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

**REPORT TO THE BOARD OF DIRECTORS**

| SUBMITTED BY: | REPORT FOR: | | IMPACT: | | |
|---|---|---|---|---|---|
| Barbara Cummings<br>Director of Performance<br>Mark Henry<br>Director of Clinical Services | 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:** 24th September 2012
**Report Title:** Performance Report

**Purpose:**

The paper provides Board members with a performance dashboard which brings together the reporting of key Trust indicators on Quality & Risk, Performance & Standards, Finance & Investment and Workforce.

**Summary:**

The enclosed report identifies the key areas of performance to August 2012 and where appropriate the forecast for year end March 2013, including the key risks to operational performance. The Monitor compliance framework position for the current month is 1.0 (Amber / Green), with a forecast of Green for the end of quarter 2.

**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:**
The Board is asked to;

a) Review performance achievement across the Trust and sign-off the performance report.
b) Note the Monitor Compliance framework position at the end of the current month is 1.0 (Amber / Green). The forecast for the end of the quarter remains Green.
c) Note that the cancer 62 day target was not achieved for the latest month. However, the forecast for the quarter remains above the 85% target.
d) Note the comments in relation to compliments, complaints and those that have been published on the NHS Choices website.
e) Identify any key issues requiring further consideration.

Author: Michael Brown
Date: 14 September 2012

# Trust Board Dashboard Aug 12

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

## Quality & Risk

| Indicator | Target | Current Month | YTD | Trend |
|---|---|---|---|---|
| 1.1 Crude Mortality | 19 | 14.1 | 16.5 | |
| 1.2 RAMI | 75.7 | 83 | 83 | |
| 1.3 SHMI* | N/A | 99.7 | 99 | |
| 1.4 Net Promoter - Friends & Family Survey | 0.71 | 0.459 | | |
| 1.8 MRSA | 1 | 0 | 0 | |
| 1.9 CDIFF | 4 | 1 | 9 | |
| 1.10 Serious Incidents | 0 | 6 | 20 | |
| 1.11 Never Events | 0 | 1 | 3 | |
| 1.12 Serious Medication Errors | 0 | 0 | 0 | |
| 1.13 Falls Resulting in Serious injury | 0 | 0 | 2 | |
| 1.14 Pressure Ulcers - Grade 3 H.A | 0 | 1 | 17 | |
| 1.15 Pressure Ulcers - Grade 4 H.A | 0 | 0 | 1 | |
| 1.16 Number of MSA Breaches ( Number of Patients) | 0 | 0 | 9 | |
| 1.17 Clinical Complaints | | 34 | 173 | |
| 1.18 Non-Clinical Complaints | | 9 | 17 | |
| 1.19 Compliments | | 63 | 506 | |
| 1.20 Safety Thermometer - No new harms | 95.0% | 94.90% | 94.50% | |
| 1.21 VTE Assessment Completeness* | 90.0% | 97.0% | 97.1% | |

*RAMI figure is shown 1 month in arrears

*SHMI figure is for period Jan - Dec 2011

| CQC Concerns |
|---|
| CQC Concern Regarding Outcome 21 |

## Performance & Standards

| Indicator | Target | Current Month | YTD | Trend |
|---|---|---|---|---|
| 3.1 Monitor Compliance Framework Score | 1 | 1 | 0 | |
| 3.2 18 Weeks - Admitted 95th Percentage* | 90% | n/a | 91.8% | |
| 3.3 18 Weeks - Non Admitted 95th Percentage* | 95% | n/a | 98.9% | |
| 3.4 Cancer - 31 Days Subsq Treatment - Surgery* | 94% | 100.0% | 100% | |
| 3.5 Cancer - 31 Days Subsq - Drug Treatments* | 98% | 100.0% | 100% | |
| 3.6 Cancer - 62 Days Referral to Treatment | 85% | 82.5% | 86% | |
| 3.7 Urgent GP Cancer - 2 Week Wait* | 93% | 97.4% | 95.8% | |
| 3.8 Cancer - 31 Days Diagnosis to Treatment* | 96% | 100.0% | 99.4% | |
| 3.9 A&E 4 Hour Attendance | 95% | 95.3% | 96.6% | |
| 3.10 MRSA Screening - All Elective Inpatients | 100% | 100.0% | 100.0% | |
| 3.11 Choose + Book - Slot Utilisation | 90% | 66.0% | 71.5% | |
| 3.12 Stroke - 90% of Stay on a Stroke Unit* | 80% | 84.1% | 85.4% | |
| 3.13 Stroke - High Risk TIA treated in 24 Hrs* | 60% | 81.8% | 74.4% | |
| 3.14 Cancelled Ops | N/A | N/A | 89 | |
| 3.15 Readmission Rate - Elective | 3% | 2.6% | 4.0% | |
| 3.16 Readmission Rate - Emergency | 9% | 7.5% | 10.6% | |
| 3.17 Diagnostic Over 6 Week Waiters | 1% | 0.8% | 0.1% | |

### Operational Efficiency

| Indicator | Target | Current Month | YTD | Trend |
|---|---|---|---|---|
| 3.18 Day Case Rate | 82% | 90.80% | 84.2% | |
| 3.19 BADs | 80% | 85.9% | 82.8% | |
| 3.20 New to Review Rate | 2.3 | 2.4 | 2.5 | |
| 3.21 DNA Rate | 5% | 5.9% | 5.1% | |
| 3.22 EL LOS | 2.2 | 1.9 | 2.2 | |
| 3.23 EM LOS | 5 | 4.6 | 4.3 | |
| 3.24 Total LOS | 4.3 | 4.3 | 4 | |

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

## Finance & Investment

| NHS Clinical Revenue (Excl Non PbR Drugs) By Point of Delivery | Current Period | | | | | |
|---|---|---|---|---|---|---|
| | ACTIVITY | | | FINANCE | | |
| | Actual | Plan | Variance | Actual | Plan | Variance |
| | | | | £000s | £000s | £000s |
| A&E | 4,978 | 4,846 | 132 | 495 | 488 | 7 |
| Elective Inpatients | 504 | 485 | 19 | 1,084 | 1,132 | (48) |
| Daycases | 2,888 | 2,851 | 37 | 1,771 | 1,724 | 47 |
| Elective Excess bed days | 23 | 93 | (70) | 5 | 22 | (17) |
| Nonelective Inpatients | 2,529 | 2,621 | (92) | 1,553 | 1,787 | (234) |
| Nonelective Excess bed days | 932 | 1,487 | (555) | 212 | 337 | (125) |
| Emergency threshold Cap | 0 | 0 | 0 | (267) | (358) | 91 |
| Outpatients | 24,661 | 26,349 | (1,688) | 2,725 | 2,896 | (171) |
| Other Clinical income | 0 | 0 | | 4,741 | 4,446 | 295 |
| Total NHS Clinical Revenue (Excl NonPbR Drugs) | 36,515 | 38,732 | (2,217) | 12,319 | 12,474 | (155) |

| | | 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 |
|---|---|---|---|---|---|---|---|---|---|
| 2.1 | Surplus | 1.7m | 1.7m | ↔ | 0.6m | 0.3m | ↑ | 0.6m | 0.5m |
| 2.2 | EBITDA | 8.8m | 8.1m | ↔ | 3.4m | 3.1m | ↑ | 1.2m | 0.9m |
| 2.3 | Cash Balance | 6.3m | 5.5m | ↓ | 8.3m | 16m | ↑ | 8.3m | 16m |
| 2.4 | BSP - Overall Position | 10.2m | 6.5m | ↓ | 2.2m | 1.8m | ↑ | 0.6m | 0.4m |

BSP figure is risk assessed

| | | Full Year Plan | Full Year Forecast | YTD Plan | YTD |
|---|---|---|---|---|---|
| 2.5 | Finance Risk Rating | 3 | 3 | 3 | 3 |

## Workforce

| Indicator | Target | Current Month | YTD | |
|---|---|---|---|---|
| 4.1 Sickness Absence Rate | 3.7% | 5.1% | 4.3% | |
| 4.2 Staff Turnover Rate | 10.0% | 8.5% | 8.3% | |
| 4.3 Appraisal Completeness % | 90.0% | 74.8% | 73.7% | |
| 4.4 Fire Training | 70.0% | 85.6% | 80.0% | |
| 4.5 Infection Control Training | 70.0% | 78.2% | 75.0% | |
| 4.6 Resuscitation Training | 70.0% | 82.1% | 81.0% | |
| 4.7 Safeguarding Children Training | 80.0% | 89.2% | 86.0% | |
| 4.8 Safeguarding Adults Training | 70.0% | 96.4% | 94.0% | |
| 4.9 Information Governance Training | 95.0% | 83.9% | 83.0% | |
| 4.10 Nurse Vancancies (as % of Nurse Posts) | | 6.4% | 6.8% | |
| 4.11 Medical Vacancies (as % of Medical Posts) | | 5.7% | -2.6% | |
| 4.12 Contracted People in Post | 2779 | 2565 | 2603 | |
| 4.13 Temporary Staff in Post | 139 | 155 | 149 | |

# 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)**

**1.8 - 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)**

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

## 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)**

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

**3.13 - 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

**3.14 - Total LOS**

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

**3.15 - Day Case Rate**
Percentage of Elective Activity that is Daycase

**3.16 - BADs**
British Association of Day Surgery's "trolley" of procedures

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

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

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

**3.20 - Stroke - High Risk TIA treated within 24 Hrs**

Percentage of High Risk TIAs that are treated within 24 hours.

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

**3.22 - 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

**3.23 - 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

**3.24 - 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)**

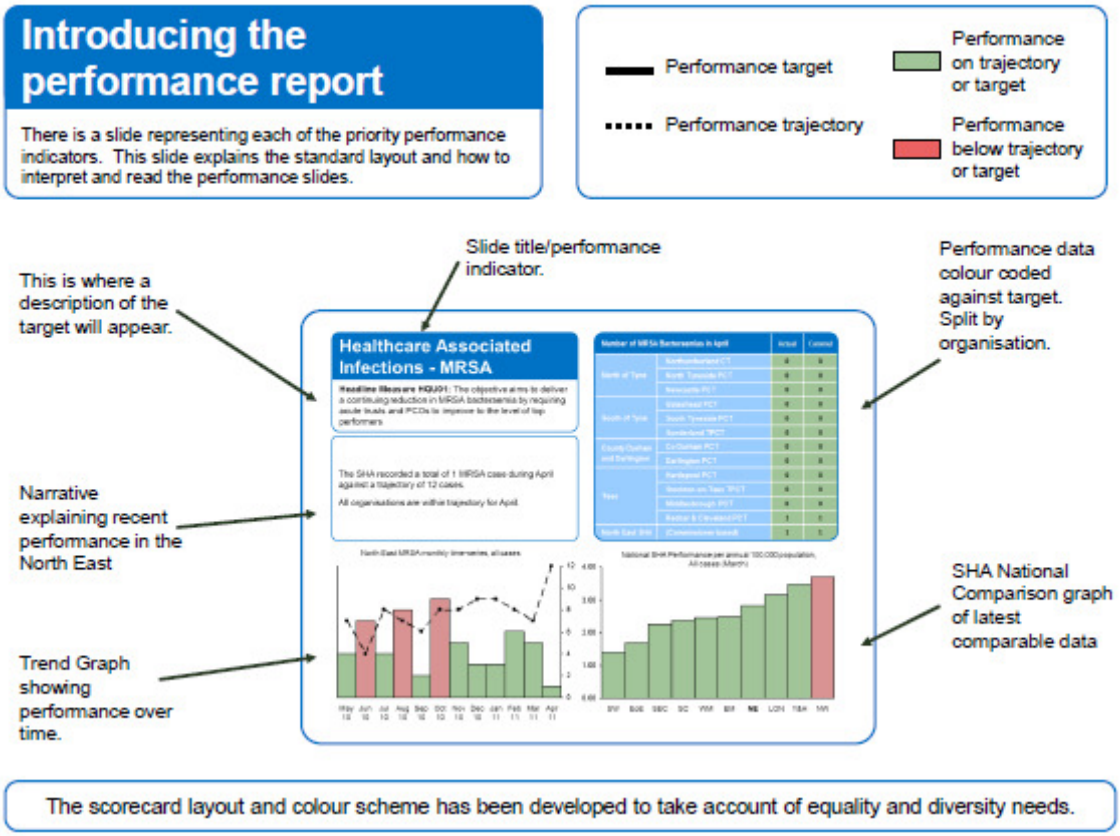
**4.5 - Finance Risk Rating**

# Explaining the Performance Report

This performance report is provided to give an an update to the Trust Board of Directors on the key areas of performance to August 2012 and the associated forecast to the end of the current quarter. The current report identifies key performance indicators linked to the four key governance areas within the Trust;

- Quality & Risk
- Finance & Investment
- Performance and Standards
- Workforce

The report currently provides performance against the key national target, with a comment on performance and a graphical trend of performance over a period of time. It is intended that future reports will be developed further to include the appropriate benchmark and comparison information similar to that outlined in the diagram below.




**Barbara Cummings**
**Director of Performance and Informatics**

# 1 EXECUTIVE SUMMARY OF PERFORMANCE

The following report provides an overall review of progress against Trust performance targets and local and national targets. Included within this report are the Performance Dashboard, Key Performance Indicators, Monitor Compliance and any associated exceptions to performance.

The **Performance Dashboard** provides an indication of the position at the end of August regarding the performance of the Trust against national and local key performance indicators.

The **Quality and Risk** section of the report includes the Trust Mortality position and how patients view the Trust. The Trust mortality position is currently 83 against an internal target of 75.7, this is however below the national expected position. The Trust received 34 clinical complaints out of 41 total complaints and 63 compliments across the Trust in the month. The Trust has also reported 1 Grade 3 pressure ulcer in the month.

