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

Integrated Report

Quality, Performance, Finance & Workforce to end April 2014

Interim Chairman: David Dean Interim Chief Executive: Manjit Obhrai
Patron: Her Majesty The Queen

The Preferred Hospital for Local People

Contents

1 Executive Summary Page 3
2 MONITOR Compliance Scorecard Page 4
3 Quality & Risk Page 5
4 Performance & Standards Page 25
5 Workforce Page 39
6 Finance Page 45
7 CQUINS Page 47
8 FFT Integrated Action Plan Page 49
9 Appendices Page 50

Context for the Integrated Report

	Current Mth	Trend on prev mth	Previous Mth
Emergency Department attendances	4684	↓	4854
Outpatient Attendances	21031	↓	23349
Inpatient Admissions	5898	↑	3305
Other (regular day patients, day cases etc)	2756	↓	2834
Total	8654	↑	6139

Executive Summary

1.1 The Trust still has several performance issues at the end of April 2014. This is due to the A&E 4 hour waiting time standard not being achieved and the continued risks to the delivery of 18 weeks and the number of Clostridium Difficile infections. The Trust position for the month in relation to the Monitor compliance / risk framework remained at "Red".

- At the end of April, the Trust reported 2 Clostridium Difficile infections against a year to date trajectory of 1.
- The Trust has failed to achieve the 90% Admitted Referral to Treatment (18 week) target for the month.
- The Trust has not achieved the 4 hour waiting time standard for Accident and Emergency in April 2014.
- The Trust has reported in excess of 1% of breaches for the 6 week diagnostic waiting time standard
- The Trust TIA target remains at risk due to increased pressure on medical beds
- There were 5 breaches of the Mixed Sex Accommodation standard

1.2 The Trust has received Contract Query Notices from commissioners for 18 weeks, Accident & Emergency and Cancer performance. Under the terms of the NHS contract for 2014/15 the maximum financial consequences of non-achievement of the above standards at the end of April are listed below should there be no "excusing notice" accepted by Commissioners:

- Accident & Emergency £30,000
- 18 weeks £21,600
- Diagnostics £3,800
- Mixed Sex £1,250

It should also be noted that the Trust will be liable for £10,000 per case above the year end trajectory of 14 for Hospital acquired Clostridium Difficile infections.

1.3 The Trust failed to achieve the Cancer 62 day target for quarter 4. However, performance improved in March and this target was achieved for the latest reported month. The Trust requested support from the national Intensive Support Team (IST) and the action plan following their recommendations is included as an appendix to this report. Actions are being led by the Chief Operating Officer. Key actions include;

- A review of pathways to confirm best practice
- The implementation of timed pathways for specific tumour sites
- A review of the cancer escalation policy

1.4 There were no reported MRSA breaches for the month.

1.5 The response rate to the FFT is slightly lower than in March although remains significantly improved. Clinical areas continue to develop sustained methods of ensuring capture of patient feedback through the FFT. Although not yet a national requirement

1.6 The Trust received 53 complaints in March, this is a decrease of 5.66% in relation to the previous month. One complaint received in April has been copied in to the CQC.

1.7 Trust mortality remains in line with that expected and there have been no new mortality alerts reported by the Dr Foster Unit.

1.8 The Trust continues to report that it is failing to achieve the 18 week admitted target for all specialties and Trust wide at 85.26% which is an improvement on March 2014 and in line with the Trust's recovery trajectory. The Trust will not recover the position for Trauma and Orthopaedics, Gynaecology, ENT, General Surgery and Urology until the end of June 2014. This is a revised position due to cancellations of Elective surgery in March and April.

1.9 Turnover has dropped to 10% and we continue to explore initiatives to improve retention. Sickness has been maintained at 4.8% and we have achieved 92% compliance for appraisals with the focus now shifting to improving the quality of the appraisals that are taking place.

1.10 A new process for capturing exit interview information is now in place which includes a shorter form available electronically and a wider group of staff including union reps available to carry out interviews. The figure has improved to 40.9% completion.

1.11 The actual deficit for the month of April is £1.556m, which is £0.137m favorable to plan. The year-end forecast deficit is as per plan at £15m.

Monitor Risk Assessment framework

	Indicators	Target	Current Qtr	Feb	Mar	Apr	Qtr 2	Qtr 3	Qtr 4	Qtr 1	*FYTD
Access	**Risk Assessment framework 2013/14**										
	18 Wks - Adm Perf	90.00%	85.26%	84.18%	78.76%	85.26%	85.26%	91.83%	88.66%	85.26%	85.26%
	18 Wks - Non Adm Perf	95.00%	97.68%	99.41%	98.39%	97.68%	97.68%	98.94%	98.03%	97.68%	97.68%
	18 Wks - Incomp Perf	92.00%	97.79%	97.15%	97.54%	97.79%	97.79%	96.04%	95.89%	97.79%	97.79%
	A&E 4 Hour Attendance	95.00%	91.89%	94.07%	95.28%	91.89%	93.50%	93.90%	95.00%	91.89%	91.89%
	Cancer-62 Days RTT	85.00%		74.34%	85.00%		87.80%	87.91%	78.88%		85.58%
	Cancer - 31 Days Subsq Treatment - Surgery	94.00%		100.00%	100.00%		97.01%	100.00%	100.00%		99.56%
	Cancer - 31 Days Subsq - Drug Treatments	98.00%		100.00%	100.00%		100.00%	99.26%	100.00%		99.50%
	Cancer - 31 Days Subsq - Radiotherapy	94.0%		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	31 Day Diag to Treat	96.00%		97.22%	100.00%		98.08%	99.37%	98.29%		98.75%
	Cancer-2 Wk Waits - All urgent Referrals (cancer suspected)	93.00%		99.07%	98.70%		98.19%	97.14%	98.68%		97.91%
	Cancer-2 Wk Waits - Symptomatic breast patients (cancer not initially suspected)	93.00%		94.64%	91.43%		98.25%	98.41%	95.02%		97.51%
	Care Programme Approach (CPA) patients										
	Follow up contact within 7 days of discharge	95%	n/a	n/a		n/a	n/a	n/a			n/a
	Having formal review within 12 months	95%	n/a	n/a		n/a	n/a	n/a			n/a
	Admissions to inpatients services had access to crisis resolution / home treat teams	95%	n/a	n/a		n/a	n/a	n/a			n/a
	Meeting commitment to serve new psychosis cases by early intervention teams	95%	n/a	n/a		n/a	n/a	n/a			n/a
	Ambulance FTs-Category A call – emergency response within 8 minutes										
	Category A call – emergency response within 8 minutes - Red 1 calls	75%	n/a	n/a		n/a	n/a	n/a			n/a
	Category A call – emergency response within 8 minutes - Red 2 calls	75%	n/a	n/a		n/a	n/a	n/a			n/a
	Ambulance FTs-Category A call – emergency response within 19 minutes										
	Category A call – ambulance vehicle arrives within 19 minutes	95%	n/a	n/a		n/a	n/a	n/a			n/a
Outcomes	**Clostridium Difficile**										
	Clostridium (C.) Difficile - meeting the C. difficile objective	14	2	7	12	2	3	5	26	2	2
	Mental Health										
	Minimising Mental Health delayed transfer of care	<7.5%	n/a	n/a		n/a	n/a	n/a			n/a
	Mental Health data completeness: identifiers	97%	n/a	n/a		n/a	n/a	n/a			n/a
	Mental Health data completeness: outcomes for patients on CPA	50%	n/a	n/a		n/a	n/a	n/a			n/a
	Certification against compliance with requirement regarding access to health care for people with a learning disabililty	N/A	n/a	n/a		n/a	n/a	n/a			n/a
	Score		3	4	3	3					

*FYTD denotes Financial Year to Date

Quality and Risk

1.1 The Quality and Risk section is supplemented with a separate paper produced by the Medical Director and Director of Nursing.

1.2 There were no reported MRSA breaches for the full year.

The performance for reported cases of hospital acquired C Difficile has improved since March 2014 with 2 cases reported in April and 1 case in May (at the time of writing this report). As part of the on-going support from the CCG and PHE a follow up IST visit was carried out on 8th May 2014. Progress against the action plan, review of the epidemiology report from PHE and visits to wards that had PII took place. Overall the feedback on the day reported significant improvements since the first visit; particularly relating to staff knowledge regarding infection prevention procedures and policies. Stanhoe and West Raynham wards received very positive feedback. Areas for continued improvement relate to developing greater understanding of the rationale behind infection prevention processes and maintaining environmental cleanliness. The Associate Medical Director is also undertaking a detailed review of all deaths in patients who also had a reported case of C Difficile.

1.3 The response rate to the FFT is slightly lower than in March although remains significantly improved.
Clinical areas continue to develop sustained methods of ensuring capture of patient feedback through the FFT.
Although not yet a national requirement surveys are also carried out in paediatrics, outpatients and the DSU; these results are shared at CLF and with ward teams. Some headlines from the free text comments made on the FFT surveys include:

Inpatient Wards:

- **271 positive comments about staff on the wards including 48 about nurses, 15 about doctors, 3 about other clinical staff, 1 about a non-clinical member of staff.**
- **6 comments were made about there not being enough staff – this is a significant reduction when compared to 42 such comments made by patients in March 2013 and 15 such comments in November 2013.**
- **6 patients complained of noise, light and other disturbance at night including 1 patient who had been moved twice after 10.00pm.**
- **There were 9 comments about delays in discharge, including 3 who waited for take-home medication.**

Improvements in discharge planning and communication with patients and carers is a key priority for the Trust

A & E:

- 168 positive comments about staff in the department including compared to 10 negative comments about staff (which related to delays and attitude).
- 56 patients said they were seen quickly whilst 28 said they waited too long including 1 who complained about the length of time waiting for a bed on a ward. The Bank holiday weekend was mentioned by some of the patients who felt they waited too long.
- 3 comments about the inaccuracy of the waiting time displayed on the screen in the waiting room

The department will continue to work on importing communication with patients about waiting times,

Maternity Services:

- 53 positive comments about staff in the delivery Suite and Postnatal ward
- 5 comments were made about there not being enough staff, 4 of these about the delivery suite

Recruitment is on-going following the skill mix review in maternity and revision of the establishment.

1.4 During the month of April, the Trust received 53 complaints; this is a decrease of 5.66% in relation to the previous month, where the Trust received 56 complaints. The number of formal complaints received in April 2014 in comparison with April 2013, is an increase of 11.32%, as the Trust received 47 complaints.

Of the 53 formal complaints received in April 2014; a total of 109 issues were raised. The Trust received 2 non-clinical complaints in April 2014. The top 5 themes within the formal complaints were in relation to Communication – 11, Staff Attitude - 9, Lack of Treatment – 6, Cancellation – 5 and Diagnosis – 4.

The Trust did not receive any referrals from the Parliamentary and Health Service Ombudsman (PHSO).

One complaint received in April was copied in to the CQC.

1.5 Hospital acquired pressure ulcer incidence has continued to decrease over the month of April 2014, reducing from 22 in March to 7 in April.

1.6 There were 5 reported occasions where MSA breaches have occurred in April 2014. Each affected patient carries a fine of £250 per day with commissioners under the terms of the NHS Contract for the time they are affected.

1.7 Trust mortality remains in line with that expected and there have been no new significant alerts reported on Dr Foster.

Quality & Risk Scorecard

	Indicators	Var to prev mth	Target	Feb	Mar	Apr	*FYTD
Safe care	Critical Incidents						
	Other Serious Incidents	⇧	5	2	0	3	3
	Never Events Reported	⇧	0	0	0	2	2
	Serious Medication Errors	⇨	0	0	0	0	0
	Falls Resulting in Serious injury	⇨	0	1	0	0	0
	Safety Thermometer						
	Pressure Ulcers - Grade 3 H.A	⇧	0	9	6	7	7
	Pressure Ulcers - Grade 4 H.A	⇨	0	0	0	0	0
	Safety Thermometer - (new harm only)	⇧	95.0%	97.8%	97.2%	98.0%	98.0%
	VTE Assessment Completeness	⇩	97.24%	97.66%	97.27%	0.0%	97.55%
	Infection Control						
	MRSA	⇨	1	0	0	0	0
	CDIFF	⇩	19	7	12	2	2

	Indicators	Var to prev mth	Target	Feb	Mar	Apr	*FYTD
Patient experience	Patient experience						
	FFT NPS (Inpatients)	⇧		69	64	64	64
	FFT NPS (AE)	⇩		62	62	46	46
	FFT Response Rate (IP & AE)	⇩	24.00%	23.98%	24.43%	19.82%	19.82%
	Mixed sex accommodation MSA breaches	⇧	0	4	0	5	5
	Number of Patient moves (over 2)	⇩	0	26	37	0	0
	Positive experience						
	Compliments	⇩	0	147	198	154	154
	Complaints						
	Non-Clinical Complaints	⇧	0	0	1	2	2
	Clinical Complaints	⇩	0	35	54	51	51

	Indicators	Var to prev mth	Target	Feb	Mar	Apr	*FYTD
Well led Trust	Mortality						
	Crude Mortality (deaths per 1000 admissions)	⇨	19	15.5	14.8	14.8	14.8
	RAMI (Risk adjusted mortality)	⇩	89.3	83.0	81.0		83.0
	Outcome						
	Stroke - 90% of Stay on a Stroke Unit	⇩	80.00%				84.40%
	Stroke - High Risk,Non admitted TIA treated in 24 Hrs	⇩	60.00%				64.80%
	Elective Length of stay	⇩	2.2	1.9	2.4	1.9	1.9
	Emergency Length of stay	⇧	5.0	3.6	3.4	4.0	4.0
	British Association of Day Surgery's "trolley" of procedures (BADS)	⇩	80%	84.1%	89.0%	88.7%	88.7%
	Readmission Rate - Elective	⇩	3.10%	4.42%	3.91%	3.58%	3.58%
	Readmission Rate - Emergency	⇩	10.40%	12.80%	11.76%	11.45%	11.45%

	Indicators	Var to prev mth	Target	Feb	Mar	Apr	*FYTD
Supporting our staff	Workforce						
	Sickness Absence Rate	⇩	4.7%	5.2%	4.8%	4.8%	4.7%
	Staff Turnover Rate Complete Trust	⇧	10.0%	10.6%	10.2%	10.6%	10.7%
	Staff Turnover Rate Medical & Dental	⇩	10.0%	17.3%	13.6%	13.0%	15.8%
	Staff Turnover Rate Registered Nursing & Midwifery	⇧	10.0%	12.3%	11.6%	12.0%	13.2%
	Staff Turnover Rate Allied Health Professionals	⇧	10.0%	14.6%	15.8%	16.5%	14.3%

Service line Clinical Indicators (by ward)

	PATIENT SAFETY																										PATIENT EXPERIENCE						PERF	
	Fluid Chart	Against Previous	MUST Assess	Against Previous	Waterlow Assess	Against Previous	Falls Assess	Against Previous	Care Rounding	Against Previous	Pressure Ulcer G2	Against Previous	Pressure Ulcer G3	Against Previous	Pressure Ulcer G4	Against Previous	Falls - Serious Harm	Against Previous	Falls Total	Against Previous	Drug Admin Errors	Against Previous	Harm Free Care	Against Previous	C.Diff > 2 days	Against Previous	Complaints	Against Previous	Family & Friends Response	Against Previous	Family & Friends Results	Against Previous	Discharge before Midday	Against Previous
Denver	100	⇔	100	⇔	100	⇔	100	⇔	85	⇩	1	⇧	1	⇩	0	⇔	0	⇔	1	⇧	2	⇩	100	⇧	1	⇔	3	⇩	31.6	⇩	52	⇩	11	⇩
Elm	100	⇧	90	⇔	80	⇩	90	⇔	95	⇧	0	⇔	0	⇔	0	⇔	0	⇔	3	⇩	2	⇔	100	⇔	0	⇔	2	⇧	24.1	⇩	59	⇩	25	⇧
Gayton	100	⇧	80	⇩	100	⇔	100	⇧	80	⇧	1	⇩	0	⇔	0	⇔	0	⇔	4	⇧	1	⇔	96	⇩	0	⇔	0	⇧	18	⇧	67	⇧	19	⇔
Leverington	100	⇧	100	⇧	100	⇧	100	⇧	98	⇧	0	⇔	0	⇔	0	⇔	0	⇔	0	⇧	0	⇔	100	⇧	0	⇔	0	⇧	29.5	⇧	68	⇔	16	⇩
SAU	80	⇧	100	⇔	100	⇔	100	⇔	98	⇧	0	⇔	0	⇔	0	⇔	0	⇔	0	⇧	1	⇔	100	⇔	0	⇔	0	⇧	30.9	⇧	43	⇩	27	⇩
MAU	80	⇔	100	⇧	100	⇔	100	⇔	98	⇧	0	⇔	0	⇔	0	⇔	0	⇔	2	⇧	7	⇩	95	⇩	0	⇔	1	⇩	37.2	⇩	64	⇧	16	⇩
Terrington	100	⇧	80	⇩	100	⇔	90	⇩	90	⇧	2	⇧	0	⇔	0	⇔	0	⇔	6	⇩	2	⇧	100	⇔	0	⇔	3	⇔	20.2	⇧	51	⇩	17	⇧
Necton	80	⇩	100	⇧	100	⇧	100	⇔	60	⇧	0	⇧	1	⇔	0	⇔	0	⇔	7	⇩	4	⇩	100	⇧	0	⇔	2	⇔	14.1	⇩	45	⇩	6	⇩
Oxborough	78	⇩	100	⇔	100	⇔	100	⇔	78	⇧	0	⇧	0	⇧	0	⇔	0	⇔	3	⇧	0	⇔	97	⇧	0	⇔	0	⇧	12.9	⇩	91	⇧	9	⇩
Pentney	70	⇔	100	⇧	100	⇧	100	⇧	80	⇧	1	⇔	0	⇧	0	⇔	0	⇔	6	⇩	7	⇩	97	⇧	1	⇔	2	⇔	10.3	⇩	86	⇧	13	⇩
Shouldham	90	⇩	100	⇔	100	⇔	100	⇔	100	⇧	1	⇧	0	⇔	0	⇔	0	⇔	2	⇩	0	⇧	100	⇔	0	⇔	0	⇔	42.4	⇧	64	⇩	4	⇧
Stanhoe	50	⇩	90	⇧	100	⇔	100	⇔	100	⇧	0	⇧	2	⇩	0	⇧	0	⇔	7	⇩	6	⇧	94	⇩	0	⇔	0	⇔	24	⇩	50	⇩	1	⇩
Tilney	80	⇩	100	⇧	100	⇧	100	⇔	95	⇧	0	⇧	0	⇔	0	⇔	0	⇔	3	⇧	0	⇧	96	⇔	0	⇔	0	⇔	29.5	⇩	72	⇧	27	⇔
West Raynham	89	⇩	100	⇧	100	⇔	100	⇔	95	⇧	1	⇔	0	⇧	0	⇔	0	⇔	6	⇩	2	⇧	100	⇧	0	⇔	1	⇩	31.8	⇩	78	⇧	8	⇩
Overall Totals	85.5		95.7		98.6		98.6		89.4		7		4		0		0		50		34		98		2		14		25		64		14	

Patient Observations > 90%
Between 80 & 89%
79% or below

⇧ Improvement on previous month
⇩ Deterioration from previous month

Key Points/Operational Actions

Definitions

Nursing indicators reported one month in arrears

Service line Clinical Indicators (Women and children)

CLINICAL INDICATORS - APRIL 2014

Strategy	Criteria by Area - Women & Children							
	Castleacre Ward	Score	NICU - Neonatal Intensive Care Unit	Score	Rudham Ward *	Score	Targets	Women & Children Service Line
Patient Safety	Mother & Baby charts labelled	100	TPR recorded	100	Temp Pulse & Resps Recorded	100	>90%	100
	Woman risk assessed / VTE	100	BP recorded correctly	100	Frequency	100	>90%	100
	Mother daily checks completed	90	Patient ID documented	100	BP Recorded >5 yrs (Essential)	100	>90%	97
	Baby daily score completed	90	Patient ID labels checked	100	PEWS score recorded	100	>90%	97
	If IV Catheter in have fluid charts been completed INS/OUTS/VARIANCE	100	Fluids/Feed chart	100	Pain Assessment/Score completed	100	>90%	100
	If NEWS >0 is NEWS chart completed	100	Pt bowels recorded	100	Fluids/Feeds documented	100	>90%	100
	If MEOWS >0 has maternity MEOWS been completed	100	Weight documented	100	Weight Documented	100	>90%	100
	Pnt obs recorded correctly on MEOWS	100	Drug Admin Errors	1	Patient ID present on all documents	100	>90%	100
	Obs done correctly on MEOWS chart	90	Harm Free Care	100	Pressure Area & Pnt handling Assess	100	>90%	97
	Frequency Recorded and Correct	100		100	PYMS Paediatric York Hill Malnutrition Assessment Complete	100	>90%	100
	Drug Admin Errors	1			Drug Admin Errors		>90%	
	Harm Free Care	100			Harm Free Care	100	>90%	100
	Falls Total	0						
Performance			Temporary Ward Closure	2	Temporary Ward Closure	0	0	2
					C.Diff > 2 days post admission	0	0	0
	Complaints	0	Complaints	0	Complaints	0	0	0
	Family & Friends Response Rate	17					>90%	17
	Family & Friends Results	52					>90%	52

Key: 90% & above = | Between 80% & 89% = | 79% & Under =

Key Points/Operational Actions

Definitions

Nursing indicators reported one month in arrears

Definition of a Serious Incident

A serious incident requiring reporting to external bodies is defined as an incident that occurred in relation to NHS-funded services and care resulting in one or more of the following:

- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public
- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention,
- Permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm including incidents graded under the NPSA definition of severe harm
- A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services, for example, actual or potential loss of Personal and or organisational information, damage to property, reputation or the environment, or IT failure
- Allegations of abuse
- Adverse media coverage or public concern about the organisation or the wider NHS
- Death in custody
- Infection control reportable notifications

Definition of a Never Event

These are serious, largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented. The incidents are considered to be Never events if; The incident either resulted in Severe harm or Death or had the Potential to cause Severe Harm or Death

The following is the list of "never events" for use in the NHS in 2012/13. DOH, The Never Events Policy Framework 2012.

1. wrong site surgery
2. wrong implant / prosthesis
3. retained foreign object post-operation
4. wrongly prepared high risk injectable medications
5. maladministration potassium-containing solutions
6. wrong route administration of chemotherapy
7. wrong route administration of oral / enteral treatment
8. intravenous administration of epidural medication
9. maladministration of insulin
10. overdose of midazolam during conscious sedation
11. opioid overdose of an opioid naïve patient
12. inappropriate administration of daily oral methotrexate
13. inpatient suicide using non-collapsible rails
14. escape of a transferred prisoner
15. falls from unrestricted windows
16. entrapment in bedrails
17. transfusion of ABO-incompatible blood components
18. transplantation of ABO or HLA-incompatible organs
19. misplaced naso-gastric or orogastric tube
20. wrong gas administered
21. failure to monitor and respond to oxygen saturation
22. air embolism
23. misidentification of patients
24. severe scalding of patients
25. in-hospital maternal

STEIS - The DH **S**Trategic **E**xecutive **I**nformation **S**ystem (STEIS) – Serious Incident (SI) system enables electronic logging, tracking and reporting of Serious Incidents. Once an incident is raised by a Trust or provider and entered into the SI module, an e-mail alert is sent to nominated officers at the Area Team (AT). The AT can also assign Clinical Commissioning Groups (CCGs) or Commissioning Support Units (CSUs) to receive e-mail alerts from Trusts/providers and to view, edit and close these Sis.

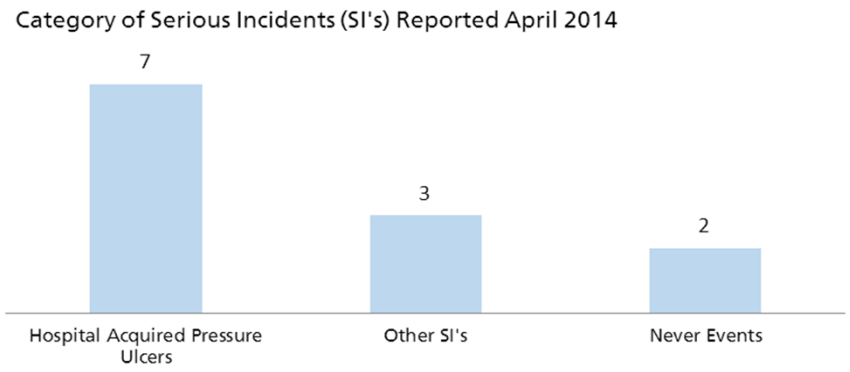
Serious Incidents

Current Month's Performance

12 Total serious incidents

2 of which were Never Events

Graphs/Charts



Number of open SIs as of 19.5.14

Unexpected death	1
Drug Incident	2
Failure to act on adverse test results	2
Wrong site surgery	1
Implementation and on-going monitoring	1
Medical device/equipment	1
Fall with harm	3
Unintended injury in the course of an operation	2
Maintenance / Estates / IT	1
Healthcare associated cross infection	1
Other incident to do with assessment	1
Pressure Ulcers	27
Total	**43**

Key Points/Operational Actions

Actions taken to improve response times for RCAs:

Pressure Ulcer specific RCA training given to band 6 & 7s on wards to increase number of staff able to complete investigations
Templates reviewed to include specific dates for completion at each stage of the process
Action chains on Datix being set up to send out reminders prior to each stage
Weekly scrutiny / peer review panel for pressure ulcers established to challenge practice, discuss and disseminate learning
Three grade 3 pressure ulcers were voided in April due to wrong classification

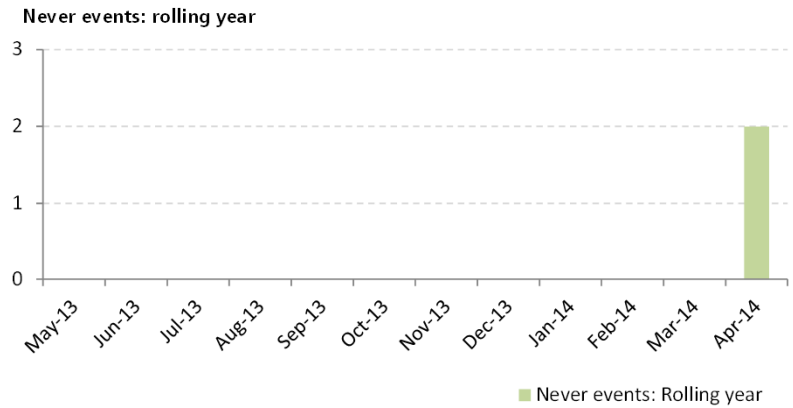
Definitions

Total number of Never Events that occurred within the reporting month
Count of the total number of patients that have had a serious medication error within the reporting month
Total count of falls within the reporting month
Total count of Grade 3 H.A Pressure Ulcers and Grade 4 H.A Pressure Ulcers within the reporting month
Other serious incidents exclude all of the above

Serious Incidents - Never events

Current Month's Performance	Ytd Month's Performance
2	2
Never events ✗	Never events ytd ✗

Graphs/Charts



Key Points/Operational Actions

Never Event wrong site surgery (2014/13074) - Case identified from a letter of complaint. Patient admitted for exploration and excision of Pilonidal Sinus in September 2013 and had a second operation in March 2014. Patient outcome – wound slow to heal (normal for type of procedure). Patient at home.

Never Event – Maladministration of Insulin (2014/13381) – Patient had a complex history of brittle Diabetes. Re-admitted with shortness of breath possible lower respiratory tract infection. Insulin not prescribed or administered appropriately resulting in admission to ITU with diabetic ketoacidosis (DKI). Patient outcome – Condition resolved within 24 hours, has been discharged home

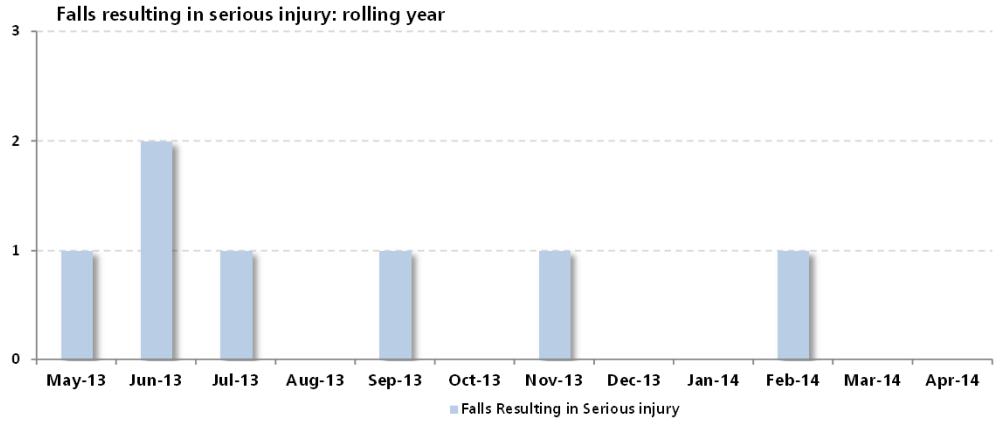
Definitions

Total count of Never events within the reporting month

Serious Incidents - Falls (Resulting in a Serious Injury)

Current Month's Performance	*Ytd Month's Performance*
0	0
Falls resulting in serious injury ✔	Falls resulting in serious injury ✔

Graphs/Charts



Key Points/Operational Actions

There were no falls resulting in serious harm reported in April

Definitions

Total count of falls within the reporting month

Serious Incidents - Pressure Ulcers

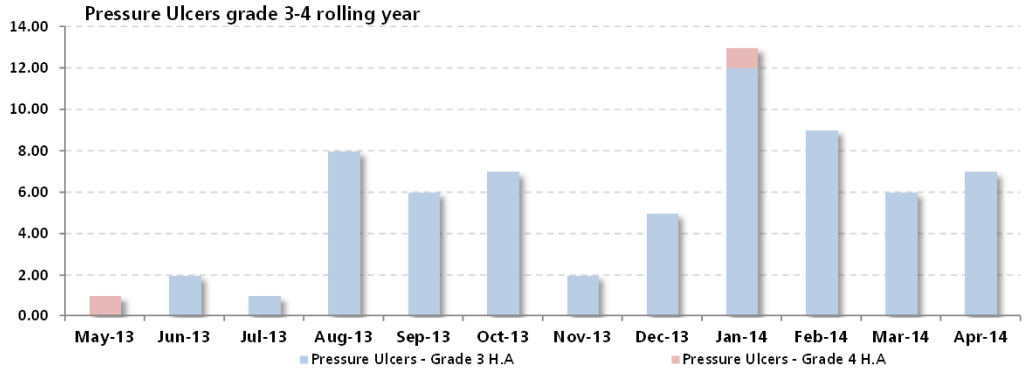
Current Month's Performance

7	7	0
Pressure Ulcers Grade 2 H.A (Target 0) ✗	Pressure Ulcers Grade 3 H.A (Target 0) ✗	Pressure Ulcers Grade 4 (Target 0) ✓

Year to date Serious incidents

0	Pressure Ulcers - Grade 4 H.A
7	Pressure Ulcers - Grade 3 H.A
7	Pressure Ulcers - Grade 2 H.A

Graphs/Charts



Pressure Ulcers grade 3-4

Hospital Acquired Pressure Ulcers Reported April 2014	
STEIS No.	**Reported to STEIS**
2014 10679	01/04/2014
2014 10736	01/04/2014
2014 11299	07/04/2014
2014 11305	07/04/2014
2014 12321	15/04/2014
2014 12944	22/04/2014
2014 12964	22/04/2014

Key Points/Operational Actions

Mitigation of Risk & Lessons learnt

Lessons learnt from SIs closed in April 2014 (all of which were pressure ulcers):

Incident Type	Root causes	Actions implemented to mitigate risk
Pressure Ulcer	• Patients with complex health or end of life care needs • Unable to position patient due to condition • Staffing not to agreed levels • Inconsistent management i.e. turning / care rounds / care planning • Extensive moisture damage • Delay in ordering equipment • Lack of equipment (bootees) • Variation in risk scoring & grading of ulcers • Failure or delay in referral to Tissue Viability Nurses • Delay in completing Datix • Poor communication / handover	• 125 pairs bootees ordered • Embedding `safety handover` to include risks such as pressure ulcers and falls • All grade 2 pressure ulcers being reviewed by Tissue Viability Nurses and scored correctly • Significant support and training on MAU and other wards • MAU auditing compliance • High profile re-launch of pressure ulcer campaign with staff reward for 100 free days • Wards now repeating body map on transfer • New Harm Free Care leaflet being developed by ward sisters to inform patients and relatives of how to help prevent harm • More training around scoring • All wards can order Medihoney for moisture lesions directly / Stanhoe hold own stock • Where necessary individual staff are being identified for training, support and remedial action

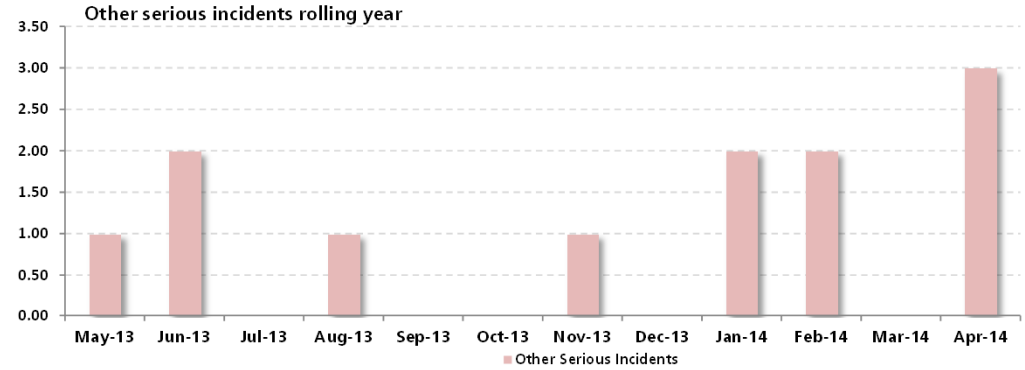
Definitions

Total count of Grade 2 H.A , Grade 3 H.A Pressure Ulcers and Grade 4 H.A Pressure Ulcers within the reporting month

Other Serious Incidents

Current Month's Performance	YTD Performance
3	3
Other serious incidents	other serious incidents

Graphs/Charts



Key Points/Operational Actions

Medical Device / equipment (2014/11846) – Patient mobilising independently with oxygen cylinder. Found in toilet having passed away. Immediate actions implemented prior to RCA to mitigate risk: Patients using >60% oxygen if mobile to be escorted with pulse oximeter monitoring – e-mail sent to all clinical areas. Urgent review of process for assessing patient`s ability to self- manage oxygen cylinders

Failure to act on adverse symptoms (2014/12314) – Patient attended with deep vein thrombosis (DVT) March 2014. Noted on admission that a previous X-ray in May 2013 had detected a lesion that required further investigation to rule out either mass or pneumonia. Although documented that action had been taken, patient did not receive referral, neither was G.P. aware of X-ray report. Patient outcome at date of report – Further investigations showing evidence of malignancy. Patient being managed as an outpatient.

Implementation and on-going monitoring (2014/12325) - Patient admitted having suffered cardiac arrest. Concern was raised over management of airway in A&E pre transfer to Norfolk & Norwich University Hospital. Patient outcome – at last report patient`s condition very poor, unlikely to survive

Definitions

Other serious incidents

Patient Experience - Friends and Family Test - Inpatients and A & E

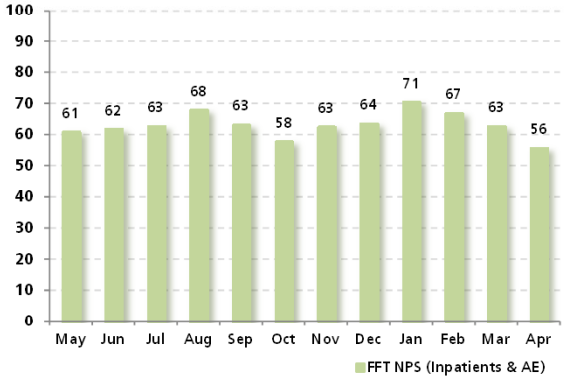
Inpatients

64	24.56%
Net Promoter Score	Response Rate (Target 25%) ✗

A & E

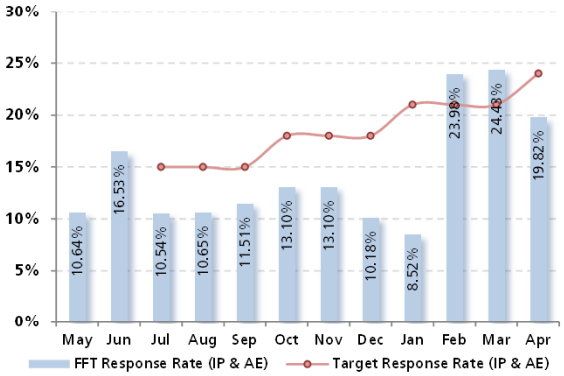
46	16.09%
Net Promoter Score	Response Rate (Target 15% ✓

Graphs/Charts



Net Promoter Scores by Ward

91	Oxborough
86	Pentney
80	Critical Care
78	West Raynham
72	Tilney
68	Leverington
67	Gayton
64	MAU
64	Shouldham
59	Elm
52	Denver
51	Terrington Short Stay
50	Stanhoe
45	Necton
43	Leverington (SAU)



Response Rates by Ward

42.4%	Shouldham
37.2%	MAU
31.8%	West Raynham
31.6%	Denver
30.9%	Leverington (SAU)
29.5%	Leverington
29.5%	Tilney
24.1%	Elm
24.0%	Stanhoe
20.2%	Terrington Short Stay
20.0%	Critical Care
18.0%	Gayton
14.1%	Necton
12.9%	Oxborough
10.3%	Pentney

Key Points/Operational Actions

The response rate to the FFT is slightly lower than in March although remains significantly improved.
Clinical areas continue to develop sustained methods of ensuring capture of patient feedback through the FFT.
Although not yet a national requirement surveys are also carried out in paediatrics, outpatients and the DSU; these results are shared at CLF and with ward teams. Some headlines from the free text comments made on the FFT surveys include:

Inpatient Wards:
271 positive comments about staff on the wards including 48 about nurses, 15 about doctors, 3 about other clinical staff, 1 about a non-clinical member of staff.
6 comments were made about there not being enough staff – this is a significant reduction when compared to 42 such comments made by patients in March 2013 and 15 such comments in November 2013.
6 patients complained of noise, light and other disturbance at night including 1 patient who had been moved twice after 10.00pm.
There were 9 comments about delays in discharge, including 3 who waited for take-home medication.
Improvements in discharge planning and communication with patients and carers is a key priority for the Trust

A & E:
168 positive comments about staff in the department including compared to 10 negative comments about staff (which related to delays and attitude).
56 patients said they were seen quickly whilst 28 said they waited too long including 1 who complained about the length of time waiting for a bed on a ward. The Bank holiday weekend was mentioned by some of the patients who felt they waited too long.
3 comments about the inaccuracy of the waiting time displayed on the screen in the waiting room. The department will continue to work on importing communication with patients about waiting times.

Maternity Services:
53 positive comments about staff in the delivery Suite and Postnatal ward
5 comments were made about there not being enough staff, 4 of these about the delivery suite
Recruitment is on-going following the skill mix review in maternity and revision of the establishment.

Definitions

The NHS friends and family test is an important opportunity for you to provide feedback on the care and treatment you receive and to improve services.
There is currently no set target for the Friends & Family Test Net Promoter Score

Patient Experience - Mixed Sex Accommodation

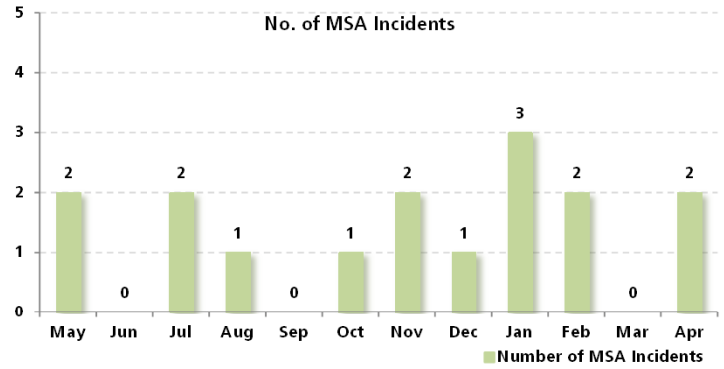
Current Month's Performance

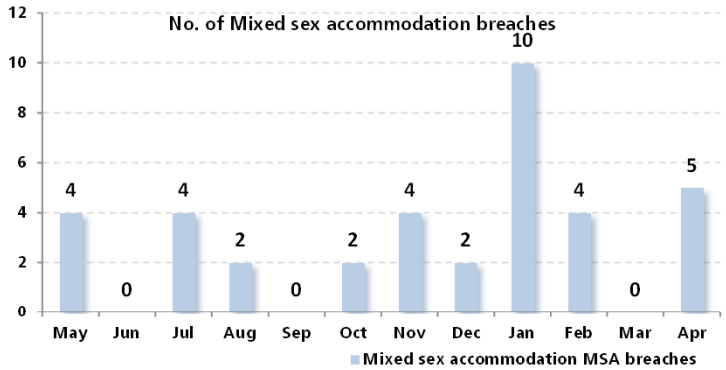
2	5
Incidents of Mixed Sex Accommodation	No. of Patients affected

Financial YTD

2	5
Incidents of Mixed Sex Accommodation	No. of Patients affected

Graphs/Charts





Key Points/Operational Actions

There were 5 reported occasions where MSA breaches have occurred in April 2014. Each affected patient carries a fine of £250 per day with commissioners under the terms of the NHS Contract for the time they are affected.

Definitions

Number of breaches of mixed sex accommodation (MSA) sleeping accommodation, per 1,000 finished consultant episodes

Infection control

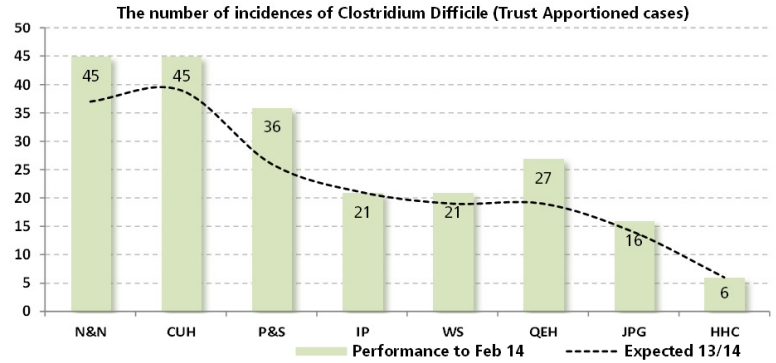
Current Month's Performance

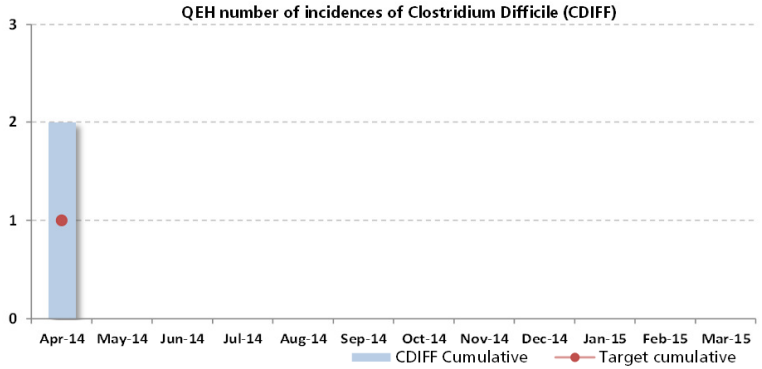
MRSA	CDIFF
0 ✔	2 ✘

Financial YTD

MRSA	CDIFF
0 ✔	2 ✘

Graphs/Charts





Key Points/Operational Actions

MRSA

There were no reported MRSA breaches for the full year.

CDIFF

The performance for reported cases of hospital acquired C Difficile has improved since March 2014 with 2 cases reported in April and 1 case in May (at the time of writing this report). As part of the on-going support from the CCG and PHE a follow up IST visit was carried out on 8th May 2014. Progress against the action plan, review of the epidemiology report from PHE and visits to wards that had PII took place. Overall the feedback on the day reported significant improvements since the first visit; particularly relating to staff knowledge regarding infection prevention procedures and policies. Stanhoe and West Raynham wards received very positive feedback. Areas for continued improvement relate to developing greater understanding of the rationale behind infection prevention processes and maintaining environmental cleanliness. The Associate Medical Director is also undertaking a detailed review of all deaths in patients who also had a reported case of C Difficile.

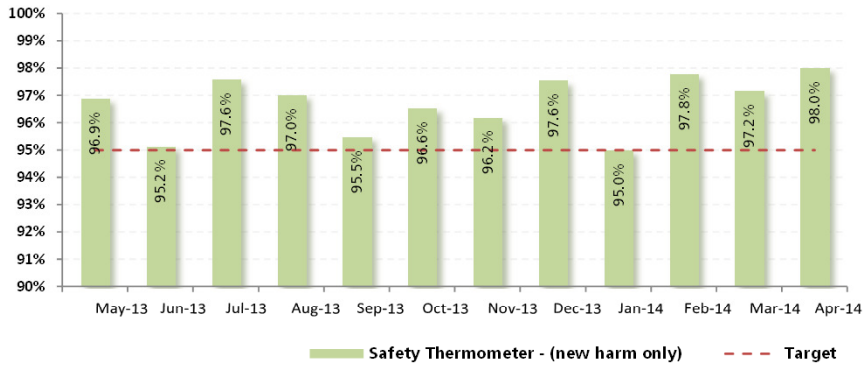
Definitions

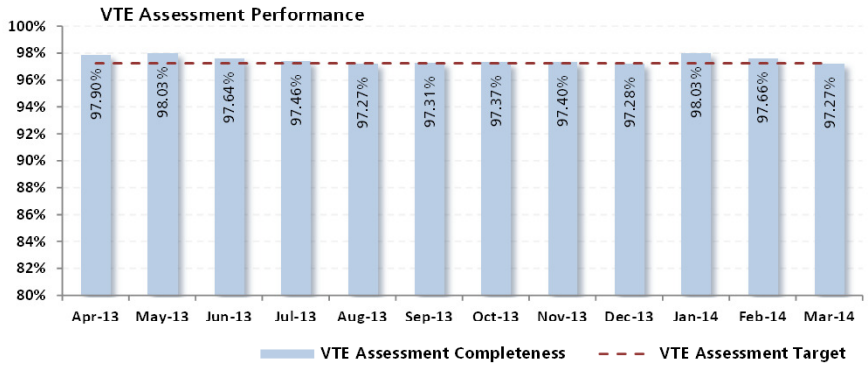
MRSA - The objective aims to deliver a continuing reduction in MRSA bacteraemia by requiring acute trusts and PCOs to improve to the level of top performers.
CDIFF - The objective aims to deliver a continuing reduction in Clostridium difficile infections. Organisations with higher baseline rates will be required to deliver larger reductions.

Safety thermometer

98.02%	97.27%
Safety Thermometer ✔	VTE ✔

Graphs/Charts





Key Points/Operational Actions

Safety Thermometer

The increase in harm free care for March reflects the reduction in harm associated with the reduction in pressure ulcers

Key Points/Operational Actions

VTE Assessment

The Trust continues to meet the target for the percentage of patients who have their risk of venous thromboembolism assessed on admission. This has previously been a national CQUINN target and is fixed locally at 97.24%.

Definitions

Safety Thermometer (Hospital Acquired Harm)CQUIN
VTE:Proportion of admissions that have been VTE assessed within the reporting month (1 month in arrears)

National Indicators used for measuring Hospital Mortality

HSMR: Hospital Standardised Mortality Ratio
Originally devised by Dr Foster, and perhaps the best known indicator.
Methodology used to derive the HSMR is freely available and we are exploring whether our current data providers, CHKS, can provide us with timely HSMR data.

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

SHMI: Summary Hospital Mortality Indicator
Devised to replace other indicators and become the 'national standard'. Current value 1.0067 – 'as expected'.

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

RAMI: Risk-Adjusted Mortality Indicator
Used by CHKS, our current data analysts.

- Risk of death based on major HRG codes used during the whole hospital stay, rather than first episode of care
- Does not include deaths after discharge
- QEH data available 1 month in arrears

Reporting to the Board
It is recommended that the Board routinely receives reports against the RAMI, to provide the timeliest intelligence for triangulation against other Trust outcome data.
In addition, the Medical Director will continue to monitor HSMR and SHMI data and provide exception reports to the Board as necessary, should these indicators demonstrate results which are other than 'as expected'.

Mortality

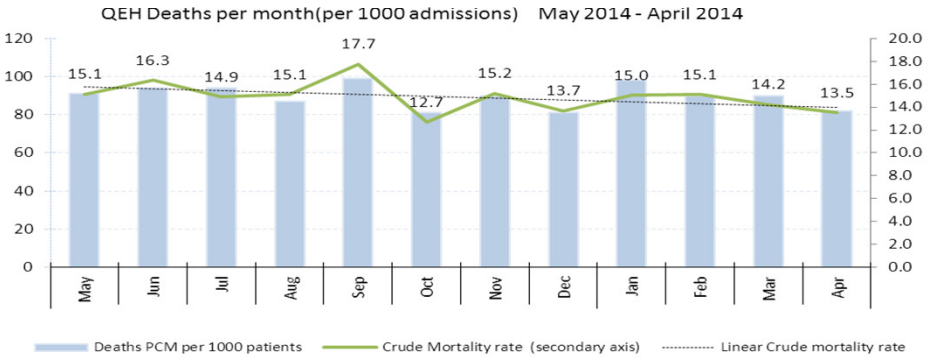
Current Months Performance

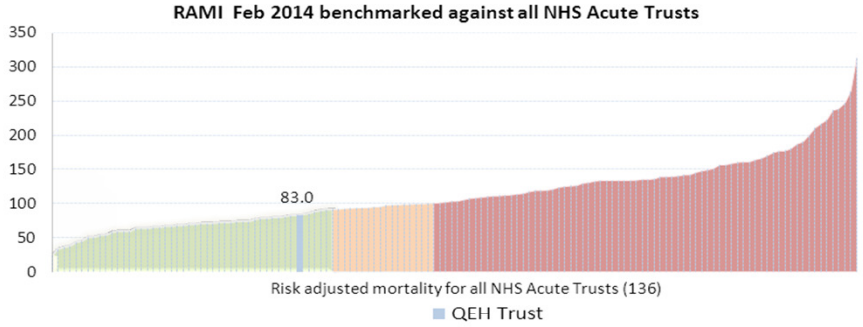
14.8	19.0
Crude mortality actual rate	Expected rate

Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
19.5	15.5	19.6	14.8	14.1	16.1	14.7	15.1	15.9	18.0	17.0	17.0

Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
19.1	15.1	16.3	14.9	15.1	17.7	12.7	15.2	13.7	15.0	15.5	14.8

Graphs/Charts



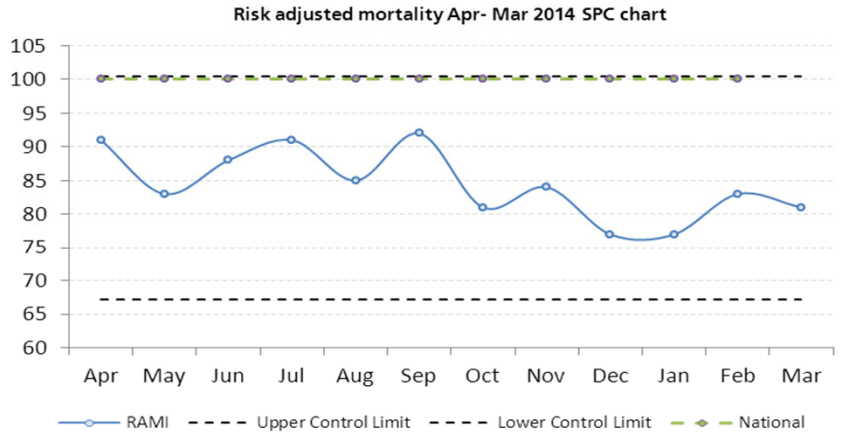


Key Points/Operational Actions

SHMI
Our current value 1.0067 – 'as expected'.

HSMR
Trust mortality remains in line with that expected and there have been no new mortality alerts reported by the Dr Foster Unit.

Actions
It is recommended that the Board routinely receives reports against the RAMI, to provide the timeliest intelligence for triangulation against other Trust outcome data. In addition, the Medical Director will continue to monitor HSMR and SHMI data and provide exception reports to the Board as necessary, should these indicators demonstrate results which are other than 'as expected'.



Definitions

Mortality Rate for the Trust per 1000 Admissions, Calculation = *Total Deaths/Total spells *1000*
RAMI (Risk Adjusted Mortality Index) Mortality Index Calculated by CHKS (2 months in arrears)

Complaints

Clinical Complaints

Current Month	YTD
51 ✗	51 ✗

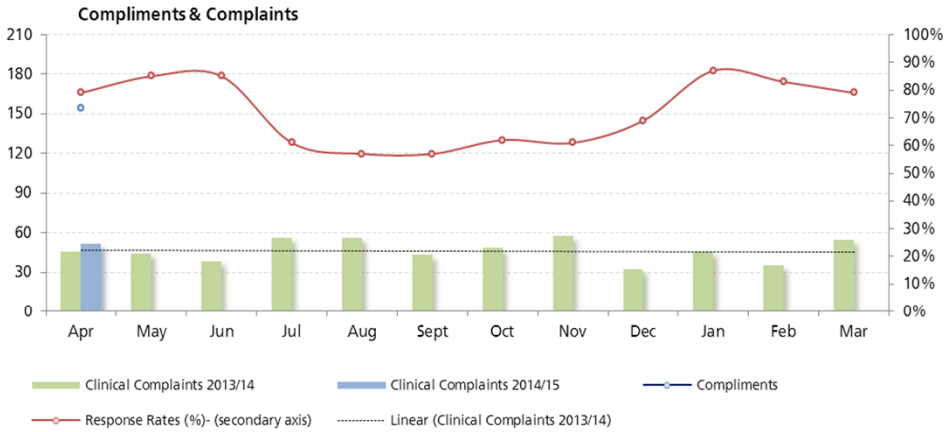
Non clinical complaints

Current Month	YTD
2 ✗	2 ✗

Compliments

Current month	YTD
154 ✓	154 ✓

Graphs/Charts



Analysis of current month

Risk score	YTD	Current Month
Very High	0	0
High	0	0
Moderate	11	1
Low	542	53

** Please note the current moderate complaint relates to wrong site surgery - this has been recorded as a never event*

Key Points/Operational Actions

Actions taken & lessons learned following conciliation meetings held in April

Key Issues	Lessons Learned	Action
During a conciliation meeting it was identified that not all specialities were provided with tests results of a deceased patient.	It is believed that this is a Trust-Wide problem, with information being filed in the medical records before being shared with the relevant parties.	Escalated to the Medical Director
The delay in inducing patients following the closure of the delivery suite due to being at full capacity; this delayed the process of providing the drug, due to staffing levels and other patients who required direct support .	If the Trust were to purchase a new drug, which worked over a period of 24 hours, rather than the need to administered every 6 hours, (as the drug works differently on different patients) this would allow staff to focus on other requirements, rather than focusing on every 6 hours.	Lead Midwife for Inpatients will speak with the Senior Obstetrics and Gynaecology team.
Nursing failings identified on a specific ward. Patient left in soiled bedding, lack of nursing care - Nurse not gentle when cleaning the patient, Nurse stated that she was unable to speak English and observations were not completed as required.	The ward is already been noted as a troubled area and an interim Matron has been assigned to the ward for 6 months.	Matron will share an action plan and outcomes within the next 3 months with the family.
Pain relief was not appropriately administered when a patient had a chest drain in place during a pleurodesis insertion.	Patients are not receiving effective pain relief whilst an inpatient.	The Lead Nurse will discuss with their Associate Chief Nurse if this is a procedure that could be undertaken

Definitions

Number of Complaints received into the Trust , Number of Compliments received into the Trust

Complaints narrative

During the month of April, the Trust received 53 complaints; this is a decrease of 5.66% in relation to the previous month, where the Trust received 56 complaints. The number of formal complaints received in April 2014 in comparison with April 2013, is an increase of 11.32%, as the Trust received 47 complaints.

Of the 53 formal complaints received in April 2014; at total of 109 issues were raised.
The Trust received 2 non-clinical complaints in April 2014.

The top 5 themes within formal complaints were in relation to Communication – 11, Staff Attitude - 9, Lack of Treatment – 6, Cancellation – 5 and Diagnosis - 4.

There were a number of complaints received relating to overseas staff and the use their language, which patients found rude, this was not confined to a specific location but rather Trust wide. This issue was raised immediately with the Associate Chief Nurses for action.

Another theme was communication about treatment and procedures, patients felt that they weren't given full information or correct details about what they are having done.

In order to identify themes relating to Staff Attitude the Complaints Manager review complaints received during the period of 1 January 2014 to 30 April 2014 and compared data to the previous 4 month period. A theme was identified is that staff attitude complaints associated with nursing staff and remained consistent, whereas complaints associated with medical staff have increased by 44%. In response to this the Complaints Manager sent an email out to Clinical Directors, Director of Nursing and Medical Director in order for this to be discussed and shared with medical teams to address the increasing numbers.

The Trust received one informal complaint during the month of April 2014. Patient was upset in clinic that no X-Ray was to be taken, an explanation was given as there was only soft tissue damage.

The Trust did not receive any referrals from the Parliamentary and Health Service Ombudsman (PHSO).

One complaint received in April was copied in to the CQC, this related to the attitude of a ward clerk.

The Trust's performance for March 2014 was that 45 of the 56 complaints received were closed within 30 working days. Six complaints remain open and they relate to Patient Services, General Surgery, Obs and Gynae, Respiratory and Urology.

During the month of April 2014 the Trust received 154 compliments, which is an increase of 42.85%, in comparison to April 2013 where 88 compliments were received.

The Complaints Manager and the Deputy Director of Nursing has recently met with Healthwatch and are going to take part in a survey. The survey has been put to other NHS Trust's in the area and will provide us with some benchmarking and importantly will give us the opportunity to share best practice. During this survey we have already completed a Trust questionnaire in relation to the service and the Trust's complaints process. A further questionnaire will also be sent out to 25-30 complainants (picked randomly from the last financial quarter) for feedback on the Trust's complaints handling. The responses will be sent directly to Healthwatch and a report will be sent out later this year.

Women and Children's Business Unit Dashboard

Maternity Clinical Performance and Governance Scorecard 2014-15

			Green	Red	Measure	Data Source	Apr	Comments / actions
ACTIVITY	Births		190-205	>205 or < 190	Births	CDS	180	
	Bookings < 12 weeks		≥ 90%	< 85%	Booking numbers	Community stats	96%	
	C Section	Total rate (planned and unscheduled)	< 22%	>24%	C Section/birth	CDS	24%	Elective (G4) = 14 Emergency (G1 & G2) = 27
	Instrumental deliveries	RCOG 10-15%	5% - 20%	<5% or >20%	Births	CDS	12%	
	Normal deliveries		> 65%	< 60%	Births	CDS	62%	
	Induction rates		<14%	> 18%	Births	CDS	19%	
	BBAs				Births	CDS	3	
	DAU	No of women at QEH	>200	<150		DAU	333	
		Closure of DAU at QEH	0	>2		DAU	3	closures due staff required for CDS
		Number of women at NCH				DAU	97	
		Closure of DAU at NCH				DAU	2	closed due to Easter bank holidays
WORKFORCE	Staffing Levels	Weekly hours of Consultant cover on Labour ward	> 40 hours	< 35 hours	Hours	Rota	44	
		SoM : Midwife ratio	≤ 1:15	> 1:20		SoM allocation sheet	1:17	
		Midwife : birth ratio	1:30	1:35		HoM	1:32	
		1:1 care in labour	> 80%	< 70%		CDS	91%	
		No. of incident forms relating to staffing levels	<5	>10	Incident forms	Datix	22	
CLINICAL INDICATORS	Maternal morbidity	PPH 1000 - 2000ml		> 8		CDS	20	
		PPH >2000ml		>2		CDS	4	
		3rd and 4th degree tears	<3	> 5		CDS	3	
		Eclampsia	0	>1	cumulative for the year	CDS	0	
		Blood transfusions > 4 units	0	>1		CDS	1	
		Postpartum hysterectomies	0	>1		CDS	0	
		ITU /HDU admissions	0	>1		CDS	1	
	Neonatal morbidity/mortality	Still Births	0	≥ 1	Births	CDS	1	
		Neonatal deaths		>1	Births	CDS	0	
		Apgars < 3 at one minute and < 5 at 5 minutes	0	>1		CDS	1	
		Cord pH <7.15	0	>1		CDS	2	
		Birth injury	0	>2		Datix	0	
	Risk management	No of SUIs	0	≥ 1		Risk dept	0	
		No of reported clinical incidents				Datix	89	
		Closure of CDS	0	>2		CDS	4	
	Breast feeding	Initiation rates	>70%	< 65%		CDS	68%	

Performance and Standards

1.1 The Performance and Standards section of the report highlights performance against national and local KPI's, along with the Trust position against Monitor compliance framework. This includes an indication of the position at the year-end for 2013/14 regarding the performance of the Trust against national and local key performance indicators.

1.2 The Trust continues to report that it is failing to achieve the 18 week admitted target for all specialties and Trust wide at 85.26%. The Trust will not recover the position for Trauma and Orthopaedics, Gynaecology, ENT, General Surgery and Urology until the end of June 2014. This is a revised position due to cancellations of Elective surgery in March and April. From 1st April 2014 each breach below the 90% standard carries a financial consequence with commissioners of £400 per case.

1.3 The Trust has failed to deliver the 62 day cancer target for quarter 4. However, performance for March was above the required standard of 85%. The Trust invited the Intensive Support Team (IST) in to review pathways. The work undertaken by the IST has been completed and an action plan is being led by the Chief Operating Officer. The action plan is included within this report as an appendix. Key actions include;

- **A review of pathways to confirm best practice**
- **The implementation of timed pathways for specific tumour sites**
- **A review of the cancer escalation policy**

1.4 The Trust failed to achieve the A&E target in April 2014.

The Emergency Department has introduced a system of Initial Assessment at the point of ambulance arrival to identify those patients requiring early clinical intervention. Two assessment cubicles are used for this assessment which comprises taking a brief history, baseline observations, Early Warning Score and pain score. Additionally, investigations are commenced at this point to reduce delays waiting for diagnostics. This practice promotes safety and facilitates the achievement of 'time to Initial Assessment within 15 minutes' and supports delivery of ambulance turnaround times (arrival to handover within 15 minutes).

The Consultant Nurse will be adopting a similar approach to patients who self-present through Minors pathway. She will provide senior clinical decision making at the point of triage and ensure xrays and other diagnostics are requested without delay. Additionally, the Consultant Nurse (and the Emergency Nurse Practitioners she will be developing to undertaking the role) will be able to re-direct patients as appropriate, including back to Primary Care.

1.5 The Trust TIA target remains at risk due to increased pressure on medical beds.

The service was temporarily stopped when there was a need to ensure high quality patient care on the wards. The Clinical Director / Lead Clinician, with the Clinical Nurse Specialist have reviewed all of the outstanding referrals. This was completed this week.

Going forward they have agreed a new approach which will ensure any new referrals for High Risk TIAs will be seen during the working day. Each day there will also be two "new" slots held for any referrals which are made outside core service hours to be seen. In addition there will also be 1 slot each day over the weekend for new referrals.

This does mean there is a risk in reliance on two key staff, however in addition to create further sustainability going forward an additional clinician has been asked to provide cover for other commitments to release time back into the stroke team as a whole.

1.6 The Trust continues to be assessed against the Monitor Compliance framework as RED.

1.7 The Trust reported 48 breaches of the 6 week diagnostic waiting time standard. This represents 98.36% of patients seen within 6 weeks. The key areas were;

- Urodynamics 1
- Scopes 30
- Echocardiology 10
- Radiology 7

Actions, led by the Chief Operating officer are in place to recover performance with the appointment of an additional locum within endoscopy to increase capacity.

