NHS
Merton
Clinical Commissioning Group

REPORT TO MERTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

Date of Meeting: 19th September 2013

Agenda No: 8.2 **Attachment:** 10

Title of Document: Quality and Performance Report	**Purpose of Report:** To receive and note
Report Author: Murrae Tolson, Head of Health Systems, Performance and Business.	**Lead Director:** Jenny Kay
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Executive Summary: The Quality and Performance Report presents performance of the key performance indicators demonstrating progress towards the five domains outlined in *Everyone Counts*. The structure of the report has been amended to align with the reporting requirements of NHS England's Balanced Scorecard which has been introduced for the purposes of CCG Assurance. Section 1 reports on those indicators related to the NHS Constitution. Failure to achieve these would result in a reduction of award of the CCGs Quality Premium. Section 2 reports on indicators which measure improvements in health outcomes for local people. This report introduces the proposed proxy measures for these annual indicators, specifically those which measure Potential Years of Life Lost and Premature Mortality within domain 2 of the balanced scorecard. These proxy measures have been jointly developed with Merton Public Health and access is being sought to the relevant data sources in order to monitor in-year progress.

Section 3 of the report provides assurance that Merton CCG is commissioning good quality of care and reports on the key Quality and Performance metrics of our 5 main providers.

Key sections for particular note (paragraph/page), areas of concern etc:
Clinical Quality is currently reported through provider CQRG's. Quality dashboards are presented for the Acute providers. Work is in progress to flow data currently reported in the SMCS Quality Report into a Quality dashboard. Development of a quality dashboard for South West London and St. Georges is in progress.

Recommendation(s):
The Governing Body is requested to review the content and format of the report and make recommendations regarding further work required to ensure Merton CCG is commissioning good quality services.

Committees which have previously discussed/agreed the report: None
Financial Implications: A Quality Premium of approx £960k is dependant on the CCG meeting all constitutional pledges and improving the quality of health for local people**.**
Implications for the Governing Body: The content of the Quality and Performance report informs domain 1 and 2 of the CCG Balanced Scorecard.
Other Implications: (including patient and public involvement/Legal/Governance/Risk/Diversity/ Staffing) None
Equality Assessment: Not completed.
Information Privacy Issues: In year proxy measures and unplanned hospitalisation data is derived from unpublished sources and subject to data quality issues.
Communication Plan: (including any implications under the Freedom of Information Act or NHS Constitution)

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Quality and Performance report

Quarter 1/Month 3 2013/14



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Content

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2. Quality Premium: Are health outcomes improving for local people?
3. CCG Assurance: Provider Assessment
    1. St. Georges Hospital NHS Trust
    2. Epsom and St. Helier Hospitals NHS Trust
    3. Sutton and Merton Community Services (Royal Marsden NHS Trust)
    4. South West London and St. Georges NHS Trust
    5. Kingston Hospital Foundation Trust



1. Constitutional pledges – Domain 2

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***Failure results in a deduction of 25% (per constitutional pledge failure) to the CCG's Quality Premium**

Merton CCG All Indicators Performance Scorecard 2013-14

Freeze date: 30-Aug-2013

	Year to Date		Target	Apr	May	Jun	Jul	Quarter 1
	Calculation	Actual						
NHS CONSTITUTION								
Monthly Indicators								
CB_B1: RTT 18 week compliance, admitted patients	Average	92.5%	*90.0%*	92.1% G	93.4% G	92.3% G	92.1% G	
CB_B2: RTT 18 week compliance, non admitted patients	Average	97.4%	*95.0%*	96.5% G	97.0% G	98.6% G	97.6% G	
CB_B3: RTT 18 week compliance, incomplete pathways	Average	95.5%	*92.0%*	95.0% G	95.5% G	95.8% G	95.6% G	
CB_B4: Diagnostic test waiting times	Average	99.69%	*99.00%*	99.65% G	99.77% G	99.86% G	99.49% G	99.86% G
CB_B5: A and E 4 hour waiting time compliance	Average							
CB_B6: All cancer two week waits	Average	97.8%	*93.0%*	98.5% G	97.1% G	97.7% G		
CB_B7: Breast symptoms (cancer not initially suspected)	Average	97.1%	*93.0%*	90.6% A	100.0% G	100.0% G		
CB_B8: Cancer first definitive treatment in 31 days	Average	98.7%	*96.0%*	96.4% G	100.0% G	100.0% G		
CB_B9: Cancer subsequent treatment 31 days, surgery	Average	93.3%	*94.0%*	100.0% G	91.7% A	87.5% R		
CB_B10: Cancer subsequent treatment 31 days, drug	Average	100.0%	*98.0%*	100.0% G	100.0% G	100.0% G		
CB_B11: Cancer subsequent treatment 31 days, radiotherapy	Average	98.4%	*94.0%*	100.0% G	100.0% G	95.7% G		
CB_B12: Cancer first treatment 62 days, GP referral	Average	88.6%	*85.0%*	90.9% G	95.8% G	79.2% R		
CB_B13: Cancer first treatment 62 days, screening referral	Average	100.0%	*90.0%*	100.0% G	100.0% G	100.0% G		
CB_B14: Cancer first treatment 62 days, consultant upgrade	Average	100.0%		100.0%	100.0%			
CB_B15_01: Ambulance category A (Red 1) 8 minute response	Average	77.7%	*75.0%*	77.6% G	77.9% G	77.4% G		77.7% G
CB_B15_02: Ambulance category A (Red 2) 8 minute response	Average	76.5%	*75.0%*	75.8% G	77.7% G	75.9% G		76.5% G
CB_B16: Ambulance category A 19 minute transportation time	Average	98.2%	*95.0%*	98.0% G	98.5% G	98.2% G		98.2% G
CB_B17: Mixed sex accommodation breach count	Cumulative	11	*0*	7 A	3 A	1 A	0 G	11 A

* A&E 4 hr waiting time cannot be calculated as NHS England have not clarified the technical calculation which will be applied. Merton CCG Performance is however dependant on St. Georges and Epsom and St. Helier performance. (Next slide)

1. Constitutional pledges – Domain 2

NHS Merton Clinical Commissioning Group

A&E: Failure of the 4 Hour Waiting time standard by Merton CCG main providers results in a 25% deduction to the CCG's Quality Premium

Quarterly Performance and Actuals Trend

Quarter: Quarter 1 | Attendance type: All

Provider	2011-12			2012-13			2013-14		
	Actuals	Breaches	Performance	Actuals	Breaches	Performance	Actuals	Breaches	Performance
KINGSTON	28,149	684	97.57%	28,482	988	96.53%	28,401	1,136	96.00%
CROYDON	33,813	751	97.78%	35,150	2,007	94.29%	34,209	1,566	95.42%
EPSOM AND ST HELIER	36,516	1,116	96.94%	35,742	787	97.80%	35,516	1,650	95.35%
GUY'S AND ST THOMAS	41,298	1,483	96.41%	41,573	2,446	94.12%	44,263	1,795	95.94%
KING'S COLLEGE	38,380	1,611	95.80%	38,704	1,773	95.42%	41,472	1,550	96.26%
LEWISHAM	28,990	766	97.36%	29,578	1,201	95.94%	28,330	1,260	95.55%
SOUTH LONDON	47,460	3,341	92.96%	66,552	2,244	96.63%	68,848	4,504	93.46%
ST GEORGE'S	45,954	1,051	97.71%	46,596	1,460	96.87%	37,786	1,682	95.55%
CHELSEA AND WESTMINSTER	30,062	451	98.50%	29,047	341	98.83%	28,338	396	98.60%
IMPERIAL COLLEGE	67,484	1,221	98.19%	71,284	1,499	97.90%	71,272	2,675	96.25%
WEST MIDDLESEX	26,954	420	98.44%	34,639	820	97.63%	35,594	1,010	97.16%

1. Constitutional pledges – Domain 2

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CCG Performance Commentary

Overall Domain rating for Q1: Amber/Red

1. Mixed Sex Accommodation (RED). Merton CCG will liaise with NHS England regarding the CCG's Amber/Red RAG rating for Q1: Current guidance sets the threshold for MSA breaches at a maximum of 10 per month, however NHS England have rated MSA against a threshold of 10 breaches over the quarter. MSA is on the agenda at both St. Georges and Epsom and St. Helier CQRGs and is being closely monitored.

2. **Cancer Maximum 31 day wait for subsequent treatment – Surgery** (Q1 93.3% against a 94% standard)
During Q1, 2 Merton patients (out of 30) breached the 31 day standard. Both cases occurred at Imperial College Health Trust. Imperial met it's 31 day standard overall (96.3%.) Imperial have, however, breached other cancer standards and therefore the Cancer Commissioning Team are using contract levers to drive general improvement in the cancer performance standards.

2. Improving Health Outcomes – Domain 3 of Balanced Scorecard.

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100% of Quality Premium

In-year proxy measures are currently in development. Unplanned hospitalisation is derived from unpublished SUS data and is subject to change.

Indicator	Quality Premium weight	Last reporting period	Data Source	Most Recent Target	Monthly target	Apr		May		Jun	
Preventing people from dying prematurely											
Potential years of life lost (PYLL) from causes considered amendable to healthcare: Males	12.5%	2009-2011	HSCIC	2069.4							
Potential years of life lost (PYLL) from causes considered amendable to healthcare: Females		2009-2012	HSCIC	1489.1							
In Year proxy: NHS Health Checks			LBM								
Under 75 mortality rate from cardiovascular disease		2011		71.3							
In-Year proxy: Actual prevelance of Cardiovascular disease (QOF)			QMAS								
Under 75 mortality rate from respiratory disease		2011		25.4							
In-Year proxy: Actual prevelance of COPD (QOF)			QMAS								
In-Year proxy: Smoking Cessation			LBM								
Under 75 mortality rate from liver disease		2011		8.1							
In-Year proxy: Actual prevelance of Liver disease (QOF)			QMAS								
In-Year proxy: Emergency admissions for liver disease		2010-12	SUS	25.9	3	1	G	3	A	2	G
Under 75 mortality rate from cancer		2010-2012		96.7							
In-Year proxy: Bowel cancer Screening			Open Exeter								
In-Year proxy: Breast cancer Screening			Open Exeter								
In-Year proxy: Cervical cancer Screening			Open Exeter								
Enhancing quality of life for people with long term conditions											
Health-related quality of life for people with long-term conditions	25.0%		CCG	N/A							
In-Year proxy: No of people accessing expert patient programmes											
Proportion of people feeling supported to manage their condition				60.4							
In-Year proxy: patient education programmes/groups (DESMOND activity?)			TBC								
*Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)			HES/SUS	668.7	96	86	G	98	R	67	G
*Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s			HES/SUS	223.3	9	9	A	11	R	6	G
Estimated diagnosis rate for people with dementia			QMAS								
In-Year proxy: Actual prevelence of Dementia			QMAS								
Helping people to recover from episodes of ill health or following injury											
Emergency admissions for acute conditions that should not usually require hospital admission			HES/SUS	893.3	134	168	R	147	R	146	R
Emergency readmissions within 30 days of discharge from hospital			SUS								
Total health gain assessed by patients i) Hip replacement				0.437							
ii) Knee replacement				0.308							
iii) Groin hernia				0.067							
iv) Varicose veins											
In-year proxy: Number of hip replacement patients on Rapid Recovery programme											
In-year proxy: Number of knee replacement patients on Rapid Recovery programme											
In-year proxy: Number of Groin hernia patients on Rapid Recovery programme											
In-Year proxy: Number of varicose veins patients on Rapid Recovery programme											
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)			HES/SUS	211.0	9	7	G	7	G	8	G
Ensuring that people have a positive experience of care											
Patient experience of primary care i) GP Services ii) GP Out of Hours services	12.5%			63.33							
Patient experience of hospital care											
Friends and family test			CSU								
Treating and caring for people in a safe environment and protecting them from avoidable harm											
Incidence of healthcare associated infection (HCAI) i) MRSA	12.5%			0		0	G	0	G	0	G
Incidence of healthcare associated infection (HCAI) ii) C.difficile				3		1	G	4	R	2	G
Others											
Are providers (defined in domain 1) meeting the 15% response rates in FFT?			CSU								
IAPT Coverage - performance against plan			SWL & St. G								
Local Priorities											
Reablement new pathway to support recovery and independence after illness or injury. Linked to integrated services and reduction of admissions.	12.5%		LBM	25		Not Commenced		Not Commenced		Not Commenced	
Reduce premature mortality from COPD by better diagnosis and treatment; reduce the gap between recorded and expected prevalence by 10% from 0.4 to 0.44% as a CCG overall total moving the 11 practices towards the target by coding review, recurrent admissions on register and increased screening of smokers	12.5%		PHE	10%		No Data avaliable		No Data available		No Data available	
Increasing immunisation uptake by 4% on 2 year DT&P/IPV/HiB, MMC (87% to 91%) and HiP MenC Booster & PCV Booster, MMR (77% to 81%).	12.5%		RIO	4%		Quarterly		Quarterly		Quarterly	

2. Improving Health Outcomes – Domain 3 of Balanced Scorecard.

12.5% of Quality Premium

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CCG Commentary

- Mortality indicators are annual indicators and usually published 12 – 18 months after the reporting period.
- In-year proxy measures are in development: Access to in year GP data is being sought in order to inform current disease diagnosis and prevalence rates.
- Emergency admissions for liver disease is derived from SUS. This information will be shared with those GP Practices with the highest/increasing admission rates.
- Unplanned hospitalisation for Ambulatory Care Sensitive Conditions. In-year activity is compared to a monthly average of 12/13 activity. The Integration Programme works towards decreasing this activity through the Risk Stratification and Prevention of Admission projects.
- Local Priorities:
  - Reablement – this service is due to go live in October 2013.
  - Immunisations – a comprehensive immunisations support programme is in place and managed by the CCG immunisations lead.
  - COPD – project outlined. Project plan to be developed.

3. Provider Assurance

CCG Assessment



3.1.1. St. Georges Hospital NHS Trust Quality Dashboard

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Category	Indicator	Reporting Period	Target	Apr	May	Jun	Jul	Aug	Data Source
Safety	Mortality: SHMI	Quarterly	<1	0.8174	0.8174	0.8174			HSCIC
	SIs: Number of SIs breaching target for RCA	Monthly	0	3	0	1			Provider Scorecard
	Number of Never Events	Monthly	0	0	0	0			Provider Scorecard
	Maternity: % women booked before 12 weeks 6 days,	:Monthly	90%	81%	80%	76%			Provider Scorecard
	Maternity: % Caesarean Section Rate	Monthly	<24%	24.0%	20.6%	22.7%			Provider Scorecard
	Maternity: Midwife/birth ratio	Monthly	1:27	1:26	-	-			Provider Scorecard
	CAS Alerts Outstanding	Monthly	0	0	1	1			NPSA
	Adult Safeguarding: % of staff compliant with training								
	Child Safeguarding: %of staff compliant with training								
	Falls: Moderate Harm	Monthly	N/A	4	5	0			NST Tool
	Falls: Major Harm	Monthly	N/A	0	0	0			NST Tool
	Falls: Death	Monthly	N/A	0	0	0			NST Tool
	Pressure Ulcers, Grade 2	Monthly	N/A	67	53	53			NST Tool
	Pressure Ulcers, Grade 3	Monthly	N/A	26	22	17			NST Tool
	Pressure Ulcers, Grade 4	Monthly	N/A	13	5	8			NST Tool
	VTE Risk Assessments Completed on Admission	Monthly	95%	95.2%	94.4%	95.0%			Unify
Experience	Complaints: Number of complaints								
	Complaints: % replied to within 25 days	Monthly	85%	78%	70%	76%			Provider Scorecard
	Friends and Family Test: Net promoter score	Monthly	N/A	48	60	59			Unify
Clinical Efficiency	Timeliness of discharge letters	Monthly	100%	87.2%	87.2%	87.8%			Provider Scorecard

3.1.1 St. Georges Hospital NHS Trust Quality Commentary

NHS Merton Clinical Commissioning Group

Quality commentary

NPSA CAS alert

The overdue alert reference is NPSA/2009/PSA004B - Safer Spinal (intrathecal), epidural and regional devices Part B. The issue is not particular to SGH. The Trust is keen not to act in isolation and a decision has been taken to wait for more robust evidence before making a change to one system

Maternity Access 12+6 Weeks

The Provider's performance has dropped since May (80%) to 76% in June. This metric and performance has been discussed at the Clinical Quality Review meeting, where it was agreed that SGH will now report on an additional 2 metrics to provide assurance:

1. the % of women referred outside of 12+6 weeks, and
2. the % of women referred late and seen within 2 weeks of referral.

Pressure Sores

The above data is from the NHS Safety Thermometer Tool.

Complaints

76% of complaints in June were responded to within the local target of 25 days. This is an improvement on last month. 88% of complaints with an agreed extension were resolved within that agreed deadline. In June, 7% of complaints were re-opened.

Discharge Letters

The Trust's performance continues to at the same level, with 87.8% of discharge letters sent within 24 hours. A CQUIN is intended to improve performance in 2013/14, with respect to all GP communications from SGH.

3.1.2. St. Georges Hospital NHS Trust Performance

NHS Merton Clinical Commissioning Group

	Target	St George's					
		Latest				YTD	
OUTCOMES FRAMEWORK							
Monthly Indicators							
CB_A13: Friends and Family Test (A and E)		Jun	46			46	
CB_A13: Friends and Family Test (Inpatients)		Jun	66			64	
CB_A15: Healthcare acquired infection (MRSA)	0	Jun	0	G		2	R
CB_A16: Healthcare acquired infection (C-Difficile)	Varies	Jun	4	R		16	R
NHS CONSTITUTION							
Monthly Indicators							
CB_B1: RTT 18 week compliance, admitted patients	90.0%	May	91.8%	G		91.0%	G
CB_B2: RTT 18 week compliance, non admitted patients	95.0%	May	98.1%	G		97.8%	G
CB_B3: RTT 18 week compliance, incomplete pathways	92.0%	May	94.9%	G		94.4%	G
CB_B4: Diagnostic test waiting times	99.0%	May	99.9%	G		99.8%	G
CB_B5: A and E 4 hour waiting time compliance	95.0%	Jun	96.1%	G		95.5%	G
CB_B6: All cancer two week waits	93.0%	May	97.2%	G		96.8%	G
CB_B7: Breast symptoms (cancer not initially suspected)	93.0%	May	96.9%	G		95.0%	G
CB_B8: Cancer first definitive treatment in 31 days	96.0%	May	99.2%	G		97.6%	G
CB_B9: Cancer subsequent treatment 31 days, surgery	94.0%	May	98.3%	G		99.0%	G
CB_B10: Cancer subsequent treatment 31 days, drug	98.0%	May	100.0%	G		100.0%	G
CB_B11: Cancer subsequent treatment 31 days, radiotherapy	94.0%	May	--			--	
CB_B12: Cancer first treatment 62 days, GP referral	85.0%	May	88.4%	G		89.2%	G
CB_B13: Cancer first treatment 62 days, screening referral	90.0%	May	95.5%	G		92.7%	G
CB_B14: Cancer first treatment 62 days, consultant upgrade		May	100.0%			100.0%	
CB_B17: Mixed sex accommodation breach count	0	Jun	0	G		38	R
SUPPORTING MEASURES							
Monthly Indicators							
CB_S4: A and E attendances, type 1		Jun	10,395			33,567	
CB_S4: A and E attendances, all types		Jun	11,736			37,786	
CB_S6: RTTs in excess of 52 weeks: Admitted patients	0	May	0	G		0	G
CB_S6: RTTs in excess of 52 weeks: Non admitted patients	0	May	0	G		0	G
CB_S6: RTTs in excess of 52 weeks: Incomplete Pathways	0	May	1	R		1	R
CB_S7: Ambulance handover delays over 30 minutes		Jun	6			56	
CB_S7: Ambulance handover delays over 60 minutes		Jun	0			1	
CB_S9: A and E trolley waits over 12 hours	0	Jun	0	G		0	G

3.1.3. St. Georges Hospital NHS Trust
CCG Commentary

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Commissioning/Contracting: Merton CCG has over performance is £311k for QQ1 with main areas being Non-Elective admissions and Direct Access. The trust is over performing by £98K on Direct Access, which is driven largely by an increase in Pathology requests. The CSU is reviewing this in collaboration with the CCG and initial insight suggests that over performance may be due to incorrect allocation of activity to Merton CCG.

Performance:

MSA - There have been particular problems at St Georges largely due to winter pressures and critical care delayed discharges (+6hrs). At St Georges, clinical commissioners have agreed that the Trust acted in the best interest of the patients to wait for a specialty specific bed. A CCG led clinical review of breaches has been undertaken for the past two months and NHSE London are looking at reporting anomalies from London vs. the rest of the country. St Georges recently attended an event hosted by NHS England for Trusts that consistently have the most breaches to review and report on current breaches, analyse breaches by clinical area, share information and best practice and understand the impact of using the national criteria.

A&E - Although St Georges achieved 95% All Type performance for Quarter 1, A&E performance remains a challenge due to an increase in A&E attendances, ambulance conveyance and admissions. There is a direct correlation with an increase in the admission of frail and elderly patients, which leads to a lower than usual number of discharges. The CCGs Risk Stratification and Prevention of Admission programs are in development to mitigate this increasing challenge.

