

# INTEGRATED PERFORMANCE REPORT for period ending 28<sup>th</sup> February 2011

## Quality

<b>EXECUTIVE RESPONSIBLE</b>	Vicky Morris <b>Director of Quality &amp; Safety / Chief Nurse</b>	<b>KEY FACTS</b>	<ul style="list-style-type: none"> <li>Stroke National &amp; Local, A&amp;E, MRSA and C. Difficile, Cancer 14, Rapid Access Chest Pain targets achieved in month.</li> <li>Cancer 31 underachieved in month.</li> <li>Thrombolysis, 18 Weeks and Cancer 62 day all failed in month.</li> </ul>	
<b>AUTHOR (if different from above)</b>	Paul Hodson <b>Head of Contracts &amp; Performance</b> Pete Gordon <b>Head of Continuous Improvement</b> William Wraith <b>Head of Human Resources</b> Tony Brown <b>Assistant Director Financial Performance</b>			
<b>CORPORATE OBJECTIVE</b>	Enhancing Patient Experience, Safety and Effectiveness, Achieving NHS Foundation Trust Status			
<b>BUSINESS PLAN OBJECTIVE NO(S)</b>	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.			
<b>EXECUTIVE SUMMARY</b>	This paper reports current performance against a number of established KPIs for the period up to the end of February 2011. As detailed in previous papers this reports only includes slides for those KPIs identified as suitable for monthly reporting. The summary sheet will continue to show a RAG for all KPIs with quarterly KPIs showing their RAG status at the end of the last full quarter.		<b>RECOMMENDATIONS</b>	The Board is asked to <b>NOTE</b> : <ul style="list-style-type: none"> <li>performance against a range of Key Performance Indicators covering Quality, Delivery and Foundations.</li> </ul>

# Integrated Performance Report: Quality (CO1)

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	=	AMBER	GREEN	Target 2010/11 89% overall patient satisfaction 5 indicators identified from 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	AMBER	=	RED	RED	12 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 February 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 84.4% in February, a reduction of 5% from January	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	Of the 157 cases opened in the third quarter all have been responded to within the 6 months statutory deadline	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 6.40%	M
		Serious Incidents Requiring Investigation (CO1.6)	MD	RED	=	GREEN	GREEN	Less than 8 SIRIs per month	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 60 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, second and third audit now completed Improvement Target agreed with PCTs has been met in full	M
Patient Falls (CQUIN)	No. of inpatients having a fall whilst an inpatient (CO1.3)	DQ&S	Amber	=	RED	RED	<ul style="list-style-type: none"> <li>Q1 Baseline – 142 Falls per month</li> <li>Q2 4%, reduction</li> <li>Q3 7%, reduction</li> <li>Q4 10% reduction</li> </ul>	M	

# Integrated Performance Report: Quality (CO1)

Target (2010/11)		Executive Lead	Monthly Performance	Direction of Travel	Year to Date	Forecast	Commentary	Frequency	
Effectiveness	<b>Hospital Standardised Mortality Ratio (HSMR)</b>	HSMR for the most recent complete 12 months based on the HSMR basket of 56 diagnosis groups	MD	AMBER	=	AMBER	AMBER	Month: 105.5 (95% CI: (89.6 – 123.4) Last Quarter: 102.8 (93.3-113) Last 12 Months: 108.7 (103.5 – 114)	M
	<b>Stroke - National Target</b>	% of Patients spending 90% of time on Stroke Unit	MD	GREEN	=	GREEN	GREEN	<b>Strong performance from PRH, with RSH under-performing against target</b>	M
	<b>Stroke – Compound Indicator</b>	Compound based on Swallow Screens, TIAs and % of Time on Stroke Unit	MD	GREEN	=	GREEN	GREEN	<b>Sustained improvement continues on both sites</b>	M
	<b>Stroke (CQUIN)</b>	Admissions to Stroke Unit within 4 hours of Arrival at Hospital	MD	GREEN	=	GREEN	GREEN	New CQUIN Target for 2010/11 value worth £200K	M
	<b>Early Access to Maternity</b>	Achieve contract milestones for early access to maternity services (90% by Q4 and 86% full year) (CO1.1)	DQ&S	RED	=	RED	AMBER	<u>February 2011</u> T&WPCT = 88% ScPCT = 88%	M
	<b>Nutrition</b>	% Completion of Nutrition Screening Tool ( CO1.7)	DQ&S	GREEN	=	GREEN	GREEN	Baseline Audit 58% Q2 65% Q3 75% Q4 90%	Q
	<b>Readmission Rates</b>	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
	<b>Venous Thromboembolism (CQUIN)</b>	% of adult inpatients who have had a VTE risk assessment on admission (CO1.3)	MD						M
	<b>Think Glucose (CQUIN)</b>	Compliance with Think Glucose guidance (CO1.3)	MD	AMBER	=	GREEN	GREEN	Action plan compliant with milestone achievement	M
<b>Tissue Viability (CQUIN)</b>	Reduction in the number of Grade 3 and 4 Pressure Ulcers – to be confirmed with PCT (CO1.3)	DQ&S	RED	=	AMBER	RED	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	AMBER	↓	GREEN	GREEN	Trust appraisal completion performance at 79%	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	RED	=	RED	RED	This was a new CQUIN standard for 2010/11	M
	Dementia	% of patients receiving cognitive assessment on admission	MD	RED		GREEN	GREEN	Trust under achieved the 90% target during January	Q
		An informed and effective workforce for people with dementia	MD	Red		GREEN	GREEN	Trust under achieved the 95% during January	Q
	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	AMBER	=	RED	RED	9a) PCT decided that payment would only be for 50% of CQUIN and this is based upon meeting and agreeing IBA deliverables in both the ED, MAU and gastro ward. All deliverables met and awaiting payment clarification	M

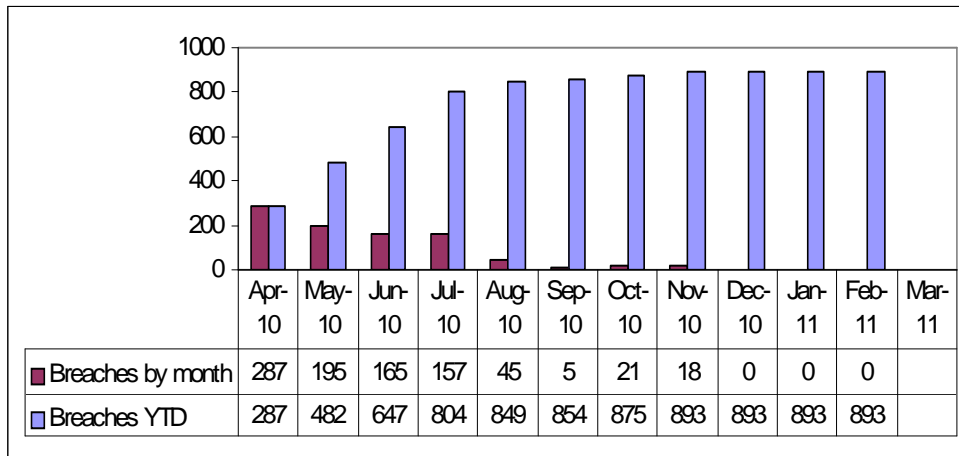
# Integrated Performance Report: Foundations (CO5 & CO6)

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 registered without conditions	Q
	Coding	To increase the numbers of FCEs with coded comorbidities	FD	GREEN	=	GREEN	GREEN	Coding levels have 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	AMBER	Local Health Economy achieved the target for February	M
	18 Weeks	1a - Admitted Clock Stops above 90%	COO	RED	=	RED	RED	Trust failed the 90% target during February	M
		1b - Non-Admitted Clock Stops above 95%	COO	RED	=	RED	RED	Trust failed the 95% target during February	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	AMBER	=	AMBER	GREEN	31 day target under achieved in month	M
		62 Day from urgent referral to treatment of all cancers	COO	RED	=	RED	RED	62 day target underachieved 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	=	AMBER	GREEN	Target 2010/11 89% overall patient satisfaction 5 indicators identified from 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



- There were no SSA breaches again in February .
- In the National inpatient Patient Survey we scored 67.3% on the 5 identified questions against a target of 67.1% . The Trust was in the top quartile of comparable Trust.
- Breakdown of results for each question are as follows :-
  - Privacy when discussing condition and treatments. **77.4%**
  - Informed about medication side effects **53.2%**
  - Hospital staff available to talk to about concerns **60%**
  - **Have you been informed who to contact if you were worried about your condition after you have been discharged from hospital** **76.4%**
  - **Were you involved as much as you wanted to be in decisions about your care and treatment** **69%**
- Overall national inpatient results to be released in April / May

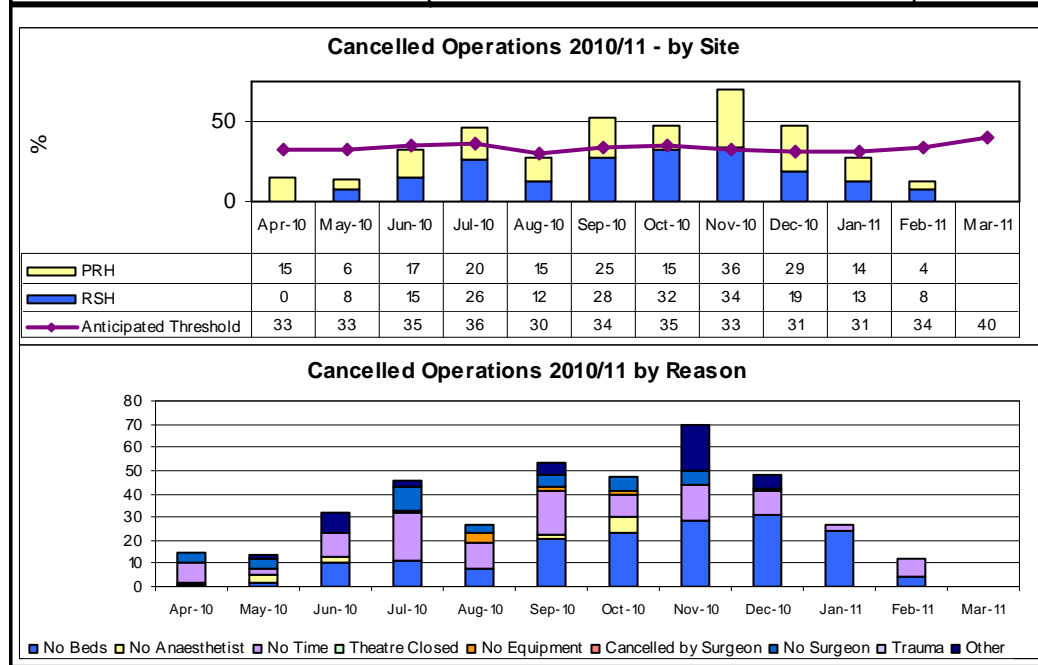
## Actions:

Complaints process to be enhanced to ensure patients and their families are supported to address their concerns.

- Senior Nurse focus at all levels will need to ensure continuous focus and engagement with staff, patients and their families whilst in our care to identify ongoing improvements and themes of care issues that need to be addressed.
- A Dignity in Care Conference is being organised at SECC for 12<sup>th</sup> May 2011 to celebrate Nurses Day.

# 28 Day Cancelled Operations

Target	Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
To maintain a minimum level of non medical cancellations in accordance with national criteria	COO	AMBER	=	RED	RED	12 cancelled in month
Readmit all non medical cancellations within 28 days in accordance with national criteria	COO	GREEN	=	GREEN	GREEN	No 28 day breaches in month



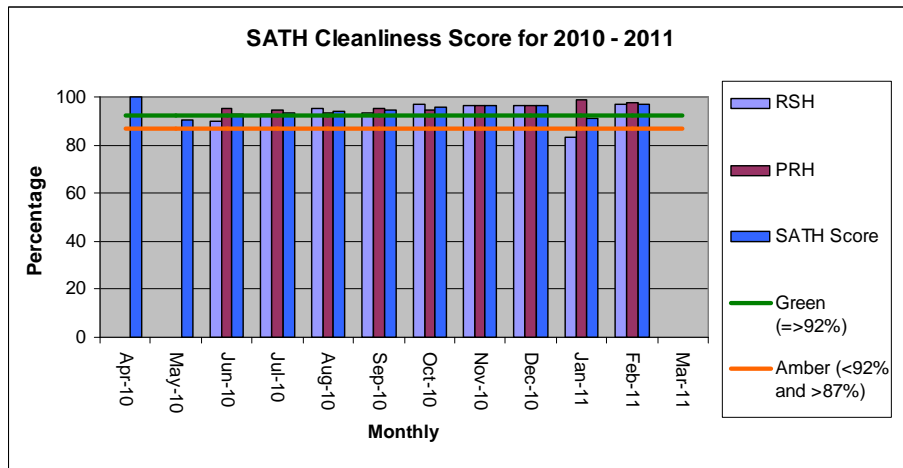
- 12 operations cancelled in February for non medical reasons.
  - 4 for no beds available
  - 8 for no theatre time available
- 391 operations cancelled for non medical reasons in the year-to-date.
- The national target applies only to those cancellations that happened on or after the day of admission 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 are currently above this figure for the year-to-date and the month.

## 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 (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Cleanliness	To maintain cleanliness score of 92% across the Trust	COO	GREEN	=	GREEN	GREEN	Both sites were Green at the time of February 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 97.75% was achieved for the Trust in February 2011
- Cleanliness Score for RSH was 96.89%
- Cleanliness Score for PRH was 97.41%
- Public Areas are much improved since their recent deep clean
- Based on April to February figures the year-end forecast is 94.79% (this will be submitted as part of the PEAT Assessment process)

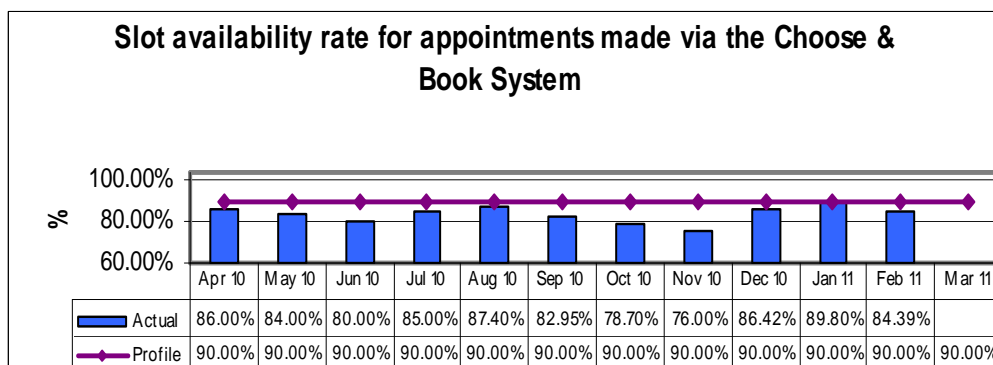
## Actions:

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 84.4% in February, a reduction of 5% from January



There were 2,452 appointments booked in directly bookable services in February compared with 2,339 in January. However, an average of 95 patients per week tried but were unable to book their appointment via C&B in February, 40 more attempts per week than in January.

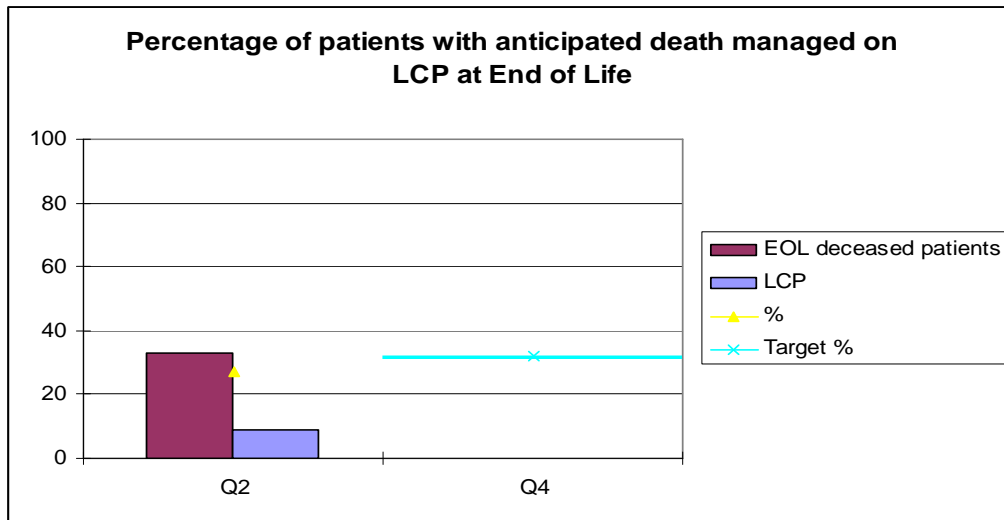
- At PRH 72% of unavailable appointments were in the following specialties:-
  - Ophthalmology – av. 11.75 per week (including Paediatric)
  - Dermatology PRH - av. 10 per week
  - Thoracic Medicine PRH - av. 6 per week
  - T&O (upper limb) - av. 6 per week
  - Neurology – av. 2.75 per week
- At RSH, 47% of total unavailable slots were in Ophthalmology (inc cataract service)
- The Cataract Service at Wrekin Community Clinic (WCC) is now open and the PRH cataract service will be removed from the Directory of Services with effect of 1<sup>st</sup> March.

## Actions:

- To provide cataract appointments at WCC for SPCT patients resident in the East of the county.
- Capacity for General Ophthalmology is being addressed.
- Investigate how additional capacity in Dermatology can be made available via C&B.

# 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%



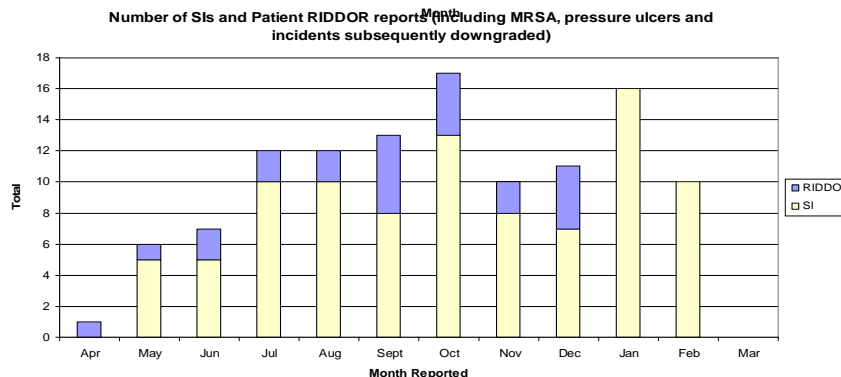
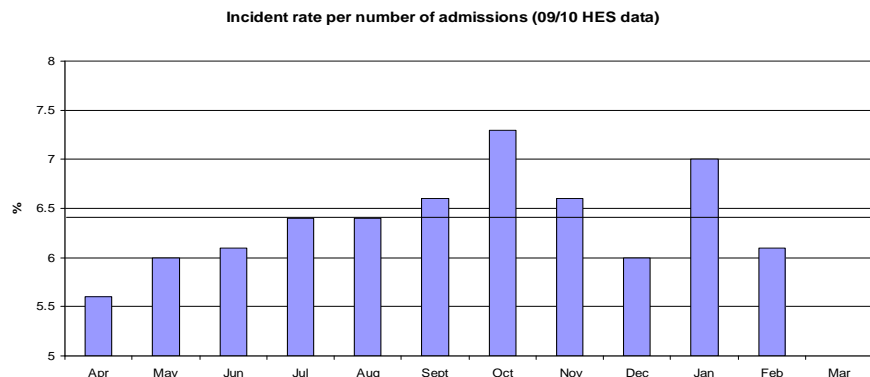
- Baseline target at the end of Q3 50%. Target for Q4 62%.
- October 27%, November 100%. December results 74%.
- Remedial work to the entrance to Mortuary at RSH been undertaken. General redecorating to the inside of Mortuary in progress. Funding for further extensive refurbishment to be progressed.
- Corridor entrance to Mortuary at PRH being addressed through the plans to resolve storage of beds.

## Actions:

- Funding for more extensive refurbishment to be progressed.

# 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 6.40%
	Serious Incidents Requiring Investigation (CO1.6)	MD	RED	=	GREEN	GREEN	Less than 8 SIRIs per month



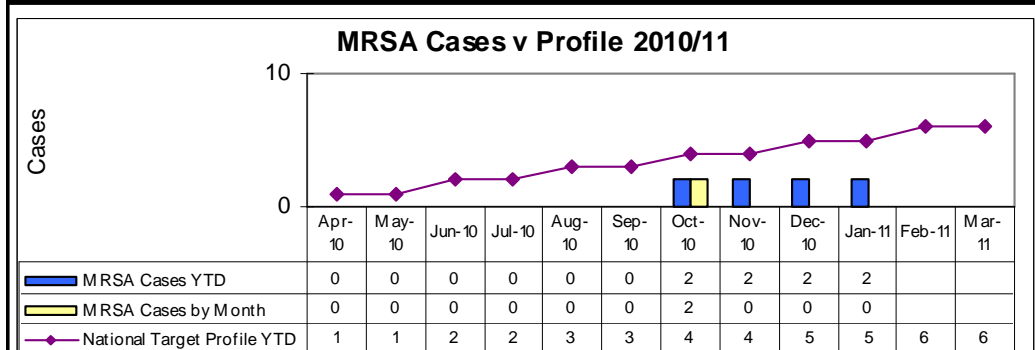
- The Trust reports Patient Safety Incidents & Near Misses to the National Reporting & Learning System (NRLS). The rate is based on the number of incidents each month as a percentage of the monthly admissions (based on 2009/10 HES data). The Care Quality Commission (CQC) receive weekly reports from the 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. From February any RIDDOR reportable patient safety incidents will also be reported as SIs.
- There were 10 SIs reported in February (16 in January)
- There were no RIDDOR reportable patient falls in January or February
- In total eleven of the 95 incidents reported have been downgraded as investigation has shown that these were not reportable incidents therefore the year to date position is green

## Actions:

- Incident Review Group meets monthly to discuss incidents & trends. New SI policy issued - Lead Nurses have additional responsibility for incident coordination.
- Outstanding RCAs being finalised with the aim of closing all outstanding incidents by the end of March

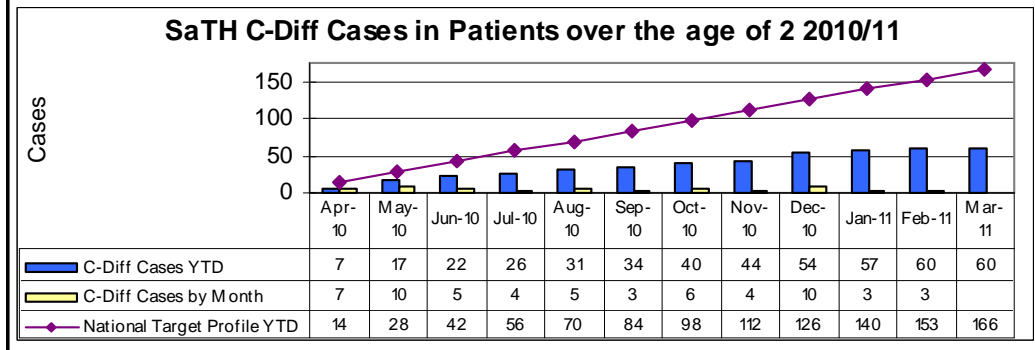
# Healthcare Associated Infections (HCAs)

Target (2010/11)	Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
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 60 C. Difficile cases YTD



**MRSA - (February unvalidated)**

- There were no cases of post 48 hr. MRSA bacteraemia in February.
- We have had 2 cases to end of February 2011 vs. target of not more than 6 post 48 hr. cases during 2010/11.
- Ongoing work – maximising admission screening, re-screening wards where acquisition occurs, reducing line sepsis, screening new staff. Recently introduced enhanced monitoring of compliance with screening of emergency admissions.



**C. Difficile – (February unvalidated)**

- To end February 2011 - 60 SaTH responsible cases (post 72 hrs.) vs. target of not more than 166 cases 2010/11.
- In February 3 SaTH cases, one at RSH and two at PRH, were diagnosed more than 72 hrs. post admission and therefore count vs. SaTH target.
- No ward has had more than one case during the month.
- 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
<b>Medicines Management (CQUIN)</b>	Delayed and missed doses of medicines for hospital inpatients	MD	GREEN	=	GREEN	GREEN	Baseline audit undertaken in May, second and third audit now completed Improvement Target agreed with PCTs has been met 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%

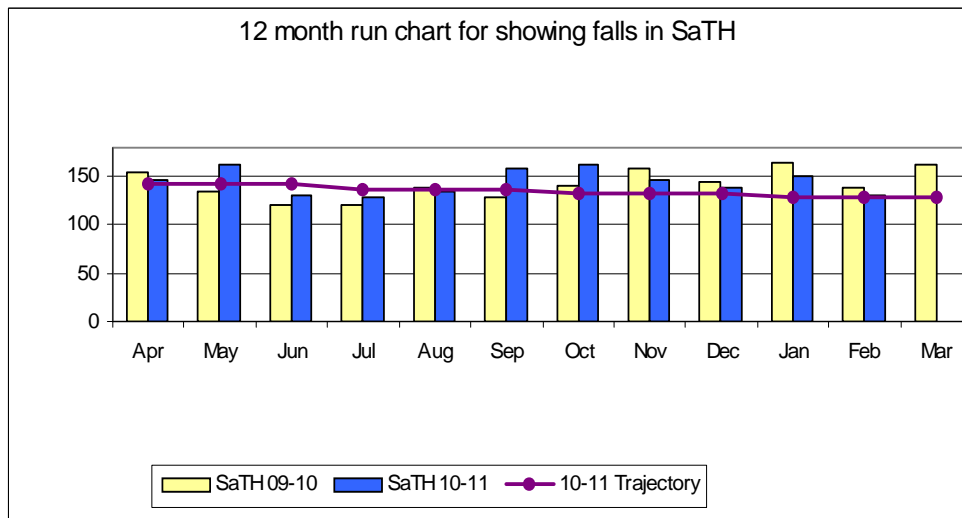
- To agree list of Critical Medicines for Baseline Audit - achieved.
- To undertake baseline audit in May 2010 - achieved. Three day audit of Admission areas, 364 patient records/charts included, second audit completed, final audit January 2011 completed.
- Report to PCTs in July 2010 - achieved, November 2010 - achieved & March 2011 achieved.
- Baseline Audit accepted & 20% improvement target provisionally agreed, based on improvement over the next two audits. Improvement Target was achieved
- 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
<b>Patient Falls (CQUIN)</b>	No. of inpatients having a fall whilst an inpatient (CO1.3)	DQ&S	<b>Amber</b>	=	<b>RED</b>	<b>RED</b>	<ul style="list-style-type: none"> <li>• Q1 Baseline – 142 Falls per month</li> <li>• Q2 4%, reduction</li> <li>• Q3 7%, reduction</li> <li>• Q4 10% reduction</li> </ul>



- February data within trajectory. November to February falls data figures demonstrate a reduction on previous year but there have been 5 months where the number of falls has been over the trajectory.
- Given that this is a key safety improvement target, further work over and above that undertaken will be required to ensure improvements. We have a significant challenge to meet the target for Q4 and therefore risk achievement of this CQUIN.
- There have been no RIDDOR reportable falls recorded for the months of January and February 2011.
- Slips, trips and falls policy has been ratified by Health and Safety Executive Committee. Final approval will be required by Quality and Safety Committee to ensure the policy reflects best practice and safety measures to reduce the harm to patients.
- Accountability for the completion of RCA for RIDDOR reportable injuries has been discussed and in light of changes to Serious Incident Policy, the RCA will be undertaken by the H&S team
- NPSA alert – post falls protocol. Working party established to implement and roll out by 14<sup>th</sup> July 2011

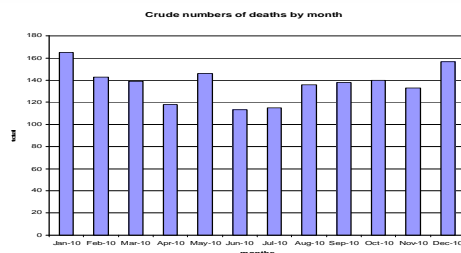
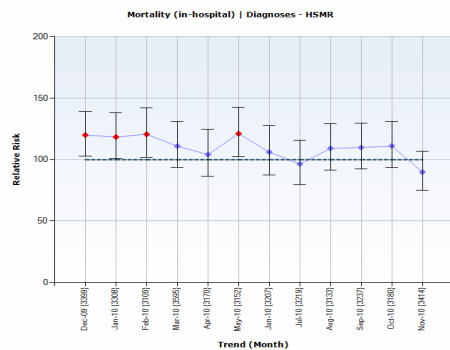
## Actions:

- Weighted alarms system – trials alarm system in progress on ward 4, PRH.

# 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)	MD	AMBER	=	AMBER	AMBER	Month: 105.5 (95% CI: (89.6 – 123.4) Last Quarter: 102.8 (93.3-113) Last 12 Months: 108.7 (103.5 – 114)

Period	HSMR
Jan 10-Mar 10	<b>RED (Worse)</b>
Apr 10-Jun 10	<b>AMBER (Comparable but One Trigger)</b>
Jul 10-Sept 10	<b>GREEN</b>
Oct 10-Dec 10	<b>GREEN</b>
Negative Triggers	<b>TWO</b>



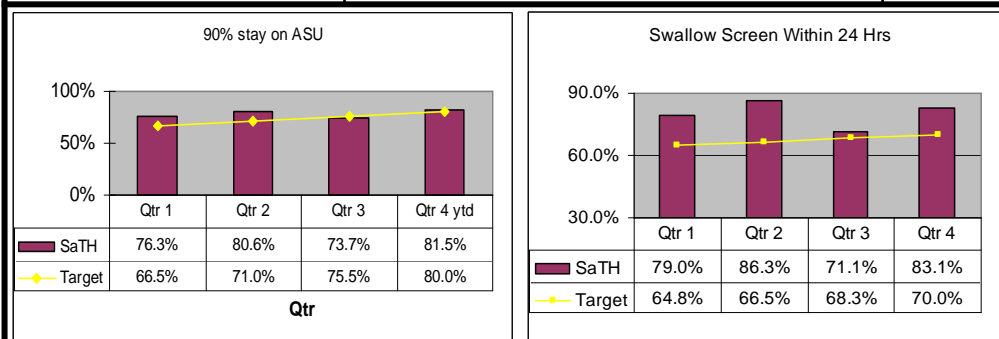
- HSMR is calculated from hospital activity using the Dr Foster Real Time Monitoring (RTM) Analysis Tool, using the most recent available data (currently three months in arrears). It compares the mortality rates in SaTH with the average expected across England, adjusted to reflect factors such as age and case mix.
- The current status of the HSMR is:  
 Jan – Dec 2010 SaTH 108.7  
 RSH 98.1  
 PRH 122.0
- Re-based HSMR for SaTH is Apr to Dec 2010 is 117 reducing from 119 for Apr to Oct 2010. This indicates that our HSMR is reducing faster than the national index.
- However with an HSMR of 117 we 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:

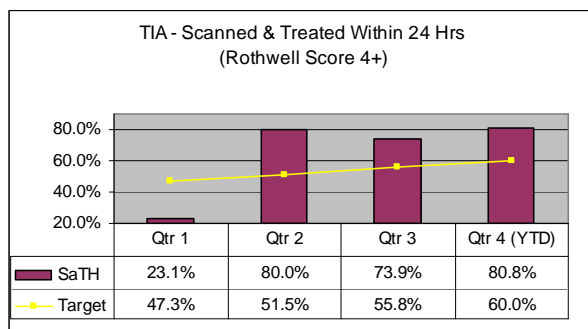
- Mortality review group has been established with representation from Catherine Woodward who is the HSMR lead for both PCT's.
- A review of the crude rate of deaths for non elective activity and a mid level review of HSMR for both PRH and RSH has been completed in order to start to understand the differences between the 2 Hospitals.
- A review of 50 consecutive deaths and 200 other patient notes using the Global Trigger Tool within the LIPS programme has been completed and results presented at the LIPS day in March. The conclusion was we are not happy with the level of care provided and need to improve it.
- The coding group 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	Year End Forecast	Commentary
Stroke National Target	% of Patients spending 90% of time on Stroke Unit	DQS	GREEN	=	GREEN	GREEN	Strong performance from PRH, with RSH under-performing against target
Stroke – Compound Indicator	Based on targets agreed with local Commissioners	DQS	GREEN	=	GREEN	GREEN	Sustained improvement continues on both sites



- Current Performance Proportion of People who spent at least 90% of their time on a Stroke Unit: Quarter 4 (YTD) Target 80%, PRH 93.2%, RSH 71.8%, **SaTH = 81.5%**
- Overall SaTH achieved target, with continued high performance at PRH, but with RSH under-performing against target.
- Current performance for Swallow Screening on both sites:  
Quarter 4 (YTD) Target 70%, PRH 84.7%, RSH 81.7%, **SaTH 83.1%**. Both sites achieving target, RSH making marked improvements in record keeping and process.
- Current Performance for TIA on both sites:  
Quarter 4 (YTD) Target 60%, PRH 77.8%, RSH 82.4, **SaTH, 80.8%**
- New Ward Manager on Ward 22S started 21/02/2011.



## Actions:

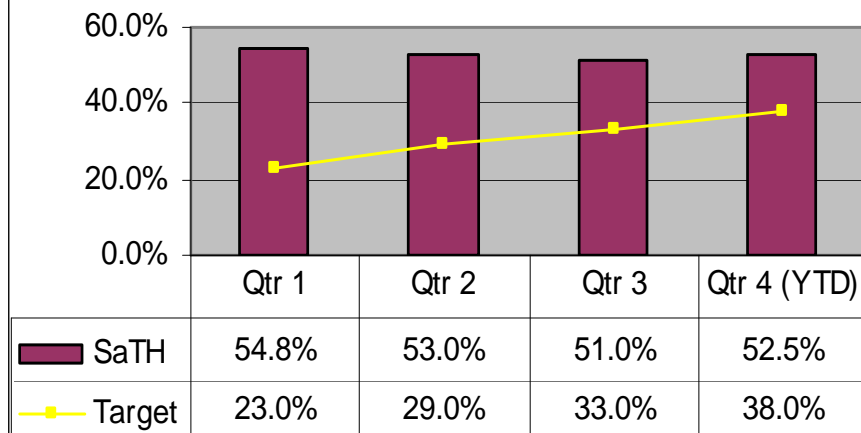
- Revised Stroke Operational Policy to be updated and issued by 11<sup>th</sup> March 2011.
- Expecting the Stroke Sentinel audit results for distribution and analysis. Clinical Lead to update Operational and Executive leads during March.
- Quality Account review for Stroke Services, being prepared, due 1<sup>st</sup> April 2011.
- Events organised to process map joint care planning for stroke patients across the health and social care economy taking place 10<sup>th</sup> March.
- Stroke Strategy Group agreed to the Early Supported Discharge project continuing for Shropshire County PCT until September 2011.



# Stroke - CQUIN

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Year End Forecast	Commentary
<b>Stroke</b>	Admissions to Stroke Unit within 4 hours of Arrival at Hospital	DQS	<b>GREEN</b>	=	<b>GREEN</b>	<b>GREEN</b>	New CQUIN Target for 2010/11 value worth £200K

Admission to Stroke Unit within 4 hours of Arrival



- Current performance for admitted to Stroke Unit within four hours of Arrival:  
Quarter 4 (YTD): Target 38%, PRH 75%, RSH 35.4%, **SaTH 52.5%**.
- Performance continues to improve at PRH, but with RSH under-achieving due to patient flow issues between A&E and admission to ASU, continued low direct admissions to ASU and cultural coding processes around outlying patients, which are under review.
- New Ward Manager on Ward 22S started 21/02/2011.

**Actions:**

- Meeting with A&E staff, and site managers to try and improve patient flow at RSH.
- Meet with Coders to refine stroke coding.

# Early Access to Maternity

Target (2009/10)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary															
<b>Early Access to Maternity</b>	Achieve contract milestones for early access to maternity services (90% by Q4 and 86% full year) [possibly also add breastfeeding targets] (CO1.1)	COO	<b>RED</b>	=	<b>RED</b>	<b>AMBER</b>	February 2011 T&WPCT = 88% SCPCT = 88%															
Quarter 1 Data: Validated Quarter 2 Data: Validated Quarter 3 Data: Validated Quarter 4: YTD			<ul style="list-style-type: none"> <li>Action plan in place for both SCPCT and T&amp;W PCT with escalation procedures agreed.</li> <li>Booking clinics established in Telford with a programme of extra capacity in January 2011 to clear pending patients.</li> <li>Sufficient venue options secured in Telford.</li> <li>Improved staffing levels in place.</li> <li>DNA rates audited - (7.6% in T&amp;W and 4.3% in Shrewsbury)</li> </ul>																			
<div style="text-align: center;"> <h3>Early Access Target</h3> <table border="1"> <thead> <tr> <th></th> <th>Qtr 1</th> <th>Qtr 2</th> <th>Qtr 3</th> <th>Qtr 4</th> </tr> </thead> <tbody> <tr> <td>SATH</td> <td>81.50%</td> <td>87%</td> <td>83%</td> <td>82%</td> </tr> <tr> <td>Target</td> <td>80%</td> <td>85%</td> <td>88.90%</td> <td>90%</td> </tr> </tbody> </table> </div>									Qtr 1	Qtr 2	Qtr 3	Qtr 4	SATH	81.50%	87%	83%	82%	Target	80%	85%	88.90%	90%
	Qtr 1	Qtr 2	Qtr 3	Qtr 4																		
SATH	81.50%	87%	83%	82%																		
Target	80%	85%	88.90%	90%																		

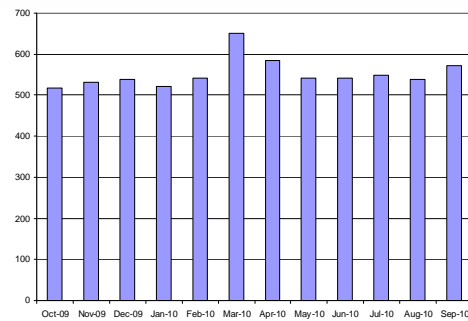
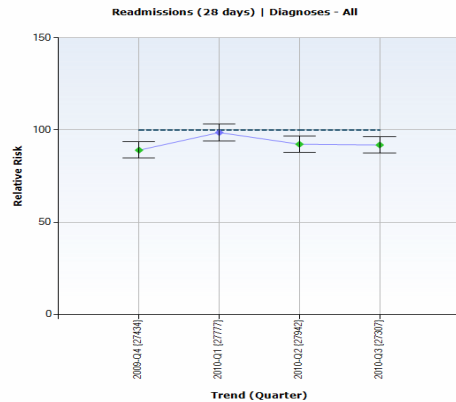
## Actions:

- Finalise booking invitation letter to try to reduce DNA's
- Investigate Malling Health as booking venue for Shrewsbury
- Produce information posters as Early Access for GP practices
- Invest to save bid submitted for purchase of digital pens to allow community midwives to book women in their own homes for hard to reach group

# Readmission Rates

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

Period	Risk Rating
Oct09 to Sept 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 (Oct. 09 to Sept. 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 in relation to readmissions

# Think Glucose

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
<b>Think Glucose (CQUIN)</b>	Compliance with Think Glucose guidance (CO1.3)	MD	<b>AMBER</b>	=	<b>GREEN</b>	<b>GREEN</b>	Action plan compliant with milestone achievement

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

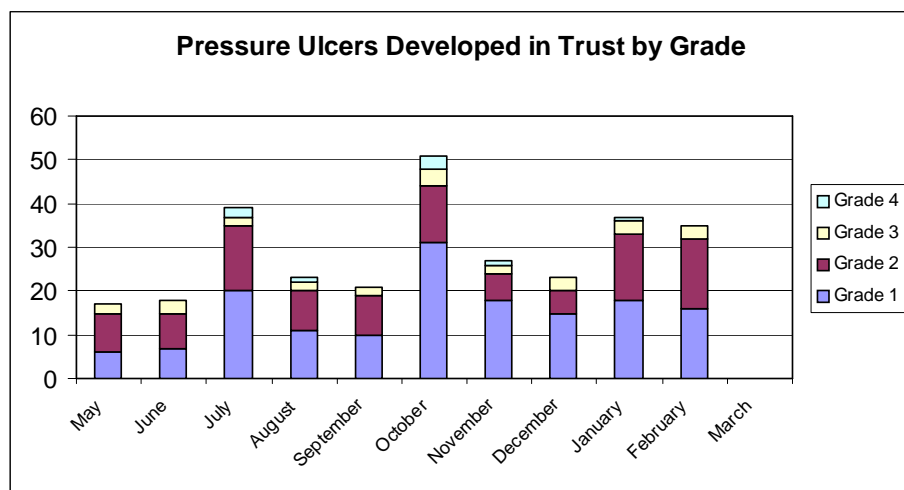
- Think Glucose is a practical and easy to use tool which improves the care, outcomes and experience of people with diabetes who are admitted to hospital with non-diabetes related problems.
- Compliance audit in February 2011 revealed that 94% of clinical areas are identifying patients with diabetes, but only 47% are following correct referral process, using the referral stickers. 42% are using the Think Glucose Checklist.
- Think Glucose CQUIN audit tool circulated. Date for final assessment to be determined.

## Actions:

- Continuation of delivery of action plan.
- Re-audit compliance.
- DSN's to review referral process in line with Think Glucose.

# Tissue Viability

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



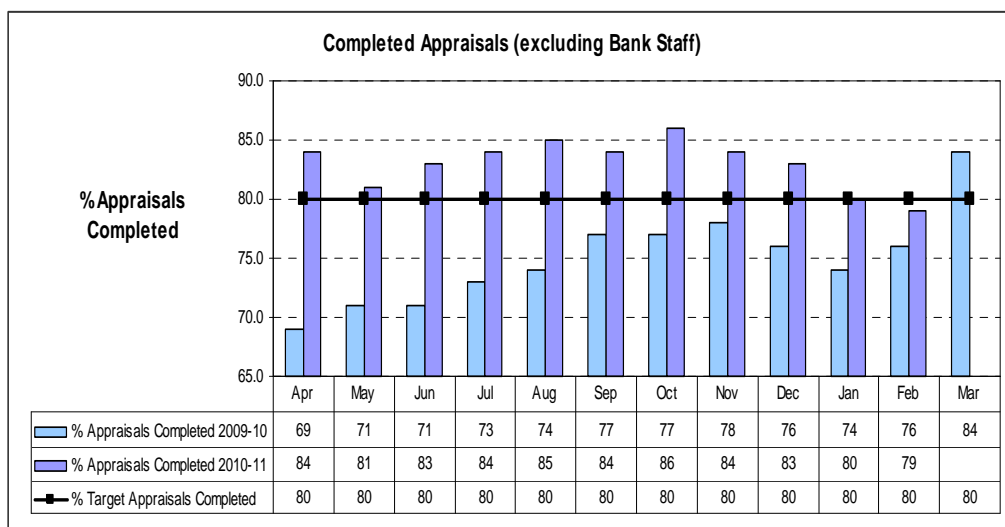
- 3 Trust acquired ulcers reported in February 2011 at grade 3/4. There are risks of not achieving the CQUIN for the year end.
- Trust wide action plan developed to address key issue from RCA. Ward Managers and Matrons to take ownership and responsibility for implementation of actions.
- The Senior Nursing Teams are currently undertaking a series of in depth reviews in clinical areas that have had more than one acquired grade 3/4 pressure ulcer to highlight underlying themes and performance issues and follow through on the performance.
- All patients to be assessed within 2 hours of admission to Ward department rather than 6 hours to give greater assurances over timely preventable actions being taken.
- Practice Educator and Wound Prevalence Survey Nurse making daily visit to Wards to advise, audit and monitor that staff are taking preventative measures for grade 1 and 2 ulcers.
- Issues around lack of pressure relieving seat cushions highlighted via company contract meeting. Increased numbers actioned by company

## Actions:

- Chief Nurse to lead improvement programme with senior nurses.
- Tissue Viability Educational Programme continues to be rolled out.
- Tissue Viability Nurse Specialist post interviews week 14<sup>th</sup> March 2011.
- Tissue Viability issues & actions to be presented to wide audience of all Trust staff at Patient Safety study day March 16th 2011
- Plan to house seat cushions in Loan library

# Appraisals

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Appraisals	SaTH target of 80%	DCRM	AMBER	↓	GREEN	GREEN	Trust appraisal completion performance at 79%



- As at month ending 28<sup>th</sup> February 2011, 79% of staff excluding Bank Staff have had a KSF appraisal within the last 15 months. This has slipped slightly from previous months. Average performance over the entire year is above 80%
- Departments that have not planned well over the year found it difficult to sustain acceptable appraisal completion rates over February/March when operational pressures normally impact.
- Line managers have been reminded of the need to sustain performance above 80% and Executive Directors are asked to address individual department performance below 60%
- The lowest 5 performing areas for February with over 15 staff were as shown. All have action plans in place to achieve 80%.

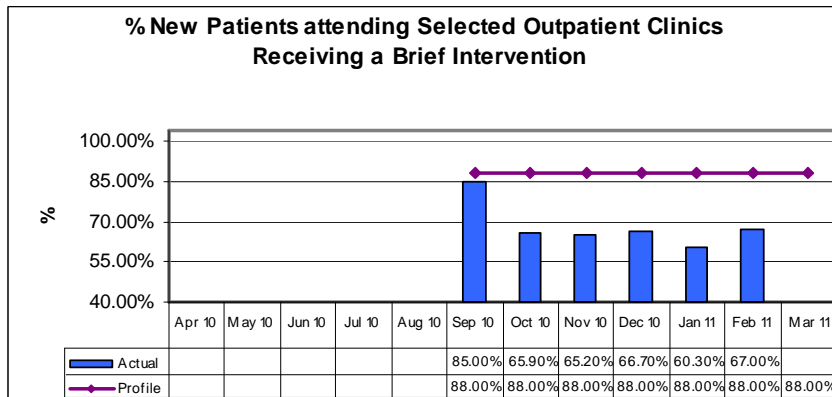
Area	Staff	Completed	%	Div.
Ward 28 – Trauma & Orthopaedics	33	12	36	1
X-Ray Department (PRH)	61	24	39	3
Ward 11 – Trauma & Orthopaedics	26	12	46	1
Pharmacy Department (PRH)	41	19	46	3
Ward 22 – Stroke & Rehabilitation Unit	58	30	52	1

## Actions:

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

# 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	RED	=	RED	RED	This was a new CQUIN standard for 2010/11



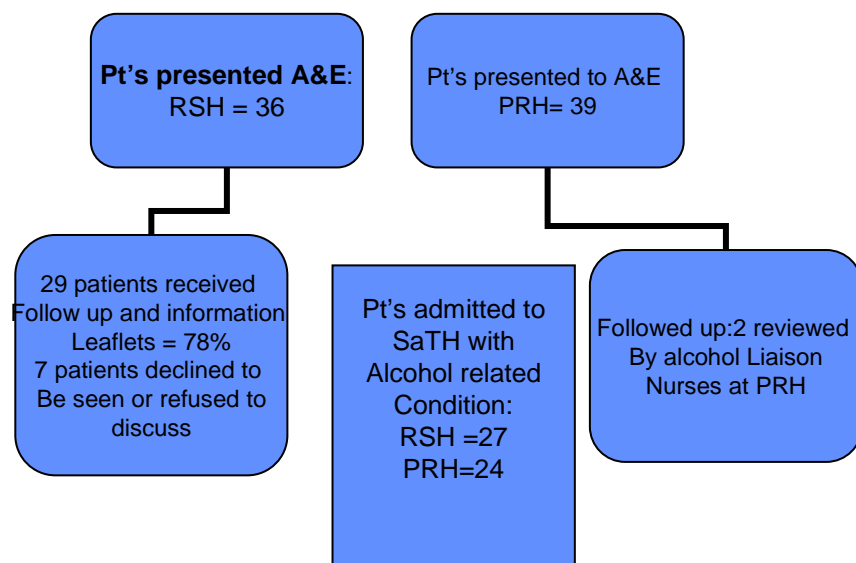
- A total of 72 new patients who required a brief intervention were seen in the selected clinics in February, including Respiratory, Cardiology, Vascular, Diabetes and ENT. 1 of these stated they were already on a stop smoking programme and 3 declined to discuss their tobacco use.
- Of the 26 patients who smoke and want to stop, 22 were offered intervention and 6 of these were referred to the Stop Smoking Nurse (not part of the CQUIN but best practice, and may become a target in the future).
- Of the 17 smokers identified who said they did not want to stop, 7 were offered advice and/or a leaflet – the target is for all smokers not just those who want to stop.
- Method of data collection and analysis remains manual and collated by Clinical Audit Department. Some patients being surveyed are not within the target group. Data collection therefore needs to be reviewed for Q4.
- Revised plan discussed but not yet formally approved by Commissioners therefore not reflected in this months report.

**Actions:**

- Agree specific clinic codes discussed with Commissioners to include target patients only.

# Staying Healthy (Alcohol) - CQUIN

Target (2010/11)	Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
<p>9a) 90% of people attending A&amp;E with alcohol related condition and are not admitted who receive a brief intervention to reduce alcohol consumption</p> <p>9b) 75% of people who are admitted to hospital with alcohol related condition receive brief interventions to reduce alcohol consumption</p>	MD	AMBER	=	RED	RED	9a) PCT decided that payment would only be for 50% of CQUIN and this is based upon meeting and agreeing IBA deliverables in both the ED, MAU and gastro ward. All deliverables met and awaiting payment clarification



Part 9a:

- Data collection and delivery of IBA in the ED's agreed by chief Nurse and Medical Director. This information shared across all emergency admission areas with key deliverables and time frames
- Information leaflet in place on both sites. Flow chart for recognising dependent, hazardous drinkers in place and training methods agreed.
- Data collection is now an issue due to constraints within Clinical audit and cost implications. The project lead will develop a paper to review options for meeting ongoing delivery and present to Director lead for agreement and sign off.

Part 9b:

- Data collection and delivery of IBA agreed and training occurring in practice to ensure delivery
- Guidelines for recognition and delivery of care for alcohol are going to CGE group for agreement March 8<sup>th</sup> 2011.

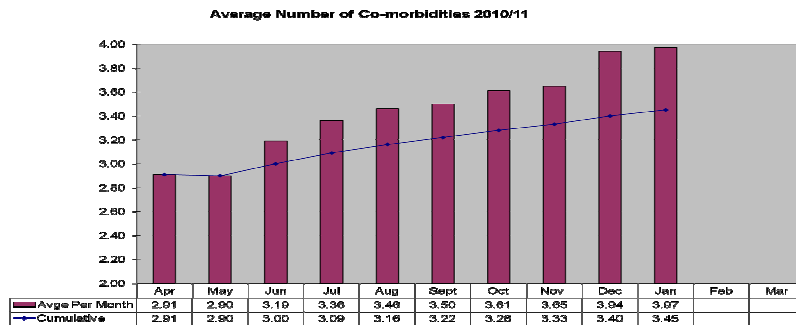
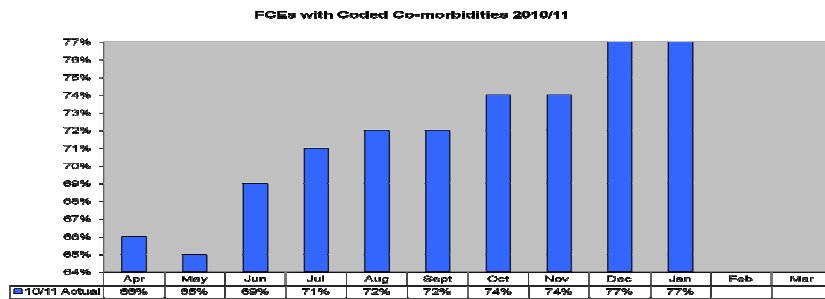
## Actions:

- PCT's to agree to release 50% of the funds for delivery of the CQUIN
- Data Collection methodology to be reviewed with PCT's, MHL and SaTH to ensure accurate, complete and transparent sharing amongst group
- Training plan for nurses agreed and PCT's working with SaTH to facilitate
- CGE group to validate revised alcohol recognition and treatment guidelines and then these to influence practice



# 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	Coding levels have increased in month



Data report one month in arrears

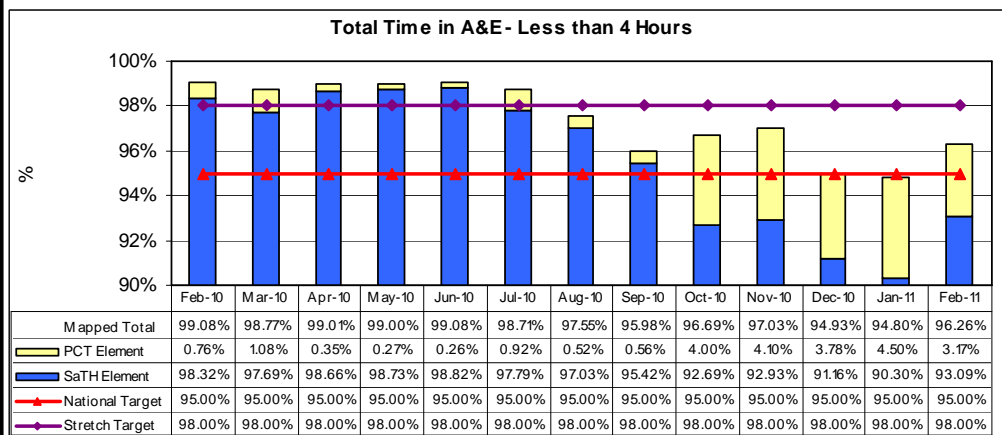
- The Target is to ensure that co-morbidities are captured by clinicians for each Finished Consultant Episode (FCE), where applicable. Both charts show a steady increase in the depth of coding.
- Work is ongoing with MedeAnalytics to analyse national coding statistics and provide a national benchmark 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	AMBER	Local Health Economy achieved the target for February



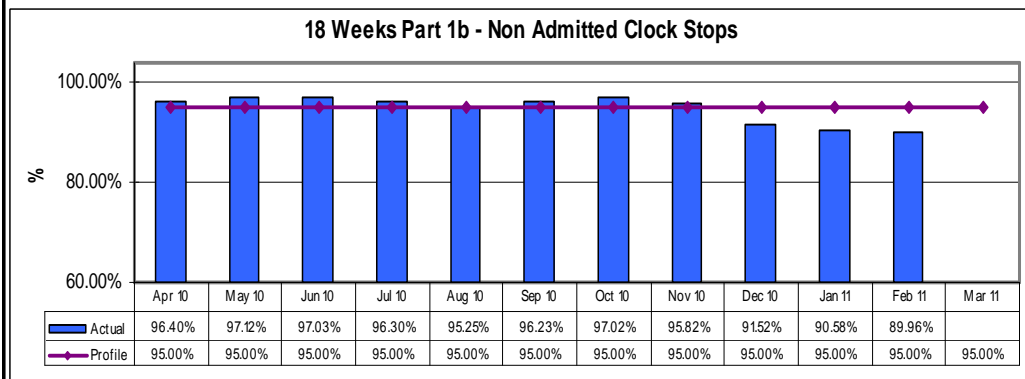
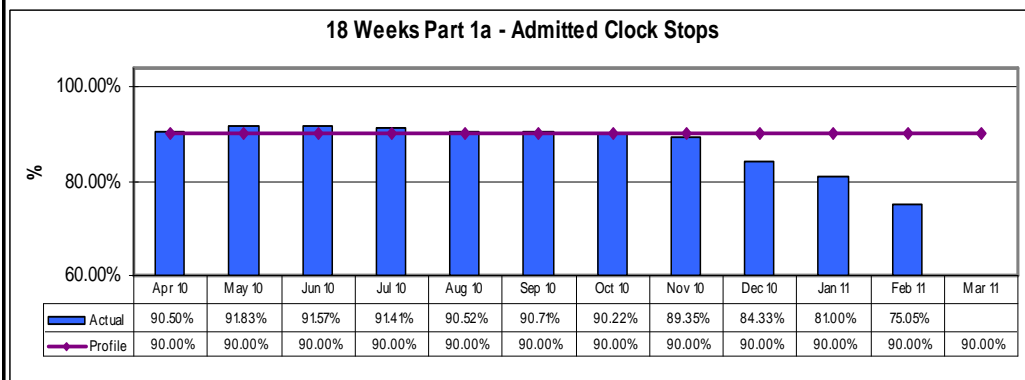
- The Trust achieved 93.09 unmapped during February
- The Local Health Economy achieved 96.29% mapped during February
- For the year-to-date the Trust has achieved 95.23% % unmapped.
- For the year to date the Local Health Economy has achieved 98.06% mapped.

## Actions:

- A focused MDT plan for quality improvements in patient flow through Emergency Care has been developed within SaTH with milestones for delivery until 31 March 2011
- Internal Winter Planning meetings taking place monthly to ensure continuous improvement of the SaTH Winter Plan.
- Urgent Care Network Review underway to determine the future Strategy for Urgent Care across the Local Health Economy.
- The Clinical Site Management team has been placed in Emergency/Critical Care Centre to ensure an overarching and empowered delivery of Site management

# 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 February
	1b - Non-Admitted Clock Stops above 95%	DSD	RED	=	RED	RED	Trust failed the 95% target during February



- The Trust failed to achieved the overall targets with 75.05%, 1a and 89.96% 1b
- PCT performance for February was:-

	1a	1b
<b>Shropshire County PCT</b>	76.65%	88.1%
<b>Telford &amp; Wrekin PCT</b>	72.86%	92.37%

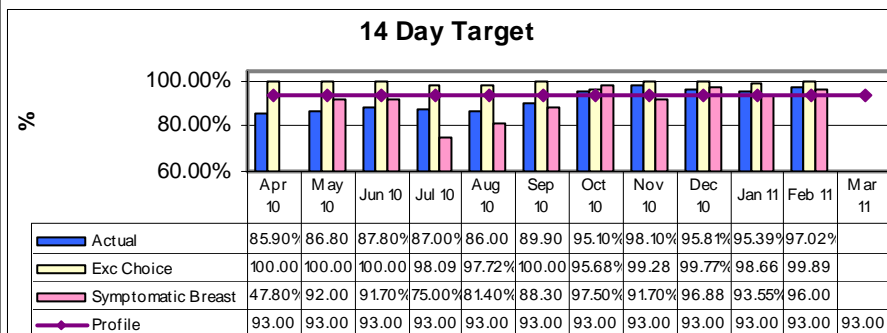
- Achieved the 95% target for Audiology in February with 97% of non admitted Audiology patients completing their pathways within 18 weeks with 122% data completeness which is within the anticipated 90 – 110% threshold.
- Specialty level performance for admitted patients (part 1a) below 90%, Cardio (69.23%), ENT (77.55%), Gen Surg (79.08%), Gynaey ( 70.27%), Ophthalmology (61.77%), Oral Surg (53.12%), Other (76.66%) T&O (61.9%), Urology (83.75%)
- Specialty level performance for non admitted patients (part 1b) below 95% Cardiothoracic Surg ( 87.5%), Dermatology (87.85%), ENT (75.67%), Gastro (91.75%), Genl Surg (93.28%), Neurology (81.31%), Ophthalmology (86.19%), Oral Surg (65.82%), Other (93.52%), Plastic Surg (90%) Rheumatology (94.28%), T&O (90.95%), Urology (84.78%)
- At the end of February there were 21,063 English responsible open clocks recorded with 5,383 of these over 18 weeks, this compares to 21,412 at the end of the previous month, of which 5,530 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 April's 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



At the time of writing this report the actual performance for the months of April, May, June, July, August, September, October, November, December and January 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).

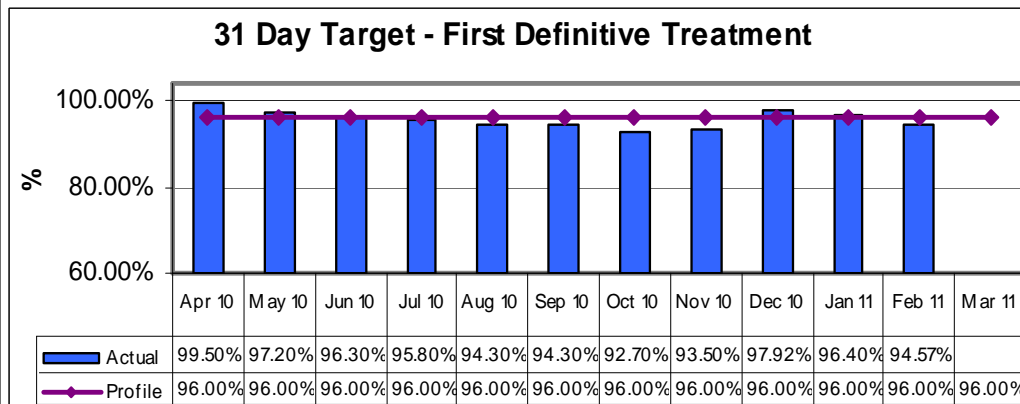
- 14 day target achieved in February 97.02%, against a year end cumulative target of 93%. There were 28 breaches out of a total of 941 referrals.
- Symptomatic Breast Performance for the month was 96.00% , against a year end cumulative target of 93%. There was 1 breach out of a total of 25 referrals.
- 27 patients chose to wait longer than 14 days for their first appointment. Details of the Specialities are as follows:  
Brain 1, Breast 1, Breast Symptomatic 1, Colorectal 5, Gynae 2, Head & Neck 5, Skin 3, UGI 7, Urology 2
- The SaTH 14 day target YTD is currently 91.97% 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 5 months since October. We are continuing to work closely with the PCTs, auditing the patients that choose not to accept an appointment within 14 days and looking into each case individually. In order to establish why patients are choosing to wait longer than 14 days, we are also telephoning patients to discover the reason why.
- Demand and capacity for all Specialities has been audited over the last 12 months and processes are being put in place to increase capacity where required.

# 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	AMBER	=	AMBER	GREEN	31 day target under 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 and January 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).

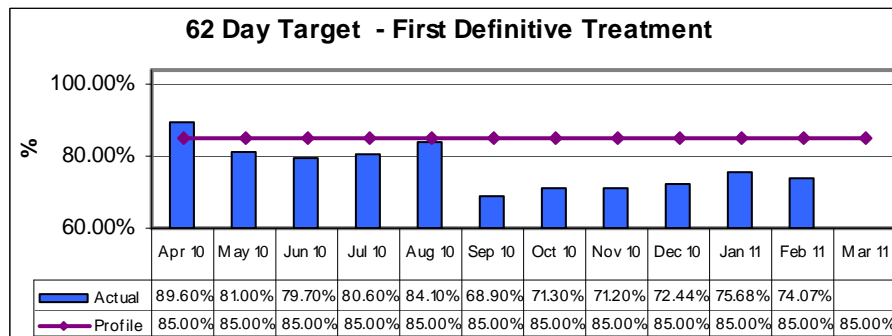
- 31 day target first definitive treatment underachieved in February (94.57%), against a year end cumulative target of 96%.
- 31 day target subsequent treatment (Surgery) underachieved in February (89.29%), against a year end cumulative target of 94%.
- 31 day target subsequent treatment (Anti Cancer Drugs) underachieved in February ( 100%) against a year end cumulative target of 98%.
- 31 day target subsequent treatment (Radiotherapy) underachieved in February (93.24%), against a year end cumulative target of 94%.
- Current YTD position for 31 day first treatment target is 95.69% against a year end cumulative target of 96%.
- 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 and January 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).

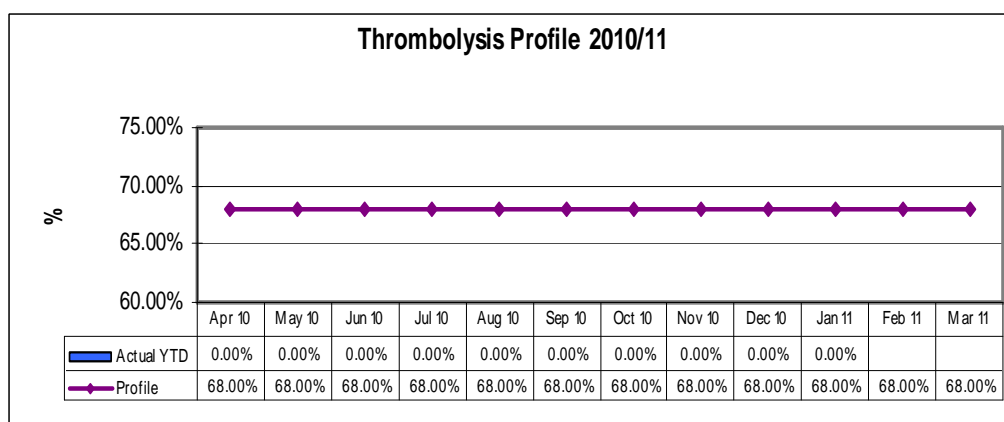
- 62 day first definitive cancer target failed in February (74.07%), against a year end cumulative target of 85%.
- 62 day screening to first definitive treatment target achieved in February (92.31%), against a year end cumulative target of 90%.
- 62 day consultant upgrade performance target in February was 96.36% – to be confirmed.
- Current 62 day traditional target YTD position is 77.34% against a year end cumulative target of 85%.
- There were 15.5 breaches in February out of 88 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:

- In order to improve and maintain the delivery of the 62 day target, the pathway for Upper GI patients will be re-designed to improve the current delays. This work is being coordinated by the Service Improvement Nurse within Cancer Services. Changes made within the Administration Team will ensure that all patients are tracked correctly to ensure there are no unnecessary delays.
- Work started in December with the Department of Health Intensive Support Team to identify areas for improvement.
- More in depth escalation and access policies are currently being drafted to ensure patients have minimal unnecessary waits.

# Thrombolysis

Target (2010/11)	Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
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



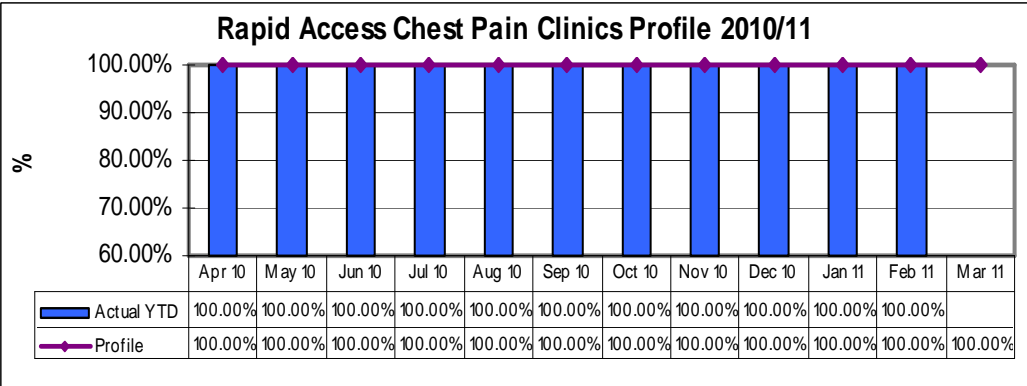
Thrombolysis Performance YTD	PRH	RSH	SaTH
Call to Needle Eligible Admissions	1	3	4
Call to Needle < 60 minutes	0	0	0
<b>Performance Achieved YTD</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>

- 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.

## Actions:

# Rapid Access Chest Pain

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



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

**Actions:**