The Queen Elizabeth Hospital NHS
King's Lynn
NHS Foundation Trust

REPORT TO

SUBMITTED BY:	REPORT FOR:		IMPACT:		
Barbara Cummings	Decision	√	High	Med	Low
CONSULTATION:	Information	√	√		
	REPORT TYPE:		RELATED WORK:		
	Strategic	√			
	Operational	√			
	Governance	√			
BAF ref:	√				
Monitor Compliance Framework:	√				
CQC Essential Standard Reference:	√				
NHSLA Standard Reference:					
Media / Communications:	√				

Meeting Date: 30 July 2012
Report Title: Integrated Performance Report

Purpose:

To provide the Board of Directors with an overview of Trust Performance against its KPI's.

Summary:
This paper is the Trusts first integrated performance paper which encompasses quality and risk, performance and standards, workforce and finance and investment performance information. This report will be developed over the coming month to report on an exception basis once levels of required detail have been confirmed by the Boards various sub committees.

Financial Implications / Efficiency Savings / Quality Improvement:

Risk Assessment (cross-reference with Risk Register where appropriate):

Strategic / External	Operational/ Organisational	Financial	Clinical	Legal/ Regulatory	Reputational / Patient Experience
√	√	√	√	√	√

Recommendations:

To note the contents of the report.

Author Barbara Cummings
Date 23 July 2012

Quality & Performance Dashboard Jun 12

The Queen Elizabeth Hospital NHS
King's Lynn
NHS Foundation Trust

Quality & Risk

Indicator	Target	Actual	Trend
Crude Mortality	19	19.6	
RAMI	75.7	72.9	
SHMI	N/A	N/A	
Net Promoter - Inpatient	90	62	
Net Promoter - Outpatient	90	37	
EL LOS	2.2	1.9	
EM LOS	5.0	4.7	
Total LOS	4.3	4.3	
MRSA	1	0	
CDIFF	4	1	
Serious Incidents	0	6	
Never Events	0	1	
Serious Medication Errors	0	0	
Falls Resulting in Serious injury	0	0	
Pressure Ulcers - Grade 3 H.A	0	3	
Pressure Ulcers - Grade 4 H.A	0	0	
Number of MSA Breaches (Number of Patients)	0	0	
Clinical Complaints	N/A	27	
Non-Clinical Complaints	N/A	3	Trend avaliable from next month
Compliments	N/A	100	

CQC Concerns
CQC Concern Regarding Outcome 21

Performance & Standards

Indicator	Target	Actual	Trend
Monitor Compliance Framework Score		0	
18 Weeks - Admitted 95th Percentile Wait	90%	92.0%	
18 Weeks - Non Admitted 95th Percentile	95%	98.9%	
Cancer - 31 Days Subsq Treatment - Surgery	94%	100.0%	
Cancer - 31 Days Subsq - Drug Treatments	98%	100.0%	
Cancer - 62 Days Referral to Treatment	85%	81.5%	
Urgent GP Cancer - 2 Week Wait	93%	95.9%	
Cancer - 31 Days Diagnosis to Treatment	96%	100.0%	
A&E 4 Hour Attendance	95%	96.7%	
MRSA Screening - All Elective Inpatients	100%	100.0%	
Choose + Book - Slot Utilisation	90%	76.0%	
Day Case Rate	82.3%	86.5%	
DNA Rate	5%	5.5%	
New to Review Rate	2.3	2.5	
Stroke - 90% of Stay on a Stroke Unit	80%	85.1%	
Stroke - High Risk TIA treated in 24 Hrs	60%	71.4%	
VTE Assessment Completeness*	90%	97.9%	
Cancelled Ops	0.80%	0.30%	
Readmission Rate - Elective	2.5%	3.2%	
Readmission Rate - Emergency	5.1%	8.7%	

*18 Weeks, Cancer, Stroke, TIA & VTE figures are shown a month in arrears, this months figures shows May 12 information

Workforce

Indicator	Target	Actual	
Sickness Absence Rate	3.7%	4.2%	
Staff Turnover Rate	10.0%	8.5%	
Appraisal Completeness %	90.0%	74.6%	
Fire Training	70.0%	86.7%	
Infection Control Training	70.0%	75.4%	
Resuscitation Training	70.0%	82.8%	
Safeguarding Children Training	80.0%	88.0%	
Safeguarding Adults Training	70.0%	94.7%	
Information Governance Training	95.0%	80.2%	
Nurse Vancancies (as % of Nurse Posts)		6.1%	
Medical Vacancies (as % of Medical Posts)		4.3%	
Contracted People in Post	2779	2582	
Temporary Staff in Post	139	141	

Finance & Investment

		Full Year Plan	Full Year Forecast	Forecast Vs Prev Month	YTD Plan	YTD Actual	Variance Change to Prev Month
3.1	Surplus	1.7m	1.7m	↔	-0.5m	-0.5m	↓
3.2	EBITDA	8.8m	8.8m	↔	1.2m	1.3m	↓
3.3	Cash Balance	6.3m	6.3m	↔	6.3m	9.9m	↑
3.4	BSP - Overall Position	10.2m	8.7m	↓	0..93m	0.99m	↑

		Full Year Plan	Full Year Forecast	YTD Plan	YTD Forecasst
3.5	Finance Risk Rating	3	3	2	2

CONTENTS OF THIS REPORT

Purpose of the Report

This report presents in one document a summary of performance against the Trust's identified KPI's as described in the Quality and Performance dashboard. These KPI's have been agreed by the relevant sub-committee of the Board. The KPIs are reviewed annually by the appropriate Sub Committee of the Board of Directors.

The Report has been sectioned to align with the Trust Integrated Dashboard Headings in Chapters covering the following topics:-

Chapter 1 – Quality and Risk
Chapter 2 – Workforce
Chapter 3 – Performance and Standards
Chapter 4 – Finance and Investment

Each Chapter provides a commentary on key in month issues arising from a review of Trust performance and reports specifically on areas where performance is below Trust /national targets.

At the beginning of the Report an Executive Summary is provided which provides the Board of Directors with a high level summary of the month's issues.

EXECUTIVE SUMMARY OF PERFORMANCE

The Following section summarises the key issues from each Chapter of this Report and reports on the Trust's Performance against Monitor's Self-Assessment of Compliance against their Governance Framework.

Chapter 1 – Quality and Risk

1 There remains 1 outstanding Care Quality Commission (CQC) compliance actions following the CQC unannounced visit in August 2011 and subsequent follow up visit in January 2012. This is a one moderate concern reported against it in relation to "Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential."

2 The Trust reported 1 Clostridium Difficile infection and 0 MRSA infections in June 2012. The trust is below trajectory for quarter 1, reporting 7 confirmed Clostridium difficile infections against a trajectory of 14.

3 There were 3 Grade 3 Pressure Ulcers Reported in June 2012.

4 There were 6 Serious Incidents Report in June 2012.

5 The Net Promoter score for the Trust deteriorated in June 2012.

6 Readmission rates rose to 3.2% for elective activity and 8.7% for non-elective activity in June 2012.

Chapter 2 – Workforce

1 Sickness absence rates are 4.2% against a target of 3.7%

2 Appraisal performance is 74.6% against a target of 90%.

3 Information Governance training is 80.2% against a target of 95%.

Chapter 3 – Performance and Standards

1 Trust A&E performance for June 2012 was 96.7%. Quarter 1 was achieved with a performance of 96.7% which was slightly below the Trust aspiration of achieving 97%.

2 The Trust reported 81.5% against the 62 day cancer target for May (Cancer performance is reported one month in arrears). This was a result of 11 patients breaching the target. All other targets were achieved for the month, and forecast for Quarter 1 is achievement of all targets.

3 18 week RTT targets at Trust level for admitted and non-admitted were achieved in June 2012. At speciality level orthopaedics did not achieve the 90% target with performance at 72.2%

4 The Trust DNA rate and the New To Review Ratio rate were above target at 5.5% (target 5%) and 2.5% (target 2.3%) respectively.

5 The Trust did not meet the targets for the following Choose and Book KPIs:-

i. Choose and Book Booking % - 76% against a target of 90%
ii. Choose and Book Appointment Slot Issues (ASIs) – 0.18 against target rate of 0.05

Chapter 4 – Finance and Investment

1 For the month the Trust has scored an FRR of 1 compared to an expected FRR of 2. Year to date the Trust scored an FRR of 2 as per the plan. Year to date three of the individual metric have scored 2 (EBITDA Margin %, Net Return After Financing % and I&E Surplus Margin %). The Financial Efficiency criterion is the only one that combines two metrics (Net Return After Financing % and I&E Surplus Margin %) and since both of these have scored a 2, the Financial Efficiency criterion also scores a 2.

Monitor's Self-Assessment of Performance May and June 2012

The Trust confirms the outcome of their Monitor self-assessment of performance in June 12 as **Green** due to the revised Compliance Framework for 2012/13. Currently May's performance is showing as **Green-Amber** due to the 62 day cancer performance.

Chapter 1

Quality and Risk

1.1 CQC Compliance

There remains 1 outstanding Care Quality Commission (CQC) compliance actions following the CQC unannounced visit in August 2011. In January 2012 the CQC revisited the Trust to conduct a further unannounced inspection to review the outcome of the initial report and a further review of services within the Trust. The published report can be found at http://www.cqc.org.uk/sites/default/files/media/reports/RCX_The_Queen_Elizabeth_Hospital_Kings_Lynn_NHS_Foundation_Trust_RCX70_The_Queen_Elizabeth_Hospital_20120307.pdf.

Following the visit in January 2012 the Trust were found to have addressed the issues raised by the CQC following their visit in August but were subsequently found to have one moderate concern reported against "Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential."

The Trust are implementing a Board approved action plan to address this issue and at Appendix 1 of this section of the Report a summary of the outcome of the monitoring undertaken to assess ongoing compliance.

1.2 Reduction in risk adjusted mortality index (RAMI)

Attached is the latest analysis of our progress in reducing the RAMI by 5% per year, together with the crude death rate (compared to medical outliers) and death rate per 1,000 admissions (see Appendix 2).

Year	The QEH	Peer Group
2010/11	97.7	102.9
2011/12	80.7	91.9
2012/13 April to May	82.1	93.2

In the 2011/12, the Trust achieved a 17 point reduction in RAMI against a peer group improvement of 11. It is proposed to set a target of 75.7 for 2012/13 in accordance with our ambition of reducing mortality by 5% per annum. So far there has been slight slippage in our RAMI score for April and May but this is also reflected in our peer group. Our crude mortality deteriorated slightly in June (crude mortality per 1,000 admissions) (Appendix 3 of this chapter) but the corresponding RAMI is not yet available.

There are 3 current alerts recorded against the Trust by CHKS as follows:

- High rates of birth trauma injury to neonates – this is being investigated by the Division
- High rates of death in hospital within 30 days of non-elective surgery – this appears related to the recording of invasive procedures e.g. intubation in ITU, insertion of picc lines for intravenous therapy – however an in depth analysis of these patients is being led by Trudy Taylor, Head of Clinical Coding, with the support of the Elective Division. The trend analysis is available in appendix 5.
- Low rates of weekend discharge for emergency admissions as a % of the weekday rate – this was also identified by Dr Foster in the last Hospital Guide and forms part of the work on POD19.

In addition, the Trust will be monitoring trends in mortality by diagnosis (Appendix 2 of this Chapter) and the first 2 months figures are available. It is too early to detect any trends but any persistent outliers will be investigated in the future.

SHMI – the figure for the period of 1st January 2011 to 31st December 2011 is 1.

1.3 Patient Thermometer– June 2012 results

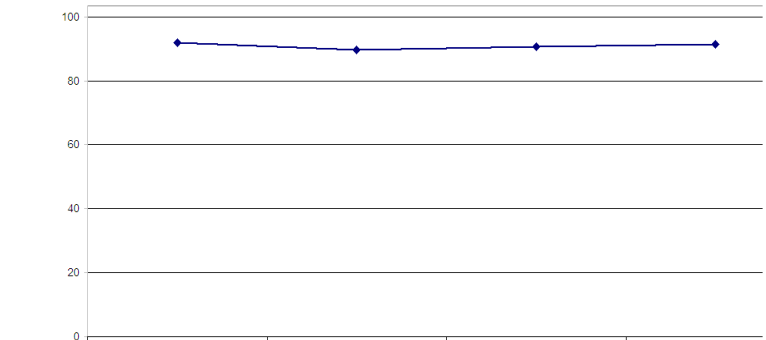
The NHS Safety Thermometer is a tool for measuring Patient Safety, developed by the NHS Information Centre. From April 2012 it is a national CQUIN target that the Safety Thermometer is used by all NHS-funded providers to collect data monthly on patient harm, specifically harm from pressure ulcers, falls, catheter-associated urinary tract infections (CAUTI), and venous thromboembolism (VTE). The Safety Thermometer is also the data collection tool for the NHS Harm Free Care programme, which has a goal of harm free care for 95% of patients by December 2012 (defined as absence of pressure ulcers, injury from falls, CAUTI and VTE).

Data was collected by the ward sisters on June 13th 2012. All eligible patients' details were captured (n = 471). 91% of patients experienced harm free care across the care pathway (i.e. 9% of patients were admitted with existing harms and/or developed a harm during their inpatient stay). 95% of patients experienced harm free care at the QEH (i.e. 5% were harmed during inpatient stay). This 5% equates to 25 patients across 10 wards with harms as follows:

- Category 2 pressure ulcer x 5 patients
- Category 3 pressure ulcer x 1 patient
- Fall with low harm x 13 patients
- Fall with moderate harm x 3 patients
- CAUTI x 3 patients

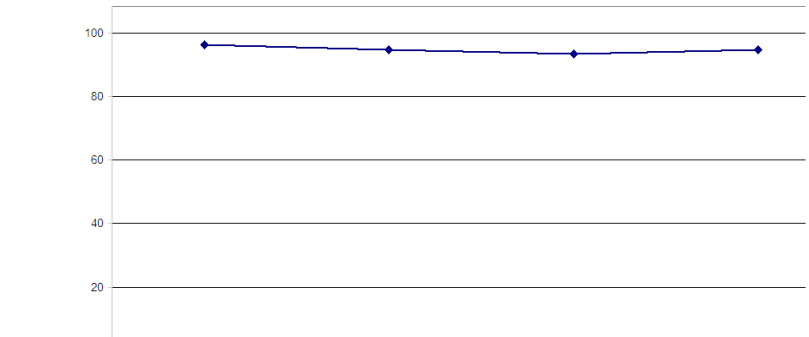
The tables below show the harm free (across patient pathway) and new harm (at QEHKL) results for the past four months (all figures are percentages).

Safety Thermometer: Proportion of patients with Harm Free Care
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST; All Wards and Teams; All Settings; All Services; All Ages; All Sexes



	Mar	Apr	May	Jun
Harm Free	91.93	89.59	90.59	91.3
Sample	508	490	489	471

Safety Thermometer: Proportion of patients with New Harms
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST; All Wards and Teams; All Settings; All Services; All Ages; All Sexes



	Mar	Apr	May	Jun
No New Harms	96.26	94.69	93.25	94.69
Sample	508	490	489	471

1.4 Readmission Rate

The readmission rate (compared to our target peer group) has deteriorated over the last year (April 2011 to March 2012) and the Trust is now in the lower quartile (Appendix 5 of this Chapter). This would require a detailed in depth analysis to determine whether there are any significant clinical issues or whether this relates to the coding of subsequent hospital attendances e.g. the recording of possible post-operative deep vein thrombosis as an inpatient (although investigated as an outpatient).