The Trust has reported no serious incidents and 3 never events in the month. There have previously been reported 20 serious incidents year to date and 5 never events for the current year, of which 2 were reported retrospectively. An update on those still open is provided within the report.

The **Performance and Standards** section of the report highlights performance against national and local KPI's, along with the Trust position against the Monitor compliance framework. The Trust are current reporting they have not achieved the Cancer 62 day target for the latest month (82.5% against the 85% target) but forecast they will achieve this target for the quarter.

With regard to **Workforce** the current report highlights that the Trust Sickness absence rate for the month is above the target of 3.7% at 5.1%, with the reasons for absence highlighted. It also focuses on appraisal completeness across the Trust which is 74.8% below the target of 90% and the annual requirement for Information Governance Training which stands at 83.9% against a target of 90%.

Whilst the Trust was visited by the Care Quality Commission for a follow up visit on Privacy and Dignity, the final report has yet to be received. It should be noted that this visit did not focus on Outcome 21 and a further visit should be expected shortly.

Finally, the Trust are reporting a YTD Financial Risk Rating of 3 and a Governance Risk Rating of 1.0 (Amber / Green).

**Recommendations**

The Trust Board are asked to;

a) Review performance achievement across the Trust and sign-off the performance report.
b) Note the Monitor Compliance framework position at the end of the current month is 1.0 (Amber / Green). The forecast for the end of the quarter remains Green.
c) Note that the cancer 62 day target was not achieved for the latest month. However, the forecast for the quarter remains above the 85% target.
d) Note the comments in relation to compliments, complaints and those that have been published on the NHS Choices website.
e) Identify any key issues requiring further consideration.

# 2 QUALITY AND RISK

The Trust's performance against its Quality and Risk KPIs was mixed. For a number of indicators performance was below that identified as a target level. The RAMI score remains above the target reduction level the Board of Directors agreed. The Trust is still awaiting the outcome of the CQC's spot check visit to the Trust on 14 August 2012.

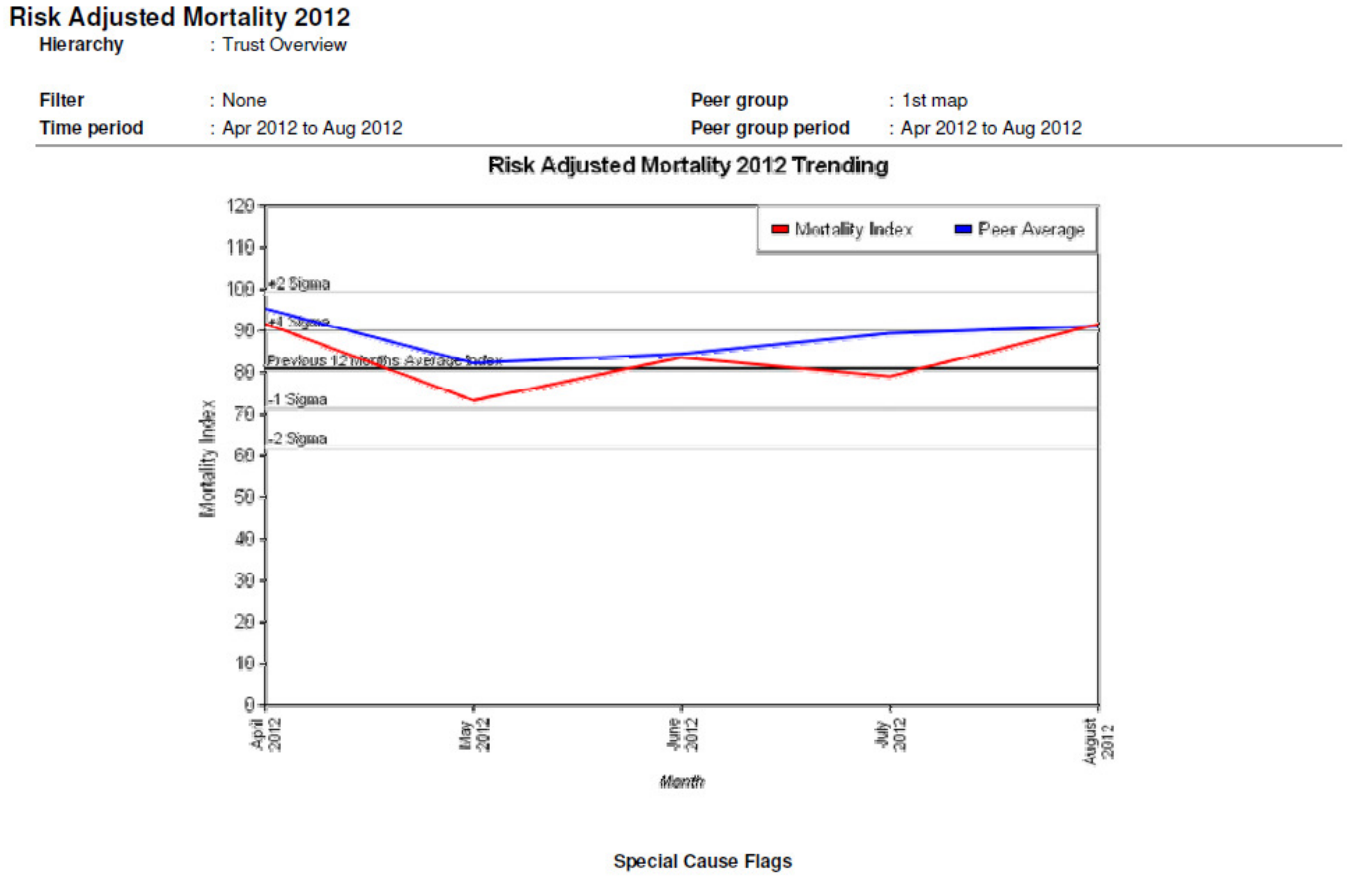
Last month, the Trust reported a Never Event for the 2nd month running and there were 3 further Never Events reported for August 2012.

The Trust continues to make progress on eliminating hospital acquired Pressure Ulcers (a Midlands and East commissioning aim) by December 2012. In July, 1 Grade 4 pressure sore was reported and 7 Grade 3's and in August only 1 Grade 3 has been reported.

Patient feedback from the monthly 'Friends and Family' survey is below the 71% target (67.2 for July and 45.9 for August) identified by NHS Midlands and East, with work underway to achieve the 10% footfall target of respondent's (a CQUIN target).

## 2.1 Trust Mortality

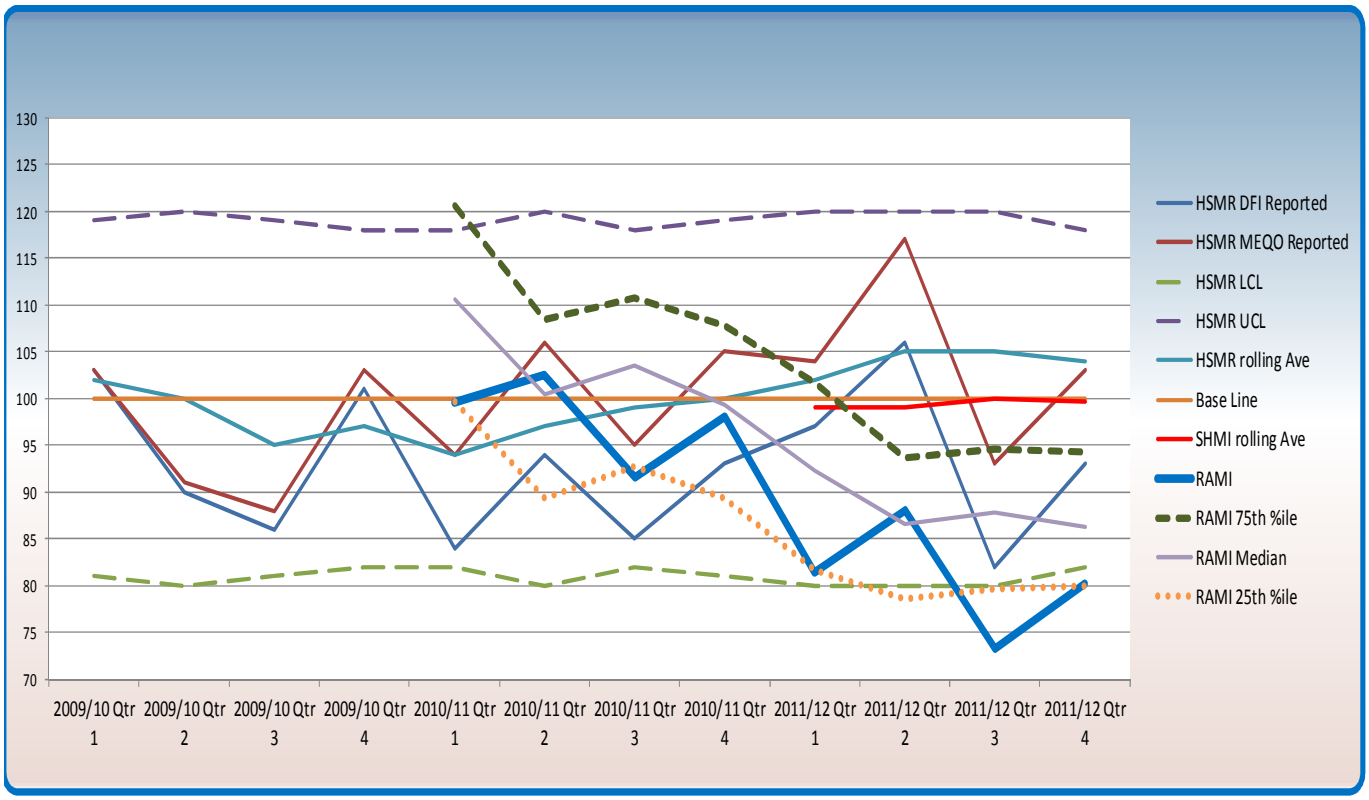
The Trust's RAMI performance over the past 15 months is show in the graph below:-



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' performance.

- Crude mortality per 1,000 admissions in August 2012 = 14.1 (target achieved)
- RAMI in August 2012 = 91 (target not achieved)

**The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust : SHMI, HSMR & RAMI Trend**



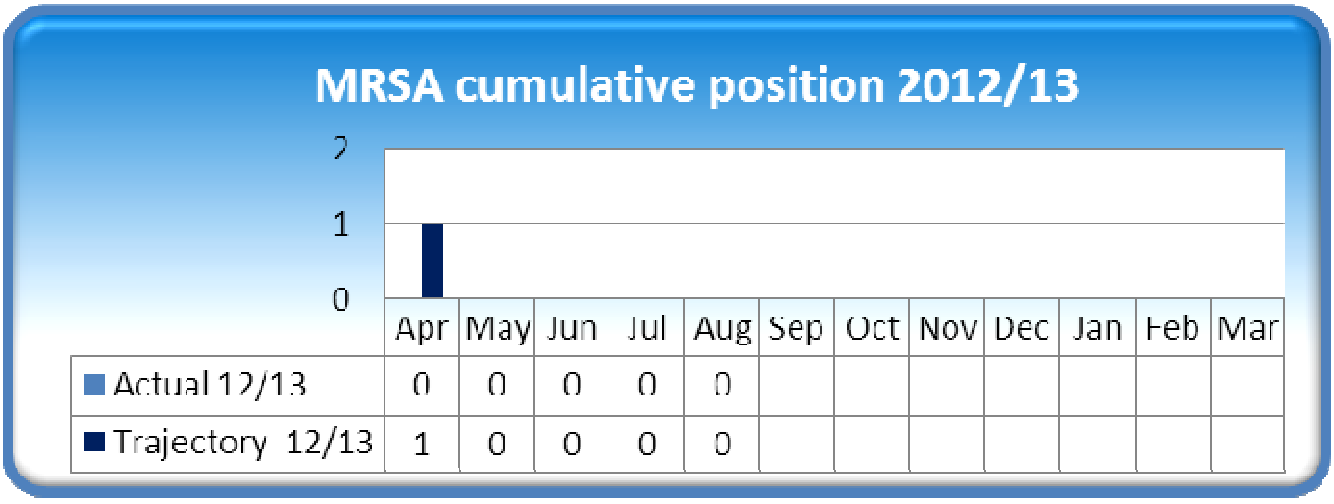

HSMR data has been sourced from MEQO (published by Dr Foster).
SHMI has been provided by the NHS Information Centre.
Rami has been provided by CHKS.

## 2.2 Hospital Acquired Infections

### Healthcare Associated Infections - MRSA

**Headline Measure HQU01**: The objective aims to deliver a continuing reduction in MRSA bacteraemia by requiring acute trusts and PCOs to improve to the level of top performers.

The Trust reported 0 MRSA Infections in August 2012

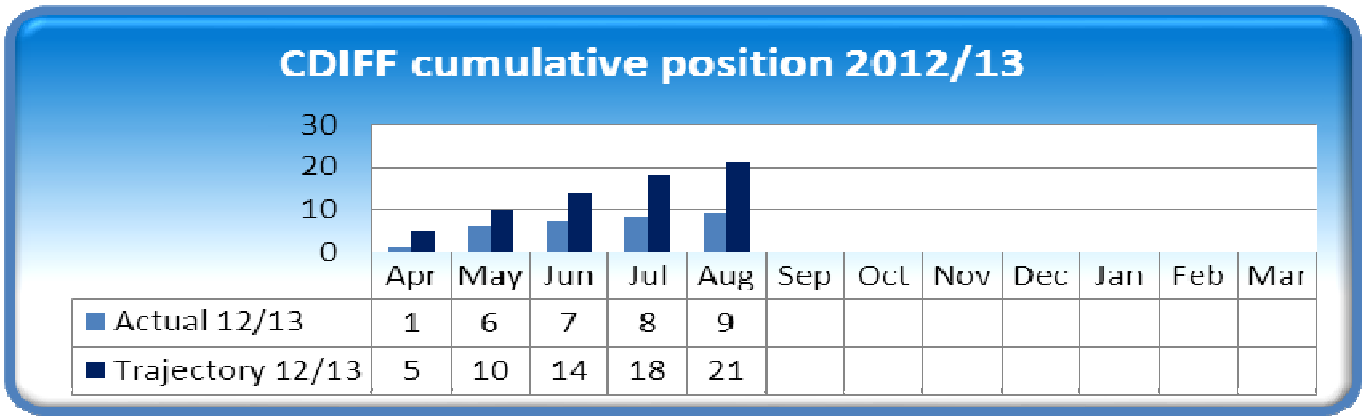



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual 12/13 | 0 | 0 | 0 | 0 | 0 | | | | | | | |
| Trajectory 12/13 | 1 | 0 | 0 | 0 | 0 | | | | | | | |

### Healthcare Associated Infections - C -difficile

The objective aims to deliver a continuing reduction in Clostridium *difficile infections.* Organisations with higher baseline rates will be required to deliver larger reductions.

The Trust reported 1 Clostridium Difficile infection in August 2012.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual 12/13 | 1 | 6 | 7 | 8 | 9 | | | | | | | |
| Trajectory 12/13 | 5 | 10 | 14 | 18 | 21 | | | | | | | |

## 2.3 Patient Experience

# Patient Experience

**Headline Measure HQU04: Patient Experience Survey**

The following comment was posted on the NHS Choices website during July 2012. There were no posts on the Patient Opinion website about this Trust during July or August.

**The Nurses did a great job. They where very helpful and tried to help as much (peepssmile visited Neurology services in July 2011) Added to NHS Choices on 29 August 12**

**NHS CHOICES**

**Overall rating**

**I would not recommend to a friend**

**The environment where I was treated was…**

clean

**The hospital staff worked well together…**

never

**I was treated with dignity and respect by the hospital staff…**

not at all

**I was involved with decisions about my care…**

never

**NHS hospitals must provide same-sex accommodation. How satisfied were you that this hospital did so?**

satisfied

**A+E Top Class, everything else a complete disaster!**

(Anonymous visited General surgery in August 2012) (Added to NHS Choices on 9 August 2012)

**PATIENT OPINIONS**

**Overall rating**

**I would not recommend to a friend**

**The environment where I was treated was…**

clean

**The hospital staff worked well together…**

some of the time

**I was treated with dignity and respect by the hospital staff…**

rarely

**I was involved with decisions about my care…**

never

**NHS hospitals must provide same-sex accommodation. How satisfied were you that this hospital did so?**

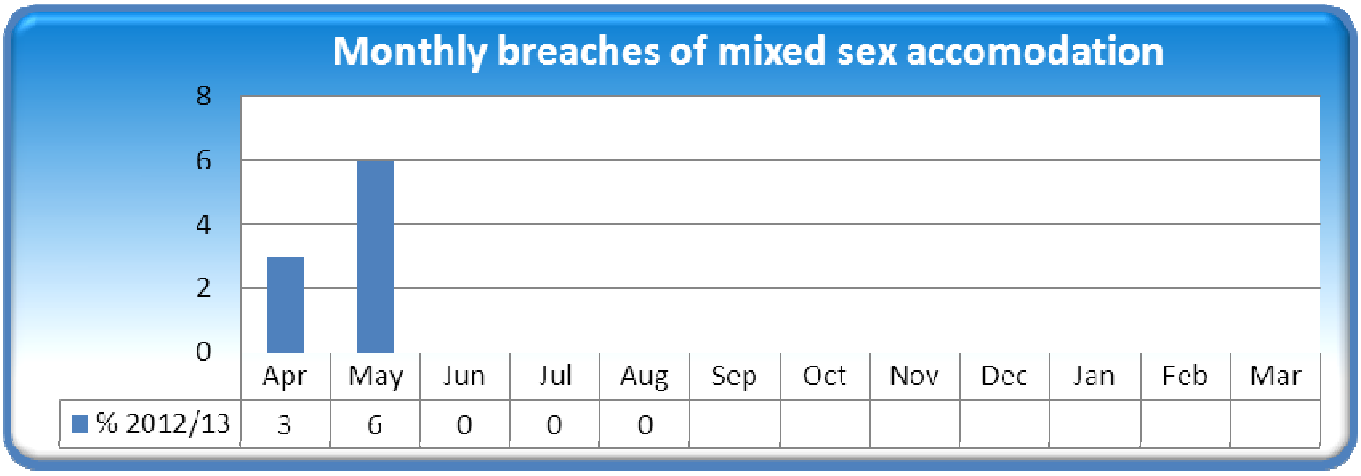
very dissatisfied

## 2.4 Mixed Sex Accommodation

### Mixed Sex Accomodation

**Headline Measure HQU08**: Number of breaches of mixed sex accommodation (MSA) sleeping accommodation, per 1,000 finished consultant episodes

The QEH recorded 0 breaches for August 2012.



## 2.5 Complaints

# Complaints

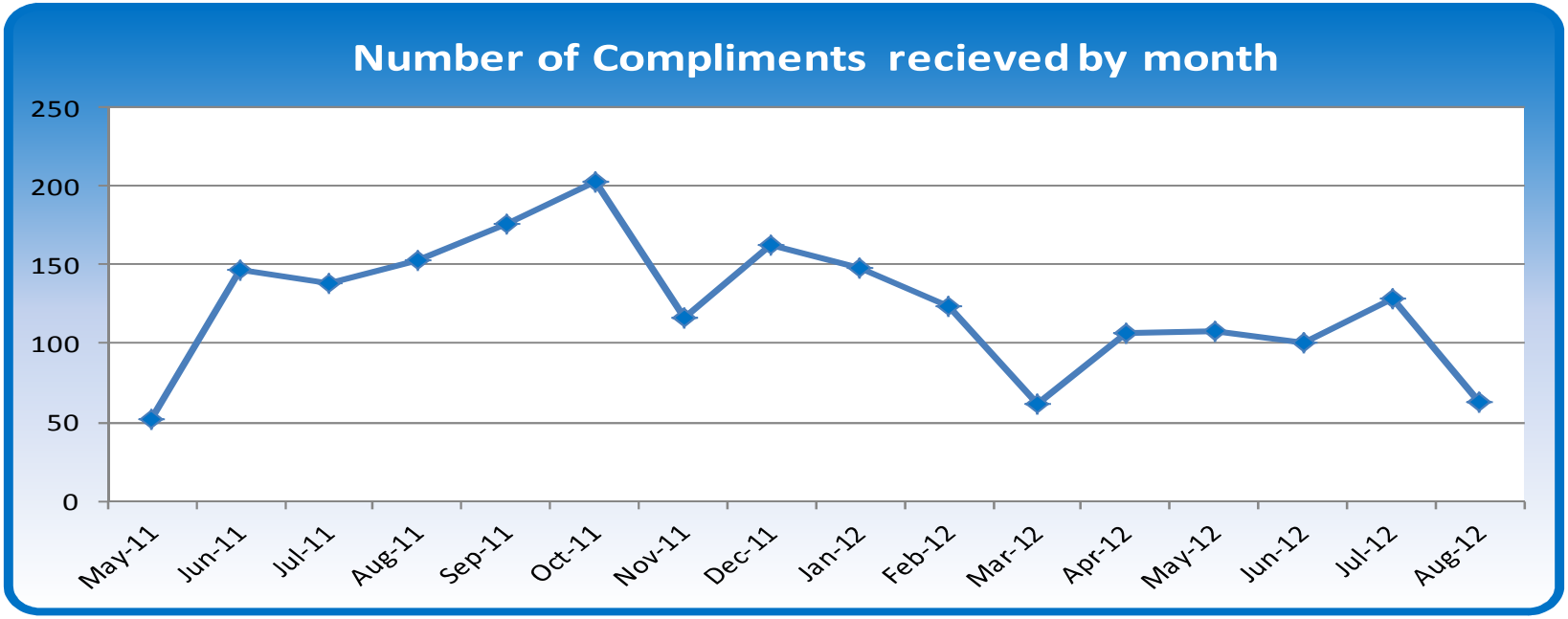
**Headline Measure: Complaints activity by division**

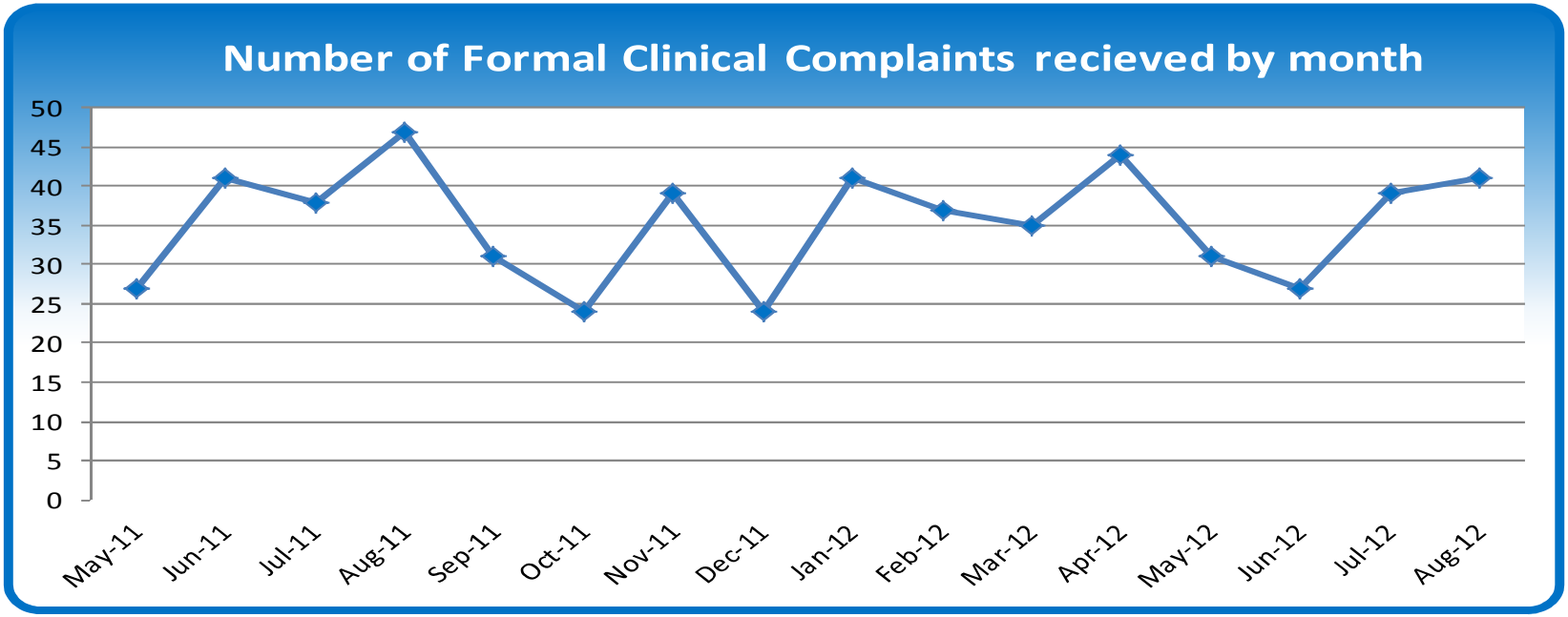
The Trust received 41 formal complaints during the month of August 2012, which was a 7% decrease in comparison to the previous month. Of the 41 complaints 34 were clinical (2 in corporate areas) and 7 were non clinical.

The themes identified for this month were 8 clinical complaints related to lack of treatment/examination and 6 were regarding staff attitude. There we no themes in relation to non clinical complaints, these ranged from car parking concerns, Chronos reminder service, patient surveys, delay in FOI and fees for insurance claims.

There were 63 written compliments received by the Trust during August 2012, this was a 44% decrease compared to July 2012. 19 compliments were received in August 2012 for the service line, General Medicine, however in July 2012 the Trust received 50.

| Divisional Activity in August 2012 | | | | | Divisional Performance in June 2012 | |
|---|---|---|---|---|---|---|
| Division | Formal Complaints | Compliments | Informal Contacts | Compliments : Formal Complaints Ratio | First Response date Target Met | Number of returning complaints where first response targets were provided |
| Surgery & Anaestethics (Elective Care) | 9 | 18 | 2 | 2:1 | 6 of 9 | |
| Emergency Care & Medicine | 17 | 38 | 0 | 2.2:1 | 10 of 14 | |
| Women & Children | 6 | 4 | 1 | 2:3 | 6 of 6 | 1 (33%) |
| Clinical Support | 0 | 1 | 1 | - | n/a | |
| Patient Services, Performance & Informatics | 4 | 0 | 0 | - | 0 of 3 | |
| Facilities & Hotel Services | 4 | 0 | 0 | - | 1 of 1 | |
| Trustwide | 0 | 1 | 1 | - | n/a | |
| Patient Experience | 0 | 1 | | - | n/a | |
| Patient Safety | 1 | 0 | 0 | - | n/a | |
| TOTAL | **41** | **63** | **5** | **1.5:1** | **23/33** | **1 (33%)** |


Number of Compliments recieved by month
250
200
150
100
50
0
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12


Number of Formal Clinical Complaints recieved by month
50
45
40
35
30
25
20
15
10
5
0
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12

## 2.6 Never Events and Serious Incident Reporting

**NEVER EVENTS REPORTED TO DATE**

The Trust has identified three Never Events year to date. These were as follows;

- June 2012 Retained Swab
- August 2012 Retained Swab
- August 2012 Incorrect Medication

Following a litigation claim from an incident that occurred in 2010 it was identified that there had been a further dental never event that had not been declared in 2010 regarding the extraction of teeth not consented to. This was therefore submitted retrospectively.

