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

REPORT TO BOARD OF DIRECTORS

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

Meeting Date: **Wednesday 29 August 2012**
Report Title: **Integrated Performance Report – July 2012**

Purpose:

This Report is the next iteration of the work the Board of Directors is undertaking to integrate performance reporting on patient safety, experience, quality, operational performance, workforce and efficiency into one consolidated report. The Board of Directors will have finalised, via the production of the Integrated Performance Report for September 2012's meeting of the Board of Directors, the content and format of the report. The Report provides a narrative commentary on the reasons for variation in performance from target and the actions being taken to mitigate/recovery to planned/target levels.

Summary:

In the month of July 2012, using Monitor's Compliance Framework Assessment of Performance on Target's and Indicators, the Trust self-assesses itself **GREEN.**

Performance against the 4 quadrants of the Integrated Dashboard in month as follows:

Quality & Risk – 19 indicators of which **6 are rated RED**
Workforce – 13 indicators of which **4 are rated RED**
Performance and Standards – 21 indicators of which **3 are rated RED**
Finance and Investment – 5 indicators of which **4 is rated RED**

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 and the action being taken to address areas of performance which are not at target levels.

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 quadrants which cover the following topics:-

- Quality and Risk
- Workforce
- Performance and Standards
- Finance and Activity

This Report will be produced monthly for discussion at the second Trust Executive Committee (TEC) meeting of each month.

The purpose of the Report is to prompt discussion by TEC members and therefore inform the operational response included in the Performance Report presented to the Board of Directors monthly.

The focus of the Report is to report on performance which is at variance to expected performance levels as identified in the attached Integrated Dashboard (**RED**).

Where items are **RED,** further information is included, where relevant to explain the variance.

For the KPIs included in the Finance and Investment quadrant of the dashboard the detailed analysis is picked up in the Board of Director's finance report.

Quality & Performance Dashboard Jul 12

The Queen Elizabeth Hospital NHS
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Quality & Risk

Indicator	Target	Current Month	YTD	Trend
1.1 Crude Mortality	19	14.8		
1.2 RAMI	75.7	84.0	88.0	
1.3 SHMI*	N/A	99.7		
1.4 Net Promoter - Friends & Family Survey*	71%	81.0%		
1.5 EL LOS	2.2	2.2	2.2	
1.6 EM LOS	5.0	4.8	4.3	
1.7 Total LOS	4.3	4.4	4.0	
1.8 MRSA	1	0	0	
1.9 CDIFF	4	1	8	
1.10 Serious Incidents	0	3	20	
1.11 Never Events	0	1	2	
1.12 Serious Medication Errors	0	0	0	
1.13 Falls Resulting in Serious injury	0	1	2	
1.14 Pressure Ulcers - Grade 3 H.A	0	7	18	
1.15 Pressure Ulcers - Grade 4 H.A	0	1	1	
1.16 Number of MSA Breaches (Number of Patients)	0	0	9	
1.17 Clinical Complaints	N/A	39	141	
1.18 Non-Clinical Complaints	N/A	5		
1.19 Compliments	N/A	128	443	
1.20 Safety Thermometer - Hospital Acquired Harm		95.0%	95.0%	

*RAMI figure & Net Promoter is shown 1 month in arrears

*SHMI figure is for period Jan - Dec 2011

CQC Concerns	CQC Concerns
CQC Concern Regarding Outcome 21	

Performance & Standards

Indicator	Target	Current Month	YTD	Trend
3.1 Monitor Compliance Framework Score		0	0	
3.2 18 Weeks - Admitted 95th Percentage*	90%	93.9%	91.8%	
3.3 18 Weeks - Non Admitted 95th Percentage*	95%	99.1%	98.9%	
3.4 Cancer - 31 Days Subsq Treatment - Surgery*	94%	100.0%	100.0%	
3.5 Cancer - 31 Days Subsq - Drug Treatments*	98%	100.0%	100.0%	
3.6 Cancer - 62 Days Referral to Treatment	85%	90.7%	86.4%	
3.7 Urgent GP Cancer - 2 Week Wait*	93%	97.1%	95.8%	
3.8 Cancer - 31 Days Diagnosis to Treatment*	96%	99.0%	99.4%	
3.9 A&E 4 Hour Attendance	95%	96.2%	96.6%	
3.10 MRSA Screening - All Elective Inpatients	100%	100.0%	100.0%	
3.11 Choose + Book - Slot Utilisation	90%	71.0%	71.5%	
3.12 Day Case Rate	82.3%	87.3%	84.2%	
3.13 DNA Rate	5%	5.4%	5.1%	
3.14 New to Review Rate	2.3	2.3	2.5	
3.15 Stroke - 90% of Stay on a Stroke Unit*	80%	89.1%	85.4%	
3.16 Stroke - High Risk TIA treated in 24 Hrs*	60%	85.7%	74.4%	
3.17 VTE Assessment Completeness*	90%	96.9%	97.1%	
3.18 Cancelled Ops		35	89	
3.19 Readmission Rate - Elective	2.9%	3.7%	4.0%	
3.20 Readmission Rate - Emergency	9.1%	8.6%	10.6%	
3.21 Diagnostic Over 6 Week Waiters	1.0%	0.09%	0.07%	

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

Workforce

Indicator	Target	Current Month	YTD	
2.1 Sickness Absence Rate	3.7%	4.9%	4.3%	
2.2 Staff Turnover Rate	10.0%	8.5%	8.3%	
2.3 Appraisal Completeness %	90.0%	75.1%	73.7%	
2.4 Fire Training	70.0%	85.5%	80.0%	
2.5 Infection Control Training	70.0%	77.5%	75.0%	
2.6 Resuscitation Training	70.0%	81.4%	81.0%	
2.7 Safeguarding Children Training	80.0%	88.8%	86.0%	
2.8 Safeguarding Adults Training	70.0%	95.9%	94.0%	
2.9 Information Governance Training	95.0%	81.8%	83.0%	
2.10 Nurse Vancancies (as % of Nurse Posts)		6.8%	6.8%	
2.11 Medical Vacancies (as % of Medical Posts)		-2.6%	-2.6%	
2.12 Contracted People in Post	2779	2603	2603	
2.13 Temporary Staff in Post	139	149	149	

Finance & Investment

		Full Year Plan	Full Year Forecast	Forecast Vs Prev Month	YTD Plan	YTD Actual	Variance Change to Prev Month	Current Month Plan	Current Month Actual
4.1	Surplus	1.7m	1.7m	↔	0	-0.2m	↑	0.1m	0.3m
4.2	EBITDA	8.8m	8.8m	↔	2.2m	2.2m	↑	1.2m	1m
4.3	Cash Balance	6.3m	6.1m	↓	7.1m	16.4m	↑	7.1m	16.4m
4.4	BSP - Overall Position	10.2m	8.7m	↓	1.6m	1.3m	↑	0.6m	0.4m

		Full Year Plan	Full Year Forecast	YTD Plan	YTD Forecast
4.5	Finance Risk Rating	3	3	2	2

Definitions

Quality & Risk

1.1 - Crude Mortality
Mortality Rate for the trust per 1000 Admissions, Calculation = *Total Deaths/Total spells *100*

1.2 - RAMI (Risk Adjusted Mortality Index)
Mortality Index Calculated by CHKS.

1.3 - SHMI (Standard Hospital Mortality Index)
Mortality within 30 days of a hospital discharge - national indicator calculated by Dr Foster

1.4 - Net Promoter (Friends & Family)

1.5 - Length of Stay - Elective
The average length of stay for Elective Patients for their Entire Spell in Hospital

1.6 - Length of Stay - Non Elective
The average length of stay for Non-Elective Patients from all sources of admission for their Entire Spell in Hospital

1.7 - Total LOS
The average length of stay for all Patients from all sources of admission (excluding Daycases) for their Entire Spell in Hospital

1.8 - MRSA
Total Number of MRSA Cases in a given month

1.9 - CDIFF
Total Number of CDIFF Cases in a given month

1.10 - Serious Incidents
Total Number of Serious Incidents within a Given Month

1.11 - Never Events
Total number of Never Events raised within a given month

1.12 - Serious Medication Errors
Count of the total number of patients that have had a serious medication error.

1.13 - Falls Resulting in Serious Injury
Total count in a given month

1.14 - Pressure Ulcers - Grade 3 H.A
Total count in a given month

1.15 - Pressure Ulcers - Grade 4 H.A
Total count in a given month

1.16 - Number of MSA Breaches (Patient Count)
The Count of the number of patients involved in a Mixed-sec occurence in a given month
A mixed-sex occurrence is defined as:
The placement of a patient within a clinical setting where one or more of the following criteria applies:
a. The patient occupies a bed in a bay or room that is occupied by a patient of the opposite gender.
b. The patient occupies a bed that does not have access to co-located same-sex toilet and washing facilities.
c. The patient must pass through an area designated for occupation by members of the opposite sex to gain access to toilet and washing facilities.
d. The patient occupies a bed in a bay or room that is occupied by a patient of the opposite gender where a clinical justification previously applied is no longer applicable.

1.17 - Clinical Complaints

1.18 - Non Clinical Complaints

1.19 - Compliments

1.20 - Safety Thermometer (Hospital Acquired Harm)

Workforce

2.1 - Sickness %
Percentage sickness absence for the month. Based on FTE days absent divided by FTE days available

2.2 - Turnover (%)
Number of leavers (HC) divided by average staff in post over the previous 12 months. Permanent staff only

2.3 - Appraisal inc bank staff%
Percentage of staff (HC) including bank, who have had an appraisal within the previous 12 months

2.4 - Fire %
% of Staff trained in Fire Safety. Legal Requirement under the regulatory reform (fire safety) order 2005

2.5 - Infection Control %
NHSLA 2012 Standard 4.6 Hand Hygeine Training

2.6 - Resuscitation %
Resuscitation Council Guidelines define levels for Acute Trusts

2.7 - Safeguarding Children %
Legal Requirement under Safeguarding Children Intercollegiate Document (September 2010)

2.8 - Safeguarding Adults %
To ensure we meet CQC standards and to support the safeguarding lead

2.9 - Information Governance %
% Staff trained on Information Governance. DoH operating framework requirement - Reported to CQC

2.10 - Nurse Vancancies (as % of Nurse Posts)

Workforce Continued……

2.11 - Medical Vacancies (as % of Medical Posts)

2.12 - Contracted People in Post
Permanent, Fixed term and Non Exec contracted staff in post at end of month

2.13 - Temporary Staff in Post
Bank, additional hours and locum FTE paid in month (worked in previous month) & Estimated FTE usage supplied by Finance, based on invoice payments in the month.

Performance & Standards

3.1 - Monitor Compliance Framework Score
Scoring Matrix based on achieving the Governance indicators set by Monitor

3.2 - 18 Weeks – Admitted
Percentage of the number of Admitted patient pathways that were completed within 18 Weeks.

3.3 - 18 Weeks - Non Admitted
Percentage of the number of Non Admitted patient pathways that were completed within 18 Weeks.

3.4 - Cancer - 31 Days Subsq Treatment – Surgery
Percentage of above Cancer Pathway completed within 31 Days in a Given Month

3.5 - Cancer – 31 Days Subsq – Drug Treatments
Percentage of above Cancer Pathway completed within 31 Days in a Given Month

3.6 - Cancer – 62 Days Referral to Treatment
Percentage of above Cancer Pathway completed within 62 Days in a Given Month

3.7 - Urgent GP Cancer – 2 Week Wait
Percentage of cancer patients first seen within 2 weeks in a Given Month

3.8 - Cancer – 31 Days Diagnosis to Treatment
Percentage of above Cancer Pathway completed within 31 Days in a Given Month

3.9 - A&E 4 Hour Attendance
Percentage of total A&E Attendances for a given month that are admitted or discharged within the 4 hour target.

3.10 - MRSA Screening - All Elective Inpatients
Percentage completion of all Elective Admissions being screened for MRSA in a given month.

3.11 - Choose + Book - Slot Utilisation
Percentage of total Slots available on the Choose & Book system for a given month that have been filled by patients using the Choose & Book system.

3.12 - Day Case Rate
Percentage of Elective Activity that is Daycase

3.13 - DNA Rate
Ratio between the total number of new and follow up appointment DNAs against the total number of Attendances and Dnas

3.14 - New to Review Rate
Ratio of total follow-up attendances against the total number of new patient attendances for the given month

3.15 - Stroke 90% of stay on a Stroke Unit
Percentage of Stroke patients that spend 90% of their hospital stay on the stroke unit

3.16 - Stroke - High Risk TIA treated within 24 Hrs
Percentage of High Risk TIAs that are treated within 24 hours.

3.17 - VTE Assessment Completeness*
Total Number of patients that have been VTE assessed against the total number of admissions in a given month

3.18 - Cancelled Ops
Total number of Cancelled ops on the day in a given month.

3.19 - Readmission Rate - Elective
Total number of Patients readmitted within 30 days following an Elective admission against the Total number of discharges within a given month

3.20 - Readmission Rate - Emergency
Total number of Patients readmitted within 30 days following an Emergency admission against the Total number of discharges within a given month

3.21 - Diagnostic over 6 Week Waiters
Total number of diagnostic waiters over 6 weeks at the end of a given month shown as a percentage of the total Diagnostic Waiting List.

Finance & Investment

4.1 - Surplus (£000's)
Total Trust Year to date Surplus

4.2 - EBITDA (£000's)
Total Trust year to date EBITDA

4.3 - Cash Balance (£000,000's)
Trust's total Cash Balance at the end of the given month

4.4 - TEP - Overall Position (£'s)

4.5 - Finance Risk Rating

1 EXECUTIVE SUMMARY OF PERFORMANCE

1.1 In July 2012 Trust performance, using Monitor's Compliance Framework Assessment of Performance on Target's and Indicators, was **GREEN.** All targets and trajectories were achieved for the month. The outstanding 'moderate' concern from the CQC on Outcome 21 no longer attracts a 'penalty' value on Monitor's Quarterly Scorecard. (Appendix 1)

1.2 On Tuesday 14 August 2012 the Trust was visited by the CQC to assess Trust compliance against Outcomes 1, 4, 5, 7 and 13. A report from the CQC on the outcome of the visit is expected in 10 days.

1.3 Excluding the outcome of the CQC visit on 14 August 2012, forecast performance against Monitor's Compliance Framework Assessment of Performance on Target's and Indicator's for Quarter 2 is **GREEN.**

1.4 Trust performance against the Quality and Risk KPI's has deteriorated from June's performance with **RED** reported for 6 indicators:-

1.4.1 RAMI – deterioration to 84.0 which is above the reduction trajectory
1.4.2 There were 3 Serious Incidents reported.
1.4.3 There was 1 Never Event Reported.
1.4.4 There were 8 Pressure Ulcers.
1.4.5 Total LOS is above peer benchmark at 4.4 days against a target of 4.3

1.5 Trust performance against the Workforce KPIs remains the same with the 3 same indicators reported as **RED.**

1.5.1 Sickness Absence rate continuing an upward trend with performance reported as 4.9% against a target of 3.7%.
1.5.2 Appraisal completeness for the month of July was 75.1%, higher than the YTD position and performance on an upward trend.
1.5.3 Information Governance training is reported at 81.8% for the month. The target is a cumulative one and YTD performance is 83% and to be delivered in March 2013 which leaves the Trust well placed to deliver.

1.6 Trust Performance against the Performance and Standards KPIs has improved in July with 3 indicators reported as **RED.**

1.6.1 Choose and Book Slot Utilisation is reported as 71%. After a period of improvement the position remains static.
1.6.2 The Trust DNA rate for the Trust in July 2012 is 5.4%, 0.4% above the Trust target.
1.6.3 The readmission rate (within 30 days) for elective surgery is 3.7% against an expected peer benchmark of 2.9%

1.7 Trust Performance against Finance and Activity KPIs shows 3 indicators as **RED.**

1.7.1 BSP Overall Position with YTD performance at £1.3m against a plan of £1.6m.
1.7.2 Monitor's finance risk rating YTD is 2.

2 QUALITY AND RISK

2.1 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. All actions have been implemented and are audited weekly via rolling programme. Where noncompliance is found a robust performance framework is put into place.

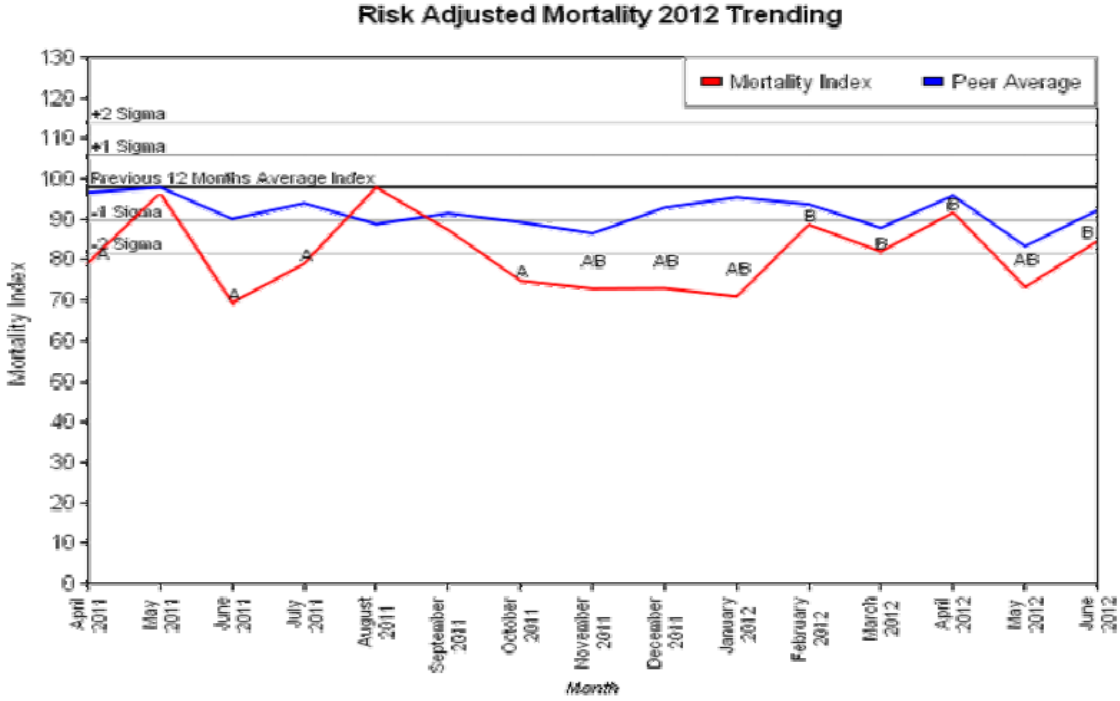
On Tuesday 14 August 2012 the Trust was visited by the CQC to assess Trust compliance against Outcomes 1, 4, 5, 7 and 13. A report from the CQC on the outcome of the visit is expected within 10 working days from the date of the visit..

2.2 Mortality Rates

The Trust's RAMI performance over the past 15 months is show in the graph below:-

Risk Adjusted Mortality 2012

Hierarchy	: Trust Overview		
	:		
Filter	: None	**Peer group**	: 1st map
Time period	: Apr 2011 to Jun 2012	**Peer group period**	: Apr 2011 to Jun 2012



Special Cause Flags

The Trust aims to reduce RAMI by 5% per year (target of 75.7 in 2012/13), and the crude death rate per 1,000 admissions (16 per 1,000 admissions). Whilst crude mortality is within target levels, and the Trust' RAMI is not above benchmarked peers June's performance is not at expected levels.

- Crude mortality per 1,000 admissions in July 2012 = 14.8 (target achieved)
- RAMI in June 2012 = 84 (target not achieved)
- RAMI for April to June 2012 = 83 (target not achieved)

The Trust uses the CHKS benchmarking data to track variation in RAMI performance and there are 3 current alerts recorded. These are:

- High rates of birth trauma injury to neonates – this is being investigated by the Division for report back to the Clinical Outcomes Group.
- 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.
- 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.

These investigations will be reported to the Clinical Outcomes Group, and subsequently to the Clinical Governance Committee. The outcomes of this work and the subsequent actions will be reported to the Board of Directors.

2.3 Net Promoter

All 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 organization 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 4.29% of patients discharged from this Trust (down from 6.2% in May).

To improve our response rate the discharge lounge staff now remind patients to complete their postcards and post them before they leave the hospital. This procedure was begun towards the end of June, too late to have an impact on the June response rate.

An email has been sent to all matrons and ward clerks to remind them of the importance of distributing these postcards in relation to the Trust's income (it is a CQUIN target).

In June 2012, the Trust score was 81 (up from 71 in May). The combined score across the regional cluster was 64 with a range from 42 to 89 (the Target Score set by NHS Midlands and East is 71).

2.4 Serious Incidents

There were 3 Serious Incidents reported in July 2012.

At present there are 32 serious incidents awaiting closure from 2012. Root cause analyses and action plans are completed and have been submitted for 14 of the incidents. There are presently 18 incidents under investigation if this is required.

Incidents reported in July / August have been categorised as follows:

Reason	Number
Grade 3 pressure ulcers	8
Grade 4 pressure ulcers	1
Missed diagnosis	1
Potential missed diagnosis	1
# Neck of Femur	3
Dental Never Event (2010)	1
Telephone failure	1

2.5 Never Events

There was 1 never event in July and this arose from a failure to obtain adequate consent for dental extraction. This is similar to the previous case in February 2012 and relates to a complaint several months previously, which was not reported as an incident. This reveals not only a failure to obtain sufficient consent but a failure to report via the normal clinical incident reporting mechanism, although the episode was fully investigated at the time.

