The Royal Wolverhampton Hospitals NHS Trust	

Trust Board Report

Meeting Date:	26th September 2011
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.
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: **(eg from/to other committees)**	-
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). For a more comprehensive view of the performance for all indicators please see the Detailed Performance Report which can be found at appendix A.
2	**Report Contents** This report covers the following areas: • Performance Dashboard • Exception Reports (Red rated PIs) • Activity Dashboard (community activity only) In addition to the overview of performance this report also provides more detailed assurance for 3 areas of performance: • A&E clinical quality indicators – new indicators and first set of national data now issued • Stroke – Update on corrective action plan • Community Services Q1 Business Plan Objectives

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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 4 indicators measured in this section, covering C Difficile, MRSA, E. Coli and re-admissions.	1	1	2	4
Patient Experience There are 3 indicators in this section. Although, the number of formal complaints received does not carry a target as the Trust welcomes all feedback.	1	0	1	2
Service Delivery This section is measured by a suite of 32 indicators, covering RTT, A&E, New & Existing national targets, patients dying in place of choice, length of stay, day case rates and theatre utilisation.	5	0	29	34
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.	6	0	7	13
Totals	13	1	39	53
Last Month	14	0	39	53
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 provided as separate dashboard as they form part of the Monitor Compliance Framework.

Theme	Red	Amber	Green	Total
Monitor Compliance Framework This sets out the approach Monitor will take to assess compliance of NHS Foundation Trusts and to intervene where necessary. This is made up of a set of 19 indicators	3	0	16	19

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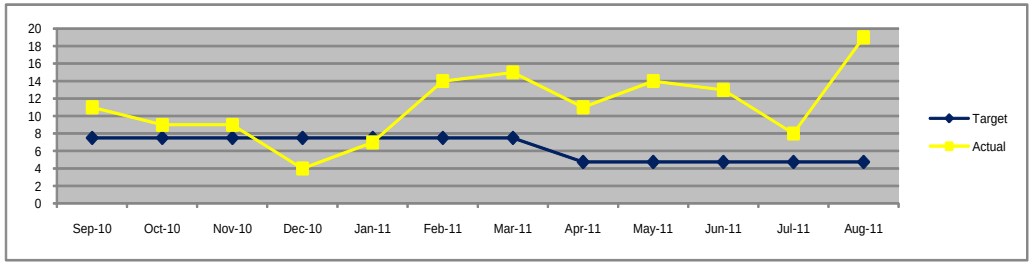
Exception Reports

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
57	23.75	65	41.25	195

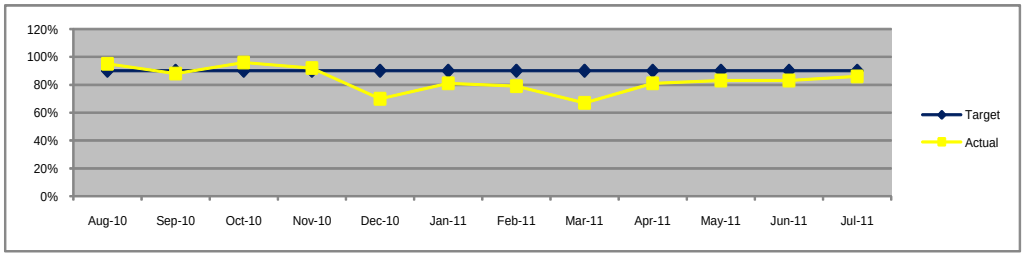


Analysis: The cases reported are attributable as follows:- ICCU x 1, Cardiac/Cardiology x 2, General Surgery/Urology x 2, Orthopaedic x 1, Elderly Care/Stroke x 1, Rehab (West Park) x 1, Renal & Diabetes x 2, Respiratory/Gastro x 5, Emergency Services x 2 and Oncology Haematology x 2.

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	May 11 Validated	June 11 Validated	July 11 Validated
90%	83%	83%	86%

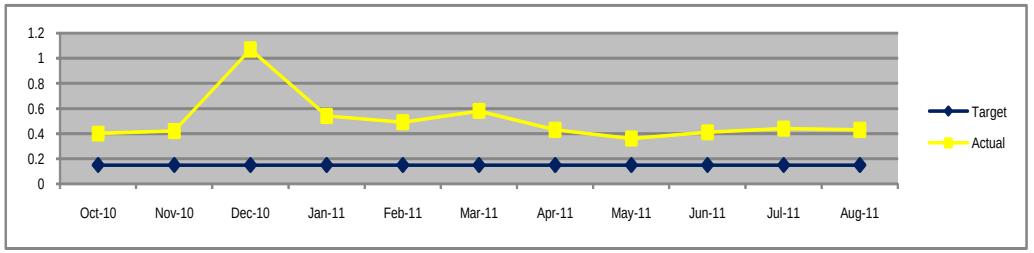


Analysis: 42 complaints were received in July, 23 of which were responded to within 25 working days. 10 complaints took longer than 25 working days, 7 of which had obtained consent to breach (3 Head & Neck, 1 Critical Care, 1 General Surgery and 1 Cardiology). 30 complaints did not have consent to breach (2 A&E, 1 Trauma & Orthpaedic). 9 complaints remain open 6 of which have consent to breach (1 Head & Neck, 1 General Surgery, 2 Ophthalmology, 1 A&E and 1 Care of the Elderly). 3 complaints remain open without consent to breach (1 A&E, 1 Estates and 1 Gastroenterology).

Time to Initial Assessment (for ambulance patients)	A	

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

Target	Aug-11	Variance
< 15 mins	43 Mins	28 mins

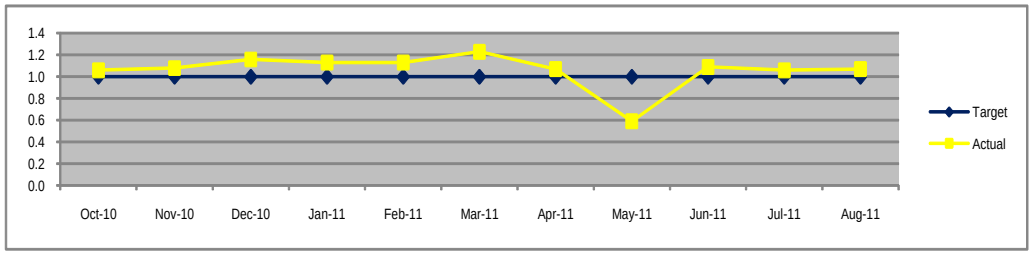


Analysis: This indicator has remained above target since shadow monitoring began in October 2010. Work continues within the department to work towards reducing the initial assessment for ambulance patients.

Time to Treatment Decision (Median)	A	

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

Target	Aug-11	Variance
< 60 mins	01:07	7 mins

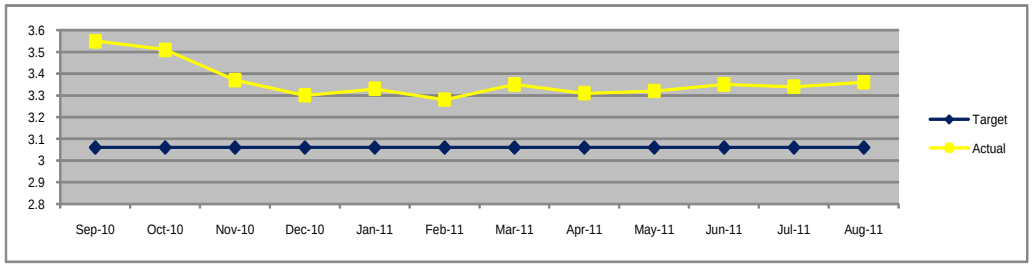


Analysis: With the exception of May 2011 this indicator has remained slightly above target since shadow montioring began in October 2010. Work continues within the department to work towards reducing the time to treatment decision.

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	Aug-11	Variance
3.06	3.36	0.30



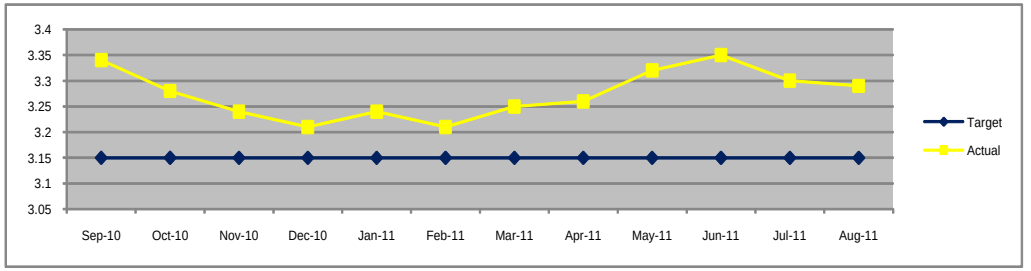
Analysis: This is a very slight deterioration from the position reported in July of 3.34%, remaining above target by 0.30%. To support the delivery of the Business Realisation Plan and Cost Improvement Programme schemes this target may change as a measurement of delivery.

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

Non-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	Aug-11	Variance
3.15	3.29	0.14



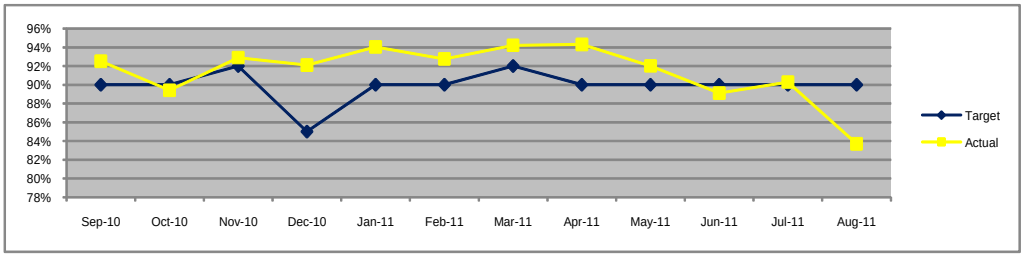
Analysis: This is a very slight improvement from the position reported in July (3.30%), remaining above target by 0.14%. One of the areas that has shown a significant increase during August is Neurology

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

Theatre Utilisation	L	A

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 this Month	Aug-11	Variance
90%	83.70%	-6.30%



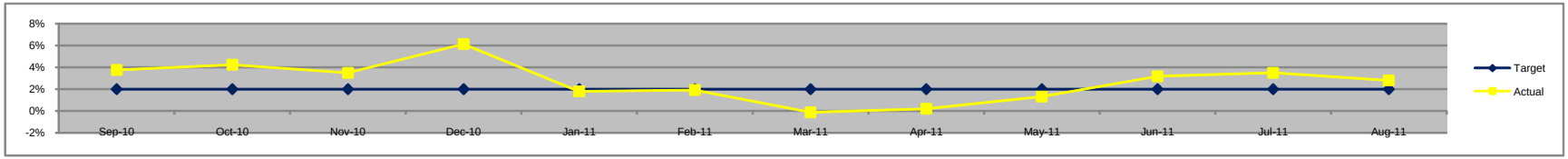
Analysis: The overall Trust position for theatre utilisation was below target for the month of August. The main reason for theatre down time during August was Consultant annual leave.

Actions: In the future theatre utilisation will also be measured by percentage of theatre time used against planned theatre time available.

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.

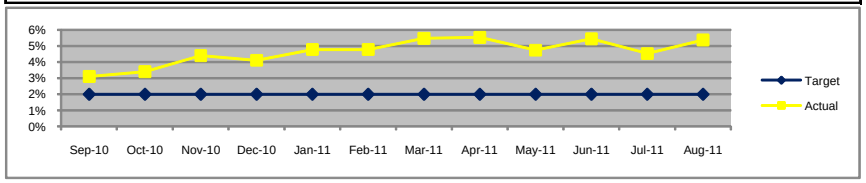
Vacancies - Non Trained Nursing Staff



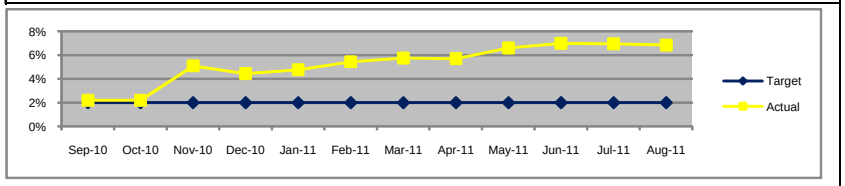
Analysis: Trained vacancies have increased slightly while untrained vacancies have decreased.

Actions: Targeted recruitment to Band 5 nursing posts continues in addition to recruitment to the winter wards.

Vacancies - Medical Training Grades



Vacancies - Non Medical Training Grades

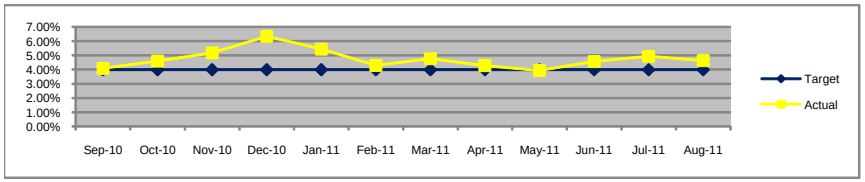


Analysis: Non-training vacancies have remained fairly constant this month while training vacancies have increased slightly. Vacancies are evident in Emergency Medicine, Cardiology and Paediatrics.

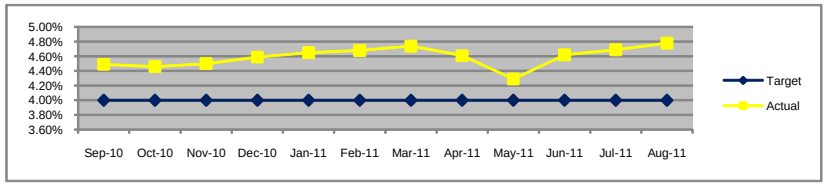
Actions: All vacant post are being advertised.

Sickness Absence	L	I	

In Month Actual - The Trust target is 4%



Moving Annual Average - The Trust target is 4%

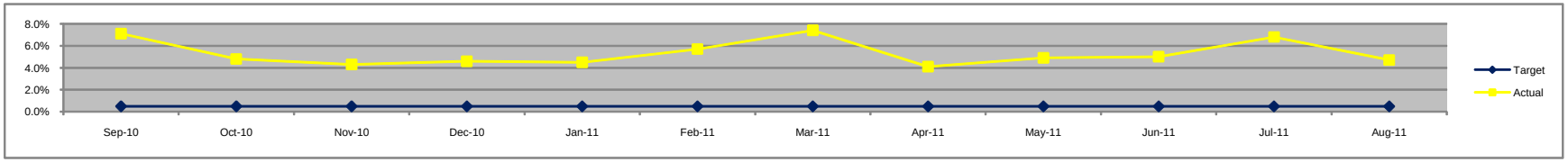


Analysis: Sickness absence for the month of August decreased by 0.29%; from 4.94% in July to 4.65% in August. This is an increase of 0.73% compared with the same period last year. During the month of August 2011 of the hours lost due to sickness absence 1.41% was due to short term absence and 3.24% was due to long term absence. The top three reasons for short term absence were, viral illness 14% of hours lost, diarrhoea and vomiting which equated to 12% of hours lost, and MSD Hip/lower limb which equated to 12% of hours lost. The top three reasons for long term sickness absence were operations/post operative recovery/other investigations 13% of absence, mental health (anxiety/stress) equated to 10% of absence and MSD Spine/Neck equated to 11% of absence.

Actions: Montly sickness absence workshops and management as per Trust policy continues to ensure managers are supported managing the absence.

Temporary Staffing	L	

Temporary Medical Staff (cumulative spend) - Agency Staff



Analysis: There has been no agency expenditure for nursing staff during August. In terms of medical agency there has been an reduction in month of 2.1% from 6.8% in July to 4.7% in August. **Surgical Division** has seen an reduction in month from £138K in July to £129K in August. Agency expenditure in Head & Neck remains high due to use of Locum's to maintain the service within the directorate. Cardiology expenditure also remains high due to the ongoing use of agency staff. **Medical Division also** saw a reduction in month from £151K in July to £76K in August. Neurology remains high due to the continuing use of Commercial services being used for Consultant Neurophysiologist work. Spend also remains high in Emergency Services due to ongoing vacancies.

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Activity Dashboard (community activity only)

It is important to note that the data for community activity only covers the period up to July, efforts are underway to align the data collection systems with those of acute activity which currently reports August data.

