Kingston Hospital NHS Foundation Trust

# Kingston Hospital NHS Foundation Trust

## Clinical Quality Report
## Jun-16 (Month 3)

**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 quality metrics are generally good in June 2016 although improvements in specific areas of poor performance have not been realised, with hand hygiene results the area of most specific focus. The exception report details a campaign of raising awareness with greater visibility of the infection control team delivering face to face training, new posters and a communication from the Director of Nursing and Patient Experience and Medical Director.

Performance with pressure ulcers, falls and hospital acquired infection are all good and the mortality indices remain in the expected range with a particularly low unadjusted mortality in June. The Board will note that the Q1 2016/7 SHMI is higher than Q4 2015/6. This remains in the expected range, and unlike the unadjusted mortality it relates to a historic period. Being a standardised algorithm the score is also subject to variations outside the Trust. The first meeting of the Trust wide Mortality group to be chaired by the Medical Director is scheduled for September 2016.

Responding to complaints in a timely still requires improvement, although this has improved since the previous month and the number of complaints received in month is slightly lower than prior months. Providing comprehensive response s to complaints is challenging in the time frame when complaints are complex and involve different departments, Service line teams are being reminded about the importance of identifying these and negotiating a reasonable timeframe for response with the complainant. The Board should note that the complaints team in the last month have also introduced a central tracker of actions arising from complaints to aid monitoring of the

The roll out of vital signs integration into the clinical record in A & E is delayed due to technical issues which is in the process of being resolved. Further focus though Trust wide messaging and the Sepsis project continues to ensure that all the vital signs measurements are recorded and therefore a NEW score created.

The Trust-wide FFT score is 94.84% of patients responding that they would recommend the Trust to friends or family for care or treatment. The rise in the score reflects the improvement in the scores in outpatients and the Emergency Department. Response rates have also improved.

The Board should note the addition of KPIs relating to Sepsis, the percentage of patients receiving antibiotics within 1 hour has risen from 57% in Q4 2015/16 to 67% in Q1 2016/17.

Safe nursing & midwifery data continues to show improvement with further ongoing reduction in agency expenditure to 8.8% in June 2016. The Trust has started mandatory returns of Care Hours Per Patient Day (CHPPD) for inpatient nursing areas and will be provided alongside existing safe staffing information over coming months, in line with national publication timeframes.

Dementia screening results have It is expected that these will improve from August as a new member of staff has joined the clinical audit team with responsibility for focus and improvement of the results. There are also planned focus on this requirement as part of the new junior doctors joining the Trust in August 2016.

A deep dive into postpartum haemorrhage (PPH) rates is taking place in maternity in response to the PPH rates in maternity which remain higher than the Trust Target. The outcome of this will be reported to the next Quality Assurance Committee.

