Management Board – 24th April 2013
Trust Board – 25th April 2013

Surrey and Sussex NHS Healthcare NHS Trust

Integrated Quality and Performance Report (IQPR)

M12 – March 2013

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An Associated University Hospital of Brighton and Sussex Medical School

Putting people first
Delivering excellent, accessible healthcare

Surrey and Sussex NHS Healthcare NHS Trust

Quality and Performance M12 – March 2013

Summary:

- For March 2013 the Trust is expecting to be rated as "Performing" for the Quality of Services based on the following ratings for Quality domains:
  - Integrated Measures – Performing
  - CQC Registration – Performing
  - User Experience – Performance Under Review
- Within the Integrated measures, aggregate 18 weeks and DTOC targets continued to show delivery of performing standard
- Although the Trust has underachieved the 4 hour ED target in month, the target was achieved for the quarter with performance at 95%.
- The Trust has achieved all the quality metrics in the DoH performance framework with the exception of Cancer 62 day from screening (low numbers and patient choice) and RTT compliance in every specialty.

Action: The Board are asked to note and accept this report

Notes:	
Legal: What are the legal considerations & implications linked to this item? Please name relevant Act	Patient safety: Legal actions from unintentional harm to patients would normally be covered by negligence, an area of English tort (civil) law, providing the remedy of compensation. Case law is extensive. Criminal action could be pursued if investigation judged intentional harm and remedies will vary according to severity. Staff safety: The Health and Safety at Work Act etc 1974 may apply in respect of employee health and safety or non clinical risk to patients (usually reported under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995)
Regulation: What aspect of regulation applies and what are the outcome implications? This applies to any regulatory body.	The Care Quality Commission (CQC) regulates patient safety and quality of care and the CQC register and therefore license care services under the Health and Social Care Act 2009 and associated regulations. The health and safety executive regulates compliance with health and safety law. A raft of other regulators deal with safety of medicines, medical devices and other aspects.

Contents

1. National Quality of Services Measures
Overview

- This section of the report outlines the Trust's performance for Quality of Services under the Department of Health Performance Framework.
- For March 2013 the Trust is expected to be rated as "Performing" for Quality of Services based on the ratings shown below for each of the individual domains within the framework:

Month	CQC Registration	Integrated Measures	User Experience	Overall Quality Of Services
September 2012	Performing	Performing (2.67)	Performance Under Review	**Performing**
October 2012	Performing	Performing (2.75)	Performance Under Review	**Performing**
November 2012	Performing	Performing (2.82)	Performance Under Review	**Performing**
December 2012	Performing	Performing (2.60)	Performance Under Review	**Performing**
January 2013	Performing	Performing (2.71)	Performance Under Review	**Performing**
February 2013	Performing	Performing (2.89)	Performance Under Review	**Performing**
March 2013	Performing	Performing (2.82)	Performance Under Review	**Performing**

- The Trust continues to be rated as Performing for the CQC registration domain and the remainder of this section sets out the Trust's position for the Integrated Measures and User Experience domains.

1. National Quality of Services Measures
Integrated Measures

Surrey and Sussex NHS Healthcare NHS Trust

- **For March 2013, the Trust is forecasting an in-month score of 2.82 which would rate the Trust as "Performing" for the Integrated Measures.**
- The table below shows the performance against each of the individual Integrated Measures on an in-month basis.

Integrated measures	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Trigger Text	Trigger Point 1	Trigger Point 2
ED 95% in 4 hours	98%	98%	92%	95%	95%	94%	> Target is Good	95%	94%
MRSA Incidences - In Month (Trust acquired)	1	0	0	1	0	0	< Target is Good	On plan	1Std Dev
C Diff Incidences - In Month (Trust acquired)	2	3	1	4	2	1	< Target is Good	On plan	1Std Dev
RTT Admitted - 90% in 18 weeks	91.2%	92.4%	92.0%	91.1%	91.2%	90.6%	> Target is Good	90%	85%
RTT Non Admitted - 95% in 18 weeks	95.3%	96.0%	95.8%	96.9%	96.8%	96.7%	> Target is Good	95%	90%
RTT Incomplete Pathways - %age under 18 weeks	93.7%	93.7%	94.0%	94.3%	95.0%	95.2%	> Target is Good	92%	87%
RTT - No of Specialties not achieving standards	11	5	4	4	3	2	< Target is Good	0	20
%age of patients waiting 6 weeks or more for diagnostic	0.2%	0.6%	0.99%	0.2%	0.0%	0.0%	< Target is Good	1%	5%
Cancer - TWR	94.7%	95.0%	95.7%	93.8%	96.2%	95.6%	> Target is Good	93%	88%
Cancer - Breast Symptomatic (2 Week Wait)	96.3%	93.7%	98.8%	93.4%	98.7%	97.0%	> Target is Good	93%	88%
Cancer - 31 Day Second or Subsequent Treatment (SURGERY)	98.3%	96.6%	100.0%	96.6%	95.2%	96.6%	> Target is Good	94%	89%
Cancer - 31 Day Second or Subsequent Treatment (DRUG)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	> Target is Good	98%	93%
Cancer - 31 Day Decision to Treatment	98.0%	96.8%	100.0%	96.9%	99.0%	98.8%	> Target is Good	96%	91%
Cancer - 62 Day Referral to Treatment from Screening	78.0%	70.0%	75.0%	85.7%	87.5%	84.6%	> Target is Good	90%	85%
Cancer - 62 Day Urgent Referral	87.1%	88.9%	88.4%	76.1%	85.4%	91.5%	> Target is Good	85%	80%
Delayed Transfers of Care (%age of bed days)	1.7%	1.7%	2.9%	2.7%	2.2%	1.6%	< Target is Good	3.5%	5.0%
Mixed Sex Breaches per FCE	0.0%	0.0%	0.0%	0.10%	0.0%	0.0%	< Target is Good	0.0%	0.5%
VTE Assessment on Admission	91.5%	90.0%	91.0%	92.7%	93.1%	94.3%	> Target is Good	90%	80%

1. National Quality of Services Measures
Integrated Measures

Surrey and Sussex NHS Healthcare NHS Trust

Significant points of note regarding performance include:

- Following a 14% increase in attendances to the ED department in month as compared to the previous month, the Trust underachieved (94%) against the four hour standard of 95%.
- There were no incidences of MRSA and one incidence of C-Diff during March resulting in C-Diff being 18 cases below the straight line YTD trajectory and MRSA on target.
- RTT performance continued as expected with the 90% Admitted, 95% non-admitted and 92% incompletes measures all being achieved in aggregate.
- Delayed Transfers of Care continued to be below the 3.5% standard – this is likely to increase in 2013/14 following changes to processes which adhere to national policy.

1. National Quality of Services Measures

Integrated Measures - 18 Weeks and Diagnostics

18 weeks and Diagnostics Indicators	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Trigger Text	Trigger Point 1	Trigger Point 2
RTT Admitted - 90% in 18 weeks	91.2%	92.4%	92.0%	91.1%	91.2%	90.6%	> Target is Good	90%	85%
RTT Non Admitted - 95% in 18 weeks	95.3%	96.0%	95.8%	96.9%	96.8%	96.7%	> Target is Good	95%	90%
RTT Incomplete Pathways - %age under 18 weeks	93.7%	93.7%	94.0%	94.3%	95.0%	95.2%	> Target is Good	92%	87%
RTT - No of Specialties not achieving standards	11	5	4	4	3	2	< Target is Good	0	20
%age of patients waiting 6 weeks or more for diagnostic	0.2%	0.6%	0.99%	0.2%	0.0%	0.0%	< Target is Good	1%	5%

- The Trust continued to achieve the 90% Admitted target in March with two non compliant specialties - General Surgery and Other. This has been part of the Trust plan to continue to reduce the number of patients waiting over 18 weeks on the admitted pathway which now sits at its lowest level in recent years.
- The Non-admitted and Incomplete targets were both achieved at aggregate and speciality level in March 2013.
- 2012/13 has seen significant progress on 18 weeks, moving from non-compliance with the incomplete and non admitted targets and over 20 specialities not achieving expected to standards, to the levels of performance we are now achieving
- 2013/14 will see continued embedding of processes and improvements of pathways with a focus on further reducing the number of patients waiting over 18 weeks for treatment
- The diagnostic target was again achieved in March 2013

Action	Person Responsible	Timeline	Monitoring Body
Ongoing RTT specialty level recovery plans and PTL processes	Divisional ADs	Ongoing	Management Board Performance

1. National Quality of Services Measures

Integrated Measures – Cancer

Cancer Indicators	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Trigger Text	Trigger Point 1	Trigger Point 2
Cancer - TWR	94.7%	95.0%	95.7%	93.8%	96.2%	95.6%	> Target is Good	93%	88%
Cancer - Breast Symptomatic (2 Week Wait)	96.3%	93.7%	98.8%	93.4%	98.7%	97.0%	> Target is Good	93%	88%
Cancer - 31 Day Second or Subsequent Treatment (SURGERY)	98.3%	96.6%	100.0%	96.6%	95.2%	96.6%	> Target is Good	94%	89%
Cancer - 31 Day Second or Subsequent Treatment (DRUG)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	> Target is Good	98%	93%
Cancer - 31 Day Decision to Treatment	98.0%	96.8%	100.0%	96.9%	99.0%	98.8%	> Target is Good	96%	91%
Cancer - 62 Day Referral to Treatment from Screening	78.0%	70.0%	75.0%	85.7%	87.5%	84.6%	> Target is Good	90%	85%
Cancer - 62 Day Urgent Referral	87.1%	88.9%	88.4%	76.1%	85.4%	91.5%	> Target is Good	85%	80%

- **The trust has sustained delivery of all Cancer Performance indicators for 2012/13 with the exception of the 62 Screening standard. Compliance with this standard continues to be a challenge due to low number of referrals and patient deferral**
- The 62 Day Screening target performance of 84.6% was the result of two 0.5 breaches out of only 6.5 accountable patients due to patient medical reasons. Work with Worthing over the historic issues relating to screening pathways is on-going.
- SWSH Cancer Network ceased to exist at the end of March and we have concerns over maintaining the good work of cancer networks in reducing variation of care across the network which could impact on Cancer Waiting Times.

Action	Person Responsible	Timeline	Monitoring Body
Robust monitoring and management of demand and capacity issues by Cancer Services team and escalation through PTL	Cancer Services Manager / Divisional Service Managers	Ongoing	Elective Care Oversight Committee
Attendance at the Strategic Clinical Network Stakeholder Planning & Engagement event.	Cancer Services Manager	May 2013	

1. National Quality of Services Measures
User Experience

Surrey and Sussex NHS Healthcare NHS Trust

User Experience Indicators	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Trigger Text	Trigger Point 1	Trigger Point 2
User Experience - Patient Opinion									
Patient Opinion - %age that would recommend SaSH	79%	80%	78%	76%	76%	74%	> Target is Good	80%	70%
User Experience - NHS Choices									
NHS Choices - would recommend SaSH	60%	61%	67%	3.5	3.5	3.5	> Target is Good	80%	70%
NHS Choices - Cleanliness (Score out of 5)	4	4	3.5	4	4	4	> Target is Good	5	4
NHS Choices - Hospital staff worked well together (Out of 5)	4	4	4	4	4	4	> Target is Good	5	4
NHS Choices - Treated with Dignity and respect (Out of 5)	4	4	4	4	4	4	> Target is Good	5	4
NHS Choices - Involved in decisions about care	3	3	4	4	4	4	> Target is Good	5	4
NHS Choices - Provision of same Sex	4	4	4	4	4	4	> Target is Good	5	4
Inpatients Survey									
Your care Matters- Response Rate		16%	14%	17%	12%	15%	> Target is Good	18%	15%
Your care Matters - Friends & Family (Net Promoter Score)			34	31	52	48	Trigger to be confirmed		
Your care Matters - Access and Waiting				75	78	71	Trigger to be confirmed		
Your care Matters - Safe, High qualtiy coordinated care				61	68	68	Trigger to be confirmed		
Your care Matters - Better Information, More Choice				64	70	68	Trigger to be confirmed		
Your care Matters - Building Closer Relationships				80	88	86	Trigger to be confirmed		
Your care Matters - Clean, comfortable and friendly place to be				76	79	79	Trigger to be confirmed		

- Patient Opinion and NHS Choices continue to highlight areas where patient experience is not achieving the internal standards expected with a slight reduction in quarter four for the Patient Opinion percentage of patients that would recommend SaSH. The NHS Choices system has been revised to an overall score out of 5 for which the Trust has achieved 3.5.
- The Your Care Matters inpatient survey continues to be well received with improvements in all areas of the survey. The scores shown above are weighted based upon the respondents answer to a series of questions in each category with zero being the worst and 100 the best. This will allow the Trust to monitor and improve patient experience in year. The questions are mapped to the national inpatient survey. Feedback from the survey will be discussed at divisional performance reviews with actions tracked over time to assess the impact on patient experience.
- The previous Patient Experience and Staff Engagement Committee has been restructured and renamed as the Patient Experience Delivery Committee. The Terms of Reference now also include the holding of the overview, benchmarking and monitoring of the Trust's patient experience elements of the NHS Constitution. The first meeting will take place on 30th April and will report to the Management Board for Quality and Risk.

Contents

2. Internal Quality of Service and Workforce Measures

Mortality, Readmissions and Safety

Mortlity, Readmissions and Safety Indicators	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Trigger Text	Trigger Point 1	Trigger Point 2
Mortality									
HSMR (rolling 12 Months)	85.8	91.3	90.7	90.7			< Target is Good	100	105
HSMR (Rolling 3 Months)	85.7	88.1	88.6	88.6			< Target is Good	100	105
Readmissions									
Emergency Readmission within 3 day of discharge - post Elective	0.6%	0.5%	0.2%	0.2%	0.6%	0.5%	Trigger to be confirmed		
Emergency Readmission within 3 day of discharge - post Non Elect	3.8%	4.1%	4.1%	3.8%	3.3%	4.6%	Trigger to be confirmed		
Emergency Readmission within 30 day of discharge - post Elective	3.0%	3.0%	3.0%	1.9%	3.1%	3.4%	Trigger to be confirmed		
Emergency Readmission within 30 day of discharge - post Non Elect	14.2%	13.7%	14.2%	13.6%	13.5%	14.7%	Trigger to be confirmed		
Other Safety Measures									
No of Never Events in Month	0	0	0	0	0	1	< Target is Good	0	1
Newly acquired Pressure Ulcers (Grade 2 and above)	16	11	9	7	8	15	< Target is Good	15	25
No of falls reported as clinical incidents	84	88	75	106	68	87	< Target is Good	70	80
No of falls resulting in fracture/head injury	0	1	1	6	4	1	< Target is Good	0	1
Number of medication errors resulting in an adverse event	0	2	1	1	3	0	< Target is Good	0	2

Falls and medication data continues to be updated following the publication of the IQPR with restatement of prior month values where required.

- Overall mortality as measured by HSMR continues to be below 100 on both a 3 and 12 month basis reflecting the Trust having a lower than expected mortality rate. The latest SHMI data published in January showed a SHMI value of 0.93 reflecting there being less deaths than the number expected.
- There has been a slight increase in the post elective readmission rates. It is expected as data quality issues are resolved the re-admission rates will move towards the rates seen in the detailed reviews carried out internally and externally.
- There was a Never Event reported in March. This related to a wrong site surgery. The investigation has been completed which identifies human error and task related factors and as such an action plan has been developed to reduce the likelihood of reoccurrence. The World Health Organisation checklist was carried out appropriately in this case.
- There was no grade 3 or 4 pressure damage in March 2013. Work is on-going with ward and specialist teams to eliminate all avoidable cases.
- The number of falls has increased in month. There has been an increased level of performance monitoring and training / intervention by the reconfigured falls team. A new falls strategy which focuses on falls prevention and targets those falls that cause harm has been disseminated for comment.

2. Internal Quality of Service and Workforce Measures

Infection Control

Infection Control Indicators	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Trigger Text	Trigger Point 1	Trigger Point 2
MRSA Incidences - In Month (Trust acquired)	1	0	0	1	0	0	< Target is Good	On plan	1Std Dev
C Diff Incidences - In Month (Trust acquired)	2	3	1	4	2	1	< Target is Good	On plan	1Std Dev
MSSA (Trust Acquired)	1	1	1	1	2	2	For monitoring		
Hand Hygiene compliance	100%	99%	100%	99%	100%	97%	> Target is Good	100%	95%
E Coli	16	24	29	18	17	20	For monitoring		

- There were no MRSA bloodstream infections (BSIs) and one incidence of C.diff infection during March 2013
- For FY 2012/3 there were a total of three MRSA BSIs and twenty five C.diff infections. Using the DH rating system this places the Trust as Performing for achievement of both objectives.
- In this financial year the Trust has reduced the number of C-diff infections by 44% in comparison with 2011/12. This is a remarkable achievement and is due to a multi-factorial approach, the most important being a concentrated focus on antimicrobial stewardship. The number of reported MRSA BSI cases has also had a significant reduction of 60%.
- The Infection Prevention Control & Antimicrobial Stewardship Team, working through the Task Force continues its focus on:
    - Antimicrobial stewardship, driven primarily by the hospital's medical staff and pharmacists which is reflected by on-going improvements over recent months in compliance with the monthly Good Antimicrobial Prescribing (GAP) audits.
    - Management of invasive devices such as urinary catheters and vascular cannulae – with use of high intervention impact care bundles
- The challenge ahead will be to continue the downward trend in HCAIs, particularly Cdiff, in the context of increasing susceptible patient population and growing antimicrobial resistance and will require careful review of focus and resource allocation

2. Internal Quality of Service and Workforce Measures

Emergency Department

Surrey and Sussex NHS Healthcare NHS Trust

Emergency Department Indicators	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Trigger Text	Trigger Point 1	Trigger Point 2
ED 95% in 4 hours	98%	98%	92.4%	95%	95%	94.0%	> Target is Good	95%	94%
Time to Treatment - Median (minutes)	22	20	19	18	19	20	< Target is Good	45 mins	60mins
Patients Waiting in ED for over 12 hours following DTA	0	0	0	0	0	0	< Target is Good	0	1
Unplanned re-attendance rate (within 7 days)	5.1%	5.1%	4.7%	5.0%	5.0%	4.0%	< Target is Good	4%	5%
Rate of patients leaving without being seen	2.2%	1.8%	2.0%	1.7%	1.7%	1.6%	< Target is Good	4%	5%
Ambulance Handover within 15 mins	35%	38%	36%	36%	36%	38%	Trigger to be confirmed		
Ambulance Handover within 60 mins	98%	98%	97%	99%	99%	99%	Trigger to be confirmed		

- **Performance against the 4 hour target remained a challenges in March, though the year end position was over 96%.**
- Median time to treatment continues to be maintained at a consistent levels.
- An eight Consultant rota is now in operation, increasing senior cover in the department during the evenings and at weekends, plus adding dedicated time to the Paediatric area.
- We have now introduced clinic's leading to an improvement in the unplanned re-attendance within 7 days figure.
- Ambulance Handover times and the embedding of a 'see and treat' model remain key areas of focus. There are on-going issues with compliance and we are now looking at internal recording solutions to support issues with recording of handover times.
- Internal escalation and utilisation of CDU with a more structured admission process and guidelines is being implemented.

	Person Responsible	Timeline	Monitoring Body
Continuous review of arrivals and receiving process to ensure new facilities and senior decision making is maximized to improve quality of service for patients.	Department Lead	On-going	ED Quality Board
Reduce LOS to further reduce bed occupancy and provide increased flexibility to avoid any delay in admission.	Director of Operations	On-going	Management Board

2. Internal Quality of Service and Workforce Measures

Stroke and TIA Care

Surrey and Sussex NHS Healthcare NHS Trust

Stroke and TIA Care Indicators	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Trigger Text	Trigger Point 1	Trigger Point 2
Stroke Patients Scanned within 1 hour of Hospital Arrival	53%	31%	58%	64%	57%	50%	> Target is Good	50%	40%
Stroke Patients Scanned within 24 hour of Hospital Arrival	100%	97%	100%	100%	98%	98%	> Target is Good	100%	90%
%age of patients admitted directly to a ASU within 4 hours of arrival	59%	46%	47%	55%	39%	35%	> Target is Good	90%	80%
Stroke - 90% or more of time spent on stroke unit	71%	73%	50%	80%	60%	55%	> Target is Good	80%	70%
Stroke/TIA - High risk TIA treated within 24 hours	100%	87%	79%	81%	74%	63%	> Target is Good	60%	50%
Stroke HSMR (Rolling 12 Months)	105.5	102.6	101.3	100.9			< Target is Good	100	105
Stroke HSMR (Rolling 3 Months)	87.8	89.1	103.3	99.6			< Target is Good	100	105

Prior month stroke data has been restated as part of a quarterly update undertaken with the stroke network.

- Performance against the direct admissions within 4 hours and time spent on the Acute Stroke Unit metrics has suffered again this month due to the continued winter pressure and infection control outbreak in the rehabilitation areas resulting in significant community bed delays. Performance against the 90% stay on the Stroke unit was achieved in January for the first time since September 2012 but this has not been sustainable and remains inextricably linked with patient flow.
- The scanning of patients within 24 hours continues with robust performance.
- The TIA 7 day a week service also continues to perform much better than target.
- Stroke mortality (rolling 3 months) has improved from last month and clinical audit is on-going.
- Stroke performance has improved in all areas on 11/12 but specific performance against the time spent on the Acute Stroke Unit has been inconsistent lacking resilience in times of operational pressure. Divisional plans to actively ring fence stroke and other sub-specialty areas will lead to robust consistently good performance in 13/14.

Action	Person Responsible	Timeline	Monitoring Body
Reduce LOS to further reduce bed occupancy and provide increased flexibility to avoid any delay in admission / admission to other wards.	Director of Operations	On-going	Management Board
Review all stroke admissions, outliers and fast track bed availability every day and escalate to senior management team where required.	Stroke Service Manager	On-going	Divisional Board

2. Internal Quality of Service and Workforce Measures

Fractured Neck of Femur

Fractured Neck of Femur Indicators	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Trigger Text	Trigger Point 1	Trigger Point 2
Admission to #NOF ward within 4 hours	86%	78%	64%	40%	49%	56%	> Target is Good	85%	80%
Operation within 36 hours	89%	91%	89%	86%	84%	76%	> Target is Good	85%	80%
Operation within 48 hours	100%	98%	98%	90%	93%	94%	> Target is Good	85%	80%
#NOF Mortality (rolling 12 months)	104.9	91.3	87.7	92.9			< Target is Good	100	105
#NOF Mortality (rolling 3 months)	88.9	92.8	93.8	88.5			< Target is Good	100	105

•There have been measurable improvements in care and service delivery for patients with fragility fractures over the past year. However, the service has experienced challenges in its ability to consistently deliver the service to the standard required to achieve the best practice Tariff, most especially 'operated within 36hours' and "admission to a specialist ward'. In line with national guidelines, the Service has also operated a Joint care since April 2011 with a monthly multidisciplinary group meeting. The increasing volume of fractured NoFs presenting with medical co-morbidities has created significant staffing issues at the ortho-geriatric middle/junior doctor grades for day to day management. The processes around preoperative management of hip fracture cases have been improved with further improvements planned through the monthly multidisciplinary group.

•The achievement of the direct admission to Orthopaedic ward target rely heavily on having a Trust commitment to ring fence beds on Newdigate Ward & Leigh wards. In 2013/14, Fractured NOF patients will continue to be prioritised on theatre lists. Plans for improving the service include:

- Proactive management of trauma lists on days of high volume cases to ensure adequate theatre time for all patients.
- The implementation of an Integrated Care Pathway for fractured NoF patients
- The development of Enhanced Recovery Programme strategies which will increase patient care outcomes and reduce Length of Stay (LoS).
- more proactive discharge planning for all fractured NoF patients

2. Internal Quality of Service and Workforce Measures

Maternity

Maternity Indicators	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Trigger Text	Trigger Point 1	Trigger Point 2
C-Section Rate	32.0%	29.0%	25.0%	22.1%	27.9%	24.8%	< Target is Good	23%	28%
1 to 1 care in labour	80%	85%	83%	83%	84%	84%	> Target is Good	100%	80%
Breastfeeding Initiation	81%	82%	81%	82%	83%	81%	> Target is Good	85%	70%
Women seen by midwife within 12 weeks and 6 days	90%	98%	98%	99%	98%	99%	> Target is Good	90%	80%

- C-Section performance improved in year with the introduction of the Birth Choices clinic and on –going scrutiny of emergency performance. The joint clinical investigation with Commissioners ended and a report was submitted to the Board
- 1:1 Care in labour performance remained at 84% in March 2013. Since this is directly linked to the ratio of midwives to women delivered and peaks in activity, improvement is not expected until recruitment takes place in the coming months. The consultation on the on-call hospital midwifery system to address peaks in activity (Helping Hands Initiative) has been completed and the service is now in place
- Work has been done with all maternity staff to promote breast feeding initiation including placing infant feeding specialists into theatres to assist post C-Section. The Breast Feeding Specialists are available by bleep to improve communication and improvement is expected (the national average is 70%). In a review of the Baby Friendly initiative for which breastfeeding is a key component the Trust was above the national average.
- The refurbishment of the Birthing unit will end in the next few days. The division is currently reviewing the home birth service with an aim to improve the current home birth rate.

Action	Person Responsible	Timeline	Monitoring Body
Improve 1 -1 in established labour - Midwifery audit Real time user reports. Promote use of Birthing Unit	Head of Midwifery and Child Health, Chief Nurse and Medical Director	On-going	Service user reporting sent to Board Develop a trajectory for the BU

2. Internal Quality of Service and Workforce Measures

Clinical Audit and Effectiveness

Clinical Audit and Effectiveness Indicators	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Trigger Text	Trigger Point 1	Trigger Point 2
% of audit programme started	62%	67%	68%	71%	80%	78%	> Target is Good	8% Per Mon	5% Per Mon
% of completed audits with agreed action plans	77%	78%	69%	73%	76%	80%	> Target is Good	90%	75%
No of NICE guidelines without a statement of compliance	2	1	1	0	2	2	> Target is Good	0	1
% of non or partially compliant NICE guidelines	16%	16%	16%	16%	16%	16%	For monitoring		

- The trust once again did not complete 100% of the programme mainly due to new audits being added during the year which changed the priorities of the programme. However there was an improvement over last year in the number of audits which had action plans with the year end figure at 80%.
- For the 2013/14 programme, following the devolving of the audit function to the divisions, it is hoped this will improve the ownership of the programme. Divisions should also once again set realistic programmes based on trust and local priorities as specified in the Clinical Effectiveness Strategy to ensure completion of the programme.
- The number of NICE guidelines without a statement of compliance remains at 2 (Venous Thromboembolic diseases; Sickle Cell Acute painful episode) due to compliance statements not being received from Medicine within the agreed timescales.
- The overall percentage of non or partially compliant NICE guidelines remains static at 16%. Divisions have been reminded to review and update compliance where applicable by mid-March. This was done for WaCH and CSS, however the fact that this figure has remained static suggests that divisions are not regularly reviewing their areas of non-compliance and this will need to be addressed going forward.

Action	Person Responsible	Timeline	Monitoring Body
Review all NICE statements of compliance and provide updates	Divisional Chiefs	March 2013	Quality & Risk Divisional Board
To confirm level of compliance against two outstanding NICE clinical guidelines	Chief for Medicine	March 2013	Quality & Risk Divisional Board

2. Internal Quality of Service and Workforce Measures

Workforce

Workforce Indicators	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Trigger Text	Trigger Point 1	Trigger Point 2
Total Establishment**	3,366	3,371	3,368	3,381	3,382	3,385	Closer to Target is Good	3366 +/-2.5%	+/-5%
Total In post	2,975	3,000	2,981	2,988	3,001	3,004	Closer to Target is Good	2973 +/-2.5%	+/-5%
Vacancy Rate	11.6%	11.0%	11.5%	11.6%	11.3%	11.3%	Closer to Target is Good	10%	12%
Total WTE bank staff	258.1	270.7	243.2	274.1	273.0	342.3	Closer to Target is Good	144	151
Total WTE agency staff	75.3	87.1	104.1	99.6	101.1	110.5	< Target is Good	46	48
WTE Worked - Locum	10.7	14.2	12.4	13.0	13.7	17.4	< Target is Good	16	17
Staff Turnover Rate	15.53%	15.72%	15.51%	15.59%	15.01%	15.47%	Closer to Target is Good	12%	14%
Sickness absence rate	4.51%	4.48%	4.52%	4.59%	4.59%	3.97%	< Target is Good	3.5%	4.5%
% of staff who have completed mandatory training in last 12 months	81.7%	85.8%	87.7%	86.3%	87.7%	89.0%	> Target is Good	80%	70%
% of staff who have completed mandatory training YTD	51.1%	62.2%	70.0%	73.8%	81.3%	89.0%	> Target is Good	80% (FY)	70% (FY)
% of staff who have been appraised in last 12 months	56.5%	64.9%	70.6%	73.2%	76.2%	93.7%	> Target is Good	90%	80%
% of staff who have been appraised YTD	30.5%	41.1%	50.7%	58.8%	69.8%	93.7%	> Target is Good	90% (FY)	80% (FY)

**includes planned contingent workforce (bank agency and locum)

Vacancy rate is difference between total establishment (which includes bank agency and locum) and staff in post – not all establishment will be recruited into to allow for flexibility (planned contingent workforce to be no more than 10% of Total establishment).

- The Trust ends the year having made significant progress in appraisal compliance – at 93% this is the highest since the Trust started reporting this indicator. This is due to a number of interventions by the Education and Training Department and managers prioritising appraisal meetings despite capacity pressures in the hospital.
- The target for completion of mandatory training was achieved in August 2012 and continued to improve each month to year end.
- Sickness absence followed season trends during 2012/13 although largely at lower levels than the previous year. 2012/13 average was 3.7% compared to 4.2% in 2011/12. Top three reasons for absence remain unchanged from 2011/12 ie Gastro problems; Anxiety/stress and Surgery with coughs colds and flu as the 4th most frequent reason for absence.
- Overall staff in post and establishment numbers are in line with our projected plans however actions will continue to be monitored by the Recruitment and Retention group (who now meet weekly)in order to reduce turnover and vacancy levels in nursing areas.

2. Internal Quality of Service and Workforce Measures

Workforce

- Actions to address locum medical staff use have proved effective this year with all but this month and July last year being green. Unfortunately this was not the case for bank staff (red throughout the year) and agency staff (red apart from May and June amber with June green). Priorities for 2013/14 will be to progress actions to improve recruitment and retention identified by the nursing Recruitment and Retention Group and which will drive the reduction in agency reliance (see summary on next page).

2. Internal Quality of Service and Workforce Measures

Workforce

Action	Person Responsible	Timeline	Monitoring Body
Absence Management - Performance management of sickness levels in Divisions at monthly meetings. - Targeted absence management training to managers has been delivered by HR BP's. - On line RTW forms on Firstcare introduced email prompts for follow up meetings and actions enable managers to track staff being managed under Trust policy. Further sessions on use of on line RTW and new functionality in Managers portal within FirstCare.	Chiefs of Service and HR Business Partners	On-going Further sessions during 2013/14 Completed May 2913	Divisional Performance Meetings
Vacancy Level – Nursing - Monthly nursing recruitment days in operation since September. - Overseas event May 2013. - Exit interviews undertaken in high turnover areas by Divisional Chief Nurse and HR Business Partner. - Divisional Chief Nurses have this work as one of their top priorities and are producing a Recruitment & Retention plan with clear timescales as to adverts, interviews and appointments.	Divisional Chief Nurses, HRBP's	On-going May 2013 Recruitment and Retention group now meeting weekly	Recruitment Retention Group
Agency Staff Use/Cost Recruit to all nursing vacancies National and overseas recruitment Block approval to recruit to establishment granted by TDG Membership of NHS South of England Agency Project New starter induction review/leavers questionnaire	Divisional Chief Nurses, HRBP's Deputy Chief Nurse	May 2013 Commenced April 2013 May 2013	Transformation Delivery Group SofE Agency Project

2. Internal Quality of Service and Workforce Measures
Research and Development

Surrey and Sussex NHS Healthcare NHS Trust

Clinical Research Indicators	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Trigger Text	Trigger Point 1	Trigger Point 2
Number of Studies recruiting - all	27	28	27	28	31	34	For monitoring		
Number of studies recruiting - commercial only	2	1	2	2	2	2	For monitoring		
Recruitment target (National Research Portfolio) - Interventional	118	141	151	158	187	205	> Target is Good	205 (FY)	195(FY)
Recruitment target (National Research Portfolio) - Non - Interventional	326	352	362	370	389	412	> Target is Good	318 (FY)	302 (FY)

- High quality national (NIHR) portfolio studies and commercial research studies are our top priority. There is a rigorous and competitive site selection process for all commercial studies. Companies choose sites which are able to ensure prompt study set up and delivery of research recruits. Time to first patient recruited (expected within 30 days of study start up) and ability to reach research targets is monitored at local (CLRN) and national level.

- The Trust currently has thirty one recruiting studies, including two commercial studies (paediatrics and rheumatology). Due to unresolved problems with temperature control in trials medicine storage area within pharmacy, recruitment to the paediatric study cannot start. We are in discussion with sponsors about 3 new commercial studies (cardiology, dermatology and diabetes). Four new non commercial studies opened in February (Paediatrics, respiratory, diabetes)

Contents

3. Action and Risk Log

Risk Log

Risk	KPI's Impacted
Emergency activity in ED and insufficient Medical Emergency bed capacity	ED [A&E], 18 wks(non-admitted), cancelled ops, FNoF, MSA
D&V outbreaks causing ward closures	ED [A&E], 18 wks(non-admitted), cancelled ops, FNoF, MSA
Continued reliance on escalation beds and medical patients being managed in the non medical bed base.	ED [A&E], 18 wks.(non-admitted)
Variable volumes of trauma being admitted at once	FNoF
Registered Nurse and HCA vacancies in the core inpatient wards	Inpatient Quality and Safety measures

Contents

4. Appendices
Glossary of Terms

AMI	Acute Myocardial Infarction
C diff	Clostridium difficile
CDS	Commissioning Data Set
FFCE	First Finished Consultant Episode
H&S	Health and Safety
HSMR	Hospital Standardised Mortality Rates
LOLER	Lifting Operations and Lifting Equipment Regulations 1998
MRSA	Methicillin-Resistant Staphylococcus aureus
RACP	Rapid Access Chest Pain
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
SUI	Serious Untoward Incident
TIA	Transient Ischaemic Attack
WTE	Whole Time Equivalent

4. Appendices

18 Week Waits – Breach Reasons

Admitted Pathways	Cardiology	Cardiothoracic Surgery	Dermatology	ENT	Gastroenterology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology	Neurology	Neurosurgery	Ophthalmology	Oral Surgery	Other	Plastic Surgery	Rheumatology	Thoracic Medicine	Trauma & Orthopaedics	Urology	Total
Patient Choice	**0**	**0**	**1**	**0**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**1**	**1**	**2**	**0**	**0**	**0**	**0**	**0**	**7**
Patient non-cooperation (e.g. DNAs)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Patient chooses to wait longer than reasonable (as defined in local access policy)	0	0	1	0	0	0	2	0	0	0	0	1	1	2	0	0	0	0	0	**7**
Not in the patients best clinical interest	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Capacity	**0**	**0**	**2**	**6**	**0**	**0**	**48**	**0**	**0**	**0**	**0**	**13**	**0**	**40**	**0**	**0**	**0**	**21**	**3**	**133**
Insufficient capacity	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	**2**
Capacity - First appointment	0	0	0	2	0	0	0	0	0	0	0	3	0	5	0	0	0	2	0	**12**
Capacity - follow up	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	4	0	**6**
Capacity - preassessment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Capacity – Theatre	0	0	2	4	0	0	45	0	0	0	0	10	0	35	0	0	0	14	3	**113**
Hospital cancellation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**1**	**2**
Hospital cancellation of Clinic	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**
Hospital cancellation - no theatre	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Hospital cancellation - no beds	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**1**
Hospital cancellation - staff absence	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Diagnostic delay	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Insufficient diagnostic capacity to deliver local standards for diagnostic tests	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Reporting delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Medically not fit	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Medically not fit at pre-assessment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Not fit while awaiting admission	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Process delay	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Paper process delay	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	**1**
Incorrect patient demographics	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Referral vetting delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Postal delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Late transfer from another provider	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other	0	0	0	0	0	0	5	0	0	0	0	1	0	3	0	0	0	0	0	**9**
Total	**0**	**0**	**3**	**6**	**0**	**0**	**55**	**0**	**0**	**0**	**0**	**16**	**1**	**46**	**0**	**0**	**0**	**21**	**4**	**152**

4. Appendices

18 Week Waits – Breach Reasons

Non Admitted Pathways	Cardiology	Cardiothoracic Surgery	Dermatology	ENT	Gastroenterology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology	Neurology	Neurosurgery	Ophthalmology	Oral Surgery	Other	Plastic Surgery	Rheumatology	Thoracic Medicine	Trauma & Orthopaedics	Urology	Total
Patient Choice	**0**	**0**	**2**	**3**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**1**	**2**	**11**
Patient non-cooperation (e.g. DNAs)	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**2**
Patient chooses to wait longer than reasonable (as defined in local access policy)	0	0	1	3	0	0	0	0	0	1	0	1	0	1	0	0	0	0	2	**9**
Not in the patients best clinical interest	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Capacity	**7**	**0**	**7**	**9**	**2**	**0**	**9**	**0**	**2**	**0**	**0**	**12**	**0**	**10**	**0**	**0**	**0**	**13**	**0**	**71**
Insufficient capacity	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Capacity – Theatre	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Capacity - First appointment	7	0	6	4	1	0	6	0	2	0	0	11	0	7	0	0	0	5	0	**49**
Capacity - follow up	0	0	1	5	1	0	3	0	0	0	0	1	0	3	0	0	0	8	0	**22**
Hospital cancellation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**2**
Hospital cancellation of Clinic	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	**1**
Hospital cancellation - no theatre	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Hospital cancellation - no beds	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Hospital cancellation - staff absence	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	**1**
Diagnostic delay	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**0**	**2**
Insufficient diagnostic capacity to deliver local standards for diagnostic tests	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**
Reporting delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**
Medically not fit	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Medically not fit at pre-assessment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Not fit while awaiting admission	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Process delay	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Paper process delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Incorrect patient demographics	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Referral vetting delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Postal delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Late transfer from another provider	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**1**
Other	0	0	1	0	0	0	5	0	1	0	0	1	0	1	0	0	1	0	0	**10**
Total	**7**	**0**	**10**	**12**	**2**	**0**	**14**	**0**	**3**	**1**	**0**	**15**	**0**	**13**	**0**	**0**	**2**	**16**	**2**	**97**