Surrey and Sussex NHS
Healthcare NHS Trust

Trust Board – 21 July 2011
Agenda item: 4.1

Integrated Quality and Performance Report M3– June 2011

Presented by: **Bernie Bluhm (Chief Operating Officer) and Jo Thomas (Chief Nurse)**
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Surrey and Sussex NHS
Healthcare NHS Trust

Performance Report M3 - June

Summary:

- The report updates the Board on the key national, contractual KPIs across the Trust for the Month 3 of 2011-12 (June).
- The Q1 forecast for the trust remains ‘underperforming’
- There remain some Issues with validating the 18 week position. The data was not available at the time of this report.
- No exception report has been provided for Appraisal and Statutory and Mandatory compliance as data the data is currently being mapped to each division
- New workforce exception reports are under development. They will utilize SPC charts to identify when a KPI is outside of control limits.
- Data quality indicators are under development

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 Trust Board is 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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- 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	Jan	Feb	March	Apr-11	May-11	Jun-11	Q1 2011/12	Q2 2010/11	Q3 2010/11	Q4 2010/11
Operating Framework														
Quality														
A&E time to initial assessment(95th percentile)	Under Construction	<15	77	▲	new metric for 2011/12			116	111	77				
Time to Treatment (median)		<60	53	▼	new metric for 2011/12			78	68	53				
Total time in A&E admitted (95th percentlie)		240	1029	▲	new metric for 2011/12			997	970	1029				
Total time in A&E non-admitted(95th percentlie)		240	294	▲				442	353	294				
% of patients in A&E under 4 hours		95%	79.7%	▼	82.4%	82.0%	81.9%	75.6%	79.9%	82.6%		95.0%	93.0%	90.7%
number of of patients in A&E over 12 hours (trolley waits)		0	2	▲	0	0	3	0	0	2		0	11	3
A&E Unplanned Re-attendance rate (within 7 days)		<5%	4.7%	▼	new metric for 2011/12			4.0%	5.0%	5.0%				
Left without being seen (LWBS) Rate		<5%	2.6%	▼	new metric for 2011/12			3.4%	2.6%	1.9%				
A&E Attaendances		N/A	11832		4379	3833	4469	2683	3829	5320				
Emergency Readmissions within 30 days of discharge		TBD	3.1%		2.9%	3.4%	2.9%	2.8%	3.0%	3.4%				
MRSA (trust acquired)		0.33	1	▶	0	1	0	0	0	1	1	1	1	1
C Diff		4.2	7	▶	5	5	8	3	2	2	7	14	19	18
MSSA (trust and community acquired)		N/A	12		new metric for 2011/12			5	2	5				
*E. Coli		N/A	3		new metric for 2011/13			Not avail	3	3				
18 weeks RTT admitted - 95th Percentile @		<=23			29.0	32.0	32.0	Not avail	Not avail	Not avail			25	32
18 weeks RTT - non-admitted including audiology (DAA)-95th percentile @		<=18.3			17.0	20.0	20.0	Not avail	Not avail	Not avail			16.7	20
RTT - incomplete - 95th percentile		<=28			25.0	26.0	26.0	Not avail	Not avail	Not avail			23	26
Median wait times -non-admitted		N/A			6.0	4.0	4.0	Not avail	Not avail	0				
Median wait times - admitted		11.1			13.0	14.0	14.0	Not avail	Not avail	0			12	13
RTT - incomplete -median		7.2			7.0	7.0	7.0	Not avail	Not avail	Not avail			8	7
RTT - admitted 90% in 18 weeks		90%			81.0	74.9	74.9	#DIV/0!	#DIV/0!	#DIV/0!		90%		
RTT - non- admitted 95% in 18 wks		95%			95.4	92.1	92.1	#DIV/0!	#DIV/0!	#DIV/0!		97%		
2 week GP referral to 1st outpatient		93%	95.0%	▲	93.9%	96.9%	95.2%	96.2%	94.1%	94.8%	95.0%	91.1%	91.7%	92.4%
2 week GP referral to 1st outpatient - breast symptoms		93.0%	94.7%	▲	93.8%	93.8%	93.9%	93.4%	98.5%	93.1%	94.7%			
31 day second or subsequent treatment (surgery)		94.0%	94.4%	▲				88.9%	92.0%	100.0%	94.4%			
31 day second or subsequent treatment (drug)		98.0%	100.0%	▲				100.0%	100.0%	100.0%	100.0%			
31 day diagnosis to Treatment		96.0%	99.2%	▲				98.7%	98.7%	100.0%	99.2%			
62 days urgent referral to treatment of all cancers		85%	86.35%	▲	89.5%	89.6%	84.5%	86.7%	82.9%	88.4%	86.35%	88.4%	88.7%	88.2%
62 wait first treatment from Consultant screening		90%	100.0%	▲	0.0%	100.0%	75.0%	100.0%	100.0%	100.0%				
Mixed Sex Accommodation		0	10	▼	6	0	10	10	26	9				
Patients that have spent more than 90% of their stay in hospital on a stroke unit		80%	65.7%	▼	56.0%	48.0%	54.0%	59.5%	69.7%	69.0%				
Fractured Neck of Femur <36		85%	65.5%	▼	59.0%	70.0%	73.3%	59.1%	76.7%	64.3%				
Resources														
Delivery of Savings Plan		N/A	1258					260	382	616				
Financial Position (£,000)		N/A	-2,807		-£66	£246	£215	£320	-3507	380				

Indicators used for external assessment

Indicators used for external assessment

Section	Indicator	Data Quality	Performance: Target	Performance: YTD Actual	Direction of Travel vs. Plan (▲=above plan ▶=on plan ▼=below plan)	Monthly Trend: Jan	Feb	March	Apr-11	May-11	Jun-11	Quarterly Trend: Q1 2011/12	Q2 2010/11	Q3 2010/11	Q4 2010/11
Resources	Delivery of Savings Plan	Under Construction	N/A	642					260	382	0				
Resources	Financial Position (£,000)	Under Construction	N/A	-3,187		-£66	£246	£215	£320	-3507	0				
Resources	Non-Elective FFCE's	Under Construction	N/A												
Outcomes framework															
Effectiveness	HSMR	Under construction	100	98.2	▼	108	84.6	74.5	93.4	Data reported in arrears	Data reported in arrears				
Effectiveness	2 wks rapid access chest pain	Under construction	100%	99%	▼	100.0%	100.0%	100.0%	100.0%	98.2%	100.0%	100.0%	100.0%	100.0%	100.0%
Effectiveness	**PPCI 150 min call to ballon time	Under construction	95%	N/A		67.0%	100.0%	100.0%	N/A	N/A	Data reported in arrears				
Effectiveness	PPCI 120 min call to ballon time	Under construction	60%	N/A		67.0%	100.0%	33.0%	N/A	N/A	Data reported in arrears				
Effectiveness	Stroke/TIA treated within 24 hours	Under construction	60%	80.0%	▲	77.8%	40.0%	75.0%	90.0%	80.0%	73.3%				
Patient Experience	% of patients surveyed who would choose to be treated at SASH in Future	Under construction	80%	N/A	▼	92.0%	77.0%	94.0%	73.0%	64.0%	71%				
Patient Experience	% of patients surveyed that staff treated them with kindness and respect	Under construction	80%	N/A	▼	78.0%	72.0%	78.0%	78.0%	65.0%	78%				
Patient Experience	% of patients surveyed who felt their dignity was maintained the whole time they were a patient	Under construction	80%	N/A	▼	83.0%	80.0%	89.0%	76.0%	70.0%	74%				
Safety	Newly acquired Pressure Ulcers (grade 2 and above)	Under construction	TBD	56		15	12	21	16	23	17				
Safety	Number of falls reported as clinical incidents	Under construction	73	95	▼	32	42	20	18	48	29				
Safety	Number of medication errors resulting in an adverse event	Under construction	0	0	▶	3	1	4	0	0	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

	Indicator	Data Quality	Target	YTD Actual	Direction of Travel vs. Plan (▲=above plan ►=on plan ▼=below plan)	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Q1 2011/12	Q2 2010/11	Q3 2011/12	Q4 2011/12
	Safe, High Quality Coordinated Care														
Clinical Quality	VTE Risk Assessments		90%	60.6%	▼	40.2%	38.5%	41.0%	43.6%	51.8%	60.6%				
Clinical Quality	HSMR Non-elective		<=100	99.2		110.4	85.5	74.9	93.3	Data reported in arrears	Data reported in arrears				
Clinical Quality	Number of falls resulting in a fracture/head injury		0	3	▼	1	0	2	1	1	1				
Clinical Quality	% of Stroke patients Scanned within 1 hour of hospital arrival		50%	43%	▼	44.0%	27.0%	29.0%	43.2%	32.1%	57.9%				
Clinical Quality	Unplanned Readmissions within 14 days					2.2%	2.4%	2.1%	1.9%	2.3%	2.3%				
Clinical Quality	Unplanned Readmissions within 30 days					2.9%	3.4%	2.9%	2.8%	3.0%	3.4%				
Clinical Quality	% of SUI's due to be closed in month that were closed		100%	N/A		new metric for 2011/12			N/A	0%	100.0%				
Clinical Quality	Number of Never events reported		0	1	►	0	0	0	0	0	1				
Clinical Quality	% Complaints responded to within agreed timeline with complainant/ 25 working days		80-90%	89%	►	65.5%	78.3%	89.8%	90.0%	89.6%	86.4%				
Maternity	**C-section rate		23%	30.2%	▼	28.8	29.7	32.7	31.9%	30.5%	28.3%				
Maternity	% of women seen by a midwife or healthcare professional at 12 wks 6dys		90%	88.3%	▼	85.9%	89.5%	93.8%	91.1%	84.5%	89.6%				
Maternity	Breastfeeding initiation		90%	80.1%	▼	81.0%	79.0%	83.7	77.9%	80.4%	82.0%				
Infection Control	Hand Hygiene compliance		99%	98.4%	▼	99.1%	99.2%	99.6%	97.6%	98.2%	99.3%				
Infection Control	MRSA screening compliance (nonelective)		100%	102%	►			102.0%	Data Reported Quarterly	Data Reported Quarterly	Data Reported Quarterly				
Infection Control	MRSA screening compliance (elective)		100%	118%	▲			118.0%	Data Reported Quarterly	Data Reported Quarterly	Data Reported Quarterly				
Productivity and effectiveness	**% of cancelled operations not treated within 28 days		<=5%	10.3%	▼	0.0%	8.3%	8.3%	11.1%	0.0%	14.3%				
Productivity and effectiveness	cancelled operations as a percentage of elective admissions		<=0.80	1.6%	▼	2.3%	2.2%	2.1%	2.5%	0.8%	1.6%	1.6%			
Productivity and effectiveness	Daycase Rate		TBD						80.4%	81.2%	79.4%				
Productivity and effectiveness	Average LOS non-Elective		TBD	6					4.1	6.0	6.3				
Productivity and effectiveness	Average LOS Elective		TBD	4.4					3.6	4.3	3.0				
Productivity and effectiveness	Delayed Transfers of Care		3.5%	1.95%	►	1.72%	2.65%	2.10%	1.81%	2.13%	1.91%	1.95%			
Productivity and effectiveness	Excess follow ups		N/A			1175	1294	1386	1063	1101	1053				
Workforce	Vacancy Rate		<=10%			10.8%	9.8%	9.8%	9.8%	10.0%	10.1%				
Workforce	Total Establishment		N/A	3167		3136	3137	3136.3	3156	3165	3167				
Workforce	Total in post		2766	2848		2799	2825	2829	2,845	2848	2848				
Workforce	Sickness absence rate		<=3.0%	3.8%	▲	4.2%	4.4%	4.4%	3.8%	3.6%	4.0%				
Workforce	Total WTE Bank Staff (excluding extra capacity nursing)		<=210	221.1	▲	246	232	240	231.4	208.8	223.2				
Workforce	Total WTE Agency Staff (excluding extra capacity nursing)		<=40	53.1	▲	63	60	59	51.7	33.9	53.1				
Workforce	% of staff who have completed stat and mandatory training		***24%	22%	▼	new construction			5.0%	13.0%	22%				
Workforce	% of staff who have been appraised		***24%	12%	▼	new construction				4.0%	12%				

* data as of 12/07/2011
** exception reports provided on a quarterly basis

****Target is cumulative

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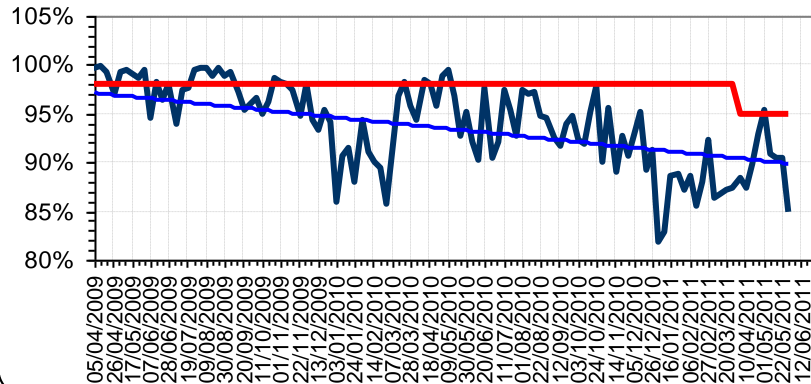
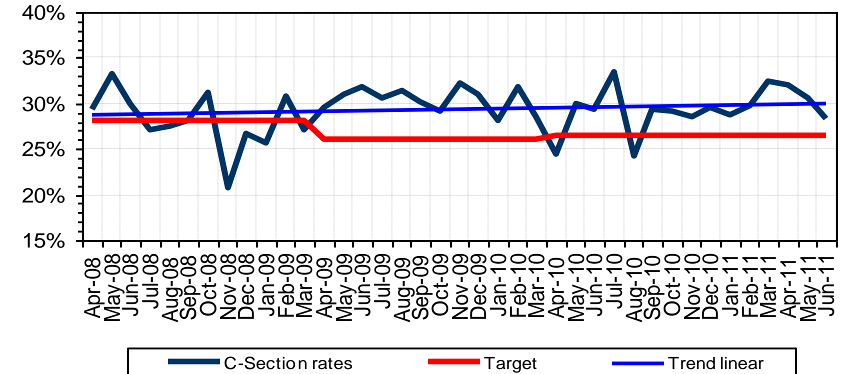
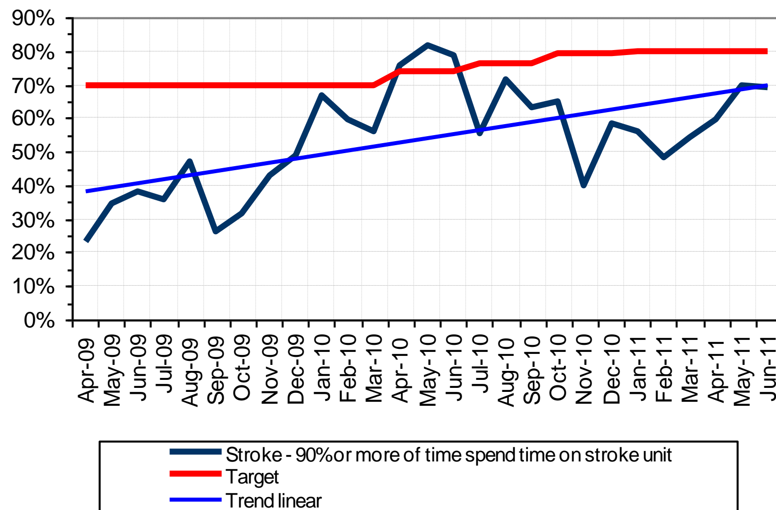
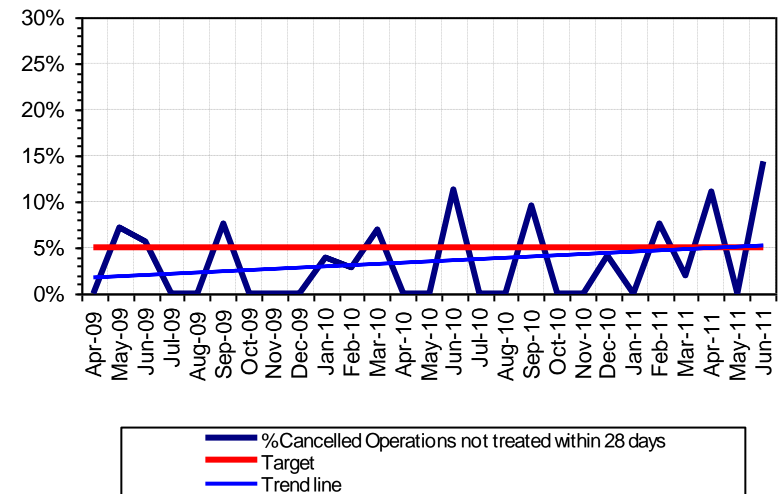
Surrey and Sussex Healthcare NHS Trust

2. Charts for Performance Exception Areas









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Performance Exception Report

Surrey and Sussex 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	**KPI Ref No:**	XXX

Standard	Current Months Perf.	YTD Perf.	Trend from previous month	Expected date to meet standard	Named Responsible Lead
95%	80%	80%	V		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 treat patients efficently. Added to this is the change in measures being recorded in ED which has required significant training with staff, followed by review to establish where data recording has been in accurate and corrections need to be made. A need to implement all actions within the ED transformation first 4 hours workstream is required to maximise internal performance.

Actions to improve performance

Num.	Action	Named Lead	New Action	Ongoing Action	Expected Completion date	Outcome
1	ED first 4 hours workstream	Carlos		x		
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	
3	Medical directorate implementation of Urgent Care Leads to provide access for consultant advice from GP's	Ben Mearns		x		implemented
4	Intergration of UTC with ED, review of patient activity and selection to support ED flow.	Paula Tooms		x	ongoing	
5	Internal refurbishment of department to facilitate improved streaming and working space, increase assessment and treatment capacity.P	Paula Tooms		x		

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.

Support from the Corporate Services

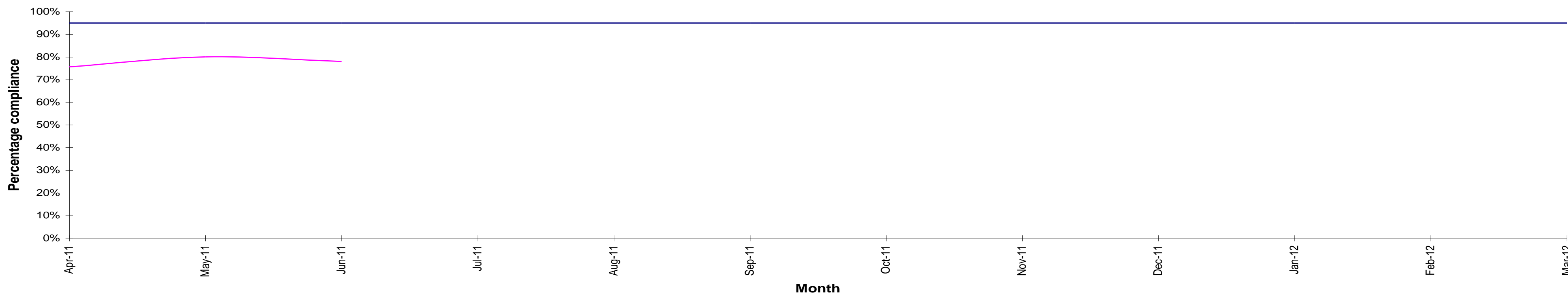
Information and IT support with data collection and validation process, also Cerner support following intergration of UTC with ED.

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/ 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%				Oct-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

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	Bernie Bluhm		X	01/07/2011	
2	Outsourcing - put in place agreements to outsource 1000 patients in Q1 & 2.	Hamish Wallis		X	25/06/2011	agreements in place (298 pts Rx YTD)
3	Validate all patients on the waiting list and ensure Trust is reporting accurate information	Clinton Krynie		X	~~01/07/2011~~ 18/07/2011	validation still continuing
4	review and implement Trust Access policy	Hamish Wallis		X	31/07/2011	
5	18 week dashboard to be implemetned and updated on weekly basis - enabling trust to report performance	Clinton Krynie		X	~~01/07/2011~~ 01/08/2011	delaied due to delay in validation

Actions for next month

Continue to increase outsourcing capacity, by bring on line three more providers (Brighton, Epsom, Gatwick Park), plus increasin capapcity with current providers
Complete validation of Admitted pathway
Resolve issues regarding cashing up of clinics and inputting of outcome forms to ensure accurate information is being input in timely manner (identify any training issues needed)
Income and Expenditure forecasted budget/plan for outsourcing
Dashboards: finalise and implement to ensure accurate weekly reporting

Support from the Corporate Services

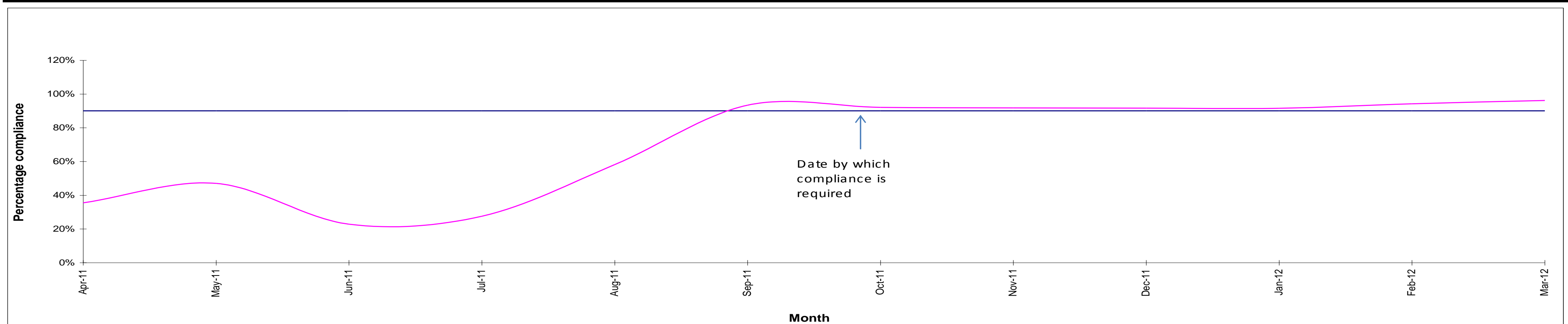
Informatics - Accurate and timely reporting of 18 weeks

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:	Medicine		
Key Performance Indicator:	mixed sex accommodation	**KPI Ref No:**	XXX

Standard	Current Months Perf.	YTD Perf.	Trend from previous month	Expected date to meet standard	Named Responsible Lead
0	9		▼		Lisa Cheek

What is Driving the Reported Under Performance

The Trust continued to be very busy through June 2011 with several escalation areas open and operationally was very challenging. The 10 breaches which occurred in the medical division were in the discharge lounge and A&E observation ward. 8 breaches occured in the observation ward and 2 breaches in the discharge lounge which is used as an escalation area over night. 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.	Angela Stevenson		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	Angela Stevenson		x	Daily	mixed sex breaches minimised

Actions for next month

As above.

Support from the Corporate Services

None

Risks

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	**KPI Ref No:**	

Standard	Current Months Perf.	YTD Avg Perf.	Trend from previous month	Expected date to meet standard	Named Responsible Lead
80%	69%	65%	▲	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. The non-performing pathways were again linked to continued pressures on bed capacity, which are not showing signs of improvement. We continue to see steady improvement month on month helped by the ring fencing of beds although this alone has not made a significant impact.

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		
2	Locum consultant on Capel ward appointed until a substantive appointment is made. Job description for the substantive post is awaiting College approval.	Natasha Hare		x	30-Sep-11	
3	TIA pathway and booking process has been reviewed and communicated to GPs to improve communication and reduce time.	Natasha Hare	x		31-May-11	Complete
4	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	Ongoing
5	Ring-fence beds on Abinger ward to be used for Stroke patients only and monitor impact on a weekly basis	Natasha Hare		x		
5	East Surrey Early Supported Discharge pilot (start date tbc but likely to start in July).	Robyn Davies (NHS Surrey)		x	30-Sep-11	
7	Introduction of Medihome / virtual ward / early discharge in July 2011	Bernie Bluhm	x			

Actions for next month

Publish LoS KPI information at ward level so that all staff can easily see current performance.

Proposal to combine stroke beds into one ward to be discussed at divisional level.

Support from the Corporate Services

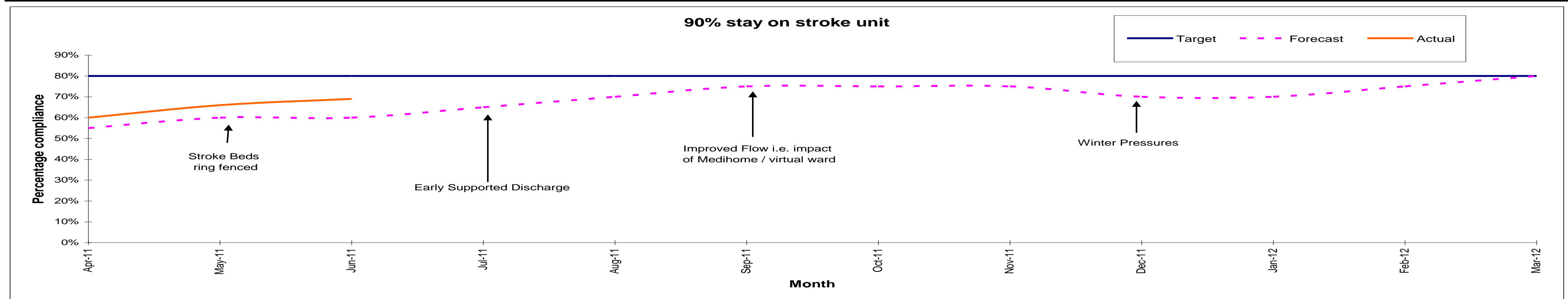
Support ring fenced beds

Risks

D&V outbreaks and subsequent ward closures

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 NHS
Healthcare NHS Trust

Division/Clinical Service:	Surgical Division/ #NOF		
Key Performance Indicator:	85% of #NOF operated on within 36 hours	**KPI Ref No:**	XXX

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

What is Driving the Reported Under Performance

In June there was a higher than normal level of patients (5) that required medical stabilisation before they could be operated on. 4 patients breached the target due to insufficent operating time and were therefore rescheduled to the next day.

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			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	
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
4	Implementation of action plan following the Moran Review	G Tselentakis		X	30/08/2011	on-going

Actions for next month

Audit the order of the list, ensuring that it is agreed the previous day and the first patient doesn't change

Agree Sunday morning list in job plan of specialty doctor

Establish effective escalation system for patients who are fit for surgery but unlikely to be operated on with 36hrs

Refocus on the Fascia Iliaca Block performance

Support from the Corporate Services

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

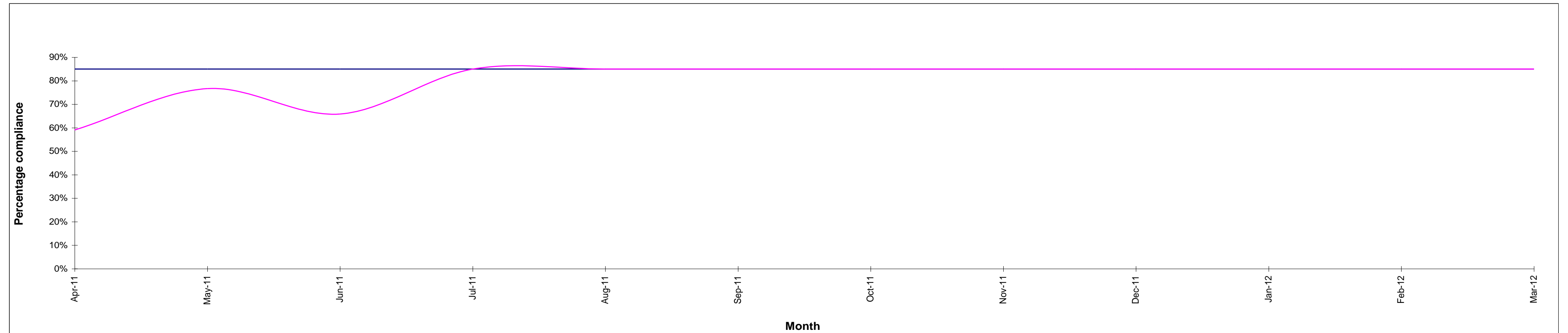
Ensure the availability of the Fast-track bed

Risks

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

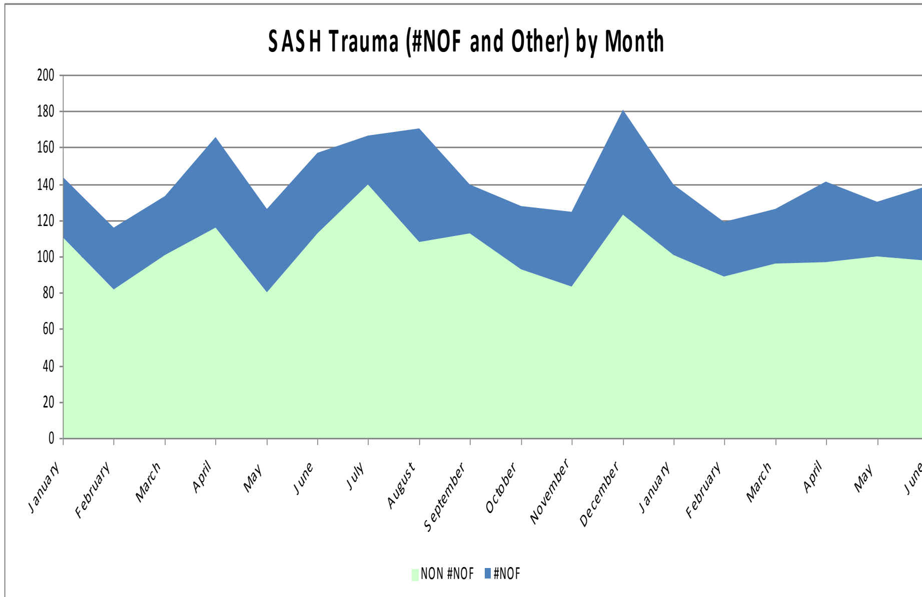
Other KPI's Affected

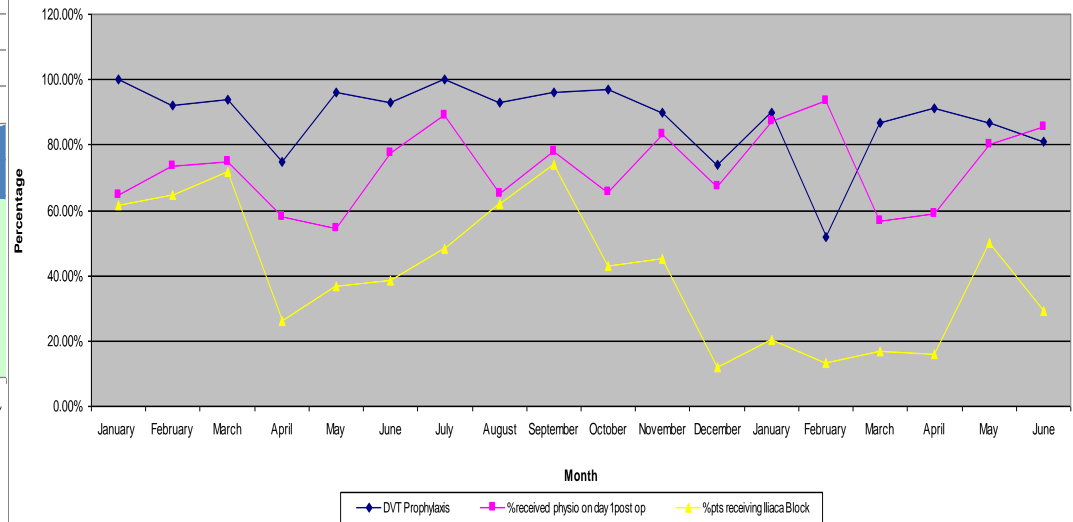
Ref No.	Description
	DVT Prophylasis - 87%
	day 1 Post op Physiotherapy - 80%
	Iliaca Femoral Block (% of patients who received) - 50%
	Number of #NOF patietns transferred to Newdigate Ward within 4 hours - 4

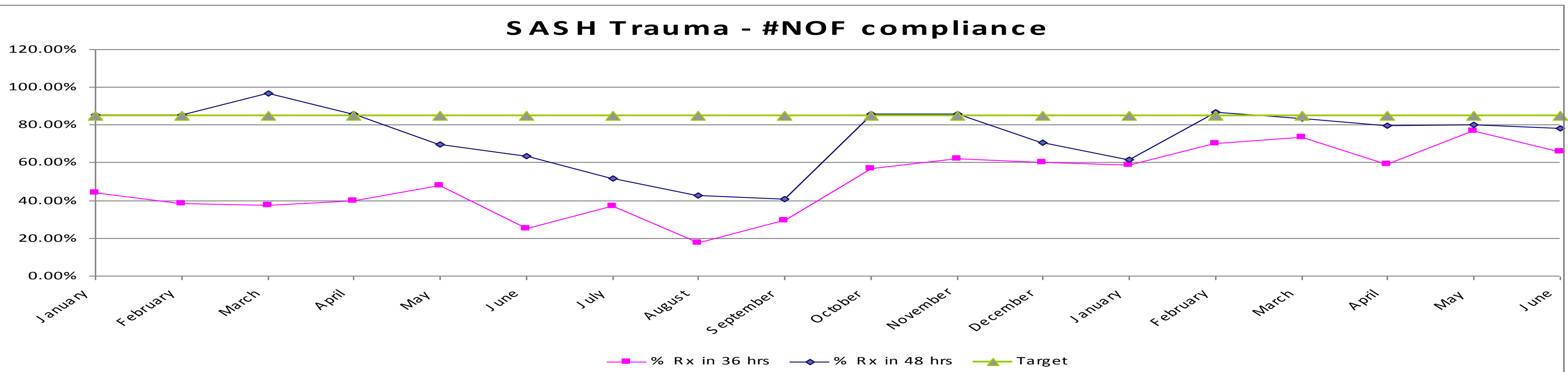


Surrey and Sussex NHS
Healthcare NHS Trust

FnoF – Exception graphs







Putting people first
Delivering excellent, accessible healthcare

Performance Exception Report

Surrey and Sussex NHS
Healthcare NHS Trust

Division/Clinical Service:	Clinical Support Services		
Key Performance Indicator:		KPI Ref No:	XXX

Standard	Current Months Perf.	YTD Perf.	Trend from previous month	Expected date to meet standard	Named Responsible Lead
0	0	1	▼	July	Jackie Brown

What is Driving the Reported Under Performance

On the 20/06/11 - Patient was walking with a nurse in the outpatient department waiting area at Horsham OPD and caught her foot on corner of one of the fixed waiting room chair legs and fell. The patient was both elderly and frail hence walking with the nurse in the waiting room area. A doctor in the OPD saw the incident and attended the patient with the nursing staff whilst they were waiting for an ambulance to arrive. It was thought from initial examnination that the patients sustained a fracture neck of femur. The patient was admitted to Newdigate Ward at ESH and found to have fractured her left neck of femur following x-ray. The incident was reports to the Head of OP&HRS and patient's next of kin. An incident report was completed. The Head of OP&HRS reported the matter to her AD of CSS. Root cause analysis showed this incident was an accident.

Actions to improve performance

Num.	Action	Named Lead	New Action	Ongoing Action	Expected Completion date	Outcome
1	Incident was investigated	Christine Powell	X		Completed	No action required

Actions for next month

None

Support from the Corporate Services

None Required

Risks

Other KPI's Affected

Ref No.	Description
	None

Performance Exception Report

Surrey and Sussex Healthcare NHS Trust

Division/Clinical Service:	Medical Division, WACH		
Key Performance Indicator:	VTE assessment within 24hours 90%	KPI Ref No:	XXX

Standard	Current Months Perf.	YTD Perf.	Trend from previous month	Expected date to meet standard	Named Responsible Lead
90%	83% Medical, 35% WACH, 44% Surgical	53.4% Trustwide	▲	Jul-11 Medical, Sept-11 WACH,	Ben Mearns (Medical), Debbie Pullen(WACH) Hamish Wallace (Surgical)

What is Driving the Reported Under Performance

All medically expected or internally referred patients are unable to be admitted unless there VTE assessment is completed as it is a mandatory field. Continued concern about the integrity of the data collection and presentation.

Actions to improve performance

Num.	Action	Named Lead	New Action	Ongoing Action	Expected Completion date	Outcome
1(Med)	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	
2(Med)	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	
3(Med)	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(wach)	VTE Assessment will be undertaken during the admissions process.	Dr. Nadim	x			
5 (wach)	VTE Assessment will be recorded on cerner by the Brockham ward staff	Dr. Nadim	x			
6(Surg)	Training and communication to Medical and Nursing staff on completing the Electronic version	Hamish Wallace		x	01/07/2011	done but being repeated
7(Surg)	Review of what is being included and what should be excluded from the list of patients eligible for VTE Assessment – there are a large portion of patients being included that should not be (i.e. Ophthalmology, Endoscopy).	Hamish Wallace		x	01/07/2011	completed
8(Surg)	Review of how and when data is be input (E.g. Urology completing 100% at Pre assessment but data not being picked up)	Hamish Wallace	x		01/07/2011	agreed to be included (?not been done)
9(Surg)	Weekly monitoring of compliance by speciality/location	Hamish Wallace	x		on going	

Actions for next month

(Med) Work with information to refine data collection and presentation

(Surg) Pre assessment VTE assessments to be included as agreed at Management Board - this has not been done and so needs to be reviewed and completed

(Surg) Continue monitoring within SAU of all eligible patients being admitted on the emergency pathway.

(Surg) Review process for elective patients on day of admission to ensure VTE Assessment is on system

(Surg) communication: continue to raise profile of VTE assessments (electronically) at all Specialty meeting and training days.

Risks

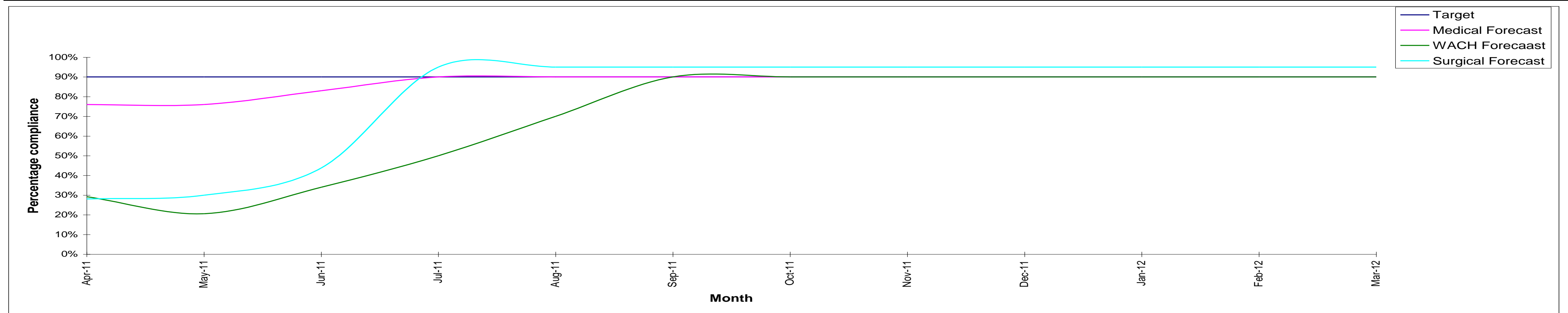
Continued data collection issues.

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

Medical Staff - time constraints

Other KPI's Affected

Ref No.	Description
	CQUIN: There is National best practice guidance which is linked to CQUIN funding to further encourage focus on this area of patient safety.



Performance Exception Report

Surrey and Sussex Healthcare NHS Trust

Division/Clinical Service:	W&CH		
Key Performance Indicator:	Caesarean sections	KPI Ref No:	XXX

Standard	Current Months Perf.	YTD Perf.	Trend from previous month	xpected date to meet standar	Named Responsible Lead
23%	29%	30%	▼	31.3.12	Sue Chapman

What is Driving the Reported Under Performance

Low tolerance to changing plan to Caesarean Section

Actions to improve performance

Num.	Action	Named Lead	New Action	Ongoing Action	Expected Completion date	Outcome
1	10 week prospective audit underway	Sharmila Sivarajan	Yes	No	Aug-11	Examine data and act on information
2	New Birthing Unit Team Leader in post - change admission pathway and admit as low risk by default and only transfer to main delivery suite if confirmed high risk. Dedicated midwifery team.	Denise Newman	Yes	No	1.8.11 & constant	Change of mindset of women and midwives re risk

Actions for next month

Monitor outcomes and build on successes

Support from the Corporate Services

Risks

Despite many previous actions we have seen little improvement in the rate

Other KPI's Affected

Ref No.	Description
	None

Performance Exception Report

Surrey and Sussex NHS
Healthcare NHS Trust

Division/Clinical Service:	W&CH		
Key Performance Indicator:	Women booked by 12wks & 6 days	KPI Ref No:	XXX

Standard	Current Months Perf.	YTD Perf.	Trend from previous month	Expected date to meet standard	Named Responsible Lead
90%	89.6%	88.3%	▲		Sue Chapman

What is Driving the Reported Under Performance

Some months women do not access care in a timely manner

Actions to improve performance

Num.	Action	Named Lead	New Action	Ongoing Action	Expected Completion date	Outcome
1	Ensure adeqaute capacity of appointments	Maureen Royds-Jones	None in month	Yes	Ongoing	

Actions for next month

Encouragement of women to book early

Support from the Corporate Services

Risks

Fluctuation as dependent upon women notifying their pregnancy and booking appointments

Other KPI's Affected

Ref No.	Description
	None

Performance Exception Report

Surrey and Sussex NHS
Healthcare NHS Trust

Division/Clinical Service:	W&CH		
Key Performance Indicator:	Breast feeding initiation rate	KPI Ref No:	XXX

Standard	Current Months Perf.	YTD Perf.	Trend from previous month	xpected date to meet standar	Named Responsible Lead
90%	82%	80%	▲	31.12.11	Sue Chapman

What is Driving the Reported Under Performance

Women's choice and inconsistent advice from various staff groups

Actions to improve performance

Num.	Action	Named Lead	New Action	Ongoing Action	Expected Completion date	Outcome
1	Undertaking 2 year Baby Friendly project	Janice Blythman	no	yes	Apr-12	Increased rates

Actions for next month

Continue with education of all relevant specialties

Support from the Corporate Services

Risks

Despite many previous actions we have seen little improvement in the rate & women's choice will always influence this

Other KPI's Affected

Ref No.	Description
	None

Performance Exception Report

Surrey and Sussex Healthcare NHS Trust

Division/Clinical Service:	Cancelled Operations not treated within 28 days
Key Performance Indicator:	% of cancelled operations not treated within 28 days
KPI Ref No:	XXX

Standard	Quarterly Perf.	YTD Perf.	Trend from previous month	Expected date to meet standard	Named Responsible Lead
%	10%	10%		Aug-11	Hamish Wallis

What is Driving the Reported Under Performance

In quarter 1 there was 138 patients cancelled on the day (vast majority due to bed pressures) and 116 patients who had 28 day breach dates of which 12 were not treated within their breach date due to capacity issues. This equates to 10.34% of cancelled operations not treated within 28 days in for Quarter 1.
Of the 4 who breached their 28 days the original reason for the cancellation on the day was due to:
9x = No Beds, 1x = Patient issue, 1x = surgeon sick and no one available to do operation.

Actions to improve performance

Num.	Action	Named Lead	New Action	Ongoing Action	Expected Completion date	Outcome
1	Cancellations are being reviewed on a weekly basis to ensure compliance.	Sue Corby		X	on going	
2	All patients cancelled on the day to be reviewed at weekly PTL meeting	Hamish Wallis		X	on going	
3	All patients cancelled for non clinical reasons to have a new TCI within 7 days of being cancelled – if not then to be escalated through weekly PTL meeting.	Sue Corby		X	on going	
4						

Actions for next month

Continue with weekly monitoring of cancellations through the PTL meeting

Support from the Corporate Services

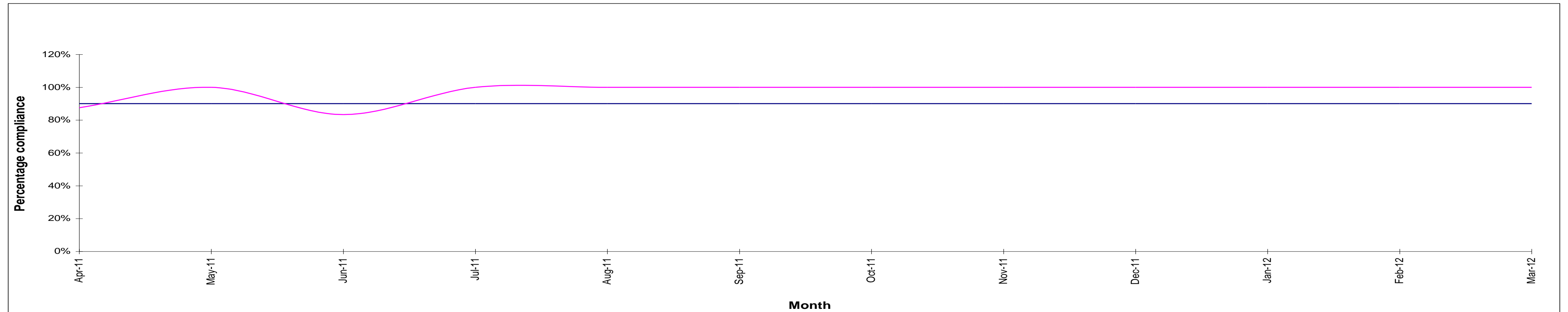
Elective beds to be refenced

Risks

Bed Capacity (Winter Pressures)

Other KPI's Affected

Ref No.	Description
	Cancelled operations as a percentage of elective admissions



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1. Integrated Quality and Performance Dashboard

2. Exception Reports

3. Glossary of Terms

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