Salford Royal NHS
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Scorecard - Board of Directors – April 2015

Quality and Safety safe

	Description	Aggregate position	Variation
Dr Foster Risk Adjusted Mortality—All Diagnoses	HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups	Our 12 month average relative risk of mortality is 81. This puts us in the statistically better than expected bracket.	There are no long term alerts and short term alerts are flagged at divisional level. EQSC is currently working with the clinical areas highlighted in the Dr Foster report into the deterioration in risk adjusted mortality
Risk Adjusted Mortality—SHMI	SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	We have been statistically better than expected for 6 out of the 12 previous quarters. The aggregate position for SHMI is deteriorating with a run of three quarters of "as expected" performance. EQSC is currently working with the clinical areas highlighted in the Dr Foster report into the deterioration in risk adjusted mortality.	**(Note: this is updated quarterly)** SHMI cannot be broken onto divisional level. There are two diagnosis groups that are higher than expected: chronic renal failure & other circulatory disease
Whole Trust Safety Thermometer: Secondary Definition	Measures percentage of patients that received 'harm free care' – defined by the absence of; pressure ulcers, falls, catheters, UT Is and VTEs	This measure only includes new harms. Our Trust aim for this measure is for 95% of our patients to be harm free. We are currently at 97.95% harm free, the national average is 97%.	Last three months harm free: Trust (inc community)- 97.20% Acute –98.13% Community –95.69% CSS – 98.19% NR – 98.51 SHC – 98.03% SURG – 97.56%
Community Safety Thermometer	Measures percentage of patients that received 'harm free care' – defined by the absence of; pressure ulcers, falls, catheters, UT Is and VTEs during the time they are under the care of SRFT.	This is the secondary definition so includes new harms only, 97.2% harm free (national community average for this measure is 97 %).	Last three month average = 95.69% DN Cluster with lowest harm free = Walkden (91.85%) DN Cluster with highest harm free = Broughton (98%)

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Infection Control clean

	Description	Aggregate position	Historical	Variation
MRSA bacteraemia	National objective is zero tolerance of avoidable MRSA bacteraemias. If breached a £10,000 penalty is incurred in respect of each incidence in the relevant month.	No avoidable MRSA bacteraemias for 2014/15	MRSA Bacteraemia	
Clostridium Difficile	National objective for 2014/2015 is 21 post 72hr cases. If breached a £10,000 penalty is incurred in respect of each incidence in the relevant month.	There were a total of 26 post 72hr cases including 3 cases in March. We were 5 cases over trajectory, however 7 were agreed as unavoidable by the CCG therefore the end of year avoidable cases were 19	C.Difficile	No significant variation across the Divisions
MSSA bacteraemia	This is local objective. If the objective is breached the consequence states “remedial or immediate action plan”. The 2014/2015 target is 11 post 48hr cases.	There were a total of 15 post 48hr cases of MSSA bacteraemia including 2 cases in March. We were 4 over trajectory for 2014/2015	MSSA	
E.coli bacteraemia	This is local objective. If the objective is breached the consequence states “remedial or immediate action plan”. The 2014/2015 target is 55 post 48hr cases	There has been a total of 28 post 48hr cases of E.coli bacteraemia including 2 in March We are currently 27 under trajectory for 2014/2015	E-Coli Bacteraemia	

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Safe Staffing Levels safe

	Description	Current month's position	Historical	Variation
Registered Staff Day time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only. (For a full breakdown please refer to appendix 1)	96% of expected Registered Nurse hours were achieved for day shifts .	December 93% January 93% February 92%	Ward B3 78.4% (Hyper acute Stroke ward) maintained safe agreed staffing levels and reported low bed occupancy. B4 76.3% , shifts filled with bank and shift co-ordinator to ensure agreed nurse to patient ratios were maintained.
Registered Staff Night time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only.	95% of expected Registered Nurse hours were achieved for night shifts.	December 96% January 95% February 95%	No individual ward fell below the 80% threshold for expected versus actual hours.
Clinical Support Worker Day time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only.	103% of expected Care Support Worker hours were achieved for day shifts.	December 99% January 99% February 96%	No individual ward fell below the 80% threshold for expected versus actual hours.
Clinical Support Worker Night time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only.	113% of expected Care Support Worker hours were achieved for night shifts.	December 114% January 115% February 115%	Higher than expected hours are due to the numbers of patients requiring 1:1 support overnight. (specialling)

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Workforce

	Description	Aggregate position	Historical	Variation
Sickness absence	Percentage of sickness between the beginning of the financial year to the reporting month (Feb 15 = % sickness between Apr 14 to Feb 15). Target is 3.6%.	Sickness absence = 4.3 Improvements made in all four Divisions. Improving trend continues in Surgery, Neuro and SHC Divisions [most notably in Surgery with 0.76% improvement in month].	Sickness Absence (Sep-13 to Mar-15)	CSS&TM 4.14 N&R 5.29 Surgery 4.86 SHC 4.78 Corporate 2.91
Staff FFT	Staff are asked the question: How likely are you to recommend this organisation to friends and family as a place to work? And given a number of options for answering	Q2 = 74% Target (from Picker) = 61%	Likely/ Extremely Likely (Q1, Q2)	Likely/ Extremely Likely (Corporate, CSSTM, N&R, SHC, Surgery, Hosted)
WTE's in post	Contracted WTE directly employed staff as at the last day of the month	WTE's = 6261.44 244.62 increase since the end of March 2014 to the end of March 2015	(Sep-13 to Mar-15)	Contracted WTE directly employed staff as at the last day of the month
Non-contracted pay	Spend on all non-contracted pay; support worker, nursing, medical, other.	£2.99m spend	Budget, Actual (Apr-14 to Sep-14)	Spend on all non-contracted pay; support worker, nursing, medical, other.

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Patient Experience personal

	Description	Aggregate position	Historical	Variation
Friends and Family Test	The DoH have recently changed how this measure is reported. The Net-Promoter Score is no longer used. Instead the % of respondents recommending to family and friends is given.	The figure that is charted is the % of inpatients prepared to recommend the Trust to Friends and Family. SRFT score for February is 94%, the NHS score is 95%		The wards with the highest score for January are L5, H7,CCU and ASU Wards with the lowest score are B6 and EAU NB only wards with 14 responses or more have been included for comparison
Inpatient Question	Inpatients are asked the question: "Did we Deliver What Matters Most to you?" And given a number of response options	The stretch aim for this measure is for 80% of patients to respond "yes, definitely", the chart above shows the current position at 77%. When considering the top two answers 'yes definitely' and 'yes to some extent' the average is 95%, against a target of 90%		The wards with the highest % positive responses are L5, Haematology and DSU. The wards with the lowest % positive response are B6, EAU and L3.
Percentage of Patients Rating Overall Care as Excellent	All patients are asked how they would rate their overall level of care.	The stretch aim for this measure is for 80% of patients to rate their care as excellent. The current average is 70%. When considering the top two answers 'Excellent' and 'very good' the average is 91%, against a target of 90%		The wards with the highest % positive responses are H2, SHDU and Haematology The wards with the lowest % positive responses are B4, B6 and EAU
Involved in Decisions about Care	Inpatients are asked the question: "Were you involved as much as you wanted to be in decisions about your care?" And given a number of response options	The stretch aim for this measure is for 80% of patients to respond "yes, definitely", the chart above shows the current position at 70%. When considering the top two answers 'yes definitely' and 'yes to some extent' the average is 94%, against a target of 90%.		The wards with the highest % positive responses are C1 and Haematology The wards with the lowest % positive responses are L3 and EAU

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Finance – Financial measures

	Description	Aggregate position	Historical	Variation
Continuity of Service Risk (COSR)	Monitor's (independent regulator) metric of financial risk	Planned and actual CoSRR score is 3. An in month surplus improves the debt service metric, however a year to date operating (EBITDA) deficit of £6.7m against plan keeps this metric below plan. Liquidity remains a score of 4 for March.		Current debt service score is 2 and liquidity a 4 giving combined CoSRR of 3. To deteriorate the debt service to 2, the reported deficit needs to deteriorate by £1.1m If the cash balance reduces by £3.5m, liquidity would fall to 3. cash balance ds to drop by £8.7m
Normalised net surplus/deficit	Net income and expenditure after adjusting for hosted services and impairments	Surplus in the month is £4.78m, reducing the year to date deficit position to £4.20m as reforecast earlier in the year.		Target surplus £+2.9m SHC £+1.5m N&R £-4.1m Surgery £-4.9m CSS&TM £-4.5m Estates & Corp £-0.5m Financing & reserves £+5.6m Total £-4.2m
Cash	Cash on deposit < 3 months deposit	Cash is £38.0m and £24.8m above plan predominantly owing to the re-profiling of the capital programme spend , and movement on working balances.		Strong cash position throughout the year has generated a score of 4 for the year; however the cash balance has reduced over course of the year and this is expected to continue in 2015/ 16 deteriorating this metric.
Capital expenditure	Year to date cumulative capital expenditure	Year to date capital expenditure is £18.1m, this is £1.6m above the revised forecast submitted to the regulator in the quarter three return largely due to the investment in the Community EPR development funded by a successful bid to the Nurse Technology Fund.		Capital plan revised during quarter 1 and again in quarter 3 and submitted to Monitor.

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Finance – Financial measures

	Description	Aggregate position	Historical	Variation
Safely reducing costs	Planned imrovements in productivity and efficiency	Schemes totalling £16.7m have been have been actioned and removed from budgets.	Safely Reducing Costs	
Length of stay	Average length of stay for inpatient episodes of care	Non elective = 5.26 Elective 4.92 Smaller is better	Length of stay	Compared to the average length of stay for 13/14: Non-elective 0.27 days lower Elective 0.97 days higher
Theatre utilisation	Percentage of Sessions which were not 'fallow' (Fallow session is where no operations are performed on a booked session)	Utilisation is 63.2% against a stretch target of 86% Red line is the target, bigger is better.	Standard Chart 14/15 - Theatre End Utilization	Improved utilisation is a major project in progress
New : follow up ratio	Number of new patient attendances in month divided by number of follow up attendances in month.	Ratio is 1: 3.70 Target is 1:2.00	I Chart - Outpatient New to Follow Up Ratio (v2)	CSS&TM 1: 5.19 N&R 1: 3.23 SHC 1: 3.20 Surgery 1: 3.24 Improvement is considered within the out-patient improvement project which is being deferred.

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Performance – Mandatory Access Standards

	Description	Aggregate position	Historical	Variation
RTT Admitted Pathways	Percentage of admitted pathways closed within 18 weeks. The threshold is 90%. This is a Monitor target and a GM KPI.	March performance 84.89%		The specialities which are not achieving this target in March (and contributing to the non-achievement in aggregate) are general surgery, urology, orthopaedics and neurosurgery.
RTT Non-Admitted Pathways	Percentage of non-admitted pathways closed within 18 weeks. The threshold is 95% This is a Monitor target and a GM KPI.	March performance 92.82%		Specialities which are not achieving this target (and contributing to the non-achievement in aggregate) in February are general surgery, orthopaedics, neurosurgery, dermatology and neurology.
RTT Incomplete Pathways	Percentage of incomplete pathways waiting within 18 weeks. The threshold is 92% This is a Monitor target and a GM KPI.	March performance 95.01%		The aggregate position of 92% is being achieved but not within the specialties of orthopaedics or general medicine.
A&E 4 hour Standard	Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge. Target of 95%. This is a quarterly Monitor target and a monthly GM KPI.	March performance 97.28% A&E performance is measured quarterly.		Although the 95% threshold wasn't achieved in Q1, it has been achieved in Q2, Q3 and Q4.

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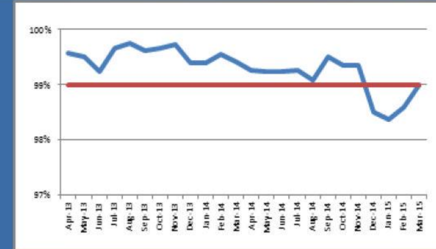
Performance – Mandatory Access Standards

Description | **Aggregate position** | **Historical** | **Variation**

Diagnostic 6 week Standard

Description: All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. This is a GM KPI. The target is 99% or over within 6 weeks and penalties for not achieving are £200 per excess breach over tolerance.

Aggregate position: March performance 99.00%



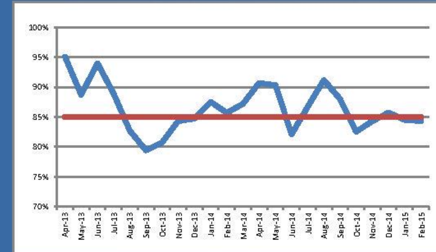
Variation: The target was achieved in March.

Cancer 62 Day standard

Description: All patients need to receive first treatment for cancer within 62 days of urgent referral. Threshold of 85%. This is a Monitor and GM KPI. GM KPI fine is £1000 per excess breach over tolerance

Aggregate position: February repatriated performance 81.5%

Cancer is a measured quarterly and reported nationally 2 months in arrears.



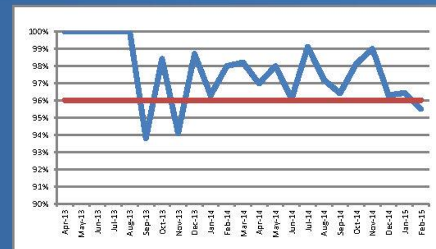
Variation: Target achieved in Q1 and Q2. Target failed for Q3.

Cancer 31 Day Standard

Description: All patients to receive first treatment for cancer within 31 days of decision to treat. Threshold of 96%. This is a Monitor and GM KPI. GM KPI fine is £1000 per excess breach over tolerance.

Aggregate position: February performance 95.5%

Cancer is a measured quarterly and reported nationally 2 months in arrears.



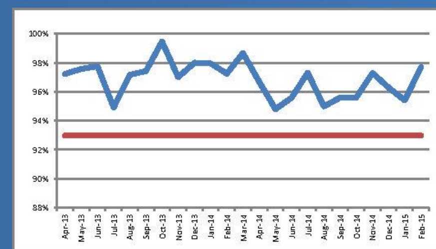
Variation: Target achieved in Q1, Q2 and Q3

Cancer 2 Week Wait Standard

Description: All patients need to receive first appointment for cancer within 14 days of urgent referral. Threshold of 93%. This is a Monitor and GM KPI. GM KPI fine is £200 per excess breach over tolerance.

Aggregate position: February performance 97.7%

Cancer is a measured quarterly and reported nationally 2 months in arrears.



Variation: Target achieved in Q1 and Q2 and Q3

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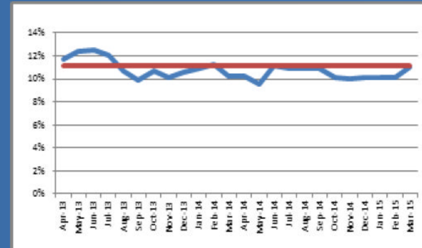
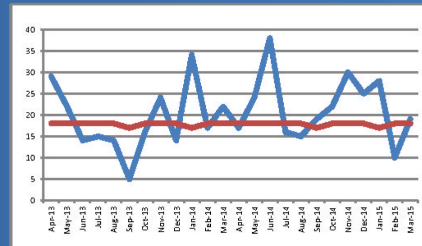
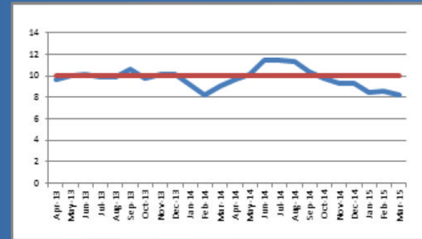
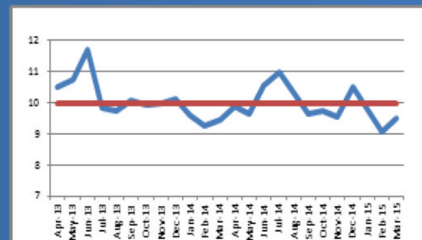
Performance – Mandatory Access Standards

	Description	Aggregate position	Historical	Variation
Readmissions	Emergency readmissions within 30 days of discharge. PbR Guidance details exclusions for this quality requirement. The agreed threshold for readmissions is 11.1% with a stretch threshold of 9.79%	March performance was 11%		The 11.1% threshold was met in Q1, Q2, Q3 and Q4. The end of year position was 10.43%
Non Clinical Cancelled Operations	Provider cancellation of Elective Care operation for Non-clinical reasons after Patient admission (all cancellations are counted but Trust only penalised for those patients admitted and then cancelled)	March performance 19 Annual threshold 214		YTD position is 263 against a threshold of 214. Surgery, Spinal Surgery, Orthopaedics and Gynaecology are lowest performing specialties. Executive Assurance and Risk Committee overseeing action to ensure improvement.
Outpatient DNA Rate (New)	% of New patients that failed to turn up for their Outpatient appointment (includes all referral types) The agreed threshold is 10%	March performance 8.19%		The threshold has been achieved in month.
Outpatient DNA Rate (Follow Up)	% of Follow Up patients that failed to turn up for their Outpatient appointment (includes all referral types) The agreed threshold is 10%	March performance 9.48%		The threshold has been achieved in month.

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Risk – 12 and above from BAF (with headline of 10's and 11's)

	Principal Risk	Key control	Action Plan
5.2 Achieve Financial Standards	If the planned activity and income levels are not achieved and/or expenditure controls are exceeding leading to a Monitor CoSRR lower than planned then this will increase regulatory investigation and integration. Risk = 13	Draft financial plan submitted 27th February 2015. Annual Plan to be submitted 10th May 2015. Formal divisional contracts detailing divisional financial plans for income and expenditure. Agreed contracts with commissioners.	Monthly Executive Finance and Information Committee and report to Board of Directors. Deficit Plan which consolidates immediate risks to be approved.
2.1 Improve productivity and cost improvements, income & cost targets to improve margins	If failure to deliver Better Care at Lower Cost at planned level then may require additional support beyond that identified in plan and ability to invest in asset replacement programme will be reduced. Risk = 13	Productivity Improvement Board (PIB) established. PI Programme established, including 11 workstreams with identified Executive /Operational/Clinical Lead. Quality & Productivity Improvement Department (QPID) established. Deloitte team assigned to establish programme management function	Each workstream to develop local risk register, tracked through Programme Improvement Board. QPID and Deloitte to continue engagement with Divisional teams to identify where divisions best placed to assist themes. IM&T to define plan to identify and release capacity. QPID job descriptions approved and advertised.
5.1 Achieve Clinical & Quality Standards	If Trust-wide **clinical staffing** is not maintained at appropriate levels, then patient care may be compromised. Risk = 12	Weekly cross-divisional review to ensure clinical staffing is maintained at appropriate levels. Established medical staffing processes. Internal bank of locum doctors. Quality assurance processes in place for external locum doctors All ward areas to provide care at a breach point of 1:8 registered nurses:patients…(cont - see BAF)	Workforce Programme Board in place and focussing on addressing this risk. Monthly report to Exec Board on recruitment to key posts. Trust Workforce Strategy to be implemented.
5.1 Achieve Clinical and Quality Standards	If unable to provide **24/7 interventional radiology** then patients may require more invasive treatment than necessary potentially resulting in permanent harm or death Risk = 12	Limited in-hours cover. Adhoc out of hours arrangements.	SRFT maximising in-house cover and current strengths.

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Risk – 12 and above from BAF (with headline of 10's and 11's)

	Description	Key Control	Action Plan
4.2 Work with partners to reconfigure services across the NWSector	If partners within the north-west sector are unable to agree a sector response to Healthier Together then services may not be sustainable for the future.. Risk = 12	NW sector Project Board and leadership group. Memorandum of Understanding agreed by Salford Royal, Bolton and Wigan FTs and in place. Joint Response from NW Sector Trusts submitted to Healthier Together Public Consultation. Strategic Outline Case approved by all three partners, subject to further consideration of site options.	Further work on site options underway and associated assurances, . Final Healthier Together now scheduled for 1st June 15.
2.1 Improve productivity and cost efficiency by £30m to deliver BCLCt	If IM&T are unable to provide analytical resource to the Better Care at Lower Cost programme then it will be difficult to generate further cost reduction ideas New risk = 12	Divisional Business Analysts providing support.	IM&T to define plan to identify and release capacity
5.4 Achieve Access Standards	If demand continues to grow robust capacity plans and appropriate systems are not in place to effectively manage the **RTT targets** (admitted, non-admitted and open) then patients will not receive their treatment within 18 weeks Risk = 12	Systems in place within each Division to monitor and validate waiting lists, and effectively track demand and capacity plans. Access to Service Triage system in place.	Roll out of Gooroo and capacity management tool. Implementation of Intensive Support Team (IST) recommendations Pan organisational weekly Access and Performance Capacity and demand workstream (BC@LC) Urgent and active discussion has taken place and continues with commissioners to effect commissioner ownership and alternative management of demand.
5.4 Achieve Access Standards	If capacity plans and patient pathways are not sufficiently robust, then the **62 day cancer target** may not be met. Risk = 11	Robust daily and weekly tracking mechanisms continue to monitor all cancer patients to ensure timely treatment, supported by a refined escalation policy which will be audited through CPIM and monitored via EARC.	Active management and validation. Escalation Policy to be fully implemented and audited.

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Risk – 12 and above from BAF (with headline of 10's and 11's)

Principal Risks

Other Risks rated 11 (Headline only)

- Estate Capacity
- Theatre Improvement Programme
- identification of Trusts for enterprise engagement (new risk)
- Prevention of C diff
- Demand for emergency admission
- NIHR Study recruitment time

Risks rated 10 (Headline only)

- demand for emergency admission
- Major Trauma Centre (single receiving site)
- health and well-being strategy
- research and development activity
- the establishment of the Salford ICO
- completion of key phases of the Salford ICO (New Risk)
- Sterile Services
- release of theatres for essential maintenance
- diagnostic standard (New Risk)
- adoption of Dalton Review recommendations Risk)
- CQuIN and KPIs
- demand for emergency admission
- Major Trauma Centre (single receiving site)
- health and well-being strategy research and development activity
- the establishment of the Salford ICO
- completion of key phases of the Salford ICO – page 15 (New Risk)
- adoption of Dalton Review recommendations – page 17 (New Risk)