**Clinical Quality Dashboard - June-16**

| | Strategic objective | KPI description | Exec Owner | Reported in | Target/ Benchmark | Actual 2015-16 | Apr-16 | May-16 | Jun-16 | 2015-16 Q4 | 2016-17 Q1 | 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 | 20 | 0 | 1 | 1 | 4 | 2 | 2 | ↓ | → | | |
| | 1 | Number of patients with hospital acquired pressure ulcers (Grade 3&4) per 1000 beddays | DB | CQIC | <=0.1 | 0.14 | 0.00 | 0.09 | 0.09 | 0.11 | 0.06 | 0.06 | ↓ | ↓ | | |
| | 1 | Number of patients with hospital acquired pressure ulcers (Grade 2) | DB | Board - CPR, CQIC | <=3 | 36 | 4 | 0 | 1 | 8 | 5 | 5 | ↓ | ↑ | | |
| | 1 | Number of patients with hospital acquired pressure ulcers (Grade 2) per 1000 beddays | DB | CQIC | <=0.51 | 0.26 | 0.35 | 0.00 | 0.09 | 0.22 | 0.15 | 0.15 | ↓ | ↑ | | |
| | 1 | Number of Patient Safety Incident (PSI) Falls | JW | CQIC | <=58 | 774 | 58 | 40 | 53 | 225 | 151 | 151 | ↓ | ↑ | | |
| | 1 | Number of Patient Safety Incident Falls where moderate or severe harm occurred | JW | CQIC | <=6 | 18 | 4 | 0 | 1 | 8 | 5 | 5 | ↓ | ↑ | | |
| | 1 | Number of Patient Safety Incident Falls per 1000 G&A beddays | JW | Board - CPR, CQIC | <=5.3 | 5.5 | 5.1 | 3.8 | 4.8 | 6.2 | 4.6 | 4.6 | ↓ | ↑ | | |
| | 1 | MRSA Bacteraemias - Post 48hour (Hospital Acquired) | DB | Board - CPR, CQIC | <1 | 2 | 0 | 0 | 0 | 1 | 0 | 0 | ↓ | → | | Target is zero tolerance as per national guidance and contract. |
| | 1 | Clostridium difficile Infections - Post 72hours (Hospital Acquired) | DB | Board - CPR, CQIC | | 19 | 0 | 2 | 0 | 5 | 2 | 2 | ↓ | ↓ | | |
| | 1 | Clostridium difficile Infections - Post 72hours (Hospital Acquired) due to Lapse in Care **CONFIRMED** | DB | Board - CPR, CQIC | <1 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | → | → | | 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 | <=1 | 9 | 0 | 0 | 1 | 2 | 1 | 1 | ↓ | ↑ | | Exception Report 1 |
| | 1 | Completed Patient Observations | DB | CQIC | >=97% | 92.6% | 91.9% | 93.0% | 93.8% | 95.3% | 93.0% | 93.0% | ↓ | ↑ | | NEWS data |
| | 1 | Medication Incidents | JW | CQIC | | 718 | 49 | 49 | 45 | 174 | 143 | 143 | ↓ | ↓ | | 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% | 0.1% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | → | → | | |
| | 1 | Number of Serious Untoward Incidents | JW | CQIC | | 46 | 4 | 2 | 0 | 10 | 6 | 6 | ↓ | ↓ | | 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 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | → | → | | |
| | 1 | Patient Safety Thermometer - % Harm Free Care | DB | CQIC | | 94.4% | 92.14% | 93.09% | 93.53% | 94.4% | 92.9% | 92.9% | ↓ | ↑ | | |
| Effectiveness | 1 | SHMI | JW | Board - CPR, CQIC | <=95 | 89.6 | | | | 87.6 | 93.18 | | ↑ | | | SHMI score < 100 is lower than expected mortality, taking into account age, gender, comorbidity and diagnosis grouping of patients.<br><br>The Q4 score is for Jul-14 - Jun-15, published in Jan-16. The Q1 score is for Oct-14 - Sep-15, published in Mar-16. |
| | 1 | Unadjusted Mortality Rate | JW | CRC | | 1.1% | 1.2% | 1.1% | 0.9% | 1.3% | 1.1% | 1.1% | ↓ | ↓ | | |
| | 1 | Sepsis - Percentage of eligible patients screened for sepsis - Emergency Department | JW | CQIC | | | 66.0% | 76.0% | 74.0% | 67.3% | 72.0% | 72.0% | ↑ | | | Sepsis data is provided on a quarterly basis by Clinical Audit and is reported in arrears. |
| | 1 | Sepsis - Percentage of eligible patients who received antibiotics within 1 hour of arrival - Emergency Department | JW | CQIC | | | 82.0% | 59.0% | 67.0% | 57.5% | 67.0% | 67.0% | ↑ | | | |
| | 1 | % of eligible patients screened for dementia | DB | CQIC | 90% | | 48.6% | 39.7% | | 82.0% | 44.2% | 44.2% | | | | Dementia reporting is carried out by Clinical Audit and is reported in arrears |
| | 1 | % of Patients with dementia who were appropriately assessed | DB | CQIC | 90% | | 60.6% | 60.7% | | 82.1% | 60.6% | 60.6% | | | | |
| | 1,4 | % Emergency Readmissions following elective admission - 30 days | DB | CQIC | | 2.1% | 1.6% | 2.4% | 1.9% | 1.9% | 2.0% | 2.0% | ↑ | ↓ | | Local data has been used to give an indication of performance. |
| | 1,4 | % Emergency Readmissions following emergency admission - 30 days | DB | CQIC | | 14.0% | 11.9% | 11.6% | 12.6% | 13.8% | 12.0% | 12.0% | ↓ | ↑ | | |
| | 1 | Prevention of hospital acquired VTE - % patients risk assessed | JW | CQIC | >=95% | 98.6% | 98.7% | 98.6% | 98.39% | 98.05% | 98.54% | 98.54% | ↑ | ↓ | | |
| | 1 | Incidence of Hospital Acquired VTE (HAT) | JW | CQIC | | 2 | 0 | 3 | 1 | 1 | 4 | 4 | ↑ | ↓ | | |
| | 1 | Hand Hygiene | DB | CQIC | >=95% | 89.3% | 83.5% | 83.6% | 83.1% | 94.1% | 83.4% | 83.4% | ↓ | ↓ | | Target is locally set. |
| | 1 | Open Incidents - % of Managers Reports Completed within policy guidelines | DB | CQIC | | 53.68% | 41% | 38% | 44% | | | 41.0% | | ↑ | | |

| Clinical Quality Dashboard - June-16 | | | | | | Actual | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Strategic objective | KPI description | Exec Owner | Reported in | Target/ Benchmark | 2015-16 | Apr-16 | May-16 | Jun-16 | 2015-16 Q4 | 2016-17 Q1 | YTD | Qtr Trend | Month Trend | Forecast | Comments |
| Patient Experience | 1 | Number of Complaints received this month | DB | CQIC | | 465 | 40 | 34 | 32 | 120 | 106 | 106 | ↓ | ↓ | | |
| | 1 | Number of Complaints reopened this month | DB | CQIC | | 65 | 9 | 4 | 4 | 17 | 17 | 17 | → | → | | |
| | 1 | Number of Complaints referred to ombudsman this month | DB | CQIC | | 7 | 0 | 0 | 0 | 2 | 0 | 0 | ↓ | → | | |
| | 1 | % Complaints responded to within 25 working days | DB | CQIC | >=90% | 81.9% | 72.5% | 82.4% | | 82.5% | 77.0% | 77.0% | ↓ | ↑ | | Data reported 1 month in arrears. |
| | 1 | Friends and Family Score - Trust | DB | CQIC | | 95.09% | 94.73% | 93.12% | 94.84% | 94.95% | 94.16% | 94.16% | ↓ | ↑ | | 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 - Inpatient | DB | CQIC | | 93.15% | 94.24% | 95.40% | 94.83% | 94.64% | 94.86% | 94.86% | ↑ | ↓ | | The Inpatients response rate was 44.5% for Jun-16<br><br>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. |
| | 1 | Friends and Family Score - Paediatric Inpatient | | | | 93.59% | 87.69% | 94.74% | 92.86% | 92.06% | 91.72% | 91.72% | ↓ | ↓ | | Paediatric inpatient FFT data is included in the main Inpatient FFT score, though the score is also reported and reviewed separately. |
| | 1 | Friends and Family Score - Outpatient | DB | CQIC | | 94.42% | 93.38% | 88.78% | 93.66% | 92.51% | 91.83% | 91.83% | ↓ | ↑ | | |
| | 1 | Friends and Family Score - A&E | DB | CQIC | | 94.34% | 95.86% | 91.42% | 94.51% | 95.40% | 93.54% | 93.54% | ↓ | ↑ | | The A&E response rate was 8.0% for Jun-16 |
| | 1 | Friends and Family Score - Maternity | DB | CQIC | | 95.37% | 96.68% | 96.39% | 96.26% | 94.94% | 96.40% | 96.40% | ↑ | ↓ | | 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 | | 98.17% | 97.95% | 98.16% | 97.37% | 98.36% | 97.81% | 97.81% | ↓ | ↓ | | |
| | 1 | Friends and Family Score - Support for Carers of Patients With Dementia | DB | CQIC | | | | | | 83.78% | | | | | | |
| | 1 | Number of Mixed Sex accommodation breaches | DB | CQIC | 0 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | → | → | | This is based on a national directive. |
| Safer Staffing | 1 | Day - Registered Midwives/Nurses Fill Rate | DB | CQIC | | 93.97% | 98.2% | 97.7% | 99.8% | 97.3% | 97.9% | 97.9% | ↑ | ↑ | | |
| | 1 | Day - Assistant Fill Rate | DB | CQIC | | 119.39% | 139.5% | 125.0% | 114.1% | 118.6% | 132.2% | 132.2% | ↑ | ↓ | | |
| | 1 | Night - Registered Midwives/Nurses Fill Rate | DB | CQIC | | 98.65% | 98.2% | 99.5% | 98.8% | 99.8% | 98.9% | 98.9% | ↓ | ↓ | | |
| | 1 | Night - Assistant Fill Rate | DB | CQIC | | 114.94% | 145.5% | 134.1% | 122.9% | 126.2% | 139.8% | 139.8% | ↑ | ↓ | | |
| | 1 | Overall Trust Fill Rate | DB | CQIC | | 102.52% | 110.5% | 106.9% | 104.5% | 105.1% | 108.7% | 108.7% | ↑ | ↓ | | |
| | 1 | % of Registered Nurse and Midwife Expenditure on Agency Staff | DB | FIC | | 14.48% | 11.4% | 9.2% | 8.8% | 15.8% | 9.8% | 9.8% | ↓ | ↓ | | |
| Maternity | 1 | Caesarean section rate | JW | CQIC | <=26% | 29.3% | 29.46% | 30.77% | 28.24% | 28.35% | 29.48% | 29.48% | ↑ | ↓ | | |
| | 1 | % women with a primary postpartum haemorrhage of 1500ml or more | JW | CQIC | <3.1% | 3.3% | 5.16% | 3.52% | 4.67% | 3.80% | 4.45% | 4.45% | ↑ | ↑ | | |
| | 1 | % women with a primary postpartum haemorrhage of 2000ml or more | JW | CQIC | <=1.0% | 1.1% | 2.02% | 1.54% | 1.70% | 0.97% | 1.75% | 1.75% | ↑ | ↑ | | |
| | 1 | Significant Perineal Trauma | JW | CQIC | | 2.69% | 3.34% | 2.20% | 3.18% | 2.76% | 2.90% | 2.90% | ↑ | ↑ | | Data reported 1 month in arrears as requires coding to be completed |

# Qualitative Summary - June 2016

## Clinical Audit

The ITU Physiotherapy Team has recently carried out a clinical audit to assess adherence to the NICE Guidelines for Rehabilitation after Critical Illness. These guidelines from the National Institute for Health and Care Excellence (NICE) provide best practice guidance for adults requiring rehabilitation after a period of critical illness. Physiotherapists play a crucial part in delivering that rehabilitation.

The audit found that all patients had a clinical assessment to determine their requirements and all patients started with rehabilitation as soon as they were clinically able. As a result of this audit, the ITU Physiotherapy team has devised a system to stratify patients into low risk and high risk, as per the NICE guidelines and to ensure this is documented on our electronic patient record. This will help them to identify which patients require goal-setting and further comprehensive assessment on discharge, which are also elements of the NICE guidelines. Additionally an information sheet is being devised to provide patients with details of their rehabilitation pathway. This audit will be repeated in six months' time after these actions have been implemented.

## Complaints

The Trust received 33 formal complaints in June 2016 compared to 42 in June 2015.

