Enclosure 6

INTEGRATED PERFORMANCE REPORT for period ending 31st December 2010

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	• Stroke National & Local, MRSA and C. Difficile, Cancer 14 and 31 day and Rapid Access Chest Pain targets achieved in month. • Thrombolysis, A&E, 18 weeks and Cancer 62 day all underachieved in month.

EXECUTIVE SUMMARY	This paper reports current performance against a number of established KPIs for the period up to the end of December 2010. As detailed in previous papers this reports includes KPIs identified as suitable for both Monthly and Quarterly reporting as December represents the completion of the 3rd 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, which require ongoing review.	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	DQ&S	RED	=	RED	RED	48 cancelled in month	M
		Readmit all non medical cancellations within 28 days in accordance with national criteria	DQ&S	GREEN	=	GREEN	GREEN	No 28 day breaches in month	M
	Cleanliness	To maintain cleanliness score of 92% across the Trust	DQ&S	GREEN	=	GREEN	GREEN	Both sites were Green at the time of December monitoring	M
	Choose & Book	Maintain a monthly slot availability rate of at least 90% for appointments made via the Choose & Book System	DQ&S	RED	=	RED	RED	The Trust achieved 86.4% in December, an improvement of 10.4% from the previous month	M
	Complaints	National response times are that all complaints are completed in their entirety within six months, unless exceptional circumstances	DCA	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 Q2 – baseline 27% Q4 to improve compliance by 20% target 32%	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	=	RED	RED	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 54 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 audit is now completed Improvement Target agreed with PCTs	M
	Patient Falls (CQUIN)	No. of inpatients having a fall whilst an inpatient (CO1.3)	DQ&S	AMBER	=	RED	AMBER	• 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	AMBER	Month: 106.4 (95% CI: (88.7.4 – 126.2) Last Quarter: 105.1 (94.9-116.1) Last 12 Months: 111.8 (106.5 – 117.4)	M
	Stroke - National Target	% of Patients spending 90% of time on Stroke Unit	MD	GREEN	=	GREEN	GREEN	Sustained improvement continues on both sites	M
	Stroke – Compound Indicator	Compound based on Swallow Screens, TIAs and % of Time on Stroke Unit	MD	GREEN	=	GREEN	GREEN	Quarter Three YTD	M
	Stroke (CQUIN)	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
	Early Access to Maternity	Achieve contract milestones for early access to maternity services (90% by Q4 and 86% full year) (CO1.1)	DQ&S	RED	⇩	RED	RED	December 2010 T&WPCT = 66% SCPCT = 87%	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					No update provided at the time of issue	M
	Think Glucose (CQUIN)	Compliance with Think Glucose guidance (CO1.3)	MD	AMBER	=	GREEN	GREEN	Action plan compliant with milestone achievement	M
	Tissue Viability (CQUIN)	Reduction in the number of Grade 3 and 4 Pressure Ulcers – to be confirmed with PCT (CO1.3)	DQ&S	GREEN	=	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 83%	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	AMBER	This was a new CQUIN standard for 2010/11. Data is available for October and November only for Q3	M
	Dementia	% of patients receiving cognitive assessment on admission	MD					Baseline to be obtained from the National Audit of Dementia. Findings due Oct. – Dec. 2010 (Q2)	Q
		An informed and effective workforce for people with dementia	MD					Preliminary Review of Educational requirements around Dementia to increase knowledge & understanding amongst all Trust Staff (Q2)	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	=	AMBER	RED	9a) PCT SLA required and Trust project group to clarify resources for delivery within the ED 9b) PCT and Trust working on definition and agreement of roles and accountability. Need for clear SLA and agreement on the immediate way forward	M

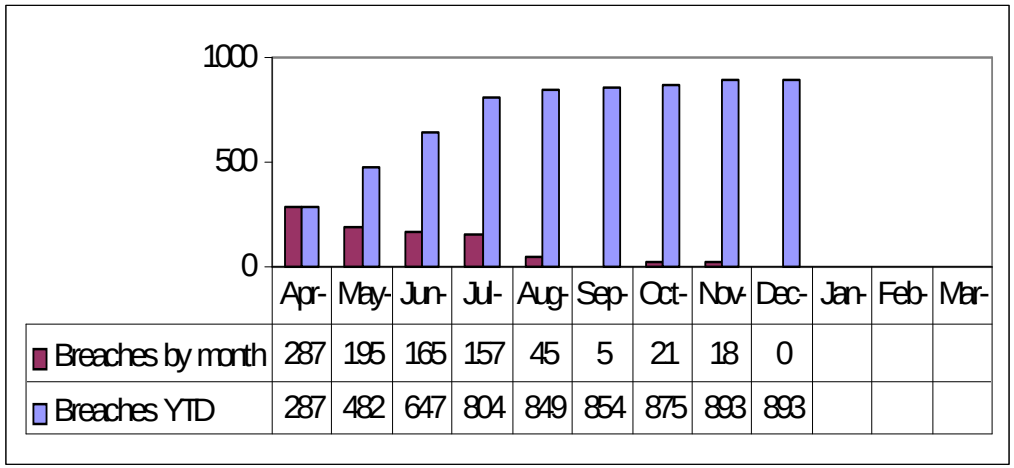
Integrated Performance Report: Foundations (CO5 & CO6)

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	DCA	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	DSD	RED	=	GREEN	AMBER	Local Health Economy underachieved target for December	M
	Delayed Transfers of Care	Reduce Delayed Transfers of Care by 50% by 31st March 31st 2011	COO	RED	⇩	RED	AMBER	The number of bed days lost due to delays increased by 458% in December	M
	18 Weeks	1a - Admitted Clock Stops above 90%	DSD	RED	=	GREEN	GREEN	Trust underachieved the 90% target during December	M
		1b - Non-Admitted Clock Stops above 95%	DSD	RED	=	GREEN	GREEN	Trust underachieved the 95% during December	M
	Cancer	14 Days from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals	DSD	GREEN	=	AMBER	AMBER	14 day target achieved in month	M
		31 Days from diagnosis to treatment for all cancers	DSD	GREEN	⇧	AMBER	GREEN	31 day target achieved in month	M
		62 Day from urgent referral to treatment of all cancers	DSD	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	DSD	RED	=	RED	GREEN	Only 3 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)	DSD	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)	DSD	**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)	DSD	**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-	May-	Jun-	Jul-	Aug-	Sep-	Oct-	Nov-	Dec-	Jan-	Feb-	Mar-
Breaches by month	287	195	165	157	45	5	21	18	0			
Breaches YTD	287	482	647	804	849	854	875	893	893			

- There were no SSA breeches in December. The 2 PCT's and Trust have reviewed both sites for any areas that can support improvements. Ward 32 and escalation area on Head and Neck to be reviewed and improvement plan to be reviewed by the Quality and safety Committee.
- A remedial Acton plan is being developed to further improve washing & toilet facilities in the Trust to support the delivery of the Same Sex Accommodation agenda.
- PET survey being undertaken in the next 3 months to audit the full 5 key indicators being used in 2010/11 CQUIN target.
- The Senor Nursing Team including the Chief Nurse commenced daily quality review of clinical areas on both sites during late December and during January which includes exploring with patients and relatives care & communication issues.
- Patient Experience stories have been presented at staff training & awareness sessions.

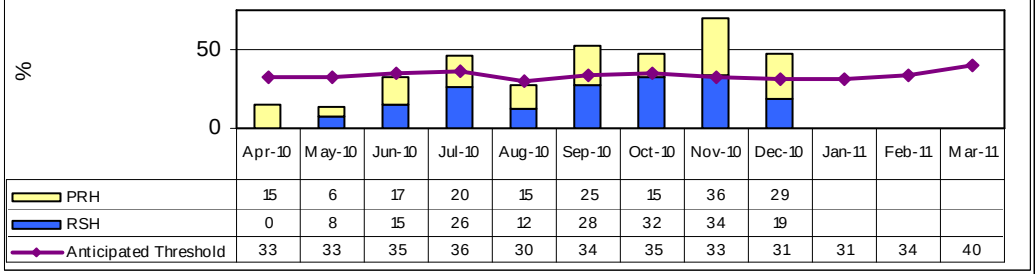
Actions:

- Results of the last quarter Trust wide patient survey results to be analysed and reported on.
- 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 May 12th 2011 to celebrate Nurses Day.

28 Day Cancelled Operations

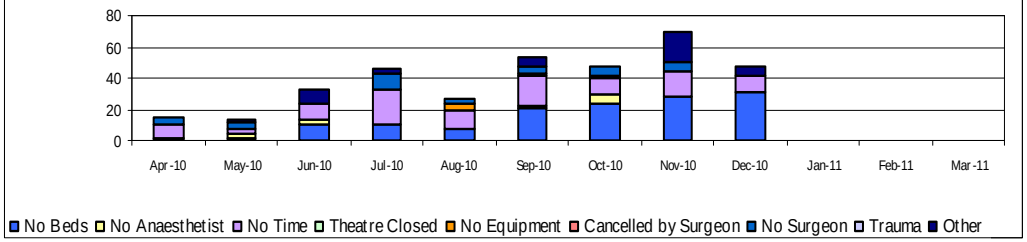
Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
28 Day Cancelled Operations	To maintain a minimum level of non medical cancellations in accordance with national criteria	DSD	**RED**	=	**RED**	**RED**	48 cancelled in month
	Readmit all non medical cancellations within 28 days in accordance with national criteria	DSD	**GREEN**	=	**GREEN**	**GREEN**	No 28 day breaches in month

Cancelled Operations 2010/11 - by Site



	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
PRH	15	6	17	20	15	25	15	36	29			
RSH	0	8	15	26	12	28	32	34	19			
Anticipated Threshold	33	33	35	36	30	34	35	33	31	31	34	40

Cancelled Operations 2010/11 by Reason



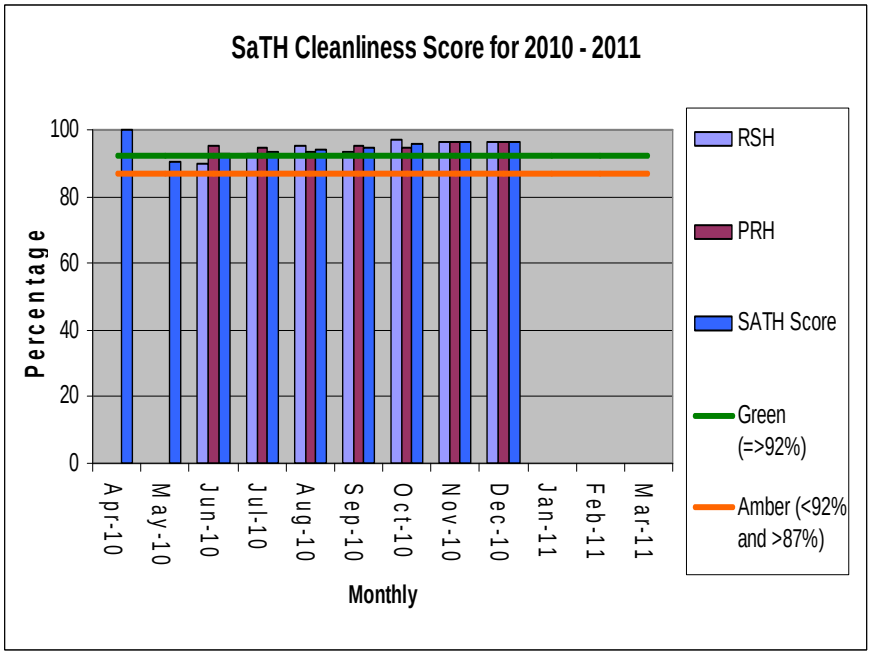
- 48 operations cancelled in November for non medical reasons.
- 352 operations cancelled for non medical reasons in the year-to-date.
- The national target applies only to those cancellations that happened on or after the day of admission and only for non-medical reasons.
- Current guidance indicates 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:

- Due to the high level of emergency admissions in January and the rise in delayed discharges, the January position for the total number of cancelled operations will increase, thus worsening our performance against this target. Work is on going with both PCTs to manage urgent care and delayed discharges.

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 December monitoring



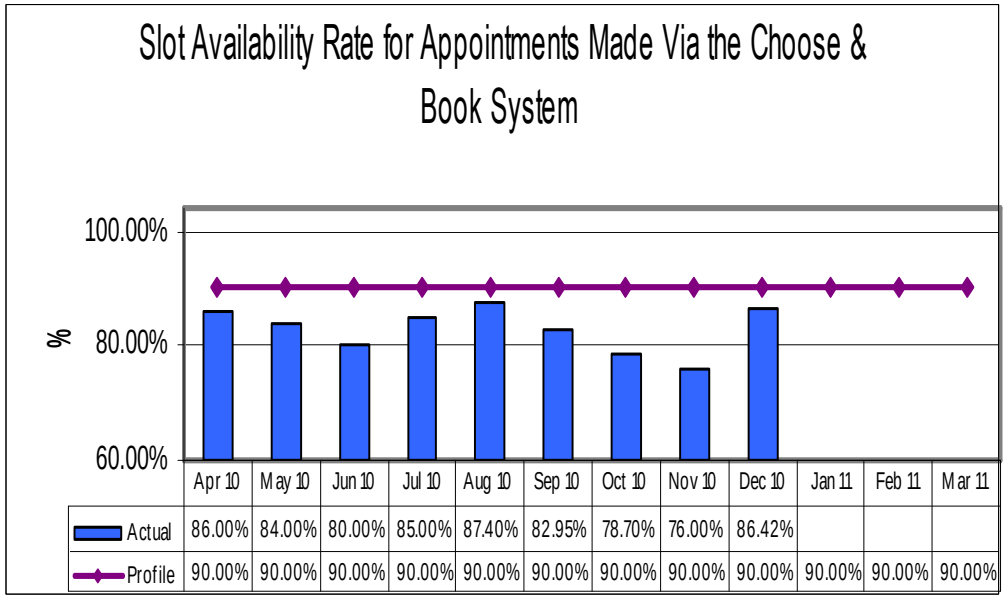
- Target score of 92% is based on the Patient Environment Action Team (PEAT) score to achieve "excellent".
- Monthly cleanliness scores collected from Domestic Services Department Quality Monitoring Programme.
- April and May figures only collated as combined scores.
- Overall score of 96.50% was achieved for the Trust in December 2010.
- Cleanliness Score for RSH was 96.58%.
- Cleanliness Score for PRH was 96.41%.
- Based on April to December figures the year-end forecast is 94.94% (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 April 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	DSD	**RED**	=	**RED**	**RED**	The Trust achieved 86.4% in December, an improvement of 10.4% from the previous month



- There were 1,712 appointments booked in directly bookable services in December compared with 2,835 in November.
- An average of 61 patients per week tried but were unable to book their appointment via C&B compared with 146 patients per week in November. This is assumed to be due to seasonal variation in demand.
- 77% of unavailable appointments were in the following specialties:-
  - Ophthalmology – av. 12.75 per week (including Paediatric Ophthalmology)
  - Dermatology - av. 15 per week (including Paediatric Dermatology)
  - Thoracic Medicine (PRH) - av. 4 per week
  - Colorectal (PRH) - av. 5 per week.
- Appointment Slot Issues (ASIs) are now directly available to the SDUs via a C&B worklist.

Actions:

- To work with the SDUs to appoint ASIs promptly and maximise available capacity.

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**	Of the 157 cases opened in the third quarter all have been responded to within the 6 months statutory deadline

	Division 1	Division 2	Division 3	Estates
Low	7	14	14	2
Moderate	54	37	8	0
Significant	12	4	0	0
High	4	1	0	0
Very High/Extreme	0	0	0	0
Total	**77**	**56**	**22**	**2**

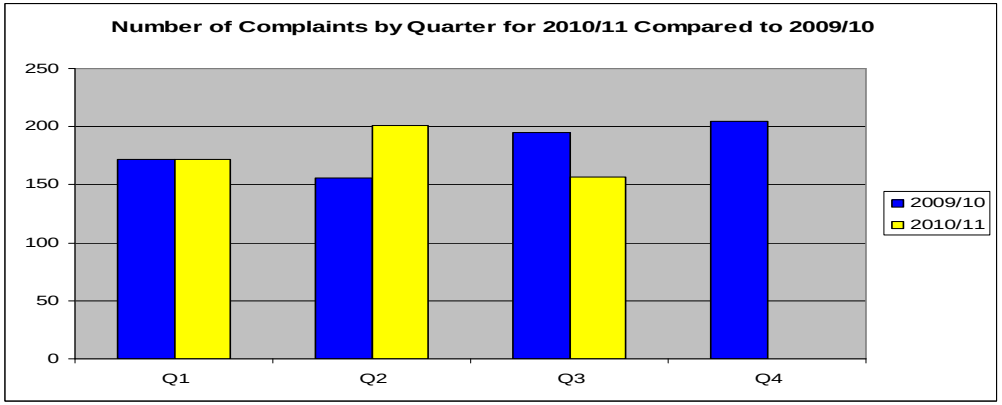


Table to show the Top Themes of Complaints for each Division

	Division 1	Division 2	Division 3	Estates
Attitude	13	6	1	0
Inadequate Medical Care	14	10	1	0
Lack of Communication	12	6	3	0
Lack of Medical Care	12	6	0	0
Waiting Time for Treatment	6	8	3	0
Administration/Clerical	0	0	11	0

Some improvements over the third quarter include:

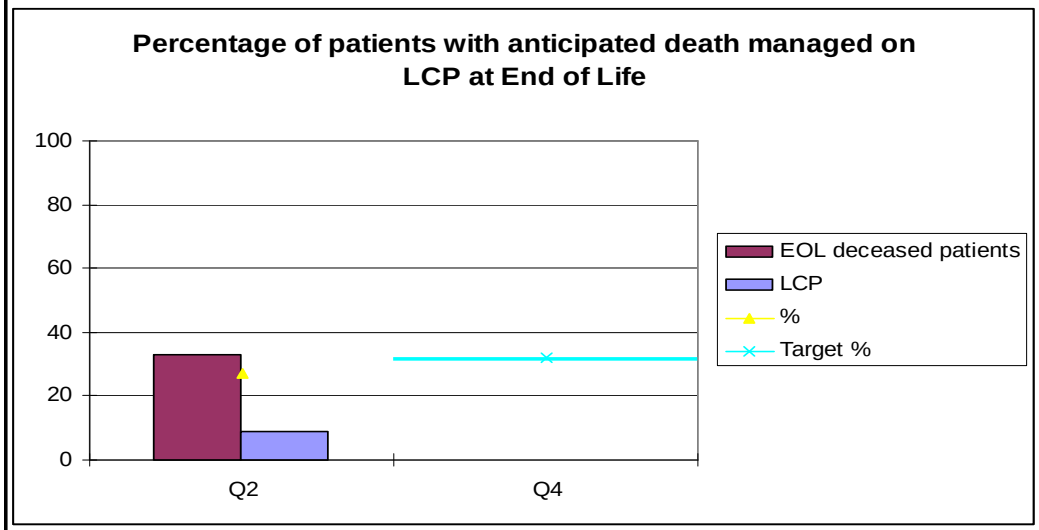
- Regular toileting rounds have been introduced on MAU to ensure that staff are checking if patients need to use the toilet.
- Lighting at night on MAU being reviewed in order to try and reduce falls.
- Appointment letters are now being sent out 4 weeks before appointment time to reduce cancellations.
- Customer Care training was arranged for some staff who had concerns raised about their attitude.
- New system for delivery of request cards for scans to improve Services.

Actions:

- A review of the Complaints process is being undertaken by the Director of Quality and Safety / Chief Nurse to ensure that patients and their families have a full opportunity to discuss their concerns and ensure that we identify the full range of issues that have led to a negative experience for the patient and their families. This review has identified a key role for the lead nurses to coordinate with the MDT team to ensure responses are comprehensive and that recommendations are tracked through and fully implemented. Trends and themes for the wider patient experience will be tracked closely by the Quality and safety Committee.
- Following final response and if the family remain concerned that the Trust has not fully addressed their concerns, the opportunity to meet the Chief Nurse or senior manager to understand their concerns and any possible solutions will be offered.

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)	DSD	**GREEN**	=	**GREEN**	**GREEN**	New CQUIN Target for 2010/11 Q2 – baseline 27% Q4 to improve compliance by 20% target 32%



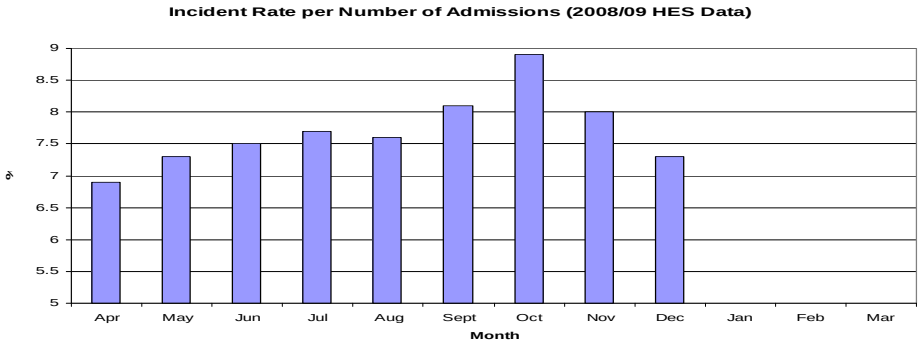
- Baseline target to be confirmed at the end of Q3 so we have full quarter of results.
- October 27%, November 100%. Awaiting December results.
- Educational Training strategy for EOLC has been developed by the Palliative Care Nurses.
- Recommendations for the development and improvement to Bereavement Services being taken through Division Three.

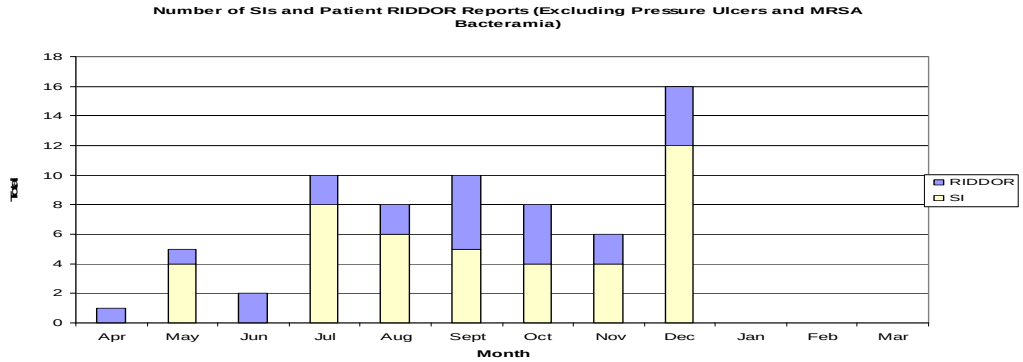
Actions:

- Q3 monitored against baseline. Monthly meeting with clinical coding and palliative care CNS to support data validation.

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**	=	**RED**	**RED**	Less than 8 SIRIs per month





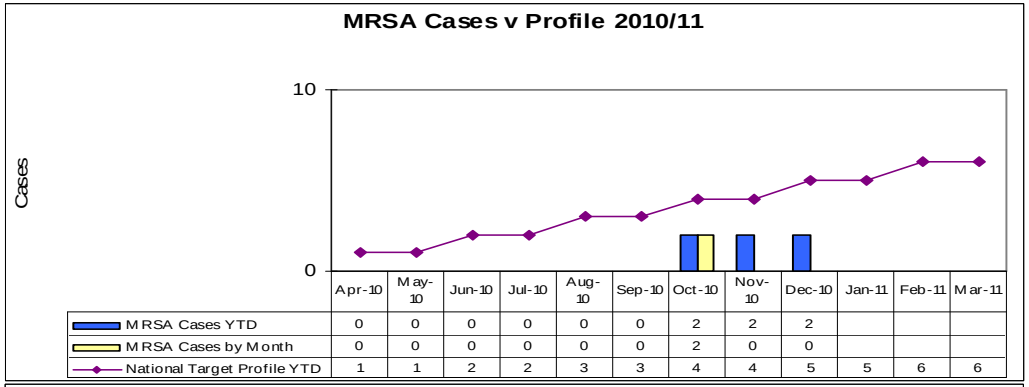
- The Trust reports Patient Safety Incidents & Near Misses to the National Reporting & Learning System (NRLS). The rate is based on the number of incidents each month as a percentage of the monthly admissions (based on 2008/09 HES data).
- The Care Quality Commission (CQC) receive weekly reports from 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 excluded as these are reported separately.
- In December the number of SIs increased due to 3 Ward closures due to Norovirus and 2 flu related incidents.

Actions:

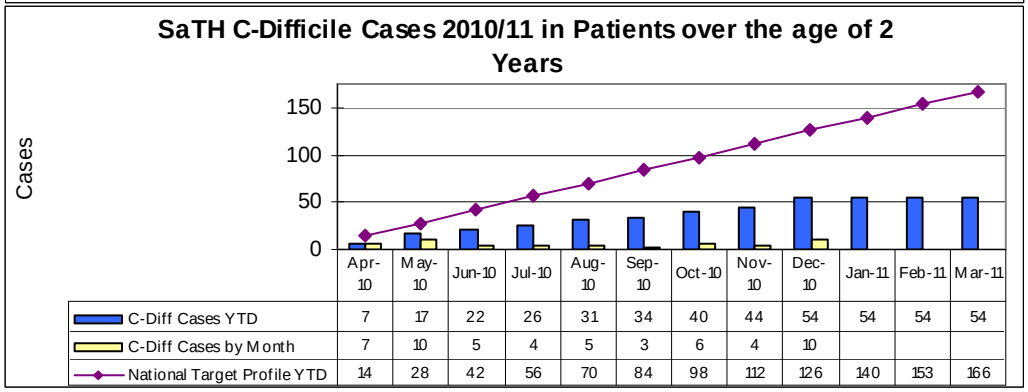
- Incident Review Group meets monthly to discuss incidents & trends. Further Root Cause Analysis training for Managers is being carried out in January to improve the consistency of investigation. New SI policy drafted- Lead Nurses have additional responsibility for incident investigation.

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 54 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			
MRSA Cases by Month	0	0	0	0	0	0	2	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	54	54	54
C-Diff Cases by Month	7	10	5	4	5	3	6	4	10			
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 December.
- We have had 2 cases to end of December 2010 vs. target of not more than 6 post 48 hr. cases during 2010/11.
- There was one pre 48 hour MRSA bacteraemia which is being investigated by the PCT.
- 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

- To end December 2010 - 54 SaTH responsible cases (post 72 hrs.) vs. target of not more than 166 cases 2010/11.
- In December 10 SaTH cases, 8 in RSH and 2 in PRH, were diagnosed more than 72 hrs. post admission and therefore count vs. SaTH target.
- One Ward has had 3 cases during the month, and another 2 cases, but typing has shown they were not related. Both Wards have had increased cleaning.
- 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, second audit is now completed Improvement Target agreed with PCTs

Second Audit Results November 2010

Patients records reviewed	270	
Number of times where medicines were prescribed	3167	
Prescription omitted for a clinical or patient specific reason i.e. patient refused	489	15.4%
Prescription omitted due to a record of non available	50	1.6%
Prescription where medicines regarded as critical	23	0.7%
% of patients with an omitted dose	23	8.5%

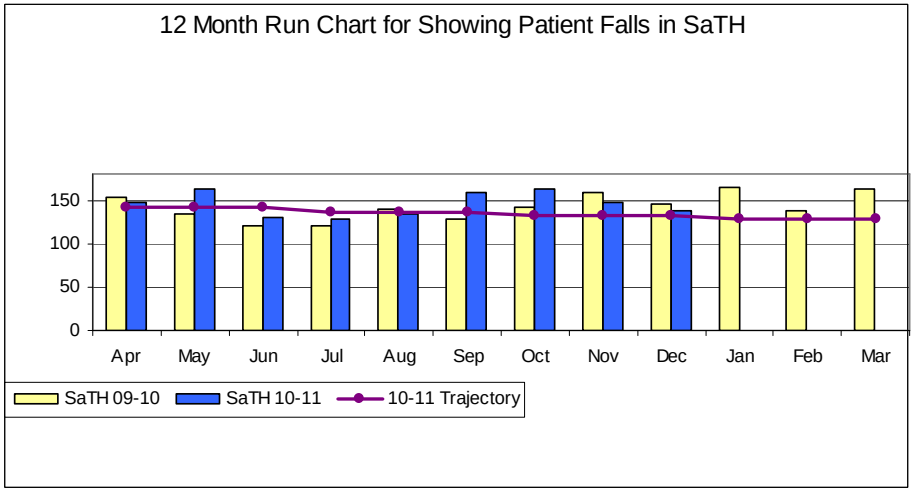
- To agree list of Critical Medicines for Baseline Audit - achieved.
- To undertake baseline audit in May 2010 - achieved. Three day audit of Admission areas, 364 patient records/charts included, second audit completed, final audit planned for January 2011.
- Report to PCTs in July 2010 - achieved, November 2010 - achieved & March 2011.
- Baseline Audit accepted & 20% improvement target provisionally agreed, based on improvement over the next two 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:

- Second Audit now completed, target achieved, final audit to be completed late January 2011.
- Result reported to PCT and for further review at Area Prescribing Committee.
- Action plan to further emphasise to staff in 15 of the 23 incidences the medicine was either in an emergency cupboard or clinical area.

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)	DSD	AMBER	=	RED	AMBER	• Q1 Baseline – 142 Falls per month • Q2 4%, reduction • Q3 7%, reduction • Q4 10% reduction



- Failed Q3 target of 7% reduction due to high numbers in October but downward reduction of falls in November and December.
- There are significant challenges if we are to meet the target for Q4. In response we have instigated a daily Datix Alerting System for falls so that we can proactively investigate frequent fallers and areas reporting multiple falls.
- Slips, trips and falls policy has been ratified by Health and Safety Executive Committee.
- Notes reviewed of frequent fallers many of which are frequent fallers prior to admission. Information presented at Band 7 Sharing Event for Ward Managers to ensure with Clinicians there is robust, timely Discharge Planning.
- The Senor Nursing Team including the Chief Nurse are undertaking a quality review of all clinical areas during January which includes review and auditing of FRASe assessment and evidence of Preventative Care Plan Strategies.

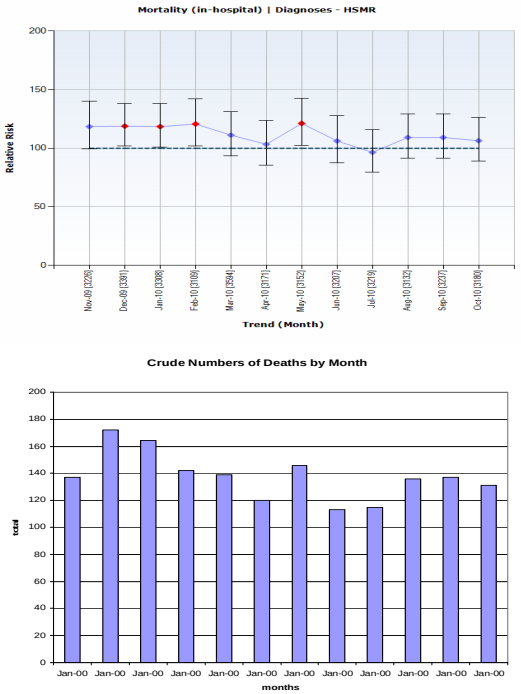
Actions:

- Falls information on Internet and Intranet.
- To undertake an audit in January 2011 of compliance with falls flow chart and care bundle.
- Senior Nurse review of falls assessments and care planning to continue on a daily basis.

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**	**AMBER**	Month: 106.4 (95% CI: (88.7.4 – 126.2) Last Quarter: 105.1 (94.9-116.1) Last 12 Months: 111.8 (106.5 – 117.4)

Period	HSMR
Oct 09-Dec 09	**RED (Worse)**
Jan 10-Mar 10	**RED (Worse)**
Apr 10-Jun 10	**AMBER** (Comparable but One Trigger)
Jul 10-Sept 10	**GREEN**
Oct 10-Dec 10	**Complete data not yet available**
Negative Triggers	**TWO**



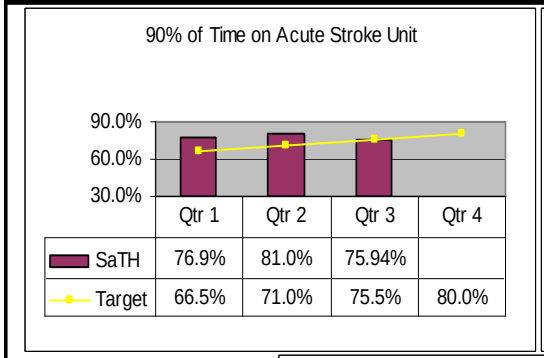
- HSMR is calculated from hospital activity using the Dr Foster Real Time Monitoring (RTM) Analysis Tool, using the most recent available data (currently three months in arrears). It compares the mortality rates in SaTH with the average expected across England, adjusted to reflect factors such as age and case mix.
- The annual HSMR for the year November 2009 to October 2010 is worse than the national average for England (based on a 95% confidence interval).
- The HSMR for the latest month is 105.1 and for the last quarter is 105.1. For the months April – October all months, with the exception of May, were close to the England averages.
- Trust-level Mortality data has been triangulated using other quality analysis tools, such as CHKS. This has not replicated the alert from the Dr Foster system.
- Intelligence from the West Midlands QI suggests that the disproportionate number of Community Hospitals within the Local Health Economy may adversely impact on the SaTH HSMR score.

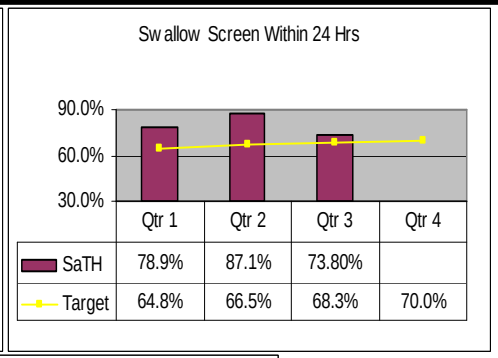
Actions:

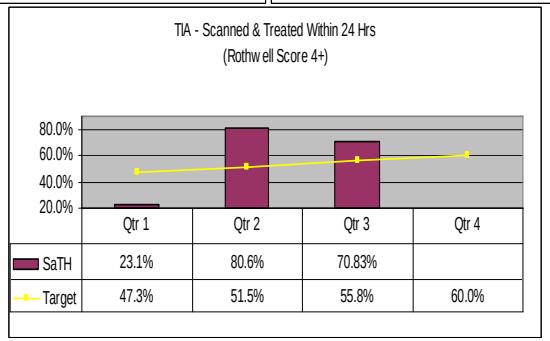
- Senior nurses have be trained in the use of the Global Trigger Tool in December with more training planned. Regular review of notes will start in January 2011 as part of LIPS project.
- A Project Manager has been identified to draw together an action plan.
- A number of Clinicians have been identified as 'Coding Champions'.
- The Trust is working with the University of Birmingham to understand the data more fully; develop an alternative system for monitoring deaths, and to set up a research project.

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	MD	GREEN	=	GREEN	GREEN	Sustained improvement continues at both sites
Stroke – Compound Indicator	Based on targets agreed with local Commissioners	MD	GREEN	=	GREEN	GREEN	Quarter Three YTD







- Current Performance Proportion of People who spent at least 90% of their time on a Stroke Unit: Quarter 3 Target 75.5%, PRH 84.62%, RSH 69.72%, SaTH = 75.94%.
- Overall SaTH achieved target. PRH consistently exceeded target and continues to maintain, however performance at RSH notably in November was low, however they showed marked improvement in December at 81.25%.
- Current Performance for swallow screening on both sites: Quarter 3 Target 68.3%, PRH 82.05% RSH 67.89%, achieving SaTH target, with RSH narrowly missing target.
- Current Performance for TIA on both sites:

  Quarter 3: Target 55.8%, PRH 76.19, RSH 66.67%.

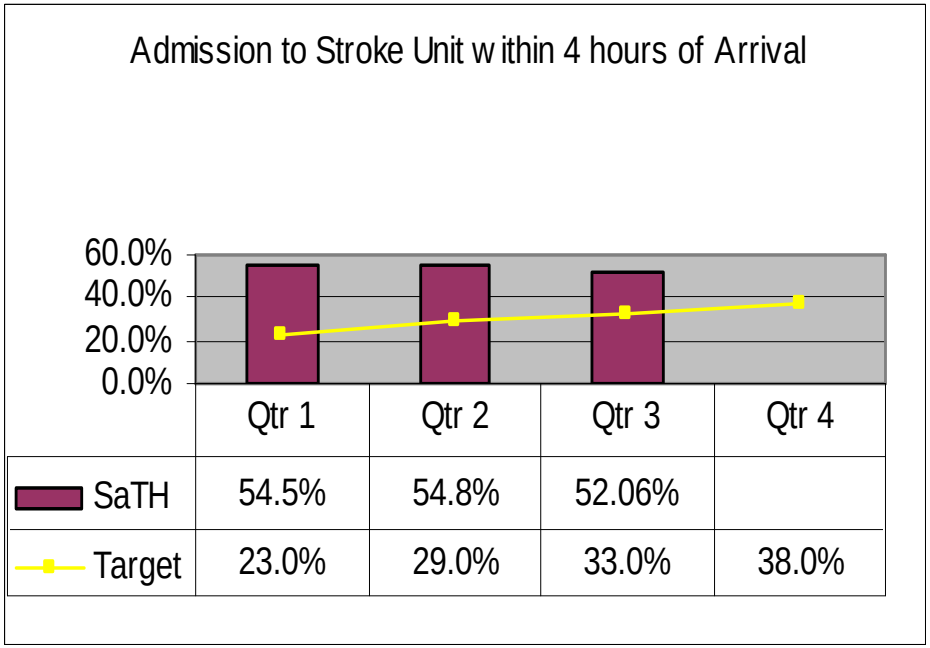
  Marked improvement continues against this target and increase in performance sustained.
- West Midlands Quality Review Service. Final report expected in January.
- 7 day Thrombolysis service 8am – 8pm commenced on both sites from 11th December 2010, with full 7 day 24 hour service commencing, with overnight service being provided at PRH.

Actions:

- New Ward Manager for Ward 22 due to start in post from 21st February 2011.
- Thrombolysis training day taking place on 19th January 2011.
- Meeting with PCT's around economy wide Stroke Strategy on 11th January 2011.
- Plans being made to enable compliance against Best Practise Tariff for TIA's, due from April 2011.
- Early Support Discharge (ESD), pilot funding of £68k successfully obtained from January – April 2011. Project Lead identified and level 2 plan completed.
- Expression of interest made to become the host provider for TeleMedicine Project across the for Heart and Stroke Network. Interviews due early February 2011.

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	MD	**GREEN**	=	**GREEN**	**GREEN**	New CQUIN Target for 2010/11 value worth £200K



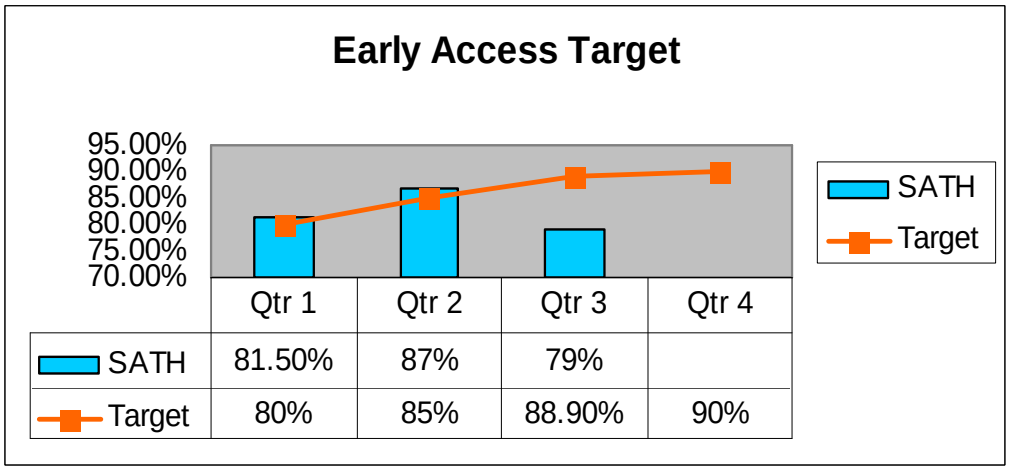
- Current performance for admitted to Stroke Unit within four hours of Arrival:
  Quarter 3: Target 33%, PRH 70.24%, RSH 38.18%.
- Performance in this area continues to improve. After a poor performance in November, RSH have significantly improved to 45.45% for December.
- New CQUIN Target from April 2010/11 to demonstrate Admission to Stroke Unit within 4 hours of Arrival at Hospital – value worth £200k.

Actions:

- Continued focus on areas of challenge with RSH team, meeting with clinicians on a fortnightly basis.
- Stroke Data Analyst to be based at RSH three times a week to try and enhance rigor in system.
- Ward Clerk training and staff education to focus on improving data capture.

Early Access to Maternity

Target (2010/11)		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) (CO1.1)	DSD	**RED**	⇩	**RED**	**RED**	December 2010 TWPCT = 66% SCPCT = 87%



	Qtr 1	Qtr 2	Qtr 3	Qtr 4
SATH	81.50%	87%	79%	
Target	80%	85%	88.90%	90%

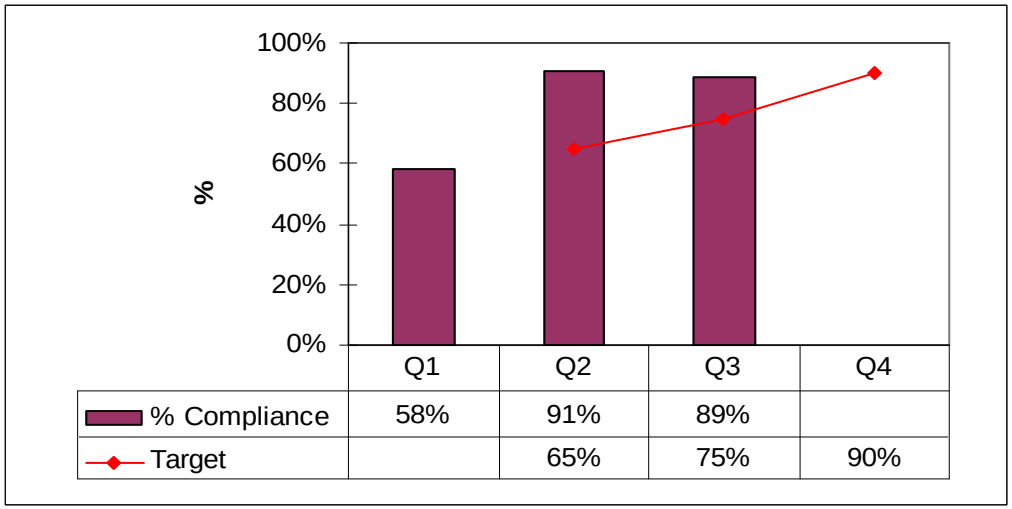
- Action plan being developed for both PCT areas.
- Meeting with TWPCT and GP Maternity Lead held in November 2010 – further meeting to be arranged in January 2011 to encourage the ongoing use of the electronic Notification of Pregnancy (NOP) with TW GP surgeries.
- Permanent booking co-ordinator posts recruited and in post.
- Regular SCPCT Service Review Meetings (as per existing TWPCT Review Meetings) are still to be confirmed.
- Work to convert the Playroom to a Booking Room at Wrekin Unit, PRH nearly completed.

Actions:

- Review of database to identify specific GP practices referring pregnant women late to Maternity Services.
- Audit by Feto Maternal Consultant now completed and the action points are being reviewed.
- SaTH Early Access Review Meetings are monitoring progress against the action plan.
- Actively investigating the use of C&B as a referral method for the NOP form.

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%	
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 and third quarter.
- More work needs to be done to refer patients to the Ward Dietician based on the screening outcomes for both Medium and High Risk patients.
- There has been a huge push by Wards to screen patients on a weekly basis – this is excellent practice.
- 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.
- The Nutritional Steering Group is established and continues to address nutrition matters.
- A visit to Coventry is due in January 2011 to review Protected Meal Times in practice. Protected Meal Times is being trialled in Wards 7, 15 and 16 at PRH.

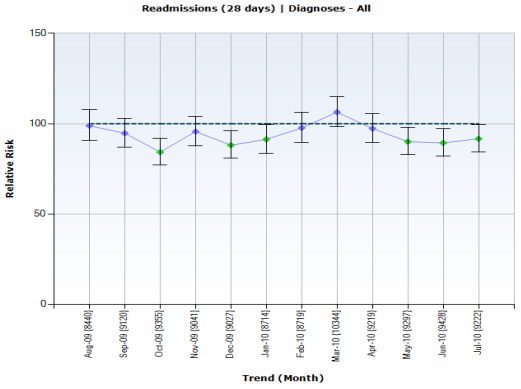
Actions:

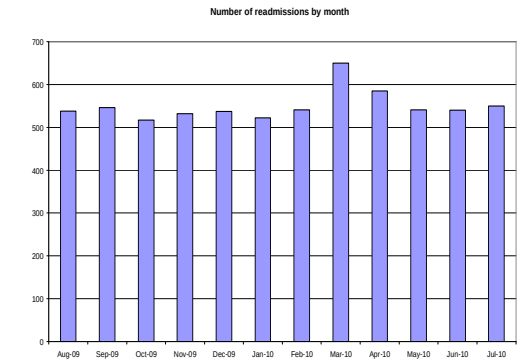
- Nutritional Steering Group members to visit Trust in the region who have successfully implemented Protected Meal Times.

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
Aug 09 to Jul10	**6.0%**
	GREEN (Better)
Jul 09-Sep 09	**GREEN (Better)**
Oct 09-Dec 09	**GREEN (Better)**
Jan 10-Mar 10	**GREEN (Comparable)**
Apr 10-June 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 (August 2009 to July 2010) 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:

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					No update provided at the time of issue

- Medical staff are aware of the NICE requirements for risk assessments and treatment. Evidence suggests that drugs are being prescribed for VTE but the formal risk assessments required by NICE need to be confirmed through a Trust wide process and national reporting.
- The VitalPac VTE Module discussed within the Trust had been delayed however this is now being piloted in PRH Ward 14 but initial evaluations are not positive and require further discussions with medical teams to engender a positive response.
- Manual systems therefore required to be implemented to collect data on the number of VTE assessment forms completed. This commenced in late December and a data set will be available for the January IPR
- Head of Nursing has been coordinating with ward managers and Ward Clerks to ensure that the data is collected and status of risk assessment confirmed on patient discharge (ie if VTE has been completed).
- A National report will be published in January on December data collection. No data will be available from the Trust.

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	**AMBER**	=	**GREEN**	**GREEN**	Action plan compliant with milestone achievement

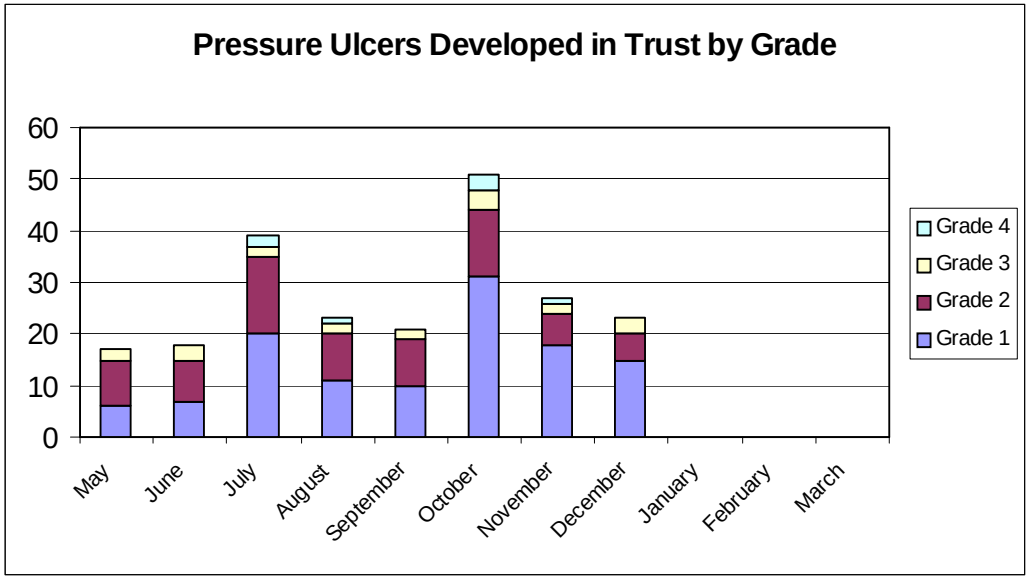
Milestones	Completion Date	Compliance
Baseline audit	Q1	**Green**
Robust process for patient identification Safe use of insulin implemented	Q2	**Green**
Review of patient identification visibility and education roll out re-audit against toolkit	Q3	**Amber**
CQUIN compliance	Q4	

- 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 November 2010 revealed that only 5 out of 37 departments were fully compliant with Think Glucose guidance.
- Compliance re-audit scheduled for January 2011.

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
Tissue Viability (CQUIN)	Reduction in the number of Grade 3 and 4 Pressure Ulcers – to be confirmed with PCT (CO1.3)	DSD	**GREEN**	=	**AMBER**	**AMBER**	New CQUIN 2010/11 Target to reduce by Q4 number of grade 3/4 ulcers by 10%



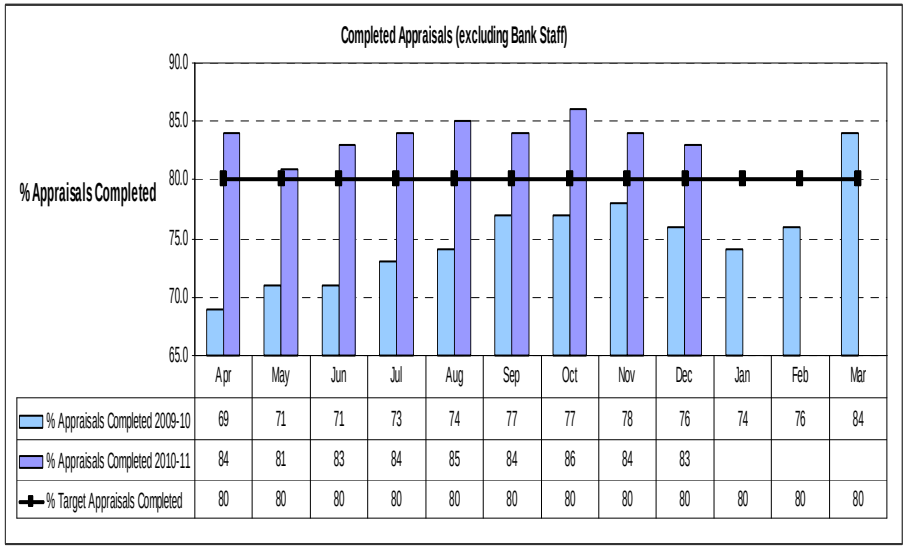
- 2 Trust acquired ulcers reported in December.
- Achieved 4 out of the 5 targets for Q2/3.
- 14 ulcers reported at end of Q3 against a target of no more than 15.
- Achieved Q2 target for initial patient assessment, reporting ulcers on Datix and completion of RCA's.
- Failed target % for documented evidence of Preventative Care Planning.
- Trust wide action plan developed to address key issue from RCA. Ward Managers and Matrons to take ownership and responsibility for implementation of actions.
- 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 measure for grade 1 and 2 ulcers.
- The Senor Nursing Team including the Chief Nurse are undertaking quality review of all clinical areas during January which includes review and auditing of pressure ulcer assessment, care and management.

Actions:

- Tissue Viability Educational Programme continue to be rolled out.
- Paper submitted to Quality Review meeting to update on progress and actions with tissue viability.

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 83%



- As at month ending 31st December 2010, 83% of staff excluding Bank Staff have had a KSF appraisal within the last 15 months.
- Departments continue to improve completion performance, although this must be sustained over the winter months when operational pressures normally impact.
- Appraisal Quality Audits are currently being trialled to improve the effectiveness of individual appraisals.
- The lowest 5 performing areas for December with over 15 staff were as shown. All have action plans in place to achieve 80%.

Area	Staff	Completed	%	Div.
Ward 23 – Haematology	18	8	44	2
Portering Department (RSH)	40	18	45	Corp.
Ward 11 - Trauma & Orthopaedics	24	12	50	1
Ward 9 - General Medicine	24	12	50	1
Estates Department (RSH)	25	13	52	Corp.

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).

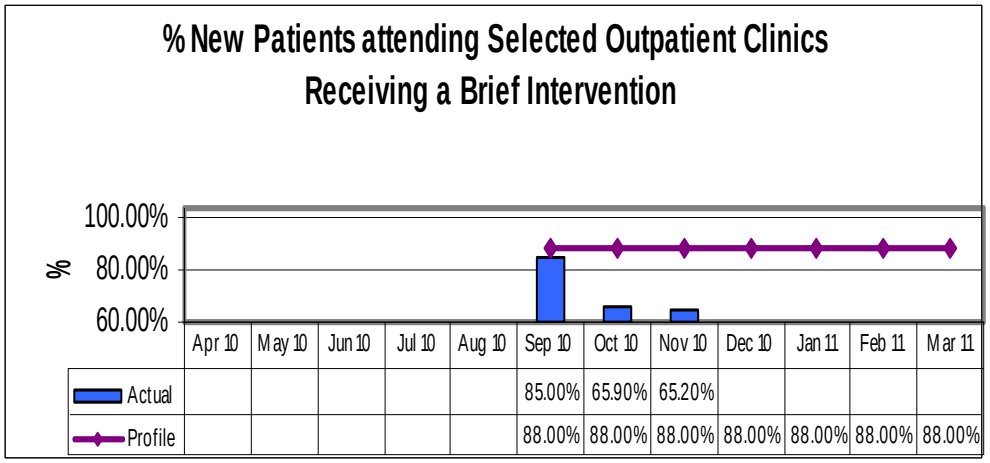
Progress in the third quarter has included:

- 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	**RED**	=	**RED**	**AMBER**	This was a new CQUIN standard for 2010/11. Data is available for October and November only for Q3



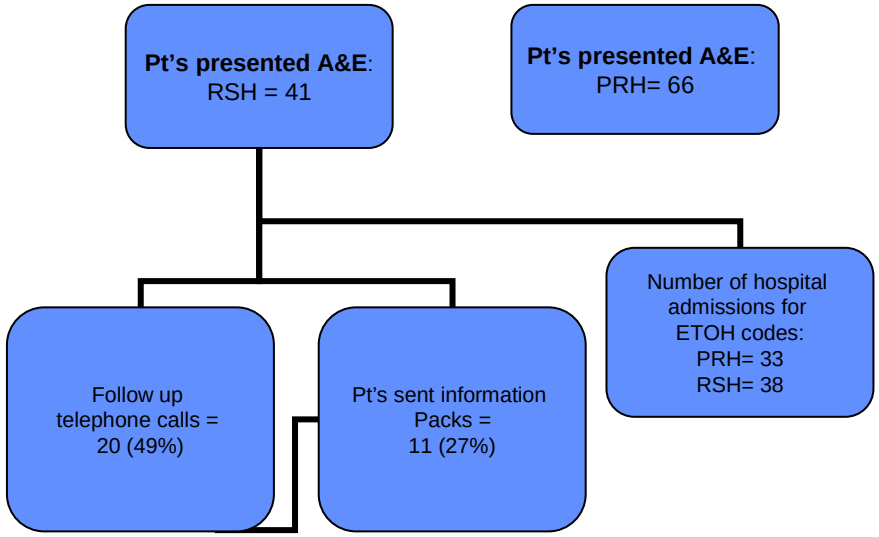
- A total of 110 new patients who required a brief intervention were seen in the selected clinics during October and November, including Respiratory, Cardiology, Vascular, Diabetes and ENT.
- Of those who smoke and want to stop, 85% were offered intervention but 36% were referred to the Stop Smoking Nurse (not part of the CQUIN but Best Practice, and may become a target in the future).
- Of the 40% of smokers identified who do not want to stop, 60% were not 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 and method of data collection needs to be reviewed for Q4.

Actions:

- Review plan with Commissioners including data collection and analysis to ensure target patients are more clearly identified.

Staying Healthy (Alcohol) - CQUIN

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Staying Healthy (Alcohol)	9a) 90% of people attending A&E with alcohol related condition and are not admitted who receive a brief intervention to reduce alcohol consumption 9b) 75% of people who are admitted to hospital with alcohol related condition receive brief interventions to reduce alcohol consumption	MD	**AMBER**	=	**AMBER**	**RED**	9a) PCT SLA required and Trust project group to clarify resources for delivery within the ED 9b) PCT and Trust working on definition and agreement of roles and accountability. Need for clear SLA and agreement on the immediate way forward



Part 9a:

- Data collection methodology agreed with SCPCT and CQUIN group as a whole. This now requires Medical Director decision making to enforce in practice.
- Information leaflet agreed by group and submitted to printers. This will be ready end of January 2011.
- Monthly project group meeting taken place across LHE: Late apologies accepted from T&W.
- SLA to define accountability across LHE requested again at monthly meeting from PCT's. Until this is in place it will be difficult to assess responsibilities and manage accordingly.

Part 9b:

- Pathway forms now available. PCT's have asked for a change to this form which SaTH will move forward with in February.
- SLA from PCT required to determine resources and accountability within commissioning streams.
- MHL nurses in place and responsibility for their roles awaiting clarification from MHLS. Office space for this role is not yet found.
- PCT's have declared that the CQUIN has not been met this year despite agreement (minuted) that this would not be expected in this financial year as long as progress made.

Actions:

- PCT's to deliver SLA for both hospital sites.
- Training plan for nurses to be agreed and delivered over next 2 months.
- CAG group to validate revised Alcohol Withdrawal Guidelines in February 2011: Clinician Lead taking this forward.

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

Outcome 1: Involvement and Information

Outcome 4: Suitability of staffing

Outcome 2: Personalised care, treatment and support

Outcome 5: Quality and Management

Outcome 3: Safeguarding and Safety

Overall contextual risk estimate

- The CQC produce monthly Quality and Risk Profiles (QRP). The QRP is a tool that gathers all that the CQC know about a provider in one place. The latest summary of the SaTH QRP (December) is shown opposite. Outcomes 3, 4 and 5 have improved since November.
- The Trust declared compliance with all outcomes across the six key areas in the January 2009 Initial Registrations process. The CQC do not annually re-assess compliance but will carry out responsive reviews on any standards which may have triggered concerns. A planned review of compliance will take place within two years of registration.
- A responsive review was published by the CQC in October; the Trust was judged compliant with the standards assessed which were: Care and Welfare of People who use Services; Management of Medicines Safety; Availability and Suitability of Equipment; Staffing; Assessing and Monitoring the Quality of Service Provision Complaints; Records.
- SaTH has set up templates for Lead Managers to collate evidence of compliance. These Provider Compliance Assessment templates will be used by the Trust as a routine internal assurance record to help the Board assess ongoing compliance. Templates will be reviewed by the Assurance Compliance Unit.
- The CQC will only ask for the Provider Assessment Tool to be submitted when gathering additional information during a review of compliance.
- The Trust remains registered with CQC without any conditions.

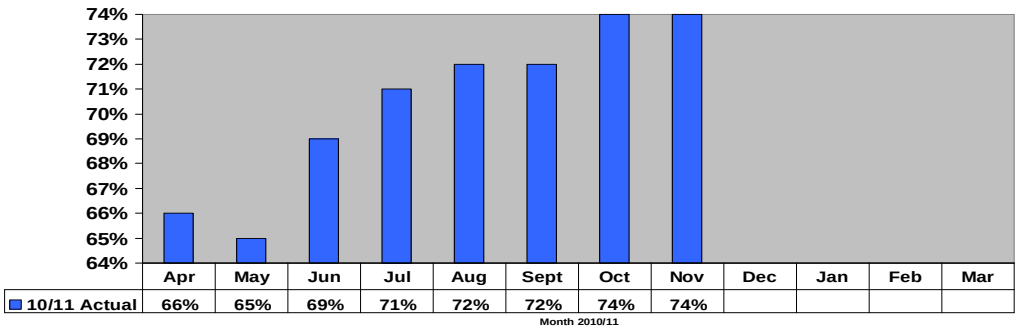
Actions:

- Lead Managers have been completing the Provider Compliance Assessment templates and collating evidence of continuing compliance against the Essential Standards of Quality and Safety for quarter 2.
- Internal Audit have audited the processes around monitoring of ongoing compliance and have provided assurance on the processes in place.

Coding

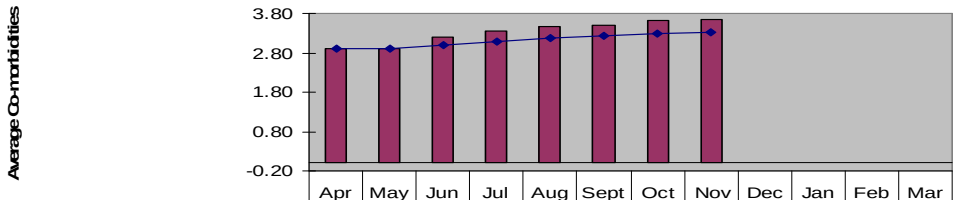
Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Coding	To increase the numbers of FCEs with coded co-morbidities	FD	**GREEN**	=	**GREEN**	**GREEN**	Coding levels have increased in month

FCEs with Coded Co-morbidities



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
10/11 Actual	66%	65%	69%	71%	72%	72%	74%	74%				

Average Number of Co-morbidities per FCE



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Combined Sites 10/11 Actual	2.91	2.90	3.19	3.36	3.46	3.50	3.61	3.65				
Cumulative	2.91	2.90	3.00	3.09	3.16	3.22	3.28	3.33				

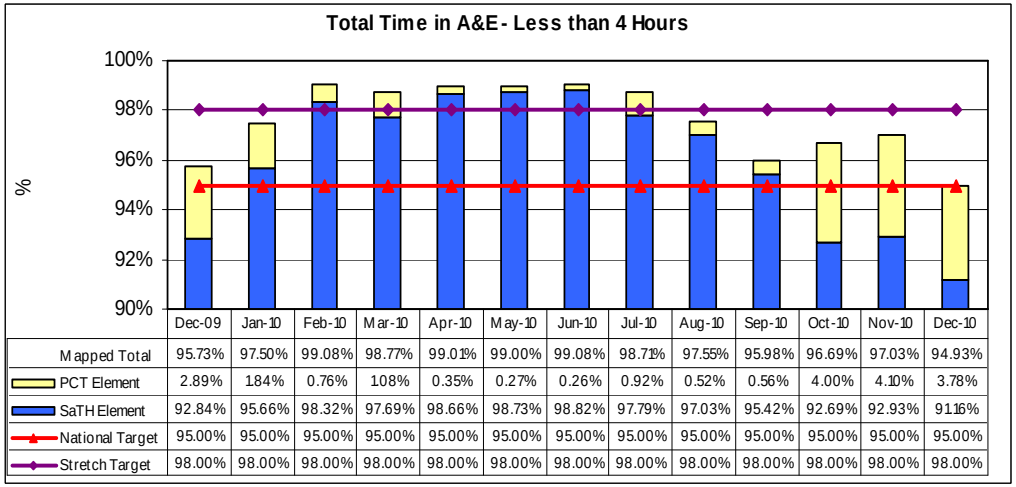
- The Target is to ensure that co-morbidities are captured by clinicians for each Finished Consultant Episode (FCE), where applicable. Both charts show a steady increase in the depth of coding.
- Work is ongoing with MedeAnalytics to analyse national coding statistics and provide a national benchmark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



	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10
Mapped Total	95.73%	97.50%	99.08%	98.77%	99.01%	99.00%	99.08%	98.71%	97.55%	95.98%	96.69%	97.03%	94.93%
PCT Element	2.89%	1.84%	0.76%	1.08%	0.35%	0.27%	0.26%	0.92%	0.52%	0.56%	4.00%	4.10%	3.78%
SaTH Element	92.84%	95.66%	98.32%	97.69%	98.66%	98.73%	98.82%	97.79%	97.03%	95.42%	92.69%	92.93%	91.16%
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%

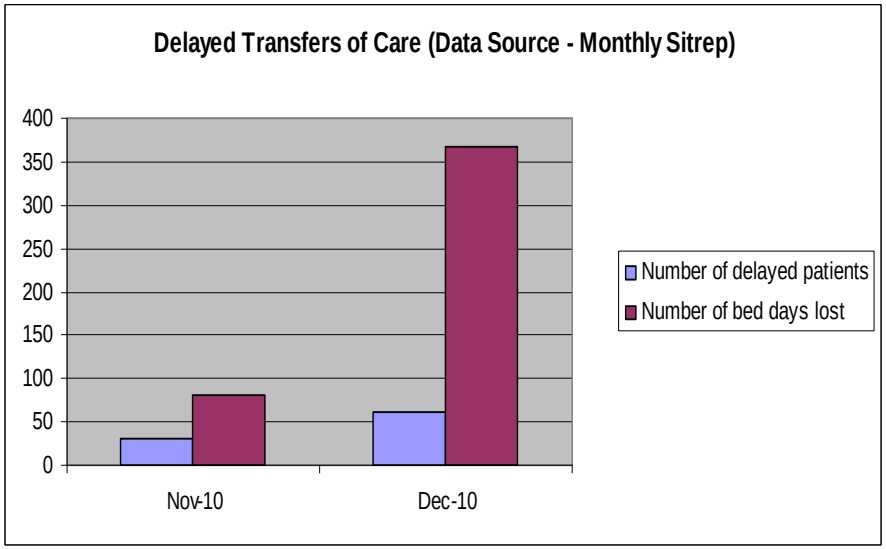
- The Trust achieved 91.15% unmapped during December.
- The Local Health Economy achieved 94.93% mapped during December.
- For the year-to-date the Trust has achieved 95.90% unmapped.
- For the year to date the Local Health Economy has achieved 97.45% mapped.

Actions:

- A focused MDT plan for quality improvements in patient flow through Emergency Care has been developed within SaTH with milestones for delivery until March 2011.
- internal Winter Planning meetings are taking place weekly 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 corporately to ensure an overarching and empowered delivery of Site Management.

Delayed Transfers of Care

Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
Delayed Transfers of Care	Reduce Delayed Transfers of Care by 50% by 31st March 2011	COO	**RED**	⇩	**RED**	**AMBER**	The number of bed days lost due to delays increased by 458% in December



- 26% of bed delays are due to - Completion of Assessments - 19 patients/94 bed days.
- 24% of bed delays are due to - Further Non Acute NHS Care (including intermediate care, rehabilitation etc.) - 18 patients/88 bed days.
- 16% of bed delays are due to - Awaiting Care Home Placement – Residential - 4 patients/59 bed days
- 14% of bed delays are due to - Awaiting Care Home Placement – Nursing Home - 6 patients/52 bed days.
- Equates to 12 beds lost due to delayed patient transfer during December 2011.

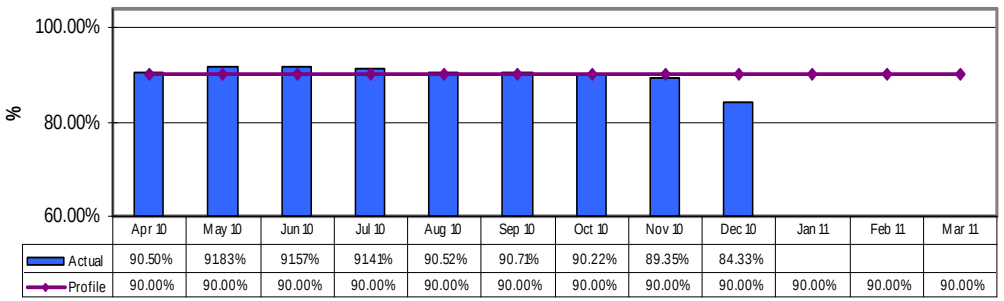
Actions:

- Review reporting criteria against SHA Guidance 2010.
- Refocus the 'Joint Discharge' Transformation Team to focus upon delayed transfers of care for the next 3 months to seek partnership improvements (next meeting February 9th 2011).
- Develop a multi agency Discharge Policy agreed across Health and Social Care.
- Develop a plan for change agreed by all partners and implement with a view to deliver 150% reduction in the number of patients with a delayed transfer of care by 31st March 2011.

18 Weeks

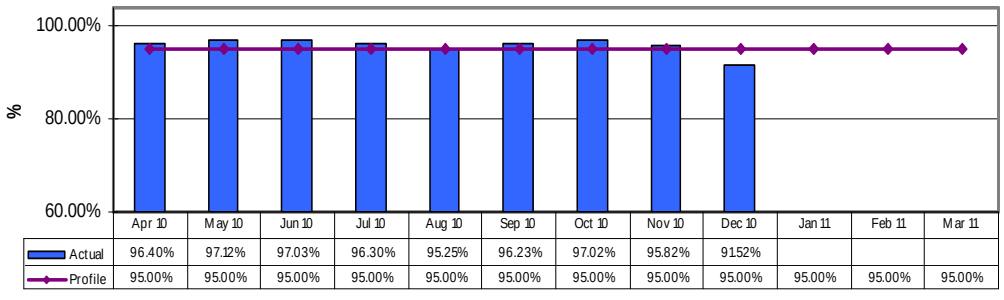
Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
18 Weeks	1a - Admitted Clock Stops above 90%	DSD	**RED**	=	**GREEN**	**GREEN**	Trust underachieved the 90% target during December
	1b - Non-Admitted Clock Stops above 95%	DSD	**RED**	=	**GREEN**	**GREEN**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

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%			
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%			
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 underachieved the overall targets with 84.33% and 91.52%.
- PCT performance for December was:-

	1a	1b
Shropshire County PCT	85.45%	90.76%
Telford & Wrekin PCT	82.95%	92.46%

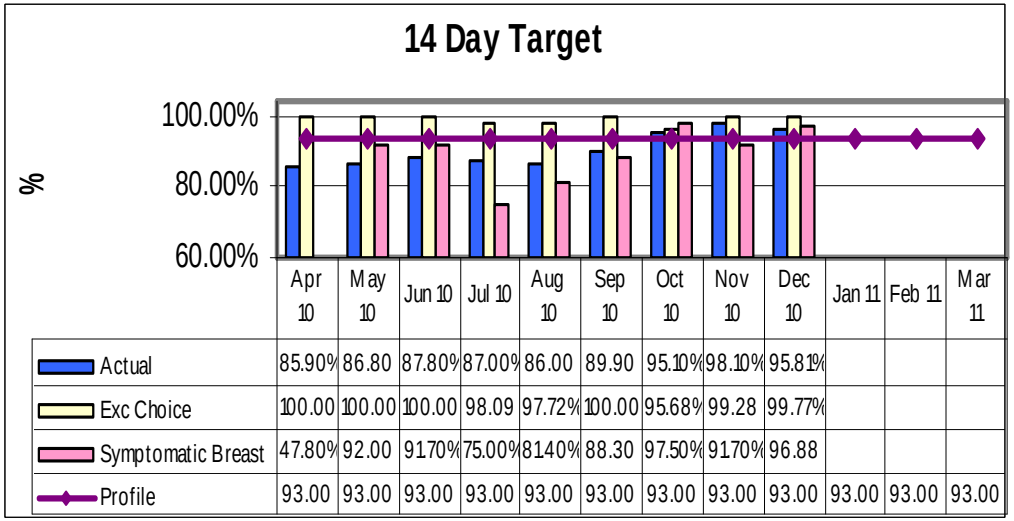
- Achieved the 95% target for Audiology in December with 98% of non admitted Audiology patients completing their pathways within 18 weeks with 99% data completeness which is within the anticipated 90 – 110% threshold.
- Specialty level performance for admitted patients (Part 1a) was below 90% in ENT (81.16%), General Surgery (82.96%), Gynaecology (82.66%), Ophthalmology (78.18%), Oral Surgery (48.93%), Other (87.8%), Plastic Surgery (94.44%), T&O (84.33%) and Urology (87.96%).
- Specialty level performance for non admitted patients (Part 1b) was below 95% in Dermatology (91.36%), ENT (80.4%), General Medicine (94.68%), General Surgery (92.47%), Gynaecology (94.78%), Neurology (94.79%), Ophthalmology (85.86%) Oral Surgery, (81.12%), Plastic Surgery (78.94%), T&O (89.68%) and Urology (83.76%).

Actions:

- Work is ongoing with the Intensive Support Team to review all 18 week pathways. A detailed action plan has been produced and the 18 week Board meetings are to be reinstated with executive support from both PCTs and SaTH.
- Plans are in place to clear the pending follow up referrals who have waited over their maximum wait time by end of February.

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	DSD	**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%			
Exc Choice	100.00	100.00	100.00	98.09	97.72%	100.00	95.68%	99.28	99.77%			
Symptomatic Breast	47.80%	92.00	91.70%	75.00%	81.40%	88.30	97.50%	91.70%	96.88			
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 and November are validated but the actual performance for the month of December 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 December (95.84%), against a year end cumulative target of 93%. There were 38 breaches out of a total of 914 referrals.
- Symptomatic Breast Performance (which is a subset of the overall activity) for the month was 96.88%.
- 32 patients chose to wait longer than 14 days for their first appointment. Details of the Specialties are as follows:

  Brain 1, Breast 2, Breast Symptomatic 1, Colorectal 5, Gynae. 2, H&N 5, Skin 4, Upper GI 9, Urology 3.
- 3 patients waited longer than 14 days due to medical reasons:

  Colorectal 1, Skin 1, Upper GI 1.
- 3 patients waited longer than 14 days due to other reasons:

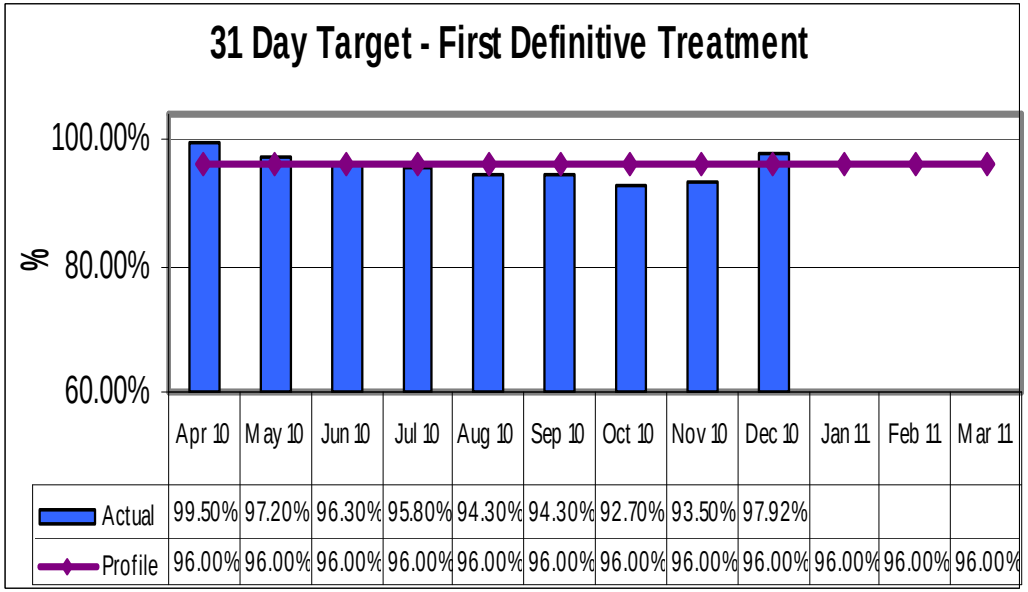
  Colorectal 1, UGI 1, Haem. 1.
- 14 day target YTD is 90.24% against a year end cumulative target of 93%.
- The application of the RAG status is as per the internal Performance Directory (within 5% of target is Amber).
- The newly appointed Cancer Services Information Manager is liaising with the SHA to confirm data sources for reporting purposes.

Actions:

- The 14 day target has improved significantly and has been sustained in the 3 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	DSD	**GREEN**	⇧	**AMBER**	**GREEN**	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 and November are validated but the actual performance for the month of December 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 December (97.92%), against a year end cumulative target of 96%.
- 31 day target subsequent treatment (Surgery) achieved in December (95.65%), against a year end cumulative target of 94%.
- 31 day target subsequent treatment (Anti Cancer Drugs) achieved in December (98.08%) against a year end cumulative target of 98%.
- 31 day target subsequent treatment (Radiotherapy) underachieved in December (81.67%), against a year end cumulative target of 94%.
- Current YTD position is 95.64% against a year end cumulative target of 96%.

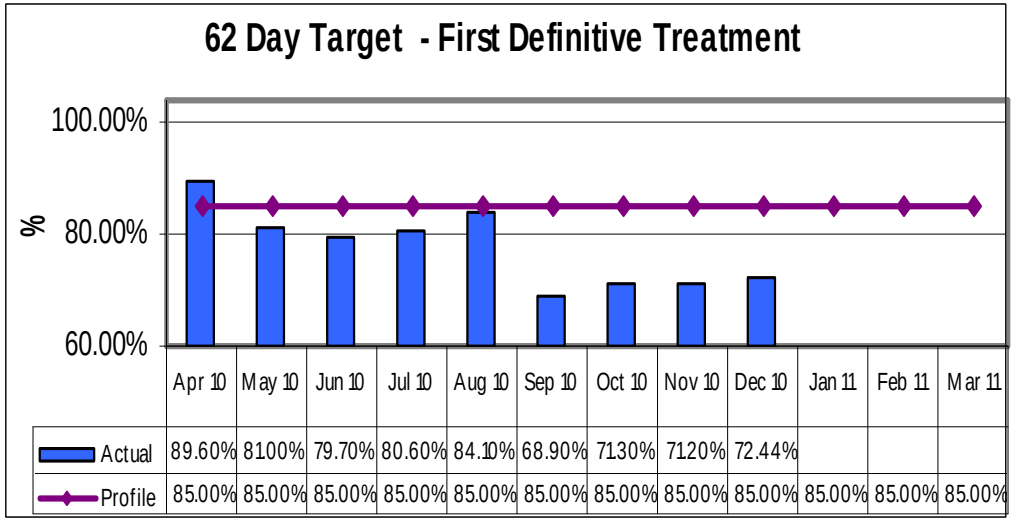
- There were 16 breaches in December out of 279 patients treated of which were due to patient choice 2, medical reasons 3 and others 11.
- The application of the RAG status is as per the internal Performance Directory (within 5% of target is Amber) which is relevant to the overall target.
- The newly 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	DSD	**RED**	=	**RED**	**RED**	62 day target underachieved in month



At the time of writing this report the actual performance for the months of April, May June, July, August, September, October and November are validated but the actual performance for the month of December 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 underachieved in December (72.44%), against a year end cumulative target of 85%.
- 62 day screening to first definitive treatment target underachieved in December (86.7%), against a year end cumulative target of 90%.
- 62 day consultant upgrade performance target in December was 87.88% – to be confirmed.
- Current YTD position is 77.64% against a year end cumulative target of 85%.
- There were 24 breaches in December out of 112 patients treated of which 6 were patient choice, 4 complex pathways, 7 were due to medical suspensions and 7 others.
- 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.

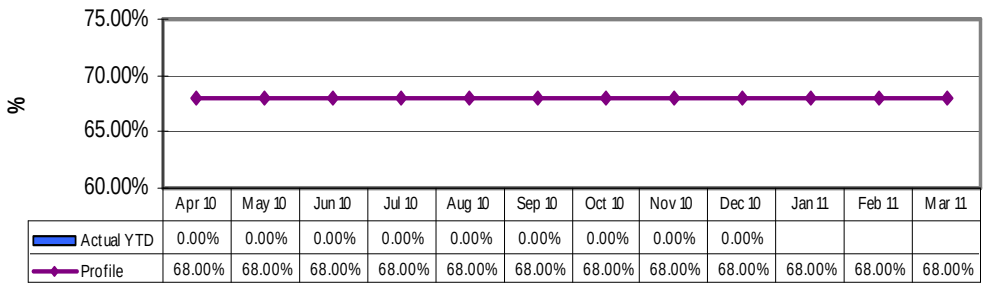
Actions:

- 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.

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	DSD	**RED**	=	**RED**	**GREEN**	Only 3 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 Profile 2010/11



	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 YTD	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%			
Profile	68.00%	68.00%	68.00%	68.00%	68.00%	68.00%	68.00%	68.00%	68.00%	68.00%	68.00%	68.00%

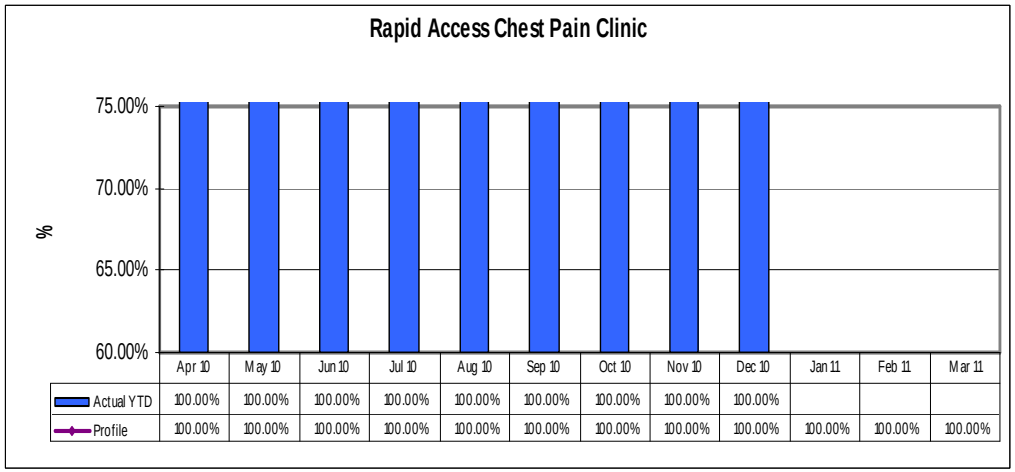
Thrombolysis Performance YTD	PRH	RSH	SaTH
Call to Needle Eligible Admissions	1	2	3
Call to Needle < 60 minutes	0	0	0
Performance Achieved YTD	**0%**	**0%**	**0%**

- 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.
- Patient 1 - (Powys) had call to door time of 132 minutes no evidence of pre-hospital thrombolysis assessment.
- Patient 2 - (Oswestry) had call to door time 42 minutes no evidence of pre-hospital thrombolysis assessment.
- Patient 3 - had call to door time of 72 minutes no evidence of pre-hospital thrombolysis/PPCI assessment.

Actions:
- Chest Pain Direct Admission to CCU project initiated, awaiting outcome report.

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)	DSD	**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: