Management Board - 26th June 2013
Trust Board – 27th June 2013

Surrey and Sussex NHS
Healthcare NHS Trust

Integrated Quality and Performance Report (IQPR)

M02 – May 2013

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An Associated University Hospital of Brighton and Sussex Medical School

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Quality and Performance M02 – May 2013

Summary:

- For May 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 target continued to deliver to a performing standard
- An increase in the numbers of patients who are safe to discharge remaining in the hospital has led to a deterioration of DTOC performance in month
- The Trust has achieved all other quality metrics in the DoH performance framework with the exception of Cancer Breast symptomatic , Cancer 62 day from screening 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.

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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. As the performance framework will no longer be used to monitor Trust performance nationally, this page will not be included in this report from month 03.
- For May 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
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**
April 2013	Performing	Performing (2.60)	Performing Under Review	**Performing**
May 2013	Performing	Performing(2.75)	Performing 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 May 2013, the Trust is forecasting an in-month score of 2.75 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	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Trigger Text	Trigger Point 1	Trigger Point 2
ED 95% in 4 hours	92%	95%	95%	94%	92%	98%	> Target is Good	95%	94%
MRSA Incidences - In Month (Trust acquired)	0	1	0	0	0	0	< Target is Good	On plan	1Std Dev
C Diff Incidences - In Month (Trust acquired)	1	4	2	1	3	2	< Target is Good	On plan	1Std Dev
RTT Admitted - 90% in 18 weeks	92.0%	91.1%	91.2%	90.6%	91.3%	91.8%	> Target is Good	90%	85%
RTT Non Admitted - 95% in 18 weeks	95.8%	96.9%	96.8%	96.7%	97.4%	96.8%	> Target is Good	95%	90%
RTT Incomplete Pathways - %age under 18 weeks	94.0%	94.3%	95.0%	95.2%	95.2%	97.2%	> Target is Good	92%	87%
RTT - No of Specialties not achieving standards	4	4	3	2	4	2	< Target is Good	0	20
%age of patients waiting 6 weeks or more for diagnostic	0.99%	0.2%	0.0%	0.0%	0.0%	0.0%	< Target is Good	1%	5%
Cancer - TWR	95.7%	93.8%	96.2%	95.6%	94.7%	93.1%	> Target is Good	93%	88%
Cancer - Breast Symptomatic (2 Week Wait)	98.8%	93.4%	98.7%	97.0%	94.0%	87.5%	> Target is Good	93%	88%
Cancer - 31 Day Second or Subsequent Treatment (SURGERY)	100.0%	96.6%	95.2%	96.6%	96.1%	94.4%	> 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	100.0%	96.9%	99.0%	98.8%	97.3%	97.7%	> Target is Good	96%	91%
Cancer - 62 Day Referral to Treatment from Screening	75.0%	85.7%	87.5%	84.6%	80.0%	85.7%	> Target is Good	90%	85%
Cancer - 62 Day Urgent Referral	88.4%	76.1%	85.4%	91.5%	100.0%	89.0%	> Target is Good	85%	80%
Delayed Transfers of Care (%age of bed days)	2.9%	2.7%	2.2%	1.6%	1.7%	4.7%	< Target is Good	3.5%	5.0%
Mixed Sex Breaches per FCE	0.0%	0.10%	0.0%	0.0%	0.0%	0.0%	< Target is Good	0.0%	0.5%
VTE Assessment on Admission	91.0%	92.7%	93.1%	94.3%	95.5%	96.1%	> Target is Good	90%	80%

1. National Quality of Services Measures
Integrated Measures

Significant points of note regarding performance include:

- ED Performance returned to performing
- There were no incidences of MRSA and two incidence of C-Diff during May
- RTT performance continued as expected with the 90% Admitted, 95% non-admitted and 92% incompletes measures all being achieved in aggregate.
- The delayed transfers of care KPI has underperformed in month. The Trust has been unable to discharge an increasing number of patients who do not require acute care into the community. We are working with our partners in the local health economy to resolve this issue.
- The Cancer Breast symptomatic two week wait target was breached in month due to machine failure

1. National Quality of Services Measures

Integrated Measures - 18 Weeks and Diagnostics

18 weeks and Diagnostics Indicators	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Trigger Text	Trigger Point 1	Trigger Point 2
RTT Admitted - 90% in 18 weeks	92.4%	92.0%	91.1%	91.2%	90.6%	91.3%	91.8%	> Target is Good	90%	85%
RTT Non Admitted - 95% in 18 weeks	96.0%	95.8%	96.9%	96.8%	96.7%	97.4%	96.8%	> Target is Good	95%	90%
RTT Incomplete Pathways - %age under 18 weeks	93.7%	94.0%	94.3%	95.0%	95.2%	95.2%	97.2%	> Target is Good	92%	87%
RTT - No of Specialties not achieving standards	5	4	4	3	2	4	2	< Target is Good	0	20
%age of patients waiting 6 weeks or more for diagnostic	0.6%	0.99%	0.2%	0.0%	0.0%	0.0%	0.0%	< Target is Good	1%	5%

- The Trust continued to achieve the 90% Admitted target in May with two non compliant specialties - General Surgery, and T&O. 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 at the end of May sat at its lowest level of 97 patients.
- The Non-admitted and Incomplete targets were both achieved at aggregate and speciality level in May 2013.
- 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. June will see continued non-compliance in a small number of specialties while backlogs are further reduced
- The diagnostic target was again achieved in May 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	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Trigger Text	Trigger Point 1	Trigger Point 2
Cancer - TWR	95.7%	93.8%	96.2%	95.6%	94.7%	93.1%	> Target is Good	93%	88%
Cancer - Breast Symptomatic (2 Week Wait)	98.8%	93.4%	98.7%	97.0%	94.0%	87.5%	> Target is Good	93%	88%
Cancer - 31 Day Second or Subsequent Treatment (SURGERY)	100.0%	96.6%	95.2%	96.6%	96.1%	94.4%	> 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	100.0%	96.9%	99.0%	98.8%	97.3%	97.7%	> Target is Good	96%	91%
Cancer - 62 Day Referral to Treatment from Screening	75.0%	85.7%	87.5%	84.6%	80.0%	85.7%	> Target is Good	90%	85%
Cancer - 62 Day Urgent Referral	88.4%	76.1%	85.4%	91.5%	100.0%	89.0%	> Target is Good	85%	80%
Mixed Sex Breaches per FCE	0.0%	0.10%	0.0%	0.0%	0.0%	0.0%	< Target is Good	0.0%	0.5%
VTE Assessment on Admission	91.0%	92.7%	93.1%	94.3%	95.5%	96.1%	> Target is Good	90%	80%

- **Following 10 months of sustained delivery the Trust has not achieved the two week breast symptomatic target in month. The The trust has also not delivered against the 62 Screening standard. Compliance with this standard continues to be a challenge due to low number of referrals and patient deferral**
- The Trust performance was below the standard for delivery of breast symptomatic performance due to a machine failure. The problem has since been corrected and all patients rebooked. Preliminary figures in June suggest the Trust will return to Performing in month 03.
- The 62 Day Screening target performance of 85.7% was the result of one 0.5 (bowel screening) breach out of only 3.5 accountable patients due to patient deferral, referral received at trust day 81. 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

1. National Quality of Services Measures

User Experience

Surrey and Sussex Healthcare NHS Trust NHS

User Experience Indicators	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Trigger Text	Trigger Point 1	Trigger Point 2
Friends and Family Test									
Friends & Family Inpatient (Net Promoter Score)	34	31	52	47	48	51	Trigger to be confirmed		
Response Rate - Inpatient	14%	17%	12%	15%	16%	18%	> Target is Good	18%	15%
Friends & Family ED (Net Promoter Score)					3.4%	4.7%	Trigger to be confirmed		
Response Rate ED					46	61	Trigger to be confirmed	18%	15%
Overall response rate						9%	Trigger to be confirmed		
Your Care Matters Inpatients									
Dignity and Respect				8.8	8.9	9.1	> Target is Good	9.7	8.8
Cleanliness of ward				9.2	9.2	9.2	> Target is Good	9.7	8.8
Pain Control				8.5	8.7	8.8	> Target is Good	9.4	8.5
Privacy				9.3	9.3	9.6	> Target is Good	9.5	8.6
Emotional Support				7.7	7.6	8.2	> Target is Good	8.0	7.1
confidence in doctors				8.6	8.6	9.0	> Target is Good	9.7	8.8
Confidence in nurses				8.5	8.5	9.0	> Target is Good	9.5	8.5
Answers patients could understand from nurses				8.2	8.1	9.0	> Target is Good	9.2	8.3
Answers patients could understand from doctors				8.1	7.6	8.3	> Target is Good	9.3	8.4
Hospital Food rating				5.3	5.4	5.8	> Target is Good	5.5	4.6
Number of Commendations				85.0	88.0	121.0			
Your Care Matters - Emergency Department									
Cleanliness of clinic					84.0%	92.0%	Trigger to be confirmed		
User Experience - Patient Opinion									
Patient Opinion - %age that would recommend SaSH	78%	76%	76%	74%	75%	75%	> Target is Good	80%	70%
User Experience - NHS Choices									
NHS Choices - would recommend SaSH	67%	3.5	3.5	3.5	4	4	> Target is Good	5	3.5
Commendations					48	69	Trigger to be confirmed		

- The Friends and Family test scores and response rate for inpatients and ED are due to be reported nationally in July. The Your Care Matters inpatient survey continues to be well received with improvements in all areas of the survey. After six months of collecting data for the survey analysis has identified key measures that are most influential in driving patients friends and family score. Targets for each area have best set using the best performing trusts from the national inpatient survey as a benchmark. Performance on these measures will be reported each month. Data from the survey can be split at divisional and ward level. This will allow the Trust to easily identify areas of good practice from patient feedback as well as areas that may need improvement. Lessons learned and actions taken from the feedback will be shared across all divisions.

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2. Internal Quality of Service and Workforce Measures

Surrey and Sussex NHS Healthcare NHS Trust

Mortality, Readmissions and Safety

Mortality, Readmissions and Safety Indicators	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Trigger Text	Trigger Point 1	Trigger Point 2
Mortality									
HSMR (rolling 12 Months)	90.7	90.7	90.3	90.9			< Target is Good	100	105
HSMR (Rolling 3 Months)	88.6	88.6	90.0	92.0			< Target is Good	100	105
Readmissions									
Emergency Readmission within 3 day of discharge - post Elective	0.2%	0.2%	0.6%	0.5%	0.4%	0.6%	Trigger to be confirmed		
Emergency Readmission within 3 day of discharge - post Non Elect	4.1%	3.8%	3.3%	4.6%	4.6%	3.0%	Trigger to be confirmed		
Emergency Readmission within 30 day of discharge - post Elective	3.0%	1.9%	3.1%	3.4%	3.4%	3.7%	Trigger to be confirmed		
Emergency Readmission within 30 day of discharge - post Non Elect	14.2%	13.6%	13.5%	14.7%	15.5%	14.4%	Trigger to be confirmed		
Other Safety Measures									
No of Never Events in Month	0	0	0	1	0	0	< Target is Good	0	1
Newly acquired Pressure Ulcers (Grade 2 and above)	9	7	8	15	9	13	< Target is Good	15	25
No of falls reported as clinical incidents	75	106	68	87	110	86	< Target is Good	70	80
No of falls resulting in fracture/head injury	1	6	4	1	1	1	< Target is Good	0	1
Number of medication errors resulting in an adverse event	1	1	3	0	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 April showed a SHMI value of 0.94 reflecting deaths are in line with expected
- There has been a slight change 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 no grade 3 or 4 pressure damage in May 2013. Work is on-going with ward and specialist teams to eliminate all avoidable cases.
- The number of falls has decreased in month. The increased level of performance monitoring has lead to a change in the sub categorisation of falls. A clearer picture of the Trust's fall profile is emerging. Previously falls from bed were deemed to be the highest risk factor but falls on mobilising has now also been identified as an area of high risk.
- Review of the falls assessment has been undertaken and adjustments made to include consideration of the patient's footwear, mobility assessment and use of mobility aids. 20 sets of chairs have been purchased to enable alternative seats heights to be provided; trials to determine the best type of movement sensor are being undertaken

2. Internal Quality of Service and Workforce Measures

Infection Control

Surrey and Sussex Healthcare NHS Trust

Infection Control Indicators	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Trigger Text	Trigger Point 1	Trigger Point 2
MRSA Incidences - In Month (Trust acquired)	0	1	0	0	0	0	< Target is Good	On plan	1Std Dev
C Diff Incidences - In Month (Trust acquired)	1	4	2	1	3	2	< Target is Good	On plan	1Std Dev
MSSA (Trust Acquired)	1	1	2	2	1	2	For monitoring		
Hand Hygiene compliance	100%	99%	100%	97%	99%	99%	> Target is Good	100%	95%
E Coli	29	18	17	20	25	20	For monitoring		

- There were no MRSA bloodstream infections (BSIs) and two incidence of C.diff infection during May 2013.
- The Trust is .16 below plan for C. diff and on plan for delivery of the MRSA objective.

- 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

Emergency Department Indicators	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Trigger Text	Trigger Point 1	Trigger Point 2
ED 95% in 4 hours	92.4%	95%	95%	94.0%	89.0%	98%	> Target is Good	95%	94%
Time to Treatment - Median (minutes)	19	18	19	20	22	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)	4.7%	5.0%	5.0%	4.0%	4.7%	4.3%	< Target is Good	4%	5%
Rate of patients leaving without being seen	2.0%	1.7%	1.7%	1.6%	2.2%	1.4%	< Target is Good	4%	5%
Ambulance Handover within 15 mins	36%	36%	36%	38%			Trigger to be confirmed		
Ambulance Handover within 60 mins	97%	99%	99%	99%			Trigger to be confirmed		

- **Performance against the 4 hour target has improved in May and standard achieved.**
- Median time to treatment continues to be maintained at a consistent levels.
- The consultant led clinic's are working well and maintaining the performance for unplanned re-attendance within 7 days .
- Ambulance Handover times have improved considerably in May as the Trust continues to work towards a robust validation process
- Changes in staffing at streaming area have been implemented which has reduce the time of handover and encouraged compliance with the handover button press.
- Internal escalation and utilisation of CDU with a more structured admission process and guidelines is being implemented to support on-going maintenance of targets.

	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	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Trigger Text	Trigger Point 1	Trigger Point 2
Stroke Patients Scanned within 1 hour of Hospital Arrival	31%	58%	64%	57%	50%	58%	40%	> Target is Good	50%	40%
Stroke Patients Scanned within 24 hour of Hospital Arrival	97%	100%	100%	98%	98%	100%	100%	> Target is Good	100%	90%
%age of patients admitted directly to a ASU within 4 hours of arrival	46%	47%	55%	39%	35%	32%	51%	> Target is Good	90%	80%
Stroke - 90% or more of time spent on stroke unit	73%	50%	80%	60%	55%	52%	60%	> Target is Good	80%	70%
Stroke/TIA - High risk TIA treated within 24 hours	87%	79%	81%	74%	63%	71%	50%	> Target is Good	60%	50%
Stroke HSMR (Rolling 12 Months)	102.6	101.3	100.9	105.0	115.0			< Target is Good	100	105
Stroke HSMR (Rolling 3 Months)	89.1	103.3	99.6	103.0	131.0			< Target is Good	100	105

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

- Performance in May against the metrics for Admission to ASU within 4 hours and Patients spending 90% of their time on ASU both show encouraging signs of improvement. The ring-fencing of stroke beds is expected to consolidate this improvement from August onwards.
- The SSNAP audit has now replaced the SINAP national audit. Going forward the ASI metrics will be calculated externally using this data. There is a concern that there may be data disparity between CERNER and SSNA - risk that the Trusts true position may be reported inaccurately. To mitigate this the stroke team will continue to monitor ASI metrics internally.
- The scanning of patients within 24 hours continues with robust performance.
- Stroke/TIA – High risk patients treated within 24 hours – There has been no interruption to the 7 Day service, The division are ensuring the process for bleeping the stoke nurse for suspected stroke is embedded. The Stroke team are reviewing the source of referrals to check any trends in delay.
- Stroke patients scanned within 1 hour of arrival has deteriorated in month. The patient pathway is being reviewed and the process for urgent notification for suspected Stroke is being reinforced amongst all stakeholders
- The Stroke Mortality data for March suggested an unexpected rise and is being investigated. Lead Clinician is auditing but obtaining notes has caused serious delay. Completion planned for no later than 28th June.

2. Internal Quality of Service and Workforce Measures

Fractured Neck of Femur

Fractured Neck of Femur Indicators	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Trigger Text	Trigger Point 1	Trigger Point 2
Admission to #NOF ward within 4 hours	64%	40%	49%	56%	31%	63%	> Target is Good	85%	80%
Operation within 36 hours	89%	86%	84%	76%	81%	78.0%	> Target is Good	85%	80%
Operation within 48 hours	98%	90%	93%	94%	92%	93%	> Target is Good	85%	80%
#NOF Mortality (rolling 12 months)	87.7	92.9	94.4	99.1			< Target is Good	100	105
#NOF Mortality (rolling 3 months)	93.8	88.5	109.2	122.0			< Target is Good	100	105

- There were 59 Fractured NoFs admitted in Month 2. This is higher than the average admission take of 42 over the last 12 months.
- There is evidence to indicate that the pilot to ring fence all emergency T&O beds from May 2013 has improved performance against the admission to orthopaedic ward target. However, the Orthopaedic wards became full to capacity due to the high number of admissions in month. 11 patients were admitted via SAU preoperatively .
- 72% of patients discharged in May following admission with Fractured NoFs attracted Best Practice Tariff.
- 6 patients did not have surgery within 36 hours due to the high amount of variable trauma and insufficient operating time. 49% of all patients were admitted over a 7 day period. The Fractured NoF MDT is proposing the implementation of a Peak Time Escalation Policy with a view to maximizing operating capacity at evenings and weekends when high volume Fractured NoFs are admitted.
- The increase in the mortality rate in HSMR for Stoke and Fnof has triggered an internal process for investigation Each death is being reviewed by the consultants in each specialty determinate the possible cause of the rise in mortality.

2. Internal Quality of Service and Workforce Measures

Maternity

Maternity Indicators	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Trigger Text	Trigger Point 1	Trigger Point 2
C-Section Rate	25.0%	22.1%	27.9%	24.8%	24.0%	18.97%	For monitoring		
1 to 1 care in labour	83%	83%	84%	84%	85%	94%	> Target is Good	100%	80%
Breastfeeding Initiation	81%	82%	83%	81%	83%	83%	> Target is Good	85%	70%
Women seen by midwife within 12 weeks and 6 days	98%	99%	98%	99%	95%	95%	> 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 HOM/DCN has written a strategy to improve the current rate this includes staffing and other actions which improve workflow through the delivery suite. 1:1 care improved in month to 94% as a result of increasing staff's understanding of the definition and other work outline in the strategy.
- 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%). The Trust's performance is in line with the best performing nationally
- .The refurbished Birthing Unit has re opened. 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

Workforce

Workforce Indicators	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Trigger Text	Trigger Point 1	Trigger Point 2
Total Establishment**	3,368	3,381	3,382	3,385	3,456	3,453	Closer to Target is Good	3366 +/-2.5%	+/-5%
Total In post	2,981	2,988	3,001	3,004	2,991	2,999	Closer to Target is Good	2973 +/-2.5%	+/-5%
Vacancy Rate	11.5%	11.6%	11.3%	11.3%	13.5%	13.2%	Closer to Target is Good	10%	12%
Total WTE bank staff	243.2	274.1	273.0	342.3	292.9	267.6	Closer to Target is Good	144	151
Total WTE agency staff	104.1	99.6	101.1	110.5	119.6	99.5	< Target is Good	46	48
WTE Worked - Locum	12.4	13.0	13.7	17.4	12.9	14.5	< Target is Good	16	17
Staff Turnover Rate	15.51%	15.59%	15.01%	15.47%	15.67%	15.12%	Closer to Target is Good	12%	14%
Sickness absence rate	4.52%	4.59%	4.59%	3.97%	3.91%	3.56%	< Target is Good	3.5%	4.5%
% of staff who have completed mandatory training in last 12 months	87.7%	86.3%	87.7%	89.0%	84.5%	80.7%	> Target is Good	80%	70%
% of staff who have been appraised in last 12 months	70.6%	73.2%	76.2%	93.7%	89.9%	87.1%	> Target is Good	90%	80%

**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).

- At 3.56% our sickness absence rate is 20% lower than the same period last year (4.45%). A downward trend in sickness absence rate has been sustained since December 2012 which is statistically significant and indicates the positive impact of the actions identified in the “Measures” slide.
  Surgery continued to be the highest reason for sickness absence in May 2013 with Anxiety/stress/depression/other psychiatric illnesses as the second highest followed by Gastrointestinal problems as the third highest. Days lost and spells for all three reasons however showed a reduction on the same period last year
- Both bank and agency usage reduced in May, although locum use increased in May.
- Turnover fell slightly to 15.12% this should fall further once the impact of the recent nurse recruitment programme in Portugal takes effect.
- Although both mandatory training and appraisal compliance has fallen for the second month, it is too early to say whether this is a trend or the expected monthly fluctuations, this is being closely monitored by Education and Training Staff.

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 2013	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 Recruitment in Portugal – 12 commenced 17/6/13 further 15 commencing 22/7/13 Block approval to recruit to establishment granted by TDG New starter induction review/leavers questionnaire Membership of NHS South of England Agency Project	Divisional Chief Nurses, HRBP's Deputy Chief Nurse	May 2013 Commenced April 2013 May 2013	Recruitment Retention Group SofE Agency Project

2. Internal Quality of Service and Workforce Measures (cont)

Surrey and Sussex Healthcare NHS Trust NHS

Workforce

Action	Person Responsible	Timeline	Monitoring Body
Mandatory Training Compliance - Performance management of compliance in Divisions at monthly meetings. - Monthly reports to HRBP's showing individual service compliance - ETD progressing Core Skills Training Framework – national scheme to 'passport' mandatory training undertaken by staff in other organizations to be recognised by the Trust	Chiefs of Service and HR Business Partners Head of ETD	On-going July 2013	Divisional Performance Meetings
Appraisal Compliance - Performance management of compliance in Divisions at monthly meetings. - Monthly reports to HRBP's showing individual service compliance identifying staff compliance status and dates due.	Chiefs of Service and HRBP's	On-going	Divisional Performance Meetings

2. Internal Quality of Service and Workforce Measures

Research and Development

Clinical Research Indicators	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Trigger Text	Trigger Point 1	Trigger Point 2
Number of Studies recruiting - all	27	28	31	34	34	33	For monitoring		
Number of studies recruiting - commercial only	2	2	2	2	2	3	For monitoring		
Recruitment target (National Research Portfolio) - Interventional	151	158	187	205	15	30	For monitoring	186(FY)	177(FY)
Recruitment target (National Research Portfolio) - Non - Interventional	362	370	389	412	15	31	For monitoring	493 (FY)	468 (FY)

- Recruitment targets for 2013/14 have been agreed at a lower level for interventional and a higher level for non interventional based on expected study activity. Most new studies anticipate low patient recruitment so in order to meet these targets we need to open up a significant number of new studies in 2013/14 and ensure that they all recruit to target. Looking further ahead, we will require additional research support staff (clinical trial nurses/ assistants, pharmacy) in order to raise our annual patient recruitment above the 600 -700 level. Our increasing research income will allow us to do this, if the staff can be accommodated at East Surrey.

Our Priorities for 2013/14 are

- Meet recruitment targets agreed with research networks
- Meet national timelines for approval and set up of new research studies
- increase number of commercial studies supported
- increase number of studies overall at SASH
- develop and strengthen research support services at SASH to facilitate research activity growth

- Non interventional recruitment numbers are below target at present. Investigators responsible for under recruiting studies will be asked to address this and improvement plans will be put in place where required. We are seeking to identify 1 or 2 higher recruiting studies to start within the next 3 months.

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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
Inability to discharge patients who are safe to be released from acute care	ED[A&E], Stroke, FnoF, DTOC
Registered Nurse and HCA vacancies in the core inpatient wards	Inpatient Quality and Safety measures

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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**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
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	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	**1**
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	**2**	**0**	**0**	**5**	**0**	**0**	**45**	**0**	**0**	**0**	**0**	**11**	**1**	**10**	**0**	**0**	**0**	**48**	**4**	**126**
Insufficient capacity	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Capacity - First appointment	2	0	0	1	0	0	4	0	0	0	0	1	0	2	0	0	0	1	0	**11**
Capacity - follow up	0	0	0	0	0	0	5	0	0	0	0	0	0	0	0	0	0	5	1	**11**
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	0	4	0	0	36	0	0	0	0	10	1	8	0	0	0	42	3	**104**
Hospital cancellation	**0**	**0**	**1**	**0**	**0**	**0**	**4**	**0**	**0**	**0**	**0**	**3**	**0**	**1**	**0**	**0**	**0**	**1**	**0**	**10**
Hospital cancellation of Clinic	0	0	1	0	0	0	2	0	0	0	0	3	0	1	0	0	0	0	0	**7**
Hospital cancellation - no theatre	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Hospital cancellation - no beds	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	**2**
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**	**1**	**0**	**0**	**0**	**0**	**0**	**2**
Paper process delay	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	**2**
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	1	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Other	0	0	1	1	1	0	3	0	0	0	0	0	0	2	0	0	0	0	0	**8**
Total	**2**	**0**	**2**	**6**	**1**	**0**	**53**	**0**	**0**	**0**	**0**	**16**	**1**	**14**	**0**	**0**	**0**	**49**	**4**	**148**

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**	**6**	**0**	**0**	**0**	**2**	**0**	**1**	**0**	**0**	**2**	**0**	**3**	**0**	**0**	**1**	**2**	**0**	**17**
Patient non-cooperation (e.g. DNAs)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**
Patient chooses to wait longer than reasonable (as defined in local access policy)	0	0	6	0	0	0	2	0	1	0	0	2	0	3	0	0	1	1	0	**16**
Not in the patients best clinical interest	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**
Capacity	**3**	**0**	**3**	**3**	**0**	**0**	**5**	**0**	**1**	**0**	**0**	**11**	**0**	**10**	**0**	**0**	**0**	**2**	**2**	**40**
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	1	0	0	0	0	0	**1**
Capacity - First appointment	3	0	2	0	0	0	1	0	0	0	0	11	0	5	0	0	0	0	1	**23**
Capacity - follow up	0	0	1	3	0	0	4	0	1	0	0	0	0	4	0	0	0	2	1	**16**
Hospital cancellation	**1**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**
Hospital cancellation of Clinic	0	0	1	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	**3**
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	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Diagnostic delay	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Insufficient diagnostic capacity to deliver local standards for diagnostic tests	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**1**
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**	**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**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Other	0	0	0	2	1	0	1	0	1	0	0	1	0	2	0	1	0	0	0	**9**
Total	**4**	**0**	**10**	**6**	**1**	**0**	**9**	**0**	**3**	**0**	**0**	**15**	**0**	**15**	**0**	**1**	**1**	**5**	**2**	**72**