Northern Lincolnshire and Goole NHS
NHS Foundation Trust

NLG(16)328

DATE	**26 July 2016**
REPORT FOR	**Trust Board of Directors – Public**
REPORT FROM	**Wendy Booth, Director of Performance Assurance & Trust Secretary**
CONTACT OFFICER	**Claire Jenkinson, Head of Performance**
SUBJECT	**Integrated Performance/KPI Framework Report – May 2016**
BACKGROUND DOCUMENT (IF ANY)	**Performance Reporting Framework**
REPORT PREVIOUSLY CONSIDERED BY & DATE(S)	**Trust Governance and Assurance Committee – 18 July 2016**
EXECUTIVE COMMENT (INCLUDING KEY ISSUES OF NOTE OR, WHERE RELEVANT, CONCERN AND / OR NED CHALLENGE THAT THE BOARD NEED TO BE MADE AWARE OF)	**The attached report outlines the position against the Trust's key performance indicators as at May 2016. This includes Monitor and Contract KPI requirements, the Internal Performance Summary.**
HAVE THE STAFF SIDE BEEN CONSULTED ON THE PROPOSALS?	**N/A**
HAVE THE RELEVANT SERVICE USERS/CARERS BEEN CONSULTED ON THE PROPOSALS?	**N/A**
ARE THERE ANY FINANCIAL CONSEQUENCES ARISING FROM THE RECOMMENDATIONS?	**NO**
IF YES, HAVE THESE BEEN AGREED WITH THE RELEVANT BUDGET HOLDER AND DIRECTOR OF FINANCE, AND HAVE ANY FUNDING ISSUES BEEN RESOLVED?	**N/A**
ARE THERE ANY LEGAL IMPLICATIONS ARISING FROM THIS PAPER THAT THE BOARD NEED TO BE MADE AWARE OF?	**NO**
WHERE RELEVANT, HAS PROPER CONSIDERATION BEEN GIVEN TO THE NHS CONSTITUTION IN ANY DECISIONS OR ACTIONS PROPOSED?	**YES**
WHERE RELEVANT, HAS PROPER CONSIDERATION BEEN GIVEN TO SUSTAINABILITY IMPLICATIONS (QUALITY & FINANCIAL) & CLIMATE CHANGE?	**N/A**
THE PROPOSAL OR ARRANGEMENTS OUTLINED IN THIS PAPER SUPPORT THE ACHIEVEMENT OF THE TRUST OBJECTIVE(S) AND COMPLIANCE WITH THE REGULATORY STANDARDS LISTED	**Ensures compliances with the key performance indicators**
ACTION REQUIRED BY THE BOARD	**The Trust Board is asked to note the report**

Northern Lincolnshire and Goole NHS
NHS Foundation Trust

DIRECTORATE OF PERFORMANCE

INTEGRATED PERFORMANCE REPORT

May 2016

Author: Claire Jenkinson
Head of Performance
Date: May 2016

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Northern Lincolnshire and Goole NHS
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MONITOR COMPLIANCE FRAMEWORK SUMMARY
Performance Against Key Thresholds For The Period 1st April 2016 to 31st May 2016

PERFORMANCE METRIC	WEIGHTING	2015/16 QTR 4	QTR 1 Threshold	Apr-16	May-16	QTR 1 Actual To Date	Qrt 1 FAILURE WEIGHTING
1. Infection Control*							
Total Hospital Acquired C.Difficile Cases Lapses in Care (YTD)	1.0	G	21	0	0	0	G
2. Referral to Treatment Waiting Times							
Incomplete - Maximum waiting time of 18 weeks	1.0	R	92%	89.40%	88.68%	89.04%	R
3. Cancer * **							
31 day wait diagnosis to treatment	1.0	G	96%	99.3%	99.3%	99.5%	G
i) 31 day wait for subsequent treatments - Surgery	1.0	G	94%	100%	100%	100%	G
ii) 31 day wait for subsequent treatments - Anti cancer drugs		G	98%	97.9%	100%	99.3%	G
i) 62 day wait GP referral to treatment POST alloaction		R	85%	77.8%	76.0%	75.6%	R
ii) 62 day wait GP referral to treatment PRE allocation	1.0	R	85%	81.5%	81.3%	81.0%	R
ii) 62 day wait Consultant screening service referrals allocation		R	90%	100%	100%	100%	G
i) 2 week wait referral to consultation	1.0	G	93%	96.2%	95.9%	96.8%	G
ii) 2 week wait breast symptomatic referrals		G	93%	98.1%	92.8%	96.4%	G
4. A&E							
A&E 4 Hour Wait Compliance	1.0	R	95%	89.76%	93.20%	91.58%	R
5. Data Completeness Community Services **							
5i) Referral to treatment information	1.0	G	50%	100%	100%	100%	G
5ii) Referral Information		G	50%	100%	100%	100%	G
5iii) Treatment Activity Information		G	50%	89.4%	89.2%	89.3%	G
6. Access **							
Access to healthcare for people with learning disability	0.5	G	Y/N	Y	Y	Y	G

