Surrey and Sussex NHS Healthcare NHS Trust

Integrated Quality and Performance Report (IQPR) M09 – December 2011

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Putting people first
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Performance & Quality M09 – December 2011

Summary:

- **The Trust's performance rating was escalated to "challenged" at Quarter Two. The basis of the performance deficit are the A&E wait and 18 week referral to treatment (RTT) indicators (these constitute, in number, a large proportion of the rating), where the Trust has not previously had sufficient capacity to deliver either.**
- **The Trust plans to deliver A&E and RTT indicators in March and February 2012, respectively. The opening of additional capacity (40 extra beds) and the first phases of the emergency department refurbishment are core to those plans. For 18 week RTT indicators, a new recovery plan is being agreed with the SHA now that additional funding has been made available to buy extra capacity, allowing the target to be delivered earlier (in February).**
- **The venous thromboembelism (VTE) assessment target of 90% of all admitted patients (a key preventative and safety KPI) was met by the Trust at M09. The Trust is performing well on its cancer targets, and although it has missed its MRSA trajectory (by one case against a target of 4) and there is risk against the C.diff indicator, there are no immediate concerns over infection control performance. Also, the actions around stroke (just one red rated KPI) are seen to be particularly positive ahead of the reconfiguration of wards.**
- **An independent clinical investigation of the emergency department (for the SHA) has provided informal feedback that services are seen to be safe while advising that with the overcrowding effective privacy and dignity for ED patients is difficult to achieve. A CQC report on escalation areas had only moderate concerns.**

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

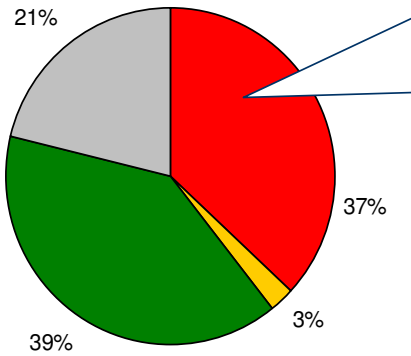
Note: changes to indicators

- The Board has discussed changes to indicators. These will be incorporated in the M10 report.

1. Domain Summary

- There are a couple more greens in the pie charts at M09 (including achieving the VTE assessment threshold). The extra red is a workforce indicator. Nevertheless, with the vast majority of the KPIs dealing with A&E and RTT and the Trust's non delivery [so far], the red indicators clearly describe the poor overall performance rating.
- **National performance rating:** With the adverse rating continuing (primarily in A&E and RTT indicators), the Trust has spent more than 3 quarters as "underperforming" in respect of performance and was escalated to "challenged" status at Quarter 2.

RAG % Effectiveness domain

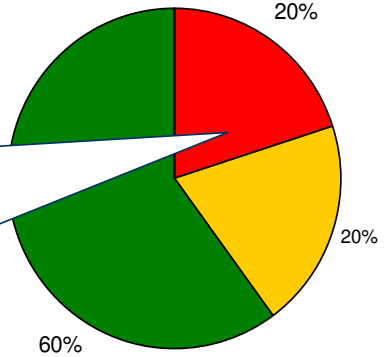


14 red rated KPIs
6 are A&E KPIs, 5 are RTT. Trust is likely to be in lowest decile for A&E and is worst performer nationally in RTT. *(Other reds are: 1 stroke and 2 FNoF).*

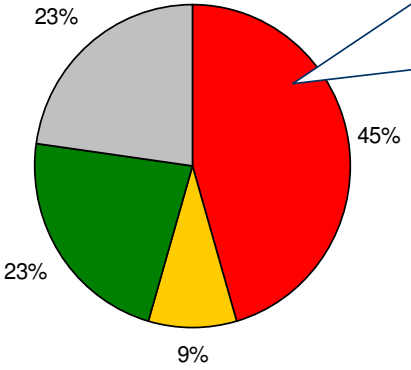
Green KPIs number 15 & for the first month equal the reds and ambers

1 Red rated KPI:
Pressure ulcers (there are only 4 KPIs in this chart).
VTE went green at M09

RAG % Safety domain



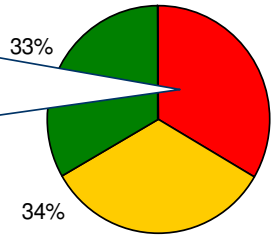
Rag % Internal Quality Domain



10 red rated KPIs
4 are workforce KPIs (1 more than M08, vacancy rate went red at M09), 4 are clinical audit and 2 are maternity. There has been no favourable trend in either of the latter two areas all year, although C-sections shows some statistical shift.

RAG % Patient Experience Domain

1 Red rated KPI:
There are now only 3 KPIs in this chart – red rated is mixed sex compliance



Contents

Effectiveness – A&E

	Performance		Direction of Travel vs. Plan	Monthly Trend				Change from last quarter (q1 vs q2)	Q3 Trend	Forecast for next Quarter (end of Q4)
	Target (mth or year)	YTD Actual / Ave / Mth	▲=fav to plan ►=on plan ▼=adv to plan	Sep-11	Oct-11	Nov-11	Dec-11	▲=improved ►=no change ▼=worse	Key: Green= on plan, Yellow = up to 5% variance, Red= below threshold	
A&E time to initial assessment (95th percentile)	<15	150	▼	157	122	130	150	▲	►	
A&E time to initial assessment (median)	N/A	20		21	21	20	23			
Time to Treatment (median)	<60	31	▲	38	27	27	31	▲	▲	
Total time in A&E admitted (95th percentlie)	240	1,091	▼	1,032	1,113	1,016	1,091	▲	▲	
Total time in A&E non-admitted (95th percentlie)	240	457	▼	384	432	350	457	▲	▲	
% of patients in A&E under 4 hours	95%	84.4%	▼	85.3%	84.8%	85.0%	78.6%	▲	▼	
number of of patients in A&E over 12 hours (trolley waits)	0	115	▼	8	73	25	0	▼	▼	
A&E Unplanned Re-attendance rate (within 7 days)	<5%	5.3%	▼	3.4%	5.7%	4.8%	5.4%	▲	▼	
Left without being seen (LWBS) Rate	<5%	3.0%	▲	3.4%	3.1%	2.6%	5.0%	▲	▼	
A&E Attendances (Number of Type 1 attendances)	N/A	54,618		6,596	6,999	6,471	6,660			
Emergency Readmissions within 30 days of discharge	TBD	3.1%		2.8%	3.5%	3.1%	3.0%			
Delayed Transfers of Care	3.5%	5.4%	▼	6.1%	6.4%	7.8%	4.6%	▼	▼	

M09 situation report

- No 12 hour breaches in M09. 4 hour wait performance is below the target and worsened from 85% at M08 to 79%. The forecast however, is delivery of 95% in March.
- A draft Emergency Care Intensive Support Team (ECIST) report (visit in December) states that the Trust improvement plan remains appropriate and good practice initiatives ECIST have recommended are being implemented.
- Early feedback from an SHA independent clinical review (in January) states that ED is seen to be safe but that privacy and dignity is an issue with the volume of patients. The CQC visit (in December) looking at escalation areas notes moderate concerns and that the Trust is already taking action in respect of ending use of some escalation areas.

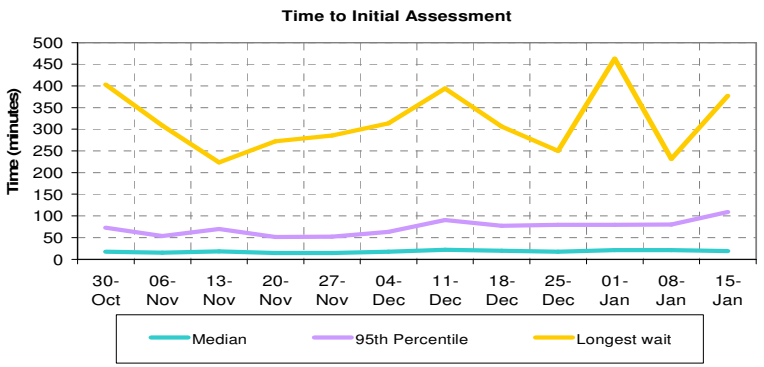
Actions to improve performance

- 4 hour target delivery is profiled for March 2012 and plans to improve performance remain on track and on time. Modular ward and ED refurbishment schemes are meeting deadlines and recruitment of staff is proceeding. The go live will be reviewed at Management Board in detail on 1 February.
- There is increased focus by senior ED staff to embed escalation processes (ensuring compliance) and leadership (better daily senior decision making) and a senior lead working at the interface with other services has been appointed (noting the specific need to improve this complex area of joint working). 2 new ED consultants have been appointed and 2 “UTC” associate specialist posts offered.

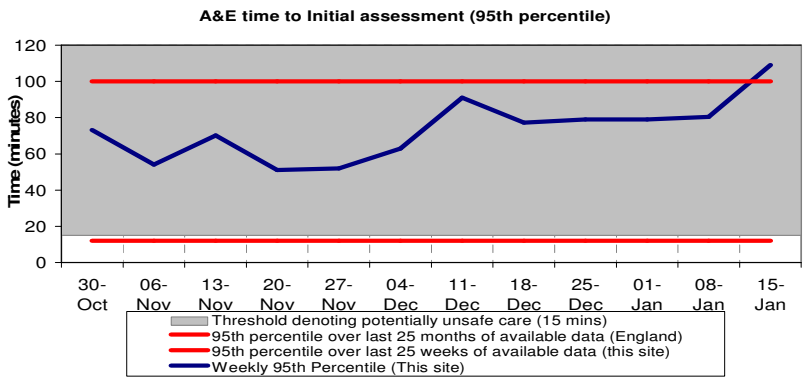
Performance Quality Indicators Graphs (A&E)

Time to initial assessment by Nurse in A&E

Site-level performance



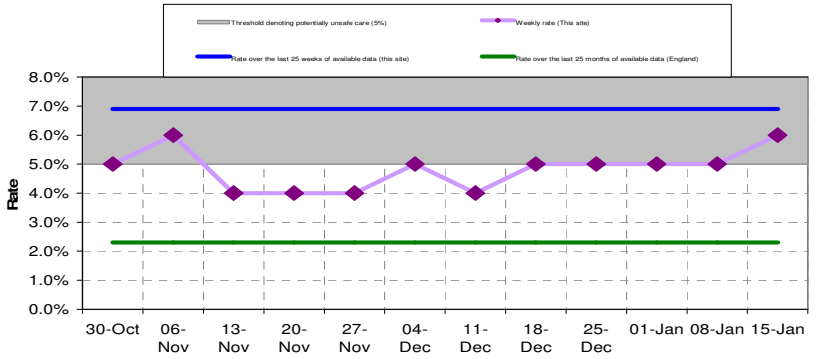
Site performance against national benchmarks and performance thresholds



109	95th percentile this month
Worse	Compared to last week
	Data Completeness

Unplanned re-attendance

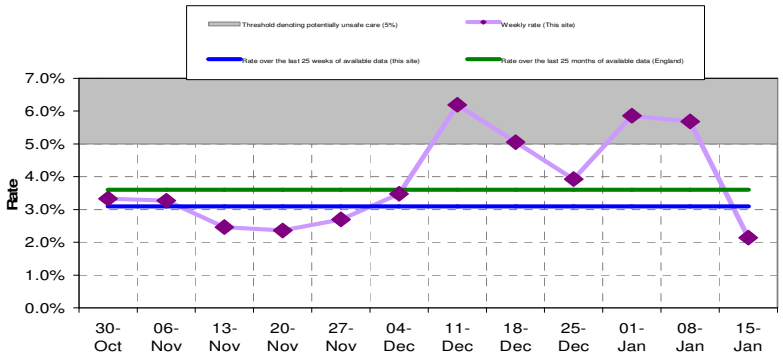
Unplanned re-attendance rate



6.0%	Rate this month
Worse	Compared to last week
	Data quality

Left without being seen

Left without being seen rate



2.1%	Rate this month
Better	Compared to last week
	Data quality

Effectiveness – 18 weeks referral to treatment

	Performance		Direction of Travel vs. Plan	Monthly Trend				Change from last quarter (q1 vs q2)	Q3 Trend	Forecast for next Quarter (end of Q4)
	Target (mth or year)	YTD Actual / Ave / Mth	▲=fav to plan ►=on plan ▼=adv to plan	Sep-11	Oct-11	Nov-11	Dec-11	▲=improved ►=no change ▼=worse	Key: Green= on plan, Yellow = up to 5% variance, Red= below threshold	
18 weeks RTT admitted - 95th Percentile	<=23	34	▼	39	37	34	36.5			
18 weeks RTT - non-admitted including audiology (DAA)- 95th percentile	<=18.3	52	▼	46	48	52	51			
RTT - incomplete - 95th percentile	<=28	33	▼	34	33	33	49			
Median wait times -non-admitted	N/A	13		12	12	13.0	13			
Median wait times - admitted	11.1	11	►	14	12	11	10			
RTT - incomplete -median	7.2	7	►	9	7	7	11			
RTT - admitted 90% in 18 weeks	90%	69.8%	▼	61.1%	67.7%	69.8%	71.2%			
RTT - non- admitted 95% in 18 wks	95%	61.8%	▼	67.8%	64.8%	61.8%	60.3%			
RTT Backlog (no of patients waiting)				1,111	1,058	920	837			
**% of cancelled operations not treated within 28 days	<=5%	5.0%	►	2.4%	3.1%	0.0%	0.0%	▲	►	
Cancelled operations as a percentage of elective admissions	<=0.80	1.6%	▲	1.4%	2.4%	1.0%	1.0%	►	►	

M09 situation report

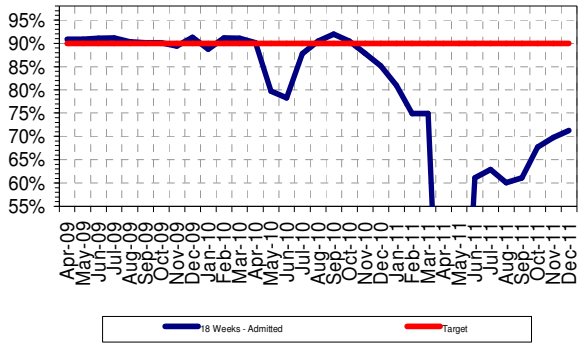
- 18 week performance remains below the target (the Trust is not meeting the 5 main indicators it is measured against for admitted and non admitted pathways) but is on track against its agreed recovery plan. It expects to deliver the targets in the last quarter. Endoscopy waiting times also remain adverse to the 6 week target.
- Action around managing beds (protocols for dealing with escalation of non elective activity, maintaining an elective bed base) and decision making day by day has reduced the number of cancellations significantly compared with previous years, and indeed the monthly performance (cancelled ops) above has improved despite this now being the busy winter period.

Actions to improve performance

- Diagnostic waiting times are subject to action that is seeing increased outsourcing to clear the backlog. It is expected that this position will be corrected in early February.
- For the overall RTT position, the Trust is in the process of agreeing a revised recovery plan with the SHA and its PCTs, that will see a significant increase in capacity (both within the Trust and from external providers) which will be afforded through the relesae of additional funds. The plan as currently drafted sees the delivery of the 90% admitted target in both February and March, whereas the previous plan saw delivery later in the financial year.

Performance Quality Indicator Graphs (18 wks)

RTT 18 Weeks - Admitted

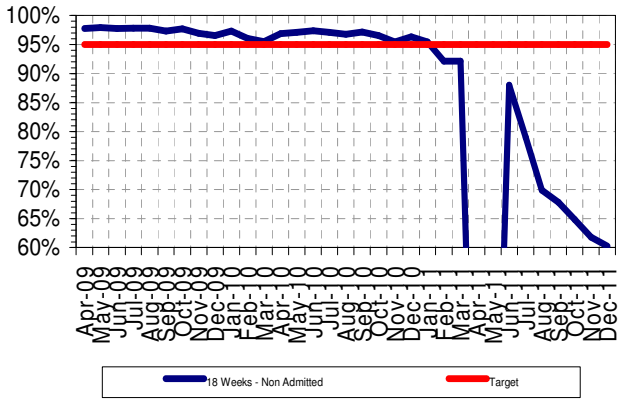


Description of data

This data illustrates % compliance with RTT waits as set out in the operating framework for 2011/12. The Trust has had agreement with it's commissioners to under perform against this target in order to clear the backlog. The trust upgraded the cerner PAS system from release 0 to LC1E early in the year and were unable to report against the standard. This is reflected in the drop in compliance to 0 demonstrated in the graph.

71.2%	Rate this month	
Greater	Compared to last mth	

RTT 18 Weeks - Non Admitted



Description of data

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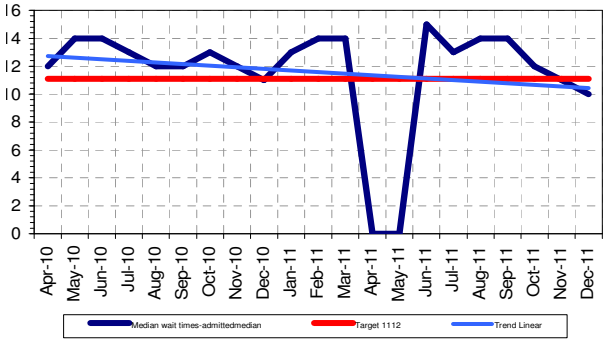
60.3%	Rate this month	
Less	Compared to last mth	

Median wait times - admitted

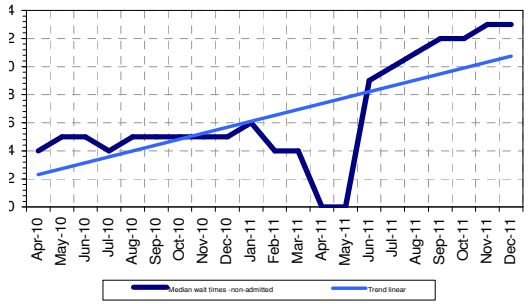


Description of data

This graph measures the median wait times for admitted patients whose clock stopped during the period. As above when the Trust upgraded the cerner PAS system earlier in the year we were unable to report against the standard. This is reflected in the drop in compliance to 0 demonstrated in the graph.

10	Rate this month	
Less	Compared to last mth	

Median wait times -non-admitted



Description of data

This graph measures the median wait times for non-admitted patients whose clock stopped during the period. As above when the Trust upgraded the Cerner PAS system earlier in the year we were unable to report against the standard. This is reflected in the drop in compliance to 0 demonstrated in the graph.

13	Rate this month	
Equal	Compared to last mth	

Effectiveness - Cancer

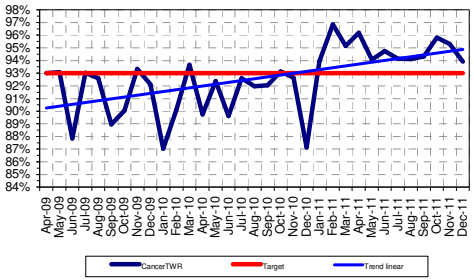
	Performance		Direction of Travel vs. Plan	Monthly Trend				Change from last quarter (q1 vs q2)	Q3 Trend	Forecast for next Quarter (end of Q4)
	Target (mth or year)	YTD Actual / Ave / Mth	▲=fav to plan ►=on plan ▼=adv to plan	Sep-11	Oct-11	Nov-11	Dec-11	▲=improved ►=no change ▼=worse	Key: Green= on plan, Yellow = up to 5% variance, Red= below threshold	
2 week GP referral to 1st outpatient	93%	94.7%	▲	94.3%	95.8%	95.3%	93.9%	▲	▲	
2 week GP referral to 1st outpatient - breast symptoms	93.0%	92.5%	▼	83.5%	93.6%	99.0%	94.0%	▲	▲	
31 day second or subsequent treatment (surgery)	94.0%	97.1%	▲	100.0%	96.6%	100.0%	100.0%	▲	▲	
31 day second or subsequent treatment (drug)	98.0%	99.5%	▲	94.4%	100.0%	100.0%	100.0%	►	▲	
31 day decision to Treat to Treatment	96.0%	98.9%	▲	98.7%	99.0%	98.9%	97.0%	►	►	
62 days urgent referral to treatment of all cancers	85%	86.16%	▲	85.0%	85.2%	87.9%	85.6%	►	►	
62 wait first treatment from Consultant screening	90%	91.7%	▲	100.0%	100.0%	80.0%	90.0%	►	►	

M09 situation report

- Performance remains OK, and the Trust is not an outlier in comparison with other organisations.
- There is improvement against the maximum 2 month (62 day) wait for those cases where priority to treat has been upgraded after screening.
- There is no issue over performance, but the fluctuations in the figure for the screening indicator in collating this report suggest that the balance between timeliness and accuracy needs to be reviewed (ie: report an estimated figure, correcting in the next month as formal figures for performance are sent to DoH after further validation that takes longer than the deadlines for this performance report – therefore the percentages can change (normally improving) in that time).

Performance Quality Indicator Graphs (Cancer)

Cancer TWR vs. Target

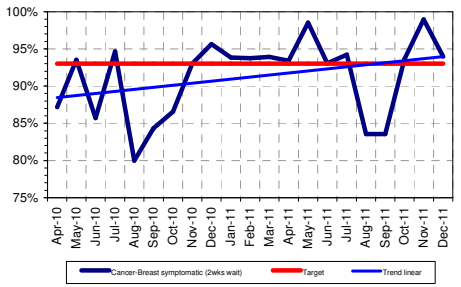


Description of data

[insert text XXXXXXXXX]

93.9%	Rate this month	
Less	Compared to last mth	

Cancer-Breast symptomatic (2wks wait) vs. Target

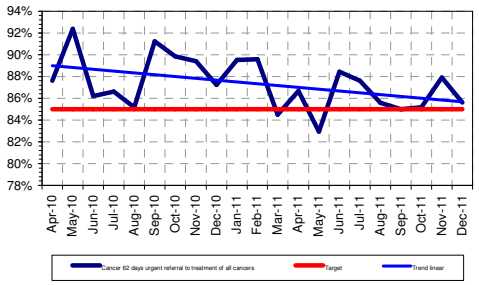


Description of data

of patients seen within two weeks of an urgent GP referral for suspected breast cancer. The Trend line illustrates increasing compliance month on month with target. The Drop in compliance in August and September was due to bank holidays and annual leave. A plan has been out in place to address these issues and

94.0%	Rate this month	
Less	Compared to last mth	

Cancer 62 Days urgent referral to treatment of all cancers

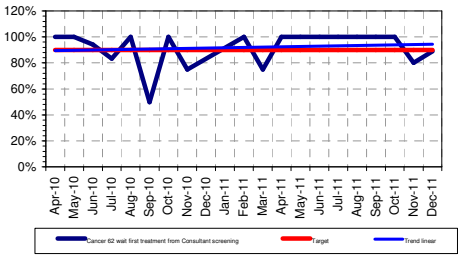


Description of data

This graph illustrates the % of patients receiving first definitive treatment for cancer within 62 days of urgent GP referral. Maintaining this standard will ensure patients move along the pathway at a clinical appropriate pace and have better outcomes. The tread line illustrates a decrease in performance however the calculation for this indicator has changed and clock stops are no longer permitted. The Trust is above the target in this area.

86%	Rate this month
Less	Compared to last mth

Cancer 62 Days wait first treatment from Consultant screening



Description of data

This graph illustrates the % of patients receiving first definitive treatment for cancer within 62 days from Consultant Screening. The tread line illustrates a slight increase on performance. However this pathway has very low numbers causing the % compliance rate to be variable.

88.9%	Rate this month
Greater	Compared to last mth

Effectiveness – Stroke

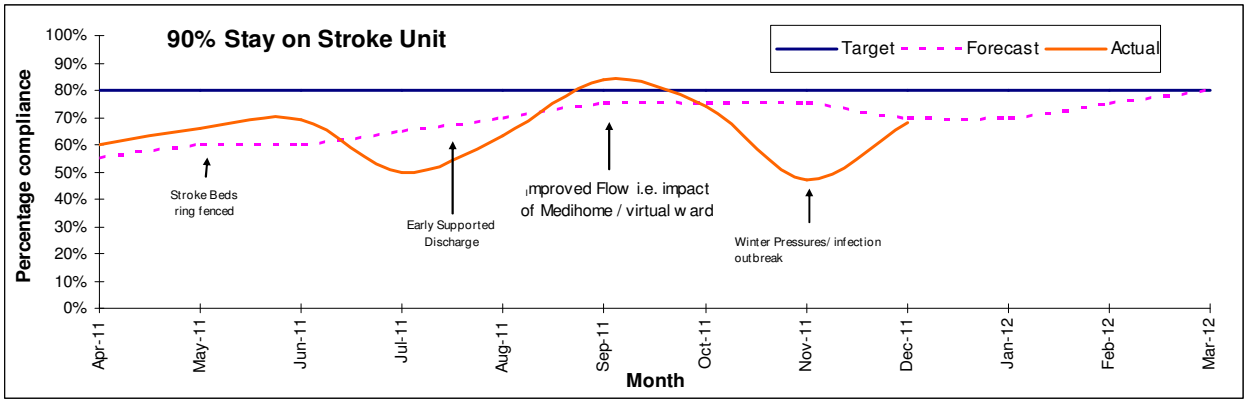
	Performance		Direction of Travel vs. Plan	Monthly Trend			Change from last quarter (q1 vs q2)	Q3 Trend	Forecast for next Quarter (end of Q4)
	Target (mth or year)		▲=above plan►=on plan▼=below plan	Oct-11	Nov-11	Dec-11	▲=improvement►=no change▼=worse	Key: Green= on plan, Yellow = up to 5% variance from threshold needs attention, Red= below threshold action plan required	
Operating Framework									
Patients that have spent more than 90% of their stay in hospital on a stroke unit	80%	64.9%	▼	74.1%	46.5%	67.6%	►	▼	
Stroke/TIA treated within 24 hours	60%	80.6%	▲	100.0%	66.7%	75.0%	▲	▲	
% of Stroke patients Scanned within 1 hour of hospital arrival	50%	46.0%	▼	42.3%	64.1%	55.9%			

M09 situation report

- The 90% indicator is not being achieved, but other targets are. Achievement of the 90% indicator is prevented by the adverse impact of the pressured emergency pathway and poor patient flow.
- The scan within 1 hour of arrival target has now been met. The previous calculation for this indicator was based on NICE guidelines. The current calculation is based on the one used in the accelerated stroke metrics (ASI).
- For M09, performance is back in line with the intended forecast (see chart below) after the dip of M08.

Actions to improve performance

- Bed capacity will be increased with the modular wards and the Acute Stroke Unit will move to a larger 28 bedded ward (all in February) - performance will not improve until bed capacity increases.
- The impact of Early Supported Discharge will be reviewed, in conjunction with the community therapy teams leading to implementation of further improvements, and the stroke pathway will be re-launched , to raise awareness, when ASU moves (the pathway has been re-written and is going to the Medicine Divisional Board for ratification in January 2012).



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Delivering excellent, accessible healthcare

Effectiveness- Fractured neck of Femur (FnoF), PPCI

	Performance		Direction of Travel vs. Plan	Monthly Trend			Change from last quarter (q1 vs q2)	Q3 Trend	Forecast for next Quarter (end of Q4)
	Target (mth or year)		▲=above plan►=on plan▼=belo w plan	Oct-11	Nov-11	Dec-11	▲=improvement►= no change▼=worse	Key: Green= on plan, Yellow = up to 5% variance from threshold needs attention, Red= below threshold action plan required	
Operating Framework									
Fractured Neck of Femur <36	85%	61.4%	▼	49.0%	66.7%	62.8%	▼	▼	
Fractured Neck of Femur <48	85%	77.8%	▼	73.3%	80.6%	76.7%	▼	►	
**PPCI 150 min call to ballon time	95%	100.0%	▲	**N/A	Data reported in	Data reported in arrears	►	►	
PPCI 120 min call to ballon time	60%	100%	▲	**N/A	Data reported in	Data reported in arrears	►	►	

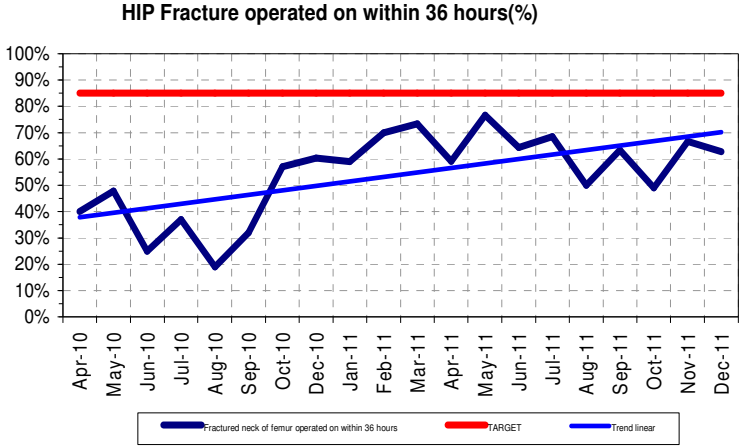
M09 situation report

- **PPCI performance** – all targets continue to be achieved.
- **Fractured neck of femur**: performance against the indicators remains adverse, and is worse than M08 in both measures. The chart on the next page describes the [static] position, which, like other indicators here cannot improve until the capacity and patient flow problems the hospital has are overcome - the limiting factor is the variable volume of Trauma admitted at any one time.
- 46 patients were admitted with fractured neck of femur in month. Only 4 patients were able to be placed in a fast track bed on Newdigate ward as currently the fast track bed for #NOF is not ring fenced (the point above about capacity)
- The Trust also sees an extremely high volume of fractured neck of femur patients, disproportionate to its overall activity levels.

Actions to improve performance

- The additional capacity coming on line is a key action to support improvements in performance – ring fencing of beds is key and the capacity should allow better flexibility to deal with variable trauma arrivals..
- The Trust is looking at securing rehabilitation beds for FNoF cases that will allow increased throughput and so ring fencing of beds.
- Morning trauma meetings are now taking place in the Theatre Seminar room - which is allowing for teaching to take place undisturbed and is providing more time to review in-week performance.
- Attempts to divert some patients to other acute trusts have not been possible, due to capacity issues in those trusts.

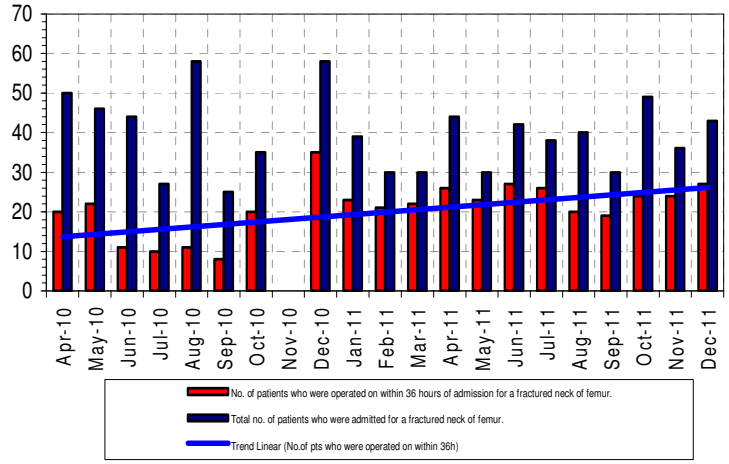
Effectiveness- Fractured neck of Femur (FnoF) charts



Description of data

This Graph illustrates the number of patients who are operated on within best practice guidelines (the national standard is 48 hours) The trend line illustrates a month on month increasing level of compliance. A contributory factor to the underperformance in month is the variable amount of trauma on theatre lists

62.8%	Rate this month	
Less	Compared to last mth	



Description of data

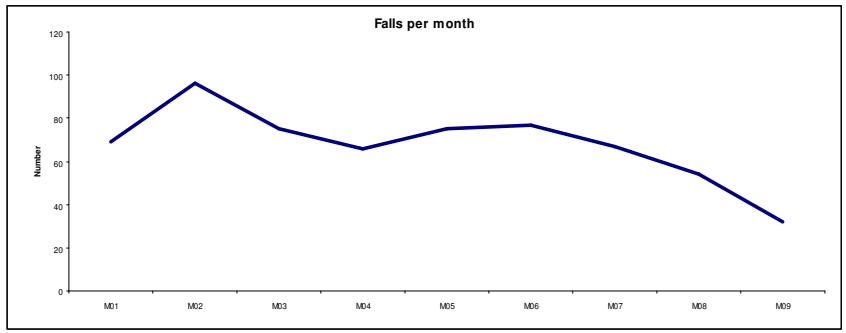
This graph illustrates the total number of patients with a hip fracture who were admitted, and of those the number of patients who went through the pathway within the timeframe for best practice. The trend line illustrates an increasing level of compliance in this area.

Safety

	Performance		Direction of Travel vs. Plan	Monthly Trend				Change from last quarter (q1 vs q2)	Q3 Trend	Forecast for next Quarter (end of Q4)
	Target (mth or year)	YTD Actual / Ave / Mth	▲=fav to plan ►=on plan ▼=adv to plan	Sep-11	Oct-11	Nov-11	Dec-11	▲=improved ►=no change ▼=worse	Key: Green= on plan, Yellow = up to 5% variance, Red= below threshold	
HSMR	100	100	►	103	Data reported in arrears	Data reported in arrears	100	►	▲	
VTE Risk Assessments	90%	90.4%	▲	75.0%	80.8%	85.6%	90.4%	▲	▲	
Newly acquired Pressure Ulcers (grade 2 and above)	71	158	▼	18	25	14	19	▲	▼	
Number of falls reported as clinical incidents	73	66	▲	77	67	54	32	▲	►	
Number of medication errors resulting in an adverse event	0	35	▼	9	4	3	0	▼	▼	

M09 situation report

- **VTE** – the Trust delivered the 90% target, belatedly but according to its stated trajectory.
- **Medication errors** – there were none in M09.
- **Pressure ulcers** – the performance fluctuates but the trend is not improving. There was an increased level of high risk patients in the Medical Division. Action is listed right.
- **Falls:**. As currently stated, and going back to April, the trend is favourable (see chart below) – the issue raised right concerns the delay in collating full data and the process of "refreshing" past months which makes month on month comparison difficult.



Actions to improve performance

- **Pressure damage**: Understanding of causation and maintaining consistency of documentation require further effort – both are being pursued - a "root cause analysis" of all cases will be undertaken with increased frequency of report collation and more focus from senior nurses on clinical Fridays to drive preventative work. The RCA action will also look at whether there is a linkage with trolley waits in ED.
- The ongoing action is coordinated by the weekly pressure damage action board, there is also a programme of training to ward staff and we have established "safety champions".
- **Falls:** For next month there will be a review of the data and recording, (which is refreshed each month, replacing data for past months as data is collated from various sources) to ensure the right balance between timeliness and accuracy is achieved. However, as it stands the action plan, falls group and other inputs appear to be having a positive impact.
- Note: HSMR will be discussed next month after collation and analysis of the re-basing changes.

Patient Experience

	Performance		Direction of Travel vs. Plan	Monthly Trend				Change from last quarter (q1 vs q2)	Q3 Trend	Forecast for next Quarter (end of Q4)
	Target (mth or year)	YTD Actual / Ave / Mth	▲=fav to plan ►=on plan ▼=adv to plan	Sep-11	Oct-11	Nov-11	Dec-11	▲=improved ►=no change ▼=worse	Key: Green= on plan, Yellow = up to 5% variance, Red= below threshold	
Mixed Sex Accommodation - Total	0	144	▼	18	46	25	32	▼	▼	
% of patients surveyed who would choose to be treated at SASH in Future	75%	76%	▲	97%	89%	74%	93%	Quarterly comparison cannot be made due to missing data	▲	
% of patients surveyed that staff treated them with kindness and respect	70%	84%	▲	98%	98%	84%	question taken off		▲	
% of patients surveyed who felt their dignity was maintained the whole time they were a patient	90%	80%	▲	89%	94%	92%	95%		▲	

M09 situation report

- **Mixed sex accommodation** – breaches continue around the same general level as in previous months – most are a consequence of managing in current overcrowded conditions. Patient surveys at M09 rated "mixed sex accommodation" as a "red" issue (see below).
- Informal feedback from the SHA clinical investigation in January recognised the privacy and dignity issues for patients in the emergency department (ED) and noted that they saw staff doing everything they could under the circumstances.
- **Patient experience:** After a significant negative change last month, "would you choose to be treated at SaSH in the future" has a much more positive response at M09.
- In the Medical Division real time monitoring (RTM) surveys completed by patients, the M08 "red" flagged comment from "not enough opportunity to speak to a doctor" is not "red" flagged at M09 after successful action between doctors and ward staff to correct it.
- Apart from mixing of sexes, the "red" items at M09 were "patients interrupted during meals", "poor quality food", "and "staff not washing their hands/using gel". Actions are listed right.
- The question about "maintaining privacy & dignity" has been green in the Division for 3 successive months.

Actions to improve performance

- The action to increase capacity (modular wards) and complete the refurbishment and enlargement of the emergency department and the impact that will have on patient flow will allow more consistent maintenance of single sex accommodation.
- There are a number of patient experience actions linked to December's RTM surveys:
  - Focus groups on nutrition and hydration – there is a programme of focussed activities in the week 23 – 27 January to highlight this;
  - ED patient well-being standard and ED comfort rounds;
  - Hourly rounding at night on all Medical Wards, Newdigate nad Leigh;
  - Divisional patient experience action plans monitored by the Nursing & Midwifery Professional Committee;
  - Clinical working Fridays;
  - Relaunch of productive ward protected mealtimes.

Contents

Maternity

	Performance		Direction of Travel vs. Plan	Monthly Trend			Change from last quarter (q1 vs q2)	Q3 Trend	Forecast for next Quarter (Q4)
	Target (mth or year)	YTD Actual / Ave / Mth	▲=above plan►=on plan▼=below plan	Oct-11	Nov-11	Dec-11	▲=improvement►=no change▼=worse	Key: Green= on plan, Yellow = up to 5% variance from threshold needs attention, Red= below threshold action plan required	
Safe, High Quality Coordinated Care									
**C-section rate	23%	29.4%	▼	26.6%	30.1%	27.7%	►	▲	
% of women seen by a midwife or healthcare professional at 12 wks 6dys	90%	88.6%	▼	85.9%	87.1%	89.5%	▲	▼	
Breastfeeding initiation	90%	81.0%	▼	81.6%	84.7%	76.5%			

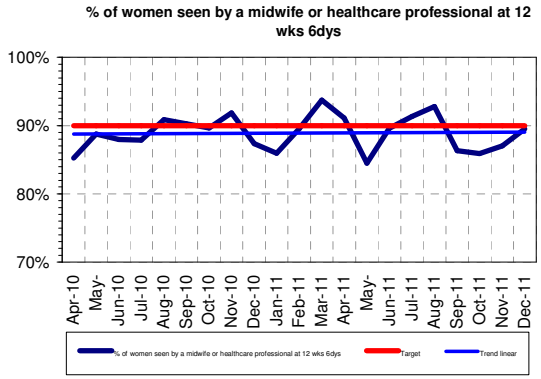
M09 situation report

- **Caesarean section rate** – the year to date position remains adverse to the 23% target at 29.4%, although M09 improves over M08, and the chart (next page) describes a 4 month moving average line with a downward trend in 2011/12.
- Within the SHA indicators the VBAC (vaginal birth after caesarean) rate is at 78% in the month, its highest for a year. This may be linked to the birthing team leader taking on the role of VBAC lead.
- NHS Surrey, but not NHS Sussex, have issued a Contract Query and are pursuing financial penalty on c-sections being adverse to the target.
- **Other indicators** – the 12 week booking indicator is just below the 90% threshold and is not seen as a significant cause for concern, relying as it does on factors outside of the Trust's control (GP advice to women and women's choice - there are no additional actions opposite). Also the Trust is not an outlier regionally (we are 4th out of 11 Trusts). For breast feeding initiation the Trust is taking the steps listed right to improve on this measure.

Actions to improve performance

- **C-sections:** non-elective sections are being audited and reviewed to identify actions. Elective sections are subject to similar audit and review but also redesigned pathways with review points and increasingly stringent monitoring with feedback to individual clinicians. The Trust has been notified by PCTs that the new NICE guidelines (which ostensibly promote greater choice to have sections) do not impact on the targets, but the Trust is keen to agree better how the health system manages the expectations of women aware of the changes to the guidance.
- **Breast feeding:** the Trust has recruited to a specialist post (an "infant feeding co-ordinator") and is in the 2nd year of a three year "baby friendly" initiative that supports breast feeding. Finally, bottles are increasingly restricted on the wards to incentivise breast feeding.

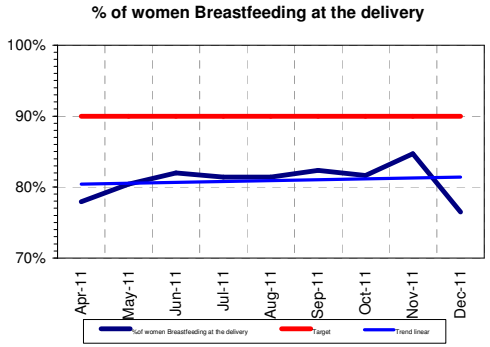
Internal Quality Metric Graphs (Maternity)



Description of data

This graph measures early access for women to maternity services. Research has shown women who access maternity care early have better outcomes.

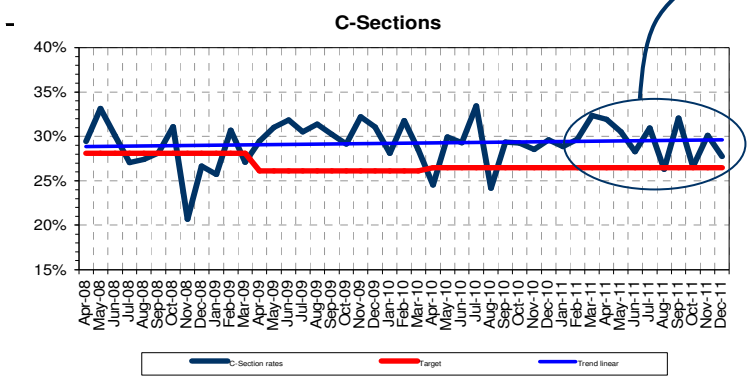
89.5%	Rate this month	
Greater	Compared to last mth	



Description of data

This graph illustrates the % of women who are breastfeeding at delivery month on month. A contributing factor to underperformance in this area will be choice. A education campaign on the benefits of breastfeeding has been launched to encourage more women to choose to breastfeed.

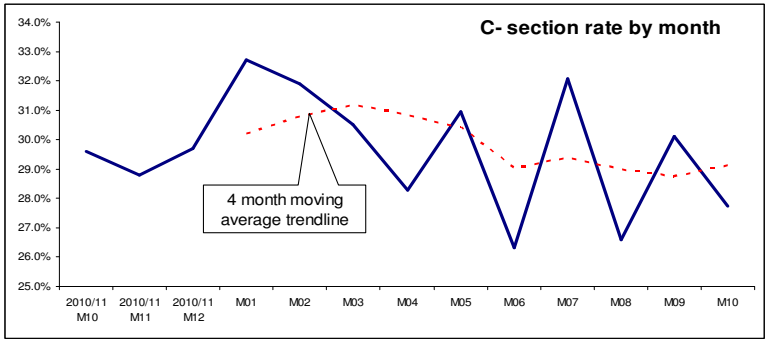
76.5%	Rate this month	
Less	Compared to last mth	



Description of data

This graph illustrates the change in c-section rate over time. Data continued in the graph is taken from Cerner. The division are aiming to achieve the Year end target of 23% though a remedial action plan that has been agreed with commissioners.

27.7%	Rate this month	
Less	Compared to last mth	



Caesarean section rates

- The chart left shows a generally static c-section rate over a long period of time, that above shows a shorter snapshot (a year) and a declining short term rate using a 4 month moving average – but that decline follows the peak rates in the last quarter of 20110/11.

Healthcare acquired infections (HCAI)

	Performance		Direction of Travel vs. Plan	Monthly Trend				Change from last quarter (q1 vs q2)	Q3 Trend	Forecast for next Quarter (end of Q4)
	Target (mth or year)	YTD Actual / Ave / Mth	▲=fav to plan ►=on plan ▼=adv to plan	Sep-11	Oct-11	Nov-11	Dec-11	▲=improved ►=no change ▼=worse	Key: Green= on plan, Yellow = up to 5% variance, Red= below threshold	
MRSA (trust acquired)	3	5	▼	0	0	2	0	▼	▼	
C Diff (trust acquired)	37.5	40	▼	5	6	3	7	▼	▲	
MSSA (trust and community acquired)	N/A	41		6	2	6	1			
*E. Coli	N/A	33		9	3	1	4			
Hand Hygiene compliance	99%	98.8%	▼	99.4%	98.8%	99%	100.0%	►	►	
MRSA screening compliance (nonelective)	100%	110%	▲	110.0%	Data Reported Quarterly			►		
MRSA screening compliance (elective)	100%	105%	▲	105.0%	Data Reported Quarterly			►		

M09 situation report

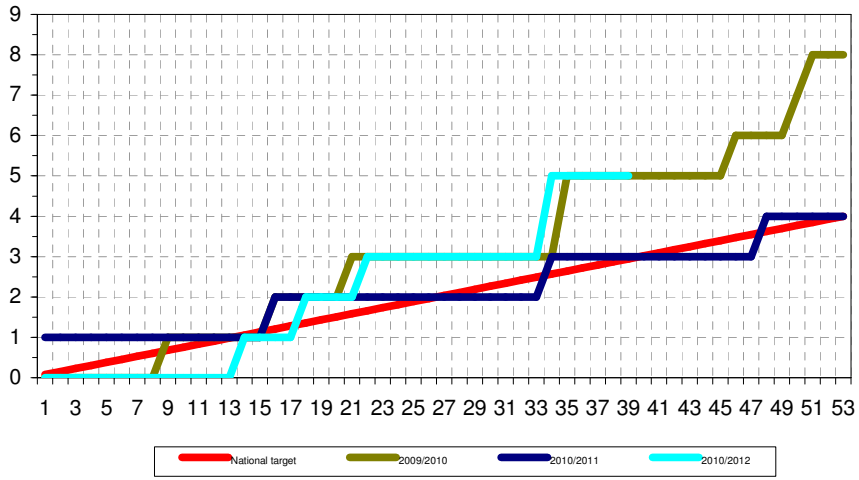
- **MRSA** – the Trust has breached the target for MRSA Blood Stream Infection (BSI) for the year. We have had 5 cases against an annual target of 4. There have been no new cases since November 2011 (M08).
- **C-diff** - The Trust has had 40 cases of *Clostridium difficile* against an annual target of 50, and we are therefore 2 (plus a fraction as 3/4 of 50 is 37.5) cases over trajectory, but forecast delivering the target. So, there is a risk here.
- This is the baseline year for MSSA bacteraemia and E.Coli bacteraemia collection. There are no reduction targets set as yet for 2012/13. We are not yet aware of any algorithm for attributing these (E.Coli) cases. So in the short term we have adopted the normal BSI algorithm using pre and post 48 hours of admission.

Actions to improve performance

- An internal audit report on the infection control framework (going to January Audit & Assurance Committee) provides a “green/amber” risk rating (reasonable assurance, some small recommendations). There are only two recommendations both around training. The first is already resolved (tracking staff who haven’t received training) the second sees action on antibiotic audit and training.
- There will therefore be an increase in the presence of infection control nurses on ward to carry out weekly audit and feedback of MRSA screening and care of intravenous devices and a number of new workstreams around use of antibiotics, including: Antibiotic Stewardship Group, revised drugs chart, reduction in the use of Augmentin.

Internal Quality Metric Graphs (HCAI)

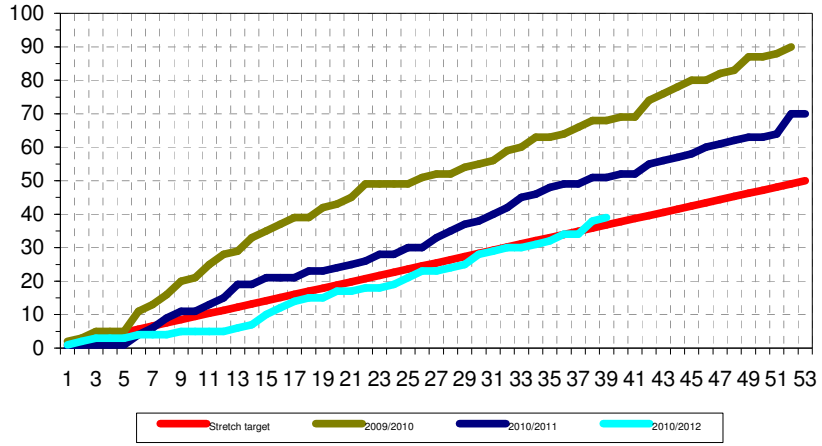
Weekly MRSA BSI Post 48Hrs vs. National Strech Target



Description of data

This graph illustrates the year on year reduction in MRSA rates by week. The numbers on the vertical axis represent # of patients. The horizontal axis represents weeks of the year. To achieve the percentage reduction over 2010/2011 figures the trust is aiming to bring it's MRSA rate to 4 cases or less. We are currently abpove plan for this indicator.

Weekly C. Diff Post 72Hrs vs. Local Stretch Target



Description of data

This graph illustrates the year on year reduction in MRSA rates by week. The numbers on the vertical axis represent # of patients. The horizontal axis represents weeks of the year. To achieve the percentage reduction over 2010/2011 figures the trust is aiming to bring it's MRSA rate to 4 cases or less. We are currently above plan for this indicator

Note: Sterilisation risk

- The steam generators at Crawley Hospital (which the Trust rents from NHS Sussex & pays for services from Sussex Community Trust) failed their tests after their servicing/upgrading. This will delay the HSDU (sterilisation) autoclaves coming on line for at least 2 weeks, which in turn threatens 18 weeks.
- The current opinion is optimistic, with improved service now being reported suggesting that the delay may not be as bad.

Workforce

	Performance		Direction of Travel vs. Plan	Monthly Trend			Change from last quarter (q1 vs q2)	Q3 Trend	Forecast for next Quarter (Q4)
	Target (mth or year)	YTD Actual / Ave / Mth	▲=above plan ►=on plan ▼=below plan	Oct-11	Nov-11	Dec-11	▲=improvement ►=no change ▼=worse	Key: Green= on plan, Yellow = up to 5% variance from threshold needs attention, Red= below threshold action plan required	
Safe, High Quality Coordinated Care									
Vacancy Rate	<=10%	9.3%	▲	10.5%	9.3%	10.7%	▲	►	
Total Establishment	N/A	Data Missing		3196	3204	Data Missing			
Total in post	2766	2865	▲	2862	2905	2886	▼	►	
Sickness absence rate	<=3.0%	4.1%	▲	4.2%	4.3%	3.9%	▼	►	
Total WTE Bank Staff (excluding extra capacity nursing)	<=210	243.0	▲	260	229	220	▼	►	
Total WTE Agency Staff (excluding extra capacity nursing)	<=40	77.7	▲	64	78	72	▼	▼	
% of staff who have completed stat and mandatory training (YTD cumulative position in mth)	***53.3%	64%	▲	62%	64%	65%	▲	▲	
% of staff who have been appraised (YTD cumulative position in mth)	***60%	72%	▲	72%	73%	71%	▲	▲	

M09 situation report

- **Establishment** – Small fluctuations – pay costs in the month actually reduced.
- **Vacancy rate** - increased from M08 to 10.7%, noting the seasonal loss of staff in December. This position needs to be watched with the need to reduce agency costs and cover the staff on the new wards.
- **Sickness absence** - fell to 3.9% and compares well with the same period last year when sickness absence was 4.8%.
- **Bank and nursing agency** – both reduced, correlating with the reduction in sickness and increased attention through the weekly meetings with senior nurses. Medical agency, however, useage increased significantly in month.
- **Training:** The additional whole day Clinical and Non-clinical updates continue to be effective in improving performance and the number of cancellations or non attendance continues to reduce. There was no “traditional” drop off in attendance during the winter months.
- **Appraisals** – fall in compliance in December is due to planned data cleaning (and is not material). This is still green.

Actions to improve performance

- HR interventions and actions by managers to prioritise sickness management continue within Divisions.
- With the above, and action on recruitment and agency management, agency usage is targeted to reduce.
- A progress report on the SHA’s agency procurement is being sought, after a period of silence.
- HR Business Partners continue to prioritise appraisals and additional performance meetings with ETD have been established to ensure the Trust target is met.

Audit

	Performance		Direction of Travel vs. Plan	Monthly Trend			Change from last quarter (q1 vs q2)	Q3 Trend	Forecast for next Quarter (Q4)
	Target (mth or year)	YTD Actual / Ave / Mth	▲=above plan►=on plan▼=below plan	Oct-11	Nov-11	Dec-11	▲=improvement►=no change▼=worse	Key: Green= on plan, Yellow = up to 5% variance from threshold needs attention, Red= below threshold action plan required	
Safe, High Quality Coordinated Care									
% of audits on audit program started	75%	62%	▼	56%	65%	62%		▲	
% of completed audits with agreed action plans	100%	77%	▼	48%	56%	77%		▲	
# of NICE guidelines without a statement of compliance	0	20	▼	33	21	20	►	►	
% of non or partially compliant nice guidelines	10%	16%	▲	15%	15%	16%	▼	►	

M09 situation report

- All indicators are red with little favourable movement against the trend. Within Divisions there is, however, more favourable news about completion of audit reports – that is anticipated to continue with the implementation of the action plan.

Actions to improve performance

- The Trust is working through the action plan agreed as part of the response to the Internal audit report (which had an adverse rating). Initila action points are now becoming due (the plan was discussed at the last Audit and assurance Committee) and are anticipated to be achieved.

Contents

4. Action Log – summary of key actions

		Exec Lead	Mgmt/ clinical Lead	Date
1	**ED/18 weeks:** Work with community partners to reduce delayed transfers of care	COO	A.Stevenson	ongoing
2	**ED/18 weeks:** Work with ambulance service to better manage busy periods in A&E and ensure patients are directed to correct provider (including community and primary care services)	COO	R.Fuller	ongoing
3	**ED/18 weeks:** Complete and implement the additional capacity and refurb plan. Review impelmentation at Management Board on 1 Feb	COO	C.Limber	1 Feb
4	**18 weeks:** find increased external capacity, increase outpatient clinics, recruit additional managerial, analytical and administrative support, secure additional SaSH capacity through medical and nursing staff.	COO	J.Davey	27 Jan
5	**VTE:** weekly monitoring of VTE outliers to ensure continued delivery	CMO	ADOs in each Division	ongoing
6	**Falls:** review of data quality, recording and reporting – currently past months are overwritten each month making it difficult to see how action is impacting on performance – that needs to be improved.	CN	J.Moore	15 Feb
7	**Clinical audit**: deliver all recommendations from IA report and complete action plan as stated	CMO	SGB	ongoing
8	**FNoF:** review all actions currently in train, including sourcing of rehab, and the timeline to allow ringfencing of dedicated beds.	COO	G.Tselentakis	28 Feb

Contents

5. Risk Log – highest rated risks

	Risk	KPIs affected
1	**High levels of non-elective activity exacerbating lack of capacity in the Trust**	ED [A&E], 18 wks, cancelled ops, FNoF, MSA
2	**High levels of delayed transfers of care leaving patients fit for discharge in beds and exacerbating lack of capacity**	ED [A&E], 18 wks, cancelled ops, FNoF, MSA
3	**D&V outbreaks causing ward closures**	ED [A&E], 18 wks, cancelled ops, FNoF, MSA
4	**External providers not delivering agreed levels of outsourced elective capacity**	ED [A&E], 18 wks
5	**Variable volumes of trauma being admitted at once**	FNoF
6	**C.diff cases continue at current rate (ie: above the trajectory)**	Infection control
7	**Sterilisation risk from the steam generators at Crawley Hospital not being serviceable**	Infection control, 18 weeks
8		

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