St George’s Healthcare NHS Trust
Performance Report

TRUST BOARD
Period ending 31th December 2013
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Section 1: Executive Summary

The Performance Management Framework
The Trust is realigning its Performance Framework with the requirements of the NHS Trust Development Authority (TDA) and Monitor. The performance report has been updated to cover the new requirements of the TDA Accountability Framework for Trusts and to include greater visibility of performance at Divisional level, alongside Trustwide aggregate performance.

The TDA Accountability Framework
The accountability framework covers three domains – Quality & Governance, Finance and Delivering Sustainability. A set of indicators has been identified in each domain and delivery will be evaluated against a threshold and aggregated for each domain. In each domain Trusts will be rated in one of five categories – No identified concerns / Emerging concerns / Concern requiring investigation / Material issue / Formal action required. The Trust is also required to sign off two self certifications on a monthly basis at Board level covering compliance with Monitor’s license requirements and a similar set of Board Statements previously reported under the NHS SOM during 2012/13.

The Monitor Compliance Framework
The Trust is reporting an AMBER/RED Governance rating and a Financial Risk Rating (FFR) of 3 in December. The Trust is forecasting that the FRR of 3 will be maintained and the Governance rating will improve to Amber / Green or Green from Q4 once ED performance and 62 day cancer performance remedial plans take full effect. The TDA have advised the Trust remains in the Emerging Concerns category.

Exceptions
The reportable areas of underperformance at month 9 are as follows:

- **MRSA** The total number of MRSA incidents remains at 4 in December and is below the de minimis limit of 6 per annum applied by Monitor and the Trust Development Agency before a penalty score is applied.

- **A&E <4hrs** In December performance for ED (Type 1) was 94.3% and ED & MIU (Type 1 & 3) was 94.9%. Quarter to date, ED (Type 1) was 93.5% and for ED and MIU it was 94.2%. Our year to date total as at the end of December was 94.9%.

- **Cancer:** In November the Trust met all of its cancer targets except the 62 day target where only 80.8% of patients were seen against a target of 85%.
Section 2: Performance Management Framework of the Trust

The Performance Management Framework of the Trust

The Trust continues to operate the Performance Framework presented to the Board and Finance and Performance Committee in April 2012. This is being refreshed to ensure the indicators included within the TDA Accountability Framework for NHS Trusts are reported against and to ensure that Divisional contributions to the Trusts aggregate reported performance are more visible.

The diagrams illustrate the components of the Trusts Performance Management Framework. The Trust operates escalation processes with Divisions that reflect the National escalation processes and the recommendations in Monitor’s toolkits for implementing Service Line Management.

Quarterly Performance Reviews at Divisional Level, regular meetings with our commissioners, weekly Executive management Team meetings to address potential risks are all part of the Trusts Performance Management strategy.

- Escalation actions following Divisional reviews have focused on the action plan for recovering A&E 4 hour waits, financial performance within SNT and MedCard Divisions and Cancer performance to look at how delivery of the 62 day target can be improved and sustained.
The Performance Management Framework of the Trust

The performance management arrangements includes quarterly reviews for each Division which review and challenge Divisional progress, with an opportunity for Divisions to share with the Executive team issues of concern.

The Trust has already extended this process by reporting divisional performance against the metrics within the TDA Accountability Framework, to the Finance and Performance committee on a monthly basis. The Trust reports on the vast majority of these metrics within the existing quarterly review process. Work continues to ensure that the Divisional scorecards and the Trust scorecard fully reflect all the metrics within the TDA Accountability Framework.

A score and RAG rating is applied to the domains within each Division by the Senior Management Team, who use the information provided at the reviews to make a judgement about the Divisions performance and determine where remedial action plans and escalation is required. Work continues to apply a scoring system to our performance framework at Divisional level and to roll that up into an integrated scorecard for each Division and for the Trust on a monthly basis (see Example 2). A draft of this report has been presented to the Executive and reports for each division are now available.
Section 3: The NHS Trust Development Authority Accountability Framework for NHS Trusts
Section 3: TDA Accountability Framework

The Accountability Framework

The TDA will assess delivery across three domains as shown in the diagram:

- Quality and Governance
- Finance
- Sustainability

Against each domain Trusts will report against a series of metrics. These are listed in detail in Section 8: definitions and metrics.

In each domain Trusts will be rated in one of five categories as follows:

<table>
<thead>
<tr>
<th>No identified concerns</th>
<th>Emerging concerns</th>
<th>Concern requiring investigation</th>
<th>Material issue</th>
<th>Formal action required</th>
</tr>
</thead>
</table>

The Trust is also required to sign off self certifications on a monthly basis at Board level covering progress against FT milestones, compliance with Monitor’s license requirements and a similar set of Board Statements that were contained within the SOM.

