Report to:	Date
Trust board - public	**31 January 2018**

Integrated Performance Report

Executive summary:

This is a regular report which outlines the key headlines relating to the reporting month of December 2017 (month 9).

The NHS Improvement Undertakings report for January is attached – as requested at the November Trust board, this has been included as part of the integrated performance report, rather than as a separate agenda item.

Recommendation to the Trust board:

The Board is asked to note this report.

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered with care and compassion.

To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

Author	Responsible executive director
Performance Support Team	William Oldfield (acting Medical Director) Janice Sigsworth (Director of Nursing) David Wells (Director of People and Organisational Development) Catherine Urch (Divisional Director) Tim Orchard (Divisional Director and acting Medical Director) Tg Teoh (Divisional Director)

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1. Scorecard

ICHT Integrated Performance Scorecard - 2017/18

Month 10 Report

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Safe					
Serious incidents (number)	William Oldfield	Dec-17	-	**6**	
Incidents causing severe harm (number)	William Oldfield	Dec-17	-	**3**	
Incidents causing severe harm (% of all incidents YTD)	William Oldfield	Dec-17	-	**0.10%**	
Incidents causing extreme harm (number)	William Oldfield	Dec-17	-	**1**	
Incidents causing extreme harm (% of all incidents YTD)	William Oldfield	Dec-17	-	**0.06%**	
Patient safety incident reporting rate per 1,000 bed days	William Oldfield	Dec-17	44.0	**50.7**	
Duty of candour compliance at 09/01/2018:					
Compliance with duty of candour (SIs)	William Oldfield	Nov-17	100%	**96.0%**	
Compliance with duty of candour (Level 1 - internal investigations)	William Oldfield	Nov-17	-	**60.0%**	
Compliance with duty of candour (Moderate and above incidents)	William Oldfield	Nov-17	-	**83.0%**	
Never events (number)	William Oldfield	Dec-17	0	**0**	
MRSA (number)	William Oldfield	Dec-17	0	**0**	
Clostridium difficile (cumulative YTD) (number)	William Oldfield	Dec-17	62	**47**	
VTE risk assessment: inpatients assessed within 24 hours of admission (%)	William Oldfield	Dec-17	95.0%	**95.8%**	
CAS alerts outstanding (number)	William Oldfield	Dec-17	0	**0**	
Avoidable pressure ulcers (number)	Janice Sigsworth	Dec-17	-	**1**	
Staffing fill rates (%)	Janice Sigsworth	Dec-17	tbc	**96.7%**	
Post Partum Haemorrhage 1.5L (PPH) (%)	Tg Teoh	Dec-17	2.8%	**2.4%**	
Core Skills (excluding Doctors in Training) (%)	David Wells	Dec-17	90.0%	**84.9%**	
Core Skills (Doctors in Training) (%)	David Wells	Dec-17	90.0%	**73.1%**	
Core Clinical Skills (excluding Doctors in Training) (%)	David Wells	Dec-17	tbc	**83.3%**	
Core Clinical Skills (Doctors in Training) (%)	David Wells	Dec-17	tbc	**64.5%**	
Staff accidents and incidents in the workplace (RIDDOR-reportable) (number)	David Wells	Dec-17	0	**1**	

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Effective					
Hospital standardised mortality ratio (HSMR)	William Oldfield	Aug-17	100	**68.0**	
Mortality reviews at 03/01/2018:					
Total number of deaths	William Oldfield	Dec-17	-	**159**	
Number of local reviews completed	William Oldfield	Dec-17	-	**58**	
% of local reviews completed	William Oldfield	Dec-17	100%	**36.5%**	
Number of SJR reviews requested	William Oldfield	Dec-17	-	**9**	
Number of SJR reviews completed	William Oldfield	Dec-17	-	**1**	
Number of avoidable deaths (Score 1-3)	William Oldfield	Dec-17	-	**0**	
Clinical trials - recruitment of 1st patient within 70 days (%)	William Oldfield	Sep-17	90.0%	**53.3%**	
Discharges before noon	Tim Orchard	Dec-17	35.0%	**10.0%**	
Unplanned readmission rates (28 days) over 15s (%)	Tim Orchard	Jun-17	**-**	**7.2%**	
Unplanned readmission rates (28 days) under 15s (%)	Tg Teoh	Jun-17	**-**	**4.7%**	
Outpatient appointments not checked-in or DNAd (app within last 90 days) (%)	Tg Teoh	Dec-17	-	**1.5%**	
Outpatient appointments checked-in AND not checked-out (%)	Tg Teoh	Dec-17	-	**1.2%**	
Diagnostic and surgical orders waiting to be processed (Add/Set Encounter)	Kevin Jarrold	Dec-17	0	**1337**	
Caring					
Friends and Family Test: **Inpatient** service - % patients recommended	Janice Sigsworth	Dec-17	95.0%	**97.9%**	
Friends and Family Test: **A&E** service - % recommended	Janice Sigsworth	Dec-17	85.0%	**94.4%**	
Friends and Family Test: **Maternity** service - % recommended	Janice Sigsworth	Dec-17	95.0%	**93.0%**	
Friends and Family Test: **Outpatient** service - % recommended	Janice Sigsworth	Dec-17	94.0%	**90.9%**	
Complaints: Total number received from our patients	Janice Sigsworth	Dec-17	100	**89**	
Non-emergency patient transport: waiting times of less than 2 hours for outward journey	Janice Sigsworth	Dec-17	-	**71.7%**	
Mixed-Sex Accommodation (EMSA) breaches	Janice Sigsworth	Dec-17	0	**19**	

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Well Led					
Vacancy rate (%)	David Wells	Dec-17	10.0%	**12.1%**	
Voluntary turnover rate (%) 12-month rolling	David Wells	Dec-17	10.0%	**9.4%**	
Sickness absence (%)	David Wells	Dec-17	3.1%	**3.3%**	
Personal development reviews (%)	David Wells	Jul-17	95.0%	**-**	
Doctor Appraisal Rate (%)	Tim Orchard	Dec-17	95.0%	**88.4%**	
Staff FFT (% recommended as a place to work)	David Wells	17/18 Q1	-	**70.6%**	
Staff FFT (% recommended as a place for treatment)	David Wells	17/18 Q1	-	**85.1%**	
Education open actions (number)	Tim Orchard	Dec-17	-	**0**	
Reactive maintenance performance (% tasks completed within agreed response time)	Janice Sigsworth	Dec-17	-	**15.8%**	
Responsive					
RTT: 18 Weeks Incomplete (%)	Catherine Urch	Dec-17	92.0%	**81.8%**	
RTT: Patients waiting over 18 weeks for treatment (number)	Catherine Urch	Dec-17	-	**11439**	
RTT: Patients waiting 52 weeks or more for treatment (number)	Catherine Urch	Dec-17	0	**242**	
Cancer: 62 day urgent GP referral to treatment for all cancers (%)	Catherine Urch	Nov-17	85.0%	**87.1%**	
Cancelled operations (as % of total elective activity)	Catherine Urch	Nov-17	0.8%	**0.9%**	
28 day rebooking breaches (% of cancellations)	Catherine Urch	Nov-17	8.0%	**7.7%**	
Theatre utilisation (elective) (%)	Catherine Urch	Dec-17	85.0%	**74.3%**	
A&E patients seen within 4 hours (type 1) (%)	Tim Orchard	Dec-17	95.0%	**64.1%**	
A&E patients seen within 4 hours (all types) (%)	Tim Orchard	Dec-17	95.0%	**84.2%**	
A&E patients spending >12 hours from decision to admit to admission	Tim Orchard	Dec-17	0	**5**	
Waiting times for first outpatient appointment (routine) (average weeks waited for attended appointments)	Tg Teoh	Dec-17	-	**7.4**	
Patients waiting longer than 6 weeks for diagnostic tests (%)	Tg Teoh	Dec-17	1.0%	**1.5%**	
Outpatient Did Not Attend rate: (First & Follow-Up) (%)	Tg Teoh	Dec-17	11.0%	**12.7%**	
Hospital initiated outpatient cancellation rate with less than 6 weeks notice (%)	Tg Teoh	Dec-17	7.5%	**9.1%**	
Outpatient appointments made within 5 working days of receipt (%)	Tg Teoh	Dec-17	95.0%	**85.6%**	
Money and Resources					
In month variance to plan (£m)	Richard Alexander	Dec-17		**-3.69**	
YTD variance to plan (£m)	Richard Alexander	Dec-17		**-4.87**	
Annual forecast variance to plan (£m)	Richard Alexander	Dec-17		**-8.09**	
Agency staffing (% YTD)	Richard Alexander	Dec-17		**4.4%**	
CIP % delivery YTD	Richard Alexander	Dec-17		**83.3%**	

2. Key indicator overviews

2.1 Safe

2.1.1 Safe: Serious Incidents

Six serious incidents (SIs) were reported in December 2017, which are undergoing root cause analysis. Each SI was from a different category. Unlike previous reports, there were none caused by treatment delay due to lack of availability of mental health beds.

A downward trend in the overall number of SIs has been seen over the last three months. The most notable categories where reductions have been seen are treatment delay (availability of mental health beds), pressure ulcers and infection control incidents.

These reductions are in part due to our improvement work, as well as a focus on expediting initial investigations to allow more accurate SI declaration, which should in turn reduce our de-escalation requests. This is supported by the launch of a new 72 hour investigation template which is being completed by our clinical and governance teams and presented to the weekly MD incident panel for all moderate and above incidents. This is helping teams to accurately describe the early findings from their initial investigations which in turn should support accurate decision making on the declaration of SIs. At the same time, we have agreed with the Director of Nursing that we will no longer routinely declare all pressure ulcers as externally reported SIs which is in line with the national SI framework.

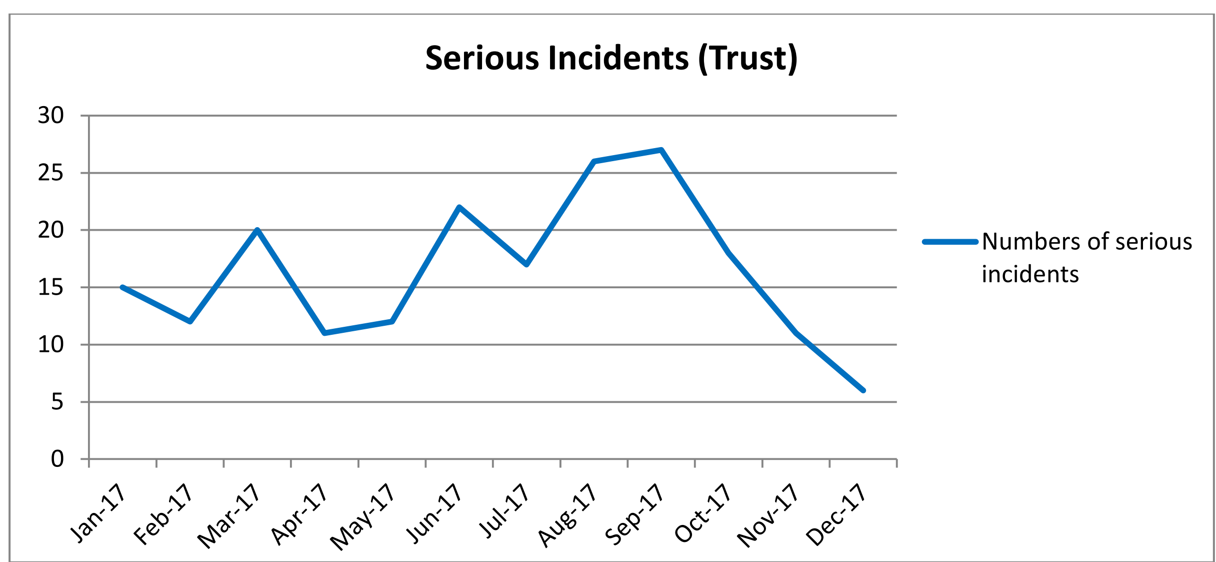

Chart 1 - Number of Serious Incidents (SIs) (Trust level) by month for the period January 2017 – December 2017

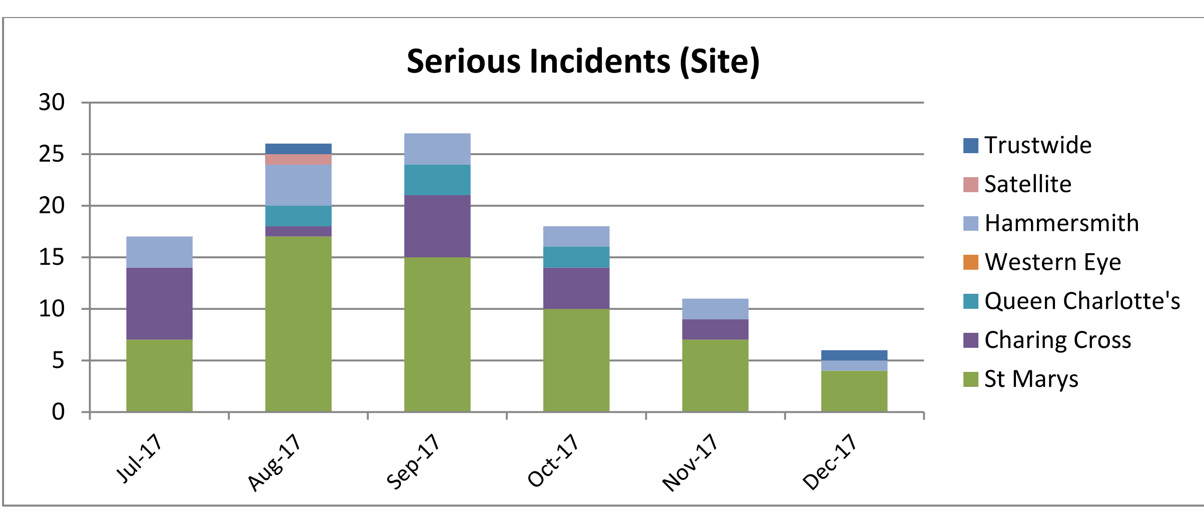

Chart 2 - Number of Serious Incidents (SIs) (Site level) by month for the period July 2017 – December 2017

In the last 12 months there has been an overall increase in the number of SIs reported compared to the preceding 12 month period, from 173 to 197. The increase reflects the Trust's commitment to improving the culture of safety through encouraging transparent identification of issues to enhance the opportunities for learning in a supportive environment. The increases are understood and our harm profile is not raising a specific cause for concern.

As reported previously nine safety improvement programmes (safety streams) have been in place to support reducing recurrence for the categories that have been reported most frequently:

1. Pressure Ulcers
2. Safe Mobility and Prevention of Falls with Harm
3. Recognising and Responding to the Very Sick Patient
4. Optimising Hand Hygiene
5. Safer Surgery
6. Fetal Monitoring
7. Safer Medicines
8. Abnormal Results
9. Positive Patient Confirmation

2.1.2 Safe: Incident reporting and degree of harm

<u>Incidents causing severe and extreme harm</u>

The Trust reported three severe/major harm incidents and one extreme harm/death incident in December 2017. These incidents are being investigated. The severe harm incident that was still under review at the time of reporting last month, has been downgraded and is undergoing a local investigation.

There have been thirteen severe and seven extreme harm incidents reported so far this year. This is below average when compared to data published by the National

Reporting and Learning System (NRLS) in September 2017 for the October 2016 – March 2017 period.

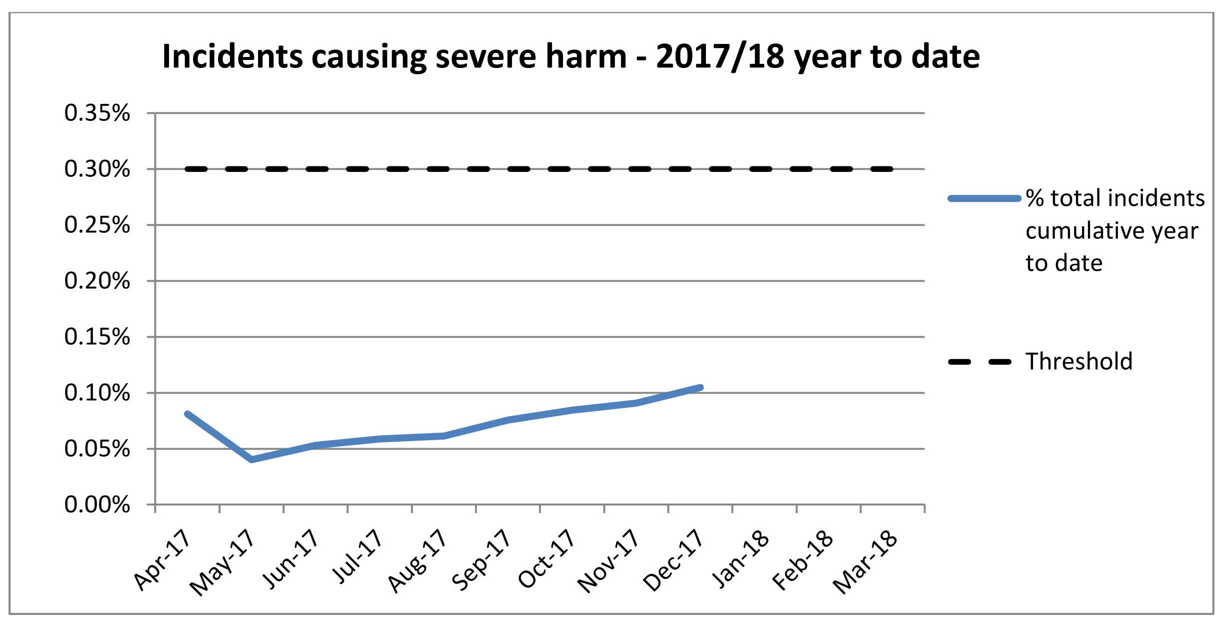

Chart 3 – Incidents causing severe harm by month from the period April 2017 – December 2017 (% of total patient safety incidents YTD). Threshold Source: National Reporting and Learning System (NRLS)

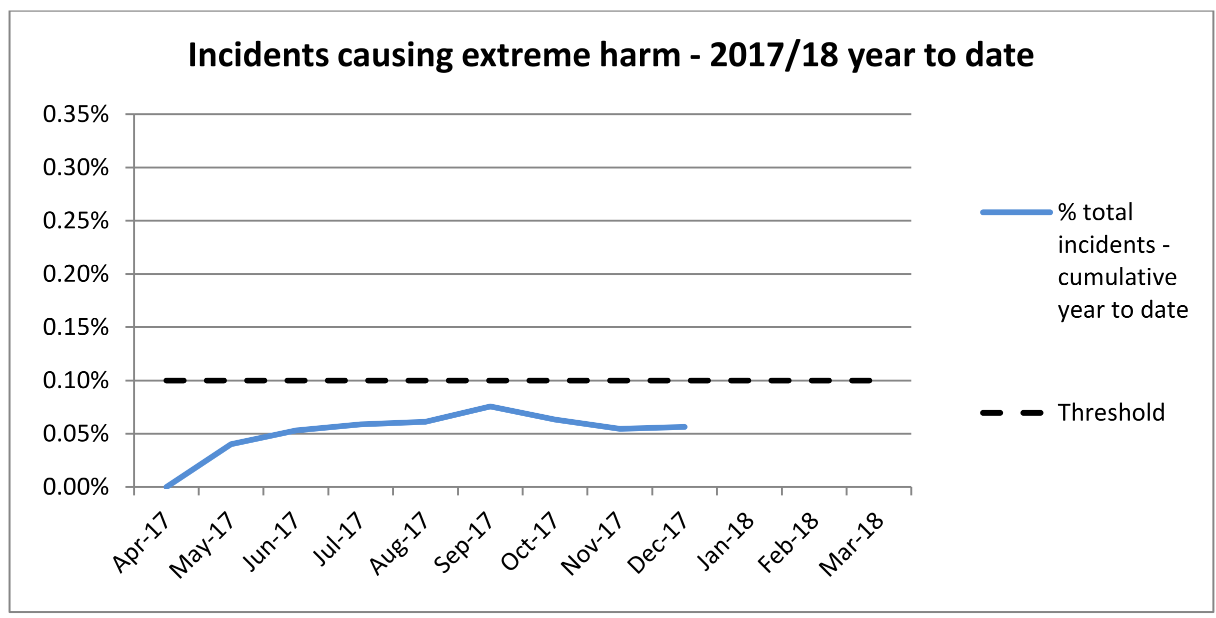

Chart 4 – Incidents causing extreme harm by month from the period April 2017 – December 2017 (% of total patient safety incidents YTD). Threshold Source: National Reporting and Learning System (NRLS)

<u>Patient safety incident reporting rate</u>

The Trust's incident reporting rate for December 2017 is 50.73 which places us within the highest 25% of reporters nationally. A high reporting rate with low levels of harm is one indicator of a positive safety culture and is one of the key focus areas for the safety culture improvement programme launched in July 2016.

Over the last 6 months there has been a steady increase in patient safety incident reporting in a number of directorates, particularly children's services and critical care, as a result of focussed local improvement work. December numbers have dropped which will be partly explained by seasonal variation (reduced activity) in particular in theatres and anaesthetics who reported 58% less.

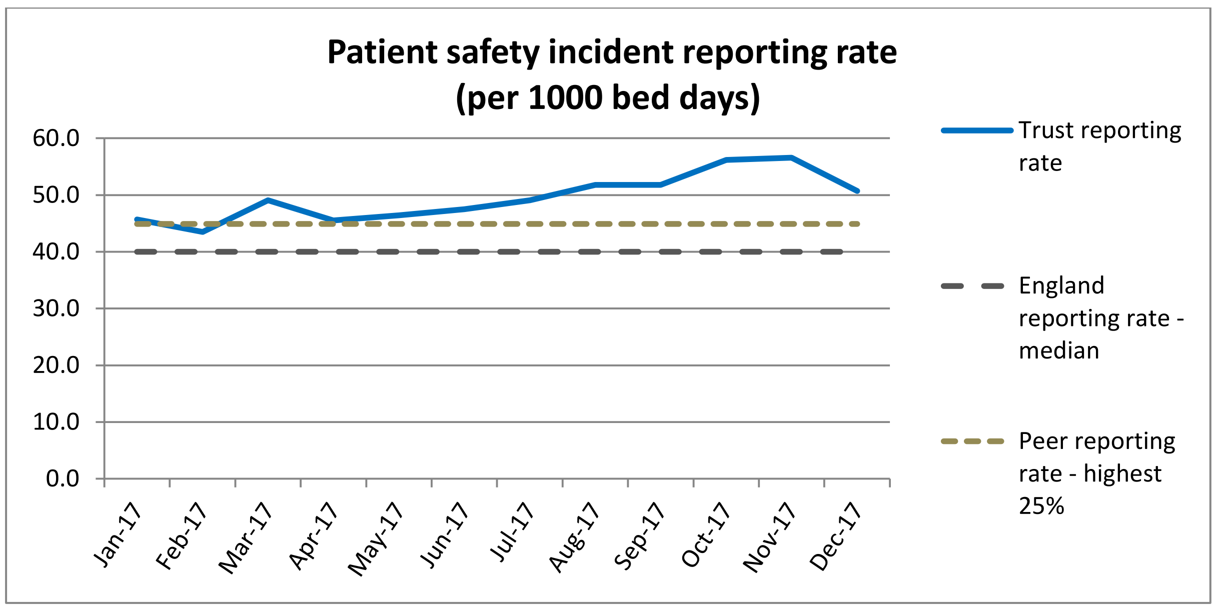

Chart 5 – Trust incident reporting rate by month for the period January 2017 – December 2017

1. Median reporting rate for Acute non specialist organisations
2. Highest 25% of incident reporters among all Acute non specialist organisations

2.1.3 Safe: Duty of candour

Concerns were raised in February 2017 about Trust compliance with duty of candour for incidents that have been declared as SIs. These concerns originated from a retrospective compliance audit in September 2016 (limited assurance) and also from an SI where the candour process was not adequate. A full review of processes across the Trust was commissioned by the Medical Director, and since April 2017 compliance for SI investigations has been monitored through the medical director's incident review panel, with improvements seen. This commenced in July 2017 for incidents graded moderate and above and all level 1 investigations.

The table below shows the number of SIs, internal investigations and cases of moderate harm reported between April and November 2017, and the percentage of these which have had stage 1 and stage 2 of the duty of candour process completed which are all improving. The data goes back to April 2017 to reflect the current financial year.

Focussed work is supporting the improving performance with internal investigations being the most difficult to influence. This is partly explained by the level of harm for patients in this group which often is not moderate. Historically we have not sent letters to patients when they did not experience moderate harm and our policy was not clear on this point. The policy has now been revised to make explicit that this is

required. The compliance for December 2017 is not yet available as data is reported one month in arrears.

	SIs	Level 1 (internal investigations)	Moderate and above incidents
Number of incidents (Apr 2017 – Nov 2017)	137	55	40
Total with stage 1 complete	135	37	33
Total with stage 2 complete	131	35	34
Total with both stages complete	131	33	33
Percentage fully compliant with duty of candour requirements	96%	60%	83%

Percentage of incidents fully compliant with duty of candour requirements at 9 January 2018

2.1.4 Safe: Never events

There have been no further never events declared since the case in July 2017. The surgery, cancer and cardiovascular (SCCS) division have implemented immediate action to minimise recurrence of the July never event by using an alert on epidural lines in the form of a printed sticker. This is a short term measure until new products which do not allow connection to inappropriate devices become available (expected in Quarter 4). An implementation plan has been developed and a Task and Finish group is being set up by the SCCS division to manage the roll out trust wide.

An audit of the sticker alert on epidural lines is currently underway in all clinical areas. It has been extended to the end of February 2018 to ensure a large enough sample size across the three sites. The results will be reported in the March report.

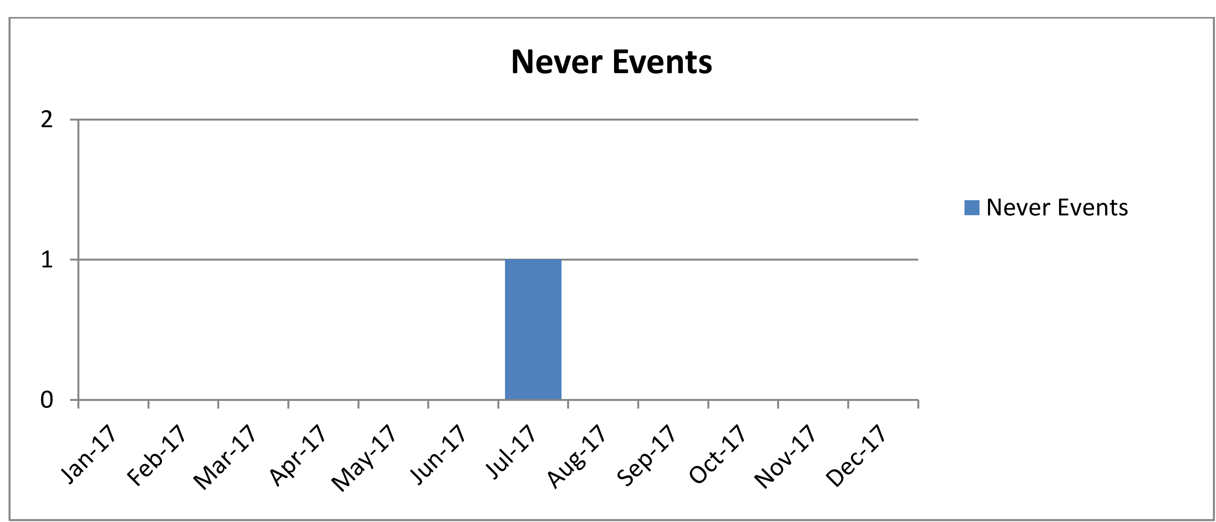

Chart 6 – Trust Never Events by month for the period January 2017 – December 2017

2.1.5 Safe: Meticillin - resistant *Staphylococcus aureus* bloodstream infections (MRSA BSI)

There were no cases of MRSA BSI identified at the Trust in December 2017. One case of MRSA BSI has been allocated to the Trust so far in 2017/18; this occurred in April 2017.

2.1.6 Safe: *Clostridium difficile*

Six cases of Clostridium difficile were allocated to the Trust for December 2017; one of these was identified as a lapse in care. Since the last report a case from November 2017 has also now been identified as a lapse in care.

Forty seven cases of Clostridium difficile have so far been allocated to the Trust in 2017/18, which is below trajectory. Four cases have been identified as a lapse in care so far in 2017/18, following multi-disciplinary team review, held monthly.

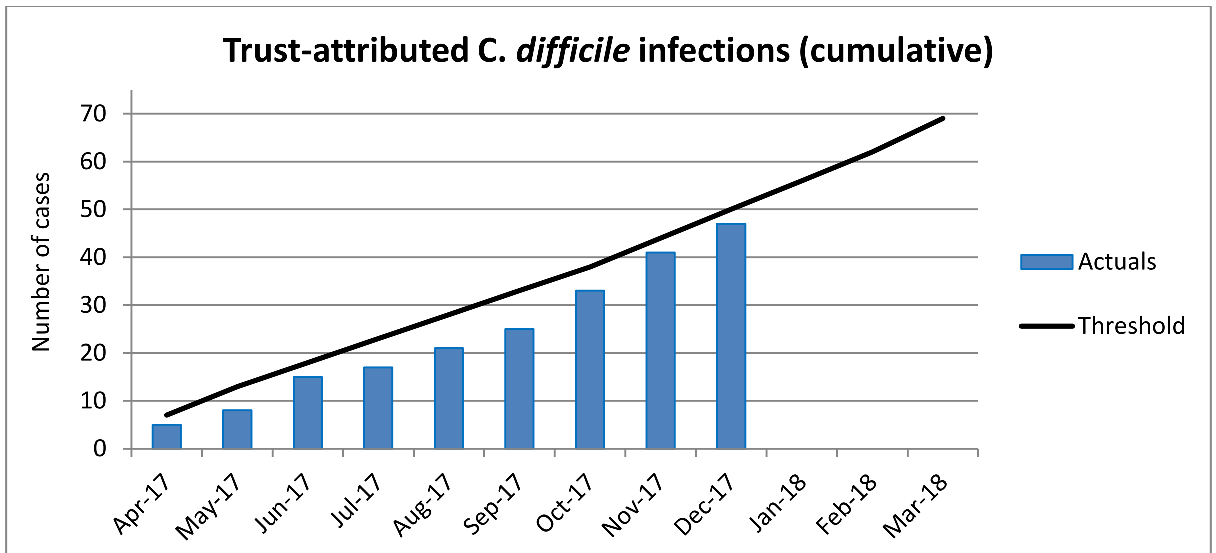

Chart 7 - Number of Trust-attributed *Clostridium difficile* infections against cumulative plan by month for the period April 2017 – December 2017

2.1.7 Safe: Venous thromboembolism (VTE) risk assessment

The Trust performance remained above target at 95.8 per cent at end December. Sustained improvements are now being seen across the divisions as a result of local action plans and monitoring arrangements. A Trust wide action plan has been in place during this financial year given the difficulties we have experienced and progress reported to Executive Quality Committee through the Trust's Quality Report.

The data quality of VTE assessment will undergo an external audit as part of the indicator testing for the Trust's 2017/18 Quality Account.

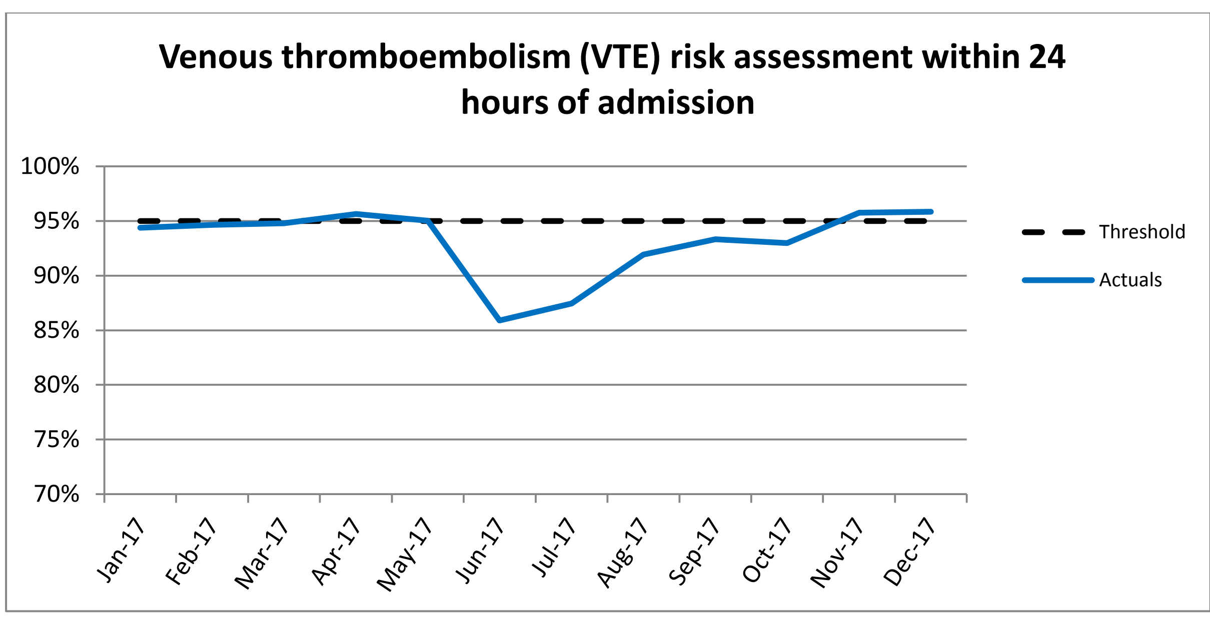

Chart 8 – % of inpatients who received a risk assessment for Venous thromboembolism (VTE) within 24 hours of their admission by month for the period January 2017 – December 2017

2.1.8 Safe: CAS alerts outstanding

The Department of Health Central Alerting System (CAS) is a system for issuing patient safety alerts, public health messages and other safety critical information and guidance to the NHS and others. There are currently no overdue alerts.

2.1.9 Safe: Avoidable pressure ulcers

There was one avoidable unstageable pressure ulcer reported for the month of December 2017 in the Division of Medicine and Integrated care. The total number of avoidable pressure ulcers for the year is now 13 compared to 21 for the same period last year. Each avoidable pressure ulcer is subject to a serious incident review by the Matron/Charge Nurse of the clinical area and an action plan put into place.

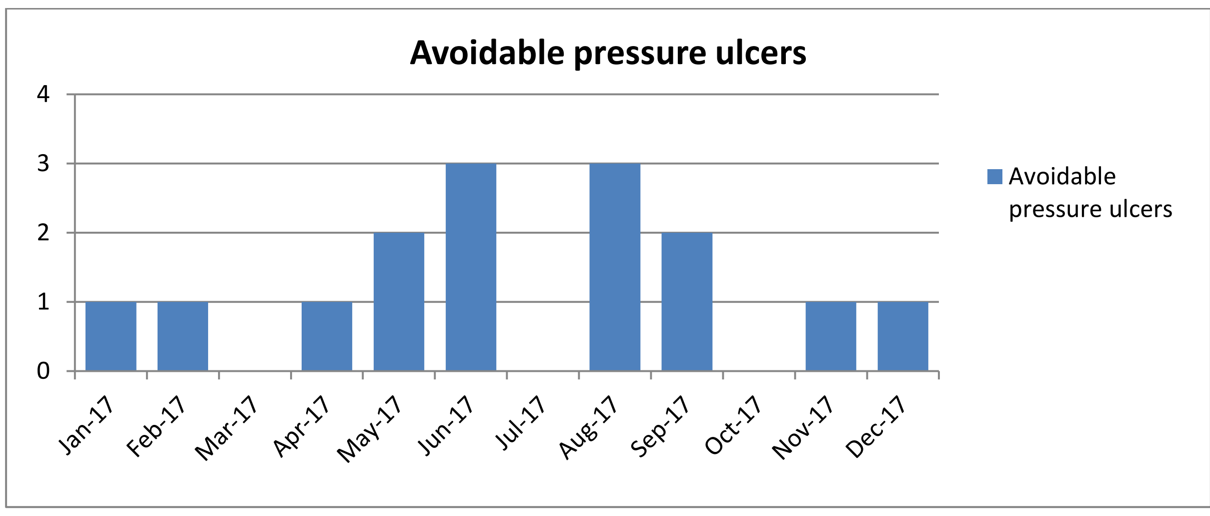

Chart 9 – Number of category 3 and category 4 (including unstageable) Trust-acquired pressure ulcers by month for the period January 2017 – December 2017

2.1.10 Safe: Safe staffing levels for registered nurses, midwives and care staff

In December 2017 the Trust met safe staffing levels for registered nurses and midwives and care staff overall during the day and at night. The thresholds are 90 per cent for registered nurses and 85 per cent for care staff. The percentage of shifts meeting planned safe staffing levels by hospital site are provided in the table below. Additional detailed for safe staffing levels below target by ward is provided in appendix 1.

Site Name	Day shifts – average fill rate		Night shifts – average fill rate	
	Registered nurses/midwives	Care staff	Registered nurses/midwives	Care staff
Charing Cross	94.7%	91.6%	96.7%	93.6%
Hammersmith	95.0%	92.2%	97.7%	94.3%
Queen Charlotte's	96.6%	98.2%	98.8%	97.2%
St. Mary's	95.0%	92.3%	96.6%	97.1%

During the month of December there was increased activity across NHS Trusts which required and initiated a national response from NHS England. As a result a number of non-urgent elective procedures were postponed to reduce the pressure on bed capacity and increased Emergency Department activity.

In order to maintain standards of care the Trust's Divisional Directors of Nursing and their teams optimised staffing and mitigated any risk to the quality of care delivered to patients in the following ways:

- Using the workforce flexibly across floors and clinical areas as described and in some circumstances between the three hospital sites.
- Cohorting patients and adjusting case mixes to ensure efficiencies of scale.

In addition, the Divisional Directors of Nursing regularly review staffing when, or if there is a shift in local quality metrics, including patient feedback.

In order to respond to the continued challenge of filling shifts for health care staff from the nurse bank, plans are being established to improve the uptake of these shifts to reduce future staffing gaps. There is also renewed focus on recruitment and retention of staff across bands 2-6 and a strategic reponse to the challenges has been developed and lead by Organisational Development with senior nursing input.

The Nursing Associate pilot commenced in April 2017 and 21 new trainees were employed across our partner organisations, 13 of which are based at Imperial.

All Divisional Directors of Nursing have confirmed to the Director of Nursing that the staffing levels in December 2017 were safe and appropriate for the clinical case mix.

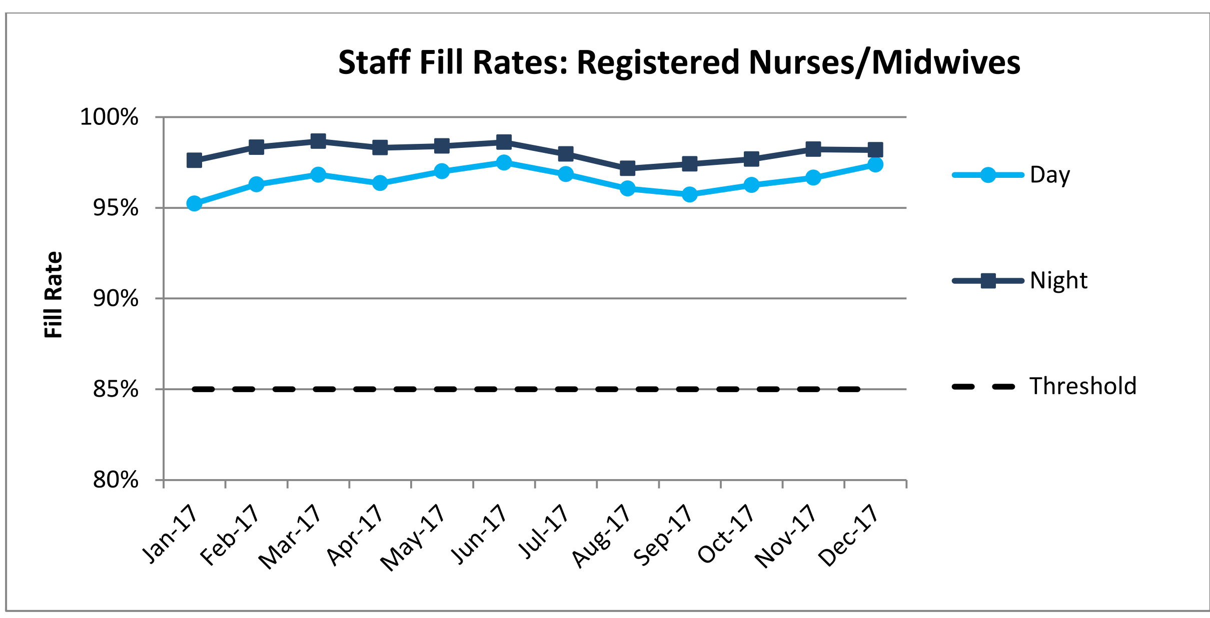

Chart 10 - Monthly staff fill rates (Registered Nurses/Registered Midwives) by month for the period January 2017 – December 2017

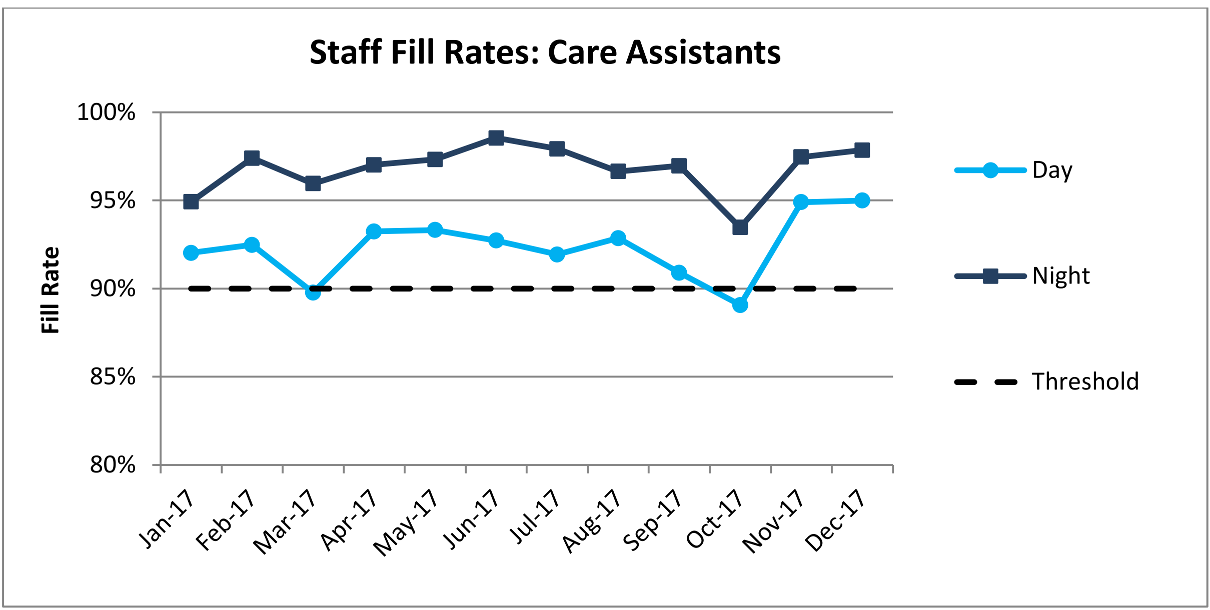

Chart 11 - Monthly staff fill rates (Care Assistants) by month for the period January 2017 – December 2017

2.1.11 Safe: Postpartum haemorrhage

In December, 2.4 per cent of women who gave birth at the Trust had a postpartum haemorrhage (PPH), involving an estimated blood loss of 1500ml or more within 24 hours of the birth of the baby. This met the Trust target of 2.8 per cent or less.

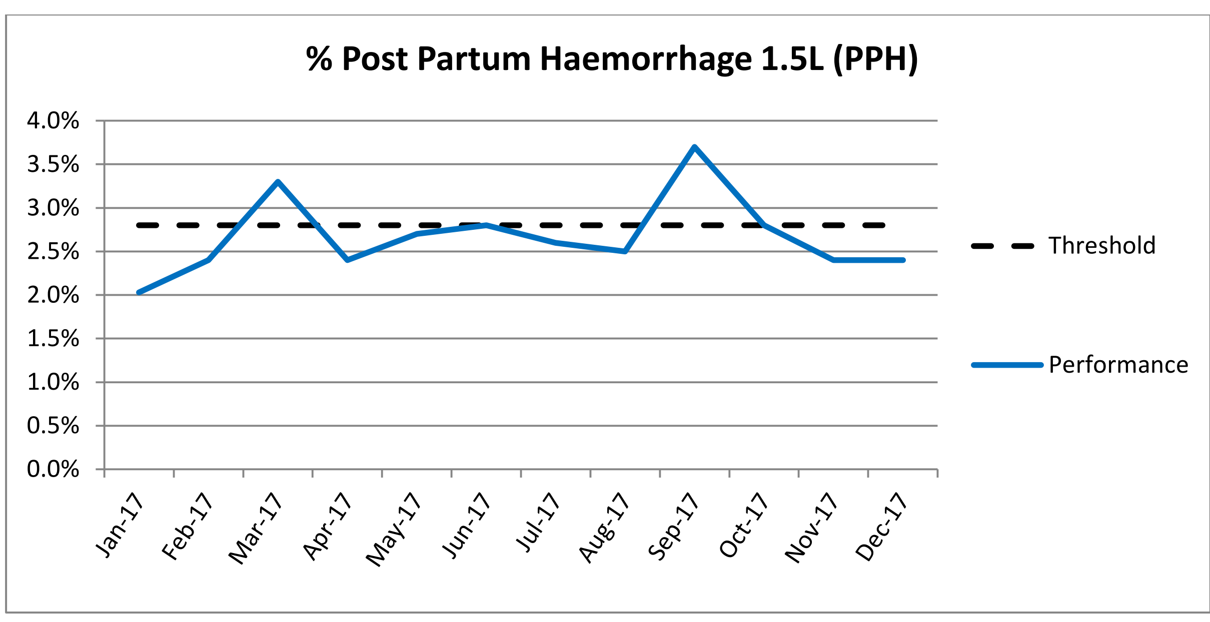

Chart 12 – Postpartum haemorrhage (PPH) for the period January 2017 – December 2017

2.1.12 Safe: Core skills training

Core Skills Training (statutory mandatory): At the end of December, the compliance rate for Doctors in Training/Trust Grade was 73.1 per cent and for all other staff, 84.9 per cent

Core Clinical Skills Training: At the end of December, the compliance rate for Doctors in Training/Trust Grade was 64.5 per cent and for all other staff, 83.3 per cent.

An audit has been completed by the Trust external auditors on the Core Skills Department concluded that there is reasonable assurance that mandatory training is being completed, recorded and monitored. They identified no urgent action points, 2 important actions, 4 routine actions and 1 operational action that are required. An action plan has been agreed and is now being delivered.

A workshop for subject matter experts has been arranged for January 2018 to discuss how the Core Skills team and Subject Matter Experts can better work together to address under-performing areas.

A pilot is being run within the finance department to send all staff that are non-compliant an email with details of the subjects that they need to complete. If the pilot is successful, it is anticipated that every 2 weeks, when the WIRED reporting tool is updated, approximately 7,000 staff will receive an email with their areas of non-compliance listed with links to the eLearning courses.

Imperial is part of a national pilot to streamline the induction of Doctors in Training (DiT). As part of the pilot, 8 Core Clinical subjects have been identified which will be transferable between Trusts making it easier to demonstrate compliance in these subjects without requiring DiT to retake training courses they have previously completed.

The first meeting of the Core Skills Governance Committee is arranged for January. The committee will meet monthly and review the Core Skills requirements, with a view to continuously monitoring the mandatory training requirements across the Trust.

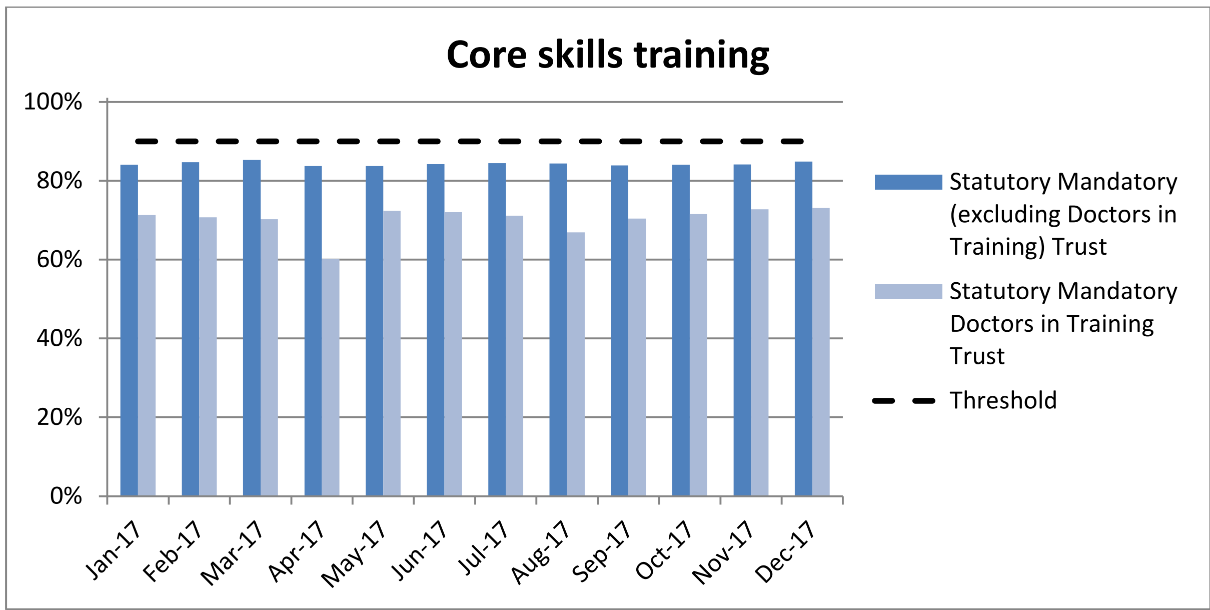

Chart 13 - Statutory and mandatory training for the period January 2017 – December 2017

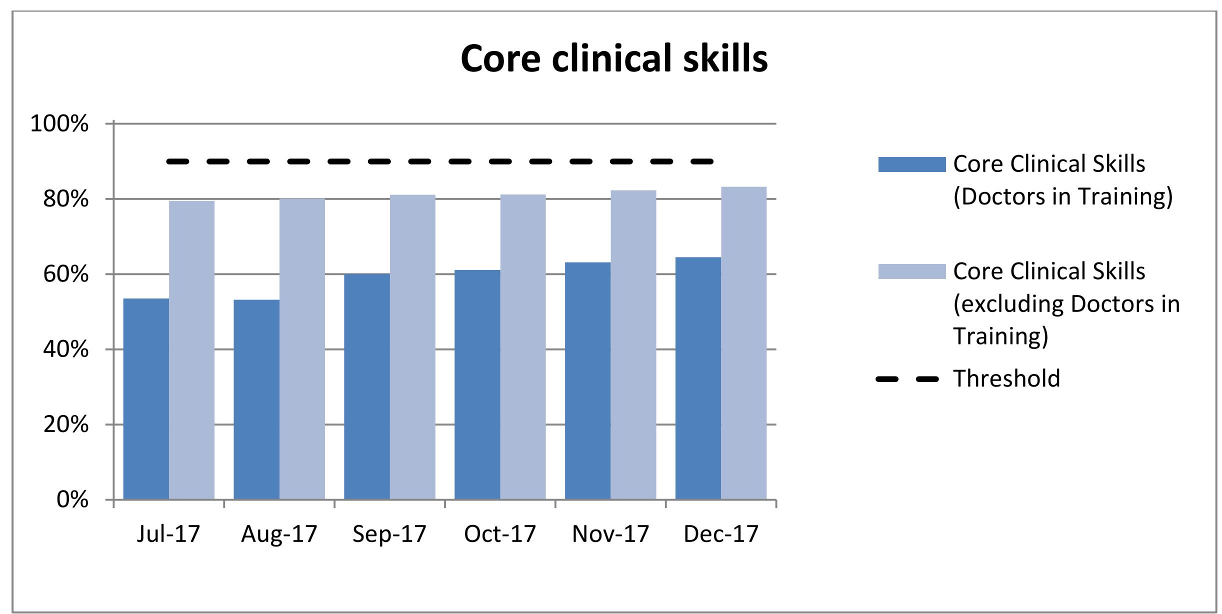

Chart 14 – Core clinical skills training for the period July 2017 (first reported) – December 2017

2.1.13 Safe: Work-related reportable accidents and incidents

There was one RIDDOR-reportable (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) incident in December 2017

-The incident involved a member of staff being struck by a falling object. The incident was reportable to the HSE because the person was absent from work sick for a period of more than 7 days.

In the 12 months to 31st December 2017, there have been 41 RIDDOR reportable incidents of which 17 were slips, trips and falls. The Health and Safety service continues to work with the Estates & Facilities service and its contractors to identify suitable action to take to ensure floors present a significantly lower risk of slipping.

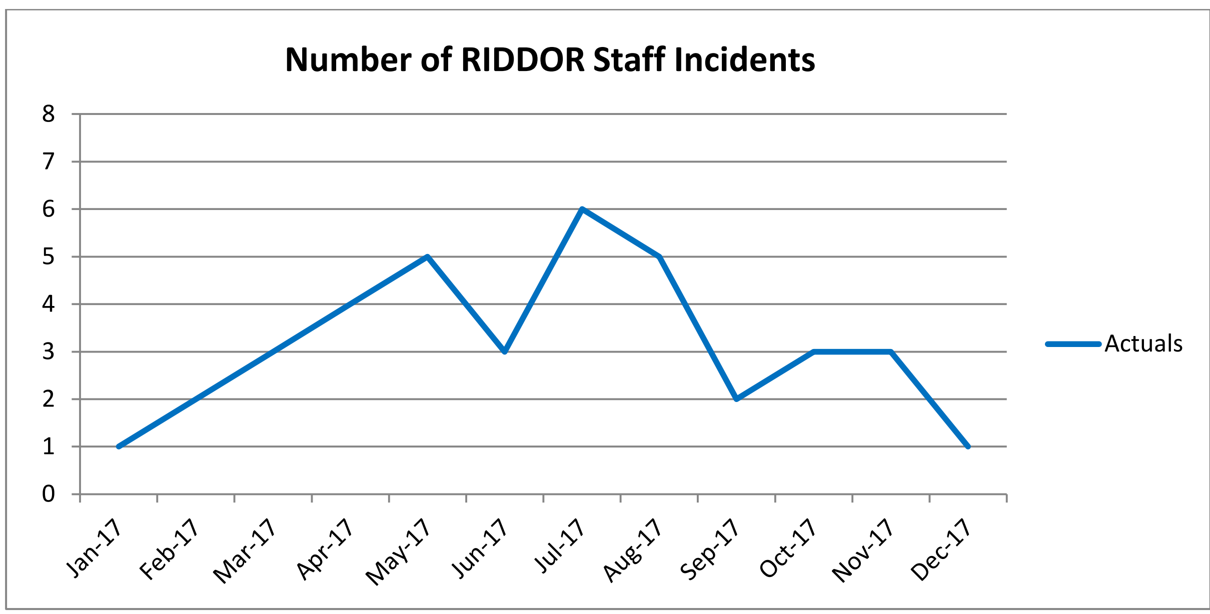

Chart 15 – RIDDOR Staff Incidents for the period January 2017 – December 2017

2.2 Effective

2.2.1 Effective: National Clinical Audits

Since April 2017, a total of 40 relevant HQIP and NCEPOD national study reports have been published. The Trust participated in 37 of these studies and the reports have been issued to the relevant divisions for a full review and are progressing through the specialty and divisional review processes. Progress is being monitored by the divisional quality and safety committees and reviewed by the quality and safety subgroup.

Three reports have been through the full trust process and levels of assurance agreed by the relevant division/directorate quality and safety committee.

2.2.2 Effective: Mortality data

The Trust target for mortality rates in 2017/18 is to be in the top five lowest-risk acute non-specialist trusts as measured by the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-Level Mortality Indicator (SHMI).

The most recent HSMR is 68 (August 2017). Over the last 12 months the Trust has had the second lowest HSMR for acute non-specialist trusts nationally. The Trust also has the 2nd lowest SHMI of all non-specialist providers in England for Q1 2016/17 – Q4 2016/17.

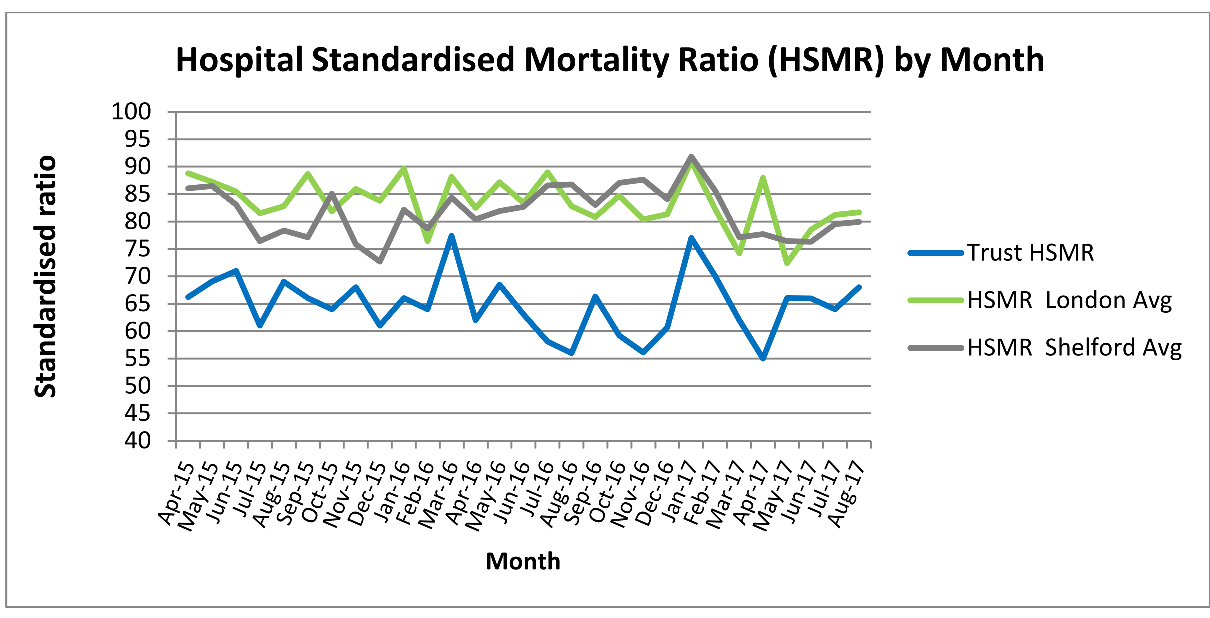

Chart 16 - Hospital Standardised Mortality Ratios for the period April 2015 – August 2017

2.2.3 Effective: Mortality reviews completed

In March 2017 a framework for NHS Trusts on identifying, reporting, investigating and learning from deaths in care was published by the National Quality Board. This includes a new requirement for a quarterly ‘learning from deaths dashboard’ to the Trust Board. This was presented to the Trust Board in November 2017 in line with the reporting requirement. The next dashboard with Q3 data is due to be presented to the Trust Board in March 2018.

The Trust implemented the structured judgement review methodology (SJR) in September 2017, which included deaths from July 2017 onwards. Data is refreshed on a monthly basis as SJRs are completed and 37 completed reports have been received to date. Cases are reviewed at the monthly Mortality Review Group with a focus on any avoidable factors and learning themes. As more cases are reviewed the group will be able to recommend work streams to be considered as part of the trust improvement programme. To date, the Trust has confirmed two cases of avoidable deaths. Both cases have undergone SI investigations, action plans have been agreed and the associated actions are currently being undertaken.

In order to instigate the SJR process at the earliest opportunity the timeframe for local, level 1 review completion has been shortened to 7 days, from the previous 30 days, effective from September 2017. This shortened process is reflected in the lower local level 1 review data whilst the transition to the new timeframe takes place. A weekly performance report in relation to overdue cases is reviewed at the MD panel.

The Trust is continuing to identify and train reviewers so that they can undertake SJR and increase the numbers of reviews completed.

Mortality reviews (at 3 January 2018)

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	YTD
Total number of deaths	119	152	137	138	163	151	161	167	159	1347
Number of local reviews completed	119	152	135	137	161	140	142	123	58	1167
% Local Reviews Completed	100%	100%	99%	99%	99%	93%	88%	74%	36%	87%
Number of SJR reviews requested	3	3	2	21	26	22	34	15	9	135
Number of SJR reviews completed	2	1	1	5	6	10	8	3	1	37
Number of avoidable deaths (Score 1-3)	1				1					2

Note: The timeframe for local, level 1 review completion was shorted from 30 days to 7 days, effective September 2017

2.2.4 Effective: Recruitment of patients into interventional studies

We did not achieve our target of 90% of clinical trials recruiting their first patient within 70 days of a valid research application for the previous two quarters. Validated data for Q2 2017/18 has recently been issued by NIHR and shows ICHT performance at 53.3%. This is an increase on the two previous quarter's performance, but slightly below the national average of 55.6%.

Historically, much of the delay for ICHT studies has been at contract negotiation stage. We have recently re-staffed the ICHT JRO with new contracts experts and new leadership. As well as now being fully resourced, the team are taking a more pragmatic and proactive approach to contract and cost negotiation (within agreed negotiation boundaries). Weekly team meetings now take place to review all studies in the pipeline, to identify potential issues and escalate.

Performance has declined nationally following process and data changes introduced by the DoH in 2016/17. A new consultation by NHS England is currently proposing to establish a single set of national clinical trials metrics – agreed by the industry sector – by Q3 2018, which are more robust and which are resistant to different interpretations by NHS Trusts as is currently the case.

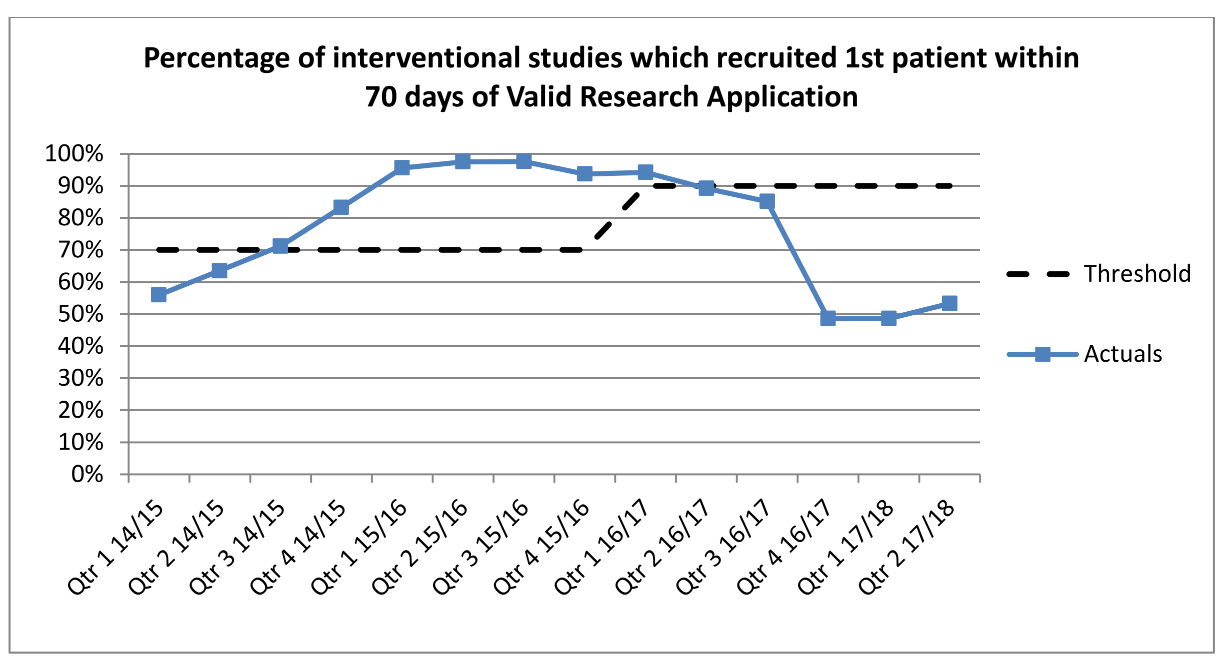

Chart 17 - Interventional studies which recruited first patient within 70 days of Valid Application Q1 2014/15 – Q3 2017/18

2.2.5 Effective: Discharges before noon

The Trust is supporting wards to implement the SAFER flow bundle which combines five elements of best practice to improve patient flow and prevent unnecessary waiting for patients. This includes early discharge to make beds available on the wards to admit new patients from A&E. In December, 10 per cent of patients were discharged before noon and the aim is to achieve the national standard of 33 per cent as set out in the SAFER bundle.

Regular reports on discharge by noon data by ward are being published on the source to show where good patient flow is being achieved and where improvements need to be prioritised. Several wards already have board rounds in place and more are expected to implement these in January as part of the roll out of SAFER. Board rounds will support early discharge by identifying patients who will be discharged the next day to the whole multidisciplinary team so work can be effectively prioritised

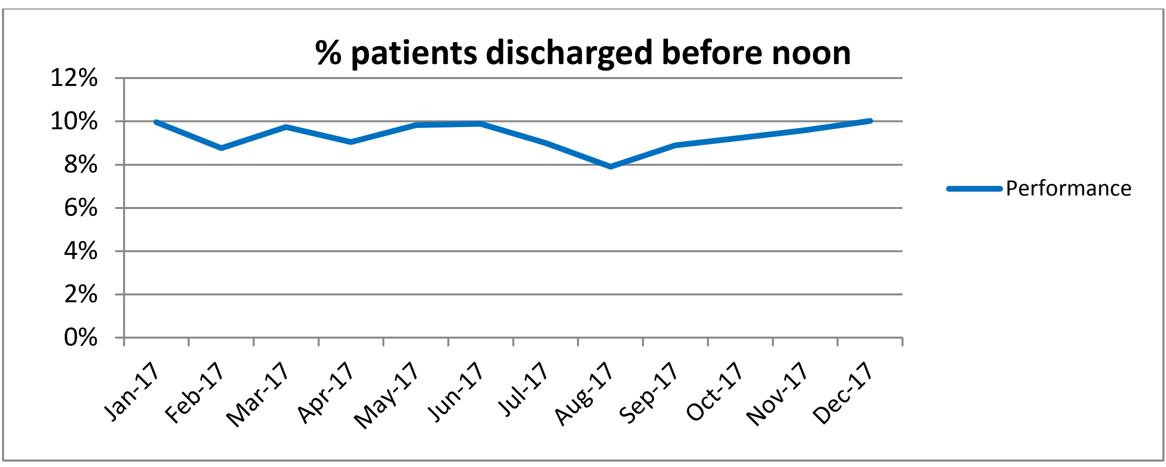

Chart 18 – Patients discharged before noon as a % of total discharges between January 2017 and December 2017

2.2.6 Effective: Readmission rates

The most recently reported 28 day readmission rates (through Dr Foster intelligence) continued to be lower in both age groups than the Shelford and National rates.

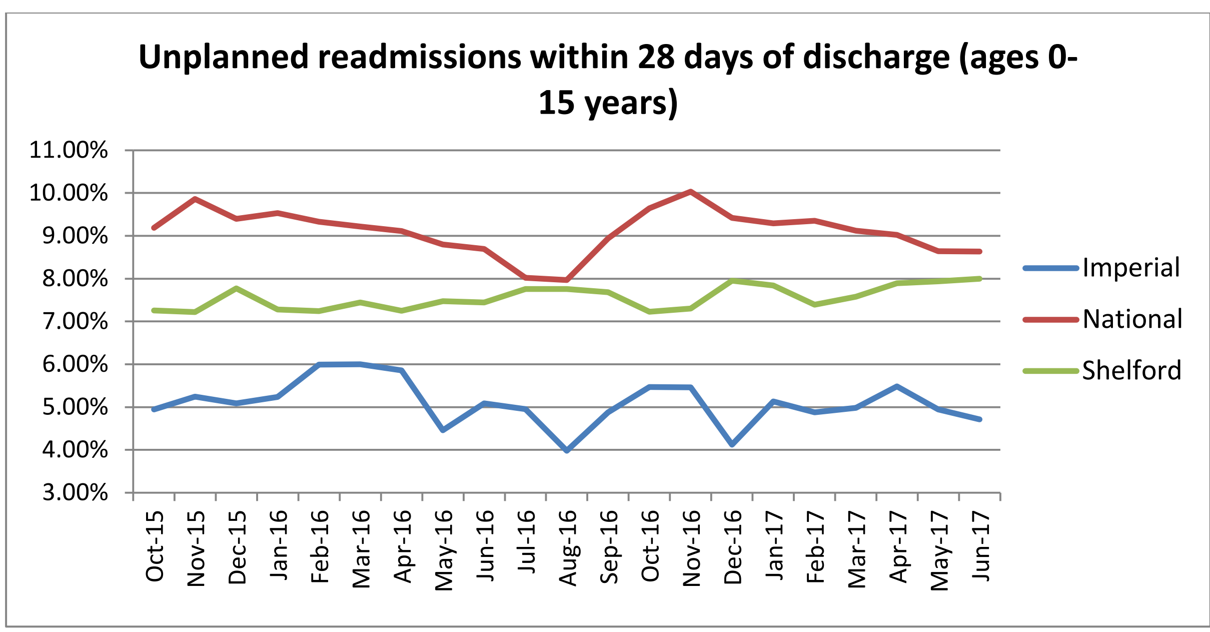

Chart 19 - Unplanned readmissions (to any NHS Trust) within 28 days of discharge from ICHT (ages -15 years) for the period October 2015 – June 2017

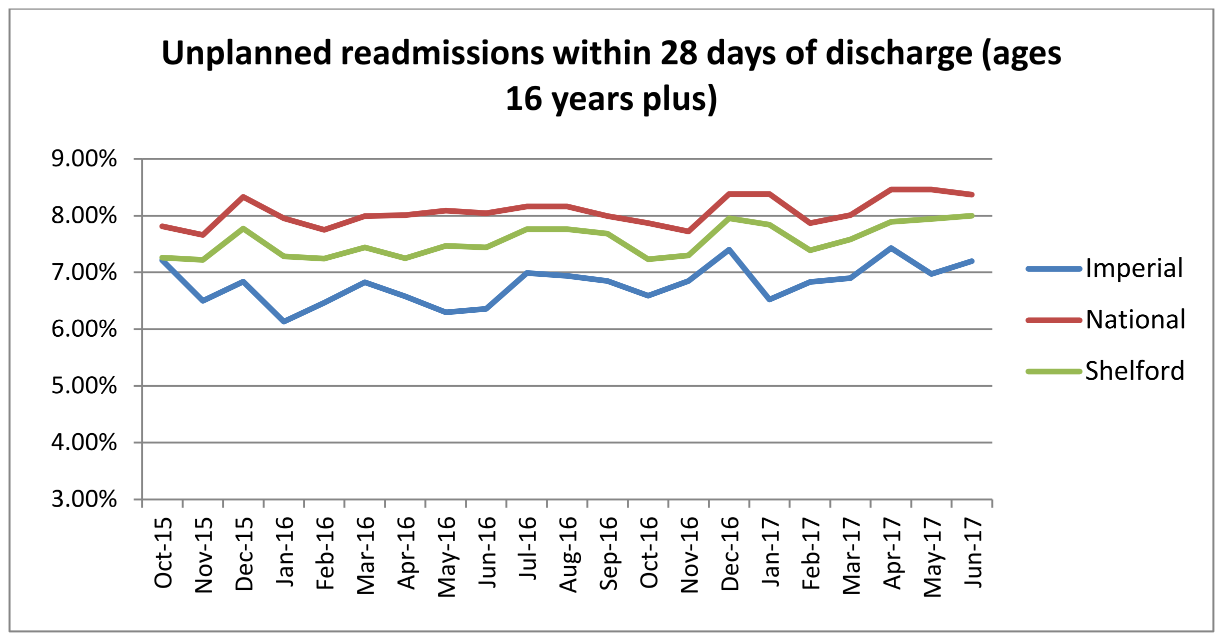

Chart 20 - Unplanned readmissions (to any NHS Trust) within 28 days of discharge from ICHT (ages 16 years plus) for the period October 2015 – June 2017

2.2.7 Effective: Diagnostic and surgical orders waiting to be placed on the inpatient waiting list

This is a key data quality indicator (DQI) in the Trust's new Data Quality Framework which is being implemented during 2017/18. It measures all patients who have had an order for a diagnostic or surgical procedure placed by the clinical team, but these have not yet been processed by the administration team. Processing orders quickly ensures patients are appropriately placed onto the inpatient waiting list and facilitates the offer of timely treatment in line with RTT targets. The Trust operating standard is that orders should be routinely processed within 2 working days of being placed by the clinician.

A data quality action group is being established and will meet end January. This will include agreeing local plans with the divisional data quality leads to process clinical orders and further improve performance in line with the trajectory.

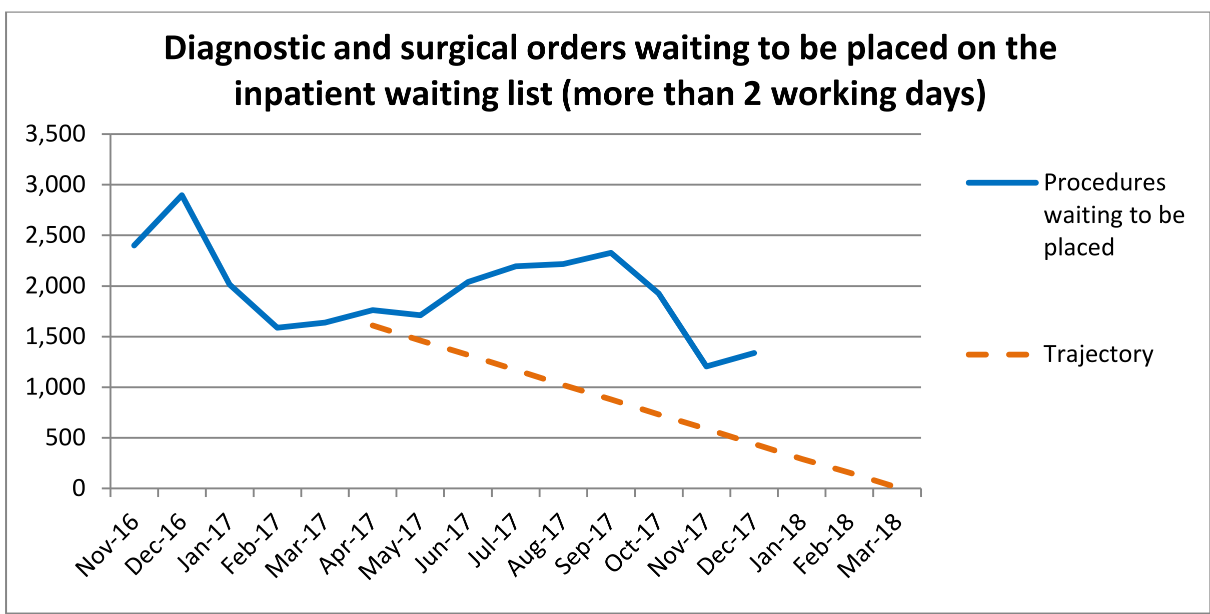

Chart 21 – Number of patients on the Add/Set Encounter request list of more than 2 working days for the period November 2016 – December 2017

2.2.8 Effective: Outpatient appointments checked in and checked out

When patients attend for their outpatient appointment they should be checked-in on the Trust patient administration system (CERNER) and then checked-out after their appointment. This is important so that the record of the patient's attendance is accurate and it is clear what is going to happen next in the patient's treatment journey. The escalation processes to clear appointments on the system in a timely manner continue to be implemented.

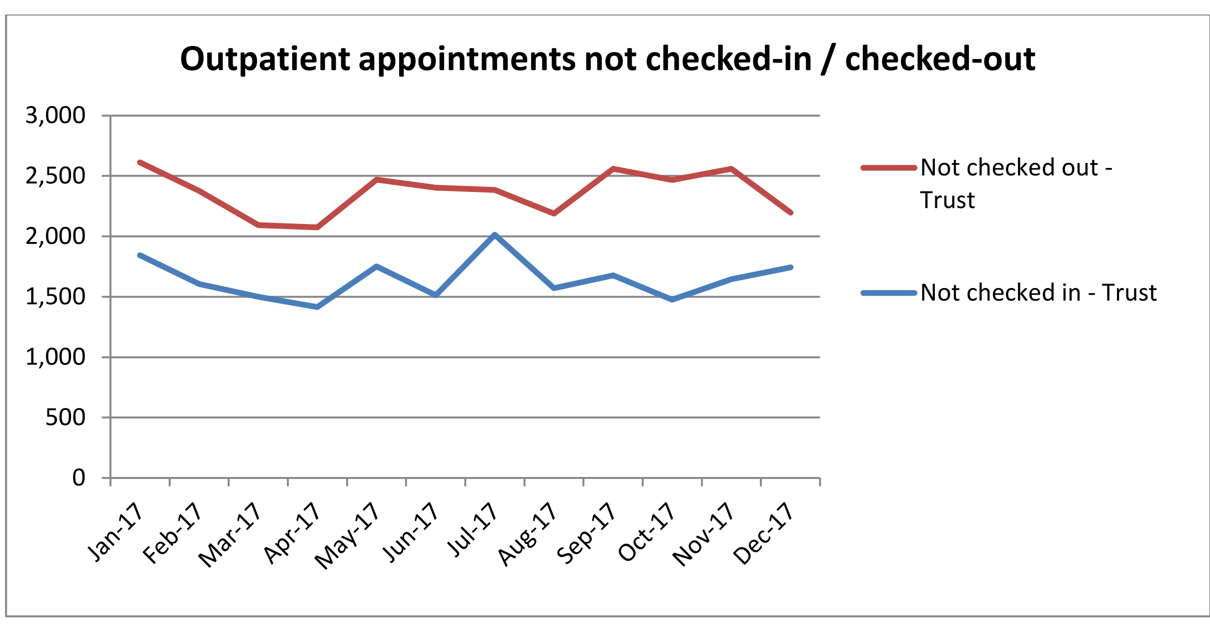

Chart 22 – Number of outpatient appointments not checked-in or DNA'd (in the last 90 days) AND number of outpatient appointments checked-in and not checked-out for the period January 2017 – December 2017

2.3 Caring

2.3.1 Caring: Friends and Family Test

Generally the likelihood to recommend score remains high across the board.

Friends and Family test results

Service	Metric Name	Oct-17	Nov-17	Dec-17
Inpatients	Response Rate (target 30%)	31.9%	32.9%	29.9%
	Recommend %	97.0%	96.8%	97.9%
	Not Recommend %	0.8%	1.2%	0.7%
A&E	Response Rate (target 20%)	12.8%	15.9%	14.9%
	Recommend %	93.1%	93.9%	94.4%
	Not Recommend %	3.7%	3.8%	2.7%
Maternity	Response Rate (target 15%)	32.9%	37.5%	26.9%
	Recommend %	93.2%	93.2%	93.0%
	Not Recommend %	2.9%	2.1%	2.6%
Outpatients	Response Rate (target 6%)	10.0%	11.1%	11.4%
	Recommend %	91.2%	92.0%	90.9%
	Not Recommend %	4.5%	3.9%	4.4%

2.3.2 Caring: Patient transport waiting times

Non-Emergency Patient Transport Service

The response times fell in December which is attributed to a shortage of DHL drivers and high sickness levels which have impacted on overall performance.

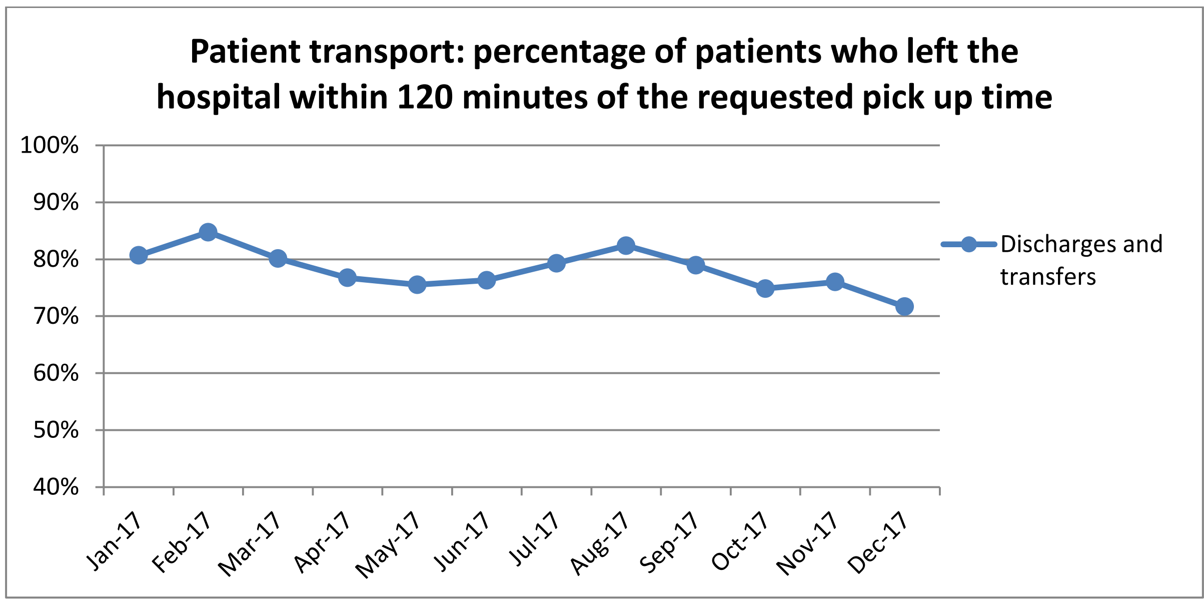

Chart 23 - Percentage of patients who left the hospital as part of the patient transport scheme within 120 minutes of their requested pick up time between January 2017 and December 2017

2.3.3 Caring: Eliminating mixed sex accommodation

The Trust reported 19 mixed-sex accommodation (MSA) breaches for December 2017. The increase in breaches since October 2016 has been mainly attributable to breaches occurring within ITU at Charing Cross. For critical care (level 2 and 3) mixing is acceptable as it is recognised nursing acuity requires gender mixing, however it is not acceptable when a patient in the critical care units no longer requires level 3 or 2 care, but cannot be placed in an appropriate level one ward bed.

The Division of Surgery and Cancer are undertaking a deep dive into the situation to understand root causes, resultant actions with progress will continue to be reported to the Executive Quality Committee.

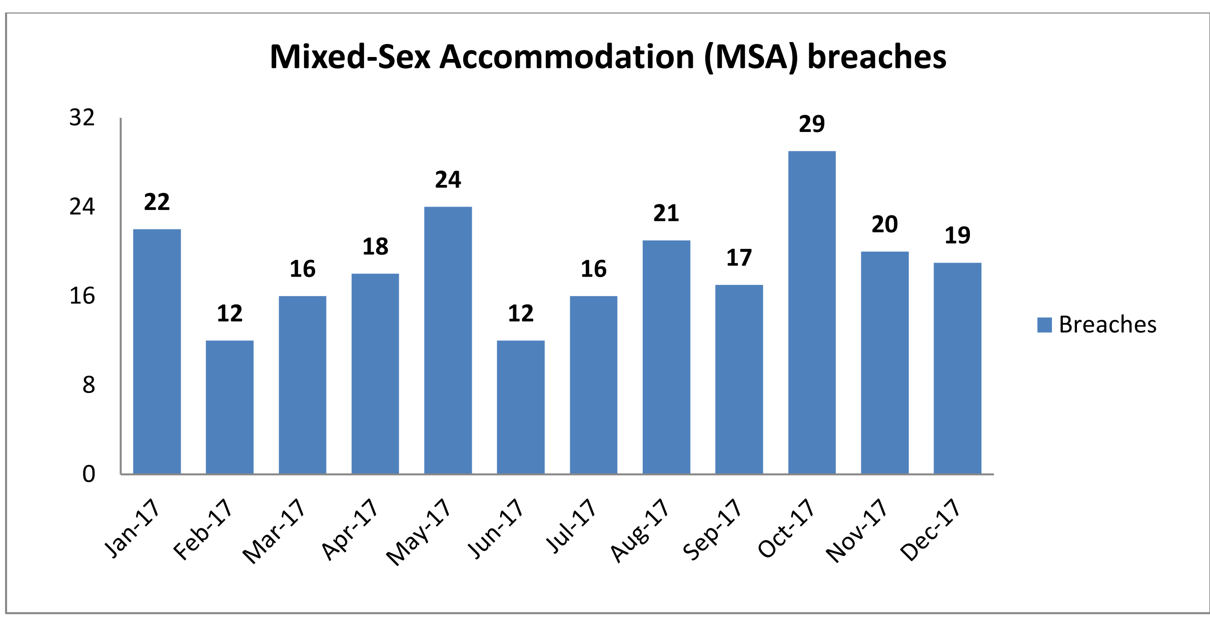

Chart 24 – Number of mixed-sex accommodation breaches reported for the period January 2017 – December 2017

2.3.4 Caring: Complaints

The number of complaints remained below the threshold and response times remain good.

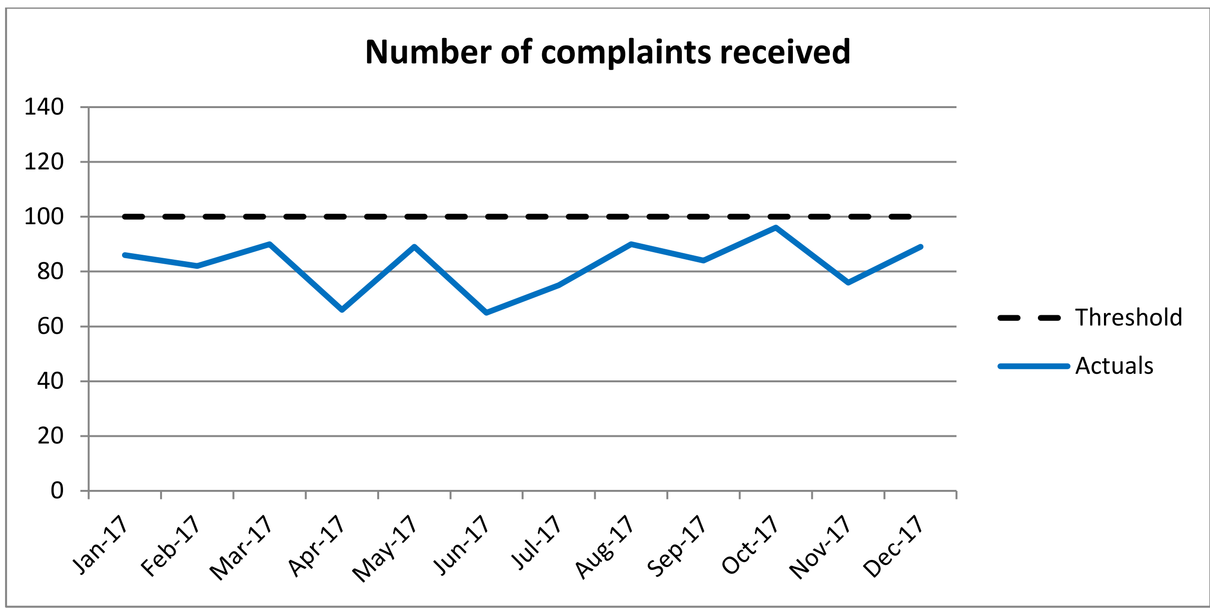

Chart 25 – Number of complaints received for the period January 2017 – December 2017

2.4 Well-Led

2.4.1 Well-Led: Vacancy rate

All roles

At end December 2017, the Trust directly employed 9,326 WTE (whole time equivalent) members of staff across Clinical and Corporate Divisions. The contractual vacancy rate for all roles was 12.13 per cent against the target of 10 per cent; remaining below the average vacancy rate of 12.4 per cent across other Acute London Teaching Trusts.

During the month there were a total of 127 WTE joiners and 148 WTE leavers across all staffing groups and the Trusts voluntary turnover rate (rolling 12 month position) stands at 9.4 per cent.

Actions being taken to support reduction in vacancies include:

- Bespoke campaigns and advertising for a variety of specialities.
- Open Days, Fairs, social media and print advertising. A preferred supplier list is in place to support hard to recruit areas.
- The Careers website content is being redrafted and further materials are being developed to support recruitment activity.
- A retention campaign including 'Our Working Lives' pages on the Source and a ‘Great Place to Work’ week which was ran in September and had positive feedback.
- We are attending a local community recruitment initiative, the Hammersmith and Fulham Employment and Skills fair on 8th March.

All Nursing & Midwifery Roles

At end of December 2017, the contractual vacancy rate for all of the Trusts Nursing & Midwifery ward roles was 14.21 per cent with 721 WTE vacancies across all bands. Within the band 2 – 6 roles of this staffing group, the vacancy rate stands at 15.28 per cent and we continue to work with other London Acute Teaching Trusts to benchmark and share information to support a reduction in these vacancies.

Actions being taken to support reduction in our Nursing and Midwifery vacancies include:

- Nursing recruitment campaigns.
- Automatic conditional offer letters to our student nurses.
- A ‘Student Attraction Strategy’ to make the Trust ‘employer of choice’.
- Open Days and social media campaigns planned for Haematology, ITU, Specialist Surgery, Trauma and Children’s services.
- Campaigns for the Charing Cross hotspots and campaigns for Stroke, Neurology,

Acute and Specialist Medicine for early 2018. A Recruitment and Retention premium is being put in place for areas which have a vacancy rate above 35 per cent in the Medicine and Integrated Care division.

- Career development pathways for midwives.
- Reducing the time an advert is open and centralising shortlisting to reduce the time to hire time.
- New careers clinics for Band 5 and 6 nursing and midwifery staff to help support them with career options and opportunities.

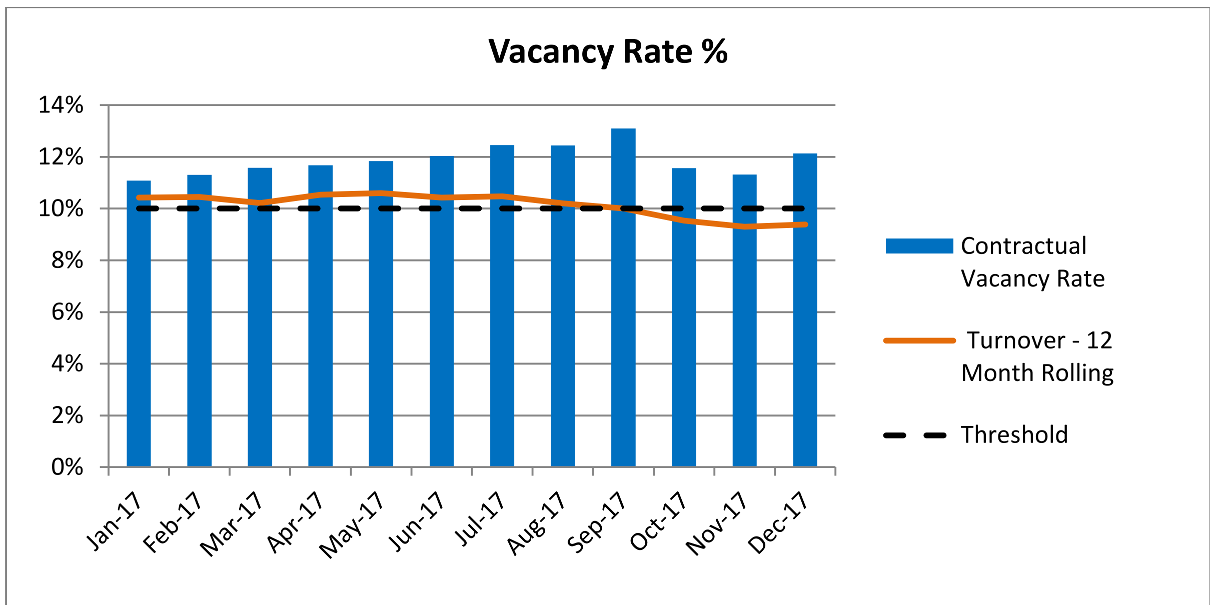

Chart 26 - Vacancy rates for the period January 2017 – December 2017

2.4.2 Well-Led: Sickness absence rate

Recorded sickness absence in December was 3.3 per cent, maintaining the Trusts rolling 12 month sickness position at 2.9 per cent against the year-end target of 3.1 per cent or lower.

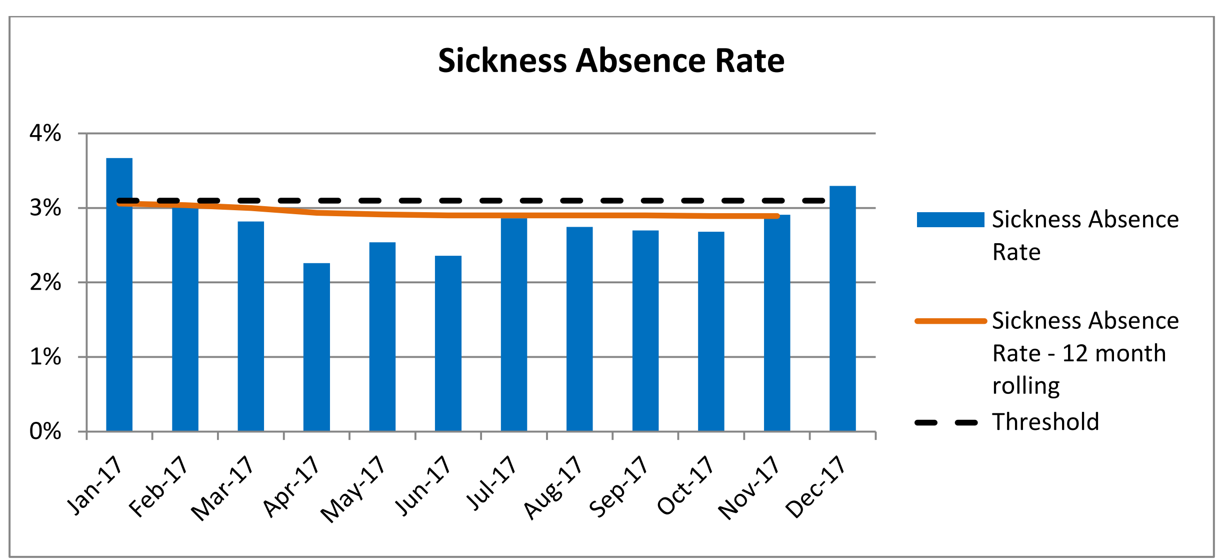

Chart 27 - Sickness absence rates for the period January 2017 – December 2017

2.4.3 Well-Led: Performance development reviews

The PDR cycle for 17/18 began on 1 April 2017 and closed on the 31 July 2017 with 88.5 per cent of staff having completed a PDR with their line manager; reviewing past year performance against objectives and the Trust values, agreeing personal development plans and setting objectives for the year. The PDR cycle for 18/19 will commence 1 April 2018.

2.4.4 Well-Led: Doctor Appraisal Rate

Doctors' appraisal rates are 89.7 per cent this month. Actions being taken to increase compliance include continuing the Professional Development monthly drop-in sessions across all Trust sites, reviewing the automated reminder emails from PREP and reviewing the system to ensure it is user friendly and easy to navigate by doctors. Individual contact continues with doctors who are overdue with application of the trust policy where appropriate.

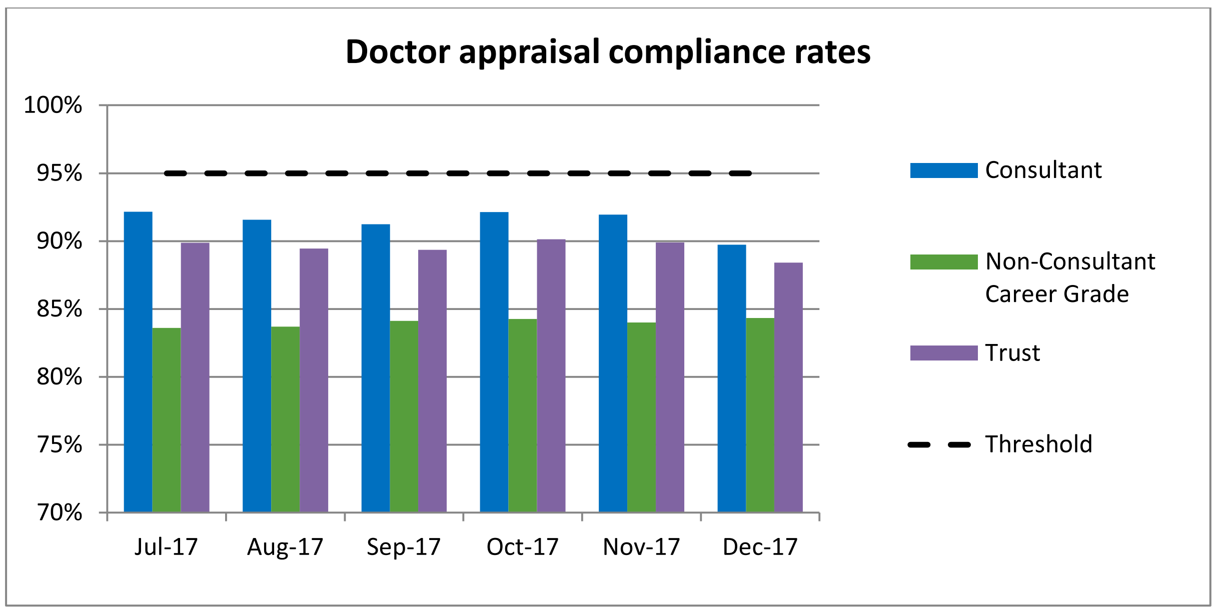

Chart 28 - Doctor Appraisal Rates for the period July 2017 to December 2017

2.4.5 Well-Led: Staff Friends and Family

The overall Engagement score increased from 77% in 2016 to 80% in 2017. The headlines of the Staff Friends and Family test results showed that:

- 86% of staff recommend the Trust as a place for care or treatment
- 72% of staff recommend the Trust as a place to work

The FFT scores were our highest performance to date in the last three years. The Trust has undertaked the 2017 NHS National Staff Survey and the results will be published in March 2018.

2.4.6 Well-Led: General Medical Council - National Training Survey Actions

Health Education England quality visit

The quality visit action plan has now been closed based on the evidence submitted.

2016/17 General Medical Council National Training Survey

The results of the General Medical Council's National Training Survey 2017 were published in July. The 2016 survey demonstrated significant improvements on previous results. The 2017 results indicate that we have maintained our performance overall, with some specialties demonstrating significant improvements, while others either remain challenged or have seen a deterioration in performance. On-going internal monitoring is being undertaken for specialities of concern through education specialty reviews.

In 2015 three specialities were put under enhanced monitoring by the GMC – critical care at Charing Cross Hospital, ophthalmology and neurosurgery. Formal actions plans were put in place with progress monitored at monthly meetings with the Medical Director, and locally through local faculty groups. The 2017 results for both ophthalmology and neurosurgery demonstrated that changes made have been sustained and therefore the GMC have agreed to remove from enhanced monitoring. Critical care remains under enhanced monitoring and the recurring red flags triggered a quality review from Health Education England in September which resulted in an additional action plan around developing the workforce, developing MDT simulation opportunities and enhancing supervision. Action plans are in place.

Health Education England (HEE) requested action plans in response to the survey results with 10 actions remaining outstanding. These are being monitored via the education specialty reviews and local faculty groups and will be reported in this report. A progress report on our actions was submitted to HEE on 19th January 2018.

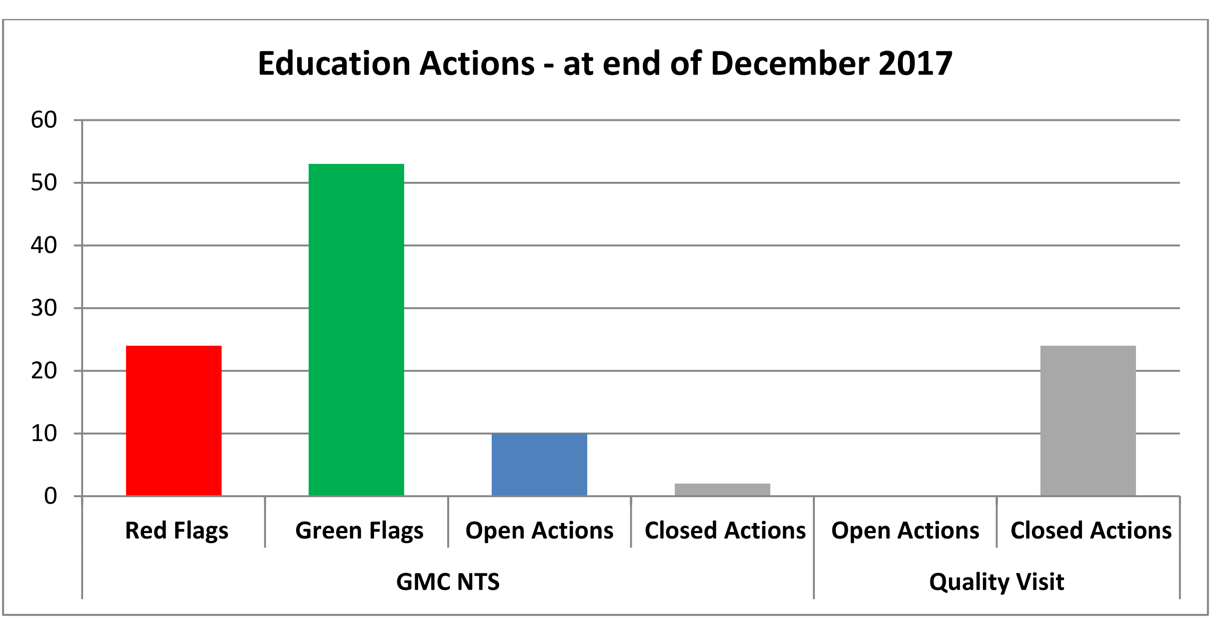

Chart 29 – General Medical Council - National Training Survey action tracker, updated at end December 2017

2.4.7 Well Led: Estates – reactive (repair) maintenance tasks completed on time

The performance for reported repair tasks completed on time during December, as delivered by the Trust's maintenance contractor (CBRE), was 16 per cent. The Deputy Head of Estates is in discussion with the contractor to produce the required action plan and improvement process.

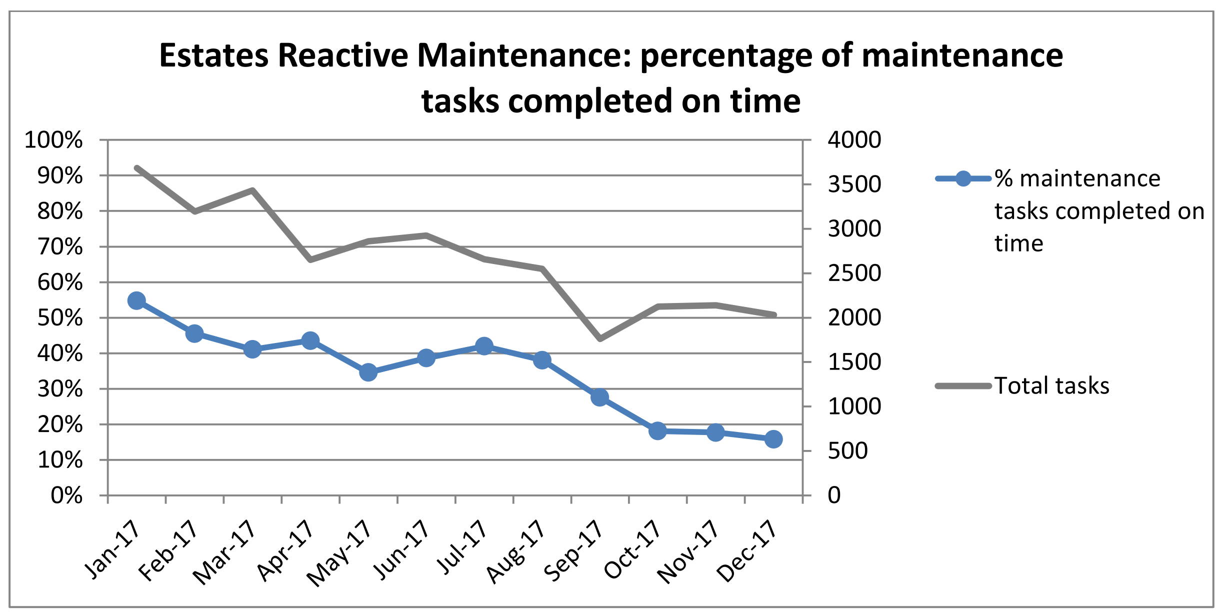

Chart 30 – Estates: percentage of maintenance tasks completed on time for the period January 2017 – December 2017

2.5 Responsive

2.5.1 Responsive: Referral to treatment waiting times

At end December 2017, 81.8 per cent of patients had been waiting less than 18 weeks to receive consultant-led treatment, against the standard of 92 per cent (November performance was 83.3 per cent).

There were 242 patients who had waited over 52 weeks for their treatment since referral from their GP. This was a slight reduction on November and was 85 below the trajectory for the month. Each patient is subject to a clinical review to make sure that their care plan is appropriate in view of the time they have waited for treatment, and we are expediting the treatment of all long-waiting patients wherever possible.

The Trust anticipates an increase in reported breaches for January as a result of the impact of temporary postponement of non-urgent elective activity in January to support emergency pathways, as part of the national response. A revised Trust-level RTT recovery trajectory is being finalised.

As reported in September, the Trust's waiting list improvement programme (WLIP) has been restructured into three key work streams responsible for delivery of the programme objectives: RTT recovery and sustainability, elective care operating framework and digital optimisation. The programme continues to be overseen by a Waiting List Improvement Programme Steering Group, with external representation from Commissioners and NHS Improvement.

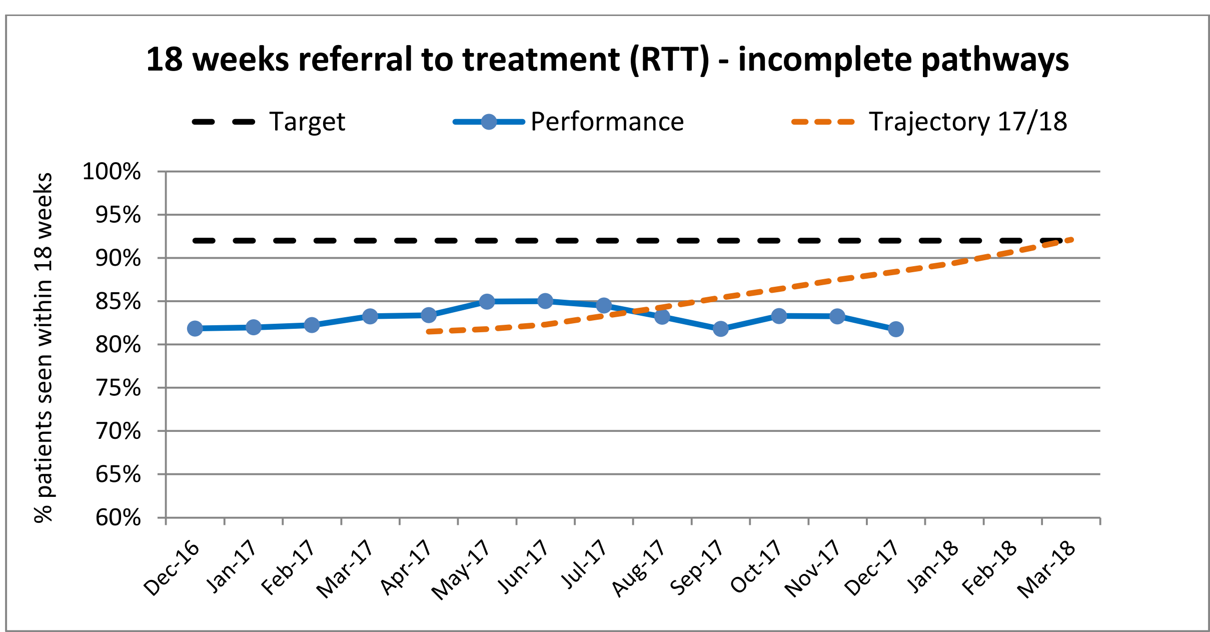

Chart 31 – Percentage of patients seen within 18 weeks (RTT incomplete pathways) for the period January 2017 – December 2017

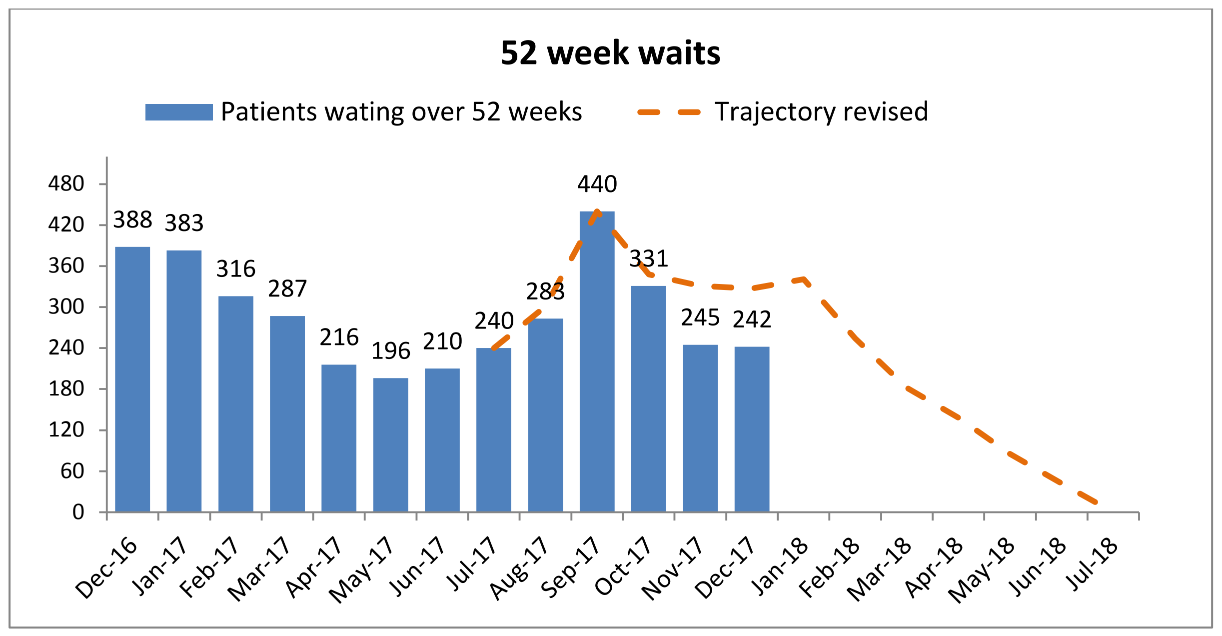

Chart 32 - Number of patients waiting over 52 weeks for the January 2017 – December 2017

2.5.2 Responsive: Cancer 62 day waits

Due to the timing of submissions cancer performance is reported for November 2017. The Trust achieved the 62-day standard, delivering performance of 87.1 per cent against, above the trajectory target of 85.1 per cent.

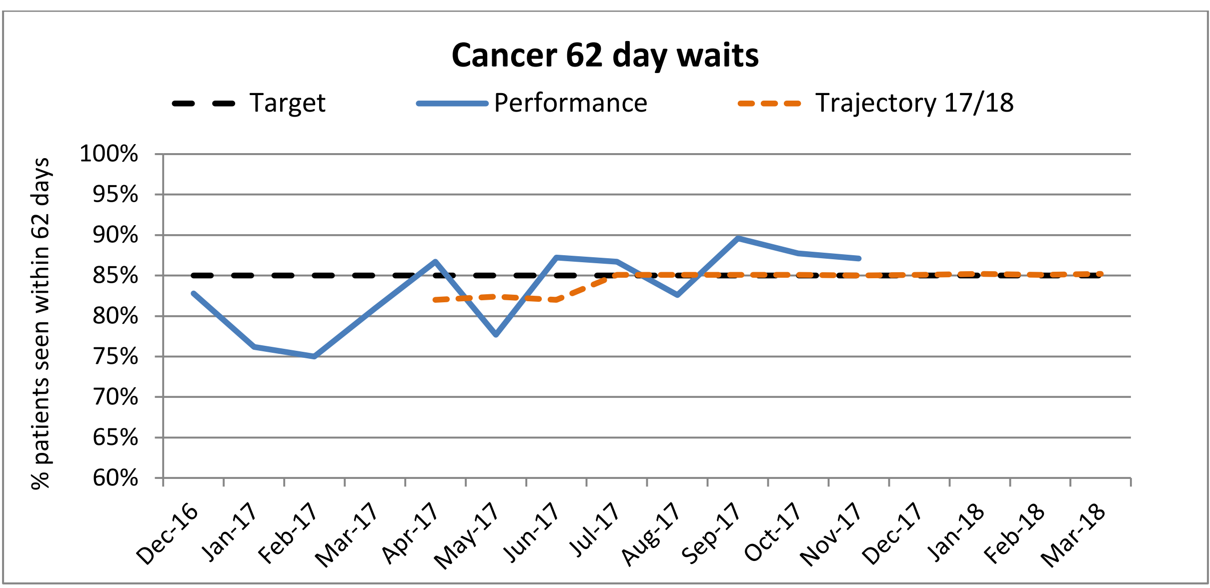

Chart 33 – Cancer 62 day GP referral to treatment performance for the period December 2016 – November 2017

2.5.3 Responsive: Theatre utilisation

The Trust overall theatre utilisation performance for elective operations was 74 per cent[1] in December 2017 against a target of 85 per cent.

The key issues remain as follows:

- On the day cancellations rose slightly across the Trust during December
- Patient unfit on the day and DNA's continue to be the main issue for cancellations at the CXH and HH sites; unavailability of wards beds at SMH accounted for 25 per cent of overall cancellations
- Largest opportunity[2] within Trauma & Orthopaedics (22 per cent of the Trust's overall opportunity for December)

Performance is continually being reviewed with the specialities at the Trust's monthly Theatre Efficiency Group. The Four Eyes productivity programme has commenced and will be looking to support the Trust in taking the following steps to improve overall theatre performance:

- Strengthening scheduling processes within the Patient Services Centre through the introduction of the Four Eyes scheduling tool in January, which gives visibility of number of cases booked and 'list fullness';

[1] Includes elective, trauma and waiting list initiative sessions (excludes emergency and private sessions)
[2] Opportunity is defined as the sum of late starts, early finishes and overruns in minutes

- Continued focus on 'start up processes' in theatres e.g. Team Brief and 'Golden Patient' sent for prior to scheduled start time; and
- Improving the utilisation of the central pre-assessment clinics to develop a pool of 'fit' patients ready for scheduling.

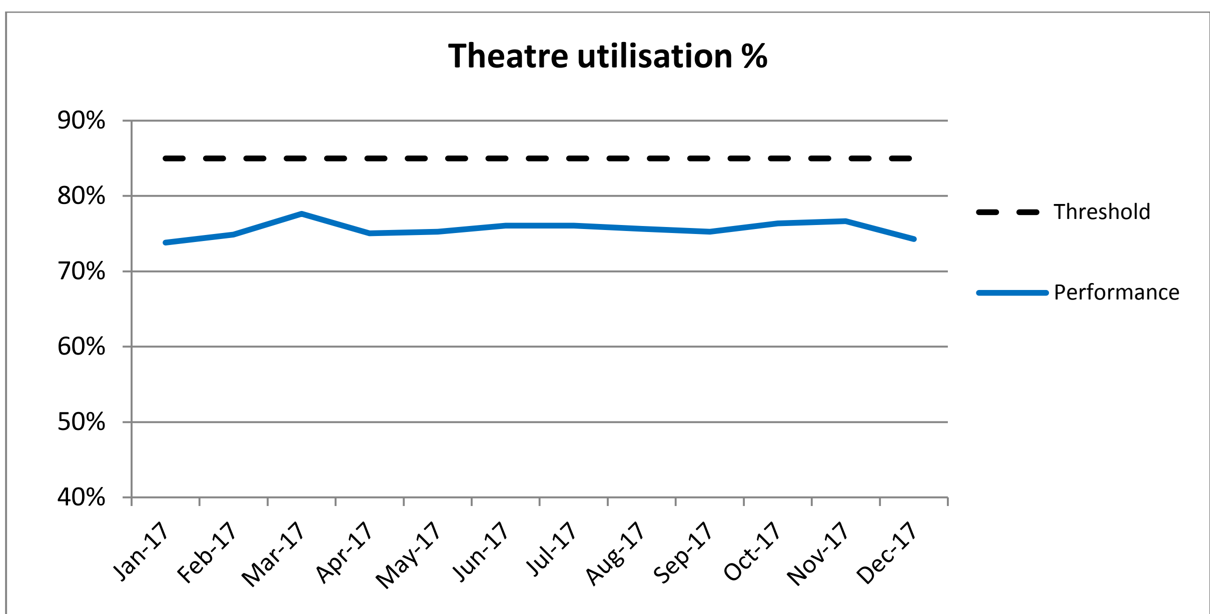

Chart 34 – Average theatre utilisation (Trust-wide, elective operations) for the period January 2017 – December 2017

2.5.4 Responsive: 28-Day Rebookings

The national submission for quarter 3 2017/18 is 25 January and a full update will be provided in the February report.

2.5.5 Responsive: Accident and Emergency

Performance against the four-hour access standard for patients attending Accident and Emergency was 84.2 per cent in December 2017 against the 90.2 per cent Sustainability and Transformation Fund (STF) target for the month. These figures are a drop from the previous month and marginally lower than the same month in 2016 where performance was 84.5 per cent. There were five 12-hour trolley wait breaches for the month.

The Trust continues to experience significant pressures and the key issues remain as follows:

- Increased demand and acuity within type 1 departments (rising type 1 attendances at CXH and an increase in arrivals via ambulance and major trauma presentations at SMH);
- An increase in arrivals via ambulance and major trauma presentations at SMH;
- Difficulties with late transfer of patients from the Vocare UCC to the Emergency Department at SMH; &

- High levels of bed occupancy and bed days lost through a combination of delayed transfers of care from the hospital, delays for mental health beds & on-going estate issues.

In line with recommendations from NHS England to free up capacity and support emergency pathways, additional temporary measures are being taken to postpone non-urgent operations and procedures that were due to take place this month.

Schemes to provide additional urgent and emergency care capacity for winter pressures are on track, including reopening of beds closed due to estates issues and opening of additional winter beds.

The Trust continues the programme of patient flow improvements which are overseen by the four-hour Performance Steering Group.

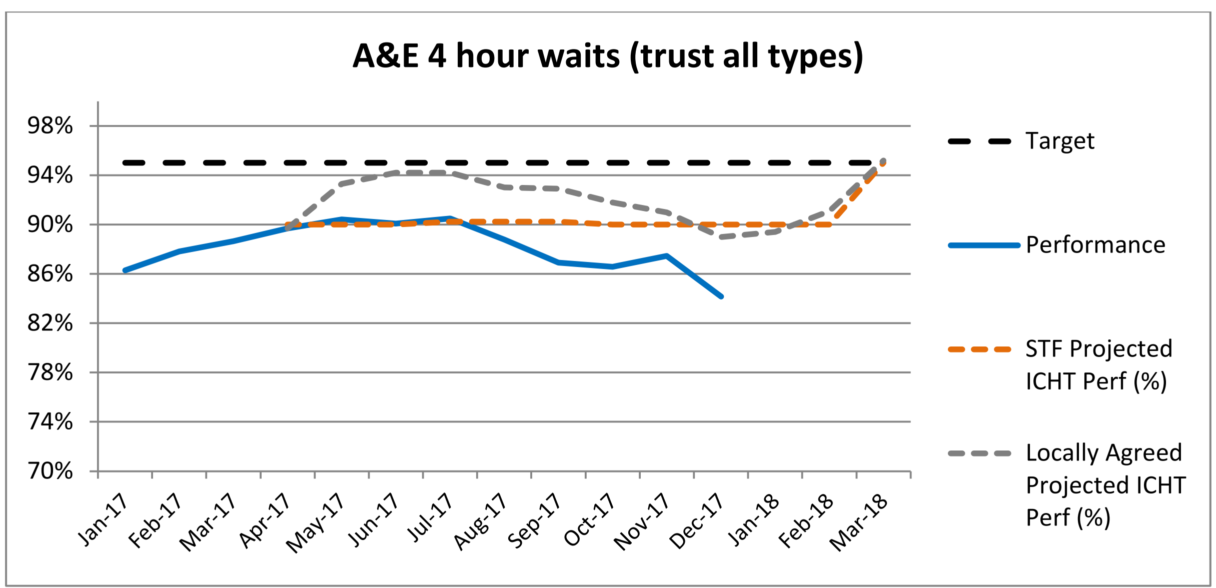

Chart 35 – A&E Maximum waiting times 4 hours (Trust All Types) for the period January 2017 – December 2017

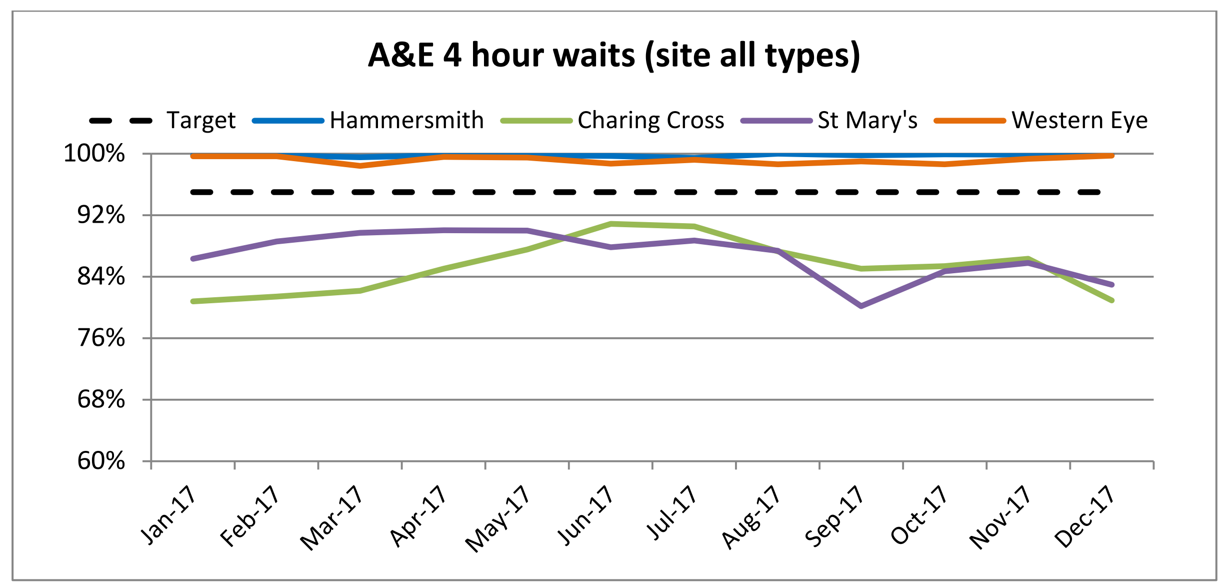

Chart 36 – A&E Maximum waiting times (Site All Types) 4 hours for the period January 2017 – December 2017

2.5.6 Responsive: Diagnostic waiting times

The latest reported performance is for December 2017 where 1.5 per cent of patients were waiting over six weeks against a tolerance of 1%. The performance was ahead of the recovery trajectory for the month of 2.2 per cent. The Trust expects to return to previously good performance of achieving the target of 1% from February onwards.

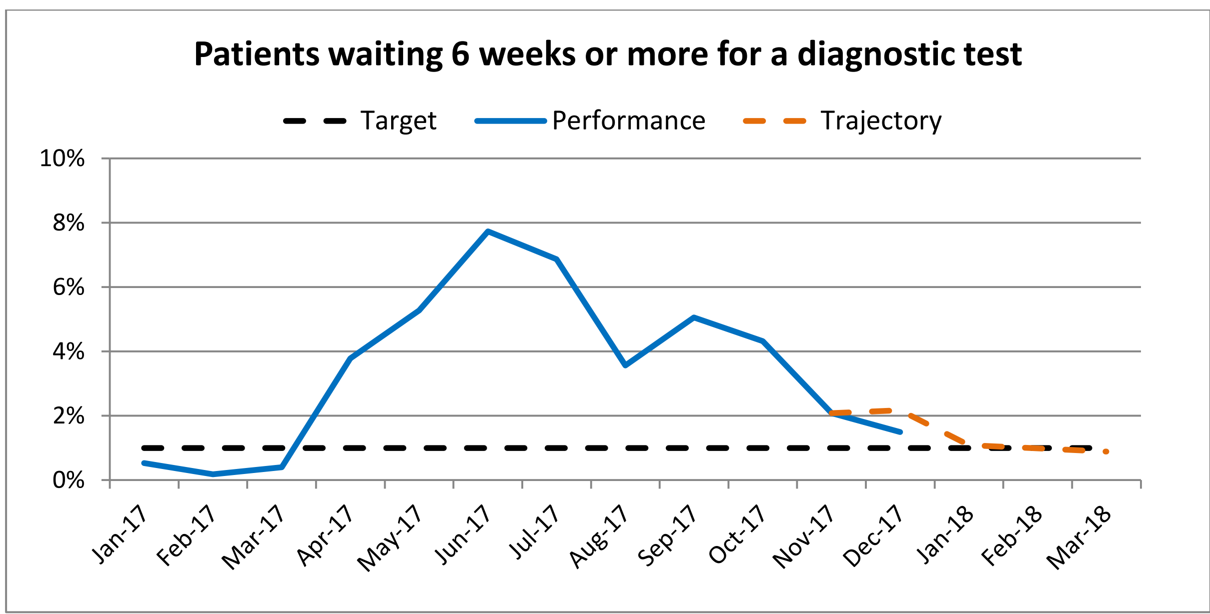

Chart 37 – Diagnostic waiting times for the period January 2017 – December 2017

2.5.7 Responsive: Waiting times for first outpatient appointment

A key milestone of the 18 week RTT pathway is the first outpatient appointment. This is where the patient will be assessed by a specialist and decisions on whether further tests are needed and the likely course of treatment are made. This indicator shows the average number of weeks that patients waited before attending their first outpatient appointment following a referral for routine appointments only. The average waiting time was 7.4 weeks to attending first appointment from referral. The waiting times vary widely between clinical services, ranging from 4 – 13 weeks.

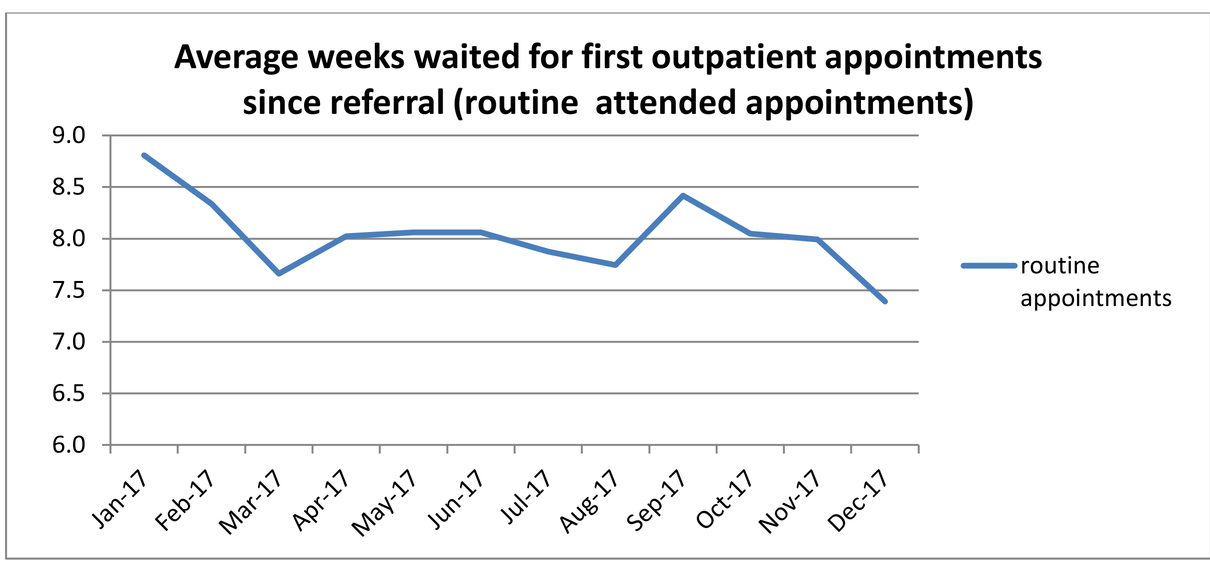

Chart 38 – Average weeks waiting time from referral to first outpatient appointment for the period January 2017 – December 2017 (routine appointments)

2.5.8 Responsive: Outpatient DNA

The overall DNA rate was 12.7 per cent in December and the priority is to reduce the numbers of patients not attending their appointments to less than 11 per cent. This continues to be above the threshold and a range of actions will continue to be put in place: These are:

- Promoting option for patients to receive appointment letters via email providing instant notification of appointments;
- Deliver a single point of access for appointment handling and queries; &
- Carrying out specialty and sub-specialty analysis of DNA rates to identify clinical pathways with increased opportunity for targeted intervention.

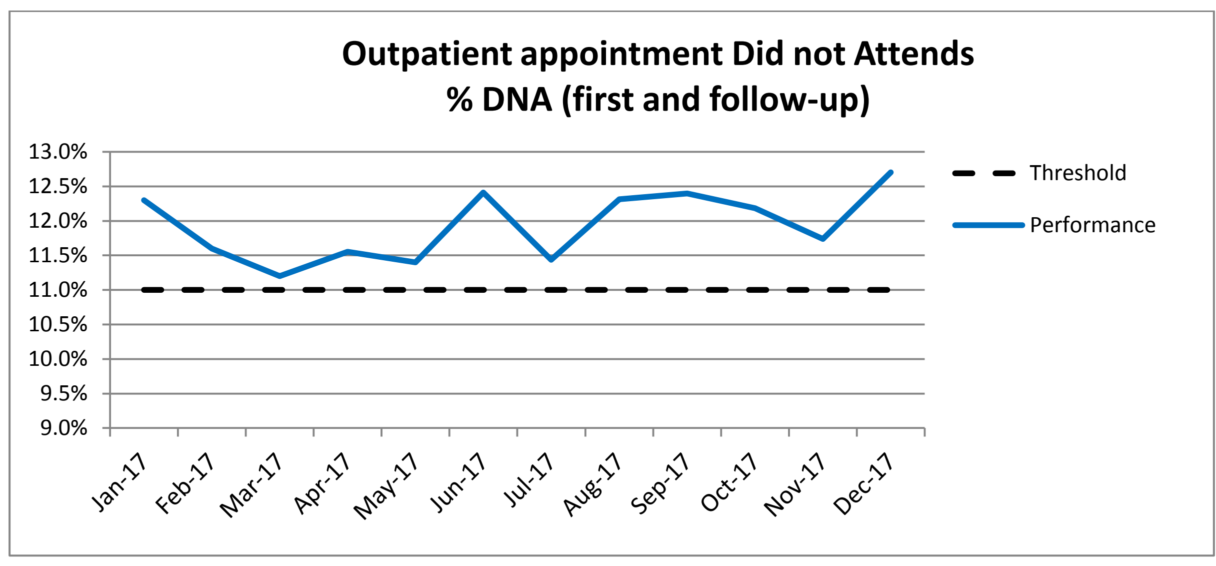

Chart 39 – Outpatient appointment Did not Attend rate (%) first and follow appointments for the period January 2017 – December 2017

2.5.9 Responsive: Outpatient appointments cancelled by the Trust

In December 9.1 per cent of outpatient appointments were cancelled by the hospital with less than 6 weeks' notice. Performance remains above the target; priority areas are as follows:

- A quality improvement project, funded by Imperial Health Charity, to improve the patient experience and reduce the cancellations of outpatient appointments.
- A deep dive to is being carried out in order to (i) understand impact of expediting appointments on cancellation rates and RTT breach status (ii) review the indicator definiton and (iii) review reasons for cancellation
- Working with specialty teams to embed the trust policy of ensuring a minimum of six weeks' notice is provided for planned leave requiring the cancelling of clinics

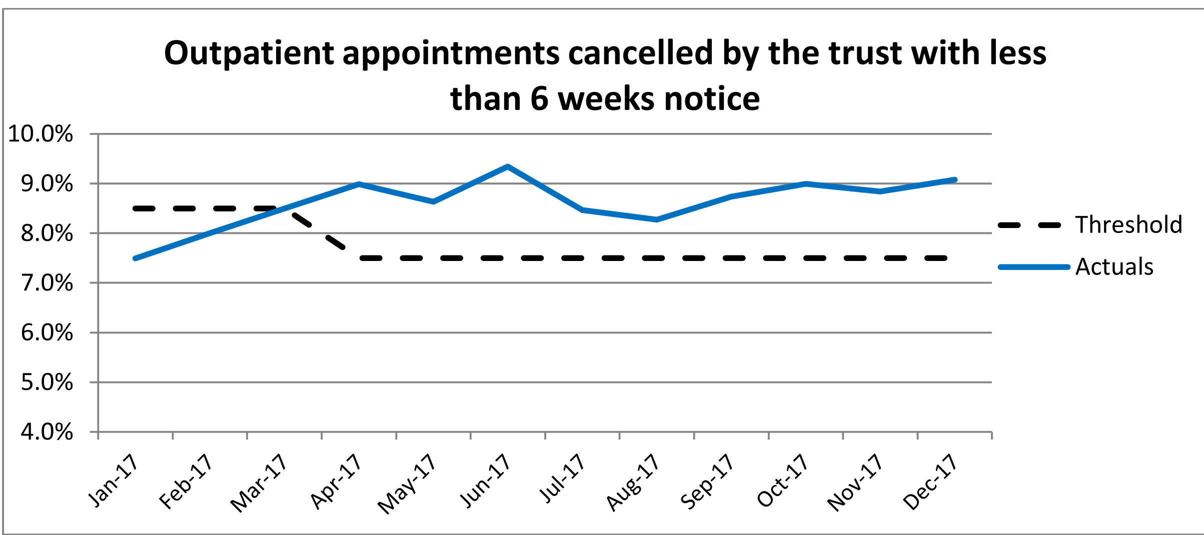

Chart 40 – Outpatient appointments cancelled by the Trust with less than 6 weeks' notice for the period January 2017 – December 2017

Note: the indicator currently measures appointments that are cancelled and rebooked to the same day, appointments that are cancelled and moved to an earlier date for the patient as well as appointments that are cancelled and pushed back and result in longer waits for the patient.

2.5.10 Responsive: Outpatient appointments made within 5 days of receipt

There has been steady improvement since January 2017 in the percentage of referrals booked for a first outpatient appointment within 5 working days since receipt. Work continues to establish new ways of working to increase responsiveness including improved tracking and roll-out of e-vetting for services within the Patient Service Centre.

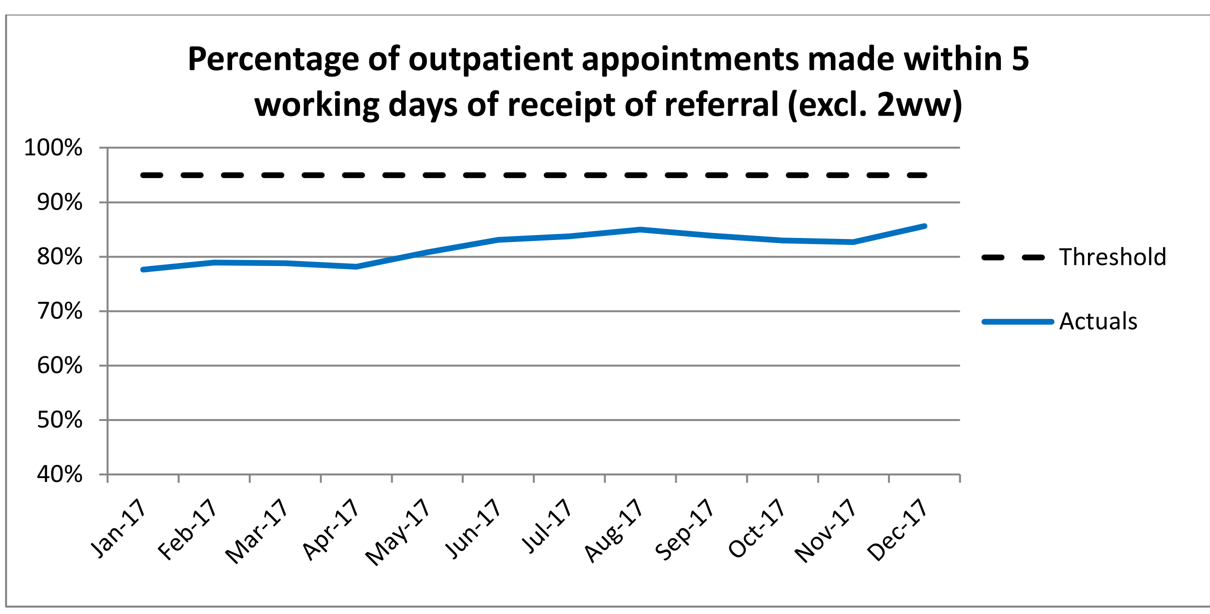

Chart 41 – % of outpatient appointments made within 5 working days of receipt of referral (excluding 2 week waits) for the period January 2017 – December 2017

3. Finance

Please refer to the Monthly Finance Report to Trust Board for the Trust's finance performance.

Appendix 1 Safe staffing levels below target by ward (additional detail)

The fill rate was below 85 per cent for care staff and 90 per cent for registered staff in the following wards:

- A8 (general surgery) had a day fill rate of 87.11 per cent for registered staff which equated to 21 shifts unfilled however, over the Christmas period there were 8 empty beds and elective procedures were postponed to relieve pressure. The matron for the area also worked clinically to support the team.
- C8 (cardiology) had a day fill rate of 68.42 per cent for care staff. This equated to 12 unfilled shifts for enhanced care of patients, which were covered by moving staff from other areas.
- Dacie ward only rosters one health care support worker at night and was unable to fill this shift over the December period and therefore the fill rate for care staff is 0 per cent. The shift was covered by moving staff from another area.
- Westen ward (haematology) had a day fill rate of 82.63 per cent for registered staff which equated to 22 shifts. During December however, activity was reduced due to planned bed closures and refurbishment.
- 10 North (neurology) had a day fill rate of 81.81 per cent which equated to 11 shifts unfilled for enhanced care of patients.
- 4 South (respiratory medicine) had a night fill rate for care staff of 84.62 per cent which equated to 7 unfilled shifts. These were covered by flexible use of rostered staff.
- 8 West (medicine) had a day fill rate of 89.45 per cent for registered staff and 81.11 per cent for care staff, which equated to 22 and 29 shifts unfilled respectively.
- John Humphrey's ward had a day fill rate of 79.77 per cent and a night fill rate of 83.64 per cent for care staff. This equated to 15 shifts unfilled for enhanced care during the day and 9 shifts at night. These shifts were safely covered by cross cover of care staff from other areas.
- Peters ward (nephrology) had a day fill rate for registered staff of 88.72 per cent which equated to 13 long day shifts and 4 shorter late shifts unfilled. The staffing gap was covered by flexible use of existing staff and skill mix.
- DAAU AMU had a day fill rate of 82.87 per cent for registered staff and 83.67 per cent day fill rate for care staff. This equated to 33 registered staff shifts unfilled during the day, 14 of which were due to an extra registered nurse added to the establishment to improve patient flow and the remaining due to sickness absence. Staff were moved from other areas to ensure patients were cared for safety.

- DAAU HDU (Douglas ward) had a day fill rate of 83.29 per cent for registered staff and 83.39 per cent during the day for care staff. This equated to 27 shifts unfilled 7 of which were for enhanced care of patients. The remainder of unfilled shifts was due to high sickness over the Christmas period and staff vacancies. These shifts were safely covered by cross cover of care staff from the first floor.
- Manver's ward had a day fill rate of 80.23 per cent for care staff. This equated to 17 shifts unfilled which were safely covered by flexible use of staff across the ward.
- Samuel Lane had a day fill rate of 78.16 per cent for care staff. This equated to 27 shifts unfilled for enhanced care and staff vacancies.
- PCCS (PICU) at St Mary's Hospital had a day fill rate of 81. 13 per cent which equated to 63 day shifts unfilled. Admissions to the unit were stopped and all non essential staff training was halted in order to release clinical staff for duty. Senior nurses worked clinically to fill the staffing gaps and medical and site teams increased their support and oversight to the unit as did the divisional management team. Patients were risk assessed daily and allocated according to available skill mix and patient acuity. Additionally, the DDN for the area maintained personal oversight of the area during times of high demand to facilitate and support staff management and patient safety.