The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Integrated Report

Quality, Performance & Workforce to end April 2018

The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

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Context for the Integrated Report

	Current Mth	Trend on prev mth	Previous Mth	Feb-18	Mar-18	Apr-18	FYTD
Emergency Department Attendances	5351	↓	5539	4774	5539	5351	5351
Outpatient Attendances	19791	↓	22065	21002	22065	19791	19791
Inpatient Admissions (Elective & Emergency)	3882	↓	3960	3647	3960	3882	3882
Other (regular day patients, day cases etc)	3266	↑	3109	3015	3109	3266	3266

Trust Risk Assessment framework

	Indicators	Target	Current QTD	Feb	Mar	Apr	Qtr 1	Qtr 2	Qtr 3	Qtr 4	*FYTD
Access	**Risk Assessment framework 2015/16**										
	18 Wks - Adm Perf (adjusted)	90.00%	77.70%	76.14%	73.97%	77.70%	77.70%				77.70%
	18 Wks - Non Adm Perf	95.00%	74.10%	86.89%	79.52%	74.10%	74.10%				74.10%
	18 Wks - Incomp Perf	92.00%	80.17%	82.76%	81.05%	80.17%	80.17%				80.17%
	A&E 4 Hour Performance	95.00%	81.29%	69.17%	79.26%	81.29%	81.29%				81.29%
	Cancer-62 Days RTT	85.00%	80.29%	79.66%	81.02%	n/a	79.37%	87.44%	85.06%	80.29%	83.23%
	Cancer - 31 Days Subsq Treatment - Surgery	94.00%	92.98%	88.24%	100.00%	n/a	93.55%	98.33%	100.00%	92.98%	95.91%
	Cancer - 31 Days Subsq - Drug Treatments	98.00%	100.00%	100.00%	100.00%	n/a	100.00%	99.47%	99.35%	100.00%	99.64%
	Cancer - 31 Days Subsq - Radiotherapy	94.00%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	31 Day Diag to Treat	96.00%	98.39%	100.00%	98.28%	n/a	98.39%	98.52%	99.38%	98.39%	98.67%
	Cancer-2 Wk Waits - All urgent Referrals (cancer suspected)	93.00%	97.21%	97.31%	96.96%	n/a	97.44%	96.21%	95.97%	97.21%	96.70%
	Cancer-2 Wk Waits - Symptomatic breast patients (cancer not initially suspected)	93.00%	97.01%	98.67%	100.00%	n/a	97.13%	99.10%	98.63%	97.01%	97.97%
	Care Programme Approach (CPA) patients										
	Follow up contact within 7 days of discharge	95%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	Having formal review within 12 months	95%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	Admissions to inpatients services had access to crisis resolution / home treat teams	95%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	Meeting commitment to serve new psychosis cases by early intervention teams	95%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	Ambulance FTs-Category A call – emergency response within 8 minutes										
	Category A call – emergency response within 8 minutes - Red 1 calls	75%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	Category A call – emergency response within 8 minutes - Red 2 calls	75%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	Ambulance FTs-Category A call – emergency response within 19 minutes										
	Category A call – ambulance vehicle arrives within 19 minutes	95%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Outcomes	**Clostridium Difficile**										
	Clostridium (C.) Difficile - meeting the C. difficile objective	4	3	5	6	3	3	0	0	0	3
	Mental Health										
	Minimising Mental Health delayed transfer of care	<7.5%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	Mental Health data completeness: identifiers	97%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	Mental Health data completeness: outcomes for patients on CPA	50%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	Certification against compliance with requirement regarding access to health care for people with a learning disabililty	N/A	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	Score			6	6	**					

*FYTD denotes Financial Year to Date (Please note - Cancer Wait Times figures are always 1 month in arrears)

** Not appropriate with absence of key data items for Cancer

Quality & Risk Scorecard

	Indicators	Var to prev mth	Target	Feb	Mar	Apr	*FYTD
Safe care	**Critical Incidents**						
	Total Never Events	→	0	0	0	0	0
	Total Falls Resulting in Serious Harm	→	0	2	0	0	0
	Pressure Ulcers - Grade 3	↑	0	2	2	5	5
	Pressure Ulcers - Grade 4	→	0	0	0	0	0
	Total Other Sis	↑	0	0	0	1	1
	Pressure Ulcers - Grade 2	↑	0	4	2	6	6
	Safety Thermometer - (New Harm Free)	↓	95.00%	90.51%	95.69%	92.04%	92.04%
	VTE Assessment Completeness	↑	97.24%	94.07%	97.66%	NA	97.10%
	Infection Control						
	MRSA	↕	0	0	0	2	2
	CDIFF	↕	4	5	6	3	3

	Indicators	Var to prev mth	Target	Feb	Mar	Apr	*FYTD
Patient experience	**Patient experience**						
	FFT % Recommended (IP & DC)	↕		96.09%	95.07%	95.38%	95.38%
	FFT % Recommended (AE)	↕		93.71%	89.73%	88.20%	88.20%
	FFT Response Rate (IP & DC)	↕	30.00%	26.76%	30.56%	31.72%	31.72%
	FFT Response Rate (AE)	↕	20.00%	13.02%	13.84%	10.35%	10.35%
	No. of Mixed Sex Accommodation breaches	↓	0	9	12	6	6
	Number of Patient moves (over 2)	↑		60	37	48	48
	Positive experience						
	Compliments	↓		105	145	128	128
	Complaints						
	Non-Clinical Complaints	↓		7	9	4	4
	Clinical Complaints	↓		19	27	26	26

	Indicators	Var to prev mth	Target	Feb	Mar	Apr	*FYTD
Well led Trust	**Mortality**						
	Crude Mortality (deaths per 1000 admissions)	↓	19	16.2	14.1	14.0	14.0
	SHMI (Summary Hospital Level Mortality Indicator)	Oct 16 - Sep 17			as expected		0.00
	HSMR (Hospital Standardised Mortality Ratio)	Feb 17 - Jan 18			as expected		0.00
	Outcome						
	Stroke - 90% of Stay on a Stroke Unit	↑	80.00%	71.74%	75.00%	NA	83.33%
	TIA - High Risk,Non admitted TIA treated in 24 Hrs	↑	60.00%	69.44%	78.57%	NA	70.29%
	Length of stay - Elective	↓	2.2	1.0	1.4	1.2	1.2
	Length of stay - Emergency	↑	5.0	4.4	4.4	4.4	4.4
	Readmission Rate - Elective	↓	3.00%	3.80%	3.26%	NA	3.56%
	Readmission Rate - Emergency	↓	10.00%	17.33%	17.11%	NA	17.37%

	Indicators	Var to prev mth	Target	Feb	Mar	Apr	Rolling 12 mths
Supporting our staff	**Workforce**						
	Sickness Absence Rate	↓	3.50%	6.18%	5.71%	4.67%	5.26%
	Staff Turnover Rate Complete Trust	↑	10.00%	12.25%	12.31%	12.69%	11.80%
	Staff Turnover Rate Medical & Dental (excluding Jnr Doctors)	↑	10.00%	11.83%	12.36%	14.61%	9.81%
	Staff Turnover Rate Registered Nursing & Midwifery	↑	10.00%	13.87%	13.60%	14.38%	14.35%
	Staff Turnover Rate Allied Health Professionals	↑	10.00%	15.82%	13.84%	14.42%	16.69%

**FYTD denotes Financial Year to Date (HSMR & SHMI will be at snapshot date specified)*

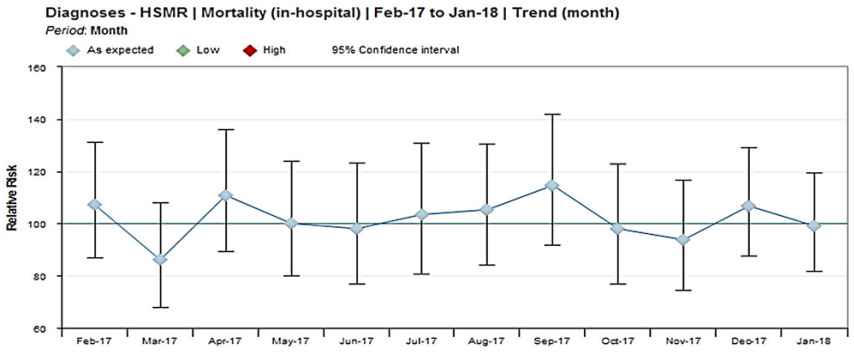
Stroke, TIA, VTE, Re-adm is 1 month in arrears.

Mortality- HSMR (Hospital Standardised Mortality Ratio)

Methodology used to derive the HSMR is freely available. Latest Dr Foster Mortality Summary shows QEH is 101.8 as expected

- Included in the new intelligence monitoring system used by the CQC and available to the public through the CQC website
- Widely reported (including as part of the Dr Foster Good Hospital Guide and in the press)
- Risk of death based on diagnosis at first episode of care
- Does not include deaths after discharge
- Can be adversely affected by low use of palliative care codes (QEH is historically a low user of these codes)

HSMR - (Monthly Trend)



Key Points/Operational Actions

HSMR for the 12 month period Feb 17 - Jan 18 is 101.8 as expected
Weekday HSMR is 100.7 as expected
Weekend HSMR is 104.4 as expected

There were 100 deaths in the hospital in April 2018, this number is lower than last year (105) and equates to 14.0 deaths per 1000 admissions which is lower than our previous rate in April 2017 at 15.6.

The most number of deaths occurred on our care of the elderly ward (11) and cancer ward (10).

The highest number of deaths were recorded against a final diagnosis of pneumonia (19) and sepsis (11)

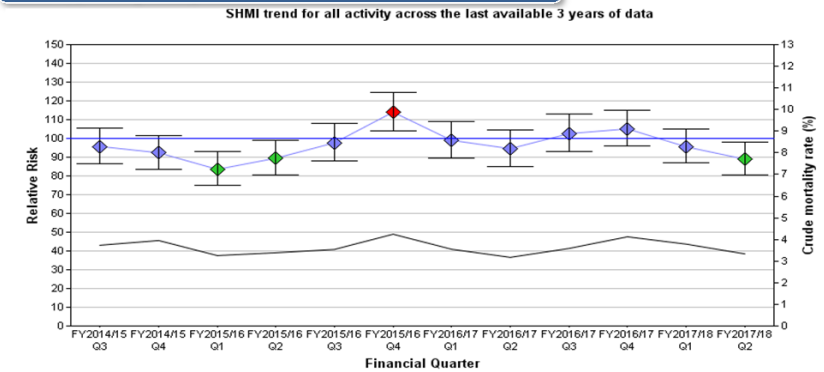
Our HSMR is within expected at 101.8. Our SHMI is also within expected at 0.98. Both weekday and weekend HSMR are within the expected ranges.

Mortality- SHMI (Summary Hospital Mortality Indicator)

Latest Report shows QEH is 97.97 as expected

- Available to public on the NHS Choices website
- Risk of death based on diagnosis at first episode of care
- Includes deaths within 30 days of discharge.
- Rolling 12 month average, *but* only published 6 months in arrears

SHMI - (Quarterly Trend)



Key Points/Operational Actions

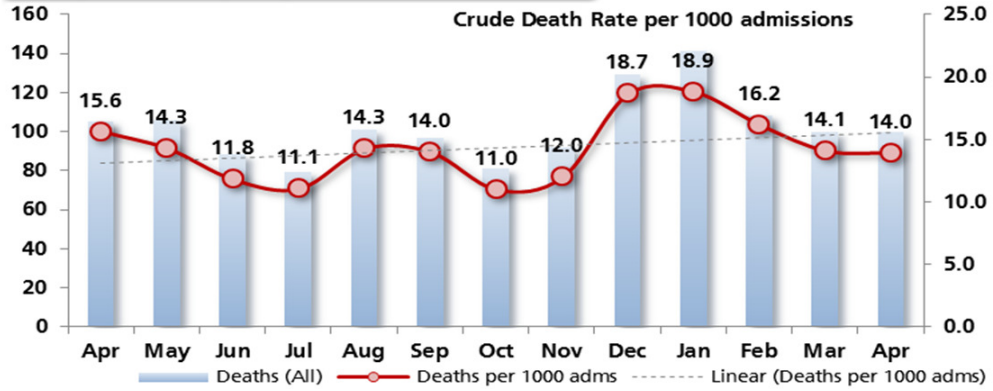
SHMI for the 12 month data period of Oct 16 - Sep 17 is 97.97 as expected
SHMI for Q2 of 17/18 is 88.93 which is as expected

Reporting to the Board - The mortality surveillance group continues to closely monitor both higher than expected areas of mortality and trends that suggest where future outliers may be. This informs audit and the work of that group. This report will show from January 2018, in addition to the present metrics, the incidence of avoidable deaths as they are identified

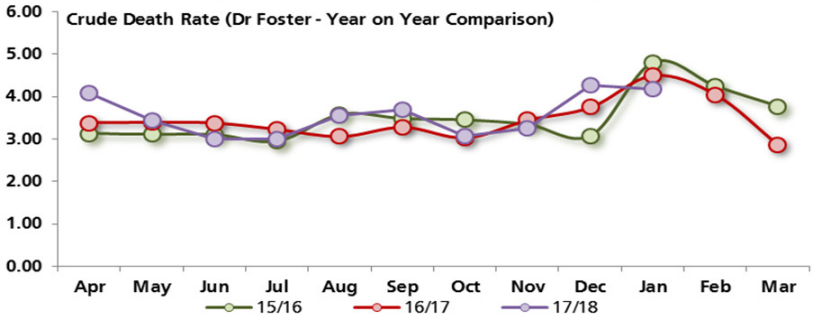
Definitions

What does 'as expected' mean? SHMI: 95% control limits from a random effects model applying a 10% trim for over-dispersion are used to give a Trust a banding of 'as expected', 'higher than expected' or 'lower than expected'.
HSMR: 99.8% control limits are applicable.

Mortality - Crude Mortality Rate (per 1000 admissions)

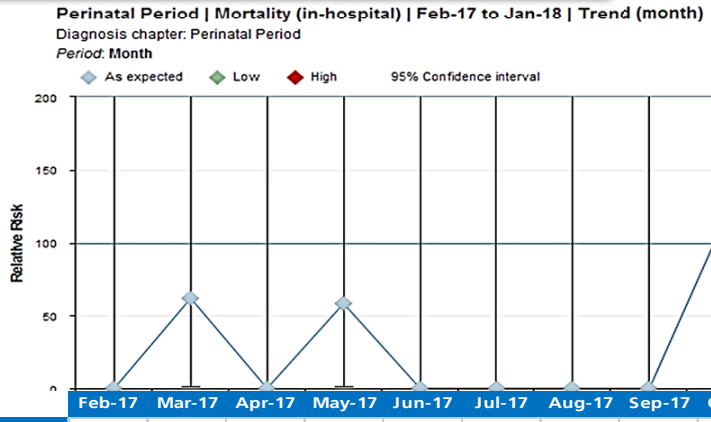


Mortality - HSMR Basket Crude Rate (Yearly Comparison)



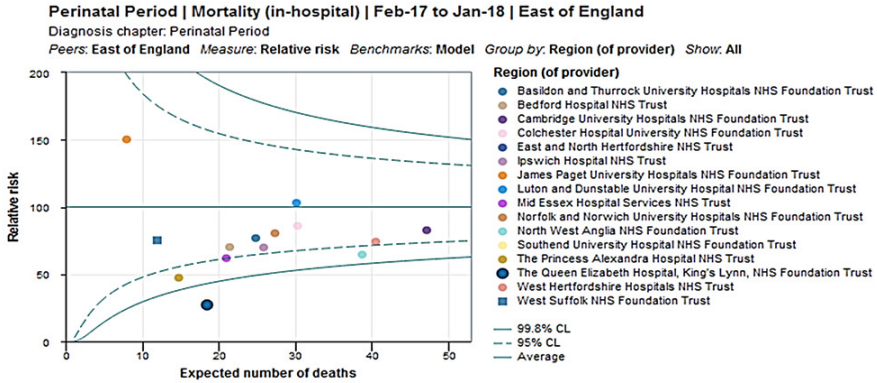
The Crude Mortality rate dropped slightly to 4.19 in Jan, from 4.27 (Dec). This is against trend when comparing against the Dec to Jan period of previous years.
Crude rate within HSMR basket is 3.6% (based on Feb 17-Jan 18),East of England rate = 3.5%

Perinatal Mortality - QEH Relative Risk (Monthly) & Observed No's



	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Observed	0	1	0	1	0	0	0	0	2	1	0	0

Perinatal Mortality - QEH Benchmarked Vs East of England



Perinatal mortality *- Death of the foetus or live born between 24 weeks gestational age to 7 days post natal*

Palliative Care Coding Rate

The Trust's Non-Elective 'Palliative Care Coding' rate of (1.79%) for 17/18, is low when compared to the National average (4.04%)

Key Points/Operational Actions

Definitions

Mortality Rate for the Trust per 1000 Admissions, Calculation = *Total Deaths/Total spells *1000*.
Perinatal mortality - Death of the foetus or live born between 24 weeks gestational age to 7 days post natal. Data taken from Dr Foster normally around 10th calendar each month.

Mortality - Learning from Deaths Dashboard

The Queen Elizabeth Hospital NHS Foundation Trust: Learning from Deaths Dashboard - March 2018-19

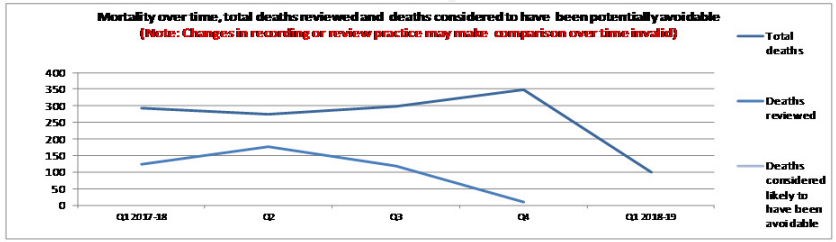
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
100	1212	0	426	0	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1



Total Deaths Reviewed by RCP Methodology Score

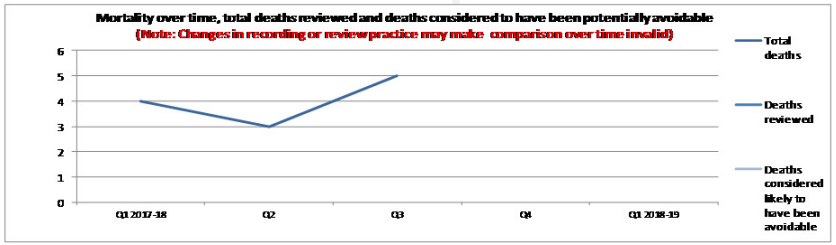
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTL	0	-
This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
0	12	0	0	0	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1



Key Points/Operational Actions

Definitions

Data Source: The dashboard above is populated based on Mortality data extracted from PAS and after discussions at the routine Trust's Mortality Review meetings.

Serious Incidents

1 Total Serious Incidents

0 of which were "Never Events"

Category of most recently Reported (SI's)

Never Events	Falls reported as SI's	PU's reported as SI's	Other SI's
0	0	0	1

Details of the Serious Incidents are shown below (shown in order of the "Incident Date").

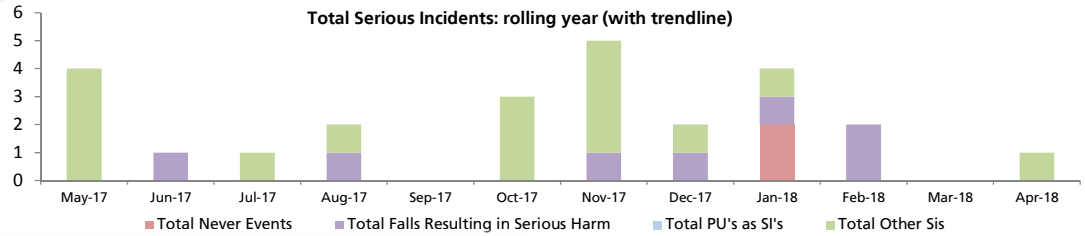
Serious Incidents during Apr 2018

Ref	Incident date	SI/NE	Inc: SI Reported Date	Location Exact	Division
WEB49478	03/04/2018	SI	19/04/2018	Central Delivery Suite	CBU 4

Number of Open Serious Incidents

Adverse Event	Number of open Si's
Never Event - Wrong site surgery	2
Healthcare associated cross infection	1
Never Event - Retained foreign object post-operation	1
Delay / difficulty in obtaining clinical assistance	1
Suspected fall	1
Fall from a height, bed or chair	1
Treatment / procedure - failed	1
Delay or failure to monitor	1
Stillbirth	1
Fall on level ground	1
Breach of patient confidentiality	1
Grand Total	12

Serious Incidents (Rolling 12 months)



No. of open SI's as at date of provision of data for Board Report

May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
17	12	12	12	10	9
Nov-17	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**
11	13	13	15	14	12

Compliance with SI Report submission dates

Month/Year	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Total no. of SI reports submitted in the month	4	4	7	8	1	1	2	0	0	2	2	1
No. of SI reports submitted in deadline/% compliance	0 (0%)	1 (25%)	1 (14%)	5 (63%)	1 (100%)	1 (100%)	2 (100%)	0 (0%)	0 (0%)	1 (50%)	2 (100%)	1 (100%)
No. of SI reports submitted post-deadline	4	3	6	3	0	0	0	0	0	1	0	0

Key Points/Operational Actions

The single SI for April relates to a stillbirth. The investigation will also consider antenatal care for the mother.

The investigation is currently progressing and is expected to report on time. This will be reported to the Board in due course.

Definitions

Data provided from DATIX and is a snapshot of data recorded on DATIX at the time which is normally around the 10th calendar day of the month after the reporting period.
Incidents are assigned to a Service Group based on the Main Specialty of the consultant assigned to the patient in question.

Learning from incidents closed

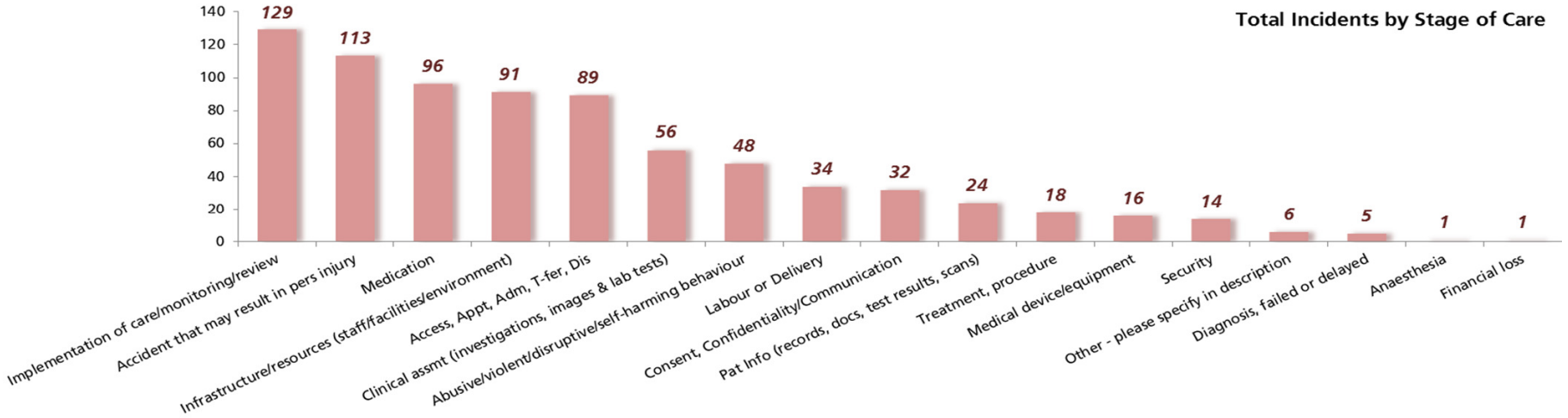
Ref	STEIS Number	SI Declared Date	Location Exact	SI/NE Summary	Root Causes	Lessons Learned	60 Day Submission Compliance
WEB46083	2017/29985	08/12/2017	Medical Assessment Unit	Patient on MAU, EWS 4 but not escalated. 2 hours later cardiac arrest resuscitation was unsuccessful	The lady was acutely unwell on admission and responded to initial treatment and management. The lack of monitoring and adequate escalation on MAU reduced the potential for a positive outcome when she deteriorated further. Had adequate monitoring and intervention taken place there is a possibility that the cardiac arrest and subsequent death might have been prevented.	There is inadequate guidance on frequency of observations for patients with complex medical conditions. Escalation was not followed despite clear documentation on the EWS chart on when to escalate and who to escalate to. Calculation of EWS did not include all the parameters leading to an incorrect EWS being calculated. There is no SBAR handover tool currently included in the A&E electronic patient summary. Emergency equipment was not working effectively - at the time of cardiac arrest. Record checks completed on MAU show that the equipment was checked in accordance with the current standards. At the time of the incident it was recommended that the suction was only checked one per week however the check log shows that the suction was checked more frequently than weekly and was last checked on the 26th November 2017. The remainder of the resuscitation equipment was checked daily and this was completed on both 27th and 28th November. Documentation of the events at resuscitation do not include times and doses of drugs administered	Y

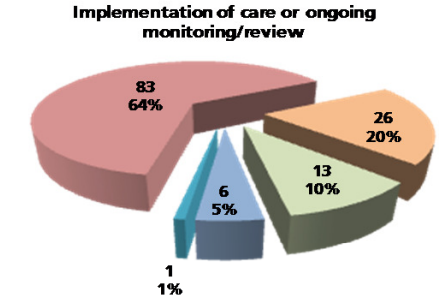
Key Points/Operational Actions

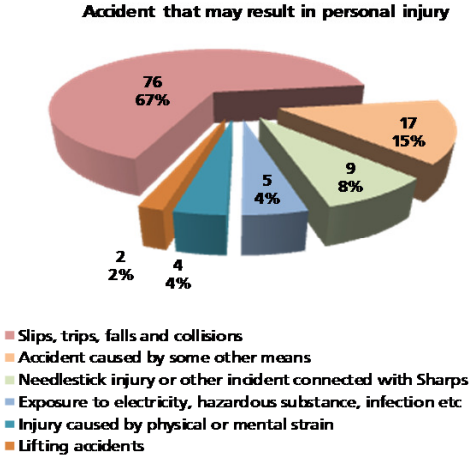
Definitions

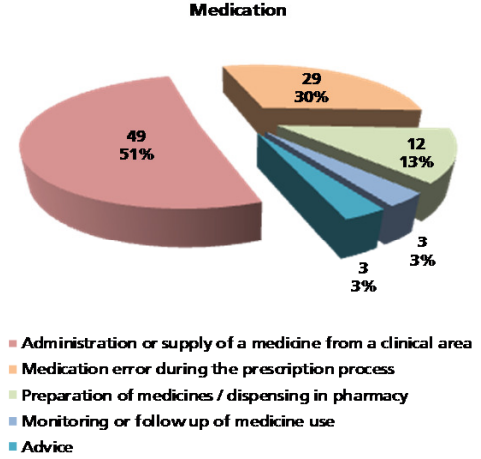
Information provided by the Risk & Governance Team normally around the 10th calendar day of the month after the reporting period.