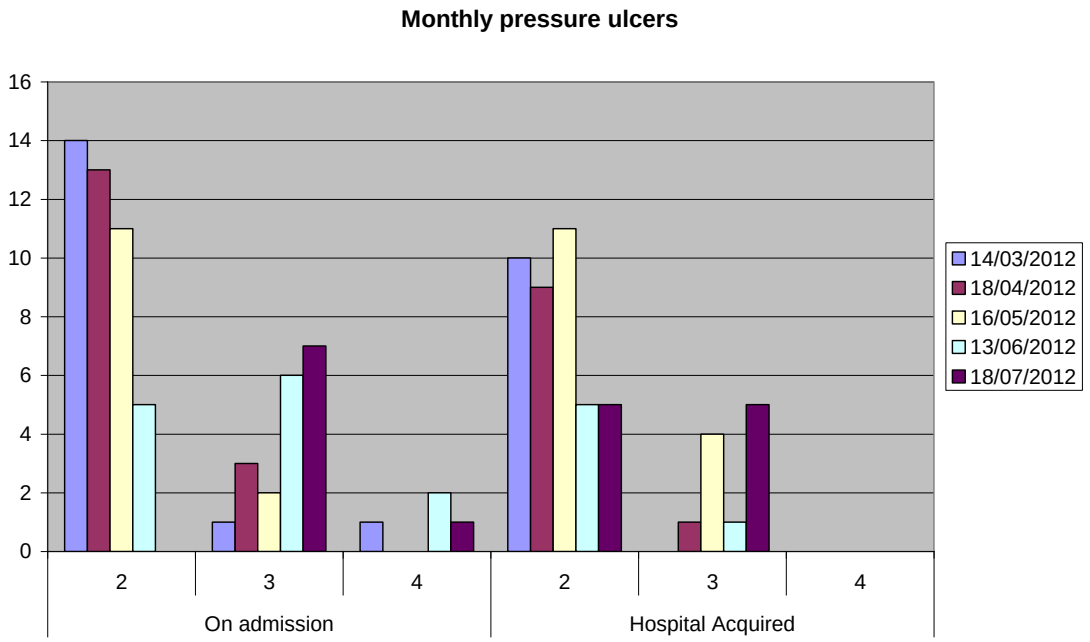
This root cause analysis and action plan from this investigation, plus the previous dental never event, will be amalgamated and presented to the Patient Safety Committee in August.

2.6 Pressure Ulcers

All grade 3 and 4 pressure ulcers are reported as a serious incident and a root cause analysis is undertaken by the ward staff and then reviewed by the Tissue Viability Nurse prior to submission.

The Trust has joined a number of other Trusts in a collaborative designed to work towards the elimination of all Hospital Acquired pressure ulcers by December 2012. The collaborative will support the team on Stanhoe ward (chosen due to the increased numbers of pressure ulcers) by provision of training and tools. The expectation is that all wards will follow suit over the next twelve month period. In preparation all wards have been issued with a Pressure Ulcer Setting Cross whereby each ward must record on a daily basis if any pressure ulcer develops on that ward or that they transfer a patient from an other ward with a ulcer. The collaborative work was launched via Clinical Leadership on Friday 17th August.

In July a Clinical Summit was held which included members of the multidisciplinary team. An action plan was developed identifying actions required to be taken in order to reduce the numbers of hospital acquired pressure ulcers.



2.7 Safety Thermometer – July 2012 results

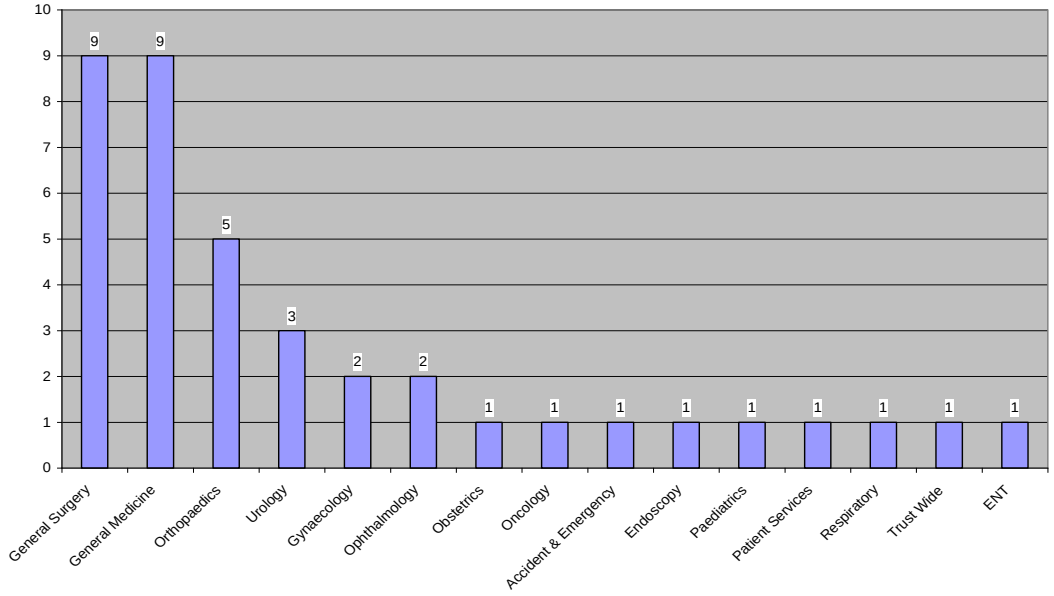
The NHS Safety Thermometer is a tool for measuring Patient Safety, developed by the NHS Information Centre. From April 2012 it is a national CQUIN target that the Safety Thermometer is used by all NHS-funded providers to collect data monthly on patient harm, specifically harm from pressure ulcers, falls, 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 July 18th 2012. All eligible patients' details were captured (n = 458). 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 22 patients across 9 wards with harms as follows:

- Category 2 pressure ulcer x 5 patients
- Category 3 pressure ulcer x 5 patients
- Fall with low harm x 6 patients
- Fall with moderate harm x 2 patients
- Fall with severe harm x 1 patient (fractured neck of femur)
- CAUTI (Cather Associated Infections) x 3 patients

2.8 Complaints

During July the Trust received 44 formal complaints. Of these there were 39 clinical complaints. The bar chart below identifies these by Service Line:



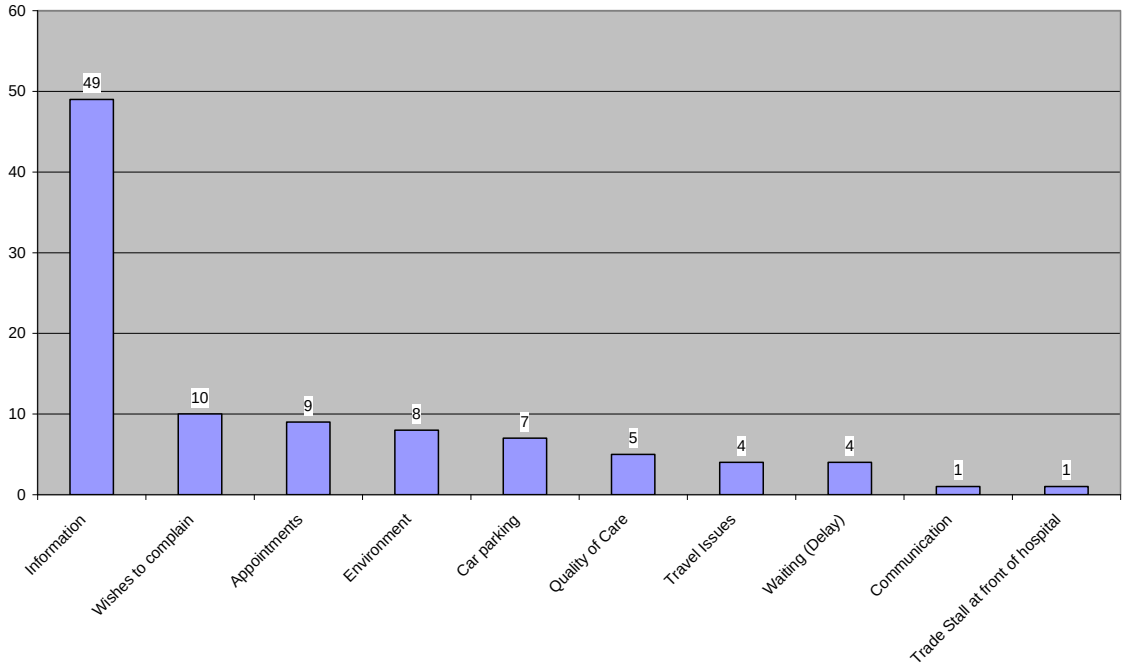
All complaints have been reviewed and there are no identified themes. General Surgery and General Medicine have had the most complaints, but have also received the most compliments, 49 for Surgery and 15 for Medicine.

Non clinical complaints relate mainly to car parking.

There were 6 conciliation meetings held during the month of July.

2.9 PALS

During July 2012 there were a total of 211 PALS enquiries, 113 of which were compliments. The other 98 contacts are detailed in the table below by subject:



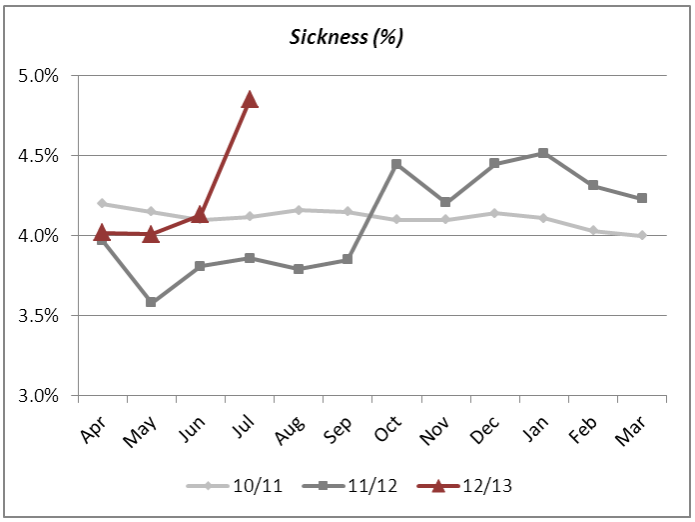
2.10 Comments On NHS Choices And Patient Opinion Websites

There has been one new story uploaded onto the NHS Choices website since the last report. There were no posts on the Patient Opinion website about this Trust

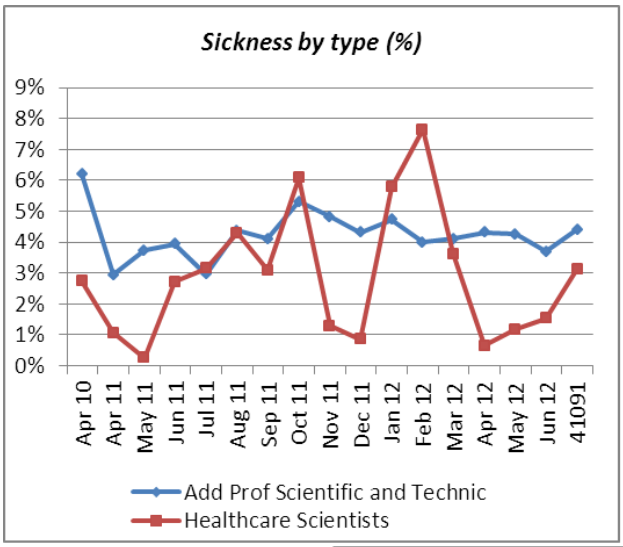
3 WORKFORCE

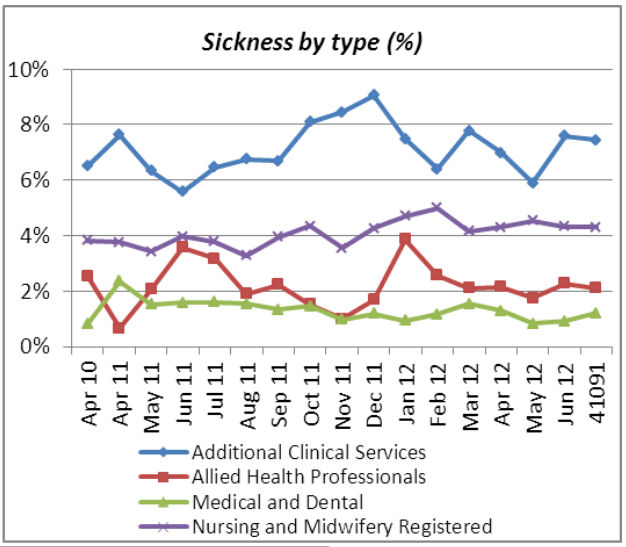
3.1 Sickness %

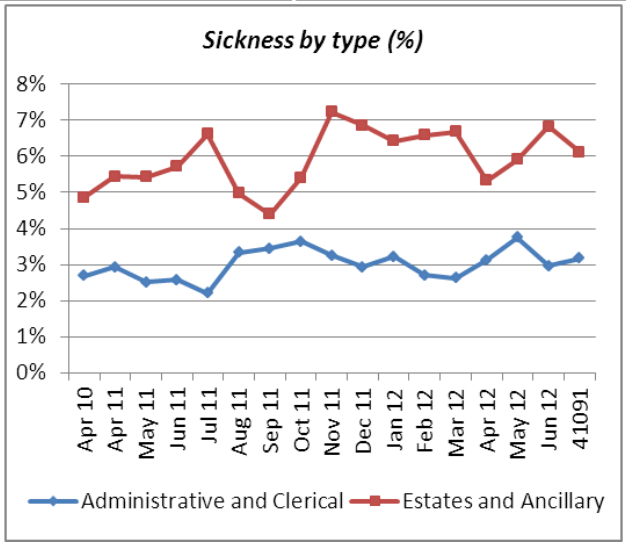
The target for the spring and summer months was for sickness to reduce to 3.5%. However, the rate remains at the winter levels of around 4.0 – 4.5%. At the moment the rates for the Trust compare favourably with other Trusts but this comparative data is 3 months (April 2012) behind because it comes from the national data warehouse.



In the following graphs analysis shows that since late 2011 there has been an upward trend in sickness for S&T and Healthcare Scientists. This correlates to the work and subsequent uncertainty over job role in pathology.







The HR Business Partners are working closely with the Divisional Management teams to address the reasons for the deterioration.

3.2 Appraisals %

The table below show performance against the appraisal target for the last 12 months.

Month	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	Apr 12	May 12	Jun 12	Jul 12
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
Actual	72.5	70.3	70.0	71.0	67.9	63.3	58.0	72.1	71.8	73.1	74.6	75.1

Listed below are the actions being taken to improve this performance.

- 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.

3.3 Information Governance Training % Complete Trust

Month	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	Apr 12	May 12	Jun 12	Jul 12	No. of staff	
													Total	Trained
Target	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0		
Actual	81.8	82.0	81.6	81.1	77.0	72.8	74.9	90.1	87.4	83.6	80.2	81.8	3174	2596

Performance by staff group is provided below.

Month	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	Apr 12	May 12	Jun 12	Jul 12	No. of staff	
													Total	Trained
Target	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0		
Add Prof Scientific & Tech	94.1	90.1	92.2	95.7	73.9	70.7	73.9	96.4	92.8	87.1	85.0	83.6	140	117
Add Clinical Services	80.9	81.6	82.8	83.5	82.9	80.1	82.4	91.0	88.3	81.2	73.1	76.2	592	451
Admin & Clerical	92.4	90.6	84.2	80.6	75.5	73.4	79.9	95.4	93.8	92.9	92.2	92.8	596	553
Allied Health Professionals	96.6	94.6	94.1	91.5	84.3	85.1	86.1	98.7	94.5	93.0	93.8	94.6	149	141
Estates & Ancillary	86.4	87.7	87.7	88.9	83.7	73.0	70.0	95.9	91.6	90.7	88.5	92.5	412	381
Healthcare Scientists	88.9	90.5	88.1	87.8	85.4	86.1	83.7	100	90.7	83.7	55.8	59.5	42	25
Medical & Dental	46.3	45.1	44.9	43.8	39.6	36.9	42.6	69.4	69.4	66.9	63.7	63.0	349	220
Nursing & Midwifery	83.2	85.2	87.1	86.7	84.9	79.6	79.9	88.8	85.6	80.5	78.1	79.2	894	708

YTD performance is 83% and whilst in month performance is below plan the Trust is well placed to achieve the 31 March target. 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.

4 PERFORMANCE AND STANDARDS

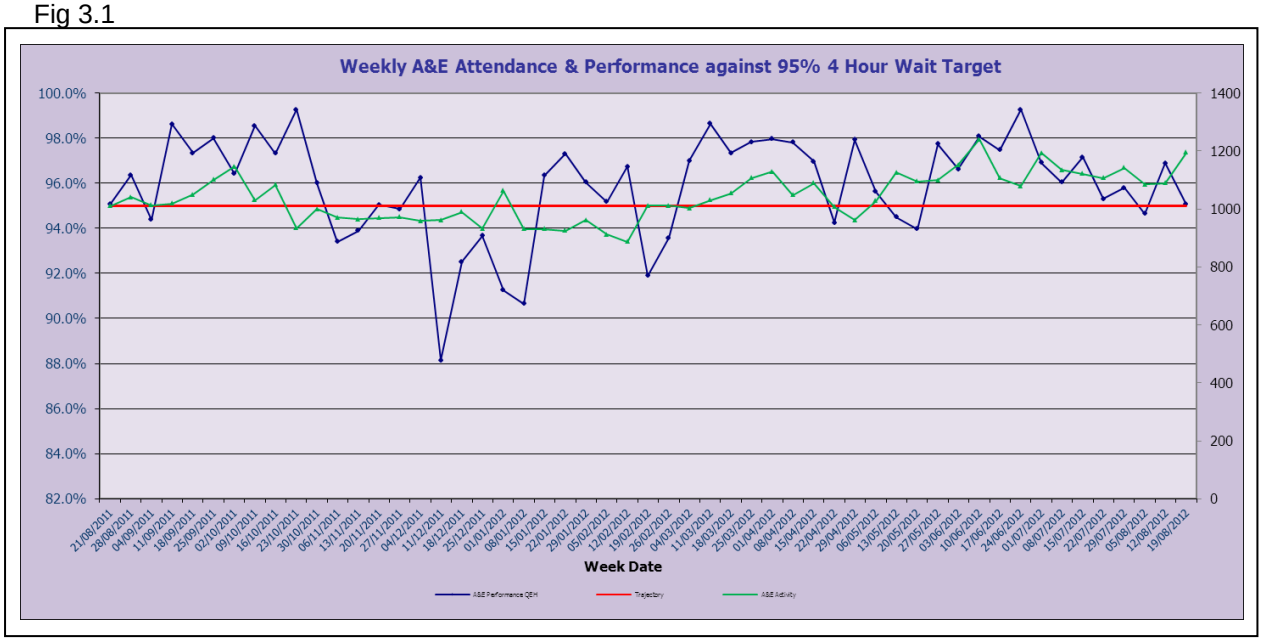
4.1 Accident & Emergency Performance Indicators

The Trust achieved the A&E target for July 2012. Performance is reported at 96.6% against the target of 95% for the month of July 2012. This is also the Quarter 2 position, however, YTD is at 96.6%.

The Board of Directors has identified 97% as the operating target for A&E they wish to achieve. On that basis current performance is below that target.

Although the intention was to push for achievement of the 97% internal target, after discussion the executive team feel it is not appropriate to do this at this point in time as the risk to Elective performance or delivery of the BSP would be too great.

Fig 3.1



The Director of Clinical Services reports that short term management support has been agreed for the Medicine Division to do some focussed work on Ambulance Turnaround times for the Trust. The Trust has a tripartite agreement with its commissioners and the East of England Ambulance Service which details the actions being taken by both organisations to improve performance. At the monthly SPRG contracting meeting with commissioners a Contract Variation (CV) was proposed by the commissioners which would aim to introduce financial penalties for acute trusts for non delivery of the target. The Director of Non-Clinical Services and Performance Management confirmed that as this was not a nationally proposed CV the Trust was not obligated to accept the in-year change and declined to agree to the CV.

Meetings are scheduled with the senior operational team of the Ambulance Service to performance manage delivery of the tripartite agreement and resolve the issue of data sharing in terms of performance.

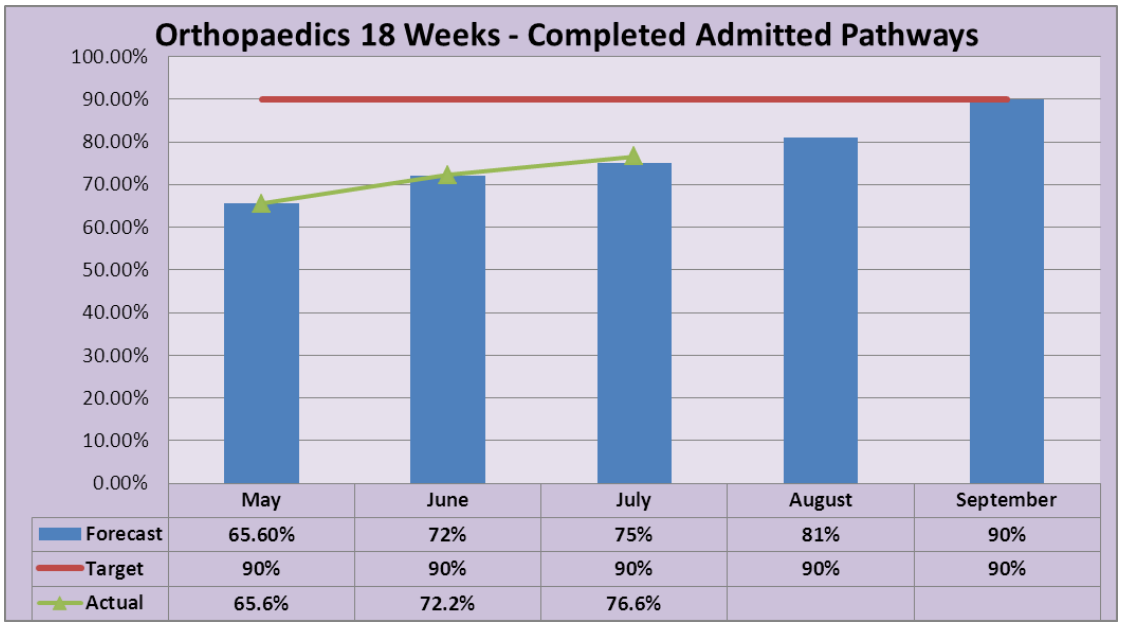
4.2 Cancer

The Trust achieved all Cancer targets for Quarter 1 2012/13. The Board of Directors are asked to note that performance for Cancer is reported one month in areas. The submitted performance for Quarter 1 is aligned with the forecast position submitted by the Trust on its Quarter 1 Monitor Statement of Compliance submission. .

Indicator	Target	April	May	June	Q1 11/12
Cancer Two Week Wait	93%	519	511	490	1521
		29	21	14	64
		94.4%	95.9%	97.1%	95.8%
Breast Symptoms Two Week Wait	93%	72	99	67	238
		1	2	4	7
		98.6%	98.0%	94.0%	97.1%
31 Day First Treatment	96%	103	117	102	330
		1	0	1	2
		99.0%	100.0%	99.0%	99.4%
Cancer Plan 62 day Standard	85%	52.5	59.5	53.5	169.5
		5	11	5	23
		90.5%	81.5%	90.7%	86.4%
Subsequent Treatments (31 day) - Drug Treatments	98%	12	10	43	141
		0	0	0	0
		100.0%	100.0%	100.0%	100.0%
Subsequent Treatments (31 day) - Surgery	94%	16	24	12	53
		0	0	0	0
		100.0%	100.0%	100.0%	100.0%
Screening (62 day)	90%	6.5	8	6.5	21
		0	0.5	0.5	1
		100.0%	93.8%	92.3%	95.2%

4.3 18 Weeks – RTT Treatment Times & Waiting Times (For Patients Treated In July 2012)

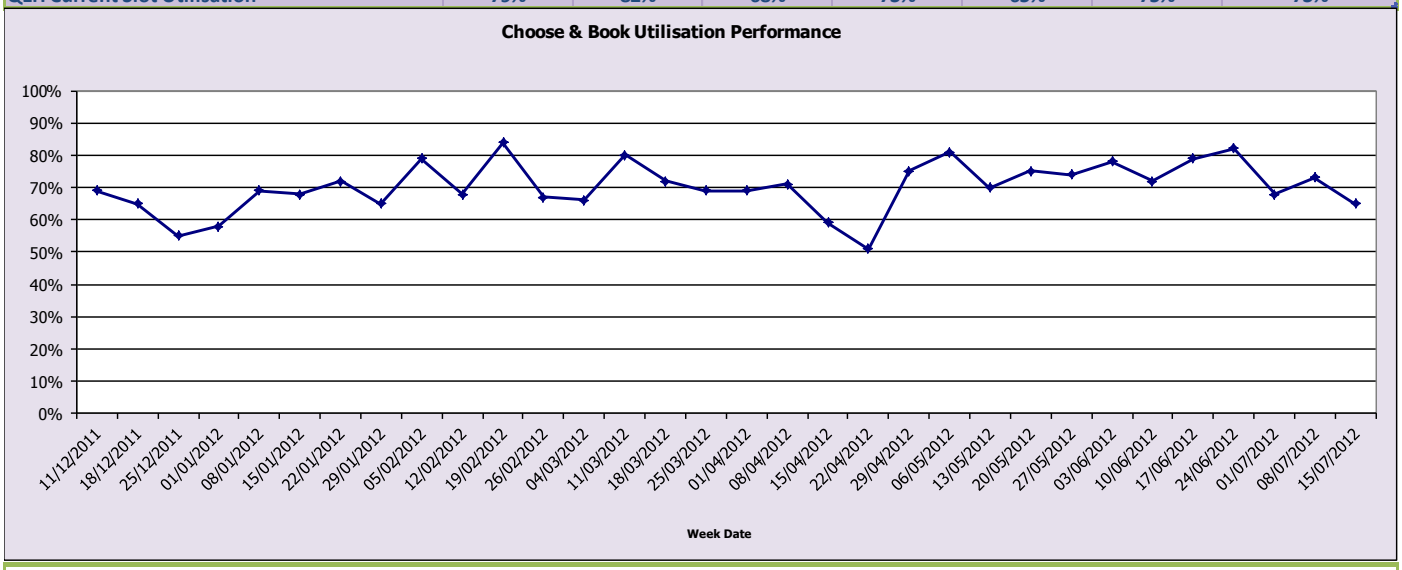
The Trust continues to achieve the 18 week RTT waiting times for admitted and non-admitted patients. As reported in last month's report a Contract Performance Notice was received from NHS Norfolk in respect of operational performance against the orthopaedics specialties performance against this target. The Trust responded to this Performance Notice with an Excusing Notice and a trajectory of recovery of 90%. NHS Norfolk have accepted this Excusing Notice and if the Trust continue to achieve the recovery trajectory no financial penalty will be applied.



4.4 Choose & Book

Choose and book performance against the booking target and Appointment Slot Issues (ASIs) ratio is detailed below. QEH performance is benchmarked against the national position. Performance is below the expected national and contractual position.

CHOOSE & BOOK UTILISATION & SLOT ISSUES	17/06/2012	24/06/2012	01/07/2012	08/07/2012	15/07/2012	22/07/2012	29/07/2012
DBS Bookings (QEH)	999	1026	836	871	812	931	900
Slot Issues (All Reasons) (QEH)	183	171	151	213	244	149	190
Slot issues per successful DBS booking (QEH)	0.18	0.17	0.18	0.24	0.30	0.16	0.21
National Issues per DBS Booking	0.11	0.12	0.12	0.13	0.12	0.13	0.12
QEH Variance to National	0.07	0.05	0.06	0.11	0.18	0.03	0.09
QEH Current Slot Utilisation	79%	82%	68%	73%	65%	75%	73%



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;

The Board of Directors at its last meeting asked for a more detailed review of where pressure points where in terms of performance and the actions being taken to address and reduce the number of patients who cannot directly book their outpatient appointment on Choose and Book.

Daily the Trust track the number of patients who are unable to book an appointment. These are called Appointment Slot Issues (ASIs) . In summary using the data above on a weekly basis it shows that on average there are circa 200 such patients. As part of POD 37, specialities are re-defining Directory of Services (DoSs) which are published on Choose and Book which will address both capacity and referral issues. The specialties being focussed on at the moment are those with the highest number of ASI's. These specialties are:-

- Neurology
- Cardiology
- Urology
- Orthopaedics
- ENT

In reviewing Choose & Book performance and talking to the POD 37 team we have agreed an improvement target of 20% decrease in Slot issues by the end of November.

4.5 Diagnostic Waiting Times

Although Trust performance was below the national KPI there were 6 Paediatric patients who did not have their Echo test within the 6 week target due to administrative error, There were also 2 Audiology breaches due to staff sickness, and 2 Endoscopy breaches due to delays in referral and non compliance with Waiting list policy. All staff have been reminded of the need to adhere to this guidance. This will further support the decision of the trust to centralise bookings.

4.6 Did Not Attend (DNA Rate)

The Trust's DNA rate for July was 5.4% and was above its target of 5% as shown in the Performance Dashboard on page 3 of this report.

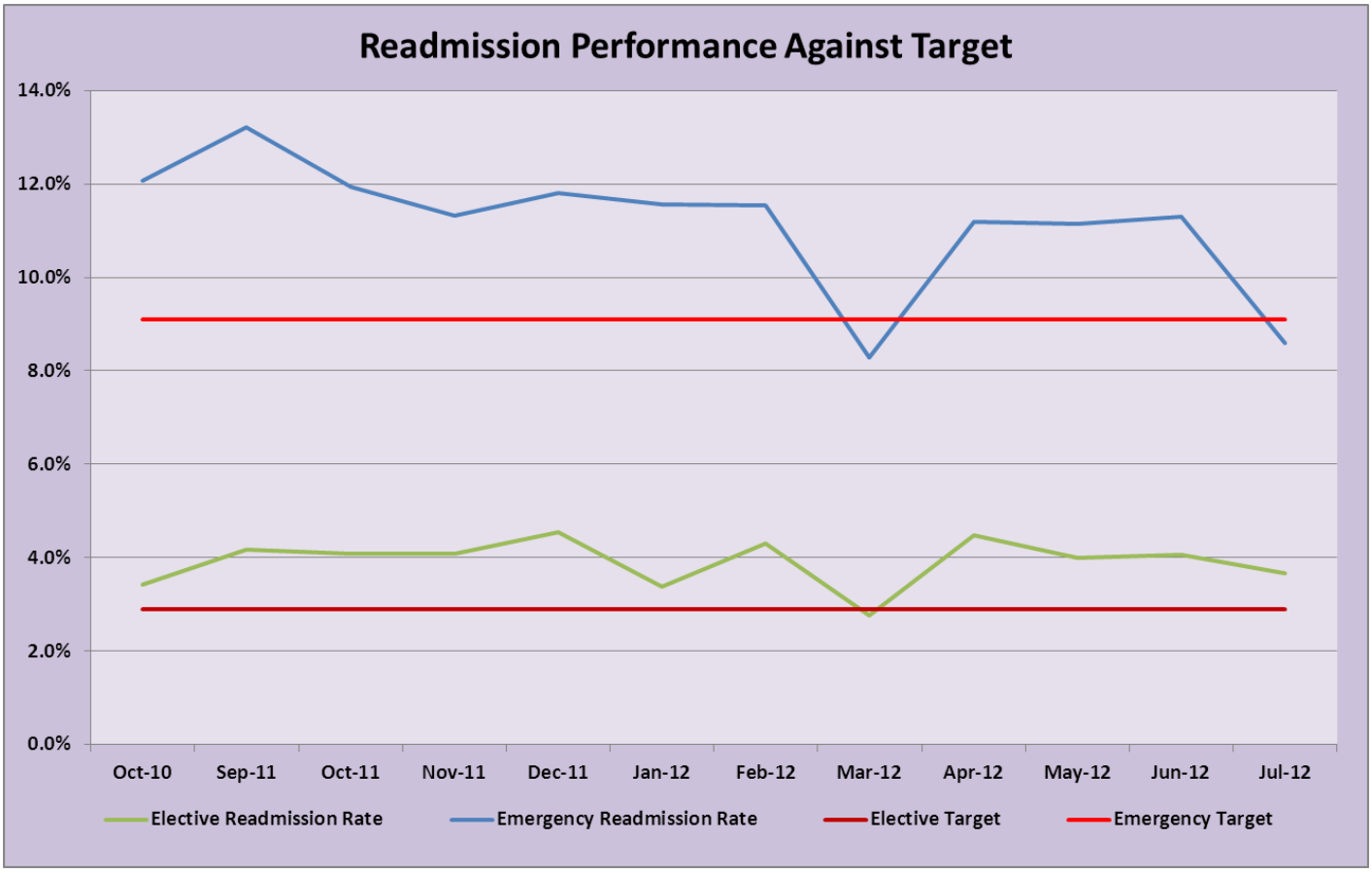
Performance YTD for high volume specialties is shown. DNA rates for smaller volume specialties are monitored regularly and are available on request.

YTD DNA Rates by Specialty (April 2012 to July 2012)			
SpecDesc	ATT	DNA	DNA Rate
ORTHOPTICS	1408	319	18.5%
PAEDIATRICS	2504	326	11.5%
ORAL SURGERY	1441	149	9.4%
ORTHOTICS	869	72	7.7%
ORTHODONTICS	713	58	7.5%
GASTROENTEROLOGY	1791	134	7.0%
PAIN CLINIC	2057	153	6.9%
NEUROLOGY	1319	92	6.5%
OBSTETRICS	1681	112	6.2%
GYNAECOLOGY	3921	259	6.2%
EAR NOSE THROAT	4414	263	5.6%
GENERAL SURGERY	3128	182	5.5%
CARDIOLOGY	2076	119	5.4%
DIABETIC MEDICINE	768	44	5.4%
TRAUMA & ORTHOPAEDICS	8887	498	5.3%
ENDOCRINOLOGY	645	32	4.7%
OPHTHALMOLOGY	12101	590	4.6%
BREAST SURGERY	1824	80	4.2%
RESPIRATORY MEDICINE	1062	46	4.2%
RHEUMATOLOGY	1460	63	4.1%
COLORECTAL	1051	42	3.8%
DERMATOLOGY	4122	163	3.8%
UROLOGY	3572	137	3.7%
GERIATRIC MEDICINE	563	20	3.4%
CLINICAL NEURO-PHYSIOLOGY	731	23	3.1%
MIDWIFERY	12058	367	3.0%
HAEMATOLOGY, CLINICAL	2438	69	2.8%
MEDICAL ONCOLOGY	755	18	2.3%
GENERAL MEDICINE	803	16	2.0%
ANTICOAGULANT	3934	73	1.8%
CLINICAL ONCOLOGY	1327	17	1.3%
Trust Total	85423	4536	5.0%

As part of POD 37 on outpatients, work is being undertaken at specialty level to investigate performance at benchmarked peer group level and where there is variance determine reasons for this and if appropriate agree actions to address.

4.7 Readmission Rates – Emergency and Elective

The Elective Readmission rate for July was 3.7% which was above its target of 2.7%. Emergency readmissions for July were under target, with a performance of 8.6% against a target of 9.1%. The Trust is in the process of commissioning some additional analysis from CHKS on readmission rates and will report back to the Quality and Risk Committee, once available.



It would appear that the improvements in patient pathways following the implementation of POD 19 actions has not resulted in a deterioration of performance on readmissions. However in relation to Elective readmissions further investigation needs to take place to determine whether this is actually an anomaly of current patient pathway management.

4.8 Total Length of Stay

Total LOS for the month is currently just above the peer benchmark, this is being monitored closely by the POD19 project team, if this continues to be the position over the next 2 months a more detailed review will be broght back to this committee

PERFORMANCE & STANDARDS APPENDIX 1 – PERFORMANCE DASHBOARDS

MONITOR COMPLIANCE FRAMEWORK SCORECARD

Declaration of performance against healthcare targets and indicators

Targets as per Compliance Framework 2012/13		Threshold	2012/13 CF Weighting	Annual Plan 2012/13	Apr-12		May-12		Jun-12		Quarter 1		Jul-11	
					Perf	Weight	Perf	Weight	Perf	Weight	Perf	Weight	Perf	Weight
C.difficile year on year reduction		30	1.0		1		5		1		7		1	
MRSA - meeting the MRSA objective		1	1.0		0		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%		100.0%		100.0%			
	Surgery	94%	1.0		100.0%		100.0%		100.0%		100.0%			
	Radiotherapy (from 1 January 2011)	94%	1.0		n/a		n/a		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%		92.3%		95.2%			
	Urgent GP Referral To Treatment	85%	1.0		90.5%		81.5%	1	90.7%		86.4%			
A&E: Total time in A&E 95% Patients withing 4 Hr Target		95%	1.0		96.9%		96.1%		96.7%		96.7%		96.6%	
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%		98.9%							
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%		99.0%		99.4%			
Two week wait from referral to date first seen	All cancers	93%	0.5		94.4%		95.9%		97.1%		95.8%			
	For symptomatic breast patients (cancer not initially suspe	93%	0.5		98.6%		98.0%		94.0%		97.1%			
Thrombolysis within 60 minutes (where this is the preferred local treatment)		68%	0.5		n/a		n/a		n/a		n/a		n/a	
Screening all elective in-patients for MRSA		100%	0.5		100%		100%		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		n/a		n/a	
	Having formal review within 12 months	95%	0.5		n/a		n/a		n/a		n/a		n/a	
Minimising delayed transfer of care		<=7.5%	1.0		1.6%		2.0%		2.6%		2.0%		2.4%	
Admissions had access to crisis resolution home treatment teams		90%	1.0		n/a		n/a		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		n/a		n/a	
Data completeness: identifiers		99%	0.5		n/a		n/a		n/a		n/a		n/a	
Data completeness: outcomes		50%	0.5		n/a		n/a		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		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						