THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST

Report to:	Trust Board
Date:	28 November 2011
Subject:	Quality & Safety Report
Report by:	Chief Nurse
Author:	Patient Safety Manager
Purpose of Report	To provide the Board with information regarding performance and progress with Trust quality and safety.

Report

The report relates to September 2011 and includes progress of the Trust's campaign to prevent harm and improve patient safety in addition to an organisational overview of incidents, complaints, inquests, and claims. It also provides information on issues that fall outside of the campaign but contribute to the quality and safety agenda.

Review Committee Approval

Recommendation(s)

The Board is asked to note the content of the report

Contents

1) EXECUTIVE SUMMARY

This report on Quality and Safety includes progress on the Campaign for Preventing Harm, Improving Safety. The report refers to the period September 2011.

Section 2 provides an overview of organisational quality and safety.

Section 3 details progress with the Preventing Harm, Improving Safety harm prevention initiatives.

Section 4 reports on the patient experience.

Section 5 includes performance on areas that impact on patient safety and quality.

The areas to note regarding progress are as follows:

- The number of falls per occupied bed days remains above our target in both acute care and rehabilitation however falls resulting in serious injury have reduced compared to last year
- There were five Grade 3 acquired pressure ulcers at New Cross, one at West Park and three in the Community
- Results of Hand Hygiene and Essence of Care audits show decrease in compliance; ward specific action plans are in place

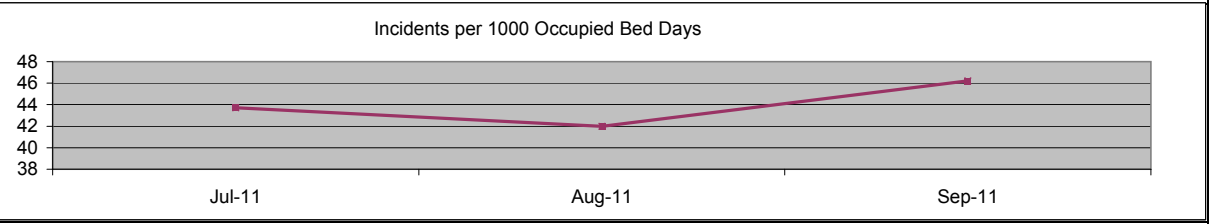
- Incident reporting continues at a high level
- There has been a reduction in radiation and radiotherapy incidents
- This was the first month since the introduction of the more sensitive testing method that we were within the external target for C Diff
- Completion of the VTE risk assessment remains above the national target
- Response times to formal complaints remain above target

2) TRUST SAFETY & QUALITY OVERVIEW

2.1 Incident Rate

Key to providing high quality care is having good systems in place for staff to report when patients have, or could have been harmed. Organisations with good levels of reporting are able to set safety priorities and direct investment, anticipate problems and reduce costly claims, identify problems and take actions. High reporting of incidents is a mark of high reliability organisations and therefore incident reporting is to be encouraged. It is essential that staff receive feedback, there is a focus on learning, frontline staff are engaged, incident reporting is easy, reporting systems focus on improving safety rather than blaming individuals and appropriate action is taken.

	Jul-11	Aug-11	**Sep-11**
Div 1	401	351	331
Div2	458	448	604
Total	859	799	935
Per 1000obd	43.7	42	46.2



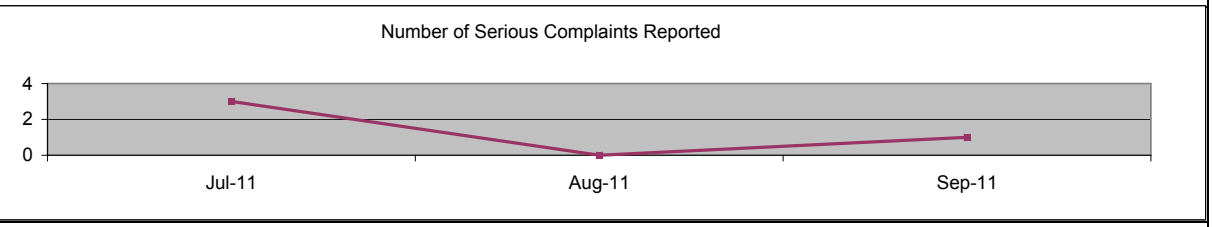
Analysis: The number of incidents reported during September has increased by 17% from the previous month. The majority of incidents are reported by nursing and midwifery staff and the largest category of incidents is patient falls (further information on patient falls in section 3.2).

Actions: The reporting of incidents continues to be encouraged and the use of online reporting of incidents via DatixWeb is extending. All directorates are working to achieve a sustained reduction in patients falls.

2.2 Serious Complaints

A serious complaint includes complaints graded amber and red on the Trust's risk matrix. These complaints are reported and monitored by the Quality & Safety Committee on a quarterly basis and the Trust Board receives a summary report of red/amber complaints on a quarterly basis.

	Jul-11	Aug-11	**Sep-11**
Div 1	1	0	0
Div2	2	0	1
Corp	0	0	0
Total	3	0	1



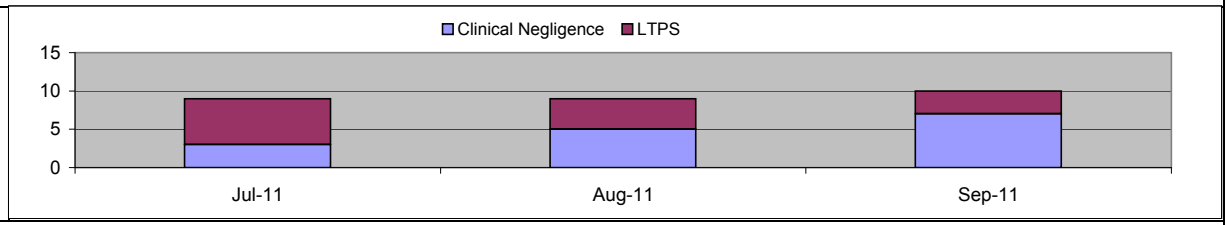
Analysis: Division 1: No complaints graded red or amber. Corporate: No complaints graded red or amber. Division 2: One complaint graded as amber. The complaint relates to a patient who attended an appointment with a Consultant and was advised that the diagnosis made by a Consultant here in 1967 was incorrect. The patient's GP at that time prescribed medication following the Consultant diagnosis in 1967 so patient was not seen again here until their appointment with the Consultant in 2011 for an unrelated clinical matter.

Actions: Patients current diagnosis confirmed, but the Trust was not able to address the concern about previous diagnosis.

2.3 New Litigation

The numbers of new clinical negligence claims and liabilities to third party (LTPS) claims received during the quarter are detailed below. A detailed report is provided in the confidential section of the Trust Board every 6 months.

	Jul-11	Aug-11	**Sep-11**
Clinical Negligence	3	5	7
LTPS	6	4	3
Total New	9	9	10



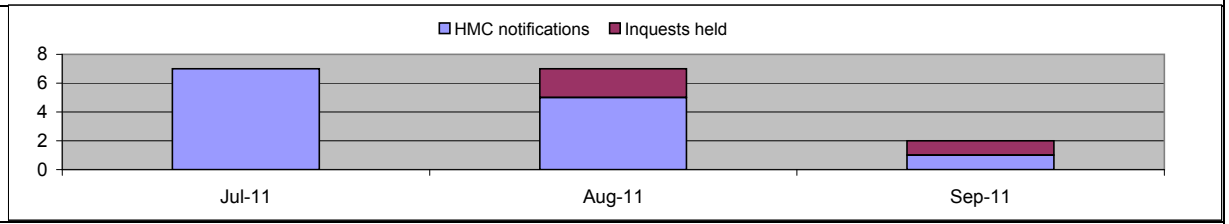
Analysis: During September the clinical negligence claims received relate to treatment, diagnosis, and obstetrics. The LTPS claims for this period all relate to sharps injury and needle stick injuries

Actions: The divisions receive notification of new claims as part of the risk management process

2.4 Inquests

The purpose of the inquest is to determine how, when and where the deceased died. Her Majesty's Coroner (HMC) may give a narrative verdict or one of a number of standard verdicts. HMC may also make recommendations on the provision of care/treatment or service provided or, issue a Coroner's Rule 43 which allows him to report the findings to an individual or body who may have the power to prevent a similar death occurring in the future.

	Jul-11	Aug-11	**Sep-11**
HMC notifications	7	5	1
Inquests held	0	2	1
HMC Recommendations	0	0	0
% Recommendations per FCE	0	0	0



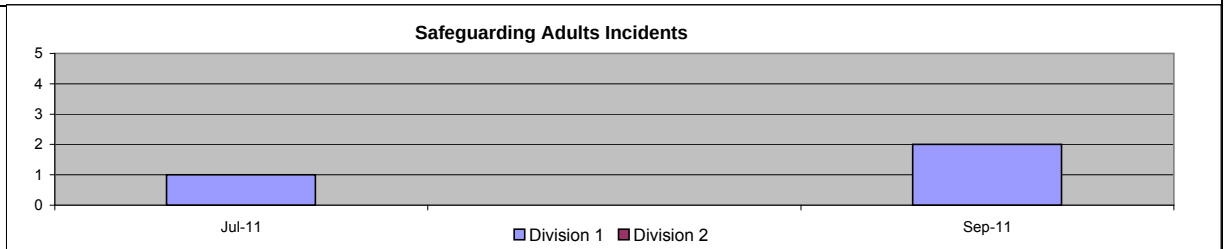
Analysis: During September there was 1 inquest notification received and 1 inquest held. The verdict is summarised as follows: The deceased suffered a cardio-respiratory arrest following the administration of analgesic agents in the immediate post operative period following surgery.

Actions: The divisions receive notification of all new inquests and the outcome of those concluded

2.5 Safeguarding Adults Incidents

A vulnerable adult is defined in 'No Secrets' (the Government's Guidance on Adult Abuse) as "a person aged 18 years or over, who is in receipt of or may be in need of community care services by reason of 'mental or other disability, age or illness and who is or may be unable to take care of themselves, or unable to protect themselves against significant harm or exploitation." It is recognised that certain groups of people may be more likely to experience abuse and less able to access services or support to keep themselves safe. The following incidents are those that have been reported under the Wolverhampton Safeguarding Adults policy and procedure 2010.

Safeguarding Adults	Jul-11	Aug-11	**Sep-11**
Div 1	1	0	2
Div2	0	0	0
Total	1	0	2



Analysis: Two referrals received in September for Division 1. One neglect by acts of omission following inpatient fall resulting in serious injury and one emotional/ psychological as a result of inappropriate communication by member of staff.

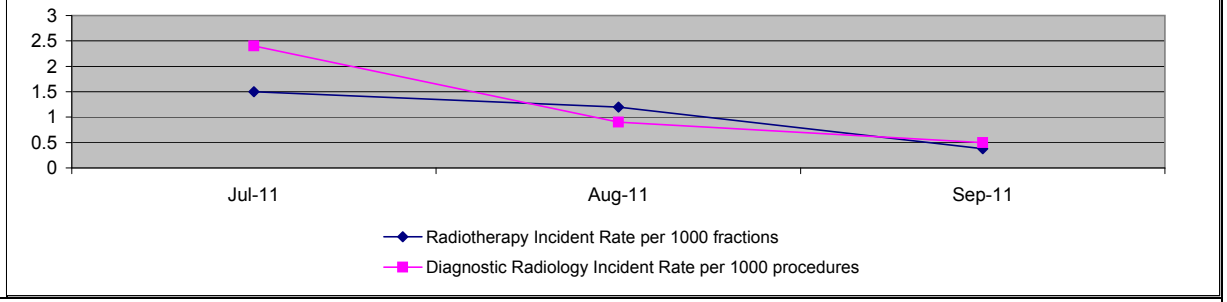
Actions: Both safeguarding allegations were already being investigated before safeguarding referrals received as per trust processes however the outcome is not yet known.

2.7 Radiation Incidents

All incidents involving radiation are reported on the Datix system following the Trusts Policies: HS05 Ionising Radiation Safety Policy and HS06 Laser Safety Policy. There is a legal requirement that incidents involving a greater than intended exposure or exposure of the incorrect patient are reported to the Care Quality Commission under the Ionising Radiation (Medical Exposures) Regulations 2000 and those involving equipment are reportable to the HSE under the Ionising Radiation Regulations 1999. The term 'greater than intended' is defined in HS05. All radiation incidents are reported to and discussed at the Trusts Radiation Safety Committee.

Radiation Incidents	Jul-11	Aug-11	**Sep-11**
Radiotherapy	4	2	1
Diagnostic Radiology	4	1	11
Nuclear Medicine	0	1	0
Laser/Non-ionising	0	1	0

Rates	Jul-11	Aug-11	**Sep-11**
Radiotherapy Incident Rate per 1000 fractions	1.5	1.2	0.38
Diagnostic Radiology Incident Rate per 1000 procedures	2.4	0.9	0.5



Analysis:

▪ Diagnostic Radiology – There was 1 incident that is externally reportable to IRMER. The incident involved a request card with ambiguous information and a CT was carried out instead of an MRI. A number of incidents involved problems with equipment in the Cath Labs. The problems have been logged on the risk register. One incident involved the contamination of staff and work area in Nuclear Imaging. The incident resulted from failure to follow procedure, actions to be carried out in response include further staff training. Incomplete information on an x-ray request card regarding also resulted in an incident as a repeat examination had to be carried out.

▪ Radiotherapy – There were 0 incidents reported externally. The one incident in radiotherapy this month involved the incorrect set up of a patient for part of one fraction of a multi-fraction treatment. There was no significant effect on the patients overall treatment.

Actions: The incidents for this quarter have now all been discussed in the Radiation Safety Committee Incident Meeting and actions agreed.

3) PREVENTING HARM, IMPROVING SAFETY MEASURES

Introduction:

This section includes progress from the Preventing Harm, Improving Safety Group for the period (month/quarter).

The following initiatives are our priority for 2011-13 and will contribute towards achieving our aim to prevent avoidable harm and avoidable death: Pressure Ulcers, Falls Prevention, Infection Prevention, Venous Thromboembolism, Deteriorating Patient, Nutritional Assessment, Device Related Infections and Clinical Handover.

3.1 Mortality

The Hospital Standardised Mortality Rate (HSMR) is an important indicator of the care provided. Figures shown are the monthly average and are the latest data available by Dr Foster.

	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Outturn	Apr-11	May-11	Jun-11	Jul-11	Aug-11	YTD
HSMR	109.8	107.9	94.2	99.9	97.5	106.4	103.4	103.4	95	102 [113]	91	84	88	89	89	88.2
Observed Death Rate (56 CCS	4.20%	3.80%	3.50%	4.30%	4.00%	5.10%	4.90%	4.50%	3.90%	4.24%	4.40%	3.50%	3.40%	3.60%	3.20%	3.62%
Expected Death Rate (56 CCS	3.80%	3.50%	3.70%	4.30%	4.10%	4.80%	4.80%	4.30%	4.10%	4.16%	4.80%	4.20%	4.10%	4.00%	3.60%	4.14%
No of In Hospital Deaths	128	116	106	128	126	165	157	128	130	1506	125	98	79	111	95	508
Expected Deaths	107.2	97.5	101.6	115.2	116.2	141.6	137.6	112.8	125.4	1343	138	117	108	119	106	588
Excess Deaths	21	19	4	13	10	23	19	15	5	163	-13	-19	-29	-8	-11	-80

Analysis: April- August 2011 is the latest available data as at November 2011. The Trust's YTD HSMR based on 5 months data is 88 with a probable rebased value of 96. It is to be noted that HSMR and other high level measures of mortality are subject to in year variation. **The 2010/11 end of year aggregate position was 102, this was rebased to 113 which will be the figure reported in the Good Hospital Guide in November 2011**

Top Diagnostic Groups Contributing to Patient Deaths by Volume

April- August 2011

Diagnosis Group	Spells	Deaths	Observed Death Rate
Pneumonia	**1049**	**246**	**23.45%**
Acute Cerebrovascular disease	**839**	**166**	**19.79%**
Congestive Heart Failure	**480**	**74**	**15.42%**
Acute Myocardial Infarction	**930**	**66**	**7.10%**

Alert Status

Analysis: .CQC Alert received in August 2011 for Complex Elderly Adults with: Nervous System Primary Diagnosis, Cardiac Primary Diagnosis, Urinary Tract or Male Reproductive System Primary Diagnosis.

Actions: A panel of consultants led by a specialist geriatrician are conducting a detailed case note review. This is being complemented by enhanced level data interrogation of the specified HRGs. The response was signed off by the Trust's Mortality Assurance Review Group (MoRAG) on 21 September 2011. In November 2011 The Trust received confirmation from the CQC that no further enquiries will be necessary with regard to these outlier alerts.

Associated Indicators of Mortality

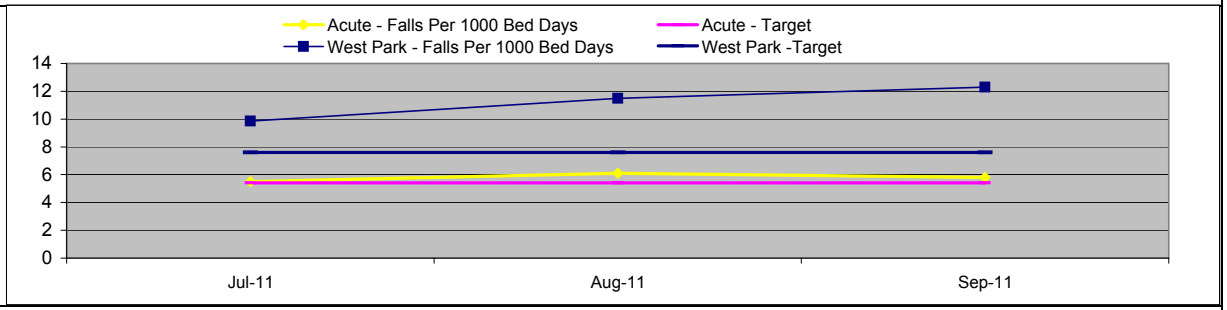
Indicator	Period	Target	Actual	RAG	TREND
Charlson Codes Per Spell (HED)	Apr-July 11	Peer Group Average **5.45**	**5.78**		
Palliative Care Deaths Per 1000 Spells (HED)	Apr-July11	Peer Group Average **24**	**39**		
Expected Death	Apr-Aug 11	Peer Group Average [4.13%]	**4.00%**		

Analysis: The Trust's Specialist Palliative Care team has received a 67% increase in Referrals since 2009. On average 100 referrals to the Specialist Palliative Care Team are received monthly. At these levels our palliative care coding rate is 58% above peer group levels. The number presented in this report is [39] palliative care deaths per 1000 discharges, this should be viewed in the context of over 100 referrals per month to the Trust's Specialist Palliative Care Team

3.2 Inpatient Falls

The proportion of reported patient falls in hospital represents avoidable episodes of harm to patients. Measurements are at a rate of falls per 1000 Occupied Bed Days.

	Jul-11	Aug-11	**Sep-11**
Acute - Target per occupied bed days	<5.4	<5.4	<5.4
Acute - Number of falls per occupied bed	5.5	6.1	5.8
West Park- Target per occupied bed days	7.6	7.6	7.6
West Park - Number of falls per occupied bed	9.8	11.5	12.3
Number of falls resulting in serious injury	3	0	3



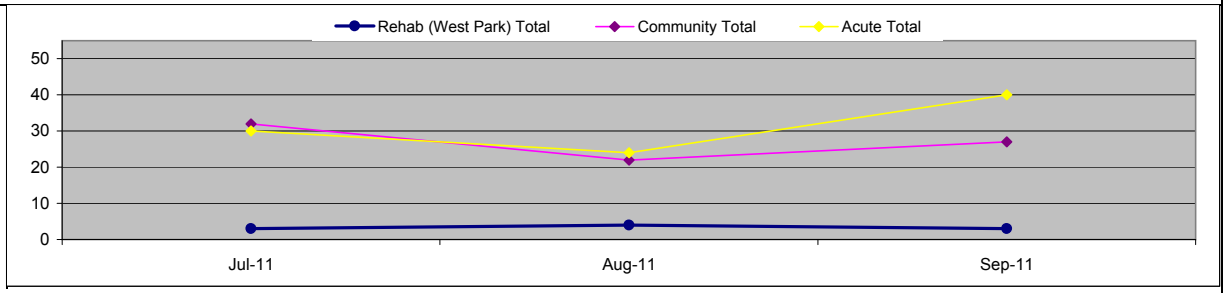
Analysis: Rates of falls per 1000OBD remains above the target however the rate of falls with serious harm which was subject to a 50% reduction target this year continues to show positive progress compared to last year.

Actions: To continue embedding use of falls care bundle and to audit compliance. Ensure as part of Creating Best Practice wards all falls prevention actions identified are consistently delivered. Contact inpatient units with recognised low levels of falls to share plans.

3.3 Pressure Ulcers

Pressure Ulcers are commonly encountered and represent largely avoidable episodes of harm to patients. All healthcare acquired pressure ulcers are reported and the number of pressure ulcers by grades 2,3 & 4 are represented below.

Healthcare acquired pressure ulcers (Grades 2, 3 & 4)	Jul-11	Aug-11	**Sep-11**
Community Services			
Grade 2	24	16	24
Grade 3	6	5	3
Grade 4	1	0	0
Rehab (West Park)			
Grade 2	3	4	2
Grade 3	0	0	1
Grade 4	0	0	0
New Cross Hospital			
Grade 2	28	24	35
Grade 3	2	0	5
Grade 4	0	0	0



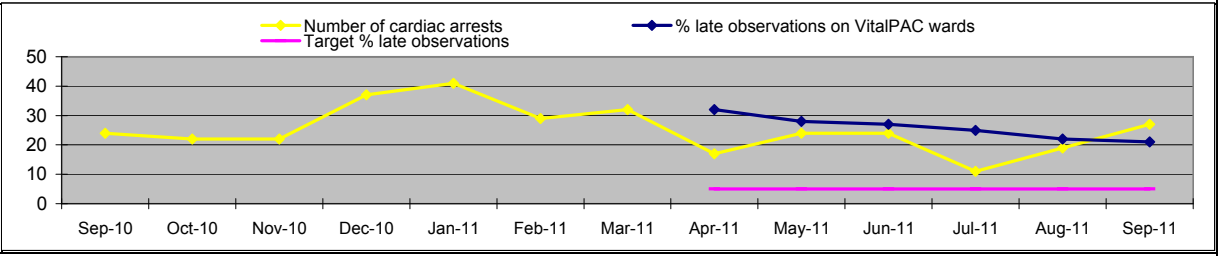
Analysis: In September there were three Grade 3 healthcare acquired pressure ulcers in Community services, one Grade 3 at West Park and five Grade 3 in New Cross Hospital during September. Following investigation three of the Grade 3 pressure ulcers were considered to be unavoidable, others are yet to be confirmed.

Actions: Ongoing education, training and RCA investigations of serious falls.

3.4 Recognition of the Deteriorating Patient

The aim is to reduce in-hospital cardiac arrest and mortality rate through earlier recognition and treatment of the deteriorating patient. This involves a review of how physiological observations are recorded and acted upon by staff, ensuring that staff are trained to undertake these procedures and understand their clinical relevance. In conjunction with this is the review of the use of the Early Warning Score system and communication of the deteriorating acutely ill adult patient. Measures include: Percentage of late patient observation and number of cardiac arrest or crash calls.

	Jul-11	Aug-11	**Sep-11**
Number cardiac arrests	11	19	27
% observations late	25%	22%	21%
Target (late observations)	5%	5%	5%



Analysis: The % late observations has only decreased by 1% this month.

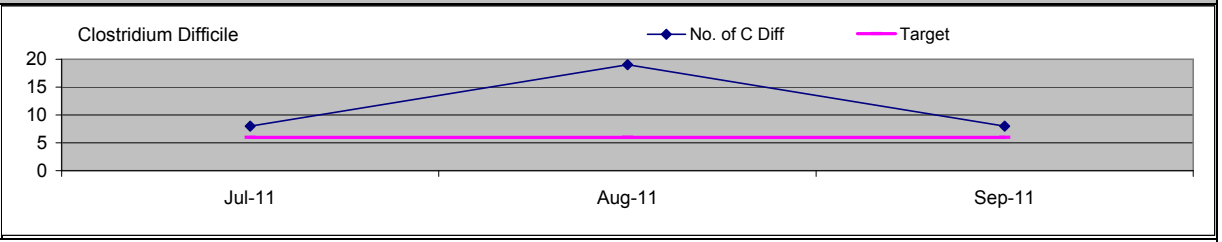
Actions: Continuing to monitor ward performance. Information sent out on a weekly basis to ward managers and Matrons. A case note review of patients who have had a cardiac arrest is currently underway, led by Dr Bryan (Consultant Anaesthetist), using an amended version of the Global Trigger Tool.

3.5 Healthcare Acquired Infections (HCAIs)

Clostridium difficile (C diff) and Meticillin Sensitive *Staphylococcus aureus* (MSSA) are an important indicator of infection prevention and control. The target for 2011/12, using the RWHT internal definition of attribution of cases, is no more than 6 C diff cases per month (72 or fewer per year) (2010-11 target was <7.5 per month) and 2.5 MSSA bacteraemias per month (30 per year attributable to RWHT).

3.5.1 Clostridium Difficile - hospital acquired for ages >2 years

	Jul-11	Aug-11	**Sep-11**
Number of C Diff	8	19	8
Cum Plan	24	30	36
Cum Actual	46	65	73
Cum Variance	22	35	37

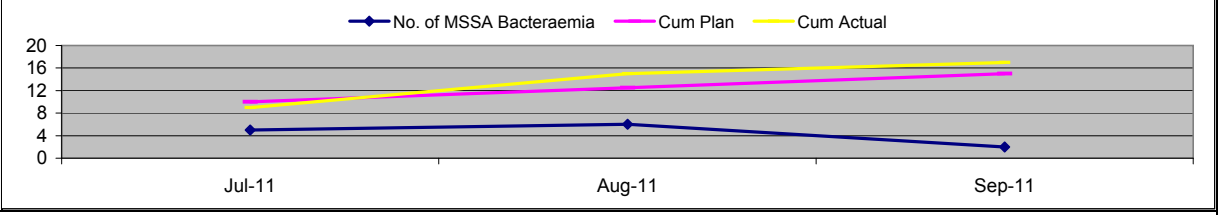


Analysis: Although the internal target was breached, this was the first month since the introduction of the more sensitive testing method that we were within the external target. Two wards each had 2 cases, while the remainder were sporadic cases from around the RWHT.

Actions: The updated Trust Antimicrobial Prescribing Guidelines have been launched on the Intranet. The meeting has now taken place between the Infection Prevention Team plus key clinical staff and an SHA HCAI Programme Specialist. This has identified several potential courses of action that will hopefully produce improvements if carried out of the coming months.

3.5.2 MSSA Bacteraemia

	Jul-11	Aug-11	**Sep-11**
No. of MSSA Bacteraemia	5	6	2
Cum Plan	10	12.5	15
Cum Actual	9	15	17
Cum Variance	-0.5	2.5	2



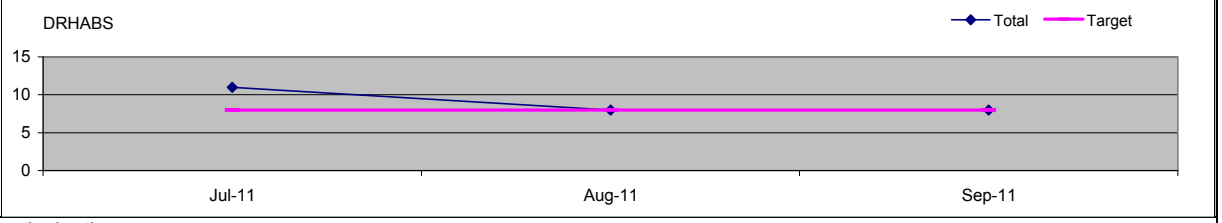
Analysis: Both cases were line-related (and are therefore also included in the DRHABS total); one was from a very complex cardiology / renal patient with very difficult intravenous access; the other was from an Oncology patient.

Actions: Work continues on reducing line-associated infection. Regular MSSA screening and decolonisation of renal patients is being considered.

3.5.3 Device Related Hospital Acquired Bacteraemias

Following a reduction in Device Related Hospital Acquired Bacteraemias (DRHABS) by 25% in 2010/11 the aim of this initiative is to reduce device related hospital acquired bacteraemias by 10% by April 2012. The current internal target is 8 per month.

	Jul-11	Aug-11	**Sep-11**
Target (monthly)	8	8	8
DRHABS	11	8	8



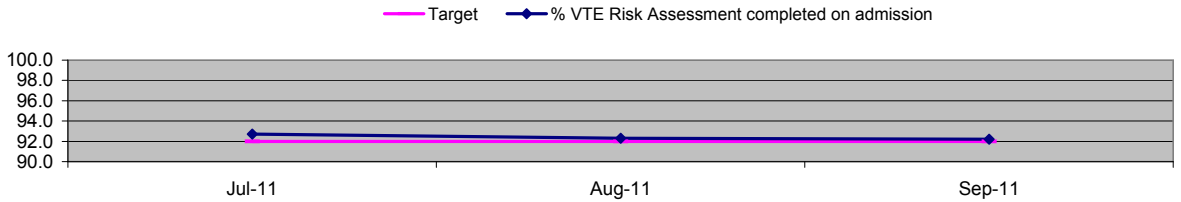
Analysis: There were 8 DRHABS during September, 7 due to central lines and 1 due to a urethral catheter

Actions: Ward audits continue - demonstrating care/documentation improvement. Central Venous Access Course ongoing. Joint urinary catheter working party of PCT and Hospital representatives formed in preparation for when new IP Lead Nurse in post.

3.6 Venous Thrombo Embolism

Venous thromboembolism (VTE) is one of the commonest causes of avoidable death in hospitals. There is a national VTE risk assessment and prevention pathway, which has been developed by the Department of Health following NICE Guidance released in January 2010. Compliance with VTE risk assessment is a CQUIN requirement, set at 90%. This is one of 7 key NICE standards for VTE prevention that the Trust is aiming to reach.

	Jul-11	Aug-11	**Sep-11**
% adult patients with completed VTE risk assessment	92.7%	92.3%	92.2%
Number of patients with hospital acquired VTE	12	8*	6*
Number of patients with community acquired VTE	42	34*	22*



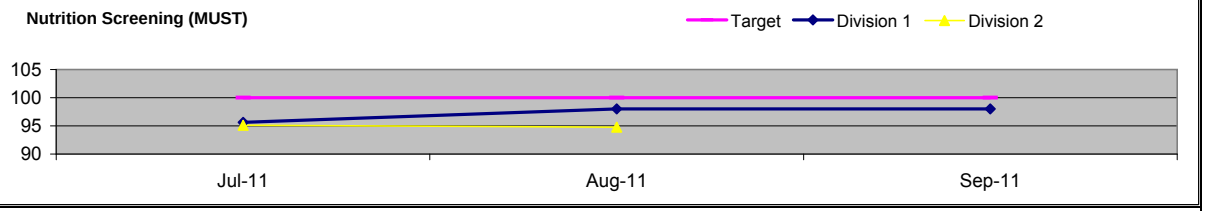
Analysis: * Awaiting the completion of 6 RCA investigations where patients were diagnosed with VTE in August and 4 for September.

Actions: The VTE nurses continue to support clinical areas to improve the completion of VTE risk assessments on VitalPAC. Incidences of confirmed VTE diagnosis are investigated and outcomes reported via governance meetings.

3.7 Nutrition

MUST is a nutritional screening tool. All adult patients should undergo nutrition risk screening and those identified as high risk should have a full nutritional assessment.

% adult inpatients with completed MUST	Jul-11	Aug-11	**Sep-11**
Division 1	95.6%	98%	98%
Division 2	95.1%	94.8%	97%
Target	100%	100%	100%



Analysis: MUST screening has improved overall. Action plans in place for specific areas.

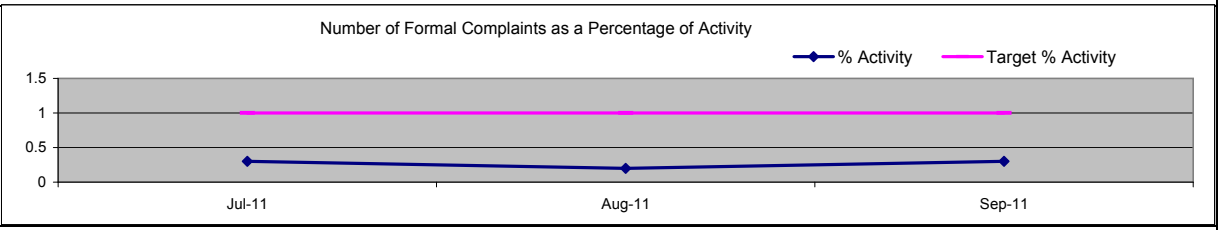
Actions: Action plans to achieve compliance have been put in place. Protected mealtimes are being re-enforced on 5 pilot wards, with ongoing work through the nutrition action team meetings. Nutrition training for nurses now being delivered at 2 levels on induction: Level 1 (Importance of nutrition, ordering meals and special diets, optimizing nutritional intake, protected mealtimes, feeding patients and monitoring intake) for HCAs and RNs, and Level 2 for RNs (nutrition screening, care planning and safe delivery of artificial nutrition). Mandatory requirement to update every 3 years, either via taught session, or e-learning (currently being developed).

4) PATIENT EXPERIENCE

4.1 Formal complaints

The following numbers are based on the number of formal complaints received during the quarter. There is no national target in relation to the number of complaints received as the Trust welcomes all feedback as this helps us to continually improve the services we provide. However there is an expectation that the number of complaints received is less than 1% of the activity for the Trust. The percentage of complaints based on the number of inpatient spells is shown in the graph below.

Target	Jul-11	Aug-11	**Sep-11**
1.00%	0.3%	0.2%	0.3%



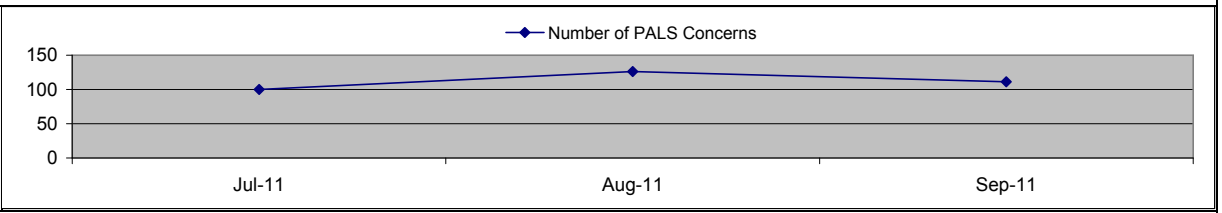
Analysis: 44 complaints were received in September 2011 which equates to 0.3% of Trust activity.

Actions: No action to be taken.

4.2 PALS Concerns

The following numbers are based on the number of informal complaints received during the quarter. There is no national target in relation to the number of complaints received as the Trust welcomes all feedback as this helps us to continually improve the services we provide. The number of informal complaints is shown in the graph below.

Jul-11	Aug-11	**Sep-11**
100	126	111



Analysis: The number of PALS contacts shows a minor decrease, as awareness of the service continues to be raised both internally and externally incorporating the community based services. The 3 most common themes for PALS are clinical treatment (regarding inappropriate treatment received or misdiagnosis), delays (including cancellation or change of appointments) and general care of patients (including poor communication with patient/relatives).

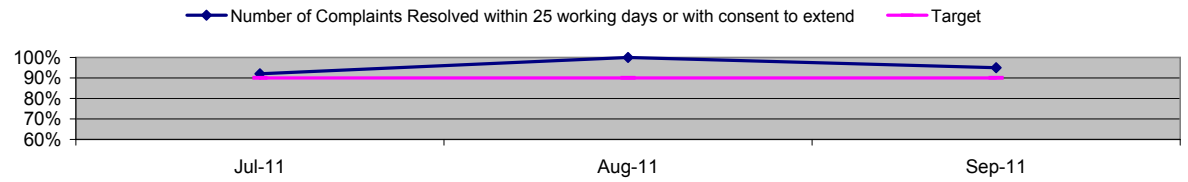
Actions: Themes of PALS enquiries will continue to be monitored

4.3 Formal Complaints resolved within 25 days

The Trust aims to provide first class responses to greater than 90% of all complaints within 25 working days and an action plan in place.

Percentage of complaints responded to within 25 working days and with action plan in place

Jul-11	Aug-11	**Sep-11**
92%	100%	95%



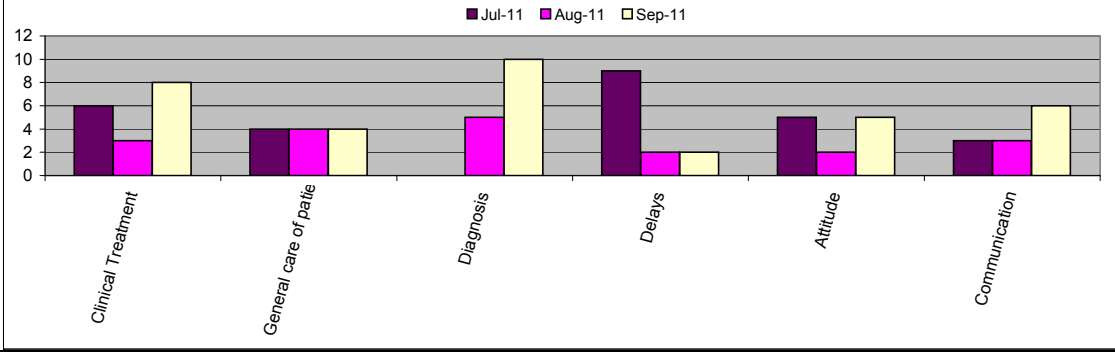
Analysis: The Trust has achieved its response target. 42 of the complaints received in September were dealt with either within the 25 working day timescale or within an extension period agreed with the complainant. 2 complaints exceeded the 25 working day timescale and did not have consent to breach.

Action: The new centralised process for obtaining consent continues to show that it is working well and will continue to be monitored.

4.4 Formal Complaints trends

Analysis of complaint themes during the quarter is detailed in the graph below.

	Jul-11	Aug-11	**Sep-11**
Number of formal complaints	36	21	44



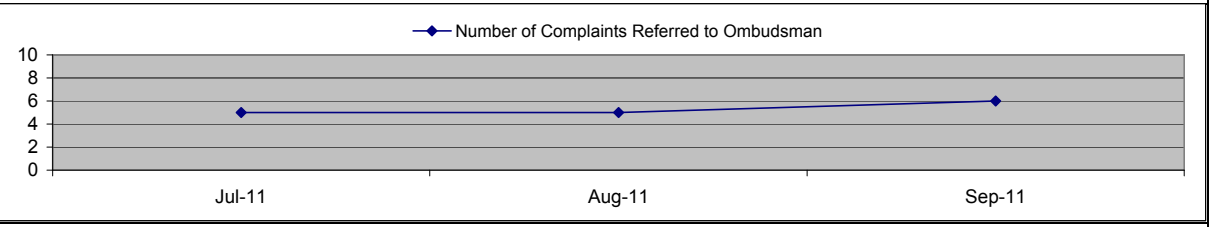
Analysis: The top three themes raised in formal complaints during September were diagnosis (incorrect or none given) and clinical treatment and communication.

Action: Formal complaints issues will continue to be monitored where trends are found these will be investigated further.

4.5 Ombudsman

The role of the Parliamentary & Health Service Ombudsman is to consider complaints that government departments, a range of other public bodies in the UK, and the NHS in England, have not acted properly or fairly or have provided a poor service. The Ombudsman will normally only take on a complaint after the complainant has first tried to resolve the complaint with the organisation involved and has received a response from them. The number of complaints referred to the PHSO by complainants is detailed below.

	Jul-11	Aug-11	**Sep-11**
Number of complaints referred to the PHSO	5	5	6

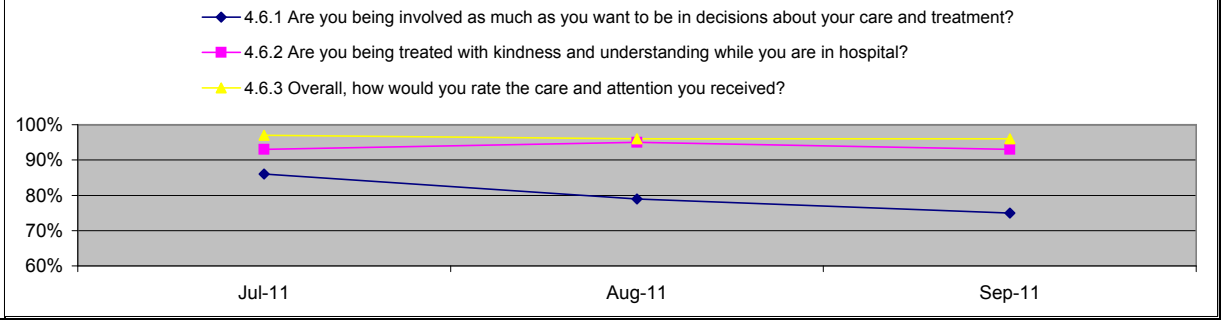


Analysis: Six complaints were referred to the PHSO during September. Of the six referred two were returned to the Trust for local resolution, papers have been requested and sent for the remaining four complaints and continue to be assessed for suitability for formal PHSO investigation.

Actions: The review of the monitoring process for complaints accepted for review by the PHSO is ongoing.

4.6 Patient Experience Tracker

	Jul-11	Aug-11	**Sep-11**
4.6.1 People that said yes definitely to: Are you being involved as much as you want to be in decisions about your care and treatment?	86%	79%	75%
4.6.2 People that answered yes all of the time to :Are you being treated with kindness and understanding while you are in hospital?	93%	95%	93%
4.6.3 People that answered 'excellent or good to :Overall, how would you rate the care and attention you received?	97%	96%	96%



Analysis: The number of patients surveyed in September was 470, there has been a slight decrease in the number of people feeling they are definitely being involved as much as they want in decisions about their care and the number of people who feel they are always treated with kindness and understanding. However overall satisfaction levels remain stable.

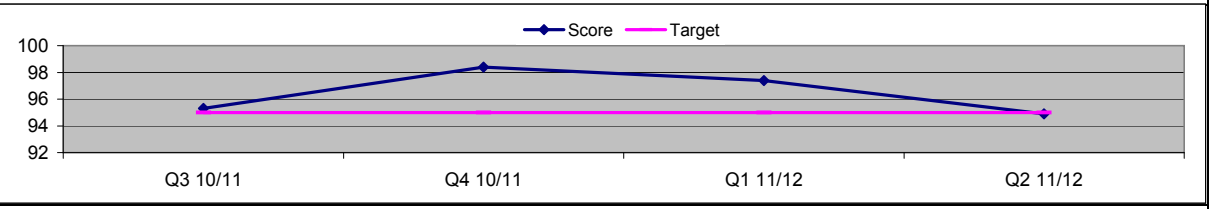
Actions: The tracker survey continues to be rolled out across the Trust

5) PATIENT SAFETY AND QUALITY

5.1 Hand Hygiene Practice

Consistent hand hygiene is key to high quality infection prevention practice. Quarterly audits measure compliance with hand hygiene standards. The Trust has set a target of 95%.

	2010/11		2011/12	
Target	Q3	Q4	Q1	**Q2**
95%	95.3%	98.4%	97.4%	94.90%



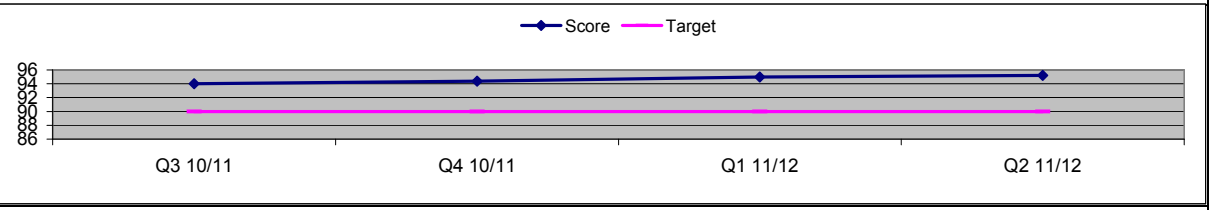
Analysis: The hand hygiene tool has been amended from Quarter 1 which has resulted in a reduction in compliance. There is now a focus on specific areas of non compliance identified in the previous audit tool.

Actions: Each area has an action plan in place to improve their areas for improvement.

5.2 Environmental standards

Cleanliness and tidiness of the environment is an important quality marker and valued highly by patients and the public. Quarterly audits measure compliance with stringent environmental standards. The Trust has set a target of 90%.

	2010/11		2011/12	
Target	Q3	Q4	Q1	**Q2**
90%	94.0%	94.4%	95.0%	95.20%



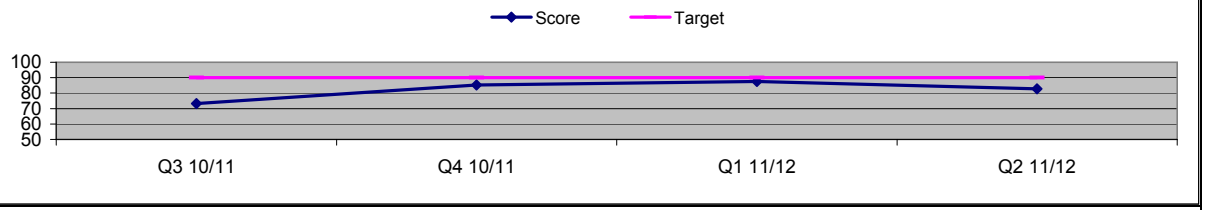
Analysis: This audit tool has also been updated. Areas of poor compliance related to de-cluttering, laminated posters and kitchen areas.

Actions: Each area has an action plan in place to improve their areas for improvement.

5.3 Essence of Care standards

Essence of Care audits are conducted quarterly to measure compliance against a small number of key standards embracing privacy & dignity, communication, nutrition, personal hygiene, mental health and continence. The Trust has set a target of 90%.

	2010/11		2011/12	
Target	Q3	Q4	Q1	**Q2**
90%	73.3%	85.2%	87.6%	82.70%



Analysis: There has been a slight deterioration in the Essence of Care audits, issues remain predominantly around the availability of training in the Mental Capacity Act

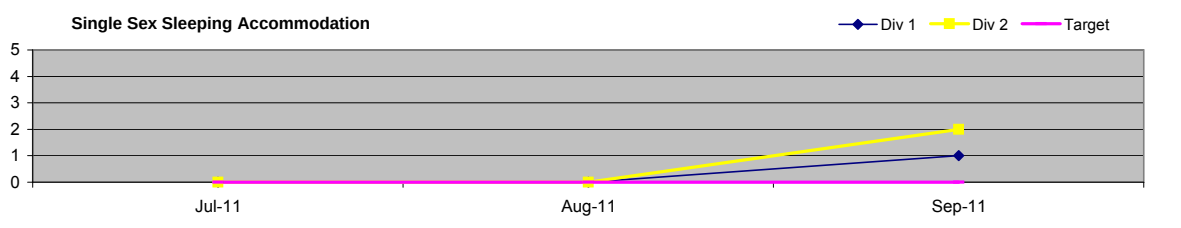
Actions: The Trust wide Essence of Care Group has allocated bench marks to specific Matrons for action. The Safeguarding Committee is looking at different levels of training in the Mental Capacity Act which is role specific.

5.4 Single sex accommodation

Patients want care delivered in single sex accommodation. The vast majority of our clinical areas have declared themselves compliant against Department of Health standards for single sex accommodation. A small number of areas are not currently compliant, these include: Deanesly Ward, EAU, Renal Unit and Endoscopy all of which are waiting for building work. Additionally, it is known that ICCU, while making every attempt to segregate men and women, will be unable to achieve this consistently for clinical reasons. The measure below includes the number of incidents in those areas that have declared themselves compliant. We will measure incidents of mixed sex sleeping accommodation.

Number of incidents	Jul-11	Aug-11	**Sep-11**
Division 1	0	0	1
Division 2	0	0	2
Target	0	0	0

Definition of Single sex incident: A patient located in a bay with patients of the opposite sex is defined as one incident (e.g in a six bedded bay, 1 incident not 6 incidents)



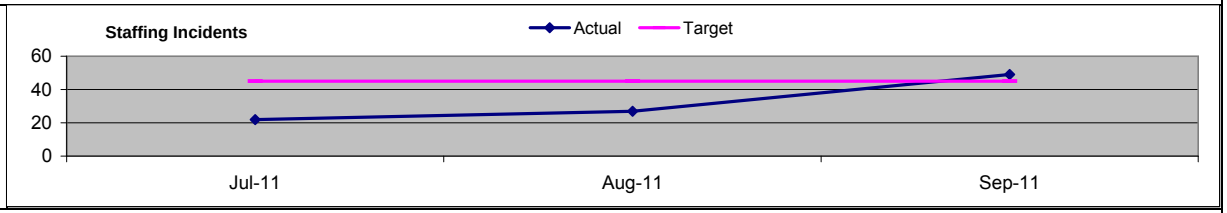
Analysis: In Division 2 one male patient was transferred to sideroom in female bay. On ICCU one Level 1 female patient cohorted with level 1 and 2 male patients in order to accommodate level 2 and 3 patients.

Actions: Patients dignity preserved as much as possible whilst more appropriate accommodation could be arranged.

5.5 Nursing & Midwifery staffing levels

Nursing staffing levels impact on the safety and quality of patient care. The wards and departments within the Trust have agreed normal staffing levels. Deviations from normal staffing levels that impact on the safety or quality of patient care are reported as incidents. The target is 45 incidents per month based on an average number of 50 incidents per month in 08/09.

	Jul-11	Aug-11	**Sep-11**
Division 1	11	10	16
Division 2	11	17	33
Total	22	27	49
Target	45	45	45



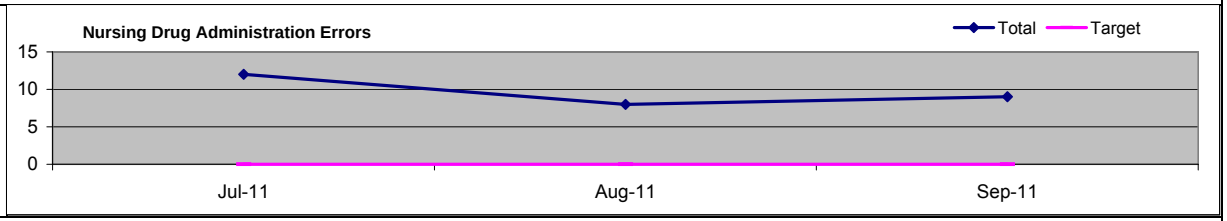
Analysis: 33 breaches in staffing levels reported in Division 2; 16 of which were rated as amber , 2 A&E, 1 D19, 1 EAU, 2 D17, 2 D16, 8 D15; there was no patient harm or care compromised. 16 breaches in Division 1 - one incident resulted in a reduction in the standard of care but no direct harm occurred as a result.

Actions: Staff escalated concerns appropriately at the time, where appropriate staff was sought from nurse bank or other base wards. Staff prioritised patient care.

5.6 Medication administration incidents

Medication incidents cover a wide range of events involving the prescription, administration and provision of medicines to take home. These incidents have the potential to harm patients and therefore all reported incidents are investigated. The indicator set for medication incidents is concentrating on nursing administration errors resulting in low, moderate & high levels of harm or causing death.

	Jul-11	Aug-11	**Sep-11**
Division 1	8	2	4
Division 2	4	6	5
Total	12	8	9
Target	0	0	0



Analysis: Division 2 - 5 medication incidents resulting in no patient harm. 1 incorrect dose and 1 incorrect drug administered. 1 incorrect drug dispensed and administered. 1 incorrect medication given on discharge. 1drug given twice. Division 1 - four medication incidents, none graded as amber or red.

Actions: Medication policy followed, action plans for specific wards/individuals.

Surgical Division - Quality & Safety Scorecard

Patient Experience	This Month	Last Month	Trend
Patient Complaints as a percentage of activity	A	G	↓
Number of complaints accepted for investigation by Ombudsmen	A	R	↑
Number of serious complaints received	G	A	↑
Percentage of complaints responded to within 25 working days (or with consent to breach)	G	R	↑
Percentage of patients who answered "yes" to being treated with care and compassion	G	G	↔
Percentage of patients who rated overall satisfaction good/excellent			
Number of cancelled/rescheduled outpatient appointments	G	G	↔
Cancelled operations as a percentage of elective admissions	R	R	↔
% of people responding "yes" to the question - Are you being involved as much as you want to be in decisions about your care and treatment?	R	R	↔
Overall Rating	A		

Patient Safety	This Month	Last Month	Trend
Number of red incidents	A	G	↓
Number of healthcare/inpatient falls	A	R	↑
Number of healthcare/inpatient falls - resulting in serious injury	G	G	↔
Number of healthcare acquired avoidable pressure ulcers acquired/deteriorated	R	R	↔
Percentage of inpatient MUST assessments completed within 24 hours of admission	A	A	↔
MSSA Bacteraemia	G	G	↔
Clostridium Difficile - hospital acquired for ages >2 years	G	G	↔
Device related bacteraemias	A	G	↓
Percentage of VitalPAC VTE risk assessments on admitting ward	A	A	↔
Percentage of late observations (VitalPAC wards only)	R	R	↔
Overall Rating	A		

Patient Outcomes	This Month	Last Month	Trend
Length of stay (elective)	A	G	↓
Length of stay (non-elective)	A	A	↔
Percentage of emergency re-admissions within 30 days	G	G	↔
Delayed discharges	G	G	↔
18 week RTT - admitted	G	G	↔
18 week RTT - non-admitted	G	G	↔
Clinical correspondence turnaround within 48 hours	R	R	↔
Overall Rating	A		

Resources	This Month	Last Month	Trend
Activity against contract	R	R	↔
Sickness absence	A	A	↔
Percentage of staff who have undergone an annual appraisal	A	A	↔
Percentage of trained nursing vacancies per funded establishment	A	A	↔
Percentage of medical training grade vacancies per funded establishment	G	G	↔
Pay budget (ward pay budget only)	R	R	↔
WTE budgeted against actual (ward WTE only)	G	G	↔
Overall Rating	A		

Trust Dashboard: October 2011

Directorates with any indicator that is red on 3 occasions during any 3 month rolling period is required to submit an exception report on the third occasion.

N/A=data not available, hash box=not reportable

Trends:
→ No change
↑ Improvement on previous month
↓ Deterioration on previous month

Surgical Division

Patient Experience	Target	Tolerance	Data Source	Diagnostics Service Group			Theatres/ ICCU Service Group			Cardio- thoracic/ Cardiology Service Group			General Surgery/ Urology			Orthopaedics			Obstetrics & Gynaecology			Ophthalmology/ Head & Neck Services Group		
				This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend
Patient complaints as a percentage of activity	<0.5%	<0.5 = Green, 0.5+ = Red	Nina Dunmore	0.1%	0	↓	0.1%	0	↓	0.1%	0.1%	→	0.5%	0.4%	↓	0.1%	0.3%	↑	0.3%	0.2%	↓	0.2%	0.1%	↓
Number of complaints accepted for investigation by the Ombudsman	0	0 = Green, else Red	Nina Dunmore	0	0	→	0	1	↑	0	2	↑	0	0	→	1	0	↓	1	0	↓	0	0	→
Number of serious complaints received	0	0 = Green, else Red	Nina Dunmore	0	0	→	0	0	→	0	0	→	0	0	→	0	1	↑	0	0	→	0	0	→
Percentage of complaints responded to within 25 working days (or with consent to breach)	90%	>/= 90% = Green, else Red	Nina Dunmore	100%	N/A	N/A	100%	N/A	N/A	100%	100%	→	100%	80%	↑	100%	100%	→	100%	67%	↑	100%	100%	→
% of people responding "yes" to the question - Are you being involved a much as you want to be in decisions about your care and treatment?	95%	>95% = Green, 85-95% = Amber, <85% = Red	Nina Dunmore	N/A	N/A	N/A	N/A	N/A	N/A	80%	88%	↓	67%	73%	↓	65%	55%	↑	100%	80%	↑	62%	78%	↓
Percentage patients who rated overall satisfaction good/excellent	95%	>95% = Green, 85-95% = Amber, <85% = Red	Nina Dunmore	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Percentage of patients who answered "yes" to being treated with care and compassion	95%	>95% = Green, 85-95% = Amber, <85% = Red	Nina Dunmore	N/A	N/A	N/A	N/A	N/A	N/A	95%	100%	↓	100%	100%	→	100%	95%	↑	95%	95%	→	100%	96%	↑
Number of cancelled/rescheduled outpatient appointments	–	Reduction of 40% in year	Lesley Taff	N/A	N/A	N/A	N/A	N/A	N/A	61	118	↑	359	195	↓	430	465	↑	92	43	↓	789	636	↓
Cancelled operations as a percentage of elective admissions	0.8%	< 0.8% = Green, else Red	Lesley Taff							4.4%	2.7%	↓	1.4%	0.4%	↓	1.2%	0.0%	↓	1.2%	1.1%	↓	0.2%	0.0%	↓
Patient Safety																								
Number of red incidents	0	0 = Green, else Red	Sukhy Khunkhuna	0	0	→	0	0	→	1	0	↓	0	0	→	1	0	↓	0	0	→	0	0	→
Number of healthcare/inpatient falls	0	Ward specific	Sukhy Khunkhuna	2	0	↓	0	2	↑	5	6	↑	7	11	↑	3	4	↑	0	2	↑	0	3	↑
Number of healthcare/inpatient falls - resulting in serious injury	0	*Green = 0, Amber = 1-4, Red = 4+	Sukhy Khunkhuna	0	0	→	0	0	→	0	1	↑	0	0	→	0	0	→	0	0	→	0	0	→
Number of healthcare acquired avoidable pressure ulcers acquired/deteriorated (Grade 2, 3 & 4)	0	0=Green, else Red	Sukhy Khunkhuna	0	0	→	2	0	↓	2	0	↓	3	4	↑	0	1	↑	0	0	→	1	0	↓
Percentage inpatient MUST assessments completed within 6 hours of admission	100%	100% = Green, 75-99% = Amber, <75% Red	Zena Young				100%	94%	↑	100%	100%	→	92%	93%	↓	95%	95%	→	100	100	→	94%	100%	↓
MSSA bacteraemia	–	<2 = Green, 2-3 = Amber, >3 = Red	Mike Cooper	0	0	→	0	0	→	2	1	↓	0	0	→	0	0	→	0	0	→	0	0	→
Clostridium Difficile - hospital acquired for ages >2 years	–	Green = 0,Amber = 1-2, Red = >2	Mike Cooper	0	0	→	0	1	↑	0	0	→	1	0	↓	0	0	→	0	0	→	0	0	→
Device related bacteraemias	–	Green = 0,Amber = 1,Red = >1	Mike Cooper	0	0	→				0	1	↑	1	0	↓	0	0	→	0	0	→	0	0	→
Device related bacteraemias (Haem/Onc, ICCU, Renal, Neonates)	–	Green = 0,Amber = 1- 2 Red = >2	Mike Cooper				0	1	↑															
Percentage VitalPAC VTE risk assessments assessed on admitting ward (VitalPAC wards only represented by Directorate, excludes maternity & low risk cohorts)	90%	90% = Green, 70-89% = Amber, <70% = Red	Jayne Lawrence	30.56	29.03	↓	94.2%	93.3%	↑	75.7%	71.9%	↑	79.1%	79.7%	↓	80.4%	74.4%	↑	90.4%	86.6%	↑	95.88	94.71	↑
Percentage of missed IV Antibiotic																								
Percentage of late observations (VitalPAC wards only)	5%	<5% = Green, 5-10% = Amber, >10% = Red	Mandy Gibbs				4.0%	4.1%	↑	10.5%	12.2%	↑	16.0%	16.3%	↑	26.0%	24.5%	↓	12.0%	14.0%	↑	16.0%	14.0%	↓
Patient Outcomes																								
Length of stay (elective)	specific	Specific	Lesley Taff							5.31	5.25	↓	3.3	3.3	→	3.4	3.6	↑	2.8	2.7	↓	1.8	1.8	→
Length of stay (non elective)	specific	Specific	Lesley Taff							5.4	5.4	→	2.6	2.5	↓	5.6	5.8	↑	1.1	1.1	→	2.9	2.9	→
Percentage of emergency readmissions within 30 days	4.19%	<4.19% = Green, 4.2-5% = Amber, >5%= Red	Lesley Taff							0.73%	2.19%	↑	1.39%	1.14%	↓	0.69%	0.46%	↓	0.79%	1.19%	↑	0.66%	0.00%	↓
Delayed discharges			Lesley Taff	0.0%	0.0%	→	0%	0%	→	0.1%	0.3%	↑	0.4%	0.7%	↑	0.0%	0.5%	↑	0.0%	0.0%	→	0.0%	0.0%	→
18 week RTT - admitted	90%	90% = Green, else Red	Lesley Taff							96.98%	96.95%	↑	92.46%	91.09%	↑	90.91%	90.50%	↑	90.91%	92.95%	↓	93.1%	96.03%	↓
18 week RTT - non-admitted	95%	95% = Green, else Red	Lesley Taff							96.96%	95.80%	↑	96.61%	96.90%	↓	95.18%	96.09%	↓	97.73%	99.78%	↓	99.18%	98.96%	↑
Clinical correspondence turnaround within 48 hours	100%	100% = Green, 75-99% = Amber, else Red	Lesley Taff	85.0%	87.0%	↓				24.0%	72.0%	↓	51.0%	44.0%	↑	58.0%	55.0%	↑	79.0%	84.0%	↓	60.0%	61.0%	↓
Support Services																								
Activity against contract	2%	2% = Green, 2-5% = Amber, >5% = Red	Lesley Taff	-15.41%	-16.18%	↑				10.25%	9.69%	↓	-0.31%	-1.62%	↑	1.44%	0.95%	↑	6.27%	6.53%	↑	0.55%	0.69%	↓
Sickness absence	<4%	<4% = Green, 4.1-5.9% = Amber, >6% = Red	Lesley Taff	3.43%	4.46%	↑	4.78%	4.91%	↑	3.90%	3.22%	↓	5.19%	7.10%	↑	6.08%	4.91%	↓	5.16%	5.89%	↑	5.10%	5.10%	→
Percentage of staff who have undergone annual appraisal	80%	>/=80% = Green, 70-79% = Amber, <70% = Red	Lesley Taff	85.2%	86.1%	↓	82.4%	81.5%	↑	86.5%	81.6%	↑	79.1%	85.4%	↓	59.3%	63.6%	↓	91.8%	91.9%	↓	82.2%	82.1%	↑
Percentage of trained nursing vacancies per funded establishment			Lesley Taff	0.00%	0.00%	→	0.00%	0.00%	→	0.54%	0.20%	↓	-1.86%	0.00%	↑	4.40%	3.10%	↓	-0.47%	0.30%	↑	2.60%	3.00%	↑
Percentage of medical training grades vacancies per funded establishment			Lesley Taff	0.00%	0.00%	→	0.00%	0.00%	→	0.00%	0.00%	→	0.70%	0.00%	↓	0.00%	0.00%	→	0.14%	1.00%	↑	0.66%	1.50%	↑
Staff feedback (Chat Back results to be reported in September 2011)			Caroline Marshall																					
Pay budget (ward pay budget only)	In balance	Yes = Green, Agreed = Amber, No = Red	Alison Reynolds							£(49) k	£(50) k	↑	£(120) k	£(104) k	↓	£(68) k	£(67) k	↓	£(38) k	£(30) k	↓	£(31) k	£(31) k	→
WTE budgeted against actual (ward WTE only)	In balance	Variances: < 5% = Green, 5-10% = Amber, >10% = Red	Alison Reynolds							4.95%	3.74%	↓	0.06%	6.62%	↓	(2.03)%	(17.6)%	↑	(0.72)%	(0.17)%	↓	2.28%	(4.06)%	↑

Medical Division - Quality & Safety Scorecard

Patient Experience	This Month	Last Month	Trend
Patient Complaints as a percentage of activity	A	G	↓
Number of complaints accepted for investigation by Ombudsmen	G	R	↑
Number of serious complaints received	G	A	↑
Percentage of complaints responded to within 25 working days (or with consent to breach)	A	R	↑
Percentage of patients who answered "yes" to being treated with care and compassion	G	A	↑
Percentage of patients who rated overall satisfaction good/excellent			
Number of cancelled/rescheduled outpatient appointments	G	G	↔
% of people responding "yes" to the question - Are you being involved as much as you want to be in decisions about your care and treatment?	R	R	↔
Overall Rating	A		

Patient Safety	This Month	Last Month	Trend
Number of red incidents	A	A	↔
Number of healthcare/inpatient falls	R	R	↔
Number of healthcare/inpatient falls - resulting in serious injury	G	A	↑
Number of healthcare acquired avoidable pressure ulcers acquired/deteriorated	R	R	↔
Percentage of inpatient MUST assessments completed within 24 hours of admission	A	A	↔
MSSA Bacteraemia	G	G	↔
Clostridium Difficile - hospital acquired for ages >2 years	A	A	↔
Device related bacteraemias	A	A	↔
Percentage of VitalPAC VTE risk assessments on admitting ward	A	A	↔
Percentage of late observations (VitalPAC wards only)	R	R	↔
Overall Rating	R		

Patient Outcomes	This Month	Last Month	Trend
Length of stay (elective)	A	A	↔
Length of stay (non-elective)	A	A	↔
Percentage of emergency re-admissions within 30 days	G	G	↔
Delayed discharges	G	G	↔
18 week RTT - admitted	G	G	↔
18 week RTT - non-admitted	G	G	↔
Clinical correspondence turnaround within 48 hours	R	R	↔
Overall Rating	A		

Resources	This Month	Last Month	Trend
Activity against contract	R	R	↔
Sickness absence	R	R	↔
Percentage of staff who have undergone an annual appraisal	R	R	↔
Percentage of trained nursing vacancies per funded establishment	A	A	↔
Percentage of medical training grade vacancies per funded establishment	G	G	↔
Pay budget (ward pay budget only)	R	R	↔
WTE budgeted against actual (ward WTE only)	G	R	↑
Overall Rating	R		

Trust Dashboard: October 2011

Emergency, Medical & Community Service Division

Directorates with any indicator that is red on 3 occasions during any 3 month rolling period is required to submit an exception report on the third occasion.

N/A=data not available, hash box=not reportable

Trends:
→ No change
↑ Improvement on previous month
↓ Deterioration on previous month

Patient Experience	Target	Tolerance	Data Source	Children's Services Group			Adult Community Services Group			Elderly Care & Stroke			Rehab (West Park)			Neurology Rheumatology Dermatology			Renal & Diabetes			Resp & Gastro			Emergency Services Group			Therapies & Pharmacy Group			Oncology & Haematology Group		
				This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend
Patient complaints as a percentage of activity	<0.5%	<0.5=Green, 0.5+=Red	Nina Dunmore	N/A	N/A	N/A	0.2%	N/A	N/A	0.2%	0.2%	→	0.1%	N/A	N/A	0.1%	0.1%	→	0.3%	0.2%	↓	0.2%	0.2%	→	0.9%	0.1%	↓	0.1%	N/A	N/A	0.1%	0.2%	↑
Number of complaints accepted for investigation by the Ombudsman	0	0 = Green, else Red	Nina Dunmore	0	1	↑	0	1	↑	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→
Number of serious complaints received	0	0 = Green, else Red	Nina Dunmore	N/A	0	N/A	N/A	0	N/A	N/A	0	N/A	N/A	0	N/A	N/A	1	N/A	N/A	0	N/A	N/A	0	N/A	N/A	0	N/A	N/A	0	N/A	N/A	0	N/A
Percentage of complaints responded to within 25 working days (or with consent to breach)	90%	>/= 90% = Green, else Red	Nina Dunmore	N/A	N/A	N/A	100%	N/A	N/A	100%	50%	↑	100%	N/A	N/A	100%	50%	↑	100%	100%	→	100%	100%	→	100%	85%	↑	100%	N/A	N/A	0%	100%	↓
% of people responding "yes" to the question - Are you being involved as much as you want to be in decisions about your care and treatment?	95%	>95% = Green, 85-95% = Amber, <85% = Red	Nina Dunmore	N/A	N/A	N/A	N/A	N/A	N/A	82%	50%	↑	N/A	N/A	N/A	N/A	N/A	N/A	62%	64%	↓	71%	74%	↓	68%	N/A	N/A	N/A	N/A	N/A	79%	85%	↓
Percentage patients who rated overall satisfaction good/excellent	95%	>95% = Green, 85-95% = Amber, <85% = Red	Nina Dunmore	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Percentage of patients who answered "yes" to being treated with care and compassion	95%	>95% = Green, 85-95% = Amber, <85% = Red	Nina Dunmore	N/A	N/A	N/A	N/A	N/A	N/A	100%	100%	→	N/A	N/A	N/A	N/A	N/A	N/A	95%	95%	→	94%	89%	↑	95%	100%	↓	N/A	N/A	N/A	100%	100%	→
Number of cancelled/rescheduled outpatient appointments	–	Reduction of 40% in year	Lesley Taff	189	188	↓	N/A	N/A	N/A	85	0	↓	N/A	N/A	N/A	166	441	↑	54	110	↑	347	310	↓	N/A	N/A	N/A	N/A	N/A	N/A	112	89	↓
Cancelled operations as a percentage of elective admissions	0.8%	< 0.8% = Green, else Red	Lesley Taff																													
Patient Safety																																
Number of red incidents	0	0 = Green, else Red	Sukhy Khunkhuna	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	1	↑	0	0	→	2	0	↓	0	0	→	0	0	→
Number of healthcare/inpatient falls	0	Ward specific	Sukhy Khunkhuna	1	0	↓	0	0	→	28	30	↑	24	30	↑	0	0	→	20	10	↓	19	23	↑	13	24	↑	0	0	→	0	2	↑
Number of healthcare/inpatient falls - resulting in serious injury	0	*Green = 0, Amber = 1-4, Red = 4+	Sukhy Khunkhuna	0	0	→	0	0	→	1	0	↓	1	0	↓	0	0	→	0	0	→	1	1	→	0	1	↑	0	0	→	0	0	→
Number of healthcare acquired avoidable pressure ulcers acquired/deteriorated (Grade 2, 3 & 4)	0	0 = Green, else Red	Sukhy Khunkhuna	0	0	→	2	1	↓	1	6	↑	1	1	→	0	0	→	0	0	→	0	1	↑	1	1	→	0	0	→	4	0	↓
Percentage inpatient MUST assessments completed within 6 hours of admission	100%	100% = Green, 75-99% = Amber, <75% Red	Rose Baker	100%	100%	→				98%	94%	↑	100%	100%	→				94	89	↑	91%	89%	↑	90	80	↑				96	95	↑
MSSA bacteraemia	–	<2 = Green, 2-3 = Amber, >3 = Red	Mike Cooper	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	1	0	↓	0	0	→	0	0	→				1	1	→
Clostridium Difficile - hospital acquired for ages >2 years	–	Green = 0,Amber = 1-2, Red = >2	Mike Cooper	0	0	→	0	0	→	2	1	↓	1	2	↑	0	0	→	1	2	↑	3	1	↓	2	1	↓				0	0	→
Device related bacteraemias	–	Green = 0,Amber = 1,Red = >1	Mike Cooper	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	1	0	↓	0	0	→	0	1	↑						
Device related bacteraemias (Haem/Onc, ICCU, Renal, Neonates)	–	Green = 0,Amber = 1- 2 Red = >2	Mike Cooper	1	1	→													2	1	↓										1	3	↓
Percentage VitalPAC VTE risk assessments assessed on admitting ward (VitalPAC wards only represented by Directorate, excludes maternity & low risk cohorts)	90%	90% = Green, 70-89% = Amber, <70% = Red	Jayne Lawrence							86.8%	90.7%	↓	N/A	N/A	N/A	89.8%	93.4%	↓	99.9%	99.9%	→	57.1%	81.8%	↓	87.3%	86.7%	↑				100	99.86	↑
Percentage of missed IV Antibiotic																																
Percentage of late observations (VitalPAC wards only)	5%	<5% = Green, 5-10% = Amber, >10% = Red	Mandy Gibbs							25.5%	28.8%	↑							24.5%	34.0%	↑	25.3%	25.3%	→	31.7%	29.0%	↓				12.0%	15.0%	↑
Patient Outcomes																																
Length of stay (elective)	specific	Specific	Lesley Taff	1.3	1.3	→										0.2	0.3	↑	0.9	0.9	→	3.8	4.0	↑							5.9	5.2	↓
Length of stay (non elective)	specific	Specific	Lesley Taff	0.7	0.7	→										5.85	6.9	↑	2.8	3.4	↑	3.2	3.3	↑							5.4	6.0	↑
Percentage of emergency readmissions within 30 days	4.19%	<4.19% = Green, 4.2-5% = Amber, >5%= Red	Lesley Taff	1.17%	2.35%	↑				0.00%	0.00%	→	0.00%	0.00%	→	0.00%	0.00%	→	0.00%	0.00%	→	0.00%	1.00%	↑	0.0%	0.0%	→				0.19%	0.00%	↓
Delayed discharges			Lesley Taff	0.3%	0.5%	↑				0.6%	0.9%	↑	0.3%	0.5%	↑	0.4%	0.7%	↑	0.0%	0.2%	↑	0.2%	0.3%	↑	0.0%	0.0%	→				0.0%	0.0%	→
18 week RTT - admitted	90%	90% = Green, else Red	Lesley Taff													100%	91.67%	↑	100%	100%	→	96.47%	96.59%	↓							100%	100%	→
18 week RTT - non-admitted	95%	95% = Green, else Red	Lesley Taff	98.92%	99.47%	↓	100%	99.6%	↑	100%	98.73%	↑				95.94%	98.31%	↓	100%	100%	→	98.45%	100%	↓				100%	100%	→	100%	100%	→
Clinical correspondence turnaround within 48 hours	100%	100% = Green, 75-99% = Amber, else Red	Lesley Taff	86.0%	78.0%	↑	N/A	N/A	N/A	86.0%	53.0%	↑	N/A	N/A	N/A	53.0%	72.0%	↓	98.0%	99.0%	↓	64.0%	60.0%	↑	69.0%	76.0%	↓	N/A	N/A	N/A	73.0%	66.0%	↑
Support Services																																
Activity against contract	2%	2% = Green, 2-5% = Amber, >5% = Red	Lesley Taff	1.15%	0.82%	↓	N/A	N/A	N/A	-31.83%	-29.88%	↓	N/A	N/A	N/A	-0.62%	0.05%	↓	3.01%	2.04%	↓	7.11%	8.49%	↑	2.67%	2.95%	↑	2.88%	3.13%	↑	8.31%	8.52%	↑
Sickness absence	<4%	<4% = Green, 4.1-5.9% = Amber, >6% = Red	Lesley Taff	6.98%	5.00%	↓	5.91%	4.74%	↓	3.97%	5.03%	↑	4.99%	5.04%	↓	4.70%	2.74%	↓	11.97%	12.10%	↑	3.80%	8.30%	↑	7.85%	5.55%	↓	2.10%	2.00%	↓	5.28%	4.27%	↓
Percentage of staff who have undergone annual appraisal	80%	>/=80% = Green, 70-79% = Amber, <70% = Red	Lesley Taff	67.9%	68.2%	↓	75.3%	62.7%	↑	75.7%	72.7%	↑	76.6%	80.7%	↓	54.4%	58.6%	↓	68.8%	68.3%	↑	80.4%	80.7%	↓	62.6%	64.4%	↓	48.6%	61.7%	↓	82.8%	84.5%	↓
Percentage of trained nursing vacancies per funded establishment			Lesley Taff	0.40%	1.00%	↑	N/A	N/A		2.30%	3.00%	↑	2.20%	3.00%	↑	0.00%	0.00%	→	-0.22%	1.50%	↑	1.55%	2.70%	↑	2.17%	3.50%	↑	0.0%	0.0%	→	-0.14%	1.20%	↑
Percentage of medical training grades vacancies per funded establishment			Lesley Taff	0.00%	0.00%	→	N/A	N/A		3.13%	2.00%	↓	0.00%	0.00%	→	0.00%	0.00%	→	0.00%	0.00%	→	0.95%	1.20%	↑	0.09%	1.50%	↑	0.0%	0.0%	→	0.00%	0.00%	→
Staff feedback (Chat Back results to be reported in September 2011)			Caroline Marshal																													
Pay budget (ward pay budget only)	In balance	Yes = Green, Agreed = Amber, No = Red	Alison Reynolds	£(29) k	£(39) k	↑	£6 k	£10 k	↓	£(177) k	£(161) k	↓	£(34) k	£(45) k	↑				£(54) k	£(47) k	↓	£(99) k	£(87) k	↓	£(16) k	£(12) k	↓				£(42) k	£(42) k	→
WTE budgeted against actual (ward WTE only)	In balance	variance < 5% = Green variance 5-10% = Amber variance >10% = Red	Alison Reynolds	3.57%	6.73%	↑	(4.17)%	21.42%	↑	(5.69)%	(7.10)%	↑	4.56%	10.56%	↑				(9.89)%	(6.18)%	↓	(2.69)%	(5.28)%	↑	3.55%	1.72%	↑				0.61%	3.05%	↓