1.8 The areas of performance where the Trust did not achieve its targets for the current month are:

- Ambulance turnaround <=15 mins is 61.% (A joint review will be undertaken by the Trust, West Norfolk CCG & EEAST)
- Readmission rate elective (3.6% against a target of 3.2%)
- Readmission rate emergency (11.5% against a target of 10.4%)
- Cancelled ops (1% against a target of 0.8%)
- 18 weeks RTT admitted performance (85%% against a target of 90%)

Performance & Standards Scorecard

Delay free

Indicators	Var to prev mth	Target	Feb	Mar	Apr	FYTD
National standards						
18 Wks - Adm Perf	↑	90.00%	84.18%	78.76%	85.26%	85.26%
18 Wks - Non Adm Perf	↓	95.00%	99.41%	98.39%	97.68%	97.68%
18 Wks - Incomp Perf	↑	92.00%	97.15%	97.54%	97.79%	97.79%
Cancer - 31 Days Subsq Treatment - Surgery	→	98.00%	100.00%	100.00%		99.56%
Cancer - 31 Days Subsq - Drug Treatments	→	94.00%	100.00%	100.00%		99.50%
Cancer-62 Days RTT	↑	85.00%	74.34%	85.00%		85.58%
Cancer-2 Wk Waits	↓	93.00%	99.07%	98.70%		97.91%
31 Day Diag to Treat	↑	96.00%	97.22%	100.00%		98.75%
A&E 4 Hour Attendance	↓	95.00%	94.07%	95.28%	91.89%	91.89%
Ambulance turmaround	↓	100.0%	68.6%	66.8%	61.9%	61.9%
MRSA Screening - All Elective Inpatients	→	100.0%	100.0%	100.0%	100.0%	100.0%
ASI's	→	3.0%	12.0%	12.0%	12.0%	15.0%
Choose + Book - Slot Utilisation	→	90.0%	78.0%	80.0%	80.0%	78.0%
Stroke - 90% of Stay on a Stroke Unit	→	80.00%				84.40%
Stroke - High Risk,Non admitted TIA treated in 24 Hrs	→	60.00%				64.80%
Total Cancelled Ops	↓	0.80%	0.67%	1.02%		
Diagnostic Over 6 Week Waiters - % of Total WL	↑	1.00%	0.19%	0.18%	1.64%	0.11%

Operational Efficiency

Indicators	Var to prev mth	Target	Feb	Mar	Apr	FYTD
Local standards						
Day Case Rate	↑	82.0%	88.6%	88.1%	89.5%	89.5%
DNA Rate	↑	5.00%	4.48%	4.59%	4.66%	4.66%
New to Review Rate	↓	2.3	2.6	2.5	2.2	2.2
Readmission Rate - Elective	↓	3.10%	4.42%	3.91%	3.58%	3.58%
Readmission Rate - Emergency	↓	10.40%	12.80%	11.76%	11.45%	11.45%
Elective Length of stay	↓	2.2	1.9	2.4	1.9	1.9
Emergency Length of stay	↑	5.0	3.6	3.4	4.0	4.0
British Association of Day Surgery's "trolley" of procedures (BADS)	↓	80.0%	84.1%	89.0%	88.7%	88.7%

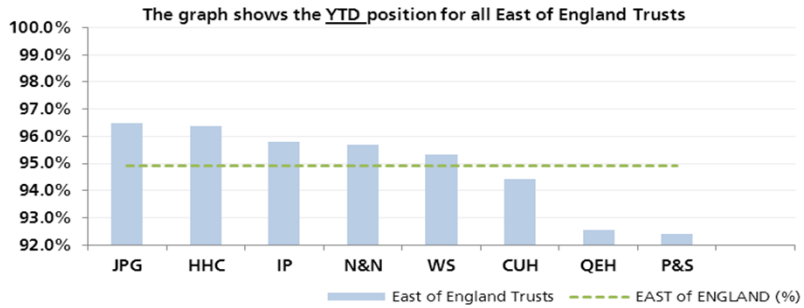
Accident and Emergency

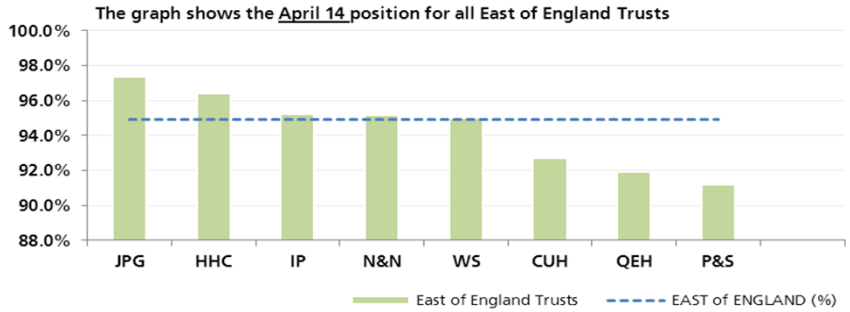
Current Month's Performance	Financial YTD
91.89%	91.89%
Patient's seen & treated within 4 hrs (Target 95%) ✗	Patient's seen & treated within 4 hrs (Target 95%) ✗

Graphs/Charts

	Organisation Name (East of england Trusts)	2013/14	April
JPG	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (JPG)	96.5%	95.2%
HHC	HINCHINGBROOKE HEALTH CARE NHS TRUST (HHC)	96.4%	96.4%
IP	IPSWICH HOSPITAL NHS TRUST (IP)	95.8%	97.4%
N&N	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (N&N)	95.7%	95.2%
WS	WEST SUFFOLK NHS FOUNDATION TRUST (WS)	95.3%	95.0%
CUH	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (CUH)	94.4%	91.2%
QEH	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST (QEH)	92.6%	91.9%
P&S	PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST (P&S)	92.4%	92.7%

Accident and Emergency Indicators	April
Key performance indicators	
Left department before being seen for treatment (≤ 5%)	↑ 1.6%
Re-attendance rate (≤ 5%)	↑ 2.3%
Total Time in A&E Admitted patients 95th percentile (≤ 04:00)	↓ 08:27:00
Total Time in A&E Non Admitted patients 95th percentile (≤ 04:00)	↑ 03:55:00
Total Time in A&E (median)	↑ 02:40:35
Total Time in A&E 95th percentile (≤ 04:00)	↓ 05:09:00
Triage time (median) AMBN (≤ 00:15)	↑ 00:14:23
Time to treatment (median) (≤ 00:60)	↑ 01:02:00





Key Points/Operational Actions

The Trust failed to achieve the A&E target in April 2014.

The Emergency Department has introduced a system of Initial Assessment at the point of ambulance arrival to identify those patients requiring early clinical intervention. Two assessment cubicles are used for this assessment which comprises taking a brief history, baseline observations, Early Warning Score and pain score. Additionally, investigations are commenced at this point to reduce delays waiting for diagnostics. This practice promotes safety and facilitates the achievement of 'time to Initial Assessment within 15 minutes' and supports delivery of ambulance turnaround times (arrival to handover within 15 minutes).

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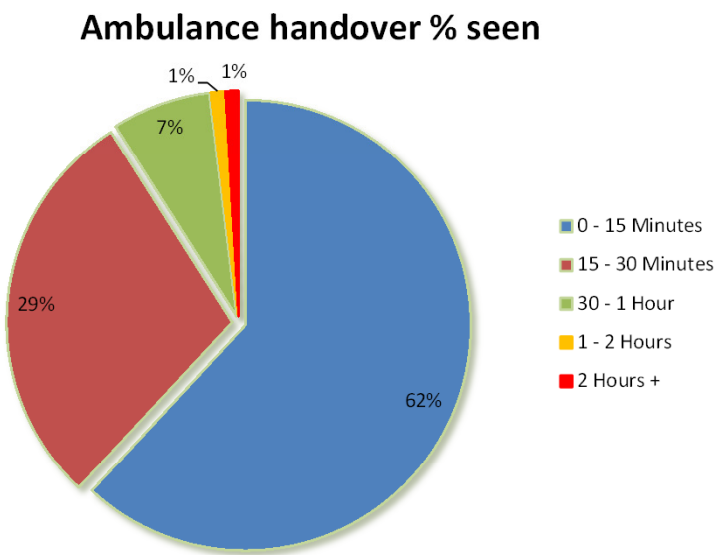
Definitions

Ambulance

Current Month's Performance	Financial YTD
61.90%	61.9%
Ambulance handover % ✗	Ambulance handover % ✗

Graphs/Charts

Potential fine per case £	Ambulance handovers	YTD
£0	0 - 15 Minutes	926
£0	15 - 30 Minutes	435
£200	30 - 1 Hour	106
£1,000	1 - 2 Hours	15
£1,000	2 Hours +	14
	Total	1496
	Percentage seen within 15 mins%	61.9%



Key Points/Operational Actions

A Hospital ambulance liaison officer (HALO) commenced work in January to work with the emergency department team and EEAST crews to facilitate timely turnaround. Emphasis continues on maintaining capacity in the emergency department and assessment units by ensuring early senior reviews and escalation.

The Trust continues working on a daily basis with EEAST and West Norfolk CCG as part of the Service Development Improvement Plan for 2014/15 to review handover performance.

Definitions

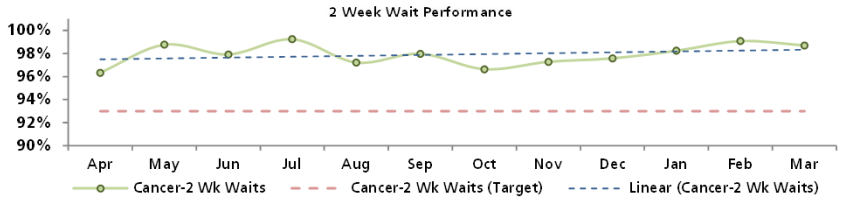
Fig 1 In the above table -arrival to handover – shows the number of hours lost in the month where the patient handover has been delayed (ie the patient has waited with the ambulance crew for more than 15 minutes before being accepted by the hospital staff). The Graph is showing the excess times per month over the 15 minutes, Handing over a patient from an ambulance to a hospital

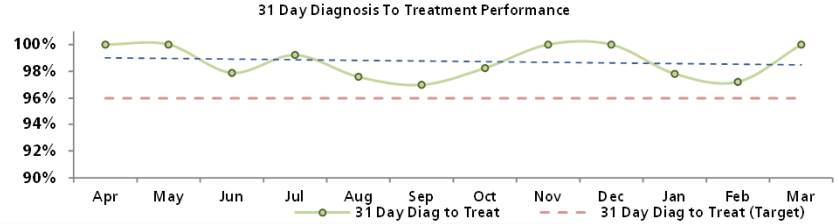
Cancer Waiting Times

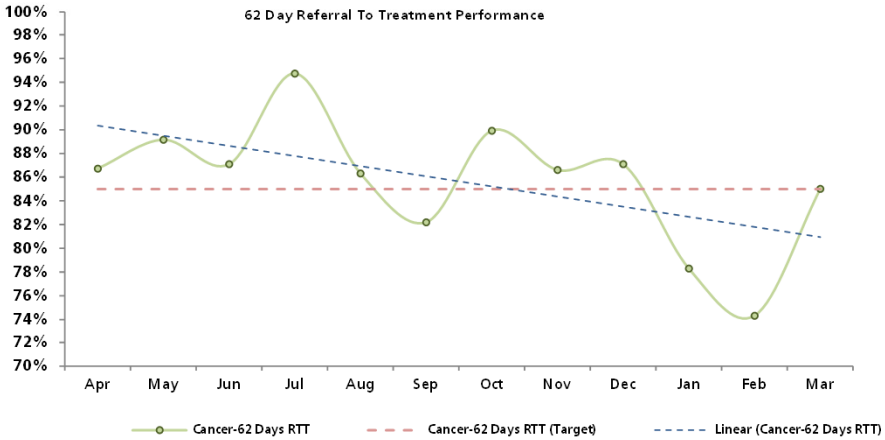
Current Month's Performance

98.7%	100.0%	85.0%	100.0%	100.0%	91.4%
Two Week Wait (Target 93%) ✔	31 Day - Diagnosis To Treatment (Target 96%) ✔	62 Day - Referral To Treatment (Target 85%) ✔	31 Day Subs Treatment - Surgery (Target 94%) ✔	31 Day Subs Treatment - Drug Target 98%) ✔	Breast Symptoms 2ww (Target 93%) ✘

Graphs/Charts







Key Points/Operational Actions

The Trust has failed to deliver the 62 day cancer target for quarter 4. However, performance for March was above the required standard of 85%. The Trust invited the Intensive Support Team (IST) in to review pathways. The work undertaken by the IST has been completed and an action plan is being led by the Chief Operating Officer.

The action plan is included within this report as an appendix. Key actions include;

A review of pathways to confirm best practice
The implementation of timed pathways for specific tumour sites
A review of the cancer escalation policy

Definitions

Percentage of cancer patients first seen within 2 weeks in the reporting month (1 month in arrears)
Percentage of above Cancer Pathway completed within 62 Days in the reporting month (1 month in arrears)
Percentage of above Cancer Pathway completed within 31 Days in the reporting month (1 month in arrears)

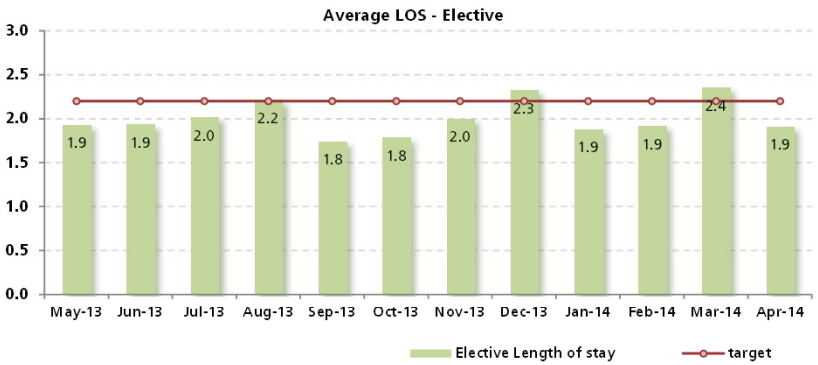
Length of stay

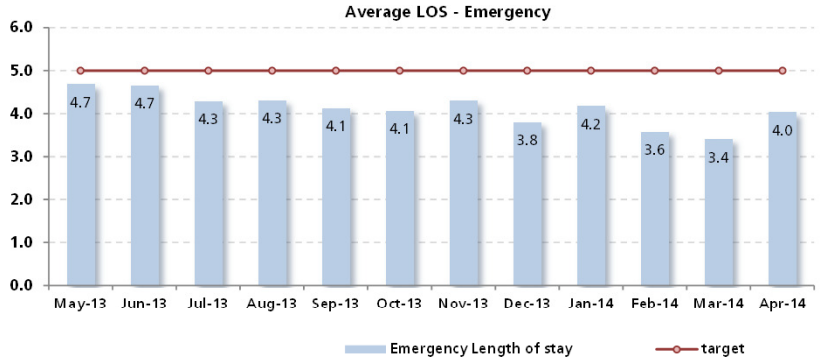
Current Month's Performance

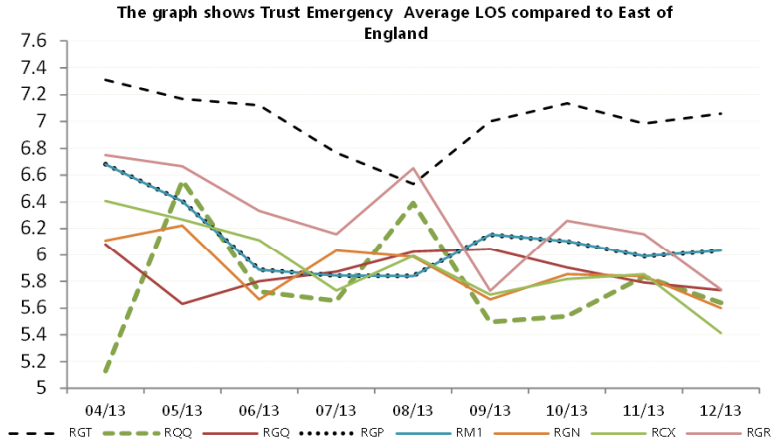
1.9
Average LOS - Elective (Target 2.2) ✔

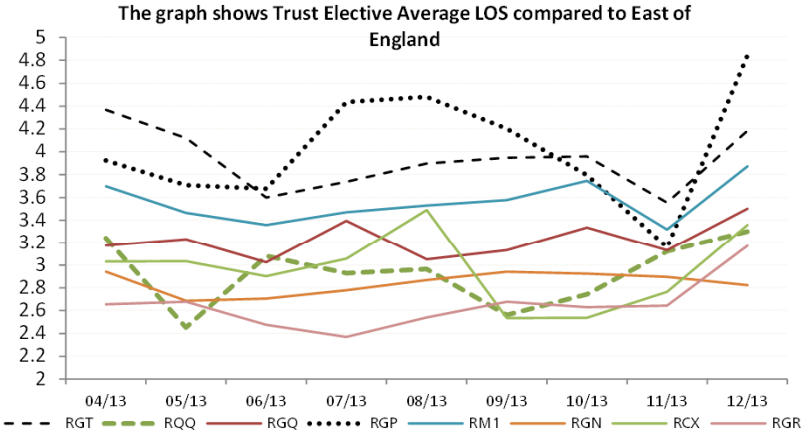
4.0
Average LOS - Emergency (Target 5) ✔

Graphs/Charts









Definitions

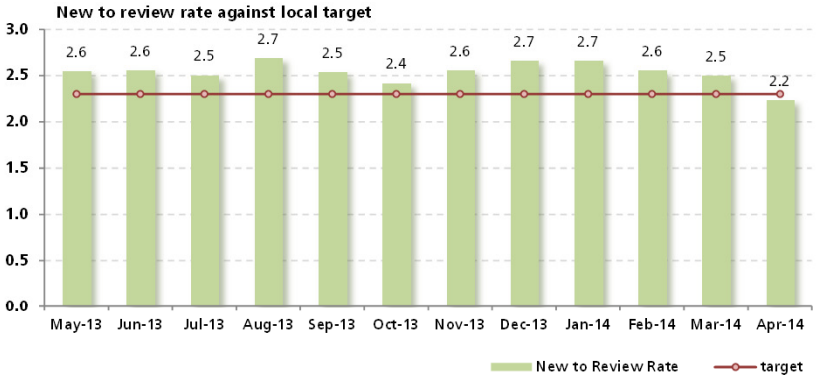
The average spell length of stay for Elective and Emergency Inpatients discharged within the reporting month

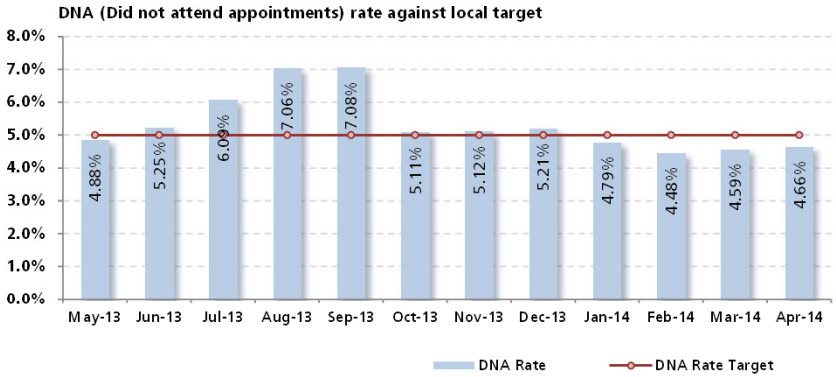
New to follow up & DNA rate

Current Month's Performance

2.2	4.66%
New to review (Target 2.3) ✗	DNA rate (Target 5) ✓

Graphs/Charts





Definitions

New to review: Ratio of total follow-up attendances against the total number of new patient attendances for the reporting month
DNA :Ratio between the total number of new and follow up appointment DNAs against the total number of Attendances and DNAs (Did not attend)

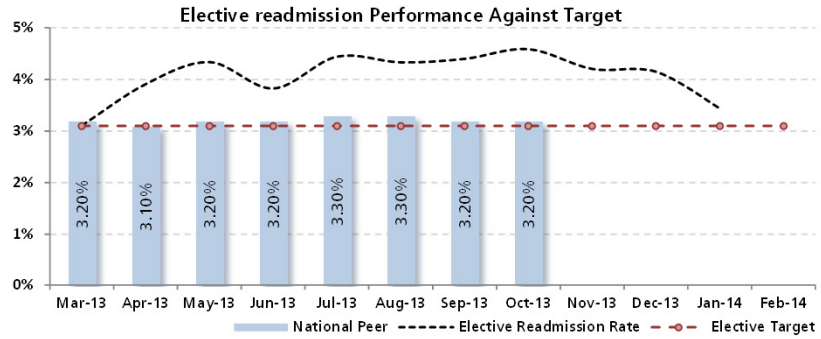
Readmissions

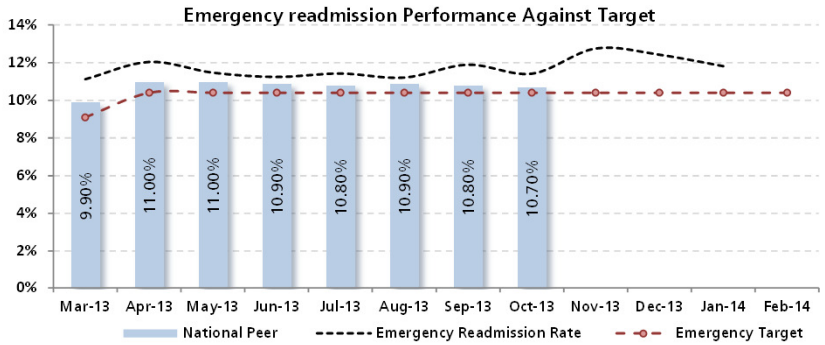
Current Month's Performance

3.58%
Re-admissions following Elective Surgery (Target 3.1%)

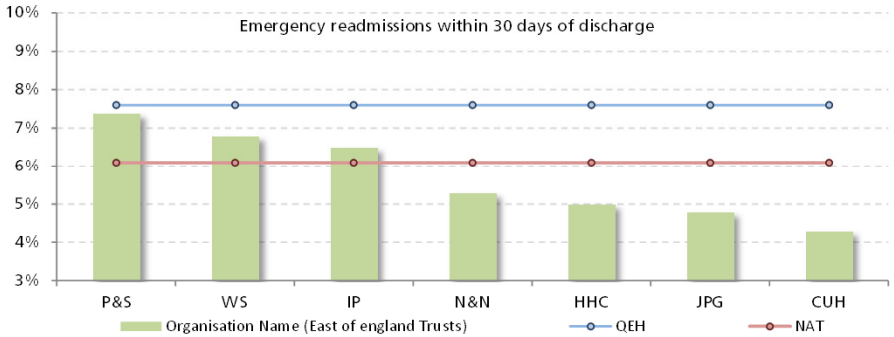
11.45%
Re-admissions following an Emergency Admission (Target 10.4%)

Graphs/Charts





Benchmarked Performance



Definitions

Total number of Patients readmitted within 30 days following an Elective admission against the Total number of discharges within the reporting month
Total number of Patients readmitted within 30 days following an Emergency admission against the Total number of discharges within the reporting month

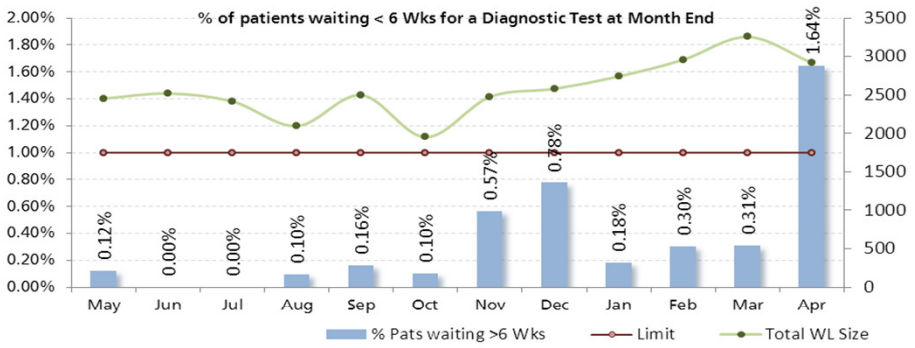
Diagnostic Waiting Times (% of Pat's Waiting >6 Wks)

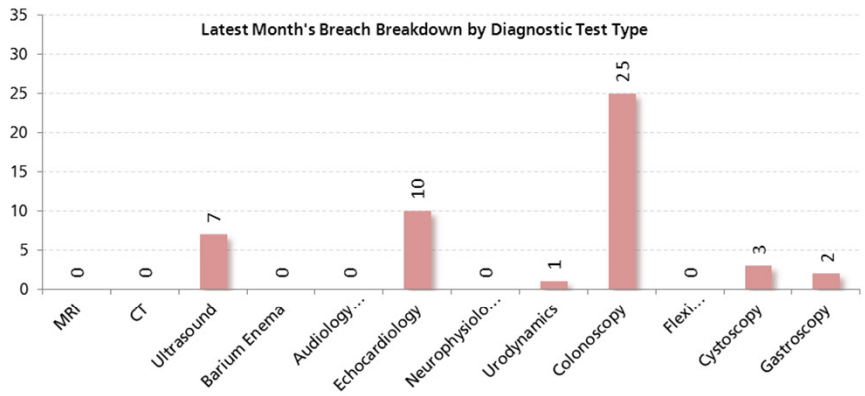
Current Month's Performance

1.64%

(Target 1%) ✗

Graphs/Charts





Key Points/Operational Actions

The 7 Ultrasound breaches were all at North Cambs Hospital, due to no available capacity.
Within Endoscopy there were 30 breaches reported. This was because the demand exceeded the available operations within the month.
An additional locum has been appointed to increase capacity.
Plans are in place to review Cardiology capacity with regards to Echo's. A meeting will take place with clinicians led by the Chief operating Officer.

Definitions

Denominator :The number of patients waiting for a diagnostic test at the end of the reporting period
Numerator: The number of patients waiting 6 weeks or more for a diagnostic test at the end of the reporting period

18 Weeks Referral To Treatment

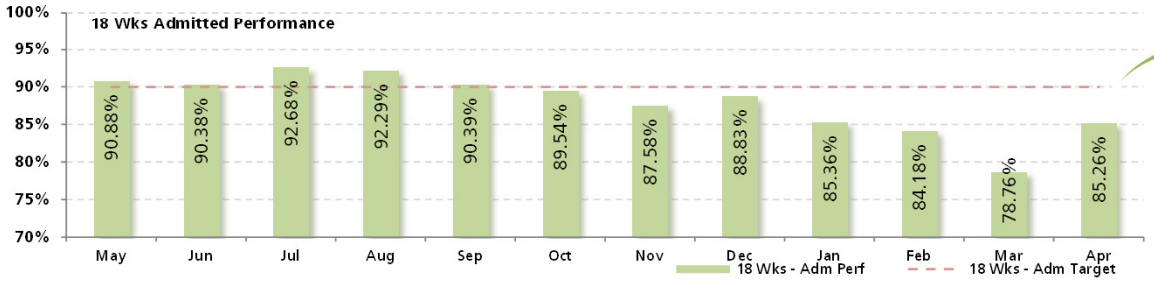
Current Month's Performance

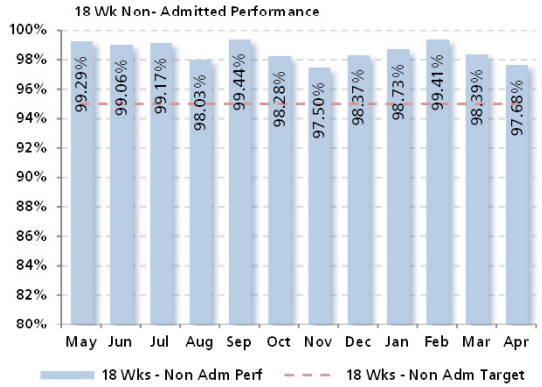
85.26%	97.68%	97.79%
Admitted (Target 90%) ✗	Non-Adm (Target 95%) ✓	Incompletes (Target 92%) ✓

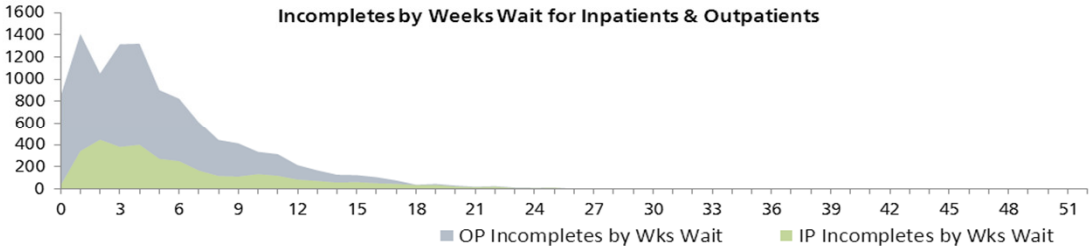
Specialties that PASSED the 18 Wk Adm Target in the month	
100.0%	Gastroenterology
100.0%	Plastics Surgery
98.2%	Dermatology
98.2%	Ophthalmology
97.4%	Gen Medicine

Specialties that FAILED the 18 Wk Adm Target in the month	
52.29%	Trauma & Ort
62.89%	Gynaecology
71.43%	Gen Surgery
72.59%	Other
75.93%	Oral Surgery
80.37%	Urology
81.82%	ENT

Graphs/Charts







Key Points/Operational Actions

The Trust continues to report that it is failing to achieve the 18 week admitted target for all specialties and Trust wide at 85.26%.

The Trust will not recover the position for Trauma and Orthopaedics, Gynaecology, ENT, General Surgery and Urology until the end of June 2014. This is a revised position due to cancellations of Elective surgery in March and April.

From 1st April 2014 each breach below the 90% standard carries a financial consequence with commissioners of £400 per case.

Improvement has been driven by additional weekend working and we will be looking for recognition of this with Commissioners.

Definitions

Referral to treatment waiting times – admitted (90% Target <18 Wks.) Referral to treatment waiting times – non-admitted (95% Target <18 Weeks) Referral to treatment waiting times - Incompletes (92%)

18 Weeks Referral To Treatment (Cont'd) - Benchmarking

Benchmarked "Admitted" Performance

QEH 84.16% Vs 89.85% National, 90.94% East Anglia

Benchmarked "Non-Admitted" Performance

QEH 99.41% Vs 96.29% National, 96.85% East Anglia

Please note that the figures used for benchmarking analysis are always 1 month behind.

Graphs/Charts

QEH Ranking and Performance (vs Area/National Performance)

Area Rank (out of 9)	Nat Rank (Out of 161)	Code	Name	Admitted Pathways % within 18 weeks	Admitted Pathways Median (weeks)	Admitted Pathways Total	Non-Admitted Pathways % within 18 weeks	Non-Admitted Pathways Median (weeks)	Non-Admitted Pathways Total
Y57	120	RCX	The Queen Elizabeth Hospital, King's Lynn. NHS Foundation Trust	84.2%	9.2	1237	99.4%	4.3	1519
Area Performance >>>		Q56	East Anglia Area Team	90.9%	9.6	13538	96.8%	4.9	31074
Nat Performance >>>		EN	England	89.9%	9.5	299895	96.3%	4.7	822389

Rank	Area	Code	Name	Admitted Pathways % within 18 weeks	Admitted Pathways Median (weeks)	Admitted Pathways Total	Non-Admitted Pathways % within 18 weeks	Non-Admitted Pathways Median (weeks)	Non-Admitted Pathways Total
Y57	Q56	RGR	West Suffolk NHS Foundation Trust	95.2%	8.7	1722	98.96%	5.0	2605
Y55	Q56	RQQ	Hinchingbrooke Health Care NHS Trust	94.0%	8.4	918	99.22%	3.1	2050
Y55	Q56	RGP	James Paget University Hospitals NHS Foundation Trust	90.3%	7.4	1398	98.97%	3.9	3117
Y57	Q56	RGM	Papworth Hospital NHS Foundation Trust	91.8%	8.8	522	98.73%	5.7	236
Y54	Q56	RM1	Norfolk and Norwich University Hospitals NHS Foundation Trust	91.3%	9.8	3052	93.92%	5.1	7544
Y54	Q56	RGT	Cambridge University Hospitals NHS Foundation Trust	89.6%	10.9	2939	96.7%	5.9	7592
Y56	Q56	RGN	Peterborough and Stamford Hospitals NHS Foundation Trust	88.3%	12.9	1718	97.18%	5.0	5489
Y55	Q56	RGQ	Ipswich Hospital NHS Trust	86.1%	11.9	1651	96.66%	6.2	3412
Y57	Q56	RCX	The Queen Elizabeth Hospital, King's Lynn. NHS Foundation Trust	84.2%	9.2	1237	99.41%	4.3	1519

Based on Performance up to End of Feb 2014

Key Points/Operational Actions

Definitions

The benchamrking data is extracted from the Department of Health's Unify Reporting Tool ,and is shown at least a month in arrears.

Stroke & TIA

Stroke - Latest Month's Performance

84.48%

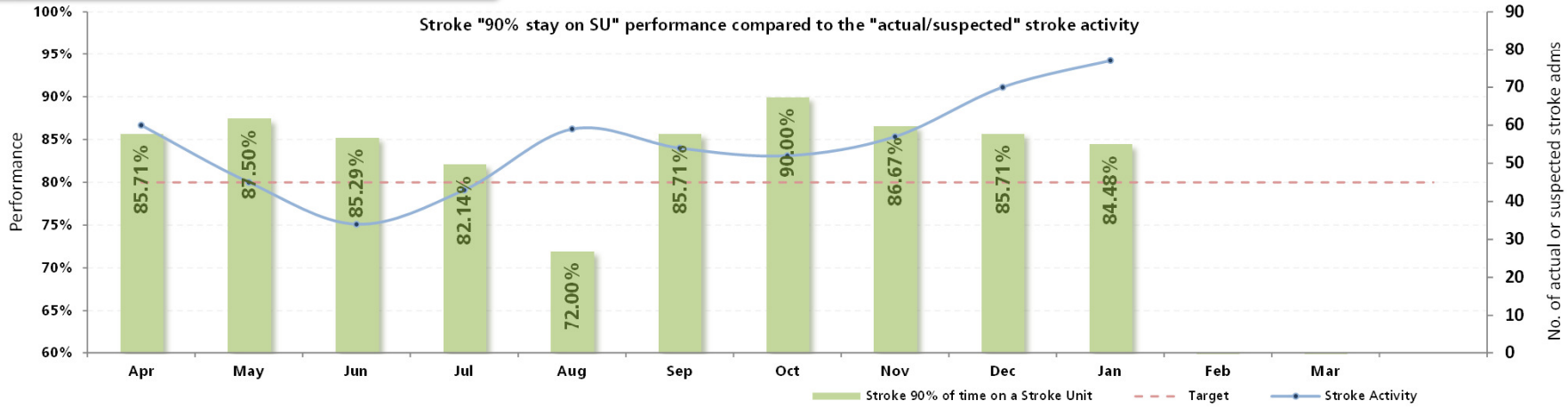
Stroke Pat's spending >=90% of stay on SU (Target 80%) ✔

Stroke - Financial YTD

84.40%

Stroke Pat's spending >=90% of stay on SU (Target 80%) ✔

Graphs/Charts



Stroke - No. of breaches, and Top 3 breach reasons (Latest Month)

9

- 4 Challenging diagnosis
- 4 Patient stepped down to accommodate acute admission
- 1 Inappropriate for transfer (clinical/patient care reasons)

Stroke - No. of breaches, and Top 3 breach reasons (Financial YTD)

68

- 33 Challenging diagnosis
- 15 Patient stepped down to accommodate acute admission
- 9 No beds available

Key Points/Operational Actions

The Trust TIA target is at risk due to increased pressure on medical beds.

There have been a number of changes within the Stroke Service including a reduction in available personnel and a significant year on year rise in referrals. The impact has been a reduction in capacity and an increase in demand; consequently the Stroke Team has been unable to provide the same level of service as before. Urgent actions led by the Chief Operating Officer are being put in place to address this. These include;

A recent review of 50 case notes has shown that the number of 'mimic' cases referred to the team has risen so the Clinical Lead is now working with the GP leads to strengthen the referral pathway and better manage the growing volumes.
In conjunction with the case note review, the Clinical Director is working with the Medical Director and Chief Operating Officer to undertake a thorough medical workforce review and redesign to ensure there is sufficient capacity and a safe service is provided. This work will be completed by 9th May and a proposal presented to the Executive Team for consideration the following week.

Immediate action taken has been taking to mitigate the risk, this includes releasing the stroke team from their MAU commitments to gain additional capacity for TIA clinics. All referrals have also been clinically reviewed to ensure there are no patients being placed at risk.

Definitions

Percentage of Stroke patients that spend 90% of their hospital stay on the stroke unit (latest available data)

Stroke & TIA

TIA - Current Month's Performance

52.38%

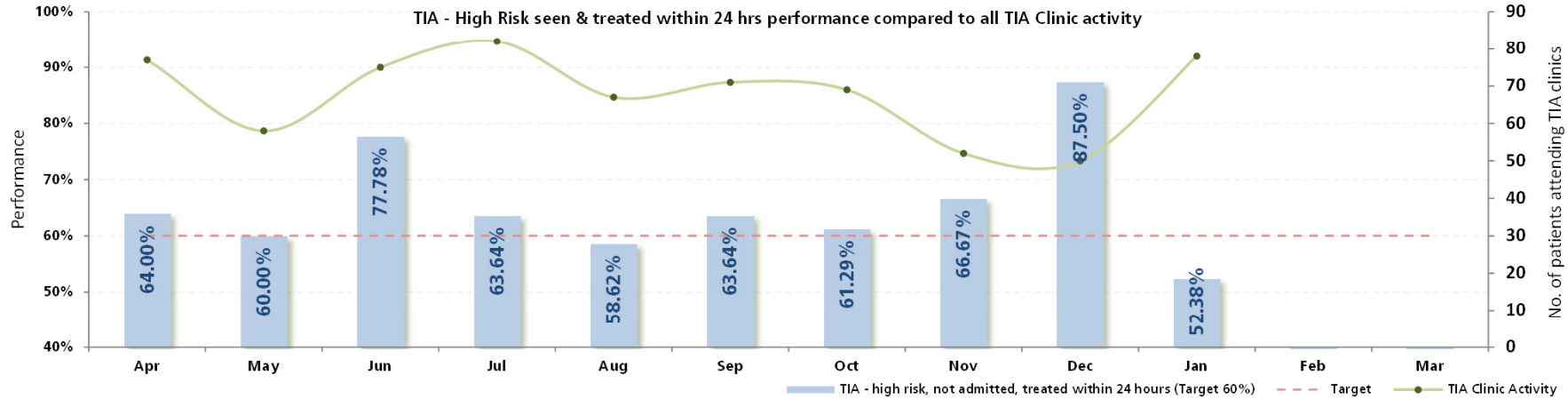
TIA High Risk, Seen & Treated within 24Hrs (Target 60%) ✗

TIA - Financial YTD

64.80%

TIA High Risk, Seen & Treated within 24Hrs (Target 60%) ✓

Graphs/Charts



TIA - No. of breaches, and Top 3 breach reasons (Latest Month)

10

- 4 Failed Date Scan
- 3 Failed Date Seen
- 3 Failed Date Doppler

TIA - No. of breaches, and Top 3 breach reasons (Financial YTD)

89

- 41 Failed Date Seen
- 26 Failed Date doppler
- 20 Failed Date Scan

Key Points/Operational Actions

The Trust TIA target remains at risk due to increased pressure on medical beds.

The service was temporarily stopped when there was a need to ensure high quality patient care on the wards. The Clinical Director / Lead Clinician, with the Clinical Nurse Specialist have reviewed all of the outstanding referrals. This was completed this week.

Going forward they have agreed a new approach which will ensure any new referrals for High Risk TIAs will be seen during the working day. Each day there will also be two "new" slots held for any referrals which are made outside core service hours to be seen. In addition there will also be 1 slot each day over the weekend for new referrals.

This does mean there is a risk in reliance on two key staff, however in addition to create further sustainability going forward an additional clinician has been asked to provide cover for other commitments to release time back into the stroke team as a whole.

Definitions

Percentage of High Risk TIAs that are seen and treated within 24 hours (latest available data)

Workforce

1.1 Vacancies – Following a number of national and international campaigns, nursing vacancies have fallen to 3.7% and although medical vacancies have fallen to 8.6%, they remain a concern. A group has been set up to look at specific hard to recruit areas and a number of initiatives such as international recruitment, redeployment packages, attendance at job fairs, return to practice and contacting leavers have been implemented.

1.2 Turnover has dropped to 10% and we continue to explore initiatives to improve retention. Apart from the staff survey action plan that focuses on improving staff satisfaction we are working with local Trusts to offer nursing professionals the chance to work across departments in different Trusts. We have introduced a nursing development programme for Band 5s and 6s and have also started a series of listening events with staff to identify key issues and a social committee has been formed.

1.3 A new process for capturing exit interview information is now in place which includes a shorter form available electronically and a wider group of staff including union reps available to carry out interviews. The figure has improved to 40.9% completion.

1.4 Sickness has been maintained at 4.8% and we have introduced monthly meetings for nursing departments which will monitor sickness, vacancy rates and e-rostering reports.

1.5 Appraisals – We have achieved the 92% compliance and we are now focusing on sustaining the rate and a drive to improve the quality of appraisals.

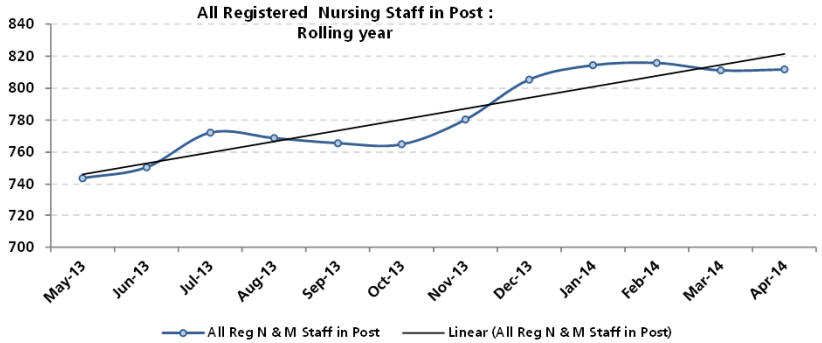
1.6 Mandatory training - The overall figure for core (pre-existing courses) is 87.39% and the focus is now on the new courses that were introduced last year means there has been significant progress with an overall average reached of 76% for all 23 components.

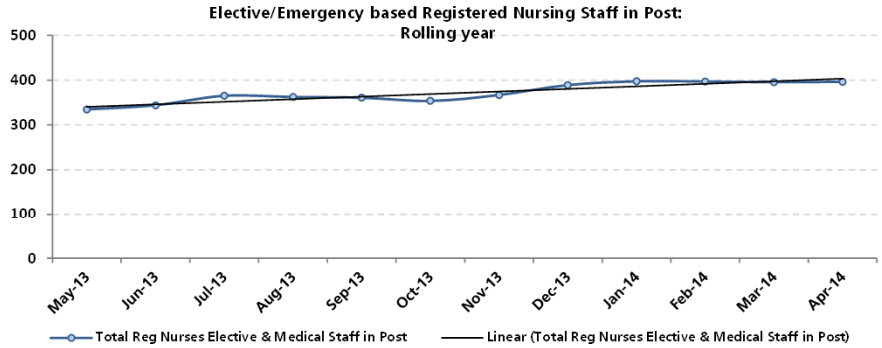
Workforce Scorecard

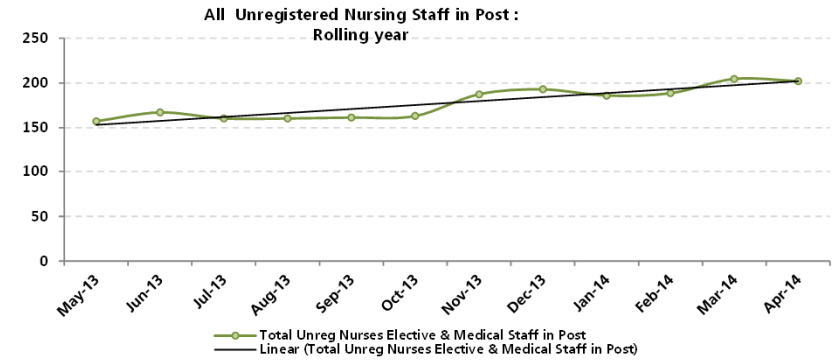
Workforce

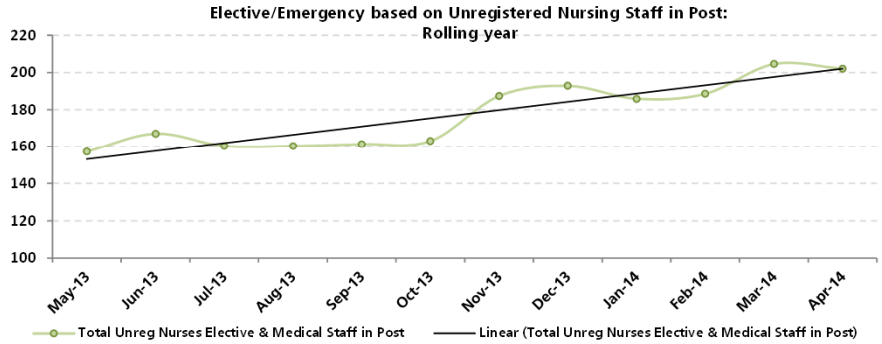
Indicators	Var to prev mth	Target	Feb	Mar	Apr	FYTD
Staff Sickness Turnover						
Sickness Absence Rate	⇩	4.7%	5.2%	4.8%	4.8%	4.7%
Staff Turnover Rate Complete Trust	⇧	10.0%	10.6%	10.2%	10.6%	10.7%
Staff Turnover Rate Medical & Dental	⇩	10.0%	17.3%	13.6%	13.0%	15.8%
Staff Turnover Rate Registered Nursing & Midwifery	⇧	10.0%	12.3%	11.6%	12.0%	13.2%
Staff Turnover Rate Allied Health Professionals	⇧	10.0%	14.6%	15.8%	16.5%	14.3%
Appraisals						
Appraisal Completeness excluding bank staff	⇧	90.0%	86.4%	91.4%	92.0%	86.4%
Vacancies						
Medical & Dental Vacancies (as % of Medical Posts)	Not available	5.0%	9.2%	8.6%	data not available	6.6%
Registered Nurses & Midwives Vacancies (as % of Nurse Posts)	Not available	6.0%	3.8%	3.7%	data not available	8.4%
Allied Health Professional Vacancies (as % of AHP Posts)	Not available	6.0%	10.0%	1.6%	data not available	1.5%
Contracted staff in Post (WTE)	⇧		2583	2599	2602.92	2521
Temporary Staff in Post (WTE)	⇧		209	221	238	199
Mandatory Training						
Conflict Resolution Training	⇩	70.0%	79.9%	81.5%	80.4%	75.7%
Consent Training	⇧	70.0%	37.9%	48.6%	53.1%	22.8%
Equality and Diversity Training	⇧	70.0%	78.2%	79.3%	79.7%	76.0%
Fire Training	⇧	70.0%	86.3%	86.6%	87.0%	83.4%
Health & Safety Training	⇩	70.0%	84.9%	85.7%	85.3%	84.1%
Incident Report Training	⇩	70.0%	84.9%	85.7%	85.3%	84.1%
Infection Control Training	⇧	70.0%	85.9%	86.5%	87.4%	79.7%
Information Governance Training	⇧	95.0%	87.1%	92.4%	94.0%	85.7%
Manual Handling Training	⇩	70.0%	78.8%	78.9%	78.5%	74.9%
Medicines Management Training	⇧	70.0%	68.0%	70.5%	72.4%	52.8%
Record Keeping Training	⇧	70.0%	59.8%	62.8%	63.9%	59.2%
Resuscitation Training	⇧	70.0%	84.2%	84.6%	85.0%	78.6%
Risk Management Training	⇩	70.0%	96.8%	96.8%	96.8%	96.8%
Safeguarding Adults Training	⇧	70.0%	92.5%	92.9%	93.6%	96.0%
Safeguarding Children Training	⇧	80.0%	93.4%	93.6%	94.4%	91.1%
Slips, Trips & Falls Training	⇧	70.0%	92.1%	92.2%	92.2%	90.0%
VTE Training	⇧	70.0%	77.5%	77.9%	78.6%	76.8%

Nursing staff









Key Points/Operational Actions

Following a number of national and international campaigns, nursing vacancies have fallen to 3.7% and although medical vacancies have fallen to 8.6%, they remain a concern. A group has been set up to look at specific hard to recruit areas and a number of initiatives such as international recruitment and redeployment packages are being investigated.

We have also introduced a nursing development programme for Band 5s and 6s.

Definitions

Number of leavers (HC) divided by average staff in post over previous 12 months. Permanent staff only.

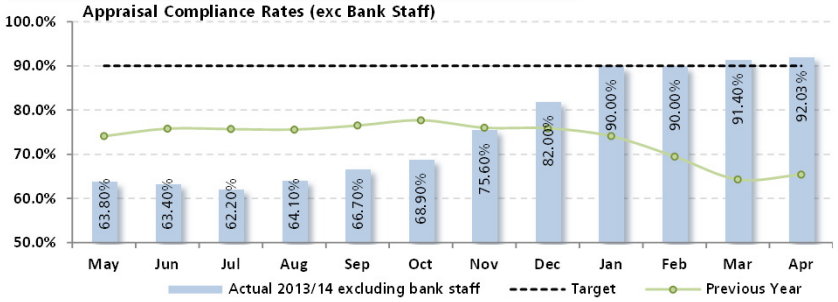
Appraisal

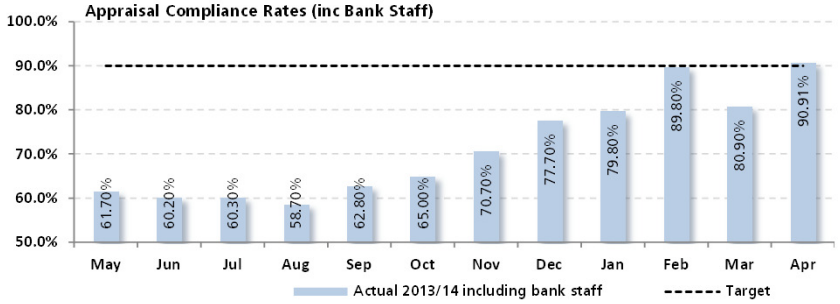
Current Month's Performance

92.03%

Appraisal Compliance
Exc Bank Staff (Target 90%) ✔

Graphs/Charts





Directorate/Service Group (includes bank staff)	% appraisal compliance rate	No. of overdue appraisals	Trend over last 12 months	Overdue by 18 months +	Overdue by 2 years +
Diagnostic Services	95.1	19	↑	4	4
Emergency Services	94.2	18	↑	4	2
Medical Services	90.0	22	↑	4	2
Oncology & Non Acute Services	93.5	8	↑	2	1
Patient Flow	93.1	2	↔	2	2
Specialist Surgical Services	94.0	3	↑	3	3
Surgical Services	91.2	10	↑	2	2
Theatre Services	95.9	9	↑	0	0
Women & Children Services	87.4	32	↑	6	6
Non Clinical Services	84.5	47	↑	10	8
Patient Experience	88.6	39	↑	2	1
Patient Safety	100.0	0	↑	0	0
Resources	95.7	6	↑	1	0
TOTAL	89.7	283	↑	63	44

Key Points/Operational Actions

We have achieved the 92% compliance and we are now focusing on on sustaining the rate and a drive to improve the quality of appraisals.

Definitions

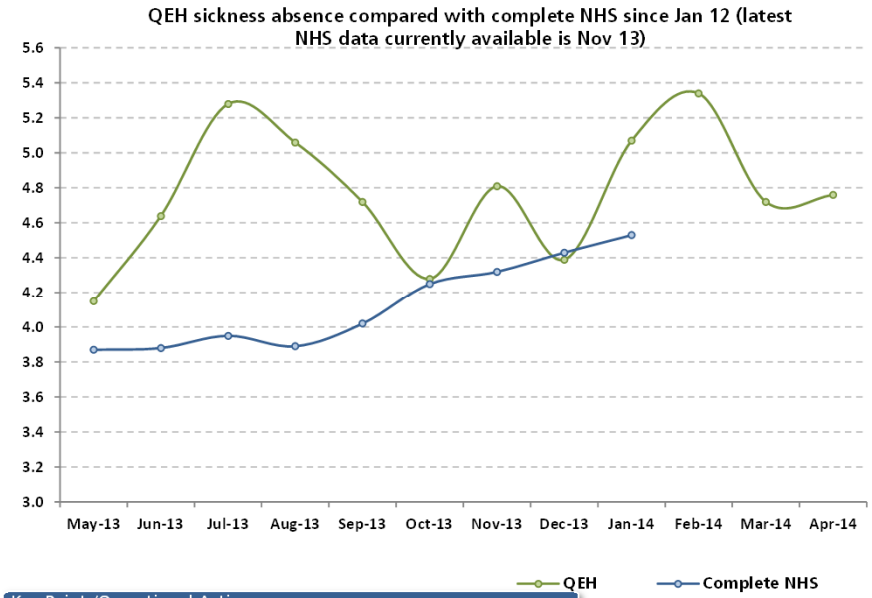
Percentage of staff (Headcount) including bank who have had an appraisal within previous 12 months.

Sickness Absence & Turnover

4.76%
Sickness Absence Rate (Target 4.7%) ✗

10.58%
Staff Turnover Rate Trust (Target 10.0%) ✗

Graphs/Charts



Sickness % absence by Service Group

Rank	Directorate/Service Group	% sickness rate	Trend over last 12 months
1	Theatre Services	6.8	↑
2	Patient Flow	6.6	↑
3	Surgical Services	6.1	↑
4	Medical Services	5.7	↓
5	Non Clinical Services	5.3	↑
6	Patient Experience	5.2	↓
7	Diagnostic Services	4.9	↑
8	Women & Children Services	4.4	↓
9	Specialist Surgical Services	4.1	↑
10	Emergency Services	3.9	↓
11	Resources	3.7	↑
12	Oncology & Non Acute Services	2.8	↓
13	Support Services (includes 123	2.2	↓
14	Patient Safety	0.8	↓
	TOTAL	4.8	↓

Key Points/Operational Actions

Sickness

Sickness has been maintained at 4.8% and we have introduced monthly meetings for nursing departments which will monitor sickness, vacancy rates and e-rostering reports.

Turnover

Turnover has dropped to 10% and we continue to explore initiatives to improve retention. Apart from the staff survey action plan that focuses on improving staff satisfaction we are working with local Trusts to offer nursing professionals the chance to work across departments in different Trusts. We have introduced a nursing development programme for Band 5s and 6s and have also started a series of listening events with staff to identify key issues and a social committee has been formed.

Definitions

Percentage sickness absence for the month. Based on FTE days absent divided by FTE days available

Mandatory Training

86.90%

Mandatory Training (Trust) ✔

Graphs/Charts

Subject	All Staff	Change from previous month	Clinical Staff	Non Clinical Staff	Date first reported
Fire	86.6	↑	86.1	87.6	Jul-10
Infection Control	86.5	↑	80.8	98.7	Jul-10
Resuscitation	84.6	↑	78.1	98.6	Jul-10
Safeguarding Children	93.6	↔	91.1	100	Jul-10
Information Governance	92.4	↑	90.5	96.5	Nov-10
Health & Safety	85.7	↑	90.2	76.1	Jul-10
Manual Handling	78.9	↑	72.8	93.3	Jul-10
Conflict Resolution	81.5	↑	75.5	94.4	Jul-10
Risk Management	96.8	↔	96.4	97.8	Jul-10
Safeguarding Adults	93.0	↑	90.3	98.8	Jul-10
VTE	77.9	↔	77.9	N/A	Apr-13
Consent	48.6	↑	48.6	N/A	Apr-13
Health Record Keeping	62.2	↑	62.2	N/A	Apr-13
Medicines Management	70.5	↑	70.5	N/A	Apr-13
Slips, Trips & Falls	92.2	↔	92.2	N/A	Apr-13
Equality & Diversity	79.3	↑	75.1	88.3	Apr-13
Dementia Awareness	68.2	↑	53.4	100	Sep-13
Mental Capacity	45.0	↑	45.0	N/A	Nov-13
Learning Difficulties	50.8	↔	50.8	N/A	Dec-13
Diabetes	44.5	↑	44.5	N/A	Dec-13
Privacy & Dignity	61.3	↑	61.3	N/A	Dec-13
Complaint Handling	14.5	↑	14.5	N/A	Jan-14
Average for 13 pre-existing subjects	86.9	↑	84.4	93.6	
Average for 9 new subjects	50.1	↑	50.1	100	
Average for all 22 subjects	72.5	↑	70.3	96.9	

Key Points/Operational Actions

Mandatory Training

Mandatory training - The overall figure for core (pre-existing courses) is 87.39% and the focus is now on the new courses that were introduced last year means there has been significant progress with an overall average reached of 76% for all 23 components

Definitions

Mandatory Training

Finance

KEY FINANCIALS - MONTH AND YEAR TO DATE

APRIL 2014					YEAR TO DATE			
Actual £000's	Plan £000's	Variance £000's	Variance %		Actual 2014/15 £000's	Plan 2014/15 £000's	Variance to Plan £000's	Variance to Plan %
				STATEMENT OF COMPREHENSIVE INCOME				
12,706	12,777	(71)	(0.6%)	Operating Income for EBITDA	12,706	12,777	(71)	(0.6%)
(10,248)	(10,230)	(18)	(0.2%)	Employee benefit expenses	(10,248)	(10,230)	(18)	(0.2%)
(3,295)	(3,408)	113	3.3%	Non Pay expenditure	(3,295)	(3,408)	113	3.3%
(837)	(861)	24	2.8%	EBITDA	(837)	(861)	24	2.8%
(1,556)	**(1,693)**	**137**	8.1%	**Net (Deficit)/Surplus**	**(1,556)**	**(1,693)**	**137**	8.1%
116	340	(224)	(65.9%)	CIP performance	116	340	(224)	(65.9%)
%	%	%		**Margins**	%	%	%	
(6.2%)	(6.3%)	0.1%		EBITDA Margin	(6.2%)	(6.3%)	0.1%	
(11.1%)	(11.5%)	0.4%		(Deficit)/Surplus Margin	(11.1%)	(11.5%)	0.4%	
				CAPITAL EXPENDITURE AND LIQUIDITY				
304	100	204		Capital Expenditure (accrual basis)	304	100	204	
1,339	(801)	2,140		Net cash flow	1,339	(801)	2,140	
3,303	1,164	2,139		Cash & cash equivalents - with PDC support	3,303	1,164	2,139	
1,403	(336)	1,739		Cash & cash equivalents - without PDC support	1,403	(336)	1,739	
(8,140)	(9,204)	1,064		Net current liabilities	(8,140)	(9,204)	1,064	
7.0	2.5	5		Days liquidity	7.0	2.5	5	
1,900	1,500	400		PDC drawdown	1,900	1,500	400	

1. Variances - favourable variances are positive figures, adverse variances are negative figures.
2. Operating income and expenditure figures exclude the income and expense of "pass-through" non-tariff drugs.

April performance

- EBITDA of negative £0.837m delivered versus plan negative £0.861m, favourable to plan.
- Actual deficit of £1.556m which is £0.137m favourable to plan.
- CIP savings delivered £0.116m, which is £0.224m adverse to plan.
- The closing cash balance stands at £3.3m, £2.1m favourable to plan. Public Dividend Capital of £1.9m was received in the month as cashflow support.
- Capital expenditure is £0.2m adverse to plan.

2014/15 Forecast Out-turn

- Year-end forecast deficit is as per plan at £15m
- Public Dividend Capital of £24m is planned and forecast to be required as cashflow support for the 2014/15 financial year.
- Capital expenditure forecast out-turn is as per plan at £10.1m.

Finance continued - Risks to Forecast

Risk	Mitigation
Achieving the day case and out-patient activity and income plans	• "Magic numbers" tool • Monthly performance review meetings
Delivering the full £6.7m recurrent CIP target	• detailed planning to align PMO schemes against gaps in service group plans
Clinical Commissioning Groups enforce contract penalties e.g. A&E, 18 weeks, c difficile	• PMO working with A&E to improve 4 hour wait performance • Monthly performance review meetings
Operational managerial capacity for delivery of key priorities	• Use of interims where appropriate • Permanent recruitment to key vacancies
Confirmation not yet received from DoH that the cash support required (£24m) will be made available.	DoH have been asked, via Monitor, for a "going concern" letter.

Key Actions

- **CIP planning and implementation pace needs to accelerate to enable successful delivery of the 2014/15 target. Specifically all areas need to supply delivery trajectories to the PMO. The additional opportunities require urgent prioritisation to bridge gaps in time for month 2 reporting.**

- **"Magic numbers" to be re-invigorated in line with the accountability agreements circulated to Service Groups.**

Definitions

National CQUINs

Goal No.	CQUIN	% split for each CQUIN	Indicator Description	Q1 Target	Q1 Actual	Q2 Target	Q2 Actual	Q3 Target	Q3 Actual	Q4 Target	Q4 Actual	Year end Target	2013/14 Final Indicator period	CQUIN Value - Plan (£)	CQUIN Value Forecast (£)	Lead
NATIONAL 1 Friends & Family Test	**Increased response rate**	40%	increasing response rate in acute inpatient and A&E areas. Achieve in top 50% which also improves on Q1 rate	15%	12.40%		10.88%		12.16%	> Q1 and at least 20%	18.90%	National Top 50% > Q1 >20% - **We achieved 18.9%**	End of March 14	£ 67,560.00	£ 67,560.00	C.Morgan
	Staff Friends & Family Test	30%	improved performance on the staff Friends & Family Test - Staff Satisfaction Theme		N/A		N/A		N/A	> 2012/13	RESULTS:- 12/13 FFT Q12d = 58.47% 13/14 FFT Q12d = 49.58%	Better results than 2012/13 - **We did not achieve this**	End of March 14	£ 50,670.00	£ 50,670.00	
NATIONAL 2 Safety Thermometer - Improvement	**Pressure Ulcers -** Number of patients recorded as having a category 2-4 pressure ulcer new, as measured using the NHS Safety Thermometer on the day of each monthly survey.	50%	First 6 months - Criteria to be met:- Median of 1.48 or lower for the first 6 months			**1.48 or lower** % of Target achieved - 80-95% = £40% 60-79% = £30% 40-59% = £20% 20-39% = £10% <20% = £0%	Apr - 2.99 May - 1.46 Jun - 1.76 Jul - 1.31 Aug - 1.73 Sep - 3.08 **Median = 1.74**					To maintain Q2 Median of 1.74 in the final 6 months. Expectations is to achieve below 1.76 - **We Failed to do this.**	End of March 14	£ 84,450.00	achieved 85% of Target = £40% £67,560.00	C.Morgan
		50%	Last 6 months - figure achieved in the first 6 months to be maintained in the final 6 months. Expectations is to achieve below 1.76							**1.76 or lower** % Target achieved - 80-95% = £40% 60-79% = £30% 40-59% = £20% 20-39% = £10% <20% = £0%	Oct - 2.21 Nov - 2.37 Dec - 1.56 Jan - 4.03 Feb - 2.2 Mar - 2.35 **Median Q4 = 2.36**			£ 84,450.00	Still waiting on confirmation of final payment from Commissioners	

Significant pressures on achieving

On track for milestones but final indicator not met as yet

Final indicator target being achieved

This is the status for Year End 2013/14.

2014-15 CQUIN update will be available next month.

Local CQUINs

Goal No.	CQUIN	% split for each CQUIN	Indicator Description	Q1 Target	Q1 Actual	Q2 Target	Q2 Actual	Q3 Target	Q3 Actual	Q4 Target	Q4 Actual	Year & Target	2013/14 Final Indicator period	CQUIN Valu (£)
LOCAL 7 Improved Breast Feeding Initiative	**Increasing the % of babies initiating breastfeeding at birth**	60%	A 2% increase on 2012/13 results of 67.3% to 69.3%	67.8%	Apr - 65% May - 69% Jun - 67% **Q1 = 67%**	68.3%	July - 71% Aug - 67% Sep - 65% **Q2 = 68%**	68.8%	Oct - 70% Nov - 64% Dec - 65% **Q3 = 67%**	Target Achieved: **>69.3% = 100%** >68.3% = 75% > 68% = 50%	Jan - 67% Feb - 71% Mar - 71% Overall % to date for this Qtr = 70% **2013/14 = 68% - 50% payment**	To achieve 69.3% by the end of Q4 to achieve 100% payment	E/O Mar 2014	£ 81,(
LOCAL 8 Staff Opinion & Empowerment -	**Staff Opinion & Empowerment - Staff Morale, Increased patient Satisfaction**	100%	1. Decrease sickness rate (ALL) 2. Reduce vacancy factor (Medical & Nursing) 3. Reduce staff unplanned turnover (Medical & Nursing) 4. Monitor all staff groups & report to CQRM Qrtly 5. Monitoring exit interviews							Decrease in all elements as agreed after Q1 data review	Still waiting for confirmation from the Commissioners regarding QEH proposal to proportionalise payment based on each element	To Decrease in all elements by Q4 - Data previously submitted - reviewed and re-submitted. Still waiting for confirmation from Commissioners that we are on track	E/O Mar 2014	£ 405,:
LOCAL 9 Discharge Planning	**Achievement of 4.1% increase of discharges before midday**	70%	To achieve 4.1% increase on baseline of 25.9% by Q2 and to maintain this in Q3 & Q4			30%	15%	30%	17%	30%	15%	To achieve 30% discharges before midday by Q4	E/O Mar 2014	£ 283,:
LOCAL 10 Stroke Mimic	**Stroke Mimic -** Development of the rosier scale to include on-going management of the patient following assessment in A & E	100%	Develop, Implement, Train and increase use of Rosier Scale in A & E	Develop Rosier Scale (20%)		Implement (to include training & pilot data collection) (20%)		Target 96.55% use of R.Scale in A&E (30%) 93% = £25% 94% = £50% 95% = £75% 96% = £100%	80%	Target 100% use of R.Scale in A&E (30%) 97% = £25% 98% = £50% 99% = £75% 100% = £100%	Confident that we have achieved - 100% - awaiting for confirmation from Commissioners	100% of all A & E staff to be trained in Rosier Scale	E/O Mar 2014	£ 270,:

Significant pressures on achieving

On track for milestones but final indicator not met as yet

Final indicator target being

This is the status for Year End 2013/14. CQUIN No. 7 & 10 have been removed completely from the 2014-15 Contract, CQUIN No. 8 & 9 will be reported as part of the Quality Schedule. 2014-15 CQUIN update will be available next month.

FT Integrated Action Plan

Presented as a separate item at the current Board Meeting - see agenda

Appendices

See attached doc - Appendix 1.pdf