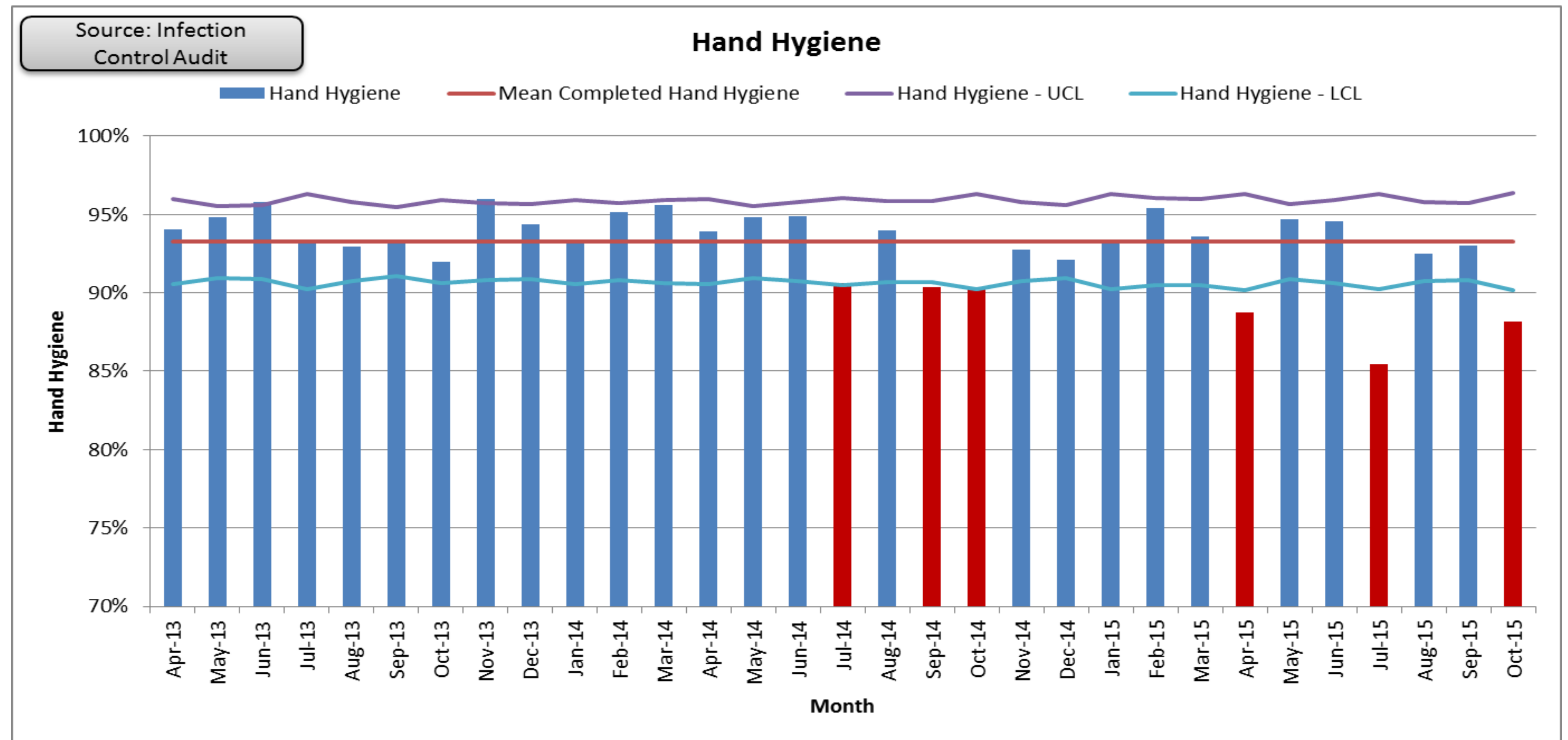
During October 2015 the Saving Lives Audits showed that our hand hygiene scores were below our 95% target. In response, the Infection Prevention and Control Team (IPCT) have put forward an action plan to increase scores.

Link Practitioners will now carry out peer review audits every month. The Link Practitioners will continue to actively challenge poor compliance during the audit and will now speak directly to the nurse in charge upon completion, getting a signature to demonstrate that a discussion has taken place.

Areas that are low scoring will be audited on a weekly basis by a senior member of staff for feedback and discussion at each ward handover.

Signage relating to hand hygiene is currently being reviewed in clinical areas by the IPCT, and hand hygiene training sessions by the Deb Rep (supplier of our soap and hand sanitiser) have been arranged for clinical areas in December 2015.

Actions are also taking place to ensure that there is proper provision of hand hygiene supplies, including all staff being encouraged to carry a small bottle of hand sanitiser while working in clinical areas.



Actions	Person Responsible	Date & RAG status	Committee monitoring delivery
1. Hand hygiene practice improvement - the IPCT to continue to target areas with poor scores	Infection Prevention and Control Team	30/11/2015	Infection Prevention & Control Group
2. Weekly audits of low scoring areas	Infection Prevention and Control Team	30/11/2015	Infection Prevention & Control Group
3. Ordering and provision of hand sanitiser to all staff working in clinical areas	Infection Prevention and Control Team	30/11/2015	Infection Prevention & Control Group

