St George's Healthcare NHS
NHS Trust

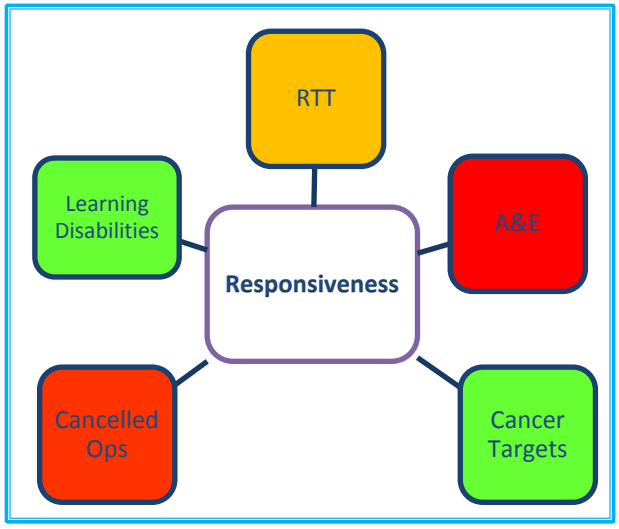
Performance Report

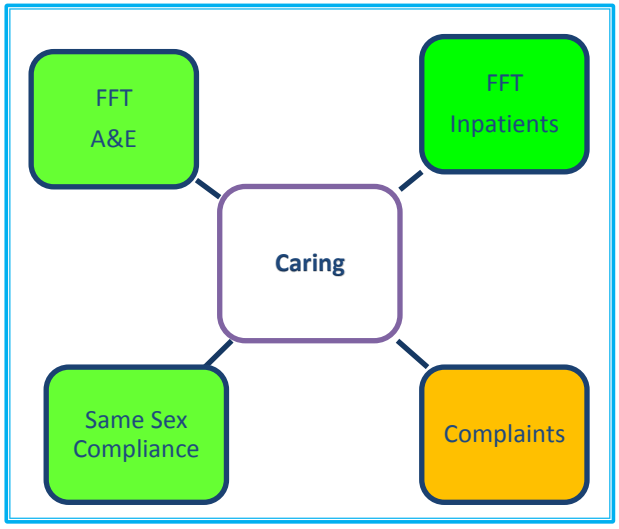
Trust Board
Month 2 - May 2014

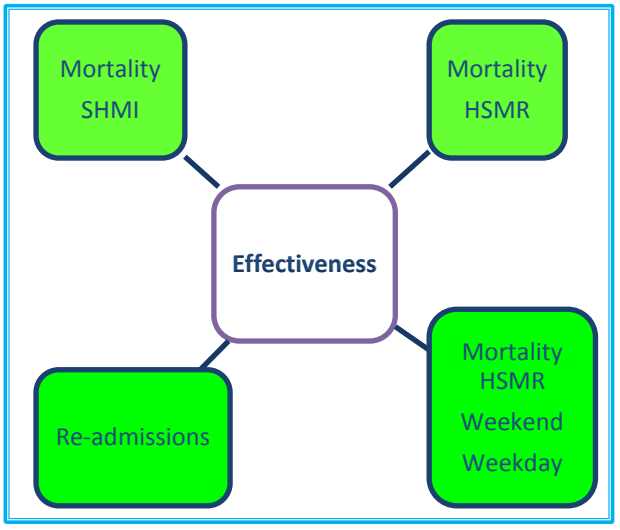
excellent kind responsible respectful

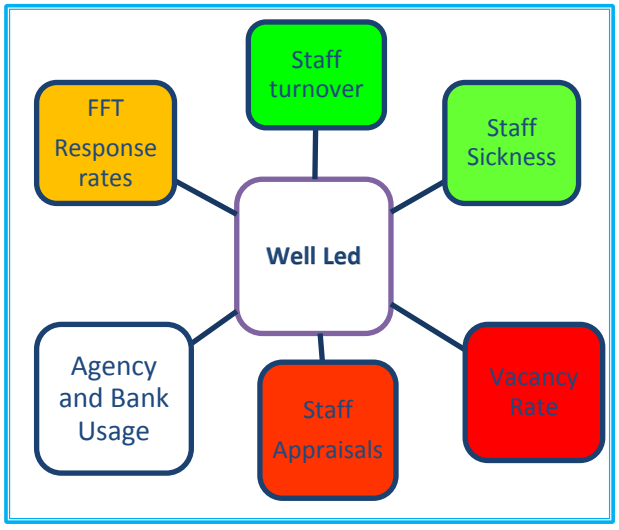
CONTENTS

1. Executive Summary - Key Priority Areas May 2014









The above shows an overview of May 2014 performance for key areas within each domain of the NHS TDA Accountability Framework. These domains reflect the change by the NHS TDA to correlate their performance framework with that of the CQC intelligent monitoring framework.

The overview references where the trust may not be meeting 1 or more related targets. (Note Cancer RAG rating is for April 2014 as reported one month in arrears)

This report is produced in line with the trust performance management framework which encompasses the NHS TDA and Monitor regulatory requirements. An overview of this is provided in appendix-A at the end of this report.

2. TDA Accountability Framework KPIs 2014/15: May 14 Performance (Page 1 of 1)

Responsiveness Domain					
Metric	**Standard**	**YTD**	**April**	**May**	**Movement**
Referral to Treatment Admitted	90%		90.30%	90.30%	➤
Referral to TreatmentNon Admitted	95%		96.70%	95.01%	
Referral to Treatment Incomplete	92%		92.90%	92.17%	⮟
Referral to Treatment Incomplete 52+ Week Waiters	0		5	3	⮟
Diagnostic waiting times > 6 weeks	1%		0.40%	0.62%	⮝
A&E All Types Monthly Performance	95%	94.57%	94.70%	94.46%	⮟
12 hour Trolley waits	0	0	0	0	➤
Urgent Ops Cancelled for 2nd time (Number)	0	0	0	0	➤
Proportion of patients not treated within 28 days of last minute cancellation	0%	2.60%	4.00%	1.50%	⮟
Certification against compliance with requirements regarding access to health care for people with a learning disability	Compliant	Yes	Yes	Yes	➤
	Standard	**YTD**	**March**	**April**	**Movement**
Two Week Wait Standard	93%	97.7%	99.3%	97.7%	⮟
Breast Symptom Two Week Wait Standard	93%	98.7%	98.1%	98.7%	⮝
31 Day Standard	96%	98.1%	97.6%	98.1%	⮝
31 Day Subsequent Drug Standard	98%	100.0%	100.0%	100.0%	➤
31 Day Subsequent Surgery Standard	94%	100.0%	100.0%	100.0%	➤
62 Day Standard	85%	85.3%	85.5%	85.3%	➤
62 Day Screening Standard	90%	93.0%	90.9%	93.0%	⮝
Domain Score			**4**		

Safe Domain					
Metric	**Standard**	**YTD**	**April**	**May**	**Movement**
Clostridium Difficile - Variance from plan	0	0	0	0	➤
MRSA bactaraemias	0	1	0	1	⮝
Never events	0	0	0	0	➤
Serious Incidents	0	36	21	15	⮟
Percentage of Harm Free Care	92%		93.13%	93.00%	➤
Medication errors causing serious harm	0	0	0	0	➤
Overdue CAS alerts	0	1	1	1	➤
Maternal deaths	1	0	0	0	➤
VTE Risk Assessment	95%		97.00%		
Domain Score			**4**		

Effectiveness Domain					
Metric	**Standard**	**YTD**	**April**	**May**	**Movement**
Hospital Standardised Mortality Ratio (DFI)	100	79.7	63.3	80.4	⮝
Hospital Standardised Mortality Ratio - Weekday	100	86.2	86.2	86.2	➤
Hospital Standardised Mortality Ratio - Weekend	100	90.8	90.8	90.8	➤
Summary Hospital Mortality Indicator (HSCIC)	100		81	81	➤
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	5%	3.4%	3.2%	3.6%	⮝
Domain Score			**5**		

Caring Domain					
Metric	**Standard**	**YTD**	**April**	**May**	**Movement**
Inpatient Scores from Friends and Family Test	60	63.2	64	63	➤
A&E Scores from Friends and Family Test	46	48	48	48	➤
Complaints		212	116	96	⮟
Mixed Sex Accommodation Breaches	0	4	4	0	⮟
Domain Score			**5**		

Well Led Domain					
Metric	**Standard**	**YTD**	**April**	**May**	**Movement**
IP response rate from Friends and Family Test	30%		42.80%	35.20%	⮟
A&E response rate from Friends and Family Test	20%		5.80%	9.30%	⮝
NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work	61%	61%			
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment	67%	69&			
Trust turnover rate	13%		14.90%	12.30%	⮟
Trust level total sickness rate	3.50%		3.60%	3.47%	⮟
Total Trust vacancy rate	11%		10.50%	12.00%	⮝
Temporary costs and overtime as % of total paybill			11.74%	10.69%	⮟
Percentage of staff with annual appraisal - Medical	85%		85.90%	84.70%	⮟
Percentage of staff with annual appraisal - non-medical	85%		82.40%	75.40%	⮟
Domain Score			**4**		

Trust Overall Quality Score	4

The trusts self-assessment against the NHS TDA Accountability framework in May 2014 is as detailed above with a overall quality score of 4.

This places the trust under the category of Standard Oversight- limited or no delivery issues.

Key: Quality/Excalation Score

1	2	3	4	5
Special Measures		**Intervention**		**Standard Oversight**

3. Monitor Risk Assessment Framework KPIs 2014/15: May 14 Performance (Page 1 of 1)

Access							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**April**	**May**	**Movement**
Referral to Treatment Admitted	90%	1	0		90.30%	90.30%	➤
Referral to Treatment Non-Admitted	95%	1	0		96.70%	95.01%	
Referral to Treatment Incomplete	92%	1	0		92.90%	92.17%	➘
A&E All Types 4 Hour Standard Monthly Performance	95%	1	1	94.57%	94.70%	94.46%	➘
62 Day Standard	85%	1	0	85.3%	85.5%	85.3%	➤
62 Day Screening Standard	90%	1	0	93.0%	90.9%	93.0%	➚
31 Day Subsequent Drug Standard	98%	1	0	100.0%	100.0%	100.0%	➤
31 Day Subsequent Surgery Standard	94%	1	0	100.0%	100.0%	100.0%	➤
31 Day Standard	96%	1	0	98.1%	97.6%	98.1%	➚
Two Week Wait Standard	93%	1	0	97.7%	99.3%	97.7%	➘
Breast Symptom Two Week Wait Standard	93%	1	0	98.7%	98.1%	98.7%	➚

Outcomes							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**April**	**May**	**Movement**
Clostridium Difficile - Variance from plan	0	1	0	0	0	0	➤
Certification of Compliance Leraning Disabilities:							
Does the trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?	Compliant	1	0	Yes	Yes	Yes	➤
Does the trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: ? treatment options; ? complaints procedures; and ? appointments?	Compliant			Yes	Yes	Yes	➤
Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities	Compliant			Yes	Yes	Yes	➤
Does the trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?	Compliant			Yes	Yes	Yes	➤
Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	Compliant			Yes	Yes	Yes	➤
Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	Compliant			Yes	Yes	Yes	➤
Data Completeness Community Services:							
Referral to treatment	50%	1	0		98%	80%	➘
referral information	50%	1	0		90%	90%	➤
treatment activity	50%	1	0		100%	100%	➤

Trust Overall Quality Governance Score	1	1	➤

Green <1.0
Amber Green= >1 and <2
Amber/Red = >2 and <4
Red= >4

May 2014 Performance against the risk assessment framework is as follows:

The trusts quality governance rating is 'Amber/Green'.

The trust CoSSR position is 3, which rated as 'Green'.

Areas of underperformance for quality governance are:

- A&E 4 hour standard performance

Further details and actions to address underperformance are further detailed in the report.

4. Performance Areas of Escalation (Page 1 of 4)
- A&E: 4 Hour Standard

Total time in A&E - 95% of patients should be seen within 4hrs						
Lead Director	April	May	Movement	2014/2015 Target	Forecast June - 14	Date expected to meet standard
FA	94.7%	94.46%	↓	>= 95%	R	July - 14

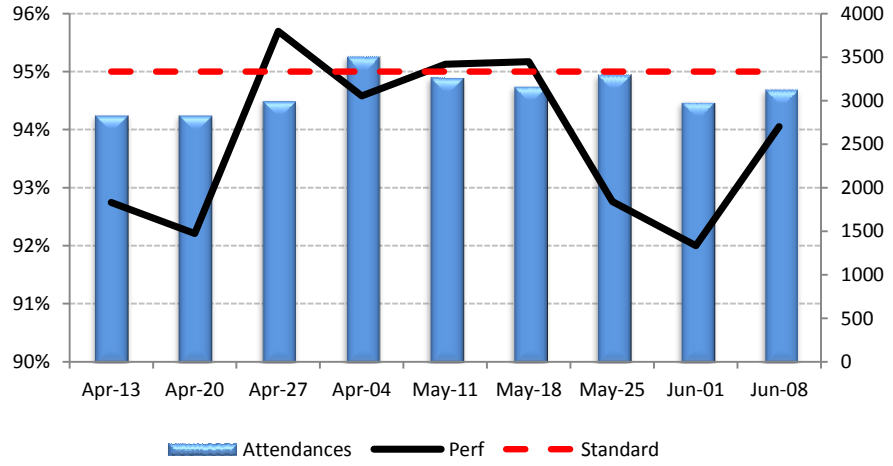
Peer Performance – QTD May 2014				
STG	Croydon	Kingston	King's College	Epsom & St Helier
94.45.%	94.65%	95.33%	88.58%	96.65%

The trust continues to face challenges with the A&E national standard of 95% of patients to be seen within 4 hours in May with performance for all types being 94.46%. Year to date performance is currently under target at 94.7%.

Current priorities and actions to sustain and further improve performance to the national standard are as follows:

- The trust achieved the 95% target for 4 weeks in a row from 21 April to 18 May. Performance and attendances are being reviewed daily.
- The trust is continuing to be supported by the Emergency Care Intensive Support Team (ECIST) to implement the recommendations which developed over a number of visits over the last 6 months focusing on improving ED patient flow and flow through the organisation (in and out).
- Weekly recovery meetings with the CEO and Director of Delivery and Performance continue. This has identified further steps the trust can be taking to improve performance.
- The ED continues to focus on any improvements that can be made to the emergency / urgent pathways. This includes a review and development of the Rapid Assessment and Treatment Service (RATS) at the front door and changes to the triage service which have both improved the flow of patients. Changes to the shop floor leadership have now been established and further work continues with the teams to embed this. Work is still underway to increase the use of the Amb Score for medically referred patients and work is continuing with the specialist teams to reduce delays.

ED Q1 2014/15 - Performance by Week



Performance Overview by Type			
	ED (Type 1)	MIU (Type 3)	ED & MIU (Type 1+3)
Month of May	94.0%	99.8%	94.46%
Quarter to date (Q1)	94.0%	99.9%	94.57%
Year to date	94.0%	99.9%	94.7%

3. Performance Areas of Escalation (Page 2 of 4) - Infection Control

MRSA						
Lead Director	April	May	Movement	2014/2015 Target	Forecast June - 14	Date expected to meet standard
ML	0	1	▲	0	G	June - 14

Peer Performance – YTD May 2014				
STG	Croydon	Kingston	King's College	Epsom & St Helier
1	0	0	1	0

C-Diff						
Lead Director	April	May	Movement	2014/2015 Target	Forecast June - 14	Date expected to meet standard
ML	3	3	➤	40	G	-

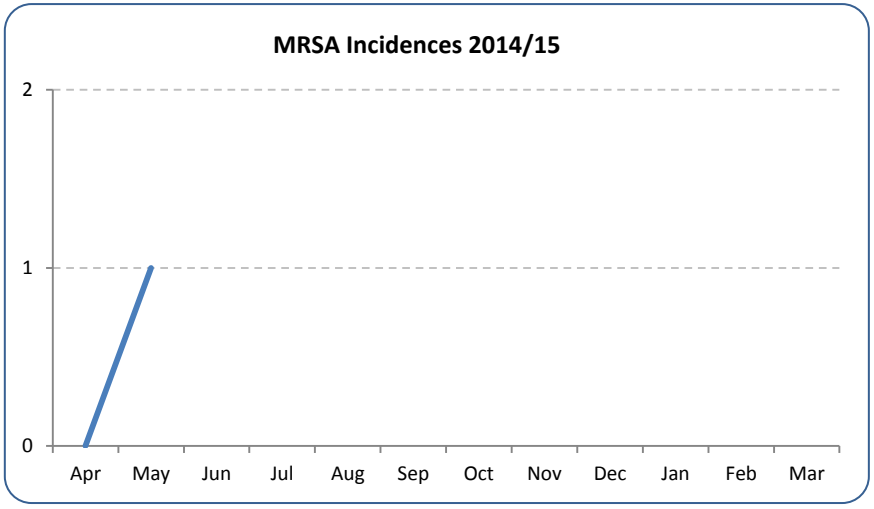
Peer Performance – YTD May 2014 (annual trajectory in brackets)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
6 (40)	2 (17)	1(24)	12 (58)	5 (40)

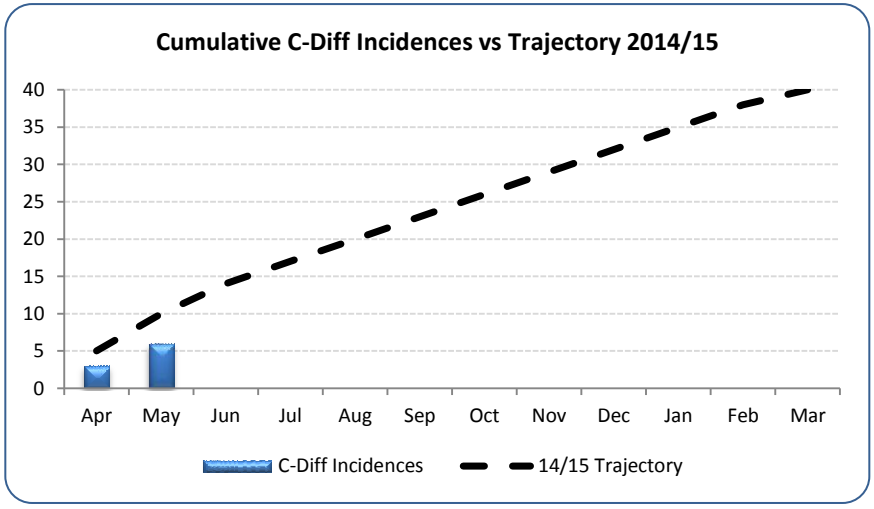
The trust has a target of no more than 40 C-diff incidences in 2014/15 and zero tolerance against MRSA continues.

In May there were 3 incidences of C-diff against a trajectory of 5 for the month.

The trust has 1 case of MRSA infection in month and thus has breached the zero tolerance standard. However, with the NTDA still applying the de minimis limit of 6, the trust is within threshold before a penalty score is applied.

The trust will continue its programme of close monitoring and vigilance to ensure compliance in 2014/15.





3. Performance Areas of Escalation (Page 3 of 4) - Cancelled Operations

Proportion of patients not treated within 28 days of last minute cancellation						
Lead Director	April	May	Movement	2014/2015 Target	Forecast June - 14	Date expected to meet standard
CC	4%	1.5%	↘	0%	G	June - 14

Peer Performance Comparison – Q4 2013/14				
STG	Croydon	Kingston	King's College	Epsom & St Helier
15	0	0	92	0

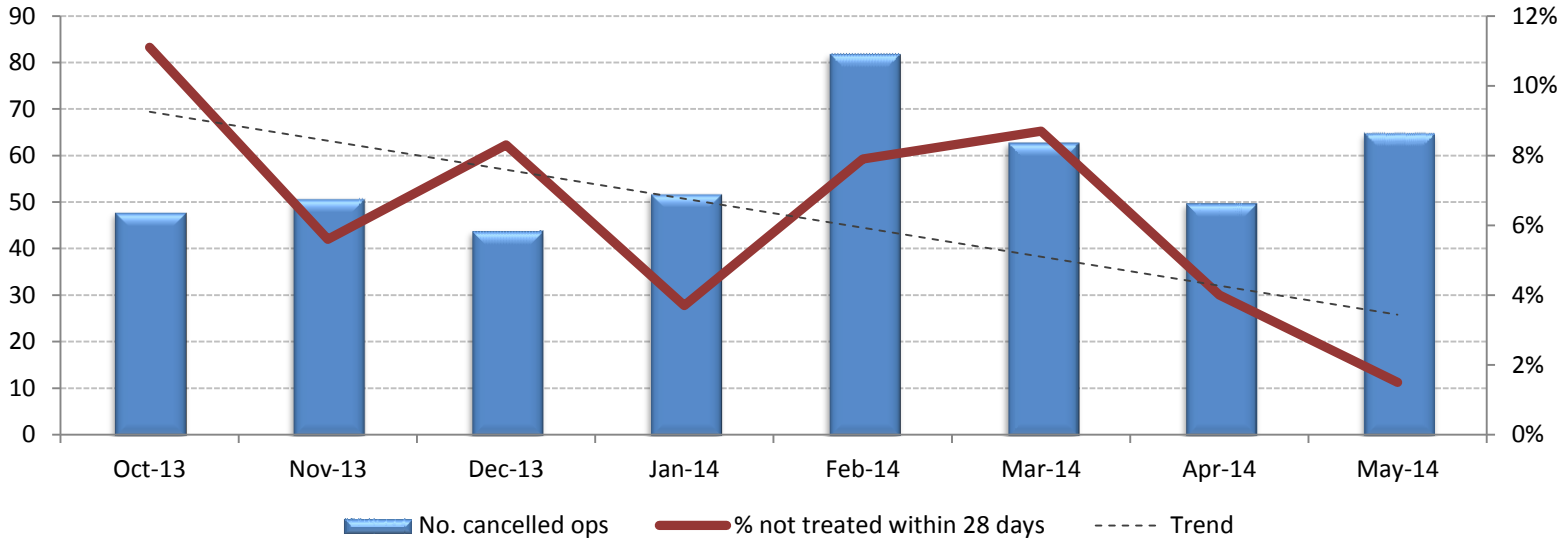
The trust was not compliant with the zero tolerance cancelled operations standard of patients being treated within 28 days of last minute cancellation for non-clinical reasons.

The trust had 65 cancelled operations in May from 3917 elective admissions, of which 1 patient was not re-booked for treatment within 28 days. This accounts for 1.5% of all cancellations and is an improvement on April position.

The breach occurred in the Medicine care-group (Renal patient) and was due to a lack of capacity of a specialist consultant required for the complex procedure. The patient was originally cancelled on 01/04/2014 and was subsequently treated on 20/05/2014.

The trust pro-actively monitors its elective programme which includes all cancelled operations closely and prioritises them for re-booking. These are also reviewed with commissioners on a monthly basis.

Cancelled Operations for non-clinical reasons Oct-13 to May-14



3. Performance Areas of Escalation (Page 4 of 4) - RTT

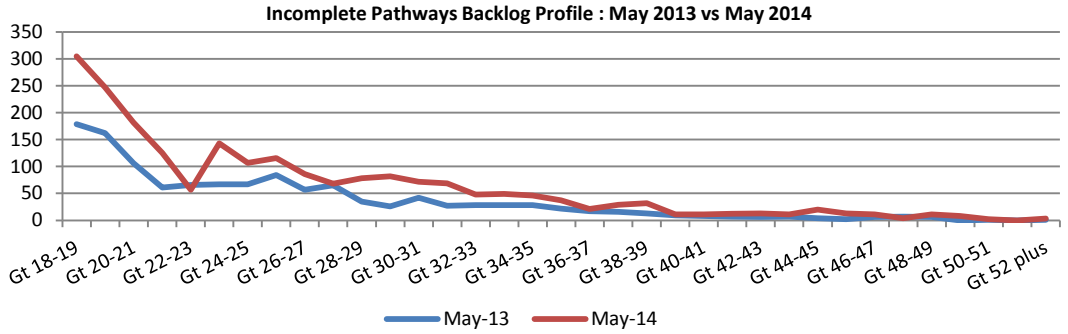
Referral to Treatment - Admitted						
Lead Director	April	May	Movement	2014/2015 Target	Forecast June - 14	Date expected to meet standard
DB	90.3%	90.3%	➤	90%	G	-

Peer Performance Comparison – April 2014				
STG	Croydon	Kingston	King's College	Epsom & St Helier
90.3%	91.7%	90.4%	80.9%	90.6%

Referral to Treatment - Incomplete						
Lead Director	April	May	Movement	2014/2015 Target	Forecast June - 14	Date expected to meet standard
DB	92.9%	92.2%	➤	92%	G	-

Peer Performance Comparison – April 2014				
STG	Croydon	Kingston	King's College	Epsom & St Helier
92.9%	93.9%	93.9%	92.1%	93.8%

Performance by Treatment Function		
	Admitted Performance	Incomplete Performance
General Surgery	90.10%	**87.00%**
Urology	89.30%	92.60%
Trauma & Orthopaedics	90.90%	**90.70%**
Ear, Nose & Throat (ENT)	86.40%	**88.10%**
Ophthalmology		100.00%
Oral Surgery	94.30%	98.20%
Neurosurgery	92.00%	**90.50%**
Plastic Surgery	91.00%	**91.90%**
Cardiothoracic Surgery	86.30%	**68.70%**
General Medicine		96.20%
Gastroenterology	94.40%	93.80%
Cardiology	77.40%	**84.50%**
Dermatology		97.00%
Thoracic Medicine		93.30%
Neurology	100.00%	97.70%
Rheumatology		95.60%
Geriatric Medicine		100.00%
Gynaecology	92.40%	92.60%
Other	98.30%	96.80%
Total	**90.30%**	**92.20%**



At the end of May there were 4 specialities which failed to meet the admitted standard of 90% and 7 specialties which failed to meet the incomplete pathways standard of 92%.

Cardiology as mentioned in last months report will continue to be non-compliant until Q3 as the recovery plan is implemented .This is currently under review with commissioners. Clinical risks in Cardiology will be reviewed at the June Patient Safety Committee.

Particular focus and pro-active management is being applied to all long waiters. Weekly RTT meetings reviewing all patients over 40 weeks is being undertaken to avoid any 52+ week waiters, Additional monthly RTT compliance meetings chaired by an Executive Director are also being undertaken to review RTT overall and to address issues of escalation from weekly meetings.

At end of May the trust had 3 patients on incomplete pathways waiting 52+ weeks as follows:

- 2 General Surgery Patients – 1 on a non-admitted pathway and 1 on an admitted pathway.
- 1 Urology patient on an admitted pathway.

Root cause analysis is currently being undertaken on the reason for the long wait and pro-active steps are being taken to get the patients booked for imminent treatment.

5. Divisional KPIs Overview 2014/15: May 14 Performance (Page 1 of 3)

Access Metrics

MetricName	Units	RAG (Mth)	Month					YTD				
			Trust	CSW	MED	SN	WC	Trust	CSW	MED	SN	WC
18 Weeks - Admitted waits	%	R ≤86 G ≥90	90.3	n/a	87.7	90.9	93.5	90.2	n/a	87.4	91.1	92.6
18 Weeks - Non Admitted waits	%	R ≤90, G ≥95	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
18 Weeks - Incomplete Waits	%	R ≤92, G ≥92	92.2	98.2	90.0	91.3	94.6	92.5	98.0	90.7	91.5	95.4
52 Week Waiters	No.	G 0, R >0	3	0	0	3	0	8	0	0	8	0
6 Week Diagnostic Waits	%	R ≤92, G ≥92	99.5	n/a	n/a	n/a	n/a	99.4	n/a	n/a	n/a	n/a
Operations cancelled for non-clinical reasons	%	G ≤0.8, R ≥1.5	1.6	n/a	2.0	1.6	0.7	1.5	n/a	1.8	1.4	1.0
Cancelled Operations re-booked within 28 days	%	G ≤5, R ≥15	1.5	n/a	0	3.3	0	2.6	n/a	1.8	3.9	0
A&E Waits (4 hours)	%	R ≤95, G ≥95	94.5	99.8	93.9	n/a	n/a	94.6	99.8	93.9	n/a	n/a
LAS handover within 15mins	%	R ≤95, G ≥99	39.7	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
LAS handover within 30mins	%	R ≤95, G ≥99	89.6	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
LAS handover within 60mins	No.	G 0, R >0	0	n/a	n/a	n/a	n/a	0	n/a	n/a	n/a	n/a
2 week GP referral to 1st outpatient -breast symptoms *	%	R ≤93, G ≥93	97.7	n/a	n/a	97.7	n/a	97.7	n/a	n/a	97.7	n/a
2 week GP referral to 1st outpatient cancer *	%	R ≤93, G ≥93	98.7	n/a	n/a	98.7	n/a	98.7	n/a	n/a	98.7	n/a
31 day second or subsequent treatment (drugs) *	%	R ≤98, G ≥98	100	n/a	n/a	100	n/a	100	n/a	n/a	100	n/a
31 day second or subsequent treatment (surgery) *	%	R ≤94, G ≥94	100	n/a	n/a	100	n/a	100	n/a	n/a	100	n/a
31 day standard - from diagnosis to first treatment *	%	R ≤96, G ≥96	98.1	n/a	n/a	98.1	n/a	98.1	n/a	n/a	98.1	n/a
62 day urgent GP referral to treament for all cancers *	%	R ≤85, G ≥85	85.3	n/a	n/a	85.3	n/a	85.3	n/a	n/a	85.3	n/a
62 day urgent GP referral to treament from Screening *	%	R ≤90, G ≥90	93.0	n/a	n/a	93.0	n/a	93.0	n/a	n/a	93.0	n/a

5. Divisional KPIs Overview 2014/15: May 14 Performance (Page 2 of 3)

Outcome Metrics

MetricName	Units	RAG (Mth)	Month					YTD				
			Trust	CSW	MED	SN	WC	Trust	CSW	MED	SN	WC
Incidence of C.Difficile	No.	G ≤3, R ≥4	3	0	1	2	0	6	0	2	3	1
Incidence of MRSA	No.	G 0, R >0	1	0	1	0	0	1	0	1	0	0
Ecoli	No.	-	22	0	0	0	0	43	0	40	2	1
MSSA	No.	-	8	0	6	1	1	15	0	13	1	1
Medication Errors causing serious harm	No.	G 0, R >0	0	0	0	0	0	0	0	0	0	0
Trust Acquired Pressure Sores (G3/4)	No.	G 0, R >0	9	6	1	2	0	24	9	7	3	5
Serious Incidents	No.	G 0, R >0	15	7	2	2	4	36	10	8	5	13
Never Events	No.	G 0, R >0	0	0	0	0	0	1	0	0	1	0
C Sections (only applicable to Womens & Children)	%	G ≤28, R ≥30	25.2	n/a	n/a	n/a	25.2	23.9	n/a	n/a	n/a	23.9
Maternal Deaths	No.	G 0, R >0	0	n/a	n/a	n/a	0	0	n/a	n/a	n/a	0
Admission of full-term babies to neo-natal harm	No.	-	5	n/a	n/a	n/a	5	9	n/a	n/a	n/a	9
SHMI	Rate	G ≤100, R ≥1..	81	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
HSMR	Rate	G ≤100, R ≥1..	80.4	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
VTE Risk Assessment (data submitted to Unify)	%	R ≤95, G ≥95	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
CAS Alerts	No.	-	1	n/a	n/a	n/a	n/a	1	n/a	n/a	n/a	n/a
WHO Surgical Checklist (Qrtly audit: sign in/time-out/sig..	%	R <100, G 100	99	n/a	97	99	100	n/a	n/a	n/a	n/a	n/a
Average LOS (elective)	days	-	3.6	n/a	4.1	3.7	2.4	3.8	n/a	4.7	3.7	2.7
Average LOS (non-elective)	days	-	4.6	26.6	4.7	6.6	2.8	4.6	24.5	4.6	6.9	2.8
30 Day emergency readmissions (fr elective)	%	-	1.6	n/a	1.5	1.9	1.6	1.5	n/a	1.3	1.8	1.4
30 Day emergency readmissions (fr non-elective)	%	-	6.0	33.3	8.2	6.9	1.3	5.8	25.9	7.7	7.1	1.3

Research

MetricName	Units	RAG (Mth)	Month					YTD				
			Trust	CSW	MED	SN	WC	Trust	CSW	MED	SN	WC
70 day - PI REPORT ..	%	R ≤30, G ≥70	50	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Green Rated Time to target of all Open CLRN Studies	%	R ≤45, G ≥70	44	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
TIME TO TARGET - PD REPORT ..	%	R ≤45, G ≥70	39.3	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Total recruitment at St Georges NHS - cumulative	No.	R ≤150, G ≥3..	1280	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

3. Divisional KPIs Overview 2014/15: May 14 Performance (Page 3 of 3)

Quality Governance Indicators

MetricName	Units	RAG (Mth)	Month					YTD				
			Trust	CSW	MED	SN	WC	Trust	CSW	MED	SN	WC
Patient satisfaction (friends and family) *	NPS	-	63	n/a	48	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mixed Sex accommodation	No.	G 0, R >0	0	0	0	0	0	4	0	4	0	0
Ward Staffing: Bank/Agency Usage	%	-	20.2	37.0	22.9	21.2	13.5	20.2	37.9	22.1	21.0	14.4
Ward Staffing: Unfilled Duty Hours	%	-	14.5	9.4	11.1	11.0	20.8	14.6	9.0	11.9	11.2	20.3
Staff Turnover	%	G ≤13, R ≥15	15.1	14.8	16.6	13.4	17.4	n/a	n/a	n/a	n/a	n/a
Voluntary Staff Turnover	%	G ≤10, R ≥12	12.3	11.4	14.8	10.4	14.0	n/a	n/a	n/a	n/a	n/a
Sickness/absence rate *	%	G ≤3.5, R ≥5	3.4	5.1	2.7	2.8	3.6	n/a	n/a	n/a	n/a	n/a
Vacancy rate	%	G ≤11, R ≥13	12.0	13.0	11.4	10.8	11.2	n/a	n/a	n/a	n/a	n/a
MAST attendance	%	R <70, G ≥85	69.5	68.4	71.1	65.9	72.0	n/a	n/a	n/a	n/a	n/a
Complaints - response within 25d *	%	R ≤85, G ≥85	54.1	50	61.1	47.2	59.0	58.6	52.4	73.6	51.8	58.5

Key Messages:

The section headed 'Access' indicates how effective the trust is at providing patients with the appointments and treatment they need and require in accordance with the national standards and the NHS Constitution.

In May there was a slight improvement in the LAS arrivals to patient handover times within 15 minutes, with the percentage of patients meeting this target increasing from 36.5% to 39.7%. Performance against the 30 minute target was also slightly better at 89.6% compared to 88.5% the month previous. There was one 60 minute breach in May. The trust will continue to monitor performance against this closely. Fines are applied where patient handovers exceed 30 and 60 minutes.

Prevention and education of PU's is important to the trust and throughout 2014/2015, the trust aiming for zero tolerance of avoidable pressure ulcers. In May there were 9 Grade 3 Pressure Ulcers and no Grade 4's. All grade 3 and 4 pressure ulcers acquired in our care are investigated as serious incidents, and a. full investigation and Root Cause Analysis is produced for each and reviewed at the Pressure Ulcer Strategy group, chaired by the Deputy Chief Nurse.

Compliance against the WHO Surgical Checklist is just below target at 99%. The WHO Surgical Checklist is a surgery safety checklist used prior to all surgical procedures to prevent serious incidents. Care group leads will continue to raise the profile and importance of this through meetings and working with non compliant areas.

There were 15 serious incidents reported in the month of May, with 3 SIs in the month not having been completed within the required timescale.

Appendix.A – trust Performance Management Framework Overview 2014/15 (Page 1 of 4)

The Performance Management Framework

The trust is realigning its Performance Framework with the requirements of the NHS trust Development Authority (TDA) and Monitor. The performance report has been updated to cover the new requirements of the TDA Accountability Framework for trusts and to include greater visibility of performance at Divisional level, alongside trust wide aggregate performance.

The TDA Accountability Framework

The accountability framework covers three domains – Quality, Finance and Delivering Sustainability. A set of indicators has been identified in each domain and delivery will be evaluated against a threshold and aggregated for each domain.
Performance against these indicators will determine a score for each domain. These domain scores in turn contribute towards an overall Escalation score for each trust. The trusts will be rated in one of five categories –

Standard Oversight – The organisation has developed a sound FT application and received a 'Good or Outstanding' rating from CIH

Standard Oversight: Limited or no delivery issues

Intervention: The organisation has some delivery issues including clinical and/or financial challenges

Intervention: The organisation has significant delivery issues clinical and/or financial challenges

Special Measures: The organisation has significant delivery issues, including serious clinical and/or financial challenges or concerns.

The trust is also required to sign a self certifications on a monthly basis at Board level covering compliance with Monitor's license requirements and a set of Board Statements .

Appendix.A – trust Performance Management Framework Overview 2014/15 (Page 2 of 4)

The Performance Management Framework of the trust

The trust continues to operate the revised Performance Framework presented to the Board and Finance and Performance Committee in April 2014. This has been refreshed to ensure the indicators included within the TDA Accountability Framework for NHS trusts are reported against and to ensure that Divisional contributions to the trusts aggregate reported performance are more visible.

The diagrams illustrate the components of the trusts Performance Management Framework. The trust operates escalation processes with Divisions that reflect the National escalation processes and the recommendations in Monitor's toolkits for implementing Service Line Management.

Quarterly Performance Reviews at Divisional Level, regular meetings with our commissioners, weekly Executive management Team meetings to address potential risks are all part of the trusts Performance Management strategy.

- Escalation actions following Divisional reviews have focused on the action plan for recovering A&E 4 hour waits, financial performance within SNT and MedCard Divisions and Cancer performance to look at how delivery of the 62 day target can be improved and sustained.

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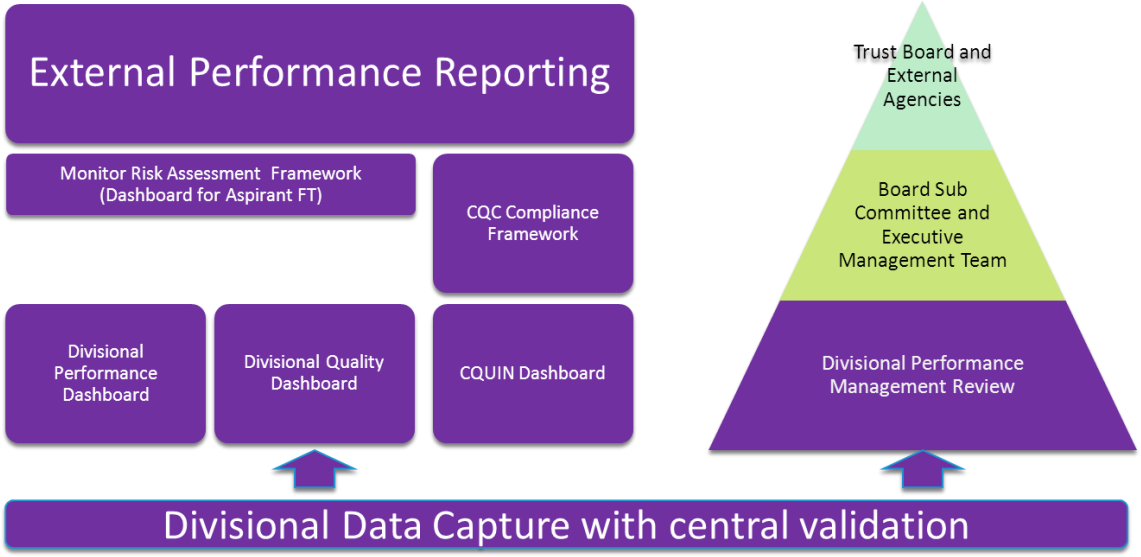
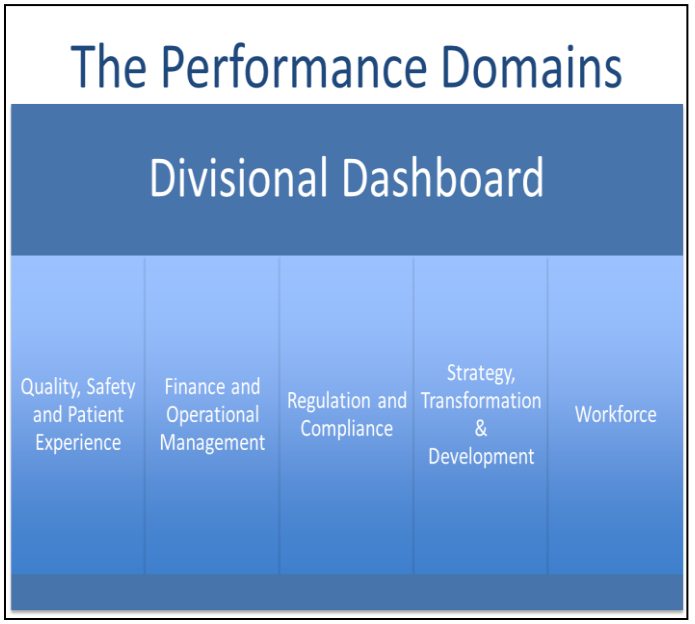


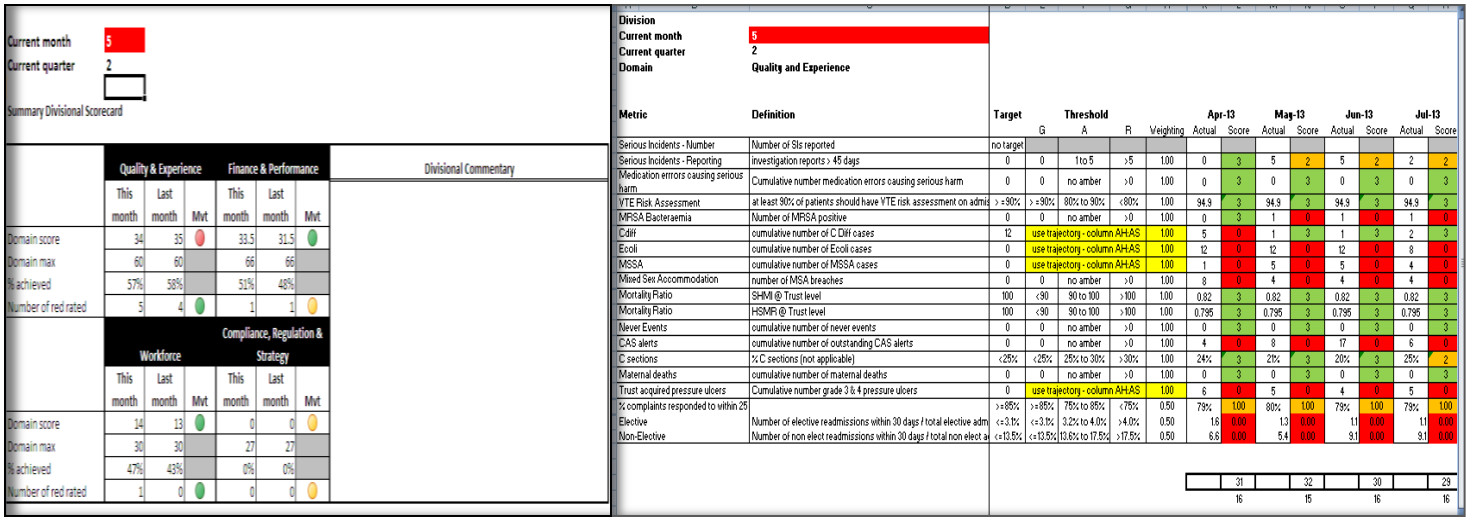


Appendix.A – trust Performance Management Framework Overview 2014/15 (Page 3 of 4)

The Performance Management Framework of the trust

The performance management arrangements includes quarterly reviews for each Division which review and challenge Divisional progress, with an opportunity for Divisions to share with the Executive team issues of concern.

The trust has extended this process by reporting divisional performance against the metrics within the TDA Accountability Framework, to the Finance and Performance committee on a monthly basis. The trust reports on the vast majority of these metrics within the existing quarterly review process. Work continues to ensure that the Divisional scorecards and the trust scorecard fully reflect all the metrics within the TDA Accountability Framework.



Current month 5
Current quarter 2

Summary Divisional Scorecard

	Quality & Experience			Finance & Performance			Divisional Commentary
	This month	Last month	Mvt	This month	Last month	Mvt	
Domain score	34	35		33.5	31.5		
Domain max	60	60		66	66		
% achieved	57%	58%		51%	48%		
Number of red rated	5	4		1	1		
	Workforce			Compliance, Regulation & Strategy			
	This month	Last month	Mvt	This month	Last month	Mvt	
Domain score	14	13		0	0		
Domain max	30	30		27	27		
% achieved	47%	43%		0%	0%		
Number of red rated	1	0		0	0		

Division
Current month 5
Current quarter 2
Domain Quality and Experience

Metric	Definition	Target	Threshold G	Threshold A	Threshold R	Weighting	Apr-13 Actual	Apr-13 Score	May-13 Actual	May-13 Score	Jun-13 Actual	Jun-13 Score	Jul-13 Actual	Jul-13 Score
Serious Incidents - Number	Number of SIs reported	no target												
Serious Incidents - Reporting	investigation reports > 45 days	0	0	1 to 5	>5	1.00	0	3	5	2	5	2	2	2
Medication errrors causing serious harm	Cumulative number medication errors causing serious harm	0	0	no amber	>0	1.00	0	3	0	3	0	3	0	3
VTE Risk Assessment	at least 90% of patients should have VTE risk assessment on admis	> =90%	> =90%	80% to 90%	<80%	1.00	94.9	3	94.9	3	94.9	3	94.9	3
MRSA Bacteraemia	Number of MRSA positive	0	0	no amber	>0	1.00	0	3	1	0	1	0	1	0
Cdiff	cumulative number of C Diff cases	12	use trajectory - column AH-AS			1.00	5	0	1	3	1	3	2	3
Ecoli	cumulative number of Ecoli cases	0	use trajectory - column AH-AS			1.00	12	0	12	0	12	0	8	0
MSSA	cumulative number of MSSA cases	0	use trajectory - column AH-AS			1.00	1	0	5	0	5	0	4	0
Mixed Sex Accommodation	number of MSA breaches	0	0	no amber	>0	1.00	8	0	4	0	4	0	4	0
Mortality Ratio	SHMI @ Trust level	100	<90	90 to 100	>100	1.00	0.82	3	0.82	3	0.82	3	0.82	3
Mortality Ratio	HSMR @ Trust level	100	<90	90 to 100	>100	1.00	0.795	3	0.795	3	0.795	3	0.795	3
Never Events	cumulative number of never events	0	0	no amber	>0	1.00	0	3	0	3	0	3	0	3
CAS alerts	cumulative number of outstanding CAS alerts	0	0	no amber	>0	1.00	4	0	8	0	17	0	6	0
C sections	% C sections (not applicable)	<25%	<25%	25% to 30%	>30%	1.00	24%	3	21%	3	20%	3	25%	2
Maternal deaths	cumulative number of maternal deaths	0	0	no amber	>0	1.00	0	3	0	3	0	3	0	3
Trust acquired pressure ulcers	Cumulative number grade 3 & 4 pressure ulcers	0	use trajectory - column AH-AS			1.00	6	0	5	0	4	0	5	0
% complaints responded to within 25		>=95%	>=95%	75% to 95%	<75%	0.50	78%	1.00	80%	1.00	79%	1.00	79%	1.00
Elective	Number of elective readmissions within 30 days / total elective adm	<=3.1%	<=3.1%	3.2% to 4.0%	>4.0%	0.50	1.6	0.00	1.3	0.00	1.1	0.00	1.1	0.00
Non-Elective	Number of non elect readmissions within 30 days / total non elect a	<=13.5%	<=13.5%	13.6% to 17.5%	>17.5%	0.50	6.8	0.00	5.4	0.00	9.1	0.00	9.1	0.00
								31		32		30		29
								16		15		16		16

Example 1 Monthly Divisional Reports

A score and RAG rating is applied to the domains within each Division by the Senior Management Team, who use the information provided at the reviews to make a judgement about the Divisions performance and determine where remedial action plans and escalation is required. Work continues to apply a scoring system to our performance framework at Divisional level and to roll that up into an integrated scorecard for each Division and for the trust on a monthly basis.

Appendix.A – trust Performance Management Framework Overview 2014/15 (Page 4 of 4)

The Accountability Framework

The TDA will assess delivery across three domains as shown in the diagram :

- Quality
- Finance
- Sustainability

Against each domain trusts will report against a series of metrics. These are listed in detail in Section 8 : definitions and metrics

For 2014/15 trusts will be scored using escalation levels 1 to with one being the highest risk rating and 5 the lowest. This is being done to ensure consistency with the CQC's approach to assessing risk.

1. Special Measures
2. Intervention due to significant delivery issues
3. Intervention due to some delivery issues
4. Standard Oversight- limited or no delivery issues
5. Standard Oversight : Organisation has a developed a sound FT application and received a 'Good or Outstanding rating from CIH.

The trust is also required to sign off self certifications on a monthly basis at Board level covering progress against FT milestones, and compliance with Monitor's license requirements

Key Elements of the Oversight Model