<table>
<thead>
<tr>
<th>TDA objectives</th>
<th>Domains</th>
<th>Informing interactions</th>
<th>and potential escalation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality and Governance domain</td>
<td>Monthly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Mandate standards incl. access, outcomes, patient experience (incl. Monitor metrics)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- CQC and third party reports (incl. Monitor metrics)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Workforce, incl. senior executive turnover, monthly indicators of staff satisfaction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarterly / annually as appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Additional measures of governance and organisational health, e.g. staff survey results, board observations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- GRR moving to RAF self-certification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Compliance with choice and competition license terms</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Finance domain

Monthly
- In year performance against plan
- In year financials
- Statutory requirement

Quarterly / annually as appropriate
- Progress against Monitor FRR/RAF
- Compliance with pricing license terms

Delivering sustainability domain

Monthly
- Progress against milestones in strategic plan, towards FT or other organisational form

- Business as usual interactions to support Trusts towards FT or alternative future organisational form
- Escalation and intervention where risks indicate this is appropriate
This section headed ‘Access’ indicates how effective the trust is at providing patients with the appointments and treatment they need and require in accordance with the national standards and the NHS Constitution.

Performance against ED (Type 1) in December was 94.3% and ED & MIU (Type 1 & 3) was 94.9%. Quarter to date, ED (Type 1) was 93.5% and for ED and MIU it was 94.2%. Our year to date total as at the end of December was 94.9%.

The Trust has met all the referral to treatment targets, treating more than 90% of all admitted patients, more than 95% of all non admitted patient and meeting >92% of incomplete pathways.

### Access Metrics

<table>
<thead>
<tr>
<th>Metric Name</th>
<th>Units</th>
<th>RAG (Mth)</th>
<th>Trust</th>
<th>CSW</th>
<th>MED</th>
<th>SN</th>
<th>WC</th>
<th>Trust</th>
<th>CSW</th>
<th>MED</th>
<th>SN</th>
<th>WC</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 Weeks - Admitted waits</td>
<td>%</td>
<td>R ≤96 G ≥90</td>
<td>92.5</td>
<td>n/a</td>
<td>89.9</td>
<td>92.7</td>
<td>96.1</td>
<td>91.5</td>
<td>n/a</td>
<td>89.5</td>
<td>92.0</td>
<td>93.3</td>
</tr>
<tr>
<td>18 Weeks - Non Admitted waits</td>
<td>%</td>
<td>R ≤90, G ≥95</td>
<td>97.6</td>
<td>99.8</td>
<td>96.8</td>
<td>95.9</td>
<td>98.7</td>
<td>97.7</td>
<td>99.6</td>
<td>97.0</td>
<td>96.2</td>
<td>98.4</td>
</tr>
<tr>
<td>18 Weeks - Incomplete Waits</td>
<td>%</td>
<td>R ≤92, G ≥92</td>
<td>92.4</td>
<td>96.7</td>
<td>90.8</td>
<td>91.3</td>
<td>96.1</td>
<td>91.4</td>
<td>n/a</td>
<td>91.4</td>
<td>91.4</td>
<td>91.4</td>
</tr>
<tr>
<td>52 Week Waiters</td>
<td>No.</td>
<td>G 0, R &gt; 0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>6 Week Diagnostic Waits</td>
<td>%</td>
<td>R ≤92, G ≥92</td>
<td>99.7</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>99.8</td>
<td>n/a</td>
<td>99.8</td>
<td>99.8</td>
<td>99.8</td>
</tr>
<tr>
<td>Operations cancelled for non-clinical reasons</td>
<td>%</td>
<td>G ≤0.8, R ≥1.5</td>
<td>1.5</td>
<td>n/a</td>
<td>1.7</td>
<td>2.0</td>
<td>0</td>
<td>1.2</td>
<td>n/a</td>
<td>1.1</td>
<td>1.4</td>
<td>0.7</td>
</tr>
<tr>
<td>Canceled Operations re-booked within 28 days</td>
<td>%</td>
<td>G ≤5, R ≥15</td>
<td>8.3</td>
<td>n/a</td>
<td>14.2</td>
<td>0</td>
<td>n/a</td>
<td>5.1</td>
<td>n/a</td>
<td>7.6</td>
<td>3.2</td>
<td>4.4</td>
</tr>
<tr>
<td>A&amp;E Waits (4 hours)</td>
<td>%</td>
<td>R ≤95, G ≥95</td>
<td>94.9</td>
<td>100</td>
<td>94.3</td>
<td>n/a</td>
<td>n/a</td>
<td>94.9</td>
<td>99.9</td>
<td>94.2</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>LAS handover within 15mins</td>
<td>%</td>
<td>R ≤95, G ≥99</td>
<td>36.2</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>LAS handover within 30mins</td>
<td>%</td>
<td>R ≤95, G ≥99</td>
<td>88.4</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>LAS handover within 60mins</td>
<td>No.</td>
<td>G 0, R &gt; 0</td>
<td>0</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>1</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>2 week GP referral to 1st outpatient-breast symptoms *</td>
<td>%</td>
<td>R ≤93, G ≥93</td>
<td>99.5</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>99.5</td>
<td>n/a</td>
<td>97.6</td>
<td>n/a</td>
<td>97.6</td>
<td>n/a</td>
</tr>
<tr>
<td>2 week GP referral to 1st outpatient cancer *</td>
<td>%</td>
<td>R ≤93, G ≥93</td>
<td>98.2</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>98.2</td>
<td>n/a</td>
<td>97.4</td>
<td>n/a</td>
<td>97.4</td>
<td>n/a</td>
</tr>
<tr>
<td>31 day second or subsequent treatment (drugs) *</td>
<td>%</td>
<td>R ≤98, G ≥98</td>
<td>100</td>
<td>n/a</td>
<td>n/a</td>
<td>100</td>
<td>n/a</td>
<td>100</td>
<td>n/a</td>
<td>100</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>31 day second or subsequent treatment (surgery) *</td>
<td>%</td>
<td>R ≤94, G ≥94</td>
<td>97.5</td>
<td>n/a</td>
<td>97.5</td>
<td>n/a</td>
<td>98.8</td>
<td>n/a</td>
<td>98.8</td>
<td>n/a</td>
<td>98.8</td>
<td>n/a</td>
</tr>
<tr>
<td>31 day standard - from diagnosis to first treatment *</td>
<td>%</td>
<td>R ≤96, G ≥96</td>
<td>97.5</td>
<td>n/a</td>
<td>97.5</td>
<td>n/a</td>
<td>97.7</td>
<td>n/a</td>
<td>97.7</td>
<td>n/a</td>
<td>97.7</td>
<td>n/a</td>
</tr>
<tr>
<td>62 day urgent GP referral to treatment for all cancers *</td>
<td>%</td>
<td>R ≤85, G ≥85</td>
<td>80.7</td>
<td>n/a</td>
<td>80.7</td>
<td>n/a</td>
<td>83.0</td>
<td>n/a</td>
<td>83.0</td>
<td>n/a</td>
<td>83.0</td>
<td>n/a</td>
</tr>
<tr>
<td>62 day urgent GP referral to treatment from Screening *</td>
<td>%</td>
<td>R ≤90, G ≥90</td>
<td>94.7</td>
<td>n/a</td>
<td>94.7</td>
<td>n/a</td>
<td>95.1</td>
<td>n/a</td>
<td>95.1</td>
<td>n/a</td>
<td>95.1</td>
<td>n/a</td>
</tr>
</tbody>
</table>
These indicators measure the outcomes resulting from treatment activity for which the Trust is responsible. The TDA framework includes monitoring Healthcare associated Infections and mortality.

The total number of MRSA incidents remains at 4 in December.

In December there was an additional 2 Cdiff incidents taking the total number of Cdiff incidents to 26 for the period April to December 2013. This is below the trust’s trajectory of 39 at the end of December 2013 and a huge improvement on our performance in 2012/13 when the trust reported 47 incidents and in 2011/12, when there were 70 incidents.

There were a total of 8 Grade 3&4 pressure ulcers in December. For the last 2 quarters we have seen a reduction in the number of grade 3 and 4 pressure ulcers. In Quarter 1 there were 41, in Quarter 2 there were 29 and in Quarter 3 there were 25. All grade 3 and 4 pressure ulcers acquired in our care are investigated as serious incidents.
Section 3: TDA Accountability Framework : Quality governance

A new process for validating breaches with the Acute Commissioning Unit and guidance on reporting breaches in critical care has contributed to trust ability to achieve this target. The trust has had 3 mixed sex accommodation breaches in December.

Complaints are a key focus for the Trust, and remain a priority for the Chief Nurse & DOO and the Quality and Risk Committee. Performance against the 25 day response target was 61% increasing to 76% where an extension has been agreed.

The Trust aims to increase it research activity and is currently developing divisional reports and targets with the Research leadership.

<table>
<thead>
<tr>
<th>Metric Name</th>
<th>Units</th>
<th>RAG (Mth)</th>
<th>Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient satisfaction (friends and family) *</td>
<td>NPS</td>
<td>-</td>
<td>Trust CSW MED SN WC</td>
<td>Trust CSW MED SN WC</td>
</tr>
<tr>
<td>Mixed Sex accommodation</td>
<td>No. G 0, R&gt;0</td>
<td>3.0</td>
<td>0.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Nurse Bed Ratio</td>
<td>%</td>
<td>-</td>
<td>0.7</td>
<td>0.7</td>
</tr>
<tr>
<td>Percentage of registered nurses</td>
<td>%</td>
<td>-</td>
<td>75.3</td>
<td>57.5</td>
</tr>
<tr>
<td>Proportion temporary staff on wards (Clinical and Non)</td>
<td>%</td>
<td>-</td>
<td>16.8</td>
<td>39.3</td>
</tr>
<tr>
<td>Staff Turnover</td>
<td>%</td>
<td>G ≤13, R &gt;13</td>
<td>13.6</td>
<td>13.2</td>
</tr>
<tr>
<td>Voluntary Staff Turnover</td>
<td>%</td>
<td>G ≤10, R &gt;10</td>
<td>11.0</td>
<td>9.5</td>
</tr>
<tr>
<td>Sickness/absence rate *</td>
<td>%</td>
<td>G ≤3.5, R &gt;3.5</td>
<td>4.3</td>
<td>5.6</td>
</tr>
<tr>
<td>Vacancy rate</td>
<td>%</td>
<td>G ≤11, R &gt;11</td>
<td>9.9</td>
<td>12.0</td>
</tr>
<tr>
<td>MAST attendance</td>
<td>%</td>
<td>R ≤85, G ≥85</td>
<td>83.0</td>
<td>84.6</td>
</tr>
<tr>
<td>Percentage of staff appraisal (medical)</td>
<td>%</td>
<td>R ≤85, G ≥85</td>
<td>74.0</td>
<td>85.5</td>
</tr>
<tr>
<td>Percentage of staff appraisal (non-medical)</td>
<td>%</td>
<td>R ≤85, G ≥85</td>
<td>61.3</td>
<td>62.5</td>
</tr>
<tr>
<td>Complaints - response within 25d *</td>
<td>%</td>
<td>R ≤85, R ≥85</td>
<td>31.5</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Research

<table>
<thead>
<tr>
<th>Metric Name</th>
<th>Units</th>
<th>RAG (Mth)</th>
<th>Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>70 day - PI REPORT ..</td>
<td>%</td>
<td>R ≤60, G ≥70</td>
<td>31.5</td>
<td>n/a</td>
</tr>
<tr>
<td>Green Rated Time to target of all Open CLRN Studies</td>
<td>%</td>
<td>R ≤45, G ≥70</td>
<td>46.0</td>
<td>n/a</td>
</tr>
<tr>
<td>TIME TO TARGET - PD REPORT ..</td>
<td>%</td>
<td>R ≤60, G ≥70</td>
<td>46.8</td>
<td>n/a</td>
</tr>
<tr>
<td>Total recruitment at St George's NHS - cumulative</td>
<td>No.</td>
<td>R ≤1.8k, G ≥2.9k</td>
<td>2635</td>
<td>n/a</td>
</tr>
</tbody>
</table>

St George’s Healthcare NHS Trust
Section 4: The Monitor Compliance Framework
Section 4: Monitor Compliance Framework
The Trust Rating as at 31st December 2013

- The Trust Overall Rating is **AMBER/RED** for Performance and a **Financial Risk Rating** of 3 at the end of December.
- There have been four MRSA incidents year to date with no occurrences in December.
- In the Monitor Compliance Framework, Monitor applies a de minimis threshold of 6 for MRSA. With the Trust total below this, no penalty is recorded against this target. There were two Cdiff incidents in December taking the trust total to 26 against a target of 39.
- Compliance against the 62 day target remains challenging with performance below target at 80.8% in December. A review with our commissioners regarding certain aspects of the 62 day pathway, reviewing diagnostic capacity and development of a more robust informatics system should result in an improvement.
- A&E: In December for both Type 1 and Type 3, 94.97% of patients were seen within 4 hours, for Type 1 only, it was 94.4%. In Qtr 3 performance was 94.2%
- The forecast position is that the Finance Rating will be maintained at 3 and the Governance rating will revert to Amber / Green or Green once A&E and cancer action plans take full effect from Q4

### Performance Rating

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Frequency</th>
<th>Period</th>
<th>Current Band Performance (%)</th>
<th>Threshold</th>
<th>Weighting achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clostridium difficile meeting the C. difficile objective</td>
<td>Quarterly</td>
<td>Oct-Dec</td>
<td>95%</td>
<td>45</td>
<td>0</td>
</tr>
<tr>
<td>Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia - meeting the MRSA objective</td>
<td>Quarterly</td>
<td>Oct-Dec</td>
<td>90%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Data Completeness CSW</td>
<td>Quarterly</td>
<td>Oct-Dec</td>
<td>50%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Referral Information</td>
<td>Quarterly</td>
<td>Oct-Dec</td>
<td>50%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Treatment activity Information</td>
<td>Quarterly</td>
<td>Oct-Dec</td>
<td>50%</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Financial Risk Rating

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Frequency</th>
<th>Period</th>
<th>Current Band Performance (%)</th>
<th>Threshold</th>
<th>Weighting achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum time of 18 weeks from point of referral to treatment in aggregate- admitted</td>
<td>Quarterly</td>
<td>Oct-Dec</td>
<td>2.5%</td>
<td>90%</td>
<td>0</td>
</tr>
<tr>
<td>Maximum time of 18 weeks from point of referral to treatment in aggregate- non-admitted</td>
<td>Quarterly</td>
<td>Oct-Dec</td>
<td>97.6%</td>
<td>95%</td>
<td>0</td>
</tr>
<tr>
<td>Maximum time of 18 weeks from point of referral to treatment in aggregate- patients on an incomplete pathway</td>
<td>Quarterly</td>
<td>Oct-Dec</td>
<td>92%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cancer first definitive treatment within 31 Day</td>
<td>Standard</td>
<td>Oct-Dec</td>
<td>94%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cancer first definitive treatment within 42 Day</td>
<td>Standard</td>
<td>Oct-Dec</td>
<td>98%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cancer two week wait from referral to date first seen (ww)</td>
<td>Standard</td>
<td>Oct-Dec</td>
<td>93%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All cancer 31 day wait from diagnosis to Treatment</td>
<td>Standard</td>
<td>Oct-Dec</td>
<td>96%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>A&amp;E maximum waiting time of four hours from arrival to admission/transfer/discharge</td>
<td>Quarterly</td>
<td>Oct-Dec</td>
<td>34.2%</td>
<td>95%</td>
<td>1</td>
</tr>
</tbody>
</table>

Total for Access: 2

### Learning Disability

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Frequency</th>
<th>Period</th>
<th>Current Band Performance (%)</th>
<th>Threshold</th>
<th>Weighting achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Disability Total for Outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 5 : Exceptions and Actions

Exceptions and Actions
The following pages provide a summary of performance for the areas where the Trust is not meeting the required standards and the actions being taken to address the performance issues.
Section 5: Exceptions and Actions

18 week Referral to Treatment (RTT) performance: Admitted pathway

Performance: 92.57% compliance in December against target of 90%

• The Trust agreed a plan with Commissioners in 2012/13 to reduce the numbers of patients on the waiting list who had waited over 18 weeks (the backlog). In doing so it was recognised that for the period April to Sept inclusive the Trust would fail to meet the 90% compliance target as a greater proportion of patients who had waited in excess of 18 weeks were seen.

• The Trust met the backlog reduction requirement whilst over achieving the trajectory agreed with and funded by Commissioners and since October 12 has sustained aggregate performance.

• The winter period has been challenging with emergency demand leading to pressure on elective capacity and further cancellations. Nevertheless, the Trust has sustained the overall levels of achievement above the 90% standard in aggregate.

Actions

Both Cardiology and Cardiac surgery will remain non compliant against the admitted wait target for the remaining months of 13/14 while reducing their backlogs. A recovery plan has been agreed for both of these specialties.

Although General Surgery has maintained the 90% target for admitted a recovery plan has also been agreed with a plan to deliver between now and March to reduce the backlog.

### Reporting specialty

<table>
<thead>
<tr>
<th>Reporting specialty</th>
<th>Within</th>
<th>Breach</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>225</td>
<td>25</td>
<td>90.00%</td>
</tr>
<tr>
<td>Urology</td>
<td>109</td>
<td>7</td>
<td>93.97%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>63</td>
<td>8</td>
<td>88.73%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>147</td>
<td>14</td>
<td>91.30%</td>
</tr>
<tr>
<td>Maxillofacial Surgery</td>
<td>107</td>
<td>4</td>
<td>96.40%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>62</td>
<td>5</td>
<td>92.54%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>216</td>
<td>14</td>
<td>93.91%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>32</td>
<td>12</td>
<td>72.73%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>160</td>
<td>5</td>
<td>96.97%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>95</td>
<td>22</td>
<td>81.20%</td>
</tr>
<tr>
<td>Neurology</td>
<td>44</td>
<td>0</td>
<td>100.00%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>196</td>
<td>9</td>
<td>95.61%</td>
</tr>
<tr>
<td>Other</td>
<td>106</td>
<td>2</td>
<td>98.15%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1562</td>
<td>127</td>
<td>92.48%</td>
</tr>
</tbody>
</table>
The Trust reports that performance has improved for the month of December, 94.97% of patients were seen within 4 hours, for both Type 1 and Type 3 performance. Type 1 only performance was 94.4%.

For Quarter 3 (October-December 2013) performance stands at 94.2% for all Types and 93.5% for Type 1 only. The Trust performance is as shown in the table below for both ED and MIU.

<table>
<thead>
<tr>
<th></th>
<th>ED (Type 1)</th>
<th>MIU (Type 3)</th>
<th>ED &amp; MIU (Type 1+3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month to date (December)</td>
<td>94.4%</td>
<td>100.0%</td>
<td>94.97%</td>
</tr>
<tr>
<td>Quarter to date (Q3)</td>
<td>93.5%</td>
<td>99.9%</td>
<td>94.2%</td>
</tr>
<tr>
<td>Year to date (up to 30 November 2013)</td>
<td>94.3%</td>
<td>100.0%</td>
<td>94.9%</td>
</tr>
</tbody>
</table>

The table shows the performance for ED and MIU. MIU data are not yet available; hence, average daily figures have been used and 100% performance assumed.

The trust is being supported by the Emergency Care Intensive Support Team (ECIST) who initially visited the hospital on 5 September 2013 making twenty recommendations. The trust continues to work with ECIST to implement the recommendations with subsequent visits taking place during September, October, November, and December. Further visits scheduled within January and February 2014 to look at ED patient flows and the frailty pathway.

Weekly recovery meetings are being held with the Exec team and the cross divisional leadership teams. This has identified further steps the Trust can be taking to improve performance including review of the current week, plans for the weekend, and a look to the week ahead. This will take note of any plans in place that would directly impact on improving ED performance and the overall flow of patients through the system.

The ED continues to focus on any improvements that can be made to the emergency / urgent pathways. The implementation of the Rapid Assessment and Treatment Service (RATS) commenced on 2 September 2013. The purpose of RATS is to provide early senior intervention in the patients pathway reducing the time to treatment within the ED. Roll out of RATS for five days a week from 2 December 2013 and 7 days from late December, through until the end of March.

Winter pressures monies received have funded additional doctors and nursing staff within the ED to support the increased patient demand. Specifically this entails a minimum of two additional junior doctors and one late long day for nursing per day, and a number of other schemes across the trust to enable flow such as additional on call registrar shifts for Stroke, Plastics, General Surgery and Paediatrics.
Section 5: Exceptions and Actions

Performance : Total of 26 Cdiff cases to date vs trajectory of 45
A total of 4 MRSA cases year to date

Actions

The Trust has a comprehensive action plan which is regularly monitored and updated.

C. difficile

• With the total cases below trajectory the trust will maintain its current strategy, continue to monitor this closely and take corrective action as required.

MRSA Bacteraemia

• The root cause analysis for the fourth bacteraemia was presented to the HCAI taskforce, the investigation did not reveal clear cause and no practice issues were highlighted. It was agreed that it was unavoidable.

• Previous bacteraemia test highlighted the need to develop a competence based assessment for taking blood cultures. This has not been approved.

• In December there was an additional 2 Cdiff incidents taking the total number of Cdiff incidents to 26 for the period April to December 2013. This is below the trusts trajectory of 39 at the end of December 2013 and a huge improvement on our performance in 2012/13 when the trust reported 47 incidents and in 2011/12, when there were 70 incidents.

• The total number of MRSA incidents remains at 4 in December and is below the de minimis limit of 6 per annum applied by Monitor and the Trust Development Agency before a penalty score is applied.
## Section 5: Exceptions and Actions

### Cancer Performance- 62 Day

#### Performance: 62 Day waits 80.8% compliance against target of 85%

<table>
<thead>
<tr>
<th>Target</th>
<th>Cancer Scorecard - 2013/14</th>
<th>St George's Healthcare NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Quality Commission Target</td>
<td>2013/14 Target</td>
<td>Year to date rating</td>
</tr>
<tr>
<td>Apr</td>
<td>May</td>
<td>Jun</td>
</tr>
<tr>
<td>14 day standards</td>
<td>62 Day GP referral for all suspected cancers</td>
<td>93%</td>
</tr>
<tr>
<td>14 day standards</td>
<td>62 Day breast symptomatic referral</td>
<td>93%</td>
</tr>
<tr>
<td>21 day standards</td>
<td>62 Day GP referral for treatment</td>
<td>100%</td>
</tr>
<tr>
<td>21 day standards</td>
<td>62 Day screening referral for treatment</td>
<td>96%</td>
</tr>
<tr>
<td>21 day standards</td>
<td>62 Day consultant upgrade to treatment</td>
<td>95%</td>
</tr>
</tbody>
</table>

The trust was non-compliant against the 62 Day target in November, reporting a performance of 80.8% against a target of 85%. The year to date position is 82.9%. All other cancer targets are being met by the trust.

#### Actions

**Contractual / commissioning issues:**
- **QMR / Kingston contract:** The scheduling, monitoring and reporting of St George’s (SGH) cancer activity at Queen Mary’s Hospital (QMH) needs to be undertaken by a single team which should be the Cancer Management Team based at SGH, providing full visibility of the cancer performance for the whole organisation. It has been agreed that the commissioning lead for the Community Services Division will serve notice on the contract with Kingston Hospital (KH), who currently undertake this function and transfer the budget and the responsibility to the existing cancer management team. This action should be completed as a priority.

**Urology pathway:** Urology breaches make up the largest percentage of the reported breaches. The LCA best practice prostate pathway is to be implemented, requiring access to MRI and TRUS biopsy as part of a one-stop clinic. This will be very difficult to achieve in the short term but a pathway has been agreed for patients to attend a consultation, MRI, TRUS biopsy, MDT discussion and follow up consultation within a ten day period (this can currently take up to eight weeks). A meeting to formalise this will be set up for February with the intention of implementing this pathway in April 2014, to coincide with the appointment of two radiology consultants.

**IT issues:**
- **PAS / Infoflex interface:** The transfer of the monitoring and reporting of QMH activity to St George’s requires a direct feed from QMH PAS to the St George’s cancer informatics system, Infoflex. A price has been agreed with the company that provide Infoflex to undertake this work. The Information department need to resolve two technical issues before this can take place.

**Administrative issues:**
- **Tracking:** The cancer management team have developed a 62 day PTL capturing all TWR referrals received at SGH (not including QMH). A data validator has been recruited to start on 10th February to cleanse the PTL, enabling immediate escalation of capacity issues against proscribed pathway milestones and assist in expediting patient pathways where clinically appropriate.
- **QMR TWRs:** All QMH two week referrals are to be scheduled by St George’s Cancer Referral Office to reduce administrative delays in the pathway and to allow for tracking. This commenced for Urology referrals in December 2013, Breast referrals are due to be taken over on 27th January 2014, with all remaining tumour types due to be transferred by February 2014.
## CQUIN PERFORMANCE as at October 2013 (Q2)

**Trust wide performance ( % of CQUIN Total)**

<table>
<thead>
<tr>
<th>CQUIN Goals &amp; Indicators</th>
<th>Value</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National Targets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends &amp; Family Test</td>
<td>581,750</td>
<td>Increased response - A&amp;E struggling</td>
</tr>
<tr>
<td>NHS Safety Thermometer</td>
<td>729,715</td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td>581,750</td>
<td>not meeting assessment target</td>
</tr>
<tr>
<td>VTE</td>
<td>581,750</td>
<td>not meeting assessment target, schemed are linked so fail one fail both</td>
</tr>
<tr>
<td><strong>Local Targets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EOLC (acute) - EOLC (Year 3 of 3)</td>
<td>210,848</td>
<td></td>
</tr>
<tr>
<td>Alcohol Misuse (Year 3)</td>
<td>276,201</td>
<td>Audit or pre-op clinic to create baseline outstanding</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>396,361</td>
<td>Recruitment issues - failed target for Q2 - planned recovery in Q4</td>
</tr>
<tr>
<td>Maternity (Year 2 of 3)</td>
<td>2,261,023</td>
<td></td>
</tr>
<tr>
<td>COPD Integration</td>
<td>424,188</td>
<td></td>
</tr>
<tr>
<td>Oncology pathway</td>
<td>189,064</td>
<td></td>
</tr>
<tr>
<td>Paediatrics Services (Year 2)</td>
<td>378,128</td>
<td>Should be green by year end</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>232,632</td>
<td></td>
</tr>
<tr>
<td>GP Communications</td>
<td>442,455</td>
<td>By year-end this will be green</td>
</tr>
<tr>
<td>Dermatology Redesign</td>
<td>112,370</td>
<td></td>
</tr>
<tr>
<td>Integrated Heart Failure Service</td>
<td>167,280</td>
<td></td>
</tr>
<tr>
<td>Integrated Fracture Liaison service</td>
<td>189,064</td>
<td></td>
</tr>
<tr>
<td>Diabetes Service redesign</td>
<td>434,956</td>
<td></td>
</tr>
<tr>
<td>Falls</td>
<td>189,064</td>
<td></td>
</tr>
<tr>
<td>CQUIN Goals &amp; Indicators</td>
<td>Value</td>
<td>RAG</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>Community Minimum Data Set</td>
<td>295,929</td>
<td>Failed Q3 - Attendance at MDT of CNS. Predicting Green for Q4</td>
</tr>
<tr>
<td>Community Ward</td>
<td>73,982</td>
<td>By year-end this will be green</td>
</tr>
<tr>
<td>Children's Phlebotomy Service</td>
<td>106,535</td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td>209,427</td>
<td></td>
</tr>
<tr>
<td>Bone Marrow Transplantation</td>
<td>837,707</td>
<td></td>
</tr>
<tr>
<td>Specialised Cancer</td>
<td>209,427</td>
<td></td>
</tr>
<tr>
<td>Renal Dialysis</td>
<td>209,427</td>
<td></td>
</tr>
<tr>
<td>Renal Transplantation</td>
<td>209,427</td>
<td></td>
</tr>
<tr>
<td>Haemophilia</td>
<td>418,854</td>
<td></td>
</tr>
<tr>
<td>Major Trauma</td>
<td>209,427</td>
<td></td>
</tr>
<tr>
<td>NICU</td>
<td>418,854</td>
<td></td>
</tr>
<tr>
<td>Fetal Medicine</td>
<td>209,427</td>
<td></td>
</tr>
<tr>
<td>Dashboards</td>
<td>411,814</td>
<td></td>
</tr>
<tr>
<td>Long Term Conditions</td>
<td>34,646</td>
<td>Data recording and Prison office staffing issues - Action plan being developed</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>34,646</td>
<td></td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>34,646</td>
<td></td>
</tr>
<tr>
<td>People with learning disability</td>
<td>34,646</td>
<td></td>
</tr>
<tr>
<td>AAA Screening - 179,376</td>
<td>66,232</td>
<td></td>
</tr>
<tr>
<td>Bowel Screening - 1,394,009</td>
<td>66,232</td>
<td></td>
</tr>
<tr>
<td>Breast Screening - 3,561,054</td>
<td>66,232</td>
<td></td>
</tr>
<tr>
<td>DESP (retinal screening) - 649,221</td>
<td>66,232</td>
<td></td>
</tr>
<tr>
<td>Early Years (HV etc) 6,843,719</td>
<td>66,232</td>
<td></td>
</tr>
<tr>
<td>Total of Schemes</td>
<td>12,668,580</td>
<td></td>
</tr>
</tbody>
</table>

Achievement: Quarter 1 - 90% Quarter 2 - 88% Quarter 3 - 90%
Section 6: Definitions and Metrics
Section 6: Definitions and metrics

TDA Accountability Framework
The following pages provide details of the metrics included in the TDA performance framework.

Appendix 1: Oversight
– Routine Quality and Governance indicators

Indicators in blue are in addition to mandatory and Monitor Risk Assessment Framework measures in support of the delivery of the TDA oversight function.

Acute NHS Trusts

<table>
<thead>
<tr>
<th>Category</th>
<th>Indicator</th>
</tr>
</thead>
</table>
| CQC Concerns | • Warning notice  
• Civil and/or criminal action |
| Access metrics | • Referral to treatment within 18 weeks  
  – Admitted 90% in 18 weeks  
  – Non admitted 95% in 18 weeks  
  – Incomplete 92% in 18 weeks  
  – Over 52 week waiters  
• Number of diagnostic tests waiting longer than 6 weeks  
• Cancelled operations re-booked within 28 days  
• Urgent operation being cancelled for the second time  
• ARE waits (4 hours)  
• 62 day wait for first treatment  
  – 62 day urgent GP referral to treatment from screening  
  – 62 day urgent GP referral to treatment for all cancers  
• 31 day wait for second or subsequent treatment  
  – 31 day second or subsequent treatment (surgery)  
  – 31 day second or subsequent treatment (drug)  
  – 31 day second or subsequent treatment (radiotherapy)  
• 31 day wait from diagnosis to first treatment  
• Two week wait referral to date first seen  
  – 2 week GP referral to 1st outpatient, cancer  
  – 2 week GP referral to 1st outpatient – breast symptoms |

<table>
<thead>
<tr>
<th>Category</th>
<th>Indicator</th>
</tr>
</thead>
</table>
| Outcomes | • 30 day emergency readmissions  
• Incidence of MRSA  
• Incidence of C. Difficile  
• Medication errors causing serious harm  
• Admissions of full-term babies to neonatal care  
• Harm free care (pressure sores, falls, C-UTI and VTE)  
• Serious incidents  
• Never events  
• eColi + MRSA cases  
• C-section rates  
• Maternal deaths  
• S-IMI  
• HSMR  
• VTE risk assessment  
• CAS Alerts  
• WHO surgical checklist compliance |
| Quality governance indicators | • Patient satisfaction (friends and family)  
• Board turnover  
• Sickness/absence rate  
• Proportion temporary staff – clinical and non-clinical  
• Staff turnover  
• Nurse:bed ratio  
• % nurses registered nurses  
• Mixed sex accommodation  
• Patient and carer voice  
• Complaints  
• % staff appraised |

3rd party reports
Any relevant report including safeguarding alerts, serious case reviews, Ad-hoc reports from MPs, GMC, Ombudsman, Commissioners, litigation, etc.
**TDA Accountability Framework**

**Appendix 3: Oversight – Financial indicators**

<table>
<thead>
<tr>
<th>Indicator No.</th>
<th>Indicator description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Bottom line I&amp;E position</td>
</tr>
<tr>
<td>1b</td>
<td>Year to date actual I&amp;E compared to plan</td>
</tr>
<tr>
<td>1c</td>
<td>Forecast I&amp;E compared to plan</td>
</tr>
<tr>
<td>2a</td>
<td>Actual efficiency compared to plan split recurring / non recurring</td>
</tr>
<tr>
<td>2b</td>
<td>Year to date actual efficiency recurring / non recurring compared to plan</td>
</tr>
<tr>
<td>2c</td>
<td>Forecast recurring efficiency / non recurring compared to plan</td>
</tr>
<tr>
<td>3</td>
<td>Forecast underlying revenue position compared to plan for the year</td>
</tr>
<tr>
<td>4</td>
<td>Forecast year and charge to capital resource limit compared to plan</td>
</tr>
<tr>
<td>5</td>
<td>Has Trust accessed a TBL or PDC for liquidity during 2013/14?</td>
</tr>
<tr>
<td>6</td>
<td>NHS Trust is in receipt of Distress Financing</td>
</tr>
</tbody>
</table>

**Appendix 2: Oversight – Other Quality and Governance indicators**

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples (not exhaustive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical standards</td>
<td>• A&amp;E consultant cover 24 x 7</td>
</tr>
<tr>
<td></td>
<td>• Emergency paediatrics consultant rota</td>
</tr>
<tr>
<td></td>
<td>• Obstetrics consultant cover 24 x 7</td>
</tr>
<tr>
<td></td>
<td>• Midwifery cover</td>
</tr>
<tr>
<td>Staff satisfaction</td>
<td>• Staff survey – friends and family test, material changes</td>
</tr>
<tr>
<td></td>
<td>• Staff survey – staff satisfaction, material changes</td>
</tr>
<tr>
<td>Board capability and capacity</td>
<td>• Board observations</td>
</tr>
<tr>
<td></td>
<td>• BGAF</td>
</tr>
<tr>
<td></td>
<td>• MQGF</td>
</tr>
<tr>
<td>Licence terms</td>
<td>• Choice, competition and integration terms (self-certification)</td>
</tr>
</tbody>
</table>

**Measures of progress towards FT status**

<table>
<thead>
<tr>
<th>Indicator No.</th>
<th>Indicator description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>EBITDA achieved (% of plan)</td>
</tr>
<tr>
<td>2</td>
<td>EBITDA margin, %</td>
</tr>
<tr>
<td>3</td>
<td>Not return after financing, %</td>
</tr>
<tr>
<td>4</td>
<td>I&amp;E surplus margin not of dividend, %</td>
</tr>
<tr>
<td>5</td>
<td>Liquidity ratio days</td>
</tr>
<tr>
<td></td>
<td>Combined Financial Risk Rating</td>
</tr>
</tbody>
</table>

**Monitor Risk Assessment Framework – Continuity of Services**

<table>
<thead>
<tr>
<th>Indicator No.</th>
<th>Indicator description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Liquidity Days</td>
</tr>
<tr>
<td>2</td>
<td>Capital Services Capacity</td>
</tr>
<tr>
<td>3</td>
<td>Combined Risk Rating</td>
</tr>
</tbody>
</table>

These indicators will be assessed less frequently. They will not contribute directly to the quality and governance rating but they will be used to contribute to the overall judgement of the delivery of the organisation.
Section 7: Appendices
Appendix 1: Benchmark Data
## Accident and Emergency (All type): 4 hour wait  December  2013

<table>
<thead>
<tr>
<th>Trust</th>
<th>08/12/13</th>
<th>15/12/13</th>
<th>22/12/13</th>
<th>29/12/13</th>
<th>4 weeks average</th>
<th>Quarter 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chelsea &amp; Westminster</td>
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## Accident and Emergency (Type 1): 4 hour wait

### December 2013

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**Blue = Trauma Centres**

### Top 5 Trusts QTD

1. Chelsea & Westminster
2. Royal Free
3. Homerton
4. Whittington
5. Guys & St Thomas’

### Bottom 5 Trusts QTD

17. Hillingdon
18. Croydon Healthcare
20. Barking, Havering & Redbridge
21. King’s
MRSA Dashboard 2013-14

NB. Trajectories for 2013-14 are Zero for MRSA.

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* Data in the body of the report may reflect more recent updates
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* Data in the body of the report may not reflect more recent updates