Enclosure 4

INTEGRATED PERFORMANCE REPORT for period ending 31st March 2011

Quality

EXECUTIVE RESPONSIBLE	Vicky Morris **Director of Quality & Safety / Chief Nurse**
AUTHOR (if different from above)	Paul Hodson **Head of Contracts & Performance** Pete Gordon **Head of Continuous Improvement** William Wraith **Head of Human Resources** Tony Brown **Assistant Director Financial Performance**
CORPORATE OBJECTIVE	Enhancing Patient Experience, Safety and Effectiveness, Achieving NHS Foundation Trust Status
BUSINESS PLAN OBJECTIVE NO(S)	6.1 - Establish a new Quality Framework for the Trust. 6.1.1 - Develop an integrated performance management framework that includes a balanced set of quality metrics across the domains of safety, effectiveness and patient experience.

KEY FACTS	• A&E, Rapid Access Chest pain Clinic, MRSA, C-Diff, Stroke National, Stroke CQUIN, Cancer 14 day, Cancer 31 day and Readmission all achieved in month • Caner 62 day and Choose & Book failed in month

EXECUTIVE SUMMARY	This paper reports current performance against a number of KPIs for the period up to the end of march 2011. As detailed in previous papers this reports includes KPIs identified as suitable for both Monthly and Quarterly reporting as March represents the completion of the 4th Quarter.

RECOMMENDATIONS	The Board is asked to **NOTE:** • performance against a range of Key Performance Indicators covering Quality, Delivery and Foundations.

Integrated Performance Report: Quality (CO1)

Appendix 1

		Target (2010/11)	Executive Lead	Monthly Performance	Direction of Travel	Year to Date	Forecast	Commentary	Frequency
Patient Experience	Patient Satisfaction	Improve responsiveness to personal needs of patients (CO1.3 / CO1.7) (CQUIN)	DQ&S	GREEN	=	GREEN	GREEN	Target 2010/11 89% overall patient satisfaction 5 indicators identified form 2009/10 results, however only 3 have been reviewed. The full set of 5 questions to be used in Q4	M
		Breaches in single sex accommodation compliance (CO1.5)	DQ&S	GREEN	=	GREEN	GREEN	Number of breaches caused by each occurrence will be equal to the total number of patients effected i.e. 1 female with 5 males is 6 breaches	M
	Cancelled Operations	To maintain a minimum level of non medical cancellations in accordance with national criteria	COO	GREEN	=	RED	RED	40 cancelled in month	M
		Readmit all non medical cancellations within 28 days in accordance with national criteria	COO	GREEN	=	GREEN	GREEN	No 28 day breaches in month	M
	Cleanliness	To maintain cleanliness score of 92% across the Trust	COO	GREEN	=	GREEN	GREEN	Both sites were Green at the time of March 2011 monitoring	M
	Choose & Book	Maintain a monthly slot availability rate of at least 90% for appointments made via the Choose & Book System	COO	RED	=	RED	RED	The Trust achieved 82% up to 27th March, a reduction of 2% from February	M
	Complaints	National response times are that all complaints are completed in their entirety within six months, unless exceptional circumstances	DQ&S	GREEN	=	GREEN	GREEN	The cases opened in the final quarter have not yet passed the 6 months statutory deadline for closure	Q
	End of Life (CQUIN)	% of admitted patients at end of life following the Liverpool End of Life Pathway (CO1.3)	DQ&S	GREEN	=	GREEN	GREEN	New CQUIN Target for 2010/11 Q3 – baseline 50% Q4 to improve compliance by 20% target 60%	M
Safety	Incidents	Rate of patient safety incidents reports (CO1.6)	MD	GREEN	=	GREEN	GREEN	Incident reporting rate of 7.3%	M
		Serious Incidents Requiring Investigation (CO1.6)	MD	RED	=	AMBER	AMBER	More than 90, less than 100	M
	Healthcare Associated Infections (HCAIs)	No more than 6 post 48-hour MRSA bacteraemias	MD	GREEN	=	GREEN	GREEN	Total of 2 MRSA cases YTD	M
		No more than 166 post 72-hour C. Difficile infections	MD	GREEN	=	GREEN	GREEN	Total of 68 C. Difficile cases YTD	M
	Medicines Management (CQUIN)	Delayed and missed doses of medicines for hospital inpatients	MD	GREEN	=	GREEN	GREEN	Baseline audit undertaken in May 2010, second and third audit completed Improvement Target agreed with PCTs has been meet in full	M
	Patient Falls (CQUIN)	No. of inpatients having a fall whilst an inpatient (CO1.3)	DQ&S	RED	=	RED	RED	• Q1 Baseline – 142 falls per month • Q2 4%, reduction • Q3 7%, reduction • Q4 10% reduction	M

Integrated Performance Report: Quality (CO1)

Appendix 1

		Target (2010/11)	Executive Lead	Monthly Performance	Direction of Travel	Year to Date	Forecast	Commentary	Frequency
Effectiveness	**Hospital Standardised Mortality Ratio (HSMR)**	HSMR for the most recent complete 12 months based on the HSMR basket of 56 diagnosis groups	MD	AMBER	⇩	AMBER	RED (Due to re-basing)	Month: 95.1 (95% CI: (80.4 – 111.8)) Last Quarter: 102.7 (93.3 - 112.8) Last 12 Months: 106.2 (101.1 – 111.5)	M
	Stroke - National Target	% of Patients spending 90% of time on Stroke Unit	MD	GREEN	=	GREEN	GREEN	Excellent improvement at RSH and sustained, high attainment at PRH means SaTH has surpassed target for Year End	M
	Stroke – Compound Indicator	Compound based on Swallow Screens, TIAs and % of Time on Stroke Unit	MD	GREEN	=	GREEN	GREEN	Sustained improvement on both sites	M
	Stroke (CQUIN)	Admissions to Stroke Unit within 4 hours of Arrival at Hospital	MD	GREEN	=	GREEN	GREEN	Sustained performance from PRH with notable improvement in last month for RSH	M
	Early Access to Maternity	Achieve contract milestones for early access to maternity services (90% by Q4 and 86% full year) (CO1.1)	DQ&S	GREEN	⇧	RED	RED	March Q4 YTD T&WPCT = 89% 78% 79% SCPCT = 93% 88% 86%	M
	Nutrition	% Completion of Nutrition Screening Tool (C01.7)	DQ&S	GREEN	=	GREEN	GREEN	Baseline Audit 58% Q2 65% Q3 75% Q4 90%	Q
	Readmission Rates	Relative Risk of Emergency Readmission within 28 days of discharge	MD	GREEN	=	GREEN	GREEN	The relative risk of Emergency Readmission remains significantly lower (better) than the average for England	M
	Venous Thromboembolism (CQUIN)	% of adult inpatients who have had a VTE risk assessment on admission (CO1.3)	MD	RED	=	RED	RED	Failed in March	M
	Think Glucose (CQUIN)	Compliance with Think Glucose guidance (CO1.3)	MD	GREEN	=	GREEN	GREEN	Compliance with Think Glucose tool kit audited. CQUIN achieved.	M
	Tissue Viability (CQUIN)	Reduction in the number of Grade 3 and 4 Pressure Ulcers – to be confirmed with PCT (CO1.3)	DQ&S	RED	=	AMBER	AMBER	New CQUIN 2010/11 Target to reduce by Q4 number of grade 3/4 ulcers by 10%	M

Integrated Performance Report: Delivery (CO2, CO3 & CO4)

Appendix 1

		Target (2010/11)	Executive Lead	Monthly Performance	Direction of Travel	Year to Date	Forecast	Commentary	Frequency
Working in partnership as the provider of choice	**Appraisals**	SaTH target of 80%	DCRM	GREEN	⇧	GREEN	GREEN	Trust appraisal completion performance at 81%	M
	Staff Satisfaction	A continual improvement in staff satisfaction, as assessed by the Annual Staff Survey (CO3.3)	DCRM	GREEN	=	GREEN	GREEN	2009 survey shows continued improvement over previous years	Q
	Smoking (CQUIN)	90% of smokers/users of tobacco attending new patient appointments at selected outpatient clinics receive brief intervention (CO4.3)	MD	GREEN	=	RED	RED	Target achieved in March	M
	Staying Healthy (Alcohol) (CQUIN)	9a) 90% of people attending A&E with alcohol related condition & are not admitted who receive a brief intervention to reduce alcohol consumption 9b) ?% of people who are admitted to hospital with alcohol related condition receive brief interventions to reduce alcohol consumption	MD					No Update Provided	M

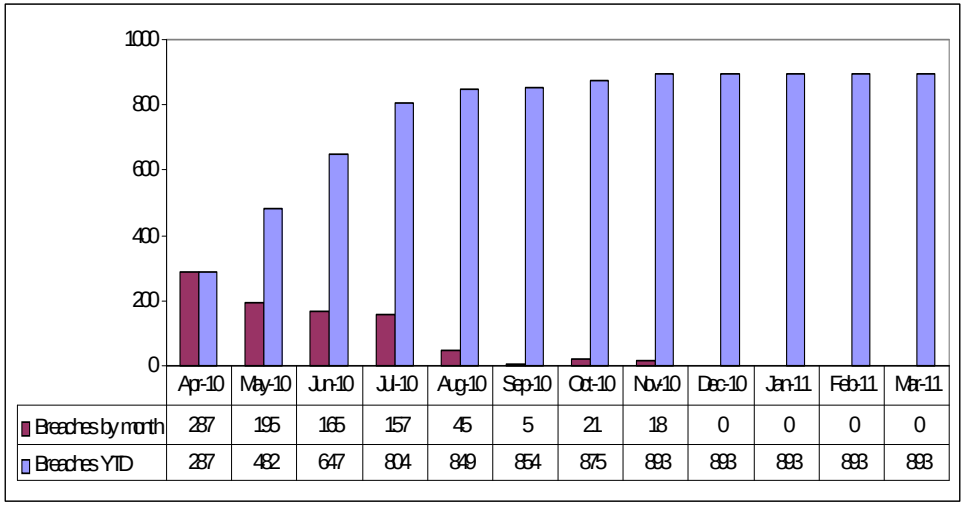
Integrated Performance Report: Foundations (CO5 & CO6)

Appendix 1

		Target (2010/11)	Executive Lead	Monthly Performance	Direction of Travel	Year to Date	Forecast	Commentary	Frequency
Achieving NHS Foundation Trust status	**Care Quality Commission Registration**	Maintain Trust Registration with the Care Quality Commission	DCRM	GREEN	=	GREEN	GREEN	Trust now registered without conditions	Q
	Coding	To increase the numbers of FCEs with coded comorbidities	FD	GREEN	=	GREEN	GREEN	Cumulative coding depth has increased in month	M
	A&E 4 Hours	95% of patients to be admitted, discharged or transferred within 4 hrs. of registering at A&E	COO	GREEN	=	GREEN	GREEN	Local Health Economy achieved the target for March	M
	18 Weeks	1a - Admitted Clock Stops above 90%	COO	RED	=	RED	RED	Trust failed the 90% target during March	M
		1b - Non-Admitted Clock Stops above 95%	COO	RED	=	RED	RED	Trust failed the 95% target during March	M
	Cancer	14 Days from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals	COO	GREEN	=	AMBER	AMBER	14 day target achieved in month	M
		31 Days from diagnosis to treatment for all cancers	COO	GREEN	=	AMBER	AMBER	31 day target achieved in month	M
		62 Day from urgent referral to treatment of all cancers	COO	RED	=	RED	RED	62 day target failed in month	M
	Thrombolysis	68% of patients admitted with ST Elevation MI should receive Thrombolysis within 60 minutes of call for help	COO	RED		RED	RED	Only 4 eligible patient in the year to date. CQC guidance states that for this indicator a 'low numbers' rule will be applied which will withdraw Trusts treating a low number of eligible cases from the assessment	M
	Rapid Access Chest Pain	A maximum of two-week wait for rapid access chest pain clinic (CO6.6)	COO	GREEN	=	GREEN	GREEN	Well established service with consistent high performance	M

Patient Satisfaction

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Patient Satisfaction	Improve responsiveness to personal needs of patients (CO1.3 / CO1.7) (CQUIN)	DQ&S	GREEN	=	GREEN	GREEN	Target 2010/11 89% overall patient satisfaction 5 indicators identified form 2009/10 results, however only 3 have been reviewed. The full set of 5 questions to be used in Q4
	Breaches in Single Sex Accommodation (CSA) compliance (CO1.5)	DQ&S	GREEN	=	GREEN	GREEN	Number of breaches caused by each occurrence will be equal to the total number of patients effected i.e. 1 female with 5 males is 6 breaches



	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Breaches by month	287	195	165	157	45	5	21	18	0	0	0	0
Breaches YTD	287	482	647	804	849	854	875	893	893	893	893	893

- There were no SSA breaches again in March.
- The results of the CQC National Inpatient Survey have been submitted this week. On the 5 identified questions SaTH scored 67.3% against a target of 67.1%. The Trust was in the top quartile of comparable Trusts.
- Overall ratings show that SaTH scored similar to other hospitals across England and that the Trust scored marginally higher on overall standards of care in our hospitals in 2010 compared to 2009.

However SaTH need to develop and improve the following areas :-

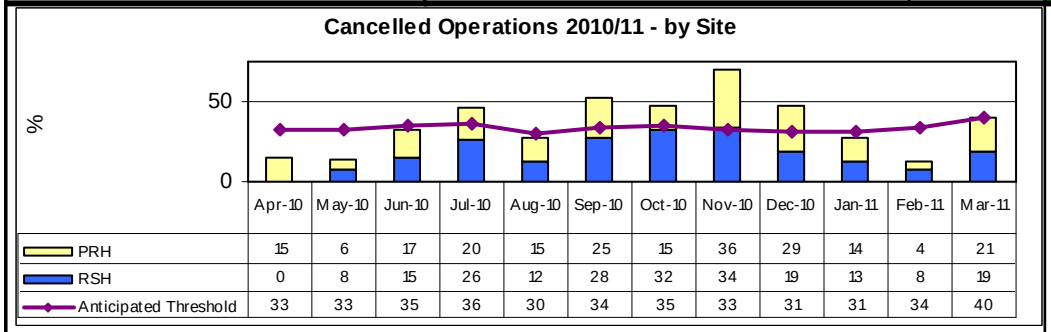
- Reducing the disturbance of noise at night for patients.
- Ensuring patients have an opportunity to talk to a doctor about their condition.
- Responding to patient call bells more promptly.
- Supporting patients with meals.
- Patients being involved in decisions about their care and discharge planning.
- Ensuring patients are provided with information on discharge.
- Enquiring about and meeting patients religious and spiritual beliefs.

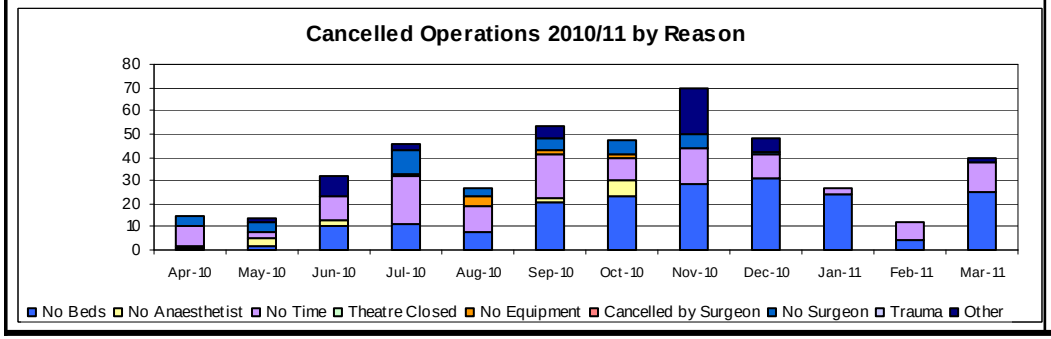
Actions:

- Complaints process to be enhanced to ensure patients and their families are supported to address their concerns.
- Refurbishment work is in progress to improve washing and toilet facilities to met SSA requirements
- A Dignity in Care Conference is being organised at the SECC for 12th May 2011 to celebrate Nurses Day.

28 Day Cancelled Operations

Target		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
28 Day Cancelled Operations	To maintain a minimum level of non medical cancellations in accordance with national criteria	DSD	**Green**	=	**RED**	**RED**	40 cancelled in month
	Readmit all non medical cancellations within 28 days in accordance with national criteria	DSD	**GREEN**	=	**GREEN**	**GREEN**	No 28 day breaches in month





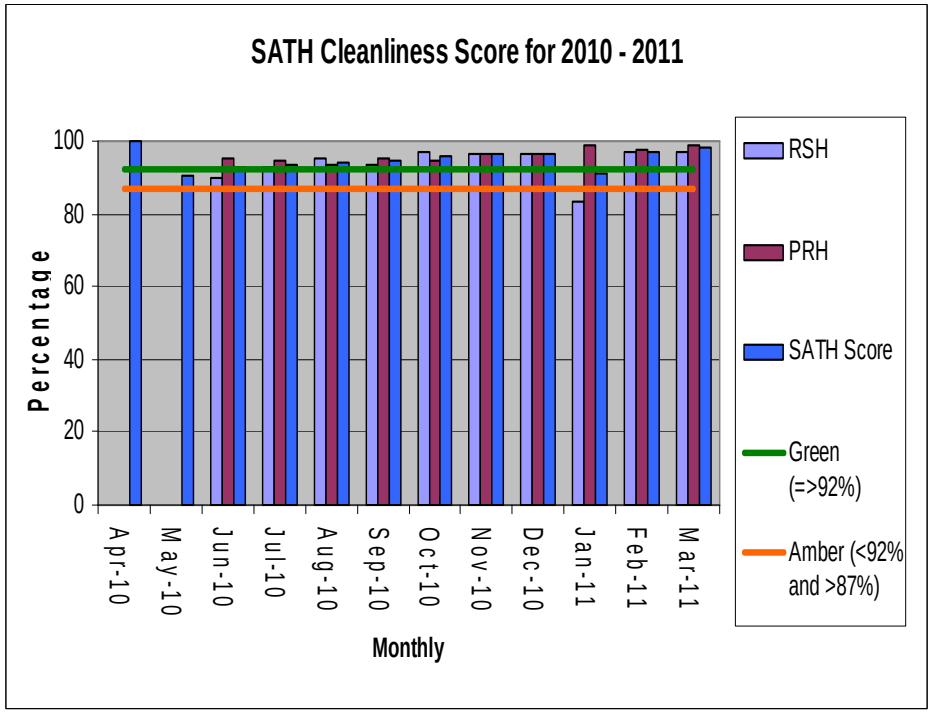
- 40 operations cancelled in March for non medical reasons.
- 431 operations cancelled for non medical reasons in the year-to-date.
- The national target applies only to those cancellations that happened on or after the day of admission and only for non-medical reasons.
- Current guidance indicates that the CQC threshold for achievement will be no more than 0.8% of relevant elective activity. We achieved this level in the month but are above this figure for the year-to-date.

Actions:

- A part of the new Surgical Centre elective and daycase patients across a range of specialties will be aligned with Theatres to implement an improved Pre Op process and redesigned elective pathway.
- Increased volume of elective surgical patients to access the Surgical Assessment Service (SAS)

Cleanliness

Target (20010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Cleanliness	To maintain cleanliness score of 92% across the Trust	DSD	**GREEN**	=	**GREEN**	**GREEN**	Both sites were Green at the time of March 2011 monitoring



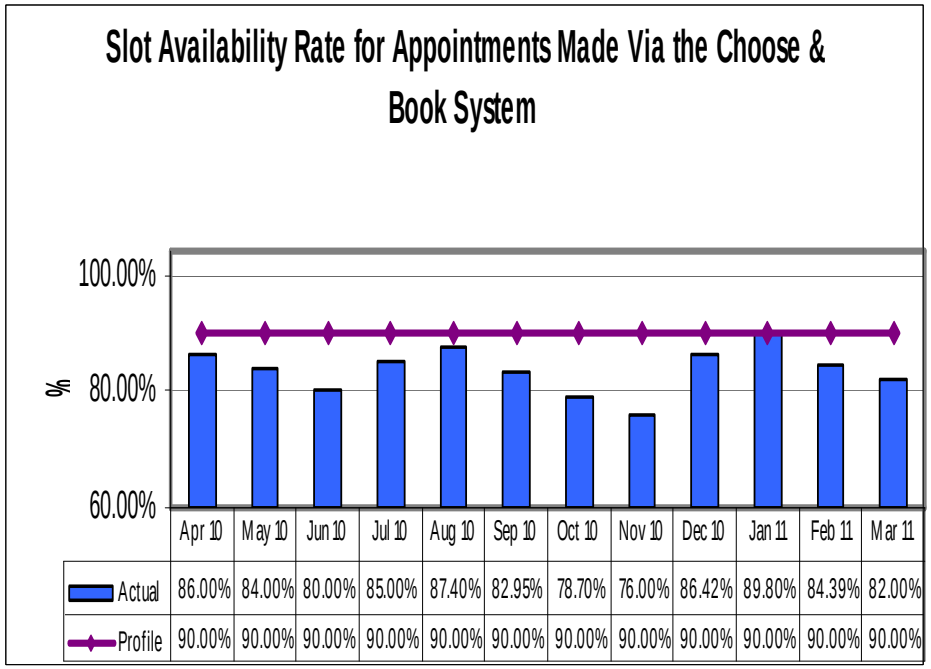
- Target score of 92% is based on the Patient Environment Action Team (PEAT) score to achieve "excellent".
- Monthly cleanliness scores collected from Domestic Services Department Quality Monitoring Programme.
- April and May figures only collated as combined scores.
- Overall score of 97.94% was achieved for the Trust in March 2011.
- Cleanliness Score for RSH was 97.14%.
- Cleanliness Score for PRH was 98.73%.
- External Contractor has been used to undertake elements of the deep clean programme.
- Based on April to February figures the year-end forecast is 95.05% (this will be submitted as part of the PEAT Assessment process).

Actions:

- Manual system of recording of monitoring used at present. Electronic system to be implemented by June 2011.

Choose and Book

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Choose and Book	Maintain a monthly slot availability rate of at least 90% for appointments made via the Choose & Book System	COO	**RED**	=	**RED**	**RED**	The Trust achieved 82% up to 27th March, a reduction of 2% from February



- There were 2,474 appointments booked in directly bookable services up to 27th March compared with 2,452 in February. However, there were approximately 70 more attempts to book an appointment via C&B in March than in February.
- At PRH 80% of unavailable appointments were in the following specialties:-
  - Ophthalmology – av. 9 per week (including Paediatrics)
  - Dermatology PRH - av. 11 per week
  - Thoracic Medicine PRH - av. 7 per week
  - T&O (upper limb) - av. 6 per week
  - Neurology – av. 6 per week.
- At RSH 49% of total unavailable slots were in Ophthalmology (including Cataract Service).
- Performance against this standard may deteriorate as a result of the plan agreed with the SHA to clear the backlog of follow-up OP appointments to ensure patient safety by October 2011.

Actions:

- Review of new appointment slots available via C&B in line with the plan agreed with the SHA to clear the backlog.

Complaints

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Complaints	National response times are that all complaints are completed in their entirety within six months, unless exceptional circumstances	DQS	GREEN	=	GREEN	GREEN	The cases opened in the final quarter have not yet passed the 6 months statutory deadline for closure

	Division 1	Division 2	Division 3	Estates
Low	6	5	11	0
Moderate	54	44	11	6
Significant	13	4	0	0
High	1	4	0	0
Very High/Extreme	0	1	0	0
Total	**73**	**68**	**22**	**6**

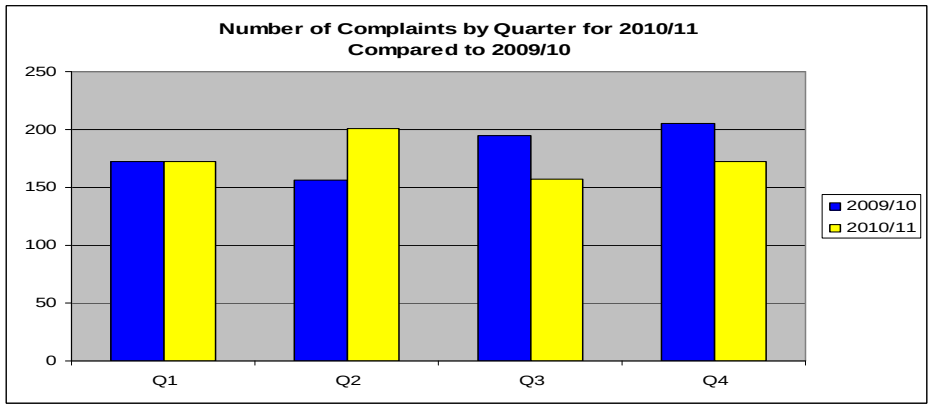


Table to show the Top Themes of Complaints for each Division

	Division 1	Division 2	Division 3	Estates
Attitude	7	8	0	3
Concerns about medical care	16	17	1	0
Lack of communication	6	12	1	0
Concerns about nursing care	15	4	0	0
Administration/Clerical	2	3	10	0

Some improvements over the fourth quarter include:

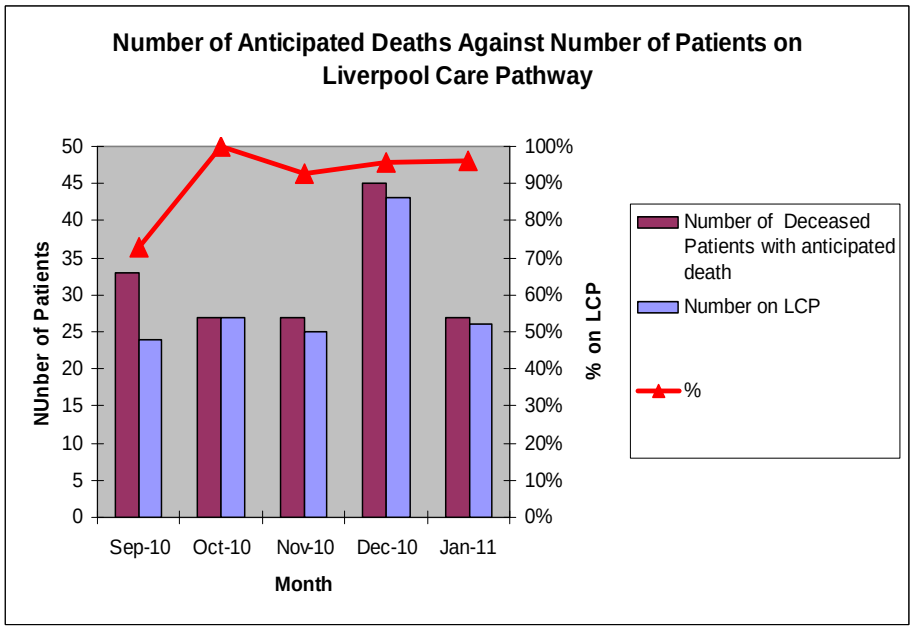
- On Ward 32 Nurse led handovers have been improved by being undertaken at the bedside with the full involvement of the patient. "Comfort Rounds" have also been introduced to ensure that those patients who are unable to articulate their needs have them met proactively.
- Oncology appointment letters are now sent from Oncology and by first class post.
- Senior Staff on MAU have been booked in for training on 'Dealing with Difficult Conversations'.
- Child Protection sheets are no longer attached to the outside of a patient's file to improve confidentiality.

Actions:

- All complainants are now offered the opportunity to meet with a Senior Manager or Director if they remain dissatisfied with their response.
- A more robust checking system has been put into place to ensure that the response fully addresses the concerns raised by the complainant and where necessary more information is sought.

End of Life

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
End of Life (CQUIN)	% of admitted patients at end of life following the Liverpool End of Life Pathway (CO1.3)	DQ&S	**GREEN**	=	**GREEN**	**GREEN**	New CQUIN Target for 2010/11 Q3 – baseline 50% Q4 to improve compliance by 20% target 60%



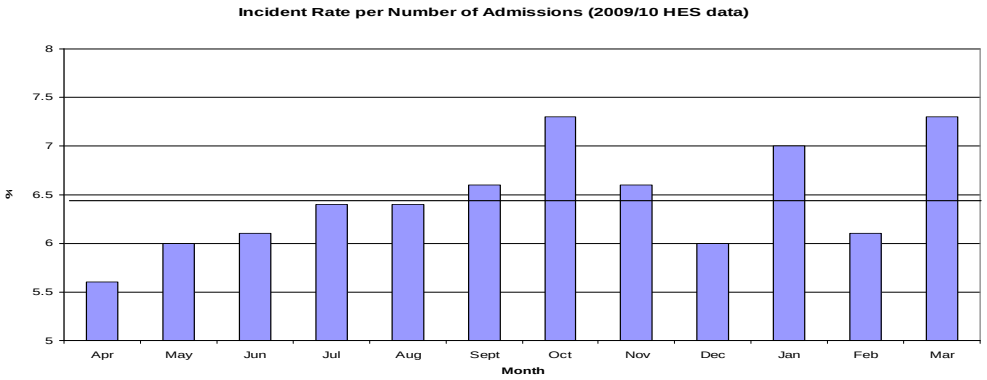
- Final Q4 data not yet available as final monthly data for each month is available after 3rd submission freeze.
- Updated version 12 Liverpool Care Pathway due for release imminently.
- Somerset Cancer Registry further developing improvement to the palliative care field to support LCP data collection in the future ~ date of release not known.

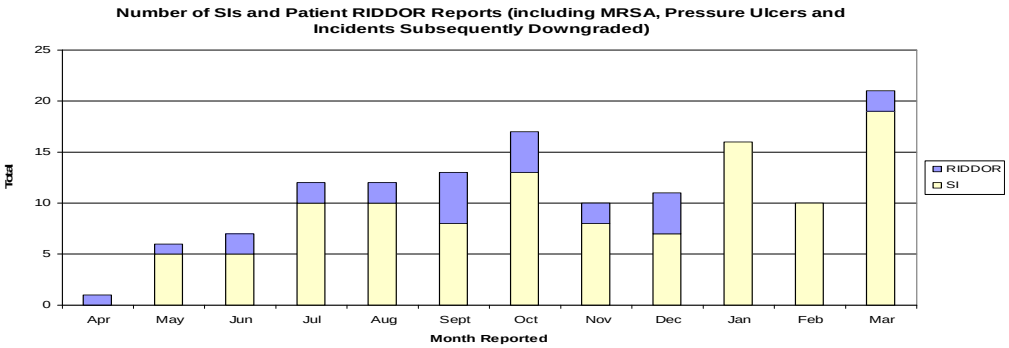
Actions:

- Ongoing CQUIN for 2011/12.

Incidents

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Year End Forecast	Commentary
Incidents	Rate of patient safety incidents reports (CO1.6)	MD	**GREEN**	=	**GREEN**	**GREEN**	Incident reporting rate of 7.3%
	Serious Incidents Requiring Investigation (CO1.6)	MD	**RED**	=	**AMBER**	**AMBER**	More than 90, less than 100





- The Trust reports Patient Safety Incidents & Near Misses to the National Reporting & Learning System (NRLS). The rate is based on the number of incidents each month as a percentage of the monthly admissions (based on 2009/10 HES data). The Care Quality Commission (CQC) receive weekly reports from the NRLS & are regularly further information about incident. Managers are reminded to ensure that compiled information on investigations & actions is included on the reports before final submission.

- The number of Serious Incidents Requiring Investigation (SIRI) includes Serious Incidents (SIs) & Patient Incidents which have been reported under RIDDOR (Reporting of Injuries, Diseases & Dangerous Occurrences Regulations). MRSA bacteraemias and grade 3/4 pressure sores are now included for completeness but are discussed elsewhere in this report.

- There were 21 SIs reported in March (16 in January; 10 in February). 4 of these were linked to the backlog of incidents in Datix, which were awaiting processing by managers. This backlog has now been cleared. This cluster of incidents related to test result's not actioned by Consultants.

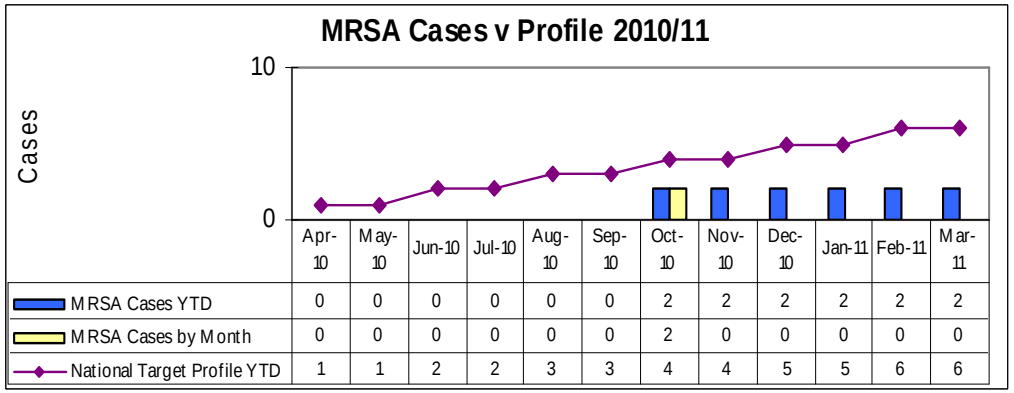
- In total 14 of the 113 incidents reported have been downgraded as investigation has shown that these were not reportable incidents.

Actions:

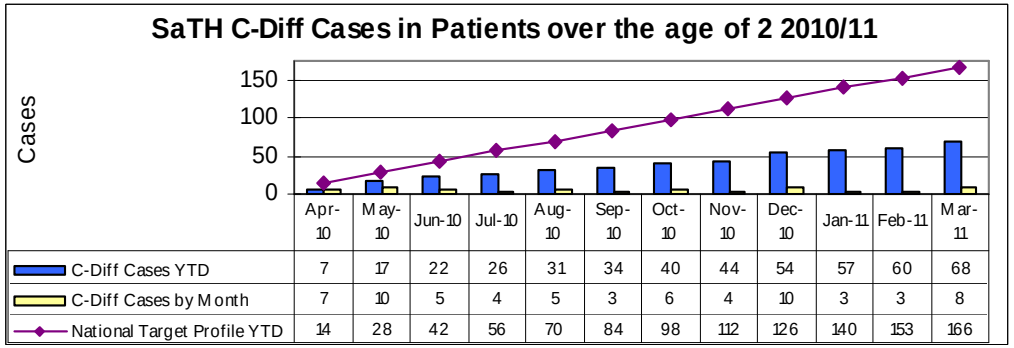
- Of the 113 incidents reported during 2010/11, 59 are still open. Work continues to complete and sign off the root cause analysis reports.

Healthcare Associated Infections (HCAIs)

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Healthcare Associated Infections (HCAIs)	No more than 6 post 48-hour MRSA bacteraemias	MD	GREEN	=	GREEN	GREEN	Total of 2 MRSA cases YTD
	No more than 166 post 72-hour C. Difficile infections	MD	GREEN	=	GREEN	GREEN	Total of 68 C. Difficile cases YTD



	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
MRSA Cases YTD	0	0	0	0	0	0	2	2	2	2	2	2
MRSA Cases by Month	0	0	0	0	0	0	2	0	0	0	0	0
National Target Profile YTD	1	1	2	2	3	3	4	4	5	5	6	6



	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
C-Diff Cases YTD	7	17	22	26	31	34	40	44	54	57	60	68
C-Diff Cases by Month	7	10	5	4	5	3	6	4	10	3	3	8
National Target Profile YTD	14	28	42	56	70	84	98	112	126	140	153	166

MRSA

- There were no cases of post 48 hr. MRSA bacteraemia in March.
- We have had 2 post 48 hr cases to end of March 2011 vs. target of not more than 6 cases during 2010/11 so we have achieved our target. In 09/10 we had 6 cases.
- There were 3 pre 48 hr cases in March. 2 were very recent inpatients in SaTH. These are not included in our target but we do joint RCA with the PCTs in such cases. Issues relevant to SaTH identified in these 2 cases included appropriate antibiotic therapy, discharge communication, and completeness of MRSA screening
- Ongoing work – maximising admission screening, re-screening wards where acquisition occurs, reducing line sepsis. Recently introduced - new admission documentation highlighting need for screening on admission.

C. Difficile

- To end March 2011 - 68 SaTH responsible cases (post 72 hrs.) vs. target of not more than 166 cases 2010/11 so we have achieved our target. In 09/10 we had 80.
- In March 8 SaTH cases, 4 at RSH and 4 at PRH, were diagnosed more than 72 hrs. post admission and therefore count vs. SaTH target.
- One ward has had more than two connected cases during the month and has had increased cleaning and monitoring of practices eg hand hygiene.
- Ongoing work – environmental cleanliness and antibiotic control.

Actions:

Medicines Management

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Medicines Management (CQUIN)	Delayed and missed doses of medicines for hospital inpatients	MD	**GREEN**	=	**GREEN**	**GREEN**	Baseline audit undertaken in May 2010, second and third audit completed Improvement Target agreed with PCTs has been meet in full

Third Audit Results January 2011

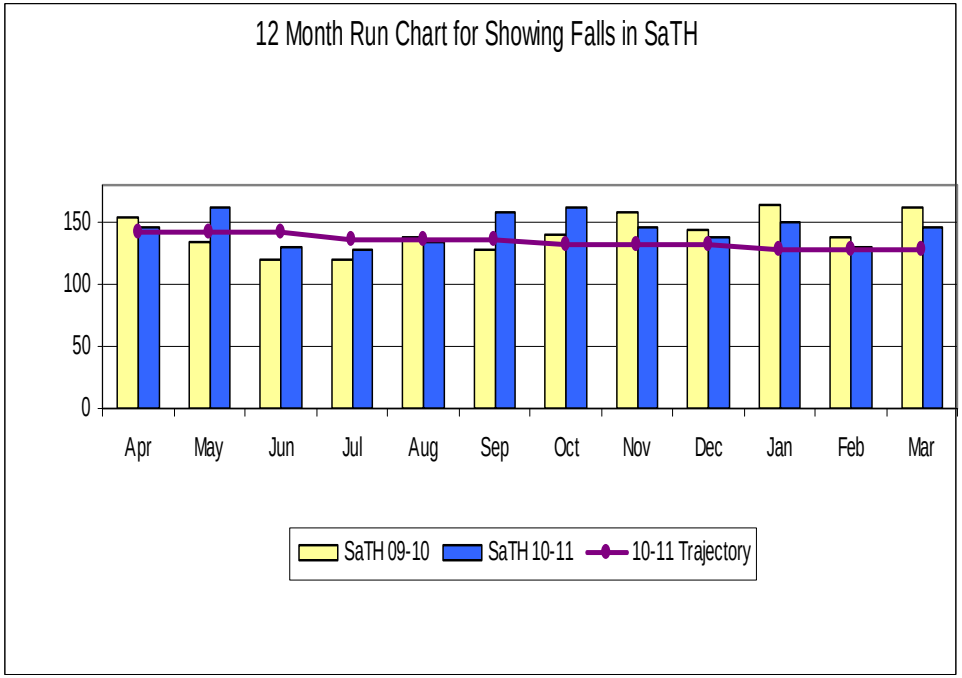
Patients records reviewed	283	
Number of times where medicines were prescribed	4727	
Prescription omitted for a clinical or patient specific reason i.e. patient refused	712	15.1%
Prescription omitted due to a record of non available	60	1.3%
Prescription where medicines regarded as critical	16	0.34 %
% of patients with an omitted dose	---	5.7%

- To agree list of Critical Medicines for Baseline Audit - achieved.
- To undertake baseline audit in May 2010 - achieved. Three day audit of Admission areas, 364 patient records/charts included, second audit completed, final audit January 2011 completed.
- Report to PCTs in July 2010 - achieved, November 2010 - achieved & March 2011 achieved.
- Baseline Audit accepted & 20% improvement target agreed, based on improvement over the subsequent two audits. Improvement Target was achieved for during both audits.
- Stock lists and out of hours arrangements amended in line with audit results & training & support advice provided to nursing staff to locate & obtain critical medicines.

Actions:
- Third Audit now completed, results show improvement target was met and exceeded.
- Results to be discussed at Area Prescribing Committee when PCTs advise of date.

Patient Falls

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Patient Falls (CQUIN)	No. of inpatients having a fall whilst an inpatient (CO1.3)	DQ&S	**RED**	=	**RED**	**RED**	• Q1 Baseline – 142 falls per month • Q2 4% reduction • Q3 7% reduction • Q4 10% reduction



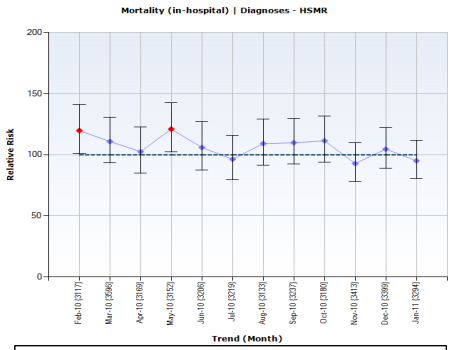
- March data over trajectory although numbers less than last year. 146 compared to 162. Have not achieved End of Year Target of 10% reduction.
- There have been 3 RIDDOR reportable falls in A&E (PRH) and 2 in 22S/R (RSH). Root Cause Analysis in progress.
- NPSA alert – post falls protocol. The working party has met Pilot wards for the protocol roll out will be ward 22c (RSH) and Ward 15 (PRH).
- Weighted alarms system being trialled in Ward 4 with positive feedback.

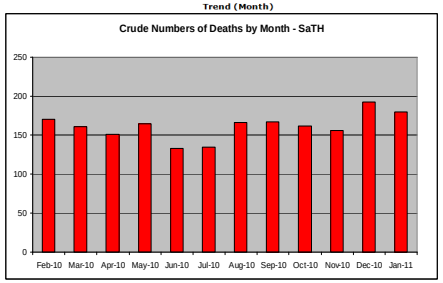
Actions:
- Ongoing CQUIN for 2011/12.

Hospital Standardised Mortality Ratio (HSMR)

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Hospital Standardised Mortality Ratio (HSMR)	HSMR for the most recent complete 12 months based on the HSMR basket of 56 diagnosis groups	MD	**AMBER**	⇩	**AMBER**	**RED** (Due to re-basing)	Month: 95.1 (95% CI: (80.4 – 111.8)) Last Quarter: 102.7 (93.3 - 112.8) Last 12 Months: 106.2 (101.1 – 111.5)

Period	HSMR
Jan 10-Mar 10	**RED (Worse)**
Apr 10-Jun 10	**AMBER** (Comparable but One Trigger)
Jul 10-Sept 10	**AMBER**
Oct 10-Jan 11	**GREEN**
Negative Triggers	**ONE**





- HSMR is calculated from hospital activity using the Dr Foster Real Time Monitoring (RTM) Analysis Tool, using the most recent available data (currently three months in arrears). It compares the mortality rates in SaTH with the average expected across England, adjusted to reflect factors such as age and case mix.
- The current status of the HSMR is:

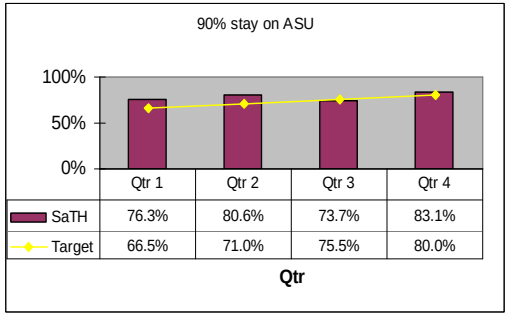
  Feb. 10 – Jan. 11 SaTH 106.2
  RSH 95.6
  PRH 120.2
- Re-based HSMR for SaTH Apr. 10 to Jan. 2011 is 115 reducing from 119 for Apr. to Oct. 2010. This indicates that our HSMR has reduced faster than the national index over the last 6 months.
- However with an HSMR of 115 SaTH will still be an outlier for start of next year.
- PRH is consistently higher than RSH and investigations are underway to understand why this is.

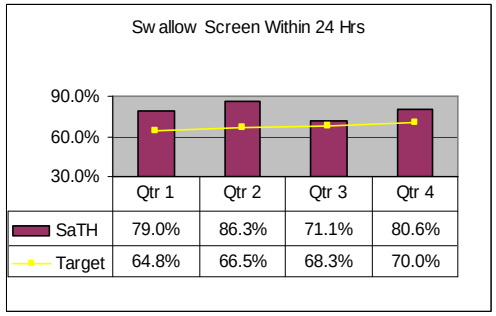
Actions:

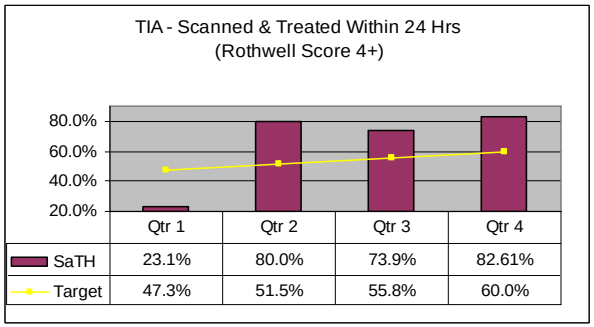
- Analysis of the numbers of deaths at PRH and RSH for the same number of spells has been conducted for the main service areas. It was found that the difference in numbers of deaths is negligible for the main services between sites. This was the case for both the HSMR and crude rates of measurement. Investigation is now underway to find out why the expected death rate is lower at PRH so giving the raised HSMR:
  - Patient notes for a specific number of deaths at PRH is being planned to be re-coded at RSH and vice-versa
  - A monthly review, by a subset of the Mortality Group supported by the Dr Foster Team, of HSMR data is being set up to look further into the differences between the two hospital sites.
- The Coding Team is leading on developing improved processes to record co-morbidities by Doctors within the Patients notes. A form for recording co-morbidities is being trailed at PRH with the involvement of 3 Consultants and the Coding Team.

Stroke

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Stroke National Target	% of Patients spending 90% of time on Stroke Unit	DQS	GREEN	=	GREEN	GREEN	Excellent improvement at RSH and sustained, high attainment at PRH means SaTH has surpassed target for Year End
Stroke – Compound Indicator	Based on targets agreed with local Commissioners	DQS	GREEN	=	GREEN	GREEN	Sustained improvement on both sites







- Current Performance Proportion of People who spent at least 90% of their time on a Stroke Unit: Quarter 4 Target 80%, PRH 94.02%, RSH 75.21%, **SaTH = 83.1%**
- SaTH achieved target for Qtr 4 and Year End. T&W and SC PCT targets were also met for year end. We are confident that improved processes with patient flow will help maintain and sustain this performance.
- Current performance for Swallow Screening on both sites:

  Quarter 4 Target 70%, PRH 82.1%, RSH 79.5%, **SaTH 80.6%.** Both sites achieving target and maintaining performance.
- Current Performance for TIA on both sites:

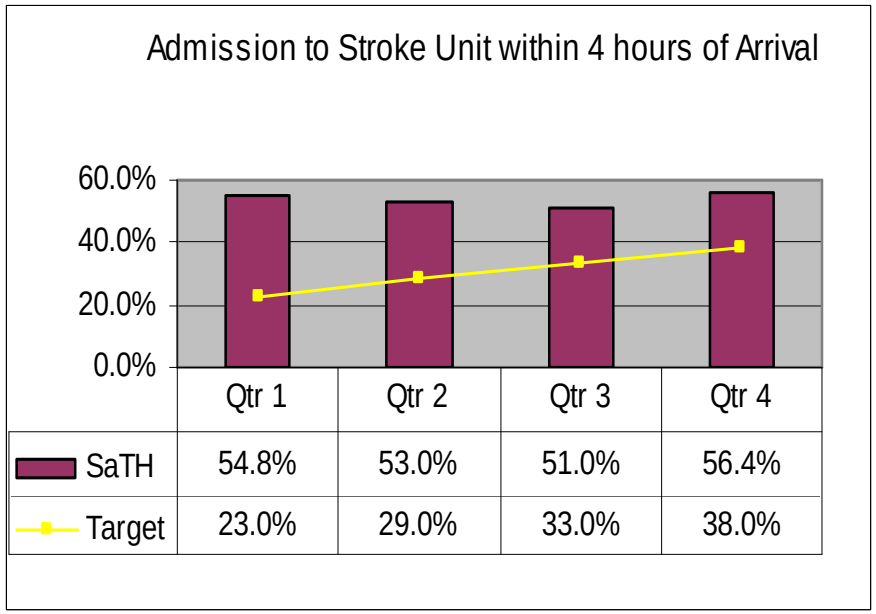
  Quarter 4 Target 60%, PRH 80%, RSH 84.6, **SaTH, 82.6%**
- Revised Operational Policy with Thrombolysis flowchart and Regional Network Consultant Rota, distributed and posted on Intranet.
- Stroke Sentinel audit results received and distributed. Meetings held 18th March (PRH) and 24th March (RSH), well attended by all disciplines/staff associated with Stroke, to discuss outcomes and areas for improvement.
- Joint Care Planning event held on 10th March 2011 involving both health and social care partners. New joint document introduced from 27th March 2011.

Actions:

- In-depth analysis of Sentinel audit figures based on Stroke Register to be undertaken and completed by end of April 2011 and in time for next Stroke Strategy meeting on 28/4/11.
- Dr Campbell to give an update on Sentinel audit findings to the Board, date to be agreed.
- To agree 2011-2012 stroke performance targets in negotiations with Commissioners.
- Currently scoping the Best Practise Tariff for High at Risk TIA over the 7 day period.

Stroke - CQUIN

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Year End Forecast	Commentary
Stroke	Admissions to Stroke Unit within 4 hours of Arrival at Hospital	DQS	**GREEN**	=	**GREEN**	**GREEN**	Sustained performance from PRH with notable improvement in last month for RSH



- Current performance for admitted to Stroke Unit within four hours of Arrival:
  Quarter 4: Target 38%, PRH 74.5%, RSH 42.5%, **SaTH 56.4%.**
- PRH have maintained steady improvement, whilst RSH have seen a 25% improvement in performance this month (to achieve target for Qtr. 4 and year end) with a March performance of 56%.
- This represents the culmination of hard work from all staff on Wd 22S (RSH) with support from A&E, MAU, Site Managers and Clinical Coding. Process and patient flow have been under scrutiny, and clear, reinforced, guidelines appear to be working.

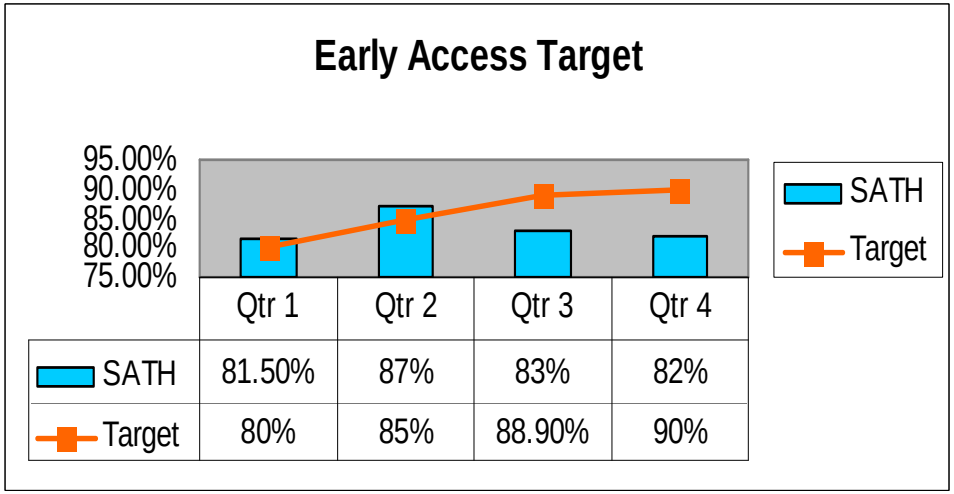
Actions:

- Currently agreeing with Commissioners the quality target to ensure sustainability of this key indicator.

Early Access to Maternity

Target (2009/10)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Early Access to Maternity	Achieve contract milestones for early access to maternity services (90% by Q4 and 86% full year) [possibly also add breastfeeding targets] (CO1.1)	COO	**GREEN**	⇧	**RED**	**RED**	March Q4 YTD T&WPCT = 89% 78% 79% SCPCT = 93% 88% 86%

Quarter 1 Data: Validated
Quarter 2 Data: Validated
Quarter 3 Data: Validated
Quarter 4: YTD



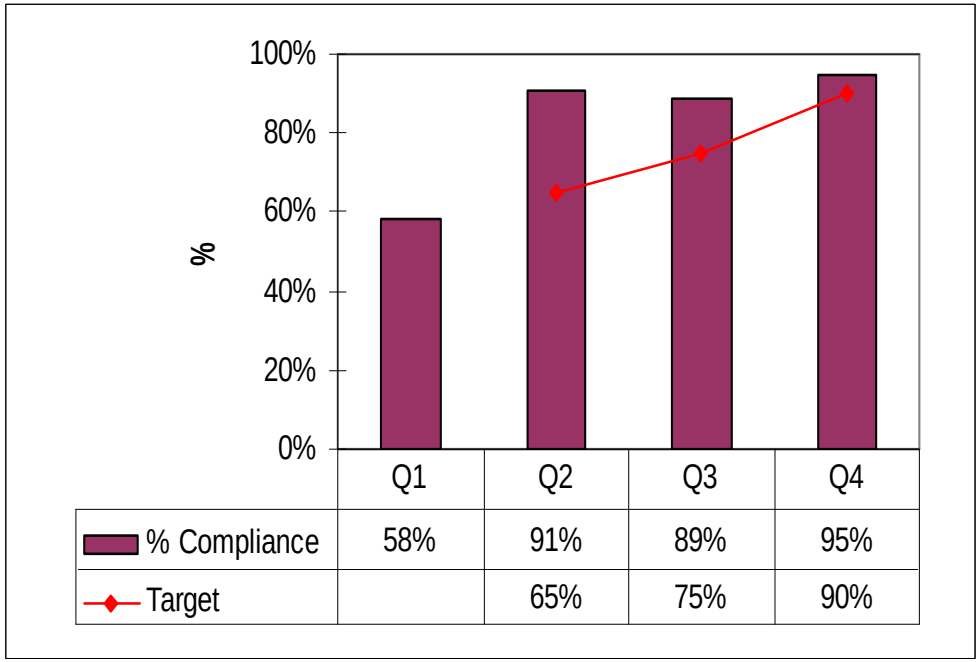
	Qtr 1	Qtr 2	Qtr 3	Qtr 4
SATH	81.50%	87%	83%	82%
Target	80%	85%	88.90%	90%

- Action plan implemented for both SCPCT and TWPCT with escalation procedures agreed.
- SCPCT has achieved the YTD target with TWPCT just a few percentage points below and improving.
- Sufficient venue options secured in Telford with an additional Children Centre coming online in May.
- Reminder letter implemented to reduce DNAs.
- Evening booking being explored in Telford.

Actions:
- Produce information posters on Early Access for GP practices.
- Improve communication with EPAS.

Nutrition

Target 2010/11		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Nutrition	% Completion of Nutrition Screening Tool (CO1.7)	DSD	**GREEN**	=	**GREEN**	**GREEN**	Baseline Audit 58% Q2 65% Q3 75% Q4 90%



	Q1	Q2	Q3	Q4
% Compliance	58%	91%	89%	95%
Target		65%	75%	90%

- Extensive work has been carried out by the wards since April 2010 to achieve above the targets for Nutritional Screening for the second, third and fourth quarter. There has been a huge push by wards to screen patients on a weekly basis – this is excellent practice.
- More responsibility needs to be carried out to refer patients onto the ward Dietitian based on the Screening outcomes for both Medium and High Risk patients.
- A new version of the Food Record Chart has been implemented – good compliance to completing these so far. Please refer to the food first advice at the back of the food chart for ward based nutrition support.
- The use of VitalPAC has been excellent in collating both height and weight. This information however, needs to be incorporated into the Nutrition Screening Tool to assist in a more accurate Nutrition Screening Score for ward patients.
- The Nutritional Steering Group is established and continues to address nutrition matters. The Meals Module is to be implemented together with the Medicine's Management module, with the view of implementing Protected Meal Times.
- A visit to a Dementia ward in Wolverhampton to share best practice is to take place end of April to assist in the implementation plans of introducing Protected Meal Times at SATH.

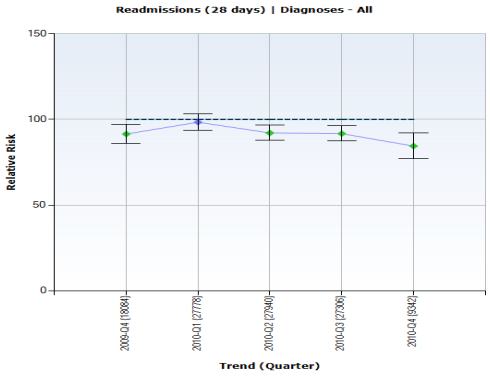
Actions:

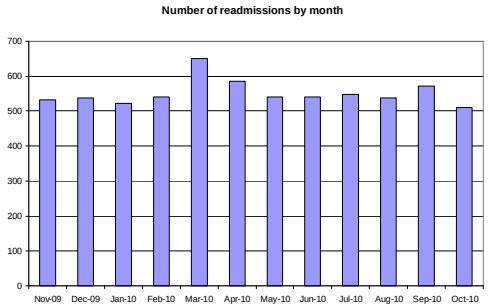
- Implementation of Protected Meal Times to commence from April 2011.
- Nutritional Steering Group members are to visit a Trust in the region who have successfully implemented Protected Meal Times.

Readmission Rates

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Readmission Rate	Relative Risk of Emergency Readmission within 28 days of discharge	MD	**GREEN**	=	**GREEN**	**GREEN**	The relative risk of Emergency Readmission remains significantly lower (better) than the average for England

Period	Risk Rating
Nov 09 to Oct 10	**6.0%**
	GREEN (Better)
Oct 09-Dec 09	**GREEN (Better)**
Jan 10-Mar 10	**GREEN (Comparable**
Apr 10-June 10	**GREEN (Better)**
Jul 10 – Sept 10	**GREEN (Better)**
Specialty Alerts	**ONE**





- Relative risk of emergency readmission within 28 days of discharge is calculated from hospital activity using the Dr Foster Real Time Monitoring Analysis Tool, using the most recent available data (currently five months in arrears, to ensure that readmissions have been mapped to previous spells). It compares the Emergency Readmission in our hospitals with the average expected across England, adjusted to reflect factors such as age and case mix.

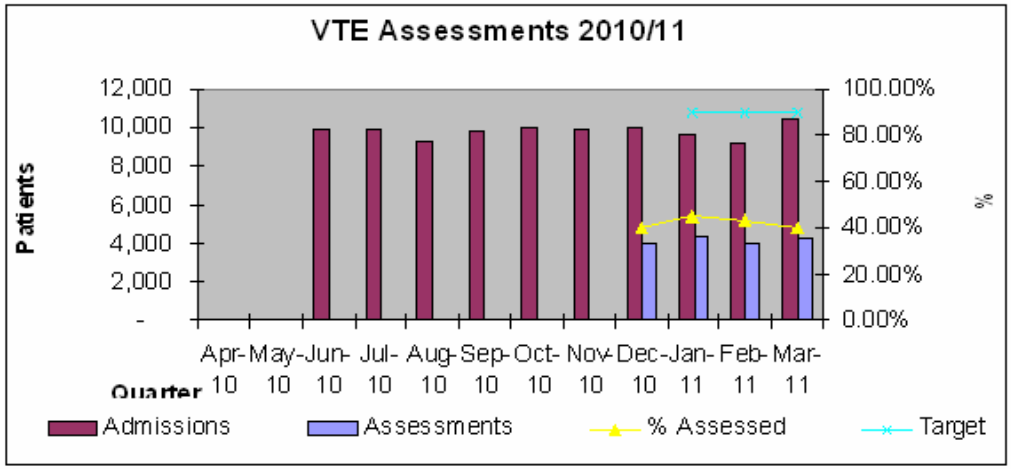
- The relative risk of Emergency Readmission was lower (better) than the average for England (based on a 95% confidence interval) for the most recent available full data year (Nov. 09 to Oct. 10) and was significantly lower than (3 quarters) or comparable with (1 quarter) the average for England in the 4 quarters of the most recent available data year.

Actions:

- Work is underway to understand the impact of recent changes in the tariff with relation to readmissions.

Venous Thromboembolism

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Venous Thromboembolism (CQUIN)	% of adult inpatients who have had a VTE risk assessment on admission (CO1.3)	MD	**RED**	=	**RED**	**RED**	Failed in March



	A	M	J	J	A	S	O	N	D	J	F	M
Admissions			9883	9901	9296	9807	10062	9954	9982	9612	9150	10,444
Assessments									4003	4316	3977	4,222
%									40%	45%	43%	40%
Target										90%	90%	90%

- Slight increase in compliance to 40% in March.
- Manual system implemented to collect data on the number of VTE assessment forms completed, with Ward Clerks checking on patient discharge if VTE has been completed.
- Vital Pac VTE Module is being rolled out across PRH in the first instance. Compliance with use of Vitalpac is poor ranging from 15 – 8% compliance.
- There has been a range of audits undertaken to ensure that patients receive appropriate prophylaxis for VTE.

All specialities October 2010:

- 69% of cases received appropriate treatment.
- 4% received prophylaxis, but did not need it.
- 27% of patients should have had prophylaxis, but did not receive it.
- Gynaecology January 2011 - 100% of patients received appropriate prophylaxis.

Actions:

Think Glucose

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Think Glucose (CQUIN)	Compliance with Think Glucose guidance (CO1.3)	MD	**GREEN**	=	**GREEN**	**GREEN**	Compliance with Think Glucose tool kit audited. CQUIN achieved.

Milestones	Completion Date	Compliance
Baseline audit	Q1	**Green**
Robust process for patient identification Safe use of insulin implemented	Q2	**Green**
Review of patient identification visibility and education roll out re-audit against toolkit	Q3	**Green**
CQUIN compliance	Q4	**Green**

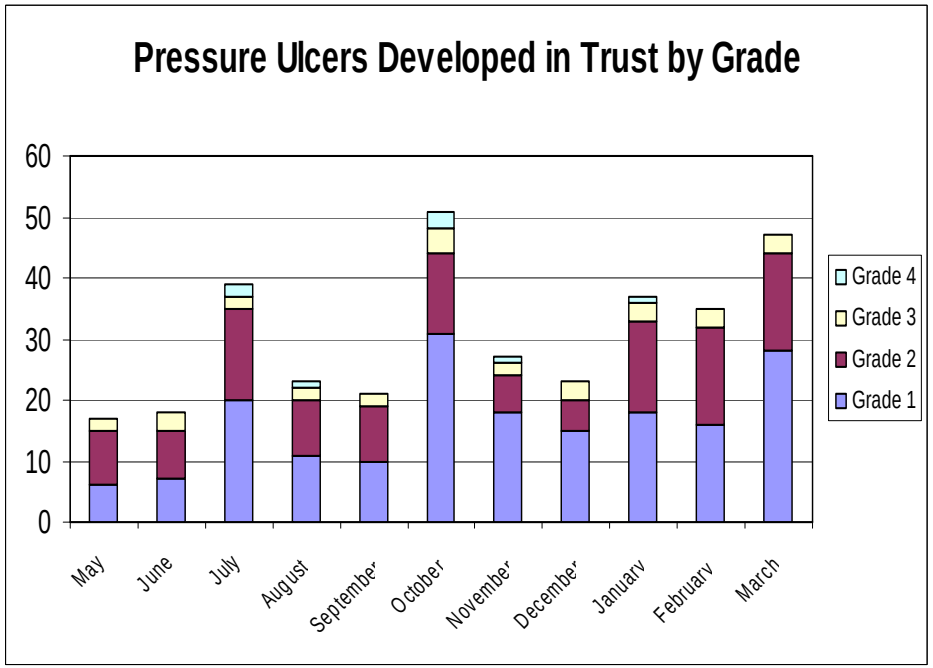
- Think Glucose is a practical and easy to use tool which improves the care, outcomes and experience of people with diabetes who are admitted to hospital with non-diabetes related problems.
- Compliance audit in March 2011 revealed that 93% of clinical areas are identifying patients with diabetes, but only 24% are following correct referral process, using the referral stickers. 24% are using the Think Glucose Checklist.
- Compliance with Think Glucose tool kit audited on 25.03.11 by PCT. CQUIN achieved.

Actions:

- Continue Monthly compliance audit.

Tissue Viability

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Tissue Viability (CQUIN)	Reduction in the number of Grade 3 and 4 Pressure Ulcers – to be confirmed with PCT (CO1.3)	DQ&S	**RED**	=	**AMBER**	**AMBER**	New CQUIN 2010/11 Target to reduce by Q4 number of grade 3/4 ulcers by 10%



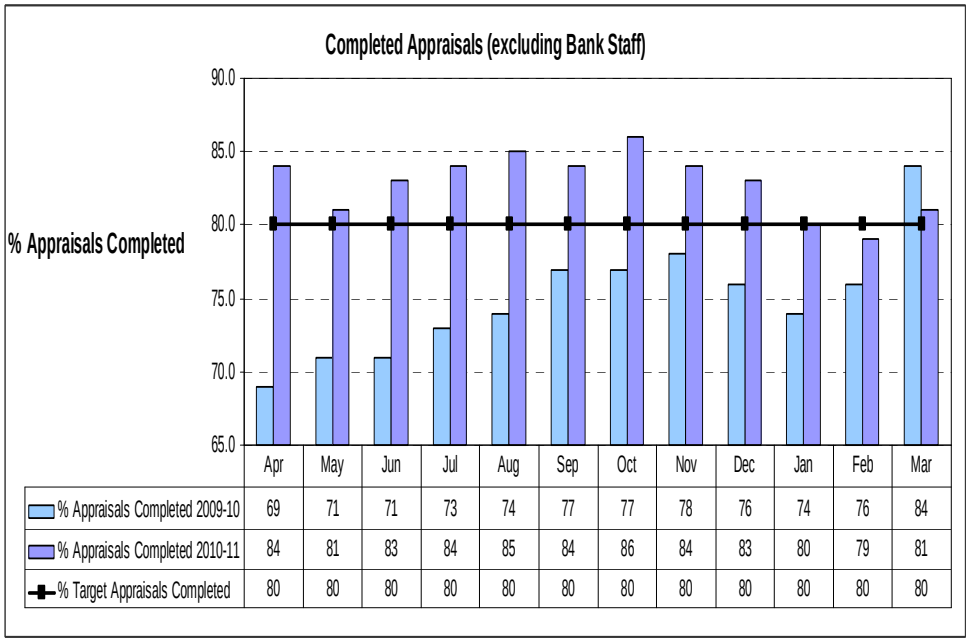
- There were 3 grade 3/4 Trust acquired ulcers reported in March 2011, giving a total of 33 grade 3/4 ulcers for the 12 months. The CQUIN target to reduce ulcers by 10 % has not been achieved.
- SaTH did meet the Q4 quality indicators for compliance of assessment on admission, achieving 98% against target of 75% and a rise from 67% in Q2.
- The Trust partially met the quality indicator for evidence of care planning, achieving a compliance of 65% which was an improvement on Q2 where SaTH achieved only 42%.
- As a result the Trust has partially achieved the CQUIN target for 2010 /11 therefore reporting amber for YTD and forecast.
- An additional full time Tissue Viability Nurse has been recruited commencing in June.
- Good uptake on the Tissue Viability teaching and training programmes.

Actions:

- Chief Nurse to lead improvement programme with Senior Nurses.
- Tissue Viability Educational Programme continues to be rolled out.
- To increase the number of cameras for medical loans to meet demand for photographing of ulcers on admission and discharge.

Appraisals

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Appraisals	SaTH target of 80%	DCRM	**GREEN**	⇧	**GREEN**	**GREEN**	Trust appraisal completion performance at 81%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% Appraisals Completed 2009-10	69	71	71	73	74	77	77	78	76	74	76	84
% Appraisals Completed 2010-11	84	81	83	84	85	84	86	84	83	80	79	81
% Target Appraisals Completed	80	80	80	80	80	80	80	80	80	80	80	80

- As at month ending 31st March 2011, 81% of staff excluding Bank Staff have had a KSF appraisal within the last 15 months. This is an increase from the previous month. Average performance over the entire year is above 80%.
- Line managers have been reminded of the need to sustain performance above 80% on a consistent basis across the year and Executive Directors are asked to address individual department performance below 60%.
- The lowest 5 performing areas for March with over 15 staff were as shown. All have action plans in place to achieve 80%.

Area	Staff	Completed	%	Div.
Ward 28 – Trauma & Orthopaedics	34	13	38	1
Catering Department (PRH)	66	33	50	Corp.
Physiotherapy Department (RSH)	48	27	56	3
Ward 22 – Stroke & Rehabilitation Unit	60	36	60	1
Appointments Team	28	17	61	3

Actions:

- Departments falling below 60% are performance managed by the relevant Executive Director.

Staff Satisfaction

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Staff Satisfaction	A continual improvement in staff satisfaction, as assessed by the Annual Staff Survey (CO3.3)	DCRM	**GREEN**	=	**GREEN**	**GREEN**	2009 survey shows continued improvement over previous years

The results in 2009 showed significant improvement in 11 areas and one significant deterioration compared to the 2007 results. Based on the results of the 2009 survey, the four key priorities for the Trust in 2010 are to:

- Improve role clarity and job design, supported by maintaining the percentage of appraisals and PDPs completed, with a focus on recognising staff contribution and quality improvement (Director of Corporate Affairs lead);
- Improve attendance at statutory and mandatory training, including Infection Control, and completion of Equality and Diversity training (Director of Corporate Affairs lead);
- Improve communications with Trust Senior Management and within teams (Director of Strategy lead);
- Improve the management of stress at work (Director of Corporate Affairs lead).

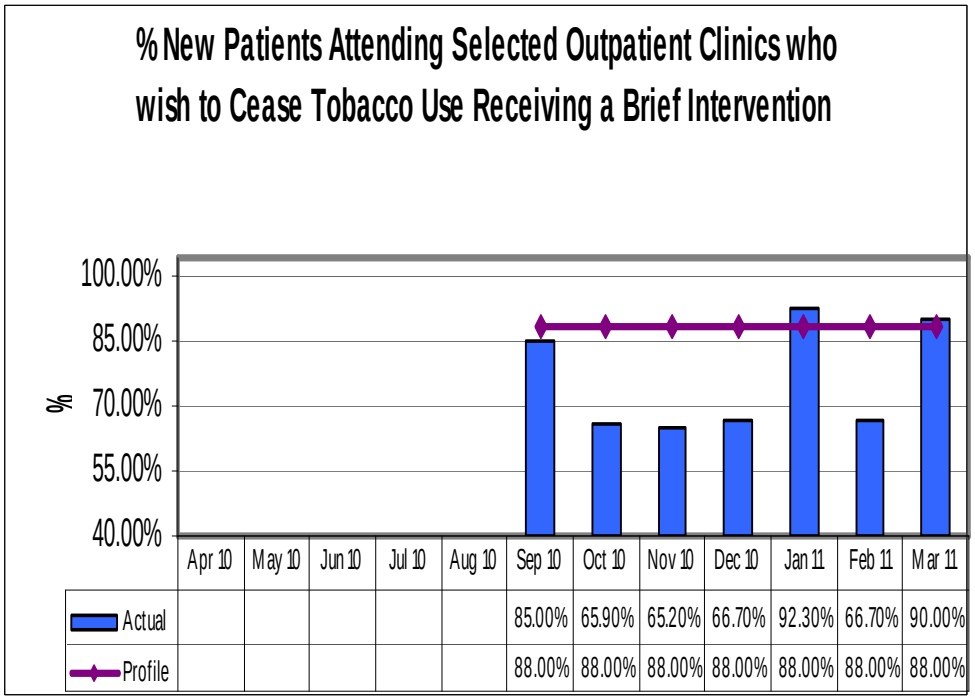
Progress in the third quarter has included:

- 83% of staff excluding Bank Staff have had a KSF appraisal within the last 15 months, ahead of target (see Appraisal report). An Appraisal Quality Audit is currently being trialled to improve the effectiveness of individual appraisals.
- Stress Risk Assessment training is on-going. H&S team are supporting line managers in carrying out both group - and individual - based Stress Risk Assessments and action plans as required.
- Submission of this year's national staff survey has now closed. Results will be published in Spring 2011.

Actions:

Smoking

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Smoking (CQUIN)	90% of smokers/users of tobacco attending new patient appointments at selected outpatient clinics receive brief intervention (CO4.3)	MD	**GREEN**	=	**RED**	**RED**	Target achieved in March



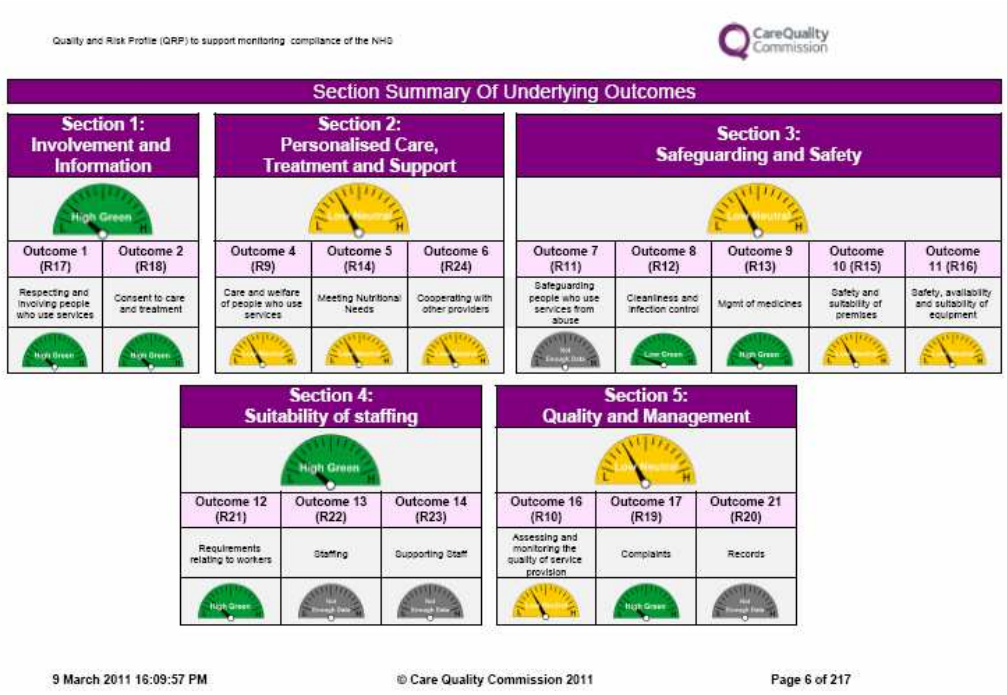
- Revised plan and paperwork has been approved by SCPCT but not yet formally approved by TWPCT. This slide has been prepared on the assumption that it will be approved in due course.
- The figures have been recalculated for Q4 on the basis that a brief intervention was delivered to patients who attended named clinics in Respiratory, Cardiology, Vascular, Diabetes and ENT and who wish to stop smoking.
- On this basis, Q4 has been partially achieved, with >80% of patients who wish to stop smoking offered a brief intervention.
- Of these, 2 were referred to the Stop Smoking Nurse and 6 declined stating they are participating in a smoking cessation programme.

Actions:

- This is not a CQUIN in 2011/12 .

Care Quality Commission Registration

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Care Quality Commission Registration	Maintain Trust Registration with the Care Quality Commission	DCA	GREEN	=	GREEN	GREEN	Trust registered without conditions



- The CQC produce regular Quality and Risk Profiles (QRP). This tool gathers all the CQC know about a provider in one place. The latest summary of the QRP (March) is shown opposite.
- The Trust declared compliance with all outcomes across the six key areas in the 2010 January Initial Registration process. The CQC do not annually re-assess compliance but carry out responsive reviews on standards which trigger concerns. A responsive review was published by the CQC in October; the Trust was judged compliant with the standards assessed. Minor concerns were raised regarding staffing (obstetrics) and care & welfare of people using services (pressure ulcers).
- The Trust was picked at random for a review in March of outcome 1 (dignity) and outcome 5 (nutrition). The final report has not been received but initial feedback indicates the CQC had concerns about care of vulnerable adults.

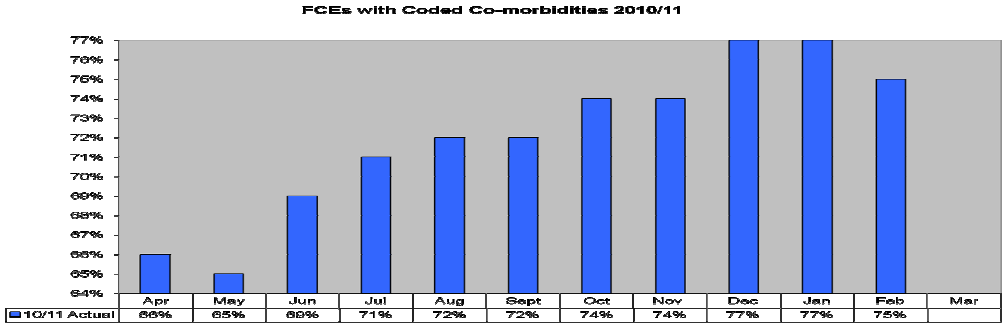
- The Trust remains registered without any conditions.
- A planned review of compliance will take place by the CQC within 2 years of registration.

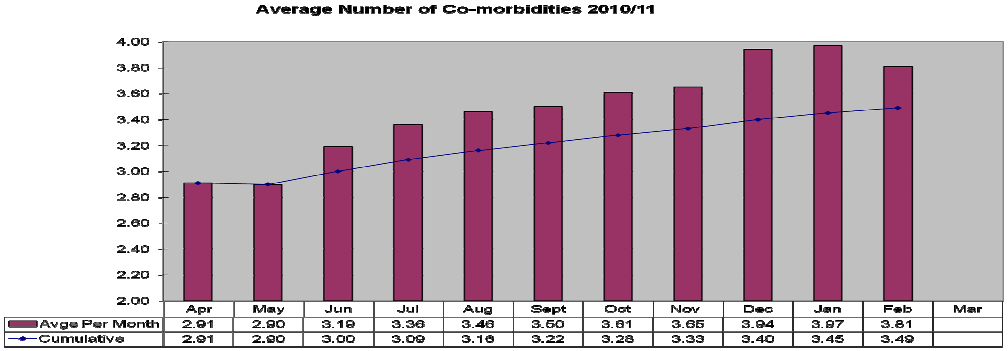
Actions:

- Lead Managers have been updating the Provider Compliance Assessment Templates and collating evidence of continuing compliance against the Essential Standards of Quality and Safety for Quarter 4.
- Internal Audit have audited the processes around monitoring of ongoing CQC compliance in 2011 and have given substantial assurance on the processes in place

Coding

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Coding	To increase the numbers of FCEs with coded co-morbidities	FD	**GREEN**	=	**GREEN**	**GREEN**	Cumulative coding depth has increased in month





Data report one month in arrears

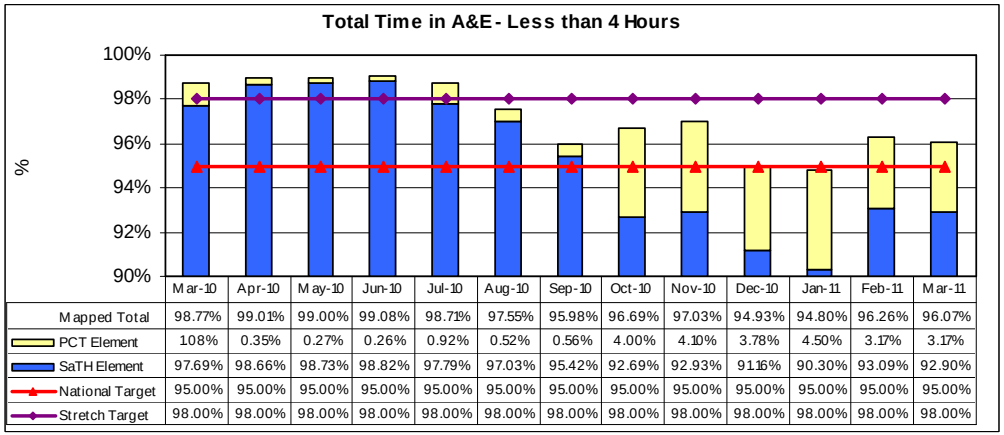
- The target is to ensure that co-morbidities are captured by clinicians for each Finished Consultant Episode (FCE), where applicable. Both charts show a steady increase in the depth of coding.
- Work is ongoing with MedeAnalytics to analyse national coding statistics and provide a national benchmark by which SaTH clinical coding can be compared.
- New guidance for 2010/11 has been issued by Connecting for Health which clarifies the recording of co-morbidities and is responsible for the increased depth of coding.

Actions:

- The Clinical Coding Manager continues to audit the recording of co-morbidities on a monthly basis making use of the Coding analytics software.

A&E 4 Hour Waits

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
A&E 4 Hour Waits	95% of patients to be admitted, discharged or transferred within 4 hrs. of registering at A&E	DSD	**GREEN**	=	**GREEN**	**GREEN**	Local Health Economy achieved the target for March



	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Mapped Total	98.77%	99.01%	99.00%	99.08%	98.71%	97.55%	95.98%	96.69%	97.03%	94.93%	94.80%	96.26%	96.07%
PCT Element	1.08%	0.35%	0.27%	0.26%	0.92%	0.52%	0.56%	4.00%	4.10%	3.78%	4.50%	3.17%	3.17%
SaTH Element	97.69%	98.66%	98.73%	98.82%	97.79%	97.03%	95.42%	92.69%	92.93%	91.16%	90.30%	93.09%	92.90%
National Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
Stretch Target	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%

- The Trust achieved 92.90 unmapped during March
- The Local Health Economy achieved 96.07% mapped during March
- For the year-to-date the Trust has achieved 94.99% unmapped.
- For the year to date the Local Health Economy has achieved 96.94% mapped.
- Shropshire County PCT A&E attendances in March were 9.8% over plan
- NHS Telford & Wrekin A&E attendances in March were 12.3% over plan

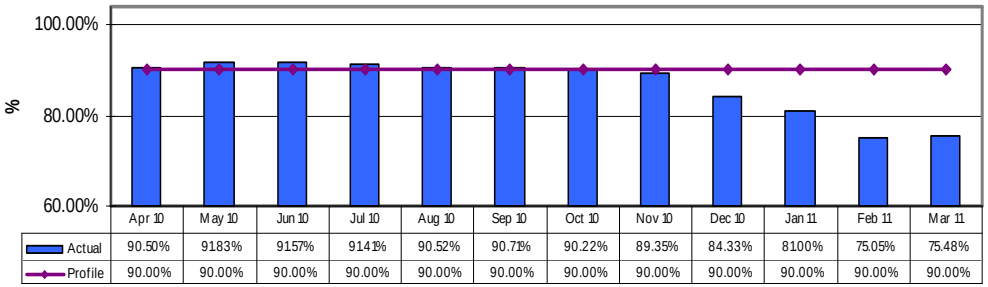
Actions:

- An Operational group chaired by the Value Stream Lead for Unscheduled care has been set up to start in Mid April to ensure optimised patient flow through the Hospital Sites
- Internal Winter Planning meetings taking place monthly to ensure continuous improvement of the SaTH Winter and Surge planning Plan.
- Urgent Care Network Review underway to determine the future Strategy for Urgent Care across the Local Health Economy, with a view to this group being clinically led
- The Clinical Site Management team has been placed in Emergency/Critical Care Centre to ensure an overarching and empowered delivery of Site management working to Standard Operating procedures

18 Weeks

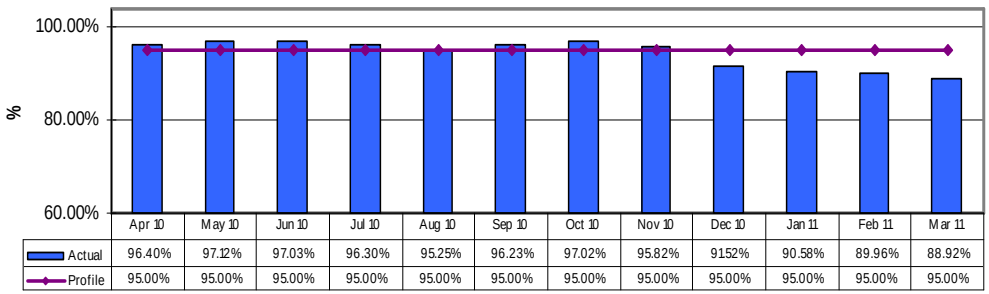
Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
18 Weeks	1a - Admitted Clock Stops above 90%	DSD	**RED**	=	**RED**	**RED**	Trust failed the 90% target during March
	1b - Non-Admitted Clock Stops above 95%	DSD	**RED**	=	**RED**	**RED**	Trust failed the 95% target during March

18 Weeks Part 1a - Admitted Clock Stops



	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11
Actual	90.50%	91.83%	91.57%	91.41%	90.52%	90.71%	90.22%	89.35%	84.33%	81.00%	75.05%	75.48%
Profile	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%

18 Weeks Part 1b - Non Admitted Clock Stops



	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11
Actual	96.40%	97.12%	97.03%	96.30%	95.25%	96.23%	97.02%	95.82%	91.52%	90.58%	89.96%	88.92%
Profile	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

- The Trust under achieved the overall targets with 75.48%, 1a and 88.92% 1b
- PCT performance for March was:-

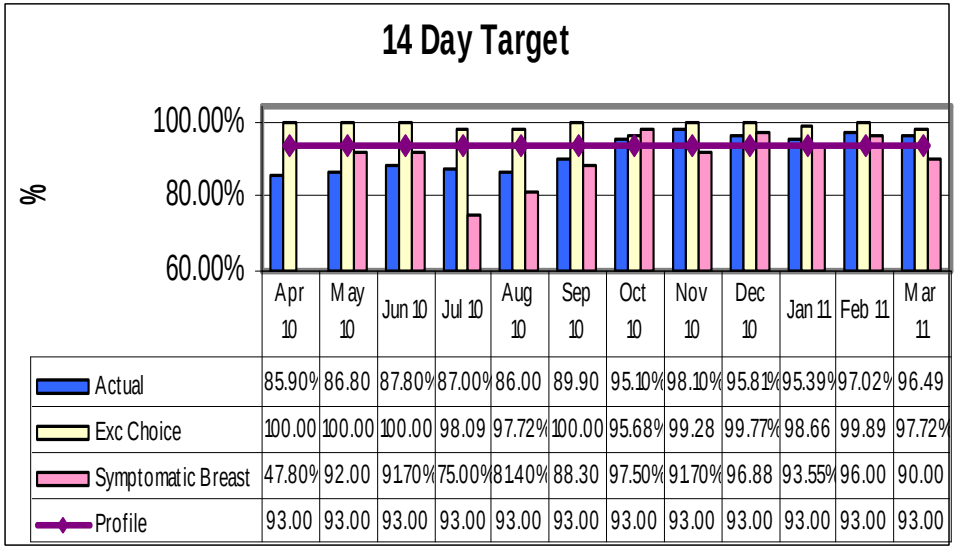
	1a	1b
Shropshire County PCT	76.2%	86%
Telford & Wrekin PCT	74.36%	92.83%

- Achieved the 95% target for Audiology in March with 98% of non admitted Audiology patients completing their pathways within 18 weeks with 102% data completeness which is within the anticipated 90 – 110% threshold.
- Specialty level performance for admitted patients (part 1a) below 90%, ENT (71.87%), Gen Surg (76.51%), Gynae (74.25%), Ophthalmology (63.27%), Oral Surg (56.77%), Other (68.84%) T&O (67.84%), Urology (70.44%)
- Specialty level performance for non admitted patients (part 1b) below 95% Cardiothoracic Surg (83.33%), Dermatology (78.45%), ENT (71.75%), Gastro (87.65%), Gen Medicine (91.26%),Gynae(93%) Neurology (77.44%),Neurosurgery(83.33%) Ophthalmology (84.41%), Oral Surg (54%), T&O (82.16%), Urology (86.48%)
- At the end of March there were 21,454 English responsible open clocks recorded with 3205 of these over 18 weeks, this compares to 21,063 at the end of the previous month of which 5,383 were over 18 weeks.

Actions: •Development of additional graphical reporting to demonstrate progress towards reducing open clocks to a sustainable level by December 2010 in line with the agreed IST action plan. It is anticipated this will be ready for Aprils data

14 Day Cancer

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Cancer – 14 Day	14 Days from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals	COO	**GREEN**	=	**AMBER**	**AMBER**	14 day target achieved in month



	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11
Actual	85.90%	86.80	87.80%	87.00%	86.00	89.90	95.10%	98.10%	95.81%	95.39%	97.02%	96.49
Exc Choice	100.00	100.00	100.00	98.09	97.72%	100.00	95.68%	99.28	99.77%	98.66	99.89	97.72%
Symptomatic Breast	47.80%	92.00	91.70%	75.00%	81.40%	88.30	97.50%	91.70%	96.88	93.55%	96.00	90.00
Profile	93.00	93.00	93.00	93.00	93.00	93.00	93.00	93.00	93.00	93.00	93.00	93.00

At the time of writing this report the actual performance for the months of April, May, June, July, August, September, October, November, December, January and February are validated but the actual performance for the month of March is still being validated before submission of data to the national Cancer Waiting Times Database (which is 'closed down' on a quarterly basis).

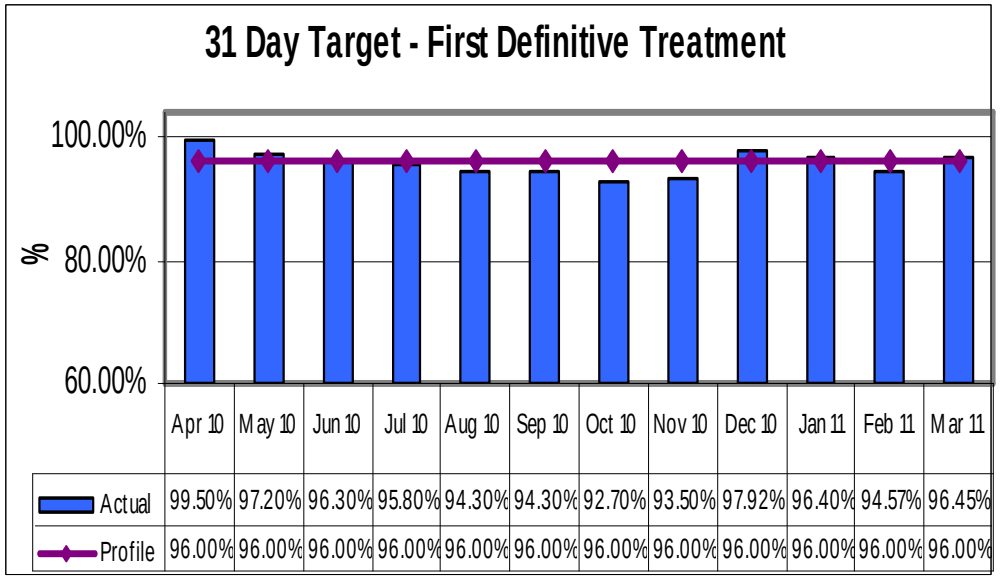
- 14 day target achieved in March 96.49%, against a year end cumulative target of 93%. There were 40 breaches out of a total of 1,139 referrals.
- Symptomatic Breast Performance for the month was 90.00%, against a year end cumulative target of 93%. There were 4 breaches out of a total of 40 referrals. These were all patient choice.
- 26 patients chose to wait longer than 14 days for their first appointment.
- The SaTH 14 day target YTD is currently 92.47% against a year end cumulative target of 93%.
- The application of the RAG status is as per the internal Performance Directory (within 5% of target is Amber).
- The newly appointed Cancer Services Information Manager is liaising with the SHA to confirm data sources for reporting purposes.

Actions:

- The 14 day target has improved significantly and has been sustained in the 6 months since October. Demand and capacity for all Specialities has been reviewed over the last 12 months and processes are being put in place to increase capacity where required.
- There are issues around Breast Symptomatic due to patients being referred in on the incorrect proforma. This has been raised at the Cancer LIT.

31 Day Cancer

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Cancer – 31 Day	31 Days from diagnosis to treatment for all cancers	COO	**GREEN**	=	**AMBER**	**AMBER**	31 day target achieved in month



At the time of writing this report the actual performance for the months of April, May, June, July, August, September, October, November, December, January and February are validated but the actual performance for the month of February is still being validated before submission of data to the national Cancer Waiting Times Database (which is 'closed down' on a quarterly basis).

- 31 day target first definitive treatment achieved in March (96.45%), against a year end cumulative target of 96%.
- 31 day target subsequent treatment (Surgery) achieved in March (100%), against a year end cumulative target of 94%.
- 31 day target subsequent treatment (Anti Cancer Drugs) achieved in March (100%) against a year end cumulative target of 98%.
- 31 day target subsequent treatment (Radiotherapy) achieved in March (98.46%), against a year end cumulative target of 94%.
- Current YTD position for 31 day first treatment target is 95.97% against a year end cumulative target of 96%, thus the Amber forecast.

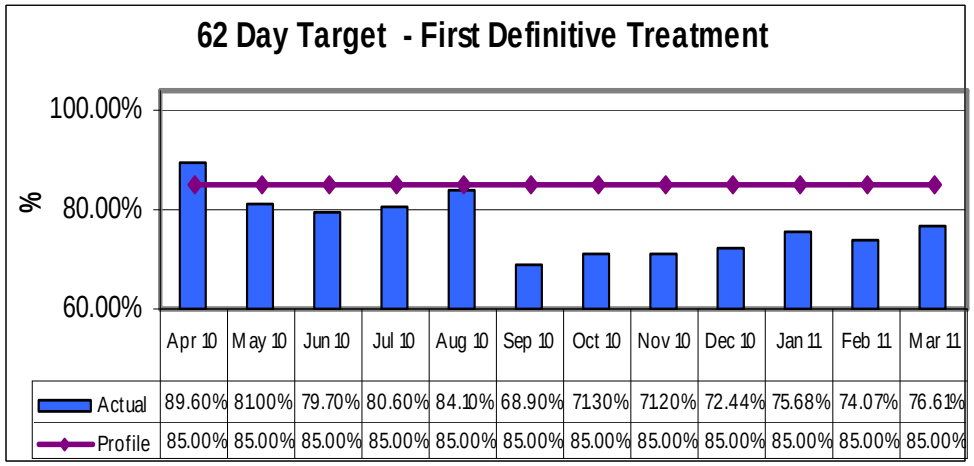
- There were 15 breaches in February out of 274 patients treated.
- The application of the RAG status is as per the internal Performance Directory (within 5% of target is Amber) which is relevant to the overall target.
- The newly appointed Cancer Services Information Manager is liaising with the SHA to confirm data sources for reporting purposes.

Actions:

- Plans have been agreed to increase Radiography and Physics staffing to increase linear accelerator capacity in line with NRAG recommendations.
- Work started in December with the Department of Health Intensive Support Team to identify areas for improvement.

62 Day Cancer

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Cancer – 62 Day	62 Day from urgent referral to treatment of all cancers	COO	**RED**	=	**RED**	**RED**	62 day target failed in month



At the time of writing this report the actual performance for the months of April, May, June, July, August, September, October, November, December, January and February are validated but the actual performance for the month of February is still being validated before submission of data to the national Cancer Waiting Times Database (which is 'closed down' on a quarterly basis).

- 62 day first definitive cancer target failed in March (76.61%), against a year end cumulative target of 85%.
- 62 day screening to first definitive treatment target achieved in March (92.86%), against a year end cumulative target of 90%.
- 62 day consultant upgrade performance target in March was 96.00% – to be confirmed.
- Current 62 day traditional target YTD position is 77.29% against a year end cumulative target of 85%.

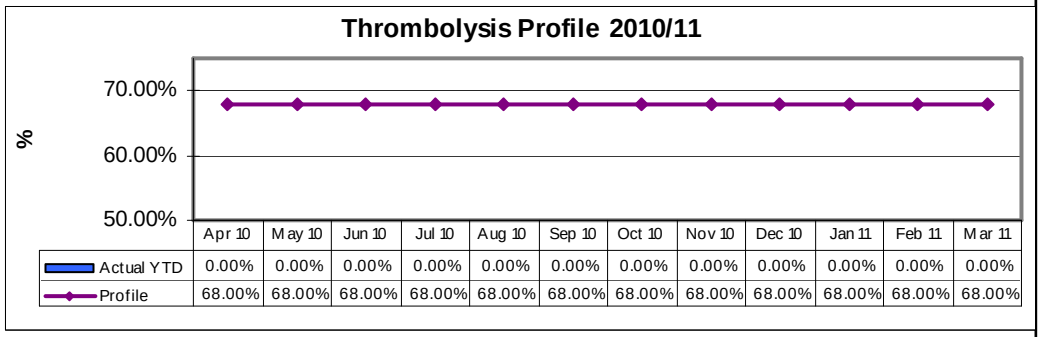
- There were 14.5 breaches in February out of 62 patients treated.
- The application of the RAG status is as per the internal Performance Directory (within 5% of target is Amber) which is relevant to the overall target.
- The newly appointed Cancer Services Information Manager is liaising with the SHA to confirm data sources for reporting purposes.

Actions:

- The Cancer Access policy has been updated. The escalation policy has also been developed and is awaiting ratification.
- There are problems with access to diagnostics for Cancer patients i.e. CT scanning four week waiting times which are causing delays in the pathway. This is being addressed by the Chief Operating Officer.
- There are delays in the pathway for procedures in Urology and Colorectal. The DGM for Surgery is addressing this.
- Work started in December with the Department of Health Intensive Support Team to identify areas for improvement.

Thrombolysis

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Thrombolysis	68% of patients admitted with ST Elevation MI should receive Thrombolysis within 60 minutes of call for help	COO	**RED**	=	**RED**	**RED**	Only 4 eligible patient in the year to date. CQC guidance states that for this indicator a 'low numbers' rule will be applied which will withdraw Trusts treating a low number of eligible cases from the assessment



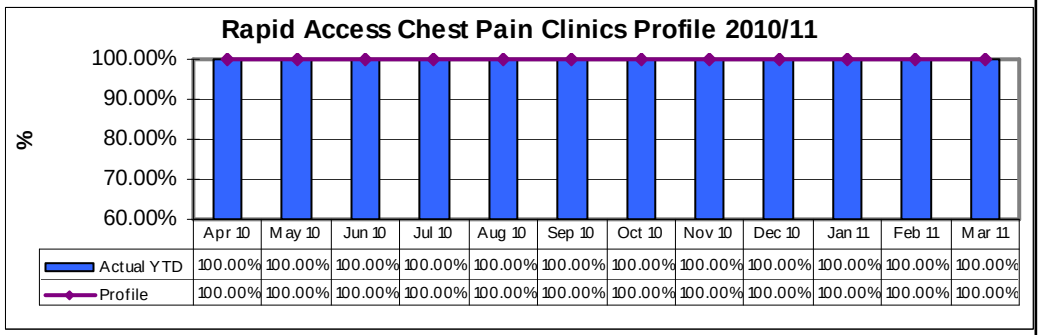
Thrombolysis Performance YTD	PRH	RSH	SaTH
Call to Needle Eligible Admissions	1	3	4
Call to Needle < 60 minutes	0	0	0
Performance Achieved YTD	**0%**	**0%**	**0%**

- Year-to-date performance of 0%.
- This is a combined target for the Trust and the Ambulance Services.
- Rurality issues within Shropshire County and Powys impact on the Call to Door time. Both West Midlands and Welsh Ambulance Services are able to deliver pre-hospital thrombolysis in accordance with strict eligibility criteria.
- The introduction of direct access Primary Angioplasty at UHNS and Wolverhampton Hospitals has led to a reduction in the number of SaTH Myocardial Infarction admissions receiving thrombolysis as the majority are transferred directly to Heart Attack Center's from community or A&E – approximately 40 YTD from A&E (full audit of numbers to be undertaken).
- The majority of patients receiving thrombolysis **within** SaTH are complex cases with justifiable reasons for exclusion from call to needle time analysis e.g. pre / in hospital cardiac arrest.
- Assurance paper completed for Chief Operating Officer

Actions:

Rapid Access Chest Pain

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Rapid Access Chest Pain	A maximum of two-week wait for rapid access chest pain clinic (CO6.6)	COO	**GREEN**	=	**GREEN**	**GREEN**	Well established service with consistent high performance



- 5 Rapid Access clinics running each week across SaTH.
- Capacity appropriately matched to demand.

Actions: