Trust Board - Public – 24 November 2011
Agenda item: 4.1

Surrey and Sussex NHS
Healthcare NHS Trust

Integrated Quality and Performance Report M7– October 2011

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Surrey and Sussex NHS Healthcare NHS Trust

Performance Report M7 - October

Overview:

- This report updates the Board on the key national, contractual KPIs across the Trust for the Month 7 of 2011-12 (October).
- There are several changes to the report this month, a heat map has been introduced to quickly give the reader an overview of which KPI's on performing, which are underperforming, and which are at risk for underperformance.
- The scorecard has been changed to reflect 3 months worth of activity, the quarterly position versus last quarter, the trend in quarter and the performance forecast for the next quarter for each KPI.
- The National indicators have been grouped according to the domains in the 2011/12 Operating Framework of Effectiveness Safety and Patient Experience.
- The domains relating to the internal metrics to deliver safe, high quality coordinated care remain the same
- Exception reports have been replaced by situation reports
- An action log noting only those actions that are expected to increase compliance in month has been added
- A risk log highlighting the risks to delivery and those KPI's affected has been added
- The DTOC calculation has been changed in line with that used on the DoH Performance Framework
- No trend can be assumed from 1 month of data, therefore the Q3 trend field in the dashboards will be populated from month 8
- Please note the figures in this report represent a snapshot of information taken at working day 10. The information contained within the report is subject to change when the information is finalized. Where updated information makes a material change to the original reported position this will be noted in the summary section of this report.

Trust Board Agenda Item:4.1

Trust objective: Please list number and statement. this paper relates to.	**Deliver safe, high quality co-ordinated care; Develop an effective organisation**

Action: The Management 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	Not applicable.
Regulation: What aspect of regulation applies and what are the outcome implications? This applies to any regulatory body – key regulators include: Care Quality Commission, MHRA, NPSA & Audit Commission)	Department of Health.

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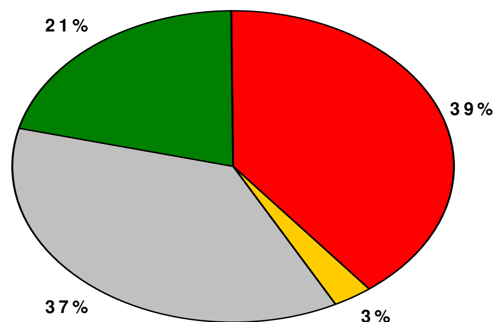
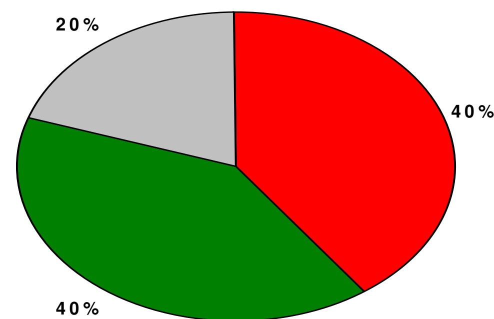
1. Domain Summary

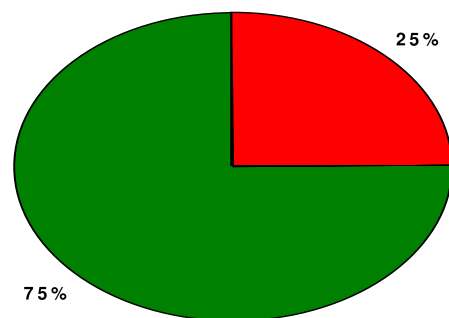
RAG % Effectiveness domain



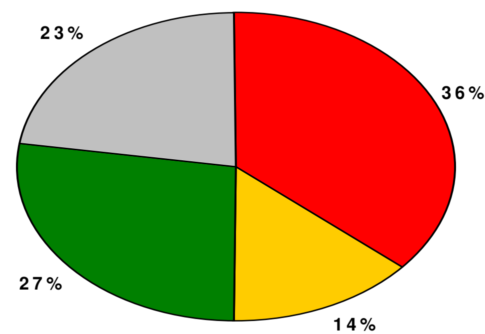
RAG % Safty domain



RAG % Patient Experience Domain



RAG % Internal Quality Domain



The graphs above demonstrate the percentage compliance with each domain. Grey sections on the graphs indicate KPI's that do not have a target against them therefore they cannot be RAG rated.

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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	YTD Actual	▲=above plan►=on plan▼=below plan	Aug-11	Sep-11	Oct-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									
A&E time to initial assessment(95th percentile)	<15	157	▲	150	157	122	▲		
A&E time to initial assessment (median)	N/A	21		16	21	21			
Time to Treatment (median)	<60	38	▼	45	38	27	▲		
Total time in A&E admitted (95th percentlie)	240	1032	▲	831	1032	1113	▲		
Total time in A&E non-admitted(95th percentlie)	240	384	▲	241	384	432	▲		
% of patients in A&E under 4 hours	95%	85.2%	▼	95.2%	85.3%	84.8%	▲		
number of of patients in A&E over 12 hours (trolley waits)	0	90	▲	1	8	73	▼		
A&E Unplanned Re-attendance rate (within 7 days)	<5%	5.4%	▼	5.6%	3.4%	5.7%	▲		
Left without being seen (LWBS) Rate	<5%	2.8%	▼	2.0%	3.4%	3.1%			
A&E Attaendances (Number of Type 1 attendances)	N/A	41487		6203	6596	6999			
Emergency Readmissions within 30 days of discharge	TBD	3.2%		3.1%	2.9%	3.6%			
Delayed Transfers of Care	3.5%	5.4%	▲	7.1%	6.1%	6.4%	▼		

•Forecast based on achievement and implementation of plan milestones. DTOC forecast based on FOT at month 7

Month 7 Situation Report

As attendances in month increase the position in ED has deteriorated. In October there were 6,999 attends as opposed to 6,400 in August when the 95% metric was achieved. The major contributory factor of this dip in performance is volume. Activity rose in September and again in October leading to bed shortages which in turn impacted the Trust's ability to admit patients and impeded the flow of patients through ED leading to breaches of the both the 4 hour and 12 hour access targets. Achievement of the targets is strongly linked to the capacity and flow of patients through the trust. Failure to allocate beds to DTA's causes a backlog of patients to build up in ED which then impedes the flow and capacity of the department to see and treat patients efficiently. In addition the increasing number of delayed transfers of care (DTOC) is having a significant impact on the Trusts ability to improve patient flow. ED has now completed phase 1 of the refurbishment plan, this has increased capacity in ED and improved the environment within the clinical decision area. This has allowed for the re-opening of the observation unit and expansion of UTC room to facilitate use by patients on Trolleys.