Theme	Red	Amber	Green	Total
Rehabilitation Covering inpatient/outpatient clinics for services such as care of the elderly, rehabilitation and falls assessment	6	1	5	12
Community Nursing Covering 11 services including community matrons, district nursing and Walk-in-Centre.	5	2	4	11
Child and Family Services Total of 6 services from school nursing to contraceptive and sexual health services	1	2	3	6
Allied Health Professionals Total of 9 services from physiotherapy, OT, speech and language therapy and foot health.	1	2	3	8
Healthy Lifestyles Total of 4 services including food health, walking for health, smoking cessation and health trainers.	3	-	1	4
Totals	18	7	16	41*
Last Month	17	11	14	42
Trend **(arrow indicates measure of improvement. i.e. ↑ is getting better)**	↓	↑	↑	

***Overall numbers have come down by 1 as podiatry surgery is no longer part of contract following the departure of the podiatry surgeon.

Details for all the Red rated indicators that are **UNDER** performing against contract are below:

Department	Service	Currency	Comments	RAG
Rehab Services	Care of the Elderly Outpatients	Follow ups	Variation affected by small numbers.	-21%
	Falls Assessment Clinic	Firsts	Variance is affected by small numbers. However, underperformance is being investigated.	-54%
	Falls Assessment Clinic	Follow ups	Variance is affected by small numbers. However, underperformance is being investigated.	-44%
Community Nursing	Continence	Total Contacts	Capacity issues resulting in less contacts. Clinic capacity being increased.	-52%
	Walk In Centre	All Contacts	Investigating reasons for decrease in activity	-20%
Allied Health Professionals	Podiatry Assessment	Totals	As Podiatry surgery is no longer provided, the service now only assess patients that needs advice related to surgical options or alternatives as opposed to first line treatment with surgical intervention.	-51%
Healthy Lifestyles	Smoking Cessation	Quitters	There is always a delay in data collection for this service so therefore it is still too early to identify that we are below target due to the nature of the service.	-43%

Details for all the Red rated indicators that are **OVER** performing against contract are below:

Department	Service	Currency	Comments	RAG
Rehab Services	Spasticity Clinic	Totals	Variation affected by small numbers.	28%
	Community Neuro Rehabilitatio	Totals	Better data collection due to the use of digi - pens.	42%
	Standard Wheelchairs	Units	Activity is based on units and unit price has gone up. Hence to achieve the same number of activity more units are required. Performance simply reflects this. Discussions are underway with the commissioner to re-base the plan.	33%
Community Nursing	Heart Failure Service (Nursing)	Total Contacts	Effects of implementation of HF service review and identifying cases through review of GP registers. Awaiting outcome of decision on 6 monthly MOT from Commissioners	24%
	Hospital at Home (CICT)	Total Contacts	IV therapy has increased within community	79%
	Community Matrons	Total Contacts	Closer working with general practice	39%
Child and Family Services	Community Childrens Nursing	Total Contacts	There was an increase in the number of new referrals to the CCN service in June and July; particularly those children requiring daily contacts for acute care such as wound dressings. There are a number of new families on caseload whose children have naso gastric tubes inserted at present and these families can call out a nurse up to three times a day to replace the tube, increasing the subsequent contacts. We also received more calls at weekends to support these children.	21%
Allied Health Professionals	Occupational Therapy	Initials	Increased performance with data entry timeliness and backlog clearance. Increase in number of GP referrals. Average no. of GP referrals ytd = 37, compared to average of 18 monthly referrals last year.	35%
	Community Falls Prevention	Totals	A new referral route has been established which has seen an increase in numbers, this may also linked to the decrease in referral numbers through to the falls assesment clinic.	22%
Healthy	Food Health	Referrals	Referral processes have become successful, however the service expects this to balance over the coming months.	125%

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Special Reports

A&E

The Operating Framework 2011/12 announced that a set of clinical quality indicators would be introduced to provide a comprehensive and balanced view of the care delivered in A&E. The eight A&E clinical quality indicators are:

	Indictor	Threshold	Assessment
Headline Measures	1) Left without being seen rate	<5%	Grouped together – need to achieve at least 1 indicator in this block
	2) Unplanned re-attendance rate	<5%	
	3) Total time spent in A&E	<240mins	Grouped together – need to achieve at least 1 indicator in this block
	4) Time to initial assessment	<15mins	
	5) Time to treatment	<60mins	
	6) Service experience		subject to separate assessment
	7) Ambulatory Care		
	8) Senior consultant sign-off		

To judge compliance against the thresholds, the five headline measures will be divided into two groups; organisations will be regarded as achieving the required minimum level of performance where robust data shows they have achieved the thresholds for at least one indicator in each of the two groups. **However** - compliance with the minimum threshold for total time in A&E will also be used for each quarter in 2011/12 by the DH.

The DH are suggesting to all providers that data for the A&E clinical quality indicators should be published so that it is accessible to the patient and helps professionals to see areas of improvement and success.

In addition to publishing quantitative information on the indicators, it is suggested that A&E sites should also compare their performance against suitable benchmarks and peer groups, reflecting the national performance figures alongside the trusts own performance information.

A narrative explanation of performance on each indicator has also been provided which reflects what constitutes good clinical care and how the Trust has delivered this. Copies of the dashboards that have been produced can be found at appendix B. These dashboards cover the shadow monitoring period of April – June and include the latest data available as at August 2011.

An overview dashboard of performance based on the national data set can be found below. **Please note this is the nationally provided data and relates to APRIL ONLY. The trust is able to provide more up to date data but this is not able to be benchmarked against national performance.**

	Left Department without being seen rate	Re-attendance rate *	Time to initial assessment (Performance; minutes)			Time to Treatment (Performance; minutes)			Time to Departure (Performance; minutes)		
			Median	95th Percentile	Longest wait	Median	95th Percentile[3]	Longest wait	Median	95th Percentile	Longest wait
ENGLAND	**3.4%**	**7.5%**	**6**	**116**	**1,439**	**57**	**198**	**1,439**	**131**	**258**	**1,439**
RWHT	4.1%	7.0%	9	43	112	66	159	265	119	234	754
	Worse	Better	Worse	Better	Better	Worse	Better	Better	Better	Better	Better

*It is important to note that the DH have published data for Re-attendance rate using a different set of data definitions, hence the 5% threshold does not apply.

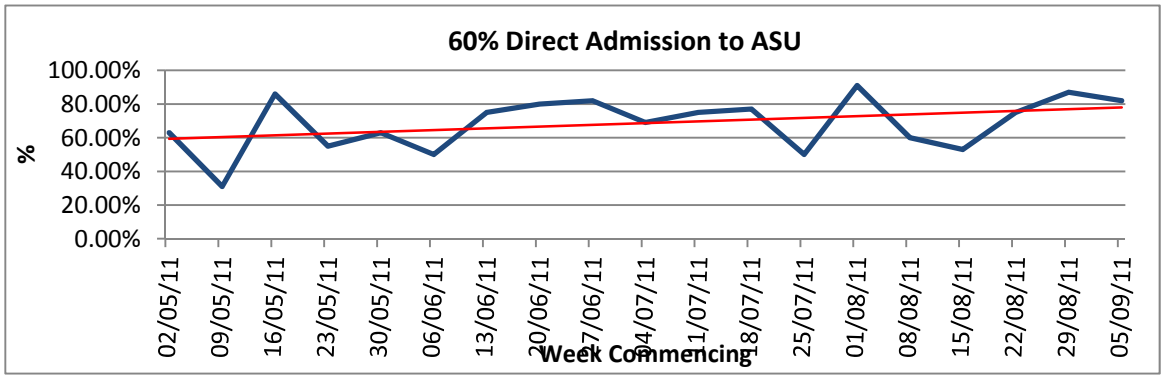
Stroke

Despite a long history of performing well against key targets, in April 2011 the service was issued with a performance notice by Wolverhampton PCT for failing to achieve national targets on key performance indicators, as a result an action plan was agreed to increase performance for the following key target areas:-

- Direct admissions to a Stroke unit – target 60% of patients within 4 hours
- Patients to spend at least 90% of time on the stroke unit –target 80% of patients
- High risk TIAs seen within 24 hrs- target 90% of patients

This report gives the current performance and actions taken to achieve improvements and details the achievements by the service in moving to an integrated pathway approach following TCS.

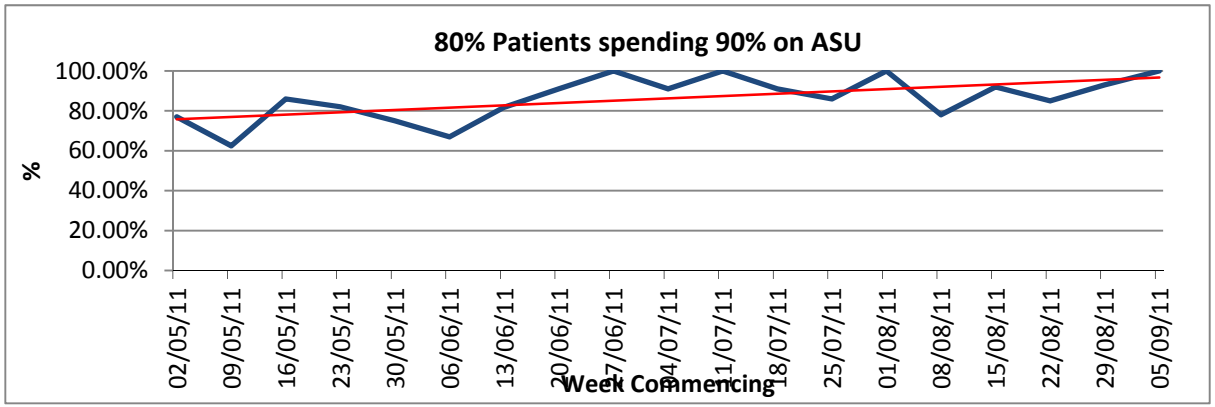
Direct Admissions to ASU



In April 2011 the average direct admissions to the ASU was 44% by August 2011 this has been increased to 73.20 %. Direct admissions within 4 hours have increased to 67%. The following actions were taken to improve the performance.

- Ring-fenced beds on ASU for direct admissions
- Better co ordination between ASU and Capacity team
- Improved pathway to Rehabilitation and Early supported discharge services in the community with reduced LOS at West Park by actively using TCS to support integration of the services.
- Arrangements agreed with Mid Staffs for early repatriation of patients 3 days post Stroke.

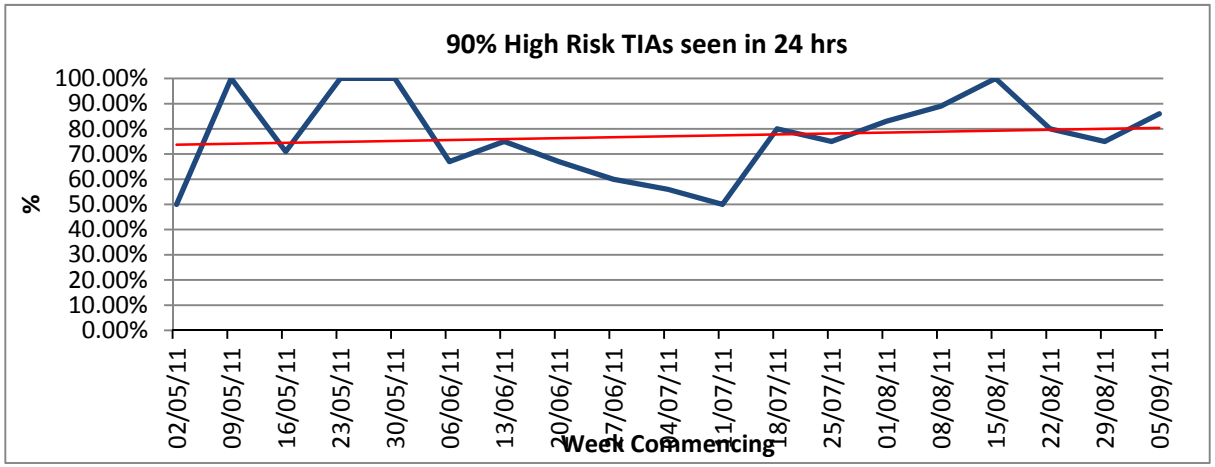
80% of patients spending 90% of stay on ASU



In April 2011 the average percentage of patients who spent 90% of their stay on an acute Stroke unit was 59% by August 2011 this has increased to 85 %. The actions taken to achieve this are the same as for direct admissions as increasing patients admitted directly has a direct consequence on the amount of time spent on the specialist unit.

	Target	April	May	June	July	August
% spending 90% of their entire stay on a stroke unit	80%	59%	68%	78%	91%	85%

% of high risk TIA seen within 24 hours



In April 2011 to average number of patients who were seen in a High Risk TIA clinic within 24hours of referral was 44% this has increased to 81%, this is expected to increase further with the introduction of weekend TIA clinics with effect from 24th September 2011. Other actions taken include

- TIA pathway revised with direct booking for A&E
- Exception reporting and investigation of each breach on a weekly basis
- Communication to GP's where TIA pathway has not been followed

	Target	April	May	June	July	August
High risk referrals in 24hrs	90%	44%	69%	72%	63%	81%
Low risk seen within 7 days	90%	82%	93%	84%	91%	92%

Community Services Business Plan

As part of the overall integration of community services with the Trust, the Business Plan has now been added as a separate item within the annual plan monitoring that is also presented quarterly to the Board (ref Business Outcome 1.1.7 of annual plan report). This report contains an overview of the projects and an exception report for any projects rated as RED.

	Description	Rating
Quality Projects	**Service Level KPIs -** Develop service level quality KPIs in line with patient safety / "no harm" indicators.	
	Patient Safety Walk rounds - Develop a programme of quality walk-round assessments as part of patient safety first campaign for 2011/12	
	Clinical Audit - Undertake an audit of clinical documentation in line with revised clinical records guidelines.	
	GP Liaison - Develop an action plan to improve GP liaison and attachments following audit results.	
Service Projects	**Service Line Reporting** - The project will offer the opportunity to correctly apportion costs across service lines and to analyse future income potential on a cost and volume/ PbR basis to develop appropriate currency and payment arrangements for community services.	
	Develop a Compliance Framework - identify all quality and operational targets and imperatives that have to be met in order to meet regulatory and mandatory operating standards.	
	Virtual Ward Development - Reduce non elective acute hospital usage through multidisciplinary case management. Support the Productive Community Services programme that will revitalise the workforce and improve productivity and skill mix of community staff.	
	Nurse Led Bed Project - Reduce length of hospital stay and providing alternative solutions to avoid acute hospital admission through the provision of both "step up" and "step down" beds. Emphasis on managing ongoing health and social care needs in a co-ordinated way.	
	Early Supported Discharge for stroke - Enable the accelerated discharge of stroke patients to their family home providing specialist rehabilitation and social support in the community comparable to that of an in-patient rehabilitation stroke unit.	
	Community Tariff Development - Develop appropriate currency and payment arrangements for community services/ patient pathways.	
	Health Visiting Review - Undertake a review of the health visiting service and evaluate the revised service model.	

Details for the RED rated project can be found below:

Objective	Current RAG	Trend	Milestones	Progress
Health Visiting Review - Given the requirement to increase the number of health visitors to a national benchmark level and the key challenges facing Wolverhampton, including; the significantly increased intensity of family support, resultant from unprecedented increases in children subject to child protection plans and the implementation of a revised commissioning model to align the service with Children's Centres. It is proposed to undertake a review of the health visiting service and evaluate the revised service model.	R		Establish external review lead Agree Terms of Reference with the lead and senior children's team. Primary Care and Local Authority (early years) input will be encouraged as part of the review.	Lead identified, Terms of reference have been established and agreed with the reviewer, work programme and proposal now received. Work to commence late September/early October .

1.1 Foundation Trust - Compliance Framework

Performance Indicator	Threshold	Weighting	Quarter 1				Jul-11				Aug-11			
			Numerator	Denominator	Result	Weighted Score	Numerator	Denominator	Result	Weighted Score	Numerator	Denominator	Result	Weighted Score
Clostridium Difficile year on year reduction	57	1.0	34	14.25	19.75	1.0	8	4.75	3.25	1.0	15	4.75	10.25	1.0
MRSA year on year reduction (year end target)	0	1.0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0
62 day wait for first treatment - from urgent GP referral to treatment	85%	1.0	195.5	220	88.86%	0.0	65.5	74.5	87.92%	0.0	64	73.5	87.07%	0.0
62 day wait for first treatment - from Consultant Screening service referral	90%		22	22.5	97.78%		14	14.5	96.55%		10	10	100.00%	
62 day wait for first treatment - Consultant Upgrades	85%		105	109	96.33%		25	25	100.00%		33	33.5	98.51%	
31 day wait for second or subsequent treatment - Surgery	94%	1.0	136	139	97.84%	0.0	45	45	100.00%	0.0	35	36	97.22%	0.0
31 day wait for second or subsequent treatment - Anti cancer drug treatments	98%		243	243	100.00%		80	80	100.00%		63	63	100.00%	
31 day wait for second or subsequent treatment - Radiotherapy	94%		456	460	99.13%		160	160	100.00%		110	112	98.21%	
31 day wait from diagnosis to first treatment - All cancers	96%	0.5	547	550	99.45%	0.0	180	182	98.90%	0.0	167	170	98.24%	0.0
Two week wait from referral to date first seen - All cancers	93%	0.5	1642	1720	95.47%	0.0	549	586	93.69%	0.0	565	597	94.64%	0.0
Two week wait from referral - Symptomatic Breast	93%		431	457	94.31%		112	113	99.12%		99	104	95.19%	
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	95%	1.0 (failing 3 or more) 0.5 (failing 2 or less)	38834	39346	98.70%	0.0	11704	11857	98.71%	1.0	13614	13920	97.80%	0.5
A&E Time to initial assessment - < 15 mins	95%								00:44				00:43	
A&E Time to treatment (Median)	<60 mins								01:06				01:07	
A&E Unplanned re-attendance rate	<5%								5.26%				4.44%	
A&E Left without being seen	<5%								4.67%				4.11%	
Patient experience - Learning Disabilities	-	0.5												
Referral to treatment waiting times - Non-admitted 18.3 weeks (95th percentile)	18.3	1.0			14.06	0.0			14.06	0.0			14.09	0.0
Referral to treatment waiting times - Admitted 23 weeks (95th percentile)	23	1.0			17.98	0.0			17.98	0.0			18.86	0.0
Screening all elective in-patients for MRSA		0.5	18857	12769	147.68%	0.0	6396	4334	147.58%	0.0	6553	4255	154.01%	0.0
				Total		1.0		**Total**		2.0		**Total**		1.5

<1 = Green

>1 - <2 = Amber - Green

>2 - <4 = Amber - Red

>4 = Red

The Trust overall performance for August 11 is rated as 1.5, this gives us an overall Governance risk rating of Amber-Green

2) PATIENT SAFETY

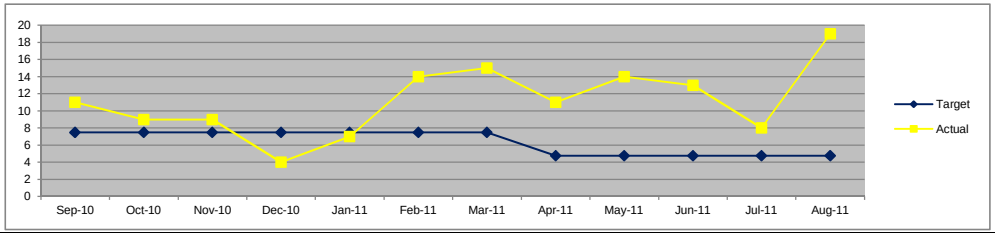
2.1 Healthcare Acquired Infections (HCAI's)

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.

2.1.1 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
57	23.75	65	41.25	195

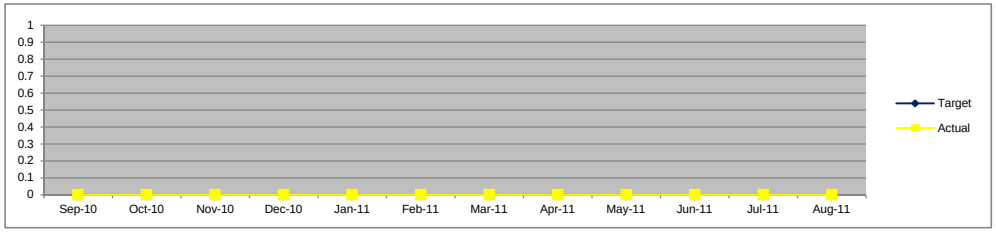


Analysis: The cases reported are attributable as follows:- ICCU x 1, Cardiac/Cardiology x 2, General Surgery/Urology x 2, Orthopaedic x 1, Elderly Care/Stroke x 1, Rehab (West Park) x 1, Renal & Diabetes x 2, Respiratory/Gastro x 5, Emergency Services x 2 and Oncology Haematology x 2.

2.1.2 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

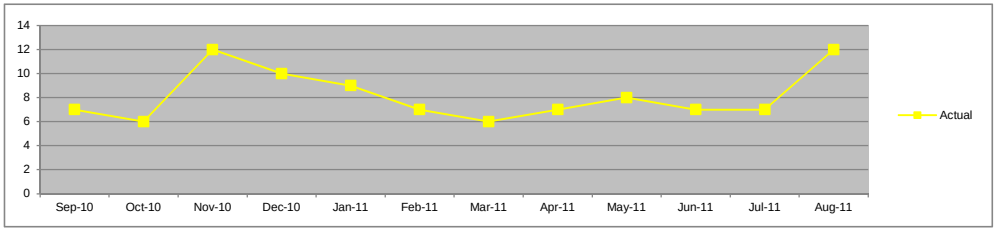


Analysis: This is the twenty sixth consecutive month without an MRSA Bacteraemia

2.1.3 E Coli Bloodstream

PCT | SHA

Number of E Coli Cases (Target)	Cum Plan	Cum Actual	Cum Variance	Year End Forecast
12	0	22	22	88

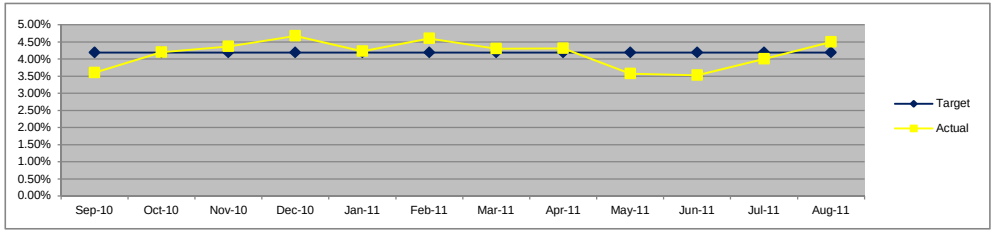


Analysis: Quarter 1 surveillance is now complete for this indicator. The results will be taken to the next Clinical Quality Review meeting which is being held in September, the benchmark for this indicator will be agreed on at this meeting.