1.5 Open Serious Incidents

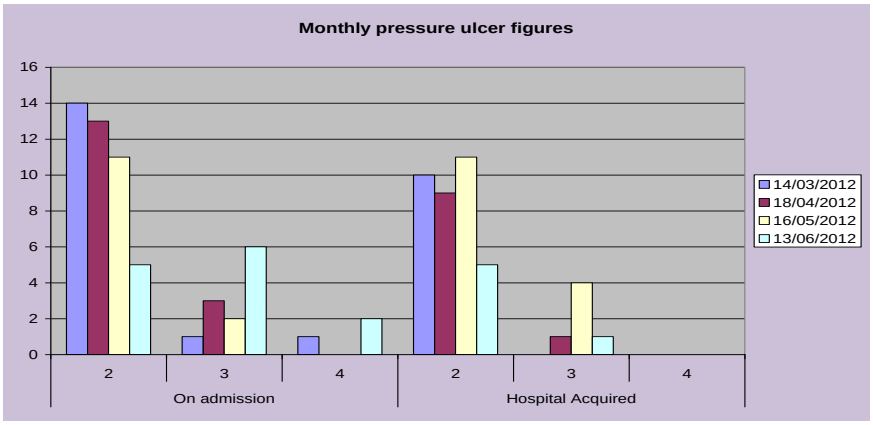
At present there are 21 serious incidents awaiting closure from 2011/12. RCA's and action plans are completed and have been submitted for 15 of the incidents. There are presently 6 incidents under investigation. Serious Incidents' reported since the last report are as follows:-

- 10 x grade 3 pressure ulcers,
- 1 x grade 4 pressure ulcer,

- 1 x delayed diagnosis and one
- 1 x Never Event (retained swab)

1.6 Pressure Ulcer Report

The Pressure ulcer data collected through the Safety Thermometer is shown below for the last three months. The number of hospital-acquired pressure ulcers fell in June.



Although not fully captured in the Safety Thermometer as it is a snap shot, we had 4 patients in the trust during June with hospital-acquired category 3 pressure ulcers.

Ward	Outcome
Leverington	Deteriorating sacral ulcer. Seen by TVNs. RCA completed; found to be unavoidable.
CCU	Sacral ulcer. Assessed by TVNs. Ward managing well. RCA completed; found to be unavoidable.
Tilney	Sacral ulcer. Seen by TVNs. RCA completed; found to be unavoidable.
Oxborough	Sacral ulcer. Not referred to TVNs; found on Safety Thermometer Audit. Assessed by TVNs. Awaiting RCA from the Matron. Ward teams have been reminded to refer all pressure ulcers to TVNs.

We are working towards the SHA's ambition of no avoidable hospital acquired pressure ulcers by December 2012. The Patient Safety Committee reviewed the action plan and agreed that it was on track – the key issues are:

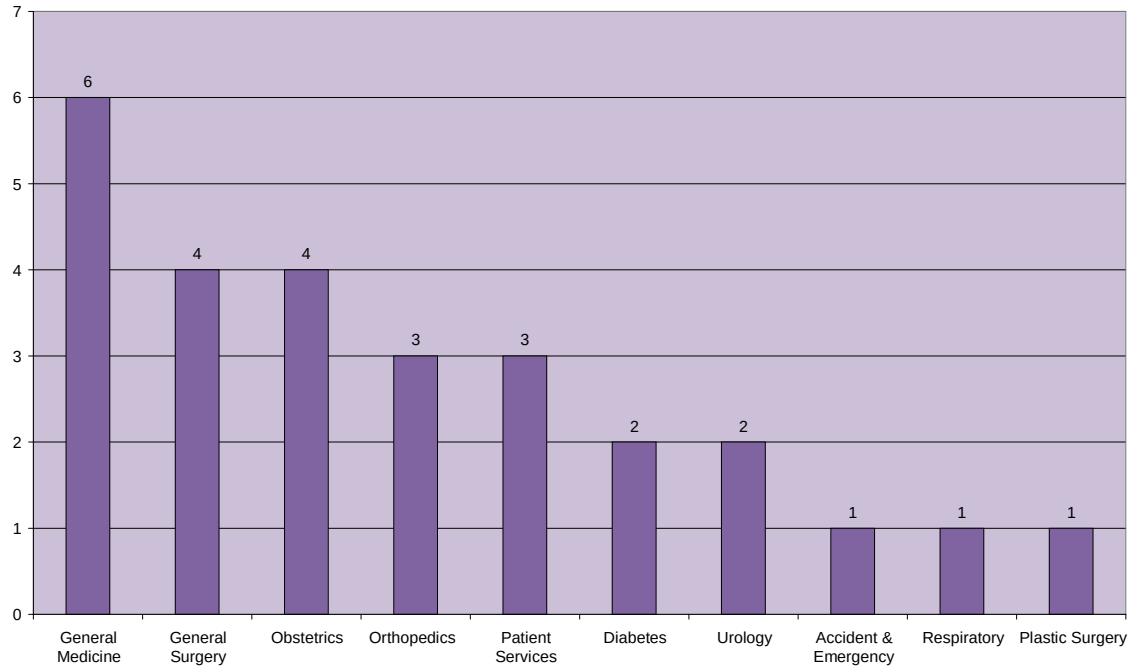
- Lack of Repose boots leading to pressure ulcer deterioration – the League of Friends have agreed to purchase these (plus other essential items) up to the value of approx. £100K.
- Poor documentation of the patient's waterlow score and wound management – new documentation implemented but additional audit and training continues.
- Patients visiting multiple wards during one inpatient stay – ward managers are flagging up to site practitioners if patients transferred more than 4 times.

1.7 Intravesical BCG for the Treatment of Bladder Cancer

There is a national shortage of intravesical BCG for the treatment of bladder cancer, which will require that this treatment is reserved for those who would most benefit from this treatment and that the management of some patients with bladder cancer is modified, necessitating surgery for some. The specialty is fully aware of this and is reviewing the management of those patients affected by this shortage.

1.8 Complaints

During June the Trust received 30 formal complaints. Of these there were 27 clinical complaints; the bar chart below identifies these by Service Line:



There were 3 non-clinical complaints reported.

1.8.1 Change of Practice as a result of a formal complaint from May 2012

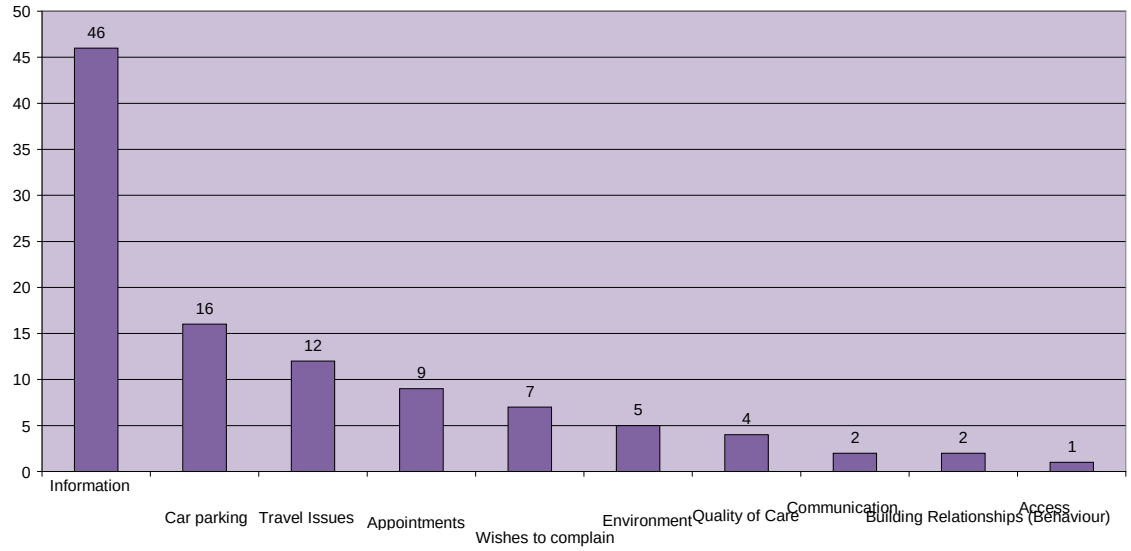
In May 2012 the Trust received a complaint from a gentleman who was admitted in 2011 for a carpal tunnel operation. Following this the patient has returned for check ups and found that the wound in his hand had not heals as well as it should have. The patient then found out he suffered a post-operative complication resulting in the patient now having reflex sympathetic dystrophy. Following an investigation where it was detailed that this is a rare complication, however, as a result of this complaint the consent forms for carpal tunnel will be updated to include that a possible side effect is reflex sympathetic dystrophy.

1.8.2 Conciliation Meetings

There were two conciliation meetings held during the month of June. The Complaints Department received positive feedback regarding a conciliation meeting that took place in May 2012. The family said that they were very pleased with the discussion and now feel that the matter is resolved. They were particularly grateful that the consultant involved attended and offered his apologies.

1.9 PALS

During June 2012 there were a total of 203 PALS enquiries, 99 of which were compliments. The other 104 contacts are detailed in the table below by subject:



1.10 Patient Experience Surveys Analysis

1.10.1 Out Patient Experience – June 2012

No outpatient surveys fully completed, reported and agreed in June 2012.

1.10.2 Inpatient Experience - June 2012

In June 2012, 800 questionnaires were distributed to all surgical and medical wards (50 per ward) as well as 100 to Women & Children wards (fifty to maternity (Castleacre) and 50 to Paediatrics (Rudham). In total 900 inpatient surveys were distributed by the Clinical Audit department across the Trust at the beginning of the first week of June.

June also saw a change to the questionnaire template (excluding Rudham questionnaire). Based on the results of the recent National Picker inpatient survey for this Trust further questions were added. We also continued to use the required NetPromoter question '*Would you recommend this hospital to friends and family'* as a score rather than a percentage as prior to April 2012. As a result of NetPromoter questions we have also included in this report the comments patients' gave when we asked *'What do we need to do to enable you to give us a score of 10?*

1.10.3 Method of distribution

The following method of distribution & analysis was used over the one month period:

- Week 1 – Surveys distributed surveys to all wards and offered to patients to complete.
- Week 2 & 3 – Surveys offered to patients to complete.
- Week 3 – Completed surveys returned to Clinical Audit for collation and analysis, on Friday of week 3.
- Week 4. Using the Key point data collection system, surveys were collated, scanned and analysis commenced prior to report writing in forthcoming week.

1.10.4 Response rates

The response rate for June fell from 72% in May to 41% in June 2012.

	June		May	
Surgical:	117/250	-47%	32/50	64%
Medical:	174/550	-32%	77/110	70%
Women & Children:	76/100	-76%	20/20	100%
Trust total response rate:	367/900	-41%	129/80	72%

1.11 Net Promoter

From June 2012, 50 surveys for each ward were included in Net Promoter indicator. Net Promoter score is used across the Trust as a way of measuring services against other services as well as allowing us to compare with other Trusts. The score is calculated by subtracting the number of patients who give a score of 0 – 6 (the detractor) from the number of patients who scored the service 9 – 10 (the promoter). Scores of 7 and 8 are excluded as patients who are ambivalent.

1.11.1 Analysis:

Key to RAG rating:

90 - 100% compliance with standard
75 - 89 % some compliance with standard
0 - 74% non compliance with standard

1.11.2 Medical and Surgical Wards

Overall, all the newly added questions failed to reach compliance with Trust standard expected**.** In the main, although some data still fails to reach compliance, communication findings have not improved in

June when compared to May findings. The findings around "*Conflicting information*" and "*Staff talk as though you are not there*" in showed improvement, but still not compliance with standards.

In the Environment strategy section, the question" *Call bell response*", the response rate dropped by 11% when compared to May 2012. Medications Strategy questions show a significant drop in all categories in June in comparison to May. In pain for the question" *Pain relief adequate*" dropped by 12% in June and in food for the question" *Offered alternate meal if missed*" improved in June by 10% when compared to last analysis.

Despite the drop in compliance with standards the overall Net Promoter score for the Medical & Surgical wards combined was 62 compared to 57 in May.

Red Indicators for these Wards were in the areas of:

- Waiting Times
- Ward Routine Information
- EDD discussed
- Contact if worried about condition
- Enough nurses to care
- Clear written information about medications
- Were you warned of side-effects of medication
- Feelings about post operation pain management
- Recommend this hospital? Net Promoter Score.

1.11.3 Women and Children Division

Both Rudham Ward and Castleacre Ward provided questionnaire data returns June 2012. Combined, there was a 55% response rate from the Women & Children Division in May but in June despite an increase of surveys to complete the response rate increased to 76%.

1.11.3.1 Castleacre Ward

Overall, the newly added questions for Castleacre ward showed compliance with Trust policy, except in two aspects.

Communication mainly showed improvement except in the question around "*EDD discussed*" and *" contact if worried about condition",* where the findings were lower than in the May analysis. 100% of the all questions in the "*Staff attitude", "privacy and dignity*" and "*pain*" sections showed that they are in compliance with trust policy.

In the medication section the question "*Were you warned of side effects"* showed a drop of 7% and in Food section for the question*" offered alternate if missed meal*" the response rate dropped significantly by 33% when compared to May. Of the 34 questions asked where a percentage response was required, 62% scored 'green' in the RAG rating.

The Net Promoter score for Castle Acre ward was 62 in June 2012.

Red Indicators for Castleacre Ward were in the areas of:

- Ward Routine Information
- EDD discussed
- Enough nurses to care
- Clear written information about medications
- Were you warned of side-effects of medication
- Offered alternative if missed meal
- Recommend this hospital? Net Promoter Score.

1.11.3.2 Rudham Ward

Of 50 questionnaires distributed to Rudham ward, 32 were completed and returned for analysis. The questionnaire is aimed at children and no changes were made to the original questionnaire distributed in April 2012, although 50 questionnaires were distributed instead of 10.

Overall the response rate received from Rudham dropped in June when compared to May. Communication and information sections showed a drop in compliance in two of the questions asked. Of the fifteen questions included in this questionnaire, 5 (33%) were rated as 'green'. When asked, "Would you be happy *to return to ward in future*" a 2% improvement was seen in June when compared to May.

The Net Promoter score for Rudham ward was excluded.

Red Indicators for Rudham Ward were in the areas of:

- Were your parents shown around the ward
- Were you in a side room
- Did you know if coming into hospital
- Enough choice of breakfast
- Enough choice of lunch
- Enough choice of dinner

1.11.4 As a result of the change in the amount of surveys distributed some administrative problems were encountered by the ward staff and the Clinical Audit team. These have been summarised below.

1.11.4.1 Issues arising

1) A lot of wards have the same patients.
2) Some wards have very few patients (ITU and Shouldham).
3) Elderly patient / dementia / confusion percentage.
4) It's very difficult for elderly patients to read and answer the questions.
5) Too many questions.
6) Increase of work load for Ward staff / Clinical Audit team.

1.11.4.2 Recommendations

1) Reduce the number of questions.
2) If inpatient surveys are done once in a year or half yearly the response rate may improve.
3) Increase the amount of time allocated to work on inpatient surveys.
4) Cost of printing / staff resources.
5) Needs to administrators to work on it
6) If we do 20 instead of 50 survey per ward that may help us to solve the problem.

1.12 The Friends and Family Test (Net Promoter Score)

Medical and surgical inpatients are now being given a postcard on discharge on which to record their answer to the question:"How likely is it that you would recommend this service to friends and family?"

The responses offered are:

- Extremely likely
- Likely
- Neither likely nor unlikely
- Unlikely
- Not at all
- Don't know

The postcards are self-addressed with postage paid to a third party organisation which analyses the results to produce the "Net Promoter" score which is reported to the Trust and to the Strategic Health Authority.

Each Trust is required to survey at least 10% of their discharged patients each month. In June 2012 postcards were received from 6.2% of patients discharged from this Trust. To improve our response rate the discharge lounge staff now remind patients to complete their postcards and post them before they leave the hospital.

In May 2012, the Trust score was 71. The average score across the regional cluster was 63 with a range from 29 to 89 (the Target Score set by NHS Midlands and East is 71).

For information the scores of all the Region's acute Trusts is shown in the table 1 overleaf. (The symbol X denotes Trusts which had a response rate of >10%).

Table 1: Net Promoter Scores of Acute Trusts in the East and Midlands May 2012

Provider		Score
Basildon and Thurrock University Hospitals NHS Foundation Trust		65
Bedford Hospital NHS Trust		53
Birmingham Children's Hospital NHS Foundation Trust		63
Birmingham Women's NHS Foundation Trust		65
Burton Hospitals NHS Foundation Trust		73
Cambridge University Hospitals NHS Foundation Trust		41
Chesterfield Royal Hospital NHS Foundation Trust		35
Colchester Hospital University NHS Foundation Trust		76
Derby Hospitals NHS Foundation Trust		60
East and North Hertfordshire NHS Trust		75
George Eliot Hospital NHS Trust		52
Hinchingbrooke Health Care NHS Trust		89
Ipswich Hospital NHS Trust		72
James Paget University Hospitals NHS Foundation Trust	X	50
Kettering General Hospital NHS Foundation Trust		64
Luton and Dunstable Hospital NHS Foundation Trust	X	29
Mid Essex Hospital Services NHS Trust		56
Mid Staffordshire NHS Foundation Trust		56
Milton Keynes Hospital NHS Foundation Trust		48
Norfolk And Norwich University Hospitals NHS Foundation Trust		65
Nottingham University Hospitals NHS Trust		55
Papworth Hospital NHS Foundation Trust		78
Peterborough and Stamford Hospitals NHS Foundation Trust		57
Robert Jones and Agnes Hunt Orthopaedic and District Hospital...		89
Sandwell and West Birmingham Hospitals NHS Trust		57
Sherwood Forest Hospitals NHS Foundation Trust		83
Shrewsbury and Telford Hospital NHS Trust		65
South Warwickshire NHS Foundation Trust		68
Southend University Hospital NHS Foundation Trust		68
The Dudley Group Of Hospitals NHS Foundation Trust		77
The Princess Alexandra Hospital NHS Trust	X	83
The Queen Elizabeth Hospital, King's Lynn. NHS Foundation Tr...	X	71
The Royal Orthopaedic Hospital NHS Foundation Trust		77
The Royal Wolverhampton Hospitals NHS Trust	X	72
University Hospital of North Staffordshire NHS Trust		66
University Hospitals Birmingham NHS Foundation Trust		53
University Hospitals Coventry and Warwickshire NHS Trust		44
University Hospitals of Leicester NHS Trust		51
Walsall Healthcare NHS Trust		66
West Hertfordshire Hospitals NHS Trust		46
West Suffolk Hospitals NHS Trust		84
Worcestershire Acute Hospitals NHS Trust		77
Wye Valley NHS Trust		49

1.13 NHS Choices

There have been two new stories uploaded onto the NHS Choices website since the last report. One was in relation to Maternity services where the comments were very positive and the second was in relation to general surgery where the overall rating was neither satisfied nor dissatisfied with the service.

Average ratings on NHS Choices website for The Queen Elizabeth Hospital King's Lynn:

(a) The environment where I was treated was…

clean

43 ratings received

(b) The hospital staff worked well together…

most of the time

43 ratings received

(c) I was treated with dignity and respect by the hospital staff…

most of the time

42 ratings received

(d) I was involved with decisions about my care…

some of the time

36 ratings received

Action taken on these comments - Each comment has been forwarded to the Director of Patient Experience and to the Divisional Chief Nurse for the services identified in the comment for them to share with their teams as appropriate.

PATIENT EXPERIENCE APPENDIX 1 – WARD HEATMAP

The Queen Elizabeth Hospital NHS
King's Lynn
NHS Foundation Trust

WARD DASHBOARD - JUNE 2012

	Measure	A & E	CCU	Castleacre	Day Surgery	Delivery Suite	Denver	Elm	Feltwell	Gayton	Leverington	MAU	Necton	Newton Rehab	NICU	Oxborough	Pentney	Rudham	SAU	Shouldham	Stanhoe	Terrington	Theatre	Tilney	W Raynham
CQC 1 Respect & Inv	comp v non																								
CQC 2 Consent	comp v non																								
CQC 4 Care & Welfare	comp v non																								
CQC 5 Nutrition	comp v non		⇔	⇔			⇔	⇔	⇔	⇔	⇔	⇩	⇩	⇩	⇔	⇔	⇧	⇧	⇔	⇔	⇩	⇩		⇔	⇔
CQC 6 Co other providers	comp v non																								
CQC 7 Safeguarding	comp v non																								
CQC 8 Inf Control	comp v non																								
CQC 9 Medication	comp v non		⇩	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇩	⇔	⇔	⇩	⇔	⇔	⇔	⇔	⇩	⇧	⇔	⇔
CQC 10/11 Safety Premises/Equip.	comp v non																								
CQC 12/13/14 Staffing	comp v non																								
CQC 16/17 Quality Service/Complaints	comp v non	⇔	⇔	⇩	⇔	⇩	⇔	⇔	⇔	⇔		⇔	⇔	⇔	⇔	⇔	⇔	⇩		⇔	⇩	⇔	⇔	⇔	⇔
CQC 21 Records	comp v non		⇔	⇩		⇩	⇔	⇔	⇩	⇧	⇩	⇔	⇧	⇔	⇩	⇧	⇩	⇔	⇧	⇩	⇔	⇩	⇔	⇧	⇩
Safety Thermometer - harm Free	95% Target		⇔	⇔		⇔	⇔	⇧	⇧	⇩	⇩	⇔	⇩	⇔	⇧	⇩	⇔	⇔	⇔	⇔	⇩	⇩		⇔	⇩
Patient Observations (orange = no fluid charts Rcvd)	%	N/A	N/A	⇧	N/A	N/A	⇔	⇧	⇩	⇩	⇧	⇧	⇧	⇧	⇔	⇧	⇧	⇧		⇧	⇧	⇩	N/A	⇔	⇔
High Impact Interventions	%	⇧	⇔	⇔	⇧		⇩	⇧	⇔	⇩	⇩	⇩	⇧	⇔	⇩		⇩	⇧	⇔	⇔	⇩	⇩		⇩	⇔
Complaints	0	⇧						⇩		⇔	⇔	⇧	⇧	⇧			⇩	⇔			⇧				
SI's & Never Events	0																								
Falls	0	⇧					⇧	⇔	⇩	⇧		⇧	⇧			⇧	⇩		⇧	⇩	⇧	⇩		⇧	⇧
Falls + SI (# of serious harm)	0																						⇧		
C Diff Positive >2 days post admission	0																				⇧				
MRSA Bacteraemias >2 days post adm.	0																								
Norovirus	0																								
Press Ulc 3/4 avoidable	0																								
Press Ulc 3/4 unavoidable	0		⇧								⇧													⇧	
Vacancy Ward Sister - Band 7	0															⇧									
Sickness Reg	<3.5%	⇧	⇩	⇧	⇧		⇧	⇧	⇧	⇩	⇩	⇩	⇩	⇧	⇩	⇩	⇧	⇧	⇧	⇧	⇩	⇧	⇩	⇩	⇩
Sickness Unreg	<3.5%	⇧	⇧	⇧	⇧		⇧	⇩	⇩	⇩	⇩	⇩	⇩	⇩	⇧	⇩	⇩	⇩	⇩	⇧	⇧	⇩	⇧	⇩	⇩
Patient Experience (Net Promoter)		N/A	⇧	⇧	N/A	N/A	⇩	⇧	⇧	⇩	⇧	⇧	⇧	⇧	N/A	⇧	⇧	⇧	N/A	⇩	⇩	⇩	N/A	⇧	⇩

NB.

Sickness - Delivery Suite results are calculated in with Castleacre by Information Services
There was no Norovirus during June. There was 1 serious incident where a swab was retained during surgery, Pauleen Pratt is leading the investigation.
Falls targets are based on the previous years performance, where the ward total is lower than the monthly total for 2011-12 they score green, if greater they score red.
The PUs were all category 3.

Key:	Compliant	Minor Non Compliance	Non compliant	Not audited	Some paperwork not received
Patient Observations	100%	Between 90 & 99%	Below 90%		
High Impact Interventions	At or above 95%	Between 85 & 94%	At or below 84%		

Appendix 2

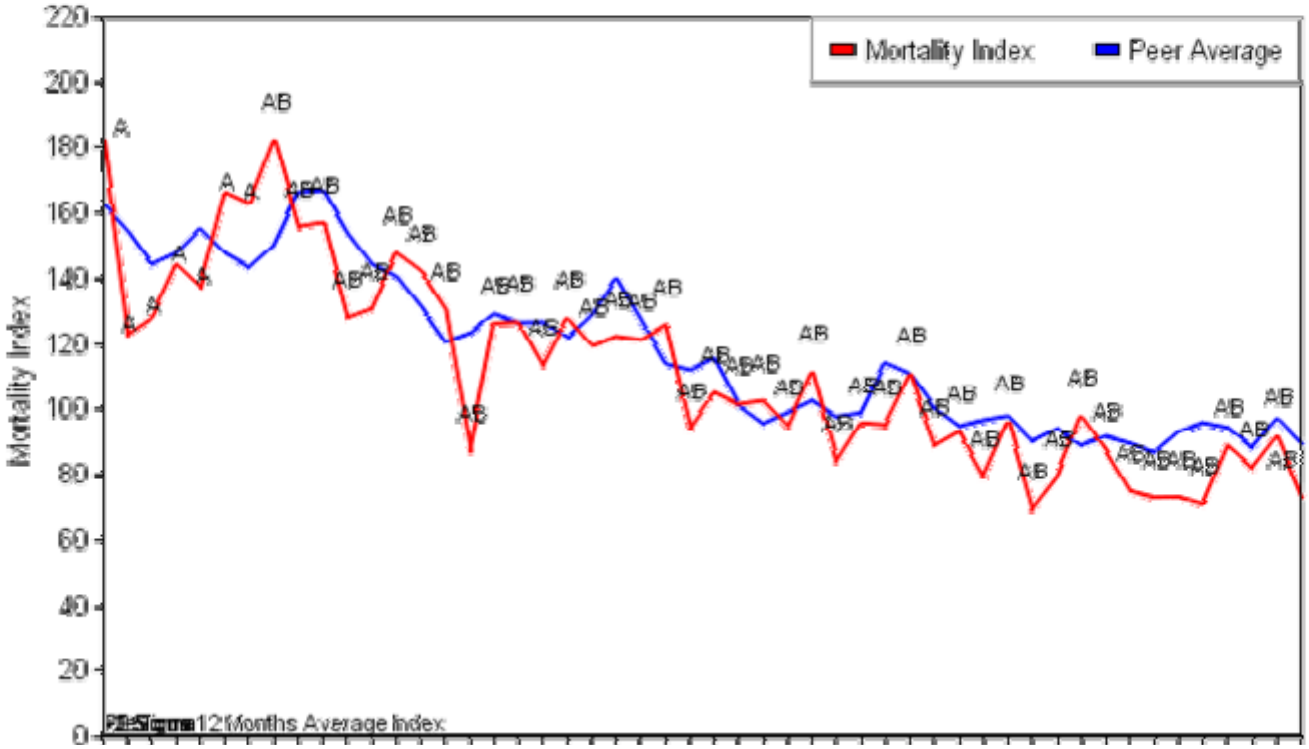
Mortality by Diagnosis Top 60 YTD: April 2012 - May

