Kingston Hospital NHS Foundation Trust

Kingston Hospital NHS Foundation Trust

Corporate Board Performance Report
Oct 2014 (Month 7)

Trust Board Meeting: 26th November 2014

Corporate Performance Report - Oct Performance							Actual performance - latest 3 months							Future performance, trends and commentary			
	Strategic objective	KPI description	Exec Owner	Target/ Benchmark	Upper Quartile (Current)	P/YR	August	September	October	Q1	Q2	Q3 to date	YTD	Qtr trend	Mnth trend	Forecast	Comments
GRR	1	Monitor Governance Rating	CB	< 1.0	Green	1.0	1.0	1.0	0 (Excluding Oct Cancer Data)	3.0	1.0	0 (Excluding Oct Cancer Data)	3 (Excluding Oct cancer data)				In Sept the cancer target for 62-day treatment from GP referral was not achieved. See Exception report 1 **Upper Quartile Benchmark as HSCIC data Jan 2013 to Dec 2013**
Safety	1	Number of patients with Hospital acquired pressure ulcers (Grade 3 and 4)	DB	<=1	NA2	13	0	1	5	3	1	5	9	↑	↑		Target set as 10% reduction on 2013/14 outturn. Target is to have =<11.3 cases in 2014/15. See Exception Report 1 in Clinical Quality Report **Benchmark data is available from the Patient Safety Thermometer Return which looks at a snapshot of patients in the Trust each month. Data shows that on average 1% of patients surveyed had new pressure ulcers across all Trusts in March 14. This figure was 0.5% for Kingston Hospital NHS Foundation Trust in March** 14
	1	Number of patients with Hospital acquired pressure ulcers (Grade 2)	DB	<=3	NA2	53	4	6	6	18	13	6	37	↓	→		Corporate objectives set target as reduction of 10% on 2013/14 Outturn but this would be higher than the 2013/14 target so keeping 2013/14 target. See Exception Report 1 in Clinical Quality Report
	1	Number of Patient Safety Incident Falls per 1000 (G&A) bed days	JW	<=4.7	NA3	5.9	6.5	4.8	5.0	5.4	5.8	5.0	5.5	↓	↑		Benchmark against Trust performance - number calculated from 20% reduction on year end rate. See Exception Report 2 in Clinical Quality Report
	1	MRSA Bacteraemias - Post 48 hour (hospital acquired)	DB	< 1	NA2	5*	0	0	0	0	0	0	0	→	→		Target is zero tolerance as per national guidance and contract **Public Health England data shows for 2013/14, KHT's rate of hospital acquired bacteramias was 3.6 per 100,000 bed days. National rate was 1.2.** *PHE have published 5 cases for KHT in 2013/14. However one of these is a contaminant and therefore we believe not a true Trust acquired MRSA case. This case is included in the published benchmarked rate
	1	Clostridium difficile Infections - Post 72 hour (hospital acquired) in year	DB	<=2	NA2	22	2	1	2	2	3	2	7	↓	↑		Target set by Department of Health **Public Health England data shows for 2013/14, KHT's rate of hospital acquired infections was 15.8 per 100,000 bed days. National rate was 14.7.**
Effectiveness	1	SHMI	JW	<= 95	95.5	92.8				94.3	93.2	89.6		↓			SHMI score < 100 is lower than expected mortality, taking into account age, gender, comorbidity and diagnosis grouping of patients. The score for the previous year is for the period Jul 12 to Jun 13 as published by the Information Centre in Jan 2014. Q3 score is for Apr 2013 to Mar 2014 as published by the Information Centre in Oct 2014 (latest available data) **Upper Quartile Benchmark as HSCIC data Apr 2013 to Mar 2014**
	1, 5	Average Length of Stay - Emergency Services (Emergency only)	CB	<=5.4	5.10	5.7	5.0	5.3	5.6	5.9	5.1	5.6	5.5	↑	↑		Target thresholds based on national benchmark for 2013/14. Green performance is within top 25% nationally. **Upper Quartile Benchmark as CHKS data Apr 2014 to Jun 2014. CHKS have not yet published Q2 benchmark data.**
	1,5	Delayed Transfers of Care per occupied bed day	CB	<=5%	1.0%		3.2%	4.9%	5.9%	6.0%	4.1%	5.9%	5.2%	↑	↑		Indicator revised following analysis of National Delayed Transfers of Care data and Number of occupied beds Benchmark Data based on Data for Q1 2014/15.
	1,5	% Emergency Readmissions following all admissions - 30 days	CB	<= 5.7%	5.0%	5.4%	5.4%			4.9%	5.2%		5.1%	↑	↑		Target based on CHKS analysis for 2013/14 - top 25% nationally. CHKS data are reported up to 3 months in arrears. **Upper Quartile Benchmark as CHKS data Apr 2014 to Jun 2014. CHKS have not yet published Q2 benchmark data.**
	3	Number of Clinics cancelled Within 6 week	CB	<=40	NA1		35	32	62	130	98	62	290	↓	↑		65% of the Oct cancellations came from 2 specialties. Oral Surgery, due to special leave and Ophthalmology due to annual leave. The service manager for Ophthalmology is investigating why the cancellation for annual leave occurred with less than 6 weeks notice.
	4	Choose & Book Slot Issues	CB	<= 4.0%	7.0%	4%	2.6%	3.9%	3.2%	7.3%	4.6%	3.2%	5.4%	↓	↓		**Upper Quartile Benchmark from Choose & Book Data published for Oct 14**
Experience	1	Number of Attitudinal Complaints	DB	<12% of complaints	NA2	21	3	0	2	4	4	2	10	↓	↑		NHS Information Centre (IC) data show for 2012/13, 11.1% of written complaints to Hospital and Community Health Services nationally related to Attitude of Staff, this was 13.7% in London and 14.4% at KHT. (Data published August 2013)
	1	% Complaints responded to within 25 working days	CB	>=90%	NA1	67.6%	56.0%	50.0%		65.1%	59.8%		62.8%	↓	↓		Data are reported 1 month in arrears. See Exception Report 3 in Clinical Quality Report
	1	Friends and Family Score - Trust	DB		NA3	63	62	65	68	56	64	68	63	↑	↑		
Finance	5	Monitor Continuity of Service Rating	SM	3.0	4.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	→	→		
	5	Percentage of planned CIPS achieved	SM	100%	NA1	95%	99%	100%	73%	82%	100%	73%	93%	↓	↓		Stepped increase of 44% in CIP plan in month.
	5	Percentage CQUIN achievement	SM	100%	NA1	91%	80%	80%	80%	90%	80%	80%	83%	↓	→		The Trust is assuming 90% of plan for Q1 and 80% for Q2
Workforce	1,2,5	Vacancy Rate	TR	<= 8.0%	NA1	7.8%	11.8%	9.7%	7.6%	12.1%	11.3%	7.6%	10.9%	↓	↓		
	1,2,5	Turnover Rate	TR	< =13.0%	NA4	45.4%	17.6%	18.0%	18.2%						↑		See Exception Report 2
	1,2,5	Sickness Rate	TR	< =2.5%	3.23%	2.7%	3.0%	3.2%	3.1%	2.5%	3.1%	3.1%	2.9%	→	↓		**Upper Quartile Benchmark for Small Acute Trusts for June 14**
	1,2	Mandatory Training	TR	>= 75%	NA1	67%	60%	59%	63%	71%	59%	63%	63%	↑	↑		See Exception Report 3
	1,2,5	Appraisals/PDRs completed	TR	>85%	NA1	79%	84%	88%	87%	71%	88%	87%	87%		↓		

NA1 Not available
NA2 Not comparable. Target is a number, Benchmark is rate see comments
NA3 DH advice. Should not be comparing data to other Trusts
NA4 Not comparable. Different Methodologies used

Board Corporate Performance Report — **Author: Tracy Dumbarton**

Exception Report 1: Cancer

Commentary

62 waits for cancer (from urgent GP referral) post local breach allocation, which was 82.0% in Q2. This means that the Trust has breached a cancer target for the third consecutive quarter on one of the targets.

For the 62 day treatment (2WW) target in Q2 there were 21 accountable (pre reallocation) breaches which were due to a combination of reasons including patient choice related delays (5), complex pathways(4) and patients medically unfit (3.5).

The position on cancer performance has improved overall and all other cancer targets have been achieved following implementation of an action plan progress of which has been reported to EMC.

	Operational Standard	Q4 2013/14	Q1	Q2	Jul-14	Aug-14	Sep-14	Year to Date
2 week wait seen	93%	94%	93.30%	93.40%	90.10%	93.50%	97.00%	93.40%
2 week breast symptomatic seen	93%	92%	86.70%	93.60%	81.10%	97.80%	95.50%	90.20%
31 Day 1st Treatment	96%	97%	96.90%	97.50%	97.10%	100%	96.30%	97.20%
31 Day 2nd Treatment (surgery)	94%	94%	89.70%	97.70%	94.10%	100%	100%	93.90%
31 Day Second Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%
62 Day Treatment (2WW)	85%	86%	74.30%	82.00%	82.90%	84.50%	81.30%	79.20%
62 Day treatment (Screening)	90%	84%	80.80%	95.00%	88.90%	100%	100%	87.00%

Action Plan	Person Responsible	Date	Committee monitoring delivery
1. Review of 62 day cancer pathways by tumour site to include escalation points and exception reporting	Head of Patient Administration	02/01/2014	EMC
2. Movement of MDT Coordinators into service line management	Head of Patient Administration	01/12/2014	EMC
3. Joint action plans with RMH & SGH to ensure efficient pathways across Trusts	Head of Patient Administration	10/12/2014	EMC

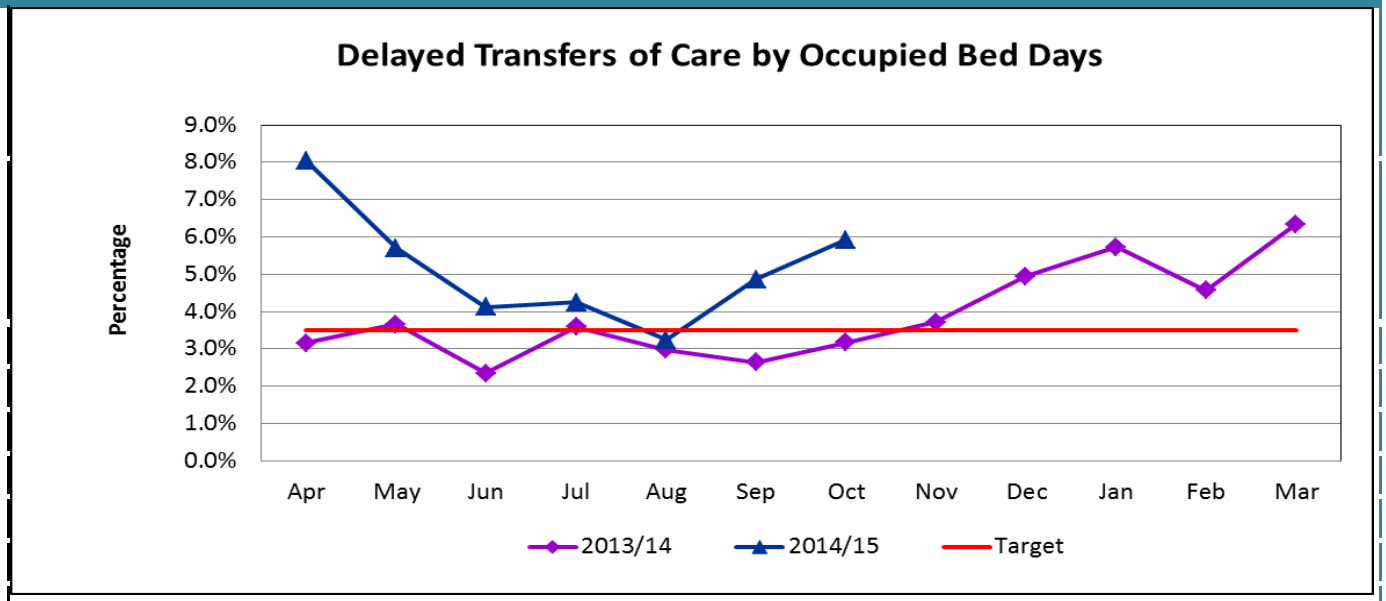
Board Corporate Performance Report — **Author: Caroline Bracewell**

Exception Report 2: Delayed Transfers of Care

Commentary

DTOC has been a changing picture over the last 12 months, with significant increases in bed days lost between December 2013 and June 2014. This increase was primarily due to delays in accessing beds in other NHS establishments and delays in family decisions. A structure of regular review was implemented to assist in the escalation and resolution of issues.
Performance then returned to levels experienced in the same period in 2013.

Analysis of August and September shows that delays due to access to other health organisations has remained low. However we have seen an increase in delays for nursing homes, residential care and packages of care. This is thought to be due to the fact that there have been no elderly mentally infirm beds within Kingston and Richmond and difficulties experienced by social care in recruiting carers and securing agency availability.



Action Plan	Person Responsible	Date	Committee
1. To continue to run the weekly long stay meeting, ensuring that issues are escalated and resolved with each borough. To consider the increase in frequency of these meetings, particularly over the winter period. The additional meetings will start at the beginning of December.	Patient flow manager	Ongoing	
2. To implement the patient flow policy, which includes early identification of discharge plans and notice to partner organisations and families	Director of operations	TBC	

Board Corporate Performance Report — **Author: Terry Roberts**

Exception Report 3: Turnover

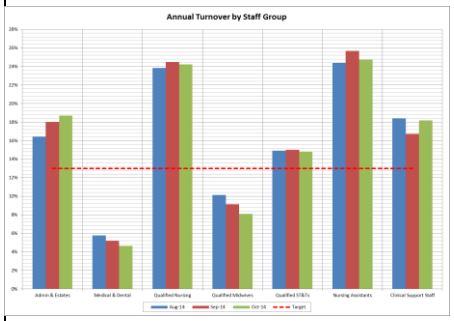
Commentary:

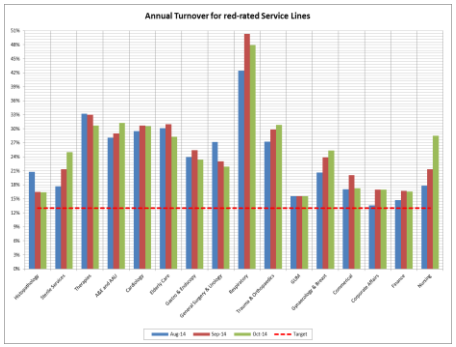
Graph 1 shows the annual turnover for the Trust by Staff Group. The only staff groups where turnover is below target is Medical & Dental and Qualified Midwives. This month turnover has increased in Admin & Estates and the Clinical Support staff groups.

