Surrey and Sussex NHS
Healthcare NHS Trust

Integrated Quality and Performance Report M5– August 2011

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Surrey and Sussex NHS Healthcare NHS Trust

Performance Report M4 - July

Overview:

- This report updates the Board on the key national, contractual KPIs across the Trust for the Month 4 of 2011-12 (July).
- The MRSA and Cdiff targets are cumulative. They have been updated to reflect the YTD position.
- Please note the figures in this report represent a snapshot of information taken at working day 10. The information contained within the report is subject to change when the information is finalized. Where updated information makes a material change to the original reported position this will be noted in the summary section of this report.

Trust Board
Agenda Item:4.1

Trust objective: Please list number and statement. this paper relates to.	**Deliver safe, high quality co-ordinated care;** **Develop an effective organisation**

Action: The Management 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	Not applicable.
Regulation: What aspect of regulation applies and what are the outcome implications? This applies to any regulatory body – key regulators include: Care Quality Commission, MHRA, NPSA & Audit Commission)	Department of Health.

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Contents

Performance Summary

ED

The position in ED has improved in month 5 and we are compliant with the percentage of patients seen under 4 hours KPI. This is partially due to a new arrivals process that came on line 1st August. The new process responds to the need for patients to be seen and assessed by a senior decision making doctor as close to arrival as possible and within the 60 minutes allowed by the quality indicator. Utilisation of a senior doctor with an experienced nurse ensures that patients are seen in the correct area of the department and there is full utilisation of our urgent treatment centre and referral to speciality teams through the assessment areas This has lead to a significant improvement in time to treatment, time to assessment and ambulance handover times. We plan to build on this work though the ED transformation program, embed the new arrivals process and modernise pathways .

It should be noted that we experienced a reduction in attendance at ED for the first 3 weeks in August. The reduction in demand at the front door supported our improved performance and allowed time for the department to assess the efficiency and workability of the new processes.

18 Weeks

For the first time since the switch to the new Cerner we are able to report on a full data set for 18 weeks. However there is still work to be done to ensure the accuracy of the data. The 18 weeks validation team are working hard to validate the backlog and connect pathways.

The Trust is working to a revised plan for 18 week delivery. The original plan developed for 18 weeks was compromised due to two factors.

- Despite long waiting times; patients chose to remain on the Trusts waiting list to be treated in house.
- The level of non-elective activity did not drop off as anticipated after the winter months.

. These 2 issues have had a significant impact on overall capacity within which to deliver 18 weeks and the back log. Q4 and Q1 cancellation levels were at an average of 100 per month, August saw an improvement with cancellation numbers at less than 20. The Trust revised the 18 weeks plan to account for these challenges. Capacity of 501 patients has been removed from the internal plan for the period of August to end of December (to allow for the current level of cancellations). This plan has been submitted and accepted by the PCT and SHA. We are working with partner providers to outsource the backlog. We are also running additional lists on the weekends to create additional capacity for the trust to treat it's backlog. The new plan delivers the 18 week pathway to a sustainable position in November 2011. The biggest challenge we face to that delivery is outsourced providers not feeding back completed pathways in a timely manner.

Stroke

Out of the six accelerated stroke metrics the Trust is currently achieving the target in scan times, high risk TIA and anticoagulation upon discharge. However the Trust is under achieving against the access targets. Achievement of the 90% Stroke indictor is linked with the Trusts ability to increase capacity to allow patients on this pathway to be placed in the same ward. The introduction of the new modular ward later this year should allow Stroke beds to be combined into one ward, the introduction of more capacity in the Trust will allow for more effective bed management and it is expected compliance will increase. However in anticipation of increased activity over the winter months, the Trust forecast for compliance with this target is March 2012

Performance Summary continued…

Fractured Neck of Femur

This month a new indicator has been added to our dashboard. Fractured neck of Femur in under 48 hours. Compliance against that target is the national standard. However the Trust will continue to strive to be compliant with the best practice pathway of Fractured neck of femur in under 36 hours and both KPI's will be included in the performance report. There were 41 patients admitted in month with a fractured neck of femur of which 28 patients were admitted within a 10 day period. As a result compliance against the standard decreased in month. There is now an internal process for identifying patients that are safe to move from the orthopaedic unit to make capacity for identified # NOF patients in ED. The process needs further focus to ensure that it becomes embedded as normal practise and will depend on the efficiency of communication between the clinical site team, ED and the orthopaedic unit. The clinical operations meetings are the forum for monitoring compliance with the process and for flagging blocks / challenges to delivering it.

Patient Experience

For the past year the Trust has been collecting patient experience data through held devices and kiosks located on wards. This real time monitoring information has allowed us to address patients queries and concerns faster and set action plans in motion to affect change. We now have a baseline of local data that will be the starting point from which we will measure improvement. New targets have been set for the patient experience KPI's that will be reviewed every 6 months to ensure contiguous improvement.

Contents

- Indicators used for external assessment

		Data Quality	Performance		Direction of Travel vs. Plan	Monthly Trend						Quarterly Trend			
			Target	YTD Actual	▲=above plan ►=on plan ▼=below plan	March	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Q1 2011/12	Q2 2010/11	Q3 2010/11	Q4 2010/11
	Operating Framework														
Quality	A&E time to initial assessment(95th percentile)		<15	150	▲	new metric for 2011/12	225	180	161	101	150				
	A&E time to initial assessment (median)		N/A	16		new metric for 2011/13	22	22	19	16	16				
	Time to Treatment (median)		<60	45	▼	new metric for 2011/12	78	68	53	60	45				
	Total time in A&E admitted (95th percentlie)		240	831	▲	new metric for 2011/12	997	970	1029	1067	831				
	Total time in A&E non-admitted(95th percentlie)		240	241	▲		442	353	294	410	241				
	% of patients in A&E under 4 hours		95%	86.8%	▼	81.9%	81.1%	85.9%	86.2%	84.7%	95.1%		95.0%	93.0%	90.7%
	number of of patients in A&E over 12 hours (trolley waits)		0	7	▲	3	0	0	7	0	0		0	11	3
	A&E Unplanned Re-attendance rate (within 7 days)		<5%	5.7%	▲	new metric for 2011/12	4.6%	5.4%	7.4%	5.5%	5.6%				
	Left without being seen (LWBS) Rate		<5%	2.7%	▼	new metric for 2011/12	3.4%	2.6%	2.6%	2.8%	2.0%				
	A&E Attaendances (Number of Type 1 attendances)		N/A	27892		4469	4248	5271	5314	6856	6203				
	Emergency Readmissions within 30 days of discharge		TBD	3.2%		2.9%	2.8%	3.0%	3.3%	3.6%	3.0%				
	MRSA (trust acquired)		1.7	2	▲	0	0	0	1	1	1	1	1	1	1
	C Diff (trust acquired)		20.8	18	▼	8	3	2	2	8	3	7	14	19	18
	MSSA (trust and community acquired)		N/A	26		new metric	5	2	5	7	7				
	*E. Coli		N/A	16		new metric for 2011/13	Data Missing	Data Missing	3	6	7				
	18 weeks RTT admitted - 95th Percentile @		<=23	42	▲	32.0	Data Missing	Data Missing	48.0	42	42			25	32
	18 weeks RTT - non-admitted including audiology (DAA)- 95th percentile @		<=18.3	39	▲	20.0	Data Missing	Data Missing	36.0	39	46			16.7	20
	RTT - incomplete - 95th percentile		<=28	38	▲	26.0	Data Missing	Data Missing	Data Missing	38	38			23	26
	Median wait times -non-admitted		N/A	10		4.0	Data Missing	Data Missing	9.0	10	11				
	Median wait times - admitted		11.1	13	▲	14.0	Data Missing	Data Missing	15.0	13	14			12	13
	RTT - incomplete -median		7.2	8	▲	7.0	Data Missing	Data Missing	Data Missing	8	8			8	7
	RTT - admitted 90% in 18 weeks		90%	62.9%	▼	74.9	#VALUE!	#VALUE!	61.1%	62.9%	60.1%		90%		
	RTT - non- admitted 95% in 18 wks		95%	79.0%	▼	92.1	#VALUE!	#VALUE!	88.0%	79.0%	69.9%		97%		
	2 week GP referral to 1st outpatient		93%	94.6%	▲	95.2%	96.2%	94.1%	94.8%	94.1%	94.1%	95.0%	91.1%	91.7%	92.4%
	2 week GP referral to 1st outpatient - breast symptoms		93.0%	92.3%	▼	93.9%	93.4%	98.5%	93.1%	94.2%	83.5%	94.7%			
	31 day second or subsequent treatment (surgery)		94.0%	95.5%	▲		88.9%	92.0%	100.0%	96.3%	100.0%	94.4%			
	31 day second or subsequent treatment (drug)		98.0%	100.0%	▲		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
	31 day diagnosis to Treatment		96.0%	99.3%	▲		98.7%	98.7%	100.0%	100.0%	98.7%	99.2%			
	62 days urgent referral to treatment of all cancers		85%	86.49%	▲	84.5%	86.7%	82.9%	88.4%	87.6%	85.6%	86.35%	88.4%	88.7%	88.2%
	62 wait first treatment from Consultant screening		90%	100.0%	▲	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
	Mixed Sex Accommodation		0	55	▲	10	10	26	9	7	3				
	Patients that have spent more than 90% of their stay in hospital on a stroke unit		80%	62.3%	▼	54.0%	59.5%	69.7%	69.0%	50.0%	63.6%				
	Fractured Neck of Femur <36		85%	62.9%	▼	73.3%	59.1%	76.7%	64.3%	68.4%	50.0%				
	Fractured Neck of Femur <48		85%	76.9%	▼	83.0%	80.0%	80.0%	78.0%	84.0%	66.0%				

Indicators used for external assessment

		Data Quality	Performance		Direction of Travel vs. Plan	Monthly Trend						Quarterly Trend			
			Target	YTD Actual	▲=above plan ►=on plan ▼=below plan	March	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Q1 2011/12	Q2 2010/11	Q3 2010/11	Q4 2010/11
Resources	Delivery of Savings Plan		N/A	1551			260	382	616	293	542				
	Financial Position (£,000)		N/A	-3,820		£215	£320	-3507	380	-93	-920				
	Outcomes framework														
Effectiveness	HSMR		100	98.2	▼	74.5	93.4	Data reported in arrears	Data reported in arrears	Data reported in arrears	Data reported in arrears				
	2 wks rapid access chest pain		100%	100%	►	100.0%	100.0%	98.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	**PPCI 150 min call to ballon time		95%	100.0%	▲	100.0%	**N/A	**N/A	100.0%	Data reported in arrears	Data reported in arrears				
	PPCI 120 min call to ballon time		60%	100%	▲	33.0%	**N/A	**N/A	100.0%	Data reported in arrears	Data reported in arrears				
	Stroke/TIA treated within 24 hours		60%	82.3%	▲	75.0%	90.0%	80.0%	85.7%	80.0%	76.9%				
Patient Experience	% of patients surveyed who would choose to be treated at SASH in Future		75%	N/A	▼	94.0%	73.0%	64.0%	71%	73%	74.0%				
	% of patients surveyed that staff treated them with kindness and respect		70%	N/A	▲	78.0%	78.0%	65.0%	78%	81%	80.0%				
	% of patients surveyed who felt their dignity was maintained the whole time they were a patient		70%	N/A	▲	89.0%	76.0%	70.0%	74%	74%	76.0%				
Safety	Newly acquired Pressure Ulcers (grade 2 and above)		85	82		21	16	23	17	15	11				
	Number of falls reported as clinical incidents		73	139	▼	20	18	48	29	24	20				
	Number of medication errors resulting in an adverse event		0	2	▲	4	0	0	0	2	0				

Notes:

*We are not yet aware of any algorithm for attributing these(E.Coli) cases. So in the short term we have adopted the normal BSI algorithm using pre and post 48 hours of admission. These figures may change

**There were no PPCI's performed in month

Indicators used for Internal assessment

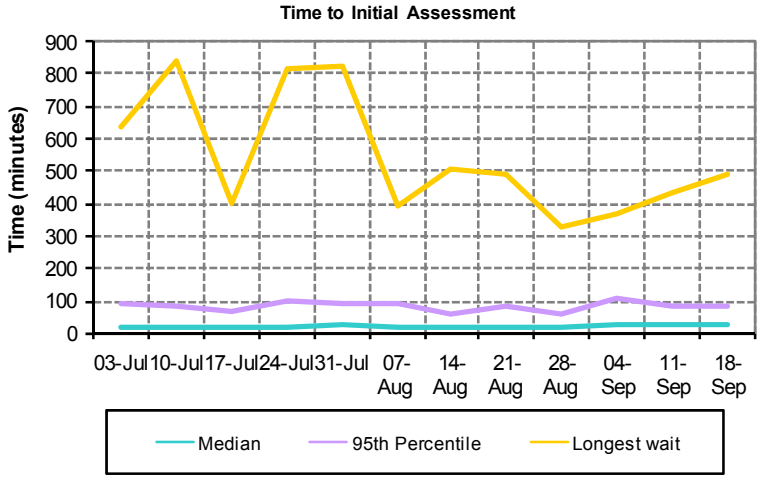
		Data Quality	Performance		Direction of Travel vs. Plan	Monthly Trend						Quarterly Trend			
			Target	YTD Actual	▲=above plan ►=on plan ▼=below plan	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Q1 2011/12	Q2 2010/11	Q3 2011/12	Q4 2011/12
	Safe, High Quality Coordinated Care														
Clinical Quality	VTE Risk Assessments		90%	60.7%	▼	41.0%	50.5%	47.7%	57.3%	64.8%	71.1%				
	Number of falls resulting in a fracture/head injury		0	7	▲	2	1	1	1	3	1				
	% of Stroke patients Scanned within 1 hour of hospital arrival		50%	49%	▼	29.0%	43.2%	32.1%	57.9%	55.6%	70.0%				
	Unplanned Readmissions within 14 days					2.1%	1.9%	2.3%	2.3%	2.5%	2.4%				
	Unplanned Readmissions within 30 days					2.9%	2.8%	3.0%	3.3%	3.6%	3.0%				
	% of SUI's due to be closed in month that were closed			N/A		new metric for	0.0%	0.0%	100.0%	0.0%	71.4%				
	Number of Never events reported		0	2	►	0	0	0	2	0	0				
	% Complaints responded to within agreed timeline with complainant/ 25 working days		85%	88%	►	89.8%	90.0%	89.6%	86.4%	88.6%	86.5%				
Maternity	**C-section rate		23%	29.6%	▼	32.7	31.9%	30.5%	28.3%	30.9%	26.3%				
	% of women seen by a midwife or healthcare professional at 12 wks 6dys		90%	89.8%	▼	93.8%	91.1%	84.5%	89.6%	91.4%	92.8%				
	Breastfeeding initiation		90%	80.6%	▼	83.7	77.9%	80.4%	82.0%	81.4%	81.4%				
Infection Control	Hand Hygiene compliance		99%	98.4%	▼	99.6%	97.6%	98.2%	99.3%	97.9%	98.9%				
	MRSA screening compliance (nonelective)		100%	102%	►	102.0%			102.00%	Data Reported Quarterly	Data Reported Quarterly				
	MRSA screening compliance (elective)		100%	118%	▲	118.0%			124.00%	Data Reported	Data Reported				
Productivity and effectiveness	**% of cancelled operations not treated within 28 days		<=5%	7.3%	▲	8.3%	11.1%	0.0%	14.3%	7.3%	0.0%				
	cancelled operations as a percentage of elective admissions		<=0.80	1.7%	▲	2.1%	2.5%	0.8%	1.6%	2.0%	1.7%				
	Daycase Rate		TBD				80.4%	81.1%	79.3%	79.6%	81.6%				
	Average LOS non-Elective		TBD	5.3			4.1	6.0	6.3	4.7	9.4				
	Average LOS Elective		TBD	3.5			3.6	4.3	3.0	3.1	3.4				
	Delayed Transfers of Care		3.5%	1.84%		2.10%	1.81%	2.13%	1.91%	1.56%	1.88%				
	Excess follow ups		N/A			1386	1064	1082	1111	879	985				
Workforce	Vacancy Rate		<=10%	10.7%	▲	9.8%	9.9%	10.0%	10.1%	10.7%	10.4%				
	Total Establishment		N/A	3204		3136.3	3156	3165	3167	3198	3204				
	Total in post		2766	2854	▲	2829	2,845	2848	2848	2855	2872				
	Sickness absence rate		<=3.0%	4.1%	▲	4.4%	3.8%	3.6%	4.0%	4.4%	4.5%				
	Total WTE Bank Staff (excluding extra capacity nursing)		<=210	244.0	▲	240	231.0	209.0	223.0	286.4	268.2				
	Total WTE Agency Staff (excluding extra capacity nursing)		<=40	46%	▲	59	52.0	34.0	53.0	44.2	67.1				
	% of staff who have completed stat and mandatory training (YTD cumulative position in mth)		***33.3%	34%	►	new construction	6%	13%	22%	29%	34%				
	% of staff who have been appraised (YTD cumulative position in mth)		***37.5%	69%	▼	new construction	2%	4%	13%	30%	69%				
Audit	% of audits on audit program started		50%	46.0%	▼	New Metric	N/A	N/A	29.3%	45.8%	46.0%			New Metric	
	% of completed audits with agreed action plans		100%	24.0%	▼	New Metric	N/A	N/A	3.3%	21.5%	24.0%			New Metric	
	# of nice guidelines without a statement of compliance		0	23	▼	New Metric	24	25	30	23	23			New Metric	
	% of non or partially compliant nice guidelines		10%	15%	▲	New Metric	0%	0%	0%	0%	15%			New Metric	

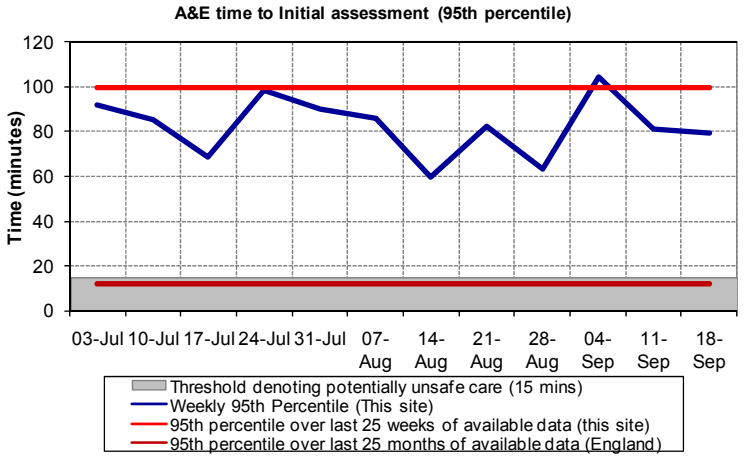
* data as of 16/08/2011
** exception reports provided on a quarterly basis

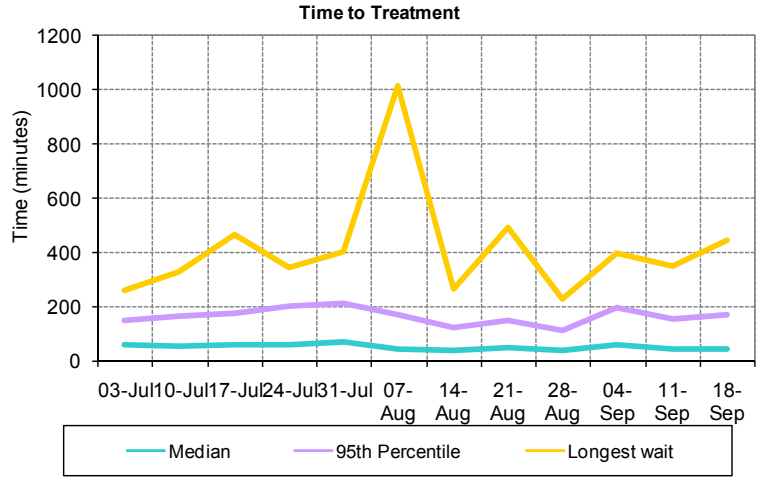
****Target is cumulative

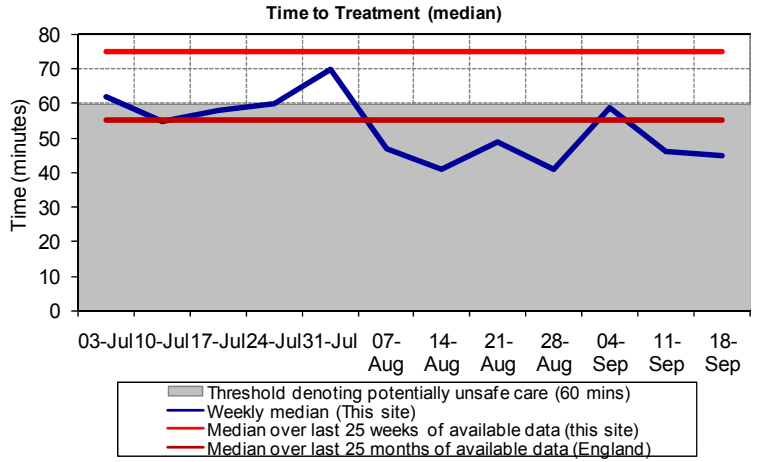
Contents

2. Performance Quality Indicators Graphs (A&E)

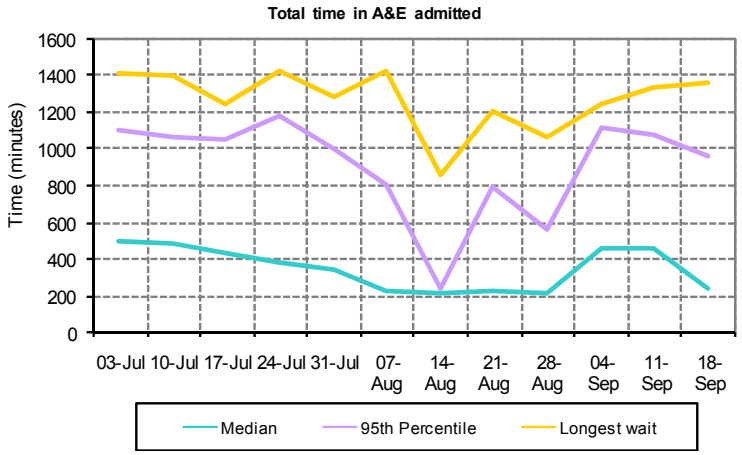


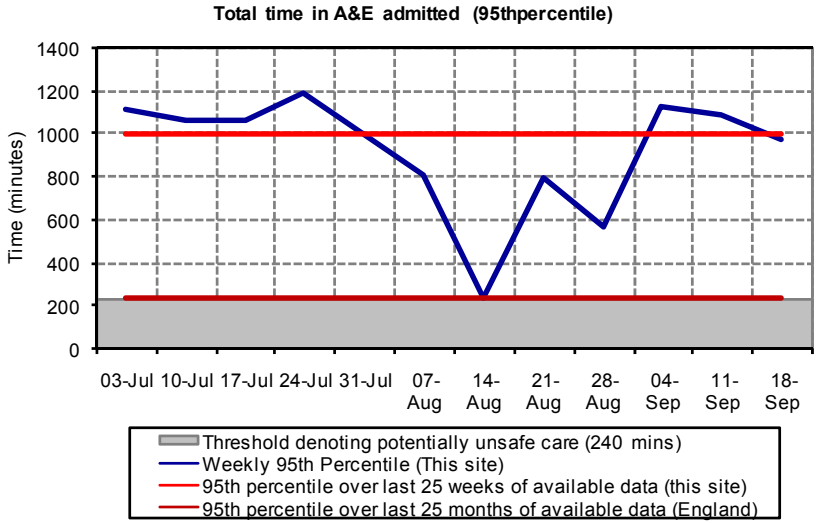


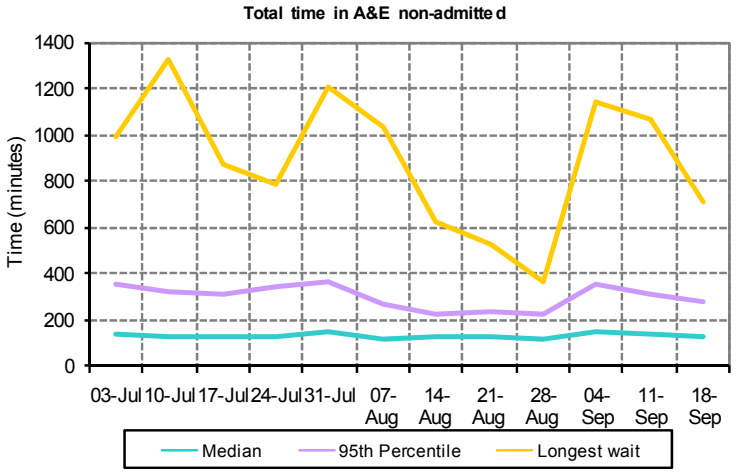