* Quarterly Cumulative figures

** Forecast Position

*** **Provisional Data**

Total Monitor Compliance Score	3.0
Monitor Compliance Rating	Green
Monitor Over ride Rating	Red

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SECTION 2
CONTRACTUAL COMPLIANCE SUMMARY
For The Period 1st April 2016 to 31st May 2016

Performance Metric		Threshold	Apr-16	May-16	Comments
Referral to Treatment					
E.B.3	Patients on incomplete RTT pathways waiting no more than 18 weeks from referral	92%	89.4%	88.7%	A range of proactive improvement measures have been instigated across the Trust to regularly manage and monitor the 18 week performance position. Service review work is a key feature of the 2016/17 sustainablity programme.
E.B.4	Patients waiting less than 6 weeks from Referral for a diagnostic test	99%	97.5%	97.9%	Patient appointments that were displaced as a result of the junior doctors strike across the Trust continues to impact on the diagnostic performance. Furthermore the reorganising the routine diagnostic patients to improve the diagnostic waiting times for patients on a cancer pathway is still impacting
E.B.S.2	Patients who have operations cancelled, on or after the day of admission, for non-clinical reasons to be offered another binding date within 28 days	0	0	1	This operation was cancelled 3 times, initially due to ward bed capacity, the second TCI date was cancelled in advance due to the doctors strike, the third instance due to ward bed capacity. Actions taken: cancelled operations to be closely monitored by the Service Manager until treatment is completed.
E.B.S.4	Zero tolerance RTT waits over 52 weeks for incomplete pathways	0	0	0	
E.B.S.6	No urgent operation should be cancelled for a second time	0	0	0	
A&E					
E.B.5	Patient admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	89.8%	93.2%	This measure experienced improved position during May, although patient attendance increased by 784 patients compared to April, performance increased by 3.4%, the highest position in the past five months. A high dependency cohort of patients and bed availability is an ongoing occurrence within the department. Operationally various processes have been instigated including shift leaders regulating staffing levels to meet capacity demands, the Trust has continued enhanced medical support across 7 days to support patient reviews and decision making.
E.B.S.5	Trolley waits in A&E no longer than 12 hours	0	0	0	
***Cancer**					
E.B.6	2ww - urgent GP referrals (cancer suspected)	93%	96.2%	95.9%	
E.B.7	2ww - urgent symptomatic breast referrals (cancer not initially suspected)	93%	98.1%	92.8%	The performance of the cancer standard has fallen below target due to 8 patients in total preferring to delay their appointment beyond the 14 day timeframe.
E.B.8	Patient waiting no more than 31 days from diagnosis to first definitive treatment for all cancers	96%	99.3%	99%	
E.B.9	Patient waiting no more than 31 days for subsequent treatment (surgery)	94%	100%	100%	
E.B.10	Patient waiting no more than 31 days for subsequent treatment (anti-cancer drug regime)	98%	97.9%	100%	
E.B.12	Patient waiting no more than 62 days from urgent GP referral to first definitive treatment	85%	81.5%	81.3%	A Trust wide Action Plan has been developed which includes all aspects of pathway management, breach review and reporting to support improved performance. In addition a new detailed report monitoring performance, Trust wide and by tumour site, has been introduced and deployed on a weekly basis. RCA for all patients breaching treatment targets is undertaken.
E.B.13	Patient waiting no more than 62 days referral from an NHS screening service to first definitive treatment (all cancers)	90%	100%	100%	
Infection Control					
E.A.S.4	Zero Tolerance MRSA	0	0	0	
E.A.S.5	Minimise rates of Clostridium Difficile Lapses in Care (YTD)	21	0	0	There were 3 episodes of Clostridium Difficile, 2 DIPC reviews have been completed establishing no lapse of care and 1 DIPC review is to be conducted.
	Clostridium Difficile (YTD)		0	3	
3	Hospital Acquired MRSA bacteraemia cases to be notified to commissioner within 2 working days	100%	n/a	n/a	No episodes of MRSA bacteraemia cases year to date
4	MRSA bacteraemia PIR report provided to commissioner within 14 working days of case being identified	100%	n/a	n/a	No episodes of MRSA bacteraemia cases year to date
5	Appropriate elective admissions screened for MRSA prior to admission	95%	100%	100%	

SECTION 2
CONTRACTUAL COMPLIANCE SUMMARY
For The Period 1st April 2016 to 31st May 2016

Performance Metric		Threshold	Apr-16	May-16	Comments
6	Appropriate emergency admissions screened for MRSA within 24 hours of admission	95%	87.9%	88.5%	Performance is being monitored at Infection Control site meetings, matrons have been asked to review and improve their screening processes.
7	In-patients with MRSA are on MRSA Care Pathway	100%	100%	100%	
8	Notification to commissioners of C. Difficile toxin positive cases within 1 working day	100%	n/a	100%	
9	RCA undertaken for all NLAG acquired C. Diff cases - key issues submitted to Commissioner	100%	n/a	100%	
Ambulance Handover					
E.B.S.7a	All handovers between ambulance & A&E must take place within 15 mins (no more than 30 mins)	0	834	429	A bi weekly task group has been implemented to review the new Ambulance Arrival Screen Project. Early indications are that this group has had a positive impact on performance which is demonstrated May's figures.
E.B.S.7b	All handovers between ambulance & A&E must take place within 15 mins (no more than 60 mins)	0	161	43	
National Quality & Governance					
**	VTE	95%	93.7%	94.6%	Weekly reports detailing the VTE status are sent to ward managers, matrons and senior managers highlighting the number of patients that are outstanding a VTE assessment.
	Publication of formulary	Y	Y	Y	
	Duty of Candour - SUIs - failure to notify relevant person	0	0		Data is currently being validated for May.
	Duty of Candour - Moderate Harm (non SUIs) - failure to notify relevant person	0	0		
	NHS Number in SUS (Acute)	99%	100%		
	NHS Number in SUS (A&E)	95%	98.8%		
	Never Events	0	0	0	
E.B.S.1	MSA - sleeping breaches	0	0	0	
Maternity					
1	Maternity - women recorded as smoking by 12 weeks & 6 days referred to smoking cessation	95%	100%	100%	
2	Maternity - women who have seen a midwife by 12 weeks and 6 days	90%	96.1%	94.0%	
Local Quality & Governance					
10	Serious incidents reported to commissioners within 48 hours of SI being identified	100%	100%	100%	
11	Completed serious incident reports to be submitted within 60 days for both Grade 1 & Grade 2	100%	100%		There were no SI reports applicable for submission in May.
	DNA rates	8.0%	8.5%	9.1%	DNA rates are being reviewed as part of the clinical administration review. Improvement strategies are being piloted in some specialities. Monthly data is rebased to reflect historic changes.
	Eligible Patients who receive thrombolysis	80%	100%	100%	

* May Provisional
** Qrt 1 Provisional

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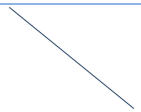
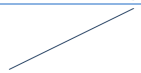
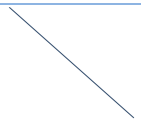
SECTION 3
TRUST KEY QUALITY PERFORMANCE INDICATORS
For The Period 1st April 2016 to 31st May 2016

	Performance Metric	Indicator Type	Committee	Threshold	Apr-16	May-16	Trend Analysis	Comments
Effectiveness								
KPI01	SHMI - hospital within expected range	MPAC	TGAC	95	106 (Dec - 15)	104 (Jan - 16)		This is a Trust quality priority which is monitored at monthly QPEC and MPAC meetings. A range of work streams have been implemented focusing on: care for patients at the end of life, accuracy of information and coding, 6 clinical led Multi Disciplinary Teams looking at quality/morality agenda. Case note reviews are also looking at care quality and a monthly detailed Mortality report is overseen by MPAC and Trust Board.
KPI02	SHMI - weekend within expected range	MPAC	TGAC	95	111 (Dec - 15)	106 (Jan - 16)		
KPI03	Adherence to NICE guidance (all guidance)	QDP	QPEC	90%	83.4%	77.6%		Work streams implemented to support healthcare professionals to assess the increasing numbers of guidelines within the required timescales. TGAC monitoring monthly performance.
KPI183	Documents in compliance within the Document Control System	PERF	TGAC	90%	78.6%	79.3%		Operational groups have implemented various work streams to improve such as using trackers, dedicated section on governance agenda and general management direct control.
Safety								
KPI04	Inpatient discharge summary to GP within 24 hours.	PERF	QPEC	98%	72.2%	73.7%		Trend analysis process created to identify problem areas.
KPI05	Safety Thermometer - Acute	PERF	TGAC	95%	89.8%	91.3%		
KPI06	Safety Thermometer - Community	PERF	TGAC	95%	97.4%	95.7%		
KPI08	5% reduction in incidents with a common theme	PERF	TGAC	855	1157	1143		
KPI09	50% reduction in incidents with same theme (Pressure Ulcers)	PERF	TGAC	16	33	23		Trust wide action plans created from RCAs and individual action plans for any grade 3 and 4 pressure ulcers. Mandatory pressure area management & documentation training introduced in July 15. Total graded pressure ulcers: 28 Grade 2 - 4 Grade 3 - 1 Grade 4.
KPI11	Incidents coded & graded within 5 working days	PERF	TGAC	95%	78.0%	79.3%		The additional coding and grading sessions delivered over the past few months are having a positive impact on this KPI.
KPI12	CCG Incidents responded to within 20 working days	PERF	TGAC	100%	44.0%	56.3%		Risk Governance Facilitators currently reviewing processes to improve response times.
KPI206	Incident Feedback to Reporter							This KPI is measuring requested feedback from incidents provided to reporter. Datux has been modified to capture this data from June 16 onwards.
KPI13	Groups achieved publication of quarterly learning lessons newsletter	PERF	TGAC	100%	100%	100%		
3.1	Dementia & Delirium - Screening over 75s	CQUIN	TGAC	90%	91.9%	95.1%		
3.2	Dementia & Delirium - Assessment	CQUIN	TGAC	90%	100%	100%		
KPI184	Serious Incident Action Plans completed within required timescales		TGAC	100%	100%	100%		
KPI185	Confidential enquires to have gap analysis		TGAC	90%	84.2%	100%		
KPI186	Patient safety alerts have been actioned by the specified deadlines		TGAC	100%	100%	100%		
KPI187	SUI responded to within the required 12 week timescale		TGAC	100%	100%	n/a		
KPI188	SUI responded to within the re-negotiated timescale		TGAC	100%	100%	n/a		
Patient Flows								
KPI14	Elective Length of Stay at or below national benchmark rate	PERF	TGAC	3.3	2.4	2.7		
KPI15	Non-elective Length of Stay at or below national benchmark rate	PERF	TGAC	4.7	5.3	5.2		
KPI16	Ward transfers due to capacity reasons	QDP	QPEC	20%	11.0%	8.0%		
KPI17	Delayed transfer of care at or below national benchmark rate	PERF	TGAC	3.8%	3.3%	2.1%		
KPI 18	Outliers on adult wards (as of March 15)	QDP	QPEC	3%	5.6%	4.4%		
KPI 182	Trust DNA Rate	QDP	QPEC	6%	8.5%	9.1%		Call reminder service resources allocated to specific specialities to be rolled out to all specialities following implementation of the new clinical admin structure.
KPI19	Fractured Neck of Femur patients to be operated on within 36 hours	QDP	QPEC	75%	64.3%	60.0%		There is discrepancy currently an issue around conciliating data on the National Hip Fracture Database compared to PAS. The operation group is in the process of procuring more administration support into #NOF validation. The performance is representative of the current information available.
* KPI19b	Fracture neck of Femur Best Practice Tariff	PERF	TGAC		39.3%	36.0%		