Analysis of "Other Incidents"







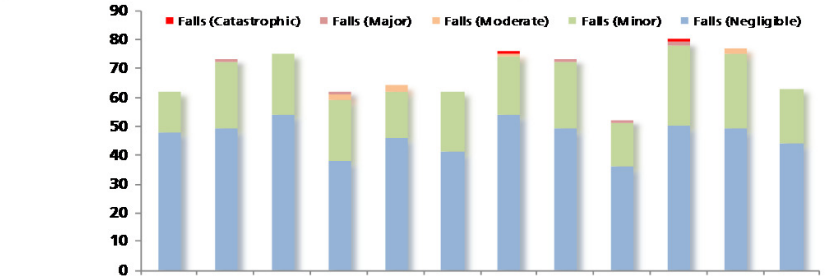


Key Points/Operational Actions

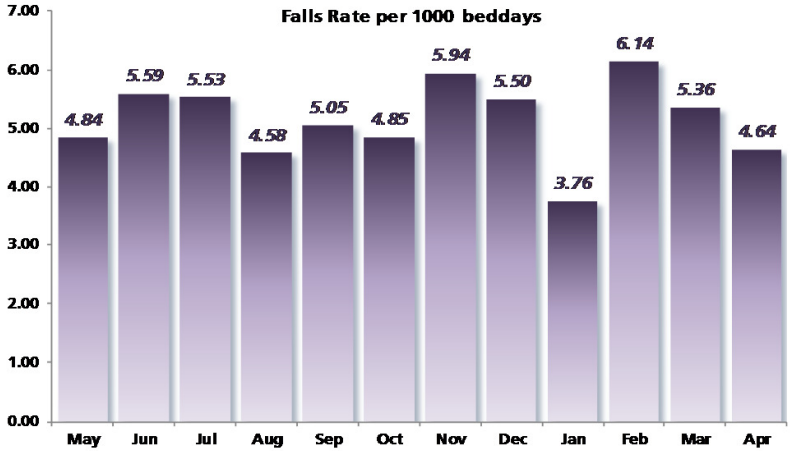
Definitions

Data provided from DATIX and is a snapshot of data recorded on DATIX at the time which is normally around the 10th calendar day of the month after the reporting period.

Falls by Degree of Harm inc rate per 1000 beddays



	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Falls (Catastrophic)	0	0	0	0	0	0	1	0	0	1	0	0
Falls (Major)	0	1	0	1	0	0	0	1	1	1	0	0
Falls (Moderate)	0	0	0	2	2	0	1	0	0	0	2	0
Falls (Minor)	14	23	21	21	16	21	20	23	15	28	26	19
Falls (Negligible)	48	49	54	38	46	41	54	49	36	50	49	44



Key Points/Operational Actions

There were 63 validated falls reported in May 2018 which is 4.64 per 1000 bed days rate. Our falls rate this month has decreased compared to previous month (April 5.36 / 1000 bed days). This month's report is below the national average rate of 6 per 1000 bed days.

This month's fall consequences are as follows: (0) Catastrophic, (0) Major, (0) Moderate, (19) Minor and (44) Negligible.

There were 8 patients fell on more than one occasion during this month:

- 1 patient had 2x falls on West Newton Ward
- 2 patients had 2x falls on Gayton Ward
- 1 patient had 2x falls on Stanhoe Ward
- 1 patient had 2x falls (1x on MAU and 1x on Windsor Ward)
- 1 patient had 2 falls (1x on A & E, 1x on Windsor Ward)
- 1 patient had 4x falls on Windsor Ward
- 1 patient had 2x falls on West Newton ward

Clinical areas with increased number of falls this month:

(10) Windsor Ward (7) Stanhoe Ward and Gayton Ward (6) Tilney ward and MAU (4) Denver, Terrington SS and West Newton Ward

- Falls prevention training on the ward is on-going particularly on clinical areas with outstanding action plan and falls resulting to harm. Training includes, Falls prevention, Management of falls, Special observations for patients at increased risk and the recommended way of RCP (Royal College of Physician) in performing lying and standing blood pressure.
- On-going/extended trial of Hi/Lo (Ultralow) bed from Medstrom continues on West Newton ward. Some of these beds have been distributed to other clinical areas (West Raynham, Oxborough, Gayton, Stanhoe and Windsor) beginning January this year. Additional training for clinical staff and porters was carried out on 15th March 2018 by Medstrom.
- An audit was completed in MAU if lying and standing blood pressure is performed for patient's aged 65 years and over in view of the Trust policy.

This audit demonstrated that L/S BP measurements were not done in line with the Trust lying and standing BP policy.

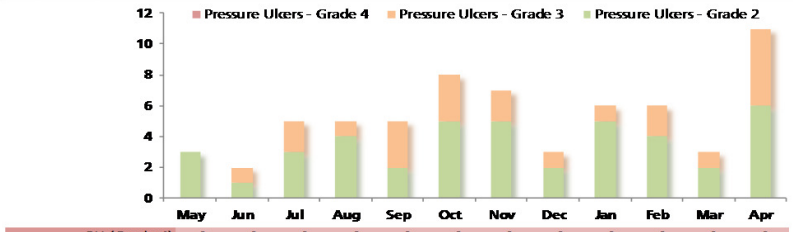
The following recommendations are being shared with the team and are to be implemented Falls Co-ordinator:

- Nursing staff (registered and health care assistants) in MAU who performs observations should be educated focusing on how to perform lying and standing blood pressure according to the Trust Policy.
- The Trust policy on lying and standing blood pressure must be included in the annual mandatory training.
- To develop a system where there is a prompt to perform lying and standing blood pressure.
- To revise the current adult clinical observations chart indicating lying and standing blood pressure must be undertaken (24 hours and 48 hours) to include clear guidance on where to record
- Develop a system to make L/S BP a mandatory on admission for patient's age over 65 and those at risk of falls and recorded on the patient's clinical observation chart

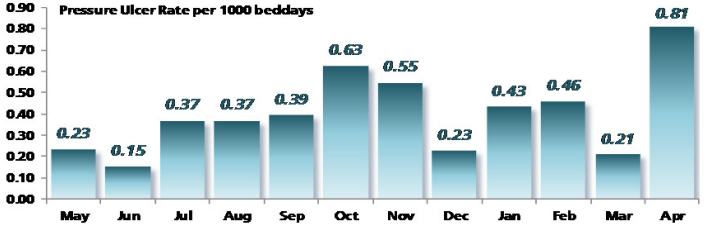
Definitions

Data provided from DATIX and is a snapshot of data recorded on DATIX at the time which is normally around the 10th calendar day of the month after the reporting period.
Total number Falls incidents per month (across all levels of Harm) . Number of Falls incidents per 1000 beddays, per month (across all levels of Harm)

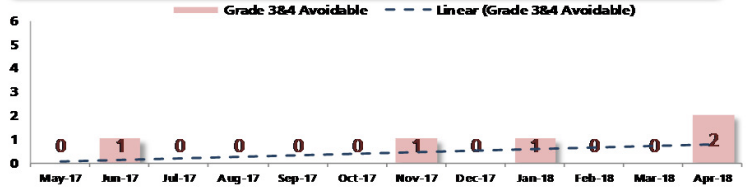
Hospital Acquired Pressure Ulcers inc rate per 1000 beddays ,and analysis of avoidable/unavoidable cases



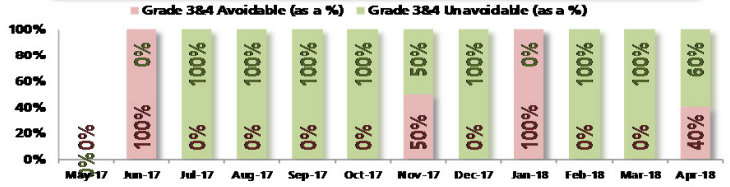
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
PU (Grade 4)	0	0	0	0	0	0	0	0	0	0	0	0
PU (Grade 3)	0	1	2	1	3	3	2	1	1	2	1	5
PU (Grade 2)	3	1	3	4	2	5	5	2	5	4	2	6

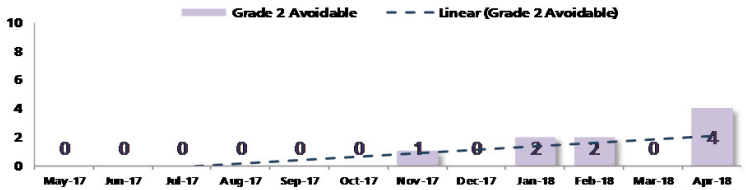


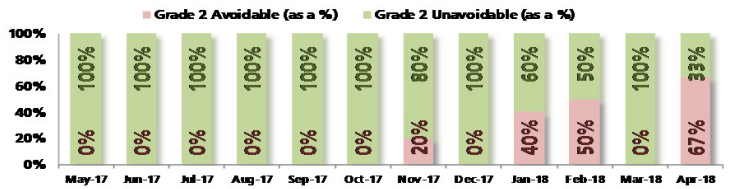
Pressure Ulcers - Actual No. of Avoidable incidents by month with trendline



Pressure Ulcers - Proportion of incidents that are Avoidable/Unavoidable







Key Points/Operational Actions

April has seen a steep rise in the number of pressure ulcers to a total of nine, an increase from three in March. Of the 9 pressure ulcers, five were grade 3 and four were grade 2.

Five of the 9 were avoidable and the other 4 were unavoidable.

The unavoidable were as follows: Critical Care – 1x grade3. The patient was too unstable to be repositioned initially. Attempts were made, but each time the patient's oxygen saturation levels dropped to a level that would impact on the patient's wellbeing, all of which was documented within the patient's record
The remainder were unavoidable due to ASKINS bundle being implemented in a timely manner and evidenced in the patient's notes;
Marham – 1 x grade 2
Necton – 1x grade 2
Windsor – 1 x grade 2
The avoidable; were as follows
Gayton - 1 x grade 3. This was related to a plaster cast. As a result, the plaster technicians (plaster room) now do a daily ward round to check any patient's in plaster for early identification/intervention of any issues.
Leverington – 1 x grade 3, 1 x grade 2, both due to lack of evidence of repositioning (grade 3) and delay in ordering appropriate equipment (grade 2).
Necton – 1 x grade 3, due to a delay in ordering adequate equipment.
Windsor – 1 x grade 3, due to ill-fitting bipap mask and staff failing to act on patient's daughter raising concern about skin becoming red.
In all the areas where there had been avoidable pressure ulcers development, the TVN team have discussed the reasons behind the pressure ulcer development so that the lessons can be learnt and implemented within the relevant area.
Each ward manager is involved in the investigation into the pressure ulcer development and has developed an action plan to prevent a reoccurrence of the harm caused on future patients and has responsibility to ensure that this learning is implemented. From May, any clinical area that has a pressure ulcer, the ward manager will meet with the Chief nurse or Deputy as soon as it is validated to discuss how the improvements will be implemented.

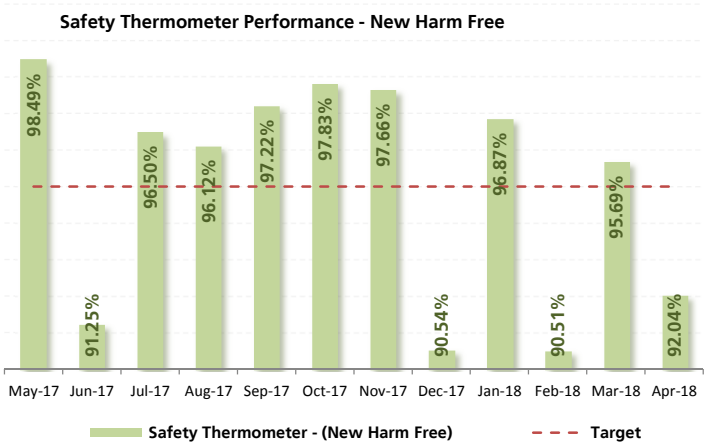
Definitions

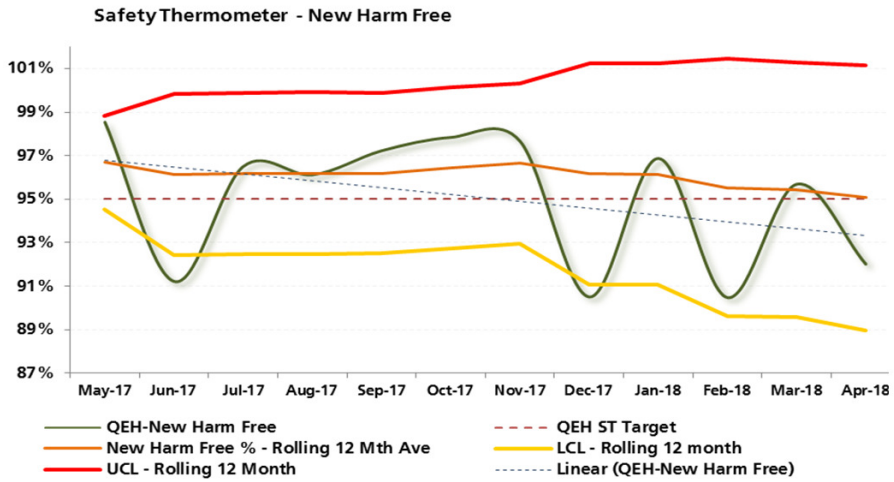
Data provided from DATIX and is a snapshot of data recorded on DATIX at the time which is normally around the 10th calendar day of the month after the reporting period.
Total No. of Pressure Ulcers incidents per month / per 1000 beddays / proportion of avoidable/unavoidable PU incidents per month. Note - Figures for previous months can sometimes change if they are retrospectively re-classified on DATIX.

Safety Thermometer

92.04%

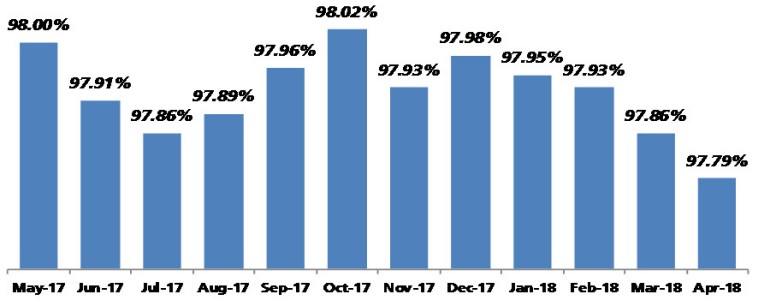
Safety Thermometer (Target 95%) ✗





	Apr17	May17	Jun17	Jul17	Aug17	Sep17	Oct17	Nov17	Dec17	Jan18	Feb18	Mar18	Apr18
Pressure Ulcers - New	0.25	0	0.47	0.47	0.68	0	0.97	1.56	0.24	0.96	1.7	0.43	0.66
Falls with Harm	1.48	0	1.18	0.93	0.68	0.7	0.24	0.52	0.47	0.48	0.97	0.65	0.66
Falls - All	1.72	0.5	3.07	1.87	1.83	1.86	0.72	1.3	2.6	1.69	1.7	1.72	2.43
Catheter & New UTI	0.74	1.01	1.42	0.7	0.91	1.39	0.48	0.52	0.24	0.96	1.46	0.86	1.55
Catheters & UTIs	1.48	2.51	2.36	1.4	2.05	2.32	2.66	2.08	1.42	1.69	1.7	1.08	2.88
Harm Free	91.38	92.21	85.82	91.82	91.55	91.65	92.03	92.47	85.82	90.84	86.37	92.24	84.96
All Harms	8.62	7.79	14.18	8.18	8.45	8.35	7.97	7.53	14.18	9.16	13.63	7.76	15.04
New VTEs	0.99	0.5	5.91	1.4	1.6	0.93	0.48	0	8.51	0.72	5.6	2.8	5.09
New Harm Free	96.55	98.49	91.25	96.5	96.12	97.22	97.83	97.66	90.54	96.87	90.51	95.69	92.04
All New Harms	3.45	1.51	8.75	3.5	3.88	2.78	2.17	2.34	9.46	3.13	9.49	4.31	7.96
Pressure Ulcers	5.17	5.53	5.44	4.44	4.34	4.87	5.07	5.97	5.2	6.51	6.33	4.09	7.08
#Surveys	16	17	18	17	18	18	18	16	16	17	17	18	18

New Harm Free Benchmarking



Key Points/Operational Actions

The Safety Thermometer undertaken in April 2018 where all in patients on one day audited which totalled 452 patients. Of these 84.96% were reported as receiving harm free care this is inclusive of 'old harm' (i.e. patients who acquire harm in the community before coming into hospital). This is a decrease from March where harm free care was 92.24%.

92.04% of patients were reported to have new harm –free care (36 patients were reported to have a new harm an increase from 20 in the previous month) this is against the national average of 97.79%.

The Deputy Chief Nurse is meeting with the audit department and information services to check the validation of data uploaded to ensure that the data uploaded is as accurate

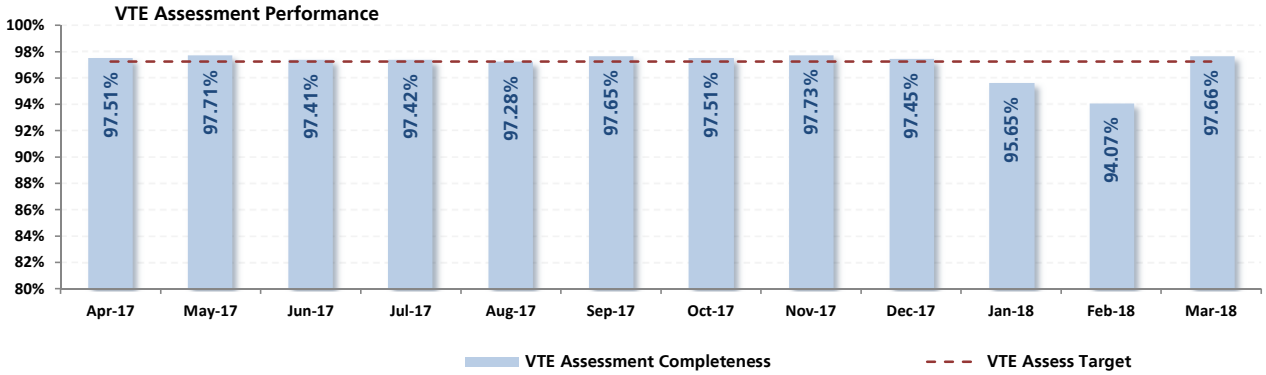
Definitions

Data Source: Data extracted from the National Safety Thermometer Tool after submission by the Trust's Clinical Audit normally around the 10th calendar day of the month after the reporting period.

VTE Assessment

97.66%

VTE Assessments Completed (Target 97.24%) ✔



Key Points/Operational Actions

The Trust reports VTE assessment completion at 97.66% for April an improvement from the previous month which was at 94.07%.

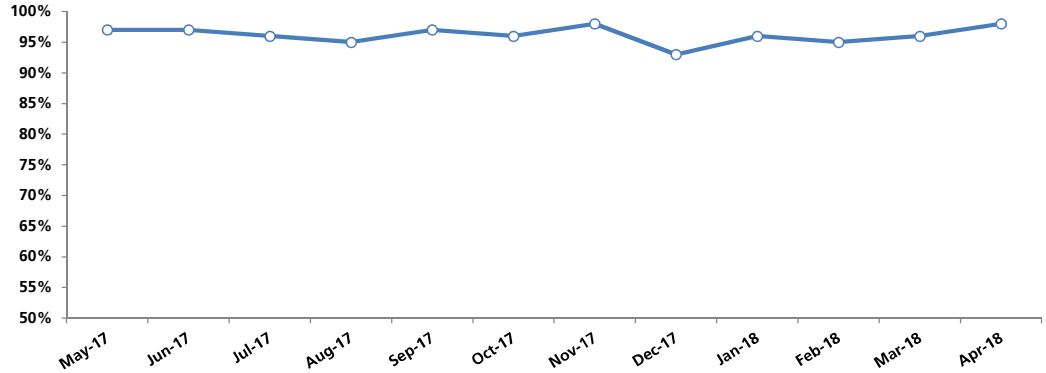
Definitions

VTE:Proportion of admissions that have been VTE assessed within the reporting month (1 month in arrears).
Data Source: VTE Assessment performance is based on Information extracted from normally around the 10th calendar day of the month after the reporting period.

MRSA

Latest Month's Performance ***Financial YTD***

MRSA Weekly Screening Compliance Across Trust



Key Points/Operational Actions

We regret to inform the Board of 2 cases of MRSA Bacteraemia were apportioned to the Trust this year. The trajectory set for the year 2018/9 was 0. These cases both have links to Oxborough Ward along with a Community Acquired Infection (CAI) case earlier in the year and typing suggests the same strain.

On further investigation there 6 further cases of MRSA linked with Oxborough, typing on all cases suggests there are 2 separate types circulating on Oxborough Ward. An outbreak has been declared and meeting have taken place. Actions that have been implemented include:

Decant of ward to facilitate estates work
Deep clean and HPV,
Screening of all patients that were on Oxborough prior to decant, including clinical sites
Staff screening,
Assurance that all patients have Octenisan body wash and it is being used correctly.

Further education in ANTT is planned over the next month, and all staff undertaking clinical interventions on Oxborough will be re trained. Communications have gone out to other trusts regarding this situation, and handover when transferring of patients between health care settings is including an IP&C element.

Octenisan body wash across the trust is illustrated below, this is a key intervention to prevent invasion of MRSA to blood stream as well as other organisms

MSSA BSI

No formal target is set for MSSA BSI but mandatory reporting is required for all cases. Any HAI cases are analysed for lapses in care. This is an indication of aseptic practice within the Hospital and identifies any areas

Definitions

MRSA - The objective aims to deliver a continuing reduction in MRSA bacteraemia by requiring acute trusts and PCOs to improve to the level of top performers.
Data Source: Data provided by the Infection Prevention and Control Team normally around the 10th calendar day of the month after the reporting period.

Clostridium Difficile

Latest Month's Performance

3

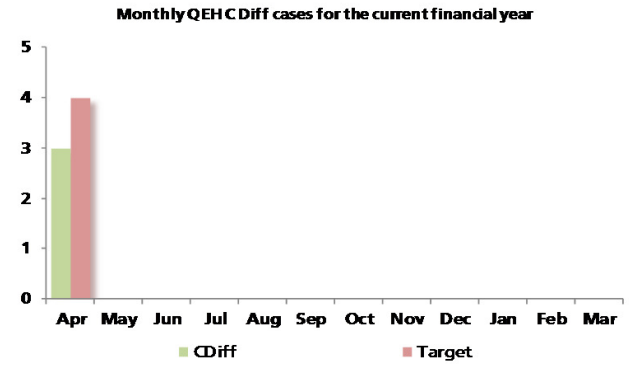
C Diff (All cases) ✔

Financial YTD

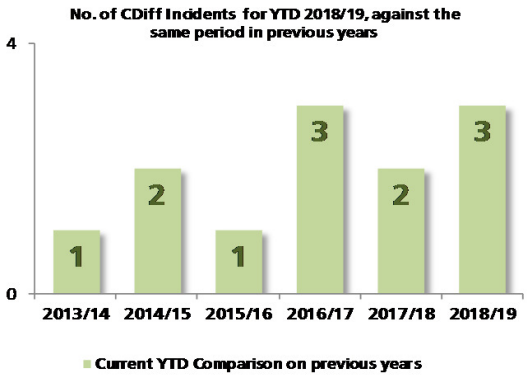
3

CDIFF (All cases) ✔

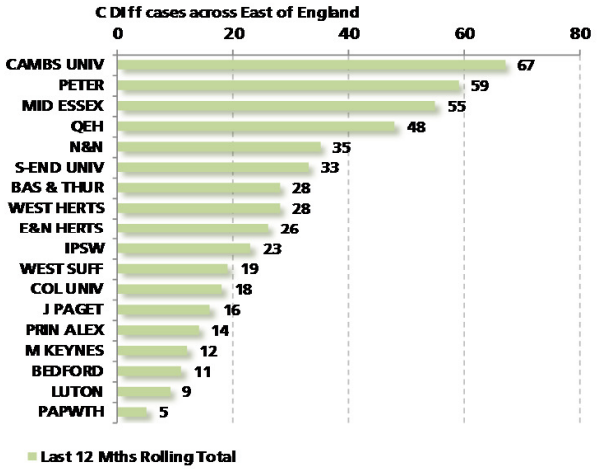
C Diff Incidents



C Diff Incidents VS Prev Years



C Diff Benchmarking



Key Points/Operational Actions

3 cases of HAI C difficile have been reported in April, x2 on ITU triggering a period of increased incidence (PII) and a third on Oxborough. This is the 2nd case on Oxborough within 28 days, so a PII has also been declared on the ward. Due to MRSA transmission as discussed above, the ward has been decant and cleaning undertaken. All 3 cases in April have links with previous cases and areas where we have had concerns. There have also been CAI cases that have been linked to wards with concerns and some ribotying has confirmed transmission within the Hospital.

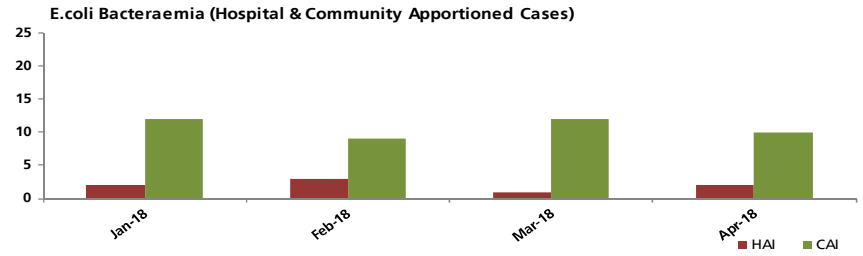
The deep clean programme has now commenced with Oxborough ward already decanted and work being undertaken.

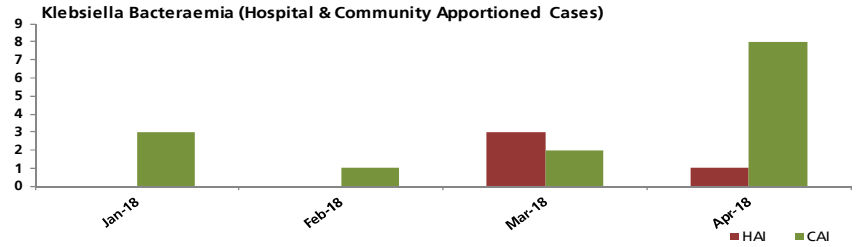
Across the trust measures to mitigate risk regarding C difficile transmission have been implemented, all clinical areas are using sporicidial wipes and extra training with these has been implemented. Standards of cleaning across the trust both Domestic and Clinical are under review. Support from NHSi IP&C Lead has included Matrons Master classes.

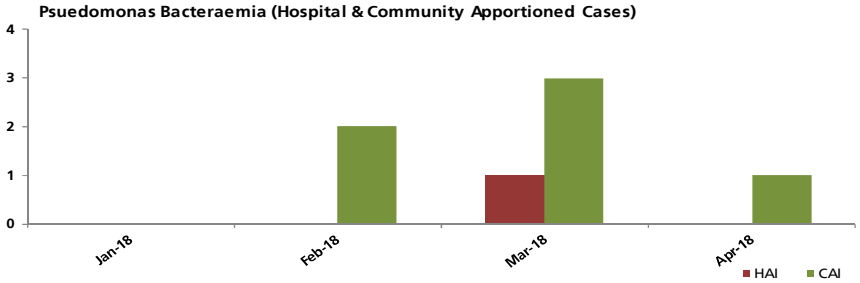
Definitions

CDIFF - The objective aims to deliver a continuing reduction in *Clostridium* difficile infections. Organisations with higher baseline rates will be required to deliver larger reductions.
Data Source: Data provided by the Infection Prevention and Control Team normally around the 10th calendar day of the month after the reporting period.

Gram Negative BSI







Key Points/Operational Actions

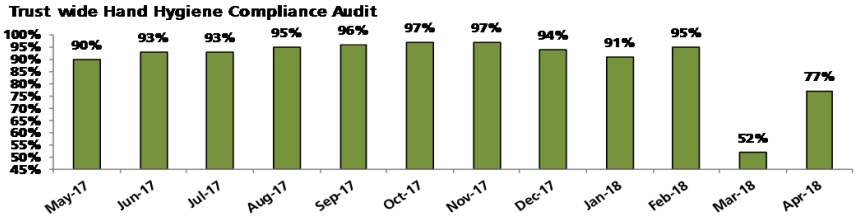
The IP&C Team are working with CCG and other Acute Trust at reducing numbers of BSI, a quality premium of a 10% reduction has been set for CCG for this year, and this has been met for WNGCCG. The IPC team have worked with other acute trust to look for themes in data to formulate a joint action plan, themes identified include Urinary Infections and Hepatic issues. Data collection of themes and numbers are reported via the PHE Data Capture System

Definitions

Data Source: Data provided by the Infection Prevention and Control Team normally around the 10th calendar day of the month after the reporting period.

IPC Dashboard

Ward	C4C	Environmental	HH	Commode	Octenisan	ANTT numbers	MRSA screening	C Diff Toxin	MRSA Bact	MRSA Colonisation	E Coli Bact	MSSA Bact	Noro HA
A&E	99	92	87	100	N/A	35	N/A	0	0	0	0	0	0
CDS	94	91	No Audit	N/A	N/A	12	N/A	0	0	0	0	0	0
CCU/ITU	99	93	99	100	N/A	61	96	2	0	0	0	0	0
Elm	95	71	86	100	75	17	95	0	0	0	0	0	0
NICU	99	95	100	N/A	N/A	13	N/A	0	0	0	0	0	0
Castleacre	95	82	100	N/A	N/A	23	N/A	0	0	0	0	0	0
Denver	98	73	82	100	88	13	100	0	0	0	0	0	0
Gayton	96	78	94	95	90	14	99	0	0	1	0	0	0
Oxborough	97	87	84	100	77	11	99	1	1	1	0	1	0
Marham	92	93	85	100	88	21	99	0	0	0	0	0	0
MAU	93	90	91	100	N/A	14	98	0	0	0	0	0	0
Necton	96	85	75	93	67	19	99	0	0	0	1	0	0
Rudham	99	95	100	N/A	N/A	17	N/A	0	0	0	0	0	0
SAU	95	71	87	100	N/A	16	92	0	0	0	0	0	0
Shouldham	97	98	100	100	100	15	100	0	0	0	1	0	0
Stanhoe	99	95	85	88	75	16	99	0	0	0	0	0	0
Terrington	95	95	91	100	45	14	91	0	0	0	0	0	0
Tilney	No Audit	89	86	100	89	14	96	0	0	0	0	0	0
W Newton	97	91	87	97	88	17	95	0	0	0	0	0	0
W Raynham	94	93	85	100	100	17	96	0	0	1	0	0	0
Leverington Esc	94	89	89	100	62	0	100	0	0	0	0	0	0
Windsor	98	84	86	100	89	17	97	0	1	1	0	0	0



Key Points/Operational Actions

IP&C audits include Hand Hygiene standards, cleaning of commodes/bed pans and other audits of practice. All data is fed back to clinical areas.

Actions and updates

Due to current IPC outbreaks in C difficile , MRSAb concerns with standards of cleaning and reduced numbers of staff in the IP&C Team NHSi have rated us a "red" for IP&C. A peer review is planned in June with representatives from other Trusts and other agencies organised by NHSi .

The IP&C have developed a IP&C quality improvement plan that is part of the Trust wide quality improvement plan as part of the CQC ongoing work.

The deep clean programme has commenced and a priority plan for order of cleaning is in place. An IPC awareness programme of several sessions led by the CEO with a film of a patient storey regarding IPC has commenced in May 2018.

Master classes for Matrons led by NHSi have taken place and Matrons are undertaking Perfect Ward audits and using a checklist devised following the class to ensure wards and areas are meeting standards.
The IP&C team are continuing supportive measurers on W Raynham, ITU and Oxborough Wards, and providing support and education to staff in these areas.
Support is being received from CCG colleagues while the IP&C Team has reduced staff, helping with auditing and completion of RCAs .

Definitions

Data Source: Data provided by the Infection Prevention and Control Team normally around the 10th calendar day of the month after the reporting period.

Service line Clinical Indicators (by ward)

	Indicator Description	Den	Elm	SAU	Gayt	Mar	C Care	Lev Esc	MAU	Nec	Oxb	Stan	Sho	Til	TSS	West New	West Ray	Wind
Patient Safety	Fluid Charts	95%	84%	63%	48%		83%	60%		53%	67%	86%	94%	60%		68%	98%	
	MUST Assessment		67%	69%	85%				60%	50%	100%	75%	100%	83%	100%	0%	100%	0%
	Waterlow Assessment	100%	100%	81%	100%				100%	100%	100%	100%	100%	100%	100%	100%	100%	50%
	Waterlow Re-Scored	71%	100%		100%	100%	75%			100%	100%	100%	100%	100%		100%	94%	93%
	Has A Body Map Been Completed	70%	60%	38%	50%	60%	67%		40%	75%	90%	60%	70%	65%	40%	85%	90%	80%
	Moving And Handling Assessment Completed	85%	67%	100%	90%	95%	100%		95%	75%	95%	95%	50%	80%	80%	90%	55%	90%
	Falls Assessment Done	100%	100%	94%	100%		100%		100%	100%	69%	100%	100%	100%	100%	100%	100%	95%
	Falls assessment rescored weekly	57%	100%		86%	100%	50%			100%	69%	80%	0%	100%		88%	82%	80%
	Is a Falls Care Plan Completed?	80%	87%	94%	90%	85%	11%		90%	85%	100%	90%	50%	85%	70%	95%	65%	95%
	EWS for each set of OBS?	95%	100%	94%	100%	100%	100%		100%	100%	100%	90%	100%	95%	100%	100%	90%	95%
	Care Rounds Completed	96%	96%	90%			100%		96%	81%	100%	96%	96%	92%		90%	99%	76%
	Bedrail Assessment if "At Risk" (on admission)	82%	67%	89%	64%	90%			82%		100%	67%	100%	86%	86%	68%	94%	0%
	Obs Frequency documented	95%	93%	50%	35%	55%	100%		90%	85%	100%	70%	30%	65%	70%	60%	85%	85%
	Total DATIX Incidents	5	2	0	9	3	3	5	9	8	6	9	0	14	8	6	5	14
	Serious Incidents	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Drug Administration Errors	1	2	0	0	1	2	2	3	4	2	2	0	7	4	2	3	3
	Falls Total	4	0	0	7	1	0	1	6	2	3	7	0	6	4	4	2	10
	H/A Pressure Ulcers Grade 2	0	0	0	1	1	0	1	0	1	1	0	0	1	0	0	0	0
	H/A Pressure Ulcers Grade 3	0	0	0	1	0	1	1	0	1	0	0	0	0	0	0	0	1
	H/A Pressure Ulcers Grade 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	C.Diff > 2 Days	0	0	0	0	0	2	0	0	0	1	0	0	0	0	0	0	0
	Harm Free Care	93%	71%	100%	75%	97%	93%	79%	83%	88%	79%	45%	92%	89%	97%	89%	100%	82%
	MRSA	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
	C4C Audit %	98%	95%	95%	96%	92%	99%	94%	93%	96%	97%	99%	97%		95%	97%	94%	98%
	Hand Hygiene %	82%	86%	87%	94%	85%	99%	89%	91%	75%	84%	85%	100%	86%	91%	87%	85%	86%
	MSSA	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
	E.Coli	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0
	ESBL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Psuedomonas	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Klebsiella	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Patient Experience	Complaints	1	1	0	0	1	0	3	1	1	0	0	0	0	1	0	1	0
	Compliments	10	3	1	1	0	4	1	0	5	3	0	0	5	3	9	6	3
	Family And Friends Response Rate	46%	33%	29%	48%	23%	300%	23%	16%	29%	49%	49%	43%	50%	34%	41%	42%	38%
	Family And Friends (% Recommended)	95%	89%	92%	92%	92%	97%	91%	100%	83%	97%	98%	100%	98%	90%	100%	86%	83%
Effectiveness	% Of Active Mentors	38%	67%	67%	75%	100%	74%		83%	50%		63%	71%	50%	0%	25%	50%	40%
	Fill Rate Registered	95%	97%	82%	100%	92%	89%		97%	95%	104%	96%	91%	97%	94%	95%	98%	97%
	Fill Rate Unregistered	120%	104%	99%	104%	97%	82%	Data N/A	113%	97%	83%	94%	95%	105%	121%	128%	85%	100%
	CHPPD	5.9	5.9	11.2	6.3	5.4	26.3		7.8	5.7	6.1	6.2	7.5	5.7	5.6	8.3	6.9	5.7
Staff Experience	Appraisals	54%	77%	96%	71%	63%	87%		91%	76%	83%	93%	88%	53%	94%	64%	98%	80%
	Sickness	7%	6%	4%	8%	6%	3%	6%	2%	7%	3%	8%	8%	9%	5%	2%	7%	2%
	Vacancies	28%	26%	19%	28%	16%	9%	Data N/A	19%	37%	40%	42%	2%	25%	50%	35%	25%	32%
	Mandatory Training	69%	79%	90%	94%	95%	92%		84%	90%	88%	89%	90%	83%	84%	91%	91%	86%

Definitions

Data Source: Patient Safety (Light Blue section) provided by Clinical Audit, Incidents data from DATIX , C Diff/MRSA data from Infection Prevention & Control Team , Compliments & Complaints provided by the Complaints Dept, FFT provided by Meridian. Fill Rates obtained from the Trust's monthly Safer Staffing Return & Staff Experience data provided by HR. Data normally received around the 10th calendar day of the month after reporting period.

Maternity Clinical Performance & Governance Scorecard 2018-19

		Descriptor	Measurement	Green	Amber	Red	Data Source	Apr
ACTIVITY	Women Delivered	Total no. of women giving birth at QEH	Local monitoring		No Target		Birth Register	191
	Babies Born	Total no. of babies born at QEH	Local monitoring		No Target		Birth Register	195
	Live Births	Total no. of live babies born at QEH	Local monitoring		No Target		Birth Register	194
	% Home Births	% of women giving birth at home	Local monitoring	>=2%	Between	<1%	Birth Register	1.05%
	BBAs	Babies born before the arrival of a professional	Local monitoring	0	Between	>=2	Birth Register	3
	Stillbirths	**Stillbirth** : Babies born after 24 weeks gestation showing no signs of life. Stillbirth Rate = 4.6/1000 births. QEH annual total should not exceed 15 stillbirths.	Yearly total that exceeds 15	0	Between	>=2	Birth Register	1
	Neonatal Death (No.)	**Neonatal death** : No. of Babies that are born alive but die within 28 days of age.	Yearly total that exceeds 7	0	Between	>=2	NICU / Datix	0
	Twins	No. babies - twins	Local monitoring		No Benchmark		Birth Register	4
	Triplets	No. of babies - triplets	Local monitoring		No Benchmark		Birth Register	0
	Transfers out	No. of transfers out of QEH Maternity unit.	local monitoring		No Benchmark		Birth Register	0
MODE	% Women Delivered on MLBU	Women who have given birth in Waterlily	Local monitoring	>=20%	Between	<15%	Birth Register	17.28%
	% Women delivered on CDS	Women who have given birth on Delivery Suite	Local monitoring	<75%	Between	>85%	Birth Register	79.58%
	% Normal Births	Spontaneous vaginal births	Benchmark against national rate 2013/14 = 60.9 %	>63%	Between	<52%	Birth Register	62.83%
	% Instrumental Deliveries	Combined rate: Forceps +Ventouse	Benchmark against national rate 2013/14 = 12.9 %	5% - 12%	12.1-19.9%	<5% or >20%	Birth Register	5.76%
	% Vaginal Breech Births				No Benchmark			0.00%
	% Elective LSCS	Women having planned CS	Local monitoring	<10%	Between	>12%	Birth Register	11.52%
	% Emergency LSCS	Women having an emergency CS	Local monitoring	<15%	Between	>16%	Birth Register	20.42%
	% Total CS	Total CS performed: Elective +Emergency	Benchmark against national rate 2013/14 = 26.2 %	<=25%	Between	>=28%	Birth Register	31.94%
	% Induction rates	Women who have their labour induced (denominator = total women minus ElSCS)		<18%	Between	>24%	Birth Register	28.27%
ACTIVITY: Antenatal and Postnatal Care	% Bookings < 12 weeks 6 days	Women who have their first booking appt by 12+6	KPI	>=90%	Between	<=85%	HoM	85.92%
	Day Assement Unit	No. of women seen on DAU @ NCH	Local monitoring		No Benchmark		DAU	120
		Closure of DAU -hours @ NCH	Local monitoring		No Benchmark		DAU	0
		% women in DAU seen within 4 hrs @ NCH	Local monitoring	>=95%	Between	<=90%	DAU	100.00%
		No. of women seen on DAU @ QEHKL	Local monitoring		No Benchmark		DAU	568
		Closure of DAU -hours @ QEHKL	Local monitoring		No Benchmark		DAU	0
		% women in DAU seen within 4 hrs @ QEHKL	Local monitoring	>=95%	Between	<=90%	DAU	99.12%
	% Breastfeeding	Breastfeeding/ breast milk initiated, attempted or achieved	KPI	>=70%	Between	<65%	BadgerNet	71.65%
	% Breastfeeding	% breast feeding on discharge from hospital	KPI	>=70%	Between	<65%	BadgerNet	50.00%
	% Breastfeeding	% women breast feeding at transfer to Health Visitor	Local monitoring		No Benchmark		BadgerNet	42.55%
	% of women who stopped smoking at delivery	Women who stopped smoking by the time of delivery	Local monitoring		No Benchmark		BadgerNet	13.56%
	Readmisions onto Castleacre Ward <28 days	Number of avoidable maternal readmission up to 28 days post birth	Local monitoring	<=4	Between	>=7	Castleacre	0
GOVERNANCE	Risk Management	No of SUIs	Local monitoring	0		>=1	Risk & DS	1
		Total number of reported clinical incidents	Local monitoring		No Benchmark		Datix	68
		TOTAL number of adverse staffing incidents reported	Local monitoring		No Benchmark		Datix	6
	Operational Targets	No. times CDS closed	Local monitoring	0	1	>=2	DS	0
		Total hours CDS closed	Local monitoring		No Benchmark		DS	0
		Suspension of HBS hrs	Local monitoring	0	1	>=2	DS	0
		Suspension of HBS Occassions	Local monitoring	0	1	>=2	DS	0

Activity

In April 191 women delivered of which 195 babies born, 194 live births.
0 Neonatal deaths
4 Set of Twins
1 stillbirth at 39 weeks (Intrauterine death)

Mode

Homebirth 1.05%, 2 women transferred in, few women booked for homebirth. Further information to be given to women throughout pregnancy to promote, homebirth forum to commence. 17.28% delivered on MLBU- further promote unit. 3 BBA's- P1 phoned @1406 contracting with urge to push, advised to attend ASAP or telephone 999 if required, delivered at 1437, all well. P1 Patient phoned CDS to say she was delivering, ambulance phone and midwife sent out. Both ambulance and midwife arrived after delivery, mum and baby well. Transferred into hospital as retained placenta. Patient booked at West Suffolk on holiday in Norfolk. P1. Phone call to QEH CDS coordinator from West Suffolk informing us that patient on her way to A and E. Patient delivered in car park.
In April the induction rate was at 28.7%
Total C-Section rate was 31.94.7%, with the 20.42% rate of emergencies and a slightly higher elective rate of 11.52%
The caesarean sections and the inductions are being audited/ monitored by a working group.

Activity: Antenatal and Postnatal Care

85.92% booked less than 12+6 weeks (need more info).
B/F initiation 71.65%, on discharge from hospital 50% - infant feeding healthcare assistant post interviews next week, transfer to health visitor 42.55%- community support worker interviews next week.

Governance

1 SI is the 39 week stillbirth which is being investigated.
CDS remained open within the month and the Home Birth Service continued as normal.

Definitions

Data provided by the Women & Children Division normally around the 20th calendar day of the month after the reporting period.

Maternity Clinical Performance & Governance Scorecard 2018-19 (continued)

			Descriptor	Measurement Reason	Green	Amber	Red	Data Source	Apr
MATERNAL & PERINATAL STATISTICS	Maternal mortality and morbidity	Local monitoring of poor outcomes and factors that may have an impact on women's future health. Includes data for the Maternity Safety Thermometer: Post partum Haemorrhage & 3rd and 4th Degree perineal tears.	PPH ≥1000 or<2000ml	Local monitoring	<9%	Between	>12%	Birth Register / CDS	7.04%
			PPH ≥2000ml	Local monitoring	<=1%	Between	>=2.5	Birth Register / CDS	1.01%
			%of women sustaining 3rd & 4th degree tears (no/total minus Elective CS)	Local monitoring	<=3%	Between	>=5%	Birth Register / CDS	2.51%
			No. of women sustaining 3rd & 4th degree tears (no/total minus Elective CS) - **3a**	Local monitoring	<=4		>=5	Birth Register / CDS	4
			No. of women sustaining 3rd & 4th degree tears (no/total minus Elective CS) - **3b**	Local monitoring	<=2		>=3	Birth Register / CDS	1
			No. of women sustaining 3rd & 4th degree tears (no/total minus Elective CS) - **3c**	Local monitoring	0		>=1	Birth Register / CDS	0
			No. of women sustaining 3rd & 4th degree tears (no/total- Elective CS) - **4**	Local monitoring	0		>=1	Birth Register / CDS	0
			Blood transfusions > 4 units	Local monitoring	No Benchmark			Haematology	0
			Postpartum hysterectomies	Local monitoring	0	1	>1	Birth Register	0
			ITU/HDU admissions	Local monitoring	0	1	>1	Birth Register	0
			Maternal Deaths	Local monitoring	0		>0	Birth Register	0
		NICU Admissions Castleacre	**Avoidable** Term Admissions to NICU from CDS	Local monitoring	No Benchmark			NICU / Datix	0
			Avoidable Term Admissions to NICU from Castleacre	Local monitoring	No Benchmark			NICU / Datix	0
			No. of babies with avoidable readmission within < 28 days old	Local monitoring	<=2	3-5	>=6	Datix	0
WORKFORCE		**1:1 Care MLBU**	1:1care in labour achieved on MLBU	Local monitoring	>=95%	90-94	<=89%	MLBU	100.00%
		1:1 Care CDS	1:1care in labour achieved on CDS	Local monitoring	>=95%	90-94	<=89%	DS	87.60%
		On Call Midwife	No. of hrs On call midwife called to work in Unit	Local monitoring	No Benchmark			DS	58
		On Call Midwife	No. of occassions On call midwife called to work in Unit	Local monitoring	No Benchmark			DS	7
PATIENT FEEDBACK		**Compliments**	Total midwifery Compliments received in month	Local monitoring				PALS Team	9
		Complaints	Total Midwifery complaints received in month	Local monitoring				PALS Team	1
		Response Rate	Antenatal	Patient Experience Team	>=15%		<15%	Patient Experience Team	37.26%
		Likely to recommend	Antenatal	Patient Experience Team	>=95%	Between	<94%	Patient Experience Team	96.20%
		Response Rate	Birth / Labour	Patient Experience Team	>=15%		<15%	Patient Experience Team	20.32%
		Likely to recommend	Birth / Labour	Patient Experience Team	>=95%	Between	<94%	Patient Experience Team	92.11%
		Response Rate	Postnatal Castleacre Ward	Patient Experience Team	>=15%		<15%	Patient Experience Team	28.57%
		Likely to recommend	Postnatal Castleacre Ward	Patient Experience Team	>=95%	Between	<94%	Patient Experience Team	95.45%
		Response Rate	Community Postnatal	Patient Experience Team	>=15%		<15%	Patient Experience Team	
		Likely to recommend	Community Postnatal	Patient Experience Team	>=95%	Between	<94%	Patient Experience Team	98.11%

Maternal & Perinatal Statistics

In April there were 0 unavoidable re-admissions
PPH >2000ml was higher at 1.01%(amber) . PPH 100-2000 has gone up to 7.04%
5 women sustaining 3rd degree tears

Workforce

All band 7 posts interviewed and band 6 posts put onto trac
1:1 care on MLBU 100%.
1:1 care on CDS is 87.6%- this will need investigation as previously this was not recorded in the electronic record but had been achieved
On call midwife called in 7 Times – total of 58 hours

Patient Feedback

FFT response rate still needs work for the birth responses

Definitions

Data provided by the Women & Children Division normally around the 20th calendar day of the month after the reporting period.

Paediatric Clinical Performance & Governance Scorecard 2018-19

		Descriptor	Measurement	Green	Red	Data Source	Apr
Activity	No. of PAU attendances	Direct referrals from GP's A&E and other agencies	East of England 5 beds	< 130	>= 131	PAU	180
	No of times PAU staffing standards not met	Middle grade medical staff not allocated / available to PAU during opening hours	East of England 5 beds	0	>= 1	PAU	15
	No of nursing assessment breaches	Length of time to be seen by nursing staff (within 15 mins)	Within 15 mins	< 0	>= 1	PAU Data	4 (2.2%)
	No of medical assessment breaches	Seen by senior clinician	Within 4 hrs	< 0	>= 1	PAU Data	19 (10.5%)
	No. of 6 hour breaches	Length of stay on PAU	Any children with a stay on PAU over 6 hrs.	< 0	>1	PAU Data	12 (6.6%)
	No. of admissions from PAU	% of the total attendances to PAU who are admitted to Rudham	Internal	<= 40%	>= 70%	PAU	52 (28.2%)
	HDU Days	No. of HDU days in month	Internal	<= 15	>= 30	Rudham Stats	7
	HDU Patients	No. of HDU patients in month	Internal	<= 3	>= 4	Rudham Stats	5
	Ward Attenders	No. of children post discharge review	Average No. of Patients from 2016 = 61	<= 61	>= 62	Rudham Stats	108
	Medical & Surgical Outliers	Patients aged 16 years and over that are not under a Paediatrician	Internal	0	>= 1	Rudham Stats	0
	Medical Investigations	No. of children attending for diagnostic investigations. Stay on ward was greater than 4 hrs.	Average No. of Patients from 2016 = 48	<= 48	>= 49	Rudham Stats	15
	Elective surgical admissions	No. of children attending ward for elective surgery. Stay on ward was greater than 4hrs	Average No. of Patients from 2016 = 48	<= 48	>= 49	Rudham Stats	21
Workforce	Transfers out with an escort	No. of transfers out requiring a nurse escort	Internal	<= 1	>= 2	Rudham Stats	1
	No. of 7 hr periods escalation beds open	5 escalation beds on Rudham ward	Rudham has more than 18 inpatients	0	>= 1	Rudham Stats	0
	No. of times recommended staffing level not met	When no of RSCN / RN child does not adhere to RCN recommendation	Meeting the children to childrens nurse ratio	0	>= 1	DATIX	20
Clinical Indicators	No. of SUI reported to CCG	Serious Incident and report prcoess actioned	Internal	0	>= 1	Risk Dept	0
	Number of babies under 28 days of age admitted to rudham	No of admissions that may have been avoided had appropriate prior intervention been in place.	Internal	0	>= 1	Datix	0
	Delayed Discharges	No. of patients medically fit who have delayed discharge.	Internal	0	>= 1	Bed stats	0
		No. of days medically fit patients who delayed discharge.	Internal	0	>= 1	Bed stats	0
	Other Clinical Incidents	All other on ward incidents	All incidents to exclude staffing incidents	0	>= 1	Datix	17

Activity
PAU 180 PATIENTS
High volume of patients exceeding 12 patients x 4 days (25th,26th,27th,30th,)
Registrar cross covering ward and PAU x 15 shifts (3rd, 4th, 5th,6th,9th,10th,11th,12th,17th, 19th, 20th, 23rd,24th, 26th,27th)
No SHO, cross covering x 5 days (17th,19th, 23rd, 24th,26Th)
No full ward clerk cover x 2 (6th,10th))
Ward attenders were 108 combination of reviews on PAU and Rudham (22 were clinical procedures requiring administration of IV antibiotics)

Workforce
No clinical incidents involving staffing
(Received 2 x resignations from band 5 staff nurses)

Governance
No SI's declared in February
Clinical incidents
Unavoidable under 28 days = 6
Clinical incidents/ direct care = 4
IG = 1
Medication errors = 3 (2 instigated outside Rudham ward)

Patient Feedback
Friends and family recommend rate has increased from last month to 92.4%, response rate 20.4%

Definitions

Data provided by the Women & Children Division normally around the 20th calendar day of the month after the reporting period.

NICU Clinical Performance & Governance Scorecard 2018-19

		Descriptor	Measurement	Green	Red	Data Source	Apr
ACTIVITY	Admissions to NICU from CDS	No. of infants admitted from CDS admitted due to level of care required	Average for 2017/2018	<=23	>23	NICU / Badgernet	34
	Admissions to NICU from MLBU	No. of infants admitted from MLBU admitted due to level of care required	Average for 2017/2018	0	>=1		2
	Admissions to NICU from Post natal Ward	No. of infants admitted from PNW admitted due to level of care required	Average for 2017/2018	<5	>=5		9
	Admissions to NICU from Home	No. of infants admitted from home admitted due to level of care required	Internal	Internal	Internal		8
	Admissions to NICU from other unit	No. of infants admitted from other units admitted due to level of care required	Internal	Internal	Internal		1
	Admissions to NICU from Rudham Ward	No. of infants admitted from Rudham Ward admitted due to level of care required	Average for 2017/2018	0	>=1		1
	Total NICU Admissions	No. / Percentage of live births admitted to NICU	10% of births	<11% of birth rate	>15% of birth rate		55 / 28.1%
	NICU TC Admissions	No. / Percentage of live births on unit in month	10% of births	<10%	>15%		26 / 13.3%
	ITU days	Available number from funded cot = 30	30	<=31	>90		17
	No of occasions >1 ITU infants on unit	No of times above funded ITU cots = 1	0	0	>=1		1
	48 hrs ventilated	No of babies ventilated for more that 48 hrs that have not been discussed with Tert centre	0	0	>=1		0
	HDU days	Available number from funded cot = 60	Average for 2016 = 52	<=60	>=61		85
	No of occasions>2 HDU infants on unit	No of times above funded HDU cots = 2	0	0	>=2		18
	SC days	Available number from funded cot = 270	Average for 2016 =299	<270	>300		222
	Normal care days	Number of babies on NICU receiving normal care	0	0	>=1		69
	No. of babies over 44 weeks of age	No. of babies aged over 44 weeks	0	0	>=1		2
	Cot occupancy	No. of occasions in month	Over 80% cot occupancy	0	>1		14
		No. of occasions in month	Over 100% cot occupancy	0	>1		1
	Number of avoidable admissions > 37 weeks	No. of admissions that may have been avoided had appropriate prior intervention been in place.	0	0	>=1	DATIX	0
	Number of babies receiving care from the NCT	No. of babies having care in the community	Internal	Internal	Internal	NICU	23
	Number of NCT visits	No. of visits carried out by NCT each month	Internal	Internal	Internal		64
	Ward attenders	No. of babies attending on ward NICU	Internal	Internal	Internal		16
	In uter transfers accepted NICU		Internal	Internal	Internal		0
	In uter transfers refused NICU		Internal	Internal	Internal		1
	Transfers out	≥1 if due to capacity issues	Internal	0	>=1		1
	Unit escalation (in hours)	No of hours NICU on divert to network	Internal	0	>=1		72
		No of hours NICU on divert internal	Internal	0	>=1		36
	Number of times BAPM staffing levels not met per month	No of times in month Staffing levels don't meet BAPM standards	BAPM	0-5 times	10 times and above	NICU / Badgernet	2

Activity

Acuity was high during the month seeing 18 days with more than 2 HDU babies with a total of 85 HDU days and 1 day with 2 Intensive care babies. There were 69 normal care days on NICU. The unit was above 80% occupancy on 14 occasions. There were 2 shifts that nurse staffing did not meet BAPM standards, the escalation policy was initiated & the unit closed to admissions during this time. NICU closed to the Neonatal network for 72 hours & CDS for 36 hours due to acuity. 2 babies were more than 44 weeks, due to extreme prematurity& complex care needs. 28.1% of live births were admitted to NICU.

Definitions

Data provided by the Women & Children Division normally around the 20th calendar day of the month after the reporting period.

NICU Clinical Performance & Governance Scorecard 2018-19 cont'd

		Descriptor	Measurement	Green	Red	Data Source	Apr
MORTALITY	Unexpected Neonatal morbidity	Hypoglycaemia	Internal Guidance and standards not followed	1	>=3	NICU	0
		Pre -Term Hypothermia less than 32 weeks (NNAP)	NNAP standard not achieved	0	>=1	NICU / BadgerNet	0
		Accidental extubation	NEVER EVENT	0	>=1	DATIX	0
		Infection (Positive culture and CSF) (NNAP)	Laboratory results	1	>=3	NICU / BadgerNet	0
		Pneumothorax	Incidents each month	1	>=3	DATIX / Badgernet	0
GOVERNANCE	Risk management	No of SUIs	Incidents each month	0	>=1	DATIX / Risk dept	0
		Total No of reported incidents	Incidents each month	Internal	Internal	DATIX	34
		Staffing Incidents	Staffing level Incidents each month	0	>=1		3
CLINICAL ACTIVITY	Less than 33 weeks babies receiving breast milk on discharge (32+6 DAYS)	NNAP standard	NNAP	>=58%	<58%	NICU / Badgernet	50.0%
		Internal	Internal	Internal	Internal	Internal	1 out of 2
	ROP Screening prior to discharge	NNAP standard	NNAP	100%	<100%	NICU / Badgernet	100.0%
	Parents seen within 24hrs of admission	NNAP standard	NNAP	>=88%	<88%		96.4%
	Delayed Discharge	No of babies delayed discharged	Local / National /Internal	0	>=1	NICU	1
PATIENT FEEDBACK	NICU Likely to recommend (Inpatient)	Percentage of patients who recommend the service	Internal	>=95%	<94%	Patient Experience Team	85.7%
	NICU FFT response rate (Inpatient)	Percentage of eligible patients who responded	National	>=30%	<30%	Patient Experience Team	466.7%
	Patient Experience	Compliments				PALS / Audit	1
	Patient Experience	Complaints				PALS / Audit	0

Mortality

Governance

There were 34 clinical incidents & 3 staffing incidents reported.

Clinical Activity

96.4% of parents were seen by a senior staff member within 24 hours of admission.
50% (1of 2) of babies born at less than 32+6 weeks were discharged receiving breast milk this was due to maternal choice.

Patient Feedback

There were no complaints and 1 compliment. The FFT response rate was 466.7%% with 85.7% recommendation.

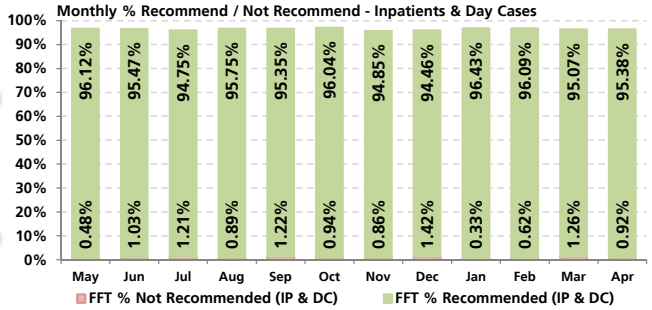
Definitions

Data Source: Data provided by the Women & Children Division normally around the 20th calendar day of the month after the reporting period.

Friends and Family Test - Inpatients and Daycase (Recommended/Not Recommmended)

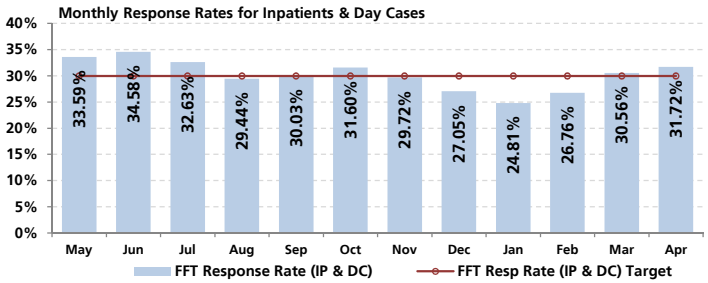
95.38%
% Recommend the service

0.92%
% Do not recommend the service



Friends and Family Test - Inpatient & Daycase (Response Rates)

31.72%
Response Rate (Target 30%)



Ward / Area Performance - Inpatient & Day Cases

Ranked by % Recommend the Service

Ward / Area Name	% Recommend the Service	% Not Recommend the Service	Response Rate	
Day Cases North Cambridgeshire Hospital	100.00%	0.00%	39.26%	
Emergency Observation and Treatment Ward	100.00%	0.00%	8.06%	
Coronary Care	100.00%	0.00%	66.67%	
MAU	100.00%	0.00%	15.54%	
Shouldham	100.00%	0.00%	43.24%	
West Newton	100.00%	0.00%	41.18%	
Day Cases Queen Elizabeth Hospital	98.51%	0.27%	31.93%	
Tilney	98.28%	0.00%	49.57%	
Rudham	98.25%	0.00%	22.53%	
Stanhoe	97.83%	2.17%	49.46%	
Oxborough	97.37%	0.00%	48.72%	
Critical Care	96.67%	0.00%	300.00%	*
Denver	95.12%	4.88%	46.07%	
Elm (SAU)	92.19%	1.56%	28.96%	
Marham	91.86%	2.33%	23.18%	
Gayton	91.67%	0.00%	48.00%	
Ambulatory Emergency Care	91.51%	1.42%	33.81%	
Leverington Escalation	90.91%	0.00%	23.16%	
PAU	89.66%	0.00%	17.16%	
Terrington Short Stay	89.66%	3.45%	34.25%	
Elm	89.29%	0.00%	32.56%	
West Raynham	86.21%	3.45%	42.03%	
NICU	85.71%	7.14%	466.67%	*
Necton	83.33%	4.17%	28.57%	
Windsor	83.33%	0.00%	38.30%	
Day Cases St Georges Medical Centre	0.00%	0.00%	0.00%	
Leverington Admissions Unit	0.00%	0.00%	0.00%	

Benchmarking - Inpatient & Day Cases

Rank	Org Code	Organisation Name (Ranked by % Recommended)	% Recommended	% Not Recommended	% Response Rate
1	RGR	WEST SUFFOLK NHS FOUNDATION TRUST	98.47%	0.19%	17.59%
2	RDE	COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST	97.81%	0.43%	39.25%
3	RGQ	IPSWICH HOSPITAL NHS TRUST	97.59%	0.65%	31.94%
4	RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	97.54%	1.05%	17.84%
5	RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	97.53%	0.44%	45.84%
6	RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	97.41%	0.97%	7.72%
7	RGM	PAPWORTH HOSPITAL NHS FOUNDATION TRUST	97.32%	0.80%	42.34%
8	RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	96.52%	0.77%	7.40%
9	RDD	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	95.90%	0.89%	38.77%
10	RGN	NORTH WEST ANGLIA NHS FOUNDATION TRUST	95.46%	1.17%	25.84%
11	RCX	***THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST***	***95.07%***	***1.26%***	***30.56%***
12	RQ8	MID ESSEX HOSPITAL SERVICES NHS TRUST	91.93%	4.40%	22.81%
13	RAJ	SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	90.91%	5.14%	26.84%

Key Points/Operational Actions

The response rate reached the target of 30% (31.72%) which is a promising start to the financial year. The likelihood to recommend score for the month achieved the 95% target (95.38%) higher than last month.
The benchmark figures for the region place the Trust 11/13 based on March's likelihood to recommend figures (a dip of three places from last month), although there were only 5 hospitals with a higher response rate.
In April there were 17 inpatient and day case patients unlikely to recommend the care that they had received – 3 provided positive or no comments. The other comments related to lack of staff leading to lack of care (delayed call bells, worse at night, left for 3 hours post op, dignity issues – bed soiled whilst waiting for call bell), staff attitude, staff chatting, problems taking blood, lack of communication, being rushed to discharge, overwork pressure on staff, noise at night and having to arrive 4 hours before operation resulting in car park issues.

Definitions

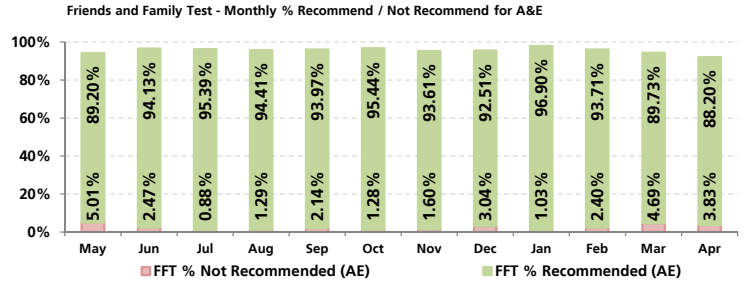
The % of patients "Recommending / Not Recommending the Service" shown above will not always equal a combined total of 100% as it does not include those who are undecided. Data Source: Meridian normally around the 10th calendar day of the month after the reporting period.The Friends & Family Test Scores & Response Rates shown above includes Inpatients & Daycase activity. The benchmarking data is extracted from the Department of Health's Unify Reporting Tool ,and is shown at least a month in arrears.

* Response rates of greater than 100% can occur when responses relating to discharges in one month are received by organisations too late for that month's submission and are submitted as part of the return in the following month or Patients/Carers/Family

Friends and Family Test - A & E (Recommended/Not Recommended)

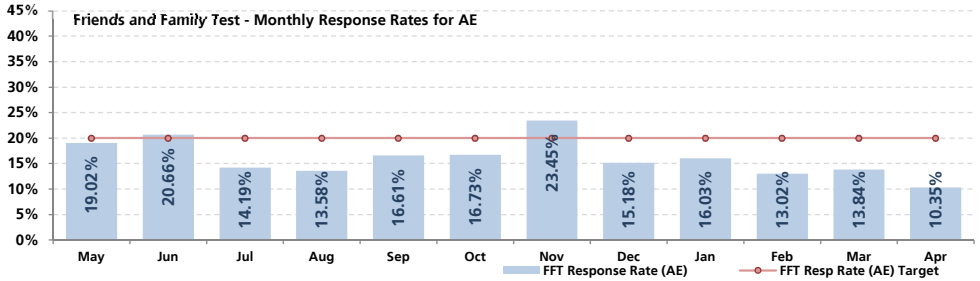
88.20% — % Recommend the service

3.83% — % Do not recommend the service



Friends and Family Test - A & E (Response Rates)

10.35% — Response Rate (Target 20%)



Benchmarking - A & E

Org Code	Organisation Name (Ranked by % Recommended)	% Recommended	% Not Recommended	% Response Rate
RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	95.05%	1.40%	31.30%
RGR	WEST SUFFOLK NHS FOUNDATION TRUST	93.84%	2.71%	17.34%
RGN	NORTH WEST ANGLIA NHS FOUNDATION TRUST	92.25%	5.63%	1.53%
RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	92.24%	5.17%	1.83%
RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	90.50%	3.17%	7.24%
RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	90.19%	4.39%	20.83%
RCX	***THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST***	***89.73%***	***4.69%***	***13.84%***
RDE	COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST	88.53%	7.14%	27.86%
RQ8	MID ESSEX HOSPITAL SERVICES NHS TRUST	87.82%	6.67%	18.96%
RAJ	SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	83.84%	10.82%	15.70%
RGQ	IPSWICH HOSPITAL NHS TRUST	81.71%	9.61%	9.16%
RDD	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	78.63%	13.03%	21.69%

Key Points/Operational Actions

The Emergency Department has missed the likelihood to recommend target of 95% (88.20%) although there was not a corresponding increase in the percentage not recommending the service (this dropped from 4.69% to 3.83%). The response rate has dropped and missed the 20% required (10.35%).

Overall the service benchmarks at 7/12 based on March's figures for likelihood to recommend (this is down from 4 in February).

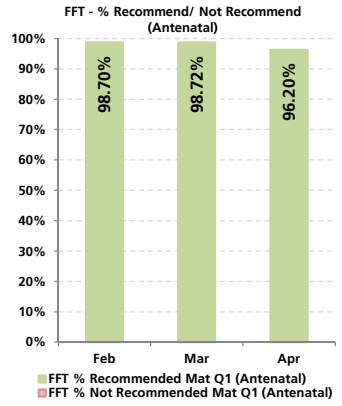
There were 13 patients unlikely to recommend the care they had received (from a total of 339 responses) and the reasons included mainly waiting (this represented 46% of all negative responses down from 65% of negative responses in March) and then staff attitude, lack of facilities whilst waiting, not accepting medical history and not able to understand staff.

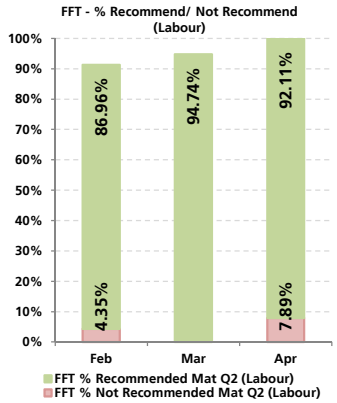
The matron is working with the patient experience lead to improve the response rate and actions include the support of volunteers with ipads to help appropriate patients complete, it has also been raised with the housekeepers to ensure that they are offering the patients the family and friends cards at the end of treatment and the importance of improving the response rate has been discussed with all senior staff in the department.

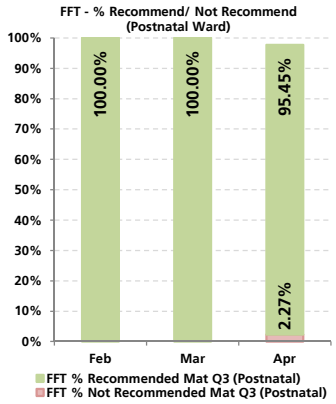
Definitions

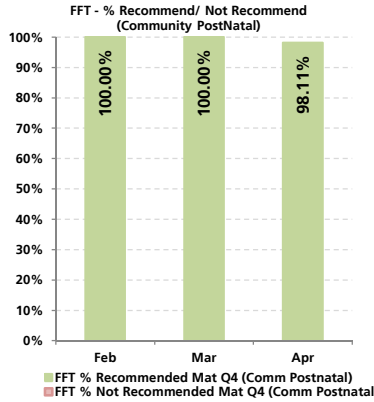
The % of patients "Recommending/Not Recommending the Service" shown above will not always equal a combined total of 100% as it does not include those who are undecided.
The benchmarking data is extracted from the Department of Health's Unify Reporting Tool, and is currently shown a month in arrears. Data Source: Meridian normally around the 10th calendar day of the month after the reporting period.

Friends and Family Test - Maternity Services (Recommended/Not Recommended)

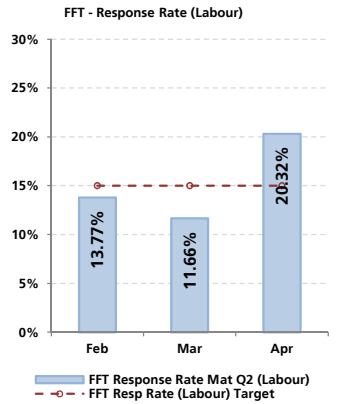








Response Rate - Labour



Benchmarking - Maternity Services

Org Code	Organisation Name (East of england Trusts)	Question 1 (Antenatal)		Question 2 (Labour)		Question 3 (Postnatal Ward)		Question 4 (Comm Postnatal)	
		% Recommended	% Not Recommended	% Recommended	% Not Recommended	% Recommended	% Not Recommended	% Recommended	% Not Recommended
RAJ	SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	100.00%	0.00%	100.00%	0.00%	100.00%	0.00%	100.00%	0.00%
RDE	COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST	100.00%	0.00%	100.00%	0.00%	98.39%	1.61%	100.00%	0.00%
RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	100.00%	0.00%	100.00%	0.00%	100.00%	0.00%	100.00%	0.00%
RGR	WEST SUFFOLK NHS FOUNDATION TRUST	100.00%	0.00%	100.00%	0.00%	*	*	96.55%	0.00%
RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	100.00%	0.00%	100.00%	0.00%	100.00%	0.00%	*	*
RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	100.00%	0.00%	99.37%	0.00%	99.37%	0.00%	100.00%	0.00%
RGQ	IPSWICH HOSPITAL NHS TRUST	100.00%	0.00%	98.48%	0.00%	96.88%	0.00%	98.75%	0.00%
RGN	NORTH WEST ANGLIA NHS FOUNDATION TRUST	98.64%	0.00%	97.71%	0.76%	96.06%	1.57%	99.03%	0.00%
RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	95.45%	0.00%	97.12%	0.72%	88.79%	3.64%	40.00%	20.00%
RDD	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	100.00%	0.00%	96.67%	0.00%	95.88%	0.00%	100.00%	0.00%
RCX	***THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST***	***98.72%***	***0.00%***	***94.74%***	***0.00%***	***100.00%***	***0.00%***	***100.00%***	***0.00%***
RQ8	MID ESSEX HOSPITAL SERVICES NHS TRUST	*	*	89.71%	7.35%	92.31%	5.77%	93.33%	2.22%

*** Denotes these have no information on NHS england download (Responses under 5 are excluded)**

Key Points/Operational Actions

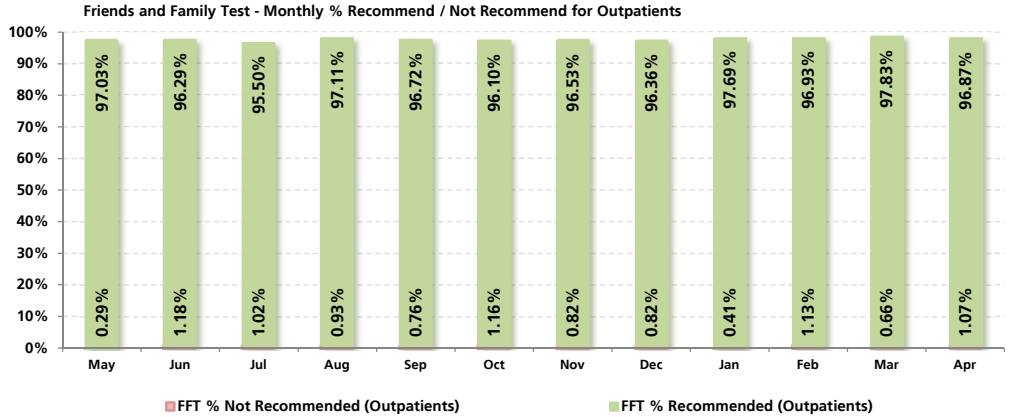
The Maternity service showed an increase in response rate (birth) to 20.32% (15% target) although there was a fall in the likelihood to recommend score to 92.11% for birth. 38 responses were collected over the month, which is twice the number collected in March.
All other areas of the maternity pathway achieved the 95% likelihood to recommend target. There were 4 patients unlikely to recommend the care they had received across the maternity pathway although one provided a positive comment the reasons that patients were unlikely to recommend were poor communication over medical treatment, patient felt rushed to move from Delivery suite to Castleacre and this impacted on skin to skin and natural exploring, on Castleacre Ward one patient highlighted lack of staff leading to lack of care.

Regional maternity information (birth) shows that based on March's 'likelihood to recommend' results the Trust benchmarked in 11/12 – this is due to one neutral response reported last month and due to the low numbers of responses received this has a greater impact on the overall score.

Definitions

The % of patients "Recommending / Not Recommending the Service" shown above will not always equal a combined total of 100% as it does not include those who are undecided. Data Source: Meridian normally around the 10th calendar day of the month after the reporting period. Maternity benchmarking is ranked by Question 2 (Labour). Benchmarking data is extracted from the Department of Health's Unify Reporting Tool, and is currently shown a month in arrears.

Friends and Family Test - Outpatient Services (Recommended/Not Recommmended)



Benchmarking - Outpatient Services

Org Code	Organisation Name (Ranked by % Recommended)	% Recommended	% Not Recommended
RGM	PAPWORTH HOSPITAL NHS FOUNDATION TRUST	98.22%	1.18%
RDE	COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST	98.00%	0.40%
RCX	***THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST***	***97.83%***	***0.66%***
RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	97.17%	0.60%
RGQ	IPSWICH HOSPITAL NHS TRUST	96.99%	0.68%
RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	96.98%	1.01%
RGR	WEST SUFFOLK NHS FOUNDATION TRUST	95.43%	0.40%
RGN	NORTH WEST ANGLIA NHS FOUNDATION TRUST	95.17%	1.28%
RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	94.29%	3.43%
RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	94.10%	1.97%
RDD	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	93.49%	2.53%
RAJ	SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	92.67%	2.95%
RQ8	MID ESSEX HOSPITAL SERVICES NHS TRUST	91.27%	3.81%

Key Points/Operational Actions

The level of recommendation within Outpatient services remains high at 96.87% and the Trust benchmarked at 3/13 regionally in March in relation to likelihood to recommend (the same as February). There were 15 patients unlikely to recommend and their concerns were across many services but focused on waiting times, staff attitude, lack of diagnosis, appointment letters, staff conversations and the car park.

Across the hospital the main areas for concern remain the same as those reported for the last 3 months and are:
Staff Attitude
Waiting time
Overworked / general lack of staff
(These three issues are regularly mentioned together on many of the responses received from patients)

Definitions

The % of patients "Recommending/Not Recommending the Service" shown above will not always equal a combined total of 100% as it does not include those who are undecided.
The benchmarking data is extracted from the Department of Health's Unify Reporting Tool, and is currently shown a month in arrears. Data Source: Meridian normally around the 10th calendar day of

Patient Experience - Mixed Sex Accommodation

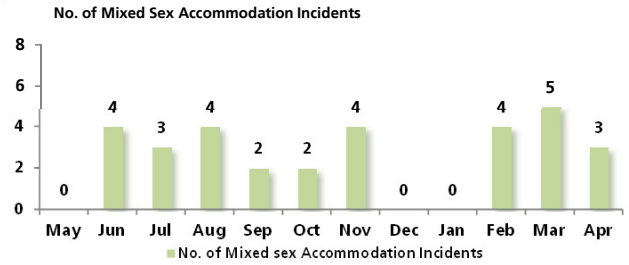
Latest Month's Performance

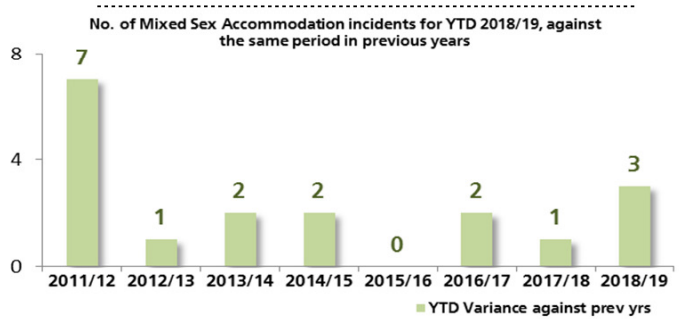
3	6
Incidents of Mixed Sex Accommodation	No. of Patients affected

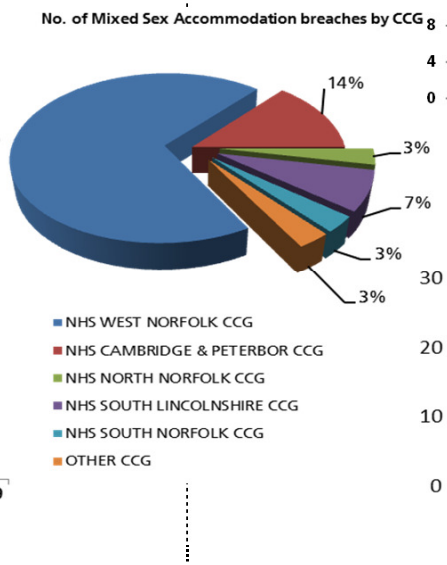
Financial YTD

3	6
Incidents of Mixed Sex Accommodation	No. of Patients affected

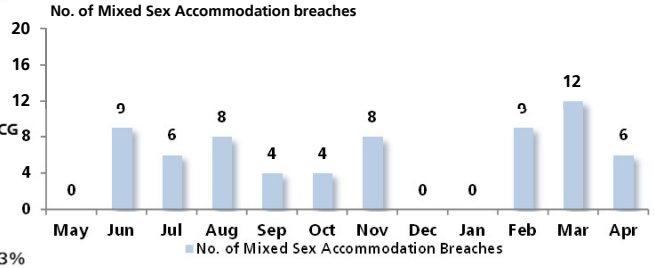
Mixed Sex Accommodation Incidents

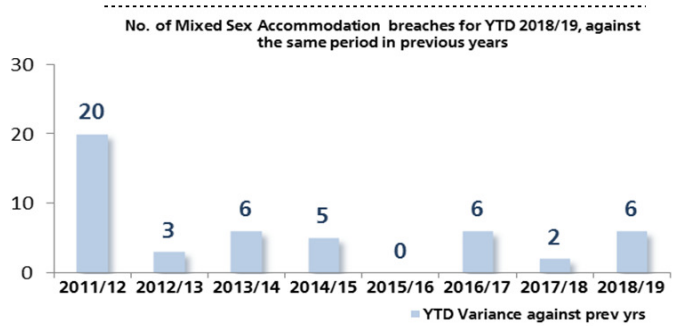






Mixed Sex Accommodation Breaches





Key Points/Operational Actions

The pressure on bed capacity has continued and there has been a further three breaches of the Mixed Sex Accommodation guidance, all within the Critical Care Unit and affecting patients six patients in total. The privacy of patients on the Unit has been enhanced with the provision of new screens to improve the experience of patients affected by this issue but the focus on transferring patients to more suitable ward accommodation when fit and able to transfer remains in place.

The ACN for the business unit covering CCC has ensured that there is increased visibility of patients who may potential EMSA breach in CCC by ensuring this is escalated as each bed meeting during the day and this is also reported monthly through critical care's quality dashboard

Definitions

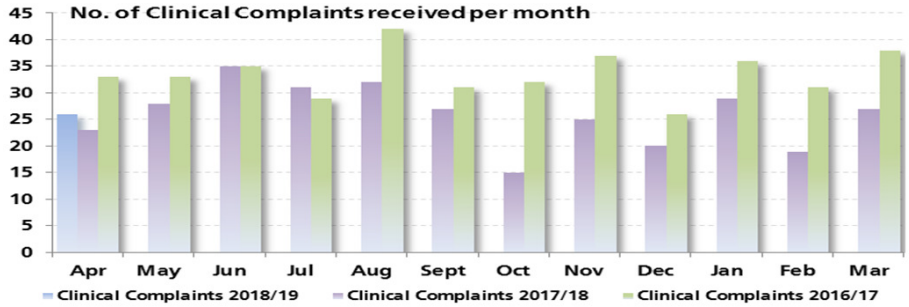
Number of Incidents of Mixed Sex Accommodation (MSA) - The number of times Mixed Sex Accommodation occurred within the specified time period.
Number of Breaches of Mixed Sex Accommodation (MSA) - The total number of patients affected by Mixed Sex Accommodation occurrences within the specified time period.
Data Source: Risk & Governance Team normally around the 5th calendar day of the month after the reporting period.

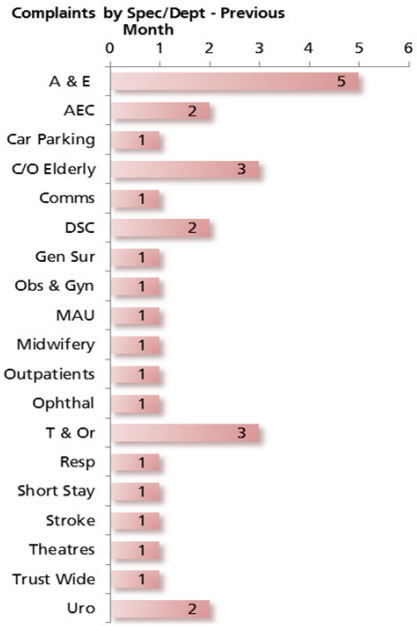
Complaints

26	26
Current Month	YTD

Non Clinical Complaints

4	4
Current Month	YTD





Key Points/Operational Actions

Number of complaints received

During the month of April 2018, the Trust received 30 formal complaints. This is six fewer than last month and five more than April 2017 when the Trust received 25 complaints.

Complaints received by Specialty/Key Issues Table

During April 2018, the Emergency Department received 5 complaints, Care of the Elderly and Trauma & Orthopaedics each received 3 complaints. The complaints regarding these areas included the following issues:

- Failure to provide adequate care
- Delay or failure to diagnose
- Staff attitude
- Discharge arrangements/Inadequate Discharge Planning
- Waiting times

Lessons Learned

- To ensure there is effective communication and planning with patients and their relatives regarding admission and end of life (EOL) arrangements. To ensure relatives have a full understanding of the plan and actions to be taken.
- To ensure a clear process across the Trust regarding admission documentation and clarification of contact details for next of kin. To ensure all staff are reminded to handover information accurately if they are unable to contact relatives prior to the end of the shift.
- To ensure patients and their partners are communicated with effectively during labour to provide reassurance.
- Patients and their families should be kept informed of the current treatment plan during admission and the reasons for any delays in treatment or decisions.
- Communication between internal departments should be clear and concise to avoid confusion or inaccurate information being provided to families.

Other Information

- No complaints have been re-opened in April 2018.
- 4 local resolution meetings were held in April 2018.
- 1 complaint was referred to the Parliamentary and Health Service Ombudsman (PHSO).
- 88 Travel Expense claims were processed in April 2018.
- 6 PALS surveys were completed in April 2018. 4 respondents found the PALS service to be extremely helpful and two respondents marked the service as poor. In relation to the two 'poor' ratings – one of the patients had already contacted the department to express his dissatisfaction for the delay in investigation and completion of their complaint response. The second patient completed his survey by rating the department that he was unhappy with as opposed to the PALS Department. Other comments included 'Prompt response and very supportive.'

Definitions

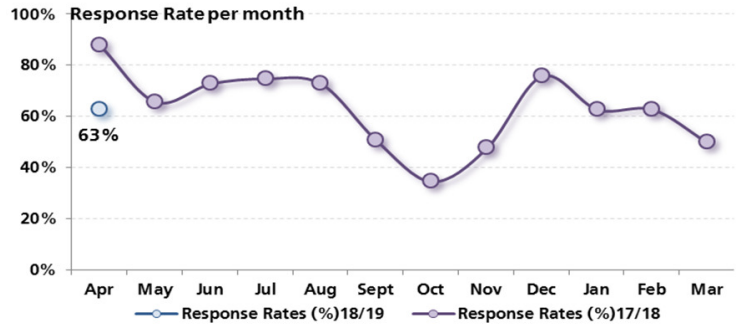
Data Sourced from Complaints Dept normally around the 10th calendar day of the month after the reporting period.

Actions Taken & Lessons Learned

Actions taken & lessons learned following conciliation meetings held in

Key Issues	Lessons Identified	Action
Patient's wife raises concern about care: - Failure to provide Intravenous fluids - Loss of documents provided by patient's wife - Despite being a vegetarian the patient was fed meat by a nurse - Doctors discussed resuscitation with the patient against his wishes - Patient left in a bathroom and staff failed to respond to a call-bell - A catheter was inserted unnecessarily and in any event was the wrong type - Patient not provided with food supplement drinks - Delays in patient's discharge so he could die at home - Inadequate care package provided when patient was discharged	To ensure there is effective communication and planning with patients and their relatives regarding admission and end of life (EOL) arrangements. To ensure relatives have a full understanding of the plan and actions to be taken to avoid distress.	Matron has shared the concerns of the family with all of the team and reiterated the need for effective communication. Matron has requested that the family write down their experience for this to be used in a future training session for all of the team in June 2018. Matron has shared concerns with the short stay ward involved to remind them of the need to confirm patient choices from previous admission to ensure patient's dietary choices and wishes are met.
Patient's son was not contacted by the ward staff to inform him of his father passing away. Son was not aware until he attended the ward the following day.	To ensure a clear process across the Trust regarding admission documentation and clarification of contact details for next of kin. To ensure all staff are aware of the requirement to handover information accurately if they are unable to contact relatives to break bad news prior to the end of the shift to avoid this incident happening again.	Checklist for transfer to mortuary has been amended to include confirmation that family are aware of the patient being transferred. Review of admission documentation to ensure it is fit for purpose. Member of staff involved has been provided with feedback and will be given additional training regarding communication to relatives to avoid a recurrence.
Patient distressed following labour as doctor failed to obtain consent prior to internal examination and procedure. Lack of communication with patient during and after labour.	To ensure patients and their partners are communicated with effectively during labour to provide reassurance. All patient documentation is now electronic in midwifery to ensure all information is easily accessible as required, not only at the time of labour but for review and available for i.e. Time to Talk sessions.	Head of Midwifery has located documentation that was not previously available for patient to review consent forms as requested, this has reassured the patient. Head of Midwifery has advised patient regarding GMC notification of the doctor involved who no longer works at the Trust. Clinical Psychology arranged for patient to attend to provide emotional support that is required following delivery of her baby. Consultant has reviewed patient's episiotomy scar and arranged follow up.
Family have concerns regarding patient's care and treatment at the hospital and EOL, delayed diagnosis, lack of communication with patient, family and between internal departments	Patients and their families should be kept informed of the current treatment plan during admission and the reasons for any delays in treatment or decisions. Communication between internal departments should be clear and concise to avoid confusion or inaccurate information being provided to families.	Following Local Resolution Meeting (LRM), patient's wife has some outstanding concerns/questions to be addressed. Associate Director of Patient Experience and Medical Director are investigating concerns and will provide final outcome for the family.

Complaints Cont'd - Response Rates



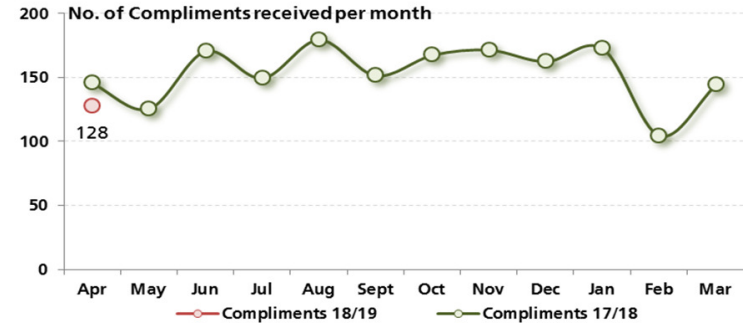
Key Points/Operational Actions

The Trust is required to investigate and share the response with the complainant within 30 working days. The compliance rate has increased from last month to 63% and 9 breaches occurred:

- Division 1 and Division 2 have each had 4 breaches out of 10 responses that were due in April 2018.

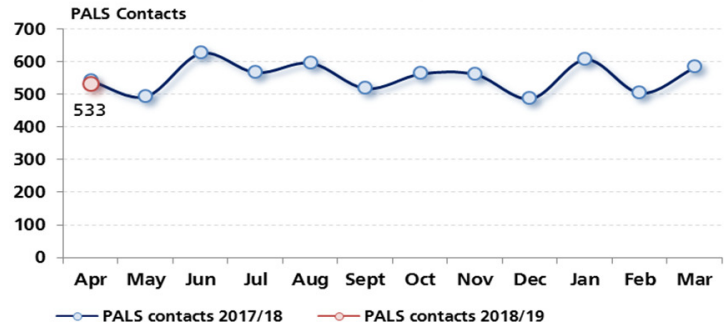
Currently there are 25 complaint investigations/responses that are overdue and have not yet been completed, these continue to be chased and escalated. Some overdue complaint responses have now been received from the Divisions and following Executive review and Chief Executive sign-off they will be completed and closed. Revised Complaints policy was launched on the 3rd April 2018, the changes made are to enhance the patient experience of the process and to improve compliance. An action plan has been developed with a trajectory to improve compliance of the 30 working day response time across the Trust and meetings have been held with the Complaints' leads within each division and local improvement plans put in place.

Compliments



128 compliments were received this month, which is a decrease from 145 compliments received last month and a decrease in comparison to April 2017, in which the Trust received 147 compliments.

PALS Contacts (including Compliments)



The PALS service has had 405 contacts this month, compared to a figure of 442 in the previous month. This is an increase in comparison to April 2017, in which 396 contacts were recorded. The top subjects for this month are noted below:

General Information	56
Travel Expenses	18
Complaints Procedure	16
Directions within the Trust	16
General enquires	16
Discharge Arrangements	15
Sign Post to another NHS Trust	14
Clinical Care	13
Enquiry	12
Waiting List In-Patients	12
Access to Health Records	11
Department Details	11

Definitions

Response Rate - No. of co.plaints closed within 30 days. Compliments - No. of compliments received into the Trust . PALS Contacts - No. of compliments received into the Trust.
Data Sourced from Complaints Dept normally around the 10th calendar day of the month after the reporting period.

Performance & Standards Scorecard

Delay free

Indicators	Var to prev mth	Target	Feb	Mar	Apr	FYTD
National standards						
18 Wks - Adm Perf (adjusted)	↑	90.00%	76.14%	73.97%	77.70%	77.70%
18 Wks - Non Adm Perf	↓	95.00%	86.89%	79.52%	74.10%	74.10%
18 Wks - Incomp Perf	↓	92.00%	82.76%	81.05%	80.17%	80.17%
Cancer-2ww	↓	93.00%	97.31%	96.96%	NA	96.70%
Cancer-2ww (Breast Symptomatic)	↑	93.00%	98.67%	100.00%	NA	97.97%
31 Day Diag to Treat	↓	96.00%	100.00%	98.28%	NA	98.67%
Cancer-62 Days RTT	↑	85.00%	79.66%	81.02%	NA	83.23%
Cancer - 31 Days Subsq Treatment - Surgery	↑	94.00%	88.24%	100.00%	NA	95.91%
Cancer - 31 Days Subsq - Drug Treatments	→	98.00%	100.00%	100.00%	NA	99.64%
Cancer Screening (62 Day)	→	90.00%	100.00%	100.00%	NA	98.51%
A&E 4 Hour Performance	↑	95.00%	69.17%	79.26%	81.29%	81.29%
Ambulance turnaround	↑	100.00%	9.76%	21.32%	40.43%	40.43%
Stroke - 90% of Stay on a Stroke Unit	↑	80.00%	71.74%	75.00%	NA	83.33%
TIA - High Risk,Non admitted TIA treated in 24 Hrs	↑	60.00%	69.44%	78.57%	NA	70.29%
Cancelled Ops - as a % of Elective Admissions	↓	0.80%	2.11%	1.97%	0.92%	0.92%
Diagnostic Over 6 Week Waiters - % of Total WL	↑	1.00%	5.72%	2.45%	7.03%	7.03%

Operational Efficiency

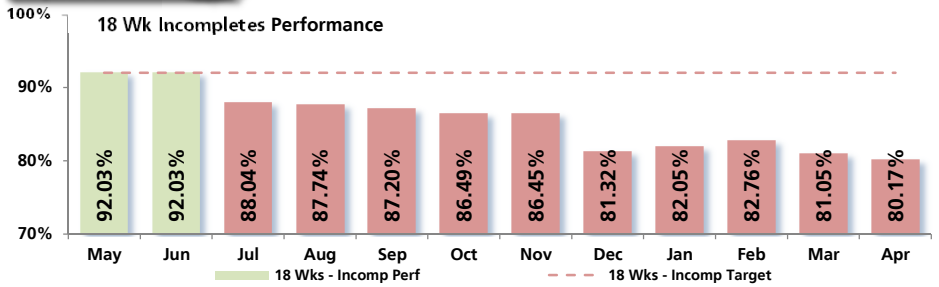
Indicators	Var to prev mth	Target	Feb	Mar	Apr	FYTD
Local standards						
Day Case Rate	↓	82.00%	89.21%	88.64%	NA	86.28%
DNA Rate	↑	5.00%	6.39%	6.60%	6.84%	6.84%
New to FUP Ratio	↓	2.3	2.4	2.4	2.2	2.2
Readmission Rate - Elective	↓	3.00%	3.80%	3.26%	NA	3.56%
Readmission Rate - Emergency	↓	10.00%	17.33%	17.11%	NA	17.37%
Length of stay - Elective	↓	2.2	1.0	1.4	1.2	1.2
Length of stay - Emergency	↑	5.0	4.4	4.4	4.4	4.4

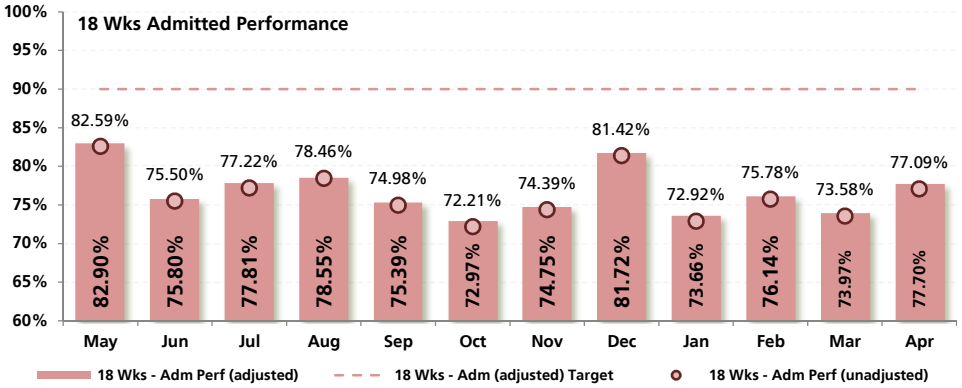
Cancer, Stroke, TIA, Day Case & Re-admissions Rates are all normally shown 1 month in arrears.

18 Weeks Referral To Treatment

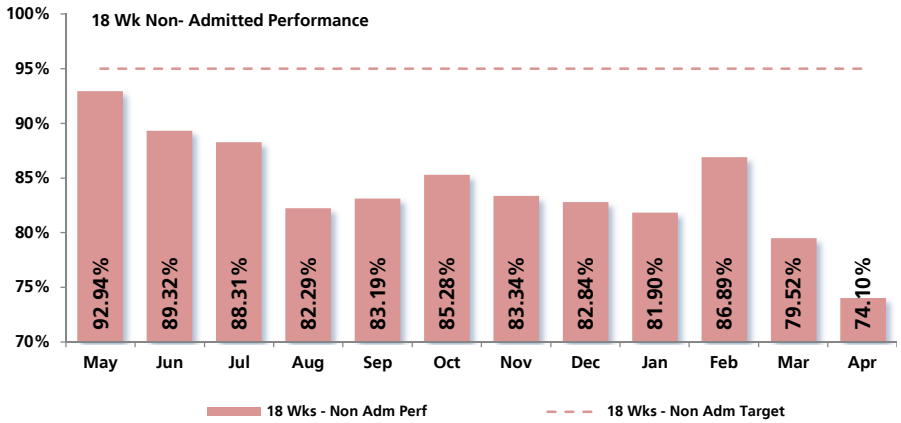
80.17%

Incompletes (Target 92%) ✗





Specialties that PASSED the 18 Wk Incompletes Target		Specialties that FAILED the 18 Wk Incompletes Target	
100.00%	Cardiothoracic	59.63%	Urology
98.49%	Gen Medicine	65.52%	Neurology
96.75%	Dermatology	71.82%	Ger Medicine
93.49%	Oral Surgery	75.14%	Trauma & Ort
92.63%	Gastroenterology	76.66%	Rheumatology
92.33%	Ophthalmology	77.67%	Gynaecology
		79.82%	ENT
		80.36%	Other
		80.42%	Cardiology
		80.53%	Gen Surgery
		88.68%	Plastics Surgery



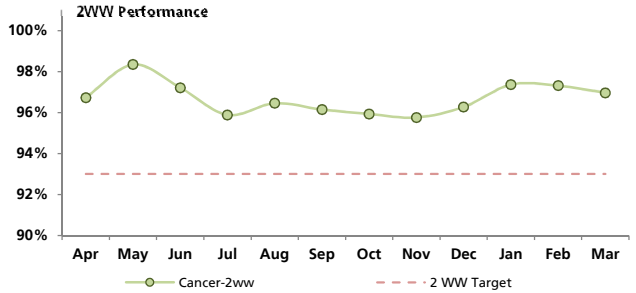
Key Points/Operational Actions

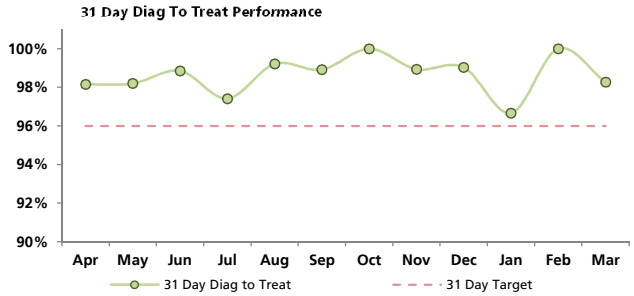
Definitions

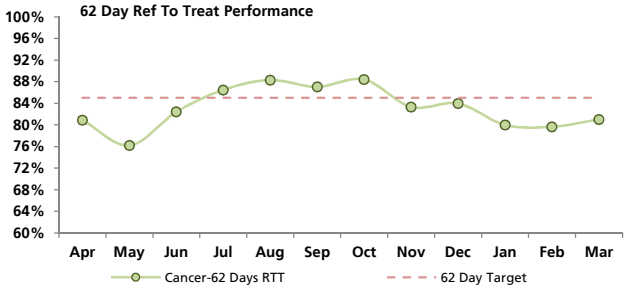
RTT Waiting Times – Admitted (90% Target <18 Wks.) RTT Waiting Times – Non-Admitted (95% Target <18 Wks). RTT Waiting Times - Incompletes (92%).
Data Source: Performance data based on activity information extracted from PAS, and provided as part of the Trust's routine monthly 18 Weeks RTT submission.

Cancer Waiting Times

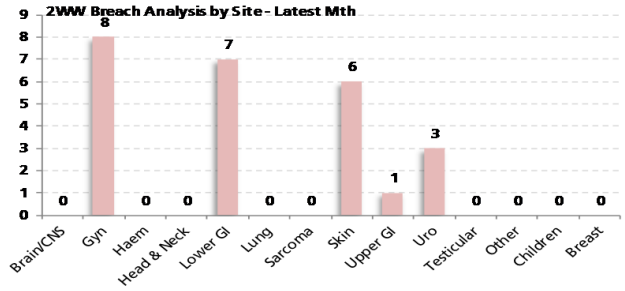
2ww (Target 93%)	31 Day (Target 96%)	62 Day (Target 85%)	31 Day Subs Treat - Surg (Target 94%)	31 Day Subs Treat - Drug (Target 98%)	2ww Breast Symptomatic (Target 93%)	62 Day Screening (Target 90%)
96.96% ✓	98.28% ✓	81.02% ✗	100.00% ✓	100.00% ✓	100.00% ✓	100.00% ✓

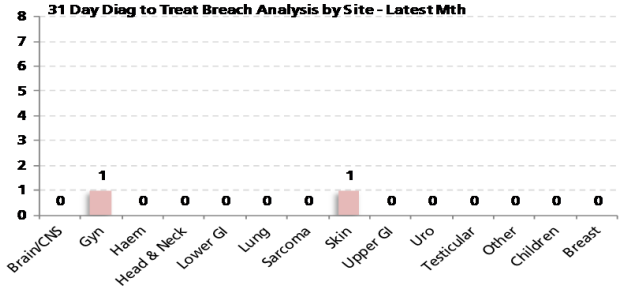


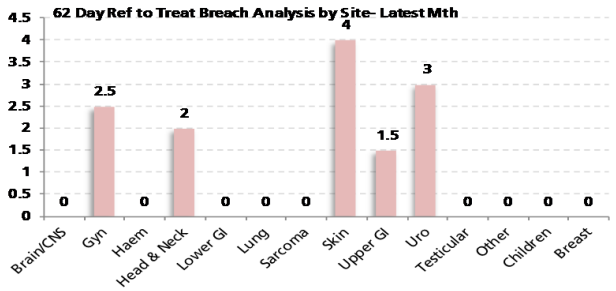




Site Level Breach Analysis - Latest Month





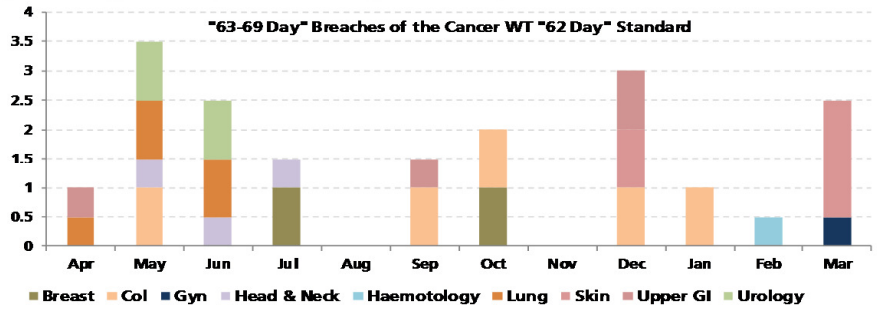


Key Points/Operational Actions

Definitions

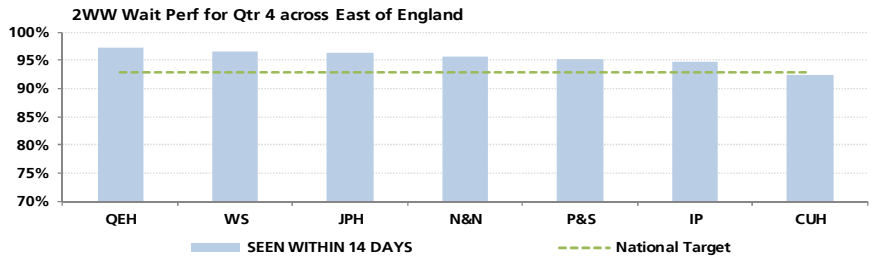
Percentage of cancer patients first seen within 2 weeks in the reporting month (1 month in arrears). Percentage of above Cancer Pathway completed within 31 Days in the reporting month (1 month in arrears)
Percentage of above Cancer Pathway completed within 62 Days in the reporting month (1 month in arrears).
Data Source: Performance data based on activity information extracted from PAS, Open Exeter and Somerset Systems, and provided as part of the Trust's routine monthly Cancer Wait Times submission.

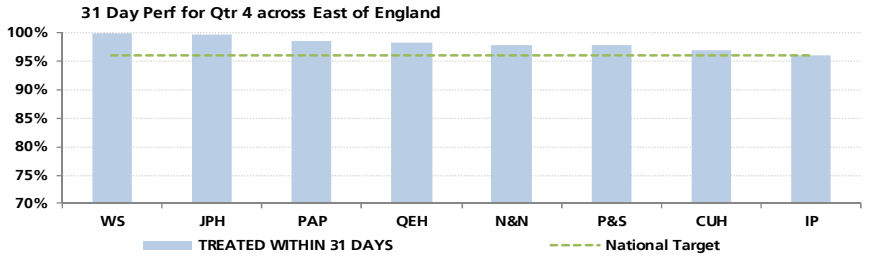
Cancer Waiting Times - 62 Day Breaches at 63-69 Days

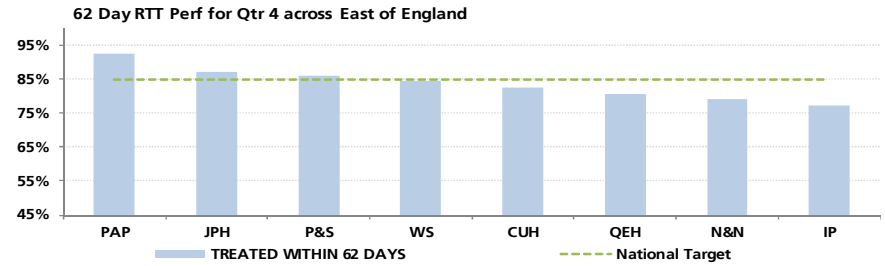


104+ Breaches by Site and Month 2017/18												
Site	Apr	May	Jun	Jul	Aug	Sep	Nov	Dec	Jan	Feb	Mar	Grand Total
Colorectal	1			1		1	1		2			12
CUP												1
Gynaecology							1			1	2	7
Haematology	1	1						1	2			9
Head And Neck				2		1		2			2	12
Lung		1		1	1				1			19
Skin					1	1				1	1	5
Upper GI							2					4
Urology		3	3	1	1	1			1	1	1	24
Grand Total	2	5	3	5	3	4	4	3	6	3	6	93

Cancer Waiting Times (Benchmarking)







Key Points/Operational Actions

Definitions

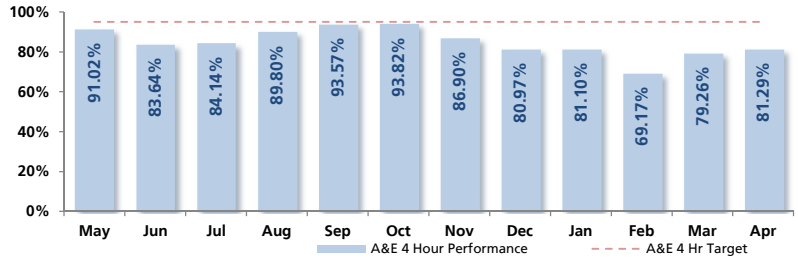
Benchmarking data provided from NHS England and will only be updated once every quarter.

Accident and Emergency

81.29%
AE Performance - Prev Mth (Target 95%) ✗

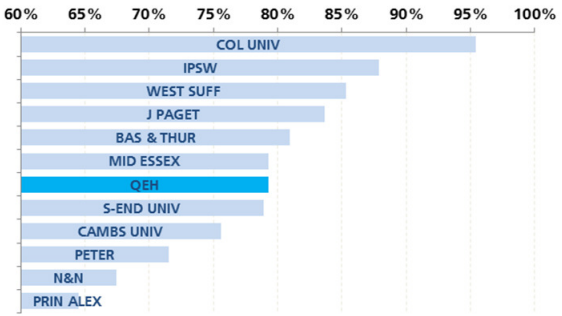
81.29%
AE Performance - YTD (Target 95%) ✗

AE performance (Last 12 month)



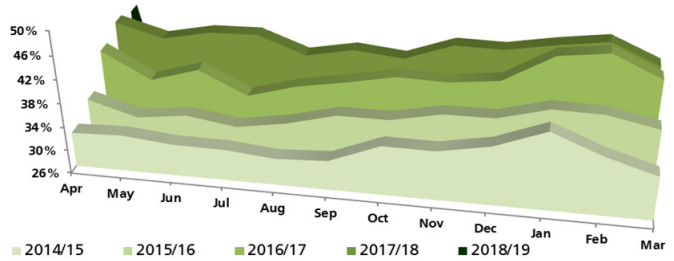
Previous Month's KPI's

Benchmarking across NHS England Midlands & East (East)



Activity & Performance levels of the last 3 months

Yr on Yr comparison of Emergency Admissions via AE over last 5 years



The chart above shows the variance in AE activity & performance levels, when compared to the previous month

Key Points/Operational Actions

- There has been an improvement within month although performance remains below the agreed recovery trajectory
- Overcrowding in the Department remains a concern – this has been particularly evident when patients are 'bedded' in the Department overnight leading to no capacity within Major areas which in turn then limits the ability to off load patients arriving by ambulance. At times it has also been necessary to utilise minor bays for major patients which has impacted on performance through the minor work stream
- Primary care streaming continue to see and treat an average of 17 patients per day
- It remains a challenge to reinstate the RAB bays on MAU on a daily basis – this results in medically GP expected patient being diverted to A& E and can challenge and already overcrowded department and lead to delays for the medical patients to be seen and reviewed by the medical team
- Issues that have been raised by the CQC in relation to Mental Health room, resus equipment and paediatric nurse cover are being addressed but will continue to need monitoring and further actions

Definitions

Percentage of total A&E Attendances for the reporting month that are admit.ted or discharged within the 4 hour target. The latest benchmarking data is based on the monthly performance (2 months in arrears).
Data Source: Performance data based on activity information extracted from EDIS system, and provided as part of the Trust's routine monthly AE submission.

Ambulance Handovers

Latest Month's Performance

40.43%

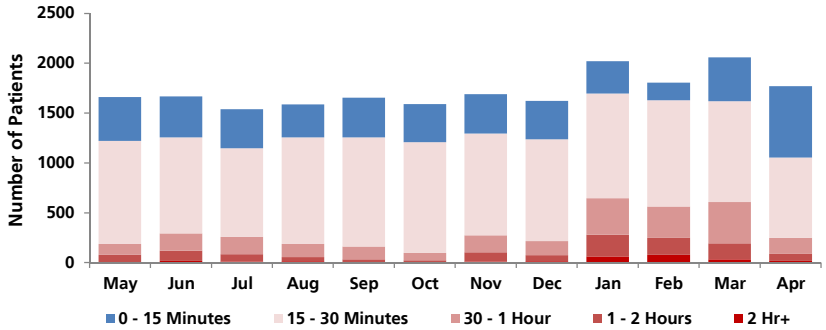
% of handovers within 15 minutes ✗

Financial YTD

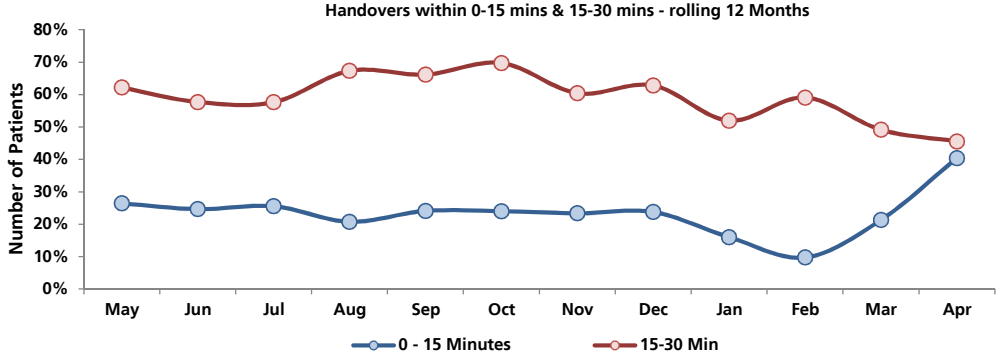
40.43%

% of handovers within 15 minutes ✗

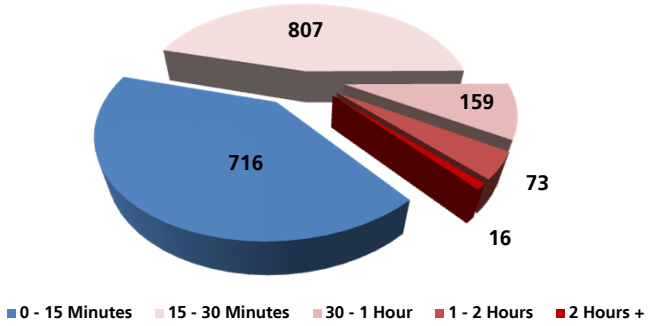
Monthly Ambulance Handover Times



Handovers within 0-15 mins & 15-30 mins - rolling 12 Months



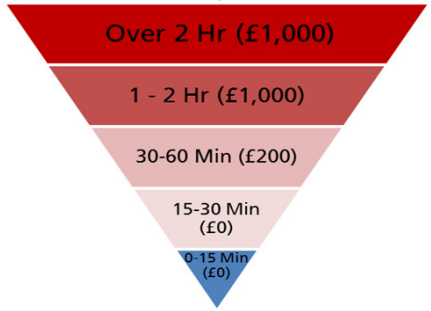
2017/18 YTD Ambulance Handover times



2017/18 YTD value of breaches

Over 2 Hr	£16,000.00
1 - 2 Hr	£73,000.00
30 - 60 Min	£31,800.00
15 - 30 Min	£0.00
0 - 15 Min	£0.00

Potential fines per case in



Key Points/Operational Actions

- In month there has been significant improvement in handover times
- The reason for delays of over 30 minutes to handover remain due to lack of flow out of the department and the resultant lack of capacity within the area
- Cohorting continues however this now comes at an additional financial cost to the Trust as this is no longer funded by winter monies
- There are still concerns with regard to the clinical risk for patients cohorted in the A and E entrance area and the patient expereince
- Handover breaches are now reviewed weekly in conjunction with 4 hour performance breaches

Definitions

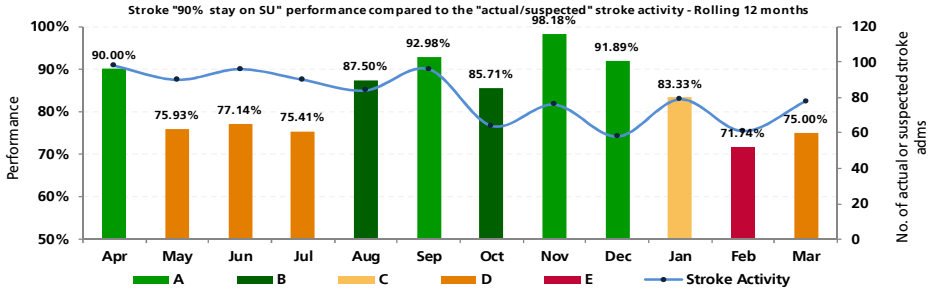
The percentage of the total Ambulance handovers within the reporting month where the handover was less than 15 minutes in duration.

Stroke Performance

Key Indicator : 90% of Stay on a Stroke Unit

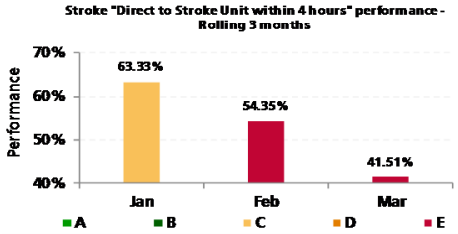
Monthly Performance % Mar-18	YTD Performance % YTD 2017/2018
75.00%	83.33%
SSNAP Level	YTD SSNAP Level
D	C

SSNAP Target Levels	
A	90.00%
B	85.00%
C	80.00%
D	75.00%
E	<75.00%



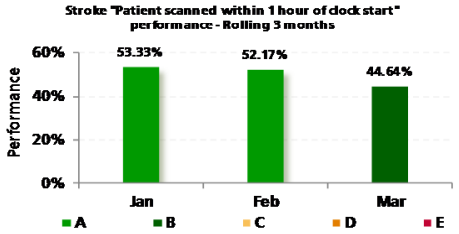
Key Indicator : Direct to Stroke Unit within 4 hours

Monthly Performance % Mar-18	SSNAP Target Levels	
41.51%	A	90.00%
	B	75.00%
SSNAP Level	C	60.00%
E	D	55.00%
	E	<55.00%



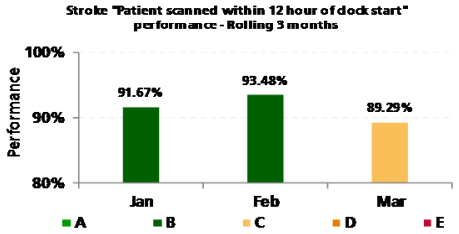
Key Indicator : Patient scanned within 1 hour of clock start

Monthly Performance % Mar-18	SSNAP Target Levels	
44.64%	A	48.00%
	B	43.00%
SSNAP Level	C	30.00%
B	D	25.00%
	E	<25.00%



Key Indicator : Patient scanned within 12 hours of clock start

Monthly Performance % Mar-18	SSNAP Target Levels	
89.29%	A	95.00%
	B	90.00%
SSNAP Level	C	85.00%
C	D	75.00%
	E	<75.00%



Key Points/Operational Actions

What's working well

- Stroke Recent National SSNAP score – we have achieved 'A' (highest quartile).
- Door to Scan time has remained consistently good
- 14 hrs consultant review has been maintained at 80% or more
- Challenging diagnosis and overall patient flow pressure did impact on overall improvement
- Appointment of new Band 7 Stroke Ward manager

Risks we are carrying at the moment

- Stroke Specialist Thrombo nurse are not available 24/7 in a consistent way as they are often included in the numbers at night (39% of nights between January and March) – it has impacted adversely on the performance of stroke services - it has been raised on many occasions as a significant risk
- ESD for West Norfolk patient as CCG is not agreeing for ESD pathway (almost all stroke services in England have ESD except us)
- Stroke AF service – Successful in getting successful bid for AHSN funded Mobile ECG devices for AF detection

Weekend 14 hrs review- discussions with the team to extend review over the weekend – to have extended hours on the weekend

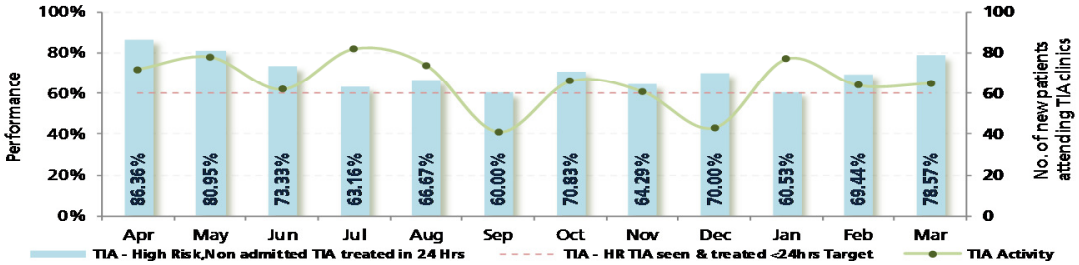
Definitions

Sentinel Stroke National Audit Programme (SSNAP) is the single source of data for stroke in England and Wales. It provides the data for all other statutory data collections in England including the NICE Quality Standard and Accelerating Stroke Improvement (ASI) metrics and is the chosen method for collection of stroke measures in the NHS Outcomes Framework and the CCG Outcomes Indicator Set. SSNAP metrics are aligned with those in the Cardiovascular Disease Outcomes Strategy. SSNAP data are being used as risk indicators for Care Quality Commission's Intelligent Monitoring and for the Stroke Care in England NHS Marker.
Key Indicators:
Percentage of Stroke patients that spend 90% of their hospital stay on the stroke unit (latest available data). Percentage of Stroke patients directly admitted to a stroke unit within 4 hours of clock start (latest available data)
Percentage of Stroke patients scanned within 1 hour of clock start (latest available data). Percentage of Stroke patients scanned within 12 hours of clock start (latest available data)

Transient Ischaemic Attack (TIA) Performance

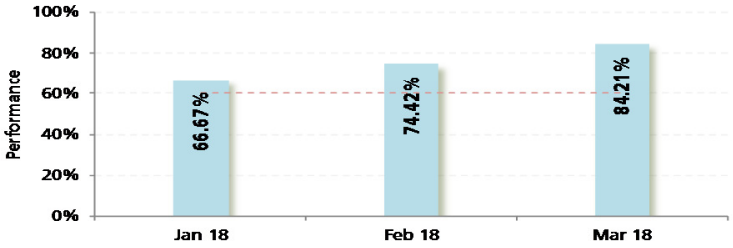
TIA - high risk, not admitted, treated within 24 hrs

Target	Performance % Mar-18	Performance % YTD 2017/2018
60.00%	78.57%	70.29%



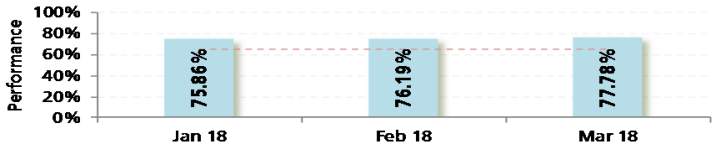
TIA - high risk, treated within 24 hours

Target	Performance % Mar-18	Performance % YTD 2017/2018
60.00%	84.21%	75.49%



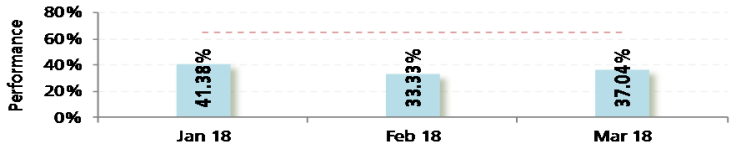
TIA - low risk, treated within 7 days from 1st contact

Target	Performance % Mar-18	Performance % YTD 2017/2018
65.00%	77.78%	78.84%



TIA - low risk, treated within 7 days from onset

Target	Performance % Mar-18	Performance % YTD 2017/2018
65.00%	37.04%	49.07%



Key Points/Operational Actions

The current RCP SSNAP still requires us to categorise TIA patients as High and Low risk where we have been achieving the target consistently for more than 6 months especially for high risk group who are at risk of impending stroke.

- *84.2% of High risk patients (risk of having stroke) are being reviewed by Stroke TIA team within 24 hours of their symptom onset (target being 60%).*
- *77.8% of suspected Low risk patients are being seen within 7 days of patients making first medical contact in the primary care ; however only 33% when their first symptoms appeared (it improves at the time of Stroke FAST national public education/awareness adverts).*

Over next 6-8 weeks starting regular full Saturday clinics, and if urgent, Sundays as well

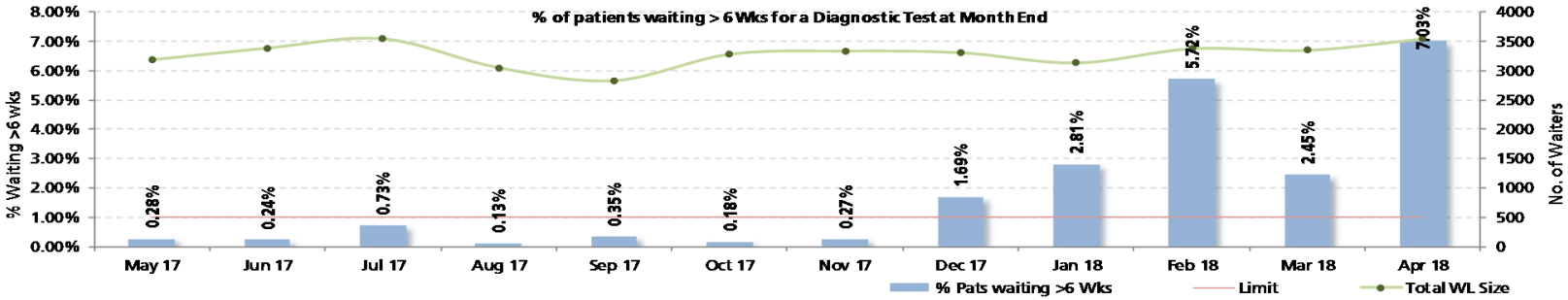
Definitions

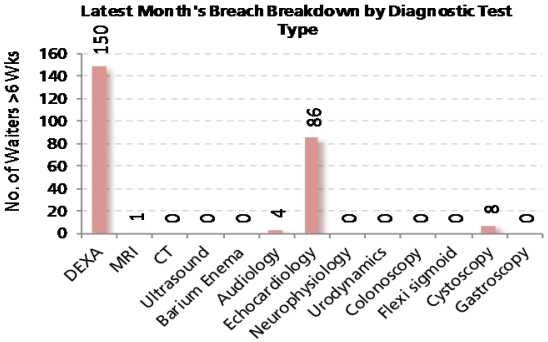
Percentage of High Risk TIA's that are not admitted, seen and treated within 24 hours (latest available data)
Percentage of High Risk TIA's that are seen and treated within 24 hours (latest available data)
Percentage of Low Risk TIA's that are seen and treated within 7 days of 1st contact with a healthcare professional (latest available data)
Percentage of Low Risk TIA's that are seen and treated within 7 days of onset of symptoms (latest available data)

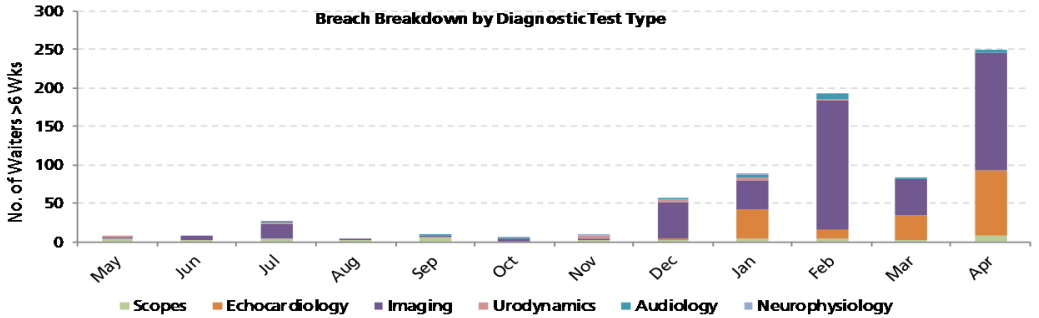
Diagnostic Waiting Times (% of Pat's Waiting >6 Wks)

7.03%

(Target 1%) ✗



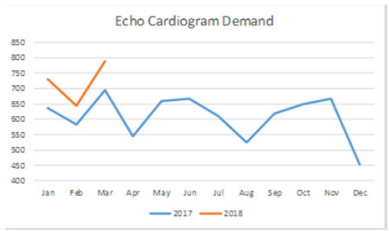




Key Points/Operational Actions

Following performance of 7% in April (against a 1% target) the Trust has now successfully realigned its capacity to this target in May onwards. This has been particularly required for Echo Cardiogram, where demand is up 10% year on year.

The Trust has also now seen all breach patients from the inherited DEXA service and anticipates 0 breaches for May (150 breaches in April). The remains a significant risk of mechanical failure of the inherited DEXA machine. A business case for a new machine is in progress.
The current forecast for diagnostics in May is expected to be within the 1% target for the above areas.



Definitions

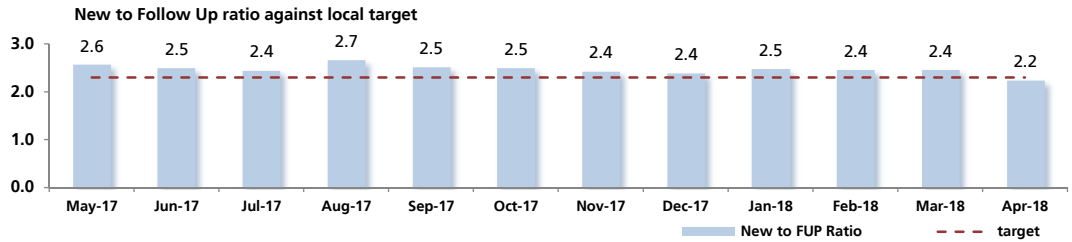
Denominator :The no. of patients waiting for a diagnostic test at the end of the reporting period. Numerator: The no of patients waiting 6 weeks or more for a diagnostic test at the end of the reporting period. Data Source: Performance data based on activity information extracted from PAS, & provided as part of the Trust's monthly Diagnostics Wait Times (DM01) submission.

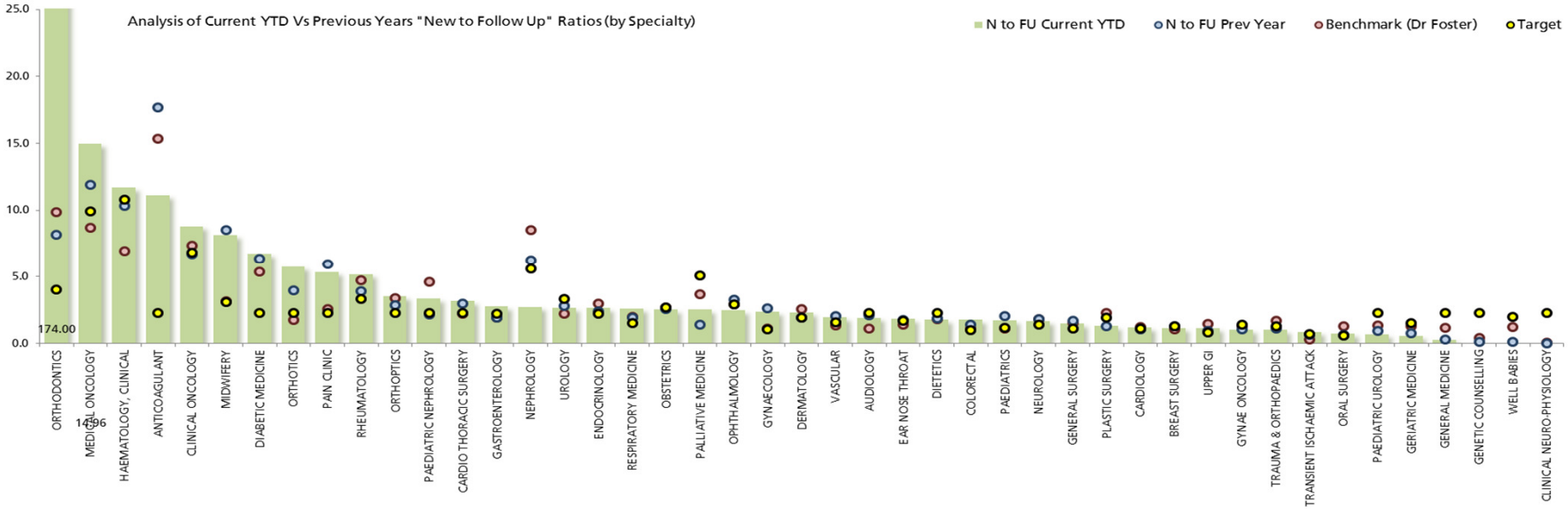
New to Follow up Ratio

Latest Month's Performance

2.2

Trust Level New to Review Rate (Target 2.3) ✔





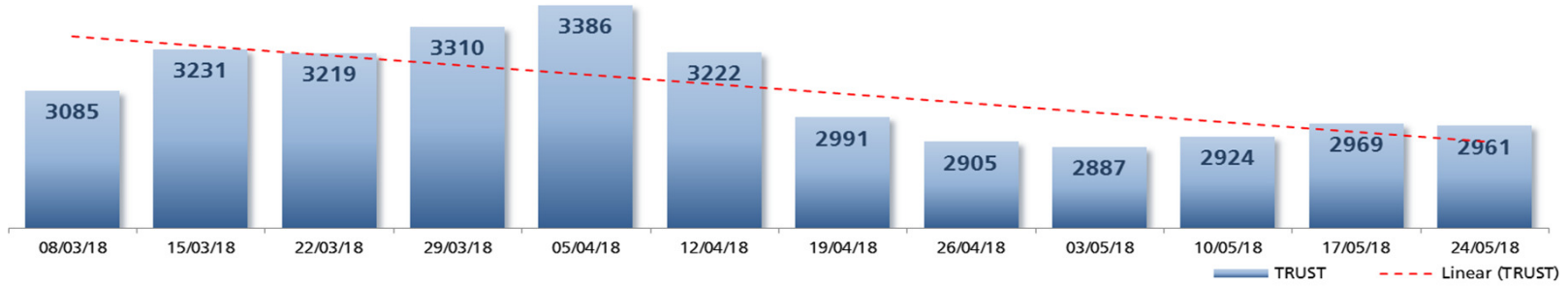
Key Points/Operational Actions

Definitions

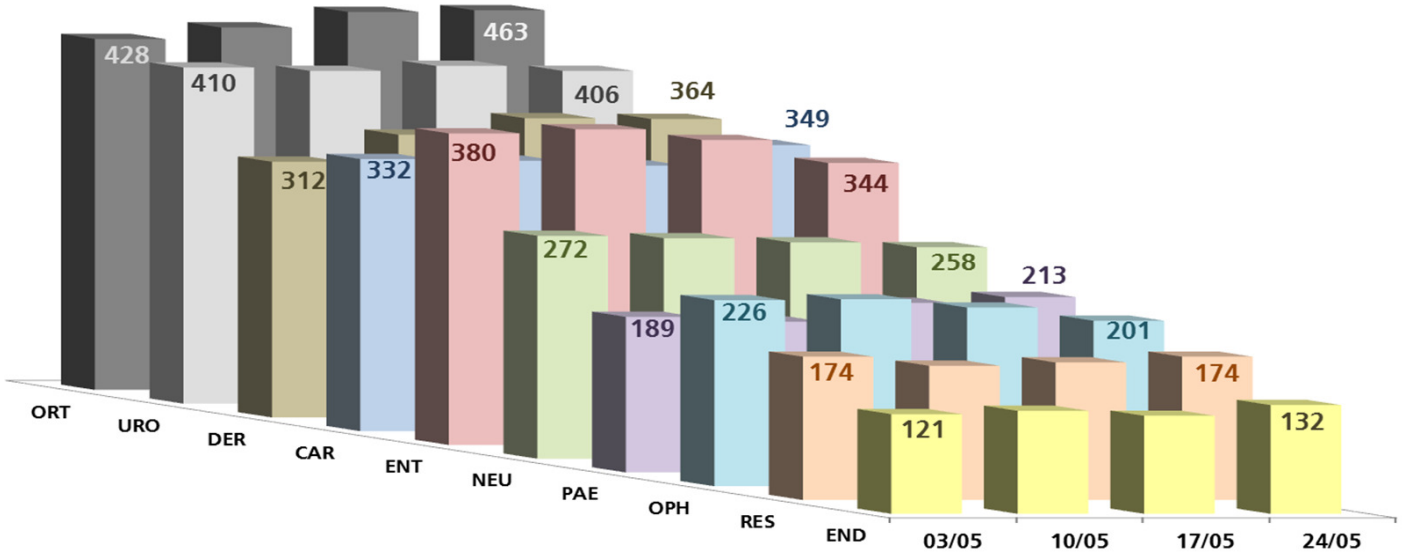
New to review: Ratio of total follow-up attendances against the total number of new patient attendances for the reporting month.
Data Source: Performance data based on activity information extracted from PAS normally collected around the 10th calendar day of the month after the reporting period.
Benchmarked data provided from Dr Foster Intelligence

ASI's (Appointment Slot Issues)

No. of Appointment Slot Issues for TRUST in the last 12 weeks



Top 10 Specialties with most ASI's in previous 4 weeks



ASI's Last 4 Weeks

	03/05	10/05	17/05	24/05
ORT	428	442	461	463
URO	410	406	412	406
DER	312	345	365	364
CAR	332	330	324	349
ENT	380	385	372	344
NEU	272	269	264	258
PAE	189	183	206	213
OPH	226	227	217	201
RES	174	163	167	174
END	121	125	119	132
2WW	27	22	43	29
PC	0	1	10	14
GER	5	5	5	8
RHE	1	1	3	5
SUR	0	0	0	1
UGI	8	18	0	0
GYN	0	1	0	0

Key Points/Operational Actions

Definitions

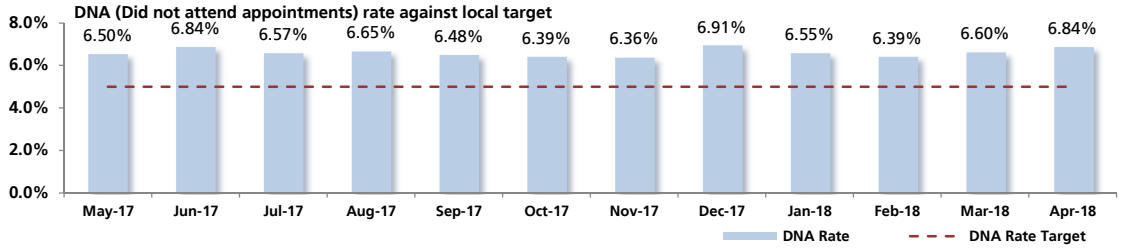
ASI are appointment slot issues. ASI's occur in e-Referral (Choose & Book) because we have an insufficient number of clinic slots available within a 'polling range' for a specialty.
Data Source: Data provided from the E Referral Booking System

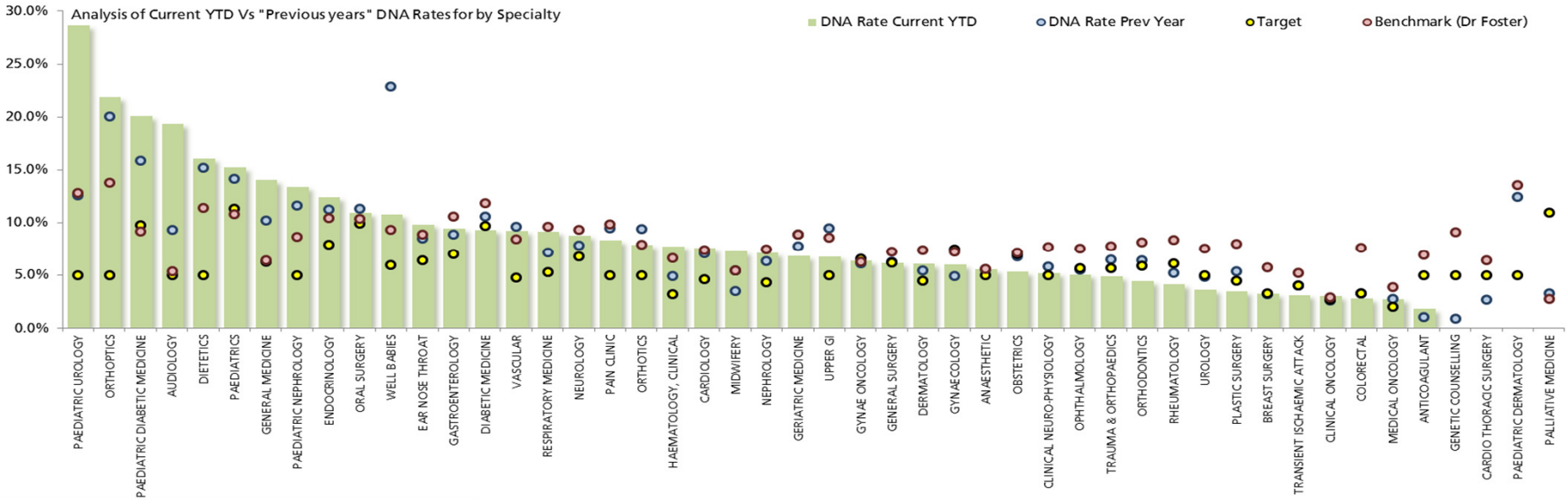
DNA rate

Latest Month's Performance

6.84%

DNA rate (Target 5.0) ✗





Key Points/Operational Actions

Definitions

DNA Rate: Total No. of New & Follow Up appointments where the outcome was "DNA" (Did Not Attend), as a proportion of the Total No. of "Attended" and DNA'd appointments
The DNA figures above exclude Ward Attender activity, and is based on "Clinic" Specialty, rather than "Referral" Specialty.
Data Source: Performance data based on activity information extracted from PAS normally collected around the 10th calendar day of the month after the reporting period.

Elective Inpatient - Average Length of Stay & Re-admissions

Latest Month's Performance

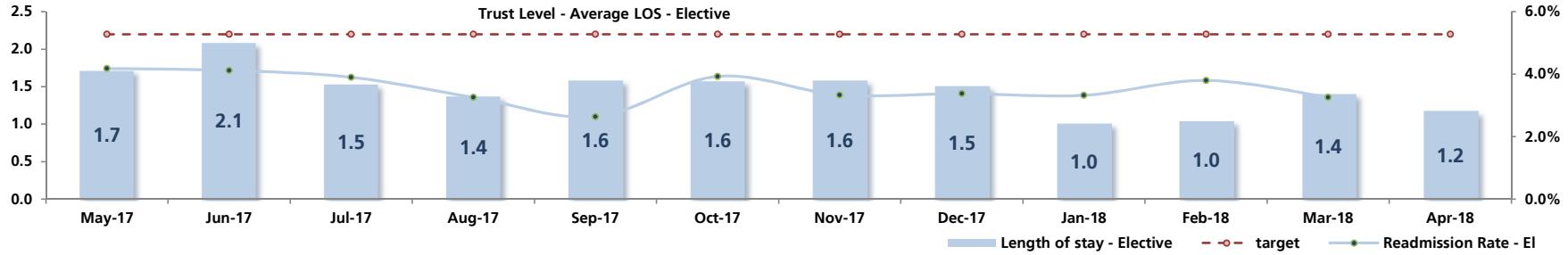
1.2

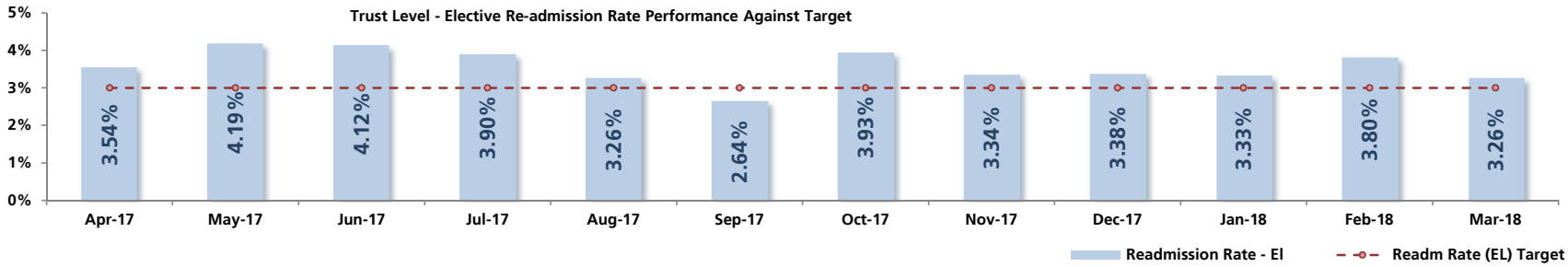
Average LOS Elective Admission (Target 2.2) ✔

Previous Month's Re-admission Rate

3.26%

Re-adm following Elective Admission (Target 3%) ✘





Re-admissions is currently reported 1 month in arrears

Key Points/Operational Actions

Definitions

Elective Average LOS - The average spell length of stay for Elective Admissions discharged within the reporting month.
Elective Re-admissions - The % of patients readmitted within 30 days of an Elective admission during the current financial year.
Data Source: Performance data based on activity information extracted from PAS normally collected around the 10th calendar day of the month after the reporting period.
Benchmarked data provided from Dr Foster Intelligence

Emergency Admissions - Average Length of Stay & Re-admissions

Latest Month's Performance

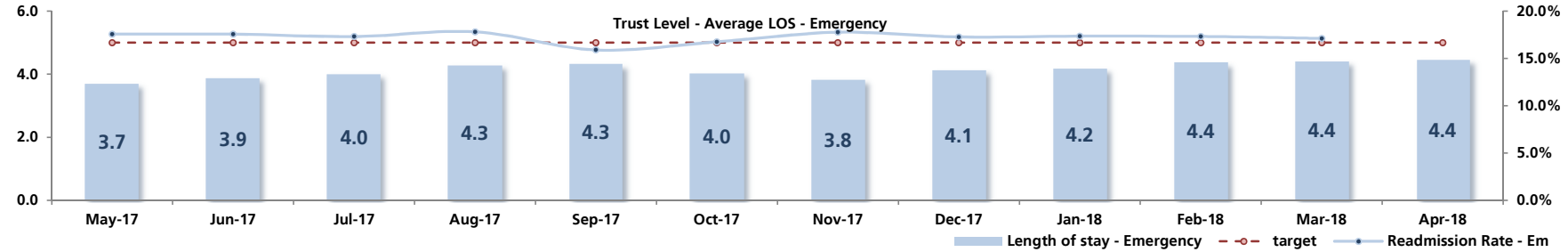
4.4

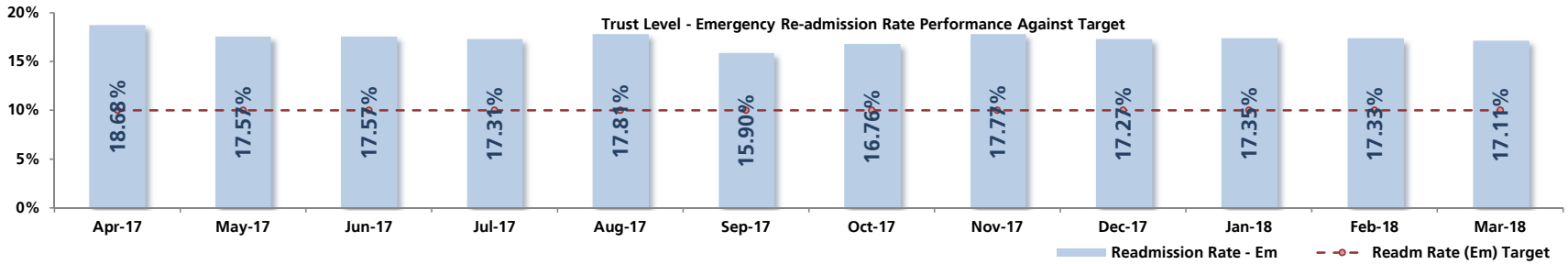
Average LOS Emergency Admission (Target 5.0) ✔

Previous Month's Re-admission Rate

17.11%

Re-adm following Emergency Admission (Target 10%) ✘





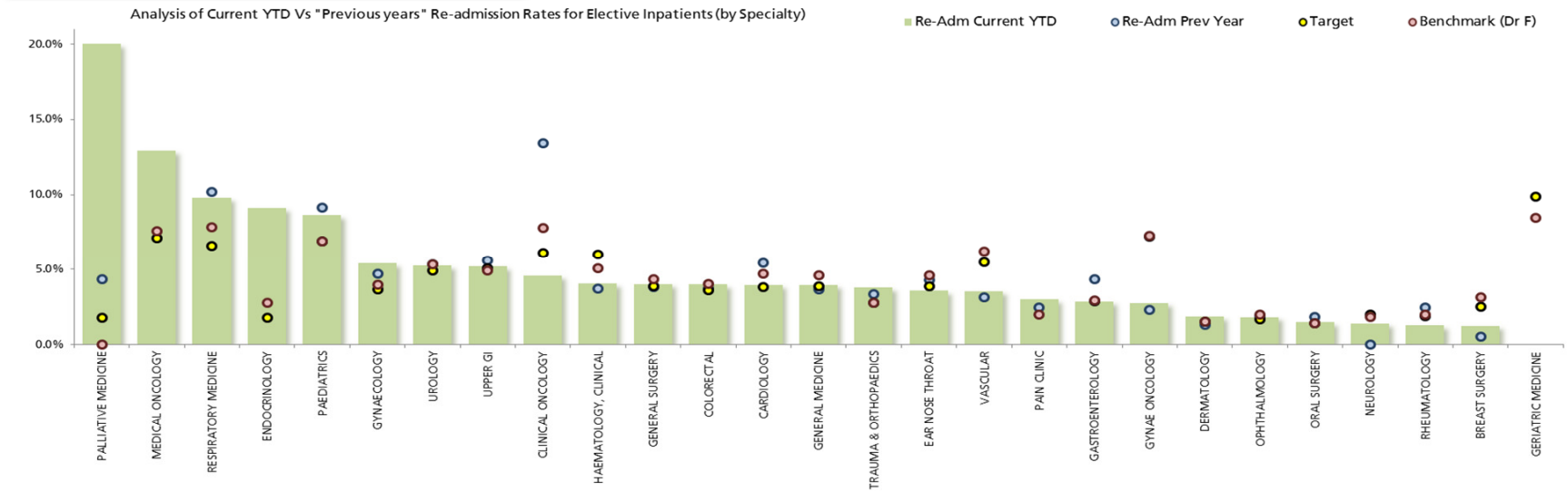
Re-admissions is currently reported 1 month in arrears

Key Points/Operational Actions

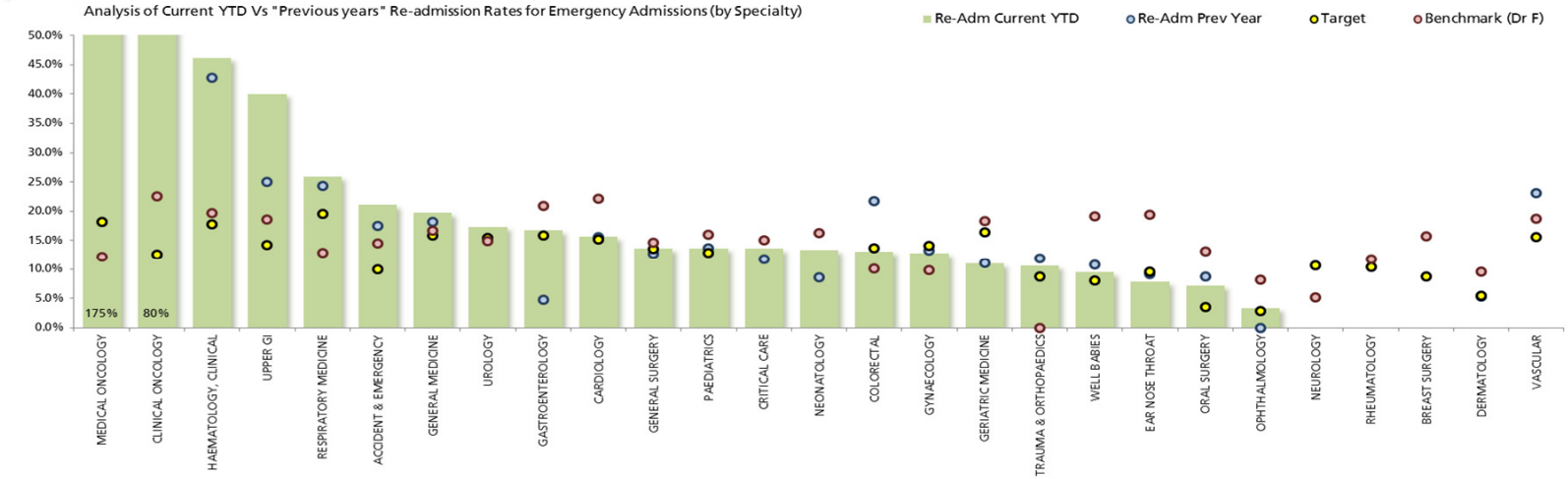
Definitions

Emergency Average LOS - The average spell length of stay for Emergency Admissions discharged within the reporting month.
Emergency Re-admissions - The % of patients readmitted within 30 days of an Emergency admission during the current financial year. This is currently reporting 1 month in arrears.
Data Source: Performance data based on activity information extracted from PAS normally collected around the 10th calendar day of the month after the reporting period.
Benchmarked data provided from Dr Foster Intelligence

Elective Re-admissions Rates by Specialty



Emergency Re-admissions Rates by Specialty



Definitions

Elective Re-admissions - The % of patients per specialty readmitted within 30 days of an Elective admission during the current financial year. Based on the specialty at discharge.
Emergency Re-admissions - The % of patients per specialty readmitted within 30 days of an Emergency admission during the current financial year. Based on the specialty at discharge.
Data Source: Performance data based on activity information extracted from PAS normally collected around the 10th calendar day of the month after the reporting period.
Benchmarked data provided from Dr Foster Intelligence

CQUINs

CQUIN No.	CQUIN Description		Q1 STATUS	Q1 VALUE	Q2 STATUS	Q2 VALUE	Q3 STATUS	Q3 VALUE	Q4 STATUS	Q4 VALUE
ACUTE CONTRACT										
1a	H&W	Heallthy Foods - more healthy options / reduced sugar content etc	N/A						TBC	£115,892.00
1b		Staff Survey - 5% improvement on 2 out of the 3 questions relating to H&W							PARTIALLY ACHIEVED 37.5%	£43,460.00
1c		Flu uptake (front line clinical staff)							TBC	£115,753.00
2a	SEPSIS	Sepsis -timely Identification	ACHIEVED 100%	£21,712.50	PARTIALLY ACHIEVED 83.25%	£21,712.50	ACHIEVED 100%	£21,712.50	ACHIEVED	£21,712.50
2b		Sepsis - timely treatment		£21,712.50		£10,856.25		£21,712.50	TBC	£21,712.50
2c		Empiric Review of antibiotic prescriptions (72hrs)		£21,712.50		£21,712.50		£21,712.50	TBC	£21,712.50
2d		Reduction in Antibiotic Consumption per 1,000 admissions	N/A						ACHIEVED 100%	£86,850.00
4	Improving services for people presenting with Mental Health needs in A&E	Frequent Attenders (more than 10 occurrences in 16/17) - identify cohort of patients who would benefit from mental health & psychology interventions	ACHIEVED 100%	£34,739.80	ACHIEVED 100%	£138,959.20	NO ACHIEVEMENT	£34,739.80	ACHIEVED 100%	£138,959.20
6	Offering Advice & Guidance	Improvement of A&E for Rhuematology & Neurology / Implement Quality standard / propose additional services in Q4 to take forward next year	ACHIEVED 100%	£86,849.50	ACHIEVED 100%	£86,849.50	ACHIEVED 100%	£86,849.50	ACHIEVED 100%	£86,849.50
7	NHS e-Referral	1. NHS e-Referrals (All providers to publish ALL such services and make ALL of their First O/P Appointments slots available on NHS e-referral services (e-RS) by 31st March 2018 following the trajectory 2. a trajectory to reduce Appointment Slot Issues to a level of 4%, or less, over Q2, Q3 and Q4	ACHIEVED 100%	£86,849.50	ACHIEVED 100%	£86,849.50	ACHIEVED 100%	£86,849.50	TBC	£86,849.50
8	Supporting Proactive and Safe Discharge	2.5% point increase discharge to usual place of residence: across Q3 and Q4 2017/18 OR an increase to 47.5% across Q3 and 4 2017/18	ACHIEVED 100%	£52,109.70	ACHIEVED 100%	£138,959.20	NO ACHIEVEMENT	£17,369.90	ASSESSMENT POSTPONED - AWAITING SUS DATA	£138,959.20
NHSE SPECIALIST CONTRACT										
1	Medicines Optimisation	The CQUIN aims to support the procedural and cultural changes required fully to optimise use of medicines commissioned by specialised services.	ACHIEVED 100%	£31,560.00	ACHIEVED 100%	£13,525.00	ACHIEVED 100%	£22,542.00	TBC	£40,577.00
2	Dental Dashboard	Provider is required to submit a fully populated Dental Quality Dashboard as per the embedded format (see actual CQUIN) in respect of the dental specialties they provide	ACHIEVED 100%	£11,089.75	ACHIEVED 100%	£11,089.75	ACHIEVED 100%	£11,089.75	TBC	£11,089.75
3	Breast Screening	Breast Cancer Screening Interval Cancer Network for Norfolk and Waveney	ACHIEVED 100%	£3,201.00	ACHIEVED 100%	£3,201.00	ACHIEVED 100%	£3,201.00	TBC	£3,201.00
4	Armed Forces	Embedding the Armed Forces Covenant to support improved health outcomes for the Armed Forces Community	ACHIEVED 100%	£6,301.50	ACHIEVED 100%	£6,301.50	Update only no Financial value		TBC	£12,603.00

Workforce Scorecard

Workforce

Indicators	Var to prev mth	Target	Feb	Mar	Apr	Rolling 12 mths
Staff Sickness & Turnover						
Sickness Absence Rate	⇩	3.50%	6.18%	5.71%	4.67%	5.26%
Staff Turnover Rate Complete Trust	⇧	10.00%	12.25%	12.31%	12.69%	11.80%
Staff Turnover Rate Medical & Dental (excluding Jnr Doctors)	⇧	10.00%	11.83%	12.36%	14.61%	9.81%
Staff Turnover Rate Registered Nursing & Midwifery	⇧	10.00%	13.87%	13.60%	14.38%	14.35%
Staff Turnover Rate Allied Health Professionals	⇧	10.00%	15.82%	13.84%	14.42%	16.69%
Appraisals						
Appraisal Completeness excluding bank staff	⇩	90.00%	83.96%	80.78%	80.47%	83.52%
Vacancies						
Medical & Dental Vacancies (as % of Medical Posts)	⇨	5.00%	20.10%	19.53%	19.53%	20.59%
Registered Nurses & Midwives Vacancies (as % of Nurse Posts)	⇨	6.00%	11.90%	12.51%	12.51%	13.05%
Allied Health Professional Vacancies (as % of AHP Posts)	⇨	6.00%	8.02%	6.29%	6.29%	8.41%
Contracted staff in Post (WTE)	⇩		2807	2791	2777	2779
Temporary Staff in Post (WTE)	⇧		207	215	234	267
Mandatory Training						
Conflict Resolution Training	⇩	95.00%	84.74%	84.22%	84.01%	83.73%
Equality and Diversity Training	⇧	95.00%	80.65%	81.16%	82.57%	73.66%
Fire Training	⇧	95.00%	75.72%	77.26%	78.23%	74.81%
Health & Safety Training	⇧	95.00%	91.44%	91.29%	91.33%	90.61%
Infection Control Training	⇧	95.00%	80.91%	81.57%	81.93%	78.60%
Information Governance Training	⇩	95.00%	84.80%	91.00%	90.08%	86.70%
Manual Handling Training	⇩	95.00%	82.62%	82.62%	81.90%	82.59%
Basic Life Support Training	⇧	95.00%	80.42%	83.69%	84.94%	81.02%
Risk Management Training (Level 2 only)	⇧	90.00%	94.49%	94.67%	94.74%	87.94%
Safeguarding Adults Training	⇩	95.00%	93.07%	92.92%	92.25%	92.70%
Safeguarding Children Training	⇩	95.00%	90.19%	93.33%	91.97%	91.22%
Slips, Trips & Falls Training	⇧	90.00%	90.83%	90.13%	92.02%	90.36%
VTE Training	⇧	90.00%	72.41%	71.89%	72.71%	74.24%
Mandatory Training Overall (10 core subjects)	⇧	95.00%	84.46%	85.91%	85.92%	83.57%

The percentage figure shown for Risk Management Training currently represents Level 2 only (Level 2 - Heads of Departments)

Key Points/Operational Actions

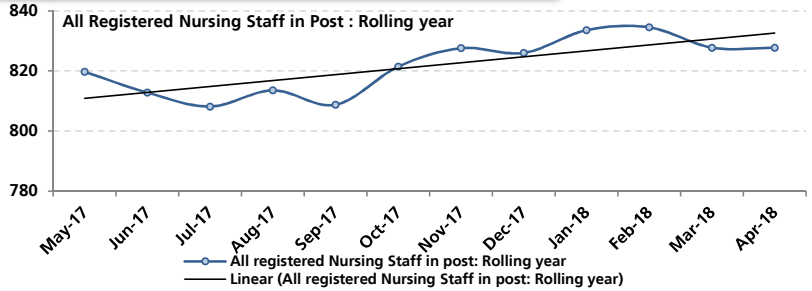
Data Source: Data provided by Human Resources normally around the 15th calendar day of the month after the reporting period

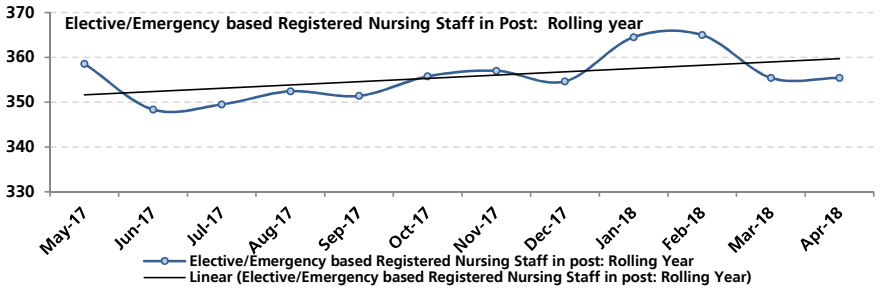
Safer Staffing Return

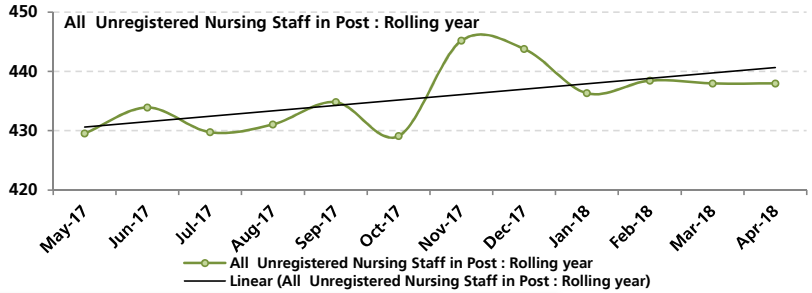
Apr-18			Day		Night		Care Hours Per Patient Day (CHPPD)			
Ward name	Main 2 Specialties on each ward		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
	Specialty 1	Specialty 2								
West Newton	430 - GERIATRIC MEDICINE		91.0%	117.4%	100.6%	144.0%	826	2.9	5.4	8.3
Necton	340 - RESPIRATORY MEDICINE		87.8%	98.7%	109.8%	95.2%	980	3.2	2.5	5.7
Windsor	430 - GERIATRIC MEDICINE		91.1%	95.6%	107.9%	108.5%	978	2.8	3.0	5.7
Stanhoe	301 - GASTROENTEROLOGY	350 - INFECTIOUS DISEASES	93.9%	94.8%	100.0%	93.7%	954	3.3	2.9	6.2
Tilney	320 - CARDIOLOGY		90.7%	105.7%	106.7%	104.1%	773	3.2	2.5	5.7
West Raynham	300 - GENERAL MEDICINE		94.2%	83.4%	102.9%	88.0%	833	4.1	2.8	6.9
Denver	100 - GENERAL SURGERY		92.0%	109.6%	99.8%	143.5%	863	2.8	3.1	5.9
Marham	100 - GENERAL SURGERY		87.3%	98.2%	101.1%	95.0%	789	3.2	2.2	5.4
Elm	100 - GENERAL SURGERY		90.5%	107.5%	106.8%	100.0%	593	3.0	2.9	5.9
Gayton	110 - TRAUMA & ORTHOPAEDICS	100 - GENERAL SURGERY	97.3%	94.2%	105.6%	120.9%	924	3.0	3.3	6.3
Shouldham	315 - PALLIATIVE MEDICINE	823 - HAEMATOLOGY	85.7%	104.4%	100.3%	89.8%	356	4.7	2.8	7.5
Critical Care	192 - CRITICAL CARE MEDICINE		86.9%	82.1%	91.1%	-	273	25.0	1.4	26.3
Central Delivery suite	501 - OBSTETRICS		94.2%	93.6%	91.0%	90.2%	166	24.1	8.0	32.1
Surgical Assessment Unit	100 - GENERAL SURGERY		84.3%	98.9%	78.9%	98.4%	231	7.9	3.2	11.2
Medical Assessment Unit	300 - GENERAL MEDICINE		86.1%	111.7%	112.9%	114.8%	666	5.4	2.4	7.8
Terrington	300 - GENERAL MEDICINE		90.1%	139.2%	98.4%	104.6%	979	3.1	2.5	5.6
Castleacre	501 - OBSTETRICS		97.3%	94.6%	112.6%	99.8%	441	4.2	3.2	7.4
NICU	420 - PAEDIATRICS		93.4%	107.3%	98.8%	100.6%	229	11.3	4.3	15.6
Rudham	420 - PAEDIATRICS		95.0%	90.4%	103.0%	100.0%	288	11.5	4.0	15.5
ED Obs Ward	180 - ACCIDENT & EMERGENCY		93.9%		100.2%		84	8.0	0.0	8.0
Oxborough	300 - GENERAL MEDICINE		96.5%	82.1%	116.7%	85.8%	963	3.0	3.2	6.1

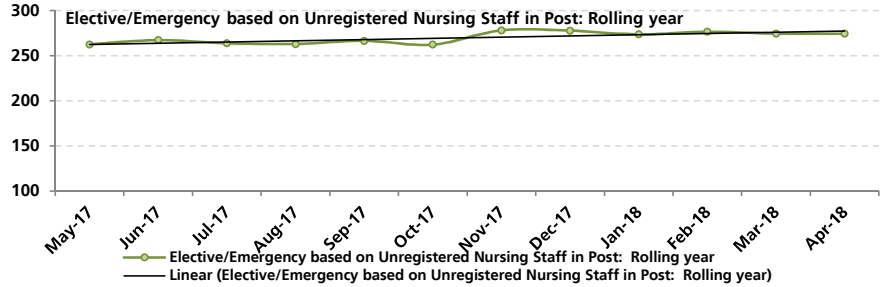
Key Points/Operational Actions

Nursing staff









Key Points/Operational Actions

Vacancies

Due to the organisational restructure and no new establishment figures from Finance, it has not been possible to have correct vacancy data for April 2018. Figures quoted are as at 31st March 2018. Registered nursing vacancies, 12.51%, Medical & Dental vacancies19.53% and AHP vacancies 6.29%.

Turnover

The turnover rate for the Trust has increased for the fifth month to 12.69% from 12.31% in March 2018.

Definitions

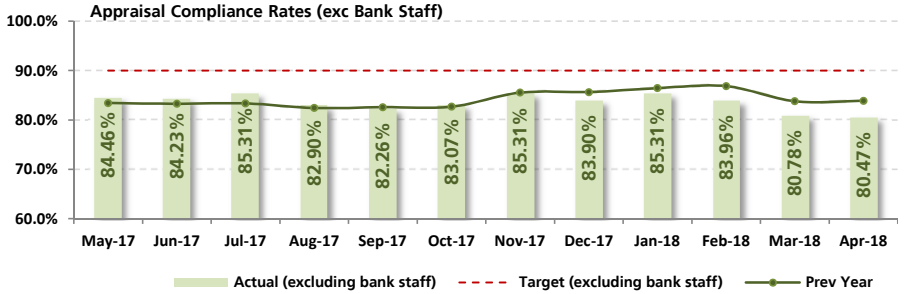
Number of leavers (HC) divided by average staff in post over previous 12 months. Permanent staff only.
Supernumerary staff are included within the Nursing & Midwifery vacancy rates calculation, providing the staff are NMC registered at the time.
Data Source: Data provided by Human Resources normally around the 15th calendar day of the month after the reporting period

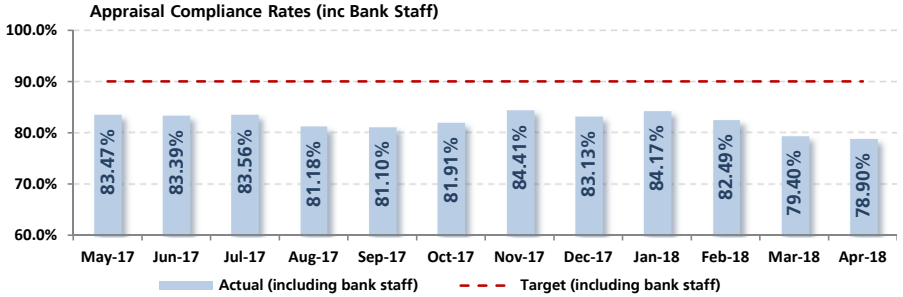
Appraisal

Latest Month's Performance

80.47%

Appraisal Compliance
Exc Bank Staff (Target 90%)





Key Points/Operational Actions

Excluding bank staff, the non-medical appraisal completion compliance has decreased to 80.47% (78.90% including bank staff) in April 2018. The number of seriously overdue appraisals in the 18 to 24 month category has decreased, to twenty one staff but there are now two staff members overdue by 24 months plus

Overdue by 18-24 months

13 Permanent, 8 Bank staff

- Scientific & Technical x 1
- Additional Clinical Services x 6
- Admin & Clerical x 5
- Allied Health Professionals x 2
- Nursing & Midwifery x 7

Overdue by 24 months +

- Scientific & Technical x 1
- Nursing & Midwifery x 1

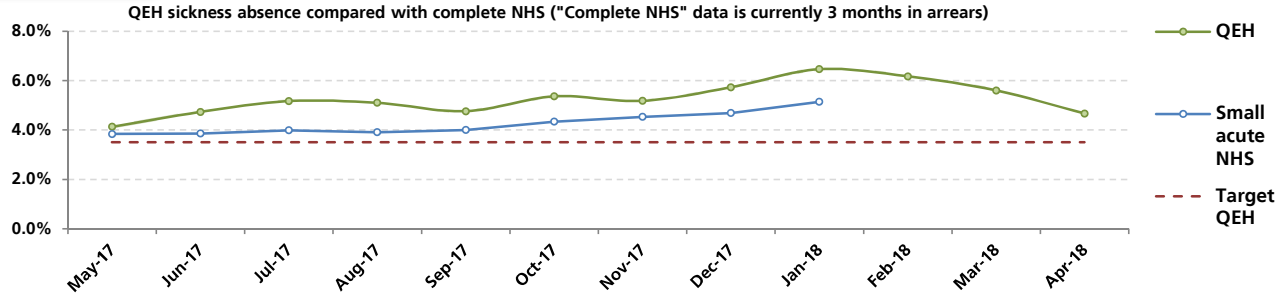
Definitions

Percentage of staff (Headcount) including bank who have had an appraisal within previous 12 months.
Percentage of staff (Headcount) excluding bank who have had an appraisal within previous 12 months.
Data Source: Data provided by Human Resources normally around the 15th calendar day of the month after the reporting period

Sickness Absence & Turnover

4.67%

Sickness Absence Rate ✕



Key Points/Operational Actions

The monthly sickness rate for April 2018 is 4.67% which is a decrease of 0.93% from last month's adjusted figure (5.60%).

The highest staff groups are:

- Estates and Ancillary (6.02%)
- Additional Clinical Services (5.38%)
- Scientific & Technical (5.22%)
- Nursing & Midwifery (5.11%)

All other staff groups were below 5%.

Definitions

Percentage sickness absence for the month. Based on FTE days absent divided by FTE days available.
Data Source: Data provided by Human Resources normally around the 15th calendar day of the month after the reporting period.

Mandatory Training

85.92%

Mandatory Training (Trust) ✗

	Apr-18	Mthly Target	Rolling 12 Mths
Conflict Resolution Training	84.01%	95.00%	83.73%
Equality and Diversity Training	82.57%	95.00%	73.66%
Fire Training	78.23%	95.00%	74.81%
Health & Safety Training	91.33%	95.00%	90.61%
Infection Control Training	81.93%	95.00%	78.60%
Information Governance Training	90.08%	95.00%	86.70%
Manual Handling Training	81.90%	95.00%	82.59%
Basic Life Support Training	84.94%	95.00%	81.02%
Risk Management Training (level 2 only)	94.74%	90.00%	87.94%
Safeguarding Adults Training	92.25%	95.00%	92.70%
Safeguarding Children Training	91.97%	95.00%	91.22%
Slips, Trips & Falls Training	92.02%	90.00%	90.36%
VTE Training	72.71%	90.00%	74.24%
Mandatory Training Overall (10 core subjects)	85.92%	95.00%	83.57%

Key Points/Operational Actions

Compliance rate for the 10 core subjects has increased to 85.92% from 85.91% in March 2018.

Definitions

The percentage figure shown for Risk Management Training currently represents Level 2 only (Level 2 - Heads of Departments).
Data Source: Data provided by Human Resource normally around the 15th calendar day of the month after the reporting period.

Finance

Finance report to follow seperately

Appendices

None