Actions to improve performance

The Trust is in regular contact with colleagues across the health economy to address the capacity issues the trust is experiencing and to develop plans to assist with the anticipated high level of activity anticipated over the coming winter months.

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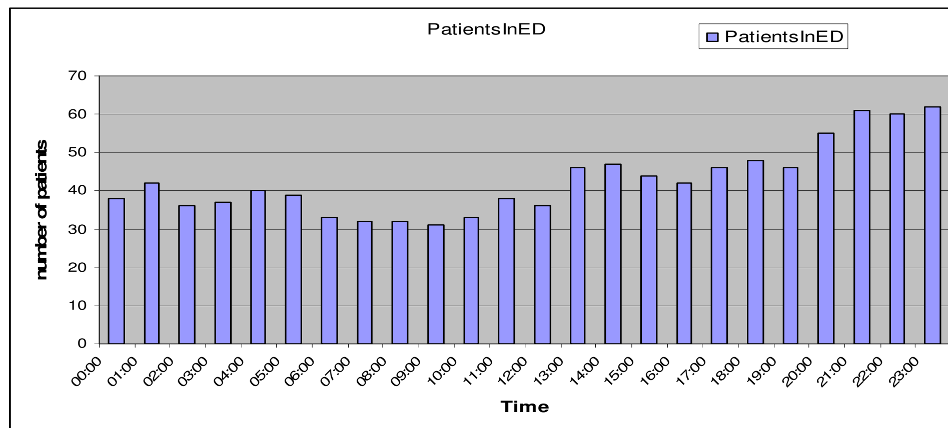
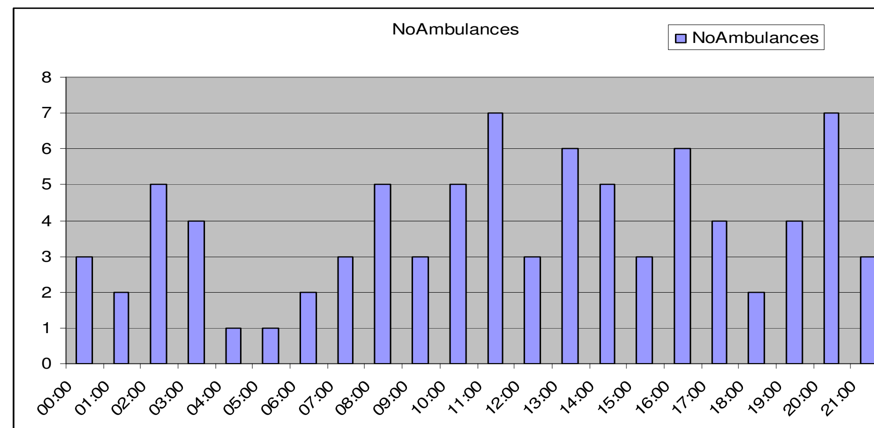
Effectiveness A&E 12 hour breaches



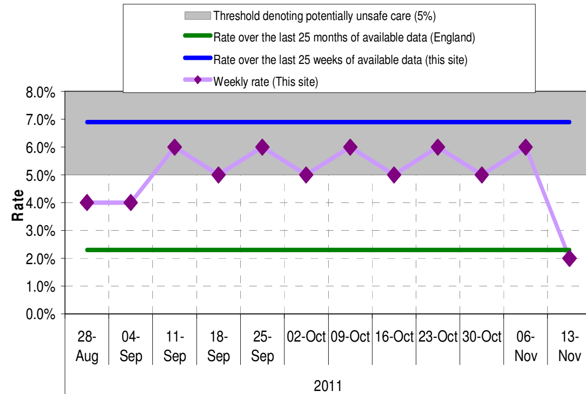


Month 7 situation report

The breaches that occurred the week of 24th of October were a direct result of restricted capacity within the Trust. There was an average of 220 attendances a day in the week preceding the event with an average of 54 admissions a day via ED. On the day of the event there were 252 attendances and 27 admissions via ED. Sash escalated the capacity issue to external colleagues and a system wide decision was taken to keep hospital open and not divert. The graphs above illustrates the number of patients who were in the department by hour and number of ambulances that arrived in the department by hour on the 24th. There was also a high incidence of Delayed transfers of care (DTOC) on the Friday preceding the breaches. 39 patients were delayed in the Trust of those 13 were Surrey patients and 13 West Sussex. The remaining patients were medically fit to be discharged but were waiting for assessment or packages of care. On the day of the breaches there were 37 DTOC's,13 or 4.55% were Surrey delays and 14 or 6.12% were Sussex delays. As above the remaining patients were medically fit to be discharged but were waiting for assessment or packages of care. Work is ongoing both internally and with external colleagues to identify and disseminate lessons learned.

Performance Quality Indicators Graphs (A&E)

Unplanned re-attendance rate

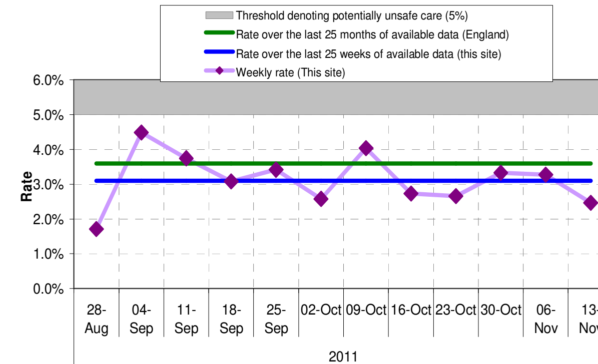


Description of data

Re-attendance rate can reflect the quality of care on the initial attendance but does not demonstrate the cause of any problems. Those with chronic conditions for example may have multiple reattendances because of the nature of their disease. Nationally unplanned reattendance account for 2.1% of all attandances. Data quality for this indicator is poor because with the recent takeover of the Redhill UTC we are currently missing the functionality in Cerner to label patients as planned re-attendances so our figures are being artifically inflated.Clinic templates now built and staff being trained to make appointments clinics become live on 1st November 2011

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

Left without being seen rate

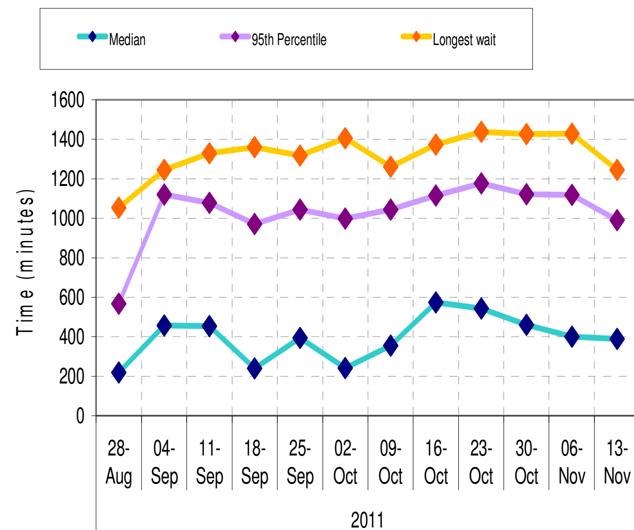


Description of data

LWBS reflects the satisfaction of pateints with the initial management and experience they recive in A&E. Best paractice is for this rate to be below 5%. Remains with acceptable limits, though will be reviewed internally for actions to improve.

2.5%	Rate this month
Better	Compared to last week
	Data quality

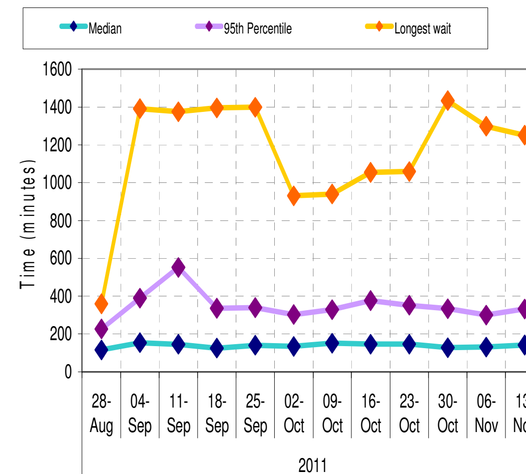
Total Time in A&E admitted



Description of data

Excessive total time in A&E is linked to poor outcomes. Monitoring the median, 95th percentile and longest time spent by patients in A&E will demonstrate the distribution of time patients spend waiting in the department. In England median time spend in A&E for patients is approximately 205 minutes, 95% of attendances admitted in approximately 340, The single longest wait should be no more than 6 hours

Total time in A&E nonadmitted



Description of data

Excessive total time in A&E is linked to poor outcomes. Monitoring the median, 95th percentile and longest time spent by patients in A&E will demonstrate the distribution of time patients spend waiting in the department. In England median time spend in A&E for non admitted patients is approximately 105 minutes, 95% of attendances departing in approximately 235 minutes, The single longest wait should be no more than 6 hours.

Effectiveness – 18 Weeks

Operating Framework	Target	YTD Actual	Direction of Travel vs. Plan (▲=above plan ►=on plan ▼=below plan)	Aug-11	Sep-11	Oct-11	Change from last quarter (q1 vs q2) (▲=improvement ►=no change ▼=worse)	Q3 Trend	Forecast for next Quarter (end of Q4)
18 weeks RTT admitted - 95th Percentile @	<=23	37	▲	42	39	37			
18 weeks RTT - non-admitted including audiology (DAA)- 95th percentile @	<=18.3	48	▲	46	46	48			
RTT - incomplete - 95th percentile	<=28	48	▲	38	34	33			
Median wait times -non-admitted	N/A	12		11	12	12			
Median wait times - admitted	11.1	12	▲	14	14	12			
RTT - incomplete -median	7.2	7	►	8	9	7			
RTT - admitted 90% in 18 weeks	90%	67.7%	▼	60.1%	61.1%	67.7%			
RTT - non- admitted 95% in 18 wks	95%	64.9%	▼	69.9%	67.8%	64.8%			
**% of cancelled operations not treated within 28 days	<=5%	5.9%	▲	0.0%	2.4%	3.1%	▲		
cancelled operations as a percentage of elective admissions	<=0.80	1.8%	▲	1.7%	1.4%	2.4%	►		

Key: Green= on plan, Yellow = up to 5% variance from threshold needs attention, Red= below threshold action plan required

* Forecast based on achievement of plan milestones

Month 7 Situation Report

The trust began outsourcing of elective procedures in April 2011 and by the end of October 1042 patients have had procedures completed elsewhere. The underperformance of this metric has been caused by a mismatch between demand and commissioned activity. The Trust is now in a position where the total waiting list for the Admitted Pathway is double the desired size (including 1300 patients over 18 weeks). In order to bring the waiting list down to the desired level and clear the backlog agreement has been reached with the PCT's and SHA for the trust to under perform on 18 weeks. Because of the volume of activity through the non-elective pathway in the month of October 2.4% of elective surgeries were cancelled. The 18 week forecast has been revised to account for these cancellations. The key challenge over the winter period will be maintaining access to admitted patient pathways. Inpatient bed capacity is often required for non-elective patients causing cancellations of elective procedures. Whilst current Referral to Treatment Time performance for admitted pathway patients is 67.7% treated within 18 weeks, through outsourcing of activity, the associated "backlog" has been reduced from 1,465 at the start of August to 987 currently. Diagnostic Testing waits are compliant with the exception of Endoscopy waiting times. The backlog for Endoscopy patients resulted from reduced capacity during winter 2010/11 when the Endoscopy recovery area was used for escalation beds The Trust has been carrying out additional activity at weekends for over a year, and has also been outsourcing patients for Endoscopy since July 2011. The number of patients waiting more than 6 weeks has been steadily reducing, and the standard is expected to be achieved during December

Actions to improve performance

Around 40% of the remaining backlog will be outsourced and compliance will be achieved from Mid March 2012. To improve and maintain performance is it essential that capacity (both internal and external) be carefully managed. Internally capacity will be managed on a rolling two week program over winter. Externally capacity (volumes and times) to be agreed with colleagues across patch.

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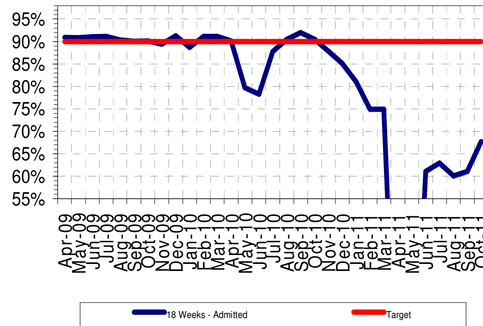
Performance Quality Indicator Graphs (18 wks)

Surrey and Sussex NHS Healthcare NHS Trust

RTT 18 Weeks - Admitted

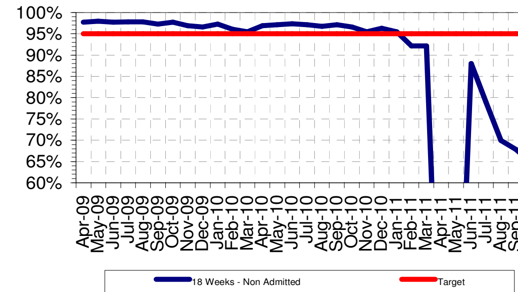


Description of data

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 migrated to a new PAS system 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.

67.7%	Rate this month	
Greater	Compared to last mth	

RTT 18 Weeks - Non Admitted



Description of data

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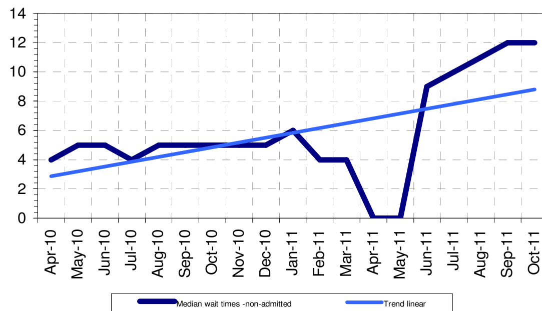
64.8%	Rate this month	
Less	Compared to last mth	

Median wait times -non-admitted

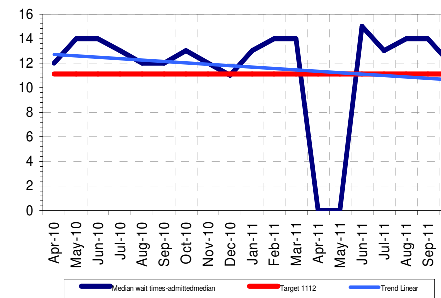


Description of data

This graph meaures the median wait times for non-admitted pateints whose clock stopped during the period. As above when the Trust migrated to the new 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

12	Rate this month	
Equal	Compared to last mth	

Median wait times - admitted



Description of data

This graph meaures the median wait times for admitted pateints whose clock stopped during the period. As above when the Trust migrated to the new 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.

12	Rate this month	
Less	Compared to last mth	

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Effectiveness – Cancer Access

	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	YTD Actual	▲=above plan►=on plan▼=below plan	Aug-11	Sep-11	Oct-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									
2 week GP referral to 1st outpatient	93%	94.8%	▲	94.1%	94.3%	95.8%	▼		
2 week GP referral to 1st outpatient - breast symptoms	93.0%	91.2%	▼	83.5%	83.5%	93.6%	▼		
31 day second or subsequent treatment (surgery)	94.0%	96.3%	▲	100.0%	100.0%	96.6%	▲		
31 day second or subsequent treatment (drug)	98.0%	99.3%	▲	100.0%	94.4%	100.0%	►		
31 day decision to Treat to Treatment	96.0%	99.2%	▲	98.7%	98.7%	99.0%	►		
62 days urgent referral to treatment of all cancers	85%	86.06%	▲	85.6%	85.0%	85.2%	►		
62 wait first treatment from Consultant screening	90%	100.0%	▲	100.0%	100.0%	100.0%	►		

* Forecast based on FOT at month 7

Month 6 Situation Report

Overall the Trust is achieving on all the Cancer targets in month. Consultant leave and bank holidays are the biggest risk to the delivery of the target. During these periods it is difficult to offer appointments in the first week; therefore making it challenging to offer patients a second appointment option within the necessary time frame.

Actions to improve performance

A Christmas plan has been agreed to ensure sufficient capacity to meet two week targets. Service managers will be responsible for managing consultant leave to ensure capacity

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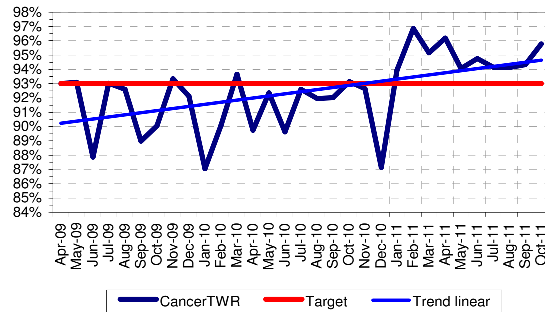
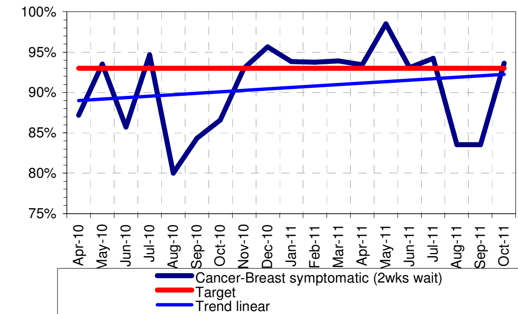
Performance Quality Indicator Graphs (Cancer)



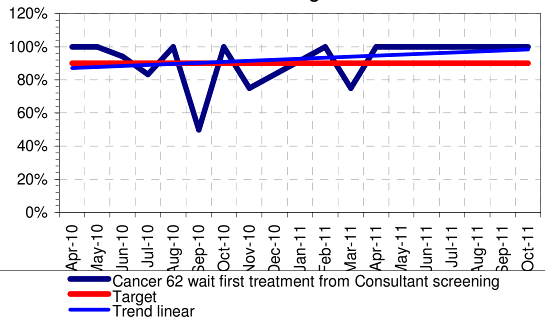
Description of data
The graph measures the % of patients seen within two weeks of an urgent GP referral. The trend line illustrate a steady increase in compliance. This indicator has been achieved in month

95.8%	Rate this month	
Greater	Compared to last mth	



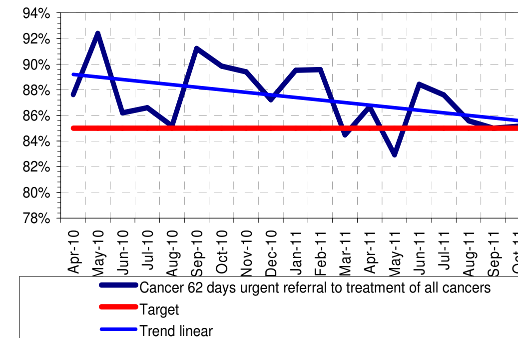
Description of data
The graph measures the % of patients seen within two weeks of an urgent GP referral for suspected breast cancer. The Trend line illustrates increasing compliance month on month with target. The Drop in compliance in August and September was due to bank holidays and annual leave. A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

93.6%	Rate this month	
Greater	Compared to last mth	



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.

100.0%	Rate this month	
Equal	Compared to last mth	



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

85%	Rate this month	
Greater	Compared to last mth	

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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	YTD Actual	▲=above plan►=on plan▼=below plan	Aug-11	Sep-11	Oct-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%	67.8%	▼	63.6%	84.1%	74.1%	►		
% of Stroke patients Scanned within 1 hour of hospital arrival	50%	41%	▼	43.8%	45.2%	42.3%	►		
Stroke/TIA treated within 24 hours	60%	83.3%	▲	76.9%	86.7%	100.0%	▲		

* Forecast based on achievement of plan milestones

Month 6 situation Report

Achievement of the 90% indicator is strongly linked to the emergency patient flow pathway and associated actions relating to bed management and effective and timely discharge. ED performance in August significantly improved and positively impacted on the stroke pathway, as many of Augusts' patients were admitted to the Stroke Unit faster and subsequently discharged in September. The non-performing pathways were again linked to continued pressures on bed capacity, which deteriorated compared to previous month and is unlikely to improve until bed capacity increases. 7 cases failed the target but only 2 were potentially avoidable (the majority were catastrophic strokes or atypical presentations). The scan within 1 hour of arrival target has not 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 stoke metrics (ASI). This change has been applied to the data retrospectively the trust is now underperforming against this measure. A two month audit is underway to establish why and where in the pathway this is happening, so that targeted improvement plan can be developed.

Actions to improve performance

In July 2011 early supported discharge was introduced to focus on moving patients out of acute beds as soon as medically possible and into community beds for the rehabilitation portion of the their journey. The impact of Early supported discharge on patient flow will be reviewed with community therapy teams. In early 2012 the Trust will Increase bed capacity to improve patient flow by moving ASU to larger 28 bedded ward. It is expected this will have a significant impact on stroke performance. Comprehensive KPI data is discussed at the fortnightly Stroke Management Team meetings and shared with ward staff, to ensure they are aware of current performance and issues.

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	YTD Actual	▲=above plan▶=on plan▼=below plan	Aug-11	Sep-11	Oct-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%	60.4%	▼	50.0%	63.3%	49.0%	▼		
Fractured Neck of Femur <48	85%	76.9%	▼	66.0%	83.0%	73.0%	▲		
**PPCI 150 min call to ballon time	95%	100.0%	▲	100%	100%	Data reported in arrears	▶		
PPCI 120 min call to ballon time	60%	100%	▲	100%	100%	Data reported in arrears	▶		

* FnoF <48 hours forecast based on achievement of plan milestones, Forecast for all other KPI's based on FOT at month 7

Month 7 situation report

Of the 49 patients admitted for FnoF, 33 patients were operated on within 48 hours of admission, 11 patients received treatment outside of that standard and 4 were managed conservatively. There are two significant challenges to delivery of this indicator. High volumes of non-elective patients results in outliers in orthopaedic wards, this causes a delay of FnoF patients utilising the fast track bed. Because of limited access to the fast track bed, there are still a lot of NOF outliers on other wards. Getting day 1 physiotherapy to these patients is extremely challenging. Also there are variable volumes of trauma admitted to Trust at any one time. There were 91 trauma admissions other than for fractured neck of femur in October 2011. 22 of these cases were paediatric, and 69 were adult cases. Of the 22 paediatric cases 21 were operated on within 24 hours of admission.

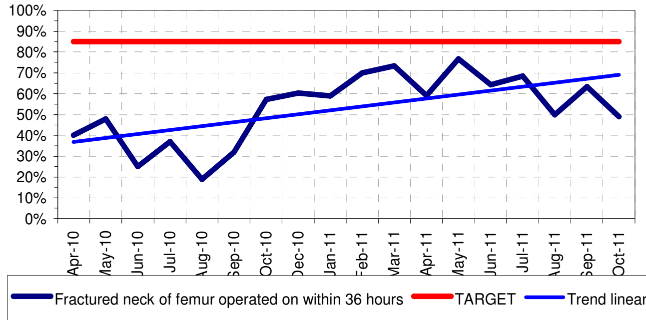
All PPCI targets were achieved in month

Actions to improve performance

Going forward theatre capacity for trauma will be increased over winter. This should allow more FnoF patients to be treated within the 48 hour standard. Management of Fnof fast track bed will be reviewed and discussed with colleagues to reduce the incidence of outliers utilising the bed and increase compliance with the target.

Performance Quality Indicator Graphs (Fractured neck of Femur, Stroke)

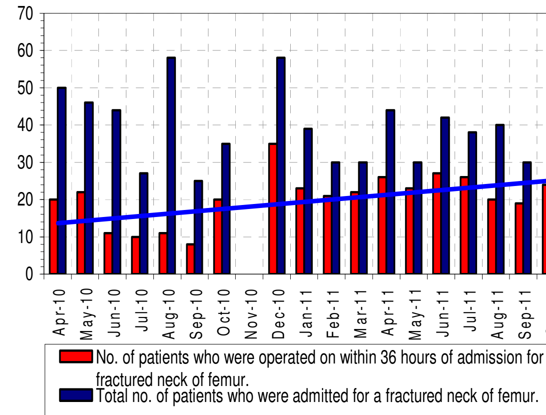
Surrey and Sussex NHS
Healthcare NHS Trust



Description of data

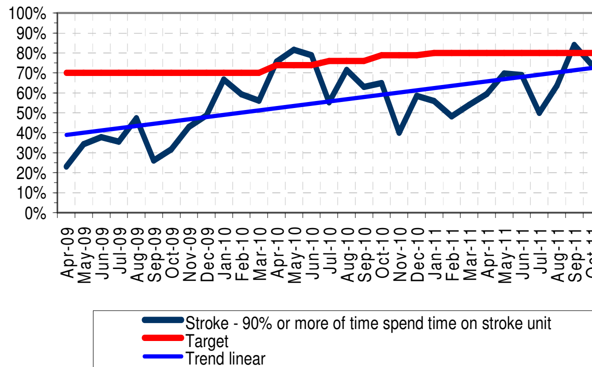
This Graph illustrates the number of patients who are operated on within best practice guidelines (the national standard is 48 hours) The trend line illustrates a month on month increasing level of compliance. A contributory factor to the underperformance in month is the variable amount of trauma on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

49.0%	Rate this month	
Less	Compared to last mth	



Description of data

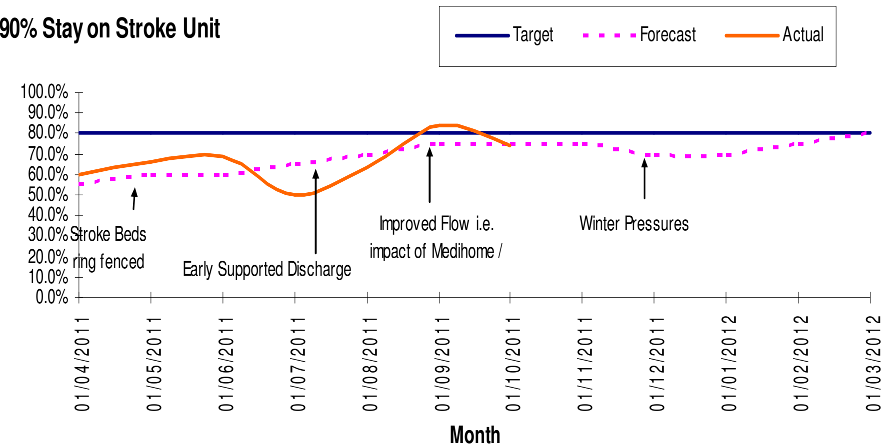
This graph illustrates the total number of patients with a hip fracture who were admitted, and of those the number of patients who went through the pathway within the timeframe for best practice. The trend line illustrates an increasing level of compliance in this area.



Description of data

This graph illustrates the people who have had a stoke who spend at least 90% of their time in hospital on a stroke unit. The tread line shows an increasing level of compliance. The indictor was achieved for August, illustrating an effective pathway when capacity is not an issue.

74.1%	Rate this month	
Less	Compared to last mth	



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	YTD Actual	▲=above plan►=on plan▼=below plan	Aug-11	Sep-11	Oct-11	▲=improvement ►=no change▼=worse		Key: Green= on plan, Yellow = up to 5% variance from threshold needs attention, Red= below threshold action plan required
VTE Risk Assessments	90%	66.6%	▼	71.1%	75.0%	80.8%	▲		
Number of falls resulting in a fracture/head injury	0	9	▲	1	1	1	▼		
% of SUI's due to be closed in month that were closed		N/A		66.7%	60.0%	100.0%	►		
Number of Never events reported	0	2	▼	0	0	0	▲		
Newly acquired Pressure Ulcers (grade 2 and above)	71	125		11	18	25	▲		
Number of falls reported as clinical incidents	73	164	▼	20	6	19	▲		
Number of medication errors resulting in an adverse event	0	2	▲	0	0	0	▼		

* Forecast based on FOT at month 7

Month 6 Situation Report

The percentage compliance with the VTE target is increasing every month. Trust snapshot audits of this metric have shown the overall percentage compliance figures to be much higher than those that can be evidenced through the electronic database. The database allows divisions to monitor VTE performance by service line and consultant to ensures that areas of underperformance are quickly identified for action. The trust has committed to delivering this KPI by March 2011 and we are on track to do so.

There has been one fall in month resulting in a fracture. An SI investigation is underway and lessons learned will be shared at the divisional Quality and Risk meeting. To reduce the number of incidence going forward , the development and introduction of a new risk assessment tool is underway and a post fall protocol is now included the medical induction.

There has been a change to the method of data collection for pressure ulcer audit which has resulted in more accurate and increased reporting. Pressure Ulcer data is now recorded daily and reported weekly at the Matrons weekly meeting. Divisional Patient safety boards are in place weekly where all Grade 2 and above hospital acquired pressure sores are reviewed. Matrons and Senior Nurses work clinically on Fridays to drive up standards and monitor performance

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	YTD Actual	▲=above plan►=on plan▼=below plan	Aug-11	Sep-11	Oct-11	▲=improvement ►=no change▼=worse	Key: Green= on plan, Yellow = up to 5% variance from threshold needs attention, Red= below threshold action plan required	
Mixed Sex Accommodation	0	119	▲	3	18	46	▼		
% of patients surveyed who would choose to be treated at SASH in Future	75%	94%	▼	74.0%	Data Missing	94%	Quarerly comparison cannot be made due to mising data		
% of patients surveyed that staff treated them with kindness and respect	70%	89%	▲	80.0%	Data Missing	89%			
% of patients surveyed who felt their dignity was maintained the whole time they were a patient	70%	98%	▲	76.0%	Data Missing	98%			
% Complaints responded to within agreed timeline with complainant/ 25 working days	85%	86%	►	86.5%	80.0%	79.1%	▼		

* Forecast based on FOT at Month 7

Month 7 situation report

The Trust continued to be very busy through October 2011. Multiple escalation areas were open, in addition the emergency department had slightly reduced capacity due to the refurbishment. This created a very challenging situation operationally. All steps possible were taken to avoid mixing of sexes and verbal information was given to the patients.

The questions on the Real Time Monitoring Devices were amended in September 2011 to enable the devices to be given to patients at any point during there admission rather than at the point of discharge. Some of the questions have been altered for clarity and better reflect some aspects of care. The very significant improvement in numbers of surveys collected reflects these changes and the efforts put in by the ward staff to increase use of the machine. Nearly all areas increased their number of participants in particular Bletchingley (from 7 to 23), Holmwood (from 28 to 81) and Discharge Lounge (from 47 to 161). Overall the scores for each question improved from September and the average score went up from 78% to 89%. Questions with lower scores are in relation to interruptions during meals and mixed sex.

Actions to increase performance for next month

All potentials to mix a bay are escalated to a Matron on duty to ensure all alternatives have been considered . Individual wards will be responsible for identifying actions in relation to areas of concern. Use of the RTM devices and data will allow for a faster response to patient concerns. Overarching themes from the data will be discussed in the bimonthly meetings of the patient and staff engagement group. Actions from that group will be identified and implemented on a trust wide level.

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Maternity

	Performance		Direction of Travel vs. Plan	Monthly Trend			Change from last quarter (q1 vs q2)	Q3 Trend	Forecast for next Quarter (Q4)
	Target	YTD Actual	▲=above plan►=on plan▼=below plan	Aug-11	Sep-11	Oct-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%	29.5%	▼	26.3%	32.1%	26.6%	►		Red
% of women seen by a midwife or healthcare professional at 12 wks 6dys	90%	88.8%	▼	92.8%	86.3%	85.9%	▲		Green
Breastfeeding initiation	90%	81.0%	▼	81.4%	82.4%	81.6%			Yellow

* Forecast based on FOT at month 7

Month 7 situation report

Month 7 has been an improvement in performance compared to that of month 6. There is an action plan in place to build on the reduction seen in month by focusing on the incidence of booked elective C-sections. The plan ensures that all staff are empowered to support women and their families with up to date evidence based information and care. Staff are encouraged to challenge poor clinical practice and /or escalate to ensure that all women have the same consistent care pathway regardless of their place of attendance or the professional with which they have their consultation. In addition the birthing team leader will take over the vaginal birth after c-section role (VBAC) to further encourage women to select that pathway.

Performance for both breastfeeding initiation and the % of women booked by 12 wks and 6 days is heavily influenced by choice. Community midwives are re- launching the message of the need for early booking. Work is also in progress with the PCT's to encourage GP surgery staff to book women in earlier.

