The Royal Wolverhampton Hospitals NHS Trust	

Trust Board Report

Meeting Date:	24th September 2012
Title:	Performance Report
Executive Summary:	This report provides the Board with an update of performance against national and local performance indicators for August 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 – trends are not possible this month due to the addition of a PI (mixed sex accommodation breaches) • Exception Reports (Red rated PIs) • Provider Management Regime (Appendix 1)

3

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	**0**	**0**	**19**	**19**
Service Delivery There are 30 (2 of which are 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, People offered NHS Health Check and Mixed Sex Accommodation	**8**	**0**	**20**	**28**
Workforce This section is measured by 14 different indicators covering, Recruitment and Retention, Turnover, Sickness Absence, Temporary Staffing (agency), and Education & Training	**4**	**5**	**5**	**14**
Totals	**12**	**5**	**44**	**61**
Last Month	**9**	**8**	**43**	**60**
Trend **(Trends are not possible this month due to the addition of a PI)**				

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.

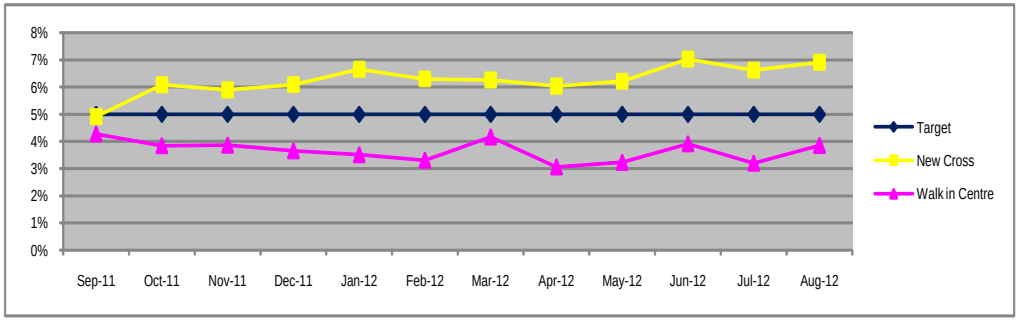
4

Exception Reports

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	Aug-12	Current Month Variance
New Cross Hospital	5%	6.91%	1.91%
Walk in Centre		3.85%	-1.15%
Combined Total		6.18%	1.18%

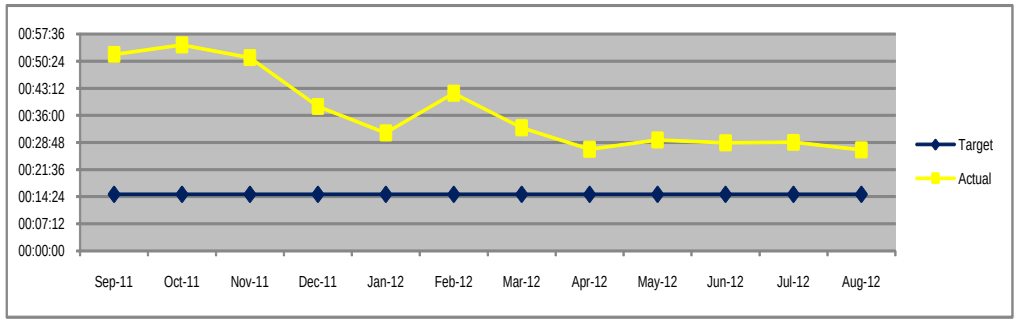


Analysis: Combined organisation total shows we remain above target by 1.18%, this is a deterioration 0.44% from July's position. Work is underway with clinicians across the health economy to improve this performance. A case file audit of patients has been undertaken to better understand reason codes.

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.

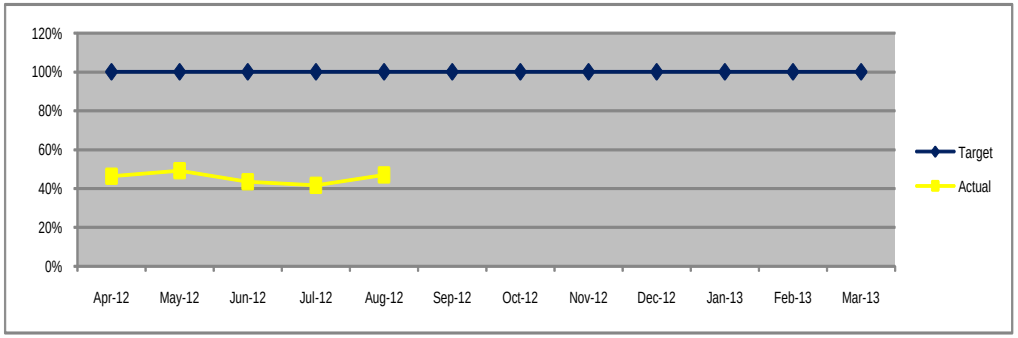
Target	Aug-12	Current Month Variance
00:15:00	00:26:49	00:11:49



Analysis: We have seen a slight improvement in this target, however, we continue to keep emphasis on the assessment target and ambulance turnaround time by the management team in A&E. Usage of the Rapid Assessment Team room commenced during July 2012 and is currently being evaluated.

