The Royal Wolverhampton Hospitals NHS Trust	

Trust Board Report

Meeting Date:	27th February 2012
Title:	Performance Report
Executive Summary:	This report provides the Board with an update of performance against national and local performance indicators. This includes the Monitor Compliance Framework and DH requirements. 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. To approve the Board Statements in the Provider Management Regime self certification and give delegated authority to the Chairman and Chief Executive to sign the return on behalf of the Board.
Report of:	Chief Operating Officer
Author: **Contact Details:**	Head of Performance & Compliance Tel: 01902 694366Email: 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). Further indicators have been added this month, as a result of the development of the Provider Management Regime. They include:- • Smoking Cessation • Human Papillomavirus (HPV) 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) • Activity Dashboard (community activity only) • Board Statement in relation to self certification as part of the Provider Management Regime (Appendix 1) In addition to the overview of performance this report also includes the following summary reports: 1. Narrative detailing the new Provider Management Regime (PMR) for Aspirant Foundation Trusts. This will now be included as an appendix to this report and replaces the current Monitor Compliance Framework performance dashboard. 2. Summary of frequent attendees at accident & emergency department and overview of key management actions In addition to the overview of performance this report also includes the Better Care, Better Value results for **Quarter 2**, this data was published on 10th February 2012. Appendix 2 – Annual Plan Quarter 3 update

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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
Patient Safety There are 5 indicators measured in this section, covering C Difficile, MRSA, E. Coli (no target), Re-admissions and VTE risk assessments	1	1	2	4
Patient Experience There are 4 indicators in this section. Although, the number of formal complaints received does not carry a target as the Trust welcomes all feedback.	0	0	3	3
Service Delivery This section is measured by a suite of 41 indicators, covering RTT, A&E, New & Existing National targets, patients dying in place of choice, length of stay, day case rates, theatre utilisation and Stroke/TIA	4	1	34	39
Workforce This section is measured by 13 different indicators covering, recruitment and retention, turnover, sickness absence, temporary staffing (agency), European Working Time Directive (EWTD) and training and education.	2	5	6	13
Healthy Lifestyles This section is measure by 2 different indicators covering, smoking cessation and HPV	1	0	1	2
Totals	8	7	46	61
Last Month	6	10	43	59
Trend **(Trends are not possible this month as additional PIs have been added)**				

PLEASE NOTE: The Monitor Compliance Framework indicators are included in the summary dashboard above, however, they are also provided as separate dashboard as they form part of the Monitor Compliance Framework.

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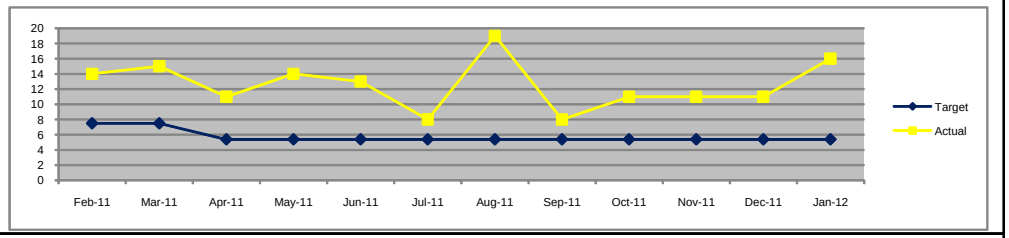
Exception Reports

1.1.1	Clostridium Difficile - hospital acquired for ages >2 years	CQC N	PCT	SHA	L	M

Number of C Diff Cases (Target)	Cum Plan	Cum Actual	Cum Variance	Year End Forecast
65	54	122	68	146

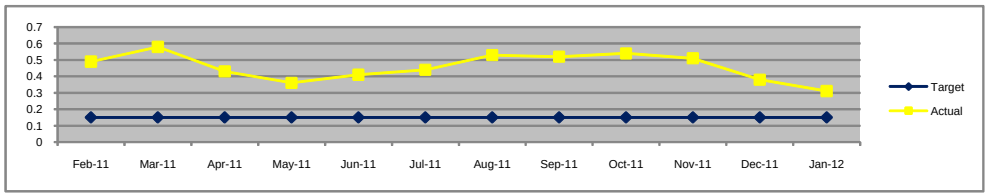


Analysis: The cases reported are attributable as follows:- ICCU x 1, Elderly Care/Stroke x 1, Renal/Diabetes x 4, Respiratory/Gastro x 4, Emergency Services x 3 and Oncology/Haematology x 2

	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-12	Current Month Variance
< 15 mins	00:31	16 mins

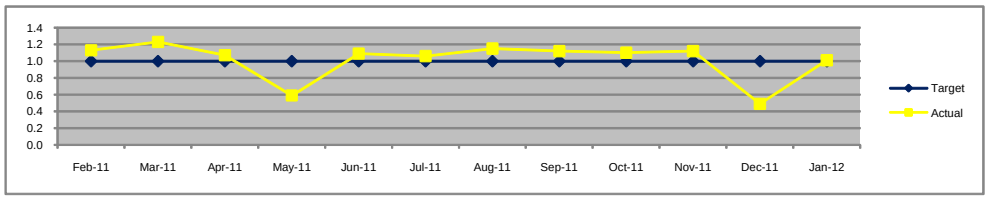


Analysis: This indicator has remained above target since shadow monitoring began in October 2010, however, we have seen a significant improvement over the last two months. Work continues within the department to work towards reducing the initial assessment for ambulance patients.

	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	Jan-12	Current Month Variance
New Cross Hospital	< 60 mins	01:01	1
Walk in Centre		00:26	-34

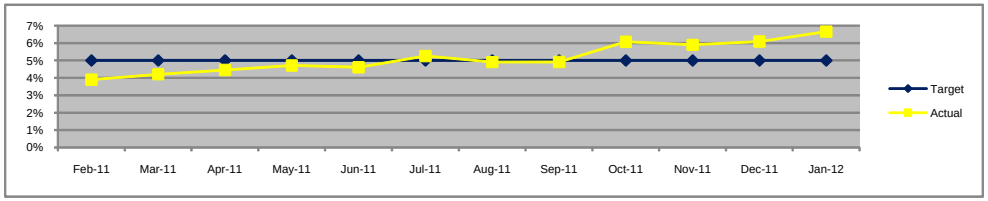


Analysis: With the exception of May & December 2011 this indicator has remained slightly above target since shadow monitoring began in October 2010. Work continues within the department to work towards reducing the time to treatment decision. This graph currently only shows New Cross data, however, this will be updated in the coming months to reflect the walk-in centre as well.

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-12	Current Month Variance
New Cross Hospital	< 5%	6.66%	1.66%
Walk in Centre		3.51%	-1.49%

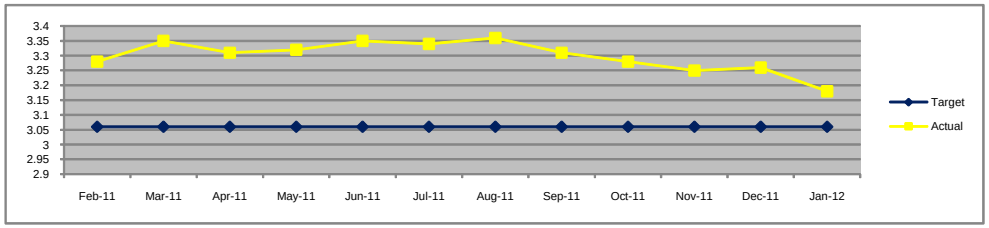


Analysis: This graph currently only shows New Cross data, however, this will be updated in the coming months to reflect the walk-in centre as well.

Elective Length of Stay

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

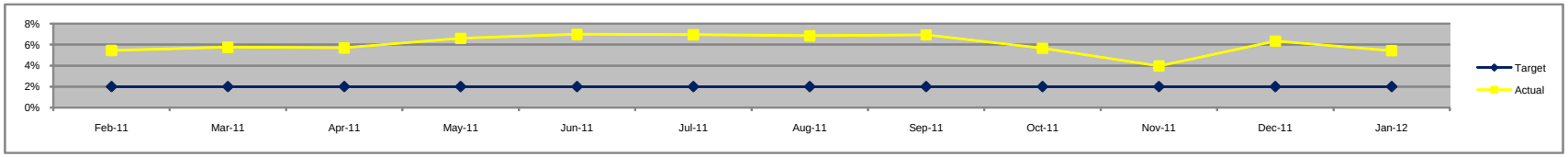
Target per Month	Jan-12	Current Month Variance
3.06	3.18	0.12



Analysis: This is an improvement from the position reported in December of 3.26. This indicator has seen a steady improvement over the last few months, however, we remain above target by 0.12.

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

Vacancies - Non Medical Training Grades

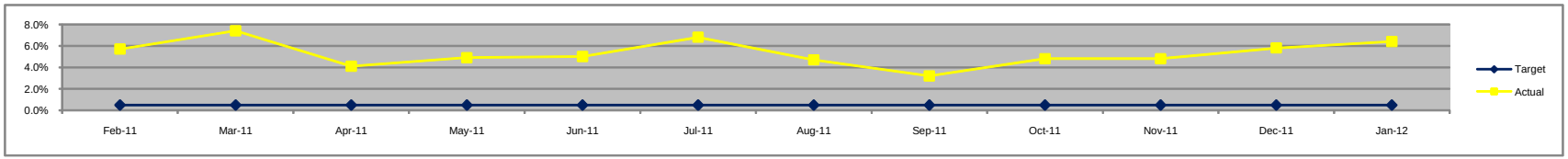


Analysis: Vacancies for trained have decreased in January while non-training posts have remained quite constant. Vacancies are still evident in Emergency Medicine and Haematology.

Actions: All vacant posts are being advertised.

3.2.4	Temporary Staffing	L	I	

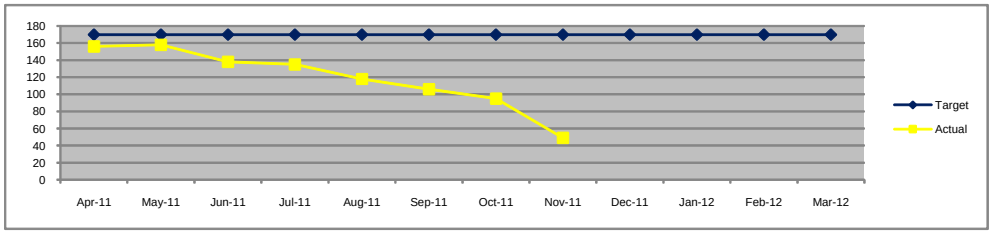
Temporary Medical Staff (cumulative spend) - Agency Staff



Analysis: There has been no agency expenditure for nursing staff during January. In terms of medical agency there has been an increase in month from 5.8% in December to 6.4% in January. **Surgical Division** has seen an increase in month from £98K in December to £106K in January. Agency expenditure in Critical Care has been high during January due to vacancies within the department. **Medical Division** saw an increase in month from £163K in December to £187K in January. Clinical Haematology was high due to agency staff covering a middle grade vacancy, A&E expenditure is high due to vacancies on middle grade and SHO rotas, Gastro and Endoscopy are also currently carrying middle grade vacancies. **Community Services** remained static in month £21K in December and £21K in January, this is due to the continued use of locum service in Rehabilitation to cover long term sick leave for a specialty doctor.

4.1	Smoking Cessation	A	

Monthly Target	Cum Plan	Cum Actual	Cum Variance
170	1360	955	-405



Analysis: Current target was based on the 2009/10 baseline which was a record year for the service. This was largely based on a national and local media campaign. The national campaign has not run this year and there has been very limited local media. This culminates in a significantly reduced interest and referral into the service.

Actions: Restructuring of the department and service model will improve the delivery of the service to maximise resources. Referral pathways have been introduced into EAU and maternity services at New Cross. This is increasing the number of high risk patients accessing the service.

5

Activity Dashboard (community activity only)

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

Theme	Red	Amber	Green	Total
Rehabilitation Covering inpatient/outpatient clinics for services such as care of the elderly, rehabilitation and falls assessment	5	1	6	12
Community Nursing Covering 11 services including community matrons, district nursing and Walk-in-Centre.	6	2	3	11
Child and Family Services Total of 6 services from school nursing to contraceptive and sexual health services	1	3	2	6
Allied Health Professionals Total of 8 services from physiotherapy, OT, speech and language therapy and foot health.	4	0	4	8
Healthy Lifestyles Total of 4 services including food health, walking for health, smoking cessation and health trainers.	3	0	1	4
Totals	19	6	16	41
Last Month	17	8	16	41
Trend **(arrow indicates measure of improvement. i.e. ↑ is getting better)**	↓	↓	→	

Of the 19 RED rates service areas, 11 are operating above plan and 8 are operating below plan. Details for the 8 areas below plan are:

- Care of the Elderly Outpatients – Following a service review the number of follow up appointments has reduced in frequency.
- Falls Assessment Clinic - There is a triage system in place within the Community Falls prevention team, they are treating more patients within the team, resulting in less referrals to the Consultant Falls clinic.
- Continence - Service Manager is ensuring coding and IPM is robust to accurately reflect activity. Triage under review to ensure standardisation. Service model is under review by consultant nurse and deputy chief nurse quality and safety.
- TB – Discussions are underway to introduce an improved system to ensure accurate data recording
- Walk in Centre - Local marketing strategy to be implemented to increase attendance.
- HIV & Aids - The service has commenced the process of evaluating target and baseline (which are currently based on 2009

	levels). This will be presented to the Commissioner. • Podiatry Assessment –The activity indicates number of patients that required a follow up review following the initial Podiatric surgery which took place prior to 1st April 2011. Activity will continue to reduce due to no Podiatric surgery taking • Smoking Cessation – Service increasing clinic capacity and advertising to maximise achievement of YTD target. Corrective action plan in place
6	**<u>Overview Reports</u>** Provider Management Regime The Midlands and East Strategic Health Authority has introduced a new reporting framework for all aspirant foundation trusts (AFT). It is proposed that this document – the Provider Management Regime (PMR) is to be used by AFTs to assess their preparedness for FT application. The approach is based on the Monitor Compliance Framework and puts the onus on Trust Boards to demonstrate self awareness in providing assurance and for the delivery of their commitments. The regime uses many of the disciplines and approaches seen in the Monitor Compliance Framework including the use of governance and financial risk ratings however it is wider in scope and includes the discretion for the SHA to intervene at an earlier stage. Full details of the Provider Management Regime can be found at Appendix 1.

Accident & Emergency Services – Frequent attendees

During the period April 2011 – December 2011 over 75,000 attendances were recorded within the A&E department. Of these 96.8% were seen within 4 hours. Within these numbers sits a small number of patients whose regularity of attendance puts them into the “frequent” category.

The top 50 frequent attendeesaccounted for 930 visits to A&E during the same time period, an average of almost 19 visits per patient over the time period. In the most extreme one patient has accessed A&E 90 times during this period.

The impact of this is felt operationally, where additional pressure is placed on an extremely busy service that constantly deals with high volumes of patients. Reducing the frequency of attendance will help reduce this pressure but will also disproportionately impact on some of the new clinical quality indicators now being used to assess performance in the A&E department.

Left Without Being Seen

This indicator was introduced this year with a view to improve patient experience and reduce the clinical risk to patients who leave A&E before receiving the care they need. The target threshold is 5% and good performance is perceived to be seen asa reduction in this number.

Using the last 6 months data, it is quite apparent that the top 50 frequent attendees have had a disproportionate impact on this indicator.

	Aug 11	Sept 11	Oct 11	Nov 11	Dec 11	Jan 12
Actual Data Reported	5%	4.11%	3.85%	3.86%	2.55%	3.32%
Rate for Top 50	0.41%	0.21%	0.26%	0.25%	0.10%	0.15%
Revised Rate	4.59%	3.90%	3.59%	3.61%	2.45%	3.17%

Un-planned re-attendance rate

This indicator was introduced this year with a view to reduce avoidable re-attendances(for the same condition) at A&E by improving the care and communication delivered during the original attendance. Again, the target threshold is 5% and good performance is perceived to be seen as a reduction in this number.

	Aug 11	Sept 11	Oct 11	Nov 11	Dec 11	Jan 12
Actual Data Reported	4.91%	4.92%	6.08%	5.90%	6.09%	6.66%

Without going through individual records for all attendances, it is not possible to accurately predict whether the attendances for the Top 50 attendees would have been coded as a re-attendance. However, taking the assumption that every attendance that occurs within 7 days is within scope, then the actual rate could be reduced by as much as 1%.

Given the impact that the frequent attendees place on operational efficiency and the disproportionate impact on performance metrics, the management team within the service frequently review the frequent attendees list and have a systematic process in place in an attempt to mitigate their impact.

This involves monthly communication with community teams including:

- Mental Health teams
- Community matrons
- GPs

Details of patient profiles are shared with the relevant teams to see how best individual patients could be supported with their individual health and care needs. Whilst this work is on-going the team are currently looking at further work around the profile of these patients to establish how preventative work could help further reduce the impact that this has on service provision.

Special Reports

Better Care, Better Value – Quarter 2 results

The Institute for Innovation and Improvement supports the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world class leadership. The Institute states that the NHS must demonstrate that it is making the most effective use it can of public money to deliver quality healthcare. Their website is designed to help local NHS organisations do this. It is based around 15 high-level indicators of efficiency that identify potential areas for improvement in efficiency. The indicators, primarily aimed at commissioners (PCT's) and acute hospital providers (AHT's) were published for the first time in October 2006 and are updated and republished every quarter thereafter. Unfortunately, the data is published with significant time lag and the information presented in this report relates to Q1 activity.

Comparison with other Trusts – The table below shows RWHT ranking out of 171 Trusts that are currently reported in the Better Care, Better Value indicators.

	Quarter 1 2011/12		Quarter 2 2011/12	
LOS	24th	Positive	21st	Positive
Day Case Rates	90th	Positive	97th	Negative
Pre Op (Non-Elective)	145th	Negative	134th	Positive
Pre Op (Elective)	75th	Positive	84th	Negative
DNA	115th	Positive	117th	Negative
New to Review	134th	Negative	137th	Negative
Emergency Readmission	114th	Positive	117th	Negative

Comparison with Trusts in the West Midlands – The table below shows RWHT ranking against 12 other Trusts in the West Midlands with a similar portfolio. i.e. single specialty and very small organisations have been excluded.

	Quarter 1 2011/12		Quarter 2 2011/12	
LOS	1st	Static	1st	Static
Day Case Rates	6th	Positive	7th	Negative
Pre Op (Non-Elective)	10th	Negative	6th	Positive
Pre Op (Elective)	4th	Positive	4th	Static
DNA	9th	Static	11th	Negative
New to Review	10th	Static	10th	Static
Emergency Readmission	8th	Positive	8th	Positive

NHS Midlands and East

SELF-CERTIFICATION RETURNS
Organisation Name:
The Royal Wolverhampton Hospitals NHS Trust
Monitoring Period:
Jan 2012

NHS Midlands & East
Provider Management Regime
2011/12

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

APPENDIX 1

NHS Midlands and East

NHS Trust Governance Declarations : 2011/12 In-Year Reporting

Name of Organisation:	The Royal Wolverhampton Hospitals NHS Trust	Period:	Jan 2012

Organisational risk rating

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

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per NHS Midlands and East PMR guidance)	Amber/Green
Financial Risk Rating (Assign number as per NHS Midlands and East PMR guidance)	4.5
Contractual Position (RAG as per NHS Midlands and East PMR guidance)	Green

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

Governance Declarations

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

Supporting detail is required where compliance cannot be confirmed.

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

Governance declaration 1

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

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

Governance declaration 2

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

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

Signed by :		Print Name :	David Loughton CBE
on behalf of the Trust Board	Acting in capacity as:	Chief Executive	
Signed by :		Print Name :	Barry Picken
on behalf of the Trust Board	Acting in capacity as:	Chairman	

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:	**C. difficile**
The Issue :	**The Trust implemented PCR testing at the beginning of the financial year. The implications of the testing were discussed in full with the commissioner and confirmed in writing**
Action :	**Each patient with C Difficile is seen by a microbiologist. There are daily ward rounds by the microbiology team. The Trust's rigourous approach to IP is reinforced constantly to all staff and visitorsThe Trust is participating in the SHA review of C difficile testing**

Target/Standard:	
The Issue :	
Action :	

ACUTE
GOVERNANCE RISK RATINGS 2011/12

The Royal Wolverhampton Hospitals NHS Trust

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

Ref	Area	Indicator	Sub Sections	Threshold	Weighting	April 2011	May 2011	Jun 2011	July 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Comments where target not achieved in month?
1	Safety	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	No	No	No	No	No	No	No	No	No	No			Trust implemented PCR testing at the beginning of the year. Daily rounds by microbiology.Awaiting outcome of SHA discussions around C diff and testing
2	Safety	MRSA	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
3	Quality	All cancers: 31-day wait for second or subsequent treatment, comprising either:	Surgery	94%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
			Anti cancer drug treatments	98%														
			Radiotherapy	94%														
4	Quality	All cancers: 62-day wait for first treatment, comprising either:	From urgent GP RTT	85%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
			From consultant screening service referral	90%														
5a	Patient Experience	RTT waiting times – admitted	95th percentile	23 wks	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
5b	Patient Experience	RTT waiting times – non-admitted	95th percentile	18.3 wks	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
6	Quality	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
7	Quality	Cancer: 2 week wait from referral to date first seen, comprising either:	all cancers	93%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
			for symptomatic breast patients (cancer not initially suspected)	93%														
8a	Quality	A&E: Total time in A&E	Total time in A&E (95%)	≤ 4 hrs	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes			this is the first breach of the target since 2009
8b	Quality	A&E: NB Please record the areas not being met in the comments sheet	Total time in A&E (95th percentile)	≤4 hrs	No weighting				3	2	2	4	4	3	4			
			Time to initial assessment (95th percentile)	≤15 mins														
			Time to treatment decision (median)	≤60 mins														
			Unplanned re-attendance rate	≤5%														
			Left without being seen	≤5%														
17	Patient experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5									Yes	Yes			
		CQC Registration																
A	Safety	CQC Registration	Are there any compliance conditions on registration outstanding.	0	1.0									No	No			
B	Safety	CQC Registration	Are there any restrictive compliance conditions on registration outstanding.	0	2.0									No	No			
C	Safety	Moderate CQC concerns regarding the safety of healthcare provision		0	1.0									No	No			CQC revisited Trust on 25/01/12. draft report shows compliance on all standards
D	Safety	Major CQC concerns regarding the safety of healthcare provision		0	2.0									No	No			
E	Safety	Formal CQC Regulatory Action resulting in Compliance Action		0	2.0									No	No			
F	Safety	Formal CQC Regulatory Action resulting in Enforcement Action		0	4.0									No	No			
G	Safety	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0									No	No			
				TOTAL		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	2.0	1.0	0.0	0.0	

COMMUNITY TRUST
GOVERNANCE RISK RATINGS 2011/12

The Royal Wolverhampton Hospitals NHS Trust

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

Ref	Area	Indicator	Sub Sections	Thresh-old	Weight-ing	Apr 2011	May 2011	June 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Comments where target not achieved in month?
1	Safety	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	No	No	Yes	Yes	Yes	No	No	Yes	Yes	Yes			
2	Safety	MRSA	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
18	Quality	Delayed Transfers of Care	Are you below the ceiling for your monthly trajectory	Contract with PCT	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
19	Patient Experience	GUM Access - within 48 hours	95th percentile	≤ 48 hrs	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			in acute contract
20	Effectiveness	Chlamydia Screening		Contract with PCT	0.5									N/A	N/A			
21	Effectiveness	Smoking quitters		Contract with PCT	0.5	No	No	No	No	No	No	No	No	No	No			This target was based on a record year of 2010 which was supported by national and local media campaigns. The performance is likely to be similar to last years outturn.
8a	Quality	Minor Injuries Unit / A&E (Q1):	Total time (95th percentile)	≤ 4 hrs	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
8b	Quality	MIU / A&E/ WiC (from Q2): NB Please record the areas not being met in the comments column	Total time (95th percentile)	≤4 hrs	No weighting													
			Time to initial assessment (95th percentile)	≤15 mins														
			Time to treatment decision (median)	≤60 mins								0	0	0	0			
			Unplanned re-attendance rate	≤5%														
			Left without being seen	≤5%														
22	Patient Experience	6 week wait for diagnostic	100%	≤ 6 wks	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
23	Safety	New birth visits		Contract with PCT	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			in acute contract
24	Effectiveness	HPV (Human Papillomavirus) Uptake		Contract with PCT	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
25	Patient Experience	Community equipment store response within seven days	100%	≤ 7 days	0.5									N/A	N/A			Not in contract however perf. Is 99.72%
26a	Safety	Urgent District Nurse response within 24 hours	100%	≤ 24 hrs	0.5									N/A	N/A			NOT IN CONTRACT - still waiting for guidance around this indicator.
26b	Patient Experience	Non-urgent District Nurse response within 48 hours	100%	≤ 48 hrs	0.5									N/A	N/A			NOT IN CONTRACT - still waiting for guidance around this indicator.
17	Patient experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5									Yes	Yes			
		CQC Registration																
A	Safety	CQC Registration	Are there any compliance conditions on registration outstanding.	0	1.0									No	No			
B	Safety	CQC Registration	Are there any restrictive compliance conditions on registration outstanding.	0	2.0									No	No			
C	Safety	Moderate CQC concerns regarding the safety of healthcare provision		0	1.0									No	No			
D	Safety	Major CQC concerns regarding the safety of healthcare provision		0	2.0									No	No			
E	Safety	Formal CQC Regulatory Action resulting in Compliance Action		0	2.0									No	No			
F	Safety	Formal CQC Regulatory Action resulting in Enforcement Action		0	4.0									No	No			
G	Safety	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0									No	No			
				TOTAL		1.0	1.5	0.5	0.5	0.5	1.5	0.5	0.5	0.5	0.5	0.0	0.0	

FINANCIAL RISK RATING 2011/12

The Royal Wolverhampton Hospitals NHS Trust

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

			Risk Ratings																		
Criteria	**Indicator**	**Weight**	**5**	**4**	**3**	**2**	**1**	**Annual Plan 2011/12**	**Apr 2011**	**May 2011**	**June 2011**	**Jul 2011**	**Aug 2011**	**Sept 2011**	**Oct 2011**	**Nov 2011**	**Dec 2011**	**Jan 2012**	**Feb 2012**	**Mar 2012**	**Comments on Performance in Month**
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1										4	4			
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50										5	5			
Financial efficiency	**Return on assets %**	20%	6	5	3	-2	<-2										4	5			
	I&E surplus margin %	20%	3	2	1	-2	<-2										4	5			
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10										4	4			
Average	**Weighted Average**	**100%**						**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**4.1**	**4.5**	**0.0**	**0.0**	
Overriding rules	**Overriding rules**																0	0			
Overall rating	**Final Overall rating**							**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**4.1**	**4.5**	**0.0**	**0.0**	

Overriding Rules :

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

FINANCIAL RISK TRIGGERS 2011/12

The Royal Wolverhampton Hospitals NHS Trust

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

	Criteria	Apr 2011	May 2011	June 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Comments on Performance in Month
1	Unplanned decrease in EBITDA margin in two consecutive quarters									No	No			
2	Quarterly self-certification by trust that the financial risk rating (FRR) may be less than 3 in the next 12 months									No	No			
3	FRR 2 for any one quarter									No	No			
4	Working capital facility (WCF) agreement includes default clause									N/A	N/A			
5	Debtors > 90 days past due account for more than 5% of total debtor balances									No	No			
6	Creditors > 90 days past due account for more than 5% of total creditor balances									No	No			
7	Two or more changes in Finance Director in a twelve month period									No	No			
8	Interim Finance Director in place over more than one quarter end									No	No			
9	Quarter end cash balance <10 days of operating expenses									No	No			
10	Capital expenditure < 75% of plan for the year to date									No	No			
	TOTAL	0	0	0	0	0	0	0	0	0	0	0	0	

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

RAG RATING :

GREEN = Score between 0 and 1

AMBER = Score between 2 and 4

RED = Score over 5

CONTRACTUAL RISK RATINGS 2011/12

The Royal Wolverhampton Hospitals NHS Trust

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

Criteria	RAG	Apr 2011	May 2011	Jun 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2011	Feb 2011	Mar 2011	Comments on Performance in Month
All key contracts are agreed and signed. Both the NHS Trust and commissioner are fulfilling the terms of the contract. There are no disputes or performance notices in place.	G									G	G			
The NHS Trust and commissioner are in dispute over the terms of the contract. Performance notices have been issued by one or both parties.	A													
One or more key contract is not signed by the start of the period covered by the contract. There is a dispute over the terms of the contract which might, or will, necessitate SHA intervention or arbitration. The parties are already in arbitration.	R													

QUALITY

The Royal Wolverhampton Hospitals NHS Trust

APPENDIX 1

Insert Performance in Month

	Criteria	Unit	Apr 2011	May 2011	June 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Comments on Performance in Month
1	SHMI - latest data	Ratio									90.5	90.0			HSMR November data from Dr Foster
2	Venous Thromboembolism (VTE) Screening	%									91.89	95.83			
3a	Elective MRSA Screening	%									100	100			
3b	Non Elective MRSA Screening	%									100	100			
4	Single Sex Accommodation Breaches	Number									4	0			
5	Open Serious Incidents Requiring Investigation (SIRI)	Number									75	85			SHA open figure, includes SUI and reportable as per SHA criteria. Figure includes 7 closed by PCT, 35 to be reviewed and closed
6	"Never Events" in month	Number									0	1			
7	CQC Conditions or Warning Notices	Number									0	0			
8	Open Central Alert System (CAS) Alerts	Number									15	12			5 MDA, 2 EFA, 5 NPSA
9	RED rated areas on your maternity dashboard?	Number									n/a	n/a			
10	Falls resulting in severe injury or death	Number									4	1			
11	Grade 3 or 4 pressure ulcers	Number									19	5			across acute and community
12	100% compliance with WHO surgical checklist	Y/N									No	No			used in all theatre areas, currently being implemented in outpatient areas
13	Formal complaints received	Number									33	32			
14	Agency and bank spend as a % of turnover	%									2.9	2.9			
15	Sickness absence rate	%									4.55	5.41			

Board Statements

The Royal Wolverhampton Hospitals NHS Trust

Jan 2012

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

	For CLINICAL QUALITY, that:	Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SHA's Provider Management Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its NHS trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	✓

If the Trust Board is unable to make the above statement, the Board must:

2	Be satisfied that, to the best of its knowledge and using its own processes (supported by CQC information and including any further metrics it chooses to adopt), its Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	
3	Be satisfied that, to the best of its knowledge and using its own processes, plans in place are sufficient to ensure ongoing compliance with the CQC's registration requirements	
4	Certify it is satisfied that processes and procedures are in place to ensure that all medical practitioners providing care on behalf of the NHS foundation trust have met the relevant registration and revalidation requirements.	
4	Be satisfied that the Trust is embedding patient experience into the service design, improvement and delivery cycle.	

	For SERVICE PERFORMANCE, that:	Response
5	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds), and compliance with all targets due to come into effect during 2011/12.	✗

	For RISK MANAGEMENT PROCESSES, that:	Response
6	Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner	✓
7	All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned	✓
8	The necessary planning, performance management and risk management processes are in place to deliver the annual plan	✓
9	A Statement of Internal Control ("SIC") is in place, and the trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to the most up to date guidance from HM Treasury (see http://www.hm-treasury.gov.uk)	✓
10	The trust has achieved a minimum of Level 2 performance against the key requirements of the Department of Health's Information Governance Toolkit	✓

	For COMPLIANCE WITH THE NHS CONSTITUTION, that:	Response
11	The Board is assured that the trust will, at all times, have regard to the NHS constitution	✓

	For BOARD, ROLES, STRUCTURES AND CAPACITY, that:	*Response*
12	The Board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the Board	✓
13	The Board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability	✓
14	The selection process and training programmes in place ensure that the non-executive directors have appropriate experience and skills	✓
15	The management team have the capability and experience necessary to deliver the annual plan	✓
16	The management structure in place is adequate to deliver the annual plan objectives for the next three years.	✓

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

NHS Midlands and East Provider Management Regime

NHS Midlands and East

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

Contents

Key to Symbols

CQC E	Existing Commitments
CQC N	National Priorities
PCT	Host Primary Care Trust
SHA	Strategic Health Authority
L	Local
M	Monitor
Dr F	Dr Foster Good Hospital Guide
QA	Quality Account
BCBV	Better Care, Better Value
NHS C	NHS Constitution
CQ	CQUIN
A	Acute
C	Community
I	Integrated

1) PATIENT SAFETY

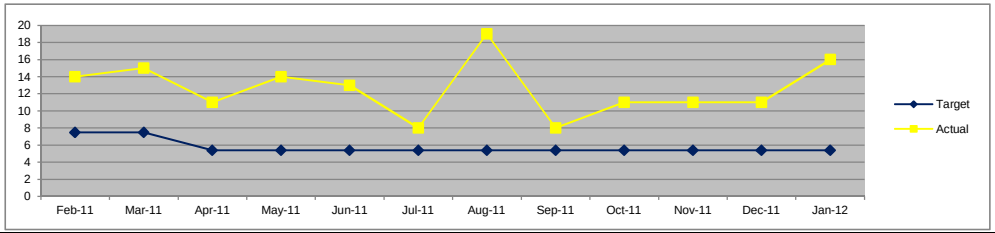
1.1 Healthcare Acquired Infections (HCAI's)

Clostridium Difficile (C Diff) and Methicillin Resistant Staphylococcus Aureus (MRSA) are an important indicator of infection prevention and control. The target for C Difficile is 57 per annum for 2011/12 which equates to 4.75 per month. In respect of MRSA Bacteraemia, the target is 1 for the year and for the purposes of monthly reporting the target will be zero. E Coli is a new target for 2011/12, we are currently doing Mandatory Surveillance for Q1 in order to determined a target.

1.1.1 Clostridium Difficile - hospital acquired for ages >2 years

CQC N | PCT | SHA | L | M

Number of C Diff Cases (Target)	Cum Plan	Cum Actual	Cum Variance	Year End Forecast
65	54	122	68	146

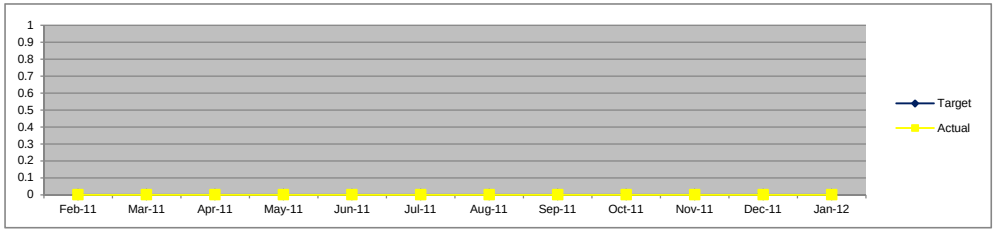


Analysis: The cases reported are attributable as follows:- ICCU x 1, Elderly Care/Stroke x 1, Renal/Diabetes x 4, Respiratory/Gastro x 4, Emergency Services x 3 and Oncology/Haematology x 2

1.1.2 MRSA Bacteraemia

CQC N | PCT | SHA | L | M

Number of MRSA Cases (Target)	Cum Plan	Cum Actual	Cum Variance	Year End Forecast
1	0	0	0	0

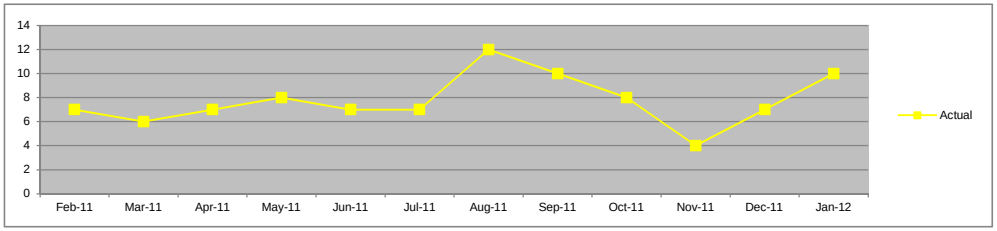


Analysis: This is the 31st consecutive month without an MRSA Bacteraemia

1.1.3 E Coli Bloodstream

PCT | SHA

Number of E Coli Cases	Cum Plan	Cum Actual	Cum Variance	Year End Forecast
10	0	80	80	96

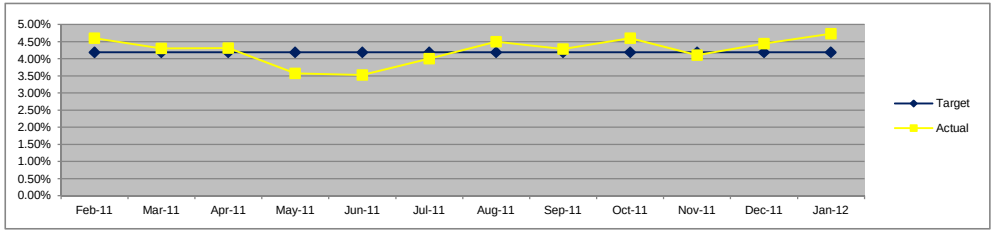


Analysis: We continue to record this indicator as surveillance only - no benchmark has been set for this indicator, Commissioners will continue to monitor numbers and will raise concerns if felt appropriate.

1.2	**Readmissions**	**L**	**BCBV**	**A**	

Emergency Readmissions may be as a result of less than optimal treatment in hospital, badly organised rehabilitation or inadequate support services when a person is transferred home following treatment. This indicator measures the number of patients who are readmitted to hospital, within 30 days (new target for 2011/12) as a percentage of all discharges.

Target	Nov-11	Dec-11	Jan-12	Current Month Variance
4.19%	4.11%	4.44%	4.73%	-0.54%

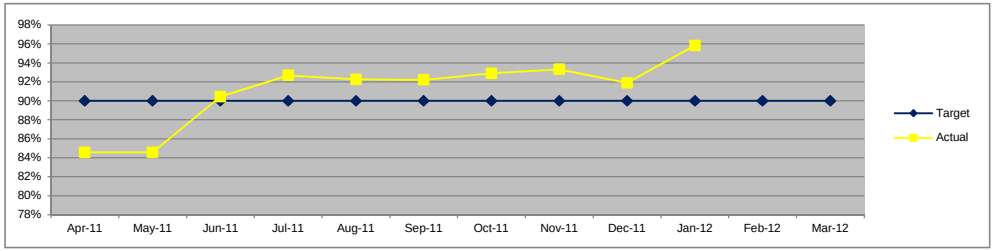


Analysis: Percentage of emergency readmissions within 30 days has shown an increase from the December position by 0.29%

1.3	**VTE Risk Assessment**	**L**	

This indicator measures the percentage of patients who have undergone a VTE Risk Assessment on admission to hospital

Target	Jan-12	Current Month Variance
90%	95.83%	5.83%



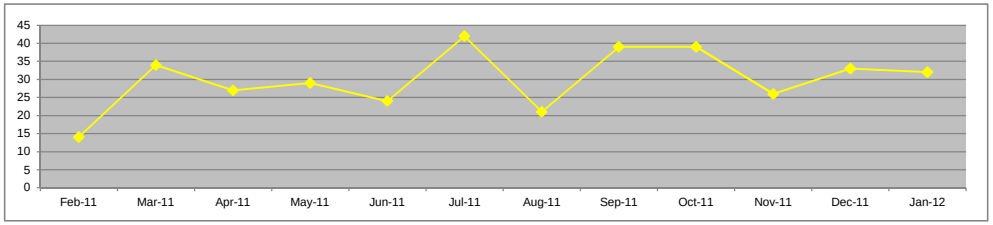
Analysis: We continue to remain above target

2) PATIENT EXPERIENCE

2.1 Formal Complaints — L — NHS C — I

The following indicates the number of formal complaints received during the month. There is no target in relation to the number of complaints received as the Trust welcomes all feedback as this helps us to continually improve the services we provide.

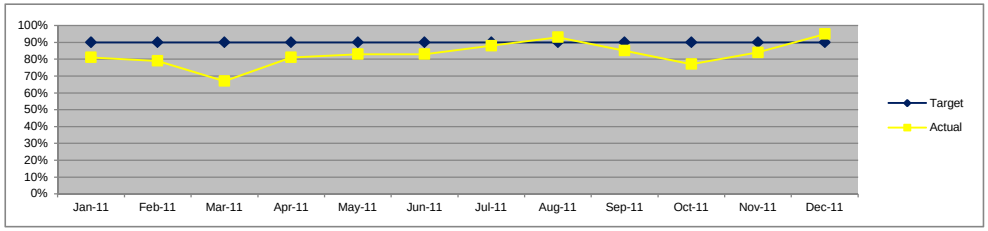
Current Month Jan 2012	Cum Actual	Year End Actual 2010/11	Year End Forecast 2011/12
32	312	272	374



2.2 Complaints resolved within 25 days — L — NHS C — I

The Trust aims to provide first class responses to greater than 90% of all complaints within 25 working days. Due to the 25 day turnaround target, we will only know the outcome of complaints received between 1st and 14th of the current reported month. Therefore, data reported in the monthly report reflects the previous months position.

Target	Oct 11 Validated	Nov 11 Validated	Dec 11 Validated
90%	77%	84%	95%

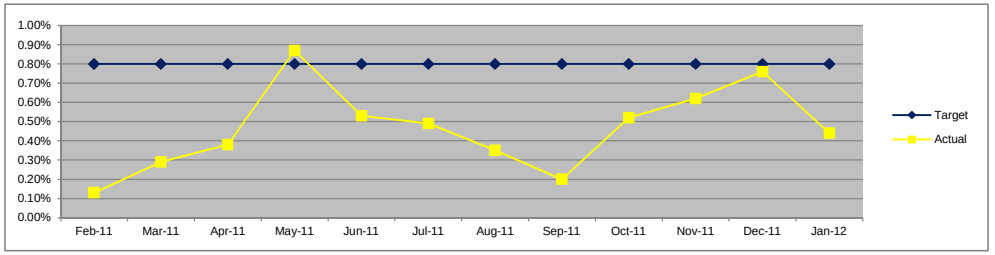


Analysis: 33 complaints were received in December, 25 of which were responded to within 25 working days. 7 complaints took longer than 25 days but did have consent to breach and 1 complaint did not have consent to breach.

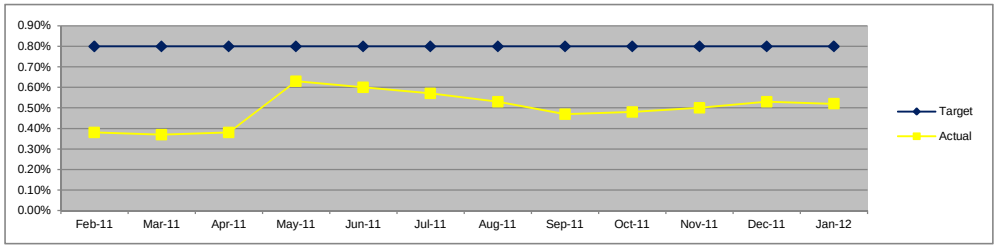
2.3	Short Notice Cancellation of Operations	CQC N	L	A

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 11 Actual	Dec 11 Actual	Jan 12 Actual
0.80%	0.62%	0.76%	0.44%



Cumulative	Nov-11	Dec-11	Jan-12
Cancellations	251	299	328
Elec Procedures	50547	56825	63382
Cumulative %	0.50%	0.53%	0.52%



	Equipment Failure	Kit not available	Ran out of theatre time	More urgent case(s)	No beds	Surgeon ill	No ITU Bed	Total
Urology								**0**
Gen Surg			1	1	2	3		**7**
Cardiac			2	4			2	**8**
Gynae			3					**3**
Ortho			1					**1**
Cardiology	1		2	4	1			**8**
H&N			2					**2**
Ophthal								**0**
Total	**1**	**0**	**11**	**9**	**3**	**3**	**2**	**29**

Actions: 29 operations were cancelled during January, this a significant improvement from 48 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.

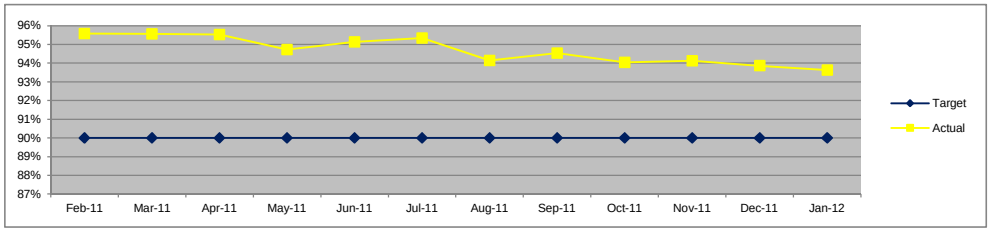
3)	EFFICIENCY AND EFFECTIVENESS					
3.1	Service Delivery					
3.1.1	18 week Referral to Treatment (RTT)	CQC N	PCT	QA	I	

In the 2009/10 Operating Framework there is a commitment that all patients will be treated within 18 weeks with effect from 1st April 2009. This expands the 18 week RTT operating standard to cover non Consultant led services but also those services provided by Allied Health Professionals and Nurses. The only exceptions to the 18 week operating standards are in relation to patient choice and clinical complexity. The NHS Constitution makes this a right for patients from 1st April 2010. Additional standards have been added for 2011/12 and will measure the 95th percentile for Admitted (<23 weeks) and Non-admitted (<18.3 weeks)

Standard 18 week Referral to Treatment

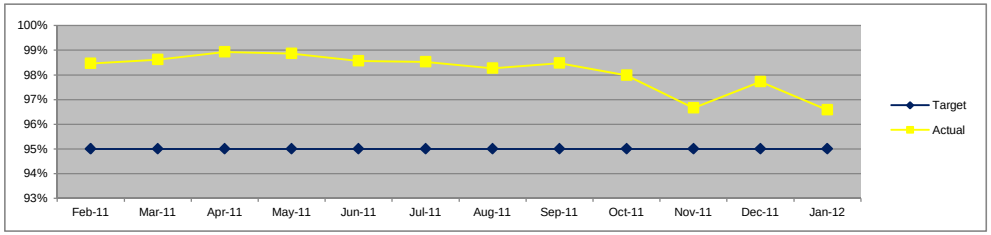
Admitted

Target	Jan-12
90%	93.63%



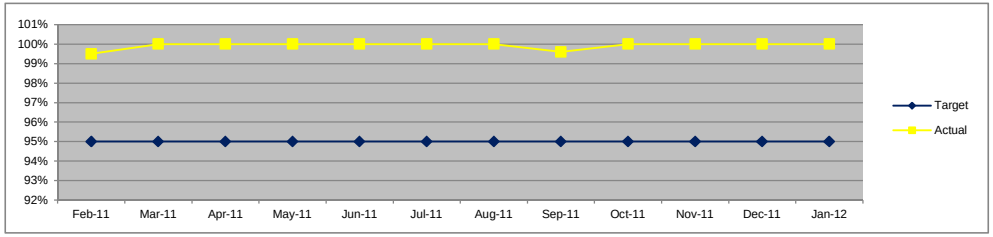
Non-admitted

Target	Jan-12
95%	96.58%



Non-admitted - Audiology (Community only)

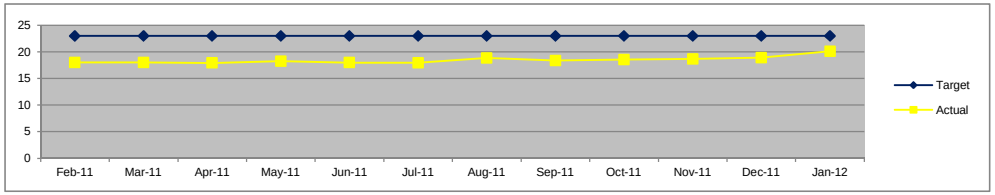
Target	Jan-12
95%	100.00%



Comments: All specialties achieved the target during January

Admitted - 95th Percentile within 23 weeks

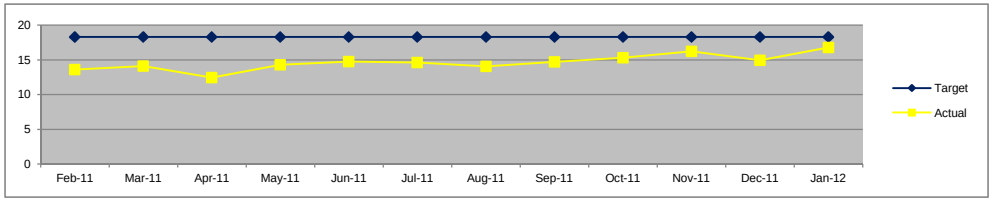
Target	Jan-12
< 23	20.11



Comments:

Non-admitted - 95th Percentile within 18.3 weeks

Target	Jan-12
< 18.3	16.80



Comments:

3.1.2 Accident & Emergency | **CQC E** | **PCT** | **SHA** | **M** | **QA** | **I**

4 Hour Wait

95% of patients accessing emergency services (including A&E Departments, PCT Walk-in Centre and Doctors on-call) 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.

The Accident and Emergency department have recently been involved in a departmental Listening into Action event. During this review the department has looked at delivery of care and new ways of working in order to aid with the recording and achievement of the new targets.

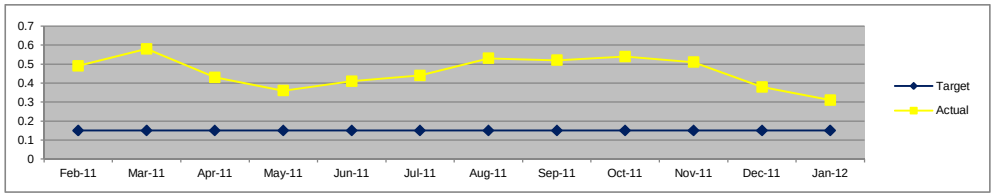
	Target	Jan-12	Current Month Variance	Cumulative	Current Month Variance
New Cross Hospital	95%	95.02%	0.02%	96.67%	1.67%
Walk-in & DOC	95%	100.00%	5.00%	100.00%	5.00%
Overall	95%	96.80%	1.80%	97.83%	2.83%

Analysis: The analysis above shows RWHT internal performance and the overall health economy performance, both by latest full month and cumulatively.

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-12	Current Month Variance
< 15 mins	00:31	16 mins

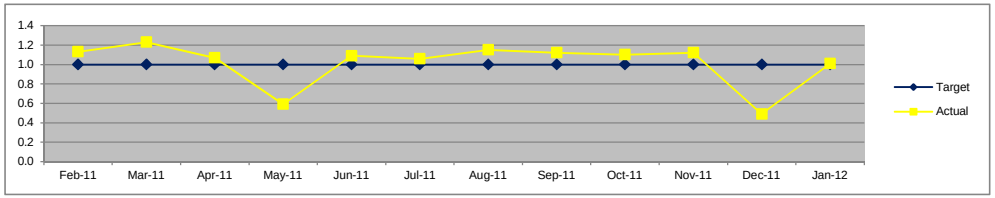


Analysis: This indicator has remained above target since shadow monitoring began in October 2010, however, we have seen a significant improvement over the last two months. Work continues within the department to work towards reducing the initial assessment for ambulance patients.

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	Jan-12	Current Month Variance
New Cross Hospital Walk in Centre	< 60 mins	01:01	1
		00:26	-34

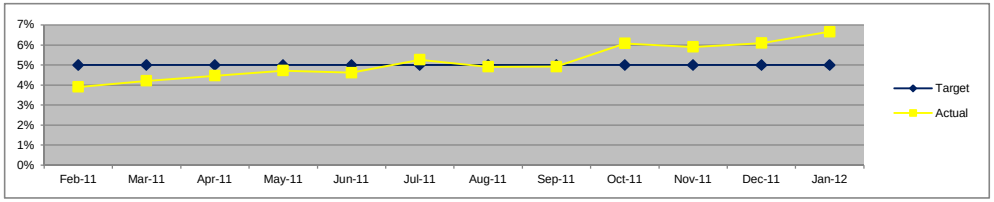


Analysis: With the exception of May & December 2011 this indicator has remained slightly above target since shadow monitoring began in October 2010. Work continues within the department to work towards reducing the time to treatment decision. This graph currently only shows New Cross data, however, this will be updated in the coming months to reflect the walk-in centre as well.

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-12	Current Month Variance
New Cross Hospital Walk in Centre	< 5%	6.66%	1.66%
		3.51%	-1.49%

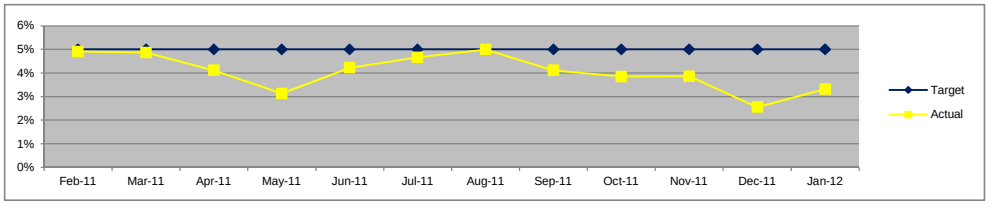


Analysis: This graph currently only shows New Cross data, however, this will be updated in the coming months to reflect the walk-in centre as well.

Left Without Being Seen | I

To improve patient experience and reduce the clinical risk to patients who leave Accident & Emergency before receiving the care they need.

	Target	Jan-12	Current Month Variance
New Cross Hospital Walk in Centre	< 5%	3.32%	-1.68%
		1.81%	-3.19%



Analysis: This graph currently only shows New Cross data, however, this will be updated in the coming months to reflect the walk-in centre as well.

3.1.3 Care Quality Commission - Existing Commitments & National Priorities (not already covered in report). Indicators for 2010/11 are yet to be finalised therefore reporting will continue against those indicators used in the 2009/10 Periodic Review process.

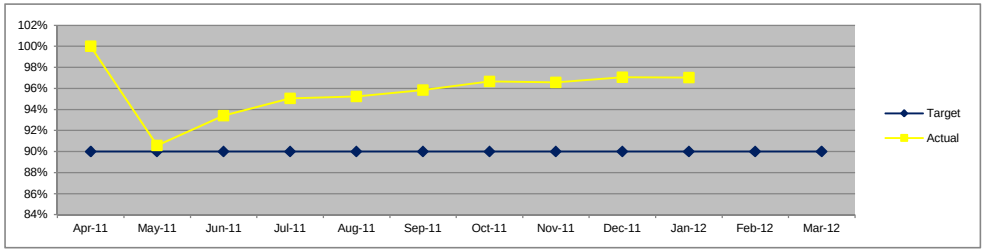
Indicator	Current	Indicator	Current
Access to Genito Urinary Medicine - 100% of patients will be offered an appointment within 48 hours	100.00%	In order to monitor the reduction of health inequalities related to ethnic diversity, it is essential that data quality on ethnic group is >/=90%	92.74%
Reducing 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 (3.5%)	3.80%	No patient will wait longer than 26 weeks for in-patient care	0
No patient will wait longer than 13 weeks for an outpatient consultation	0	No patient will wait any longer than three months (13 weeks) for revascularisation	0
2 week waiting time for Rapid Access Chest Pain Clinic (98%)	100.00%	All Cancer Two Week Wait (93%)	95.48%
Two Week Wait for symptomatic breast patients (cancer not initially suspected) (93%)	94.21%	31 day (diagnosis to treatment) Wait for first treatment - all cancers (96%)	97.30%
31 day wait for second or subsequent treatment: Surgery (94%)	96.88%	31 day wait for second or subsequent treatment: Anti Cancer Drug Treatment (98%)	98.46%
31 day wait for second or subsequent treatment: Radiotherapy Treatments (94%)	97.77%	62 days (traditional) from urgent GP referrals to first definitive cancer treatment - all cancers (85%)	85.37%
62 day wait for first treatment from consultant screening - all cancers (90%)	100.00%	62 days for first treatment for those patients who are upgraded with a suspicion of cancer (85%)	86.15%
Cancelled operations - patients not readmitted with 28 days	0	Infant health and inequalities (smoking and breastfeeding initiation) - identify all mothers	100.00%

Comments:

62 Day Traditional - 14 breaches - 10 x tertiary referrals received at 57 days or more, and 4 x complex cases. Late referrals from other hospitals continue to be a problem with referrals arriving as late as 128 days.

3.1.4 Patients Dying in Place of Choice **C**

Target	Jan-12	Current Month Variance
90%	97.03%	7.03%

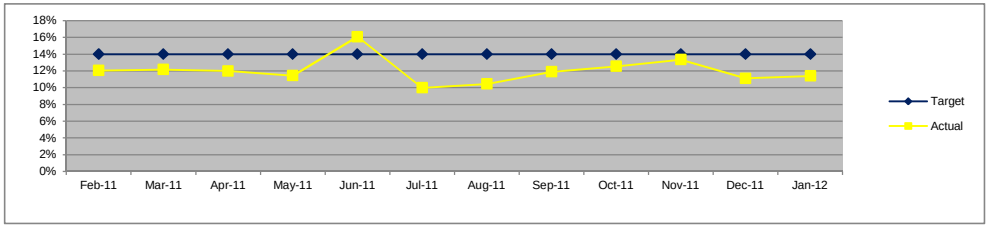


Comments: This measure is a percentage of the total number of patients in contact with the service who have died in their place of choice.

3.1.5	**Pre-Op Length of Stay**	**L**	**BCBV**	**A**	

This indicator is a sum of all bed days between date of patient admission and the date of their procedure. It is expressed as a percentage of all bed days for the hospital.

Target per Month	Jan-12	Current Month Variance
14%	11.38%	-2.62%



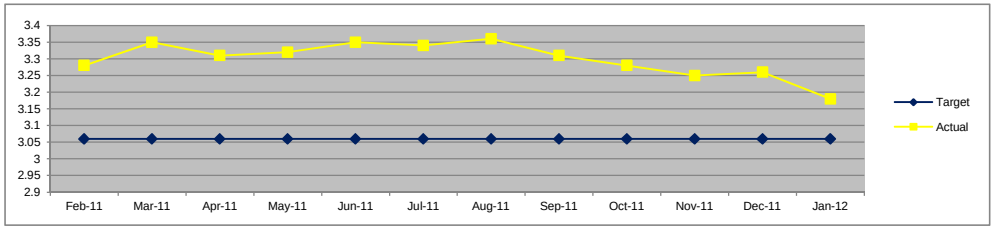
Analysis: Percentage of bed days spent pre-operatively has shown a very slight deterioration from the position reported in December of 11.11%, we remain below target by 2.62%.

Actions:

	Elective Length of Stay	**A**	

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

Target per Month	Jan-12	Current Month Variance
3.06	3.18	0.12

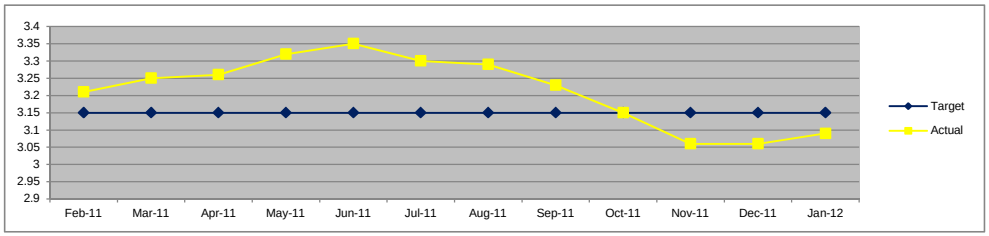


Analysis: This is an improvement from the position reported in December of 3.26. This indicator has seen a steady improvement over the last few months, however, we remain above target by 0.12.

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

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

Target per Month	Jan-12	Current Month Variance
3.15	3.09	-0.06

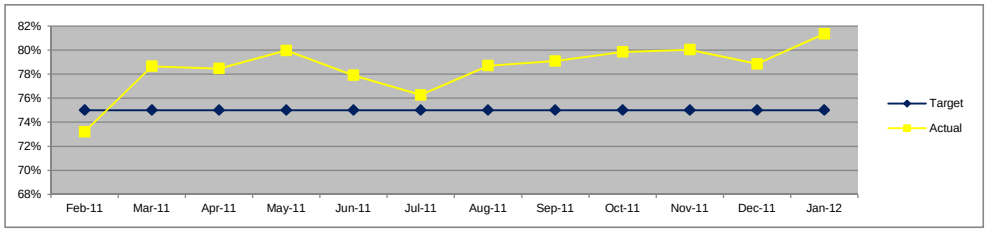


Analysis: This is the fourth consecutive month that Trust has achieved this target. We will continue to focus on timely discharge and admission avoidance

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

3.1.6	**Day Case Rates**	**L**	**BCBV**	**A**	
	The calculation of performance is based on our position against benchmarks set by the British Association of Day Surgery (BADS)				

Target per Month	Jan-12	Current Month Variance
75%	81.35%	6.35%

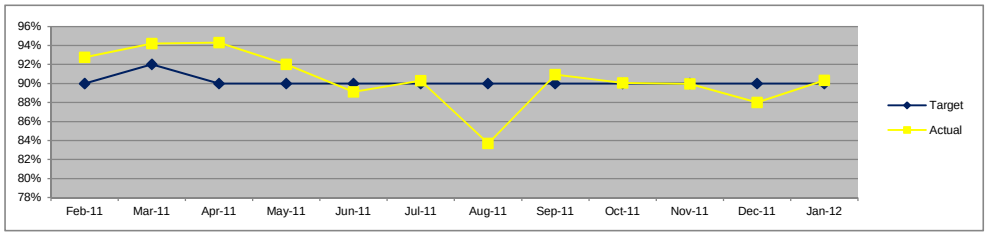


Analysis: This is a significant improvement from the position reported in December (78.85%) by 2.5%, we remain well above target. The following specialties have an overall compliance rate of less than 75% - Breast Surgery (56.5%), ENT (42.7%), General Surgery (64.3%) and Vascular (61.6%).

Actions: We are continuing to look at any specialties that are significantly below expectation

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

Target	Jan-12	Current Month Variance
90%	90.32%	0.32%



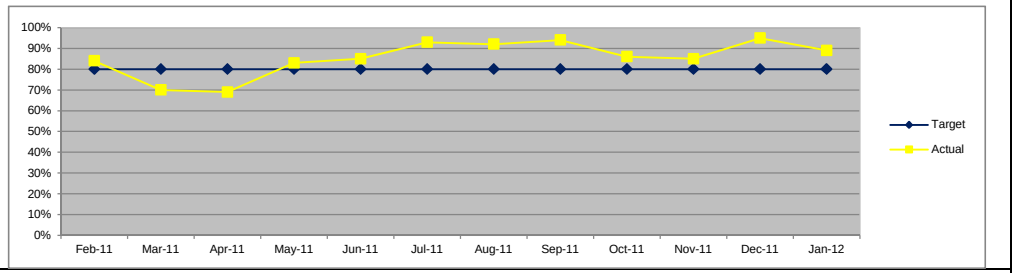
Analysis: The overall Trust position for theatre utilisation was above the target for the month of January.

Actions:

3.1.8	Stroke/TIA	L	QA	

This indicator shows the percentage of patients who receive a CT scan within 24 hours following admission with primary diagnosis of stroke

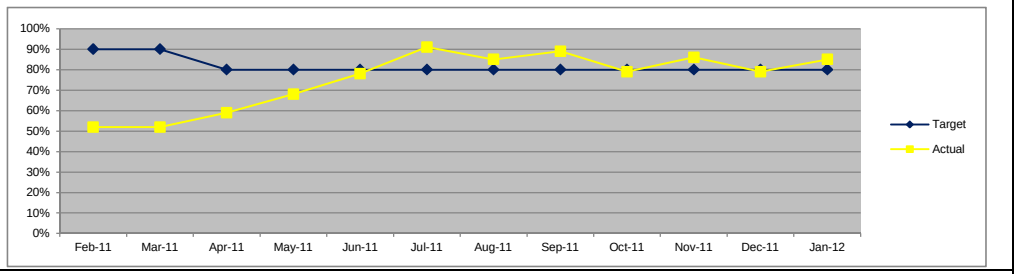
Target per Month	Jan-12	Current Month Variance
80%	89%	9%



Analysis: Remaining above target by 9%

This indicator shows the percentage of patients admitted with primary diagnosis of stroke should spend greater than 90% of their hospital stay on a dedicated Stroke Unit

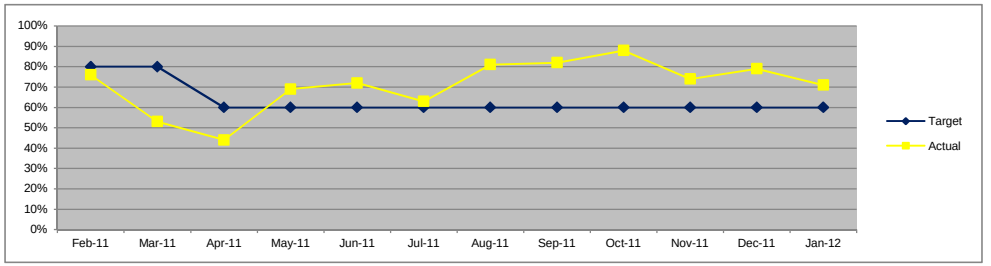
Target per Month	Jan-12	Current Month Variance
80%	85%	5%



Analysis: This shows an improvement from last months position and has taken us back above target by 5%.

This indicator shows the TIA Service - High risk patients will be assessed and treated within 24 hours

Target per Month	Jan-12	Current Month Variance
60%	71%	11%

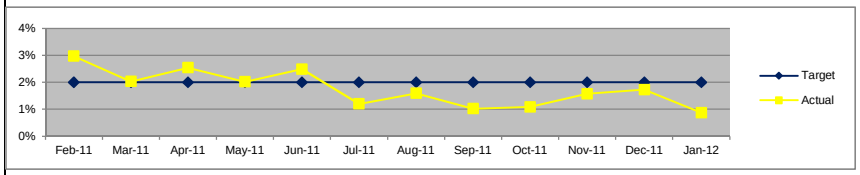


Analysis: This indicator remains above target by 11%.

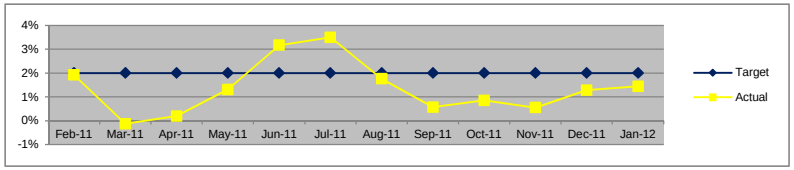
3.2	**Workforce**		
3.2.1	**Recruitment and Retention**	**L**	**I**

Recruitment is seen as a key priority for the Trust, most particularly into nursing posts. Keeping vacancies to a minimum will not only improve patient and staff experience, it will also help with our aim to reduce the reliance and therefore expenditure on temporary staff.

Vacancies - Trained Nursing Staff



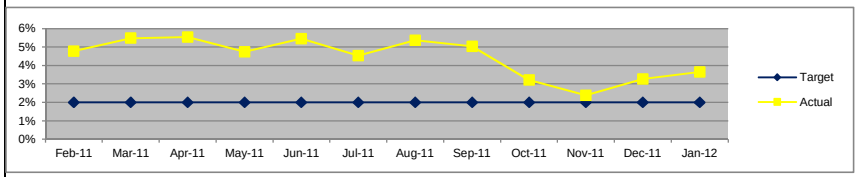
Vacancies - Non Trained Nursing Staff



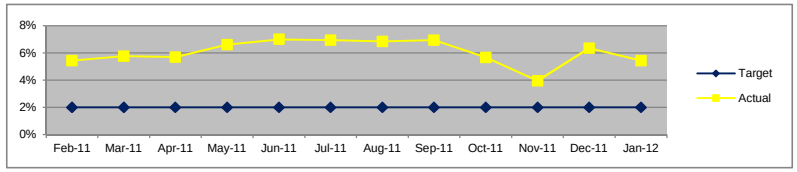
Analysis: Trained and untrained vacancies have decreased with the placements of the newly qualified staff.

Actions: Vacancies are low across the Trust at the moment and advertising has slowed down ready for the re-deployment of winter ward staff over the next couple of months.

Vacancies - Medical Training Grades



Vacancies - Non Medical Training Grades



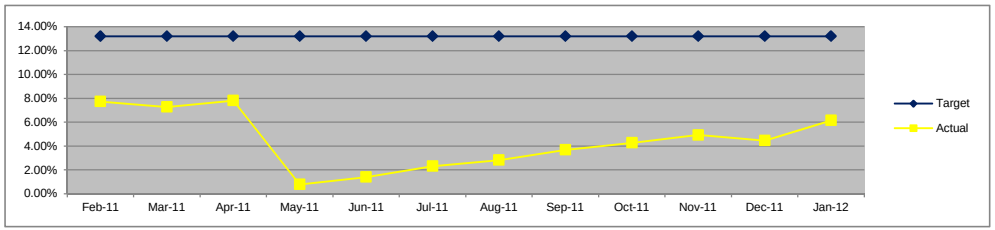
Analysis: Vacancies for trained have decreased in January while non-training posts have remained quite constant. Vacancies are still evident in Emergency Medicine and Haematology.

Actions: All vacant posts are being advertised.

3.2.2	**Turnover**	**L**	**I**	

Figures from the Chartered Institute of Personnel and Development's Recruitment and Retention Survey 2008, indicated that the annual turnover rate in the UK is 17.3% and within the NHS has increased from 12.1% to 13.2%. The Trust internal target for last year was 11.5% but given the change in the national turnover rate, the target has been set at 13.2%.

Target	Jan-12	Current Month Variance
13.20%	6.15%	-7.05%

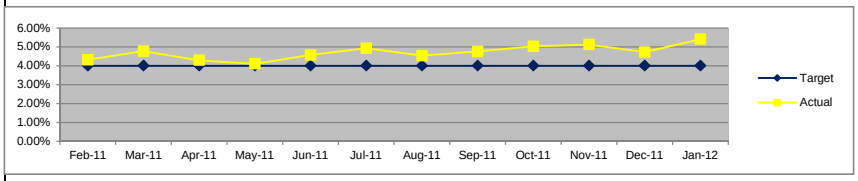


Analysis: We continue to achieve a much better turnover rate than the national NHS rate of 13.2%

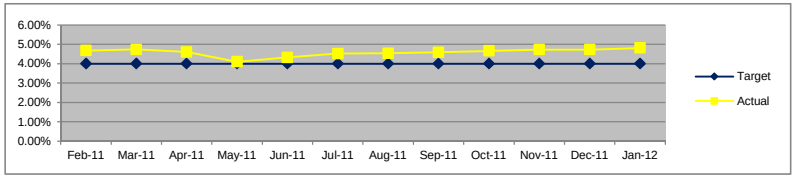
Actions:

3.2.3	**Sickness Absence**	**L**	**I**	

In Month Actual - The Trust target is 4%



Moving Annual Average - The Trust target is 4%

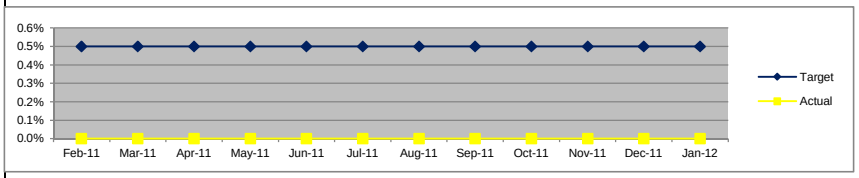


Analysis: Overall sickness for January was 5.41%, of this absence the top four reasons were:- Other musculoskeletal (16.09%), Anxiety/stress/depression (12.28%), Other known causes not elsewhere classified (11.59%) and Back problems (9.56%).

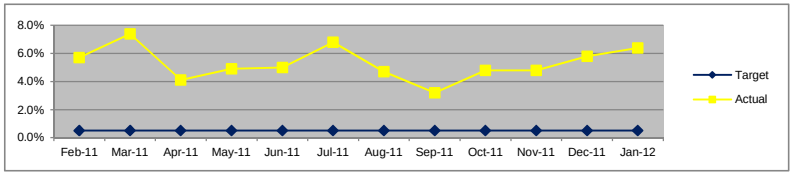
Actions: Sickness absence workshops continue to provide managers with help and support in the management of sickness absence. Those areas with high absence rates are being offered additional support. There is a policy review group currently looking at the existing arrangements for managing sickness absence with a view to trialling a revised process from March 2012.

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

Temporary Nursing Staff (cumulative spend) - Agency Staff



Temporary Medical Staff (cumulative spend) - Agency Staff



Analysis: There has been no agency expenditure for nursing staff during January. In terms of medical agency there has been an increase in month from 5.8% in December to 6.4% in January. **Surgical Division** has seen an increase in month from £98K in December to £106K in January. Agency expenditure in Critical Care has been high during January due to vacancies within the department. **Medical Division** saw an increase in month from £163K in December to £187K in January. Clinical Haematology was high due to agency staff covering a middle grade vacancy, A&E expenditure is high due to vacancies on middle grade and SHO rotas, Gastro and Endoscopy are also currently carrying middle grade vacancies. **Community Services** remained static in month £21K in December and £21K in January, this is due to the continued use of locum service in Rehabilitation to cover long term sick leave for a specialty doctor.

Actions:

3.2.5	**Compliance with European Working Time Regulations**	**L**	

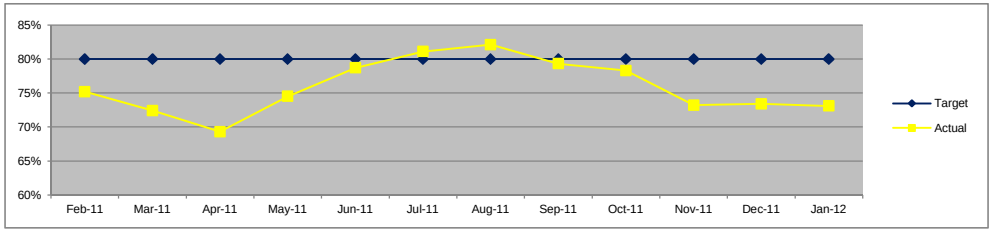
The European Working Time Directive lays down minimum requirements in relation to working hours, rest periods, annual leave and working arrangements for night workers. The EWTD is a legal requirement and leads to a better health and safety and work life balance for all employees.

Analysis: For Junior Medical Staff we are 100% compliant.

3.2.6	**Education and Training**	**L**	**NHS C**	**I**	

Annual Appraisal: Workforce performance outcomes will be addressed through the Trust's annual appraisal and personal development processes. This indicator shows the percentage of all staff who have had an appraisal in the last 12 months. For 2011/12 the target remains at 80%.

Target	Jan-12	Current Month Variance
80%	73.10%	-6.90%

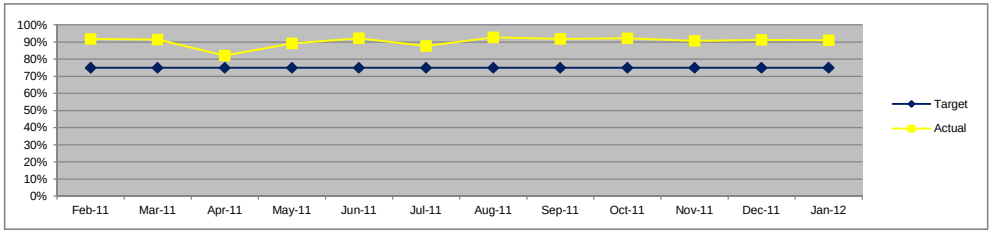


Analysis: January's position has seen a slight deterioration from the one reported in December, the overall Trust position remains below the target set for 2011/2012. The following Divisions are showing as red i.e. <70% overall compliance. **Medical Division** - of a total of 2,311 staff of which 793 staff do not have an up to date appraisal giving the division a compliance rate of 65.7% **Corporate Services** - of a total of 699 staff of which 228 staff do not have an up to date appraisal giving the division a compliance rate of 67.4%

Mandatory Training | I

The Trust has a list of eight mandatory training topics which are generic and therefore applicable to all staff. The areas of focus are: Customer Care, Fire Safety, Hand Hygiene, Information Governance, Risk Management/Incident Reporting, Safeguarding Adults, Safe Guarding Children & Bullying and Harassment

Target	Jan-12	Current Month Variance
75%	91.03%	16.03%

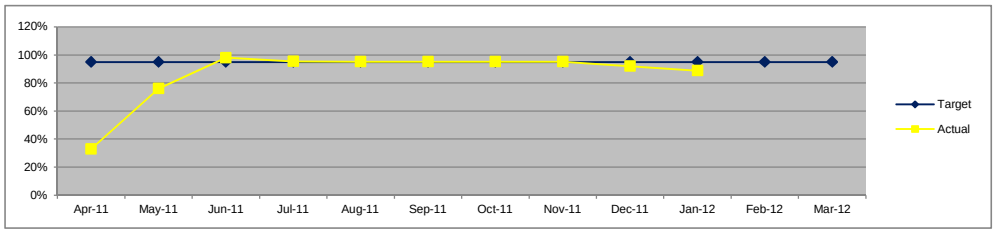


Analysis: This is a slight deterioration from last months position of 91.38% in December to 91.03% in January, we continue to remain above target. There are four areas with departments showing <65% compliance i.e. 'red' performance are; **Bullying & Harassment** (Care Services, Palliative Medicine & Trust Management Team) **Fire Safety** (Capacity & Emergency Planning, Endoscopy, Palliative Medicine, Social Workers Support & Trust Management Team) **Safeguarding Adults** (Palliative Medicine) **Safeguarding Children** (Palliative Medicine & Estates Development)

Information Governance | I

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

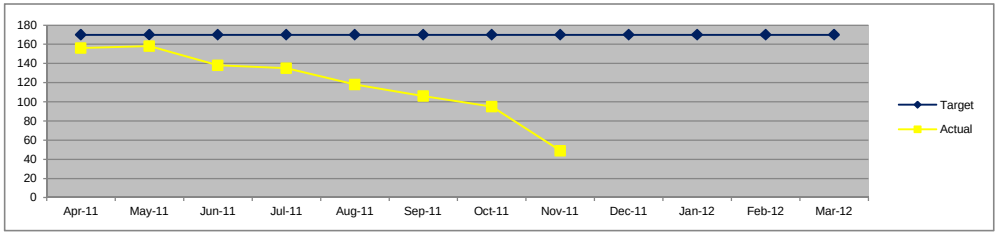
Target	Jan-12	Current Month Variance
95%	88.80%	-6.20%



Analysis: This is a deterioration from the position reported last month 91.99% in December against 88.8% in January, we remain below target by 3.19%. The following areas are showing <65% compliance i.e. 'red' performance. **Surgical Division** (Speech & Language Therapy) **Medical Division** (Palliative Medicine & Therapies)

4)	HEALTHY LIFESTYLES		
4.1	**Smoking Cessation**	**C**	

Monthly Target	Cum Plan	Cum Actual	Cum Variance
170	1360	955	-405

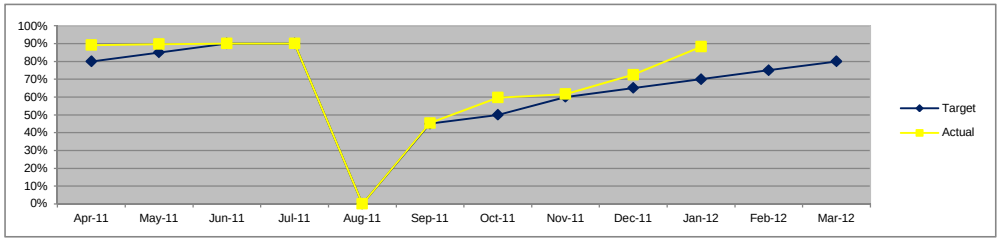


Analysis: Current target was based on the 2009/10 baseline which was a record year for the service. This was largely based on a national and local media campaign. The national campaign has not run this year and there has been very limited local media. This culminates in a significantly reduced interest and referral into the service.

Actions: Restructuring of the department and service model will improve the delivery of the service to maximise resources. Referral pathways have been introduced into EAU and maternity services at New Cross. This is increasing the number of high risk patients accessing the service.

4.2	**Human Papillomavirus (HPV)**	**C**	

Target	Jan-12	Current Month Variance
70%	88%	18%



Analysis: This indicator carries a profiled target as it usually runs alongside the academic school year (hence no target for August)

Actions:

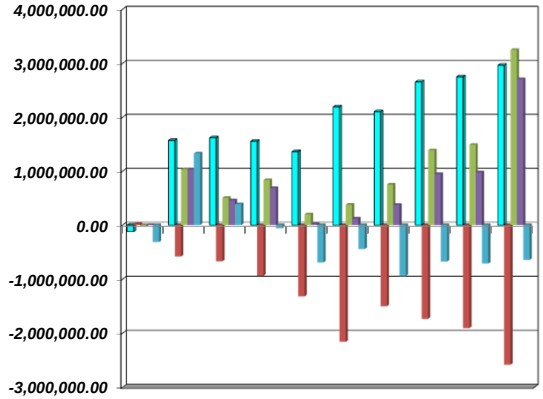
5) FINANCE

A

RWHT

5.1 Income variance vs. Plan
5.2 Expenditure variance vs. Plan
5.3 EBITDA is in line with plan
5.4 Achieve income and expenditure net surplus
5.5 SLA income against plan

Analysis: With the exception of expenditure variance vs plan and SLA income against plan, all areas are reporting a favourable position at Month 10



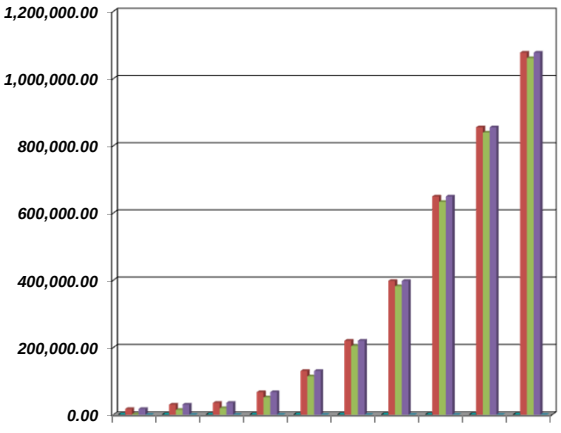
	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12
5.1	-122,000	1,570,000	1,616,000	1,552,000	1,359,000	2,189,000	2,101,000	2,653,000	2,747,000	2,961,000
5.2	20,000	-585,000	-673,000	-941,000	-1,322,000	-2,161,000	-1,503,000	-1,737,000	-1,907,000	-2,584,000
5.3	-31,000	1,033,000	504,000	834,000	200,000	376,000	750,000	1,386,000	1,487,000	3,245,000
5.4	1,000	1,028,000	459,000	684,000	18,000	121,000	374,000	944,000	978,000	2,705,000
5.5	-317,000	1,328,000	387,000	-58,000	-692,000	-446,000	-944,000	-676,000	-713,000	-647,000

C

Community

5.1 Income variance vs. Plan
5.2 Expenditure variance vs. Plan
5.3 EBITDA is in line with plan
5.4 Achieve income and expenditure net surplus
5.5 SLA income against plan

Analysis: With the exception of expenditure variance vs plan and SLA income against plan, all areas are reporting a favourable position at Month 10



	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12
5.1	0	0	0	0	0	0	0	0	0	0
5.2	17,000	30,000	35,000	67,000	130,000	220,000	398,000	649,000	855,000	1,077,000
5.3	1,000	14,000	19,000	51,000	114,000	204,000	382,000	633,000	839,000	1,061,000
5.4	17,000	30,000	35,000	67,000	130,000	220,000	398,000	649,000	855,000	1,077,000
5.5	0	0	0	0	0	0	0	0	0	0

5.6 Delivery of Cost Improvement Programme

	Dec-11	Jan-12
2011/12 Total CIP	£14,075	£14,075
Quarter 4 (100%)	£11,260	£14,075
Current Position	£9,043	£10,303
Variance against Q3 Plan	**-£2,217**	**-£3,772**

The table above shows year to date actual delivery of CIP against plan for Quarter 4. This equates to 73.2% removed from budgets against a plan of 100%.

5.7 Actual Performance against contract

	Plan	Actual	Variance
Emergency In-patients	35,750	36,456	**706**
Elective In-patients	8,446	8,033	**-413**
New Out-patients	83,085	85,788	**2,703**
All Out-patients	214,771	217,260	**2,489**

The table above shows year to date actual performance against cumulative plan

6) ENVIRONMENT

6.1 Capital Programme is delivered to CRL

Annual Plan	Year End Forecast	Variance
£19,240,000	£18,303,909	**-£936,091**

Analysis: Total forecasted annual is £936K under plan (4.9% under spend).

6.2 Capital spend is managed within plan

Cumulative Plan	Cumulative Actual	Variance
£11,652,338	£9,236,272	**-£2,416,066**

Analysis: Cumulative spend is £2,416K behind plan (20.7%).