Trust Board in Public
31 May 2012
Agenda Item 3.1

Surrey and Sussex NHS
Healthcare NHS Trust

Integrated Quality and Performance Report (IQPR) M01 – April 2012

Presented by: **Bernie Bluhm (Chief Operating Officer) and Jo Thomas (Chief Nurse)**
Author: **Wendy Mahoney (Senior Performance Manager)**

An Associated University Hospital of Brighton and Sussex Medical School

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Delivering excellent, accessible healthcare

Performance & Quality M10 – January 2012

Summary: This summary report will point you to the main areas of improvement or concern held within this report.

- **The Trust's 18 week referral to Treatment (RTT) has been met and performance continues to improve across all admitted and non-admitted care pathways.**
- **There is a significant improvement in the 4 hour A&E access standard in M1 (to 92.12%, which is favourable to the agreed performance level) and the Trust is working to deliver weekly performance of >95% moving into M2**
- **There is concern around the Endoscopy waits currently seen in M1 as a result of the National Bowel Awareness campaign. The DOH predicted a 30% increase in referral – we allowed for a 50% increase, but we are showing a 100%increase in referrals. The Trust is implementing additional waiting lists to meet the demand.**
- **The Trust is focusing on the improvement of the Workforce metrics in 2012/13**

Action: The Board are asked to note and accept this report

Notes:

Legal: What are the legal considerations & implications linked to this item? Please name relevant Act	Patient safety: Legal actions from unintentional harm to patients would normally be covered by negligence, an area of English tort (civil) law, providing the remedy of compensation. Case law is extensive. Criminal action could be pursued if investigation judged intentional harm and remedies will vary according to severity. Staff safety: The Health and Safety at Work Act etc 1974 may apply in respect of employee health and safety or non clinical risk to patients (usually reported under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995)
Regulation: What aspect of regulation applies and what are the outcome implications? This applies to any regulatory body.	The Care Quality Commission (CQC) regulates patient safety and quality of care and the CQC register and therefore license care services under the Health and Social Care Act 2009 and associated regulations. The health and safety executive regulates compliance with health and safety law. A raft of other regulators deal with safety of medicines, medical devices and other aspects.

Contents

A&E

Indicator	Jan	Feb	Mar	Apr	Trigger Point 1	Trigger Point 2	RAG Status
A&E							
A&E time to initial assessment (95th percentile)	156	144	173	173	N/A		R
% of patients in A&E under 4 hours	80.1%	78.9%	87.4%	92.12%	95%	90%SHA	G
A&E time to initial assessment (median)	24	26	26	26	<15		
Time to Treatment (median)	33	33	39	42	<60		G
Total time in A&E admitted (95th percentile))	1132	1083	977	858	240		R
Total time in A&E non-admitted (95th percentile)	488	486	353	239	240		G
No. of patients in A&E over 12 hours (trolley waits)	7	0	0	0	0		G
A&E unplanned re-attendance rate (within 7 days)	5.5%	4.8%	5.3%	5.39%	<5%		A
Left without being seen	4.3%	4.3%	4.2%	3%	<5%		G
HSMR				91.4%	100	103	G

M1 situation report

- The Trust has achieved the A&E target for the 4 hour wait performance indicator in M1. Current YTD is at 92.12%. We are working to deliver weekly performance of >95% moving into M2
- There are no 12 hour breaches in M1
- Re-admissions within 7 days also achieved the target for M1

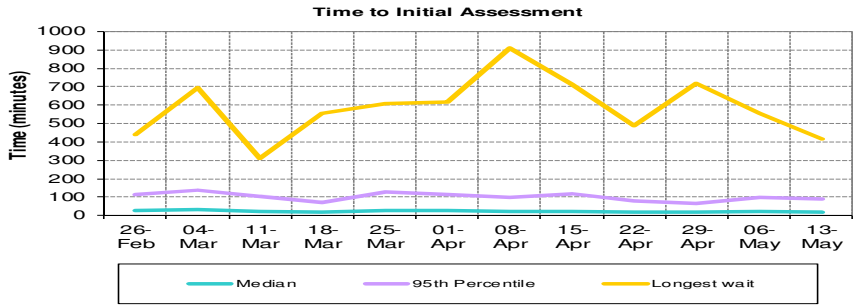
Actions to improve performance

- The Trust continues to focus on delivering the A&E targets through robust daily planning and communication between all departments.
- Further improvements are being made at the initial streaming point to improve performance in 'time to assess' and to reduce ambulance handover delays.

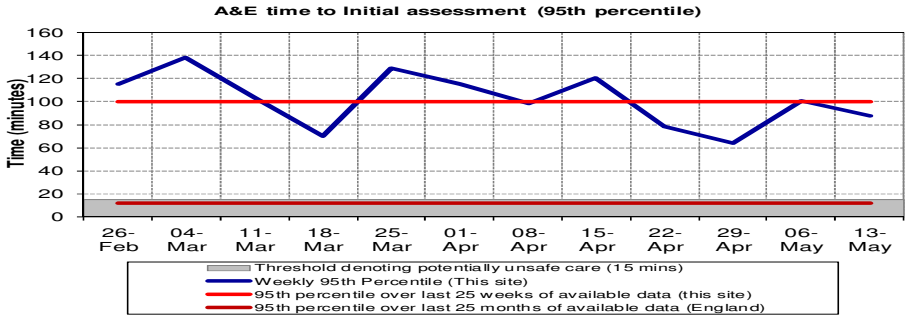
Performance Quality Indicators Graphs (A&E)

Time to initial assessment by Nurse in A&E

Site-level performance



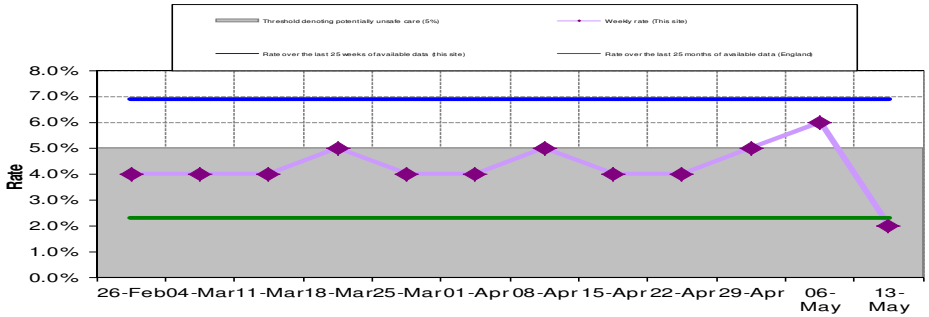
Site performance against national benchmarks and performance thresholds



88	95th percentile this month
Better	Compared to last week

Unplanned re-attendance

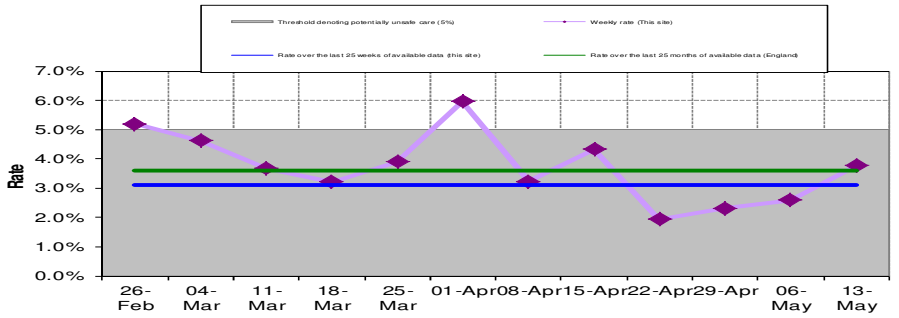
Unplanned re-attendance rate



2.0%	Rate this month
Better	Compared to last week
	Data quality

Left without being seen

Left without being seen rate



3.8%	Rate this month
Worse	Compared to last week
	Data quality

18 Weeks

Indicator	Jan	Feb	Mar	Apr	Trigger Point 1	Trigger Point 2	RAG Status
18 Weeks							
rtt admitted 18 wk %	73.1%	90.3%	92.7%	90.62%	90%	90%	G
rtt non-admitted 18 wk %‡	62.3%	61.8%	88.1%	93%	95%	93%	A
Incomplete pathways under 18 weeks	84.39%	85.05%	87.2%	90.05%	92%	90%	A
Rtt failing specialties	43	37	28	22			A

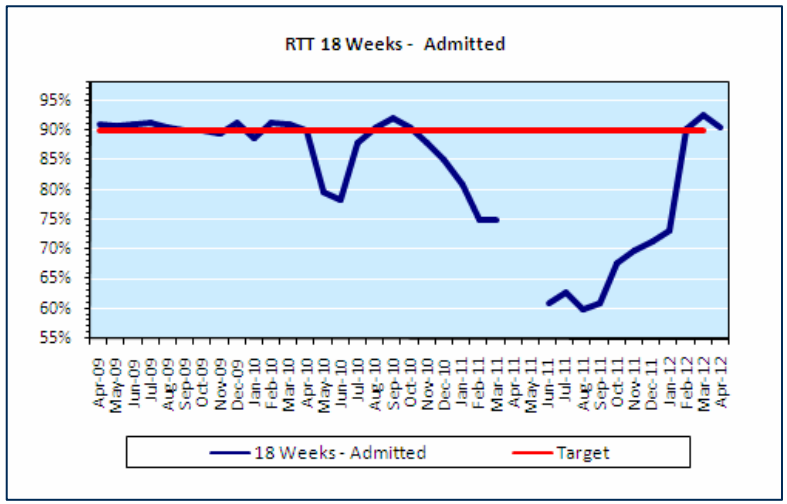
M1 situation report

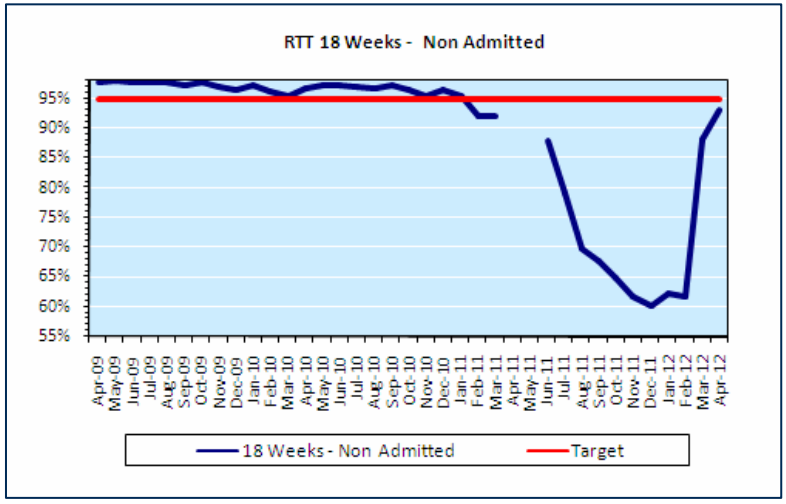
- Trust achieved 90.62% against the 90% target for admitted in M1 and significantly improved performance for he non-admitted pathway of 93%
- This has been a result of robust 18 weeks monitoring management using a newly developed process hat allows the Trust to have sight on a daily basis a projected compliance with the i8 week indicators.
- Plans to drop compliance to 85% RTT in May will no longer apply. The Trust will deliver >90% RTT moving forward. The current admitted back log continues to reduce month by month and by the end of April will be circa 500

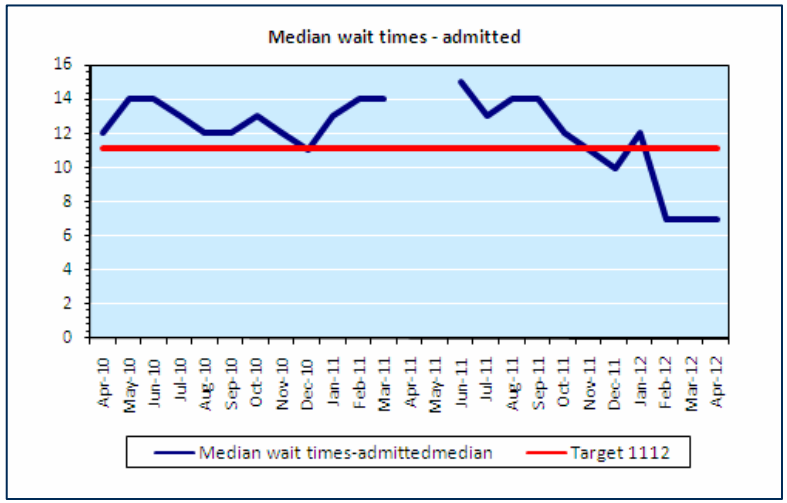
Actions to improve performance

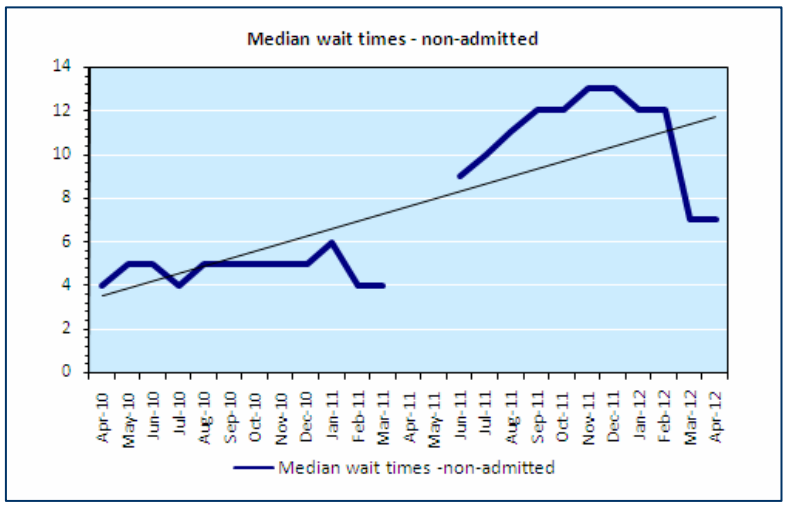
- The Trust is currently implementing an automated IT solution that will allow easier monitoring of the 18 week RTT compliance and ensuring theatre utilisation is being managed in terms of capacity and activity levels to sustain the admitted and non admitted pathways as well as clearing the backlog.
- Currently, additional capacity continues to be provided with outsourcing of T&O and ENT to external providers the remaining addition capacity is being provided in house at the weekends by Trust Health. We are also continuing to run Waiting lists at the weekend for Endoscopy.
- Work continues on the validation of the non-admitted pathway and the Trust is required to deliver 92% in-completes by the end of June.

Performance Quality Indicators Graphs (18 weeks)









Breach reports – admitted patients (18 weeks)

Admitted Pathways	Cardiology	Cardiothoracic Surgery	Dermatology	ENT	Gastroenterology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology	Neurology	Neurosurgery	Ophthalmology	Oral Surgery	Other	Plastic Surgery	Rheumatology	Thoracic Medicine	Trauma & Orthopaedics	Urology	Total
Patient Choice				**1**			**2**		**1**				**1**	**1**						**6**
Patient non-cooperation (e.g. DNAs)							1													**1**
Patient chooses to wait longer than reasonable (as defined in local access policy)				1			1		1				1	1						**5**
Not in the patients best clinical interest							**2**		**1**											**3**
Capacity	**3**			**15**	**7**		**19**		**6**			**15**	**6**	**13**				**14**	**12**	**110**
Insufficient capacity																				
Capacity - First appointment	3			8	5		7		3			7		7				3	3	**46**
Capacity - follow up					2		1											1		**4**
Capacity - preassessment							1		2			1						1	1	**6**
Capacity – Theatre				7			10		1			7	6	6				9	8	**54**
Hospital cancellation							**2**													**2**
Hospital cancellation of Clinic																				
Hospital cancellation - no theatre																				
Hospital cancellation - no beds																				
Hospital cancellation - staff absence							2													**2**
Diagnostic delay																				
Insufficient diagnostic capacity to deliver local standards for diagnostic tests																				
Reporting delay																				
Medically not fit																				
Medically not fit at pre-assessment																				
Not fit while awaiting admission																				
Process delay																				
Paper process delay																				
Incorrect patient demographics																				
Referral vetting delay																				
Postal delay																				
Late transfer from another provider																				
Other			1		2		3					1		4				1	3	**15**
Total	**3**		**1**	**16**	**9**		**28**		**8**			**16**	**7**	**18**				**15**	**15**	**136**

The patients in the Admitted Pathway under the title of “capacity” are those patients from the Trust historical backlog, as we reduce the backlog this figure will drop and the backlog should only then contain clinical complexity and patient choice. We are utilising all funded theatre session and have also through efficient use of the staffing establishment been able to use some of the unfunded session.

Breach reports – non- admitted patients (18 weeks)

Non Admitted Pathways	Cardiology		Cardiothoracic Surgery	Dermatology	ENT	Gastroenterology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology	Neurology	Neurosurgery	Ophthalmology	Oral Surgery	Other	Plastic Surgery	Rheumatology	Thoracic Medicine	Trauma & Orthopaedics	Urology	Total
Patient Choice	**5**		**1**	**6**		**1**	**3**			**4**		**4**	**1**	**8**		**3**	**2**	**4**	**5**	**47**
Patient non-cooperation (e.g. DNAs)	5		1	6			2					1	1	4		1	2	2	5	**30**
Patient chooses to wait longer than reasonable (as defined in local access policy)						1	1			4		3		4		2		2		**17**
Not in the patients best clinical interest	**1**		**1**		**1**		**3**							**1**						**7**
Capacity	**2**			**2**	**2**	**1**	**1**			**3**				**3**				**5**	**1**	**20**
Insufficient capacity																				
Capacity – Theatre					1									1						**2**
Capacity - First appointment	2			1						3				2				3	1	**12**
Capacity - follow up				1	1	1	1											2		**6**
Hospital cancellation	**3**		**1**	**7**			**1**	**1**				**5**	**1**	**1**			**1**	**2**		**23**
Hospital cancellation of Clinic	1		1	2			1	1				2	1	1						**10**
Hospital cancellation - no theatre																				
Hospital cancellation - no beds																				
Hospital cancellation - staff absence	2			5								3					1	2		**13**
Diagnostic delay																				
Insufficient diagnostic capacity to deliver local standards for diagnostic tests																				
Reporting delay																				
Medically not fit														**1**						**1**
Medically not fit at pre-assessment														1						**1**
Not fit while awaiting admission																				
Process delay																				
Paper process delay																				
Incorrect patient demographics																				
Referral vetting delay																				
Postal delay																				
Late transfer from another provider																		**2**		**2**
Other	15		1	33	3		3	1	1	3		3		8		1		4	6	**82**
Total	**26**		**4**	**48**	**6**	**2**	**11**	**2**	**1**	**10**		**12**	**2**	**22**		**4**	**3**	**17**	**12**	**182**

Cancer

Indicator%	Jan	Feb	Mar	Apr	Trigger Point 1	Trigger Point 2	RAG Status
Cancer Access targets							
Cancer - TWR	95.4%	93.0%	94.8%	93.1%	93%%	93%	G
Cancer - 31 Day Second or Subsequent Treatment (SURGERY)	96.8%	100.0%	100.0%	100%	94%	94%	G
Cancer - 31 Day Second or Subsequent Treatment (DRUG)	100.0%	100.0%	100.0%	100%	98%	98%	G
Cancer - 31 Day Diagnosis to Treatment	98.8%	100.0%	98.3%	100%	96%	96%	G
Cancer - 62 Day Referral to Treatment from Screening	92.3%	100.0%	100.0%	100%	90%	90%	G
Cancer - 62 Day Urgent Referral	89.8%	87.2%	85.9%	85.3%	85%	85%	G
Cancer - Breast Symptomatic (2 Week Wait)	94.7%	94.5%	94.4%	88.4%	93%	93%	R

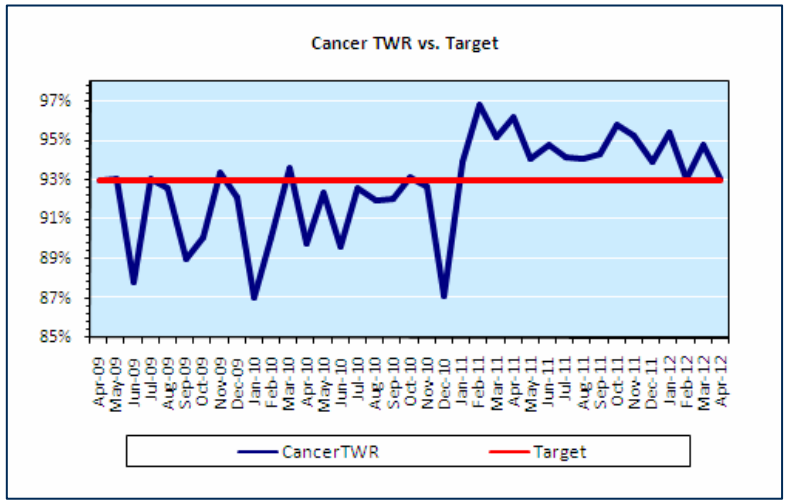
M1 situation report

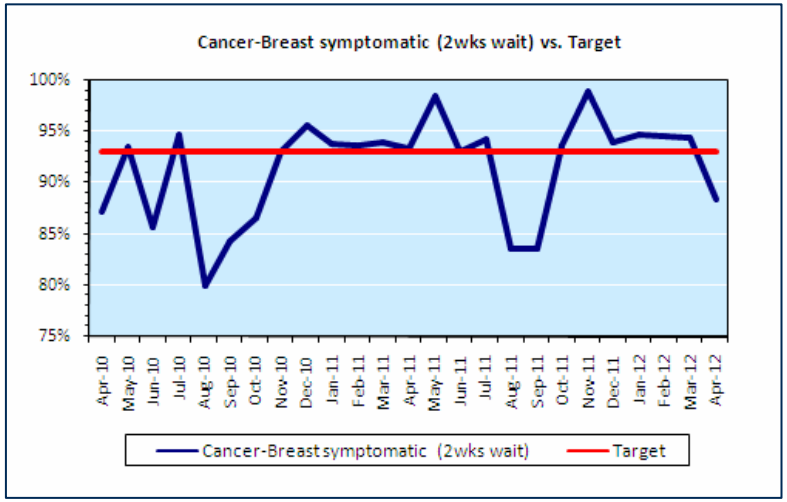
- The Trust continue to perform well against all Cancer targets. However, there has been a drop in performance in M1 for the 2 Week Breast Symptomatic indicator where the Trust only achieved 88.4% against the 93% target. 11 patients breached the 2 week wait – of which 11 were due to Patient choice over the Easter period as there was sufficient capacity.

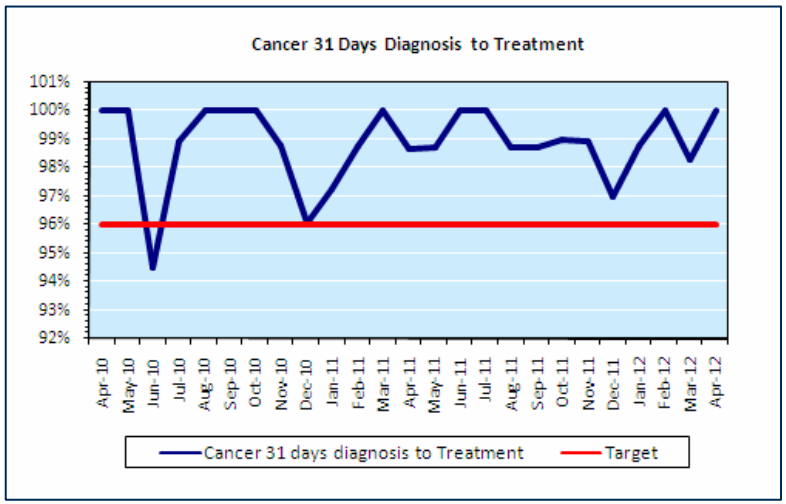
Actions to improve performance

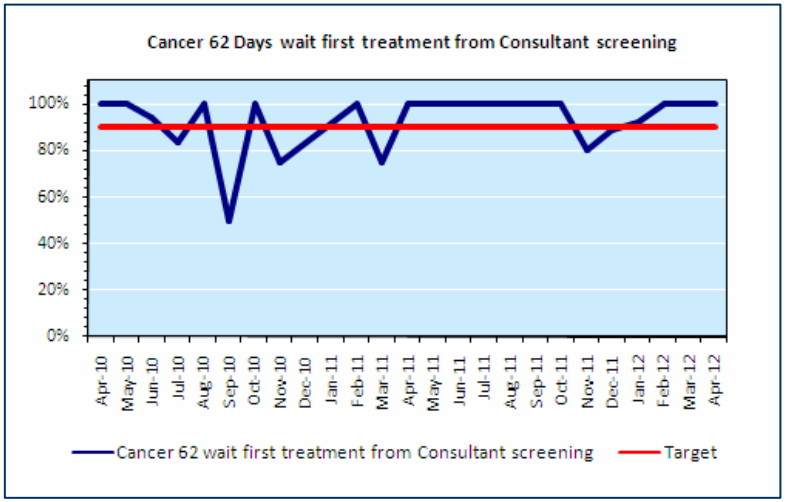
- The Trust continues to achieve compliance with the Cancer KPI's and will continue to work towards implementing all recommendations.
- Focus will be made on achieving the Breast Symptomatic target of 93% by ensuring .. The Service Manager will contact the patients to try to get them to attend. GP's will be contacted to see if they can talk to the patients as well. As a result of the approach it is hoped that patients will agree to attend within the 2 weeks and Improved patient pathway flow that allows patient to have Digital monograph with the 1 week.

Performance Quality Indicators Graphs (cancer)



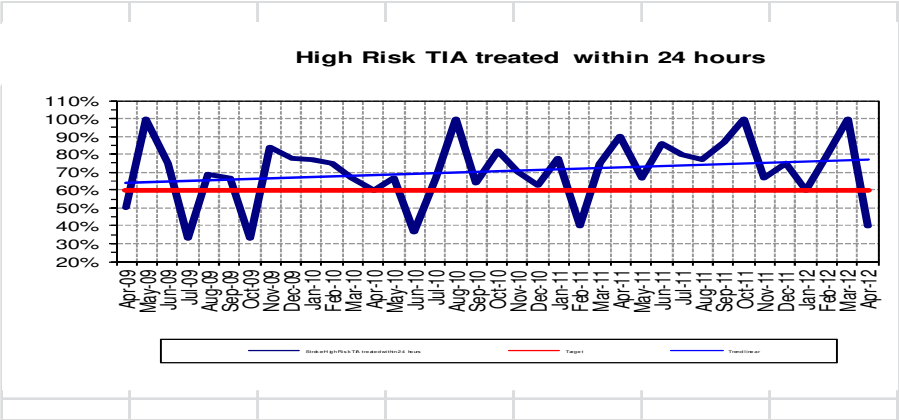






Stroke

Stroke	Jan	Feb	Mar	Apr	Trigger Point 1	Trigger Point 2	RAG Status
% of stroke patients scanned within 1 hour of hospital arrival	59.3%	40.0%	55.6%	40%	100%		R
Stroke TIA treated within 24 hours	60.0%	78.6%	100.0%	40%	60%		R
Stroke patients – CT within 24 hours				100%	100%		G
No of stroke patients who stayed more than 90% of their time on a stroke unit	48.1%	80.0%	51.9%	56.7%	90%	90%	R



M1 situation report

- The Trust performance against the Stroke Indicators for M1 have only met compliance in the CT within 24 hours indicator.
- For the 90% stay on a stroke ward, the Division has identified the inability to maintain flow through fast track bed and also delayed discharges at Redhill and at Crawley rehab.
- TIA treated within 24 hours - Volume was low for M1 and 3 of the 5 referrals were over the weekend.

Actions to improve performance

- The Trust is putting processes in place to ensure all Fast Track Stoke Beds are identified and communicated to on-site managers particularly over night as part of the written handover and escalation strategy of the Trust.
- Daily monitoring of admissions, outliers and delayed discharges is now in place. Stroke Care pathway is being revised to emphasise the escalation process for admission to ASU <4hrs.
- Review referral process to Crawley Stroke Rehab .
- Increased number of stroke beds by using stroke expertise on Capel ward.
- Stroke scan within 1 hour - Radiology staff now included in early stroke call / bleep should help improve performance. Will be monitored in-month.
- Weekend TIA service plans are to be progressed and a plan agreed and implemented by the end of Q1.

Fractured NOF

Indicator	Jan	Feb	Mar	Apr	Trigger Point 1	Trigger Point 2	RAG Status
Fractured Neck of Femur							
Fractured Neck of Femur <36 hours	80%	63.4%	79.3%	87.8%	85%	80%	G
Fractured Neck of Femur <48 hours	90%	73.2%	92.5%	95.1%	90%	90%	G

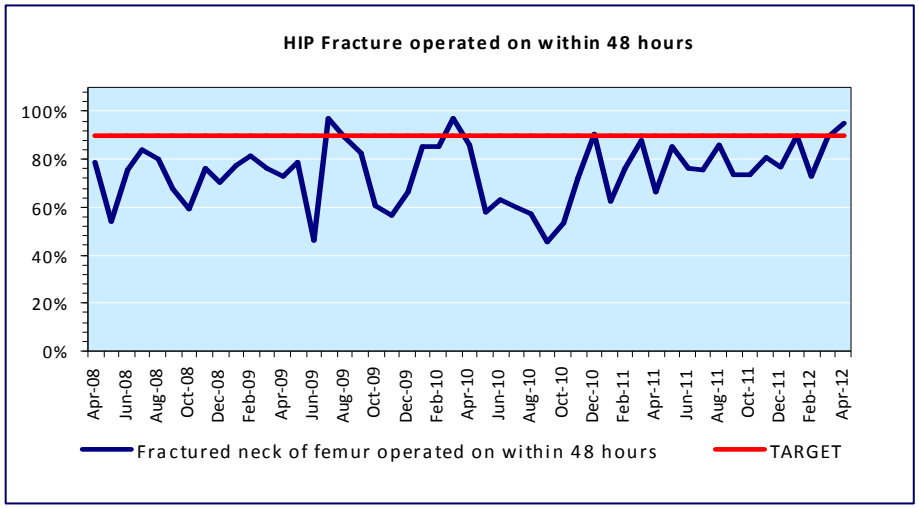
M1 situation report

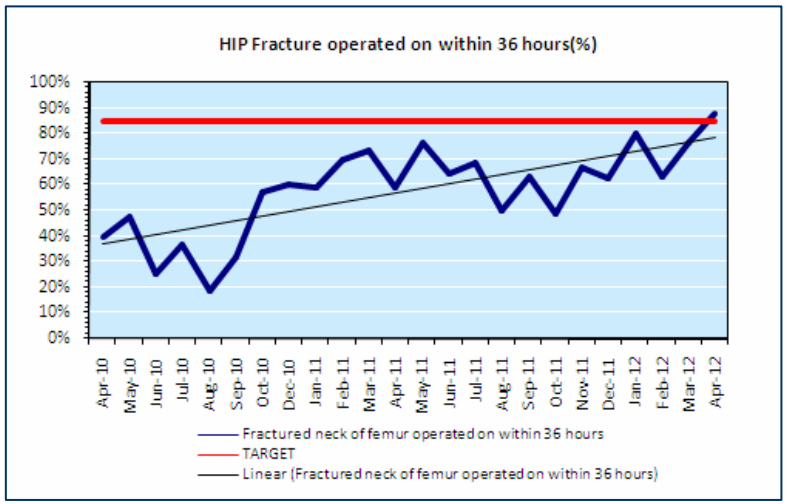
- The Trust has performed excellently against the #NoF targets in M1 to achieve the 48 hour indicator at 95.1%, an improvement on M12 and has also significantly improved against the 36 hour target at 87.8%, exceeding the target.
- The action plan implemented in theatres to accommodate #NoF in March has continued to pay dividends resulting in the significant improvement in performance seen in month to achieve both targets for the first time.

Actions to improve performance

- Improved performance follows the implementation of the action plan, which continues to be pursued and reviewed.
- Theatres continue to prioritise space on trauma surgery lists including the Sunday theatre lists.

Performance Quality Indicators Graphs (#NOF)





Safety

Indicator	Jan	Feb	Mar	Apr	Trigger Point 1	Trigger Point 2	RAG Status
Safety							
VTE Risk Assessments	93.2%	91.8%	90.5%	90.1%	90%	90%	G
Number of Never Events reported	0	0	0	0	0	0	G
Newly acquired Pressure Ulcers (Grade 2 and above)	20	11	11	12	121plan		R
No of falls reported as clinical incidents	87	87	56	46	73	74	G
No of falls resulting in fracture/head Injury	1	3	1	2	0	0	R
No of medication errors resulting in an adverse event	4	5	2	4	0	0	R

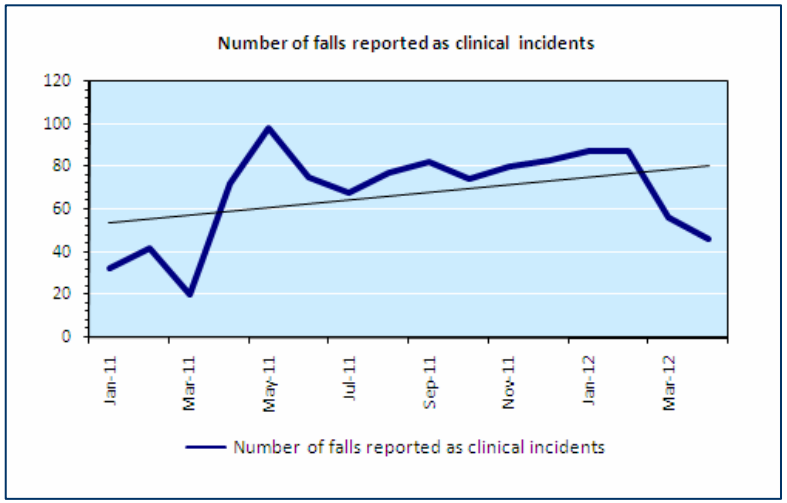
M1 situation report

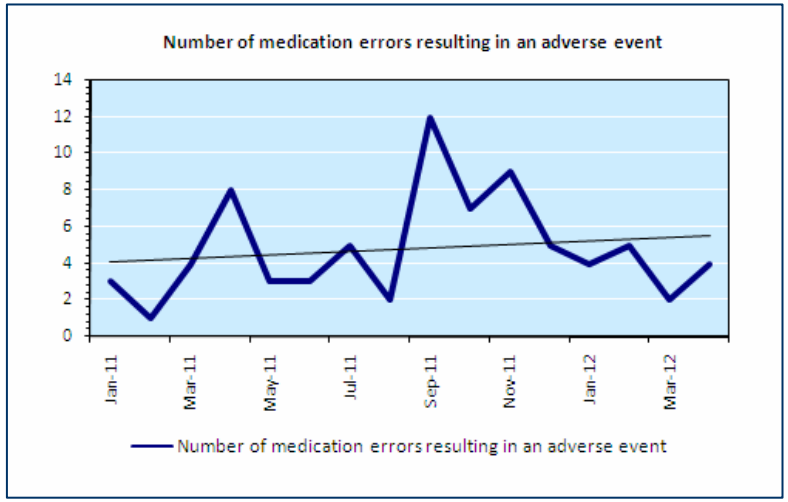
- Pressure Ulcers – Trust performance has slipped in M1 with 12 cases being reported.
- VTE – Trust is currently reporting performance at 90.1%.
- Falls – The Trust is currently reporting 46 Falls for M1 which is an improvement on M12 at 56, However, manual collection of the falls data means that this figure may be subject to change and an updated position would be noted in the M2 report.

Actions to improve performance

- VTE – The manual collection of VTE data is proving problematic in some areas of the Trust . The automated system is being developed.
- Pressure Ulcers – RCA's and immediate implementation of education and training is on going throughout the wards across the Trust.
- Falls – The installation of the ultra low beds appear to be having an effect on the number of falls being reported. The Trust envisage further improvement month on month.

Performance Quality Indicators Graphs (Safety)





Patient experience

Indicator	Apr	Trigger Point 1	Trigger Point 2	RAG Status
Patient Experience				
% of patients who were involved as much as they wanted in decisions bout their care and treatment	93%	90%	85%	G
% of patients who were able to talk to hospital staff about worries and fears	92%	90%	85%	G
% patients who were given privacy when discussing their condition or treatment	92%	90%	85%	G
% of patients who were told about medication side effects to watch for when they went home	82%	90%	85%	R
% of patients who were told who to contact if they were worried about their condition or treatment after they left hospital	77%	90%	85%	R
% of patients who felt they were treated with dignity and respect at all times during their stay	87%	90%	85%	A
% of patients who rated the hospital food	69%	90%	85%	R
% of patients surveyed who would recommend SASH to family and friends	77%	90%	85%	R
EMSA Breaches	36			

M1 situation report

- Patient Experience- The Trust continue to make improvements at Divisional level to ensure all patient experience is being captured and acted upon.
- Mixed Sex Accommodation – The Trust have reported 7 Index breaches which resulted in 29 affected patients. There were 35 ITU Breaches.

Actions to improve performance

- MSA – The Trust have recently trialled the new screens specifically designed to maintain privacy and dignity within such areas as ITU and agreed with Commissioners that should enable to Trust to reduce the number of EMSA breaches. The Trust have order 10 screens and are awaiting delivery.
- Patient Experience – Each Division is driving staff to capture patient experience and as part of the new Performance Assurance Framework metrics ensuring more focus is being placed on monitoring on-line real time information to which the Trust can act. Staff are reporting improved patient experience feedback despite the Trust undergoing huge cosmetic transformation, assuring the Teams that care is not being compromised.

Contents

Maternity

Indicator	Jan	Feb	Mar	Apr	Trigger Point 1	Trigger Point 2	RAG Status
Maternity							
C-Section Rate	25.9%	24.3%	27.2%	28.8%	23%	23.9%	R
% of women seen by a midwife or healthcare professional at 12 weeks 6 days	83.7%	88.8%	83.6%	92%	90%	90%	G
Breastfeeding initiation	84.2%	81.0%	76.0%	75%	90%	90%	R

M1 situation report

- C- Section – The Trust performance in this area has slipped in M1 achieving 28.8% compared to M12
- Breastfeeding initiation – The Trust only managed to achieve 75% compliance in this area for M1 continuing the downward trend of performance in this area
- 12 Week Referral to Midwife/Consultant – has achieved target in M1

Actions to improve performance

- C- Section - Actions continue to be taken by the lead consultant to make real headway in 2012/13 to achieve the target. The position is being reviewed against actions in place, tied to recruitment of new midwifery and obstetric staff . WaCH plan for 25% rate for the full year, which requires a 3% improvement over 11/12
- The Trust is developing the new Performance Assurance Framework reporting tool that will allow the Trust to capture the SEC Maternity dashboard and report to the Board as part of our overall performance and quality reporting.

Healthcare Acquired Infections (HCAIs)

Indicator	Jan	Feb	Mar	Apr	Trigger Point 1	Trigger Point 2	RAG Status
HCAIs							
MRSA (trust acquired)	0	0	1	0	4	4	G
C-Diff (trust acquired)	5	6	6	6	4	4	R
MSSA (trust acquired)	4	5	6	0	0	0	R
E-Coli (trust and community acquired)	11	14	10	8	N/A	YTD33	R
Hand Hygiene	99.7%	99.4%	99.9%	99.4%	99%		G

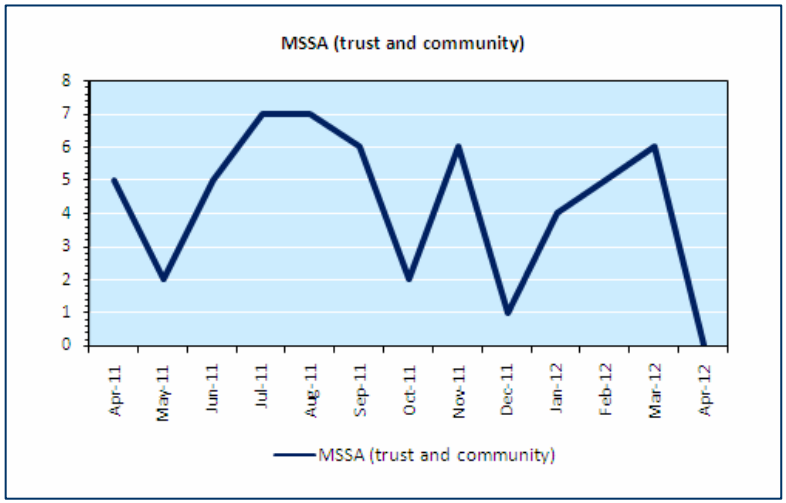
M1 situation report

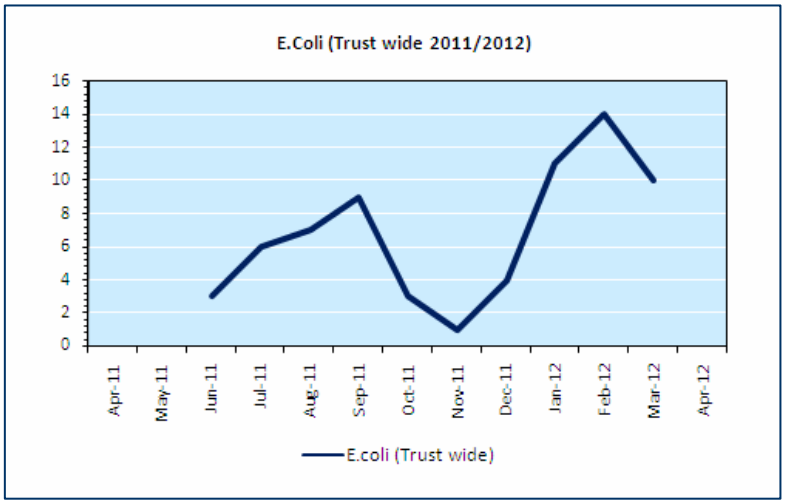
- MRSA – The Trust have no reported cases at M1
- C-Diff – The Trust have 6 reported cases in M1
- MSSA – The Trust no reported cases in M1
- E-Coli infections have been high in M1

Actions to improve performance

- Action in respect of HCAI is a Trust priority. The Infection Control Taskforce meeting is now weekly (was fortnightly). CEO now attends (in addition to MD and either Chief Nurse or her deputy).
- The main risk factors for CDiff are broad spectrum antibiotic use and cleaning standards. A new antibiotic prescribing policy is being introduced and a new drug chart is being piloted.
- That is supported by reporting on prescribing to identify risk areas (KPIs have been developed for all wards and performance in relation to these is on public display in all ward areas) and targeting of those areas by the pharmacy team, including pharmacy support to wards. Each Division is taking steps in advance of the issue of the policy to ensure effective implementation among medical staff.
- All Cdiff cases have RCA performed and consultant team responsible for care of the patient attends infection control taskforce to give feedback and help develop education and action plans.

Performance Quality Indicators Graphs (HCAIs)





Workforce

Indicator	Jan	Feb	Mar	Apr	Target	Trigger Point 1	RAG Status
Workforce							
Vacancy Rate	10.7%	13.0%	12.2%	13.2%	<=10%	<=10%	R
Total Establishment	3236.53	3326.62	3329.28	3336.51	3177	3313	R
Total in post	2890	2895	2923.49	2896	2832	2832	R
Turnover	13.69%	14.16%	13.6%	14.41%	12%	12%	R
Sickness absence rate	3.8%	4.6%	4.3%	4.14%	<=3.0%	<=3.0%	R
Total WTE bank staff (excluding extra capacity / nursing)	292	274	314.6	287.97	<210	<210	R
Total WTE Agency staff (excluding extra capacity / nursing)	62	81	113.2	105.4	<40	<40	R
Total WTE Locum	15.58	13.6	16.1	15.4	<10	<10	R
% of staff who have completed mandatory training (YTD cumulative position in month)				8.4%	80%	6%	G
% of staff who have been appraised (YTD cumulative position in month)				2%	90%	4%	R

M1 situation report

- Despite active recruitment to vacant clinical posts the vacancy rate has increased this month due to the fall in the number of staff in post
- Sickness absence again shows a small reduction this month however rolling average continues above the target of 3%. Gastrointestinal symptoms continues to be the main reason for absence this month. There are localised high sickness rates in some Divisions (notably WaCH).
- Due to high vacancy levels bank and agency levels continue to be above target however April saw a reduction in numbers when compared with March
- Expected levels of attendance at statutory and mandatory training have been maintained in April although it is disappointing that levels of appraisal fell below that expected

Actions to improve performance

- Establishment data requires adjustment (timing delay) to deal with posts identified through cost improvement plans to be removed. Note: the Trust has started consultation in respect of potential redundancies from Corporate posts.
- Targets for Workforce Metrics within Divisions and Corporate Services to be set and monitored as part of the Performance Assurance Framework being introduced within the Trust.
- Appraisal for senior managers to be prioritised during May and June

Audit

Indicator	Jan	Feb	Mar	Apr	Trigger Point 1	Trigger Point 2	RAG Status
Audit							
Total number of audits				366			
% of audits on audit program started	67%	74%	78%	83%	75%		G
% of completed audits with agreed action plans	72%	61%	38%	71%	100%		R
No of NICE guidelines without a statement of compliance	18	16			0		
% of non or partially compliant nice guidelines	16%				10%		

M1 situation report

- The Trust has achieved compliance against the number of Audit programmes started in 2011/12 and there is an improving picture in most Divisions going forward to 2012/13
- The trajectory of audit for 2012/13 is 366 of which 83% have already been started.
- The number of audits completed with agreed action plans has significantly improved since M12

Actions to improve performance

- The Trust are introducing a new Performance Assurance Framework monitoring process that will ensure all Divisions are completing the mandatory and on-going audits required for CQC and Divisional compliance as well as implementing an additional audit schedule for 2012/13. All Divisions will ensure 100% of Audits completed going forward have agreed action plans

Contents

Action log – summary of key actions

		Exec Lead	Mgmt/ clinical Lead	Date
1	**18 weeks:** Continue monitoring 18 week booking processes and deliver to the plan agreed with the SHA	COO	H. Wallis	ongoing
2	**ED:** To embed and monitor the impact of the new processes put in place throughout March. To provide accurate performance data daily and ensure all staff groups are aware of the requirement to achieve compliance. To work in partnership with the wider system to support the delivery of whole health economy action plan to reduce unscheduled attendances.	COO	R.Fuller	ongoing
3	**Stroke:** Implement, monitor and performance manage a zero tolerance on the allocation of non stroke patients into stroke ward.	COO	N. Hare	Commence 21.5
4	**Stroke:** Daily review by stroke and clinical site team of outlying patients and repatriation as soon as clinically possible	COO	N. Hare	ongoing
5	**MSA:** Site meetings attended by operational and clinical staff with opportunities explored for the prevention of Mixed Sex Accommodation.	COO	R. Fuller	ongoing
6	**MSA:** Effectiveness of additional capacity to be monitored.	COO	L.Cheek	ongoing
7	**Clinical audit**: deliver all recommendations from IA report and complete action plan as stated	CMO	SGB	ongoing
8	**FNoF:** Implementation of action plan – review with CEO	COO	B Bray	31 March

Contents

5. Risk Log – highest rated risks

	Risk	KPIs affected
1	**Emergency activity in ED and insufficient Medical Emergency bed capacity**	ED [A&E], 18 wks(non-admitted), cancelled ops, FNoF, MSA
2	**D&V outbreaks causing ward closures**	ED [A&E], 18 wks(non-admitted), cancelled ops, FNoF, MSA
3	**Continued reliance on escalation beds and medical patients being managed in the non medical bed base.**	ED [A&E], 18 wks(non-admitted)
4	**Variable volumes of trauma being admitted at once**	FNoF
5	**C.diff cases continue at current rate (ie: above the trajectory)**	Infection control
6	**Sterilisation risk from the steam generators at Crawley Hospital not being serviceable**	Infection control, 18 weeks
7	**NICE guidance and women wishing to exercise what they see as their right to choose mode of delivery**	C-Sections, 12 weeks 6 days

Contents

6. Glossary of Terms

- AMI – Acute Myocardial Infarction
- C diff – Clostridium difficile
- CDS – Commissioning Data Set
- FFCE – First Finished Consultant Episode
- H&S – Health and Safety
- HSMR – Hospital Standardised Mortality Rates
- ITU – Intensive Treatment Unit
- LOLER – Lifting Operations and Lifting Equipment Regulations 1998
- MRSA – Methicillin-Resistant Staphylococcus aureus
- RACP – Rapid Access Chest Pain
- RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
- SUI – Serious Untoward Incident
- TIA – Transient Ischaemic Attack
- WTE – Whole Time Equivalent