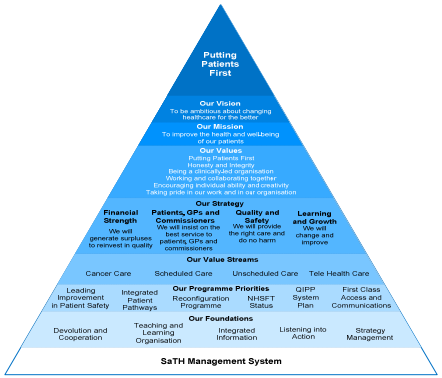
The Shrewsbury and Telford Hospital NHS
NHS Trust

Strategic Performance Report

as at Month 3



Date of Report 19/07/2011

Putting Patients First | Honesty and Integrity | Being a Clinically-Led Organisation | Working and Collaborating Together | Encouraging Individual Ability and Creativity | Taking Pride in our Work and our Organisation

Balanced Score Card

FINANCIAL STRENGTH

We will develop & deliver robust plans that generate surpluses to reinvest in quality

				Status Report			Directors Risk Assessment	
Ref	Freq	Objectives	Measures	Month RAG	Year-to-Date RAG	Direction of Travel	Forecast RAG	Level of Confidence in Delivery
A1	M	Develop & implement sustainable clinical strategies	% Contribution	RED	RED	=	RED	5
A2	Q	Develop & grow services that make a positive financial contribution	Service Portfolio Matrix					
A3	M	Increase surpluses to reinvest in quality and innovation	Financial Risk Rating	RED	RED	=	GREEN	5
A4	M	Maximise the productivity and efficiency of our services	Upper Quartile benchmark Index	AMBER	AMBER	=	GREEN Mth 12	4
A5	M	Eliminate waste and non value adding processes	Reference Cost Index	RED	RED	=	RED	5

QUALITY & SAFETY

We will always provide the right care for our patients

				Status Report			Directors Risk Assessment	
Ref	Freq	Objectives	Measures	Month RAG	Year-to-Date RAG	Direction of Travel	Forecast RAG	Level of Confidence in Delivery
C1	Q	Ensure that we learn from mistakes & embrace what works well	Staff Reported Outcomes Score					
C2	Q	Design care around patient needs	Local Inpatient Survey					
C3	M	Provide the right car, right time, right place, right professional	Time & Place Index	AMBER	RED	=	GREEN Month 9	3
C4	M	Deliver services that offer safe, evidence-based practice	Fewer Avoidable Deaths	RED	RED	=	GREEN Oct 2012	3
C5	Q	Meet regulatory requirements & healthcare standards	Compliance Index	AMBER	AMBER	n/a	AMBER	3
C6	M	Ensure that our patients suffer no avoidable harm	Patient Care Index	RED	RED	=	AMBER Q3	3

PATIENTS, GP'S & COMMISSIONERS

We will insist that we deliver the best service to our patients, GP's & Commissioners

				Status Report			Directors Risk Assessment	
Ref	Freq	Objectives	Measures	Month RAG	Year-to-Date RAG	Direction of Travel	Forecast RAG	Level of Confidence in Delivery
B1	Q	Involve patients in decisions about them	Patient Involvement Index					
B2	Q	Ensure our patients have a good experience	Patient Satisfaction Score					
B3	Q	Deliver services which are convent & timely for patients	Convenience & Timely Services Index					
B4	Q	Ensure access to clear care pathways to meet the needs of pour patients	GP Satisfaction Score (Signposting)					
B5	Q	Improve our appointments system and process	GP Satisfaction Score (Scheduling)					
B6	Q	Improve the communication processes and the information we provide	GP Satisfaction Score (Communication)					
B7	Q	Work in partnership to ensure services meet the local needs	Commissioner Satisfaction Score (Delivery)					
B8	Q	Engage with GP's to plan & deliver future services	Commissioner Satisfaction Score (Planning)					
B9	M	Reflect commissioners plans in our capacity plans & deliver our contractual commitments	Contractual Commitments Index	RED	RED	=	GREEN	3

Legend		
RAG	*Status Report (in mth and YTD performance)*	*Directors Forecast*
RED	Target Not achieved in line with Performance Directory Threshold	Performance is off track and **plans will be put in place but there remains some level of risk**
AMBER	Target underachieved in line with Performance Directory Thresholds	Performance is off track but **action plans are in place** and expected to deliver original plan by the agreed timescale
GREEN	Target achieved in line with Performance Directory Threshold	Performance against plan and **targets have been achieved** within the defined tolerance level

Putting Patients First

Honesty and Integrity

Being a Clinically-Led Organisation

Working and Collaborating Together

Encouraging Individual Ability and Creativity

Taking Pride in our Work and our Organisation

A1. Develop & Implement a Sustainable Clinical Strategy

Executive Sponsor	Headline Measure	Mth Status	YTD Status	Direction of Travel	Forecast	Level of Confidence in Recovery Plan	Supporting Papers
Finance Director	Percentage Contribution	Red	Red	=	Red	5	

Supporting Measure	Current Performance	Forecast Performance	Exception Report
Percentage Contribution (Trust/Centre/ Service Line)			
Division 1	24% in Month and 22% YTD. As expected Income has increased by circa £0.2m from last Month due to the number of working days available in June compared to May 2011. Non pay expenditure has reduced by circa £0.1m, however, this is offset by a pay expenditure increase of circa £0.1m. Division 1 however, did overspend against their planned expenditure budgets in June by circa £0.7m which illustrates why their percentage achieved is lower than Division 2.	40% (Target Contribution for Indirect and Overhead costs i.e. Division 3 and Corporate Services respectively)	
Division 2	42% in Month and 40% YTD. As with Division 1, Income has increased by circa £0.5m month due to the number of working days available, however, non pay costs have increased by circa £0.3m. Direct expenditure budgets for Division 2 are reporting a balanced position for June 2011, therefore the improvement on this target from Month 2 is due to the increase in activity in June.	40% (Target Contribution for Indirect and Overhead costs i.e. Division 3 and Corporate Services respectively)	

A3. Increase Surpluses to Reinvest in Quality & Innovation

Executive Sponsor	Headline Measure	Mth Status	YTD Status	Direction of Travel	Forecast	Level of Confidence in Recovery Plan	Supporting Papers
Finance Director	Financial Risk Rating	RED	RED	=	GREEN	5	

Supporting Measure	Current Performance	Forecast Performance	Exception Report
FRR Overall	2 (Plan 3)	The end of quarter 1 review of the financial position illustrates that whilst income will come back in line with plan, expenditure will continue to overspend if management actions of £3.5m are not implemented.	
EBITDA Margin	2: +2.7%The majority of the in month EBITDA improvement is due to the recognition of SHA support of £1.4m. Excluding this amount the EBITDA is £0.5m and would result in an EBITDA margin of 0.8% that would have scored 1. Planned +5%		
EBITDA Percentage Achieved of Plan	3: +77.4% An over-performance of £0.2m within income has been offset by adverse pay variances of £0.5m and adverse non-pay variances of £0.2m. This results in the Trust not achieving the planned EBITDA. EBITDA Planned to Month 3 £2.4m Actual £1.9m. Planned 100% of the Plan.		
Return on Assets	2: (0.2%) Planned +3.4%		
Income & Expenditure Surplus Margin	1: (2.3%) As with the EBITDA plan, the Trust planned a £1.1m deficit to Month 3 which it has underachieved by £0.5m. Planned Surplus Margin 0% (breakeven)		
Liquidity Ratio	2: 12.6 days Improvement in liquidity ratio of 1.9 days from previous month. This is the result of the in month improvements within the EBITDA position and the resulting positive effects within working capital. Planned 11 days		

A4. Maximise the Productivity of Our Services

Executive Sponsor	Headline Measure	Mth Status	YTD Status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Chief Operating Officer	Upper Quartile Benchmark Index	AMBER	AMBER	=	GREEN Mth 12	4	

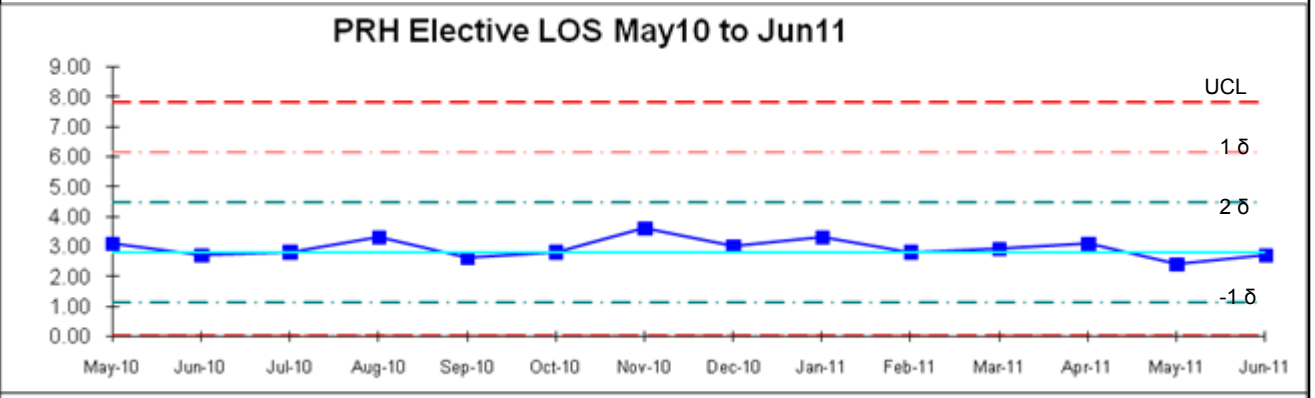
Supporting Measure	Current Monthly Performance	Forecast Performance	Exception Report
Elective Length of Stay (mean) - monthly	The target for the Trust is 2.8 days, the performance in June was as follows: RSH 3.7 days PRH 2.8 days	The current forecast is that the Trust will deliver the target by February 2012	Y
Elective surgical pre-op bed days - monthly	The target for 2011/12 is a 60% reduction against the 2010/11 out-turn equating to 60days per month There were 170 elective surgical pre-op bed-days in June 2011	The current forecast is that the Trust will deliver the target by September 2011	N
Non Elective Length of Stay - monthly	The target is 4.7 days, the performance in June was as follows: RSH 4.7 days PRH 5.7 days	The current forecast is that the Trust will deliver the target by September 2011	Y
Elective (funded) Theatre Utilisation - monthly	The target for 2011/12 is 85% on both sites, the utilisation for June was as follows: RSH – 78% PRH – 78%	The current forecast is that the Trust will achieve 85% on both sites by March 2012	Y

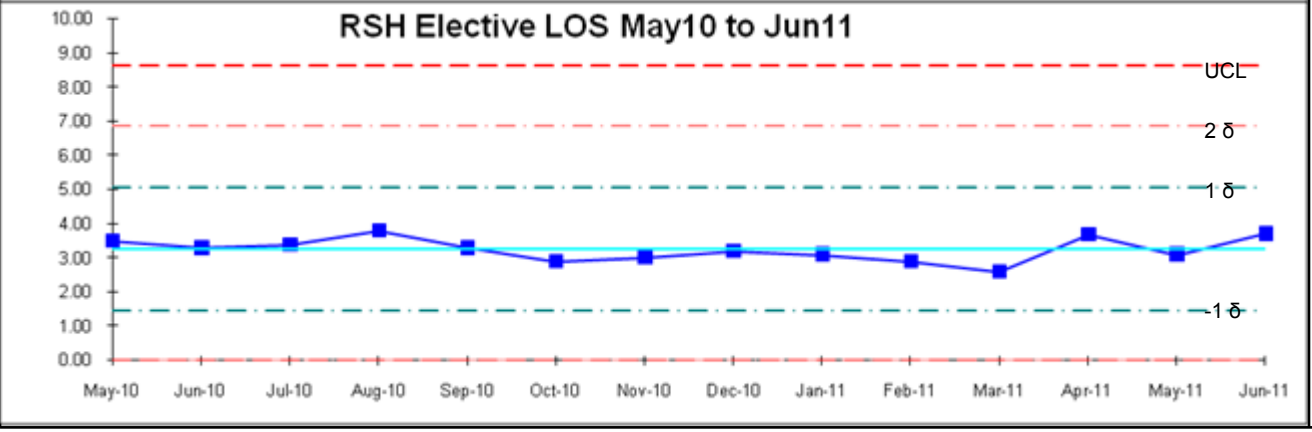
Exception Report

A4. Maximise the productivity of our services – elective length of stay

		Status Report			Directors Risk Assessment		
Executive Sponsor	Headline Measure	Mth status	YTD status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Chief Operating Officer	Upper Quartile Benchmark index	AMBER	AMBER	=	GREEN Mth 11	4	

Position Analysis –Elective length of stay: PRH 2.8 days, RSH 3.7 days **Target** 2.8 days





Future Actions:

Continued implementation of enhanced recovery Programme in colorectal, orthopaedics and urology

Maintain a minimum 78% day surgery rate across all specialties by August 2011

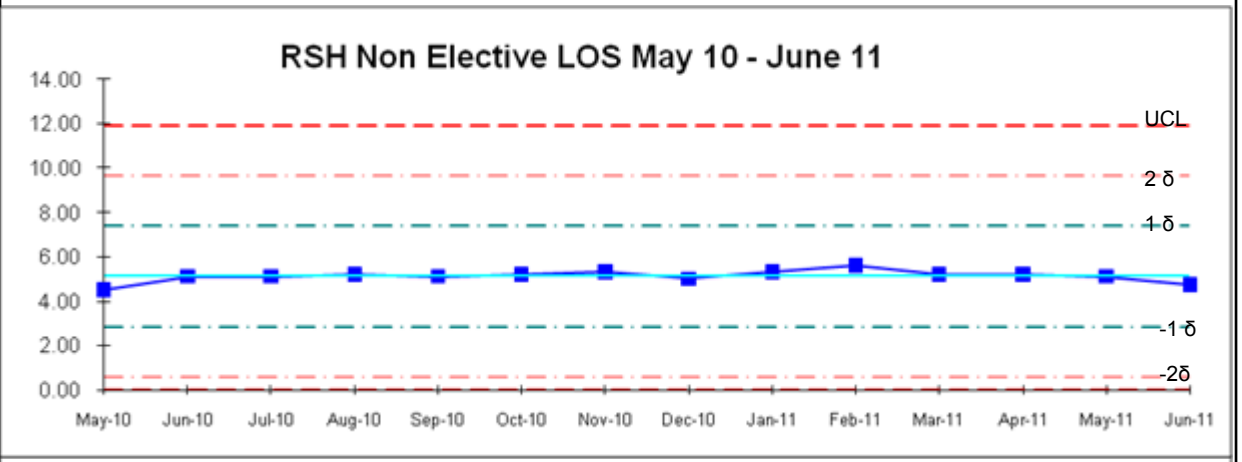
Reduce elective surgical pre-operative length of stay by increased use of the Surgical Admissions Suite by September 2011

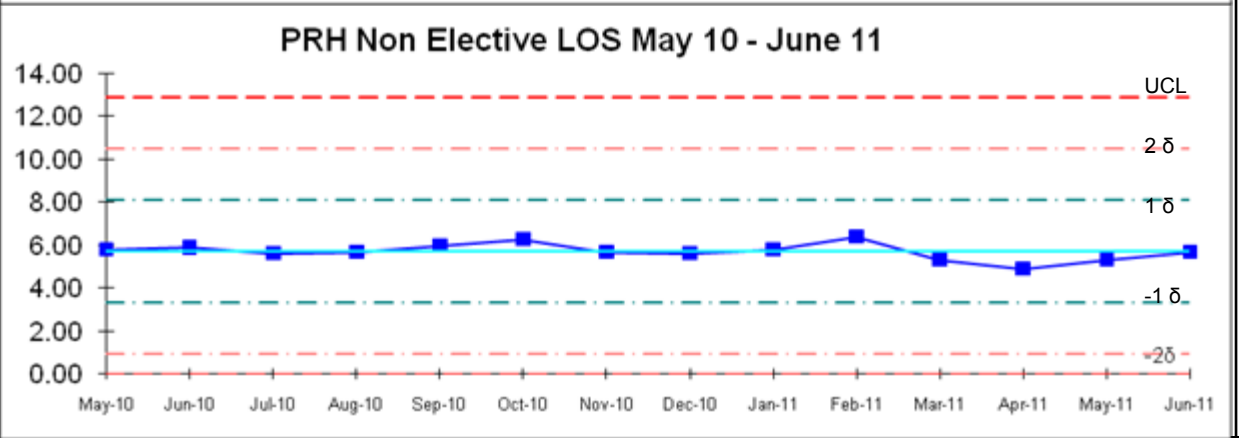
Exception Report

A4. Maximise the productivity of our services – non elective length of stay

		Status Report			Directors Risk Assessment		
Executive Sponsor	Headline Measure	Mth status	YTD status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Chief Operating Officer	Upper Quartile Benchmark index	AMBER	AMBER	=	GREEN Mth 12	3	

Position RSH 4.7 days, PRH 5.7 days Target – 4.7 days





- RSH Non Elective LOS

  Decreased between May and June by 0.4 days

- PRH Non Elective LOS

  Increased between May and June by o.4 days

Future Actions:

Continued implementation of the unscheduled care improvement plan including:

Creation of ambulatory care units on both sites by the July 31st 2011

Improved ward discharge processes

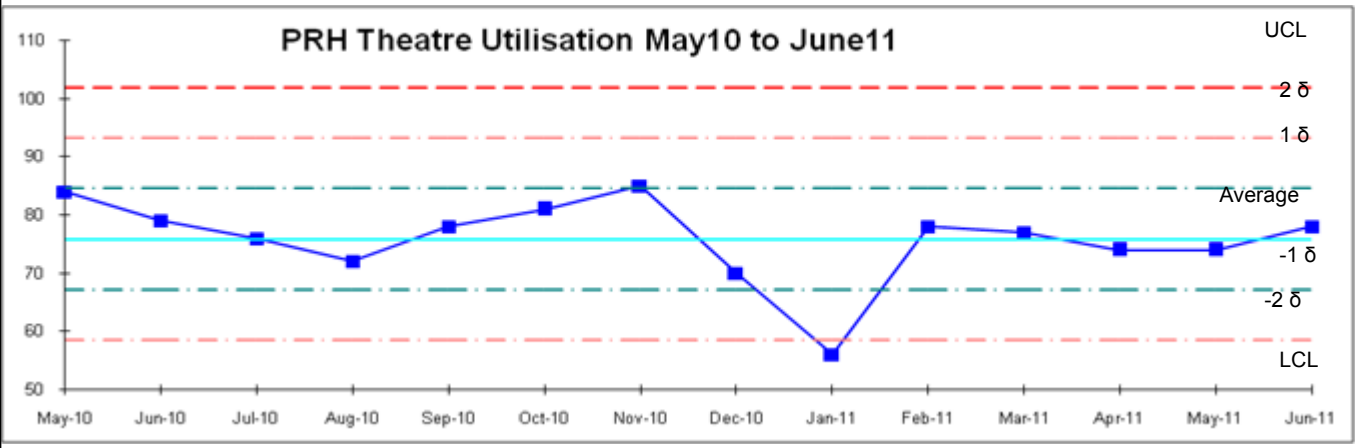
A sustained reduction in the number of patients with delayed transfers of care to 26 or lower by July 31st

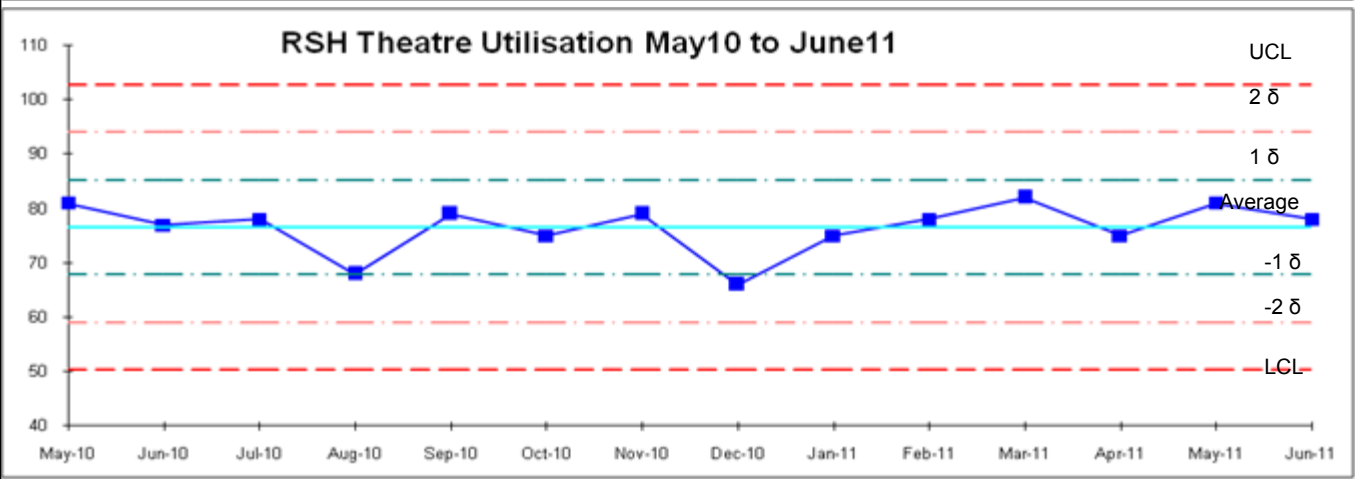
Exception Report

A4. Maximise the productivity of our services – elective funded operating theatre utilisation

		Status Report			Directors Risk Assessment		
Executive Sponsor	Headline Measure	Mth status	YTD status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Chief Operating Officer	Upper Quartile Benchmark index	AMBER	AMBER	=	AMBER	4	

Position Analysis – elective funded operating theatre utilisation – 78% on both sites





Future Actions

Theatre improvement (TPOT – the productive operating theatre) plan commenced at RSH & PRH

All operation names, duration & length of stay to be updated on the Trust's patient administration system (commencing with RSH General surgery) to enable improved scheduling

All elective theatre sessions to be confirmed 4 weeks in advance

A5. Eliminate Waste & Non Value Adding Processes

Executive Sponsor	Headline Measure	Mth Status	YTD Status	Direction of Travel	Forecast	Level of Confidence in Recovery Plan	Supporting Papers
Finance Director	Reference Cost Index	Red	Red	=	Red	5	

Supporting Measure	Current Performance	Forecast Performance	Exception Report
Reference Cost Index Availability	The Reference Cost Index (RCI) is produced on an annual basis as a national submission to the Department of Health. The calculations are based on FCE data rather than spell data. SATH has a FCE to Spell ratio significantly higher than the national average, and as a result, the unit price calculated is diluted which improves the Trust's RCI. As a result the RCI, although a measure, does not truly reflect the Trust's cost per spell of care.		
Monthly Trend of Average Cost per Spell	£2,799 in Month and £2,913 YTD. This reflects the anticipated increase in activity for June with expenditure remaining constant between the two Months.	£2,748 (Target based on annual budgeted expenditure and planned activity)	

B9. Reflect Commissioner's Plans in Our Capacity Plans & Deliver Our Contractual Commitments

Executive Sponsor	Headline Measure	Mth Status	YTD Status	Direction of Travel	Forecast	Level of Confidence in Recovery Plan	Supporting Papers
Finance Director	Contractual Commitments Index	RED	RED	=	GREEN	3	

Supporting Measure	Current Performance	Forecast Performance	Exception Report
DoH Performance Framework	The Trust continues to under perform against a number of key National Targets in respect of Cancer, 18 Weeks and A&E	High level discussions to sign off and implement recovery / improvement plans are continuing	Y
CQUIN	9 CQUIN goals agreed with local Commissioners for 11/12.	Specific measures for each CQUN goal in the process of being finalised with Commissioners. This is anticipated to be completed by end of May 2011.	Y
Other Contractual Commitments	Discussion with local commissioners regarding the specific local measures to be included within the contract are continuing		N
Activity Plan Variation	To Be Progressed		N

Exception Report

B9. Reflect Commissioner's Plans in Our Capacity Plans & Deliver Our Contractual Commitments

		Status Report			Directors Risk Assessment		
Executive Sponsor	Supporting Measure	Mth status	YTD status	Direction of Travel	Forecast	Confidence Level	Supporting Papers
Finance Director	DoH Performance Framework	RED	RED	=	AMBER	3	

Acute Trusts

Service Performance (Integrated Performance M

Quality of service

Performance Indicator	Thresholds: Performing	Thresholds: Under-performing	June 2011 Performance	Year-to-date 2011 Performance
Four-hour maximum wait in A&E from arrival to admission, transfer or discharge[1]	95%	94%	93.81%	92.78%
Unplanned re-attendance rate - Unplanned re-attendance at A&E within 7 days of original attendance (including if referred back by another health professional)	Data Completeness/Data Quality Measure for Q1		0	0
Left department without being seen rate			0	0
Time to initial assessment - 95th centile			0	0
Time to treatment in department - median			0	0
Cancelled ops - breaches of 28 days readmission guarantee as % of cancelled ops	5.0%	15.0%	0	0
MRSA	0	>1SD*	0	0
C Diff	0	>1SD	3	13
RTT - admitted - 95th percentile@	<=23	>27.7	51.41	44.67
RTT - non-admitted - 95th percentile@	<=18.3		31.15	29.35
RTT - incomplete - 95th percentile	<=28	>36	35.16	36.22
RTT - admitted - 90% in 18 weeks	90%	85%	67.02%	70.32%
RTT - non-admitted - 95% in 18 weeks	95%	90%	85.79%	87.93%

RTT focus is currently to reduce the proportion of open clocks that have waited over 18 weeks. As a proportion of total open clocks those waiting over 18 weeks reduced from 22% at the end of May to 17% at the end of June. As these patients seen or treated in month, actual admitted and non admitted performance will deteriorate.

Exception Report - Continued

B9. Reflect Commissioner's Plans in Our Capacity Plans & Deliver Our Contractual Commitments

Position Analysis - Continued

Performance Indicator	Performing	Under-performing	June 2011 Performance	Year-to-date 2011 Performance
2 week GP referral to 1st outpatient	93%	88%	90.59%	92.61%
2 week GP referral to 1st outpatient - breast symptoms	93%	88%	93.42%	93.85%
31 day second or subsequent treatment - surgery	94%	89%	100.00%	94.23%
31 day second or subsequent treatment - drug	98%	93%	100.00%	98.83%
31 day diagnosis to treatment for all cancers	96%	91%	92.50%	95.37%
Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments)	94%	89%	94.81%	97.12%
62 day referral to treatment from screening	90%	85%	83.87%	85.44%
62 day referral to treatment from hospital specialist	85%	80%	81.19%	85.43%
62 days urgent GP referral to treatment of all cancers	85%	80%	71.08%	74.32%
Patients that have spent more than 90% of their stay in hospital on a stroke unit	80%	60%	87.30%	87.77%
Delayed transfers of care	3.5%	5.0%	5.60%	Unavailable

Future Actions / Key Points

June Cancer Numbers will be fully validated in time for the next Strategic Performance Report.

Exception Report

B9. Reflect Commissioner's Plans in Our Capacity Plans & Deliver Our Contractual Commitments

		Status Report			Directors Risk Assessment		
Executive Sponsor	Supporting Measure	Mth status	YTD status	Direction of Travel	Forecast	Confidence Level	Supporting Papers
Finance Director	CQUIN	AMBER	AMBER	=	AMBER	3	

CQUIN Goal	Lead Manager / Executive	% of overall scheme	Month	Year to Date	Narrative
VTE	Medical Director	15.00%			Month 1 and 2 not achieved, Month 3 unvalidated data also shows not achieved. See C4
Patient Experience	Director of Quality & Safety	15.00%			Measure agreed with commissioners. End of year assessment.
Reduction in Falls of Patients admitted to Hospital	Director of Quality & Safety	10.00%			Month 3 YTD achieved.
Tissue Viability - Pressure Ulcers	Director of Quality & Safety	15.00%			Data unavailable, therefore unable to apply a RAG assessment. See C6
End of Life - Liverpool Care Pathway	Medical Director	10.00%			Month 2 YTD achieved. Month 3 not available.

Future Actions / Key Points

For this month the overall assessment has been based on the 6 measures which have been agreed and / or data is available.

The RAG rating applied to CQUINs within B9 reflects the status against the agreed CQUIN measure from a financial achievement perspective and as such the RAG rating may differ to that reported for the same measure in other areas of the report. For example VTE is rated as Red in B9 because the Trust did not achieve the monthly target in month 3 and will not receive the CQUIN payment from commissioners. However within C4 VTE is rated as Amber because it is under performing against the internally agreed SaTH trajectory.

Discussion taking place with relevant executive and operation leads to ensure the relevant data re Tissue Viability is routinely provided to the Contracts & Performance team. In future months, if this data is not available this goal will be rated as red.

Exception Report

B9. Reflect Commissioner's Plans in Our Capacity Plans & Deliver Our Contractual Commitments

CQUIN Goal	Lead Manager / Executive	% of overall scheme	Month	Year to Date	Narrative
Medicines Management	Medical Director	10.00%			Measure and baseline agreed with commissioners.
Maternity	Director of Quality & Safety	5.00%			Q1 achieved. Position of specialist midwife advertised and appointed.
Improved Patient Discharge Ready to Go No Delays and EDD for all Inpatients	Chief Operating Officer	10.00%			Detailed discussions with Commissioners continue. As such data unavailable, therefore unable to apply a RAG assessment.
Nutrition	Director of Quality & Safety	10.00%			Detailed discussions with Commissioners continue. As such data unavailable, therefore unable to apply a RAG assessment.

The relevant executive and operational leads are being asked to conclude discussion with Commissioners regarding the improved patient discharge and nutrition goals as a matter of urgency. In future months these will be assessed as red if agreement is still outstanding.

C3: Provide the Right Care, Right Time, Right Place and Right Professional

Executive Sponsor	Headline Measure	Mth Status	YTD Status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Chief Operating Officer	Time and Place Index	AMBER	RED	=	GREEN Month 9	3	

Supporting Measure	Current Monthly Performance	Forecast Performance	Exception Report
Delayed Transfers of Care	The target for 2011/12 is 26 patients per day (3.5% of bed base) In June the average daily number of patients confirmed as Delayed Transfers of Care was 42 (50 in April)	The Trust is forecasting that the overall number of 26 patients or less will be achieved by December 2011	Y
Discharge Time	The current target is for 50% of discharges to take place before midday (adult inpatient wards excluding maternity). 32% of patients were discharged before midday during June 2011	The Trust is forecasting delivery of the 50% target by 30th September 2011	Y
Day Surgery Rate	The target for 2011/12 is 78%, the trust achieved a 78% day surgery rate during June 2011	The Trust is forecasting that the target will be achieved by August 2011	N
Outliers	18% of surgical, gynaecology, head & neck, oncology & haematology beds had outliers within them during June 2011 (an outlier being defined as a medical or orthopaedic patient) Note – a new report by clinical centre will be available for the August 2011 performance report.	Zero medical outliers by 1st October 2011	Y

Exception Report

C3: Provide the Right Care, Right Time, Right Place and Right Professional - Delayed Transfers of Care

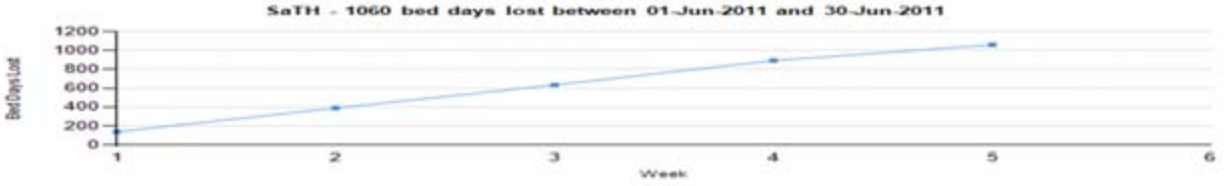
		Status Report			Directors Risk Assessment		
Executive Sponsor	Headline Measure	Mth status	YTD status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Chief Operating Officer	Time and Place Index	AMBER	RED	⇧	GREEN mth 9	2	

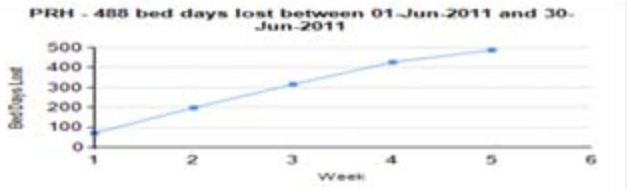
Position Analysis – Delayed transfers of care

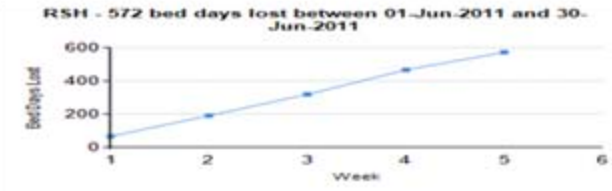
RSH: 2 main reasons for delay in June 2011 – nursing care home placement and residential care home placement

PRH: 2 main reasons for delay in June 2011 – nursing care home placement and residential care home placement

1060 lost bed days within SaTH (35 beds) due to delayed transfers of care during June 2011







Future Actions

Continued executive level discussions within local health and social economy

PCT led monthly delayed discharge meetings

Formation of a local health & social care integrated case management team

Mobilisation of reform of medicine taskforce and continued implementation of the unscheduled improvement plan

Maintain the number of patients with delayed transfers of care below 26 patients per day (target achieved since July 1st 2011)

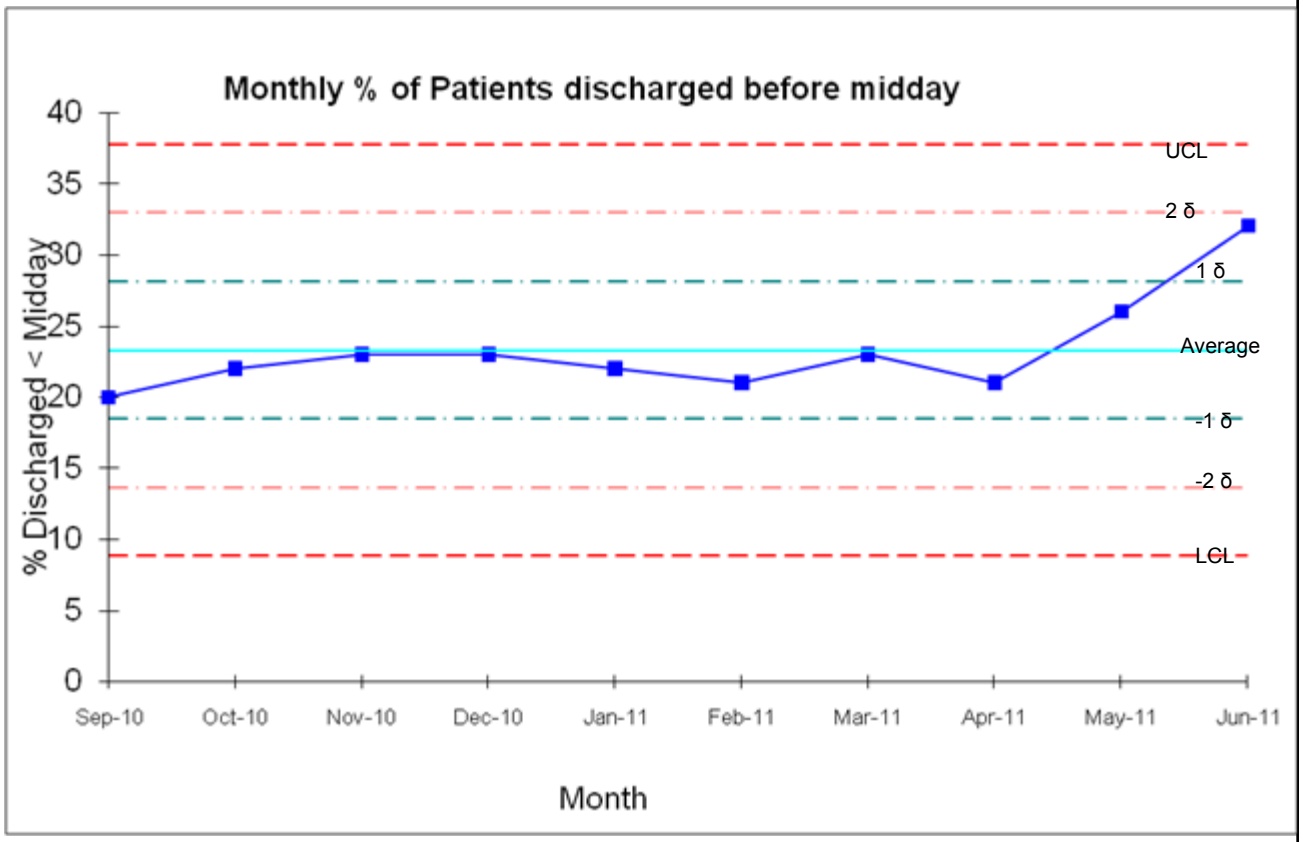
Exception Report

C3: Provide the Right Care, Right Time, Right Place and Right Professional – Discharge time

		Status Report			Directors Risk Assessment		
Executive Sponsor	Headline Measure	Mth status	YTD status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Chief Operating Officer	Time and Place Index	AMBER	RED	⇧	GREEN Mth 7	3	

Position Analysis – Discharge time

32% of patients discharged before 12:00 in June



Future Actions

Weekly ward level discharge time automated email league table reports to all key stakeholders. Intervention / rapid improvement for all wards not achieving 50% of discharges before midday

Daily morning board rounds by decision making clinicians

Expected date and time of discharge in place for all patients

All staff, patients and visitors to be made aware that discharges take place before midday

Exception Report

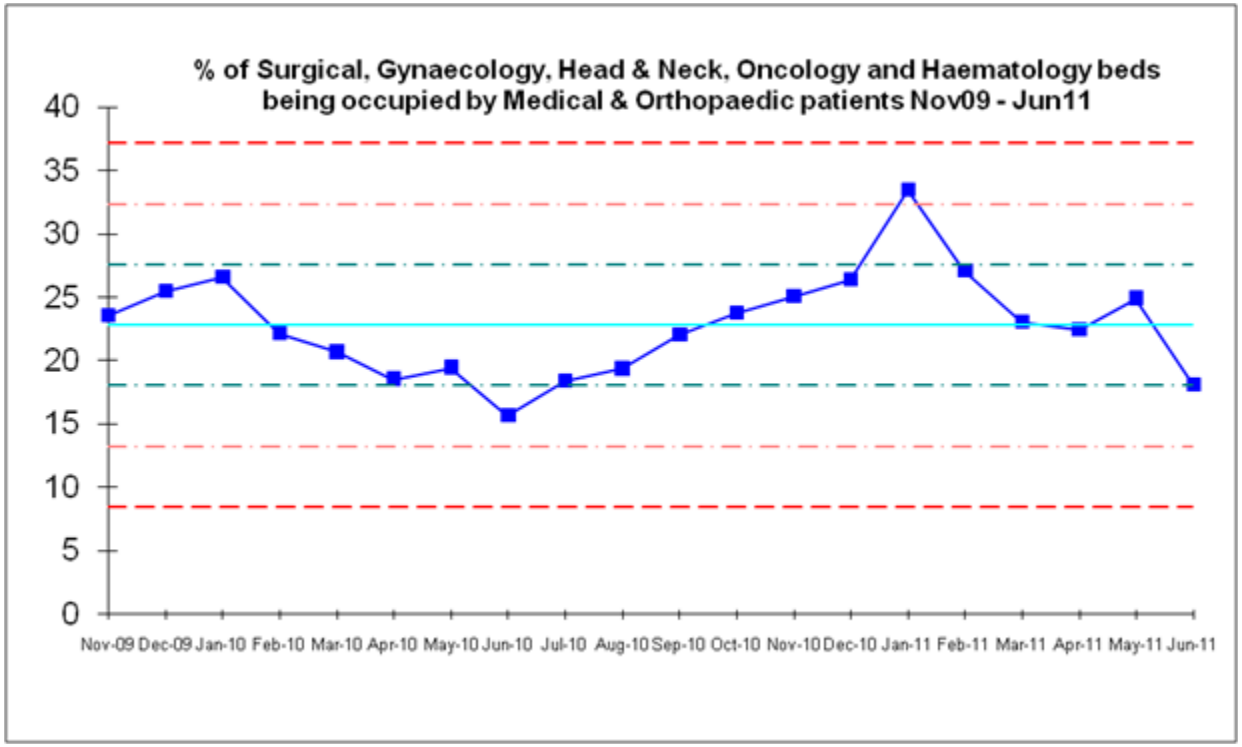
C3: Provide the Right Care, Right Time, Right Place and Right Professional – Outliers

		Status Report			Directors Risk Assessment		
Executive Sponsor	Headline Measure	Mth status	YTD status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Chief Operating Officer	Time and Place Index	RED	RED	⇧	GREEN month 9	3	

Position Analysis – The percentage of beds occupied by outliers decreased by 6.5% between May and June 2011

(note - a new outlier report based on the Clinical Centre Structure is being developed and will be available for the August performance report. The current report is based upon the previous divisional management structure.)

The report below shows the % of medical and orthopaedic patients occupying surgical, gynaecology, oncology and haematology beds



Future Actions:

Implementation of the Chief Executives reform of medicine task force which includes zero medical outliers by 1st October 2011

Continued implementation of the unscheduled care improvement plan

Creation of a detailed live outlier report by 1st August 2011 which displays the number of outliers by ward, consultant and clinical centre

C4. Deliver Services that Offer Safe Evidence-Based Practice

Executive Sponsor	Headline Measure	Mth Status	YTD Status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Medical Director	Fewer Avoidable Deaths	RED	RED	=	GREEN Oct 2012	3	

Supporting Measure	Current Performance	Forecast Performance	Exception Report
HSMR	Rebased YTD: SaTH = 112.5 In Month: SaTH = 96 Rebased HSMR below National index for the 2nd month in a row showing continued downward trend. HSMR is on track against trajectory to achieve National index of 100 by Oct 2012	At present if the current trend continues we should achieve the target of re-based HSMR at the National index of 100 in Month Oct 2012.	Y
Crude Number of Deaths	The number of deaths YTD: SaTH = 433 against a target of 399. This is 10 less than the same period last year	The LIPS programme is expected to start to positively impact crude death rates from end July 2011 at the earliest.	Y
VTE	Rollout of VTE on Vitalpac at RSH and PRH has been completed as planned. June figure reported Mid July was 60.21%. (3 recent snapshots at the end of June on vitalpac have indicated that VTE reporting on vitalpac has been over 70%. This represents a positive step change in VTE reporting. VTE is within trajectory to hit target by data for Sept 2011.	The trust target is now set for achieving 90% for data for the month of Sept 2011 (reported Nov 2011).	Y

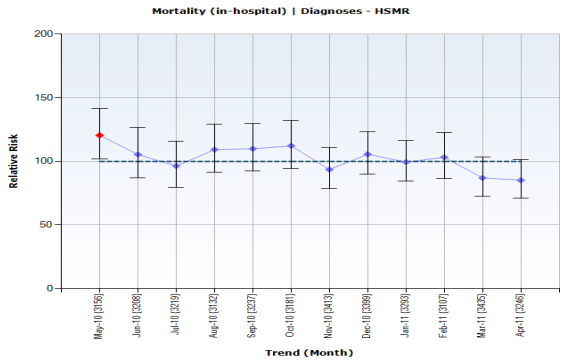
EXCEPTION REPORT

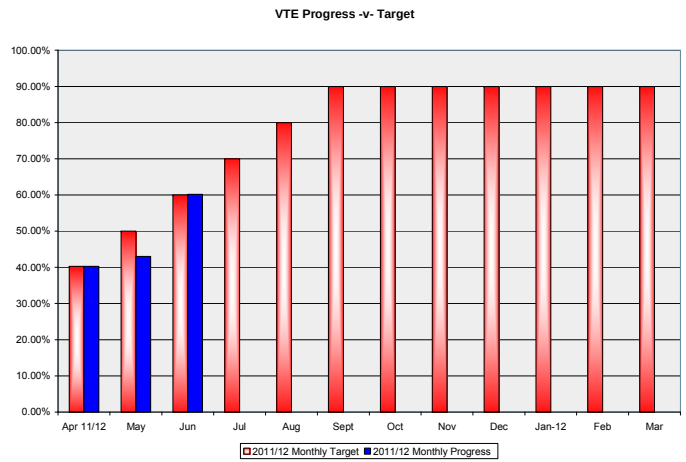
C4: Deliver services that offer safe, evidence-based practice

		Status Report			Directors Risk Assessment		
Executive Sponsor	Supporting Measure	Mth status	YTD status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Medical Director	HSMR + Crude Deaths + VTE	RED	RED		GREEN Oct 2012	3	

Position Analysis

Graph – SaTH HSMR Monthly Trend (not re-based) and Progress against target – VTE





Future Actions/Key Points

Crude Deaths – slight decrease of 10 against the same YTD last year. YTD Target = 399. Achieved = 433

This will not significantly decrease until LIPS improvements start to have an impact

HSMR – Continued downward trend with the 2nd month in a row below the National index.

2011/12 SaTH HSMR - 115

Last 12 months ending April 11 SaTH HSMR = 112.5. In month HSMR (April) = 96.0

Analysis of HSMR data has identified clinical opportunities which are included in the improvements within the LIPS programme. Additional opportunities for further improving coding have been identified and implemented at PRH.

Key point with the HSMR is that coding improvements are expected to deliver an HSMR of approx 108. Further reductions must come from clinical improvements and impact mortality before Nov 2011 for the current downward trend to continue.

VTE – June 2011 reported in mid July 2011 is at 60.21%

Target to achieve 90% has been set at data for the month of Sept 2011(reported in Nov). Initial indications based on snapshots of Vitalpac are that there has been a step change improvement in recording of VTE at over 70% on vitalpac. This is still a long way short of the 90% target.

There is a focus on the reporting of VTE to ensure that there are no gaps in hospital areas which would count against us and to enable the Trust to produce accurate league tables by Consultant/Specialty and Centre

C5. Meet regulatory Requirements and Healthcare Standards

Executive Sponsor	Headline Measure	Mth Status	YTD Status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Director of Compliance & Risk Management	Compliance Index	AMBER	AMBER	n/a	AMBER	3	

Supporting Measure	Current Performance	Forecast Performance	Exception Report
CQC quality and risk profile	The June Quality and Risk Profile shows in improving position in relation to three outcomes: meeting nutritional needs; safety and suitability of premises and safety; and availability and suitability of equipment. These have all improved from low neutral to high green (a one step improvement). However, the outcome of supporting staff has shown a deterioration from low amber to low red (a two step deterioration).	The poor performance is mainly due to the results of the annual staff survey but the details behind the indicator have not changed since May, (when the profile was showing low amber rather than low red) suggesting that the CQC's calculation for assessment of risk has changed. The next survey will take place in October 2011 with the results published in April/May 2012 so it is unlikely that the position will change in year	N
NHSLA compliance	The Trust is currently at level 2 of the NHSLA standards and Level 1 of the CNST maternity standards. Level 2 CNST assessment is on track and will take place in June 2012	The Trust will be reassessed against the NHSLA standards in December 2011 and it is anticipated that this will be a level 1 assessment as due to the changes in the Trust Committees it will not be possible to provide 12 months of evidence of implementation to support a level 2 assessment	N
IGT compliance – status of action plan	The Information Governance Toolkit Assessment was completed and submitted by the Trust by the 31 March 2011. The overall result for SaTH was 72%. The Trust attained level 2 or higher in the 22 key requirements and achieved level 2 in 43/45 requirements overall. However, the mandatory requirement is for all NHS organisations to achieve level 2 compliance in all 45 requirements otherwise a 'not satisfactory' score is awarded. All staff are required to undergo IG training by end June 2011. Compliance at June 23rd was 53%	The two requirements scored at level one were: 8-324 - Pseudonymised and/or anonymised data is used for all secondary purposes. 8-505 - This requirement is scored by using the results from a 'clinical coding audit'. This was carried out in early March and the results of accuracy did not meet the requirement to achieve a level 2. IG Training sessions being held in workplace. IG manager has trained over 1000 members of staff. E learning also available.	N
HSE – status of action plans	Work place Transport – HSE improvement notice lifted and action plan on target Management Audit – action plan will be submitted to HSE in line with timescale		N

C5. Meet regulatory Requirements and Healthcare Standards

Supporting Measure	Current Performance	Forecast Performance	Exception Report
FOI compliance – response times	Overall performance for last three months – 70% March - 86% (18/21) April - 50% (8/16) May - 72% (18/25)	Overdue responses are in the main only overdue by 1 or 2 days. Where there are long delays, this relates to the complexity of the request	N
Rule 43 responses – timeliness and status of action plans	One rule 43 letter within the quarter. The response was submitted within the timeframe. No action plan required as Trust had already taken all pertinent actions prior to the inquest		N
Monitor compliance	Currently reported in A3 and B9		N
Submission of national contract information	This supporting measure is currently being developed		

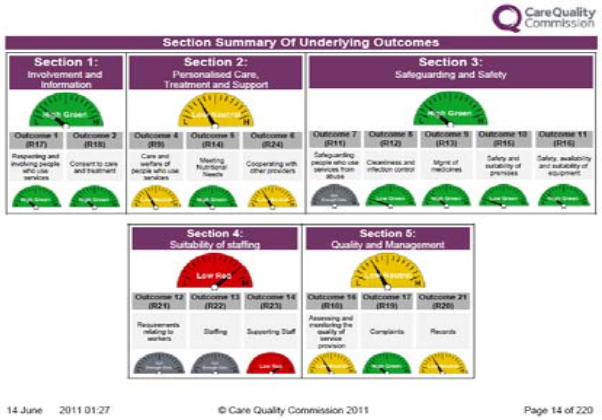
EXCEPTION REPORT

C5. Meet regulatory Requirements and Healthcare Standards

		Status Report			Directors Risk Assessment		
Executive Sponsor	Supporting Measure	Mth status	YTD status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Director of Compliance & Risk Management	CQC QRP FOI responses	AMBER	AMBER	n/a	AMBER	3	

Position Analysis

CQC QRP



FOI responses

Responses are delayed for two main reasons: poor responses sent back which then need further work before they can be sent out; and managers not taking responsibility for the queries that relate to their area

Future Actions

CQC QRP

Supporting staff – actions included in staff survey action plan and include participation in 'Listening into Action'

'Red' performance is linked to results of annual staff survey

FOI responses

They will be a named senior manager responsible for each FOI. Increasing granularity of performance data will be linked to increasing senior manager ownership of data relating to their area of responsibilty

C6. Ensure Our Patients Suffer No Avoidable Harm (1 of 2)

Executive Sponsor	Headline Measure	Mth Status	YTD Status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Director of Quality & Safety / Chief Nurse	Patient Care Index	RED	RED	=	AMBER Q3	3	Serious Incident Update paper to HEC and Trust Board

Supporting Measure	Current Performance	Forecast Performance	Exception Report
No. of Patient Safety Incidents	There have been 667 patient safety incidents identified in June 2011 which equates to a 6.1% reporting rate . This is within control limits: but SPC charting shows a statistically significant increase in reporting starting in April 2010.	The current rate of reporting datix incidents reflects an improvement within the 'reporting culture' of the organisation. Work is ongoing in relation to improving RCA's and action planning. Future work will include benchmarking to understand how the Trust compares to other Trusts.	N
No of Serious Incidents	There have been 16 SIs declared in June 2011. All of these incidents are being reviewed and RCA's will be completed in line with the agreed timescales.	In line with the SI policy, each case is being investigated fully with an RCA and Action Plan for Improvement. Action plans will be implemented following the completion of the RCAs with a process for tracking through the agreed improvements. In addition themes will be monitored and fully addressed.	Y
No. of inpatient Falls	There were 132 falls in June which is a reduction in 11 from May but up by 1 patient from this time last year. Of this number, 3 were RIDDOR Reportable . To date, the specific trend or themes emerging from the RCA on these falls is the number of times an in patient is moved between wards.	The High Impact Actions Group continue to focus on improvements to ensure that effective assessment and preventative measures continue. Although a slight increase this month there remains confidence the Trust will achieve its 5% improvement .	N
No. of grade 3 /4 Pressure Sores	There was 1 Trust acquired pressure ulcer reported for June	This is the second month we have reported less than 2 ulcers in the month. This remains encouraging indication of us achieving the 10% reduction target	N
No. of HCAIs	In June there were zero MRSA bacteraemia, 12 C Diff cases of which 3 are apportioned to SaTH. There were also 6 MSSA bacteraemia of which 3 were post 48 hours. We also had 20 EColi bacteraemia of which 1 was post 48, but 3 were probably acquired in SaTH.	The Trust is now green again with regard to C difficile as we are just within our trajectory at 13 cases year to date (trajectory 13.5 cases). At this point last year we had had 22 cases but our target is very challenging this year. In June we started collecting risk factor data for the national database on E coli bacteraemia including probably point of acquisition.	N

C6. Ensure Our Patients Suffer No Avoidable Harm (2 of 2)

Supporting Measure	Current Performance	Forecast Performance	Exception Report
Breaches in Same Sex Accommodation	There were no breaches in June	Despite on going operational pressures with capacity there were no breaches and we remain confident that we will sustain improvement s	N
Cleanliness Score	Overall Domestic Cleanliness Monitoring scores for June were as follows: PRH: 92.98% RSH: 94.57% SATH: 93.78% The target is to maintain a cleanliness score of 92% across the Trust	On-going staff shortages are impacting on quality standards on both sites. Short listing for vacancies in progress. Supervisors continue to monitor standards and support Domestic Staff during periods of staff shortages. Recruitment to Bank staff on-going	N
No of Complaints	For the first time this year the third month of 2011/12 saw an increase in complaints, not only compared to the previous month but also compared to the previous year. There were 67 new complaints compared to 52 in 2010/11. Of the 67 complaints in June 38 related to clinical concerns and 13 related to access times. 10 related to poor communication.	There was 68 new complaints last year for July and it is hoped that there will be a reduction in complaints for the next month.	N
No of Drug Errors Resulting in Harm	There were 51 medication errors reported in Datix, 3 of which resulted in short term harm to the patient. This is a reduction of 19 incidents to the previous month.	There have been no serious incidents or never events reported for drug administration in June 2011.	N

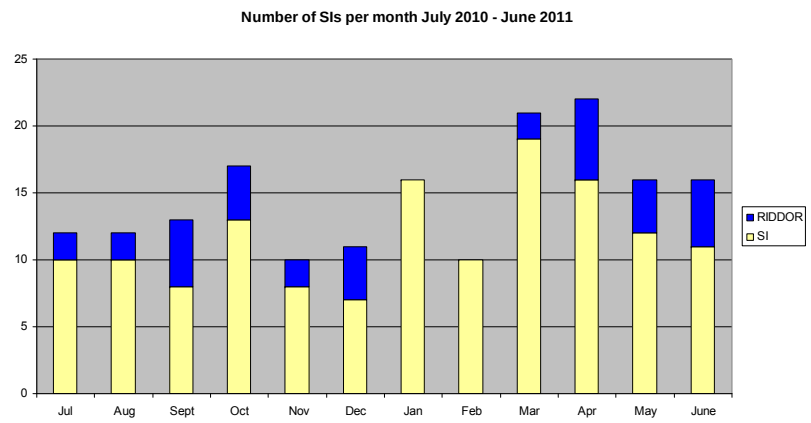
EXCEPTION REPORT

C6: Ensure that our patients suffer no avoidable harm – Serious Incidents and Drug Errors

		Status Report			Directors Risk Assessment		
Executive Sponsor	Supporting Measure	Mth status	YTD status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Director of Quality and Safety	No. of Serious Incidents	RED	RED		AMBER Q3	3	Serious Incident Update paper to HEC and Trust Board

Position Analysis

Serious Incidents



The 16 SIs in June related to:

5 Falls

5 Missed / delayed opportunity for treatment (including 2 delayed outpatient appointments)

1 Confidential information leak

1 Neonatal admission to NNU

1 Pressure ulcer

1 unexpected death

1 ward closure

1 infection control issue

Future Actions

Serious Incidents

Leading Improvements In Patient Safety (LIPS) will work on projects to improve reliability in healthcare and improve safety.

The key actions re tracking of outcomes include
interim support to lead:

1. Formal Panel Reviews
2. Development of a tracking outcomes process
3. Lead the development of identifying trends and themes

All Serious Incidents have a full root cause analysis and action plan in place and there are falls and pressure sore workstreams with action plans to reduce these incidents