SECTION 3
TRUST KEY QUALITY PERFORMANCE INDICATORS
For The Period 1st April 2016 to 31st May 2016

	Performance Metric	Indicator Type	Committee	Threshold	Apr-16	May-16	Trend Analysis	Comments
KPI20	30 day emergency readmissions at or below national benchmark rate	PERF		6.6%	5.8%	4.1%		
KPI21	New to review ratio at or below national benchmark rate	PERF		1:9	2:0	1:9		
KPI191	QA and NCAPOP National Audit on Target for Completion	PERF	TGAC	100%	96.5%	96.7%		Quality Accounts and National Clinical Audit Patient Outcomes Programme are National Audits that the Trust must take part in. Group performance of these QA/NCAPOP audits is monitored through the Quality & Audit Deptment.
KPI192	QA and NCAPOP National Audits have in place a signed action plan agreed at Governance	PERF	TGAC	100%	100%	100%		
KPI193	QA and NCAPOP action plans are on target	PERF	TGAC	100%	60.0%	76.5%		
KPI194	Hospital Outpatient Cancelled Appointments	PERF			13.2%	8.6%		This data is rebased each month to capture back logged activity
KPI195	Appointment cancellation rates by Patients	PERF			11.8%	12.4%		
KPI196	Hospital Followup appointments - Over Due	PERF			18266	18190		Data for May as at 24.05.16
KPI203	Hospital Followup appointments - Due date not known	PERF			12838	13095		
KPI197	18 wk Pathway validation numbers - Active to inactive	PERF			1593	3147		This is an accumlative number April 16 to May 16
KPI198	Cancelled Clinic Rate	PERF			2.3%	0.9%		The improvement of this indicator could be the result of only booking clinic sessions 4 weeks in advance, therefore less clinics require cancelling.
Stroke								
KPI22	Stroke patients spending time on stroke unit	PERF	TGAC	80%	100%	88.0%		
KPI23	TIA with high risk of stroke - assessed & treated within 24 hours	PERF	TGAC	60%	88.0%	100%		
KPI24	Stroke patients scanned within 1 hour of hospital arrival	PERF	TGAC	50%	72.0%	54.0%		
KPI25	Stroke patients scanned within 24 hours of hospital arrival	PERF	TGAC	100%	100%	100%		
KPI26	Stroke patients & carers with joint care plans	PERF	TGAC	85%	100%	100%		
KPI27	Stroke patients support from Early Supported Discharge Team	PERF	TGAC	40%	60.0%	70.0%		
Patient Experience								
KPI28 (a)	In patient Friends & Family Test response rate FFT (all)	QPEC	TGAC	40%	19.3%	17.0%		Clinical Group have implemented measures to improve response rate. NHS England FFT Lead stipulated the team have implemented amble measure for promotion, provision of cards and staff awareness. Ongoing monitoring by department managers. Card collection and data entry capacity issues has impacted on low response rates Going forward a robust web based data entry system will go live in February. A budget has been allocated for an NHS Apprentice who will lead on card collection and data in put.
KPI28 (b)	In patient Friends & Family Test response rate FFT (inpatients)	QPEC	TGAC	40%	41.6%	39.0%		
KPI29	A&E Friends & Family Test response rate	QPEC	TGAC	20%	8.9%	7.7%		
KPI30	Complaints acknowledged within 3 working days	PERF	TGAC	100%	100%	100%		
KPI31	Complaint action plans drafted	PERF	TGAC	90%	100%	100%		
KPI32	Complaints action plans implemented	PERF	TGAC	90%	100%	100%		
KPI189	PALS concerns responded to within 5 working days	QDP	QPEC	90%	62.0%	62.2%		Complexity of the concern raised can require additional time to be allocated to the PALs concern. PALS daily prioritization monitor report being developed. Other issues can be due to the groups not dealing with the concern within the agreed timescales. Groups are prompted to deal with concerns via the weekly PALs report which is to prompt / escalate concerns.
KPI190	Complaints investigated within timescale agreed with complainant	QDP	QPEC	95%	100%	100%		
KPI33	5% reduction in complaints received with same theme	PERF	TGAC	52	76	80		
KPI34	Performance across 5 areas contained within menu card survey	PERF	TGAC	90%	96.7%	97.4%		
KPI35	Patient Experience across the nursing care indicators	PERF	TGAC	95%	99.6%	99.9%		
KPI36	Patients involved in decisions about their care & treatment	PERF	TGAC	95%	98.8%	100%		
KPI44	Appropriate action was taken in response to NEWS score in accordance with Trust policy	PERF	TGAC	95%	100%	100%		
Maternity								
KPI45	Rate for stillbirths at or below national benchmark rate	PERF	TGAC	4.7	5.7	4.8		

SECTION 3
TRUST KEY QUALITY PERFORMANCE INDICATORS
For The Period 1st April 2016 to 31st May 2016

	Performance Metric	Indicator Type	Committee	Threshold	Apr-16	May-16	Trend Analysis	Comments
KPI46	Neonatal deaths less than 28 days at or below national benchmark rate	PERF	TGAC	TBC	0	0		
KPI47	Caesarean Rate - Overall	PERF	TGAC	26.2%	23.3%	26.3%		
KPI48	Induction Rate	PERF	TGAC	25.0%	29.0%	27.4%		Induction rates nationally are increasing due to recent work around still births and neonatal deaths.
KPI49	Unexpected Admissions to NICU	PERF	TGAC	TBC	4	0		
KPI82	No gynaecology patient outliers on maternity (admissions and transfers)	PERF	TGAC	0	0	0		
WORKFORCE INDICATORS								
Staffing & Roistering								
KPI50	Staff turnover rates				15.2%	14.7%		
KPI51	Reduction in nursing vacancy rate	QDP	QPEC	6%	9.7%	10.0%		Review meetings held every week. Recruitment incentive packages developed and agreed, European recruitment ongoing, University partnerships developed, Retention plan progression including band 5+, Nursing academies and return to practice, Enhanced pay for bank staff within 'specialist areas'.
KPI52	Reduction in medical staffing vacancy rate	QDP	QPEC	14.17%	16.3%	18.9%		
KPI53	Reduction in AHP vacancy rate	QDP	QPEC	6.86%	6.9%	7.4%		
KPI54	Reduction in average monthly spend on nursing locum & agency staff	QDP	QPEC	£476,000	£747,000	£741,000		Increased spend due to use of high cost agency. Controlled system in place to use cost effective agencies, enhancement schemed commenced to increase use of hospital bank staff.
KPI55	Reduction in average monthly spend on locum & agency medical staff	QDP	QPEC	£1,467,000	£1,508,000	£1,436,000		
KPI56	Sickness levels at or below national benchmark rate	QDP	QPEC	4%	4.4%	4.3%		April's data has been rebased to capture back logged historic activity.
KPI207	No Band 4s are rostered to RN shifts at roster approval stage'							This is a new KPI - a data extract to populate the report is currently being developed.
Staff Experience								
KPI59	Staff FFT - would be happy for friend or family member to receive care on this ward	PERF	TGAC	80%	100%	100%		
KPI60	Staff are satisfied with care that they provide	PERF	TGAC	80%	100%	100%		
KPI61	Director visit evaluation forms received from every visit	PERF	TGAC	75%	100%	100%		
Training & Development								
KPI62	Relevant staff have received dementia awareness training (by 31 Dec 16)	QDP	QPEC	60%	67.6%	68.7%		

SECTION 3
TRUST KEY QUALITY PERFORMANCE INDICATORS
For The Period 1st April 2016 to 31st May 2016

	Performance Metric	Indicator Type	Committee	Threshold	Apr-16	May-16	Trend Analysis	Comments
KPI63	Mandatory training compliance rate	QDP	QPEC	95%	93.3%	93.1%		Failure to achieve this indicator has been escalated to and discussed at the Trust's Governance & Assurance Committee. A range of actions were identified and these will be undertaken over the coming months. Monthly reports are distributed to group managers highlighting staff who are nearing the cut off point for training compliance.
KPI64	Staff to have undertaken an annual Vision & Values PADR	QDP	QPEC	95%	85.3%	77.9%		This continues to be monitored at all levels of the Trust. Monthly reports are distributed to group managers highlighting staff who are nearing the cut off point for PADR compliance.
KPI66	All relevant wards & departments to have a nominated LD champion	QDP	QPEC	100%	97.9%	97.9%		
KPI67	All LD champions to have received relevant training	QDP	QPEC	100%	52.2%	52.2%		
Clinical Indicators								
KPI68	Clinical lead roles appointed to	QDP	QPEC	90%	97.4%	97.4%		
KPI69	Mandatory training target for clinicians	QDP	QPEC	95%	69.1%	70.9%		Failure to achieve this indicator has been escalated to and discussed at the Trust's Governance & Assurance Committee. Monthly reports are distributed to group managers highlighting staff who are nearing the cut off point for training compliance.
KPI70	Relevant doctors have a refreshed and reviewed job plan	QDP	QPEC	100%	22.0%	28.0%		Due to a service review SGH radiology job plans have been recalled for review and re-issue.
KPI71	Completed job plans recorded on the central database	QDP	QPEC	100%	100%	100%		
KPI72	Job plan clearly differentiates between DCC and SPA activity	QDP	QPEC	100%	100%	100%		
KPI73	All PAs > 10 to be clearly identified as additional PAs on a fixed term basis	QDP	QPEC	100%	N	N		Process is currently being developed to differentiate between the 10 PA contract and the fixed term additional PA's on the e-job planning system.
KPI74	Doctors have undertaken annual appraisal	QDP	QPEC	95%	96.8%	97.9%		
KPI75	Doctors have undertaken revalidation	PERF	TGAC	95%	80.0%	0.0%		2 doctors were recommended to the GMC both were deferred.
KPI76	Job plans are Quality Assured annually by AMDs	QDP	QPEC	100%	N	N		Robust process is currently being developed. Audit meeting will be scheduled following the release of e job plans.
KPI77	Appropriate AMDs & Clinical Leads have attended development programme within 6 months of being in post	QDP	QPEC	90%	82.9%	82.9%		Work is onging to provide a new Development Programme which will review the programme content and forward delivery.
KPI204	Antimicrobial Stewardship within 48-72 hours							
Estates and Facilities Indicators								
KPI78	Patient satisfaction with hospital food	PERF	QPEC	90%	89.1%	89.3%		Patient comments to be discussed at the Catering Sub Group meeting and menu update. Wards to inform kitchen and Trust dietician regarding specialist diet requests.
KPI79	Patient satisfaction with ward/hospital cleanliness	PERF	QPEC	90%	99.6%	99.5%		
KPI80	Preventative Maintenance	PERF	RES	90%	90.4%	88.4%		Currently reviewing all existing planned preventative maintenances. A portion of maintenance delays can be attributed waiting for delivery of parts and spares. Impact of additional new plant and equipment installations with no additional in house workforce.
KPI81	Reactive Maintenance	PERF	RES	90%	73.2%	82.1%		
Administration Indicators								
KPI199	Percentage of letters on Dictate IT system	PERF						This is a new KPI - The system supplier are currently interrogating their reporting module to identify and extract raw data that will populate the Trust's data ware house.
KPI200	No. of letters waiting over threshold	PERF		10 Days	14.0	13.5		Data reflects the position as at 27th May
KPI201	Percentage of abandoned telephone	PERF			7.1%	6.4%		This KPI is measuring the percentage of telephone calls from patients to the SAT team that are abandoned.
KPI202	Number of abandoned letters	PERF						This new indicator is reporting on the number of letters that have been dictated onto the Dictate IT system but no letter have been produced.

* Included within the Performance KPIs to demonstrate the 2 ~NOF measures reported on by the Trust.

SECTION 3
TRUST KEY QUALITY PERFORMANCE INDICATORS
For The Period 1st April 2016 to 31st May 2016

Performance Metric	Indicator Type	Committee	Threshold	Apr-16	May-16	Trend Analysis	Comments