Clinical Quality Report **Author: Pinar Confait**

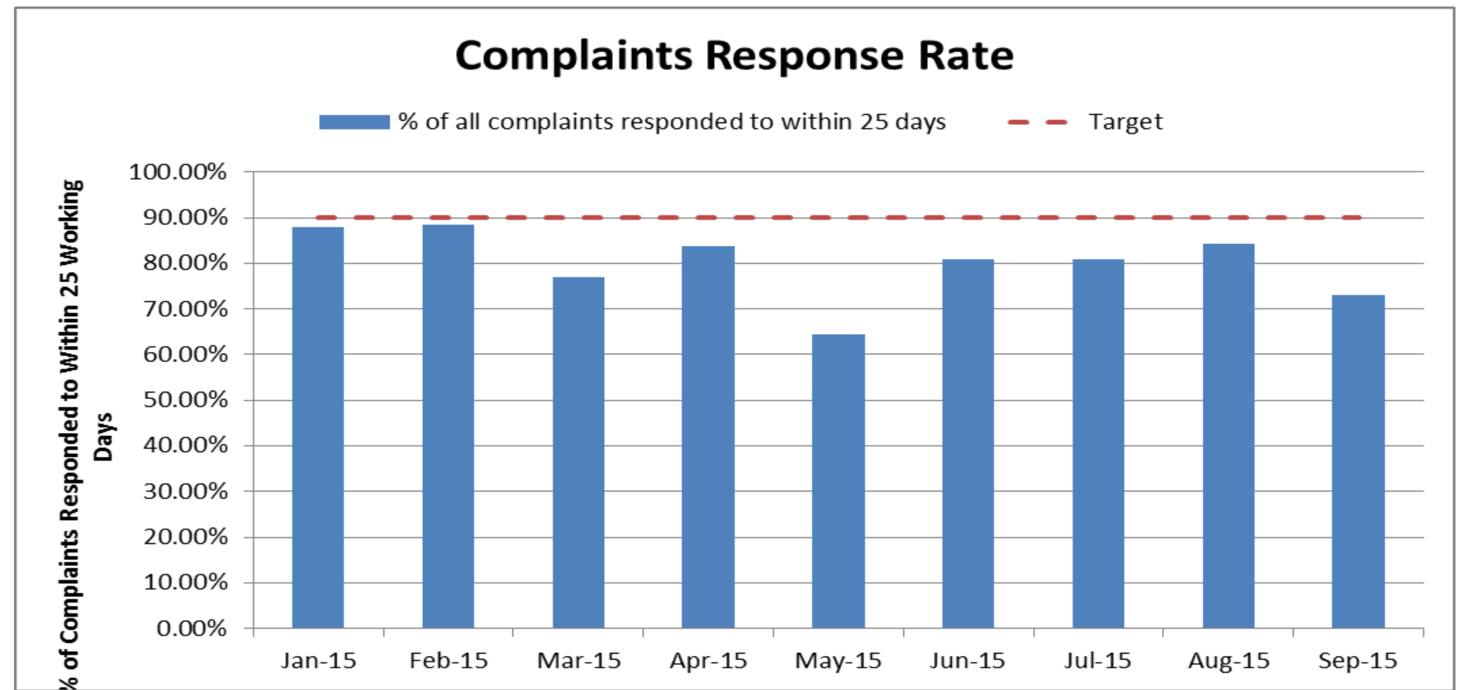
Exception Report 3: Complaints Response Rate

The complaint response rate in Oct-15 was 73.0%.

The service lines failing to respond within the target were Accident & Emergency, Breast, Upper & Lower GI and A, Gastroenterology, General Surgery, Haematology, Paediatrics, Stroke Services and Urology. Reasons for this include complexity of complaints requiring additional time to investigate; availability of key staff to give statements due to leave; and the need to contact clinicians outside of the Trust (for example the patient's GP).

Considerable effort is being made to redress this declined performance. SLMs are alerted to complaints that do not meet the internal target, and chasing emails and telephone calls are made weekly. Delayed complaint responses are escalated throughout the service line governance meetings.

Further support has been offered by the Complaints team to support areas needing additional help. This includes a proactive look forward to identify potential areas of risk The complaints department are for example providing additional support to the Emergency Department currently to enable complaints performance to be maintained.



	Person Responsible	Date	Committee monitoring delivery
1. Ensure all service lines meeting timelines for complaints response	Divisional Directors	30/11/2015	Executive Management Committee

Clinical Quality Report - Action Log

Action Number	Date	KPI	Action	Owner	Action By	Status
1	Oct-14	Falls	1. Continue implementation of actions arising through Trust Falls Group	JW	Ongoing	
2	Jun-15	Complaints	1. Ensure all service lines meeting timelines for complaints response	DB	30/11/2015	
3	Jun-15	FFT	1. Complete Team Development Programme by all Inpatient Wards	DB	30/11/2015	
4	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	
5	Jun-15	Maternity PPH	1. All midwives recruited will be in post by end of October 2015	DB	01/10/2015	
6	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	
7	Jun-15	Pressure Ulcers	1. Development of the Pressure Ulcer Prevention Strategy	DB	01/10/2015	
8	Aug-15	Pressure Ulcers	3. Serious Incident Report - Derwent	DB	14/10/2015	
9	Oct-15	Falls	Implement local SWARM	JW	01/11/2015	
10	Oct-15	Hand Hygiene	1. Hand hygiene practice improvement - the IPCT to continue to target areas with poor scores	DB	30/11/2015	
11	Oct-15	Hand Hygiene	2. Weekly audits of low scoring areas	DB	30/11/2015	
12	Oct-15	Hand Hygiene	3. Ordering and provision of hand sanitiser to all staff working in clinical areas	DB	30/11/2015	
13	Oct-15	Pressure Ulcers	1. Serious Incident Report - Bronte	DB	14/10/2015	
14	Oct-15	Pressure Ulcers	2. Serious Incident Report - Cambridge	DB	21/10/2015	
15	Oct-15	Pressure Ulcers	3. Serious Incident Report - Derwent	DB	14/10/2015	