Enclosure 7

INTEGRATED PERFORMANCE REPORT for period ending 31st January 2011

Quality

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

KEY FACTS	• Stroke National & Local, MRSA and C. Difficile, Cancer 14 and 31 day and Rapid Access Chest Pain targets achieved in month. • Thrombolysis, A&E 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 January 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.

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	=	AMBER	GREEN	Target 2010/11 89% overall patient satisfaction 5 indicators identified form 2009/10 results, however only 3 have been reviewed. The full set of 5 questions to be used in Q4	M
		Breaches in single sex accommodation compliance (CO1.5)	DQ&S	GREEN	=	GREEN	GREEN	Number of breaches caused by each occurrence will be equal to the total number of patients effected i.e. 1 female with 5 males is 6 breaches	M
	Cancelled Operations	To maintain a minimum level of non medical cancellations in accordance with national criteria	COO	AMBER	=	RED	RED	27 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 January 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 89.8% in January, an improvement of 3.4% from the previous month	M
	Complaints	National response times are that all complaints are completed in their entirety within six months, unless exceptional circumstances	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 7.0%	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 57 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	RED	=	RED	RED	• Q1 Baseline – 142 Falls per month • Q2 4%, reduction • Q3 7%, reduction • Q4 10% reduction	M

Integrated Performance Report: Quality (CO1)

Appendix 1

	Target (2010/11)		Executive Lead	Monthly Performance	Direction of Travel	Year to Date	Forecast	Commentary	Frequency
Effectiveness	**Hospital Standardised Mortality Ratio (HSMR)**	HSMR for the most recent complete 12 months based on the HSMR basket of 56 diagnosis groups	MD	AMBER	=	AMBER	AMBER	Month: 89.9 (95% CI: (75.1 – 106.8) Last Quarter: 105.3 (95.1-116.1) Last 12 Months: 109.9 (104.7 – 115.3)	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	Sustained improvement continues on both sites	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	January 2011 TWPCT = 59% SCPCT = 82%	M
	Nutrition	% Completion of Nutrition Screening Tool (C01.7)	DQ&S	GREEN	=	GREEN	GREEN	Baseline Audit 58% Q2 65% Q3 75% Q4 90%	Q
	Readmission Rates	Relative Risk of Emergency Readmission within 28 days of discharge	MD	GREEN	=	GREEN	GREEN	The relative risk of Emergency Readmission remains significantly lower (better) than the average for England	M
	Venous Thromboembolism (CQUIN)	% of adult inpatients who have had a VTE risk assessment on admission (CO1.3)	MD	RED	=	RED	RED		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 80%	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	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	=	AMBER	RED	9a) PCT SLA required and Trust Director responsible to clarify delivery method within the ED 9b) PCT and Trust working on definition and agreement of roles and accountability. Need for clear SLA and agreement on the way forward	M

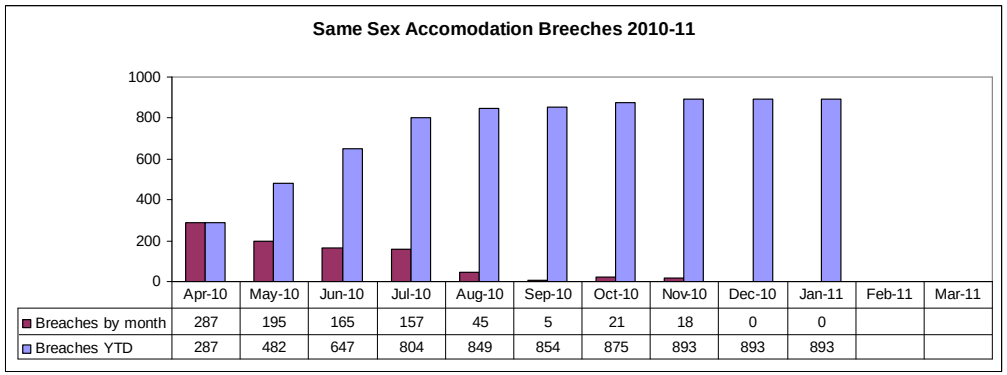
Integrated Performance Report: Foundations (CO5 & CO6)

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	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	RED	=	GREEN	AMBER	Local Health Economy underachieved target for January	M
	Delayed Transfers of Care	Reduce by 50% (by 31st March 31st 2011)	COO	RED	=	RED	RED	The number of bed days lost due to delays increased by 262% from December 2010 to January 2011	M
	18 Weeks	1a - Admitted Clock Stops above 90%	COO						M
		1b - Non-Admitted Clock Stops above 95%	COO						M
	Cancer	14 Days from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals	COO	GREEN	=	AMBER	AMBER	14 day target achieved in month	M
		31 Days from diagnosis to treatment for all cancers	COO	GREEN	=	AMBER	GREEN	31 day target 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	GREEN	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 form 2009/10 results, however only 3 have been reviewed. The full set of 5 questions to be used in Q4
	Breaches in Single Sex Accommodation (CSA) compliance (CO1.5)	DQ&S	**GREEN**	=	**GREEN**	**GREEN**	Number of breaches caused by each occurrence will be equal to the total number of patients effected i.e. 1 female with 5 males is 6 breaches



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

- There were no SSA breeches in January.
- YTD score Amber as not all 5 indicators have been reviewed.
- Quarterly 3 Trust Patient Experience Survey results identify similar results to previous quarter on the 3 indicators.
- 80% of patients felt they were involved in decisions about their care.
- 85% of patients felt they were able raise concerns with staff.
- 90% of patients felt they were cared for with privacy and dignity.
- CNS are to work in teams to undertake patient experience audits in all wards and departments each month. The audits will capture the full set of 5 CQUIN indicators.
- The Senor Nursing Teams are currently undertaking serious in depth reviews in clinical areas which have been identified as hotspots following the preliminary quality visits.

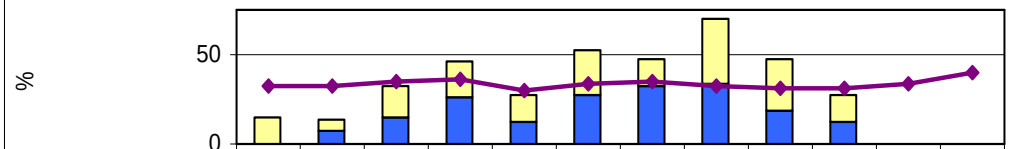
Actions:

- 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 12th May 2011 to celebrate Nurses Day.

28 Day Cancelled Operations

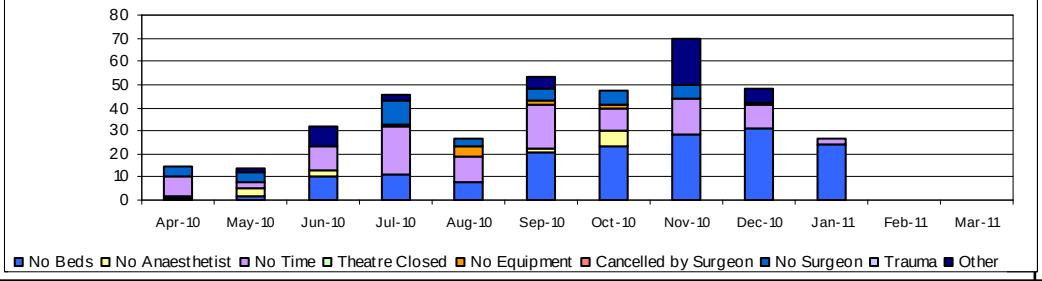
Target (2010/11)		Executive Lead	Monthly Status	Direction of Travel	Year to Date	Forecast	Commentary
28 Day Cancelled Operations	To maintain a minimum level of non medical cancellations in accordance with national criteria	COO	**AMBER**	=	**RED**	**RED**	27 cancelled in month
	Readmit all non medical cancellations within 28 days in accordance with national criteria	COO	**GREEN**	=	**GREEN**	**GREEN**	No 28 day breaches in month

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	14		
RSH	0	8	15	26	12	28	32	34	19	13		
Anticipated Threshold	33	33	35	36	30	34	35	33	31	31	34	40

Cancelled Operations 2010/11 by Reason

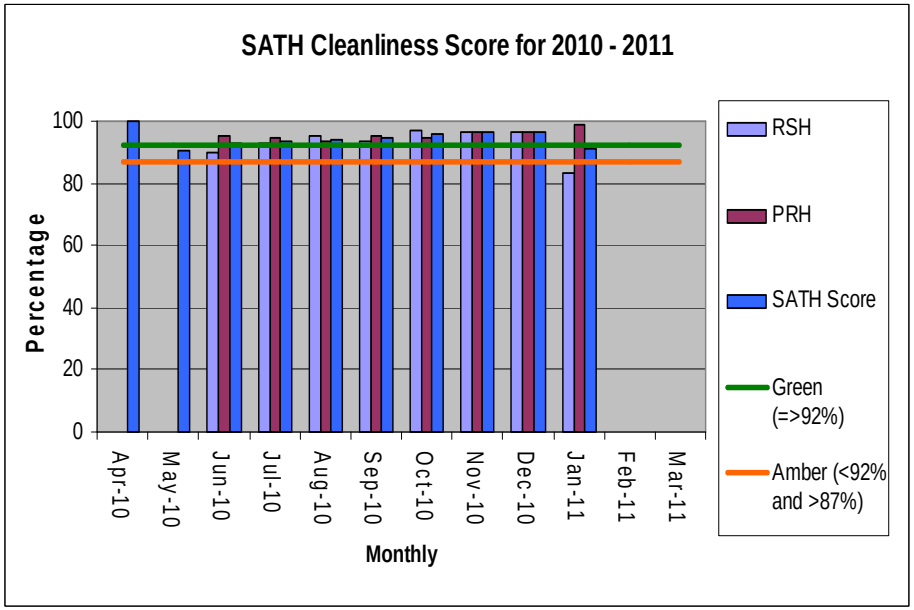


- 27 operations cancelled in January for non medical reasons.
- 379 operations cancelled for non medical reasons in the year-to-date.
- The national target applies only to those cancellations that happened on or after the day of admission and only for non-medical reasons.
- Current guidance indicates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

Actions:

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	COO	**GREEN**	=	**GREEN**	**GREEN**	Both sites were Green at the time of January 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 91.02% was achieved for the Trust in January 2011.
- Cleanliness Score for RSH was 83.36%.
- Cleanliness Score for PRH was 98.67%.
- Public Areas were below target for RSH but deep clean monies have been used to address problems.
- Based on April to January figures the year-end forecast is 94.55% (this will be submitted as part of the PEAT Assessment process).

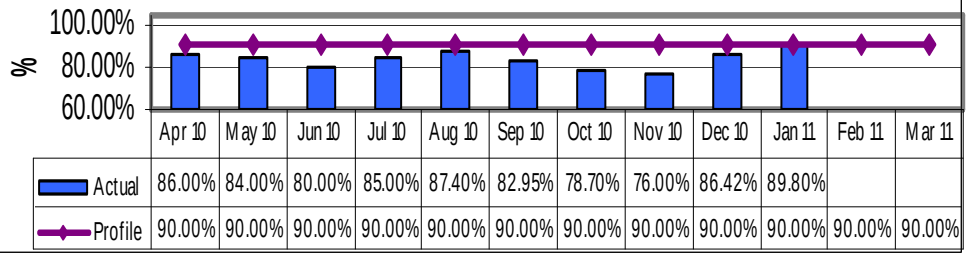
Actions:

- 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	COO	**RED**	=	**RED**	**RED**	The Trust achieved 89.8% in January, an improvement of 3.4% from the previous month

Slot Availability Rate for Appointments Made via the Choose & Book System



	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	86.00%	84.00%	80.00%	85.00%	87.40%	82.95%	78.70%	76.00%	86.42%	89.80%		
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%

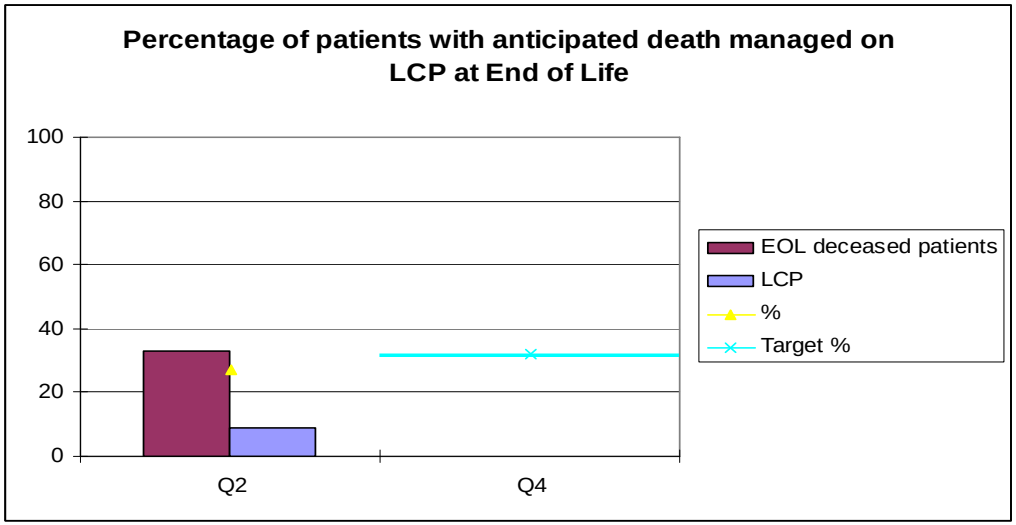
- There were 2,339 appointments booked in directly bookable services in January compared with 1,713 in December.
- An average of 59 patients per week tried but were unable to book their appointment via C&B in January and this is similar to December.
- 71% of unavailable appointments were in the following specialties:-
  - Ophthalmology – av. 21 per week (including Paediatric Ophthalmology)
  - Dermatology PRH - av. 9 per week
  - Thoracic Medicine PRH - av. 5 per week
  - Colorectal PRH - av. 7 per week.
- The new Cataract Service at Wrekin Community Clinic has been added to the Directory of Services and is available to NHS Telford and Wrekin patients from 24th January.

Actions:

- To investigate how additional capacity in Dermatology can be made available via C&B.
- To ensure that the new Cataract (ICAT) Service is accessible 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%

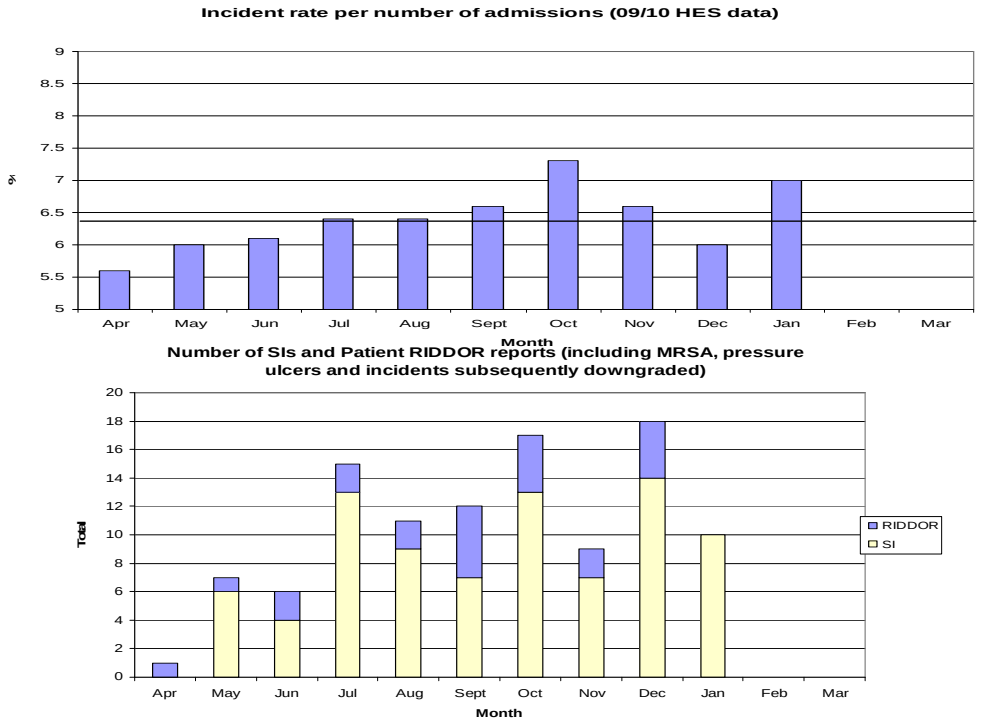


- Baseline target at the end of Q3 50%. Target for Q4 62%.
- October 27%, November 100%. December provisional results 74%.
- Remedial work to the entrance to Mortuary at RSH been undertaken. General redecorating to the inside of Mortuary in progress. Funding for further extensive refurbishment to be 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 7.0%
	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.

- The SHA have just clarified their guidance on reporting of Intrauterine Deaths. The Trust was over reporting these incidents and as a result, all seven of the previously reported incidents in this category will be downgraded and closed.

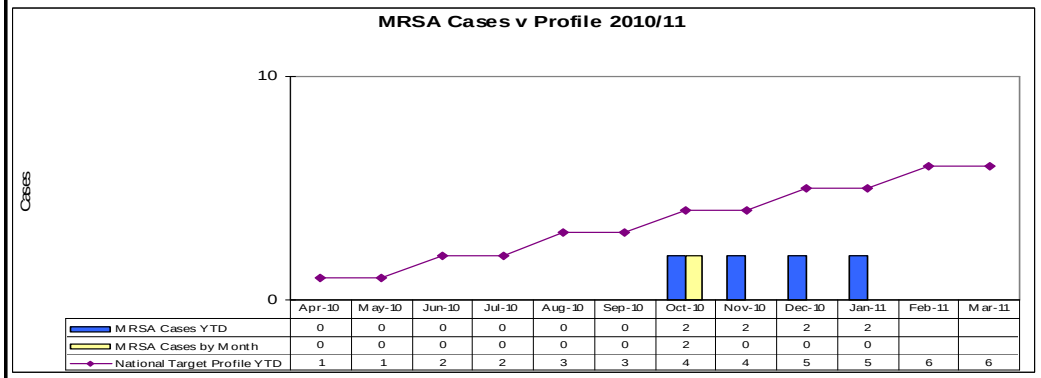
- In total of eleven of the 84 incidents reported have been downgraded as investigation has shown that these were not reportable incidents therefore the year to date position is green

Actions:

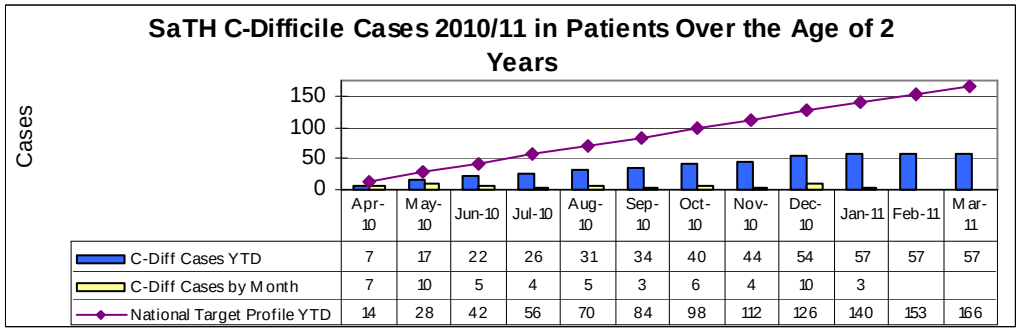
- Incident Review Group meets monthly to discuss incidents & trends. Further Root Cause Analysis training for Managers was carried out in January to improve the consistency of investigation. New SI policy issued - Lead Nurses have additional responsibility for incident coordination.

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 57 C. Difficile cases YTD



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



	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
C-Diff Cases YTD	7	17	22	26	31	34	40	44	54	57	57	57
C-Diff Cases by Month	7	10	5	4	5	3	6	4	10	3		
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 January.
- We have had 2 cases to end of January 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

- To end January 2011 - 57 SaTH responsible cases (post 72 hrs.) vs. target of not more than 166 cases 2010/11.
- In January 3 SaTH cases, all at RSH, 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
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

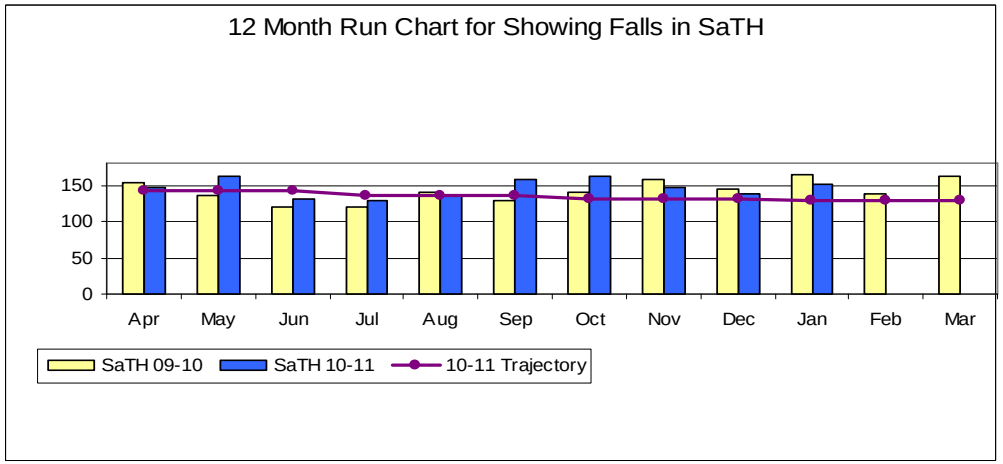
Patients records reviewed	270	
Number of times where medicines were prescribed	3167	
Prescription omitted for a clinical or patient specific reason i.e. patient refused	489	15.4%
Prescription omitted due to a record of non available	50	1.6%
Prescription where medicines regarded as critical	23	0.7%
% 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:
- Third Audit now commenced, actual audit completed, awaiting results.
- Result report to PCT by mid March and for further review at Area Prescribing Committee.

Patient Falls

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



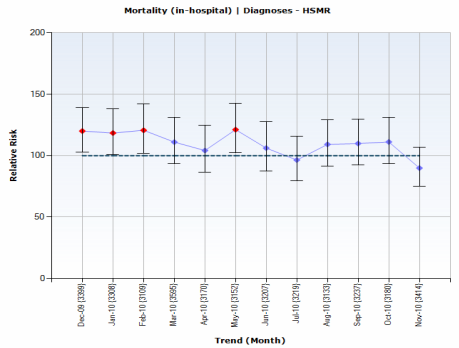
- There are significant challenges if we are to meet the target for Q4. In response we have instigated a daily Datix Alerting System for falls so that we can proactively investigate frequent fallers and areas reporting multiple falls.
- Slips, trips and falls policy has been ratified by Health and Safety Executive Committee. Final approval by Director for Patient Safety and Quality and Chief Nurse.
- Accountability for the completion of RCA for RIDDOR reportable injuries will be devolved to Matrons and Ward Managers in March 2011. RCA and action plan to be presented to Falls Project group.
- The Senor Nursing Teams are currently undertaking serious in depth reviews in clinical areas which have been identified as hotspots following the preliminary quality visits. These will explore further the assessment and management of patients at risk of falls.

Actions:
- RCA for RIDDOR reportable injuries to be devolved to Ward Manager and Matrons – March 2011.
- RIDDOR reportable injuries to be reported as Serious Incidents, commencing February 2011.

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: 89.9 (95% CI: (75.1 – 106.8) Last Quarter: 105.3 (95.1-116.1) Last 12 Months: 109.9 (104.7 – 115.3)

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**



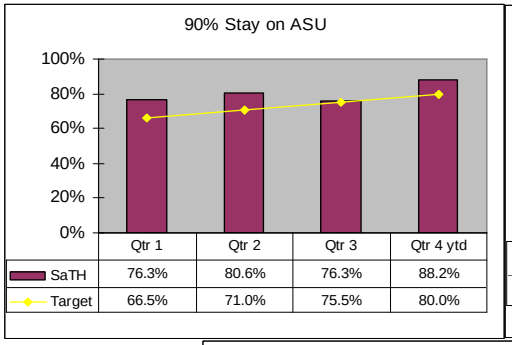
- HSMR is calculated from hospital activity using the Dr Foster Real Time Monitoring (RTM) Analysis Tool, using the most recent available data (currently three months in arrears). It compares the mortality rates in SaTH with the average expected across England, adjusted to reflect factors such as age and case mix.
- The annual HSMR for the year December 2009 to November 2010 is worse than the national average for England (based on a 95% confidence interval).
- The HSMR for the latest month is 89.9 and for the last quarter is 105.3. For the months April – November 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.

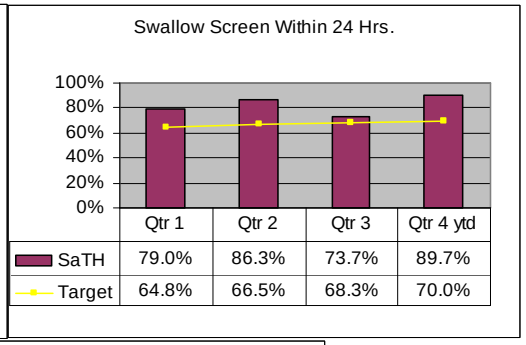
Actions:

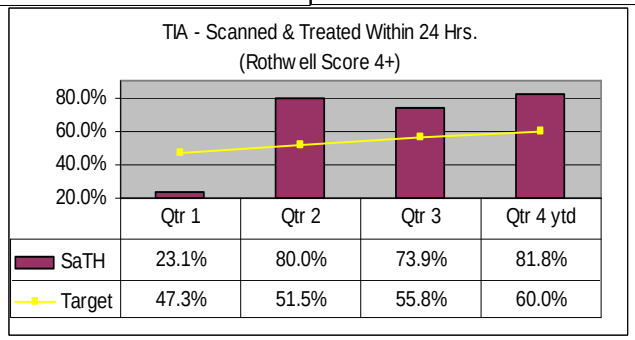
- Senior Nurses have be trained in the use of the Global Trigger Tool in December with more training planned. Regular review of notes started in January 2011 as part of LIPS Project.
- A Project Manager has been identified to draw together an action plan.
- A number of Clinicians have been identified 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 on both sites
Stroke – Compound Indicator	Based on targets agreed with local Commissioners	MD	GREEN	=	GREEN	GREEN	Sustained improvement continues on both sites







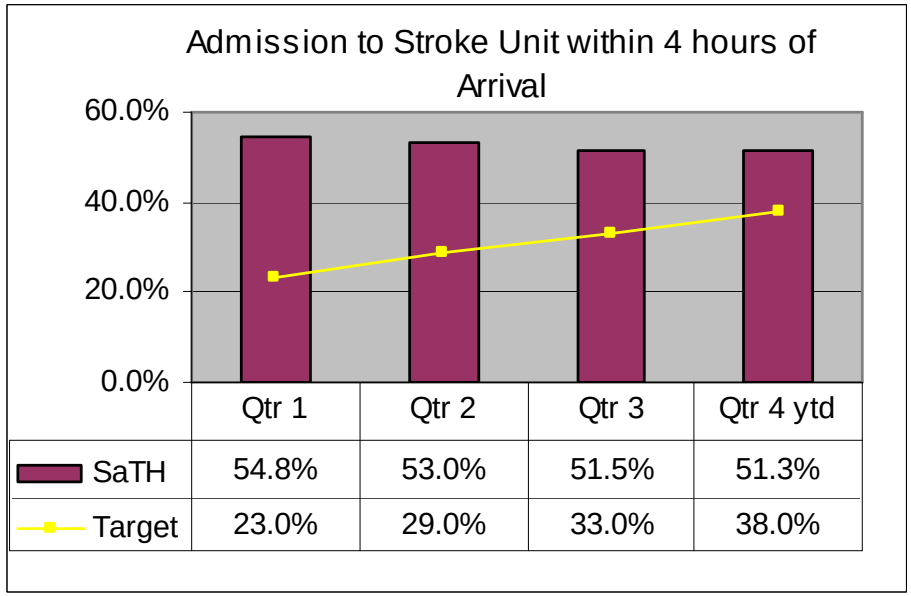
- Current Performance Proportion of People who spent at least 90% of their time on a Stroke Unit: Quarter 4 (YTD) Target 80%, PRH 93.5%, RSH 83.7%, **SaTH = 88.2%.**
- Overall SaTH and both PRH and RSH achieved target, with continued high performance at PRH and significant, sustained, improvement at RSH.
- Current Performance for Swallow Screening on both sites: Quarter 4 (YTD) Target 70%, PRH 90.3%, RSH 89.2%, **SaTH = 89.7%.** Both sites achieving target, showing marked improvement, notably record keeping at RSH.
- Current Performance for TIA on both sites:
  Quarter 4 (YTD) Target 60%, PRH 80%, RSH 83.3, **SaTH = 81.8%.**
- West Midlands Quality Review Service. Final report received.
- Network wide Consultant Support Rota, providing out of hours support for Stroke, commenced 7th February, in readiness for introduction of Telemedicine in June 2011.
- Clinical Nurse Specialists for Stroke currently undertaking Physical Assessment Skills Training to enable them to support outpatient follow-up for TIA patients.

Actions:

- Economy wide Stroke Strategy meeting planned for the 14th February 2011.
- Position Statement supplied by Chief Executive Officer to the PCTs, confirming delivery of Stroke Services and 24/7 Thrombolysis Service at both sites following the WMQRS - 4th February 2011.
- Events organised to process map Joint Care Planning for Stroke Patients across the health and social care economy - 28th February.
- Meeting organised to pursue becoming the clinical partner in hosting the Telemedicine Project for Stroke.

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



	Qtr 1	Qtr 2	Qtr 3	Qtr 4 ytd
SaTH	54.8%	53.0%	51.5%	51.3%
Target	23.0%	29.0%	33.0%	38.0%

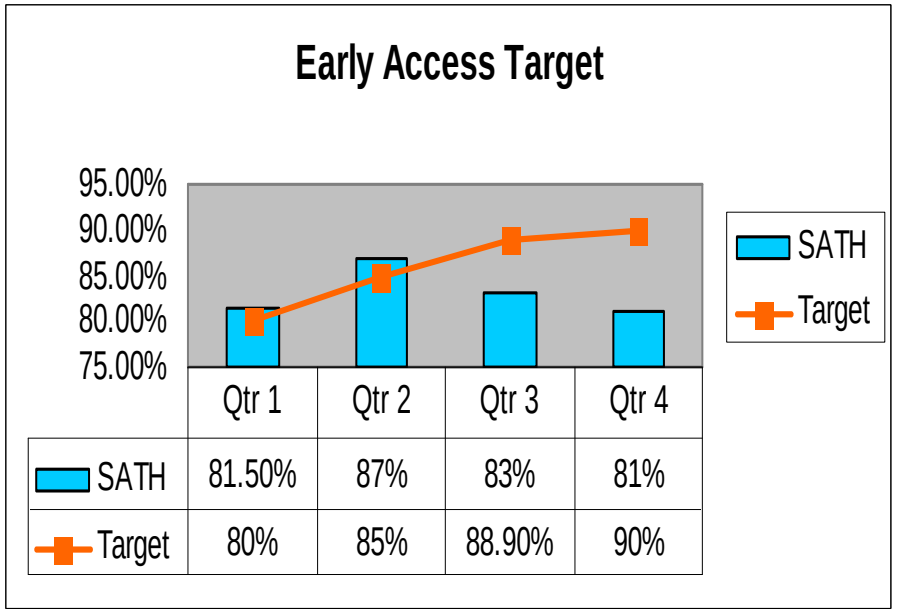
- Current performance for admitted to Stroke Unit within four hours of Arrival:
  Quarter 4 (YTD): Target 38%, PRH 71.4%, RSH 39.6%, **SaTH = 51.3%.**
- Performance generally continues to improve, although patient flow at RSH continues to be a challenge.

Actions:

- Reinforce the importance of Direct Admission to Acute Stroke Unit. Needs to be a priority of the Clinical Site Managers on both sites.
- Also to be a key target for the new Ward Manager for Ward 22S/R at RSH.

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)	DQ&S	**RED**	=	**RED**	**RED**	<u>January 2011</u> TWPCT = 59% SCPCT = 82%



	Qtr 1	Qtr 2	Qtr 3	Qtr 4
SATH	81.50%	87%	83%	81%
Target	80%	85%	88.90%	90%

- Action plan in place for both SCPCT and TWPCT with escalation procedures agreed.
- Booking clinics established in Telford with a programme of extra capacity in January 2011 to clear waiting patients.
- Sufficient venue options secured in Telford.
- Improved staffing levels in place.
- While January 2011 figures were disappointing, the first week of February 2011 shows significant improvement, particularly in Telford:

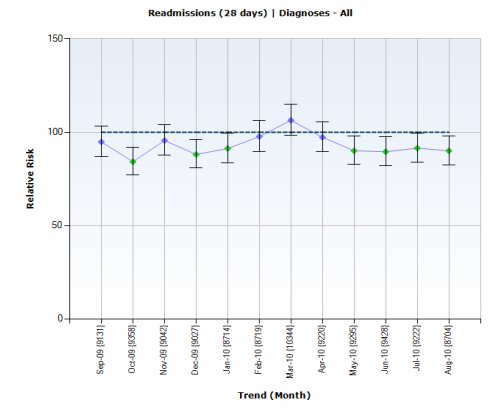
  TWPCT = 89% SCPCT = 89%

Actions:
- Audit DNA rates for SCPCT and TWPCT.
- Collate information on late referrals received.
- Work to establish an additional venue for booking appointments in SCPCT.

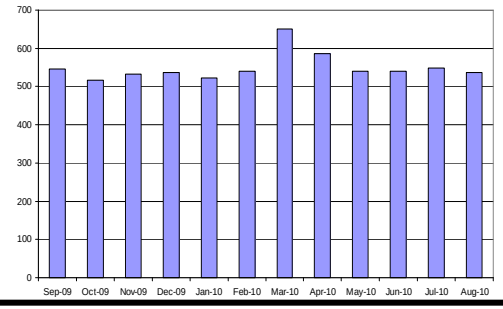
Readmission Rates

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
Sep09 to Aug10	**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**



Number of readmissions by month



- 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 (Sep. 2009 to Aug. 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	**RED**	=	**RED**	**RED**	

- There were 9,455 adult admissions in January. Manual systems to collect data on the number of VTE assessment forms has been implemented during January. Ward Clerks collecting data on patient discharge There have been 951 returns with 212 patients having a completed VTE form giving 22.2% compliance for these patients, and 2.2% of all admission.
- In addition the patients deemed to be assessed on a 'cohort approach' basis will be around 4,000 (tbc) which would give a score of approximately 42.3% against a Q4 target of 90%.
- Combined cohort and manual data would give performance of 44.5%
- The VitalPac VTE Module is being piloted in PRH Ward 14 but initial evaluations are not positive and require further discussions with medical teams to engender a positive response. End of January only 8 VTE forms had been completed on the system. However a concentrate push during February has seen 182 completed in the first 2 weeks.
- 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.
- A National report will be published in January on December data collection.

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

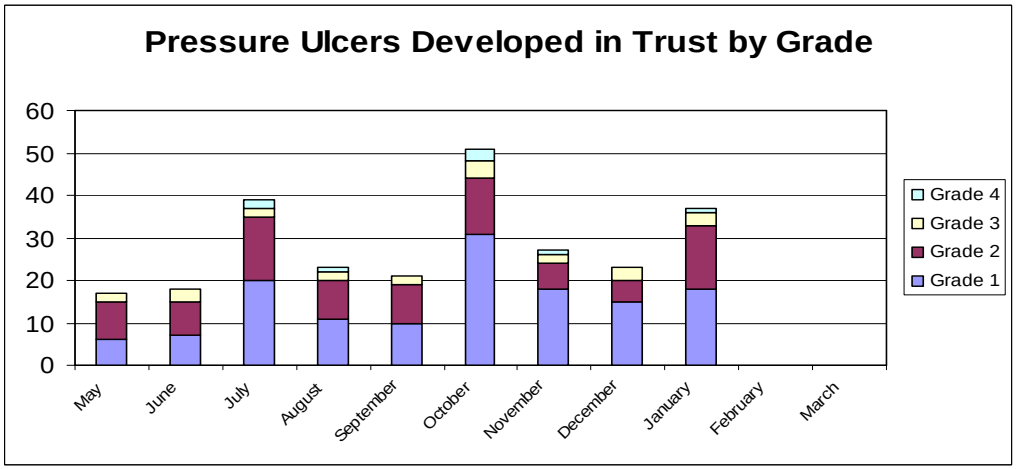
Milestones	Completion Date	Compliance
Baseline audit	Q1	**Green**
Robust process for patient identification Safe use of insulin implemented	Q2	**Green**
Review of patient identification visibility and education roll out re-audit against toolkit	Q3	**Amber**
CQUIN compliance	Q4	

- 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 January 2011 revealed that 81% of clinical areas are identifying patients with diabetes, but only 30% are following correct referral process.
- Compliance re-audit scheduled for February 2011.
- Pre-filled Insulin syringes introduced to the Trust.

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)	DQ&S	**GREEN**	=	**AMBER**	**AMBER**	New CQUIN 2010/11 Target to reduce by Q4 number of grade 3/4 ulcers by 10%

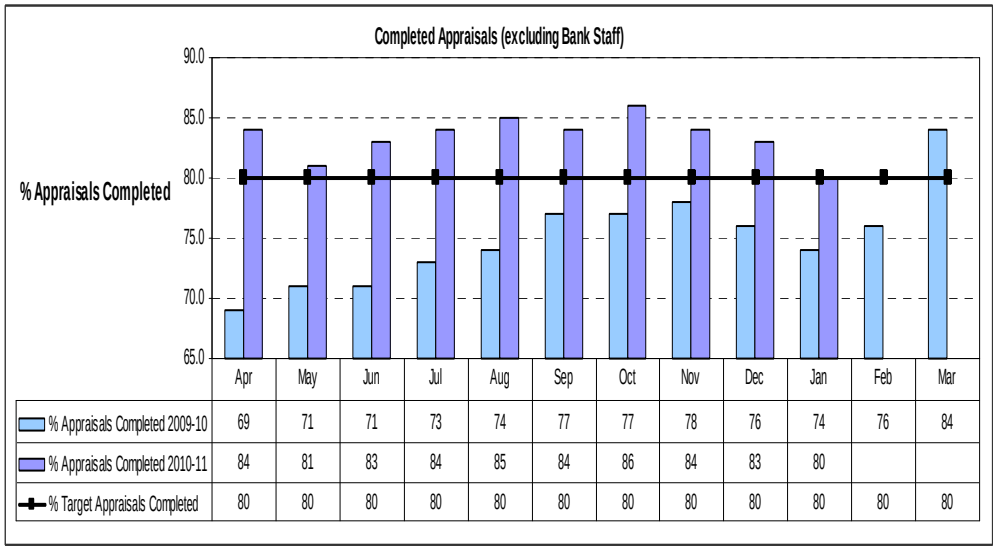


- 4 Trust acquired ulcers reported in January 2011.
- Trust wide action plan developed to address key issue from RCA. Ward Managers and Matrons to take ownership and responsibility for implementation of actions.
- All patients to be assessed within 2 hours of admission to Ward department rather than 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 measures for grade 1 and 2 ulcers.
- Initial quality reviews completed and issues around Tissue Viability have been fed back to Matron & Ward Managers for information and action.
- The Senor Nursing Teams are currently undertaking serious 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.
- Individual Ward Managers have been written to reminding them of their accountability and responsibility.
- Tissue Viability Nurse Specialist post re advertised.

Actions:
- Tissue Viability Educational Programme continues to be rolled out.
- Letters sent to Ward Managers.

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 80%



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

- As at month ending 31st January 2011, 80% of staff excluding Bank Staff have had a KSF appraisal within the last 15 months. This has slipped slightly from previous months.
- Departments that have not planned well over the year may find it difficult to sustain acceptable appraisal completion rates over February/March when operational pressures normally impact.
- Appraisal Quality Audits have been trialled in 4 departments and results are being written up. Initial results show variations in performance between departments.
- The lowest 5 performing areas for January with over 15 staff were as shown. All have action plans in place to achieve 80%.

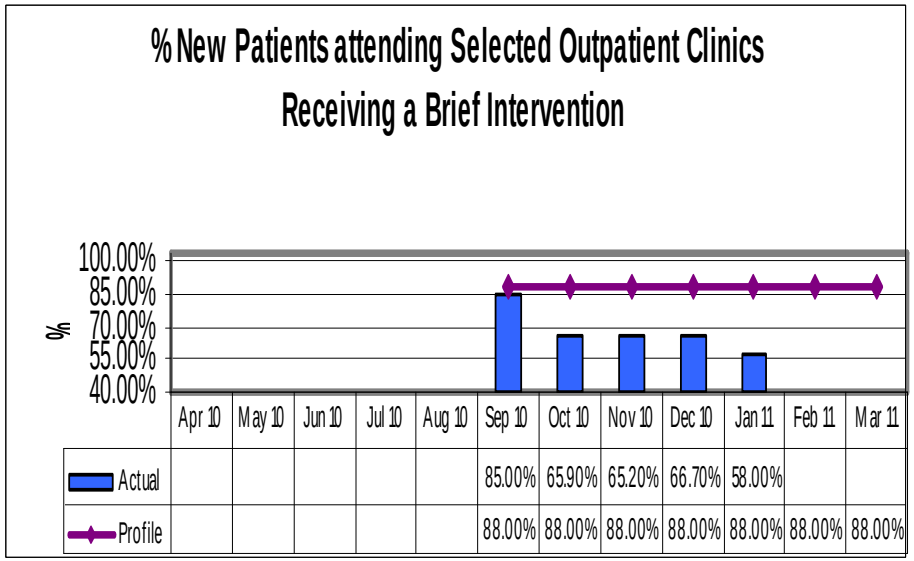
Area	Staff	Completed	%	Div.
X-Ray Department (PRH)	63	24	38	3
Ward 11 - Trauma & Orthopaedics	25	12	48	1
Ward 22 - Stroke & Rehabilitation Unit	56	29	52	1
Ward 9 - General Medicine	23	12	52	1
Portering (RSH)	41	22	54	Corp.

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**	**AMBER**	This was a new CQUIN standard for 2010/11



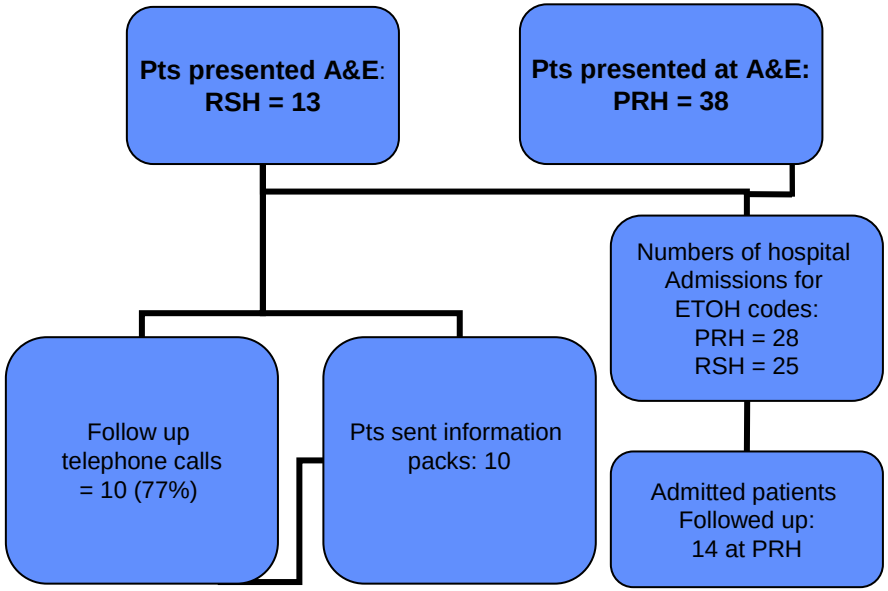
- A total of 60 new patients who required a brief intervention were seen in the selected clinics in January, including Respiratory, Cardiology, Vascular, Diabetes and ENT.
- Of the 50% of patients who smoke and want to stop, 70% were offered intervention and 20% of these were referred to the Stop Smoking Nurse (not part of the CQUIN but best practice, and may become a target in the future).
- Of the 24 smokers identified who said they did not want to stop, 6 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. Data collection therefore needs to be reviewed for Q4.
- Revised plan not yet approved by Commissioners for Q4 therefore not reflected in this months report.

Actions:

- Agree revised plan 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
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 Director responsible to clarify delivery method within the Emergency Department 9b) PCT and Trust working on definition and agreement of roles and accountability. Need for clear SLA and agreement on the way forward



Part 9a:

- Data collection methodology agreed with SCPCT and CQUIN Group as a whole. This now requires Medical Director leadership to enforce in practice.
- Information leaflet agreed by Group, proof returned and some changes requested from TWPCT. Changes accommodated and awaiting printing. SaTH to fund this but need to establish cost centre for charging.
- SLA to define accountability across LHE requested from PCTs. There is a meeting established in February with Lead Commissioners and PCT to clarify progress and accountability.

Part 9b:

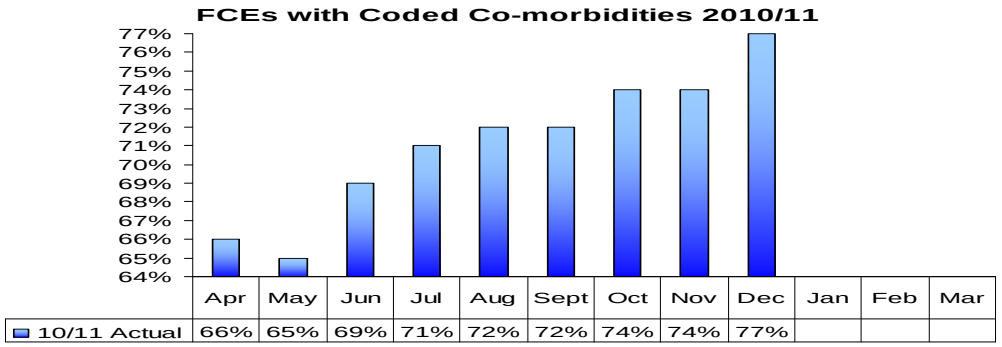
- PCTs discussing together the 4 key identified questions to be asked in the Emergency Departments and on the flow chart to meet IBA.
- No representation from SCPCT at January monthly meeting so decisions stalled awaiting combined response. TWPCT Commissioner to liaise with SCPCT Lead to agree before next meeting.
- SLA requested to define MHL nurses roles and responsibilities at SaTH and in conjunction with meeting CQUIN. There also needs to be clear data sharing across LHE.
- Office space found and TWPCT agreed to partially fund office space improvements at Ward 9 to ensure there is a defined desk close to ward area.

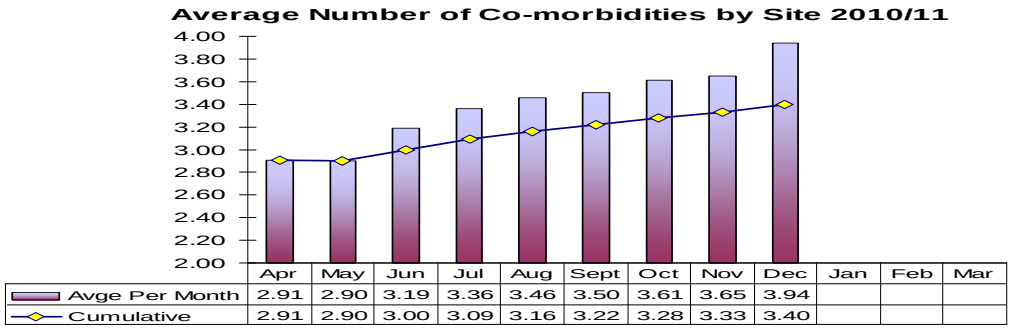
Actions:

- PCTs to agree and deliver SLA for both Hospital sites.
- Training plan for Nurses to be agreed across LHE.
- Clinical Advisory Group to validate revised Alcohol Withdrawal Guidelines in March: Clinical Lead taking this forward.

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

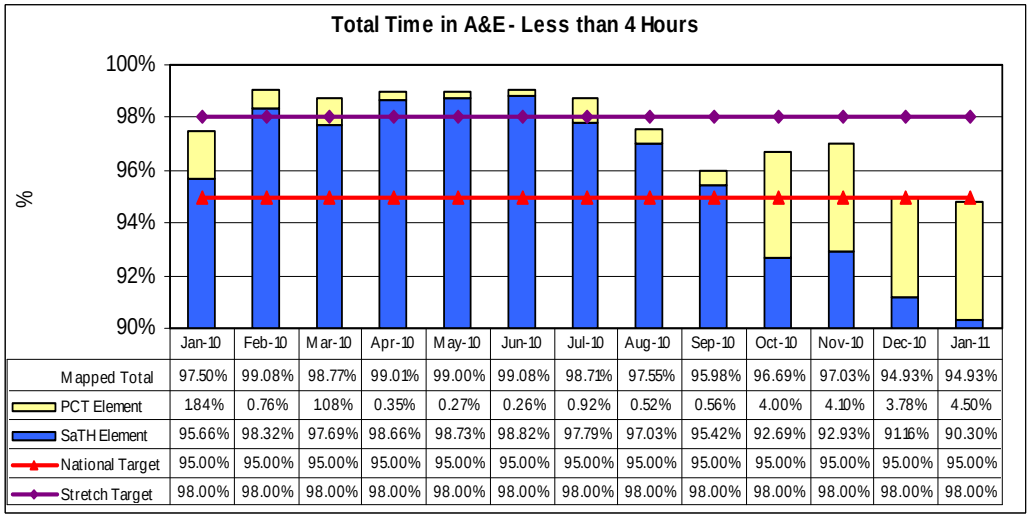
- The Target is to ensure that co-morbidities are captured by clinicians for each Finished Consultant Episode (FCE), where applicable. Both charts show a steady increase in the depth of coding.
- Work is ongoing with MedeAnalytics to analyse national coding statistics and provide a national benchmark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



	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11
Mapped Total	97.50%	99.08%	98.77%	99.01%	99.00%	99.08%	98.71%	97.55%	95.98%	96.69%	97.03%	94.93%	94.93%
PCT Element	1.84%	0.76%	1.08%	0.35%	0.27%	0.26%	0.92%	0.52%	0.56%	4.00%	4.10%	3.78%	4.50%
SaTH Element	95.66%	98.32%	97.69%	98.66%	98.73%	98.82%	97.79%	97.03%	95.42%	92.69%	92.93%	91.16%	90.30%
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%

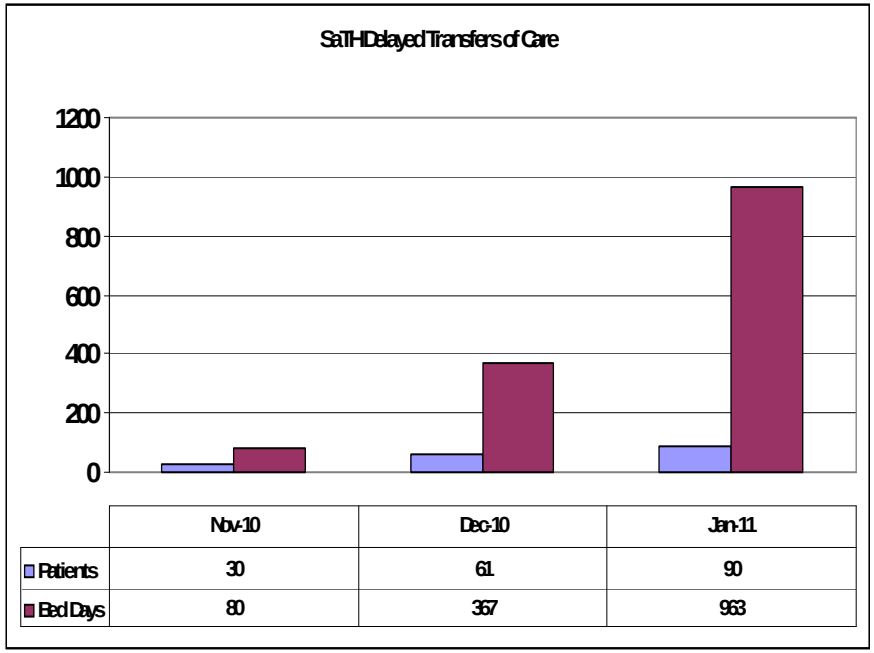
- The Trust achieved 90.30% unmapped during January.
- The Local Health Economy achieved 94.93% mapped during January.
- For the year-to-date the Trust has achieved 95.41% unmapped.
- For the year to date the Local Health Economy has achieved 97.05% mapped.

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 continue to take 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**	**RED**	The number of bed days lost due to delays increased by 262% from December 2010 to January 2011



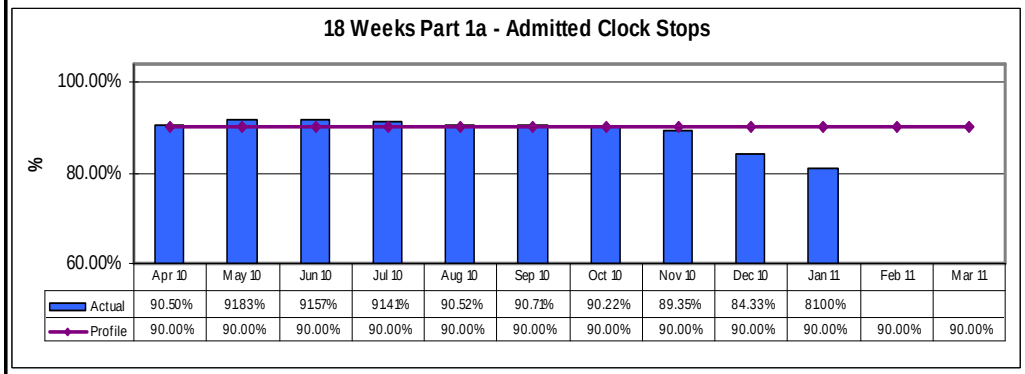
- 25% of Bed Delays are due to Completion of Assessments
  - 28 patients / 243 bed days.
- 16% of Bed Delays are due to Further Non Acute NHS Care (including intermediate care, rehabilitation etc.) – 23 patients / 153 bed days.
- 16% of Bed Delays are due to Awaiting Care Home Placement (Residential)
  - 10 patients / 153 bed days.
- 20% of Bed Delays are due to Awaiting Care Home Placement (Nursing Home)
  - 11 patients / 195 bed days.
- Equates to an average of 31 beds lost per day due to delayed patients during January.

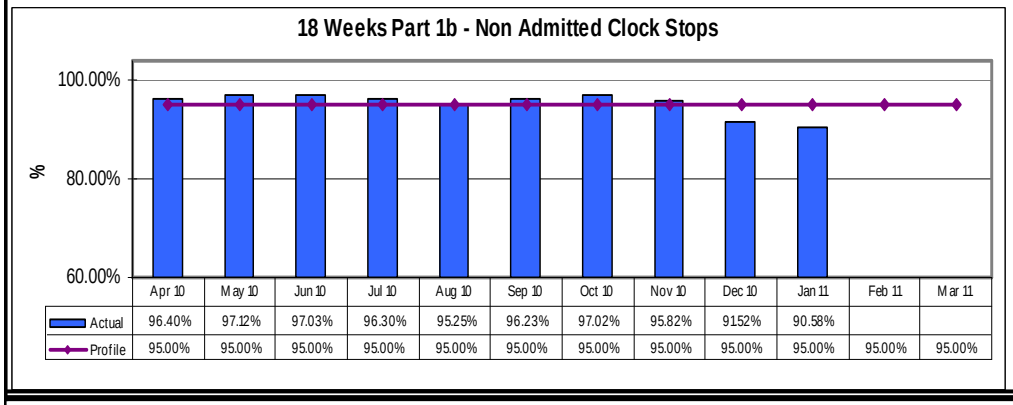
Actions:

- Launch Delayed Transfer of Care live SQL report – to be made available to all stakeholders within local health & social economy.
- Refocus the Joint Discharge Transformation Team (now meeting fortnightly) to focus upon a 50% reduction in the number of Delayed Transfers 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 under achieved the 90% target during January
	1b - Non-Admitted Clock Stops above 95%	DSD	**Red**	=	**GREEN**	**GREEN**	Trust under achieved the 95% during January





- The Trust under achieved the overall target of 81.00% and 90.58%

PCT performance for January was:-

	1a	1b
Shropshire County PCT	81.27%	90.23%
Telford & Wrekin PCT	80.85%	91.15%

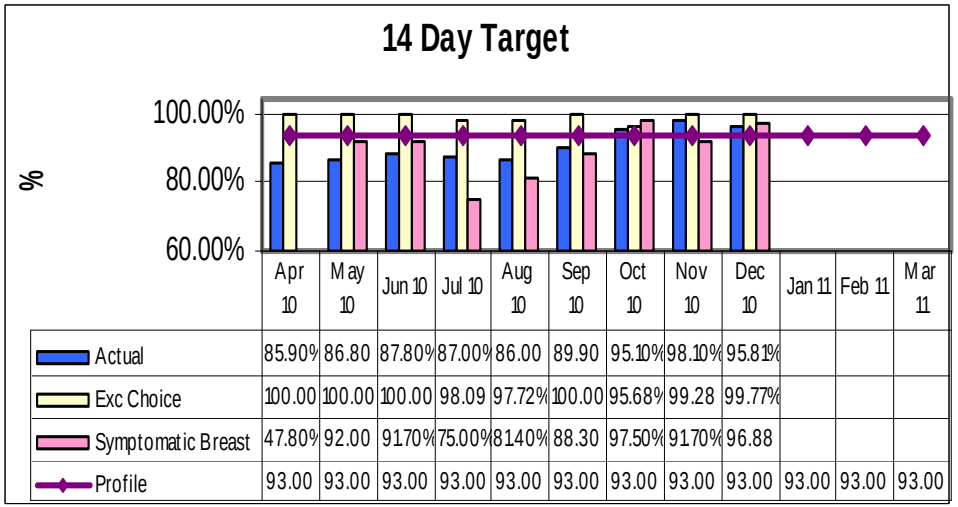
- Specialty level performance for admitted patients (part 1a) was below 90% in ENT (81.02%) General Surgery (81.81%) Gynaecology (80.43%) Ophthalmology (68.83%) Oral Surgery (51.64%) Plastic Surgery (84.61%) T&O (72.17%) Urology (82.41%).

- Specialty level performance for non admitted patients (part 1b) was below 95% Dermatology (86.47%) ENT (81.96%) Gastroenterology (93.1%) General Medicine (92.51%) General Surgery (93.18%) Neurology (88.34%) Ophthalmology (82.78%) Oral Surgery (66.86%) Other (94.76%) Rheumatology (89.47%) Thoracic Medicine (93.75%) T&O (85.79%) Urology (86.95%).

•The Trust is working with the IST to deliver and 18 week sustainable solution for 2011/12. A detailed action plan has been submitted to Trust Board and will be project managed through the 18 week operational group and LHE 18 week Board.

14 Day Cancer

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



	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11
Actual	85.90%	86.80	87.80%	87.00%	86.00	89.90	95.10%	98.10%	95.81%			
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, November and December are validated but the actual performance for the month of January 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 January (95.39%), against a year end cumulative target of 93%. There were 38 breaches out of a total of 824 referrals.
- Symptomatic Breast Performance for the month was 93.55% %, against a year end cumulative target of 93%. There were 2 breaches out of a total of 31 referrals.
- 27 patients chose to wait longer than 14 days for their first appointment. Details of the Specialties are as follows:

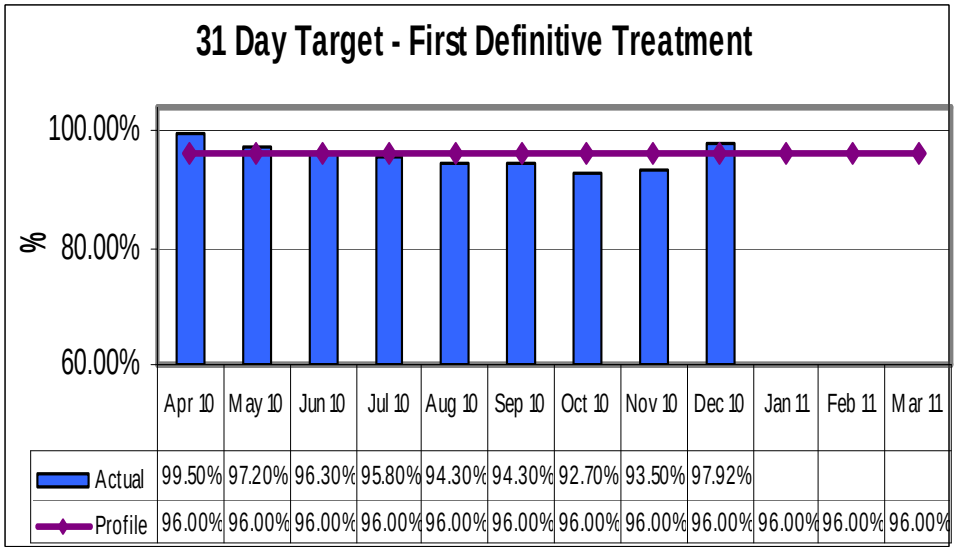
  Breast 2, Breast Symptomatic 2, Colorectal 6, Lung 6, H&N 4, Upper GI 7, Urology 4.
- The SaTH 14 day target YTD is currently 91.3% against a year end cumulative target of 93%.
- The application of the RAG status is as per the internal Performance Directory (within 5% of target is Amber).
- The newly 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	COO	**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, November and December are validated but the actual performance for the month of January is still being validated before submission of data to the national Cancer Waiting Times Database (which is 'closed down' on a quarterly basis).

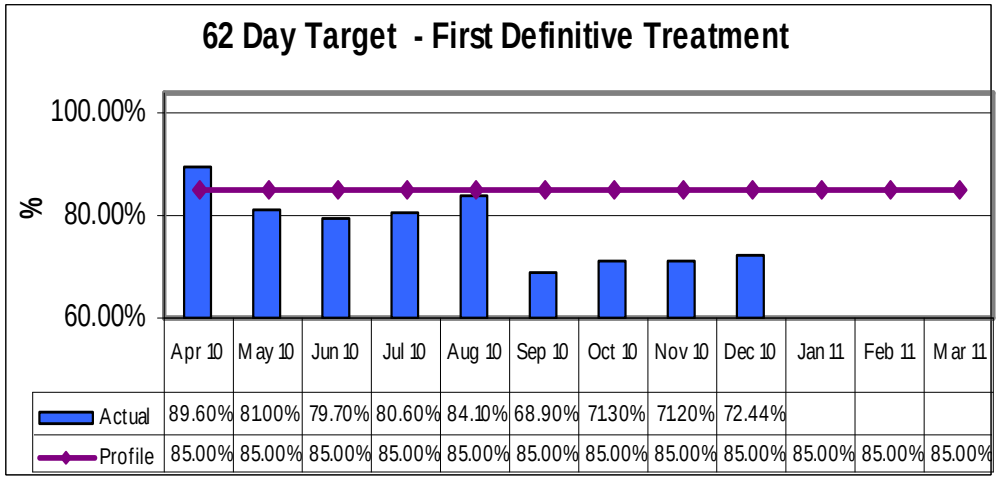
- 31 day target first definitive treatment achieved in January (96.40%), against a year end cumulative target of 96%.
- 31 day target subsequent treatment (Surgery) underachieved in January (84.21%), against a year end cumulative target of 94%.
- 31 day target subsequent treatment (Anti Cancer Drugs) underachieved in December (93.55%) against a year end cumulative target of 98%.
- 31 day target subsequent treatment (Radiotherapy) underachieved in December (77.78%), against a year end cumulative target of 94%.
- Current YTD position for 31 day first treatment target is 95.74% against a year end cumulative target of 96%.

- There were 28 breaches in January out of 292 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 underachieved in month



At the time of writing this report the actual performance for the months of April, May, June, July, August, September, October, November and December are validated but the actual performance for the month of January 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 January (75.68%), against a year end cumulative target of 85%.
- 62 day screening to first definitive treatment target achieved in January (100%), against a year end cumulative target of 90%.
- 62 day consultant upgrade performance target in January was 95.92% – to be confirmed.
- Current 62 day traditional target YTD position is 77.75% against a year end cumulative target of 85%.

- There were 14.5 breaches in January out of 89.5 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.

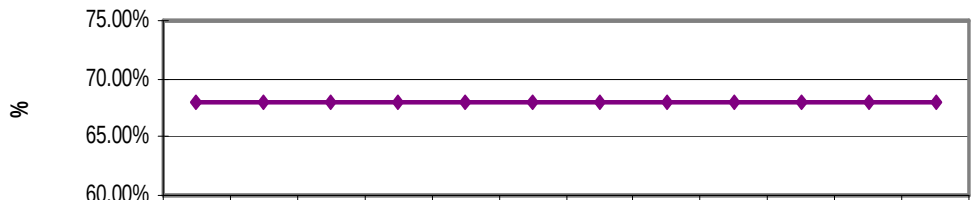
Actions:

- 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
Thrombolysis	68% of patients admitted with ST Elevation MI should receive Thrombolysis within 60 minutes of call for help	COO	**RED**	=	**RED**	**RED**	Only 4 eligible patient in the year to date. CQC guidance states that for this indicator a 'low numbers' rule will be applied which will withdraw Trusts treating a low number of eligible cases from the assessment

Thrombolysis 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%	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%

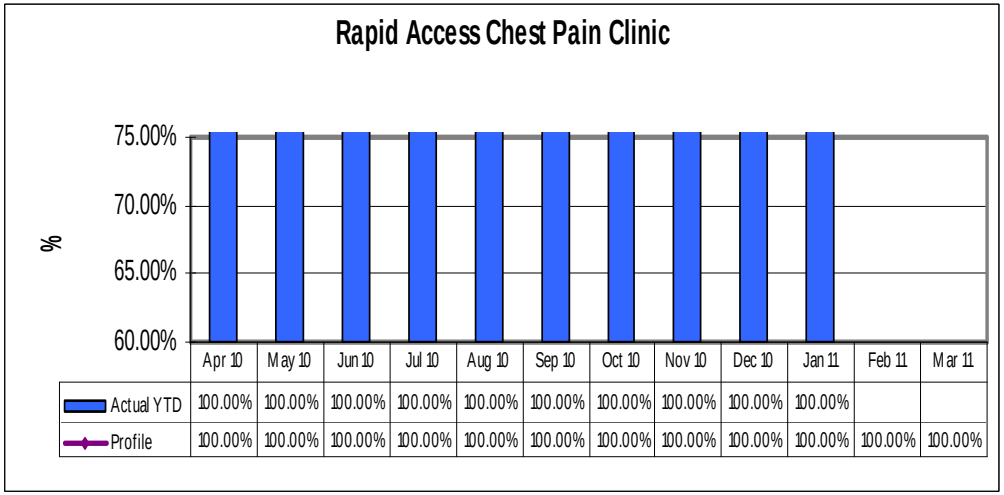
Thrombolysis Performance YTD	PRH	RSH	SaTH
Call to Needle Eligible Admissions	1	3	4
Call to Needle < 60 minutes	0	0	0
Performance Achieved YTD	**0%**	**0%**	**0%**

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

Actions:

Rapid Access Chest Pain

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



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

Actions: