Balanced Scorecard Summary

Month 3

The Shrewsbury and Telford Hospital NHS

NHS Trust

Operational Performance

	Previous Month	This Month	Year to Date
		Number	Number
Green	16	17	17
Amber	4	3	3
Red	3	2	1
No RAG Applied	1	2	3

Finance

	Previous Month	This Month	Year to Date
	Number	Number	Number
Green	7	7	0
Amber	0	1	0
Red	9	7	0
No RAG Applied	1	2	17

SaTH Overall Performance

	Previous Month	This Month	Year to Date
	Number	Number	Number
Green	36	37	21
Amber	4	4	3
Red	14	11	3
No RAG Applied	11	13	38

Quality

	Previous Month	This Month	Year to Date
	Number	Number	Number
Green	1	1	1
Amber	0	0	0
Red	1	1	1
No RAG Applied	4	4	4

Safety

	Previous Month	This Month	Year to Date
	Number	Number	Number
Green	12	12	3
Amber	0	0	0
Red	1	1	1
No RAG Applied	5	5	14

Operational Performance

Domain	Lead Exec	Indicator	Definition	Performing Threshold	Under-performing Threshold	Unit	Apr-12	May-12	Jun-12	2012/13 YTD	Actions	Reference
OP	WD	Sickness absence rate		3.39%		%	4.60%	4.15%	4.33%	N/A		
OP	DoO	A&E	Four-hour maximum wait in A&E from arrival to admission, transfer or discharge[1]	95%	94%	%	90.91%	94.50%	95.63	93.80%	Continue to manage implementation of agreed action plan ongoing. Director of Operations and Director of Patient Safety & Quality	Urgent Care Pathway Improvement Action Plan
OP	DoO	A&E	Unplanned re-attendance rate - Unplanned re-attendance at A&E within 7 days of original attendance (including if referred back by another health professional)		>5%	%	1.78%	1.89%	2.06%	1.91%		
OP	DoO	A&E	Left department without being seen rate		>5%	%	0.91%	1.28%	1.30%	1.17%		
OP	DoO	A&E	Time to initial assessment - 95th centile		>15 Mins	Minutes	30	35	35	34	1- Continue to manage implementation of agreed action plan on-going. Director of Operations and Director of Patient Safety & Quality 2- Contracts & Performance to seek confirmation from the Centre that they are the Time to Initial Assessment numbers are accurate and are signed off on a monthly basis	Urgent Care Pathway Improvement Action Plan
OP	DoO	A&E	Time to treatment in department - median		>60 Mins	Minutes	39	45	31	42		
OP	DoO	Cancelled ops	Breaches of 28 days readmission as % of Prev month cancelled ops	5%	15%	%	17.24%	5.76%			June information not available at time of publishing the report.	
OP	DoO	Referral To Treatment	RTT - admitted - 95th percentile	<=23	>27.7	Weeks	25.79	25.93	27.23	26.41	Centre Chiefs for Ophthalmology & T&O are to sign off detailed action plans from both specialties within a fortnight	
OP	DoO	Referral To Treatment	RTT - non-admitted - 95th percentile	<=18.3		Weeks	17.98	17.38	17.46	17.61		
OP	DoO	Referral To Treatment	RTT - incomplete - 95th percentile	<=28	>36	Weeks	19.18	18.82	18.26	18.47		
OP	DoO	Referral To Treatment	RTT - admitted - 90% in 18 weeks	90%	85%	%	85.22%	82.84%	77.54%	81.63%	Centre Chiefs for Ophthalmology & T&O are to sign off detailed action plans from both specialties within a fortnight	
OP	DoO	Referral To Treatment	RTT - non-admitted - 95% in 18 weeks	95%	90%	%	95.04%	96.08%	96.59%	95.90%		
OP	DoO	Cancer	2 week GP referral to 1st outpatient	93%	88%	%	97.85%	94.46%	95.39	96.74%		
OP	DoO	Cancer	2 week GP referral to 1st outpatient - breast symptoms	93%	88%	%	98.41%	100.00%	96.34	97.67%		
OP	DoO	Cancer	31 day second or subsequent treatment - surgery	94%	89%	%	91.67%	94.34%	96.67	95.59%		
OP	DoO	Cancer	31 day second or subsequent treatment - drug	98%	93%	%	96.49%	98.77%	98.25	98.62%		
OP	DoO	Cancer	31 day diagnosis to treatment for all cancers	96%	91%	%	98.13%	97.35%	96.08	97.44%		
OP	DoO	Cancer	Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments)	94%	89%	%	100%	98.65%	98.72	99.09%		
OP	DoO	Cancer	62 day referral to treatment from screening	90%	85%	%	94.44%	92.86%	85.71	91.40%		
OP	DoO	Cancer	62 day referral to treatment from hospital specialist	85%	80%	%	96.55%	94.67%	94.12	95.49%		
OP	DoO	Cancer	62 days urgent GP referral to treatment of all cancers	85%	80%	%	86.42%	82.43%	85.19	85.18%		
OP	DoO	Stroke	Patients that have spent more than 90% of their stay in hospital on a stroke unit	80%	60%	%	86.30%	83.60%	89.90%	85.80%		
OP	DoO	Delayed transfers of care	Delayed transfers of care	4%	5%	%	3.23%	3.85%	3.38%	3.38%		
OP	DoO	Cancelled ops	Ops Cancelled on day of or following Admission for non Medical reason			Number	52	59	114	225		

Quality

Domain	Lead Exec	Indicator	Definition	Target / Threshold	Unit	Apr-12	May-12	Jun-12	2012/13 YTD	Actions	Reference
Q	DQ&S	Single Sex Accommodation Breaches			Number	0	0	0	0		
Q	DQ&S	RED rated areas on your maternity dashboard?			Number	No	No	No	No		
Q	DQ&S	Falls resulting in severe injury or death			Number	3	2	0	5		
Q	DQ&S	Grade 3 or 4 pressure ulcers			Number	3	4	3	10		
Q	DQ&S	Formal complaints received			Number	47	64	61	172		
Q	DQ&S	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Certification against compliance with requirements regarding access to healthcare for people with a learning disability			No	No	No	N/A	Associate Director of Quality & Patient Experience is implementing the agreed action plan which is anticipated to deliver compliance with all 6 measures by Dec 2012	Quality & Safety Report

Safety

Domain	Lead Exec	Indicator	Definition	Target / Threshold	Unit	Apr-12	May-12	Jun-12	2012/13 YTD	Actions	Reference
S	MD	SHMI - latest data			Ratio	109	109	109	N/A		
S	MD	Venous Thromboembolism (VTE) Screening		90%	%	90.05%	91.72%	90.12%	90.97%		
S	MD	Elective MRSA Screening			%	90.16%	90.28	89.16%	N/A		
S	MD	Non Elective MRSA Screening			%	97.08	96.37	97.38%	N/A		
S	DQ&S	Open Serious Incidents Requiring Investigation (SIRI)			Number	96	88	61	N/A		
S	DQ&S	"Never Events" in month		0	Number	2	0	0	2		
S	DCRM	CQC Conditions or Warning Notices			Number	No	No	No	N/A		
S	DCRM	Open Central Alert System (CAS) Alerts Past Completion Date			Number	3	3	3	N/A		
S	MD	100% compliance with WHO surgical checklist		100%	Y/N	99.60%	99.50%	100%	N/A		
S	MD	Clostridium Difficile		45	Number	2	2	5	9	1- Root Cause Analysis(RCA) of all cases is being undertaken by the Infection Prevention & Control team. 2- Findings to be presented at the routine Infection Prevention and Control Operational Meeting 3- escalted to the relevant Centres if apprpriate.	HCAI Report
S	MD	MRSA		2	Number	1	0	0	1		
S	DCRM	CQC Registration	Are there any compliance conditions on registration outstanding.			No		No	N/A		
S	DCRM	CQC Registration	Are there any restrictive compliance conditions on registration outstanding.			No	No	No	N/A		
S	DCRM	CQC Registration	Moderate CQC concerns regarding the safety of healthcare provision			Yes	No	No	N/A		
S	DCRM	CQC Registration	Major CQC concerns regarding the safety of healthcare provision			No	No	No	N/A		
S	DCRM	CQC Registration	Formal CQC Regulatory Action resulting in Compliance Action			No	No	No	N/A		
S	DCRM	CQC Registration	Formal CQC Regulatory Action resulting in Enforcement Action			No	No	No	N/A		
S	DCRM	CNST	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements			No	No	No	N/A		

Finance

Domain	Lead Exec	Indicator	Definition	Target / Threshold	Unit	Apr-12	May-12	Jun-12	2012/13 YTD	Actions	Reference
F	FD	Agency and bank spend as a % of turnover			%	6.61%	5.30%	5.70%	5.80%	Please refer to the Month 3 Finance Report for actions and narrative related to the Finance Measures.	Month 3 Finance Report
F	FD	FRR Underlying performance	EBITDA margin %	3.0		1	2	2	N/A		
F	FD	FRR Achievement of plan	EBITDA achieved %	5.0		1	3	3	N/A		
F	FD	FRR Financial efficiency	Return on assets %	3.0		2	2	2	N/A		
F	FD	FRR Financial efficiency	I&E surplus margin %	2.0		1	1	2	N/A		
F	FD	FRR Liquidity	Liquid ratio days	2.0		2	2	2	N/A		
F	FD	FRR Average	Weighted Average	2.8		1.5	1.9	2.1	N/A		
F	FD	Unplanned decrease in EBITDA margin in two consecutive quarters				No	No	No	N/A		
F	FD	Quarterly self-certification by trust that the financial risk rating (FRR) may be less than 3 in the next 12 months				No	No	No	N/A		
F	FD	FRR 2 for any one quarter				Yes	Yes	Yes	N/A		
F	FD	Working capital facility (WCF) agreement includes default clause				N/A	N/A	N/A	N/A		
F	FD	Debtors > 90 days past due account for more than 5% of total debtor balances				No	No	No	N/A		
F	FD	Creditors > 90 days past due account for more than 5% of total creditor balances				Yes	No	No	N/A		
F	FD	Two or more changes in Finance Director in a twelve month period				No	No	No	N/A		
F	FD	Interim Finance Director in place over more than one quarter end				No	No	No	N/A		
F	FD	Quarter end cash balance <10 days of operating expenses				Yes	Yes	Yes	N/A		
F	FD	Capital expenditure < 75% of plan for the year to date				No	No	Yes	N/A		