Specialist Services received the highest amount of complaints accounting for 45% of the total, followed by Emergency Services (39%), Trust (9%) and Clinical Support Services (6%).

The most frequent complaint subjects that were received related to communication (33%), followed by appointments and care and treatment (15% each), estates (12%), procedural issues, tests/investigations and diagnosis (6% each), admission/discharge and medical devices and equipment (3% each).

## Reopened complaints

Four complaints were reopened in June 2016, arising from complaints first received in March 2016 (1) and April 2016 (3).

The reasons for these complaints reopening were:

Facts Inaccurate – 1
Facts Challenged – 1
Further Questions – 1
Recurrent Issues – 1

## Ombudsman Referrals

No complaints were referred to the Ombudsman in June 2016.

**Clinical Quality Report** **Author: Fran Brooke-Pearce**

**Exception Report 2: Hand Hygiene**

Matrons / Senior Sisters are now joining the Link Practitioners for hand hygiene auditing in order to strengthen active challenging of poor practice at the time audits are completed. Staff who repeatedly fail to follow Trust policy will continue to be reported to Jane Wilson / Duncan Burton.

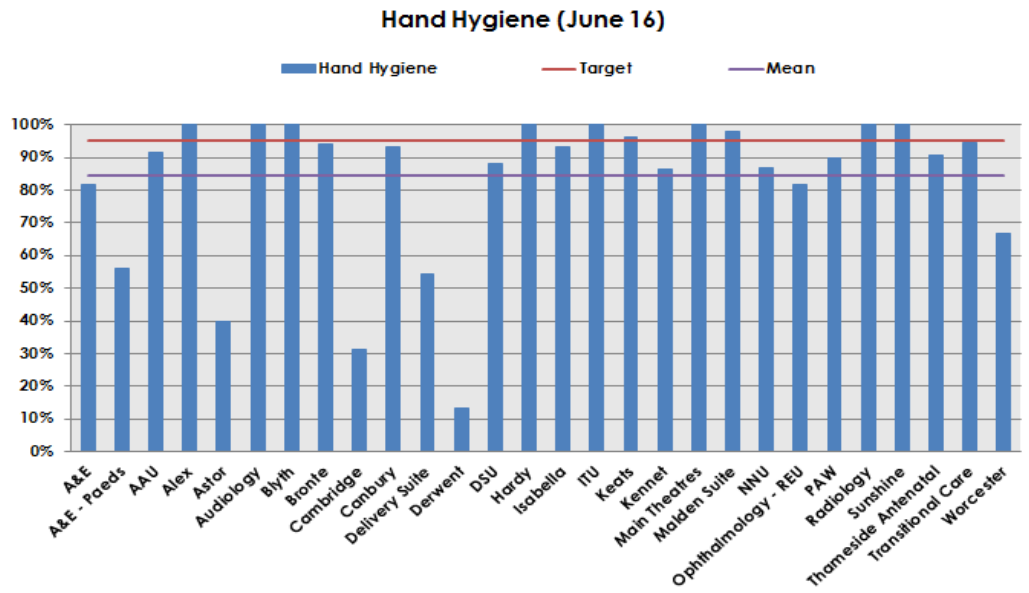
The IPCT continue to implement initiatives from the new Hand Hygiene Action Plan. The 'Surewash' mobile Hand Hygiene training and assessment unit is in place and is staying in clinical areas for four days each to enable all staff to complete the Hand Hygiene challenge. Areas with poor compliance are being targeted first.

The IPCT have displayed new hand hygiene posters in most clinical areas.

The IPCT held a Trust Hand Hygiene week at the end of June 2016.

A training plan for re-introducing face to face mandatory Infection Control training has been devised and it has been agreed to include infection control training on corporate induction. Discussions are still taking place regarding the format of face to face training for mandatory update.

Source: Infection Control Audit




| Actions | Person Responsible | Date & RAG status | Committee monitoring delivery |
|---|---|---|---|
| Matrons to accompany staff on infection control audits | Matrons | 31/07/2016 | Clinical Quality Improvement Committee |
| Production of new posters for the Trust and for clinical areas | Infection Prevention and Control Team/Communications | 30/06/2016 | Infection Prevention & Control Group |
| Production of new posters for the Trust and for clinical areas | Infection Prevention and Control Team/Communications | 30/06/2016 | Infection Prevention & Control Group |
| Link Practitioner training to promote and ensure audit compliance | Infection Prevention and Control Team | 30/06/2016 | Infection Prevention & Control Group |

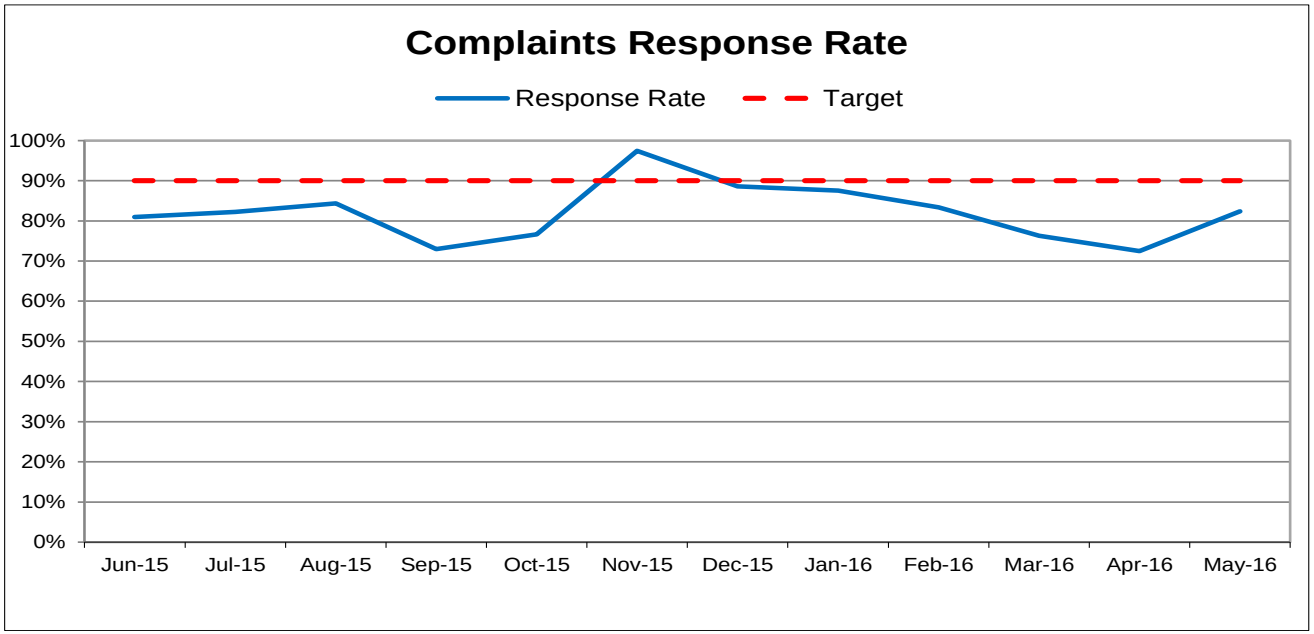
**Clinical Quality Report** **Author: Clare Parker**

**Exception Report 3: Complaints Response Rate**

The Complaints Response Rate for May-16 was 82.4% which is below the 90% target.

There were 6 complaints which were delayed as a result of further comment or information required from our A&E (3), Bronte Ward (1), ENT (1) and Derwent Ward (1). Two A&E and one ENT complaint were delayed due to the delay in the Radiology department providing comments. This was due to leave of the SLM. There were no themes or common causes for delays in responding to complaints for Derwent and Bronte Wards.

The Complaints team continue to anticipate, and regularly and robustly chase up any responses that are approaching the response deadline. The Complaints Manager dedicates the majority of her time to the accurate logging, notifying and chasing up of potentially overdue responses, and giving her support to ensure that Service Line Managers have the best opportunity to provide responses on time. Where necessary, and increasingly, the Complaints team draw together complaint responses where multiple Service Lines are involved . The Complaints team will continue to regularly remind Service Line Managers of response deadlines and to offer support where needed.



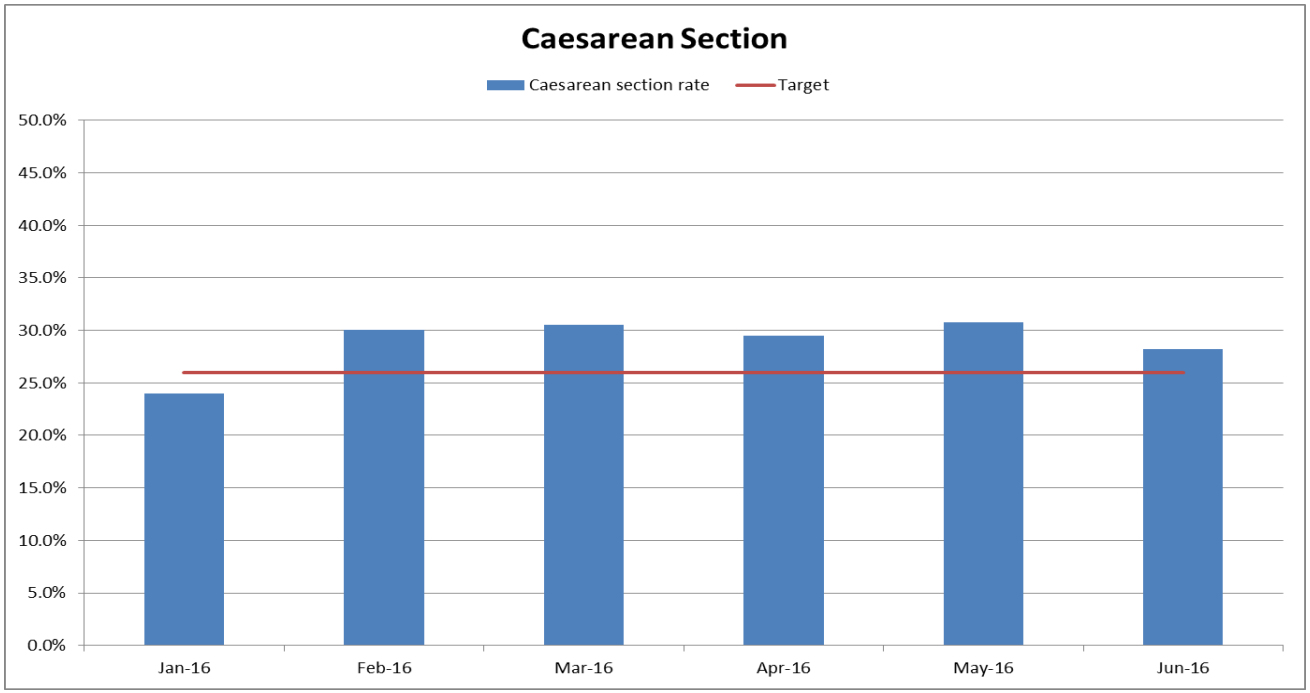

| Actions | Person Responsible | Date & RAG status | Committee monitoring delivery |
|---|---|---|---|
| Meet with service line managers in areas of consistent non- compliance to review plans to meet requirements | Director of Nursing & Patient Experience | 31/08/2016 | Clinical Quality Improvement Committee |

**Clinical Quality Report** **Author: Anna Dellaway**

**Exception Report 3: Maternity - Caesarean Section**

The maternity service continues to see a high CS rate and in June 2016 saw a rate of 28.24%. All emergency births were reviewed by the SUTS team to determine whether the management was appropriate.

The number of elective CSs remains high and we have seen an increase of emergency CSs. The consultant labour ward lead is completing a review on 24 cases of maternal request LSCS to identify themes and ensure the correct pathway is being followed and this action is in progress. The consultant midwife and consultant obstetrician for labour ward are planning to implement a pathway particularly for VBAC women. This approach has been successful elsewhere and it is anticipated that the % will gradually come down.



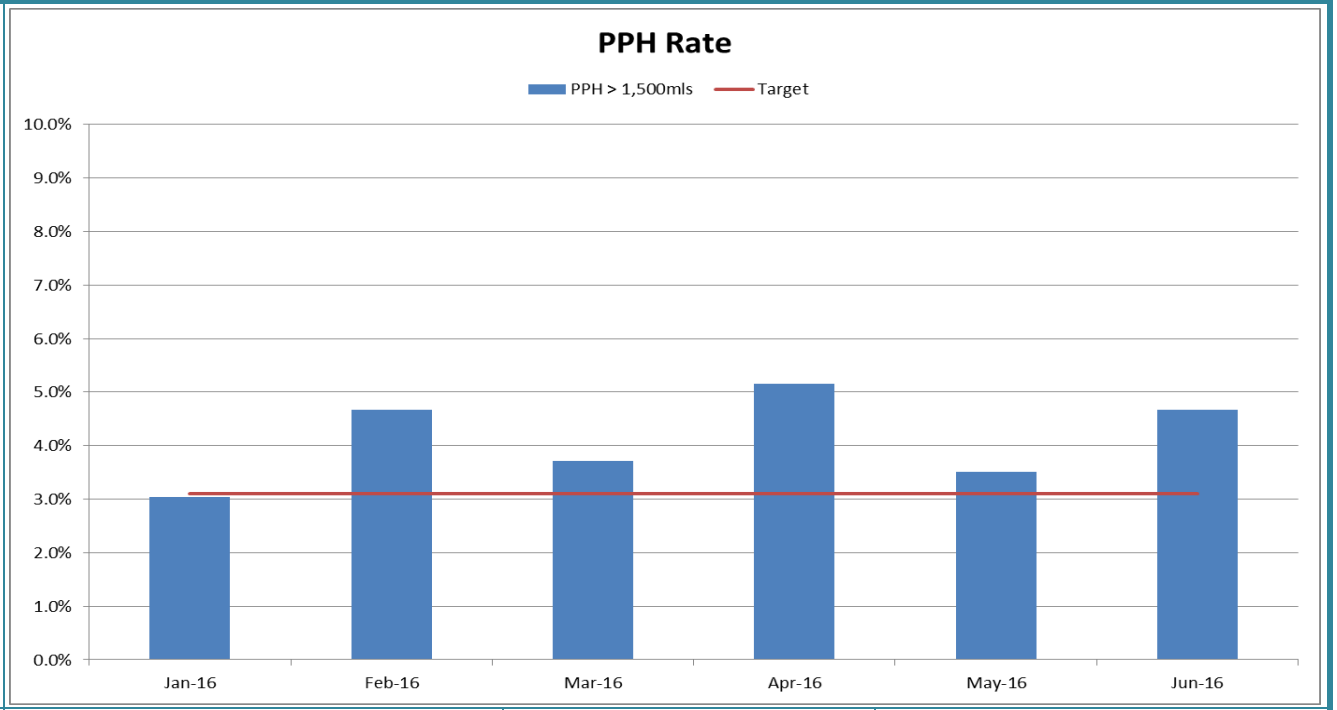

| Actions | Person Responsible | Date & RAG status | Committee monitoring delivery |
|---|---|---|---|
| Review all emergency birth April- June. Provide a summary report of themes and issues | SUTS team | 31/07/2016 | Maternity Risk Group/SLM |
| Complete review of case series maternal request LSCS | Gabby Bambridge | 01/08/2016 | Maternity Risk Group/SLM |
| Implement VBAC pathway | Elizabeth Hamilton and Gabby Bambridge | 01/08/2016 | Maternity Risk Group/SLM |

**Clinical Quality Report** **Author: Anna Dellaway**

**Exception Report 4: Maternity - Postpartum Haemorrhage**

The maternity service has fluctuation in the PPH rate. The target is <3.1% for 1,500mls and in June the rate increased from 3.5% to 4.7%. The overall PPH rate for 2015/16 was 3.3%. There is a rolling audit of PPH cases, and as a result of themes from the most recent audit, labour ward lead consultant is carrying out targeted teaching for junior doctors on the instrumental delivery to minimise trauma. There has also been a teaching session for junior doctors on the possible contribution perineal trauma makes to PPH.

The risk team will now carry out a deep dive on PPH to identify any further themes and concerns. This should be in a position to report back in July. The SUTS team review all emergency births for further discussion and learning on whether a CS or instrumental delivery was necessary. The higher LSCS rate may also have contributed to the raised PPH rate. The unit is following the recommendations of the SWL PPH toolkit. We will continue to monitor the rates of PPH and complete actions below to ensure the upward trend does not continue.

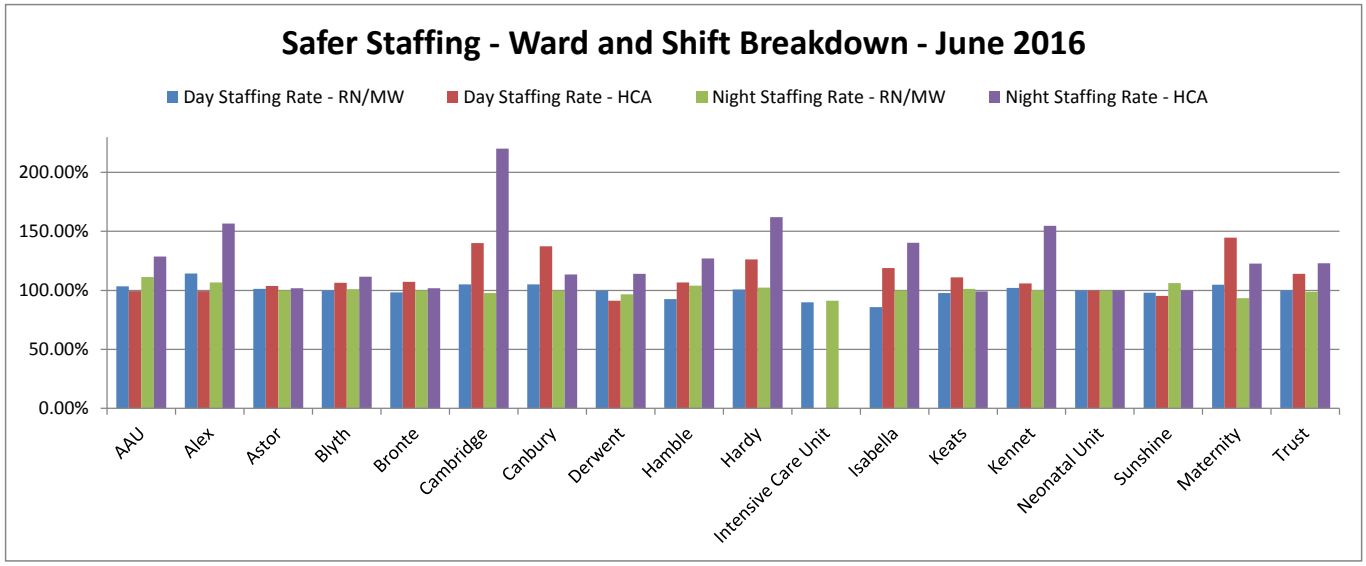



| Actions | Person Responsible | Date & RAG status | Committee monitoring delivery |
|---|---|---|---|
| Deep dive into PPH to identify themes and concerns | Anna Dellaway, Louise Wheeler and Diana Fleming | 01/08/2016 | Maternity Risk Group/SLM |

In June 2016 the staffing rates are much improved which is reflective of the impact of nurse recruitment. There was a higher rate of Healthcare Assistants availability compared to expected figures due to requirements for 1:1 nursing care during the period (to support patients identified at high risk e.g. falling, confusion), and replacement of registered nurses where they cannot be sourced. The Trust is commencing a project aimed at 1:1 supervision of patients also known as 'specialing' which will take into consideration work that has been undertaken in other Trusts as part of the Carter recommendations.

| Ward | Day Staffing Rate - RN/MW | Day Staffing Rate - HCA | Night Staffing Rate - RN/MW | Night Staffing Rate - HCA |
|---|---|---|---|---|
| AAU | 103.41% | 99.41% | 111.23% | 128.72% |
| Alex | 114.34% | 99.35% | 106.67% | 156.67% |
| Astor | 101.29% | 103.68% | 100.00% | 101.67% |
| Blyth | 99.88% | 106.49% | 100.99% | 111.45% |
| Bronte | 98.15% | 107.32% | 100.00% | 101.69% |
| Cambridge | 104.92% | 140.05% | 97.78% | 220.00% |
| Canbury | 105.16% | 137.46% | 100.00% | 113.33% |
| Derwent | 99.72% | 91.21% | 96.77% | 114.04% |
| Hamble | 92.70% | 106.69% | 103.96% | 127.12% |
| Hardy | 100.75% | 126.29% | 102.25% | 161.92% |
| Intensive Care Unit | 89.79% | - | 91.19% | - |
| Isabella | 85.75% | 118.88% | 100.00% | 140.43% |
| Keats | 97.76% | 111.04% | 101.12% | 99.06% |
| Kennet | 101.95% | 105.83% | 100.12% | 154.71% |
| Neonatal Unit | 100.00% | 100.00% | 100.00% | 100.00% |
| Sunshine | 98.05% | 95.16% | 106.13% | 100.00% |
| Maternity | 104.70% | 144.80% | 93.30% | 122.6% |
| **Trust** | **99.77%** | **114.12%** | **98.75%** | **122.88%** |

| 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 | Oct-14 | Falls | 1. Continue implementation of actions arising through Trust Falls Group | JW | Ongoing | |
| 2 | Jun-15 | FFT | 1. Complete Team Development Programme by all Inpatient Wards | DB | 30/11/2015 | |
| 3 | Feb-16 | Pressure Ulcers | 1. Rollout of MDT/SWARM approach to pressure ulcers | DB | 08/03/2016 | |
| 4 | Mar-16 | Infection Control | VIP Scoring Guideline Changes | DB | 19/04/2016 | |
| 5 | Apr-16 | Maternity - C-Section | Review all emergency birth April- June. Provide a summary report of themes and issues | JW | 31/07/2016 | |
| 6 | Apr-16 | Maternity - C-Section | Complete review of case series maternal request LSCS | JW | 01/08/2016 | |
| 7 | Apr-16 | Maternity - C-Section | Implement VBAC pathway | JW | 01/08/2016 | |
| 8 | Apr-16 | Maternity - PPH | Deep dive into PPH to identify themes and concerns | JW | 01/08/2016 | |
| 9 | Apr-16 | Hand Hygiene | Production of new posters for the Trust and for clinical areas | DB | 30/06/2016 | |
| 10 | Apr-16 | Hand Hygiene | Request the return to face to face IC mandatory corporate induction and update training | DB | 30/06/2016 | |
| 11 | Dec-15 | Hand Hygiene | Link Practitioner training to promote and ensure audit compliance | DB | 30/06/2016 | |
| 12 | Dec-15 | Hand Hygiene | IPCT to monitor the Trust Hand Hygiene Action Plan and report through ICG. | DB | 22/01/2016 | |

## 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<br>Red | Full year < = 14.4<br>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<br>Red | <= 0.1<br>>0.1 |
| 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<br>Red | Full year <= 36<br>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<br>Red | <= 0.5<br>> 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<br>Red | <=51<br>>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<br>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<br>Red | <=5.3<br>>5.3 |
| 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<br>Amber<br>Red | Full year =< 1<br>Full year > 1 and =< 6<br>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<br>Red | Full year < =24<br>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<br>Amber<br>Red | Full year =< 1<br>Full year > 1 and =< 6<br>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<br>Red | <=2<br>>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<br>Amber<br>Red | >=85%<br>>=70% and <85%<br><70% |
| 14 | Completed Patient Observations | | Target is Locally set | Year to date performance is red | Data Source: Clinical Audit | Green<br>Amber<br>Red | > =97%<br>< 97% and > 94%<br>< 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<br>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<br>Red | =0<br>>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<br>Amber<br>Red | < =95<br>>95 and < 105<br>>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<br>Red | <= 5.7<br>> 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<br>Amber<br>Red | >= 95%<br>< 95% and > 90%<br>< 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<br>Amber<br>Red | >= 95%<br>>= 90% and < 95%<br>< 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.<br>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<br>Amber<br>Red | >=90%<br><90% and >80%<br><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<br>Amber<br>Red | >=96<br><96 and >91<br><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<br>Amber<br>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<br>Amber<br>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<br>Amber<br>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<br>Amber<br>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<br>Red | =0<br>>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<br>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<br>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<br>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<br>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<br>Red | TBC |
| 47 | Caesarean section rate | The percentage of deliveries performed as a C section<br><br>Numerator: Number of C-section deliveries<br><br>Denominator: Total number of deliveries | CHKS - SHA London Peer 75th Percentile | Exception report if latest 3 months are red | CRS | Green<br>Amber<br>Red | <= 26%<br>26% - 29%<br>>= 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<br><br>Denominator: The total number of deliveries | TBC | TBC | CRS | Green<br>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<br><br>Denominator: The total number of deliveries | HCC Review of Maternity Services 2008<br>median of 1.9 per 1,000 births<br>ranging from 0.1 per 1,000 to 8 per 1,000. | Exception report if latest 3 months are red | CRS | Green<br>Red | < =1%<br>> 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<br><br>Numerator: The number of stillbirths + neonatal deaths<br><br>Denominator: Total number of births | Last Year's Performance = 3.7<br>2011 National Data = 7.5 | When Quarterly performance is red | CRS | Green<br>Red | TBC |
| 47 | Number of Red Maternity Escalations | | | | | | |