The Shrewsbury and Telford Hospital NHS
NHS Trust

Report to:	Trust Board – 30th May 2013

Enclosure 4

Title	Integrated Performance Report – April 2013
Sponsoring Executive Director	Peter Herring – Chief Executive
Author(s)	Peter Herring – Chief Executive
Purpose	To inform the Trust Board of performance against Key Performance Indicators in the Trust.
Previously considered by	Not applicable

Executive Summary
This report summarises the Trust's performance against all the key quality, finance, compliance, and workforce targets and indicators for 2012-13 and considers all elements of the Provider Management Regime.

Related SATH Objectives	**SATH Sub-Objectives**
A – Financial Strength B – Patients and Commissioner C – Quality and Safety	The report covers a range of organisational sub-objectives in the three strategic domains.

Risk and Assurance Issues (including resilience risks)	Ensuring that we develop robust measures to assess strategic performance will minimise the risk associated with the delivery of our strategies and provide a warning system for the Trust Board where further attention is required.
Equality and Diversity Issues	None
Legal and Regulatory Issues	The national standards, CQC and local contractual requirements will form part of the performance framework.

Action required by the Trust Board
The Trust Board is asked to **CONSIDER** performance for April 2013.

Enclosure 4

Trust Board

Integrated Performance Report – Month 1 2013/14

1 Overview of Performance

1.1 This Integrated Performance report provides an overview of key quality, operational, financial and workforce performance indicators from which the Board can review any variances to the required performance and identify the actions being pursued to ensure on-going improvements.

2 Regulatory Requirements

2.1 The Care Quality Commission provides a regulatory overview of all the required outcome measures for which we are registered. Last month's Trust Board papers set out the outcomes of four different reviews which provided positive assurance. The Trust liaises regularly with CQC to ensure they are updated on any care related issues of concern.

3 Quality: Patient Safety, Effectiveness and Patient Experience

3.1 The report provides high level metrics and gives members an overview of patient safety, clinical effectiveness and patient experience. The report also contains key information relating to clinical care metrics where performance is not meeting the required standard of good practice.

Table 1

Measure		Standard 2013/14	Year End 2012/13	April 2013
	Risk Adjusted Mortality Index (RAMI)	<100	94	Not yet Available
	RIDDOR reportable Falls (20% reduction)	< 15	20	4
	Grade 3 Pressure Ulcer	0	28	3
	Grade 4 Pressure Ulcer	0	13	0
	C-Diff	27	45	1
	MRSA Bacteraemias	0	1	0
	MSSA Bacteraemia	21	24	3
	E-Coli	40	45	5
	Elective MRSA Screening	95%	N/A	93.7%
	Non Elective MRSA Screening	95%	N/A	94%
	Number of Serious Incidents	<36 per Quarter	174	31
	Never Events	0	2	0
	WHO Surgical Checklist	100%	99.96%	100%
	VTE Assessment	95%	90.48%	90.10% (Mar)

	Maternity Dashboard	Green		Amber
Patient experience	Number of patient complaints	actual	671	55
	Access to Healthcare for people with LD	Yes		Yes
	Same Sex Accommodation Breaches	0	0	0

A summary of patient outcome measures agreed for the Board are outlined in Table 1 above. Additional patient specific metrics are outlined in Table 8 and 9 of this paper. These metrics provide the patient experience and outcomes chosen to monitor the impact of care provided for the patient. Where key performance Indicators are amber or red the key summary points for the Boards attention are as follows:

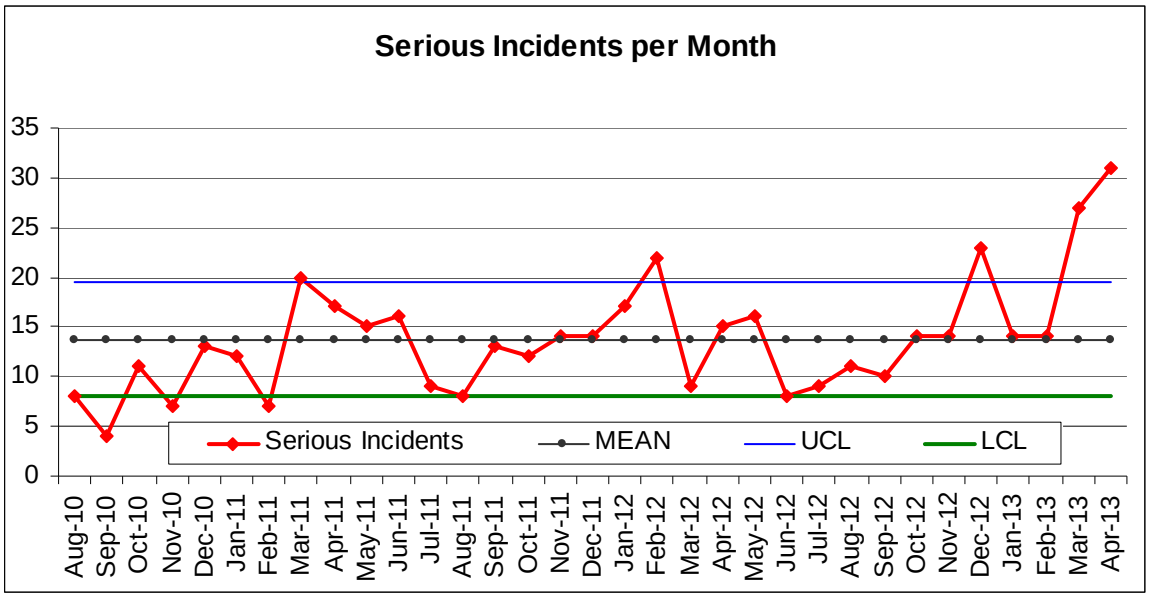
Patient Safety and Effectiveness

3.2 Serious Untoward Incidents

There were 31 SI's reported for April 2013. This is an increase of incidents compared to March (28) and more than double compared to the same reporting period for 2012/13. Of the SI's, 14 were related to clinical effectiveness with the remaining 17 SI's being Operational in nature. The peak of Serious Incident activity in April 2013 is reflective of the demand and capacity issues within the Trust. Details of operational performance are discussed further within the report. The highest reporters of SI for the month were Emergency Care. 16 of their 18 SI's were 12 hour trolley beaches.

The Board are aware of the Emergency Department remedial action plan to improve capacity and flow. The Board paper on Emergency Dept patient experience in May provides some assurance following the concerns regarding long trolley waits in April. A further case note review undertaken on the 16th May 2013 has provided additional positive assurance in relation to the safety of those patients whilst under our care.

Table 2



3.3 Pressure ulcers

There were 3 Grade (3) pressure ulcers reported in April, and 0 Grade 4's. While this is a reduction in numbers from March, it is highlighted as red as this is a variance to the zero target established and agreed by the Board.

However, on initial review, it would appear that 2 of the 3 may be unavoidable and subject to review and sign off by the Board. The Trust has appointed 2 new Tissue Viability nurses who have commenced in post in April 2013. These roles will support ongoing education and training of staff and the reduction of pressure damage. The Trust wide action plan for eradicating pressure ulcers is being led by the Associate Director of Patient Safety and stringent performance measures being led by the Chief Nurse and corporate nursing team to ensure current care is meeting requirements. Quality ward rounds are being carried out from May 2013.

A Pressure Ulcer Prevention group has been established with the aims of sharing best practice and enhancing clinical practice to support pressure ulcer prevention. The group will also review all RCA actions for pressure ulcer prevention to ensure that patient outcomes improve.

3.4 Falls

There were 133 falls reported in April 2013 compared to 108 reported within April 2012. These figures include all adult inpatient falls however exclude spontaneous fits/ faints/ collapses, staff assisted guided falls, and falls from low beds to crash mats. Of the 133 falls 4 were RIDDOR reportable and related to fractures or dislocation sustained as result of the fall.

Table 3 gives a comparison to the 12/13 position whereby the Trust reported approximately 130 per month. Using the M1 3013/14 position as a trend assumption this indicates a potential increase in falls per month for 2013/14. The Associate Director for Patient Safety is leading a task group to reduce falls within the Trust.

2 falls occurred in 22S, one on Ward 32E and the other on Ward 12E. This may relate to where patients are being cared for in escalation areas. However, each area has a post falls meeting to review the incident to ensure remedial actions are appropriate and timely and to ensure that all aspects of the incident are reviewed in order to support the RCA process including implementation of RCA action plans.

Table 3

Year	Number of falls	RIDDOR Reportable
2012/13	1562	20
2013/14 (April 2013)	133	4

3.5 Infection Control

C –Difficile

A separate Board paper is presented within the Board papers which outlines the actions to ensure achievement of the reduced trajectory in 2013/14. In month this is on target as is MRSA Bacteremia. A 20% internal reduction has been agreed for the MSSA and E-Coli Infections. This is subject to sign off by the STIPCC Committee but agreed with the DIPC.

The Cdiff Improvement Plan forms part of an overarching strategy across the local health community including all NHS Providers, Clinical Commissioning Groups, their member Practices and the Independent Care Sector.

Clostridium difficile reduction targets are set nationally for acute trusts and for 2013 the Trust is required to reduce the incidence of CDiff by 40% giving a target of 27 compared to 45 in 2012/13.

MRSA Screening – Emergency and elective Admissions

Compliance in both emergency and elective admission screening for MRSA remains below 95%. This is critically important in preventing MRSA acquisition and MRSA bacteraemia so we need this performance to improve. Emergency admission screening is particularly effective in reducing MRSA bacteraemia. We are now sending lists of patients with missed screens at 48 hours post admissions to all wards but we are still seeing patients unscreened over a week after they have been admitted. All centres need to take responsibility for ensuring patients are screened but this particularly falls on Emergency and Critical Care. Specific discussions to improve performance have taken place with Head & Neck, pre-operative assessments and the CDC. TAMU reported a number of missed emergency screens by agency staff; the Ward Manager will address this with these staff if they work in the Trust again. This will also be addressed with current substantive staff. SAMU are looking into setting up packs with MRSA screens to make it screening easier for staff.

3.6 Current Status – Mortality

SaTH uses 3 mortality indicators to monitor changes in mortality; an update on each is given below.

Summary Hospital-level Mortality Indicator (SHMI)

The principle national measure for mortality is now the Summary Hospital-level Mortality Indicator (SHMI). The principle difference between SHMI and other mortality indicators is that it includes deaths in the community within 30 days of discharge.

The latest release – year ending Sept 2012 shows a sharp drop to 105.27 reflecting continued improvements in our mortality rates during this period. Despite this significant drop the rate is still above the national index of 100, although it is well within expected range. A review of the deaths recorded in SHMI, focusing on deaths within 30 days of discharge, will take place shortly under the direction of the newly formed Formal Mortality Group

The table below shows the rolling 12 months trend in SHMI.

Table 4

Summary Hospital-Level Mortality Indicator (SHMI - Rolling 12 months)							
Measure	**Apr 10 - Mar 11**	**Jul 10-Jun 11**	**Oct 10 - Sept 11**	**Jan 11 - Dec 11**	**Apr 11 - Mar 12**	**Jul 11 - Jun 12**	**Oct 11 - Sept 12**
SHMI	111.21	110.51	108.85	107.53	106.68	106.64	105.27

Risk Adjusted Mortality Indicator (RAMI)

We have transferred from Dr Foster to the CHKS reporting tool as of April 2013. The CHKS tool uses a different methodology for reporting mortality called Risk Adjusted Mortality Indicator (RAMI). The RAMI is similar to the HSMR in that it can be used to benchmark progress against other organisations; however RAMI and HSMR should not be compared to each other as they are very different measures. The main differences are:

- HSMR uses a group of 56 diagnosis codes and RAMI includes many more diagnosis codes
- RAMI excludes Patients coded as palliative care where as HSMR includes them

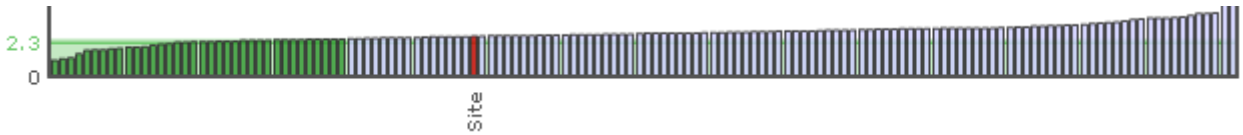
The data for April is not yet available but the position for 2012/ 13 was an index figures of 94.

Crude Death Rate as a Percentage of Spells

The crude death rate is simply the number of people that die at SaTH; it takes no account of the clinical condition, age or any other factor affecting mortality. It is best measured against the number of hospital Patient spells and is used mainly as a supporting indicator to the SHMI and RAMI models.

The graph below gives an indication of the current rate of mortality as a percentage of hospital Patient spells benchmarked against the National Peer group of all acute trusts in England.

Graph showing: Emergency Patient deaths as a percentage of spells for April 2012 – Jan 2013 benchmarked against all acute Trusts in England.



Site = Shrewsbury & Telford Hospitals Trust at 2.8% of spells
Trusts highlighted in green = top quartile 2.3% or less
Highest = 5.2% of spells

Mortality Group

The first meeting of the formal Mortality Group took place on 30th April 2013. The initial focus of the mortality group was agreed as:

- 100% review of deaths with the intention of having a consistent outcome measure for scoring – this is proposed as CESDI
- Review of deaths post discharge as part of the SHMI analysis

VTE

The rate of reported VTE assessments across the Trust for March 2013 is 90.10%. The VitalPAC assessment rate trend for April 2013 is 78% against a VTE assessment target at 95% from April onwards.

VTE Assessment Compliance

The CQUIN rate for VTE in 2013/14 is being raised to 95%. So far this rate has not been achieved by the Trust and will require a step change in processes to enable it to be achieved. VTE is being reflected on the PSAG boards in each ward from 15th April to enable VTE assessments to be fully integrated into the board/ward rounds each day.

Table 6

	VTE Monthly Report 2012/13											
Recording Month	Apr 12/13	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan-12	Feb	Mar
Assessment Monthly Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
Monthly Progress	90.05%	91.72%	90.12%	90.15%	90.03%	90.78%	90.42%	90.37%	90.12%	91.06%	90.03%	90.10%

3.8 Patient Experience and Outcomes

Table 7& 8 provide a Board level overview of a range of patient outcome measures and these are reviewed in a more granular manner at Clinical Centre and ward level to determine specific actions for improvement. The Board will note that further work is required to improve the performance of patient observations and nutrition whilst a slight improvement is noted with fluid management.

The real time patient feedback process continues on each ward every month and this continues to highlight required improvements in discharge arrangements. The Chief Nurse and Chief Operating officer are working together to develop a composite measure for monitoring discharge arrangements in detail and this will be included in the Board reports from early 13/14.

Significant work is required to ensure that this area improves over the next few months. An increasing number of referrals relating to discharge arrangements have been made in March through the vulnerable adult safeguarding process, this has significantly reduced in April. Whilst not all of these have been substantiated, the need for careful planning and documentation relating to all aspects of discharge arrangements are being discussed with matrons and Ward Managers. The Chief Nurse is working with other agencies to review the rise in referrals and a task and Finish group will report back to the Adult Safeguarding Board with recommendations.

The real time patient feedback is disappointing with the overall score which has stayed down and particularly linked to:

- Privacy when discussing treatment or care
- Involvement of patient in their care
- Patients being able to discuss worries or concerns

Further discussions with Matrons and ward managers are planned in May to discuss improvements and support for patients.

3.9 External feedback and Assurance

In April 2013, one unannounced visit was made to the Emergency Department in the Princess Royal Hospital. A report has been received and responded to with mainly positive experience.

Table 7: Ward to Board Patient Care Metrics for April 2012 – April 2013

	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Apr 2013
Medication Storage and Administration	97%	98%	99%	96%	97%	96%	97%	99%	98%	98%	95%	97%	97%
Infection Control and Privacy & Dignity	91%	95%	96%	94%	94%	93%	93%	96%	95%	94%	95%	96%	98%
Patient Observations	84%	83%	87%	85%	86%	90%	86%	95%	90%	89%	89%	86%	84%
Pain Management	84%	87%	91%	91%	92%	88%	90%	93%	92%	93%	93%	93%	91%
Tissue Viability	91%	90%	89%	87%	91%	91%	94%	95%	96%	93%	92%	92%	93%
Nutrition	91%	92%	91%	90%	90%	95%	94%	95%	92%	91%	91%	85%	89%
Fluid Management													

	85%	87%	82%	85%	80%	90%	93%	90%	85%	87%	83%	85%	86%
Falls assessment	98%	96%	98%	97%	98%	96%	98%	99%	98%	97%	95%	94%	94%
Continence	97%	93%	88%	93%	93%	97%	97%	98%	95%	96%	96%	96%	97%
Comfort Rounds				83%	92%	90%	94%	93%	93%	90%	90%	94%	94%
Total	91%	92%	92%	91%	92%	92%	94%	95%	94%	93%	92%	92%	93%

Table 8: Ward to Board Patient Experience Metrics for April 2012 – April 2013

	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Apr 2013
How clean is this ward (including toilets)?	95%	95%	95%	95%	96%	96%	96%	97%	97%	97%	98%	95%	96%
As far as you know do the staff wash or clean their hands between touching patients?	95%	92%	95%	94%	96%	96%	96%	97%	96%	96%	98%	97%	97%
Do you feel informed about potential medication side effects?	46%	57%	65%	65%	72%	64%	72%	83%	76%	86%	82%	75%	72%
Do you feel you have enough privacy when discussing your condition or treatment with staff?	88%	89%	85%	83%	86%	85%	86%	91%	91%	87%	93%	86%	84%
Do you feel that you have been treated with respect and dignity while you are on this ward?	91%	95%	98%	93%	95%	94%	95%	96%	97%	95%	97%	97%	94%
Do you feel involved in decisions about your treatment and care?	80%	83%	77%	78%	77%	79%	84%	89%	86%	87%	89%	84%	81%
Have hospital staff been available to talk about any worries or concerns you have?	82%	92%	90%	90%	86%	91%	93%	93%	90%	89%	92%	87%	89%
Do you get enough help from staff to eat your meals?	92%	90%	98%	87%	90%	95%	98%	95%	92%	85%	99%	92%	97%
Whilst you have been on this ward have you ever shared a sleeping area with a member of the opposite sex?	100%	96%	98%	99%	99%	97%	97%	98%	99%	97%	100%	98%	96%
Do you think hospital staff do everything they can to help control your pain?	89%	93%	89%	90%	89%	87%	93%	95%	92%	90%	96%	91%	91%
When you use the call buzzer is it answered?	88%	93%	89%	87%	90%	90%	87%	91%	90%	89%	91%	90%	90%
Have staff talked to you about your discharge from hospital?	64%	74%	63%	65%	68%	68%	64%	71%	72%	75%	73%	69%	68%
Total	83%	87%	86%	86%	87%	86%	88%	91%	90%	90%	92%	88%	87%

4 Operational Performance

Emergency Access Target

4.1 The Trust failed to achieve the 95% target in April 2013 with 86.67% for the month, giving a year to date position of 86.67%.

Factors contributing to affect performance are:

- Pressure remained constant during the month of April with the number of ED attenders remaining high for the third month running; an average of 306 attendances a day in April compared with 307 a day in February. Total attendances for April reporting period 8600.
- An increase in the number of non-elective admissions – this average also follows a similar pattern of increases.

    - Jan 3829 Ave 123 a day
    - Feb 3585 Ave 129 a day
    - March 4153 Ave 133 a day
    - April 4403 Ave 146 a day

- A significant cohort of patients who are fit to transfer but remain in a hospital bed, RSH are still averaging at over 50 patients a day. There was also an increase in Powys patients, even though small in number, they add to long delays whilst waiting to transfer.
- A lack of available capacity (beds to meet expected demand); this has subsequently been reduced by the ward reconfiguration at the end of April .
- During April SaTH and its community endured a sizeable Influenza type A outbreak up until 25th April 2013. This is unusually late in the winter and patients affected aged 70 years or over had a mean average inpatient stay of 8-12 days.

The patient flow action plan has begun to address some of the internal performance issues. The first of these actions were implemented at the end of April, so no improvements were felt during the month of April. We are however now seeing improvements in performance and would expect to achieve 95% in May. I am pleased to report that over the last 3 weeks 4 hour performance has improved and we have delivered the 4 hour target for two consecutive weeks. This is summarised in the table below.

Week Ending	PRH	RSH	SaTH
28/04/2013	93.84%	82.89%	89.88%
05/05/2013	97.45%	89.29%	94.20%
12/05/2013	98.53%	92.31%	95.96%
19/05/2013	97.65%	95.32%	96.76%

4.2 During the month of April; 16 patients breached the 12 hour trolley wait standard on the RSH site all due to significant capacity challenges on the days in question. A major incident was called on Tuesday 9th April 2013 to support the Trust due to the number of 12 hour breaches, overcrowding of the emergency department and the Royal Shrewsbury site. This resulted in a whole health economy focused response, and allowed us on the day to match the demand. There were no immediate patient safety concerns whilst the patients were in the emergency department. RCA's were completed and an investigative meeting took place on Monday 22nd April attended by the CCG Director of Nursing.

4.3 Following the whole system review of the urgent care system in Shropshire, Telford & Wrekin, five high impact projects have been agreed and are due to delivery by the end of September 2013.

4.4 As part of the patient flow action plan presented to Trust Board last month, the reconfiguration of the AMU/SAU and additional ward swaps has been completed.

This is now bedding in and we are already beginning to see some short term benefits around Right Patient Right Bed First Time, with a reduction in multiple moves of patients and an improvement in performance of the A&E 4 hour target.

These enabling actions will fully support the further actions in the plan over the coming months and will ensure that as a Trust we continue to improve patient quality and safety within the assessment units and ensure delivery of the 4 hour target.

4.5 A future structure of Medical, Nursing and Management has been agreed within the Unscheduled Care Group. This new structure will further support quality outcomes and will enable true leadership accountability and ownership to be held at the correct level, providing further improvements to patient quality.

Scheduled Care Access Targets

4.6 18 weeks Referral to Treatment Target (RTT) – Admitted

The Trust failed the RTT target for Admitted patients with 73.92 against the 90% target in March.

The Trust has again failed to deliver the admitted pathway for 18 weeks RTT. This was as a result of the day case unit being used as an escalation area and therefore any routine elective day cases were cancelled. The day ward reconfiguration has now taken place and since May 3rd 2013, we have not cancelled any day surgery due to bed capacity.

4.7 Each centre has constructed a recovery plan which details when the specialty will be sustainable. All specialties will deliver 18 weeks RTT from 1st July 2013, with the following exceptions:

- Orthopaedics – will deliver 18 Weeks from 1st November 2013;
- Urology – will deliver 18 Weeks from 1st October 2013.

Remedial Action Plans (RAP) are in place for the above specialties and will be monitored via the weekly RTT meetings with the CCGs.

4.8 18 weeks Referral to Treatment Target (RTT) – Non Admitted

The Trust achieved the RTT target for Non Admitted patients with 95.51% against the 95% target in April.

- Dermatology failed the target in April but is on track to deliver in May;
- Ophthalmology and Plastic surgery marginally failed the target but will be sustainable from July;
- The specialty 'other' which includes orthodontics failed the target in April.

Each Centre has completed a demand and capacity model, which details their current capacity and how it is used together with an analysis of demand. This tool will be used to monitor 18 week performance and also the expenditure on waiting list sessions.

4.9 18 weeks Referral to Treatment Target (RTT) – Incompletes

The target for incomplete pathways is that we should have no more than 8% of patients waiting over 18 weeks for treatment, currently our performance is 10.95%. This performance will improve from quarter 2.

4.10 Cancer

The unvalidated position for April 2013 shows that we failed to deliver four of the nine standard cancer targets.

1) 2 week wait was due to the cancellations of breast outpatients on the day of the major incident;
2) 31 day subsequent treatment (anti-cancer drug) was due to a lost script and the illness of a patient;
3) 31 day surgery was due to cancellations due to no beds on the day of the major incident
4) 62 day traditional target was due to waits for diagnostics and complex surgery.

A cancer action plan is in place to ensure delivery of the standards from July and reduce the inconsistency in performance.

We are also introducing a tracking and reporting process for patients waiting 62-84 days, 85-99 days and patients over 100 days. For patients waiting over 100 days there is, in general, a clinical reason for this. The focus in particular, will be those patients in the 62-84 day category who have breached due to poor processes.

The table below summarises the in month Performance for each Cancer target.

4.11

	Measure	2013/14 Standard	M1 Apr-13
Cancer	2 Week GP referral to 1st OP Appointment	93%	92.17%
	2 Week GP to 1st OP Appointment Breast Symptoms	93%	93.17%
	31 day diagnosis to treatment	96%	94.74%
	31 day second or subsequent treatment - Drug	98%	96.67%
	31 day second or subsequent treatment - Surgery	94%	95.65%
	31 day second or subsequent treatment - Radiotherapy	94%	96.67%
	62 days urgent referral to treatment	85%	73.00%
	62 days referral to treatment from Screening	90%	100.00%
	62 days referral to treatment from Hospital Specialist	85%	100.00%

4.12 Cancelled Operations

There were 265 cancelled operations in April 2013, of which 53 will need to be readmitted with 28 days, as a result of increased levels of escalation on the day surgical unit. There were 12 patients that were not readmitted within their 28 day standard, after being cancelled in March. Centres have been reminded off the importance of this target and further validation is taking place within each Centre.

4.13 Booking & Scheduling

There are significant challenges within the Booking and scheduling service at present and therefore a Task and Finish group has been established to improve the following areas:

- Clinic templates and codes
- Letters to patients
- IT developments within outpatients and day surgery
- Choose & Book

We are failing to achieve the Choose and Book target in April, 95% of patients should be able to book an appointment using the choose and book system. At present our performance is at 55%, which is significantly below the national target. A meeting has been set up with the CCGs and relevant Centre managers to understand and improve this position from July.

5 Finance

Finance Performance Summary – Month 1

Measure		Standard	Quarterly Method	2012/13 Q1	2012/13 Q2	2012/13 Q3	2012/13 Q4	Data Period	Period Actual	YTD
Finance	PMR Finance Risk Rating	4	Q YTD	2	2	2	2	Mar-13	2	2
	EBITDA Achieved	85%	Q YTD	84.20%	88%	98%	87.81%	Mar-13	52.80%	52.80%
	EBITDA Margin	5%	Q YTD	2.8%	4%	4.7%	4.6%	Mar-13	-3.0%	-3.0%
	I&E Surplus Margin	1%	Q YTD	-1.90%	-0.50%	0.00%	0.03%	Mar-13	-7.85%	-7.85%
	Return on Assets	5%	Q YTD	0.03%	1.20%	2.60%	3.30%	Mar-13	-0.85%	-0.85%
	Liquidity ratio	15 days	Q YTD	13.5	14.4	12.9	13.3	Mar-13		14.2
	Total Income (actual v plan)	0.5% of plan	Q YTD	99.6%	99.6%	99.90%	99.73%	Mar-13	100.00%	100.00%
	Pay Expenditure (actual v plan)	At or below plan	Q YTD	101%	102.40%	99.90%	100.27%	Mar-13	104.75%	104.75%
	Non Pay Expenditure (actual v plan)	At or below plan	Q YTD	98.04%	95.20%	100.3%	101.03%	Mar-13	98.69%	98.69%
	CIP (actual v plan)	At or below plan	Q YTD	100%	74%	98.00%	100.00%	Mar-13	42.60%	42.60%
	Capital Expenditure (actual v plan)	At or below plan	Q YTD	13%	38%	59.00%	68.00%	Mar-13	4.00%	4.00%

5.1 Budgetary movements

Since authorising the 2013/14 budget at the March Trust Board meeting, a series of budgetary alterations have occurred, these are summarised below.

	Budget Approved March 2013	*Alterations*	*Revised Budget*
Income	303,427	(3,345)	300,083
Expenditure			
Pay	(208,000)	124	(207,876)
Non Pay	(91,499)	(339)	(91,839)
Reserves	-	-	
Cost Improvement Programme	11,875	-	11,875
Total Expenditure	(287,624)	(215)	(287,839)
EBITDA	15,803	60	15,863
Dividends and Amortisation	(14,602)	(69)	(14,671)
Surplus / (Deficit)	1,201	(3,629)	(2,428)

5.1.1 Income changes

Since the March Trust Board, the Trust has reached agreement over the value of the 2013/14 contracts with the two local commissioners and the National Commissioning Board (NCB). The profile of Trust Budgeted Income for the 2013/14 year has therefore been revised as follows:

	Shropshire County	*Telford and Wrekin*	*Powys Health Board*	*NCB (Specialised Services)*	*Other CCG*	*Other Clinical*	*Non Clinical Income*	*Income CIP*	*Income Risk*	*Total*
Approved Budget	**136,217**	**94,583**	**21,585**	**15,680**	**9,555**	**3,978**	**20,829**	**1,000**		**303,427**
Contract Settlement	**331**	**(358)**	**871**	**(69)**	**239**	**-**	**(739)**	**-**	**(3,620)**	**(3,345)**
Transfer to NCB	**(16,444)**	**(10,053)**	**-**	**27,501**	**(1,004)**	**-**	**-**	**-**		**-**
Revised Income Profile	**120,104**	**84,172**	**22,456**	**43,112**	**8,790**	**3,978**	**20,090**	**1,000**	**(3,620)**	**300,083**

Key observations from the above are:

- Emergency Threshold – Contained within the contract values for Shropshire County CCG and Telford and Wrekin CCG is an Emergency Threshold against which, when activity levels for emergency exceed the Threshold payment is based upon 30 per cent of Tariff. This provides a gain to Shropshire County CCG of £460,000 and £1.75 million to Telford and Wrekin CCG.

- QIPP – In agreeing the contract with the two local CCG's, it was accepted that the risk of the CCG QIPP programme would be held by the CCG's. The value of QIPP for Shropshire County CCG amounts to £3.8 million and £2.5 million for Telford and Wrekin CCG.

- Specialised Services – The value of services commissioned by the NCB and transferred from the CCG's amounts to £27.5 million. This transfer when added to the value of specialised service contracts in the 2012/13 year increases the value of the specialised services contract to £43.112 million in 2013/14.

5.1.2 Expenditure Changes

Danwood Printing scheme - The principal budgetary change effected since approving the budget for 2013/14 has been to increase Non Pay budgets by £280,000 in recognition of an on going contractual issue with Danwood suppliers of printing materials to the Trust. This scheme set up as a Cost Improvement Programme opportunity in the 2009/10 year, aimed at reducing costs through the introduction of improved Printing capability and control over printing activities has exceeded contract values significantly over the last three years.

5.2 *Pay Expenditure*

- In the month of April Pay spending increased to £17.591 million. The budget for the month of April, excluding the expected impact of the Trust 2013/14 Cost Improvement Programme, amounted to £17.193 million. Allowing for savings associated with the CIP reduces the available budget by a £400,000. Accordingly, in the month of April the Pay budget has overspent by £798,000.

The average level of monthly Pay budget for the period May 2013 to March 2014 now amounts to £17.262

million, after allowing for the achievement of Cost Improvement savings in the year the level of average monthly Pay budget reduces to £16.456 million.

Immediately this then emphasises the need for the:

- Increased costs incurred in the month of April to be brought back to budgeted levels; and
- Pay savings as contained within the Cost Improvement Programme to be achieved in full

An Analysis of pay spending has identified that:

- The number of staff employed within the Trust increased from the November 2012 levels by 142.12 WTE posts
- During the period November 2012 to April 2013 the number of employed nursing staff increased by 125.63 WTE posts
- Since November the number of Trust permanently employed Nursing staff has increased by 48.87 posts, and at the same time the number of temporary Nursing staff increased by 76.76 posts.
- In the month of April the number of Permanent and Temporary Nursing staff employed by the Trust exceeded budgeted levels by 140.84 WTE posts.
- Agency spending has increased from an average of £855,000 per month during the period June – September 2012 to £1.239 million in April 2013
- The level of Agency Nursing spending increased from £232,000 in September 2012 to £504,000 in April 2013.

Achievement of the Trust forecast Outturn is dependant upon the Trust reducing pay spending to budgeted levels and also delivering upon the Pay elements of the Cost Improvement Programme

5.3 *Non Pay*

The budget for the month of April (before allowing for CIP) assumed spending at a rate of £7.289 million, in the month the actual level of spending amounted to £7.084 million. In the month of April the Cost Improvement Programme is targeted to deliver non pay savings in the month of £111,000. Adjusting for the CIP savings, results in a Non Pay underspend in April of £94,000.

In setting the budget for the year the Trust is now assuming Non Pay spending, before the application of CIP, at a rate of £7.541 per month over the period May - March. Discounting for the achievement of CIP, and the level of available Non Pay budget per month over the period May 2013 to April 2014 is £7.26 million

5.1 Capital Programme

The position in respect of the Capital programme is presented in the table below.

Scheme	2013/14 Capital Budget £000's	2013/14 Spend to date £000's	Forecast Outturn £000's	Variance (under)/ over spend £000's
Reconfiguration	20,630	21	20,630	0
Patient Monitoring equipment	350	0	350	0
LINAC Installation works	69	0	69	0
Enabling work to implement Gender Separation	332	0	332	0
Path lab Reconfiguration	400	0	400	0
Solution re non-closure of beds to enable Recon	300	0	300	0
Other Capital Schemes	3,009	5	3,009	0
Capital contingencies	3,990	18	3,990	0
Total Discretionary Capital Schemes	8,450	23	8,450	0
Total including reconfiguration	29,080	44	29,080	0

Further to approval at Trust Board of the Capital Programme, the Internally Generated CRL is set at £8,450k. In light of changes to the way the Trust intends to deliver Project 2 of the Reconfiguration Project (FCHS) and a final submission of Plan for 2013/14, there has been a rephasing of expenditure and thus PDC drawdown over 2013/14 and 2014/15 financial years.

The CRL for 2013/14 in respect of Reconfiguration is now £20,630k in 2013/14, giving a total CRL of:

- £8,450k Internally Generated CRL
- £20,630k PDC Future Configuration of Hospital Services
- £29,080k CRL
-

5.5 Cash flow

The cash flow describes the activities being planned to enable the Trust to successfully achieve its External Financing Limit for the year and in so doing conclude the year with a cash balance of £3,400k.

Key observations from the April cash flow statement are as follows:

- A balance of £4,741k is held at the end of April due to payment for Linear Accelerator to be made in May £2,129k; additional income received in respect of changes in Commissioning bodies £986k (will be repayable); requirement to maintain a cash balance c£1,000k. Income of £626k was received on 30 April which had not been forecast and therefore could not be spent.
- Capital Spending (excluding Reconfiguration) – It has been assumed that the level of cash payments in respect of Capital creditors in 2013/14 will be in line with the Trust's CRL of £8,450k.
- PDC Receipts – It is anticipated that the Trust will make cash payments in respect of the Reconfiguration project amounting to £19,832k. It is planned that the level of PDC to be drawn down will match this. During April payments were less than forecast and no PDC draw down was made due to the requirement to align expenditure over financial years.

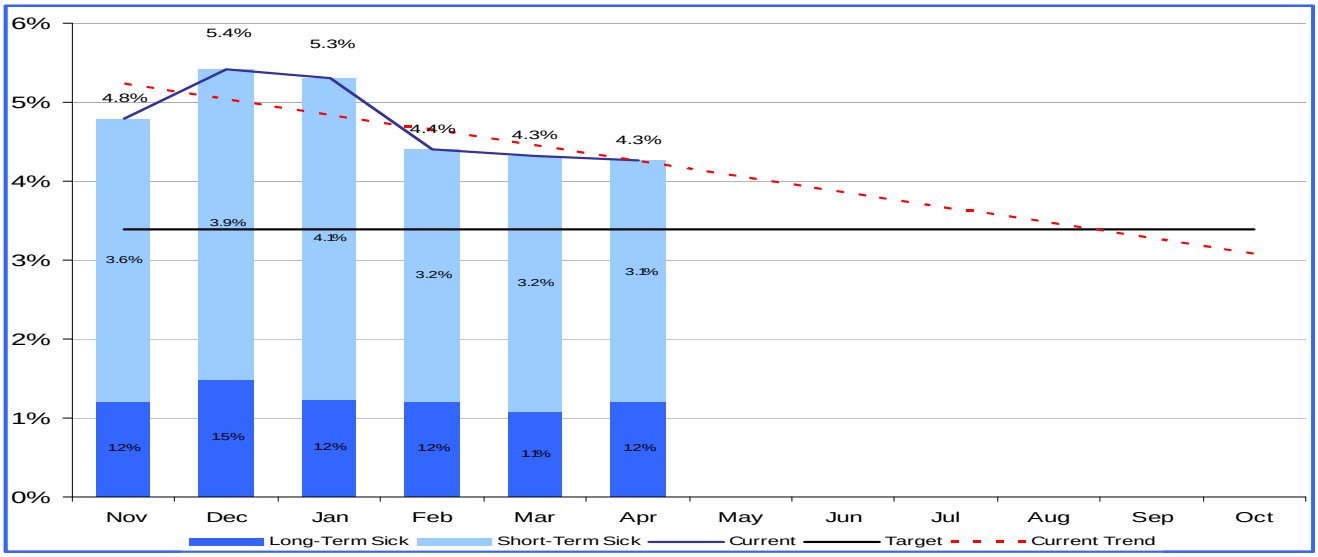
- Cash movement – The Trust is required to increase cash balances by £1,200k, in line with forecast surplus in 2013/14 Income and Expenditure.

- Creditor suppression – It was necessary to suppress creditor payments at the end of April by £1,713k., this being necessary because of the existence of a planned Income and Expenditure deficit in the month of April.

6 Workforce

6.1 Sickness Absence

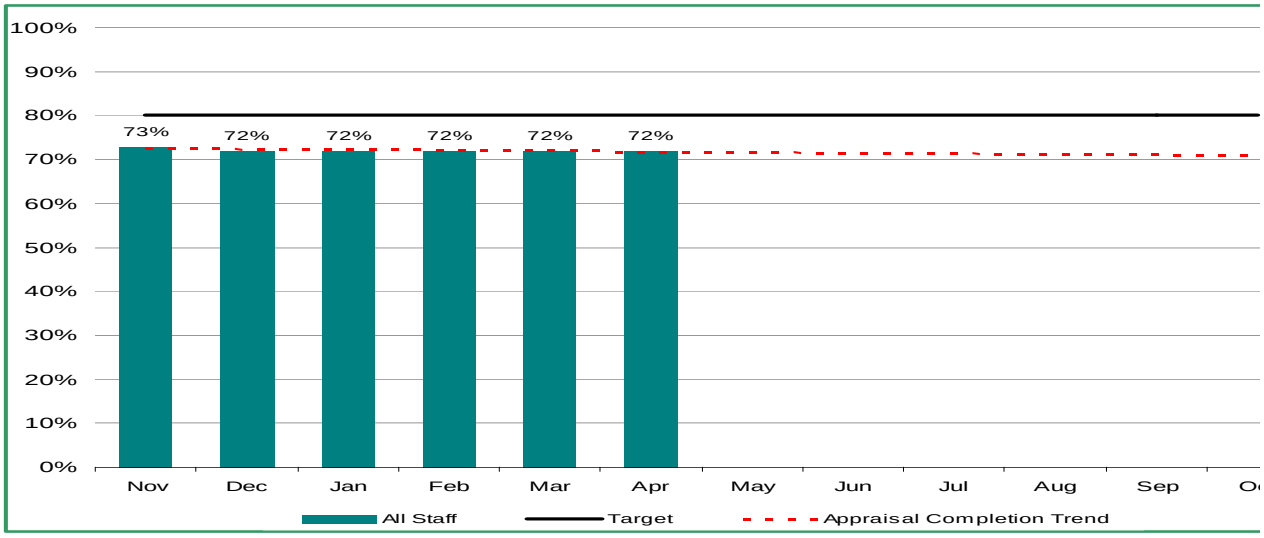
Absence remains at 4.32% which is close to a 20% reduction in absence since January. The organisation has developed a Health and Wellbeing plan which ensures that a reduction continues and is sustainable. A review of Occupational Health Services will provide additional support to staff and managers. Whilst it is encouraging to see absence falling the cost and impact of absence remains significant as just over £400k was paid during the month to staff not attending work due to sickness. Psychiatric illness continues to be the most common reason for absence at 14% and the highest absence levels being seen amongst the Estates and Ancillary workforce



6.2 Appraisals

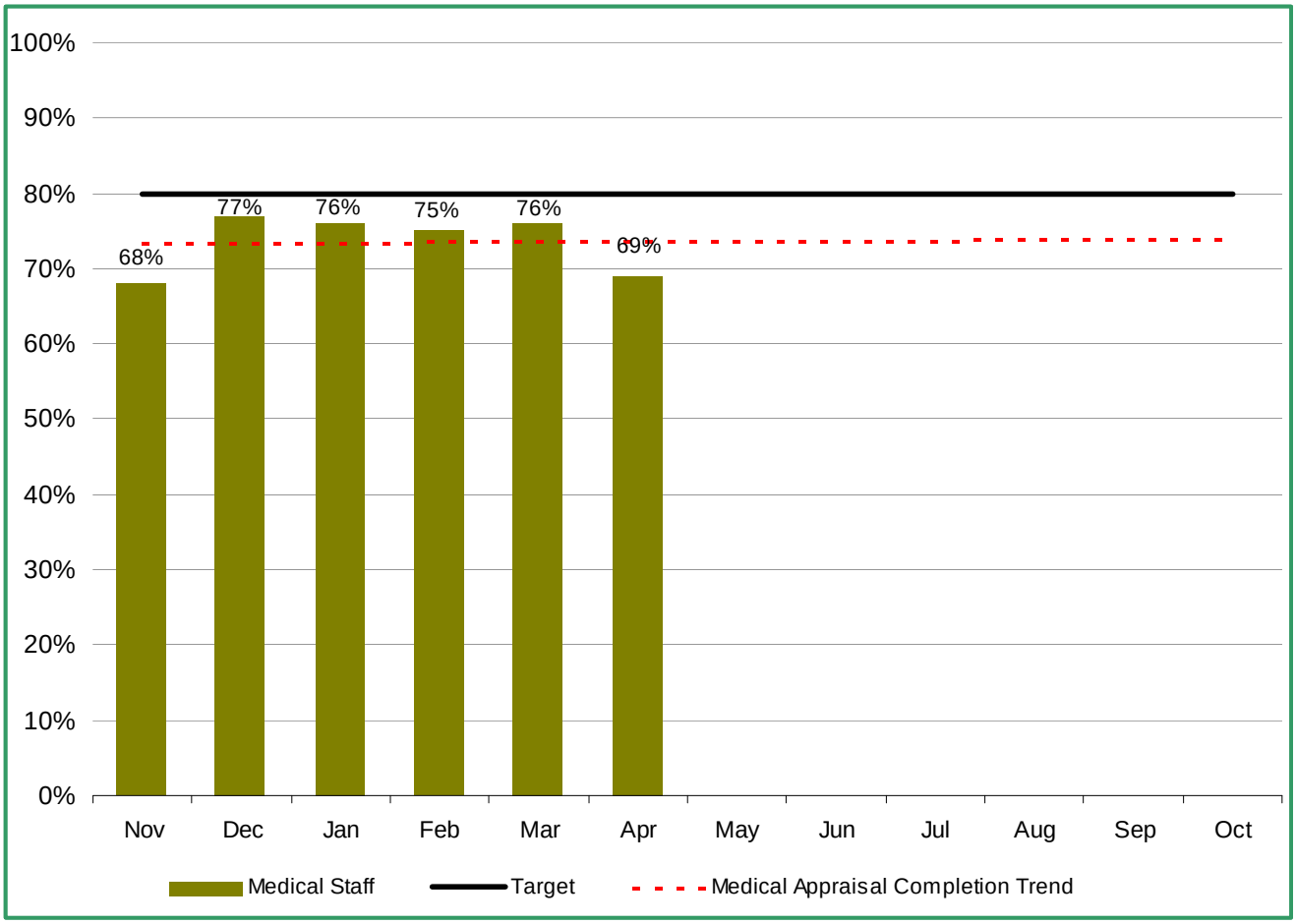
Non-medical staff appraisal rates continue at 72%, which is below our 80% target. A clear focus on appraisals will be given over the forthcoming months; an appraisal is an important aspect of employment. Achievement of appraisals will be monitored through the Operational Performance Group led by the Chief Operating Officer

Non Medical Appraisal Coverage



Medical staff appraisal rates have fallen to 76% from 69% in April. This overall figure is an average of consultant and non-consultant appraisal. The Medical Director is leading on completion of medical appraisals and is developing a clear approach to achieving higher coverage.

Medical Appraisal Coverage



7. Monthly self-certifications – NTDA requirement

The NTDA have introduced a new mandatory requirement for monthly self certifications in relation to the FT application process. The Trust has submitted self certification templates in May covering the month of April relating to:

1. Monitor Licensing Requirements – covering Monitor licence requirements. A summary of the submission is included at Appendix 2
2. Trust Board Statements – covering a number of Board statements. A summary of the submission is included at Appendix 3

For each statement, the Trust has to declare 'Yes' (compliant), or 'No' (not compliant) or 'Risk' (of non-compliance). For areas of non-compliance, or risk of non-compliance a short commentary is required along with a timescale for completion of actions. The timescale for submission each month is around the middle of the month. A third form relating to Progress Towards FT Status is in development by the NTDA and will be issued later in the year.

APPENDIX 1 MATERNITY DASHBOARD

SHA Monitoring Dashboard for Maternity - 2013/14

No	Indicator	Descriptor	Expected (Per Month)	APR	YTD	2012/13
1	Births by Unit	Overall Trust total births	450	406	**406**	**5154**
2	Birth rate by Location Type	% of births in Consultant Unit	75%	79.8%	**79.8%**	**77.8%**
		% of births in any MLU	25%	19.2%	**19.2%**	**20.1%**
		% Home Births	1%	1.0%	**1.0%**	**1.8%**
		% BBA/Other	<1%	0.0%	**0.0%**	**0.4%**
3	Normal and Assisted Deliveries	Overall Normal Births rate %	65%	71.7%	**71.7%**	**71.9%**
		Overall Assisted Births rate %	10%	12.1%	**12.1%**	**10.8%**
4	Operative Deliveries	Caesarean Section rate %	< 20%	14.8%	**14.8%**	**15.7%**
5	Rate of Outcomes	Stillbirths rate	<1%	0.2%	**0.2%**	**0.5%**
		% of deliveries PPH >2000 mls	<1%	0.8%	**0.8%**	**1.0%**
		3rd/4th Degree tears rate	<5%	4.5%	**4.5%**	**2.4%**
6	National Smoking and Breastfeeding Targets	Breastfeeding within 48 hours of delivery (Unvalidated Figures)	67%	69.5%	**69.5%**	**70.2%**
		'Current Smoker' at delivery (Unvalidated Figures)	<20%	17.0%	**17.0%**	**18.1%**
	Access to Maternity Services	% of bookings with a gestation of less than 12 weeks 6 days	90%	89.6%	**89.6%**	**90.9%**
8	Clinical Effectiveness	Supervisor to Midwife Ratio	1.15	1.21	**1.21**	
		Midwife to Birth Ratio	1.31	1.32	**1.32**	
	Patient Safety	Number of CQC Mortality Alerts	0	0	**0**	
		Number of Maternal Deaths	0	0	**0**	
		Number of SI's reported to LSA	0	2	**2**	0

Paper 4

Appendix 1 Summary of each relevant licence condition

General Conditions & Trust response

G4: Fit and proper persons - YES
This condition requires that licensees do not allow unfit persons to become or continue as governors or directors. 'Unfit persons' are: undischarged bankrupts, individuals who have served a prison sentence of three months or longer during the previous five years, and disqualified directors. A company may also be an unfit person.

G5: Having regard to Monitor guidance - YES
The Licensee shall at all times have regard to guidance issued by Monitor and where the Licensee decides not to follow the guidance it shall inform Monitor of the reasons for that decision.

G7: Registration with the Care Quality Commission - YES
This condition reflects the obligation in the Act for licensees to be registered with the CQC. This condition allows Monitor to withdraw the licence from providers whose CQC registration is cancelled and who therefore cannot continue to lawfully provide services.

G8: Patient eligibility and selection criteria – NO: *SaTH will develop and publish appropriate criteria and ensure system in place to test application of criteria eg clinical audit sample review*
This condition requires licensees to set and publish transparent patient eligibility and selection criteria and to apply these in a transparent manner. This includes criteria for determining patient eligibility for particular services, for accepting or rejecting referrals, or determining the manner in which services are provided to that person.

Pricing Conditions & Trust response

P1: Recording of information - YES
Under this licence condition, Monitor may require licensees to record information, particularly information on their costs, in line with approved guidance. [Monitor] recently published a draft of this guidance for the collection of 2012/13 costs. The licence condition is worded in a way that any cost and other information that may be required can be collected from both licensees and their sub-contractors.

P2: Provision of information - YES
Having recorded the information in line with Pricing Condition 1 above, Monitor can then require licensees to submit this information.

P3: Assurance report on submissions to Monitor - YES
Monitor may require licensees to submit an assurance report confirming the accuracy of the information they have provided.

P4: Compliance with the National Tariff - YES
The Health and Social Care Act 2012 requires commissioners to pay prices corresponding to those in the National Tariff and, where prices aren't specified, to pay prices in line with the rules contained in the National Tariff. This licence condition imposes a similar obligation on licensees, that is, the obligation to charge for NHS health care services in line with the National Tariff.

P5: Constructive engagement concerning local tariff modifications - YES
[Monitor] will seek to make prices more reflective of the efficient cost of providing a service, but even so, in some circumstances it may be uneconomic for a provider to offer a particular service without additional funding over and above that allowed for in the National Tariff. For this purpose, the Act allows for local modifications, or adjustments, to prices.

Choice and Competition & Trust response

C1: Patient choice - YES

This condition:

- requires licensees to notify their patients when they have a choice of provider, and to tell them where they can find information about the choices they have. This must be done in a way that is not misleading;
- requires that information and advice that licensees provide to patients about their choice of provider does not unfairly favour one provider over another and is presented in a manner that helps patients to make well-informed choices; and
- prohibits licensees from offering gifts and benefits in kind for patient referrals or for the commissioning of services.

C2: Competition oversight - YES

This condition prohibits the licensee from entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.

Integrated Care Condition & Trust response

IC1: Provision of integrated care - YES

In most cases, [Monitor] would expect integrated care to be delivered locally by commissioners specifying their requirements and working with providers. The requirement for care to be delivered in an integrated way would be captured in contracts… [Monitor's] policies in areas such as pricing would act as our main tools for enabling integrated care. The purpose of this licence condition is to enable Monitor to step in where integrated care is not being delivered, in spite of decisions and efforts made by commissioners.

Appendix 2 Self-Certification Board Statements

1 CLINICAL QUALITY – YES

The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

2 CLINICAL QUALITY – YES

The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

3 CLINICAL QUALITY – YES

The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.

4 **FINANCE – YES**

The board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.

5 GOVERNANCE – NO. *The Trust has a planned deficit position of £1.8m in April.*
A&E performance in the month of April was 86.7% with improved performance during may to date
RTT in March was 78% for Admitted and 95.1% for non-admitted. Trajectories have been agreed with the NTDA to deliver the relevant targets at a speciality level between July and November 2013
Cancer under-achieved against elements of both the 31 day and 62 day pathways, achievement is anticipated in May
VTE compliance in April was below 95% target
Action plans are in place to recover all the above targets
The board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.

6 GOVERNANCE – YES

All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.

7 GOVERNANCE – YES

The board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.

8 GOVERNANCE – YES

The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.

9 **GOVERNANCE – YES**

An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).

10 GOVERNANCE – YES

The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.

11 GOVERNANCE – YES

The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.

12 GOVERNANCE – YES

The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.

13 GOVERNANCE – YES

The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.

14 GOVERNANCE – YES

The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.

Enclosure 4 – Annex A

Reporting to:	**Trust Board, 30 May 2013**
Title	Annex to the Integrated Performance Report: Cdiff Improvement Plan 2013/14
Sponsoring Director	Vicky Morris, Chief Nurse and Director of Quality & Safety
Author(s)	Jo Bank, Associate Director of Nursing (Patient Safety) Dr Patricia O'Neill, Director for Infection Prevention and Control
Previously considered by	Not applicable
Executive Summary	The purpose of this report is to inform the Trust Board & Quality and Safety Committee of the Trust's plan to prevent and reduce the incidence of Clostridium difficile (CDiff) infection during 2013/14. The plan forms part of an overarching strategy across the local health community including all NHS Providers, Clinical Commissioning Groups, their member Practices and the Independent Care Sector. Clostridium difficile reduction targets are set nationally for acute trusts and for 2013 the Trust is required to reduce the incidence of CDiff by 40% giving a target of 27 compared to 45 in 2012/13.
Strategic Priorities Quality and Safety Healthcare Standards Community and Partnership	**Strategic Objectives** All areas
Board Assurance(BAF) Risks	Deliver Safe Care or patients may suffer avoidable harm and poor clinical outcomes and experience
Care Quality Commission (CQC) outcome	Outcome 8 – Cleanliness and Infection Control
Action (Please tick box) ☒ **Receive** ☒ Note ☐ Review ☐ Approve	**Recommendation** The Board is asked to NOTE the action plan for improvement and the processes for monitoring and assurance by the Trust Board

The Shrewsbury and Telford Hospital NHS
NHS Trust

Trust Board – May 2013

Clostridium Difficile Reduction 2013 – 2014

1.0 Introduction

Clostridium difficile infections are a significant patient safety issue and are the predominant cause of antibiotic-associated diarrhoea. The risk of infection is higher in a healthcare setting due to a combination of risk factors including a predominantly elderly frail population, antibiotic use, and the possibility of cross-infection. It is distressing for patients who acquire an infection, for their family and friends and for staff who treat them. The on going reduction of Clostridium difficile (C Diff) is therefore a top priority for the Trust

2.0 Purpose

The purpose of this report is to provide a summary update of the Trusts plan to prevent and reduce the incidence of Clostridium difficile (CDiff) infection for the forthcoming year 2013-14. The plan forms part of an overarching strategy across the local health economy including all NHS Providers, Clinical Commissioning Groups, their member Practices and the Independent Care Sector. Clostridium difficile reduction targets are set nationally for acute trusts and for 2013 the Trust is required to reduce the incidence of CDiff by 40% giving a target of 27 cases compared with 45 in 2012/13. (Appendix 3)

3.0 Clinical profile of Clostridium difficile

Acquisition of Clostridium difficile may manifest as asymptomatic colonisation of the intestine, or as an infection ranging in severity from mild diarrhoea through to severe disease in the forms of pseudomembranous colitis and toxic megacolon, both of which can prove fatal.

4.0 Improvement Plan

From a national perspective, the Government has been clear that the NHS should adopt a zero tolerance approach to all avoidable healthcare associated infections. The expectation is that the NHS will minimise those infections through adherence to best practice in infection prevention and control practices however, it is recognised that there are some infections that cannot be prevented. From a local level the Trust has demonstrated year on year improvements outlined in Appendix 2 .The Local Health Economy have recognised the significant challenge for the reductions required in 2013/14 and as part of the Clostridium difficile Strategy the Shropshire and Telford Clostridium difficile Action Plan (Appendix 1)details the work the Clostridium difficile Task and Finish Group. This group will take forward the work required to prevent and reduce the incidence of Clostridium difficile infections across Shropshire and Telford for the coming year 2013 – 2014.
There are 7 key improvement areas within the CDiff improvement plan.

5.0 Campaign for Improvement

It is recognised that there is significant work to ensure that a campaign for improvement is created within the Trust and across the Health economy. The action plan contains the areas to be included within a campaign but similar to the successful MRSA reduction campaign in the Trust, this will require consistent and strong leadership from the Chief Nurse and Medical Director and a zero tolerance to any standards that deviate from the best practice standards required to reduce C Diff from all professional leaders within the Trust.

6.0 Monitoring Improvement

As the Executive lead for Infection, prevention control, the Chief Nurse will work with the Director of Infection, Prevention and Control (DIPC) Dr O'Neil to provide support and leadership to ensuring standards required are met leading to a reduction in C Diff figures. They will monitor progress through the Shrewsbury and Telford Infection prevention and Control Committee and report through to the Clinical Governance Executive Committee and through to Quality and Safety Committee.

The Trust Board will be able to monitor monthly performance through the Integrated performance report and variance reporting will be included if variance from the improvement plan are noted.

7.0 Conclusion and Recommendations

The Trust Board are asked to note the action plan for Improvement, the methodology for tracking improvements and reporting processes and that formal updates will be provided on a Quarterly basis.

Vicky Morris
Chief Nurse/ Director of Quality and Safety
May 2013

Appendix 1

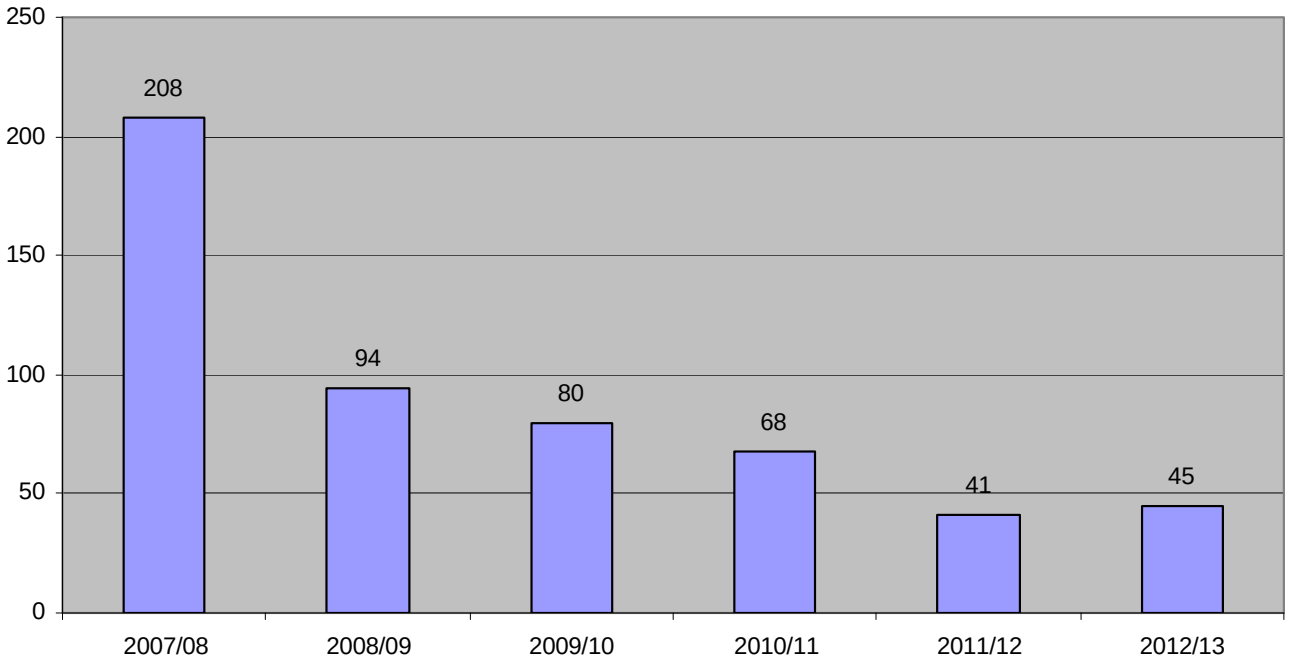
OUTCOME	ACTIONS REQUIRED	PEOPLE RESPONSIBLE
1. LABORATORY TESTING		
1.1 Clostridium difficile testing algorithm and reporting will be implemented as per national guidance.	• Develop a local laboratory protocol for the testing of samples. • Provide assurance that all laboratory staff process samples in line with national guidance.	Dr Patricia O'Neill
2. ENHANCED SURVEILLANCE		
2.1 Surveillance of acquisition and periods of increased incidence at ward level will be available to reduce spread enhance and learning.	• Review HPA tracking tool to develop real time surveillance information including patient movements/transfers leading up to and following infection (including timeliness of isolation) to help spot any time/place person interactions between cases.	Dr Patricia O'Neill Janette Pritchard
2.2 Surveillance of carrier status will be available to reduce spread and enhance learning.	• Map all carrier cases to enable a full understanding of the risks posed as a source for cross infection. • Review ribotyping to identify difference between Shropshire and Telford residents.	Dr Patricia O'Neill Janette Pritchard
3. ANTIMICROBIAL STEWARDSHIP		
3.1 A zero tolerance to inappropriate antibiotic prescribing.	• Establish a health economy wide antimicrobial prescribing group to take forward prescribing actions contained in this action plan, reporting progress to Health Economy IPC Group and to appropriate committees in individual organisations.	Dr Patricia O'Neill Bruce McElroy & Mark Bott Dr Edwin Borman
Antibiotic guidelines will be readily available and reflect best practice.	• Review hospital antibiotic guidelines including restricting broad -spectrum use at the same time taking into consideration unintended consequences including increased infection & mortality rates from gram negative organisms. • Explore format options of revised antibiotic guidelines for prescribers i.e. admission proformas, pocket sized laminated card/leaflets	Dr Patricia O'Neill Bruce McElroy
Improvements in Acute prescribing of antimicrobials in accordance with guidelines. O***utcome -100% compliance with antibiotic prescribing practice.***	• Audit antimicrobial prescribing – course length, daily review of on-going antibiotics, choice of antibiotic and produce improvement action plan	Bruce McElroy & Mark Bott
4. OTHER EVIDENCE BASED PRESCRIBING RELATING TO CDiff.		
Understand other relevant prescribing patterns across health economy e.g. PPIs. ***Outcome - to reduce volume***	• Review prescriptions of PPI's and where possible encourage use as clinically indicated	Bruce McElroy Dr Edwin Borman

of PPIs as measured by ADQ/STAR PU		
Reduce use of NSAID ***Outcome - NSAIDs will only be prescribed when absolutely necessary. Ibuprofen or Naproxen will be first line treatment and prescribed at the lowest possible dose, for the shortest possible duration***	• Audit NSAID prescribing discouraging clinicians from using Diclofenac	Bruce McElroy Dr Edwin Borman
5. OPTIMISING INFECTION PREVENTION AND CONTROL PRACTICES INCLUDING ISOLATION AND REDUCING CONTAMINATION		
Best practice with IPC measures.	• Establish a health economy wide IPC practice group to take forward IPC practice actions contained in this action plan (5.2 – 5.7, 6.3 & 7.1) incorporate into NHS Trust 2013/14 IPC work programmes, reporting progress to appropriate committees in individual organisations and to CDI T&F Group	Janette Pritchard
Patients will be given appropriate hand hygiene opportunities within NHS Trusts.	• Determine hand washing before meals.	Janette Pritchard
Adoption of NPSA cleaning schedules (2009) within NHS Trusts.	• Gap analysis from provider organisations regarding cleaning standards. • • Consider new cleaning technologies including hydrogen peroxide vapour (HPV).	Janette Pritchard
Suspected and confirmed cases are promptly isolated in a single room	• Monitor availability of side rooms escalating concerns to Executive Leads when capacity exceeded.	Janette Pritchard
High percentage – >98% usage of HII/Care bundle for *Clostridium difficile* within NHS Trusts	• Review HII/Care bundle for *Clostridium difficile* and standardise elements of care across Trust.	Janette Pritchard
High percentage >95% of staff within NHS Trusts will have completed IPC training in accordance with mandatory training matrix.	• IPC mandatory training programmes are developed and delivered by IPC teams.	Janette Pritchard (SaTH)
A cleanliness culture will be established across NHS Trusts.	• Revisit the 'Matron's Charter' ensuring Matrons/Ward Managers lead in the delivery of a safe clean environment including continued emphasis on de-cluttering, cleanliness and efficient use of ward space.	Vicky Morris
Enhanced assurance will be available from clinical areas with raised incidence of *Clostridium difficile*	• Plan a programme of planned and unplanned visits to service areas with an agreed assessment process including antimicrobial use, hand hygiene and environment and equipment cleanliness.	Vicky Morris

	• Executive nurses to work collaboratively with planned visits to enhance assessment and learning	
Enhanced actions for 'at risk groups' will be identified.	• Consider groups of patients who are at high risk of developing *Clostridium difficile* and possible actions that can be taken to reduce this risk.	Dr Patricia O'Neill Janette Pritchard
6. CLOSTRIDIUM DIFFICILE CASE MANAGEMENT AND TREATMENT		
Improvements in the management, care and treatment in the Trust.	• A weekly multidisciplinary review of symptomatic cases by microbiologist, gastroenterologist, dietician and IPC nurse to ensure patient is not deteriorating and in receipt optimal treatment and support	Dr Patricia O'Neill
Learning from the incidence of *Clostridium difficile* cases will be shared across Shropshire and Telford	• Undertake an RCA for all positive cases to understand possible causative factors and improvements and table summary report at each. Health Economy IPC Group. Share findings and best practice in Trusts newsletters/blog.	Janette Pritchard
The *Clostridium difficile* passport will be implemented across the health economy.	• Provide assurance the *Clostridium difficile* passport is implemented in the health economy.	Janette Pritchard
7. FURTHER AWARENESS RAISING		
A zero tolerance to avoidable *Clostridium difficile* infection will be evident throughout the health economy with opportunities to educate/communicate key messages in relation to *Clostridium difficille.*	• Draft communication plan and undertake a planned communication programme to ensure that awareness of *Clostridium difficile* is known by relevant healthcare professionals across the health economy.	Vicky Morris Adrian Osborne
	• Provide educational sessions as indicated across the health economy on *Clostridium difficile* associated diarrhoea and how occurrence can be minimised.	Dr Patricia O'Neill Janette Pritchard
	• Explore availability and use of e-learning packages across the health economy	Janette Pritchard
	• Ensure IPC link nurses champion *Clostridium difficile* reduction – IPC nurses to provide additional training/information	Janette Pritchard
	• Explore further local initiatives to promote prudent antibiotic prescribing and IPC key messages amongst NHS and health and social care providers including road shows to remind staff, patients and visitors alike about the importance of hand hygiene and cleanliness in all health and social care environments.	Janette Pritchard

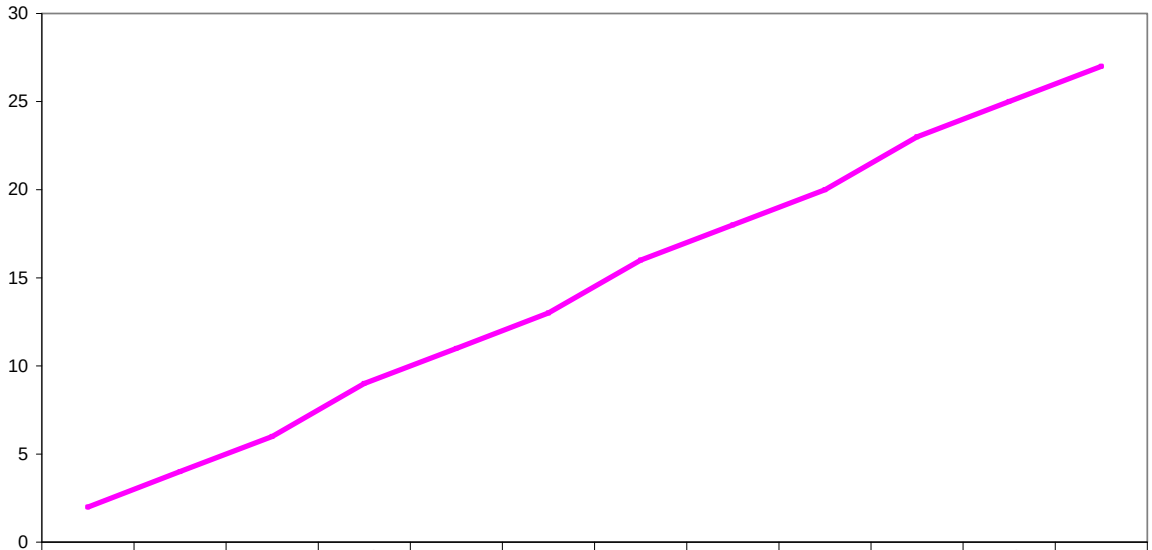
Appendix 2

Annual cases apportioned to SaTH to end Mar 13



Appendix 3

C difficile cases and recurrences over 2 yrs 2013/14 - SATH Responsible



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cases per month												
Cumulative												
Target 13/14	2	4	6	9	11	13	16	18	20	23	25	27

Cases per month Cumulative Target 13/14