Surrey and Sussex NHS
Healthcare NHS Trust

Integrated Quality and Performance Report M9– December 2010

Presented by: **Bernie Bluhm (Chief Operating Officer) and Mary Sexton (Chief Nurse)**
Authors: **Sharon Gardner Blatch (Head of Integrated Governance and Quality) Char Fletcher (Senior Performance Manager)**

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Performance Report M6 – September

Summary:

- The Department of Health has signalled that the Performance Framework that has been in place from quarter 4 of 2008/9 until quarter 1 of 2010/11 will no longer exist in it's current format.
- The calculation of the weighting of indicators has changed for Q3.
- The forecast for the trust has been revised from '*performing*' to '*performance under review'.*
- The forecast is affected by underperformance in A&E, RTT incomplete median and cancer 62 day referral to treatment from screening
- The 18 week position contained within this report is unvalidated.
- The Department of health has instituted a monthly mixed sex accommodation (MSA) return. It collects monthly data on the total occurrences of patients receiving care that are in breach of the sleeping accommodation guidelines. In line with that return, the trust will now report mixed sex breaches according to that definition.

Action: The Board is asked to note and accept this report.

Trust Board
27th January 2011
Agenda Item:

Trust objective:
Please list number and statement. this paper relates to.

Notes: (please cut & paste to a new page if not enough room)

Legal: What are the legal considerations & implications linked to this item? Please name relevant Act	
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)	

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1. Performance Framework Forecast

The Q3 performance framework forecast has been revised from 'performing' to 'performance under review'. This is due to several factors:

- High numbers of patients cancelled due to extreme weather conditions and demand on non-elective trust capacity, has led to an increase in the 18 wk median waiting time
- The inability to discharge patients from hospital and improve patient flow caused an underperformance in A&E
- Low numbers of patients on 62 day consultant screening service referrals pathway causes a large shift in compliance percentage month on month. 1 breach in month 9 has caused an in month compliance level of 0%.

Performance Indicator	Performing	Under-performing	Weighting for PF	Data frequency	Quarterly/YTD	Actual	FOT for Q3	Achieve / Fail Score	Weighted Score	Achieve / Fail
Four-hour maximum wait in A&E from arrival to admission, transfer or discharge	>95%	<94%	1	Quarterly data aggregated to YTD	YTD	93.33%	93.33%	0	0.0	under performing
Cancelled ops - breaches of 28 days readmission guarantee as % of cancelled ops	5.0%	15.0%	1	Quarterly	YTD	2.70%	2.70%	3	3.0	Performing
MRSA	0	>1SD*	1	Monthly	YTD	4	On trajectory	3	3.0	Performing
C Diff	0	>1SD	1	Monthly	YTD	61	On trajectory	3	3.0	Performing
18 weeks RTT - admitted - Median@	<=11.1		0.50	Monthly data aggregated to quarterly	Quarter	12.3	12	0	0.0	under performing
18 weeks RTT admitted - 95th Percentile @	<=27.7		0.50		Quarter	25.0	25	3	1.5	Performing
18 weeks RTT - non-admitted including audiology (DAA)- median @	<=6.6		0.50		Quarter	5.0	5	3	1.5	Performing
18 weeks RTT - non-admitted including audiology (DAA)- 95th percentile @	<=18.3		0.50		Quarter	16.7	16.7	3	1.5	Performing
RTT incomplete - Median	<=7.2		0.50		Quarter	8.0	8	0	0.0	under performing
RTT - incomplete - 95th percentile	<=36		0.50		Quarter	23.0	23.0	3	1.5	Performing
2 week GP referral to 1st outpatient	93%	88%	0.50	Monthly	YTD	91.70%	91.70%	2	1.0	performance under review
2 week GP referral to 1st outpatient - breast symptoms	93%	88%	0.50	Monthly	YTD	89.06%	86.06%	2	1.0	performance under review
31 day second or subsequent treatment - surgery	94%	89%	0.33	Monthly	YTD	96.40%	96.40%	3	1.0	Performing
31 day second or subsequent treatment - drug	98%	93%	0.33	Monthly	YTD	99.60%	99.60%	3	1.0	Performing
31 day second or subsequent treatment - all cancers	96%	91%	0.33	Monthly	YTD	98.90%	98.90%	3	1.0	Performing

Q3 Performance Framework Forecast Cont…

Acute Trusts

Service Performance (standards and targets) - Indicators, weighting and scoring

	Thresholds					Q3 Forecast as at 14 01 11				
Performance Indicator	**Performing**	**Under-performing**	**Weighting for PF**	**Data frequency**	**Quarterly/YTD**	**Actual**	**FOT for Q3**	**Achieve / Fail Score**	**Weighted Score**	**Achieve / Fail**
Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments) compared to plan.	94% (only applies for Q4)	89% (only applies for Q4)		Monthly	Q4	Not Applicable				
62 day referral to treatment from screening	90%	85%	0.33	Monthly	YTD	82.5%	83%	0	0.0	under performing
62 day referral to treatment from hospital specialist	85%	80%		Monthly	YTD	Low Numbers				
62 days urgent referral to treatment of all cancers	85%	80%	0.33	Monthly	YTD	88.75%	88.00%	3	1.0	Performing
Reperfusion : Primary Angioplasty (PPCI)^	75.0%	60.0%	0.50	Annual but moving to quarterly during 2010/11	YTD	90.70%	90.70%	3	1.5	Performing
Reperfusion : Thrombolysis^	68.0%	48.0%	0.50	Annual but moving to quarterly during 2010/11	YTD	93.30%	93.30%	3	1.5	Performing
2 week RACP	98%	95%	1	Quarterly	YTD	100%	100%	3	3.0	Performing
Patients that have spent more than 90% of their stay in hospital on a stroke unit	60%	30%	1	Bi-Annual	08/09	28.20%	28.20%	2	2.0	Under performing
48 hours GUM access	98%	95%		Monthly	YTD	Not Applicable				
Delayed transfers of care	3.5%	5.0%	1	Quarterly	Total in period	1.20%	1.20%	3	3.0	Performing
Sum of weights			13.66667					Unweighted score	**32.0**	

Scoring values		
Underperforming:	**0**	
Performance under review:	**2**	
Performing:	**3**	

Overall performance score threshold			
Underperforming if less than	**2.1**	Weighted score	**2.3**
Performance under review if between	**2.1 and 2.4**		

Performance Under Review

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- Exception report page numbers are listed next to the reference number

Quality and
Performance Dashboard

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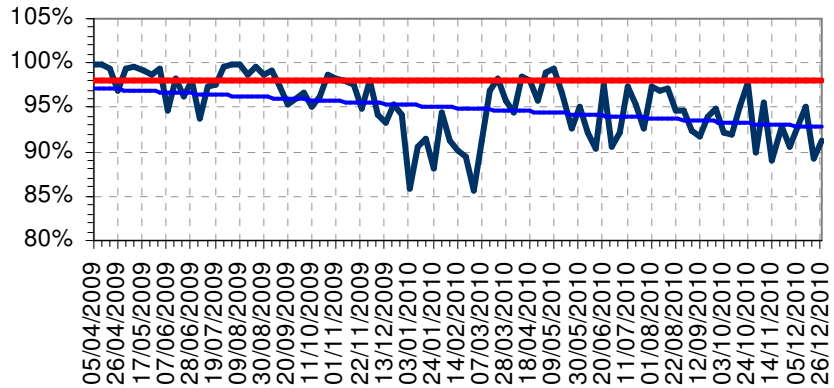
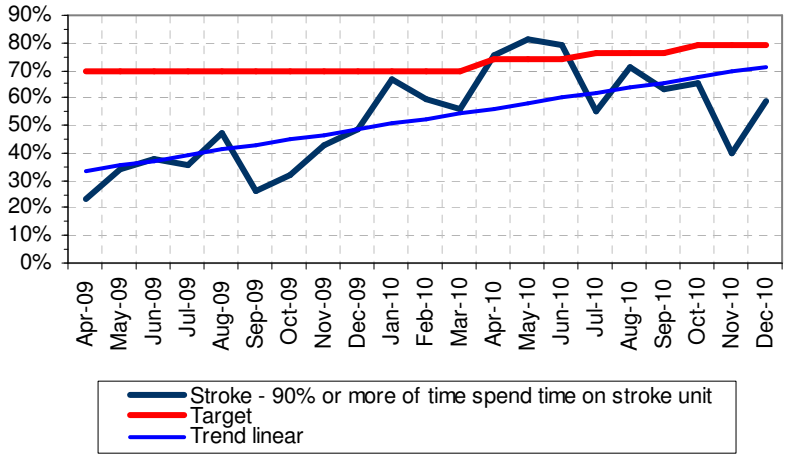
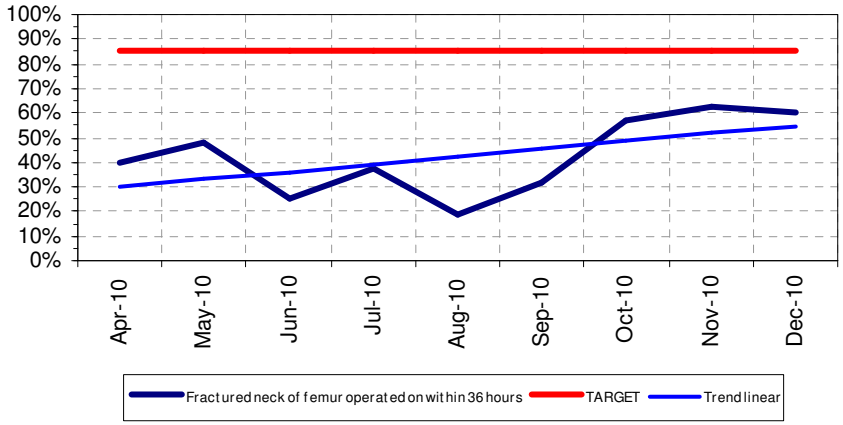
Weekly Type1&3 A&E Attendances seen in less then 4 hours



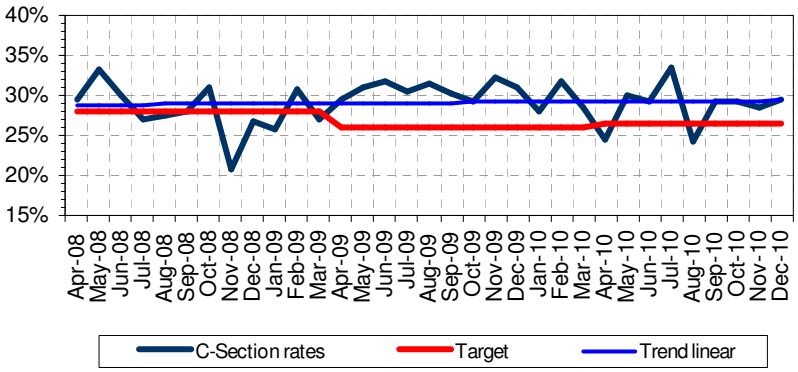
Stroke - 90% or more of time spend time on stroke unit



HIP Fracture operated on within 36 hours

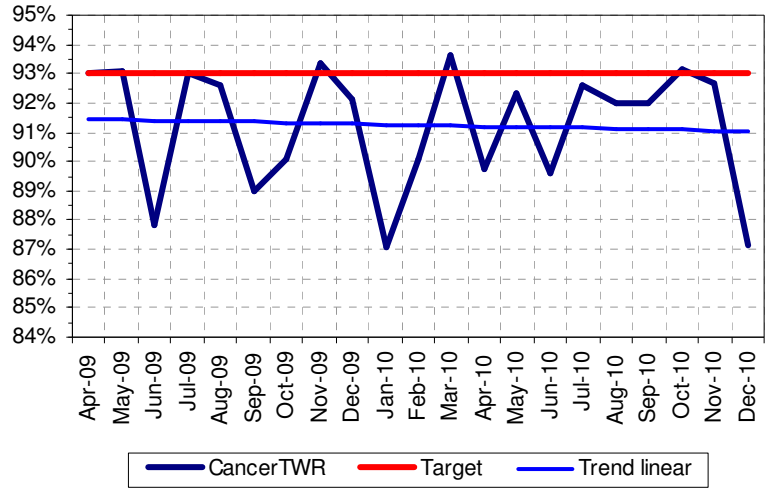


C-Sections

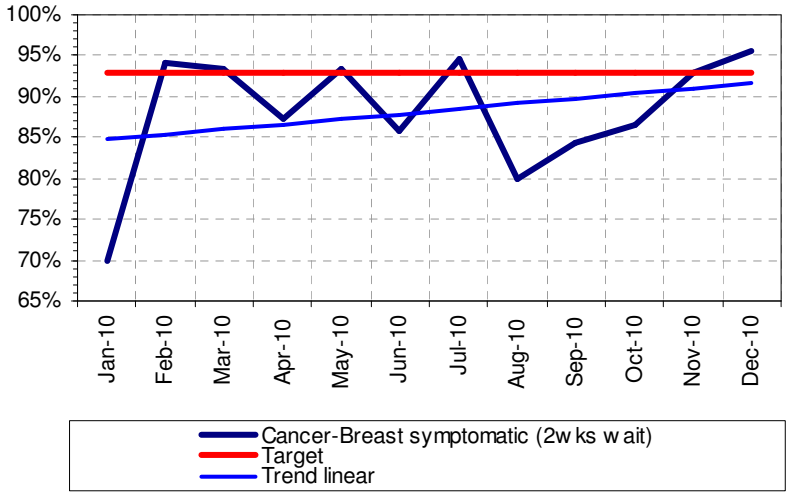


Charts for Performance Exception Areas

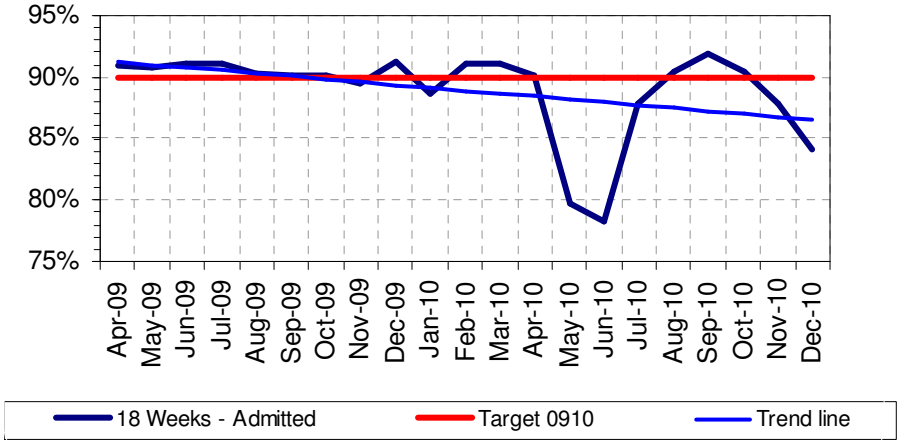
Cancer TWR vs. Target



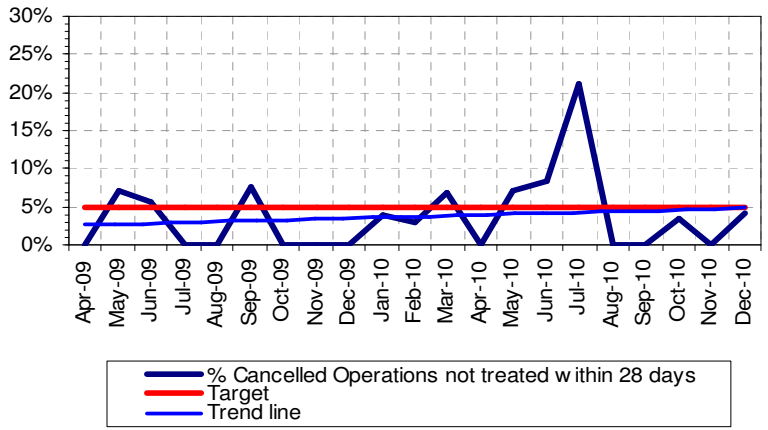
Cancer-Breast symptomatic (2wks wait) vs. Target



RTT 18 Weeks - Admitted



Cancelled Operations not treated within 28 days vs.Target



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Exception Report – HR DECEMBER 2010 (EO3- EO13)

Indicator Rationale	The Key Performance Indicators for HR include tracked measures for total staff in post, vacancies, agency and bank usage. Thresholds have been reduced in wte agency, wte bank and sickness absence in order to focus on planned reductions Total establishment increased from 3130 to 3140 – source Finance Total Agency amended to exclude medical staff with separate line for locum medical agency usage. RAG rating amended for locum medical staff to reflect % of total medical establishment consistent with % of total establishment for agency non medical. National target for sickness absence 3% by end of 2013 with current national average of 4.6%. Trust working to target of 3% by end of 2010.
Context	▪Bank and Overtime : Data for bank and overtime to be treated with caution. Due to the Christmas period, no additional payments were made in week 39 therefore any bank and overtime worked in that week was paid in week 40 which will be included in January's figures. ▪Agency: Wte agency excluding extra capacity reduced from 62 to 58. Wte bank and agency, extra capacity increased from 31 to 36 with a split of 60%/40% Agency – Bank. ▪Medical Absence : Sickness absence continues on an upward trend with an increase of 0.7%. Over a 13 month period Musculo skeletal - other join lower limb shows as the highest number of days lost although this is now reducing. Days lost as a result of D & V have shown a reduction in December against November 2010. Days lost for flu-like symptoms have significantly increased in December showing total of 453.5 against 145.3 in November 2010. Significant increases in 1-2 days and 3-7 days lost compared to November 2010. Long term absence significantly reduced in comparison with December 09. Non Medical Absence: 738 days lost in December 10 compared to 221 in December 09. Main reason for increase = 550.5 days lost to adverse weather conditions and 129 days lost in the care of dependent category Over 12 month period days lost in the category of non medical absence = 2505.5
Actions to Date	▪General Recruitment and Senior Appointments: Vacancy rate increased by 0.1%. Seasonal reduction in new starters. ▪Interviews held and appointments made to Assistant Directors and Service Managers – start dates to be confirmed ▪Interviews held and appointments made to HRBPs 1.5 wte – start dates to be confirmed. ▪Clinical Leads all appointed varying start dates ▪Recruitment to Medical Director underway
Operational Lead and Author	Yvonne Parker
Executive Lead	Yvonne Parker

Exception Report – HR December 2010

Actions to Date (cont)	Firstcare reports provide sickness absence trends for follow up by HR BPs. In addition, sickness absence cases are highlighted during monthly budget clinics and HR BPs meet regularly with managers and department heads liaising with Capsticks HR Advisory Service. ▪OH health reviewing take up of flu vaccine and targeting gaps and priority areas. ▪Deputy Director of HR commenced employment with the Trust.

Exception Report – HR December 2010 (cont'd)

Actions for Next Month	▪Continued work on Temporary Staffing Recovery Plan projects ▪Involvement of HRBPs in job planning and other areas of priority with medical staff within their specific directorates to be part of HRBP objectives ▪HRBPs to work in liaison with ETD to raise the % of appraisals within their specific Directorates ▪Monthly reports on ER issues to be produced for Directorates indicating trends for analysis and priority areas ▪Non Medical data from FirstCare to be reviewed and areas of concern targeted by HRBPs ▪Recruitment: : ▪11 nurses from recruitment campaign to Ireland to join the Trust in January 2011 ▪12 further nurses from Ireland interviewed January 2011 with planned start date of March 2011 ▪6 nurses from Ireland delayed start date – due to commence March 2011.
Risks	Unplanned and urgent operational requirements including extra capacity will have negative impact on reducing agency and bank usage. Measures in place across South East Coast to protect posts for staff at risk across the patch to minimise redundancies.

Operational Lead and Author	Yvonne Parker, Acting Director of HR
Executive Lead	Yvonne Parker, Acting Director of HR

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Bank Usage

All Bank Usage for DECEMBER 2010

WTE

CSS

Grade	May	June	July	August	September	October	November	December
Band 1	0	0	0	0	0	0	0	1.38
Band 2	2.08	3.28	3.09	4.21	6.25	3.71	4.88	6.75
Band 3	0	0.43	0	0	0	0	0.05	1.9
Band 4	0	0	0.95	0.46	0	0	0	0.54
Band 5	0.67	0.88	0.92	0.48	0.41	0	0	0
Band 6	0.3	0	0.17	0	0	1.05	0.48	0
Band 7	0.3	0.37	0.52	0.32	0.69	0.82	0	0.26
Band 8	0	0	0	0	0	0	0	0
Total	**3.35**	**4.96**	**5.65**	**5.47**	**7.35**	**5.58**	**5.41**	**10.83**

Nursing

Grade	May	June	July	August	September	October	November	December
Band 1	0	0	0	0	0	0	0	0
Band 2	83.07	81.52	78.61	88.87	79.45	78.23	75.73	75.76
Band 3	2.27	4	3.46	4.27	3.62	2.67	2.32	2.55
Band 4	0.69	0.35	0.41	0.14	0.49	0.28	0.5	0.21
Band 5	82.76	76.49	75.65	74.68	73.39	76.97	76.08	60.19
Band 6	16.04	14.43	11.73	11.37	11.78	13.19	14.15	11.74
Band 7	4.27	4.01	1.23	3.34	3.98	3.99	3.57	3.4
Band 8	0	0	0	0	0	0	0	0
Total	**189.1**	**180.8**	**171.09**	**182.67**	**172.71**	**175.33**	**172.35**	**153.85**

Estates & Faciltiites

Grade	May	June	July	August	September	October	November	December
Band 1	53.06	43.16	41.34	52.48	39.07	46.56	32.27	20.4
Band 2	0.16	0.14	0.26	0.28	0.03	0.73	2.54	3.62
Band 3	2.15	2.67	2.22	3.86	3.51	4.78	5.52	3.71
Band 4	0.74	0.4	0.55	0.69	0.59	0.55	0.41	0.41
Band 5	0	0	0	0	0	0	0	0
Band 6	0	0	0	0	0	0	0	0
Band 7	0	0	0	0	0	0	0	0
Band 8	0	0	0	0	0	0	0	0
Total	**56.11**	**46.37**	**44.37**	**57.31**	**43.2**	**52.62**	**40.74**	**28.14**

Exception Report – Fractured Neck of Femur (S20)

Indicator Rationale	Fractured neck of femur is the most serious consequence of falls in older people with a mortality rate 10% at one month after a fall, 20% at four months and 30%at one year.
Context	As of 1st April 2010, best practice guidelines changed to 36 hours from admission to operation. Figures are now calculated using these guidelines although both this and the previous target of 48 hours are reported.
Month 7 Performance	58 patients admitted with fractured neck of femur in month 9 of which 2 were delayed to surgery due to being unfit. ***36 Hours Compliance:*** 60% (35 patients) ***48 Hours Compliance:*** 71% (41 patients) ***Day 1 post op Physiotherapy:*** 67% (39 patients) ***NOF Bed:*** 4 patients transferred to a NOF bed within 4 hours ***Iliaca Femoral Block:*** 12% (7 patients) **DVT Prophyaxis**: 74% **Other Trauma:** there was 123 trauma admissions other than #NOF in month 8 (of which 5 were paediatrics)
Actions to Date	•extended Trauma lists (to 7.30pm) per week in situ • Implemented the revised #NOF Action Plan • Orthogeriatric Ward commence date moved for 17th Jan to 1st Feb • External review of T&O Service undertaken. Verbal report received, but awaiting full written report. Microsoft Word Document
Actions for Next Month	• Iliac block: training for bleep holder to ensure that protocol is followed especially during busy periods. • Ongoing review of role of the # NOF coordinator and Trauma Coordinator • Develop protocol regarding the cancellation of #NOF patients for medical reasons. • Operational Trauma policy to be agreed and published.
Risks	• Fluctuations of demand and our ability to adapt quickly to this (impact on Elective pathway) • Winter Bed Pressures – restricting ability to ensure patients in #NOF bed (Newdigate Ward) within 4 hours

Operational Lead and Author	Hamish Wallis, Assistant Director of Clinical Services for Surgery
Executive Lead	Bernie Bluhm, Director of Clinical Operations

Exception Report – Cancelled Operations not treated within 28 days (E7)

Surrey and Sussex NHS Healthcare NHS Trust

Indicator Rationale	The NHS Plan (published in July 2000) states that patients will have the right to redress when things go wrong. When a patient's operation is cancelled by the hospital on the day of admission, or later, for non-clinical reasons, the hospital will have to offer another binding date to treat the patient within a maximum of 28 days. This continues to be a standard which should be maintained by the NHS, as set out in the 2009/10 NHS Operating Framework.
Context	In month 12 there was 100 patients cancelled on the day (vast majority due to weather and bed pressures) and 108 patients who had 28 day breach dates of which 4 were not treated within their breach date due to capacity issues. This equates to 4% of cancelled operations not treated within 28 days in the month of December. Of the 4 who breached their 28 days the original reason for the cancellation on the day was due to: 3x = No Beds 1x = Administrative error (patient given incorrect fasting instructions)
Actions to Date	▪Cancellations are being reviewed on a weekly basis to ensure compliance. ▪All patients cancelled on the day to be reviewed at weekly PTL meeting ▪All patients cancelled for non clinical reasons to have a new TCI within 7 days of being cancelled – if not then to be escalated through weekly PTL meeting.
Actions for Next Month	▪ Continue with weekly monitoring of cancellations through the PTL meeting
Risks	▪ Bed Capacity (Winter Pressures)

Operational Lead and Author	Hamish Wallis, General Manager, Surgical Directorate
Executive Lead	Bernie Edwards, Director of Clinical Services

Exception Report – 62 day Screening / Cancer two week rule (S31)

Indicator Rationale	Cancer is a major health issue in the UK; one in three people will be diagnosed with cancer in their lifetime, and one in four will die of cancer. Late diagnosis has been a major factor contributing to poor cancer survival rates in the UK.	
Context	**62 Day Screening:** In Month 9 there were 1 breach (Breast) from 1 referral giving a compliance of 0%. Of those: •1 was due to no capacity due to annual leave. **62 Day Treatment:** In month 9 Trust compliance was 87.23% however there were 6.5 breaches between Breast, Lung, UGI and Urology.	**Cancer 2 Week Rule (excluding Breast Symptomatic):** In Month 9 Trust compliance was 87.1%, six specialities were below 93% (Head & Neck, LGI, Lung, Skin, UGI and Urology). There were 58 breaches (46 in Month 8) from 451 referrals of those: • 26 adverse weather • 6 Patients Deferred or declined one OPA • 10 Patients Deferred or Declined two OPA • 2 Patients Deferred because of holiday • 1 Patient Deferred • 10 Patients cancelled appointments • 1 breach due to the Trust
Actions to Date	▪ Endoscopy – capacity issues due to unit being used as escalation over night (which is reducing through put of patients next day) and cancellations due to adverse weather. Matrons and Waiting List team working together to minimise impact and activity being move to Crawley. ▪ GP practises continue to be called where a patient is deferring their appointment beyond two weeks. ▪ Breast waiting list reduced to 1 week	
Actions for Next Month	▪Annual leave management being re-vamped to ensure sufficient cover provided to meet demand and Targets ▪Out patient capacity being reviewed as part of business planning	
Risks	▪ Lack of capacity in Endoscopy due to winter bed pressures and equipment failure ▪ Referrals higher than planned	

Operational Lead and Author	Hamish Wallis, Assistant Director of Clinical Services for Surgery
Executive Lead	Bernie Bluhm, Director of Clinical Operations

Exception Report – 18 weeks admitted (E10)

Indicator Rationale	The CQC Periodic Review in 2009/10 outlines that Trusts are expected to maintain a maximum waiting time of 18 weeks from referral to start of treatment for 90% of admitted patients and 95% of non admitted patients. The DH is no longer performance managing Trusts centrally on 18 weeks but locally this target remains in force embedded through the acute contract and the NHS Constitution pledge	
Context	**Non- Admitted Pathway:** In Month 9 the Trust over all compliance was 96.3% (unvalidated), five specialities were below the 93% threshold: •General Surgery – 94.9% •Dermatology – 94.1% •Urology – 93.6% •Neurology – 87.8% •ENT – 86.8%	**Admitted Pathway:** In Month 9 the Trust over all compliance was 84.7% (unvalidated), five specialities were below 90% threshold, which were: •General Surgery – 89.5% •Other – 87.7% •Ophthalmology – 85.5% •Trauma and Orthopaedics – 73.3% •ENT – 57.0% During the month of December 255 patients were cancelled due to bed pressures and 33 patients cancelled due to Snow •The backlog at the end of the month was 835
Actions to Date	▪ Have continued to outsource ENT and T&O patients to McIndoe and North Downs respectively ▪ Waiting List team have actively re scheduling patients to minimise potential breachs ▪ Elective lists are reviewed 24 hours prior to operating day in conjunction with operational bed pressures with view prevent cancellations on the day	
Actions for Next Month	▪ Continue to outsource ENT and T&O patients ▪ Pursuing option of spot purchasing rehabilitation beds at North Downs and Ashtead Hospitals ▪Full review of 18 weeks taking place and options for going forward to be discussed that will start to reduce backlog.	
Risks	▪ Winter bed pressures – resulting in cancellation of Elective Surgery ▪ Due to high number of cancellations there is a on going high risk of breaching the 26week target and 28 day target due to capacity issues	

Operational Lead and Author	Hamish Wallis, Assistant Director of Clinical Services for Surgery
Executive Lead	Bernie Bluhm, Director of Clinical Operations

Exception Report – Caesarean Sections (S22)

Indicator Rationale	SEC SHA have committed to reducing caesarean sections across the health economy to achieve a reduction in maternal morbidity whilst maintaining good clinical outcomes for babies. The current plan is to achieve 23% across Southeast Coast by the end of 2010 / 11, following a successful bid for innovation funding for a one year project to normalise birth in the region.
Context	SaSH have historically had a c section rate in excess of 30% and outturn for 2009/10 was 29.6% against a contractual target of 26.1%. The Trust have been engaged in a Joint Clinical Investigation with the PCTs over this high rate and have agreed that the target for 2010/11 should be 26.5% recognising the step change that needs to occur. **Calendar year 2010 28.6%, which is a 1.8% reduction on the previous years data. Although off plan, certainly in the right direction. Quarter 3 figures = 30.2, 27.8, 28.1%**
Actions to Date	▪ Creation of birthing unit ▪ Information to women in first pregnancy that elective LSCS not an option in the absence of clinical need ▪ Workshops / staff engagement sessions to educate all staff in line with NHSi recommendations ▪ Weekly review of all potentially avoidable emergency LSCS's ▪ Part of SEC launch for project following SHA Innovations bid – aim to reduce LSCS rates across SEC by 7% in 12 months to 23% ▪ Reviewed VBAC pathway agreed (Matron Project) ▪Consultant debrief on ward post delivery to record discussions re next pregnancy recommendations ▪Action plan worked up and submitted 10.8.10 & further updated December 2010
Actions for Next Month	▪Continue to submit names of medical staff booking electives with reason to COO & AD for W&CH weekly ▪Plans to staff birthing unit separately under community midwifery remit & now midwife numbers set to improve + recruit identified band 7 team leader for Birthing Unit – interviews early February 2011
Risks	▪ Although we seem to be on a downward trend over recent months, historically it is not maintained. ▪ Some women are very forthright regarding their perceived rights around mode of delivery.

Operational Lead and Author	Sue Chapman, Head of Midwifery / Nursing & Governance, Women & Child Health
Executive Lead	Mary Sexton, Director of Nursing, Quality & Governance

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Exception Report – 90% or more time spent of stroke unit (S17)

Indicator Rationale	110,000 people have a stroke each year, around a third of whom die. Stroke is the largest single cause of adult disability – there are around 300,000 people in England living with moderate to severe disabilities as a result of a stroke. Good care on a dedicated stroke unit is the single most effective way to improve outcomes for people with stroke. This indicator is a good proxy for reducing disability and death due to stroke. Expected position by the end of 2010-11: 80% of people with stroke spend at least 90% of their time on a stroke unit.
Context	• There were 41 stroke admissions in month with 56% spent 90% of their stay on the stroke unit. • Poor performance this month is due to extreme bed pressure made more challenging by outbreaks of D&V and subsequent ward closures. •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.
Actions to Date	▪ We have undertaken an analysis on performance which demonstrates that optimum monthly discharges are 35 and that performance improves inversely with occupancy rate. ▪ We have increased our compliment of band 6 nurses so that bed placement can be improved over the 24/7 period. ▪We undertake a weekly breach report to identify outliers.
Actions for Next Month	Commencement of the Transformation Programme in particular the workstreams focussed on ED and discharges since stroke performance will not improve until we have sustained flow. Explore dedicating beds in AMU as stroke beds to ensure that patients are not placed in other medical beds (it is difficulty to retrieve patients from outlying medical beds especially with bed closures) Review length of stay and onward flow and timeliness of patients accessing Crawley for stroke rehab.
Risks	Winter pressures. Norovirus and subsequent ward closures. Lack of a second consultant (during Dr Shah's absence) leads to pressure on the team and particularly on Capel ward with regards to placement of patients and strong medical leadership.

Operational Lead and Author	Jacqui Adams, Interim Service Manager for Stroke
Executive Lead	Bernie Bluhm, Director of Clinical Operations

Exception Report – A&E (E1)

Indicator Rationale	98% of all A&E attendances should spend 4 hours or less from arrival in A&E to discharge, admission or transfer. This indicator includes a % of patients that attend local walk in centres. This indicator is calculated monthly for this report using the CQC / DH Framework methodology. The final CQC and the DH Performance Framework ratings are calculated using quarterly mandatory returns – these may differ slightly from the monthly figures as at the point of the quarterly return the walk in centre figures have been finalised.
Context	Performance in month was 84.07% and year to date stands at 92.91%. This is against a revised target of 95%. Patient flow through the hospital remains the key factor in the ability to achieve under 4 hour waits for A&E patients. There remains an outstanding performance notice from the PCTs for A&E performance. 3 consecutive months of performance at 98% or above will remove the performance notice. The expectation is that this will be revised to 3 consecutive months at 95%.
Actions to Date	▪ Circulation and increased monitoring of team roles and professional standards ▪ Refocus on ED escalation plan to ensure compliance with appropriate response times ▪ Refocus role of Head of Capacity and the site team and revised management and timings of site meetings ▪ Delayed discharge taskforce has been established.
Actions for Next Month	▪ Commencement of the ED Transformation Workstream to redefine the clinical pathway through ED. The first meeting takes place in early January the outcome of which will be an agreed list of projects which will be project managed through the Transformation Team. ▪Completion of review and implementation of changes to consultant job plans to ensure appropriate timing and delivery of inpatient ward rounds and implementation.
Risks	▪ Increased attendances and admissions in winter months ▪ Increased age and acuity of patients leading to an increase in delayed discharges and subsequent length of stay ▪ Outbreaks of norovirus ▪ Increased delayed discharges ▪Severe weather impeding discharges and limiting staff availability

Operational Lead and Author	Angela Stevenson, General Manager for Medicine
Executive Lead	Bernie Edwards, Director of Clinical Services

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Exception Report – Falls (S47)

Indicator Rationale	Within the last 12 months there has been a total of 538 patient related falls reported in the Medical Division. 162 of these falls occurred in Quarter 3, 105 resulted in no harm, 56 in minor injuries, 0 moderate injuries and 2 in major (fractured neck of femurs)
Context	Patient admitted to an orthopaedic ward, under the care of the elderly care team, to assess his inability to manage at home. Case conference held where the therapists were concerned that the patient was at risk of falling if he was discharged home. On 7.12.10 patient was transferred from Leigh ward to Nutfield ward. On the 10.12.10 patient sustained 2 falls. The first was witnessed and second was unwitnessed. Patient suffered a fractured neck of femur. Investigation identified that on transfer to Nutfield ward the concerns raised by the therapists of the patients potential high risk of falling was not highlighted or communicated. Falls risk assessment and care plan was not completed between 22.11.10 and 10.12.10. Falls risk assessment was underscored.
Actions to Date	▪Incident fed back to ward staff for local learning. ▪Audit completed on 21/12/10 on Nutfield ward auditing completion of falls risk assessment. 5 out of 5 pts audited completed all had a falls risk assessment completed. ▪Amber investigation form completed.
Actions for Next Month	▪Incident learning to be shared with Leigh ward about improving inter ward transfer of care planning. ▪Ward to review local policy for risk assessment of patients on transfer or a system for ensuring all dates of last risk assessment are incorporated into weekly falls risk assessment process. ▪Falls group set up and first meeting due end January 2011. ▪Elderly care matron appointed (due to start mid March).
Risks	▪ Reduced staffing due to vacancies or sickness resulting in reduced supervision. ▪Potential Increase in confused elderly patients more at risk of falls.

Operational Lead and Author	Lisa Cheek – Divisional Chief Nurse
Executive Lead	

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Exception Report – Health and Safety (S51)

Indicator Rationale	▪ The Key Performance indicators for Health and Safety include Environmental Safety and Manual Handling and measure legislative compliance against the Health and Safety at Work etc. Act 1974 and various other EU Regulations. ▪ The measures will be externally monitored by the Health and Safety Executive (HSE) in relation to the Improvement Notice/Inspection report Action Plans detailing progress made against identified deficiencies. ▪ To provide safe high quality coordinated care to our service users and our staff have a right to safety as a priority. ▪ The information does not include Security or Fire matters who report independently.
Context	▪ Incident reports are an indicator of how effective the organisations H&S arrangements are and provide analysis of trends. ▪ As incident reports are received on average between 1 – 7 months after the event, the resulting % statistics will need to be amended month on month. This impacts on RIDDOR statistics also. Incident reporting is due to upgrade to DatixWeb on-line system in 2011 which will eliminate the delay in both internal and external reporting requirements. Training statistics based on WTE substantive, bank and temporary staff in post. (This calculation is currently under review to bring in line with T&E KPIs) ▪ Audit rates are based on current figure of 65 areas throughout the Trust in total to be audited and provide further indication of overall H&S management.
Actions to Date	▪Datix incident reporting database was recoded in Q1 for H&S incidents to enable more concise/precise analysis of incident type, location, etc.
Actions for Next Month	▪ Training analysis meeting with Head of T&E ▪ Further instruction to managers to reinforce the timescales for processing incident reports. ▪ New H&S Officer to commence employment.
Risks	▪ Training statistics affected this month due to trainer sickness and weather conditions. ▪ Non compliance with UK H&S legislation can lead to enforcement action and/or prosecution and/or fines.

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Exception Report – Pressure Ulcers

Indicator Rationale	A key indicator and one of the High Impact Actions Data monitored by Commissioners and SHA with expectations for significant reductions SHA monitor monthly data in relation to any SaSH acquired grade 2 and above
Context	Quality of reporting has increased in the last few months allowing more accurate information to be reported. Numbers are higher in Surgery and Orthopaedics. There are some reported incidents of difficulty in accessing specialist equipment quickly There is very little provision for Bariatric patients in the contract – the contract is currently under review which will address the provision of specialist equipment to support patients. Plans are being agreed to devolve responsibility to divisions to monitor appropriateness and usage Pressure ulcers are being reported as both number of ulcers and number per patient with weekly reporting now in place.
Actions to Date	▪Key area of Quality Standards framework with auditing of documentation and actions ▪There has been an improvement in documentation/assessment in 16 out of 19 areas ▪Report reviewed in monthly Nursing &Midwifery meeting, actions taken are evaluated and discussed ▪TVN has sourced heel prevention devices and are in the process of being trialled.
Actions for Next Month	▪ Awaiting actions plans for Surgical and Medical divisions with explanation of increases and plans for reduction ▪To be discussed as part of quality performance review for divisions ▪Quality standards continue top focus for another 4 weeks
Risks	▪Concerns that there is still some under reporting in certain areas ▪There is a need for more ownership and rigorous interrogation of data by the clinical areas with a clear approach to action planning and prevention with an agreed reduction figure ▪Numbers reported in orthopaedics has increased considerably ▪Incidence now back in line with national average ▪Pressure Ulcers now becoming part of Safeguarding Vulnerable adults agenda and incidences may be raised through alerts with formal investigations

Operational Lead	Louise Evans, Tissue Viability Nurse
Executive Lead	Mary Sexton, Chief Nurse

Contents

5. 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