The Royal Wolverhampton Hospitals NHS Trust	

Trust Board Report

Meeting Date:	26th November 2012
Title:	Performance Report
Executive Summary:	This report provides the Board with an update of performance against national and local performance indicators for October 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 • Exception Reports (Red rated PIs) • Provider Management Regime (Appendix 1) In addition to the overview of performance this report also includes the National NHS Performance Framework results for the Trust. This is Quarter 1 data and was published by the Department of Health on 18th October 2012.

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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.

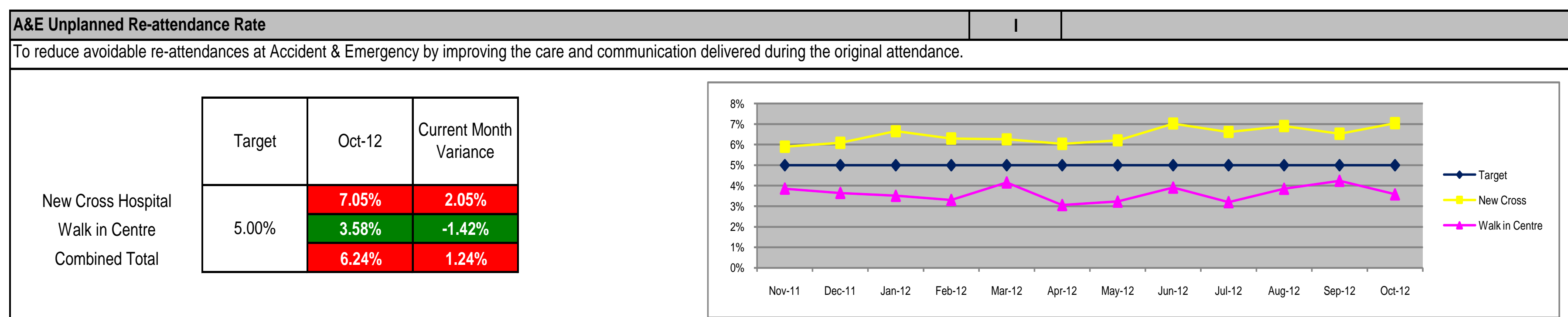
Theme	Red	Amber	Green	Total
Monitor Compliance Framework There are 19 indicators measured in this section, covering C Difficile, MRSA, Cancer Waits, Accident & Emergency (4 hour), RTT and Data Completeness	1	0	18	19
Service Delivery There are 30 (2 of which are monitoring only) indicators in this section, 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	1	19	28
Workforce This section is measured by 14 different indicators covering, Recruitment and Retention, Turnover, Sickness Absence, Temporary Staffing (agency), and Education & Training	3	5	6	14
Totals	12	6	43	61
Last Month	16	5	40	61
Trend **(arrow indicates measure of improvement. i.e. ↑ is getting better)**	↑	↓	↑	

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

Monitor Compliance Framework (Learning Disability) – The trust has been unsuccessful in recruiting to Specialist Nurse – Learning Disabilities following two rounds of applications, this has led to slippage against some of the deliverables around the development of Learning Disability specific leaflets and the ongoing role out of specialist staff training.

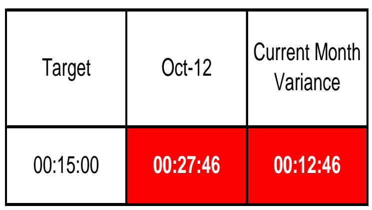


A&E Unplanned Re-attendance Rate	I	
To reduce avoidable re-attendances at Accident & Emergency by improving the care and communication delivered during the original attendance.		

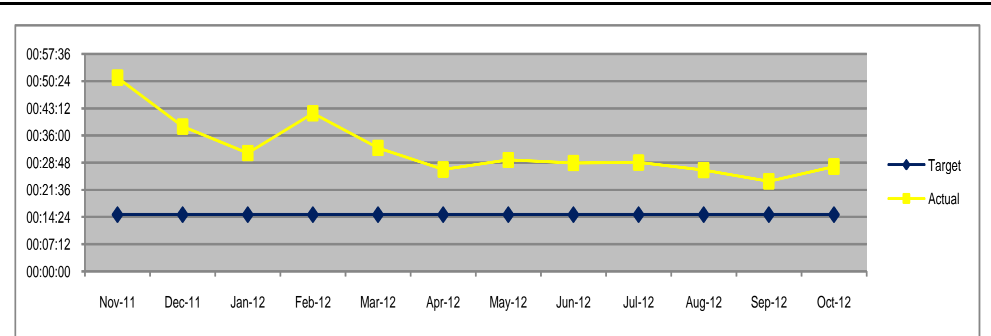
	Target	Oct-12	Current Month Variance
New Cross Hospital	5.00%	7.05%	2.05%
Walk in Centre		3.58%	-1.42%
Combined Total		6.24%	1.24%

Analysis: Combined organisation total shows we remain above target by 1.24%, this is a deterioration of 0.21% from September's position. The workshop set up for cross party working to target high attenders met in October, work is underway to collect data and identify patients who frequently make contact with specific organsiations along with those who access multiple agencies on a regular basis.

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.		



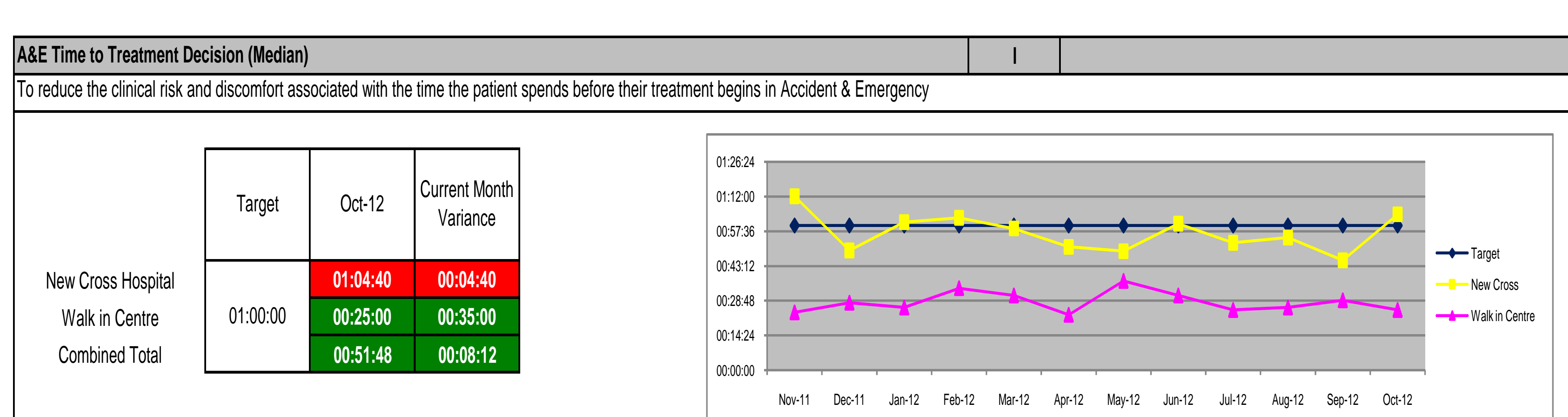
Target	Oct-12	Current Month Variance
00:15:00	00:27:46	00:12:46



Analysis: We have seen a slight deterioration in this target, we remain above target by 00:12:46 minutes. The department has enlisted the help of the service re-design team to undertake a time and motion study within the department to highlight problems and support any the changes that are identified in order to move forward with achieving and sustaining this indicator.

A&E Time to Treatment Decision (Median)	I	

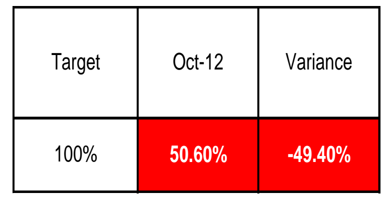
To reduce the clinical risk and discomfort associated with the time the patient spends before their treatment begins in Accident & Emergency



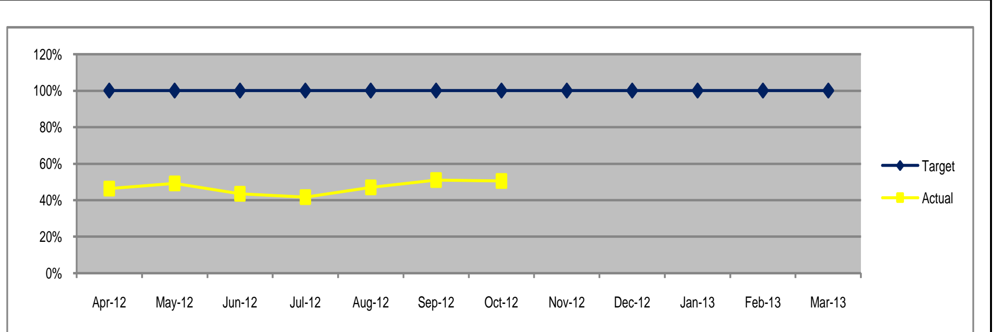
	Target	Oct-12	Current Month Variance
New Cross Hospital	01:00:00	01:04:40	00:04:40
Walk in Centre		00:25:00	00:35:00
Combined Total		00:51:48	00:08:12

Analysis: Although we did not achieve the target for New Cross during the month of October the combined organisation total remains below target by 8 minutes.

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



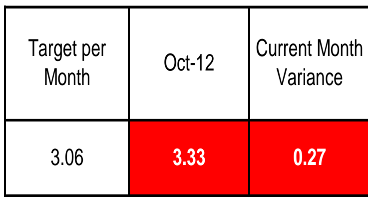
Target	Oct-12	Variance
100%	50.60%	-49.40%



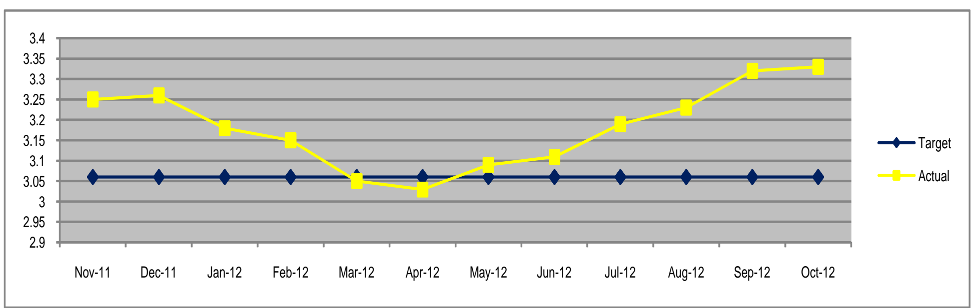
Analysis: Work is ongoing with daily meetings now being held, issues are being investigated regarding the network speed and links to other systems. Incremental improvements are expected throughout the calendar year. Performance continues to be monitored weekly at the Divisional Managers Meeting.

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 2012/13 remains unchanged pending the commencement of the capacity and demand project.



Target per Month	Oct-12	Current Month Variance
3.06	3.33	0.27



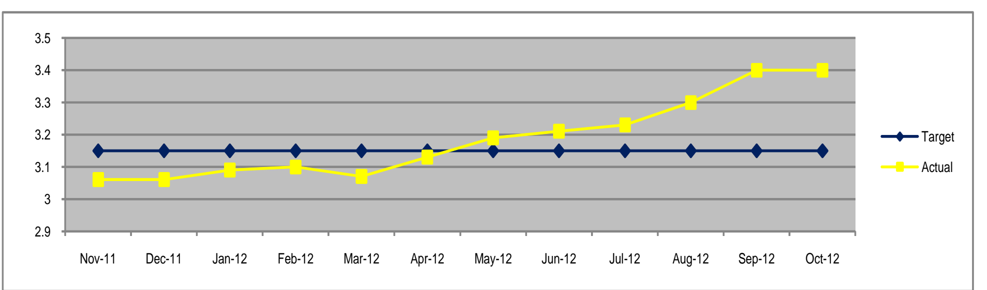
Analysis: This is a very slight deterioration from the September position of 3.32, we remain above target by 0.27. Areas that have seen an increase in length of stay during October are:- Oral Surgery/Maxillo Facial, Cardiac Surgery, Thoracic Surgery, Renal and Rheumatology.

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 2012/13 remains unchanged pending the commencement of the capacity and demand project.

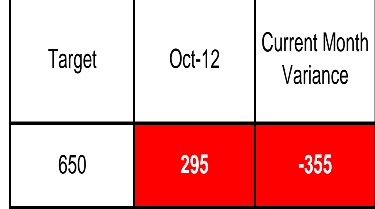
Target per Month	Oct-12	Current Month Variance
3.15	3.40	0.25



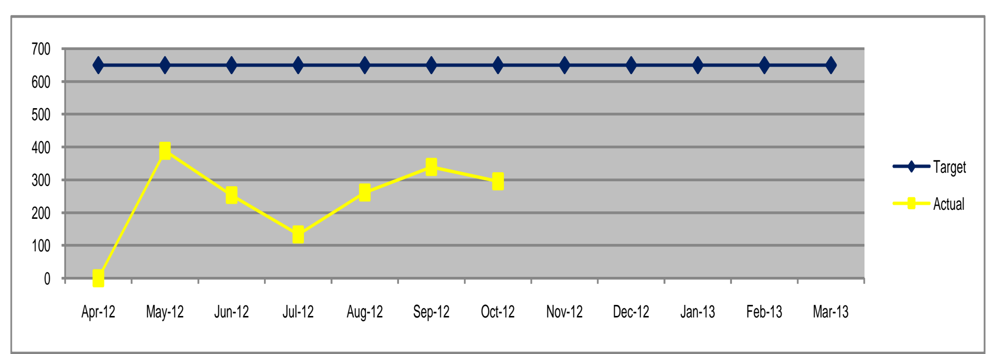
Analysis: This is a static position from the one reported in September of 3.40, we remain above target by 0.25. Areas that have seen an increase in length of stay during October are:- Orthopaedics, Cardiac Surgery, Thoracic Surgery, and Clinical Oncology

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

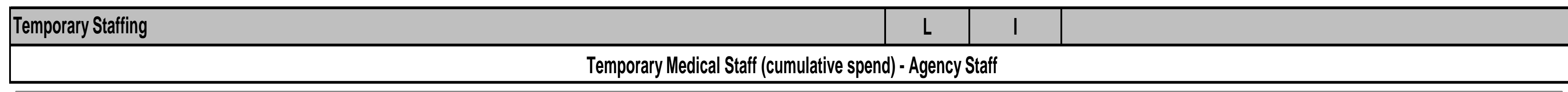
Number of People offered an NHS Health Check



Target	Oct-12	Current Month Variance
650	295	-355

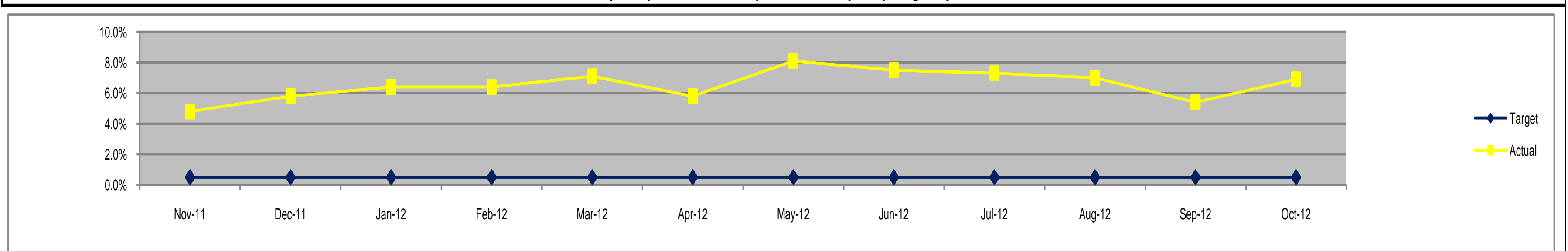


Analysis: This is a slight deterioration from the position reported in September (339). A comprehensive recovery action plan has been produced to recover this position, this includes a focus on local businesses who employ large numbers of staff.



Temporary Staffing | L | I

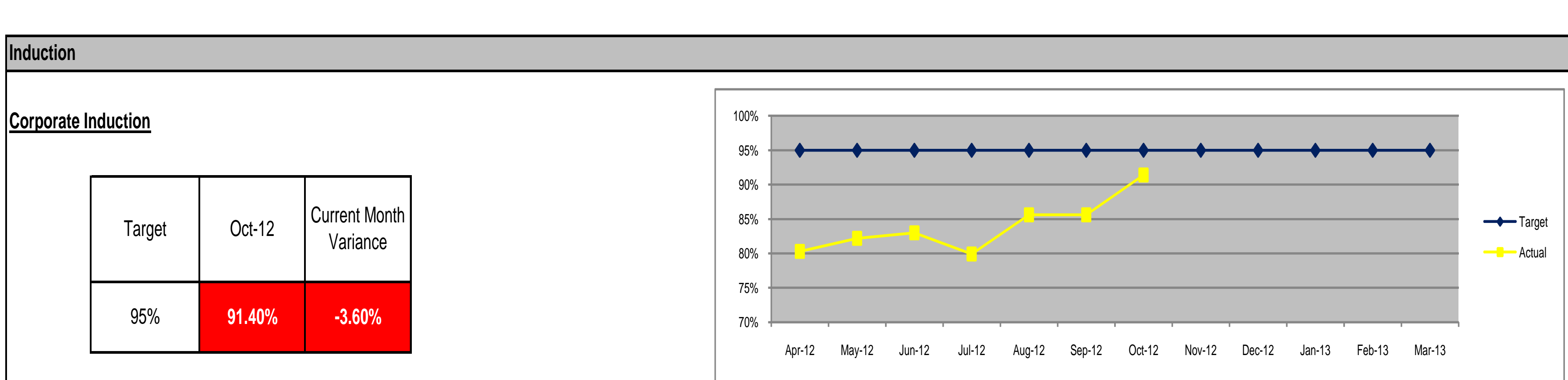
Temporary Medical Staff (cumulative spend) - Agency Staff



Analysis: Medical agency costs for October saw an increase in month from 5.4% in September to 6.9% in October. **Surgical Division** has seen an increase in month from £44K in September to £72K in October. Agency expenditure was high in Head & Neck due to the use of a locum to cover maternity leave, Urology was high due to the use of a locum consultant to cover the 5th substantive post (appointee commences in February). Ophthalmology remains high due to the use of locums to cover a vacancy and sickness within the department. **Medical Division** also saw an increase in month from £233K in September to £275K in October. A&E has remained high due vacancies at Consultant and Middle Grade level, these posts are being re-advertised. Clinical Haematology has remained high during October due to the continuing use of a Locum Consultant to cover long term sick leave within the Specialty, an ongoing return to work programme is in place, Stroke was high due to the use of locum to cover sick leave.

Induction

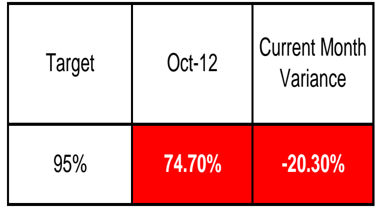
Corporate Induction



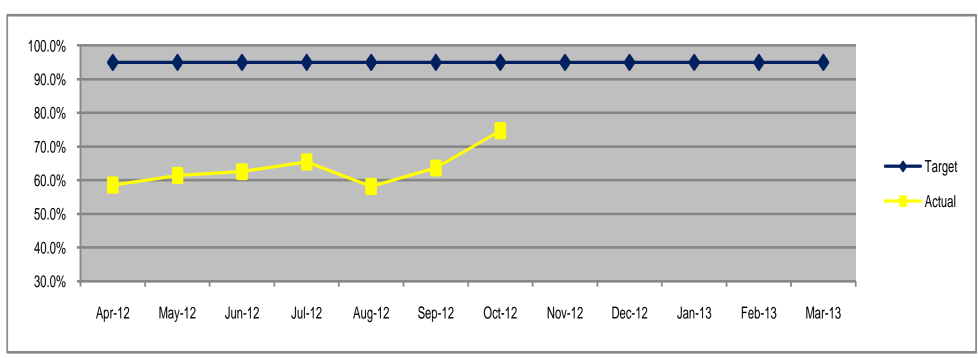
Target	Oct-12	Current Month Variance
95%	91.40%	-3.60%

Analysis: This is an improvement from the position reported in September of 85.6%. 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** - 90.15% (26), **Medical Division** - 93.46% (21), **Estates & Facilities** - 93.94% (2) and **Corporate** - 85.07% (10)

Local Induction



Target	Oct-12	Current Month Variance
95%	74.70%	-20.30%



Analysis: This is an improvement from the position of 63.7% reported in September. 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** - 77.27% (60), **Medical Division** - 67.29% (105), **Estates and Facilities** - 93.94% (2) and **Corporate** - 91.04% (6)

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Overview Reports

Full details of the Provider Management Regime can be found at Appendix 1.

Special Reports

National NHS Performance Framework – Quarter 4 overall results

Indicator	Scoring	Assessment
Overall Finance	3	Performing
Integrated Performance Measures	2.79	Performing
Registration	3	Performing
User Experience	5	Performing
Overall Quality		Performing

RWHT is reported as 'performing'. A position which has remained unchanged from the opening assessment in Quarter 4 2008/09. Across our region the following surrounding Trust's are reported as:-

'Performance Under Review' – for the following measures:-

- George Eliot Hospital – Quality: User Experience
- Wye Valley NHS Trust – Overall Finance Score and Quality: User Experience

No surrounding Trust's are reported as **'Under Performing'**

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

Returns to XXX by the last working day of each month

TFA Progress

Oct-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:	October 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)	advised to leave blank by SHA

*** 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:	Chief Executive	
Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:	Chairman	

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 Mar-12	Historic Data: Qtr to Jun-12	Historic Data: Qtr to Sep-12	Current Data: Oct-12	Current Data: Nov-12	Current Data: Dec-12	Current Data: Qtr to Dec-12	Comments where target not achieved
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information Referral information Treatment activity information	50% 50% 50%	1.0		Yes	Yes	Yes			Yes	
	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	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	
	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	
	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	
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes	Yes	No			No	Failure to recruit to new Learning Disability Nurse following two rounds of applications. Review underway and looking to appoint in December
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising :	Surgery Anti cancer drug treatments Radiotherapy	94% 98% 94%	1.0	Yes	Yes	Yes	Yes			Yes	
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer From NHS Cancer Screening Service referral	85% 90%	1.0	Yes	Yes	Yes	Yes			Yes	
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes			Yes	
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals for symptomatic breast patients (cancer not initially suspected)	93% 93%	0.5	Yes	Yes	Yes	Yes			Yes	
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	Yes	Yes	Yes	Yes			Yes	
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge Having formal review within 12 months	95% 95%	1.0		N/a	N/a	N/a			Yes	
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0		N/a	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	N/a			Yes	
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5		N/a	N/a	N/a			Yes	
	3j	Category A call – emergency response within 8 minutes		75%	1.0		N/a	N/a	N/a			Yes	
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0		N/a	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	Yes			Yes	
	4b	MRSA	Are you below the ceiling for your monthly trajectory	*Enter contractual ceiling*	1.0	Yes	Yes	No	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	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	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	
				TOTAL		**1.0**	**0.0**	**1.0**	**0.5**	**0.0**	**0.0**	**0.5**	

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**

Ref	Overriding Rules - Nature and Duration of Override at SHA's Discretion		Qtr to Mar-12	Qtr to Jun-12	Qtr to Sep-12	Oct-12	Nov-12	Dec-12	Qtr to Dec-12	Comments
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

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Reported Position: Year to Date	Reported Position: Forecast Outturn	Normalised Position*: Year to Date	Normalised Position*: 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	4	4	4	4	
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	3	3	3	
Weighted Average		**100%**						**3.7**	**3.8**	**3.7**	**3.8**	
Overriding rules												
Overall rating								**4**	**4**	**4**	**4**	

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

Overriding Rules :

Max Rating	Rule		Year to Date	Forecast Outturn	Year to Date	Forecast Outturn
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: Qtr to Mar-12	Historic Data: Qtr to Jun-12	Historic Data: Qtr to Sep-12	Current Data: Oct-12	Current Data: Nov-12	Current Data: Dec-12	Current Data: Qtr to Dec-12	Comments where risks are triggered
1	Unplanned decrease in EBITDA margin in two consecutive quarters	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	
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	
5	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	No			No	
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No			No	
7	Interim Finance Director in place over more than one quarter end	No	No	No	No			No	
8	Quarter end cash balance <10 days of operating expenses	No	No	No	No			No	
9	Capital expenditure < 75% of plan for the year to date	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 Mar-12	Qtr to Jun-12	Qtr to Sep-12	Oct-12	Nov-12	Dec-12	Qtr to Dec-12	
Are the prior year contracts* closed?	Yes	Yes	Yes	Yes			Yes	
Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes			Yes	
Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes			Yes	
Are there any disputes over the terms of the contract?	No	No	No	No			No	
Might the dispute require SHA intervention or arbitration?	No	No	No	No			No	
Are the parties already in arbitration?	No	No	No	No			No	
Have any performance notices been issued?	No	No	No	Yes			Yes	The commissioner has agreed the recovery action plan
Have any penalties been applied?	No	No	No	No			No	

QUALITY

The Royal Wolverhampton NHS Trust

Insert Performance in Month

	Criteria	Unit	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-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	100.0	100.0	Q1-Q3 2011/12 show the Trust's SHMI to be at 100 2011/12 final HSMR is 100
2	Venous Thromboembolism (VTE) Screening	%		91.89	95.83	94.67	96.09	96.25	96.61	94.4	96.75	95.45	95.6	96.07	
3a	Elective MRSA Screening	%		100	100	100	100	100	100	100	100	100	100	100	
3b	Non Elective MRSA Screening	%		100	100	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	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number		75	85	74	84	102	101	117	111	140	93	67	Total number of SUI's open on STEIS - 67, number over 45 days - 14 (SHA reported figure)
6	"Never Events" in month	Number		0	1	0	1	1	1	0	0	0	0	0	
7	CQC Conditions or Warning Notices	Number		0	0	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	5	10	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	N/A	N/A	
10	Falls resulting in severe injury or death	Number		4	1	0	0	0	2	4	2	1	2	0	
11	Grade 3 or 4 pressure ulcers	Number		19	5	11	12	10	14	18	12	16	12	14	
12	100% compliance with WHO surgical checklist	Y/N		No	No	No	No	No	No	Yes	Yes	Yes	Yes	Yes	
13	Formal complaints received	Number		33	32	62	42	26	43	34	54	35	48	51	
14	Agency as a % of Employee Benefit Expenditure	%		2.9	2.9	3	3	3.1	3.03	3.16	3.6	3.3	3.2	3.2	
15	Sickness absence rate	%		4.55	5.41	5.27	5.08	4.46	4.53	4.11	4.76	4.45	3.98	4.02	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%		71.9	71.6	70.7	67.8	68.9	80.3	78.9	73.4	74	71.1	76.1	

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