3.2.1. Epsom and St. Helier Hospital NHS Trust Quality Dashboard

NHS Merton Clinical Commissioning Group

Category	Indicator	Apr	May	Jun	Jul	Aug	Source
Safety	Mortality: SHMI	0.9501	0.9501	0.9501			HSCIC
	SIs: Number of SIs	19	20	10			Provider Scorecard
	Number of Never Events	0	1	0			Provider Scorecard
	Maternity: % women booked before 12 weeks 6 days,						
	Maternity: % Caesarean Section Rate	25.7%					Provider Scorecard
	Maternity: Midwife/birth ratio	1:29					Provider Scorecard
	CAS Alerts Outstanding		0	0			
	Adult Safeguarding: % of staff compliant with training						
	Child Safeguarding: %of staff compliant with training						
	Falls: Moderate Harm	2	8	7			NST Tool
	Falls: Major Harm	0	1	1			NST Tool
	Falls: Death	0	0	0			NST Tool
	Pressure Ulcers, Grade 2	36	29	45			NST Tool
	Pressure Ulcers, Grade 3	11	6	6			NST Tool
	Pressure Ulcers, Grade 4	1	5	2			NST Tool
	VTE Risk Assessments Completed on Admission	82.31%	88.51%	88.58%			NST Tool
Experience	Complaints: Number of complaints						
	Complaints: % replied to within agreed timeframe	100%	88.51%	91.7%			Provider Scorecard
	Friends and Family Test: Net promoter score			74			Provider Scorecard
	Nutrition: Nutrition score not completed within 48 hours						
	Nutrition: Nutrition score not maintained weekly, instances per month						
Clinical Efficiency	Timeliness of discharge letters	87.1%					Provider Scorecard

3.2.1. Epsom and St. Helier Hospital NHS Trust - Quality Commentary

NHS Merton Clinical Commissioning Group

Quality commentary

Never Event

Retained swab – this is the second retained swab never event at ESH in previous 6 months and is subject to CQRM oversight.

Maternity Dashboard

Maternity performance is subject to CQRM oversight

CQRM

The August CQRM was not quorate and a formal meeting was not held. An informal meeting was held and a number of reports and actions were held over until the September meeting.

Falls

The Trust is undertaking an internal review of its falls. This will be reported to and considered by the CQRM.

3.2.2. Epsom and St. Helier Hospitals NHS Tru
Performance

NHS Merton Clinical Commissioning Group

	Target	Epsom and St Helier				
		Latest			YTD	
OUTCOMES FRAMEWORK						
Monthly Indicators						
CB_A13: Friends and Family Test (A and E)		Jun	77		74	
CB_A13: Friends and Family Test (Inpatients)		Jun	69		70	
CB_A15: Healthcare acquired infection (MRSA)	0	Jun	1	R	1	R
CB_A16: Healthcare acquired infection (C-Difficile)	Varies	Jun	1	G	5	G
NHS CONSTITUTION						
Monthly Indicators						
CB_B1: RTT 18 week compliance, admitted patients	90.0%	May	92.2%	G	92.1%	G
CB_B2: RTT 18 week compliance, non admitted patients	95.0%	May	96.7%	G	96.7%	G
CB_B3: RTT 18 week compliance, incomplete pathways	92.0%	May	96.2%	G	95.9%	G
CB_B4: Diagnostic test waiting times	99.0%	May	100.0%	G	100.0%	G
CB_B5: A and E 4 hour waiting time compliance	95.0%	Jun	96.8%	G	95.4%	G
CB_B6: All cancer two week waits	93.0%	May	95.1%	G	96.4%	G
CB_B7: Breast symptoms (cancer not initially suspected)	93.0%	May	--		--	
CB_B8: Cancer first definitive treatment in 31 days	96.0%	May	100.0%	G	98.8%	G
CB_B9: Cancer subsequent treatment 31 days, surgery	94.0%	May	100.0%	G	100.0%	G
CB_B10: Cancer subsequent treatment 31 days, drug	98.0%	May	100.0%	G	100.0%	G
CB_B11: Cancer subsequent treatment 31 days, radiotherapy	94.0%	May	--		--	
CB_B12: Cancer first treatment 62 days, GP referral	85.0%	May	82.3%	A	83.2%	A
CB_B13: Cancer first treatment 62 days, screening referral	90.0%	May	--		--	
CB_B14: Cancer first treatment 62 days, consultant upgrade		May	60.0%		85.7%	
CB_B17: Mixed sex accommodation breach count	0	Jun	6	R	36	R
SUPPORTING MEASURES						
Monthly Indicators						
CB_S4: A and E attendances, type 1		Jun	8,653		27,882	
CB_S4: A and E attendances, all types		Jun	10,991		35,516	
CB_S6: RTTs in excess of 52 weeks: Admitted patients	0	May	1	R	1	R
CB_S6: RTTs in excess of 52 weeks: Non admitted patients	0	May	0	G	0	G
CB_S6: RTTs in excess of 52 weeks: Incomplete Pathways	0	May	0	G	0	G
CB_S7: Ambulance handover delays over 30 minutes		Jun	12		89	
CB_S7: Ambulance handover delays over 60 minutes		Jun	1		12	
CB_S9: A and E trolley waits over 12 hours	0	Jun	0	G	0	G

3.2.3. Epsom and St. Helier Hospitals NHS Trust - CCG Commentary

NHS Merton Clinical Commissioning Group

Commissioning/Contracting: The main area of over performance is on maternity pathways, which is over performing by £440k at month 3. This is due to antenatal pathways crossing between financial years charged at full tariff. The CSU is conducting a review of these pathways and is challenging the recording of activity.

Performance:

MSA – YTD Merton CCG have been allocated 11 Mixed Sex Accommodation Breaches, 6 at Epsom & St Helier, who are experiencing on going challenges due to critical care delayed discharges (+6hrs). There has been a reduction in MSA breaches at ESH with only one in June compared to 4 in April. The Trust has a robust escalation process in place and each breach has been escalated internally at director level. Epsom & St Helier recently attended an event hosted by NHS England for Trusts that consistently have the most breaches to review and report on current breaches, analyse breaches by clinical area, share information and best practice and understand the impact of using the national criteria.

Cancer - The CCG continues to work with the Cancer Commissioning Team to ensure all contract leavers are being utilised to drive improvement.

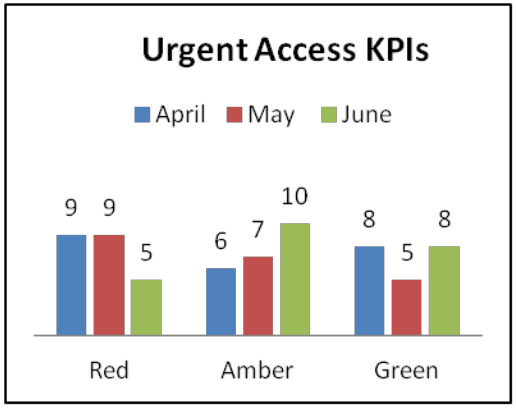
3.3.1. Sutton and Merton Community Services - Quality Dashboard

