St George's Healthcare NHS
NHS Trust

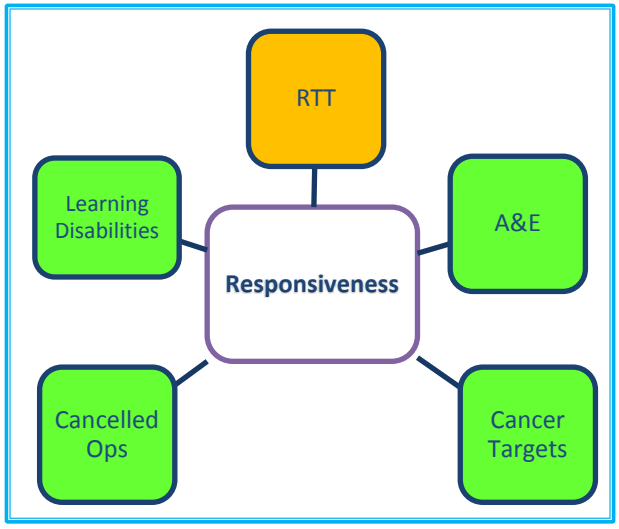
Performance Report

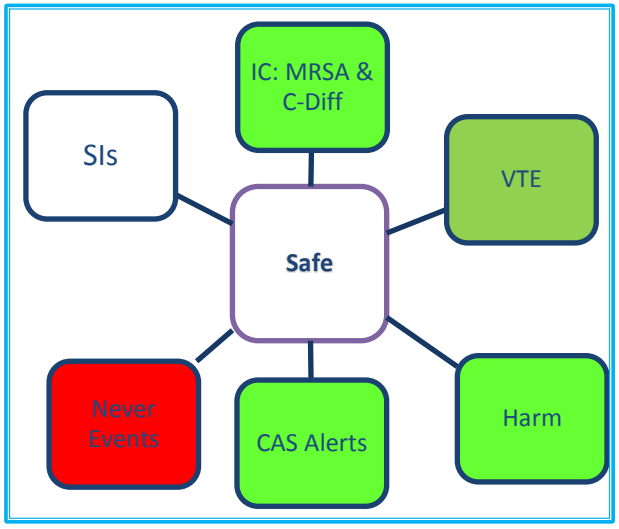
Trust Board
Month 6 - September 2014

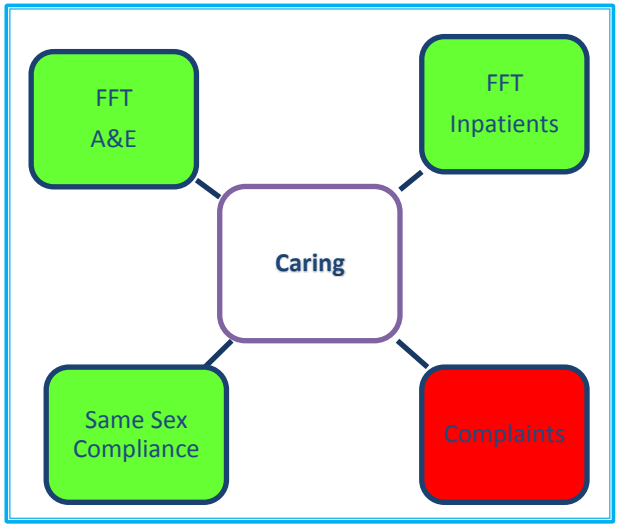
excellent kind responsible respectful

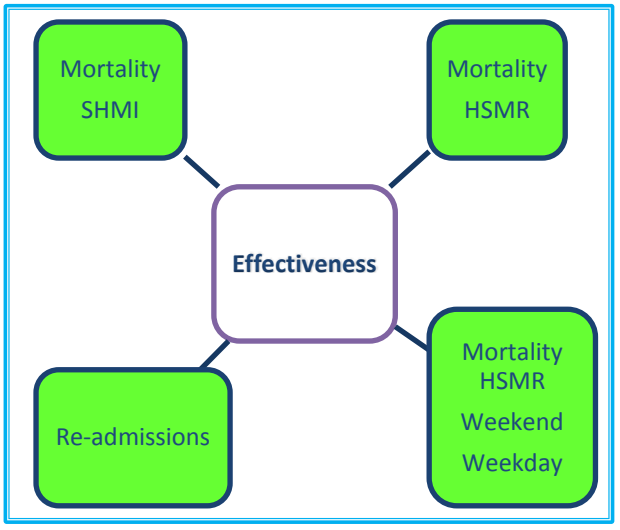
CONTENTS

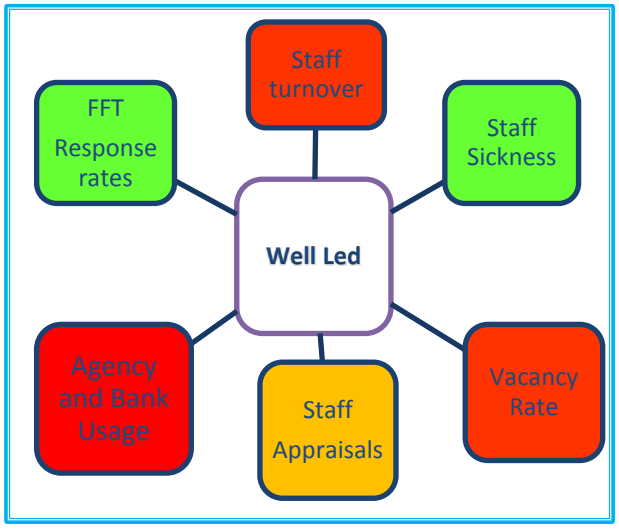
1. Executive Summary - Key Priority Areas September 2014











The above shows an overview of September 2014 performance for key areas within each domain of the NHS TDA Accountability Framework. These domains as per decision by the NHS TDA correlate to those 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 August 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: September 14 Performance (Page 1 of 1)

Responsiveness Domain					
Metric	Standard	YTD	August	September	Movement
Referral to Treatment Admitted	90%		85.2%	87.9%	
Referral to Treatment Non-Admitted	95%		95%	NYA*	
Referral to Treatment Incomplete	92%		91.36*	91.80%	
Referral to Treatment Incomplete 52+ Week Waiters	0		3	3	↑
Diagnostic waiting times > 6 weeks	1%		0.88%	0.57%	↓
A&E All Types Monthly Performance	95%	95.06%	94.33%	95.7%	↑
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%	1.7%	0.00%	0.00%	→
Certification against compliance with requirements regarding access to health care for people with a learning disability	Compliant	Yes	Yes	Yes	→
NYA* Not yet available					
	Standard	YTD	Q1	Q2 (Aug)	Movement
Two Week Wait Standard	93%	94.8%	95.3%	94.29%	↓
Breast Symptom Two Week Wait Standard	93%	95.9%	94.5%	98.2%	↑
31 Day Standard	96%	98.4%	98.2%	98.5%	↑
31 Day Subsequent Drug Standard	98%	100.0%	100.0%	100.0%	→
31 Day Subsequent Surgery Standard	94%	98.7%	97.8%	100.0%	↑
62 Day Standard	85%	86.9%	86.8%	87.09%	↑
62 Day Screening Standard	90%	91.9%	90.4%	94.1%	↑
Domain Score	5				

Safe Domain					
Metric	Standard	YTD	August	September	Movement
Clostridium Difficile - Variance from plan	0	-1	-1	-1	→
MRSA bactaraemias	0	3	0	0	→
Never events	0	3	0	1	↓
Serious Incidents	0	99	12	19	↑
Percentage of Harm Free Care	95%		95.06%	94.52%	↓
Medication errors causing serious harm	0	0	0	0	→
Overdue CAS alerts	0	1	1	1	→
Maternal deaths	1	1	0	0	→
VTE Risk Assessment ((July)	95%		96.5%	96.5%	→
Domain Score	3				

Effectiveness Domain							
Metric	Standard	Weighting	Score	YTD	August	September	Movement
Hospital Standardised Mortality Ratio (DFI)	100	5	0		77.7	77.7	↓
Hospital Standardised Mortality Ratio - Weekday	100	5	0		85.1	84.4	↓
Hospital Standardised Mortality Ratio - Weekend	100	5	0		83	82.2	↓
Summary Hospital Mortality Indicator (HSCIC)	100	5	0		79	80	→
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	5%	5	0	3.3%	3.5%	3.5%	→
Domain Score	5						

Caring Domain							
Metric	Standard	Weighting	Score	YTD	August	September	Movement
Inpatient Scores from Friends and Family Test	60	5	0		65	65	→
A&E Scores from Friends and Family Test	46	5	5		62	75	↑
Complaints		5	0		92	94	↑
Mixed Sex Accommodation Breaches	0	2	0	4	0	0	→
Domain Score	4						

Well Led Domain							
Metric	Standard	Weighting	Score	YTD	August	September	Movement
IP response rate from Friends and Family Test	30%	2	0		39%	46.5%	↑
A&E response rate from Friends and Family Test	20%	2	0		27.2%	26.3%	↓
NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work	61%	2	0	61%			
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment	67%	2	0	69%			
Trust turnover rate	13%	3	3		16.3%	17.1%	↑
Trust level total sickness rate	3.50%	3	0		3.1%	3.3%	↑
Total Trust vacancy rate	11%	3	3		12.9%	13%	↑
Temporary costs and overtime as % of total paybill	3.50%	3	3		7.5%	9.34%	↑
Percentage of staff with annual appraisal - Medical	85%	1.5	0		85.2%	86.5%	↑
Percentage of staff with annual appraisal - non-medical	85%	1.5	1.5		80.8%	83.2%	↑
Domain Score	3						

Trust Overall Quality Score	4

The trust's self-assessment against the NHS TDA Accountability framework in September 2014 is as detailed above with a overall quality score of 4. (Note: RTT admitted has been excluded for scoring as breach of target is authorised as part of the national RTT resilience programme).

This places the trust under the category of low risk with no escalation, and under standard oversight with NHS TDA.

Key: Quality/Excalation Score

1	2	3	4	5
Special Measures		Intervention		Standard Oversight

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

Access							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**August**	**Sept**	**Movement**
Referral to Treatment Admitted	90%	1	0		85.2%	87.94%	
Referral to Treatment Non Admitted	95%	1	0		95%	NYA	
Referral to Treatment Incomplete	92%	1	0		91.36%	91.80%	
A&E All Types Monthly Performance (Quarter to date)	95%	1	1	95.06%	94.33%	95.2%	↑
				YTD	**July**	**Aug**	
62 Day Standard	85%	1	0	86.8%	86.7%	87.6%	↑
62 Day Screening Standard	90%	1	0	91.2%	93.3%	95.1%	↑
31 Day Subsequent Drug Standard	98%	1	0	100.0%	100.0%	100%	→
31 Day Subsequent Surgery Standard	94%	1	0	98.3%	100%	100%	→
31 Day Standard	96%	1	0	98.4%	98.9%	98%	↓
Two Week Wait Standard	93%	1	0	95.3%	95.3%	93.1%	↓
Breast Symptom Two Week Wait Standard	93%	1	0	95.6%	99.4%	97.3%	↓

* NYA Not yet available

Outcomes							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**August**	**Sept**	**Movement**
Clostridium Difficile - Variance from plan	0	1	0	-1	-1	-1	→
Certification of Compliance Learning 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 (July and August)	50%	1			58%	53%	↓
referral information	50%	1			92%	93%	↑
treatment activity	50%	1			72%	71%	↓

Trust Overall Quality Governance Score	1	1	→

Green <1.0

Amber Green= >1 and <2

Amber/Red = >2 and <4

Red= >4

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

The trust's quality governance rating is 'Amber/Green

Note: From July – September 14 RTT admitted has been excluded from scoring as breaching the target has been authorised as part of the national RTT resilience programme.

The trust 's CoSSR position is expected to remain at 3 which is rated as 'Green'. At the time of producing this report it was not yet available and is therefore subject to change.

Areas of underperformance for quality governance are:

- RTT 52+ Week Waits
- Never Event
- Workforce

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

4. Performance Area under Review (Page 1 of 4)
- A&E: 4 Hour Standard

Total time in A&E - 95% of patients should be seen within 4hrs						
Lead Director	August	September	Movement	2014/2015 Target	Forecast Oct - 14	Date expected to meet standard
FA	94.33%	95.7%	▲	>= 95%	G	-

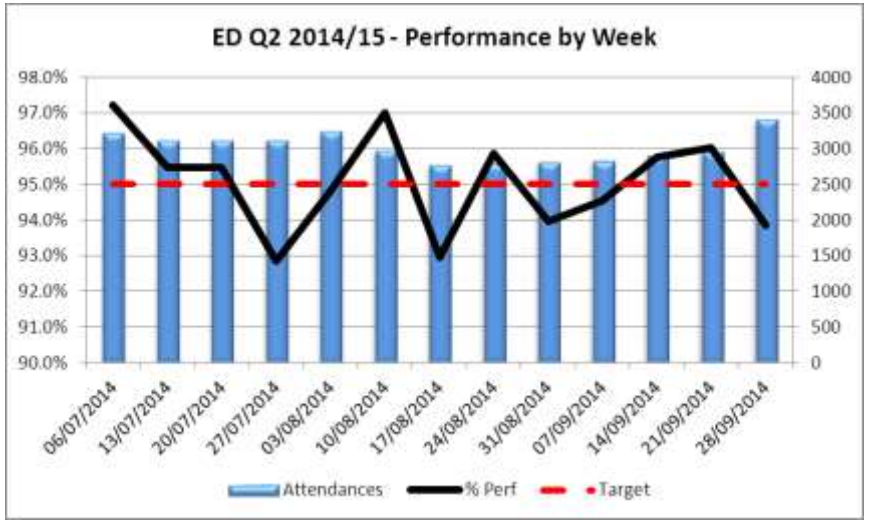
Peer Performance September 2014-15 (4 week Avg)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
95.7.%	94.94%	95.89%	90.89%	95.47%

The ED target is that 95% or more of patients should be seen and discharged within 4 hours of attending the Emergency Department. In September the trust achieved and exceeded the target with 95.7% of patients being seen within 4 hours. The Trust continues to implement and further embed actions to maintain performance improvement as addressed by the trust action plan which focuses on: the wider system, hospital and emergency department. An overview of these is as follows:

Wider health system
- Increasing capacity – including in primary care, social care and community care
- Standardising models and access criteria for schemes to avoid admission and facilitate earlier discharge to enable greater usage. Requires alignment across four Boroughs and four community providers.
- Mobilising rapid system wide response when any part under significant pressure

Whole hospital emergency pathway
- Right sizing capacity (beds, ICU, theatre, diagnostics…)
- Developing an 'emergency floor' with ED, medicine & surgery
- Ensuring specialty / ward operational standards (e.g. consultant lead daily ward rounds and morning discharges) are met each day
- Building on whole site meetings to provide a hospital 'control tower' with appropriate rigour, leadership, live information , escalation triggers, & ability to drive appropriate specialty, ward & department response

Emergency Floor
- Providing a consultant delivered service including RATS
- 7 day ambulatory care across the extended day
- Timely specialty response and decision to admit
- Rapid access laboratory diagnostics & hot lab
- Temporary Clinical Decision Unit followed by new build
- Reviewing operational response to multi-trauma



Performance Overview by Type			
	ED	MIU	ED & MIU
	(Type 1)	(Type 3)	(Type 1+3)
Month to Date (September)	95.18%	100.00%	95.70%
Quarter to Date	94.63%	99.86%	95.21%
Year to Date	94.46%	99.82%	95.06%

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

MRSA						
Lead Director	August	September	Movement	2014/2015 Target	Forecast Oct - 14	Date expected to meet standard
JH	0	0	>	0	G	October 14

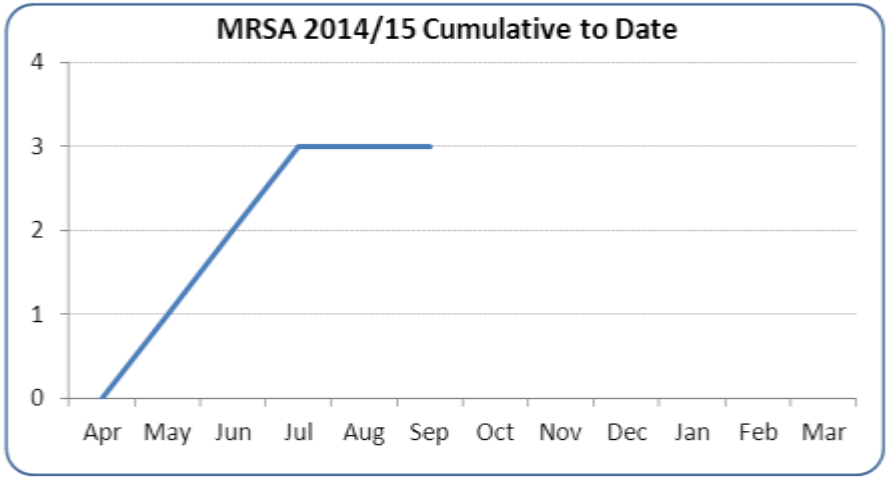
Peer Performance – YTD September 2014				
STG	Croydon	Kingston	King's College	Epsom & St Helier
3	1	0	2	4

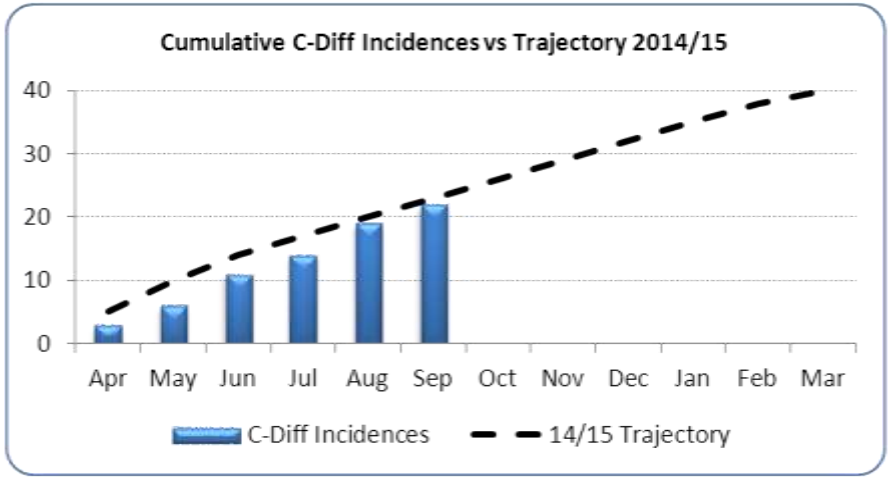
C-Diff						
Lead Director	August	September	Movement	2014/2015 Target	Forecast Oct - 14	Date expected to meet standard
JH	5	3	v	40	G	-

Peer Performance – YTD September 2014 (annual trajectory in brackets)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
22 (40)	8 (17)	4(24)	37 (58)	23 (40)

In 2014/15 the Trust has a target of no more than 40 Cdiff incidents and zero tolerance against MRSA. With a zero tolerance against this target, the trust is non-compliant with 0 incidents in September and 3 incidents year to date. This is still within the de minimis limit of 6 applied to each trust by the NTDA so no penalty score has been applied.

In September there were 3 Cdiff incidents, a total of 22 for the period April to September, This is against a trajectory of 23 and an annual target of 40. Close monitoring will continue to ensure compliance is maintained.





4. Performance Areas of Escalation (Page 3 of 4) - RTT Incomplete 52+ Week Waiters

Referral to Treatment Incomplete 52+ Week Waiters						
Lead Director	August	September	Movement	2014/2015 Target	Forecast Oct – 14	Date expected to meet standard
SB	3	3	➤	0	R	Dec-14

Specialty	Patient Type	Date for patient to be treated	Commentary
ENT	Inpatient	Patient has been treated	Patient was on the waiting list for treatment on 10/10/2014. The trust can confirm that the patient has now had treatment thus is no longer waiting.
ENT	Outpatient	28/10/2014	Patient was scheduled for a follow-up in September post a CT scan. The trust can confirm that the patient attended the appointment and has been added to the waiting list for treatment in October.
ENT	Inpatient	Patient has been discharged	The patient was scheduled for treatment in early October as per patients choice The trust can inform that the patient DNA'd this appointment. However, on the day the patient was called by the consultant and was given the opportunity to still attend, but declined. The patient has now been discharged back to the care of the GP as per the trust Access Policy.

The trust is pro-actively addressing the issue of long waiters and in particular the prevention of 52+ week waiters. The following actions are in support of this:

- Weekly RTT management meetings by care group are now in place which track the PTL and review at patient level, review capacity and escalate long waits.
- A weekly escalation email of long waiters is now sent by the Associate Director of Finance, Contracting and Performance to the Divisional Directors of Operations and Divisional Clinical Chairs to review personally and action those patients waiting for more than 35 weeks.
- A monthly RTT Compliance meeting chaired by an Executive Director is held which reviews; performance by care group with a particular focus on patients waiting 40+ weeks to ensure treatment plans are in place, review/facilitate escalation, provide senior decision making support to drive actions forward, reviews and monitors elective cancellations, their rebooking to target and their impact on RTT performance.
- Recruitment of additional consultants in clinical areas of capacity constraints, such as ENT.
  - 2 additional Paediatric ENT Consultants have been appointed, with 1 actively in post from 6th October 2014 and the 2nd from the 1st January 2015
  - An additional Head and Neck Consultant has been appointed, who is currently undertaking some Ad-hoc clinics in October and is due to be in post full time from 1st November 2014.
  - ENT – new Service Manager and an Assistant General manger have been appointed and commenced post as at end August 2014, providing renewed focus to the specialty and actively addressing areas of data quality and capacity.
- Two Executive Director led Task and Finish Groups have been initiated with the first focusing on data quality and IT technical improvements and the second on operational workflow and process improvement. Key workstreams are being identified and actioned upon both in terms of delivering short term 'quick wins' and long term strategic service improvement.

4. Performance Areas of Escalation (Page 4 of 4) - Never Events

Never Events							
Lead Director	YTD	August	September	Movement	2014/2015 Target	Forecast Oct – 14	Date expected to meet standard
JH	3	0	1	➢	0	G	Nov -14

The trust is reporting 1 Never Event, in September taking the total number of Never Events in 2014/15 thus far to 3 as follows:

- 1 in April 2014 pertaining to a retained throat swab.
- 1 in July 2014 pertaining to a retained vaginal swab.
- 1 in September 2014 pertaining to a retained vaginal swab.

The never event in September was regarding a patient with a retained vaginal swab. The patient was in her fourth pregnancy following two previous vaginal deliveries, booked with a BMI of 33 and was diagnosed with gestational diabetes mellitus requiring insulin. Induction of labour was commenced due to diabetes and the patient was delivered by ventouse in theatre.

The patient suffered an atonic postpartum haemorrhage and the perineum was sutured. Following transfer to the ward post delivery, the midwife noted that there was a 'vaginal pack in situ'. The midwife contacted the registrar on call, and a large vaginal swab, used as a pack, was removed that afternoon during review.

A full serious incident investigation is currently being undertaken and due to be completed as per guidance within 60 working days and reported to the trust patient safety committee and to commissioners.

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

Access Metrics

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	87.9	n/a	85.6	88.7	90.1	88.2	n/a	85.8	88.8	90.8
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	91.8	100	90.3	90.8	92.8	n/a	n/a	n/a	n/a	n/a
52 Week Waiters	No.	G 0, R >0	3	0	0	3	0	23	0	0	23	0
6 Week Diagnostic Waits	%	R ≤92, G ≥92	99.4	n/a	n/a	n/a	n/a	99.3	n/a	n/a	n/a	n/a
Operations cancelled for non-clinical reasons	%	G ≤0.8, R ≥1.5	1.3	n/a	1.6	1.3	1.1	1.5	n/a	1.4	1.6	1.3
Cancelled Operations re-booked within 28 days	%	G ≤5, R ≥15	1.7	n/a	0	3.7	0	1.7	n/a	1.6	2.8	0
A&E Waits (4 hours)	%	R ≤95, G ≥95	95.7	100	95.2	n/a	n/a	95.0%	99.8%	94.5%	n/a	n/a
LAS handover within 15mins	%	R ≤95, G ≥99	31.7	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
LAS handover within 30mins	%	R ≤94, G ≥99	85.9	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	n/a	n/a	n/a	n/a	n/a
2 week GP referral to 1st outpatient -breast symptoms *	%	R ≤93, G ≥93	97.3	n/a	n/a	97.3	n/a	95.9	n/a	n/a	95.9	n/a
2 week GP referral to 1st outpatient cancer *	%	R ≤93, G ≥93	93.1	n/a	n/a	93.1	n/a	94.8	n/a	n/a	94.8	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	98.7	n/a	n/a	98.7	n/a
31 day standard - from diagnosis to first treatment *	%	R ≤96, G ≥96	98.0	n/a	n/a	98.0	n/a	98.4	n/a	n/a	98.4	n/a
62 day urgent GP referral to treament for all cancers *	%	R ≤85, G ≥85	87.6	n/a	n/a	87.6	n/a	86.9	n/a	n/a	86.9	n/a
62 day urgent GP referral to treament from Screening *	%	R ≤90, G ≥90	95.1	n/a	n/a	95.1	n/a	91.9	n/a	n/a	91.9	n/a

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

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	2	1	0	22	0	14	5	3
Incidence of MRSA	No.	G 0, R >0	0	0	0	0	0	3	0	2	1	0
Ecoli	No.	-	21	0	17	2	2	149	0	123	16	10
MSSA	No.	-	8	0	7	1	0	34	1	29	4	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	6	2	2	2	0	53	22	14	10	7
Serious Incidents	No.	G 0, R >0	19	3	7	4	4	98	n/a	n/a	n/a	n/a
Never Events	No.	G 0, R >0	1	0	0	0	1	3	0	0	1	2
C Sections (only applicable to Womens & Children)	%	G ≤28, R ≥30	21.8	n/a	n/a	n/a	21.8	24.4	n/a	n/a	n/a	24.4
Maternal Deaths	No.	G 0, R >0	0	n/a	n/a	n/a	0	1	n/a	n/a	n/a	1
Admission of full-term babies to neo-natal harm	No.	-	10	n/a	n/a	n/a	10	41	n/a	n/a	n/a	41
SHMI	Rate	G ≤100, R ≥100	80	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
HSMR	Rate	G ≤100, R ≥100	77.7	n/a	n/a	n/a	n/a	77.7	n/a	n/a	n/a	n/a
VTE Risk Assessment (data submitted to Unify)	%	R ≤95, G ≥95	96.5	n/a	n/a	n/a	n/a	96.5	n/a	n/a	n/a	n/a
WHO Surgical Checklist (Qrtly audit: sign in/time-out/sign-out)	%	R <100, G 100	99	n/a	99	99	100	n/a	n/a	n/a	n/a	n/a
Average LOS (elective)	days	-	3.8	n/a	3.8	4.0	2.6	3.7	n/a	4.5	3.6	2.7
Average LOS (non-elective)	days	-	4.8	32	4.9	7.0	2.7	4.6	26.1	4.7	6.8	2.7
30 Day emergency readmissions (fr elective)	%	-	1.5	n/a	1.3	1.9	1.6	1.4	n/a	1.3	1.7	1.5
30 Day emergency readmissions (fr non-elective)	%	-	5.7	19.0	7.5	7.0	1.5	5.8	23.7	8.1	6.4	1.1

Research

MetricName	Units	RAG (Mth)	Month				
			Trust	CSW	MED	SN	WC
70 day - PI REPORT ..	%	R ≤30, G ≥70	70.7	n/a	n/a	n/a	n/a
Green Rated Time to target of all Open CLRN Studies	%	R ≤45, G ≥70	54.7	n/a	n/a	n/a	n/a
TIME TO TARGET - PD REPORT ..	%	R ≤45, G ≥70	41.3	n/a	n/a	n/a	n/a
Total recruitment at St Georges NHS - cumulative	No.	R ≤150, G ≥320	4814	n/a	n/a	n/a	n/a

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

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	-	66.2	n/a	66.8	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: Unfilled Duty Hours	%	-	9.1	11.2	8.9	9.1	8.7	11.5	7.9	9.2	9.6	15.8
Staff Turnover	%	G ≤13, R ≥15	17.1	18.0	16.8	14.6	18.6	n/a	n/a	n/a	n/a	n/a
Voluntary Staff Turnover	%	G ≤10, R ≥12	13.7	13.6	14.6	12.1	14.2	n/a	n/a	n/a	n/a	n/a
Sickness/absence rate *	%	G ≤3.5, R ≥5	3.4	4.2	2.9	3.4	3.3	n/a	n/a	n/a	n/a	n/a
Vacancy rate	%	G ≤11, R ≥13	13.0	15.9	10.7	13.1	10.3	n/a	n/a	n/a	n/a	n/a
MAST attendance	%	R <70, G ≥85	68.6	71.8	67.3	65.7	70.5	n/a	n/a	n/a	n/a	n/a
Percentage of staff appraisal (medical)	%	R <70, G ≥85	86.5	78.3	87.6	89.5	83.5	n/a	n/a	n/a	n/a	n/a
Percentage of staff appraisal (non-medical)	%	R <70, G ≥85	83.2	83.6	87.6	82.6	81.0	n/a	n/a	n/a	n/a	n/a
Complaints - response within 25d *	%	R ≤85, G ≥85	70.7	75	69.6	69.2	83.3	62.6	58.9	70.8	61.8	60.8

Key Messages:

This 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.

LAS arrivals to patient handover times, continues to fluctuate. As the end of September 31.7% of patients had handover times within 15 minutes and 85.9% within 30 minutes. It must be noted that St Georges are not outliers in the sector (, overall performance in the sector was 45.6% for 15 minutes and 93.6% for 30 minutes, both of which are below the required target of 100%. There were no 60 minute breaches.

The trust is aiming for zero tolerance of avoidable pressure ulcers in 2014/15 and has placed significant importance on prevention and education of PU's . In September the trust reported a total of 6 Grade 3 and 4 Pressure Ulcers (5 Grade 3's and1 Grade 4.) 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.

There were 19 serious incidents reported in the month of September with all SIs in the month completed within deadline.

* Data for Complaints is 1 month in retrospect and is

5. Divisional KPIs Overview 2014/15 : Trends in performance (Page 4 of 5)

Access Metrics

MetricName	Units	RAG (Mth)	Month M6	M7	M8	M9	M10	M11	M12	M1 14/15	M2 14/15	M3 14/15	M4 14/15	M5 14/15	M6 14/15
18 Weeks - Admitted waits	%	R ≤86 G ≥90	91.6	91.9	91.4	92.6	91.3	90.3	90.3	90.1	90.3	90.2	85.0	85.2	87.9
18 Weeks - Non Admitted waits	%	R ≤90, G ≥95	97.9	97.6	97.5	97.6	97.5	96.8	97.0	96.7	97.7	97.2	96.3	97.2	n/a
18 Weeks - Incomplete Waits	%	R ≤92, G ≥92	94.0	93.8	94.2	92.4	92.3	92.3	92.3	92.9	92.2	92.6	92.0	91.4	91.8
52 Week Waiters	No.	G 0, R >0	0	1	0	2	2	2	5	5	3	4	5	3	3
6 Week Diagnostic Waits	%	R ≤92, G ≥92	99.8	100.0	100.0	99.8	99.9	99.8	99.7	99.3	99.5	99.4	99.3	99.1	99.4
Cancelled Operations re-booked within 28 days	%	G ≤5, R ≥15	0	12.1	10.9	8.3	7.7	8.0	8.7	4	1.5	3.1	0	2.0	1.7
Operations cancelled for non-clinical reasons	%	G ≤0.8, R ≥1.5	1.6	1.5	1.5	1.5	1.4	2.6	2.0	1.3	1.6	1.7	1.5	1.4	1.3
A&E Waits (4 hours)	%	R ≤95, G ≥95	94.8	93.7	93.8	95.0	95.4	91.3	93.7	94.3	94.5	95.9	95.5	94.3	95.7
LAS handover within 15mins	%	R ≤95, G ≥99	3.4	40.2	32.4	36.2	46.2	30.1	32.4	36.5	39.7	40.5	36.6	36.9	31.7
LAS handover within 30mins	%	R ≤94, G ≥99	37.9	87.6	86.5	86.4	94.4	82.6	83	88.5	89.6	92.6	98.1	94	85.9
LAS handover within 60mins	No.	G 0, R >0	0	0	1	0	1	4	0	0	1	0	0	0	0
2 week GP referral to 1st outpatient -breast symptoms *	%	R ≤93, G ≥93	98.9	98.7	99.5	99.6	97.8	99.5	99.5	99.3	98.7	86.8	94.3	99.4	97.3
2 week GP referral to 1st outpatient cancer *	%	R ≤93, G ≥93	97.0	97.5	97.6	98.3	96.8	97.2	96.0	98.1	97.8	93.5	94.8	95.3	93.1
31 day second or subsequent treatment (drugs) *	%	R ≤98, G ≥98	100	100	100	100	100	100	100	100	100	100	100	100	100
31 day second or subsequent treatment (surgery) *	%	R ≤94, G ≥94	100	100	100	97.6	100	100	100	100	100	92.9	98.0	100	100
31 day standard - from diagnosis to first treatment *	%	R ≤96, G ≥96	97.2	97.5	98.4	97.5	98.4	96.9	96.3	97.6	98.1	97.3	99.3	98.9	98.0
62 day urgent GP referral to treament for all cancers *	%	R ≤85, G ≥85	86.0	78.1	82.7	80.8	85.3	86.2	80.4	85.5	84.4	92.2	82.1	86.7	87.6
62 day urgent GP referral to treament from Screening *	%	R ≤90, G ≥90	100	97.2	94.4	94.7	90.9	100	91.4	90.9	93.0	94	82.9	93.3	95.1

Outcome Metrics

MetricName	Units	RAG (Mth)	Month M6	M7	M8	M9	M10	M11	M12	M1 14/15	M2 14/15	M3 14/15	M4 14/15	M5 14/15	M6 14/15
Incidence of C.Difficile	No.	G ≤3, R ≥4	1	0	2	2	1	1	2	3	3	5	3	5	3
Incidence of MRSA	No.	G 0, R >0	1	0	1	0	2	0	0	0	1	1	1	0	0
Ecoli	No.	-	21	16	20	16	18	24	16	23	24	24	32	25	21
MSSA	No.	-	2	4	11	6	7	10	9	7	8	2	4	5	8
Medication Errors causing serious harm	No.	G 0, R >0	0	0	0	0	0	1	0	0	0	0	0	0	0
Trust Acquired Pressure Sores (G3/4)	No.	G 0, R >0	6	10	7	8	7	12	13	15	9	2	11	10	6
Serious Incidents	No.	G 0, R >0	8	16	15	13	12	29	21	21	15	9	23	11	19
Never Events	No.	G 0, R >0	1	1	0	0	0	1	0	1	0	0	1	0	1
C Sections (only applicable to Womens & Children)	%	G ≤26, R ≥30	24.3	24.1	17.5	23.4	26.8	27.1	24.3	22.4	26.5	29.4	23.5	21.8	21.8
Maternal Deaths	No.	G 0, R >0	0	0	0	0	0	0	0	0	0	0	1	0	0
Admission of full-term babies to neo-natal harm	No.	-	0	6	n/a	2	6	5	5	4	5	6	6	10	10
SHMI	Rate	G ≤100, R ≥1..	82	81	81	81	81	81	81	81	81	78	78	79	80
HSMR	Rate	G ≤100, R ≥1..	85.3	84.6	84.6	85.8	85.8	85.8	79.5	79.5	80.4	78.7	78.7	77.7	77.7
VTE Risk Assessment (data submitted to Unify)	%	R ≤95, G ≥95	94.2	95.2	94.5	94.9	96.1	93.9	97.1	96.3	96.4	97.3	99	97.3	96.5
WHO Surgical Checklist (Qrtly audit: sign in/time-out/sign-out)	%	R <100, G 100	99	99	99	99	99	99	99	99	99	99	99	99	99
Average LOS (elective)	days	-	3.6	3.6	4.0	4.0	3.5	3.9	3.6	3.9	3.5	3.8	3.3	3.6	3.8
Average LOS (non-elective)	days	-	4.5	4.6	4.5	4.6	4.7	5.1	4.8	4.6	4.5	4.5	4.6	4.8	4.8
30 Day emergency readmissions (fr elective)	%	-	1.3	1.3	1.4	1.5	1.2	1.7	1.7	1.3	1.4	1.3	1.4	1.5	1.5
30 Day emergency readmissions (fr non-elective)	%	-	5.6	6.1	6.1	5.6	5.7	6.2	6.2	5.0	6.0	6.0	6.0	6.1	5.7

5. Divisional KPIs Overview 2014/15 : Trends in performance (Page 5 of 5)

Quality Governance Indicators

MetricName	Units	RAG (Mth)	Month M6	M7	M8	M9	M10	M11	M12	M1 14/15	M2 14/15	M3 14/15	M4 14/15	M5 14/15	M6 14/15
Patient satisfaction (friends and family) *	NPS	-	62	56	59	65	61	62	63	63	63	62.2	61.1	60.2	66.2
Mixed Sex accommodation	No.	G 0, R >0	0	0	0	3	0	0	3	4	0	0	0	0	0
Ward Staffing: Bank/Agency Usage	%	-								20.3	20.2	n/a	1.5	n/a	n/a
Ward Staffing: Unfilled Duty Hours	%	-								14.7	14.5	10.4	9.6	10.7	9.1
Nurse Bed Ratio	%	-	1.0	0.8	0.8	0.8	0.9	0.9	0.9	n/a	n/a	n/a	n/a	n/a	n/a
Percentage of registered nurses	%	-	80.1	80.4	76.2	75.4	75.2	79.0	75.8	n/a	n/a	n/a	n/a	n/a	n/a
Proportion temporary staff on wards (Clinical and Non)	%	-	15.1	17.4	17.5	16.9	16.2	19.9	17.0	n/a	n/a	n/a	n/a	n/a	n/a
Staff Turnover	%	G ≤13, R ≥15	13.4	13.2	13.4	13.6	14.1	14.4	14.9	14.6	15.1	15.4	15.9	16.3	17.1
Voluntary Staff Turnover	%	G ≤10, R ≥12	10.4	10.5	10.7	11.1	11.6	11.8	12.1	12.0	12.3	12.6	13.1	13.4	13.7
Sickness/absence rate *	%	G ≤3.5, R ≥5	4.1	4.0	3.9	4.4	3.9	4.1	3.7	3.4	3.4	3.6	3.5	3.1	3.4
Vacancy rate	%	G ≤11, R ≥13	10.9	9.4	10.1	9.9	10.7	9.9	10.5	11.2	12.0	12.3	13.1	12.9	13.0
MAST attendance	%	R <70, G ≥85	59.1	59.1	59.1	n/a	n/a	n/a	68.6	68.5	69.5	70.9	71.3	68.0	68.6
Percentage of staff appraisal (medical)	%	R <70, G ≥85	78.5	79.9	79.0	83.0	83.1	86.4	85.9	75.4	75.4	84.9	86.8	85.2	86.5
Percentage of staff appraisal (non-medical)	%	R <70, G ≥85	80	79.6	74.1	74	74	76.7	76.2	82.4	84.7	73.7	78.4	80.8	83.2
Complaints - response within 25d *	%	R ≤85, G ≥85	68.5	75	65.4	61.3	64.8	56.5	56.7	60.5	54.3	66.2	69	60.2	70.7

Research

MetricName	Units	RAG (Mth)	Month M6	M7	M8	M9	M10	M11	M12	M1 14/15	M2 14/15	M3 14/15	M4 14/15	M5 14/15	M6 14/15
70 day - PI REPORT ...	%	R ≤30, G ≥70	23.8	24.5	24.5	31.5	31.5	31.5	50	50	50	66.7	66.7	66.7	70.7
Green Rated Time to target of all Open CLRN Studies	%	R ≤45, G ≥70	42	44.8	47	46	41	44	45	43	44	52.4	57.5	54	54.7
TIME TO TARGET - PD REPORT ...	%	R ≤45, G ≥70	16.2	35.9	35.9	46.8	46.8	46.8	39.3	39.3	39.3	45.6	45.6	45.6	41.3
Total recruitment at St Georges NHS - cumulative	No.	R ≤150, G ≥3..	1731	1887	2296	2635	2920	3078	3662	170	1280	1824	2350	3313	4814

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 trust's 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 trust's 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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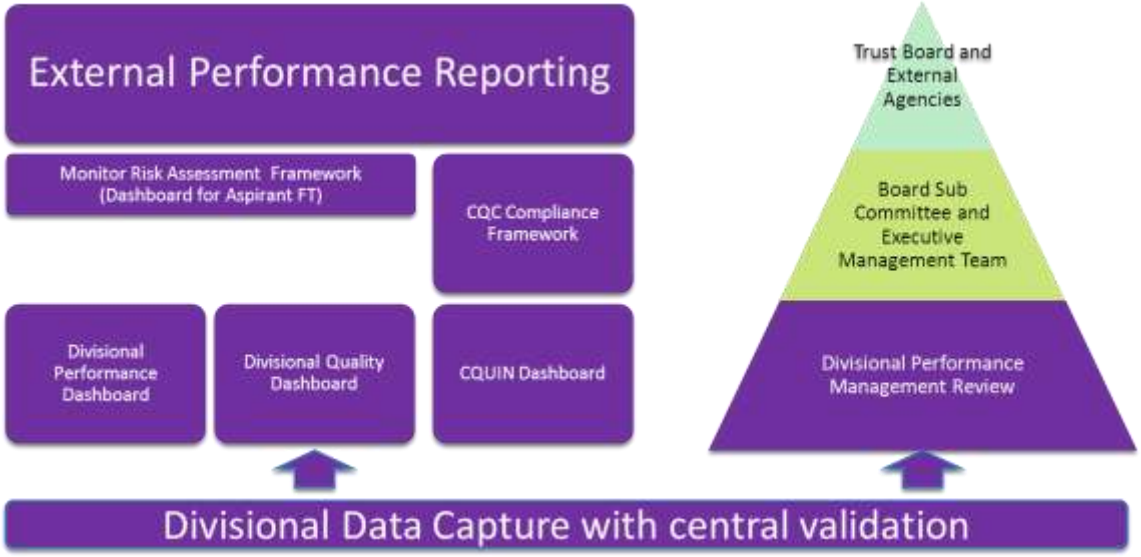

Appendix.A – trust Performance Management Framework Overview 2014/15 (Page 3 of 4)

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.

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