Enclosure 5

Report to:	Trust Board – 31st January 2013

Title	Integrated Performance Report
Sponsoring Executive Director	Peter Herring – Chief Executive
Author(s)	Peter Herring – Chief Executive
Purpose	To inform the Trust Board of performance against Key Performance Indicators in the Trust.
Previously considered by	Not applicable

Executive Summary
This report summarises the Trust's performance against all the key quality, finance, compliance, and workforce targets and indicators for 2012-13 and considers all elements of the Provider Management Regime. An additional section that benchmarks Trust performance with national averages is included.

Related SATH Objectives	SATH Sub-Objectives
A – Financial Strength B – Patients and Commissioner C – Quality and Safety	The report covers a range of organisational sub-objectives in the three strategic domains.

Risk and Assurance Issues (including resilience risks)	Ensuring that we develop robust measures to assess strategic performance will minimise the risk associated with the delivery of our strategies and provide a warning system for the Trust Board where further attention is required.
Equality and Diversity Issues	None
Legal and Regulatory Issues	The national standards, CQC and local contractual requirements will form part of the performance framework.

Action required by the Trust Board
The Trust Board is asked to CONSIDER performance for December 2012

Trust Board
Integrated Performance Report – December 2012

1 Overview of performance

1.1 This Integrated Performance report provides an overview of key quality, operational, financial and workforce performance indicators from which the Board can review any variances to the required performance and identify the actions being pursued to ensure ongoing improvements.

Additional information is attached as Appendix B from the NHS Midlands and East Quality Dashboard which shows Trust performance against national means in respect of a range of indicators. Please note that this is taken from the Autumn dashboard and does not reflect current levels of performance.

2 Regulatory requirements

2.1 The Care Quality Commission provide a regulatory overview of all the required outcome measures with which we are registered.

As an outcome to visits to the Trust and the information provided to the Care Quality Commission during 2012/13, the Trust Board are receiving 3 positive reports in today's meeting which will provide assurance to the Board and to the Public and lifts a previous minor concern placed on the RSH which was reported in 2011/12.

Regulatory notices	CQC Conditions or Warning Notices	Green	Q1 Green	Q2 Green	Dec 13 Green	Q3 Green

3 Quality

3.1 The following High level Metrics provides an overview of patient safety, effectiveness and Patient Experience. The report then contains any key information relating to clinical care metrics where performance is not meeting the required standard or particularly good practice noted.

Measure		Standard	Q1	Q2	Dec '12	Q3	YTD	Yr End
Patient safety & Effectiveness	HSMR - All Diagnoses	<100%	95.7	95.2	93%	93%		
	RIDDOR reportable Falls	< 20	3	2	2	11	16	19
	Grade 3 & 4 Pressure Ulcers	< 22	8	12	7	12	32	38
	C-Diff	45	9	8	7	15	32	44
	MRSA Bacteraemias	2	1	0	0	0	1	1
	MSSA Bacteraemia	28	7	5	1	4	16	21
	E-Coli	65	11	18	3	9	38	49
	Elective MRSA Screening	95%	90.03%	92.1%	95.5%	95.54%	92.5%	95%
	Non Elective MRSA Screening	95%	96.8%	95.69%	90.6%	92.56%	95.1%	95%

	Number of Serious Incidents	<36 per Quarter	38	30	23	51	119	149
	Never Events	0	2	1	0	0	3	3
	WHO Surgical Checklist	100%	100.00%	100%	99.60%	99.86%	99.86 %	100%
	VTE Assessment	90%	90.97%	90.41%	90.83%	90.0%	90%	90%
	Maternity Dashboard	Green	Green	Green	Green	Green		
Patient experience	Number of patient complaints	actual	173	165	41	146	484	
	Access to Healthcare for people with LD	Yes	No	Yes	Yes	N/A		
	Same Sex Accommodation Breaches	0	0	0	0	0		

Patient Safety and Effectiveness

3.2 A summary of patient outcome measures taken across all ward areas has been outlined in Table 4 for information. Key points for the Boards attention are as follows:

RIDDOR reportable Falls

3.3 In 2011/12 there were 30 RIDDOR reportable falls and a priority for 2012/13 within the Trust was to ensure a reduction in the overall falls through implementation of effective risk assessments and clear plans of care and support to vulnerable patients. Improvements have been made in year to both the falls policy and risk assessment documentation.

There has been a month on month reduction in falls overall and to date whilst Quarter 3 is flagged red due to the increase of RIDDOR reportable falls compared to the previous 2 Quarters, the year to date trajectory is in line to achieve a decrease in both RIDDOR reportable falls as well as an overall reduction in falls incidence.

The Trust undertakes detailed root cause analysis on each and every RIDDOR reportable Serious Incident and has implemented the actions arising from those cases and the Trust Falls group continue to monitor these incidents of harm very closely. The Trust point prevalence survey (safety thermometer) demonstrates a positive performance against the SHA collective data.

Grade 3 or 4 pressure ulcers

3.4 The revised metrics for Quality Indicators in this report provides the actual number of grade 3 and 4 pressure ulcers.

- Quarter 3 and particularly December's performance on the number of pressure ulcers is of concern. However, five of the seven pressure ulcers sustained whilst an inpatient are currently being evaluated against the documentation / medical records and may meet the "national unavoidable" criteria. The Board will be updated on the final confirmed figures in next months report.

- The latest published Safety Thermometer identifies that the Trust is (below the regional point prevalence survey) demonstrating that whilst significant reductions are required, the incidence of pressure ulcers is below the collective % performance. With the agreed aim to see month on month reduction to achieve the

eradication of grade 3&4 ulcers by the end of December (grade 4) and end of March (grade 3), the target for the dashboard has been based on a 33% reduction per quarter.

- Whilst the metrics provides the actual number of reported pressure ulcers in each Quarter, this is readjusted in the Year to date figure once pressure ulcers which are unavoidable are agreed/ validated with Commissioners (2 pressure ulcers from Quarter 1 were classified as unavoidable, which brings the year to date figure to 32.

- To date the validated figures of unavoidable pressure ulcers is 2

3.5 The Board will note the improvement target established in 2012/13 was to eliminate grade 4 pressure ulcers from the end of December 2012 and grade 3 pressure ulcers from the end of March 2013. To support this improvement a range of actions are in place to ensure all previous gaps in care are addressed and a root cause analysis is undertaken on each grade 3&4 pressure ulcer. This RCA is then reviewed formally by the Chief Nurse or Deputy Chief Nurse with the Ward manager and Matron. This review demonstrates in most cases the complexity of the patients' who have sustained a pressure ulcer whilst in our care and the improving practice and documentation which has developed in the last year, which enables the Trust to identify those which meet the unavoidable criteria. There are however, still cases where improvements clearly need to be consistently applied, including the timeliness of initial assessments and a clear care plan in place for ongoing interventions to support improvements in a patient's skin condition.

3.6 There are specific surgical and medical ward areas where an increase in pressure ulcers have been noted and these ward areas have agreed a programme of improvements, staff training/ initiatives and a quality improvement framework placed on one ward to ensure improvements are made. Ward managers and Matrons are actively engaged with the work programme to eliminate grade 3 &4 pressure ulcers and the reporting culture for grade 2 pressure ulcers being positive as seen in Quarter 3 with clear actions being taken to avoid deterioration to grade 3&4 being demonstrated.

C-Difficile and Infection Control synopsis

3.7 There were 7 new cases in December which is above trajectory for this month. No wards had more than one case. The methodology for screening Clostridium difficile (C-diff) changed at the end of 2011/12 and the Health Protection agency have seen a national increase in reporting of 40% with the Trust seeing a third more cases. The Infection prevention Control Committee have considered the increase in cases for December and consider that the considerable cases of Norovirus screened in December have led to the increase in month for C-diff.

3.8 One of the Serious Incidents include in the metrics figures, included the closure of ward 15 to admissions due to Norovirus in December. In total 16 wards were affected, with 22 Bay closures. In total 92 patients were affected with 20 confirmed cases of norovirus. The IPCC committee praised staff and the Infection Control team for the effective management of these cases to prevent further impact on the Trust.