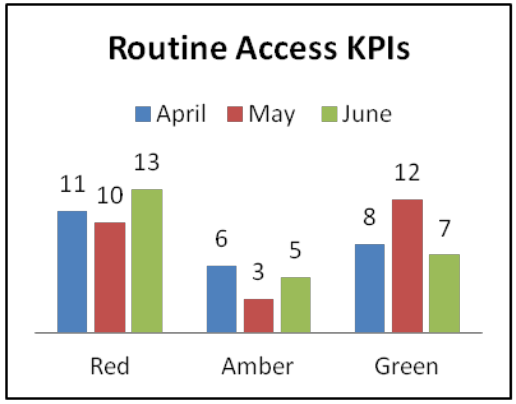
NHS Merton Clinical Commissioning Group

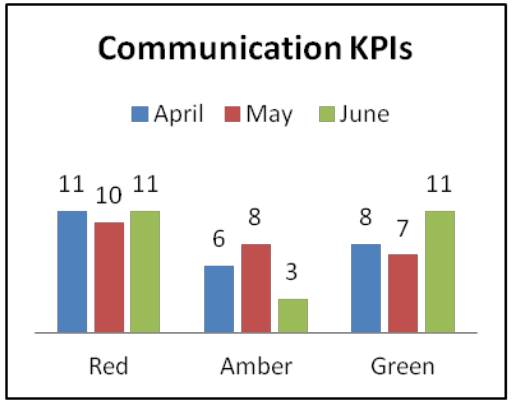
SMCS Quality Dashboard in development. Quality is currently reported separately via CQRC reporting: SMCS Quality Report

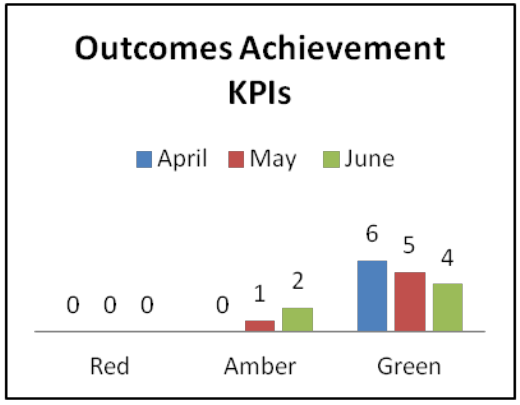
3.3.2. Sutton and Merton Community Services - Performance Overview

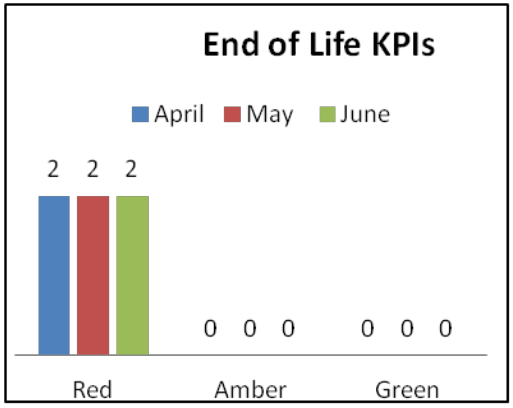
NHS Merton Clinical Commissioning Group











3.3.2. Sutton and Merton Community Services – Performance (1)

NHS Merton Clinical Commissioning Group

ServiceDescription	MetricRefDescription	Target	April 13 Performance	May-13 Performance	Jun-13 Performance
Adult Continence	Percentage of urgent referrals offered an appointment within five working days of acceptance of referral	90%	#DIV/0!	#DIV/0!	#DIV/0!
	Percentage of routine referrals offered an appointment within twenty working days of acceptance of referral	90%	98.31%	100.0%	98.08%
	Percentage of referrals where referrer is notified of acceptance / non-acceptance within two working days of screening	90%	18.31%	47.9%	60.29%
Adult Dietetics	Urgents offered appointment within 10d of acceptance	90%	62.50%	78.3%	70.00%
	Routines offered appointment within 30d of acceptance	90%	36.36%	42.3%	62.50%
	GP notified of acceptance / non-acceptance within 5d	90%	74.55%	85.2%	78.42%
	Patients achieving goals	tbc	100.00%	100.0%	100.00%
	GP notified of discharge within 5d	90%	84.09%	80.0%	94.67%
Adult Speech and Language Therapy	Urgents offered appointment within 10d of receipt	90%	#DIV/0!	#DIV/0!	100.00%
	Routines offered appointment within 30d of acceptance	90%	90.24%	96.3%	100.00%
	GP notified of discharge within 5d	90%	78.95%	86.8%	100.00%
	Patients achieving goals	75%	100.00%	100.0%	85.71%
	GP notified of acceptance / non-acceptance within 2d	90%	24.39%	2.7%	69.05%
Contraception and Sexual Health	Patients seen within 1.5h of clinic registration	90%	95.94%	96.7%	97.28%
	Routines seen within 18w of receipt	90%	100.00%	100.0%	100.00%
	GP notified of discharge within 5d	90%	100.00%	68.8%	100.00%
Children's Services	New birth visits undertaken within 14d of birth	90%	91.39%	93.0%	94.46%
	Patients achieving goals	75%	94.38%	95.5%	93.50%
	Urgents offered assessment within 10d of acceptance	90%	#DIV/0!	#DIV/0!	#DIV/0!
	Urgents offered assessment within 5d of acceptance	90%	8.57%	12.9%	100.00%
	Routines offered assessment within 30d of acceptance	90%	37.14%	29.0%	29.55%
	Statement referrals meeting timeframes	90%	84.62%	100.0%	87.50%
	Feeding referrals offered appointment within 30d of acceptance	90%	33.33%	0.0%	0.00%
	SALT language + OT refs offered appointment within 18w of acceptance	90%	89.69%	90.7%	89.81%
Community Nursing	Urgents assessed within 4h of receipt	95%	73.68%	93.3%	100.00%
	Routines assessed within 48h of receipt	95%	98.88%	99.9%	98.53%
	Attendance at GP MDT meetings	90%	95.45%	100.0%	95.24%
	Attendance at GP GSF meetings	90%	95.24%	100.0%	96.15%
	GP notified of discharge within 5d	90%	36.78%	25.2%	39.00%
	EOLC patients who die in preferred place	80%	16.67%	31.8%	11.11%
	EOLC patients with an EOLC plan	90%	54.55%	48.1%	57.58%

3.3.2. Sutton and Merton Community Services – Performance (2)

NHS Merton Clinical Commissioning Group

ServiceDescription	MetricRefDescription	Target	April 13 Performance	May-13 Performance	Jun-13 Performance
Community Rehabilitation	POA referrals assessed within 4h of receipt	90%	33.33%	14.3%	100.00%
	SD referrals assessed within 2d of hospital discharge	90%	64.13%	63.4%	74.03%
	GP notified of discharge within 5d	90%	82.19%	82.5%	85.42%
	Patients achieving goals	75%	79.02%	80.7%	66.67%
	GP / referrers notified of acceptance / non-acceptance within 2d	90%	70.28%	71.2%	78.49%
	LTC referrals assessed within 20d of receipt	90%	76.72%	85.0%	69.89%
Dysphagia for Adults with a Learning Disability	Referrals having appointment within 5d of receipt	90%	100.00%	57.1%	100.00%
	Eating/drinking summary sent within 5d of assessment	90%	100.00%	100.0%	100.00%
	Reports sent to LD team within 5d	90%	100.00%	#DIV/0!	100.00%
Falls Prevention	Home-response referrals offered appointment within 2d of acceptance	90%	10.00%	26.9%	22.73%
	Falls-class referrals offered appointment within 8w of acceptance	90%	85.71%	100.0%	78.33%
	GP notified of discharge within 5d	90%	95.45%	94.2%	96.49%
	Patients showing improvement in TUAG / VAS at discharge	90%	90.48%	100.0%	100.00%
	Patients who haven't fallen 3m after discharge	65%	82.61%	75.0%	78.95%
Heart Failure Specialist Nursing	Urgents seen within 5d of acceptance	90%	100.00%	100.0%	#DIV/0!
	Routines seen within 4w of acceptance	90%	100.00%	87.8%	80.00%
	GP notified of discharge within 5d	90%	100.00%	96.0%	100.00%
	GP notified of acceptance within 1d	90%	100.00%	100.0%	100.00%
HIV Specialist Nursing	Referrals contacted within 5d of acceptance	95%	100.00%	100.0%	100.00%
	GP notified of discharge within 5d	90%	#DIV/0!	0.0%	0.00%
Musculoskeletal Centre	Referrals offered an appointment that is within 20d of acceptance	90%	16.67%	12.4%	25.62%
	GP notified of acceptance / non-acceptance within 2d	90%	21.37%	3.4%	17.94%
	GP notified of discharge within 5d	90%	79.82%	77.4%	78.87%
OPARS	Urgent referrals offered appointment for within 7d of contacting them	90%	#DIV/0!	#DIV/0!	#DIV/0!
	Patients achieving goals	70%	85.05%	69.5%	67.68%
	Non-urgent referrals offered appointment for within 20d of receipt	90%	67.35%	53.5%	74.47%
Outpatient Physiotherapy	Urgents offered appointment within 1 week of acceptance	90%	8.00%	4.3%	9.15%
	Routines offered appointment within 6 weeks of acceptance	90%	4.60%	3.9%	7.52%
	GP notified of acceptance / non-acceptance within 2d	90%	8.45%	7.3%	57.85%
	GP notified of discharge within 5d	90%	69.66%	82.1%	82.28%
Parkinson's Disease Specialist Nursing	Urgents offered appointment within 5d of acceptance	95%	#DIV/0!	#DIV/0!	#DIV/0!
	Routines offered appointment within 15d of acceptance	95%	28.57%	44.4%	44.44%
Podiatric Surgery	Patients seen within 18w of receipt	95%	100.00%	100.0%	100.00%
	Patients seen within 18w of receipt	98%	100.00%	100.0%	100.00%
Podiatry	Urgents offered appointment within 5d of acceptance	90%	#DIV/0!	#DIV/0!	#DIV/0!
	Routines offered appointment within 30d of acceptance	90%	75.09%	77.7%	75.00%
	Attendance at carer workshops	85%	#DIV/0!	#DIV/0!	75.00%
Rapid Response	Referrals screened within 30 minutes (from Emergency Dept)	90%	70.86%	70.2%	86.57%
	Referrals seen within 2 hours (from AMU or equivalent)	90%	93.89%	85.6%	91.75%
Respiratory	Urgents offered an appointment within 2d of acceptance	90%	100.00%	100.0%	#DIV/0!
	GP notified of discharge within 5d	90%	85.71%	91.5%	91.67%
	GP notified of acceptance within 1d	90%	0.00%	0.0%	0.00%
	Urgents seen within 2d of acceptance	90%	100.00%	100.0%	#DIV/0!
	Non-urgents assessed within 4 weeks of acceptance	90%	83.33%	100.0%	80.00%
	Pulmonary rehab referrals offered an appointment within 3m of referral	90%	80.49%	92.3%	55.56%
Diabetes Specialist Nursing	DESMOND referrals offered session within 1 week of receipt	100%	4.00%	0.0%	0.00%
	GP notified of discharge within 5d	90%	81.40%	86.5%	71.74%
	DESMOND referrals attending session within 4 weeks of receipt	80%	25.81%	26.7%	28.57%
	DESMOND referrals seen within 3 months of diagnosis	100%	#DIV/0!	#DIV/0!	#DIV/0!
	Urgent non-DESMOND referrals seen within 2 days of receipt	100%	100.00%	#DIV/0!	#DIV/0!
	Non-urgent non-DESMOND referrals seen within 4 wks of receipt	100%	73.91%	56.9%	78.82%

3.3.3. Sutton and Merton Community Service CCG Commentary

NHS Merton Clinical Commissioning Group

Quality: SMCS presented a comprehensive quality report which provides assurance to the commissioners that the appropriate quality indicators are being monitored. Further work has been initiated to enable this information to be captured in a format that can be used as a basis for informing the priorities to be addressed by the CQRG and can be presented to the CCG Quality Committee going forwards. It is anticipated that this report will be included in the Month 4 Quality and Performance report.

CQRG: SMCS presented a comprehensive action plan identifying the main areas affecting performance of the district nursing service. They identified a number of organisational initiatives which are believed will contribute to improving both the quality and performance of this service. The action plan for out-patient physiotherapy service continues to be monitored and the organisation is proposing a number of initiatives which aim to reduce DNA rates and improve waiting times for new referrals.

Commissioning/Contracting: The Director of Commissioning is close to ensuring all partners sign up to the Collaboration Agreement

Performance: SMCS has declared that KPI data is unreliable and does not reflect the actual performance position. The CCG has been assured that work continues to improve data reliability, with reporting being addressed individually for each service. Service managers receive and review performance data and are working with the information team to improve reporting.

3.4.1. South West London and St. Georges NHS Trust - Quality Dashboard

NHS Merton Clinical Commissioning Group

Placeholder: Quality Dashboard in development.

3.4.2. South West London and St. Georges NHS Trust – Performance Q1

NHS Merton Clinical Commissioning Group

Indicator Details			Total		Merton	
Indicator	Definition	CCG / LA	YTD Target	YTD Actual	YTD Target	YTD Actual
Patient identity data completeness metrics (from the MHMDS)	Average percentage completeness of NHS number, date of birth, postcode, gender, marital status, GP and commissioner organisational code	LA	97%	99.2%	97%	99.1%
Outcomes for patients on CPA (from MHMDS). This KPI assesses the completeness of data to make assessments of employment and accommodation status. This is in order to assess performance against the indicators in question, not performance itself.	Average percentage of patients on CPA who: 1) have settled accommodation recorded 2) have employment status recorded, 3) have an up to date HONOS (updated)	LA	50%	91%	50%	88%
Unify Indicator 5411: The number of OBDs on adult facilities of patients who are < 16 years of age	The number of OBDs on adult facilities of patients who are < 16 years of age	CCG	0	0	0	0
Unify Indicator 5412: The number of OBDs on adult facilities of patients who are 16 or 17 years of age	The number of OBDs on adult facilities of patients who are 16 or 17 years of age	CCG	4	3	4	0
Service users with a high frequency of A&E use through the psychiatric liaison teams	Number of service users who have had 12 or more referral episodes in the last 12 months or 4 or more referral episodes in any given month in the Quarter	LA		6		1
Service users with a high frequency of A&E use through the psychiatric liaison teams	Proportion of patients with high frequency of A&E use through the psychiatric liaison teams that have been subsquently reviewed.	LA				
Ensuring a timely review of service users' CPA	The proportion of those on Care Programme Approach reviewed in at least the last 12 months	LA	95%	97%	95%	97%
This is a new indicator but a key aspect of the Mental Health Act and again is a good gauge of wider organisational performance	The number of episodes of absence without leave (AWOL) for the number of patients detained under the Mental Health Act 1983	LA	11	15	1	1
Percentage DNA rates for all services	First Appointment - All Services	LA	3%	3%	3%	4%
Percentage DNA rates for all services	Follow Up Appointments - All Services	LA	9%	6%	9%	7%
Percentage of carers who have been offered a carer's assessment	Percentage of identified carers who have been offered a carer's assessment.	CCG	34%	44%	34%	11%
Percentage of adults in settled accommodation	Percentage of adult service users who are on CPA who are in settled accommodation	LA	71%	84%	71%	81%
Percentage of adults in employment	Percentage of adult service users who are on CPA who are currently in employment.	LA	9%	10.2%	9%	10.5%
BME patients and the recording of their ethnicity	Proportion of all current patients who have ethnicity recorded	LA	95%	97.0%	95%	95.0%
Improving communication between primary and secondary care to ensure they are able to deliver the best care to service users.	Dementia service users to have a discharge summary sent to the GP and family / carer within 14 days of discharge	CCG	90%	91%	90%	89%
Promoting recovery orientated practice in care planning	Service Users on the CPA to have two or more recovery outcome goals recorded on RiO.	CCG	50%	61%	50%	55%
Improving the physical health care of service users through medicines reconcilliation.	Medicines reconcilliation with care plans to occur within 72 hours of admission	Managed Borough	68%	78%	68%	70%

3.4.2. South West London and St. Georges NHS Trust – Performance June 13

NHS Merton Clinical Commissioning Group

Indicator Details			Total			Merton		
Indicator	Service	Unit of Measurement and Period	YTD Target	YTD Actual	Change	YTD Target	YTD Actual	Change
All service users to have a care plan in line with their needs that is reviewed and updated as appropriate	All Inpatient Services	Percentage of discharges YTD	95%	98%	Aprx NC	95%	98%	Worse
Increase in number of individuals entering psychological therapies	IAPT Services	Number of service users YTD as a proportion of contracted requirement						Check
Increase in number of individuals successfully completing course of intervention	IAPT Services	Proportion of service users YTD	45%	40%	Aprx NC	45%	40%	Aprx NC
Comprehensive coverage of the population by CR/HT services which meet National Standards	Home Treatment Teams	Number of home treatment episodes YTD	520	633	N/A	98	112	N/A
Comprehensive coverage of the population by CR/HT services which meet National Standards	Adult Acute Wards	Percentage of admissions in the month	95%	99%	Better	95%	100%	Better
Comprehensive coverage of the population by CR/HT services which meet National Standards	Adult Acute Wards	Percentage of admissions in the month	95%	99%	Aprx NC	95%	100%	Better
EIS for psychosis provided meets national standards	Early Intervention Teams	Snapshot of the caseload at the end of the month	468	491	Decreasing	88	96	Decreasing
EIS for psychosis provided meets national standards	Early Intervention Teams	Number of cases YTD	38	59	N/A	7	18	N/A
Comprehensive coverage of the assertive outreach services which meet national standards	Assertive Outreach Teams	Snapshot of the caseload at the end of the month	417	431	Increasing	79	80	Aprx NC
Ensuring CAMHS population has timely and appropriate access to services	CAMHS Teams	Average length of wait in days YTD	60	51	Worse	60	57	Aprx NC
Referral To Treatment (RTT) Waiting Times - Admitted patients	All Inpatient Services	Percentage based on patients admitted in the current month	90%		Check	90%		Check
Referral To Treatment (RTT) Waiting Times	All community services	Percentage based on patients entering 'treatment' in the current month	95%	97%	Aprx NC	95%	97%	Aprx NC
Referral To Treatment (RTT) Waiting Times	All Patients	Percentage snapshot at end of the month	92%	95%	Aprx NC	92%	96%	Aprx NC
Delayed transfers of care as a proportion of bed days	All Inpatients	Percentage of occupied bed days YTD	8%	2.6%	Aprx NC	8%	2.6%	Worse
Community Mental Health teams: Ensuring access to services for service users on CPA	All Community Mental Health Teams	Percentage of the CPA caseload - YTD	81%	80%	Aprx NC	81%	75%	Aprx NC
Community Mental Health teams: Ensuring access to services for service users not on CPA	All Community Mental Health Teams	Percentage of the non CPA caseload - YTD	46%	47%	Aprx NC	46%	40%	Aprx NC
Community Mental Health teams: Ensuring population has timely and appropriate first access to services for non-urgent referrals	All Community Services	Percentage of patients YTD	22%	19%	Worse	22%	16%	Aprx NC
SIs reported to NHS London	All Services	Number of SIs YTD		20	N/A		3	N/A
Ensuring timely STEIS investigations (Closure by NHS London)	All Services	Number of STEIS investigations currently open & overdue	11	3	Aprx NC		1	Aprx NC
Ensuring timely STEIS investigations (Submission to NHS London)	All Services	Number of STEIS investigations currently overdue for submission	0	0	Aprx NC	0	0	Aprx NC
Completeness of STEIS Investigations	All Services	Percentage of YTD submitted STEIS reports with further details requested	30%	0%	Aprx NC	30%	0%	Aprx NC
Percentage of service users with an up to date and valid cluster	All Services	Percentage snapshot at end of the month	95%	83%	Aprx NC	95%	84%	Better
NDTMS: Retention 12 weeks/care planned discharge in advance of 12 weeks	All Substance Misuse Services	Percentage in the last 12 months that can be fully reported	84%	86%	Worse	84%	84%	Worse
Zero Tolerance for RTT waits over 52 weeks	All Services	Number of Service users	0		N/A	0		N/A

3.4.2. South West London and St. Georges NHS Trust – Performance (2)

NHS Merton Clinical Commissioning Group

	Target	SW London and St George's				
		Latest			YTD	
NHS CONSTITUTION						
Monthly Indicators						
CB_B1: RTT 18 week compliance, admitted patients	90.0%	May	100.0%	G	100.0%	G
CB_B2: RTT 18 week compliance, non admitted patients	95.0%	May	96.4%	G	96.2%	G
CB_B3: RTT 18 week compliance, incomplete pathways	92.0%	May	95.1%	G	95.2%	G
CB_B17: Mixed sex accommodation breach count	0	Jun	0	G	0	G
SUPPORTING MEASURES						
Monthly Indicators						
CB_S6: RTTs in excess of 52 weeks: Admitted patients	0	May	0	G	0	G
CB_S6: RTTs in excess of 52 weeks: Non admitted patients	0	May	1	R	1	R
CB_S6: RTTs in excess of 52 weeks: Incomplete Pathways	0	May	1	R	1	R

3.4.3. South West London & St. Georges NHS Trust - CCG Commentary

NHS Merton Clinical Commissioning Group

The trust reports both monthly and quarterly metrics and has a proactive approach to implementing improvement plans where targets falls below the required standard.

Proportion of identified carers offered a carers assessment : Merton has entered the carers assessment data into the Local Authority system (Care First) but not RiO and this is the reason for the low performance reported. There is a plan in place the to reconcile the two systems and this is being progressed through the Adult and Older Peoples CMHTS, EIS team and DART with support from the administration teams. The reconciliation is expected to be completed by the next Quarterly report.

Proportion of caseload receiving contact in the month - YTD (Trust green for non-CPA and amber for CPA clients). In June 2013, the Trust had monthly contact with a slightly greater proportion of non-CPA service users when compared the previous year (47% vs. 46% by June last year). Conversely, the Trust had monthly contact with a slightly lower proportion of CPA service users when compared the previous year (80% vs. 81% by June last year).

The areas with the greatest variance compared to the Trust position last year were:

Merton, has for 2013-14 YTD, seen a lower proportion of service users on CPA (75% vs. 81% in 2012-13) and a lower proportion of service users not on CPA (40% vs. 46% in 2012-3).

Proportion of patients with a valid cluster (Trust and all boroughs red rated)

National Benchmarks for Q4 from the mental health minimum data set show that the Trust has the second highest rate of clustering in London (87% compared to a London average of 78%). The indicator used of "valid clustering" is a measure of whether these clusters are still in date and have basic data quality metrics applied.

There has been a slight improvement in clustering validity compared to May and the Trust now has 83% of all service users with a valid and in-date cluster present. The previous deterioration was a concern for the Trust and a consultant was identified to provide clinical leadership to this issue and an event for clinicians to reinforce this priority is planned. The proportion of valid and in-date clusters is expected to increase further by next month.

3.5.1. Kingston Hospital Foundation Trust Quality Dashboard

NHS Merton Clinical Commissioning Group

Category	Indicator	Report Period	Target	Apr	May	Jun	Jul	Aug	Data Source
Safety	Mortality: SHMI	1st October 2011 – 30th September 2012	<1	0.8872	0.8872	0.8872			
	SIs: Number of SIs	Monthly	0	5	0				KHT CQRG report May 2013
	Number of Never Events	Monthly	0	0	1	0			KHT CQRG report May 2013
	Maternity: % women booked before 12 weeks 6 days,	Monthly	90						
	Maternity: % Caesarean Section Rate (Non-Elective)	Monthly	26	25.3%	28%				
	Maternity: Midwife/birth ratio	Monthly	1:28						
	CAS Alerts Outstanding	Monthly	0	0	0	0			
	Adult Safeguarding: % of staff compliant with training	Monthly	80						
	Child Safeguarding: %of staff compliant with training	Monthly	80						
	Falls: Moderate Harm	Monthly		0	0	1			Safety Thermometer
	Falls: Major Harm	Monthly		0	0	1			Safety Thermometer
	Falls: Death	Monthly		0	0	0			Safety Thermometer
	Pressure Ulcers, Grade 2	Monthly		14	14	3			Safety Thermometer
	Pressure Ulcers, Grade 3	Monthly		4	7	0			Safety Thermometer
	Pressure Ulcers, Grade 4	Monthly		1	1	0			Safety Thermometer
	VTE Risk Assessments Completed on Admission	Monthly	95	62.93%	68.35%	72.75%			Safety Thermometer
Experience	Complaints: Number of complaints	Monthly		26	34				KHT CQRG report May 2013
	Friends and Family Test: Net promoter score	Monthly		67	67				KHT CQRG report May 2013
Clinical Efficiency	Timeliness of discharge letters	Monthly							

3.5.1. Kingston Hospital Foundation Trust Quality Commentary

NHS Merton Clinical Commissioning Group

Quality commentary

Pressure Sores

- No grade 3 and 4 pressure ulcers in May
- 5 grade 2 pressure ulcers in May
- Weekly audit of pressure area management documentation is taking place
- Pressure area awareness is being covered in ward meetings
- Implementation of the patient safety cross and the 'stop, swarm, solve' strategy to ensure that patients with skin reddening are promptly managed by the whole team
- Stage 2 checklists for the pressure ulcers identified will be presented to the Skin High Impact Actions Group in July.

C.Difficile

- There were 3 Trust-apportioned CDiff infections in May 2013.
- KHT noted the following; KHT were not taking specimens fast enough. KHT fell foul of the day count rules. YTD 4 cases were attributed to one ward area, this has now been closed.

Complaints

Key points: There were 34 complaints in May and 34 in June.

- Complaints about Communication (Incl. Consent)/Information (13) and admission/discharge (6) dominated June's reported complaints.
- June's report included evidence of action being taken by staff following complaints received
- There was one SI reported in June 2103
- At 1st July, there were two serious incidents undergoing investigation.
- Grade 3 and 4 pressure ulcers remain the most frequently occurring SI with 3 occurring during Q1 2013/1
- SI reference 2013/12323 was confirmed as a never event

3.5.2.Kingston Hospital Foundation Trust Performance

NHS Merton Clinical Commissioning Group

	Target	Kingston				
		Latest			YTD	
OUTCOMES FRAMEWORK						
Monthly Indicators						
CB_A13: Friends and Family Test (A and E)		Jun	44		39	
CB_A13: Friends and Family Test (Inpatients)		Jun	62		63	
CB_A15: Healthcare acquired infection (MRSA)	0	Jun	0	G	0	G
CB_A16: Healthcare acquired infection (C-Difficile)	Varies	Jun	3	R	8	R
NHS CONSTITUTION						
Monthly Indicators						
CB_B1: RTT 18 week compliance, admitted patients	90.0%	May	94.7%	G	94.6%	G
CB_B2: RTT 18 week compliance, non admitted patients	95.0%	May	97.6%	G	97.6%	G
CB_B3: RTT 18 week compliance, incomplete pathways	92.0%	May	95.3%	G	95.4%	G
CB_B4: Diagnostic test waiting times	99.0%	May	99.5%	G	99.6%	G
CB_B5: A and E 4 hour waiting time compliance	95.0%	Jun	97.1%	G	96.0%	G
CB_B6: All cancer two week waits	93.0%	May	97.3%	G	97.7%	G
CB_B7: Breast symptoms (cancer not initially suspected)	93.0%	May	98.4%	G	97.5%	G
CB_B8: Cancer first definitive treatment in 31 days	96.0%	May	100.0%	G	98.7%	G
CB_B9: Cancer subsequent treatment 31 days, surgery	94.0%	May	92.3%	A	95.2%	G
CB_B10: Cancer subsequent treatment 31 days, drug	98.0%	May	100.0%	G	100.0%	G
CB_B11: Cancer subsequent treatment 31 days, radiotherapy	94.0%	May	--		--	
CB_B12: Cancer first treatment 62 days, GP referral	85.0%	May	91.5%	G	93.7%	G
CB_B13: Cancer first treatment 62 days, screening referral	90.0%	May	--		100.0%	G
CB_B14: Cancer first treatment 62 days, consultant upgrade		May	--		100.0%	
CB_B17: Mixed sex accommodation breach count	0	Jun	0	G	0	G
SUPPORTING MEASURES						
Monthly Indicators						
CB_S4: A and E attendances, type 1		Jun	7,954		26,133	
CB_S4: A and E attendances, all types		Jun	8,630		28,401	
CB_S6: RTTs in excess of 52 weeks: Admitted patients	0	May	0	G	0	G
CB_S6: RTTs in excess of 52 weeks: Non admitted patients	0	May	3	R	3	R
CB_S6: RTTs in excess of 52 weeks: Incomplete Pathways	0	May	1	R	1	R
CB_S7: Ambulance handover delays over 30 minutes		Jun	1		21	
CB_S7: Ambulance handover delays over 60 minutes		Jun	0		1	
CB_S9: A and E trolley waits over 12 hours	0	Jun	0	G	0	G

3.5.3. Kingston Hospital Foundation Trust CCG Commentary

NHS Merton Clinical Commissioning Group

Commissioning/Contracting: There is an over performance of £118k on elective, with the biggest driver at month 3 being neonatal- this activity should be attributed to NHS England and has been challenged with the Trust.
An over performance of £94k is reported under non-elective which is mainly due to general medicine. There is also an over performance of £67k on critical care mainly due to high activity on 2 & 3 organs supported. A contract query has been submitted to the Trust to provide assurance that the Trust is correctly attributing activity to CCGs.

Performance: Overall the trust is performing well. None of the trust's indicators that are not meeting targets impact on Merton CCG performance.