Imperial College Healthcare NHS
NHS Trust

Report to:	Date
Trust board - public	29 November 2017

Integrated Performance Report

Executive summary:

This is a regular report and outlines the key headlines that relate to the reporting month of October 2017 (month 7).

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 efficiently and with compassion.

Author	Responsible executive director
Terence Lacey (Performance Support Business Partner) Julie O'Dea (Head of Performance Support)	Julian Redhead (Medical Director) Janice Sigsworth (Director of Nursing) David Wells (Director of People and Organisational Development) Catherine Urch (Divisional Director) Tim Orchard (Divisional Director) Tg Teoh (Divisional Director)

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1. Scorecard

ICHT Integrated Performance Scorecard - 2017/18

Month 7 Report

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Safe					
Serious incidents (number)	Julian Redhead	Oct-17	-	**18**	
Incidents causing severe harm (number)	Julian Redhead	Oct-17	-		
Incidents causing severe harm (% of all incidents YTD)	Julian Redhead	Oct-17	-	**0.08%**	
Incidents causing extreme harm (number)	Julian Redhead	Oct-17	-	**1**	
Incidents causing extreme harm (% of all incidents YTD)	Julian Redhead	Oct-17	-	**0.09%**	
Patient safety incident reporting rate per 1,000 bed days	Julian Redhead	Oct-17	44.0	**56.6**	
Duty of candour compliance (Feb 17 - Sep 17) at 31/10/17:					
Compliance with duty of candour (SIs)	Julian Redhead	Sep-17	100%	**98.0%**	
Compliance with duty of candour (Level 1 - internal investigations)	Julian Redhead	Sep-17		**48.0%**	
Compliance with duty of candour (Moderate and above incidents)	Julian Redhead	Sep-17		**74.0%**	
Never events (number)	Julian Redhead	Oct-17	0	**0**	
MRSA (number)	Julian Redhead	Oct-17	0	**0**	
Clostridium difficile (cumulative YTD) (number)	Julian Redhead	Oct-17	62	**33**	
VTE risk assessment: inpatients assessed within 24 hours of admission (%)	Julian Redhead	Oct-17	95.0%	**93.0%**	
CAS alerts outstanding (number)	Janice Sigsworth	Oct-17	0	**3**	
Avoidable pressure ulcers (number)	Janice Sigsworth	Oct-17	-	**0**	
Staffing fill rates (%)	Janice Sigsworth	Oct-17	tbc	**96.5%**	
Post Partum Haemorrhage 1.5L (PPH) (%)	Tg Teoh	Oct-17	2.8%	**2.8%**	
Core Skills (excluding Doctors in Training) (%)	David Wells	Oct-17	90.0%	**84.0%**	
Core Skills (Doctors in Training) (%)	David Wells	Oct-17	90.0%	**71.5%**	
Core Clinical Skills (excluding Doctors in Training) (%)	David Wells	Oct-17	tbc	**80.4%**	
Core Clinical Skills (Doctors in Training) (%)	David Wells	Oct-17	tbc	**63.4%**	
Staff accidents and incidents in the workplace (RIDDOR-reportable) (number)	David Wells	Oct-17	0	**1**	
Effective					
Hospital standardised mortality ratio (HSMR)	Julian Redhead	Jun-17	100	**66.0**	
Mortality reviews at 21/11/17:					
Total number of deaths	Julian Redhead	Sep-17	-	**161**	
Number of local reviews completed	Julian Redhead	Sep-17	-	**112**	
% of local reviews completed	Julian Redhead	Sep-17	100%	**70.0%**	
Number of SJR reviews requested	Julian Redhead	Sep-17	-	**24**	
Number of SJR reviews completed	Julian Redhead	Sep-17	-	**1**	
Number of avoidable deaths (Score 1-3)	Julian Redhead	Sep-17	-	**0**	

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Effective					
Clinical trials - recruitment of 1st patient within 70 days (%)	Julian Redhead	Sep-17	90.0%	**48.8%**	
Unplanned readmission rates (28 days) over 15s (%)	Tim Orchard	Mar-17	-	**6.9%**	
Unplanned readmission rates (28 days) under 15s (%)	Tg Teoh	Mar-17	-	**5.0%**	
Outpatient appointments not checked-in or DNAd (app within last 90 days) (number)	Tg Teoh	Oct-17	-	**1326**	
Outpatient appointments checked-in AND not checked-out (number)	Tg Teoh	Oct-17	-	**1916**	
Diagnostic and surgical orders waiting to be processed (Add/Set Encounter)	Kevin Jarrold	Oct-17	0	**1925**	
Caring					
Friends and Family Test: **Inpatient** service - % patients recommended	Janice Sigsworth	Oct-17	95.0%	**97.0%**	
Friends and Family Test: **A&E** service - % recommended	Janice Sigsworth	Oct-17	85.0%	**93.1%**	
Friends and Family Test: **Maternity** service - % recommended	Janice Sigsworth	Oct-17	95.0%	**93.2%**	
Friends and Family Test: **Outpatient** service - % recommended	Janice Sigsworth	Oct-17	94.0%	**91.2%**	
Complaints: Total number received from our patients	Janice Sigsworth	Oct-17	100	**96**	
Non-emergency patient transport: waiting times of less than 2 hours for outward journey	Janice Sigsworth	Oct-17	-	**74.8%**	
Mixed-Sex Accommodation (EMSA) breaches	Janice Sigsworth	Oct-17	0	**29**	
Well Led					
Vacancy rate (%)	David Wells	Oct-17	10.0%	**11.6%**	
Voluntary turnover rate (%) 12-month rolling	David Wells	Oct-17	10.0%	**9.5%**	
Sickness absence (%)	David Wells	Oct-17	3.1%	**2.7%**	
Personal development reviews (%)	David Wells	Jul-17	95.0%	**-**	
Doctor Appraisal Rate (%)	Julian Redhead	Oct-17	95.0%	**90.1%**	
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)	Julian Redhead	Oct-17	-	**1**	
Reactive maintenance performance (% tasks completed within agreed response time)	Janice Sigsworth	Oct-17	98%	**18.1%**	
Responsive					
RTT: 18 Weeks Incomplete (%)	Catherine Urch	Oct-17	92.0%	**83.3%**	
RTT: Patients waiting over 18 weeks for treatment (number)	Catherine Urch	Oct-17	-	**10744**	
RTT: Patients waiting 52 weeks or more for treatment (number)	Catherine Urch	Oct-17	0	**331**	
Cancer: 62 day urgent GP referral to treatment for all cancers (%)	Catherine Urch	Sep-17	85.0%	**87.8%**	
Cancelled operations (as % of total elective activity)	Catherine Urch	Sep-17	0.8%	**1.1%**	
28 day rebooking breaches (% of cancellations)	Catherine Urch	Sep-17	8.0%	**7.6%**	
Theatre utilisation (%)	Catherine Urch	Oct-17	85.0%	**76.0%**	

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
A&E patients seen within 4 hours (type 1) (%)	Tim Orchard	Oct-17	95.0%	**68.9%**	
A&E patients seen within 4 hours (all types) (%)	Tim Orchard	Oct-17	95.0%	**86.6%**	
A&E patients spending >12 hours from decision to admit to admission	Tim Orchard	Oct-17	-	**3**	
Waiting times for first outpatient appointment (routine) (average weeks waited for attended appointments)	Tg Teoh	Oct-17	-	**8.1**	
Patients waiting longer than 6 weeks for diagnostic tests (%)	Tg Teoh	Oct-17	1.0%	**4.3%**	
Outpatient Did Not Attend rate: (First & Follow-Up) (%)	Tg Teoh	Oct-17	11.0%	**12.2%**	
Hospital initiated outpatient cancellation rate with less than 6 weeks notice (%)	Tg Teoh	Oct-17	7.5%	**9.0%**	
Outpatient appointments made within 5 working days of receipt (%)	Tg Teoh	Oct-17	95.0%	**83.0%**	
Money and Resources					
In month variance to plan (£m)	Richard Alexander	Oct-17		**-1.39**	
YTD variance to plan (£m)	Richard Alexander	Oct-17		**-0.67**	
Annual forecast variance to plan (£m)	Richard Alexander	Oct-17		**-3.69**	
Agency staffing (% YTD)	Richard Alexander	Oct-17		**4.4%**	
CIP % delivery YTD	Richard Alexander	Sep-17		**87.1%**	

2. Key indicator overviews

2.1 Safe

2.1.1 Safe: Serious Incidents

Eighteen serious incidents were reported in October 2017, all of which are undergoing root cause analysis investigations.

The themes to note include an increased number of SIs related to treatment delay (availability of mental health beds). This category is an internally amended version of the StEIS category; ‘Treatment Delay’ which was introduced to enable the capture of any patient safety risks that are being experienced in the emergency departments due to a lack of downstream mental health beds.

The other area to note is an increasing number of incidents relating to infection prevention and control issues. This increase relates to the number of incidents related to carbapenemase-producing Enterobacteriaceae (CPE) transmission. Screening for these organisms and their subsequent identification has increased in the last year however transmission is concerning and therefore an SI investigation is undertaken where this is suspected. Whilst the root cause of these incidents is multifactorial, there are themes and actions in common including ensuring high compliance with CPE admission screening locally, improved hand hygiene and aseptic non-touch technique (ANTT) practice, assurance around cleaning standards and the environment, and a focus on appropriate use of antibiotics. The Trust CPE action plan is currently being refreshed.

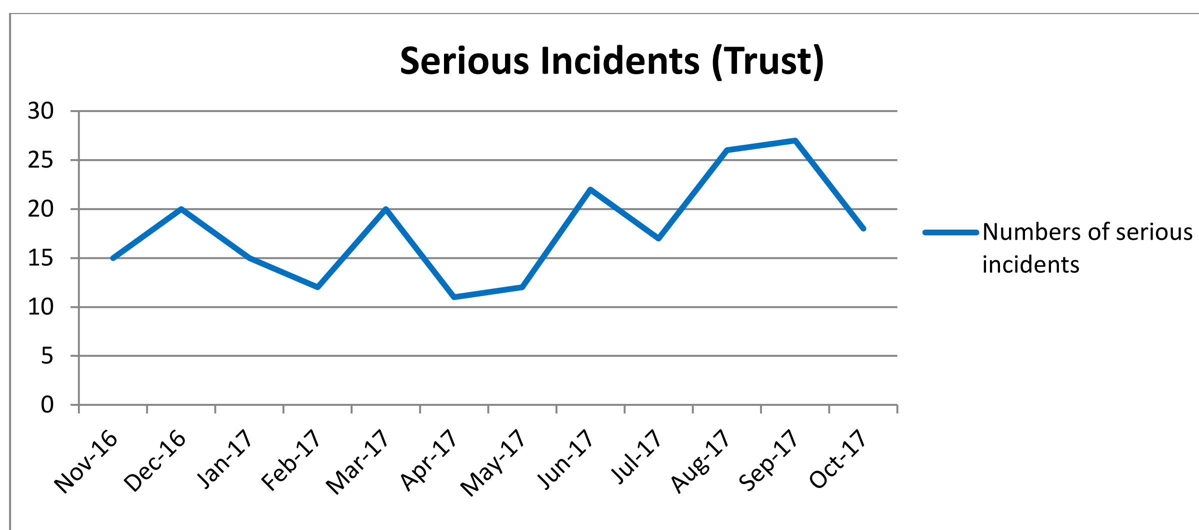

Chart 1 - Number of Serious Incidents (SIs) (Trust level) by month for the period November 2016 – October 2017

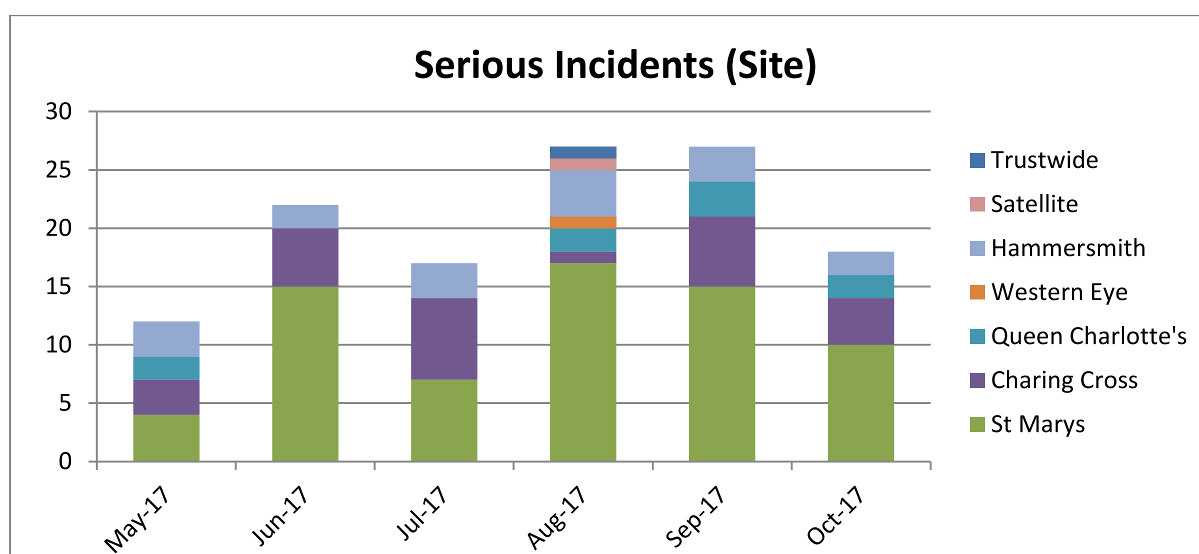

Chart 2 - Number of Serious Incidents (SIs) (Site level) by month for the period May 2017 – October 2017

In the last 12 months there has been an overall increase in the number of SIs reported compared to the preceding 12 month period. 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.

Safety improvement programmes (safety streams) are in place to support reducing recurrence for the categories that have been reported most frequently. The nine safety improvement programmes are:

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

Incidents causing severe and extreme harm

The Trust reported one severe/major harm incidents and one extreme harm/death incident in October 2017. Both incidents are being investigated as SIs.

There have been seven severe and eight 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. According to NRLS, the national average for extreme harm/deaths incidents has increased slightly from 1 per cent to 1.2 per cent when compared to data for the April 2016 – September 2016 period and has remained the same for severe/major harm incidents.

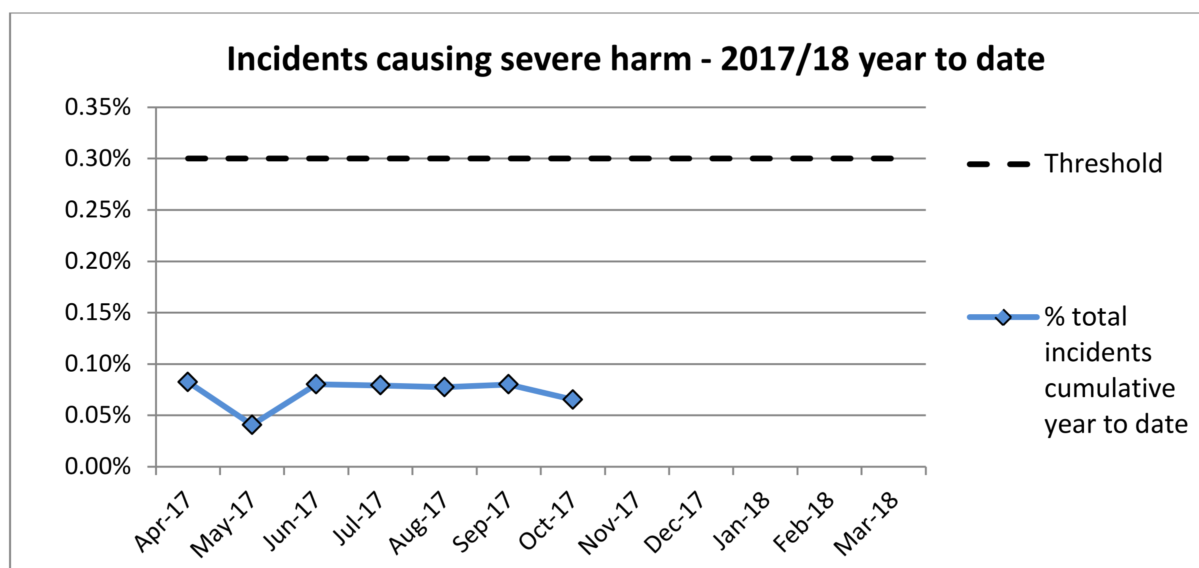

Chart 3 – Incidents causing severe harm by month from the period April 2017 – October 2017 (% of total patient safety incidents YTD). Threshold Source: National Reporting and Learning System (NRLS)

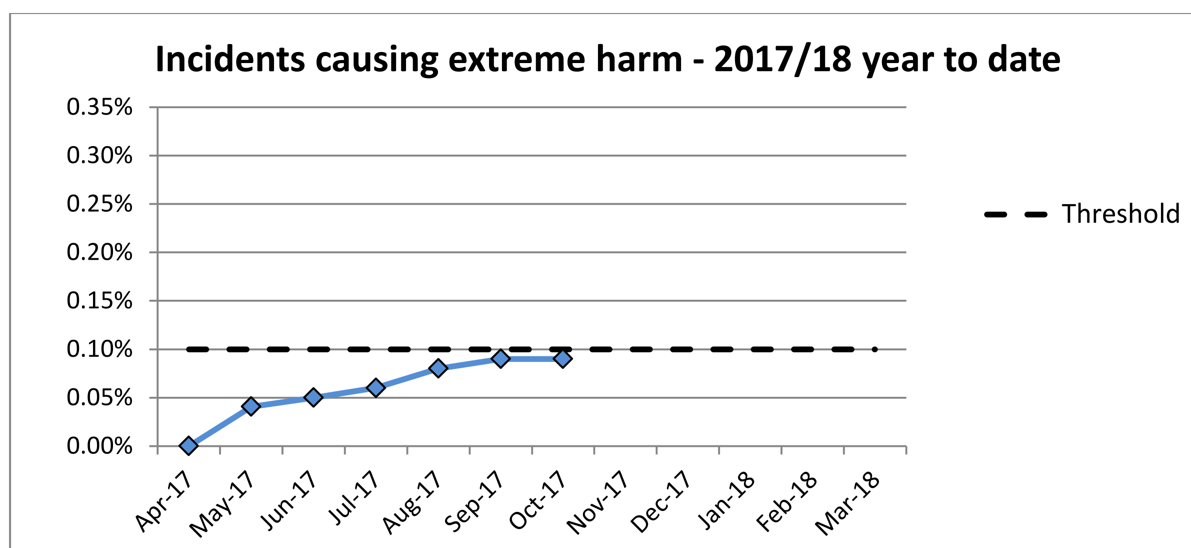

Chart 4 – Incidents causing extreme harm by month from the period April 2017 – October 2017 (% of total patient safety incidents YTD). Threshold Source: National Reporting and Learning System (NRLS)

Patient safety incident reporting rate

The Trust's incident reporting rate for October 2017 is 56.6. This means that the organisation is meeting the target to be within the highest 25 per cent of reporters nationally. Through the safety culture programme we are committed to continuing to encourage and support increased reporting; the overall number of incidents reported in October increased by 130 compared to the September reporting number.

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.

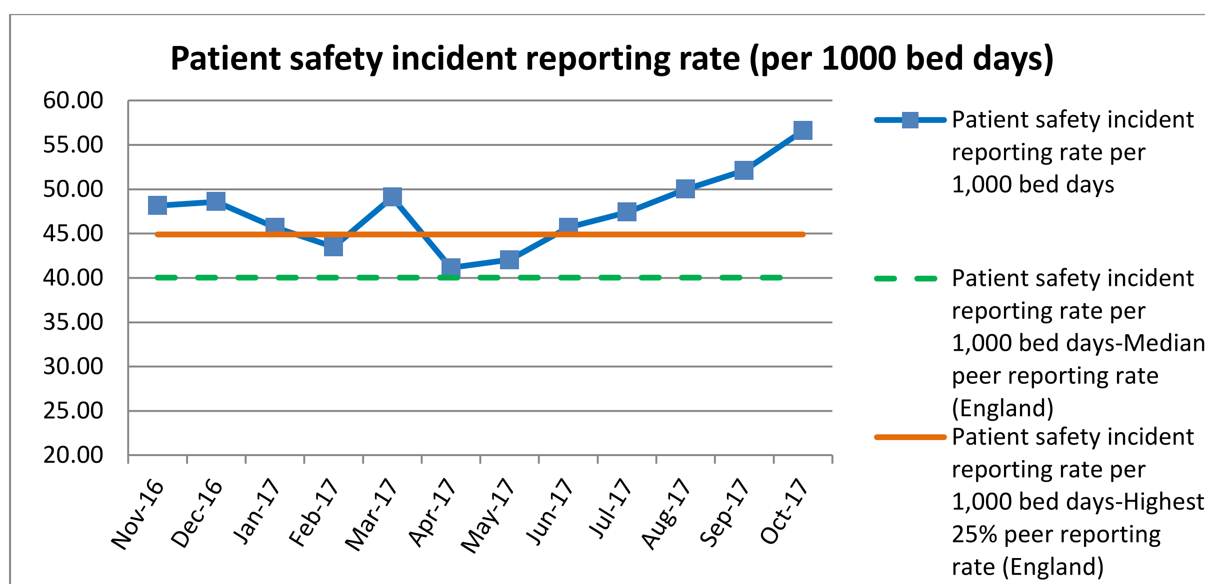

Chart 5 – Trust incident reporting rate by month for the period November 2016 – October 2017

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 one investigations.

The table below shows the number of SIs, internal investigations and cases of moderate harm reported between February and September 2017, and the percentage of these which have had stage 1 and stage 2 of the duty of candour process completed. The data goes back to February 2017 because the look back exercise covered the preceding months and all letters were sent as appropriate.

Although we are making improvements across all areas, we will now commence more focussed work on improving compliance for level 1 investigations. The compliance for October 2017 is not yet available as data are reported one month in arrears.

	SIs	Level 1 (internal investigations)	Moderate and above incidents
Number of incidents (Feb 2017 – Sept 2017)	128	60	23
Total with stage 1 complete	125	29	18
Total with stage 2 complete	126	28	18
Total with both stages complete	125	27	17
Percentage fully compliant with duty of candour requirements	98%	45%	74%

Percentage of incidents fully compliant with duty of candour requirements at 31 October 2017

2.1.4 Safe: Never events

There have been no further never events declared since the case in July 2017. The root cause analysis for that event has not been approved by the Medical Director as it was not as thorough as required and is now overdue. The division of SCCS are reviewing this investigation but have implemented immediate action to minimise recurrence by using an alert on epidural lines in the form of a printed sticker. An audit of compliance with this will be reported in December 2017. 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 division of SCCS to manage the roll out trust wide.

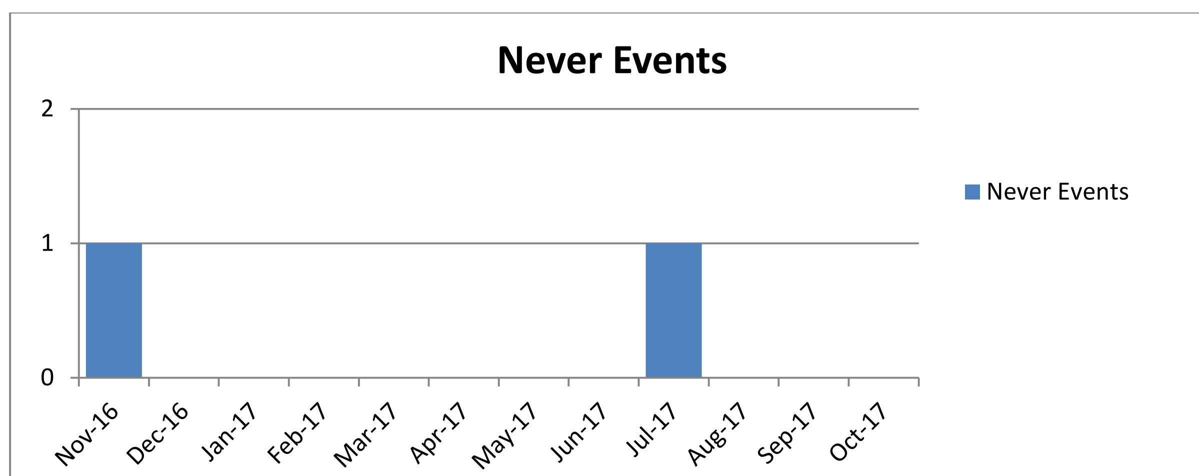

Chart 6 – Trust Never Events by month for the period November 2016 – October 2017

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

There were no cases of MRSA BSI identified at the Trust in October 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*

Eight cases of Clostridium difficile were allocated to the Trust for October 2017, one of which was identified as a lapse in care.

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

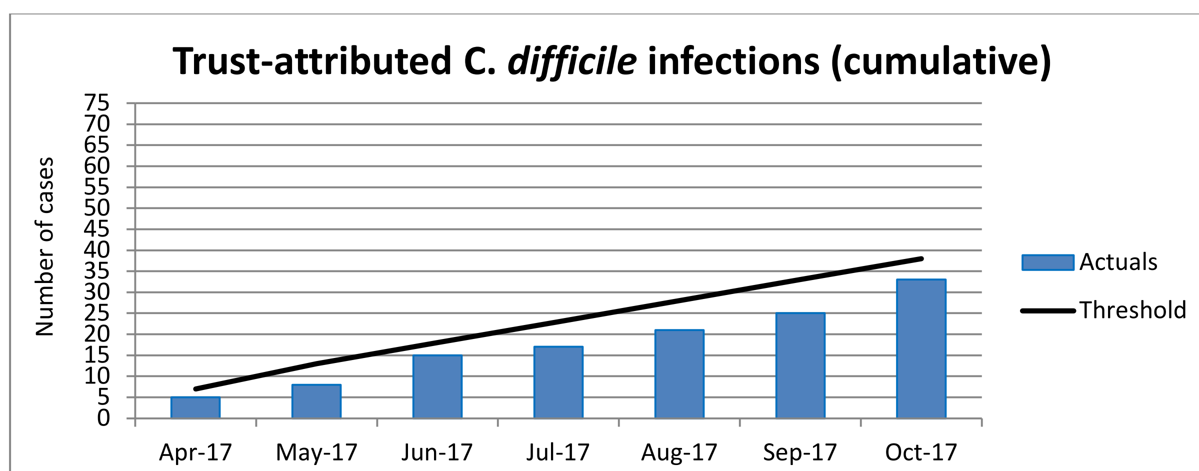

Chart 7 - Number of Trust-attributed *Clostridium difficile* infections against cumulative plan by month for the period April 2017 – October 2017

2.1.7 Safe: Venous thromboembolism (VTE) risk assessment

Performance is below target at 92.98 per cent at the end of October.

Divisions have local action plans in place to drive up and monitor improvements in compliance and a key area of focus is in maternity. All divisions provide a weekly progress update to the VTE task and finish group, chaired by the Medical Director. A Trust wide action plan is in place and progress is reported to Executive Quality Committee through the Trust's Quality Report.

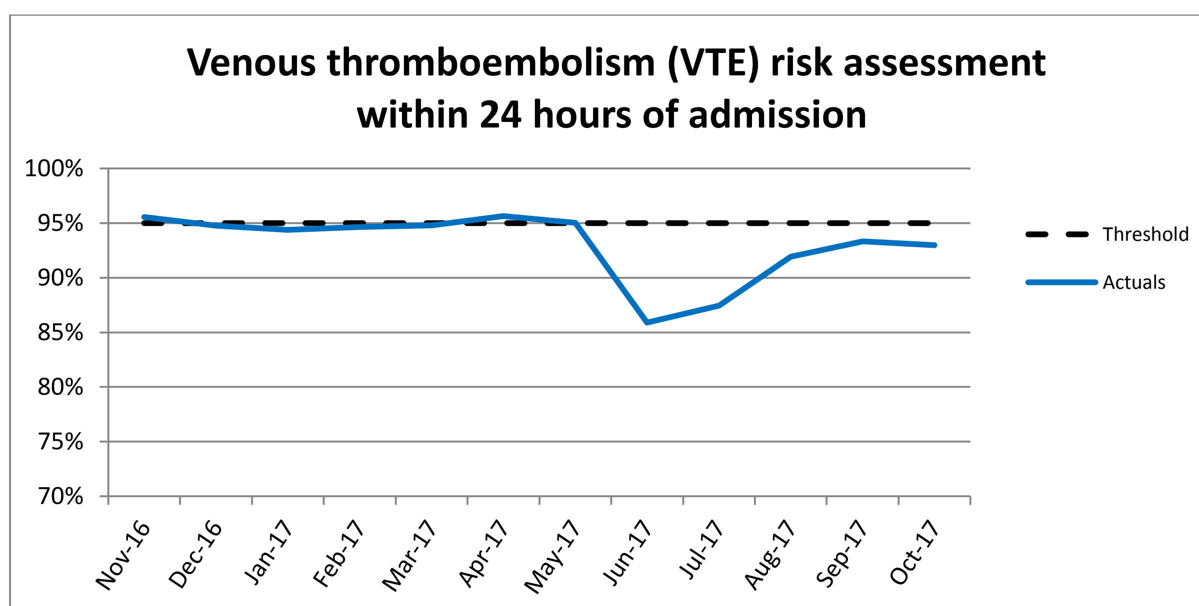

Chart 8 – % of inpatients who received a risk assessment for Venous thromboembolism (VTE) within 24 hours of their admission by month for the period November 2016 – October 2017

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. At end October 2017 three alerts were outstanding and all are being reviewed so that actions can be put in place and alerts closed.

- MDA/2017/018 (metal-on-metal (MoM) hip replacements: updated advice for follow-up of patients) - An action plan has been produced.
- MDA/2017/028R (replacement bileaflet mechanical heart valves: risk of inverted implantation) - A response is being completed by the SCCS Division.
- MDA/2017/031 (IntelliVue patient monitors used with 12-lead ECG: risk of ECG trace distortion Specific models and software versions affected) – Devices have been identified and the software upgrade has been booked with Phillips Healthcare.

2.1.9 Safe: Avoidable pressure ulcers

There were zero avoidable hospital acquired pressure ulcers recorded for October 2017 across all Divisions. The 2017/18 year to date total is 11.

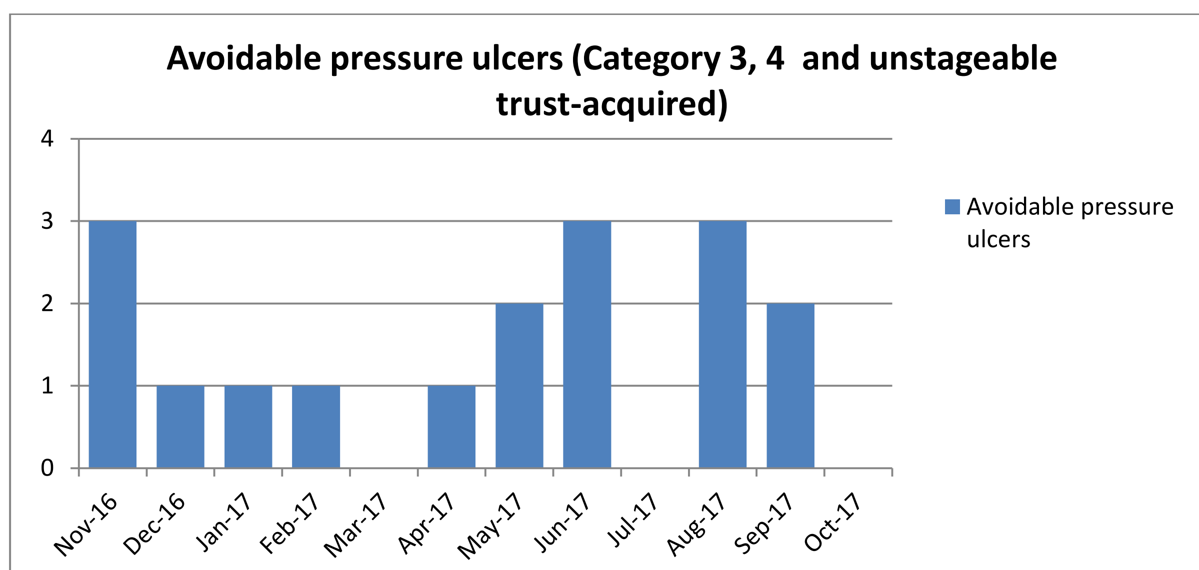

Chart 9 – Number of category 3 and category 4 (including unstageable) Trust-acquired pressure ulcers by month for the period November 2016 – October 2017

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

In October 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 as follows:

Site Name	Day shifts – average fill rate		Night shifts – average fill rate	
	Registered nurses/midwives	Care staff	Registered nurses/midwives	Care staff
Charing Cross	94.89%	89.31%	97.14%	96.12%
Hammersmith	96.37%	87.38%	98.52%	97.58%
Queen Charlotte’s	98.15%	91.48%	97.99%	89.41%
St. Mary’s	95.74%	93.66%	96.91%	96.06%

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 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 and 21 new trainees were employed across our partner organisations, 13 of which are based at Imperial.

The development of the apprentice nurse pathway in the coming months will also offer an opportuntiy to bolster up the workforce whilst new recruits train towards registration over a four year period, whilst being employed as apprentices. The divisons will consider increasing numbers of trainees in the coming months.

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

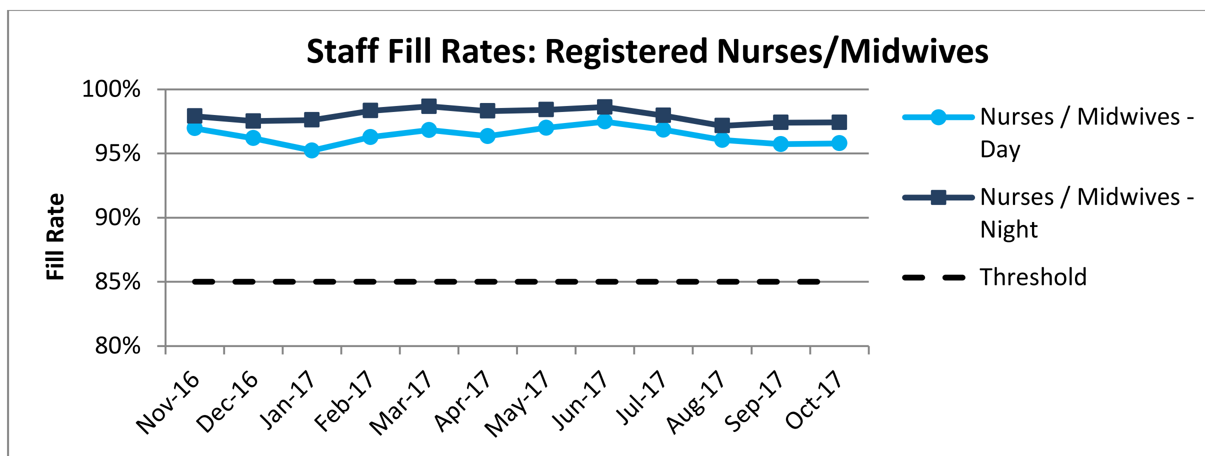

Chart 10 - Monthly staff fill rates (Registered Nurses/Registered Midwives) by month for the period November 2016 – October 2017

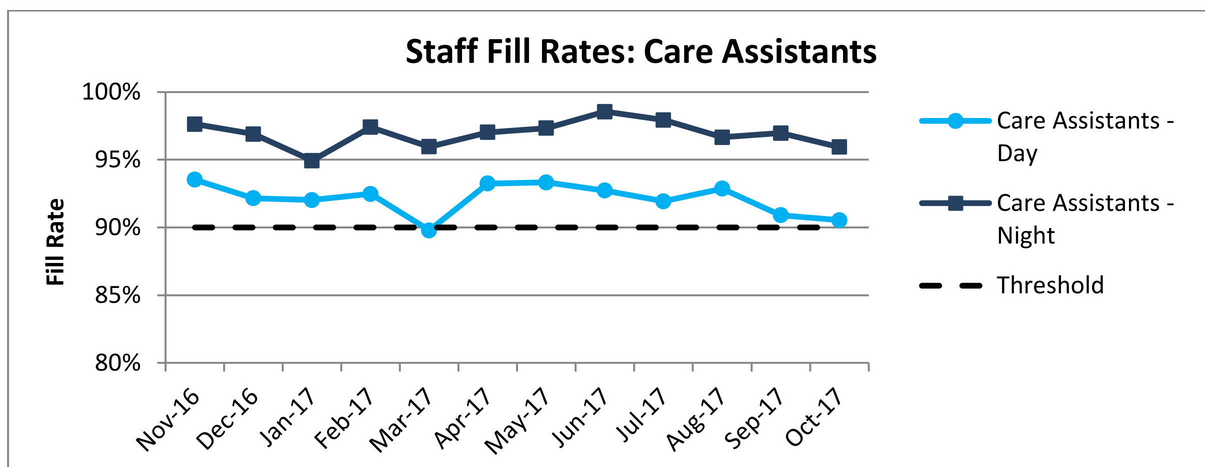

Chart 11 - Monthly staff fill rates (Care Assistants) by month for the period November 2016 – October 2017

2.1.11 Safe: Postpartum haemorrhage

In October 2.8 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.

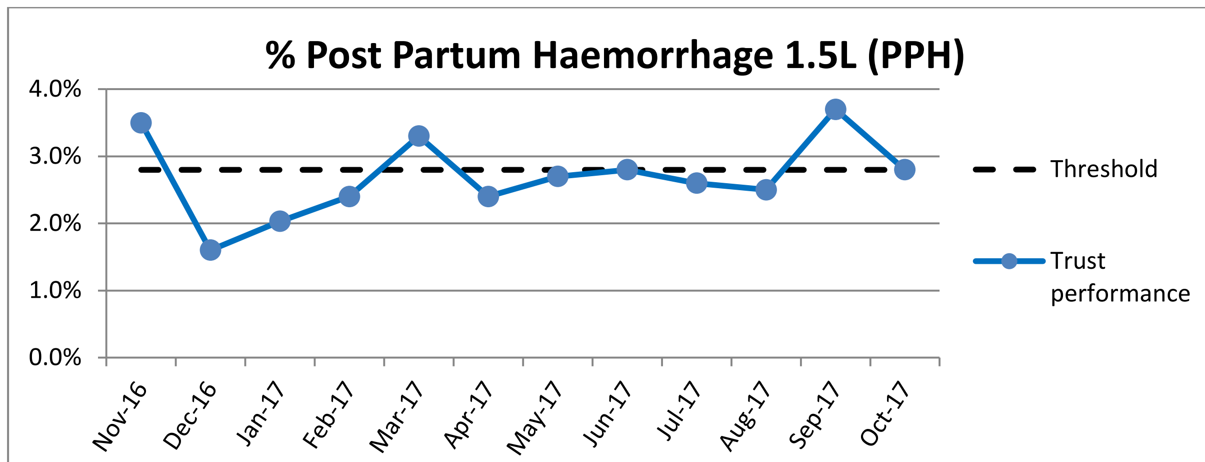

Chart 12 – Postpartum haemorrhage (PPH) for the period November 2016 – October 2017

2.1.12 Safe: Core skills training

Core Skills Training (statutory mandatory): The compliance rate for doctors in training was 71.5 per cent and for all other staff, 84.0 per cent

Core Clinical Skills Training: The compliance rate for doctors in training was 61.1 per cent and for all other staff, 81.2 per cent.

A campaign is running to improve compliance rates for Core Skills. A managers' briefing has been cascaded, with ideas for improving compliance within teams (such as checking establishments and removing staff on honorary contracts who are no longer in the Trust). Core skills and subject matter experts continue to work together to address under-performing areas. The compliance rate for Juniors Doctors continues to improve since introducing a new process.

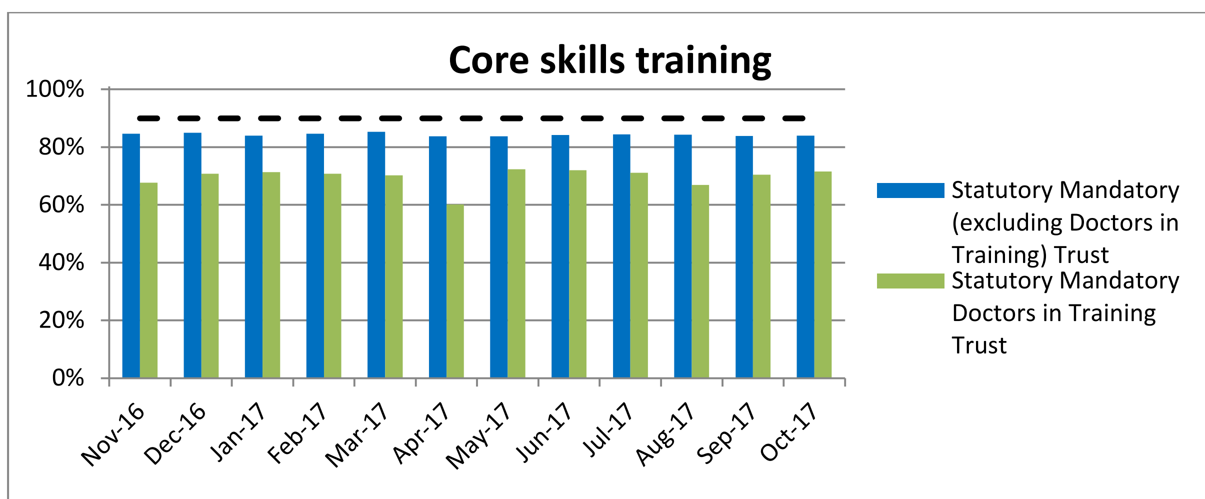

Chart 13 - Statutory and mandatory training for the period November 2016 – October 2017

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 October 2017.

The incident involved a member of staff sustaining a needle-stick injury with a medical 'sharp' contaminated with blood from a Hep C +ve patient. The incident was reportable to the HSE as a Dangerous Occurrence (release or escape of a biological agent).

In the 12 months to 31st October 2017, there have been 49 RIDDOR reportable incidents of which 20 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.

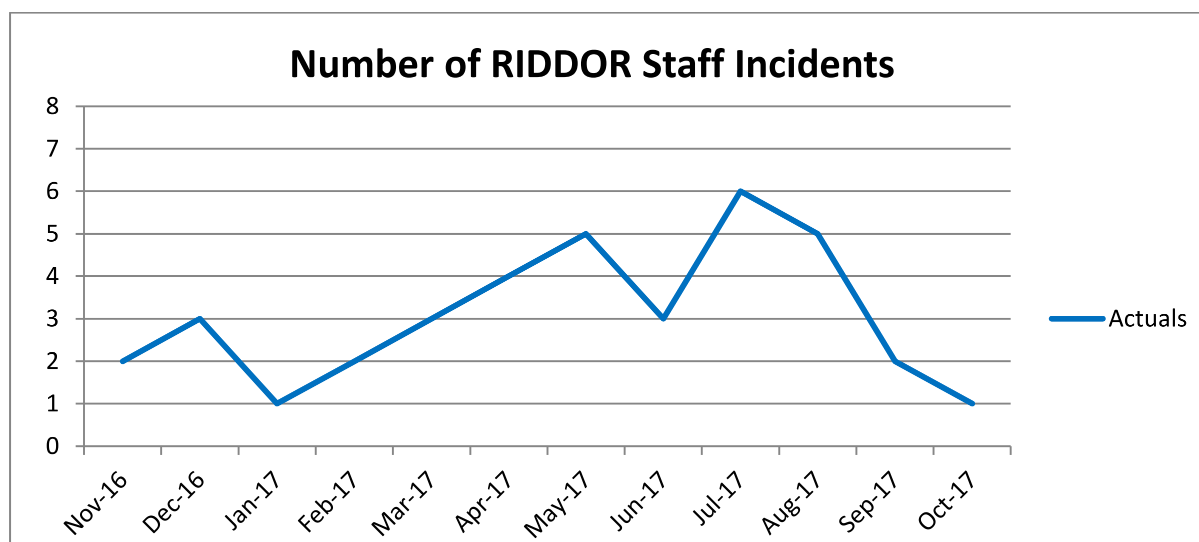

Chart 14 – RIDDOR Staff Incidents for the period November 2016 – October 2017

2.2 Effective

2.2.1 Effective: National Clinical Audits

Since April 2017, a total of 26 national study reports have been published for studies that the Trust participated in. The reports for these 26 studies 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.

Two reports have completed the review cycle in the WCCS division. These were the MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme and the National Pediatrics Diabetes Audit. The division approved substantial assurance for both and the Trust was commended as being a positive outlier.

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 60 (June 2017). Over the last 12 months the Trust has had the second lowest HSMR for acute non-specialist trusts nationally. The Trust now has the 2nd lowest SHMI of all non-specialist providers in England for Q1 2016/17 – Q4 2016/17 compared to the 4th lowest, last quarter.

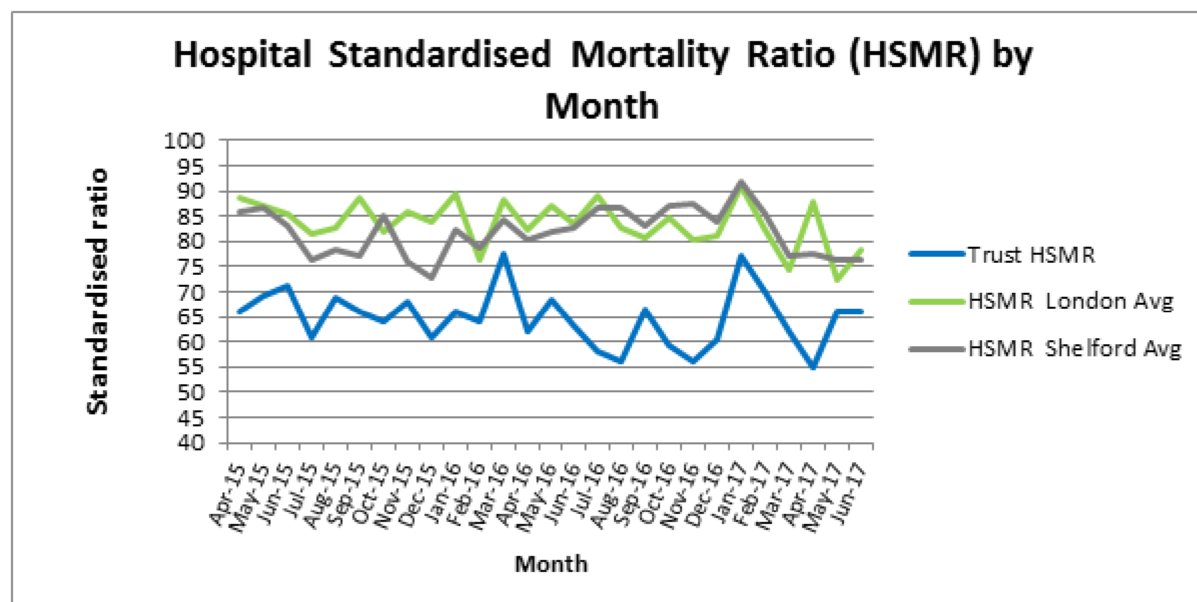

Chart 15 - Hospital Standardised Mortality Ratios for the period April 2015 – June 2017

2.2.3 Effective: Mortality reviews completed

Since the online mortality review system went live in February 2016, twelve avoidable deaths have been confirmed. These have all been investigated either as serious incidents or internal investigations, with learning and actions shared through the mortality review group (MRG).

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 to a quarterly 'learning from deaths dashboard' to the Trust Board. This is being presented as a separate paper to the Trust Board this month in line with the reporting requirement.

The Trust has implemented the structured judgement review methodology (SJR) and reports are starting to be received. Data are refreshed on a monthly basis as SJRs are completed. 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.

Mortality review measure	2017/18								
	Apr	May	Jun	Jul	Aug		Sep	Oct	YTD
Total number of deaths	119	150	137	137	161		149	161	1014
Number of local reviews completed	117	149	135	133	155		131	112	932
% Local reviews completed (target 100%)	98%	99%	98%	97%	96%		88%	70%	92%
Number of SJR reviews requested	3	3	2	20	24		18	24	94
Number of SJR reviews completed	1	0	0	1	4		3	1	10
Number of avoidable deaths (Score 1-3)	0	0	0	0	0		0	0	0

Mortality reviews (at 20 November 2017) 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

The Trust did not achieve its target of 90 per cent of clinical trials recruiting their first patient within 70 days of valid research application in Q1. Our validated performance by NIHR was 48.6% which although below target was above the national average of 46%. The Trusts forecast performance for Q2 is 63.6%. The anticipated improvement is due to the implementation of plans to speed up contract negotiations internally through more joined up processes, clearer escalation points and standard terms to enable more studies to be initiated within the 70 days,

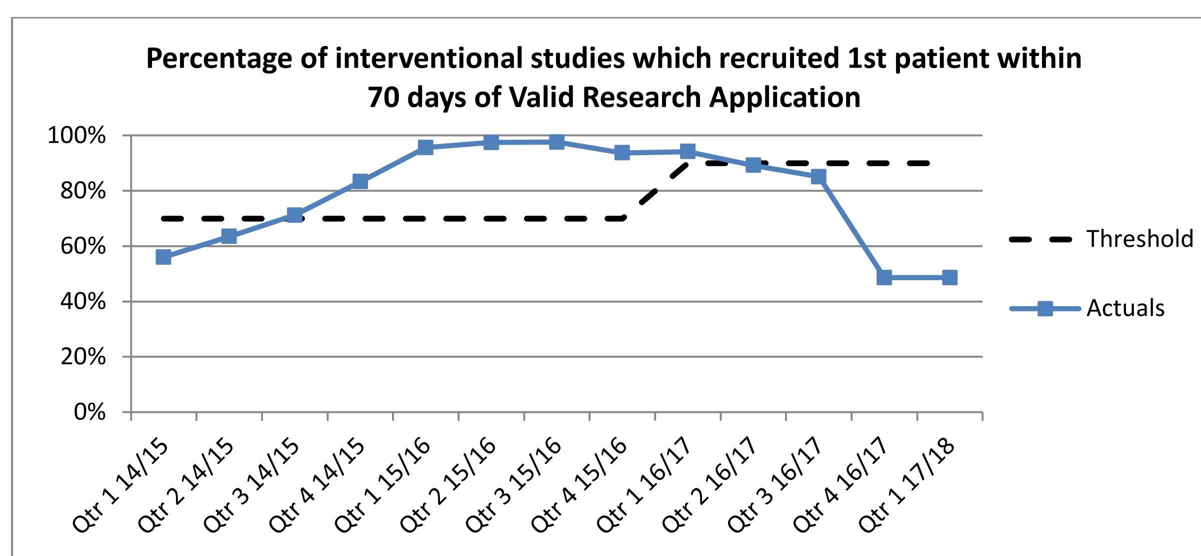

Chart 16 - Interventional studies which recruited first patient within 70 days of Valid Application Q1 2014/15 – Q1 2017/18

2.2.5 Effective: Readmission rates

For April 2017 (the latest month reported), the Trust 28 day readmission rates as reported through Dr Foster intelligence continued to be lower in both age groups than the Shelford and National rates for both age groups (0-15 years and ages 16 plus).

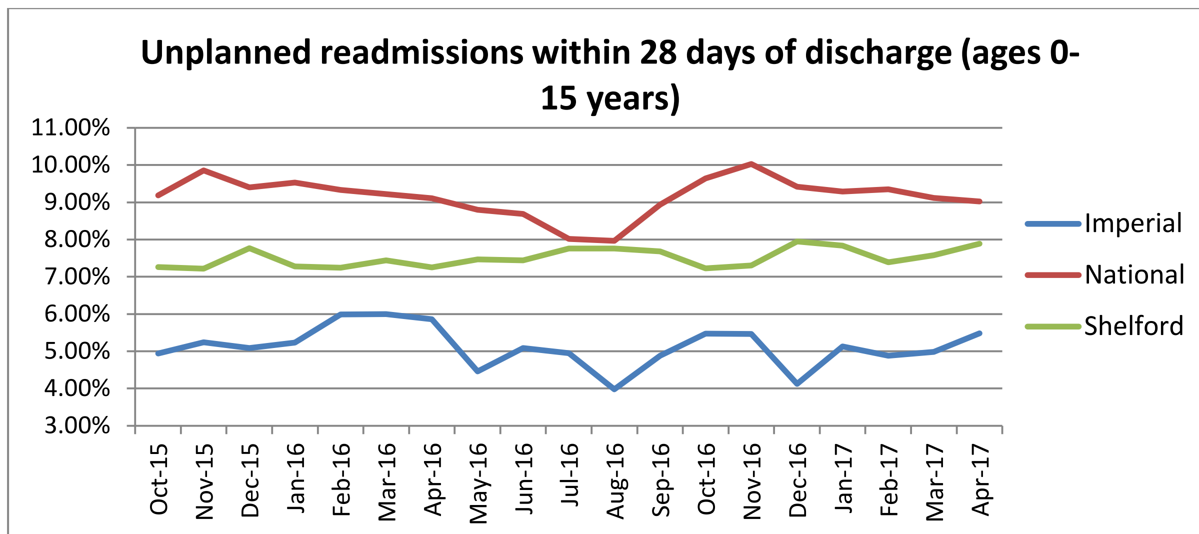

Chart 17 - Unplanned readmissions (to any NHS Trust) within 28 days of discharge from ICHT (ages -15 years) for the period October 2015 – April 2017

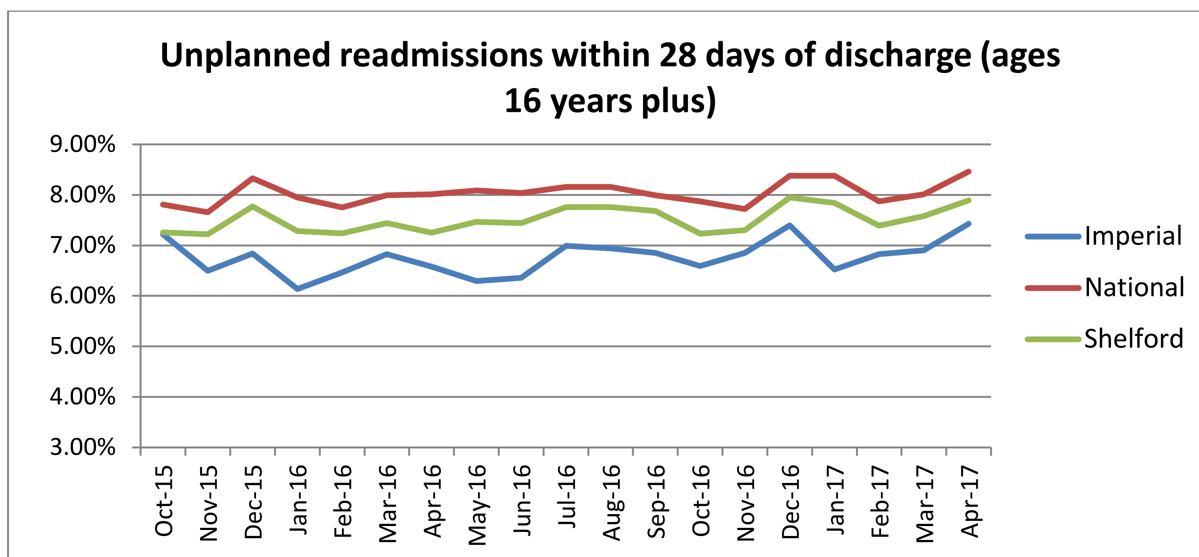

Chart 18 - Unplanned readmissions (to any NHS Trust) within 28 days of discharge from ICHT (ages 16 years plus) for the period October 2015 – April 2017

2.2.6 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, with representation from the responsible divisional data quality leads. The group will review and monitor all DQIs and provide assurance to the Data Quality Steering Group. This will include agreeing local plans with the divisional data quality leads to process clinical orders within the trust standard and trajectories.

It should be noted that a new endoscopy workflow went live in June 2017 to provide full visibility of all endoscopy orders on Cerner; this is consistent with the increase in orders on the list from June onwards, as shown in the chart below.

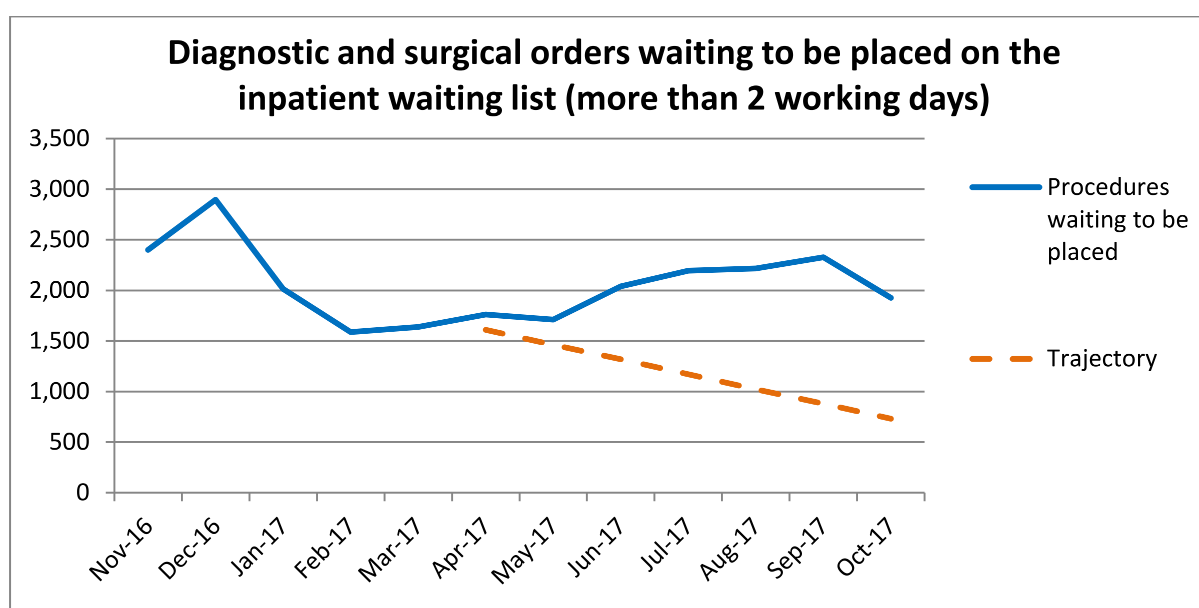

Chart 19 – Number of patients on the Add/Set Encounter request list of more than 2 working days for the period November 2016 – October 2017

2.2.7 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.

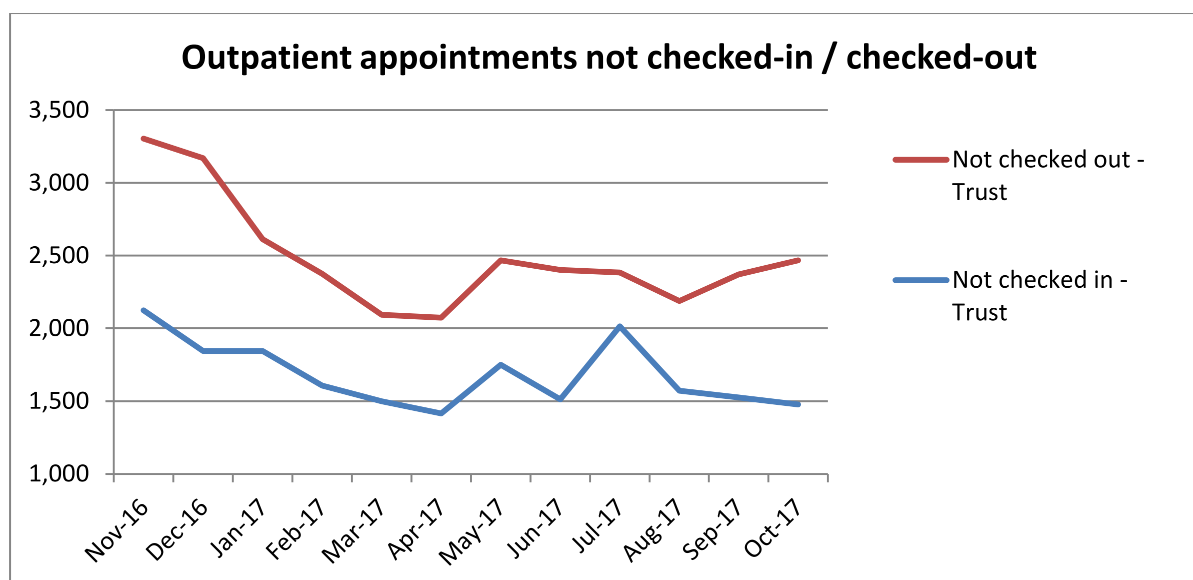

Chart 20 – Number of outpatient appointments not checked-in or DNA'd (in the last 90 days) AND number of outpatient appointments checked-in and not checked-out for the period November 2016 – October 2017

2.3 Caring

2.3.1 Caring: Friends and Family Test

Generally the likelihood to recommend score remains high across the board. A&E response rates have dipped again, but an improvement plan has been presented in November.

Friends and Family test results

Service	Metric Name	Aug-17	Sep-17	Oct-17
Inpatients	Response Rate (target 30%)	33.0%	32.5%	**31.9%**
	Recommend %	97.0%	96.9%	**97.0%**
	Not Recommend %	1.0%	1.1%	**0.8%**
A&E	Response Rate (target 20%)	13.0%	14.7%	**12.8%**
	Recommend %	95.0%	94.2%	**93.1%**
	Not Recommend %	3.1%	3.6%	**3.7%**
Maternity	Response Rate (target 15%)	26.0%	20.3%	**32.9%**
	Recommend %	94.0%	94.9%	**93.2%**
	Not Recommend %	3.0%	2.4%	**2.9%**
Outpatients	Response Rate (target 6%)	10.0%	10.1%	**10.0%**
	Recommend %	91.0%	91.5%	**91.2%**
	Not Recommend %	4.0%	4.2%	**4.5%**

2.3.2 Caring: Patient transport waiting times

Non-Emergency Patient Transport Service

Generally the response times have remained static between 70-80 per cent.

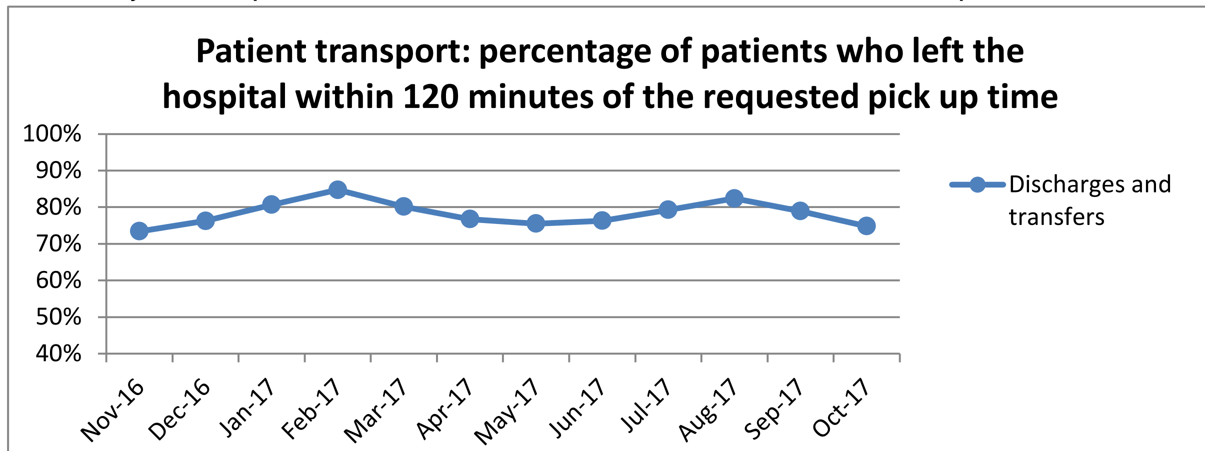

Chart 21 - Percentage of patients who left the hospital as part of the patient transport scheme within 120 minutes of their requested pick up time between Nov 2016 and October 2017

2.3.3 Caring: Eliminating mixed sex accommodation

The Trust reported 29 mixed-sex accommodation (MSA) breaches for October 2017. All breaches were incurred by patients awaiting step down from critical care to ward areas and whose discharge is delayed.

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 increase in breaches since October 2016 has been mainly attributable to breaches occurring within ITU at Charing Cross. The Division of Surgery and Cancer continue to undertake a deep dive into the situation to understand root causes and an action plan is being put in place to address the recommendations.

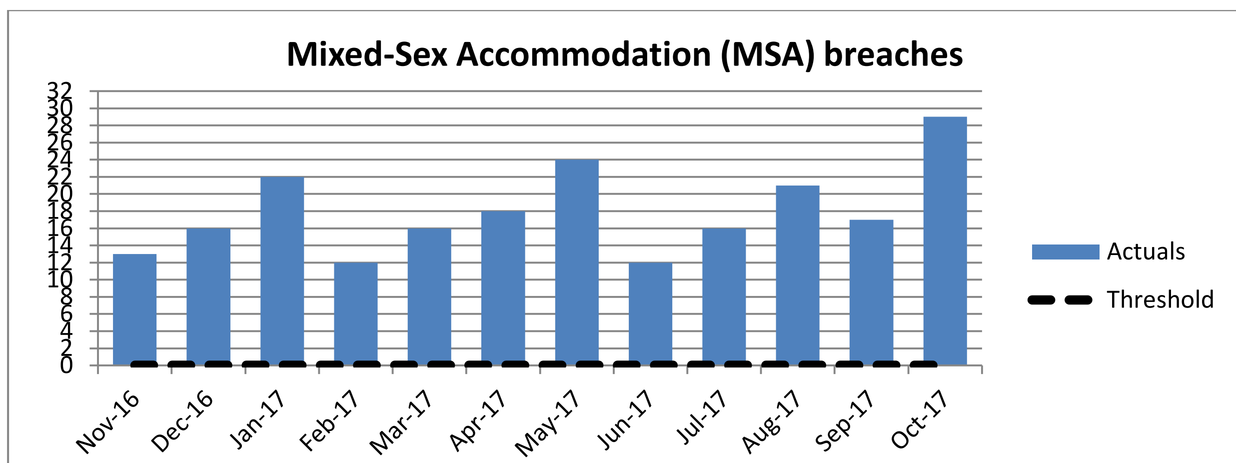

Chart 22 – Number of mixed-sex accommodation breaches reported for the period November 2016 – October 2017

2.3.4 Caring: Complaints

Complaints were up slightly in October, but remain below the threshold. All complaints were responded to within 3 days and in month 100 per cent were responded to within the timeframe agreed with the complainant.

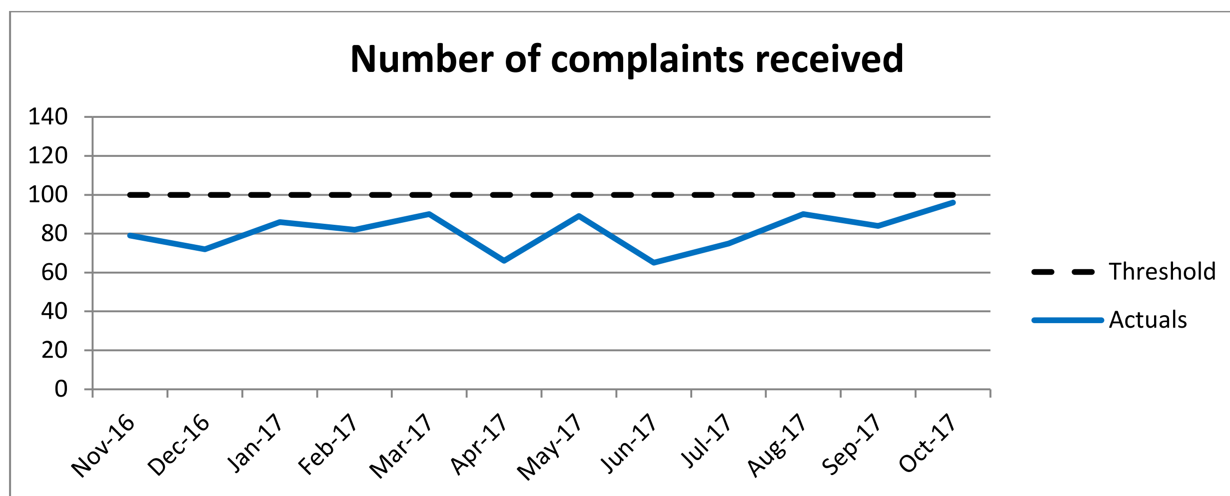

Chart 23 – Number of complaints received for the period November 2016 – October 2017

2.4 Well-Led

2.4.1 Well-Led: Vacancy rate

<u>All roles</u>

At the end of October 2017, the Trust directly employed 9,273 WTE (whole time equivalent) members of staff across Clinical and Corporate Divisions; an increase of 141 WTE from September 2017. The contractual vacancy rate for all roles was 11.6 per cent against the target of 10 per cent; below the average vacancy rate of 13.2 per cent across all London Trusts.

There were 299 WTE joiners and 158 WTE leavers across all staffing groups. The voluntary turnover rate (rolling 12 month position) was 9.5 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.

<u>All Nursing & Midwifery Roles</u>

At end of October 2017, the contractual vacancy rate for all Nursing & Midwifery ward roles was 14.6 per cent with 736 WTE vacancies across all bands. Within the band 2 – 6 roles of this staffing group, the vacancy rate was 15.8 per cent and we continue to work with other London Acute Teaching Trusts to benchmark and share information to reduce 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.
- Reducing the time an advert is open and centralising shortlisting to reduce the time to hire time.
- New launched careers clinics for Band 5 and 6 nursing and midwifery staff to help support them with career options and opportunities.

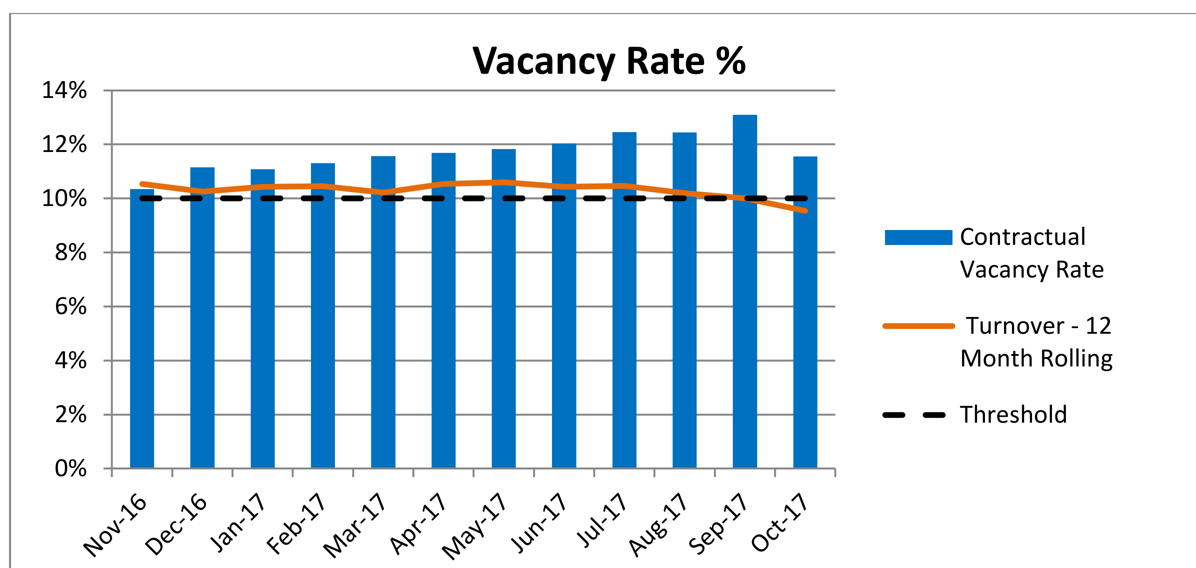

Chart 24 - Vacancy rates for the period November 2016 – October 2017

2.4.2 Well-Led: Sickness absence rate

Recorded sickness absence in October was 2.7 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.

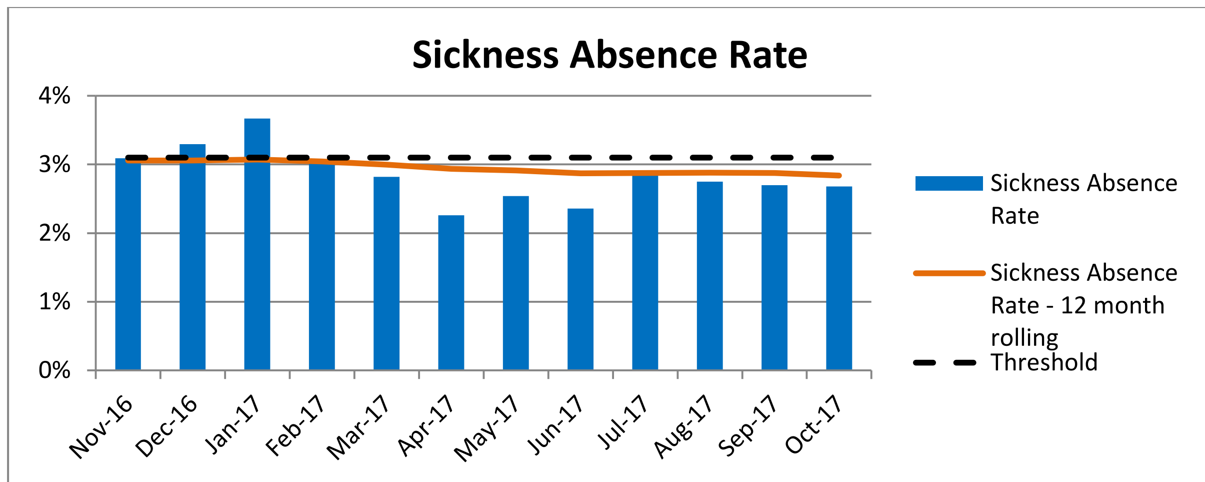

Chart 25 - Sickness absence rates for the period November 2016 – October 2017

2.4.3 Well-Led: Performance development reviews

The PDR cycle for 2017/18 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.

2.4.4 Well-Led: Doctor Appraisal Rate

Doctors' appraisal rates are 90.1 per cent this month which is in line with the national average of 90.1 per cent for designated bodies within the same sector (source: Medical Revalidation Annual Organisational Audit Comparator Report, published July 2017). Actions being taken to increase compliance include continuing to promote the Professional Development monthly drop-in sessions to provide one to one assistance for doctors with all aspects of their professional development and updating The Source with advice for a doctor if their appraisers are not able to see them in a timely manner which has been a recurring problem. Additionally, work has been undertaken with the PREP team to ensure that the system remains user friendly and easy to navigate by doctors whilst completing their appraisal on the system. Doctors who have not completed their appraisal are being managed in line with GMC guidance.

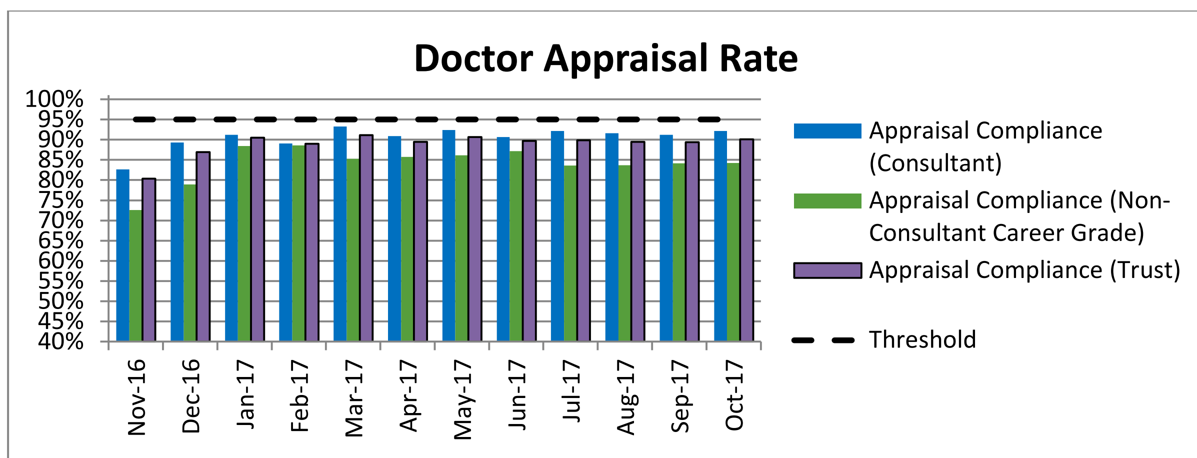

Chart 26 - Doctor Appraisal Rates for the period November 2017 to October 2017

2.4.5 Well-Led: Staff Friends and Family

As well as the annual NHS National Staff Survey, ICHT runs a trust-wide local engagement survey entitled: "Our Voice, Our Trust". The survey was last run between May and June 2017 and had 2,809 responses. 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 results and associated action plans were reported to the Trust's executive committee in July and October 2017. The Trust is currently undertaking 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

One action remains open from the quality visit and is being monitored through the local faculty group meetings (LFGs).

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 changes made are sustainable therefore the GMC have agreed to remove from enhanced monitoring. We continue to monitor critical care and the division have an action plan in place to support improvement.

Health Education England (HEE) have specified 10 programmes which require actions in response to red flags; an action plan consisting of 12 actions has therefore been developed in response and was submitted to HEE in September 2017. Progress with completion of these actions will be monitored through the medical education committee and be reported in this report.

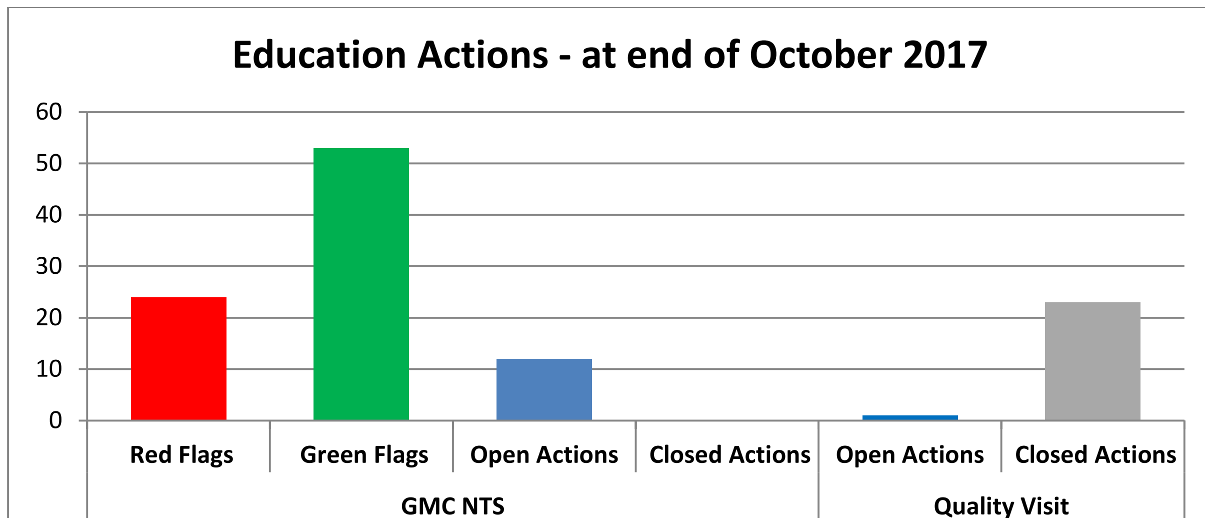

Chart 27 – General Medical Council - National Training Survey action tracker, updated at end October 2017

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

The performance for reported repair tasks completed on time, as delivered by the Trust's maintenance contractor (CBRE), deteriorated further in October to 18 per cent. There does not appear to be any external influences e.g. staff training, sickness or absences, for an allowance to be made for this. The backlog of repairs tasks not completed was 1481 which is an unacceptably high number. The Deputy Head of Estates is in discussion with the contractor to produce the required action plan and improvement process. Further contractual meetings with CBRE are taking place in December.

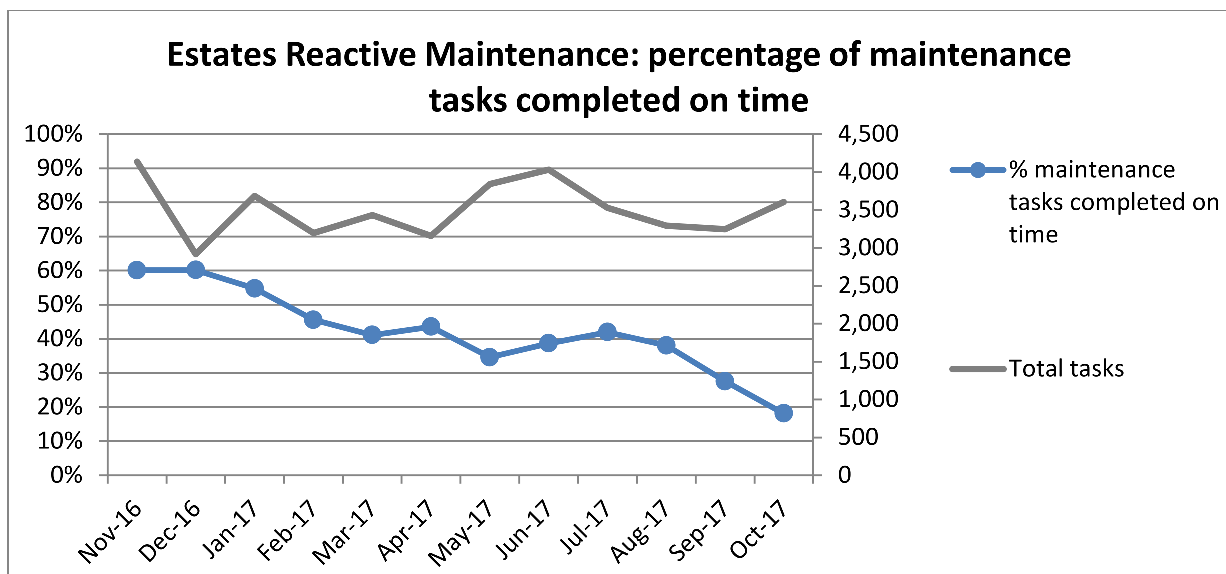

Chart 28 – Estates: percentage of maintenance tasks completed on time for the period November 2016 – October 2017

2.5 Responsive

2.5.1 Responsive: Consultant-led Referral to Treatment waiting times

At the end of October 2017, 83.3 per cent of patients had been waiting less than 18 weeks to receive consultant-led treatment, against the standard of 92 per cent. This was below the trajectory target of 86.4 per cent.

There were 331 patients who had waited over 52 weeks for their treatment since referral from their GP. As previously reported a significant majority of these patients were identified during a review and data clean-up of our inpatient waiting lists. 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 these patients wherever possible.

The Trust has already seen a notable reduction in reported breaches from the September position; additional measures have been implemented to monitor and mitigate any further areas of risk in our waiting lists.

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. Although a number of challenges remain, significant progress has been made across projects. The workstreams are supported by associated work on clinical harm review processes, outsourcing, elective care pathway transformation and training strategy.

The programme continues to be overseen by a Waiting List Improvement Programme Steering Group, with external representation from Commissioners and NHS Improvement. The Trust has also introduced the Trust's quality improvement team as additional support to the programme.

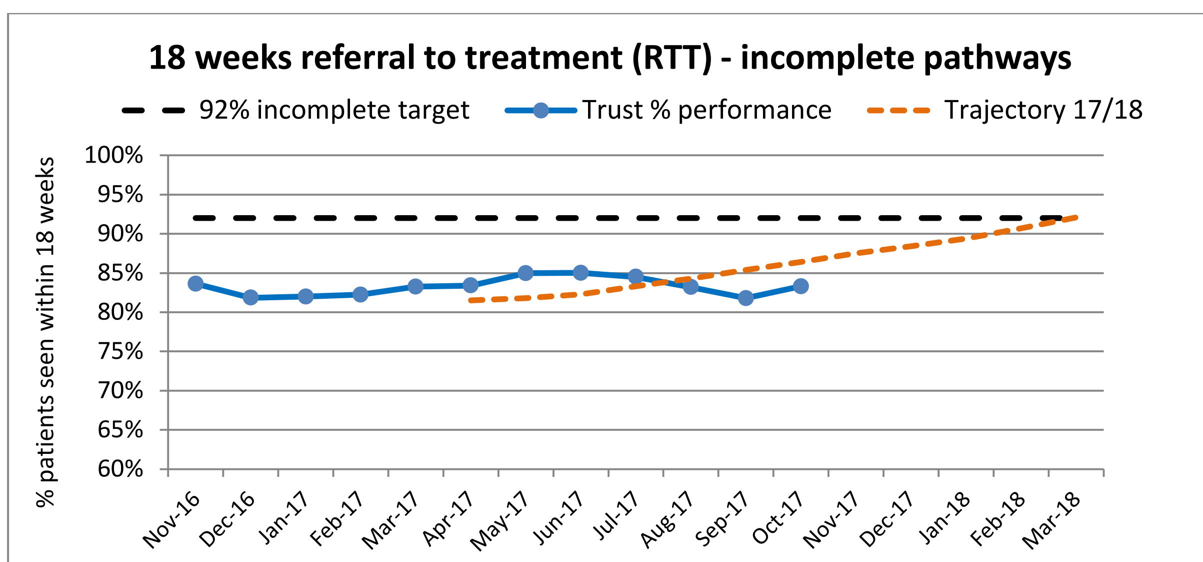

Chart 29 – Percentage of patients seen within 18 weeks (RTT incomplete pathways) for the period November 2016 – October 2017

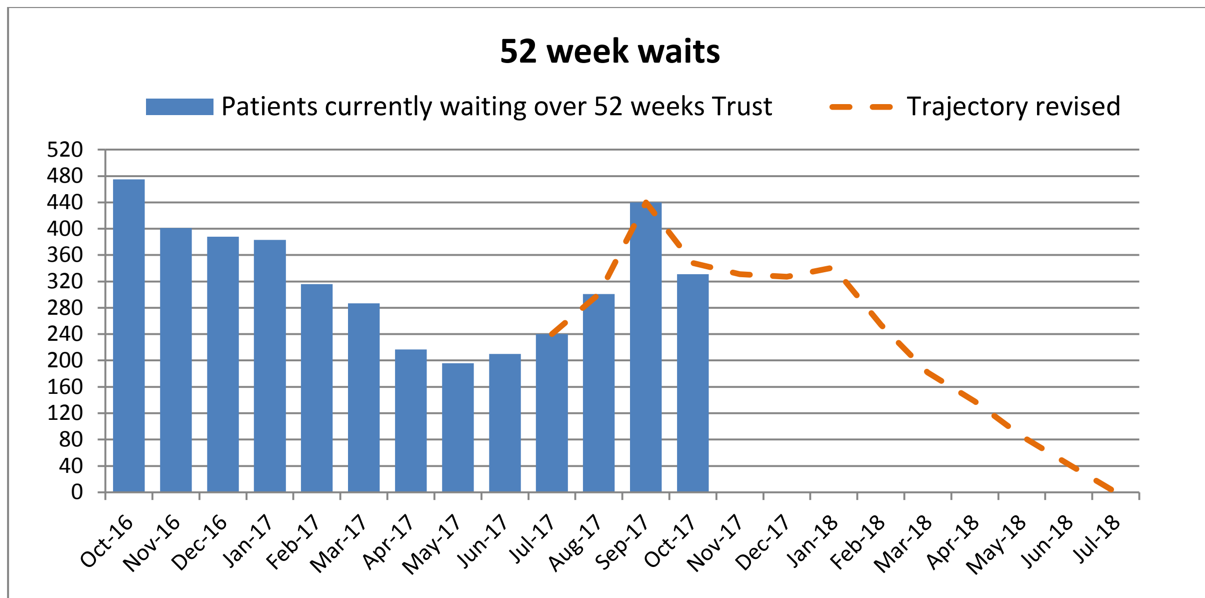

Chart 30 - Number of patients waiting over 52 weeks for the October 2016 – November 2017

2.5.2 Responsive: Cancer 62 day waits

In November 2017, performance is reported for the Cancer waiting times for September 2017. The Trust delivered performance of 89.6 per cent against the 62-day standard, above the trajectory target of 85.1 per cent.

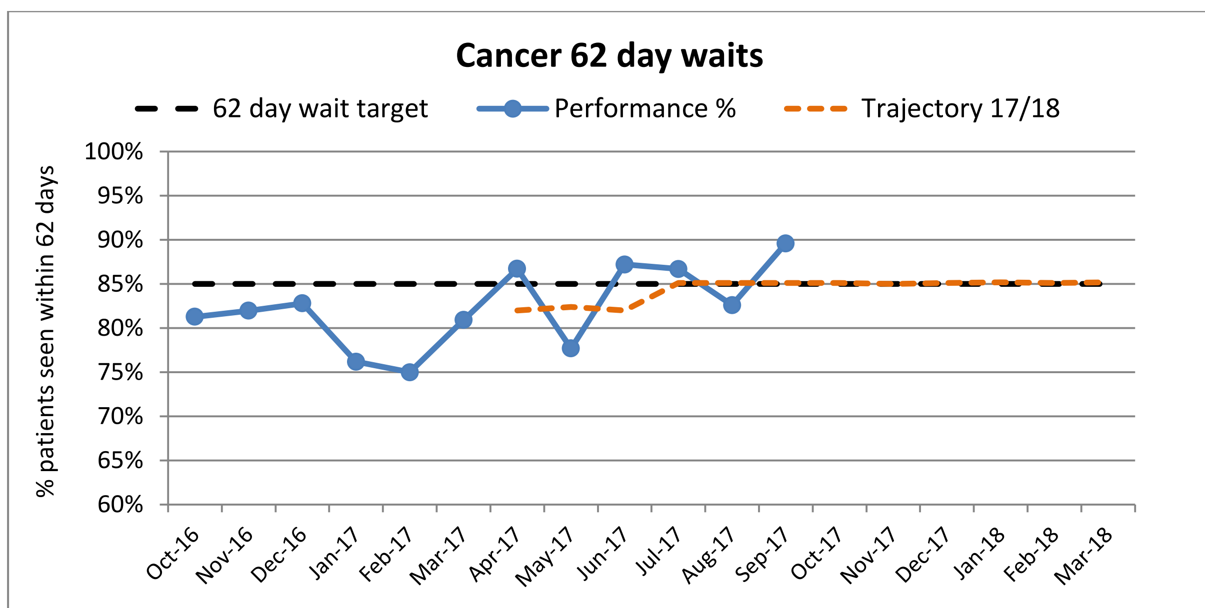

Chart 31 – Cancer 62 day GP referral to treatment performance for the period October 2016 – September 2017

2.5.3 Responsive: Theatre utilisation

The Trust overall theatre utilisation performance was 76 per cent in October 2017 against a target of 85 per cent. The key issues remain as follows:

- High levels of on the day cancellations at CXH and SMH (DNA's and patient unfit

for anaesthetic being the two biggest reasons);

- Scheduling processes leading to under utilised capacity in Riverside Day Surgery
- Capacity issues at SMH often leading to late starts and/or cancellations on the day

Performance is continually being reviewed monthly with the specialities at the Trust's Theatre Efficiency Group.

The Trust is taking the following steps to improve overall theatre performance:

- Undertaking deep dive analysis of under performing lists and agreeing further interventions with specialties where off-trajectory;
- Strengthening scheduling processes within the Patient Services Centre through the introduction of the Four Eyes scheduling tool which gives visibility of 'list fullness'; and
- Improving the consistency of 7 Day and 48 hour reminder calls to patients for their operations.

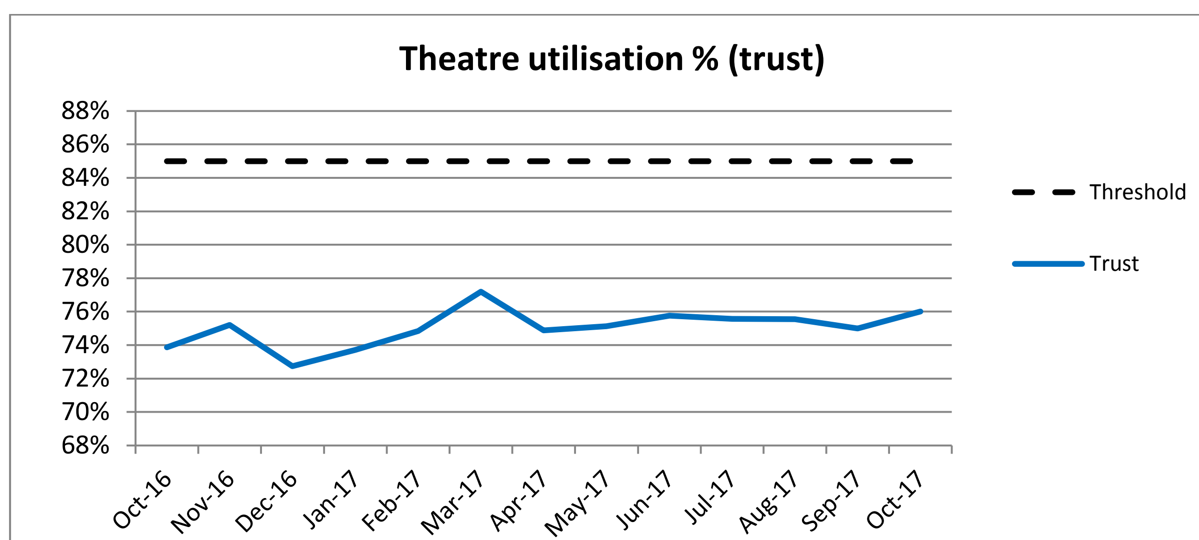

Chart 32 – Theatre utilisation average % (Trust) for the period October 2016 – October 2017

2.5.4 Responsive: 28-Day Rebookings

Cancelled operations (for on the day, non-clinical reasons only) during quarter 2 represented 1 per cent of all elective activity, which brought it slightly higher than the national rate of 0.9 per cent. Of these cancellations 28 patients (9 per cent) were not treated within the national standard 28 days. The national average was 8 per cent breach rate. There is now increased monitoring and engagement with teams to ensure all steps are being taken to prevent breaches from occurring.

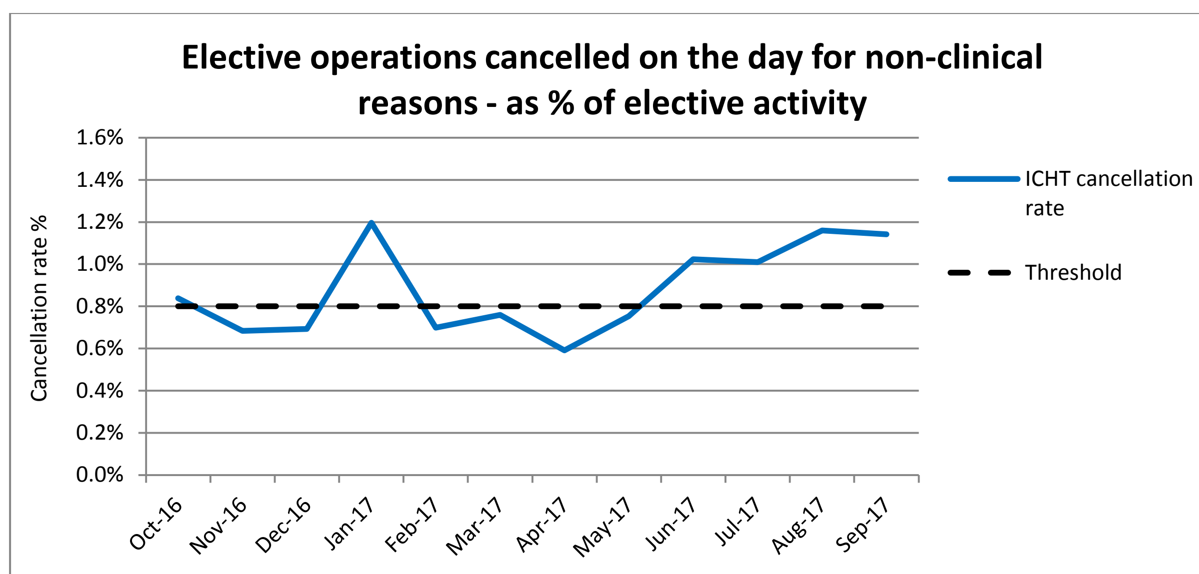

Chart 33 – Non-clinical cancellations as a % of total elective activity Trust for the period October 2016 – September 2017

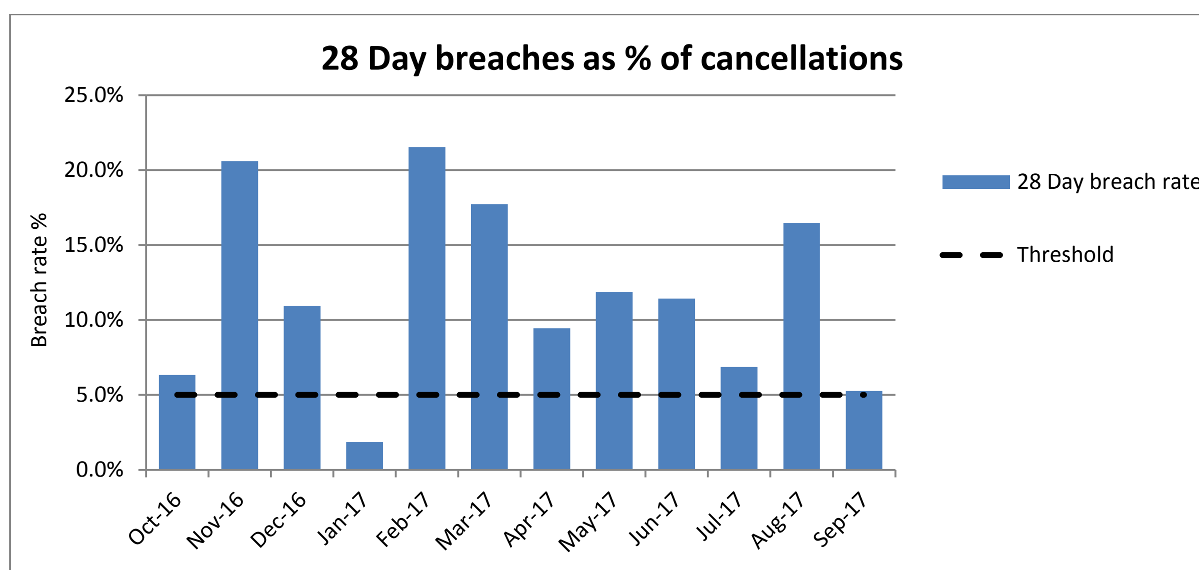

Chart 34 – Patients not treated within 28 days of their cancellation as a % of cancellations for the period October 2016 – September 2017

2.5.5 Responsive: Accident and Emergency

Performance against the four-hour access standard for patients attending Accident and Emergency was 86.6 per cent in October 2017 against the 90.2 per cent Sustainability and Transformation Fund (STF) target for the month. Three 12-hour trolley wait breaches were reported (A&E patients spending >12 hours from decision to admit to admission).

The key issues remain as follows:

- Difficulties with transfer of patients from the Vocare UCC to the Emergency Department at SMH;

- Increased demand and acuity within type 1 departments;
- High levels of bed occupancy;
- High numbers of bed days lost through a combination of delayed transfers of care from the hospital, delays for mental health beds & on-going estate issues.

The Trust has launched a programme of developments, focussing on the following six work streams:

1. Streaming and admission avoidance strategies
2. Effective emergency department operations
3. Efficient specialist decisions and pathways
4. Managing beds effectively
5. Improving ward processes
6. Effective discharge processes

A four-hour Performance Steering Group has been established to oversee the activities within the six work streams. In addition a programme scorecard has been developed to measure the impact of the individual work streams. The group is chaired by the Divisional Director of the Medicine and Integrated Care and attended by the Chief Executive Officer. Each work stream is led in partnership by a senior clinician and a senior manager.

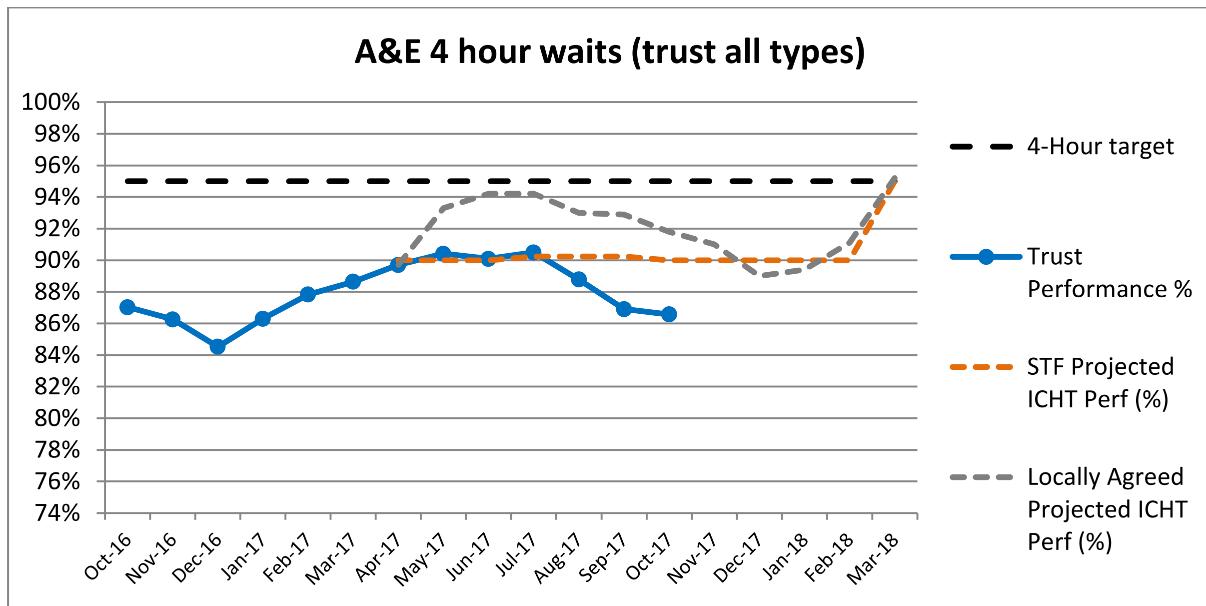

Chart 35 – A&E Maximum waiting times 4 hours (Trust All Types) for the period October 2016 – October 2017

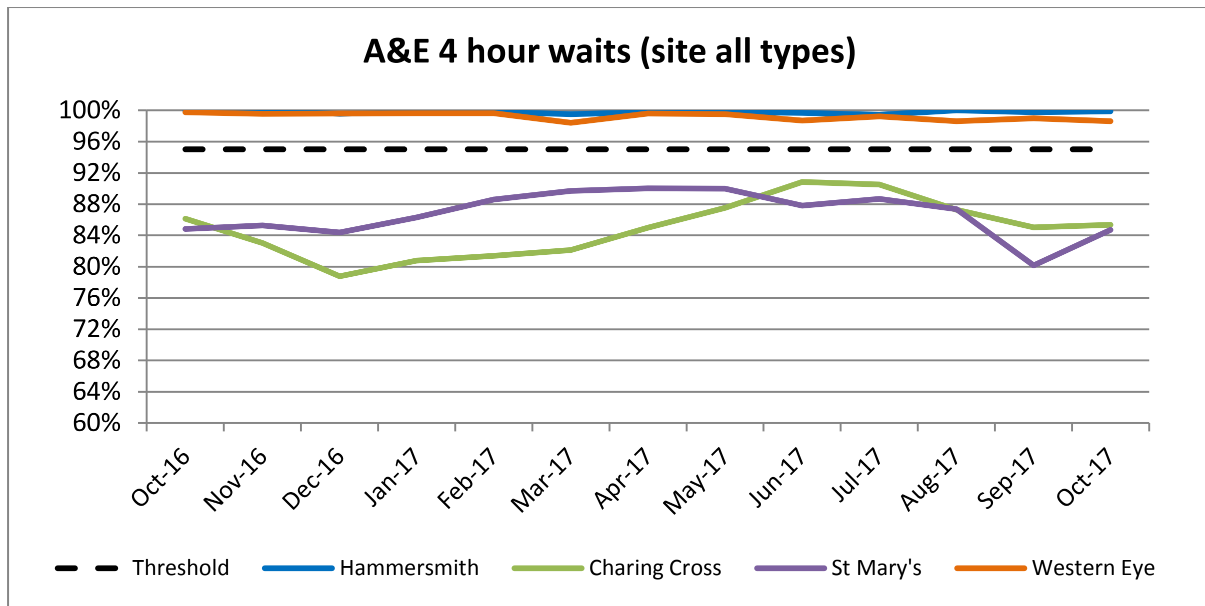

Chart 36 – A&E Maximum waiting times (Site All Types) 4 hours for the period October 2016 – October 2017

2.5.6 Responsive: Diagnostic waiting times

In October, 4.3 per cent of patients were waiting over six weeks against a tolerance of 1 per cent. The deterioration in performance resulted from a deep dive into local data records, this identified an issue with patient tracking and the recording of offer dates for some patients. The Trust has continued to hold a weekly steering group which is carrying out a full assessment. The Trust expects to return to delivering performance against the standard over the next few months. Steps are being taken to ensure the improvement of performance and weekly progress updates are being made to NHS Improvement and Commissioners.

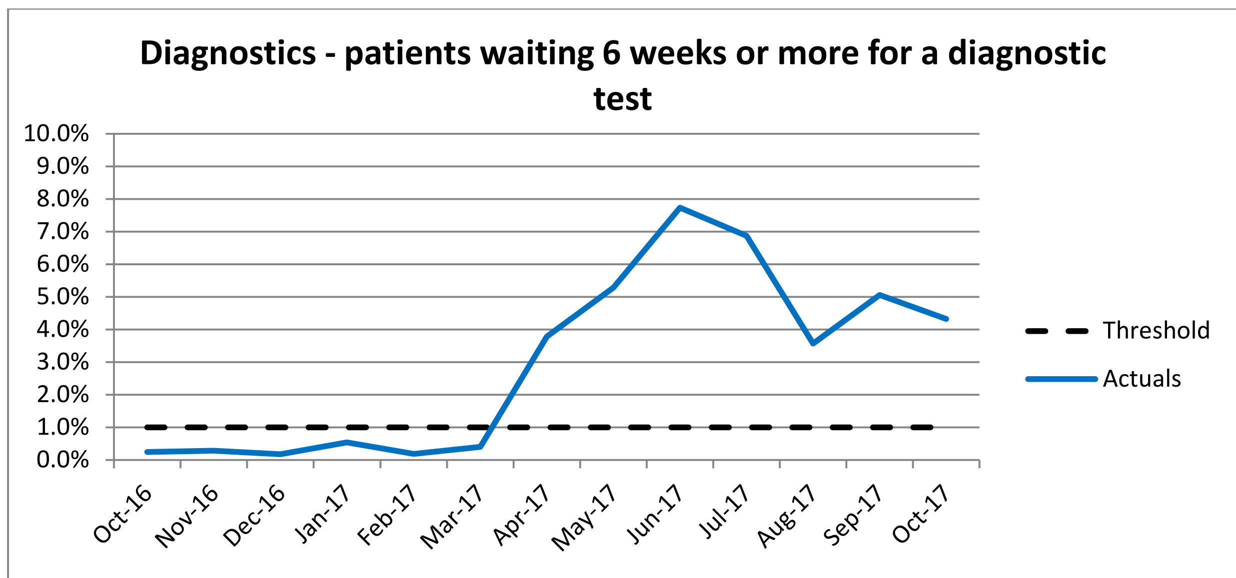

Chart 37 – Diagnostic waiting times for the period October 2016 – October 2017

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.

ON average patients who attended their appointment in October had waited for 8.1 weeks. At overall Trust level the average waiting time was 9.1 weeks to attending first appointment from referral. However the average waiting times vary widely between clinical services, ranging from 4 – 13 weeks. Future updates to this section will highlight progress of specialty level actions plans relating to this indicator.

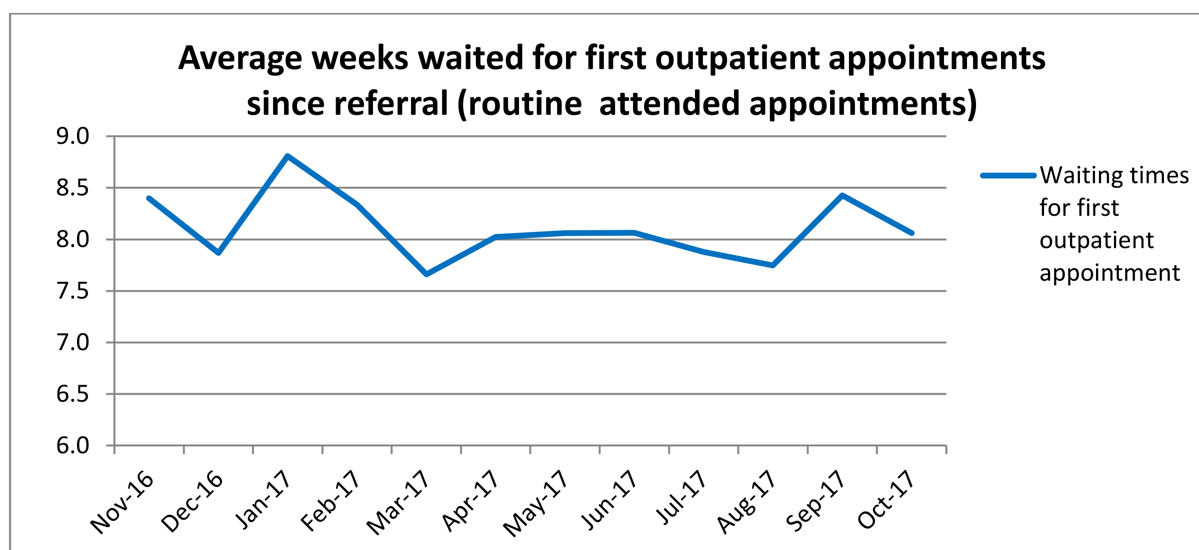

Chart 38 – Average weeks waiting time from referral to first outpatient appointment for the period November 2016 – October 2017 (census date: 17/11/17) (routine appointments)

2.5.8 Responsive: Outpatient DNA

The overall DNA rate (first and follow up) was 12.5 per cent in October and remains above the target threshold. The priority is to reduce the numbers of patients not attending their appointments to less than 11 per cent. Actions include:

- Continue to promote 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.

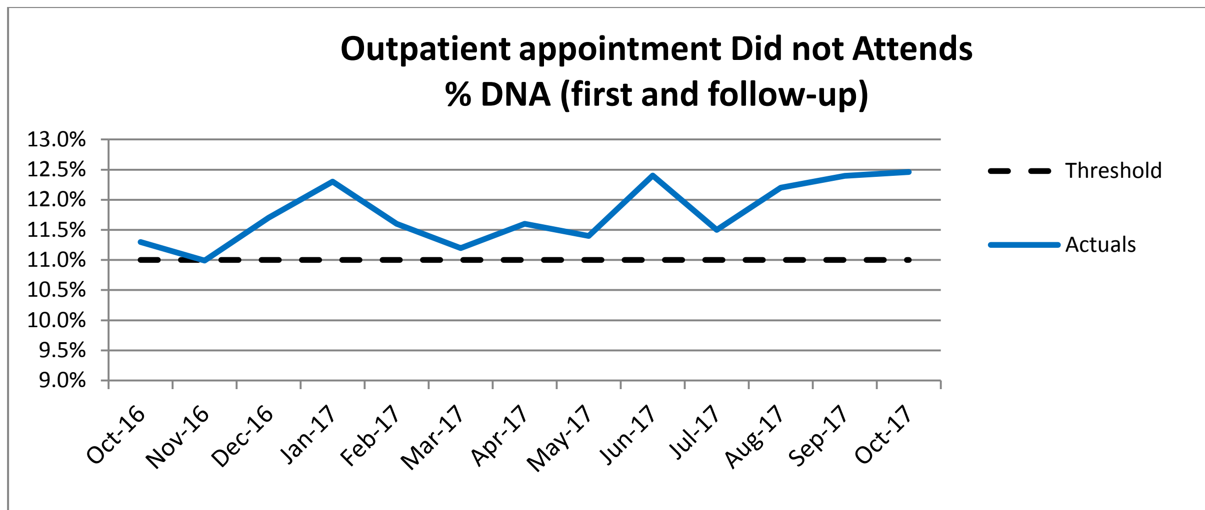

Chart 39 – Outpatient appointment Did not Attend rate (%) first and follow appointments for the period October 2016 – October 2017

2.5.9 Responsive: Outpatient appointments cancelled by the Trust

In October, 8.6 per cent of outpatient appointments were cancelled by the hospital with less than 6 weeks' notice. Performance remains above the agreed threshold of 7.5 per cent. The priority areas for improvement to reduce such cancellations are as follows:

- A one-year quality improvement project, funded by Imperial Health Charity, is underway to improve the patient experience and reduce the cancellations of outpatient appointments. Running until March 2018.
- Undertake a deep dive to understand the impact of expediting appointments on cancellation rates.
- Continue to work with specialty teams to embed the Trust Elective Access Policy, ensuring a minimum of six weeks' notice is provided for planned leave requiring the cancelling of clinics

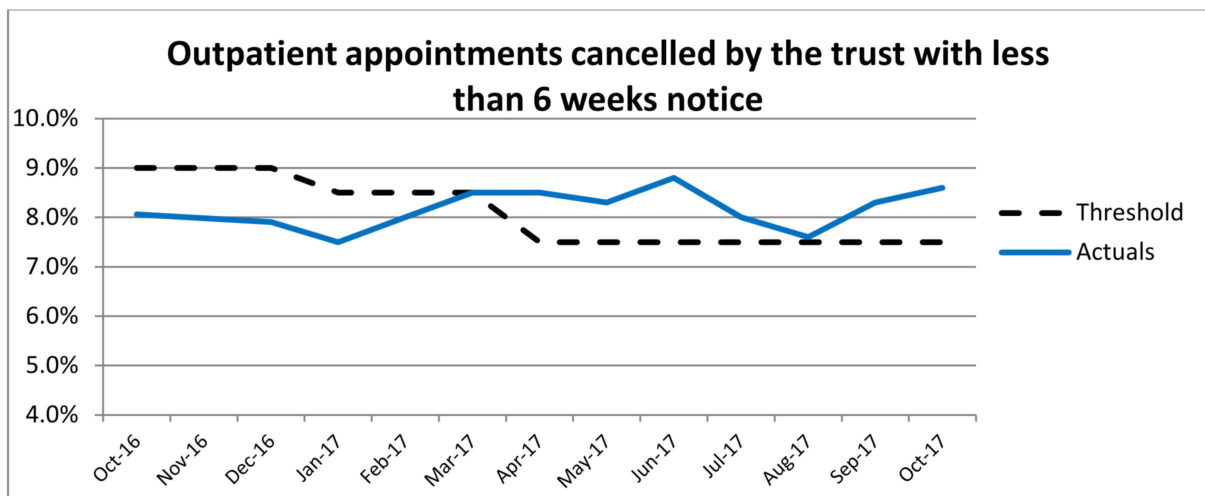

Chart 40 – Outpatient appointments cancelled by the Trust with less than 6 weeks' notice for the period October 2016 – October 2017

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.

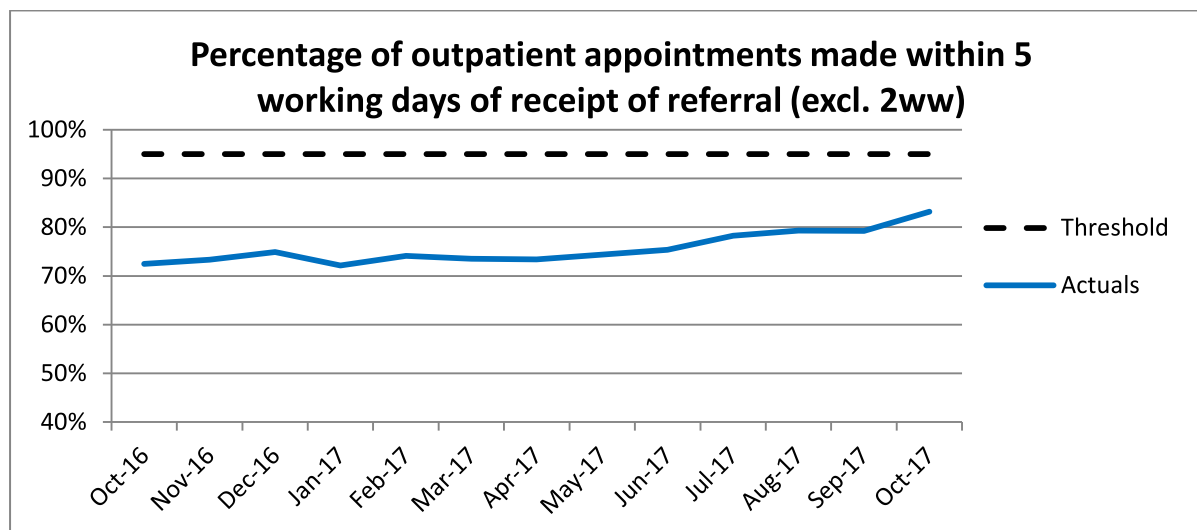

Chart 41 – % of outpatient appointments made within 5 working days of receipt of referral (excluding 2 week waits) for the period October 2016 – October 2017

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:

- Weston ward had a day fill rate of 78.83 per cent for care staff. This equated to 8 shifts unfilled for enhanced care. These shifts were safely covered by cross cover of care staff and cohorting patients with nurse in charge oversight. The overall day fill rate was 89.59 per cent.
- 10 North had a day fill rate of 83.52 per cent for care staff. This equated to 9 shifts unfilled for enhanced care. These shifts were safely covered by the Ward Manager and redeployment of care staff. The overall day fill rate was 94.05 per cent.
- CXH AAU had a day fill rate of 69.70 per cent for care staff. This equated to 12 shifts unfilled for enhanced care. These shifts were safely covered by the Ward Manager and redeployment of care staff. The overall day fill rate was 86.56 per cent.
- CXH AMU had a day fill rate of 82.04 per cent for care staff. This equated to 27 shifts unfilled for enhanced care. These shifts were safely covered by the Ward Manager and redeployment of care staff. The overall day fill rate was 89.50 per cent.
- John Humphrey had a day fill rate of 70.69 per cent for care staff. This equated to 42 shifts unfilled for enhanced care and staffing vacancies. These shifts were safely covered by the Ward Manager and cross cover of care staff by the ward. The overall day fill rate was 80.62 per cent.
- Peters Ward had a day fill rate of 82.04 per cent for care staff, This equated to 17 unfilled for enhanced care, patient transfers and staffing vacancies. These shifts were safely covered by the Matron and cross cover of care staff by the ward. The overall day fill rate was 87.46 per cent.
- DAAU AMU had a day fill rate of 89.53 per cent for registered nurse staff. This equated to 19 shifts unfilled, 10 of which were due to an extra registered nurse added to the establishment to improve patient flow and the remaining due to sickness absence. These shifts were safely covered by the Matron and redeployment of care staff. The overall day fill rate was 89.57 per cent.
- DAAU Joseph Toynbee had a day fill rate of 84.02 per cent for care staff. This equated to 11 shifts unfilled for enhanced care and staffing vacancies. These shifts were safely covered by cross cover of carer staff from the first floor. The overall day fill date was 92.19 per cent.
- Manvers Ward had a day fill rate of 88.26 per cent for registered nurse staff. This equated to 23 shifts unfilled due to an extra registered nurse added to the establishment to improve patient flow and sickness absence. These shifts were safely covered by the Matron and redeployment of care staff. The overall day fill rate was 90.65 per cent.
- Samuel Lane had a day fill rate of 83.82 per cent for care staff. This equated to 11 shifts unfilled for enhanced care and staffing vacancies. These shifts were safely covered by the Ward Manager and redeployment of care staff. The overall day fill date was 93.27 per cent.