The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS

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

Meeting Date: **February 2013**
Report Title: **Performance Report**

Purpose:

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

Summary:

The enclosed reports identify performance to February 2013 against the Trusts KPIs and where appropriate the forecast for year end March 2013, including the key risks to operational performance. The Monitor compliance framework position for quarter 4 is forecast as 1 (Amber / Green) due to the A&E 4 hour waiting time.

Financial Implications / Efficiency Savings / Quality Improvement:

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

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

Recommendations:
The Board is asked to;

a) Review performance achievement across the Trust and sign-off the performance report.

b) Note the Monitor Compliance framework position forecast at the end of the current quarter is 1 (Amber / Green) due to the A&E 4 hour waiting time.

c) Note the comments in relation to compliments, complaints and those that have been published on the NHS Choices website.

d) Identify any key issues requiring further consideration.

Author: Michael Brown
Date: 18 February 2013

Quality & Risk Dashboard Feb 13

Indicator	Target	Current Month	YTD	Trend
1.1 Crude Mortality	19	17	16	
1.2 RAMI	75.7	77	87	
1.3 SHMI*	100	N/A	99.3	
1.4 Net Promoter - Friends & Family Survey score	71	47.3		
1.4 Net Promoter - Friends & Family Survey Footfall (Inp)	10%	16.50%		
1.4 Net Promoter - Friends & Family Survey Footfall (A&E)	5%	4.0%		
1.8 MRSA	1 (YTD 1)	0	0	
1.9 CDIFF	30 (YTD 28)	2	17	
1.10 Serious Incidents Reported	0	7	80	
1.11 Never Events Reported	0	0	5	
1.12 Serious Medication Errors	0	0	0	
1.13 Falls Resulting in Serious injury	0	1	13	
1.14 Pressure Ulcers - Grade 3 H.A	0	6	66	
1.15 Pressure Ulcers - Grade 4 H.A	0	0	0	
1.16 Number of MSA Breaches (Number of Patients)	0	0	18	
1.17 Clinical Complaints	N/A	59	441	
1.18 Non-Clinical Complaints	N/A	1	47	
1.19 Compliments	N/A	74	1054	
1.20 Clinical Complaints - Communication	-5% vs 11/12	16 (7% Increase)	155 (22% Increase)	
1.21 Clinical Complaints - Staff Attitude	-5% vs 11/12	7 (-22% decrease)	101 (4% Increase)	
1.22 Safety Thermometer - No new harms	95%	95.8%	95.0%	
1.23 VTE Assessment Completeness*	90%	97.3%	97.1%	

*RAMI figure is shown 1 month in arrears

*SHMI figure is for period Apr - Mar 2012

CQC Concerns

1 moderate concern

Workforce Feb 13

Indicator	Target	Current Month	YTD
4.1 Sickness Absence Rate	3.7%	5.1%	4.5%
4.2 Staff Turnover Rate	10.0%	10.5%	9.4%
4.3 Appraisal Completeness %	90.0%	68.7%	73.8%
4.4 Fire Training	70.0%	86.0%	82.6%
4.5 Infection Control Training	70.0%	79.5%	77.9%
4.6 Resuscitation Training	70.0%	78.7%	80.6%
4.7 Safeguarding Children Training	80.0%	90.0%	88.3%
4.8 Safeguarding Adults Training	70.0%	96.8%	95.6%
4.9 Information Governance Training	95.0%	92.0%	92.0%
4.10 Nurse Vacancies (as % of Nurse Posts)		10.0%	7.4%
4.11 Medical Vacancies (as % of Medical Posts)		3.9%	3.5%
4.12 Contracted People in Post (WTE)	0	2475	2550
4.13 Temporary Staff in Post (WTE)	139	179	157

* This figure includes the removal of staff transferred under the EPA arrangement. The target figure will be recalculated by fiannce to include this reduction from April 2013.

Performance & Standards Feb 13

Indicator	Target	Current Month	YTD	Trend
3.1 Monitor Compliance Framework Score	0	1	1	
3.2 18 Weeks - Admitted 95th Percentage*	90%	92.6%	93.2%	
3.3 18 Weeks - Non Admitted 95th Percentage*	95%	99.0%	98.9%	
3.4 Cancer - 31 Days Subsq Treatment - Surgery*	94%	100.0%	99.5%	
3.5 Cancer - 31 Days Subsq - Drug Treatments*	98%	98.6%	99.8%	
3.6 Cancer - 62 Days Referral to Treatment	85%	89.2%	86.4%	
3.7 Urgent GP Cancer - 2 Week Wait*	93%	97.0%	97.3%	
3.8 Cancer - 31 Days Diagnosis to Treatment*	96%	100.0%	99.3%	
3.9 A&E 4 Hour Attendance	95%	83.1%	94.3%	
3.10 MRSA Screening - All Elective Inpatients	100%	100.0%	100.0%	
3.11 Choose + Book - Slot Utilisation	90%	73.0%	71.9%	
3.12 Stroke - 90% of Stay on a Stroke Unit*	80%	64.5%	87.6%	
3.13 Stroke - High Risk TIA treated in 24 Hrs*	60%	51.5%	75.4%	
3.14 Cancelled Ops	0.8%	1.1%	0.9%	
3.15 Readmission Rate - Elective	2.7%	3.1%	3.9%	
3.16 Readmission Rate - Emergency	9.1%	9.8%	11.2%	
3.17 Diagnostic Over 6 Week Waiters	1%	0.2%	0.2%	

Operational Efficiency

Indicator	Target	Current Month	YTD	Trend
3.18 Day Case Rate	82%	92.6%	85.0%	
3.19 Basket of Daycase Procedures	80%	90.4%	82.4%	
3.20 New to Review Rate	2.3	2.5	2.5	
3.21 DNA Rate	5%	4.3%	5.2%	
3.22 EL LOS	2.2	2.1	2.1	
3.23 EM LOS	5	4.1	4.7	
3.24 Total LOS	4.3	3.9	4.3	

Cancer, Stroke, TIA & VTE figures are shown a month in arrears, this months figures shows Jan 13 information

Finance Feb 13

NHS Clinical Revenue (Excl Non PbR Drugs) By Point of Delivery	Current Period						Year To Date (YTD)						Operational Recovery Plan
	ACTIVITY			FINANCE			ACTIVITY			FINANCE			
	Actual	Plan	Variance	Actual £000s	Plan £000s	Variance £000s	Actual	Plan	Variance	Actual £000s	Plan £000s	Variance £000s	Board 29/10/12 Var £000s
Out-patients	25,358	24,369	989	2,854	2,669	185	273,260	278,462	(5,202)	29,951	30,558	(607)	(111)
Day cases	2,772	2,699	73	1,744	1,651	93	30,454	30,220	234	18,469	17,931	538	341
Elective In-patients	299	387	(88)	570	905	(335)	4,825	5,040	(215)	10,692	11,778	(1,086)	(30)
Elective Excess Bed Days	45	82	(37)	10	19	(9)	747	1,012	(265)	174	237	(63)	(74)
Planned Total Income				5,178	5,244	(66)				59,286	60,504	(1,218)	126
A&E	4,141	4,376	(235)	420	440	(20)	50,993	52,234	(1,241)	5,046	5,257	(211)	
Non-elective In-patients	2,415	2,554	(139)	4,064	3,988	76	28,076	28,768	(692)	45,846	46,394	(548)	
Non-elective Excess Bed Days	1,144	1,351	(207)	256	307	(51)	12,477	15,905	(3,428)	2,864	3,614	(750)	
Emergency Threshold Cap		0		(467)	(335)	(132)				(3,346)	(3,965)	619	
Unplanned Total Income				4,273	4,400	(127)				50,410	51,300	(890)	
Critical Care	629	614	15	536	486	50	8,042	7,652	390	6,200	5,962	238	
Direct Access	45,576	39,888	5,688	502	409	93	472,826	438,596	34,230	5,157	4,488	669	
CQUIN				255	287	(32)				2,960	3,155	(195)	
Patient Transport				62	26	36				634	287	347	
Winter Pressures Funding				14	0	14				169	0	169	
Other				753	722	31				7,392	7,550	(158)	
Other Clinical Total Income				2,122	1,930	192				22,512	21,442	1,070	
Total NHS Clinical Revenue (Excl Non PbR Drugs)				11,573	11,574	(1)				132,208	133,246	(1,038)	

		Full Year Plan £m	Full Year Forecast £m	Forecast Vs Prev Month	YTD Plan £m	YTD Actual £m	Variance Change to Prev Month	Current Month Plan £m	Current Month Actual £m
2.1	Surplus	1.6	(1.0)	↓	1.5	0.3	↓	(0.1)	(0.4)
2.2	EBITDA	8.8	6.4	↓	8.0	6.4	↓	0.6	0.2
2.3	Cash Balance	6.3	4.6	↔	6.5	12.9	↑	6.5	12.9
2.4	BSP - Overall Position	10.2	6.7	↔	8.8	5.8	↓	1.4	0.8

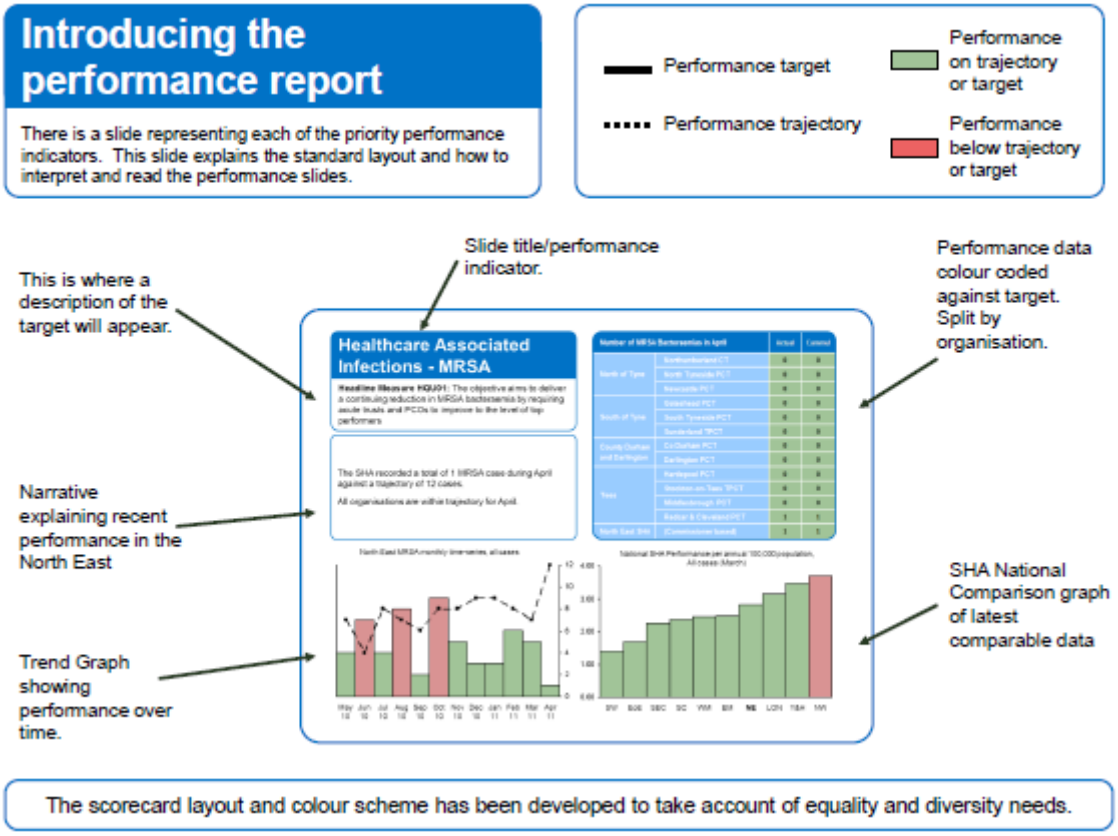
		Full Year Plan	Full Year Forecast	YTD Plan	YTD
2.5	Finance Risk Rating	3	2	3	2

Explaining the Performance Report

This performance report is provided to give an update to the Trust Board of Directors on the key areas of performance to January 2013 and the associated forecast to the end of the current quarter. The current report identifies key performance indicators linked to the four key governance areas within the Trust;

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

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



Barbara Cummings
Director of Performance and Informatics

1 EXECUTIVE SUMMARY OF PERFORMANCE

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

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

The **Quality and Risk** section of the report includes the Trust Mortality position and how patients view the Trust. The Trust mortality position is currently 77.0 for the current month and 87.0 year to date which is above the internal target of 75.7, this is also below the national expected position. The Trust received 59 clinical complaints out of a total of 60 complaints and there were 74 compliments across the Trust in the month. The Trust has reported 6 Grade 3 pressure ulcers in the month but no Grade 4 being reported.

The Trust has reported 7 serious incidents in the current month, which means that there have been 80 reported year to date. There were 0 never events for the current month, which means there are 5 never events year to date. An update on those still open is provided within the Report.

The Trust latest CQC report following a visit in August 2012 has been published on the CQC website during December. This has been reported separately to the Trust Board.

The **Performance and Standards** section of the report highlights performance against national and local KPI's, along with the Trust position against the Monitor compliance framework.

The Trust achieved the following key targets: -

- All Cancer Targets
- MRSA Screening – 100% against a target of 100%
- Daycase Rate – 92.6% against a target of 82%
- Basket of Daycase Procedures – 91.2% against a target of 80%
- Emergency length of stay – 4.1 against a target of 5.0
- Elective length of stay – 2.1 against a target of 2.2

However, the Trust did not achieve: -

- A&E 4 Hour Attendance
- The national target for the admitted 18wk RTT for Plastics and Gynaecology
- 18 week RTT Incomplete pathways for Gynaecology
- Choose & Book
- Cancelled Operations
- Stroke – 90% of stay on the Stroke Unit – 64.5% against a target of 80%
- TIA – High risk, not admitted, treated within 24 hrs – 51.5% against a target of 60%

The Trust did not achieve on internal indicators:-

- Readmission rates
- New to Follow up ratio

The Workforce scorecard highlights that the Trust Sickness absence rate for the month is above the target of 4.7% at 4.8% (4.5 YTD), with the reasons for absence highlighted. It also focuses on appraisal completeness across the Trust which is 73.0% below the target of 90% and the annual requirement for Information Governance Training which stands at 92%.

Monitor has completed its review of Q3 2012-13 submissions from NHS Foundation Trusts and is now publishing the results of its Q3 monitoring exercise to NHS Foundation Trusts. A formal letter has been received and can be found in appendix 2.

Recommendations

The Trust Board are asked to;

a) Review performance achievement across the Trust and sign-off the performance report.

b) Note the Monitor Compliance framework position forecast at the end of the current quarter is 1 (Amber / Green) due to the A&E 4 hour waiting time and the likely impact on it achieving the year to date A&E target.

c) Note the comments in relation to compliments, complaints and those that have been published on the NHS Choices website.

d) Identify any key issues requiring further consideration.

2 QUALITY AND RISK

The Trust's performance against its Quality and Risk KPIs was varied. For a number of indicators performance was below target level.

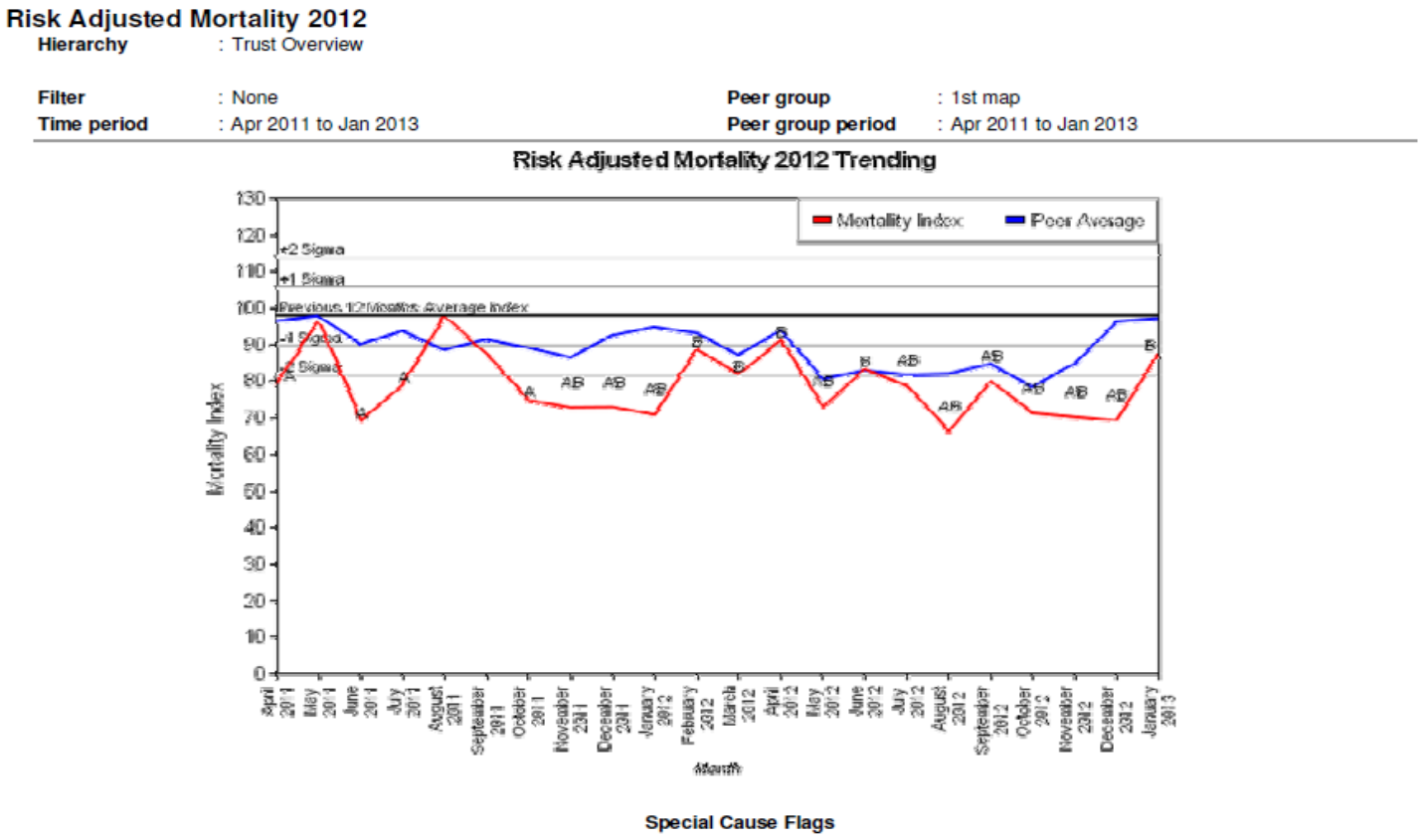
There were zero Never Events reported in the current reported month.

While the Trust is working hard to maintain its performance towards eliminating hospital acquired pressure ulcers 6 Grade 3 were reported in February.

Patient feedback from the monthly 'Friends and Family' survey is below the 71% target identified by NHS Midlands and East and is reported at 47.3% for the current month (45.9 for August, 45.4 for September, 49 for October, 44.7 for November, 50.7 for December and 50.1 for January). The Trust continues to meet the 10% footfall target of respondent's, which is part of a CQUIN target and is currently 12.6%.

2.1 Trust Mortality

The Trust's RAMI performance over the past 18 months is shown in the graph below:-



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

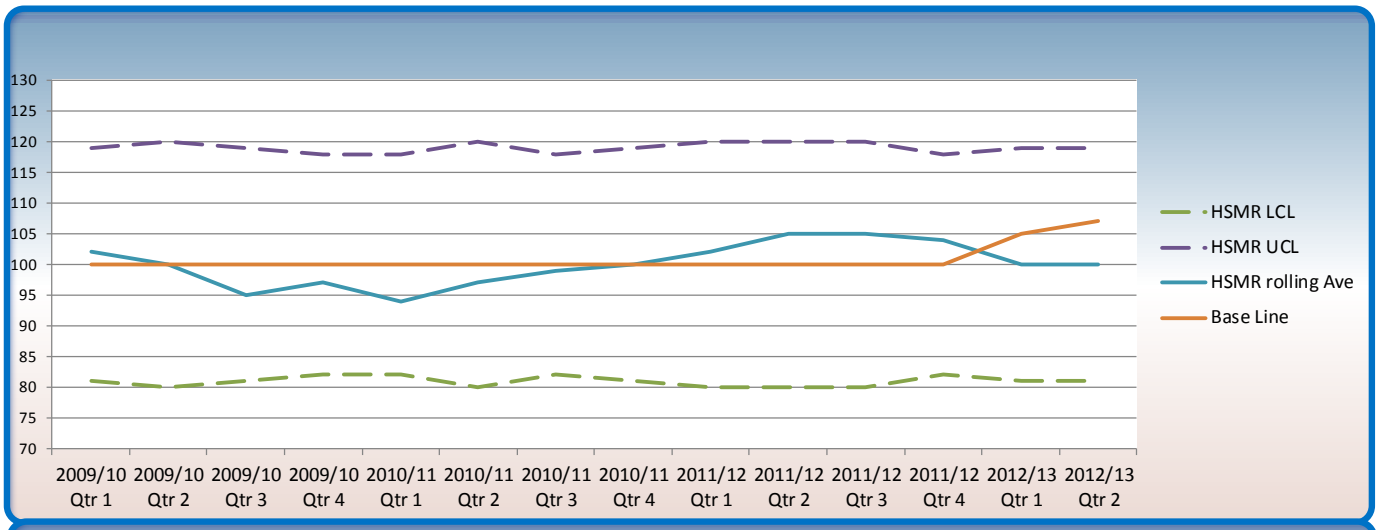
- Crude mortality per 1,000 admissions in February 2013 = 17.0 (target achieved)
- RAMI in January 2013 = 77 (target achieved)

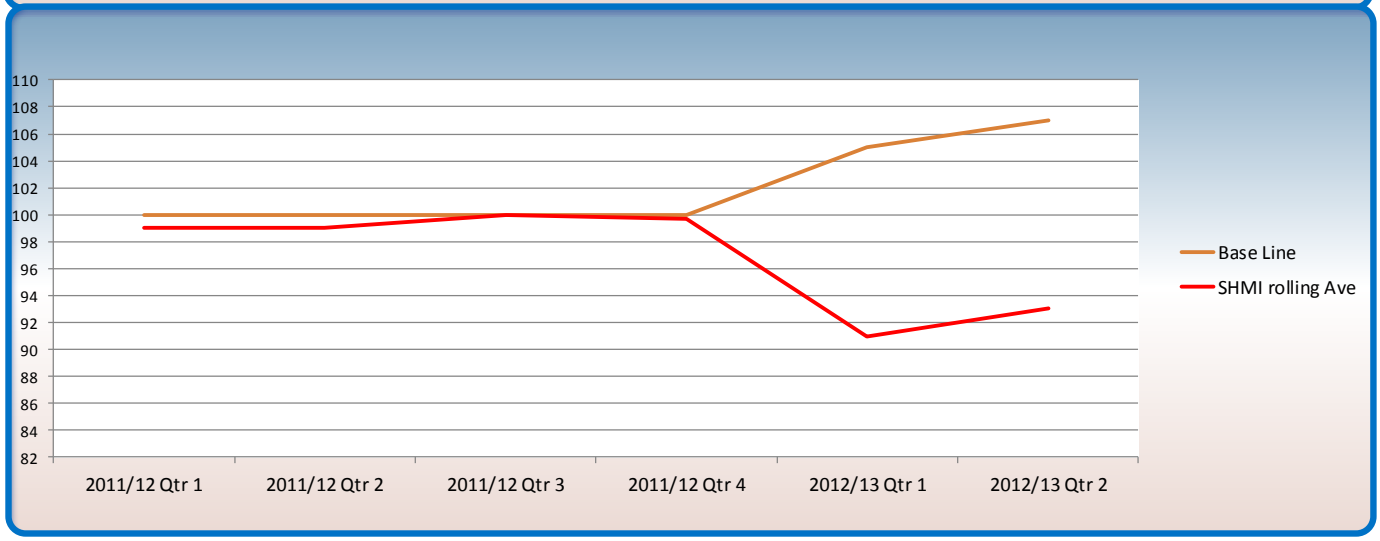
HSMR and SHMI Trend for the Queen Elizabeth Hospital

Alongside the RAMI, the Trust is continuing to monitor the HSMR of the Trust. The first graph below shows the latest position available.

The Trust is also monitoring the SHMI. The bottom graph shows this position as published by the Information Centre.

Neither graph is alerting the Trust of any issues at this level.





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

Operational Actions

The Clinical Outcomes Group continues to monitor mortality trends and commissions specific audits where deaths from a specific diagnosis or HRG appear to be greater than expected. At present, the Group has not identified any specific concerns related to any trends in mortality but will continue to monitor this. The Trust is in the process of developing patient safety reports with CHKS for the new service lines, which will include mortality trends. Training will be provided for the new Clinical Directors in the new financial year enabling them to conduct more detailed analysis of any patient safety alerts.

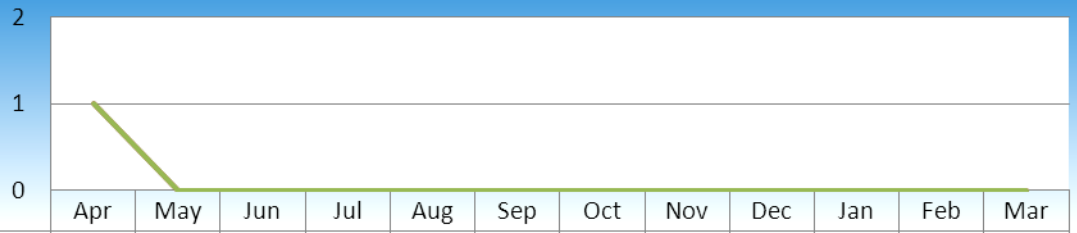
2.2 Hospital Acquired Infections

Healthcare Associated Infections - MRSA

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

The Trust reported 0 MRSA Infections in February 2013. Performance year to date is 0.

MRSA position 2012/13



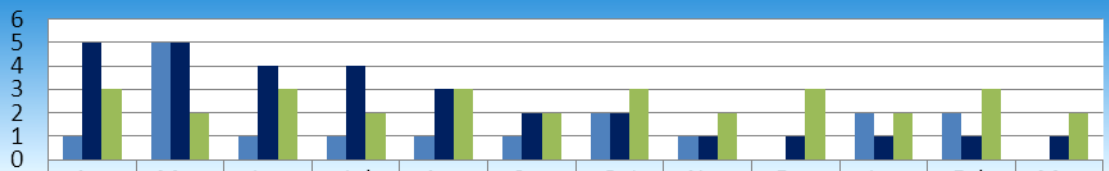
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	0	0	0	0	0	0	0	0	0	0	0	
Commisioner Target	1	0	0	0	0	0	0	0	0	0	0	0
Monitor Target	1	0	0	0	0	0	0	0	0	0	0	0

Healthcare Associated Infections - C -difficile

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

The Trust reported 2 Clostridium Difficile infections in February 2013.
Cumulatively the number of infections reported is 17 against a monitor trajectory of 28, and the Commissioner agreed trajectory of 29

CDIFF Position 2012/13



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	1	5	1	1	1	1	2	1	0	2	2	
Commisioner Target	5	5	4	4	3	2	2	1	1	1	1	1
Monitor Target	3	2	3	2	3	2	3	2	3	2	3	2

Operational Actions

The Trust remains below trajectory for MRSA and Clostridium Difficile with infections being closely monitored by the Director of Patient Experience and the Head of Nursing and Non-Medical professionals.

2.3 Patient Experience

Patient Experience

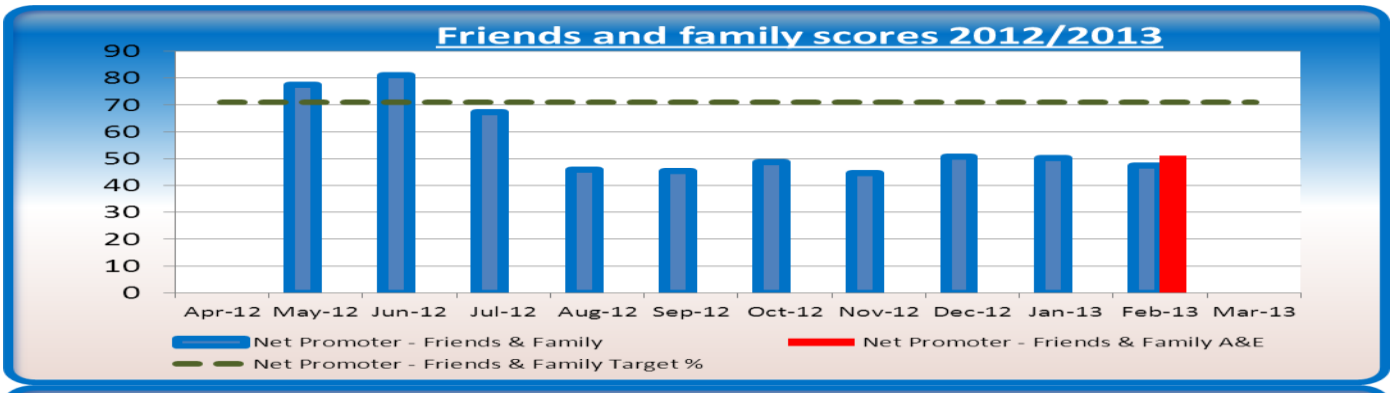
Headline Measure HQU04: The Friends and Family Test (Net Promoter Score) for January 2013

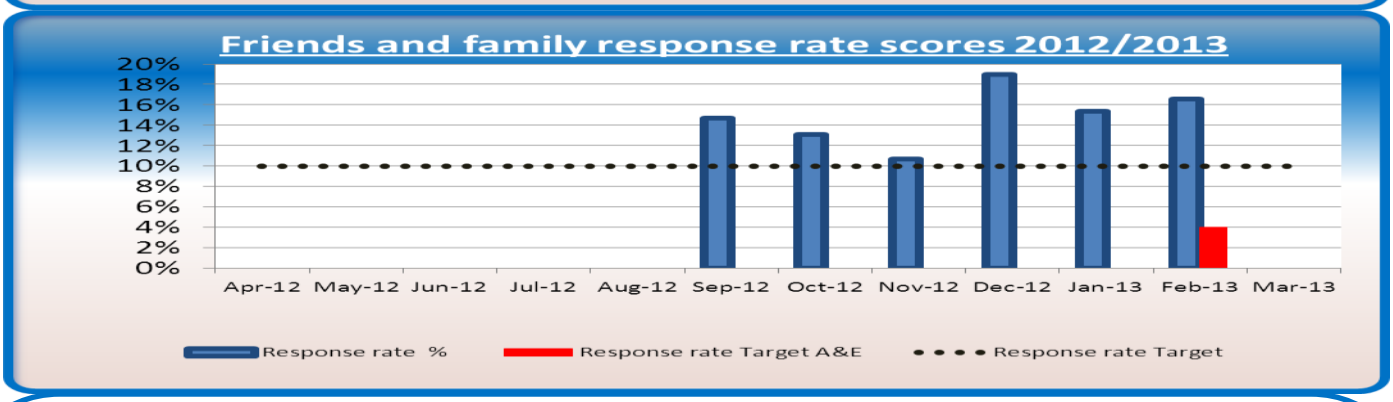
There were no new comments posted on the NHS Choices or Patient Opinion websites Appendix 4,5,6 provide A feedback letter and details on the Acute readiness report and the A&E readiness report

The FFT score for the wards was 47.3 with a response rate of 16.5% and for A & E the score was 51 with a response rate of 4.0%. The targets set by NHS Midlands and East are a score of 71 and a response rate of 10% for the wards. Targets for A & E have not yet been set. A graph showing the scores and response rates for May to February 2013 is shown below

Prior to the launch of the NHS Friends and Family test nationally on 1st April all acute Trusts were visited by a company called Fre3dom Health. The aim of the visit was to provide assurance that Trusts had robust plans in place to meet the 1st April introduction.

The Trust has scored 100% compliance in all areas. The one area identified as red within the report relates to the framing of the question and this is being rectified by the contractor who is managing the service on our behalf.





Operational Actions

The Friends and Family Test looks at how likely a patient is to recommend this service to their friends and family. At appendix 3 there is a report on the Trusts visit from the Department of Health. The Trust is implementing the following actions to support this:

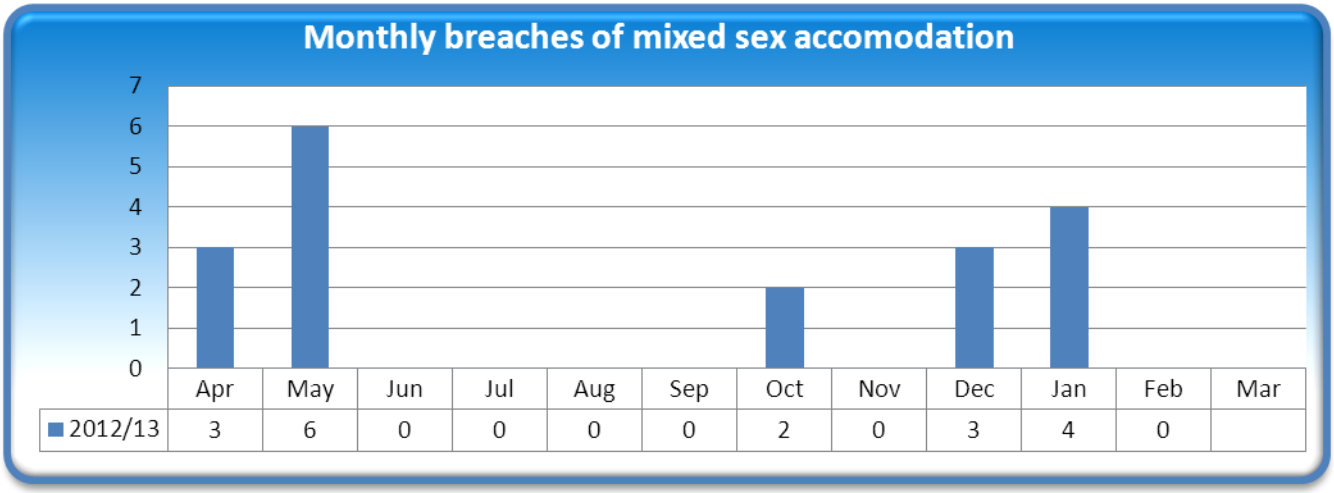
- From 1 February 2013 began using a new provider for the analysis of this test whose score cards include a space in which patients may leave free text comments. It is expected that the addition of this facility will enable us to be clearer about what patient's value about our services which we can then replicate in other wards and what areas they feel could be improved so that we can take action to deal with these.
- Also, from 1 February, we are trialling this test in A&E prior to its national roll-out from 1 April.
- The new company analyses the results for the A & E department and by ward using a score out of 5. In February the average score for the whole Trust was 4.5: the top scoring wards with 5 points each were West Raynham, Stanhoe and the Neonatal Intensive Care Unit. The summary of results is shown on the above graph.
- The results arising from the FFT and from this additional analysis are being made available to the Quality, Risk and Audit Standards Committees, the Senior Clinical Nurses meeting and to the A & E department and to the wards directly.

Mixed Sex Accommodation

Mixed Sex Accommodation

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

The QEH recorded 0 breaches for February 2013.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	3	6	0	0	0	0	2	0	3	4	0	

Operational Actions

There were 0 MSA breaches for February 2013. The Trust has reported 18 breaches year to date.

2.5 Complaints

Complaints

Headline Measure: Complaints activity by service line

Complaints Report February 2013

The Trust received 60 formal complaints during the month of February 2013, which was an 11.1% (54 last month) increase in comparison to the previous month. The number of formal complaints received in February 2013 is 15.4% (8) higher than the number of formal complaints received in the same period in 2011/12.

Of the 60 formal complaints received in February 2013, a total of 86 issues were raised.

60 complaints were clinical and the themes identified for this month were 12 clinical complaints related to Communication, 9 were in relation to Cancellations (cancelled surgery) and 6 were regarding staff attitude. There were no non clinical complaints received.

The Trust has received two requests from the Health Service Ombudsman to review in February 2013. Patient records were sent out and a decision on whether they are to proceed to investigate will be received in due course.

The performance by Service line has been awarded a red, amber or green indicator for the month December. 68% (25 out of 37) of the complaints received during this period were responded to within the target of 30 working days. There were 12 complaints that did not meet the required target and where chased regularly and reported to the Department Heads for support.

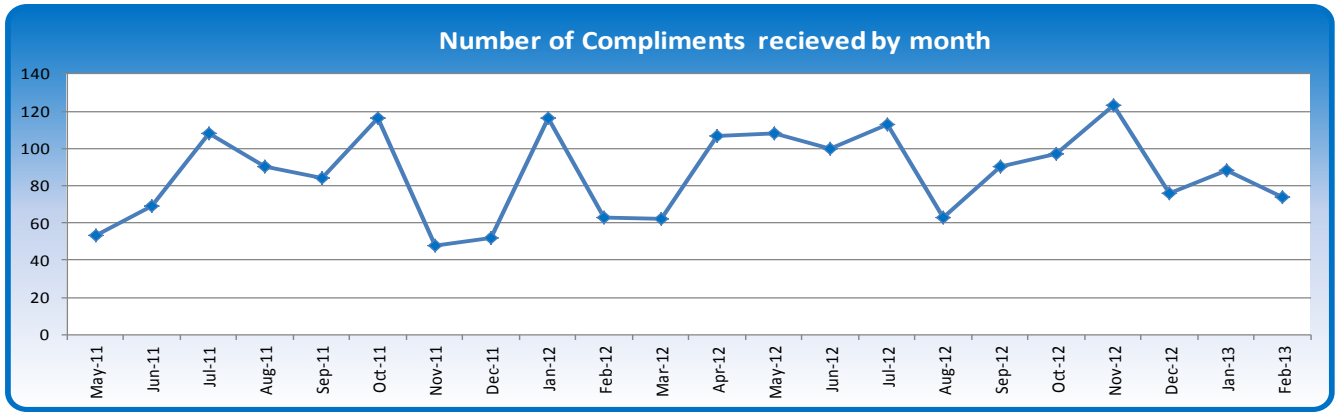
As part of the Trusts Quality Strategy Implementation programme 2012/13 we aim to reduce the number of clinical complaints for the top scoring areas of communication & staff attitude by 5% which equates to:

- a reduction of 6 clinical complaints relating to communication based on last year – from 127 to 121
- a reduction of 5 clinical complaints relating to staff attitude based on last year – from 102 to 97

		Current Month			Year to date		
Clinical Complaints	Target	11/12	12/13	Percentage	11/12	12/13	Percentage
Communication	-5%	15	16	7%	127	155	22%
Staff Attitude	-5%	9	7	-22%	97	101	4%

There were 74 written compliments received by the Trust during February 2013, this was a decrease of 15.9% compared to 88 in January 2013.

Divisional Activity in February 2013						Divisional Performance in December 2012			
Service Line	Formal Complaints	Compliments	Informal Contacts	Compliments : Formal Complaints Ratio	Number of cases referred to Parliamentary and Health Service Ombudsman (PHSO)	First Response date Target Met	Number of conciliation meetings	Number of complaints upheld	Number of returning complaints where first response targets were provided
Accident & Emergency	4	8	0	2:1		4 of 5			
Anaesthestics	0	0	0						
Audiology	0	0	0						
Breast Care	0	4	0						
Breast Screening	0	0	0						
Car Parking	0	0	0			2 of 2			
Cardio Respiratory Dept	0	0	0						
Cardiology	0	1	0				1		
Clinical Haemotology	0	0	0						
Critical Care	0	5	0						
Care of the Elderly	2	3	0	1.5:1					
Cancer Servives	0	1	0						
Dermatology	1	0	0						
Day Surgery	0	0	0						
Diabetes	2	0	0						
Orthodontics	0	0	0						
ECG/EEG	0	0	0						
Endoscopy	0	0	0						
ENT	1	0	1			1 of 2		2	1
Estates	0	0	0			1 of 1		1	
Gastroenterology	0	1	0						
General Surgery	9	11	0	1.2:2	1	2 of 5	2	5	
Gynaecology	0	0	0						
Human Resources	0	0	0						
Medical Assessment Unit	4	1	0	0.25:1					
Medical Day Unit (West Walton)	0	0	0			0 of 1			
General Medicine	2	11	0	5.5:1	1				
Legal Services	0	0	0						
Midwifery	1	1	0	1:1		0 of 2	1	2	
Neonatalology	0	7	0						
Neurology	2	0	0			1 of 1			
Obstetrics & Gynaecology	7	0	0				3		
Occupational Health	0	0	0						
Occupational Therapy	0	0	0						
Oncology	1	0	1			1 of 1		1	
Ophthalmology	2	0	0						
Trauma & Orthopaedics	3	1	0	0.33:1		4 of 4	1	2	
Outpatients	2	0	0						
Paediatrics	2	0	0			1 of 1	1		
Pain Management	1	0	0			1 of 1			
Palliative Medicine	0	0	0						
PALS	0	1	0						
Pathology	0	0	0						
Pharmacy	0	0	1						
Patient Services	9	0	0			1 of 1			
Performance & Informatics	0	0	0						
Portering Services	0	0	0						
Radiology	0	0	0			1 of 1			
Respiratory	2	9	0	4.5:1		1 of 1			
Rheumatology	0	0	0			1 of 1		1	
Security	0	0	0						
Stroke	0	1	0			0 of 3	1	1	
Surgical Assessment Unit	1	0	0			1 of 2	1	2	
Terrington - Short Stay	0	5	0						
Trust wide	2	3	0	1.5:1					
Urology	0	0	0			2 of 2		2	
TOTAL	**60**	**74**	**3**	**1.23:1**	**2**	**25 of 37**	**11**	**19**	**1**


Number of Compliments recieved by month
140
120
100
80
60
40
20
0
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
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Aug-12
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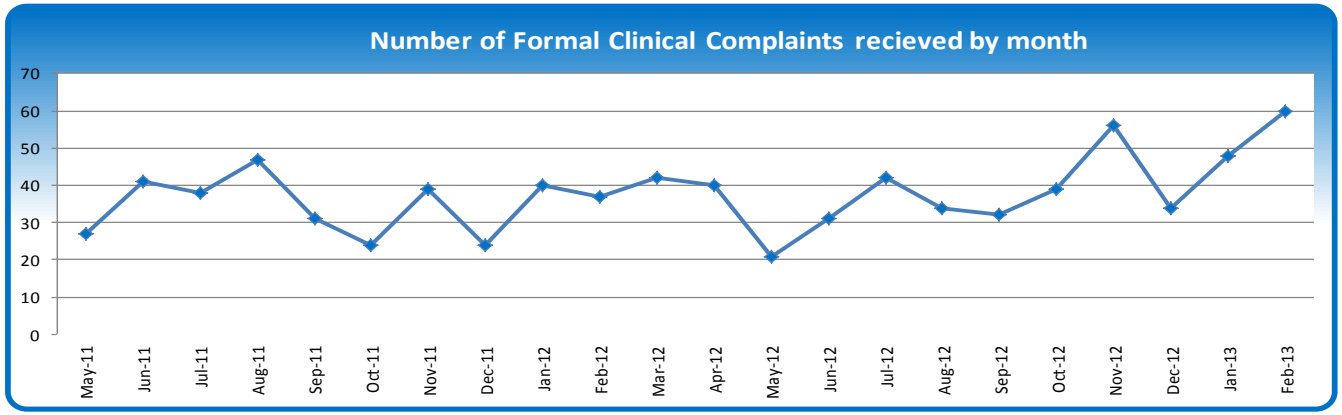
Nov-12
Dec-12
Jan-13
Feb-13


Number of Formal Clinical Complaints recieved by month
70
60
50
40
30
20
10
0
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
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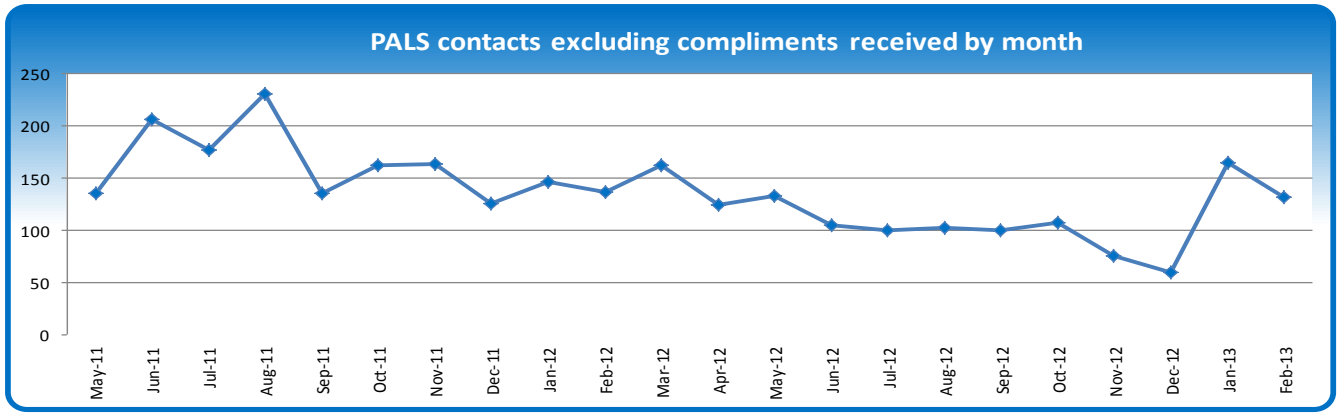
Nov-12
Dec-12
Jan-13
Feb-13


PALS contacts excluding compliments received by month
250
200
150
100
50
0
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13

2.6 Never Events and Serious Incident Reporting

Never Events Reported To Date

The Trust has identified 5 Never Events year to date. These were as follows;

- June 2012 Retained Swab
- August 2012 Retained Swab
- August 2012 Incorrect Medication
- September 2012 Wrong Site Surgery
- November 2012 retained guide wire

Open Serious Incidents as at 31/01/2013

As at 28th February 2013, YTD there were 24 open incidents (50 closed).
A total of 6 new serious incidents were reported during February.

Pressure Ulcer update February 2013

During February we have continued to roll out the work of the SHA pressure ulcer collaborative across the Trust. Denver, Elm, SAU, Necton and Tilney are now involved with the support of the ward sisters, matrons and PDNs in those areas.

The Trust is looking to purchase turning clocks to hang at the bedsides of at risk patients as a visual reminder of when the patient was last moved. These clocks were found very helpful when piloted in a homemade format on Stanhoe and have been requested by several ward managers.

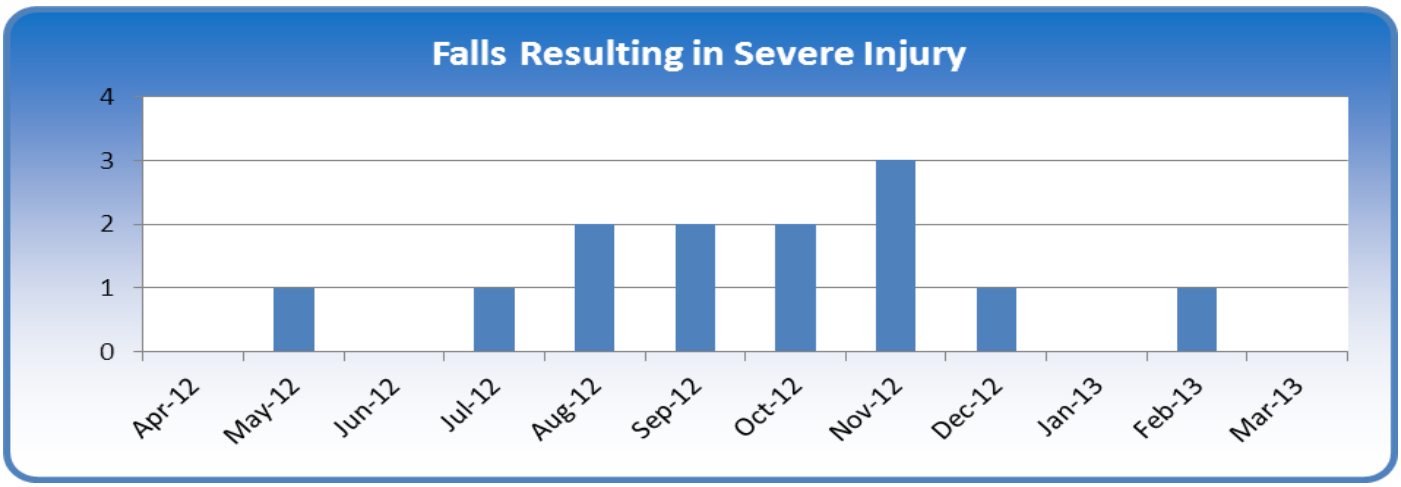
All pressure ulcers continue to be checked by the TVNs with the RCAs being reviewed at the pressure ulcer forum and then any actions escalated to the divisional QRS meetings.

2.7 Falls

Falls Resulting in a Severe Injury

Number of falls resulting in a severe injury during the month

The Trust reported that there was 1 fall where severe harm was caused for February 2013.



Operational Actions

1 fall reported for February 2013. This took place on Pentney Ward. A root cause analysis investigation is underway

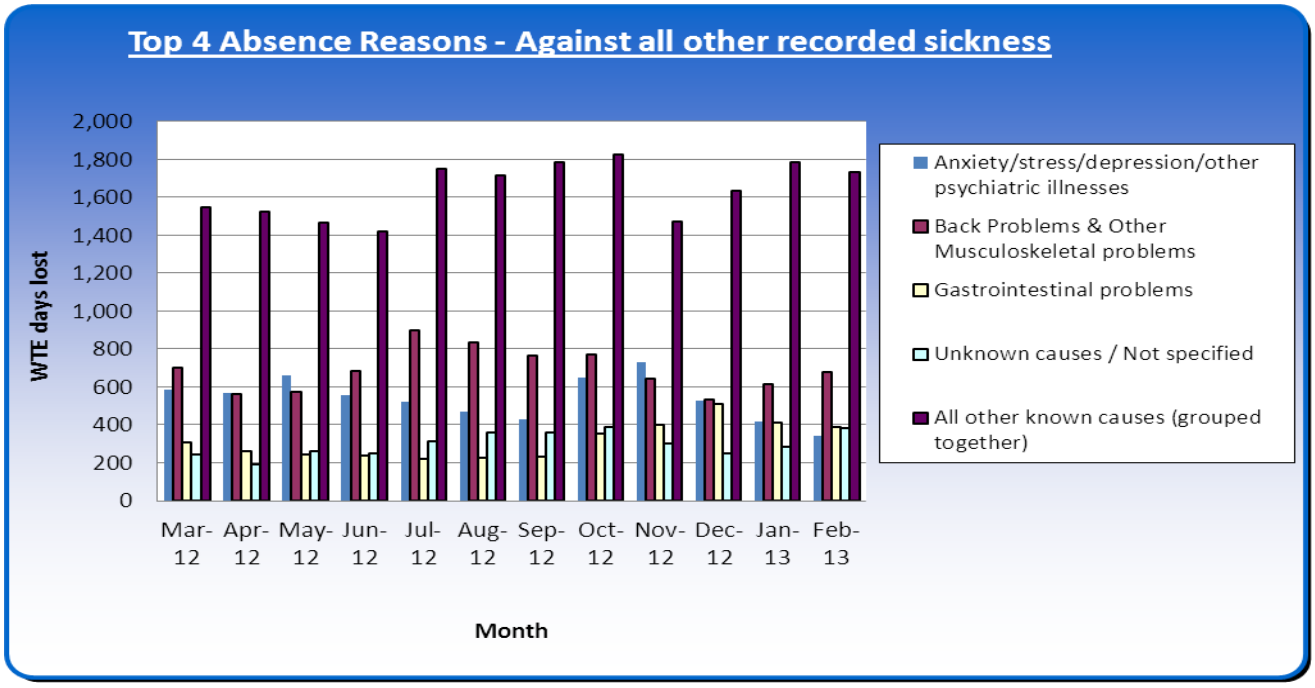
3 WORKFORCE

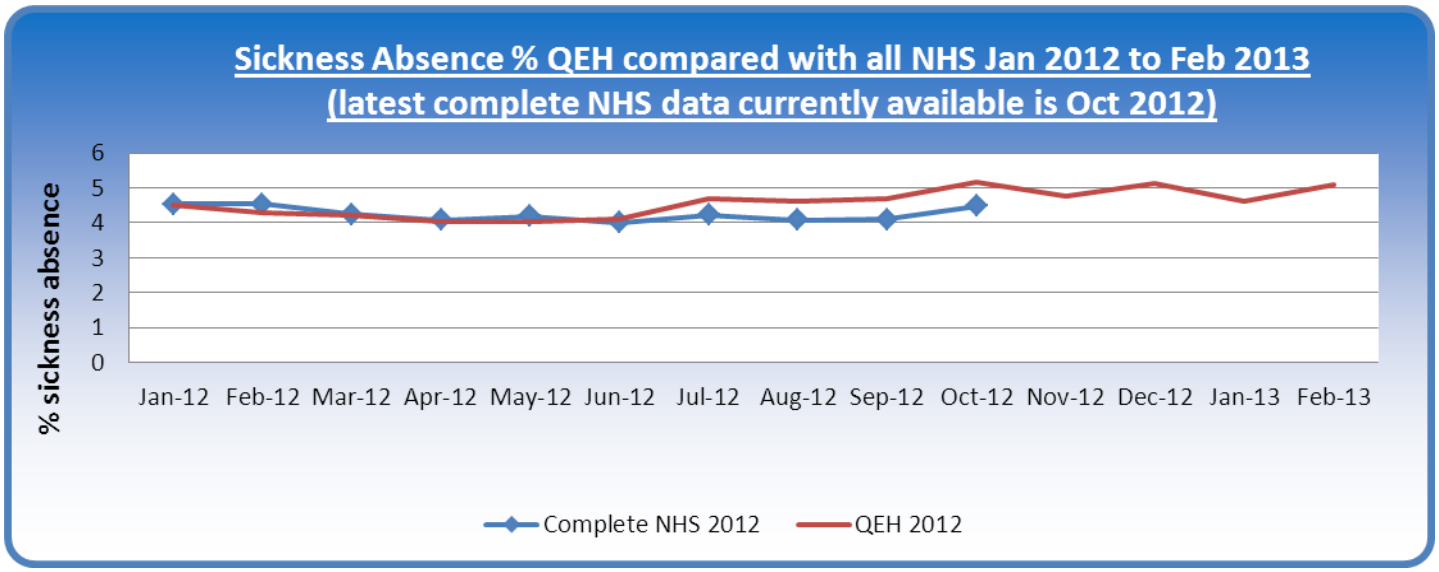
3.1 Sickness Absence

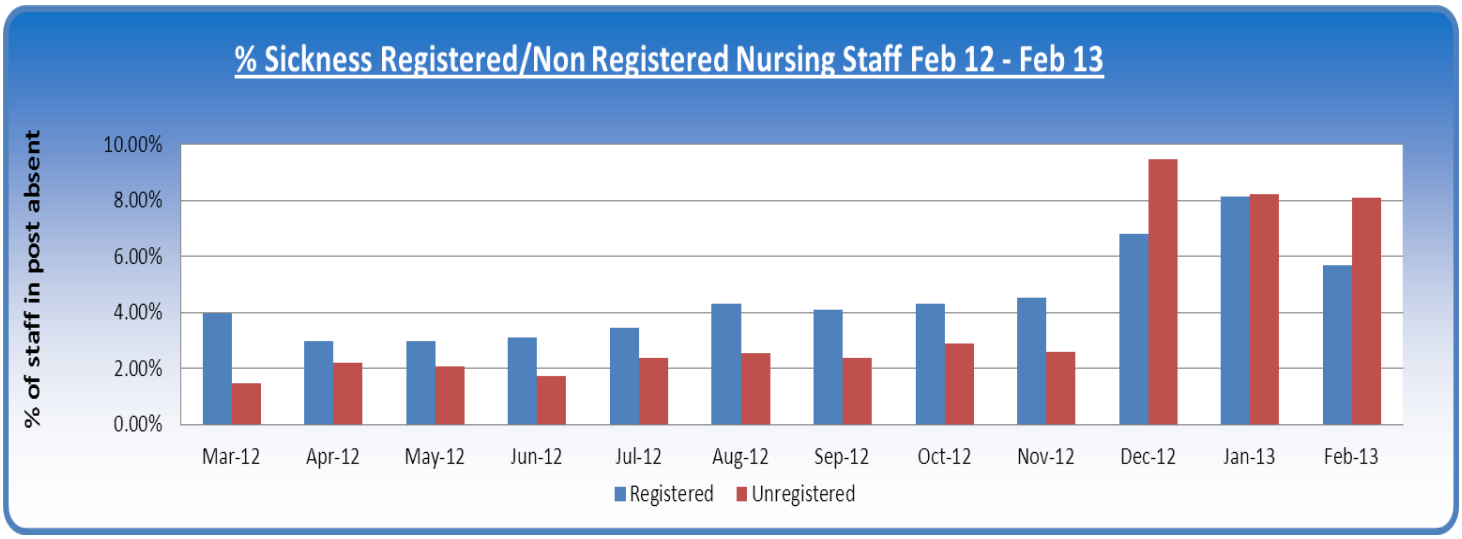
Absence Reasons

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

It is expected that when the NHS average figures are available for December and January it will show QEH figures are more in line with the national average. However, the rate in February shows an increase and stands at 5.1% as compared to 4.3% at February last year.







Operational Actions

HR Business Partners continue to work hard with Management and Unions/Staff Side. Robust management of the 'Top 50' cases determined by (a) total time absent and (b) the number of episodes of absence. Management and HR have developed action plans for each case with several 'concluding' each month.

Table of Progress for the Long Term Sickness Absence of Registered and Non Registered Nursing

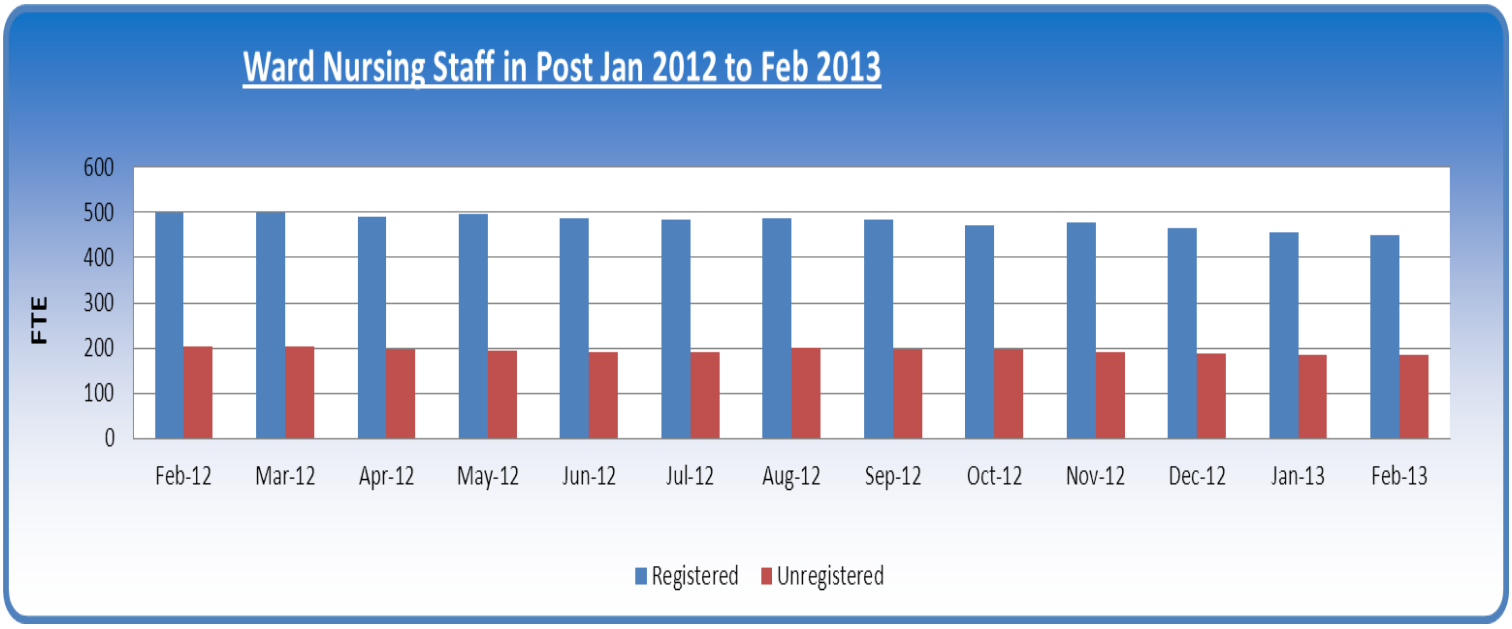
Registered

Elective	Medicine	Total	
1	0	1	Ill Health Retirement
6	6	12	Returned
3		3	Returning in March
4	0	4	Receiving treatment being managed with meetings and regular updates with their manager where appropriate.
0	5	5	Formal meeting arranged
0	0	0	On notice
14	11	25	**TOTAL**

Unregistered

Elective	Medicine	Total	
0	0	0	Ill Health Retirement
3	4	7	Returned
1	0	1	Returning in March
2	1	3	Receiving treatment being managed with meetings and regular updates with their manager where appropriate.
0	4	4	Formal meeting to be arranged
0	0	0	On notice
6	9	15	**TOTAL**

3.2 Nursing Staff Numbers

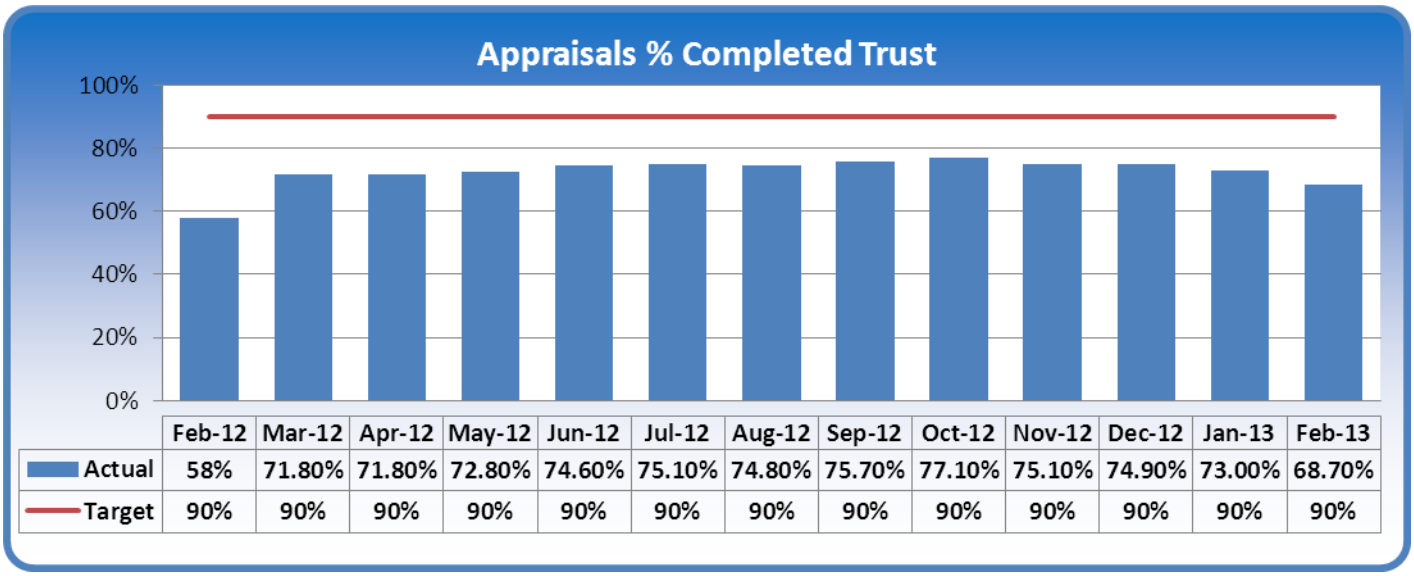


Operational Actions

Ward based nurse numbers have been decreasing month on month since September 2012. However the size of reduction in February is only 3.56 FTE

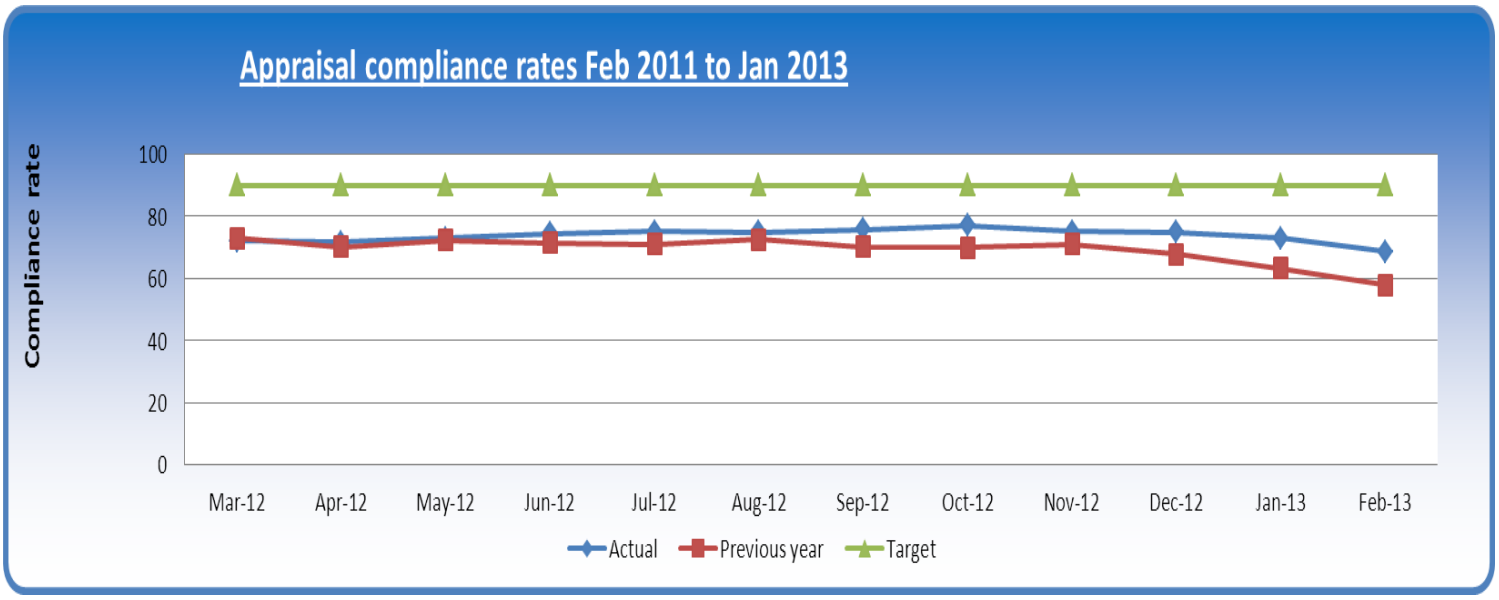
The international recruitment exercise in Portugal scheduled for 25th-27th March is seeking to secure up to 45 registered nurses. However these are not likely to significantly increase capacity on the wards until June/July. Other initiatives around local recruitment etc are already being progressed as highlighted in last month's report.

3.3 Appraisals % Complete Trust



	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13
Actual	58%	71.80%	71.80%	72.80%	74.60%	75.10%	74.80%	75.70%	77.10%	75.10%	74.90%	73.00%	68.70%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

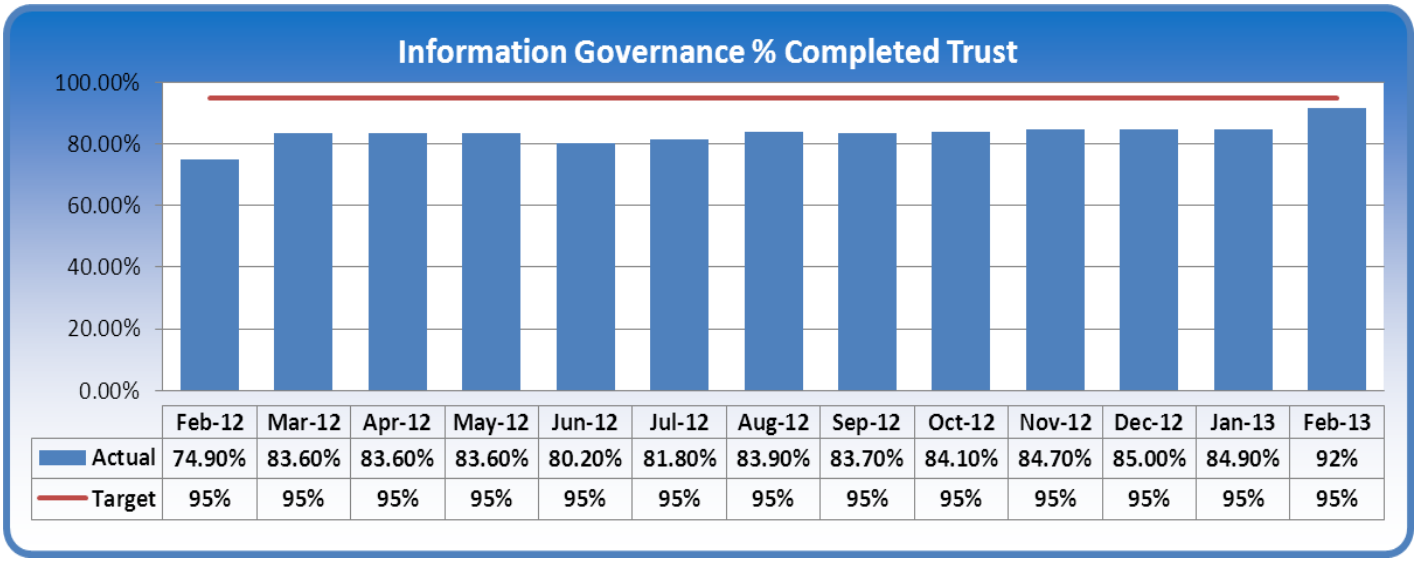
Month	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13
Target	90	90	90	90	90	90	90	90	90	90	90	90
Actual	72.1	71.8	73.1	74.6	75.1	74.9	75.7	77.1	75.1	74.9	73	68.7
	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12
Actual	73	70.3	72.4	71.5	71	72.5	70.3	70	71	67.9	63.3	58



Operational Actions

Although at 10% above the corresponding rate last year, at 68.7% it is unlikely that the target of 90% will be met by the end of March. All senior teams have been given a forward 12 month schedule of appraisals due in order that they can give assurance over planned achievement of the 90% target. We are awaiting confirmation from teams but have set out clear expectation of achievement by April 2013.

3.4 Information Governance Training % Complete Trust



	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13
Actual	74.90%	83.60%	83.60%	83.60%	80.20%	81.80%	83.90%	83.70%	84.10%	84.70%	85.00%	84.90%	92%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Operational Actions

In order to improve, departments that have low compliance rates are being specifically targeted with reports detailing those non-compliant individuals, and the IG training Workbook have been handled personally to managers for completion. These are often followed up by visits from the IG team, to ensure managers are taking appropriate action, and the number of completed Workbooks being returned has started to increase. In addition, broadcast emails highlighting imminent classroom sessions and clinical training days are beginning to see an increase in attendance.

As at 21/03/2013 we have 105 workbooks that need to be completed by the end of March.

4 PERFORMANCE AND STANDARDS

The Trust achieved the following key targets: -

- All Cancer Targets
- MRSA Screening – 100% against a target of 100%
- Daycase Rate – 92.6% against a target of 82%
- Basket of Daycase Procedures – 91.2% against a target of 80%
- Emergency length of stay – 4.1 against a target of 5.0
- Elective length of stay – 2.1 against a target of 2.2

However, the Trust did not achieve: -

- A&E 4 Hour Attendance
- The national target for the admitted 18wk RTT for Plastics and Gynaecology
- 18 week RTT Incomplete pathways for Gynaecology
- Choose & Book
- Readmission rates
- Cancelled Operations
- New to Follow up ratio
- Stroke – 90% of stay on the Stroke Unit – 64.5% against a target of 80%
- TIA – High risk, not admitted, treated within 24 hrs – 51.5% against a target of 60%

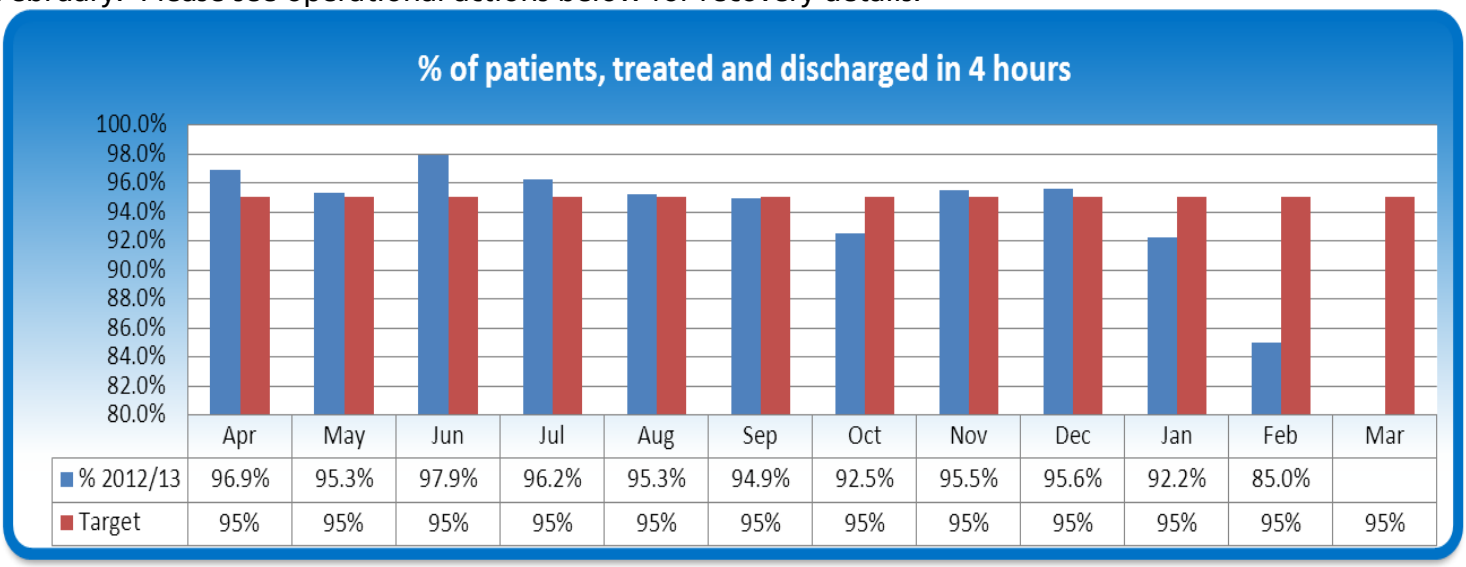
4.1 Emergency Care Performance

Accident and emergency patient waiting times

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

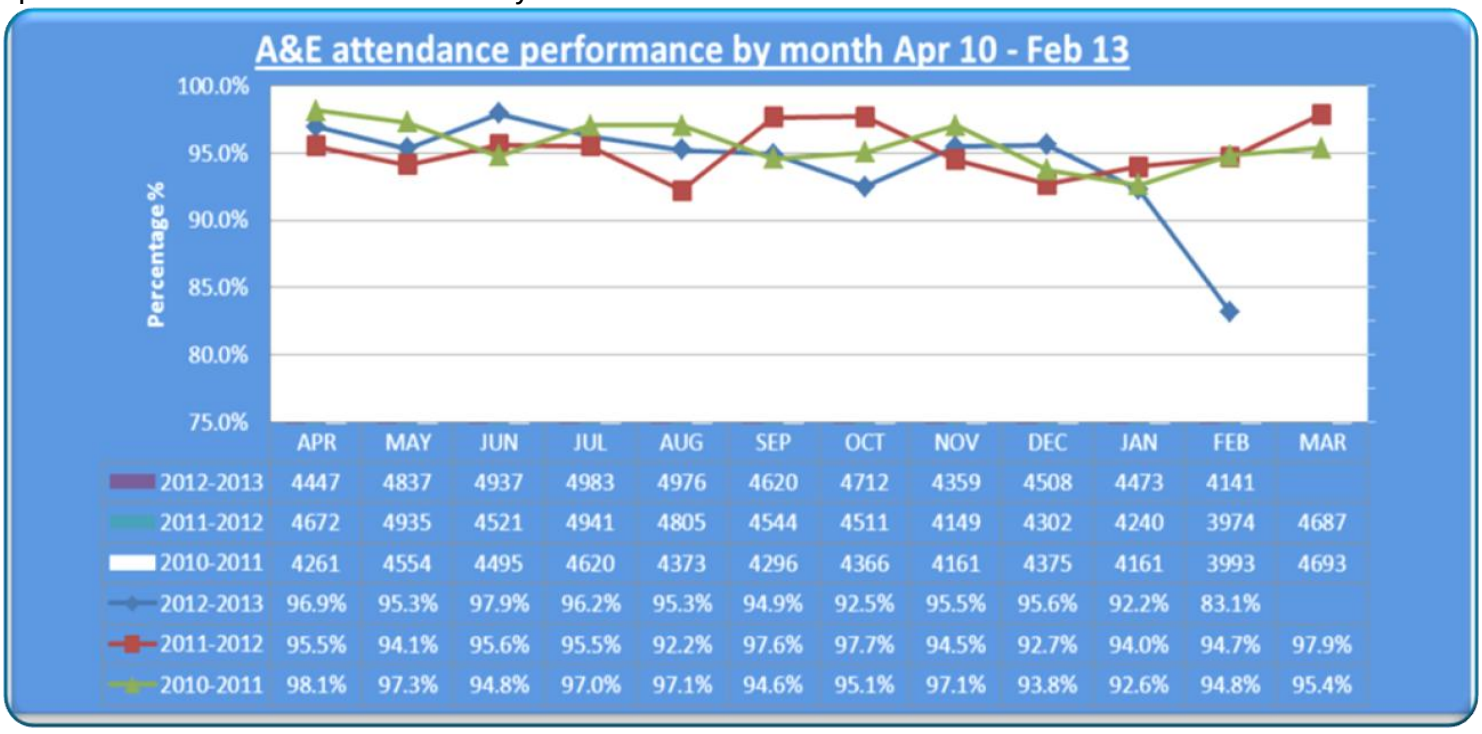
The Trust performance was 85.0% for February 2013.

The graph below shows that A&E performance has continued to be below the target of 95% in February. Please see operational actions below for recovery details.



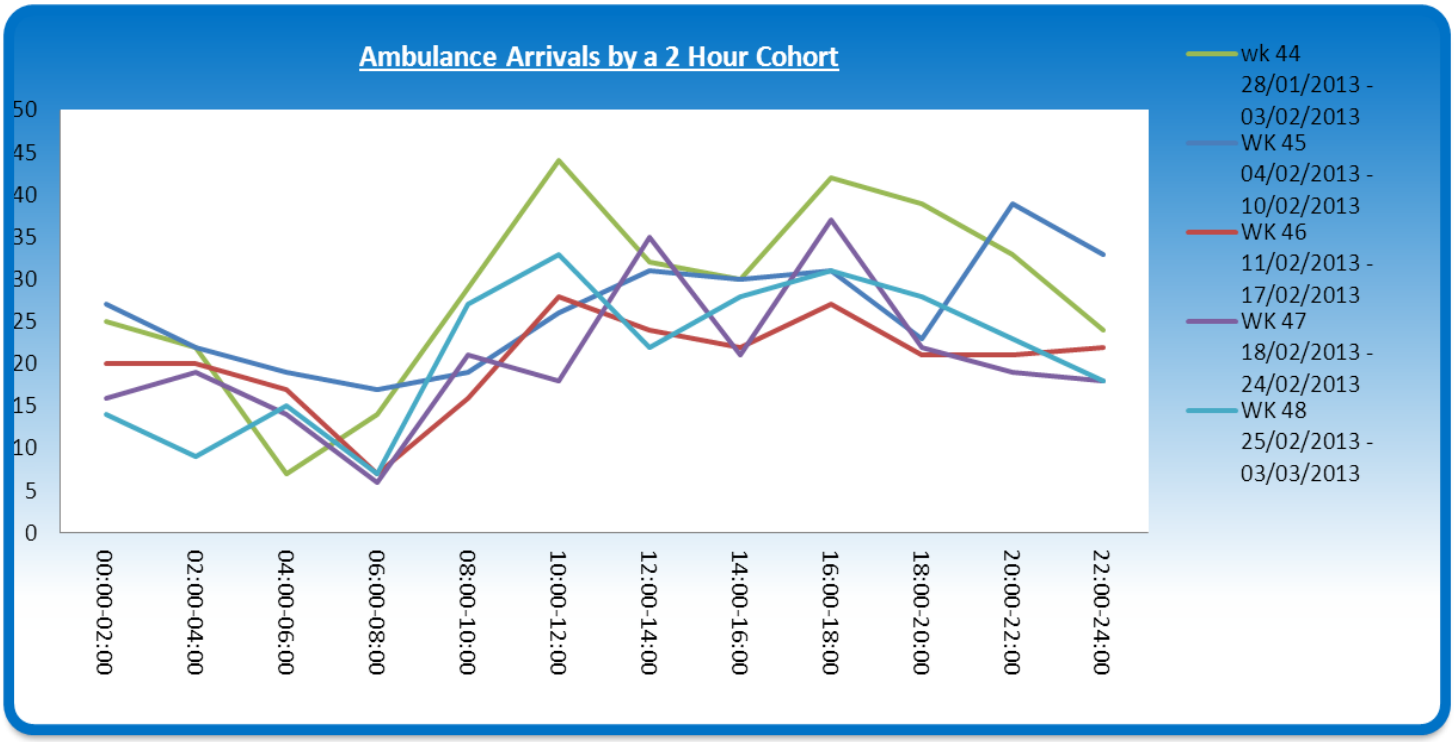
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% 2012/13	96.9%	95.3%	97.9%	96.2%	95.3%	94.9%	92.5%	95.5%	95.6%	92.2%	85.0%	
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

The graph below demonstrates that A&E attendances have increased at an average of 6% from 10/11 to 12/13 which will have been a contributory factor in the decline of A&E performance. Please see operational actions below for recovery details.



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2012-2013	4447	4837	4937	4983	4976	4620	4712	4359	4508	4473	4141	
2011-2012	4672	4935	4521	4941	4805	4544	4511	4149	4302	4240	3974	4687
2010-2011	4261	4554	4495	4620	4373	4296	4366	4161	4375	4161	3993	4693
2012-2013	96.9%	95.3%	97.9%	96.2%	95.3%	94.9%	92.5%	95.5%	95.6%	92.2%	83.1%	
2011-2012	95.5%	94.1%	95.6%	95.5%	92.2%	97.6%	97.7%	94.5%	92.7%	94.0%	94.7%	97.9%
2010-2011	98.1%	97.3%	94.8%	97.0%	97.1%	94.6%	95.1%	97.1%	93.8%	92.6%	94.8%	95.4%

The ambulance arrival data for February 2013 shows a pattern of increased levels of arrivals for each week between 10:00-12:00 and again at 16:00-18:00.



The table below shows a persistent stream of medically fit for transfer (highlighted red) patients and Delayed Transfers of Care by week.

	WK 44	WK 45	WK 46	WK 47	WK 4
Total DTOCs	86	81	102	82	66
PCT Wait community bed	8	3	10	5	5
PCT Booked to go today	9	6	5	4	6
PCT Booked to go advance date	0	0	0	0	0
PCT Awaiting Panel	0	0	0	0	0
PCT Planned	0	0	0	0	0
PCT Awaiting Equipment	0	0	0	0	0
PCT Awaiting Assessment/Placement	0	3	4	7	8
PCT Funding	6	7	10	4	2
PCT Care package	1	1	1	0	0
PCT TOTAL	24	20	30	20	21
NORFOLK SS Wait assessment	0	0	0	0	0
NORFOLK SS Wait Placement	4	2	0	0	1
NORFOLK SS Wait Package of Care	0	4	5	0	0
NORFOLK SS Booked to go today	0	0	0	0	1
NORFOLK SS Booked to go advance date	0	0	0	0	0
NORFOLK SS Assessments ongoing	0	0	0	0	0
NORFOLK SS Awaiting panel	0	0	0	0	0
NORFOLK SS Awaiting planning bed	0	0	0	0	0
NORFOLK SS Funding	0	0	0	0	0
NORFOLK SS Patient choice	0	0	0	0	0
NORFOLK SS TOTAL	4	6	5	0	2
QEH Self- Funding	0	2	0	0	0
QEH Wait Assessment	5	0	3	0	2
QEH Equipment	3	0	0	4	0
QEH Wait full CCA*	10	9	11	10	2
QEH Booked to go in advance	0	0	0	0	0
QEH Patient Family Choice	0	0	5	6	0
QEH Housing	0	0	0	0	0
QEH Mental Health	0	0	0	0	0
QEH Nursing/Resi Home Assessment	1	0	1	0	4
Total DTOCs	19	11	20	20	8
Out of County	0	0	0	0	1
Wait Housing	0	0	0	0	0
NHS Lincs	0	2	1	10	7
Lincs Social Services	3	7	5	0	0
NHS Cambs	21	15	11	8	5
Cambs Social Services	15	20	30	24	15
Others	0	0	0	0	7
RESPONSIBLE PCT TOTAL	39	44	47	42	35
Potential delays still in progress not DTOC					
QEH Waiting checklist (for QEH info)	17	23	33	43	49
MEDICALLY FIT NHS Norfolk	135	167	115	138	148
MEDICALLY FIT NHS Cambs	27	41	61	46	48
MEDICALLY FIT NHS Lincs	7	6	5	9	14
MEDICALLY FIT Other Com.	3	0	0	2	6

Operational Actions

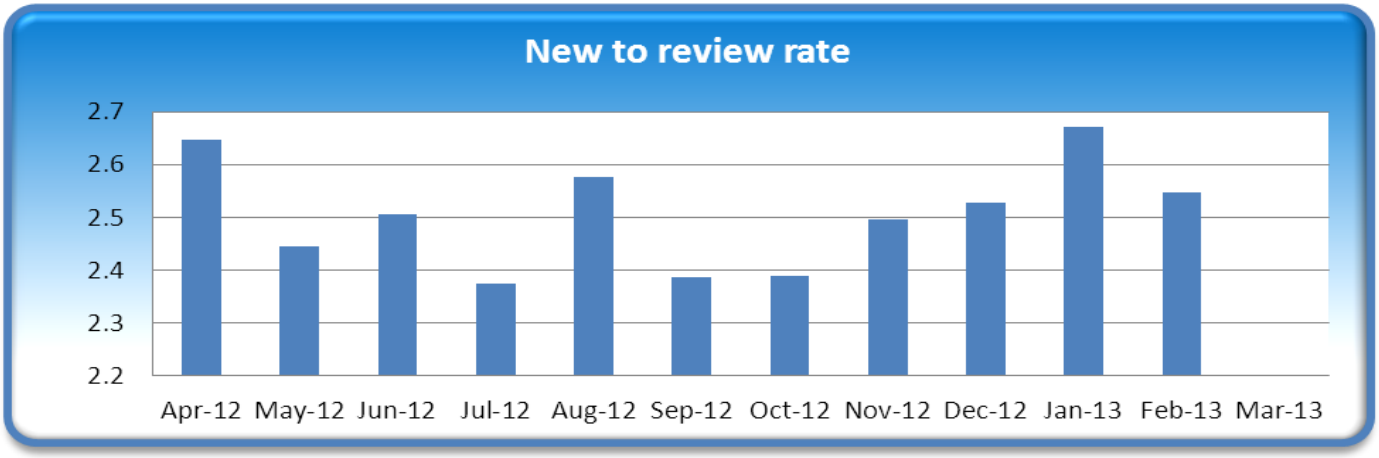
The ability of the Trust to meet the 4 hour access target has been severely compromised this month.
A comprehensive diagnostic review has identified a number of delays both internal and external affecting the flow of patients through the hospital.
A number of meetings have been held and a comprehensive action plan developed.
All patients who have a 14 day plus length of stay are tracked on a daily basis as are those patients who are medically fit to transfer to an alternative abode.
The attendances through the Emergency department are higher than last year but below planned level. The department has not been able to move patients through the department and into an appropriate bed. A full report can be found in appendix 3.

4.2 New to review rate

New to review rate

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

The Trust's new to review ratio is 2.5

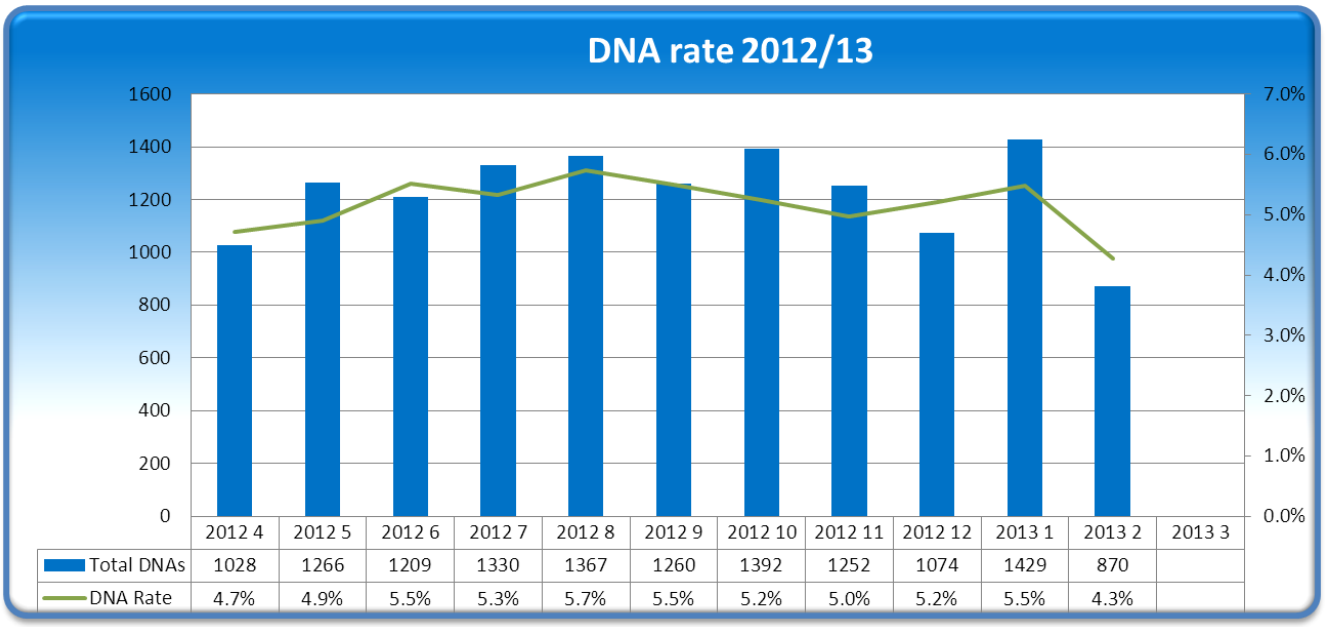


4.3 DNA rate

DNA rate

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

The Trust DNA Rate is currently below the nationally reported figure of 10% but slightly above the local target of 5%.



	2012 4	2012 5	2012 6	2012 7	2012 8	2012 9	2012 10	2012 11	2012 12	2013 1	2013 2	2013 3
Total DNAs	1028	1266	1209	1330	1367	1260	1392	1252	1074	1429	870	
DNA Rate	4.7%	4.9%	5.5%	5.3%	5.7%	5.5%	5.2%	5.0%	5.2%	5.5%	4.3%	

Operational Actions

Demand and capacity plans for outpatients are complete and being discussed with Clinical Directors. This is being aligned to consultant level and informing the job planning exercise. These actions and the implementation continue to be managed with POD37 – Outpatient Transformation.

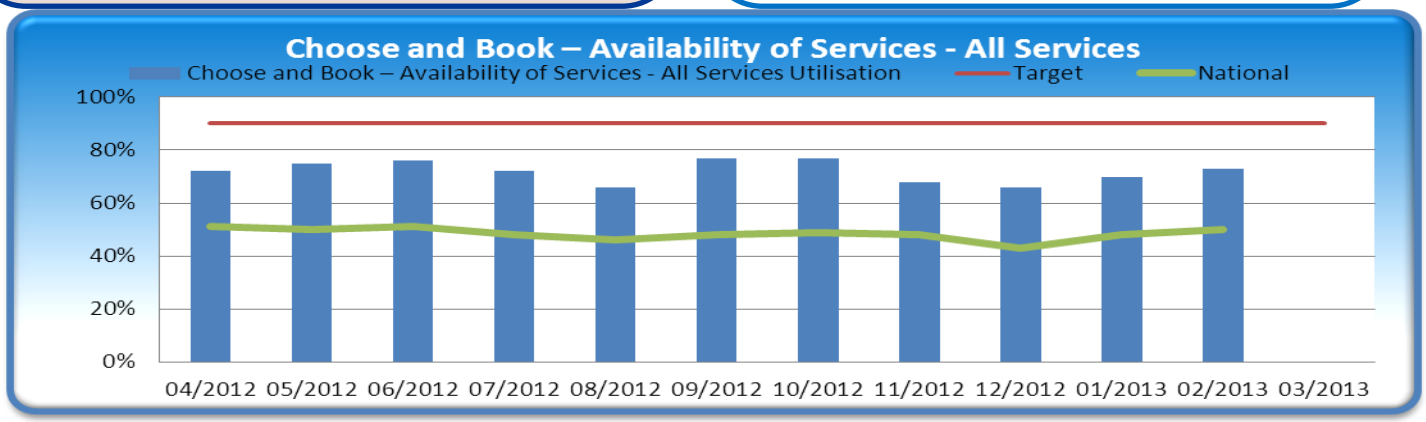
4.4 Choose and Book

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

Choose and Book

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

The Trust currently has 70% of its services available through Choose and Book.



Month	Choose and Book – Availability of Services - All 2WW Services	Choose and Book – Availability of Services - All Services Utilisation		Choose and Book – Availability of Appointment slots ASI'S	
	QEH	National	QEH	National	QEH
Target	90%	90%		< 0.05 (5%)	
Apr-12	100%	51%	72%	0.09	0.19
May-12	100%	50%	75%	0.10	0.23
Jun-12	100%	51%	76%	0.09	0.18
Jul-12	100%	48%	72%	0.10	0.22
Aug-12	100%	46%	66%	0.08	0.24
Sep-12	100%	48%	77%	0.07	0.21
Oct-12	100%	49%	77%	0.08	0.20
Nov-12	100%	48%	68%	0.09	0.22
Dec-12	100%	43%	66%	0.08	0.15
Jan-13	100%	48%	70%	0.06	0.07
Feb-13	100%	50%	73%	0.08	0.12
Mar-13					

Operational Actions

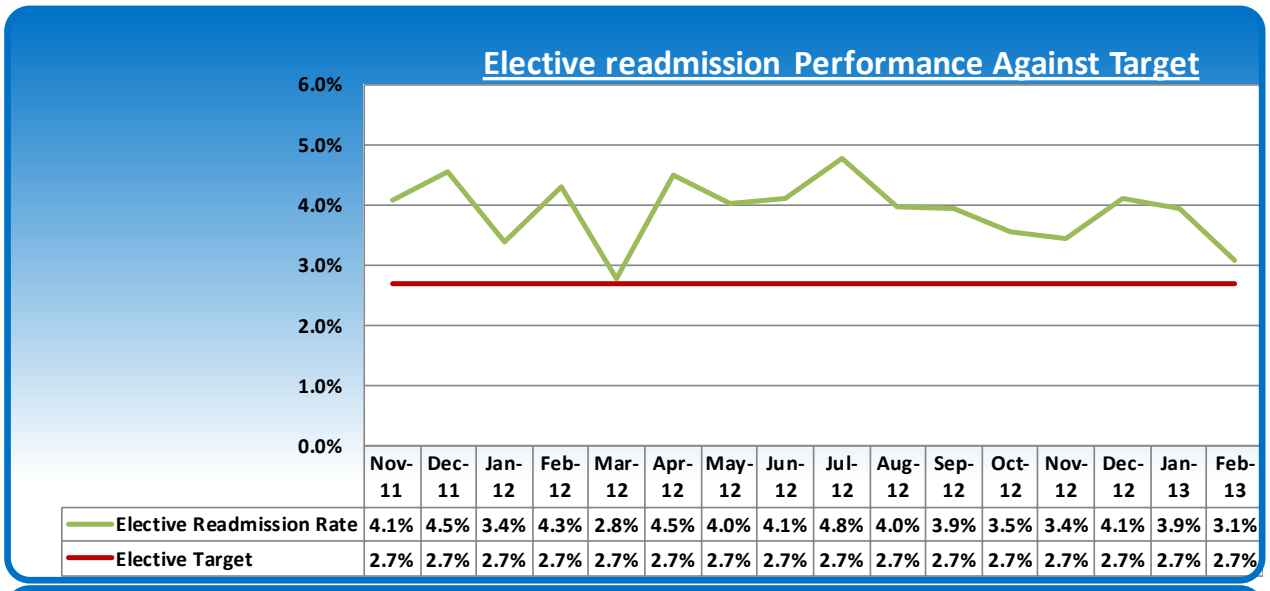
February performance on ASI was affected by the 6 weekly slot polling range incorporating the Easter holiday period and therefore having 2 less working days. While the Trust can easily accommodate this work in its capacity by putting on extra clinics, this was not planned in advance of the impact on Choose and Book therefore not being recognised. The extra clinics were not available to Choose and Book. This issue is being addressed via the outpatient PTL meetings.

4.5 Readmission Rates – Emergency and Elective

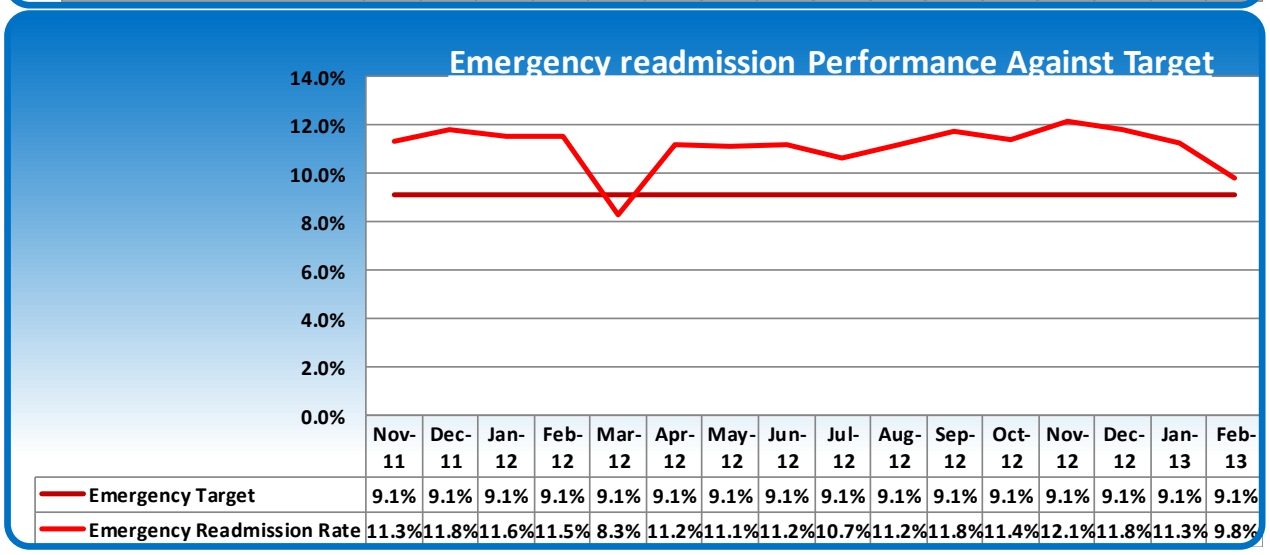
Readmission rate

Elective readmissions target is 2.7%.
Emergency readmissions target is 9.1%.

The Elective Readmission rate for January was 3.1% which was above its target of 2.7% Emergency readmissions for November were above target, with a performance of 9.9% against a target of 9.1%.



	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13
Elective Readmission Rate	4.1%	4.5%	3.4%	4.3%	2.8%	4.5%	4.0%	4.1%	4.8%	4.0%	3.9%	3.5%	3.4%	4.1%	3.9%	3.1%
Elective Target	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%



	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13
Emergency Target	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%
Emergency Readmission Rate	11.3%	11.8%	11.6%	11.5%	8.3%	11.2%	11.1%	11.2%	10.7%	11.2%	11.8%	11.4%	12.1%	11.8%	11.3%	9.8%

Operational Actions

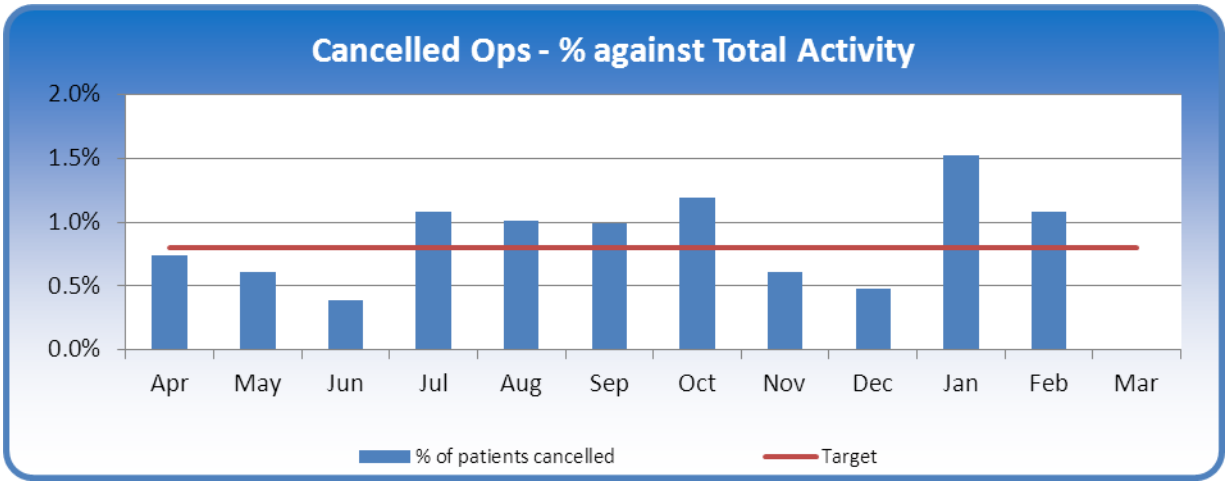
The Quality and Risk committee met at the end of February. The next performance Board paper will detail the operational actions that are applicable to this section.

4.6 Cancelled Ops

Cancelled Operations

% of Cancelled operations against Total Activity for the month

The Trust reported 36 Cancellations on the day for February 2013, this equates to 1.1% of Activity within the Trust for the month, higher than the national target of 0.8%



Cancelled Ops	spe								
status	COL	ENT	GYN	OPH	ORT	SUR	URO	VAS	Grand Total
Requiring a rescheduled operation date	1	1		2	1	1	1	1	8
Breach		2		1	1	1		3	8
Untreated	1				4				5
Treated within 28 days		2	1	8	2		2		15
Grand Total	2	5	1	11	8	2	3	4	36

Operational Actions

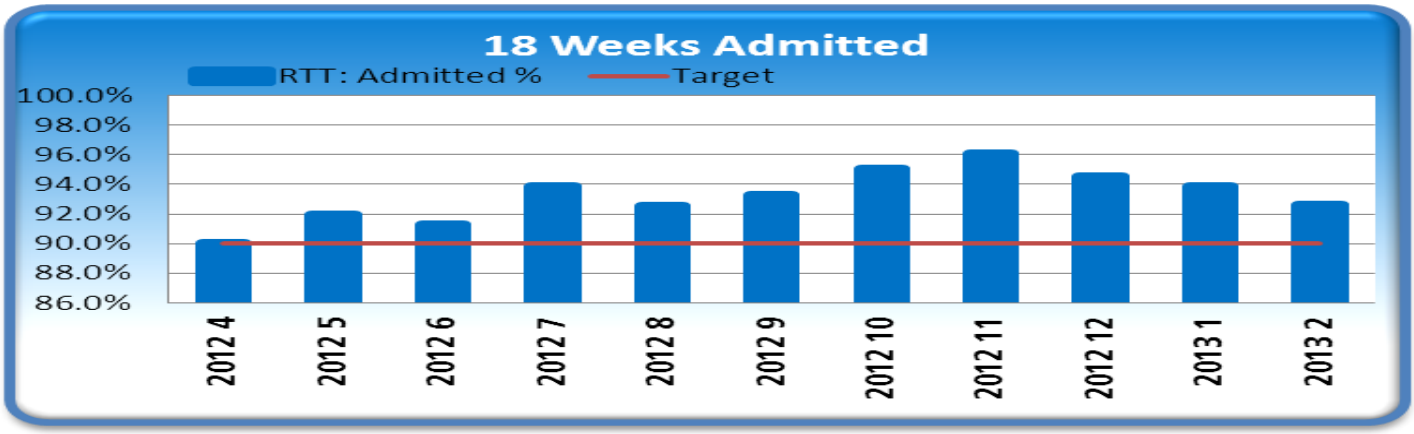
Despite the designation of ring fenced beds, pressure on the trust in terms of patient flow saw an increase in the number of patients who had their operation cancelled on the day of surgery. This was 36 in February. Of these cancellations 8 breached the 28 day target, there are currently still 5 untreated with no rescheduled operation date. 15 patients were treated within 28 days leaving 8 patients who have been given a rescheduled operation date within 28 days but have not yet been treated.

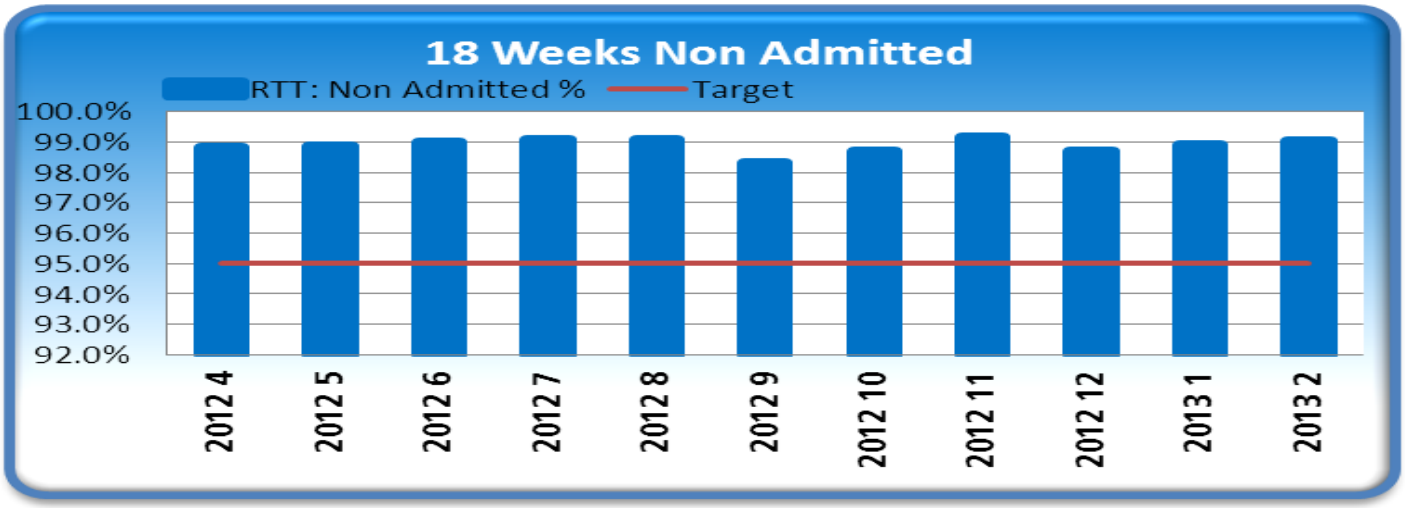
4.8 18 weeks

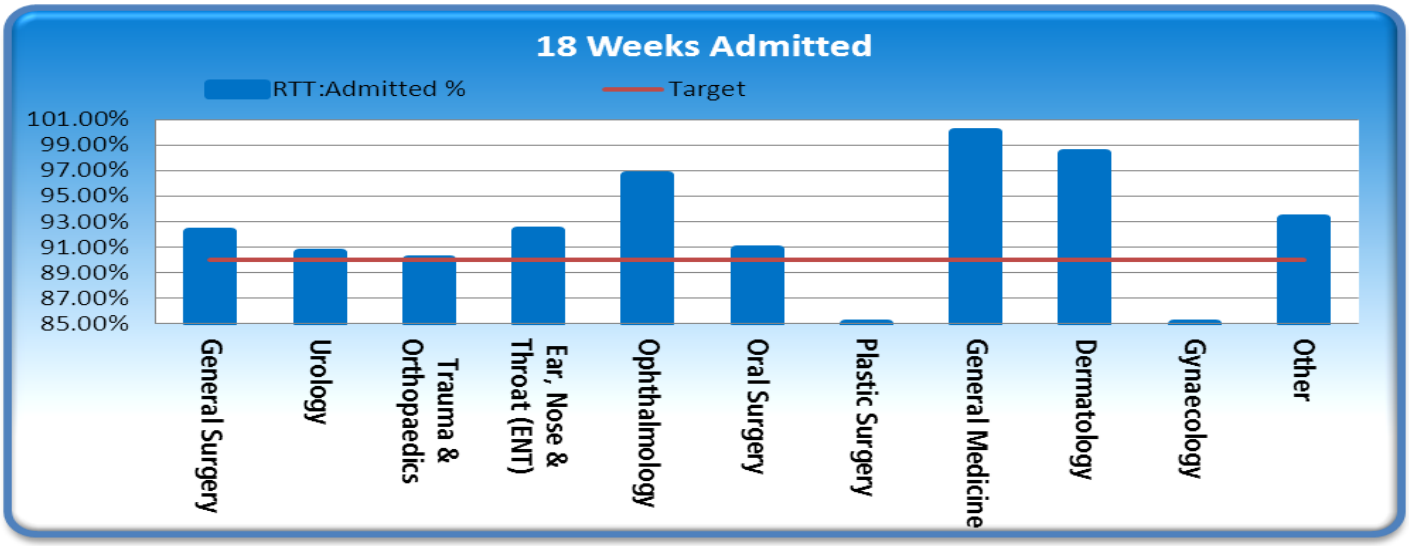
RTT: Admitted and Non Admitted

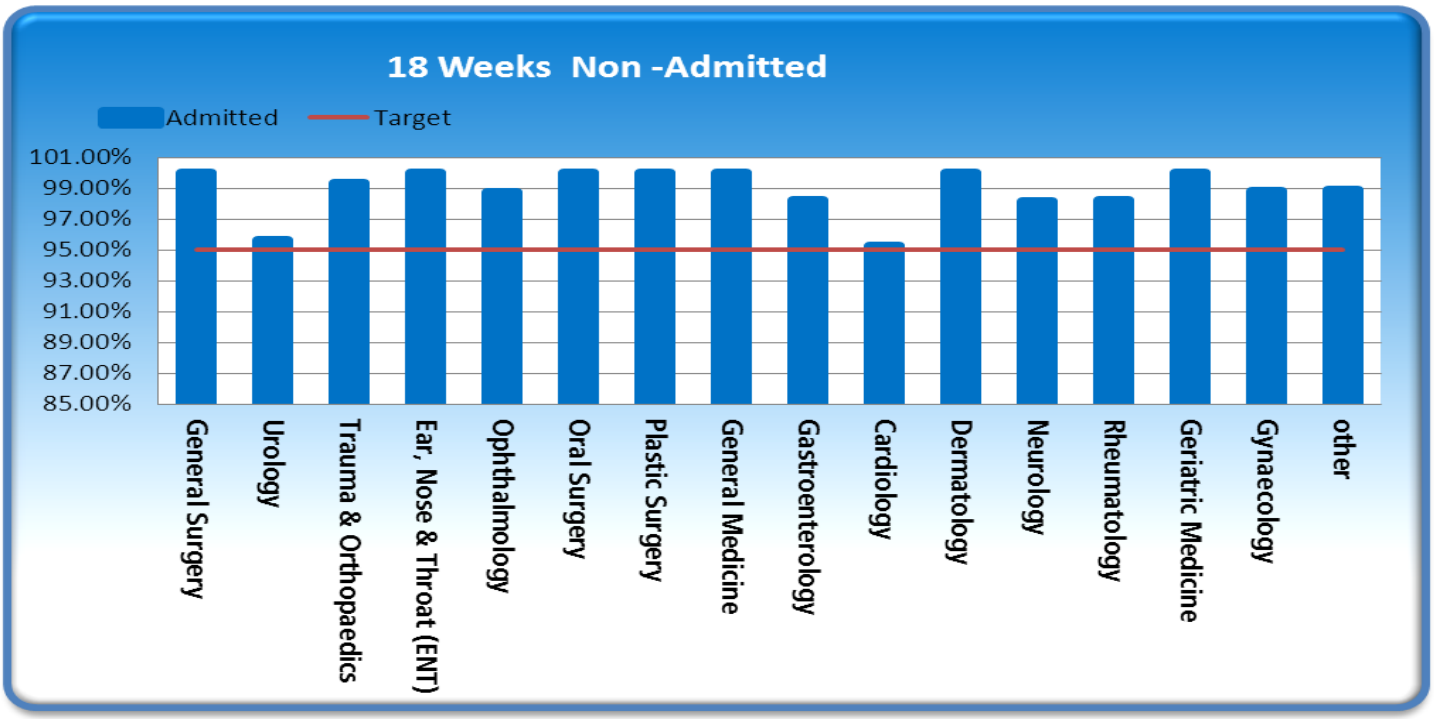
Headline Measure:
Referral to treatment waiting times – admitted (90% Target within 18 Weeks.)
Referral to treatment waiting times – non-admitted (95%

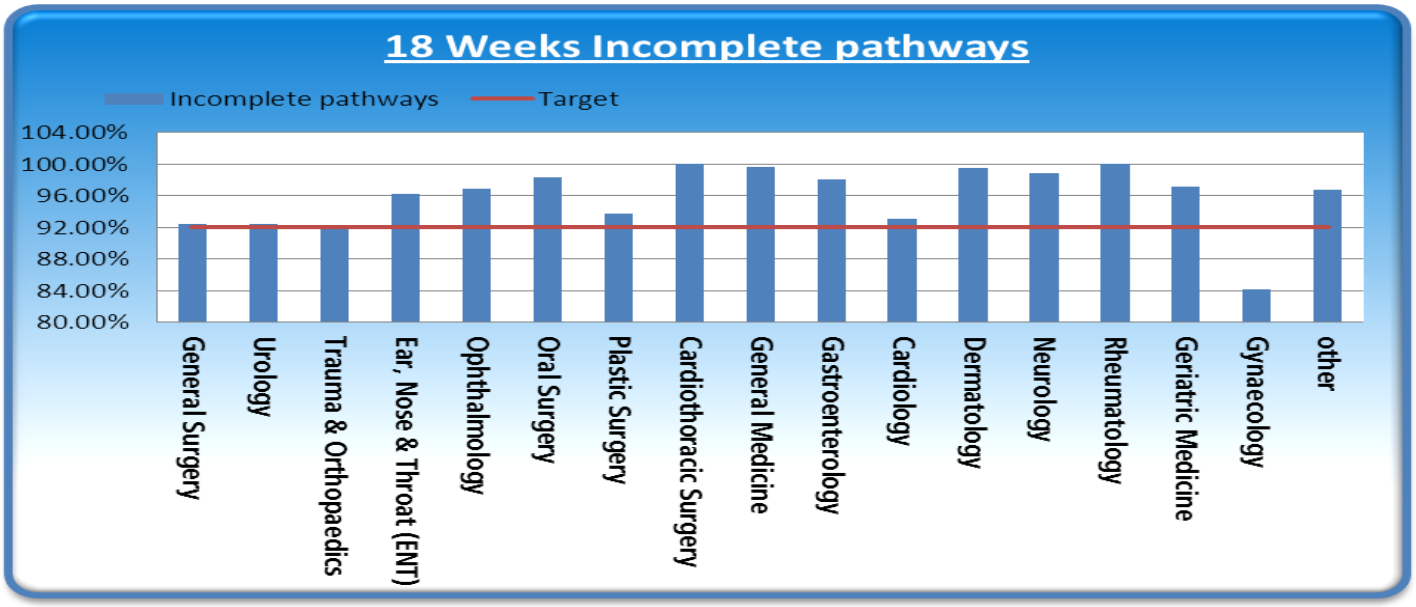
The Trust continues to achieve the 18 week RTT waiting times for admitted and non-admitted patients at trust level.











Operational Actions

The Trust continues to achieve the 18 week RTT waiting times for admitted and non-admitted patients at trust level, however the plastic surgery specialty 18 week admitted was not achieved.

Nationally scrutiny is on achieving the 92% target for incomplete pathways. The Trust has 3 services which did not achieve this target.

Performance on this target (specifically Admitted RTT) has been severely impacted by the patient flow issues experienced by the Trust. As at the end of February the Trusts backlog of patients on an 18 week RTT is 430.

4.9 Stroke

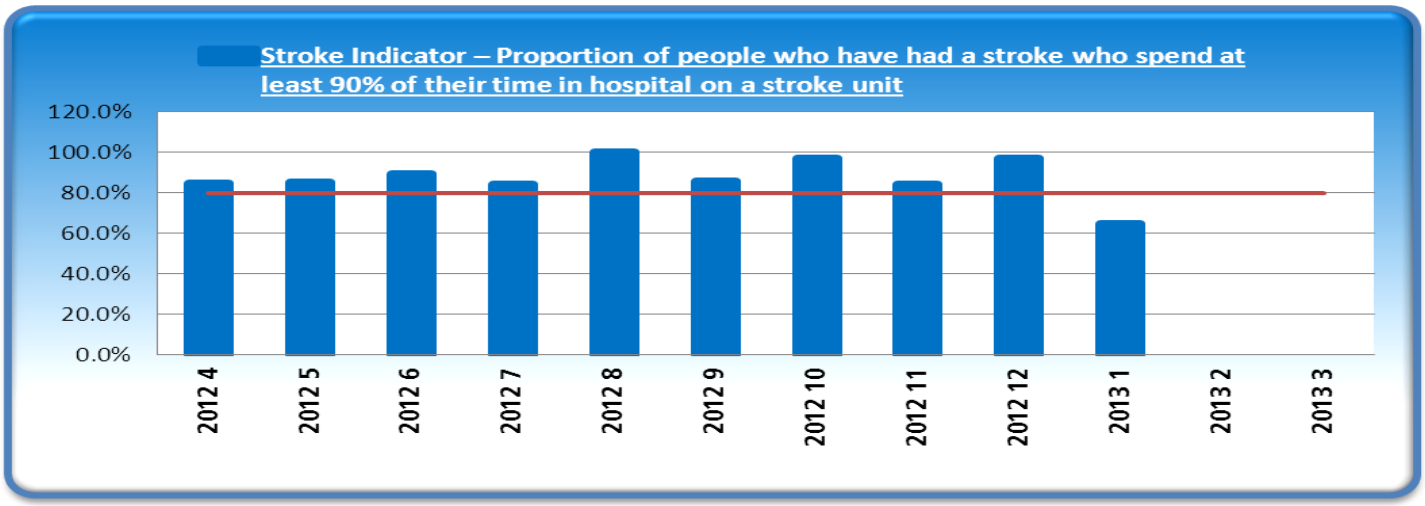
Stroke

Stroke Indicator – Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit

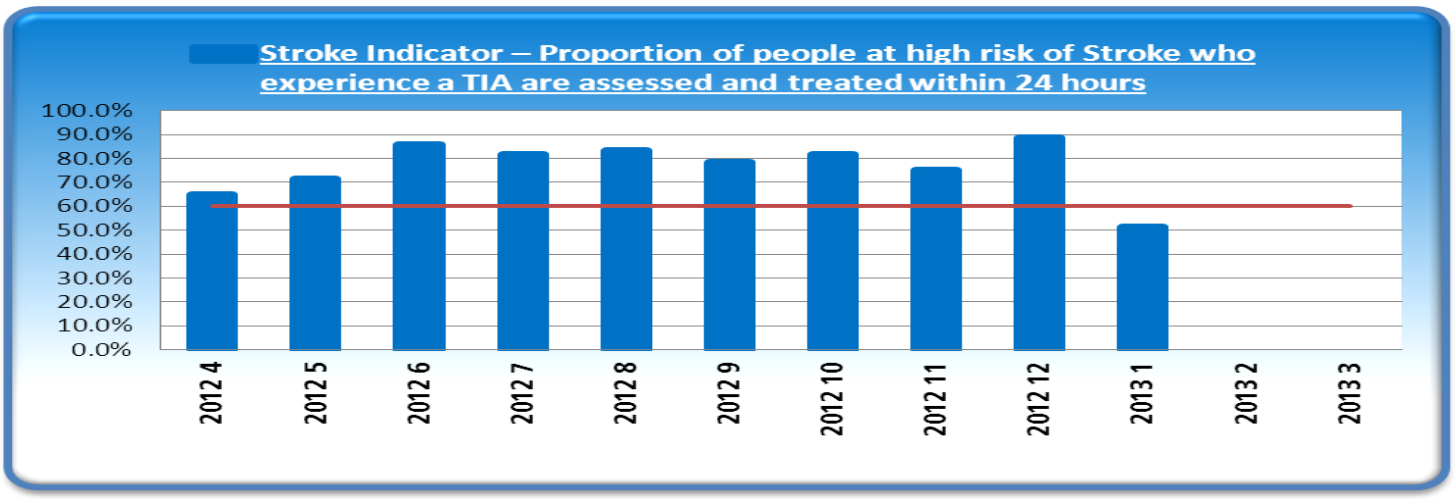
Stroke Indicator – Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours

Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit was 64.5% for February failing to achieve the target of 80%

Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours was 51.5% for February failing to achieve the target of 60%



Breaches provided from the 90% time on a stroke unit	
Description	
Challenging Diagnosis	4
No beds available, short stay will not meet 90%	4
Other operation reasons	3



Breaches provided from Stroke patients who experience a TIA are assessed and treated within 24 hours	
Description	
Failed date seen	6
Failed date scan	4
Failed date doppler	6

Operational Actions

As a result of the stroke unit being closed for the majority of January 2013 due to Norovirus, we failed to achieve both the 90% of stay on a stroke unit and the 60% of high risk TIA patients treated in 24 hours. At the time alternative arrangements were made for patients requiring thrombolysis to be cared for in Critical Care to ensure they received optimum treatment at level 2 care. The other patients were admitted to MAU and supported by the specialist stroke team. However, as neither area is classified as dedicated stroke facilities, we were unable to attain the target.

The current TIA pathway means high risk patients go to the stroke unit as ward attenders to be seen and treated by the specialist team. Again as the ward was closed, these patients had to be seen in the limited clinics available as an alternative. Each patient was fully screened in advance to ensure their care and treatment was not compromised.

This is a one off special cause variation and prior to this the stroke service has consistently demonstrated sustained performance and is now one of the highest achievers in the network. As such no remedial action is required as this was an unavoidable event. The year-end position remains strong and is still on track to achieve all targets. This forecast includes a risk adjustment in relation to February's position, which is also at risk of failing of the 90% stay target because the data is based on patients discharged in month. This means anyone admitted in January but not discharged until February count in February's data return and a number of patients were admitted when the ward was closed so only part of their stay was in the stroke unit. The indicative end of year position is therefore 87.6% for stroke and 75.4% for TIAs.

4.9 Emergency Length of stay

Emergency Length of stay

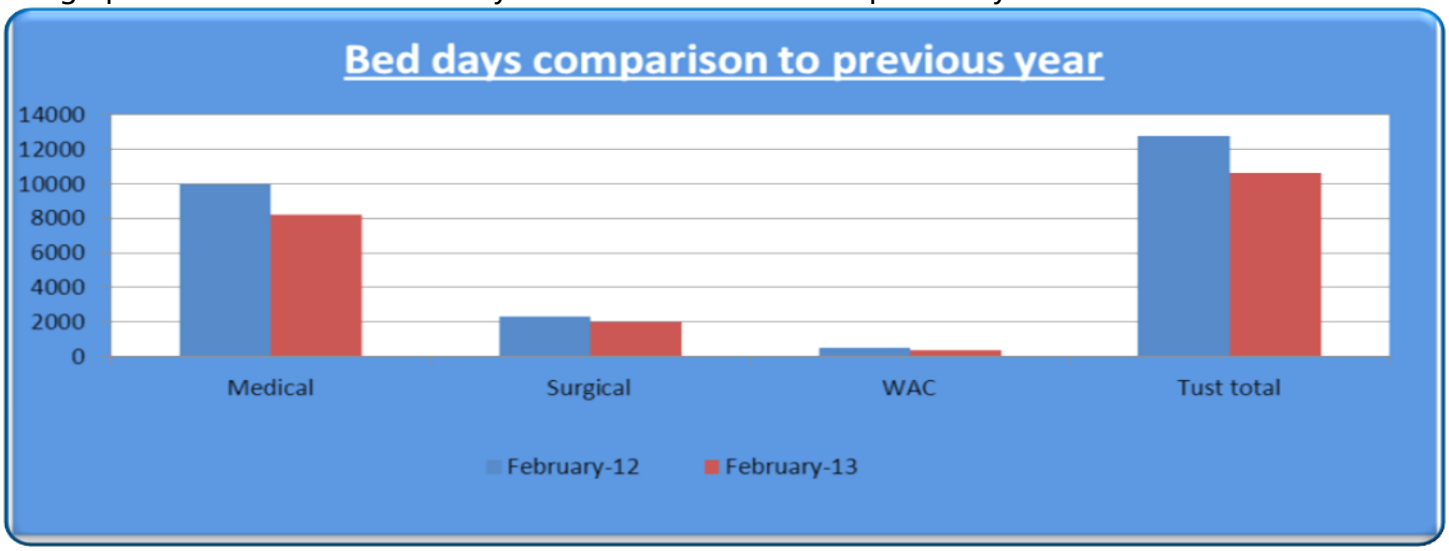
- Overall Trust target of 5 days set internally by POD19 working group

This measure shows the length of patient stay in hospital after they have been admitted under an emergency.

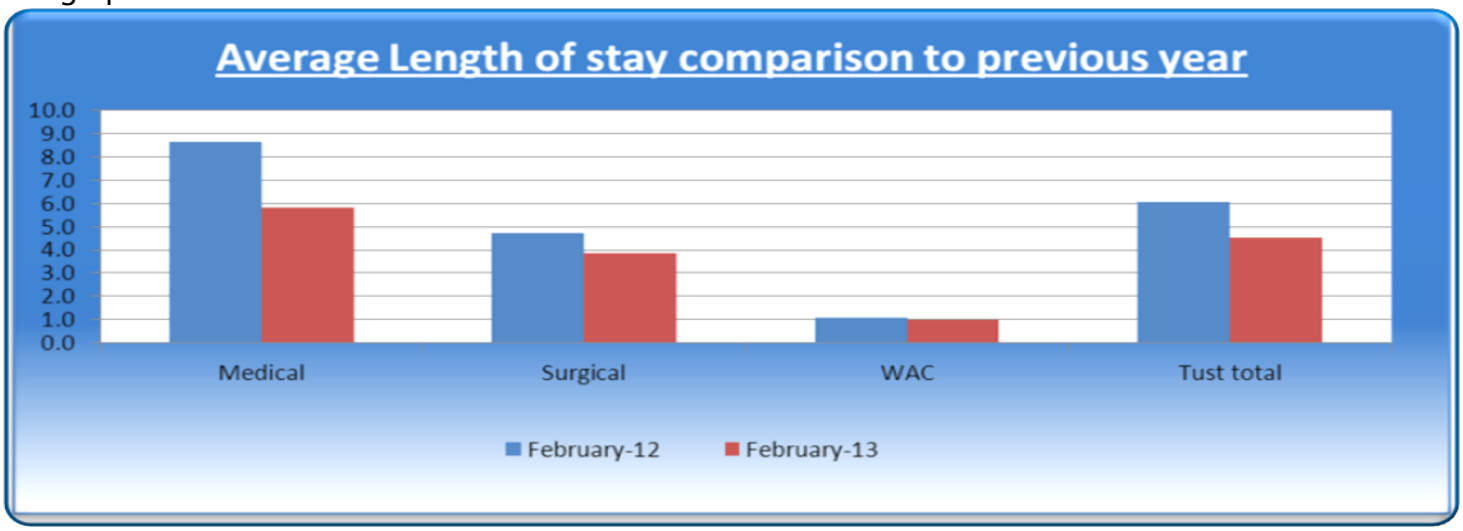
The table below shows that the average length of stay has fallen from 6.1 days to 4.6.

Specialty	Year	Patient Admissions	Sum length of stay	Average Length of stay
Medical	Feb-12	1147	9940	8.7
Medical	Feb-13	1417	8238	5.8
Surgical	Feb-12	491	2328	4.7
Surgical	Feb-13	510	1966	3.9
WAC	Feb-12	403	403	1.0
WAC	Feb-13	469	508	1.1
Trust total	Feb-12	2107	12776	6.1
Trust total	Feb-13	2330	10607	4.6

The graph below shows that bed days have decreased over the previous year.



The graph below demonstrates a reduction in all areas.



5 FINANCE

SUMMARY FINANCIAL POSITION

1.1 For the month the Trust achieved an EBITDA margin of 1.4% (£186k) against a planned EBITDA margin of 4.2% (£560k), an adverse variance of 2.8% (£374k).

1.2 For the month the Trust reported a net loss of £436k against a planned net loss of £67k, an adverse variance of £369k.

1.3 During February, bed capacity pressure to support emergency care has resulted in non-urgent elective admissions being cancelled. The consequence has been elective in-patient activity being below plan by 88 spells, £335k. Gains in other areas of clinical income mean that for the month of February the overall clinical income matched original plan. However, compared to forecast the financial position has further deteriorated in terms of the expected activity catch up and recovery assumptions.

1.4 In the month, pay overspent against original plan by £348k and non-pay overspent by £53k. The pay overspend was in line with forecast whereas the non-pay overspend was £158k lower than forecast.

1.5 Year to date the Trust has delivered 80% of its planned EBITDA with an actual EBITDA margin of 4.2% (£6,392k) against a planned EBITDA margin of 5.3% (£8,013k), an adverse variance of 1.1% (£1,621k).

1.6 The Trust reported a year to date surplus margin of 0.2% (£282k) against a planned surplus margin of 1.0% (£1,532k), an adverse variance of 0.8% (£1,250k). The year to date surplus position has only been achieved because of donated income of £820k. The majority of this income is associated with the capital development of the McMillian unit, if this had not been received the Trust would be in a deficit position.

1.7 In the month the Trust scored an FRR of 1 against an expected FRR of 2 and year to date the Trust is reporting a FRR of 2 against a planned FRR of 3. As highlighted in previous reports, this is of concern to the Trust as Monitor view an FRR score of 2 as an indicator that a NHS Foundation Trust is facing an unacceptably high level of financial risk.

1.8 Operational pressures continue to be experienced by the Trust with regard to the flow of emergency patients in March 2013 and non-urgent elective activity continues to be cancelled. Consequently, previously forecast levels of activity and income for March will not be achieved and the likely outturn position will be lower than previously reported downside scenarios. There is minimal change to forecast pay and non-pay costs, but the lower level of income will have an adverse impact on forecast EBITDA and FRR.

1.9 The planned EBITDA margin for 2012/13 is 5.3% (£8,761k). The forecast is that 73% of the planned level of EBITDA will be delivered at a margin of 4.3% (£6,368k). This means that forecast EBITDA has deteriorated by £859k over the months of February and March.

1.10 The Trust is forecasting to be in a deficit position of £1,019k after the one off income received from donated sources and making a provision of £800k for costs associated with restructuring pathology services.

1.11 **The forecast FRR for 2012/13 is a 2 against a plan and previous forecast of 3**. There are two drivers for the lower FRR, one being the reduction in EBITDA the other being the planned non-renewal of the working capital facility which adversely impacts on the liquidity risk rating.

1.12 The deterioration in performance is disappointing and it is now vital we address the significant issues around patient flow to deliver improved performance in Q1 of the new financial year.

BOARD REPORT APPENDIX 1 – PERFORMANCE DASHBOARDS

Declaration of performance against healthcare targets and indicators

Targets as per Compliance Framework 2012/13		Threshold			Quarter 1		Quarter 2		Oct-12		Nov-12		Dec-12		Quarter 3		Jan-13		Feb-13	
					Perf	Weight	Perf	Weight	Perf	Weight	Perf	Weight	Perf	Weight	Perf	Weight	Perf	Weight	Perf	Weight
C.difficile year on year reduction		30	1.0		7		3		2		1		0		3		2		2	
MRSA - meeting the MRSA objective		1	1.0		0		0		0		0		0		0		0		0	
All cancers: 31-Day Wait For Second Or Subsequent Treatment	Anti Cancer Drug Treatments	98%	1.0		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		98.6%			
	Surgery	94%	1.0		100.0%		100.0%		100.0%		95.2%		100.0%		100.0%		100.0%			
	Radiotherapy (from 1 January 2011)	94%	1.0		n/a		n/a		n/a		n/a		n/a		n/a		n/a			
All cancers: 62-Day Wait For First Treatment	From Consultant Screening Service Referral	90%	1.0		95.2%		100.0%		100.0%		100.0%		100.0%		100.0%		83.3%			
	Urgent GP Referral To Treatment	85%	1.0		86.4%		85.3%		85.5%		85.4%		87.2%		85.3%		89.2%			
A&E: Total time in A&E 95% Patients withing 4 Hr Target		95%	1.0		96.7%		95.5%		92.6%	1	95.5%		95.6%		94.5%	1	95.3%			
Referral to treatment waiting times – admitted (90% Target within 18 Weeks)		90%	1.0		91.1%		93.7%		95.0%		96.1%		94.6%		95.2%		93.9%			
Referral to treatment waiting times – non-admitted (95% Target Within 18 Weeks)		95%	1.0		98.9%		98.7%		98.7%		99.2%		98.7%		98.9%		98.9%			
Referral to treatment waiting times – Incomplete (92% Target Within 18 Weeks)		92%	1.0																	
31-Day (Diagnosis To Treatment) Wait For First Treatment	All cancers	96%	0.5		99.4%		99.7%		97.1%		98.9%		100.0%		100.0%		100.0%			
Two week wait from referral to date first seen	All cancers	93%	0.5		95.8%		97.9%		98.6%		98.9%		100.0%		100.0%		97.0%			
	For symptomatic breast patients (cancer not initially suspected)	93%	0.5		97.1%		98.5%		96.0%		94.8%		93.6%		98.5%		98.8%			
Thrombolysis within 60 minutes (where this is the preferred local treatment)		68%	0.5		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a	
Screening all elective in-patients for MRSA		100%	0.5		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%	
Care Programme Approach (CPA) patients	Follow up contact within 7 days of discharge	95%	0.5		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a	
	Having formal review within 12 months	95%	0.5		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a	
Minimising delayed transfer of care		<=7.5%	1.0		2.0%		2.7%		3.0%		2.2%		2.3%		2.5%		2.1%		n/a	
Admissions had access to crisis resolution home treatment teams		90%	1.0		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a	
Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a	
Data completeness: identifiers		99%	0.5		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a	
Data completeness: outcomes		50%	0.5		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a	
Ambulance FTs - Category A call – emergency response within 8 minutes		75%	1.0	No Risk	n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a	
Ambulance FTs - Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	No Risk	n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a	
Ambulance FTs - Category B call – a response within 19 minutes		95%	1.0	No Risk	n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a	
Self certification against compliance with requirements regarding access to healthcare for people with a learning disabi		N/A	0.5																	
Moderate CQC concerns regarding the safety of healthcare provision		N/A	1.0																	
Major CQC concerns regarding the safety of healthcare provision		N/A	2.0																	
Failure to rectify a compliance or restrictive condition(s) by the date set by CQC within the condition(s) (or as subseque		N/A	4.0																	
Does the Trust have outstanding compliance actions applied by the CQC ?				YES																
Does the Trust have outstanding enforcement actions applied by the CQC				No																
Registration conditions imposed by Care Quality Commission																				
Restrictive registration conditions imposed by Care Quality Commission																				
Restrictive registration conditions imposed by Care Quality Commission																				
				Rating																

6 March 2013

Ms Patricia Wright
Chief Executive
The Queen Elizabeth Hospital King's Lynn NHS
Foundation Trust
Foundation Trust Office
Gayton Road
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PE30 4ET

Monitor

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Dear Patricia

Q3 2012/13 monitoring of NHS foundation trusts

Our analysis of Q3 is now complete. Based on this work, the Trust's current ratings are:

- Financial risk rating - 3
- Governance risk rating - RED

The Trust has been assigned a Red governance risk rating, which reflects that the Trust is in significant breach of its Authorisation as a result of financial and governance concerns. The Trust will remain Red rated for governance risk until such time as Monitor is satisfied that the Trust has a sustainable financial position.

Compliance with targets and national core standards is a requirement of the Trust's terms of Authorisation. The *Compliance Framework* sets out the significance that Monitor attaches to a failure to comply. Monitor expects the Trust to have plans in place such that your Board will be in a position to submit unqualified self-certifications in future monitoring cycles.

I have attached a one page executive summary (Appendix 1) of your Trust's Q3 results for your information and a report on the aggregate performance of the NHS foundation trust sector will shortly be available on our website (in the ***News, events and publications*** section) which I hope you will find of interest.

For your information, we will shortly be issuing a press release setting out a summary of the key findings across the NHS foundation trust sector from the Q3 monitoring cycle.

If you have any queries relating to the above, please contact me by telephone on 020 7340 2501 or by email (Tim.Halford@monitor-nhsft.gov.uk).

Yours sincerely

T. W. Halford

Tim Halford
Senior Regional Manager

cc: Ms Kate Gordon, Chair
Mr David Stonehouse, Director of Finance & Business Development

BOARD REPORT APPENDIX 3 – PATIENT FLOW REPORT FOR EMERGENCY ACCESS

Introduction

Over the past few weeks, the Trust has had great difficulty in managing flow through the organisation; this in turn has prevented the Trust from achieving the four hour emergency access target through the Accident and Emergency Department.

Why was the target failed?

There are a number of contributing factors which have contributed to the Trust missing the four hour access target:

- Regular breaches
- Significant numbers of patients who are medically stable and fit for transfer
- Escalation beds open
- Significant nursing vacancies and increased sickness
- Cancelled operations
- Staff raising concerns about patient safety
- Significant numbers of emergency patients in elective beds
- Multiple bed moves

It is important to be clear where the problems are, A&E is often the place where the symptoms of the broader problems the Trust face have been more visible. While the A&E Department is not the root cause of many of the problems we are facing – it has at times played a contributing role.

During the week beginning 25 February a set of fresh eyes has identified the need to undertake, complete and implement some urgent work to get flow back into the system. Some of these are already projects within i-Flow (POD19) but for various reasons have not been implemented quick enough or have not been supported and sustained across the organisation.

In order to improve flow, it is a whole system priority and work will need to be undertaken with our partners in relation to referrals to MAU and A&E and discharges. BUT there is significant work the Trust MUST undertake with immediate effect.

- Every patient on every ward must be reviewed every day by a Senior Clinician -
    - This should be via the white board and should happen prior to a ward round and ideally before 9am.
- Every patient confirmed for discharge that day, without exception, should be transferred to the Discharge Lounge by 11am.
- Tackling internal waits –
    - A review of every patient over a four week period will be initiated to identify what the internal waits are. The Trust needs to be aware of what constitutes an internal wait, and then plan to eradicate them. Examples of identified waits so far identified include:
        - PEG insertion as only two lists per week
        - Only twice weekly ward rounds where decision to discharge are made
        - Delays in booking scans etc
        - Lack of weekend services
        - Completion of discharge letters
        - Waiting medication and in particular dosset boxes
        - Not getting a specific time for a treatment

Internal processes for tackling complex discharges

The review of delayed patients appears to have been more effective when attended/cleared by a Senior Manager. These meetings should be attended by all relevant agencies. The discussion should include all patients who are medically stable and fit for transfer, those with a delayed length of stay – 14 days past expected date of discharge or whom there are concerns that an individual may become a delay so that early intervention can be planned.

A regular review of all patients whose hospital stay is above 14 days and are not ready for discharge to be reviewed by a small group of clinicians to expedite action and identify trends.

- What needs to be done now to expedite a safe discharge?
- What could or should have been done earlier in the patient's stay to prevent or mitigate a long length of stay?

Where a patient has an extended length of stay (over 50 days) the clinical team will be required to present the case details to the appropriate Clinical Director.

Reinstate the circulation of the details of patients staying in the Trust for over 30 days to service line leadership and ward teams.

Dementia care - Whilst we have an excellent service, it is important that clinical teams do not rely on these individuals. Training/awareness should be provided for staff ensuring dementia friendly environments, nutritional support and use of the common assessment tool. Particular areas for this are Gayton and Tilney wards as well as medical sub specialties.

Updating the Home of Choice Policy and placing without prejudice needs to be completed urgently and then implemented.

External Parties

On 21st March, the Trust is meeting with members of community and social care to agree standards in relation to assessments. The Trust will be pushing for 'parallel' rather than sequential assessments.

A nursing/care home discharge proforma will be developed to be sent with the patient on discharge, covering medication, diagnosis, treatment, ongoing and follow-up care.

Standards for information sharing between the Trust and nursing/residential care will need to be agreed and implemented clearly outlining expectations on both sides. The aim of these standards will be designed to prevent the need for reassessment from the home prior to discharge.

Weekend Discharges

Weekend discharges need to be maximised and should be seen as a whole system issue, requiring co-ordination between partners. This will be picked up at a meeting with external parties.

Care Home Reassessments

Many Trusts now have managed to agree with residential/care homes that their client will not need to be reassessed if their condition has not changed – this will be addressed and hopefully supported with the implementation of appropriate discharge information.

Failed/problem discharges are currently reported to the Trust via Risk Management – we need to agree a mechanism whereby these are discussed widely so that lessons can be learnt and thereby reducing such problems.

Other Actions

Other areas to be addressed will include review of the current daily management of flow through the hospital and strengthening the out of hours on call arrangements so that escalation is to a person rather than via a phone call.

Review of the discharge team and skills of ward staff to undertake the discharge process.

Roll out of nurse led discharge across the organisation.

Activate recruitment and retention of nursing staff.

Review of all breaches in February to see what the themes are, and identify ones where breaches are related to issues other than waiting for beds.

Specific projects looking at reducing patients to be admitted are:

- 23 hour day surgery
- Increasing activity on TIU

Conclusion

There is a lot of work to do, but more importantly we have to change the way we work. We cannot continue as we currently are as managing flow is becoming more and more difficult, safety is being compromised, complaints about poor care and cancelled operations are increasing.

We all work in the NHS and more importantly, at The Queen Elizabeth Hospital, for one reason, and that is because we care and want to make a difference to our patients. ***Please, let's all pull together and get flow sorted.***

Gwyneth Wilson
Director of Nursing and Acting Director of Clinical Services
4th March 2013

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Website: www.eoe.nhs.uk

Our ref: ADM/NFFT031

Date 6th March 2013

To: Patient Experience Lead

CC: Chief Executive

Dear Colleague,

NHS Friends and Family Test Readiness Review Feedback

Prior to the launch of NHS Friends and Family Test nationally on the 1st April all Acute and A&E Trusts in England have, within the last 4 weeks, had a readiness review visit to support the Trust with a readiness assessment. The aim of these visits was to provide assurance for everyone including providers that we are approaching a sufficient state of readiness both regionally and nationally. The response by trusts and colleagues herein has been fantastic and much appreciated by the Strategic Projects Team and their contractors' co-ordinating the visits.

All Acute and A&E Trusts were provided with feedback at the end of the site visit, and we are now able to provide a copy of the feedback for your Trust. For further clarity about the implementation of the NFFT please refer to the documents and FAQ's available on the Strategic Projects website: http://www.strategicprojectseoe.co.uk or http://www.dh.gov.uk/health/2012/10/guidance-nhs-fft.

The Strategic Projects Team will be placing a follow up call to your trust in mid March, to discuss your feedback and next steps. If however you wish to discuss feedback prior to this please call us on 0800 923 3301.

Once again, thank you for the support you have given to the Friends and Family Test over the last year, and for your continuing support for the national programme. If you, or your team need any clarification please contact us at patient.revolution@eoe.nhs.uk or call us on 0800 923 3301

My regards

Andrew MacPherson
Director of Customer Service Strategy and the Strategic Projects Team
NHS Midlands and East

NHS

NHS Midlands and East

Friends and Family Test Readiness Report

2013

The Queen Elizabeth Hospital, King's Lynn. NHS Foundation Trust (A&E)

Prepared by the Audit Team, Fr3dom Health

Prepared : 26/Feb/2013

Fr3dom Health Solutions Limited | Fr3dom House | 11 North Street | Portslade | E Sussex | BN41 1DH | www.fr3domhealth.co.uk

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Forward

The Friends and Family Test (FFT) is a simple, comparable test which, when combined with follow-up questions, provides a mechanism to identify both good and bad performance and encourage staff to make improvements where services do not live up to expectations. The FFT has been used by all acute Trusts in Midlands and East to listen to patients and drive improvements in the experiences of patients since April 2012.

On 25th May 2012, the Prime Minister announced that the FFT would be rolled out to all acute inpatient and A&E departments in England from 1st April 2013. Following the publication of Implementation Guidance in October 2012, Trusts have been progressively implementing the FFT, in order to ensure that they are fully ready for implementation from 1st April 2013. Implementation has been further supported through publication of Unify Reporting Guidance and Publication Guidance (links available in the 'further information' section at the end of this document).

In February 2013, Fr3dom Health were commissioned by the NHS Midlands and East Strategic Projects Team, on behalf of the Department of Health, to undertake a review of the readiness of Trusts to fully implement the programme from 1st April 2013. This series of visits has been designed to provide assurance for everyone including providers that we are approaching a sufficient state of readiness both regionally and nationally. This report is designed to support Trusts in the final stages of implementation and provides an assessment of readiness in relation to the key deliverables outlined in the implementation guidance.

The FFT is an opportunity to ensure that organisations and individuals are truly focused on the experiences of patients. Organisations must ensure that information generated through the FFT can be quickly and effectively fed back to staff from "boards to wards" so that all have access to up-to-date patient feedback and thus will be informed and empowered to take immediate action to tackle areas of weak performance and build on success. In addition, patients will be able to use the information to make decisions about their care and to challenge their local Trusts to improve services while championing those who excel.

About your report

This report is based on the responses given by the Trust representative(s) we spoke to on our visit(s).

The purpose of the visit and this report is to try to assist Trusts in becoming ready for the challenge of implementing FFT in their environments. There is no "pass mark" as such and the intention is to present information that, it is hoped, will provide comfort that many Trusts are wholly ready, as well as highlighting where attention may be needed.

The feedback has been processed in two ways. There are a series of questions to which the Trust responses have been recorded. These are presented in the table at the back of this document. As well as asking these questions a broader conversation took place where we discussed approaches in general as well as some of the challenges FFT brings. These conversations have influenced assessments of the readiness of the Trust as a whole, using a simple likelihood scale to indicate our feelings as to the potential success of the chosen approaches. Conversations were and remain confidential and as such are not included in any report.

One key measure to look for is the balance between operational and submission readiness. For example a high score in submission readiness indicates a strong grasp of the Unify response requirements as well as a clear interpretation of the mandated guidance and so on. However if this is not supported by an equally strong readiness in data capture, or operational readiness, then it may be undermined.

About your auditor

All the Fr3dom Health Audit Team have extensive backgrounds in health sector research, patient experience and market research in a wider context. They have been asked to supplement the data collected with their own views formed from the conversations held with the Trust representative on site. The need to be confidential and candid has been explained in detail to all the team and your confidentiality will be observed at all times by your auditor and Fr3dom Health. If there is anything in your report you would like clarified please contact Fr3dom Health Audit Team directly so we may clarify any queries you may have.

Adherence

This section is a simple Yes/No adherence assessment. Trusts should have been selecting suppliers at the tail end of 2012 and seeking to test methodologies and tools over the first quarter of 2013. There are also a clear set of properties that are meant to be in place for the delivery of FFT. These are set out below together with the Trust ability to provide a copy of the survey to be used as requested in advance. There is no penalty at this stage for not adhering to the published guidance, or producing the survey to be used, however with the "Go Live" date fast approaching it is felt that these elements should be in place.

Was a specimen survey provided?	YES	
Was framing in line with guidance?		NO
Was question wording in line with guidance?	YES	
Were response options in line with guidance?	YES	
Is the FFT question the first on the survey?	YES	

So what should it be?

Firstly you should have by now designed your surveys (paper and electronic) and be able to provide an example. The FFT question should always be the first one asked to avoid order affect. Then the following elements must also be accurate (except for the framing which is suggested, not mandatory):

Framing

For inpatients: 'We would like you to think about your experience in the ward where you spent most time during this stay'

For A&E patients: 'We would like you to think about your experience in the A&E department during this visit'

Question wording

'How likely are you to recommend our <ward / A&E department> to friends and family if they need similar care or treatment?

Response options (layout and numbers are not mandated):

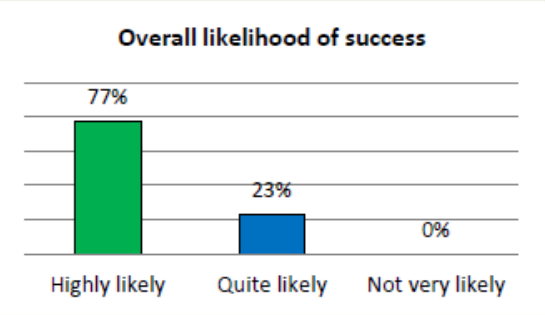
1 ☐ Extremely likely
2 ☐ Likely
3 ☐ Neither likely nor unlikely
4 ☐ Unlikely
5 ☐ Extremely unlikely
6 ☐ Don't know

Overall likelihood of success

The overall likelihood of success is determined by combining auditor likelihood ratings (coded as highly likely, quite likely or not likely) against the questions answered (see table) combined with positive responses to enquiries such as whether test surveys have been run so far and a key consideration – how Trusts are going to be sure patients respond within 48hrs of discharge? The overall score is an indication of how likely we think it is that the current state of readiness will satisfy the demands of the FFT roll out.

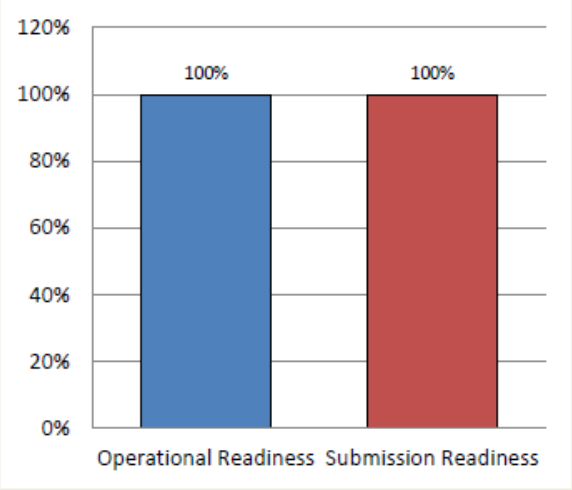
Overall scores are calculated by combining scores (from relevant questions) of highly or quite likely (as a % of all) less the % of responses graded unlikely.

(Highly likely + Quite likely) - Not likely = Overall likelihood expressed as a % of all relevant question responses. to be



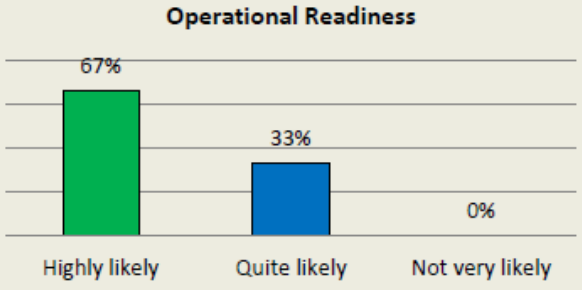
100%

The relationship between operational and submission readiness is important. If there is a difference between these two scores then it indicates a potential imbalance between the ability to collect, collate and submit the data accurately. Ideally the scores should be the same, a variance of up to 10% may present an acceptable risk, any greater than that then a review of both areas particularly the weaker would be advisable.



Operational readiness

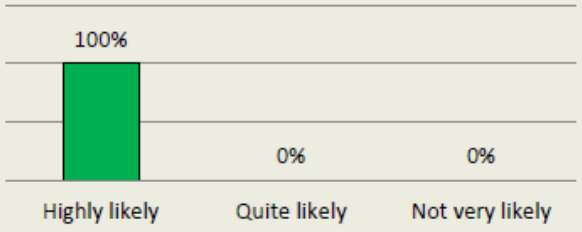
Operational readiness explores the extent to which we are confident that processes and considerations are in place that will enable the collection the data in line with the national guidance and that will support the filing of accurate submissions. Again it is a consideration based on our conversation and Trust responses to the specific questions that can be found in the table at the back of this document. Operational readiness of course may change between now and live date, this is how the picture looked in February 2013.



100%

Submission readiness

Submission readiness explores the extent to which we are confident that processes and considerations will enable compliant submissions to be made into Unify. It is a consideration based on our conversations and Trust responses to the specific questions that can be found in the table at the back of this document. The data below is representative of our view of the likelihood of your processes delivering compliant submissions and is based upon an assessment of responses and the accompanying conversations. Submission readiness of course may change between now and live date, this is how the picture looked in February 2013.



100%

Coded responses from interviews

Has a FFT questionnaire been prepared?

Yes

Can I please see a copy?

Yes

Looking at the survey provided, does it adhere to the guidance in the following:

Framing

Needs a change

Question wording

Approved

Response options

Approved

Is the FFT question the first on the survey?

Approved

Is the FFT question part of a longer survey?

Yes

Follow-up free text

Yes

Demographics

Yes

How will you know when the patient has visited A&E and allocate it to the right Unify return?

only collect data on day of discharge plus online form has discharge date

How will the FFT question be delivered?

Paper survey complete on site and Online

Are you offering the following language options?

N/A - not offering languages

Coded responses from interviews

Who will be responsible for distribution of FFT question in A&E?

receptionists in first instance~ if patient comes in by ambulance nurse will be responsible at discharge

How will you ensure that FFT is not delivered by somebody delivering treatment that can influence the patient?

Patient is left alone to complete the survey and training issue

How will you ensure that 100% of patients are given the opportunity to respond ?

There is no planned / consistent approach as it is decided by each ward and receptionist will hand out form to all patients presenting ~ intention is that nurses wil hand forms to ambulance cases discharged home

How will you ensure that you receive responses from at least 15% of eligible patients?

Comparing the number of dischargers and returns ongoing

What have you done to ensure you are as inclusive of your population as you can be?

Assessed our patient demographic in advance and Have included demographics in survey

How will you ensure that that the question is asked within 48 hours of discharge?

question only asked at discharge

Do you know who you should be including when asking for responses? [Need both for acute] (Adults that have attended A&E without being admitted to hospital or were transferred to MAU)

Yes

Have you started collecting responses from A&E?

Yes

How will you ensure that you are able to make Unify returns every month?

Have appointed Information Team responsible person

Do you have any agreements with your Commissioners for reporting your results and follow-up actions, over and above the mandated process?

Yes

Coded responses from interviews

How are you collating the responses?

Outsourced

Do you have a plan to validate responses?

Monthly review and provider iwgc maintains that they check for suspiciously repeated phrases on scanned survey forms which can lead to hand check for unusual electronic submission

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NHS
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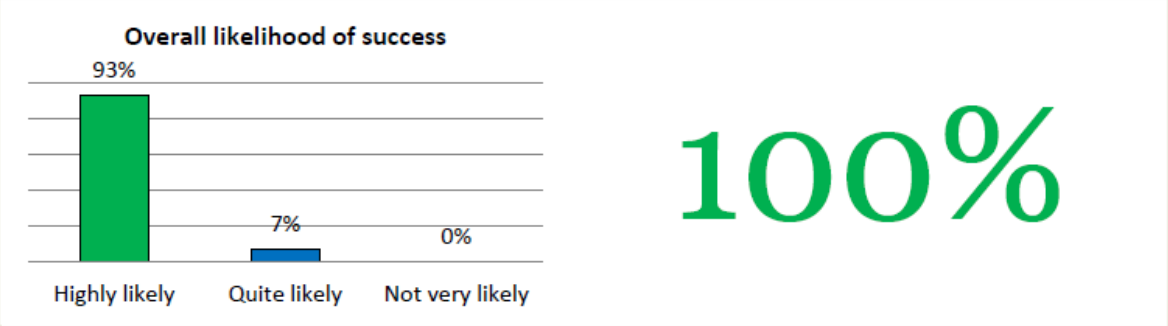

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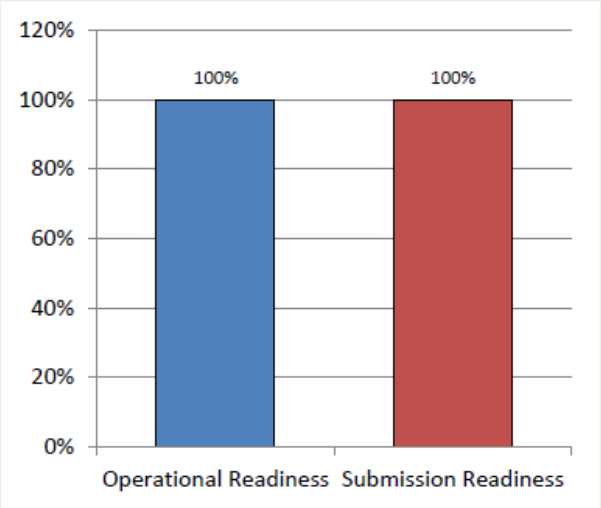

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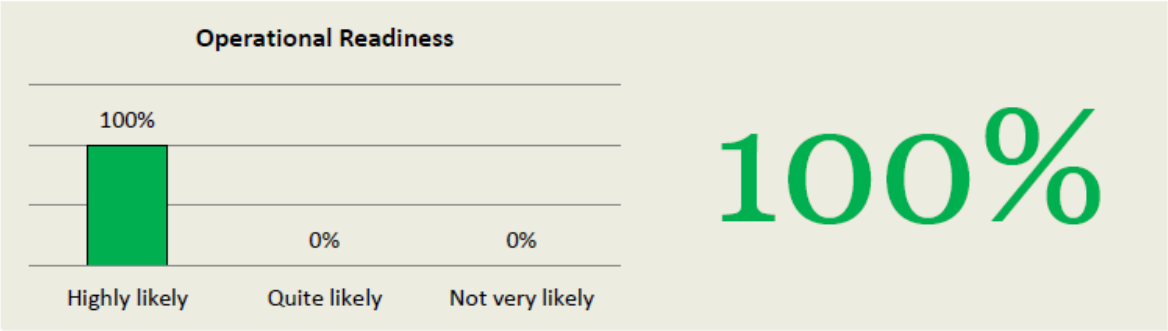

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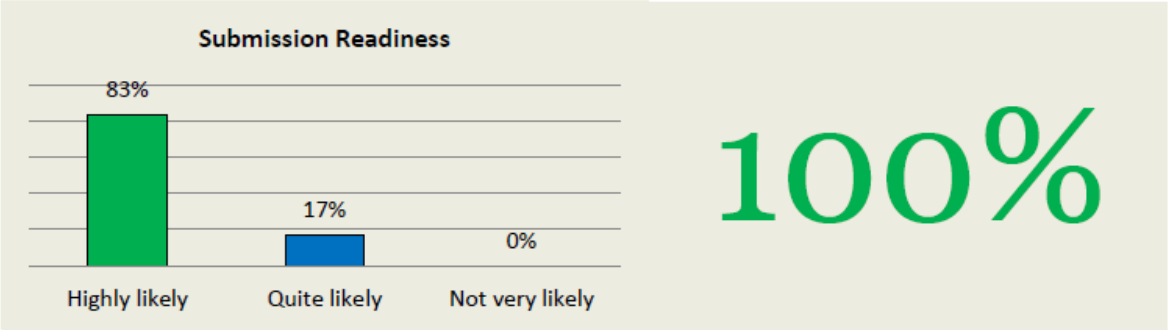

Coded responses from interviews

Has a FFT questionnaire been prepared?

Yes

Can I please see a copy?

Yes

Looking at the survey provided, does it adhere to the guidance in the following:

Framing

Needs a change

Question wording

Approved

Response options

Approved

Is the FFT question the first on the survey?

Approved

Is the FFT question part of a longer survey?

Yes

Follow-up free text

Yes

Demographics

Yes

How will you know when the patient was discharged, and allocate it to the correct Unify return?

paper based version collected at least weekly and collated in month-on line will have date stamp

How will you ensure that the responses are attributed to the correct ward (ie where the patient spent the most time)?

Patient completes and Information pre populated by staff

How will the FFT question be delivered?

Paper survey complete on site and Online

Coded responses from interviews

Do you have any agreements with your Commissioners for reporting your results and follow-up actions, over and above the mandated process?

Yes

How are you collating the responses?

Outsourced

Do you have a plan to validate responses?

provider claims to be able to spot repeated phrases on cards or inappropriate submissions on line automatically which can trigger hand search.

Friends and Family Test Readiness Report 2013

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