The Royal Wolverhampton Hospitals NHS Trust	

Trust Board Report

Meeting Date:	25th June 2012
Title:	Performance Report
Executive Summary:	This report provides the Board with an update of performance against national and local performance indicators for May 2012/13. It also provides assurances to the Board of the actions taken for any indicator that is underperforming.
Action Requested:	To note: current progress To approve: any corrective actions identified.
Report of:	Chief Operating Officer
Author: **Contact Details:**	Head of Performance & Compliance Tel: 01902 694366 Email: simon.evans8@nhs.net
Resource Implications:	None
Public or Private: **(with reasons if private)**	Public Session
References: **(e.g. from/to other committees)**	Appendix 1 – Provider Management Regime (PMR)
Appendices/ **References/** **Background Reading**	Detailed Performance Report
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

Detail	
1	**Background** This report provides an overview of the performance of the Trust and covers national, regulatory and local performance indicators (PIs). The report contains a summary of all performance for both acute and community activity. Where possible performance is now integrated to give one measure. However, some indicators are required (nationally) to be reported separately whilst some indicators are solely for acute or community activity, in these instances the report clearly denotes whether the PI is either Acute Only (A), Integrated (I) or Community Only (C). In addition to the performance indicators in the Provider Management Regime the Board is required to provide compliance against a number of statements as part of the monthly self certification process. Following discussion by the Board in a formal meeting the Chairman and Chief Executive will sign the self certification and Board Statements on behalf of the Board.
2	**Report Contents** This report covers the following areas: • Performance Dashboard - a new indicator has been added (no longer shadow monitoring) as the requirements have now been agreed with the Commissioner. • Exception Reports (Red rated PIs) • Activity Dashboard (Community activity only) – there are a number of new indictors introduced from April 2012:- Community Stroke Co-ordinators - Stroke (new addition) Community Stroke Co-ordinators – TIA (new addition) End of Life Care – Palliative (new addition) Community Paediatricians – First and Follow Up (new addition) • Provider Management Regime (Appendix 1)

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Performance Report Dashboard

The summary report provides a dashboard using the themes within the detailed report to give an overview of performance. To accompany this, an exception report has been provided for any PI that has been reported as RED. This gives the Board an overview of performance and details the areas that are underperforming and the corrective actions that have been taken. The dashboard covers each of the PIs that are reported within the detailed report; however the dashboard simply covers the themes through which have previously been reported to Board. A legend which explicitly details which regulator monitors the PI is also found in appendix A.

Theme	Red	Amber	Green	Total
Monitor Compliance Framework There are 19 indicators measured in this section, covering C Difficile, MRSA, Cancer Waits, Accident & Emergency (4 hour), RTT and Data Completeness	2	0	17	19
Service Delivery There are 29 (1 of which is monitoring only) indicators in this section, covering Stroke/TIA, RTT, Delayed Transfers, Cancelled Operations, A&E Indicators, Cancer Upgrade, Diagnostic Waits, Correspondence, LOS, Day Case Rates, Theatre Utilisation, C&B, Smoking, End of Life and Health Check	5	2	21	28
Workforce This section is measured by 14 different indicators covering, Recruitment and Retention, Turnover, Sickness Absence, Temporary Staffing (agency), and Education & Training	4	6	4	14
Totals	11	8	42	61
Last Month	9	8	43	60
Trend **(Trends are not possible this month due to the additions of PIs)**				

PLEASE NOTE: The Monitor Compliance Framework indicators are included in the summary dashboard above, however, they are also separated out in the Provider Management Regime report (Appendix 1) as this is a requirement for SHA monitoring purposes.

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Exception Reports

Clostridium Difficile - hospital acquired for ages >2 years	PCT	SHA	L	M	I

	Number of C Diff Cases (Target)	May-12	Cum Plan	Cum Actual	Cum Variance
New Cross	57	7	11.5	9	-2.5
Community	12	0			

Analysis: C Difficile is reported as above target for the month of May, however, cumulatively year to date we remain below target by 2.5.

62 Day Wait for First Treatment from Consultant Screening - All Cancers	M	A

Target	May-12	Variance
90%	89.47%	-0.53%

Analysis: This indicator is always vulnerable due to the low numbers of patients thus not giving us any capacity for breaches. During May 1 patient breached this target, this patient was a bowel screening patient, this patients pathway included many investigations and was very complex, this required a very specific and complex treatment plan.

A&E Unplanned Re-attendance Rate	I

To reduce avoidable re-attendances at Accident & Emergency by improving the care and communication delivered during the original attendance.

	Target	May-12	Current Month Variance
New Cross Hospital	< 5%	6.21%	1.21%
Walk in Centre		3.23%	-1.77%
Combined Total		5.49%	0.49%

Analysis: This graph now also includes walk-in centre data. Also included is the combined organisation total which shows we are above target by 0.49%.

A&E Time to Initial Assessment (for ambulance patients) | A

To reduce the clinical risk associated with the time the patient spends unassessed in Accident & Emergency. Time from arrival to start of full initial assessment.

Target	May-12	Current Month Variance
< 15 mins	00:29	00:14

Analysis: We continue to keep emphasis on the assessment target and ambulance turnaround time by the management team in A&E, ensuring that a nurse is available between 12 midday and 12 midnight whose main function is to provide assessment and care for patients who arrive by ambulance.

Percentage of GP's who receive Correspondence within 24 Hours of Discharge

Target	May-12	Variance
100%	49.20%	-50.80%

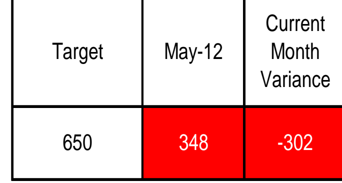
Analysis: Work is underway across all areas within the trust, a roll-out plan has commenced and all in-patient areas are now live. Performance is monitored weekly at the Divisional Managers Meeting.

Smoking Quitters | C

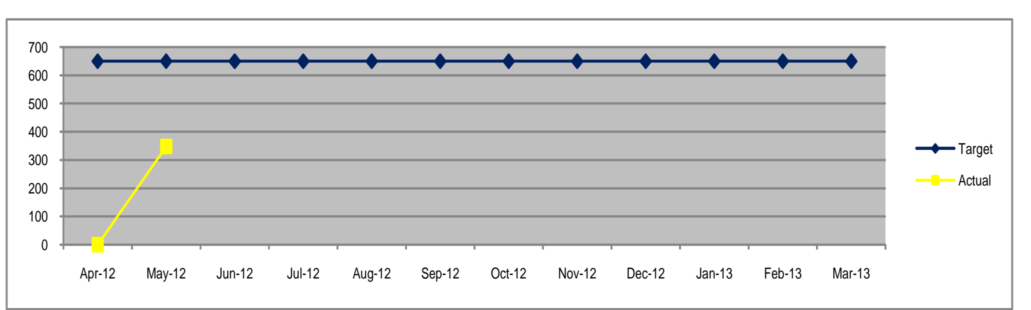
Monthly Target	Cum Plan	Cum Actual	Cum Variance
170	2043	1403	-640

Analysis: Current target was based on the 2009/10 baseline which was a record year for the service. This was largely based on a national and local media campaign. The national campaign has not run this year and there has been very limited local media. This culminates in a significantly reduced interest and referral into the service. Due to the data lag with this indicator this is the final outturn position for the year 2011/12.

Number of People offered an NHS Health Check



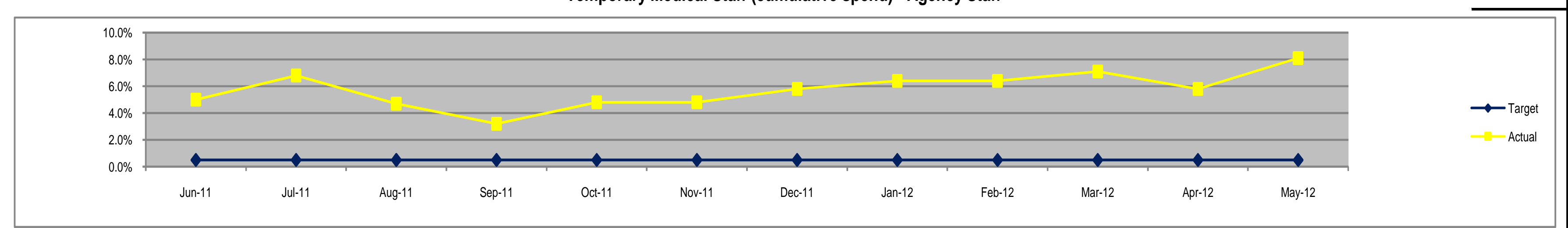
Target	May-12	Current Month Variance
650	348	-302



Analysis: This is a new indicator; there has been a delay in agreeing the service requirements which has meant the service did not commence until May. A remedial action plan has been developed including the training of all st

Temporary Staffing	**L**	**I**	

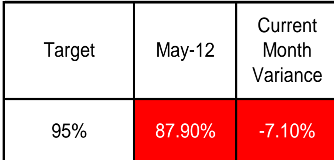
Temporary Medical Staff (cumulative spend) - Agency Staff



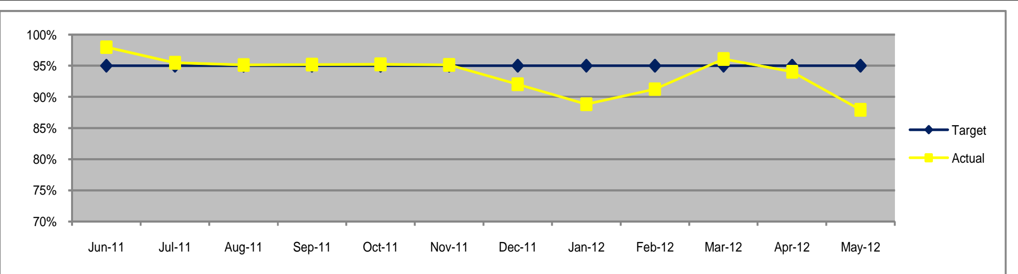
Analysis: There has been no agency expenditure for nursing staff during May. In terms of medical agency there has been a n increase in month from 5.8% in April to 8.1% in May. **Surgical Division** has seen an increase in month from £66K in April to £103K in May. Agency expenditure in Critical Care, Obs & Gynaecology and Ophthalmology have been high during May due to vacancies within the departments. **Medical Division also** saw an increase in month from £222K in April to £303K in May. A&E has remained high due vacancies at Consultant level and middle grade and SHO rotas.

Information Governance Toolkit

Good Information Governance practice ensures necessary safeguards for, and appropriate use of, corporate, patient and personal information. The purpose of this tool is to ensure that IG training is available to all staff covering a range of training needs and learning competencies to support the implementation and development of an IG framework within the organisation.



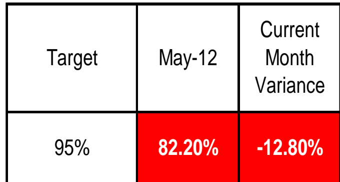
Target	May-12	Current Month Variance
95%	87.90%	-7.10%



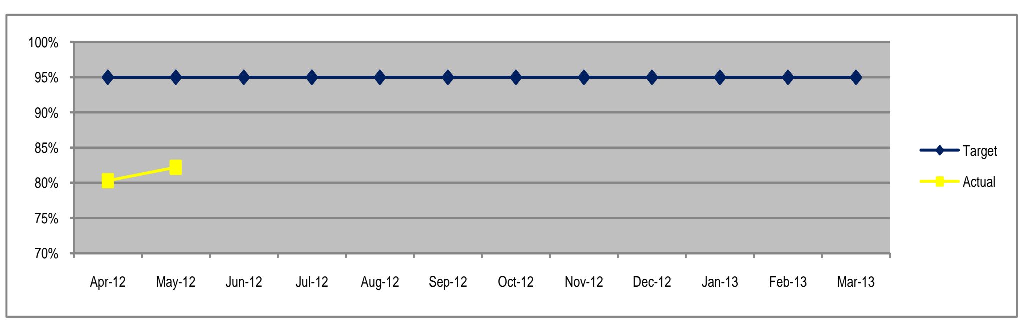
Analysis: This is a deterioration from the position reported last month 94.02% in April against 87.9% in May, we remain below target by 7.1%. The following Divisions are showing as red i.e. <95% overall compliance. **Surgical Division** - of a total of 2,101 staff of which 271 have not completed training giving the division compliance rate of 87.1%, **Medical Division** - of a total of 2,412 staff of which 275 have not completed training giving the division compliance rate of 88.6%, **Corporate Division** - of a total of 664 staff of which 121 have not completed training giving the division compliance rate of 81.8%

Induction

Corporate Induction

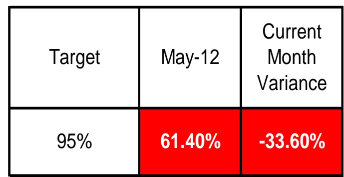


Target	May-12	Current Month Variance
95%	82.20%	-12.80%

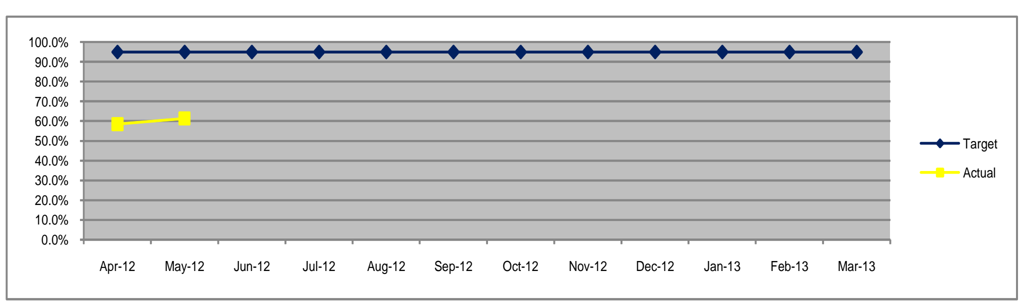


Analysis: This has seen a slight improvement from the position of 80.3% reported in April. The following Divisions are showing as red i.e. <95% overall compliance with the number of staff not having attended Corporate Induction in brackets. **Surgical Division** - 85.6% (38), **Medical Division** - 76.9% (75), **Estates & Facilities** - 88.9% (4) and **Corporate** - 89.9% (8)

Local Induction



Target	May-12	Current Month Variance
95%	61.40%	-33.60%



Analysis: This has seen a slight improvement from the position of 61.4% reported in April. The following Divisions are showing as red i.e. <95% overall compliance with the number of staff not having received a Local Induction in brackets. **Surgical Division** - 70.1% (79), **Medical Division** - 54.2% (149), **Estates & Facilities** - 72.2% (10) and **Corporate** - 57% (34)

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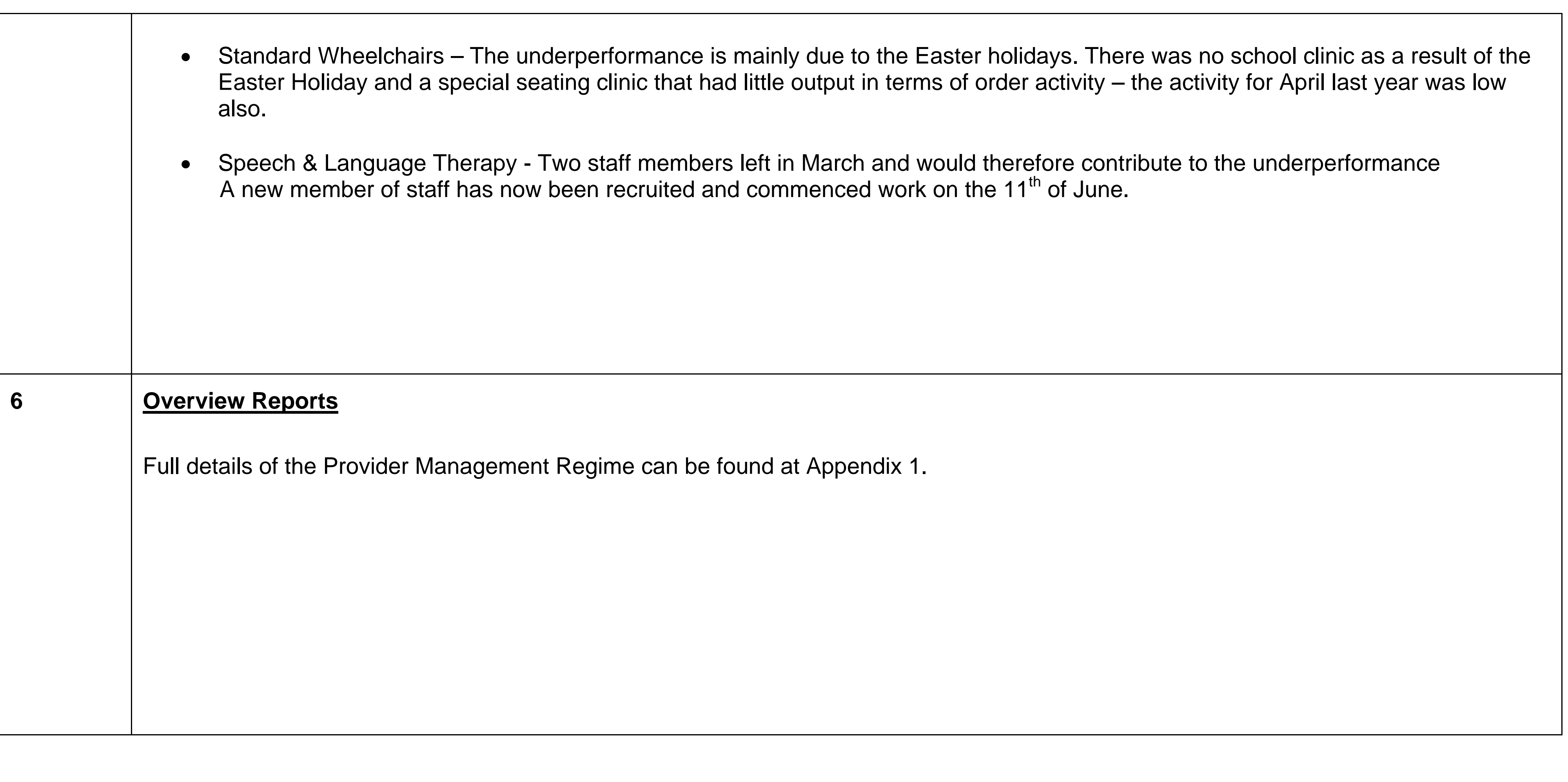
Activity Dashboard (community activity only)

It is important to note that the data for community activity only covers the period up to April.

Theme	Red	Amber	Green	Total
Rehabilitation Covering inpatient/outpatient clinics for services such as care of the elderly, rehabilitation, falls assessment and community stroke	6	7	1	14
Community Nursing Covering 12 services including community matrons, district nursing, Walk-in-Centre and palliative care	2	1	9	12
Child and Family Services Total of 7 services from school nursing to contraceptive and sexual health services	1	3	3	7
Allied Health Professionals Total of 8 services from physiotherapy, OT, speech and language therapy and foot health.	2	2	4	8
Healthy Lifestyles Total of 4 services including food health, walking for health, smoking cessation and health trainers.	0	0	4	4
Totals	11	13	21	45
Trend **(Trends are not possible this month due to the additions and removals of PIs)**				

Of the 11 RED rates service areas, 7 are operating above plan and 4 are operating below plan. Details for the 4 areas below plan are:

- Rehabilitation outpatients – This is due to very small numbers, however, the service will monitor this very closely over the coming months
- Community Neuro Rehabilitation Team Totals (including consultant) - 2 vacant posts. The vacancies have been advertised and the Service hopes to recruit shortly.



	• Standard Wheelchairs – The underperformance is mainly due to the Easter holidays. There was no school clinic as a result of the Easter Holiday and a special seating clinic that had little output in terms of order activity – the activity for April last year was low also. • Speech & Language Therapy - Two staff members left in March and would therefore contribute to the underperformance A new member of staff has now been recruited and commenced work on the 11th of June.
6	**<u>Overview Reports</u>** Full details of the Provider Management Regime can be found at Appendix 1.

SELF-CERTIFICATION RETURNS
Organisation Name:
Royal Wolverhampton Hospitals NHS Trust
Monitoring Period:
May 2012
NHS Midlands & East Provider Management Regime 2012/13

Returns to provider.development@westmidlands.nhs.uk by the last working day of each month

NHS Trust Governance Declarations : 2012/13 In-Year Reporting

Name of Organisation:	Royal Wolverhampton Hospitals NHS Trust	Period:	May 2012

Organisational risk rating

Each organisation is required to calculate their risk score and RAG rate their current performance as per the 2011/12 Provider Management Regime, in addition to providing comment with regard to any contractual issues and compliance with CQC essential standards:

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per NHS Midlands and East PMR guidance)	Green
Financial Risk Rating (Assign number as per NHS Midlands and East PMR guidance)	4.1
Contractual Position (RAG as per NHS Midlands and East PMR guidance)	Green

*** Please type in R, A or G**

Governance Declarations

NHS Midlands and East organisations, subject to the Provider Management Regime, must ensure that plans in place are sufficient to ensure compliance in relation to all national targets and including ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections, CQC Essential standards and declare any contractual issues.

Supporting detail is required where compliance cannot be confirmed.

Please complete sign **one** of the two declarations below. If you sign declaration 2, provide supporting detail using the form below. Signature may be either hand written or electronic, you are required to print your name.

Governance declaration 1

The Board is satisfied that plans in place **are sufficient** to ensure continuing compliance with all existing targets (after the application of thresholds), and with all known targets going forward. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections (including the Hygiene Code) and CQC Essential standards. The board also confirms that there are no material contractual disputes.

Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		
Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		

Governance declaration 2

For one or some of the following declarations Governance, Finance, Service Provision, Quality and Safety, CQC essential standards or the Code of Practice for the Prevention and Control of Healthcare Associated Infections the Board cannot make Declaration 1 and has provided relevant details below.

The board is suggesting that at the current time there is **insufficient assurance available** to ensure continuing compliance with all existing targets (after the application of thresholds) and/or that it may have material contractual disputes.

Signed by :		Print Name :	
on behalf of the Trust Board	Acting in capacity as:		
Signed by :		Print Name :	
on behalf of the Trust Board	Acting in capacity as:		

If Declaration 2 has been signed:

Please identify which targets have led to the Board being unable to sign declaration 1. For each area such as Governance, Finance, Contractual, CQC Essential Standards, where the board is declaring insufficient assurance please state the reason for being unable to sign the declaration, and explain briefly what steps are being taken to resolve the issue. Please provide an appropriate level of detail.

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

ACUTE
GOVERNANCE RISK RATINGS 2011/12

Royal Wolverhampton Hospitals NHS Trust

Insert YES (target met in month), NO (not met in month) or N/A (as appropriate)
See separate rule for A&E

Appendix 1

Ref	Area	Indicator	Sub Sections	Thresh-old	Weight-ing	Apr-12	May-12											Comments where target not achieved in month?
1	Safety	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	Yes	No											
2	Safety	MRSA	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	Yes	Yes											
3	Quality	All cancers: 31-day wait for second or subsequent treatment, comprising either:	Surgery Anti cancer drug treatments Radiotherapy	94% 98% 94%	1.0	Yes	Yes											
4	Quality	All cancers: 62-day wait for first treatment, comprising either:	From urgent GP RTT From consultant screening service referral	85% 90%	1.0	Yes	No											62 Day Screening target has not been achieved during May. This indicator is always vulnerable due to the low numbers of patients thus not giving us any capacity for breaches. During May 1 patient breached this target, this patient was a bowel screening patient, this patients pathway included many investigations and was very complex, this required a very specific and complex treatment plan.
5a	Patient Experience	RTT waiting times – admitted	95th percentile	23 wks	1.0	Yes	Yes											
5b	Patient Experience	RTT waiting times – non-admitted	95th percentile	18.3 wks	1.0	Yes	Yes											
6	Quality	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes											
7	Quality	Cancer: 2 week wait from referral to date first seen, comprising either:	all cancers for symptomatic breast patients (cancer not initially suspected)	93% 93%	0.5	Yes	Yes											
8a	Quality	A&E: Total time in A&E	Total time in A&E (95%)	≤ 4 hrs	1.0	Yes	Yes											
8b	Quality	A&E: NB Please record the areas not being met in the comments sheet	Total time in A&E (95th percentile) Time to initial assessment (95th percentile) Time to treatment decision (median) Unplanned re-attendance rate Left without being seen	≤4 hrs ≤15 mins ≤60 mins ≤5% ≤5%	No weighting	2	2											Areas not met - Unplanned re-attendance rate and Time to initial assessment for ambulance patients
17	Patient experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes											
		CQC Registration																
A	Safety	CQC Registration	Are there any compliance conditions on registration outstanding.	0	1.0	No	No											
B	Safety	CQC Registration	Are there any restrictive compliance conditions on registration outstanding.	0	2.0	No	No											
C	Safety	Moderate CQC concerns regarding the safety of healthcare provision		0	1.0	No	No											
D	Safety	Major CQC concerns regarding the safety of healthcare provision		0	2.0	No	No											
E	Safety	Formal CQC Regulatory Action resulting in Compliance Action		0	2.0	No	No											
F	Safety	Formal CQC Regulatory Action resulting in Enforcement Action		0	4.0	No	No											
G	Safety	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	No	No											
				TOTAL		**0.0**	**2.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	

COMMUNITY TRUST
GOVERNANCE RISK RATINGS 2012/13

Royal Wolverhampton Hospitals NHS Trust

Insert YES (target met in month), NO (not met in month) or N/A (as appropriate)
See separate rule for MIU/A&E

Ref	Area	Indicator	Sub Sections	Thresh-old	Weight-ing	Apr-12	May-12											Comments where target not achieved in month?
1	Safety	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	Yes	Yes											
2	Safety	MRSA	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	Yes	Yes											
18	Quality	Delayed Transfers of Care	Are you below the ceiling for your monthly trajectory	Contract with PCT	0.5	Yes	Yes											
19	Patient Experience	GUM Access - within 48 hours	95th percentile	≤ 48 hrs	0.5	Yes	Yes											
20	Effectiveness	Chlamydia Screening		Contract with PCT	0.5	N/A	N/A											
21	Effectiveness	Smoking quitters		Contract with PCT	0.5	No	Yes											The contract reporting for this indicator is approximately 7 weeks after the month end (necessary as a 4 week quit period is required) the figure reported is March position
8a	Quality	Minor Injuries Unit / A&E (Q1):	Total time (95th percentile)	≤ 4 hrs	1.0	Yes	Yes											
8b	Quality	MIU / A&E/ WiC (from Q2): NB Please record the areas not being met in the comments column	Total time (95th percentile) Time to initial assessment (95th percentile) Time to treatment decision (median) Unplanned re-attendance rate Left without being seen	≤4 hrs ≤15 mins ≤60 mins ≤5% ≤5%	No weighting	0	0											
22	Patient Experience	6 week wait for diagnostic	100%	≤ 6 wks	0.5	Yes	Yes											
23	Safety	New birth visits		Contract with PCT	0.5	Yes	Yes											
24	Effectiveness	HPV (Human Papillomavirus) Uptake		Contract with PCT	0.5	Yes	Yes											
25	Patient Experience	Community equipment store response within seven days	100%	≤ 7 days	0.5	N/A	N/A											
26a	Safety	Urgent District Nurse response within 24 hours	100%	≤ 24 hrs	0.5	N/A	N/A											
26b	Patient Experience	Non-urgent District Nurse response within 48 hours	100%	≤ 48 hrs	0.5	N/A	N/A											
17	Patient experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes											
		CQC Registration																
A	Safety	CQC Registration	Are there any compliance conditions on registration outstanding.	0	1.0	No	No											
B	Safety	CQC Registration	Are there any restrictive compliance conditions on registration outstanding.	0	2.0	No	No											
C	Safety	Moderate CQC concerns regarding the safety of healthcare provision		0	1.0	No	No											
D	Safety	Major CQC concerns regarding the safety of healthcare provision		0	2.0	No	No											
E	Safety	Formal CQC Regulatory Action resulting in Compliance Action		0	2.0	No	No											
F	Safety	Formal CQC Regulatory Action resulting in Enforcement Action		0	4.0	No	No											
G	Safety	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	No	No											
				TOTAL		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	

FINANCIAL RISK RATING 2012/13

Royal Wolverhampton Hospitals NHS Trust

Insert the Score (1-5) Achieved for each Criteria Per Month

			Risk Ratings																		
Criteria	Indicator	Weight	5	4	3	2	1	Annual Plan 2011/12	Apr-12	May-12											Comments on Performance in Month
Underlying performance	EBITDA margin %	25%	11	9	5	1	<1		3	3											
Achievement of plan	EBITDA achieved %	10%	100	85	70	50	<50		5	5											
Financial efficiency	Return on assets %	20%	6	5	3	-2	<-2		5	5											
	I&E surplus margin %	20%	3	2	1	-2	<-2		3	4											
Liquidity	Liquid ratio days	25%	60	25	15	10	<10		4	4											
Average	Weighted Average	100%						0.0	3.9	4.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Overriding rules	Overriding rules																				
Overall rating	Final Overall rating							0.0	3.9	4.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	

Overriding Rules :

Max Rating	Rule
3	Plan not submitted on time
3	Plan not submitted complete and correct
2	PDC divident not paid in full
2	One Financial Crieterion at "1"
3	One Financial Crieterion at "2"
1	Two Financial Criteria at "1"
2	Two Financial Criteria at "2"

FINANCIAL RISK TRIGGERS 2012/13

Royal Wolverhampton Hospitals NHS Trust

Insert "Yes" / "No" Assessment for the Month

	Criteria	Apr-12	May-12											Comments on Performance in Month
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No											
2	Quarterly self-certification by trust that the financial risk rating (FRR) may be less than 3 in the next 12 months	No	No											
3	FRR 2 for any one quarter	No	No											
4	Working capital facility (WCF) agreement includes default clause	No	No											
5	Debtors > 90 days past due account for more than 5% of total debtor balances	No	No											
6	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No											
7	Two or more changes in Finance Director in a twelve month period	No	No											
8	Interim Finance Director in place over more than one quarter end	No	No											
9	Quarter end cash balance <10 days of operating expenses	No	No											
10	Capital expenditure < 75% of plan for the year to date	No	No											
	TOTAL	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	

NB **Scoring: An answer of "YES" = 1.0**

RAG RATING :

GREEN = Score between 0 and 1

AMBER = Score between 2 and 4

RED = Score over 5

CONTRACTUAL RISK RATINGS 2012/13

Royal Wolverhampton Hospitals NHS Trust

Insert R, A or G into appropriate row for the Month

Criteria	RAG	Apr-12	May-12											Comments on Performance in Month
All key contracts are agreed and signed. Both the NHS Trust and commissioner are fulfilling the terms of the contract. There are no disputes or performance notices in place.	G	G	G											
The NHS Trust and commissioner are in dispute over the terms of the contract. Performance notices have been issued by one or both parties.	A													
One or more key contract is not signed by the start of the period covered by the contract. There is a dispute over the terms of the contract which might, or will, necessitate SHA intervention or arbitration. The parties are already in arbitration.	R													

QUALITY

Royal Wolverhampton Hospitals NHS Trust

Insert Performance in Month

	Criteria	Unit	Apr-12	May-12										Comments on Performance in Month
1	SHMI - latest data	Ratio	108.5	108.5										SHMI figure is Q3 10/11 to Q2 11/12. HSMR Doctor Foster data April 11 to March 12 is 92 rebased to 101
2	Venous Thromboembolism (VTE) Screening	%	96.25	96.61										
3a	Elective MRSA Screening	%	100	100										
3b	Non Elective MRSA Screening	%	100	100										
4	Single Sex Accommodation Breaches	Number	0	0										
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	102	101										SHA Open figure, includes SUI and reportable as per SHA criteria. Figure includes 18 to be closed by PCT.
6	"Never Events" in month	Number	0	1										
7	CQC Conditions or Warning Notices	Number	0	0										
8	Open Central Alert System (CAS) Alerts	Number	12	12										7 MDA, 2 EFA, 3 NPSA
9	RED rated areas on your maternity dashboard?	Number	N/A	N/A										
10	Falls resulting in severe injury or death	Number	0	2										
11	Grade 3 or 4 pressure ulcers	Number	10	14										
12	100% compliance with WHO surgical checklist	Y/N	No	No										Used in all Theatres, 75% compliance in outpatient areas, full compliance will be achieved by end of May 2012.
13	Formal complaints received	Number	26	43										
14	Agency and bank spend as a % of turnover	%	3.1	3.03										
15	Sickness absence rate	%	4.46	4.53										

Board Statements

Royal Wolverhampton Hospitals NHS Trust

May 2012

For each statement, the Board is asked to confirm the following:

	For CLINICAL QUALITY, that:	Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SHA's Provider Management Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its NHS trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	✓
	If the Trust Board is unable to make the above statement, the Board must:	
2	Be satisfied that, to the best of its knowledge and using its own processes (supported by CQC information and including any further metrics it chooses to adopt), its Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	
3	Be satisfied that, to the best of its knowledge and using its own processes, plans in place are sufficient to ensure ongoing compliance with the CQC's registration requirements	
4	Certify it is satisfied that processes and procedures are in place to ensure that all medical practitioners providing care on behalf of the NHS foundation trust have met the relevant registration and revalidation requirements.	
5	Be satisfied that the Trust is embedding patient experience into the service design, improvement and delivery cycle.	
	For SERVICE PERFORMANCE, that:	**Response**
6	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds), and compliance with all targets due to come into effect during 2012/13.	✓
	For RISK MANAGEMENT PROCESSES, that:	**Response**
7	Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner	✓
8	All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned	✓
9	The necessary planning, performance management and risk management processes are in place to deliver the annual plan	✓
10	A Statement of Internal Control ("SIC") is in place, and the trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to the most up to date guidance from HM Treasury (see http://www.hm-treasury.gov.uk)	✓
11	The trust has achieved a minimum of Level 2 performance against the key requirements of the Department of Health's Information Governance Toolkit	✓
	For COMPLIANCE WITH THE NHS CONSTITUTION, that:	**Response**
12	The Board is assured that the trust will, at all times, have regard to the NHS constitution	✓
	For BOARD, ROLES, STRUCTURES AND CAPACITY, that:	***Response***
13	The Board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the Board	✓
14	The Board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability	✓
15	The selection process and training programmes in place ensure that the non-executive directors have appropriate experience and skills	✓
16	The management team have the capability and experience necessary to deliver the annual plan	✓
17	The management structure in place is adequate to deliver the annual plan objectives for the next three years.	✓

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO		**David Loughton**	
Chair		**Barry Picken**	

NHS Midlands and East Provider Management Regime

Ref	Area	Details
Thresh-olds		The SHA will not utilise a general rounding principle when considering compliance with these targets and standards, e.g. a performance of 94.5% will be considered as failing to achieve a 95% target. However, exceptional cases may be considered on an individual basis, taking into account issues such as low activity or thresholds that have little or no tolerance against the target, e.g. those set between 99-100%.
1	C.Diff	Performance against contract with main commissioner
2	MRSA	MRSA objective: those trusts which are not in the best performing quartile for MRSA should deliver performance that is at least in line with the MRSA objective target figures calculated for them by DH. The SHA expects those NHS trusts without a centrally calculated MRSA objective to agree an MRSA target for 2011/12 that at least maintains existing performance. Where a trust has an annual MRSA objective of six cases or fewer and has reported six cases or fewer in the year to date, the MRSA objective will not apply for the purposes of the SHA's Provider Management Regime If a trust with an annual objective of six cases or fewer declares a risk of exceeding the de minimis level and its annual MRSA objective in-year, but has not yet done so, it will be required to [provide, and then] report monthly against, an MRSA action plan until the risk has been satisfactorily addressed.
3	Cancer: 31 day wait	31-day wait: measured from cancer treatment period start date to treatment start date. Failure against any threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter.
4	Cancer: 62 day wait	62-day wait: measured from day of receipt of referral to treatment start date. This includes referrals from screening service and other consultants, including consultant upgrades. Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. For patients referred from one provider to another, breaches of this target are automatically shared and treated on a 50:50 basis. These breaches may be reallocated in full back to the referring organisation(s) provided there is written agreement to do so between the relevant providers (signed by both Chief Executives) in place at the time the trust makes its monthly declaration to the SHA.
5a&b	RTT	While performance is measured on an aggregate basis, NHS trusts are required to meet the threshold on a monthly basis – consequently failure in any month represents failure for the quarter and should be reported via the exception reporting process.
6	Cancer	Measured from decision to treat to first definitive treatment. The target will not apply to trusts having five cases or fewer in a quarter.
7	Cancer	Measured from day of receipt of referral – existing standard (includes referrals from general dental practitioners and any primary care professional). Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or Specific guidance and documentation concerning cancer waiting targets can be found at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation
8a	A&E (Q1)	In Quarter one - 95th percentile waits for 4 hours or less to be used
8b	A&E (Q2)	From Quarter two: • 95th percentile waits for 4 hours or less to be used • Time to initial assessment: for ambulance arrivals. Initial assessment to include a pain score and early warning score. • Time to treatment decision: time from arrival to see a decision-making clinician (defining management plan and may potentially discharge the • Unplanned reattendance rate: within 7 days of original attendance. Includes patients referred back by another health professional. The SHA will not score this for paediatric specialist NHS trusts. • Left without being seen The SHA will keep these measures under review during 2011/12 and may change its implementation in line with national policy.
9	Stroke	The SHA will consider its introduction during 2011/12 following publication of DH's technical guidance.
10	Mental Health: CPA	7-day follow up: **Numerator**: The number of people under adult mental illness specialties on Care Programme Approach who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care. **Denominator:** the total number of people under adult mental illness specialties on Care Programme Approach who were discharged from psychiatric inpatient Contact can include face-to-face or telephone contact. Guidance on what should and should not be counted when calculating the achievement of this target can be found on Unify2. For 12 month review (from Mental Health Minimum Data Set): **Numerator:** The number of adults in the denominator who have had at least one formal review in the last 12 months. Date last seen by care coordinator will be used as a proxy for formal Care Programme Approach review during 2011/12. **Denominator:** The total number of adults who have received secondary mental health services and who were on the Care Programme Approach at any point during the reporting period. For full details of the changes to the Care Programme Approach process, please see the implementation guidance, Refocusing the Care Programme Approach on the Department of Health's website. All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. Exemptions from both the numerator and the denominator of the indicator include: • patients who die within seven days of discharge; • where legal precedence has forced the removal of a patient from the country; or • patients discharged to another NHS psychiatric inpatient ward.
11	Mental Health: DTOC	**Numerator:** The number of non-acute patients (aged 18 and over) whose transfer of care was delayed averaged over the quarter. **Denominator:** Number of non-acute patients (aged 18 and over) admitted to the trust, summed across the quarter. Delayed transfers of care attributable to social care are excluded.
12	Mental Health: I/P and CRHT	This indicator applies only to admissions to the NHS trust's mental health psychiatric inpatient care. The following cases can be excluded: • admissions to psychiatric intensive care units; • internal transfers of service users between wards in a trust and transfers from other trusts; • patients recalled on Community Treatment Orders; or • patients on leave under Section 17 of the Mental Health Act 1983. An admission has been gate-kept by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission. For full details of the features of gate-keeping, please see Guidance Statement on Fidelity and Best Practice for Crisis Services on the Department of Health's website. As set out in Guidance Statement on Fidelity and Best Practice for Crisis Services the crisis resolution home treatment team should: a) provide a mobile 24 hour, seven day a week response to requests for assessments; b) be actively involved in all requests for admission: for the avoidance of doubt, 'actively involved' requires face to face contact unless it can be demonstrated that face-to-face contact was not appropriate or possible. For each case where face-to-face contact is deemed inappropriate, a declaration that the face-to-face contact was not the most appropriate action from a clinical perspective will be required; c) be notified of all pending Mental Health Act assessments; d) be assessing all these cases before admission happens; and e) be central to the decision making process in conjunction with the rest of the multidisciplinary team
13	Mental Health	Monthly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.
14	Mental Health: MDS	Patient identity data completeness metrics (from Mental Health Minimum Data Set) to consist of: • NHS number; • Date of birth; • Postcode (normal residence); • Current gender; • Registered General Medical; • Practice organisation code; and • Commissioner organisation code. Numerator: count of valid entries for each data item above. NB For details of how data items are classified as VALID please visit the data quality constructions available on the Information Centre's website: www.ic.nhs.uk/services/mhmds/dq Denominator: total number of entries.
15	Mental Health: CPA	**Outcomes for patients on Care Programme Approach:** • Employment status: **Numerator:** The number of adults in the denominator in paid employment (i.e. those recorded as 'employed') at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting, in a financial year. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported quarter. **Denominator:** The total number of adults (aged 18-69) who have received secondary mental health services and who were on the Care Programme Approach at any point during the reported quarter. • In settled accommodation: **Numerator:** The number of adults in the denominator who were in settled accommodation at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported quarter. **Denominator:** The total number of adults (aged 18-69) who have received secondary mental health services and who were on the Care Programme Approach at any point during the reported quarter. • Having an HoNOS assessment in the past 12 months: **Numerator:** The number of adults in the denominator who have had at least one HoNOS assessment in the past 12 months. NOTE: When implemented MHMDS v4 will allow services to report all HoNOS variants, including those for young people and people in secure services. Until this time trusts should report standard HoNOS inclusive of all ages and ward types. **Denominator:** The total number of adults who have received secondary mental health services and who were on the Care Programme Approach during the reference period.
16a	Ambulance Cat A	Life threatening
17	Learning Disabilities: Access to healthcare	Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All (2008): a) Does the NHS trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? b) Does the NHS trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria?: • treatment options; • complaints procedures; and • appointments. c) Does the NHS trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? d) Does the NHS trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? e) Does the NHS trust have protocols in place to encourage representation of people with learning disabilities and their family carers? f) Does the NHS trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? Note: Boards are required to certify that their trusts meet requirements a to f above at the annual plan and in each quarter. Failure to do so will result in the application of the service performance score for this indicator.
18	DTCs	Performance against contract with main commissioner
19	GUM Access	Access to GUM within 48hours against a target of 95% compliance.
20	Chlamydia Screening	Performance against contract with main commissioner
21	Smoking Quitters	Performance against contract with main commissioner
22	6 Wk Wait Diagnostics	Access to diagnostics against a target of 100% compliance
23	New birth visits	Performance against contract with main commissioner
24	HPV	Human Papillomavirus (HPV) uptake Performance against contract with main commissioner
25	Comm'ty Equip Store	Responses within 7 days
26 a	Urgent DN	Response by a DN within 24 hours of receiving an urgent request / referral
26 b	Non-Urgent DN	Response by a DN within 48 hours of receiving a non-urgent request / referral