Data Table 1 analyses the staff groups above target and shows the average number of leavers from that staff group in a month. The Actual V Target shows how many leavers the staff group needs to reduce by to reach the turnover target of 13%.

Graph 2 shows the Service Lines that have turnover above target. This month see an increase in Sterile Services, A&E and AAU, Trauma & Orthopaedics, Gynaecology & Breast and The Director of Nursing Service Lines.

Data Table 2 again analyses the average numbers of leavers and how many leavers the Service need to reduce to to reach the Target turnover. A retention analysis of Leavers for Quarter 1 & 2 has been produced which anlysis the reasons for leaving, destination and length of service.





Data Table 1	Oct-14	Average Headcount	Average Leavers in the year	Average Leavers per month	Target Leavers per year	Target Leavers per month	Actual V Target
Histopathology	16.38%	24	4	0.3	3	0.3	-0.1
Sterile Services	25.00%	28	7	1	4	0.3	-0.3
Therapies	30.68%	91	28	2	12	1	-1
A&E and AAU	31.27%	163	51	4	21	2	-2
Cardiology	30.56%	72	22	2	9	1	-1
Elderly Care	28.32%	152	43	4	20	2	-2
Gastro & Endscopy	23.34%	56	13	1	7	1	-0.5
General Surgery & Urology	21.92%	96	21	2	12	1	-1
Respiratory	47.95%	40	19	2	5	0.4	-1
Trauma & Orthopaedics	30.85%	78	24	2	10	1	-1
GUM	15.57%	39	6	1	5	0.4	-0.1
Gynaecology & Breast	25.32%	55	14	1	7	1	-1
Commerical	17.22%	35	6	1	5	0.4	-0.4
Corporate Affairs	17.00%	29	5	0.4	4	0.3	-0.4
Finance	16.55%	48	8	1	6	0.5	-0.4
Nursing	28.53%	28	8	1	4	0.3	-0.4

Turnover	Oct-14	Average Headcount	Average Leavers in the year	Average Leavers per month	Target Leavers per year	Target Leavers per month	Actual V Target
Admin & Estates	18.69%	642	120	64	83	7	-57
Qualified Nursing	24.22%	677	164	70	88	7	-63
Qualified ST&Ts	14.82%	310	46	30	40	3	-26
Nursing Assistants	24.74%	218	54	23	28	2	-20
Clinical Support Staff	18.18%	182	33	18	24	2	-16

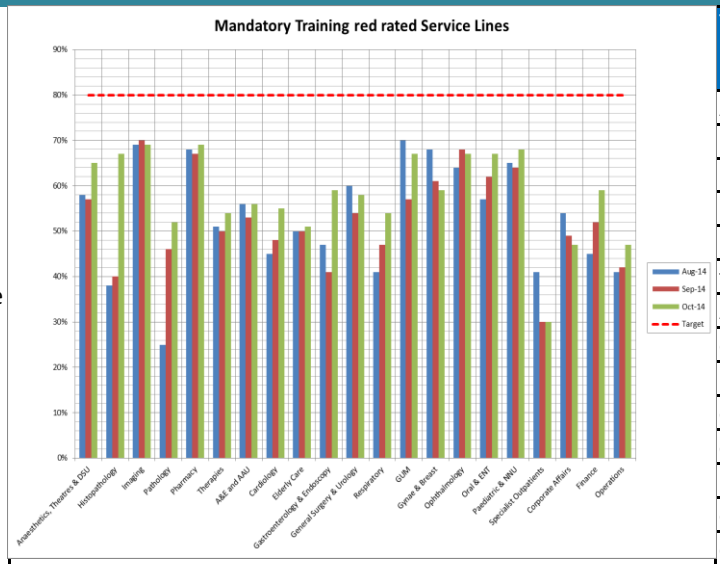
Action Plan:	Person Responsible and Date	Committee monitoring delivery
The action plan has been broken down into three major areas, understanding the root cause of turnover, improvement in the recruitment process and the recruitment and induction of new staff. This includes initiatives such as implementing the new exit interview process to enable a better understanding of the reasons for leaving e.g. work life balance, introduction of 100 day interviews, focus groups with cross section of staff, deep dive into red rated service lines, agreeing a recruitment Service Level Agreement with Service lines, reviewing and developing local and corporate induction, introducing buddying for new staff, promoting our unique selling points, brand and values internally and externally, developing the Trust training and development offering for all staff, Line managers to carrying out one to ones in clinical and non-clinical areas in a coaching manner and Coaching becomes the predominate style of management. Every red rated service line will be regularly monitored to ensure that the initiatives that they are taking is having an effect on turnover and retention and to unblock any issues corporately.	Terry Roberts	EMC and Workforce Committee

Board Corporate Performance Report
Exception Report 4: Turnover

Author: Terry Roberts

Commentary:

The graph show the progress of red rated service lines to reach 80% compliance for Mandatory Training. This month Imaging, Gynaecology & Breast, Ophthalmology and Corporate Affairs have all reduced compliance. The data table shows the percentage of staff by red rated Service Line who have completed the Training booklet. Some of these are very low. Continued promotion of the booklet and release of staff to complete this training will increase compliance.



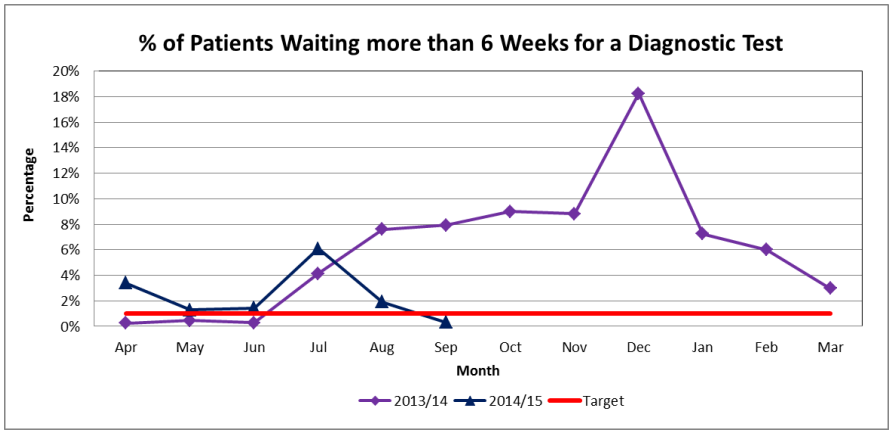
Training	Heads	Training Booklet Completed	% booklets complete
Anaesthetics, Theatres & DSU	179	90	50%
Histopathology	26	16	62%
Imaging	117	37	32%
Pathology	7	3	43%
Pharmacy	64	13	20%
Therapies	90	20	22%
A&E and AAU	193	33	17%
Cardiology	75	9	12%
Elderly Care	215	46	21%
Gastroenterology & Endoscopy	56	26	46%
General Surgery & Urology	124	14	11%
Respiratory	40	2	5%
GUM	38	24	63%
Gynae & Breast	62	7	11%
Ophthalmology	63	15	24%
Oral & ENT	71	41	58%
Paediatric & NNU	153	25	16%
Specialist Outpatients	45	18	40%
Corporate Affairs	31	8	26%
Finance	49	12	24%
Operations	240	83	35%

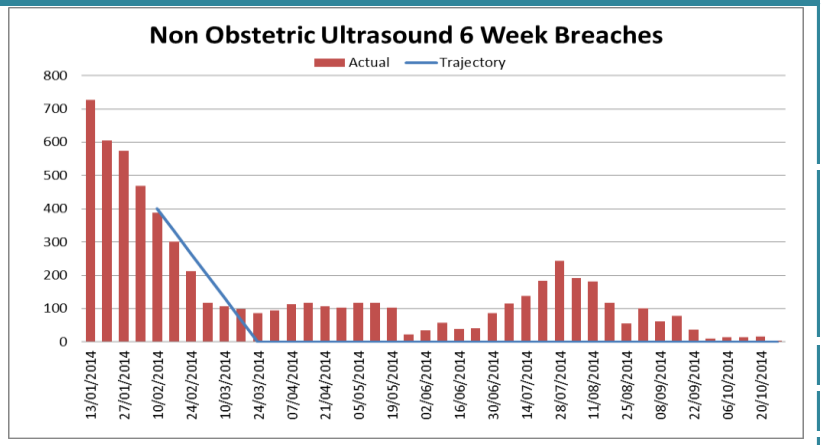
Action Plan:	Person Responsible and Date	Committee monitoring delivery
The introduction of the training booklets has enabled staff to complete their training. We are ensuring further distribution to wards and other low scoring areas to help staff achieve this objective. Service lines and Department managers showing red have been emailed and asked to target non-compliant members of staff to access the mandatory training booklets via the intranet home page. Global emails have been sent asking staff to access the mandatory training booklets and also advertising dates and availability for fire training. The Performance Review meetings will monitor performance and Divisional Directors, supported by the HR Managers, will ensure completion.	Terry Roberts 31/12/2014	EMC and Workforce Committee

Board Corporate Performance Report **Author: Diana Lacey**

Exception Report 5: Diagnostics

Non-Obstetric ultrasound performance has been driven by 3 main factors:- 1. High Demand, 2. National shortage of suitably qualified staff, 3. Increase in complex studies, eroding capacity





Action Plan	Person Responsible	Date	Committee monitoring
1. Match capacity to demand (using PTL) in a flexible way to account for deviation in specific ultrasound requirements	Radiology Service Manager	On-going	
2. Make clerical / administration process robust, particularly in relation to timeliness of appointment making and DNA rate	Radiology Service Manager	On-going	
3. Build substantive sonography team (using in-house training scheme where applicable)	Radiology Service Manager	Sept 2014 - March 2015	

Corporate Performance Report - Action Log

Action Number	Month	KPI	Action	KPI Owner	Action by	Status
1	May-13	Cancer	1. Cancer Tracking meeting to escalate patients requiring action	CB	Ongoing	
2	Sep-14	Cancer	2. Complete review of cancer services resulting in development of an improvement plan	CB	31/12/2014	
3	Sep-14	Cancer	3. Review of cancer improvement plan with London Cancer Alliance.	CB	18/09/2014	
4	Oct-14	Cancer	4. Review of 62 day cancer pathways by tumour site to include escalation points and exception reporting	CB	02/01/2014	
5	Oct-14	Cancer	5. Movement of MDT Coordinators into service line management	CB	01/12/2014	
6	Oct-14	Cancer	6. Joint action plans with RMH & SGH to ensure efficient pathways across Trusts	CB	10/12/2014	
7	Oct-14	Delayed Transfers of Care	1. To continue to run the weekly long stay meeting, ensuring that issues are escalated and resolved with each borough. To consider the increase in frequency of these meetings, particularly over the winter period. The additional meetings will start at the beginning of December.	CB	Ongoing	
8	Oct-14	Delayed Transfers of Care	2. To implement the patient flow policy, which includes early identification of discharge plans and notice to partner organisations and families	CB	tbc	
9	Jun-14	Vacancies	1. Continue current Recruitment plan to fill all vacant Nursing posts.	TR	30/09/2014	
10	Sep-14	Turnover Rate	1. Retention analysis carried out for each service line. Suite of measures developed to address retention issues. Service lines implement service specific measures to reduce turnover and increase retention	TR	30/11/2014	
11	Oct-14	Turnover Rate	2. The action plan has been broken down into three major areas, understanding the root cause of turnover, improvement in the recruitment process and the recruitment and induction of new staff. This includes initiatives such as implementing the new exit interview process to enable a better understanding of the reasons for leaving e.g. work life balance, introduction of 100 day interviews, focus groups with cross section of staff, deep dive into red rated service lines, agreeing a recruitment Service Level Agreement with Service lines, reviewing and developing local and corporate induction, introducing buddying for new staff, promoting our unique selling points, brand and values internally and externally, developing the Trust training and development offering for all staff, Line managers to carrying out one to ones in clinical and non-clinical areas in a coaching manner and Coaching becomes the predominate style of management. Every red rated service line will be regularly monitored to ensure that the initiatives that they are taking is having an effect on turnover and retention and to unblock any issues corporately.	TR	Ongoing	
12	Oct-14	Mandatory Training	1. The introduction of the training booklets has enabled staff to complete their training. We are ensuring further distribution to wards and other low scoring areas to help staff achieve this objective. Service lines and Department managers showing red have been emailed and asked to target non-compliant members of staff to access the mandatory training booklets via the intranet home page. Global emails have been sent asking staff to access the mandatory training booklets and also advertising dates and availability for fire training. The Performance Review meetings will monitor performance and Divisional Directors, supported by the HR Managers, will ensure completion.	TR	31/12/2014	
13	Oct-14	Diagnositcs	1. Match capacity to demand (using PTL) in a flexible way to account for deviation in specific ultrasound requirements	CB	Ongoing	
14	Oct-14	Diagnositcs	2. Make clerical / administration process robust, particularly in relation to timeliness of appointment making and DNA rate	CB	Ongoing	
15	Oct-14	Diagnositcs	3. Build substantive sonography team (using in-house training scheme where applicable)	CB	01/03/2015	

