The Royal Wolverhampton Hospitals NHS Trust

NHS

Trust Board Report

Meeting Date:	25th February 2013
Title:	Performance Report
Executive Summary:	This report provides the Board with an update of performance against national and local performance indicators for January 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 2 data and was published by the Department of Health on 18th January 2013.

3	**Performance Report Dashboard**

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.

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	3	0	16	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	9	1	18	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	15	6	40	61
Last Month	16	5	40	61
Trend **(arrow indicates measure of improvement. i.e. ↑ is getting better)**	↑	↓	←	

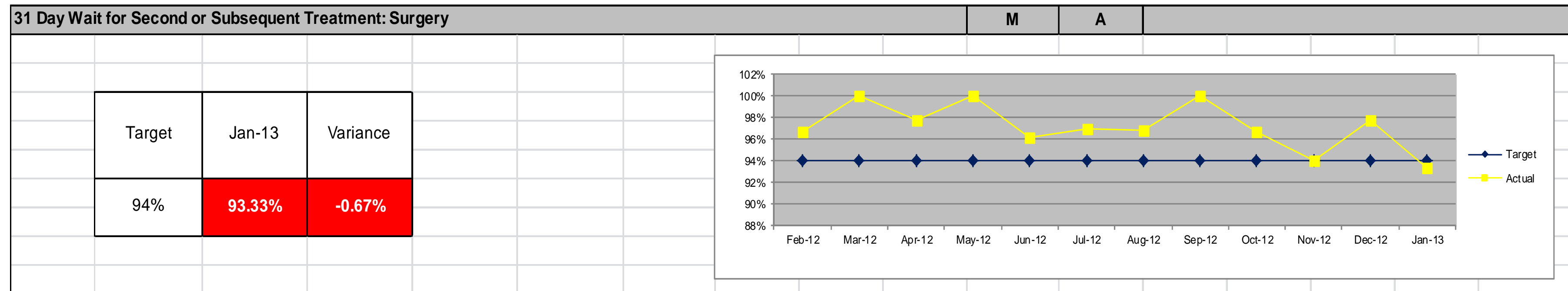
PLEASE NOTE: The Monitor Compliance Framework indicators are included in the summary dashboard above, however, they are also separated out in the Provider Management Regime report (Appendix 1) as this is a requirement for SHA monitoring purposes.

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. Further interviews to recruit to this post are being held during February.

31 Day Wait for Second or Subsequent Treatment: Surgery	M	A

Target	Jan-13	Variance
94%	93.33%	-0.67%



Analysis: This indicator narrowly missed the agreed tarectory by 0.67%. The numbers involved are very small and only two patients were treated outside of the agreed standard. Both of these patients elected to have robotic surgery for which there is currently a longer wait than standard surgery, this is due to limited availability for robotic surgery.

1.4	Accident & Emergency - 4 Hour Wait

95% of patients accessing emergency services (including A&E Departments and PCT Walk-in Centre) should spend no more than four hours in the 'department' from their arrival to admission, transfer or discharge. The 5% tolerance is in place to reflect the complexity of clinical condition.

	Target	Jan-13	Current Month Variance	Year to Date	Variance
New Cross Hospital	95%	91.90%	-3.10%	94.78%	-0.22%
Walk-in Centre	95%	100.00%	5.00%	100.00%	5.00%
Overall	95%	93.99%	-1.01%	96.09%	1.09%

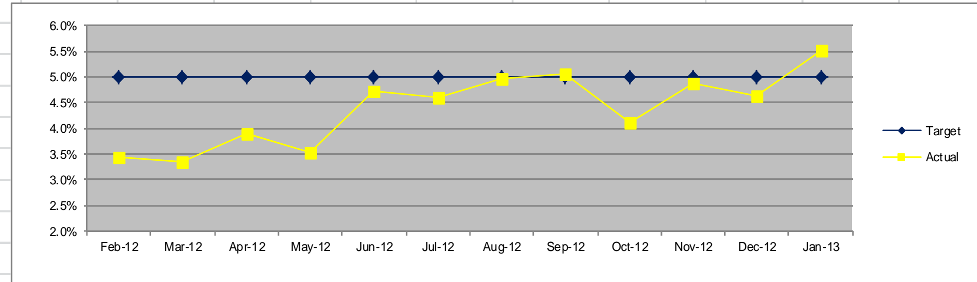
Analysis: The analysis above shows RWT internal performance, Walk-in Centre performance and the overall health economy position, in month and year to date.

Reduce Delays in Transfer of Care

Reducing delays in transfer of care will enable us to measure the impact of community based care in facilitating timely discharge from hospital and the mechanisms in place within the hospital to facilitate timely discharge.

National Target

	Target	Jan-13	Variance
New Cross	5%	5.52%	0.52%
West Park	35	30	-5

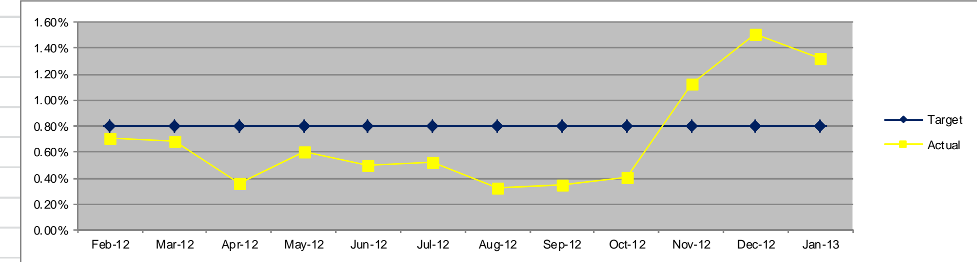


Analysis: This is a deterioration in month and has taken us over target by 0.52%.

Short Notice Cancellation of Operations | L | A

The aim of this measure is to reduce the number of operations cancelled at short notice for non-medical reasons. Short notice is defined as "on the day of procedure or day of admission". Short notice cancellation not only leads to poor patient experience but also results in a loss of operating capacity. When a patient's operation is cancelled by the hospital at the last minute for non clinical reasons, we must offer another binding date within a maximum of the next 28 days or fund the patient's treatment at the time and hospital of the patient's choice - a potential further cost to the organisation.

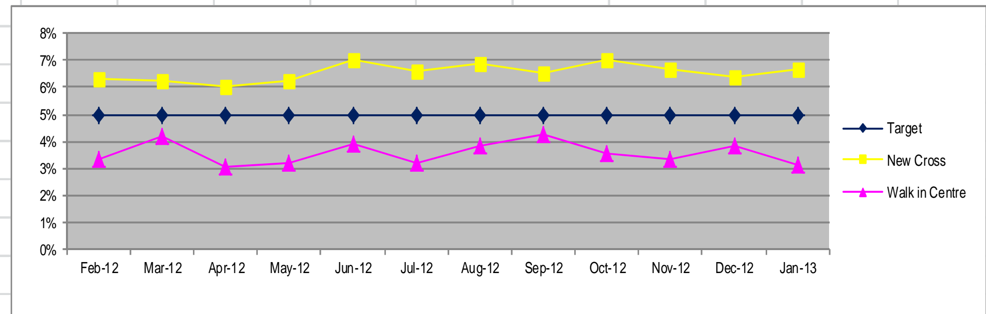
Monthly Target	Nov 12 Actual	Dec 12 Actual	Jan 13 Actual
0.80%	1.13%	1.51%	1.32%



Actions: 89 operations were cancelled during January, this is a very slight improvement from 93 in December. A root cause analysis continues to be undertaken for every cancelled operation to ensure that systems can be put in place to minimise cancellations for non-medical reasons therefore improving the patient experience. The highest number of cancelled operations were due to lack of beds, this reflects the continuing operational pressures within the Trust.

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.		

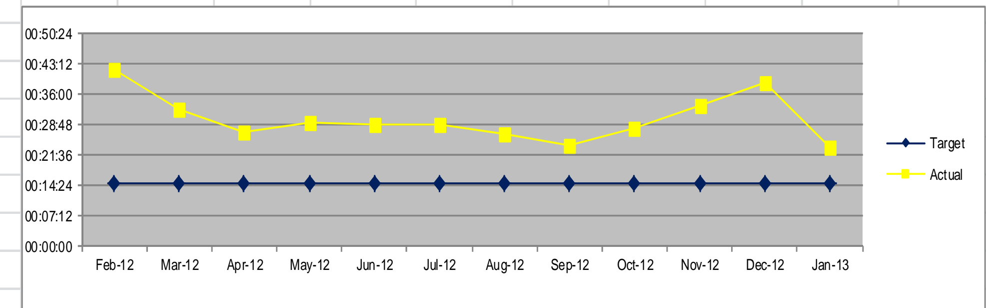
	Target	Jan-13	Current Month Variance
New Cross Hospital	5.00%	6.67%	1.67%
Walk in Centre		3.11%	-1.89%
Combined Total		5.77%	0.77%



Analysis: Combined organisation total saw a deterioration in month, this has taken us above target by 0.77%.

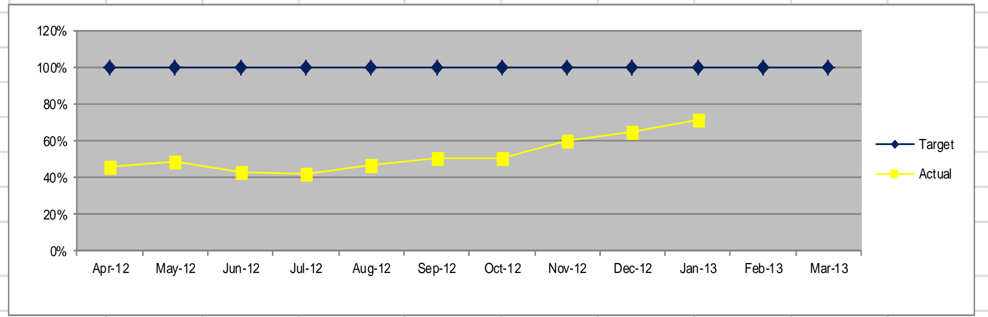
A&E Time to Initial Assessment (for ambulance patients)	A	
To reduce the clinical risk associated with the time the patient spends unassessed in Accident & Emergency. Time from arrival to start of full initial assessment.		

Target	Jan-13	Current Month Variance
00:15:00	00:23:39	00:08:39



Analysis: We have seen a significant improvement in this target, we remain above target by 00:08:39 minutes. A dedicated nurse has been assigned to a Majors Triage role greeting ambulance crews to take handover of the patients using a portable computer, the continued increase in ambulances arriving at the department means that further work needs to be done to ensure consistency and sustainability.

Percentage of GP's who receive Correspondence within 24 Hours of Discharge			
	Target	Jan-13	Variance
	100%	71.40%	-28.60%
Jan action plan target	80%	80.50%	0.50%

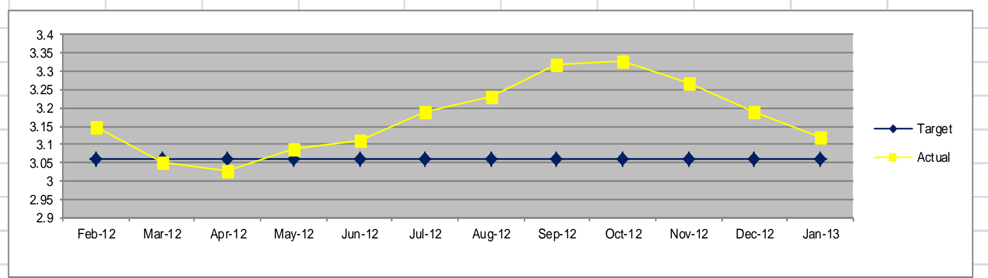


Analysis: A recovery action plan has been produced which is being monitored by the Commissioner. All targets for January have been met and we are currently working towards the February milestone. Further improvements have been seen during January, this is largely around those areas where sign off for all 3 elements of e-discharge was problematic. The recovery action plan contains targets identified by the commissioner that corresponds to the improvement plan. The target for January is 80%, February 90% and March 100%. The target relates to all areas identified as "in-scope" for e-discharge, at this stage PAU is excluded as it forms part of the day case solution, this explains the difference between the two reported figures. Performance continues to be reported and 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	Jan-13	Current Month Variance
3.06	3.12	0.06



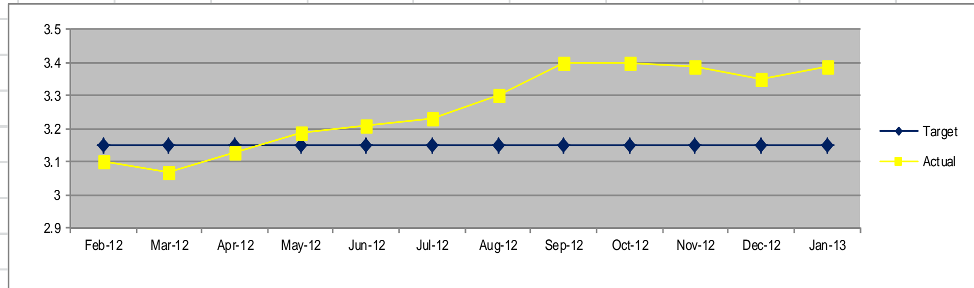
Analysis: This is an improvement from the December position of 3.19, however, we remain above target by 0.06. Most areas have seen a decrease in length of stay during January.

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	Jan-13	Current Month Variance
3.15	3.39	0.24

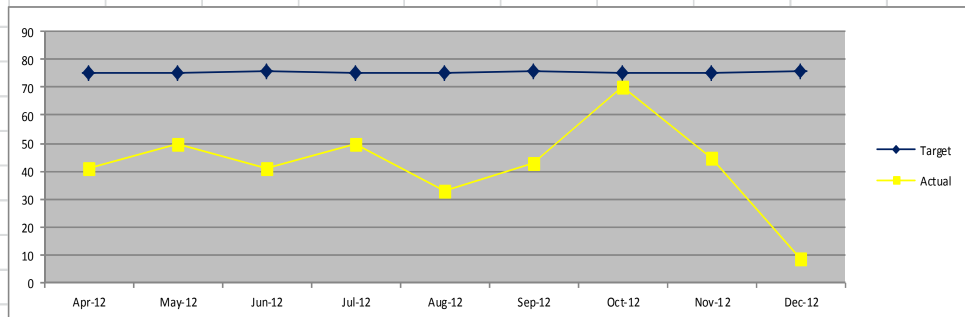


Analysis: This is a slight deterioration from the position reported in December of 3.35, we remain above target by 0.24. Areas that have seen an increase in length of stay during January are:- Cardiac Surgery, Thoracic Surgery and Oncology.

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

Smoking Quitters	C

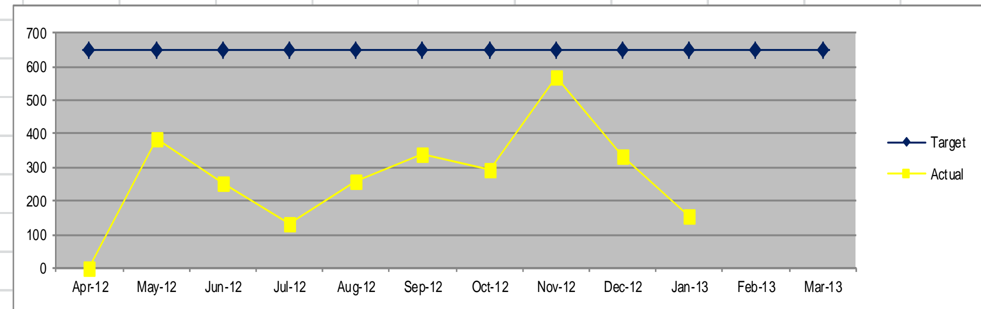
	Annual Target	Cum Plan	Cum Actual	Cum Variance
Smoking Service	1043	678	382	-296
Contracted Value	2043	1328	816	-512



Analysis: Skills development and training completed for intermediate advisors. Training is in progress to develop smoking cessation as a core skill for all staff. Advertising/marketing continues with a focus on the no smoking week in march. Additional clinics have been arranged as part of this campaign.

Number of People offered an NHS Health Check

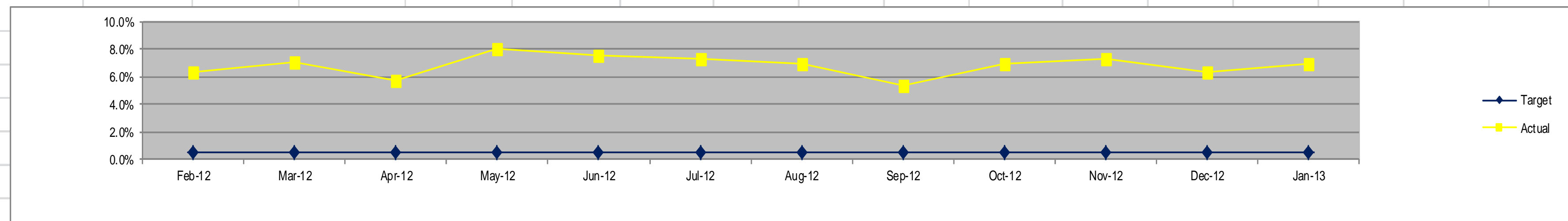
Target	Jan-13	Current Month Variance
650	157	-493



Analysis: This is a deterioration from the position reported in December (335). Meeting have been held with the local GP's and re-profiling has been undertaken to identify the number of Health Check invites per practice. The service was been invited to TATA and the local Authority to perform health checks.

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

Temporary Medical Staff (cumulative spend) - Agency Staff

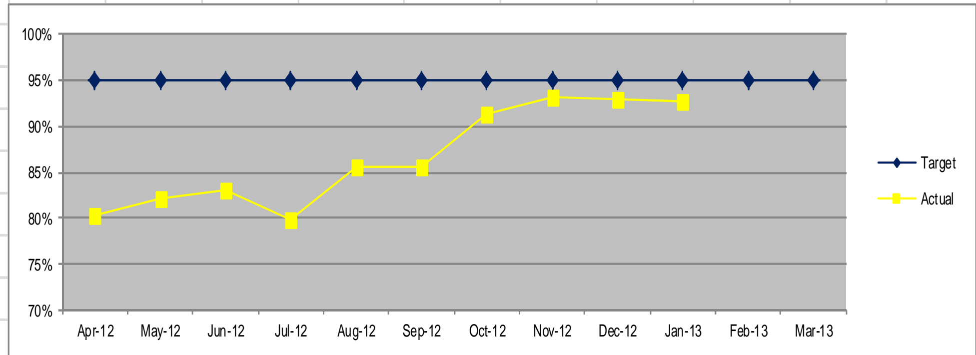


Analysis: Medical agency costs for January saw an increase in month from 6.4% in December to 6.9% in January. **Surgical Division saw** an increase in month from £48K in December to £55K in January. Agency expenditure remained high in Head & Neck due to the use of a locum to cover maternity leave, Ophthalmology also remained high due to the continuing use of locums to cover a vacancy and sickness within the department. **Medical Division** also saw an increase in month from £272K in December to £302K in January. 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 January due to the continuing use of a Locum Consultant to cover long term sick leave within the Specialty, an on-going return to work programme is in place, Stroke also continues to be high due to the use of locum to cover sick leave.

Induction

Corporate Induction

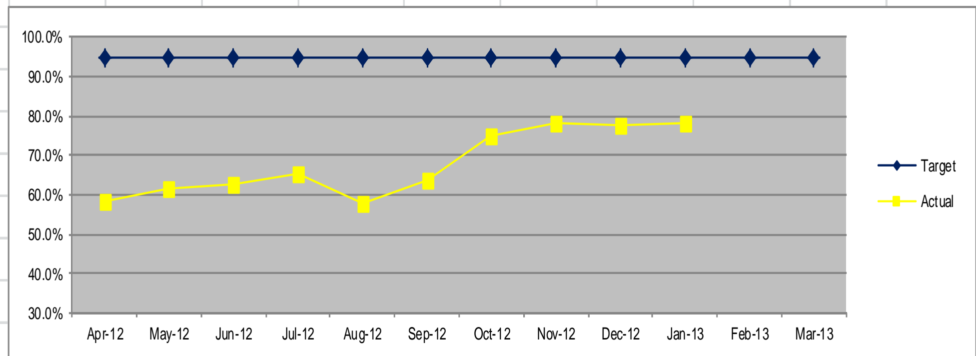
Target	Jan-13	Current Month Variance
95%	92.80%	-2.20%



Analysis: This is a very slight improvement from the position reported in December of 93%. 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** - 92.9% (18), **Estates & Facilities** - 90.9% (3) and **Corporate** - 84% (12)

Local Induction

Target	Jan-13	Current Month Variance
95%	78.10%	-16.90%



Analysis: This is an improvement from the position of 77.5% reported in December. 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** - 80.6% (49), **Medical Division** - 74% (83), **Estates & Facilities** - 87.9% (4) and **Corporate** - 82.7% (13)

5

Overview Reports

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

Special Reports

National NHS Performance Framework – Quarter 2 overall results

Indicator	Scoring	Assessment
Overall Finance	3	Performing
Integrated Performance Measures	2.75	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 NHS Trust – Overall Finance and Quality: User Experience
- Shrewsbury & Telford Hospital NHS Trust – Overall Quality Score and Quality: Integrated Performance Measures
- University Hospital of North Staffordshire NHS Trust – Overall Finance Score
- 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:
January 2013
NHS Trust Over-sight self certification template

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

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

Name of Organisation:	The Royal Wolverhampton NHS Trust	Period:	January 2013

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)	AR
Normalised YTD Financial Risk Rating (Assign number as per SOM guidance)	4

*** Please type in R, AR, AG or G and assign a number for the FRR**

Governance Declarations

Declaration 1 or declaration 2 reflects whether the Board believes the Trust is currently performing at a level compatible with FT authorisation.

Supporting detail is required where compliance cannot be confirmed.

Please complete **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 sufficiently assured in its ability to declare conformity with **all** of the Clinical Quality, Finance and Governance elements of the Board Statements.

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

At the current time, the board is yet to gain sufficient assurance to declare conformity with all of the Clinical Quality, Finance and Governance elements of the Board Statements.

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:	Vice Chair	

If Declaration 2 has been signed:

For each target/standard, 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:	**14. All directors have the appropriate qualifications, experience and skills.**
The Issue :	**Following Monitor's deferral of the Trust's application and the resignation of the Chair the Board is unable to**
Action :	**An outline action plan was approved by the Board at its meeting on 29th October covering the following**

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Board Statements

The Royal Wolverhampton NHS Trust
January 2013

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 SOM's Oversight 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 registration requirements.	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 at all times 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 occurrence 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 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 Governance Risk Rating; and a commitment to comply with all commissioned targets going forward.	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, and that any elections to the shadow board of governors are held in accordance with the election rules.	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.	No
15	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual plan; and the management structure in place is adequate to deliver the annual plan.	Yes

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

QUALITY

Information to inform discussion meeting

The Royal Wolverhampton NHS Trust

Insert Performance in Month

	Criteria	Unit	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Board Action
1	SHMI - latest data	Score	109.9	109.9	108.5	108.5	98.2	98.2	100.0	100.0	100.0	102.5	100.1	99.9	SHMI figures is October 2011 to September 2012
2	Venous Thromboembolism (VTE) Screening	%	94.67	96.09	96.25	96.61	94.4	96.75	95.45	95.6	96.07	95.87	96.18	97.09	
3a	Elective MRSA Screening	%	100	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	100	
4	Single Sex Accommodation Breaches	Number	0	0	0	0	0	3	0	5	0	0	3	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	74	84	102	101	117	111	140	93	67	77	62	38	Total number of SUI's open on STEIS - 38, number over 45 days - 8 (SHA reported figure)
6	"Never Events" occurring in month	Number	0	1	1	1	0	0	0	0	0	1	0	0	The CQC conducted an unannounced inspection on 25th January. Initial feedback was extremely positive in particular around Nes and the WHO checklist
7	CQC Conditions or Warning Notices	Number	0	0	0	0	0	0	0	0	0	0	0	0	
8	Open Central Alert System (CAS) Alerts	Number	14	13	12	12	16	15	13	5	10	7	4	4	Total number of CAS alerts - 4, number overdue - 1 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	N/A	N/A	N/A	
10	Falls resulting in severe injury or death	Number	0	0	0	2	4	2	1	2	0	1	4	0	
11	Grade 3 or 4 pressure ulcers	Number	11	12	10	14	18	12	16	12	14	16	15	13	
12	100% compliance with WHO surgical checklist	Y/N	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
13	Formal complaints received	Number	62	42	26	43	34	54	35	48	51	34	21	30	
14	Agency as a % of Employee Benefit Expenditure	%	3	3	3.1	3.03	3.16	3.6	3.3	3.2	3.2	3.2	3.2	3.1	
15	Sickness absence rate	%	5.27	5.08	4.46	4.53	4.11	4.76	4.45	3.98	4.02	4.4	4.51	5.1	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%	70.7	67.8	68.9	80.3	78.9	73.4	74	71.1	76.1	81.5	83.1	85	

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	Board Action
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	5	5	5	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%**						**3.8**	**3.8**	**3.8**	**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					
3	Plan not submitted on time	No				
3	Plan not submitted complete and correct	No				
2	PDC dividend not paid in full	No				
2	Unplanned breach of PBC	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				Board Action
		Qtr to Jun-12	Qtr to Sep-12	Qtr to Dec-12	Jan-13	Feb-13	Mar-13	Qtr to Mar-13	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	No	No			No	
2	Quarterly self-certification by trust that the normalised 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	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
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	
10	Yet to identify two years of detailed CIP schemes	No	No	No	No			No	

GOVERNANCE RISK RATINGS

The Royal Wolverhampton NHS Trust

Insert YES, NO or N/A (as appropriate)

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

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Jun-12	Historic Data: Qtr to Sep-12	Historic Data: Qtr to Dec-12	Current Data: Jan-13	Current Data: Feb-13	Current Data: Mar-13	Current Data: Qtr to Mar-13	Board Action
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0		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	N/a	N/a	N/a	
			Patients dying at home / care home	50%			N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: identifiers MHMDS		97%	0.5		N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: outcomes for patients on CPA		50%	0.5		N/a	N/a	N/a	N/a	N/a	N/a	
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				
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	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				
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes	Yes	No				The Trust failed to recruit at the last round of interviews and is now looking at more robust interim arrangements to ensure compliance with this indicator
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising :	Surgery	94%	1.0	Yes	Yes	Yes	No				
			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				
			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				
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	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	No				The Trust continues to see significant increases in A&E attendences and ambulance numbers. An attachment has been provided showing the trend over the last year
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3j	Category A call – emergency response within 8 minutes	Red 1	80%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Red 2	75%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Safety	4a	Clostridium Difficile	Is the Trust below the de minimus	*12*	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Is the Trust below the YTD ceiling	*Enter contractual ceiling*		Yes	Yes	Yes	Yes				
	4b	MRSA	Is the Trust below the de minimus	*6*	1.0								The Trust has had 1 case and is below the de minimus
			Is the Trust below the YTD ceiling	*0*		Yes	Yes	No	No				
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No				
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	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				
				TOTAL		**0.0**	**0.0**	**0.0**	**2.5**	**0.0**	**0.0**	**0.0**	
						G	G	G	AR	G	G	G	

RAG RATING :

GREEN	**= Score less than 1**
AMBER/GREEN	**= Score greater than or equal to 1, but less than 2**
AMBER / RED	**= Score greater than or equal to 2, but less than 4**
RED	**= Score greater than or equal to 4**

GOVERNANCE RISK RATINGS

The Royal Wolverhampton NHS Trust

Insert YES, NO or N/A (as appropriate)

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

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Jun-12	Historic Data: Qtr to Sep-12	Historic Data: Qtr to Dec-12	Current Data: Jan-13	Current Data: Feb-13	Current Data: Mar-13	Current Data: Qtr to Mar-13	Board Action
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 breaches the cumulative year-to-date trajectory for three successive quarters										
	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 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: 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 either Red 1 or Red 2 targets 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 other Indicator weighted 1.0	Breaches the indicator for three successive quarters.										
			Adjusted Governance Risk Rating			0.0	0.0	0.0	2.5	0.0	0.0	0.0	
						G	G	G	AR	G	G	G	

CONTRACTUAL DATA

The Royal Wolverhampton NHS Trust

Information to inform discussion meeting

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

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Jun-12	Qtr to Sep-12	Qtr to Dec-12	Jan-13	Feb-13	Mar-13	Qtr to Mar-13	
1	Are the prior year contracts* closed?	Yes	Yes	Yes	Yes			Yes	
2	Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes			Yes	
3	Has the Trust received income support outside of the NHS standard contract e.g. transformational support?	No	No	No	No			No	
4	Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes			Yes	
5	Are there any disputes over the terms of the contract?	No	No	No	No			No	
6	Might the dispute require third party intervention or arbitration?	No	No	No	No			No	
7	Are the parties already in arbitration?	No	No	No	No			No	
8	Have any performance notices been issued?	No	No	Yes	No			No	
9	Have any penalties been applied?	No	No	No	No			No	

*All contracts which represent more than 25% of the Trust's operating revenue.

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