

## Integrated Quality and Performance Report



December 2015

## **In this month (page 5)**

December saw very high levels of both patient referrals and patient treatments across all of our services. Volumes are summarised on page 5, with a comparison between this month (and the year so far) with the same periods last year. This is important context for other aspects of our performance.

## **Are we safe? (pages 6-16)**

We continue to perform exceptionally well across mortality indicators when compared to the England average and our peers. We remain focused on achieving safe staffing standards to ensure that our nursing hours are closely matched to each patient's dependency and care needs. We have continued to see a rise in the number of reported incidents, partly as a result of awareness of, and compliance with, the Duty of Candour. Three further never events were reported in December, and there is now urgent work in hand to understand the increase in number of these events despite the vigilance of staff across the Trust.

## **Are we effective? (pages 17-24)**

We continue to perform well against most of the indicators being monitored. The Trust is working with Commissioners on 'Local Incentive Schemes' for this year to replace CQUINs. These are linked to medicines optimisation, care planning and disease prevention (smoking, alcohol and health promotion).

## **Are we caring? (pages 25-35)**

Although our Friends and Family Test feedback remains very positive, and we are maintaining satisfactory response rates in many areas, there has been a slight dip in response rates for inpatients, day case and patient transport, although 'not recommend' scores are improving and 'recommend' scores are stable in many areas. Response rates in A&E have improved, but this continues to be challenging in other (newly monitored) areas of care. We are taking sustained action to improve response levels in areas where there has been a reduction in performance by ensuring that more real time information is available to Directorates. We have contacted other Trusts who have achieved better response rates in these areas and will aim to learn from their best practice. We continue to encourage teams to review key themes emerging from free text comments and identify actions for improvement.

## **Are we responsive? (pages 36-53)**

Our performance against the standard in emergency care dropped further in December. We have focused on the flow within the Emergency Department and across the emergency pathway on our complex and medically fit patient discharges and we have seen a reduction in patients experiencing a Delayed Transfer of Care (DTOC). We continue to work hard to improve the timeliness of treatment for patients on a cancer pathway, but failed to achieve the two week standard in December. Our focus remains improving our ability to offer a patient's a choice of dates, so that we avoid unnecessary breaches and to work with partner hospitals to improve the pathways for all patients within our network. Unfortunately, we still receive a large number of patient referrals too late for us to treat them within the pathway target of 62 days. With respect to Referral to Treatment (RTT) we failed to achieve the 92% of patients treated within 18 week target. We are focused on reducing longer waits through increased activity and as well as chronological booking and improved validation accuracy on our pathways. Our diagnostic performance is still significantly better than this point last year however, we our performance deteriorated to 2% against a target of 1% of diagnostics remaining incomplete at 6 weeks. We have focused plans on recovering performance back to previous levels during Quarter 4.

## **Are we well-led? (pages 54-58)**

Our Quarter 2 Staff Friends and Family Test results highlight that our staff continue to give the Trust a huge vote of confidence as a provider of care and as a recommended employer. We await national results enable comparisons. Our vacancy rate remains above our internal target, but we expect this to reduce further as new starters join the Trust during Quarter 3. The number of completed personal development reviews has decreased slightly in December but staff have been reminded of the importance of undertaking these.

## **How effective are our enabling services? (pages 59-72)**

The Trust has recorded a loss of £16.0M to the end of December, an adverse variance to plan of £1.7M. This has been driven mainly by the level of unidentified savings. Essentia Patient Services - who provide non-clinical support services across the Trust - have provided additional metrics from this month to enable a wider review of how it supports the Trust in its day to day activity.

# Trust overview

December 2015

Page 3

Domain	Ref	Theme	Page	Management priority (last month)	Management priority (this month)	Forecast status	Briefings
<b>1 Safe</b>	1.1	Patient safety - incident reporting	8	Moderate	Moderate	Stable	
	1.2	Patient safety - harm-free care	9	Minor	Minor	Stable	
	1.3	Infection control and cleanliness	11	Minor	Minor	Stable	
	1.4	Screening on admission	13	Minor	Minor	Stable	
	1.5	Mortality indicators	14	Excellent	Excellent	Stable	
	1.6	Safe staffing (nursing and midwifery)	15	On track	On track	Stable	Nursing and Midwifery Safe Staffing/Infection Control (HCAI)
<b>2 Effective</b>	2.1	Quality Indicators	18	On track	On track	Stable	
	2.2	Quality Indicators - Specialist	21	On track	On track	Stable	
	2.3	Clinical best practice (inc readmission management)	23	Minor	Minor	Stable	
<b>3 Caring</b>	3.1	Admitted Patient Experience	26	Moderate	Moderate	Improving	Admitted Friends and Family Test
	3.2	A&E Patient Experience	29	Moderate	Moderate	Improving	A&E Friends and Family Test
	3.3	Maternity Experience	31	On track	On track	Improving	
	3.4	Outpatient Experience	32	Minor	Minor	Improving	
	3.5	General patient and carers' experience (inc involvement in care and treatment)	33	Moderate	Moderate	Improving	
<b>4 Responsive</b>	4.1	A&E access	34	Significant	Significant	At risk	A&E waits
	4.2	Elective treatment access (inc referral to treatment performance)	35	Significant	Significant	At risk	Referral to Treatment waits
	4.3	Cancer access	38	Significant	Significant	Improving	Cancer Waits
	4.4	Diagnostic access	39	Significant	Significant	At risk	
	4.5	Bed capacity and management	42	Moderate	Moderate	Stable	
	4.6	Outpatient management	48	Moderate	Moderate	Stable	
	4.7	Theatre and critical care management	49	Moderate	Moderate	Improving	
	4.8	Complaints management	50	Moderate	Moderate	Stable	
<b>5 Well-led</b>	5.1	External assessments	51	Moderate	Moderate	Stable	
	5.2	Staff experience (inc open and honest reporting)	52	Excellent	Excellent	Stable	
	5.3	Workforce indicators	53	Minor	Minor	Improving	
<b>6 Enablers</b>	6.1	Overall financial position	54	Significant	Significant	Stable	
	6.2	Activity volumes ('magic numbers')	60	Moderate	Moderate	Improving	
	6.3	Fit for the Future programme - inc cost improvement plan (CIP) delivery	61	Significant	Significant	Stable	
	6.4	Data quality, clinical coding, information and IT	63	On Track	On track	Improving	
	6.5	Essentia Patient services	64	Minor	Minor	Stable	Exception reports across Essentia services.

# Key to scorecard assessments

December 2015

Page 4

## Management priority

## Individual theme in 'Trust overview'

Significant	Significant interventions are planned or in progress due to one or more factors: an externally-reported metric is off-track; multiple internal metrics are off-track; qualitative experiences are raising significant concerns
Moderate	Moderate interventions are planned or in progress due to one or more factors: an important internal metric is off-track; qualitative experiences are raising concerns; future projections are off-track
Minor	Some interventions are planned or in progress: stretch targets are off-track; trends are adverse; qualitative experiences suggest performance may be at risk
On track	All areas within this theme on track
Excellent	Amongst top performers nationally, with internal stretch targets consistently met

## Forecast status

## Individual theme in 'Trust overview'

At risk	Expected to worsen by next reporting period
Stable	Not expected to change significantly by next reporting period
Improving	Expected to improve by next reporting period

## Indicator status

## Individual metric in 'Domain scorecard'

	Achieving national standard or internal target (this reporting period)
	Not achieving internal target (this reporting period)
	Not achieving national standard (this reporting period)
	Indicator only - not measured against a set target

## We received...

Referrals from GP's  
Urgent cancer referrals  
Referrals to @Home and ERR

December

15,585

1,210

412

## Compared to last year

Same month

Year so far

17.3%

14.7%

18.9%

14.7%

-2.8%

45.8%

## We treated...

A&E attendances  
Non-elective admissions  
Outpatient attendances  
Day cases  
Elective inpatients

14,289

3,604

80,974

4,853

2,196

4.1%

1.8%

2.6%

2.9%

7.4%

7.7%

11.5%

12.2%

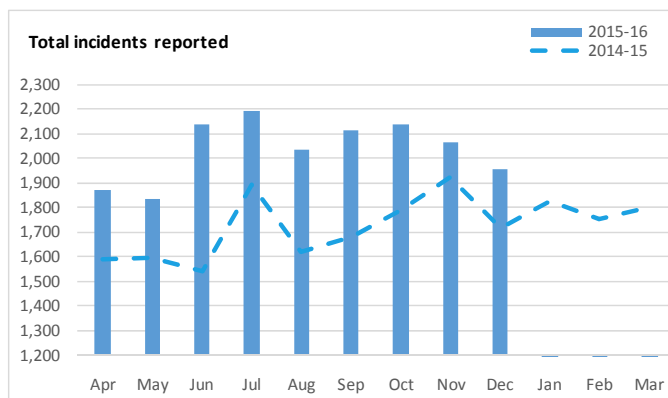
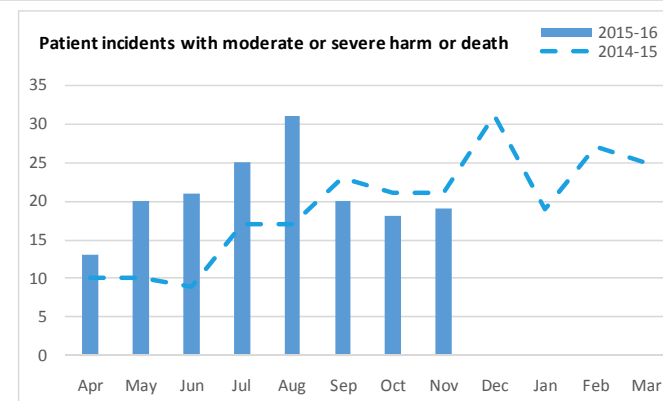
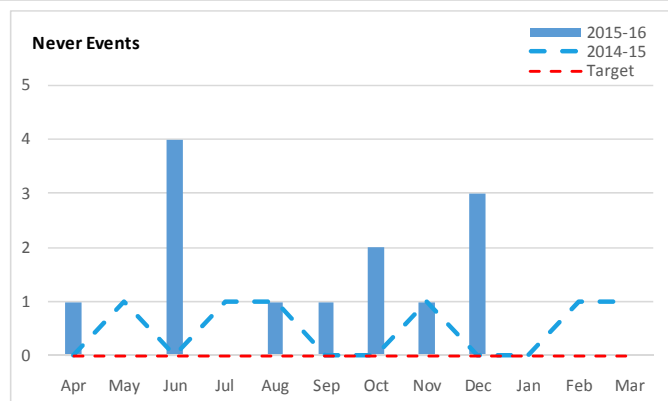
8.6%

5.0%

Theme	Ref	Indicator	Units	Target	R	G	Prior year	Oct	Nov	Dec	YTD avg	Monitor Quality priorities	Trend chart
1.1 Patient safety - incident reporting	INC 06	Total incidents reported	Number	-			1,880	2,138	2,066	1,954	2,036		Y
	INC 06S	Total incidents reported on STEIS	Number	-			11.4	7	2	5	7.0		
	INC 06ST	Total incidents reported on STEIS - not attributable to Trust	Number	-			4.6	0	0	0	0.0		
	INC 07	Never Events	Number	Zero			0.5	2	1	3	1.4		Y
	INC 01	Incidents resulting in unexpected death	Number	-			1.6	0	3	1	2.3		Y
	INC 02	Incidents resulting in severe harm	Number	-			2.5	3	1	2	2.1		Y
	INC 03	Incidents resulting in moderate harm	Number	-			17.2	15	15	18	16.4		Y
	INC 04	Incidents resulting in low harm	Number	-			332	326	308	332	315		
	INC 05	Incidents resulting in no harm	Number	-			1,375	1,330	1,317	1,249	1,278		
	INC 01S	Incidents resulting in unexpected death - reportable on STEIS	Number	-			0.8	1	1	1	1.8		
	INC 02S	Incidents resulting in severe harm - reportable on STEIS	Number	-			1.4	4	0	1	2.2		
	INC 03S	Incidents resulting in moderate harm - reportable on STEIS	Number	-			1.4	1	0	1	1.1		
	INC 04S	Incidents resulting in low harm - reportable on STEIS	Number	-			2.7	0	0	2	0.9		
	INC 05S	Incidents resulting in no harm - reportable on STEIS	Number	-			3.9	1	1	0	0.9		
	INC 08P	% incidents relating to patients	Mthly %	-				78.4%	79.7%	82.0%	79.2%		
1.2 Patient safety - harm-free care	Therm	Measure of harm-free care - Safety Thermometer	Mthly %	>95%			89.2%	96.3%	96.3%	96.8%	96.8%		Y
	305T	Pressure ulcer acquisitions (grade 2 and above) attributable to Trust	Number	<5			2.3	3	3	3	3.3		Y
	305TA	Admissions with pressure ulcers (grade 2 and above)	Cases	-			43	46	32	45	40		Y
	INC 22	Medication incidents reported	Number	-			234	286	279	226	259		Y
	INC 21	Patient falls with moderate or severe harm	Number	-			2.3	0	2	2	1.7		Y
	INC 20	Patient slips trips and falls	Number	-			117	118	147	141	140		Y
	313BD	Incidence of falls per 1000 bed days	Number	-			4.0	3.7	4.8	4.8	4.8		Y
	WHO	WHO surgical safety checklist	Ann %	-			85%				85.5%		

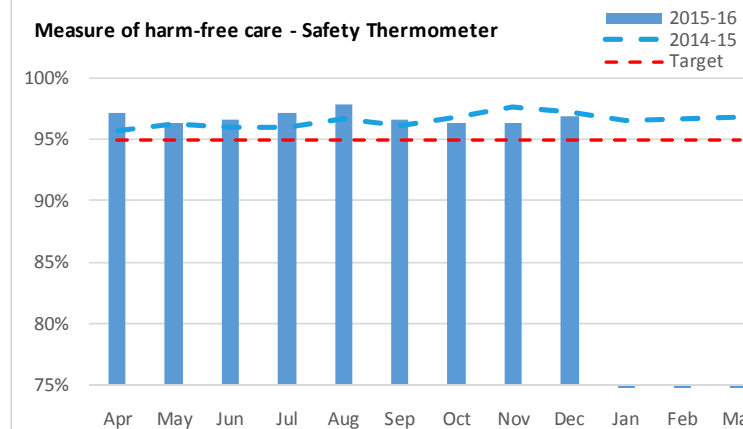
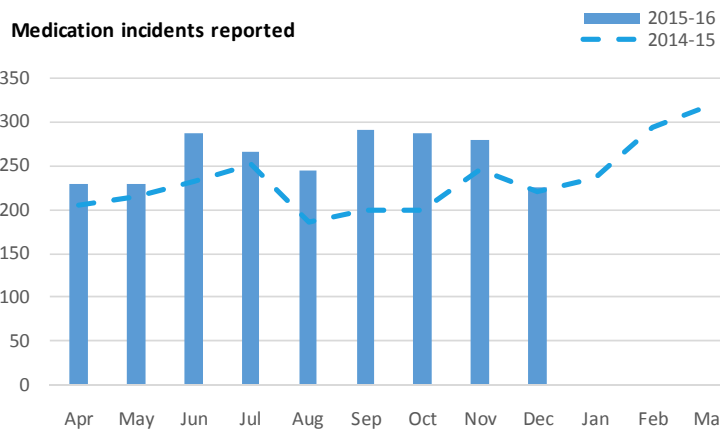
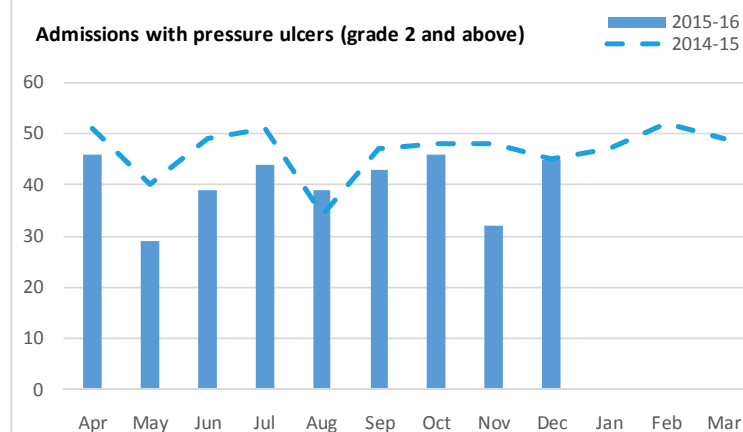
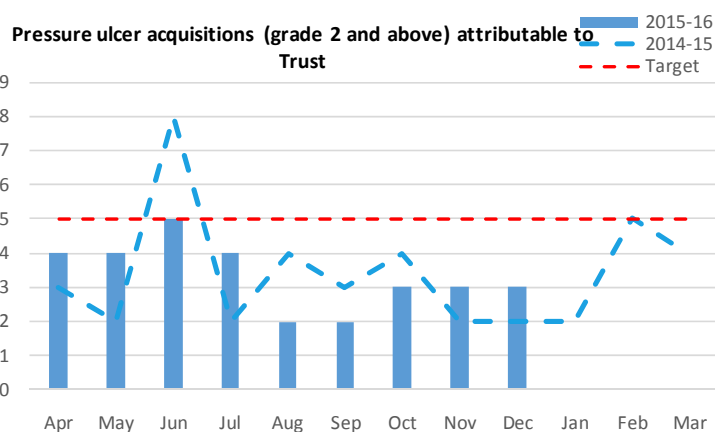
Theme	Ref	Indicator	Units	Target	R	G	Prior year	Oct	Nov	Dec	YTD avg	Monitor	Quality priorities	Trend chart
1.3 Infection control and cleanliness	324	MRSA screening of admissions	Mthly %	>95%			94%	91.5%	92.0%	91.9%	95.8%			Y
	301	MRSA bacteraemia (Trust-attributable)	Number	Zero			0.2	0	0	0	0.1			Y
	302L	C-Diff acquisitions resulting from lapse in care	Number	Zero			0.4	1	0	0	0.2			Y
	302T	C-Diff acquisitions (Trust-attributable)	Number	<4 pm			4.2	3	2	1	4.2			Y
		Catheter attributable urinary tract infection (CAUTI)		In devt										
	AMS	Anti-microbial stewardship	Score	>85			79.4	90	94	96	93.2			Y
	NPSA	Cleanliness standards (NPSA)	Mthly %	>95%			89.5%	98.2%	97.9%	97.9%	97.5%			Y
1.4 Screening on admission	9936	VTE screening (externally reported)	Mthly %	>95%			96.0%	96.8%	96.9%	97.1%	97.1%			Y
		VTE screening within 24 hours		In devt										
	Dem75	Dementia screening (patients aged over 75)	Mthly %	>90%			-	89.6%	86.4%	93.0%	91.7%			Y
1.5 Mortality indicators	350	Deaths in hospital - number in month	Number	-			85.5	76	86	102	89.4			Y
	HSMR	Hospital standardised mortality ratio (HSMR) - most recent score	Ratio	<90			-	76.0	76.0	75.6	75.6			Y
	SHMI	Standardised healthcare mortality index (SHMI) - most recent score	Ratio	<90			-	82.7	79.0	74.5	80.5			Y
		Deaths in low risk diagnosis groups		In devt										
1.6 Safe staffing	SafeS	Safe Staffing - ratio of actual to planned hours	Mthly %	-			-	100.7%	100.1%	98.5%	100.4%			

- This month's data is still under investigation; therefore the degree of harm may change. The Patient Safety Team monitor on a daily basis (Monday to Friday) all incidents reported in the previous 24 hour period to review harm reported, escalate where necessary and identify any emerging trends or hot spots. We continue to remain in the top percentile for incident reporting under National Reporting and Learning System (NRLS) benchmarking.
- The increase in reported incidents has been consistent and we now believe this to represent a permanent improvement in reporting rates and a demonstration of a positive reporting culture. There has been an increase in incidents across all degrees of harm but the majority of these are no harm incidents.
- Directorates are also now reporting all unexpected deaths via the Datix system and have put in place processes to ensure all unexpected deaths are reviewed, discussed and lessons learnt are shared across the teams involved.
- Never events are serious incidents (regardless of the degree of harm caused) which are wholly preventable (as guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Despite this, never event incidents do sometimes happen. As with all serious incidents, never events require very thorough investigation. There were three never events in December and there is now an urgent programme of work to understand the increase in the number of these events despite the vigilance of staff across the Trust.

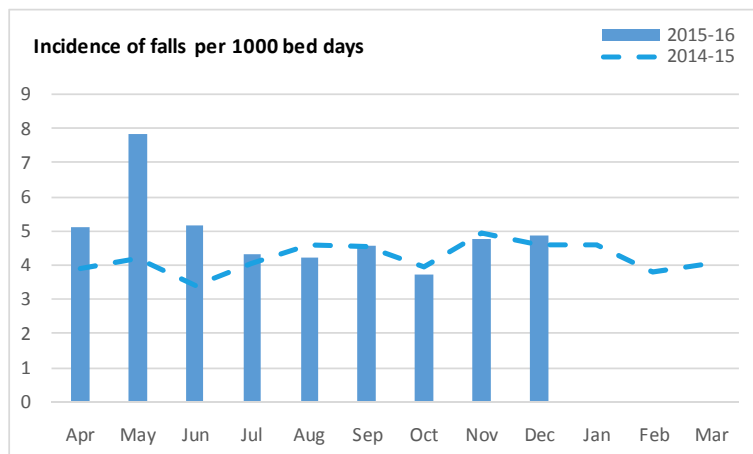
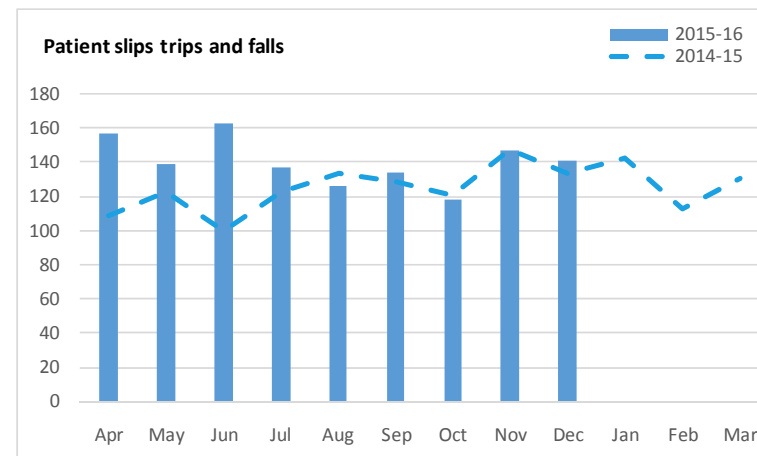
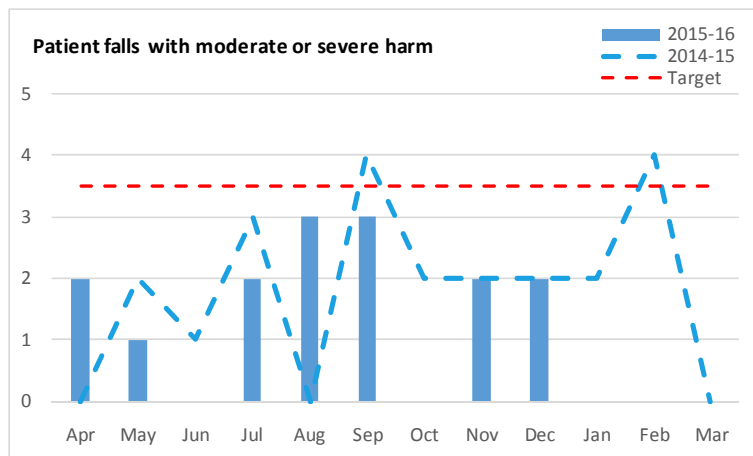




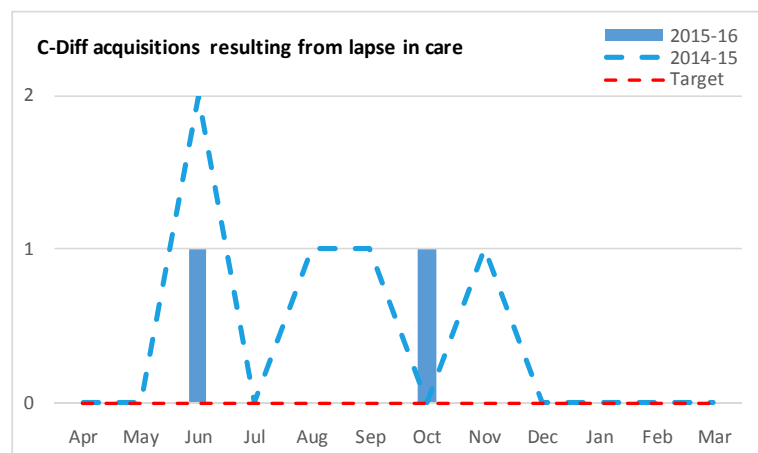
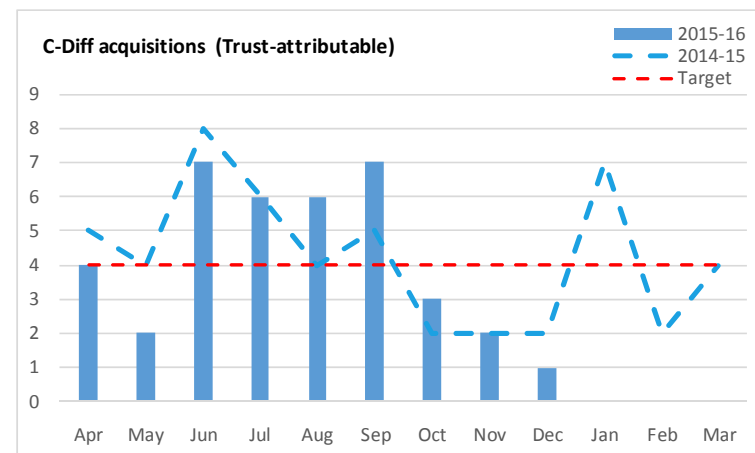
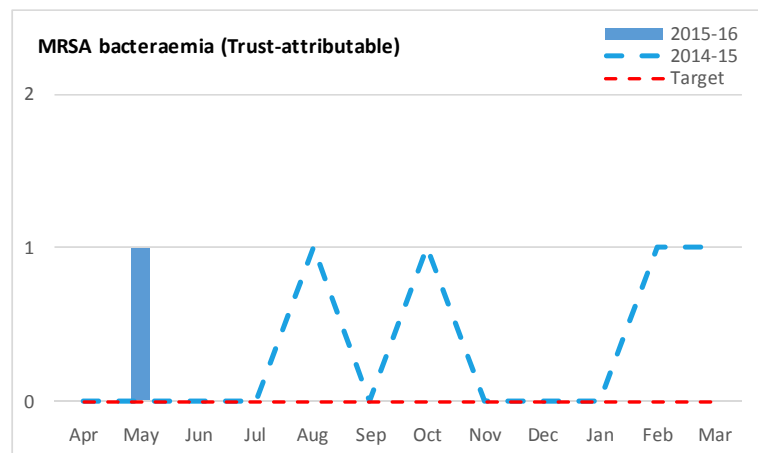
- The Trust continues to have low numbers of attributable stage 2, 3 and 4 pressure ulcers each month. Incidence remains below 1%. Of the 3 attributable pressure ulcers for December, 2 were stage 2 and the other stage 3. All have been subject to a mini RCA, with lessons learned integrated into clinical practice.
- These lessons included: (i) The importance of regular risk assessment of all patients as per GSTT policy, as early detection helps both prevention and progression (ii) Escalation to nurse in charge and tissue viability team of all patients who are proving challenging with positioning or have vulnerable pressure points (iii) Identify gaps in knowledge and address the learning needs of staff.
- We saw an increase in the number of admitted patients with pressure ulcers this month. The majority of these were in acute medicine and involved high risk patients with multiple comorbidities. Numbers were comparable to December 2014.
- We continue to focus on awareness of the importance of reporting medication incidents. The majority of those incidents reported were of no or low harm.



This month the Trust has seen a small reduction in the incidence of falls with 141 reported compared to 146 in November. This is due to a reduction in Non ward and Community falls. This month there was an increase in the incidence of inpatient falls with 111 reported compared to 103 in November. 111 falls were reported in 97 patients. 16 assisted falls were reported this month, an increase over the last 2 months when 8 were reported per month. The directorates with the highest incidence of inpatient falls were Acute Medicine and Cardiovascular. There were 2 falls resulting in moderate harm, or above, this month. One of these occurred in Acute Medicine, the other in Haematology and Oncology.



- The Trust has reported no attributable cases of MRSA bacteraemia in December.
- The Trust remains on track to deliver the trajectory for the external Clostridium-difficile (C-diff) objective of no more than 51 reportable cases during 2015/16, with 38 reportable cases so far. No cases were assigned to the Trust in December.



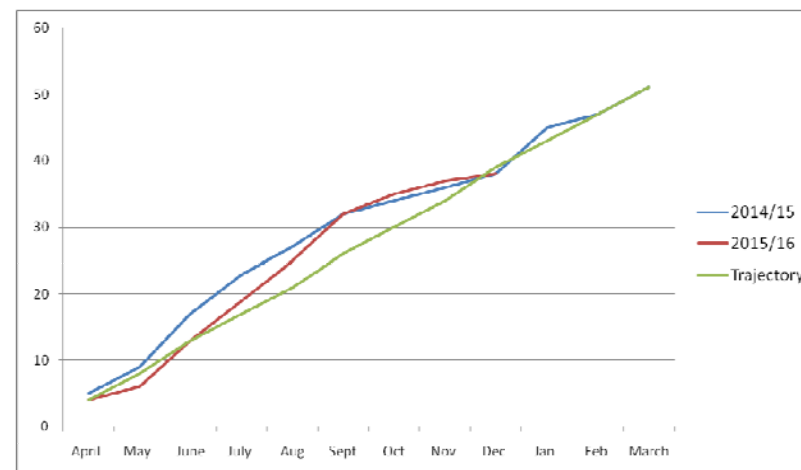
•Where we want to be. Targets and benchmarks:

- ***Clostridium difficile*** - The external objective for reportable cases of *C. difficile* (Cdiff) for 2015/16 is 51 cases. Reportable cases are those that are 'toxin positive' (Enzyme-linked Immunoassay or 'EIA' positive) and are identified beyond three days of admission to the organisation (attributed). In addition the Trust must determine and report to the commissioners any reportable cases that are deemed to be due to any 'lapse in care'.
- **Methicillin Resistant *Staphylococcus aureus* (MRSA)**. The organisation has a zero tolerance threshold for MRSA bacteraemia.
- **Other bacteraemia** - The Trust is required to report all cases of MSSA and E-coli bacteraemia via the Public Health England (PHE) reporting system. There is no national objective for these bacteraemia at present

•Where we are: trends and patterns:

- ***C. difficile***
  - To the end of December 2015 the Trust is on target to achieve our external Cdiff objective with 38 reportable cases and two lapses in care. The second lapse in care occurred in October and was related to inappropriate prescribing. The trajectory against the Cdiff objective continued to improve in December.
- **MRSA**
  - There were no cases assigned to the Trust in December. The total for 2014/15 remains at one case (deemed to be an unavoidable contaminant)
- **Other bacteraemia**
  - MSSA - To the end of December 2015 the Trust reported 60 cases of which 21 were deemed to be Trust attributable (identified > 48 hours after admission)
  - E coli - To the end of August 2015 the Trust reported 164 cases, of which 32 were categorised as healthcare associated.

Figure 1. Cdiff cases 2015/16 compared with 2014/15 with a linear trajectory to 51 cases.



### Incidents and Investigations:

### Status

Sporadic cases of seasonal Influenza have been identified however numbers of cases remain low. Seasonal Respiratory Syncytial Virus (RSV) is being managed in Children's services

**Actions underway**

Sporadic cases of Norovirus have been seen and Norovirus preparedness is underway; however numbers of cases are low

**Actions underway**

Mycobacterium chimera in heater/cooler units used in cardiac bypass machines – this issue will remain active for the foreseeable future

**Actions underway**

Intelligence triangulated

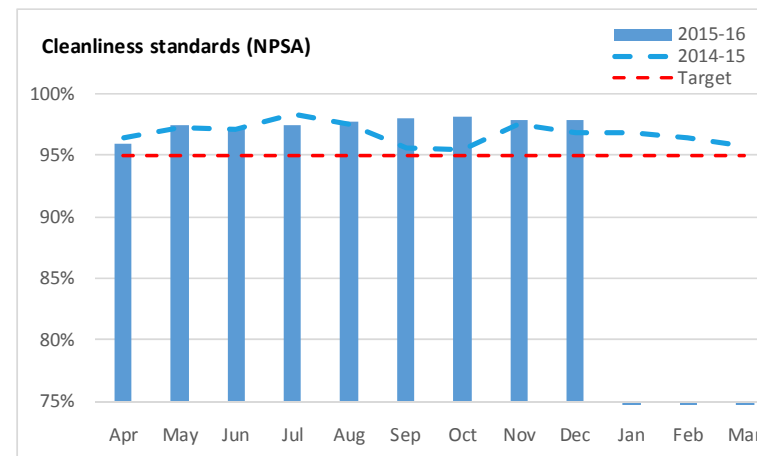
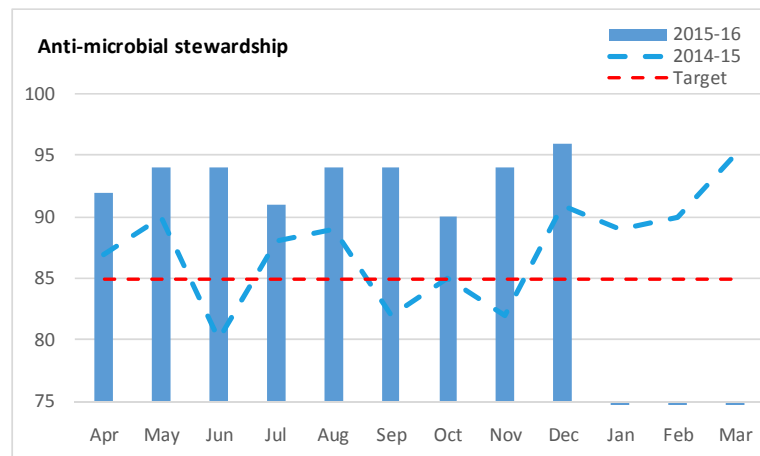
Root cause understood

Action plan set

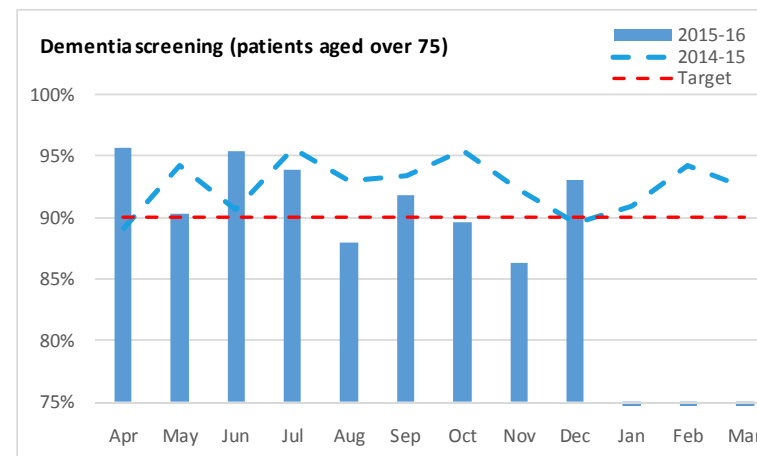
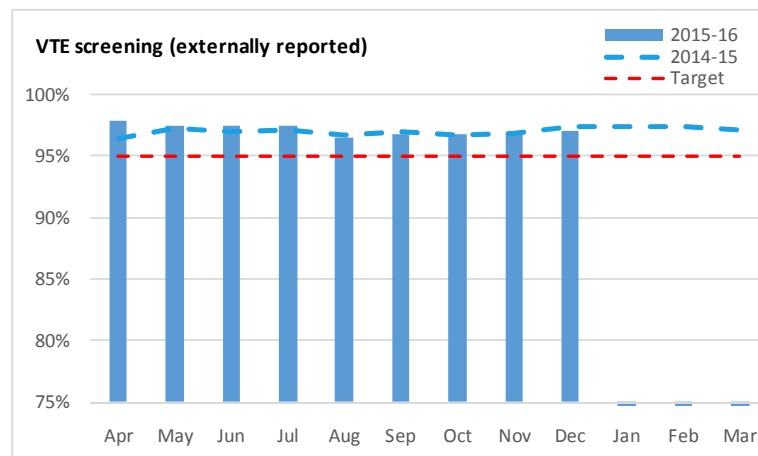
Actions underway

Actions complete

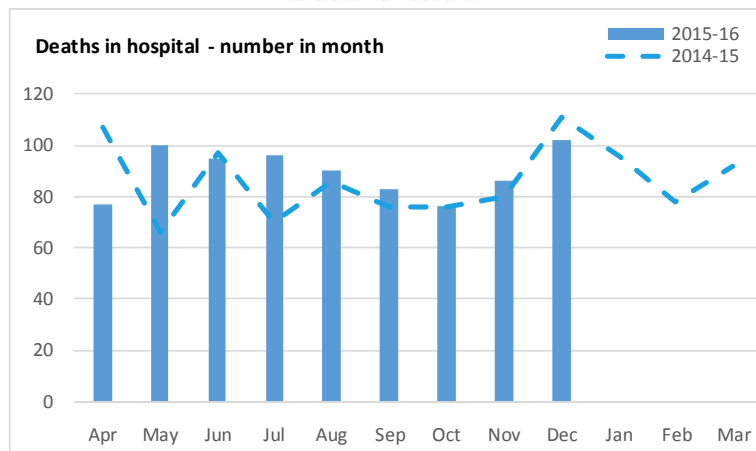
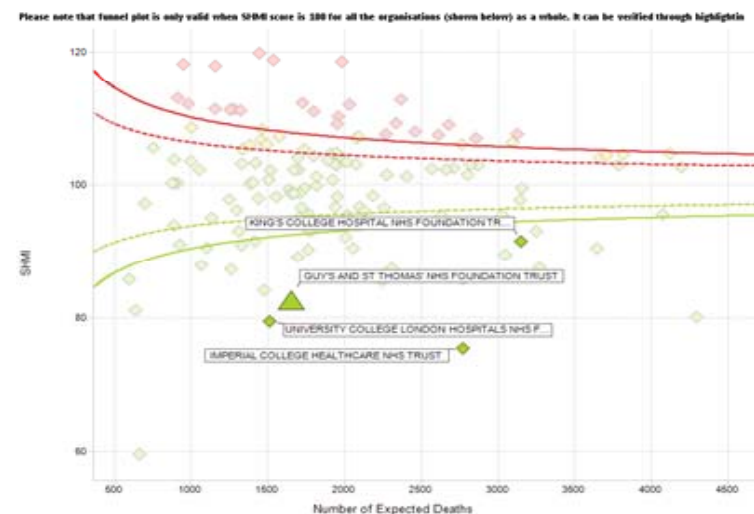
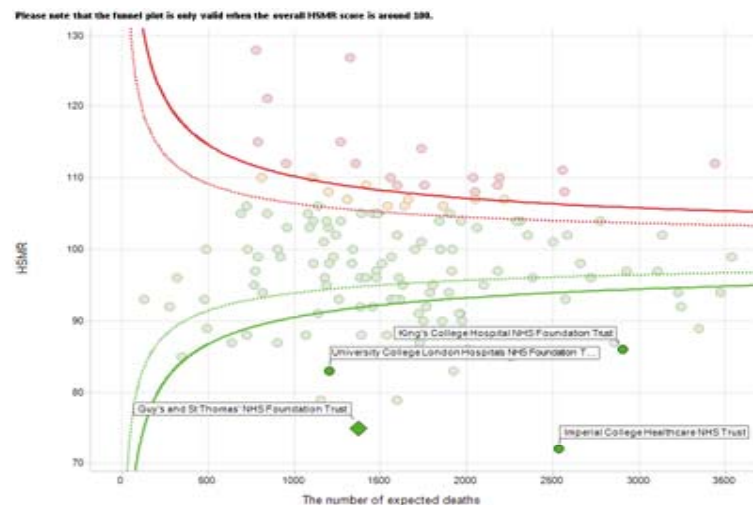
- The Trust continues to maintain high standards of anti-microbial stewardship.
- Cleanliness scores across both acute and community sites consistently exceed the 95% target.



- We continue to achieve our screening target for Venous Thromboembolism (VTE) across all directorates, but we are seeking to improve the percentage of inpatient and day case admissions screened in individual specialties. These include some surgical areas, particularly nurse-led day-case services.
- Dementia screening compliance has improved for December and is now over the target of 90%.
- A Dementia screening review is carried out for all the breaches and for those screened after 72 hrs to ensure that there have not been more than one screen where the later screen could have invalidated the original screen. The team remind staff about screening at every opportunity and also provide training to wards and areas where compliance has been low.



- Benchmarked mortality allows case-mix corrected risk of death to be compared across organisations. The Trust continues to perform exceptionally well, both against the England average and other London acute hospitals. Two measures are used: Hospital Standardised Mortality Rate (HSMR) shown in graph upper right; and Summary Hospital Mortality Indicator (SHMI) shown in graph upper left. SHMI includes deaths within 30 days of discharge. For both indicators a low score is good.
- The publication of these measures is delayed to allow meaningful interpretation and comparison. In view of this we also examine the crude mortality data on a monthly basis to help us monitor deaths in hospital as soon as possible after they occur. This allows us to react to any concerning clusters of deaths on a ward or within a service immediately. No significant issues have been identified in 2015/16.



### •Where we want to be. Targets and benchmarks:

Actual nursing hours used across the Trust to closely match patient dependency and care needs in order to provide high quality patient care whilst remaining financially viable as an organisation. Stable workforce: reduction in nursing and midwifery vacancies and high retention rates.

### •Where we are. Trends and patterns. Nursing Hours: Planned Vs. Actual:

-Overall in December 2015 there was a marginal increase in vacancies of 4.68 wte (ESR data, and staff in post at 18/12/2015 compared to 26/11/2015). The Trust vacancy level is 11.16% (not including external pipeline starters). In month there was an increase of 9.8 wte external starters compared to the month of November.

-Planned versus actual nursing hours for December was 1.5% below plan; a decrease of 1.6% from November (figure 1). This is the fourth month where the hours have been reduced against the same periods last year.

-Registered nurse (RN) actual hours were 5,544 below plan (equivalent to 34 wte) with Nursing Assistant (NA) actual hours 723 hours above planned (equivalent to 4.4 wte).

-Average fill rates of planned hours in December for RNs for day was 97.6% and 98.3% at night.

-Average fill rates for planned hours for NA was 99.4% for day and 104.4% for the nights. NA hours above plan was primarily due to 1:1 specialing, alongside a small number of overseas (RN) nurses waiting NMC registration who are currently working as non-registered nurses (NA).

-There were five wards that closed from 24th December 2015 (Sarah, Esther, Nightingale, Florence and Howard Ward) until the beginning of January 2016 due to decreased activity. During the period of ward closure, all staff rostered to work were reallocated to wards either within their host directorate or elsewhere according to need. This enabled backfilling of posts that were vacant, eg due to short term sickness or where acuity was high to be undertaken without booking temporary staff

-During the period of 21st December until 4<sup>th</sup> January, temporary staffing within nursing and midwifery was used only in those areas where it was clinically required to maintain patient and staff safety. Due to the availability of staff from the closed wards, combined with a reduction in activity and dependency in some areas, it was safe to reduce the actual nursing hours used. This resulted in the Trust level actual hours total being below plan. The Heads of Nursing (HoN) have given assurance that, where actual hours were reduced, the shifts were always deemed to be safely staffed.

### ▪Risks or opportunities for the Trust. Nursing:

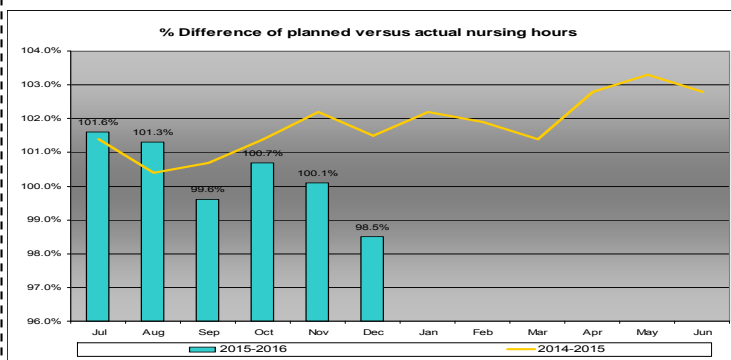
-The current nursing and midwifery establishment is 5676.76 wte (excluding research and development nurses not hosted in directorates), with 5043.24 wte staff in post.

-There are 633.52 wte vacancies (11.16 % ESR data 18/12/15), of these there are 258.79 wte external starters in the pipeline. There remains 374.73 wte posts to be appointed.

### ▪Actions set and progress to date:

- In December the Trust introduced vacancy controls as part of its financial recovery programme. Key posts providing direct patient care eg, band 5 ward nurses are exempt. Those outside the exemptions are subjected to scrutiny from a financial perspective but each has a quality impact assessment prior to submission. Directorate peer to peer reviews were completed in the month of December led by the directorate Head of Nursing. The objective of these was to review the current workforce size and shape and to challenge as a peer where they may be efficiencies or changes proposed in the current workforce.

### Trend (Figure 1)

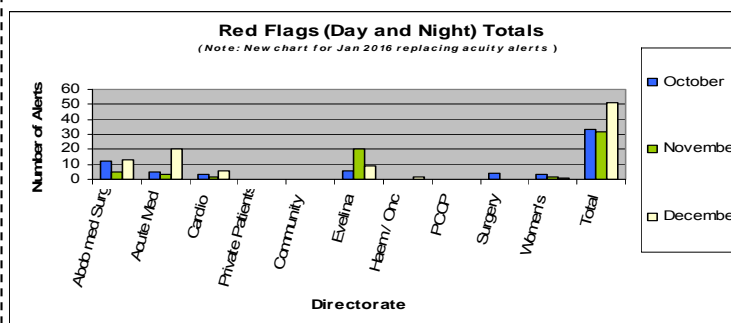


### Benchmark (Figure 2)

Safe Staffing levels – taken from NHS Choices at 22/01/16

St Thomas' Hospital site	100%
Guy's Hospital site	99%
King's College Hospital	100%
Chelsea and Westminster Hospital	95%
University College Hospital	100%

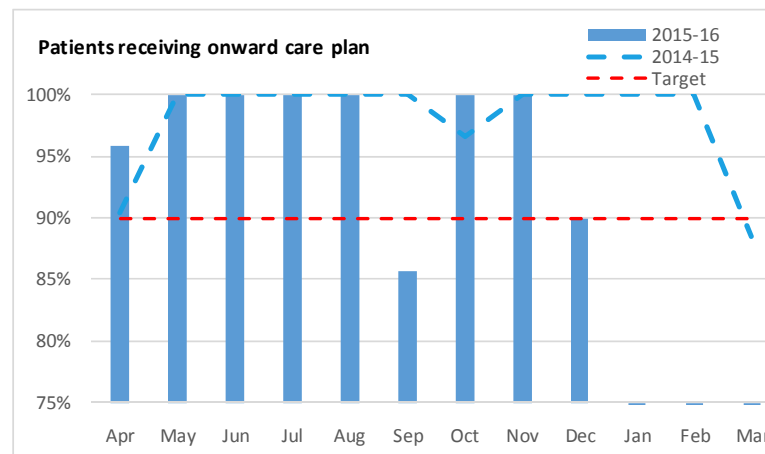
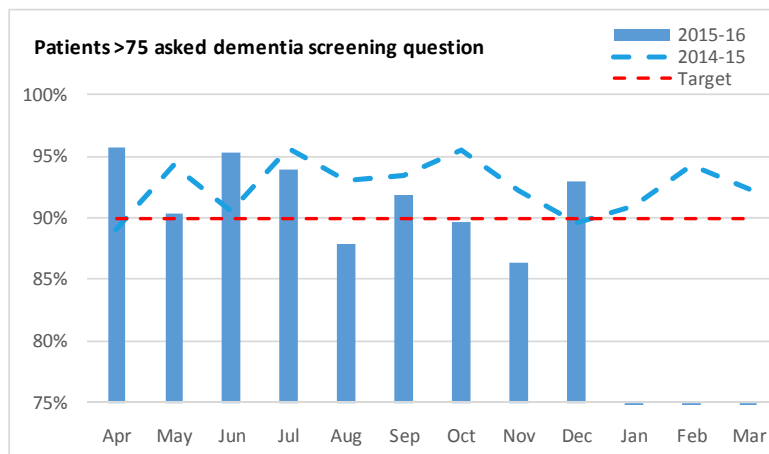
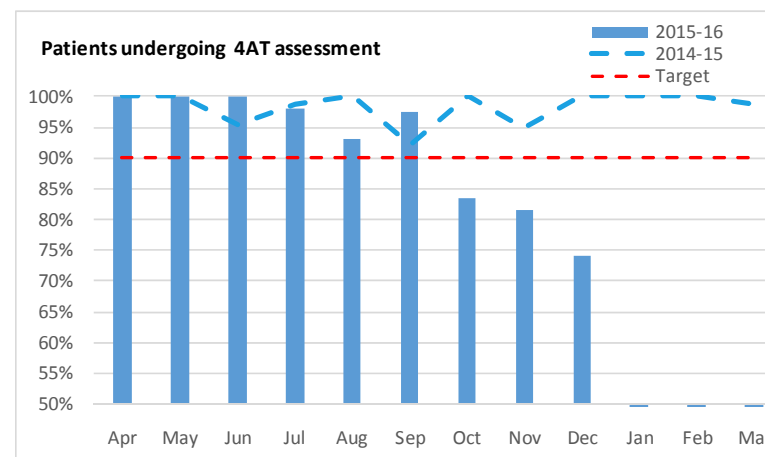
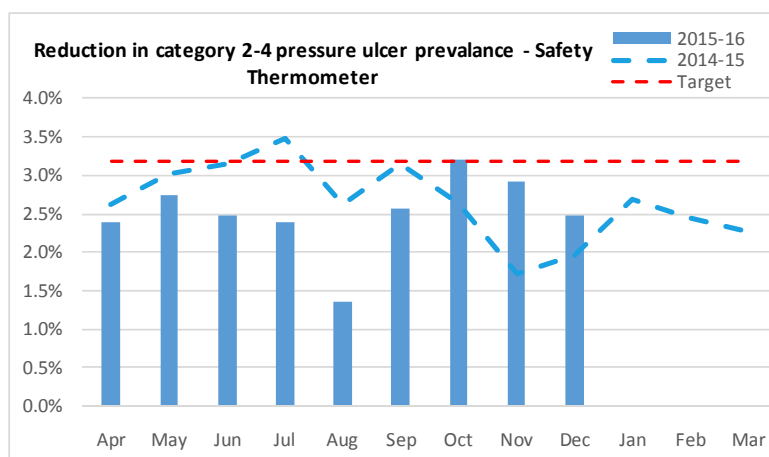
### Directorate heat map (Figure 3)



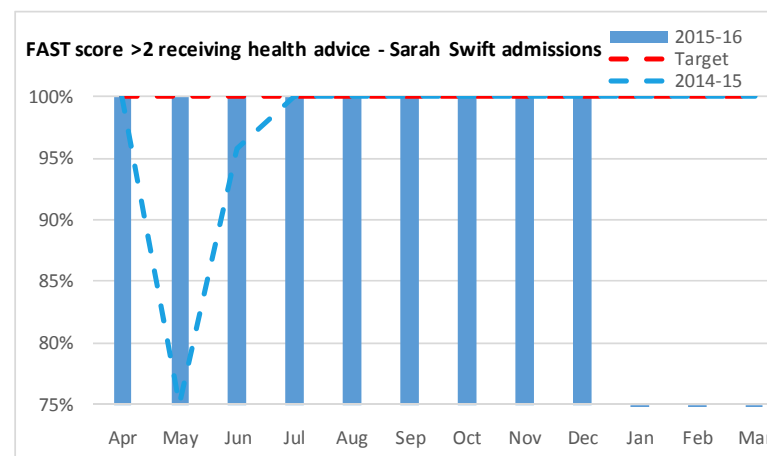
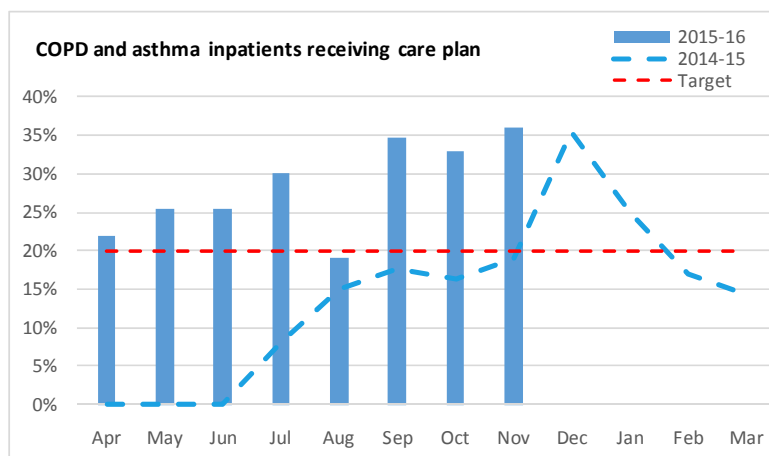
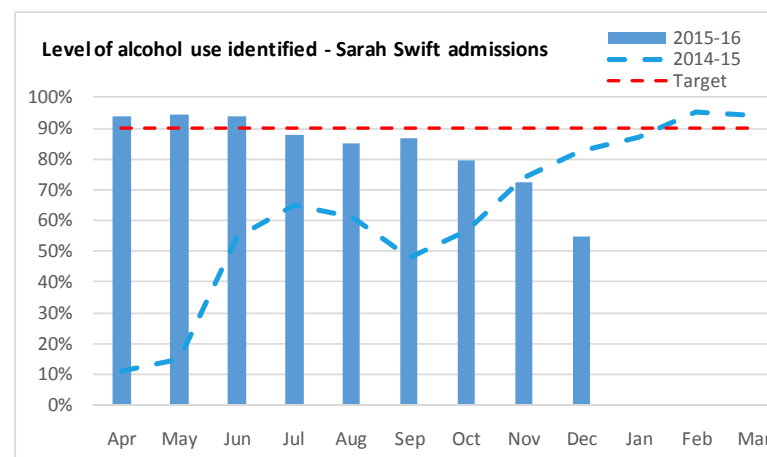
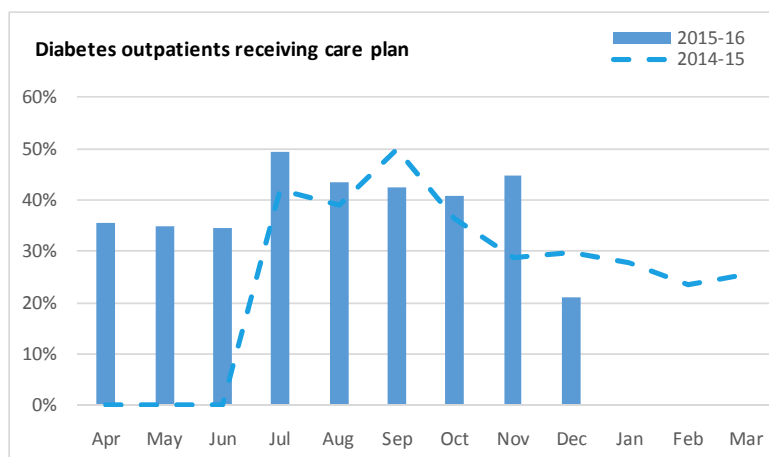


Theme	Ref	Indicator	Units	Target	R	G	Prior year	Oct	Nov	Dec	YTD avg	Monitor	Quality priorities	Trend chart
2.1 Quality improvement initiatives - general	CQ5q	Reduction in category 2-4 pressure ulcer prevalence - Safety Therm	Qtly %	<3.18%			-	3.2%	2.9%	2.5%	2.5%			Y
	Dem75Aq	Patients >75 asked dementia screening question	Qtly %	>90%			-	89.6%	86.4%	93.0%	91.7%			Y
	Dem75Bq	Patients undergoing 4AT assessment	Qtly %	>90%			-	83.3%	81.6%	74.2%	92.0%			Y
	Dem75Cq	Patients receiving onward care plan	Qtly %	>90%			-	100.0%	100.0%	90.0%	96.4%			Y
	CQ6Aq	Diabetes outpatients receiving care plan	Qtly %				-	40.8%	44.9%	20.9%	38.8%			Y
	CQ10q	COPD and asthma inpatients receiving care plan	Qtly %	>20%			-	32.9%	36.1%		28.2%			Y
	CQ7Aq	Level of alcohol use identified - Sarah Swift admissions	Qtly %	>90%			-	79.3%	72.3%	54.9%	80.7%			Y
	CQ7Bq	FAST score >2 receiving health advice - Sarah Swift admissions	Qtly %	100%			-	100.0%	100.0%	100.0%	100.0%			Y
	CQ12Aq	Smoking levels identified - Vascular and ARU	Qtly %	>90%			-	96.2%	94.0%	95.9%	94.0%			Y
	CQ12Bq	Smokers receiving health advice - Vascular and ARU	Qtly %	100%			-	100.0%	100.0%	100.0%	100.0%			Y
2.2 Quality improvement initiatives - specialist	CQ1Aq	CABG within 7 days of GSTT angiogram	Qtly %	>66%			-	100.0%	50.0%	100.0%	96.0%			Y
	CQ1Bq	CABG within 7 days of referral received (angiogram elsewhere)	Qtly %	>38%			-	60.0%	57.1%	90.0%	73.3%			Y
	CQ1Cq	CABG within 7 days - combined GSTT and external angiograms	Qtly %	>59%			-	75.0%	61.5%	92.9%	78.4%			Y
	CQ2Aq	Perinatal autopsy reports produced within 42 days of autopsy	Qtly %	>80%			-	96.3%	89.2%	84.4%	93.4%			Y
	CQ2Bq	Perinatal autopsy reports produced within 56 days of autopsy	Qtly %	>90%			-	100.0%	97.3%	93.8%	97.2%			Y
	CQ3q	Number of Fetal Medicine referrals seen within 3 working days	Qtly %	>90%			-	100.0%	100.0%	100.0%	97.6%			Y
	CQ4q	Babies undergoing 1st Retinopathy of Prematurity (ROP) screening	Qtly %	>95%			-	100.0%	100.0%	100.0%	98.8%			Y
	CQ14	Severe asthma patients receiving care plan	Number	>20			-	19	17	9	12			Y
2.3 Clinical best practice	352	Emergency readmissions (within 28 days - in arrears)	Cum %	<5.3%			5.3%	5.7%	5.7%		5.7%			Y
	353	Emergency readmissions (within 14 days - in arrears)	Cum %	<3.4%			3.4%	3.6%	3.6%		3.6%			Y
		Elective surgical readmissions within 28 days		In devt										
	IC48	Critical Care Unplanned Readmissions within 48 Hours	Mnthly (%)	<=1.3			-	2.0%	2.4%	1.0%	1.3%			
	913	% Caesarean sections	Mthly %	<28%			-	35.4%	30.3%	37.8%	33.2%			
	ICNARC-STH	Critical care mortality indicator-STH+VH DU	Quarterly	<=1.0			-	0.82	0.82	0.82	0.84			
	ICNARC-Guys	Critical care mortality indicator-Guys CCU	Quarterly	<=1.0			-	0.66	0.66	0.66	0.80			
	EOL	End of life care - % of deaths supported by Priorities for Care	Mthly %	>25%			-	33.8%	33.7%	28.1%	36.6%			

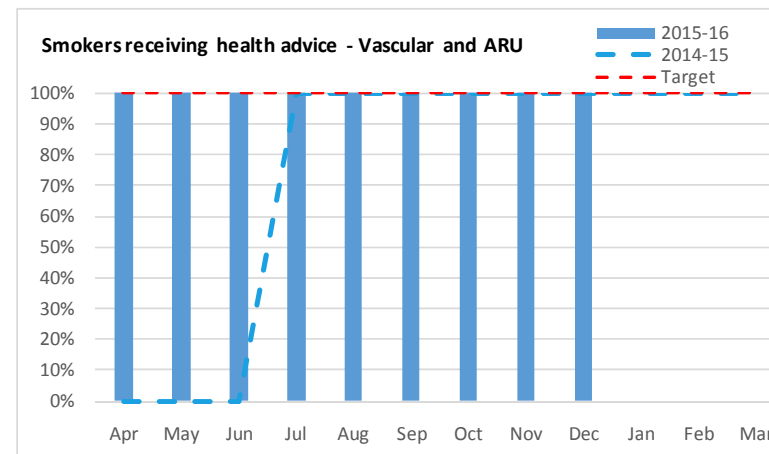
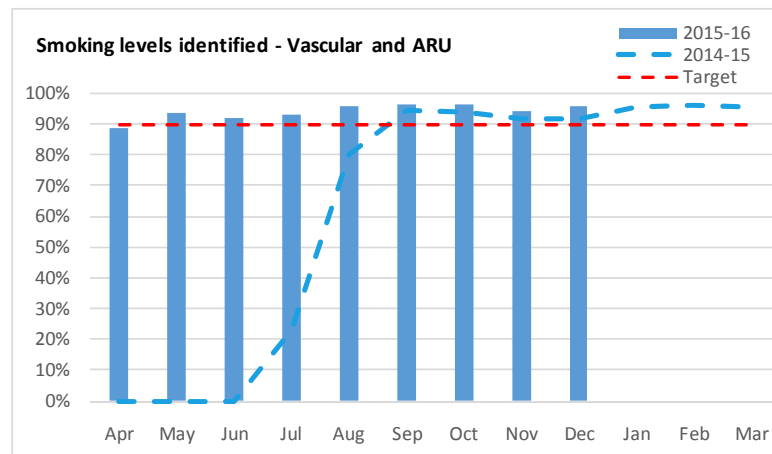
- Contract changes for 2015/16 mean that the Trust is not subject to the same Clinical Quality and Improvement and Innovation schemes (CQUINs) as in previous years. In their place, we have agreed a number of Local Incentive Schemes (LIS) with our main Clinical Commissioning Groups, some of which continue planned improvements from last year.
- Clinical teams are working through additional actions to further improve performance during the year especially in 4AT assessment, where we are reminding clinical staff of the procedure and rationale for screening.
- A Dementia screening review is carried out for all the breaches and for those screened after 72 hrs to ensure that there have not been more than one screen where the later screen could have invalidated the original screen. The team remind staff about screening at every opportunity and also provide training to wards and areas where compliance has been low.



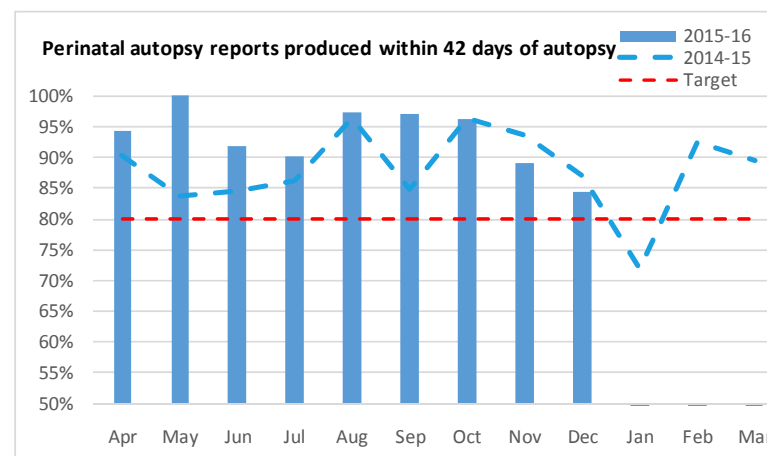
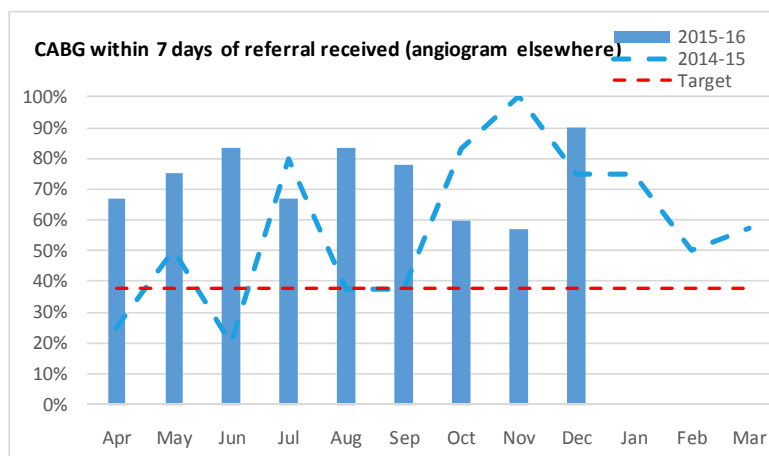
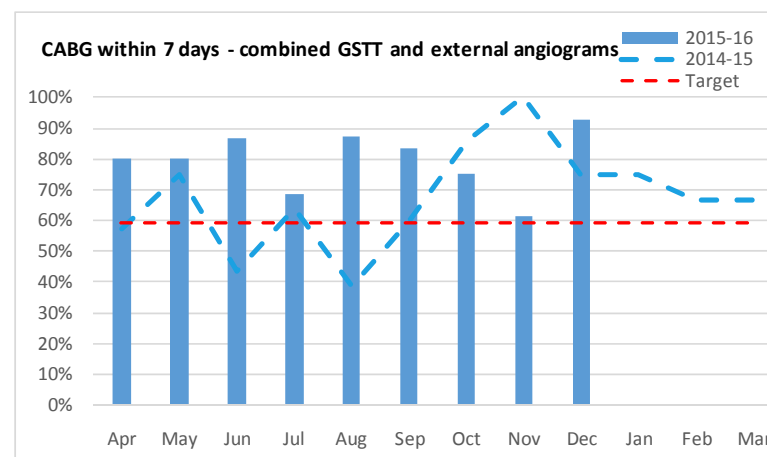
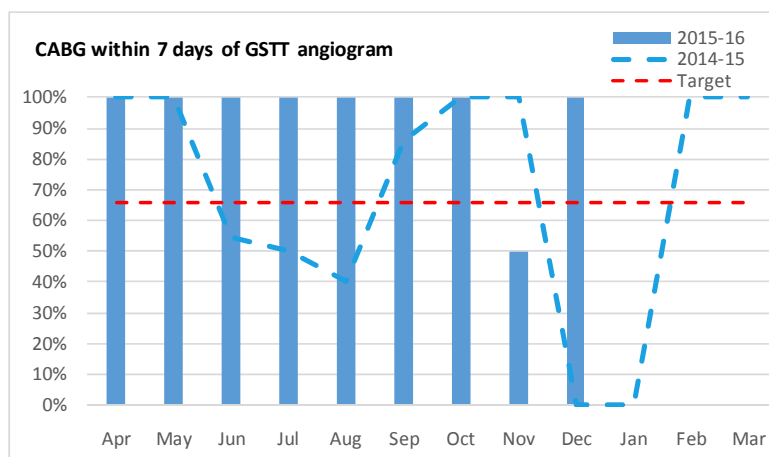
- Contract changes for 2015/16 mean that the Trust is not subject to the same Clinical Quality and Improvement and Innovation schemes (CQUINs) as in previous years. In their place, we have agreed a number of Local Incentive Schemes (LIS) with our main Clinical Commissioning Groups, some of which continue planned improvements from last year.
- We continued to perform well against all of the clinical quality indicators. Clinical teams are working through additional actions to further improve performance during the year. For Diabetes care plans we are tracking actual numbers rather than the percentage delivery and are seeing similar levels of delivery in comparison to last year.



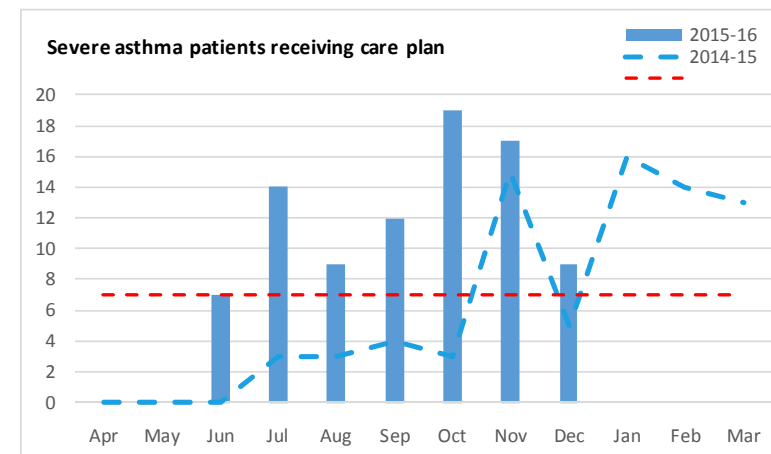
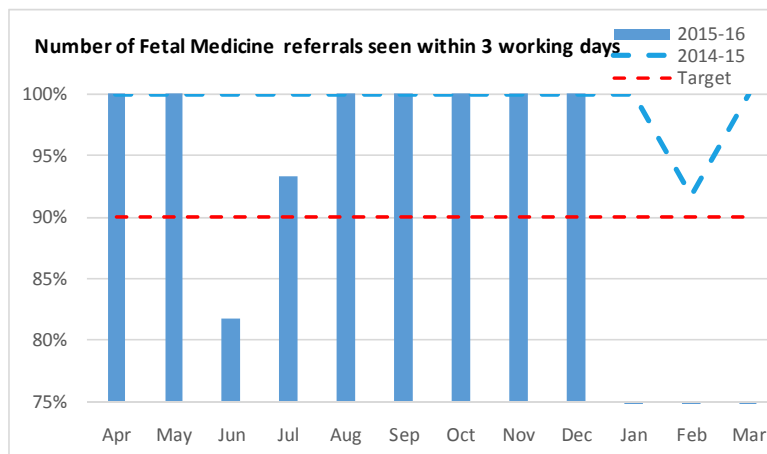
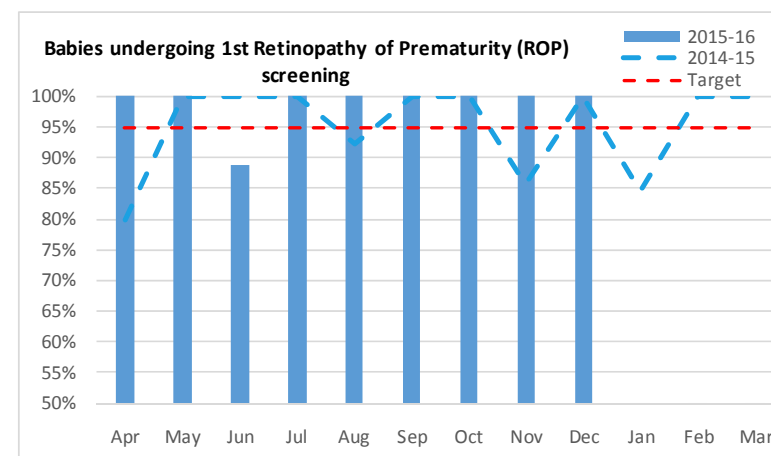
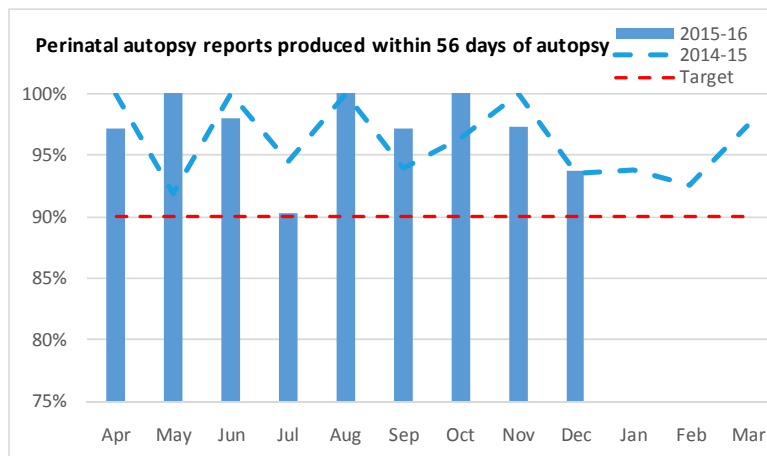
- There are two services where there is a particular focus to ensure that smokers are offered health advice to help stop smoking: vascular surgery and the Acute Respiratory Unit (ARU). The number of people identified within these services has consistently improved since April and the service has met the target of 90% for the last three months.
- Targets for both smoker identification and health advice are being met within the vascular surgery and ARU services.



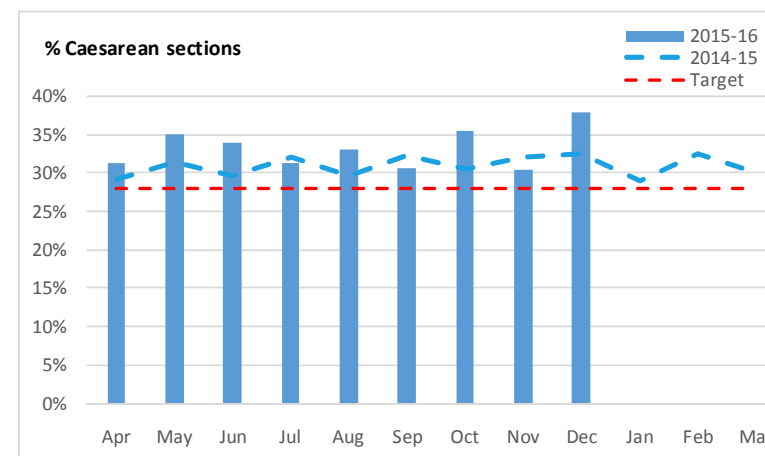
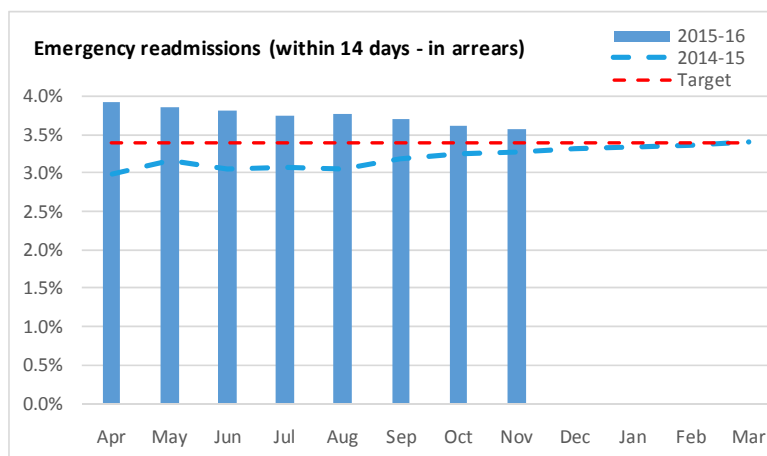
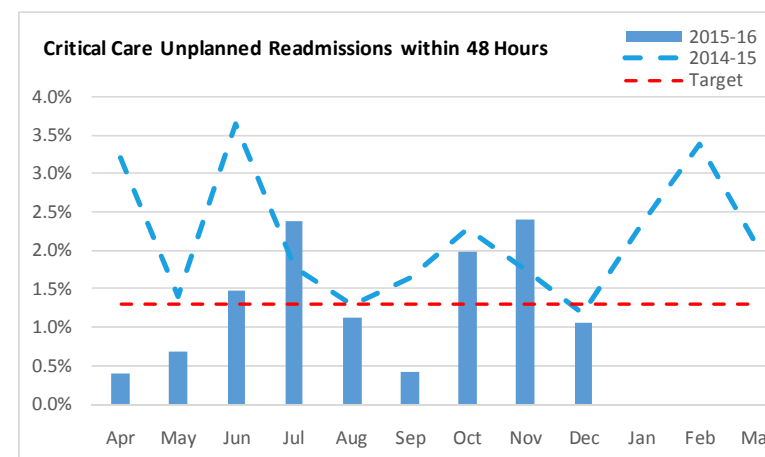
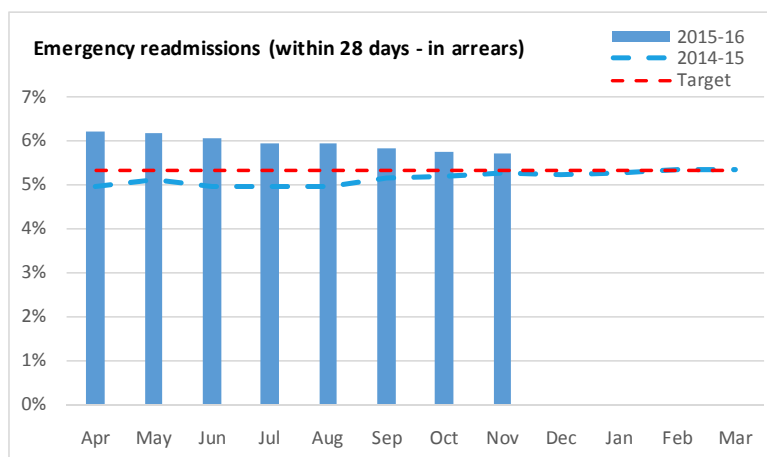
- Although the Trust is not contractually subject to specialised CQUINs in 2015-16, we continue to monitor our performance against the indicators in use last year.
- Performance remains very good across most areas. However, November saw delays in finding a suitable bed for patients referred by other providers to our cardiovascular services, as increased activity across our emergency pathways caused capacity constraints. This improved in December.
- Current contract discussions with NHS England aim to agree an appropriate set of indicators for this year.



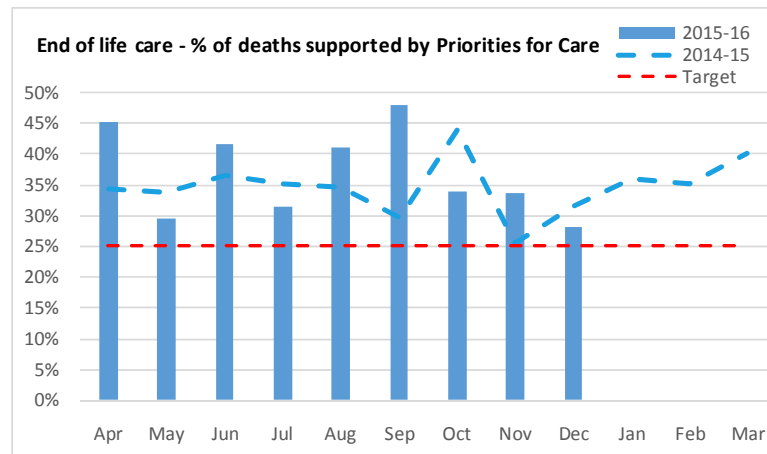
- Performance continues to be above target levels for most indicators currently being reported.
- Staffing issues previously reported within fetal medicine are now resolved and the service has consistently met the target for the last five months and we are confident this will continue.
- A drop in performance for severe asthma patients receiving was linked to reduced clinics and overall patient numbers being seen during the festive period. All follow-up patients often have an asthma plan in place.



- Readmission rates vary depending on the clinical service and by patient group. The Outcomes Group review this data to look for any trends and we have established a Handover Group to focus on improving the quality of discharge of patients from hospital and will take action if required.
- The caesarean section rate is higher than target and shows a small increase from last year. This reflects the case-mix of mothers who deliver at St Thomas'. In order to reduce the overall number of caesarean sections within the Trust we have introduced measures to review the appropriateness of emergency caesarean sections, as well as to reduce the number of repeat caesarean sections.
- Unplanned readmissions to Critical Care fell in December. Patients who are discharged to a lower acuity ward area are supported by the Critical Care Outreach Team.



- The proportion of adult inpatient deaths supported by the priorities for care of the dying person remained above target, although lower than we would like. Our audits have shown a high standard of care. End of life care (EoLC) champions' meetings have restarted on both hospital sites with the aim of supporting local ownership and knowledge. A cross-Trust re-launch of EoLC in April 2016 will improve staff awareness, confidence and competence.





# 3 Caring

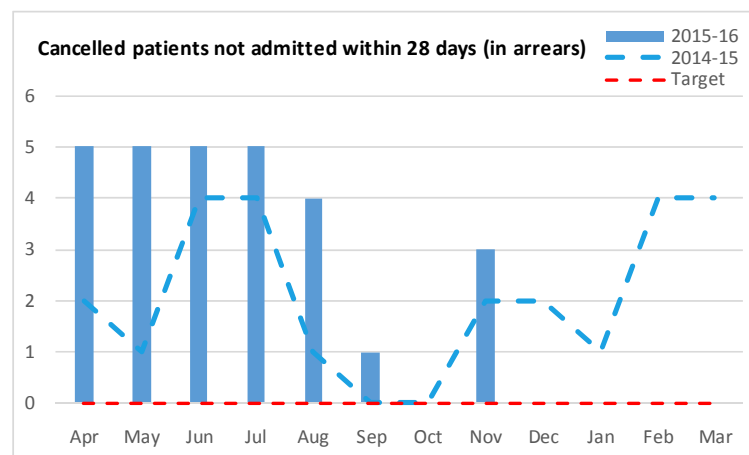
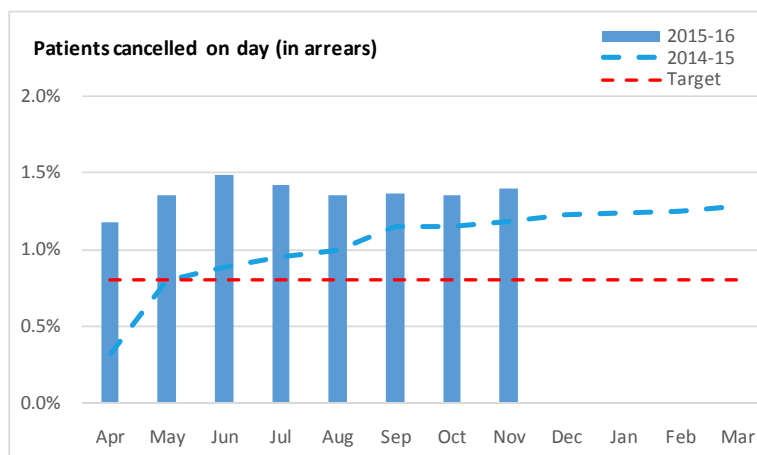
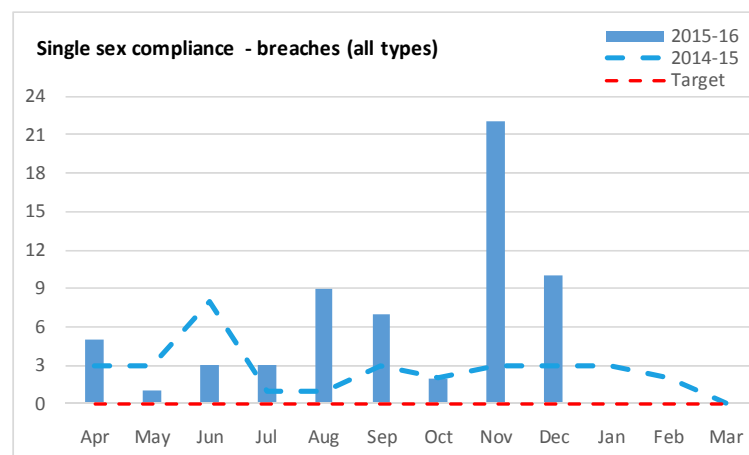
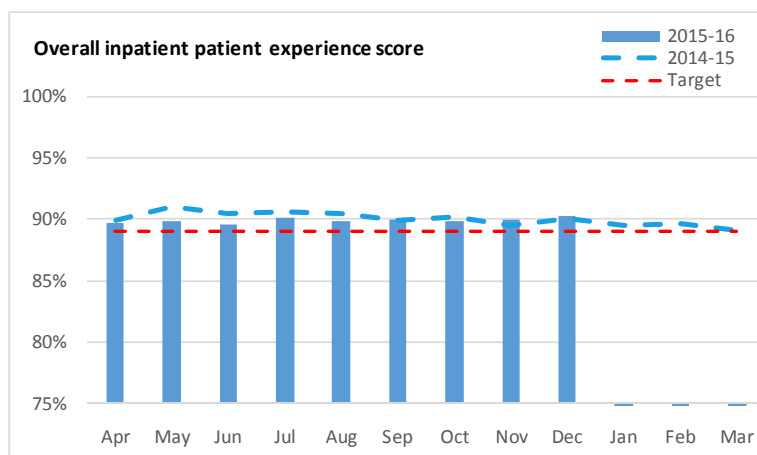
## Domain scorecard

December 2015

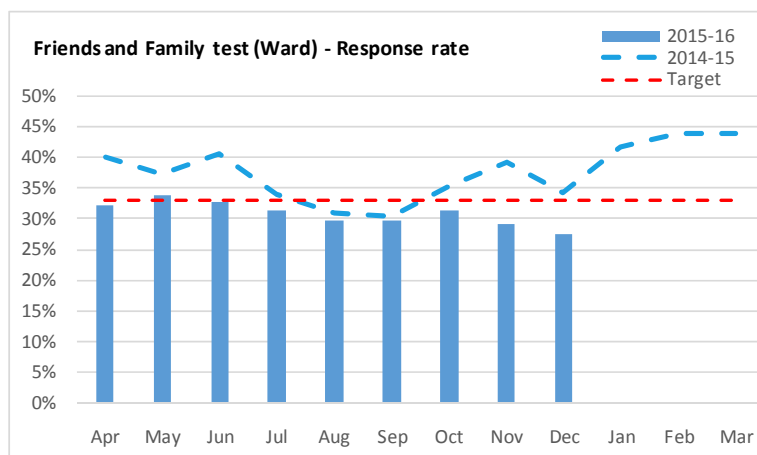
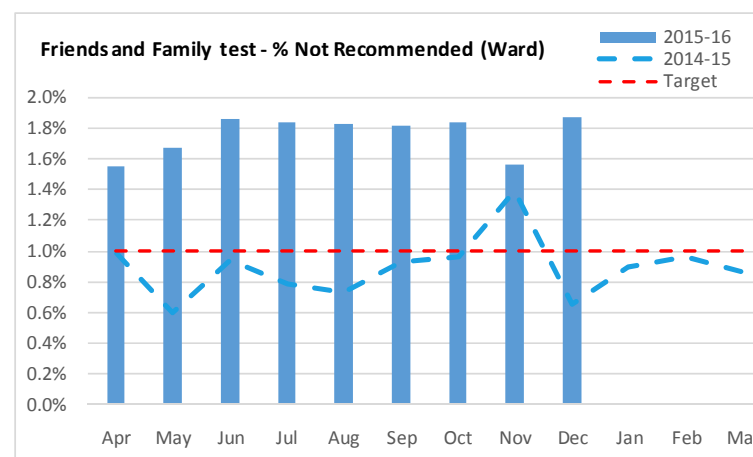
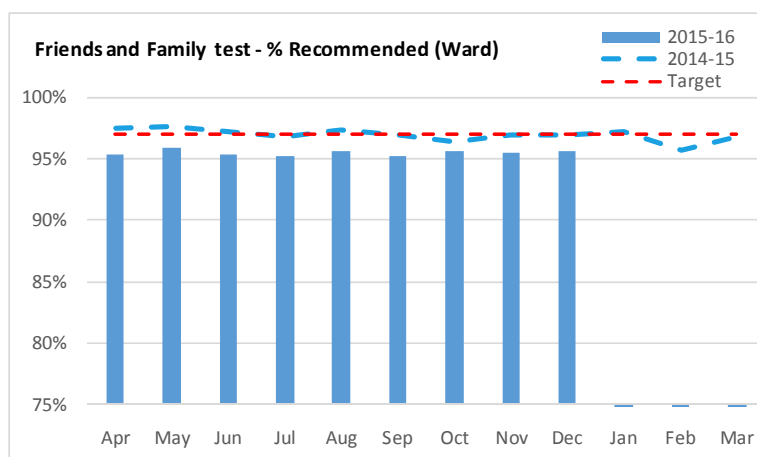
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Theme	Ref	Indicator	Units	Target	R	G	Prior year	Oct	Nov	Dec	YTD avg	Monitor	Quality priorities	Trend chart
3.1 Admitted care	258	Overall inpatient patient experience score	Mthly %	>89%			90%	89.9%	90.0%	90.2%	89.9%			Y
	310	Single sex compliance - breaches (all types)	Cases	Zero			0.0	2	22	10	6.9			Y
	501	Patients cancelled on day (in arrears)	Cum %	<0.8%			-	1.4%	1.4%		1.4%			Y
	502	Cancelled patients not admitted within 28 days (in arrears)	Number	Zero			-	0	3		3			Y
	FFT1W	Friends and Family test (Ward) - Response rate	Mthly %	>=33%				31.4%	29.1%	27.6%	30.8%			Y
	FFT2W	Friends and Family test - % Recommended (Ward)	Mthly %	>=97%				95.6%	95.5%	95.6%	95.5%			Y
	FFT3W	Friends and Family test - % Not Recommended (Ward)	Mthly %	<=1%				1.8%	1.6%	1.9%	1.8%			Y
3.2 A&E care	FFT1AE	Friends and family test (A&E) - Response rate	Mthly %	>=18%				15.3%	12.7%	14.2%	15.9%			Y
	FFT2AE	Friends and Family test - % Recommended (A&E)	Mthly %	>=88%				84.6%	84.6%	86.6%	85.3%			Y
	FFT3AE	Friends and Family test - % Not Recommended (A&E)	Mthly %	<=6%				7.8%	8.9%	8.0%	7.6%			Y
3.3 Maternity care	FFT1M	Friends and Family test (Maternity) - Response rate overall	Mthly %	-				23.6%	18.6%	18.6%	18.3%			Y
	FFT2M	Friends and Family test - % Recommended (Maternity)	Mthly %	-				94.6%	91.2%	91.2%	92.5%			Y
	FFT3M	Friends and Family test - % Not Recommended (Maternity)	Mthly %	-				0.9%	3.3%	2.6%	2.0%			Y
3.4 Outpatient care	FFT2OP	Friends and Family test - % Recommended (Outpatients)	Mthly %	-				92.1%	92.5%	91.6%	92.4%			Y
	FFT3OP	Friends and Family test - % Not Recommended (Outpatients)	Mthly %	-				3.4%	4.0%	3.9%	3.5%			Y
3.5 Community care	FFT1CS	Friends and Family test (Community) - Response rate	Mthly %	-				4.3%	5.4%	3.2%	5.8%			Y
	FFT2CS	Friends and Family test - % Recommended (Community)	Mthly %	-				96.5%	96.8%	95.2%	95.8%			Y
	FFT3CS	Friends and Family test - % Not Recommended (Community)	Mthly %	-				0.3%	0.8%	1.3%	0.9%			Y
	260C	Adult community health centre patient experience score	Mthly %	>89%			-	94.5%	94.3%	94.0%	93.9%			Y
3.6 Patient Transport	FFT1PT	Friends and Family test (Transport) - Response rate	Mthly %	-				2.4%	3.0%	1.4%	2.8%			Y
	FFT2PT	Friends and Family test - % Recommended (Transport)	Mthly %	-				93.2%	94.7%	91.2%	92.2%			Y
	FFT3PT	Friends and Family test - % Not Recommended (Transport)	Mthly %	-				2.9%	1.9%	1.1%	3.2%			Y
3.7 General patient and	Food	Satisfaction with food (PLACE)	Mthly %	>85%			91%	92.6%	92.6%	92.6%	91.8%			Y

- Cancellations have increased in proportion to our increased activity, so work to reduce cancellations is a key focus of the Fit for the Future work-stream that supports theatre productivity. We have also seen an increase in the number of patients not being rebooked within 28 days compared to last year. Although numbers are small we know that some are the result of patient's choosing later dates as well as Consultant specific procedures that cannot be booked within the time limit.
- During December the Trust experienced a higher number of single sex accommodation breaches that for previous months (with the exception of November). The reasons for this are still being investigated.
- Experience scores continue to reflect well on inpatient care, with an overall satisfaction rate of 90.2% in December which is which is similar to the November score of 90%.



- The Friends and Family test has been extended to include responses from adult and young patients admitted for day case treatment. This has increased the total number of patients surveyed, although response rates from day-case patients have so far been lower than for inpatients.
- The Trust has set itself a combined response rate of 33%. This was achieved in April and May but has fallen since June and is 29.1% for November. This is a slight decrease on the October response rate of 31.4%. Clinical areas are being contacted to discuss their response rates to see if additional support is required to help them reach the target. The briefing on page 31 provides further detail.
- The proportion of patients who would recommend the Trust has remained above 95% in all months and was 95.6% in December which is similar to the November score of 95.6%. The percentage of patients who would not make a recommendation has declined slightly in December rising from 1.6% in November to 1.9% and this is above our internal target of 1%.
- All responses have been reviewed and feedback to areas has been given so that actions can be taken to both improve response rates and patients' experience.



### Where we want to be: targets and benchmarks

- Work towards achieving a 33% response rate
- Increase our FFT score/proportion of patients who would recommend us to 97%
- Improve our response rate and the proportion of patients who would recommend the Trust when compared with Shelford Peers

### Where we are: trends, patterns and causes

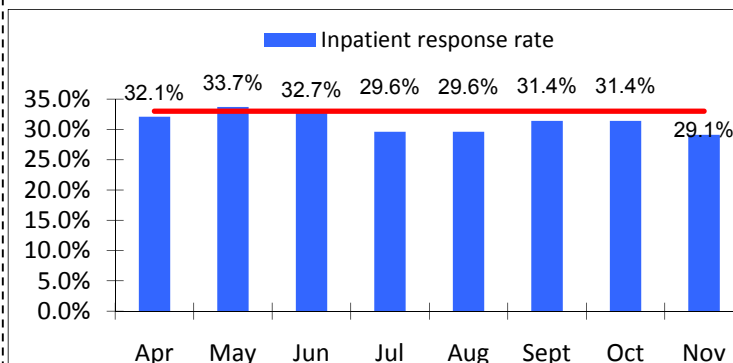
- The response rate fell slightly from 29.1% in November to 27.6% in December.
- A small number of wards and day case areas have response rates of below 20%. However, a more detailed review of the data has shown that response rates for day case areas are much lower than the wards
- In November our response rate placed us in the upper third of the Shelford Group, and our recommend score was in the upper half of the group in October and above the national and London average.
- The proportion of patients who would recommend us has remained consistent at above 95%.

### Risks or opportunities for the Trust

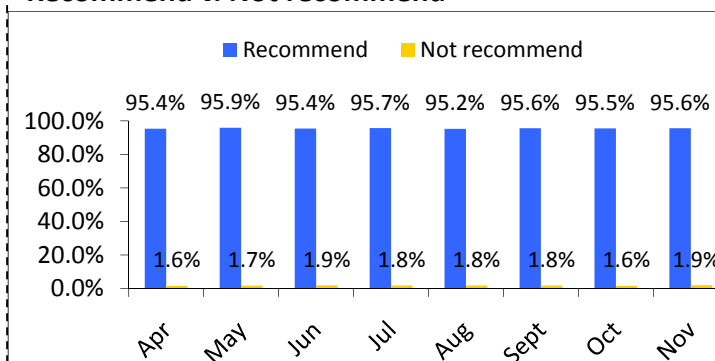
- It is important to ensure that we continue to capture feedback captured from patients and it is used to further improve the experience of patients staying on our wards
- The proportion of patients would recommend our care and proportion of those who would not places us in the lower third of the Shelford Group

Action and progress	Owner	Next review date
Free text comments highlighting areas of good practice and areas for improvement have been shared with Directorates so that actions can be identified.	S. Allen	Completed
Wards with very low response rates have been contacted, reminded of response rates and invited to contact the Patient Experience should they need further support.	S. Allen	Completed
Explore what support wards may need to increase data capture	S. Allen & A. Millard	Ongoing
Intelligence triangulated	Root cause understood	Action plan set
	Actions underway	Actions complete

### Trend – Inpatient Friends and Family Test response rate



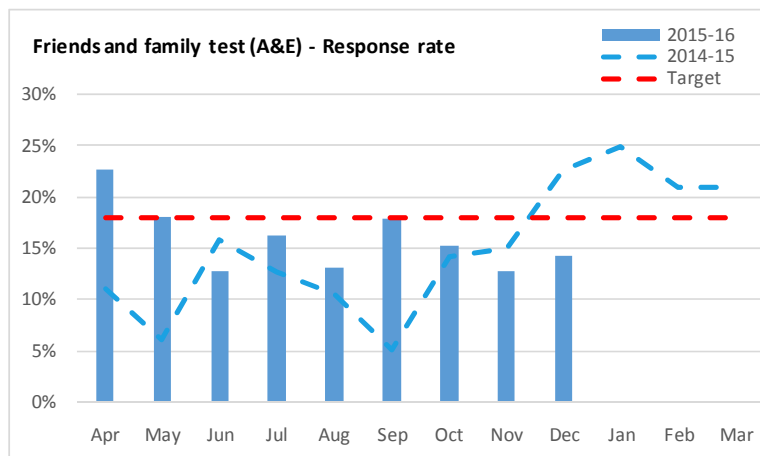
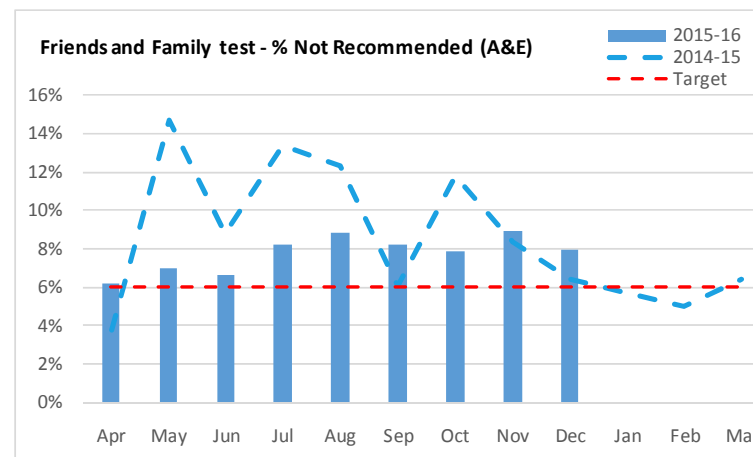
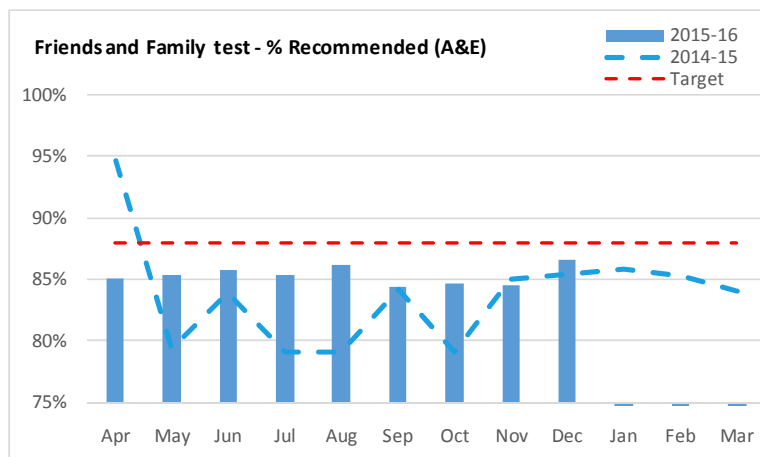
### Trend – Inpatient Friends and Family Test percentage Recommend v. Not recommend



### Comparator – Shelford Group

Shelford Group		November		Response Rate
Trust/Month		Recommend %	Not recommend %	November Inpatients
National Score for England		95%	2%	24.4%
London region score		95%	2%	24.9%
Guy's and St Thomas' NHS Foundation Trust		96%	2%	29.1%
University College London Hospitals NHS Foundation Trust		97%	1%	25.0%
Newcastle-Upon-Tyne Hospitals NHS Foundation Trust		98%	1%	14.8%
Sheffield Teaching Hospitals NHS Foundation Trust		95%	2%	30.0%
University Hospitals Birmingham NHS Foundation Trust		97%	2%	33.5%
Oxford University Hospitals NHS Trust		96%	2%	16.7%
King's College Hospital NHS Foundation Trust		95%	2%	15.7%
Cambridge University Hospitals NHS Foundation Trust		95%	2%	14.3%
Imperial College Healthcare NHS Trust		96%	1%	28.9%
Central Manchester University Hospitals NHS Foundation Trust		93%	3%	17.0%

- The A&E Friends and Family Test (FFT) has been extended to include patients attending our Urgent Care Centre at Guy's Hospital.
- The response rate increased from 12.7% in November to 14.2% in December. The team are continuing to take measures to increase the numbers of responses in the coming months.
- The proportion of patients who would recommend the service has increased from 84.6% in November to 86.6% in December. The proportion of patients who said they would not recommend the service has improved from 8.9% in November to 8.0% in December. The briefing on page 33 provides further detail of actions underway.



### Where we wanted to be: targets and benchmarks

- Work towards achieving a 18% response rate
- Increase our FFT score/proportion of patients who would recommend us to 88%
- Improve our response rate and the proportion of patients who would recommend the Trust when compared with Shelford Peers

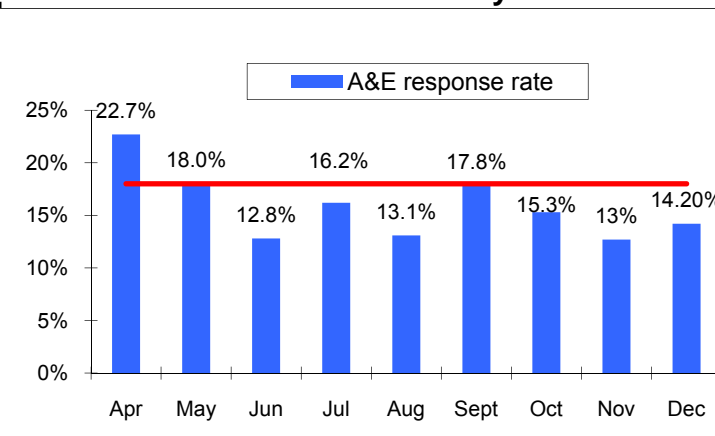
### Where we are: trends, patterns and causes

- In November the response rate increased from 12.7% in November to 14.2% in December.
- The proportion of responses received via the SMS systems was slightly lower due to staff shortages resulting in delays in recording discharges on the system, reducing the number of eligible response. The number of A5 response postcards collected fell considerably in November.
- The proportion of patients who would recommend us has remained increased to 86.6% in December. The proportion of patients who would not recommend us has also improved falling from 8.9% in November to 8.0% in December.
- The improvement in the recommend and not recommend scores reflect the continued focus of the team to embed actions introduced to improve patient experience including the erection of a privacy screen in the temporary reception area. Free text comments from patients show the verbal updates on waiting times are well received and the team continue to provide these.

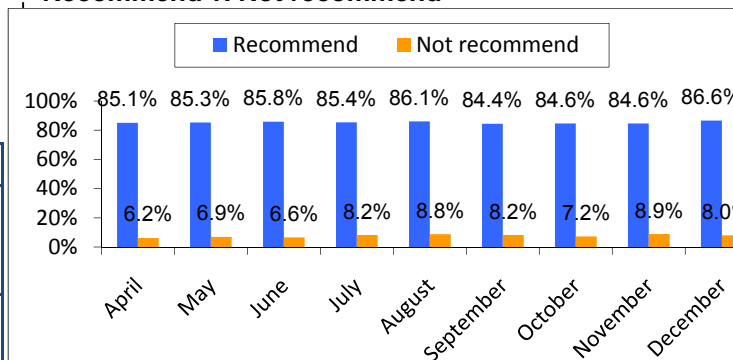
### Risks or opportunities for the Trust

- Feedback captured from patients can be used to improve the service and inform the on-going development of the Emergency Floor and associated pathways.
- Both our response rates and recommend scores for November are in the lower half of the Shelford Group.

### Trend – A&E Friends and Family Test



### Trend – A&E Friends and Family Test percentage Recommend v. Not recommend

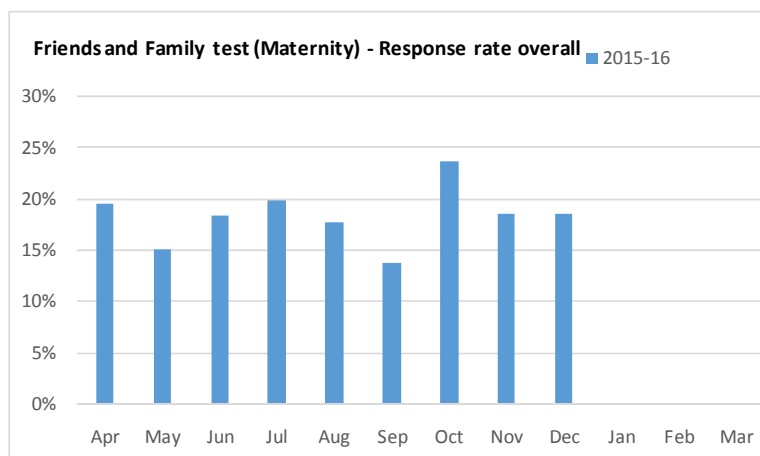
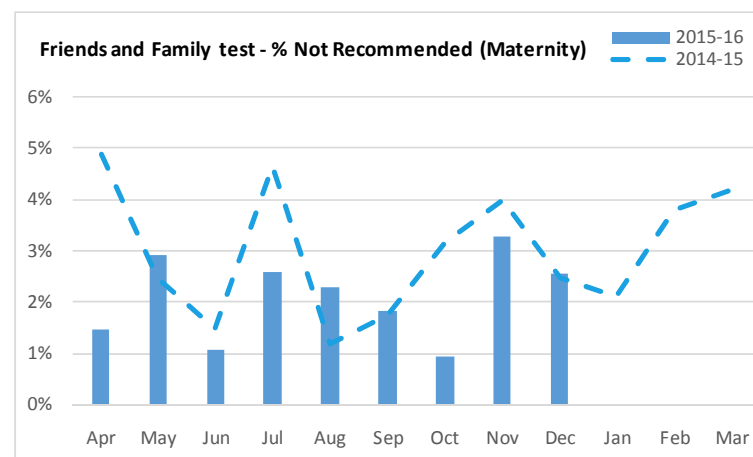
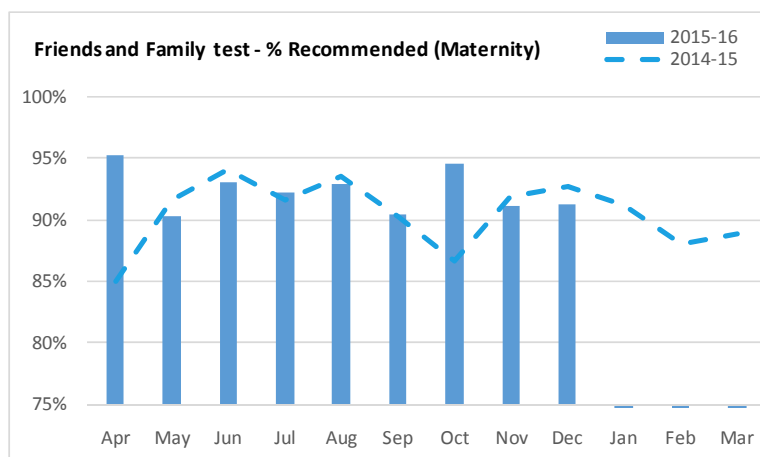


### Comparator – Shelford Group

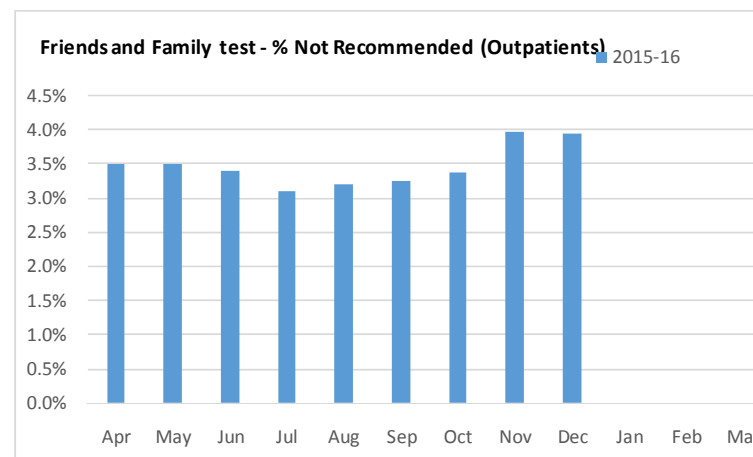
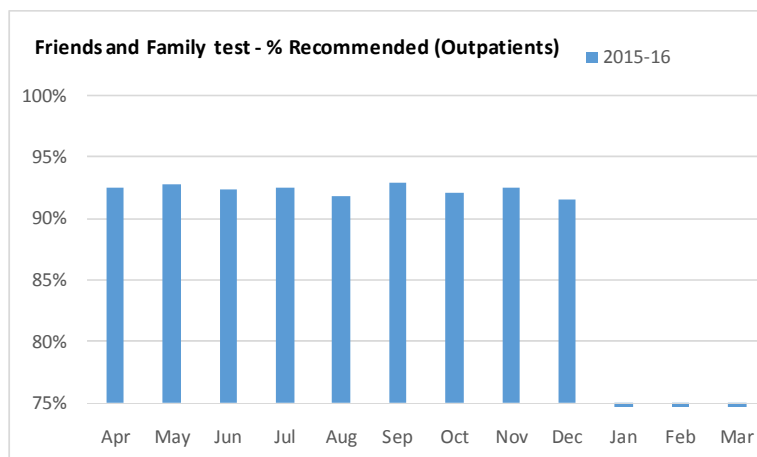
Shelford Group	November		Response Rate
	Recommend %	Not recommend %	
Trust/Month			November
National Score for England	86.9%	7.0%	13.1%
London region score	85.8%	7.5%	12.4%
Guy's and St Thomas' NHS Foundation Trust	84.6%	8.9%	12.7%
University College London Hospitals NHS Foundation Trust	94.2%	2.7%	18.8%
Cambridge University Hospitals NHS Foundation Trust	93.1%	3.6%	22.4%
Newcastle-Upon-Tyne Hospitals NHS Foundation Trust	88.9%	4.0%	3.4%
Central Manchester University Hospitals NHS Foundation Trust	89.3%	5.5%	8.6%
Oxford University Hospitals NHS Trust	83.3%	10.0%	24.6%
Imperial College Healthcare NHS Trust	94.1%	2.1%	9.2%
University Hospitals Birmingham NHS Foundation Trust	86.6%	9.0%	14.2%
King's College Hospital NHS Foundation Trust	81.6%	10.7%	19.8%
Sheffield Teaching Hospitals NHS Foundation Trust	77.8%	14.3%	19.8%

Action and progress	Owner	Next review date
Continued focus on promoting A5 response postcards but have diversified the number of teams who collect responses so we are not reliant on just a few staff.	C. Mitchell	Ongoing weekly review
Development of patient facing dashboard so that patients can receive updates on waiting times in real time. Delayed as work to complete the historic dashboard has to be completed first.	ED IT lead	Delayed timeframe - TBC
Regular dissemination of scores and actions to promote collection. Staff are also reminded to continue to update patients on waiting times and these are also displayed and updated at streaming.	C. Mitchell	Ongoing monthly review
All staff have received their hello my name is badges and have been reminded to fully introduce themselves to all patients.	J. Hill & C. Mitchell	Ongoing weekly review
Intelligence triangulated	Root cause understood	Action plan set
	Actions underway	Actions complete

- The overall response rate for the Friends and Family Test for maternity services remains stable at 18.6%. This exceeds our internal target of 15%. This reflects concerted efforts by the teams to encourage women to provide feedback on their experience.
- The proportion of women who would recommend the service is consistent with the November figure of 91.2%. The proportion of women who said they would not recommend the service has improved falling from 3.3% in November to 2.6% in December. The team regularly review comments and using the emerging themes to identify actions for improvement.

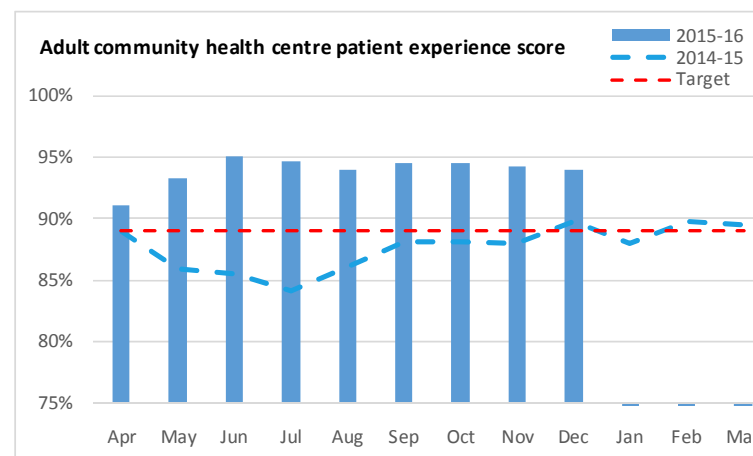
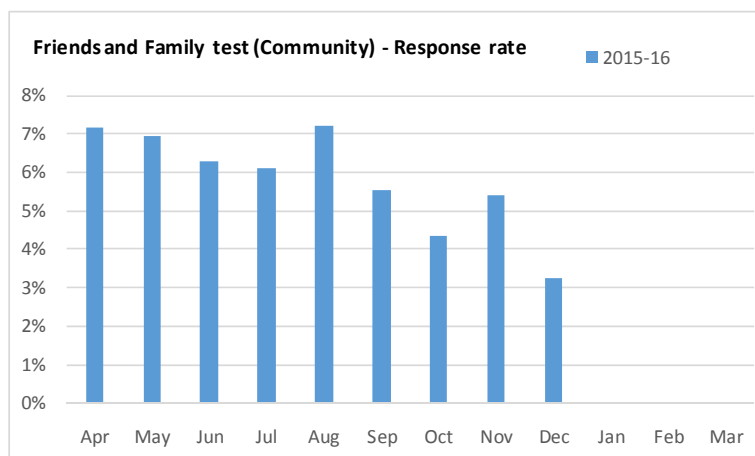
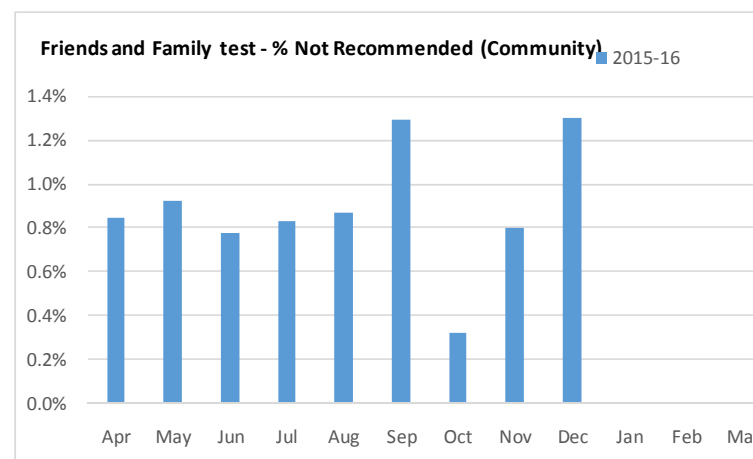
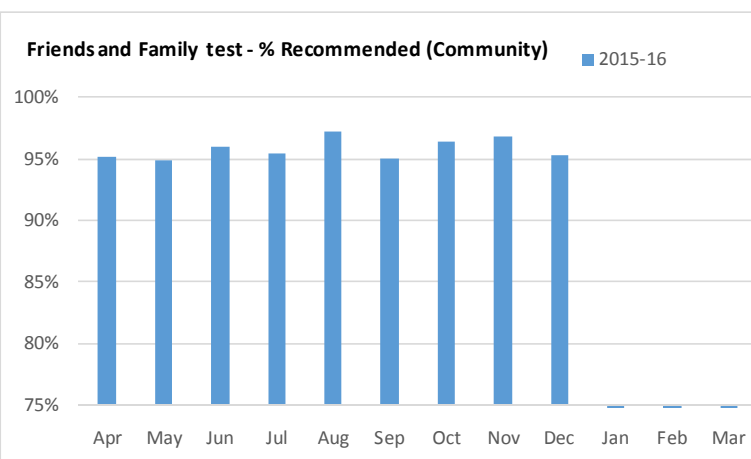


- From April, the Friends and Family Test has also been extended to adults and young patients using our outpatient services. This is a new area and no specific response rate targets have yet been set. NHS England is waiting until after all returns for Quarter 1 have been submitted before publishing data nationally. They will be using a monthly average from the NHS England Quarterly Activity Return as an eligible population.
- The proportion of outpatients who would recommend the Trust has been very similar for each month so far this year, although the score has fallen slightly rising from the November figure of 92.5% to 91.6% in December. The proportion of patients who would not recommend the Trust has improved slightly, falling from 4.0% in November to 3.9% in December.
- As part of the Fit for the Future outpatient work stream, directorates are working to improve communication with patients regarding their appointments by introducing text messaging where it is not currently in use and introducing a system for booking follow ups - "partial booking" - which allows patients to be involved in the choice of appointment date and time. As well as improving patient experience these initiatives are also aimed at reducing non-attendance rates.
- This work stream is also looking at alternative pathways for outpatients to reduce unnecessary visits to the hospital by reviewing discharge criteria, introducing more telephone appointments, as well as introducing more one-stop visits where the consultation appointment and any associated diagnostic tests occur on the same day. As well as improving patient experience some of these initiatives will improve follow-up to new ratios.

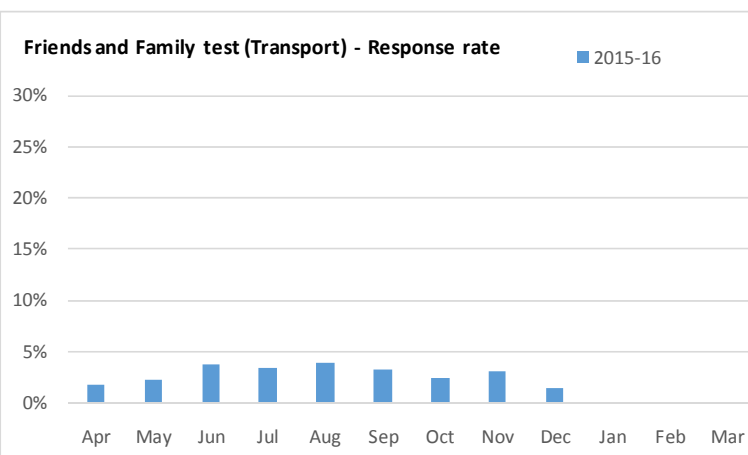
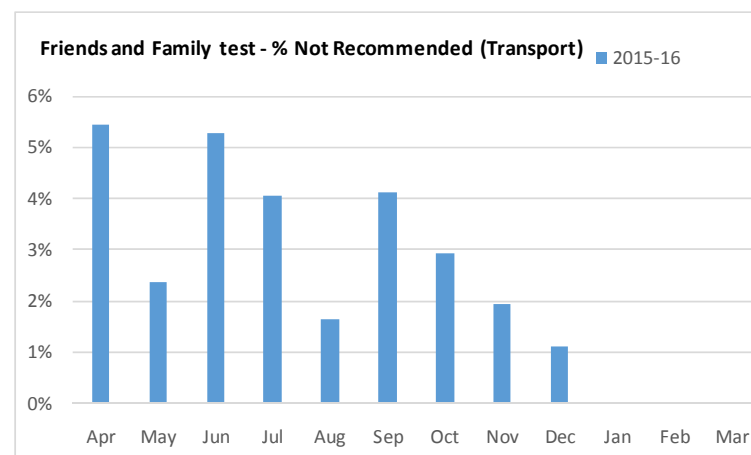
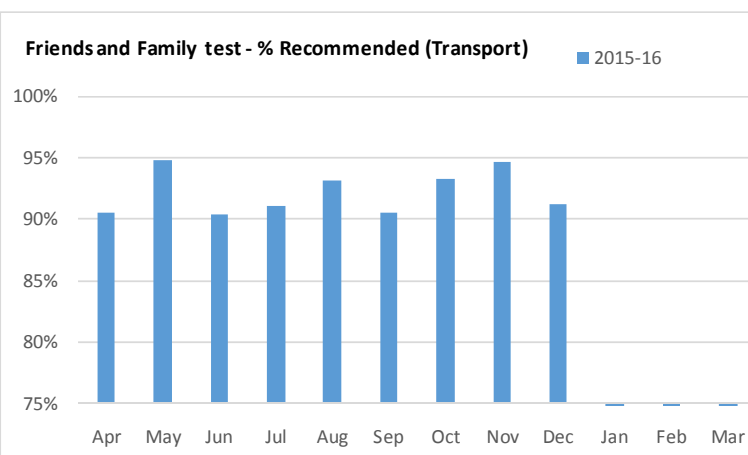




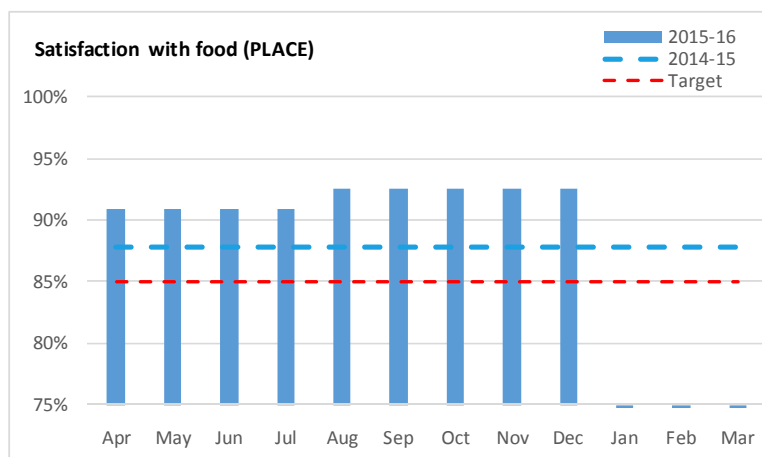
- From April, the Friends and Family Test (FFT) has also been extended to adults and young patients using our community-based services. This is a new area and no specific response rate targets have yet been set by NHS England.
- Our response rate has shown a decreasing trend in Quarter 3. We are reviewing this to see why the rate is low in comparison with replies in hospital settings. Now that national data has been released on this area of care we are in the process of contacting Trusts with higher response rates to learn from their practice. Based on this review, we will review data collection approaches and set an appropriate target for monitoring.
- The proportion of patients who would recommend community-based services has fallen slightly from 96.8% in November to 95.2% in December. The proportion of patients who would not recommend services has increased slightly rising from 0.8% in November to 1.3% in December. Both measures compare favourably with other areas of care that are subject to the same FFT survey.
- The overall patient satisfaction score remains strong although the score has remains at 94%.



- From April, the experience of patients using our transport services has also been subject to the Friends and Family Test survey. NHS England is waiting until after all returns for Quarter 1 have been submitted before publishing data nationally.
- The new patient transport contract commenced on the 1st December 2015. The new service is delivered by three providers: Savoy Ventures (75%), Essentia in-house (20%) and Private Ambulance Service (5%).
- The new contract contains enhanced service standards which will be developed over the initial three month mobilisation period. In the meantime, performance will continue to be reported against the pre-contract KPI's in order to assess the stability of the service throughout this phase.



- The Trust has scored strongly for catering as reflected in the National Inpatient Survey 2014, published by the Care Quality Commission (CQC). The Trust's catering scores exceed those of other London Trusts.
- The Catering Team continue to work closely with both Nursing and Dietetic staff to consolidate and introduce further quality improvements, and the Trust is working towards full compliance with the Hospitals Food Standards Report



# 4 Responsive

## Domain scorecard 1

December 2015

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Theme	Ref	Indicator	Units	Target	R	G	Prior year	Oct	Nov	Dec	YTD avg	Monitor	Quality priorities	Trend chart
4.1 A&E access	AE1	A&E stays less than 4 hours (type 1 and 3)	Mthly %	>95%			-	93.1%	92.7%	92.3%	93.7%			Y
	AE1STH	A&E stays less than 4 hours (type 1)	Mthly %	>95%			-	91.3%	90.9%	90.5%	92.2%			Y
	AE30	Ambulance handover times - breaches of 30 mins	Number	<3			-	1	1	7	2.4			Y
	AE60	Ambulance handover times - breaches of 60 mins	Number	Zero			-	0	0	0	0.1			Y
4.2 Elective treatment access - referral to treatment (RTT) performance	403M	RTT - Incomplete pathways < 18 weeks	Mthly %	>92%			92.7%	92.3%	92.1%	91.4%	92.5%			Y
	RTT 52I	RTT - Incomplete pathways over 52 weeks	Mthly	Zero			0.9	21	15	10	6.7			Y
	RTT TQ	RTT - total incomplete pathways	Mthly	-			42,138	48,893	48,041	48,453	47,326			Y
	RTT 18Q	RTT - incomplete pathways over 18 weeks	Mthly	-			2,791	3,786	3,784	4,188	3,590			Y
	401M	RTT - Non-admitted patients <18 weeks	Mthly %	>95%			94.8%	92.5%	93.0%	93.1%	93.5%			Y
	402M	RTT - Admitted patients < 18 weeks	Mthly %	>90%			86.3%	85.1%	82.6%	85.5%	84.2%			Y
	RTT 52	RTT - treatments over 52 weeks	Mthly	Zero			3.7	4	15	7	6.9			Y
4.3 Cancer access	451M	Cancer - 2 week wait	Qtly%	>93%			95.4%	95.1%	93.6%	92.1%	93.9%			Y
	941	Cancer - breast symptomatic referrals <2 wks	Qtly %	>93%			-	97.6%	95.1%	93.9%	95.7%			Y
	453M	Cancer - 31 day first treatments	Qtly%	>96%			95.9%	95.9%	93.2%	96.8%	94.8%			Y
	459M	Cancer - 31 day subs treatments - surgical	Qtly%	>94%			95.0%	91.2%	89.9%	100.0%	92.3%			Y
	943	Cancer - secondary chemotherapy <31 days	Qtly %	>98%			-	98.8%	98.9%	97.6%	98.9%			Y
	942	Cancer - secondary radiotherapy <31 days	Qtly %	>94%			-	97.3%	94.4%	95.6%	96.2%			Y
	454M	Cancer - 62 day urgent GP referrals	Qtly %	>85%			74.7%	64.3%	69.7%	76.7%	69.3%			Y
		Cancer - 62 day urgent GP referrals (LCA cases only)		In devt										
	454I	Cancer - internal 62-day referrals	Qtly%	>85%			84.2%	74.5%	83.8%	84.6%	78.9%			Y
	456M	Cancer - 62 day screening	Qtly %	>90%			77.7%	90.0%	100.0%	100.0%	92.2%			Y
4.4 Diagnostic access	Diag 6	Diagnostic waits - % over 6 weeks	Mthly	<1%			2.42%	1.34%	1.35%	2.05%	1.48%			Y
	FFF19	Turnaround time - inpatient MRI within 24 hours	Mthly %	>80%			73.5%	61.2%	65.6%	68.2%	71.1%			Y
	FFF20	Turnaround time - inpatient CT within 24 hours	Mthly %	>80%			83.7%	82.5%	85.6%	82.8%	83.4%			Y
	FFF21	Turnaround time - inpatient Ultrasound within 24 hours	Mthly %	>80%			76.5%	78.1%	76.1%	81.1%	77.9%			Y

# 4 Responsive

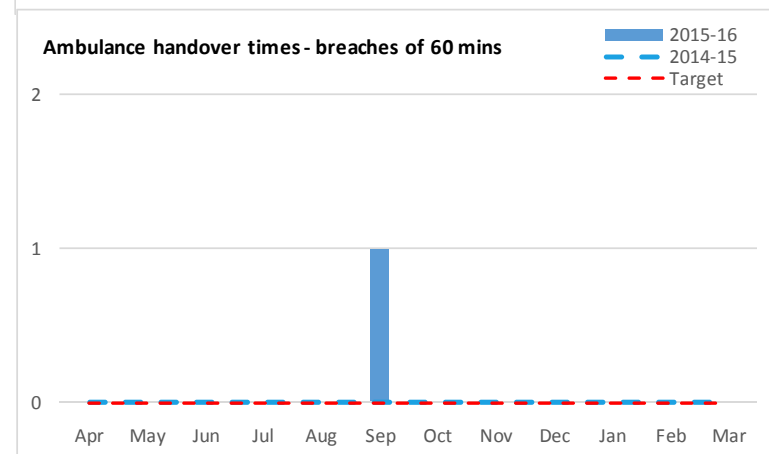
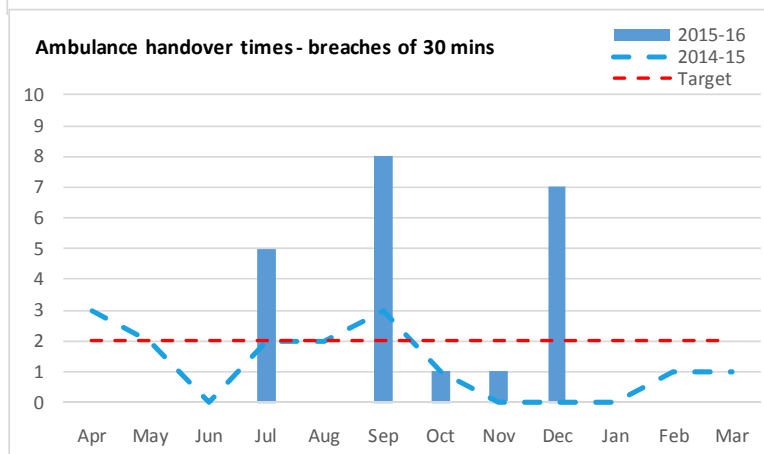
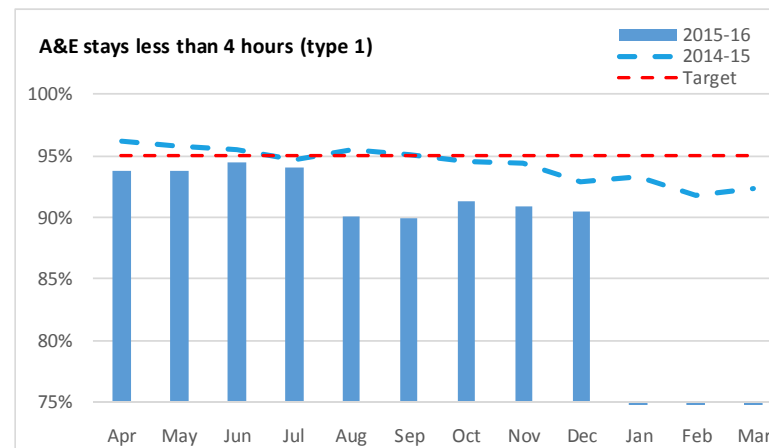
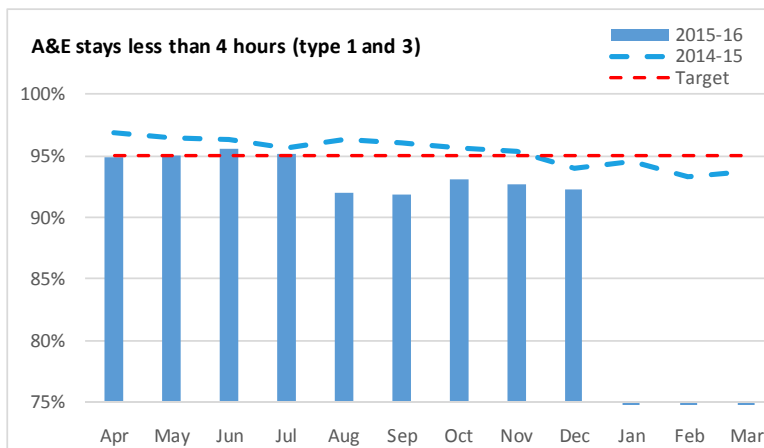
## Domain scorecard 2

December 2015

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Theme	Ref	Indicator	Units	Target	R	G	Prior year	Oct	Nov	Dec	YTD avg	Monitor	Quality priorities	Trend chart
4.5 Bed capacity and management	531	Average length of stay (elective)	Cum ALOS	<last yr			3.61	3.46	3.46	3.47	3.47			Y
	LOS>1	Non-elective average LOS >1 night	Cum ALOS	<last yr			8.52	8.52	8.57	8.63	8.63			Y
	535	Discharges before noon	Mthly %	>25%			20.1%	20.4%	20.6%	21.3%	21.1%			Y
	Home	GSTT referrals to @Home service	Cases	>100			-	74	54		66			Y
	DTtoCPS	Patients with a DTtoC (snapshot)	Number				14	13	10		17			Y
	DTtoCDT	DTtoC total delayed days	Number				396	455	428		439			Y
		Total beds open		In devt										
		Total occupied bed nights		In devt										
4.6 Outpatient management	604	Appointments re-scheduled by hospital <6wks	Cum %	<4%			4.9%	4.8%	4.7%	4.6%	4.8%			Y
	FFF57	Gassiot House Room Utilisation	Mthly %	>75%			-	91.0%	91.9%	88.1%	85.6%			
	618	Choose and Book - % slot unavailability	Mthly %	<5%			7.1%				29.3%			Y
	601R	Follow-up ratio - adj cons appts (in arrears)	Ratio	2.13			-	2.18	2.20		2.22			Y
	602	Non-attendance rate (new appts)	Mthly %	<11%			11.9%	12.4%	12.4%	13.5%	12.2%			Y
4.7 Theatre management	533M	Daycase rate - basket (in arrears)	Mthly %	>85%			83.1%	82.3%	80.2%		82.9%			Y
	TH2	Daycase rate (trolley) vs BADS	Mthly %	In devt			-	-	-	-	-			
	505	Theatres Gross Cancellation Rate (in arrears)	Mthly %	<7%				7.2%	7.1%	7.8%	7.3%			Y
		Theatre utilisation indicators		In devt										
		Theatre scheduling indicators		In devt										
4.8 Complaints mgt	COM1T	Complaints opened in month (Trust total)	Cases	-			-	91	97	96	94			Y
	COM2T	Complaints re-opened in month (Trust total)	Cases	-			-	7	4	1	5			Y
	COM5T	Timely response to complaints - median wait	Days	-			-	38	54	45	51			Y

- December saw a further deterioration in performance in the patient waiting time within our A&E services. Performance remains below 95% across all standards. Average ambulance handover times at the St Thomas site remained in-line with previous months, however there were 7 >30 minutes ambulance off-load breaches but zero >60 minute delays. (Lower graphs). The increase in 30 minute breaches was caused by periods of high inflow (December saw an increase in Ambulance arrivals from November) with Majors and Resus cubicles at full capacity, therefore handovers taking longer to complete. Ambulance turnaround times are still a priority for the Service and the department has maintained its position in London (3rd best receiving hospital in relation to 30 min breaches).
- The Trust internal 'Star Chamber' approach has been focussing on improvements both within A&E and across the emergency pathway. These include better outflow processes from A&E to the admitting wards, reviewing the escalation process as well as improving the internal processes within the department.
- The 'Platinum Call' escalation project has continued to review complex discharge patients and patients with a long length of stay across speciality wards with the aim to unblock and manage delays in a more proactive way.



# 4 Responsive

## A&E Performance

Information Owner: COO Team

December 2015

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### • Where we want to be: targets and benchmarks

- We are seeking to reduce the number of patients waiting over 4 hours to be transferred, admitted or discharged.

### • Where we are: trends and patterns

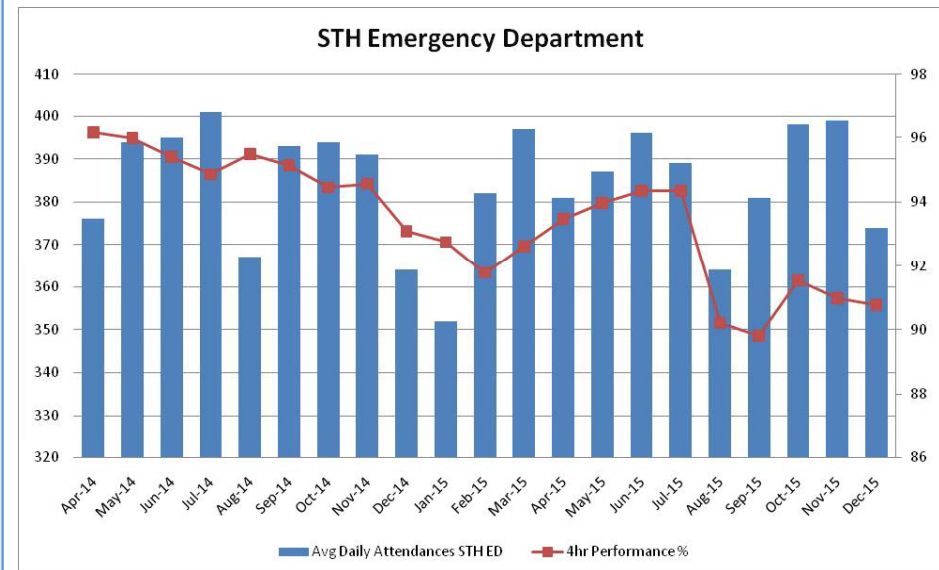
- We saw a deterioration in the performance against the 4hr target in December at the St Thomas Site. The December period saw a high number of mental health patients and attendances at night due to intoxication. Both these patient cohorts are difficult to manage, although the department allocated staff to a dedicated area (LARC) to most appropriately assess alcohol intoxication.
- Guy's Urgent Care Centre has maintained performance with approximately 2 breaches per week despite increasing attendance numbers.

### • Risks or opportunities for the Trust

- Additional inpatient capacity was opened in December and will reduce pressure on the admitted pathway.
- The reestablishment of the frailty will improve both patient experience (in those over age 75) and performance against the access standard.

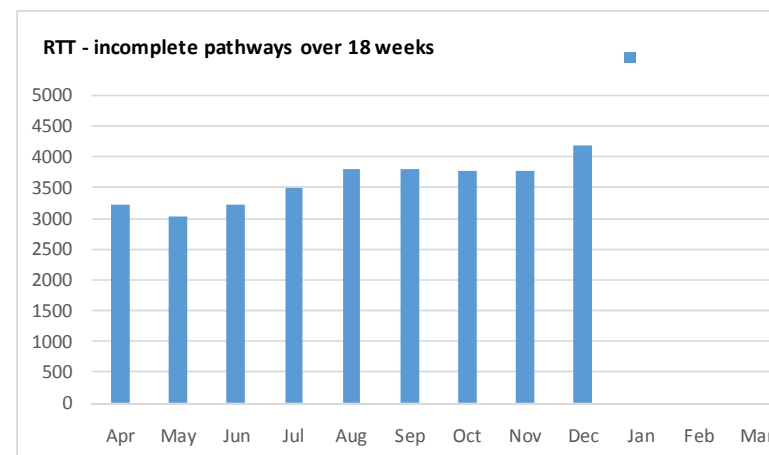
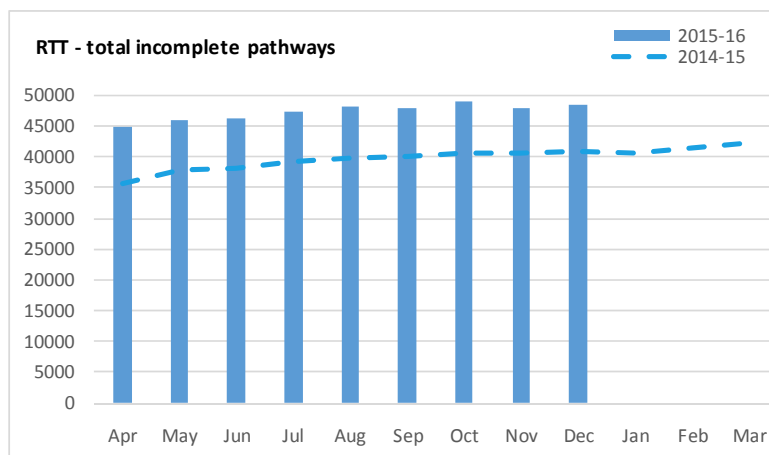
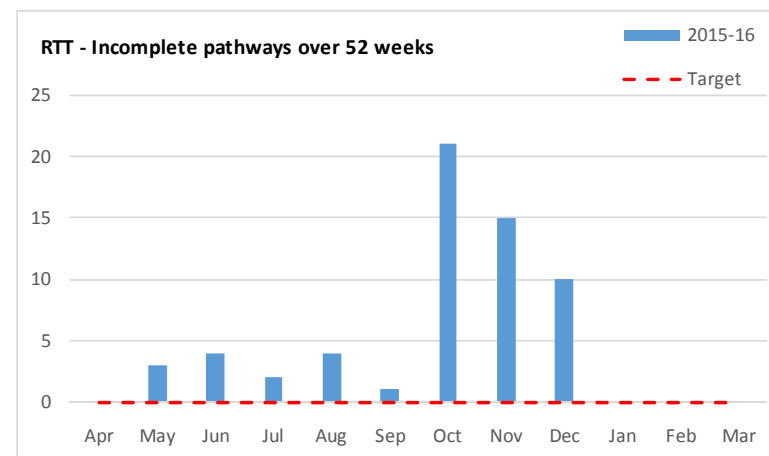
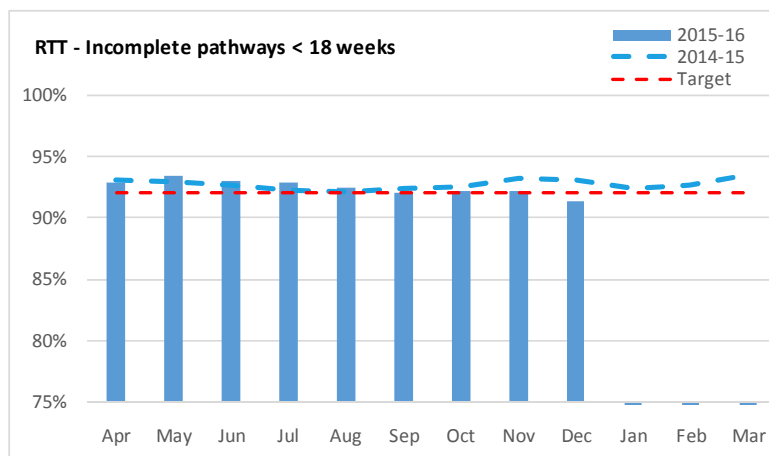
### - Root cause analysis and insights

- The three key drivers for current A&E performance are:
  1. Reduced physical capacity in the AE as part of the estate reconfiguration necessary in our Emergency Care Programme.
  2. Reduced performance of all 3 admission avoidance pathways – AAU, SAU and OPAU as a part of the Emergency Care Programme transitional phase.
  3. Increase in complex patients, requiring extensive clinical input.



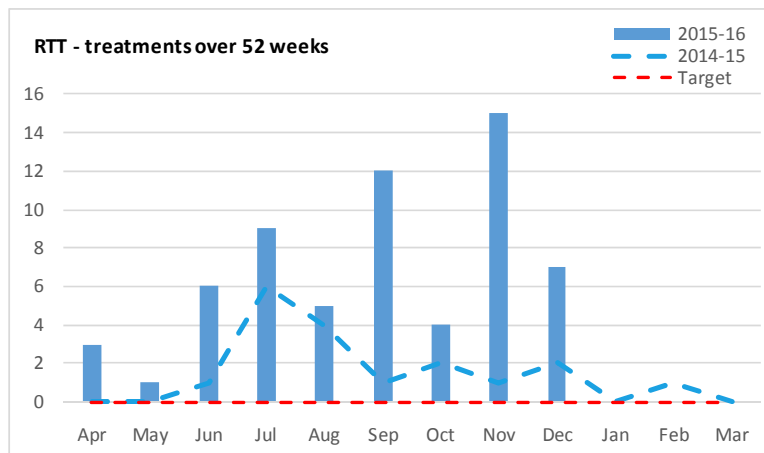
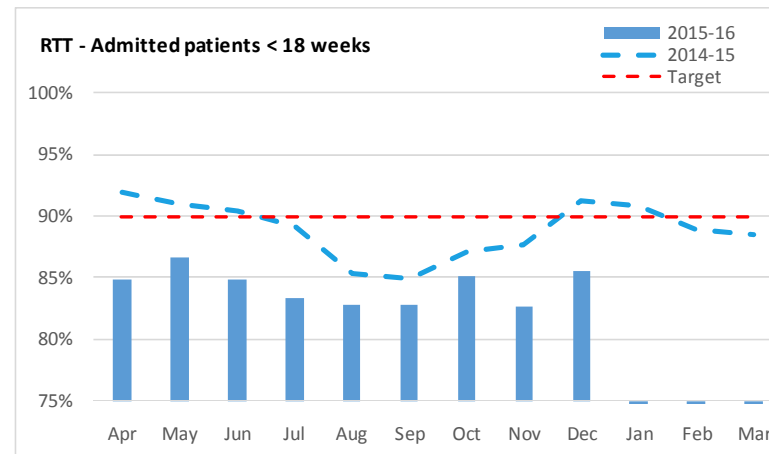
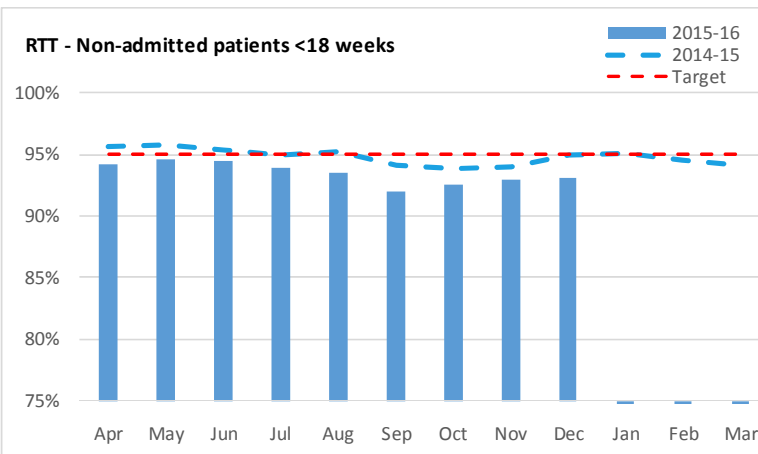
Action and progress	Owner	Next review date
Open 14 inpatient beds on 1 <sup>st</sup> December & a further 14 beds mid-December.	Acute Medicine DMT	Completed
Re-established the Frailty Unit on Evan Jones to support the over 75 year old pathway. Plans to start the 3-take model in January in Medicine (before the full functioning model is in-place in Q1 2016/17) with SAU moving to Alan Apley.	Acute Medicine DMT	Completed
December's Star Chamber actions are completed or currently in progress.	Deputy Dir of Operations.	January 2016

- From April, the NHS focus is now entirely on the experience of patients awaiting treatment, with an expectation that at least 92% of patients at any one time are waiting less than 18 weeks.
- The Trust failed to meet this 'incomplete' pathway standard in aggregate (chart upper left) for December. There is a seasonal trend that occurs due to reduced activity and reduced referrals due to the festive season, but despite increased focus during December and January to review our pathways we were unable to achieve the target at the end of the month. The Trust has now implemented an RTT recovery plan which focuses on improving our weekly processes to ensure more patients over 18 weeks are booked appropriately, with earlier sight of outcomes from clinics and enhanced training for staff involved in tracking patients along their pathway.
- We have reported 10 pathways over 52 weeks. These are often reported when a patient has requested a pause or delay to their treatment and has been seen in both Plastic Surgery and Orthopaedics. 1 patient in Paediatric ENT service was offered a date beyond 52 weeks and the service is continuing to take actions to reduce waits.
- There has been significant focus on RTT, with actions taken to give additional assurance on activity and to try to actively reduce our backlog (those patients waiting >18 weeks). Whilst the backlog numbers levelled between August and November, it increased in December as a result of an expected reduction in activity (and patient choice) over the festive season and changes in case-mix.





- We are no longer required to report our non-admitted and admitted position to our external regulators, but our performance improved during December. This was the result of case-mix changes and because more patients who had been waiting a shorter time chose appointments during the festive season.
- The combination of increased referrals and changes to both case-mix and booking practices means that more patients are now waiting >18 weeks for treatment (i.e. our backlog is growing), particularly in an outpatient setting. Services have been asked to focus on delivering extra capacity to ensure patients are seen in a more timely way and that longer waiting patients are seen first (unless urgent patients need to take priority). Further detail is provided in the briefing note on page 41.
- We have reported 7 treatments over 52 weeks. Five of these related to patients (within Plastic Surgery and Paediatrics) declining treatment, having previously delayed their treatment through choice. In addition, a user of our pain service experienced an unacceptable delay as a result of an error in the vetting of their referral. Administrative errors also led to a long delay for a patient using our GI service. Root cause analysis shows that neither patient suffered harm as a consequence of these delays, although long periods of waiting can clearly be a source of avoidable anxiety. Actions have been taken to prevent a recurrence.



# 4 Responsive

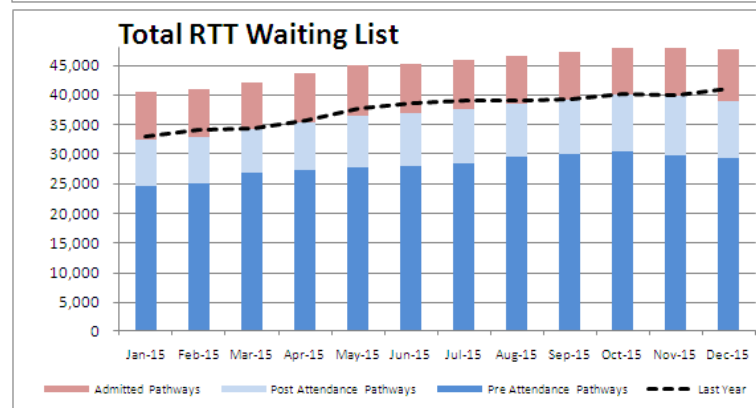
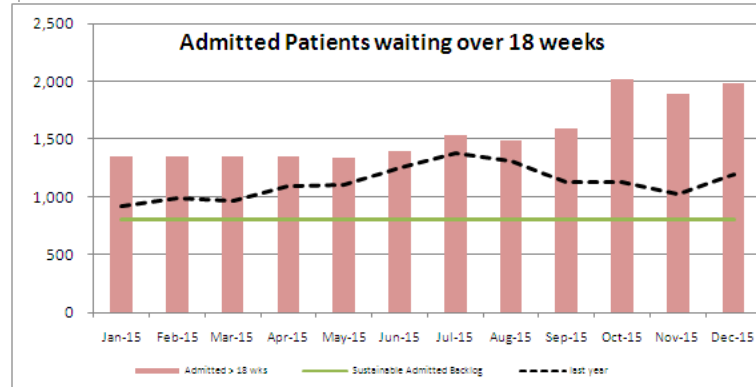
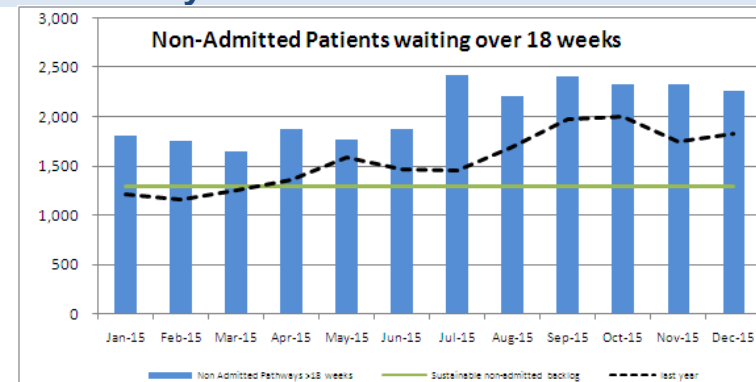
## Referral to treatment (RTT)

Information Owner: Sean McCloy

December 2015

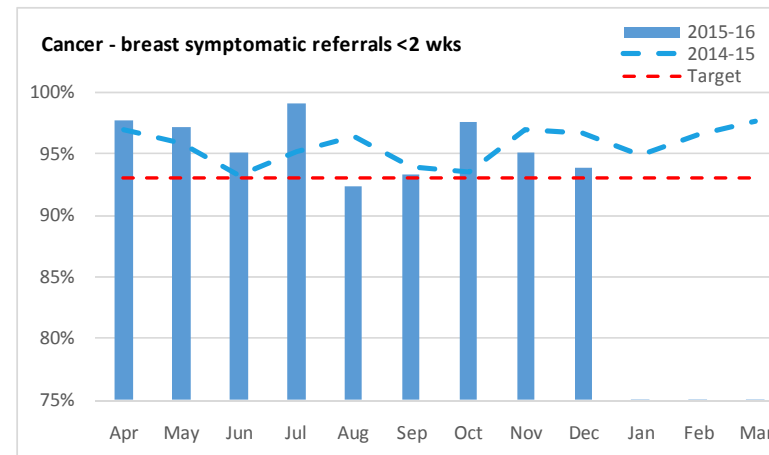
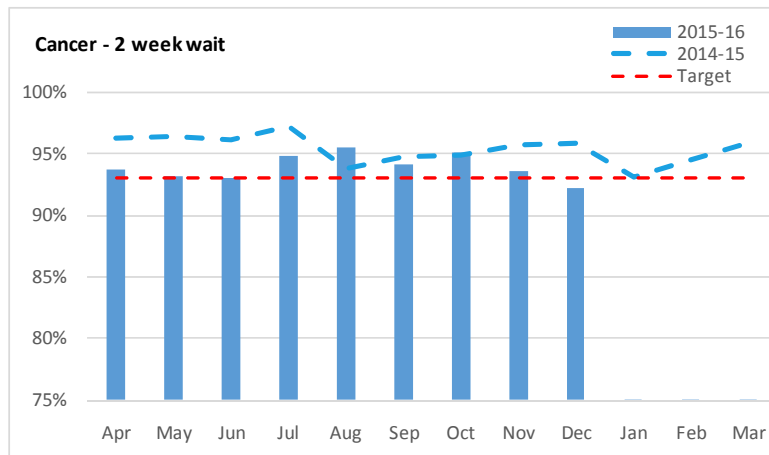
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- **Where we want to be: targets and benchmarks**
  - We are seeking to reduce the number of patients waiting over 18 weeks to a level at which we can sustain performance against the national standards for incomplete pathways.
- **Where we are: trends and patterns**
  - We have seen a rise in the proportion of admitted and non-admitted patients waiting over 18 weeks.
  - Our overall waiting list is significantly larger than at the same time a year ago and 4188 patients had been waiting >18 weeks at the end of December.
  - year and the number waiting over 18 weeks reduced slightly to 4188 at the end of December
- **Risks or opportunities for the Trust**
  - Referrals volumes increased in Q3 above previously high levels. This carries a risk for the Trust even though we are achieving record levels of activity.  
Services in addition to those with limited alternative provision have struggled to meet demand.
- **Root cause analysis and insights**
  - We are doing record levels of activity but we need to ensure that we are focussed on treating non-urgent patients in an appropriate chronological order.
  - We need to ensure that all referrals are booked onto our patient record system within 48 hours. We are currently reviewing our electronic vetting system and processes to achieve this.
  - We need to improve how we record the outcome after a patient has attended a clinic at the Trust. Improving this will reduce the lag time to find out what the outcome was and update records. This would help to reduce the number of patients whose pathways remain open erroneously.
  - We need to improve our current capacity to check pathways and will be employing additional validators for this purpose with the support of our CCGs.
  - The Trust has been seeking to increase the numbers of patients treated in the independent sector and has asked for support from the NHSE Project Management Office (PMO) to identify some providers locally to the Trust. This continues to be a priority to ensure we maximise the space available for surgical work that we need to do on site. However potential alternative sites have not been favourably located for the Trust's patients, or the cost of the work (often considerably above NHS tariff) is prohibitive given current financial constraints.

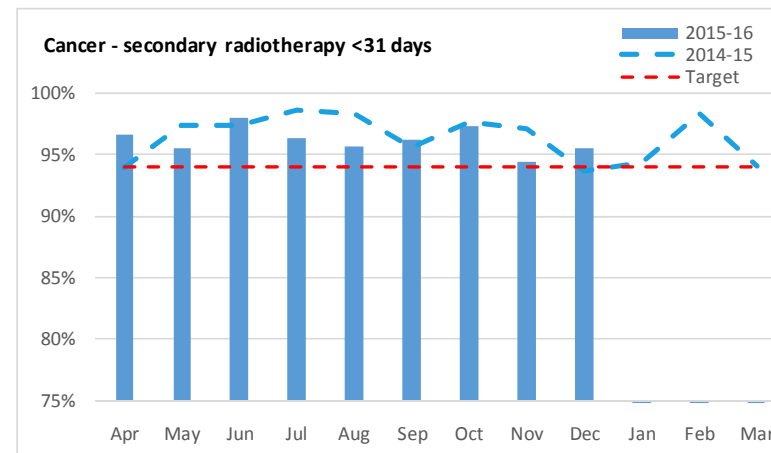
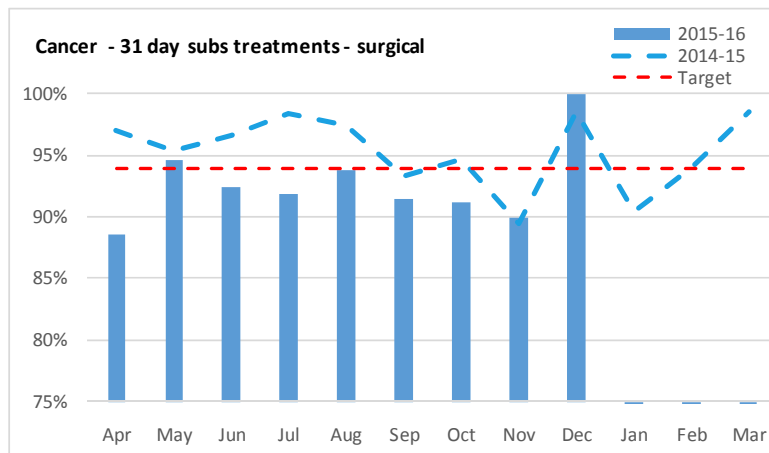
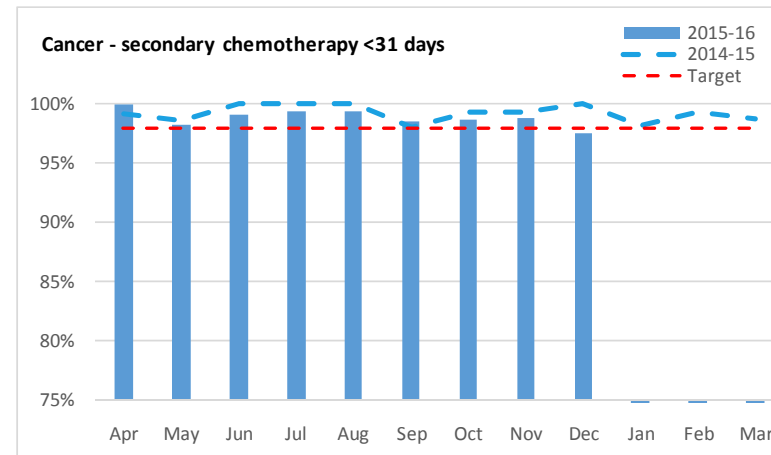
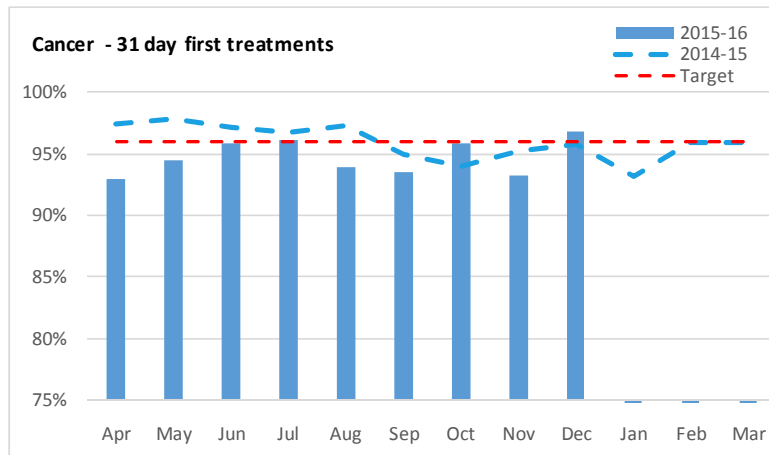


Action and progress	Owner	Next review date
Review validation and PTL process to ensure better pathway management.	General Managers	January 2016
Chronological booking review and weekly RTT rhythm	DMT/Performance Team	February 2016
Identify external capacity through NHSE PMO to support treatments.	DMT/Performance Team	December 2016
Intelligence triangulated	Root cause understood	Action plan set
	Actions underway	Actions complete

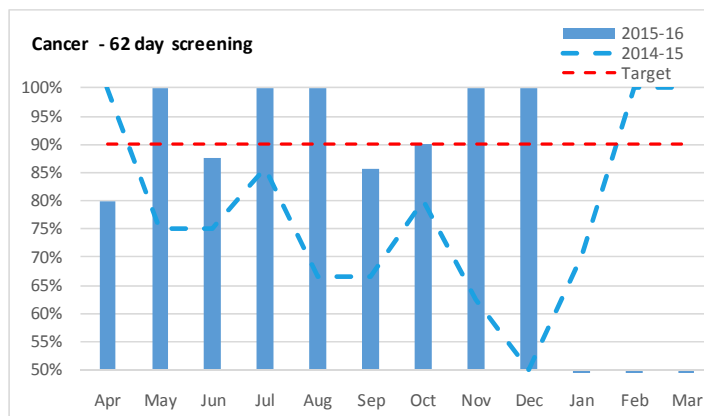
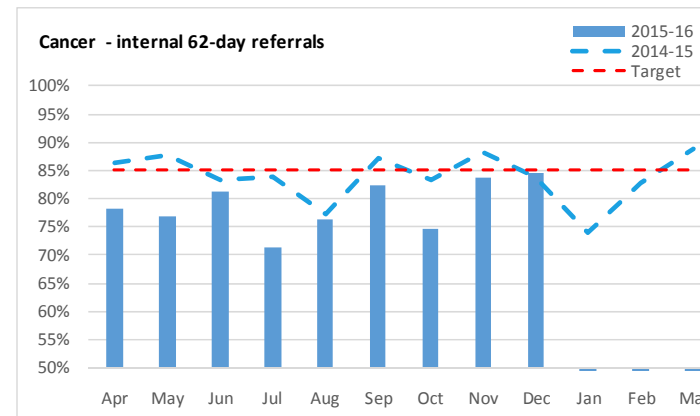
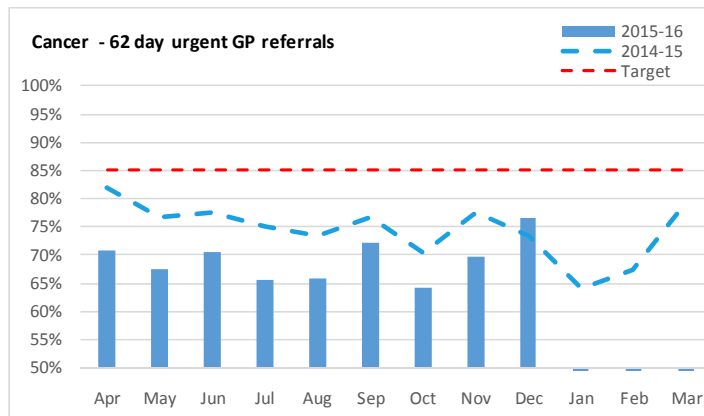
- The Trust did not achieve the 2 week wait target for patients with a suspected cancer diagnosis in December. However, we did achieve this standard in Quarter 3.
- One of the main reasons for failing this standard relates to patient choice, particularly over the festive season. Another recent challenge has been with our 'straight to test' offering for patients in our lower GI service. Many patients choose to have their test after day 14. The service is currently working to increase the choice of available slots before day 14.



- We met all the 31 day targets apart from *subsequent drugs* in December.
- There were 3 breaches for subsequent drugs (chemotherapy), resulting from medical pathway delays. This gave the Trust a performance of 97.7% against a standard of 98%



- Overall performance for 62-day maximum wait for first treatment remains below the 85% target. Our overall performance was 76.79%, but with an internal performance of 84.6%. Of the 12 internal breaches this month only 4 were avoidable (1 Radiotherapy (RT) capacity and 3 admin breaches). The rest of the breaches were due to medical/complexity reasons (6) and patient choice reasons (2). We are continuing to working closely with the cancer data team and Directorates to ensure that we do not have further avoidable breaches in the future. We are investing additional resource in the team, supported by our CCG colleagues, as well as reviewing our daily and weekly processes and system checks to ensure that errors are identified and corrected as quickly as possible.
- The main factor in our failure to meet the overall target relates to the external referrals into the Trust. There were 31 external breaches in December. 24 were referred late (>42 days) in the 62 day pathway and 14 had already breached before reaching us. Unfortunately, we had 2 avoidable breaches, one due to a delay in receiving histopathology material from the referrer and the other due to a referral being directed to the wrong team.



62 Day Treatment - December	62 Day Treatment Status		
CWT Code	Internal Treatments	Internal Breach	Internal Performance
Brain CNS	0	0	
Breast	10	0	100.0%
Gynae	4	0	100.0%
Haematological	4	1	75.0%
Head and Neck	12	2	83.3%
Lower GI	3	1	66.7%
Lung	9	4	55.6%
Other	0	0	
Skin	1	0	100.0%
Skin Haematology	0	0	
Thoracic	0	0	
Thyroid	0	0	
Upper GI	2	0	100.0%
Urological	33	4	87.9%
<b>Internal total</b>	<b>78</b>	<b>12</b>	<b>84.6%</b>
<b>External total</b>	<b>81</b>	<b>31</b>	<b>61.7%</b>

62 Day Treatment - Q3 2015/16			
CWTCODE	Internal Treatments	Internal Breach	Internal Performance
Brain CNS	0	0	
Breast	28	1	96.4%
Gynae	9	0	100.0%
Haematological	12	3	75.0%
Head and Neck	20	4	80.0%
Lower GI	11	3	72.7%
Lung	11	5	54.5%
Other	0	0	
Skin	9	0	100.0%
Skin Haematology	1	0	100.0%
Thoracic	5	1	80.0%
Thyroid	3	1	66.7%
Upper GI	8	2	75.0%
Urological	96	19	80.2%
<b>Internal total</b>	<b>213</b>	<b>39</b>	<b>81.7%</b>
<b>External total</b>	<b>268</b>	<b>127</b>	<b>52.6%</b>

- There were 2 internal avoidable breaches which affected our performance. One occurred in Head and Neck, the other in Urology - both a consequence of administrative errors. There remains a strong focus on eliminating all such issues through training and support for the coordinators as well as weekly huddles to identify and immediately address live issues on the patient tracking list (PTL).
- The external position remains very challenging, however the focus on working with colleagues at other Trusts remains a priority. Additional funding has been received from our commissioners to appoint joint coordinators across the providers in the network. This is part of a system wide collaboration to facilitate earlier referral.

# 4 Responsive

## Cancer waits Information Owner: COO Team

December 2015

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### • Where we want to be: targets and benchmarks

- We want to be able to sustainably achieve the cancer waiting time standards.

### • Where we are: trends and patterns

- We have consistently achieved the 2 week wait standards and the 31 day targets for chemotherapy and radiotherapy.
- The Trust has not been able to achieve the 62-day standard sustainably, principally due to patients from our referring hospitals being referred late in their pathway leaving the Trust unable to deliver treatments within maximum waiting times.
- We have not achieved the 85% standard for those patients referred directly to us from GPs in Q1 and 2 of 15/16. There has been a slight improvement in Q2. The main driver remains surgical capacity and some administrative failures which are being addressed with the Pathway trackers.

### • Risks or opportunities for the Trust

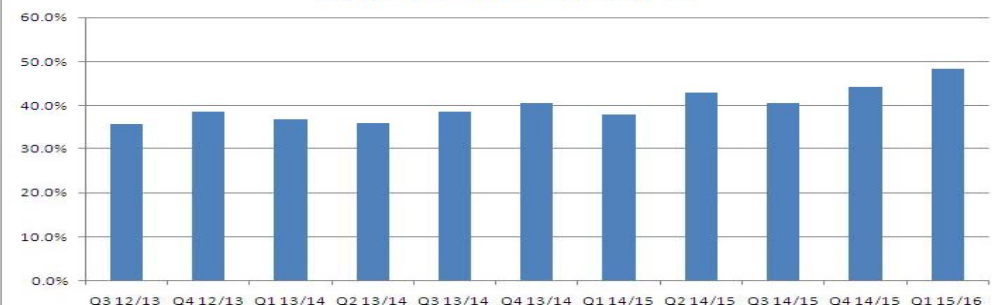
- Key Tumour Groups are Head and Neck ,Thoracic, Urology, and GI – Upper and Lower
- The volume of external referrals (which is greater than internal referrals) and the level of late referrals are the main drivers behind our failure to achieve the overall standard.

### • Root cause analysis and insights

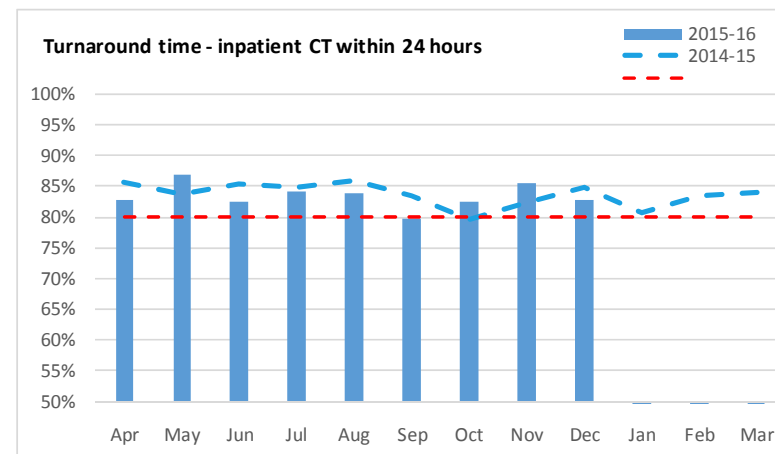
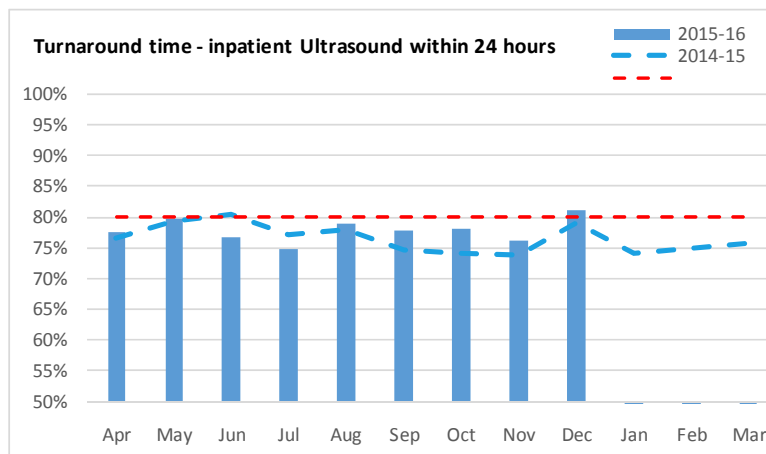
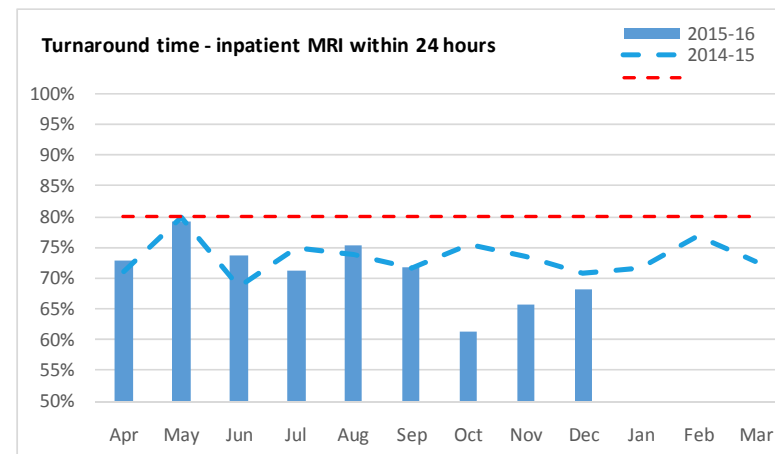
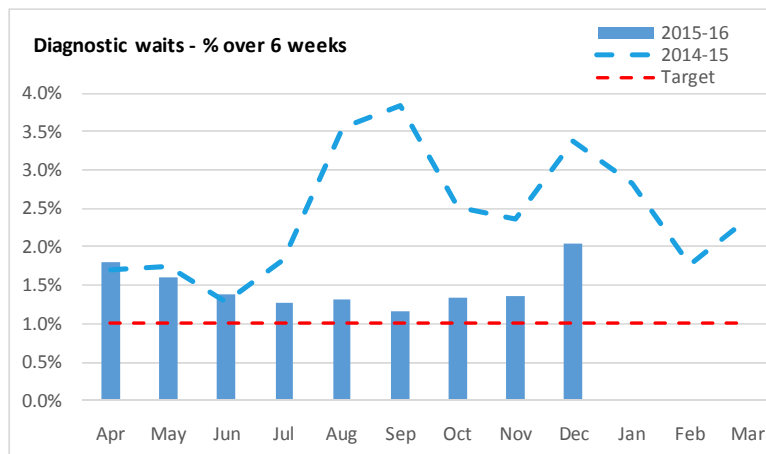
- The Chief Operating Officer team continues to drive through a comprehensive action plan covering each of the tumour groups which aims to continually improve these pathways for patients.
- A monthly senior team meeting made up of the cancer lead clinicians and managers from SEL has been set up to ensure that all issues that can be tackled jointly are done as well as a Cancer resilience group chaired by the Chief Officer of the CCGs
- The weekly conference call with referring Trusts in SEL continues to ensure all patients referred to the centre are immediately visible and appropriately fast tracked where possible.
- We are working with Clinicians in SEL Trusts at tumour specific levels to ensure that pathways and processes are further streamlined. This has happened for the Head and Neck pathway and the lung/thoracic meeting is scheduled for January 2016.

Performance target	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16
Target: 85% cancer patients treated within 62 days from GP referral	79.20%	74.70%	73.60%	71.40%	69.20%	67.37%
Internal referrals	86.70%	83.30%	85.00%	83.00%	78.11%	75.89%
Target: 90% cancer patients treated within 62 days from Screening	84.00%	70%	66%	92.60%	80%	93.33%
Target: 96% cancer treatment started within 31 days from Decision to treat	97.50%	96.80%	95.20%	95.10%	94.07%	94.77%
Target :94% subsequent cancer surgery treated within 31 days	94.20%	96.60%	92.70%	89.90%	92.19%	93.66%
Target: 98% subsequent chemotherapy treatment started within 31 days	99.60%	99.60%	99.60%	98.80%	98.95%	99.29%
Target :94% subsequent Radiotherapy treatment started within 31 days	96.50%	97.30%	96.10%	95.50%	96.74%	96.19%
Target:93% urgent cancer referrals seen within 2 weeks	96.30%	95.20%	95.40%	94.50%	93.15%	94.83%
Target:93%breast symptomatic referrals seen within 2 weeks	95.30%	95.30%	95.80%	96.50%	96.55%	94.97%

%age received after day 42



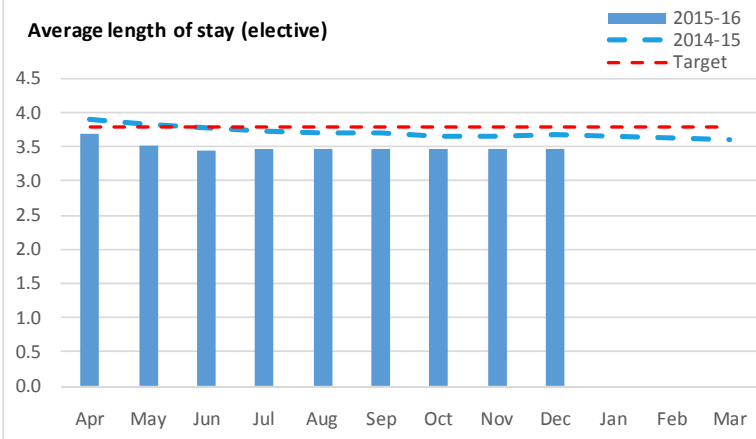
- The number of patients who received their diagnostic test within 6 weeks was 2% in December against a target of 1%. However, this is a significantly improved position in comparison to 2014/15.
- During December there was an administrative error in the Cardiovascular Directorate and a small number of patients waiting for Echocardiograms waited longer than 6 weeks for their test. Increased clinic slots during December and January is expected to resolve these waits. In addition there was a small increase in patients waiting over 6 weeks across Paediatric MRI and Sleep studies, GA Cystoscopy and Urodynamics in both adult and paediatric services. Plans are in during January to ensure extra capacity is in place to reduce the number of patients waiting for their tests. We continue to outsource routine adult MRI and we are exploring outsource opportunity for Paediatric MRI, however this is more complex as these tests require a general anaesthetic.



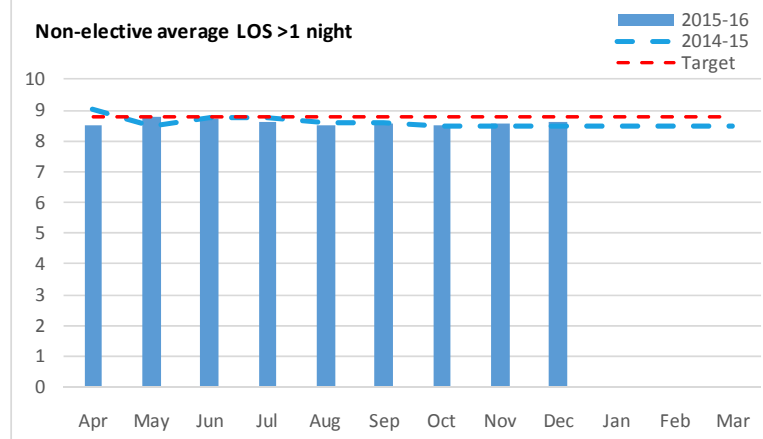


- Provision of alternatives to hospital admission continue, including our @Home and Enhanced Rapid Response (ERR) services. In December pal@home commenced providing care overnight to palliative and other patients. Referral rates to @Home for September and October are similar to last year. Data for community activity is not available from 25 November and December due to migration from Rio to Advanced Carenotes. There were capacity issues relating to staff sickness in @home.
- Average length of stay for elective patients remains better than target and is an improvement on last year. This is helping to support the significant additional activity we are currently delivering. Directorates are currently working on further LOS improvement plans to improve performance for Q3 and Q4 and the Inpatient support team are developing tracking scorecards to support ongoing analysis.
- Work continues on improving hospital discharges before noon, with a new dashboard launched for Directorates to review weekly across a number of metrics relating to early discharge. These will be reviewed as part of the huddle process within Directorates.

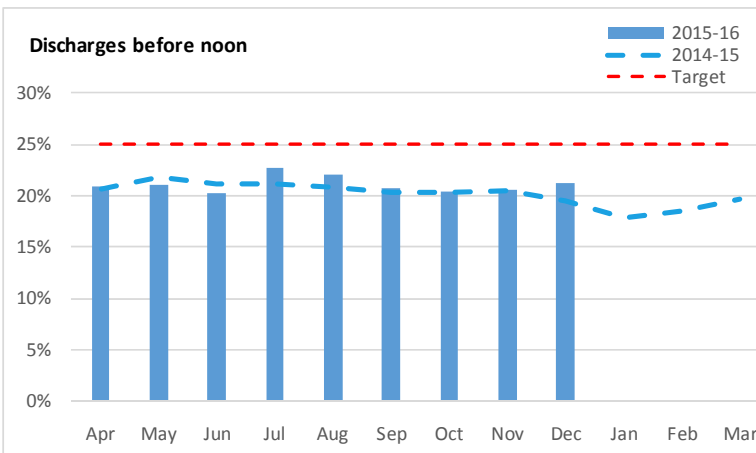
Average length of stay (elective)



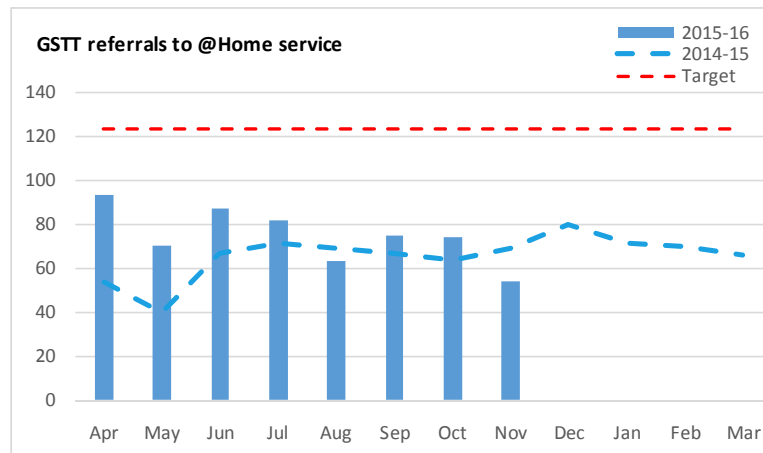
Non-elective average LOS >1 night



Discharges before noon

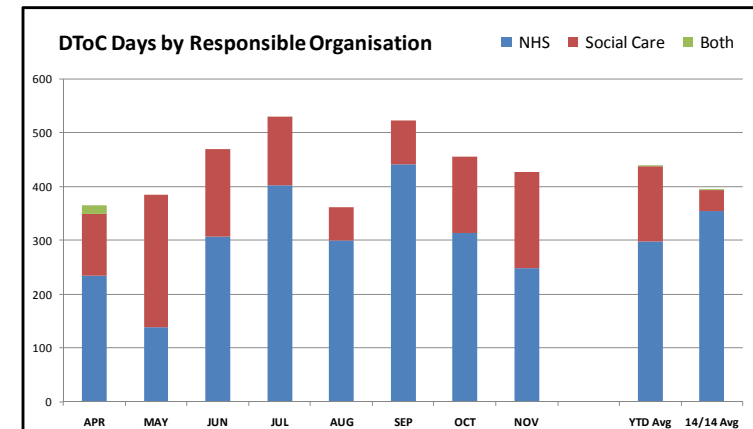
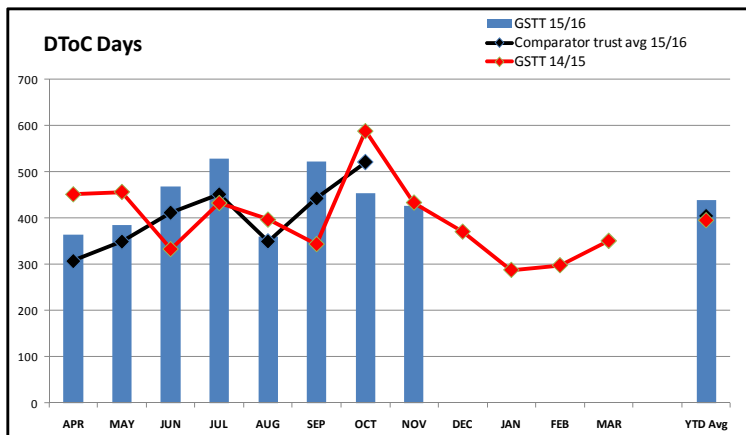
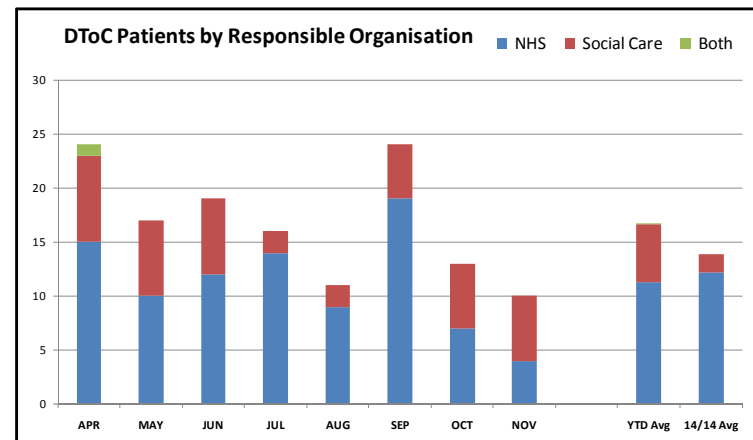
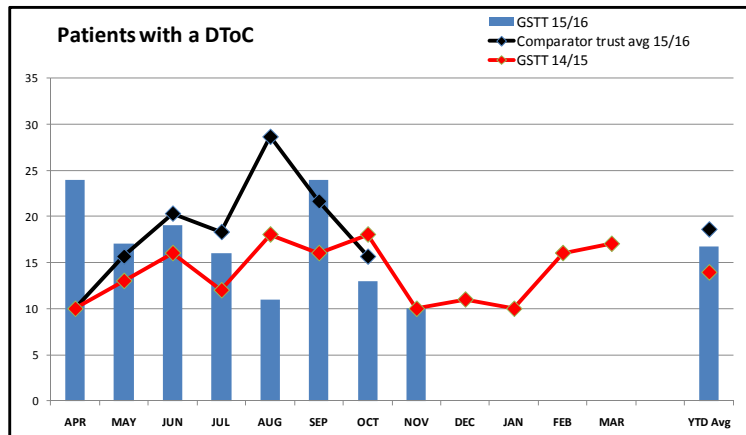


GSTT referrals to @Home service

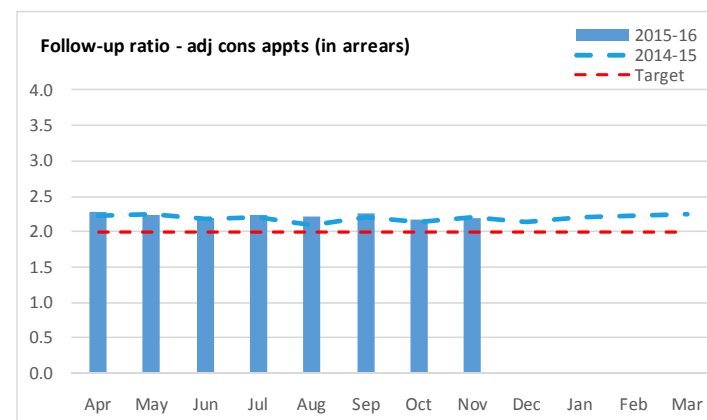
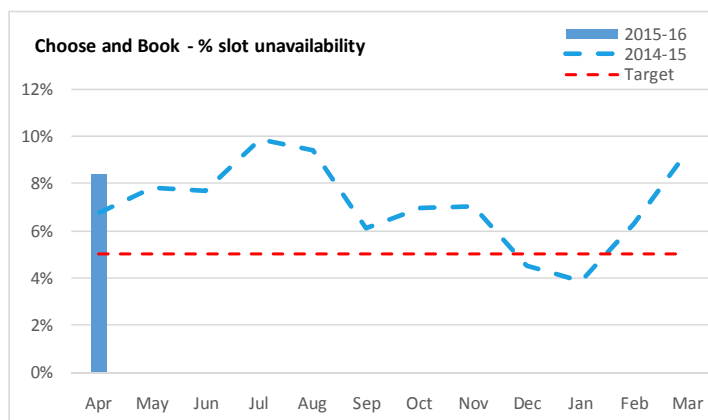
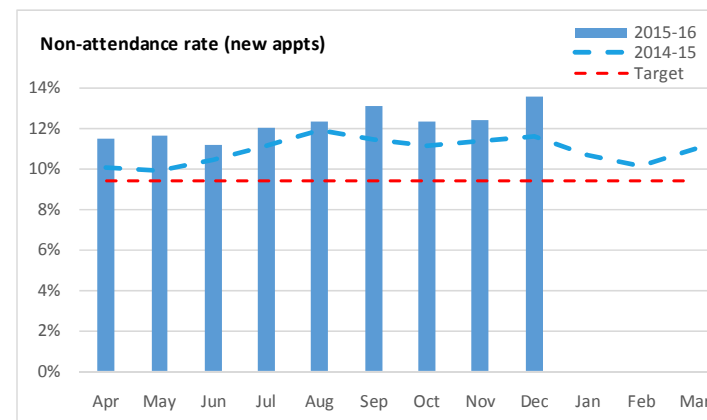
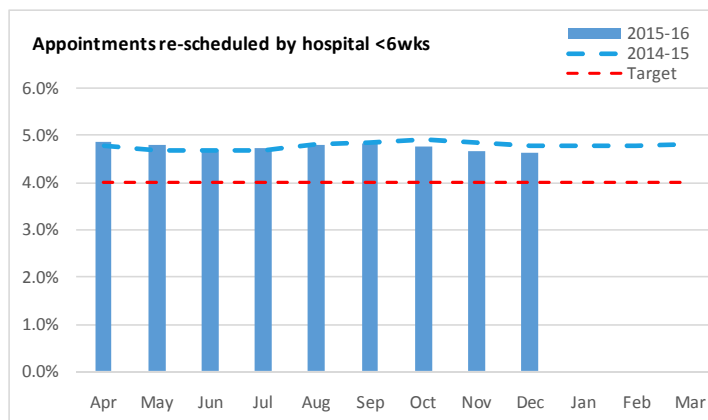


### Delayed Transfer of Care (DToC) –

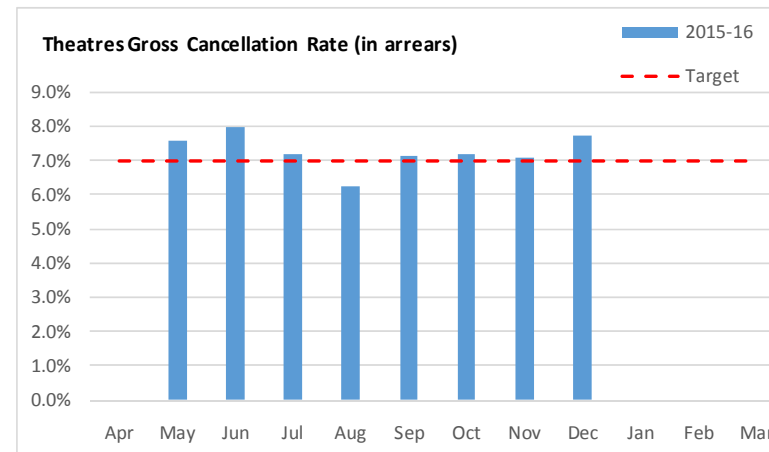
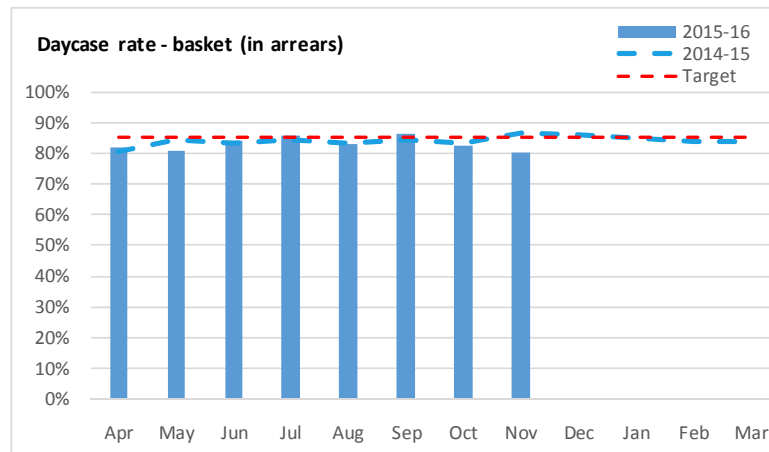
- The definition of a DToC is when a patient is ready to transfer from acute to non-acute setting, but remains in an acute hospital bed. This implies that a multidisciplinary clinical decision has been made that the patient is safe and ready for transfer.
- In December we have continued to have a bi-weekly "Ops Forum" for complex discharge to review all complex discharge with matrons and a bi-weekly "Platinum Call" with senior colleagues across the healthcare system to escalate issues. We continue to share a report of all complex discharge patients with various CCG colleagues to enable better communication of actions required for individual patients.
- The graphs below show that our DToC levels are now comparable to last year and have dropped since October, especially for those where the Trust is responsible for the patients. We have been focussed on reducing these levels as part of our emergency pathway improvement plan and this seems to be having an impact.



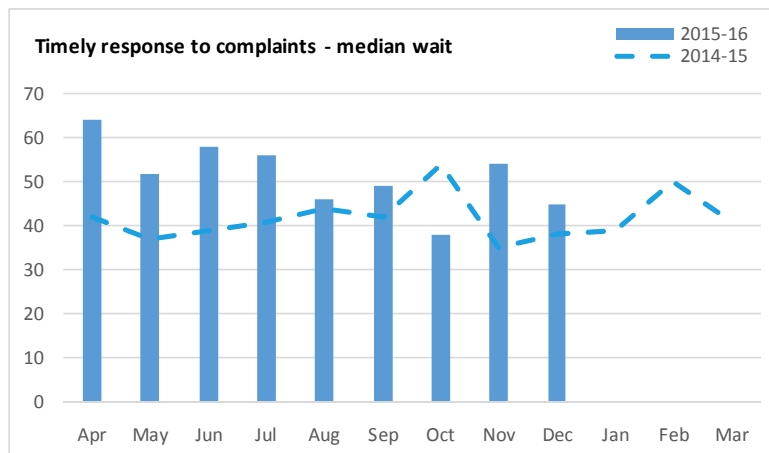
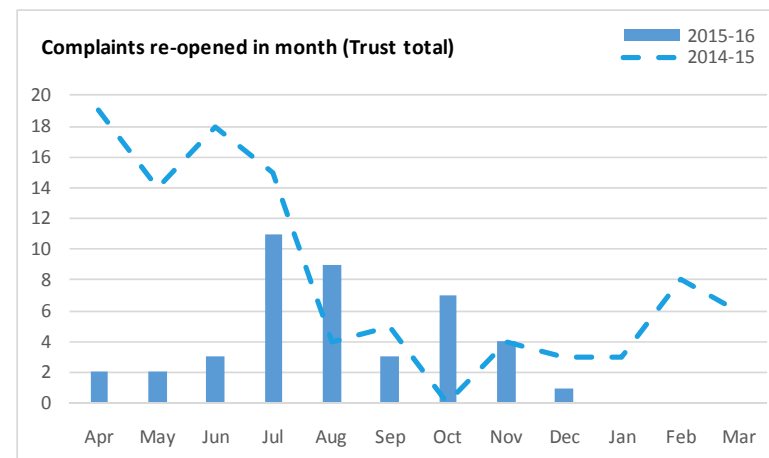
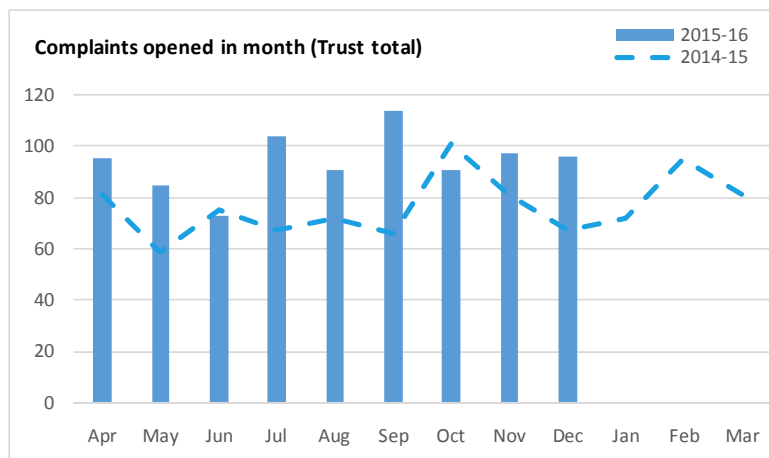
- **Appointments re-scheduled by the hospital within 6 weeks of an appointment** – The number of rescheduled patients in December has remained fairly static compared to November. Services are continuing to implement new ways of booking e.g. partial booking and monitoring annual leave to reduce the likelihood of needing to reschedule patients. Standards are being reinforced with regard to notice of cancelled clinics, and work continues to business plan for 2016-17 to ensure capacity reflects and meets demand.
- **e-RS (National e-referral system) - % slot availability** – National reporting is still unavailable on e-RS. The Appointment Slot Issues (ASI) have reduced to a total of 695 in December compared to a total of 730 in November. Action plans are being developed for Orthopaedics & ENT who have high number of ASIs to review in the service. Monthly meetings have been set up with Lambeth CCG & KCH (with Southwark also invited). Two practices have had refresher GP training by Lambeth CCG and plan is to tie this in with GSTT/ KCH e-RS promotion of services. These GPs have provided positive feedback and follow up on issues which trainers could not answer is being undertaken by GSTT/ KCH. "Release 4.7" an version upgrade is planned for deployment by National team for 29/30th January – this is a substantial release and we are hoping that this will resolves some of the issues logged by GSTT with the HSCIC National Service desk.
- **Non-attendance for new appointments** – DNA rates for December have increased. One particular service has seen a high increase in DNA appointments which appears to be as a result of patients preferring not to come in over the Christmas period. Services with higher DNA rates have identified local improvement plans, largely concerning ensuring the Access Policy is being implemented in terms of contacting the patient to agree appointments. The use of an electronic solution called "Dr Dr" by one Directorate has led to a significant reduction in DNAs in recent months and a business case has been written for consideration of a Trust wide roll out.



- Daycase rates continue to be challenging to achieve but there is on-going focus on ensuring that daycase pathways are followed for all clinical appropriate cases.
- A small increase in the number of cancellations during December was during December was driven by an increase in bed pressures on the St Thomas' site. Infrastructure issues meant we lost an operating theatre for nearly 1 week and there was some additional impact from the first junior doctors strike. Furthermore an increased number of patient cancelled minor operations due to the festive period.



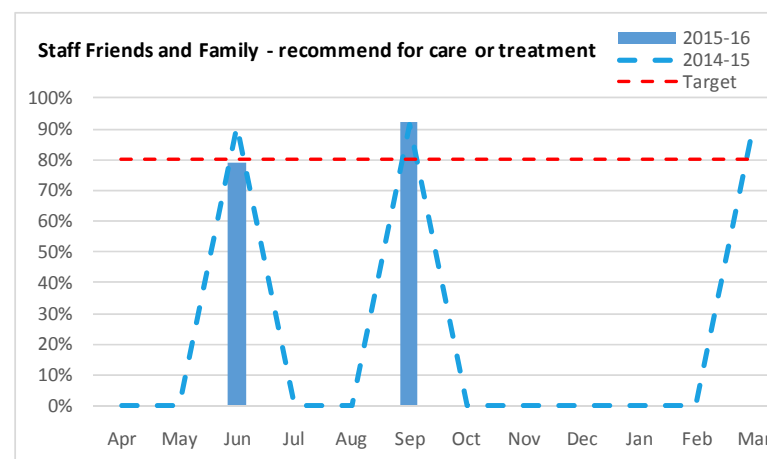
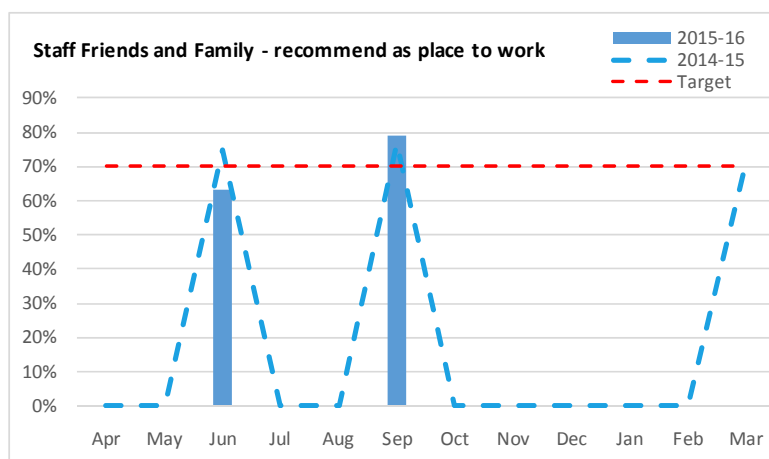
- The number of formal complaints received in December (96) remains high. There has been a noticeable increase in complaints across the Trust in the year to date. The reason for this is not certain but it is noted that efforts have been made to raise awareness of the option to make a complaint. The method for recording complaints has also changed over the course of the year and we are now identifying formal complaints more accurately.
- The time taken to respond to complaints is recorded when a complaint closes and can show considerable variation according to the time taken to investigate and the complexity of the issues raised. The Trust currently tracks the median response time (chart lower left) but will move to showing modal averages (most common response times) when the introduction of a classification system for complaints is complete. The median reduced in December to 45 working days.
- We aim to reduce the number of complaints re-opened due to complainant dissatisfaction with our response by investigating and responding to complaints fully and promptly, and have been focusing more strongly on getting it right first time.



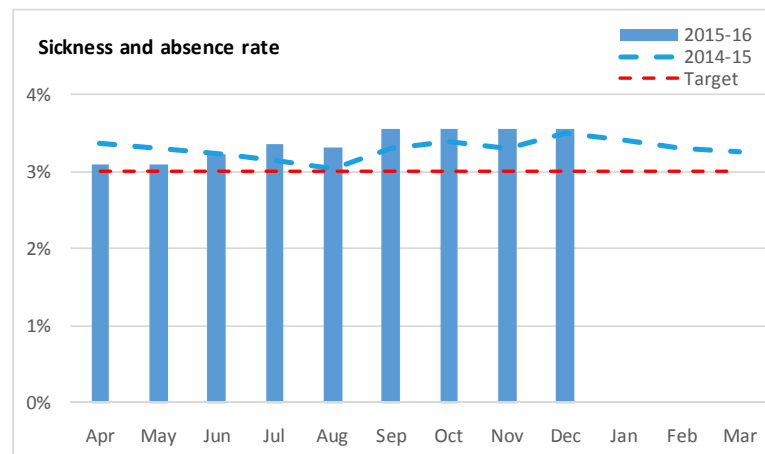
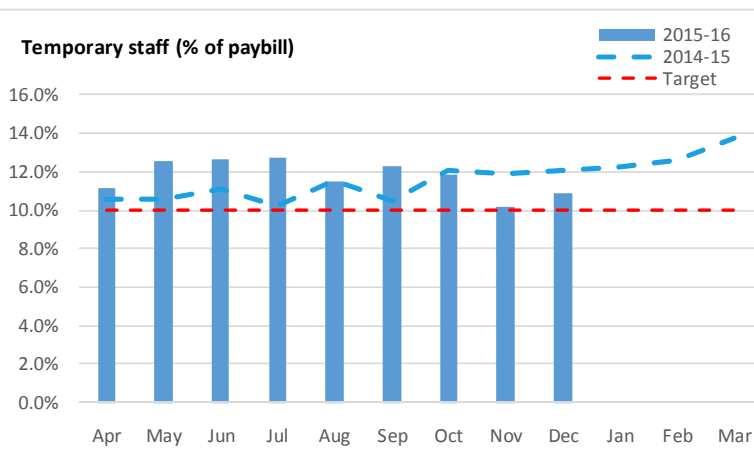
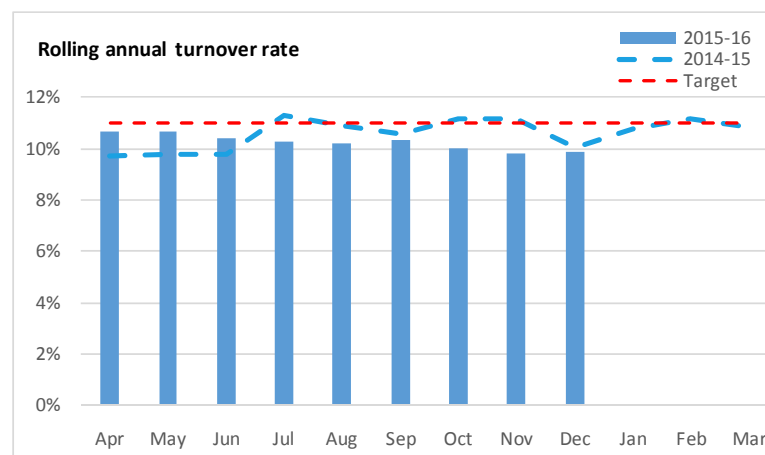
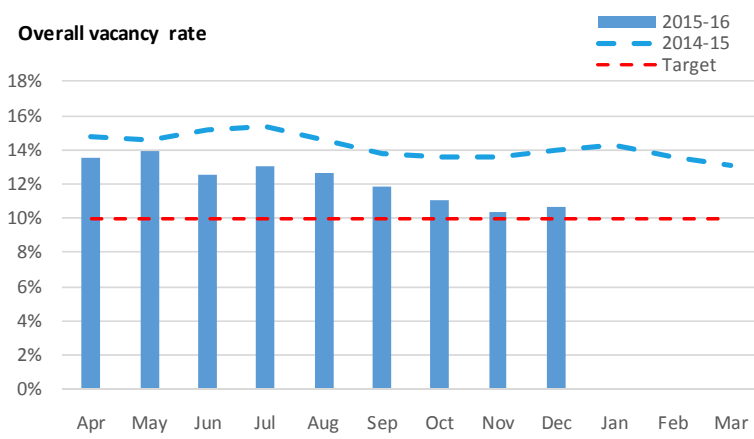
*The Trust's ambition is to provide a complaints system which is open to complaints, supports patients, families, and staff through the process, and which delivers a timely apology, explanation and determination to learn from mistakes. The aim is to produce a service about which complainants are able to say: I felt confident to speak up; making my complaint was simple; I felt listened to and understood; I felt that my complaint made a difference.*

Theme	Ref	Indicator	Units	Target	R	G	Prior year	Oct	Nov	Dec	YTD avg	Monitor	Quality priorities	Trend chart
5.1 External assessments	GOV	Overall governance rating (Monitor, in arrears)	Rating	Green			Green				Green			
	CQC	Care Quality Commission (CQC) risk assessment	Score	>5			6	6	6	6	6			Y
5.2 Staff experience	FFTS1	Staff Friends and Family - recommend as place to work	Qtly %	>70%			77.0%	-	-	-	71.0%			Y
	FFTS2	Staff Friends and Family - recommend for care or treatment	Qtly %	>80%			91.0%	-	-	-	85.5%			Y
5.3 Workforce indicators	VACTB	Overall vacancy rate	Mthly %	<10%			14.2%	11.1%	10.3%	10.7%	12.2%			Y
	TEMPTB	Temporary staff (% of paybill)	Mthly %	<10%			11.6%	11.8%	10.2%	10.9%	11.8%			Y
	TURNTB	Rolling annual turnover rate	Mthly %	<11%			10.6%	10.0%	9.8%	9.8%	10.3%			Y
	206TB	Sickness and absence rate	Mthly %	<3.0%			3.3%	3.55%	3.55%	3.56%	3.37%			Y
	211TB	Appraisal compliance (non-medical staff)	Mthly %	>95%			71.4%	77.1%	76.9%	75.5%	73.4%			Y
	MTTB	Mandatory training compliance	Mthly %	>95%			86.1%	86.2%	86.4%	86.5%	86.6%			Y

- Staff opinion on whether they would recommend a health care organisation for care or for work is statistically associated with the quality of care. Any fall in the positive opinion should be seen as a potential early indicator of a reduction in quality of care.
- 1474 staff participated in the Quarter 2 Staff Friends and Family Test (SFFT), which was open from 27 August for 3 weeks. The results show that 92% of our staff said that they would recommend the Trust as a place to be treated, much higher than the national average of 79%. 76% of our staff said that they would recommend the Trust as a place to work, again higher than the national average of 62%.
- All staff were invited to participate in The National Staff Survey, which takes place in the third quarter of each year and was open from 25th September to 27th November 2015. 4454 staff members responded. The Survey asked for staff to share their experience of working in the Trust, including questions about their job, their managers, their personal development, their health and wellbeing and their safety at work. Complete results will be available in 2016; which will give us a broader picture of staff experience within the organisation and how we compare nationally, with other NHS Trusts.
- The Trust has been recognised as a gold standard employer by Investors in People, a national standard used to measure the way in which organisations lead, manage and develop in staff. Of the 12,000 organisations in the UK that hold the Investors in People award only the top 7% achieve the gold standard.

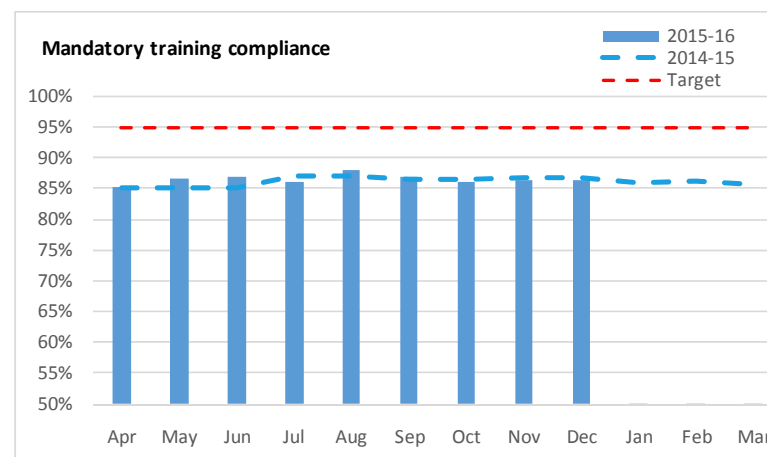
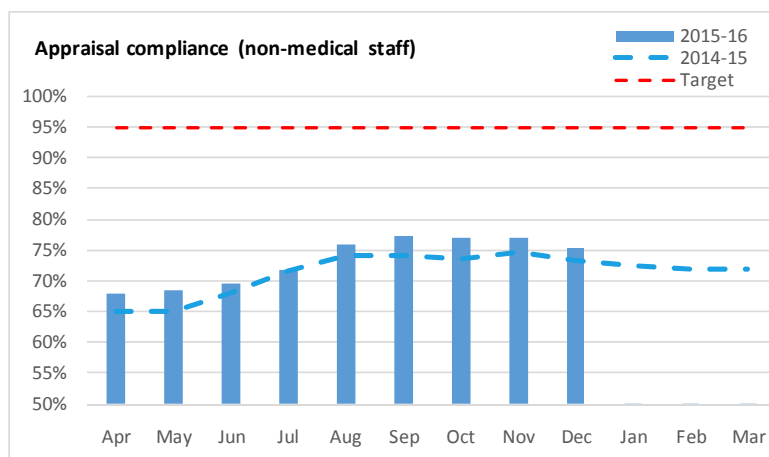


- The overall vacancy rate (10.68%) increased in December, although remains below the long term average. This was primarily due to reduced inductions over the seasonal period and an increase in the numbers of leavers that is an expected seasonal variation. We anticipate further reductions over the coming months, albeit at a slower rate than of late.
- Temporary staffing spend showed an increase in December to 10.92% of the pay bill. Christmas booking controls were in place to reduce non essential bookings and spend continues to be monitored closely through the Fit for the Future programme. The Trust is continuing to monitor Agency bookings following the introduction of the Monitor price cap during November, with weekly updates being shared with the Board.
- The Turnover rate was stable at 9.85% and remains below the Trust target, benchmarking well against other London trusts.
- The Sickness rate remained stable at 3.56% but continues to track above the long term average, as well as above target.

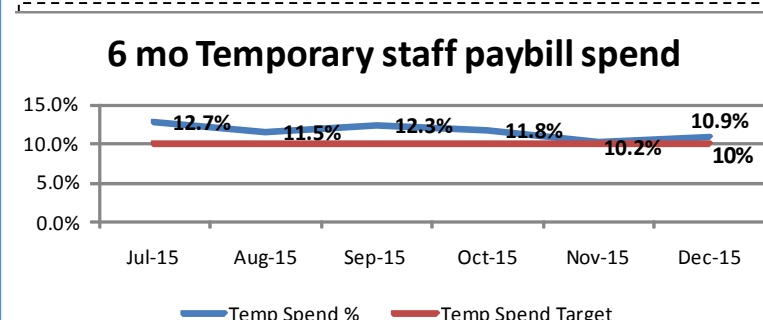




- Personal Development Review (appraisal) compliance rates for December reduced to 75.45%; however this was higher than the same month last year. The Trust has yet to achieve its target of 95%. Communication regarding the importance of PDRs continues to be raised across the Trust as well as encouragement for staff and managers to report compliance to the central database to ensure accurate rates are reported.
- Mandatory training increased slightly to 86.45%; however compliance remains below Trust target level of 95%. There were several individual Directorates that have achieved over 90%.



- **Where we want to be: targets and benchmarks**
- The Trust has set a stretch target of <10% for temporary staffing spend which includes bank and agency spend. This is to ensure that we maintain safe staffing levels but ensure that we recruit and retain a stable workforce and keep costs within payroll.
- In December 2015, temporary staffing spend was reported 10.92% of the total payroll, which while lower than the 12 month average was higher than the previous month. The increase was driven by increased Bank usage, while Agency costs reduced (in part due to Christmas booking controls).
- **Trends and patterns**
- 10.92% represents an increase on the previous month, and the Trust rate continues to be above target, as it has been throughout the financial year. Nursing Agency spend increased on the previous month to £1.4m while Admin & Clerical spend decreased to £0.6m.
- **Root cause analysis and insights**
- The main reason for temporary staffing spend is associated with vacancy cover.
- Other main reasons include activity which relates to covering extended services (e.g. 3 session days or weekend working) where this is either ad hoc or not planned into the existing workforce (PCCP) and also where patient acuity may be high and require the use of specials (Acute). December activity while down on an average month was higher than the previous December.
- **Risks or opportunities for the Trust**
- Although ensuring safe staffing levels, the high usage of temporary staff needs to be monitored to ensure there is no detrimental impact on financial spend and quality of patient care and experience
- **Actions set and progress to date**
- Action Plans to reduce Nursing Agency spend to 6% or below are underway
- The Trust is continuing to monitor Agency bookings against the Monitor price cap and is implementing further action plans to address the further reduction in clinical price caps from February.



### Benchmark (November 2015)

% Temporary Staffing Spend	Nov-15
Chelsea & Westminster	12.30%
Imperial College Healthcare	14.30%
Univ. College London Hospital	12.10%

### Directorate Heatmap-December 2015

Directorate	Temporary staff (% of payroll)
Community Adults	30.1%
Essentia	22.6%
Acute Medicine	19.9%
Womens Services	12.7%
Corporate Directorates (exc Essentia)	11.9%
Surgery	10.2%
Therapies	9.7%
PCCP	9.5%
Clinical Imaging & Med Physics	8.9%
Cardiovascular Services	8.9%
Abdominal Medicine and Surgery	8.7%
Medical Specialties	8.0%
Evelina London	5.6%
Pharmacy	4.5%
GRIDA	3.9%
Dental Services	-0.4%
Oncology & Haematology	-4.7%
Trust	10.9%

Intelligence triangulated	Root cause understood	Action plan set	Actions underway	Actions complete
White – Not started	Red – Not successfully completed / facing significant issues			
Green – Successfully underway/completed	Amber – Underway / completed with minor risks or issues			

# 6 Enablers

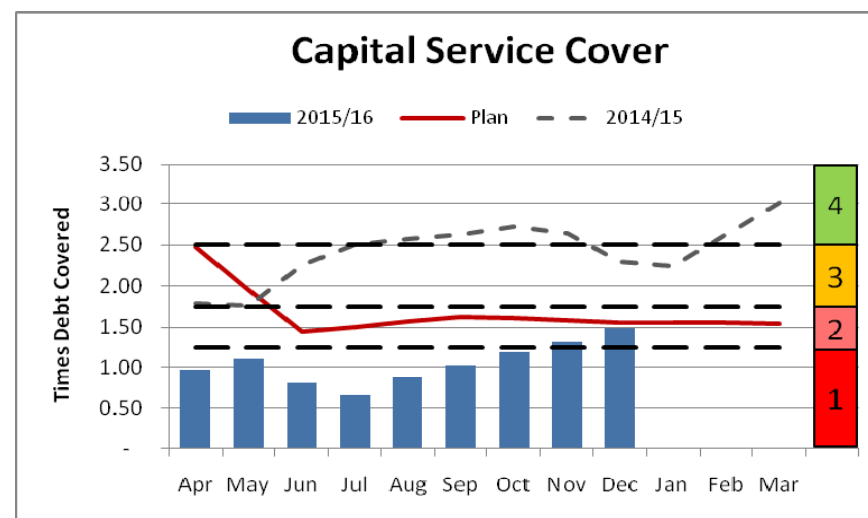
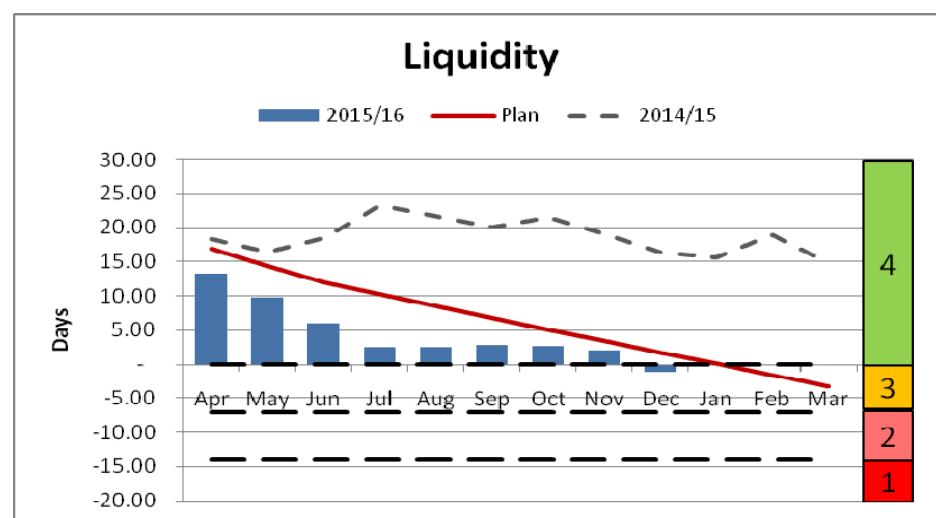
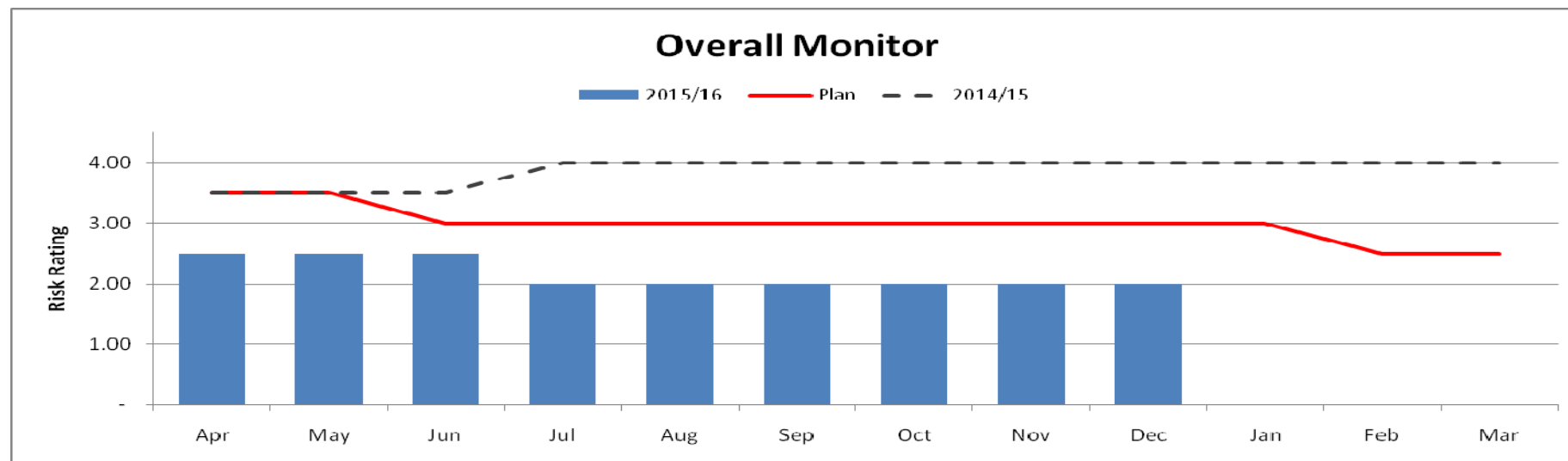
## Domain scorecard

December 2015

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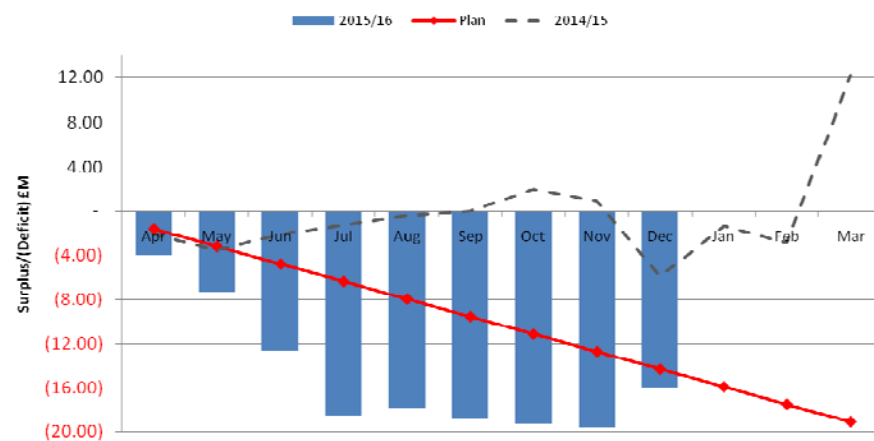
Theme	Ref	Indicator	Units	Target	R	G	Prior year	Oct	Nov	Dec	YTD avg	Monitor	Quality priorities	Trend chart
6.1 Overall financial position	MRRT	Monitor continuity of service risk rating	Score	>3			3.5	2.0	2.0	2.0	2.2			Y
	LQRT	Liquidity ratio (in days)	Days	>0			17.4	2.7	2.1	-1.0	4.5			Y
	DSCCT	Capital service cover	Ratio	>2.59			2.2	1.19	1.31	1.48	1.05			Y
	FIN01T	Overall underlying financial surplus/(deficit)	£M	>£14.3m			-£0.5	-£19.3	-£19.6	-£16.0	-£14.9			Y
	CSHT	Cash flow	£M	>£143m			£126.1	£102.0	£96.0	£96.0	£98.8			Y
	CAPT	Capital spend vs plan (year-to-date variance)	Mthly %	+/- 15%			78.6%	73.1%	70.4%	68.9%	82.5%			Y
	VRPT	Variance from Plan	Mthly %	> 0				-1.5%	-1.24%	-0.50%	-1.9%			Y
	UNPT	Underlying Performance	Mthly %	> 0.6%				-2.2%	-1.9%	-1.1%	-1.7%			Y
6.2 Activity levels (magic numbers)	560	Elective activity vs profiled plan - cumulative variance	Cum var %	>0%			-	-2.0%	-0.9%	-1.3%	-1.3%			Y
	606T	New patients seen vs plan (all categories, in arrears)	Mthly var	>0			-	-1,472	1,936		-1,414			Y
	714	External cons referrals	Number	>last yr			1,752	2,046	2,028	1,773	1,921			Y
	713	GP referrals	Number	>last yr			14,404	17,114	17,566	15,585	15,868			Y
6.3 Fit for the Future	CIPSTC	Cost improvement plans (CIPs) - var to plan YTD	£M	>£0m			-£5.2	-£14.7	-£17.5	-£18.0	-£12.9			Y
6.4 Data quality and clinical coding	CM024	Community data completeness - % contacts outcomed	Mthly %	≥ 95%			93.3%	92.9%	93.2%		84.8%			Y
	712	NHS number coverage	Cum %	>98%			97.4%	97.5%	97.3%	97.3%	97.6%			Y
	710x	Clinical coding - diagnostic depth (in arrears)	Ratio	>4.5			4.51	4.92	4.72		4.90			Y

An overall Financial Sustainability Risk Rating of two has been achieved at month nine, which is behind plan. Negative liquidity is due to changes in working balances, the cash position remains unchanged at £96m.

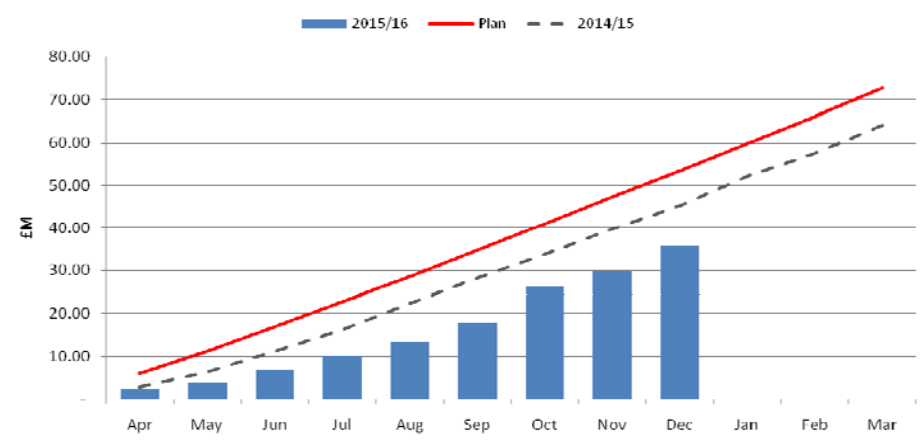


A loss of £16.0M has been recorded at Dec, which is £1.7M behind plan; CIPs (Cost Improvement Programmes) of £35.6M have been confirmed, but are £17.7M less than plan which has been mitigated by income performance; the cash position at £96M is below the plan of £99.3M. Capital expenditure as a percentage of plan has fallen below the Monitor threshold of 85% (to 69%). A reforecast of the Capital plan may need to be considered having breached the threshold.

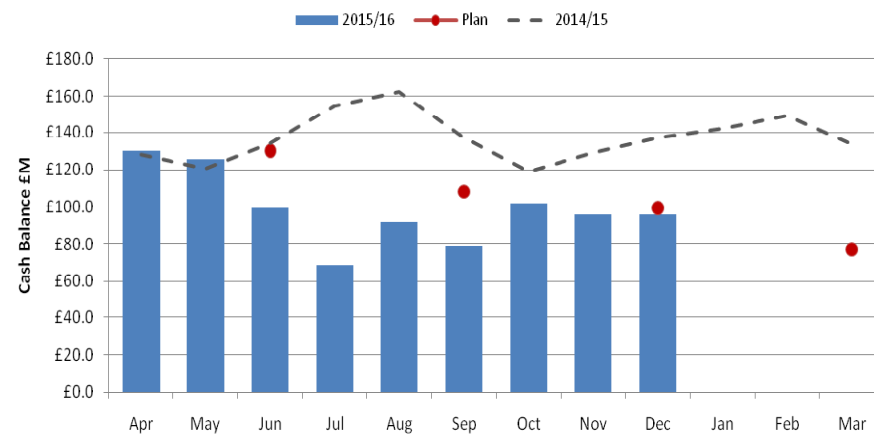
Overall Underlying Financial Surplus/(Deficit)



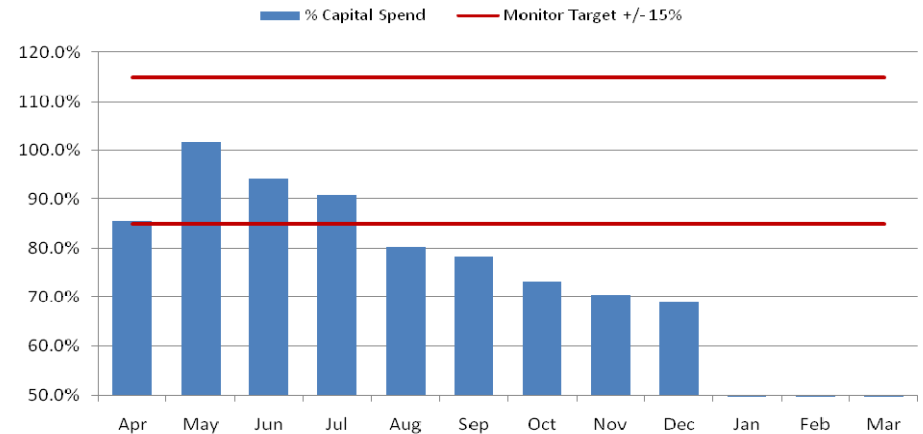
YTD Trust CIP Performance



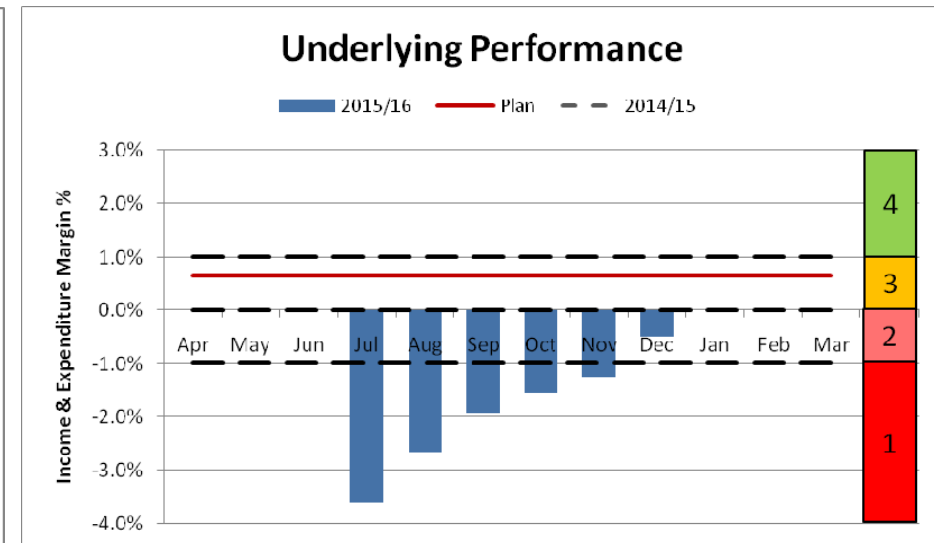
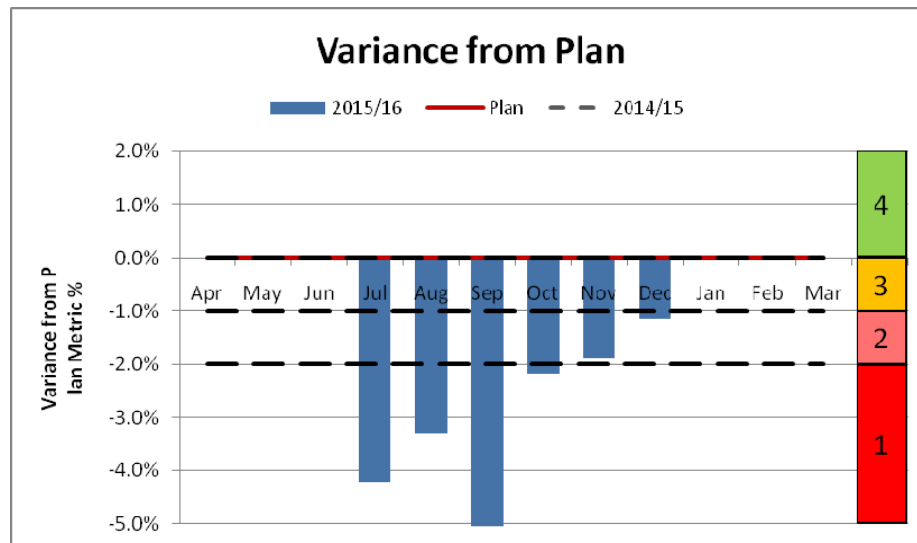
Cash - Actual Cash vs Plan and Prior Year (£m)



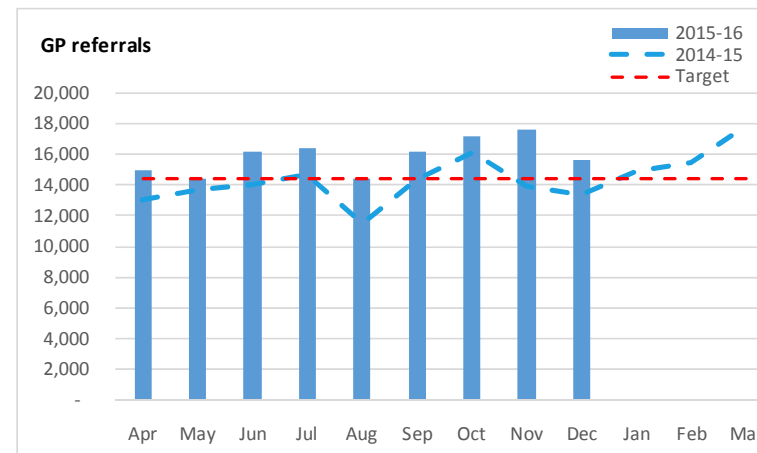
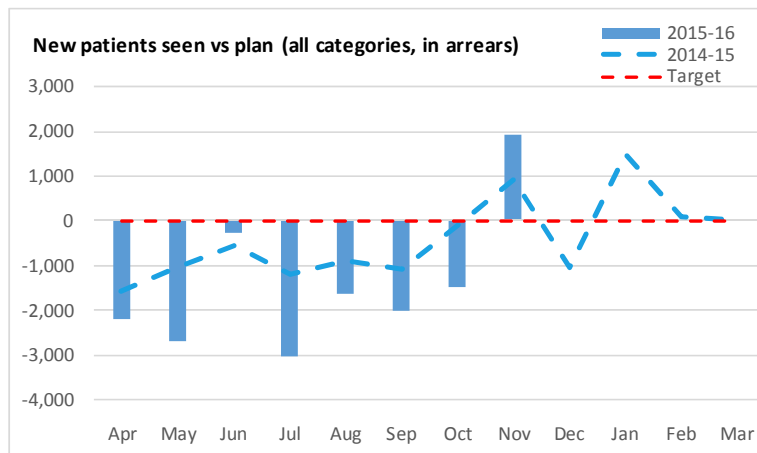
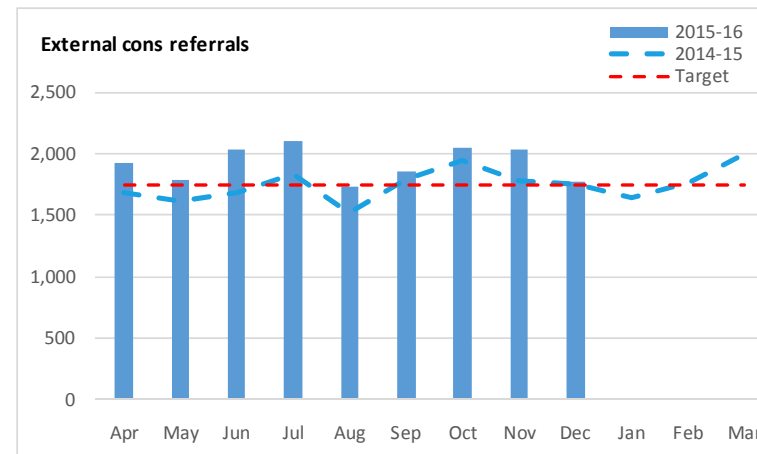
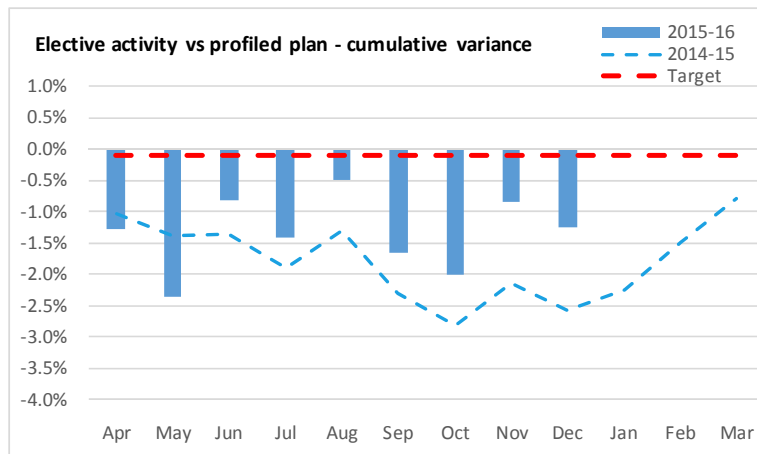
YTD Capital Spend % of Plan



A loss of £16.0M has been recorded at Dec, which is £1.7M behind plan; CIPs (Cost Improvement Programmes) of £35.6M have been confirmed, but are £17.7M less than plan which has been mitigated by income performance; the cash position at £96M is below the plan of £99.3M. Capital expenditure as a percentage of plan has fallen below the Monitor threshold of 85% (to 69%). A reforecast of the Capital plan may need to be considered having breached the threshold.

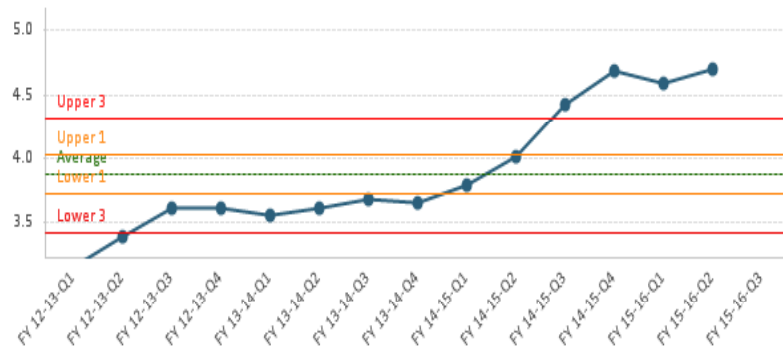


- We have improved on the cumulative variance against plan for both elective admissions and outpatients with the volume of patients being treated has increased significantly compared to last year.
- Demand – as measured in referral volumes – has risen during Quarter 3. This increases the level of concern around our ability to provide enough capacity to meet this further growth. The December drop in demand is linked to the Christmas period and was expected.
- Directorates have reviewed their activity plans to address any shortfalls. Extended working patterns in theatres and additional outpatient clinics are the main measures being adopted to increase the volume of patients treated. This continued to be high as expected during December and is expected to continue through into Quarter 4.

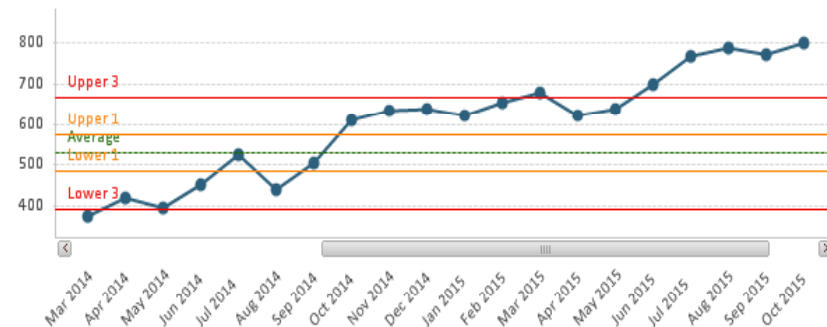


- Accurate and complete clinical coding of our activity is important to ensure patient safety, accurate benchmarking and appropriate payment for the services we provide. Improving the quality of all our data ensures that the information on which we base decisions is reliable.
- Diagnostic depth - the average number of diagnoses recorded per admitted episode - increased markedly during 2014-15 (top left) and we have re-set targets for further improvements in 2015-16. Capture of smoking status is being used as a lead indicator for how well we are capturing co-morbidities, especially by non-medical staff (top right). This showed a material improvement from September of last year and we are expecting to see further improvements as a result of more structured capture of patients' underlying medical conditions within E-noting.
- NHS number coverage (bottom right) in December was 97.3% close to the target level of 98% overall. Particular measures are in place to try to improve capture of accurate demographic information amongst patients attending our A&E departments.
- Within the community setting, the capture of outcomes from patient contacts is our key indicator. For December, performance improved slightly (bottom left). The drop is linked to the transfer of information from Rio which was the old community IT system to Advanced Care Notes towards the end of November.

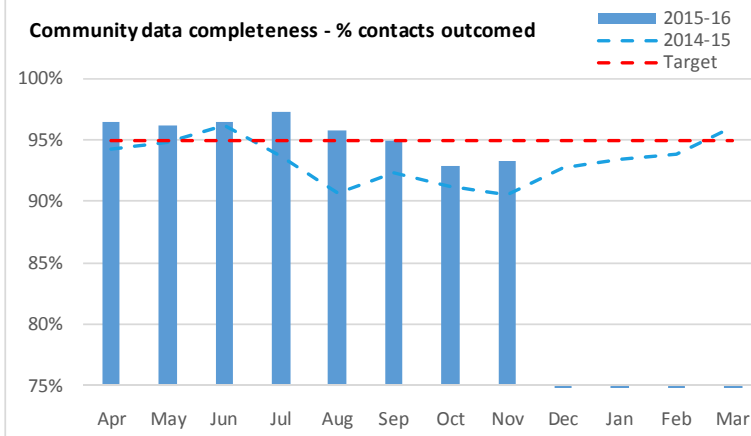
Diagnosis Depth by Quarter - SPC



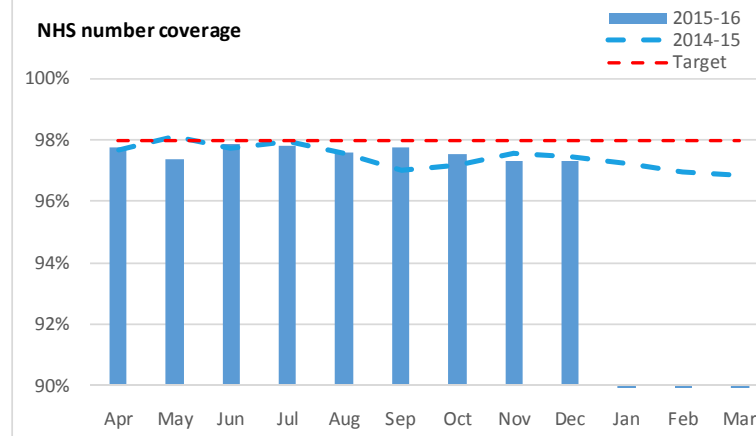
Number of Spells by Month - SPC



Community data completeness - % contacts outcomed



NHS number coverage





### Summary:

- Cleanliness scores continue to track above the performance targets, both as measured in the monthly Inpatient survey and in the internal audit against NPSA standards. The Trust has received the 2015 PLACE results and scored above the national average for Cleanliness. The Trust's scores were the highest across the entire London Commissioning Group for NHS Hospitals, (excluding private and independent facilities).
- The Trust uses "Meridian" which is an online programme to monitor performance. In December there were 1366 Surveys completed
- Credits for Cleaning is a programme that is used by the auditors to measure cleanliness against the NPSA Trust compliant risk score.

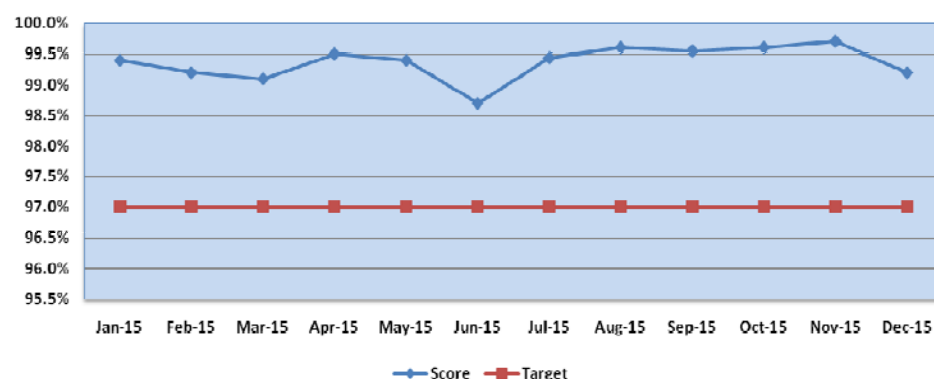
### Action and Progress to Date:

- Cleanliness scores are tracking consistently above the target thresholds, both as measured by the Meridian Inpatient survey and through the internal auditing of cleanliness standards.
- The NPSA target score is an aggregated score which is derived from the weighted profile of the clinical functional area risk categories across the Trust.
- The Trust has scored strongly for cleanliness as reflected in the National Inpatient Survey 2014, as published by the Care Quality Commission (CQC). The Trust's aggregate score and that for rooms/wards exceed those of other London Trusts.

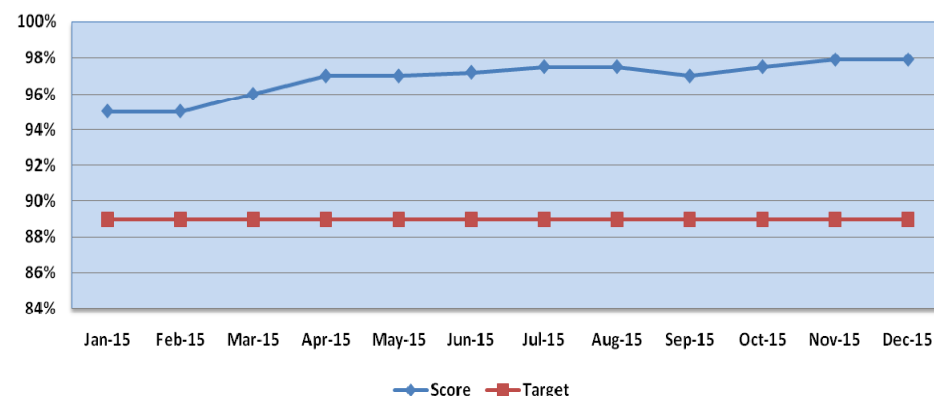
### Cleanliness Scores compared with other London Trusts

Trust	Rooms / Wards	Toilets / Bathrooms	Total
GSTT	9.1	8.3	17.4
Imperial	8.7	8.2	16.9
Kings	8.7	8.4	17.1
UCLH	8.8	8.1	16.9
Chelsea and Westminster	8.6	8.1	16.7
Royal Free	8.8	8.3	17.1
Barts	8.5	7.9	16.4
St Georges	8.5	7.9	16.4

### Meridian On-Line Inpatient Survey - Ward Cleanliness



### Credits for Cleaning NPSA Trust Risk Profile

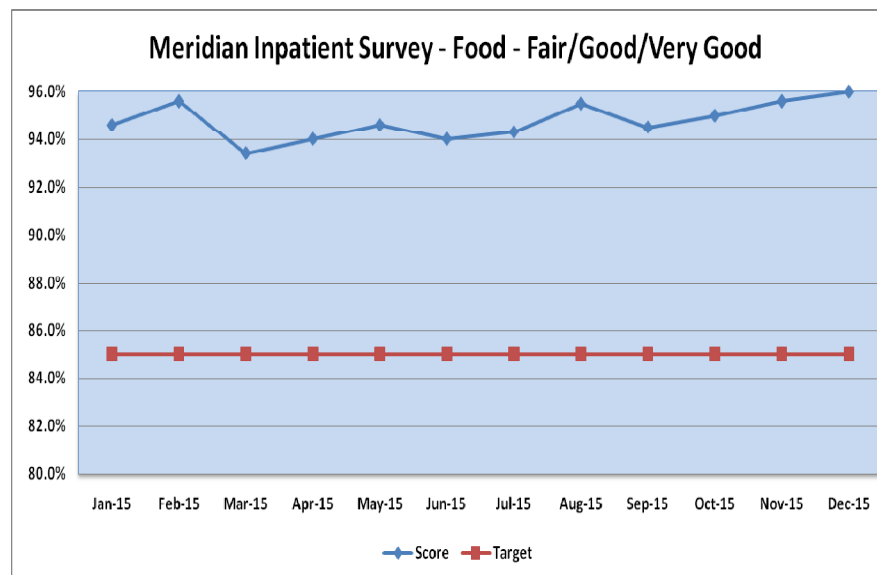


## Summary:

- The Meridian survey of inpatients' assessments of catering services demonstrates a performance consistently above the locally set target of 85%.
- The Trust has scored strongly for catering as reflected in the National Inpatient Survey 2014, as published by the Care Quality Commission (CQC).

## Action and Progress to Date:

- In-patient catering feedback as measured by the Meridian survey remains above the target of 85% with 1342 surveys completed in December 2015. The Trust has received the 2015 PLACE results and scored 92.61% for food and hydration, the second highest among London Commissioning Group for NHS Hospitals.
- Surveys are undertaken monthly through Meridian (survey & free text), Hospedia (poll, survey & free text), in house surveys carried out by supervisors and feedback from clinical meetings such as EWP (Excellent Ward Project), Nutritional Steering Group & Management ward visits.
- The Catering team is fully engaged in supporting the Trust's Food and Nutrition Strategy and is working towards a 'Bronze' Food For Life Catering Mark award. This award is closely linked with the Government Buying Standards for Catering which focuses on compliance & national standards for food & nutrition for health & well being delivered to patients, staff & visitors. It focuses on sustainability, ensuring farm assured meats are used, local produce, carbon footprints measured and raw energy efficiency.

Catering Services Scores compared with other London Trusts

Trust	Quality	Choice	Help	Total
GSTT	5.6	8.9	7.4	21.9
Imperial	5.4	8.6	6.1	20.1
UCLH	5.1	9	6.5	20.6
Kings	5.4	8.5	6.7	20.6
Barts	4.7	8	6.3	19
Royal Free	5.3	8.8	7.4	21.5
Chelsea and Westminster	5.4	8.5	7.6	21.5
St Georges	5.6	8.4	6.8	20.8

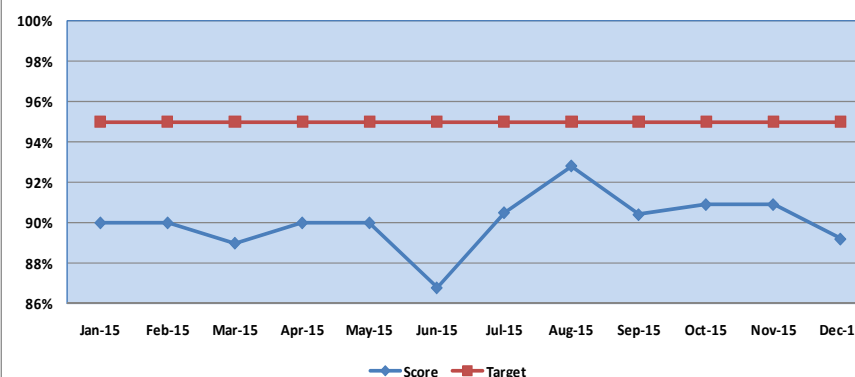
### Summary:

- The new patient transport contract commenced on the 1st December 2015. The new service is delivered by three providers: Savoy Ventures (75%), Essentia in-house (20%) and Private Ambulance Service (5%).
- The new contract contains enhanced service standards which will be developed over the initial three month mobilisation period. In the meantime, performance will continue to be reported against the pre-contract KPI's in order to assess the stability of the service throughout this phase.
- The principal KPIs in the new contract are:
  - 95% of patients should arrive no earlier than 45 minutes before their appointment and no later than 15 minutes before.
  - 95% of patients should depart within 30 minutes of reporting ready to travel.

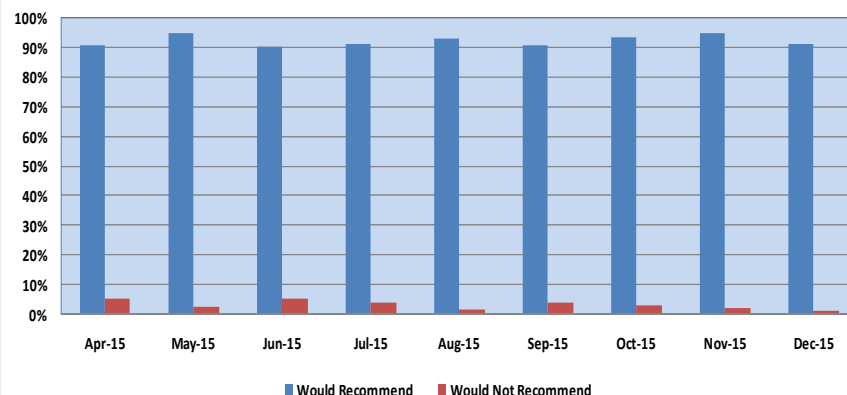
### Action and Progress to Date:

- There have been operational challenges in the first month of the new service but these are being resolved. The main issue concerned availability of driver and vehicle resource from the main provider but this has been addressed.
- The Friends and Family score (see graph below) reflects a slight decrease in performance, almost certainly as a result of the major service transition. The Trust has retained operational capability and has been able to intervene as issues have arisen.
- There have been operational issues in the four renal units where the service transferred to the new transport provider. These have been addressed.
- Essentia is working closely with the contractors to drive performance towards the new contract KPI's. Regular operational and performance meetings are held, where the focus is on service improvement and delivery of the enhanced performance standards.

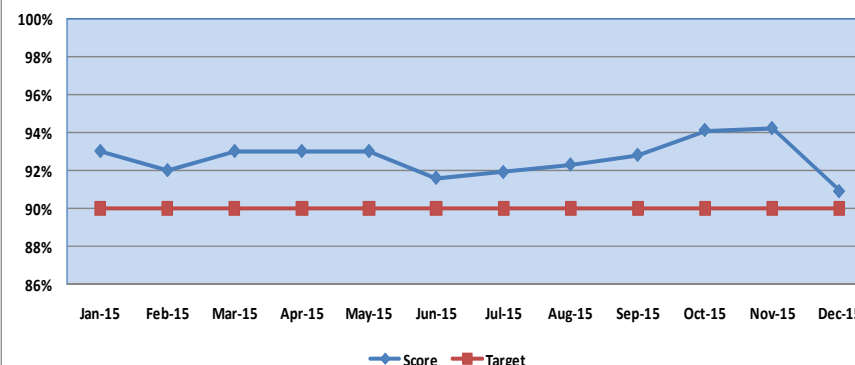
Patient Transport - Patients arriving within 90 minutes prior to appointment



Patient Transport - Friends and Family



Patient Transport - Patients picked up within 90 minutes of reporting 'ready to travel'



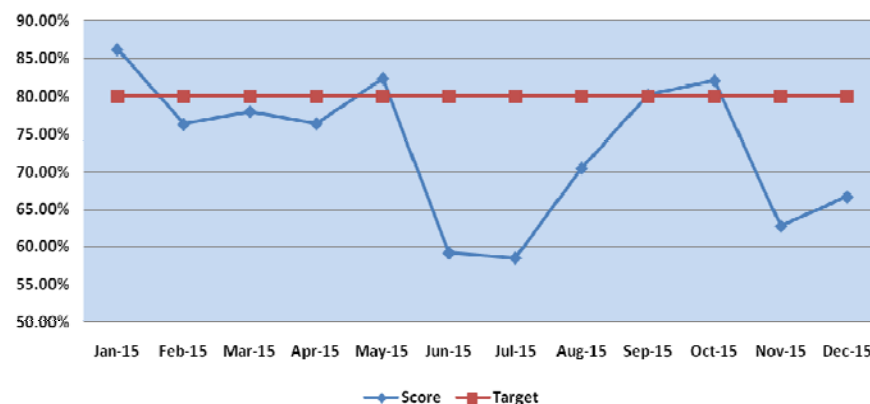
## Summary:

- Pick up of internal (23,304) and external (59,052) calls both deteriorated against their respective targets for December. The percentage of calls answered within 30 seconds increased slightly against target this month, although still remains in red RAG status.

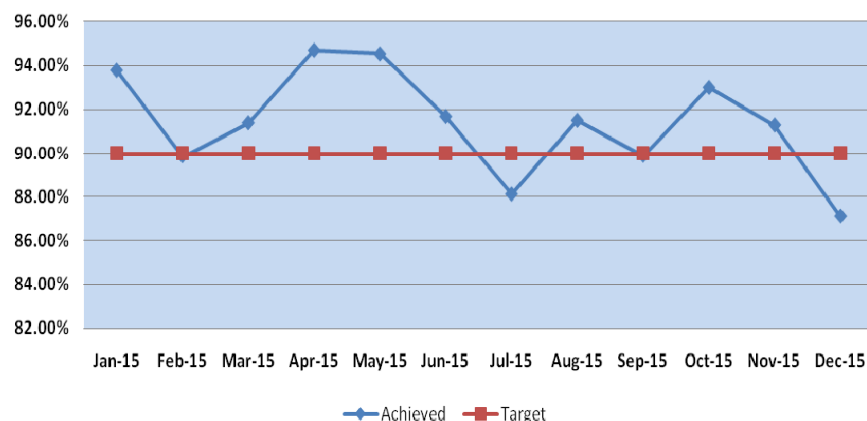
## Action and Progress to Date:

- The main driver for below target performance is due to staff shortages. Currently the Customer Services department have 12 WTE vacancies, with 3 staff on maternity leave and 3 staff on long term sickness absence.
- Temporary staff coverage via the Bank is being used to mitigate the staff issues currently being faced.
- Interviews for vacant posts are due to take place in January, however it is expected that figures will maintain a downward trend as January is historically the busiest month of the year.
- A further four members of staff are being recruited, subject to Operations Board approval, which is to be funded by Cancer Services to manage the CNS helpline.

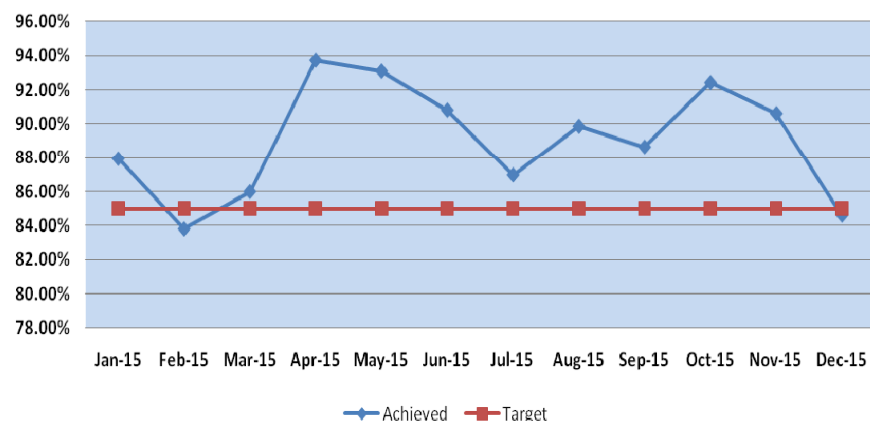
% of Calls Answered Within 30 Seconds



GSTT External Calls - % Achieved



GSTT Internal Calls - % Achieved



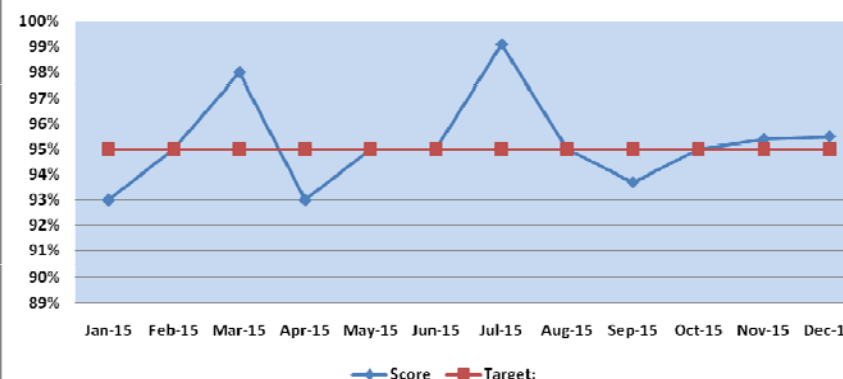
## Summary:

- Following the proven investment in an enhanced out of hours maintenance regime, lift availability performance is running at approximately 95% each month. This is across the 2 acute sites and measures the up time in hours (excluding scheduled lift maintenance).
- Priority 2 calls (responded to within 4 hours) have achieved and exceeded the target set out in the Service Level Agreement during the past seven months. The target is purely measuring the time it takes to respond to the calls, as resolution may require out of hours work procuring of additional parts etc.
- Priority 1 calls are rare and infrequent therefore they are not graphed.

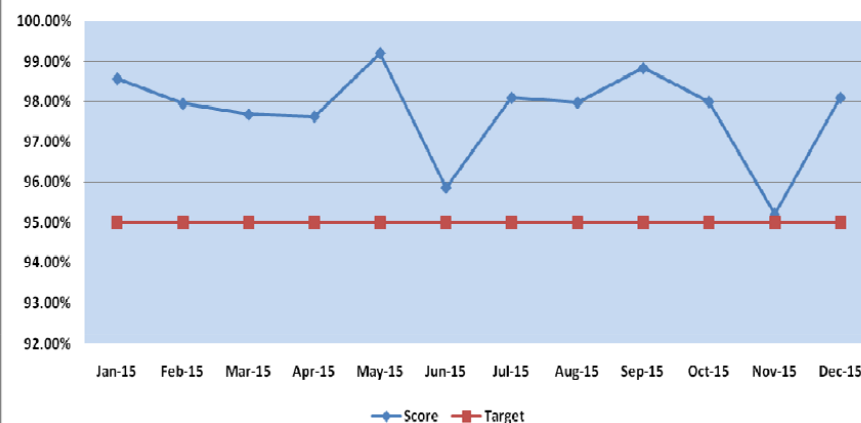
## Action and Progress to Date:

- Capital Backlog Maintenance investment is being targeted at key elements of the lift infrastructure, where the age of the systems is an issue.
- The Building & Engineering team remains challenged by the 70% monthly target for Priority 2 calls within 4 hours. Deployment of PDAs to front line teams is complete and this is improving productivity and work monitoring. In the medium term, the Essentia COO is undertaking a wider review of the team's workload.

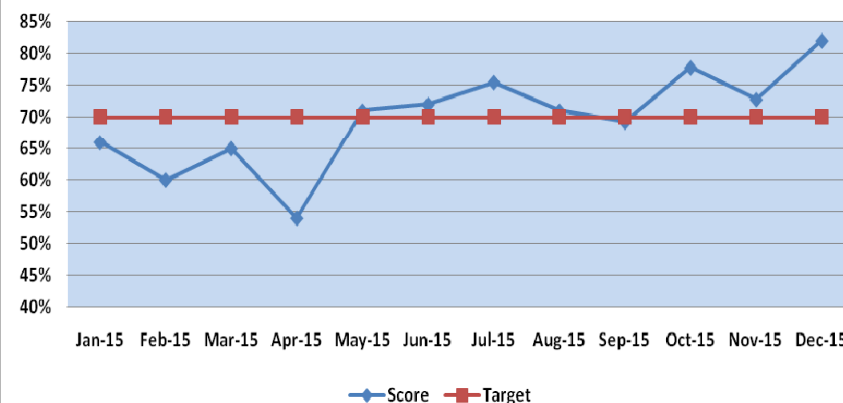
Guy's &amp; St Thomas' - Lift Performance



Essentia Facilities Service Desk - % Calls Answered



Building &amp; Engineering - Priority 2 Calls



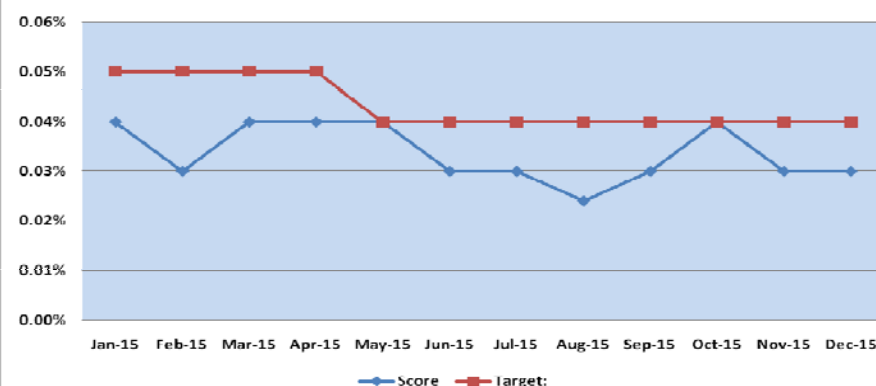
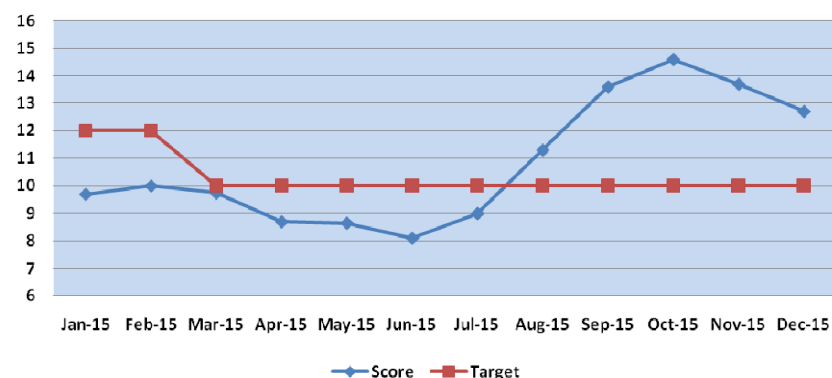
## Summary:

- With the exception of one of the last 12 months, Sterile Services has met its challenging non-conformances targets. The threshold was reset by the SSD team and made more challenging in May.
- A bid has been submitted to North Middlesex University Hospital NHS Trust to provide decontamination services in order to secure additional income and generate return on the investment made in sterile services. The results have been received and Essentia's bid was successful.

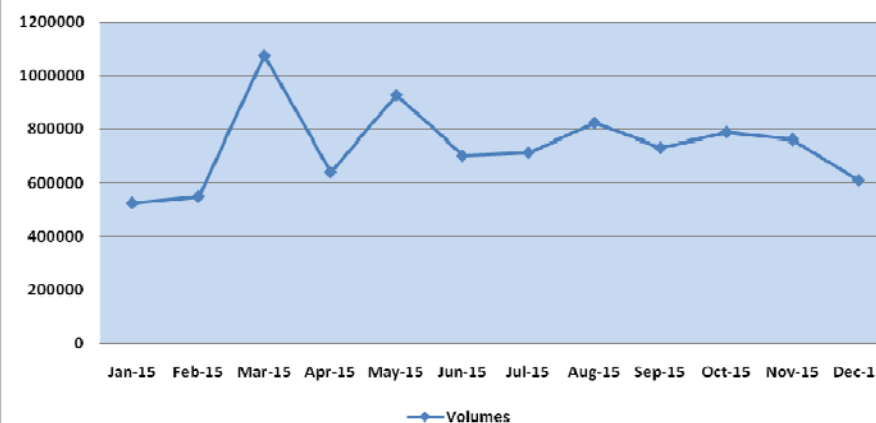
## Action and Progress to Date:

- The Sterile Services KPI target for average instrument processing turnaround time has been reduced from <12 hours to <10 hours due to consistently achieving below the target. This reflects the greater efficiency at which the unit is operating, which in turn is the result of continual overview of production processes and individual performance. Sterile Services expect to move towards <8 hours average over the next six months despite an upturn during the holiday period.
- Performance levels of individuals will be challenged in the next two months, in particular through-put speeds, in a effort to reduce the average processing time back to its target.

Sterile Services - Non Conformities

Sterile Services - Average Instrument Processing  
Turnaround Time

Sterile Services - Instrument Volumes



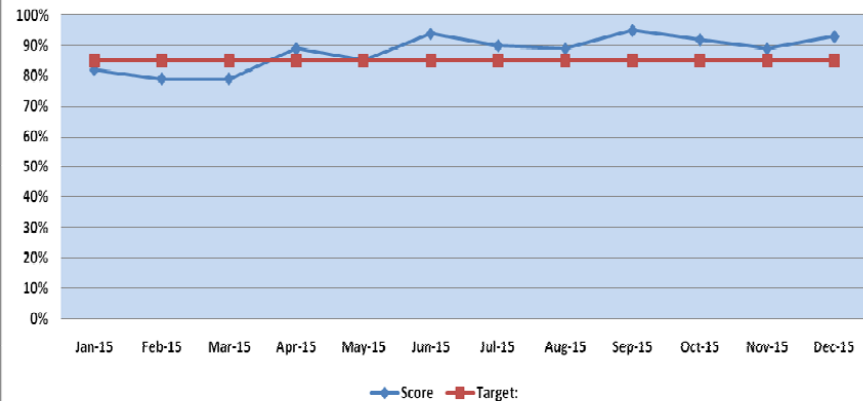
### Summary:

- The agreed service level for customer satisfaction (85%) was exceeded for last six months (82 responses received in December).
- Incidents resolved within target are also being consistently achieved.

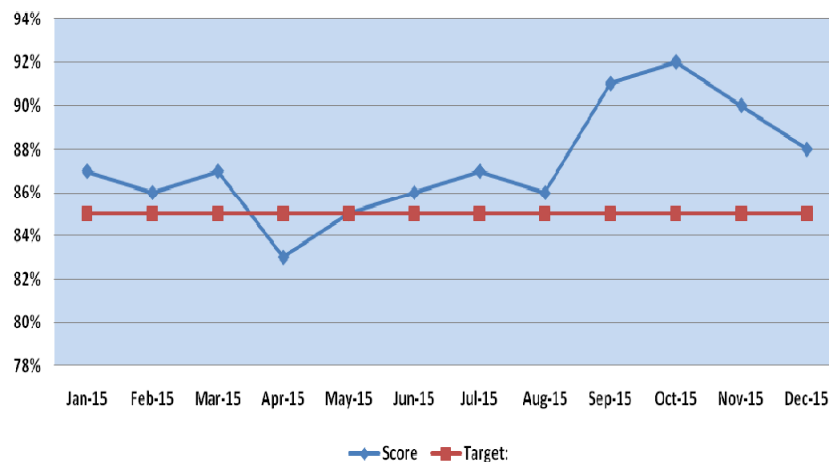
### Action and Progress to Date:

- The average time to answer calls by the IT Service Desk increased in performance to 53 seconds against a target of 60 seconds in December, compared to 158 seconds reported in November.
- There was one serious incident in December relating to the failure of the Biztalk backups.
- IT Service availability was generally good for key IT services achieving the target of 99.9% uptime, with five applications experiencing partial unavailability for short periods.

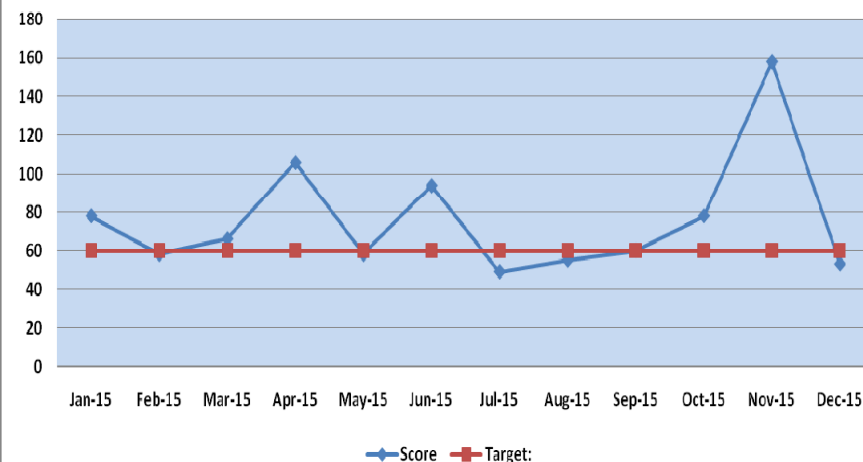
IT - User Satisfaction



IT - Incidents Resolved Within Target



IT - Service Desk Avg. Call Answer Time (Seconds)



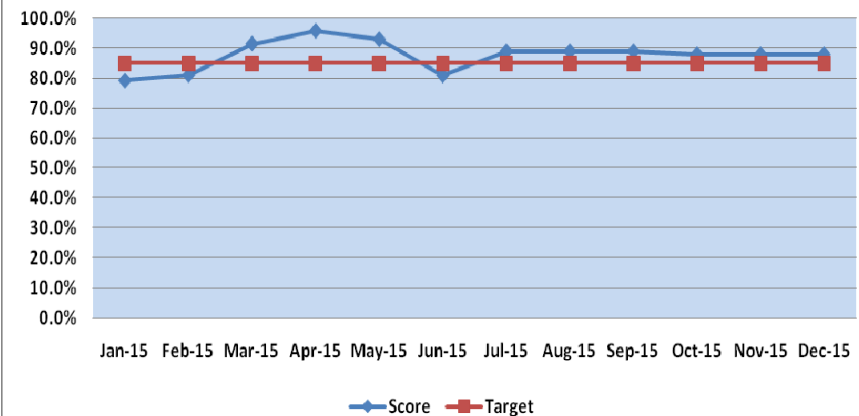
### Summary:

- Community Reactive Maintenance and PPM Tasks are consistently achieving and exceeding their targets.
- Community cleanliness scores consistently score above the 95% target.

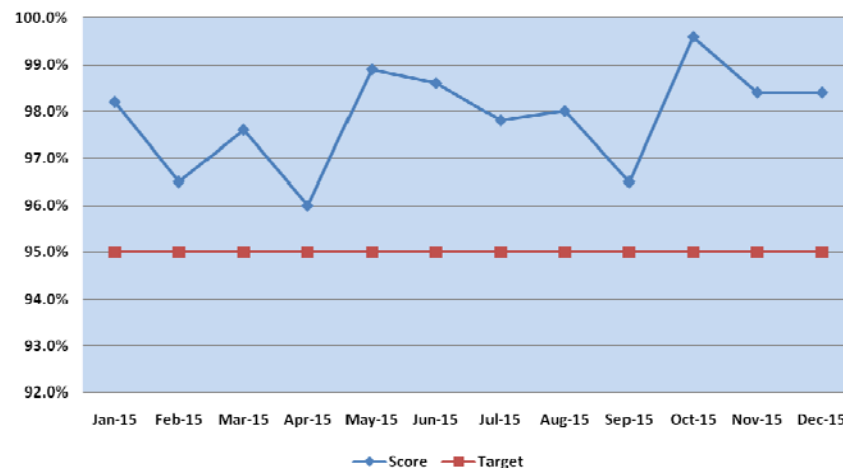
### Action and Progress to Date:

- The performance target for PPM Tasks Completed was not met in the period of January and February due to a staff absence issue. The issue of staff shortages affected the statistics for June.
- For Reactive Maintenance, the performance against the target has on the whole improved in the last 10 months.
- Community cleaning scores continue to meet the target of >95%.

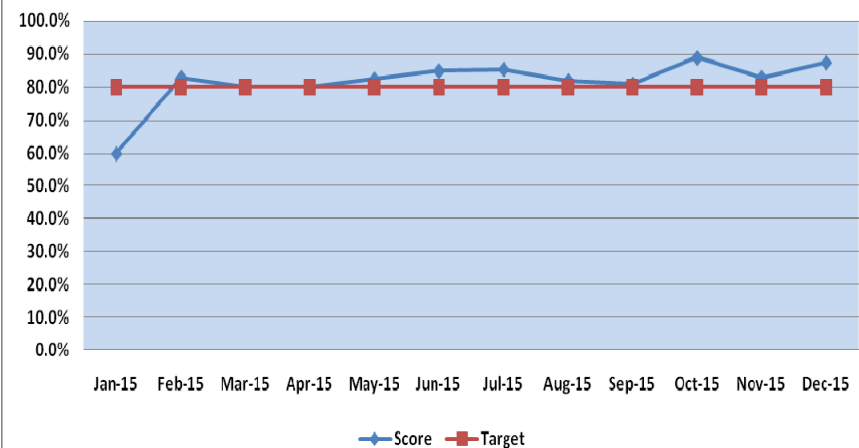
### Community - PPM Tasks Completed



### Community - Cleaning Scores



### Community - Reactive Maintenance





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				Trust-wide	Acute Medicine	Perioperative, Critical Care & Pain	Surgery	Cardiovascular Services	Abdominal Medicine and Surgery	Oncology And Haematology	Women's Services	Clinical Imaging & Medical Physics	Medical Specialities	Dental Services	GRIDA	Therapies	Adult Community Services	Children's Community Services	Children's Medical Services	Children's Surgical Services	Monitor	COUIN	Fit for future workstream	Quality priorities	
Domain		Type	Target																						
Safe	Patient safety - Incident Reporting	Total incidents reported	Number	-	1,954	357	229	56	98	151	220	205	38	25	25	29	14	121	21	222	0				
		Total incidents reported on STEIS	Number	-	5	0	1	0	0	1	2	0	0	0	0	0	0	0	0	0	0	0			
		Total incidents reported on STEIS - not attributable to Trust	Number	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
		Never Events	Number	Zero	3	0	1	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0			
		Incidents resulting in unexpected death	Number	-	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0			
		Incidents resulting in severe harm	Number	-	2	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0			
		Incidents resulting in moderate harm	Number	-	18	1	3	2	0	1	2	1	3	0	0	0	0	0	3	0	1	0			
		Incidents resulting in low harm	Number	-	332	54	46	9	18	21	26	72	7	3	0	3	2	26	4	41	0				
		Incidents resulting in no harm	Number	-	1,249	261	146	35	69	113	176	104	18	19	13	17	6	63	8	140	0				
		Incidents resulting in unexpected death - reportable on STEIS	Number	-	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
		Incidents resulting in severe harm - reportable on STEIS	Number	-	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0			
		Incidents resulting in moderate harm - reportable on STEIS	Number	-	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
		Incidents resulting in low harm - reportable on STEIS	Number	-	2	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0			
		Incidents resulting in no harm - reportable on STEIS	Number	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
	Patient safety Harm Free Care	Never events (confirmed)	Cases	Zero	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			
		Patient slips trips falls (DATIX)	Cases	-	141.0	58.0	5.0	10.0	23.0	10.0	10.0	0.0	2.0	0.0	0.0	0.0	1.0	0.0	0.0	1.0	0.0				
		Incidence of falls per 1000 bed days	Number	-	4.8	8.4	4.4	5.8	5.4	2.2	3.1	0.0	76.9	0.0	0.0	0.0	-	-	0.0	-	0.4	0.0			
		Falls with moderate or severe harm	Cases	0	2.0	1.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			
	Infection Control and Cleanliness	Pressure ulcer acquisitions (grade 2 and above)	Number	0	3.0	0.0	0.0	1.0	1.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			
		MRSA screening of admissions	Mthly %	>95%	92%	62%	93%	97%	93%	99%	97%	96%	100%	90%	100%	100%	-	-	-	100%	95%				
		MRSA bacteraemia (Trust-attributable)	Number	Zero	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			
		C-Diff acquisitions	Number	0	1.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			
	Screening	VTE screening (externally reported)	Mthly %	>95%	97%	95%	100%	91%	90%	98%	97%	94%	97%	100%	100%	99%	-	-	100%	-	90%	79%			
		Dementia screening (patients aged over 75)	Mthly %	>90%	93%	97%	-	62%	100%	79%	78%	-	-	100%	100%	-	-	-	-	100%	-				
Mortality	Deaths in hospital - number in month	Number	-	102.0	46.0	5.0	2.0	17.0	9.0	10.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	10.0	3.0					
Caring	Admitted care	Friends and Family test (Ward) - Response rate	Mthly %	>=33%	28%	36%	17%	47%	21%	33%	25%	15%	-	-	-	-	-	38%	-	29%	-				
		Friends and Family test - % Recommended (Ward)	Mthly %	>=97%	96%	97%	100%	96%	96%	96%	100%	92%	-	-	-	-	-	100%	-	97%	-				
		Friends and Family test - % Not Recommended (Ward)	Mthly %	<=1%	2%	1%	0%	0%	2%	1%	0%	4%	-	-	-	-	-	0%	-	2%	-				
		Overall inpatient patient experience score	Mthly %	>89%	90%	92%	85%	90%	89%	90%	91%	85%	-	98%	-	87%	-	-	-	-	-				
		Single sex compliance - breaches (all types)	Cases	Zero	10.0	0.0	6.0	0.0	4.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			
		Patients cancelled on day (in arrears)	Cum %	<0.8%	1.4%	-	0.5%	0.9%	7.2%	1.4%	1.8%	1.1%	-	0.7%	0.2%	-	-	-	-	-	0.7%	2.0%			
	Outpatient care	Overall outpatient patient experience score	Mthly %	>89%	89%	91%	93%	86%	89%	86%	75%	89%	-	88%	93%	89%	94%	-	-	83%	-				
		Friends and Family test - % Recommended (Outpatients)	Mthly %	-	92%	89%	85%	87%	93%	92%	89%	91%	100%	91%	94%	91%	95%	-	-	88%	100%				
		Friends and Family test - % Not Recommended (Outpatients)	Mthly %	-	4%	4%	12%	6%	2%	2%	6%	4%	0%	5%	4%	3%	3%	-	-	4%	0%				

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