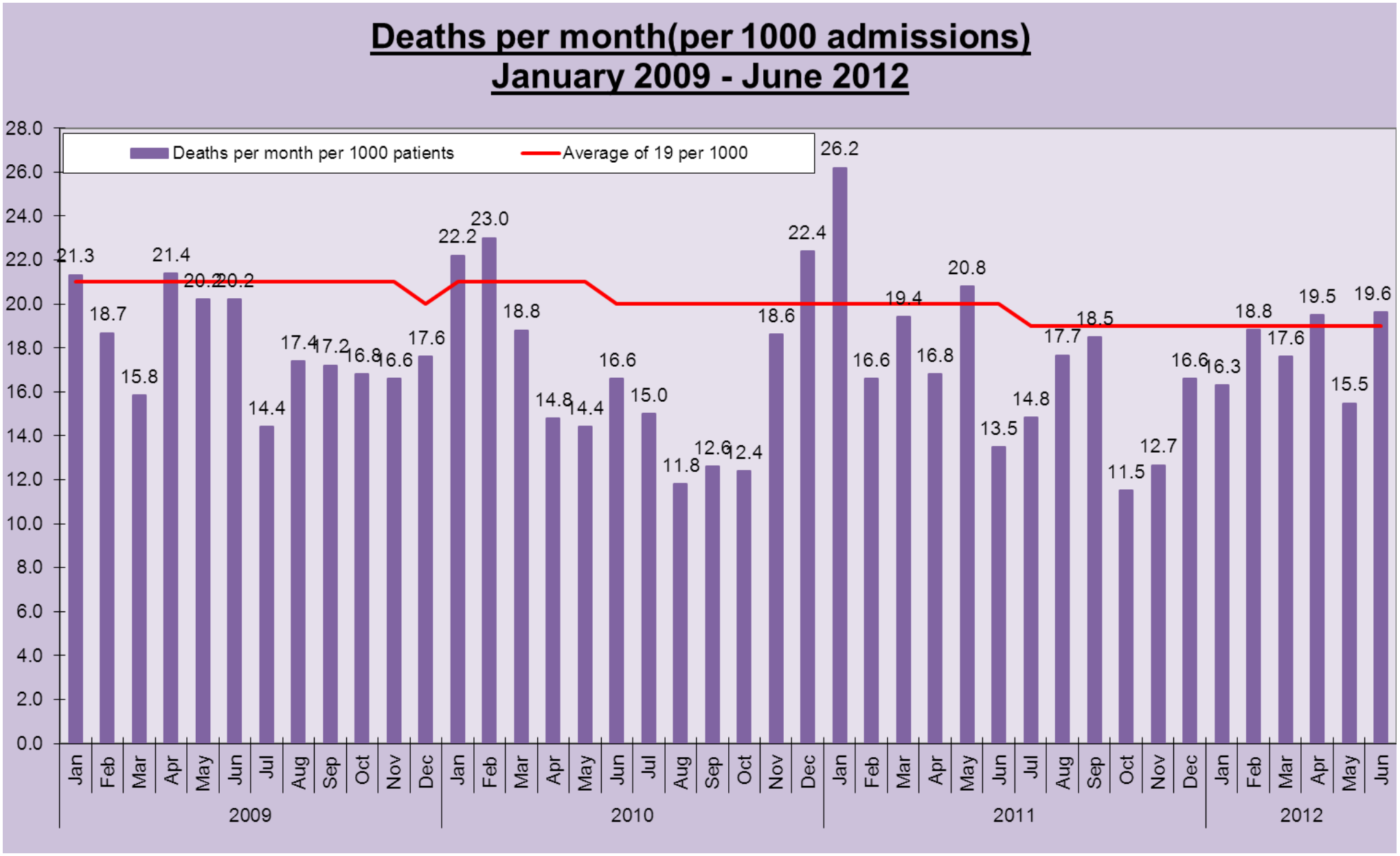
Procedure	Actual	Expected	Crude	RAMI
J18 - Pneumonia; organism unspecified	41	45.24	23.70%	91
I50 - Heart failure	14	13.66	25.45%	102
J22 - Unspecified acute lower respiratory infection	11	8.87	10.00%	124
N39 - Other disorders of urinary system	9	4.76	5.92%	189
J69 - Pneumonitis due to solids and liquids	8	7.64	72.73%	105
N17 - Acute renal failure	7	5.37	25.93%	130
J44 - Other chronic obstructive pulmonary disease	5	15.72	3.65%	32
A41 - Other sepsis	5	11.62	8.93%	43
I21 - Acute myocardial infarction	5	6.28	6.41%	80
K92 - Other diseases of digestive system	5	3.42	4.03%	146
C34 - Malignant neoplasm of bronchus and lung	4	2.83	4.71%	141
R54 - Senility	4	5.05	7.02%	79
L03 - Cellulitis	3	2.45	6.82%	123
C56 - Malignant neoplasm of ovary	3	0.84	9.68%	356
C71 - Malignant neoplasm of brain	3	0.03	33.33%	10909
C92 - Myeloid leukaemia	3	1.81	7.89%	166
R41 - Other symptoms and signs involving cognitive functions and awareness	3	2.87	7.69%	105
I61 - Intracerebral haemorrhage	3	4.86	27.27%	62
R55 - Syncope and collapse	3	5.03	3.13%	60
S72 - Fracture of femur	3	4.55	4.92%	66
I62 - Other nontraumatic intracranial haemorrhage	3	2.73	75.00%	110
K56 - Paralytic ileus and intestinal obstruction without hernia	2	2.62	7.69%	76
C50 - Malignant neoplasm of breast	2	0.85	0.94%	236
K70 - Alcoholic liver disease	2	0.61	18.18%	327
C20 - Malignant neoplasm of rectum	2	0.15	4.17%	1362
C80 - Malignant neoplasm without specification of site	2	0	50.00%	0
I63 - Cerebral infarction	2	7.06	3.03%	28
S01 - Open wound of head	2	2.26	4.88%	88
C61 - Malignant neoplasm of prostate	2	0.14	3.28%	1381
I26 - Pulmonary embolism	2	2.1	16.67%	95
I71 - Aortic aneurysm and dissection	2	1.81	33.33%	110
R00 - Abnormalities of heart beat	1	0.18	9.09%	555
C15 - Malignant neoplasm of oesophagus	1	0.01	4.55%	7752
R13 - Dysphagia	1	0.11	3.85%	890
D50 - Iron deficiency anaemia	1	1.26	0.35%	79
J15 - Bacterial pneumonia; not elsewhere classified	1	1.07	50.00%	93
D64 - Other anaemias	1	0.41	2.78%	245
R10 - Abdominal and pelvic pain	1	0.68	0.40%	146
E11 - Non-insulin-dependent diabetes mellitus	1	0.64	2.44%	155
R40 - Somnolence; stupor and coma	1	0.42	20.00%	239
K22 - Other diseases of oesophagus	1	0.88	1.35%	114
R63 - Symptoms and signs concerning food and fluid intake	1	0.2	5.00%	505
E16 - Other disorders of pancreatic internal secretion	1	0.63	3.85%	160
C54 - Malignant neoplasm of corpus uteri	1	0.78	7.14%	127
K63 - Other diseases of intestine	1	1.03	1.75%	97
R07 - Pain in throat and chest	1	1.55	0.50%	65
G40 - Epilepsy	1	0.43	2.63%	233
R11 - Nausea and vomiting	1	1.21	3.45%	83
C22 - Malignant neoplasm of liver and intrahepatic bile ducts	1	0.45	16.67%	223
R19 - Other symptoms and signs involving the digestive system and abdomen	1	0.56	1.52%	179
C25 - Malignant neoplasm of pancreas	1	0.79	4.35%	127
C18 - Malignant neoplasm of colon	1	0.81	1.09%	124
L89 - Decubitus ulcer and pressure area	1	0.11	50.00%	873
C91 - Lymphoid leukaemia	1	0.87	2.78%	115
M25 - Other joint disorders; not elsewhere classified	1	1	2.86%	101
A09 - Other gastroenteritis and colitis of infectious and unspecified origin	1	1.71	0.85%	59
I27 - Other pulmonary heart diseases	1	0.85	100.00%	118
T85 - Complications of other internal prosthetic devices; implants and grafts	1	0.83	5.88%	121
N32 - Other disorders of bladder	1	0.33	1.12%	300
C64 - Malignant neoplasm of kidney except renal pelvis	1	0.01	12.50%	9524
Grand Total	**194**	**193.02**	**5.52%**	**101**

Risk Adjusted Mortality 2012

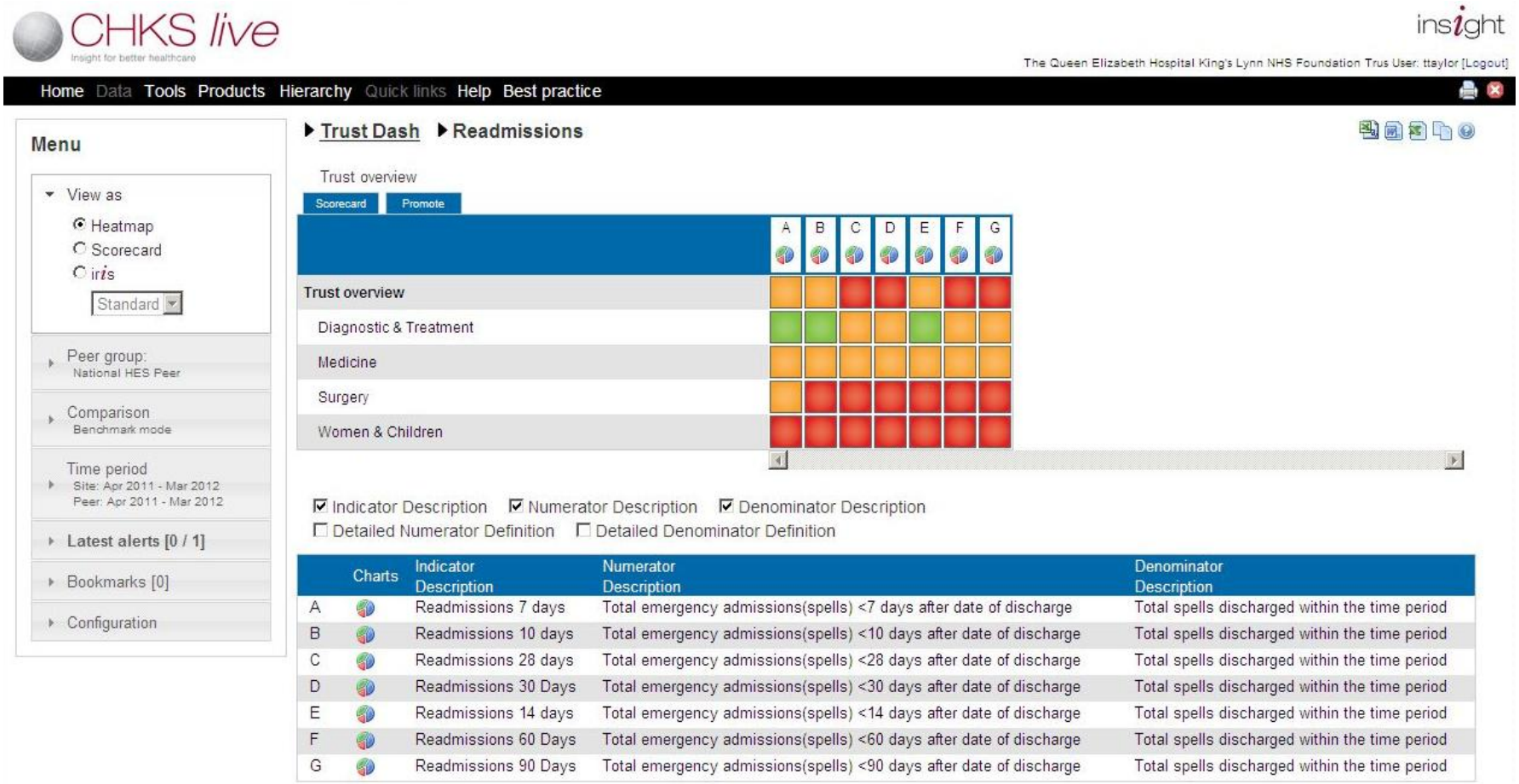
Hierarchy	: Trust Overview		
	:		
Filter	: None	**Peer group**	: 1st map
Time period	: Apr 2008 to May 2012	**Peer group period**	: Apr 2008 to May 2012

Risk Adjusted Mortality 2012 Trending




Deaths per month(per 1000 admissions)
January 2009 - June 2012
Deaths per month per 1000 patients
Average of 19 per 1000
28.0
26.0
24.0
22.0
20.0
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
21.3
18.7
15.8
21.4
20.2
20.2
14.4
17.4
17.2
16.8
16.6
17.6
22.2
23.0
18.8
14.8
14.4
16.6
15.0
11.8
12.6
12.4
18.6
22.4
26.2
16.6
19.4
16.8
20.8
13.5
14.8
17.7
18.5
11.5
12.7
16.6
16.3
18.8
17.6
19.5
15.5
19.6
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
2009
2010
2011
2012

Patient Safety Appendix 5 – Readmissions Heat Map



	Charts	Indicator Description	Numerator Description	Denominator Description
A		Readmissions 7 days	Total emergency admissions(spells) <7 days after date of discharge	Total spells discharged within the time period
B		Readmissions 10 days	Total emergency admissions(spells) <10 days after date of discharge	Total spells discharged within the time period
C		Readmissions 28 days	Total emergency admissions(spells) <28 days after date of discharge	Total spells discharged within the time period
D		Readmissions 30 Days	Total emergency admissions(spells) <30 days after date of discharge	Total spells discharged within the time period
E		Readmissions 14 days	Total emergency admissions(spells) <14 days after date of discharge	Total spells discharged within the time period
F		Readmissions 60 Days	Total emergency admissions(spells) <60 days after date of discharge	Total spells discharged within the time period
G		Readmissions 90 Days	Total emergency admissions(spells) <90 days after date of discharge	Total spells discharged within the time period

Patient Safety Appendix 6– Deaths within 30 days of surgery – trend analysis

CHKS *live*
Insight for better healthcare

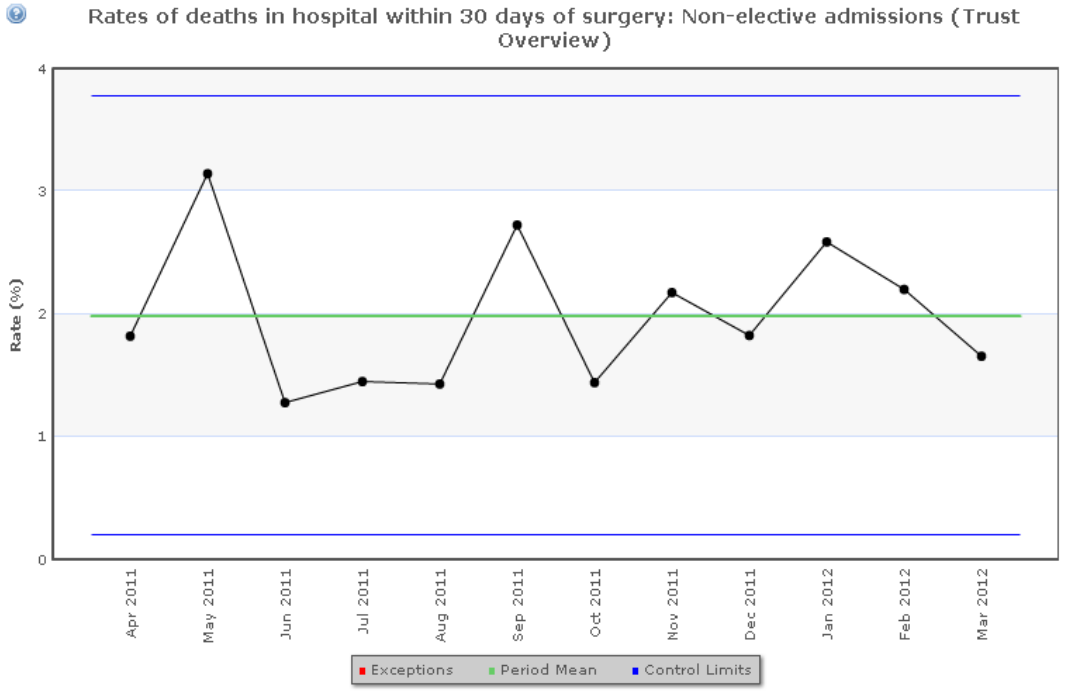
insight

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trus User: GHunnam [Logout]

Home Data Tools Products Hierarchy Quick links Help Best practice

Patient Safety

Hierarchy	: Trust Overview			
Report	: Summary -> Patient Safety Theme: Organisation wide -> Drill Down -> Time Analysis			
Filter	: None	Peer group	:	1st map
Time period	: Apr 2011 to Mar 2012	Peer group period	:	Apr 2011 to Mar 2012



Chapter 2

Workforce

2.1 Staff Sickness %

The higher absence rate could be contributed to the change within the organisation. Within both Elective and Corporate the HRBP is working with managers to ensure that for all long term absences of four or more there is a plan in place and monitoring meetings go ahead.

The absence levels for theatres meant that we did lose Day Surgery Case theatre lists in the w/c 2/7/12, however this is not the norm. Day surgery experienced excessive sickness that week and unfortunately this was the case in main theatres too. Usually Day Surgery can help out if there is a high level of absence in main theatres and vice versa but on this occasion cover could not be provided. One list was lost all day on Wednesday, Thursday and Friday of that week but none since. Theatres are currently in the process of interviewing for three band five nurses/ODPs on Friday 20th July which should help. Unfortunately it is not possible to cover these absences with locum staff although cover with bank staff is arranged where at all possible. However, it should be noted that for the week including 2nd/3rd July the average of 180 cases (excluding gynae) was exceeded (187 cases) so although there was an impact, it was limited as far as practically possible.

2.2 Appraisals %

Month	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Target	90	90	90	90	90	90	90	90	90	90	90	90
Actual	71	72.5	70.3	70	71	67.9	63.3	58	72.1	71.8	73.1	74.6

Action taken to ensure target is met

- Appraisal workshops for managers provided on a regular basis.
- Reports produced on a monthly basis indicating the appraisal percentage by Directorate/Division/Department. Sent to Divisional Managers and HR Business Partners.
- Monthly reports detailing individual staff whose appraisal is overdue. Sent to Department Managers.
- A KPI discussed at Divisional Performance Reviews
- Bespoke interventions tailored to meet Divisional requirements e.g. team and 'express' appraisal.

2.3 Bank Usage

Increases in vacancies and a high level of sickness has led to a slight increase in bank usage. Divisions continue to review Bank usage such as not to exceed post establishment levels. (It should be noted that bank staff are paid a month in arrears so data relates to work done the previous month).

2.4 Mandatory Training

The only area of mandatory training highlighted as red on the integrated dashboard is Information Governance with a score of 80.2% against a target of 95%.

Information Governance Training % Complete Trust

Month	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	No. of staff	
													Total	Trained
Target	95	95	95	95	95	95	95	95	95	95	95	95		
Actual	81.6	81.8	82	81.6	81.1	77	72.8	74.9	90.1	87.4	83.6	80.2	3202	2569

Action taken to ensure target is met

- The date last year to meet 95% compliance was 30 June. In order to achieve that target 554 staff were trained in June 2011 compared with 205 in June 2012.
- Consequently, the rate has continued to drop but it's anticipated that it will start to increase from July onwards.
- All those non-compliant staff has been identified, local management informed and assurances sought that these staff are to undertake training.

Areas of mandatory training flagged as amber across the Trust are presented below:

Conflict Resolution Training % Complete Trust

Month	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	No. of staff	
													Total	Trained
Target	70	70	70	70	70	70	70	70	70	70	70	70		
Actual	57.2	57.5	53.8	50.2	48.6	49	48.8	54.2	54.3	56.4	58.2	60.4	3202	1935

Action taken to ensure target is met

Trust needs to ensure managers send staff to available sessions to reach the 70% target figure.

The low figure is as a direct result of all staff being trained 3 years ago and all now needing a refresher course at the same time. The intention is to train over 12 months to avoid the same situation reoccurring again in the future.

With effect from 2012 the 1-day Conflict Resolution Training (CRT) has been incorporated into induction week at the start of each month

Two additional members of staff are now trained to deliver training which should positively impact on the figures.

Progress is being made however this is slow and continues to be a priority.

2.4 General Workforce Updates

2.4.1 e-Rostering

The Trust made the decision in Spring 2011 to invest in an e-Rostering system. The main benefits of e-Rostering are;

- It enables managers to quickly build their rosters, defining the number of employees (by skill mix) needed to meet the demands of the service.
- Reduction in temporary staff due to optimising the use of existing permanent staff.
- Employees can roster themselves to work within the slots defined.
- Pay details are interfaced directly to the payroll, avoiding the need to complete claim forms.
- Integrates with the bank module, improving management of temporary staff.
- It enables trusts to manage their workforce more flexibly.
- It makes it easier for employees to choose a better work-life balance.

The system chosen was HealthRoster, provided by Allocate., which is the UK's most widely used e-Rostering solution, used in over 60% of trusts.

Phase 1 of the project, roll out of training and use of the system to the nursing wards is on target for completion by the end of August. The next phase will be to implement;

1. The claim form interface to payroll (ESR), removing the need to complete manual forms.
2. The bank module, which will allow users to request temporary staff cover when setting the roster.
3. The absence interface to ESR, removing the need to record absence directly on to ESR.

Plans are shortly to be developed to explore the potential of rolling out the system to other areas, which may include Hotel Services, Estates and Clinical Support.

By the end of August, 985 staff will be using the system which is 80% of the nursing workforce (33% of the entire workforce). If all 824 staff in Hotel Services, Estates and Clinical Support

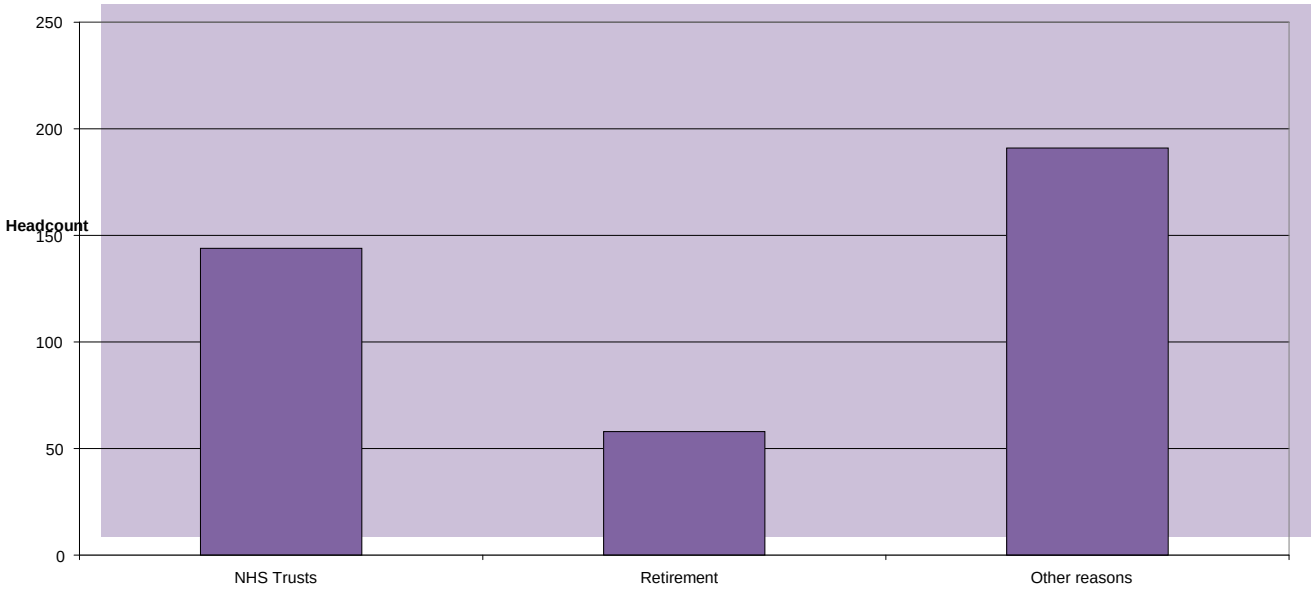
are also to use the system this would account for a further 27%, bringing the figure for the staff using eRostering up to 60% of the entire workforce.

2.4.2 Reasons for Leaving

Updated analysis, based on the reference period 1st April 2011 to 31st March 2012 is as follows;

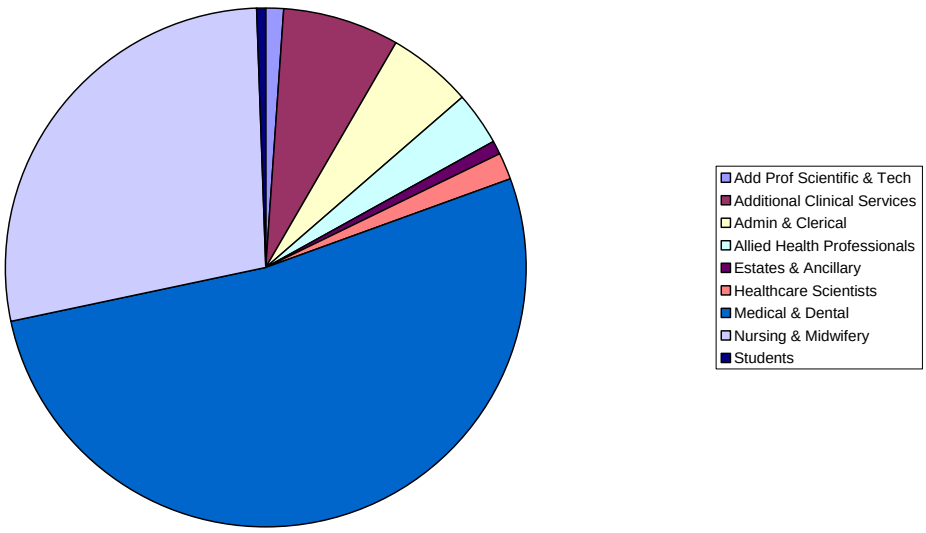
393 staff (headcount) left during the period. 144 moved to other NHS Trusts, 58 retired and the remaining 191 left for other reasons, including moving abroad, further education, General Practice, dismissal and end of fixed term contract.

Leavers 1 April 2011 to 31 March 2012 by reason for leaving

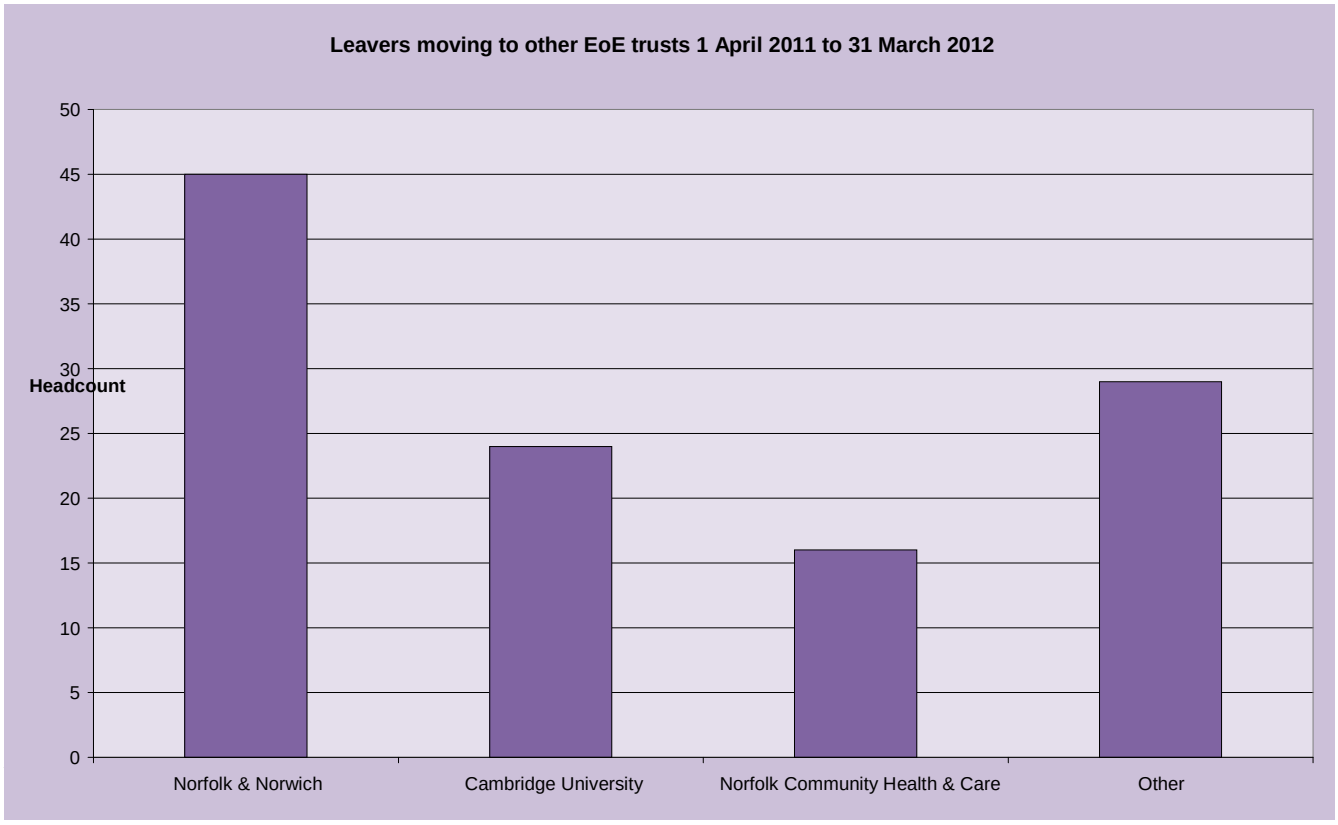


As would be expected, the vast majority of staff leaving for other trusts move within the East of England. Medical & Dental staff account for the highest numbers moving to other trusts. This is mainly due to doctors in training (73) moving as part of their rotation.

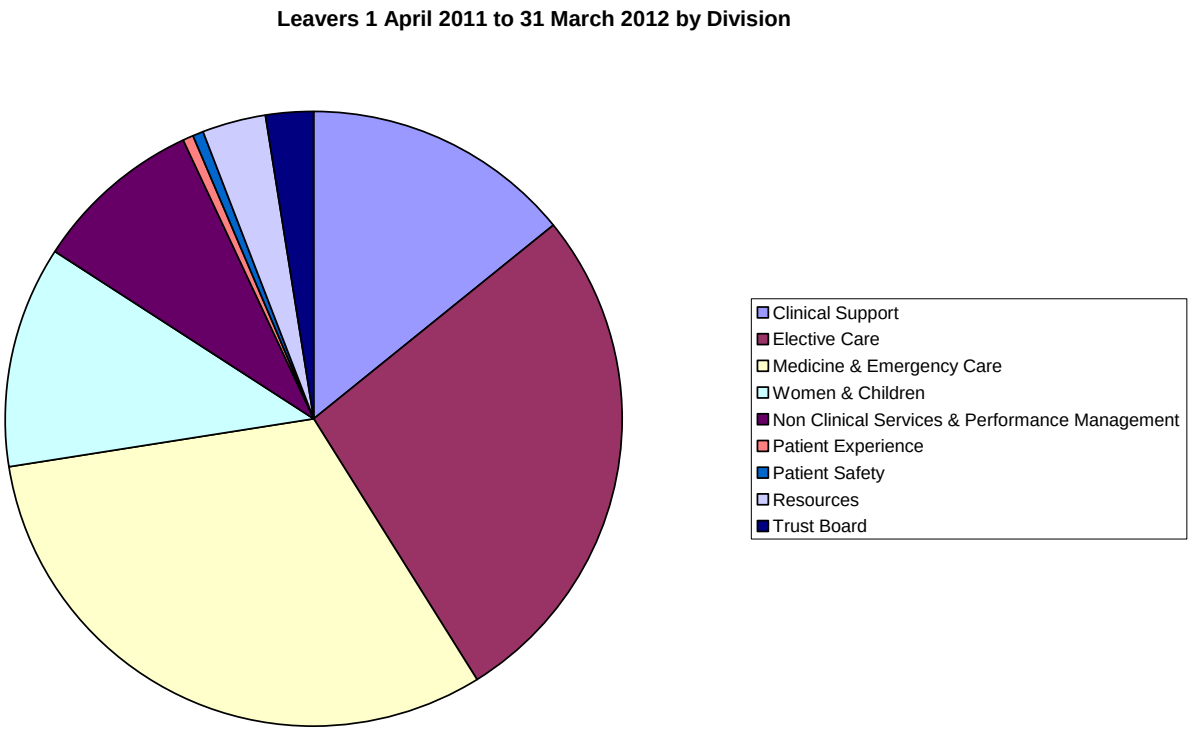
Leavers 1 April 2011 to 31 March 2012 to other NHS Trusts by Staff Group



Further analysis of leavers moving to trusts within the East of England shows that most move to either the Norfolk & Norwich University NHS Foundation Trust, Cambridge University or Norfolk Community Health & Care NHS Trust.



When analysed by Directorate/Division, based on the number of staff in each area, there is a uniform spread.



2.5 NHS Protect – Violence against staff

The Trust's violence against staff (VAS) figures have been submitted to NHS Protect.

They are as follows;

- Total number of physical assaults on QEH staff between 1 April 2011 and 31 March 2012 was 115 (an increase of 8 on last year).
- Number of assaults which were defined as 'clinical' where lack of capacity was a factor was 108 (an increase of 11 on last year).
- Number of physical assaults reported to police was 6 (an increase of 6 on last year).
- Number of criminal sanctions obtained was 4 (an increase of 4 on last year).

2.6 NHS Resilience Project

Work to identify a preferred provider for Resilience development is progressing well. A follow up teleconference call is planned for 19 July after which we expect to be in a position to agree our preferred solution and plan a pilot roll out.

WORKFORCE PERFORMANCE SCORECARD (1)

		Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Average
STAFF NUMBERS														
1. Workforce Planned Establishment (FTE)	Target	2718	2723	2728	2728	2731	2736	2739	2738	2738	2773	2778	2779	2742
2. Contracted Staff in Post (FTE)	Actual	2599	2589	2603	2614	2620	2617	2614	2608	2606	2588	2591	2582	2603
3. Vacancies (Actual Staff in Post vs actual establishment) (FTE)	Actual	119	134	125	114	112	119	125	130	132	185	187	197	140
TEMP STAFF USAGE														
4. Bank Usage (FTE)	Target	152	150	148	146	144	142	140	138	136	126	126	126	140
	Actual	150	143	144	138	132	134	112	126	143	156	122	129	136
5. Agency Usage (FTE)	Target	22	20	19	18	17	16	15	14	13	14	14	13	16
	Actual	20	17	11	15	13	14	15	12	14	9	12	12	14
6. Total Temporary Staff Usage (FTE)	Target	174	170	167	164	161	158	155	152	149	140	140	139	156
	Actual	170	160	156	153	145	149	127	137	156	166	134	141	149
7. Agency Spend (£)	Actual	273,845	305,108	194,445	217,212	171,552	212,362	164,579	126,726	165,819	145,460	147,039	138,971	188,593
STAFF DATA														
8. Sickness/Maternity (FTE)	Actual	146	142	147	163	165	176	181	162	170	170	169	166	163
9. Headcount	Actual	3036	3029	3039	3038	3047	3045	3044	3047	3044	3024	3016	3007	3035
10. Turnover (%)	Target	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0
	Actual	8.9	8.8	8.7	7.9	8.1	7.5	7.5	7.5	7.2	8.0	8.1	8.5	8.0
11. Stability Index (%)	Target	90	90	90	90	90	90	90	90	90	90	90	90	90
	Actual	88	89	89	91	91	92	92	92	92	91	91	91	91
12. Potential retirees (HC)	Actual	23	20	19	19	21	20	23	24	22	20	20	19	21
13. Management Costs %	Target	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0
	Actual	4.9	4.9	5.0	5.0	5.0	5.0	5.0	5.0	5.4	5.0	4.9	4.9	5.0
14. Core Induction %	Target	100	100	100	100	100	100	100	100	100	100	100	100	100
	Actual	100	100	100	100	100	100	100	100	100	100	100	100	100

WORKFORCE PERFORMANCE SCORECARD (2)

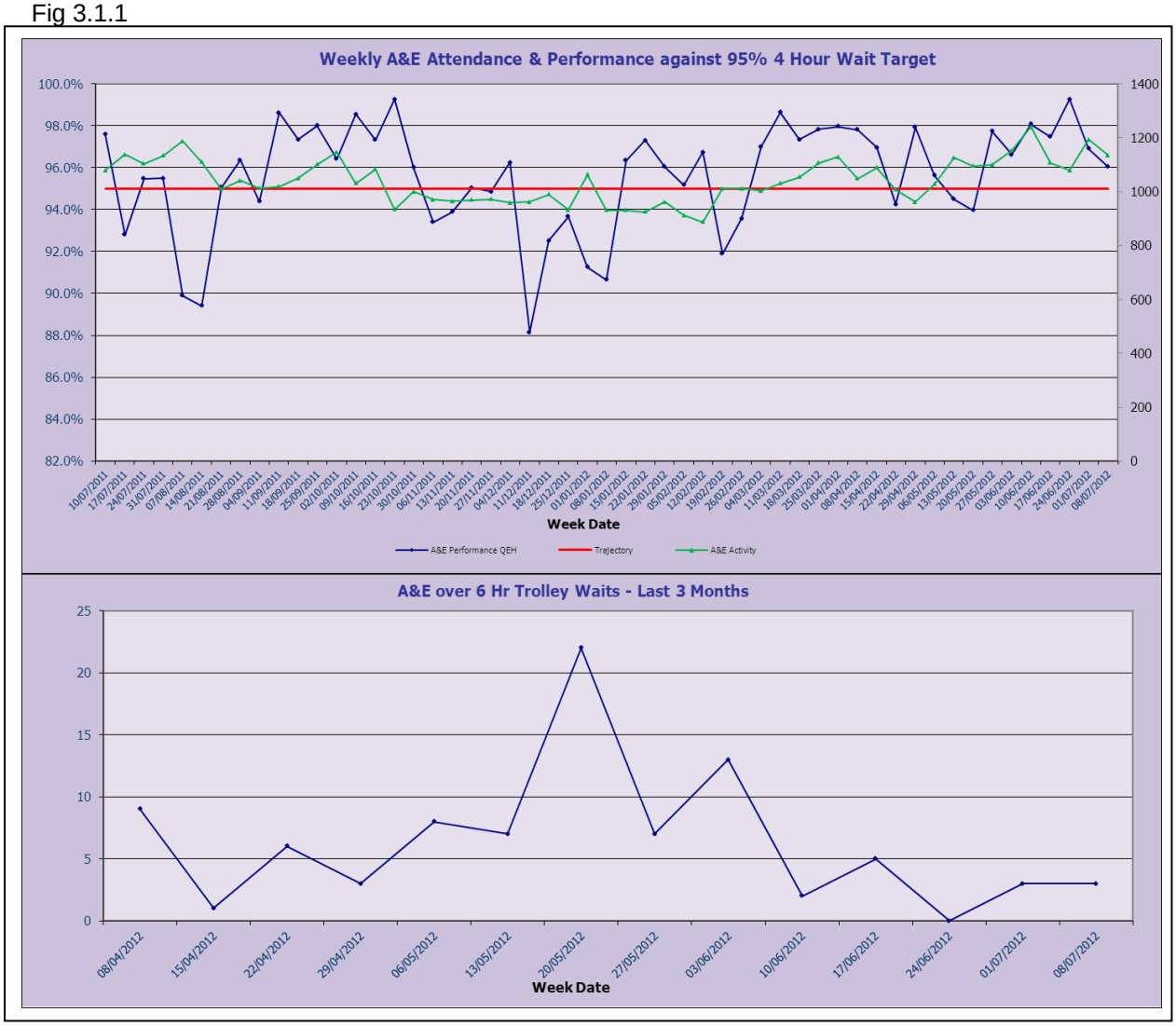
		Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Average
ABSENCE														
15. Sickness %	Target	3.7	3.7	3.9	3.9	4.2	4.6	4.9	4.5	3.9	3.5	3.5	3.5	4.0
	Actual	3.9	3.8	3.9	4.4	4.2	4.4	4.5	4.3	4.2	4.1	4.4	4.2	4.2
16. Rolling 12 month sickness %	Target	4.1	4.1	4.1	4.1	4.0	4.0	4.0	4.0	4.0	4.0	4.0	3.9	4.0
	Actual	4.1	4.0	4.0	4.1	4.1	4.1	4.1	4.1	4.1	4.1	4.2	4.2	4.1
17. Sickness cost £	Actual	230,735	215,259	209,936	258,254	231,697	260,076	304,044	244,585	262,907	256,212	258,491	225,883	246,507
18. Number of staff w ith 4 or more sickness occasions in previous 12 months	Target	358	358	358	358	358	358	358	358	358	336	335	334	352
	Actual	323	319	326	317	328	321	310	335	313	308	318	315	319
19. Long term sickness %	Target	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0
	Actual	6.8	6.4	6.6	6.7	6.9	7.0	7.0	7.2	7.2	7.4	7.3	7.5	7.0
20. Number of sickness episodes over 28 days	Actual	329	311	336	343	355	353	339	354	352	370	376	378	350
21. Number currently sick for more than 28 days	Actual	48	47	50	45	57	70	57	62	66	63	58	64	57
22. Average w orked days lost due to sickness (FTE)	Actual	8.8	8.8	8.8	8.9	9.0	9.0	9.0	9.0	9.1	9.2	9.3	9.4	9.0
23. Maternity/Paternity leave %	Actual	1.8	1.7	1.8	1.8	2.0	2.1	1.9	1.9	2.1	2.1	2.2	2.1	1.9
CAREER														
24. Appraisal inc bank staff%	Target	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0
	Actual	71.0	72.5	70.3	70.0	71.0	67.9	63.3	58.0	72.1	71.8	73.1	74.6	69.6
25. Appraisal exc bank staff%	Target	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0
	Actual	72.2	72.5	71.0	70.6	71.2	68.1	63.4	58.6	73.3	72.6	74.1	75.8	70.3
26. New employee relations cases	Actual	13	14	7	9	5	10	4	4	10	9	12	2	8
27. Closed employee relations cases	Actual	15	16	11	10	8	9	5	7	8	3	10	1	9

Chapter 3

Performance and Standards

3.1 Accident & Emergency Performance Indicators

Fig 3.1.1



The Trust achieved the A&E target for June 2012. Performance is reported at 96.7% against the target of 95%. The Trust achieved Quarter 1 12/13 with a final percentage of 96.7% and is on course to achieve the target for Quarter 2

Performance was also achieved against:

- A&E Total Time Spent in A&E (95th percentile); 3 hours 59 minutes against a target of 4 hours
- Patients leaving the department without being seen; 1.9% of total A&E attenders against a target of 5%

98 patients waited over four hours in the A&E Department. Of these 98, 30 patients were waiting for a bed, 20 patients were waiting for an A&E clinician and 11 patients were delayed due to waiting for a psychiatry assessment. A table showing the breakdown reasons for breaches is shown in Fig 3.1.2 on the next page:-

Fig 3.1.2

Code	Breach Reason	June-2012
A21	Delay to see A&E doctor/ENP - waiting time	20
A3	Delay to decision to refer/discharge/plan management	4
A4	Waiting for nurse lead treatment	2
A99	Other (specify)	2
B1	delay in making contact with specialty doctor	1
B2	Delay in specialty coming to see the patient	3
B3	Delay to decision to refer/discharge/plan management	5
B4	Referred between specialties	1
B99	Other (specify)	1
C19/29	X-Ray - other (specify)	1
C22/C23	Delay in X-ray/X-Ray - availability of nurse escort	1
D1	Patient requiring active resus best continued in A&E	6
D2	Patient required fracture or dislocation reduction	4
D4	Patient condition changed/deteriorated prior to discharg	2
D8	Psychiatry assessment/treatment	11
D99	Other (specify)	1
E1	Waiting for bed	30
F3	Waiting for transport	3
	Grand total	98

Operational Action

- Performance is being closely monitored by the Director of Clinical Services who will take necessary action to ensure the target is met.
- A separate report on performance against the attendance to Dr 1 waiting time has been produced and will be discussed by the Performance & Standards Committee.

3.2 Stroke Performance Indicators

While stroke targets are not included within the 2012/13 Monitor compliance Framework, there are 2 targets being measured within the contract. These are:-

1 Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit. The position for the Trust on this at the end of May is 85.1% against a national target of 80%.

- This equates to 40 patients achieved out of 47 (85.1%)

Of the 7 that failed the target, 4 were due to a challenging diagnosis of stroke, 2 were due to not being referred to the Stroke Unit on admission and 1 for a patient being stepped down from the stroke unit to accommodate an acute admission

2 Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours. The position at the end of May is 71.4% against a national target of 60%.

- This represents - 20 Patients achieved out of a total of 28 (71.4%)

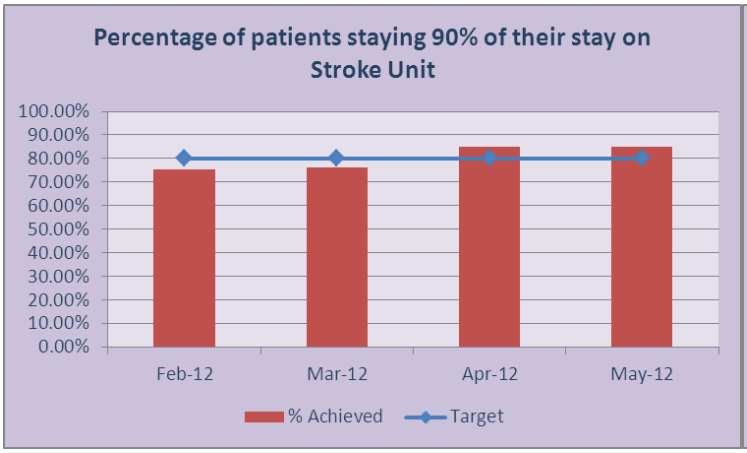


Fig 3.2.1

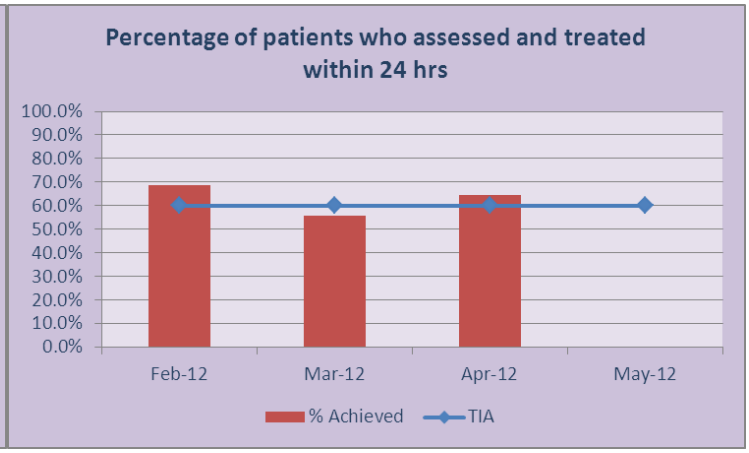


Fig 3.2.2

Operational Action

- The increased performance demonstrates the actions that have been taken have been effective. The team will continue with these actions in subsequent months.
- A report on the Stroke Service has been produced for discussion at July's Performance and Standards Committee.

3.3 18 Weeks – RTT Treatment Times & Waiting Times (For Patients Treated In June 2012)

The Trust achieved the 18 week target for non-admitted and admitted patients. Performance by specialty for the admitted target is below 90% for some specialties.

Fig 3.3.1

Specialty	Admitted Pathways			Non- Admitted Pathways			Incomplete Pathways
Target	Total Completed	Breached Patients	90.0%	Total Completed	Breached Patients	95.0%	92.0%
General Surgery	152	14	90.8%	60	2	96.7%	94.2%
Urology	85	5	94.1%	13	0	100.0%	85.2%
Trauma & Orthopaedics	158	44	72.2%	164	2	98.8%	89.9%
Ear, Nose & Throat (ENT)	48	4	91.7%	163	0	100.0%	90.6%
Ophthalmology	264	13	95.1%	198	1	99.5%	96.1%
Oral Surgery	117	1	99.1%	65	0	100.0%	97.9%
Plastic Surgery	11	0	100.0%	2	0	100.0%	93.3%
Cardiothoracic Surgery				4	0	100.0%	89.5%
General Medicine	34	2	94.1%	37	0	100.0%	92.8%
Gastroenterology				100	0	100.0%	98.6%
Cardiology				154	7	95.5%	94.4%
Dermatology	76	0	100.0%	82	0	100.0%	99.2%
Neurology				71	0	100.0%	99.4%
Rheumatology	20	0	100.0%	81	1	98.8%	92.1%
Geriatric Medicine				30	1	96.7%	95.2%
Gynaecology	135	12	91.1%	103	0	100.0%	92.6%
Other	129	12	90.7%	452	4	99.1%	91.2%
Total	1229	107	91.3%	1779	18	99.0%	93.3%

From 1 April 2012 the commissioners are able to enact a financial penalty for 18 weeks breaches at a speciality level for admitted and non-admitted pathways.

Should these financial penalties be enforced by the commissioners the penalties will be:

Speciality	%age to be deducted	Revenue line for speciality and admission type	Total value of penalty
Urology	2.5%	£93,461	£2,337
Trauma and Orthopaedics	5%	£655,900	£32,795

Discussions are on-going with commissioners regarding the implementation of these penalties.

A new target on 18 weeks was introduced from April 2012. Trust performance against this indicator is presented in the previous table. The target relates to the number of patients with an incomplete 18 week admitted pathway which is below 18 weeks. The target is 92% - current trust performance is 94.2%.

The Trust has no patients waiting in excess of 52 weeks from referral to treatment.

Operational Action

- The Trust has been working hard to reduce the backlog of patients to ensure the targets were met and the financial penalty was not used.
- An action plan to address orthopaedic performance has been produced for discussion at July Performance and Standards Committee.
- The Trust is reviewing every patient over 18 weeks and if the reason for patients waiting in excess of 18 weeks is due to capacity to treat a full RCA is being undertaken. This process is being managed at the weekly PTL and Operational Performance.
- Orthopaedics are forecast to achieve 90% performance in September 2012

At the end of June 2012 the Trust had 329 patients waiting in excess of 13 weeks for an OP appointment.

The number of patients waiting in excess of 26 weeks that are still on an 18 week pathway is 111.

Fig 3.3.2 identifies this by specialty.

	Outpatients	Incomplete RTT
Specialty	Pts over 13 wks	Pts over 26 wks
Anticoagulant		
Cardiology	33	5
Dermatology	1	
Ear Nose Throat	1	12
Endocrinology	24	
Gastroenterology	57	
General Medicine	7	
General Surgery	4	5
Gynaecology	10	12
Haematology, Clinical	7	
Medical Oncology		
Nephrology	4	1
Neurology	12	1
Ophthalmology	4	7
Oral Surgery	1	
Orthopaedics	6	32
Paediatric Cardiology	4	
Paediatric Surgery		
Paediatric Urology	15	
Paediatrics	15	3
Pain Clinic	38	6
Respiratory Medicine	7	
Rheumatology	41	6
Upper GI		
Urology	38	21
Total	329	111

3.3.1 Benchmarking 18 week performance as at April 2012

NHS RTT waiting times figures for April 2012 have been published by the Department of Health. These include data for England, Primary Care Trusts, Strategic Health Authorities, and NHS Trusts.

The key points from the latest release are:

- At national level, 92% of admitted patients (measured on an adjusted basis) and 97.7% of non-admitted patients completed their RTT pathway within a maximum of 18 weeks.
- The median time waited for patients completing an RTT pathway in April 2012 was 8 weeks for admitted patients and 4 weeks for non-admitted patients. (Trust reported 7.02 admitted and 4.66 non-admitted April 12)
- For patients still waiting for treatment (incomplete pathways) at the end of April 2012, the median waiting time was 5.2 weeks (Trust reported 5.23 weeks in April 12)

Title: **Referral to Treatment (RTT) Waiting Times**
Summary: Monthly Referral to Treatment (RTT) waiting times for completed non-admitted pathways.
Period: **April 2012**
Source: Unify2 data collection - RTT
Basis: Provider
Revised: N/A
Status: Published
Contact: RTTdata@dh.gsi.gov.uk

DELIVERED BY KNOWLEDGE & INTELLIGENCE K&I

Provider Level Data

SHA Code	Org Code	Provider Name	Average (median) waiting time (in weeks)	95th percentile waiting time (in weeks)	% within 18 weeks
Q35	5PT	SUFFOLK PCT	6.6	13.7	100.0%
Q35	RAJ	SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	3.9	13.0	98.6%
Q35	RC1	BEDFORD HOSPITAL NHS TRUST	4.3	13.9	98.2%
Q35	RC9	LUTON AND DUNSTABLE HOSPITAL NHS FOUNDATION TRUST	2.1	13.6	97.8%
Q35	RCX	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	4.6	14.2	99.0%
Q35	RDD	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	6.5	17.9	95.1%
Q35	RDE	COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST	6.6	15.8	97.9%
Q35	RGM	PAPWORTH HOSPITAL NHS FOUNDATION TRUST	6.2	14.3	98.1%
Q35	RGN	PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST	4.6	16.0	97.1%
Q35	RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	4.1	16.5	98.0%
Q35	RGQ	IPSWICH HOSPITAL NHS TRUST	5.0	14.6	98.7%
Q35	RGR	WEST SUFFOLK NHS FOUNDATION TRUST	4.0	12.3	100.0%
Q35	RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	4.9	15.3	97.8%
Q35	RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	3.3	14.9	97.1%
Q35	RQ8	MID ESSEX HOSPITAL SERVICES NHS TRUST	1.7	13.7	98.3%
Q35	RQQ	HINCHINGBROOKE HEALTH CARE NHS TRUST	3.9	12.0	98.8%
Q35	RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	4.0	16.3	97.5%
Q35	RRD	NORTH ESSEX PARTNERSHIP NHS FOUNDATION TRUST	4.2	10.5	99.5%
Q35	RT1	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	-	-	100.0%
Q35	RWG	WEST HERTFORDSHIRE HOSPITALS NHS TRUST	3.2	14.2	97.9%
Q35	RWH	EAST AND NORTH HERTFORDSHIRE NHS TRUST	5.0	14.8	98.0%
Q35	RWN	SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	-	-	100.0%
Q35	RY3	NORFOLK COMMUNITY HEALTH AND CARE NHS TRUST	4.7	19.4	94.0%
Q35	RY4	HERTFORDSHIRE COMMUNITY NHS TRUST	1.9	10.8	100.0%
Q35	RYV	CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST	6.5	16.6	97.0%

Title: **Referral to Treatment (RTT) Waiting Times**
Summary: Monthly Referral to Treatment (RTT) waiting times for completed admitted pathways (on an adjusted basis).
Period: **April 2012**
Source: Unify2 data collection - RTT
Basis: Provider
Revised: N/A
Status: Published
Contact: RTTdata@dh.gsi.gov.uk

DELIVERED BY KNOWLEDGE & INTELLIGENCE K&I

Provider Level Data

SHA Code	Org Code	Provider Name	Average (median) waiting time (in weeks)	95th percentile waiting time (in weeks)	% within 18 weeks
Q35	5PT	SUFFOLK PCT	4.2	12.5	100.0%
Q35	RAJ	SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	12.1	30.1	83.2%
Q35	RC1	BEDFORD HOSPITAL NHS TRUST	8.1	19.6	93.8%
Q35	RC9	LUTON AND DUNSTABLE HOSPITAL NHS FOUNDATION TRUST	6.7	22.8	91.5%
Q35	RCX	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TF	7.0	22.6	90.0%
Q35	RDD	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATIOI	9.3	23.2	92.0%
Q35	RDE	COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST	11.5	21.5	91.5%
Q35	RGM	PAPWORTH HOSPITAL NHS FOUNDATION TRUST	8.2	20.3	93.2%
Q35	RGN	PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRU	8.6	22.9	86.4%
Q35	RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	6.8	32.5	82.5%
Q35	RGQ	IPSWICH HOSPITAL NHS TRUST	9.6	22.9	90.7%
Q35	RGR	WEST SUFFOLK NHS FOUNDATION TRUST	5.4	15.5	100.0%
Q35	RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	8.9	25.3	85.6%
Q35	RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION	8.9	24.7	87.1%
Q35	RQ8	MID ESSEX HOSPITAL SERVICES NHS TRUST	9.5	19.3	93.9%
Q35	RQQ	HINCHINGBROOKE HEALTH CARE NHS TRUST	7.7	17.7	96.1%
Q35	RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	7.3	18.9	93.5%
Q35	RRD	NORTH ESSEX PARTNERSHIP NHS FOUNDATION TRUST	-	-	0.0%
Q35	RWG	WEST HERTFORDSHIRE HOSPITALS NHS TRUST	9.2	21.5	90.9%
Q35	RWH	EAST AND NORTH HERTFORDSHIRE NHS TRUST	7.6	22.8	92.8%

3.4 Cancer

The Trust has failed the 62 day Cancer target for May 2012, however performance is calculated on a quarterly basis and the Trust is on course to achieve this and all other cancer targets for Quarter 1 11/12.

Indicator	Target	April	May
Cancer Two Week Wait	93%	519	511
		29	21
		94.4%	95.9%
Breast Symptoms Two Week Wait	93%	72	99
		1	2
		98.6%	98.0%
31 Day First Treatment	96%	103	117
		1	0
		99.0%	100.0%
Cancer Plan 62 day Standard	85%	52.5	59.5
		5	11
		90.5%	81.5%
Subsequent Treatments (31 day) - Drug Treatments	98%	12	10
		0	0
		100.0%	100.0%
Subsequent Treatments (31 day) - Surgery	94%	16	24
		0	0
		100.0%	100.0%
Screening (62 day)	90%	6.5	8
		0	0.5
		100.0%	93.8%

An analysis of the breaches for the 62 day target in May was conducted by the Director of Non-Clinical Services and Performance Management with each breach being subject to a full RCA. In summary the findings were that there a larger number of lung patients were being treated than in previous months (in fact no lung patients were treated in April) and a larger than expected number of tertiary (cross organisational) patients were treated than in previous months.

The one Urology breach waiting over 104 days was due to the patient asking to delay their treatment to consider all their treatment options.

Cancer Wait Times 62 Day Pathway Analysis 2012

April				Breach Breakdown			
	Patients	Breaches	% Passed	63 - 76	77 - 90	91 - 104	Over 104
Breast	13	0	100%				
Colorectal	4	0	100%				
Gynae	2	0	100%				
Haematology	3	1	67%		1		
Head and Neck	1	0	100%				
Lung							
Skin	8	0	100%				
Upper GI	2	0	100%				
Urology	16	2	88%	2			
Total	**49**	**3**	94%	**2**	**1**	**0**	**0**

May				Breach Breakdown			
	Patients	Breaches	% Passed	63 - 76	77 - 90	91 - 104	Over 104
Breast	8	0	100%				
Colorectal	6	0	100%				
Gynae	1	0	100%				
Haematology	4	0	100%				
Head and neck							
Lung	9	5	44%	1	3	1	
Skin	8	0	100%				
Upper GI	4	0	100%				
Urology	14	3	79%			2	1
Total	**54**	**8**	85%	**1**	**3**	**3**	**1**

Tertiary Patients				Breach Breakdown			
	Patients	Breaches	% Passed	63 - 76	77 - 90	91 - 104	Over 104
Colorectal	1	0.5	50%	0.5			
Gynae							
Haematology	0.5	0.5	0%		0.5		
Head and Neck	0.5	0	100%				
Lung	1	1	0%		0.5	0.5	
Sarcoma							
Skin	0.5	0	100%				
Upper GI							
Urology							
Total Tertiary	**2.5**	**1.5**	40%	**0**	**1**	**0.5**	**0**

Tertiary Patients				Breach Breakdown			
	Patients	Breaches	% Passed	63 - 76	77 - 90	91 - 104	Over 104
Colorectal							
Gynae	0.5	0.5	0%			0.5	
Haematology	0.5	0	100%				
Head and Neck	0.5	0	100%				
Lung	1	0.5	50%	0.5			
Sarcoma	0.5	0	100%				
Skin	0.5	0	100%				
Upper GI	1	1	0%				1
Urology	1	1	0%	1			
Total Tertiary	**5.5**	**3**	45%	**1.5**		**0.5**	**1**

Grand Total	**51.5**	**4.5**	91%	**2**	**2**	**0.5**	**0**

Grand Total	**59.5**	**11**	82%	**2.5**	**3**	**3.5**	**2**

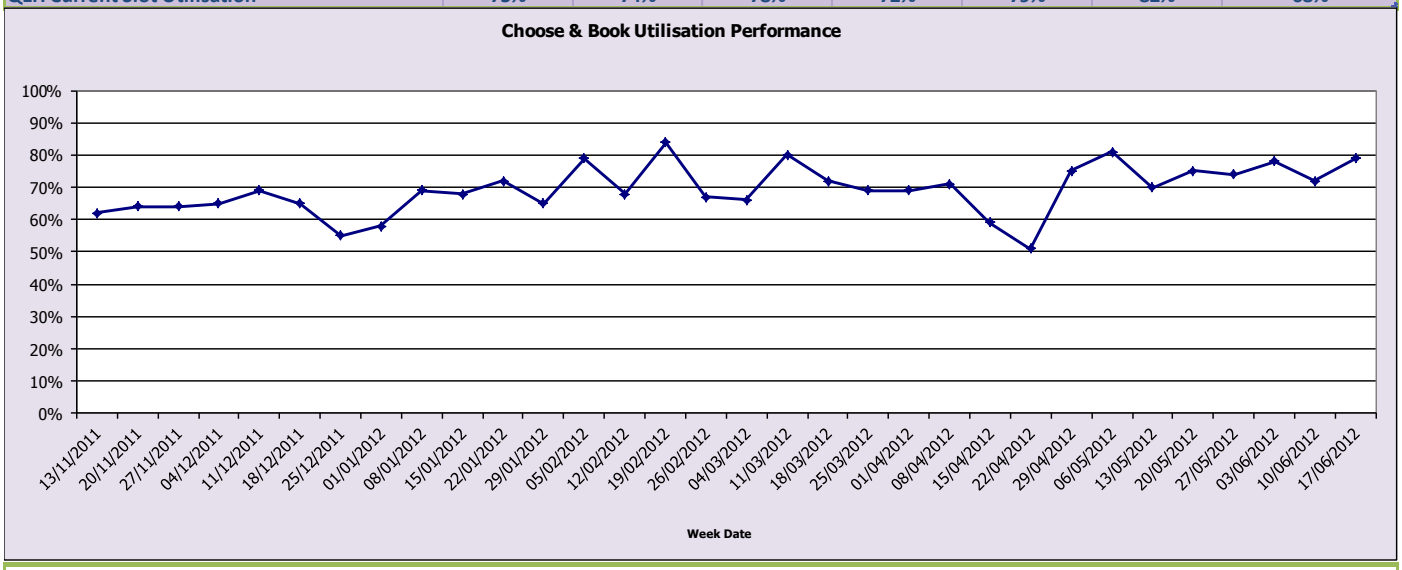
It should be noted that an early view on June position indicates high levels of performance across all cancer targets so the Trust should expect to achieve the target on a quarterly basis. Focused effort has been made by the Performance and Cancer Services Team to ensure that all potential patients on the cancer pathway and planned for treatment in June were submitted onto the national database early to gain an accurate prediction for the end of Quarter 1 statement to Monitor. This work was completed on Monday 23 July 2012 and it predicts the Trust achieve all cancer targets.

3.5 Choose & Book

Choose and book performance against the booking target and ASI ratio is detailed in Fig 3.5.1. QEH performance is benchmarked against the national position.

Fig 3.5.1

CHOOSE & BOOK UTILISATION & SLOT ISSUES	20/05/2012	27/05/2012	03/06/2012	10/06/2012	17/06/2012	24/06/2012	01/07/2012
DBS Bookings (QEH)	957	890	970	549	999	1026	836
Slot Issues (All Reasons) (QEH)	206	196	222	72	183	171	151
Slot issues per successful DBS booking (QEH)	0.22	0.22	0.23	0.13	0.18	0.17	0.18
National Issues per DBS Booking	0.11	0.12	0.13	0.09	0.11	0.12	0.12
QEH Variance to National	0.11	0.10	0.10	0.04	0.07	0.05	0.06
QEH Current Slot Utilisation	75%	74%	78%	72%	79%	82%	68%



DBS - Directly Bookable Outpatient Services
Slot issues - Where patients are having difficulty booking their appointment because of a slot unavailability or technical issue

Slot issues per successful DBS booking - This is the ratio of slot issues (all types) to DBS bookings in the same period (outpatient only). It is not necessarily the same as the percentage of patients encountering issues because some patients may encounter multiple issues;

Operational Action

- The Trust are reviewing divisional choose and book / Appointment slot issue plans at performance reviews and action to address performance is included in the Outpatient BSP POD.
- A paper on Choose & Book will be presented at the Performance and Standards meeting in August 2012.

3.6 Cancelled Operations

In June 2012 there were 11 Cancelled Operations on the day of admission or procedure that meet national guidance criteria. A breakdown of the reasons for these cancellations is shown in the Fig 3.6.1. Of the 11 cancellations 4 were due to no bed being available. Of those cancelled the number of patients who were not reappointed and treated within the 28 day national guideline was 4. The specialty split is listed in Fig 3.6.2.

Fig 3.6.1

Cancellation Reason	Num.of cancellations
No bed	4
Insufficient theatre time	5
Equipment Not Available	2
Total	11

Fig 3.6.2

Cancelled Operations not re-admitted within 28 days	
Specialty	Feb-12
General Surgery	2
Ear, Nose & Throat (ENT)	1
General Medicine	1
Total	4

Operational Action

- Of the 4 patients not re-admitted within 28 days all now been treated. None of the patients were on a cancer or urgent pathway.

3.7 Diagnostic Waiting Times

There were 3 CT diagnostics procedures waiting over 6 weeks at the end of June 2012, these were all due to a CT machine malfunction.

Operational Action

- Performance is being closely monitored by the Director of Clinical Services who will take necessary action to ensure the target is met.

3.8 Outpatient New To Review Ratio – Contract Performance

This indicator looks at the ratio of follow-up appointments in relation to first appointments for ENT and Rheumatology only. Within the Trust NHS contract performance is based on performance targets against the Better Care Better Value upper quartile.

Specialty	Target Rate	New	Follow-Up	Actual Rate
ENT	1.3	246	312	1.3
Rheumatology	3.6	108	308	2.9

Operational Action

- Follow up ratios in these areas have fallen over the previous month to within the target rate. These are being closely monitored to ensure the specialties stay within the contracted performance.

3.9 Ambulance Turnaround Times

Recent correspondence from the DH has prompted an additional focus on Ambulance Turnaround time. For information purposes the Trust's performance is included in this month's report. The Trust signed a Tripartite Agreement on Ambulance Performance as part of Contract Negotiations and is on track to achieve the milestones in this agreement.

Figure 3.9.1 below shows the East of England Ambulance hospitals performance regarding hand over times and "submit" compliance.

53% of ambulance handovers at the trust are greater than 30 minutes from arrival, against the east of England total of 37%. Handovers that occur over 60 minutes of arrival at the trust is 7% of total handovers, against the east of England total of 4%.

Fig 3.9.1

	Patient Journeys	No of Patient 'Handover' Times	Submit Compliance	Percentage of journeys where the time between arrival at hospital and clinical handover (trolley clear) is greater than 15 minutes	Percentage of journeys where the time between clinical handover (trolley clear) and ambulance clear at hospital is greater than 15 minutes	Hours lost over*					Number of patient journeys over			
						15 Mins (Arrival - Handover) [journeys where handover is recorded]	15 Mins (Handover - Clear) [journeys where handover is recorded]	20 mins (all journeys)	30 mins (all journeys)	Equivalent 12 hour shifts (hours lost over 30 mins)	30 min	%	60 min	%
Addenbrookes	491	124	25%	81%	28%	32:23	8:22	150:37	91:22	7.6	277	56%	43	9%
Basildon	474	276	58%	37%	19%	8:41	7:17	41:38	14:50	1.2	93	20%	5	1%
Bedford General South Wing	269	142	53%	15%	47%	3:24	12:30	28:34	9:46	0.8	72	27%	1	0%
Broomfield	403	331	82%	47%	33%	35:14	17:13	79:50	41:15	3.4	153	38%	23	6%
Colchester General	483	332	69%	57%	30%	32:03	19:39	74:39	31:19	2.6	174	36%	10	2%
Hinchingbrooke Hospital	211	71	34%	73%	28%	10:04	4:21	31:40	12:13	1.0	77	36%	3	1%
Ipswich Hospital	455	368	81%	38%	25%	37:43	23:15	92:02	59:31	5.0	157	34%	42	9%
James Paget Hospital	360	235	65%	57%	28%	34:18	11:11	76:23	45:32	3.8	145	40%	26	7%
Lister Hospital	478	341	71%	39%	41%	23:50	23:27	79:39	37:49	3.2	174	36%	21	4%
Luton And Dunstable	548	362	66%	35%	31%	19:50	17:23	66:10	24:36	2.1	164	30%	5	1%
Norfolk & Norwich	645	511	79%	41%	26%	67:15	31:47	135:00	82:32	6.9	248	38%	55	9%
Peterborough City Hospital	378	334	88%	36%	47%	14:27	30:29	63:47	29:37	2.5	154	41%	7	2%
Princess Alexandra	390	314	81%	35%	21%	17:32	10:33	45:35	19:43	1.6	107	27%	5	1%
Queen Elizabeth (Kings Lynn)	367	212	52%	62%	27%	31:52	10:53	86:22	46:26	3.9	193	53%	25	7%
Queen Elizabeth WGC	54	28	58%	36%	39%	1:38	1:19	4:36	1:13	0.1	9	17%	0	0%
Southend	418	226	54%	58%	19%	17:43	6:05	55:58	21:48	1.8	129	31%	10	2%
Watford General	540	358	66%	53%	34%	35:34	24:51	111:19	62:02	5.2	229	42%	27	5%
West Suffolk General	290	256	88%	39%	25%	17:56	13:02	44:21	21:42	1.8	96	33%	5	2%
Total	7254	4821	**66%**	47%	27%	**441:36**	**273:47**	**1268:18**	**653:27**	**54.45**	**2651**	**37%**	**313**	**4%**

Operational Action

- The Director of Clinical Services has met with the Director of Non Clinical Services & Performance Management and the Divisional Manager for Medicine to confirm the actions are in place to deliver the tripartite agreement. This will be monitored in the Monthly Divisional Performance Reviews.

3.10 CQUINS

CQUINs for 12/13 are still under discussion with the Commissioners

Operational Action

- Latest draft received is being reviewed by the Trust.
- The aim for completion and sign off by the end of July.
- The Trust has begun the work required to deliver the CQUINS in their current form as only small issues remain.

Declaration of performance against healthcare targets and indicators

MONITOR COMPLIANCE FRAMEWORK SCORECARD

Targets as per Compliance Framework 2012/13		Threshold	2012/13 CF Weighting	Annual Plan 2012/13	Apr-12		May-12		Jun-12	
					Perf	Weight	Perf	Weight	Perf	Weight
C.difficile year on year reduction		30	1.0		1		5		1	100.0%
MRSA - meeting the MRSA objective		1	1.0		0		0		0	
All cancers: 31-Day Wait For Second Or Subsequent Treatment	Anti Cancer Drug Treatments	98%	1.0		100.0%		100.0%			
	Surgery	94%	1.0		100.0%		100.0%			
	Radiotherapy (from 1 January 2011)	94%	1.0		n/a		n/a		n/a	
All cancers: 62-Day Wait For First Treatment	From Consultant Screening Service Referral	90%	1.0		100.0%		93.8%			
	Urgent GP Referral To Treatment	85%	1.0		90.5%		81.5%	1		
A&E: Total time in A&E 95% Patients withing 4 Hr Target		95%	1.0		96.9%		96.1%		96.7%	
Referral to treatment waiting times – admitted (90% Target within 18 Weeks		90%	1.0		90%		90%			
Referral to treatment waiting times – non-admitted (95% Target Within 18 Weeks)		95%	1.0		98.8%		98.90%			
Referral to treatment waiting times – Incomplete (92% Target Within 18 Weeks)		92%	1.0		94.4%		94.20%			
31-Day (Diagnosis To Treatment) Wait For First Treatment	All cancers	96%	0.5		99.0%		100.0%			
Two week wait from referral to date first seen	All cancers	93%	0.5		94.4%		95.9%			
	For symptomatic breast patients (cancer not initially suspe	93%	0.5		98.6%		98.0%			
Thrombolysis within 60 minutes (where this is the preferred local treatment)		68%	0.5		n/a		n/a		n/a	
Screening all elective in-patients for MRSA		100%	0.5		100%		100%		100%	
Care Programme Approach (CPA) patients	Follow up contact within 7 days of discharge	95%	0.5		n/a		n/a		n/a	
	Having formal review within 12 months	95%	0.5		n/a		n/a		n/a	
Minimising delayed transfer of care		<=7.5%	1.0		1.6%		2.0%		2.6%	
Admissions had access to crisis resolution home treatment teams		90%	1.0		n/a		n/a		n/a	
Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5		n/a		n/a		n/a	
Data completeness: identifiers		99%	0.5		n/a		n/a		n/a	
Data completeness: outcomes		50%	0.5		n/a		n/a		n/a	
Ambulance FTs - Category A call – emergency response within 8 minutes		75%	1.0	No Risk	n/a		n/a		n/a	
Self certification against compliance with requirements regarding access to healthcare for people with a learning dis		N/A	0.5							
Moderate CQC concerns regarding the safety of healthcare provision		N/A	1.0							
Major CQC concerns regarding the safety of healthcare provision		N/A	2.0							
Failure to rectify a compliance or restrictive condition(s) by the date set by CQC within the condition(s) (or as subse		N/A	4.0							
Does the Trust have outstanding compliance actions applied by the CQC ?				YES	1	1				
Does the Trust have outstanding enforcement actions applied by the CQC				No						
Registration conditions imposed by Care Quality Commission										
Restrictive registration conditions imposed by Care Quality Commission										
Restrictive registration conditions imposed by Care Quality Commission										
				Rating		1		1		

Chapter 4

Finance and Investment

4.1 Summary Income & Expenditure Position

For the month the Trust achieved an EBITDA of £43k against a planned EBITDA of £320k, an adverse variance of £277k. Year to date the Trust achieved £1,263k EBITDA against a plan of £1,119k, a favourable variance of £144k.

For the month the Trust reported a deficit of £538k against a planned deficit of £229k, an adverse variance of £309k. Year to date the Trust reported a deficit of £484k against a planned deficit of £529k, a positive variance of £45k.

Expenditure for the month was generally in line with plan but the deterioration of income in month 3 has reduced the financial "cushion" that had been built up over the first two months of the quarter. Whilst the Trust is still ahead of planned EBITDA by £144k, delivery of the Business Sustainability Programme (BSP) becomes more challenging over quarter 2. It was expected that the elective activity would return to plan by the end of this month but this has not occurred. As a consequence additional Executive management overview will be provided to assist in the management of activity planning (detailed by speciality) to support delivery of activity and clinical income.

For the month the Trust EBITDA margin was 0.3% against a planned EBITDA margin of 2.4%, 2.1% below plan. Year to date the Trust EBITDA margin is 3.1% against a plan of 2.7%, 0.4% over plan.

The Trust plan delivered an EBITDA margin of 5.0%, an FRR score of 3, by Quarter 2. Current EBITDA forecasts indicates an EBITDA Margin of 4.75% by quarter 2 which, dependant on the other factors of the overall FRR calculation means an overall FRR of 3 could still be achieved.

Overall the Trust is forecasting to deliver planned EBITDA by year-end, although the Trust's contingency will be fully utilised to achieve this.

4.2 Financial Risk Rating

For the month the Trust has scored an FRR of 1 compared to an expected FRR of 2. Year to date the Trust scored an FRR of 2 as per the plan. Year to date three of the individual metric have scored 2 (EBITDA Margin %, Net Return After Financing % and I&E Surplus Margin %). The Financial Efficiency criterion is the only one that combines two metrics (Net Return After Financing % and I&E Surplus Margin %) and since both of these have scored a 2, the Financial Efficiency criterion also scores a 2.

The overall consequence of this is that three metrics have scored 2 and two criterion have scored 2 (Underlying Performance & Financial Efficiency). The override rule applies and the Trust scores an FRR of 2 for the quarter.

3.0 Key Messages

As per current forecast the achievement of an FRR of 3 by quarter 2 is marginal. Therefore it is absolutely essential for all divisions to deliver their activity plans, for all areas to maximise vacancy savings (ensuring appropriate staffing levels for patient safety) and for POD leads to deliver their BSP savings as forecast for quarter 2.

Due to the importance of delivering an FRR of 3 by quarter 2 and planned EBITDA by year-end, additional involvement from the Executive is required to support divisional management teams. The initial focus of this support is a series of performance meetings with key specialties to assist their planning processes with a view to delivering the required activity and income levels. These meetings are already in train.