

Integrated Quality and Performance Report



November 2015

In this month (page 5)

November 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. We had another never event reported in November, when pain relief was administered by IV when it was intended for epidural administration: this led to an authorised change to the size of luer-lock fittings on connecting tubes to reduce the risk of mis-connections.

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 a number of areas, although recommend and not recommend scores are improving. Response rates remain challenging for A&E and some newer 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 will have contacted other Trusts with higher response rates in the new areas of care and we will be discussing these findings with teams and implement learning from other Trust's 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 November; 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 which have a DTOC status. We continue to work hard to improve the timeliness of treatment for patients on a cancer pathway. We achieved the two-week standard in November, but continue to hold ourselves to account so that we can offer patients appointments within 7 days. We are now seeing the effect of the reduction in our Robotic surgical waiting list in Urology with patients being offered dates before they breach the target. We continue 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. Over 92% of patients are currently waiting less than 18 weeks for treatment, but we are still focused on reducing longer waits in several key specialties through increased activity and improved accuracy on our pathways. Our diagnostic performance is still significantly better than this point last year however we remain just outside the target of 1%.

Are we well-led? (pages 54-57)

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 November and with reminders to staff and management teams this is expected to improve again.

How effective are our enabling services? (pages 58-72)

The Trust has recorded a loss of £19.6M to the end of November, an adverse variance to plan of £6.9M. This is in the main driven by the level of unidentified savings, coupled with reduced income for specialised services. 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

November 2015

Page 3

Domain	Ref	Theme	Page	Management priority (last month)	Management priority (this month)	Forecast status	Briefings
1 Safe	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	On track	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)
2 Effective	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	
3 Caring	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	Stable	
	3.4	Outpatient Experience	32	On track	Minor	Improving	
	3.5	General patient and carers' experience (inc involvement in care and treatment)	33	Minor	Moderate	Improving	
4 Responsive	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	Stable	Referral to Treatment waits
	4.3	Cancer access	38	Significant	Significant	Improving	Cancer Waits
	4.4	Diagnostic access	39	Significant	Significant	Stable	
	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	
5 Well-led	5.1	External assessments	51	Significant	Moderate	At risk	
	5.2	Staff experience (inc open and honest reporting)	52	Excellent	Excellent	Stable	
	5.3	Workforce indicators	53	Minor	Minor	Improving	
6 Enablers	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.

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

November	Compared to last year	
	Same month	Year so far

We received...

Referrals from GP's

17,194

23.3%

13.6%

Urgent cancer referrals

1,100

12.7%

14.2%

Referrals to @Home and ERR

303

-6.8%

50.4%

We treated...

A&E attendances

15,002

4.3%

1.5%

Non-elective admissions

3,472

-1.8%

2.9%

Outpatient attendances

93,032

12.8%

7.7%

Day cases

5,456

16.5%

12.3%

Elective inpatients

2,454

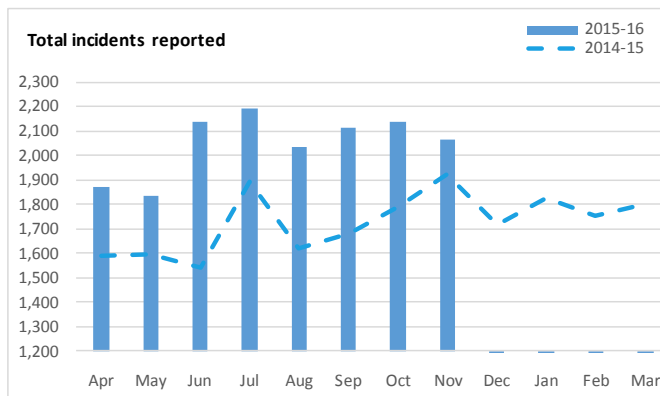
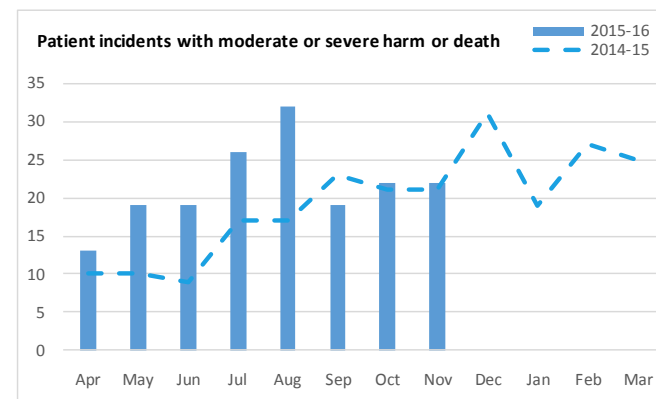
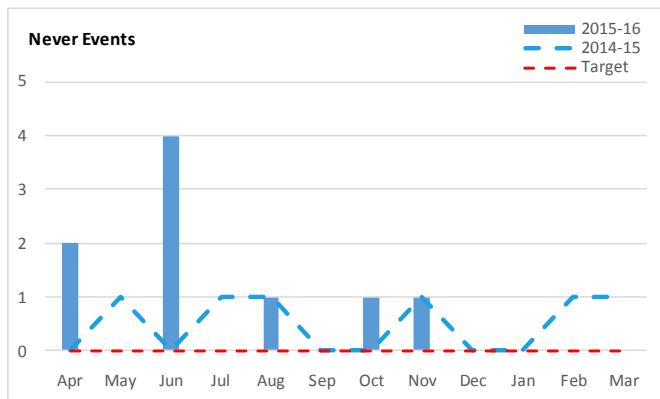
5.8%

4.6%

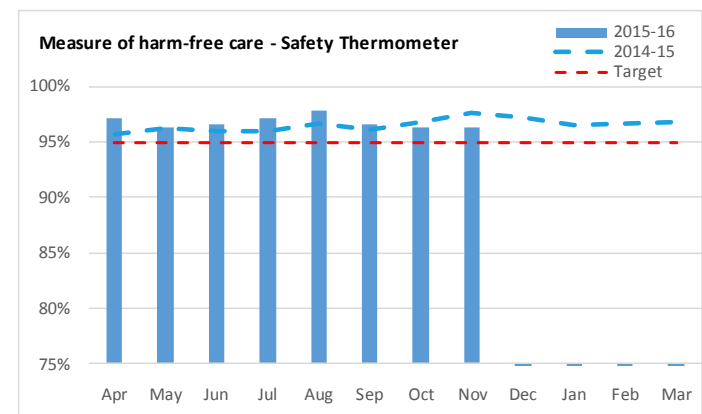
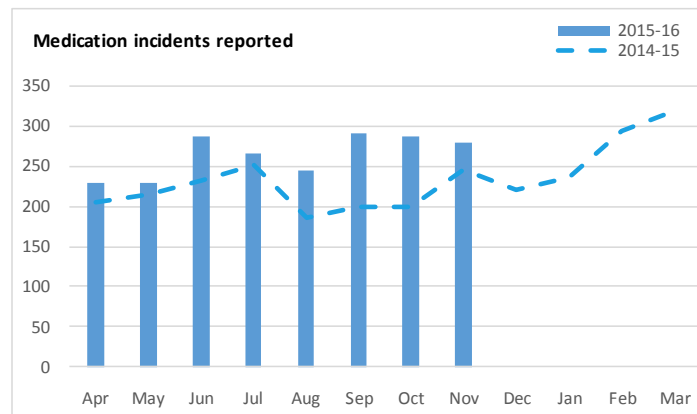
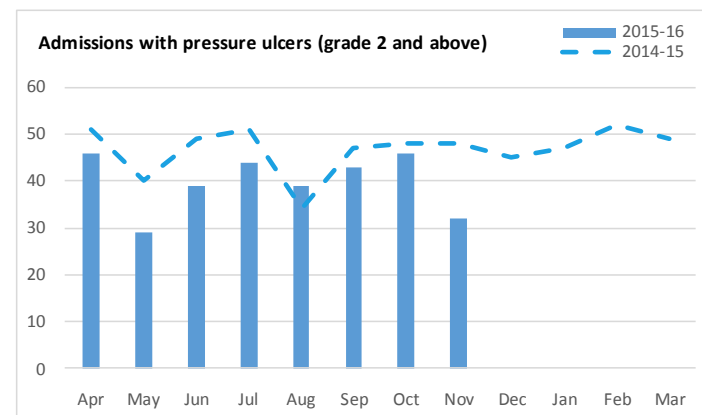
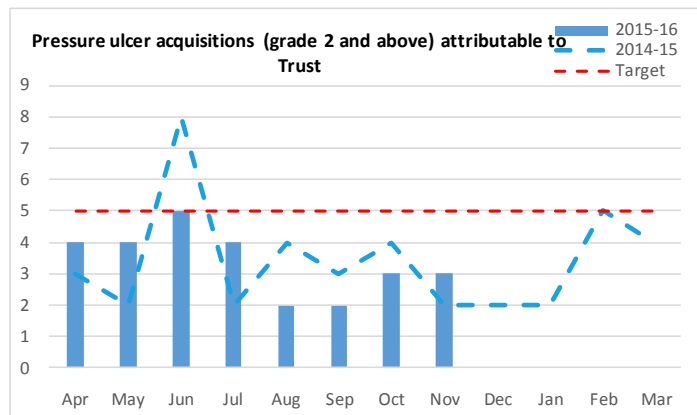
Theme	Ref	Indicator	Units	Target	R	G	Prior year	Sep	Oct	Nov	YTD avg	Monitor Quality priorities	Trend chart
1.1 Patient safety - incident reporting	INC 06	Total incidents reported	Number	-			1,880	2,113	2,138	2,066	2,047		Y
	INC 06S	Total incidents reported on STEIS	Number	-			11.4	6	7	2	7.3		
	INC 06ST	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	0	1	1	1.1		Y
	INC 01	Incidents resulting in unexpected death	Number	-			1.6	1	0	2	2.3		Y
	INC 02	Incidents resulting in severe harm	Number	-			2.5	3	3	1	1.9		Y
	INC 03	Incidents resulting in moderate harm	Number	-			17.2	15	19	19	17.4		Y
	INC 04	Incidents resulting in low harm	Number	-			332	341	323	304	313		
	INC 05	Incidents resulting in no harm	Number	-			1,375	1,309	1,330	1,321	1,281		
	INC 01S	Incidents resulting in unexpected death - reportable on STEIS	Number	-			0.8	0	1	1	1.9		
	INC 02S	Incidents resulting in severe harm - reportable on STEIS	Number	-			1.4	5	4	0	2.4		
	INC 03S	Incidents resulting in moderate harm - reportable on STEIS	Number	-			1.4	1	1	0	1.1		
	INC 04S	Incidents resulting in low harm - reportable on STEIS	Number	-			2.7	0	0	0	0.8		
	INC 05S	Incidents resulting in no harm - reportable on STEIS	Number	-			3.9	0	1	1	1.0		
	INC 08P	% incidents relating to patients	Mthly %	-				78.8%	78.4%	79.7%	78.9%		
1.2 Patient safety - harm-free care	Therm	Measure of harm-free care - Safety Thermometer	Mthly %	>95%			89.2%	96.6%	96.3%	96.3%	96.8%		Y
	305T	Pressure ulcer acquisitions (grade 2 and above) attributable to Trust	Number	<5			2.3	2	3	3	3.4		Y
	305TA	Admissions with pressure ulcers (grade 2 and above)	Cases	-			43	43	46	32	40		Y
	INC 22	Medication incidents reported	Number	-			234	290	286	279	264		Y
	INC 21	Patient falls with moderate or severe harm	Number	-			2.3	3	0	2	2.0		Y
	INC 20	Patient slips trips and falls	Number	-			117	134	118	147	140		Y
	313BD	Incidence of falls per 1000 bed days	Number	-			4.0	4.6	3.7	4.9	4.8		Y
	WHO	WHO surgical safety checklist	Ann %	-			85%	90%			85.5%		

Theme	Ref	Indicator	Units	Target	R	G	Prior year	Sep	Oct	Nov	YTD avg	Monitor	Quality	priorities	Trend chart
1.3 Infection control and cleanliness	324	MRSA screening of admissions	Mthly %	>95%			94%	97.6%	91.5%	92.0%	96.2%				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	0	1	0	0.3				Y
	302T	C-Diff acquisitions (Trust-attributable)	Number	<4 pm			4.2	7	3	2	4.6				Y
		Catheter attributable urinary tract infection (CAUTI)		In devt											
	AMS	Anti-microbial stewardship	Score	>85			79.4	94	90	94	92.9				Y
	NPSA	Cleanliness standards (NPSA)	Mthly %	>95%			89.5%	98.0%	98.2%	97.8%	97.5%				Y
1.4 Screening on admission	9936	VTE screening (externally reported)	Mthly %	>95%			96.0%	96.7%	96.7%	96.8%	97.1%				Y
		VTE screening within 24 hours		In devt											
	Dem75	Dementia screening (patients aged over 75)	Mthly %	>90%			-	91.8%	89.6%	86.8%	91.5%				Y
1.5 Mortality indicators	350	Deaths in hospital - number in month	Number	-			85.5	83	76	86	87.9				Y
	HSMR	Hospital standardised mortality ratio (HSMR) - most recent score	Ratio	<90			-	79.0	76.0	76.0	75.6				Y
	SHMI	Standardised healthcare mortality index (SHMI) - most recent score	Ratio	<90			-	79.0	82.7	79.0	81.3				Y
		Deaths in low risk diagnosis groups		In devt											
1.6 Safe staffing	SafeS	Safe Staffing - ratio of actual to planned hours	Mthly %	-			-	99.6%	100.7%	100.1%	100.7%				

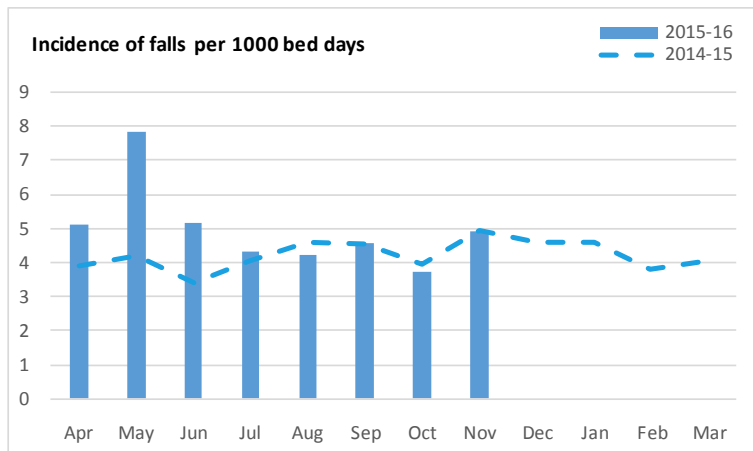
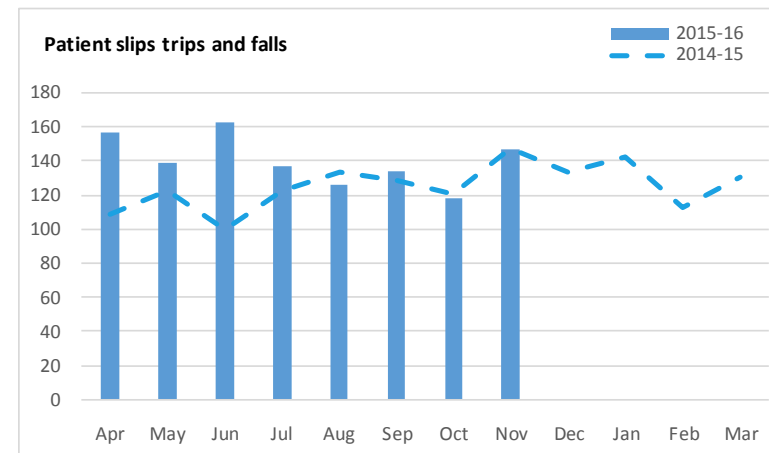
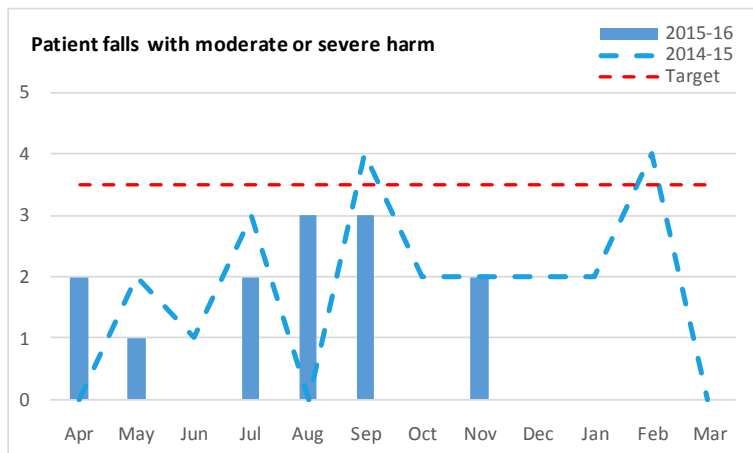
- This month's data is still under investigation; therefore the degree of harm may change. The Patient Safety Team monitor on a daily basis (Monday to Friday) all incidents reported in the previous 24 hour period to review harm reported, escalate where necessary and identify any emerging trends or hot 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; 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, where guidance or safety recommendations that provide 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 undergo robust investigation. One never event reported in November, when pain relief was administered by IV when it was intended for epidural administration: this led to an authorised change to the size of luer-lock fittings on connecting tubes to reduce the risk of misconnections.



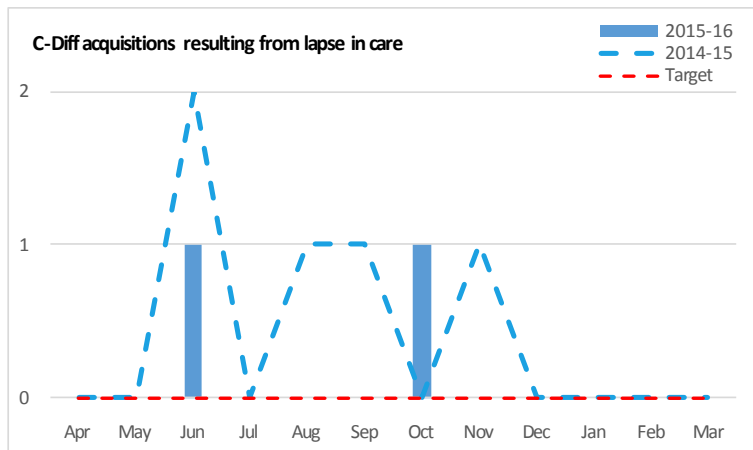
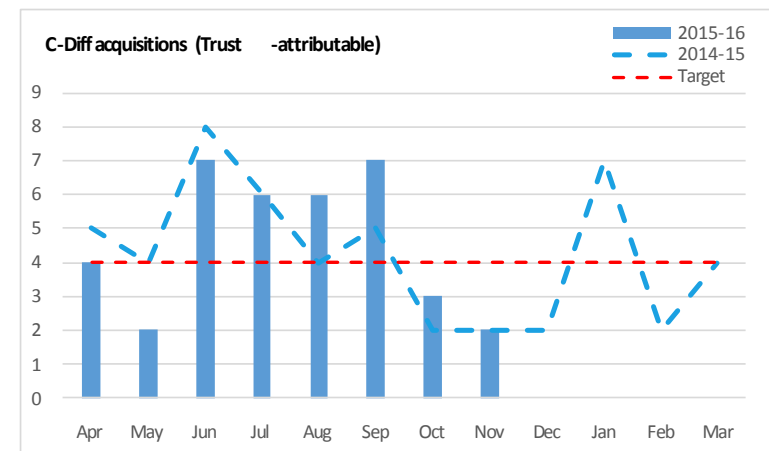
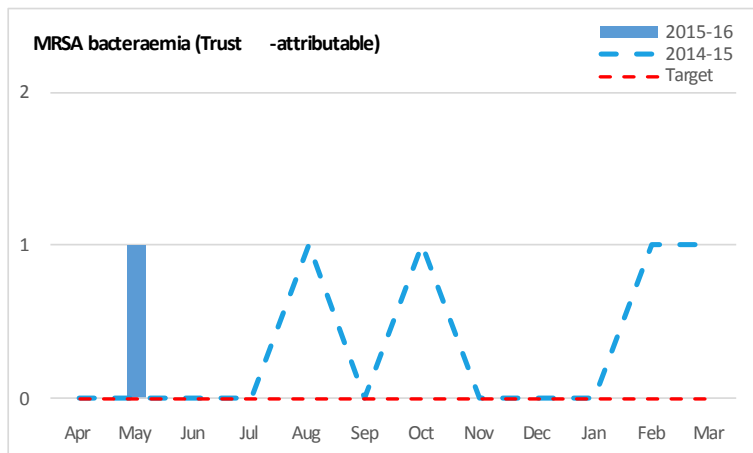
- The Trust continues to have low numbers of attributable stage 2, 3 and 4 pressure ulcers each month. Incidence remains below 1%; the 3 attributable pressure ulcers for November were all stage 2 this is the fourth month for the trust to have only stage 2 attributable pressure ulcers.
- Lessons learned for these incidents include: (i) the importance of regular risk assessment of all patients as per GSTT policy whenever and wherever and this early detection helps reduce stages of pressure ulceration and deterioration (ii) Escalation to nurse in charge and tissue viability team of all patients who are proving challenging with repositioning or contracted affecting positioning and pressure points (iii) identify gaps in knowledge and address the learning needs of staff.
- We continue to see patients admitted with pressure ulcers and this month the numbers are lower than average the cause or this is unknown. Our motto is “prevention is better than cure” and this is helping us target key areas within the community with the zero pressure campaign.
- We continue to focus on increasing the awareness of reporting of medication incidents. The majority of those incidents reported were of no or low harm.



- This month the Trust has seen an increase in the incidence of falls with 147 reported compared to 118 in October; this increase is due to an increase in in-patient falls with 104 reported this month compared to 88 last month, and an increase in non ward falls with 35 reported this month compared to 21 in October; Community falls remain comparable to last month.
- There were 92 patients that fell and 104 inpatient falls reported meaning that 12 falls involved a patient falling more than once during admission; 8 assisted falls were reported this month, which is comparable to last month.
- The directorates with the highest incidence of inpatient falls were Acute Medicine, Cardiovascular and Haematology and Oncology.
- There were 2 falls resulting in moderate harm or above this month; 1 which occurred in Acute Medicine and 1 in Abdominal Medicine & Surgery.



- The Trust has reported no attributable cases of MRSA bacteraemia in November.
- The Trust remains slightly above trajectory for the external Clostridium-difficile (C-diff) objective of no more than 51 reportable cases during 2015/16, with 37 reportable cases so far; however the improvement in our position continued in November.



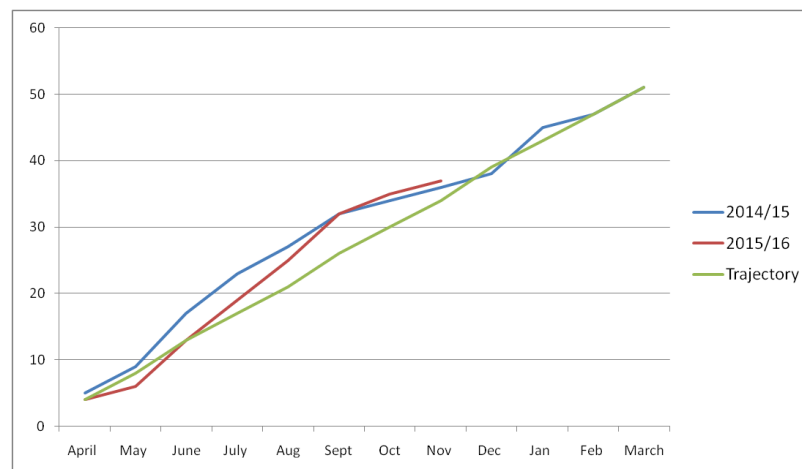
Where we want to be. Targets and benchmarks:

- ***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 November 2015 the Trust is not on target to achieve our external Cdiff objective with 37 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 November.
- We are working hard to identify any other actions we can take, but we have not identified anything else we can do at present, with the exception of stepping up our drive on antibiotic stewardship. The Antibiotic Stewardship Committee and Paul Wade (Consultant Pharmacist) have assessed the raft of recent guidance on stewardship and identified a number of additional activities, including more intense audit once the 'ABX-Alert' software is fully operational (expected January 16).
- **MRSA**
- There were no cases assigned to the Trust in November. The total for 2014/15 remains at one case (deemed to be an unavoidable contaminant) One case is awaiting final assignment following arbitration
- **Other bacteraemia**
- MSSA - To the end of November 2015 the Trust reported 51 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 146 cases, of which 28 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**

The Trust has stepped down the Ebola response on advice from Public Health England. Posters and action cards are being removed.

Actions underway

Sporadic cases of Norovirus and influenza have been noted and the Norovirus preparedness is underway

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

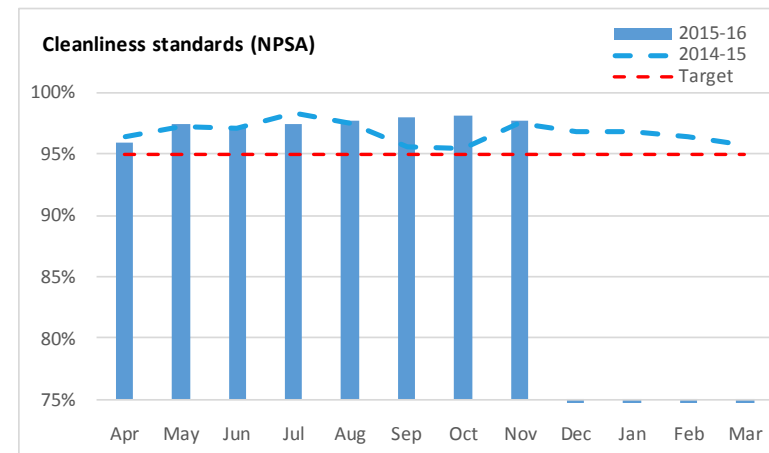
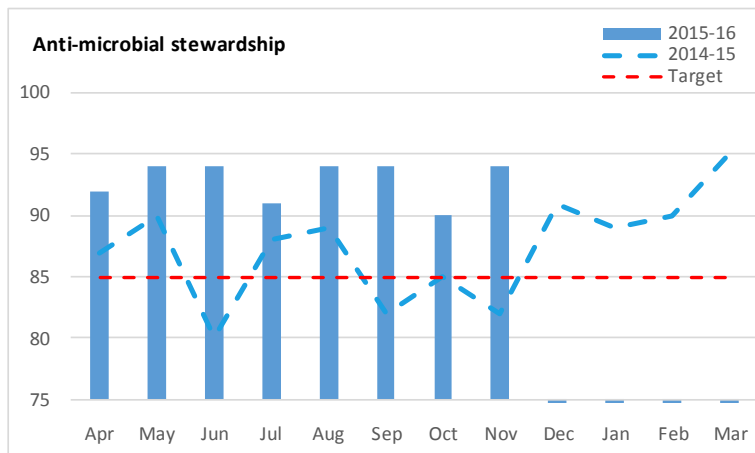
Root cause understood

Action plan set

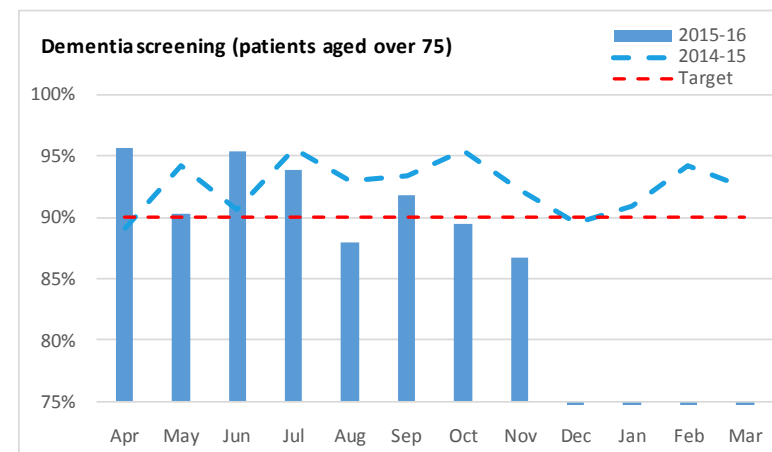
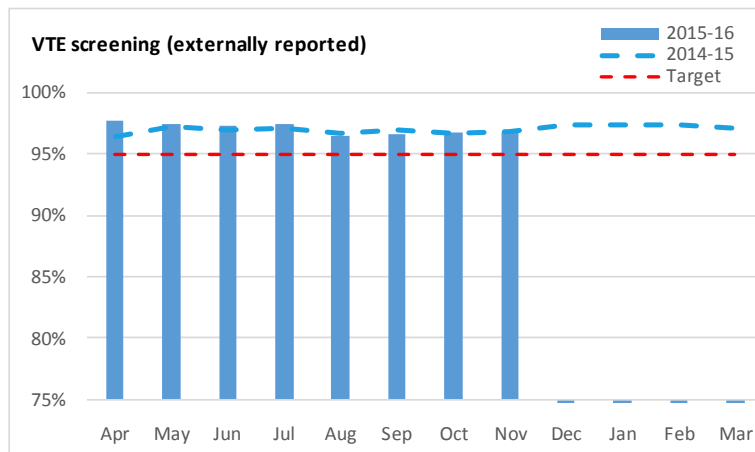
Actions underway

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.

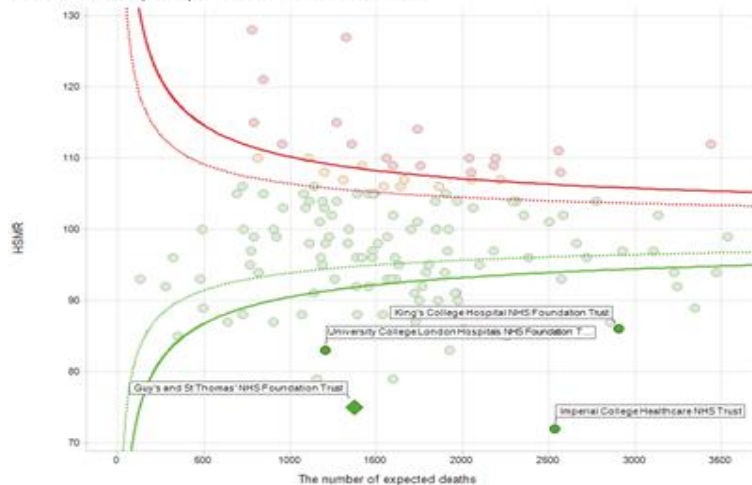


- We continue to achieve our screening target for Venous Thromboembolism (VTE), across all directorates but we are seeking to improve the percentage of inpatient and day case admissions screened in individual specialties. These include some surgical areas, particularly nurse-led day-case services.
- Dementia screening compliance is still below 90% for start of third quarter. Numbers not screened are small compared to the numbers screened but can still produce negative results.
- A review is carried out for all the breaches and 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. In addition we are still finding that staff are not updating the dementia screening section in the electronic patient record, having already used clinical e-noting. The Dementia Clinical Nurse Specialist is following this up and supporting staff to complete the screening records.

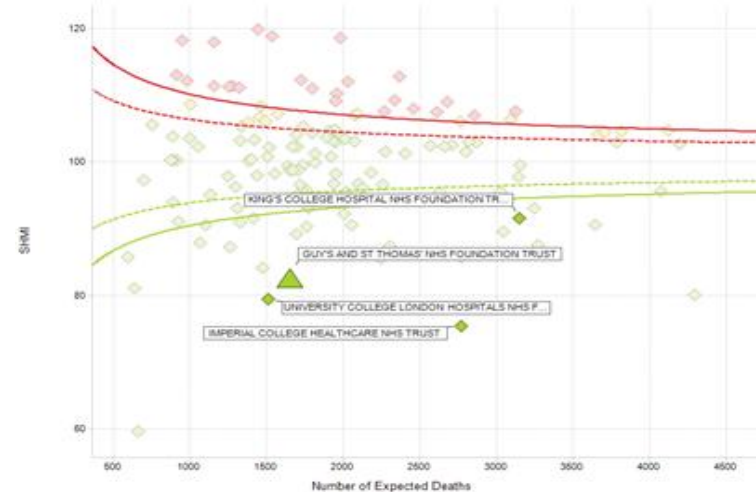


- Benchmarked mortality allows case-mix corrected risk of death to be compared across organisations. The Trust continues to perform exceptionally well, both against the England average and to other London acute hospitals. Two measures are used: Hospital Standardised Mortality Rate (HSMR) shown in graph 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.

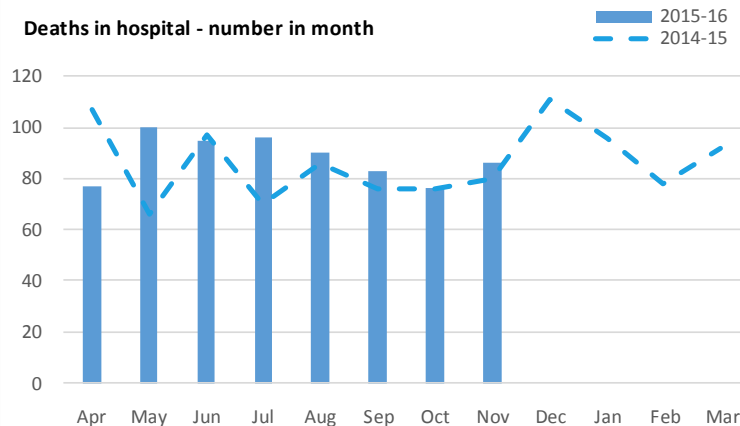
Please note that the funnel plot is only valid when the overall HSMR score is around 100.



Please note that funnel plot is only valid when SHMI score is 100 for all the organisations (shown below) as a whole. It can be verified through highlight



Deaths in hospital - number in month



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 November there was a net gain in the nursing workforce of 56 whole time equivalents.

-Planned versus actual nursing hours for November 2015 was 0.1% above plan; a decrease of 0.6% from October (figure 1). Registered nurse (RN) actual hours were 1695 below plan (equivalent to 10.4 FTE) as a result of vacancies and actions to reduce temporary staff use.

-Where episodes of reduced registered nurse availability were reported, the Heads of Nursing gave assurance that this did not directly affect the safety of our patients. Use of temporary staff and movement of staff within directorates ensured there was safe staffing in all clinical areas.

-32 red flags were raised in month; this was decrease by three percent (one flag) on the October figures.

-There was significant focus by all departments to ensure that all nurses recruited and in the pipeline, were transitioned into post as quickly as possible.

-The National Monitor rules on use of agency staff in nursing and midwifery were implemented in month. Reducing the trust reliance on temporary nursing and midwifery staffing remained the highest priority. The Directors of Nursing (Adult & Children's services) and Head of Financial Management held individual meetings in month with the majority of directorate management teams to support directorate recruitment and reductions in agency spends.

Risks or opportunities for the Trust. Nursing:

- The current nursing and midwifery establishment is 5681.92 wte (excluding research and development nurses not hosted in directorates), with 5053.08 wte staff in post

-There are 628.84 wte vacancies (11.07 % ESR 26/11/15); of these 248.99 wte are external starters in the pipeline. There are 379.85 wte posts to be appointed.

-Directorates continue to focus on reducing temporary staffing with all agency bookings being approved by the Heads of Nursing. Weekly exception reporting of any use of agency staff above the national pay cap commenced in the month of November. Monitoring and scrutiny of agency use is a key trust priority in reducing the pay costs within nursing and midwifery without reducing safe staffing levels.

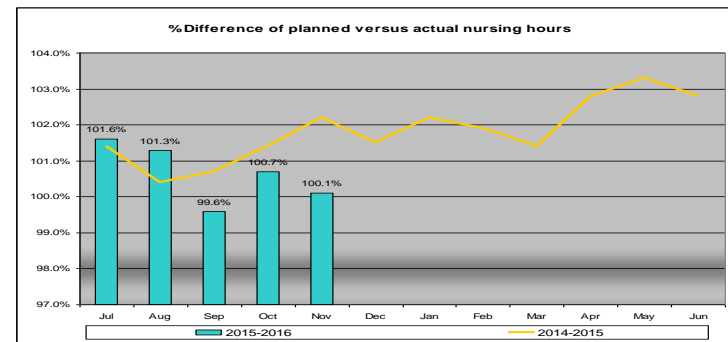
Actions set and progress to date:

- The Trust Nursing and Midwifery Committee (TNMC) held a successful meeting in the month of November focused exclusively on workforce and productivity. A number of key actions were agreed, which included job planning for band 7 and above, staffing the pathway and not the area and ensuring the effective use of Health-roster (e-rostering system) and a review of all nursing structures. It was agreed these action areas and others identified throughout the day will be implemented and help to ensure the nursing and midwifery workforce remains, skilled productive and cost effective moving into 2016.

-Health Roster Committee has been set up to commence in Jan 2016 to focus on metrics and driving best practice

-Ensuring stability of the Nursing and Midwifery Workforce is through the NMWGG which meets twice a month where senior nursing and HR representatives focus on ensuring a stable workforce and a reduction in temporary staffing.

Trend (Figure 1)

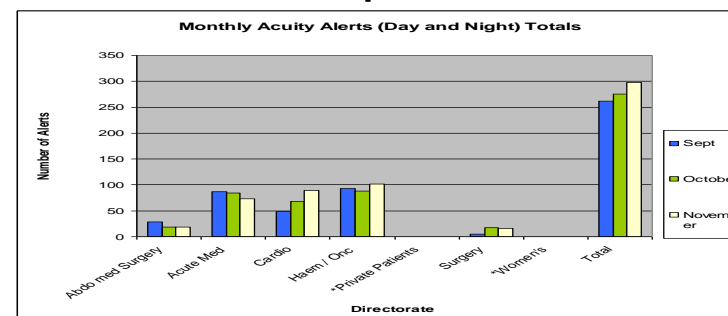


Benchmark (Figure 2)

Safe Staffing levels – taken from NHS Choices 21.12.15

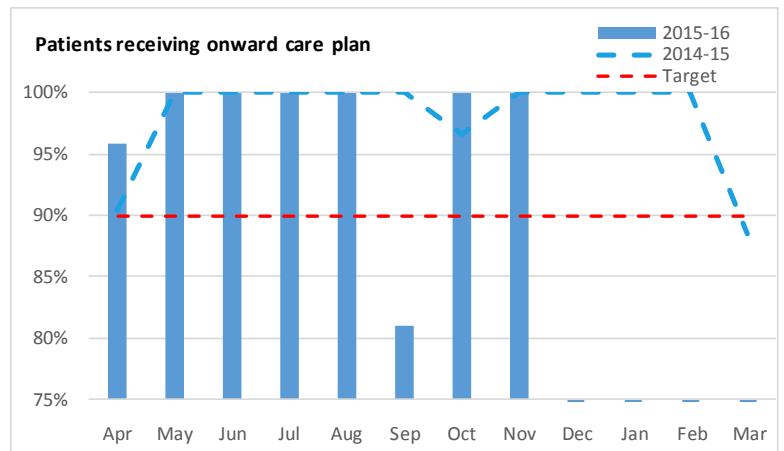
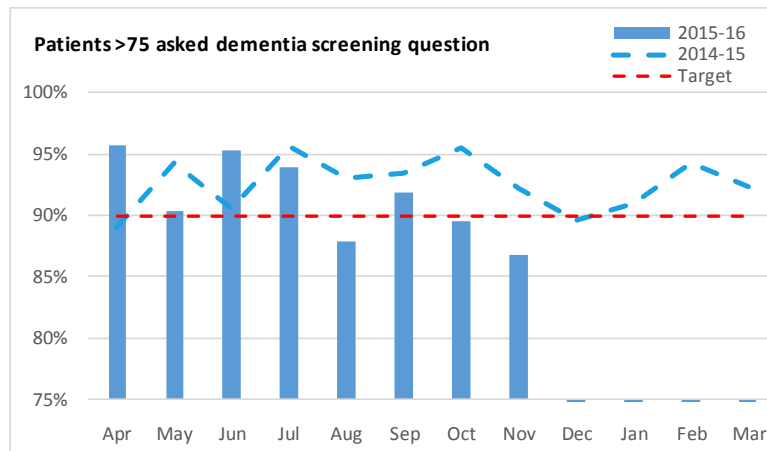
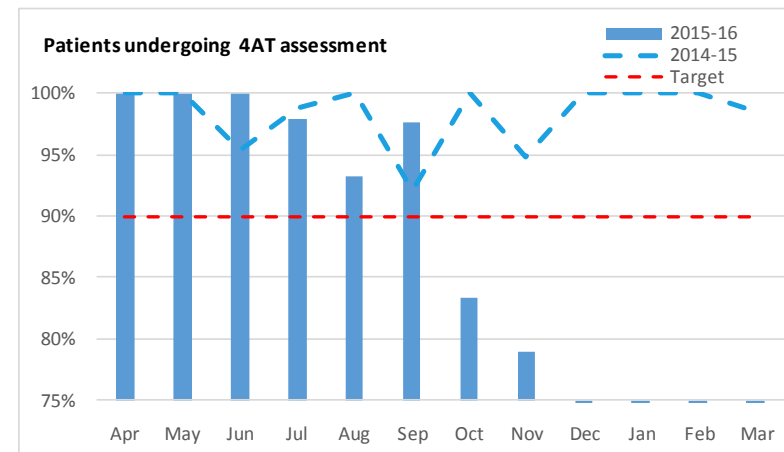
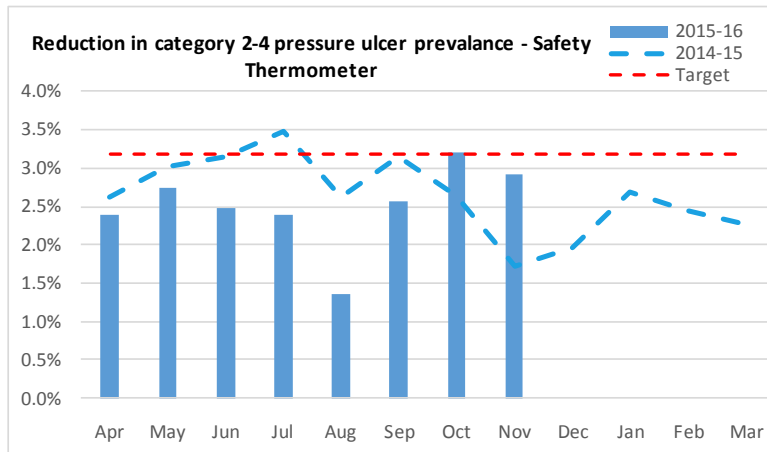
St Thomas' Hospital site	101%
Guy's Hospital site	99%
King's College Hospital	99%
Chelsea and Westminster Hospital	96%
University College Hospital	101%

Directorate heat map (Figure 3)

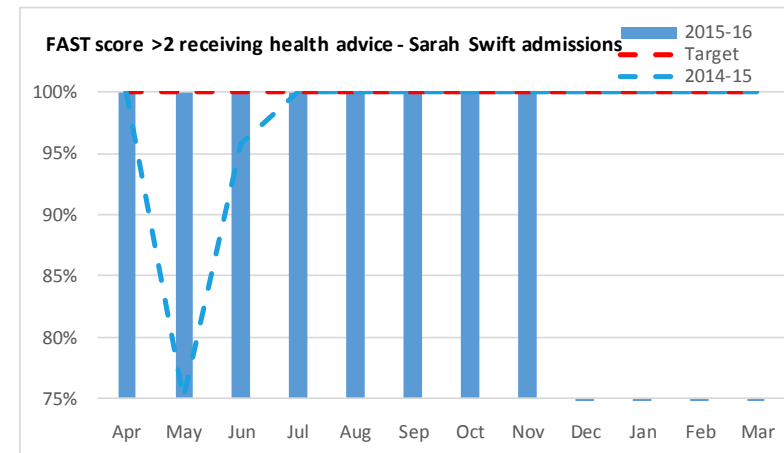
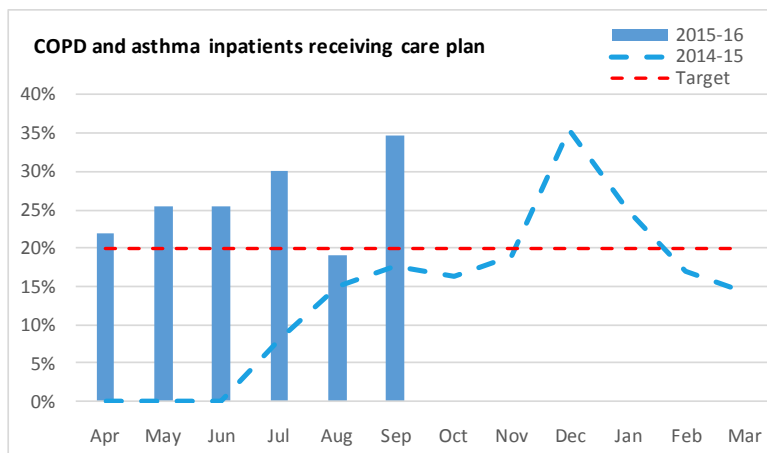
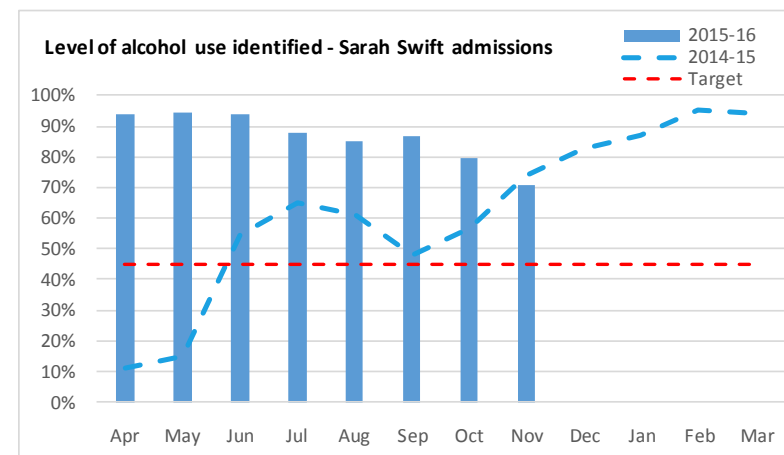
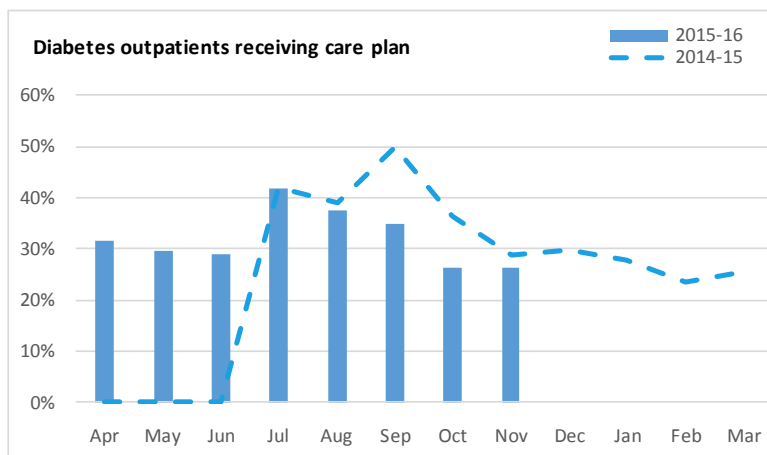


Theme	Ref	Indicator	Units	Target	R	G	Prior year	Sep	Oct	Nov	YTD avg	Monitor	Quality priorities	Trend chart
2.1 Quality improvement initiatives - general	CQ5q	Reduction in category 2-4 pressure ulcer prevalence - Safety Therm	Qtly %	<3.18%			-	2.6%	3.2%	2.9%	2.5%			Y
	Dem75Aq	Patients >75 asked dementia screening question	Qtly %	>90%			-	91.8%	89.6%	86.8%	91.5%			Y
	Dem75Bq	Patients undergoing 4AT assessment	Qtly %	>90%			-	97.6%	83.3%	78.9%	94.6%			Y
	Dem75Cq	Patients receiving onward care plan	Qtly %	>90%			-	81.0%	100.0%	100.0%	96.6%			Y
	CQ6Aq	Diabetes outpatients receiving care plan	Qtly %	-			-	34.9%	26.2%	26.4%	31.8%			Y
	CQ10q	COPD and asthma inpatients receiving care plan	Qtly %	>20%			-	34.6%			26.3%			Y
	CQ7Aq	Level of alcohol use identified - Sarah Swift admissions	Qtly %	>45%			-	86.5%	79.3%	71.0%	84.7%			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%			-	96.5%	96.2%	95.7%	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%	100.0%	50.0%	95.2%			Y
	CQ1Bq	CABG within 7 days of referral received (angiogram elsewhere)	Qtly %	>38%			-	77.8%	60.0%	57.1%	71.1%			Y
	CQ1Cq	CABG within 7 days - combined GSTT and external angiograms	Qtly %	>59%			-	83.3%	75.0%	61.5%	76.3%			Y
	CQ2Aq	Perinatal autopsy reports produced within 42 days of autopsy	Qtly %	>80%			-	97.3%	96.3%	89.5%	94.4%			Y
	CQ2Bq	Perinatal autopsy reports produced within 56 days of autopsy	Qtly %	>90%			-	94.6%	100.0%	97.4%	97.2%			Y
	CQ3q	Number of Fetal Medicine referrals seen within 3 working days	Qtly %	>90%			-	100.0%	100.0%	100.0%	97.4%			Y
	CQ4q	Babies undergoing 1st Retinopathy of Prematurity (ROP) screening	Qtly %	>95%			-	100.0%	100.0%	100.0%	98.6%			Y
	CQ14	Severe asthma patients receiving care plan	Number	>20			-	12	19	17	78			Y
2.3 Clinical best practice	352	Emergency readmissions (within 28 days - in arrears)	Cum %	<5.3%			5.3%	5.8%	5.7%		5.7%			Y
	353	Emergency readmissions (within 14 days - in arrears)	Cum %	<3.4%			3.4%	3.7%	3.6%		3.6%			Y
		Elective surgical readmissions within 28 days		In devt										
	IC48	Critical Care Unplanned Readmissions within 48 Hours	Mnthly (%)	<=1.3			-	0.4%	2.0%	2.4%	1.4%			
	913	% Caesarean sections	Mthly %	<28%			-	30.6%	35.4%	30.3%	32.7%			
	ICNARC-STH	Critical care mortality indicator-STH+VH DU	Quarterly	<=1.0			-	0.88	0.88	0.88	0.88			
	ICNARC-Guys	Critical care mortality indicator-Guys CCU	Quarterly	<=1.0			-	1.07	1.07	1.07	1.07			
	EOL	End of life care - % of deaths supported by Priorities for Care	Mthly %	>25%			-	48.1%	33.8%	33.7%	37.7%			

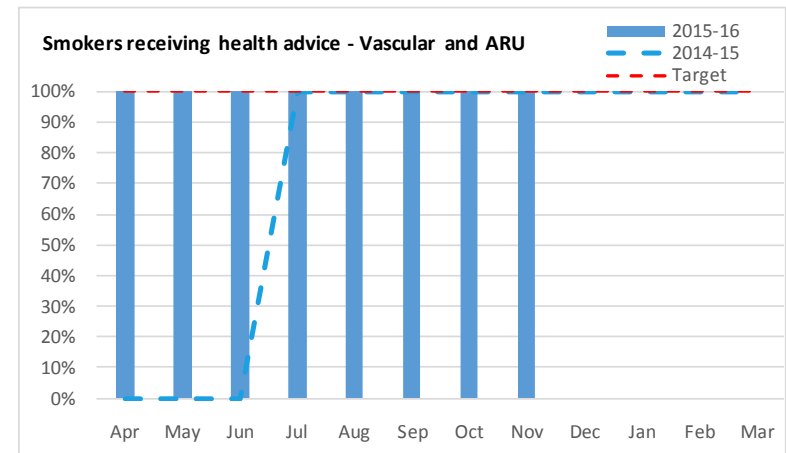
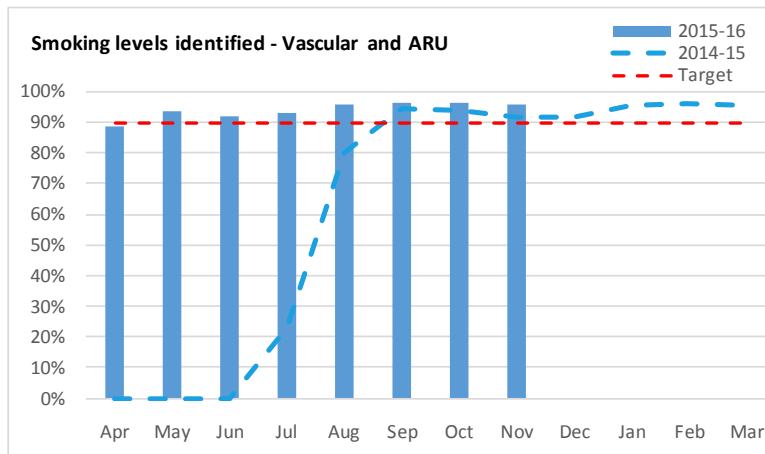
- Contract changes for 2015/16 mean that the Trust is not subject to the same Clinical Quality and Improvement and Innovation schemes (CQUINs) as in previous years. In their place, we have agreed a number of Local Incentive Schemes (LIS) with our main Clinical Commissioning Groups, some of which continue 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 and the importance of this and we expect this to improve.
- A Dementia screening review is carried out for all the breaches and 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. In addition we are still finding that staff are not updating the dementia screening section in the electronic patient record, having already used clinical e-noting. The Dementia Clinical Nurse Specialist is following this up and supporting staff to complete the screening records.



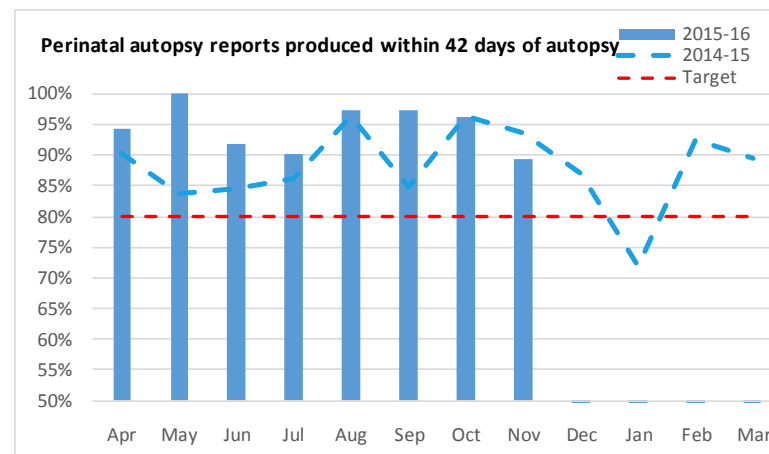
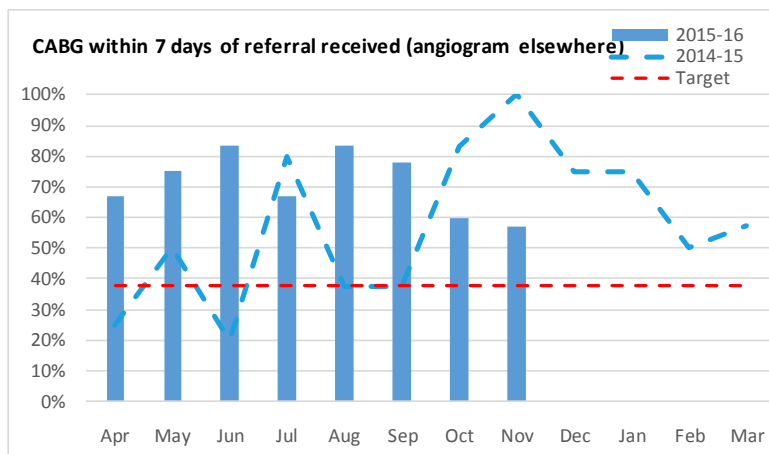
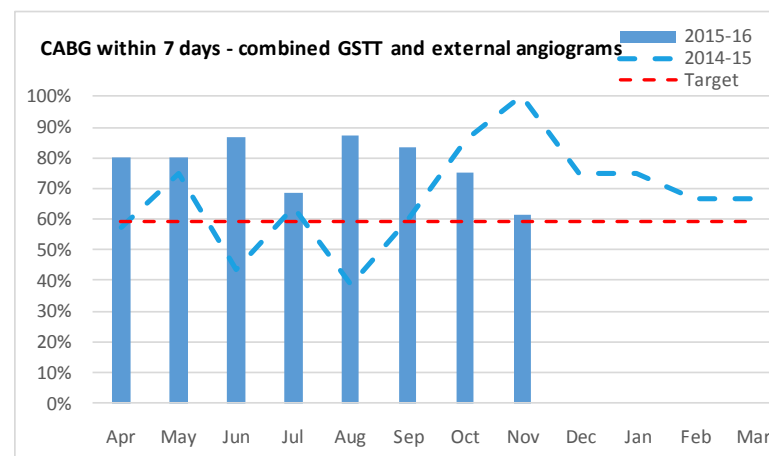
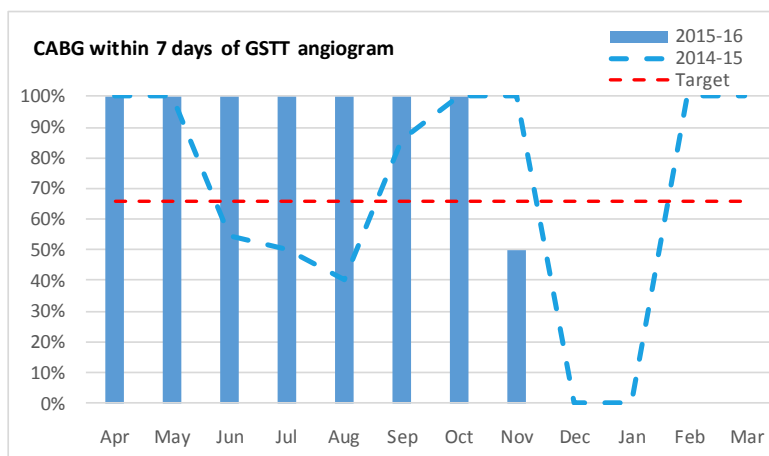
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- We continued to perform well against all of the clinical quality indicators. Clinical teams are working through additional actions to further improve performance during the year. For Diabetes care plans we are tracking actual numbers rather than the percentage delivery and are seeing similar levels of delivery in comparison to last year.



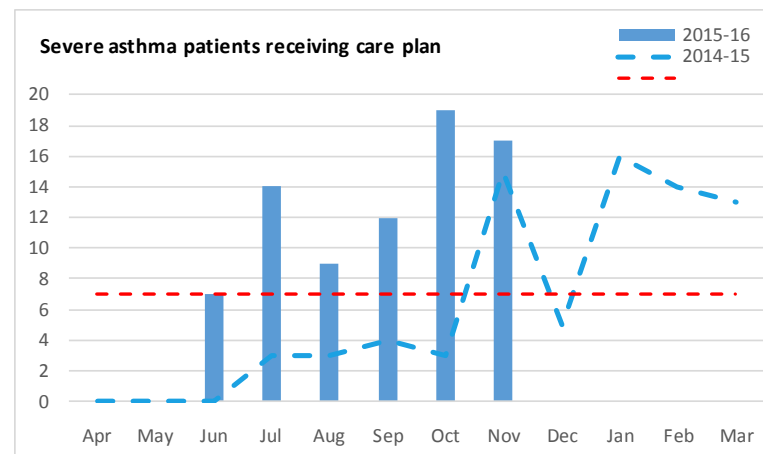
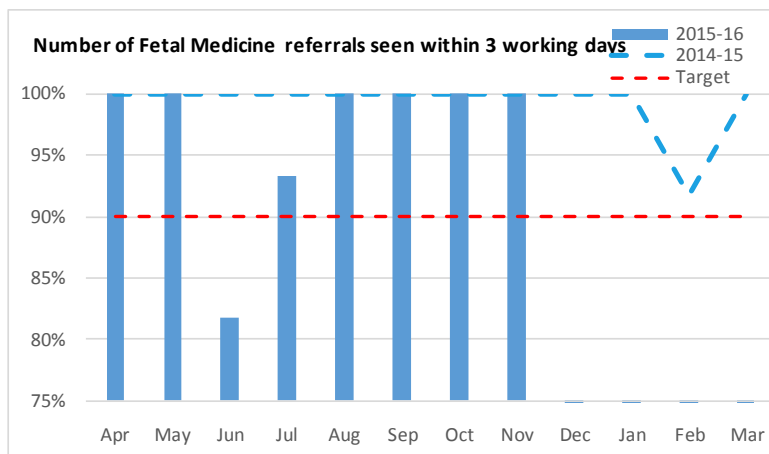
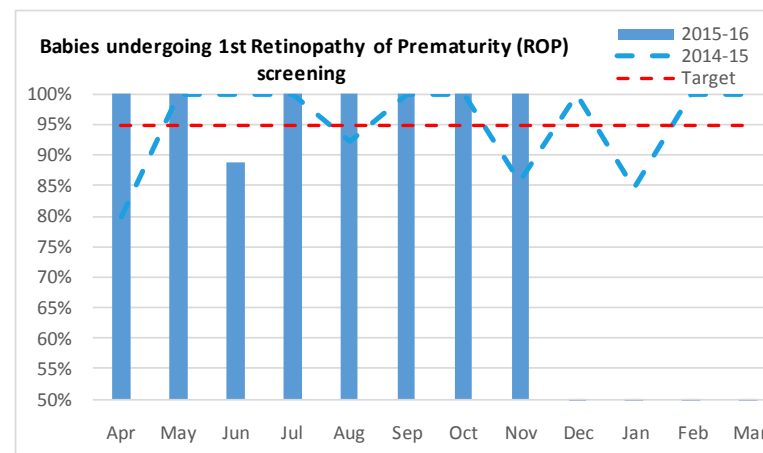
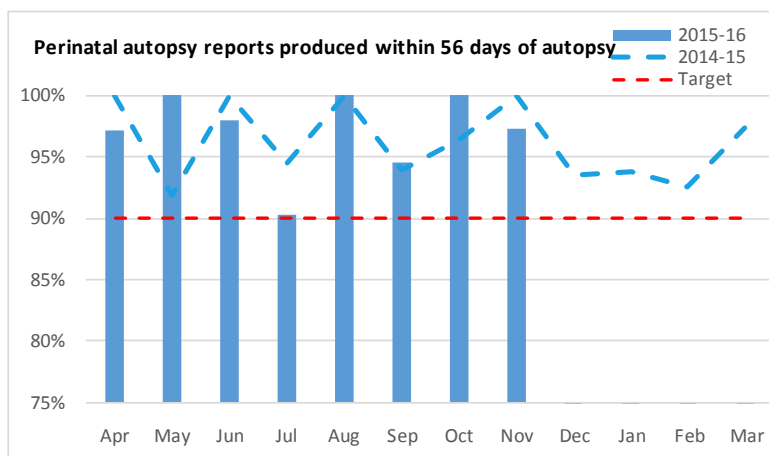
- There are two services where there is a particular focus to ensure that smokers are offered health advice to help stop smoking: vascular surgery and the Acute Respiratory Unit (ARU). The number of people identified within these services has consistently improved since April and the service has met 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.