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

Target	Aug-12	Variance
100%	47.10%	-52.90%

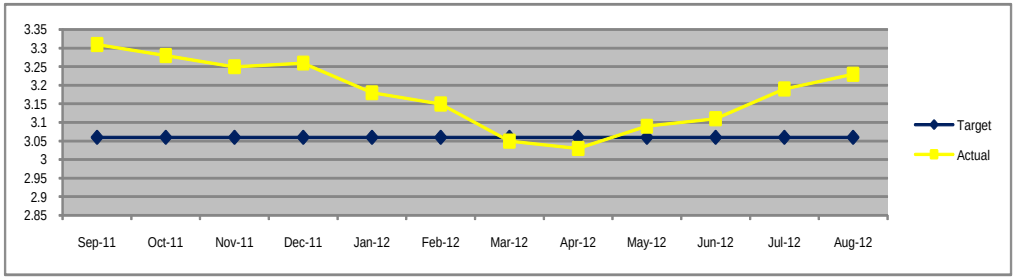


Analysis: IT have put in place a programme of work to improve the performance of the application to speed up data entry, incremental improvements are expected throughout the calendar year. Performance continues to be monitored weekly at the Divisional Managers Meeting.

Elective Length of Stay **A**

We continually strive to reduce length of stay in an effort to improve the patient experience by avoiding unnecessarily long stays in hospital. This also ensures that we are optimising the available bed capacity. Figures below show a 12 month moving average. The target for 2011/12 remains unchanged pending the commencement of the capacity and demand project.

Target per Month	Aug-12	Current Month Variance
3.06	3.23	0.17



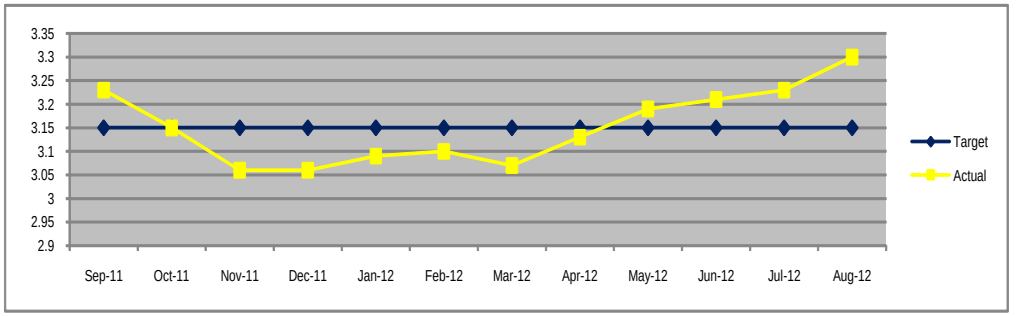
Analysis: This is a deterioration from the July position of 3.19, we remain above target by 0.17. Areas that have seen an increase in length of stay during August are:- Cardiac Surgery, General Medicine and Haematology.

Actions: Continue to focus on reducing long stayers, timely discharge and admission avoidance increasing day case rates.

Non-Elective Length of Stay	A	

We continually strive to reduce length of stay in an effort to improve the patient experience by avoiding unnecessarily long stays in hospital. This also ensures that we are optimising the available bed capacity. Figures below show a 12 month moving average. The target for 2011/12 remains unchanged pending the commencement of the capacity and demand project.

Target per Month	Aug-12	Current Month Variance
3.15	**3.30**	**0.15**



Analysis: This is a deterioration from the July position of 3.23, we remain above target by 0.15. Areas that have seen an increase in length of stay during August are:- ENT, Cardiac Surgery, Medical and Clinical Oncology.

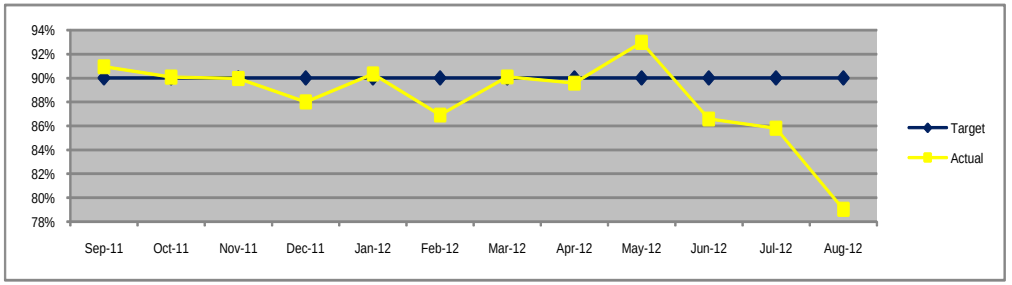
Actions: See actions associated with Elective Length of Stay (above)

Theatre Utilisation	L	A

As a percentage of planned sessions

This indicator shows the number of theatre sessions used expressed as a percentage of sessions planned. With the launch of Productive Theatre, indicators associated with theatre utilisation may be amended during the course of 2011/12.

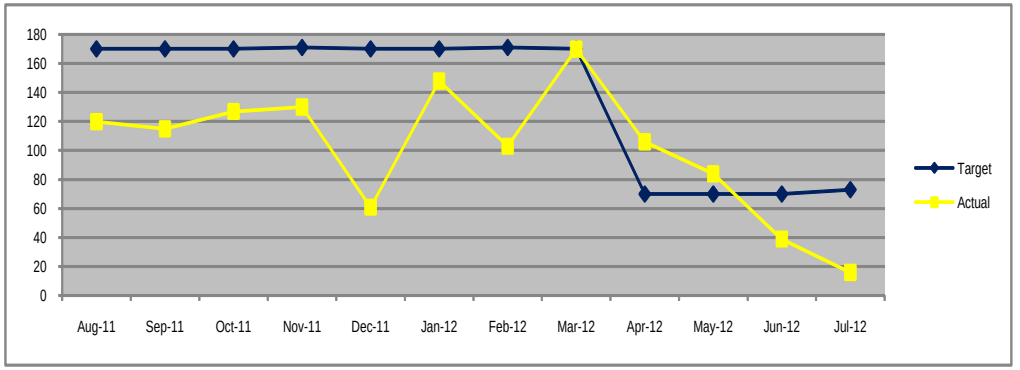
Target	Aug-12	Current Month Variance
90%	**79.03%**	**-10.97%**



Analysis: This is a deterioration from the position reported in August, the overall Trust position is below target by 10.97%. This is a seasonal deterioration due to high levels of leave during August.

Smoking Quitters	C	

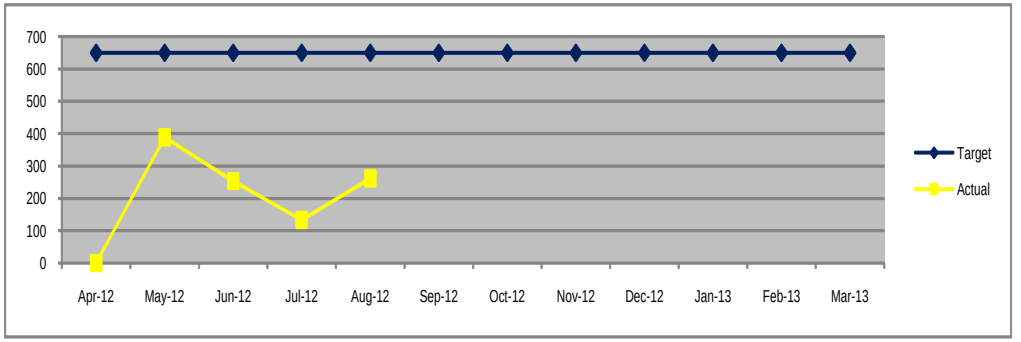
Monthly Target	Cum Plan	Cum Actual	Cum Variance
73	283	245	-38



Analysis: Following agreement with the commissioner, a revised trajectory has now been agreed for the service. A comprehensive recovery action plan has been produced to recover this position, this includes a local marketing campaign to accompany the National "Stoptober" campaign.

Number of People offered an NHS Health Check

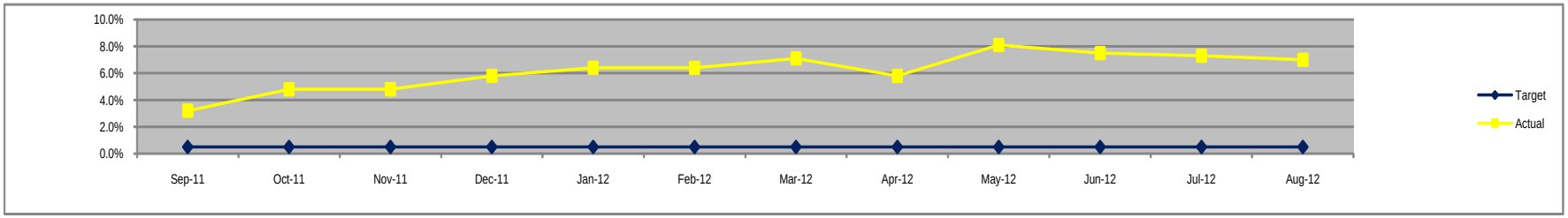
Target	Aug-12	Current Month Variance
650	261	-389



Analysis: A comprehensive recovery action plan has been produced to recover this position. The figure for August is currently unvalidated.

Temporary Staffing	L	I	

Temporary Medical Staff (cumulative spend) - Agency Staff

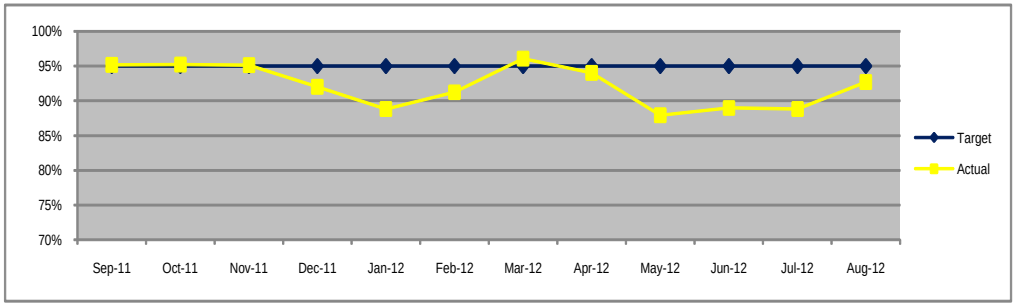


Analysis: Medical agency costs for August saw a slight decrease in month from 7.3% in July to 7.0% in August. **Surgical Division** has seen a slight increase in month from £47K in July to £50K in August. Agency expenditure in Ophthalmology is high during August due to the use of locums to deal with the high volume of review patients. **Medical Division** saw a decrease in month from £312K in July to £304K in August. A&E has remained high due vacancies at Consultant and middle grade level. Clinical Haematology has remained high in August due to the continuing use of a Locum Consultant to cover long term sick leave within the Specialty. Rehabilitation saw an increase in August, this was due to a locum covering long term sickness this is likely to continue to the end of September.

Information Governance Toolkit	I	

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	Aug-12	Current Month Variance
95%	**92.70%**	**-2.30%**

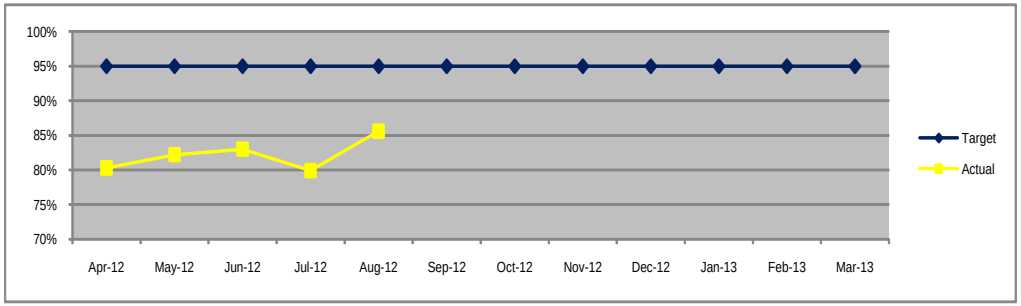


Analysis: This is an improvement from the position reported last month 88.8% in July against 92.7% in August, however, we remain below target by 2.3%. The following Divisions are showing as red i.e. <95% overall compliance. **Surgical Division** - of a total of 2,234 staff 225 have not completed training giving the division compliance rate of 89.9%, **Medical Division** - of a total of 2,610 staff 147 have not completed training giving the division compliance rate of 94.4%, **Corporate Division** - of a total of 768 staff 58 have not completed training giving the division compliance rate of 92.4%

Induction

Corporate Induction

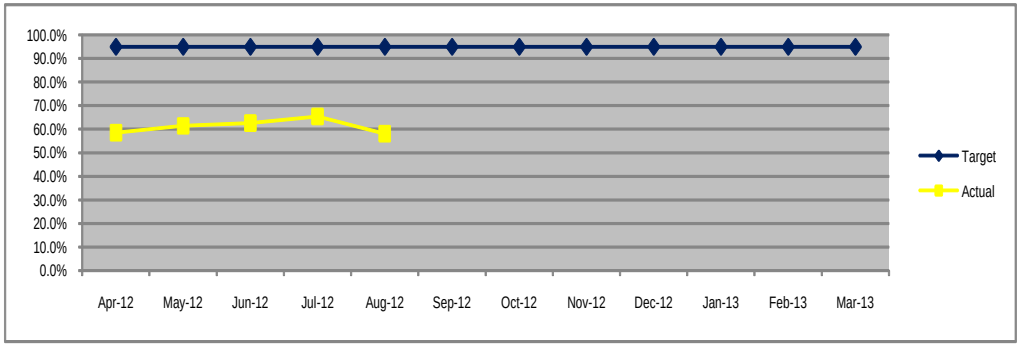
Target	Aug-12	Current Month Variance
95%	**85.60%**	**-9.40%**



Analysis: This is an improvement from the position of 79.9% reported in July. 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** - 87% (35), **Medical Division** - 84.8% (50), **Estates & Facilities** - 90.3% (3) and **Corporate** - 81.3% (14)

Local Induction

Target	Aug-12	Current Month Variance
95%	**58.10%**	**-36.90%**



Analysis: This is a deterioration from the position of 65.4% reported in July. 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** - 58.5% (112), **Medical Division** - 53.6% (153), **Estates and Facilities** - 80.6% (6) and **Corporate** - 66.7% (25)

5	**<u>Overview Reports</u>** Full details of the Provider Management Regime can be found at Appendix 1.

SELF-CERTIFICATION RETURNS
Organisation Name:
The Royal Wolverhampton NHS Trust
Monitoring Period:
August 2012
NHS Trust Over-sight self certification template

Returns to XXX by the last working day of each

TFA Progress

Aug-12

The Royal Wolverhampton NHS Trust

Select the Performance from the drop-down list

	TFA Milestone (All including those delivered)	Milestone Date	Performance	Comments where milestones are not delivered or where a risk to delivery has been identified
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				

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

Name of Organisation:	The Royal Wolverhampton NHS Trust	Period:	August 2012

Organisational risk rating

Each organisation is required to calculate their risk score and RAG rate their current performance, 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 SOM guidance)	Green
Financial Risk Rating (Assign number as per SOM guidance)	4
Contractual Position (RAG as per SOM guidance)	Green

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

Governance Declarations

NHS Trusts 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 :	

GOVERNANCE RISK RATINGS

The Royal Wolverhampton NHS Trust

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

See 'Notes' for further detail of each of the below indicators

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Dec-11	Historic Data: Qtr to Mar-12	Historic Data: Qtr to Jun-12	Current Data: Jul 12	Current Data: Aug-12	Current Data: Sep-12	Current Data: Qtr to Sep-12	Comments where target not achieved
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0			Yes	Yes	Yes		Yes	
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%				N/a	N/a	N/a		Yes	
			Patients dying at home / care home	50%					N/a	N/a		Yes	
	1c	Data completeness: identifiers MHMDS		97%	0.5			N/a	N/a	N/a		Yes	
	1c	Data completeness: outcomes for patients on CPA		50%	0.5			N/a	N/a	N/a		Yes	
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes	Yes	Yes	Yes		Yes	
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising :	Surgery	94%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes	Yes		Yes	
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes	Yes		Yes	
			for symptomatic breast patients (cancer not initially suspected)	93%									
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0				N/a	N/a		Yes	
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0				N/a	N/a		Yes	
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0				N/a	N/a		Yes	
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5				N/a	N/a		Yes	
	3j	Category A call – emergency response within 8 minutes		75%	1.0				N/a	N/a		Yes	
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0				N/a	N/a		Yes	
Safety	4a	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	*Enter contractual ceiling*	1.0	No	Yes	Yes	No	Yes		No	Calculator still not working correctly
	4b	MRSA	Are you below the ceiling for your monthly trajectory	*Enter contractual ceiling*	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No	No	No	No	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	No	No	No	No	No	No	
	C	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	No	No	No	No	No	
				TOTAL		1.0	0.0	0.0	1.0	0.0	0.0	1.0	

RAG RATING :

GREEN	**= Score of 1 or under**
AMBER/GREEN	**= Score between 1 and 1.9**
AMBER / RED	**= Score between 2 and 3.9**
RED	**= Score of 4 or above**

	Overriding Rules - Nature and Duration of Override at SHA's Discretion											
i)	Meeting the MRSA Objective	Greater than six cases in the year to date, and either:										
		Breaches the cumulative year-to-date trajectory for three successive quarters										
		Breaches its full year objective										
ii)	Meeting the C-Diff Objective	Greater than 12 cases in the year to date, and either:										
		Breaches the cumulative year-to-date trajectory for three successive quarters										
		Breaches its full year objective										
		Reports important or signficant outbreaks of C.difficile, as defined by the Health Protection Agency.										
iii)	RTT Waiting Times	Breaches:										
		The admitted patients 18 weeks waiting time measure for a third successive quarter										
		The non-admitted patients 18 weeks waiting time measure for a third successive quarter										
		The incomplete pathway 18 weeks waiting time measure for a third successive quarter										
iv)	A&E Clinical Quality Indicator	Fails to meet the A&E target twice in any two quarters over a 12-month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.										
v)	Cancer Wait Times	Breaches either:										
		the 31-day cancer waiting time target for a third successive quarter										
		the 62-day cancer waiting time target for a third successive quarter										
vi)	Ambulance Response Times	Breaches either:										
		the category A 8-minute response time target for a third successive quarter										
		the category A 19-minute response time target for a third successive quarter										
vii)	Community Services data completeness	Fails to maintain the threshold for data completeness for:										
		referral to treatment information for a third successive quarter;										
		service referral information for a third successive quarter, or;										
		treatment activity information for a third successive quarter										
viii)	Any Indicator weighted 1.0	Breaches the indicator for three successive quarters.										
			Number of Overrides Triggered			*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	

FINANCIAL RISK RATING

The Royal Wolverhampton NHS Trust

			Risk Ratings					Insert the Score (1-5) Achieved for each Criteria Per Month				
								Reported Position		Normalised Position*		
Criteria	Indicator	Weight	5	4	3	2	1	Year to Date	Forecast Outturn	Year to Date	Forecast Outturn	Comments where target not achieved
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	3	3	3	3	
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	4	5	4	5	
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	5	5	5	5	
	I&E surplus margin %	20%	3	2	1	-2	<-2	3	4	3	4	
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	4	3	4	3	
Weighted Average		**100%**						**3.8**	**3.8**	**3.8**	**3.8**	
Overriding rules												
Overall rating								**4**	**4**	**4**	**4**	

Overriding Rules :

Max Rating	Rule	
3	Plan not submitted on time	No
3	Plan not submitted complete and correct	No
2	PDC dividend not paid in full	No
2	One Financial Criterion at "1"	
3	One Financial Criterion at "2"	
1	Two Financial Criteria at "1"	
2	Two Financial Criteria at "2"	

* Trust should detail the normalising adjustments made to calculate this rating within the comments box.

FINANCIAL RISK TRIGGERS

The Royal Wolverhampton NHS Trust

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

	Criteria	Historic Data			Current Data				Comments where risks are triggered
		Qtr to Dec-11	Qtr to Mar-12	Qtr to Jun-12	Jul 12	Aug-12	Sep-12	Qtr to Sep-12	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	No	No	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	No	No	No		No	
3	Working capital facility (WCF) agreement includes default clause								
4	Debtors > 90 days past due account for more than 5% of total debtor balances	No	No	No	No	No		No	
5	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	No	No		No	
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No		No	
7	Interim Finance Director in place over more than one quarter end	No	No	No	No	No		No	
8	Quarter end cash balance <10 days of operating expenses	No	No	No	No	No		No	
9	Capital expenditure < 75% of plan for the year to date	No	No	No	No	No		No	

CONTRACTUAL DATA

The Royal Wolverhampton NHS Trust

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

Criteria	Historic Data			Current Data				Comments where reds are triggered
	Qtr to Dec-11	Qtr to Mar-12	Qtr to Jun-12	Jul 12	Aug-12	Sep-12	Qtr to Sep-12	
Are the prior year contracts* closed?	Yes	Yes	Yes	Yes	Yes		Yes	
Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes	Yes		Yes	
Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes	Yes		Yes	
Are there any disputes over the terms of the contract?	No	No	No	No	No		No	
Might the dispute require SHA intervention or arbitration?	No	No	No	No	No		No	
Are the parties already in arbitration?	No	No	No	No	No		No	
Have any performance notices been issued?	No	No	No	No	No		No	
Have any penalties been applied?	No	No	No	No	No		No	

QUALITY

The Royal Wolverhampton NHS Trust

Insert Performance in Month

	Criteria	Unit	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Comments on Performance in Month
1	SHMI - latest data	Ratio				90.5	90.0	109.9	109.9	108.5	108.5	98.2	98.2	100.0	92 HSMR April - June 2012. SHMI Q1 - Q3 2011/12
2	Venous Thromboembolism (VTE) Screening	%				91.89	95.83	94.67	96.09	96.25	96.61	94.4	96.75	95.45	
3a	Elective MRSA Screening	%				100	100	100	100	100	100	100	100	100	
3b	Non Elective MRSA Screening	%				100	100	100	100	100	100	100	100	100	
4	Single Sex Accommodation Breaches	Number				4	0	0	0	0	0	0	3	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number				75	85	74	84	102	101	117	111	140	Total number of SUI's open on STEIS. 36 were reported in August, 23 request to close by Commissioner
6	"Never Events" in month	Number				0	1	1	1	0	1	0	0	0	
7	CQC Conditions or Warning Notices	Number				0	0	0	0	0	0	0	0	0	
8	Open Central Alert System (CAS) Alerts	Number				15	12	14	13	12	12	16	15	13	MDA 10; EFA 1; NPSA 2 - overdue NPSA 2011 PSA 003 Insulin passport. There are 4 actions, we comply with 3, the 4th is related to patient lockers and is a national issue.
9	RED rated areas on your maternity dashboard?	Number				N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
10	Falls resulting in severe injury or death	Number				4	1	0	0	0	2	4	2	1	
11	Grade 3 or 4 pressure ulcers	Number				19	5	11	12	10	14	18	12	16	
12	100% compliance with WHO surgical checklist	Y/N				No	No	No	No	No	No	Yes	Yes	Yes	
13	Formal complaints received	Number				33	32	62	42	26	43	34	54	35	
14	Agency as a % of Employee Benefit Expenditure	%				2.9	2.9	3	3	3.1	3.03	3.16	3.6	3.3	
15	Sickness absence rate	%				4.55	5.41	5.27	5.08	4.46	4.53	4.11	4.76	4.45	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%													

Board Statements

The Royal Wolverhampton NHS Trust

August 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), the 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.	Yes
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's	Yes
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Yes
	For FINANCE, that:	**Response**
4	The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.	Yes
5	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	Yes
	For GOVERNANCE, that:	**Response**
6	The board will ensure that the trust remains at all times compliant with has regard to the NHS Constitution.	Yes
7	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner.	Yes
8	The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of it occurring and the plans for mitigation of these risks.	Yes
9	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	Yes
10	An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	Yes
11	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant GRR; and a commitment to comply with all known targets going forwards.	Yes
12	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Yes
13	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.	Yes
14	The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Yes
15	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.	Yes

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO			
Chair			

Notes

Ref	Indicator	Details
Thresholds	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%.	
1a	Data Completeness: Community Services	Data completeness levels for trusts commissioned to provide community services, using Community Information Data Set (CIDS) definitions, to consist of: - Referral to treatment times – consultant-led treatment in hospitals and Allied Healthcare Professional-led treatments in the community; - Community treatment activity – referrals; and - Community treatment activity – care contact activity. While failure against any threshold will score 1.0, the overall impact will be capped at 1.0. Failure of the same measure for three quarters will result in a red-rating. **Numerator:** all data in the denominator actually captured by the trust electronically (not solely CIDS-specified systems). **Denominator:** all activity data required by CIDS.
1b	Data Completeness Community Services (further data):	The inclusion of this data collection in addition to Monitor's indicators (until the Compliance Framework is changed) is in order for the SHA to track the Trust's action plan to produce such data. This data excludes a weighting, and therefore does not currently impact on the Trust's governance risk rating.
1c	Mental Health MDS	Patient identity data completeness metrics (from MHMDS) 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. (For details of how data items are classified as VALID please refer to the data quality constructions available on the Information Centre's website: www.ic.nhs.uk/services/mhmds/dq) **Denominator:** total number of entries.
1d	Mental Health: CPA	**Outcomes for patients on Care Programme Approach:** • Employment status: **Numerator:** the number of adults in the denominator whose employment status is known 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 month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Accommodation status: **Numerator:** the number of adults in the denominator whose accommodation status (i.e. settled or non-settled accommodation) is known 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 month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Having a Health of the Nation Outcome Scales (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. **Denominator:** The total number of adults who have received secondary mental health services and who were on the CPA during the reference period.
2a-c	RTT	Performance is measured on an aggregate (rather than specialty) basis and trusts are required to meet the threshold on a monthly basis. Consequently, any failure in one month is considered to be a quarterly failure. Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process. Will apply to consultant-led admitted, non-admitted and incomplete pathways provided. While failure against any threshold will score 1.0, the overall impact will be capped at 2.0. The measures apply to acute patients whether in an acute or community setting. Where a trust with existing acute facilities acquires a community hospital, performance will be assessed on a combined basis. The SHA will take account of breaches of the referral to treatment target in 2011/12 when considering consecutive failures of the referral to treatment target in 2012/13. For example, if a trust fails the 2011/12 admitted patients target at quarter 4 and the 2012/13 admitted patients target in quarters 1 and 2, it will be considered to have breached for three quarters in a row.
2d	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 (DH, 2008): a) Does the 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 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 trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? d) Does the trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? e) Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers? f) Does the 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: trust boards are required to certify that their trusts meet requirements a) to f) above at the annual plan stage and in each month. Failure to do so will result in the application of the service performance score for this indicator.
3a	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. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter.. Will apply to any community providers providing the specific cancer treatment pathways
3b	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. 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. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. National guidance states that 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 the SHA receive evidence of 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. In the absence of any locally-agreed contractual arrangements, the SHA encourages trusts to work with other providers to reach a local system-wide agreement on the allocation of cancer target breaches to ensure that patients are treated in a timely manner. Once an agreement of this nature has been reached, the SHA will consider applying the terms of the agreement to trusts party to the arrangement.
3c	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. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways.

Notes

Ref	Indicator	Details
3d	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 fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. Specific guidance and documentation concerning cancer waiting targets can be found at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation
3e	A&E	Waiting time is assessed on a site basis: no activity from off-site partner organisations should be included. The 4-hour waiting time indicator will apply to minor injury units/walk in centres.
3f	Mental	7-day follow up: **Numerator**: the number of people under adult mental illness specialties on CPA 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 CPA who were discharged from psychiatric inpatient care. 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. 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. **Denominator:** the total number of adults who have received secondary mental health services during the reporting period (month) who had spent at least 12 months on CPA (by the end of the reporting period OR when their time on CPA ended). For full details of the changes to the CPA process, please see the implementation guidance Refocusing the Care Programme Approach on the Department of Health's website.
3g	Mental Health: DTOC	**Numerator:** the number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed during the month. For example, one patient delayed for five days counts as five. **Denominator:** the total number of occupied bed days (consultant-led and non-consultant-led) during the month. Delayed transfers of care attributable to social care services are included.
3h	Mental Health: I/P and CRHT	This indicator applies only to admissions to the foundation trust's mental health psychiatric inpatient care. The following cases can be excluded: - planned admissions for psychiatric care from specialist 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. The indicator applies to users of working age (16-65) only, unless otherwise contracted. 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 this guidance, the crisis resolution home treatment team should: a) provide a mobile 24 hour, seven days 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.
3i	Mental Health	Monthly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.
3j-k	Ambulance Cat A	For patients with immediately life-threatening conditions. The Operating Framework for 2012-13 requires all Ambulance Trusts to reach 75 per cent of urgent cases, Category A patients, within 8 minutes. From 1 June 2012, Category A cases will be split into Red 1 and Red 2 calls: • Red 1 calls are patients who are suffering cardiac arrest, are unconscious or who have stopped breathing. • Red 2 calls are serious cases, but are not ones where up to 60 additional seconds will affect a patient's outcome, for example diabetic episodes and fits. Ambulance Trusts will be required to improve their performance to show they can reach 80 per cent of Red 1 calls within 8 minutes by April 2013.
4a	C.Diff	Will apply to any inpatient facility with a centrally set C. difficile objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Both avoidable and unavoidable cases of C. difficile will be taken into account for regulatory purposes. Where there is no objective (i.e. if a mental health trust without a C. difficile objective acquires a community provider without an allocated C. difficile objective) we will not apply a C. difficile score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of C. difficile is set at 12. However, Monitor may consider scoring cases of <12 if the Health Protection Agency indicates multiple outbreaks. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation. If the Health Protection Agency indicates that the C. difficile target is exceeded due to multiple outbreaks, while still below the de minimis, the SHA may apply a score.
4b	MRSA	Will apply to any inpatient facility with a centrally set MRSA objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Those trusts that 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 the Department of Health. We expect those trusts without a centrally calculated MRSA objective as a result of being in the best performing quartile to agree an MRSA target for 2012/13 that at least maintains existing performance. Where there is no objective (i.e. if a mental health trust without an MRSA objective acquires a community provider without an allocated MRSA objective) we will not apply an MRSA score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of MRSA is set at 6. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation