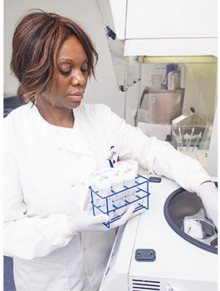


# Integrated Quality and Performance Report



December 2016

**In this month (page 5)**

The trend of high levels of patient referrals and non elective admissions continued in December. In particular increases in GP referrals for cancer continued as in previous months. The Trust has continued to work collaboratively with the CCGs during December to develop further demand management schemes across priority services.

**Are we safe? (pages 6-17)**

GSTT reported one Never Event in December. This related to an incident where it was discovered that a patient had wrong site surgery, the wrong rib was operated on. This is currently being investigated. The patient has had additional treatment. The organisation reported two serious incident's in December where a patient sustained serious harm following a fall while at GSTT. These are being reviewed and will include learning from a multi-incident review recent trust-audits and external audits carried out by the Royal College of Physician's. The emergency department are carrying out a quality improvement project to prevent incidents where blood samples are mis-labelled following a serious incident which was declared in December at the Trust. The CQC published a paper of their findings on how NHS trusts review and investigate the deaths of patients called: 'Learning, Candour and Accountability'. Quality and Assurance directorate will be undertaking a gap analysis against the recommendations and identifying any actions that GSTT need to take. Analysis of NRLS data has shown a significant improvement in GSTT turn around times for investigating incidents.

**Are we effective? (pages 18-27)**

We continue to perform well against most of the indicators being monitored. We have agreed new CQUINs for 2016-17 and we are now starting to report against some of the metrics for these CQUINs in this month.

**Are we caring? (pages 28-38)**

Our Friends and Family Test feedback remains very positive and we are maintaining satisfactory response rates in many areas. During the month “recommend” scores have dipped slightly in some of the acute care settings such as admitted care, A&E and maternity, although scores have improved in ambulatory areas of care such as community and outpatients. “Not recommend” scores show a similar pattern although performance in maternity has improved slightly. Response rates continue to improve in a number of areas, however sustaining this in A&E has been challenging due to continuing high levels of activity and the emergency re-development. Maternity response rate has dropped significantly this month although measures are in place to address this in November. We are ensuring that more real time information is available to Directorates and continue to encourage teams to review key themes emerging from free text comments and identify actions for improvement.

**Are we responsive? (pages 39-55)**

Performance against the 95% standard improved in December to 88.3%. This was achieved against a back drop of rising attendances, up by 6% in December when compared to the same period in 2015. In December the Trust's performance against the internal 62 day cancer standard deteriorated by 12.4% to 67.6% when compared to the previous month. This was driven primarily by patient choice, with patients choosing not to have their treatment leading up to Christmas, coupled with a continued focus by the Trust to reduce the backlog in Q3. Overall performance against the 62 day target was 65.9. Referral to Treatment (RTT) performance deteriorated from 89.9% in November to 88.8% in December. The primary factors sighted as impacting RTT performance were reduced activity due to Christmas and the railway strikes. Both the waiting list and backlog did not experience any significant growth in December. Diagnostic performance worsened to 1.6% from 1.3% in November. This was due to c. 60 endoscopy breaches caused by administrative error. A recovery plan is in place and the Trust anticipates improved performance against this standard in January.

**Are we well-led? (pages 56-59)**

Our quarter one 2016/17 Staff Friends and Family Test results show that our staff continue to give the Trust a huge vote of confidence as a provider of care and as a recommended employer and our quarter two survey is currently underway.

Our vacancy rate reduced to 11.2% but remains above target. Agency spend decreased to 4.15% of the paybill, with a reduction on the same month last year. Usage continues to be monitored closely on a weekly basis. Turnover increased slightly to 12.15%. The number of completed personal development reviews (PDR) increased to 75.29%. Managers and staff have been reminded of the importance of undertaking and reporting PDRs.

**How effective are our enabling services? (pages 60-73)**

The Trust has recorded a loss of £2.0M has been recorded at December, which is £2.8M better than the planned loss of £4.8M. Essentia Patient Services - who provide non-clinical support services across the Trust, have provided reports across its services. This enables a wider review of how it supports the Trust in its day to day activity.

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

Management priority (last month)	Management priority (this month)	Forecast status
Moderate	Moderate	Stable
Minor	Minor	Stable
Minor	Minor	Stable
Minor	Minor	Stable
Excellent	Excellent	Stable
On track	On track	Stable
Minor	Minor	Stable
Minor	Minor	Stable
Minor	Minor	Stable
Moderate	Moderate	Improving
Moderate	Moderate	Improving
Moderate	Moderate	Improving
Moderate	Moderate	Improving
Moderate	Moderate	Improving
Significant	Significant	stable
Significant	Significant	stable
Significant	Significant	stable
Significant	Significant	Stable
Moderate	Moderate	Stable
Moderate	Moderate	Stable
Moderate	Moderate	Stable
Moderate	Moderate	Stable
Minor	Minor	Stable
Excellent	Excellent	Stable
Minor	Minor	Improving
Significant	Significant	Stable
Significant	Significant	Stable
Significant	Significant	Stable
On Track	On track	Stable
Minor	Minor	Stable

[illegible]

## 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

December	Compared to last year	
	Same month	Year so far

## We received...

Referrals from GP's

16,193

7.1%

10.5%

Urgent cancer referrals

1,341

13.5%

14.0%

Referrals to @Home and ERR

368

9.5%

-9.1%

## We treated...

A&E attendances

14,873

4.1%

2.7%

Non-elective admissions

3,955

9.2%

7.0%

Outpatient attendances

80,481

-1.0%

3.1%

Day cases

4,999

3.0%

4.9%

Elective inpatients

2,121

-3.2%

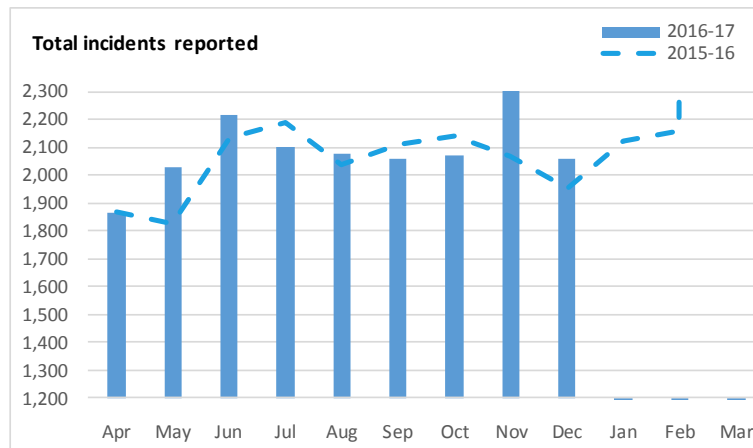
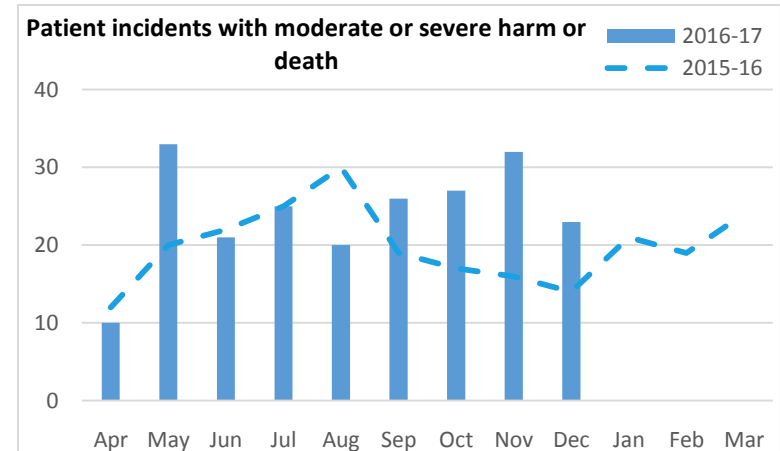
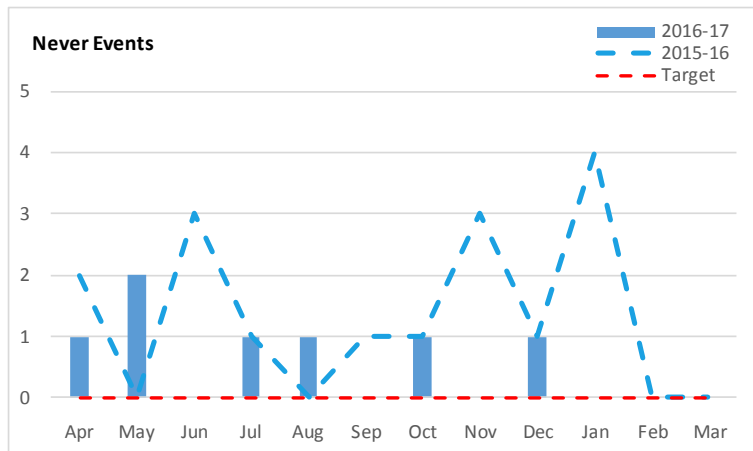
-4.5%

Theme	Ref	Indicator	Units	Target	R	G	Prior year	Oct	Nov	Dec	YTD avg	Monitor	Quality priorities	Trend chart
1.1 Patient safety - incident reporting	INC 06	Total incidents reported	Number	-			2,052	2,072	2,341	2,059	2,091			Y
	INC 06S	Incidents - Reported on STEIS (total number)	Number	-			6.6	7	9	7	8.7			
	INC 06ST	Incidents reported on Datix that are STEIS reportable (total number)	Number	-			0.0	3	10	4	6.2			
	INC 07	Never Events	Number	Zero			1.3	1	0	1	0.8			Y
	INC 01	Incidents resulting in unexpected death	Number	-			2.3	2	4	2	2.7			Y
	INC 02	Incidents resulting in severe harm	Number	-			2.2	3	5	3	3.1			Y
	INC 03	Incidents resulting in moderate harm	Number	-			15.4	22	23	18	18.3			Y
	INC 04	Incidents resulting in low harm	Number	-			317	274	339	290	311			
	INC 05	Incidents resulting in no harm	Number	-			1,294	1,351	1,450	1,340	1,343			
	INC 01S	Incidents resulting in unexpected death - reported on STEIS	Number	-			2.0	4	2	1	2.2			
	INC 02S	Incidents resulting in severe harm - reported on STEIS	Number	-			1.7	1	4	2	2.9			
	INC 03S	Incidents resulting in moderate harm - reported on STEIS	Number	-			0.9	1	1	1	1.7			
	INC 04S	Incidents resulting in low harm - reported on STEIS	Number	-			1.1	0	1	1	0.8			
	INC 05S	Incidents resulting in no harm - reported on STEIS	Number	-			0.9	1	1	2	1.6			
	INC 08P	% incidents relating to patients	Mthly %	-			79.5%	79.7%	77.8%	80.3%	80.3%			
1.2 Patient safety - harm-free care	305T	Pressure ulcer acquisitions (grade 2 and above) attributable to Trust	Number	<5			3.2	4	2	3	4.0			Y
	305TA	Admissions with pressure ulcers (grade 2 and above)	Cases	-			41	37	42	33	39			Y
	INC 22	Medication incidents reported	Number	-			263	293	305	263	267			Y
	INC 21	Patient falls with moderate or severe harm	Number	-			1.6	2	3	5	3.0			Y
	INC 20	Patient slips trips and falls	Number	-			145	167	170	138	159			Y
	313BD	Incidence of falls per 1000 bed days	Number	-			4.9	2.7	2.8	4.6	4.4			Y
	WHO	WHO surgical safety checklist	Ann %	-			86%				85.0%			



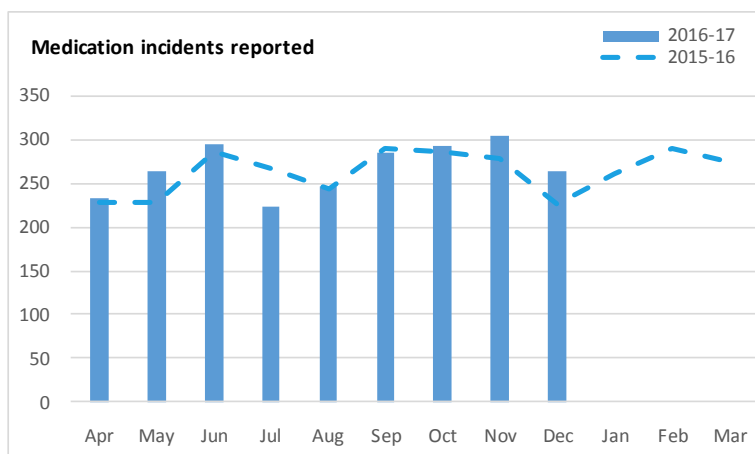
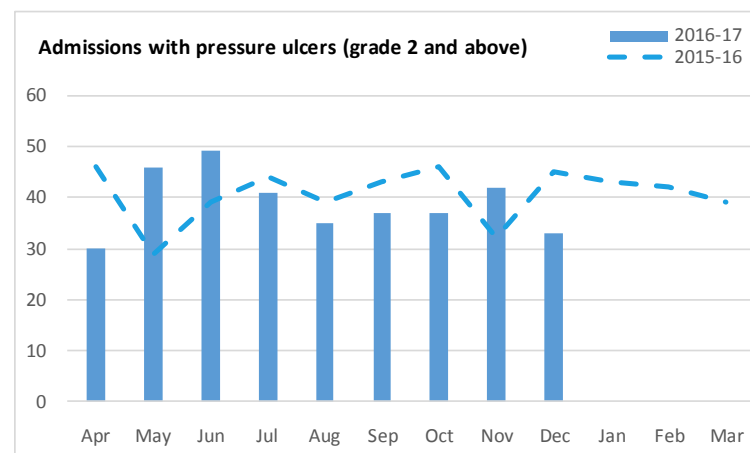
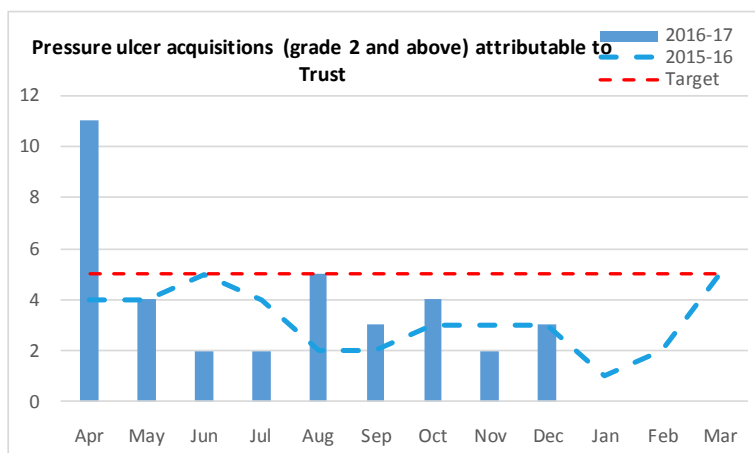
Theme	Ref	Indicator	Units	Target	R	G	Prior year	Oct	Nov	Dec	YTD avg	Monitor	Quality priorities	Trend chart
1.3 Infection control and cleanliness	324	MRSA screening of admissions	Mthly %	>95%			95%	90.5%	91.1%	91.1%	90.1%			Y
	301	MRSA bacteraemia (Trust-attributable)	Number	Zero			0.2	1	0	0	0.2			Y
	302L	C-Diff acquisitions resulting from lapse in care	Number	Zero			0.3	0	0	0	0.1			Y
	302T	C-Diff acquisitions (Trust-attributable)	Number	<4 pm			4.3	1	3	4	2.8			Y
	AMS	Anti-microbial stewardship	Score	>85			92.7	89	91	91	91.1			Y
1.4 Screening on admission	9936	VTE screening (externally reported)	Mthly %	>95%			97.2%	96.5%	96.3%	96.0%	96.8%			Y
	Dem75	Dementia screening (patients aged over 75)	Mthly %	>90%			92.7%	89.7%	85.4%	83.4%	89.5%			Y
1.5 Mortality indicators	350	Deaths in hospital - number in month	Number	-			93.7	80	97	82	86.1			Y
	HSMR	Hospital standardised mortality ratio (HSMR) - most recent score	Ratio	<90			75.6	70.4	70.0	73.0	73.0			Y
	SHMI	Standardised healthcare mortality index (SHMI) - most recent score	Ratio	<90			79.0	76.0	74.2	76.0	75.1			Y
1.6 Safe staffing	SafeS	Safe Staffing - ratio of actual to planned hours	Mthly %	-			100.1%	100.8%	101.1%	98.6%	99.9%			

- The Trust reported eight serious incidents externally to the Commissioners. These are currently under investigation and relate to the following incident categories; one incident of suspected self harm, one patient fall with serious harm, three delays in treatment, one surgical invasive treatment and one medication incident. There was one never event reported during December 2016 and this relates to wrong site surgery.
- Two SI's stemmed from complaints raised. One related to a neonate who sadly had a poor outcome following delivery the cause of which is unknown. The other related to a patient who suffered complications following surgery. The QIPS team, directorates and complaints are working on these together with the complainants.
- Delays in the reporting of imaging in radiology remains a priority and the Executive will continue to monitor performance indicators by radiology on a weekly basis. It is anticipated that the new PACS system due in January 2017 can offer an IT solution to help clinicians follow-up on requested imaging and the reported results.
- The organisation was able to meet the NRLS deadline in December for uploading reported incidents between April-Sept 2016 for which the investigations had been completed. A few hundred were still being investigated and could therefore not be uploaded.

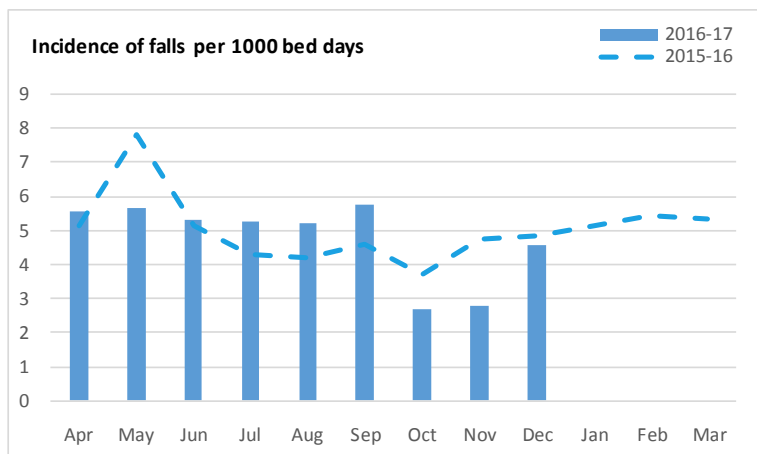
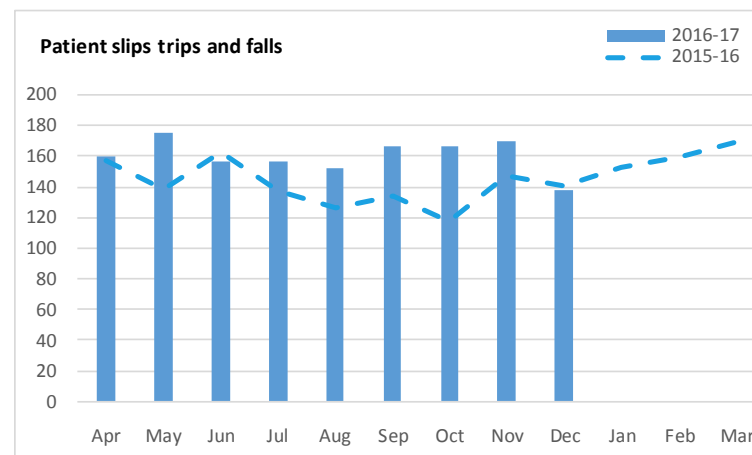
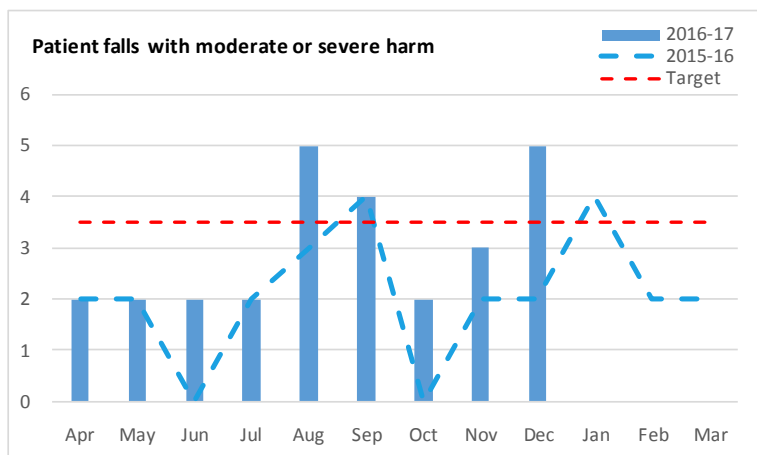




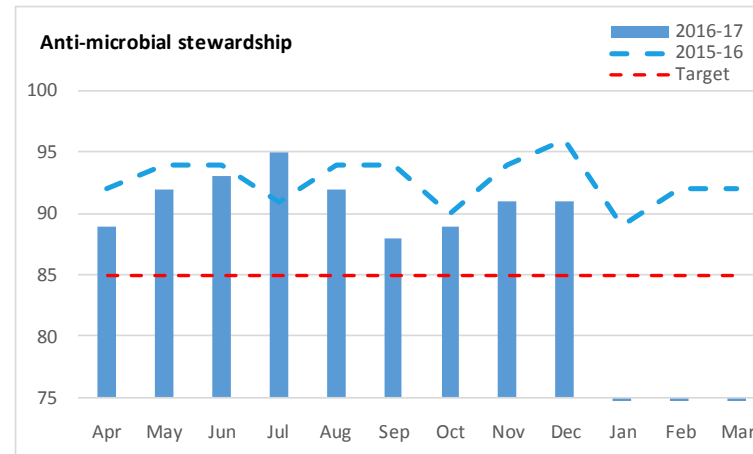
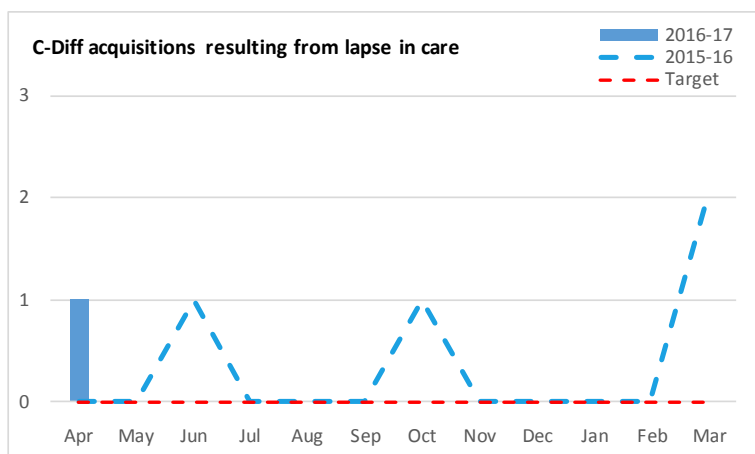
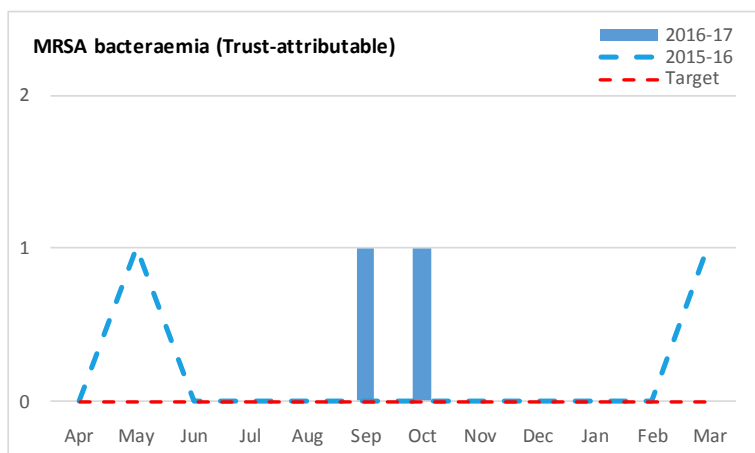
- There were 3 stage 2 pressure ulcers in cardiovascular, renal/urology and surgery this month all being reviewed locally for learning needs.
- Admissions with ulcers were lower than previous months mainly due to the Christmas period and getting patients home and keeping them at home during this time and fewer out of area admissions.
- Medication incidents reporting increases steadily and is higher than the similar period in 2015. High incident reporting is positive as it reflects an open safety culture, facilitates improvement and prevention of future recurrence, and meets NHS Outcomes Framework Domain 5 (report more incidents, reduce harm, reduce recurrence).
- Harm from medication incident reports remains low with data reported in the Trust Medication Safety Forum and weekly communication meeting 'Safe in our Hands' where staff share learning and improvement.



- This month there was a large reduction in the incidence of falls with 136 reported compared to 170 in November-this is likely due to a number of factors including a large reduction in the number of repeat falls this month. The highest reduction was seen in inpatients with 104 falls reported compared to 134 in the previous month; Community falls remained stable with 6 reported, but a slight reduction in the incidence of falls in non ward areas was also seen, with 27 reported in December compared to 32 in November.
- Looking in more depth at the data there were 126 patients that fell and 137 falls reported, which meant that there were only 11 occasions where a patient fell more than once during admission (compared to 32 in November). However, there were less assisted falls this month with 24 reported compared to 31 in November.
- The directorates with the highest incidence of in-patient falls were Acute Medicine, Haematology & Oncology and Cardiovascular.
- There were 5 falls resulting in moderate harm or above this month which occurred in GI Medicine and Surgery, Acute Medicine, Transplant Renal & Urology, Surgery and Cardiac Outpatients



- C-diff performance is good with no lapses in case since April.
- There were no cases of MRSA bacteraemia in December
- The Trust continues to maintain high standards of anti-microbial stewardship.



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

- ***Clostridium difficile*** - The external objective for reportable cases of *C. difficile* (Cdiff) for 2016/17 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'.
- **Meticillin 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*

- The Trust remains below trajectory. There were no 'lapses in care' during December; Figure 1.

### MRSA bacteraemia

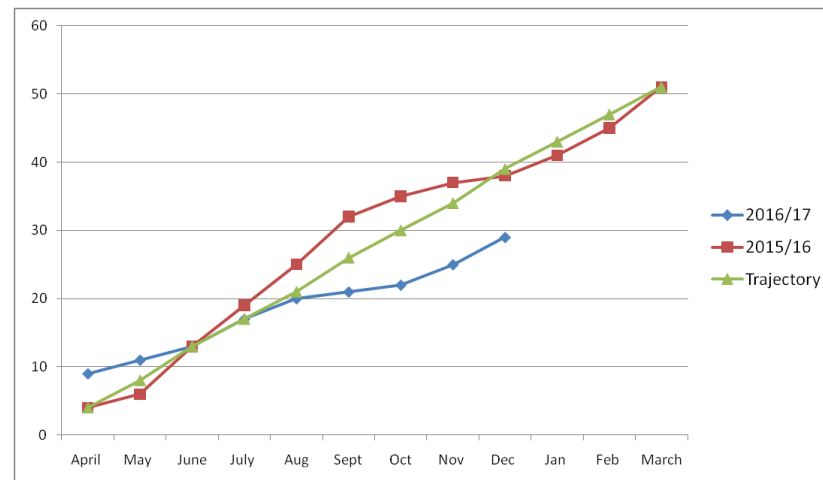
- There were no MRSA bacteraemia in December, year to date total remains at 2

### Other bacteraemia

- MSSA – For December 2016 the Trust reported 5 cases of which 0 were deemed to be Trust attributable (identified > 48 hours after admission). Overall the position is similar to the same period in 2015/16 but there have been increased cases since September. A review of cases is underway to consider any common themes and identify any necessary action.

- E coli – For December 2016 the Trust reported 14 cases, of which 5 were categorised as healthcare associated. We expect an increased focus on *E coli* and other Gram negative bacteraemia from NHS England. Preparations to respond are underway.

Figure 1. Cdiff cases 2016/17 compared with 2015/16 with a linear trajectory to 51 cases.



## Incidents and Investigations:

## Status

Mycobacterium chimera in heater/cooler units used in cardiac bypass machines - A national patient notification exercise is being planned

**Actions underway**

Endoscopy decontamination failures in ENT – under investigation and some remedial actions in place. Investigations not completed yet.

**Actions underway**

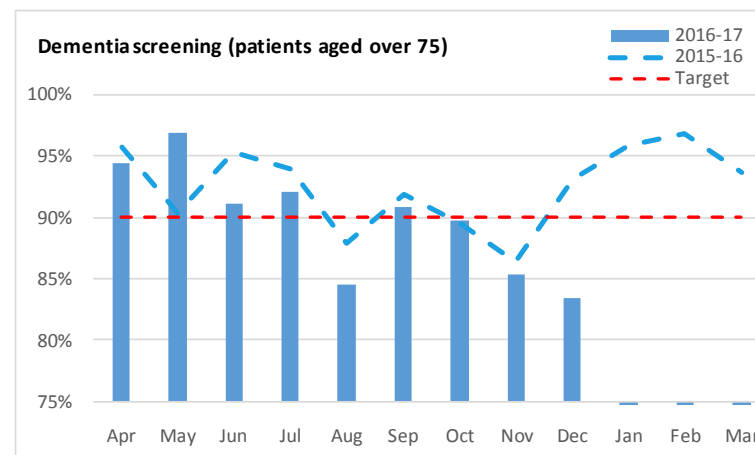
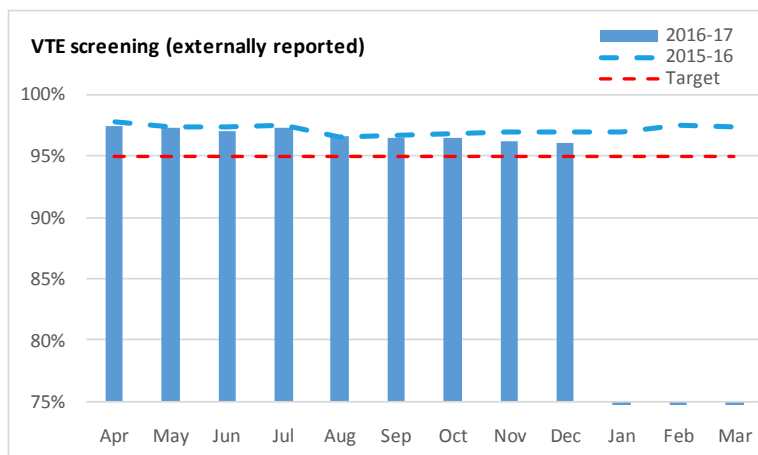
The Trust has established screening and preparedness for the threat of resistant *Candida auris* – one imported case to date only

**Actions underway**

Both Norovirus and Influenza have been experienced in December, Influenza season not peaked, both are being managed with limited operational impact

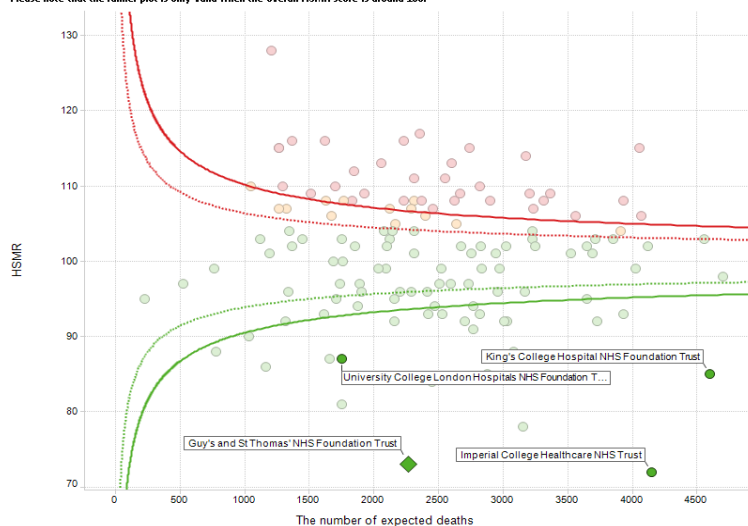
**Actions underway**

- 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.
- The Delirium and Dementia (DaD) team is undertaking the following actions to improve compliance: The Clinical Lead is working with junior doctors to ensure they are aware of the dementia assessment and how to complete it. The DaD Clinical Nurse Specialists (CNS) regularly provide reminder sessions to staff of the wards of how and when to complete a dementia screen. Dementia screening teaching given to wards that have lower screening compliance.
- The DaD CNSs' have already been working closely with Acute Admission Ward (AAW) who have the greatest number of eligible admissions. The DaD CNSs continue to check which new inpatients require a dementia assessment and remind staff daily via email and a phone reminder of those patients with outstanding dementia screens. The DaD CNSs also remind ward staff in addition by adding reminders to e-noting and informing staff when they are on the wards.

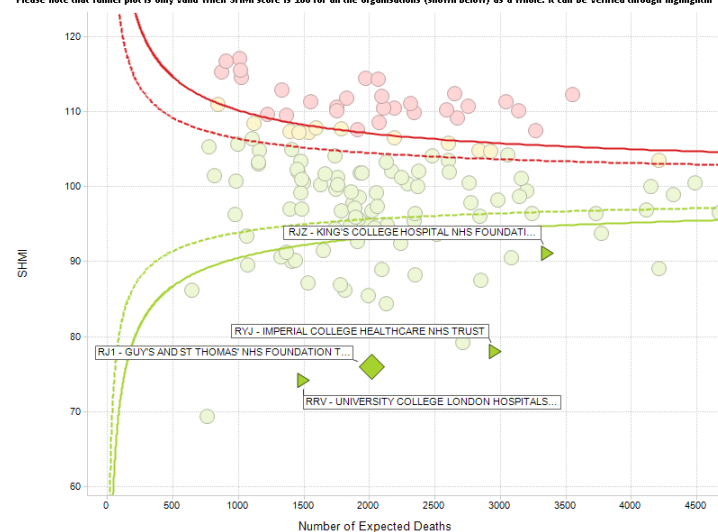


- Benchmarked mortality allows case-mix corrected risk of death to be compared across organisations. The Trust continues to perform exceptionally well, both against the England average and other London acute hospitals. Two measures are used: Hospital Standardised Mortality Rate (HSMR) shown in graph upper right; and Summary Hospital Mortality Indicator (SHMI) shown in graph upper left. SHMI includes deaths within 30 days of discharge. For both indicators a low score is good.
- Crude mortality for Q1/2/3 2016/7 is lower than the previous year despite overall increased activity including for emergency admissions where most death occur. There was an increase in crude mortality in November 2016 but this is expected as part of winter seasonality. Review of deaths in November did not show any clustering of deaths and deaths in December were lower than average. Benchmarked mortality indices remain low compared to peers.

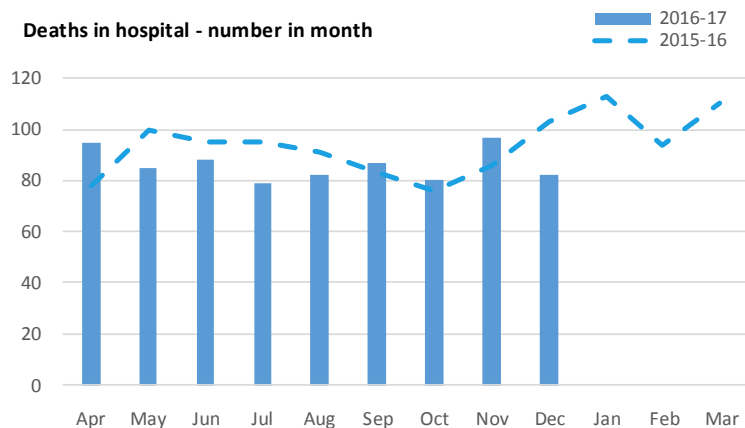
Please note that the funnel plot is only valid when the overall HSMR score is around 100.



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 highlightin



Deaths in hospital - number in month



### Key highlights for December 2016

Average fill rates of planned hours for RN's for day were 97.3%, with night at 99.4%. Average fill rates for planned hours for NA's was 100.3% daytime and 106.2% for the night. Overall 99.0% of planned hours were used.

The Directorates have been working hard to maintain patient safety whilst also addressing the reduction in the nurse and midwifery agency spend required to meet the NHS Improvement regulations. Nurse Agency usage was 4.66% of the total paybill in December. This is a significant improvement on the same period in 2015 where it was 6.45%.

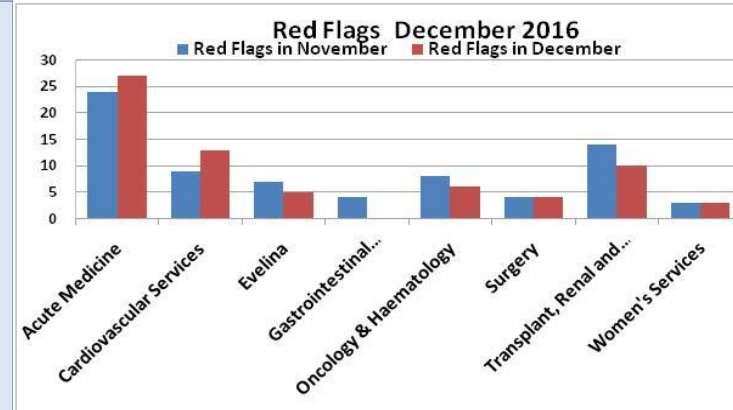
Vacancies have gone up 1.3% from November 2016 where the number of staff in post has decreased and the overall establishment has increased along with a seasonal drop in new starters. At 6<sup>th</sup> January 2017 there were 385 external candidates in the Recruitment Pipeline, who are expected to join the Trust over the next few months which will have a positive impact on the vacancy rate, however due to turnover this is likely to remain above the target of 9%. The Heads of Nursing and Midwifery (HoN/Ms) have given assurance that they have reviewed their staffing numbers and assessed their areas to be safely staffed on a daily basis and their establishments have been approved at January Board.

### Patient Acuity

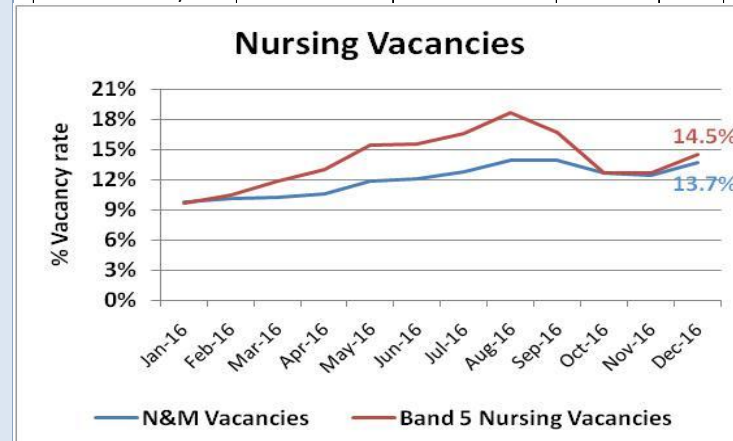
Bed days in December stood at 33,042 - a decrease of 1,735 on the previous month and 3,888 more than the previous year. The balance of bed days to each level of acuity has seen an increase in Level 1b, with the patients requiring that level accounting for the most bed days with a share of 48.3%. The spike in Level 2 bed days recorded last month has virtually reversed, while level 0 days recorded dropped 12%. Acuity and Dependency is collected twice daily from the wards through the iPAMS system to enable the site team to have an accurate picture of the sickest/most dependent patients in the hospital.

### Red Flags

A total of 68 Red Flags were raised in December, 5 fewer than the previous month. Red flags are mostly used as a marker for potential rather than actual unsafe levels of staffing. These issues are predominantly resolved internally without impacting on patient care, which has the potential to reduce the significance of a red flag. The workforce team are exploring options to make this a more meaningful trigger whereby red flags are only raised in instances where staffing concerns are unresolved, despite best efforts of the Directorate Team, and this in turn prompts action from the wider nursing team.



Staffing measures	Dec-15	Dec-16	Change	
Nursing Establishment WTE	5668.52	5849.78	181.26	▲
Nursing Staff in Post WTE	5021.69	5049.43	27.74	▲
Vacancies WTE	646.83	800.35	153.52	▲
Vacancy rate	11.41%	13.68%	2.27%	▲
Red Flags raised	51	68	17	▲
Agency % of Paybill	6.45%	4.66%	-1.79%	▼
Planned v Actual Hrs used	98.5% of planned used	99.0% of planned used	0.5%	▲
Care Hours per Patient Day	N/A	10.6	N/A	N/A





**Recruitment**

The overall Nursing vacancy rate increased to 13.7%, which is 1.3% higher than the previous month. The number of nursing staff in post decreased by 51.1 WTE. The number of leavers remained steady compared to November 2016 but there were 61 new starters in November and only 26 in December. The low number of new starters in December is an expected seasonal variation. There have already been 88 new nursing and midwifery starters in the first two weeks of January 2017 which will positively impact upon the overall vacancy rate, and as stated in the Key Highlights there are a further 385 WTE nurses and midwives in the pipeline to commence over the next few months.

- The new format of assessment centres for Band 5 nurses is now on a 3 weekly cycle with adverts being placed to link with the upcoming assessment centre. Candidate and interviewer feedback is overwhelmingly positive and a steady number of candidates are being offered positions. A formal review of the metrics and feedback will take place by the end of March to inform the ongoing strategy for Band 5 recruitment.
- Further discussions are in progress to inform a strategy for Band 6 recruitment particularly in PCCP, Evelina, Community and the Emergency Department. These areas will need an individualised approach as their challenges are unique to specialty and are a national issue.
- There is also work underway to improve retention of staff. This will involve some focus groups in the first instance to understand what our staff are saying – what makes them want to stay at GSTT and what are the initiatives they are looking for. The Staff Internal Transfer Policy has been rewritten and will be re-launched in February to encourage staff to look for other internal opportunities and make moving around the Trust an easier option.

**Planned v Actual Hrs**

Actual Hours for Registered nursing (RN) staff were 4,914 below plan for the month, which equates to 30.16 WTE, while Nursing Assistants (NA) were 1,611 above plan (9.88 WTE).

**Health Roster**

**Predictive Roster project plan :** The first cohort of in -patient areas are TRU, GIU and Alan Apley Ward, Mark Ward, Lane Fox Unit and Doulton HDU, Home From Home birth centre and Hospital Birth Centre. Planned for live predictive rosters by March 2017.

**Key Performance Indicators :**

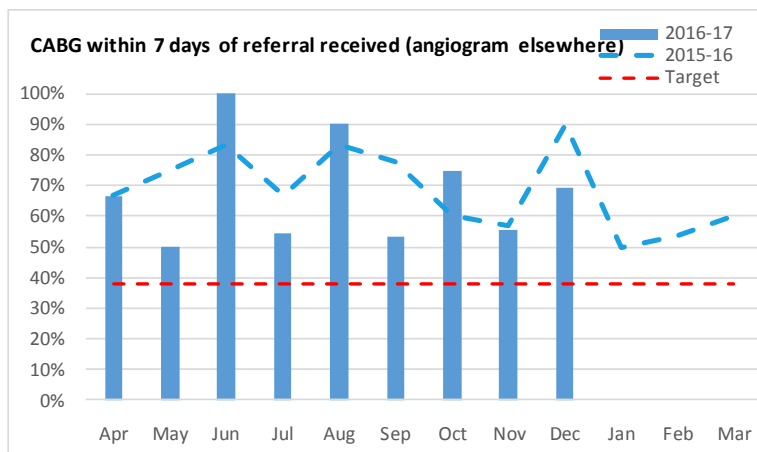
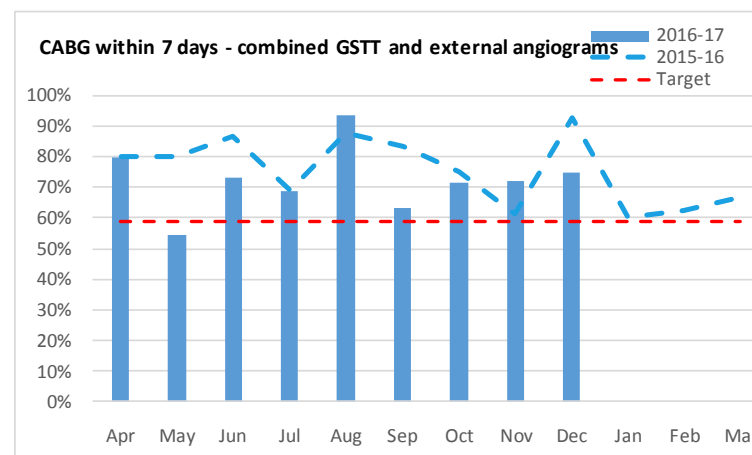
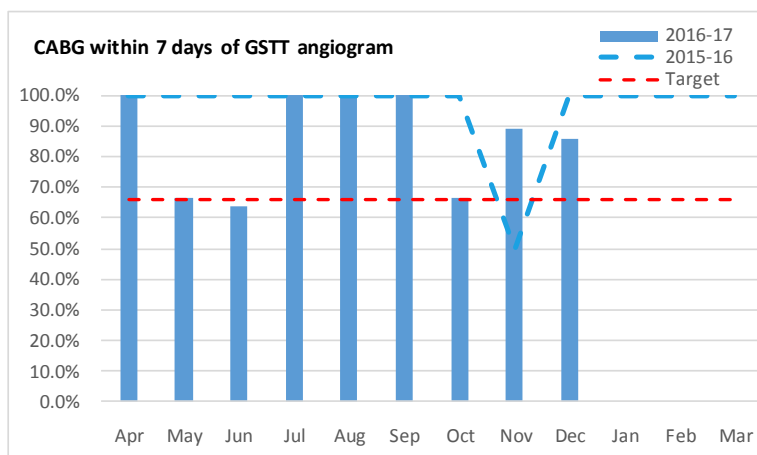
A new KPI is to be included on the Roster Metrics – “Finalising Roster Compliance”. Non-compliance has the potential of considerable impact on pay extraction each month.

Workforce utilisation of staff continues to improve, confirmed by a further drop in % of agency spend in December of 0.97% to 4.66%. This demonstrates ongoing commitment of teams to reduce reliance on agency staff to deliver high quality care to patients and reduce the financial burden on the Trust.

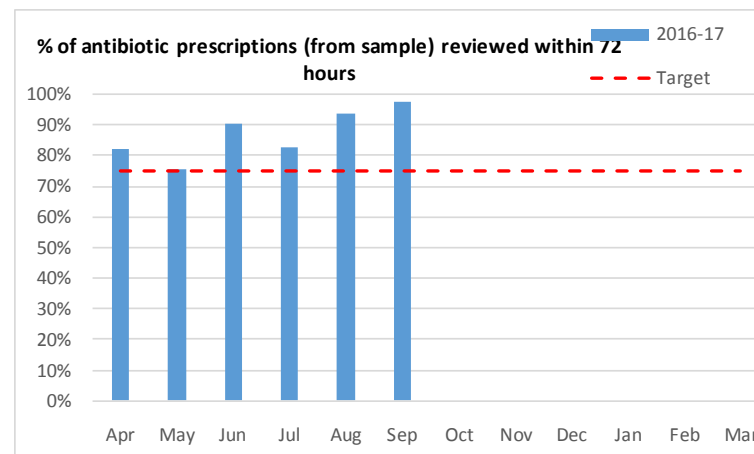
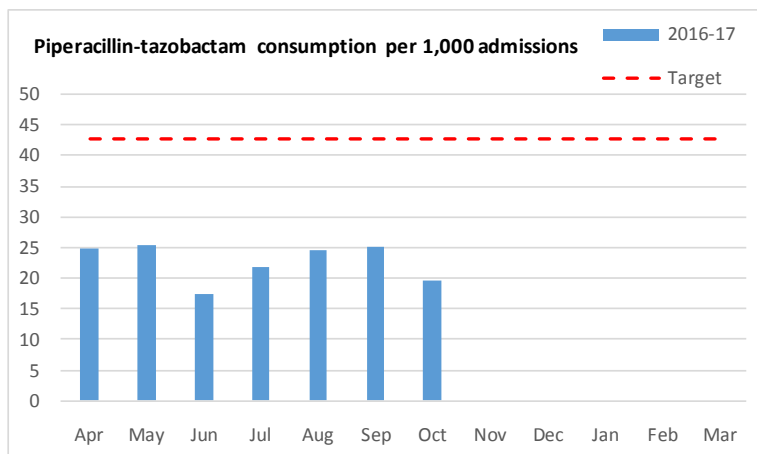
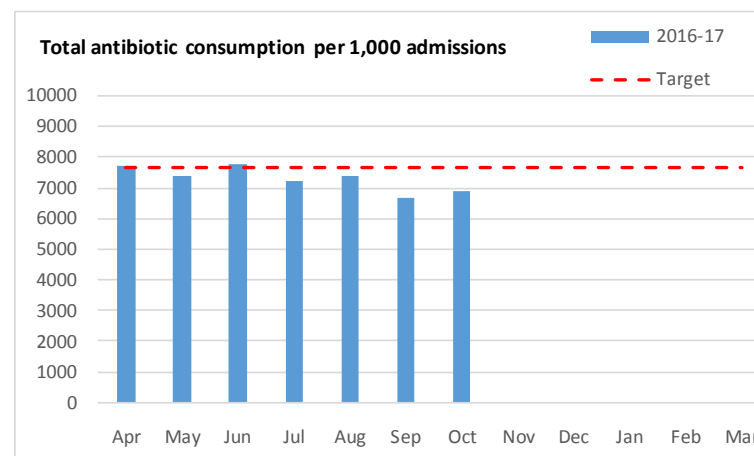
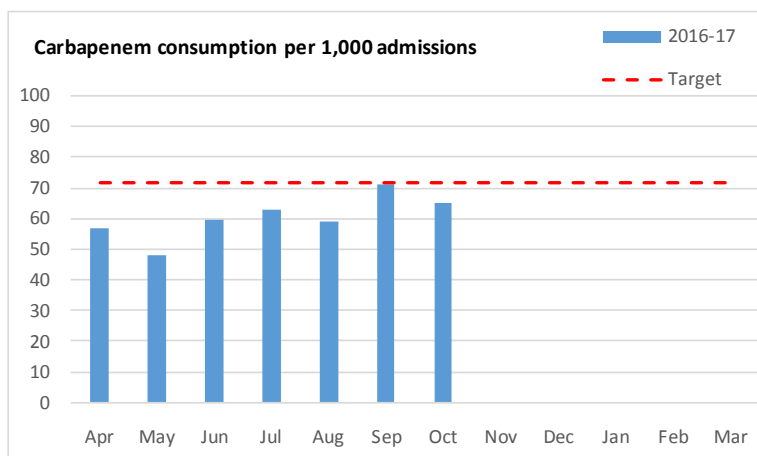
Theme	Ref	Indicator	Units	Target	R	G	Prior year	Oct	Nov	Dec	YTD avg	Monitor	Quality priorities	Trend chart
2.1 Quality improvement initiatives	CQ1Aq	CABG within 7 days of GSTT angiogram	Qtly %	>66%			97%	66.7%	88.9%	85.7%	83.3%			Y
	CQ1Bq	CABG within 7 days of referral received (angiogram elsewhere)	Qtly %	>38%			68%	75.0%	55.6%	69.2%	65.5%			Y
	CQ1Cq	CABG within 7 days - combined GSTT and external angiograms	Qtly %	>59%			74%	71.4%	72.2%	75.0%	72.5%			Y
2.2 Quality improvement Sepsis	1617CQ2	% A&E patients appropriately screened for sepsis	Mthly %	>90%				89.1%	91.7%	83.3%	-			Y
	1617CQ3	% A&E patients prescribed antibiotics within timeframe and reviewed	Mthly %	>65%							-			Y
	1617CQ5	% INPATIENTS prescribed antibiotics within timeframe and reviewed	Qtly %	>15%							-			Y
2.3 Quality improvement Antimicrobial resistance & stewardship	1617CQ6	Carbapenem consumption per 1,000 admissions	Number	71.7				64.9			54.9			
	1617CQ7	Piperacillin-tazobactam consumption per 1,000 admissions	Number	42.6				19.6			22.5			
	1617CQ8	Total antibiotic consumption per 1,000 admissions	Number	7,650				6,912			7,640			
	1617CQ9	% of antibiotic prescriptions (from sample) reviewed within 72 hours	Mthly %	>75%							87.1%			
2.4 Quality improvement Prevention	1617CQ10	% assessed for smoking in Vascular	Mthly %	>80%				99.1%	100.0%	98.1%	98.2%			
	1617CQ11	% assessed for smoking in Cardiology	Mthly %	>80%				86.8%	84.4%	78.6%	88.1%			
	1617CQ12	% assessed for smoking in Cardiac Surgery	Mthly %	>80%				98.5%	85.1%	94.9%	93.7%			
	1617CQ13	% assessed for smoking in Elderly Care	Mthly %	>80%				86.7%	87.5%	85.7%	72.9%			
	1617CQ14	Total (all areas) % assessed for smoking	Mthly %	>80%				92.2%	89.2%	87.2%	89.0%			
	1617CQ15	% assessed for alcohol use in admissions ward	Mthly %	>80%				84.2%	88.4%	81.7%	84.0%			
	1617CQ16A	Number of NRT and Varenicline prescriptions	Number					444	500	498	466			
2.5 Dental	1617CQ20	Tier recording for Oral Surgery - new patients only	Mthly %	>40%				44.1%	51.0%	38.7%	33.1%			
	1617CQ21	Tier recording in Orthodontics - new patients only	Mthly %					34.8%	33.0%	8.5%	-			

Theme	Ref	Indicator	Units	Target	R	G	Prior year	Oct	Nov	Dec	YTD avg	Monitor	Quality	Trend chart
<b>2.6 Adult critical care timely discharge</b>	1617CQ30	% critical care discharges delayed for more than 4 hours	Mthly %					26.4%	25.5%	21.2%	26.4%			
	1617CQ31	% critical care discharges delayed for more than 48 hours	Mthly %	< 5.1%				2.6%	1.8%	0.8%	1.4%			
<b>2.7 Automated exchange transfusion sickle</b>	1617CQ26	% Children with Sickle Cell receiving automated exchange transfusion	Mthly %	>80%							-			
	1617CQ25	% Adults with Sickle Cell receiving automated exchange transfusion	Mthly %	>95%							99.5%			
<b>2.8 Nationally Standardised Dose Banding</b>	1617CQ27	% of rituximab SACT doses matching standardised doses	Qtly %	>30%						98.8%	83.9%			
	1617CQ28	% of vincristine SACT doses matching standardised doses	Qtly %	>30%						100.0%	81.3%			
<b>2.9 Clinical best practice</b>	352	Emergency readmissions (within 28 days - in arrears)	Cum %	<5.7%			5.7%	5.8%	5.8%		5.8%			Y
	353	Emergency readmissions (within 14 days - in arrears)	Cum %	<3.5%			3.6%	3.7%	3.7%		3.7%			Y
	IC48	Critical Care Unplanned Readmissions within 48 Hours	Mnthly (%)	<=1.3			1.4%	1.6%	0.8%	1.1%	1.3%			
	913	% Caesarean sections	Mthly %	<28%			33%	36.3%	34.2%	32.2%	32.5%			
	ICNARC-STH	Critical care mortality indicator-STH+VH DU	Quarterly	<=1.0			0.83	0.89	0.89	0.89	0.91			
	ICNARC-Guys	Critical care mortality indicator-Guys CCU	Quarterly	<=1.0			0.99	0.77	0.77	0.77	0.79			
	EOL	End of life care - % of deaths supported by Priorities for Care	Mthly %	>25%			37.0%	36.8%	47.7%	45.2%	42.9%			

- The Trust will be submitting the Q3 CQUIN milestones to our commissioners at the end of January.
- Currently we are defining the milestones for the 2017/19 CQUIN schemes with our commissioners (National, local and specialist services), in preparation for commencement of the new schemes in April.
- The graphs below, show our performance against three cardiovascular quality indicators from previous years, which we continue to monitor, as they continue to be important to the Trust and our patients.
- Performance for all three elements is exceeding the target. Although previous months show that performance is variable and the dip in performance is related to pressure our critical care which is a risk to us especially during the winter months.

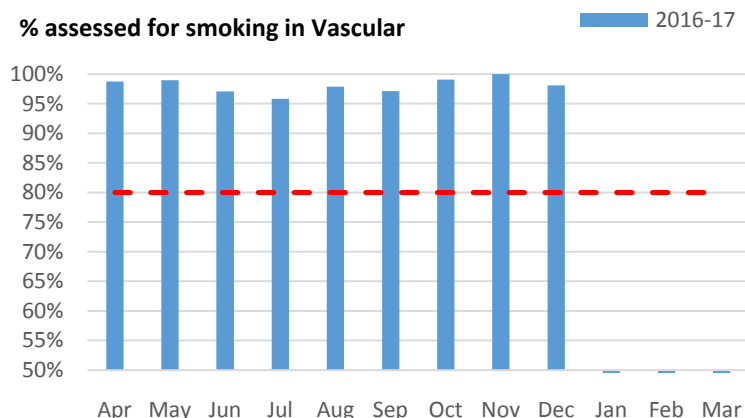


- The monitoring of our consumption of 3 key antibiotics per 1,000 admissions is not reportable for the CQUIN until Q4. Monitoring the standard ahead of submission, shows that we are still ahead of the target. (see graphs below).
- We have exceeded the target of 25% for antibiotic prescriptions (from sample) reviewed within 72 hours'.
- The data is collected on a quarterly basis, which is still being reviewed and will be included in next month's report.

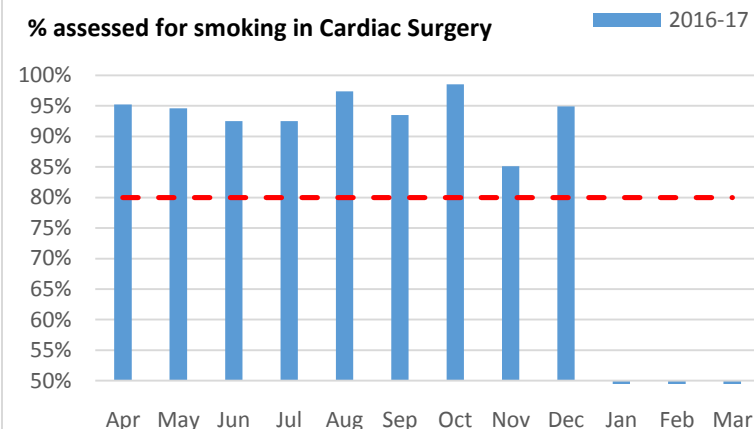


- The Prevention CQUIN is the promotion of mental and physical health and wellbeing for patients and staff. It involves the development of the skills in key frontline staff to make every contact count. The areas of focus for this CQUIN are smoking and alcohol assessments for patients, with signposting and brief intervention.
- We are exceeding and meeting the target for the percentage of patients assessed for smoking in all areas, which are evident in the graphs below.

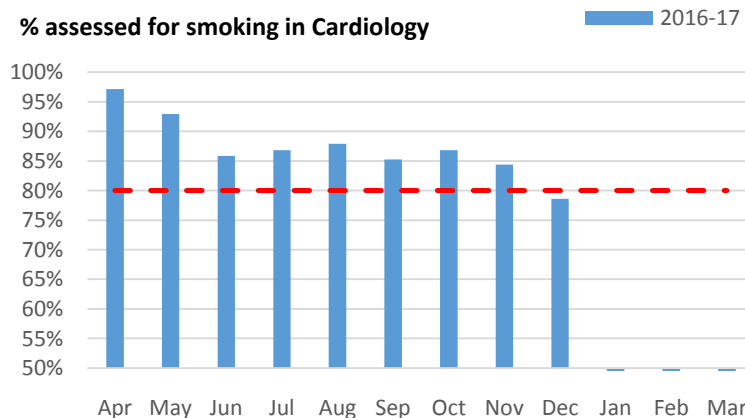
% assessed for smoking in Vascular



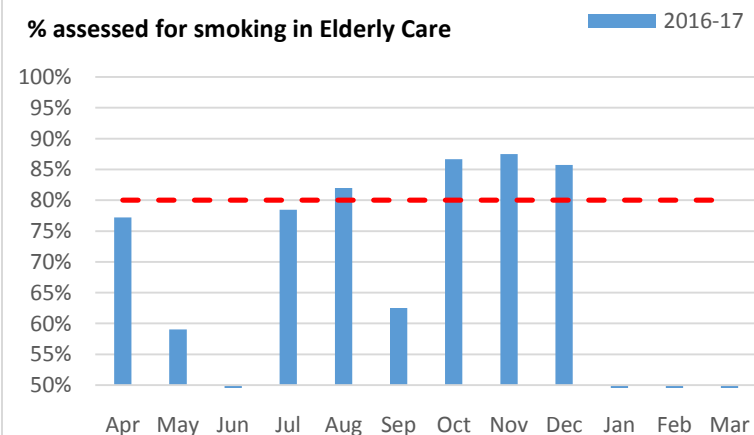
% assessed for smoking in Cardiac Surgery



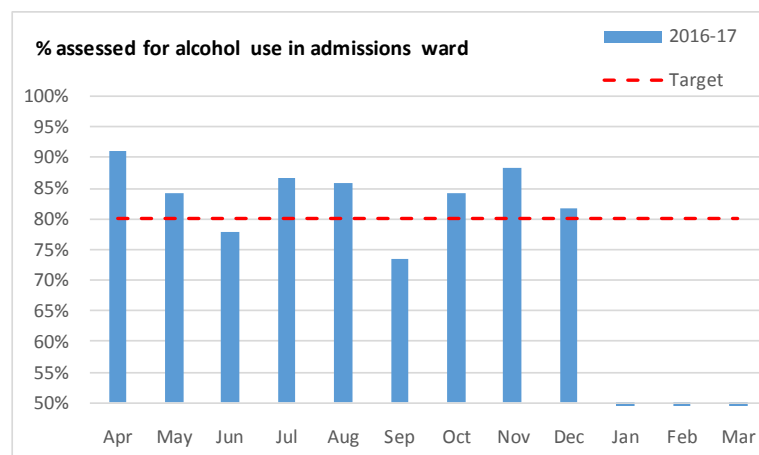
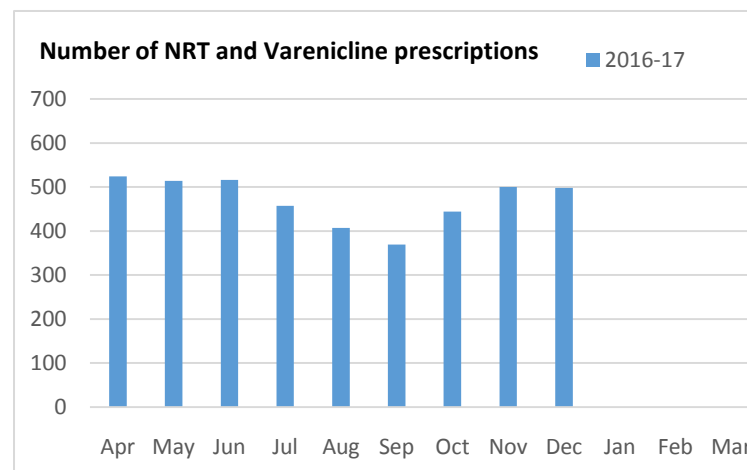
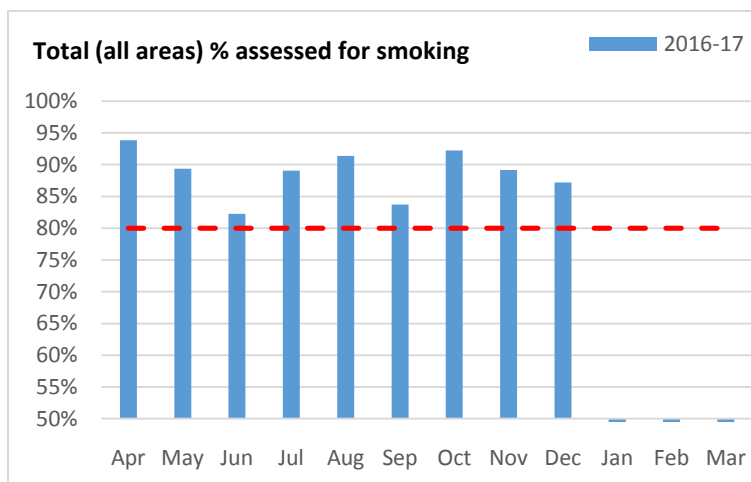
% assessed for smoking in Cardiology



% assessed for smoking in Elderly Care

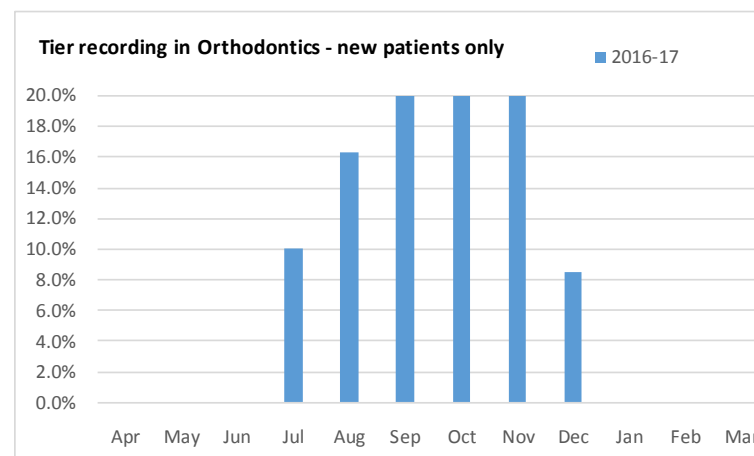
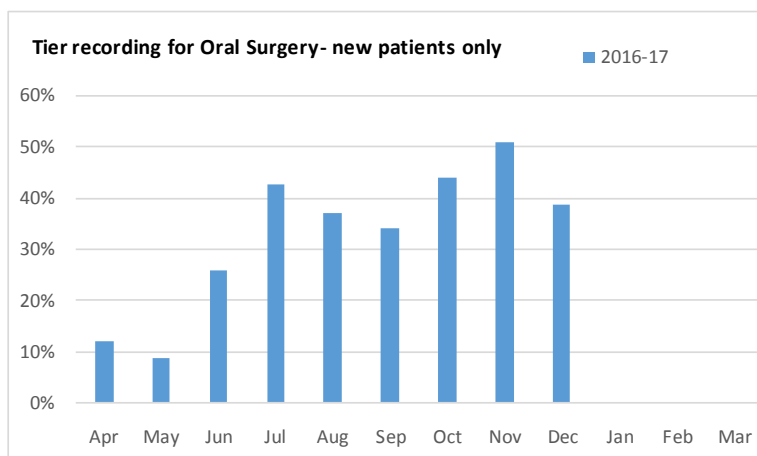


- Across the Trust we have consistently met the smoking target (Top left graph), with monthly improvements.
- The prevention CQUIN also requires us to report on number of NRT and Varenicline prescriptions (Outpatients and Inpatients), which has increased since September.
- The percentage assessed for alcohol used in admissions wards is exceeding the 80% target.

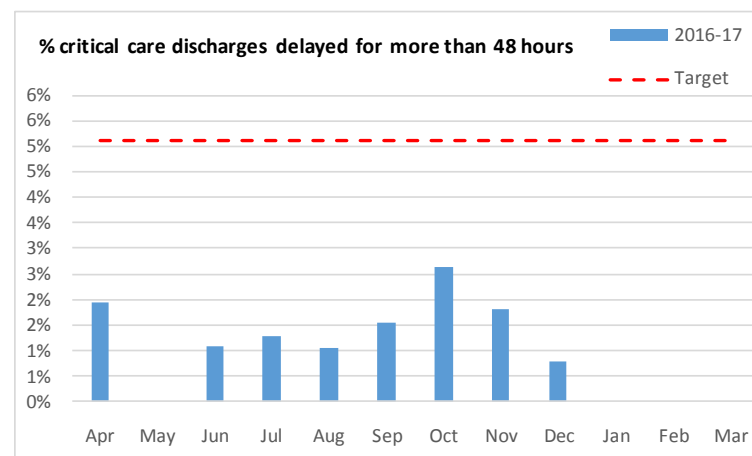
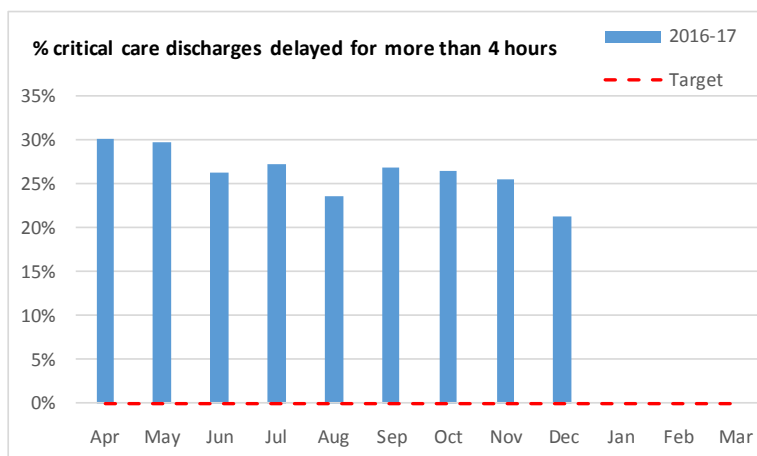




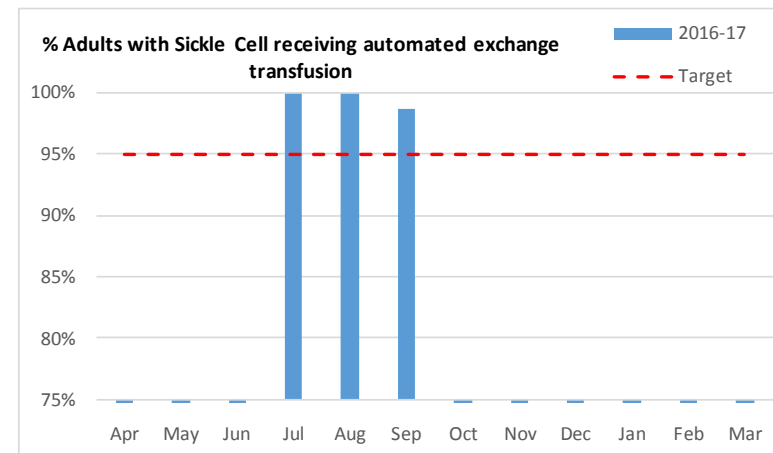
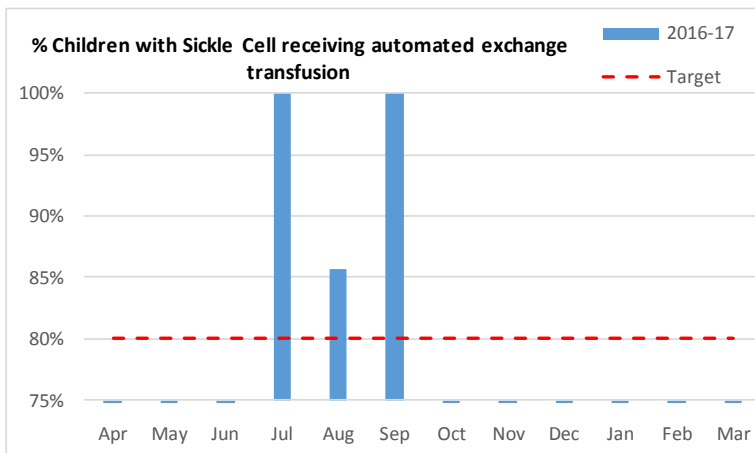
- The CQUIN for dental is related to tier recording on patients referred for Oral Surgery. The Tier system reviews complexity of referral and as you can see percentage of Tier recording has improved substantially since Q1.
- Tier recording in Orthodontics (2<sup>nd</sup> Graph) is no longer part of the CQUIN requirement for 2016/17. Our performance has dipped in December, due to difficulties with data collection.
- We achieved against the target for Q3 which was 40%, with 45% in the quarter. This target increases to 45% in Q4.



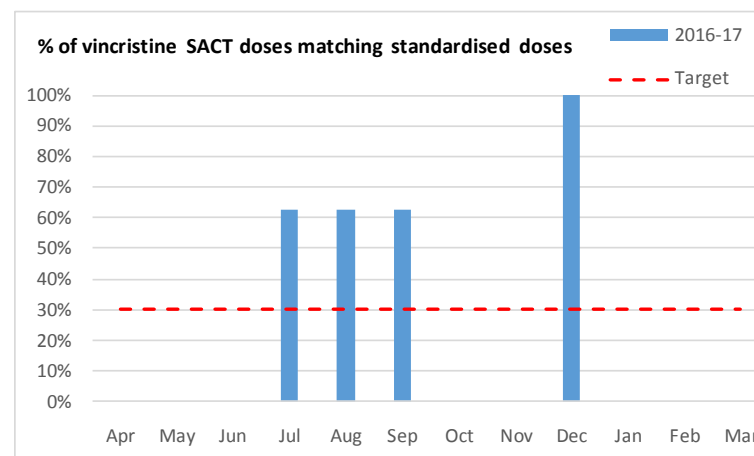
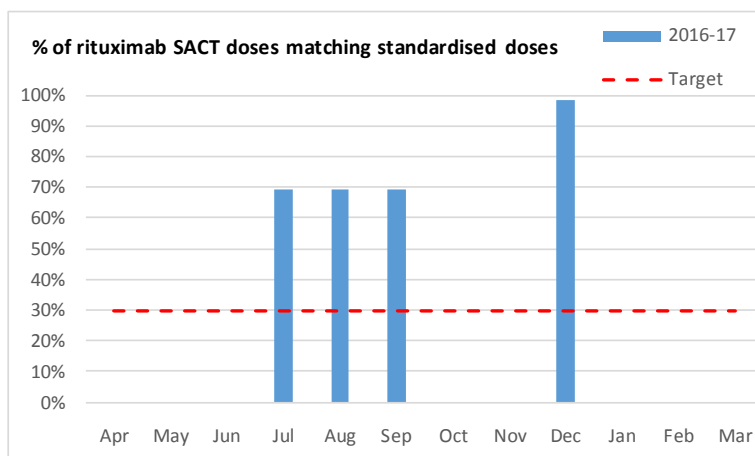
- The Critical Care CQUIN is specifically focused on delayed discharges from Critical Care and delays over 4 hours and 48 hours are both monitored.
- Although Critical Care is a risk area for the Trust in 2016/17, due to limitation in beds and this CQUIN has encouraged further improvement work to reduce the delays in both 4 hours and more than 48 hours.
- There is no target for critical care delays more than 4 hours, but the CQUIN still requires for this data to be monitored on a monthly basis. A reduction in percentage of delays discharges can be seen from April.
- We are below and therefore achieving against the target for “% critical care discharges delayed for more than 48 hours”.



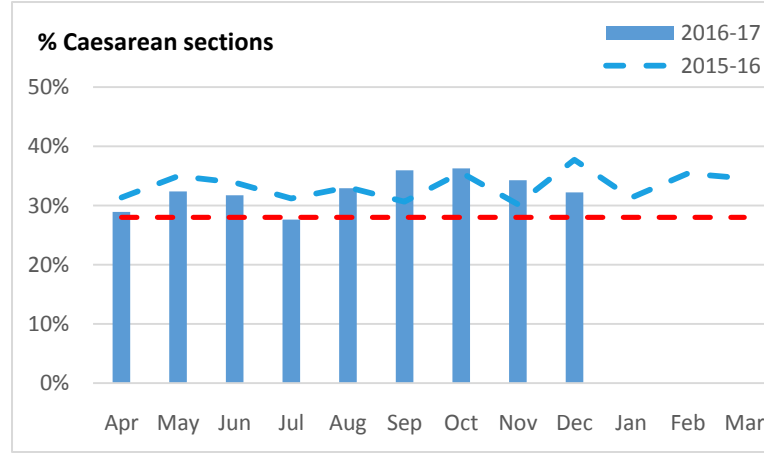
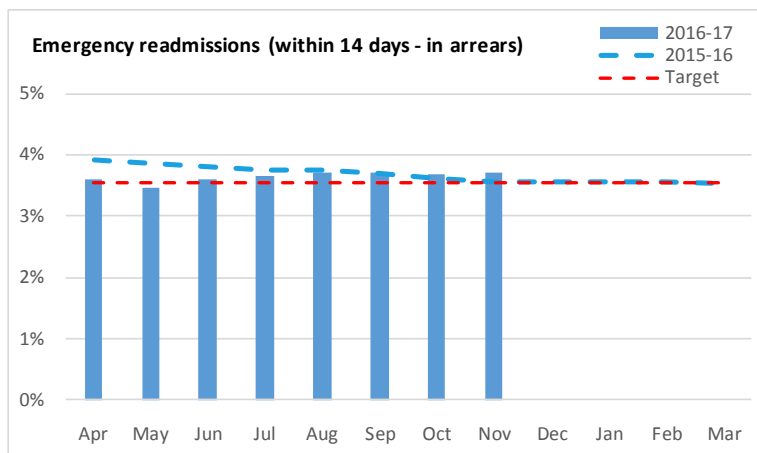
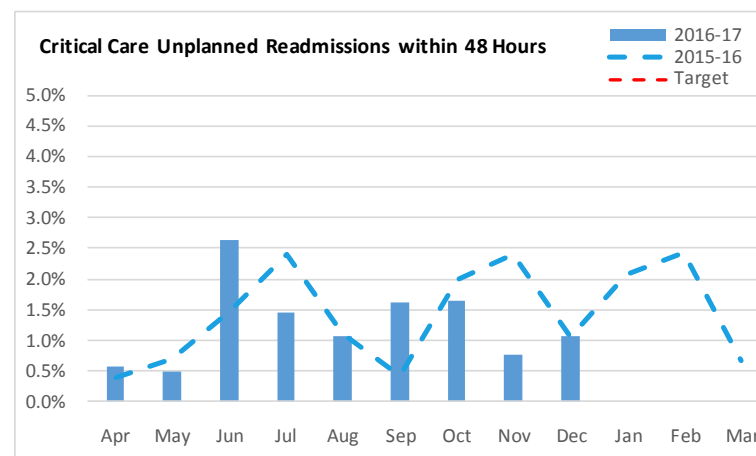
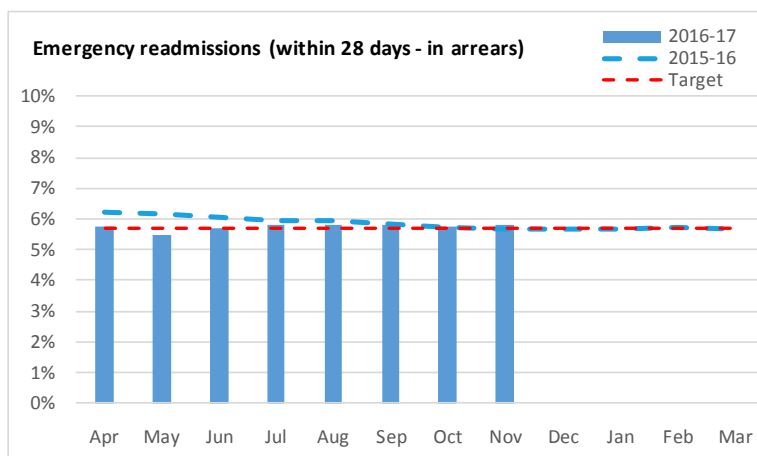
- Automated exchange transfusion for sickle cell improves patient experience and use of clinical resources and this CQUIN has been developed to incentivise this over manual exchange for both adults and children.
- We are exceeding against the target with this CQUIN for both Adults and Children, which is evident in the graphs below.
- The data is collected on a quarterly basis, which is still being reviewed and will be included in next month's report.



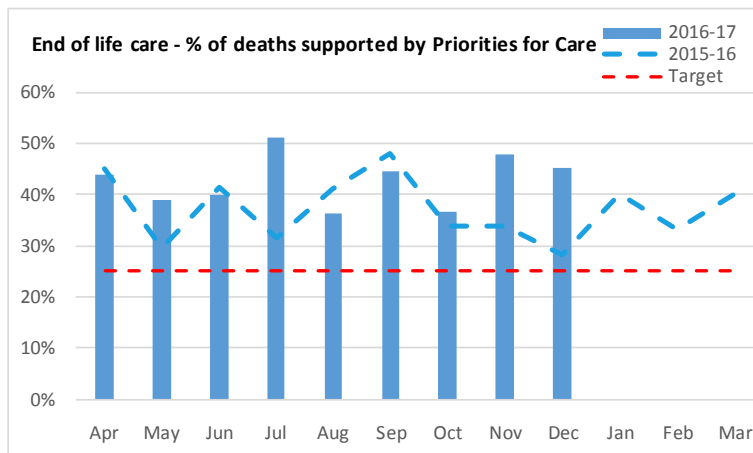
- This CQUIN is a national incentive to standardise the doses of Intravenous systemic anticancer therapy (SACT), for adults across England. The purpose is to increase safety, efficiency and support parity of care across NHS providers. NHS England realised a set of dose banding principles and dosage tables to which all pharmacy departments have to apply to new patients. All the dose banding principles have to be agreed with my local Drug and Therapeutic committees.
- The CQUIN is monitored on a quarterly basis for two drugs (Rituximab and Vincristine), which we are exceeding the targets for both of these drugs. Although previously collected on a monthly basis, the data is now collated on a quarterly basis and Q3's total performance has been included in the month of Dec.



- Readmission rates vary depending on the clinical service and by patient group. There is an Outcomes group to review the data and look for any trends as well as 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 slightly lower than target and shows a higher level to last year in November. This reflects the case-mix of mothers who deliver at St Thomas'. In order to reduce the overall number of caesarean sections within the Trust we have introduced measures to review the appropriateness of emergency caesarean sections, as well as to reduce the number of repeat caesarean sections.
- Unplanned readmissions to critical care is lower than last year. Patients were prioritised according to clinical need for a HDU bed. Those patients who were discharged to a lower acuity ward area were supported by the Critical Care Outreach Team. Rapid return to critical care was facilitated when necessary.



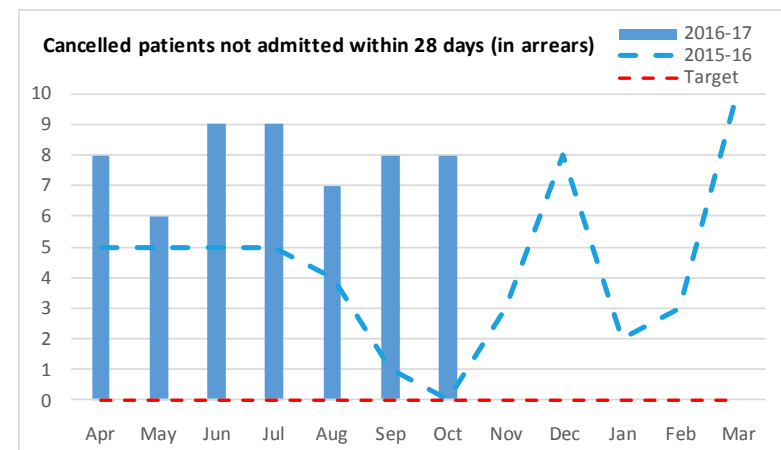
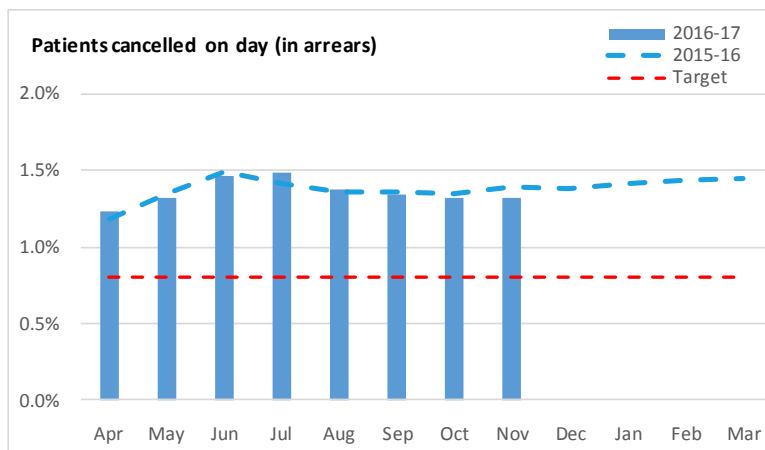
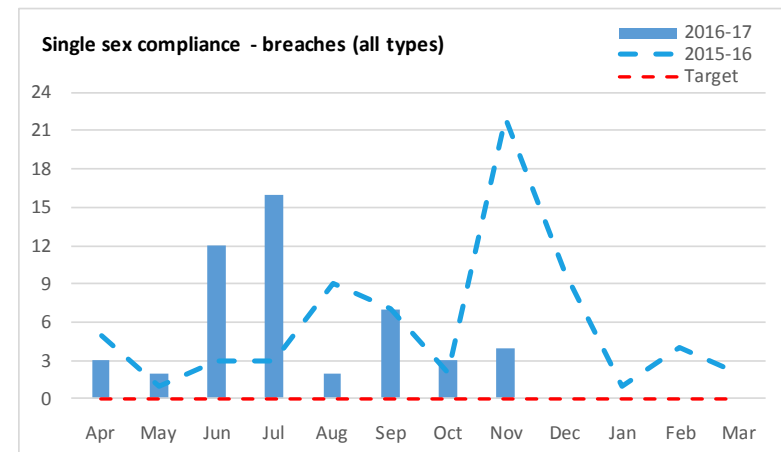
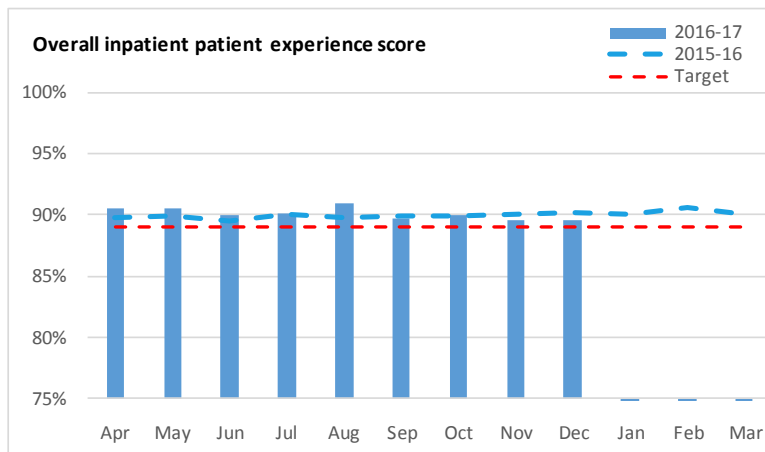
- The level of use of the Priorities for Care of the Dying Person indicates good levels of identification by ward teams when patients are deteriorating on a background of poor potential for reversibility.
- The acute admissions ward, medicine, elderly care and oncology are all recognising people in whom death can be expected in a high proportion of those who go on to die. This supports active communication, planning and provision of holistic care to patients and those important to them.



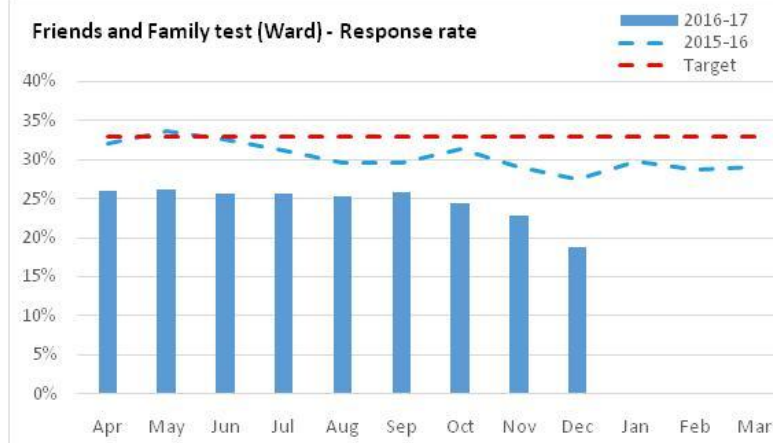
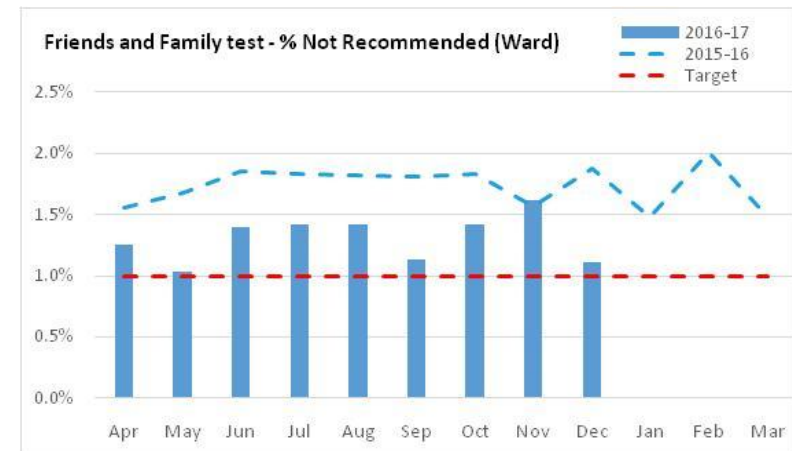
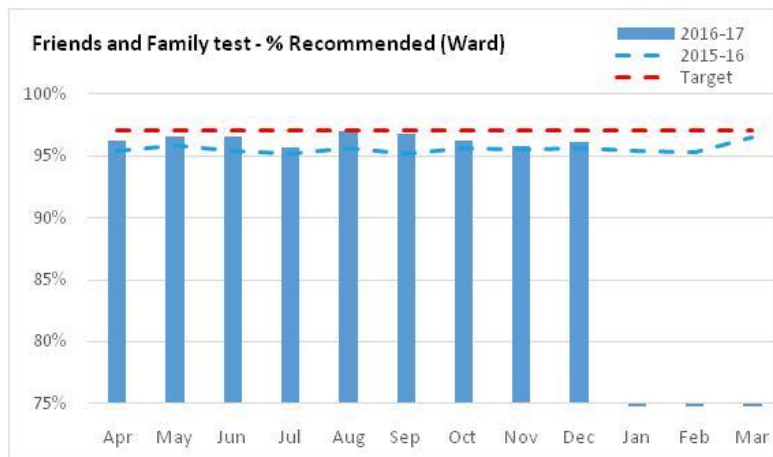
Theme	Ref	Indicator	Units	Target	R	G	Prior year	Oct	Nov	Dec	YTD avg	Monitor	Quality priorities	Trend chart
3.1 Admitted care	258	Overall inpatient patient experience score	Mthly %	>89%			90%	90.0%	89.6%	89.5%	90.2%			Y
	310	Single sex compliance - breaches (all types)	Cases	Zero			5.8	3	4	0	5.4			Y
	501	Patients cancelled on day (in arrears)	Cum %	<0.8%			1.4%	1.3%	1.3%		1.4%			Y
	502	Cancelled patients not admitted within 28 days (in arrears)	Number	Zero			3.4	8	0		6.1			Y
	FFT1W	Friends and Family test (Ward) - Response rate	Mthly %	>=33%			30.4%	24.4%	22.8%	18.8%	24.5%			Y
	FFT2W	Friends and Family test - % Recommended (Ward)	Mthly %	>=97%			95.5%	96.2%	95.8%	96.1%	96.4%			Y
	FFT3W	Friends and Family test - % Not Recommended (Ward)	Mthly %	<=1%			1.7%	1.4%	1.6%	1.1%	1.3%			Y
3.2 A&E care	FFT1AE	Friends and family test (A&E) - Response rate	Mthly %	>=18%			15.6%	12.5%	13.8%	14.2%	14.4%			Y
	FFT2AE	Friends and Family test - % Recommended (A&E)	Mthly %	>=88%			85.0%	83.5%	83.7%	86.8%	84.9%			Y
	FFT3AE	Friends and Family test - % Not Recommended (A&E)	Mthly %	<=6%			8.1%	8.6%	8.8%	6.1%	7.3%			Y
3.3 Maternity care	FFT1M	Friends and Family test (Maternity) - Response rate overall	Mthly %	-			18.1%	18.3%	23.5%	20.4%	28.2%			Y
	FFT2M	Friends and Family test - % Recommended (Maternity)	Mthly %	-			92.6%	91.5%	89.4%	90.0%	91.1%			Y
	FFT3M	Friends and Family test - % Not Recommended (Maternity)	Mthly %	-			2.1%	3.4%	3.3%	3.6%	3.1%			Y
3.4 Outpatient care	FFT2OP	Friends and Family test - % Recommended (Outpatients)	Mthly %	-			92.6%	92.8%	93.5%	94.3%	93.0%			Y
	FFT3OP	Friends and Family test - % Not Recommended (Outpatients)	Mthly %	-			3.4%	3.5%	3.0%	2.9%	3.2%			Y
3.5 Community care	FFT1CS	Friends and Family test (Community) - Response rate	Mthly %	-			5.4%	4.6%	4.9%	2.9%	4.7%			Y
	FFT2CS	Friends and Family test - % Recommended (Community)	Mthly %	-			96.0%	94.8%	96.0%	99.3%	95.6%			Y
	FFT3CS	Friends and Family test - % Not Recommended (Community)	Mthly %	-			0.8%	0.7%	0.0%	0.7%	0.7%			Y
	260C	Adult community health centre patient experience score	Mthly %	>89%			93.9%	94.0%			94.1%			Y
3.6 Patient Transport	FFT1PT	Friends and Family test (Transport) - Response rate	Mthly %	-			2.5%	2.4%	3.5%	2.5%	2.3%			Y
	FFT2PT	Friends and Family test - % Recommended (Transport)	Mthly %	-			91.9%	92.7%	91.7%	90.0%	92.9%			Y
	FFT3PT	Friends and Family test - % Not Recommended (Transport)	Mthly %	-			3.0%	2.9%	2.5%	3.1%	2.0%			Y
3.7 General patient and	Food	Satisfaction with food (PLACE)	Mthly %	>85%			92%	91.8%	91.8%	91.8%	92.2%			Y



- Cancellations have increased in proportion to our increased levels of 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 very high levels of activity which presented challenges regarding capacity.
- Patient experience scores continue to reflect well on inpatient care, with an overall satisfaction rate of 89.5%. This is similar to the November score of 89.6% within Cardiology with managing step down of some patients.
- Single sex compliance is also reported a month in arrears.



- Having reviewed the previous years data on inpatients and day case/surgery as a new area of care, the Trust has set itself a combined response rate of 30% for 2016-17. In December we achieved a response rate of 18.8% which is a decrease on the November figure of 22.8%. The decrease in response rate is due to the switch over to the new patient feedback system which went live on 1<sup>st</sup> December. As the system becomes embedded response rates will increase. The Patient Experience Team are reviewing the data in detail to establish trends and themes in feedback and have contacted teams who may need additional support in capturing responses.
- The proportion of patients who would recommend the Trust in December figure has increased slightly from the November figure of 95.8% to 96.1%. The percentage of patients who would not make a recommendation has improved slightly falling from 1.6% in November to 1.1% in December.
- 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.
- The briefing on page 32 provides further analysis and detail of actions underway.



### 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

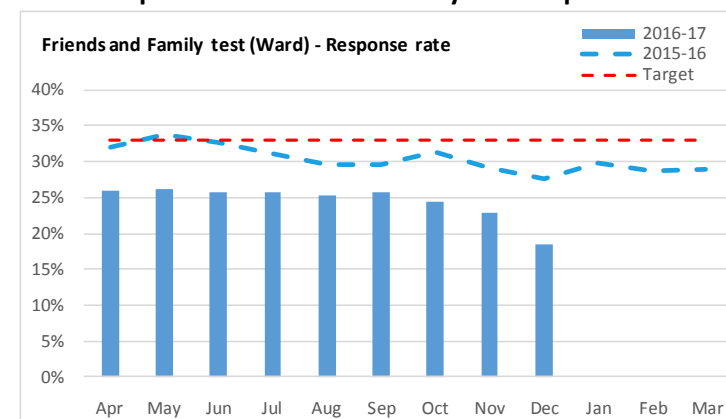
### Where we are: trends, patterns and causes

- The response rate fell from 22.8% in November to 18.8% in December.
- This fall in the response due to the switch over to a new patient feedback system at the end of November.
- In January teams were contacted to ensure all ipads are working and additional training session have been set up at York Road and the patient experience team have also been carrying out small group training sessions with Directorate management teams. Additional training sessions have been set up for February and will also be offered in March.
- A review of comments made by patients completing the inpatient survey has shown that noise at night continues to disrupt many patients sleep and a number of patients have commented that the beds are uncomfortable. These issues will be explored and addressed via the Environmental Sub-Group of the Nightingale Project.
- In November our response rate placed us in the upper third of the Shelford Group, whilst our "recommend" scores placed us in the mid-range and "not recommend" scores were in the upper half of the group. Our scores are in line with national and London average.
- The proportion of patients who would recommend us has remained consistent at above 95%.

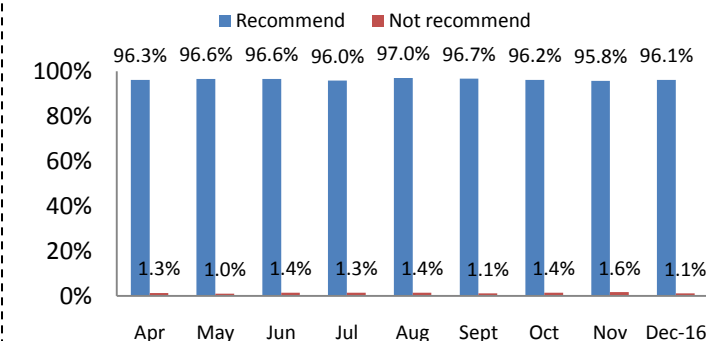
### Risks or opportunities for the Trust

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

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



### Trend –2016 Inpatient Friends and Family Test percentage Recommend v. Not recommend

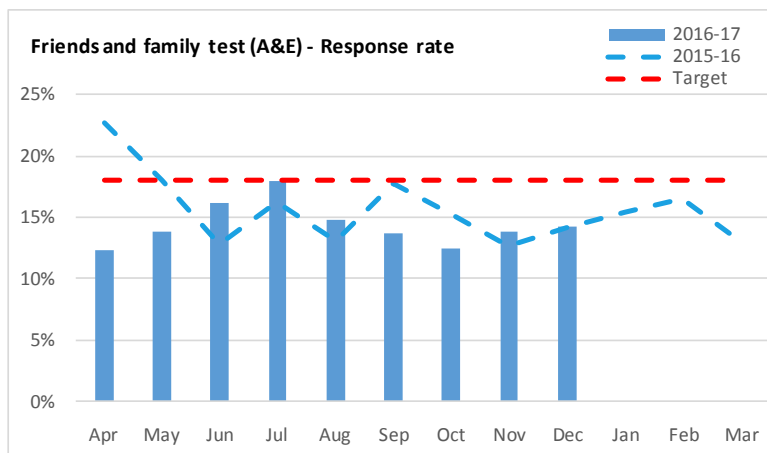
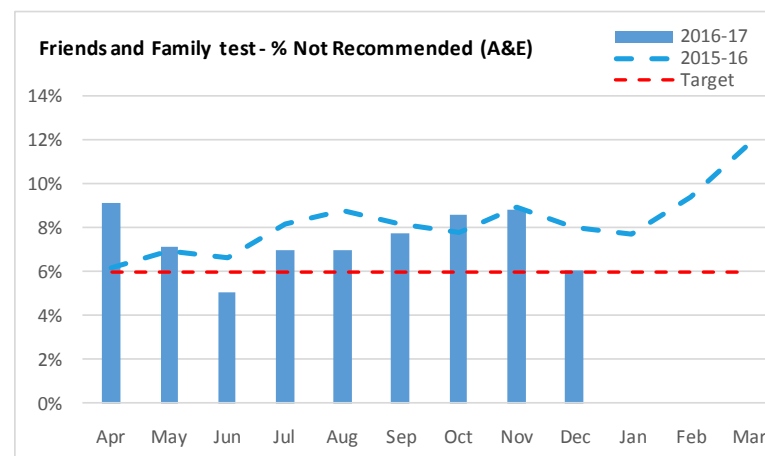
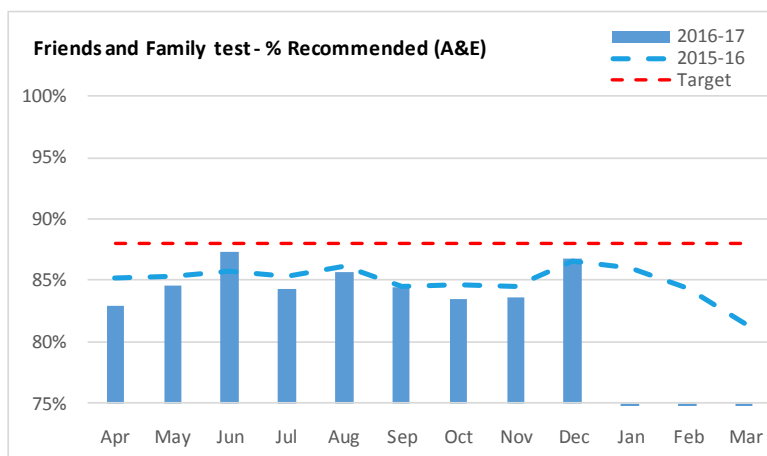


### Comparator – Shelford Group

Shelford Group Trust/Month	November		Response Rate November Inpatient
	Recommend %	Not recommend %	
National Score for England	95%	2%	24.7%
London region score	95%	2%	26.8%
Guy's and St Thomas' NHS Foundation Trust	96%	2%	22.8%
University College London Hospitals NHS Foundation Trust	95%	1%	11.1%
Newcastle-Upon-Tyne Hospitals NHS Foundation Trust	98%	1%	16.0%
Sheffield Teaching Hospitals NHS Foundation Trust	97%	2%	32.2%
University Hospitals Birmingham NHS Foundation Trust	98%	1%	16.7%
Oxford University Hospitals NHS Trust	97%	1%	15.0%
King's College Hospital NHS Foundation Trust	95%	2%	11.1%
Cambridge University Hospitals NHS Foundation Trust	97%	1%	7.4%
Imperial College Healthcare NHS Trust	97%	1%	28.9%
Central Manchester University Hospitals NHS Foundation Trust	95%	2%	18.2%

Action and progress			Owner	Next review date
Free text comments highlighting areas of concern for patients have been identified. Improvements regarding environment aspects will be taken forward via the Environmental Sub-Group of the Nightingale Project			Environmental Sub-Group of the Nightingale Project	March 2016
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 & Directors of Nursing	February 2016
Explore what support wards may need to increase data capture and support with new patient feedback system			Patient Experience Team	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.
- Having reviewed local and national data for 2015-16 the Trust has set itself a target response rate of 16% for 2016-17. The response rate for A&E increased from 13.8% in November to 14.2% in December. The department continues to be very busy. The team is continuing to take measures to increase the numbers of responses in the coming months and a dedicated member of staff is now in post to help capture feedback from patients.
- The proportion of patients who would recommend the service has increased from 83.7% in November to 86.8% in December. The proportion of patients who said they would not recommend the service has improved falling from 8.8% in November to 6.1% in December. The team are reviewing themes from feedback to identify actions which can be put in place to improve patients experience.
- The briefing on page 33 provides further analysis and 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

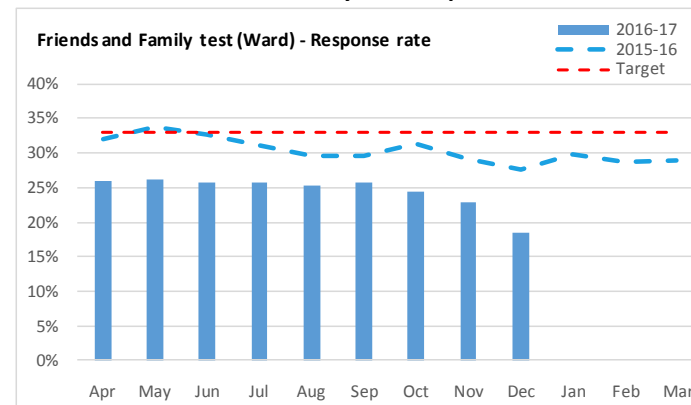
- The response rate increased from 13.8% in November to 14.2% in November.
- The proportion of patients who would recommend us has increased from 83.7% in November to 86.8% in December. The proportion of patients who would not recommend us has markedly improved falling from 8.8% in November to 6.1% in December.
- The service has been focusing on encouraging more patients to complete FFT postcards . A review of comments made by patients has cited issues regarding communication by staff in particular in relation to waiting times and explanations of aspects of care as areas for improvement.

### Risks or opportunities for the Trust

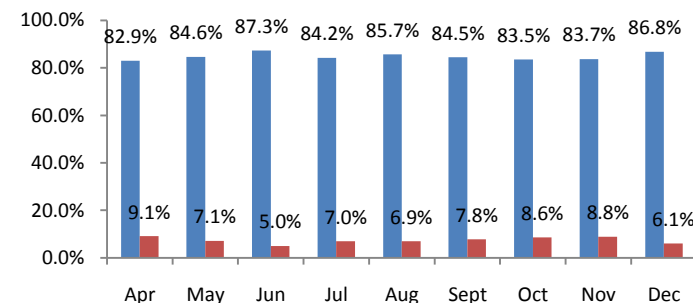
- Feedback captured from patients can be used to improve the service and inform the on-going development of the Emergency Floor and associated pathways.
- In October our response rate, our recommend and not recommend scores were in the lower half of the Shelford Group.

Action and progress	Owner	Next review date
Signs giving current waiting times are now displayed in the department. Work is underway to ensure that these are regularly updated and the same waiting times are displayed through out the department.	ED Team	Ongoing weekly review
Development of patient facing dashboard so that patients can receive updates on waiting times in real time. The development of the board has been delayed due as the member of IT staff recruited cannot start at the Trust until February.	ED IT lead	Feb -Mar 2017
The team is planning a focused session on FFT themes and trends at their next clinical governance meeting to identify actions for the team to take forward	H. Todman & ED Team	Feb 2017
The team introduced a tea-trolley in the UCC at STH to improve patient experience and also hand out response cards.	H. Todman	Ongoing monthly review
Intelligence triangulated	Root cause understood	Action plan set
	Actions underway	Actions complete

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



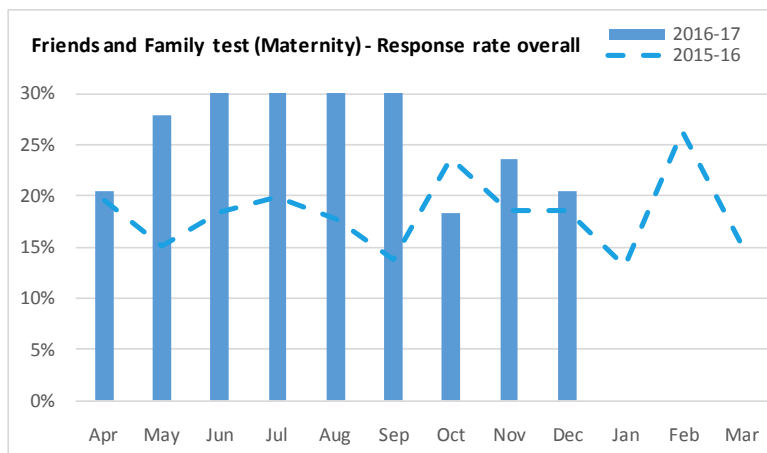
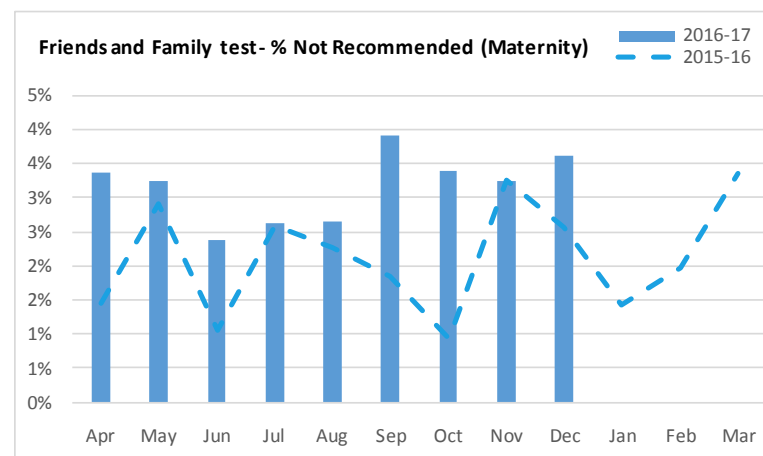
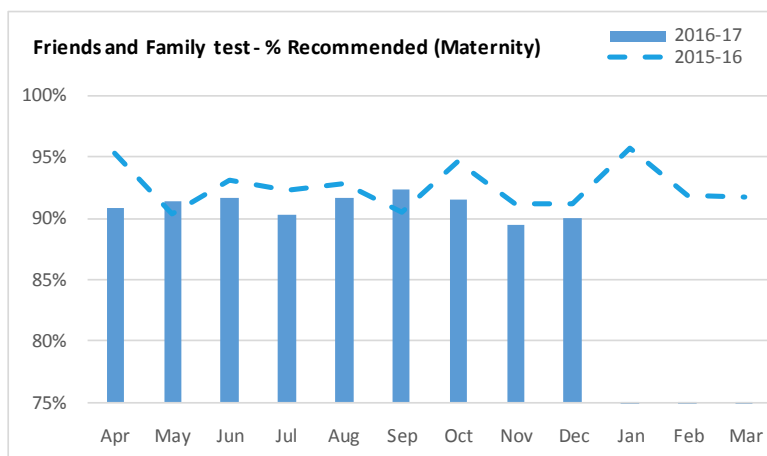
### Trend – A&E Friends and Family Test percentage Recommend v. Not recommend



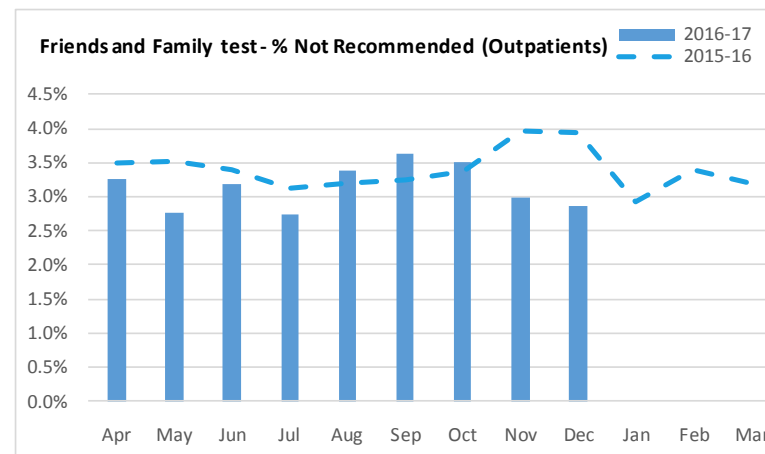
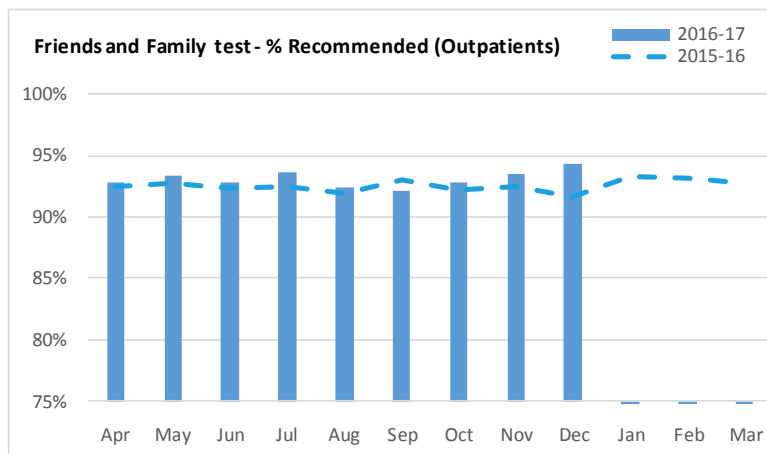
### Comparator – Shelford Group

Shelford Group	November		Response Rate
Trust/Month	Recommend %	Not recommend %	November
National Score for England	86.0%	7.0%	12.7%
London region score	85.0%	8.0%	13.9%
Guy's and St Thomas' NHS Foundation Trust	84.0%	9.0%	13.8%
University College London Hospitals NHS Foundation Trust	94.0%	2.0%	21.2%
Cambridge University Hospitals NHS Foundation Trust	90.0%	4.0%	21.4%
Newcastle-Upon-Tyne Hospitals NHS Foundation Trust	92.0%	4.0%	4.4%
Central Manchester University Hospitals NHS Foundation Trust	87.0%	8.0%	6.2%
Oxford University Hospitals NHS Trust	88.0%	8.0%	21.1%
Imperial College Healthcare NHS Trust	95.0%	3.0%	17.4%
University Hospitals Birmingham NHS Foundation Trust	83.0%	12.0%	14.8%
King's College Hospital NHS Foundation Trust	77.0%	18.0%	3.1%
Sheffield Teaching Hospitals NHS Foundation Trust	86.0%	9.0%	23.4%

- Having reviewed local and national data for 2015-16 the Trust has set itself a target response rate of 20% for 2016-17. The overall response rate for the Friends and Family Test for maternity services fell from 23.5% in November to 20.4% in December. However this is on target. The team continues to encourage colleagues to invite feedback from women before and after the birth of their baby and there has been a significant increase in responses from women at the postnatal community touch point compared with September.
- The proportion of women who would recommend the service increased slightly in December, rising from 89.4% in November to 90%. The proportion of women who said they would not recommend the service has increased slightly rising from 3.3% in November to 3.6% in December. The team regularly review comments and use the emerging themes to identify actions for improvement.

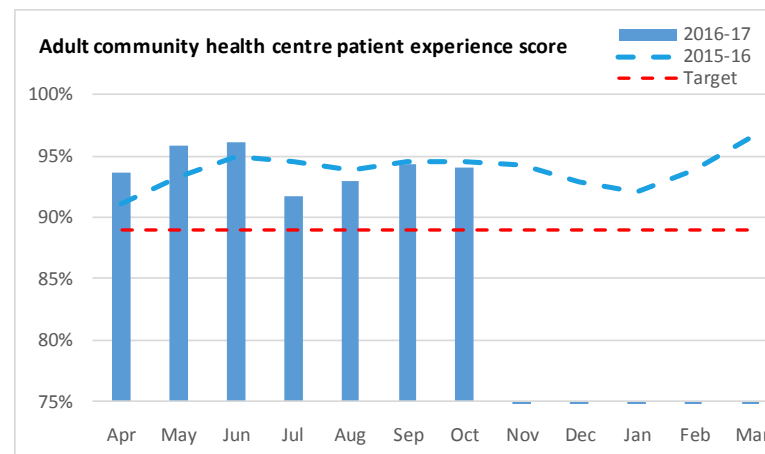
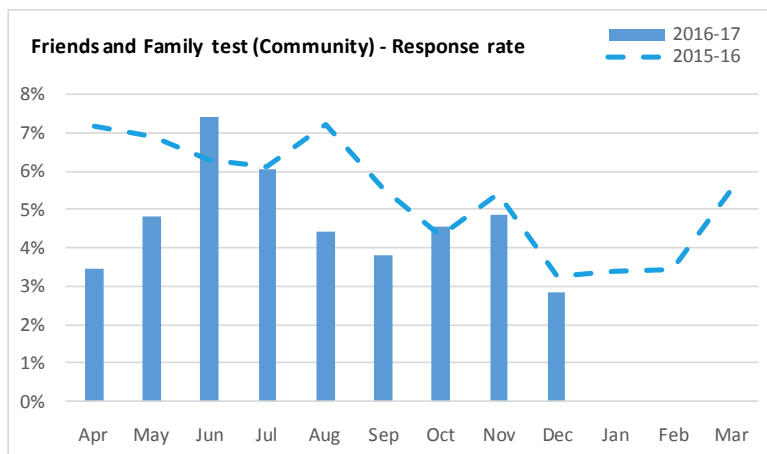
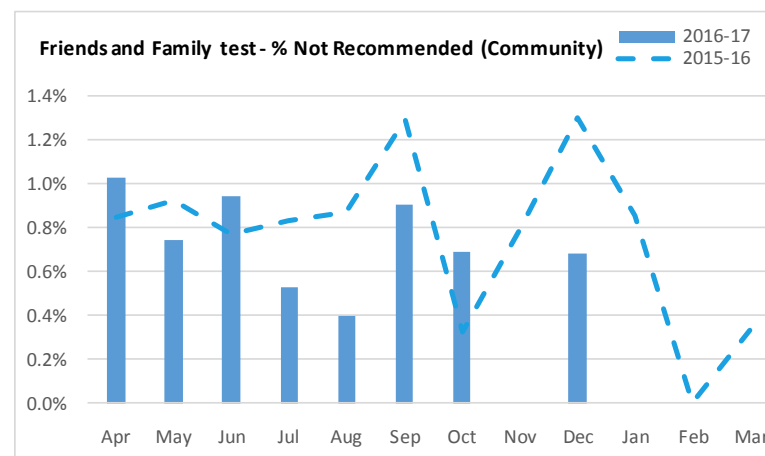
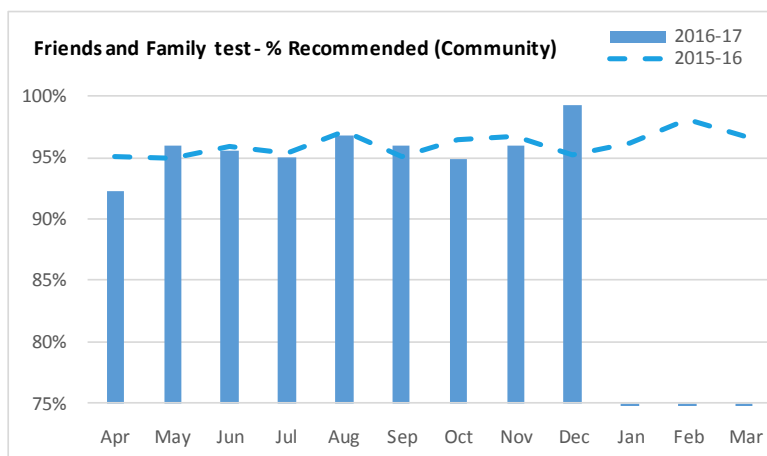


- We have reviewed local and national 2015-16 data and have set a response rate target of 7%.
- The proportion of outpatients who would recommend the Trust was 94.3% which is a slight increase on the November figure of 93.5%. The proportion of patients who would not recommend the Trust was 2.9% which is similar to the November figure of 3.0%.
- As part of the Fit for the Future outpatient work stream, directorates are improving communication with patients regarding their appointments through text messaging, where it is not currently in use and introducing a system for booking follow ups. "Partial booking" of follow up appointments 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, and introducing more one-stop visits (where the consultation appointment and any associated diagnostic tests occur on the same day). Through improving patient experience some of these initiatives will improve new to follow-up ratios.

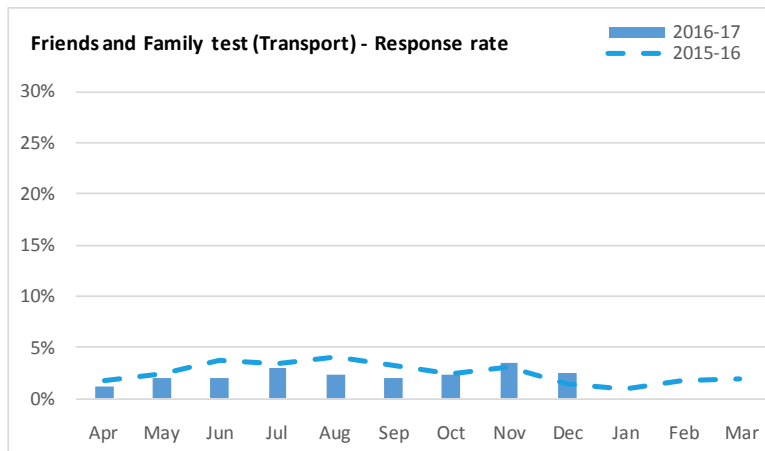
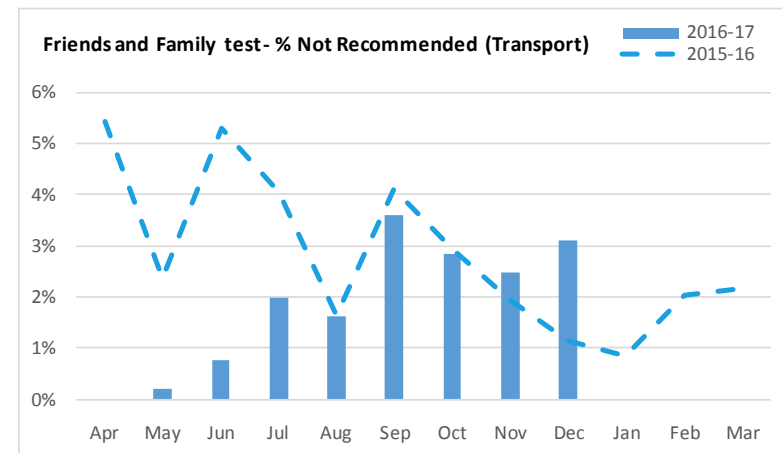
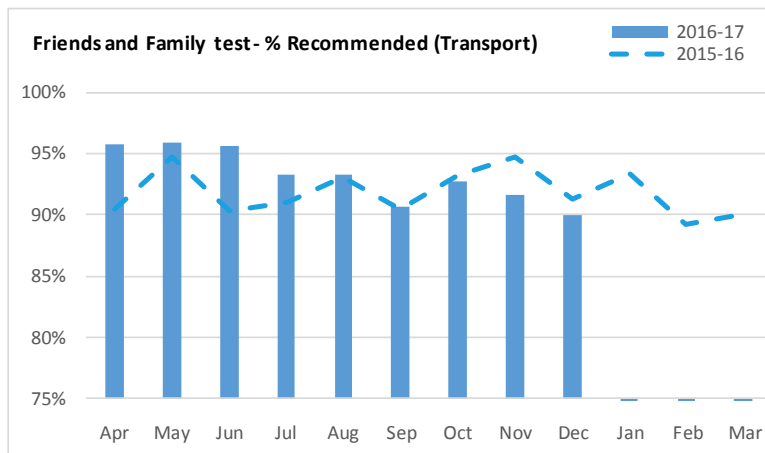




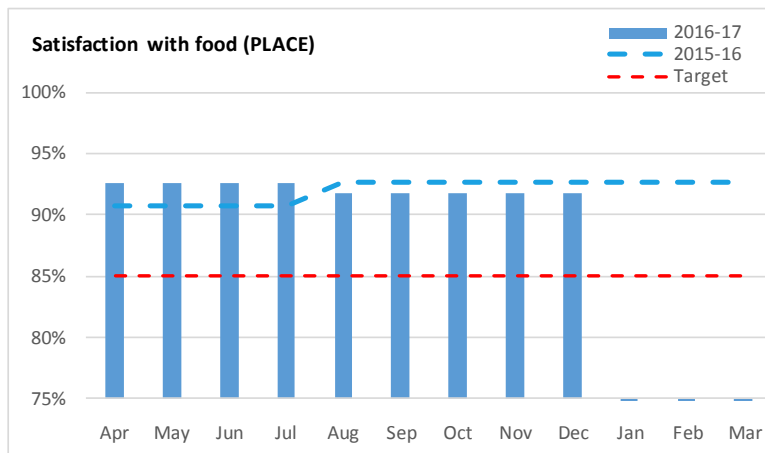
- We have reviewed 2015-16 local and national data and set a response rate target of 7%.
- In December the response rate fell from the November figure of 4.9% to 2.9%. The decrease in response rate is due to the switch over to the new patient feedback system which went live on 1<sup>st</sup> December. As the system becomes embedded response rates will increase.
- The proportion of patients who would recommend community-based services has increased from 96.0% in November to 99.3% in December. The proportion of patients who would not recommend services has increased slightly from 0.0% in November to 0.7% in December.
- The overall patient satisfaction score of 94% is similar to the October score of 94.3%.



- The proportion of patients recommending the transport dipped slightly this month falling from 91.7% in November to 90.0% in December. The not recommend score has increased slightly rising from 2.5% in November to 3.1% in December.
- The response rate has fallen slightly from 3.5% in November to 2.5% in December.



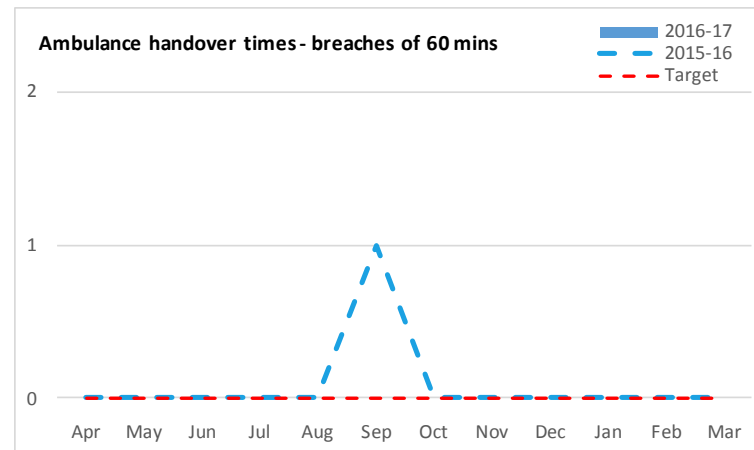
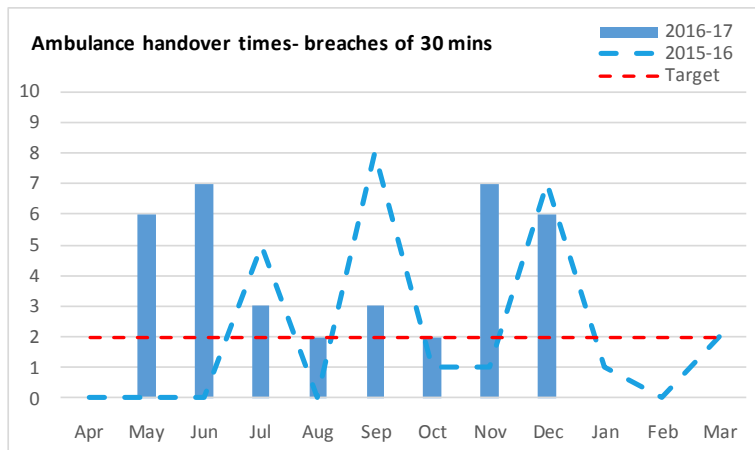
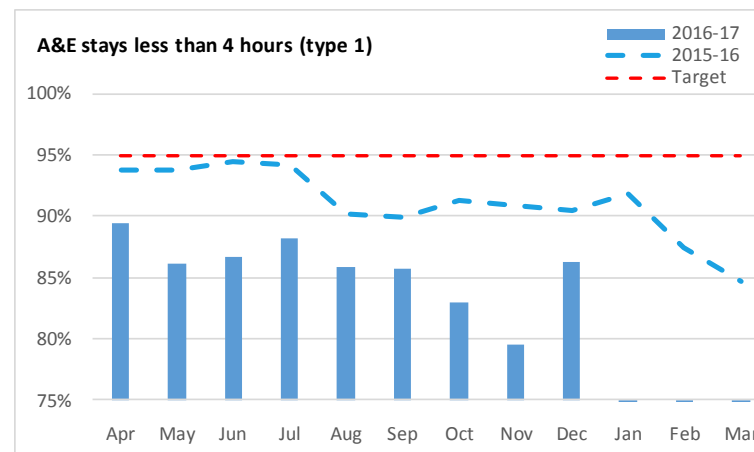
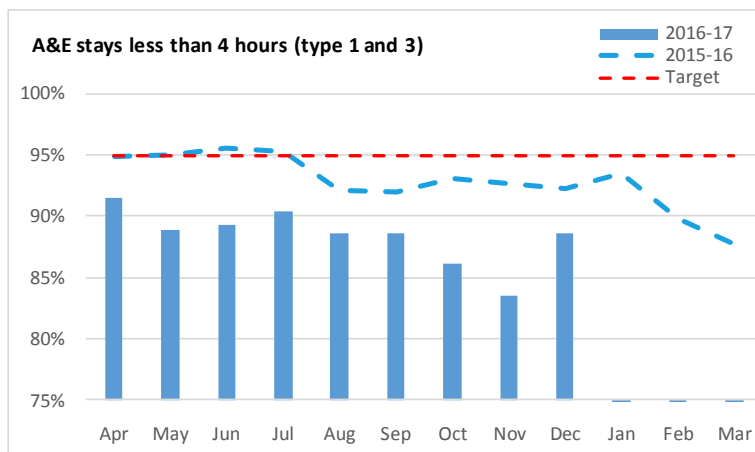
- The Trust has scored strongly for the quality of its catering as reflected in the National Inpatient Survey 2015, published by the Care Quality Commission (CQC). The Trust's catering scores exceed those of other London Trusts.
- The catering team continue to work closely with both Nursing and Dietetic staff to consolidate and introduce further quality improvements, and the Trust is working towards full compliance with the Hospitals Food Standards Report.
- Data in development for 2016/17.



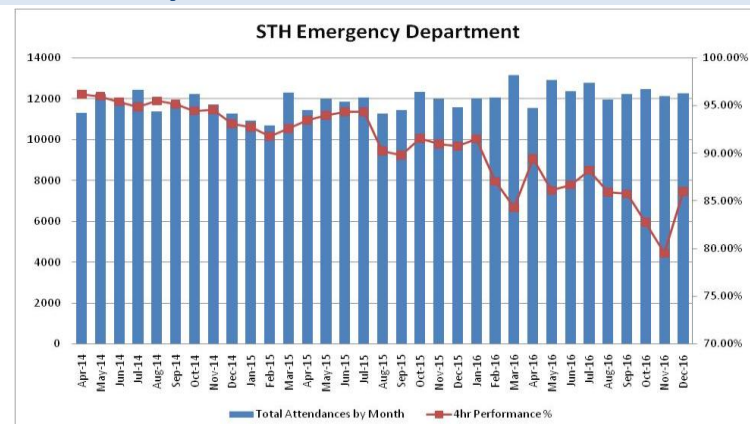
Theme	Ref	Indicator	Units	Target	R	G	Prior year	Oct	Nov	Dec	YTD avg	Monitor Quality priorities	Trend chart
4.1 A&E access	AE1	A&E stays less than 4 hours (type 1 and 3)	Mthly %	>95%			92.8%	86.2%	83.5%	88.6%	88.4%		Y
	AE1STH	A&E stays less than 4 hours (type 1)	Mthly %	>95%			91.0%	82.9%	79.5%	86.2%	85.6%		Y
	AE30	Ambulance handover times - breaches of 30 mins	Number	<3			2.1	2	7	6	4.0		Y
	AE60	Ambulance handover times - breaches of 60 mins	Number	Zero			0.1	0	0	0	0.0		Y
4.2 Elective treatment access - referral to treatment (RTT) performance	403M	RTT - Incomplete pathways < 18 weeks (unadjusted)	Mthly %	>92%			92.3%	89.6%	89.9%	88.8%	90.8%		Y
	RTT 52I	RTT - Incomplete pathways over 52 weeks	Mthly	Zero			7.9	26	18	17	17.8		Y
	RTT TQ	RTT - Total incomplete pathways	Mthly	-			47,493	59,045	58,112	58,293	56,647		Y
	RTT 18Q	RTT - Incomplete pathways over 18 weeks	Mthly	-			3,671	6,113	5,898	6,519	5,266		Y
	401M	RTT - Non-admitted patients <18 weeks (unadjusted)	Mthly %	>95%			93.2%	89.5%	88.6%	89.8%	90.7%		Y
	402M	RTT - Admitted patients < 18 weeks (unadjusted)	Mthly %	>90%			83.7%	77.1%	79.6%	81.8%	81.4%		Y
	RTT 52	RTT - Treatments over 52 weeks (unadjusted)	Mthly	Zero			7.1	16	26	12	12.6		Y
4.3 Cancer access	451M	Cancer - 2 week wait	Qtly%	>93%			92.8%	90.2%	91.9%	92.5%	90.4%		Y
	941	Cancer - breast symptomatic referrals <2 wks	Qtly %	>93%			95.0%	92.5%	89.1%	90.3%	89.8%		Y
	453M	Cancer - 31 day first treatments	Qtly%	>96%			94.4%	94.4%	94.1%	95.3%	95.4%		Y
	459M	Cancer - 31 day subs treatments - surgical	Qtly%	>94%			91.5%	95.0%	87.0%	90.3%	90.4%		Y
	943	Cancer - secondary chemotherapy <31 days	Qtly %	>98%			98.7%	98.0%	99.6%	98.4%	98.2%		Y
	942	Cancer - secondary radiotherapy <31 days	Qtly %	>94%			96.0%	94.6%	95.4%	95.2%	94.9%		Y
	454M	Cancer - 62 day urgent GP referrals	Qtly %	>85%			69.8%	65.4%	69.3%	66.5%	68.4%		Y
		Cancer - 62 day urgent GP referrals (LCA cases only)		In devt									
	454I	Cancer - internal 62-day referrals	Qtly%	>85%			79.6%	72.9%	80.7%	68.1%	79.5%		Y
	456M	Cancer - 62 day screening	Qtly %	>90%			89.5%	100.0%	20.0%	100.0%	83.9%		Y
	457	Cancer Backlogs - pathways over 62 days	Number	-				153	143	157	141		
	458	Cancer Backlogs - pathways over 62 days	Number	-				59.0%	57.8%	67.1%	49.0%		

Theme	Ref	Indicator	Units	Target	R	G	Prior year	Oct	Nov	Dec	YTD avg	Monitor	Quality priorities	Trend chart
4.4 Diagnostic access	Diag 6	Diagnostic waits - % over 6 weeks	Mthly	<1%			1.48%	0.85%	1.34%	1.60%	1.21%			Y
	FFF19	Turnaround time - inpatient MRI within 24 hours	Mthly %	>80%			70.9%	59.7%	63.8%	59.3%	62.8%			Y
	FFF20	Turnaround time - inpatient CT within 24 hours	Mthly %	>80%			83.5%	83.0%	85.3%	89.2%	84.7%			Y
	FFF21	Turnaround time - inpatient Ultrasound within 24 hours	Mthly %	>80%			77.6%	75.0%	75.9%	78.9%	77.1%			Y
4.5 Bed capacity and management	531	Average length of stay (elective)	Cum ALOS	<last yr			3.44	3.46	3.45	3.52	3.52			Y
	LOS>1	Non-elective average LOS >1 night	Cum ALOS	<last yr			8.6	8.7	8.8	8.7	8.7			Y
	535	Discharges before noon	Mthly %	>25%			20.9%	19.7%	20.2%	20.7%	20.8%			Y
	Home	GSTT referrals to @Home service	Cases	>100			61	77	68	72	75			Y
	DTtoCPS	Patients with a DTtoC (snapshot)	Number	-			16	20	17	14	18			Y
	DTtoCDT	DTtoC total delayed days	Number	-			449	548	402	497	535			Y
4.6 Outpatient management	604	Appointments re-scheduled by hospital <6wks	Cum %	<4%			4.7%	4.8%	4.7%	4.7%	4.7%			Y
	FFF57	Gassiot House Room Utilisation	Mthly %	>75%			87.0%	89.1%	90.0%	85.2%	88.0%			
	618	Choose and Book - % slot unavailability	Mthly %	<5%							-			Y
	601R	Follow-up ratio - adj cons appts (in arrears)	Ratio	2.11			2.20	2.20	2.12		2.13			Y
	602	Non-attendance rate (new appts)	Mthly %	<11%			12.1%	10.7%	11.0%	12.4%	11.2%			Y
	603	Non-attendance rate (f/up appts)	Mthly %	<10.5%			13.1%	11.7%	11.9%	13.3%	12.6%			Y
4.7 Theatre management	533M	Daycase rate - basket (in arrears)	Mthly %	>85%			83.3%	85.6%	83.6%		83.7%			Y
	505	Theatres Gross Cancellation Rate (in arrears)	Mthly %	<7%			7.3%	6.9%	7.0%		6.4%			Y
4.8 Complaints mgt	COM1T	Complaints opened in month (Trust total)	Cases	-			95.1	97	97	95	97			Y
	COM2T	Complaints re-opened in month (Trust total)	Cases	-			4.7	2	3	5	3			Y
	COM6T	Complaints CLOSED in month (total Trust)	Cases	-			-	80	74	107	101			Y

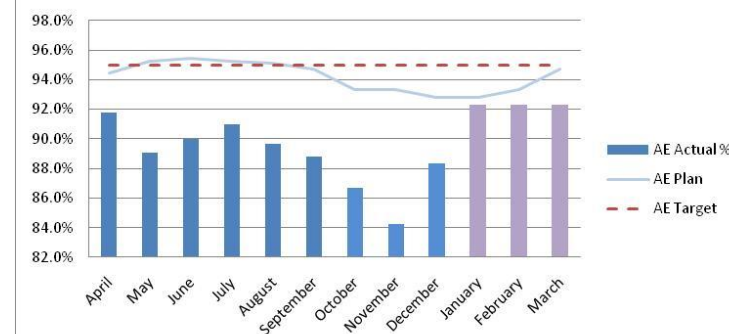
- December saw a improvement in performance in the patient waiting time within our A&E services. The department had six breaches of the >30 minutes ambulance off-load target with no >60 minute delays (lower graphs). The number of ambulance arrivals has increased and the department is now regularly seeing over 100 ambulance patients each day. The department and Trust are committed to ensuring safe and effective ambulance handovers. St Thomas' was the 2<sup>nd</sup> best receiving hospital in London (in terms of the number of 30 minute breaches) in 2015 and continued to be at this level in 2016 despite increasing ambulance arrivals.
- This month has continued the trend of increased overall attendances over the last year. There was an increase of 6% in December 2016 compared to December 2015. The increase in attendances have been seen across all areas of the department, including Majors and Urgent Care.
- Majors moved into its temporary location which will eventually become the Emergency Medical Unit in a year's time. The ED team continued to work hard in December to mitigate the impact of operating Majors in a ward environment.
- The next Trust 'Star-Chamber' will be held in January to review the Emergency Pathway.



- **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.
- We want to achieve our submitted performance trajectory for 4 hour performance – see bottom right graph (purple columns).
- **Where we are: trends and patterns**
- December continued the trend of increased attendances in the department. Guy's Urgent Care Centre has retained performance with approximately 2 breaches or less per week however this is being closely monitored.
- **Risks or opportunities for the Trust**
- The increase in Emergency demand is creating a significant challenge within ED and the Emergency Pathway with a particular pressure on capacity. Actions addressing this are outlined below.
- Effective ambulatory pathways (including Frailty, Acute Assessment Unit & the Surgical Assessment Unit) remain key to improving flow through the Emergency Pathway and reducing demand on the ED capacity, as well as clinically safe Emergency Pathways for other specialties which avoid patients having to be seen in the Emergency Department.
- **Root cause analysis and insights**
- The three key drivers for current A&E performance are:
  1. A sustained increase in attendance numbers, including an increase in ambulance arrivals.
  2. A challenging physical environment due to the current temporary phase of the Emergency Care Pathway rebuild.
  3. High number of patients with complex clinical requirements including mental health conditions.

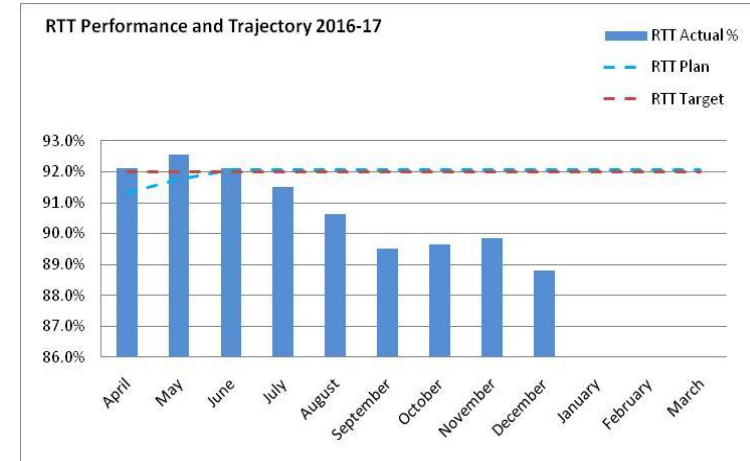
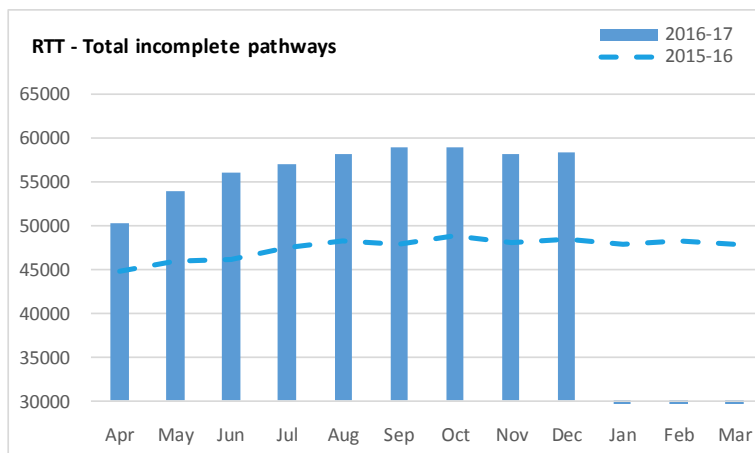
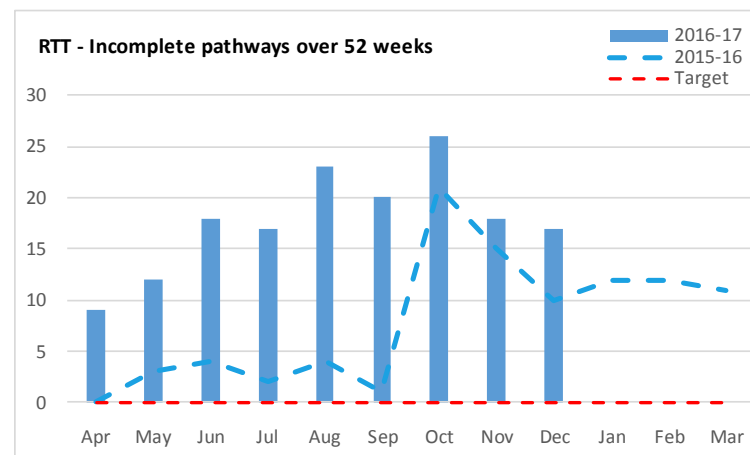
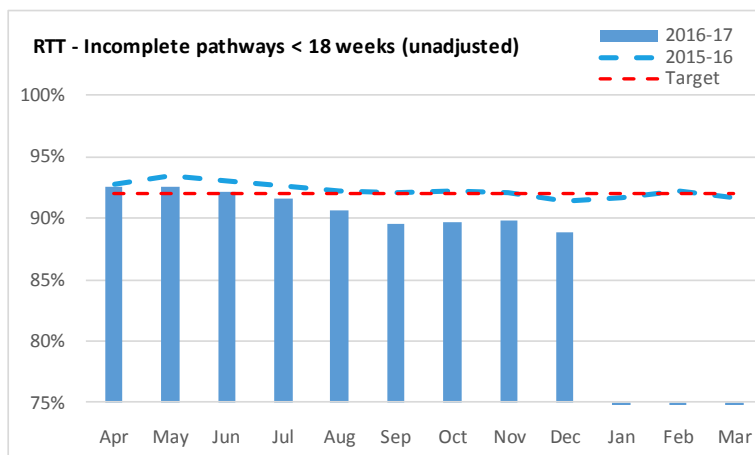


**A&E Performance and Trajectory 2016-17**



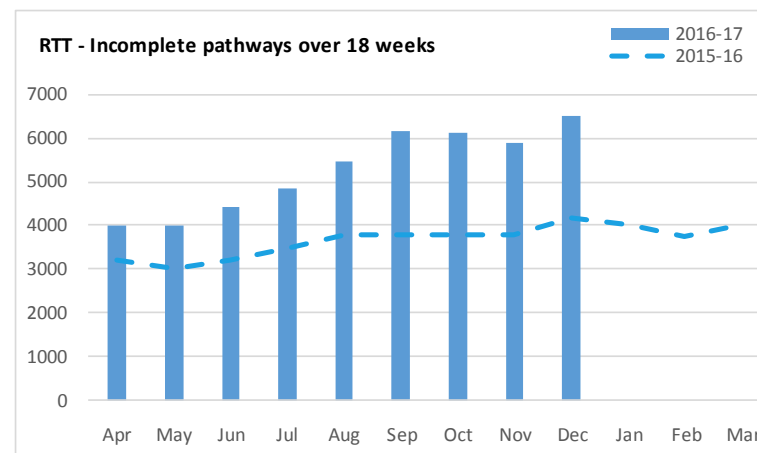
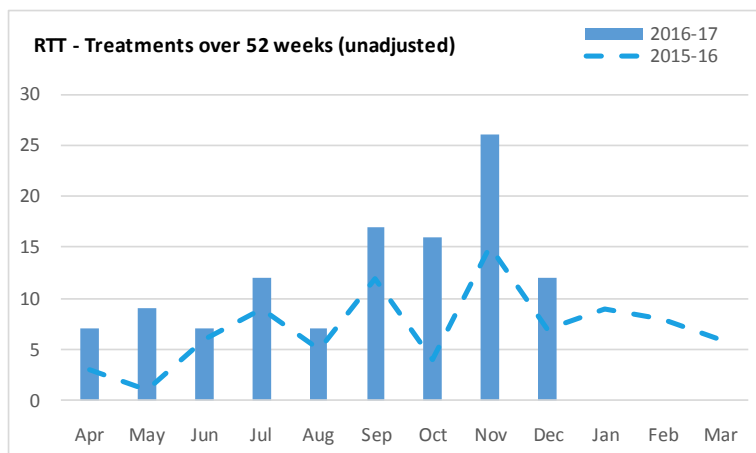
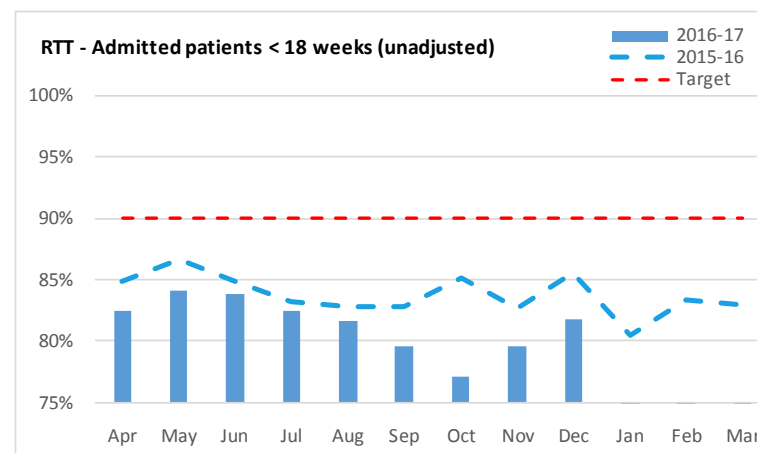
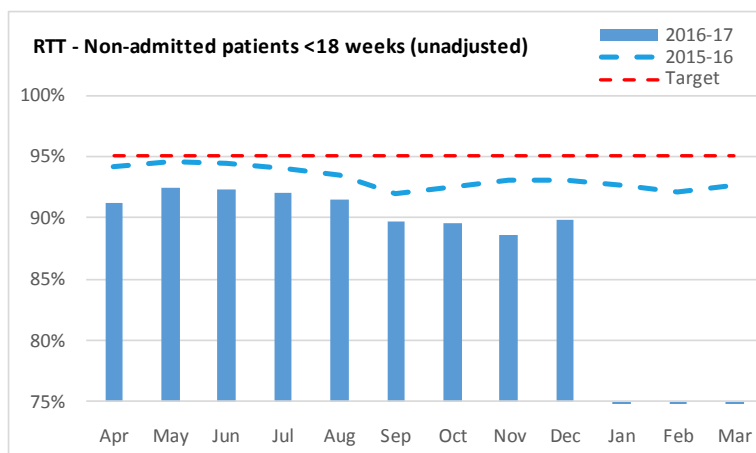
Action and progress	Owner	Next review date
The service continues to safely redirect patients to alternative providers, including GP Hubs and the Waterloo Health Centre. An audit is being undertaken of re-direction in January.	Acute Medicine DMT	January 2016
The next Trust 'Star Chamber' will be held in January to review the progress made within the emergency pathway. Reporting into Star Chamber is the new Urgent & Emergency Care Board which includes the various leads of work-streams across these pathways.	Deputy Dir of Operations & Acute Medicine DMT	January 2016
'ACE Team' projects within Acute Medicine are live and reporting back on actions – including: 1) Emergency Department internal improvements, 2) the Medical Model & Admissions Ward flow and 3) North Wing Complex discharge work. A bid has been submitted to NHSE and internal Trust Capital Planning groups as part of the transformation fund to ask for the capital funding to create a new Ambulatory Care Unit which will help reduce the demand on the Emergency Department.	Acute Medicine DMT	January 2016

- Performance has dipped in December to 88.8%. This was mainly related to Christmas and reduced activity due to patient choice. All directorates have been asked to focus on delivery of activity plans throughout January to ensure improved performance back to or above the November position.
- To help manage our growth in PTL, we are working with our local commissioners holding demand and capacity workshops, to bring together specialty consultants and GPs. An outcome of the demand and capacity workshops with the services, is that the directorates have been asked to develop innovative ways to follow up patients virtually to enable greater capacity for additional new work.
- Data validation remains a priority. GSTT's elective assurance team has advertised for 4 additional validator posts, which will be a central resource that can be utilised by directorates, to help validation of large waiting lists. Candidates are being interviewed in January. Until these posts are filled permanently, extra validation work is being offered to current admin staff, as additional bank shifts.

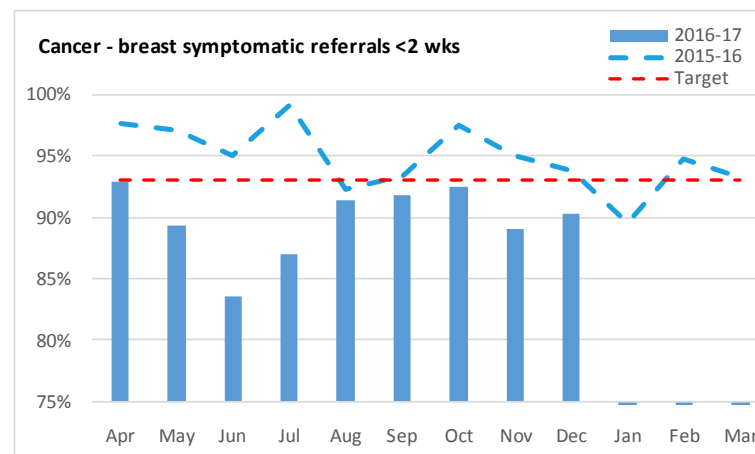
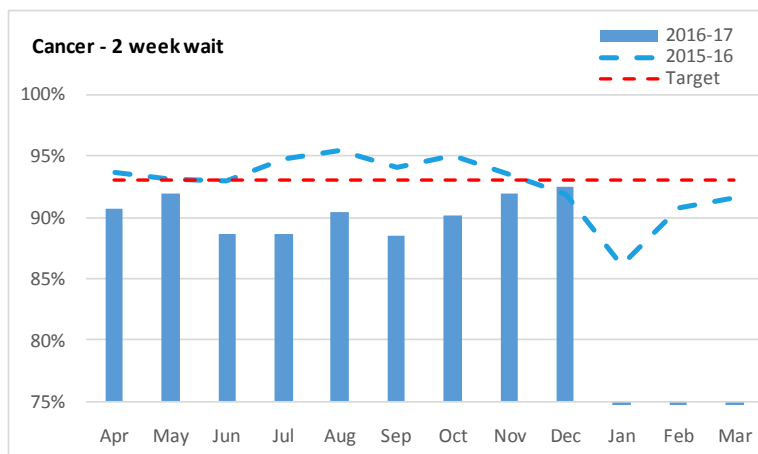




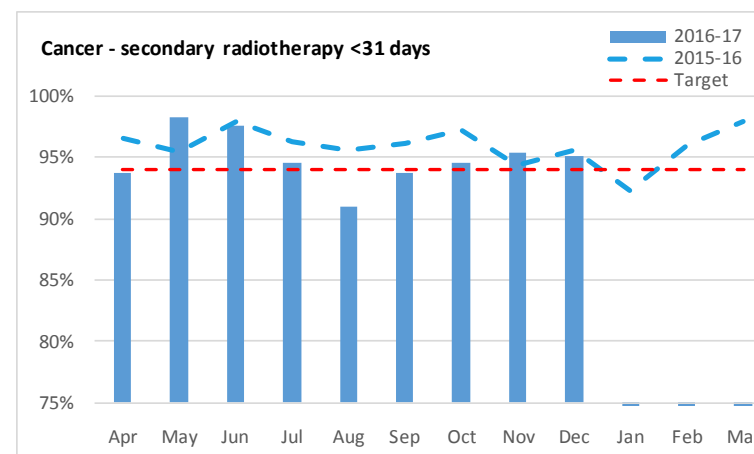
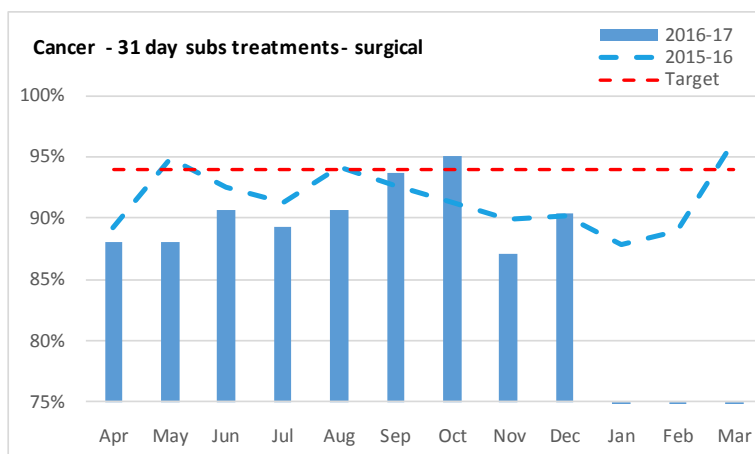
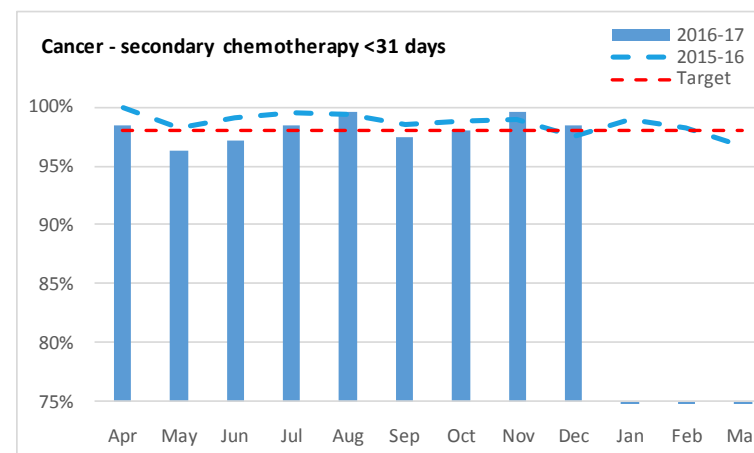
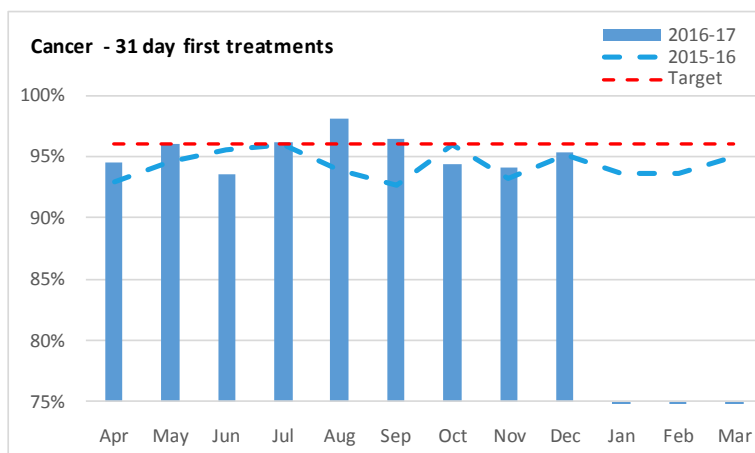
- There has been an increase in backlog from November (5898) to December (6519), this is mainly related to Christmas and patient choice to wait for treatment. All directorates are focusing on recovering performance and reducing backlog further in January. The outsourcing of 453 ENT patients has also started in January. This will have a positive effect on the backlog for ENT and in turn the total Trust backlog.
- In December, we have reported 12 clock stops over 52 weeks and 17 incomplete pathways over 52 weeks. We continue to hold biweekly meetings with the all the directorate General Managers to go through all long waiters (inc potential 52 week breaches) at patient level to ensure a treatment plan is in place. All RCA themes and actions are fed back into this RTT recovery meeting.
- In January, services have seen a negative impact on outpatient activity due to the tube and train strikes. Patients have been cancelling outpatient appointments, due to travel issues. This has resulted in wasted capacity on the day of the strike and then difficulty with rebooking patients into future clinics.
- Our RTT performance/recovery action plan focused meeting at Trust wide level is chaired at Director level. New reports have been developed to assist this meeting and provide further assurance that our recovery actions are having the desired affect.



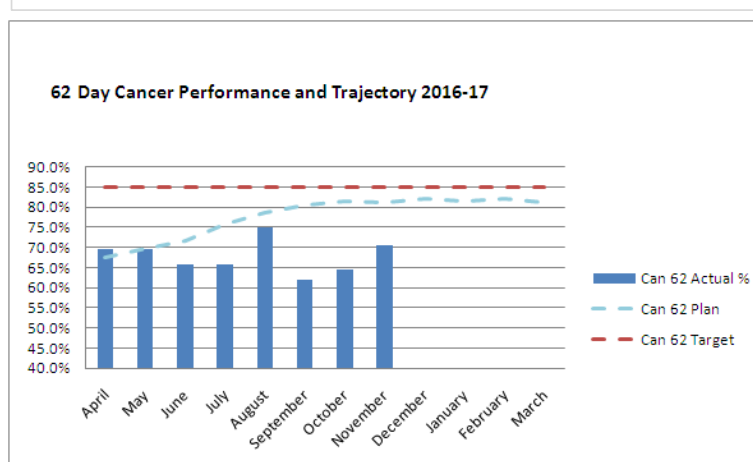
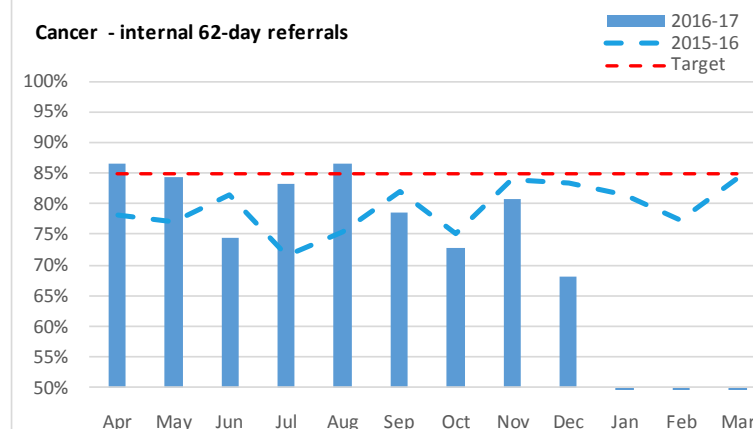
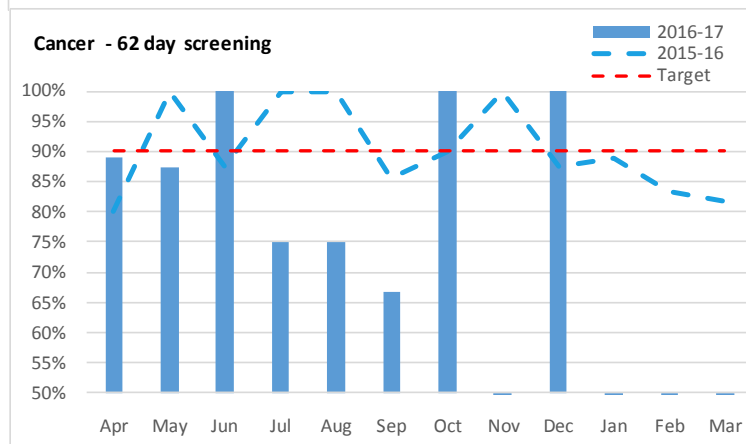
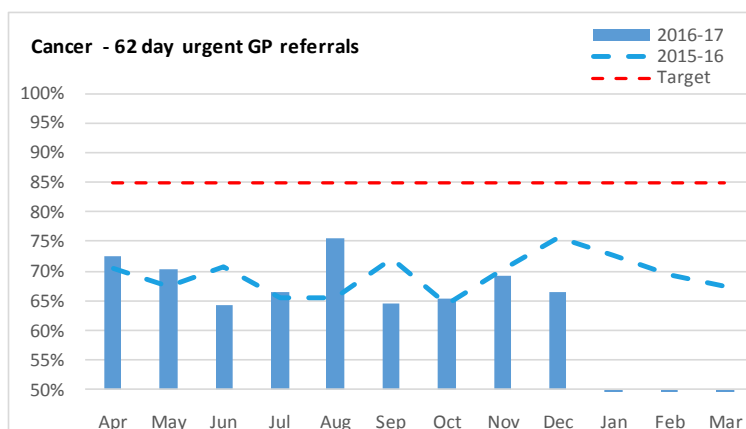
- The Trust Position for the 2-week wait target set for patients with a suspected cancer diagnosis continues to be below target. We achieved 92.6% and 90.3% for breast symptomatic, in December.
- The highest number of breaches occurred in Lower GI. The main breach reasons are still linked to patients choosing to be seen after day 14. This appears to be greater in Lower GI. In addition to offering more clinics for both out-patient appointments and diagnostics to improve choice, we have also increased support for booking process.
- Breast Symptomatic breach analysis continues to shows a high number of rescheduled appointments, the team are re assessing to ensure that all appointments are agreed with the patient by making telephone contact with the patient before booking the appointment, this process is being evaluated over the next couple of months.



- We did not achieve the 31 day First and subsequent surgery targets in December. There was a slight reduction in the number of avoidable breaches in December. 3 of the breaches analysed identified areas needing more focus in the administrative processes, and 4 were due to surgical capacity constraints mainly in Head and Neck and Thoracic.
- There is an expectation that the performance will improve over the next couple of months, with the new staff becoming more familiar with the processes and the targeted training that has been offered.



- Overall performance for 62-day maximum wait for first treatment remains below the 85% target. We achieved 66.4 % overall which is below our trajectory of 74%, and 68.7% for the internal patients. There were 21 internal breaches in December with only 67 treatments. 15 of these patients were long waiters ( treated >than 14 days after breach). There were 4 avoidable breaches this month. The “star chamber” approach to review the work of the central cancer data team continues to make good progress to eliminate most of these going into Q4.
- There were 32 external breaches in December. 20 were referred late (>38 days) in the 62 day pathway and 8 had already breached the 62-day target before the referral was received. 4 of these were treated within 24 days of referral. 12 patients were referred before or on day 38, but still breached, mainly due to the need for further diagnostics or optimisation before treatment. We had 5 further avoidable breaches . We are continuing with the shared care PTL conference calls with Maidstone and Tunbridge Wells which help track patients once they are referred to us. There are plans to extend these to other areas in South of England starting with Hospitals in Sussex in February.



Dec-16	62 Day Treatment Status		
CWT Code	Internal Treatments	Internal Breach	Internal Performance
Brain CNS	0	0	
Breast	11	1	90.90%
Gynae	0	0	
Haematological	5	3	40.00%
Head and Neck	7	3	57.10%
Lower GI	5	2	60.00%
Lung	6	4	33.30%
Other	0	0	
Skin	5	0	100.00%
Skin Haematology	0	0	
Thoracic	3	1	66.70%
Thyroid	3	0	100.00%
Upper GI	2	1	50.00%
Urological	20	6	70.00%
<b>Internal total</b>	<b>67</b>	<b>21</b>	<b>68.70%</b>
<b>External total</b>	<b>86</b>	<b>32</b>	<b>62.80%</b>

Q3 2016/17	62 Day Treatment Status		
CWTCODE	Internal Treatments	Internal Breach	Internal Performance
Brain CNS	0	0	
Breast	32	4	87.50%
Gynae	11	2	81.80%
Haematological	18	6	66.70%
Head and Neck	15	6	60.00%
Lower GI	16	6	62.50%
Lung	9	5	44.40%
Other	0	0	
Skin	12	2	83.30%
Skin Haematology	0	0	
Thoracic	5	2	60.00%
Thyroid	7	2	71.40%
Upper GI	3	1	66.70%
Urological	83	19	77.10%
<b>Internal total</b>	<b>211</b>	<b>55</b>	<b>73.90%</b>
<b>External total</b>	<b>278</b>	<b>125</b>	<b>55.00%</b>

- Overall performance in December was 66.4 % mainly due to the focus on tackling a number of the long waiters and late external referrals. Of the 32 tertiary referrals, 20 (over 50%) were referred beyond day 38 and 8 of these were treated within 24 days after referral to GSTT. The remainder all required further diagnostics prior to treatment.
- The highest number of breaches overall, were in Urology and Lung. We continue to work through the recovery plan in place to support the Cancer data team, this is constantly reviewed to ensure the actions will deliver the improvement required, we expect to begin to see the improvement reflected in performance from February/March 2017 and the remainder of quarter 4. The backlog of patients who are over 62 days is gradually reducing recognising that some of the factors leading to the long waits are complex medical issues. The additional Assurance PTLs continues to support services on focusing on not just addressing the long waiters but in helping services to address patient pathway delays early enough to avoid further “avoidable” breaches.

### Inter Trust Referrals

- **Where we want to be: targets and benchmarks**

- We want to be achieving 85% of referrals to GSTT within 38 days.

- **Where we are: trends and patterns**

- The proportion of Pre day 38 day referrals from South East London Trusts remains around 70%. It was 71% in November and 72% in December.
- For the South of England Trusts the proportion of early referrals remains low, In November only 41% were referred before day 38. This fluctuates due to the low volumes of referrals across multiple providers.
- Both Joint Coordinators working between GSTT and LGT and KCH are managing to support those cohorts of patients who may need to be referred and are facilitating these transfers. They have also identified improvements needed within pathways and those are being tackled

- **Risks or opportunities for the Trust**

- We are focused on improving the processes and workflow for staff within the Cancer data team. The urgent referrals Booking Team successfully established a paperless process in November with future plans to establish a call centre during Q4. High sickness rates and turnover continues to be a challenge to the pace of change required to implementing further changes.
- The “Star Chamber” approach continues to provide a focus for delivering the agreed improvements and actions over the next 3 months.
- The risk with continuous late referrals (>38 days) is the adverse affect on our ability to treat patients within 62 days.

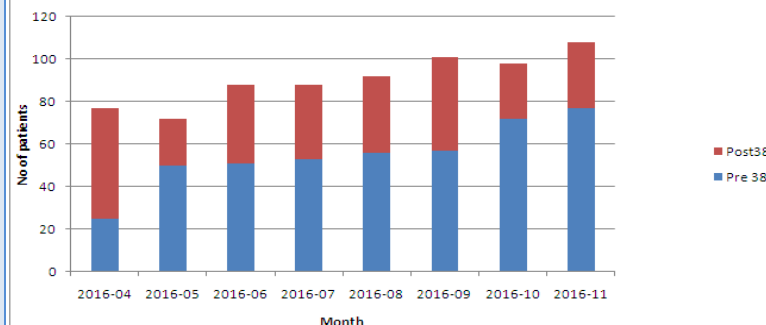
- **104 day patients**

- There were 14 long wait breaches( treated after day 104) in November . 3 in urology, 5 in Lung/Thoracic, 1 in UGI, 1 in Skin, Head and Neck, Haematology, Breast and Colorectal
- The reasons for the long delays were: A mixture of late referrals and complex pathways(12), patient choice delays(2).
- 14 out of the 17 the external long wait breaches were referred after day 79 from other Trusts, 4 of which were referred after day 104.
- We have established an independent review group to support how we might tackle these areas in order to improve the pathway and reduce the number of long waiters.

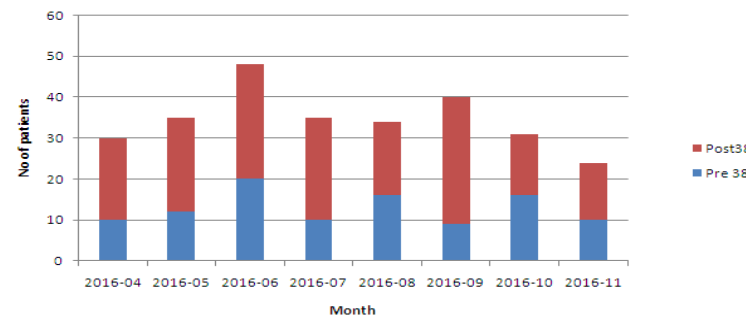
- **Root Cause analysis and Action**

- Focused work on monitoring the use of timed pathway in each tumour site.
- Establishing the joint coordinators between the Trust and KCH/LGT.
- 7 days for first OPA for 2ww referrals involving use of eRS.
- Building resilience within the Coordination and Tracking team

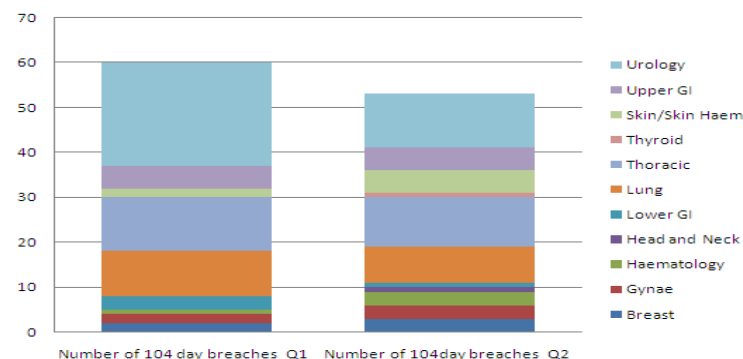
External referral - SEL - Apr 16 onwards



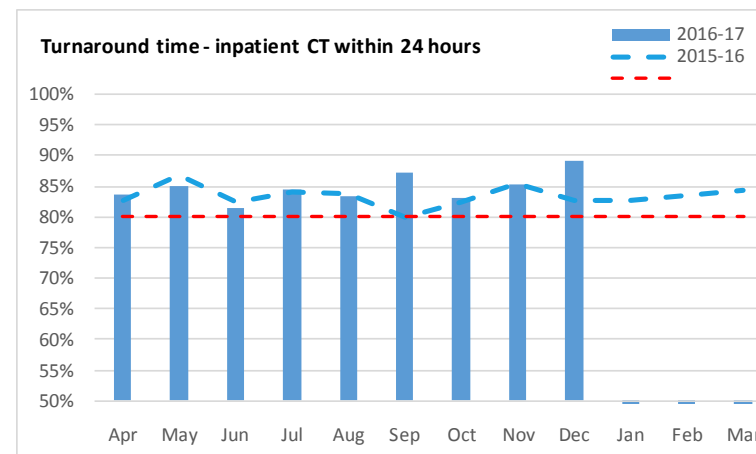
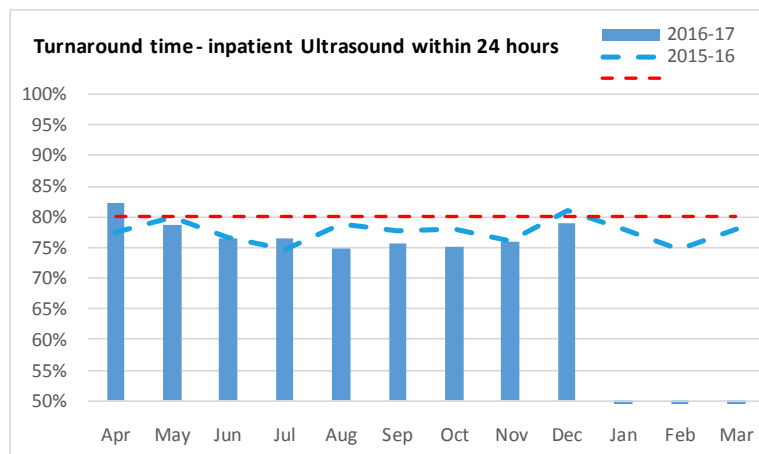
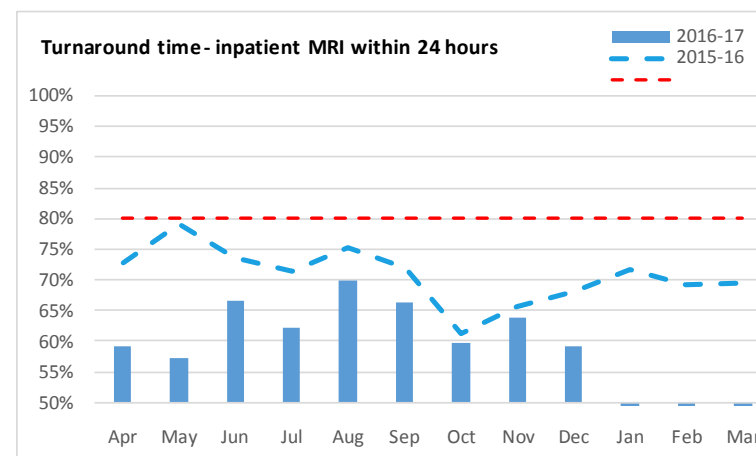
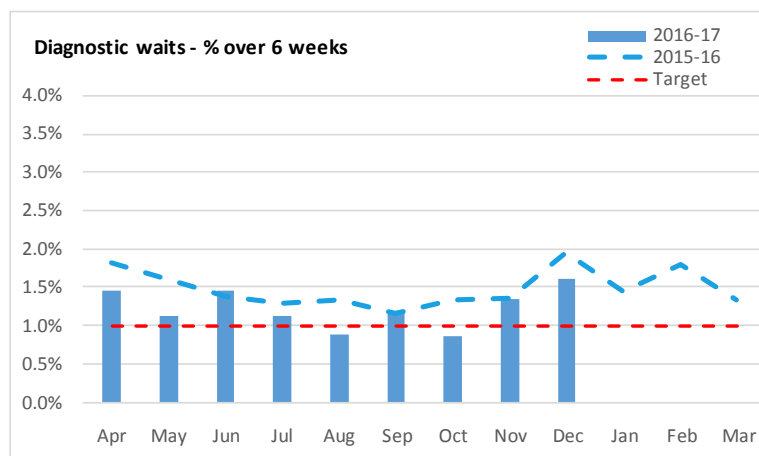
External referrals - Non SEL - Apr 16 onwards



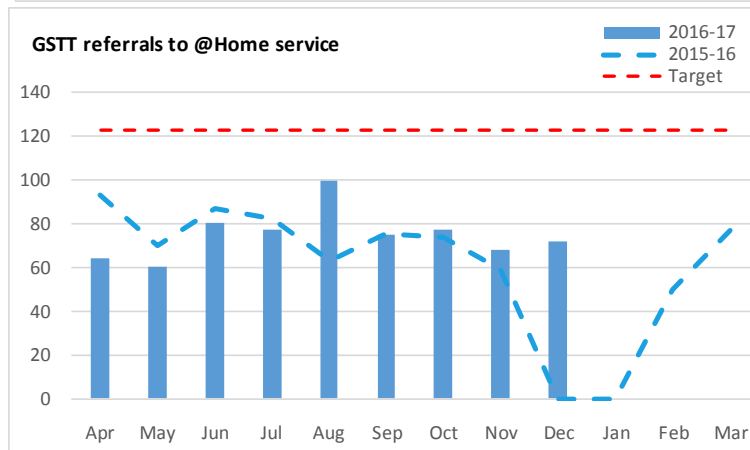
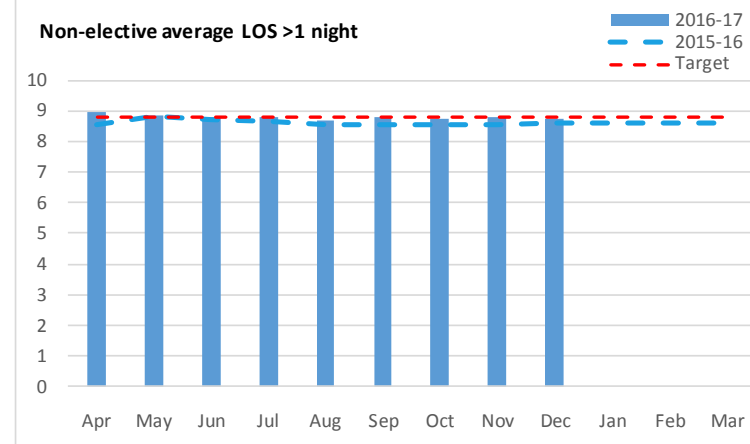
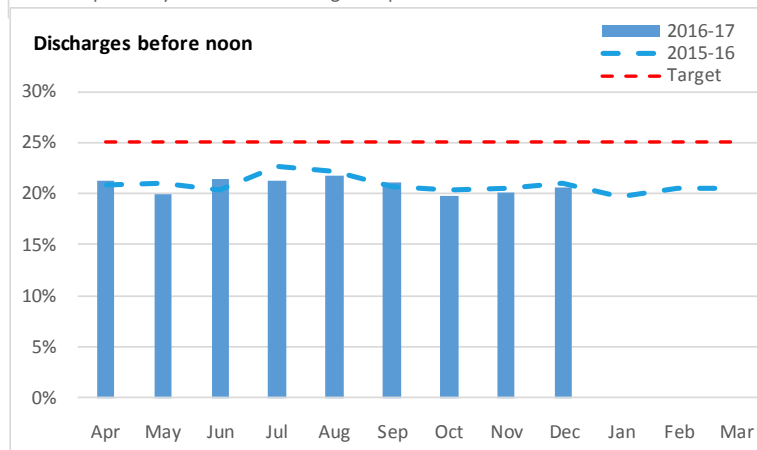
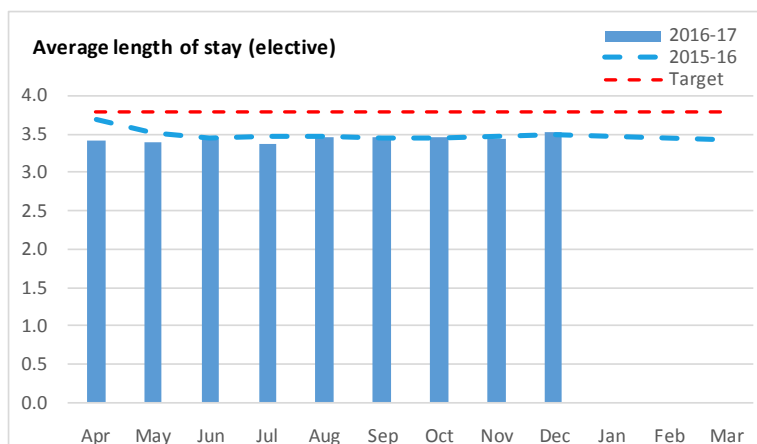
No. of 104 day breaches per tumour site Q1&Q2 2016/17



- In December, the diagnostics target was not met and the performance dipped to 1.6%.
- Non-compliance this month was due to an administration issues with staff in endoscopy. The service has since rectified the issues and has assured us that this should not reoccur in the future.
- Over the last few months it has become evident that there are a number of directorates that have encountered administrative issues. This is being addressed as a Trust wide approach, through the RTT biweekly meeting and service manager meetings to ensure that learning is shared across all directorates.
- Turnaround times for inpatient MRI and CT within 24 hours have improved further in December, which is due to increase in available capacity.

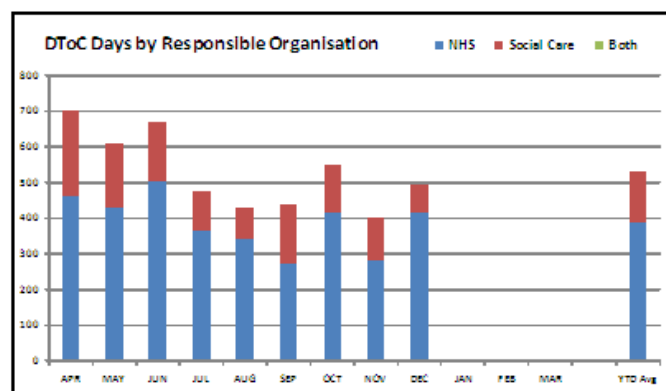
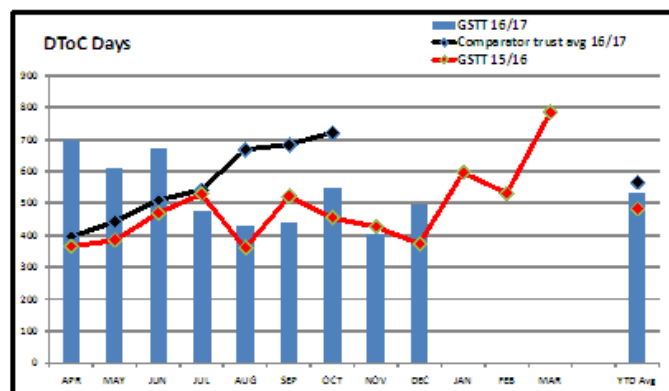
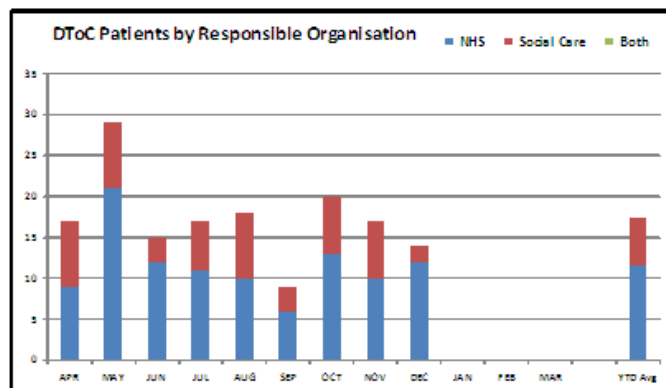
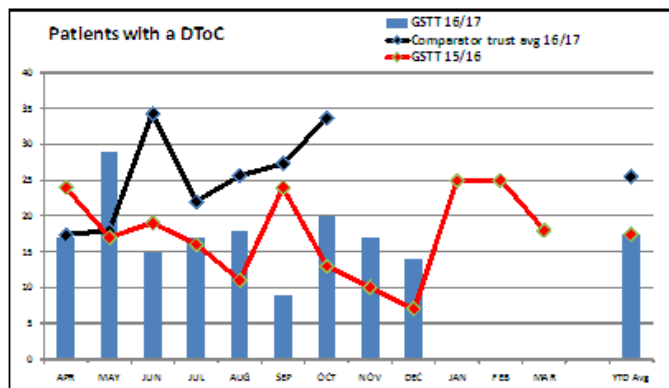


- Efforts to provide alternatives to hospital admission continue. The capacity targets for @home now reflect the demand from patients presenting with increased levels of acuity. We have recently reviewed current utilisation of @home across referral routes; LAS, Community/GP and acute in order to provide assurance to our commissioners that capacity is being optimally utilised.
- @home: 16/17 referral data compared with 15/16 referral data indicates a reduction in referrals. Accepted referrals now average 725 per quarter. There has been a reduction of 30 accepted referrals per week across referral sources, however overall contacts have not reduced; there is a possible link to data recording processes following implementation of Carenotes.
- Average length of stay for elective patients remains better than target and is at similar levels to last year. This is helping to support the significant additional activity we are currently delivering. Directorates are currently working on further length of stay (LOS) improvement plans to ensure we can meet our activity plans for 2016/17.
- Work continues on improving hospital discharges before noon, Directorates use their huddles to continue focusing on improvements to early discharge.

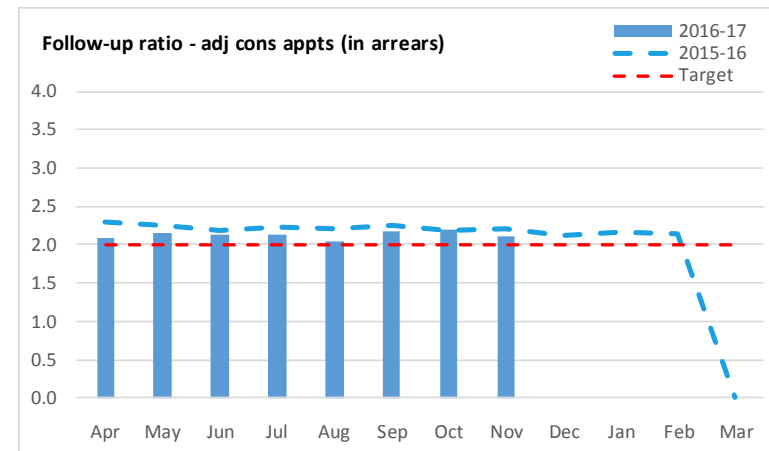
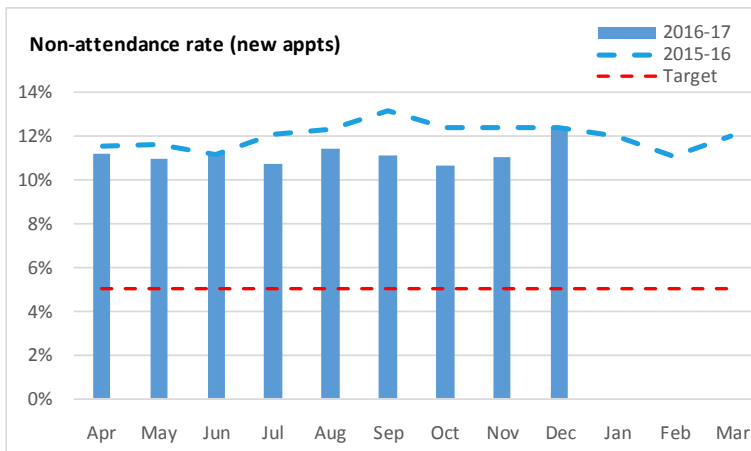
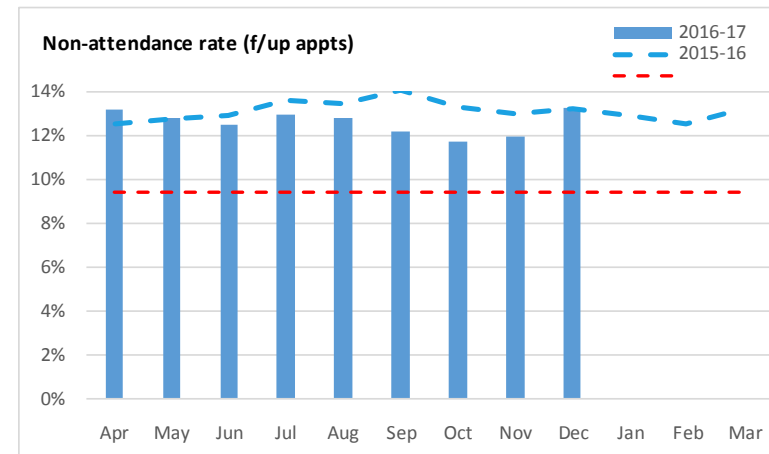
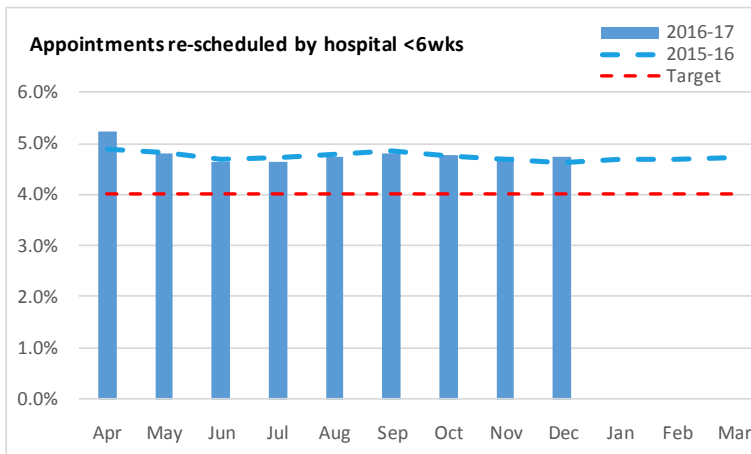




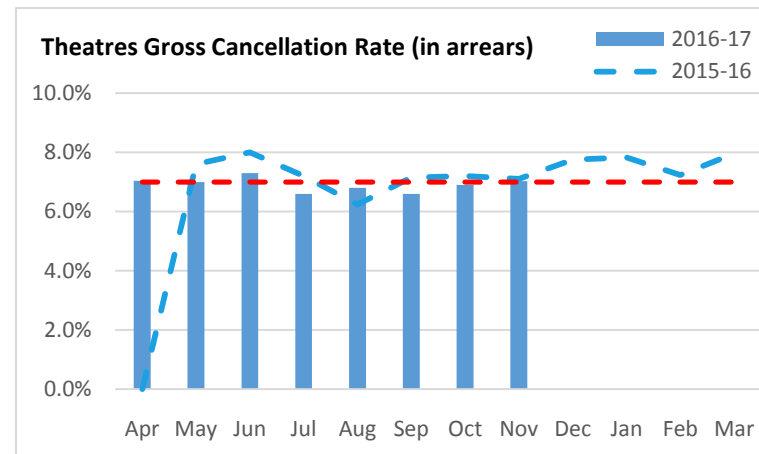
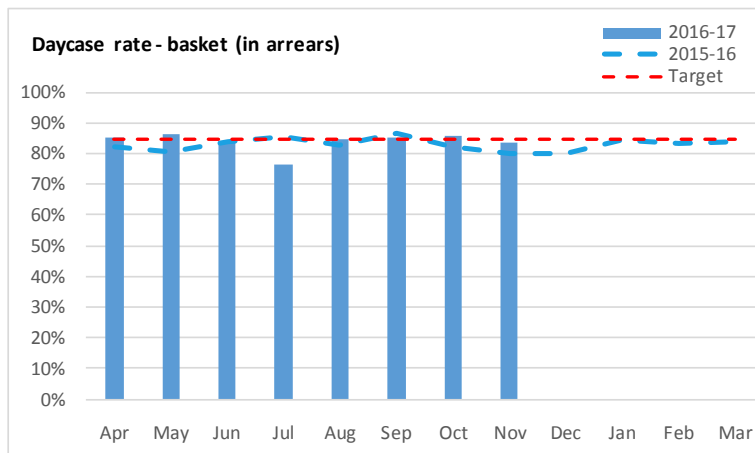
- The definition of a DTOC is when a patient is ready to transfer from acute to non-acute setting, but remains in an acute hospital bed.
- The Trust has launched a 'Transfers of Care' improvement workstream within the Fit for the Future programme, with three overarching improvement aims:
  - To join up improvement initiatives across the Trust relating to transfers of care / discharge
  - To develop an IT solution to capture data on discharge delays (as part of Live Bed State)
  - To work with our external partners across health and social care to develop new ways of working, including 'Trusted Assessments' and 'Discharge to Assess' models.
- The first Steering Group Meeting for this workstream was held in November 2016
- Planning is also underway for a 'Perfect Transfers of Care Week', to be held in January 2017, in line with ECIST guidance
- We continue to have a twice-weekly "Discharge Ops Forum" (MDT patient level review of complex discharges) which is now attended by Lambeth/Southwark social services, and we escalate complex issues to our CCGs for support.



- **Appointments re-scheduled by the hospital within 6 weeks of an appointment** – The number of rescheduled patients has continued at a rate below 2015/16 levels. This improvement is linked to the reduced impact of strike action and improvements in planning clinics and clinician's annual leave.
- **e-RS (National e-referral system) - % slot availability** – Appointment slot issues (ASIs) dropped to 1028 from November's high of 1272. Advice and Guidance mirrors the reduction from 222 in November to 192. These reductions are in line with the holiday period bringing fewer working days. Work will commence, as identified by the planned care board, in ophthalmology and gynaecology to look at issues with full use of eRS. The aim will be to stop paper referrals from an agreed date in the future. The January 2017 mtg will not be a full steering group session but a sub group with representation from affected specialities to formulate a work plan. Work also continues on CQUIN preparation and planning.
- **Non-attendance for new and follow up appointments** – Work has commenced on setting the conditions to initiate a pilot phase of the enhanced drdoctor functionality (digital correspondence, pre appointment questionnaires and date self selection) as soon as higher base usage is confirmed.
- **Follow-up ratio** – OP page of FFF Intranet site continues as Trust wide information sharing hub, providing current guidance on improving DNA rates.

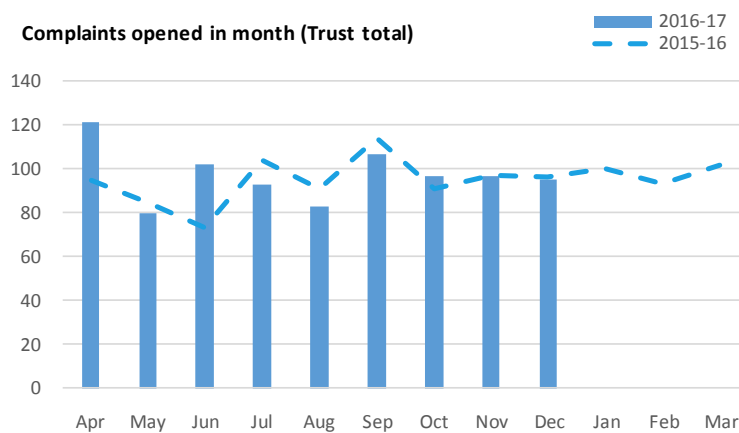


- Cancellation rates continue to be held below the target and plans are now in place to pilot text reminders for elective admissions in February 2017
- Day case rates also continue to meet the target of 85%

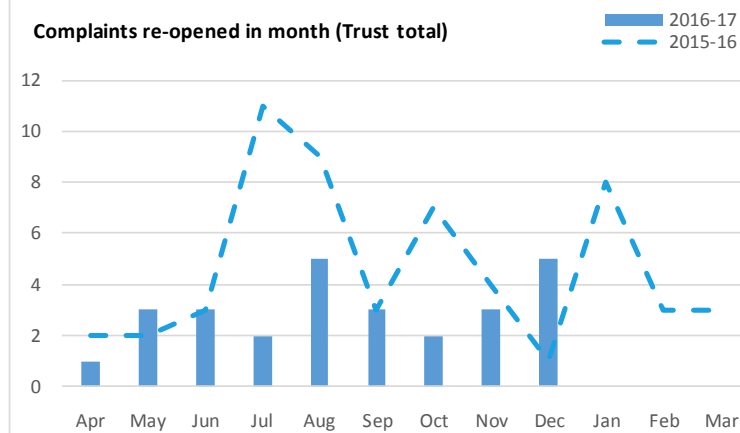


- The complaints team continue to work together with the directorate teams to produce high quality responses following a robust investigation, to ensure learning is shared and that action is taken to improve the experience of future patients. In December the Trust received 95 formal complaints and the complaints team also resolved an additional 71 contacts from patients and their families where concerns were raised. The number of complaint responses sent out by the Trust has improved significantly in December.
- In December we received two investigation reports from the Parliamentary and Health Service Ombudsman (PHSO). The first report found 'no fault' with the Trust. The second report found 'no failings in care and treatment provided' and did not uphold the complaint having considered the apology given and the action taken to address other concerns. The outcomes from the PHSO give us some confidence that the quality of investigation and the responses to complaints are of a high standard.

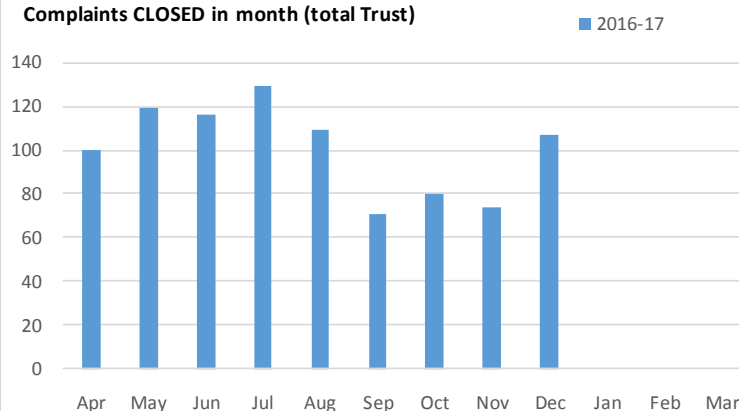
Complaints opened in month (Trust total)



Complaints re-opened in month (Trust total)



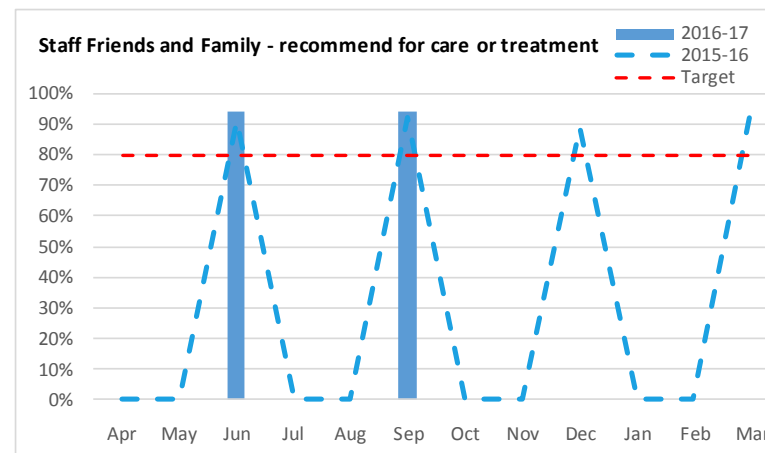
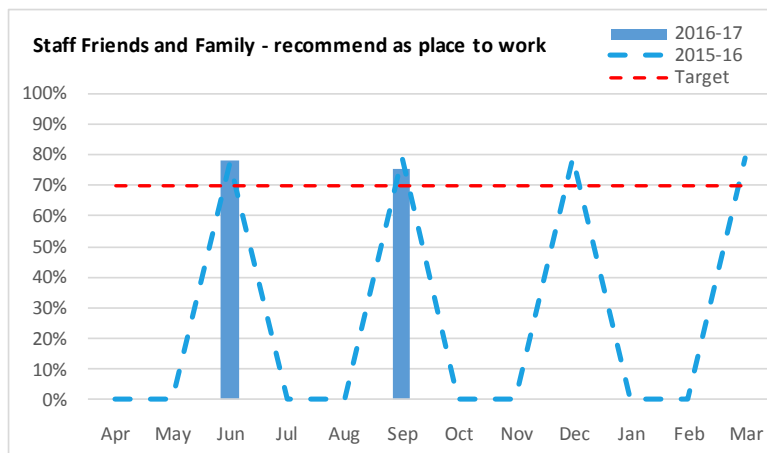
Complaints CLOSED in month (total Trust)



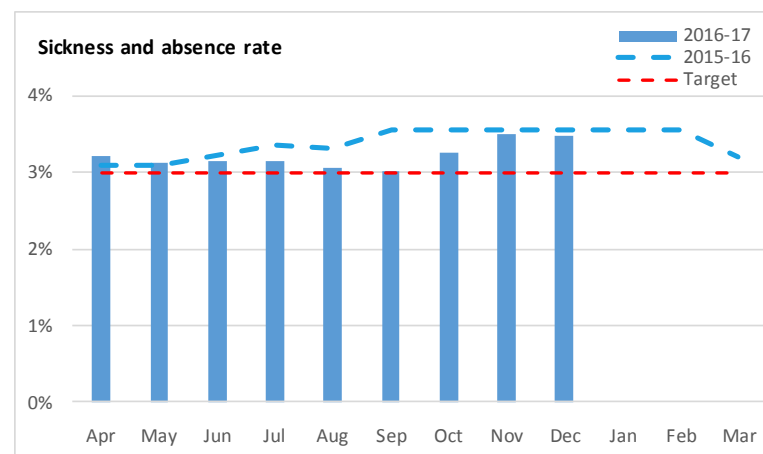
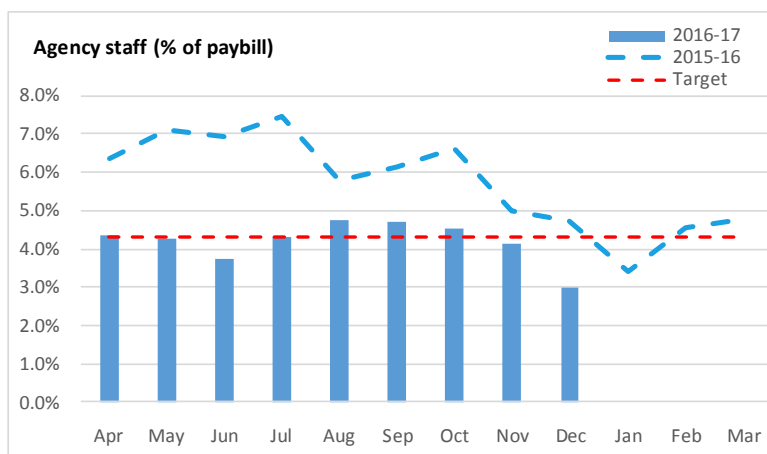
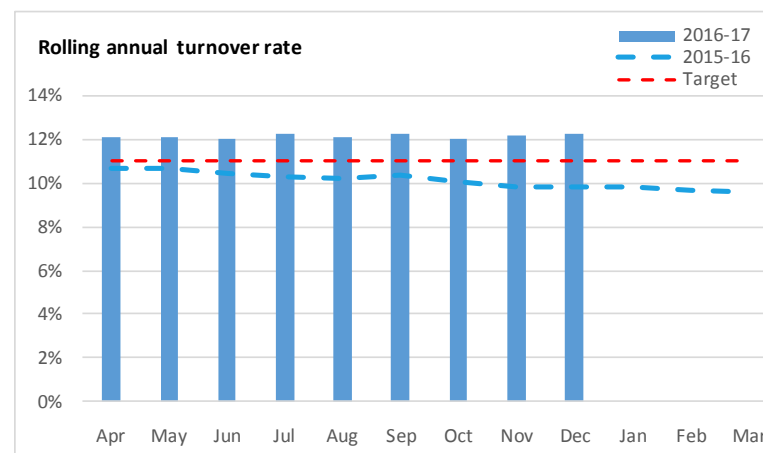
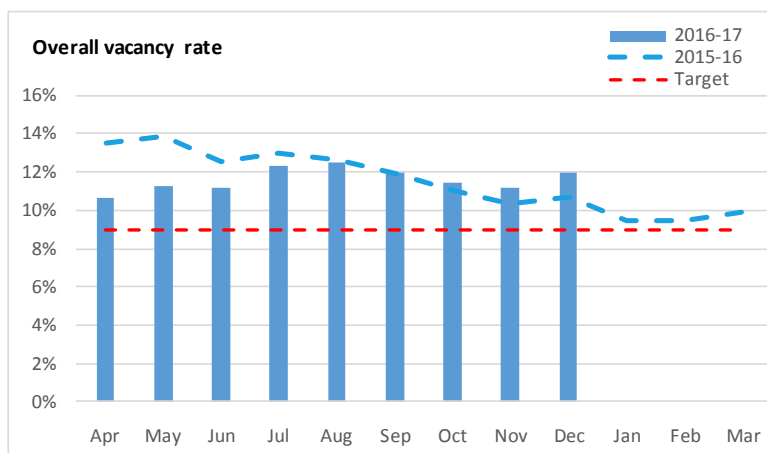
*The Trust's ambition is to provide a complaints system which is open to complaints, supports patients, families, and staff through the process, and which delivers a timely apology, explanation and determination to learn from mistakes. The aim is to produce a service about which complainants are able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

Theme	Ref	Indicator	Units	Target	R	G	Prior year	Oct	Nov	Dec	YTD avg	Monitor	Quality priorities	Trend chart
5.1 External assessments	GOV	Overall governance rating (Monitor, in arrears)	Rating	Green			Green	Green	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%			78.5%				77%			Y
	FFTS2	Staff Friends and Family - recommend for care or treatment	Qtly %	>80%			91.5%				94%			Y
5.3 Workforce indicators	VACTB	Overall vacancy rate	Mthly %	<9%			11.5%	11.4%	11.2%	11.9%	11.6%			Y
	TEMPTB	Agency staff (% of paybill)	Mthly %	<4.3%			5.7%	4.6%	4.2%	3.0%	4.2%			Y
	TURNTB	Rolling annual turnover rate	Mthly %	<11%			10.1%	12.0%	12.2%	12.3%	12.1%			Y
	206TB	Sickness and absence rate	Mthly %	<3.0%			3.4%	3.25%	3.50%	3.48%	3.21%			Y
	211TB	Appraisal compliance (non-medical staff)	Mthly %	>95%			73.1%	73.1%	75.3%	76.0%	71.4%			Y
	MTTB	Mandatory training compliance	Mthly %	>95%			86.3%	84.4%	84.8%	84.9%	84.9%			Y

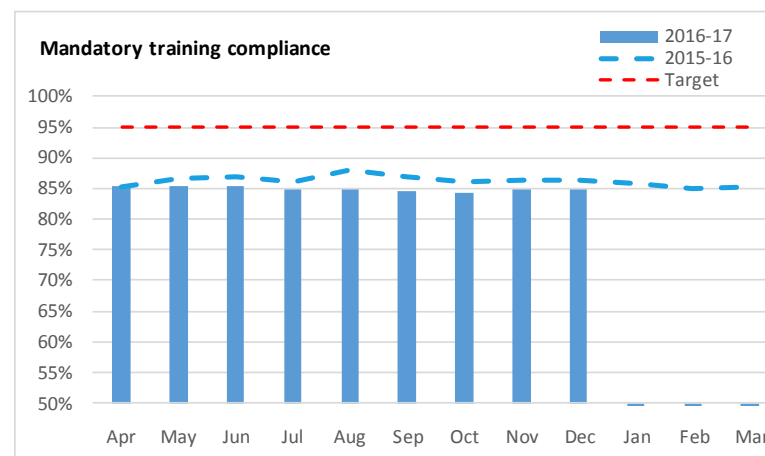
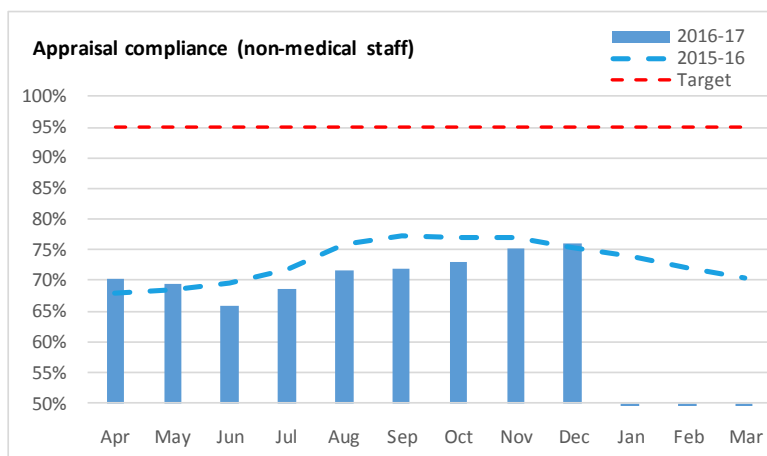
- Staff opinion on whether they would recommend a health care organisation for care or for work is statistically associated with the quality of care. Any fall in the positive opinion should be seen as a potential early indicator of a reduction in quality of care.
- 700 staff participated in the Quarter 2 Staff Friends and Family Test (SFFT), which was conducted between August and September 2016. The results show that 94% of our staff would recommend the Trust as a place to be treated. This figure is well above the national average of 80%. 75% of our staff said that they would recommend the Trust as a place to work, again a higher figure than the national average of 64%.
- All staff were invited to participate in The NHS National Staff Survey, which takes place in the third quarter of each year. This year's survey ran from 3rd October to 7th December 2016. 5128 staff members took time to respond. 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. The results will be available in February 2017 and will give us a clear picture of staff experience within the organisation and how we compare nationally, with other NHS Trusts.



- The overall vacancy rate (11.94%) increased in December and remains above target. The rate is 1.26% higher than the same month last year, despite the staff in post being over 365 wte higher. There are currently nearly 650 external applicants in the recruitment pipeline scheduled to join the Trust over the next few months and we currently project the vacancy rate to move closer towards the 9% target, without reaching it.
- Agency spend as a proportion of paybill decreased to 3.00% in December which was below target for the month. The YTD figure currently is below the NHS I mandated cap, however usage remains under close scrutiny to ensure that the position does not deteriorate in the last quarter. Spend was lower than the same month last year (4.73%). Agency usage continues to be monitored on a weekly basis, with price cap breaches reported to NHS Improvement and the Trust Board.
- Staff Turnover increased to 12.25%, and remains above the target of 11%, however the Trust continues to benchmark favourably other London Trusts.
- The sickness rate fell slightly to 3.48%, remaining above target, but lower than the equivalent 2015 month and NHS average.



- Personal Development Review (appraisal) compliance rates saw a further increase to 76.04% in December, a marginal rise on the same month last year. The Trust has yet to achieve its target of 95%. Work is ongoing to engage with Directorates with low compliance rates to offer support to improve these.
- Mandatory training increased slightly to 84.91% in December, slightly lower than the December 2015 rate, with compliance remaining below Trust target level of 95%. Most directorates are now over 75% compliant, with three achieving over 90% compliance in November. Training data is updated weekly on WIRED which is available to all staff and managers.





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

- The Trust has set a local stretch target of <9% for vacancies. In December, the Trust vacancy rate increased to 11.94%. Despite being above target, the Trust benchmarks well against other local trusts.

### Trends and patterns

- The Trust vacancy rate has fluctuated over the last 6 months, and remains above target, and is higher than the same month last year despite a higher staff in post. Current projections indicate the vacancy rate will fall towards target but may not achieve it by year end. The vacancy rate for Estates and Ancillary staff (20.7%) and Additional Clinical Services (Nursing & Therapy Assistants-17.4%) are the highest vacancy rates currently. The Nursing & Midwifery Registered vacancy rate was 13.4% in December, with Band 5 vacancies at 14.8%. Essentia, Adult Community & Acute Medicine continue to have higher than average vacancy rates.

- The active vacancy rate (posts advertised during the month) increased to 4% of the establishment,

### Root cause analysis and insights

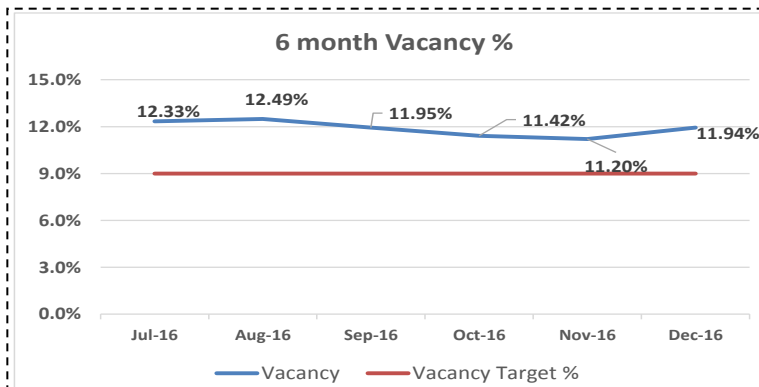
- Reconciliation between Finance and HR establishments is currently slightly under its 95% target however work is ongoing to address areas below the target. The recruitment pipeline has over 600 external applicants awaiting a start date with the Trust, with over 300 nurses scheduled to start in the coming months. The increase in the vacancy rate from November reflects a seasonal trend that has been evidenced over the last several years, as staff leave an organisation at the end of the year, while induction activity is reduced over the holiday period.

### Risks or opportunities for the Trust.

- Projections for the vacancy rate indicate that over the next three months, it will come down toward the Trust target but remain above it.
- Changes to the recruitment process which have delivered improvements to the Time to hire metric, which brings people into substantive posts quicker continue to be implemented by Workforce.
- The Recruitment team has recently reviewed conversion rates from offer to starting with the Trust, with an aim to increase the numbers of successful applicants who join us.

### Actions set and progress to date

- The Trust has initiated a review of the ESR establishment to ensure that the establishment is accurate. Working with Directorates we will review long term vacancies, to identify those posts that are supporting the use of temporary staffing, while also assessing opportunities for savings.



## Directorate Heatmap-December 2016

		<span style="color: red;">■</span> Above Target and Trust average <span style="color: orange;">■</span> Above Target and below average <span style="color: green;">■</span> Meeting Target	
Directorate	Vacant FTE	% Vacancy	
Community Adults	209.14	21.8%	Red
Essentia	331.22	17.2%	Red
Acute Medicine	173.04	17.1%	Red
Gastrointestinal Medicine & Surgery	56.38	15.2%	Red
Clinical Imaging & Med Physics	82.63	15.0%	Red
Transplant, Renal and Urology	65.00	12.0%	Red
PCCP	203.47	12.7%	Red
Medical Specialties	59.35	10.3%	Orange
Evelina London Childrens Healthcare	209.61	10.2%	Orange
Corporate Directorates	150.51	9.6%	Orange
Specialist Ambulatory Services	46.65	8.1%	Green
Cardiovascular Services	41.73	7.3%	Green
Oncology & Haematology	75.25	7.2%	Green
Dental Services	30.75	4.9%	Green
Womens Services	39.02	5.9%	Green
Pharmacy	16.35	4.5%	Green
Therapies	14.12	3.2%	Green
Surgery	8.99	1.4%	Green
Trust	1813.21	11.9%	Red

Intelligence triangulated

Root cause understood

Action plan set

Actions underway

Actions complete

White – Not started

Green – Successfully underway/completed

Red – Not successfully completed / facing significant issues

Amber – Underway / completed with minor risks or issues

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

- The Trust has set a stretch target of <4.3% for Agency spend to ensure it achieves it NHS Improvement (NHS I) mandated cap for 2016/17 of £33.2 million
- In December, Agency spend was reported as 3% of the paybill. This is based on financial information including accruals.

### Trends and patterns

- Agency spend amounted to £1.9 million in December, which represents 35% of all temporary staffing costs in the month. This was over £0.97 million lower than the same month last year, where agency accounted for 43% of temporary costs. Nursing staff (£1 million) Administrative staff (£0.37 million) and Medical staff (£0.36 million) represent the largest proportion of these costs. The reduction to 3% is in part due to seasonal controls on agency usage of non essential staffing and it is anticipated that the rate will increase again next month.

### Root cause analysis and insights

- The main reason for agency spend is associated with vacancy cover, which is expected to reduce as the staff in the recruitment pipeline join the Trust. The Trust is meeting additional demand as activity increases and this is primarily met through the use of temporary staffing. Although every effort is made to utilise internal Bank staff where possible, Agency staff are used to ensure service delivery when no other avenues are available. The ratio of Agency to Bank shifts continues to improve.

### Risks or opportunities for the Trust

- Although ensuring safe staffing levels, the high usage of temporary staff needs to be monitored to ensure there is no detrimental impact on financial spend and quality of patient care and experience. With the increasing vacancy rate there is a risk that we will see increased Agency usage.
- Agency shifts are monitored on a weekly basis to identify any breaches of the NHS I price cap and breaches are reported to the Board on a weekly basis. High level of breaches may lead to increased monitoring by NHS I. Additional signoff at Chief Executive level will be required for high cost shifts with reporting for these shifts required to NHS I on a regular basis.

### Actions set and progress to date

- The Finance team have developed a projection model to show agency spend trajectories. This will support Board and Directorate decision making in identifying areas of concern earlier.
- Directorates have been asked to review areas with high levels of retrospective bookings to reduce these. Currently retrospective bookings (Bookings made more than 2 days after the shift) account for nearly 25% of all bookings. This impedes the ability of the Trust to accurately monitor usage, and report breaches to NHS I.

Intelligence  
triangulatedRoot cause  
understood

Action plan set

Actions  
underwayActions  
complete

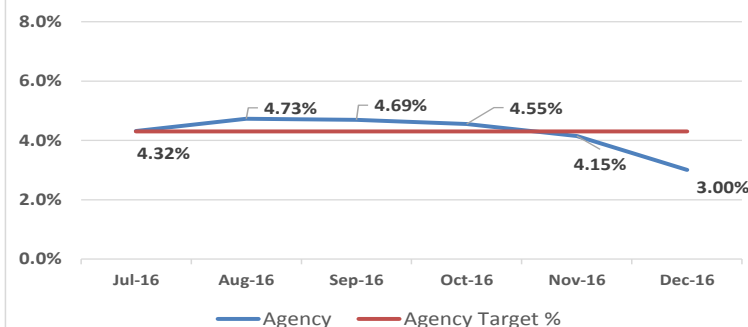
White – Not started

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6 month Agency Trend



## Directorate Heatmap-December 2016

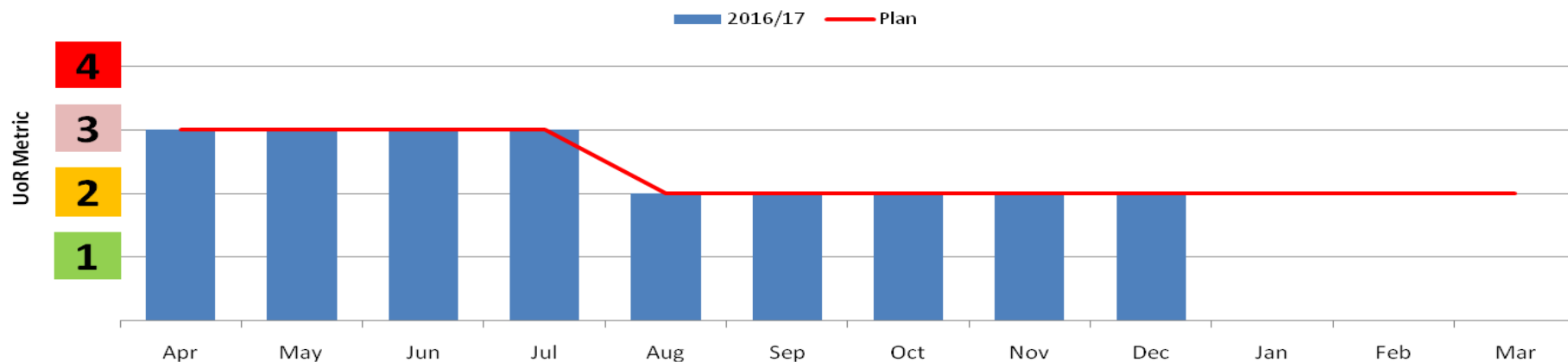
<span style="color: red;">■</span> Above Target and Trust average <span style="color: orange;">■</span> Below Target and above average <span style="color: green;">■</span> Meeting Target		
Directorate	Agency Spend	% of Paybill
Acute Medicine	£452.8k	10.0%
Adult Community Services	£177.9k	5.5%
Essentia	£230.7k	3.9%
Corporate Directorates	£258.4k	3.7%
Transplant, Renal and Urology	£76.8k	3.3%
Womens Services	£97.3k	3.3%
Cardiovascular Services	£81.0k	3.1%
PCCP	£216.5k	3.0%
Gastrointestinal Medicine & Surgery	£42.9k	2.8%
Dental Services	£31.2k	1.7%
Evelina London Childrens Healthcare	£140.2k	1.6%
Medical Specialties	£31.8k	1.4%
Surgery	£14.1k	1.0%
Oncology & Haematology	£38.0k	0.8%
Clinical Imaging & Med Physics	£14.6k	0.7%
Therapies	£3.5k	0.2%
Pharmacy	-125	0.0%
Specialist Ambulatory Services	-3315	-0.1%
Trust	£1,904.2k	3.0%

Theme	Ref	Indicator	Units	Target	R	G	Prior year	Oct	Nov	Dec	YTD avg	Monitor	Quality priorities	Trend chart
6.1 Overall financial position	MRRT	Finance Use of Resources	Score	<=2			2.2	2.0	2.0	2.0	2.4			Y
	LQRT	Liquidity ratio (in days)	Days	>0			3.6	15.2	16.2	14.1	14.0			Y
	DSCT	Capital service cover	Ratio	>2.59			1.1	2.06	2.06	2.09	1.68			Y
	FIN01T	Overall underlying financial surplus/(deficit)	£M	>-£0.30m			-£13.0	-£1.9	-£1.2	-£2.0	-£4.8			Y
	CSHT	Cash flow	£M	>£143m			£94.3	£144.0	£151.0	£137.0	£140.6			Y
	CAPT	Capital spend vs plan (year-to-date variance)	Mthly %	+/- 15%			72.6%	-32.1%	-31.9%	-32.6%	-32.6%			Y
	VRPT	Variance from Plan YTD	Mthly %	> 0			-1.3%	0.43%	0.28%	0.08%	-0.2%			Y
	UNPT	Underlying Performance	Mthly %	> 0.6%			-0.9%	0.3%	0.3%	0.3%	-0.2%			Y
6.2 Activity levels (magic numbers)	560	Elective activity vs profiled plan - cumulative variance	Cum var %	>0%			-0.3%	-2.2%	-2.1%		0.5%			Y
	606T	New patients seen vs plan (all categories, in arrears)	Mthly var	>0			-946	119	4,361		67			Y
	714	External cons referrals	Number	>last yr			1,937	2,007	2,218	1,713	2,087			Y
	713	GP referrals	Number	>last yr			16,199	18,107	18,592	16,193	17,902			Y
6.3 Fit for the Future	CIPSTC	Cost improvement plans (CIPs) - var to plan YTD	£M	>£0m			-£13.4	-£5.8	-£4.0	-£6.8	-£4.2			Y
6.4 Data quality and clinical coding	CM024	Community data completeness - % contacts outcomed	Mthly %	≥ 95%			93.7%	95.8%	95.0%	94.2%	95.2%			Y
	712	NHS number coverage	Cum %	>98%			97.7%	97.8%	97.7%	97.8%	97.9%			Y
	710x	Clinical coding - diagnostic depth (in arrears)	Ratio	>4.5			4.93	5.01	4.78		5.06			Y

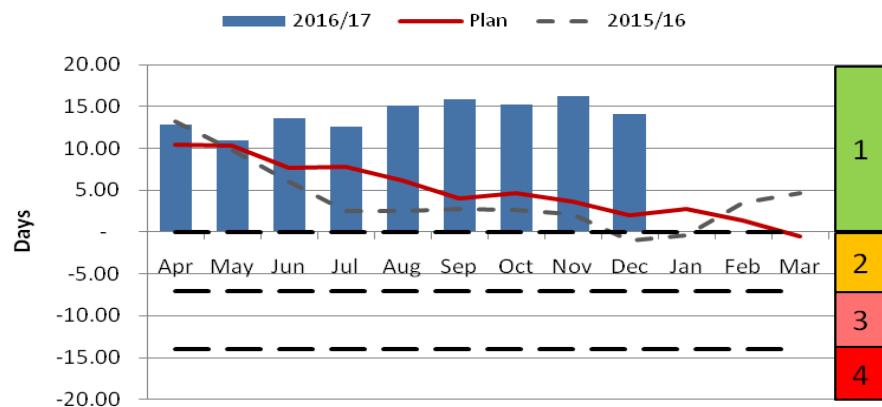
The FSRR was replaced by the Single Oversight Framework from October 2016, the scoring has now reversed (compared with the FSRR ratings) so that one is now the highest score and four is now the lowest.

This shows that we are achieving a rating of 2 which is in line with plan. Indicative ratings have been calculated using historical data for prior periods in 16/17.

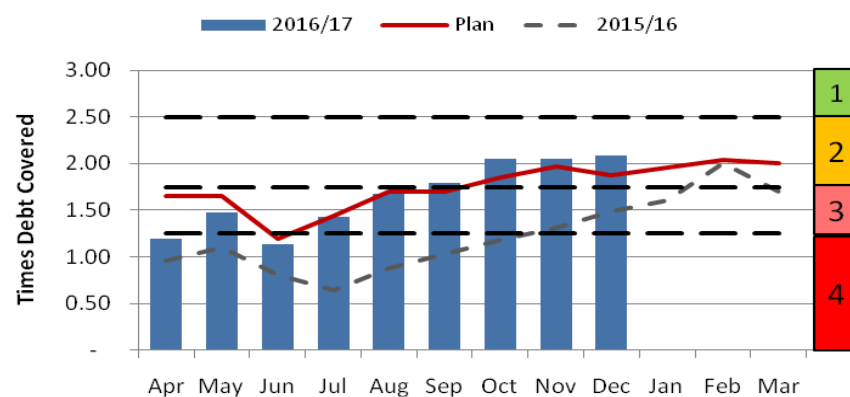
### Finance Use of Resources Metric



### Liquidity



### Capital Service Cover

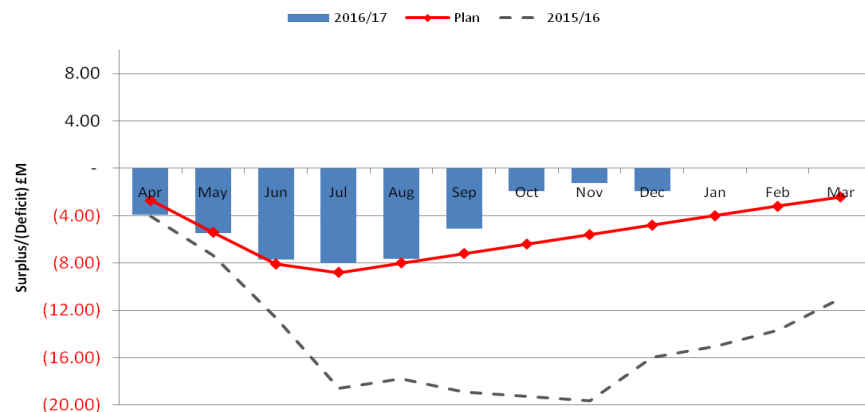


The annual plan has been amended to a deficit of £2.4m. A loss of £2.0M has been recorded at December, which is £2.8M better than the planned loss of £4.8M.

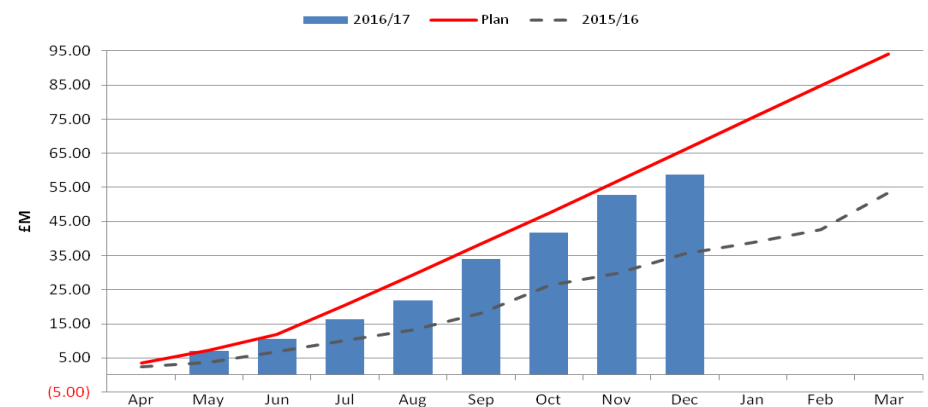
The CIP requirement for 16/17 is £94.2m. Current schemes have identified £81m of new savings or income growth. At month 9 £58.7m of savings or income growth has been achieved against a plan of £65.5m

The cash position at £137M is £20.2m ahead of the plan of £116.8M. Capital expenditure as a percentage of plan has fallen below the threshold of 85% (to 67%). A reforecast of the Capital plan may need to be considered having breached the threshold.

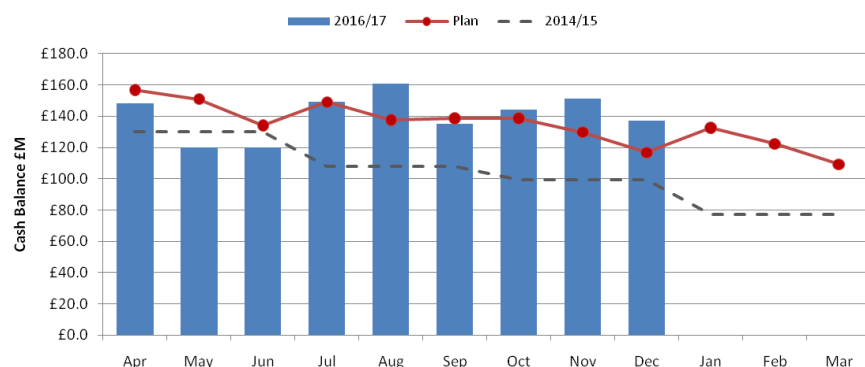
**Overall Underlying Financial Surplus/(Deficit)**



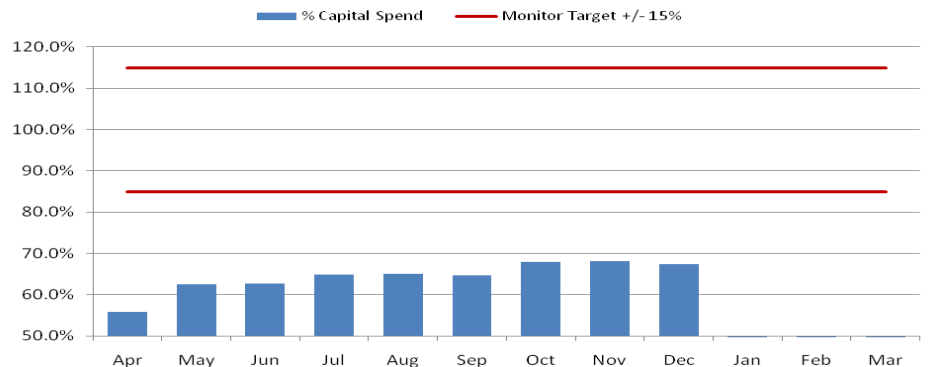
**YTD Trust CIP Performance**

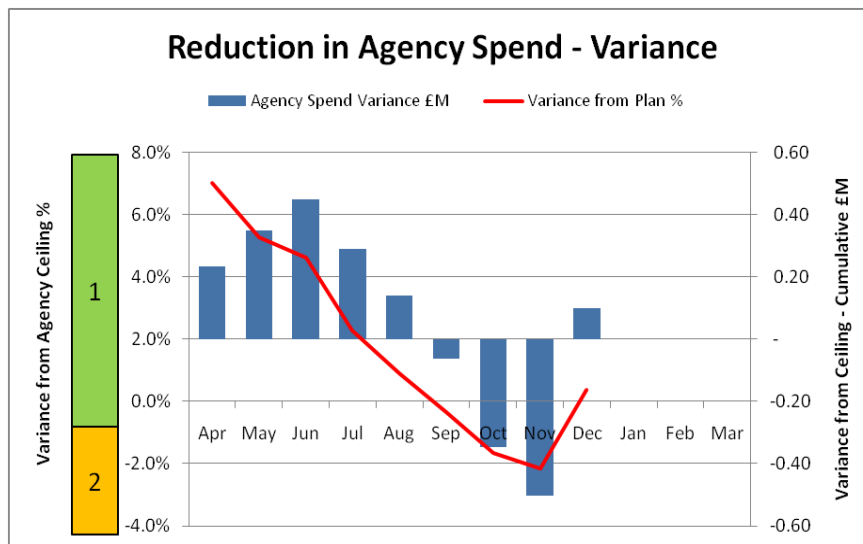
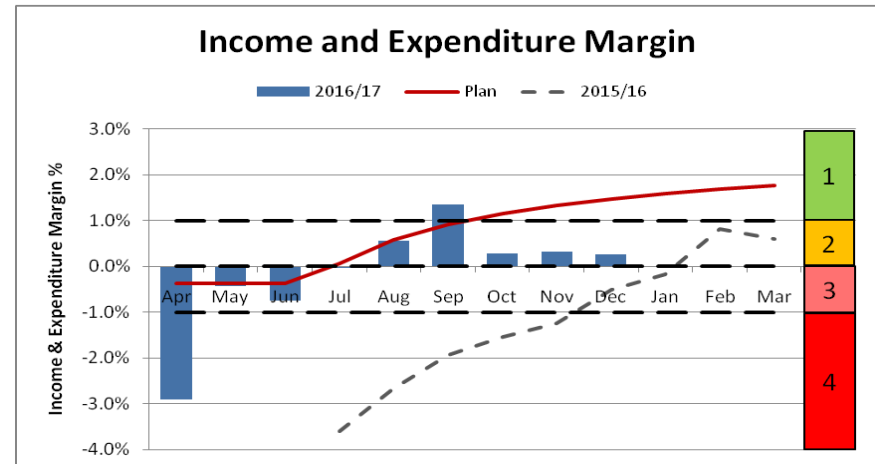
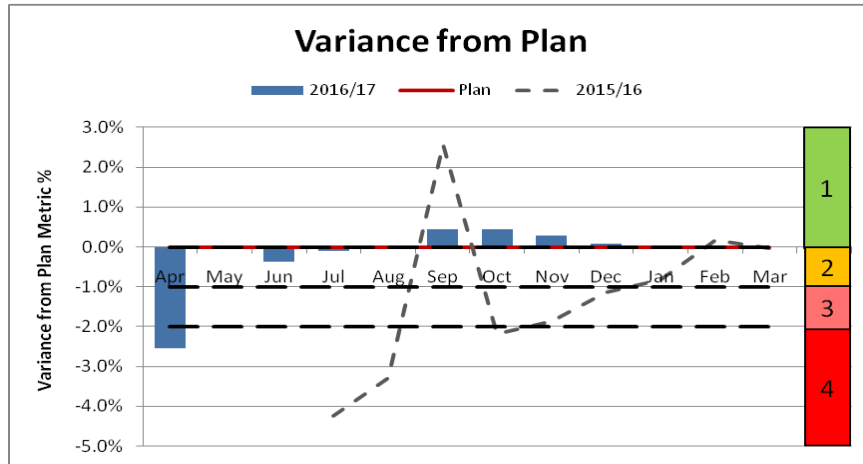


**Cash - Actual Cash vs Plan and Prior Year (£m)**

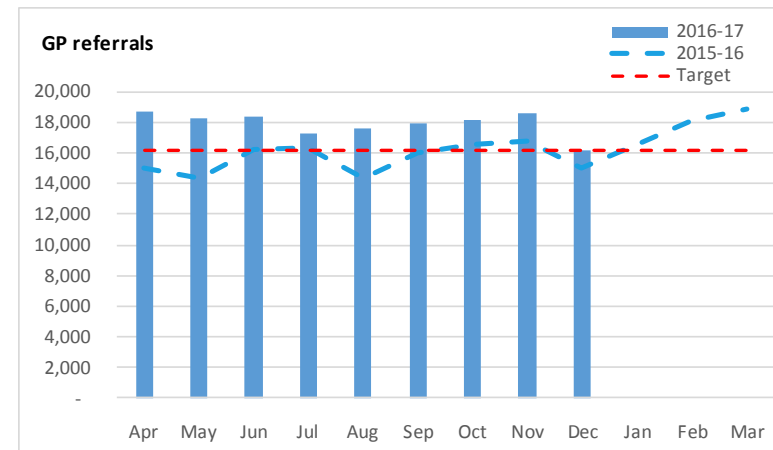
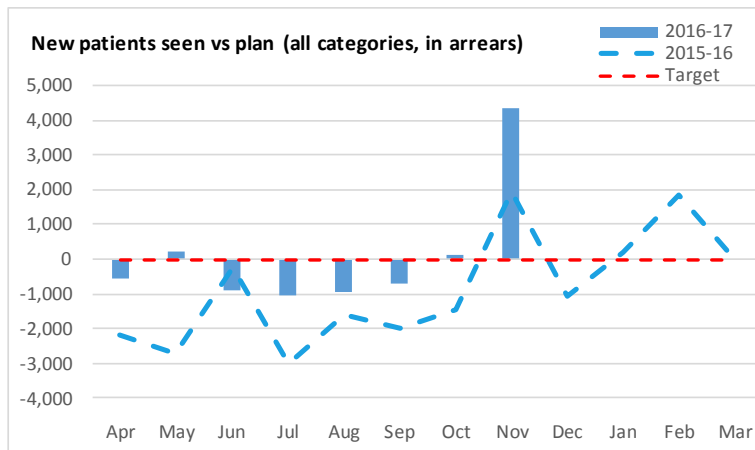
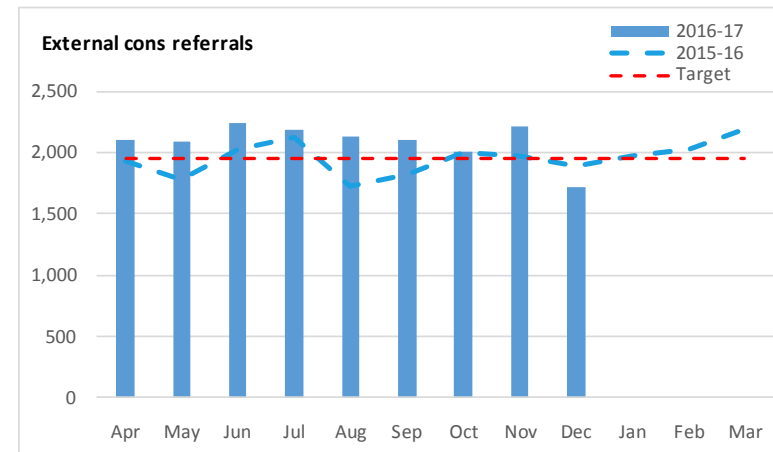
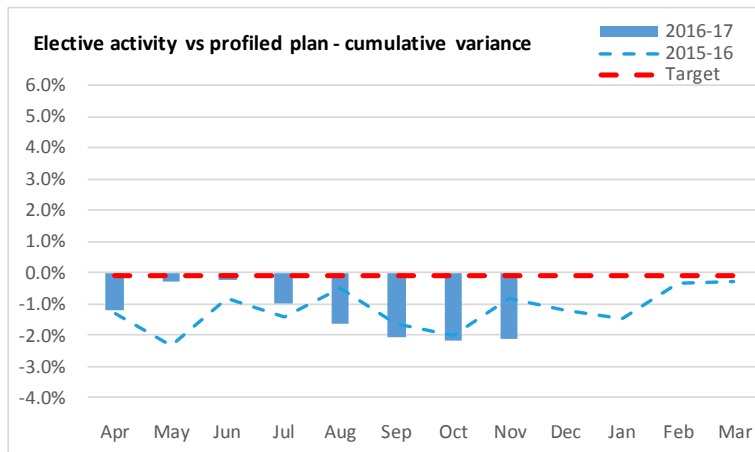


**YTD Capital Spend % of Plan**



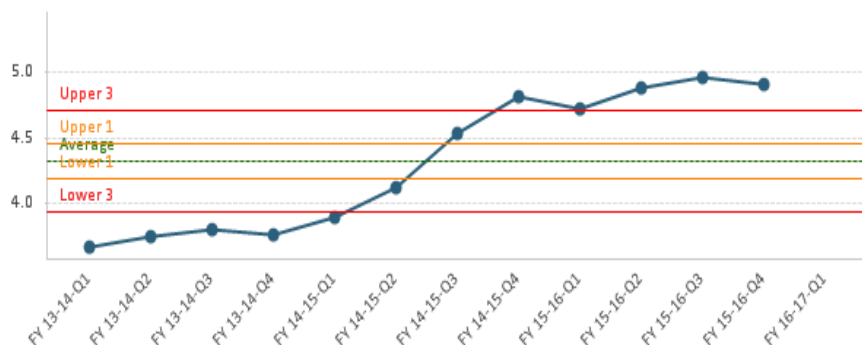


- We are behind on our cumulative variance for elective admissions and are working with directorates to improve this position. Our new patient profile is better than last year, but we are behind during Q2. Directorates are planning to improve their activity levels through increased capacity across elective and out-patient areas.
- Demand – as measured in referral volumes – has remained high for Q1 and has continued into Q2. For GPs it is currently 14% higher than the same period last year. This increases the level of concern around our ability to provide enough capacity to meet this level of demand in 2016-17. We have highlighted that growth above 5% compared to 15/16 has impacted on our ability to achieve the national standards. We are investigating the data further we have a started a series of meetings with our CCG colleagues to determine what mitigating actions can be taken.

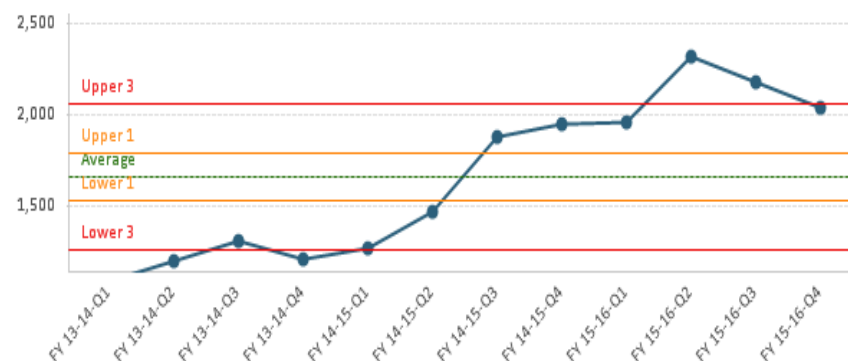


- Accurate and complete clinical coding of our activity is important to ensure patient safety, accurate benchmarking and appropriate payment for the services we provide. Improving the quality of all of our data ensures that the information on which we base decisions is reliable.
- Diagnostic depth - the average number of diagnoses recorded per admitted episode - increased to nearly 5 diagnoses during 2015-16 (top left) and we have re-set targets for further improvements in 2016-17. 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). We are expecting to see further increases during 2016-17 as a result of more structured capture of patients' underlying medical conditions within E-noting. We anticipate that the current level still understates the true prevalence of smoking amongst our admitted patients.
- Within the community setting, the capture of outcomes from patient contacts is our key indicator (bottom left). Plans are in place to raise this back above 95% in 2016-17 following a dip in performance linked to the introduction of Advanced Care Notes – the new community clinical IT system.
- NHS number coverage (bottom right) is 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.

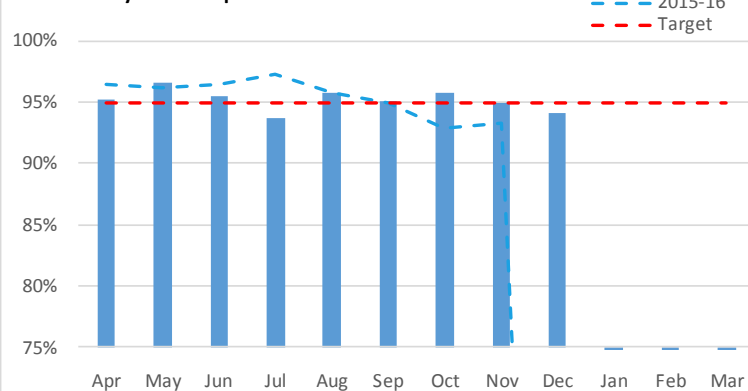
Diagnosis Depth by Quarter - SPC



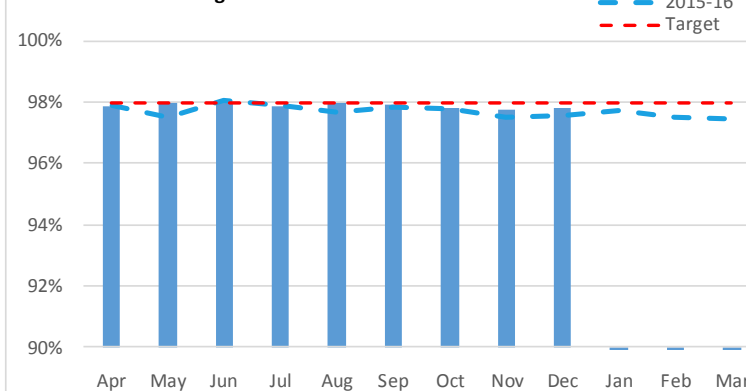
Number of Spells by Quarter - SPC



Community data completeness - % contacts outcomed



NHS number coverage





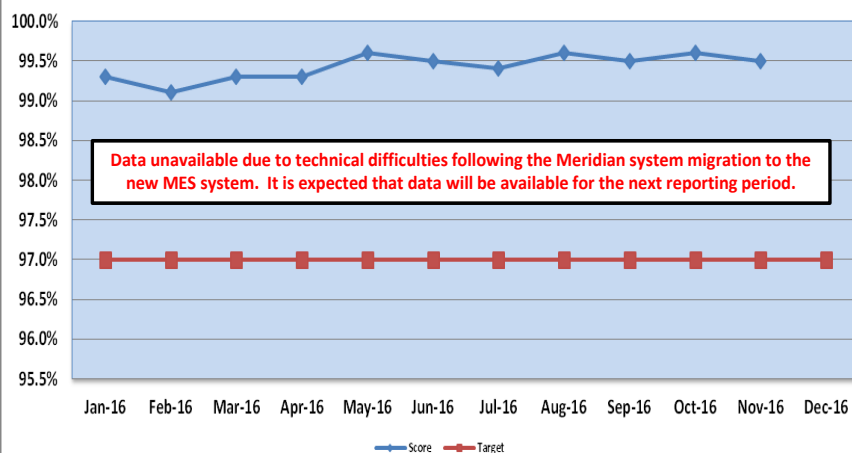
## Summary:

- Cleanliness scores continue to meet and exceed the performance targets, both as measured in the monthly Inpatient survey and in the internal audits which are undertaken by Essentia staff. The monthly Inpatient Survey for cleanliness is conducted via 'Meridian', an on-line survey that is available on patients' bedside entertainment systems.
- Due to technical issues experienced during the migration of the Meridian system to the new MES system, survey information was not available for December 2016. It is expected that data will be available to be published for January reporting and continue to maintain its current trend.
- Essentia's team of specialist internal auditors assess cleanliness against a range of National Patient Safety authority (NPSA) standards. The results of their audits is shown in the graph below, with an aggregate score of 98.3% being achieved in December against a target of 90%.
- The PLACE results were published in August and reflected the very strong success achieved in 2015. Cleaning was scored at 99.42% versus a national average of 98.1%.

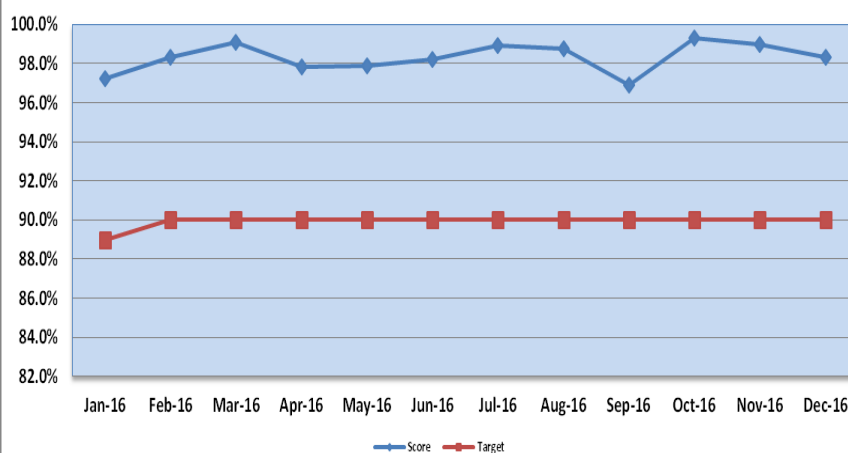
## Action and Progress to Date:

- 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. This ensures that scores are consistently evaluated and comparable externally.
- The St Thomas' and Guy's housekeeping rapid response team carried out 304 and 389 decontamination cleans using Vaporised Hydrogen Peroxide and Ultra Violet respectively. The increase in VHP and UV-C at St Thomas' in December was due to a Norovirus outbreak on Sarah Swift and Doulton Ward, which resulted in decontaminations being carried out in a number of side rooms, bays and bathrooms. It is forecasted that this trend will continue into Quarter 4, due to the nature of winter pressures.

Inpatient Survey - Feedback on Ward Cleanliness



Internal Audit NPSA Trust Risk Profile



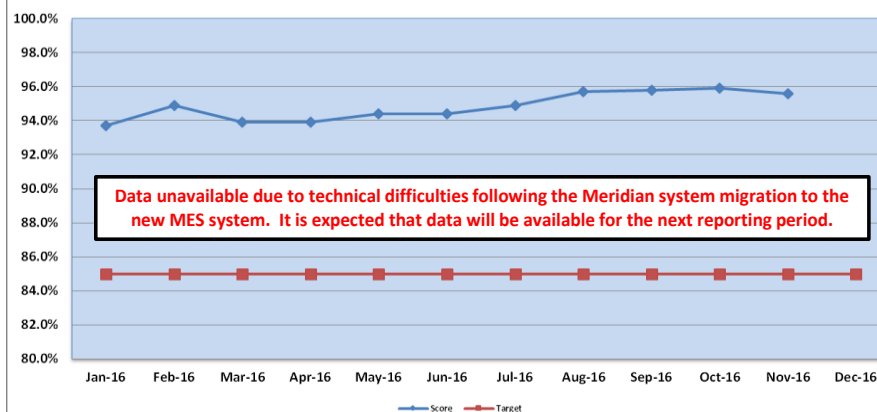
## Summary:

- Inpatients' feedback on catering services (undertaken via the Meridian online survey) demonstrates a performance consistently above the locally set target of 85%. Due to technical issues experienced during the migration of the Meridian system to the new MES system, survey information was not available for December 2016. It is expected that data will be available to be published for January reporting and continue to maintain its current trend.
- The PLACE results were published in August and catering were broadly comparable to 2015. The catering score was 91.88% versus a national average of 88.2% and was one of the strongest performers compared to our London peer group hospitals and the Shelford Group.
- A table and narrative of the Trust's Food Safety performance for December 2016 is at the bottom of this page.

## Action and Progress to Date:

- Aligned with the Trust's Nutritional strategy, work continues to ensure that our staff catering and retail units meet the CQUIN requirements for healthy food. The main focus is on reducing the sales of sugary drinks and foods high in fat, sugar and salt, and ensuring that healthy options are available at any point, including for staff working night shifts.
- Following the successful award of the Serco contract to Barts Health NHS Trust, negotiations are continuing to finalise the contract. A phased mobilisation will commence in May 2017, completing in September 2017.
- Food hygiene and safety audits are undertaken by the Essentia Assurance and Compliance Team through an ongoing program based on risk. The general performance across all sites continues to track above the internal performance target of 90% compliance. Where under-performance has been identified action plans have been put in place to address the issues identified.

## Inpatient Survey of Food Quality: Fair/Good/Very Good

Food Safety

Audit Area	Internal Audit Scores	Food Safety Rating (5 = Full Compliance)	Accreditation
CPU Kitchen	95%	5	SALSA
Wards	94%	5	-
Community Wards	91%	5	-
Trust Retail	93%	5	-
Trust Hospitality	87%	5	-
Trust Creche's	89%	5	-
Thomas Guys Club	94%	5	-
Goods-In Stores	93%	-	-

**Food Safety**

Independent internal food safety compliance monitoring is carried out unannounced in all Trust catering venues. The audits are conducted to assure compliance with the food hygiene regulations and adherence to the Trust's food safety policy and procedures. Food venues are also inspected periodically by the Local Authority Environmental Health Department who issue a food safety rating between 0 and 5, with 5 representing full legal compliance with the food safety and hygiene regulations.

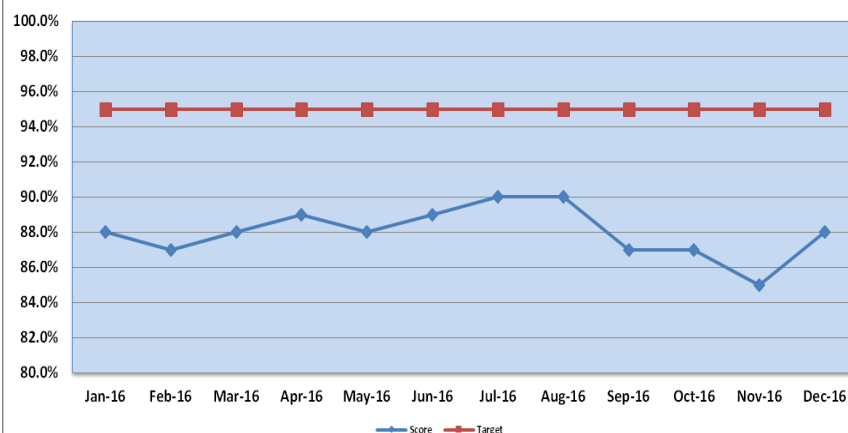
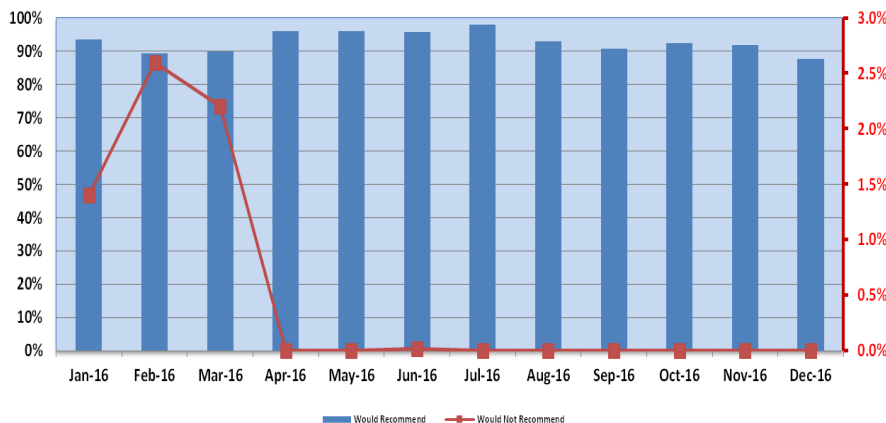
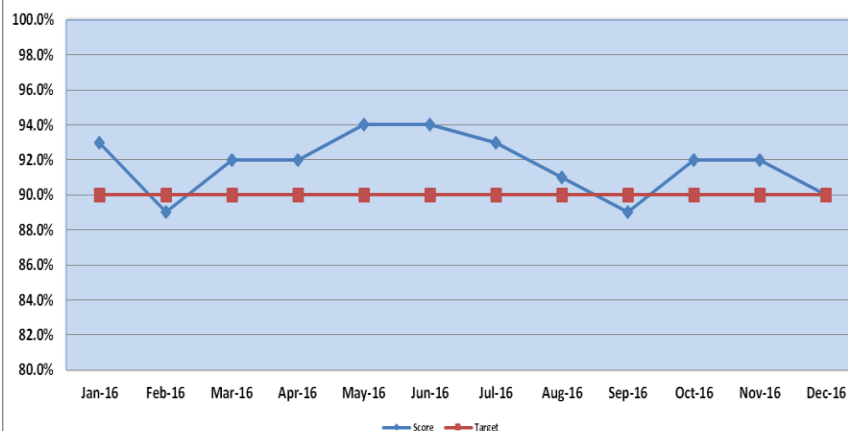
Trust Hospitality and Creche's fell below target in December which may be due to seasonal pressures. Measures have been taken to resolve the issues identified, which include regular probe calibration, improvement in cleaning and sanitising with sign off and accountability being carried out by the managers of each area. All areas are revisited within 28 days to assess progress and to assure key performance targets are brought back into line.

**Summary:**

- The new Patient Transport Service (PTS) contract commenced on the 1st December 2015. The new service is delivered by three providers: Savoy Ventures (75%), Essentia in-house (20%) and Bears / G4S (5%).
- Overall performance is in line with pre-contract levels but arrival times continue to remain extremely challenging. However, mitigating factors, such as local traffic conditions and continuing highways work local to hospital sites, compromise our ability to make significant improvements. Our main supplier Savoy Ventures has introduced additional resources including dedicated ambulances for the kidney units.

**Action and Progress to Date:**

- The Friends and Family score for December, in respect of 'would recommend', continues to reflect a decrease against the levels achieved when the service had reached its most stable since the new contract began in December 2016.
- The PTS service to Kidney Units has continued to make progress and in December, feedback from all units was that services had settled into a steady and largely problem free routine, both those provided by Savoy and G4S. The service provided over Christmas has also been verified and the feedback suggests very few issues. Discussions are ongoing with the providers in challenging them with looking at innovative solutions that will provide an assurance that all renal patients arrive within 15 minutes of their treatment and depart within 15 minutes post treatment.

**Patient Transport - Patients arriving within 90 minutes prior to appointment****Patient Transport - Friends and Family****Patient Transport - Patients picked up within 90 minutes of reporting 'ready to travel'**

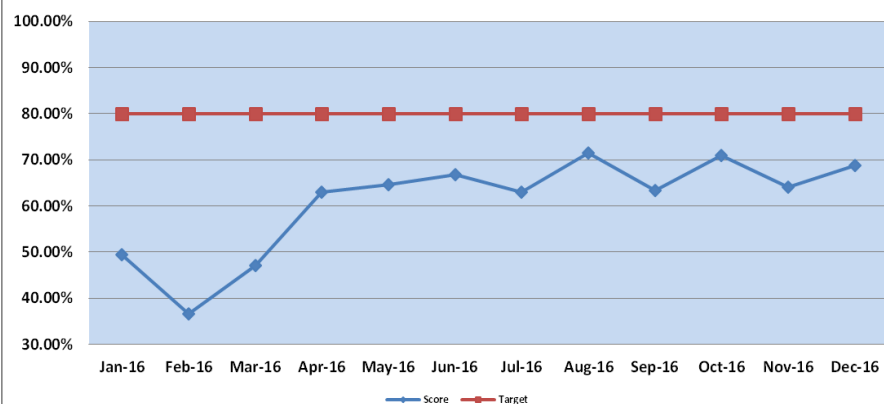
## Summary:

- The Telephony service saw a slight increase in performance in December for all KPIs compared to their respective reported figures for November.
- Pick up of internal (21,066) and external (55,553) calls per month have increased in performance for December, however the KPI for external calls remains as red status. Calls answered within 30 seconds has also maintained its red status.

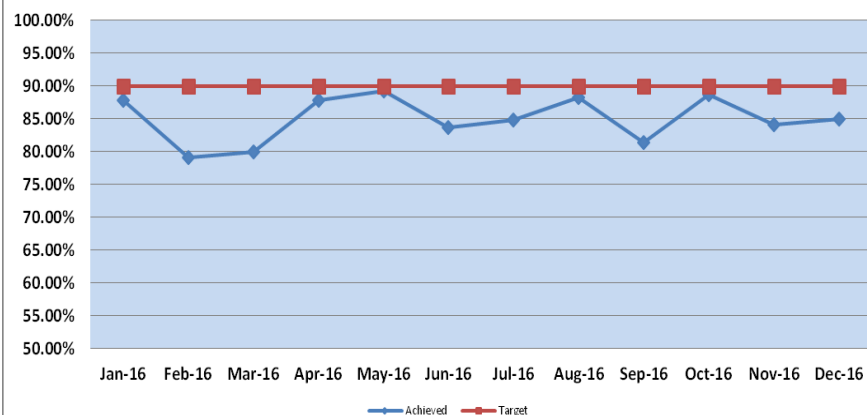
## Action and Progress to Date:

- Customer Services held their third games in December mirroring the principles of an advent calendar. Improvements were seen in performance but the most significant change was to staff morale.
- Recruitment for a Band 6 Customer Service Manager is now complete and the post will be developed towards service improvement, focussing on embedding structure around staff training auditing.
- Multi-skilling has remained a focus in December concentrating on existing staff with their newly acquired skillsets. More than 30% of staff are trained on a secondary service.
- Customer Services managers have been working towards building hot topics as part of the Essentia Way programme and adopting the 'back to the floor' principle within the department. This will allow staff of differing levels to shadow each other to fully understand the challenges and pressures of their colleagues.

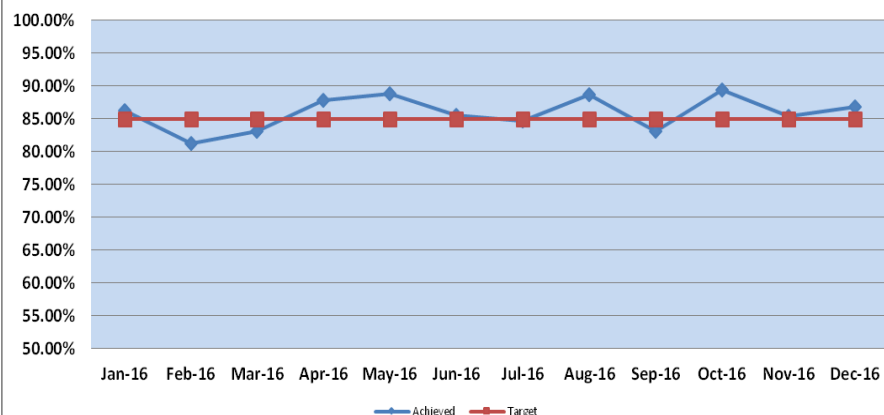
% of Calls Answered Within 30 Seconds



GSTT External Calls - % Achieved



GSTT Internal Calls - % Achieved



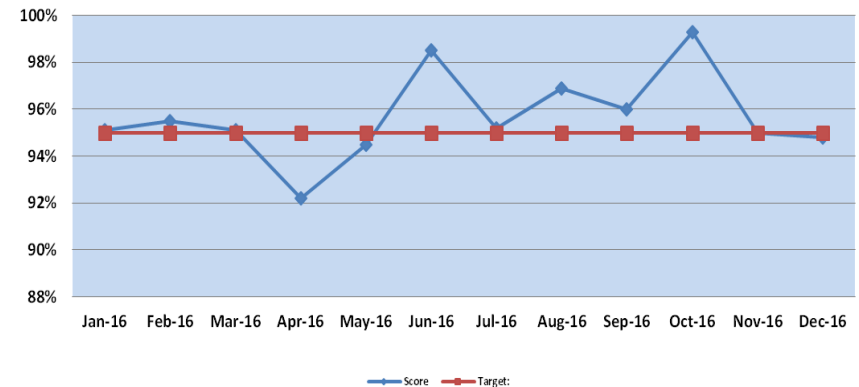
### Summary:

- Following additional revenue investment in an enhanced out of hours maintenance regime, lift availability on the two acute sites has been running at approximately 95% each month, with December reported slightly below target at 94.8%.
- Priority 2 calls (responded to within 4 hours) have for much of the last 12 months, achieved and exceeded the target set out in the Service Level Agreement. The KPI measures the time it takes to respond to calls, as full resolution and repair may require out of hours work or the procurement of additional parts.
- 203 Priority 1 and 939 Priority 2 calls were logged in December, achieving a 90% and 72% performance respectively against a locally set target of 70%.

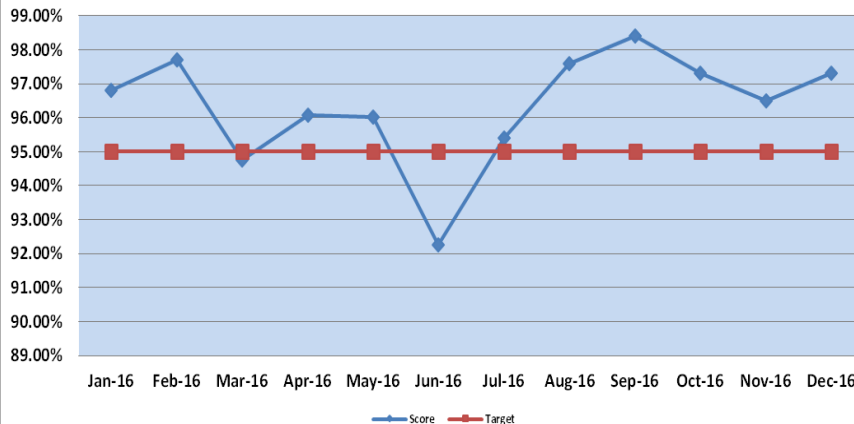
### Action and Progress to Date:

- There have been no major infrastructure issues in December 2016.
- Capital Backlog Maintenance investment is being targeted at key elements of the lift infrastructure, where the age of the systems is an issue. Lift performance deteriorated slightly below target in December primarily due to faults experienced at Guy's during the second week of December.
- Recruitment is underway to ensure resources required to maintain the new Cancer Treatment Centre are in place.

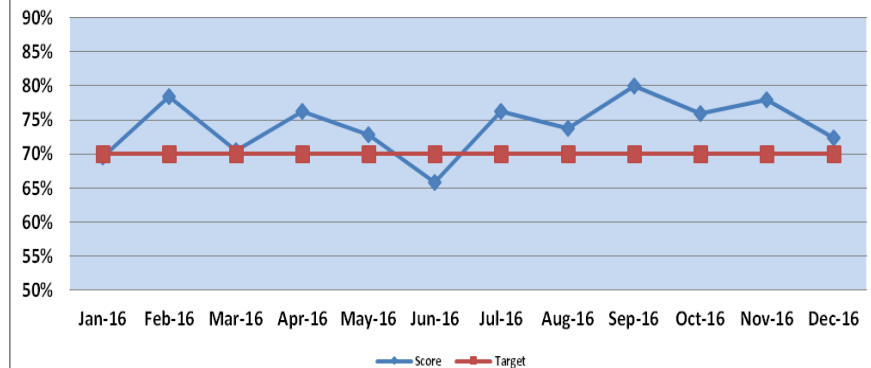
### Guy's & St Thomas' - Lift Performance



### Essentia Facilities Service Desk - % Calls Answered



### Building & Engineering - Priority 2 Calls Attended within Target (4 Hours)



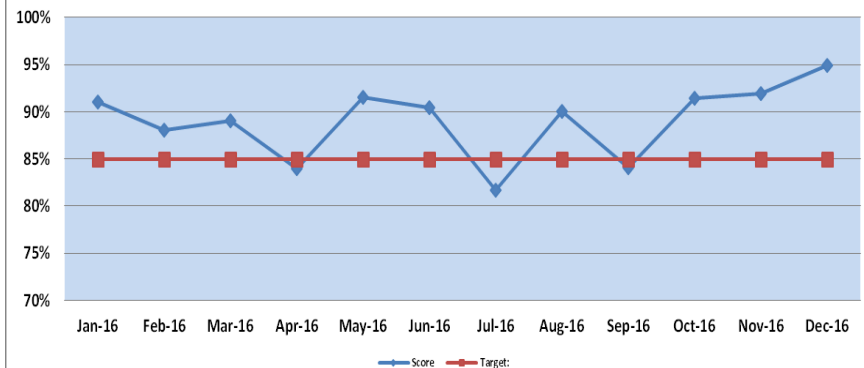
## Summary:

- The agreed service level for customer satisfaction (85%) increased in performance in December being reported at 94.9%, however there was a reduced response rate (59) compared with November. Continued work is being done to increase the numbers of responses received. Trust members of staff are invited to provide feedback once their issue or problem has been resolved.
- Incidents resolved within target breached its locally set target of 85%, being reported at 81.6% in December. This was primarily due to a number of Priority 3 incidents not being resolved within the SLA period. Priority 3 incidents represent the largest proportion of tickets processed.

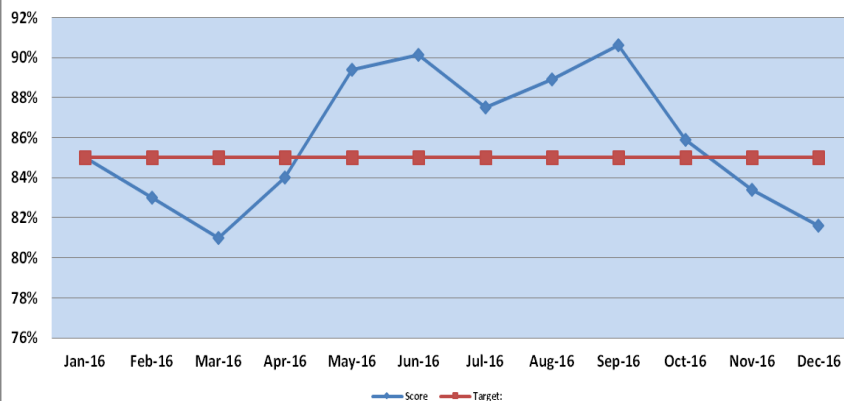
## Action and Progress to Date:

- The average time to answer calls by the IT Service Desk was reported at 133 seconds against a target of 60 seconds, maintaining red status for this KPI.
- Two notable issues with EPR label printing and Google search led to higher call volumes, that had a detrimental effect on the average call answer time.
- There was 1 declared serious incidents experienced in December relating to the MedChart service, where users were unable to prescribe or update drugs for new and existing patients.
- IT Service availability was generally very good with key IT services achieving the target of 99.9% uptime. PACS experienced a full service outage and a further five applications experienced partial unavailability for short periods, which had no impact to clinical activity.

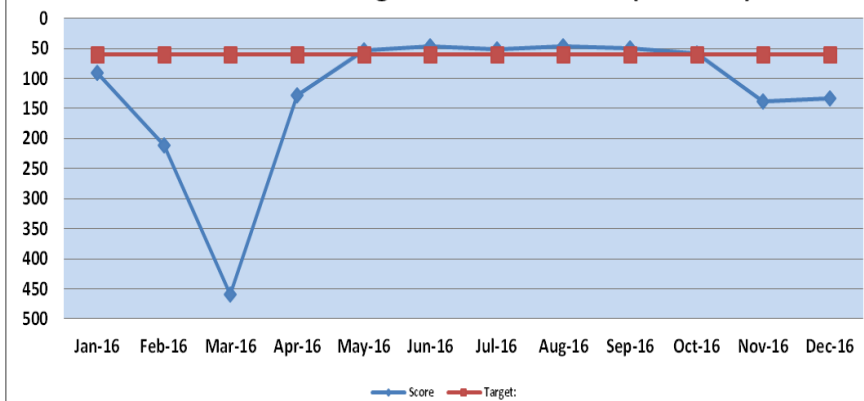
IT - Helpdesk User Satisfaction



IT - Incidents Resolved Within Target



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



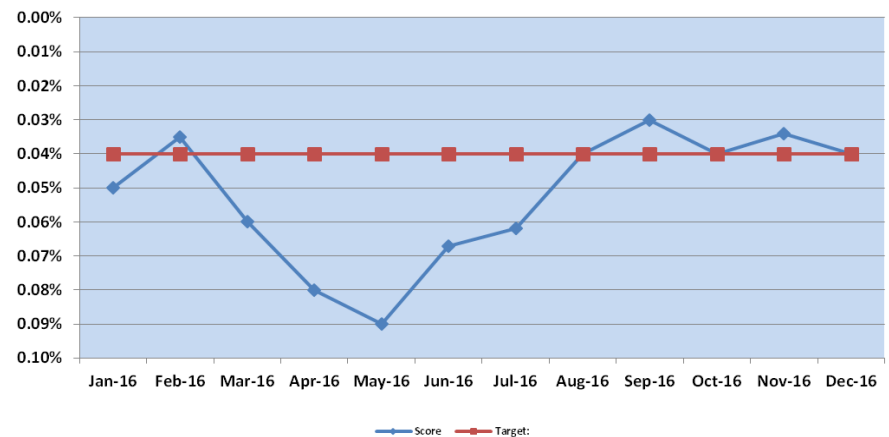
### Summary:

- Non conformance levels are maintained at 0.042% equating to on non-conformance in 2,381 packs.
- The average instrument processing time is 8.1 hours, against a target of less than 12.

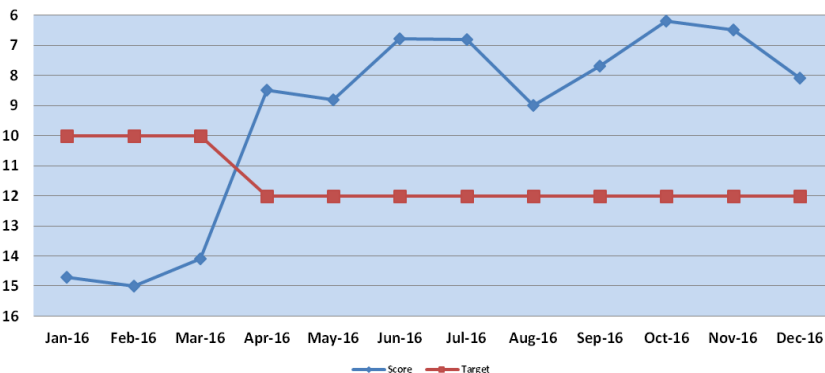
### Action and Progress to Date:

- Activity volumes continue to maintain at a high level. In December 844,506 instruments were processed for a four week month, averaging over 200,000 instruments per week, this being comparable to previous months.
- The teams continue to maintain instrument processing times ahead of target. Against a background of increased volumes this is a significant achievement.
- The North Middlesex contract continues to settle with positive feedback from the customer reporting a continued improvement and satisfaction with service performance. The contract negotiation was positive with SLA sign off due in January 2017.
- Work with Great Ormond Street continues to support the re-tendering process also due in January 2017.

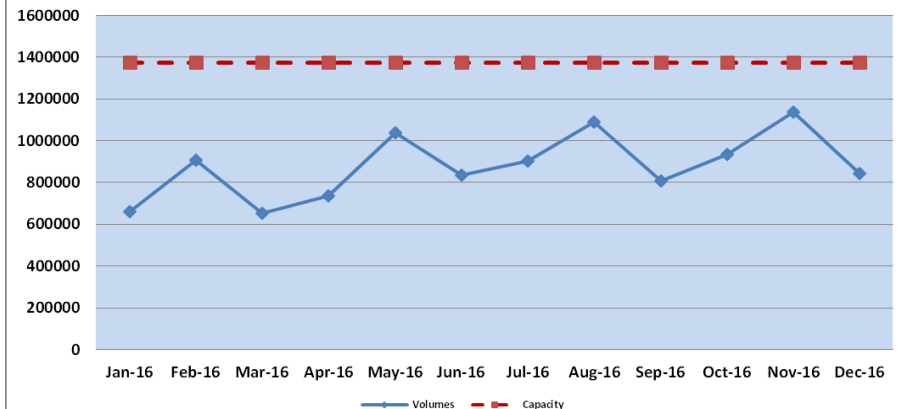
### Sterile Services - Non Conformities



### Sterile Services - Average Instrument Processing Turnaround Time (in hours)



### Sterile Services - Instrument Volumes



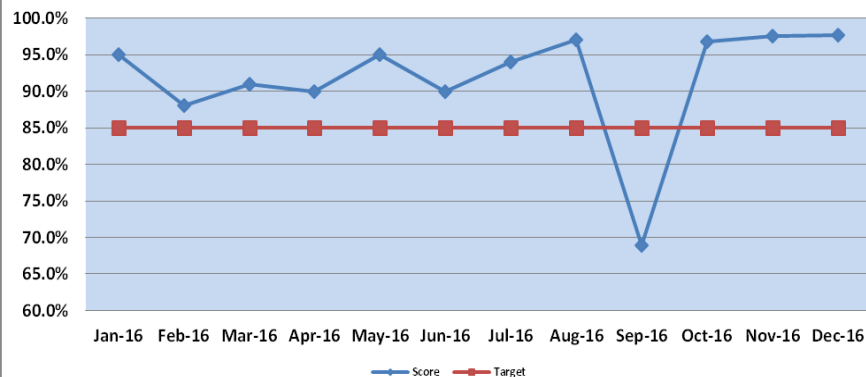
## Summary:

- Community teams are consistently achieving and exceeding their targets for reactive and PPM maintenance.
- Community cleanliness scores consistently exceed the 95% target.

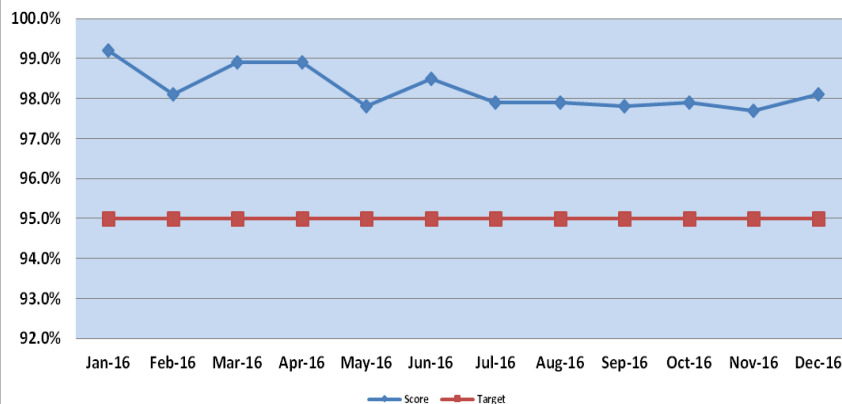
## Action and Progress to Date:

- Reactive Maintenance is tracking consistently above its target of 80% with December reported at 90%.
- Community PPM tasks was reported at 97.7% in December.
- Community cleaning scores continue to exceed the target of 95%, being reported at 98.1% in December.

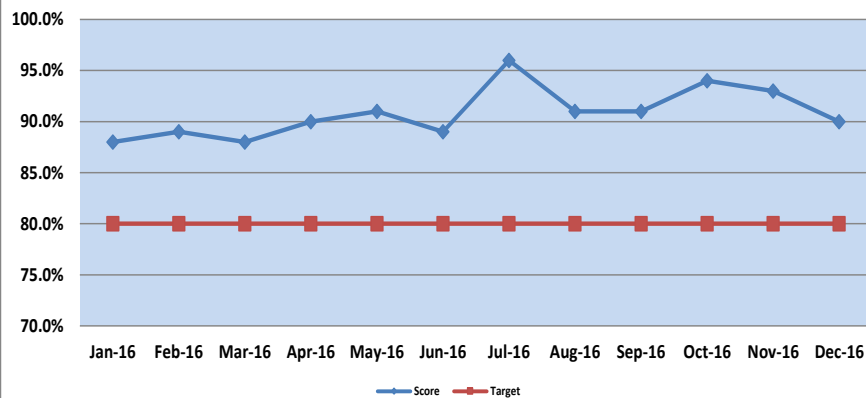
Community - PPM Tasks Completed



Community - Cleaning Scores



Community - Reactive Maintenance







# 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 (unadjusted)	Mthly %	>95%	90%	89%	56%	88%	76%	90%	86%	96%	81%	97%	96%	91%	94%	100%	100%	81%	83%					
		RTT - Admitted patients < 18 weeks (unadjusted)	Mthly %	>90%	82%	96%	80%	78%	75%	82%	75%	84%	92%	89%	89%	97%	-	-	-	85%	61%					
		RTT - Incomplete pathways < 18 weeks (unadjusted)	Mthly %	>92%	89%	94%	85%	82%	85%	88%	79%	91%	83%	96%	95%	96%	94%	97%	100%	85%	78%					
		RTT - Treatments over 52 weeks (unadjusted)	Mthly	Zero	12.0	0.0	0.0	4.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0					
		RTT - Total incomplete pathways	Mthly	-	58,293	2,376	2,129	4,423	4,071	2,638	6,115	3,028	157	5,974	8,419	7,661	1,127	109	2	2,796	2,999					
		RTT - Incomplete pathways over 18 weeks	Mthly	-	6,519	147	311	807	614	311	1,268	276	26	229	405	317	69	3	0	407	661					
	Cancer access	Cancer - 2 week wait	Qtly%	>93%	93%	97%	-	-	-	97%	94%	98%	-	100%	-	93%	-	-	-	80%	-					
		Cancer - breast symptomatic referrals <2 wks	Qtly %	>93%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%					
		Cancer - 31 day first treatments	Qtly%	>96%	95%	96%	-	-	-	97%	97%	94%	-	50%	-	96%	-	-	-	-	-					
		Cancer - 31 day subs treatments - surgical	Qtly%	>94%	90%	-	-	-	-	81%	81%	100%	-	-	-	100%	-	-	-	-	-					
		Cancer - 62 day urgent GP referrals	Qtly %	>85%	67%	41%	-	-	-	66%	71%	86%	-	-	-	88%	-	-	-	-	-					
		Cancer - internal 62-day referrals	Qtly%	>85%	68%	33%	-	-	-	68%	73%	-	-	-	-	100%	-	-	-	-	-					
		Cancer - 62 day screening	Qtly %	>90%	100%	-	-	-	-	-	100%	100%	-	-	-	-	-	-	-	-	-					
			Mthly	<1%	2%	1%	-	-	0%	24%	5%	-	0%	0%	-	-	-	-	-	-	4%	45%				
Responsive	Diagnostics	Diagnostic waits - % over 6 weeks	Cum ALOS	<last yr	3.5	1.9	6.1	2.9	5.2	3.3	4.4	3.2	1.1	3.3	3.7	9.3	0.0	40.5	0.0	2.5	1.9					
	Bed management	Average length of stay (elective)	Cum ALOS	<last yr	8.7	6.7	22.8	9.8	2.3	6.5	15.4	9.2	0.0	64.8	0.0	41.4	0.0	19.0	0.0	5.8	30.6					
		Non-elective average LOS >1 night	Mthly %	>25%	21%	31%	64%	23%	9%	12%	26%	9%	44%	27%	0%	10%	-	71%	-	16%	28%					
		Discharges before noon	Cum %	<4%	5%	3%	5%	6%	7%	6%	8%	1%	8%	4%	4%	2%	1%	0%	4%	5%						
	Outpatient mgt	Appointments re-scheduled by hospital <6wks	Ratio	2.11	2.12	2.53	1.61	1.49	2.29	3.43	2.63	0.93	0.70	2.43	2.76	1.59	-	-	-	2.89	1.89					
		Follow-up ratio - adj cons appts (in arrears)	Mthly %	<11%	12%	17%	12%	11%	23%	19%	13%	13%	38%	14%	7%	12%	-	-	0%	14%	8%					
		Non-attendance rate (new appts)	Mthly %	>85%	84%	-	100%	86%	89%	47%	75%	93%	-	99%	-	-	-	-	-	50%	56%					
	Theatre management	Daycase rate - basket (in arrears)	Mthly %	<7%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%					
		Theatres Gross Cancellation Rate (in arrears)	Cum %	<5.7%	5.8%	11.4%	1.6%	3.6%	4.8%	5.8%	9.9%	2.3%	3.1%	1.6%	0.2%	2.1%	0.0%	8.7%	0.0%	3.3%	1.9%					
	Effective	Readmission mgt	Emergency readmissions (within 28 days - in arrears)	Cum %	<3.5%	3.7%	8.3%	0.9%	2.6%	3.3%	3.2%	6.2%	1.6%	1.7%	1.0%	0.1%	1.3%	0.0%	7.2%	0.0%	2.1%	1.5%				
Emergency readmissions (within 14 days - in arrears)			Qtly %	>90%	83%	85%	-	54%	96%	83%	78%	-	100%	-	-	-	-	-	-	-	-					
Enablers	CQUIN - general	Patients >75 asked dementia screening question	Cum %	>98%	98%	94%	100%	98%	99%	100%	100%	99%	100%	99%	93%	99%	99%	100%	100%	98%	99%					
		NHS number coverage	Ratio	>4.5	4.8	7.0	4.8	4.0	7.2	5.9	4.4	6.2	3.7	3.5	2.4	3.2	-	9.8	0%	2.9	3.5					
	Data quality	Clinical coding - diagnostic depth (in arrears)	Cum var %	>0%	-2%	7%	-4%	-3%	-10%	-9%	-4%	-5%	30%	2%	3%	-9%	0%	0%	0%	2%	-6%					
		Elective activity vs profiled plan - cumulative variance	Mthly var	>0	4,361	110	98	500	136	190	362	163	-4	358	425	653	869	0	0	6	164					
Activity (magic numbers)	New patients seen vs plan (all categories, in arrears)	Number	>last yr	1,713	78	40	180	230	83	214	63	10	49	44	258	0	0	0	106	171						
		GP referrals	Number	>last yr	16,193	475	122	585	821	488	1,237	2,535	5	1,194	2,492	1,579	3,136	3	0	180	236					