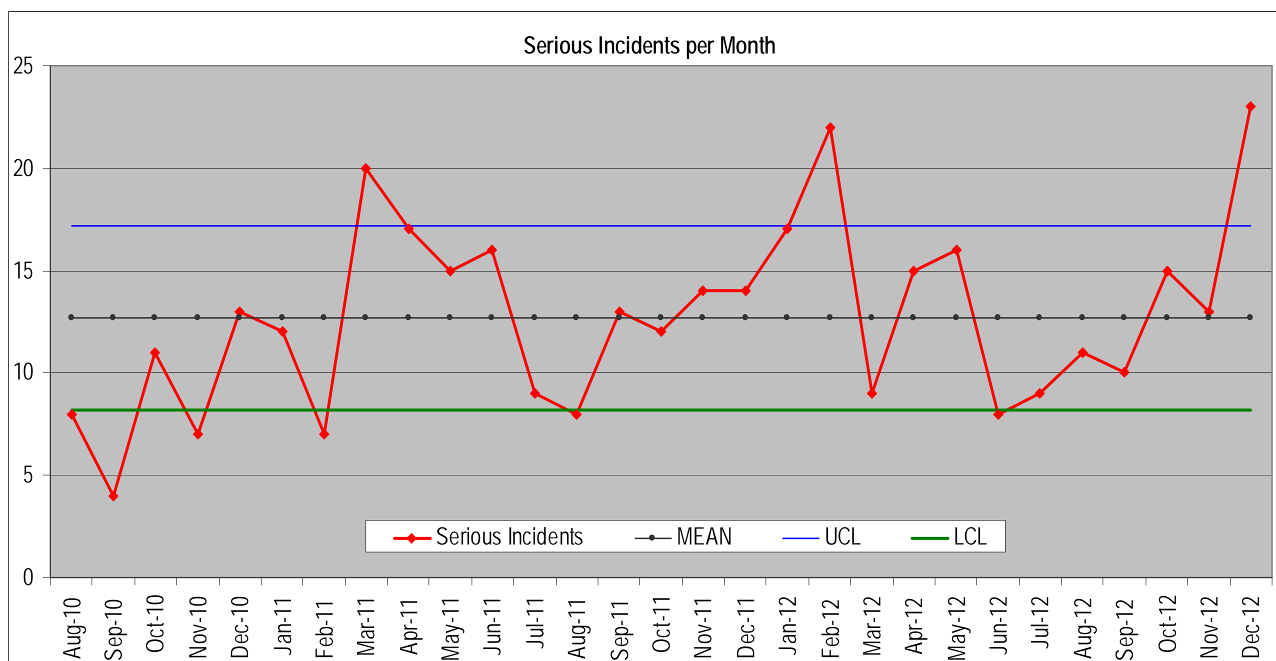
3.9 MRSA screening for Emergency cases fell below the target in December due to the Surgical assessment unit and the Acute medical unit missing a high number of patients who required screening. This has been discussed with the teams and screening closely monitored each week to ensure the required number

Serious Untoward Incidents

3.10 The Board in 2010/11 had established a RAG rating of red if there were more than 8 Serious Incidents (SI) in any given month. On an ongoing basis since 2011, the SI rates reported have breached this. It is important to note that in 2011/12 that 25 additional criteria were added to the national list of SI's which has led to an increase of reportable cases. To support Board analysis, the metrics now identifies the trigger level of SI's at 12 per month picking up the mean figure provided in table1.

3.11 In December 2012 a significant number of SI's were reported across a range of issues which for confidentiality reasons are covered under the High risk report in the private session. Within these SI numbers the Board need to note that this includes the 7 pressure ulcers and 2 RIDDOR reportable falls recorded in separate sections of the metrics.

Table 1



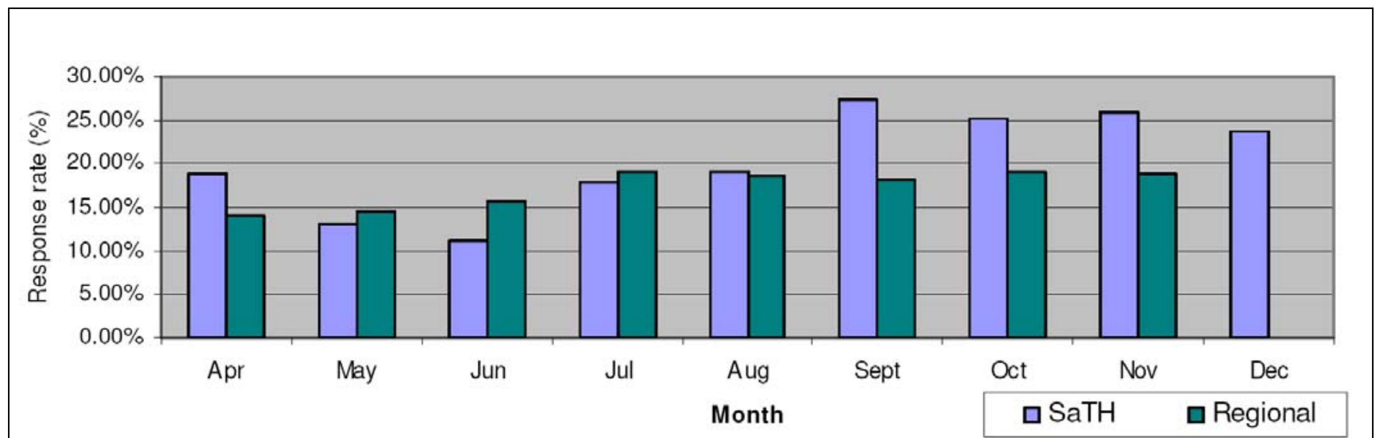
WHO surgical checklist

3.12 The score on the metrics for December is the outcome of 1 emergency case where the team did not undertake the pre-team briefing prior to surgery. All other elements and stages of the checks with that case were undertaken. All other audits demonstrate 100% compliance. The surgical team involved with the emergency case will now undertake an audit of all emergency cases to ensure the full range of checks are embedded into practice. The Director of Quality and Safety will work with the scheduled value stream lead to also undertake a wider emergency case audit.

Complaints

3.13 The complaints RAG rating is based on actual figures with comparison to last years data. The table below shows the Family and Friend test outcomes demonstrating positive improvements in patient feedback. The ward to Board patient metrics in table 5 outlines positive improvements in the overall score demonstrating improvements in patient experience.

Table 2



CQUIN Measures (Code - Shaded = Nationally Mandated; Border = Regionally Mandated)

3.14 A national driver to improve Quality has been established through our Contracts established with our commissioners. Table 3 sets out a summary of the initiatives and a current status against those quality improvements.

Table 3

Quality Improvement Indicator	Q1 Actual	Q2 Actual	Q3 Actual	Q 4 forecast	Quality improvement achieved
Indicator 1 Percentage of adult inpatients assessed for the risk of VTE - based on national guidance (NICE)					Performance has continued to remain above the required level, however there are opportunities for further improvement which will be mandated for 13/14. A small decrease towards the end of Q3 has led to an amber forecast for the highest emergency activity quarter
Indicator 2 Improve responsiveness to personal needs of patients					As this CQUIN is based on the annual national CQC inpatient survey, it can be difficult to reliably predict the performance in this area. Much work has been undertaken to replicate some of the data collection from the survey to enable a temperature gauge and improvement actions to be taken. This work to date has given some confidence in improved performance.
Indicator number 3 Patient Safety Thermometer					The safety thermometer data has been collected by the Trust since the first pilot in February 2012 and reported from April as required. Data is reported through the Quality and Safety report to Q&S committee and Commissioning Quality Review
Indicator number 4 ,5 & 6 Dementia – Identifying a screening tool, use of the screening questionnaire and referral to specialist					Work has been undertaken to find a solution to the requirement for all patients who meet the criteria to be screened after admission. This solution has been implemented in Q4 but may take some time to become embedded and achieve full compliance
Indicator number 7, 9 &10 Meds Mgt – improving information for patients and identifying risks on patients admission and discharge					These improvements required changes to eScript to enable better information to be provided on discharge which have been made for Q4. These changes may not become embedded in practice before the end of the quarter

Indicator					Comments
Indicator number 11 - 13 Nutrition – patient assessments and protected mealtimes/red tray system supporting patients with assistance where required	**No data rqd**		**No data rqd**		Baseline audit data for nutritional assessments/red tray and protected meal times was very good (90%+)which makes improvement more challenging to achieve in Q4.
Indicator number 14 - 16 Pressure Ulcers (assessments, intervention, education and eradication of grade 3&4 by end March					Improvements in assurance have been seen in assessment and intervention, however grade 3 and 4 pressure ulcers continue to occur. Good compliance seen with workbook completion by ward staff.
Indicator number 18 Net Promoter Question					A steady increase in score has been seen since commencement in April, however this must be sustained throughout Q4
Indicator number 19 Maternity – Baby Friendly Initiative					Improvements in breast feeding services by ensuring that sufficient training is provided and attended to achieve accreditation. W&C centre has demonstrated good compliance with training.
Indicator number 20 -22 MECC – Board commitment, train 80% of agreed staff groups and increase referrals		**No data rqd**	**No data rqd**		The required increase in referrals for the year was seen in Q1, however training is an ongoing issue due to the number of staff and mode of training
Indicator number 23 VTE prophylaxis Percentage of patients on appropriate prophylactic agent according to NICE guidance					Percentage of patients on appropriate prophylactic agent with an increasing compliance trajectory each quarter. Q4 requires 90% compliance

Table 4: Ward to Board Patient Metrics for April 2012 – December 2012

	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012
Medication Storage and Administration	97%	98%	99%	96%	97%	96%	97%	99%	98%
Infection Control and Privacy & Dignity	91%	95%	96%	94%	94%	93%	93%	96%	95%
Patient Observations	84%	83%	87%	85%	86%	90%	86%	95%	90%
Pain Management	84%	87%	91%	91%	92%	88%	90%	93%	92%
Tissue Viability	91%	90%	89%	87%	91%	91%	94%	95%	96%
Nutrition	91%	92%	91%	90%	90%	95%	94%	95%	92%
Fluid Management	85%	87%	82%	85%	80%	90%	93%	90%	85%
Falls assessment	98%	96%	98%	97%	98%	96%	98%	99%	98%
Continence	97%	93%	88%	93%	93%	97%	97%	98%	95%
Comfort Rounds				83%	92%	90%	94%	93%	93%
Total	**91%**	**92%**	**92%**	**91%**	**92%**	**92%**	**94%**	**95%**	**94%**

Table 5: Ward to Board Patient Experience Metrics for April 2012 – December 2012

	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012
How clean is this ward (including toilets)?	95%	95%	95%	95%	96%	96%	96%	97%	97%
As far as you know do the staffs wash or clean their hands between touching patients?	95%	92%	95%	94%	96%	96%	96%	97%	96%
Do you feel informed about potential medication side effects?	46%	57%	65%	65%	72%	64%	72%	83%	76%
Do you feel you have enough privacy when discussing your condition or treatment with staff?	88%	89%	85%	83%	86%	85%	86%	91%	91%
Do you feel that you have been treated with respect and dignity while you are on this ward?	91%	95%	98%	93%	95%	94%	95%	96%	97%
Do you feel involved in decisions about your treatment and care?	80%	83%	77%	78%	77%	79%	84%	89%	86%
Have hospital staff been available to talk about any worries or concerns you have?	82%	92%	90%	90%	86%	91%	93%	93%	90%
Do you get enough help from staff to eat your meals?	92%	90%	98%	87%	90%	95%	98%	95%	92%
Whilst you have been on this ward have you ever shared a sleeping area with a member of the opposite sex?	100%	96%	98%	99%	99%	97%	97%	98%	99%
Do you think hospital staff do everything they can to help control your pain?	89%	93%	89%	90%	89%	87%	93%	95%	92%
When you use the call buzzer is it answered?	88%	93%	89%	87%	90%	90%	87%	91%	90%
Have staff talked to you about your discharge from hospital?	64%	74%	63%	65%	68%	68%	64%	71%	72%
Total	**83%**	**87%**	**86%**	**86%**	**87%**	**86%**	**88%**	**91%**	**90%**

4 Operational performance

Emergency Access Target – progress report

4.1 The Trust failed to achieve the 95% target in December 2012 with 90.36% for the month, giving 90.41% for Quarter 3, and a year to date position of 92.14%.

Factors affecting performance are:

- **an increase in the number of ED attendances**
- **an increase in the number of non-elective admissions**
- **an increase in the number of patients who are delayed transfers of care and fit to transfer**
- **a mismatch in demand versus available beds.**

Bed modelling has identified a significant gap in bed capacity associated with these factors and a supporting presentation will be provided to the Board to illustrate the impact of this on our inability to consistently deliver this target.

4.2 A whole health economy remedial action plan to deliver 95% has been agreed with commissioners and is included as ***appendix A.*** This improvement plan was developed following the release of Winter monies to the health and social care economy on the premise that 95% was achieved on a weekly basis from 27th January 2013. This target is challenging given the underlying mismatch between demand and availability of beds.

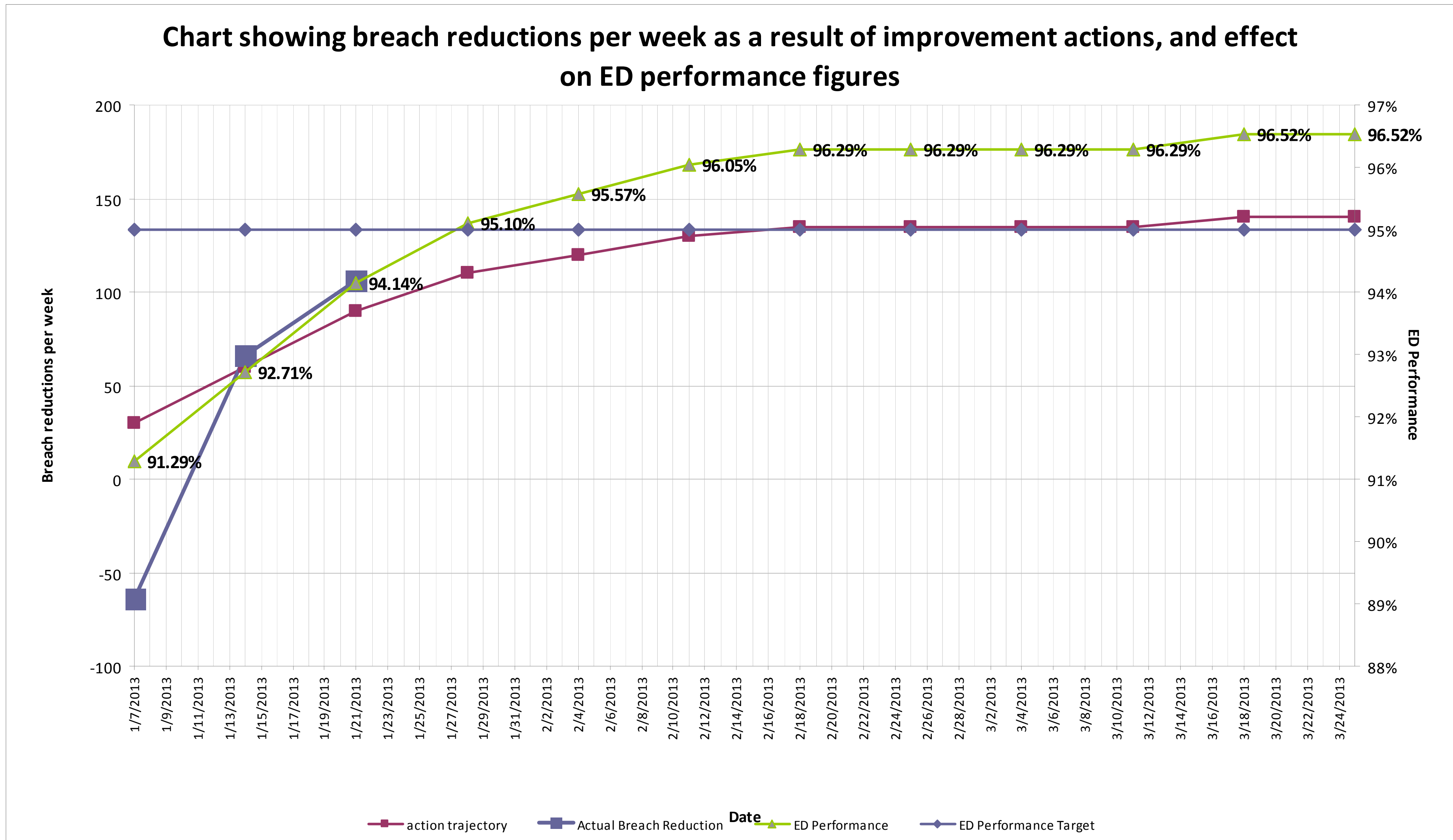
4.3 It is imperative that the whole health economy plan delivers the expected outcomes otherwise the Trust will not achieve the target through its actions alone.

The Trust received £201K of additional funding for the following initiatives:

- Additional ED Consultant capacity
- ED nurse co-ordinators
- Additional Junior Drs across all SaTH departments
- Conversion of ‘Hospital at Night’ arrangements into daytime weekend hours
- Additional site manager capacity
- Additional Porters
- Additional admin support for ED
- Additional discharge liaison nurse capacity
- Discharge trackers

The following page shows the trajectory to deliver 95% by 27th January 2013.

Trajectory for the delivery 95% by 27th January 2013



4.4 Whilst the target was missed for December 2012 there are signs that performance is improving as can be seen from the weekly performance figures from December through to week ending 20th January 2013.

Week Ending	Total Attendances	>4hrs	% Performance
02/12/2012	2004	219	89.07
09/12/2012	2031	139	93.16
16/12/2012	2033	303	85.10
23/12/2012	2107	211	89.99
30/12/2012	1837	119	93.52
06/01/2013	2002	267	86.66
13/01/2013	1875	147	92.16
20/01/2013	1862	107	94.25

4.5 From 7th – 20th January 2013 the Trust has achieved 95% daily on numerous occasions on one or occasionally both sites as can be seen from the tables below, and Trust performance at the end of last week was just below the target at 94.25%, however, given the bed capacity deficit, small variations in any of the factors means the Trust's ability to consistently deliver remains fragile.

A&E Performance week ending 13th January 2013

Period Ending	Day of Week	Shrewsbury & Telford Hospital NHS Trust			The Princess Royal Hospital			The Royal Shrewsbury Hospital			ARC RSH		
		Total	>4hrs	%	Total	>4hrs	%	Total	>4hrs	%	Total	>4hrs	%
07/01/2013	Monday	278	22	92.09%	142	6	95.77%	105	16	84.76%	31	0	100.00%
08/01/2013	Tuesday	298	31	89.60%	142	5	96.48%	121	26	78.51%	35	0	100.00%
09/01/2013	Wednesday	236	23	90.25%	121	3	97.52%	81	20	75.31%	34	0	100.00%
10/01/2013	Thursday	280	21	92.50%	149	17	88.59%	96	4	95.83%	35	0	100.00%
11/01/2013	Friday	275	14	94.91%	127	1	99.21%	117	13	88.89%	31	0	100.00%
12/01/2013	Saturday	235	16	93.19%	117	4	96.58%	103	12	88.35%	15	0	100.00%
13/01/2013	Sunday	273	20	92.67%	141	4	97.16%	118	16	86.44%	14	0	100.00%
WE 13.1.13		**1875**	**147**	**92.16%**	**939**	**40**	**95.74%**	**741**	**107**	**85.56%**	**195**	**0**	**100.00%**

A&E Performance week ending 20th January 2013

Period Ending	Day of Week	Shrewsbury & Telford Hospital NHS Trust			The Princess Royal Hospital			The Royal Shrewsbury Hospital			ARC RSH		
		Total	>4hrs	%	Total	>4hrs	%	Total	>4hrs	%	Total	>4hrs	%
14/01/2013	Monday	276	18	93.48%	139	7	94.96%	108	11	89.81%	29	0	100.00%
15/01/2013	Tuesday	310	28	90.97%	152	7	95.39%	124	21	83.06%	34	0	100.00%
16/01/2013	Wednesday	283	23	91.87%	145	6	95.86%	109	17	84.40%	29	0	100.00%
17/01/2013	Thursday	256	9	96.48%	121	4	96.69%	107	5	95.33%	28	0	100.00%
18/01/2013	Friday	214	19	91.12%	89	6	93.26%	94	13	86.17%	31	0	100.00%
19/01/2013	Saturday	254	7	97.24%	126	1	99.21%	114	6	94.74%	14	0	100.00%
20/01/2013	Sunday	269	3	98.88%	131	0	100.00%	127	3	97.64%	11	0	100.00%
W/E 20.1.13		1862	107	94.25%	903	31	96.57%	783	76	90.29%	176	0	100.00%

4.6 The Local Area Team has requested a sustainable action plan from the Trust for consistent delivery against the 4 hour operational performance standard for 2013-14. This is currently being developed but at this early stage it is apparent that investment will be needed in both staff and infrastructure. This will be presented to the Board in February.

18 weeks Referral to Treatment Target (RTT) - Admitted

4.7 The Trust failed the RTT for Admitted patients with 81.21% against the 90% target in December.

- The non achievement of the target was due to the ongoing work to reduce the numbers of patients on an admitted pathway that have been waiting longer than 18 weeks in the specialties of Ophthalmology and Orthopaedics. Obviously by reducing the number of patients treated who have waited 18 weeks impacts upon the performance for those specialties and the Trust as a whole.

- The programme of work to reduce the number of patients waiting over 18 weeks continues in all specialties with particular focus upon ophthalmology and orthopaedics. The Trust has agreed with Commissioners a timescale of the end of March to be compliant across all specialties and at Trust level.

18 weeks Referral to Treatment Target (RTT) – Admitted

4.8 The Trust failed the RTT for Non Admitted patients with 88.66 % against the 95% target in December. The non achievement of the target was due to a combination of the following reasons:

- A number of medical specialties failed to achieve the target which meant it was not possible to achieve the Trust overall target. The particular specialties in question are:

  - Neurology where there has been a high number of patients waiting over 18 weeks over the last three months that has been reducing but not yet to a point where they are 18 week compliant.
  - Respiratory medicine where there has been an increased number of patients waiting for review of test results.
  - Cardiology where increased demand and a reduction in clinical capacity due to sickness absence has increased the numbers of patients waiting over 18 weeks
  - Dermatology where an increase in referral demand which has not been matched by clinical capacity due significant absence and vacancy levels.

- Ophthalmology remains a specialty with a significant number of patients waiting over 18 weeks. The number has reduced over the course of the last 3 months but is still not yet in a position to be 18 week compliant.

- The medicine centre has put in place clinical capacity in cardiology and respiratory medicine to reduce the numbers of patients waiting for review of test results at the end of January.

- In Dermatology changes to administrative processes to ensure referral review and patient booking times are reduced have been put in place, however, the reduction in available clinical capacity remains a significant risk. Capacity is being sought from a partner organisation in order to continue to reduce the waiting times.

- Increased capacity for ophthalmology has been put in place through the appointment of locums to accelerate the clearance of the numbers of patients waiting over 18

weeks. At present, however, this is unlikely to achieve the target for the specialty until the end of February as the specialty has seen a significant level of sick leave within the medical staffing complement.

Cancer

4.9 The Trust achieved the necessary performance for 10 of the 12 target areas in December. The two areas where the target was not achieved were:

- To receive treatment within 31 Days of diagnosis – Achieved 94.9% against the standard of 96%
- To receive surgical cancer treatment within 31 Days of diagnosis – Achieved 92% against the standard of 94%

The Trust continues to achieve within all the standards for the year to date period.

Cancelled Operations

4.10 There were 149 cancelled operations in December, 41 of which were for medical reasons and 108 for non medical reasons. The cancellation for non-medical reasons represent an increase on the previous months and reflects the additional pressures placed upon our hospitals as a result of the numbers of emergency admissions.

30 of the 108 patients (28%) cancelled for non-medical reasons were not readmitted in December within the mandated 28 days or could be offered an alternative provider.

- The reduction of cancelled operations is wholly dependant on delivery of the recovery plan for the improvement in patient flow.

- Work continues to ensure patients are re-admitted with 28 days of the cancellation, an action plan has been agreed with each centre to track and escalate individual cases where re-admission is proving challenging.

5 Trust wide Finance Performance

Month 9 – December 2012

	Measure	Standard	Quarterly Method	2012/13 Q1	2012/13 Q2	2012/13 Q3	Data Period	Period Actual	YTD	Forecast Next Month
Finance	PMR Finance Risk Rating	4	Q YTD	2	2	2	Dec-12	2	2	
	EBITDA Achieved	85%	Q YTD	84.20%	88%	98%	Dec-12	92%	98%	
	EBITDA Margin	5%	Q YTD	2.8%	4%	4.7%	Dec-12	4.9%	4.7%	
	I&E Surplus Margin	1%	Q YTD	-1.90%	-0.50%	0.00%	Dec-12	0.0%	0.00%	
	Return on Assets	5%	Q YTD	0.03%	1.20%	2.60%	Dec-12	3.6%	2.60%	
	Liquidity ratio	15 days	Q YTD	13.5	14.4	1290%	Dec-12	12.9%	1290%	
	Total Income (actual v plan)	0.5% of plan	Q YTD	99.6%	99.6%	99.90%	Dec-12	99.7%	99.90%	
	Pay Expenditure (actual v plan)	At or below plan	Q YTD	101%	102.40%	99.90%	Dec-12	101.0%	99.90%	
	Non Pay Expenditure (actual v plan)	At or below plan	Q YTD	98.04%	95.20%	100.3%	Dec-12	98%	100.30%	
	CIP (actual v plan)	At or below plan	Q YTD	100%	74%	98.00%	Dec-12	98%	98.00%	
	Capital Expenditure (actual v plan)	At or below plan	Q YTD	13%	38%	59.00%	Dec-12	125%	59.00%	

Income and Expenditure Position

5.1 The Income and Expenditure position of the Trust is presented in the table below:

	Months 1-9 Budget £000s	Month 1- 9 Actual £000s	Variance £000s	Planned Forecast Outturn £000s	Forecast Outturn £000s	Variance £000s
Income	221,920	221,750	(170)	298,287	297,602	(685)
Expenditure						
Pay	(151,575)	(151,408)	167	(202,042)	(202,409)	(367)
Non Pay	(64,461)	(64,667)	(206)	(86,493)	(86,567)	(74)
Reserves	623	618	(7)	1,215	1,508	293
Finance Cost	(10,475)	(10,510)	(35)	(13,967)	(14,005)	(35)
Total Expenditure	(225,888)	(225,967)	(79)	(301,287)	(301,470)	(183)
Under / Over spend	(3,968)	(4,216)	(249)	(3,000)	(3,868)	-
Transitional support	4,264	4,264	-	4,900	4,900	-
	296	48	(248)	1,900	1,032	(868)

As can be seen from the above at the end of December the Trust had recorded a cumulative surplus amounting to £48,000. The Trust had planned to record a cumulative surplus at the end of December amounting to £296,000. The Trust is presently assuming a forecast Outturn surplus at the year end amounting to £1.032 million.

Income

5.2 At the end of December the Trust had recorded an under recovery of Income as compared with the revised Income budgets approved in October of £170,000. At the year end the Trust is forecasting to under achieve against Income Targets by £685,000.

In order to achieve the Forecast Income levels by the year end, the level of Income delivered will need to exceed average levels recorded in the period April to December by £2.066 million. This is expected and is consistent with the pattern of Income generated over the previous three financial years.

Expenditure

5.3 **Pay Spending**

- Pay spending in the month of December amounted to £16.952 million and is £162,000 above the planned level for the month.
- In October three Clinical Centres approved Pay spending considerably in excess of their revised budget, these being Medicine, Emergency and Critical Care and Surgery.
- During the month the level of spending in respect of Agency costs increased in respect of Nursing staff to £472,000. In the quarter June to September the average level of Agency spend for Nursing staff amounted to £185,000 per month.
- In forecasting an outturn for the year, it has been assumed that Pay spending will amount to £17.0 million per month. In the year to date the average level of monthly Pay spend amounts to £16.823 million.
- At the year end the Trust will have overspent against the revised budgets by £367,000.

5.4 **Non Pay**

- In the month of December the Trust underspent by £163,000.
- The three month average spending covering the period October – December amounts to £7.318 million, in forecasting an outturn it is assumed that Non Pay will spend at the rate of £7.3 million per month throughout the period January – March.

Centre Financial performance

5.5 In order for the Trust to successfully achieve the Financial Target for the year and in doing so achieve a surplus of £1.9 million, it is critical for Budget Managers to contain spending within the revised budget levels as approved at the Trust Board in October. The table below provides a description of performance as at the end of December.

Centre	Pay (Under) / Overspend £000's	Non Pay (Under) / Overspend £000's	Total (Under) / Overspend £000's	
Diagnostics	-94	-140	-234	Green
Ophthalmology	-80	-41	-121	Green
Emergency and Critical Care	-104	125	21	Amber
Pharmacy	-11	26	15	Amber
Head and Neck	4	-18	-14	Green
Surgery	47	84	131	Red
Medicine	148	2	150	Red
Therapy	-13	5	-8	Green
MSK	-49	35	-14	Green
Women and Children	-94	79	-15	Green
Oncology	-5	22	17	Amber
Corporate services	-48	27	-13	Green
MARS / Reorganisation Payments	132		132	Red
Total overspend	-167	206	39	Red

Cost Improvement Programme

5.6 In determining the forecast Outturn for the 2012/13 year a comprehensive review of the status of schemes being taken forward in the year has been undertaken. The results of this review are presented in the table below.

Revised CIP Plan	Plan REC	NREC	In year TOTAL		Forecast Outturn Rec	In year	Status Rec
Medical Consultants	1000		1000		300	100	Amber
WLI Payments	1000		1000		1000	0	Green
Nursing	1100	-1100	0		0	0	Green
Bed Reductions	3500	-3500	0		0	0	Green
Theatres	1000	-500	500		1000	400	Amber
Admin and outpatients	1700	-1700	0		0	0	Green
Pathology reconfiguration	1300	-1300	0		500	0	Red
Allied Health Professionals	700	-700	0		0	0	Green
On Call Payments	1000	-500	500		200	0	Red
Estates and Corprate services	800	-400	400		800	400	Green
Temporary staff reduction	3828	-740	3088		0	0	Green
Temporary staff reduction - Medica	1212		1212		1212	1212	Green
Diagnostic tests	600	-600	0		0	0	Amber
Coding alterations	1000		1000		1000	491	Green
Procurement	2000	-1000	1000		2000	1000	Green
Centre identified Non Pay savings	1019		1019		1019	804	Green
VAT Changes - Locum Doctors		300	300		0	150	Amber
Reduce Non Pay to Month 10 leve	1325		1325		1325	1325	Green
Nuffield / Prof Fees Redn	700		700		700	700	Green
MARS Scheme	1200	-500	700		0	0	Green
Non Recurrent savings						1358	Green
Inflation Reserves					3694	4546	Green
Slippage 2011/12 CIP		-670	-670				
Total	25984	-12910	13074		14750	12486	
Revised CIP Level					25984	13074	
Variance					-11234	-588	

Significantly when compared with the position as presented within the month 7 finance report, the level of CIP achieved on a recurrent basis has reduced from £17.9 million to a revised level of £14.75 million. The further reduction has occurred because savings associated with:

- New working practices impacting upon Administration and Outpatients,
- A redefinition of services provided by Allied Health Professionals; and
- A reduction in costs as a consequence of greater control over the use of diagnostic tests have now been discounted.

Long Term Financial Position

5.7 The Trust is expecting to deliver recurrent Cost Improvement savings in the year of £14.75 million. The plan for the year was to put in place schemes delivering recurrent savings amounting to £25.98 million.

The effect of not achieving the level Cost Improvement savings, and also reversing the savings from bed closures implemented in the 2011/12 year results in the Trust carrying forward a recurrent deficit of £3.2 million into the 2013/14 financial year.

The effect of the recurrent deficit, negative tariff and Pay and Non Pay Inflationary is to create a £16 million deficit in the 2013/14 year. Achieving a 6 per Cost Improvement Programme in the year generates savings to offset the deficit amounting to £16.4 million.

Applying working assumptions as presented by Telford and Wrekin CCG in respect of demographic growth, general activity increases and Commissioner QIPP savings enables the Trust to record a surplus in the 2013/14 year of £2.3 million rising to £5.2 million by 2017/18.

	Recurrent Surplus /(deficit) £000s	Non Recurrent Surplus/ (deficit) £000s	Total Surplus /(deficit) £000s
2010/11	(14,400)	14,426	26
2011/12	200	(200)	-
2012/13	(3,300)	4,300	1,000
2013/14	1,600	700	2,300
2014/15	2,800		2,800
2015/16	3,800		3,800
2016/17	4,600		4,600
2017/18	5,200		5,200

Statement of Cashflow

5.8 The cash flow, as detailed below, demonstrates that significant pressure will continue to be felt over the coming months through the delay in making creditor payments (a net

positive movement within working capital). Further to the payment of the first PDC dividend payment made in September 2012, the second payment of £2,885k is due in March 2013. The following additional actions are being taken to mitigate the effects of the future dividend payment and the requirement to meet the Trust's EFL of £2,220m:

- Closer management of working capital positions to create a cash 'buffer'.
- Following previous cash receipts in respect of the financial support from Shropshire County PCT and Telford and Wrekin PCT, the final cash receipt of £530k from Shropshire County PCT was received in December and the remaining 50% (£950k) from Telford and Wrekin PCT will be received in January.
- The Trust is taking further action to slow-down the commitments of the capital expenditure programme.
- Trust in negotiations with PCTs regarding cash receipts in relation to overperformance.
- Continued monitoring of the rolling 13 week cash flow forecast and sensitised against any deviations in the forecast outturn position. Significant deviations will be reviewed with the Finance Director and appropriate cash management actions will take place.

Overall Financial Risks

5.9 The key risks to the financial performance of the Trust are:

- Contract Income – Need to close the gap between the Trust and local Commissioners in respect of the forecast Contract Income for the 2012/13 year.

- Penalties and CQUIN – Managing the consequences of financial penalties and non compliance with CQUIN schemes.

- Patient Flow – Ensuring that costs of delivering increased activity over the winter period are contained within revised budgeted levels. Doing so necessitates the achievement of improved Patient flow.

- Agency costs – Requirement to significantly reduce Agency costs through the recruitment of Nursing staff into vacant posts and also to improve sickness levels across the Trust.

- Clinical Centre overspending – Centres need to ensure that they are putting in place the corrective actions to ensure a balanced Pay/Non pay Centre position is achieved by year end.

6 Workforce

Measure	Standard	Q1	Q2	Dec 12	Q3	YTD
Appraisal Rate	80%	71.00%	72.00%	72%	73%	72%
Sickness absence rate	3.39%	4.33%	4.32%	5.4%	4.94%	4.50%

Appraisals

6.1 Appraisals continue at a consistent rate, through discussions with centres plans are in place to achieve 80% by April 2013. Medical Appraisals are continuing to see an upward trajectory which is encouraging.

Sickness

6.2 Sickness rates increased in December, an increase is not unusual due to seasonal fluctuation however the increase was significant. Reasons for the increase include sickness (related to nor virus outbreaks) and Stress. The organisation has recently undertaken an assessment of its Health and Wellbeing Agenda with support form NHS Employers, the results are being translated into an Action Plan which will be discussed at the Workforce Committee.

6 Declaration Against Provider Management Review Framework

7.1 Quality, safety and national targets

The Trust fell short of the monthly target in the following areas:

A&E 4 hour wait standard – 1 penalty point
18 Weeks RTT Target (Admitted) – 1 penalty point
18 Weeks RTT Target (Non Admitted) - 1 penalty point
18 Weeks RTT Target (Open Clocks) – 1 penalty point
31 day diagnosis to treatment – 0.5 penalty point
31 day second or subsequent treatment – Drug / Surgery / Radiotherapy – 1 penalty point
Clostridium Difficile – 1 penalty point

Against the Governance Risk Rating the Trust is rated as RED with 6.5 penalty points compared to 5 in November.

7.2 Financial performance

Against the Finance Risk Rating the Trust is rated as RED with a score of 2. This is the same score as in November.

7.3 Governance declaration recommendation

Due to ongoing concerns around delivery of the ED 4 hour wait target and financial performance the Board will be asked to authorise the Chair and Chief Executive to sign declaration 2: '***There is insufficient assurance available to ensure continuing compliance with all existing targets'.***

Release 5.00 : Autumn 2012

Created and maintained by NHS Midlands and East Quality Observatory

Acute Trust Quality Dashboard

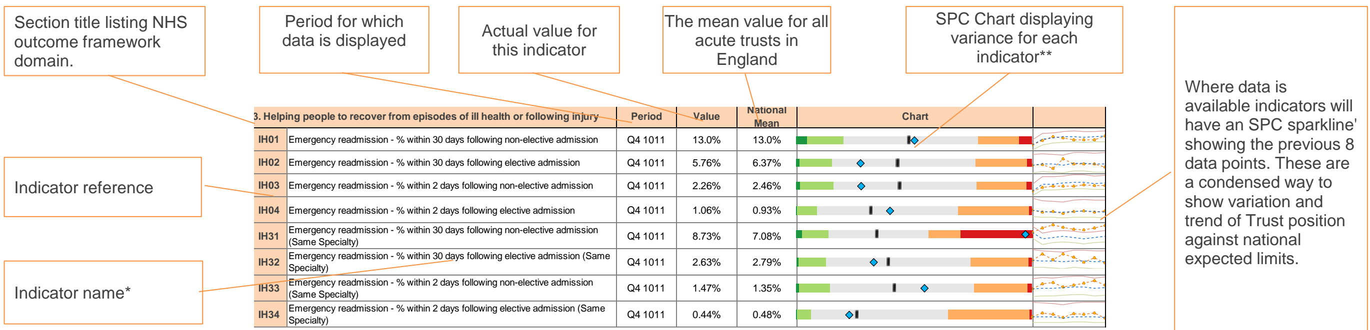
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

The Acute Trust Quality Dashboard provides an assessment of quality across the 5 domains of the NHS Outcomes Framework:

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long-term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protect them from avoidable harm

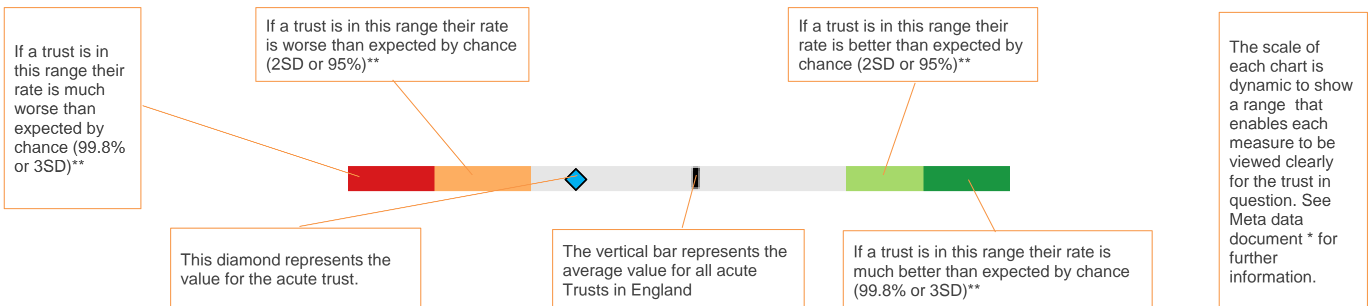
A sixth domain has been created "Organisational Context" which contains a number of metrics which look at organisational behaviour and measures useful in interpreting other metrics in the Dashboard.

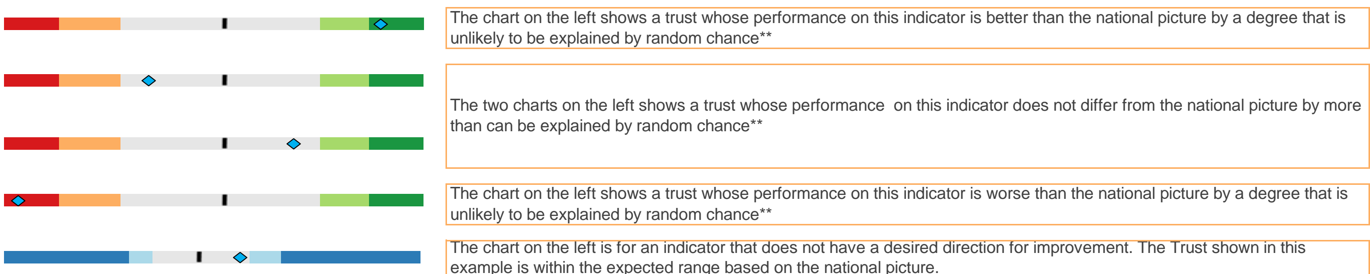
Report Overview



3. Helping people to recover from episodes of ill health or following injury		Period	Value	National Mean	Chart
IH01	Emergency readmission - % within 30 days following non-elective admission	Q4 1011	13.0%	13.0%	
IH02	Emergency readmission - % within 30 days following elective admission	Q4 1011	5.76%	6.37%	
IH03	Emergency readmission - % within 2 days following non-elective admission	Q4 1011	2.26%	2.46%	
IH04	Emergency readmission - % within 2 days following elective admission	Q4 1011	1.06%	0.93%	
IH31	Emergency readmission - % within 30 days following non-elective admission (Same Specialty)	Q4 1011	8.73%	7.08%	
IH32	Emergency readmission - % within 30 days following elective admission (Same Specialty)	Q4 1011	2.63%	2.79%	
IH33	Emergency readmission - % within 2 days following non-elective admission (Same Specialty)	Q4 1011	1.47%	1.35%	
IH34	Emergency readmission - % within 2 days following elective admission (Same Specialty)	Q4 1011	0.44%	0.48%	

How to interpret charts





The chart on the left shows a trust whose performance on this indicator is better than the national picture by a degree that is unlikely to be explained by random chance**

The two charts on the left shows a trust whose performance on this indicator does not differ from the national picture by more than can be explained by random chance**

The chart on the left shows a trust whose performance on this indicator is worse than the national picture by a degree that is unlikely to be explained by random chance**

The chart on the left is for an indicator that does not have a desired direction for improvement. The Trust shown in this example is within the expected range based on the national picture.

* For a full description of each metric and metadata, please see technical guidance available at http://www.emqo.eastmidlands.nhs.uk/welcome/atqd/

** These charts are constructed using statistical process control (SPC) principles and use control limits to indicate variation from the national mean. The display shows both two standard deviation (95%) control limits and three standard deviation (99.8%) control limits. Values within these limits (the light grey section) are said to display 'normal cause variation' in that variation from the mean can be considered to be random. Values outside these limits (in the light green or orange sections) are said to display 'special cause variation' at a two standard deviation level, and a cause other than random chance should be considered. Values outside these sections (in the dark green or red sections) also display 'special cause variation' but against a more stringent test.

Variation at the two standard deviation level can be considered to raise an alert, and variation at the three standard deviation level to raise an alarm.

meqo Midlands and East Quality Observatory

NHS

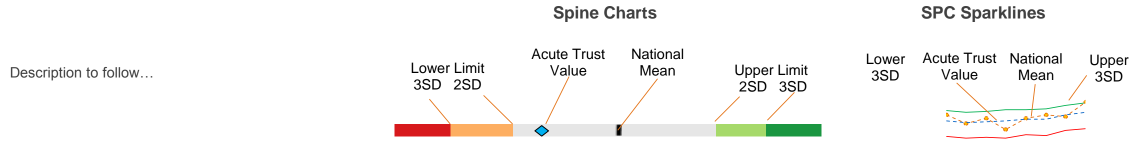
Created and maintained by NHS Midlands and East Quality Observatory

Acute Trust Quality Dashboard

SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

Release 5.00 : Autumn 2012

Description to follow…



Clinical Effectiveness

Code	1. Preventing People from dying prematurely	Period	Value	National Mean	Chart	Trend
PD02	Age / Sex standardised hospital mortality from conditions amenable to healthcare	RY Q1 1213	78.7	100.0		
PD03	Age / Sex standardised in hospital mortality in low risk HRGs	RY Q1 1213	100.1	100.0		
PD04	Crude in hospital perinatal mortality per 1,000 births (including still births)	RY Q1 1213	8.72	8.35		
PD06	Summary Hospital-level Mortality Indicator (SHMI) - Emergency & Elective	RY Q4 1112	106.7	100.3		
PD07	SHMI - Elective (pending data)	xxx	xxx	xxx		
PD08	SHMI - Emergency (pending data)	xxx	xxx	xxx		
PD09	SHMI - Stroke (sub-group 66)	RY Q4 1112	94.0	100.3		
PD10	SHMI - COPD (sub-group 75)	RY Q4 1112	83.4	100.3		
PD11	SHMI - MI (sub-group 57)	RY Q4 1112	82.4	100.1		
PD12	SHMI - #NOF (group 120)	RY Q4 1112	98.8	99.8		
PD13	SHMI - Pneumonia (sub-group 73)	RY Q4 1112	107.1	100.1		
PD14	SHMI - CHF (sub-group 65)	RY Q4 1112	116.8	100.0		
PD15	SHMI - Renal (sub-group 99)	RY Q4 1112	125.9	100.2		
PD16	SHMI - Diabetes (sub-group 34+35)	RY Q4 1112	80.9	100.7		
PD25	% of patients with a fractured neck of femur operated on within 48 hours	Q1 1213	71.1%	76.3%		
PD30	Cancer waits – % waiting less than 31 Days from decision to treat to first treatment	Q1 1213	97.7%	98.4%		
PD31	Cancer waits – % waiting less than 62 days from GP referral to first treatment (HQU15)	Q1 1213	85.4%	87.7%		
	2. Enhancing quality of life for people with long term conditions	**Period**	**Value**	**National Mean**	**Chart**	
EQ01	% emergency admissions for >65 years old with dementia	Q1 1213	10.5%	13.4%		
EQ02	LOS (Days) for patients >65 years old admitted in an emergency with Dementia	Q1 1213	12.9	14.5		
EQ03	LOS (Days) for patients >65 years old admitted in an emergency	Q1 1213	9.4	10.2		
EQ04	Ambulatory care sensitive conditions - % of emergency admissions for cellulitis and DVT (based on SQU04_01)	Q1 1213	1.59%	1.61%		
EQ05	% of admissions with zero day LOS for emergency ambulatory care conditions	Q1 1213	29.2%	39.5%		
	3. Helping people to recover from episodes of ill health or following injury	**Period**	**Value**	**National Mean**	**Chart**	
IH01	Emergency readmission - % within 30 days following non-elective admission	Q1 1213	11.14%	13.08%		
IH02	Emergency readmission - % within 30 days following elective admission	Q1 1213	7.79%	6.65%		
IH03	Emergency readmission - % within 2 days following non-elective admission	Q1 1213	2.29%	2.50%		
IH04	Emergency readmission - % within 2 days following elective admission	Q1 1213	1.10%	1.02%		
IH31	Emergency readmission - % within 30 days following non-elective admission (Same Specialty)	Q1 1213	7.41%	6.87%		
IH32	Emergency readmission - % within 30 days following elective admission (Same Specialty)	Q1 1213	4.19%	2.89%		
IH33	Emergency readmission - % within 2 days following non-elective admission (Same Specialty)	Q1 1213	1.66%	1.33%		
IH34	Emergency readmission - % within 2 days following elective admission (Same Specialty)	Q1 1213	0.88%	0.50%		
IH05	Emergency readmission - % within 30 days following discharge - Angina	Q1 1213	10.86%	15.09%		
IH35	Mean length of stay (LOS) for patients admitted for Angina	Q1 1213	3.9	4.1		
IH06	Emergency readmission - % within 30 days following discharge - Asthma	Q1 1213	9.92%	12.12%		
IH36	Mean length of stay (LOS) for patients admitted for Asthma	Q1 1213	5.9	6.0		
IH07	Emergency readmission - % within 30 days following discharge - CCF	Q1 1213	14.57%	19.04%		
IH37	Mean length of stay (LOS) for patients admitted for CCF	Q1 1213	9.8	11.1		
IH08	Emergency readmission - % within 30 days following discharge - COPD	Q1 1213	17.87%	23.28%		
IH38	Mean length of stay (LOS) for patients admitted for COPD	Q1 1213	7.3	7.2		
IH09	Emergency readmission - % within 30 days following discharge - Diabetes	Q1 1213	10.91%	15.99%		
IH39	Mean length of stay (LOS) for patients admitted for Diabetes	Q1 1213	13.5	11.2		
IH10	Emergency readmission - % within 30 days following discharge - Epilepsy	Q1 1213	14.72%	15.38%		
IH40	Mean length of stay (LOS) for patients admitted for Epilepsy	Q1 1213	6.0	6.4		
IH11	Emergency readmission - % within 30 days following discharge - Renal	Q1 1213	13.78%	14.93%		
IH41	Mean length of stay (LOS) for patients admitted for Renal	Q1 1213	7.8	7.5		
IH21	% patients discharged to usual place of residence	Q1 1213	94.7%	95.1%		
IH22	% of eligible patients taking part in PROMS (eligible FCEs) (Apr-Sept 11)	1112	78.5%	68.8%		
IH23	Patient Reported Outcome Measures - % Patients reporting an improvement following hip replacement (Apr-Dec 11)	1112	90.5%	87.0%		
IH24	Patient Reported Outcome Measures - % Patients reporting an improvement following knee replacement (Apr-Dec 11)	1112	82.0%	78.7%		
IH25	Patient Reported Outcome Measures - % Patients reporting an improvement following varicose vein procedure (Apr-Dec 11)	1112	62.0%	52.0%		
IH26	Patient Reported Outcome Measures - % Patients reporting an improvement following hernia procedure (Apr-Dec 11)	1112	53.5%	51.6%		

meqo Midlands and East Quality Observatory

NHS

Created and maintained by NHS Midlands and East Quality Observatory

Acute Trust Quality Dashboard

Patient Experience

	4. Ensuring that people have a positive experience of care	Period	Value	National Mean	Chart
PE00	95th Percentile wait for elective inpatient treatment (weeks)	Aug-12	26.5	21.0	
PE01	Median wait for elective inpatient treatment (weeks)	Aug-12	10.00	8.60	
PE02	Diagnostic Waits - % of patients waiting over 5 weeks	Q1 1213	5.01%	5.79%	
PE03	Cancer waits – % seen within 14 days of GP referral to first out-patient appointment (HQU14)	Q1 1213	96.7%	95.2%	
PE23	A&E - % of patients admitted, tranferred or discharged within 4 hours of arrival	Q1 1213	92.2%	94.0%	
PE08	A&E re-attendance - % within 7 days (HQU09)	Q1 1213	4.8%	6.9%	
PE10	Median total time in minutes spent in A&E for admitted and non admitted patients (HQU10)	Q1 1213	114	132.0	
PE11	A&E attendances - % of patients who leave without being seen (HQU11)	Q1 1213	1.1%	2.9%	
PE12	A&E - Median Time to initial assessment for patients brought in via ambulance in minutes (HQU12)	Q1 1213	5.0	3.0	
PE13	A&E - Median Time to treatment in minutes (HQU13)	Q1 1213	42.0	56.0	
PE14	A&E - % Admissions with zero day LOS	Q1 1213	18.5%	25.3%	
PE15	Mixed sex accommodation breach rate per 1000 FCEs (HQU08)	Sep-12	0.00	0.12	
PE16	On the day cancellations of elective surgery per 1000 procedures for non-clinical reasons	Q1 1213	17.1	8.4	
PE17	Overall inpatient experience measure	1011	7.5	7.4	
PE18	Overall outpatient experience measure	1011	7.7	7.9	
PE19	Overall A&E experience measure	0809	75.9	75.7	
PE20	Mother satisfaction measure	2010	88.9	83.8	
PE21	Delayed Transfers of Care per 1,000 occupied beds - NHS Responsibility	Q1 1213	53.9	598.0	
PE22	Delayed Transfers of Care per 1,000 occupied beds - Social Care Responsibility	Q1 1213	96.8	167.3	

Patient Safety

	5. Treating and caring for people in a safe environment and protecting them from avoidable harm	Period	Value	National Mean	Chart
SC01	Rate of patient safety incidents reported in trusts per 100 admissions	OCT11-MAR12	6.80	6.58	
SC02	Rate of "serious harm" patient safety incidents reported in trusts per 100 admissions	OCT11-MAR12	0.79	0.43	
SC03	% of all admissions who have venous thromboembolism risk assessment (SQU01)	Jun-12	90.1%	93.3%	
SC04	Rate of surgical site infections per 10,000 specified orthopaedic operations	1011	220.6	97.1	
SC05	HCAI - MRSA bacteraemia rate per 1,000,000 occupied beds (HQU01)	Q1 1213	15.1	10.7	
SC06	HCAI - C. diff bacteria rate per 100,000 bed days (HQU02)	Q1 1213	6.89	5.11	
SC20	HCAI - MSSA rate per 100,000 bed days	Q1 1213	10.5	8.2	
SC07	Adult - BADS Efficiency Score (As per BADS V4 directory thresholds)	Q1 1213	85.6	81.4	
SC21	Paediatric - BADS Efficiency Score (As per BADS V4 directory thresholds)	Q1 1213	82.2	86.0	
SC08	% of planned day case procedures that are converted to inpatients on the day	Q1 1213	1.4%	4.4%	
SC09	% of deliveries via Caesarean Section - Elective	Q1 1213	6.03%	10.53%	
SC10	% of deliveries via Caesarean Section - Non Elective	Q1 1213	9.01%	14.58%	
SC11	% Admission of full-term babies to neonatal care	Q1 1213	Methodology Currently Being Reviewed		
SC12	Emergency readmission - % babies within 30 days following delivery	Q1 1213	6.44%	7.15%	
SC17	Medication errors per 1,000 bed days	OCT11-MAR12	7.57	7.17	
SC19	Incidence of patients with pressure ulcers per 1000 admissions	Jun-12	3.46	3.54	

Organisational Context

	6. Organisational Context	Period	Value	National Mean	Chart
OQ01	Admitted Patient Care - % Valid data (Average for all fields)	Aug-12	99.7%	97.95%	
OQ02	Out Patient - % Valid data (Average for all fields)	Aug-12	99.3%	95.26%	
OQ03	Accident and Emergency - % Valid data (Average for all fields)	Aug-12	99.5%	96.74%	
OQ21	Admitted Patient Care - % Records submitted with valid HRG on first submission	Jun-12	100.0%	94.7%	
OQ04	Elective - Depth of coding (mean number of secondary diagnosis)	Q1 1213	1.98	2.21	
OQ05	Non-elective - Depth of coding (mean number of secondary diagnosis)	Q1 1213	4.19	4.35	
OQ06	Rate of palliative care (ICD10: Z515) per 1,000 episodes	Q1 1213	16.03	8.14	
OQ20	Rate of palliative care (main specialty 315) per 1,000 episodes	Q1 1213	0.00	0.38	
OQ18	Rate of use of integrated palliative care pathway (ICD10: Z518) per 1,000 episodes	Q1 1213	3.65	5.45	
OQ07	Rate of written complaints per 1,000 episodes	1112	4.41	4.43	
OQ08	NHSLA Claims per 10,000 bed days	1112	1.36	1.91	
OQ09	Workforce - FTE Nurses per bed day	Aug-12	1.48	1.96	
OQ10	Workforce - Sickness % - Medical	Aug-12	2.13%	0.94%	
OQ11	Workforce - Sickness % - Nurse	Aug-12	5.3%	4.2%	
OQ12	Workforce - Sickness % - Midwife	Aug-12	3.4%	4.5%	
OQ13	Workforce - Sickness % - Other	Aug-12	4.5%	4.2%	
OQ14	Staff recommendation of the trust as a place of work (CQC survey)	2011	44.5%	52.4%	
OQ15	Staff recommendation of the trust as a place to receive treatment (CQC Survey)	2011	50.9%	62.8%	
OQ16	Overall medical trainees global satisfaction score (GMC survey)	2012	78.7	78.6	
OQ17	Consultant clinical supervision trainers given to their trainees	2012	87.3	86.8	
OQ19	% of A&E attendances which are "inappropriate" (V08 / VB11Z)	Q1 1213	7.8%	15.6%	

meqo
Midlands and East Quality Observatory

NHS

Release 5.00 : Autumn 2012

Created and maintained by NHS Midlands and East Quality Observatory

Acute Trust Quality Dashboard

This section of the dashboard is included to allow hospitals to provide notes on the content of the dashboard and indicators where required.

There are no notes for this trust.