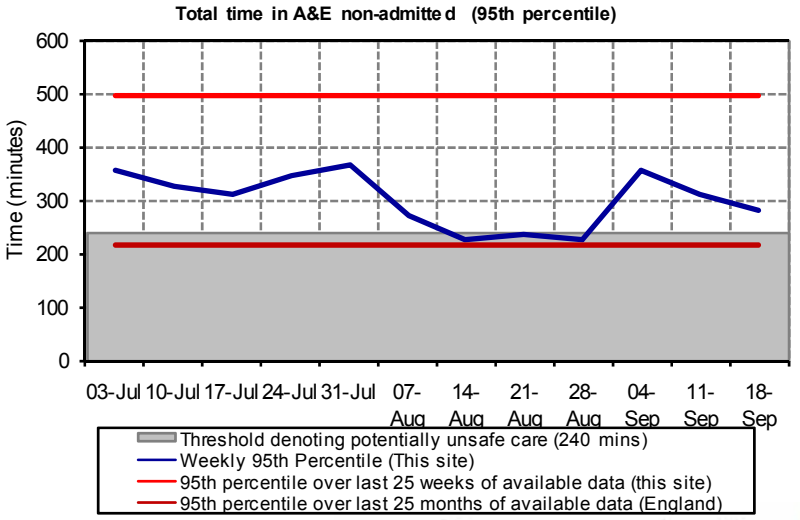


Performance Quality Indicators Graphs (A&E) continued…



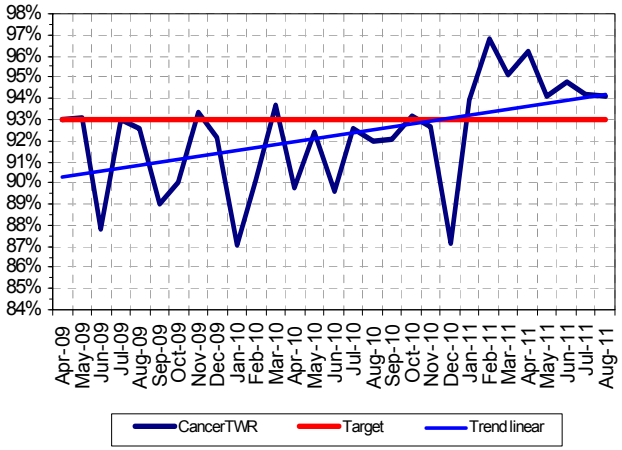




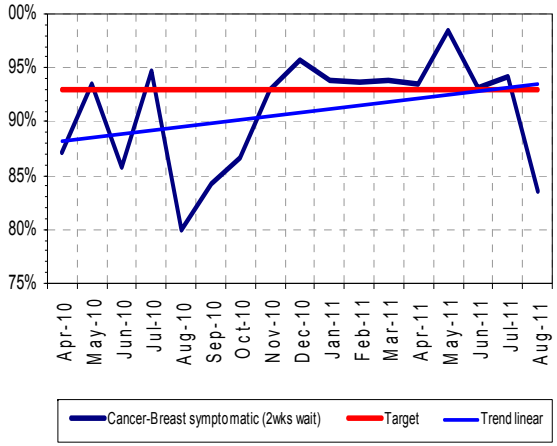


Charts for Performance Quality Indicators (Cancer Access)

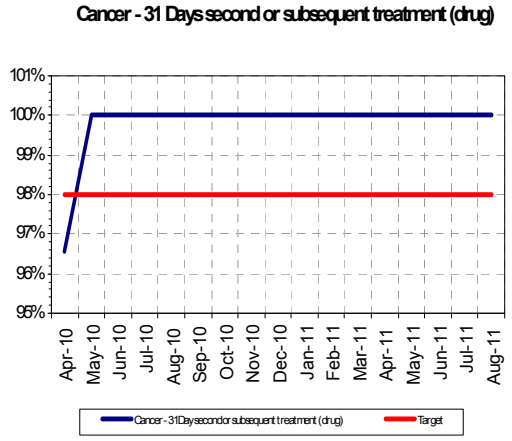
Cancer TWR vs. Target



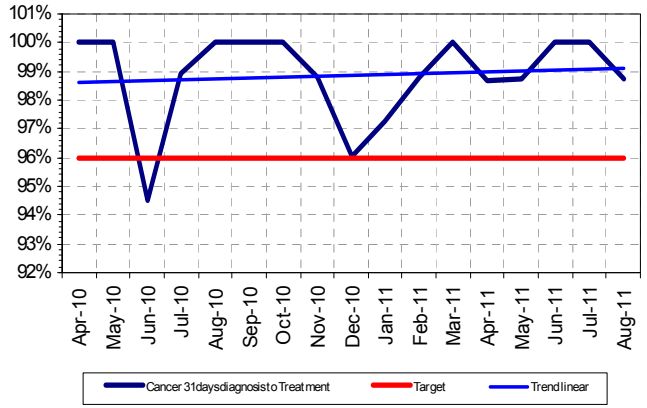
Cancer-Breast symptomatic (2wks wait) vs. Target



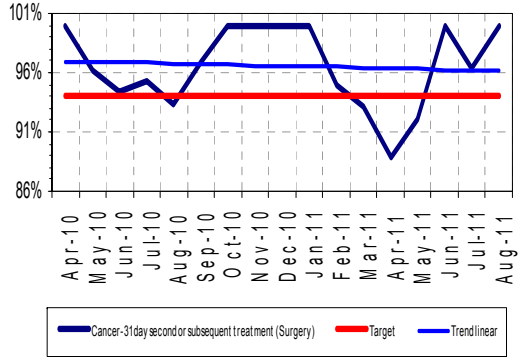
Cancer - 31 Days second or subsequent treatment (drug)



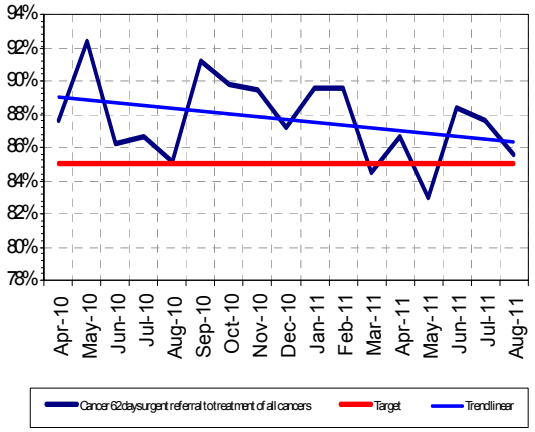
Cancer 31 Days Diagnosis to Treatment



Cancer - 31 Days second or subsequent treatment (surgery)



Cancer 62 Days urgent referral to treatment of all cancers



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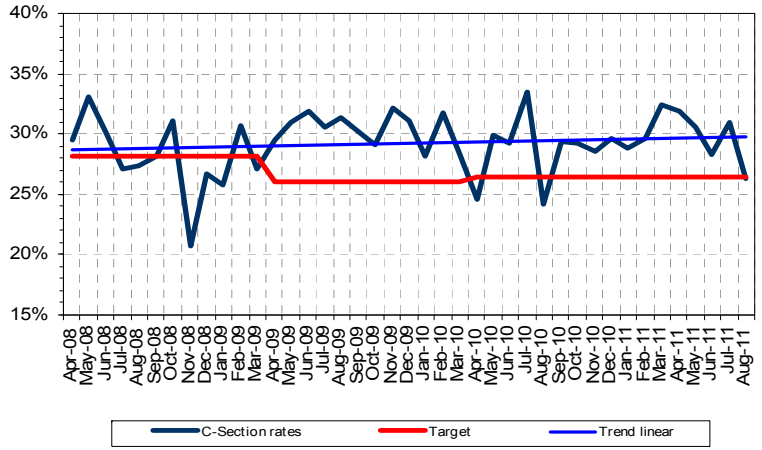
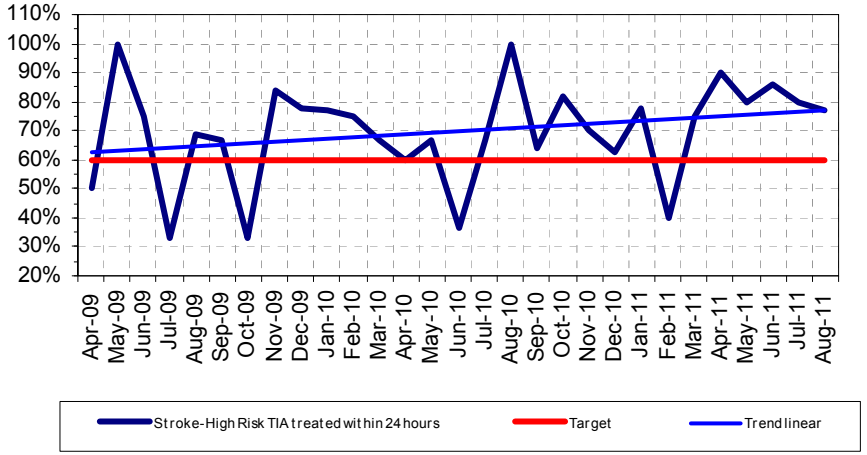
3. Charts for performance exception areas

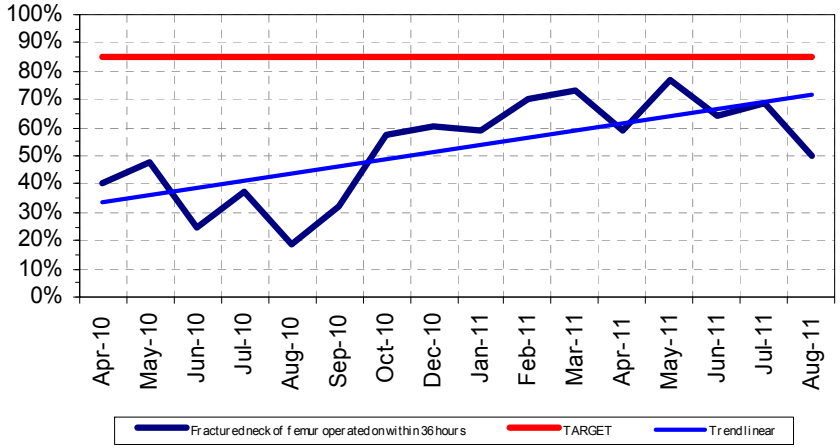
C-Sections



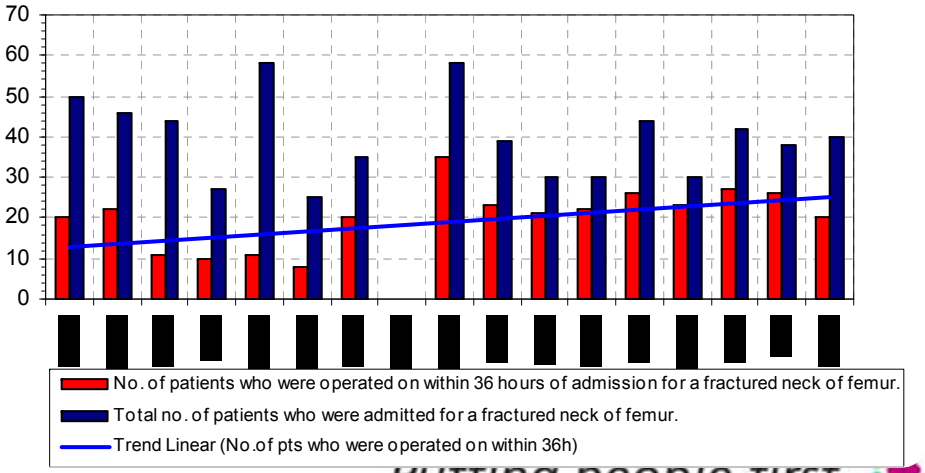
High Risk TIA treated within 24 hours



HIP Fracture operated on within 36 hours(%)



HIP fracture operated on within 36H



Performance Exception Report

Surrey and Sussex NHS Healthcare NHS Trust

Division/Clinical Service:	Medical Division Emergency Department.	
Key Performance Indicator:	95% of patients seen and treated in under 4 hours in ED	XXX

Standard	Current Months Perf.	YTD Perf.	Trend from previous month	Expected date to meet standard	Named Responsible Lead
95%	95%	87%	▲		Paula Tooms

What is Driving the Reported Under Performance

Acheivement of the targets is strongly linked to the capacity and flow of patients through the trust. Failure to allocate beds to DTA's causes a backlog of patients to build up in ED which then impedes the flow and capacity of the department to see and tr

Actions to improve performance

Num.	Action	Named Lead	New Action	Ongoing Action	Expected Completion date	Outcome
1	ED first 4 hours workstream	Carlos		x	30th October	
2	Internal review of weekly metrics to identify changes in performance that are inconsistent with expectation and provide action plans or rationale for change, then implement action plan if required.	Paula Tooms		x	continuous	implemented
3	Medical directorate implementation of Urgent Care Leads to provide access for consultant advice from GP's	Ben Mearns			Completed	implemented
4	Intergration of UTC with ED, review of patient activity and selection to support ED flow.	Paula Tooms		x	Oct-11	
5	Internal refurbishment of department to facilitate improved streaming and working space, increase assessment and treatment capacity.F	Paula Tooms		x		phase 1 commenced
6	commencement of phase 1 of refurbishment according to schedule. Observation bay closed, Clinical Descion Unit open with 6 beds.					

Actions for next month

Ongoing actions from ED workstream cover Arrivals, Majors,Observation Unit, Consultant Job Planning, recruitment, revising of rotas and continued review of metric's.

1st August implement new junior and middle grade rotas. Commence new workflow streaming for patients through the department, with triage, arrivals, treatment process.

complete review of UTC activity and demand, matching to staffing need, medical, ENP and NP's. Middle grade rota not implemented in August, is now nearing completion, aim to implement in October. Pattern agreed with

Support from the Corporate Services

Imformation and IT support with data collection and validation process, also Cerner support following intergration of UTC with ED.

Risks

Continued lack of capacity with Trust

Other KPI's Affected

Ref No.	Description
	ED quality indicators are now broken down into several area's, one's linked to time are all potientially affected due to delays being cascaded once we have accumulated them.

Performance Exception Report

Surrey and Sussex NHS Healthcare NHS Trust

Division/Clinical Service:	Surgical Division/Cancer Services	
Key Performance Indicator:	Breast Symptomic two week wait	XXX

Standard	Current Months Perf.	YTD Perf.	Trend from previous month	Expected date to meet standard	Named Responsible Lead
93%	84%	92%	▼		Hamish Wallis

What is Driving the Reported Under Performance

13 out of 92 patient referred to the breast symptomic clinic were not seen within two weeks (5 - Pt declined one OPA, 2 Pt's declined 2 or more OPA, 2 pt's deferred due to being on holiday and 4 pt's cancelled their agreed OPA), due to consultant leave

Actions to improve performance

Num.	Action	Named Lead	New Action	Ongoing Action	Expected Completion date	Outcome
1	Agree additional clinics to reduce waiting time to 1 weeks	Andrea Francis	X		30/09/2011	
2						
3						

Actions for next month

Agree additional clinics to make up for lost capacity and bring waiting lsit back down to 1 week

Continue to monitor leave management

Support from the Corporate Services

Risks

Bank Holidays, Winter Pressures, Annual Leave

Other KPI's Affected

Ref No.	Description
	None

Performance Exception Report

Surrey and Sussex Healthcare NHS Trust

Division/Clinical Service:	Medical Division, Stroke
Key Performance Indicator:	Stroke 90% or more time spent on Stroke Unit

Standard	Current Months Perf.	YTD Avg Perf.	Trend from previous month	Expected date to meet standard	Named Responsible Lead
80%	63%	62%	▲	Apr-12	Natasha Hare

What is Driving the Reported Under Performance

Achievement of the 90% indicator is strongly linked to the emergency patient flow pathway and associated actions relating to bed management and effective and timely discharge. ED performance in August greatly improved and positively impacted on the stroke pathway. Current performance is on track to get us back to forecast by the end of next month.
The second chart below shows the target failure reasons for 11 of the patients discharged in August; it may have been possible to avoid 6 of these if the issues had been escalated earlier. A new process (action 8) will be introduced in September to see if escalating the matter early has a positive impact.
Comprehensive KPI data is discussed at the fortnightly Stroke Management Team meetings and shared with ward staff, to ensure they are aware of current performance and issues.

Actions to improve performance

Num.	Action	Named Lead	New Action	Ongoing Action	Expected Completion date	Outcome
1	Outlying patients are reviewed daily and repatriated as soon as clinically appropriate.	Natasha Hare		X	Ongoing	
2	Locum consultant on Capel ward appointed until a substantive appointment is made. Job description for the substantive post has received College approval. Interviews due 27-Sep-2011.	Natasha Hare		X	30-Sep-11	
3	West Sussex Early Supported Discharge pilot underway (too early for results and under threat due to funding cuts).	Fiona White (NHS West		X	30-Sep-11	
4	Ring-fence beds on Abinger ward to be used for Stroke patients only and monitor impact on a weekly basis	Natasha Hare		X	Ongoing	
5	East Surrey Early Supported Discharge pilot started July 2011 - review impact at end September.	Robyn Davies (NHS Surrey)		X	30-Sep-11	
6	Introduction of Medihome / virtual ward / early discharge in July 2011 - review impact by end of September.	Bernie Bluhm		X	30-Sep-11	
7	Improve KPI data available at ward level to ensure staff are aware of current performance and issues.	Natasha Hare		X	Ongoing	
8	Introduction of formal daily breach report (informal process already exists). Stroke nurses to complete and stroke manager to be contacted on each admission that cannot go direct to ASU.	Natasha Hare	X		Ongoing	

New actions for next month

Action 8 - Introduction of daily breach report

Support from the Corporate Services

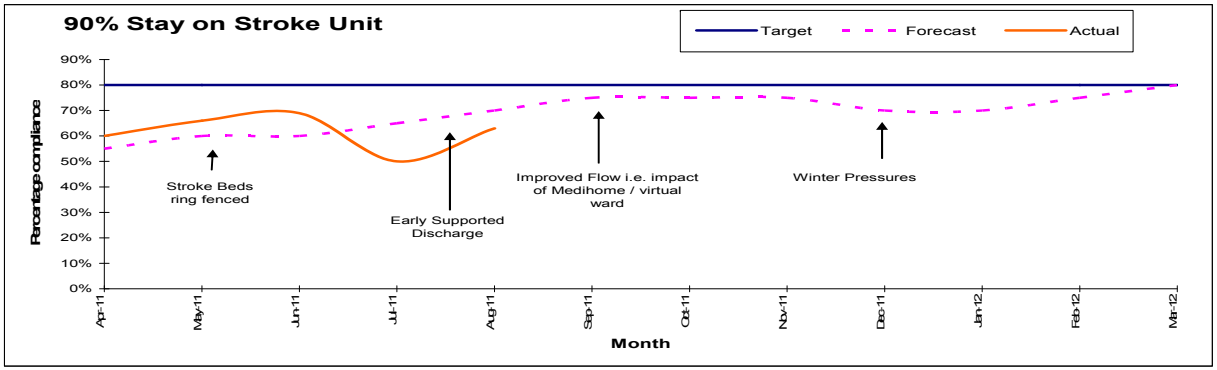
Support ring fenced beds. Outliers are actively discussed and managed at the daily site meetings.

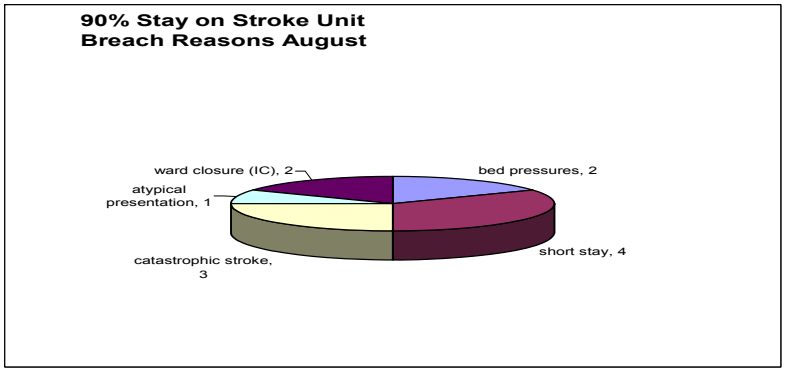
Risks

D&V outbreaks resulting in ward closures
Emergency admission pressures.

Other KPI's Affected

Ref No.	Description
	% of patients admitted directly to ASU within 4 hours of hospital arrival
	Achievement of best practice tariff





Performance Exception Report

Surrey and Sussex Healthcare NHS Trust

Division/Clinical Service:	Surgical/ 18 weeks (Admitted Pathway)		
Key Performance Indicator:	90% of all Admitted pathway patients treated within 18 weeks	**KPI Ref No:**	XXX

Standard	Current Months Perf.	YTD Perf.	Trend from previous month	Expected date to meet standard	Named Responsible Lead
90%	60%		▼	Nov-11	Hamish Wallis

What is Driving the Reported Under Performance

Historical backlog of patients caused by: Referral demand in excess to commissioned activity, Theatre efficiency, Bed Pressures - on the day/day before cancellation due to non-availability of beds (28 in May), Late decision making with regards to DTA from the Non Admitted Pathway, Annual Leave Management – historically this has been poorly managed. The Trust is now in a position where the total waiting list for the Admitted Pathway is double the desired size (including 1300 patients over 18 weeks). In order to bring the waiting list down to the desired level and clear the backlog agreement has been reached with the PCT's and SHA for the trust to underperform on 18 weeks in Quarter 1 and 2.
An update meeting took place with our Principle PCT and the SHA at which it was agreed to submit a revised realistic plan based on current capacity issues. The new plan moves compliance back a month to the end of November 2011

Actions to improve performance

Num.	Action	Named Lead	New Action	Ongoing Action	Expected Completion date	Outcome
1	Agree plan (**in place**) and monitoring with PCT's and SHA for clearance of backlog (using IST modelling) - weekly/monthly monitoring forum to be established. **Monthly monitoring with the PCTS at the Capapcity Meeting**	Bernie Bluhm		X	ongoing	Monthly monitoring
2	Outsourcing - continue to outsource and monitor performance against plan	Hamish Wallis		X	On going	agreements in place (465 pts Rx YTD)
4	review and implement Trust Access policy	Hamish Wallis		X	30/09/2011	on going
5	18 week dashboard to be implemetned and updated on weekly basis - enabling trust to report performance	Clinton Krynie		X	~~01/07/2011~~ 19/09/2011	dashboard now active

Actions for next month

Reviewing process as to how to get infomration back quicker from Outsourced providers
Complete validation of Admitted pathway
Dashborad: complete missing data on dashboard and make adjustments requested by PCT's
Attendance at Pan Sussex 18 week Board meeting
Implement changes to Pre assessment and elctive pathway

Support from the Corporate Services

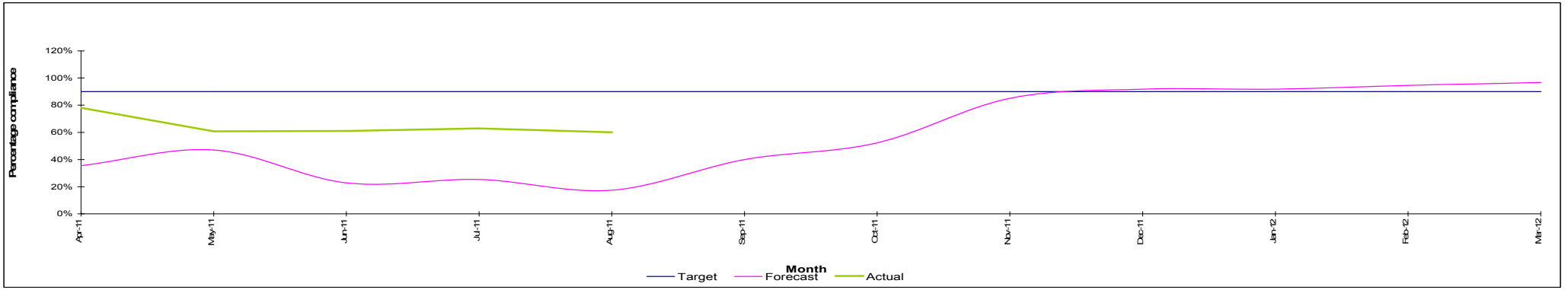
Informatics - Accurate and timely reporting of 18 weeks

Risks

bed pressures - demand for beds from the emergency flow results in elective patients being cancelled
reduce income for elective activity due to cancellation of internal activity due to capacity - lack of ability to make up lost capacity (other than by outsourcing)

Other KPI's Affected

Ref No.	Description
	Non Admitted Pathway performance
	Median Waiting times
	Cancelled ops(non clincal reason) not treated within 28 days



Performance Exception Report

Surrey and Sussex NHS Healthcare NHS Trust

Division/Clinical Service:	Surgical Division/#NOF
Key Performance Indicator:	85% of #NOF operated on within 48 hours

Standard	Current Months Perf.	YTD Perf.	Trend from previous month	Expected date to meet standard	Named Responsible Lead
85%	66%	76.9%	▼	Oct-11	Hamish Wallis

What is Driving the Reported Under Performance

Of the 38 patients admitted this month 1 patient died within hours of her admission to hospital secondary to multiple co morbidities, 1 patient who was admitted to SSDU was never fit for surgery due to the complexity of her medical problems

Actions to improve performance

Num.	Action	Named Lead	New Action	Ongoing Action	Expected Completion date	Outcome
1	Ensure order of list is agreed and set the night before with #NOF patient first on list	Sally Paterson		x	01/07/2011	complete - needs to be audited
2	Sunday Trauma list to run for 6 hours starting at 10.30am - Medical teams have agreed, this needs to go into new specialty Doctor contract, Theatre nursing rota now this cover session	G Tselentakis		X	01/08/2011	Now in place
3	Transfer Trauma list from white Board to Electronic system within Cerner - resulting in better management of lists and accessablity of list	Hamish Wallis		X	30/07/2011	part complete, currently using electronic spreadsheet
4	Implementation of action plan following the Moran Review	G Tselentakis		X	30/08/2011	on-going

Actions for next month

Trauma meeting move to Theatre seminar room (refurbishment work to be completed in September)

Demand and Capacity review of Trauma to be undertaken - so that capacity can be set correctly and contigency for changes in demand can be meet.

Establish effective escalation system for patients who are fit for surgery but unlikely to be operated on with 48hrs

Reduce number of medical outliers on Newdigate ward

Support from the Corporate Services

Ensure that patients admitted with Fracture neck of femur are admitted to Newdigate ward, not outlying wards

Ensure the availability of the Fast-track bed

Risks

Other Non #NOF trauma patients being admitted that are clinical urgent (activity is increasing)

Other KPI's Affected

Ref No.	Description
	DVT Prophylasis - 87%
	day 1 Post op Physiotherapy - 80%
	Iliaca Femoral Block (% of patients who received) - 50%
	Number of #NOF patietns transferred to Newdigate Ward within 4 hours - 4

Performance Exception Report

Surrey and Sussex Healthcare NHS Trust

Division/Clinical Service:	Medical Division, VTE
Key Performance Indicator:	VTE assessment within 24hours 90%

Standard	Current Months Perf.	YTD Perf.	Trend from previous month	Expected date to meet standard	Named Responsible Lead
90%	72%	61%	▲	Jul-11	Ben Mearns (medical) Hamish Wallace (surgical), Debbie Pullen (W&CH)

What is Driving the Reported Under Performance

• Lack of understanding of the electronic system has resulted in the electronic assessment not being closed off properly resulting in the assessment not being counted.
• Lack of engagement from junior doctors
• Only coded activity can be excluded, large numbers on uncoded activity present in data. Continued issue with observation ward/CDU patients in ED. Further review required to establish excluded patients, particularly haematology activity

Actions to improve performance

Num.	Action	Named Lead	New Action	Ongoing Action	Expected Completion date	Outcome
1	Remove Endoscopy and Angiography day case activity from medical admission data. Needs further refining in sense of only zero LOS patients to be excluded.	Jeff Thompson		x	end July	Coding issue
2	Review of 10 patient episodes coded to ED observation and Discharge lounge to assess pathway of patients and establish whether they fulfil the criteris for inclusion in the data	Paula Tooms		x	end July	continued problem in CDU
3	Review of internal referrals to medicine, i.e surgical or MET calls to see if reason for failure to assess as already admitted.	Jeff Thompson		x	end July	
4	All new doctors to be trained and passwoards given on rotation. Nursing staff to under go refreasher training from IT	Hamish Wallace		x	12/08/2011	done but being repeated
5	Review of how and when data is be input (E.g. Urology completing 100% at Pre assessment but data not being picked up)	Hamish Wallis	x		01/07/2011	agreed to be included, needs verification
6	Weekly monitoring of compliance by speciality/location and publication of results on ward notice boards	Hamish Wallis	x		ongoing	

Actions for next month

Work with information to refine data collection and presentation
Meet with Tara Thorpe to establish what issues there are with coding.
Raise with VTE leads the issue of exclusions and request executive sign off.
Review of sticker sytem to ensure that is being used effectively
Issue within Urology still - need to review and see where the blockage/issue is
Publish weekly compliance on ward notice boards
Focus on ENT and T&O emgergency pathways to improve their compliance.

Support from the Corporate Services

Information and IT

Risks

Continued data collection issues.
Non-eligible patients appearing on the list, which is distorting the results - due to no distinction in coding between GA and Local's

Other KPI's Affected

Ref No.	Description
	None

Performance Exception Report

Surrey and Sussex NHS Healthcare NHS Trust

Division/Clinical Serv Falls resulting in Fracture or head injury
Key Performance Indicator: XXX

Standard	Current Months Perf.	YTD Perf.	Trend from previous month	Expected date to meet standard	Named Responsible Lead
0			▶		Philip Kemp

What is Driving the Reported Under Performance

In August 2011 there was 1 fall resulting in a fracture, the same as in July. As a fall resulting in a fracture needing major surgery that potentially put the person's life at risk it was declared a SUI. The results of the investigation found that the fall was portentially AVOIDABLE despite Specials being arranged. The patient was alcohol dependent and was not prescribed medication to manage his detoxing behaviour on admission to the ward. He became confused, physically agressive and non-comliant with care.

Actions to improve performance

Num.	Action	Named Lead	New Action	Ongoing Action	Expected Completion date	Outcome
	Participation in the Falls Group	Matrons				
	Full RCA's being performed on all falls resulting in a fracture and investigated as a SUIG2 and above PU to review care	DCN				
	Sharing of learning at the Governance, Matrons and Sisters' Meetings	DCN				

Actions for next month

Continued participation in the Falls Group, use of Falls Prevention Proforma

Support from the Corporate Services

None Required

Risks

Patients not co-operating with nursing staff
Prompt prescibing of a detox plan

Other KPI's Affected

Ref No.	Description

Performance Exception Report

Surrey and Sussex NHS Healthcare NHS Trust

Division/Clinical Service:	Medicine		
Key Performance Indicator:	Mixed Sex Accomodation	**KPI Ref No:**	Aug-11

Standard	Current Months Perf.	YTD Perf.	Trend from previous month	Expected date to meet standard	Named Responsible Lead
	3		▼		Lisa Cheek

What is Driving the Reported Under Performance

The Trust continued to be very busy through August 2011 with several escalation areas open and operationally was very challenging. The 3 breaches which occurred in the medical division were in the discharge lounge, which is an area which is used overnight as an escalation area. All measures were taken to prevent any mixed sex breaches and verbal information was given to the patients..

Actions to improve performance

Num.	Action	Named Lead	New Action	Ongoing Action	Expected Completion date	Outcome
1	site meeting attended by operation staff and clinical staff and all oportunities explored to prevent any mixed sex accomodation.	Roberta Fuller		x	Daily	Mixed sex breaches minimised
2	All potentials to mix a bay are escalated through a matron to ensure all alternatives are considered first.	Lisa Cheek		x	Daily	mixed sex breaches minimised
3	Patients are moved at the earliest opportunity if a breach has occurred	Roberta Fuller		x	Daily	mixed sex breaches minimised

Actions for next month

As above.

Support from the Corporate Services

None Required

Risks

Other KPI's Affected

Ref No.	Description
	None

Surrey and Sussex NHS
Healthcare NHS Trust

Workforce Highlight Report – Month 5

The revised Trust Performance Report uses Statistical Control Processes which identifies when performance indicators are outside of tolerance and require intervention over an above existing controls to bring them back into line.

This means that there will be occasions when the workforce indicators remain red but in terms of SCP they may not generate deviations that are statistically significant and which require an exception report.

Because of the impact of the workforce indicators on overall Trust performance the Director of HR has agreed with executive colleagues that the monthly performance report will provide "Workforce Highlight Report" which will update activity within the HR Directorate which supports the Trust in achieving improvements in the Workforce indicators.

Establishment & Staff in post	The increase in Establishment this month is matched by a corresponding increase in staff in post figures.
Vacancy Rate	The weekly review of all vacancies by the Executive team continues, this month there is a small decrease in the vacancy rate from 10.7% last month to 10.4% in August.
Sickness absence	Although August saw a very slight reduction in sickness absence to 4.5% this remains higher than the same period last year when it was 3.2%. Analysis of the split between short term and long term absence shows a very small decrease in long term absence. HR interventions for long term absence require a case management approach with occupational health, the manager and individual in order to secure a return to work. The Trusts return to work interview compliance (68%) continues to benchmark well against other organisations and this continues to be promoted at regular sickness review meetings held by HR Business Partner's
Agency and Bank	Both bank and agency use increased this month; this is being tightly monitored through divisional savings and transformation plans. Additional WTE for both agency and bank is however down on the same month last year.

Workforce Highlight Report – Month 5

Statutory and Mandatory Training	The additional whole day Clinical and Non-clinical updates are proving very effective in improving performance. The number of cancellations or non attendance is also reducing indicating the priority being given to compliance.
Appraisals	The actions identified last month (direct contact with Divisional Leads/corporate senior managers by Head of ETD bespoke training) are beginning to show with an improvement in compliance from 30% to 49% this month.

Contents

3. Glossary Of terms

- MRSA - Methicillin-resistant *Staphylococcus aureus*
- Cdiff - *Clostridium difficile*
- HSMR – Hospital Standardised Mortality Rates
- TIA - Transient Ischaemic Attack
- RIDDOR – Reporting of Injuries Dieses And Dangerous Occurrences
- ITU – Intensive Treatment Unit
- WTE – Whole Time Equivalent
- FFCE – First Finished Consultant episode
- AMI – Acute Myocardial Infraction
- RACP – Rapid Access Chest Pain
- CDS – Commissioning Data Set
- LOLER - Lifting Operations and Lifting Equipment Regulations 1998
- SUI – Serious Untoward Incident
- ITU – Intensive Treatment Unit
- H&S – Health and Safety