It was also identified, following a complaint received in 2011 regarding this incident which was investigated and an action plan commenced but no retrospective incident report submitted. Unfortunately a second event occurred in February before all the recommendations could be carried out.

Following the submission of 2 retrospective never events a full review of all incidents (6500) submitted over a 12 month period ending 31st August 2012 is being undertaken by the Patient Safety Lead who has the clinical expertise to assess if further information on any incident is required.

The results of this review will be available by 17th September and will be presented at the Patient Safety Committee.

**Open Serious Incidents as at 31/8/12**

During August 3 serious incidents were downgraded following investigations and have now been classed as void leaving 36 serious incidents with an open status.
Of the open incidents, RCA's and action plans are completed and have been submitted for 24 of the incidents, the remaining 12 incidents were under investigation.

A total of 6 new serious incidents were reported during August and these were as follows:-

- 2 x Never events, one regarding maladministration of Insulin and a second regarding a retained vaginal swab.
- 1 x Grade 3 pressure Ulcer
- 2 x # NOF
- 1x ITC telephone failure

## 2.7 Patient Experience Surveys

## OUT PATIENT EXPERIENCE – AUGUST 2012

Patient Experience of Chemotherapy Outpatient Service:

Nine of the patients responding to the survey said that they had to wait longer than 15 minutes from the time of their allocated appointment to be seen. However, of those nine patients 78% (7) said they had been informed of the delay, two patients said that they were not.

Fifty four percent of the respondents said that the holistic assessment was explained to them and 30% said they had completed this holistic assessment document.

Although a new initiative, 30% of patents questioned said that they recalled receiving a Patient Information Prescription.

Of the 30 respondents questioned, 19 patients said that they had contact with the Acute Oncology Service. Of those 19 patients, 16 responded to questions about the AOS specialist nurses. 100% of the patients said that they felt they had been listened to and 94% said they were happy with the advice / outcome they had been given. 92% said that they felt their problems had been dealt with.

The results for the AOS, 24/7 helpline were positive, although 5 patients said that they had difficulty getting through on the telephone advice line but didn't elaborate.

100% of the 29 patients responding to the full satisfaction survey, said that based on their experience of the AOS and oncology service; they would recommend the Hospital to friends and family.

## RECOMMENDATIONS AND ACTION PLAN

As a result of the study, several recommendations were made and these have been discussed and agreed at peer review. Future reaudit will take place to monitor the changes

1. To ensure that patients receive a Holistic Assessment and permanent record of their Chemotherapy treatment plan.
2. Routinely point out to individual patients at each clinic review that an assessment sheet is being completed and explain to the patient in a way they can understand.
3. To improve privacy at reception desk
4. Ensure that patients are aware of their Key Worker.
5. Review waiting times for patients being seen.
6. Investigate the reasons why patients said that they had difficulty 'getting through' to the 24 /7 helpline and implement any changes necessary to make improvements.

## DIABETES OUTPATIENT EXPERIENCE:

Seven areas showed improvement or were equal when compared to the 2011 study. One of the main areas to show improvement was patients being informed of a delay to their appointment, with an increase of more than 50% when compared to the previous year score. Although more patients said that they had to wait longer than 15 minutes after their allocated appointment time.

All patients responding said that they felt involved in decisions about their care or treatment and 97% said that they felt that staff were available to talk about worries or concerns

Thirty three patients were included in this study and 32 of those patients (97%) said that they would rate the overall service provided by the outpatient clinic as '7' or above. This was the same as in the 2011 study.

## RECOMMENDATIONS AND ACTIONS

The following recommendations were highlighted in the study for 2011.

1. *Improve systems in clinic for informing patients of delays in being seen.*
2. *Review information leaflets available to patients*
3. *Continue to work towards a dedicated Diabetes Centre to improve the waiting environment for patients*

In response to the actions from 2011, an improvement of more than 50% was seen in informing patients of delays in this study.

The Diabetes Consultant gave a response to the outcomes: Given the current commissioning environment, there is little prospect of a dedicated Diabetes Centre being developed in the near future. Leaflet review, therefore, remains one way forward and has already been highlighted as a Clinical Governance priority. Work to maintain the improvement in communication to patients -re delay is also important. Both recommendations will be taken forward following this audit.

# 3 WORKFORCE

There are three key areas of workforce where the Trust is currently off target / plan. These are sickness absence rates, appraisal completeness and Information Governance Training.

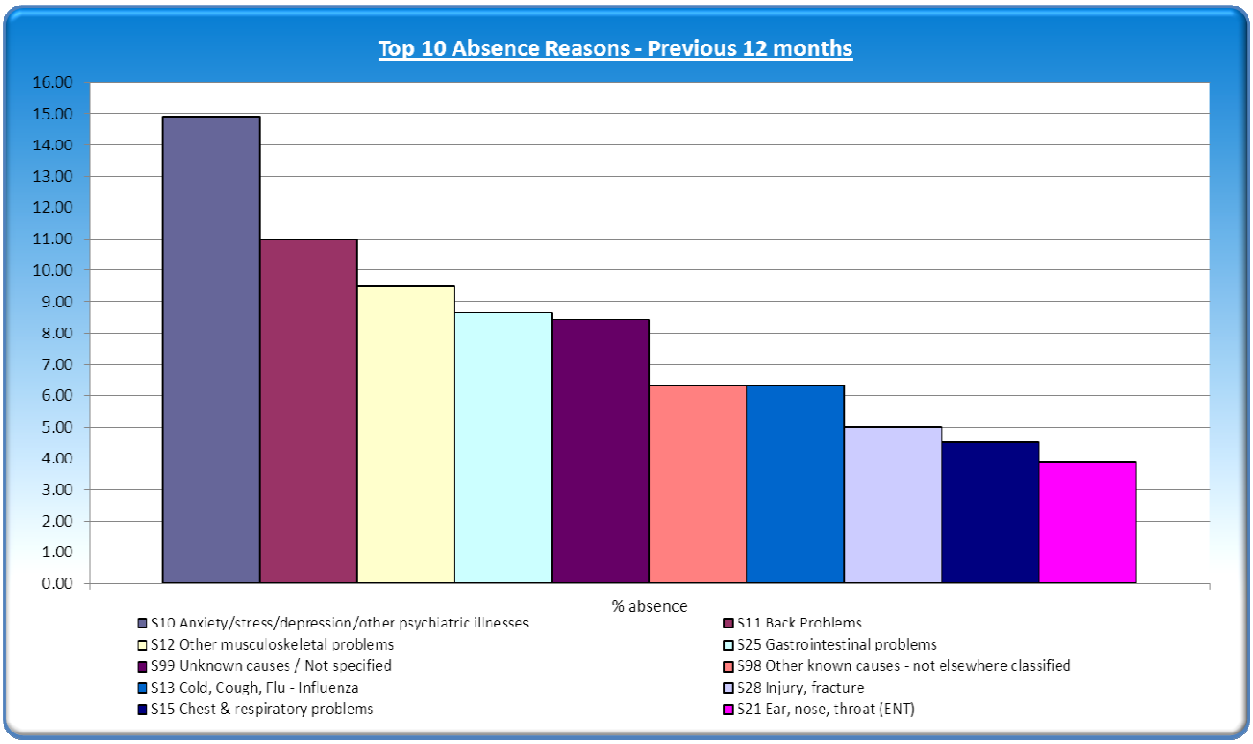
The Trust Sickness absence rate for the month is above the target of 3.7% at 5.1%, with the reasons for absence highlighted. It also focuses on appraisal completeness across the Trust which is 74.8% below the target of 90% and the annual requirement for Information Governance Training which stands at 83.9% against a target of 90%.

## 3.1 Sickness Absence

### Absence Reasons

**Headline Measure**: Top 10 Absence reasons over the last 12 month period

Long Term Sickness has increased this month with the number of staff currently off for more than 28 days of 93.

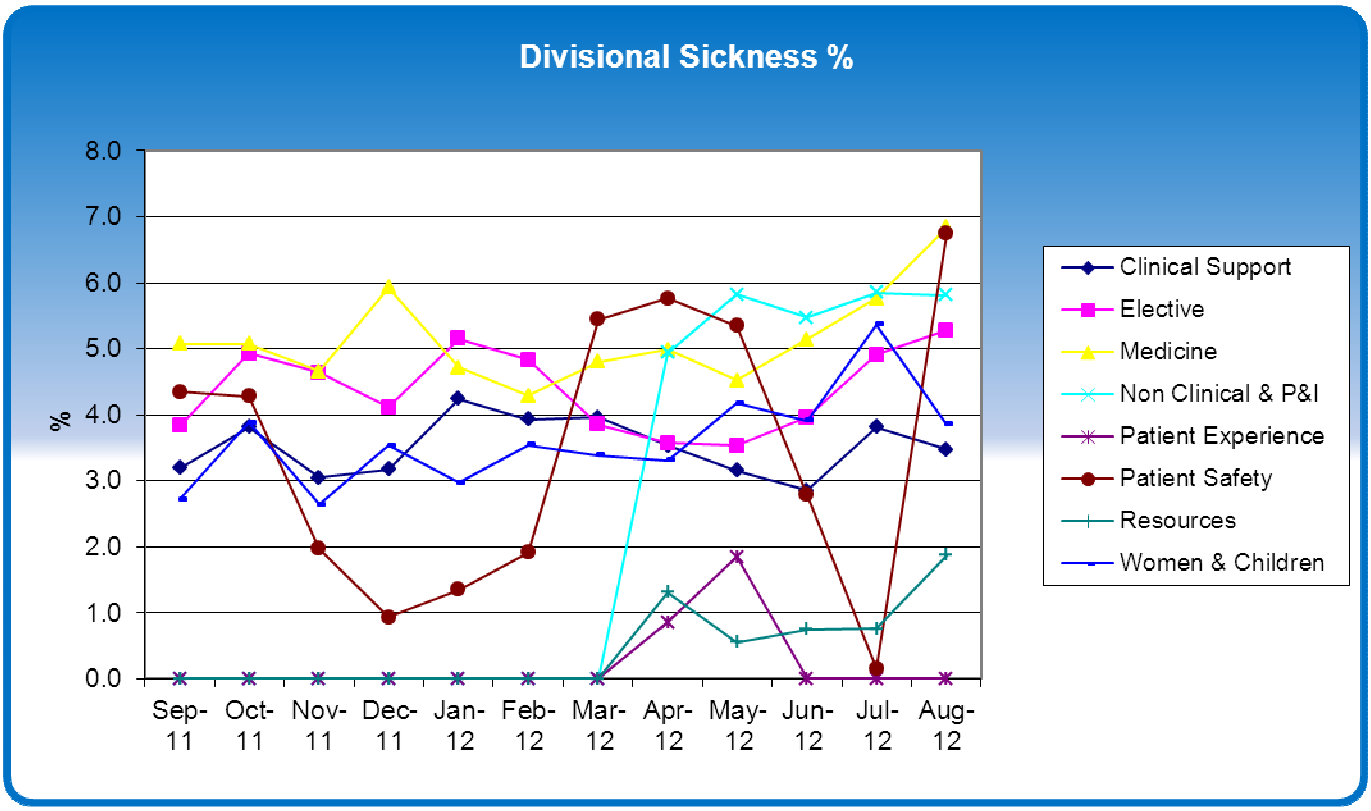



Analysis of the reasons does not suggest any one reason for the on-going increased level of sickness absence and the current emphasis is on robustly managing our current absence via existing policy and procedures.