Monitor Governance Risk Rating - Performance against national measures

Area	Ref	Indicator	Threshold	Weighting	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14
Access	1	Maximum time of 18 weeks from point of referral to treatment in aggregate - admitted	90%	1.0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	2	Maximum time of 18 weeks from point of referral to treatment in aggregate - non-admitted	95%	1.0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	3	Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on incomplete pathway	92%	1.0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	4	A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	1.0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
	5	All cancers: 62-day wait for first treatment from:		1.0	0	0	0	0	0	1	0	1	1	1	1	1	1	0	0	
		urgent GP referral for suspected cancer	85%																	
		NHS Cancer Screening Service referral	90%																	
	6	All cancers: 31-day wait for second or subsequent treatment,		1.0	0	0	0	0	0	0	0	1	1	1	1	1	0	0	0	
		Surgery	94%																	
		Anti cancer drug treatments	98%																	
	7	All Cancers: 31-day wait from diagnosis to first treatment	96%	1.0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	8	Cancer: two week wait from referral to date first seen, comprising:		1.0	0	0.5	0	0	0	0	1	1	0	1	1	1	1	1	1	
		all urgent referrals	93%																	
		for symptomatic breast patients (cancer not initially suspected)	93%																	
	9-13	Not applicable to Kingston Hospital NHS Foundation Trust																		
Outcomes	14	Clostridium (C.) Difficile - meeting the C. Difficile objective	DM	1.0	1	1	1	1	1	1	1	1	1	0	0	0	0	0	0	0
	16-18	Not applicable to Kingston Hospital NHS Foundation Trust																		
	19	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	1.0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	20	Not applicable to Kingston Hospital NHS Foundation Trust																		
		TOTAL			1	1.5	1	1	1	2	2	4	3	4	3	3	2	1	1	0

RAG RATING :

GREEN = No grounds for concern.

NARRATIVE = with additional description of the concern and steps being taken. At some point Monitor would expect this to either revert to green or move to red.

RED = where Monitor has begun enforcement action.

Corporate Performance Report - Glossary

Strategic Objectives	
1	To Deliver Quality Patient Centred Healthcare Services with an Excellent Reputation
2	To Deliver Care by Competent and Caring Staff Working in Effective and Supportive Teams who Feel Valued by the Trust
3	To Work with Partners to Consolidate and Strengthen the Healthcare we Deliver Together to our Local Community
4	To Work with GPs and Other Providers to Support the Delivery of More Care in Primary and Community Settings
5	To Deliver Well Managed, Quality Services Which are Value for Money for the Tax Payer

KPI definitions

Indicator	KPI description	KPI Definition	Source of Benchmark target	Exception Report Criteria	Data Source	RAG Colour	RAG Score
1	Monitor Governance Rating	Based on Monitor scores for performance in 18 weeks, A&E, Cancer, C diff and learning disabilities.	Governance rating based on Monitor's guidance contained within the Compliance Framework	A red or amber score on any part of the composite measure will generate an exception report for that area	Data Source: Various: C-Diff as reported by Infection Control team to HPA Cancer - as reported by Cancer team to OpenExeter 18 Week RTT - as reported to Department of Health A&E - as reported to Department of Health Patient Experience - local declaration		< 1.0 >1.0 to <4.0 >4.0
2	Number of patients with hospital acquired pressure ulcers (Grade 3-4)	Number of patients with a newly hospital acquired pressure ulcers (Grade 3-4)	Target set as 10% reduction on 2013/14 outturn. Target is to have =<14.4 cases in 2014/15	Year to date performance is red	Data Source: Ulysses	Green Red	Full year < = 14.4 Full year > 14.4
3	Number of patients with hospital acquired pressure ulcers (Grade 2)	Number of patients with hospital acquired pressure ulcers (Grade 2)	Corporate objectives set target as reduction of 10% on 2013/14 Outturn but this would be higher than the 2013/14 target so keeping 2013/14 target	Year to date performance is red	Data Source: Ulysses	Green Red	Full year <= 36 Full year > 36
4	Number of Patient Safety Incident Falls per 1000 G&A beddays		Benchmark against Trust performance - number calculated from 20% reduction on year end rate		Data Source: Ulysses	Green Red	<=4.7 >4.7
5	MRSA Bacteraemias - Post 48hour (Hospital Acquired)	Number of hospital acquired MRSA bacteraemia (admission to positive test >48 hours)	Target is based on Department of Health set objective (maximum of 1) and Monitor Compliance Framework (de minimis of 6 cases).	An exception report will be generated each month there is an occurrence.	Data Source: Infection Control team - as reported to HPA	Green Amber Red	Full year =< 1 Full year > 1 and =< 6 Full year > 6
6	Clostridium difficile Infections - Post 72hours (Hospital Acquired)	Number of hospital acquired C diff bacteraemia (admission to positive test >72 hours)	Target set by Department of Health, Full year target is <= 15 cases. This has been profiled evenly over the year.	Year to date performance is red	Data Source: Infection Control team - as reported to HPA	Green Red	Full year < =24 Full year > 24
7	SHMI	SHMI is the national hospital-level indicator used for reporting mortality across the NHS. The SHMI indicator gives an indication of whether the mortality ratio of a provider is as expected, higher than expected or lower than expected when compared to the national baseline (England). The SHMI is a ratio of the observed number of deaths to the expected number of deaths for a provider. The observed number of deaths is the total number of patients who died in hospital plus those who died within 30 days of discharge from the hospital. The expected number of deaths is calculated from a risk adjusted model using patient age, gender, admission method, Charlson Comorbidity Index and diagnosis grouping.	Figure calculated is based on benchmark across hospitals	Exception report if above target	Data shown are from NHS Information Centre	Green Amber Red	< =95 >95 and < 105 >105
8	Average Length of Stay - Medical & Surgical Specialties (Emergency only)		Thresholds are based on national upper quartile (CHKS). Green better than National 25th percentile, red is 1 day worse than national 25th percentile.	An exception report will be generated on red quarterly performance.	Data Source: CHKS	Green Amber Red	<=5.4 >5.4 and <5.9 >5.9
9	Delayed Transfers of Care	Proportion of occupied bed days delayed transfers of care by .	Unify Delayed Transfers of Care and KH03 Occupied bed days by Trust	Where monthly performance is red	Data Source: Local KHT data as reported to Department of Health	Green Amber Red	< =5% 5% to 7.5% > 7.5%
10	% Emergency Readmissions following all admissions - 30 days		Thresholds are based on national upper quartile performance, CHKS analysis for Apr 2013 - Feb 2014.	An exception report will be generated on red performance at YTD.	Data Source: SSRS	Green Red	<= 5.7 > 5.7
11	% of hospital caused cancellations of outpatient attendances (new and FU)	Percentage of outpatient appointments that did not take place due to hospital cancellation for both first attendances and follow up attendances.	TBC	An exception report will be generated on red performance at YTD.	Data Source: KHT PAS system - data as reported to SUS	Green Red	
12	C&B Slot Issues (%)	Percentage of patients using Choose & Book who are unable to book due to slot unavailability		An exception report will be generated on red performance at YTD.	Data Source: NHS London Choose & Book Dashboard	Green Red	< 4.0% > 4.0%
13	Number of Attitudinal Complaints	This was taken from data in N&M scorecard which is attitudinal complaints for nursing only.	10% reduction compared to 2011/12 profiled evenly across the year.	Exception reports will be generated quarterly when number of complaints is above target.	Data Source: Ulysses	Green Red	Full year <= 46 Full year > 46
14	% Complaints responded to within 25 working days	Percentage of the received complaints which were responded to within the 25 day deadline. Data are reported 1 month in arrears to allow 25 day deadline.	Target Locally Set	An exception report will be generated when monthly performance red.	Data Source: KHT Datix/Ulysses	Green Amber Red	>=90% <90% and >80% <80%
15	Friends and Family Score - Trust	The Friends and Family Test is a simple, comparable test. The Friends and Family Test (FFT) score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent.			Data Source: FFT - run by external company	tbc	tbc
16	Monitor Financial Risk Rating	Shadow Finance rating based on Monitor's guidance contained within the Compliance Framework Performance is shown as an NHS Trust, i.e. without Working Capital Facility	Governance rating based on Monitor's guidance contained within the Compliance Framework		Data Source: Finance systems	Green Amber Red	On target 1 point below target 2 points below target
17	Percentage of planned CIPS achieved				Data Source: Finance systems	Green Amber Red	=100% <100% and > 95% < 95%
18	Percentage CQUIN achievement	Target and budget assumptions set at 70% of the maximum achievable.			Data Source: Finance systems	Green Amber Red	=100% <100% and > 95% < 95%
19	Vacancy Rate			Latest Monthly performance is red	Data Source: HR and Finance systems	Green Amber Red	< =8% 8% to 10% > 10%
20	Turnover Rate			Latest Monthly performance is red	Data Source: HR systems	Green Amber Red	< =13% 13% to 15% > 15%
21	Sickness Rate			Latest Monthly performance is red	Data Source: HR systems	Green Amber Red	<= 2.5% 2.5% to 4.5% > 4.5%
22	Mandatory Training	Percentage of staff who have completed mandatory training for their role		Latest snapshot performance is red	Data Source: HR systems	Green Amber Red	> = 75% < 75 and > 65% < 65%
23	Appraisals/PDRs completed		Target increases as cascade of appraisals and objectives takes place through the organisation	Latest snapshot performance is red	Data Source: HR Systems	Green Month 1 Month 2 Month 3 on	> 0 > 20% > 85%

Abbreviations and Acronyms

ESR	NHS Electronic Staff Record
FT	Foundation Trust
HPA	Health Protection Agency
KHT	Kingston Hospital NHS Trust
NHS IC	NHS Information Centre
NPSA	National Patient Safety Agency
RTT	Referral to Treatment Time
SHMI	Summary Hospital-level Mortality Indicator
SWL	South West London