Performance Report

as at Month 1

Date of Report 23/05/2011
**Balanced Score Card**

**FINANCIAL STRENGTH**
We will develop & deliver robust plans that generate surpluses to reinvest in quality.

<table>
<thead>
<tr>
<th>Ref</th>
<th>Freq</th>
<th>Objectives</th>
<th>Measures</th>
<th>Status Report</th>
<th>Directors Risk Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>M</td>
<td>Develop &amp; implement sustainable clinical strategies</td>
<td>% Contribution RED</td>
<td>RED</td>
<td>RED 5</td>
</tr>
<tr>
<td>A2</td>
<td>Q</td>
<td>Develop &amp; grow services that make a positive financial contribution</td>
<td>Service Portfolio Matrix RED</td>
<td>RED</td>
<td>RED 5</td>
</tr>
<tr>
<td>A3</td>
<td>M</td>
<td>Increase surpluses to reinvest in quality and innovation</td>
<td>Financial Risk Rating RED</td>
<td>RED</td>
<td>RED 5</td>
</tr>
<tr>
<td>A4</td>
<td>M</td>
<td>Maximize the productivity and efficiency of our services</td>
<td>Upper Quartile benchmark Index AMBER</td>
<td>AMBER</td>
<td>GREEN 4</td>
</tr>
<tr>
<td>A5</td>
<td>M</td>
<td>Eliminate waste and non-value adding processes</td>
<td>Reference Cost Index RED</td>
<td>RED</td>
<td>RED 5</td>
</tr>
</tbody>
</table>

**QUALITY & SAFETY**
We will always provide the right care for our patients.

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<tbody>
<tr>
<td>C1</td>
<td>Q</td>
<td>Ensure that we learn from mistakes &amp; embrace what works well</td>
<td>Staff Reported Outcomes Score</td>
<td>RED</td>
<td>RED</td>
</tr>
<tr>
<td>C2</td>
<td>Q</td>
<td>Design care around patient needs</td>
<td>Local Inpatient Survey</td>
<td>RED</td>
<td>RED</td>
</tr>
<tr>
<td>C3</td>
<td>M</td>
<td>Provide the right care, right time, right place, right professional</td>
<td>Time &amp; Place Index</td>
<td>RED</td>
<td>RED</td>
</tr>
<tr>
<td>C4</td>
<td>M</td>
<td>Deliver services that offer safe, evidence-based practice</td>
<td>Fewer Avoidable Deaths AMBER</td>
<td>AMBER</td>
<td>GREEN 3</td>
</tr>
<tr>
<td>C5</td>
<td>Q</td>
<td>Meet regulatory requirements &amp; healthcare standards</td>
<td>Compliance Index</td>
<td>RED</td>
<td>RED</td>
</tr>
<tr>
<td>C6</td>
<td>M</td>
<td>Ensure that our patients suffer no avoidable harm</td>
<td>Patient Care Index</td>
<td>RED</td>
<td>RED</td>
</tr>
</tbody>
</table>

**PATIENTS, GP’S & COMMISSIONERS**
We will insist that we deliver the best service to our patients, GP’s & Commissioners.

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<tbody>
<tr>
<td>B1</td>
<td>Q</td>
<td>Involve patients in decisions about them</td>
<td>Patient Involvement Index</td>
<td>RED</td>
<td>RED</td>
</tr>
<tr>
<td>B2</td>
<td>Q</td>
<td>Ensure our patients have a good experience</td>
<td>Patient Satisfaction Score</td>
<td>RED</td>
<td>RED</td>
</tr>
<tr>
<td>B3</td>
<td>Q</td>
<td>Deliver services which are convenient &amp; timely for patients</td>
<td>Convenience &amp; Timeliness Services Index</td>
<td>RED</td>
<td>RED</td>
</tr>
<tr>
<td>B4</td>
<td>Q</td>
<td>Ensure access to clear care pathways to meet the needs of our patients</td>
<td>GP Satisfaction Score (GPs)</td>
<td>RED</td>
<td>RED</td>
</tr>
<tr>
<td>B5</td>
<td>Q</td>
<td>Improve our appointments system and process</td>
<td>GP Satisfaction Score (Scheduling)</td>
<td>RED</td>
<td>RED</td>
</tr>
<tr>
<td>B6</td>
<td>Q</td>
<td>Improve the communication processes and the information we provide</td>
<td>GP Satisfaction Score (Communication)</td>
<td>RED</td>
<td>RED</td>
</tr>
<tr>
<td>B7</td>
<td>Q</td>
<td>Work in partnership to ensure services meet the local needs</td>
<td>Commissioner Satisfaction Score (Delivery)</td>
<td>RED</td>
<td>RED</td>
</tr>
<tr>
<td>B8</td>
<td>Q</td>
<td>Engage with GPs to plan &amp; deliver future services</td>
<td>Commissioner Satisfaction Score (Planning)</td>
<td>RED</td>
<td>RED</td>
</tr>
<tr>
<td>B9</td>
<td>M</td>
<td>Reflect commissioners plans in our capacity plans &amp; deliver our contractual commitments</td>
<td>Contractual Commitments Index</td>
<td>RED</td>
<td>RED</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Executive Sponsor</th>
<th>Headline Measure</th>
<th>Mth Status</th>
<th>YTD Status</th>
<th>Direction of Travel</th>
<th>Forecast</th>
<th>Level of Confidence in Delivery</th>
<th>Supporting Papers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance Director</td>
<td>Percentage Contribution</td>
<td>Red</td>
<td>Red</td>
<td>Red</td>
<td>5</td>
<td>Month 1 Finance Report</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supporting Measure</th>
<th>Current Performance</th>
<th>Forecast Performance</th>
<th>Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage Contribution (Trust/Centre/Service Line)</td>
<td>20% Income is lower than an average month due to the number of working days available in April 2011. Predominately fixed costs results in expenditure remaining broadly constant. Recovery of the income shortfall is expected in the remaining months as the number of working days available increases. Division 1 however, did overspend against their planned expenditure budgets in April by circa £0.5m which illustrates why their percentage achieved is lower than Division 2.</td>
<td>40% (Target Contribution for Indirect and Overhead costs i.e. Division 3 and Corporate Services respectively)</td>
<td></td>
</tr>
<tr>
<td>Division 1</td>
<td>36% As will Division 1, Income is lower than for an average month due to the number of working days available, whilst expenditure remains constant. Direct expenditure budgets for Division 2 under spent by circa £0.3m in April 2011, so the underachievement of this target is wholly due to the planned reduction in activity (and consequently income) in Month 1, which will be reversed in future months.</td>
<td>40% (Target Contribution for Indirect and Overhead costs i.e. Division 3 and Corporate Services respectively)</td>
<td></td>
</tr>
<tr>
<td>Division 2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## A3. Increase Surpluses to Reinvest in Quality & Innovation

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<tr>
<td>Finance Director</td>
<td>Financial Risk Rating</td>
<td>RED</td>
<td>RED</td>
<td>RED</td>
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</thead>
<tbody>
<tr>
<td>FRR Overall</td>
<td>1 (Plan 3)</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>EBITDA Margin</td>
<td>1: (3.0%)</td>
<td>The negative EBITDA is as a result of income reflecting the available working days in the month, whereas expenditure is relatively fixed. As a result the plan for Month 1 was a circa £0.3m negative EBITDA, which is reversed over the remainder of the year as a result of activity phasing. <strong>Planned +5%</strong></td>
<td></td>
</tr>
<tr>
<td>EBITDA Percentage Achieved of Plan</td>
<td>1: (200%)</td>
<td>An adverse pay variance of circa £0.3m results in the Trust not achieving the planned EBITDA. EBITDA Planned Month 1 (£327k) Actual (£654k). <strong>Planned 100% of the Plan.</strong></td>
<td></td>
</tr>
<tr>
<td>Return on Assets</td>
<td>2: (1.2%)</td>
<td>Planned +3.4%</td>
<td></td>
</tr>
<tr>
<td>Income &amp; Expenditure Surplus Margin</td>
<td>1: (8.3%)</td>
<td>As with the EBITDA plan, the Trust planned a £1.5m deficit in Month 1 which it underachieved by £0.3m. <strong>Planned Surplus Margin (7%)</strong></td>
<td></td>
</tr>
<tr>
<td>Liquidity Ratio</td>
<td>1: 8.9 days</td>
<td>An element of the liquidity ratio (cash) has improved from previous months as we have received cash payment for deferred income also with no significant outstanding debtors. However, the deferred income liability results approx 3 days reduction in overall liquidity, with current cash position expected to deteriorate in future months. <strong>Planned 11 days</strong></td>
<td></td>
</tr>
</tbody>
</table>
## A4. Maximise the Productivity of Our Services

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<tr>
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</thead>
<tbody>
<tr>
<td>Chief Operating Officer</td>
<td>Upper Quartile Benchmark Index</td>
<td>AMBER</td>
<td>AMBER</td>
<td>GREEN Mth 12</td>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Supporting Measure

<table>
<thead>
<tr>
<th>Supporting Measure</th>
<th>Current Monthly Performance</th>
<th>Forecast Performance</th>
<th>Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Length of Stay (mean) - monthly</td>
<td>The target for the Trust is 2.8 days, the performance in April was as follows: RSH – 3.7 days PRH - 3.1 days</td>
<td>The current forecast is that the Trust will deliver the target by February 2012</td>
<td>Y</td>
</tr>
<tr>
<td>Elective surgical pre-op bed days - monthly</td>
<td>The target for 2011/12 is a 60% reduction against the 2010/11 out-turn equating to 60 days per month RSH – 79 PRH - 39</td>
<td>The current forecast is that the Trust will deliver the target by September 2011</td>
<td>N</td>
</tr>
<tr>
<td>Non Elective Length of Stay - monthly</td>
<td>The target is 4.7 days, the performance in April was as follows: RSH – 5.1 days PRH – 4.9 days</td>
<td>The current forecast is that the Trust will deliver the target by September 2011</td>
<td>Y</td>
</tr>
<tr>
<td>Elective (funded) Theatre Utilisation - monthly</td>
<td>The target for 2011/12 is 85% on both sites, the utilisation for April was as follows: RSH – 75% PRH – 74%</td>
<td>The current forecast is that the Trust will achieve 85% on both sites by March 2012</td>
<td>Y</td>
</tr>
</tbody>
</table>
### Exception Report

**A4. Maximise the productivity of our services – elective length of stay**

<table>
<thead>
<tr>
<th>Executive Sponsor</th>
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<tbody>
<tr>
<td>Chief Operating Officer</td>
<td>Upper Quartile Benchmark index</td>
<td>AMBER AMBER</td>
<td>GREEN Mth 11</td>
</tr>
</tbody>
</table>

**Position Analysis – elective length of stay:**

- PRH – 3.1 days
- RSH – 3.7 days

**Future Actions:**

- Continued implementation of enhanced recovery Programme in colorectal, orthopaedics and urology
- Increase day surgery rate across all specialties
- Reduce elective surgical pre-operative length of stay by increased use of the Surgical Admissions Suite
## A4. Maximise the productivity of our services – non elective length of stay

<table>
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<td>Chief Operating Officer</td>
<td>Upper Quartile Benchmark index</td>
<td>AMBER AMBER</td>
<td>GREEN Mth 12 3</td>
</tr>
</tbody>
</table>

### Position

RSH – 5.1 days (April 2011) PRH – 4.9 days (April 2011 – no significant change over the past 12 months)

### Future Actions:

- Earlier direct consultant physician patient contact in MAU/A&E – appointment of additional acute care physicians to provide 7 day a week cover
- Increased ambulatory care provision for non elective patients
- Re-align Trust bed base to match to actual patient demand
- Formation of a local health & social economy integrated case management team to enable improved management of delayed transfers of care patients
- Implementation of a patient & hospital status at a glance system
- Consultant and Nursing lead for wards to ensure daily board round, expected date of discharge and discharge time are adhered to
- Weekly multi-disciplinary meetings
- SQL reporting to ensure all stakeholders can see performance from ward level upwards

### Graphs

- **PRH Non Elective Length of Stay Apr10 - Apr11**
  - UCL
  - LCL
  - Average
  - RSH – 5.1 days (April 2011) PRH – 4.9 days (April 2011 – no significant change over the past 12 months)

- **RSH Non Elective Length of Stay Apr10 - Apr11**
  - UCL
  - LCL
  - Average
Exception Report
A4. Maximise the productivity of our services – elective funded operating theatre utilisation

<table>
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<tr>
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<td>Chief Operating Officer</td>
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<td>AMBER</td>
<td>AMBER</td>
<td>AMBER</td>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Position Analysis – elective funded operating theatre utilisation
Elective operating theatre utilisation decreased on both sites during April 2011:
59 elective funded operating sessions were not used due to annual leave during the Easter holiday •The number of operations cancelled due to no bed being available was the second highest for the past 12 months (January 2011 being the highest).

Future Actions
Theatre improvement (TPOT – the productive operating theatre) plan commenced at RSH – Project Manager in post
Theatre improvement plan ((TPOT – the productive operating theatre) to commence at PRH June 2011- Project Manager to be appointed and in post by June 2011
Trust wide elective theatre session start & finish time to be confirmed by June 1st 2011
All operation names, duration & length of stay to be updated on the Trust’s patient administration system (commencing with RSH General surgery) to enable improved scheduling
All elective theatre sessions to be confirmed 4 weeks in advance
‘Human Factors’ training arranged with the NHS Institute for Innovation & Improvement (July 2011)
Web based Operating Theatre Operational status at a glance system to be in place by July 2011
<table>
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<tr>
<td>Finance Director</td>
<td>Reference Cost Index</td>
<td>Red</td>
<td>Red</td>
<td>Red</td>
<td>5</td>
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<tr>
<td>Reference Cost Index Availability</td>
<td>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.</td>
<td>£3,014 Reflects the additional pay costs in April and activity at a lower than an average month due to the lower working days available in April.</td>
<td>£2,748 (Target based on annual budgeted expenditure and planned activity)</td>
</tr>
</tbody>
</table>
### B9. Reflect Commissioner’s Plans in Our Capacity Plans & Deliver Our Contractual Commitments

<table>
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<tr>
<td>Finance Director</td>
<td>Contractual Commitments Index</td>
<td>RED</td>
<td>RED</td>
<td></td>
<td>GREEN</td>
<td>3</td>
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#### Supporting Measure

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<tbody>
<tr>
<td>DoH Performance Framework</td>
<td>Not achieving a number of key National Targets in respect of Cancer, 18 Weeks and A&amp;E</td>
<td>Discussions with operational managers to finalise / refine action plans ongoing</td>
<td>Y</td>
</tr>
<tr>
<td>CQUIN</td>
<td>9 CQUIN goals agreed with local Commissioners for 11/12.</td>
<td>Specific measures for each CQUIN goal in the process of being finalised with Commissioners. This is anticipated to be completed by end of May 2011.</td>
<td>N</td>
</tr>
<tr>
<td>Other Contractual Commitments</td>
<td>Discussion$S$ with local commissioners regarding the specific local measures to be included within the contract are continuing</td>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Activity Plan Variation</td>
<td>To Be Progressed</td>
<td></td>
<td>N</td>
</tr>
</tbody>
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### Exception Report

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

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<td>GREEN</td>
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</table>

#### Position Analysis

<table>
<thead>
<tr>
<th>DoH Acute Trust National Performance Indicator</th>
<th>Performing Threshold</th>
<th>Under-performing</th>
<th>April 2011 Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Four-hour maximum wait in A&amp;E from arrival to admission, transfer or discharge</td>
<td>95%</td>
<td>94%</td>
<td>92%</td>
</tr>
<tr>
<td>Unplanned re-attendance rate - Unplanned re-attendance at A&amp;E within 7 days of original attendance (including if referred back by another health professional)</td>
<td>Data Completeness/Data Quality Measure for Q1</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>Left department without being seen rate</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>Time to initial assessment - 95th centile</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>Time to treatment in department - median</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>Cancelled ops - breaches of 28 days readmission guarantee as % of cancelled ops</td>
<td>5.0%</td>
<td>15.0%</td>
<td>0</td>
</tr>
<tr>
<td>MRSA – variation from plan</td>
<td>0</td>
<td>&gt;1 Standard Deviation*</td>
<td>0</td>
</tr>
<tr>
<td>C Diff – variation from plan</td>
<td>0</td>
<td>&gt;1 Standard Deviation</td>
<td>4</td>
</tr>
<tr>
<td>RTT - admitted - 95th percentile (Weeks)</td>
<td>&lt;=23</td>
<td>&gt;27.7</td>
<td>37.51</td>
</tr>
<tr>
<td>RTT - non-admitted - 95th percentile (Weeks)</td>
<td>&lt;=18.3</td>
<td>26.51</td>
<td></td>
</tr>
<tr>
<td>RTT - incomplete - 95th percentile (Weeks)</td>
<td>&lt;=28</td>
<td>&gt;36</td>
<td>34.43</td>
</tr>
<tr>
<td>RTT - admitted - 90% in 18 weeks</td>
<td>90%</td>
<td>85%</td>
<td>71.85%</td>
</tr>
</tbody>
</table>

#### Future Actions / Key Points

Attendances at the A&E departments remain above plan. The Unscheduled Care Action Team is being introduced from 23rd May to ensure the necessary focus on patient flow. Additional staff have been allocated to Weekend and Bank Holiday shifts to ensure safety and quality and an additional A&E Consultant has been appointed. 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)

Proposals to improve 18 week performance discussed at Hospital Executive Committee on 17th May 2011. Following this, detailed plans (at Specialty level) are being refined. The current expectation is that the national targets will be delivered across all specialties by the end of December 2011.
### Exception Report - Continued

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

**Position Analysis**

<table>
<thead>
<tr>
<th>Performance Indicator - Continued</th>
<th>Performing</th>
<th>Under-performing</th>
<th>April 2011 Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT - non-admitted - 95% in 18 weeks</td>
<td>95%</td>
<td>90%</td>
<td>89.23%</td>
</tr>
<tr>
<td>Cancer - 2 week GP referral to 1st outpatient</td>
<td>93%</td>
<td>88%</td>
<td>96.48%</td>
</tr>
<tr>
<td>Cancer - 2 week GP referral to 1st outpatient - breast symptoms</td>
<td>93%</td>
<td>88%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Cancer - 31 day second or subsequent treatment - surgery</td>
<td>94%</td>
<td>89%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Cancer - 31 day second or subsequent treatment - drug</td>
<td>98%</td>
<td>93%</td>
<td>95.23%</td>
</tr>
<tr>
<td>Cancer - 31 day diagnosis to treatment for all cancers</td>
<td>96%</td>
<td>91%</td>
<td>97.39%</td>
</tr>
<tr>
<td>Cancer - Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments)</td>
<td>94%</td>
<td>89%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Cancer - 62 day referral to treatment from screening</td>
<td>90%</td>
<td>85%</td>
<td>75.79%</td>
</tr>
<tr>
<td>Cancer - 62 day referral to treatment from hospital specialist</td>
<td>85%</td>
<td>80%</td>
<td>68.00%</td>
</tr>
<tr>
<td>Cancer - 62 days urgent GP referral to treatment of all cancers</td>
<td>85%</td>
<td>80%</td>
<td>75.79%</td>
</tr>
<tr>
<td>Patients that have spent more than 90% of their stay in hospital on a stroke unit</td>
<td>80%</td>
<td>60%</td>
<td>90.20%</td>
</tr>
<tr>
<td>Delayed transfers of care (Based on submitted March 2001 data as per DoH / SHA definition)</td>
<td>3.5%</td>
<td>5.0%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td></td>
<td>RED</td>
</tr>
</tbody>
</table>

**Future Actions / Key Points**

The Value Stream Lead for Cancer has planned to meet all Centre Chiefs to agree their responsibilities in relation to the cancer targets. The latest iteration of the action plan has been forwarded to all Clinical Centres and has also been submitted to the Health Economy wide Cancer Group. Further copies are available on request.
### C3: Provide the Right Care, Right Time, Right Place and Right Professional

<table>
<thead>
<tr>
<th>Executive Sponsor</th>
<th>Headline Measure</th>
<th>Mth Status</th>
<th>YTD Status</th>
<th>Direction of Travel</th>
<th>Forecast</th>
<th>Level of Confidence in Delivery</th>
<th>Supporting Papers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Operating Officer</td>
<td>Time and Place Index</td>
<td>RED</td>
<td>RED</td>
<td>GREEN</td>
<td>Mth 9</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

#### Supporting Measure

<table>
<thead>
<tr>
<th>Supporting Measure</th>
<th>Current Monthly Performance</th>
<th>Forecast Performance</th>
<th>Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed Transfers of Care</td>
<td>The target for 2011/12 is 26 patients per day (3.5% of bed base) In April the average daily number of patients confirmed as Delayed Transfers of Care during was 50.</td>
<td>The Trust is forecasting that the overall number of 26 patients or less will be achieved by December 2011.</td>
<td>Y</td>
</tr>
<tr>
<td>Discharge Time</td>
<td>The current target is for 50% of discharges to take place before midday. The actual performance in April showed only 25% (approximately)</td>
<td>The Trust is forecasting delivery of the 50% target by July 2011.</td>
<td>Y</td>
</tr>
<tr>
<td>Day Surgery Rate</td>
<td>The target for 2011/12 is 78% the performance at mth 1 is 76.8%</td>
<td>The Trust is forecasting that the target will be achieved by August 2011.</td>
<td>Y</td>
</tr>
</tbody>
</table>
## Exception Report

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

<table>
<thead>
<tr>
<th>Status Report</th>
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</tr>
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<tbody>
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<td>Headline Measure</td>
</tr>
<tr>
<td>Chief Operating Officer</td>
<td>Time and Place Index</td>
</tr>
</tbody>
</table>

### Position Analysis – Delayed transfers of care

**RSH:** 2 main reasons for delay in April 2011 – awaiting further non acute NHS care & care package in own home  
**PRH:** main reason for delay in April 2011 – nursing care home placement

### Future Actions

- Continued executive level discussions within local health and social economy  
- PCT led monthly delayed discharge meetings  
- Formation of a local health & social care integrated case management team  
- Live visualisation of nursing home and intermediate care capacity for all key stakeholders to enable patients to move into nursing home and non acute NHS care without unnecessary waiting
Exception Report
C3: Provide the Right Care, Right Time, Right Place and Right Professional – Discharge time

<table>
<thead>
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<tbody>
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<td>Mth status: RED</td>
<td>Directors Risk Assessment: RED</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YTD status: RED</td>
<td>Forecast: GREEN Mth 4</td>
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<tr>
<td></td>
<td></td>
<td>Direction of Travel</td>
<td>Level of Confidence in Delivery: 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Supporting Papers</td>
<td></td>
</tr>
</tbody>
</table>

Position Analysis – Discharge time

Average monthly discharge time 15.16hrs during April 2011

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
**Exception Report**

**C3: Provide the Right Care, Right Time, Right Place and Right Professional – Day Surgery Rate**

<table>
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</thead>
<tbody>
<tr>
<td>Chief Operating Officer</td>
<td>Time and Place Index</td>
<td>AMBER AMBER</td>
<td>GREEN Mth 5</td>
</tr>
</tbody>
</table>

**Position Analysis – Day surgery rate**

Day surgery rate decreased to 76.8% due to a predicted decrease in the number of ophthalmology patients being coded as day surgical cases. Specific ophthalmology day case procedures are now (from April 2011) coded as outpatient procedures (they do not take place in theatres), resulting in 60% less ophthalmology procedures being classified as day surgical cases.

**Future Actions**

- Centre chiefs & clinical leads to review and improve current day surgery performance utilising the BADs (British Association of Day Surgery) criteria
- Improve day surgery planning – all lists to be confirmed 4 weeks before hand
- All operations on the Trust’s patient administration system to be reviewed (commencing with RSH General surgery) by Centre and Value Stream Chiefs. Where appropriate, day surgery will be listed as the ‘norm’. Once this process has been completed, TCI forms will be amended accordingly.
## C4. Deliver Services that Offer Safe Evidence-Based Practice

<table>
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<th>Forecast</th>
<th>Level of Confidence in Delivery</th>
<th>Supporting Papers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Director</td>
<td>Fewer Avoidable Deaths</td>
<td>AMBER</td>
<td>AMBER</td>
<td>GREEN Mth 12</td>
<td>3</td>
<td></td>
<td></td>
</tr>
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</table>

### Supporting Measure

<table>
<thead>
<tr>
<th>Measure</th>
<th>Current Performance</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Crude Number of Deaths</td>
<td>The number of deaths in April was 151, this was a reduction of 4 deaths when compared to the same month last year</td>
<td>Data collection commenced in April 2011, the Trust will require 4 months data to identify trend analysis to enable a forecast</td>
<td>N</td>
</tr>
<tr>
<td>HSMR</td>
<td>Rebased YTD: SaTH = 115.1 In Month: SaTH = 111.4 (estimated re-basing) The trend continues down at a faster rate than National index despite a rise at PRH in month.</td>
<td>At present, if the current trend continues we should achieve the target of HSMR below the last reported National index (non rebased) by the end of Quarter 1.</td>
<td>Y</td>
</tr>
</tbody>
</table>
### Exception Report

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

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<td>HSMR</td>
<td>AMBER</td>
<td>GREEN Mth 12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AMBER</td>
<td>3</td>
</tr>
</tbody>
</table>

#### Position Analysis

**Graph – HSMR Monthly Trend (not re-based)**

![Graph showing HSMR Monthly Trend](image)

#### Future Actions/Key Points

- **A reduction of 4 deaths was achieved against the same month last year**
- Reducing crude deaths can only be achieved through clinical improvements (LIPS) and ensuring Patients die at the place of their choice.

- As well as LIPS, a review of deaths for Jan 2011 at PRH is being undertaken by the Consultant Physicians, starting 20 May, 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 compared to the 115 this month.

- The trend continues downwards and for the last 3 months has been around the National index of 100 (not re-based).

- 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 of this will be discussed in the Mortality Group meeting and fed into the Quality and Safety committee for appropriate action.
### C6. Ensure Our Patients Suffer No Avoidable Harm 1 of 2

<table>
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</thead>
<tbody>
<tr>
<td>No. of Patient Safety Incidents</td>
<td>The Trust reported a total of 715 incidents in April. The latest figures (as at March 2011) from NRLS indicated a reporting rate of 4.05% which was between the median and lower quartile for large acute trusts. The Trust had previously had a reporting rate between the median and upper quartile, but a backlog of incidents for processing meant that not all incidents were submitted in time.</td>
<td>A Trust Board Report has identified the previous backlog of incidents and the Action Plan is in place to achieve timely reporting of incidents into the NRLS, a robust RCA process, external reporting and closure. The current rate of datix incidents reflects an improvement within the ‘reporting culture’, work is ongoing with staff to improve RCA and action planning. Future work will include benchmarking to understand how the Trust compares to other trusts.</td>
<td>N</td>
</tr>
<tr>
<td>No of Serious Incidents</td>
<td>In April there were 22 Serious Incidents, all of these incidents are being reviewed and RCAs will be completed in line with the agreed timescales.</td>
<td>In line with the Serious Incidents Policy, each case is being fully investigated with a RCA and Action Plan for Improvement. Action Plans will be implemented following the completion of the RCAs with a process for tracking through agreed improvements.</td>
<td>Y</td>
</tr>
<tr>
<td>No. of inpatient Falls</td>
<td>There were 130 falls in April which is lower than the previous 3 months however 6 of these fall resulted in Serious Harm and are RIDDOR Reportable, these incidents are included in the 22 Serious Incidents above.</td>
<td>The High Impact Actions Group continue to focus on improvements to ensure that effective assessment and preventative measures continue. If current practice continues the Trust is likely to achieve its 5% improvement</td>
<td>N</td>
</tr>
<tr>
<td>No. of grade 3 /4 Pressure Sores</td>
<td>In April the Trust had no Grade 4 Pressure Ulcers and only 1 Grade 3 Pressure Ulcer, this is the first month where improvement has been made.</td>
<td>This is the first month when the Trust has reported less than 2 – 3 pressure ulcers. This is an encouraging start to the Trust achieving its 10% improvement target.</td>
<td>N</td>
</tr>
<tr>
<td>No. of HCAIs</td>
<td>The number of cases in April was as follows: MRSA - 0 C.Diff – 4 cases MSSA - 5 cases E.Coli – 20 cases</td>
<td>For MSSA and E.Coli the Trust does not yet have a clear target or clarification on what should be counted. The Trust is collecting data awaiting further guidance from the DoH.</td>
<td>N</td>
</tr>
<tr>
<td>Supporting Measure</td>
<td>Current Performance</td>
<td>Forecast Performance</td>
<td>Exception Report</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Breaches in Same Sex Accommodation</td>
<td>The trust had 4 Same Sex Accommodation breaches in April at RSH MAU due to extreme pressure of beds and an unusually high % of female admissions. Prior to this there have been no breaches since November 2010.</td>
<td>There has been a significant improvement in delivering same sex accommodation. The breaches in April were disappointing but there remains a positive culture and approach to Same Sex Accommodation and at this moment in time we remain assured we will continue to make improvements.</td>
<td>N</td>
</tr>
</tbody>
</table>
| Cleanliness Score                                      | Overall Domestic Cleanliness Monitoring scores for April were as follows: PRH: 94.60% RSH: 96.36% SATH: 95.51% The target is to maintain a cleanliness score of 92% across the Trust | • Recruitment to posts required to address shortfalls in cleanliness in some areas as identified in budget setting is now underway (This includes the re-instatement of the ‘Deep Clean’ provision)  
• Domestic Cleanliness Monitoring procedure being revised to include discussion and sign off by wards/department staff  
• Monitoring framework under review to accommodate the needs of the new Centres  
• Electronic monitoring system (Credits 4 Cleaning) implementation project near completion with a view to piloting in August 2011  
• Internal PEAT inspections to be reinstated with effect from June 2011 | N                |
| No of Complaints                                       | There was a reduction in complaints in the first month of 2011/12 compared to the previous year where there had been 61 complaints. In the first month of 2011/12 there were 44 new complaints. Of those complaints 27 related to clinical concerns and 9 related to access times. | There was 59 new complaints last year for May and I would anticipate that we will once again seen a reduction in complaints for the next month. In addition there has been a further introduced stage in the complaints process added whereby complex complaints are allocated to a lead nurse to contact the complainant to discuss the concerns and co-ordinate the investigation. | N                |
| No of Drug Errors Resulting in Harm                    | 6 medication incidents were reported via the Datix incident system which resulted in demonstrable harm. | There have been no medication ‘never events’ reported. Omission of anticoagulants account for the largest number of medication errors although direct harm cannot always be demonstrated. | Y                |
EXCEPTION REPORT
C6: Ensure that our patients suffer no avoidable harm – Serious Incidents and Drug Errors

<table>
<thead>
<tr>
<th>Executive Sponsor</th>
<th>Supporting Measure</th>
<th>Status Report</th>
<th>Directors Risk Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Quality and Safety</td>
<td>No. of Serious Incidents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of Serious Incidents</td>
<td>RED</td>
<td>RED</td>
<td>AMBER Q3</td>
</tr>
<tr>
<td>No. if Drug Errors Resulting in Harm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>High Risk Update paper to HEC and Trust Board</td>
</tr>
</tbody>
</table>

Position Analysis
Serious Incidents

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.

Drug Errors Resulting in Harm

A full investigation has commenced for the serious incident that resulted in harm and the Pharmacy Department have sent out an Alert to inform all staff.

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

Drug Errors Resulting Harm

Follow up action has been taken to implement the anticoagulation education programme and extend the anticoagulation prescribing service to PRH in order to reduce the number of incidents reported which involve anticoagulants.

The Serious Incident Review panel has been formed to review the serious incident that resulted in harm and to ensure all systems and processes are improved.