The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Integrated Report

Quality, Performance & Workforce to end December 2018

Chief Operating Officer	*Jonathan Wade*
Chief Nurse	*Emma Hardwick*
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The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

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Context for the Integrated Report - Hospital activity			
	Current Mth	Trend on prev mth	Previous Mth
Emergency Department Attendances	5678	↑	5640
Outpatient Attendances	18685	↓	24183
Inpatient Admissions (Elective & Emergency)	3979	↓	4182
Other (regular day patients, day cases etc)	2800	↓	3628

EXECUTIVE SUMMARY

The Trust strategy for 2018/19 is based upon delivering **high quality, patient focused and integrated healthcare for our community.**

The QEH is ranked 8th (out of 18 regional Trusts) for the Trust Safety Thermometer in December (5th in November) with a score of 97.94% (in relation to New Harm Free only). This is equal to the national average of 97.94%. More detail can be found on page 6.

The reported Hospital Standardised Mortality Ratio (HSMR) for the latest available data (Oct 2017 to Sep 2018) is 105.05, which is ' as expected' . The crude mortality rate within the HSMR basket puts the QEH slightly below the region for the Oct 17 to Sep 18 period. Details can be found on page 7.

There were no Never Events reported in December (zero in November). 3 Serious Incidents were reported this month (3 in November). There have been 0 cases of MRSA bacteraemia in December (zero in November).

There were 2 cases of Trust acquired C.Difficile infection in December compared to 3 in November. The latest C. Difficile comparative data (12 months to Nov-18) puts the Trust 2nd highest when compared to our "Recommended Peers" (Model Hospital).

The Friends & Family Test (FFT) Recommend scores are being monitored in line with NHS England guidance. The Trust achieved the "95% recommended" target in all areas during December with the exception of AE at 89.94% (89.80% in November), and Maternity (Birth) at 94.12% (94.74% in November). The "Response Rate" was below target in AE, Inpatient and Daycase areas during December, but above target in Maternity (Birth).

Performance against the Four Hour standard rose to 83.99% in December, from 78.09% in November.

Type 1 attendances in December were 183 per day on average, which reflects growth of 0.4% compared to 2017 but a decrease of 2.6% on November. Year to date growth in attendances is 4.7% (5.3% YTD in November). The conversion rate for December was 33% (32% in November).

In December 2018 the Trust saw 2047 ambulance conveyances to the QEH. We have seen an increased number of 137 conveyances from previous month. December is showing a higher percentage of handovers cleared within 15mins at 51.0%, the previous month was 39.9%, 30 minute handover delays were 18.17%. Over 60 mins handovers we saw a decrease to 5.62% compared to last month which was 10.79%.

Bed days lost to Delayed Transfer of Care (DToC) decreased In December to 693 compared to 783 in November. This represents 5.6% of occupied bed days, down from Novembers position of 6.5%.

3 Cancer standards were missed during November 2018. 62 Day Referral to Treatment (82.35%), 31 Day Subsequent treatment - Surgery (92.86%) and 62 Day Screening (85%). All other Cancer standards were met.

The number of patients over 18 weeks increased by 252 in the last month. The overall waiting list size decreased by 18. Of the 18 nationally reported specialties 2 sustained the 92% standard in December. The poorest performing specialty was Neurology, with the best performing being Cardiothoracic Surgery. Geriatric Medicine was the most recovered specialty.

December saw a slight decrease in substantive FTE and headcount, this is expected to improve in January.

Appraisal rates were on trajectory to achieve 90% by December 2018 in November unfortunately the appraisal compliance rate fell in December to 85.61%. This is being reviewed against detailed plans available for every CBU, and areas are being asked to refresh their appraisal trajectories to the end of March 2019 to ensure the 90% compliance rate is achieved. This will continue to be monitored through the Workforce Committee. Our fast track nurse recruitment day took place on November 3rd with four offers made on the day. The disappointing trend is in sickness absence with a high reporting rate of viral infections. The Trust flu campaign has vaccinated 80% of staff to help protect staff and patients during the winter period.

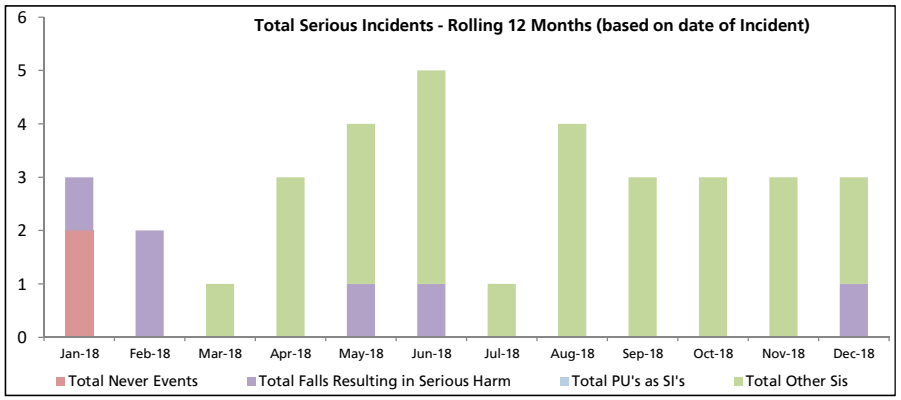
Page Authors: Nick Lyons, Emma Hardwick, Jonathan Wade, Roy Jackson, Karen Charman

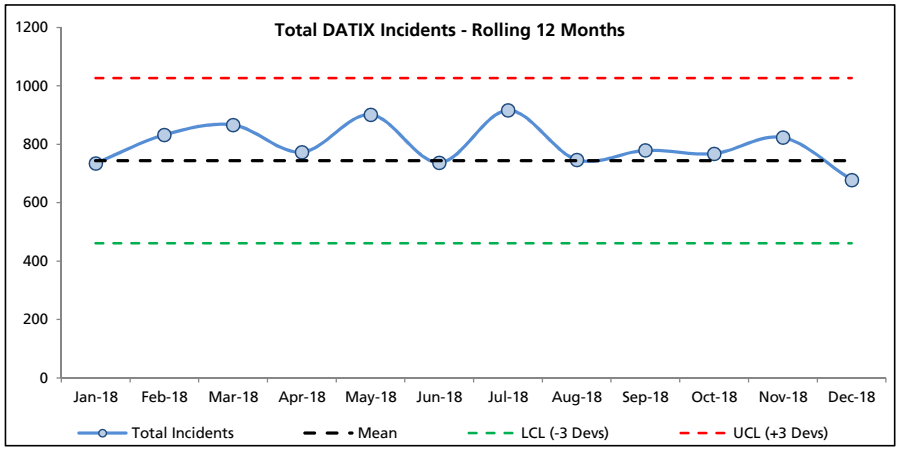
Quality Account

Priority	Indicators	
Patient Safety	Introduction of NEWS 2 Improvements in Infection Control Cleaning standards Matrons charter Quality improvement programme around nutrition and hydration Improvements in Medicines Management – Anti-coagulation	Patient safety indicators are monitored within the new quality improvement plan. There is a launch day planned for November for NEWS2 The matrons charter, nutrition and hydration and improvements in medicines management are all in review and we will align metrics to measure and monitor in the coming month.
Patient Experience	Quality improvement programme around nutrition and hydration Improve understanding of the Mental Capacity Act 2005 amongst staff and how it is used within healthcare practice. Quality improvements within End of Life care Improving communication with patients who have a sensory impairment such as deafness or visually impairment	The Trust has developed a more robust Quality Improvement plan with oversight from the CEO and Board. There are agreed timeframes regarding training and embedding MCA. Our practice development nurses continue to train our staff in awareness of patients with sensory impairment and visual impairment
Clinical effectiveness	Development of an Older People's Strategy encompassing dementia and delirium care and frailty management. Quality improvements within maternity care.	The Trust has been an active participant in cohort 8 of the Acute Frailty network. We have regular conference calls with the network to update on our plans and share bets practice with peers.
Well led	I would recommend my organisation as a place to work [FFT] When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again I would feel confident that the organisation would address concerns about unsafe clinical practice 18/19	

Page Authors: Various: Owner Emma Hardwick

Serious Incidents





Key Points / Operational actions

There were a total of 8 Serious Incidents declared during December 2018. These include 2 12 hour breaches for patients waiting in the Emergency department occurring during November 2018. 2 reported safeguarding incidents reported retrospectively from (August and October) following a complaint and staff raising concerns. 1 failed transfer/Handover causing harm, 1 missed diagnosis, 1 Delay in beginning treatment and 1 fall with Harm.

The Trust continues to work hard to identify report and investigate Serious Incidents as they occur.

Change in performance in the last month

Overall reporting saw a reduction over the month, to below our tracking median. Whilst still within our predicted control limits.

Planned actions for the forthcoming month

The risk and governance team will look for trends in areas reporting less incidents and formulate actions based on the data with the participation of the service areas where reporting has reduced.

The risk and governance team will also produce some information for practitioners on recognising and reporting Serious Incidents.

Page Owner: Nick Lyons *Narrative: Mark Rose*

Safety Thermometer

The QEH is ranked 8th (out of 18 regional Trusts) for the Trust Safety Thermometer in December (5th in November) with a score of 97.94% (in relation to New Harm Free only). This is equal the national average of 97.94%.

Key Points / Operational actions

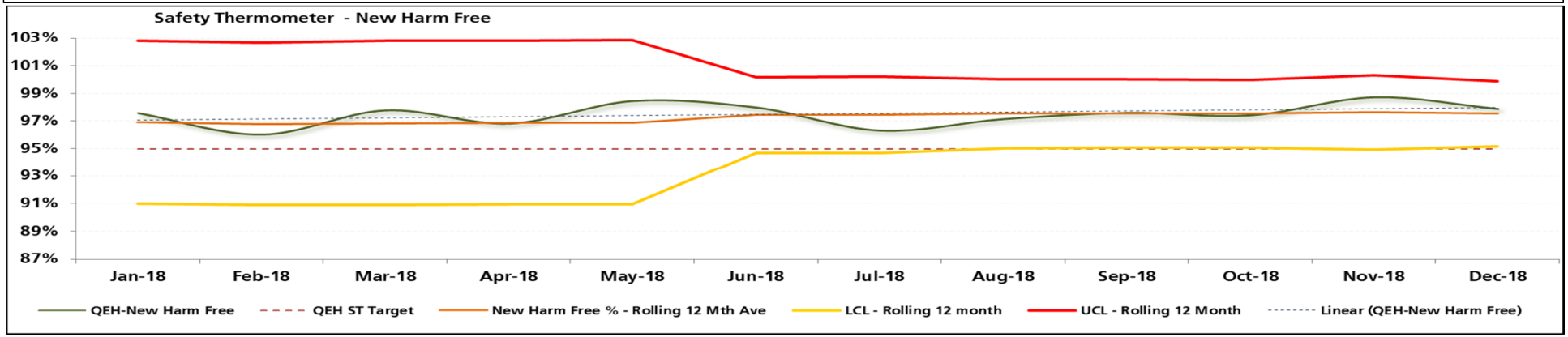
No Hospital acquired CAUTI this month. One fall with no harm. Four HAPU.
Three VTEs were reported, however following investigation one VTE only was hospital acquired. This will be adjusted on the National data base for next month. This will increase the level of Harm Free Care and could lift our score above the National average.

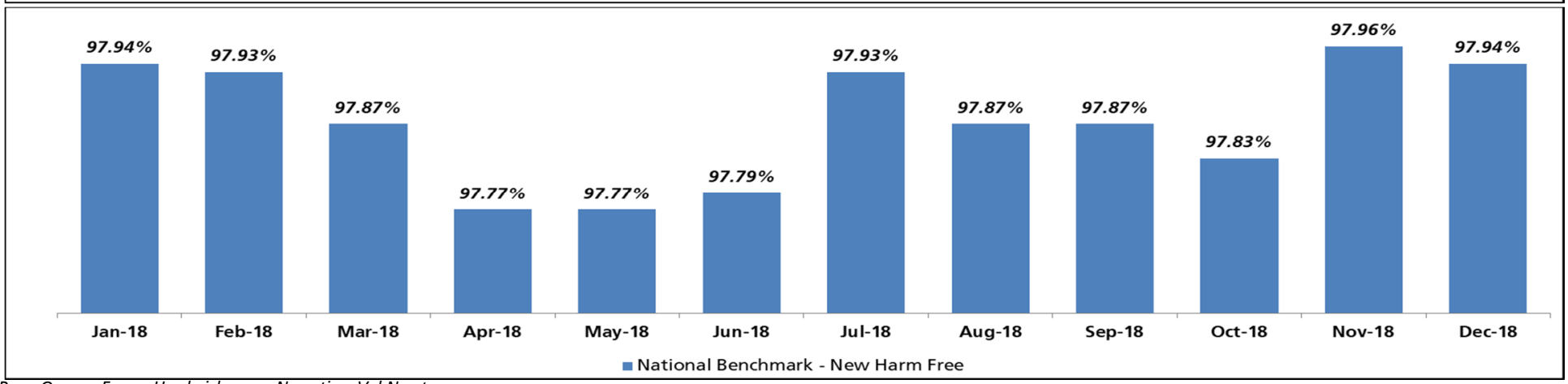
Change in performance in the last month

The Trust is equal with the National Average for Harm Free care this month. Last month the Trust was above the national average, the reduction in harm free care was due to an increased number of HAPU and reported VTE's. December is the second consecutive month which reported no CAUTI's.

Planned actions for the forthcoming month

We continue with our training and education plan to improve pressure care and availability of pressure relieving equipment.





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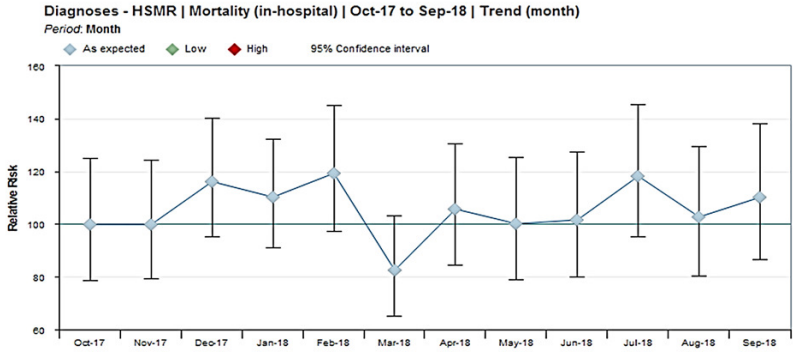
Mortality- HSMR (Hospital Standardised Mortality Ratio)

Methodology used to derive the HSMR is freely available. Latest Dr Foster Mortality Summary shows QEH is 105.5 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 Oct 17 - Sep 18 is 105.5 as expected
Weekday HSMR is 102.8 as expected
Weekend HSMR is 113.6 above expected

There were 88 deaths in the hospital in December 2018, this number is lower than last year (129) and equates to 13.0 deaths per 1000 admissions which is lower than our previous rate in December 2017 at 18.7

The most number of deaths occurred on our critical care (11) and respiratory (9) wards.

The highest number of deaths were recorded against a final diagnosis of pneumonia.

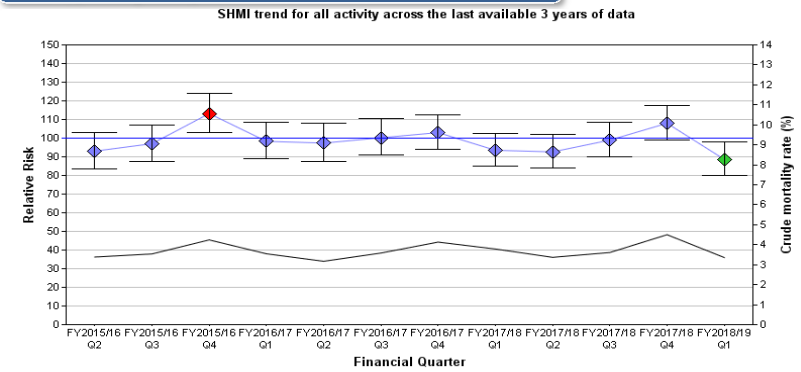
Our HSMR is within expected at 105.5. Our SHMI is also within expected at 0.97. The weekday HSMR is within expected at 102.8 but the weekend HSMR is 113.6 and above expected, this appears to be the trend nationally.

Mortality- SHMI (Summary Hospital Mortality Indicator)

Latest Report shows QEH is 97.29 as expected

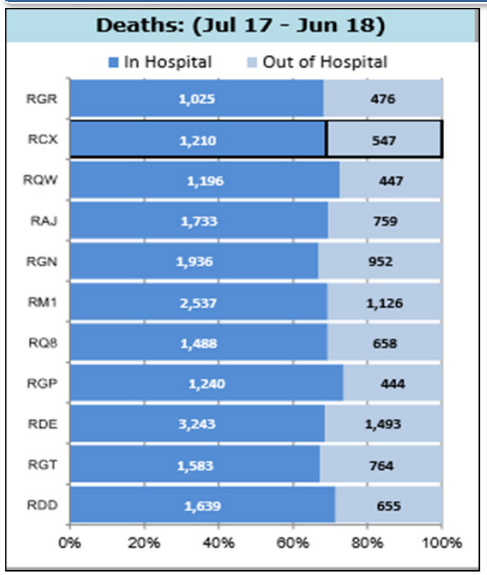
- Available to public on the NHS Choices website
- Risk of death based on diagnosis at first episode of care
- Includes deaths within 30 days of discharge.
- Rolling 12 month average, *but* only published 6 months in arrears

SHMI - (Quarterly Trend)



SHMI for the 12 month data period of Jul 17 - Jun 18 is 97.29 as expected
SHMI for Q1 of 18/19 is 88.61 which is below expected

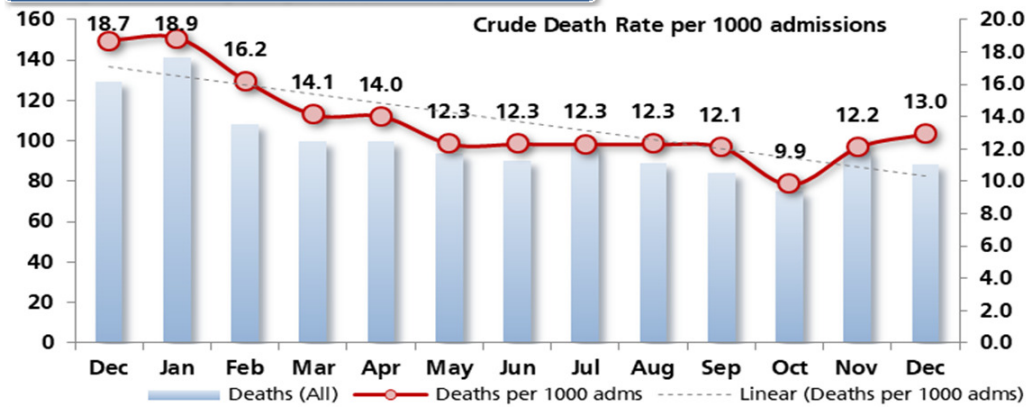
Mortality - In Hospital Deaths Ratio



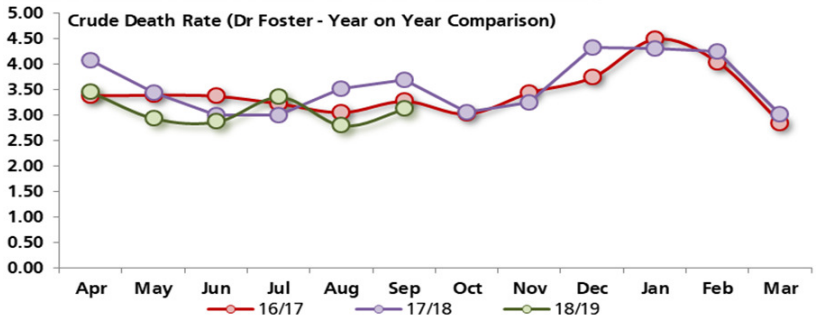
The mortality surveillance group monitors both higher than expected areas of mortality & trends that suggest where future outliers may be. This report shows in addition to the present metrics, the incidence of avoidable deaths as they are identified

Page Owner: Nick Lyons Narrative: Trudy Taylor

Mortality - Crude Mortality Rate (per 1000 admissions)

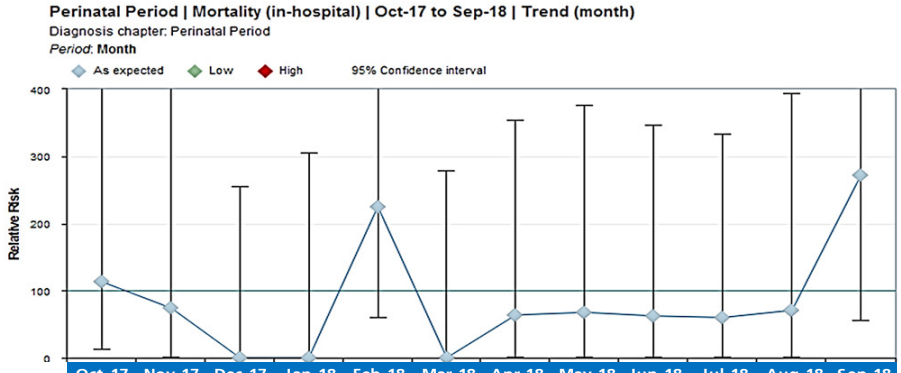


Mortality - HSMR Basket Crude Rate (Yearly Comparison)



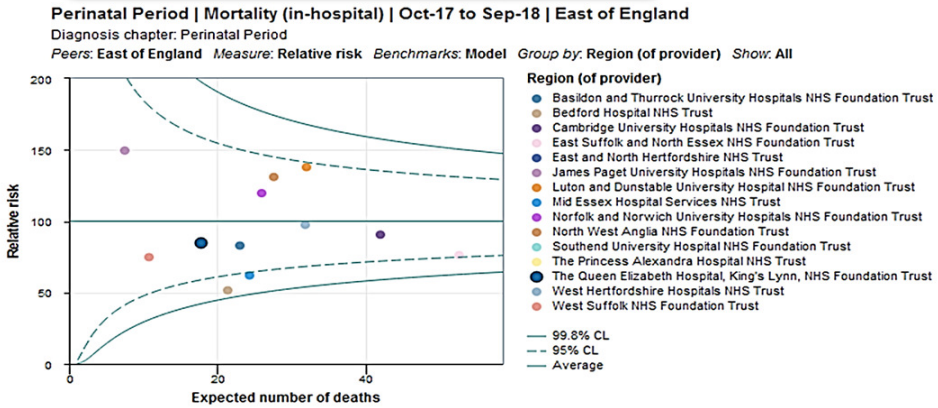
As has been the case in the previous 2 years the crude mortality rate increased between Sep (3.14) & August (2.80). Crude rate within HSMR basket is 3.42% (based on Oct 17-Sep 18) which is comparable with the East of England rate (3.44%)

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



	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Observed	2	1	0	0	4	0	1	1	1	1	1	3

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 (1.75%) for 18/19, is low when compared to the National average (4.09%)

Page Owner: Nick Lyons *Narrative: Trudy Taylor*

Mortality - Learning from Deaths Dashboard

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

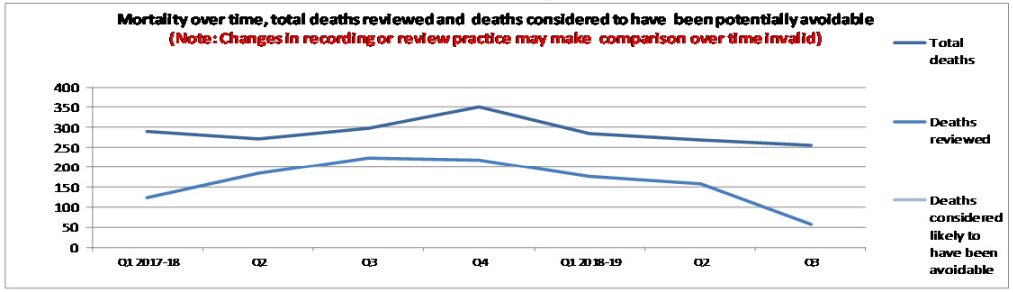
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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
88	94	0	27	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
257	269	57	157	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
810	1211	391	750	0	0

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q3



Total Deaths Reviewed by RCP Methodology Score

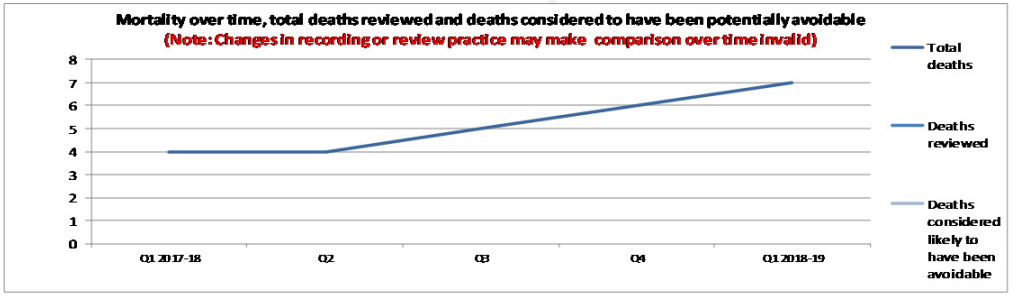
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD	57	100.0%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	0.3%	This Year (YTD)	3	0.8%	This Year (YTD)	387	99.0%

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
1	2	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
10	13	0	0	0	0

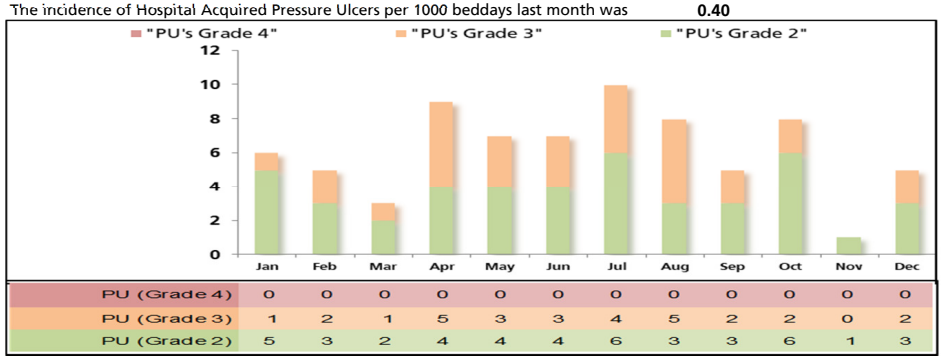
Time Series: Start date 2017-18 Q1 — End date 2018-19 Q1



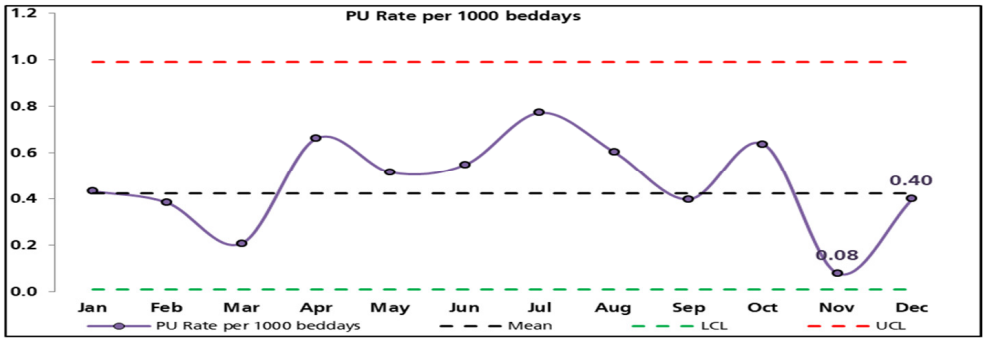
Page Owner: Nick Lyons

Pressure Ulcers

The incidence of Hospital Acquired Pressure Ulcers per 1000 beddays last month was **0.40**



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



Indicator	Pressure Ulcers (Tissue Viability)
Standard	No Hospital Aquired Pressue Ulcers with lapses in care
Name	
Month	Dec-18
Data Frequency	Monthly
CQC Area	Safe

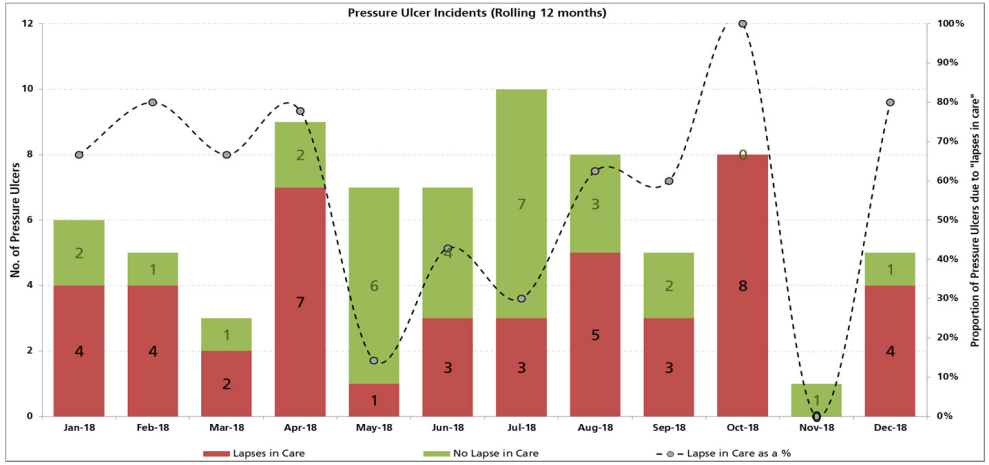
Summary of Current Performance & Reasons for under performance

Q3 shows a 24% reduction in HAPU's compared to the same time period last year Oct – Dec (see table).

	2017	2018
October	8	7
November	6	1
December	3	5
Totals	17	13

December saw a total of 5 HAPU's, 3 x category 2's and 2 x category 3's. Lapses in care are as follows; medical device related - stabilisation device not used with catheter, inaccurate waterlow, missed opportunities to implement upgraded pressure relieving equipment and poor evidence of regular repositioning.

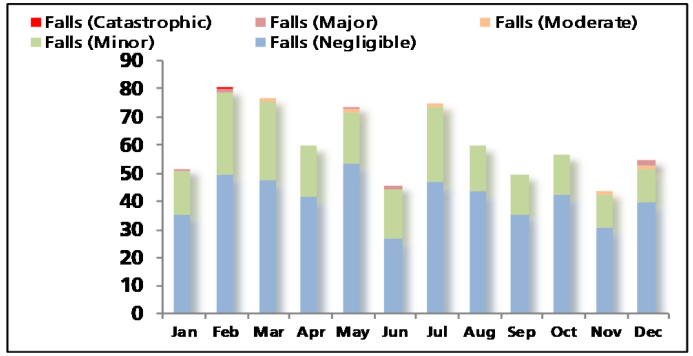
	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Total Pressure Ulcers	6	5	3	9	7	7	10	8	5	8	1	5
% of patients with Ward Acquired Pressure Ulcers that were due to "lapses in care"	67%	80%	67%	78%	14%	43%	30%	63%	60%	100%	0%	80%



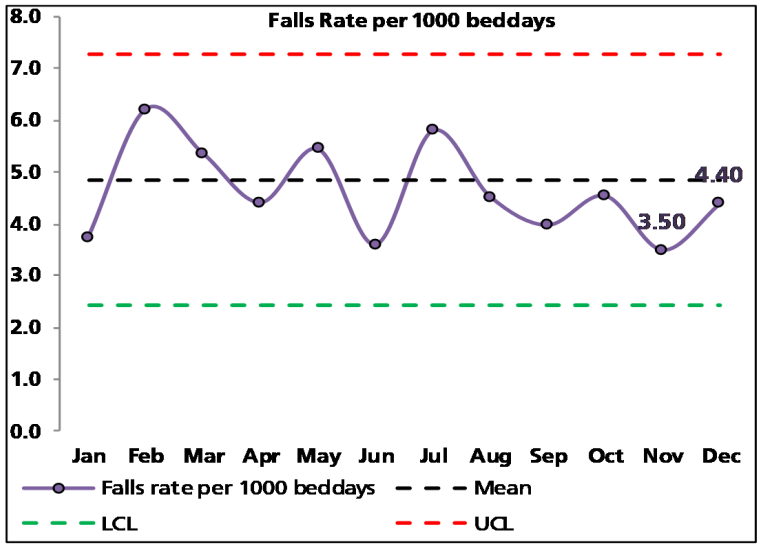
Description	Owner	Start	End
Implementation of the 2018 NHSi guidance on classification/reporting of pressure damage has commenced. Focused training in assessment areas. TVN's have re-commenced delivery of mandatory training.	TVN's	Dec-18	Apr-19
Total Bed Management (TBM) programme reviewed and restarted. Tender process for new equipment to commence.	Deputy Head of Procurement	Dec-18	Aug-19
Implementation of a daily bedside pressure damage risk assessment and equipment check', to ensure that the optimal and appropriate pressure ulcer prevention equipment is in use.	Ward Managers	Dec-18	Ongoing
Review and revise the current practice of HAPU investigation and action plans with prompt review by the Harm Free Care Panel.	ACN Corporate Nursing	Jan-19	Ongoing
Letter sent to all ward based nursing staff (registered/non registered) outlining trust position with HAPU's, training booklet included incorporating new NHSi guidance on prevention and management of pressure ulcers.	TVN/ACN Corporate Nursing	Dec-18	Closed
Pressure ulcer prevention booklets distributed and presented at clinical induction.	TVN's	Jan-19	Ongoing
Additions to be made to Metavision in Critical Care to better evidence position and repositioning of patient.	Clinical Governance Nurse Critical Care	Jan-19	Feb-19
Re-implementation of the use of stabilisation devices with catheters.	Ward managers/ TVN's	Jan-19	Ongoing

Page Author: Emma Hardwick *Narrative: Jane Parker & Tracey Oats*

Falls



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Falls (Catastrophic)	0	1	0	0	0	0	0	0	0	0	0	0
Falls (Major)	1	1	0	0	1	1	0	0	0	0	0	2
Falls (Moderate)	0	0	1	0	1	0	1	0	0	0	1	1
Falls (Minor)	15	29	28	18	18	18	27	16	14	14	12	12
Falls (Negligible)	36	50	48	42	54	27	47	44	36	43	31	40



The incidence of Falls per 1000 beddays last month was **4.40**

Key Points / Operational actions
The falls co-ordinator continues to provide Trust induction for new staff.

The falls co-ordinator will continue to review patients who fall on more than one occasion and provides advice and supportive measure to ward areas as appropriate.

We continue to support and provide information daily to senior nurse (Matron) of patients assessed to require enhanced care observations.

Change in performance in the last month
There were fifty five (55) validated falls in December which is a falls per 1000 bed day's rate of 4.40. The Trust remains below the national falls rate of 6.63. In comparison to the last month's data where we have 3.50 falls per 1000 bed days, the number of falls this month has increased. This month's data shows a slight ascending trajectory of reported falls across the Trust.

During this month, falls consequence were recorded as (0) catastrophic (2) major (0) moderate (13) minor (40) negligible.
The moderate harm indicated on the graph above was a minor where a patient sustained a small skin laceration on his arm.

Planned actions for the forthcoming month
Frailty training program has commenced in 29 November and 10 January 2019 for Windsor and Oxborough encompassing quality nursing including falls prevention. Four more sessions or dates have been arranged for frailty programme this year 2019.

Continue to evaluate the effectiveness of the rental hi/lo beds and propose on going plan from findings. This will ensure a robust pathway of care that support safe effective care for patients and ensures optimal use of financial resource within the falls prevention strategy.

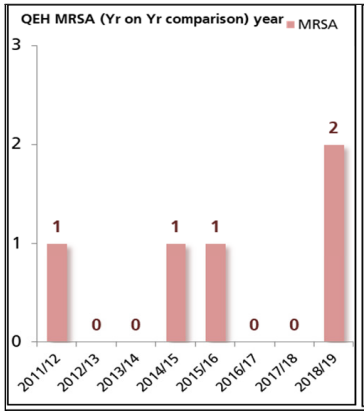
Falls Coordinator and Osteoporosis Nurse continue to collaborate to develop a Dexa scan pathway and aim to increase awareness of clinical staff to include Osteoporosis assessment into clinical practice.

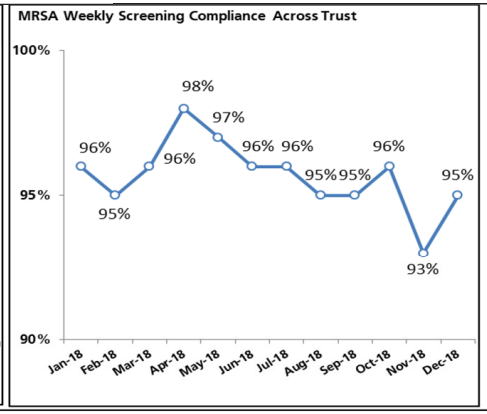
Health and Safety Officer, Falls Co-ordinator and Manual Handling Officers will continue to collaborate and complete the training video in moving and handling. The purpose of the video is to provide guidance how to use specialised equipments (Safe system of work) in retrieving patients from the floor after the fall. Fundraising is underway to potentially fund specialised equipment/s for the Trust.

New Falls Prevention Care Plan is awaiting approval from Health Records Committee. This form will be trialled by 2-3 clinical areas for a period of time prior to formal launch and will be supported by training to help and promote documentation compliance.

Page Author: Emma Hardwick Narrative: Rose Avonzado/Alison Webb

MRSA





MRSA bacteraemia ceiling for 2018/19 is 0 avoidable Trust acquired cases.
There has been 2 cases of avoidable Trust acquired MRSA bacteraemia in 2018/19.
There have been 0 cases of MRSA bacteraemia in Dec-18

Key Points / Operational actions

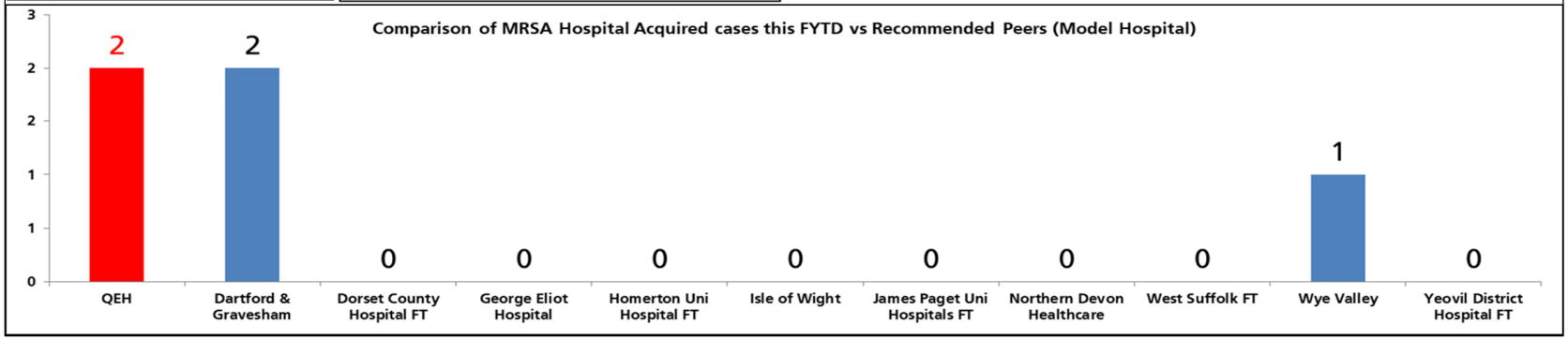
We continue to screen patients on admission and rescreen weekly. Where possible patients are isolated and or barrier nursed in a bay.

Change in performance in the last month

We have three cases of hospital acquired MRSA colonisation in December which have been treated with a decolonisation protocol.

Planned actions for the forthcoming month

Monitor screening rates and audit decolonisation treatment.



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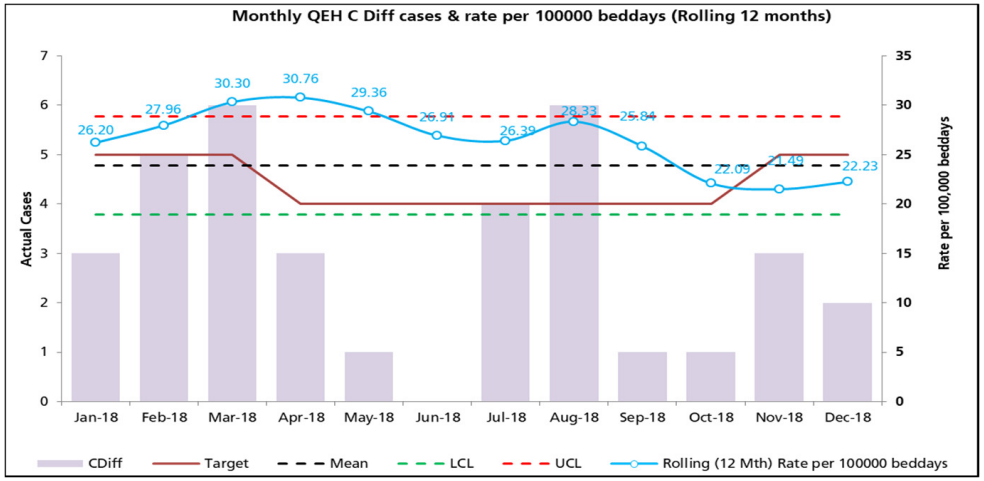
Clostridium Difficile



C. Difficile Infection

The latest C. Difficile comparative data (12 months to November 2018 puts the Trust 2nd highest when compared to our "Recommended Peers" in Model Hospital.
There were 2 cases of Trust acquired C.Difficile infection in Dec.

Key Points / Operational actions

The team continue to review the RCAs into the C diff cases with the wards. There are still outstanding reviews which have been delayed as we have been unable to get ward and medical teams to attend and review the case. The CCG are currently still allowing cases to be submitted for appeal once reviewed.

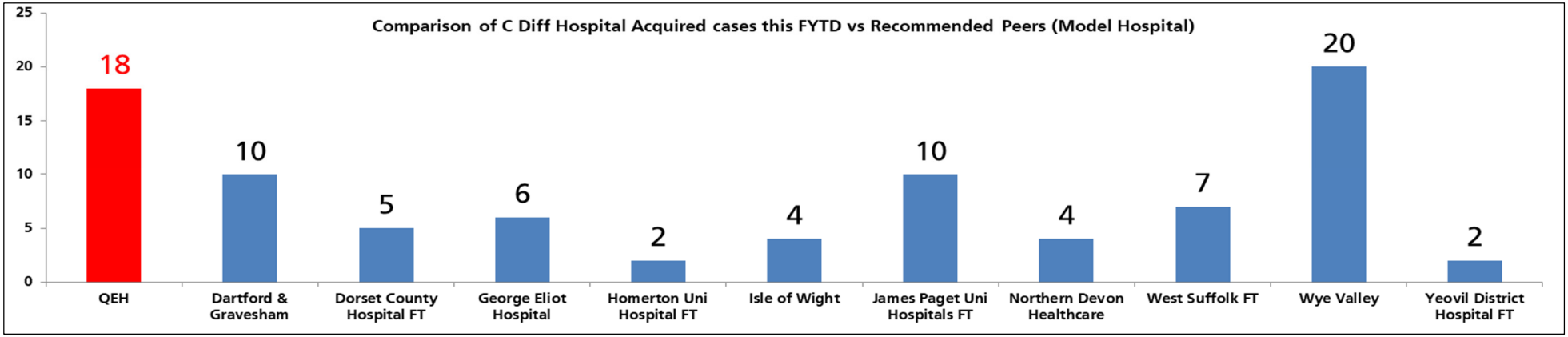
Learning and changes to practice or processes is still not very robust and the team continue to promote ways to share learning and improve patient outcomes.

Change in performance in the last month

Review and strengthen the post infection review process to enable learning and practice challenges to be identified and corrected.

Planned actions for the forthcoming month

Review all C diff cases to identify any lapses in care and improvements to practice.



Benchmarked figures will always be 1 month in arrears and recent months figures can be subject to change.

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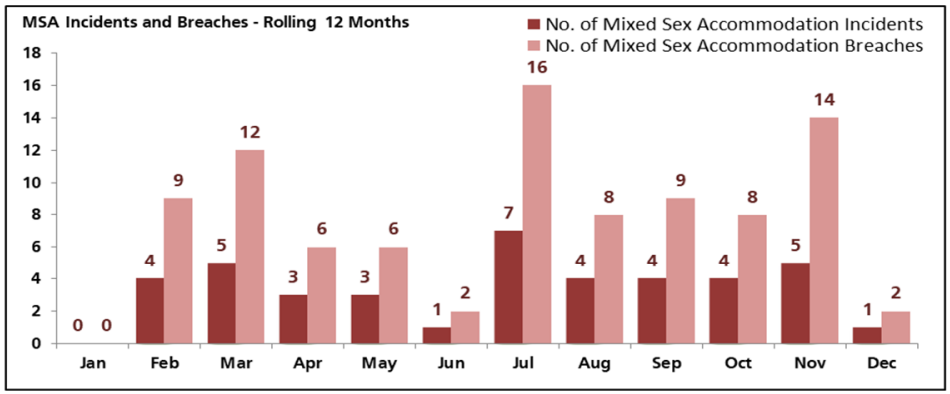
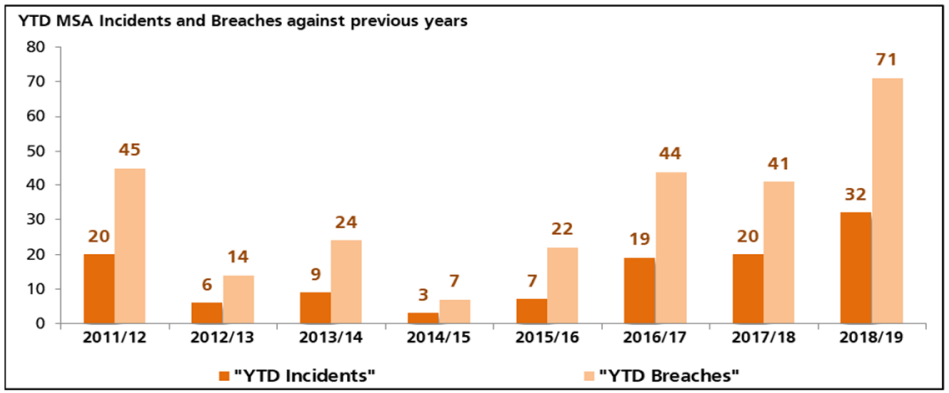
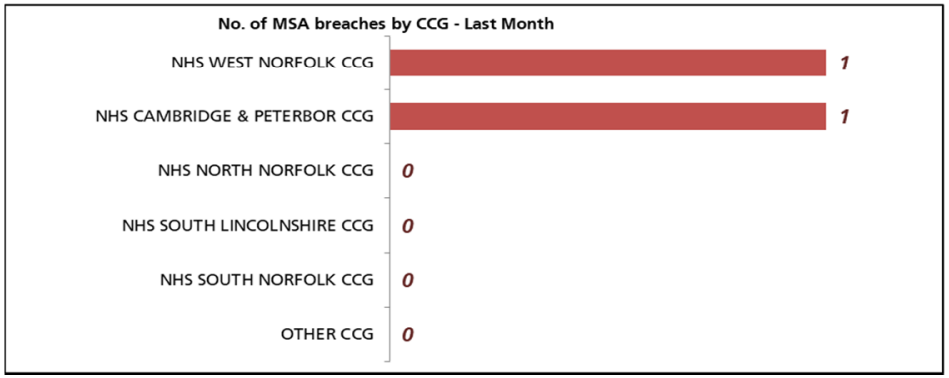
Mixed Sex Accommodation

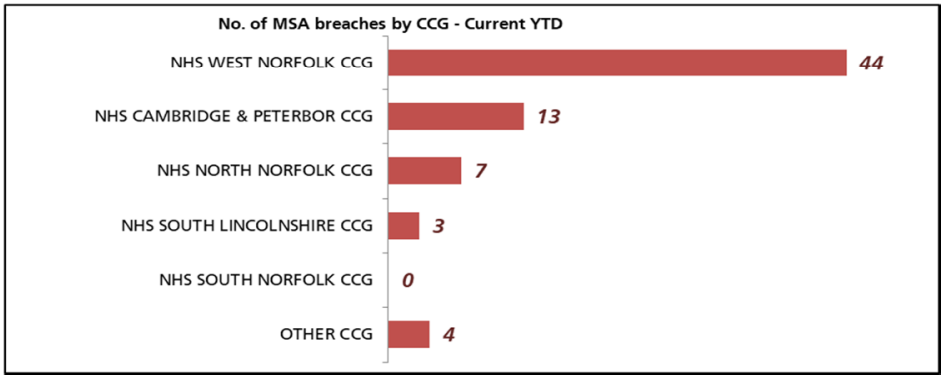




Key Points / Operational actions

For the month of December there was 1 incident of EMSA on Critical Care involving 2 patients. This is a significant improvement from the previous month of 5 incidents involving 14 patients, and is because CCC were able to repatriate patients back to the ward without delay.





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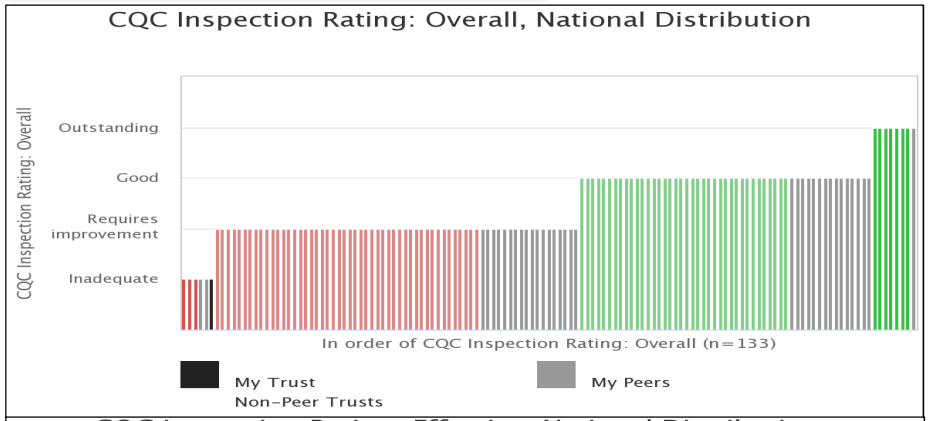
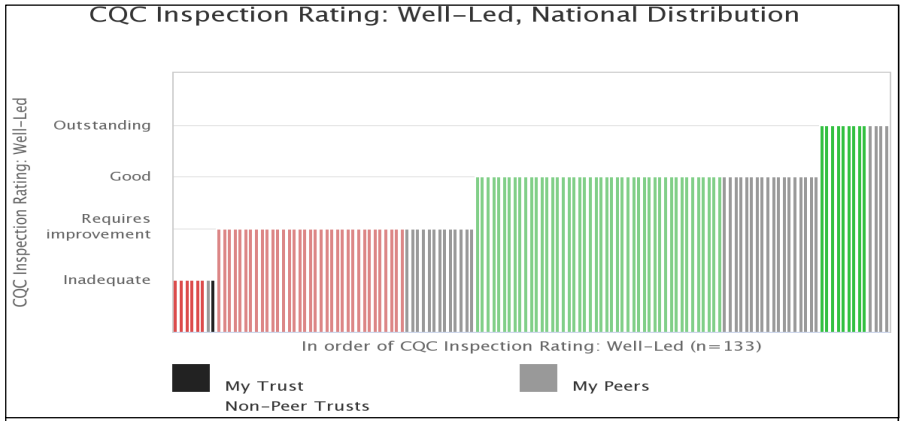
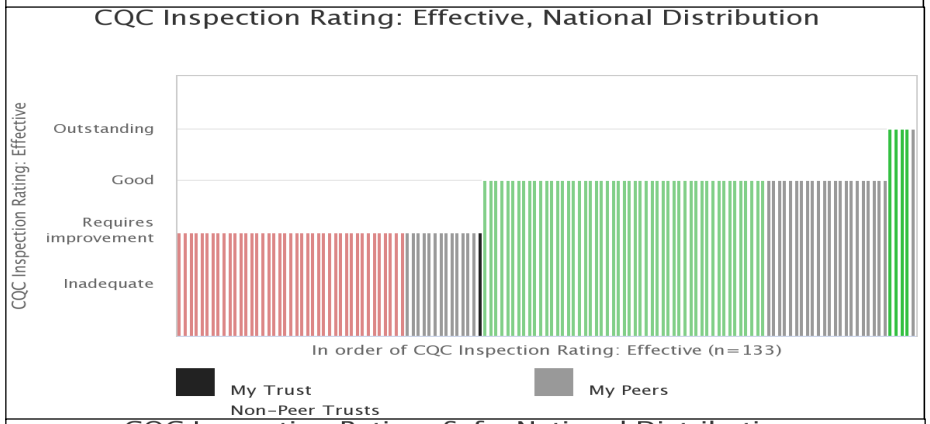
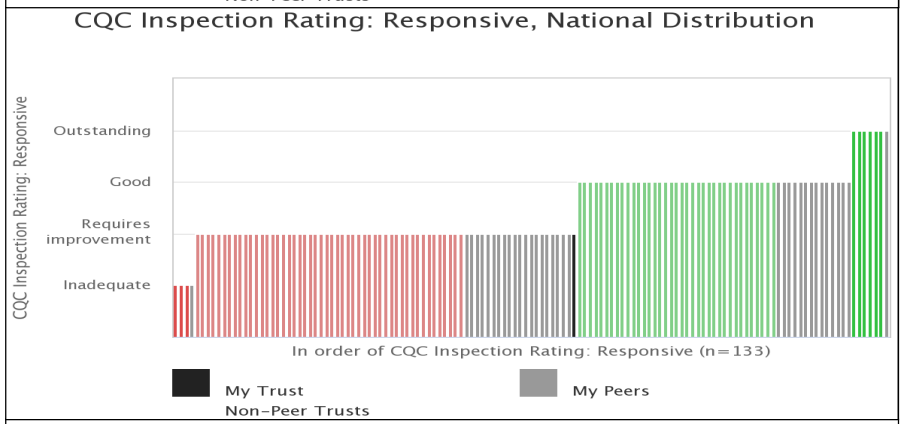
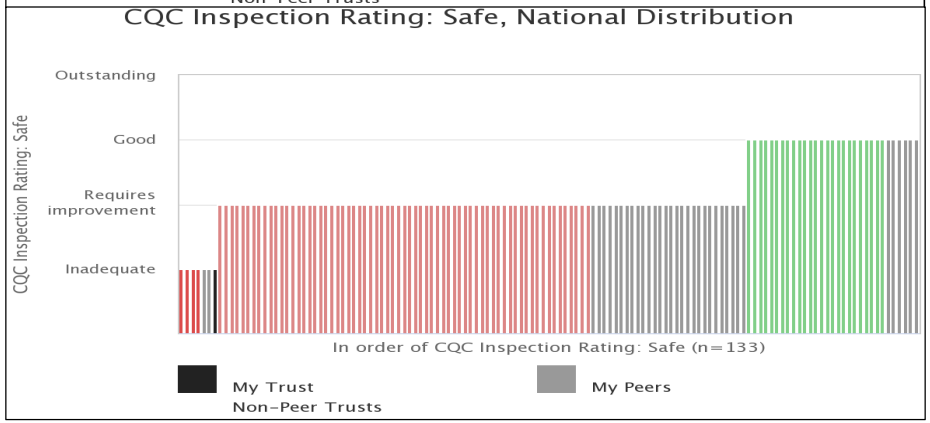
Model Hospital - CQC Inspection Rating (Benchmarked)

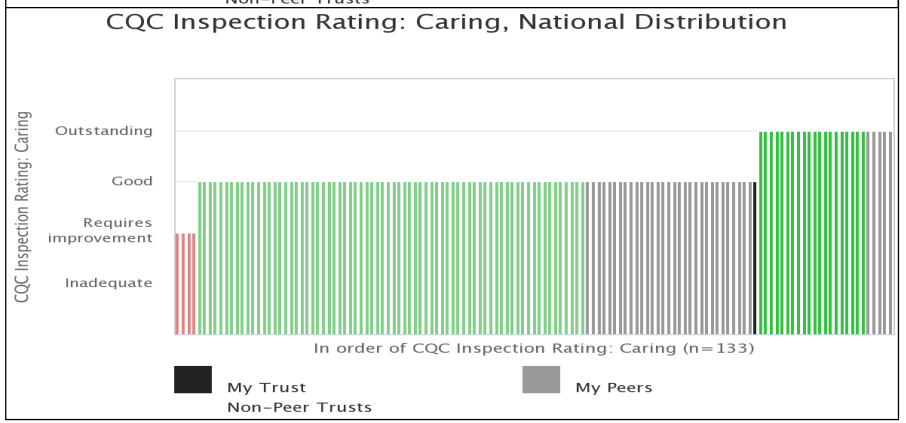




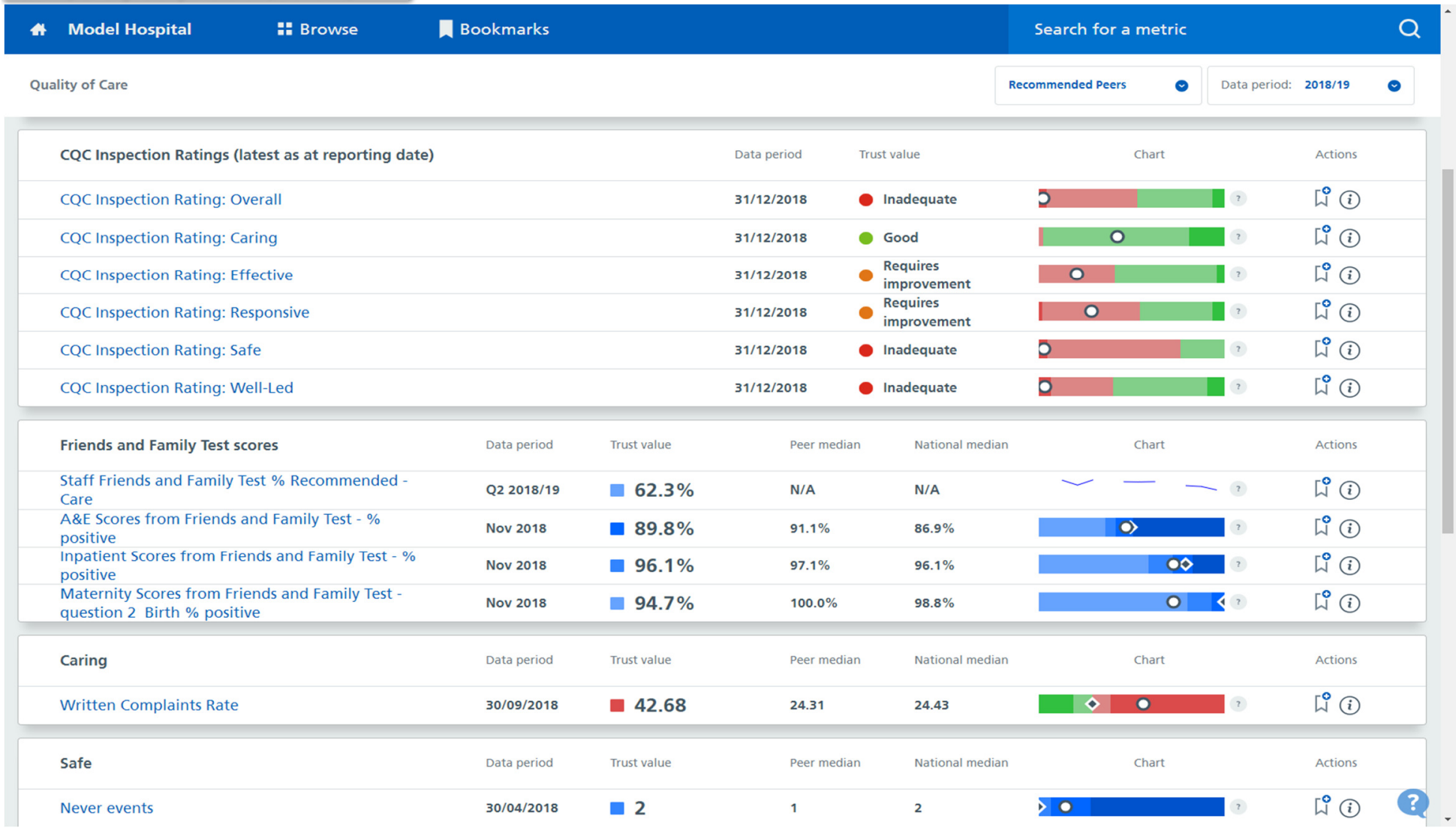








Model Hospital - Single Oversight Framework (Benchmarked)



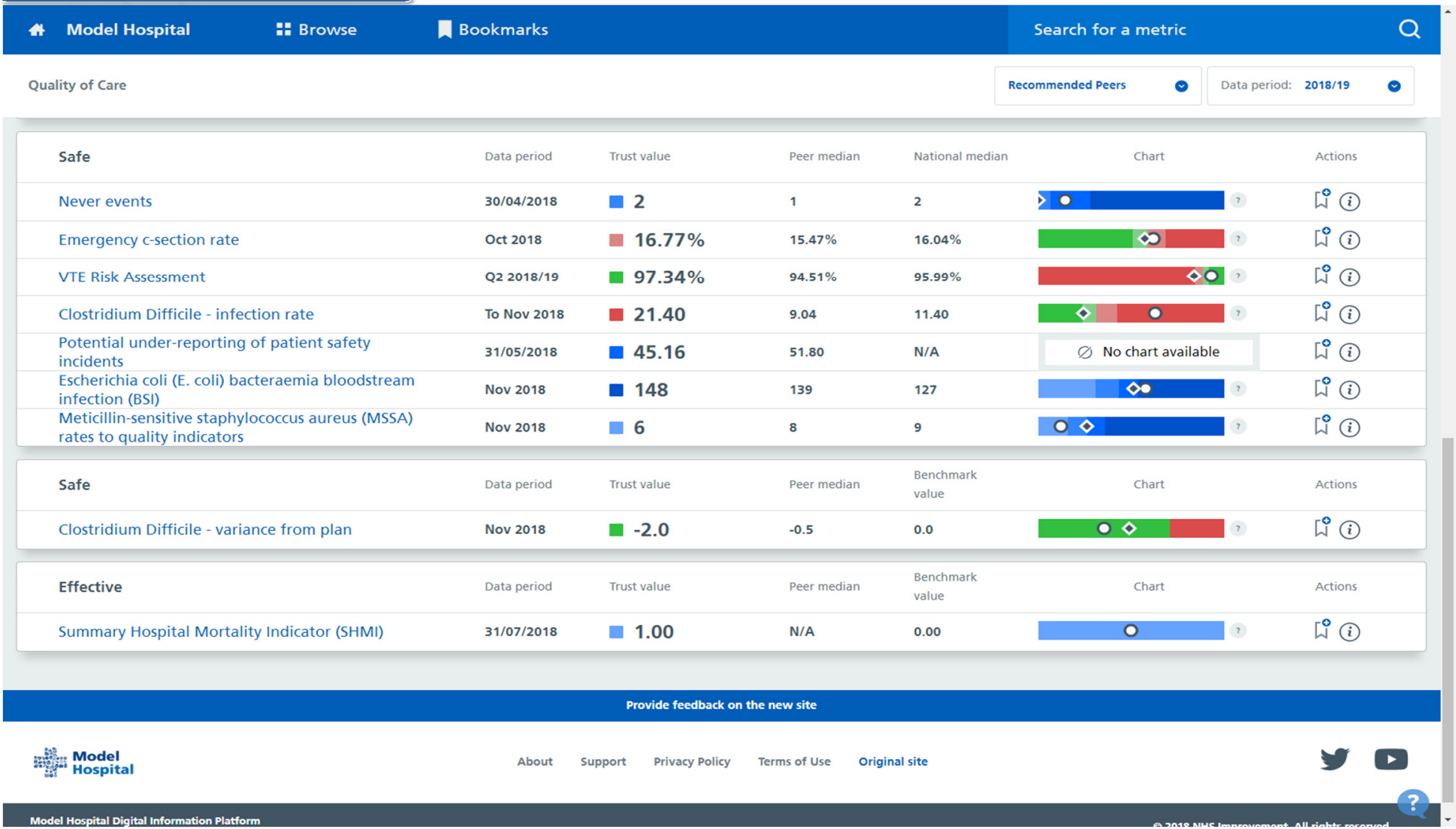
CQC Inspection Ratings (latest as at reporting date)	Data period	Trust value	Chart	Actions
CQC Inspection Rating: Overall	31/12/2018	Inadequate		
CQC Inspection Rating: Caring	31/12/2018	Good		
CQC Inspection Rating: Effective	31/12/2018	Requires improvement		
CQC Inspection Rating: Responsive	31/12/2018	Requires improvement		
CQC Inspection Rating: Safe	31/12/2018	Inadequate		
CQC Inspection Rating: Well-Led	31/12/2018	Inadequate		

Friends and Family Test scores	Data period	Trust value	Peer median	National median	Chart	Actions
Staff Friends and Family Test % Recommended - Care	Q2 2018/19	62.3%	N/A	N/A		
A&E Scores from Friends and Family Test - % positive	Nov 2018	89.8%	91.1%	86.9%		
Inpatient Scores from Friends and Family Test - % positive	Nov 2018	96.1%	97.1%	96.1%		
Maternity Scores from Friends and Family Test - question 2 Birth % positive	Nov 2018	94.7%	100.0%	98.8%		

Caring	Data period	Trust value	Peer median	National median	Chart	Actions
Written Complaints Rate	30/09/2018	42.68	24.31	24.43		

Safe	Data period	Trust value	Peer median	National median	Chart	Actions
Never events	30/04/2018	2	1	2		

Model Hospital - Single Oversight Framework (Benchmarked)



Service line Clinical Indicators (by ward)

Dec-18	Indicator Description	Den	Elm	SAU	Gayt	Mar	C Care	Lev Esc	AEC	A&E	MAU	Nec	Oxb	Stan	Sho	Til	TSS	West New	West Ray	Wind
Patient Safety	Total Incidents (SI's, Falls, PU's & Drug Errors only)	1 ↓	1 ↓	0 →	4 ↑	0 ↓	2 ↑	0 ↓	0 →	5	8 ↑	4 ↓	4 ↑	11 ↑	2 ↓	14 ↑	8 ↓	7 →	3 ↓	6 →
	Serious Incidents	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	1 ↓	0 ↓	1 ↑	0 →	0 →	0 →	0 →	1 ↑	0 →	0 →	0 →
	Drug Administration Errors	1 ↑	1 →	0 →	0 ↓	0 ↓	1 →	0 →	0 →	3 ↓	2 ↓	2 ↓	1 ↑	0 ↓	1 →	3 ↑	1 ↓	0 ↓	2 ↓	1 ↓
	All Drug Errors (inc Admin)	3 ↑	1 →	1 →	1 →	0 ↓	2 →	0 ↓	0 →	4 ↓	5 ↑	4 ↓	2 →	1 ↓	1 →	3 →	6 ↑	1 ↓	2 ↓	2 ↓
	Falls Total	0 ↓	0 ↓	0 →	3 ↑	0 ↓	0 →	0 ↓	0 →	1 ↑	6 ↑	0 ↓	3 ↑	10 ↑	1 ↓	11 ↑	6 ↑	7 ↑	1 ↓	5 ↑
	H/A Pressure Ulcers Grade 2	0 →	0 →	0 →	1 ↑	0 →	1 ↑	0 →	0 →	0 →	0 →	1 ↑	0 →	0 ↓	0 →	0 →	0 →	0 →	0 →	0 →
	H/A Pressure Ulcers Grade 3	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	1 ↑	0 →	0 →	0 →	0 →	0 →	0 →
	H/A Pressure Ulcers Grade 4	0 →	0 →	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 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 ↓	0 ↓	0 ↓	1 ↑	0 →	0 →	1 ↑
	Harm Free Care	100% ↑	95% ↓	100% →	93% ↓		89% ↓				95% →	97% ↑	97% ↓	97% ↑	83% ↓	96% →	100% →	85% ↑	88% ↓	81% ↓
	MRSA	0 →	0 →	0 →	0	0 →	0 →	0 →	0 →	0 →	0	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →
	C4C Audit %	90% ↓	96% →	96% →	91% ↓	95% ↓	95% →	Data N/A		98%	97% ↑	93%	99% ↑	96% ↓	99% →	97% →	94% ↓	93% ↓	98% ↑	93% ↓
	Hand Hygiene %	100% ↑	79% ↓	75% ↓	58% ↓	96% ↑	93% ↓			86%	70% ↑	88% ↓	66% ↓	93% ↑	96% ↑	91% ↑	81% ↑	83% ↓	82% ↓	86% ↓
	MSSA	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 ↓	0 ↓	0 ↓	0 →	0 →	0 →	0 →
	E.Coli	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 ↓	1 ↑	0 →	0 →	0 →	0 →	0 →	0 →
	ESBL	0 →	0 →	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 →	0 →	0 →
	Klebsiella	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →
Patient Experience	Complaints	0 →	1 ↑	1 →	2 ↑	0 →	0 →	0 →	0 →	4 ↓	0 →	1 →	0 →	1 →	0 ↓	0 →	1 ↑	0 →	0 →	1 →
	Compliments	1 ↓	2 ↓	0 ↓	11 ↑	0 ↓	4 ↓	0 →	2 ↑	5 ↓	2 ↓	7 ↑	0 →	7 ↑	0 ↓	1 ↓	1 ↑	17 ↑	6 ↑	4 ↑
	Family And Friends Response Rate	22.3% ↓	19.0% ↓	20.8% ↓	21.7% ↓	19.3% ↑	281.8% ↓	0.0% →	35.9% ↑	14.6% ↓	17.5% ↓	65.1% ↑	58.3% ↓	25.0% ↓	18.2% ↑	46.5% ↑	21.0% ↓	32.1% ↑	60.8% ↑	14.0% ↓
	Family And Friends (% Recommended)	95.2% ↑	100.0% ↑	86.4% ↓	95.0% ↑	90.3% ↓	100.0% →	0.0% →	93.8% ↓	89.9% ↑	95.6% ↑	97.2% ↓	89.8% ↓	92.3% ↓	66.7% ↓	93.6% ↑	86.8% ↓	88.2% ↓	91.1% ↑	95.5% ↓
Effectiveness	% Of Active Mentors	75.0% ↑	62.5% ↑	60.0% ↑	100.0% →	100.0% →	81.4% ↑		33.3% →	42.9% ↑	50.0% ↓	66.7% →	40.0% →	50.0% ↓	87.5% ↑	85.7% →	20.0% →	42.9% →	70.0% ↓	33.3% →
	Fill Rate Registered	109.9% ↑	92.6% ↓	92.2% ↓	94.9% ↓	75.9% ↓	88.8% ↑		Data N/A	91.6% ↓	94.3% ↓	95.7% ↑	96.1% ↓	96.9% ↑	92.0% ↑	97.4% ↓	89.2% ↓	98.0% ↑	97.3% ↓	98.0% ↑
	Fill Rate Unregistered	122.3% ↓	116.8% ↓	98.1% ↓	105.2% ↑	103.4% ↓	82.7% ↑			↑	134.0% ↑	102.9% ↑	93.7% ↓	97.1% ↑	96.2% ↓	119.7% ↑	79.8% ↓	136.4% ↓	101.0% ↓	109.6% ↑
	CHPPD	6.6 ↑	7.2 ↑	11.7 ↑	6.4 ↑	7.3 ↑	29.5 ↑	Data N/A		11.9 ↑	10.5 ↑	6.2 ↓	6.1 ↓	6.6 ↑	7.8 ↓	6.1 ↑	8.2 ↑	8.9 ↑	7.7 ↑	6.1 ↓
Staff Experience	Appraisals	93.9% ↓	88.9% ↓	95.2% ↓	93.0% ↓	96.8% ↓	92.3% ↑		64.3% ↑	81.7% ↓	87.1% ↓	84.8% ↑	84.6% ↓	83.7% ↓	95.2% ↓	81.5% →	85.0% ↓	64.0% ↓	97.7% ↑	94.7% ↓
	Sickness	7.5% ↑	17.3% ↓	7.5% ↑	6.3% ↑	14.1% ↑	5.7% ↓		1.1% ↑	6.0% ↑	9.9% ↑	7.1% ↑	15.5% ↑	17.1% ↑	10.1% ↑	10.0% ↑	10.9% ↑	8.6% ↑	8.7% ↑	4.7% ↓
	Vacancies	20.0% ↑	18.5% ↑	24.6% ↑	14.3% ↑	24.0% ↑	10.2% ↑		4.0% ↑	18.6% ↑	32.2% ↑	20.2% ↑	38.5% ↑	18.1% ↓	9.7% ↑	15.3% ↑	17.3% ↓	17.0% ↑	11.6% ↑	30.8% ↑
	Mandatory Training	84.9% ↓	85.0% ↑	95.5% ↓	91.7% ↑	89.4% ↓	90.4% ↓		80.7% ↑	84.4% ↓	86.3% ↓	93.8% ↑	83.8% ↓	89.6% ↓	93.8% ↑	90.3% ↑	83.3% ↑	90.0% ↑	94.7% ↑	91.0% ↑

"Total Incidents (SI's, Falls, PU's & Drug Errors only)" figure includes Serious Incidents, Falls, Pressure Ulcers and Drug "Administration Errors" only, not all Drug Errors.

Page Owner: Emma Hardwick *Narrative: Val Newton*

Perfect Ward (Documentation Audit)

Ward Level Indicators (based on Documentation Perfect Ward Audit)

		Denver Ward	Elm Ward	Surgical Assessment Unit	Gayton Ward	Marham Ward	Critical Care	Medical Assessment Unit (MAU)	Necton Ward	Oxborough Ward	Stanhoe Ward	Shouldham Ward	Tilney Ward	Terrington Short Stay	West Newton Ward	West Raynham Ward	Windsor Ward
Is the documentation compliant with record keeping standards?	General records	33%	100%	100%	92%	89%	92%	Documentation Audit not complete for December 2018	100%	100%	100%	100%	100%	100%	89%	100%	100%
Are demographic details contained on history sheet, observations, admission pack etc.?	General records	0%	100%	100%	100%	100%	100%		100%	100%	100%	100%	100%	67%	89%	100%	100%
Is there an up to date care/treatment plan that reflects patient needs?	General records	100%	100%	100%	100%	100%	92%		100%	100%	100%	100%	100%	100%	100%	100%	100%
Is there evidence that care has been discussed with the patient/carers?	General records	100%	100%	67%	100%	100%	100%		79%	33%	100%	100%	100%	33%	100%	100%	89%
Is the frequency of observations prescribed?	General records	100%	100%	89%	100%	100%	100%		100%	100%	100%	100%	100%	100%	89%	100%	100%
Is the recording of vital signs as per plan with Early Warning Score (EWS/NEWS2)?	General records	100%	100%	100%	100%	100%	0%		100%	100%	100%	100%	100%	100%	100%	100%	100%
If the patient has triggered, has this been documented to show that it has been escalated and actioned (on SBAR proforma)?	General records	100%	100%	0%	0%	0%	0%		100%	100%	0%	100%	100%	50%	100%	100%	100%
Is there a care round chart completed as necessary?	General records	100%	100%	89%	100%	100%	100%		100%	100%	67%	100%	100%	67%	100%	100%	100%
Is the transfer documentation complete?	General records	67%	75%	0%	100%	100%	50%		100%	0%	33%	100%	33%	50%	83%	100%	33%
Were observations taken within the first 15 minutes of arrival for assessment area, or within 30 minutes of arrival for a ward?	General records	100%	50%	100%	83%	89%	88%		100%	100%	100%	100%	78%	67%	56%	100%	61%
Is the property documentation complete? (including teeth and hearing aids)	General records	100%	83%	89%	92%	67%	79%		56%	100%	100%	100%	89%	50%	44%	92%	89%
Has the discharge planning checklist been started?	General records	0%	17%	0%	67%	100%	100%		56%	33%	0%	50%	0%	50%	67%	11%	67%
Is the post operative care plan completed?	General records	100%	100%	0%	100%	0%	0%		0%	0%	0%	0%	0%	0%	0%	0%	0%
Is the initial referral available?	General records	100%	100%	100%	11%	0%	0%		100%	0%	0%	0%	83%	100%	100%	100%	50%
Are x-rays available if indicated in the referral?	General records	0%	0%	0%	100%	0%	0%		100%	0%	0%	0%	100%	100%	100%	100%	50%
Is the ASKINS bundle in place (see back of care round)?	Risk assessments	100%	83%	78%	100%	67%	100%		100%	100%	67%	100%	100%	83%	100%	100%	100%
Have safeguarding concerns been identified and addressed?	Risk assessments	100%	0%	100%	100%	100%	100%		100%	0%	0%	0%	100%	50%	100%	100%	0%
Has the pressure ulcer risk/waterlow been completed?	Risk assessments	100%	100%	100%	100%	100%	100%		89%	100%	100%	100%	100%	83%	100%	100%	100%
For patients deemed at risk of PU, have appropriate protective measures in place?	Risk assessments	100%	100%	100%	100%	0%	100%		100%	100%	100%	100%	100%	100%	100%	100%	78%
Have the moving and handling documentation been completed?	Risk assessments	100%	100%	100%	100%	100%	88%		67%	100%	67%	100%	100%	100%	100%	92%	100%
Have the falls documentation been completed?	Risk assessments	100%	100%	100%	92%	89%	89%		89%	100%	100%	100%	100%	100%	100%	100%	100%
Has lying and standing blood pressure taken for over 65s?	Risk assessments	78%	67%	50%	0%	0%	0%		33%	0%	0%	100%	0%	25%	33%	8%	44%
Has a bed rail assessment been completed?	Risk assessments	100%	100%	100%	100%	67%	79%		100%	100%	67%	100%	100%	67%	89%	100%	100%
Do patients documented for high risk of falls have a red dot by their bedside and on patient safety board?	Risk assessments	100%	100%	50%	100%	0%	0%		100%	100%	100%	100%	83%	67%	100%	100%	89%
Do patients with the red dot have high risk of falls documented in their notes?	Risk assessments	100%	100%	100%	100%	100%	0%		100%	100%	100%	100%	100%	100%	100%	100%	67%
Has the dementia screening been completed (>75s)?	Risk assessments	100%	0%	0%	100%	100%	0%		17%	0%	0%	0%	33%	100%	56%	13%	44%
Was nutritional screening taken within six hours of admission (if the area does not take direct admission, was the patient screened on transfer to the ward)?	Meeting nutritional needs	100%	100%	100%	100%	100%	100%		100%	100%	100%	100%	100%	100%	67%	100%	67%
Is the nutrition assessment (MUST/PYMS) completed in full and in date with actions noted?	Meeting nutritional needs	100%	100%	100%	100%	100%	88%		89%	100%	100%	100%	89%	83%	89%	92%	100%
Is the NG tube care recorded and correct?	Meeting nutritional needs	100%	100%	0%	0%	0%	67%		0%	100%	0%	100%	0%	0%	100%	100%	0%
Has the food chart been completed?	Meeting nutritional needs	100%	100%	0%	100%	0%	0%		0%	100%	0%	100%	0%	0%	100%	100%	100%
Has the patients body map been completed, dated, timed and signed?	Tissue Viability	100%	100%	67%	83%	89%	75%		100%	100%	100%	100%	100%	67%	33%	100%	89%
Is the QEH adapted waterlow assessment accurate?	Tissue Viability	100%	100%	100%	92%	100%	83%		89%	100%	100%	100%	100%	67%	100%	100%	100%
Is the drug chart legible and signed?	Drug charts	100%	100%	100%	100%	100%	100%		100%	100%	100%	100%	100%	100%	100%	100%	100%
Have allergies been recorded (if any check patient has red clips)?	Drug charts	100%	92%	100%	100%	100%	92%		100%	100%	100%	100%	100%	100%	100%	100%	100%
If antibiotics are being used, has it been prescribed with review date (not Theatre/DSU)?	Drug charts	100%	88%	0%	89%	0%	100%		44%	0%	0%	100%	75%	50%	100%	100%	67%
Has patient weight been recorded?	Drug charts	89%	92%	44%	92%	78%	100%		89%	100%	100%	100%	78%	100%	67%	67%	100%
Has the VTE assessment been completed?	Drug charts	100%	100%	67%	100%	100%	100%		100%	100%	100%	100%	78%	83%	67%	100%	100%
If the patient is requiring oxygen has this been prescribed correctly?	Drug charts	100%	100%	33%	100%	100%	0%		100%	100%	100%	100%	100%	100%	0%	0%	100%
How long in situ and is date recorded?	Cannula care	78%	100%	67%	50%	100%	100%		100%	100%	50%	100%	75%	100%	100%	89%	89%
Has the date of dressing change been documented?	Cannula care	100%	0%	0%	0%	67%	89%		100%	100%	0%	100%	50%	67%	50%	50%	56%
Has the VIP score been recorded?	Cannula care	100%	100%	100%	100%	50%	89%		100%	100%	50%	100%	100%	100%	50%	100%	100%
Is there correct documentation re: insertion and removal?	Cannula care	72%	83%	67%	25%	100%	89%		100%	100%	50%	100%	75%	50%	50%	100%	78%
Are there pain chart assessments as required?	Pain assessment	100%	100%	100%	8%	0%	79%		100%	100%	0%	50%	67%	67%	0%	100%	33%
Is there evidence of actions taken?	Pain assessment	100%	100%	100%	83%	0%	79%		100%	100%	0%	50%	100%	0%	0%	100%	33%
Has there been reassessment following intervention?	Pain assessment	100%	100%	100%	75%	0%	56%		100%	100%	0%	50%	83%	0%	0%	100%	0%
Has the adequate input been recorded?	Fluids	100%	75%	100%	100%	67%	100%		100%	100%	100%	100%	100%	100%	100%	100%	100%
Has the adequate output been recorded?	Fluids	100%	100%	100%	100%	67%	100%		100%	100%	100%	100%	100%	100%	100%	100%	100%
Has Fluid chart been documented every 2 hours? (Day & Night)	Fluids	100%	75%	100%	100%	50%	100%		100%	100%	0%	100%	100%	0%	50%	100%	67%
Has the chart been subtotalled every 4 hours?	Fluids	67%	75%	100%	100%	33%	100%		100%	100%	100%	100%	100%	100%	50%	100%	100%
Is the fluid balance chart accurate within 100mls?	Fluids	100%	100%	100%	100%	100%	100%		100%	100%	100%	100%	100%	100%	100%	100%	100%
Are IV fluids being delivered to patient as prescribed?	Fluids	100%	100%	100%	100%	100%	0%		100%	100%	100%	100%	100%	100%	100%	100%	100%
Overall is the fluid chart considered safe?	Fluids	100%	75%	100%	100%	67%	100%		100%	100%	100%	100%	100%	100%	100%	100%	100%

This month we are reporting data collected by the Perfect Ward electronic audit system. The Perfect Ward system allows us to capture audit findings directly in to the app. As audits are collected inspection results are instantly available to all users. This clear and transparent reporting engages and empowers frontline staff and allows areas to address issues right away. We use a system of peer review each month for the IPAC audit data collection and plan that each quarter the audit team will carry out the inspection audits for our quality assurance. The current version of Perfect Ward includes an anomaly that Not Applicable shows as 0%, this is a misrepresentation of data and is currently being addressed by the company.

Exception Report December - Div 1. 0% scores

- Demographic details on documentation- One label missing Denver.
- No documented escalation of NEWS2 -this is an area of focused education as SAU, Gayton, Marham and CCS all scored 0%.
- Discharge planning documented not recorded on Denver, Marham, SAU and CCU.
- Lying and standing BP recorded on patients over 65 years - noncompliance and therefore 0% on Gayton, Marham and CCU. This will be a focus area with the exception of CCU which due to the acuity of patients in critical care and coronary care will be N/A for the majority of their in-patient stay in these areas.
- If prescribed oxygen, is this prescribed correctly – noncompliance for CCS.

Div 2. 0% scores

- Stanhoe - no documented escalation for raised NEWS, no discharge checklist.
- Oxborough -Transfer document not completed, safeguarding – not applicable as no safeguarding concerns, no lying and standing blood pressures recorded.
- Tilney –no discharge checklist.
- If prescribed oxygen is this prescribed correctly – noncompliance for West newton and West Raynham.
- Has fluid chart been documented every two hours – noncompliance for Stanhoe and Terrington.
- MAU and ED did not carry out this audit.
- All remaining 0% score were not applicable for the area at the time.

We are aware of training needs which continue for staff completing the electronic audits to ensure standard approach and that all wards are assessed in same way. These issues will be addressed before next audit report, some further questions need to be removed from some ward areas as they are not applicable to these areas, this will be addressed with Perfect Ward.Associate Chief Nurses for the Divisions will be addressing shortfalls in performance by meeting with each matron and ward manager who will be held to account for individual performance going forward.
Areas of concern will be added to ward quality action plan and improvements monitored by the relevant CBU.Any identification of training needs will be actioned.

Page Owner: Emma Hardwick *Narrative: Val Newton*

Friends and Family Test

FFT Summary Scorecard

		2018/01	2018/02	2018/03	2018/04	2018/05	2018/06	2018/07	2018/08	2018/09	2018/10	2018/11	2018/12	Difference (Prev Mth)
A&E	% Recommend (Target 95%)	96.90%	93.71%	89.73%	88.20%	90.00%	90.87%	93.15%	93.21%	90.94%	89.42%	89.80%	89.94%	⇧ 0.14%
	% Not Recommend	1.03%	2.40%	4.69%	3.83%	2.50%	2.48%	1.76%	2.79%	3.75%	4.15%	2.23%	2.76%	
	Response Rate	16.03%	13.02%	13.84%	10.35%	11.52%	17.67%	14.65%	12.96%	8.84%	21.32%	20.81%	14.60%	⇩ -6.22%
	Response Rate Target	20.00%	20.00%	20.00%	20.00%	20.00%	20.00%	20.00%	20.00%	20.00%	20.00%	20.00%	20.00%	
Inpatient / Day Case	% Recommend (Target 95%)	96.43%	96.09%	95.07%	95.38%	96.18%	95.87%	95.48%	95.01%	95.50%	95.15%	96.15%	95.17%	⇩ -0.97%
	% Not Recommend	0.33%	0.62%	1.26%	0.92%	1.17%	0.84%	0.81%	1.14%	0.81%	0.92%	1.13%	1.33%	
	Response Rate	24.81%	26.76%	30.56%	31.72%	31.14%	33.96%	30.36%	34.62%	34.97%	31.47%	33.05%	28.58%	⇩ -4.47%
	Response Rate Target	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	
Maternity Antenatal	% Recommend (Target 95%)	96.91%	98.70%	98.72%	96.20%	100.00%	97.70%	93.81%	100.00%	97.30%	97.50%	94.59%	97.06%	⇧ 2.46%
	% Not Recommend	1.03%	0.00%	0.00%	0.00%	0.00%	1.15%	4.12%	0.00%	2.70%	2.50%	0.00%	2.94%	
Maternity Birth	% Recommend (Target 95%)	100.00%	86.96%	94.74%	92.11%	95.65%	100.00%	95.12%	100.00%	100.00%	100.00%	94.74%	94.12%	⇩ -0.62%
	% Not Recommend	0.00%	4.35%	0.00%	7.89%	0.00%	0.00%	4.88%	0.00%	0.00%	0.00%	5.26%	0.00%	
	Response Rate	9.52%	13.77%	11.66%	20.32%	26.74%	29.51%	21.24%	14.71%	11.58%	22.94%	23.31%	20.12%	⇩ -3.19%
	Response Rate Target	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%	
Maternity PostNatal Ward	% Recommend (Target 95%)	97.22%	100.00%	100.00%	95.45%	98.04%	100.00%	96.72%	97.14%	97.50%	97.50%	97.83%	100.00%	⇧ 2.17%
	% Not Recommend	0.00%	0.00%	0.00%	2.27%	0.00%	0.00%	1.64%	2.86%	0.00%	2.50%	0.00%	0.00%	
Maternity Comm PostNatal	% Recommend (Target 95%)	100.00%	100.00%	100.00%	98.11%	98.00%	100.00%	100.00%	100.00%	100.00%	97.22%	100.00%	100.00%	⇨ 0.00%
	% Not Recommend	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.78%	0.00%	0.00%	
Outpatient	% Recommend (Target 95%)	97.69%	96.93%	97.83%	96.87%	97.38%	97.34%	97.10%	97.72%	96.65%	96.03%	96.79%	97.40%	⇧ 0.61%
	% Not Recommend	0.41%	1.13%	0.66%	1.07%	0.51%	0.93%	0.82%	1.22%	0.92%	0.65%	0.72%	0.43%	

Key Points / Operational actions

A&E – response rate has fallen by 6% and did not reach the 20% target in December. Likelihood to recommend, whilst missing the target of 95%, slightly exceeded November's figure and is just below 90%
Inpatient – response rate dropped over 4% and failed to reach the response rate (another 80 responses across the hospital would have reached the target) . The likelihood to recommend dipped slightly but remains above the 95% target.
Maternity – only birth response rate is reported on – this exceeded the target of 15% response rate for the third month in a row, despite a dip of 3%. The likelihood to recommend dipped below the target of 95% for the second month in a row. 95% + likelihood to recommend was achieved in antenatal and both postnatal touchpoints.
Outpatient – there is no response rate target – the likelihood to recommend score is above the 95% target and is at the highest point it has been since August 2018.

Change in performance in the last month

Only birth achieved the response rate target across the hospital.
The areas not to achieve their likelihood to recommend target were A&E and birth. Negative comments continue to be returned to the areas where the experience took place in order to address the concerns, share learning and improve future experiences. Area leads are requested to comment or advise of changes based on this feedback within 5 working days of receipt. Feedback from the FFT will be included in the new learning and improvement boards sited across the hospital from the end of January.

Planned actions for the forthcoming month

A rolling 12 month review of response rate targets which highlights the individual wards/areas not achieving target is communicated to Matrons / Ward Managers and ACNs to prompt suggestions or sharing of best practice.
A volunteer continues to support wards to collect feedback one day a week as do the Patient Experience Team –specifically focussing on those areas which fail to meet their target.
New methods of collecting feedback to be trialled in A&E – when capacity within Patient Experience allows documentation to be put in place.
Trial of feedback collection via electronic tablet in conjunction the Perfect Ward on AEC to commence when technical issues can be resolved.
A plan to share learning across the hospital is underway to allow all areas to see how changes can be introduced based on feedback from patients (PALS, complaints and FFT) and incidents – due to commence at the end of January.

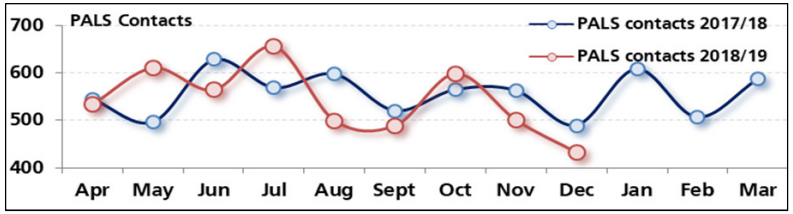
Page Owner: Val Newton *Narrative: Val Newton*

Complaints

Numbers at date of report	Oct-18	Nov-18	Dec-18
Complaints Received	36	32	27
Complaints remaining open	85	65	88
Complaints closed	48	31	18
Re-opened Complaints			
Complaints acknowledged in three working days	92%	91%	89%
Complaints receiving a response within 30 working days	19 out of 41 = 46%	22 out of 48 = 54%	10 out of 30 = 33%
Responses meeting agreed extended timeframe beyond 30 working days	3	8	1
Total complaints responded to within 30 working days OR by agreed extension date	22	30	11
Severity Grading			
Of those closed: no or low impact on patient care/patient experience	27	25	24
Of those closed: moderate impact on care/patient experience	9	5	2
Of those closed: high impact on care/patient experience	0	1	1

Top Complaints Types (last 3 months)

Oct-18		Nov-18		Dec-18	
Delay or failure to diagnose (inc e.g. missed fracture)	6	Delay or failure to diagnose (inc e.g. missed fracture)	5	Communication with patient	2
Discharge Arrangements (inc lack of or poor planning)	3	Delay or failure in treatment or procedure	4	Communication with relatives/carers	2
Appointment Cancellations	3	Length Of Waiting List	2	Attitude of Nursing Staff/midwives	2
Communication with patient	2	Discharge Arrangements (inc lack of or poor planning)	2	Inappropriate treatment	2
Delay or failure in treatment or procedure	2	Wait for operation/procedure	2		



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Discharge Arrangements	9
Poor Communication	8
Sign Post to another NHS Trust	8

Complaints Received
During the month of December 2018, the Trust received 27 formal complaints. This is 5 less than received last month and 1 more than in December 2017 when the Trust received 26 complaints.

Response Rates
The Trust is required to investigate and share the response with the complainant within 30 working days. The compliance rate has decreased from last month to 33% with 19 breaches occurring:

- Division 1 has had 9 breaches out of 13 responses that were due to be sent in December 2018.
- Division 2 has had 10 breaches out of 16 responses that were due to be sent in December 2018.
- Patient Services has had 2 breaches out of 2 due to be sent in December 2018.

Currently there are 17 complaint investigations/responses that are overdue and have not yet been completed, these continue to be chased and escalated. An action plan has been developed to improve compliance with the 30 working day response time across the Trust to achieve 90% but progress remains inconsistent with delays occurring within the Divisions and whilst awaiting final approval.

The PALS & Complaints Department have had an internal audit completed in November 2018. The Department has received the debrief and awaiting the final report that will be shared with the Divisions. The audit highlighted non-compliance with policy timeframes to receive responses in a timely manner and to complete courtesy call backs within the agreed timeframes.

The audit also highlights the requirement for Divisions to complete the Learning Experience & Action Plans (LEAP) once a complaint investigation has been completed. The Complaints Department have already updated the LEAP section on Datix in order to improve the functionality and simplify the gathering of thematic data by use of a drop box system of options to choose.

Complaints received by Specialty / Key Issues Table
During December 2018, A&E has had 4 complaints, Gynaecology and Trauma & Orthopaedics has had 3 complaints. The complaints regarding these areas included the following issues:

- Communication with patient
- Attitude of Nursing Staff

Lessons Learned

- To ensure patients and their relatives are communicated with regarding their concerns regarding patient transfer or test results.
- Ensure pain is addressed where significant injury is identified. Where patients are immobilised take care to be in view and to show appropriate empathy.
- Parents should be kept informed of possible difficulties during labour and are provided with relevant information and advice in a compassionate manner when providing information about diagnosis of hydrocephalus.
- To ensure that patient confidentiality is maintained at all times.

Other Information

- 3 complaints have been re-opened in December 2018.
- 5 local resolution meetings were held in December 2018 .
- The Parliamentary and Health Service Ombudsman (PHSO) have requested a complaint file and health care records to review for investigation. They have advised a provisional report for a further case that they are not to uphold the complaint, awaiting final report. They have also advised a further complainant to contact the Trust to complete Local Resolution as a meeting has not yet been attended.
- 54 Travel Expense claims were processed in December 2018.
- PALS Survey – Out of 4 respondents, 3 respondents found the service extremely or very helpful. One respondent rated the service as poor, they left a comment to explain 'that PALS are employed by the Trust that their complaint is about'.

PALS Contacts (excluding compliments)
The PALS service has had 275 contacts this month, compared to a figure of 370 in the previous month. This is a decrease in comparison to December 2017, in which 327 contacts were recorded. This is in keeping with the bank holidays during December. The top subjects for this month are noted opposite:

Compliments
157 compliments were received this month, which is an increase from 130 compliments received last month and a slight decrease in comparison to December 2017, in which the Trust received 165 compliments.

Page Owner: Val Newton *Narrative: Val Newton*

Maternity Clinical Performance & Governance Scorecard 2018-19

		Descriptor	Measurement Reason	Green	Amber	Red	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
ACTIVITY	Women Delivered	Total no. of women giving birth at QEH	Local monitoring		No Target		191	174	186	198	175	195	173	164
	Babies Born	Total no. of babies born at QEH	Local monitoring		No Target		195	177	189	200	176	196	175	166
	Live Births	Total no. of live babies born at QEH	Local monitoring		No Target		194	176	189	199	174	194	175	166
	% Home Births	% of women giving birth at home	Local monitoring	>=2%	Between	<1%	1.05%	0.57%	2.69%	3.03%	1.71%	2.05%	1.73%	0.61%
	BBAs	Babies born before the arrival of a professional	Local monitoring	0	Between	>=2	3	1	3	4	1	3	3	2
	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	1 / 0.5%	1 / 0.6%	0 / 0.0%	1 / 0.5%	0 / 0.0%	2 / 1.0%	0 / 0.0%	0 / 0.0%
	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	0	0	0	0	1	1	0	2
	Twins	No. babies - twins	Local monitoring		No Benchmark		4	3	3	2	1	1	2	2
	Triplets	No. of babies - triplets	Local monitoring		No Benchmark		0	0	0	0	0	0	0	0
	Transfers out	No. of transfers out of QEH Maternity unit.	local monitoring		No Benchmark		0	0	0	0	0	0	1	0
MODE	% Women Delivered on MLBU	Women who have given birth in Waterlily	Local monitoring	>=20%	Between	<15%	17.28%	17.82%	15.59%	14.65%	17.71%	11.28%	16.76%	17.07%
	% Women delivered on CDS	Women who have given birth on Delivery Suite	Local monitoring	<75%	Between	>85%	79.58%	80.46%	80.65%	80.81%	79.43%	85.13%	79.77%	81.71%
	% Normal Births	Spontaneous vaginal births	Benchmark against national rate 2013/14 = 60.9 %	>63%	Between	<52%	62.83%	62.64%	59.14%	64.14%	64.00%	51.28%	65.32%	62.80%
	% Instrumental Deliveries	Combined rate: Forceps + Ventouse	Benchmark against national rate 2013/14 = 12.9 %	5% - 12%	12.1-19.9%	<5% or >20%	5.76%	9.20%	5.38%	4.04%	8.57%	9.23%	6.36%	7.93%
	% Vaginal Breech Births				No Benchmark		0.00%	0.57%	0.00%	0.51%	0.00%	0.00%	0.00%	0.00%
	% Elective LSCS	Women having planned CS	Local monitoring	<10%	Between	>12%	11.52%	5.17%	9.14%	15.66%	10.86%	16.41%	12.72%	12.80%
	% Emergency LSCS	Women having an emergency CS	Local monitoring	<15%	Between	>16%	20.42%	24.71%	27.96%	17.17%	16.00%	23.59%	16.76%	17.68%
	% Total CS	Total CS performed: Elective +Emergency	Benchmark against national rate 2013/14 = 26.2 %	<=25%	Between	>=28%	31.94%	29.89%	37.10%	32.83%	26.86%	40.00%	29.48%	30.49%
	% Induction rates	Women who have their labour induced (denominator = total women minus EISCS)		<18%	Between	>24%	28.27%	31.61%	26.34%	33.33%	41.14%	31.28%	36.42%	30.49%
ACTIVITY: Antenatal and Postnatal Care	% Bookings < 12 weeks 6 days	Women who have their first booking appt by 12+6	KPI	>=90%	Between	<=85%	85.92%	88.39%	90.20%	89.64%	85.78%	92.06%	83.57%	89.78%
	Day Assement Unit	No. of women seen on DAU @ NCH	Local monitoring		No Benchmark		120	105	132	115	127	140	137	49
		Closure of DAU -hours @ NCH	Local monitoring		No Benchmark		0	8	6	0	18	0	12	0
		% women in DAU seen within 4 hrs @ NCH	Local monitoring	>=95%	Between	<=90%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
		No. of women seen on DAU @ QEHKL	Local monitoring		No Benchmark		568	462	469	542	480	426	472	359
		Closure of DAU -hours @ QEHKL	Local monitoring		No Benchmark		0	24	10	0	12	24	8	12
		% women in DAU seen within 4 hrs @ QEHKL	Local monitoring	>=95%	Between	<=90%	99.12%	99.13%	100.00%	98.71%	98.54%	97.18%	98.94%	99.72%
	% Breastfeeding	Breastfeeding/ breast milk initiated, attempted or achieved	KPI	>=70%	Between	<65%	71.65%	71.59%	72.58%	67.84%	76.44%	75.77%	76.00%	70.48%
	% Breastfeeding	% breast feeding on discharge from hospital	KPI	>=70%	Between	<65%	50.00%	59.04%	59.55%	61.68%	55.42%	66.98%	60.00%	61.04%
	% Breastfeeding	%women breast feeding at transfer to Health Visitor	Local monitoring		No Benchmark		42.55%	35.62%	44.00%	54.17%	49.47%	49.07%	57.89%	45.07%
	% of women who stopped smoking at delivery	Women who stopped smoking by the time of delivery	Local monitoring		No Benchmark		13.56%	20.34%	14.00%	1.96%	15.38%	17.65%	19.51%	12.50%
	Readmisions onto Castleacre Ward <28 days	Number of avoidable maternal readmission up to 28 days post birth	Local monitoring	<=4	Between	>=7	0	0	0	0	0	1	0	0
GOVERNANCE	Risk Management	No of SUIs	Local monitoring	0		>=1	1	0	2	4	1	1	1	0
		Total number of reported clinical incidents	Local monitoring		No Benchmark		68	68	64	120	92	111	84	97
		TOTAL number of adverse staffing incidents reported	Local monitoring		No Benchmark		6	2	6	9	9	9	8	5
	Operational Targets	No. times CDS closed	Local monitoring	0	1	>=2	0	0	0	1	0	0	0	0
		Total hours CDS closed	Local monitoring		No Benchmark		0	0	0	43	0	0	0	0
		Suspension of HBS hrs	Local monitoring	0	1	>=2	0	0	0	0	0	0	0	12
		Suspension of HBS Occassions	Local monitoring	0	1	>=2	0	0	0	0	0	0	0	1

Activity
164 women delivered – 9 less from last month.
166 babies born – 2 sets of twins.

Mode
Home birth 0.61% down. MLBU 17.07% steadily increasing. 2 BBAS. 1 of an unknown gestation but unregisterable. 1 to be investigated. Induction of Labour 30.49%. Total CS rate 30.49% up from 29.48%. Elective CS 12.80% marginal increase. Emergency CS 17.68% increase. Neonatal deaths at 21 weeks both born with heartbeats and subsequently died.

Activity: Antenatal and Postnatal Care
89.78% booked before 12+6 weeks requested that the numbers are broken down so we can understand how we are down on figures as the women book their own appointments as we need to understand whether the women are booking late or whether the delay is because we have not got the capacity to book before 12+6.

Governance
0 SIs declared.
97 incidents reported in November.
Homebirth service closed once for a 12 hour period – need to unpick as to the reason.

Page Owner: Bharat Patel

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

			Descriptor	Measurement Reason	Green	Amber	Red	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
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%	7.04%	7.22%	5.91%	1.01%	9.71%	2.56%	2.89%	4.27%
			PPH >2000ml	Local monitoring	<=1%	Between	>=2.5	1.01%	0.56%	0.54%	0.51%	1.14%	2.05%	1.16%	1.22%
			% of women sustaining 3rd & 4th degree tears (no/total minus Elective CS)	Local monitoring	<=3%	Between	>=5%	2.51%	1.75%	2.15%	3.54%	1.14%	1.54%	2.89%	3.05%
			No. of women sustaining 3rd & 4th degree tears (no/total minus Elective CS) - **3a**	Local monitoring	<=4		>=5	4	1	2	5	0	2	3	2
			No. of women sustaining 3rd & 4th degree tears (no/total minus Elective CS) - **3b**	Local monitoring	<=2		>=3	1	2	2	1	2	1	2	0
			No. of women sustaining 3rd & 4th degree tears (no/total minus Elective CS) - **3c**	Local monitoring	0		>=1	0	0	0	0	0	0	0	2
			No. of women sustaining 3rd & 4th degree tears (no/total- Elective CS) - **4**	Local monitoring	0		>=1	0	0	1	1	0	0	0	1
			Blood transfusions > 4 units	Local monitoring	No Benchmark			0	0	0	0	0	0	0	0
			Postpartum hysterectomies	Local monitoring	0	1	>1	0	0	0	0	0	0	0	0
			ITU /HDU admissions	Local monitoring	0	1	>1	0	0	0	0	0	0	0	0
			Maternal Deaths	Local monitoring	0		>0	0	0	0	0	0	0	0	0
		NICU Admissions Castleacre	**Avoidable** Term Admissions to NICU from CDS	Local monitoring	No Benchmark			0	0	0	0	1	2	3	0
			Avoidable Term Admissions to NICU from Castleacre	Local monitoring	No Benchmark			0	0	0	0	3	1	1	0
			No. of babies with avoidable readmission within < 28 days old	Local monitoring	<=2	3-5	>=6	0	0	0	0	0	1	1	0
WORKFORCE		1:1 Care MLBU	1:1 care in labour achieved on MLBU	Local monitoring	>=95%	90-94	<=89%	100.00%	100.00%	100.00%	94.87%	96.77%	100.00%	100.00%	100.00%
		1:1 Care CDS	1:1 care in labour achieved on CDS	Local monitoring	>=95%	90-94	<=89%	87.60%	93.13%	93.75%	82.50%	74.31%	81.93%	79.71%	96.99%
		On Call Midwife	No. of hrs On call midwife called to work in Unit	Local monitoring	No Benchmark			58	46	32	25	0	0	143	75
		On Call Midwife	No. of occassions On call midwife called to work in Unit	Local monitoring	No Benchmark			7	5	4	2	0	0	12	6
PATENT FEEDBACK		Compliments	Total midwifery Compliments received in month	Local monitoring				9	53	6	35	6	10	2	8
		Complaints	Total Midwifery complaints received in month	Local monitoring				1	0	3	7	4	4	1	2
		Response Rate	Antenatal	Patient Experience Team	>=15%		<15%	37.26%	39.32%	39.37%	44.70%	31.10%	19.89%	21.51%	18.69%
		Likely to recommend	Antenatal	Patient Experience Team	>=95%	Between	<94%	96.20%	100.00%	98.85%	93.81%	100.00%	97.30%	97.50%	94.59%
		Response Rate	Birth / Labour	Patient Experience Team	>=15%		<15%	20.32%	26.74%	29.51%	21.24%	14.71%	11.58%	22.94%	22.62%
		Likely to recommend	Birth / Labour	Patient Experience Team	>=95%	Between	<94%	92.11%	95.65%	100.00%	95.12%	100.00%	100.00%	100.00%	94.74%
		Response Rate	Postnatal Castleacre Ward	Patient Experience Team	>=15%		<15%	28.57%	38.06%	34.64%	38.61%	23.81%	24.69%	28.99%	32.62%
		Likely to recommend	Postnatal Castleacre Ward	Patient Experience Team	>=95%	Between	<94%	95.45%	98.04%	100.00%	96.72%	97.14%	97.50%	97.50%	97.83%
		Response Rate	Community Postnatal	Patient Experience Team	>=15%		<15%								
		Likely to recommend	Community Postnatal	Patient Experience Team	>=95%	Between	<94%	98.11%	98.00%	100.00%	100.00%	100.00%	100.00%	97.22%	100.00%

Maternal & Perinatal Statistics

No current data regarding admissions to NICU and baby readmissions less than 28 days.
1:1 care MLBU 100%.
1:1 care CDS 96.99%, huge improvement, work currently being undertaken in the promotion of the definition and the importance of documentation.

Workforce

5 adverse staffing incidents reported.

Patient Feedback

FFT response rate shows a reduction, staff reminded to push for feedback.
8 Compliments. Significant improvement
2 Complaints. 1 more than last month, but a significant drop from July.

Page Owner: Bharat Patel

Paediatric Clinical Performance & Governance Scorecard 2018-19

		DESCRIPTOR	MEASURMENT	Green	Red	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
ACTIVITY	No. of PAU attendances	Direct referrals from GP's, A&E and other agencies	East of England 5 beds	<130	>=131	180	183	157	169	147	161	207	303
	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	15	6	7	7	14	17	12	9
	No. of nursing assessment breaches	Length of time to be seen by nursing staff (within 15 mins)	Not seen within 15 mins	0	>=1	4 / 2.2%	8 / 4.4%	4 / 2.5%	13 / 7.7%	8 / 5.4%	18 / 11.2%	17 / 8.2%	35 / 11.6%
	No. of medical assessment breaches	Seen by senior clinician	Within 4 hrs	0	>=1	19 / 10.6%	25 / 13.7%	22 / 14.0%	19 / 11.2%	8 / 5.4%	19 / 11.8%	2 / 1.0%	29 / 9.6%
	No. of 6 hour breaches	Length of stay on PAU	Any children with a stay on PAU over 6 hrs.	0	>=1	12 / 6.7%	10 / 5.5%	10 / 6.4%	14 / 8.3%	10 / 6.8%	13 / 8.1%	12 / 5.8%	29 / 9.6%
	No. of admissions from PAU	% of the total attendances to PAU who are admitted to Rudham	Internal	<=40%	>=70%	52 / 28.9%	64 / 35.0%	54 / 34.4%	55 / 32.5%	51 / 34.7%	52 / 32.3%	62 / 30.0%	98 / 32.3%
	HDU days	No. of HDU days in month	Internal	<=15	>= 30	7.0	23.0	1.5	9.0	6.5	5.0	9.5	10.5
	HDU patients	No. of HDU patients in month	Internal	<=3	>= 4	5	13	2	5	2	8	10	8
	Ward Attenders	Ward Attenders No. of children post discharge review	Average number of patients from 2016 = 61	<=61	>=62	108	118	92	117	97	80	72	83
	Medical and Surgical outliers	Patients aged 16 years and over that are not under a Paediatrician	Internal	0	>=1	0	3	0	1	1	1	0	0
	Medical Investigations	No. of children attending for diagnostic investigations. Stay on ward was greater than 4 hrs.	Average number of patients from 2016 = 48	<=48	>=49	15	17	18	34	32	24	23	28
	Elective surgical admissions	No. of children attending ward for elective surgery. Stay on ward was greater than 4hrs	Average number of patients from 2016 = 48	<=48	>=49	21	7	15	22	31	25	35	15
	Tier 4 transfers	No. of children awaiting transfer to a tier 4 bed	Internal	Local monitoring	Local monitoring	0	0	0	0	2	0	1	1
	Days Wait	No. of days waited by children	Internal	Local monitoring	Local monitoring	0	0	0	0	15	0	5	5
WORKFORCE	Transfers out with an escort	No. of transfers out requiring a nurse escort	Internal	<=1	>=2	1	3	2	0	0	1	0	1
	No. of 7hr periods escalation beds open	5 escalation beds on Rudham ward	Rudham has more than 18 inpatients	0	>=1	0	0	N/A	N/A				
	Long shift 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	20	41	42	41	61	51	38	0
CLINICAL INDICATORS	No. of SUI reported to CCG	Serious Incident and report process actioned	Internal	0	>=1	0	0	0	0	0	0	0	0
	No. 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	0	0	0	0	2	0	0	0
	Delayed discharges	No. of patients medically fit who have delayed discharge.	Internal	0	>=1	0	0	0	0	2	0	0	0
		No. of days medically fit patients who delayed discharge.	Internal	0	>=1	0	0	0	0	15	0	0	0
	Other Clinical Incidents	All other on ward incidents	All incidents to exclude staffing incidents	0	>=1	17	19	11	19	22	13	21	28
FRIENDS & FAMILY	Patient Feedback	Compliments	Total Rudham Compliments received in month	Local monitoring	Local monitoring	6	13	10	3	6	15	5	2
	Patient Feedback	Complaints	Total Rudham complaints received in month	Local monitoring	Local monitoring	0	1	0	1	1	1	0	0
	Patient Feedback	Response Rate	Rudham Ward	>=15%	<15%	22.53%	7.80%	33.75%	16.16%	30.43%	25.09%	21.89%	19.57%
	Patient Feedback	Likely to recommend	Rudham Ward	>=95%	<94%	82.46%	95.65%	88.89%	90.57%	94.51%	92.65%	95.38%	92.06%

Activity

PAU

Total number patients seen: 303 PATIENTS + 32 PPAU, (18 sat, 14 sun,). Total Patient numbers discharged (admissions avoided): 201 (66.3%). Total numbers of patients admitted to Rudham ward: 98 (32.32%). Total number of ward attenders: 58.

RECORDED REASONS FOR BREECHES/ DELAYs

High patient volume and acuity patient causing delays (5th,15th,16th,19th,14th,25th,26th,30th). Delay in discharge, awaiting blood results prior to senior review 16th. 26th. Delay in discharge awaiting USS 2nd, 14th. Delay in discharge awaiting surgical review 15th. Delay in discharge awaiting orthopaedic review 1st, 15th. Delay in senior review awaiting space to see 19th. Delay in discharge awaiting OFC completion 19th, 26th. Delay in discharge awaiting observation of feeds 25th. Delay in discharge awaiting xray and review with results 24th x 2, 5th, 12th. Delay in nursing and first review breeches due to ANP clerking and discharging patients, No NA, NO SHO until 2pm, No ward clerk, And three new registrars helping who were unable to complete discharge letters and unfamiliar with processes 30th.

Rudham

Rudham ward attenders = 25. Rudham's ward attenders as per table below

MONTH	BLOODS	DRESSINGS	IVAB'S/IM INJ	CF REVIEWS	ONCOLOGY	REVIEWS	TOTAL
NOVEMBER	0	2	8	4	4	7	25

CAMHS patients = 4. In-patient with Eating disorder – 7 days. Patient requiring Tier 4 bed - 5 days.

Workforce

Paediatric Assessment unit

Below Registrar establishment, requiring cross covering ward and PAU x9 days. 5th,6th,7th,14th,16th,22nd,29th,30th. Plus 7 locum shifts:12th,13th,14th,15th,23rd,26th,27th,28th. Below ward clerk establishment x 12 days. 1st,2nd,6th,7th,8th,9th,14th,15th,16th,19th,23rd,30th. Below nursing establishment x 10 days. 1st,6th,7th,12th,14th,16th,22nd,27th,26th,30th. High volume of patients (exceeding 12 patients) x 14 days. 5th,12th,13th,15th,19th,20th,21st,22nd,23rd,26th,27th,28th,29th,30th.

Rudham

Recommended staffing levels not met are now identified when the following staffing levels are not met. Day shift – 5 registered staff. Night shift – 4 registered staff. Month of November 22 shifts had reduction in staffing levels. (12 day shifts & 10 Night shifts) - Covered with internal rotation, bank and HCAs where required.

Governance

No SI's declared in November. Clinical incidents = 32. Unavoidable under 28 days = 0.

Patient Feedback

Friends and family recommend rate 92.06% and response rate 19.57%. Using a combination of electronic & paper responses.

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NICU Clinical Performance & Governance Scorecard 2018-19

		Descriptor	Measurement	Green	Red	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov
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	17	15	19	20	6	19	10	10
	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	1	0	0	0	1	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	7	5	3	0	14	8	4	3
	Admissions to NICU from Home	No. of infants admitted from home admitted due to level of care required	Internal	Internal	Internal	1	0	1	2	2	4	2	2
	Admissions to NICU from other unit	No. of infants admitted from other units admitted due to level of care required	Internal	Internal	Internal	1	1	2	2	6	1	0	2
	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	0	0	0	0	0	0	0
	Total NICU Admissions	No. / Percentage of live births admitted to NICU	10% of births	<11% of birth rate	>15% of birth rate	29 / 14.8%	22 / 12.4%	25 / 13.2%	24 / 12.0%	28 / 15.9%	33 / 16.8%	17 / 9.7%	19 / 11.4%
	NICU TC Admissions	No. / Percentage of live births on unit in month	10% of births	<10%	>15%	26 / 13.3%	24 / 13.6%	27 / 14.3%	22 / 11.0%	17 / 9.7%	0.24 / 12.2%	27 / 15.4%	20 / 12.0%
	ITU days	Available number from funded cot = 30	30	<=31	>90	17	9	5	27	2	12	18	3
	No of occasions >1 ITU infants on unit	No of times above funded ITU cots = 1	0	0	>=1	1	0	0	6	0	2	2	0
	48 hrs ventilated	No of babies ventilated for more that 48 hrs that have not been discussed with Tert centre	0	0	>=1	0	0	0	0	0	0	1	0
	HDU days	Available number from funded cot = 60	Average for 2016 = 52	<=60	>=61	85	56	32	35	33	37	36	39
	No of occasions>2 HDU infants on unit	No of times above funded HDU cots = 2	0	0	>=2	18	8	0	2	0	4	1	2
	SC days	Available number from funded cot = 270	Average for 2016 =299	<270	>300	222	217	289	256	257	232	232	188
	Normal care days	Number of babies on NICU receiving normal care	0	0	>=1	69	38	68	50	56	42	55	45
	No. of babies over 44 weeks of age	No. of babies aged over 44 weeks	0	0	>=1	2	0	0	0	2	0	1	0
	Cot occupancy	No. of occasions in month	Over 80% cot occupancy	0	>1	14	0	8	2	3	0	2	0
		No. of occasions in month	Over 100% cot occupancy	0	>1	1	0	0	2	2	0	0	0
	Number of avoidable admissions > 37 weeks	No. of admissions that may have been avoided had appropriate prior intervention been in place.	0	0	>=1	0	0	0	2	4	5	4	0
	Number of babies receiving care from the NCT	No. of babies having care in the community	Internal	Internal	Internal	23	24	30	30	21	25	17	17
	Number of NCT visits	No. of visits carried out by NCT each month	Internal	Internal	Internal	64	76	66	54	63	69	42	34
	Ward attenders	No. of babies attending on ward NICU	Internal	Internal	Internal	16	6	8	12	18	17	3	10
	In uter transfers accepted NICU		Internal	Internal	Internal	0	0	1	0	3	0	2	2
	In uter transfers refused NICU		Internal	Internal	Internal	1	3	3	0	0	4	1	0
	Transfers out	>1 if due to capacity issues	Internal	0	>=1	1	0	0	0	3	0	0	0
	Unit escalation (in hours)	No of hours NICU on divert to network	Internal	0	>=1	72	0	90	134	143	0	39	0
		No of hours NICU on divert internal	Internal	0	>=1	36	0	57	98	143	0	13	0
	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	21	0	0	3	5	0	5	1

Activity

There were 3 intensive care days & 39 HDU days with 2 days having 3 patients.

There were 188 special care days & 45 normal care days; the normal care days were predominantly where parents were rooming in to prepare for discharge home; 21 of these days were on NICU & 24 were on Transitional care.

17 babies were admitted to NICU of which 11 were 37 weeks or more
2 from MLBU – 1 was unavoidable & 1 has yet to be reviewed.
2 were from CDS - not yet reviewed.
3 were from the postnatal ward & were unavoidable.
2 postnatal re admission's from the community& were unavoidable
2 were ex-utero transfers in from RAF Lakenheath
Currently all that have been reviewed were unavoidable, the dashboard reflects this total and can be updated if this changes once all cases have been reviewed.

There was 2 in utero transfer requests – NICU were able to accept both but CDS refused 1 due to workload.

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

		Descriptor	Measurement	Green	Red	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov
MORTALITY	Unexpected Neonatal morbidity	Hypoglycaemia	Internal Guidance and standards not followed	1	>=3	0	1	0	0	0	0	0	0
		Pre -Term Hypothermia less than 32 weeks (NNAP)	NNAP standard not achieved	0	>=1	0	1	0	0	0	0	1	0
		Accidental extubation	NEVER EVENT	0	>=1	0	1	0	0	0	0	1	0
		Infection (Positive culture and CSF) (NNAP)	Laboratory results	1	>=3	0	0	0	0	0	0	0	0
		Pneumothorax	Incidents each month	1	>=3	0	1	0	0	0	0	0	1
GOVERNANCE	Risk management	No of SUIs	Incidents each month	0	>=1	0	0	0	0	0	0	0	0
		Total No of reported incidents	Incidents each month	Internal	Internal	34	27	11	21	28	45	23	3
		Staffing Incidents	Staffing level Incidents each month	0	>=1	3	0	0	2	1	1	2	0
CLINICAL ACTIVITY	Less than 33 weeks babies receiving breast milk on discharge (32+6 DAYS)	NNAP standard	NNAP	>=58%	<58%		0.0%	33.3%	Not Eligible	37.5%	Not Eligible	Not Eligible	100.0%
		Internal	Internal	Internal	Internal	1 out of 2	0 out of 1	1 out of 3	0 out of 0	3 out of 8	0 out of 0	0 out of 0	1 out of 1
	ROP Screening prior to discharge	NNAP standard	NNAP	100%	<100%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	
	Parents seen within 24hrs of admission	NNAP standard	NNAP	>=88%	<88%	96.4%	93.8%	85.0%	89.5%	97.8%	100.0%	93.3%	90.0%
	Delayed Discharge	No of babies delayed discharged	Local / National /Internal	0	>=1	1	0	0	0	0	0	0	0
PATIENT FEEDBACK	NICU Likely to recommend (Inpatient)	Percentage of patients who recommend the service	Internal	>=95%	<94%	85.7%	100.0%	93.3%	100.0%	100.0%	90.9%	90.0%	100.0%
	NICU FFT response rate (Inpatient)	Percentage of eligible patients who responded	National	>=30%	<30%	466.7%	325.0%	250.0%	57.1%	100.0%	183.3%	250.0%	225.0%
	Patient Experience	Compliments				1	6	3	10	11	7	9	9
	Patient Experience	Complaints				0	0	0	3	0	1	0	1

Mortality

One baby had a pneumothorax which resolved with conservative management.

Governance

There were 3 clinical incidents reported. (Midwifery are now reporting all term admissions to NICU as part of the ATAIN project).

Clinical Activity

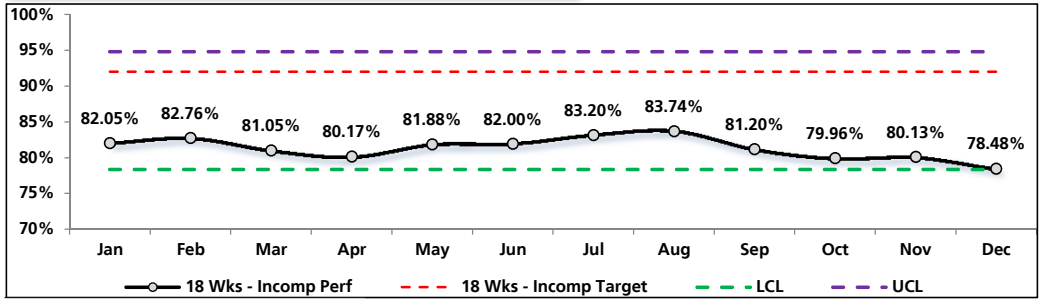
9/10 of parents were seen by a senior staff member within 24 hours of admission.

Patient Feedback

There were 9 compliments & I complaint. The FFT response rate was 225% with 100% recommendation.

Page Owner: Bharat Patel *Narrative: Carley Gibbens*

18 Weeks Referral To Treatment



RTT Backlog and still waiting volumes

DOH Group	Nov-18 Total Incomplete	Nov-18 > 18 Weeks	Nov-18 % Incomplete	Dec-18 Total Incomplete	Dec-18 > 18 Weeks	Dec-18 % Incomplete	Backlog Variance	>18Wk Variance
General Surgery	954	199	79.14%	970	215	77.84%	16	16
Urology	906	196	78.37%	884	191	78.39%	-22	-5
Trauma & Orthopaedics	1671	434	74.03%	1709	515	69.87%	38	81
Ear, Nose & Throat (ENT)	1217	185	84.80%	1154	208	81.98%	-63	23
Ophthalmology	1944	348	82.10%	1912	344	82.01%	-32	-4
Oral Surgery	1243	81	93.48%	1331	185	86.10%	88	104
Plastic Surgery	108	14	87.04%	124	17	86.29%	16	3
Cardiothoracic Surgery	1	0	100.00%	4	0	100.00%	3	0
General Medicine	232	33	85.78%	244	32	86.89%	12	-1
Gastroenterology	620	80	87.10%	656	93	85.82%	36	13
Cardiology	731	104	85.77%	685	82	88.03%	-46	-22
Dermatology	964	55	94.29%	895	65	92.74%	-69	10
Neurology	937	489	47.81%	908	495	45.48%	-29	6
Rheumatology	532	162	69.55%	555	176	68.29%	23	14
Geriatric Medicine	73	40	45.21%	69	23	66.67%	-4	-17
Gynaecology	982	208	78.82%	1048	236	77.48%	66	28
other	2392	453	81.06%	2341	456	80.52%	-51	3
Total	15507	3081	80.13%	15489	3333	78.48%	-18	252

Key Points / Operational actions

There has been the usual expected dip in RTT performance in December as a result of the Christmas period. There has been a noticeable deterioration in some surgical specialties (orthopaedics, ENT, oral surgery), when at that time, only urgent and cancer patients were being treated. These specialties have a high proportion of routine patients and therefore are affected more by this. There is also a specific issue with oral surgery referrals in that the trust is no longer commissioned to undertake tier 2 work, but as the new provider is not yet in a position to take these referrals they continue to come to QEH.

During December the validation of the admitted patient waiting list was completed, both inpatients and day case patients. During this process patients waiting over 18 weeks for treatment were also asked whether they would be prepared to have their treatment undertaken at another provider if it could be done sooner.

Planned actions for January 19 include:

- Opening of the Surgical Extended Recovery Unit – will accommodate both urgent and routine patients for an overnight stay to a maximum of 12 per night.
- Contract agreed and signed with the Fitzwilliam Hospital in Peterborough, notes of the patients who have expressed a wish to be considered for treatment elsewhere have been transferred and reviewed and patients booked from Jan 19.
- Medinet engaged to deliver weekend outpatient capacity for ophthalmology and neurology. Clinics booked to commence 12/13th Jan 19 and run for most weekends. Ophthalmology patients will be follow up backlog patients but this will release weekday capacity to undertake more new outpatient work.
- Commissioners to be contacted regarding oral surgery referrals to ensure only appropriate referrals received.
- A RAP to be agreed with CCG to ensure that the trust meets the planning guidance of waiting list size by the end of March 19.
- Weekly monitoring to continue and a new COO escalation process to be implemented for specialties of concern.

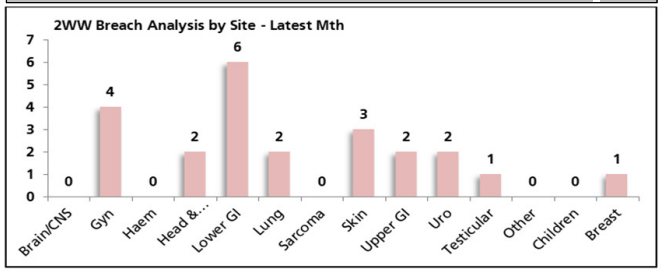
18 Weeks RTT Incomplete Performance Trajectory

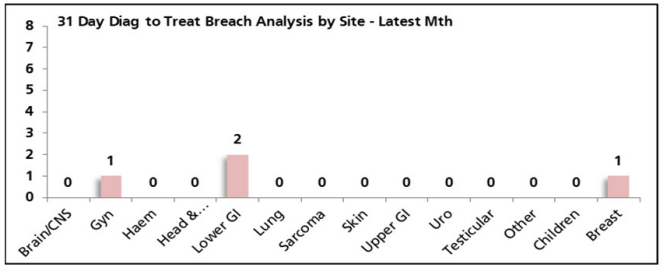
2018-19	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Referral to treatment incompletes - >18 weeks	2501	2340	2099	1958	1845	1697	1566	1414	1304	1195	1033	939
Referral to treatment incompletes - Total patients	12929	12895	12762	12642	12581	12522	12580	12574	12524	12488	12523	12486
Referral to treatment incompletes - Trajectory %	80.66%	81.85%	83.55%	84.51%	85.34%	86.45%	87.55%	88.75%	89.59%	90.43%	91.75%	92.48%
Actual performance	80.17%	81.88%	82.00%	83.20%	83.74%	81.20%	79.96%	80.13%	78.48%			

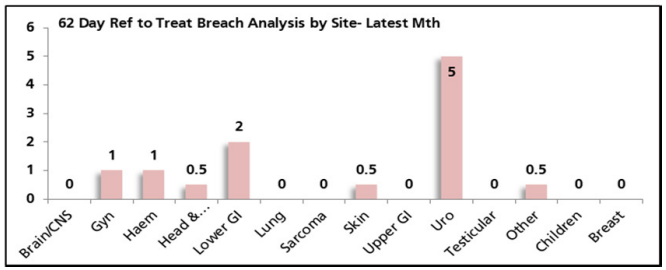
Page Owner: Jonathan Wade. *Narrative: Sarah Jones*

Cancer Waiting Times

KPI	2018 4	2018 5	2018 6	2018 7	2018 8	2018 9	2018 10	2018 11	YTD
Cancer-2ww	96.68%	96.83%	97.29%	96.04%	94.64%	93.20%	98.32%	97.30%	96.23%
31 Day Diag to Treat	99.02%	98.25%	97.50%	97.41%	97.41%	97.35%	97.66%	96.15%	97.63%
Cancer-62 Days RTT	72.80%	84.28%	89.73%	81.45%	80.42%	80.31%	85.94%	82.35%	82.39%
Cancer-2ww (Breast Symptomatic)	97.62%	97.33%	100.00%	100.00%	95.56%	98.46%	96.92%	100.00%	98.28%
Cancer - 31 Days Subsq Treatment - Surgery	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	92.86%	99.16%
Cancer - 31 Days Subsq - Drug Treatments	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	97.92%	98.04%	99.55%
Cancer Screening (62 Day)	100.00%	100.00%	100.00%	95.00%	93.33%	96.00%	100.00%	85.00%	96.61%







Key Points / Operational actions

- 62D standard missed in November, but achieved RAP trajectory
- Continued high referral numbers
- Demand and operational pressures continue, particularly in Gynae, Lower GI & Urology, with 8 out of the 10.5 breaches in those specialties
- Pathway transformation work has begun with Gynae
- Continued review of Imaging capacity to manage diagnostic demand

Change in performance in the last month

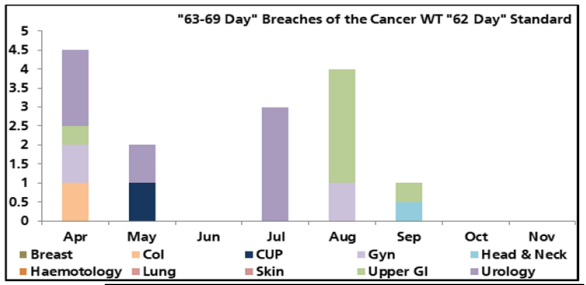
- 62D performance has decreased, but still achieved RAP trajectory
- Work continues for standard compliance from March

Planned actions for the forthcoming month

- Roll-out of Cancer Dashboard
- Radiology going paperless
- IST – development of Cancer Action plans for 3 key tumour sites

104+ Day Breaches by Site and Month for 2018/19

Site	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Grand Total
Colorectal		1		1	1	1		1					5
Gynaecology				1		1		1					3
Haematology	2					1							3
Head & Neck			1					1					2
Lung	2		2	1									5
Skin						1							1
Upper GI						1							1
Urology	1	3	1	3	1	1	2	3					15
Grand Total	5	4	4	6	2	6	2	6	0	0	0	0	35



104+ Day Breach Distribution by Site for 2018/19

Site	104	105	107	108	110	112	116	117	118	119	120	122	123	125	129	133	134	136	142	145	147	150	175	176	187	Grand Total
Colorectal		1							1	1					1	1										5
Gynaecology								1												1					1	3
Haematology															1		1						1			3
Head & Neck			1						1																	2
Lung	1				1		1									1			1							5
Skin																	1									1
Upper GI											1															1
Urology	1	1	1	1	1	2						2	1	1		1					1	1		1		15
Grand Total	2	2	2	1	2	2	1	1	2	1	1	2	1	1	2	3	1	1	1	1	1	1	1	1	1	35

Key Points / Operational actions (104 Day breaches)

Between 01/01/2018 and 15/01/2019 there have been a total of 37.5 patients that were treated after day 104.

22 of these were treated at the QEH, the rest were treated at tertiary centres.

Breach reports (Datix) have been completed on all patients. A Breach Review Panel is due to take place on 31 January.

Engagement is continuing with stakeholders. IST is offering on-going support with 3 key areas, prostate, colorectal and gynaecology.

Macmillan Transformation work also on-going working with teams on pathway work

Cancer Wait Times (62 Day Performance) Trajectory

	04/2018	05/2018	06/2018	07/2018	08/2018	09/2018	10/2018	11/2018	12/2018	01/2019	02/2019	03/2019
Cancer 62 days - > 62 days	18.5	16.5	11.5	10.5	10.5	9	9	10	8	8	8.5	9
Cancer 62 days - Total seen	62.5	75	64	71	74	65	64	67.5	57	54	58.5	64.5
Cancer 62 days - Trajectory%	70.40%	78.00%	82.03%	85.21%	85.81%	86.15%	85.94%	85.19%	85.96%	85.19%	85.47%	86.05%
Actual performance	72.80%	84.28%	89.73%	81.45%	80.42%	80.31%	85.94%	82.35%				

62 Day Cancer Performance Vs National Benchmark

		Monthly (signed off position) 2018/19							
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
QEH	Total	62.5	79.5	73	62	71.5	63.5	64	59.5
	Breaches	17	12.5	7.5	11.5	14	12.5	9	10.5
	%	72.80%	84.28%	89.73%	81.45%	80.42%	80.31%	85.94%	82.35%
National Benchmark	%	82.29%	81.10%	79.24%	78.19%	79.36%	78.25%	76.96%	

Boxes shaded in green denotes a pass of the national target of 85%
Boxes shaded in red denotes a fail of the national target of 85%

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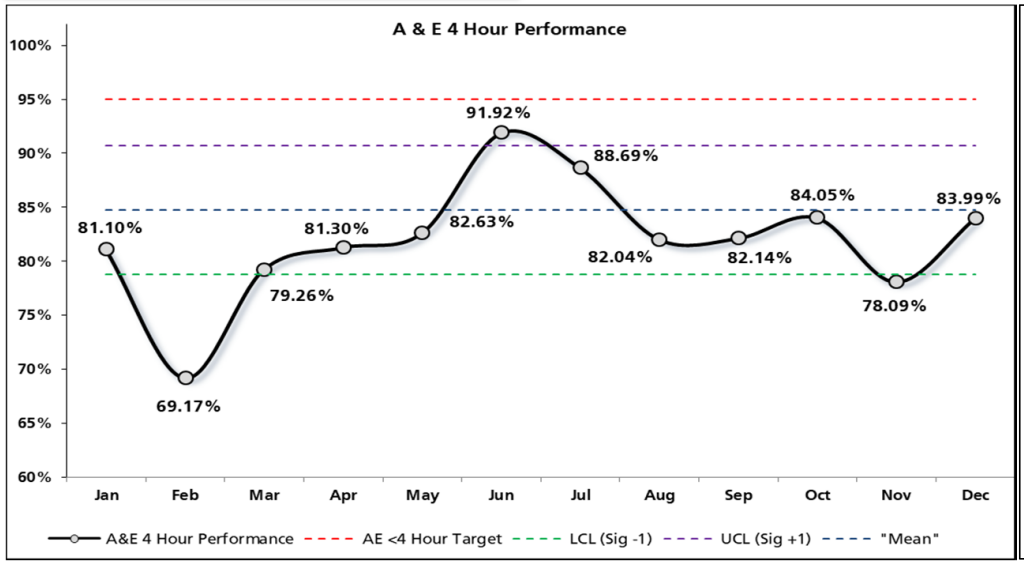
AE performance (Last 12 months)



Key Points / Operational actions

- Lack of capacity and flow through the department remains a challenge throughout the 24 hour period.
- Despite the increased bed capacity over the Christmas week there has still regularly been a large number of patients bedded in the Department from early morning – this creates safety issues with major patients in minor cubicles , a reduction in capacity and a knock on effect to be unable to off load ambulance arrivals with the inherent issues that causes for patient both in the Department and in the community.
- The effect of delays to off load on the clinical care/harm remains a concern. Plans are in place to review and monitor this with Datix incidents being completed for patients who have delayed off loads.

Change in performance in the last month

- There has been an improvement in overall Trust performance thanks primarily due to the increase in discharges over the Christmas period creating capacity.
- However there have been an increase in QIR's received by the Trust relating to delays to off load and possible harm for both those patients and patients awaiting collection in the community.

Planned actions for the forthcoming month

- Continue to work with the CCG and partners to develop and support ECIST projects particularly focussing on nurse streaming and the role of the GP in the Department.
- Continue the use of the Big Winter Room to identify issues and develop solutions.
- Support the implementation of the Assessment Zone and Acute Medical Unit as a new way of working.

A & E Performance Trajectory

2018-19	Y1 M01	Y1 M02	Y1 M03	Y1 M04	Y1 M05	Y1 M06	Y1 M07	Y1 M08	Y1 M09	Y1 M10	Y1 M11	Y1 M12
	04/2018	05/2018	06/2018	07/2018	08/2018	09/2018	10/2018	11/2018	12/2018	01/2019	02/2019	03/2019
Accident and Emergency - >4 hour wait	927	893	868	779	665	532	520	472	450	402	307	288
Accident and Emergency - Total Patients	5545	5765	5766	5603	5854	5362	5366	5185	5790	5760	4921	5946
Accident and Emergency - Trajectory %	83.28%	84.51%	84.95%	86.10%	88.64%	90.08%	90.31%	90.90%	92.23%	93.02%	93.76%	95.16%
Actual performance	81.29%	82.63%	91.92%	88.69%	82.04%	82.14%	84.05%	78.09%	83.99%			

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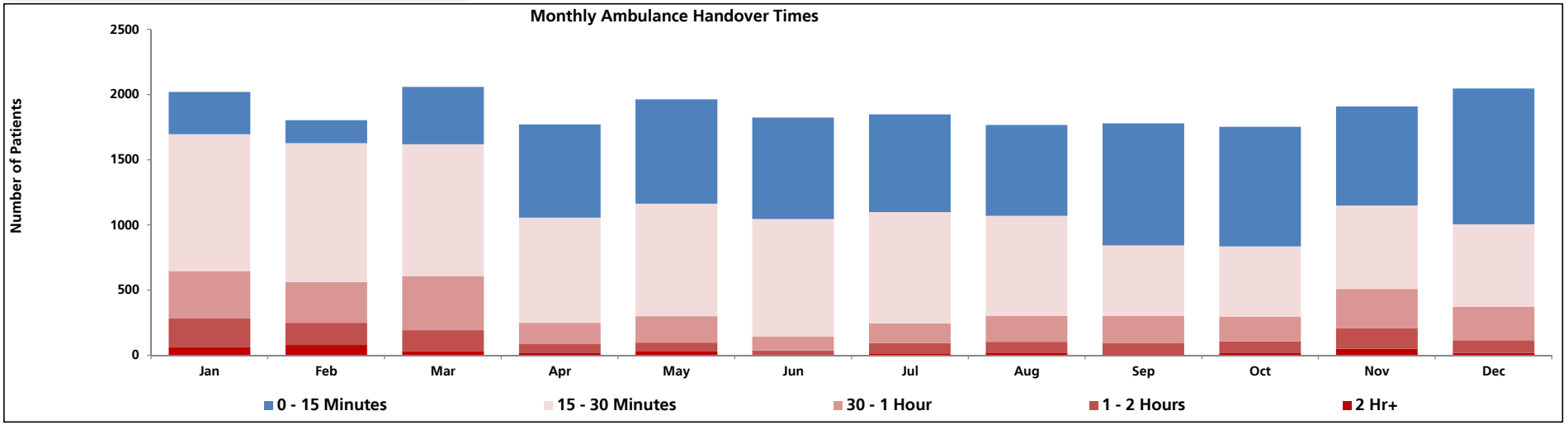
Ambulance Handovers



Key Points / Operational actions

- Ambulance handover delays remains the first identified trigger for poor flow out of the Emergency Department.
- There have been an increasing number of QIR's being received by the Trust from EEAST with regard to delays – in all cases investigated so far there has been no clinical harm to the patient resulting from the delay.
- Overcrowding in the entrance of ED remains a concern – this is being addressed by Matron with EEAST and QE personnel on a person by person format.

Change in performance in the last month

- There has been an incremental increase in the number of conveyances by ambulance to the Trust.
- In month there has been a notable improvement in handover times for under 15 minutes.
- There has also been a related decrease in the number of patients waiting over 1 hour to off load.

Planned actions for the forthcoming month

- Additional on site support from EEAST to assess handover process from both QE and EEAST perspective.
- All over 3 hour delays are now being logged as incidents on Datix system.
- Cohort support continues.
- Additional support from PSIT team has and can be utilised with discussion with EEAST.

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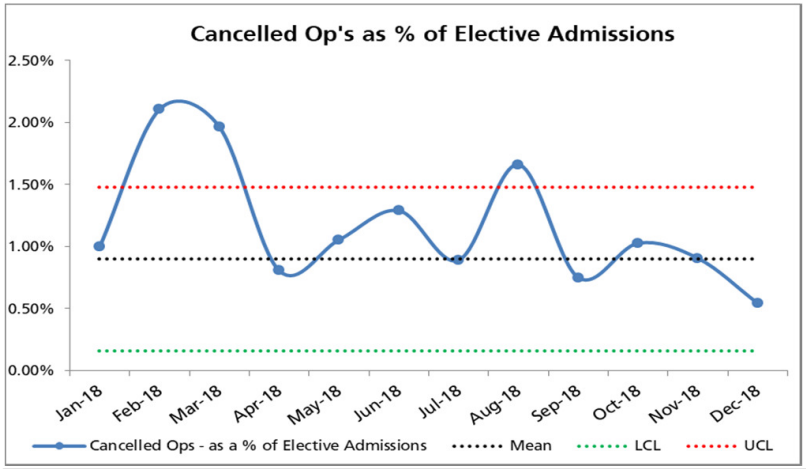
Cancelled Operations

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
No. of Ops cancelled at the "last minute"	38	70	66	29	42	49	36	60	26	41	37	17
Canc Ops - Not Re-adm within 28 days	8	6	26	9	4	11	2	2	7	2	0	2



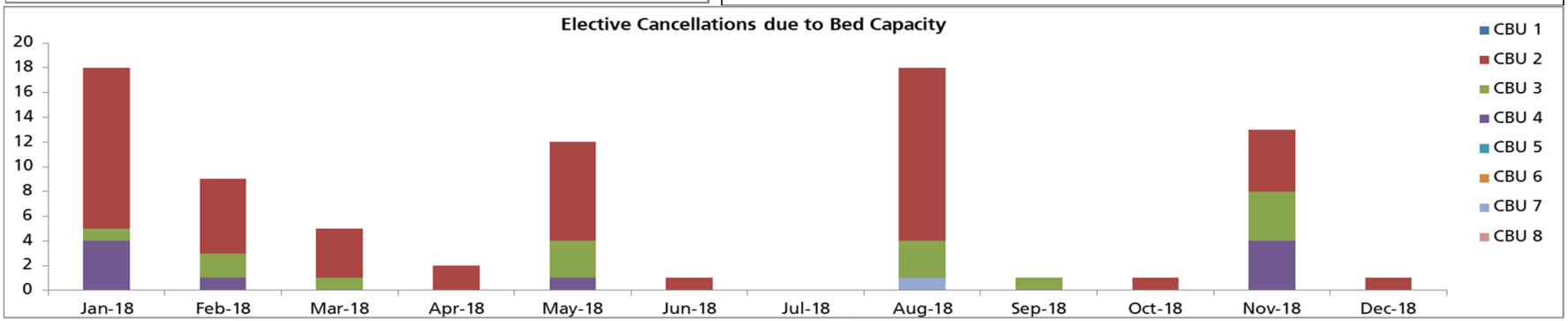
Key Points / Operational actions

Cancelled Ops as a % of elective admissions is the lowest it has been for the year.

Change in performance in the last month

Overall improvement against last month and a significant focus on ensuring patients are re-admitted within 28 days.

Planned actions for the forthcoming month



	CBU 1		CBU 2		CBU 3		CBU 4		Ops Division 1		CBU 5		CBU 6		CBU 7		CBU 8		Ops Division 2		Trust	
Cancellation Reasons	Last Mth	YTD	Last Mth	YTD	Last Mth	YTD	Last Mth	YTD	Last Mth	YTD	Last Mth	YTD	Last Mth	YTD	Last Mth	YTD	Last Mth	YTD	Last Mth	YTD	Last Mth	YTD
Administrative error	0	0	0	10	1	18	0	5	1	33	0	1	0	0	1	1	0	5	1	7	2	40
Drug Shortages	0	0	0	2	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	2
Equipment failure	0	0	3	3	0	0	0	0	3	3	0	0	0	0	0	0	0	0	0	0	3	3
Equipment not available	0	1	1	4	0	4	0	1	1	10	0	2	0	0	0	3	0	0	0	5	1	15
More urgent to do	0	0	0	5	0	23	0	2	0	30	0	0	0	0	0	0	0	0	0	0	0	30
No HDU/ITU Bed Available	0	0	0	7	0	0	0	0	0	7	0	0	0	0	0	0	0	0	0	0	0	7
No Ward Bed Available	0	0	1	25	0	11	0	5	1	41	0	0	0	0	0	1	0	0	0	1	1	42
Other	0	1	1	14	1	9	0	8	2	32	0	5	0	0	0	3	1	16	1	24	3	56
Out of time	0	4	0	29	0	18	0	11	0	62	0	0	0	0	0	0	0	0	0	0	0	62
Staff Shortages	0	0	1	26	2	29	0	9	3	64	0	0	0	0	1	2	0	0	1	2	4	66
Staff Sickness	0	0	0	2	2	9	0	0	2	11	1	1	0	0	0	0	0	0	1	1	3	12
Transport issues	0	0	0	0	0	2	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	2
Total	0	6	7	127	6	123	0	41	13	297	1	9	0	0	2	10	1	21	4	40	17	337

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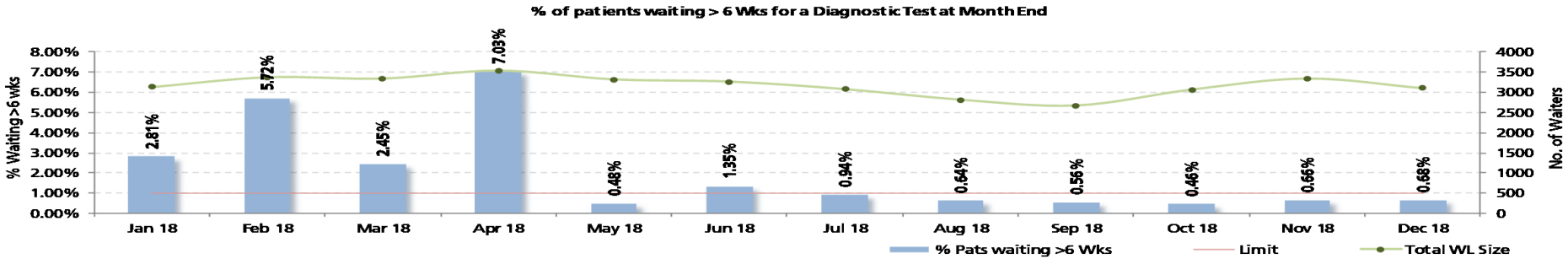
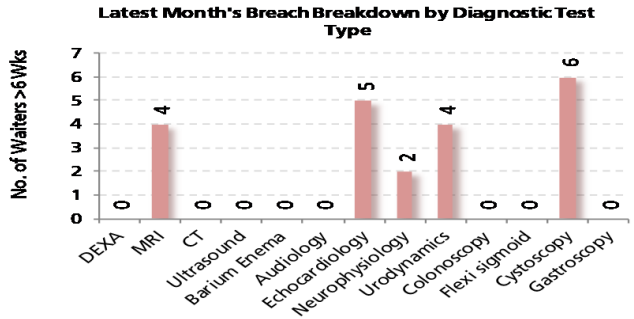
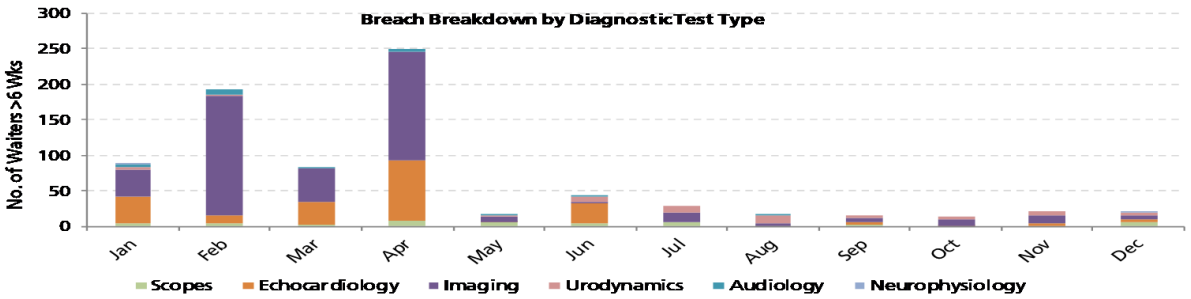
Diagnostic Waiting Times (% of Pat's Waiting >6 Wks)







Key Points / Operational actions

- Continued timely monitoring of diagnostic performance across all modalities
- Strong focus through each month on weekly monitoring capacity and demand
- Additional capacity and flexibility directed to diagnostics under pressure
- Emphasis on sufficient notice for patients to enable attendance and minimise cancellations/DNA's

Change in performance in the last month

Overall performance very similar to previous month;

- Imaging improved with fewer MRI breaches and none in Ultrasound
- 2 Neurophysiology breaches which is unusual – both breaches due to clarification of referrals from particular medical centre causing delays leading to breaches
- Urodynamics significant number of breaches reflective of demand and capacity issues

Planned actions for the forthcoming month

- Continued focus on close monitoring of performance and addressing issues as they arise
- Gynae Urodynamics under pressure in January – robust plan for delivery requested from team to address this

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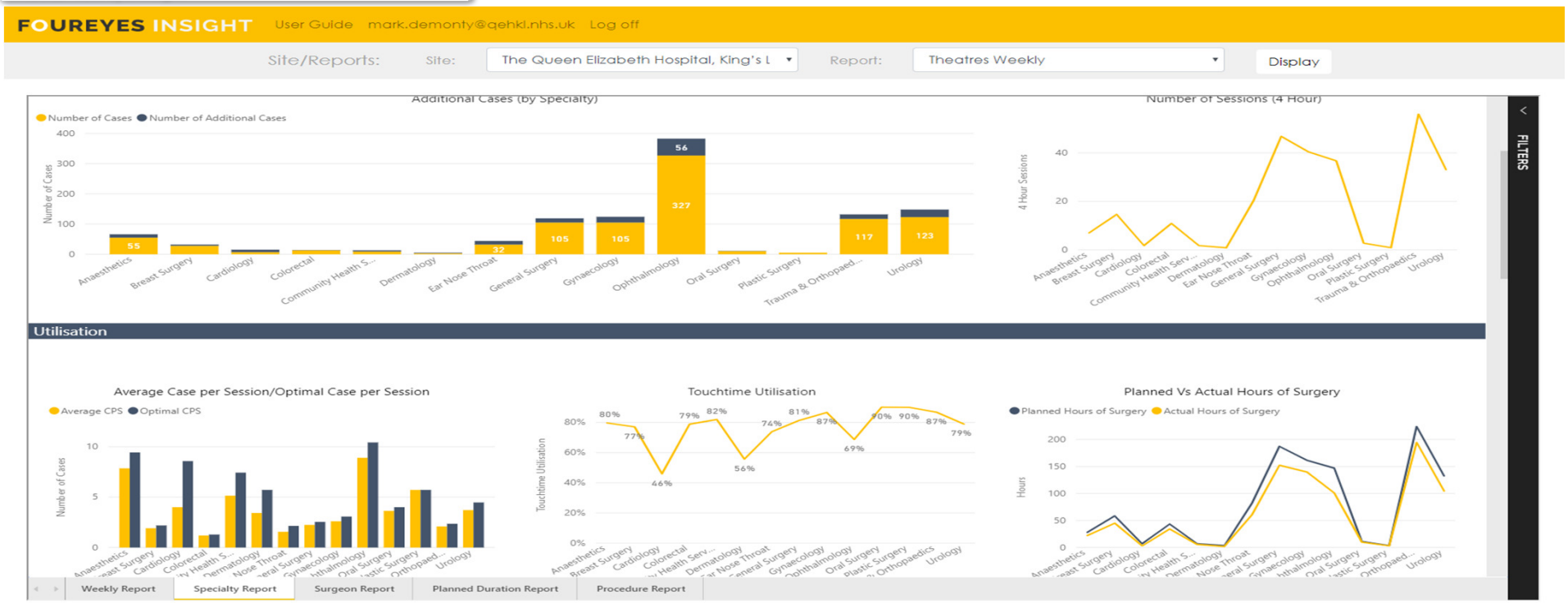
Theatres - Four Eyes Insight



Performance in the dashboard above represents activity within the previous month for both Main Theatres and Day Surgery combined

Key Points / Operational actions

On-going good theatre utilisation.
On-going work with ophthalmology as the data always shows opportunity for additional cases.

Change in performance in the last month

Positive reduction in the number of additional cases that could be added for urology.
Overall touch time remain stable.

Planned actions for the forthcoming month

Continue with theatre planning and capacity meeting.
Monitor the effect of the extended recovery unit and admissions unit to overall theatre productivity.

Page Owner: Bharat Patel *Narrative: Bharat Patel/Kate Jackman*

Stroke Performance													
Key Indicator Area	Key Indicator	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Primary Key Indicators	Stroke 90% of time on a Stroke Unit	A	C	E	D	C	C	C	C	B	E	A	D
	Direct to Stroke Unit within 4 hours	B	C	E	E	D	C	C	C	B	C	B	D
	Patient scanned within 1 hour of clock start	A	A	A	B	D	B	B	A	A	B	A	D
	Patient scanned within 12 hours of clock start	A	B	B	C	C	B	C	A	A	A	B	B
Other Key Indicators	Thrombolysed within 1 hour	A	A	A	A	A	D	B	A	A	A	A	D
	Swallow screen within 4 hours	A	C	B	B	B	A	A	B	A	B	A	C
	Formal swallow assessment within 72h	B	D	E	A	B	D	A	A	A	C	A	D
	Mood screening by discharge/transfer	A	A	A	A	A	A	A	A	A	A	A	A
	Cognition screening by discharge/transfer	A	A	A	B	A	A	A	A	A	A	A	A

Key Points / Operational actions - Stroke

- 'A' rated.
- 6th best unit rated in the country.
- Joint first rated in the eastern region.
- Issues in month were centred on poor trust flow, high demand and the scheduled cleaning of the entire ward. This resulted in a decant to Leverington ward between Sunday 4th November and Tuesday 13th November.
- There is no Early Supported Discharge (ESD) service for West Norfolk patients.

Change in performance in the last month - Stroke

Six (6) areas saw a decrease in performance. This was due to:

- Time to the Stroke Unit over 4hrs was adversely affect by;
  - 18 occurrences where no bed was available.
  - 5 occurrences where there wasn't a stroke alert prior to arrival.
  - 2 occurrences of challenging diagnosis.
- Time on Stroke Unit under 90%
  - 10 occurrences where no bed was available.
  - 3 occurrences of the patient being a short stay patient only.
  - 1 occurrence of challenging diagnosis.
- No West Norfolk ESD that results in performance routinely rated at an 'E'.
- Negative impact of the decant to facilitate the deep clean on West Raynham ward.

Planned actions for the forthcoming month - Stroke

- To sign-off the SOP regarding the utilisation of the Thrombolysis nurse.
- To work with West Norfolk Clinical Commissioning Group (WNCCG) on an Early Supported Discharge (ESD) service proposal.

TIA - Performance Scorecard			Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
TIA - high risk, not admitted, treated within 24 hrs														
Target	60.00%	Performance % > >	70.00%	60.53%	69.44%	78.57%	90.91%	75.76%	77.78%	76.67%	52.50%	82.05%	81.82%	81.25%
TIA - high risk, treated within 24 hours														
Target	60.00%	Performance % > >	75.00%	66.67%	74.42%	84.21%	84.62%	80.95%	81.82%	81.08%	54.76%	81.82%	80.00%	81.48%
TIA - low risk, treated within 7 days from 1st contact														
Target	65.00%	Performance % > >	57.89%	75.86%	76.19%	77.78%	80.95%	77.42%	70.83%	72.73%	66.67%	69.70%	82.14%	72.73%
TIA - low risk, treated within 7 days from onset														
Target	65.00%	Performance % > >	31.58%	41.38%	33.33%	37.04%	38.10%	25.81%	25.00%	21.21%	22.22%	39.39%	32.14%	18.18%

Change in performance in the last month - TIA

Passed 3 out of the 4 metrics. The failed metric is routinely not achievable.

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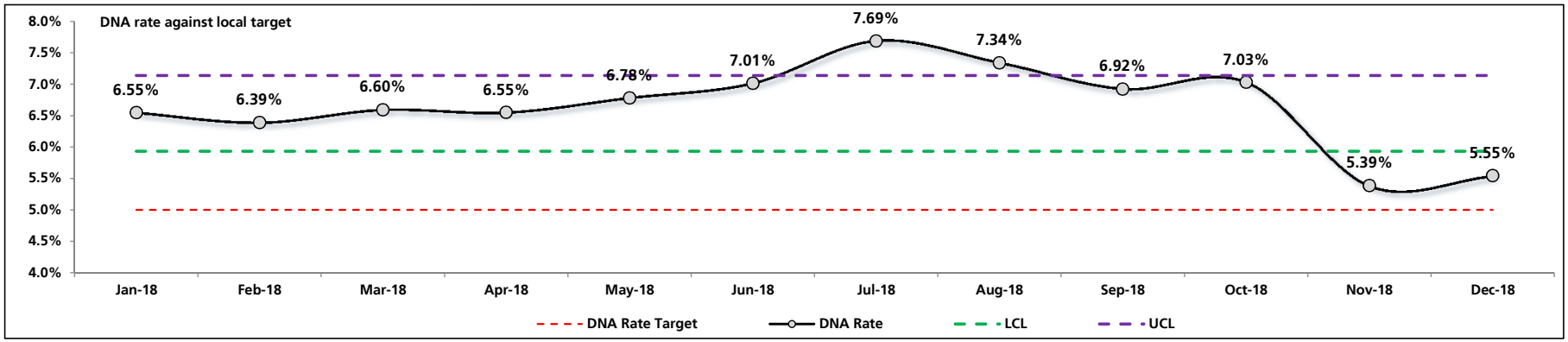
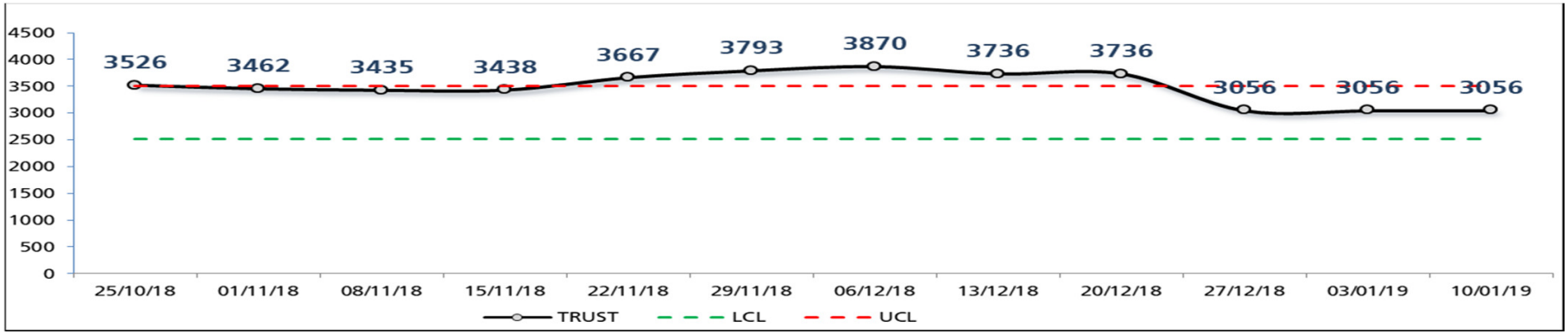
Outpatients





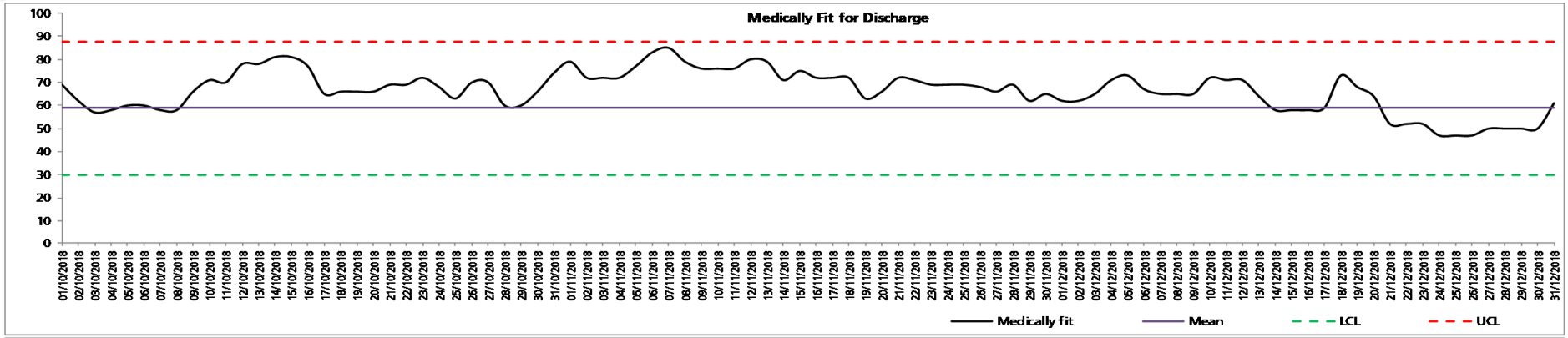
Key Points / Operational actions
Analysis remains on going to target particular specialties/appointment types to try and reduce the DNA rate further.

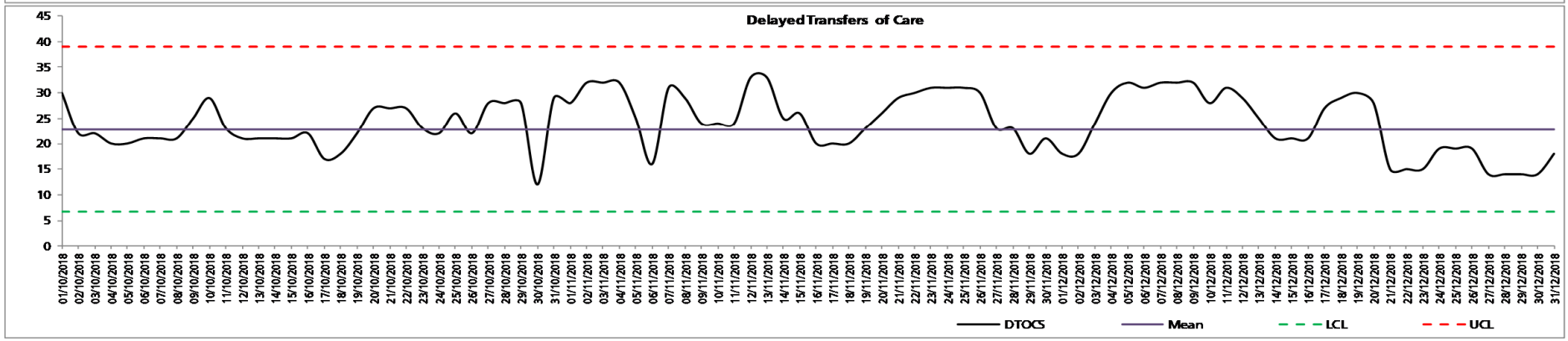
Change in performance in the last month
We expect to see an increase in DNA's around the Christmas holiday period but remain committed to reducing this to a low rate as possible.

Planned actions for the forthcoming month
To include Radiology into the text reminder service.
Consider reducing the number of attempts to contact the patient as some patients have become concerned at the number of attempts, we need to balance this with an improved DNA rate.

Page Owner: Sarah Jones *Narrative: Trudy Taylor/Sarah Jones*

Delayed Transfers of Care/ Medically Fit for Discharge





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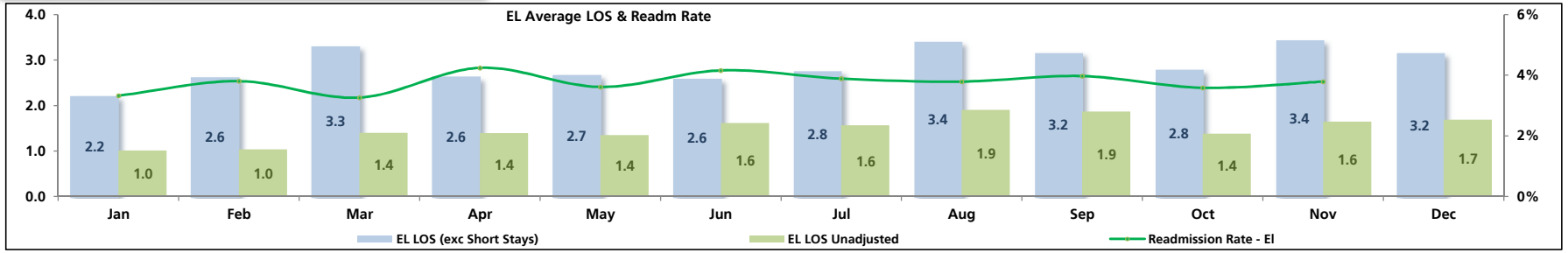
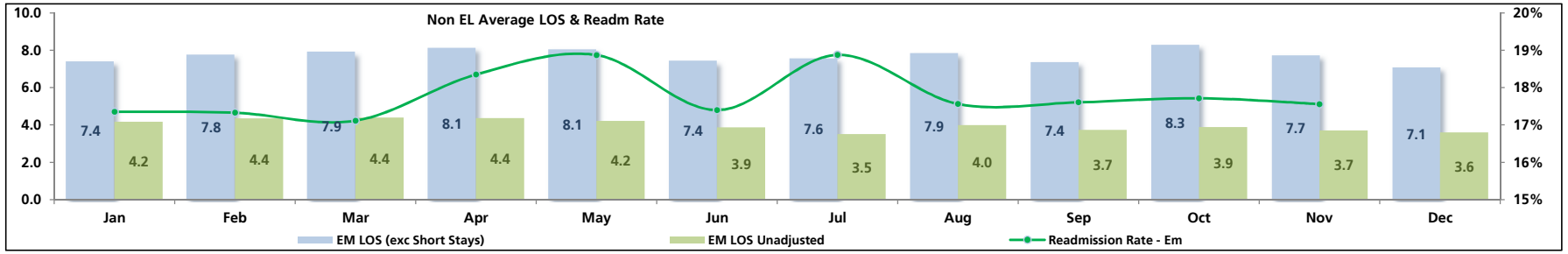
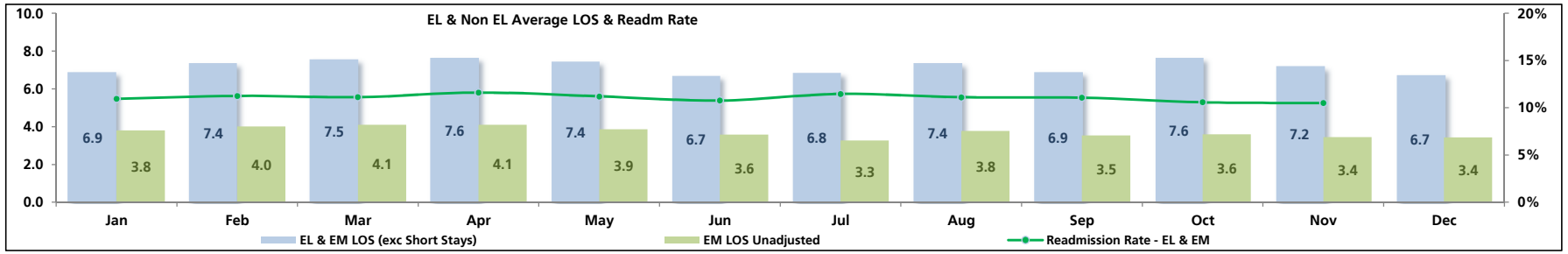
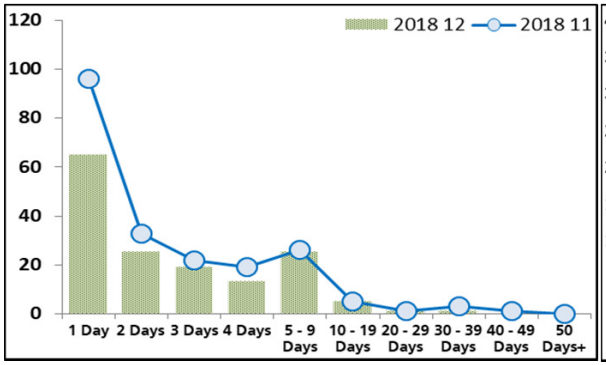
Average Length of Stay & Re-admissions

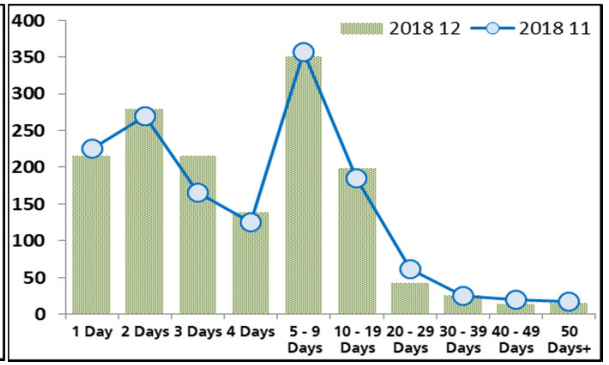


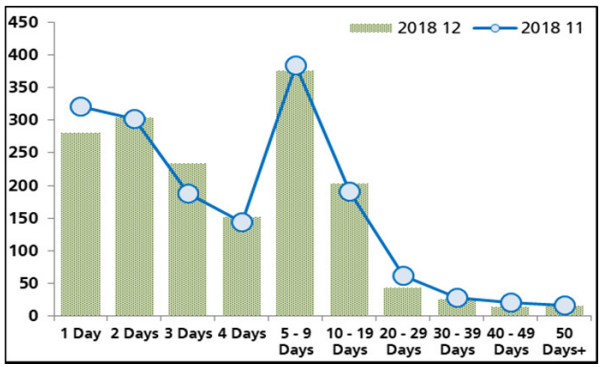




Count of Patients per LOS cohort - Previous 2 months comparison







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CQUINs

CQUIN No.	CQUIN Description		Q1 STATUS	Q1 VALUE	Q2 STATUS	Q2 VALUE	Q3 STATUS	Q3 VALUE	Q4 STATUS	Q4 VALUE	Narrative
ACUTE CONTRACT											
1a	H&W	Heallthy Foods - more healthy options / reduced sugar content etc	N/A							£121,175.00	
1b		Staff Survey - 5% improvement on 2 out of the 3 questions relating to H&W								£121,029.00	
1c		Flu uptake (front line clinical staff) 75%								£121,029.00	
2a	SEPSIS	Sepsis -timely Identification	Achieved	£22,702.00	Partialy Achieved	£22,702.00		£22,702.00		£22,702.00	
2b		Sepsis - timely treatment		£22,702.00		£11,351.00		£22,702.00		£22,702.00	
2c		Empiric Review of antibiotic prescriptions (72hrs)		£22,702.00		£22,702.00		£22,702.00		£22,702.00	
2d		Reduction in Antibiotic Consumption per 1,000 admissions	N/A							£90,808.00	
4	Improving services for people presenting with Mental Health needs in A&E	Frequent Attenders - Maintain improvement made in 17/18 and identify new cohort of patients from 1718 and reduce by 20%. Improvement coding for ECDS	N/A		Achieved	£72,647.00	N/A			£290,587.00	
6	Offering Advice & Guidance	Trust to achieve 80% of A&G requests within 2 working days for on a group of specialties which receive 75% of GP referrals by Q4. Trajectory:- Q1 – 50% Q2 – 60% Q3 – 70% Q4 – 80%	Achieved	£54,485.00	Not Achieved	£54,485.00		£54,485.00		£54,485.00	**CQUIN Update** All Risks relating to delivery continue to be highlighted to the CQUIN owners and to the Executive owners. Risky Behaviour and A&G CQUINs continue to be the main areas of concern for the Trust. Both have seen an improvement throughout Q3 but both still require further engagement from clincians to enable achievement. The Health and Wellbeing Staff Survey CQUIN is also a concern, the requirment is to achieve 5% point increase in the 2 out or 3 key areas.
9a	Risky Behaviours - Alcohol and Tobacco	Tobacco Screening	Achieved	£4,540.00	Partialy Achieved	£4,540.00		£4,540.00		£4,540.00	
9b		Tobacco brief advice		£18,162.00		£18,162.00		£18,162.00		£18,162.00	
9c		Tobacco referral and medication offer		£22,702.00		£22,702.00		£22,702.00		£22,702.00	
9d		Alcohol Screening		£22,702.00		£22,702.00		£22,702.00		£22,702.00	
9e		Alcohol brief advice or referral		£22,702.00		£22,702.00		£22,702.00		£22,702.00	
8	STP	Sustainability and Transformation Plans	Achieved	£454,042.00	Achieved	£454,042.00		£454,042.00		£454,042.00	
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	£43,031.30	Achieved	£6,536.40		£6,536.40		£52,835.40	
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	£11,199.41	Achieved	£11,199.41		£11,199.41		£11,199.41	
3	Breast Screening	Breast Cancer Screening Interval Cancer Network for Norfolk and Waveney	N/A		Achieved	£6,615.19	N/A			£6,615.19	
4	Armed Forces	Embedding the Armed Forces Covenant to support improved health outcomes for the Armed Forces Community	N/A		TBC	£5,876.00	N/A			£13,710.90	

Q3 CQUIN submission due January 27th

CQUINs continue to be a challenge for the Trust and therefore require the support and drive from the Trust Board

Page Owner: Karen Wilson *Narrative: Karen Wilson*

Safer Staffing Return

Dec-18			Day		Night		Care Hours Per Patient Day (CHPPD)				Benchmark CHPPD (Model Hospital) to period ending Aug-18	
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	Peer Median	National Median
	Specialty 1	Specialty 2										
West Newton	430 - GERIATRIC MEDICINE		95.3%	125.2%	101.8%	153.4%	839	3.1	5.9	8.9	6.08	6.76
Necton	340 - RESPIRATORY MEDICINE		88.8%	97.4%	110.7%	111.0%	954	3.4	2.8	6.2	23.46	6.41
Windsor	430 - GERIATRIC MEDICINE		96.1%	102.5%	101.2%	122.5%	1000	2.8	3.3	6.1	N/A	5.78
Stanhoe	301 - GASTROENTEROLOGY	350 - INFECTIOUS DISEASES	94.0%	95.3%	102.2%	99.4%	944	3.1	3.5	6.6	6.34	6.12
Tilney	320 - CARDIOLOGY	300 - GENERAL MEDICINE	96.4%	112.1%	98.9%	132.2%	783	3.3	2.9	6.1	8.67	8.13
West Raynham	300 - GENERAL MEDICINE		95.7%	99.7%	99.7%	103.0%	827	4.2	3.5	7.7	8.35	8.26
Denver	100 - GENERAL SURGERY		115.8%	111.8%	101.2%	145.0%	861	3.4	3.2	6.6	6.27	7.46
Marham	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	69.9%	95.5%	86.0%	115.7%	552	3.9	3.4	7.3	6.27	7.46
Elm	100 - GENERAL SURGERY		89.0%	131.4%	98.4%	96.1%	518	3.4	3.9	7.2	6.27	7.46
Gayton	110 - TRAUMA & ORTHOPAEDICS		92.4%	102.1%	98.9%	110.9%	917	3.0	3.5	6.4	6.66	7.26
Shouldham	315 - PALLIATIVE MEDICINE	823 - HAEMATOLOGY	87.0%	115.0%	100.4%	85.9%	359	4.8	3.0	7.8	N/A	9.09
Critical Care	192 - CRITICAL CARE MEDICINE		84.0%	82.7%	93.8%		252	28.0	1.4	29.5	23.99	27.20
Central Delivery suite	501 - OBSTETRICS		89.1%	104.0%	92.0%	94.1%	155	30.4	9.5	39.9	19.93	14.94
Surgical Assessment Unit	100 - GENERAL SURGERY		95.4%	94.4%	88.9%	101.8%	249	8.6	3.1	11.7	6.27	7.46
Medical Assessment Unit	300 - GENERAL MEDICINE		83.4%	145.6%	110.5%	118.6%	528	6.9	3.7	10.5	6.59	7.36
Terrington	300 - GENERAL MEDICINE		89.8%	72.6%	88.4%	89.7%	696	4.3	3.9	8.2	6.59	7.36
Castleacre	501 - OBSTETRICS		94.4%	92.4%	96.9%	97.1%	395	4.5	3.6	8.1	19.93	14.94
NICU	420 - PAEDIATRICS		90.2%	74.2%	106.1%	91.0%	145	18.7	8.7	27.5	12.44	13.42
Rudham	420 - PAEDIATRICS		98.6%	92.5%	102.7%	134.5%	421	8.6	3.2	11.7	12.44	13.42
ED Obs Ward	180 - ACCIDENT & EMERGENCY		94.2%		88.7%		55	11.9	0.0	11.9	N/A	8.23
Oxborough	430 - GERIATRIC MEDICINE		97.1%	82.9%	94.4%	113.4%	913	3.0	3.1	6.1	6.59	7.36

The Trust continues to aim to meet a daily fill rate of 95% for RNs/ RMs and reports the fill rate for a 24 hour period to NHSI on a daily basis.

The fill rate for RN/ RM day was 91.4% with a 97.8% for RN/ RM night .

13 areas had a fill rate of 90% or over and included the following:
West Newton – 95.3%
Windsor – 96.1%
Stanhoe – 94%
Tilney 96.4%
West Raynham – 95.7%
Denver – 115% - due to increased fill rate required due to extremely high acuity of step down patients from critical care.
Gayton – 92.4%
SAU – 95.4%
Castleacre – 94.4%
NICU – 90.2%
Rudham – 98.6% - increased fill rate required to support increased acuity of patient with RSV and who required increased respiratory support and observation.
94.2% - ED observation bay
97.1% - Oxborough
7 areas had a fill rate of less than 90% which were Necton, Elm, Shouldham, MAU, Terrington, CDS, CCC, .

It should be noted that due to the changes on MAU and Terrington, which commenced 27th December – Terrington (now the assessment zone is due to close at 22.00hrs each night) had over the end of December, overnight stay patients).

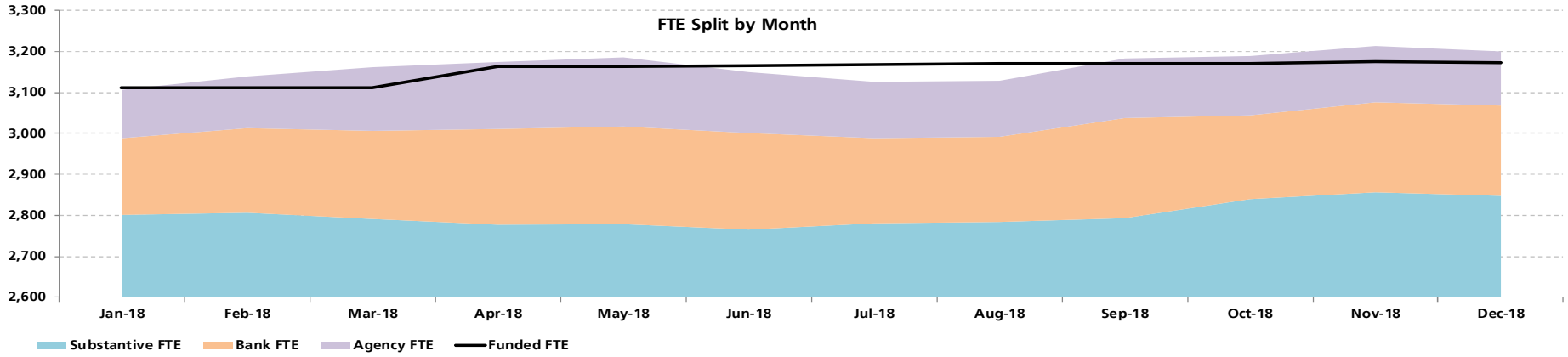
Marham has a fill rate of 69% - however there were intermittent bed closures throughout December which resulted in a reduction of the number of RNs required to cover the area.

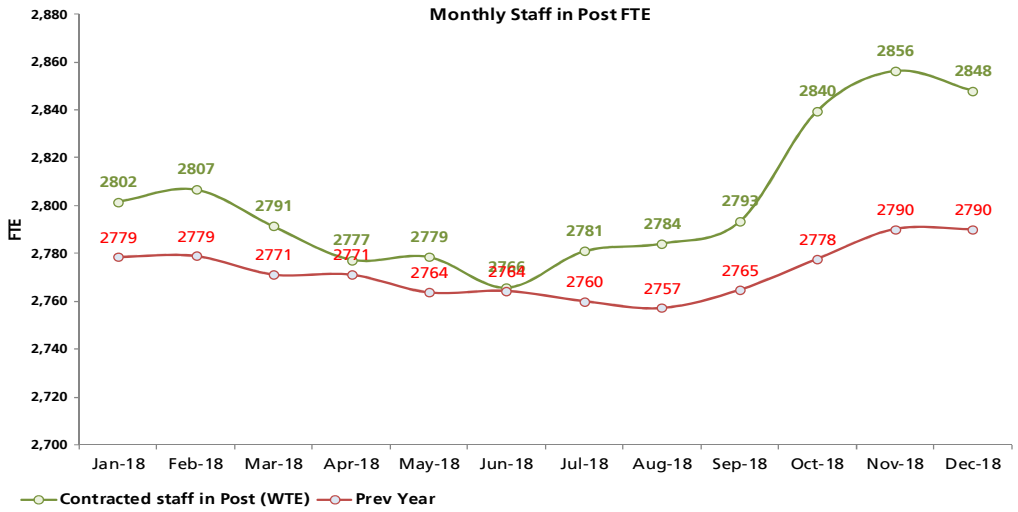
Page Owner: Emma Hardwick *Narrative: Val Newton*

Workforce - Current Staffing Profile

Section 1: Current Staffing Profile and Bank Agency

The data below displays the current staffing profile of the Trust and key Bank and Agency data





Produced by the Workforce Information Team

COMMENTARY

The Trust currently employs 3279 substantive headcount, working a substantive whole time equivalent of 2848.04, against a funded establishment of 3172.95 as of December 2018

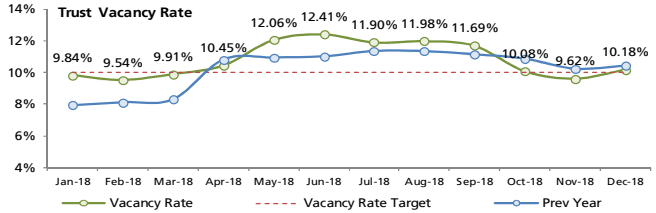
December 2018 FTE Split:

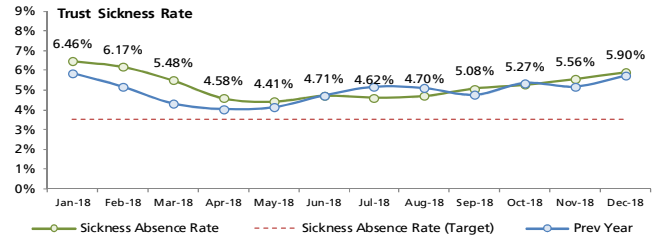
Establishment	3172.95
Substantive	2848.04
Bank	220.02
Agency	132.36
Over Established	27.47

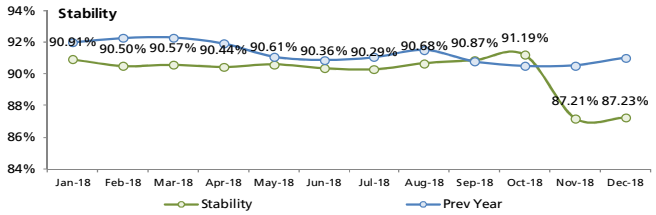
Both substantive FTE and headcount decreased in December
Bank usage FTE remained static. Agency usage FTE decreased for the third month in a row.
Trust vacancy rate increased slightly to 10.18% from 9.62% whilst Staff Turnover decreased to 11.65% and Trust Stability % remained static at 87.2%

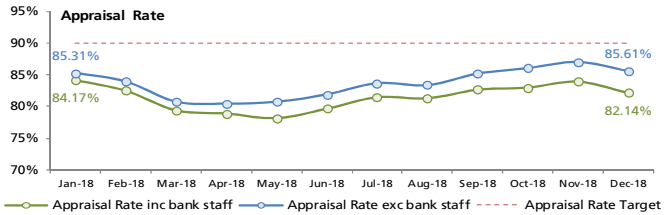
Page Owner: Karen Charman *Data provided by Workforce Information Team*

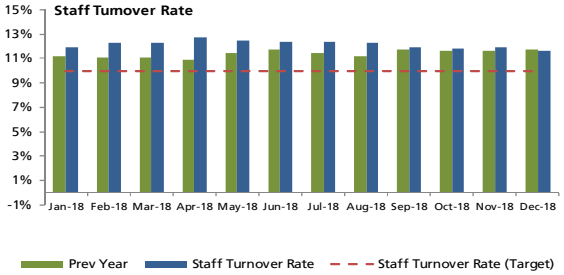
Workforce KPI's - Trust Level



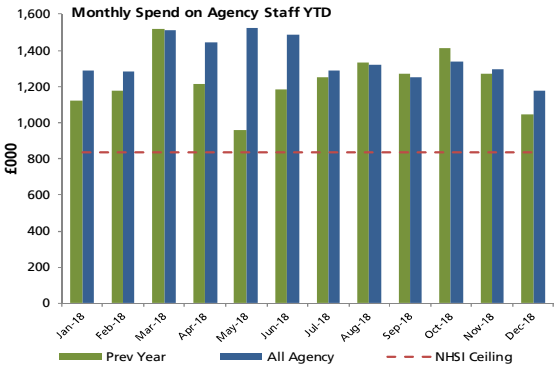


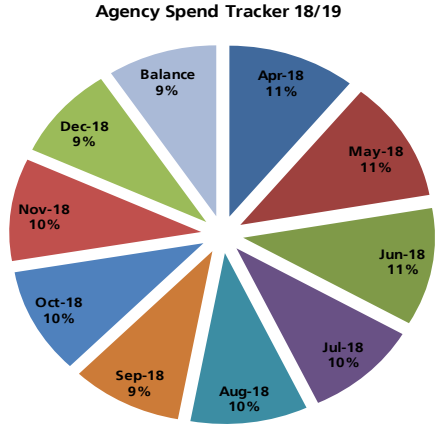


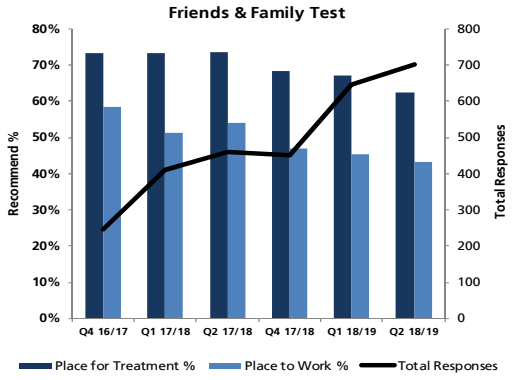




KPI	Change over the year	Change since last month
Vacancy	0.34%	0.56%
Sickness	-0.56%	0.34%
Stability	-3.68%	0.02%
Turnover	-0.21%	-0.28%
Appraisal (exc Bank)	0.30%	-1.43%
Appraisal (inc Bank)	-2.03%	-1.79%





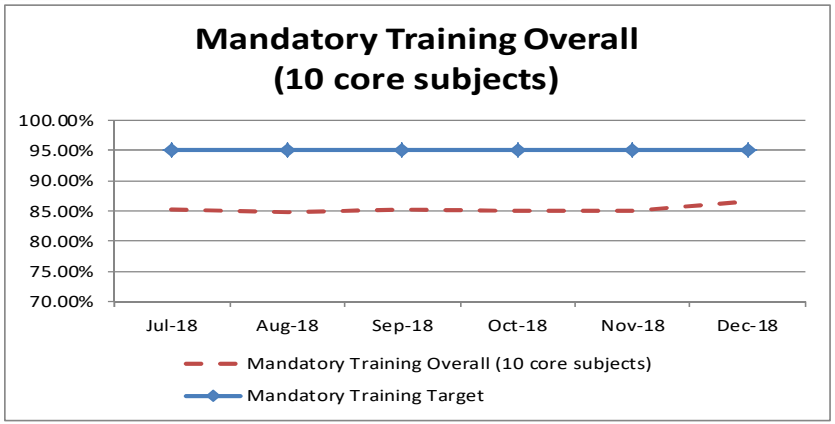


Appraisal rates were on trajectory to achieve 90% by December 2018 in November unfortunately the appraisal compliance rate fell in December to 85.61%. This is being reviewed against detailed plans available for every CBU, and areas are being asked to refresh their appraisal trajectories to the end of March 2019 to ensure the 90% compliance rate is achieved. This will continue to be monitored through the Workforce Committee.

Sickness saw an increase in December 2018, the top reasons for sickness were musculoskeletal, back pain, stress and anxiety. For some sickness, whilst the sickness is recorded the reasons for absence were not, this is being reviewed by the HR Business Partnering team to ensure this is rectified.

Page Owner: Karen Charman *Data provided by Workforce Information Team*

Workforce - Mandatory Training

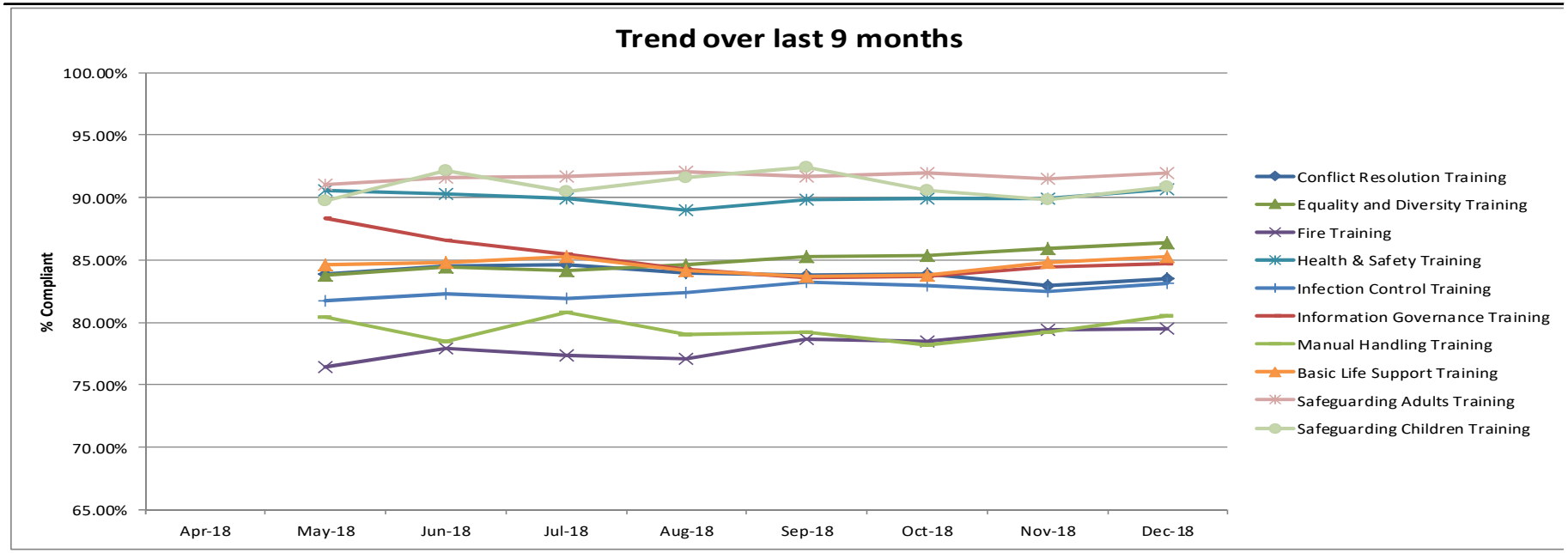


COMMENTARY

The mandatory training PDSA group was set up towards the end of 2017 and has achieved progress across many of the subject areas with an increase in the percentage compliance in nine of the ten mandatory subjects

The group is now looking into other training options and with ESR log in and self-service now successfully rolled out , the group can launch e-learning and local programme content from November 2018.

HR are also trialling a new support role to find innovative ways of delivering training on site which support clinical area pressures ie appraisal training at lunchtimes in locally based seminar rooms.



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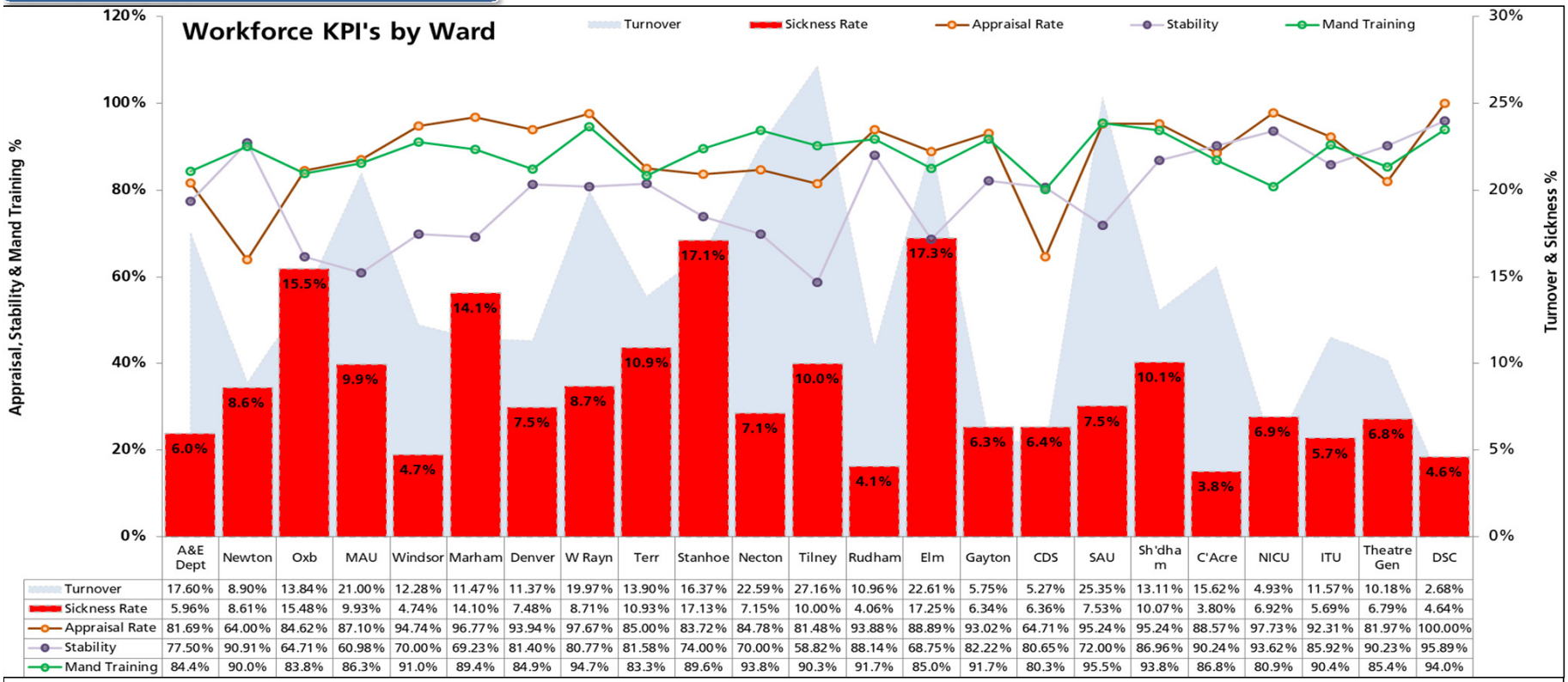
Workforce - KPI's by Ward



	A&E Dept	Newton	Oxb	MAU	Windsor	Marham	Denver	W Rayn	Terr	Stanhoe	Necton	Tilney	Rudham	Elm	Gayton	CDS	SAU	Sh'dham	C'Acre	NICU	ITU	Theatre Gen	DSC
Turnover	17.60%	8.90%	13.84%	21.00%	12.28%	11.47%	11.37%	19.97%	13.90%	16.37%	22.59%	27.16%	10.96%	22.61%	5.75%	5.27%	25.35%	13.11%	15.62%	4.93%	11.57%	10.18%	2.68%
Sickness Rate	5.96%	8.61%	15.48%	9.93%	4.74%	14.10%	7.48%	8.71%	10.93%	17.13%	7.15%	10.00%	4.06%	17.25%	6.34%	6.36%	7.53%	10.07%	3.80%	6.92%	5.69%	6.79%	4.64%
Appraisal Rate	81.69%	64.00%	84.62%	87.10%	94.74%	96.77%	93.94%	97.67%	85.00%	83.72%	84.78%	81.48%	93.88%	88.89%	93.02%	64.71%	95.24%	95.24%	88.57%	97.73%	92.31%	81.97%	100.00%
Stability	77.50%	90.91%	64.71%	60.98%	70.00%	69.23%	81.40%	80.77%	81.58%	74.00%	70.00%	58.82%	88.14%	68.75%	82.22%	80.65%	72.00%	86.96%	90.24%	93.62%	85.92%	90.23%	95.89%
Mand Training	84.4%	90.0%	83.8%	86.3%	91.0%	89.4%	84.9%	94.7%	83.3%	89.6%	93.8%	90.3%	91.7%	85.0%	91.7%	80.3%	95.5%	93.8%	86.8%	80.9%	90.4%	85.4%	94.0%

The graph shows some correlation with areas with high sickness, turnover and stability and mandatory training compliance – in particular Oxborough, Tilney, Marham and Stanhoe Wards.

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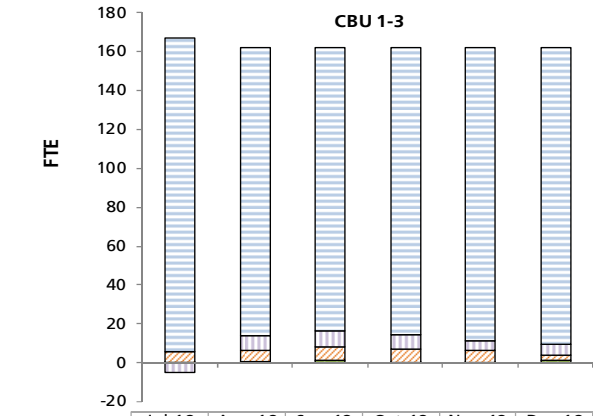
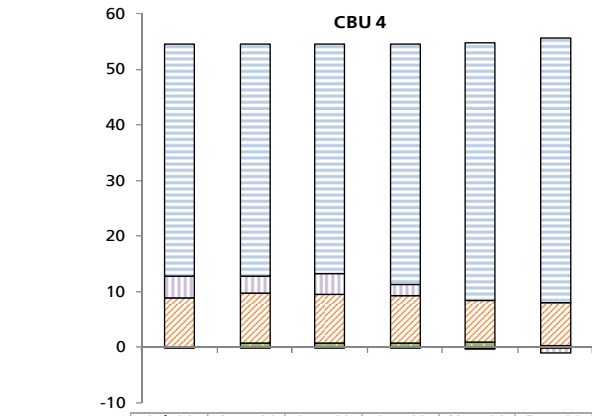
Workforce - FTE Split (Medical Workforce)

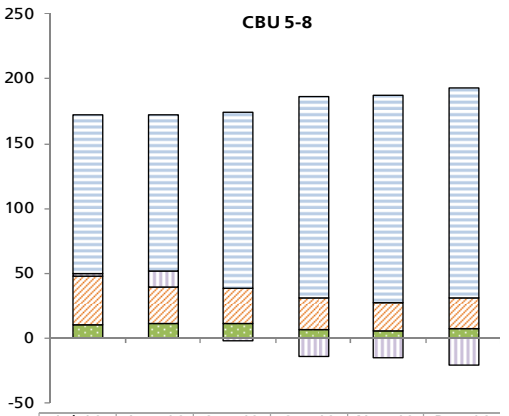
Medical Workforce - FTE Split



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Substantive	161.34	148.04	145.34	147.79	150.79	152.45
Unfilled	-5.08	7.45	8.17	7.31	5	5.41
Agency	5.51	6.08	7.11	6.64	5.88	2.79
Bank	0.33	0.53	1.48	0.36	0.43	1.45



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Substantive	41.93	41.93	41.33	43.33	46.35	47.75
Unfilled	3.79	3	3.78	2.02	-0.14	-1
Agency	8.76	9.1	8.71	8.51	7.47	7.56
Bank	0.24	0.69	0.9	0.86	1.04	0.41



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Substantive	122.35	120.48	135.55	155.55	159.58	161.23
Unfilled	1.76	12.1	-2.22	-14.28	-15.09	-20.84
Agency	37.09	28.52	27.11	23.6	21.49	23.64
Bank	10.77	10.87	11.53	7.1	5.99	7.94

Medical staffing continues to grow in substantive posts and long term fixed term agency reducing high cost short term agency use. Medical Vacancies have decreased from 16.67% in September 2018 to 7.31% in December 2018.

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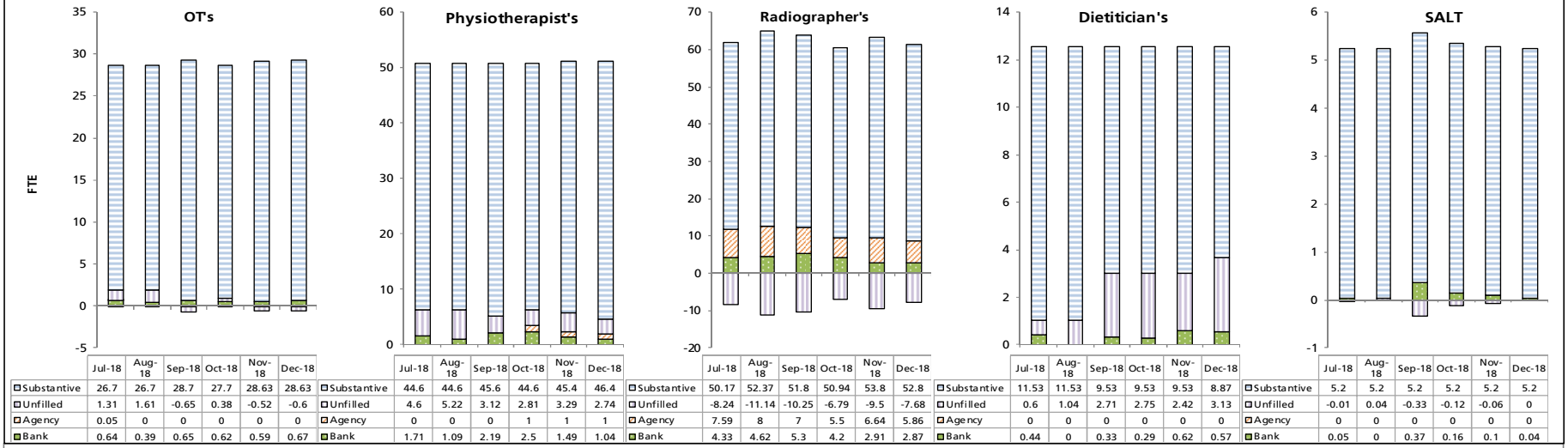
Workforce - FTE Split (Allied Health Professionals)

Allied Health Professionals - FTE Split



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Substantive	26.7	26.7	28.7	27.7	28.63	28.63
Unfilled	1.31	1.61	-0.65	0.38	-0.52	-0.6
Agency	0.05	0	0	0	0	0
Bank	0.64	0.39	0.65	0.62	0.59	0.67

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Substantive	44.6	44.6	45.6	44.6	45.4	46.4
Unfilled	4.6	5.22	3.12	2.81	3.29	2.74
Agency	0	0	0	1	1	1
Bank	1.71	1.09	2.19	2.5	1.49	1.04

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Substantive	50.17	52.37	51.8	50.94	53.8	52.8
Unfilled	-8.24	-11.14	-10.25	-6.79	-9.5	-7.68
Agency	7.59	8	7	5.5	6.64	5.86
Bank	4.33	4.62	5.3	4.2	2.91	2.87

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Substantive	11.53	11.53	9.53	9.53	9.53	8.87
Unfilled	0.6	1.04	2.71	2.75	2.42	3.13
Agency	0	0	0	0	0	0
Bank	0.44	0	0.33	0.29	0.62	0.57

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Substantive	5.2	5.2	5.2	5.2	5.2	5.2
Unfilled	-0.01	0.04	-0.33	-0.12	-0.06	0
Agency	0	0	0	0	0	0
Bank	0.05	0	0.37	0.16	0.1	0.04

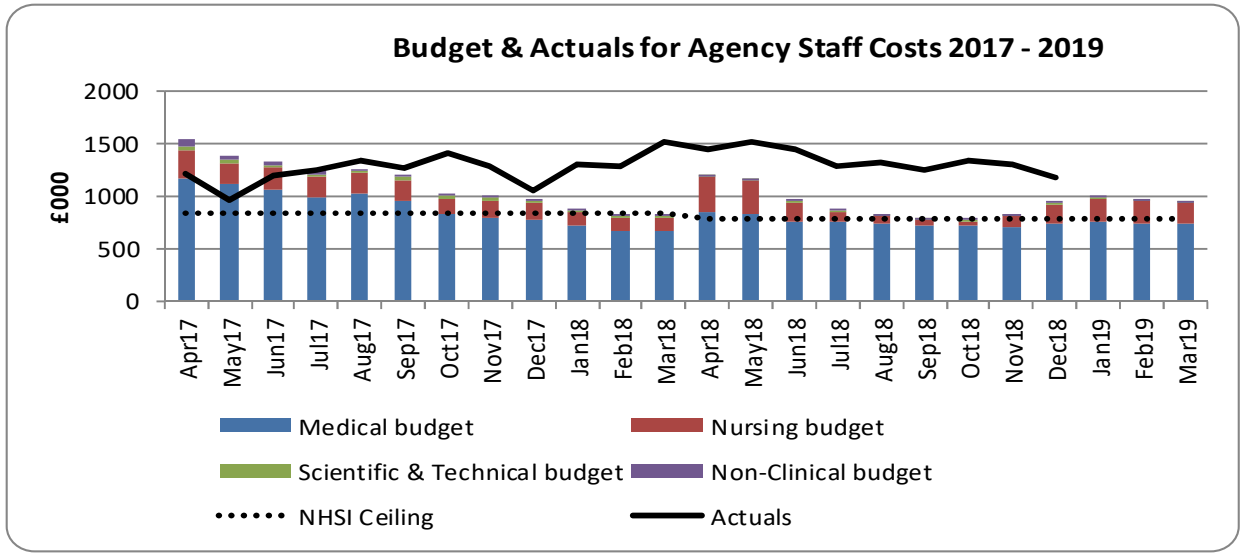
Physios – greater fill rate with bank staff and use of agency December. Successful recruitment has taken place at band 6 level started in January 2019
Radiography – Our successful campaign to over recruit radiographers can be demonstrated in the graph above. We are now reviewing the use of the extended workforce to support further productivity improvements. Overall seen a reduction in bank and agency usage and a higher fill rate.

Page Owner: Karen Charman *Data provided by Workforce Information Team*

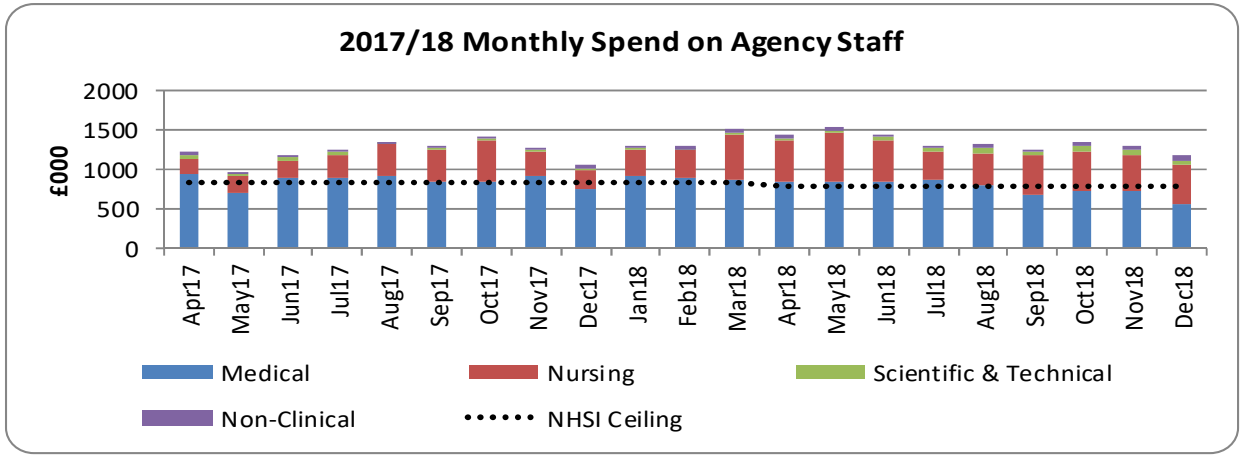
Trust Agency Summary December 2018

Overall Trust Dashboard

A: Total Agency against spend ceiling



B:Budget profile by month for agency 18/19



Commentary

Agency costs are driven primarily by vacancies.

Leverington Escalation has been budgeted to be open April and May 2018., then closed until December 2018.

Agency budget assumptions 2018/19 include substantive medical staff recruitment, sickness absence reduction and rate reductions.

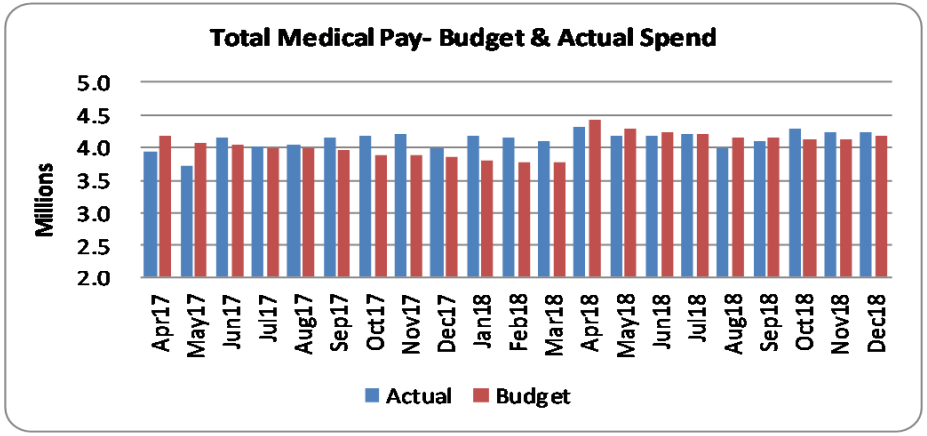
The current monthly budget profile is running higher thewn the NHSI cap.

Page Owner: Karen Charman *Data provided by Workforce Information Team*

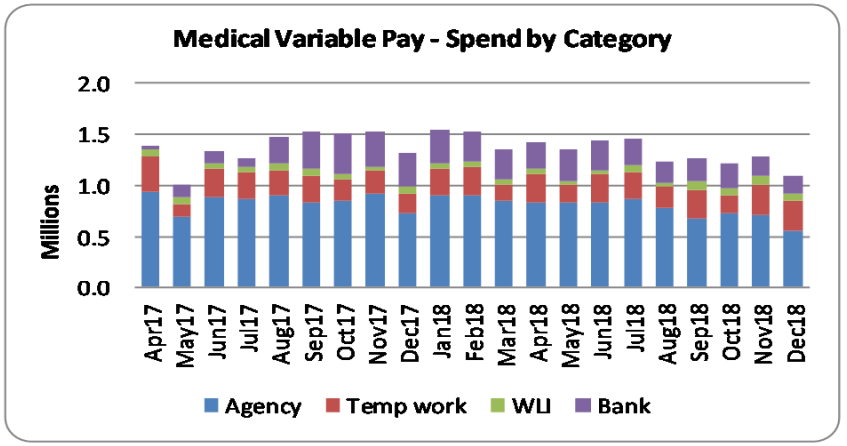
Medical Pay Gap December 2018

Medical Pay Dashboard

C: Medical Pay - Budget v Actual



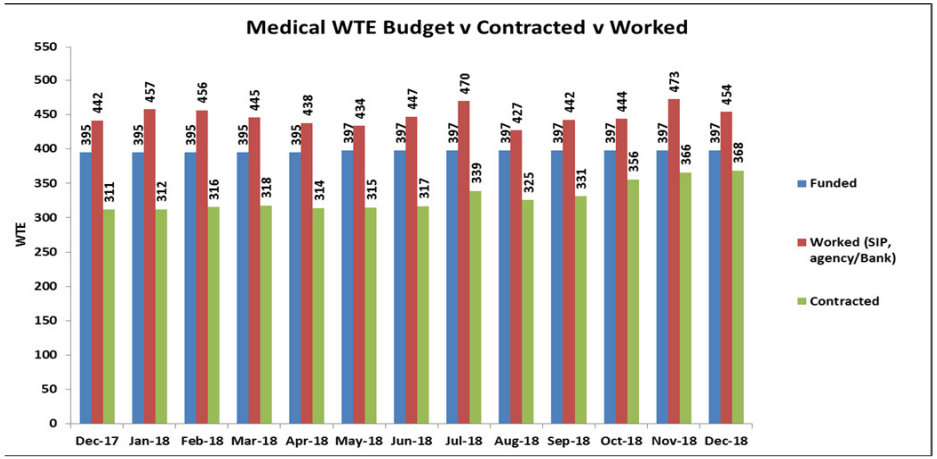
D: Medical Variable Pay - Total Spend by Category



Commentary

Medical pay costs exceeded budget in 2016/17 by £4.3m (10%) driven primarily by medical staff vacancies, sickness absence and failure of WLI cost reduction plan. Reversal of provisions in May 2017 disguises an underlying flat agency run rate in April - Aug 2017, despite an increase in staff on bank contracts instead of agency.

E: Vacancies and worked WTEs



Commentary

Funded FTE is the funded establishment for medical staff.

Contracted FTE is the total number of staff in post not including locum and bank staff but including those on long term sick and maternity leave.

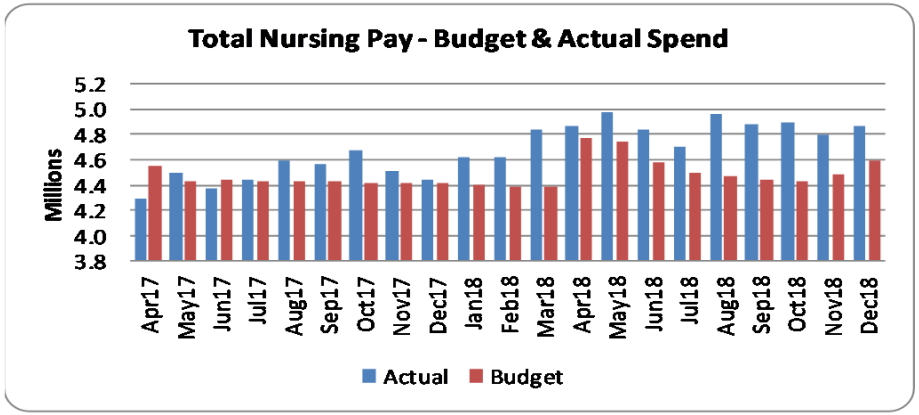
Worked FTE is all staff in post including agency and bank.

Page Owner: Karen Charman *Data provided by Workforce Information Team*

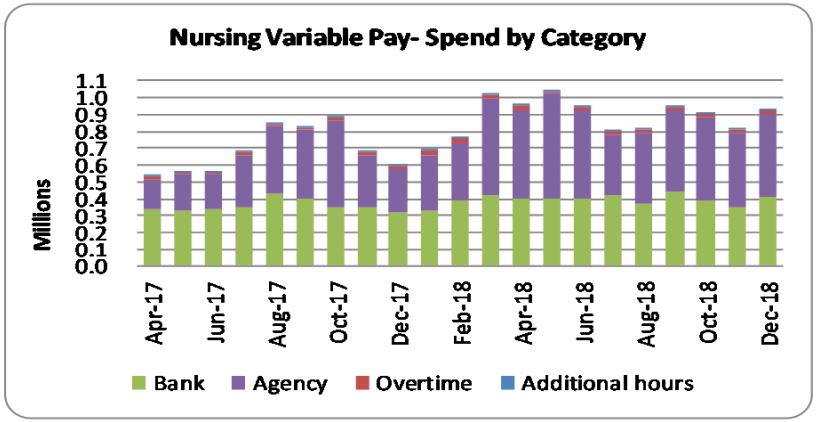
Nursing Pay, Gap December 2018

Nursing Pay Dashboard

K: Nursing Pay Budget & Actual Spend



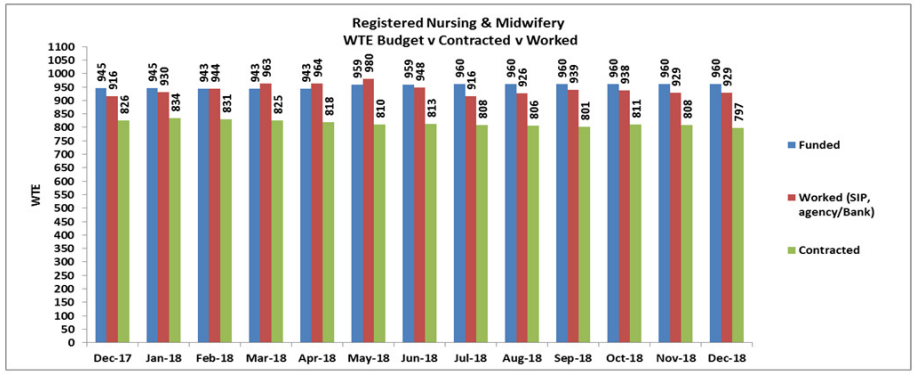
L: Nursing Variable Pay - Total Spend by Category



Commentary

Nursing variable cost driven by vacancies and high rate of sickness absenteeism. Currently 3.10% Short Term and 2.73% Long Term, totalling 5.83% N&M Sickness. Nursing pay cost budget increased in 2017/18 to reflect pay award, apprenticeship levy, agency cost out-turn 2016/17 and expansion of medical in-patient capacity. Both agency and bank hours have increased in recent months with the aim of increasing the fill rate on the wards.

M: Vacancies within the Trust



Commentary

There are currently 162.87 FTE (16.96%) Registered Nurse and Midwifery vacancies across the Trust.

The contracted staff levels for Registered Nurses has remained fairly steady. International Nurse recruitment has contributed to staffing levels as well as local and national recruitment.

The Trust has invested in 'growing our own' staff through apprenticeships and other programmes to develop staff into Registered Nurses.

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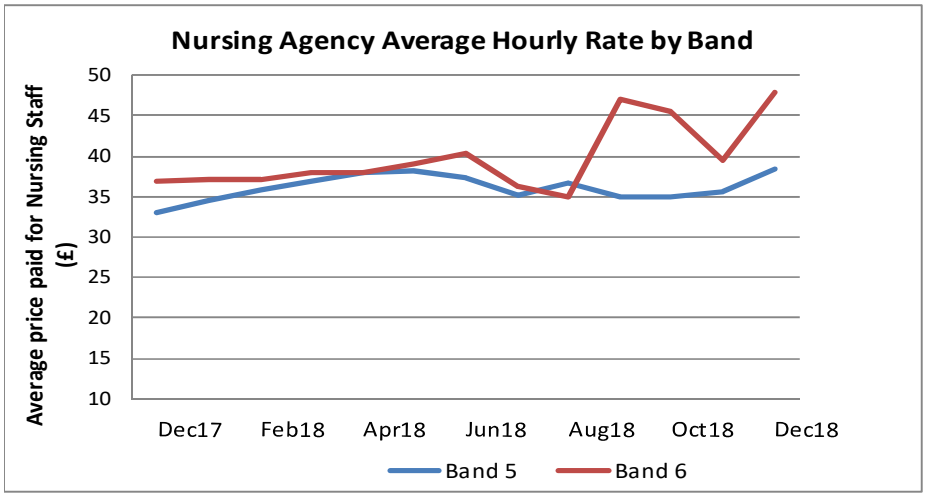
Nursing Pay, Fill Rate December 2018

Nursing Pay Dashboard

N: How have the prices paid for nursing staff changed



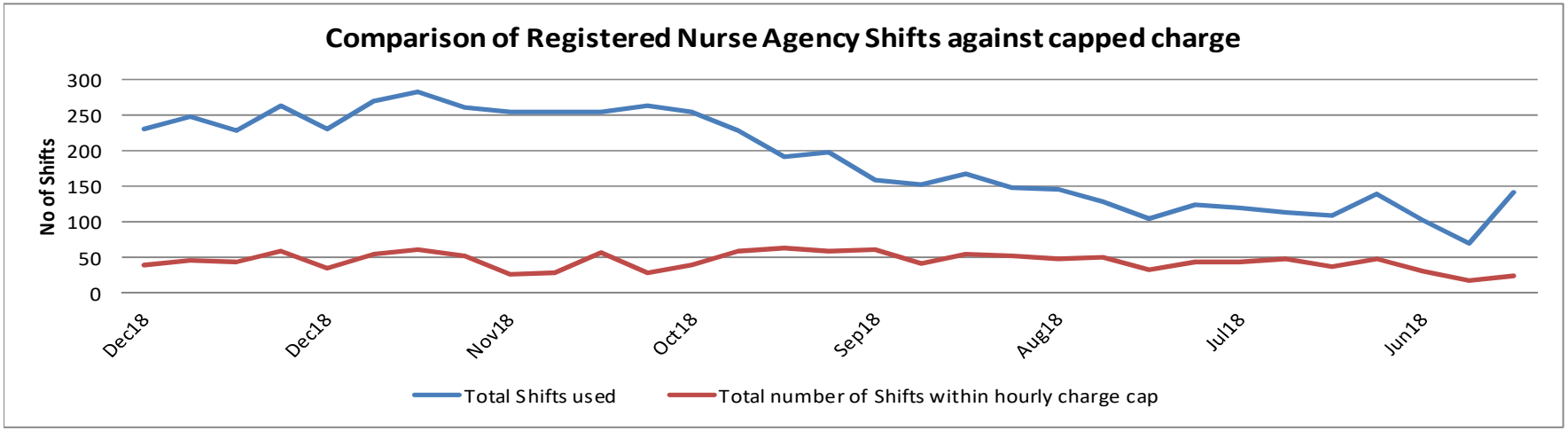
Commentary

The Band 5 agency nurse average cost has increased to £38.44 per hour and Band 6 agency nurse has increased to £47.80 per hour .

The Trust has improved compliance with NHS Improvement Overall Price Caps for agency nurses particularly for night shift/Saturday and Sundays. Compliance with the NHS Improvement Band 5 Day Rate has been more difficult to achieve.

The new NHSI price cap figures issued in July have affected our compliance and total shifts within the capped rates. Due to many of our agency nurses having been booked for regular work and having recently agreed to reductions to their hourly rate, we are unlikely to see any substantial progress in driving down the hourly rate.

O: Agency Shifts within cap



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Finance

Finance report to follow seperately

Quality and Risk Scorecard
Performance & Standards Scorecard
Definitions

Quality & Risk Scorecard

	Indicators	Var to prev mth	Target	Oct	Nov	Dec	*FYTD
Safe care	**Critical Incidents**						
	Total Never Events	→	0	0	0	0	0
	Total Falls Resulting in Serious Harm	↑	0	0	0	1	3
	Pressure Ulcers - Grade 3	↑	0	2	0	2	26
	Pressure Ulcers - Grade 4	→	0	0	0	0	0
	Total Other Sis	↓	0	3	3	2	26
	Pressure Ulcers - Grade 2	↑	0	6	1	3	34
	Safety Thermometer - (New Harm Free)	↓	95.00%	97.49%	98.77%	97.94%	97.63%
	VTE Assessment Completeness	↑	97.24%	97.36%	97.57%	NA	97.42%
	Infection Control						
	MRSA	→	0	0	0	0	2
	CDIFF	↓	5	1	3	2	21

	Indicators	Var to prev mth	Target	Oct	Nov	Dec	*FYTD
Patient experience	**Patient experience**						
	FFT % Recommended (IP & DC)	↓		95.15%	96.15%	95.17%	95.56%
	FFT % Recommended (AE)	↑		89.42%	89.80%	89.94%	90.64%
	FFT Response Rate (IP & DC)	↓	30.00%	31.47%	33.05%	28.58%	32.20%
	FFT Response Rate (AE)	↓	20.00%	21.32%	20.81%	14.60%	14.71%
	No. of Mixed Sex Accommodation breaches	↓	0	8	14	2	71
	Number of Patient moves (over 2)	↓		37	32	28	272
	Positive experience						
	Compliments	↑		179	130	157	1383
	Complaints						
	Non-Clinical Complaints	↑		7	3	6	59
	Clinical Complaints	↓		29	29	21	246

	Indicators	Var to prev mth	Target	Oct	Nov	Dec	*FYTD
Well led Trust	**Mortality**						
	Crude Mortality (deaths per 1000 admissions)	↑	19	9.9	12.2	13.0	12.3
	SHMI (Summary Hospital Level Mortality Indicator)	Jul 17 - Jun 18			as expected		97.29
	HSMR (Hospital Standardised Mortality Ratio)	Oct 17 - Sep 18			as expected		105.50
	Outcome						
	Stroke - 90% of Stay on a Stroke Unit	↓	80.00%	93.75%	77.42%	NA	83.29%
	TIA - High Risk,Non admitted TIA treated in 24 Hrs	↓	60.00%	81.82%	81.25%	NA	75.09%
	Length of stay - Elective	↑	2.2	1.4	1.6	1.7	1.6
	Length of stay - Emergency	↓	5.0	3.9	3.7	3.6	3.9
	Readmission Rate - Elective	↑	3.00%	3.58%	3.79%	NA	3.87%
	Readmission Rate - Emergency	↓	10.00%	17.71%	17.56%	NA	18.00%

	Indicators	Var to prev mth	Target	Oct	Nov	Dec	Rolling 12 mths
Supporting our staff	**Workforce**						
	Sickness Absence Rate	↑	3.50%	5.27%	5.56%	5.90%	5.25%
	Staff Turnover Rate Complete Trust	↓	10.00%	11.83%	11.93%	11.65%	12.16%
	Staff Turnover Rate Medical & Dental (excluding Jnr Doctors)	↓	10.00%	12.47%	14.06%	11.80%	13.23%
	Staff Turnover Rate Registered Nursing & Midwifery	↑	10.00%	14.63%	14.91%	15.28%	14.32%
	Staff Turnover Rate Allied Health Professionals	↑	10.00%	13.29%	12.65%	14.79%	13.96%

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

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

Performance & Standards Scorecard

Delay free

Indicators	Var to prev mth	Target	Oct	Nov	Dec	FYTD
National standards						
18 Wks - Adm Perf (adjusted)	↓	90.00%	72.71%	72.35%	70.56%	73.37%
18 Wks - Non Adm Perf	↓	95.00%	76.31%	76.55%	76.48%	77.00%
18 Wks - Incomp Perf	↓	92.00%	79.96%	80.13%	78.48%	81.18%
Cancer-2ww	↓	93.00%	98.32%	97.30%	NA	96.23%
Cancer-2ww (Breast Symptomatic)	↑	93.00%	96.92%	100.00%	NA	98.28%
31 Day Diag to Treat	↓	96.00%	97.66%	96.15%	NA	97.63%
Cancer-62 Days RTT	↓	85.00%	85.94%	82.35%	NA	82.39%
Cancer - 31 Days Subsq Treatment - Surgery	↓	94.00%	100.00%	92.86%	NA	99.16%
Cancer - 31 Days Subsq - Drug Treatments	↑	98.00%	97.92%	98.04%	NA	99.55%
Cancer Screening (62 Day)	↓	90.00%	100.00%	85.00%	NA	96.61%
A&E 4 Hour Performance	↑	95.00%	84.05%	78.09%	83.99%	83.90%
Ambulance turnaround	↑	100.00%	52.42%	39.90%	50.95%	44.44%
Stroke - 90% of Stay on a Stroke Unit	↓	80.00%	93.75%	77.42%	NA	83.29%
TIA - High Risk,Non admitted TIA treated in 24 Hrs	↓	60.00%	81.82%	81.25%	NA	75.09%
Cancelled Ops - as a % of Elective Admissions	↓	0.80%	1.03%	0.91%	0.54%	1.00%
Diagnostic Over 6 Week Waiters - % of Total WL	↑	1.00%	0.46%	0.66%	0.68%	1.52%

Operational Efficiency

Indicators	Var to prev mth	Target	Oct	Nov	Dec	FYTD
Local standards						
Day Case Rate	↓	82.00%	88.47%	87.61%	NA	88.14%
DNA Rate	↑	5.00%	7.03%	5.39%	5.55%	6.72%
New to FUP Ratio	↑	2.3	2.4	2.2	2.3	2.33
Readmission Rate - Elective	↑	3.00%	3.58%	3.79%	NA	3.87%
Readmission Rate - Emergency	↓	10.00%	17.71%	17.56%	NA	18.00%
Length of stay - Elective	↑	2.2	1.4	1.6	1.7	1.6
Length of stay - Emergency	↓	5.0	3.9	3.7	3.6	3.9

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

Definitions

Incidents (including Serious Incidents, Falls and Pressure Ulcers) - *Data based on a snapshot of data from DATIX approx 10th calendar day each month.*
Total no. of Falls/PU incidents per month. Total No. of Falls/PU incidents per 1000 beddays, per month.

Safety Thermometer - *Data extracted from the National Safety Thermometer Tool approx 10th calendar day each month & represents the % of patients reported to have Harm Free Care*

Mortality
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 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.
The learning from deaths dashboard is populated based on Mortality data extracted from PAS and after discussions at the routine Trust's Mortality Review meetings.

MRSA & C Diff - *Data provided by the IPACS Team approx 10th calendar day each month.*
CDIFF - Deliver a continuing reduction in C Diff infections. Organisations with higher baseline rates will be required to deliver larger reductions. **MRSA** - Deliver a continuing reduction in MRSA bacteraemia by requiring acute Trusts & PCOs to improve to the level of top performers.

Mixed Sex Accommodation - *Data provided by the Risk & Governance Team approx 5th calendar day each.*
No. of Incidents of Mixed Sex Accommodation within the specified time period. No. of breaches (i.e Patients affected) of Mixed Sex Accommodation within the specified time period.

Service line Clinical Indicators (by ward)
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.

Friends and Family Test
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.
* 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 members may also choose to submit responses at multiple points during a period of care/treatment resulting in multiple submissions to the same month.
Complaints/Compliments - *Data provided by the Complaints Dept approx 8th calendar day each month.*

Women & Children Dashboards *- including Maternity, NICU and Paediatric areas & provided by the Women & Children Division and is normally a month in arrears.*

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

Cancer Wait Times *- (reported 1 month in arrears) Based on activity extracted from PAS, Open Exeter & Somerset Systems, & provided as part of the Trust's routine Cancer Wait Times submission.*
2WW *- % of cancer patients seen within 2 weeks in the reporting month.*
31 Day Diag to Treatment *- % of above Cancer Pathway completed within 31 Days in the reporting month (1 month in arrears).*
62 Day Referral To Treatment *- % of above Cancer Pathway completed within 62 Days in the reporting month.*

AE - *Based on activity extracted from EDIS system, and provided as part of the Trust's routine monthly AE submission.*
% of total A&E Attendances for the reporting month that are admitted or discharged within the 4 hour target. The latest benchmarking data is based on the monthly performance (2 months in arrears).

Ambulance Handovers - *The % of the total Ambulance handovers within the reporting month where the handover was less than 15 minutes in duration.*

Cancelled Operations - *Based on activity extracted from PAS, & provided as part of the Trust's monthly Quarterly Cancelled Operations Return (QMCO) submission.*
Cancelled Operations:The no. of patients cancelled at the "last minute" for "non clinical" reasons. A breaches of the 28 day standard occurs if that patient does not have their operation within 28 days of the cancellation.

Diagnostic Wait Times - *Performance data based on activity information extracted from PAS, & provided as part of the Trust's monthly Diagnostics Wait Times (DM01) submission.*
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.*

Theatres Dashboard - Four Eyes - *Data Source: Four Eyes Insight*

Stroke (reported 1 month in arrears)
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.
Primary Key Indicators:
1) *% of patients spending 90% of their stay on the stroke unit.* ***2)*** *% of patients directly admitted to a stroke unit <4 hrs of clock start.* ***3)*** *% of patients scanned <1 hr of clock start.* ***4)*** *% of patients scanned <12 hrs of clock start.*
Other Key Indicators:
1) *% of patients thrombolysed <1 hr of clock start (Door to needle time within 1 hour).* ***2)*** *% of applicable patients given a swallow screen <4hrs of clock start.* ***3)*** *% of applicable patients given a formal swallow assessment <72hrs of clock start.*
4) *% of applicable patients who have mood screening by discharge.* ***5)*** *% of applicable patients who have cognition screening by discharge*

TIA (reported 1 month in arrears)
1) *% of High Risk TIA's (not adm), seen & treated <24 hrs.* ***2)*** *% of High Risk TIA's seen & treated <24 hrs.* ***3)*** *% of Low Risk TIA's seen & treated <7 days of 1st contact with a healthcare prof.* ***4)*** *% of Low Risk TIA's seen & treated <7 days of onset.*

Outpatients - *DNA Data Source based on activity from PAS, normally taken approx 5th calendar day each month.Excludes Ward Attenders & is based on "Clinic" Specialty, not "Referral" Specialty.*
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
ASI - Appointment Slot Issues. *ASI's occur in e-Referral (Choose & Book) because of an insufficient no. of slots available within a 'polling range' for a specialty. Data Source: E Referral Booking System*

Ave LOS and Readmissions - *Based on activity extracted from PAS taken approx 5th calendar day each month.*
Average LOS *- The average spell length of stay for Elective & Emergency Admissions discharged within the reporting month.* ***Re-admissions*** *- The % of patients readmitted within 30 days of an Elective & Emergency admission during the current financial year.*

CQUIN - *Data provided by Karen Wilson - Commissioning & Contracting Team.*

Safer Staffing - *The Safer Staffing figures represent those submitted to the DOH as part of the Trust's mandatory monthly Safer Staffing return.*