There is a baby friendly project in progress which includes an education programme that address inconsistent messages given to women regarding breastfeeding. Although the Trust is under target, we do exceed the national rate of 78%.

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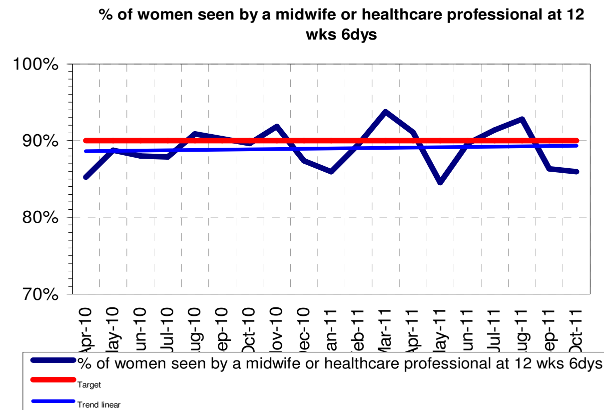
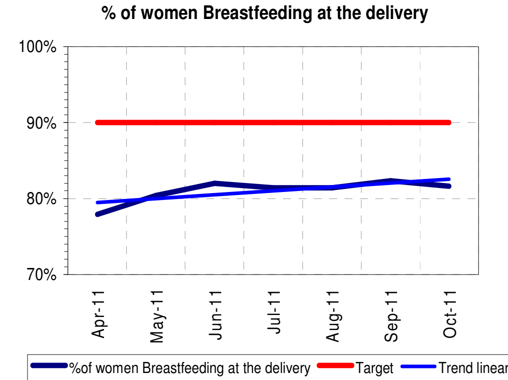
Internal Quality Metric Graphs (Maternity)



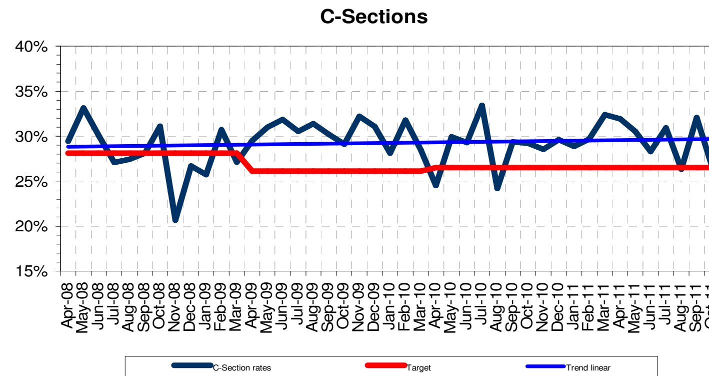
Description of data
This graph measures early access for women to maternity services. Research has shown women who access maternity care early have better outcomes.

86.3%	Rate this month	
Less	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.

81.6%	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.

26.6%	Rate this month	
Less	Compared to last mth	

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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	YTD Actual	▲=above plan►=on plan▼=below plan	Aug-11	Sep-11	Oct-11	▲=improvement ►=no change▼=worse	Key: Green= on plan, Yellow = up to 5% variance from threshold needs attention, Red= below threshold action plan required	
MRSA (trust acquired)	2.3	3	▲	1	0	0	▼		
C Diff (trust acquired)	29	29	►	3	5	6	▲		
MSSA (trust and community acquired)	N/A	34		7	6	2			
*E. Coli	N/A	28		7	9	3			
Hand Hygiene compliance	99%	98.6%	▼	98.9%	99.4%	98.8%	►		
MRSA screening compliance (nonelective)	100%	102%	►	Data Reported Quarterly	Data Reported Quarterly	Data Reported Quarterly			
MRSA screening compliance (elective)	100%	118%	▲	Data Reported Quarterly	Data Reported Quarterly	Data Reported Quarterly			

* Forecast based on forecast outturn at month 7

Month 7 situation report

The Trust is on target to achieve the Cdiff and MRSA screening compliance targets. The Trust is slightly above target however the Trust still hopes to achieve this indicator. This is the baseline year for MSSA E.Coli collection. It is expected reduction targets will be set 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.

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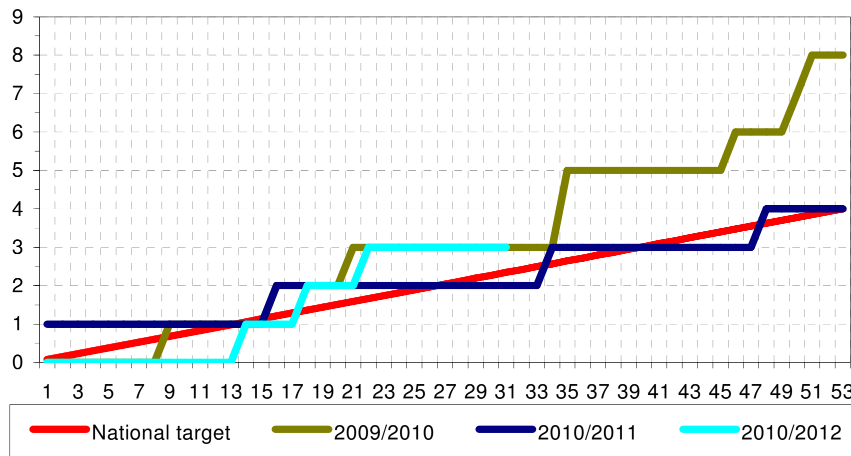
Internal Quality Metric Graphs (HCAI)

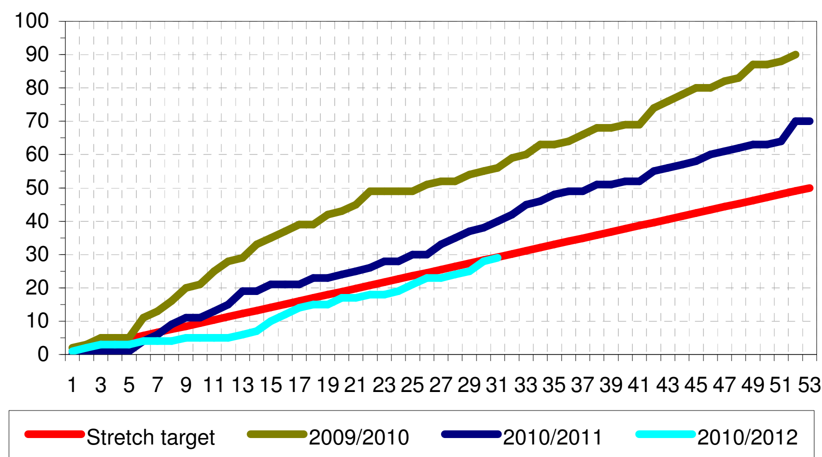
Weekly MRSA BSI Post 48Hrs vs. National Stretch Target



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 achievement.

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



Description of data

This graph illustrates the year on year reduction in Cdiff 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 C. Diffcule rate to 50 cases or less. We are currently on track to achieve this goal.

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Workforce

Measure	Performance: Target	Performance: YTD Actual	Direction of Travel vs. Plan (▲=above plan ▶=on plan ▼=below plan)	Monthly Trend: Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Change from last quarter (q1 vs q2) (▲=improvement ▶=no change ▼=worse)	Q3 Trend	Forecast for next Quarter (Q4) (Key: Green= on plan, Yellow = up to 5% variance from threshold needs attention, Red= below threshold action plan required)
Vacancy Rate	<=10%	10.7%	▲	9.9%	10.0%	10.1%	10.7%	10.4%	10.7%	10.5%	▲		
Total Establishment	N/A	3196		3156	3165	3167	3198	3204	3204	3196			
Total in post	2766	2856	▲	2845	2848	2848	2855	2872	2861	2862	▼		
Sickness absence rate	<=3.0%	4.0%	▲	3.8%	3.6%	4.0%	4.4%	4.5%	3.9%	4.2%	▼		
Total WTE Bank Staff (excluding extra capacity nursing)	<=210	248.0	▲	231.0	209.0	223.0	286.4	268.2	258.9	260.3	▼		
Total WTE Agency Staff (excluding extra capacity nursing)	<=40	64.2	▲	52.0	34.0	53.0	44.2	67.1	75.7	64.2	▼		
% of staff who have completed stat and mandatory training (YTD cumulative position in mth)	***46.6%	34%	▶	6%	13%	22%	29%	34%	54%	62%	▲		
% of staff who have been appraised (YTD cumulative position in mth)	***52.5%	72%	▼	2%	4%	13%	30%	69%	70%	72%	▲		

* Total WTE Bank and agency staff forecast based on FOT at month 7. ** All other KPI Forecast based on achievement of plan milestones

Establishment & Staff in post	Small fluctuations in the Trusts Establishment as the changes due to additional staff required for new wards and the work within the Divisions transformation savings plans. Divisions continue to work with finance and HR Business Partners to ensure that workforce costs do not exceed budgeted establishment .
Vacancy Rate	This continues at around 10% which benchmarks with other NHS organisations
Sickness absence	October saw an increase in sickness absence to 4.2% which is in line with seasonal variation. However HR interventions and actions by managers to prioritise sickness management continue within Divisions.
Agency and Bank	Both bank and agency use increased this month; weekly meetings with senior nurses have been introduced in addition to divisional savings and transformation plan monitoring in order to manage activity in this area.
Statutory and Mandatory Training	The additional whole day Clinical and Non-clinical updates continue to be effective in improving performance. The number of cancellations or non attendance continues to reduce although this is likely to increase as we hit the winter months and may need corrective action
Appraisals	Managers supported by HR Business Partners continue to prioritise appraisals and we are beginning to establish a culture of compliance. This success requires considerable chasing by the department, however, there is room for optimism that the Trust will meet its target of 90% by 31st March 2011

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Audit

	Performance		Direction of Travel vs. Plan	Monthly Trend			Change from last quarter (q1 vs q2)	Q3 Trend	Forecast for next Quarter (Q4)
	Target	YTD Actual	▲=above plan▶=on plan▼=below plan	Aug-11	Sep-11	Oct-11	▲=improvement ▶=no change▼=worse	Key: Green= on plan, Yellow = up to 5% variance from threshold needs attention, Red= below threshold action plan required	
% of audits on audit program started	50%	56.0%	▼	46.0%	49.0%	56%			
% of completed audits with agreed action plans	100%	48.0%	▼	24.0%	19.0%	48%			
# of nice guidelines without a statement of compliance	0	23	▼	23	33	33	▶		
% of non or partially compliant nice guidelines	10%	15%	▲	15%	15%	15%	▼		

* FOT based on run rate

Month 7 Situation Report
All divisions have started at least half of their audit projects which more or less puts them on track to complete them by the end of 2011/12. WaCH has made significant progress in advancing their programme whilst Medicine remain static having not being able to allocate out their audits to the current intake of junior doctors, their focus remains on the significant workload around the National Audit Programme which accounts for the increase.

Actions to improve performance
For action planning, once again progress is now being made with action plans being forwarded on to the audit team. With this now happening in nearly 50% of cases and in particular, note should be made of progress made by WaCH which has now put in systems that has seen their performance reach 100%. Medicine has also seen a rise however they remain the lowest in terms of compliance of the four divisions.

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Summary Of Actions				
Num.	Action	Executive Lead	Management Lead	Expected Completion date
1	Revise escalation process with Deputy Director of operations to facilitate patient Flow from the Department	Bernie Bluhm	Angela Stevenson	18/11/2011
2	Work with Community Partners to reduce delayed transfers of care	Bernie Bluhm	Roberta Fuller	ongoing
3	Agree external capacity (volume and time)	Bernie Bluhm	Hamish Wallace	30-Nov-11
4	Access policy to be signed off and implemented	Bernie Bluhm	Hamish Wallace	17/12/2011
5	Two month audit for 1 hour scan within arrival stroke KPI to be undertaken	Bernie Bluhm	Angela Stevenson	02-Dec-11
6	Theatre capacity for Trauma to be increased over winter	Bernie Bluhm	Hamish Wallace	30-Nov-11
7	Weekly monitoring and identification of VTE outliers	Des Holden	Roberta Fuller	ongoing
8	Birthing team leader to take on VBAC role	Jo Thomas	Sue Chapman	ongoing
9	All incidence of MSA will continue to be escalated appropriately to ensure all available options are considered	Jo Thomas	Heads of Nursing	ongoing
10	Matrons and Senior nurses to work clinically on Fridays to drive up standards and monitor pressure ulcer performance	Jo Thomas	Heads of Nursing	ongoing

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Risk Log		
Num.	Risk	KPI's Affected
1	High levels of non-elective activity creating Lack of capcity within Trust	ED, Stroke, 18 wks, Cancelled ops, Fnof, MSA
2	External providers not delivering agreed levels of activity	18 weeks
3	D&V outbreaks causing bed/ward clousures	ED, Stroke, 18 wks, Cancelled ops, Fnof, MSA
4	High Levels of DTOC	ED, Stroke, 18 wks, Cancelled ops, Fnof, MSA
5	Variable volumes of Truama being admitted at once	FnoF
6	Non-eligible patients appearing on VTE list distorting compliance level	VTE

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6. Glossary Of terms

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