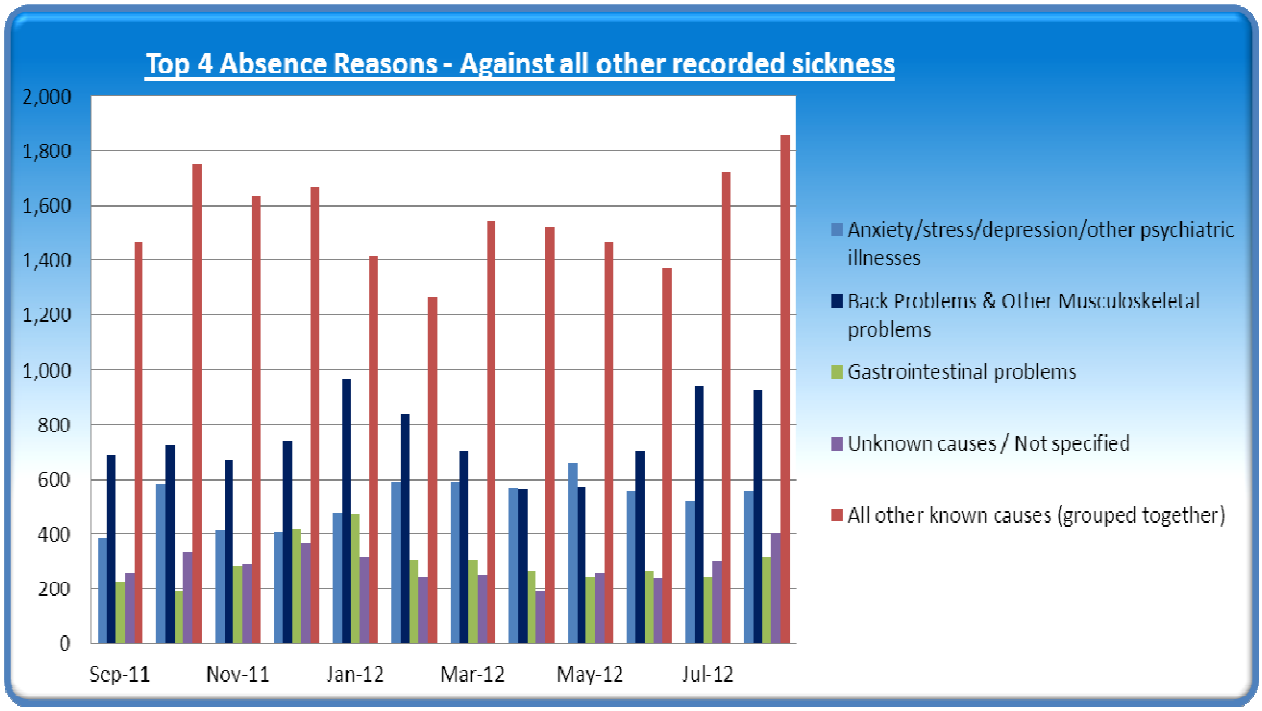
# Sickness Absence Rate

**Headline Measure**: % Absence rate by staff group over the last 12 months

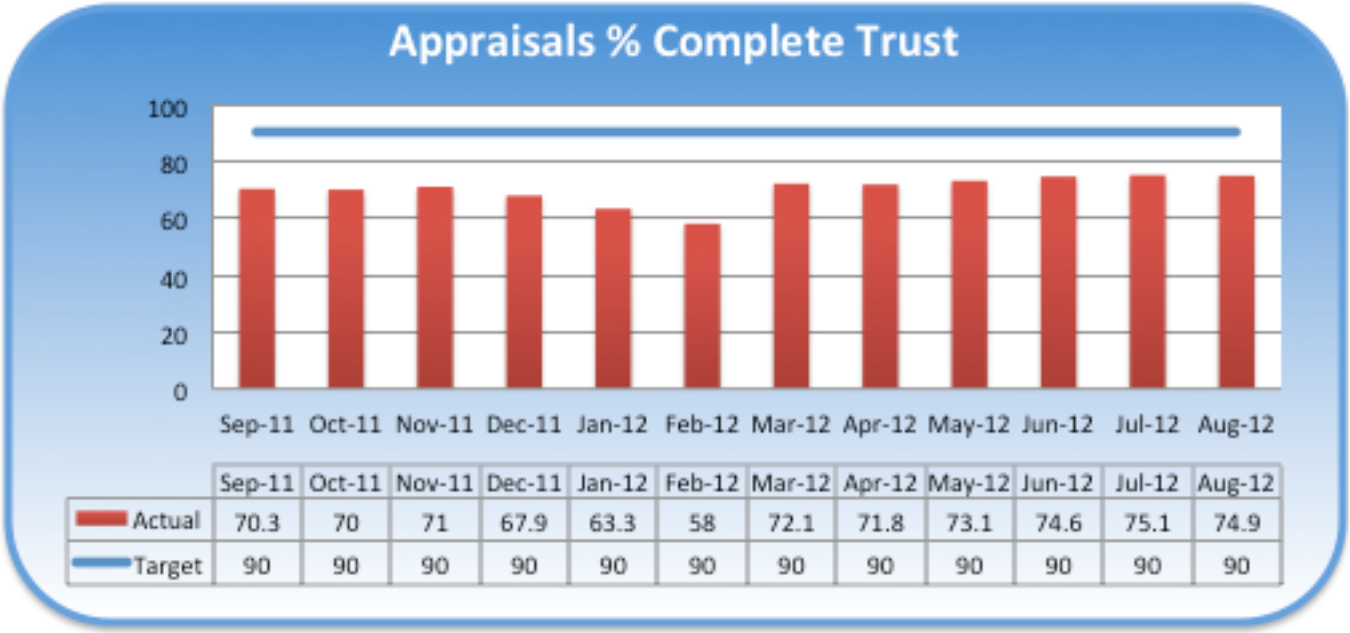
The target for the spring and summer months was for sickness to reduce to 3.5%. However, the rate remains at the winter levels of around 4.5 – 5.5%.




Long Term Sickness has increased this month with the number of staff currently off for more than 28 days of 93. The HR Business Partners continue to work closely with OH and the Divisional leads to monitor progress.




## 3.2 Appraisals % Complete Trust

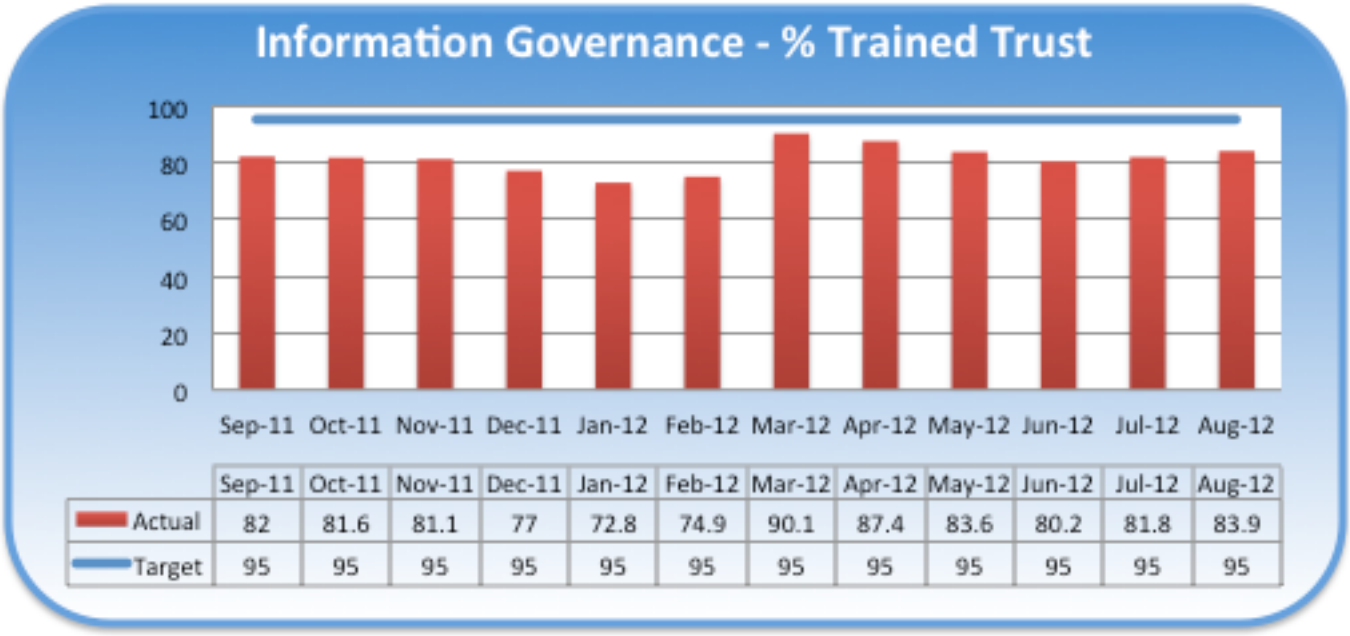



| | Sep-11 | Oct-11 | Nov-11 | Dec-11 | Jan-12 | Feb-12 | Mar-12 | Apr-12 | May-12 | Jun-12 | Jul-12 | Aug-12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 70.3 | 70 | 71 | 67.9 | 63.3 | 58 | 72.1 | 71.8 | 73.1 | 74.6 | 75.1 | 74.9 |
| Target | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 |

The current appraisal target is below the target of 90% at 75.1%. The Trust has put in place the following actions to address this. These are;

- 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




| | Sep-11 | Oct-11 | Nov-11 | Dec-11 | Jan-12 | Feb-12 | Mar-12 | Apr-12 | May-12 | Jun-12 | Jul-12 | Aug-12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 82 | 81.6 | 81.1 | 77 | 72.8 | 74.9 | 90.1 | 87.4 | 83.6 | 80.2 | 81.8 | 83.9 |
| Target | 95 | 95 | 95 | 95 | 95 | 95 | 95 | 95 | 95 | 95 | 95 | 95 |

The current national target for Information Governance training is 95% on an annual cycle of training. The Trust is currently undertaking a refresher programme and has trained 83.9% of the staff. Plans have been implemented to allow staff to complete the training electronically and via a workbook and questionnaire.

All those non-compliant staff have been identified, local management informed and assurances sought that these staff are to undertake training. This is being monitored very closely.

# 4 PERFORMANCE AND STANDARDS

Overall the Trusts performance in August 2012 was excellent against Monitor's Compliance Framework Targets with 7 targets achieved in month. However, the Trust did fail to achieve the Cancer 62 day target dues to a number of complex pathway in Urology and Lung.

The report now includes a number of additional operational key performance indicators. These are as follows;

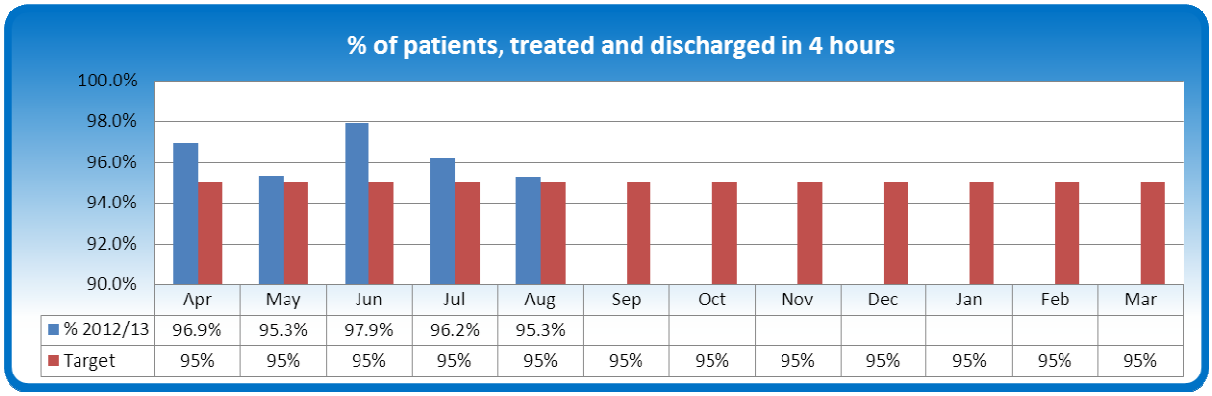
- Day case rate
- British Association of Day Surgery (BADS Rate) – Basket of 25 procedures
- New to review ratio
- Elective Average Length of Stay
- Emergency Average Length of Stay

## 4.1 Emergency Care Performance

### Accident and emergency patient waiting times

**Existing Commitment**: Proportion of all patients attending A&E department seen, treated and discharged or admitted within 4 hours of arrival

The Trust achieved performance of 95.3% for August 2012. The current position quarter to date remains above 95% and the Trust forecast achievement of this target for quarter 2.



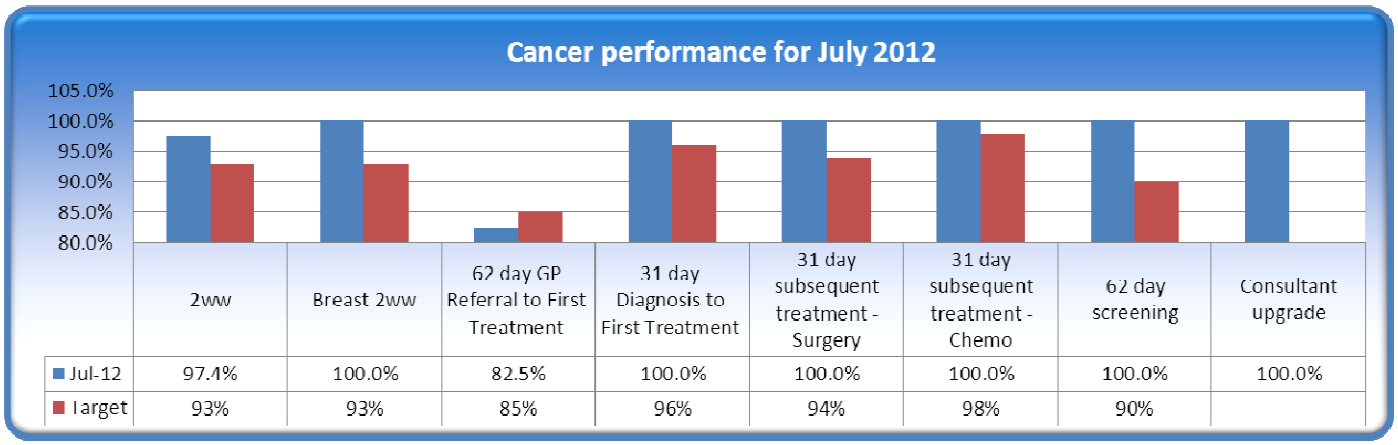

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % 2012/13 | 96.9% | 95.3% | 97.9% | 96.2% | 95.3% | | | | | | | |
| Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |

## 4.2 Cancer

# Cancer reporting 2012/13

Ensuring Better Treatment:
Going Further on Cancer Waits

The Trust has failed the 62 day Cancer target for July 2012. With a performance of 82.5%




| | 2ww | Breast 2ww | 62 day GP Referral to First Treatment | 31 day Diagnosis to First Treatment | 31 day subsequent treatment - Surgery | 31 day subsequent treatment - Chemo | 62 day screening | Consultant upgrade |
|---|---|---|---|---|---|---|---|---|
| Jul-12 | 97.4% | 100.0% | 82.5% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Target | 93% | 93% | 85% | 96% | 94% | 98% | 90% | |

There are 6 operational standards that are applicable to the Trust, 2ww, 62 day standard, 31 day first treatment, 62 day screening, 31 day subsequent for both surgery and chemo. In July 2012, the Trust failed the 62 day standard. It was highlighted to the Trust at an early stage that we were likely to fail.

As per the Cancer Services Operational Policy, timelines were completed on all patients breaching by the 28th of the following month. These were then submitted to divisions to complete a root cause analysis on each breach.

There was no common theme among the breaches.

Out of 59 patients that were treated at the QEH, 8 breached - 1 lung, 1 skin, 6 urology

Patients that are sent to tertiary centres to be treated are shared between the two trusts. 3.5 were treated at either CUH or N&N, 2.5 breached - 1.5 Colorectal (CUH), 0.5 lung (CUH), 0.5 urology (N&N)

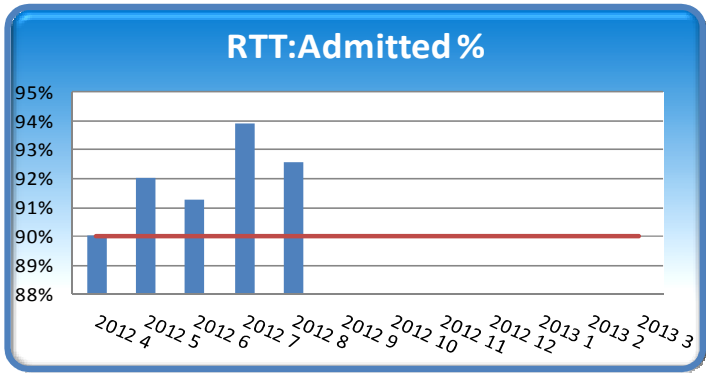
## 4.3 18 Weeks – RTT Treatment Times & Waiting Times (For Patients Treated In August 2012)

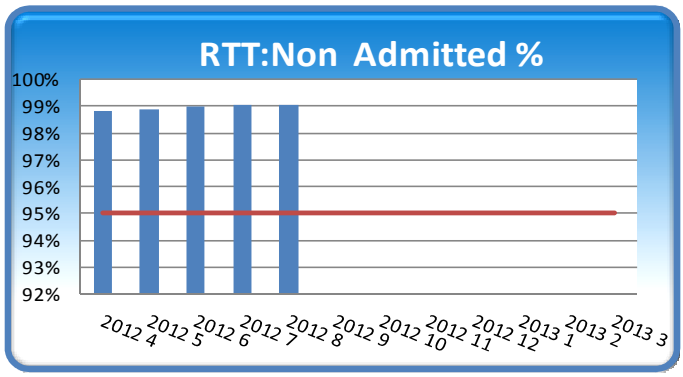
The Trust continues to achieve the 18 week RTT waiting times for admitted and non-admitted patients. As reported in last month's report a Contract Performance Notice was received from NHS Norfolk in respect of operational performance against the orthopaedics specialties performance against this target.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

### RTT: Admitted and Non Admitted

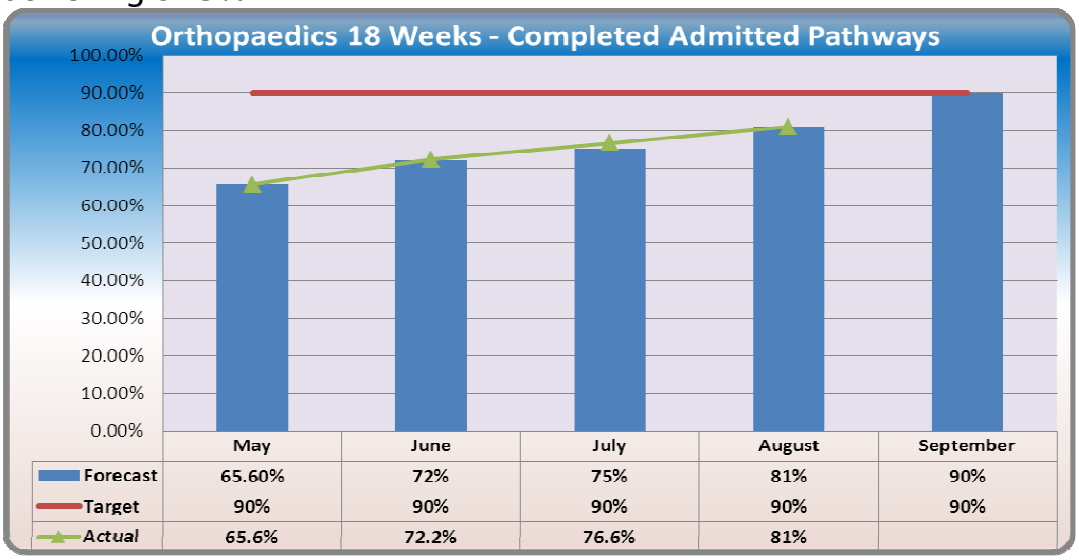
Referral to treatment waiting times – admitted (90% Target within 18 Weeks.)
Referral to treatment waiting times – non-admitted (95% Target Within 18 Weeks)

The Trust continues to achieve the 18 week RTT waiting times for admitted and non-admitted patients.




The current position for Orthopaedics is above the agreed commissioner trajectory of 81%, achieving 81.3%.




| | May | June | July | August | September |
|---|---|---|---|---|---|
| Forecast | 65.60% | 72% | 75% | 81% | 90% |
| Target | 90% | 90% | 90% | 90% | 90% |
| Actual | 65.6% | 72.2% | 76.6% | 81% | |

## 4.4 Stroke Services

### Stroke Services

Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit
Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours.

The Trust continues to achieve the two key measures for the Stroke pathway

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

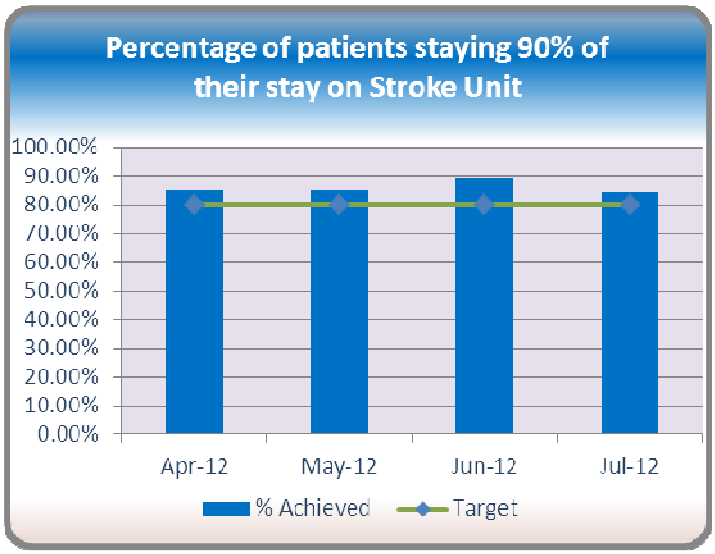
Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit. The position for the Trust on this at the end of July is 84.1% against a national target of 80%.

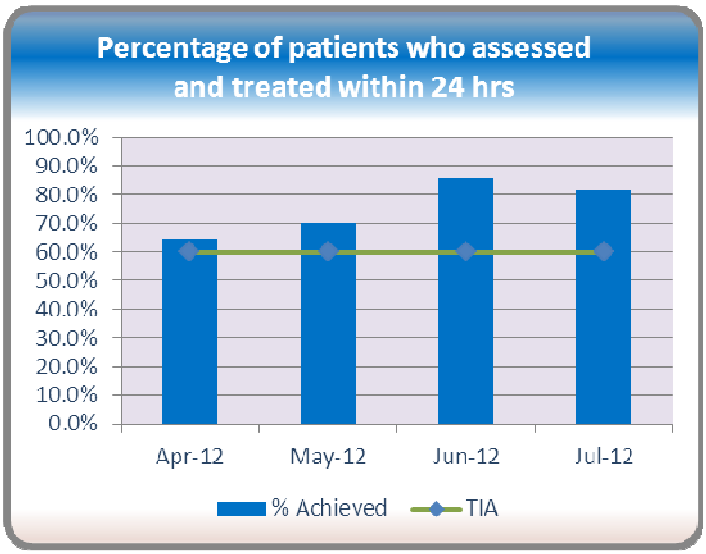
- This equates to 37 patients achieved out of 44 (84.1%)

Of the 7 that failed the target, 5 were due to a challenging diagnosis of stroke, 1 was due to not being referred to the Stroke Unit on admission and 1 for a patient related reason.

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 July is 81.8% against a national target of 60%.

- This represents - 18 Patients achieved out of a total of 22 (81.8%)



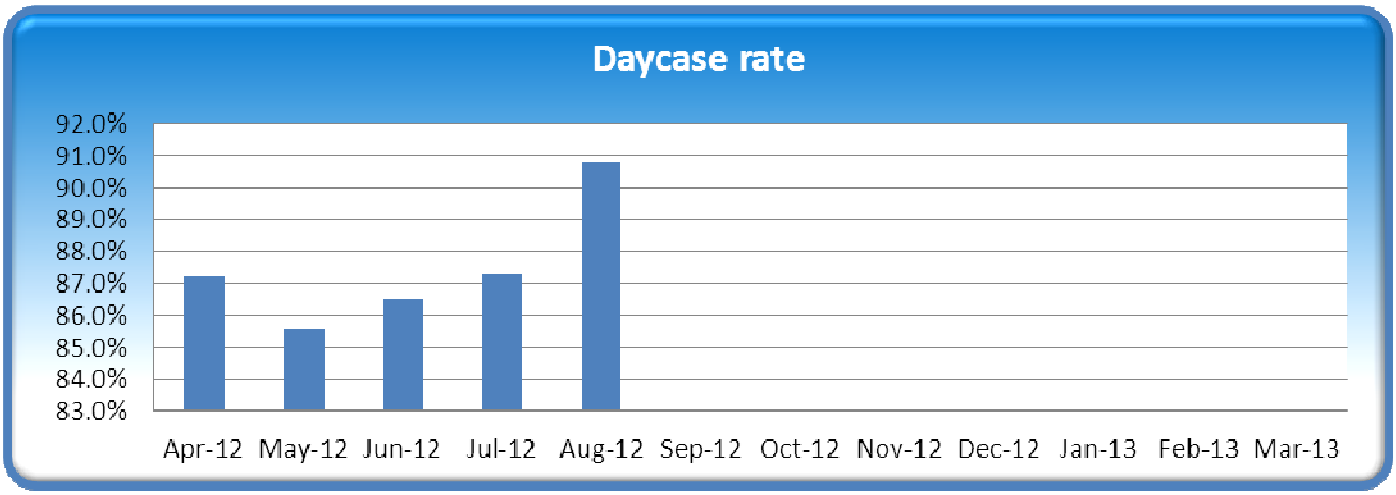



## 4.5 Operational Efficiency Indicators

### Day Case Rate

The number of day cases undertaken at the Trust as a percentage of total elective activity

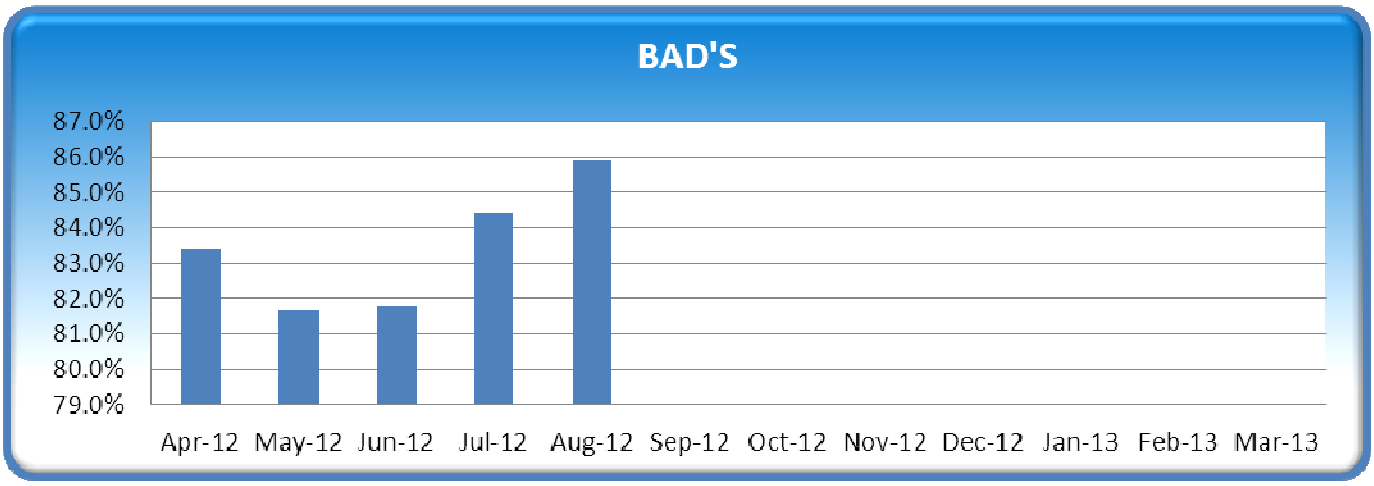
The Trust continues to achieve a high volume of day case activity in comparison to elective activity with a number of additional lists being undertaken within the Day Surgery Unit to support the Trusts financial position




### BADs

The Audit Commissions recommended basket of 25 surgical procedures that should be performed in a day case setting.

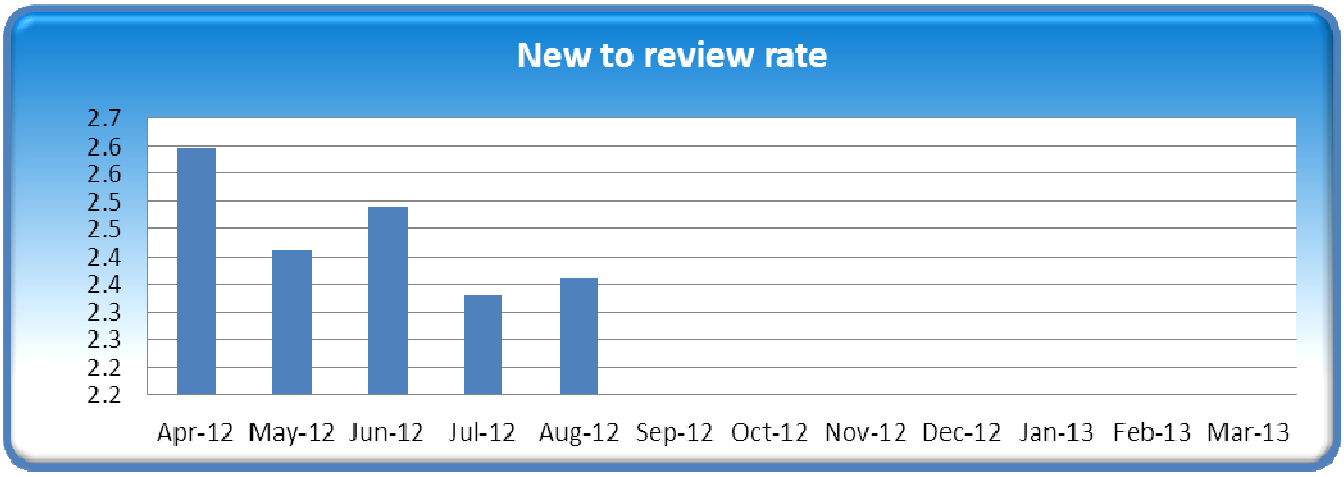
The Trusts current Basket of Procedure rate is 84.4%, against an audit commission recommended level of around 80%



## New to review rate

The number of outpatient follow up appointments seen versus the number of new outpatient appointments seen.

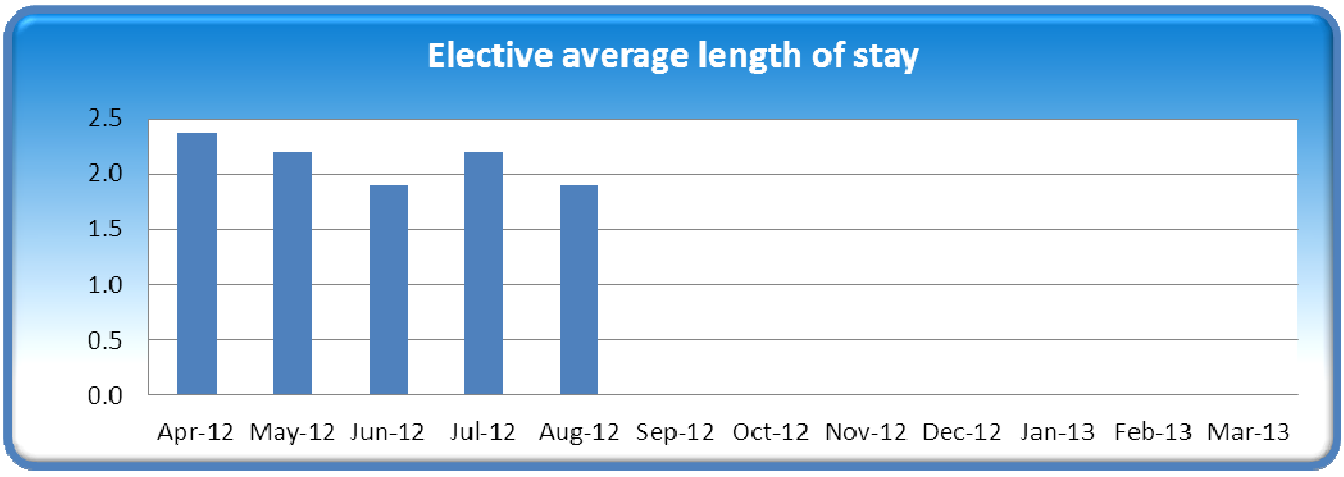
The Trust's new to review ratio is 2.4, this is slightly above the contracted target of 2.3.




## Elective average length of stay

Average number of days spent in an acute trust for Elective treatment (excluding day case).

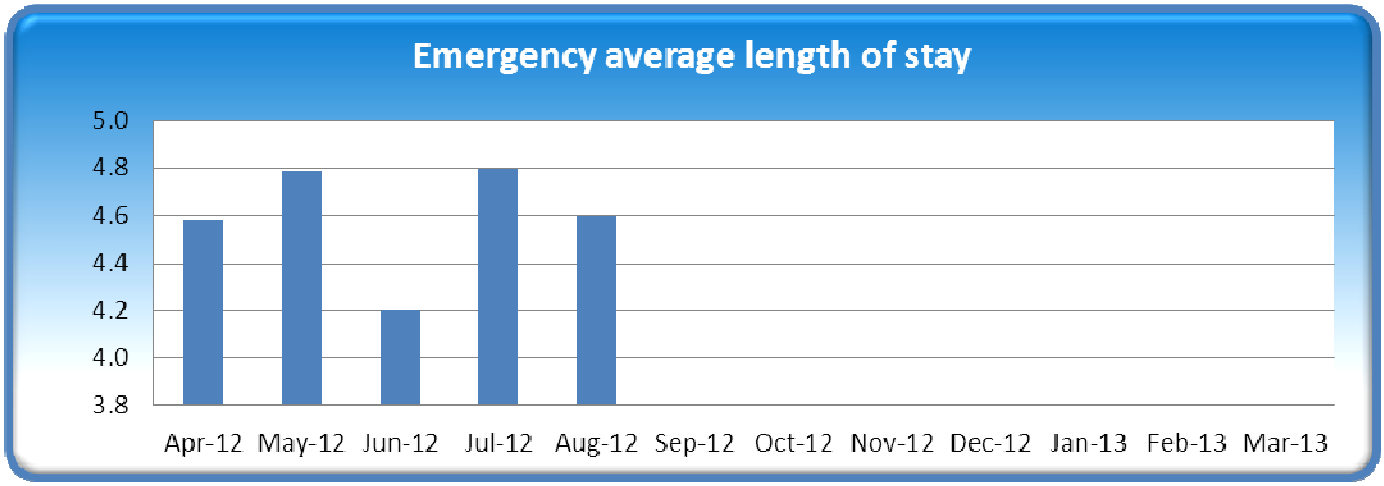
The Length of stay for Elective Care is being targeted with the planned reconfiguration of the surgical beds from the 1st October 2012.



## Emergency average length of stay

The Average number of days spent in an acute trust for Emergency treatment.

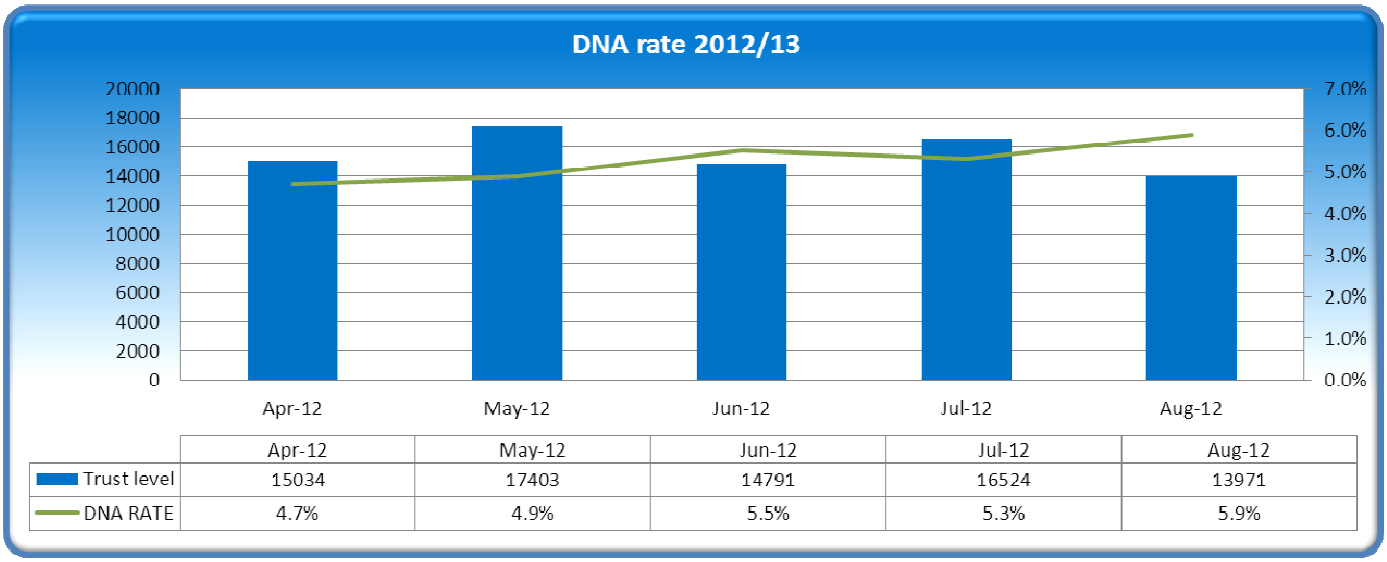
The Length of stay for Emergency Care is being targeted by POD19 with the closure of a ward last month and the planned future reconfiguration of the ward base at the Trust.




## DNA rate

**Existing Commitment**: DNA rate target to achieve is < 5%

The Trust DNA Rate is currently below the nationally reported figure of 10% but slightly above the local target of 5%. The Trust continues to target a reduction of DNA's through the Chronos Service and actions within POD37 Outpatient Transformation




| | Apr-12 | May-12 | Jun-12 | Jul-12 | Aug-12 |
|---|---|---|---|---|---|
| Trust level | 15034 | 17403 | 14791 | 16524 | 13971 |
| DNA RATE | 4.7% | 4.9% | 5.5% | 5.3% | 5.9% |

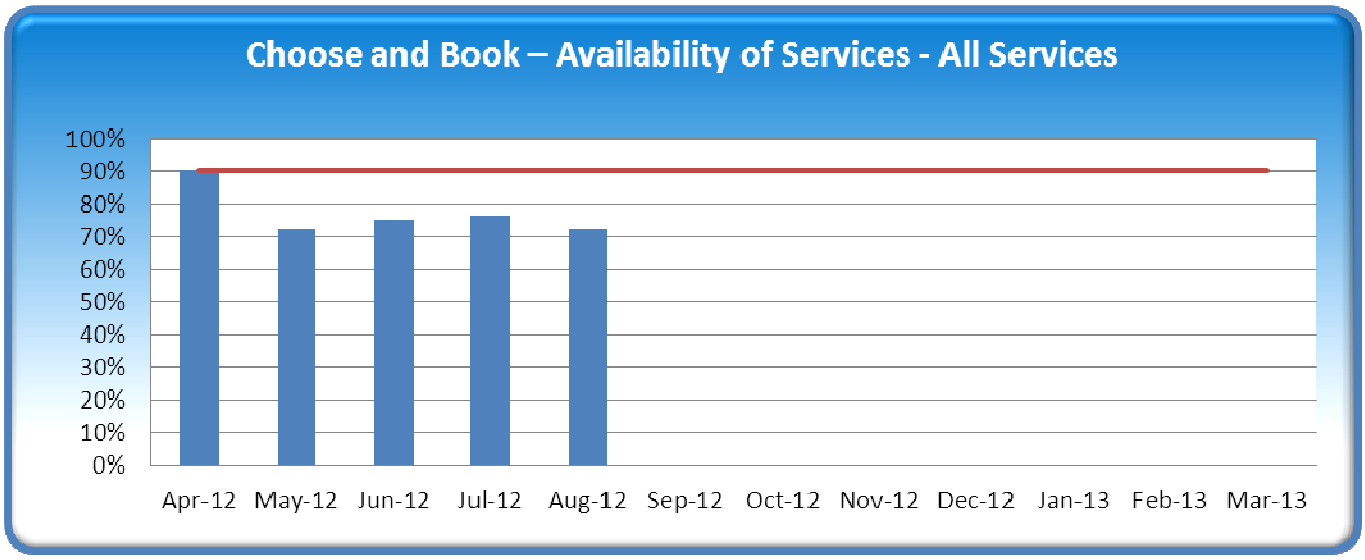
## 4.6 Choose and Book

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 and Book

**Existing commitment:** Choose and Book – Availability of Services - All 2WW Services 90% target
Choose and Book – Availability of Services - All Services 90% target
Choose and Book – Availability of Appointment slots >0.05 5%

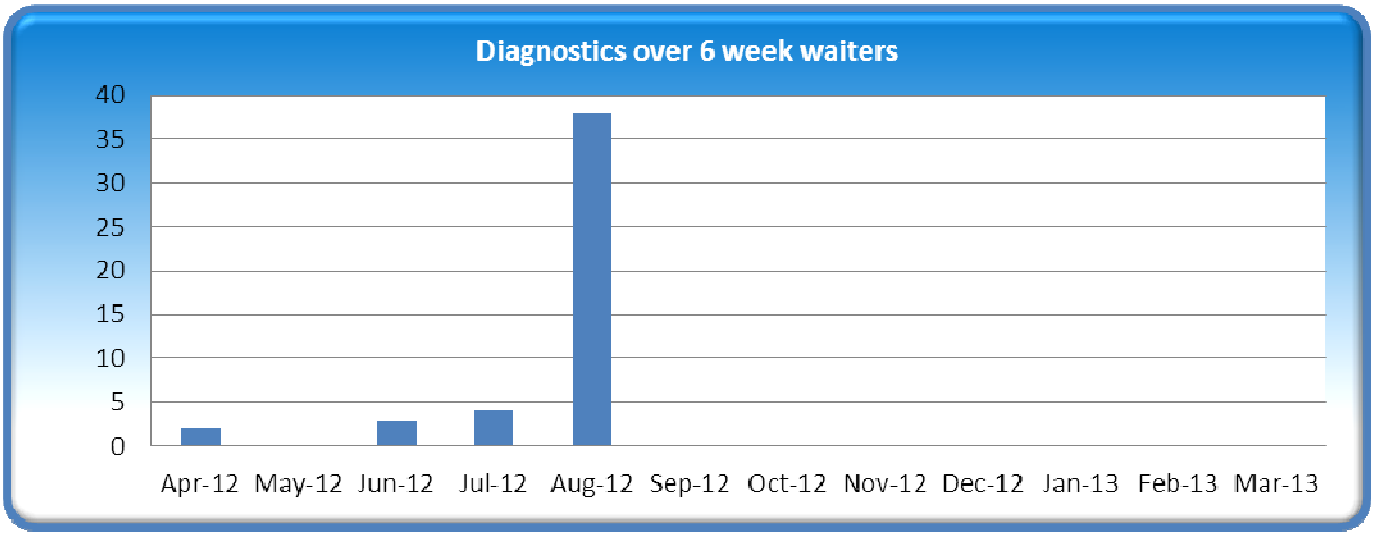
The Trust currently has 71% of its services available through Choose and Book. The Chief Executive and the Medical Director have written to all clinicians to confirm that outpatient templates will be reviewed as part of the job planning exercise over the next 6-8 weeks to maximise availability of C&B slots and the OP policy has been updated to ensure unused C&B slots are filled.

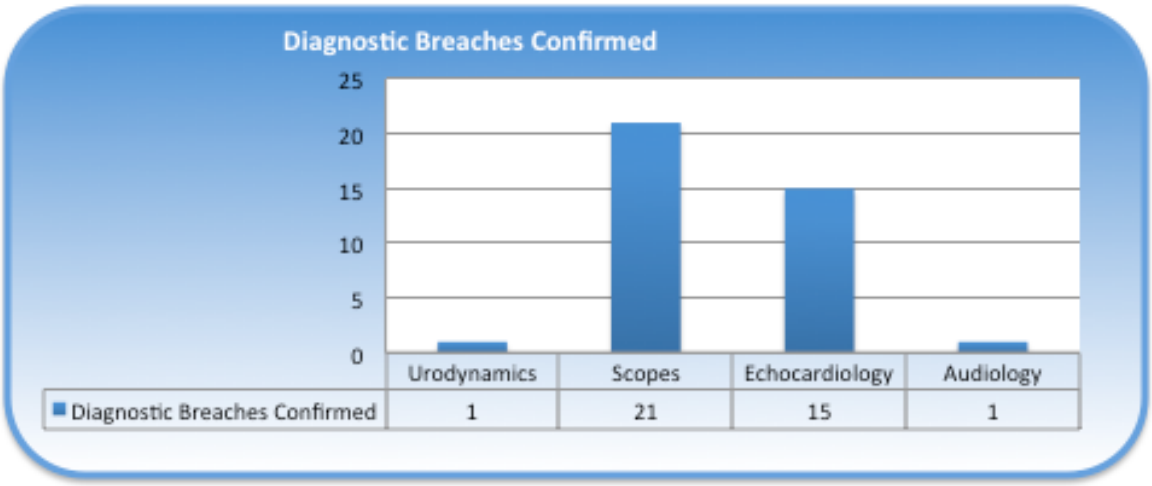


# Diagnostic Waiting Times

The NHS Improvement Plan set out the target of a maximum 18-week start to treatment waiting time by December 2008. This included a 6 week wait for the diagnostic element of the pathway.

Trust performance was below the national KPI and there were 38 patients that did not have their diagnostic test within 6 weeks.




The majority of the Trust diagnostic breaches were in Endoscopy and Echocardiology. In both areas, demand exceeded cacpacity for the current month. The Division are working up a plan for a Nurse Endoscopist and utilising additional Saturday sessions for the Echocardiology patients.

38 breaches remains below the contractual target of 1% of activity seen at 0.8%.

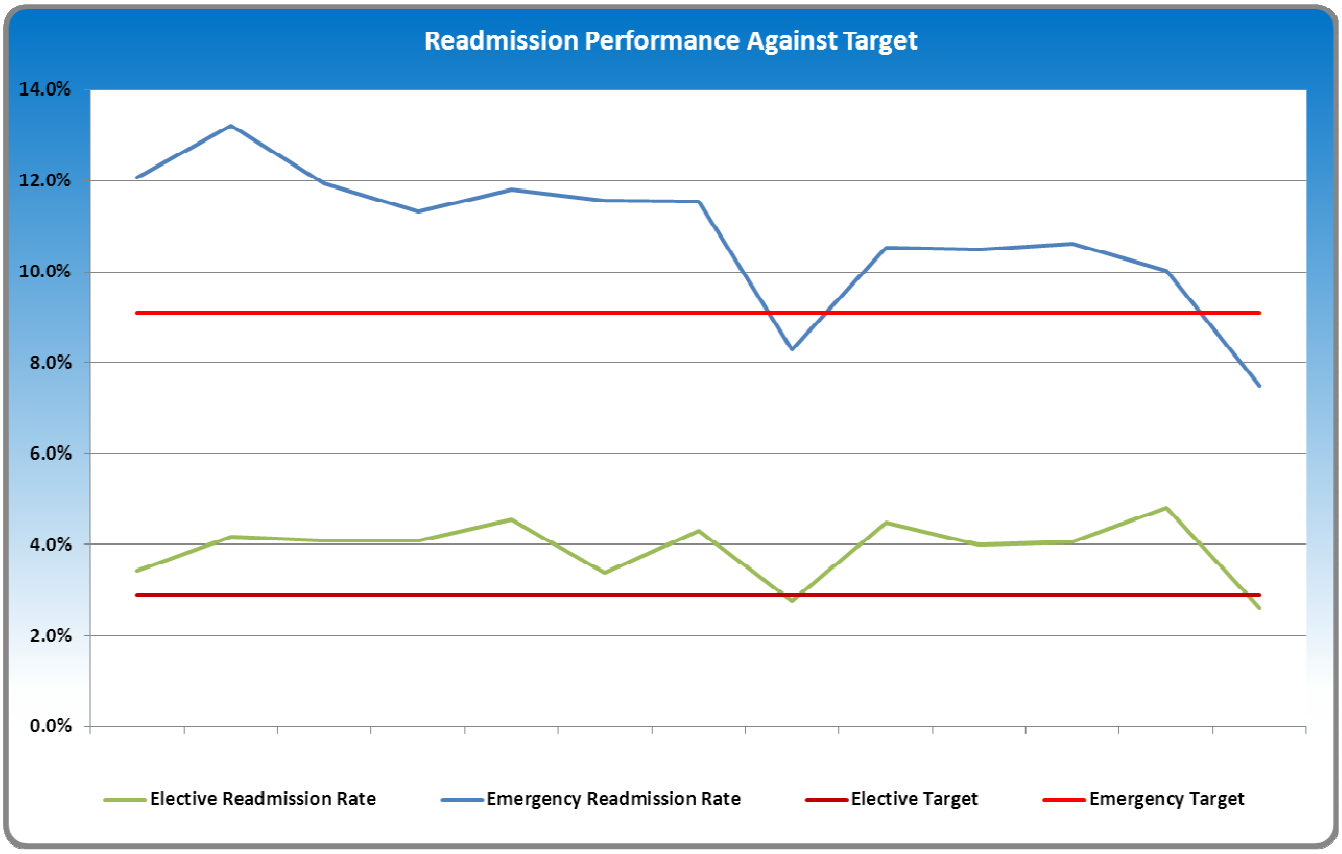
## 4.7 Readmission Rates – Emergency and Elective

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.

### Readmission rate

Elective readmissions target is 3%.
Emergency readmissions target is 9%.

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 awaiting the outcome of a deep dive review of performance and standards committee.



# 5 FINANCE & INVESTMENT

For the month the Trust achieved an EBITDA of £901k against a planned EBITDA of £1,185k, an adverse variance of £284k. For the month the Trust reported a surplus of £449k against a planned surplus of £548k, an adverse variance of £99k. The Trust EBITDA margin was 6.4% against a planned EBITDA margin of 8.4%, 2% below plan.

Recovery actions together with prior months data capture improvement on elective activity helped ensure that income was close to plan for the month but as yet we are not catching up on prior months underperformance. Outpatient activity was significantly below plan and is the main driver for clinical income being £155k below plan for the month. Further specialty level recovery actions are being escalated where there is no trend in improvement upon recent weekly performance. Assertive management action continues to identify gaps and then on a daily basis attempts to maximise clinical income with constant review of patient booking numbers.

Pay was overspent in the month by £198k which is essentially driven by BSP under-delivery on plan and some emerging staffing pressure e.g. medical agency being off-set by other underspends on vacant posts.

Year to date the Trust has achieved an EBITDA of £3,147k against a plan of £3,479k, an adverse variance of £332k. The Trust reported a surplus of £282k against a planned surplus of £557k, an adverse variance of £275k. Year to date the Trust EBITDA margin is 4.6% against a plan of 5.0%, 0.4% below plan.

In the month the Trust scored an FRR of 4 against an expected FRR of 4 and year to date the Trust is reporting an FRR of 3 against a planned FRR of 3. Whilst our financial risk rating is in line with plan, our EBITDA margin to date has very little headroom given September is a month with lower than average working days and consequently less planned income. Current EBITDA forecasts indicate an EBITDA Margin of 4.45% by the end of Q2 which, when combined with the other factors in the overall FRR calculation, indicates that it remains just possible to achieve an overall FRR of 3.

The year end forecast includes an assessment of delivery risk on the Business Sustainability Programme as well as other estimated operational movements. This still delivers an FRR of 3 for Q3 and Q4 with revised forecast EBITDA of £8.1m being below original plan by £623k. The revised EBITDA forecast includes classification of £800k of the non-recurrent estimated cost of change for the EPA project as exceptional restructuring. These costs appropriately fall outside of the EBITDA and FRR calculations. There is also some uncertainty as to the timing and extent of these costs but they are likely to accrue in Q4.

Having allowed for the aforementioned adjustment a small net surplus is still forecast.

It is important to emphasis at this point that the revised forecast still assumes a “ramp up” of schemes to achieve the BSP delivery phased in Q4 which if not successful gives an additional financial risk of circa £800k. The Trust continues to push delivery of its BSP programme alongside active management of operational performance.

# 6 Reference/contacts

6.1 Further information can be obtained from:

6.1.1 Barbara Cummings
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6.1.2 Michael Brown
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## BOARD REPORT APPENDIX 1 – PERFORMANCE DASHBOARDS

### 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-12 | | Aug-11 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Perf | Weight | Perf | Weight | Perf | Weight | Perf | Weight | Perf | Weight | Perf | Weight |
| C.difficile year on year reduction | | 30 | 1.0 | | 1 | | 5 | | 1 | | 7 | | 1 | | 1 | |
| MRSA - meeting the MRSA objective | | 1 | 1.0 | | 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% | | 100.0% | | | |
| | Surgery | 94% | 1.0 | | 100.0% | | 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 | | 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% | | 100.0% | | | |
| | Urgent GP Referral To Treatment | 85% | 1.0 | | 90.5% | | 81.5% | 1 | 90.7% | | 86.4% | | 82.5% | 1 | | |
| A&E: Total time in A&E 95% Patients withing 4 Hr Target | | 95% | 1.0 | | 96.9% | | 96.1% | | 96.7% | | 96.7% | | 96.2% | | 95.2% | |
| Referral to treatment waiting times – admitted (90% Target within 18 Weeks | | 90% | 1.0 | | 90.0% | | 92.0% | | 91.3% | | 91.1% | | 94.0% | | | |
| Referral to treatment waiting times – non-admitted (95% Target Within 18 Weeks) | | 95% | 1.0 | | 98.8% | | 98.9% | | 99.0% | | 98.9% | | 99.1% | | | |
| Referral to treatment waiting times – Incomplete (92% Target Within 18 Weeks) | | 92% | 1.0 | | 94.4% | | 94.2% | | 93.3% | | 94% | | | | | |
| 31-Day (Diagnosis To Treatment) Wait For First Treatment | All cancers | 96% | 0.5 | | 99.0% | | 100.0% | | 99.0% | | 99.4% | | 100.0% | | | |
| Two week wait from referral to date first seen | All cancers | 93% | 0.5 | | 94.4% | | 95.9% | | 97.1% | | 95.8% | | 97.4% | | | |
| | For symptomatic breast patients (cancer not initially suspe | 93% | 0.5 | | 98.6% | | 98.0% | | 94.0% | | 97.1% | | 100.0% | | | |
| Thrombolysis within 60 minutes (where this is the preferred local treatment) | | 68% | 0.5 | | n/a | | 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% | | 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 | | n/a | |
| | Having formal review within 12 months | 95% | 0.5 | | n/a | | 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% | | 2.1% | |
| Admissions had access to crisis resolution home treatment teams | | 90% | 1.0 | | n/a | | 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 | | n/a | |
| Data completeness: identifiers | | 99% | 0.5 | | n/a | | 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 | | 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 | | 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 | | | | | | 1 | | |