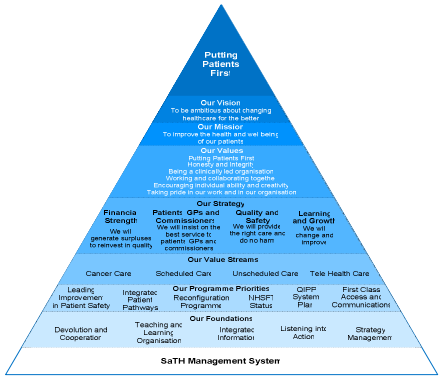
The Shrewsbury and Telford Hospital NHS
NHS Trust

Performance Report

as at Month 2



Date of Report 17/06/2011

Putting Patients First | Honesty and Integrity | Being a Clinically-Led Organisation | Working and Collaborating Together | Encouraging Individual Ability and Creativity | Taking Pride in our Work and our Organisation

Balanced Score Card

FINANCIAL STRENGTH

We will develop & deliver robust plans that generate surpluses to reinvest in quality

				Status Report			Directors Risk Assessment	
Ref	Freq	Objectives	Measures	Month RAG	Year-to-Date RAG	Direction of Travel	Forecast RAG	Level of Confidence in Delivery
A1	M	Develop & implement sustainable clinical strategies	% Contribution	RED	RED	=	RED	5
A2	Q	Develop & grow services that make a positive financial contribution	Service Portfolio Matrix					
A3	M	Increase surpluses to reinvest in quality and innovation	Financial Risk Rating	RED	RED	=	RED	5
A4	M	Maximise the productivity and efficiency of our services	Upper Quartile benchmark Index	AMBER	AMBER	↑	GREEN	4
A5	M	Eliminate waste and non value adding processes	Reference Cost Index	RED	RED	=	RED	5

QUALITY & SAFETY

We will always provide the right care for our patients

				Status Report			Directors Risk Assessment	
Ref	Freq	Objectives	Measures	Month RAG	Year-to-Date RAG	Direction of Travel	Forecast RAG	Level of Confidence in Delivery
C1	Q	Ensure that we learn from mistakes & embrace what works well	Staff Reported Outcomes Score					
C2	Q	Design care around patient needs	Local Inpatient Survey					
C3	M	Provide the right car, right time, right place, right professional	Time & Place Index	RED	RED	=	GREEN	3
C4	M	Deliver services that offer safe, evidence-based practice	Fewer Avoidable Deaths	RED	RED	↓	GREEN	4
C5	Q	Meet regulatory requirements & healthcare standards	Compliance Index					
C6	M	Ensure that our patients suffer no avoidable harm	Patient Care Index	RED	RED	=	AMBER	3

PATIENTS, GP'S & COMMISSIONERS

We will insist that we deliver the best service to our patients, GP's & Commissioners

				Status Report			Directors Risk Assessment	
Ref	Freq	Objectives	Measures	Month RAG	Year-to-Date RAG	Direction of Travel	Forecast RAG	Level of Confidence in Delivery
B1	Q	Involve patients in decisions about them	Patient Involvement Index					
B2	Q	Ensure our patients have a good experience	Patient Satisfaction Score					
B3	Q	Deliver services which are convent & timely for patients	Convenience & Timely Services Index					
B4	Q	Ensure access to clear care pathways to meet the needs of pour patients	GP Satisfaction Score (Signposting)					
B5	Q	Improve our appointments system and process	GP Satisfaction Score (Scheduling)					
B6	Q	Improve the communication processes and the information we provide	GP Satisfaction Score (Communication)					
B7	Q	Work in partnership to ensure services meet the local needs	Commissioner Satisfaction Score (Delivery)					
B8	Q	Engage with GP's to plan & deliver future services	Commissioner Satisfaction Score (Planning)					
B9	M	Reflect commissioners plans in our capacity plans & deliver our contractual commitments	Contractual Commitments Index	RED	RED	=	GREEN	3

Legend		
RAG	*Status Report (in mth and YTD performance)*	*Directors Forecast*
RED	Target Not achieved in line with Performance Directory Threshold	Performance is off track and **plans will be put in place but there remains some level of risk**
AMBER	Target underachieved in line with Performance Directory Thresholds	Performance is off track but **action plans are in place** and expected to deliver original plan by the agreed timescale
GREEN	Target achieved in line with Performance Directory Threshold	Performance against plan and **targets have been achieved** within the defined tolerance level

Putting Patients First

Honesty and Integrity

Being a Clinically-Led Organisation

Working and Collaborating Together

Encouraging Individual Ability and Creativity

Taking Pride in our Work and our Organisation

A1. Develop & Implement a Sustainable Clinical Strategy

Executive Sponsor	Headline Measure	Mth Status	YTD Status	Direction of Travel	Forecast	Level of Confidence in Recovery Plan	Supporting Papers
Finance Director	Percentage Contribution	Red	Red	=	Red	5	

Supporting Measure	Current Performance	Forecast Performance	Exception Report
Percentage Contribution (Trust/Centre/ Service Line)			
Division 1	23% in Month and 22% YTD. As expected Income has increased by circa £0.65m from last Month due to the number of working days available in May compared to April 2011. Non pay expenditure remains broadly constant, however, Pay expenditure has increased by circa £0.3m. Division 1 however, did overspend against their planned expenditure budgets in May by circa £0.7m which illustrates why their percentage achieved is lower than Division 2.	40% (Target Contribution for Indirect and Overhead costs i.e. Division 3 and Corporate Services respectively)	N
Division 2	41% in Month and 39% YTD. As will Division 1, Income has increased by circa £0.9m month due to the number of working days available, however, unlike Division 1 expenditure remains constant. Direct expenditure budgets for Division 2 continue to under spend by circa £0.3m in May 2011, therefore the improvement on this target from Month 1 is due to the increase in activity in May.	40% (Target Contribution for Indirect and Overhead costs i.e. Division 3 and Corporate Services respectively)	N

A3. Increase Surpluses to Reinvest in Quality & Innovation

Executive Sponsor	Headline Measure	Mth Status	YTD Status	Direction of Travel	Forecast	Level of Confidence in Recovery Plan	Supporting Papers
Finance Director	Financial Risk Rating	RED	RED	=	RED	5	

Supporting Measure	Current Performance	Forecast Performance	Exception Report
FRR Overall	**1 (Plan 3)**	Initial review of the financial position illustrates that whilst income will come back in line with plan, expenditure will continue to overspend. Further work is being undertaken to finalise the value of this.	N
EBITDA Margin	**1: (1.1%)**The negative EBITDA is as a result of Income reflecting the available working days in the first two months, whereas expenditure is relatively fixed. As a result the plan for the two Months was a circa £0.3m negative EBITDA, which is reversed over the remainder of the year as a result of activity phasing. **Planned +5%**		N
EBITDA Percentage Achieved of Plan	**1: (163.5%)** An adverse pay variance of circa £0.2m results in the Trust not achieving the planned EBITDA. EBITDA Planned to Month 2 (£299k) Actual (£489k). **Planned 100% of the Plan.**		N
Return on Assets	**2: (1.3%) Planned +3.4%**		N
Income & Expenditure Surplus Margin	**1: (6.3%)** As with the EBITDA plan, the Trust planned a £2.7m deficit to Month 2 which it has underachieved by £0.2m. **Planned Surplus Margin 0% (breakeven)**		N
Liquidity Ratio	**1: 10.7 days** Deterioration in liquidity ratio of 1.8 days from previous month. This is the result of two elements (i) the negative effect of I&E deficits offset by the benefit of the cash backed deferred income from 2010/11 and (ii) the benefit of c£1M overall reduction in debtors. Further deterioration is expected over the coming months up to the receipt of the cash backed SHA support that should mitigate this effect and will stabilise the position. **Planned 11 days**		N

A4. Maximise the Productivity of Our Services

Executive Sponsor	Headline Measure	Mth Status	YTD Status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Chief Operating Officer	Upper Quartile Benchmark Index	AMBER	AMBER	⇧	GREEN Month 12	4	

Supporting Measure	Current Monthly Performance	Forecast Performance	Exception Report
Elective Length of Stay (mean) - monthly	The target for the Trust is 2.8 days, the performance in May was as follows: RSH – 3.1 days PRH - 2.4 days	The current forecast is that the Trust will consistently deliver the target by February 2012	N
Elective surgical pre-op bed days - monthly	The target for 2011/12 is a 60% reduction against the 2010/11 out-turn equating to 60 days per month RSH – 61 PRH - 41	The current forecast is that the Trust will deliver the target by September 2011 with a reduction of 14 elective surgical pre-operative bed days per month between May and September	N
Non Elective Length of Stay (mean) - monthly	The target is 4.7 days, the performance in May was as follows: RSH – 5.1 days PRH – 5.3 days	The current forecast is that the Trust will deliver the target by February 2012	N
Elective (funded) Theatre Utilisation - monthly	The target for 2011/12 is 85% on both sites, the utilisation for May was as follows: RSH – 81% PRH – 74%	The current forecast is that the Trust will achieve 85% on both sites by March 2012	N

A5. Eliminate Waste & Non Value Adding Processes

Executive Sponsor	Headline Measure	Mth Status	YTD Status	Direction of Travel	Forecast	Level of Confidence in Recovery Plan	Supporting Papers
Finance Director	Reference Cost Index	Red	Red	=	Red	5	

Supporting Measure	Current Performance	Forecast Performance	Exception Report
Reference Cost Index Availability	The Reference Cost Index (RCI) is produced on an annual basis as a national submission to the Department of Health. The calculations are based on FCE data rather than spell data. SATH has a FCE to Spell ratio significantly higher than the national average, and as a result, the unit price calculated is diluted which improves the Trust's RCI. As a result the RCI, although a measure, does not truly reflect the Trust's cost per spell of care.		
Monthly Trend of Average Cost per Spell	£2,900 in Month and £2,973 YTD. This reflects the anticipated increase in activity for May with expenditure remaining constant between the two Months.	£2,748 (Target based on annual budgeted expenditure and planned activity)	

B9. Reflect Commissioner's Plans in Our Capacity Plans & Deliver Our Contractual Commitments

Executive Sponsor	Headline Measure	Mth Status	YTD Status	Direction of Travel	Forecast	Level of Confidence in Recovery Plan	Supporting Papers
Finance Director	Contractual Commitments Index	RED	RED	=	GREEN	3	

Supporting Measure	Current Performance	Forecast Performance	Exception Report
DoH Performance Framework	The Trust continues to under perform against a number of key National Targets in respect of Cancer, 18 Weeks and A&E	High level discussions to signoff recovery / improvement plans are continuing	Y
CQUIN	9 CQUIN goals agreed with local Commissioners for 11/12.	Specific measures for each CQUN goal in the process of being finalised with Commissioners.	Y
Other Contractual Commitments	Discussion with local commissioners regarding the specific local measures to be included within the contract are continuing		N
Activity Plan Variation	Final activity plans with local commissioners signed off. Spell activity 1.7% over plan and outpatient activity 7% over plan at month 2.	Impact of activity to reduce backlog on overall contract position still being quantified, (particularly with respect to outpatients)	N

Exception Report

B9. Reflect Commissioner's Plans in Our Capacity Plans & Deliver Our Contractual Commitments

		Status Report			Directors Risk Assessment		
Executive Sponsor	Supporting Measure	Mth status	YTD status	Direction of Travel	Forecast	Confidence Level	Supporting Papers
Finance Director	DoH Performance Framework	RED	RED	=	AMBER	3	SaTH DOH Framework

Position Analysis

Acute Trusts

Service Performance (Integrated Performance Measures) - Indicators, weighting and scoring for Q1 2011/12 onwards

Quality of service

Performance Indicator	Thresholds: Performing	Thresholds: Under-performing	May 2011 Performance	Year-to-date 2011 Performance
Four-hour maximum wait in A&E from arrival to admission, transfer or discharge[1]	95%	94%	92.80%	92.30%
Unplanned re-attendance rate - Unplanned re-attendance at A&E within 7 days of original attendance (including if referred back by another health professional)	Data Completeness/Data Quality Measure for Q1			
Left department without being seen rate				
Time to initial assessment - 95th centile				
Time to treatment in department - median				
Cancelled ops - breaches of 28 days readmission guarantee as % of cancelled ops	5.0%	15.0%	0	0
MRSA	0	>1SD*	0	0
C Diff	0	>1SD	6	10
RTT - admitted - 95th percentile@	<=23	>27.7	43.89	
RTT - non-admitted - 95th percentile@	<=18.3		29.5	
RTT - incomplete - 95th percentile	<=28	>36	30.49	
RTT - admitted - 90% in 18 weeks	90%	85%	72.61%	
RTT - non-admitted - 95% in 18 weeks	95%	90%	89.17%	

Future Actions / Key Points

The Unscheduled Care Action Team has been in place from 23rd May to ensure the necessary focus on patient flow. Further a new system to report the new national quality measures has been Developed to ensure they can be reported by Quarter 2 (in line with national Requirements)

Work to ensure the 18 week year to date position is reported in the required format is being completed by the Information Team

Exception Report - Continued

B9. Reflect Commissioner's Plans in Our Capacity Plans & Deliver Our Contractual Commitments

Position Analysis - Continued

2 week GP referral to 1st outpatient	93%	88%	92.26%	94.25%
2 week GP referral to 1st outpatient - breast symptoms	93%	88%	93.22%	96.58%
31 day second or subsequent treatment - surgery	94%	89%	89.74%	92.59%
31 day second or subsequent treatment - drug	98%	93%	94.87%	95.00%
31 day diagnosis to treatment for all cancers	96%	91%	92.66%	94.52%
Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments)	94%	89%	98.00%	98.15%
62 day referral to treatment from screening	90%	85%	93.33%	81.82%
62 day referral to treatment from hospital specialist	85%	80%	72.92%	80.45%
62 days urgent GP referral to treatment of all cancers	85%	80%	67.95%	70.92%
Patients that have spent more than 90% of their stay in hospital on a stroke unit	80%	60%	91.10%	90.70%
Delayed transfers of care	3.5%	5.0%	6.60%	6.67%

Overall	Underperforming

The latest iteration of the Cancer action plan has been forwarded to all Clinical Centres and has also been submitted to the Health Economy wide Caner Group.

Cancer Performance reported for the month of May are not fully validated and will not be 'locked down' until the Q1 report is submitted to the National Cancer Database in late July.

Exception Report

B9. Reflect Commissioner's Plans in Our Capacity Plans & Deliver Our Contractual Commitments

		Status Report			Directors Risk Assessment		
Executive Sponsor	Supporting Measure	Mth status	YTD status	Direction of Travel	Forecast	Confidence Level	Supporting Papers
Finance Director	CQUIN	RED	RED	=	AMBER	2	

CQUIN Goal	Lead Manager / Executive	% of overall scheme	May	Year to Date	Narrative
VTE - Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Head of Nursing / Medical Director	15.00%	Red	Red	Measure agreed with commissioners. Month 1 not achieved, Month 2 not available. See C4
Patient Experience - Improve responsiveness to personal needs of patients	Head of Nursing / Medical Director	15.00%	Green	Green	Measure agreed with commissioners. End of year assessment.
Reduction in Falls of Patients Admitted to Hospital - Reducing falls in hospital will reduce unnecessary length of stay and further health deterioration.	Division 3 Lead Nurse / Director of Quality & Safety	10.00%	Amber	Amber	Measure agreed with commissioners. Trajectory being finalised.
Tissue Viability - Pressure Ulcers - Improvement in early identification, treatment and classification / recoding of pressure ulcers	Division 1 Lead Nurse / Director of Quality & Safety	15.00%	Green	Green	Currently on track to deliver target. See C6
End of Life - Number of admitted patients (identified as at end of life) who had followed the Supportive Care pathway or Liverpool End of Life Care Pathway for (at least) the last 3 days or duration of their admission if less than 3 days.	Division 2 Lead Nurse / Director of Quality & Safety	10.00%	Amber	Amber	Measure agreed with commissioners. Internal trajectory being finalised.

Exception Report

B9. Reflect Commissioner's Plans in Our Capacity Plans & Deliver Our Contractual Commitments

CQUIN Goal	Lead Manager / Executive	% of overall scheme	Month	Year to Date	Narrative
Medicines Management - % of at risk patients discharged with a medicines care plan chart which has been discussed with patients and % of at risk patients discharged in the week for whom information in discharge summary includes allergies (drug sensitivities), changes and starts / stops.	Centre Chief Pharmacy / Medical Director	10.00%	Amber	Amber	Measure agreed with commissioners. Biannual assessment due month 7 & 11.
Maternity - To provide a quality bereavement service by supporting patients with timely assessment by a senior clinician and a bereavement counsellor	SDM Women's & Children's / Director of Quality & Safety	5.00%	Amber	Amber	Measure agreed with commissioners. Quarterly assessments will be provided
Improved Patient Discharge process – including all patients having an estimated discharge date, ready to leave within 4 hour of discharge and relevant reduction in LoS.	DGM Division 1 / Chief Operating Officer	10.00%	Amber	Amber	Discussions with commissioners to agree targets ongoing.
Nutrition - Nutritional screening, assessment and delivery of an agreed individual action plan to maintain or improve an 'at risk' inpatients nutritional intake.	Head of Dietetics / Director of Quality & Safety	10.00%	Amber	Amber	Discussions with commissioners to agree targets ongoing.

C3: Provide the Right Care, Right Time, Right Place and Right Professional

Executive Sponsor	Headline Measure	Mth Status	YTD Status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Chief Operating Officer	Time and Place Index	RED	RED	=	GREEN Month 9	3	

Supporting Measure	Current Monthly Performance	Forecast Performance	Exception Report
Delayed Transfers of Care	The target for 2011/12 is 26 patients per day (3.5% of bed base) In May the average daily number of patients confirmed as Delayed Transfers of Care was 42 (50 in April)	The Trust is forecasting that the overall number of 26 patients or less will be achieved by December 2011	Y
Discharge Time	The current target is for 50% of discharges to take place before midday.	The Trust is forecasting delivery of the 50% target by 30th September 2011	Y
Day Surgery Rate	The target for 2011/12 is 78%, the performance at month 2 is 77.6%	The Trust is forecasting that the target will be achieved by August 2011	N

Exception Report

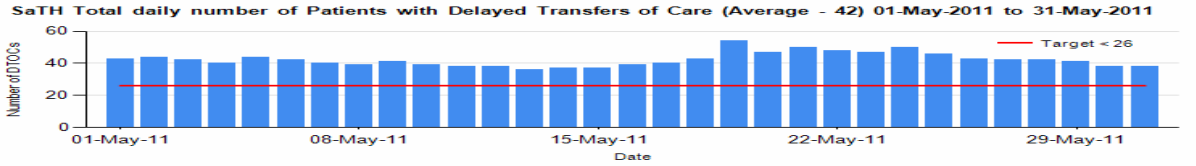
C3: Provide the Right Care, Right Time, Right Place and Right Professional - Delayed Transfers of Care

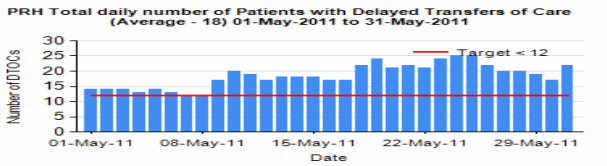
		Status Report			Directors Risk Assessment		
Executive Sponsor	Headline Measure	Mth status	YTD status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Chief Operating Officer	Time and Place Index	RED	RED	=	GREEN month 9	2	

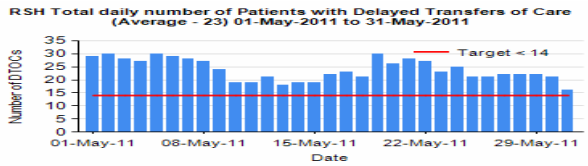
Position Analysis – Delayed transfers of care

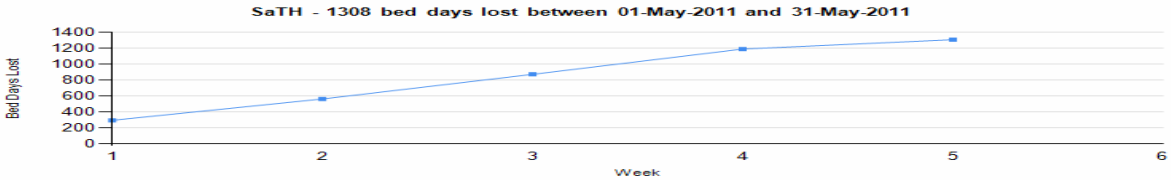
RSH: 2 main reasons for delay in May 2011 – awaiting further non acute NHS care and residential care home placement

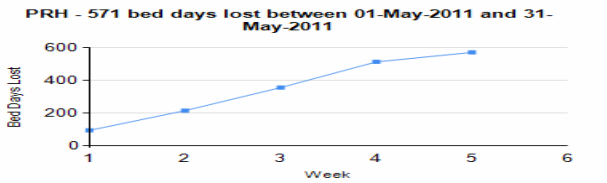
PRH: 2 main reason for delay in May 2011 – nursing care home placement and residential care home placement

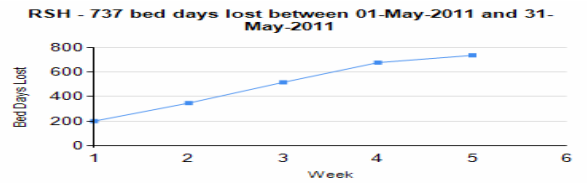












Future Actions:

Continued executive level discussions within local health and social economy

Implementation of the local health economy improvement plan

PCT led monthly delayed discharge meetings

Formation of a local health & social care integrated case management team (commences July 2011)

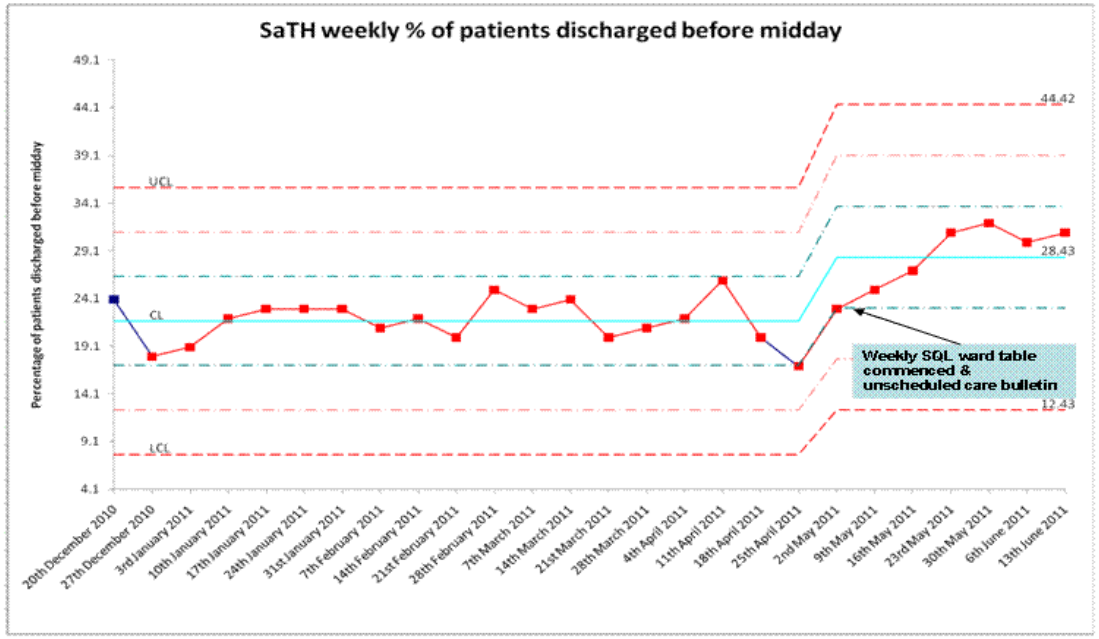
Exception Report

C3: Provide the Right Care, Right Time, Right Place and Right Professional – Discharge time

		Status Report			Directors Risk Assessment		
Executive Sponsor	Headline Measure	Mth status	YTD status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Chief Operating Officer	Time and Place Index	RED	RED	=	GREEN month 6	3	

Position Analysis – Discharge time (adult inpatient wards – excluding maternity)

26% of patients discharged before 12:00 in May (target 50% before midday)



Future Actions

Weekly ward level discharge time automated email league table reports to all key stakeholders. Intervention / rapid improvement for all wards not achieving 50% of discharges before midday

Daily morning board rounds by decision making clinicians

Expected date and time of discharge in place for all patients

All staff, patients and visitors to be made aware that discharges take place before midday

C4. Deliver Services that Offer Safe Evidence-Based Practice

Executive Sponsor	Headline Measure	Mth Status	YTD Status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Medical Director	**Fewer Avoidable Deaths**	RED	RED	⇩	GREEN month 4	3	

Supporting Measure	Current Performance	Forecast Performance	Exception Report
HSMR	Rebased YTD: SaTH = 113 In Month: SaTH = 94.7 (estimated re-basing) There has been a significant drop this month in the HSMR figures which, even when re-based, is well below the National index. Although the overall assessment remains as RED significant progress is being made The trend continues down at a faster rate than National index	At present if the current trend continues we should achieve the target of re-based HSMR at the National index of 100 in Month 13 (July 2012)	Y
Crude Number of Deaths	The number of deaths in May was 141, this was a reduction of 7 deaths when compared to the same month last year. YTD reduction in deaths of 12 against a target of 30. This is a 4% reduction in deaths against a target of 10%.	Data collection commenced in April 2011, the Trust will require 4 months data to identify trends to enable future forecasting. The LIPS programme is expected to start to positively impact on the crude death rates from end July 2011 at the earliest.	Y
VTE	Rollout of VTE on Vitalpac at RSH and PRH has been completed as planned. April figure reported in May was 40.32%. May's figure will be reported on 28th June and will include the Vitalpac element for the first time	Data collection for a new measure commenced in April 2011, the Trust will require 4 months data to identify trend analysis to enable a forecast.	N

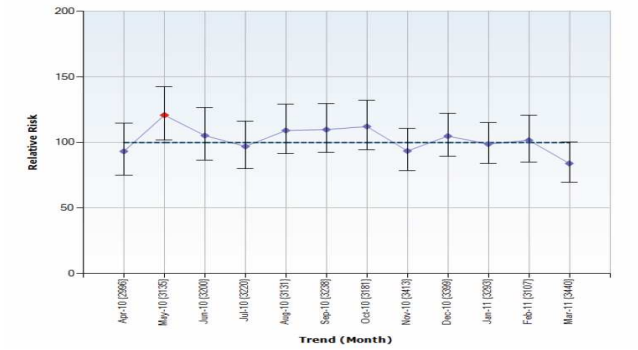
EXCEPTION REPORT

C4: Deliver services that offer safe, evidence-based practice

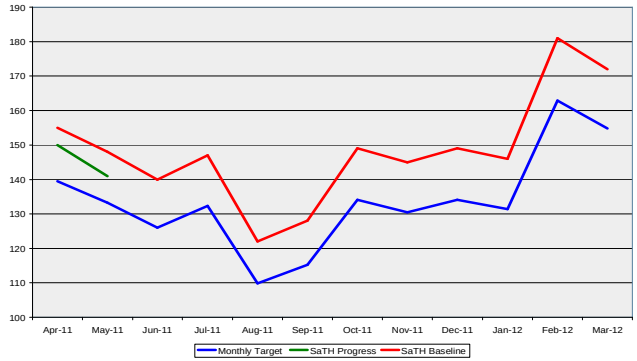
		Status Report			Directors Risk Assessment		
Executive Sponsor	Supporting Measure	Mth status	YTD status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Medical Director	**HSMR + Crude Deaths**	RED	RED		GREEN month 4	3	

Position Analysis

Graph – SaTH HSMR Monthly Trend (not re-based) and Progress against target – crude deaths



Crude Deaths - Progress against Target



Future Actions/Key Points

A reduction of 12 deaths was achieved against the same YTD last year against a target of 30

Reducing crude deaths can only be achieved through clinical improvements (LIPS) and ensuring Patients die at the place of their choice. It is expected that LIPS improvements will positively impact the crude deaths from end July 2011 onwards

As well as LIPS, a review of deaths for Jan 2011 at PRH is being undertaken by the Consultant Physicians, the aim is to identify clinical opportunities. Outputs will be fed into the Quality & Safety Committee for appropriate action.

The Trust SMR is reducing at a faster rate than the National index resulting in a reducing re-based figure each month. In Dec we reported a re-based HSMR of 119, last month it was 115 compared to the 113 this month. If this trend continues we should see the Trust hit the re-based National index in month 13 – July 2012. This is sooner than originally expected.

A recoding exercise was completed in May and the outputs have indicated further improvements that should reduce the HSMR. These improvements are being implemented at PRH over the next 2 weeks in order to get the benefits as soon as possible.

A peer review has been completed with the support of the Dr Foster Team against 6 other hospitals. (3 local and 3 of the best UK County Town DGH Hospitals). This was done to identify differences for our top 10 key HSMR diagnosis. The outcomes indicated areas to focus on and these are within the planned scope of the LIPS programme commencing mid June.

C6. Ensure Our Patients Suffer No Avoidable Harm (1 of 2)

Executive Sponsor	Headline Measure	Mth Status	YTD Status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Director of Quality & Safety / Chief Nurse	Patient Care Index	RED	RED	=	AMBER Q3	3	Serious Incident Update paper to HEC and Trust Board

Supporting Measure	Current Performance	Forecast Performance	Exception Report
No. of Patient Safety Incidents	There have been 785 patient safety incidents identified in May 2011 which equates to a 7.8% reporting rate . This reflects an increase in compared to April 2011.	The current rate of reporting datix incidents reflects an improvement within the 'reporting culture' of the organisation. Work is ongoing in relation to improving RCA's and action planning. Future work will include benchmarking to understand how the Trust compares to other Trusts.	N
No of Serious Incidents	There have been 19 SIs declared in May 2011, 3 have been removed with agreement with the PCT, SHA and DH, leaving a total of 16 S's, this is a decrease from April 2011. All of these incidents are being reviewed and RCA's will be completed in line with the agreed timescales.	In line with the SI policy, each case is being investigated fully with an RCA and Action Plan for Improvement. Action plans will be implemented following the completion of the RCAs with a process for tracking through the agreed improvements. In addition themes will be monitored and fully addressed.	Y
No. of inpatient Falls	There were 143 falls in May which is a slight rise from April but down from this time last year 5 of these were RIDDOR Reportable. To date, there is no specific trend or themes emerging from the RCA on these falls	The High Impact Actions Group continue to focus on improvements to ensure that effective assessment and preventative measures continue. Although a slight increase this month there remains confidence the Trust will achieve its 5% improvement .	Y
No. of grade 3 /4 Pressure Sores	There was 1 Trust acquired pressure ulcer reported for May	This is the second month we have reported less than 2 ulcers in the month. This remains encouraging indication of us achieving the 10% reduction target	N
No. of HCAIs	In May there were **zero** MRSA bacteraemia, 13 C Diff cases of which **6** are apportioned to SaTH. There were also 12 MSSA bacteraemia of which **4** were post 48 hours. We also had **20** E.Coli bacteraemia.	The Trust is currently amber with regard to C difficile as we are above our trajectory at 10 cases year to date (trajectory 9 cases). At this point last year we had had 17 cases but our target is very challenging this year. Each case has RCA carried out to look for preventable causes. Antibiotic use rather than cross infection is the most common cause and work continues to ensure appropriate use.	Y

C6. Ensure Our Patients Suffer No Avoidable Harm (2 of 2)

Supporting Measure	Current Performance	Forecast Performance	Exception Report
Breaches in Same Sex Accommodation	There were no breaches in May	Despite on going operational pressures with capacity there were no breaches and we remain confident that we will sustain improvement s	N
Cleanliness Score	Overall Domestic Cleanliness Monitoring scores for May were as follows: PRH: 96.01% RSH: 96.86% SATH: 96.44% The target is to maintain a cleanliness score of 92% across the Trust	Areas falling below target:- • Ward 33 and Ward 25 at RSH falling in red •Main entrance and corridors at PRH falling in red •9 areas across the 2 sites falling into Amber Corrective action taken to address issues in all areas including advertising vacant posts	N
No of Complaints	In the second month of 2011/12 there were 49 new complaints, this was a reduction compared to the same month in the previous year where there had been 59 complaints. Of the 49 complaints in May 33 related to clinical concerns and 8 related to access times.	There was 52 new complaints last year for June and I would anticipate that we will once again seen a reduction in complaints for the next month.	N
No of Drug Errors Resulting in Harm	There were 70 medication errors reported, 3 of which resulted in short term harm to the patient including an incident relating to chemotherapy drugs.	There has been no never events for drugs administration. A case review has been held on the chemotherapy incident.	N

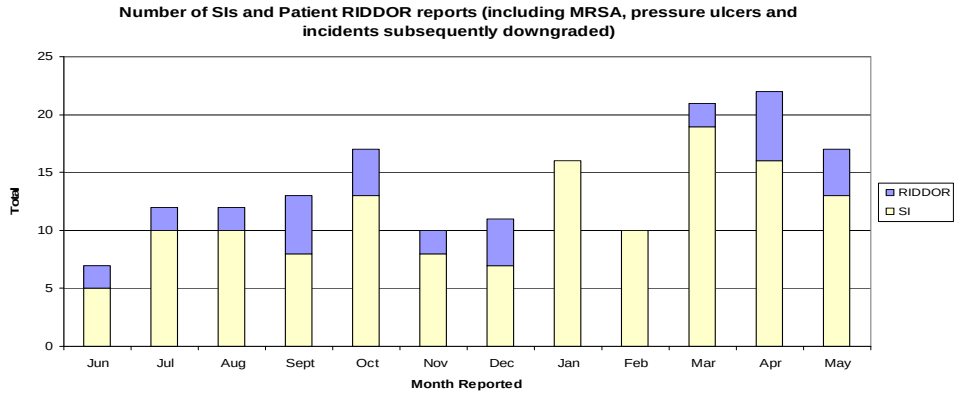
EXCEPTION REPORT

C6: Ensure that our patients suffer no avoidable harm – Serious Incidents and Drug Errors

		Status Report			Directors Risk Assessment		
Executive Sponsor	Supporting Measure	Mth status	YTD status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Director of Quality and Safety	**No. of Serious Incidents**	RED	RED		AMBER Q3	3	Serious Incident Update paper to HEC and Trust Board

Position Analysis

Serious Incidents



The 16 SIs in May related to:

2 Drug incidents

1 Allegation of abuse by member of staff

1 Abuse of patient by patient

2 Delayed diagnosis

4 Falls

1Pressure ulcer

2 Maternal admission to ITU

1 Unexpected admission to neonatal unit

1 12 hour breach

Future Actions

Serious Incidents

Leading Improvements In Patient Safety (LIPS) will work on projects to improve reliability in healthcare and improve safety.

The key actions re tracking of outcomes include
interim support to lead:

1. Formal Panel Reviews
2. Development of a tracking outcomes process
3. Lead the development of identifying trends and themes

All Serious Incidents have a full root cause analysis and action plan in place and there are falls and pressure sore workstreams with action plans to reduce these incidents

EXCEPTION REPORT

C6: Ensure that our patients suffer no avoidable harm –

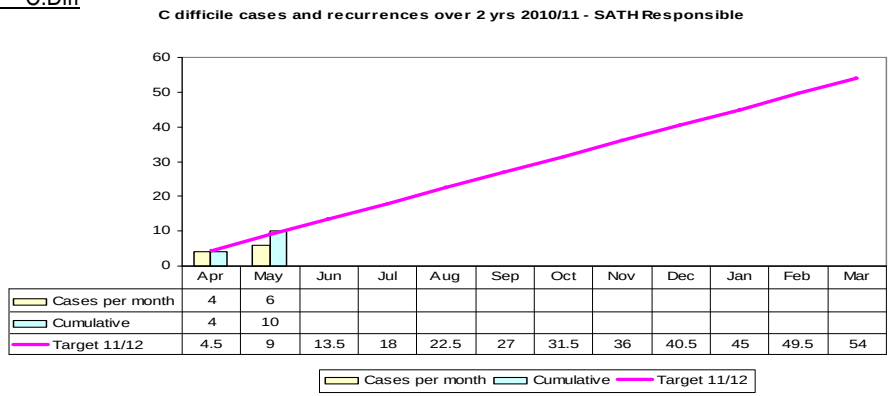
		Status Report			Directors Risk Assessment		
Executive Sponsor	Supporting Measure	Mth status	YTD status	Direction of Travel	Forecast	Level of Confidence in Delivery	Supporting Papers
Director of Quality and Safety	**No of Inpatient Falls** **HCAIs – C Diff** **No of Drug Errors Resulting in Harm**	AMBER	AMBER		AMBER Q3	3	

Position Analysis

No. of inpatient falls

In May there was 5 RIDDOR reportable falls. 4 resulted in Fractures and 1 resulted in a pnuemothorax . RCA have not identified any trends or themes . Completion of risk assessments have been accurate with appropriate care plans in place. Several patients that fell were not high risk but fell from simple activities like leaning over to reach mobile, slipping on own slippers .

HCAIs – C.Diff



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cases per month	4	6										
Cumulative	4	10										
Target 11/12	4.5	9	13.5	18	22.5	27	31.5	36	40.5	45	49.5	54

In May of the 6 SaTH cases, 3 occurred at RSH and 3 at PRH. no individual wards have had more than one case this month. The causes identified from the RCA were ABx from Sath 4 cases, ABx from Sath and GP 1 case, not known 1 case.

No of Drug Errors Resulting in Harm (Chemotherapy Serious Incident)

There was an incident of the administration of an out of date chemotherapy. There is no evidence of any demonstrable harm to the patient .

Future Actions

No. of inpatient falls

Raise awareness and reinforce with staff the key contributing factors to falls and preventative actions

To ensure compliance with Falls bundles

Trial of Sensor alarms has been positive . Plan to purchase and make available to all areas.

HCAIs – C.Diff

Much of the ABx prescribing was according to policy but this will be reviewed in the antimicrobial management group

No of Drug Errors Resulting in Harm (Chemotherapy Serious Incident)

A case review has been held for the chemo drug error . It has identified a need to review systems and process for the administration, storage and preparation of chemotherapy

Directors Assessment

Legend		
RAG	*Status Report (in mth and YTD performance)*	*Directors Forecast*
RED	Target Not achieved in line with Performance Directory Threshold	Performance is off track and **plans will be put in place but there remains some level of risk**
AMBER	Target underachieved in line with Performance Directory Thresholds	Performance is off track but **action plans are in place** and expected to deliver original plan by the agreed timescale
GREEN	Target achieved in line with Performance Directory Threshold	Performance against plan and **targets have been achieved** within the defined tolerance level

Each Director will also provide an assessment of their confidence level in the action plan designed to deliver the agreed targets. The scoring will range from:

1 (little confidence) to 5 (**complete confidence**)

and will be reviewed each month as part of the process of producing the Performance Report.