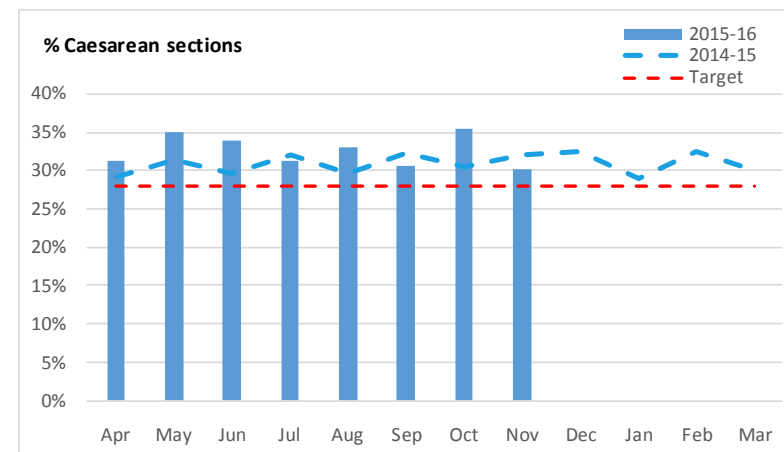
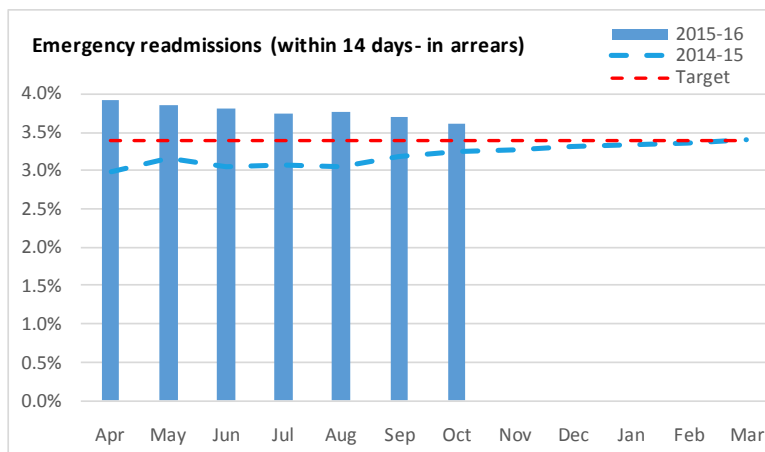
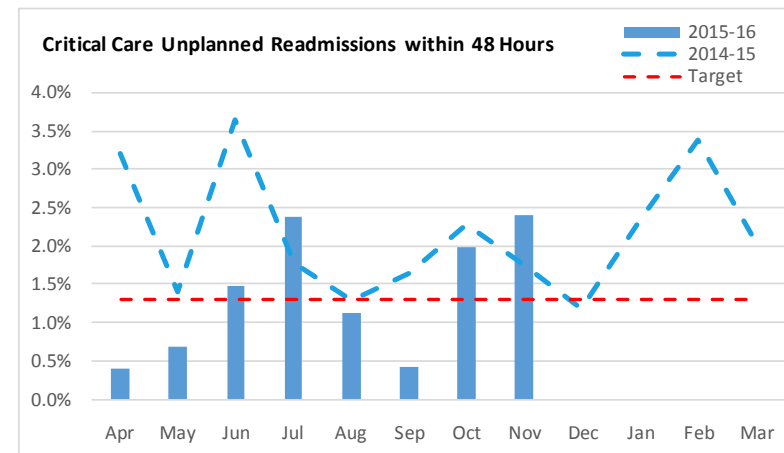
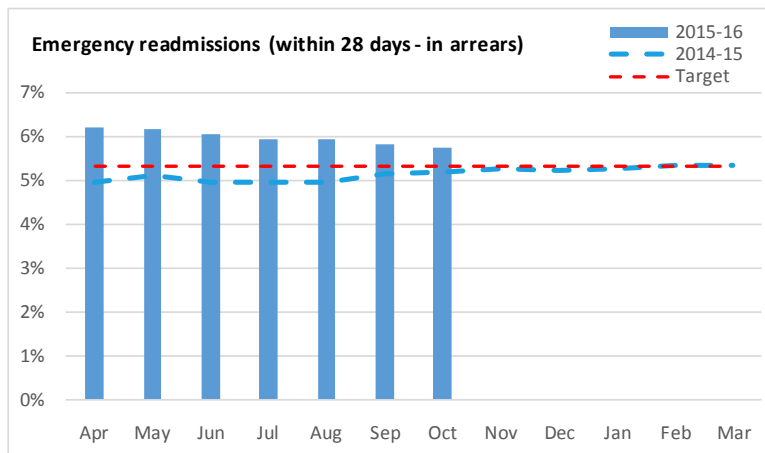
- Although the Trust is not contractually subject to specialised CQUINs in 2015-16, we continue to monitor our performance against the indicators in use last year.
- Performance remains very good across most areas; however in November there were delays in finding a suitable bed for patients transferred across from referring providers and within the Trust as a result of increased pressure from the emergency pathway.
- Current contract discussions with NHS England aim to agree an appropriate set of indicators for this year.



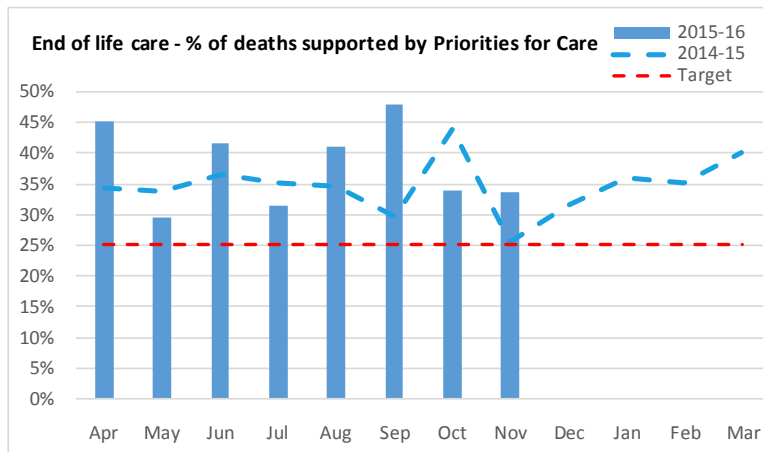
- Performance continues to be above target levels for most indicators currently being reported.
- Staffing issues previously reported within fetal medicine are now resolved and the service has consistently met the target for the last two months. The service has consistently met the target over the previous years and we are confident this will continue.



- 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.
- During November the Trust experience significant bed pressures at all acuity levels. Patients were prioritised according to clinical need for an HDU bed. Those with lower acuity were returned to a ward bed supported by the critical care outreach team. Rapid return to critical care was facilitated when necessary.

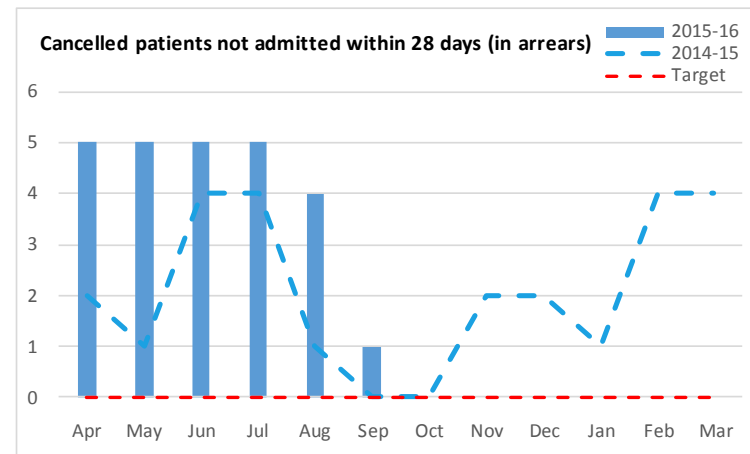
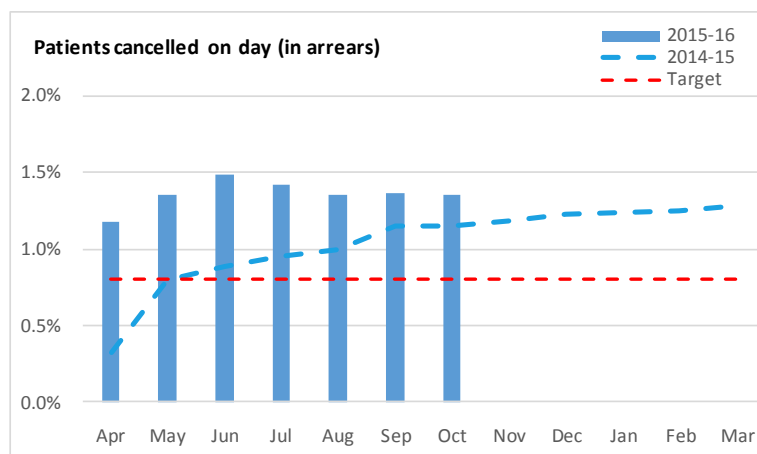
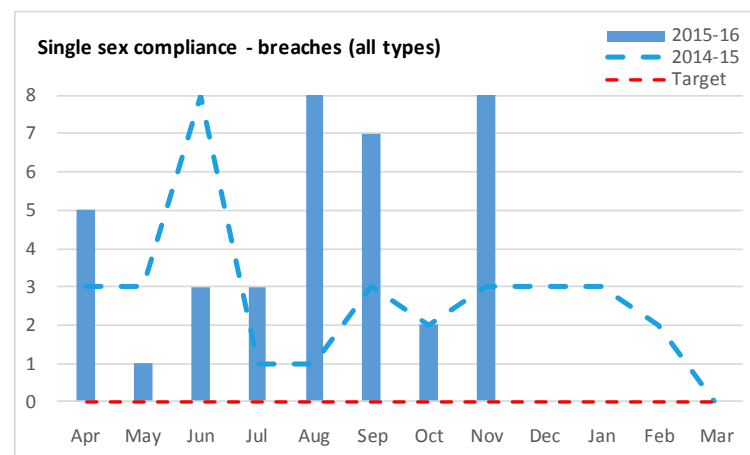
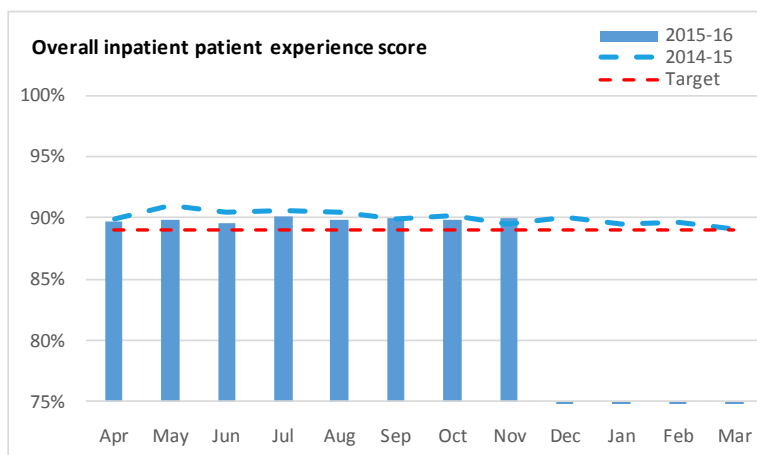


- In November 2015, the proportion of adult inpatient deaths supported by *the priorities for care of the dying person* remained just below 35%. The importance of these priorities and the electronic notification placed alongside them is the development of an individualised plan of care with which those important to the patient are involved as well as senior support from primary consultant/team, End of Life Care (EoLC) team and Senior Nurse Practitioner (SNP) team as needed. The end of life care Clinical Nurse Specialists (CNS) perform regular proactive ward visits to facilitate case finding and support of staff with decision making, planning and communication. Each ward has been charged with identifying EoLC champions who will support a planned EoLC re-launch in March / April 2016.

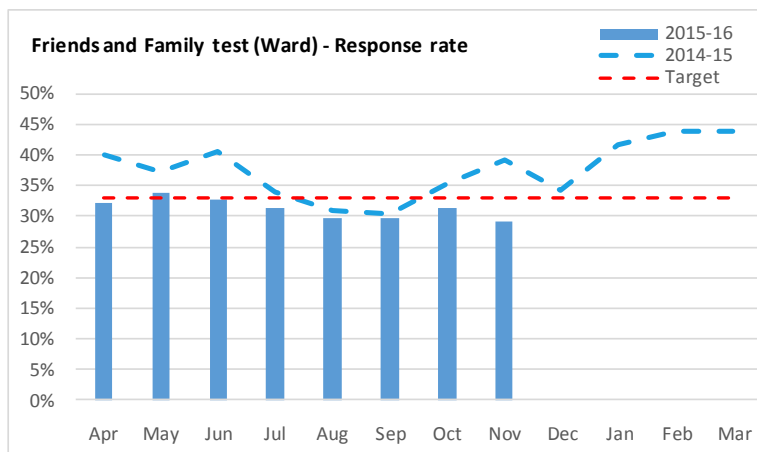
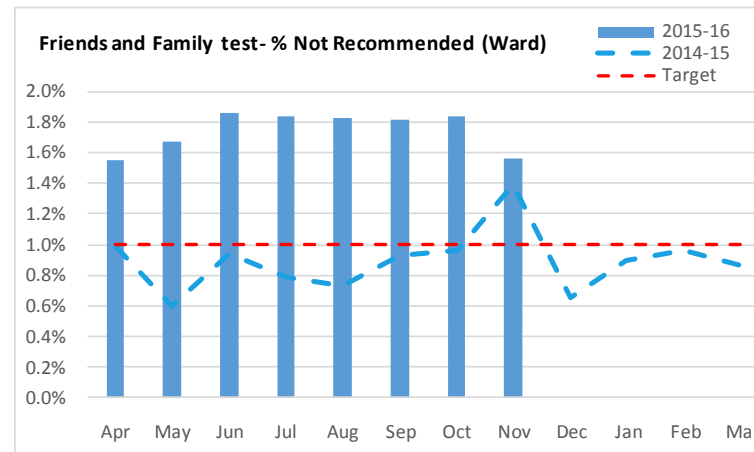
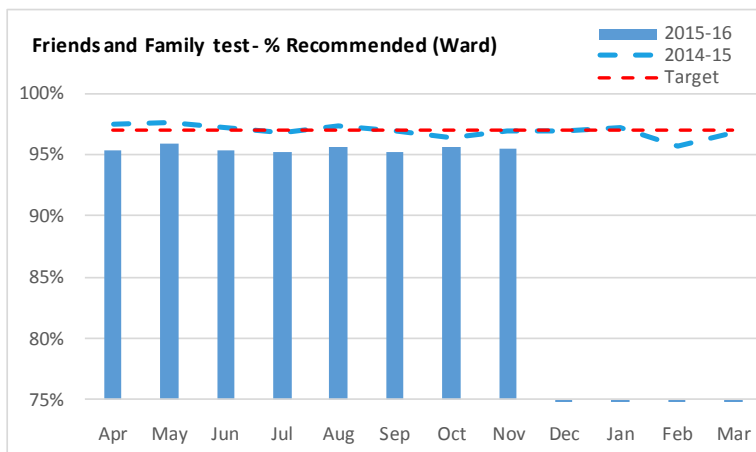


Theme	Ref	Indicator	Units	Target	R	G	Prior year	Sep	Oct	Nov	YTD avg	Monitor	Quality priorities	Trend chart
3.1 Admitted care	258	Overall inpatient patient experience score	Mthly %	>89%			90%	90.0%	89.9%	90.0%	89.9%			Y
	310	Single sex compliance - breaches (all types)	Cases	Zero			0.0	7	2	22	6.5			Y
	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			-	1	0		3			Y
	FFT1W	Friends and Family test (Ward) - Response rate	Mthly %	>=33%				29.6%	31.4%	29.1%	31.2%			Y
	FFT2W	Friends and Family test - % Recommended (Ward)	Mthly %	>=97%				95.2%	95.6%	95.5%	95.5%			Y
	FFT3W	Friends and Family test - % Not Recommended (Ward)	Mthly %	<=1%				1.8%	1.8%	1.6%	1.7%			Y
3.2 A&E care	FFT1AE	Friends and family test (A&E) - Response rate	Mthly %	>=18%				17.8%	15.3%	12.7%	16.1%			Y
	FFT2AE	Friends and Family test - % Recommended (A&E)	Mthly %	>=88%				84.4%	84.6%	84.6%	85.1%			Y
	FFT3AE	Friends and Family test - % Not Recommended (A&E)	Mthly %	<=6%				8.2%	7.8%	8.9%	7.6%			Y
3.3 Maternity care	FFT1M	Friends and Family test (Maternity) - Response rate overall	Mthly %	-				13.8%	23.6%	18.6%	18.3%			Y
	FFT2M	Friends and Family test - % Recommended (Maternity)	Mthly %	-				90.4%	94.6%	91.2%	92.7%			Y
	FFT3M	Friends and Family test - % Not Recommended (Maternity)	Mthly %	-				1.8%	0.9%	3.3%	2.0%			Y
3.4 Outpatient care	FFT2OP	Friends and Family test - % Recommended (Outpatients)	Mthly %	-				93.0%	92.1%	92.5%	92.4%			Y
	FFT3OP	Friends and Family test - % Not Recommended (Outpatients)	Mthly %	-				3.2%	3.4%	4.0%	3.4%			Y
3.5 Community care	FFT1CS	Friends and Family test (Community) - Response rate	Mthly %	-				5.6%	4.3%	5.4%	6.1%			Y
	FFT2CS	Friends and Family test - % Recommended (Community)	Mthly %	-				95.1%	96.5%	96.8%	95.8%			Y
	FFT3CS	Friends and Family test - % Not Recommended (Community)	Mthly %	-				1.3%	0.3%	0.8%	0.8%			Y
	260C	Adult community health centre patient experience score	Mthly %	>89%			-	94.5%	94.5%	94.3%	93.9%			Y
3.6 Patient Transport	FFT1PT	Friends and Family test (Transport) - Response rate	Mthly %	-				3.2%	2.4%	3.0%	3.0%			Y
	FFT2PT	Friends and Family test - % Recommended (Transport)	Mthly %	-				90.5%	93.2%	94.7%	92.3%			Y
	FFT3PT	Friends and Family test - % Not Recommended (Transport)	Mthly %	-				4.1%	2.9%	1.9%	3.3%			Y
3.7 General patient and	Food	Satisfaction with food (PLACE)	Mthly %	>85%			91%	92.6%	92.6%	92.6%	91.7%			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 November the Trust experienced significantly higher than usual emergency admissions, with a higher number of admissions into critical care. Bed occupancy continued to be high throughout November with the St Thomas' site on amber bed escalation for the majority of the month and escalation to internal red throughout the week beginning the 16th November. On the 19th and 23rd November the Trust experienced particular problems with 3 critical care step down breaches on each day, on each of these days the number of patients requiring step down from critical care was approximately 3 times the average (18 patients), with a number of patients requiring side room isolation. At the beginning of December the Trust opened 9 additional beds.
- Experience scores continue to reflect well on inpatient care, with an overall satisfaction rate of 90 in November which is a slight increase on the October score of 89.9%.



- 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 95.5% in November which is similar to the October score of 95.6%. The percentage of patients who would not make a recommendation improved slightly in November falling from 1.8% in October to 1.6% 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

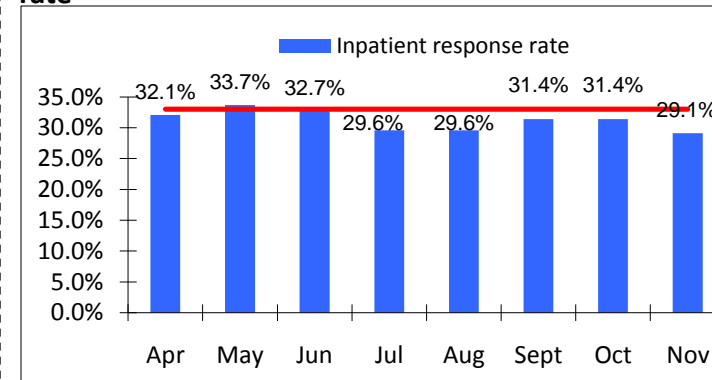
Where we are: trends, patterns and causes

- The response rate fell slightly from 31.4% in October to 29.1% in November.
- 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 October our response rate placed us at the top of the Shelford Group, and our recommend score was in the upper half of the group in October
- The proportion of patients who would recommend us has remained consistent at above 95% but decreased slightly to 95.5% in November.

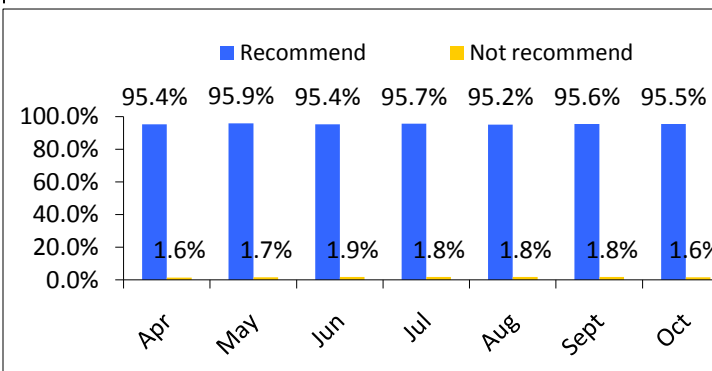
Risks or opportunities for the Trust

- 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

Trend – Inpatient Friends and Family Test response rate



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

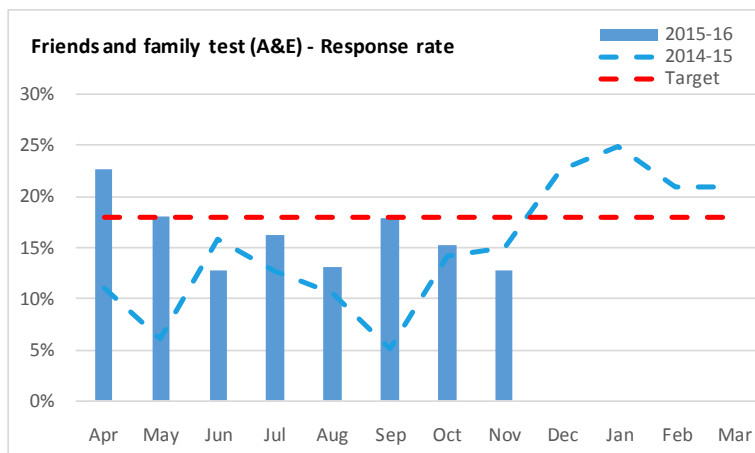
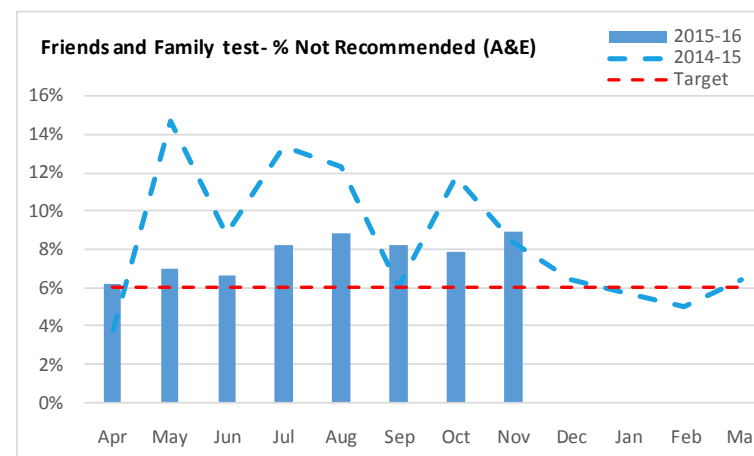
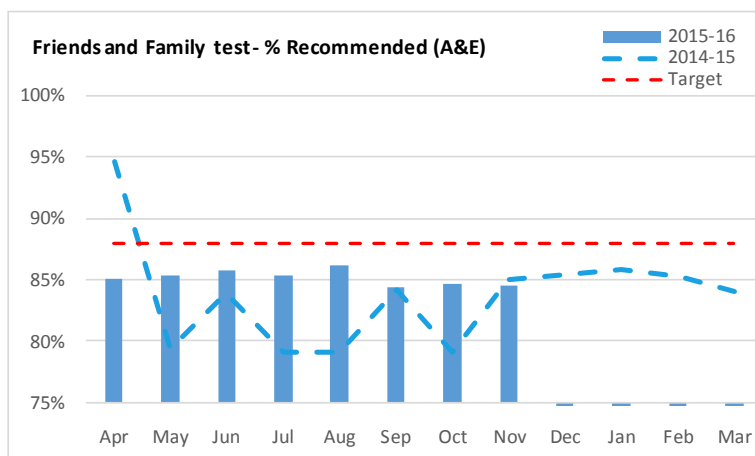


Comparator – Shelford Group

Shefford Group			Response Rate
Trust/Month	October		October
	Recommend %	Not recommend %	Inpatients
National Score for England	95%	2%	24.4%
London region score	95%	2%	25.2%
Guy's and St Thomas' NHS Foundation Trust	96%	2%	31.4%
University College London Hospitals NHS Foundation Trust	96%	1%	27.5%
Newcastle-Upon-Tyne Hospitals NHS Foundation Trust	97%	1%	19.0%
Sheffield Teaching Hospitals NHS Foundation Trust	96%	1%	25.3%
University Hospitals Birmingham NHS Foundation Trust	97%	2%	27.4%
Oxford University Hospitals NHS Trust	96%	1%	16.6%
King's College Hospital NHS Foundation Trust	94%	2%	12.1%
Cambridge University Hospitals NHS Foundation Trust	95%	1%	18.8%
Imperial College Healthcare NHS Trust	96%	1%	33.8%
Central Manchester University Hospitals NHS Foundation Trust	94%	2%	15.9%

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

- The A&E Friends and Family Test (FFT) has been extended to include patients attending our Minor Injuries Unit at Guy's Hospital.
- Unfortunately the response rate fell from 15.3% in October to 12.7% in November. During November the department was exceptionally busy and capturing feedback was challenging. 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 remained the same as the score for October at 84.6%. The proportion of patients who said they would not recommend the service has increased slightly and risen from 7.2% in October to 8.9% in November. 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

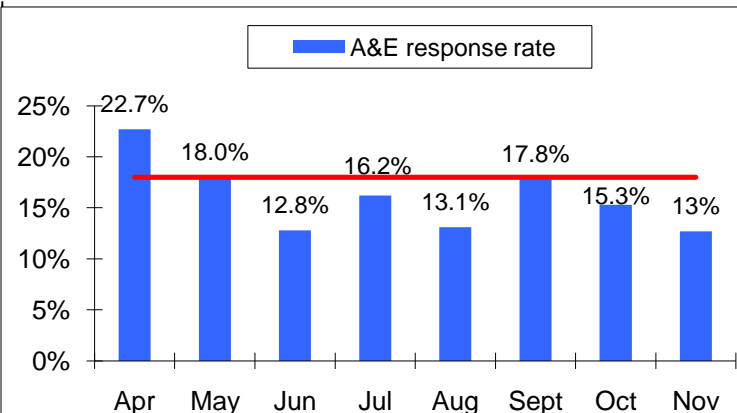
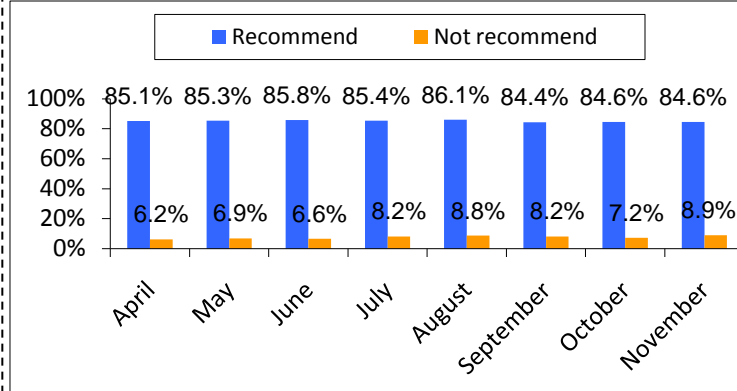
Where we are: trends, patterns and causes

- In November the response rate fell from 15.3% in October to 12.7% in November.
- The department saw extremely high levels of activity in November
- 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 consistent at 84.6%. The proportion of patients who would not recommend us has risen from 7.8% in October to 8.9% in November.
- The improvement in the recommend and not recommend scores reflect the success of the measure the team have put in place to improve patient experience including the team have erecting privacy screen in the temporary Reception area to improve patient experience. 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

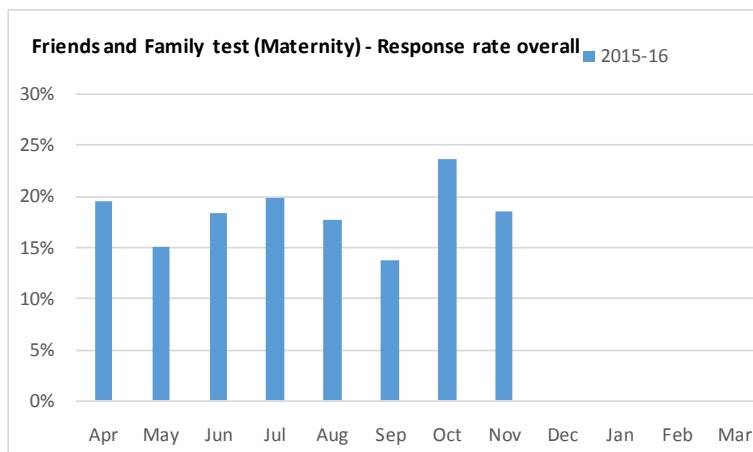
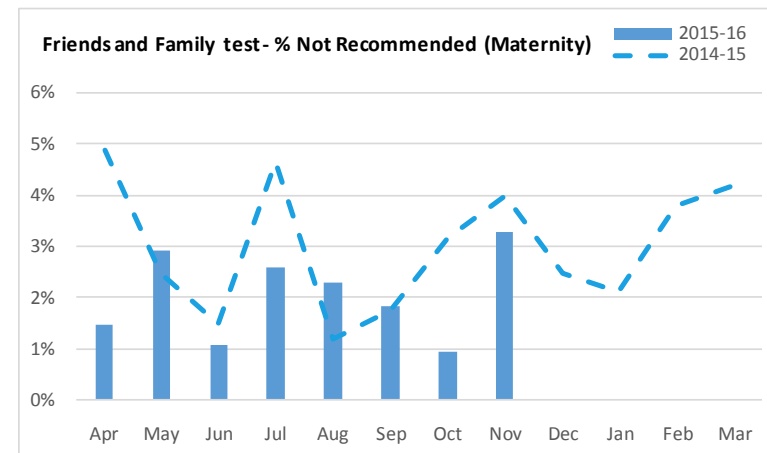
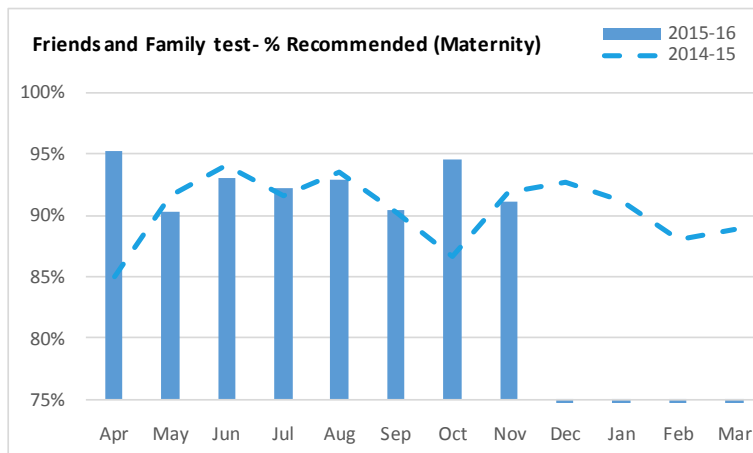
- Feedback captured from patients can be used to improve the service and inform the on-going development of the Emergency Floor and associated pathways.
- Both our response rates and recommend scores for September are in the lower half of the Shelford Group.

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. Will be raised on 21/01 ECP IT Board.	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

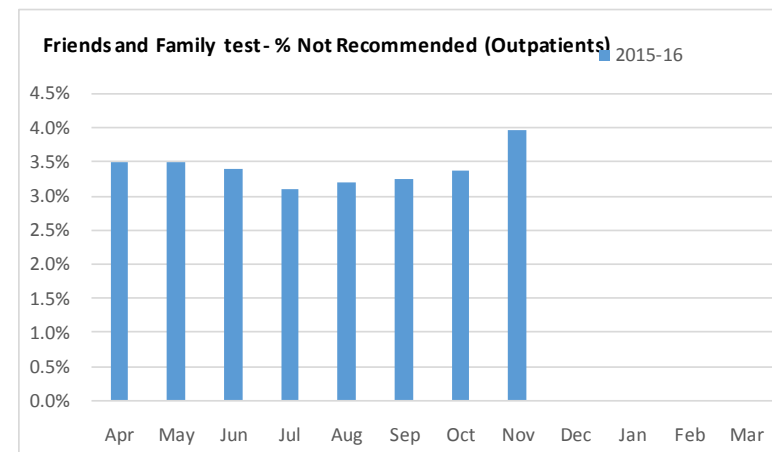
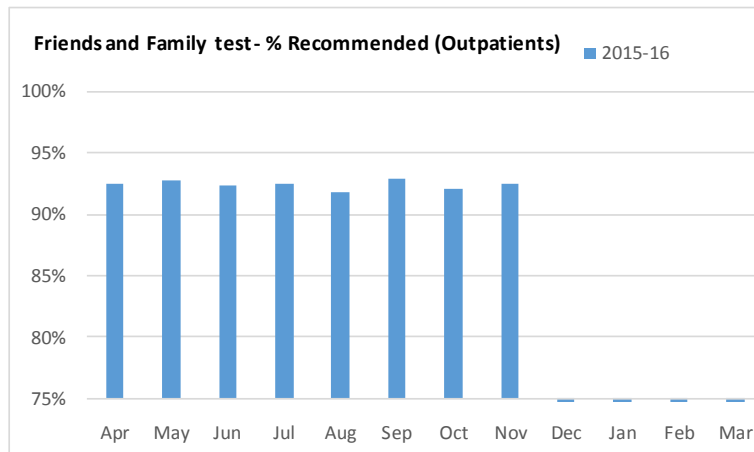
Trend – A&E Friends and Family Test response rate**Trend – A&E Friends and Family Test percentage Recommend v. Not recommend****Comparator – Shelford Group**

Shelford Group		Response Rate	
Trust/Month	October		October
	Recommend %	Not recommend %	A&E
National Score for England	87.2%	6.7%	13.6%
London region score	88.4%	5.9%	12.2%
Guy's and St Thomas' NHS Foundation Trust	84.6%	7.8%	15.3%
University College London Hospitals NHS Foundation Trust	94.5%	3.1%	17.9%
Cambridge University Hospitals NHS Foundation Trust	92.5%	3.2%	24.1%
Newcastle-Upon-Tyne Hospitals NHS Foundation Trust	87.6%	7.7%	1.7%
Central Manchester University Hospitals NHS Foundation Trust	88.6%	6.6%	10.8%
Oxford University Hospitals NHS Trust	83.2%	10.8%	23.2%
Imperial College Healthcare NHS Trust	95.6%	2.1%	10.2%
University Hospitals Birmingham NHS Foundation Trust	85.3%	8.5%	12.8%
King's College Hospital NHS Foundation Trust	83.3%	10.0%	18.3%
Sheffield Teaching Hospitals NHS Foundation Trust	74.5%	15.3%	17.6%

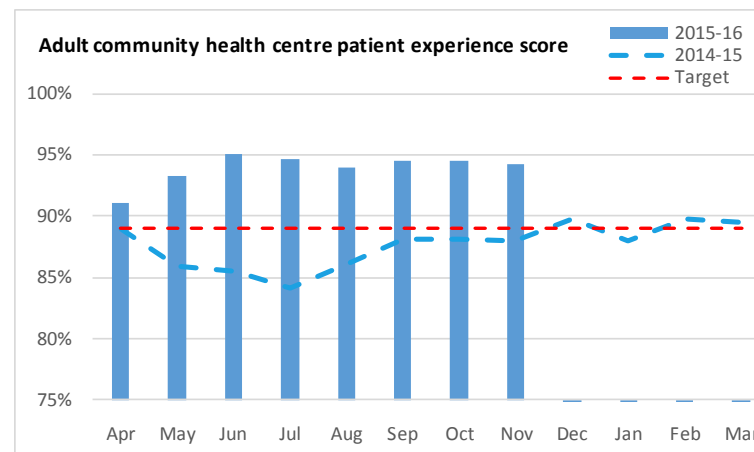
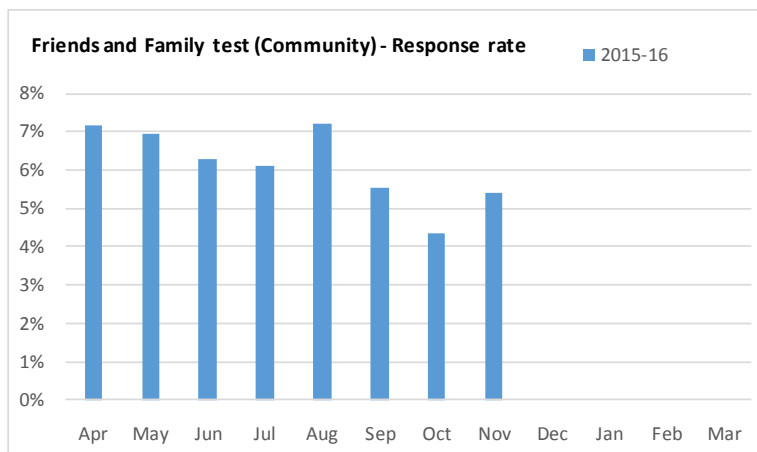
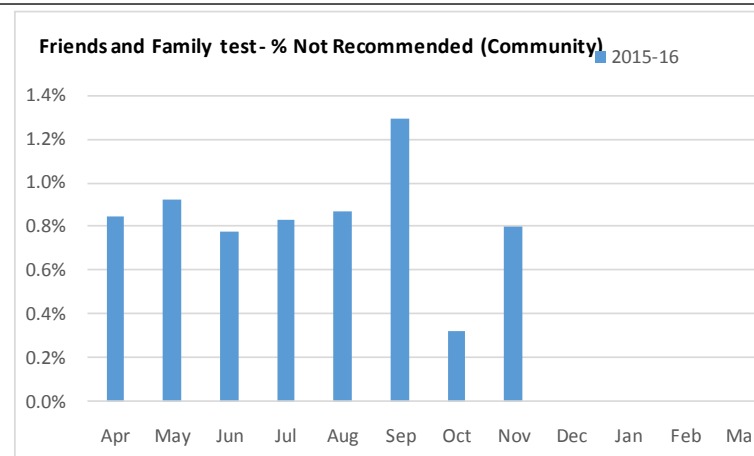
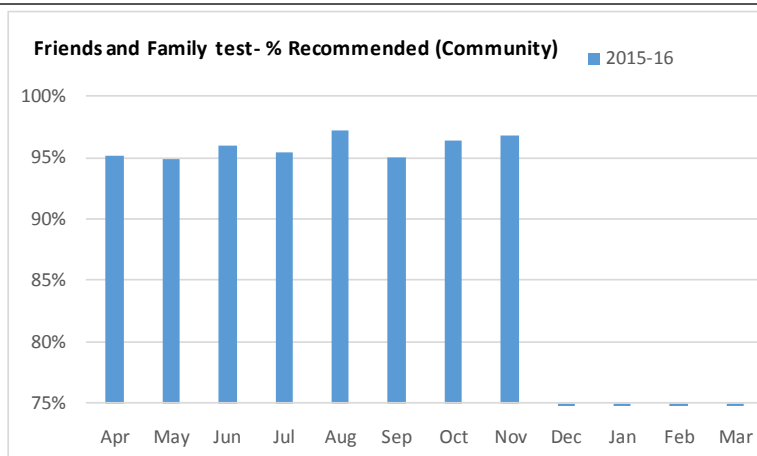
- The overall response rate for the Friends and Family Test for maternity services decreased from 23.6% in October to 18.6%. This exceeds our internal target of 15%. This reflects concerted efforts by the teams to encourage women to provide feedback on their experience.
- The proportion of women who would recommend the service has fallen slightly from 94.6% in October to 91.2% in November. The proportion of women who said they would not recommend the service has increased from 0.9% in October to 3.3% in November. The team regularly review comments and using the emerging themes to identify actions for improvement.



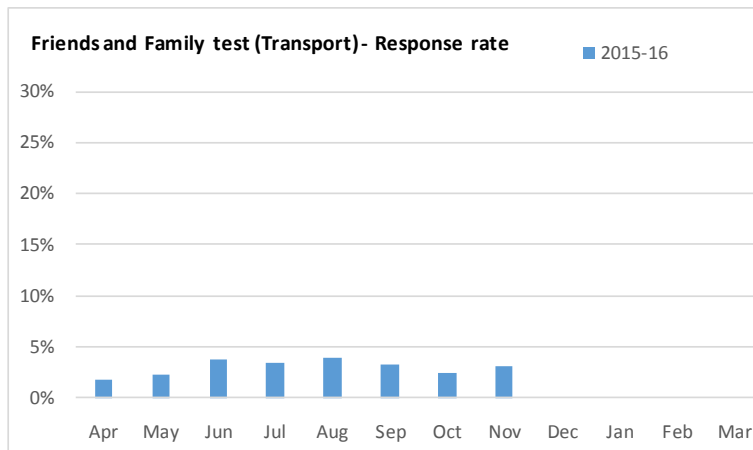
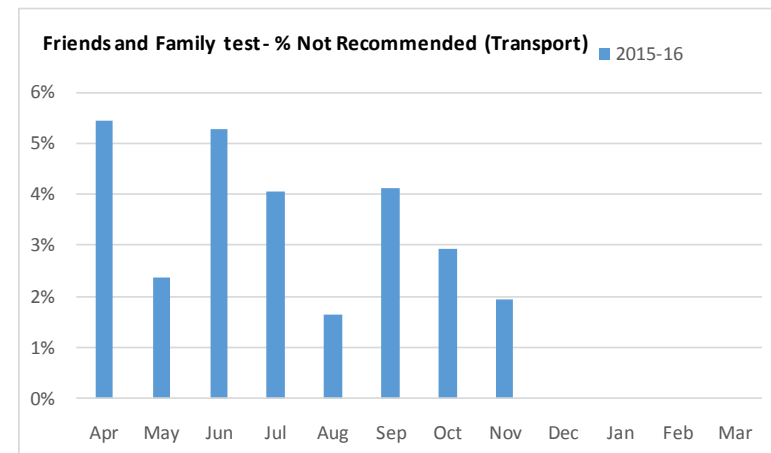
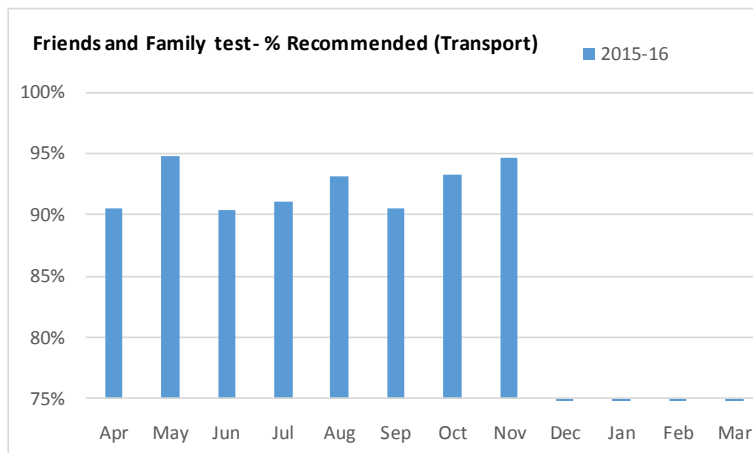
- From April, the Friends and Family Test has also been extended to adults and young patients using our outpatient services. This is a new area and no specific response rate targets have yet been set. NHS England is waiting until after all returns for Quarter 1 have been submitted before publishing data 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 increased slightly rising from 92.1% in October to 92.5% in November. The proportion of patients who would not recommend the Trust has increased slightly, rising from 3.4% in October to 4.0% in November.
- 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.



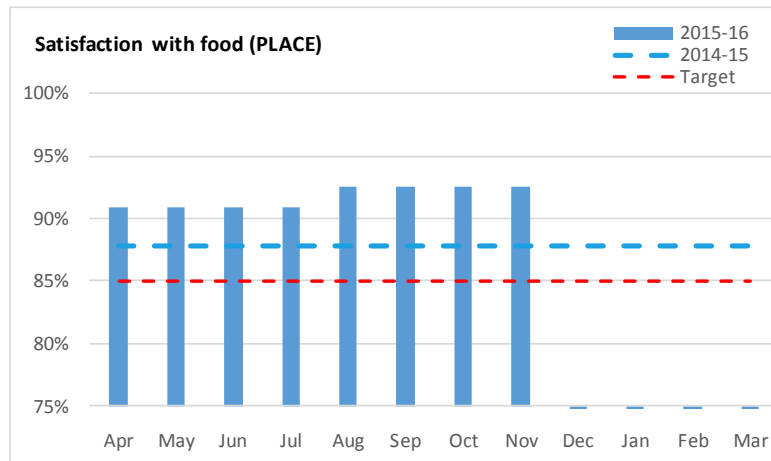
- From April, the Friends and Family Test (FFT) has also been extended to adults and young patients using our community-based services. This is a new area and no specific response rate targets have yet been set by NHS England.
- Our response rate has increased slightly from 4.2% in October to 5.4% in November. 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 increased slightly from 95.5% in October to 96.8% in November. The proportion of patients who would not recommend services has increased slightly rising from 0.3% in October to 0.8%. 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 proportion of patients who would recommend our transport services has increased from 93.2% in October to 94.7% in November. The proportion of patients who would not recommend the service has improved with the score falling from 2.9% in October to 1.9%.
- Drivers are being put through Passport to Transport customer service training and a new contractor will commence on 1st December.
- Comments have been highlighted to the service for review so that an improvement plan can be developed.



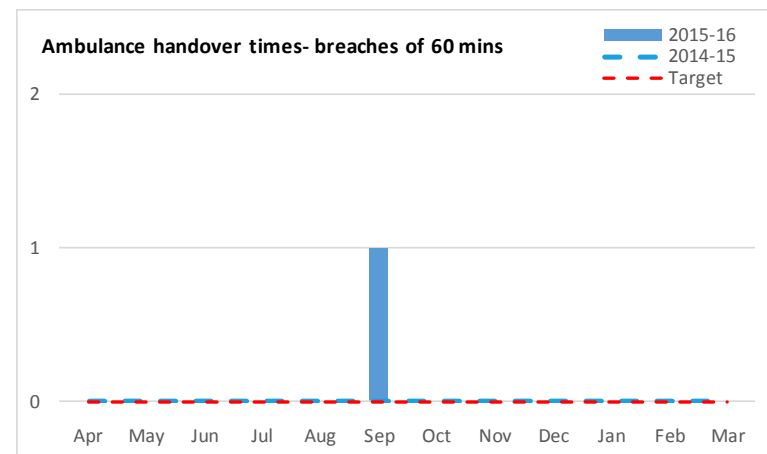
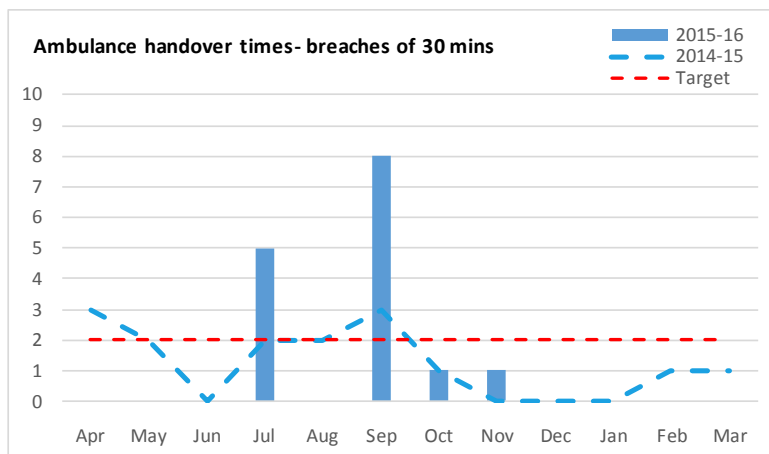
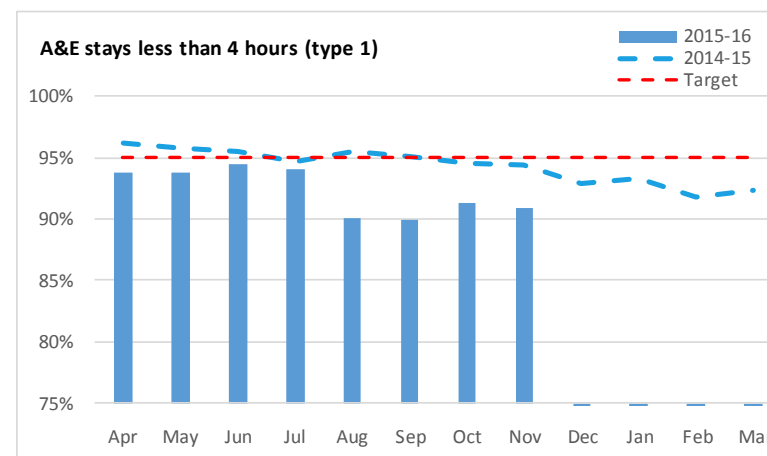
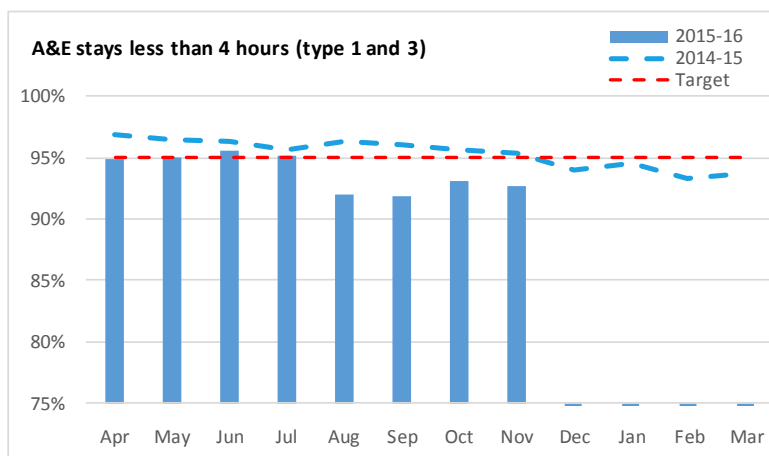
- The Trust has scored strongly for catering as reflected in the National Inpatient Survey 2014, published by the Care Quality Commission (CQC). The Trust's catering scores exceed those of other London Trusts.
- The Catering Team continue to work closely with both Nursing and Dietetic staff to consolidate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



Theme	Ref	Indicator	Units	Target	R	G	Prior year	Sep	Oct	Nov	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%			-	91.9%	93.1%	92.7%	93.9%		Y
	AE1STH	A&E stays less than 4 hours (type 1)	Mthly %	>95%			-	90.0%	91.3%	90.9%	92.4%		Y
	AE30	Ambulance handover times - breaches of 30 mins	Number	<3			-	8	1	1	1.9		Y
	AE60	Ambulance handover times - breaches of 60 mins	Number	Zero			-	1	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%	92.1%	92.3%	92.1%	92.6%		Y
	RTT 52I	RTT - Incomplete pathways over 52 weeks	Mthly	Zero			0.9	1	21	15	6.3		Y
	RTT TQ	RTT - total incomplete pathways	Mthly	-			42,138	47,855	48,893	48,113	47,194		Y
	RTT 18Q	RTT - incomplete pathways over 18 weeks	Mthly	-			2,791	3,799	3,786	3,790	3,516		Y
	401M	RTT - Non-admitted patients <18 weeks	Mthly %	>95%			94.7%	91.6%	91.9%	92.5%	93.3%		Y
	402M	RTT - Admitted patients < 18 weeks	Mthly %	>90%			87.2%	86.1%	88.0%	85.8%	86.7%		Y
	RTT 52	RTT - treatments over 52 weeks	Mthly	Zero			2.4	6	4	15	4.1		Y
4.3 Cancer access	451M	Cancer - 2 week wait	Qtly%	>93%			95.4%	94.1%	95.1%	93.6%	94.1%		Y
	941	Cancer - breast symptomatic referrals <2 wks	Qtly %	>93%			-	93.4%	97.7%	94.8%	95.9%		Y
	453M	Cancer - 31 day first treatments	Qtly%	>96%			95.9%	93.6%	95.8%	96.1%	94.9%		Y
	459M	Cancer - 31 day subs treatments - surgical	Qtly%	>94%			95.0%	91.5%	91.2%	90.9%	91.8%		Y
	943	Cancer - secondary chemotherapy <31 days	Qtly %	>98%			-	98.5%	98.8%	98.8%	99.0%		Y
	942	Cancer - secondary radiotherapy <31 days	Qtly %	>94%			-	96.2%	97.3%	93.2%	96.1%		Y
	454M	Cancer - 62 day urgent GP referrals	Qtly %	>85%			74.7%	72.1%	63.8%	72.0%	68.6%		Y
		Cancer - 62 day urgent GP referrals (LCA cases only)		In devt									
	454I	Cancer - internal 62-day referrals	Qtly%	>85%			84.2%	82.4%	74.1%	84.8%	78.3%		Y
	456M	Cancer - 62 day screening	Qtly %	>90%			77.7%	85.7%	90.0%	100.0%	91.7%		Y
4.4 Diagnostic access	Diag 6	Diagnostic waits - % over 6 weeks	Mthly	<1%			2.42%	1.16%	1.34%	1.35%	1.41%		Y
	FFF19	Turnaround time - inpatient MRI within 24 hours	Mthly %	>80%			73.5%	71.9%	61.2%	65.6%	71.5%		Y
	FFF20	Turnaround time - inpatient CT within 24 hours	Mthly %	>80%			83.7%	79.9%	82.5%	85.6%	83.5%		Y
	FFF21	Turnaround time - inpatient Ultrasound within 24 hours	Mthly %	>80%			76.5%	77.8%	78.1%	76.1%	77.5%		Y

Theme	Ref	Indicator	Units	Target	R	G	Prior year	Sep	Oct	Nov	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	3.46	3.46				Y
	LOS>1	Non-elective average LOS >1 night	Cum ALOS	<last yr			8.52	8.56	8.50	8.54	8.54				Y
	535	Discharges before noon	Mthly %	>25%			20.1%	20.7%	20.5%	20.6%	21.1%				Y
	Home	GSTT referrals to @Home service	Cases	>100			-	75	74	54	75				Y
	DToCPS	Patients with a DToC (snapshot)	Number	0			14	24	13	10	17				Y
	DToCDT	DToC total delayed days	Number	0			396	365	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%	4.8%	4.7%	4.8%				Y
	FFF57	Gassiot House Room Utilisation	Mthly %	>75%			-	88.0%	91.9%	90.2%	85.1%				
	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			-	2.26	2.18		2.23				Y
	602	Non-attendance rate (new appts)	Mthly %	<11%			11.9%	13.1%	12.4%	13.3%	12.3%				Y
4.7 Theatre management	533M	Daycase rate - basket (in arrears)	Mthly %	>85%			83.1%	86.3%	82.4%		82.9%				Y
	TH2	Daycase rate (trolley) vs BADS	Mthly %	In devt			-	-	-	-	-				
	505	Theatres Gross Cancellation Rate (in arrears)	Mthly %	<7%				7.2%	7.2%		7.2%				Y
		Theatre utilisation indicators		In devt											
		Theatre scheduling indicators		In devt											
4.8 Complaints mgt	COM1T	Complaints opened in month (Trust total)	Cases	-			-	114	91	97	94				Y
	COM2T	Complaints re-opened in month (Trust total)	Cases	-			-	3	7	4	5				Y
	COM5T	Timely response to complaints - median wait	Days	-			-	49	38	54	52				Y

- Compared to October, November saw deterioration in performance in the patient waiting time experience within our A&E services. Performance remains below 95% across all sites and at St Thomas' A&E. Ambulance handover times at the St Thomas site remained in-line with October with only 1 >30 minutes ambulance off-load breach and zero >60 minute delays. (Lower graphs).
- The Trust has been focussing on improvements both within A&E and across the emergency pathway. These include better outflow processes from A&E to admitting wards, improving escalation process and review of the Emergency Medical Unit.
- On the emergency pathway we are improving the processes for tracking and escalating some of our more complex discharge patients and patients with a long length of stay across the speciality wards with the aim to unblock and manage delays in a more proactive way.



• Where we want to be: targets and benchmarks

- We are seeking to reduce the number of patients waiting over 4 Hours to a level at which we can sustain performance against the national standards for incomplete pathways.

• Where we are: trends and patterns

- We saw deterioration in the performance against the 4hr target in November at the St Thomas Site. Average attendances were high compared to previous months and marginally higher than October. Guys Urgent Care Centre has retained performance with approximately 2 breaches per week.

• Risks or opportunities for the Trust

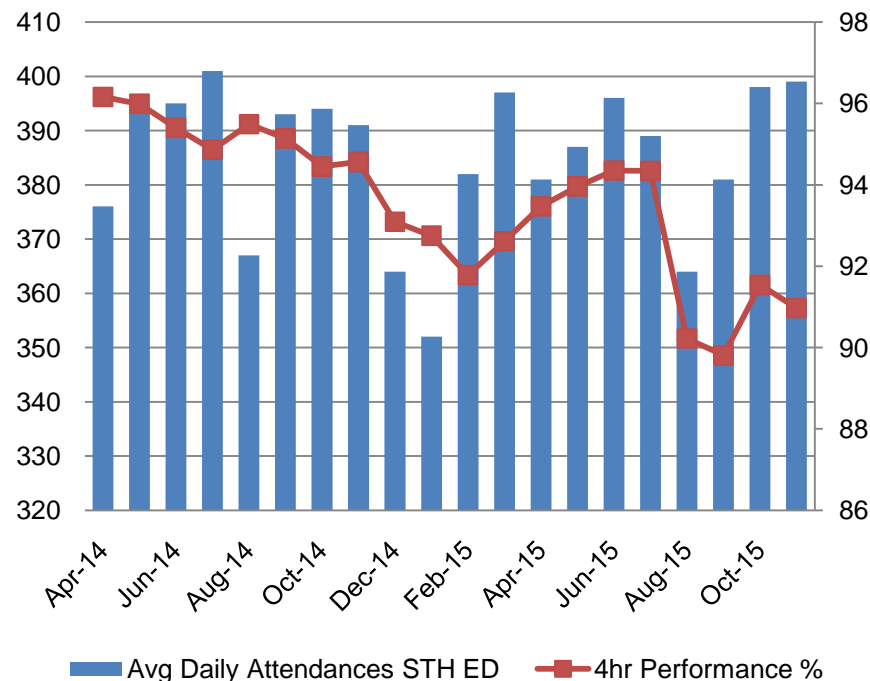
- Additional inpatient capacity will be opened in December and will reduce pressure on the admitted pathway.
- The reestablishment of the frailty pathway will improve the experience and performance against the over 75 year old cohort.

- Root cause analysis and insights

- The three key drivers for current A&E performance are:

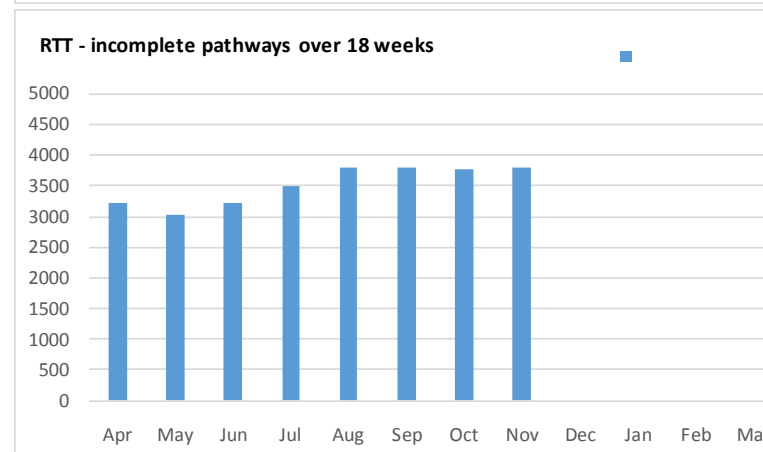
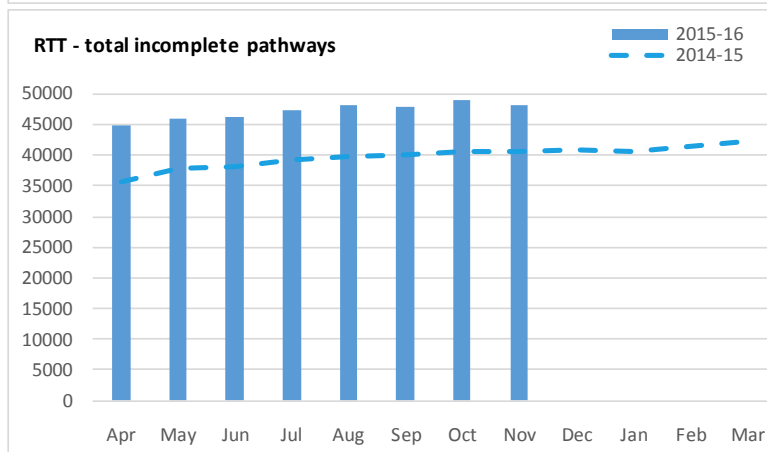
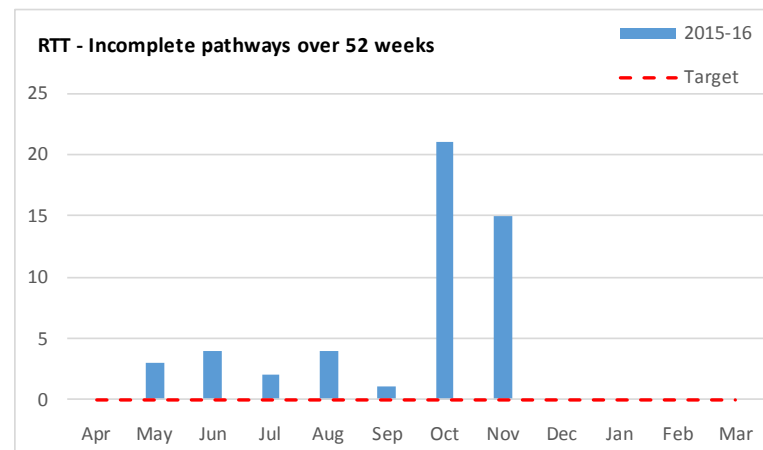
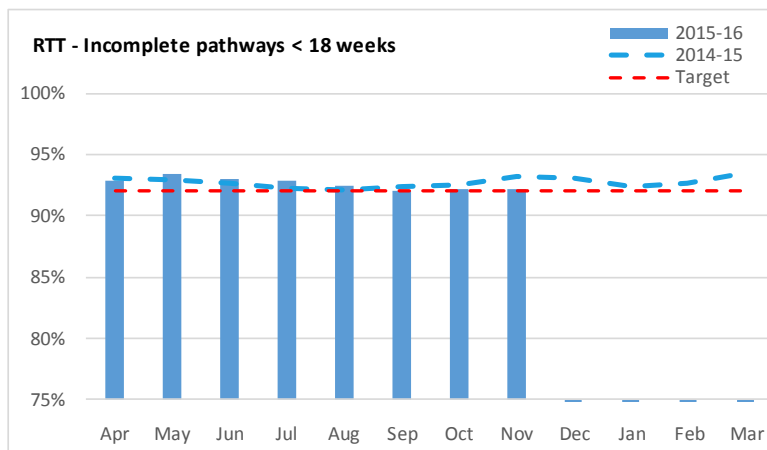
1. Reduced physical capacity of medical beds due to nursing shortfall, which will be open in December.
2. Reduced performance of all 3 admission avoidance pathways – AAU, SAU and OPAU as a part of the Emergency Care Programme transitional phase.
3. Reduced physical capacity in the AE as part of the Emergency Care Programme transitional phase.

STH Emergency Department

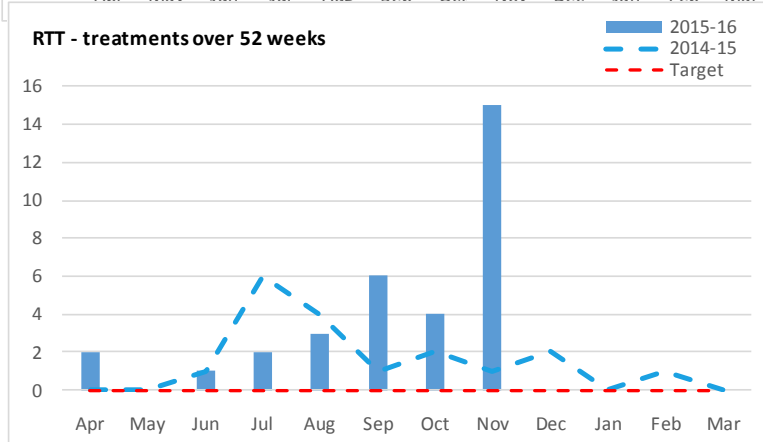
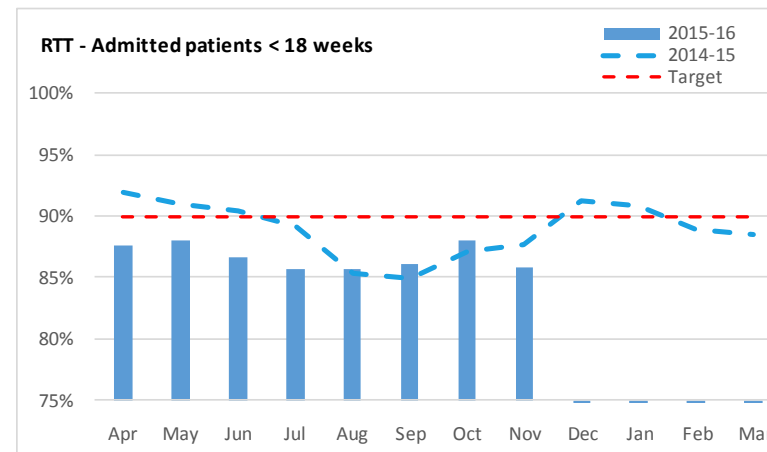
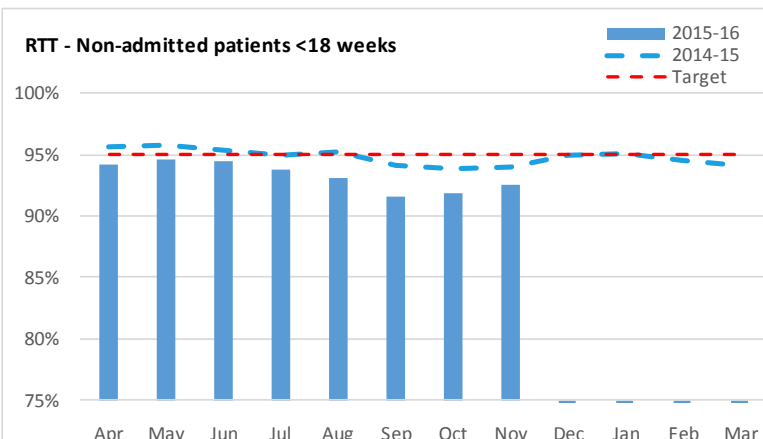


Action and progress	Owner	Next review date
Open 14 inpatient beds on 1 st December & a further 14 beds mid-December.	Acute Medicine DMT	End of December
Re-establish the Frailty Unit on Evan Jones to support the over 75 year old pathway . Plans to start the 3-take model in January in Medicine (before the full functioning model is in-place in Q1 2016/17)	Acute Medicine DMT	End of December
Internal 'red week' w/c 16/11 and platinum complex discharge week planned for December. Actions plans agreed at Star Chamber.	Deputy Dir of Operations.	End of December

- 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 continues to meet the 'incomplete' pathway standard in aggregate (chart upper left) but not for all services. A small number of services remain a particular concern as they are continuing to experience increasing demand, but have limited options for alternative provision. Adult plastic surgery and ENT and paediatric ear nose and throat (ENT) surgery continue to remain a priority focus.
- We have reported 15 pathways over 52 weeks. This is as a result of the rule change that removes the ability to "adjust" a patient's pathway when they have requested a pause or delay to their treatment; this is seen in Plastic surgery and Orthopaedic pathways. In addition the Trust identified additional patients that were potentially waiting for our Pain services during November which added to the increase in patients. We expect the number to reduce however it will remain higher than the months prior to October.
- There has been significant focus on RTT, with additional assurance on activity and actions to actively reduce the backlog. The trend of a rising backlog has since been halted since August and is now slowly reducing, however the overall size of the waiting list remains a concern and we continue to work with commissioners of demand management options.



- Whilst we don't report on our non-admitted and admitted performance to external regulators, our performance shows that we have focussed on reducing our backlogs, as performance would drop as additional patients were treated over 18 weeks. This is noted particularly in the non-admitted graph (top right).
- The combination of increased referrals and not meeting our planned levels has meant that more patients are now waiting over 18 weeks whilst in the Out-patient setting of their treatment pathway. Directorate teams has been asked to focus on delivering additional capacity to ensure patients are seen more timely and the overall number of patients over 18 weeks reduces. Further detail is provided in the briefing note on page 41.
- We have reported 15 clock stops for treatment over 52 weeks. 3 of these patients were linked to patients declining treatment having delayed their treatment through choice. This is seen in Plastic surgery and Orthopaedic pathways. In addition the Trust identified 12 patients in our Pain and INPUT service who as a result of an administrative error in the vetting procedure within the service had waited a long time for a response; 3 required treatment during November 2015 and 9 patients subsequently did not require any form of treatment from the service. The error has now been resolved.



• 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 continue to treat a higher proportion of patients who have waited over 18 weeks as we aim to reduce our backlog. The number in admitted has increased as a result of now showing the full unadjusted position, as part of the RTT rule change in October.
- The overall number of patients waiting remained steady, but the number waiting over 18 weeks reduced slightly to 4210 at the end of November.

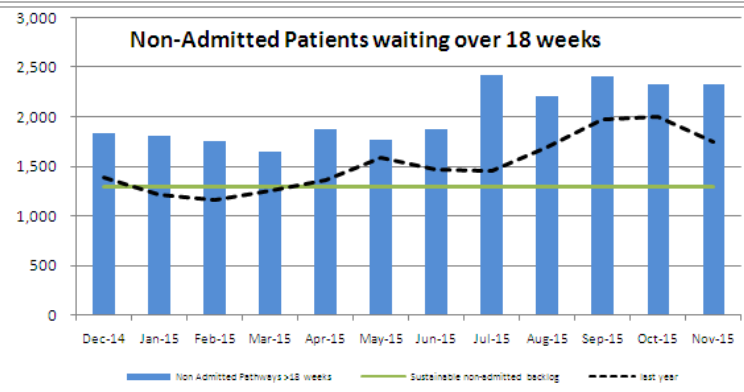
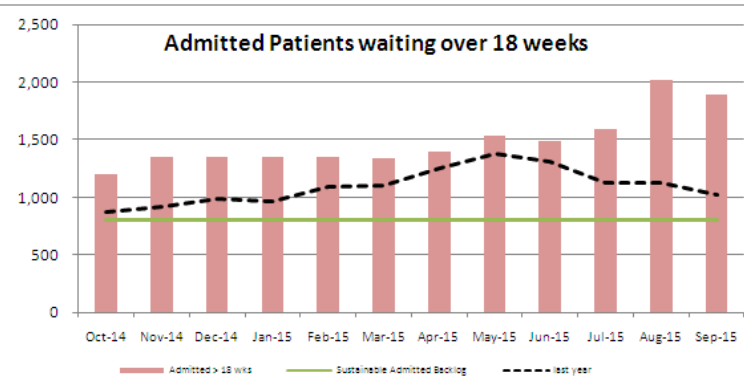
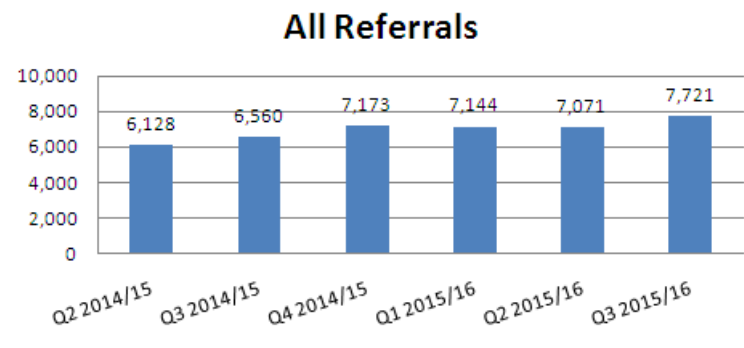
• Risks or opportunities for the Trust

- Referral volumes whilst steady in Q2 have risen further in Q3 2015/16. This is particularly noted in Dentistry services, Adult ENT, Breast Surgery and Gynaecology.

Services in addition to those with limited alternative provision have struggled to meet demand.

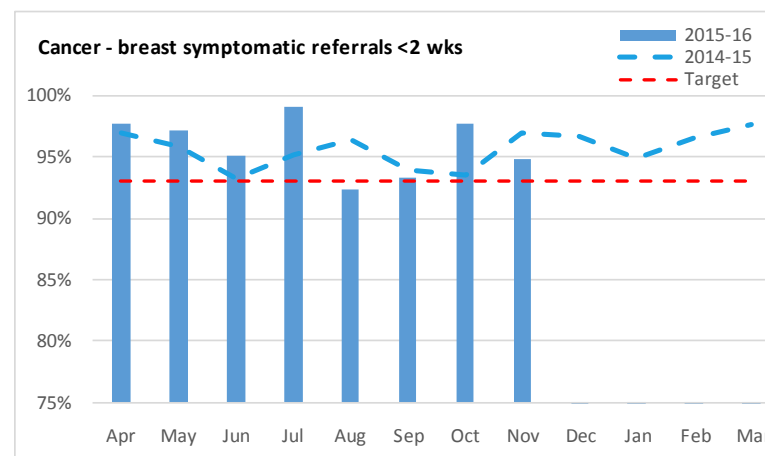
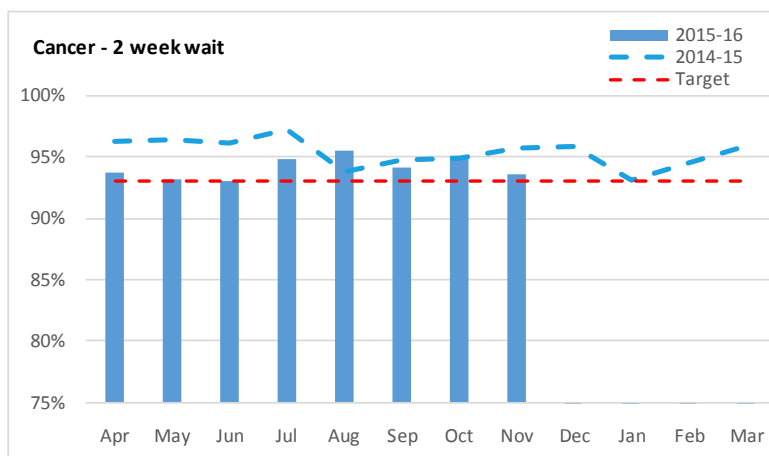
• Root cause analysis and insights

- It has not been possible to reduce the numbers of patients waiting over 18 weeks sufficiently.
- We have been work to mitigated capacity constraints by significantly increasing weekend and evening working, whilst also recruiting additional staff and seeking to increase productivity by reducing cancellations.
- However in November we continued to treat significantly high numbers of elective patients and maintain the levels of outpatient activity seen in October.
- 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 sites have not been close to the Trust, or the value given to the work is significantly above the amount received by the Trust.
- We are ensuring that our validation processes are robust and that lessons learnt are embedded in into the standard operating processes within directorates.

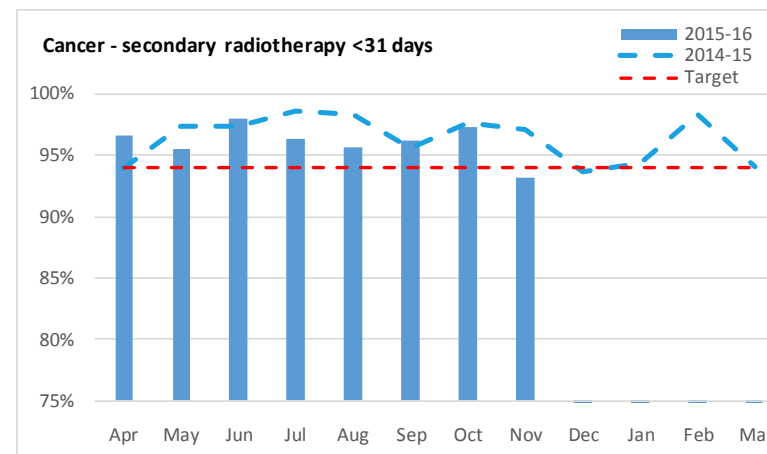
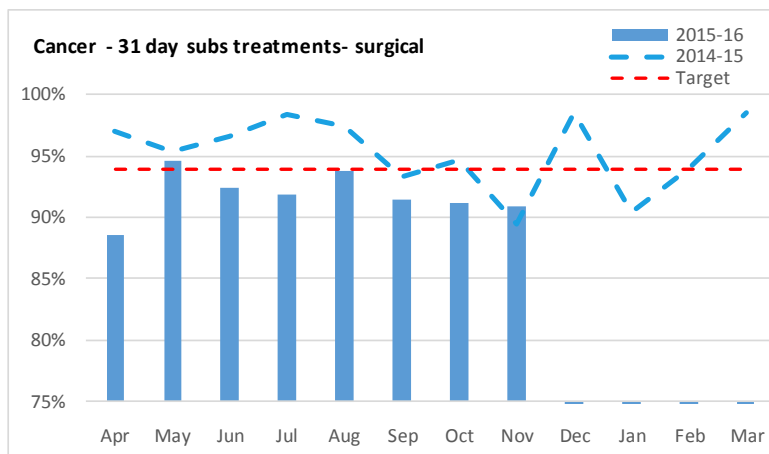
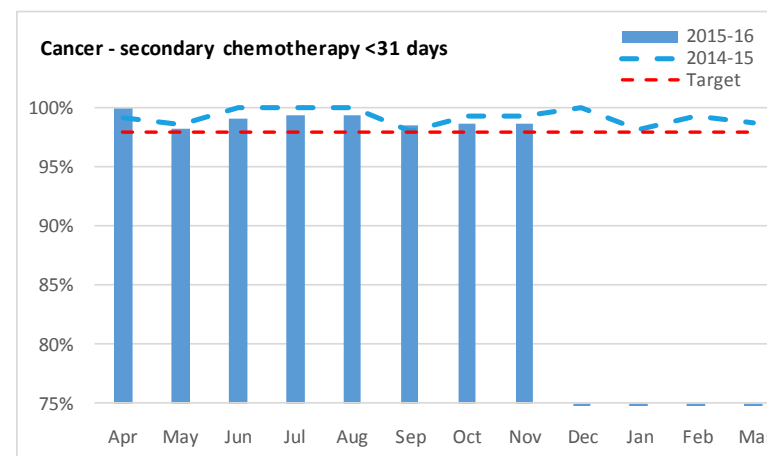
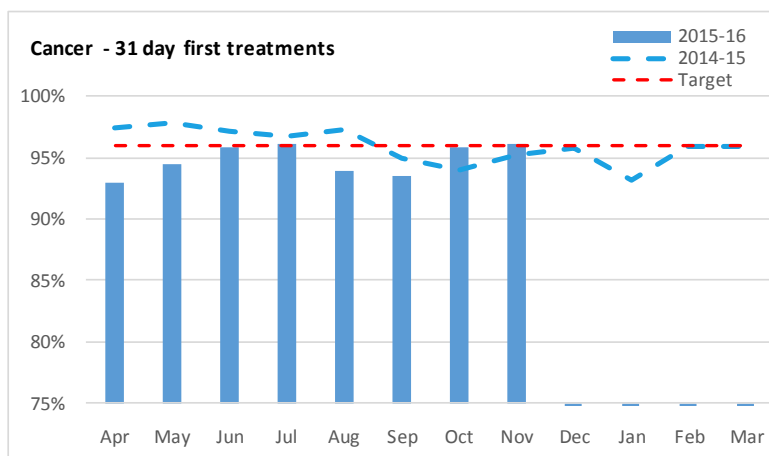


Action and progress	Owner	Next review date
Review validation and PTL process to ensure better pathway management.	General Managers	January 2016
Identify external capacity through NHSE PMO to support treatments.	DMT/Performance Team	December 2016
Intelligence triangulated	Root cause understood	Action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

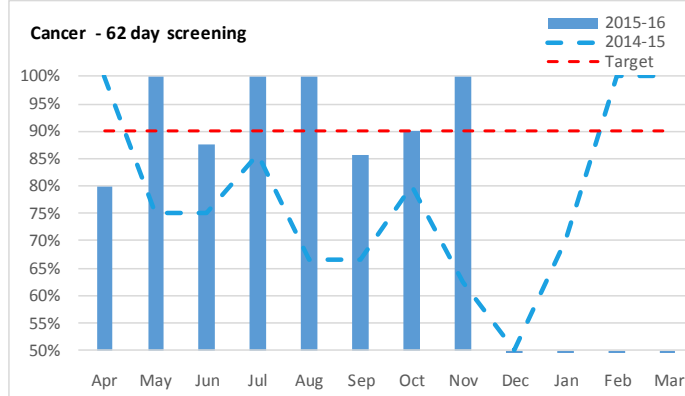
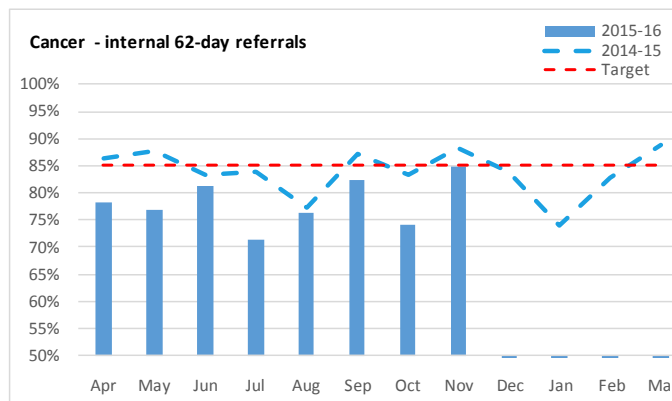
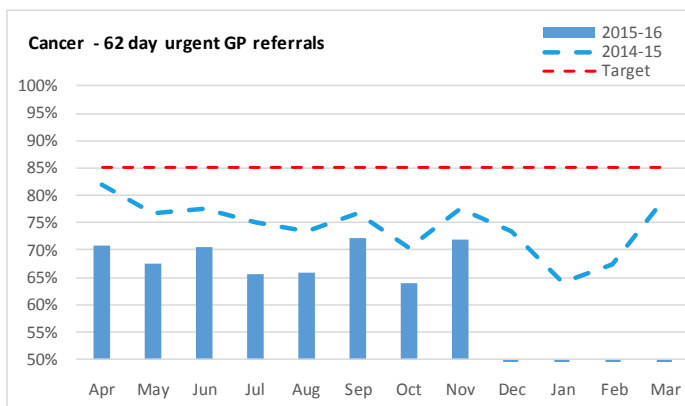
- The Trust Continues to achieve the 2 week wait targets for patients with a suspected cancer diagnosis.
- The internal target of seeing 70% of patients by day 7 of the pathway (rather than day 14) is monitored weekly. The proportion of patients seen for their first appointment by day 7 across all tumour sites remains at approximately 40%. Patient choice reasons remain one of the key challenges to the target and we continue to monitor our out-patient capacity to ensure we respond to seasonal variations in referral rates.



- We met all the 31 day targets apart from Subsequent surgery in November. This reflects the work in urology since the purchase of the 2nd robot which has supported the improvement of waiting times for treatments.
- There were 12 breaches out of a total of 126 subsequent treatments, a performance of 90.5% (standard is 94%). 7 were urology patients, 2 Breast, 2 Skin and 1 Upper Gastro-intestinal patient.
- The subsequent surgery breaches were due to a combination of medical, capacity and patient choice reasons. The Directorates analyse these breach reasons to ensure that they can respond to the trends and themes to correct these in future months.



- Overall performance for 62-day maximum wait for first treatment remains below the 85% target. Overall performance of 72.29% with an internal performance of 84%. Of the 13 internal breaches this month only 2 were avoidable. The majority of breaches were due to medical/complex reasons or patient choice reasons. However we are working closely with the Cancer data team and Directorates to ensure that we don't have avoidable breaches and we are investing additional resource in the team, supported by our CCG colleagues as well as reviewing the weekly rhythm and system checks to ensure that we capture errors and delays on daily basis so that we can take action immediately.
- The main factor in our failure to meet the overall target relates to the external referrals into the Trust for treatments. The majority of the breaches in November 60% (27) were referred late and 33% (15) had already breached. We unfortunately had 8 avoidable breaches, in total; 3 were due to capacity constraints (oncology) and 5 were due to internal delays after receiving inter-trust Transfers. As well as training and support we are recruiting 2 Inter Trust coordinators to ensure patients requiring treatment at the centre are referred in a timely manner and their pathways transferred seamlessly.



62 Day Treatment- November			
CWT Code	Internal Treatments	Internal Breach	Internal Performance
Brain CNS	0	0	
Breast	12	1	91.7%
Gynae	3	0	100.0%
Haematological	3	0	100.0%
Head and Neck	3	1	66.7%
Lower GI	7	2	71.4%
Lung	1	0	100.0%
Other	0	0	
Skin	3	0	100.0%
Skin Haematology	2	1	50.0%
Thoracic	2	0	100.0%
Thyroid	1	0	100.0%
Upper GI	3	0	100.0%
Urological	41	8	80.5%

Internal total	81	13	84.0%
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External total	87	43	50.6%
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62 Day Treatment- Q2 2015/16			
CWTCode	Internal Treatments	Internal Breach	Internal Performance
Brain CNS	0	0	
Breast	19	0	100.0%
Gynae	17	3	82.4%
Haematological	11	1	90.9%
Head and Neck	23	7	69.6%
Lower GI	16	8	50.0%
Lung	11	4	63.6%
Other	1	0	100.0%
Skin	13	0	100.0%
Skin Haematology	1	1	0.0%
Thoracic	2	0	100.0%
Thyroid	1	1	0.0%
Upper GI	13	5	61.5%
Urological	96	24	75.0%

Internal total	224	54	75.9%
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External total	266	125	53.0%
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- Our current internal performance Improved to 84% in November . There were 2 internal avoidable breaches which affected our performance . The remaining internal breaches were in Head and Neck(1) LGI(2), Breast (1), Haematology (1). There was one internal breach relating to an administrative error. There remains a strong focus on eliminating all admin errors through training and support for the coordinators.
- The external position remains challenging however the focus on working with the Trusts in SEL remains a priority with additional funding being made available to appoint joint coordinators working between the cancer centre and Kings College Hospital Hospitals Foundation Trust (KCH) and Lewisham and Greenwich NHS Trust (LGT). This will directly support patient pathways by improving the timeliness of referrals.

• 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

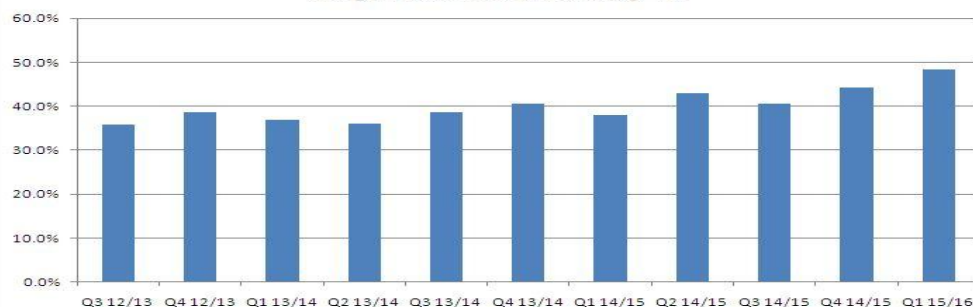
- Key Tumour Groups are Head and Neck ,Thoracic, Urology, and GI – Upper and Lower
- The amount of external referrals (which are greater than internal referrals), and the level of late referrals particularly from these Trusts, account for the fact that we cannot meet overall performance.

• Root cause analysis and insights

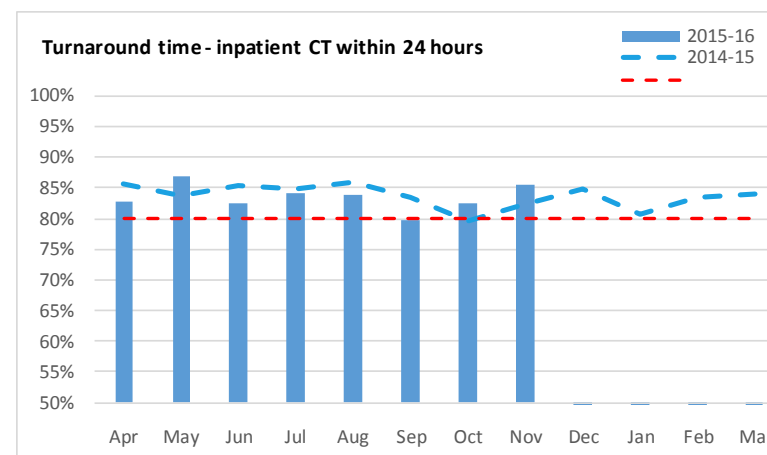
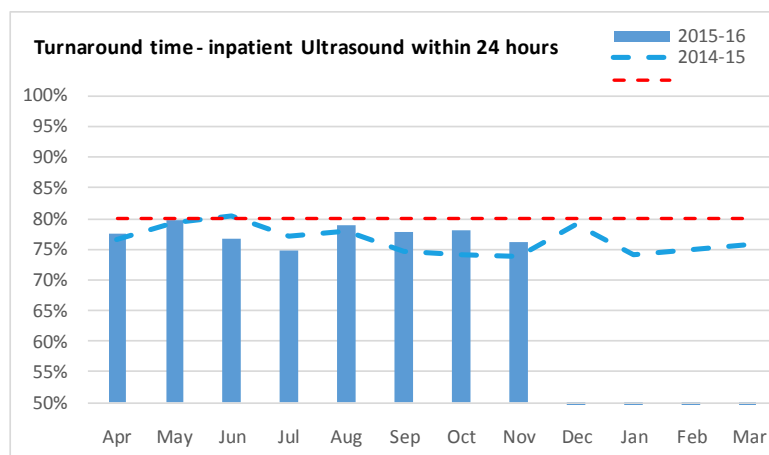
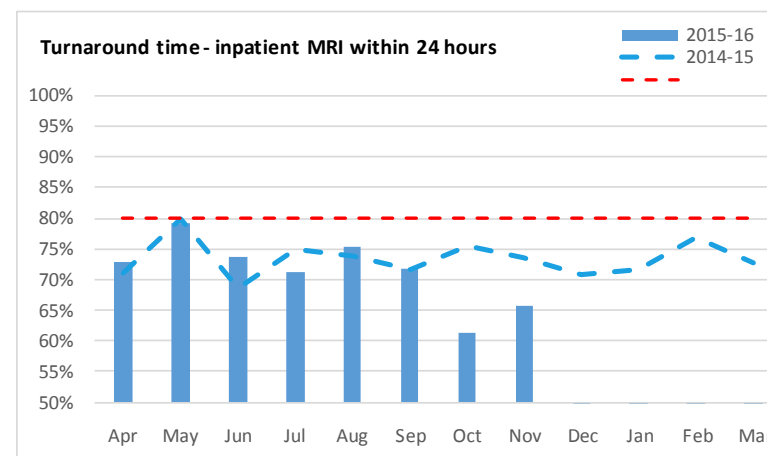
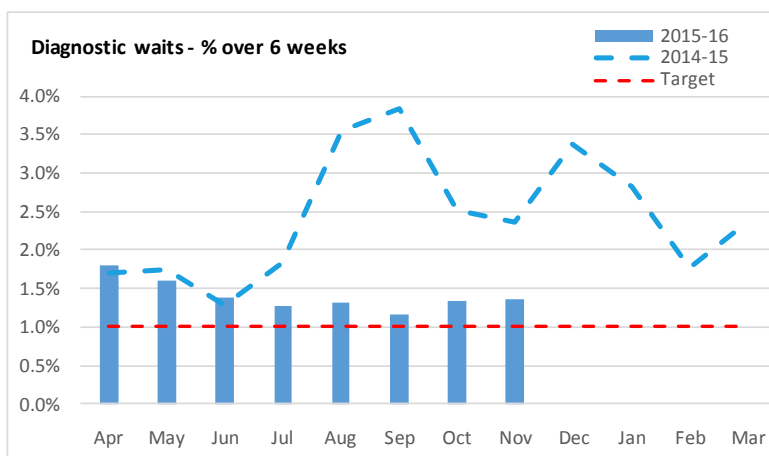
- The Chief Operating Officer team continues to drive through a comprehensive action plan covering each of the tumour groups which aims to continually improve these pathways for patients.
- A monthly senior team meeting made up of the cancer lead clinicians and managers from SEL has been set up to ensure 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%

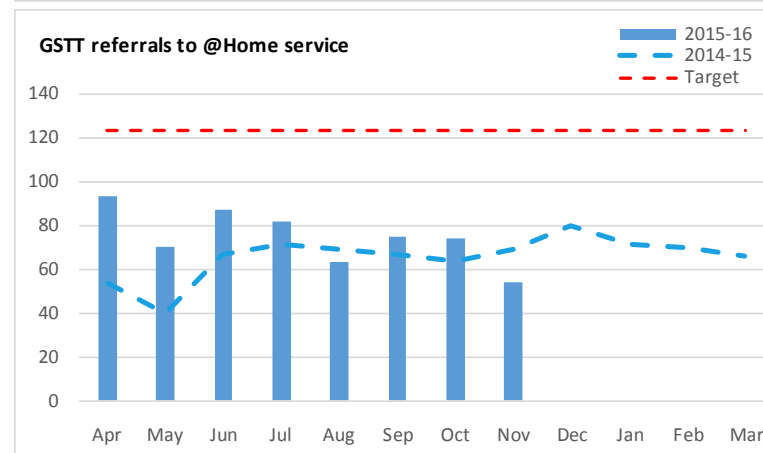
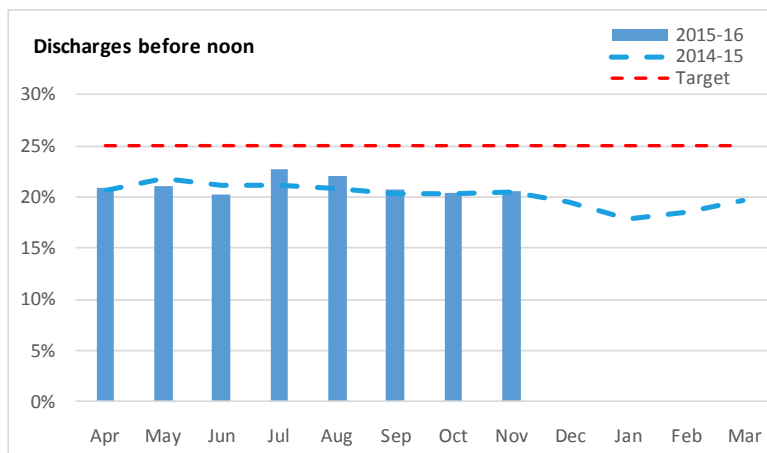
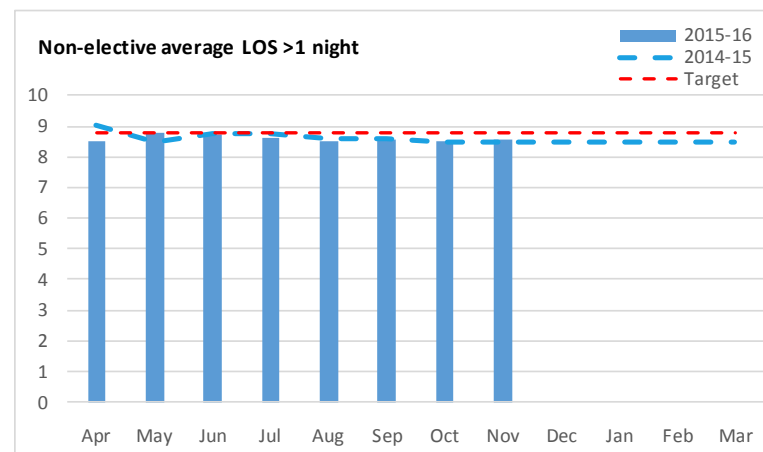
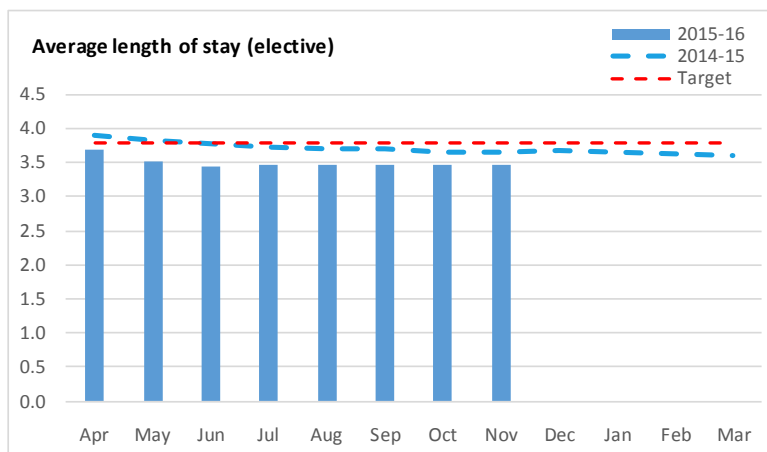
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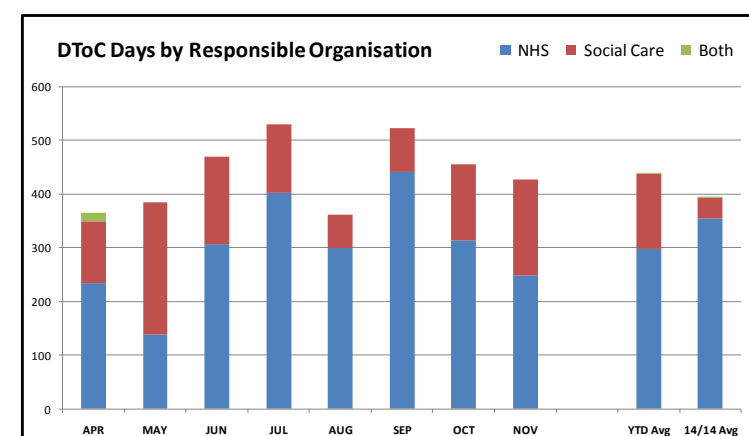
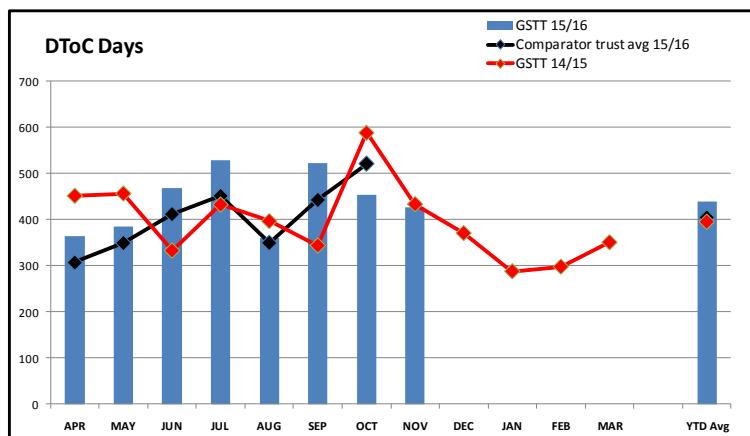
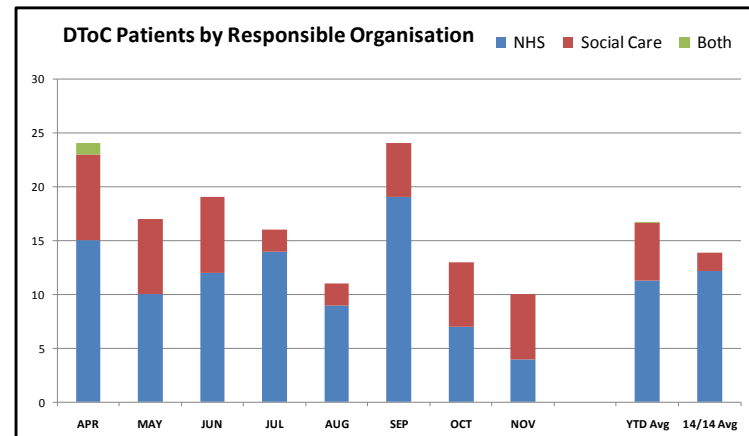
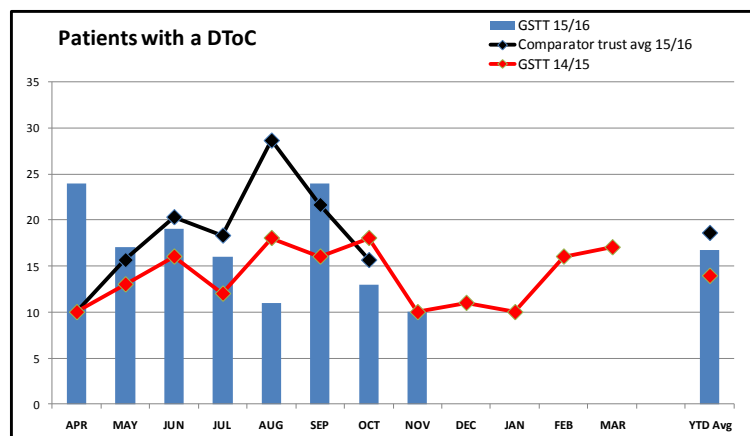
- The number of patients who received their diagnostic test within 6 was 1.35% November against the target of 1%. This continues to remain at a significantly improved position in comparison to 2014/15.
- Remaining drivers for non-delivery against the target are Paediatric MRI, GA Cystoscopy and Urodynamics in both adult and paediatric services. We are unable to secure alternative capacity for paediatric MRI, however we are reviewing our trajectory action plans for both Cystoscopy and Urodynamics to reduce the number of patients waiting



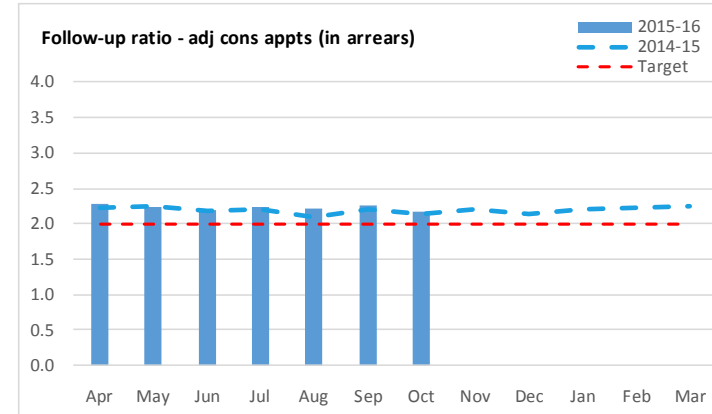
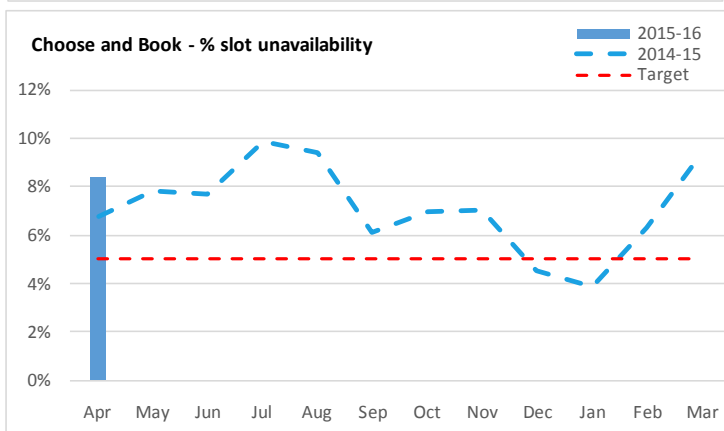
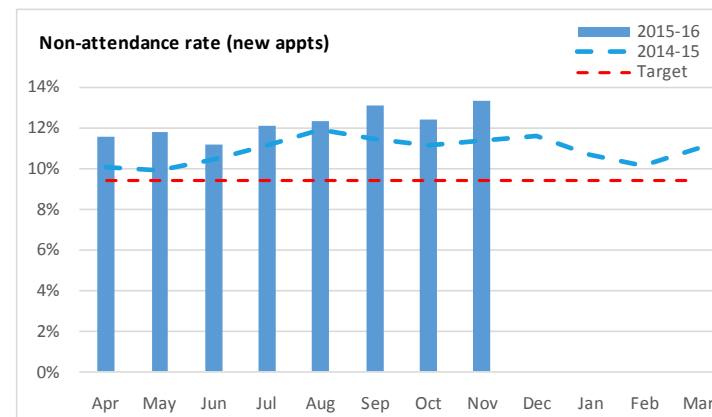
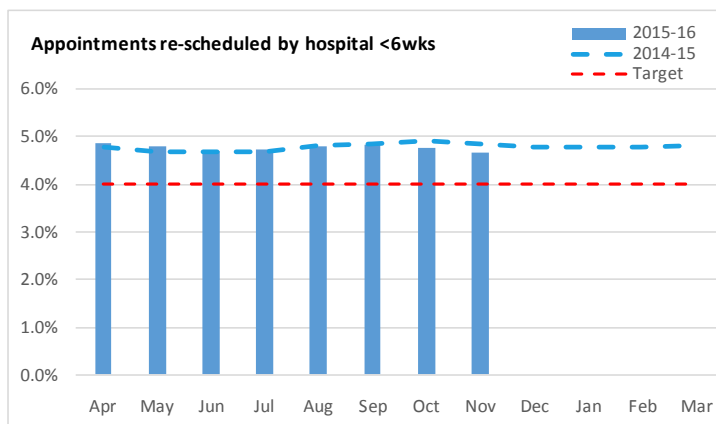
- Efforts to provide alternatives to hospital admission continue, including our @Home and Enhanced Rapid Response (ERR) services. Referral rates to @Home and ERR for Quarter 2 are similar to last year, but remain short of the Trust target of 120 a month. There were capacity issues relating to staff sickness, however there was a change of IT operating system towards the end of the month from RIO to Care-notes which will have had some impact on the available data.
- 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.



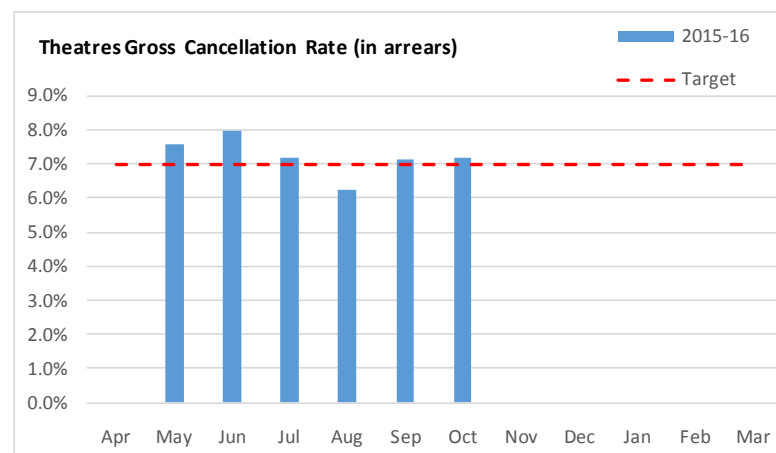
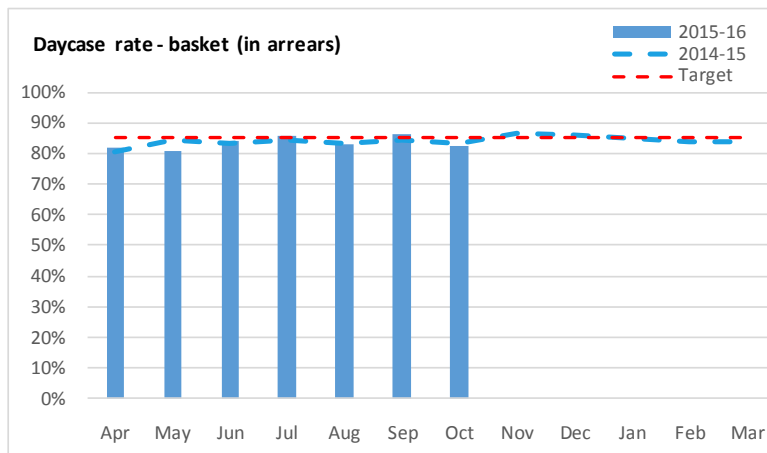
- **Delayed Transfer of Care (DTOC) –**
- The definition of a DTOC is when a linked to a delayed transfer of care from acute to non-acute care where patient is ready to depart from such care and is still occupying a bed. Ready for transfer implies that a clinical decision has been made and that a multi-disciplinary decision has been made that the patient is ready for transfer and that the patient is safe to discharge/transfer.
- In November we initiated 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 also started communicating a report of all complex discharge patients with various CCG colleagues to enable better communication of actions required for individual patients.
- This shows that our DTOC levels are now comparative 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, which seems to be having an impact.



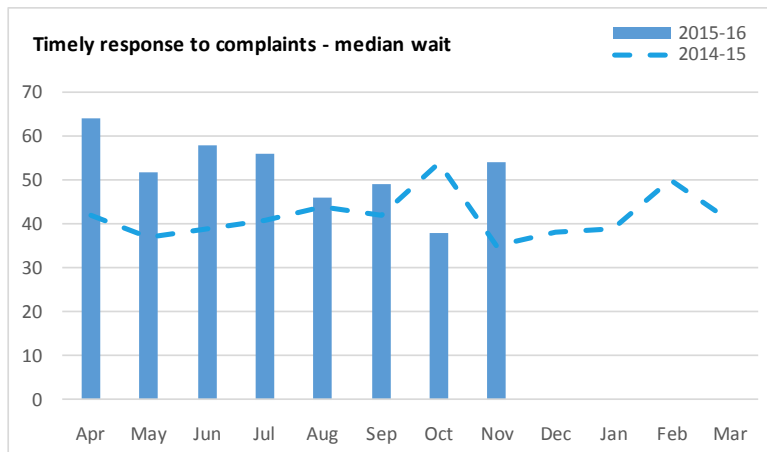
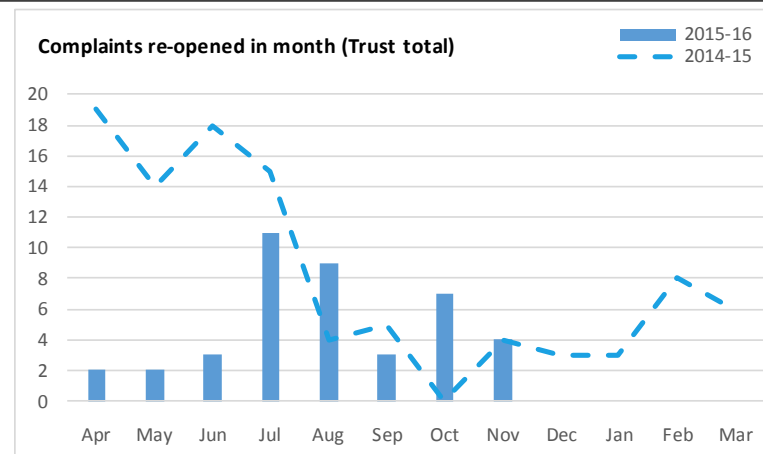
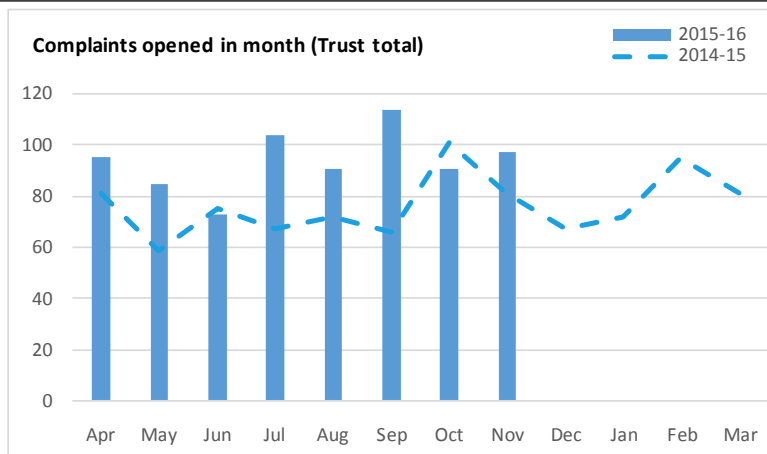
- **Appointments re-scheduled by the hospital within 6 weeks of an appointment** – Fewer patients were rescheduled in November compared to the prior year. Services are continuing to implement new ways of booking e.g. partial booking, to reduce the likelihood of needing to reschedule patients. Standards 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 and we are looking to use local data for inclusion in this report for December. Local data indicates % slot availability has marginally improved this month and over the next few months we will be reviewing all our services on e-RS to improve this further.
- Our indirectly bookable services are being scoped to move to direct booking, and we are working with Lambeth CCG & KCH to commence GP visits as well as developing a local SLA focusing on all outpatient activity.
- **Non-attendance for new appointments** – DNA rates for November have increased. One particular service has seen a high increase in DNA appointments which appears to be as a result of incorrect recording of rescheduled appointments. 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. The Trust is considering highlighting the impact DNAs have had on the organisation in terms of cost and wasted time, in outpatient letters and SMS texts, as other Trusts have done.



- The continued focus on cancellations across the organisation has resulted in achieving the target of 7% gross cancellation rate for the past four months. Further work is underway to explore if this can be reduced further.
- On-going work focus on the cancellation rates has sustained the reduced levels of cancellations across the theatres. The pilot for texting inpatients is currently being finalised and is planned to go live in December 2015.



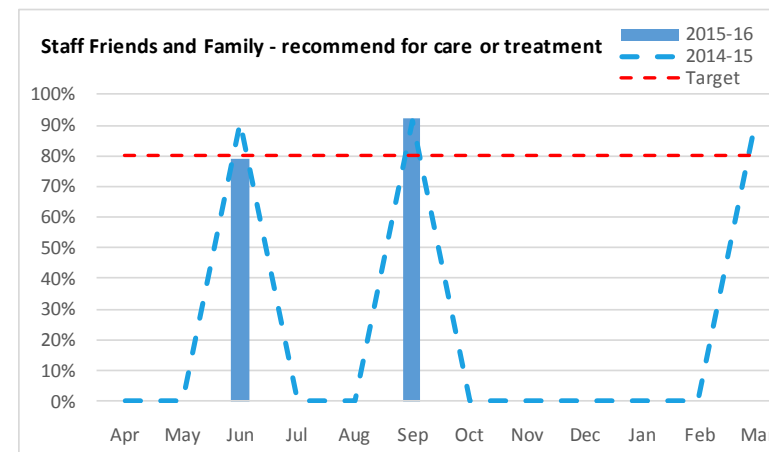
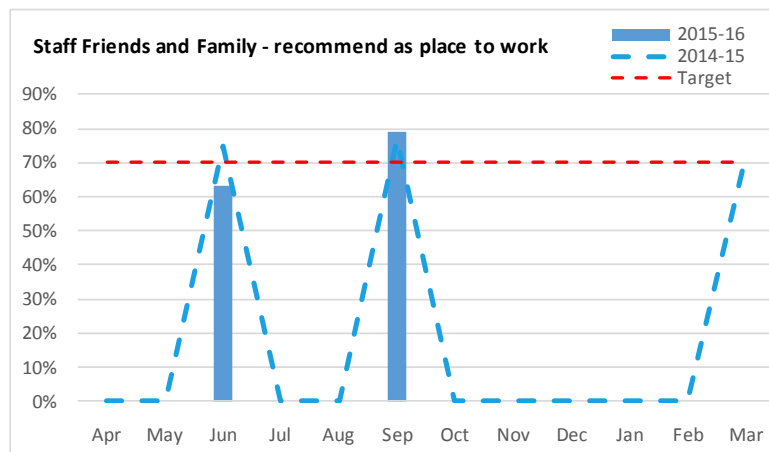
- The number of formal complaints received in November (97) was the highest since July. There has been a noticeable increase in complaints across the Trust in the year to date. The reason for this is not certain but it is noted that efforts have been made to raise awareness of the option to make a complaint. 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 increased in November and reflects that we closed a significant number of our older cases in that month.
- We aim to reduce the number of complaints re-opened due to complainant dissatisfaction with our response by responding to complaints fully and promptly, and have been focusing more strongly on getting it right first time.



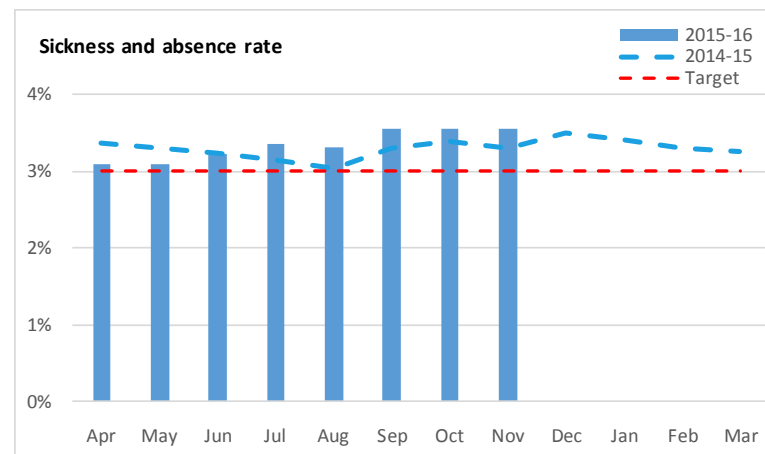
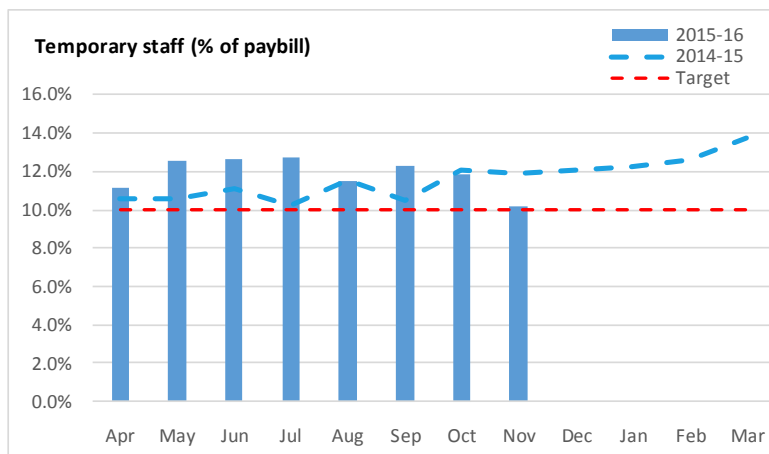
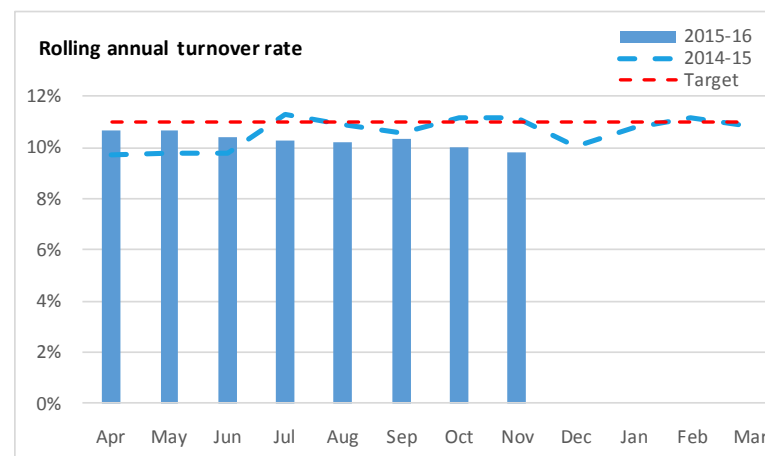
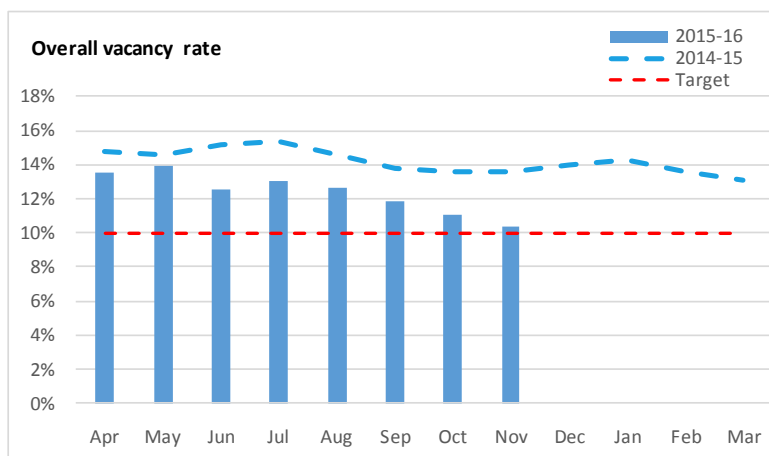
The Trust's ambition is to provide a complaints system which is open to complaints, supports patients, families, and staff through the process, and which delivers a timely apology, explanation and determination to learn from mistakes. The aim is to produce a service about which complainants are able 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	Sep	Oct	Nov	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%	79.0%	-	-	71.0%		Y
	FFTS2	Staff Friends and Family - recommend for care or treatment	Qtly %	>80%			91.0%	92.0%	-	-	85.5%		Y
5.3 Workforce indicators	VACTB	Overall vacancy rate	Mthly %	<10%			14.2%	11.9%	11.1%	10.3%	12.4%		Y
	TEMPTB	Temporary staff (% of paybill)	Mthly %	<10%			11.6%	12.3%	11.8%	10.2%	11.9%		Y
	TURNTB	Rolling annual turnover rate	Mthly %	<11%			10.6%	10.4%	10.0%	9.8%	10.3%		Y
	206TB	Sickness and absence rate	Mthly %	<3.0%			3.3%	3.56%	3.55%	3.55%	3.34%		Y
	211TB	Appraisal compliance (non-medical staff)	Mthly %	>95%			71.4%	77.3%	77.1%	76.9%	73.1%		Y
	MTTB	Mandatory training compliance	Mthly %	>95%			86.1%	86.9%	86.2%	86.4%	86.6%		Y

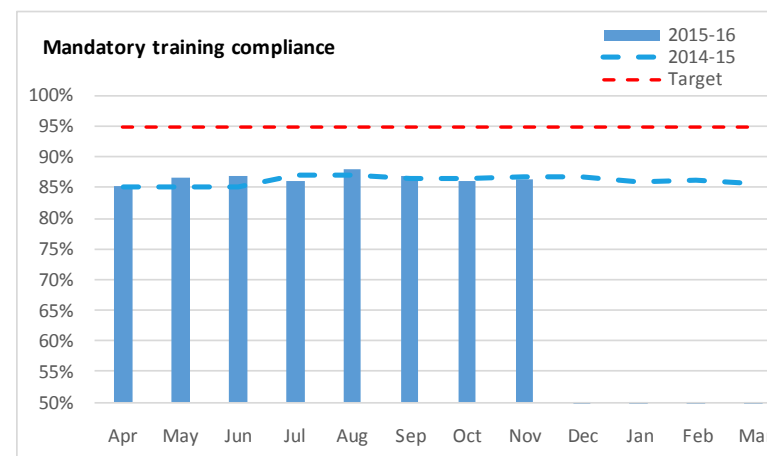
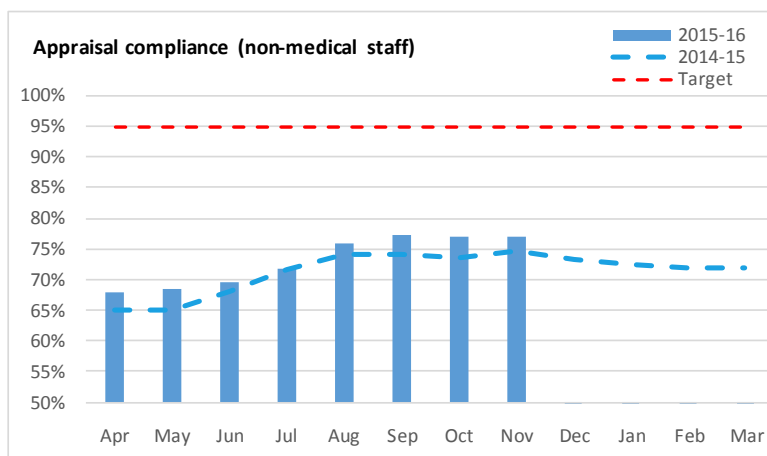
- Our Quarter 2 Staff Friends and Family Test (SFFT) results highlight that our staff continue to give the Trust a huge vote of confidence as a provider of care where 92% of our staff said that they would recommend the Trust as a place to be treated, much higher than the national average of 79%. 76% of our staff said that they would recommend the Trust as a place to work, again higher than the national average of 62%. 1474 staff participated in the Survey which was open from 27 August for 3 weeks.
- 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.
- The National Staff Survey, which takes place in the third quarter of each year, was open from 25th September to 27th November 2015. 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. All staff were invited to participate and 4454 staff members responded. Complete results will be available next year; which will give us a broader picture of staff experience within the organisation and how we compare nationally, with other NHS Trusts.



- The overall vacancy rate (10.34%) reduced further last month but continues to be above the Trust stretch target level of 10%. This compares favourably to a November 2014 rate of 13.63%. We anticipate further reductions over the coming months, albeit at a slower rate than of late
- Temporary staffing spend showed a decrease in November to 10.2% of the pay bill. Agency costs reduced to just over £3 million, with a significant reduction on Nursing spend on previous months. Temporary spend will continue to be monitored closely as vacancies are filled and Trust controls through the Fit for the Future work stream on temp staff usage take effect. The Trust introduced enhanced monitoring of Agency shifts following the introduction of the Monitor price cap during November.
- The Turnover rate continued to fall to 9.84% and it remains in line with the Trust target, benchmarking well against other London trusts.
- The Sickness rate remained stable at 3.55% but continues to track above the long term average, as well as above target.

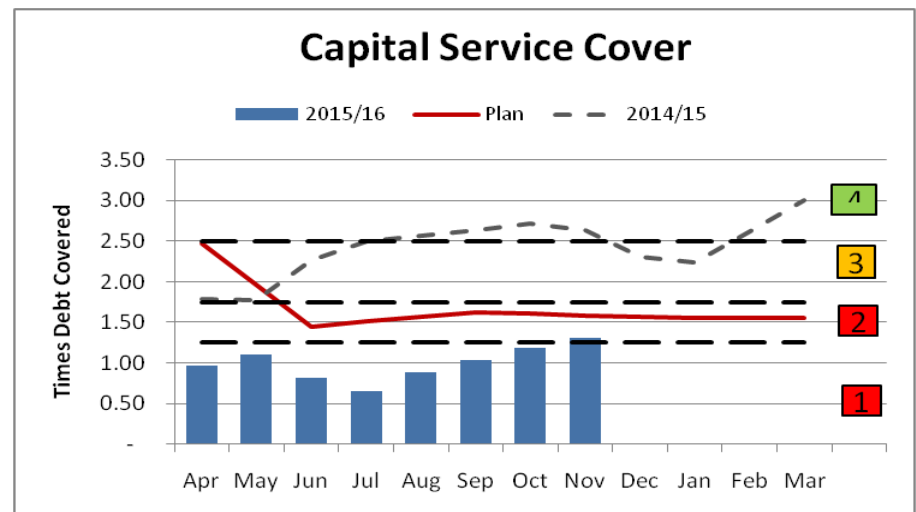
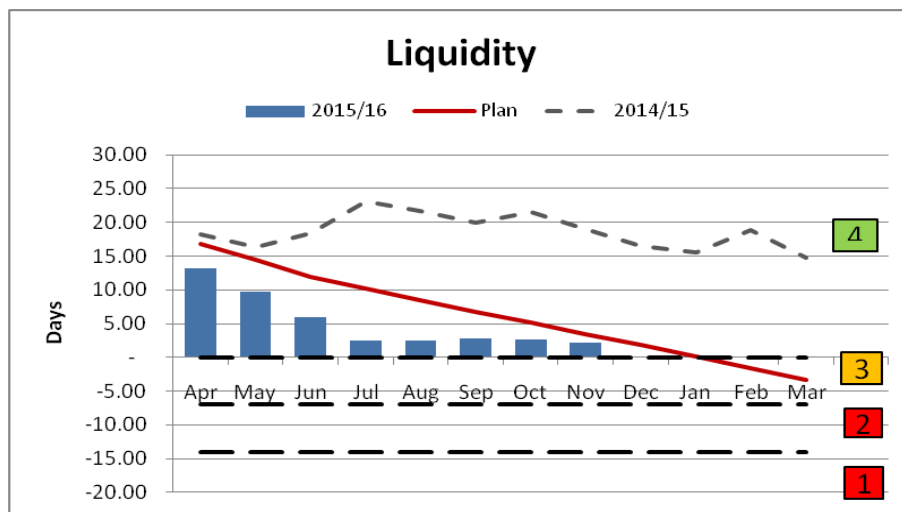
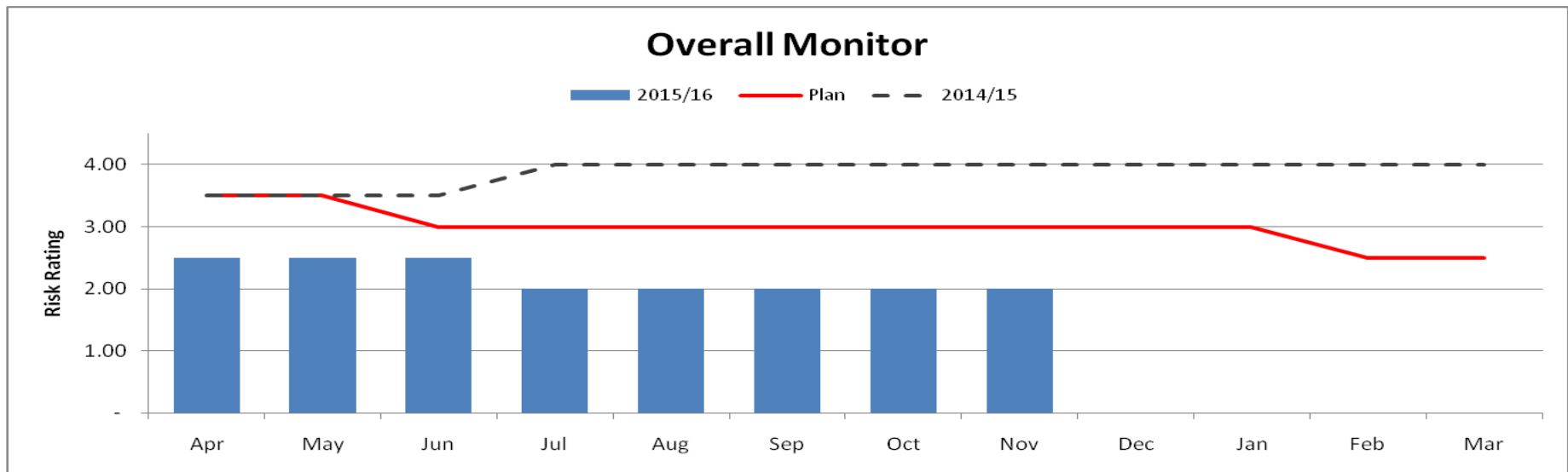


- Personal Development Review (appraisal) compliance rates for November reduced slightly to 76.91%, however this was higher than the same month last year. The Trust has yet to achieve it's target of 95%. Communication regarding the importance of PDRs continues to be raised across the Trust as well as encouragement for staff and managers to report compliance to the central database to ensure accurate rates are reported.
- Mandatory training increased slightly to 86.4%, however compliance remains below Trust target level of 95%. There were several individual Directorates have achieved over 90%.



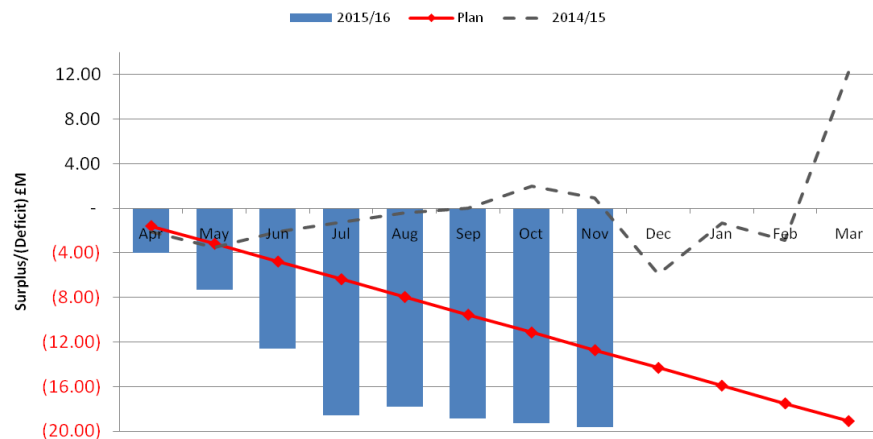
Theme	Ref	Indicator	Units	Target	R	G	Prior year	Sep	Oct	Nov	YTD avg	Monitor	Quality priorities	Trend chart
6.1 Overall financial position	MRRT	Monitor continuity of service risk rating	Score	>3			3.5	2.0	2.0	2.0	2.2			Y
	LQRT	Liquidity ratio (in days)	Days	>0			17.4	2.8	2.7	2.1	5.2			Y
	DSCT	Capital service cover	Ratio	>2.59			2.2	1.03	1.19	1.31	0.99			Y
	FIN01T	Overall underlying financial surplus/(deficit)	£M	>£12.73m			-£0.5	-£18.9	-£19.3	-£19.6	-£14.8			Y
	CSHT	Cash flow	£M	>£143m			£126.1	£78.8	£102.0	£96.0	£99.1			Y
	CAPT	Capital spend vs plan (year-to-date variance)	Mthly %	+/- 15%			78.6%	78.1%	73.1%	70.4%	84.2%			Y
	VRPT	Variance from Plan	Mthly %	0.0%				-1.9%	-1.5%	-0.01%	-1.9%			Y
	UNPT	Underlying Performance	Mthly %	0.6%				2.6%	-2.2%	-1.9%	-1.8%			Y
6.2 Activity levels (magic numbers)	560	Elective activity vs profiled plan - cumulative variance	Cum var %	>0%			-	-1.7%	-2.0%	-1.0%	-1.0%			Y
	606T	New patients seen vs plan (all categories, in arrears)	Mthly var	>0			-	-2,008	-1,477		-1,893			Y
	714	External cons referrals	Number	>last yr			1,752	1,857	2,040	1,755	1,900			Y
	713	GP referrals	Number	>last yr			14,404	16,280	17,354	17,194	15,787			Y
6.3 Fit for the Future	CIPSTC	Cost improvement plans (CIPs) - var to plan YTD	£M	>£0m			-£5.2	-£16.7	-£14.7	-£17.5	-£12.3			Y
6.4 Data quality and clinical coding	CM024	Community data completeness - % contacts outcomed	Mthly %	≥ 95%			93.3%	94.9%	92.9%	85.9%	94.5%			Y
	712	NHS number coverage	Cum %	>98%			97.4%	97.7%	97.5%	97.2%	97.5%			Y
	710x	Clinical coding - diagnostic depth (in arrears)	Ratio	>4.5			4.51	4.98	4.64		4.87			Y

An overall Financial Sustainability Risk Rating of two has been achieved at month eight, which is behind plan.

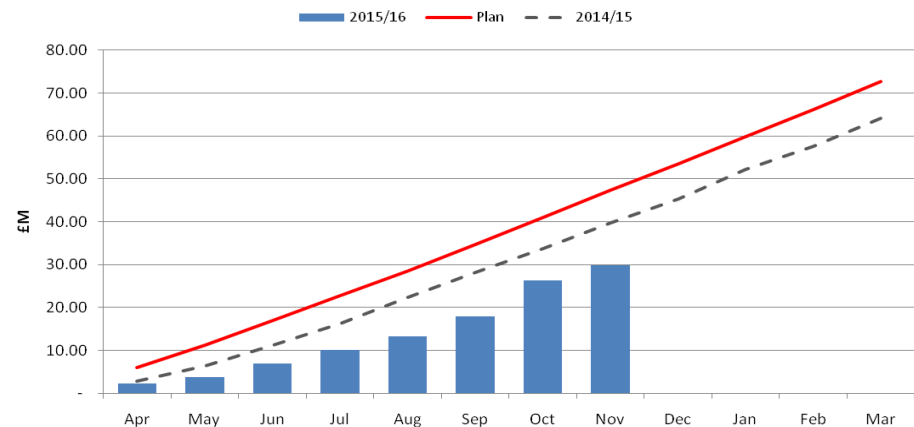


A loss of £19.6M has been recorded at November, which is £6.9M behind plan; CIPs (Cost Improvement Programmes) of £30.7M have been confirmed, but are £16.2M less than plan; the cash position at £96M is below the plan of £108.1M. Capital expenditure as a percentage of plan has fallen below the Monitor threshold of 85% (to 70%). A reforecast of the Capital plan may need to be considered having breached the threshold.

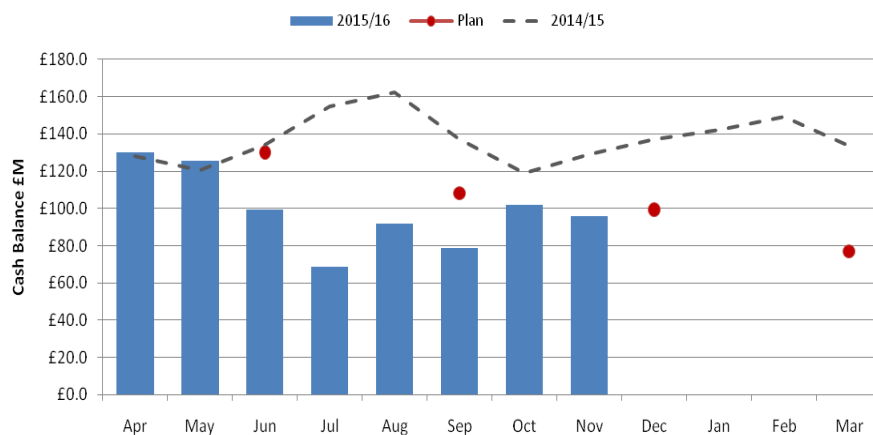
Overall Underlying Financial Surplus/(Deficit)



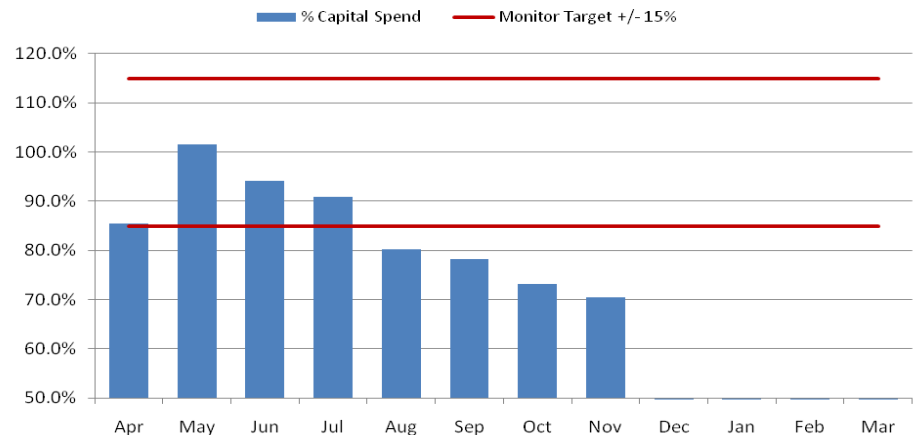
YTD Trust CIP Performance



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

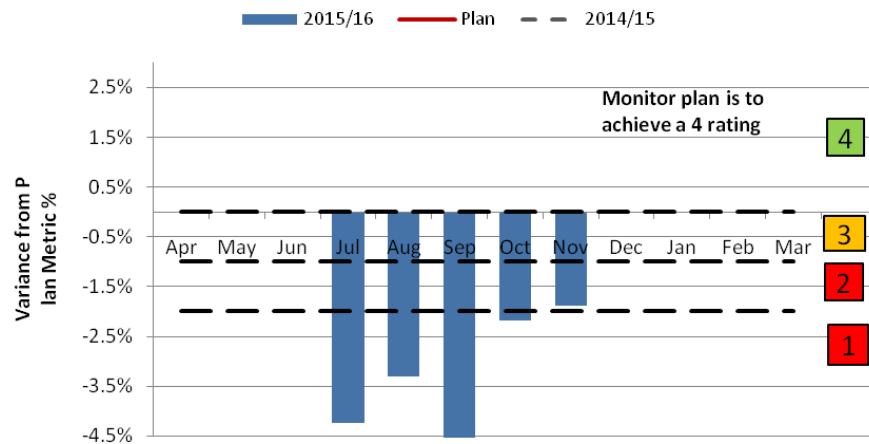


YTD Capital Spend % of Plan

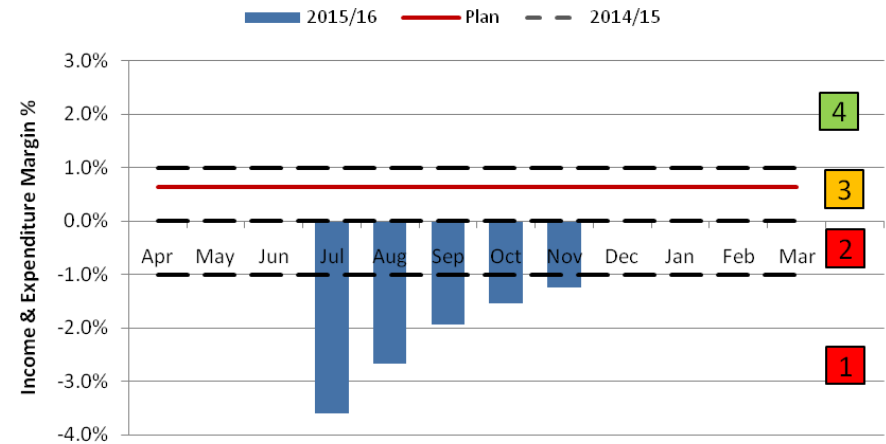


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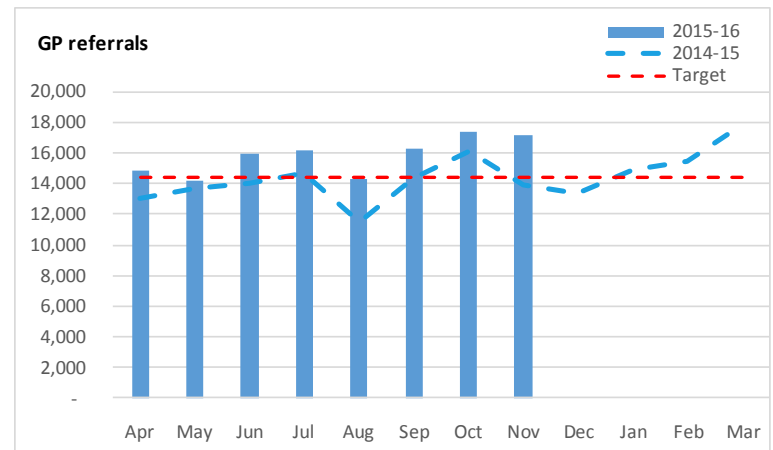
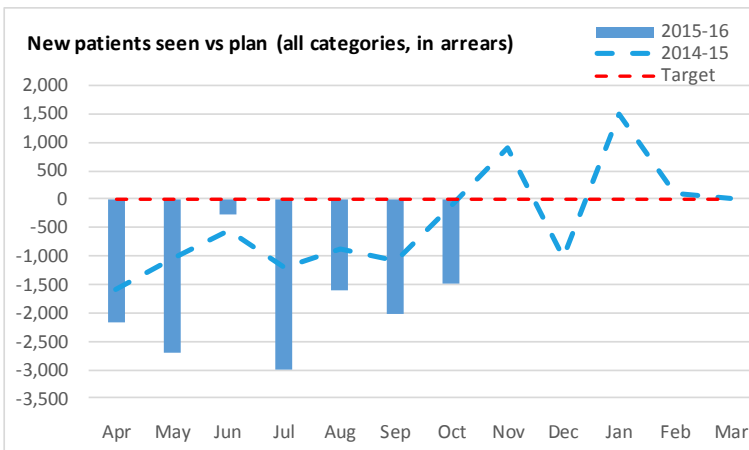
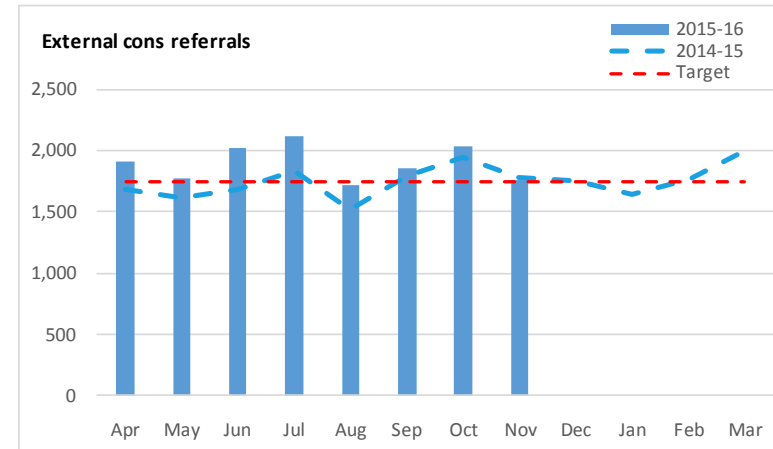
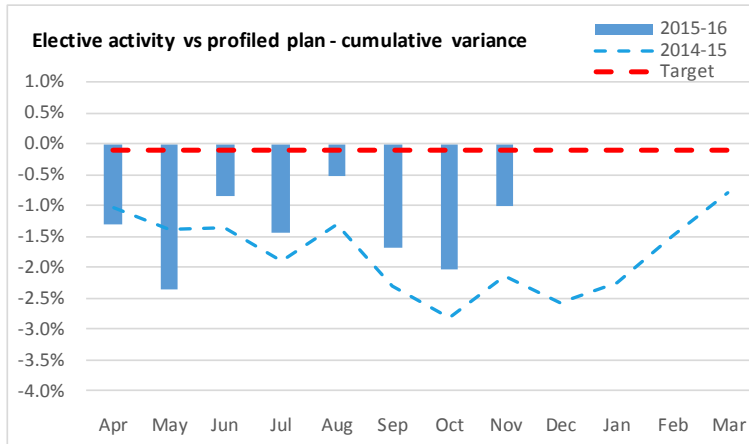
Variance from Plan



Underlying Performance

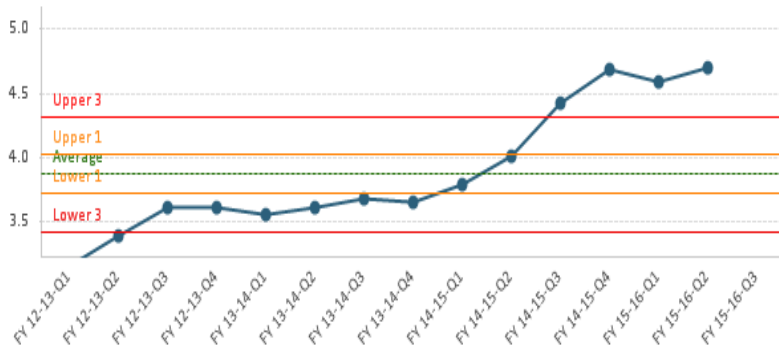


- We have improved on the cumulative variance against plan for both elective admissions and outpatients with the volume of patients being treated has increased significantly compared to last year.
- Demand – as measured in referral volumes – has risen during Quarter 3. This increases the level of concern around our ability to provide enough capacity to meet this further growth.
- 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 expected remain at high levels during December and into Quarter 4.

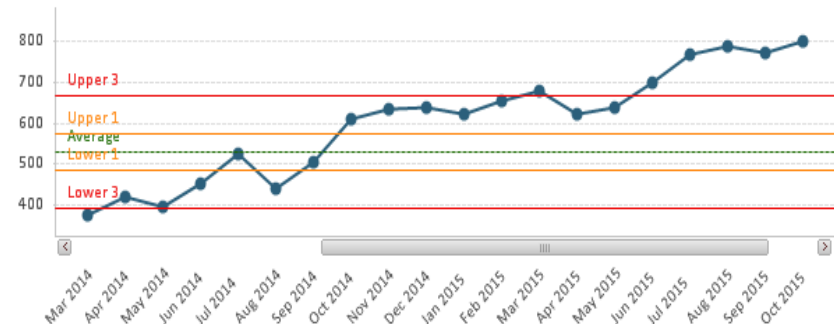


- Accurate and complete clinical coding of our activity is important to ensure patient safety, accurate benchmarking and appropriate payment for the services we provide. Improving the quality of all our data ensures that the information on which we base decisions is reliable.
- Diagnostic depth - the 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 November was 97.5% 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 November, performance dipped markedly (bottom left) which 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.

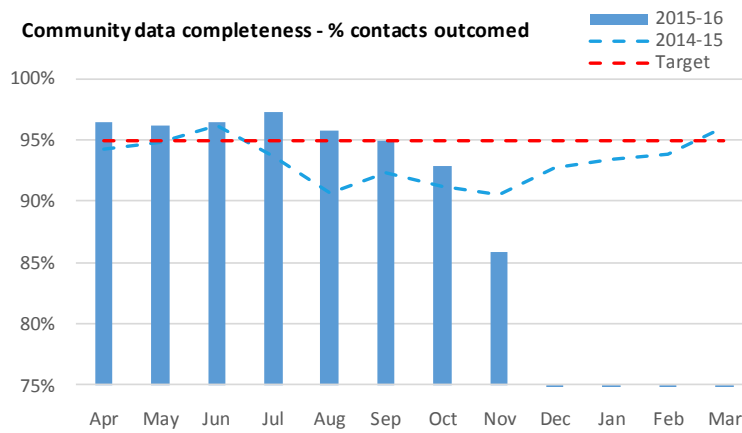
Diagnosis Depth by Quarter - SPC



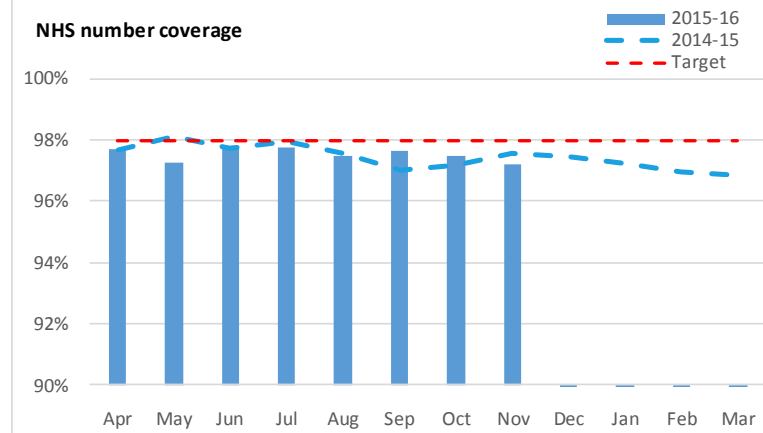
Number of Spells by Month - SPC



Community data completeness - % contacts outcomed



NHS number coverage



Where we want to be:

- Digital Clinical Programmes take advantage of new digital tools such as e-Noting, MedChart (Electronic Prescribing & Medicines Administration) and KHP online. The goal is to improve quality, safety and efficiency e.g. by moving clinical noting and medicines management online throughout 2015/16.

Where we are:

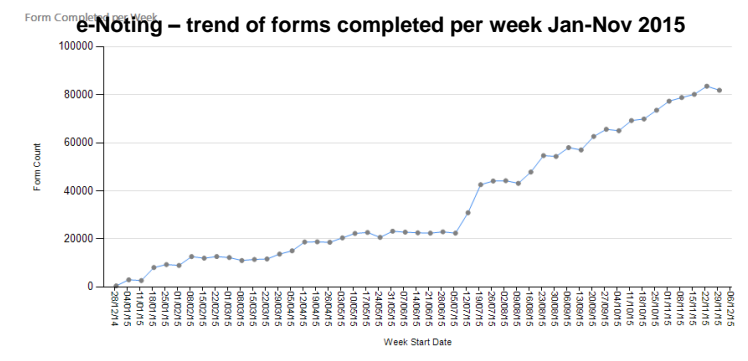
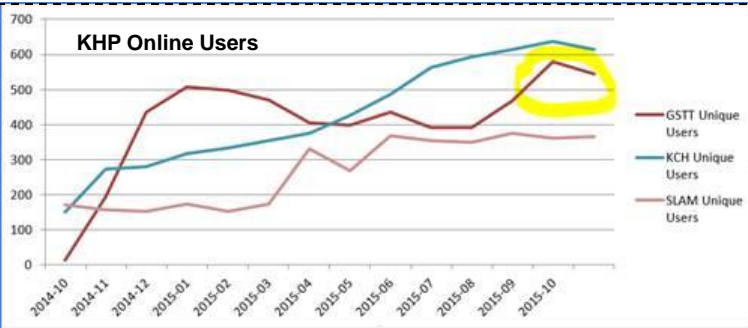
- MedChart** is now in use in all inpatient areas in Guy's, St Thomas' and the Evelina London Children's Hospital. 5,816 staff have been trained on the system.
- Similarly **e-Noting** has now been rolled out to inpatient areas in all three sites. At the end of November 2015 there were 45,959 e-Noting patients, over 5,600 active users and 1.75 million forms had been completed.
- In mid October a new diagnoses function was added to e-Noting; this is already starting to improve the quality of the data we collect for coding purposes. More accurate coding can assist the Trust in ensuring it is paid correctly for its clinical activities.
- KHP online, the portal that allows clinicians to see components of care from across KHP sites, is seeing increasing use by GSTT users.
- We have rolled out Advanced Care notes for community users, which went live on 30th November 2015.
- Opportunities or Risks for the Trust**
- Work has commenced on piloting a live bed state (LBS) app. This aims to provide the Trust with the ability to manage the occupancy of each ward, provide an estimated discharge date to capture when the bed is likely to become available, and allow clinicians to manage patient bed allocation out of hours in real time.
- The Faster IT (FIT) programme will provide all Trust IT users with faster, more efficient IT software and devices, starting next year. This programme will make our IT systems fit for the future by enabling staff to be more efficient and supporting them to deliver safe, quality care to our patients.

Actions set and progress to date:

- We are working with the clinical team on e-Noting outpatient forms. The scope and requirements have been agreed and are in development. They will include a procedures function to build on the improved coding information that has already been seen from the implementation of diagnoses. A pilot will begin in January 2016.
- An upgrade to MedChart is being worked on and will add five key areas of functionality including the ability to use the system on tablet devices e.g. iPads

Benefits

MedChart: Cumulative savings from implementing MedChart currently £1.2M including reduced printing costs and productivity improvements from the removal of illegible prescriptions, time saved locating charts and time saved transporting charts to Pharmacy. (YTD 15/16 financial year plus full year 14/15).



e-Noting Usage *since January 2015

No of active users	5,652
No. of e-Noting patients	45,959
Average no. of forms completed per patient	41
Average no. of forms completed per user	347

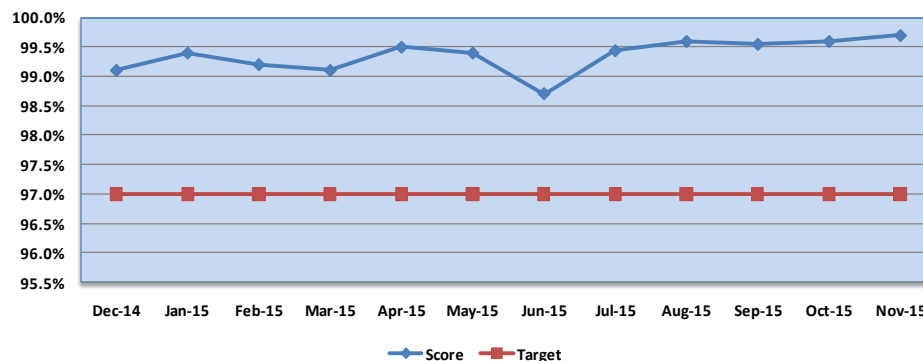
Summary:

- Cleanliness scores continue to track above the performance targets, both as measured in the monthly Inpatient survey and in the internal audit against NPSA (National Patient Safety Agency) standards. The 2015 PLACE results placed Trust scores 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 November 2015 there were 1669 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.

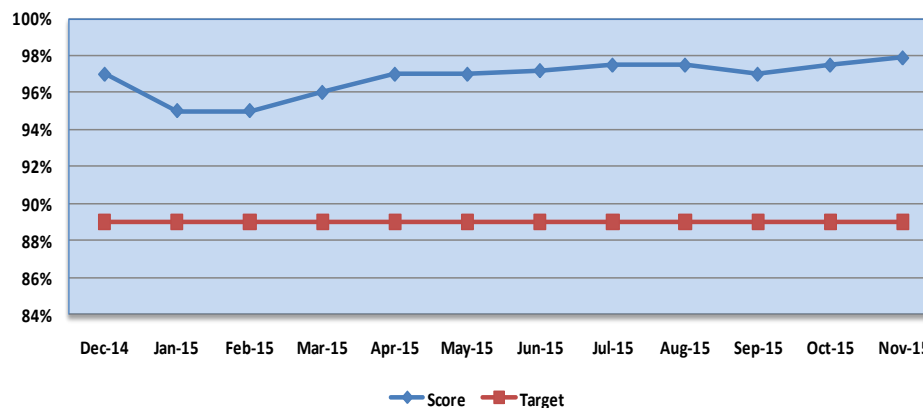
Meridian On-Line Inpatient Survey - Ward Cleanliness



National In-Patient Survey 2014 - Cleanliness Scores compared with other London Trusts

Trust	Rooms / Wards (Out of 10)	Toilets / Bathrooms (Out of 10)	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

Credits for Cleaning NPSA Trust Risk Profile



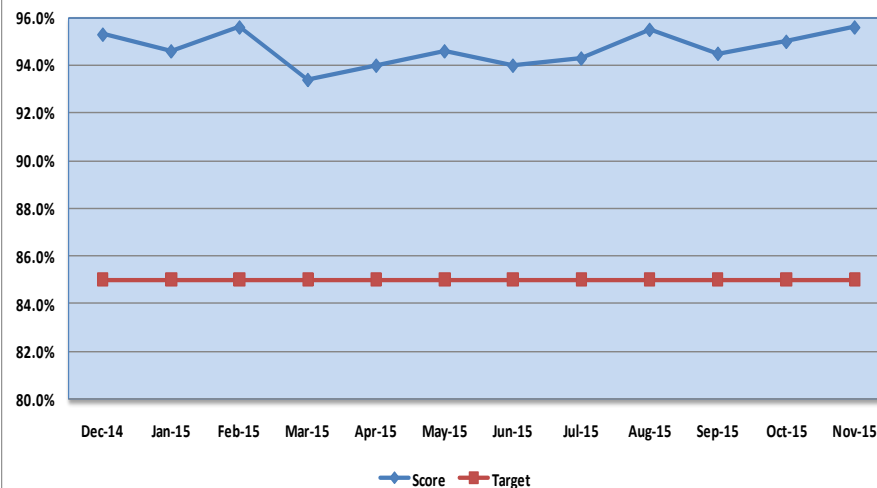
Summary:

- 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.

Action and Progress to Date:

- In-patient catering feedback as measured by the Meridian survey remains above the target of 85% with 1671 surveys completed in November 2015. The 2015 PLACE results placed Trust scores at 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, raw energy efficiency.

Meridian Inpatient Survey - Food - Fair/Good/Very Good



National In-Patient Survey 2014 - Catering Services Scores compared with other London Trusts

Trust	Quality (Out of 10)	Choice (Out of 10)	Help (Out of 10)	Total (Out of 10)
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

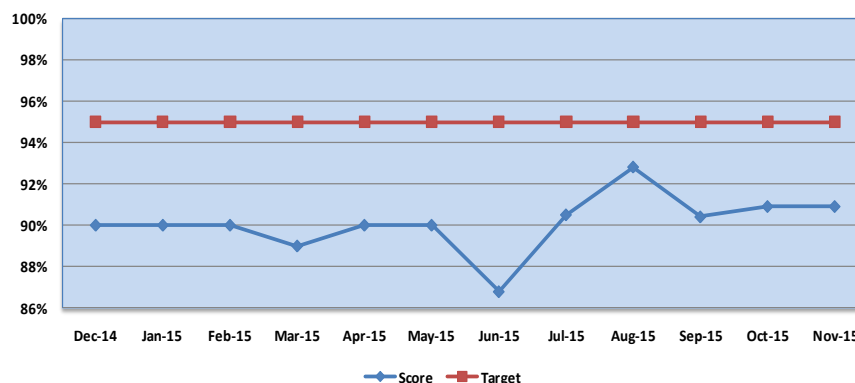
Summary:

- There are no national targets set for Patient Transport, other than for Renal patients – the Trust's performance is currently not available by speciality. The targets reported below are what we as a Trust have set and aspire to achieve.
- Patient Transport survey feedback demonstrates that the patient satisfaction target threshold of 90% is generally, but not consistently, being met. The target for patients arriving within 90 minutes is consistently not being met.

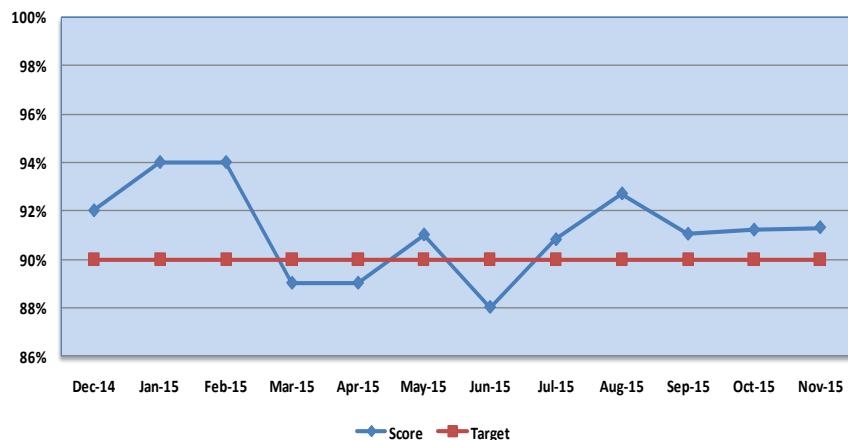
Action and Progress to Date:

- 770 patients were surveyed this month regarding their experience of the Patient Transport Service. The survey reveals that the target patient satisfaction threshold of 90% has been achieved for the last five months.
- A locally set stretch target of 95% has been set for patients arriving within 90 minutes of their appointment. This target is consistently not being met.
- The new Patient Transport Service commenced in December 2015, which incorporates enhanced performance standards.

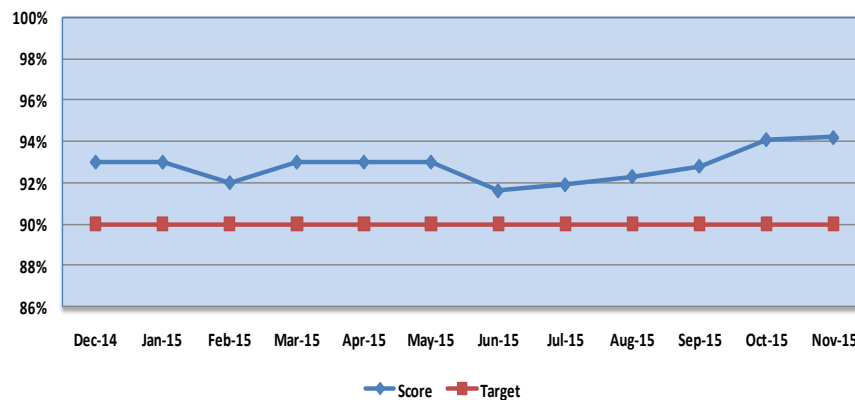
Patient Transport - Patients arriving within 90 minutes prior to appointment



Patient Transport - Monthly Patient Satisfaction Survey Scores



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



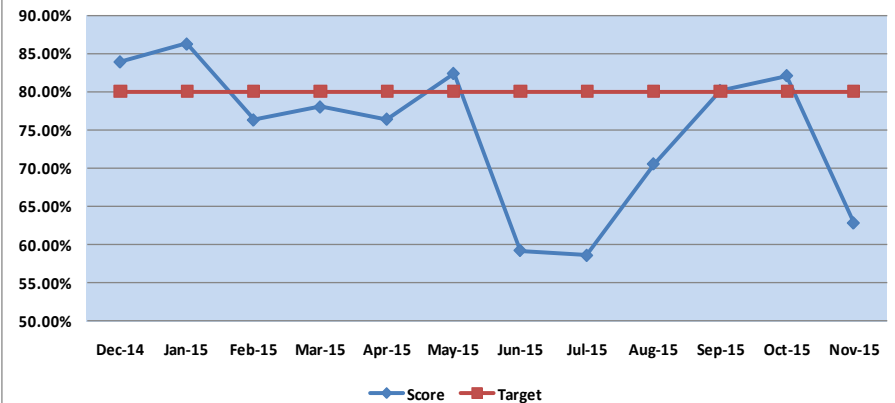
Summary:

- Pick up of internal (22,888) and external (63,716) calls both met their respective targets for November. The percentage of calls answered within 30 seconds has deteriorated against target this month.

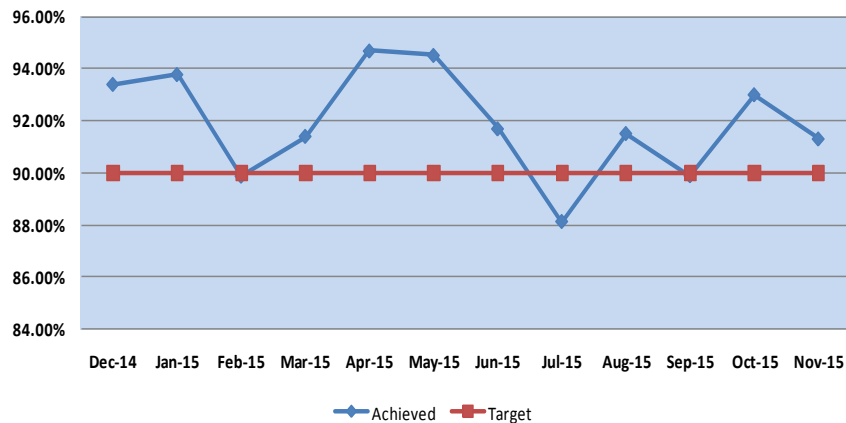
Action and Progress to Date:

- The main driver for below target performance of calls answered within 30 seconds 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. This affected call answer times rather than abandoned call rate.
- Both the Community Patient Transport Assessment and Community District Nursing Out of Hour service will be joining the Customer Services responsibility in December.
- Temporary staff coverage via the Bank is being used to mitigate the staff issues currently being faced.
- 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.

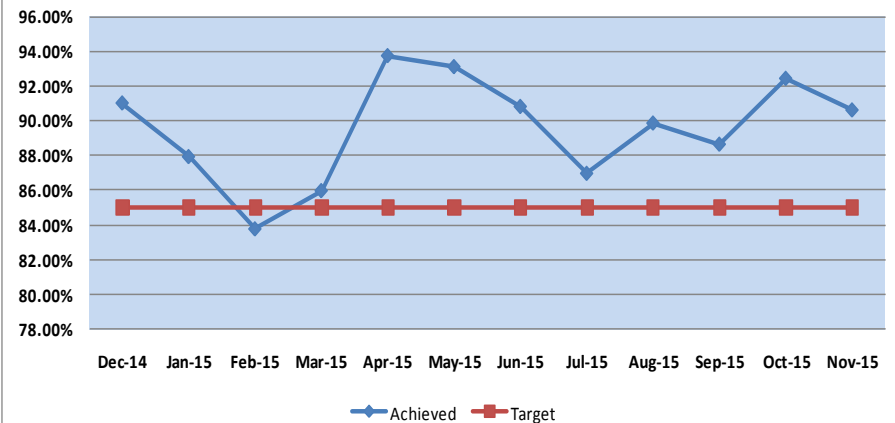
% of Calls Answered Within 30 Seconds



GSTT External Calls - % Achieved



GSTT Internal Calls - % Achieved



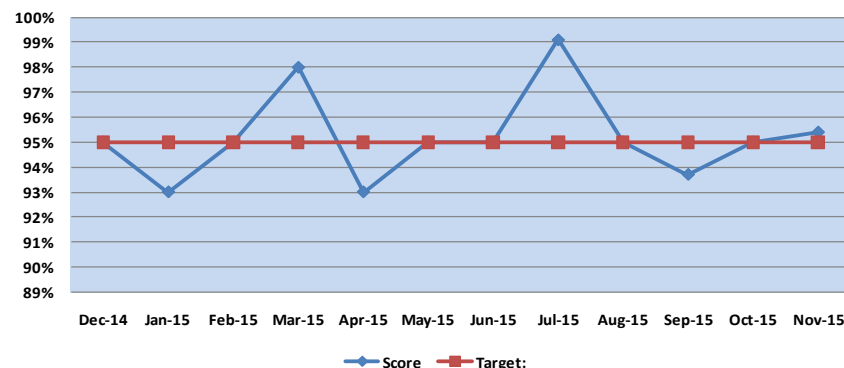
Summary:

- Following the proven investment in an enhanced out of hours maintenance regime, lift availability performance is running at on average 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.

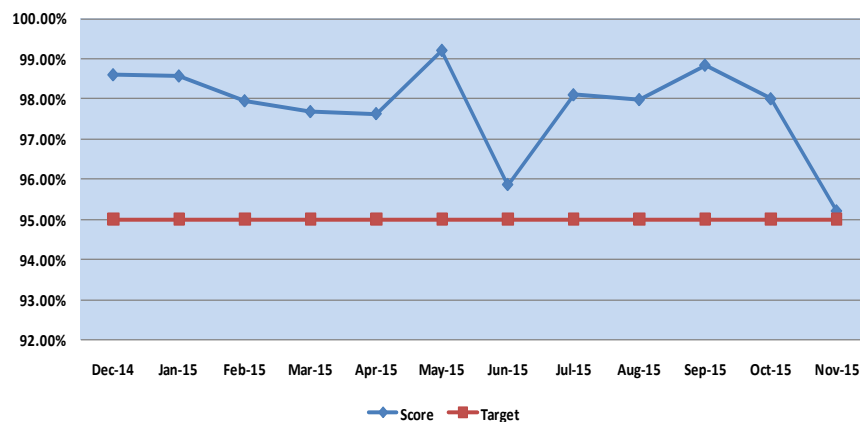
Action and Progress to Date:

- 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.

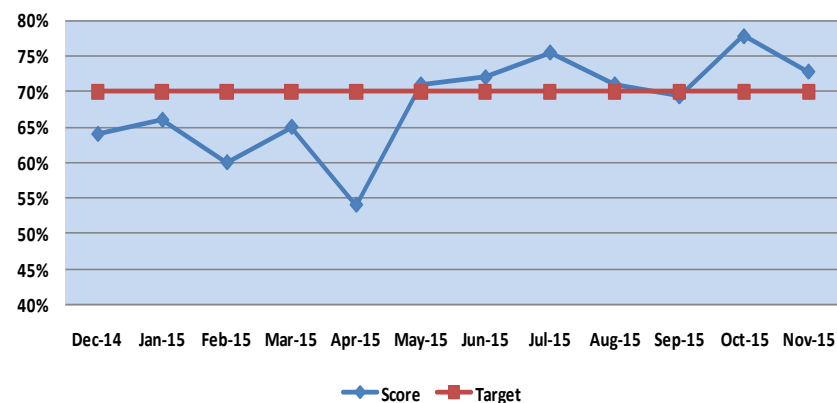
Guy's & St Thomas' - Lift Performance



Essentia Facilities Service Desk - % Calls Answered



Building & Engineering - Priority 2 Calls



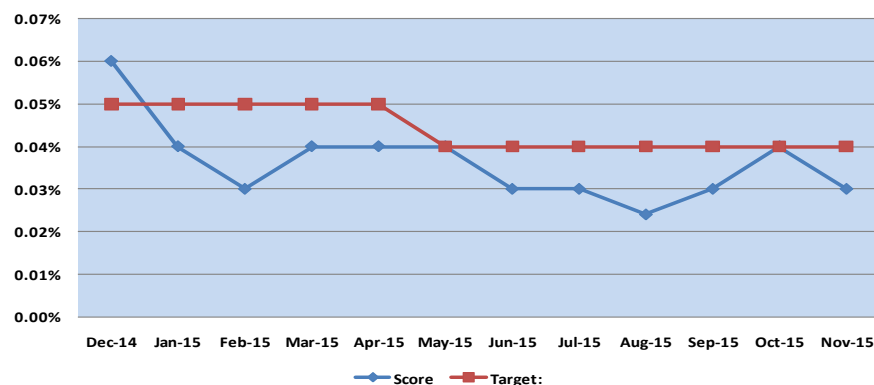
Summary:

- 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.
- Essentia's bid 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, has been successful.

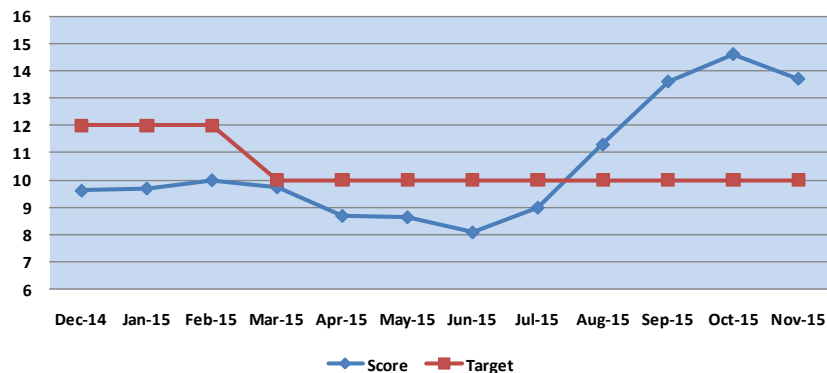
Action and Progress to Date:

- 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.

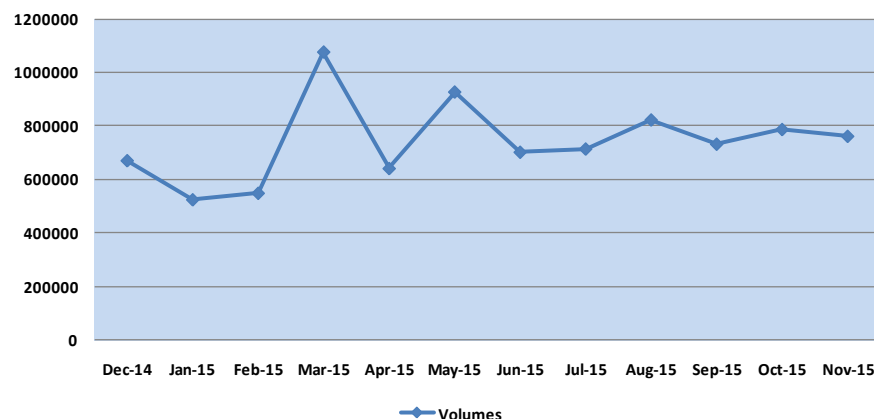
Sterile Services - Non Conformities



Sterile Services - Average Instrument Processing Turnaround Time



Sterile Services - Instrument Volumes



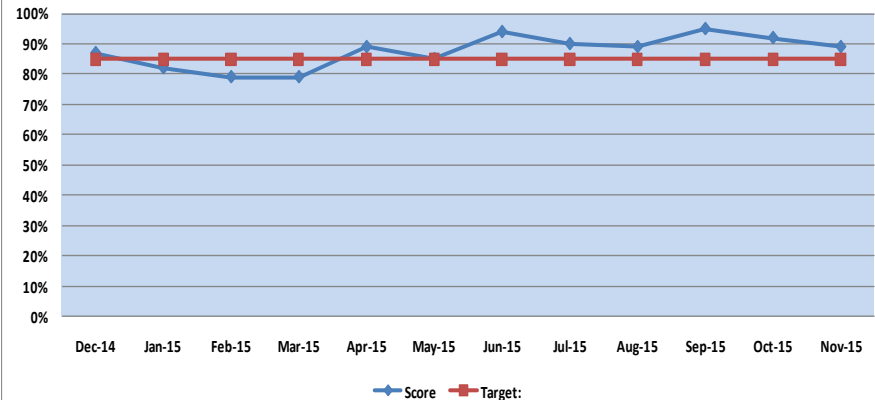
Summary:

- The agreed service level for customer satisfaction (85%) was exceeded for last five months (72 responses received in November).
- Incidents resolved within target are also being consistently achieved.

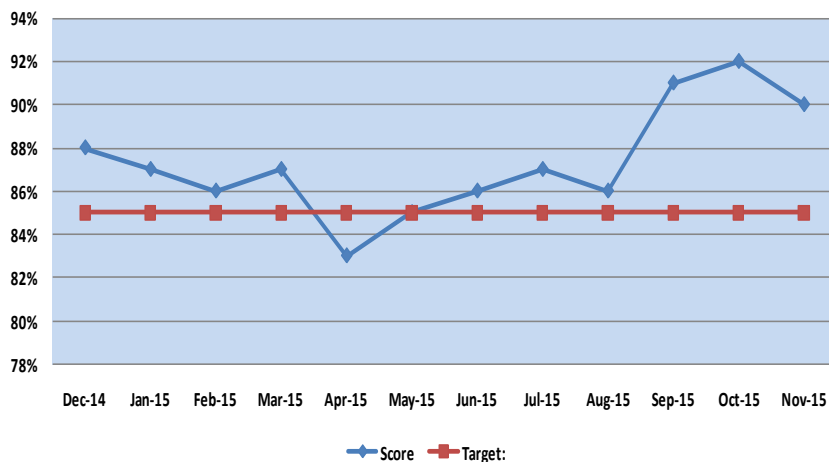
Action and Progress to Date:

- The average time to answer calls by IT Service Desk deteriorated to a record low with 158 seconds against a target of 60 seconds. This was due to record call volume (10,760) in relation to a number of incidents (4 serious) affecting a large proportion of the Trust.
- There were four serious incidents in November: 1. EPR Label Printing (x2) where patients blood order and blood bank forms were unable to be printed; 2. Medchart (ePMA) was slow when switching between patient record tabs; 3. Internet Explorer / Firefox was prompting users for username and password when trying to access clinical websites.
- IT Service availability was generally good for key IT services achieving the target of 99.9% uptime, with seven applications experiencing partial unavailability for short periods.

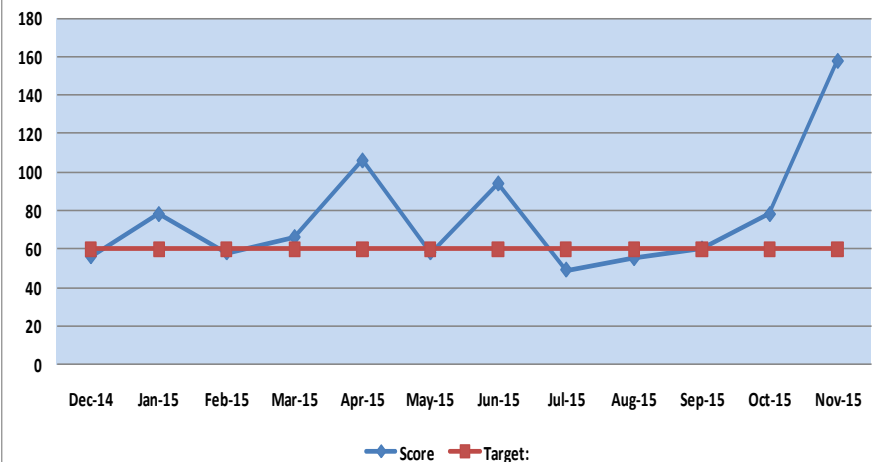
IT - User Satisfaction



IT - Incidents Resolved Within Target



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



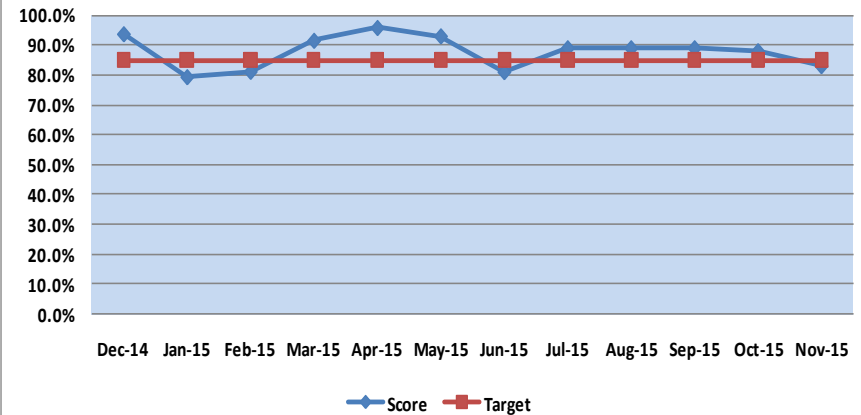
Summary:

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

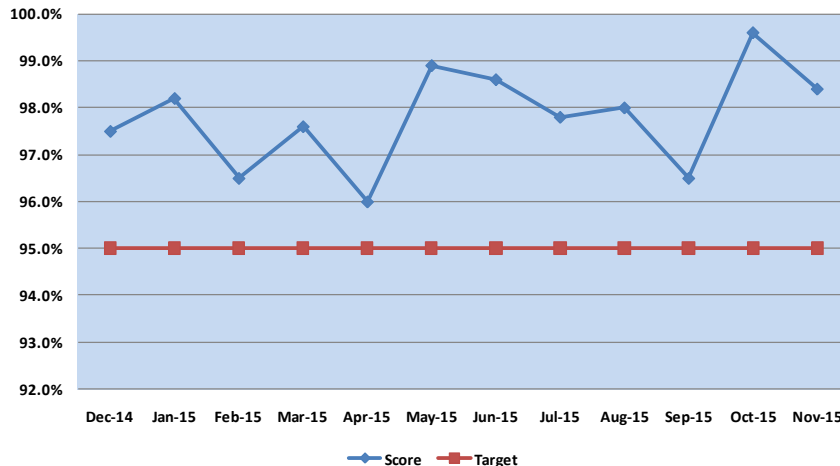
Action and Progress to Date:

- 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%.

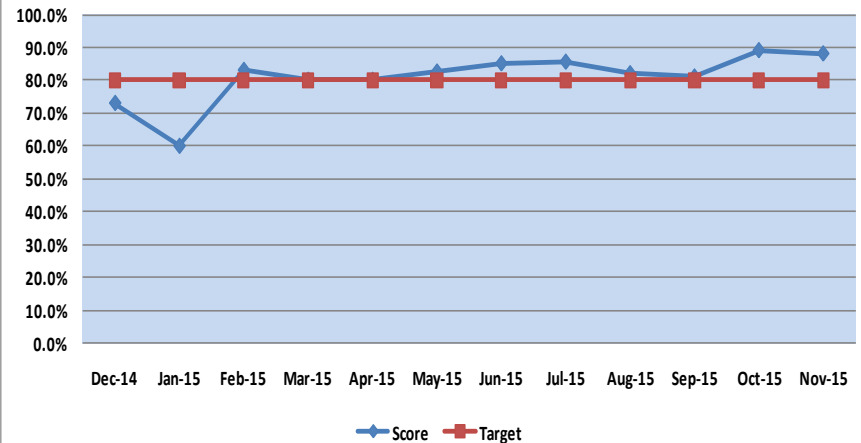
Community - PPM Tasks Completed



Community - Cleaning Scores



Community - Reactive Maintenance



Appendix: directorate-level heatmap (1 of 2)

Domain

			Type	Target	Trust-wide	Acute Medicine	Peroperative, Critical Care & Pain	Surgery	Cardiovascular Services	Abdominal Medicine and Surgery	Oncology And Haematology	Women's Services	Clinical Imaging & Medical Physics	Medical Specialties	Dental Services	GRIDA	Therapies	Adult Community Services	Children's Community Services	Children's Medical Services	Children's Surgical Services	Monitor	CQUIN	Fit for Future workstream	Quality priorities	Local
Safe	Patient safety - Incident Reporting	Total incidents reported	Number	-	2,066	389	260	49	119	121	224	196	52	29	36	26	12	153	18	0	0					
		Total incidents reported on STEIS	Number	-	2	0	1	0	0	0	1	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					
		Never Events	Number	Zero	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0					
		Incidents resulting in unexpected death	Number	-	2	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0					
		Incidents resulting in severe harm	Number	-	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0					
		Incidents resulting in moderate harm	Number	-	19	1	5	2	0	2	0	0	1	0	0	0	1	4	0	0	0					
		Incidents resulting in low harm	Number	-	304	56	33	6	17	19	38	46	8	4	3	2	4	29	4	0	0					
		Incidents resulting in no harm	Number	-	1,321	281	165	28	85	79	158	118	38	28	13	17	6	75	9	0	0					
		Incidents resulting in unexpected death - reportable on STEIS	Number	-	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0					
		Incidents resulting in severe harm - reportable on STEIS	Number	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0					
		Incidents resulting in moderate harm - reportable on STEIS	Number	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0					
		Incidents resulting in low harm - reportable on STEIS	Number	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0					
		Incidents resulting in no harm - reportable on STEIS	Number	-	1	0	1	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					
		Patient slips trips falls (DATIX)	Cases	-	146.0	50.0	3.0	5.0	15.0	17.0	15.0	3.0	1.0	0.0	0.0	0.0	2.0	0.0	0.0	1.0	0.0					
		Incidence of falls per 1000 bed days	Number	-	4.9	7.1	2.9	2.3	3.4	3.5	4.9	1.3	37.0	0.0	0.0	0.0	-	0.0	-	0.4	0.0					
		Falls with moderate or severe harm	Cases	0	1.0	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	0.0					
	Infection Control and Cleanliness	Pressure ulcer acquisitions (grade 2 and above)	Number	0	3.0	1.0	0.0	1.0	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					
		MRSA screening of admissions	Mthly %	>95%	92%	63%	94%	97%	96%	98%	97%	96%	92%	92%	100%	100%	-	-	-	100%	100%					
		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					
	Screening	VTE screening (externally reported)	Mthly %	>95%	97%	95%	96%	87%	92%	98%	97%	93%	95%	98%	100%	99%	-	100%	-	73%	67%					
		Dementia screening (patients aged over 75)	Mthly %	>90%	87%	89%	-	87%	81%	100%	50%	100%	-	100%	-	0%	-	-	-	-	-					
	Mortality	Deaths in hospital - number in month	Number	-	86.0	40.0	3.0	1.0	12.0	8.0	19.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0					
		Friends and Family test (Ward) - Response rate	Mthly %	>=33%	29%	27%	34%	48%	24%	45%	24%	11%	-	-	-	-	-	0%	-	27%	-					
Caring	Admitted care	Friends and Family test - % Recommended (Ward)	Mthly %	>=97%	96%	99%	95%	94%	97%	95%	99%	95%	-	-	-	-	-	-	-	99%	-					
		Friends and Family test - % Not Recommended (Ward)	Mthly %	<=1%	2%	1%	0%	3%	1%	1%	0%	0%	-	-	-	-	-	-	-	0%	-					
		Overall inpatient patient experience score	Mthly %	>89%	90%	93%	87%	88%	89%	89%	91%	85%	89%	99%	-	80%	-	-	-	-	-					
		Single sex compliance - breaches (all types)	Cases	Zero	22.0	0.0	19.0	0.0	3.0	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%	-	0.4%	0.9%	6.7%	1.4%	1.7%	1.1%	-	0.6%	0.2%	-	-	-	-	0.6%	1.9%					
		Overall outpatient patient experience score	Mthly %	>89%	90%	91%	-	91%	88%	89%	89%	89%	99%	89%	93%	90%	90%	-	-	95%	-					
		Friends and Family test - % Recommended (Outpatients)	Mthly %	-	93%	89%	89%	93%	97%	91%	94%	91%	89%	90%	93%	93%	91%	-	-	91%	97%					
		Friends and Family test - % Not Recommended (Outpatients)	Mthly %	-	4%	4%	6%	3%	0%	4%	3%	6%	11%	6%	3%	4%	6%	-	-	9%	3%					
	Outpatient care	Overall outpatient patient experience score	Mthly %	>89%	90%	91%	-	91%	88%	89%	89%	89%	99%	89%	93%	90%	90%	-	-	95%	-					
		Friends and Family test - % Recommended (Outpatients)	Mthly %	-	93%	89%	89%	93%	97%	91%	94%	91%	89%	90%	93%	93%	91%	-	-	91%	97%					

Appendix: directorate-level heatmap (2 of 2)

Domain			Type	Target	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	CQUIN	Fit for Future workstream	Quality priorities	Local	
Responsive	RTT	RTT - Non-admitted patients <18 weeks	Mthly %	>95%	93%	96%	64%	87%	87%	87%	93%	97%	95%	99%	96%	97%	97%	100%	100%	81%	86%						
		RTT - Admitted patients < 18 weeks	Mthly %	>90%	86%	100%	84%	83%	83%	76%	84%	90%	99%	92%	97%	100%	-	-	-	85%	59%						
		RTT - Incomplete pathways < 18 weeks	Mthly %	>92%	92%	97%	93%	83%	89%	89%	90%	97%	90%	99%	98%	98%	96%	98%	100%	87%	77%						
		RTT - treatments over 52 weeks	Mthly	Zero	6.0	0.0	2.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	1.0						
		RTT - total incomplete pathways	Mthly	-	48,113	2,227	1,794	4,240	3,133	6,947	4,742	2,480	114	4,647	6,637	4,843	816	146	4	2,425	2,503						
		RTT - incomplete pathways over 18 weeks	Mthly	-	3,790	58	130	704	329	780	468	81	11	62	152	87	36	3	0	324	566						
	Cancer access	Cancer - 2 week wait	Qtly%	>93%	94%	97%	-	-	-	91%	95%	99%	-	100%	-	94%	-	-	-	-	100%	-					
		Cancer - breast symptomatic referrals <2 wks	Qtly %	>93%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%					
		Cancer - 31 day first treatments	Qtly%	>96%	96%	96%	-	-	-	94%	98%	93%	-	100%	-	100%	-	-	-	-	-	-					
		Cancer - 31 day subs treatments - surgical	Qtly%	>94%	91%	-	-	-	-	85%	94%	100%	-	-	-	93%	-	-	-	-	-	-					
		Cancer - 62 day urgent GP referrals	Qtly %	>85%	72%	56%	-	-	-	70%	77%	75%	-	-	-	70%	-	-	-	-	-	-					
		Cancer - internal 62-day referrals	Qtly%	>85%	85%	100%	-	-	-	82%	86%	100%	-	-	-	100%	-	-	-	-	-	-					
		Cancer - 62 day screening	Qtly %	>90%	100%	-	-	-	-	-	100%	-	-	-	-	-	-	-	-	-	-	-					
			Mthly	<1%	1%	0%	-	-	4%	5%	0%	-	0%	0%	-	-	-	-	-	-	9%	21%					
Responsive	Diagnostics	Diagnostic waits - % over 6 weeks	Mthly	<1%	1%	0%	-	-	4%	5%	0%	-	0%	0%	-	-	-	-	-	9%	21%						
		Bed management	Average length of stay (elective)	Cum ALOS	<last yr	3.5	1.6	5.3	2.8	5.0	4.0	4.4	3.1	1.0	2.7	1.4	7.2	0.0	42.0	0.0	2.3	2.5					
			Non-elective average LOS >1 night	Cum ALOS	<last yr	8.5	6.4	38.5	0.0	5.1	4.5	14.6	8.6	5682.0	44.8	73.0	22.1	0.0	16.5	0.0	5.9	41.3					
	Outpatient mgt	Discharges before noon	Mthly %	>25%	21%	32%	20%	17%	13%	11%	26%	8%	55%	26%	67%	19%	-	100%	-	19%	29%						
		Appointments re-scheduled by hospital <6wks	Cum %	<4%	5%	3%	5%	7%	6%	6%	7%	1%	1%	8%	4%	4%	2%	2%	0%	4%	5%						
		Follow-up ratio - adj cons appts (in arrears)	Ratio	2.13	2.18	1.90	1.61	1.48	2.03	2.40	2.84	0.96	0.70	2.69	2.59	2.10	2.04	-	-	3.04	1.55						
Effective	Theatre management	Non-attendance rate (new appts)	Mthly %	<11%	13%	21%	12%	10%	24%	17%	16%	13%	4%	13%	9%	12%	-	-	25%	14%	13%						
		Daycase rate - basket (in arrears)	Mthly %	>85%	82%	-	-	77%	82%	63%	81%	93%	-	99%	-	-	-	-	-	70%	64%						
	Readmission mgt	Theatres Gross Cancellation Rate (in arrears)	Mthly %	<7%	720%	720%	720%	720%	720%	720%	720%	720%	720%	720%	720%	720%	720%	720%	720%	720%	720%						
		Emergency readmissions (within 28 days - in arrears)	Cum %	<5.3%	5.7%	12.2%	0.8%	4.0%	4.4%	5.4%	9.6%	2.1%	2.8%	1.4%	0.2%	1.7%	0.0%	8.2%	0.0%	4.3%	2.5%						
Enablers	CQUIN - general	Emergency readmissions (within 14 days - in arrears)	Cum %	<3.4%	3.6%	8.5%	0.4%	3.0%	2.8%	3.1%	6.0%	1.5%	2.7%	0.9%	0.1%	1.2%	0.0%	8.2%	0.0%	2.7%	1.9%						
		Patients >75 asked dementia screening question	Qtly %	>90%	87%	89%	-	87%	81%	100%	50%	100%	-	100%	-	0%	-	-	-	-	-						
	Data quality	NHS number coverage	Cum %	>98%	97%	93%	100%	98%	100%	100%	100%	99%	100%	99%	90%	99%	99%	99%	100%	98%	99%						
		Clinical coding - diagnostic depth (in arrears)	Ratio	>4.5	4.6	6.7	4.2	4.2	7.9	4.7	4.5	5.1	3.8	2.8	2.5	2.7	-	10.0	-	2.6	3.1						
Activity (magic numbers)		Elective activity vs profiled plan - cumulative variance	Cum var %	>0%	-94%	-100%	-100%	-46%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	0%	0%	0%	-100%	-100%						
	New patients seen vs plan (all categories, in arrears)	Mthly var	>0	-1,477	-134	-34	-344	53	-330	-416	104	60	-136	-53	-335	-72	0	0	117	43							
	External cons referrals	Number	>last yr	1,755	113	49	162	180	216	233	38	11	54	53	261	2	23	0	163	197							
	GP referrals	Number	>last yr	17,194	522	163	722	852	1,266	1,450	2,672	11	1,154	2,497	1,674	3,439	112	0	263	206							