2.3	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	Jun-11	Jul-11	Aug-11	Current Month Variance
4.19%	3.53%	4.00%	4.50%	-0.31%



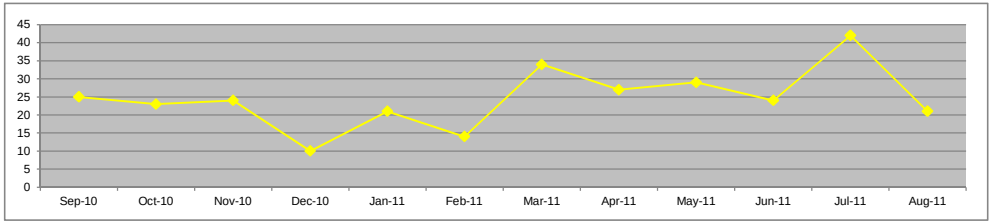
Analysis: Percentage of emergency readmissions within 30 days has shown an increase from the July position by 0.5%

3) PATIENT EXPERIENCE

3.1	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.

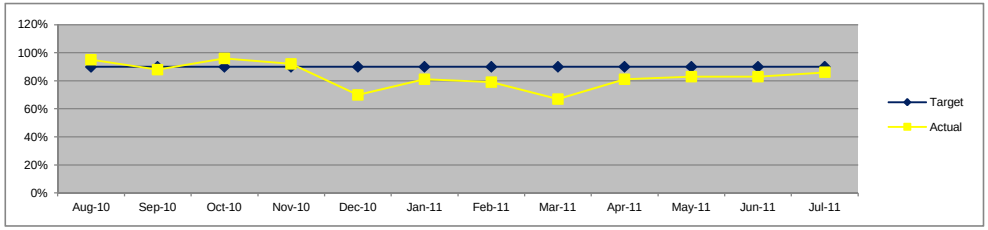
Current Month August 2011	Cum Actual	Year End Actual 2010/11	Year End Forecast 2011/12
21	143	272	343



3.2	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	May 11 Validated	June 11 Validated	July 11 Validated
90%	83%	83%	86%

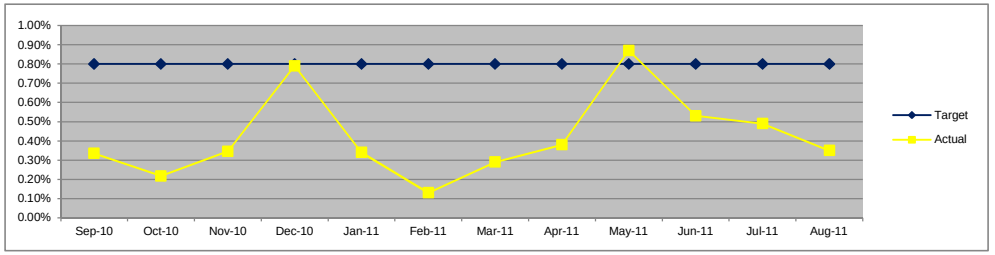


Analysis: 42 complaints were received in July, 23 of which were responded to within 25 working days. 10 complaints took longer than 25 working days, 7 of which had obtained consent to breach (3 Head & Neck, 1 Critical Care, 1 General Surgery and 1 Cardiology). 30 complaints did not have consent to breach (2 A&E, 1 Trauma & Orthopaedic). 9 complaints remain open 6 of which have consent to breach (1 Head & Neck, 1 General Surgery, 2 Ophthalmology, 1 A&E and 1 Care of the Elderly). 3 complaints remain open without consent to breach (1 A&E, 1 Estates and 1 Gastroenterology).

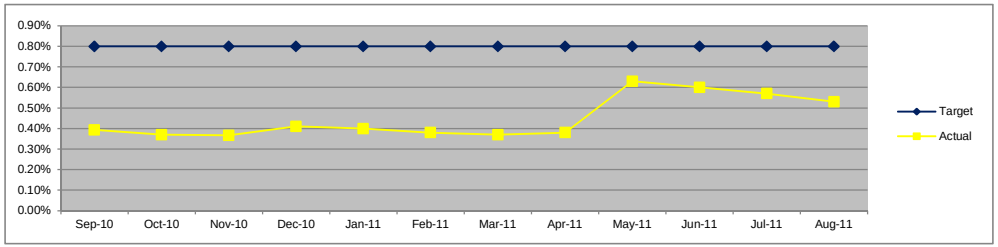
3.3	**Short Notice Cancellation of Operations**	**CQC N**	**L**	**A**

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	June 11 Actual	July 11 Actual	August 11 Actual
0.80%	0.53%	0.49%	0.35%



Cumulative	Jun-11	Jul-11	Aug-11
Cancellations	110	142	164
Elec Procedures	18387	24906	31231
Cumulative %	0.60%	0.57%	0.53%



	Anaes not available	Electrical Fault	Ran out of theatre time	More urgent case(s)	No beds	Surgical Assistant not avail	Staff Sickness	Total
Urology			1					**1**
Gen Surg	3	2	2					**7**
Cardiac			2	1	2	1		**6**
Gynae			1					**1**
Ortho					4			**4**
Cardiology								**0**
H&N			3					**3**
Ophthal								**0**
Total	**3**	**2**	**9**	**1**	**6**	**1**	**0**	**22**

Actions: 22 operations were cancelled during August, this an improvement 32 in July. 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. 9 cases were cancelled due to running out of theatre time, these were mainly due to unforeseen circumstances and complications on patients who were earlier on the operating lists.

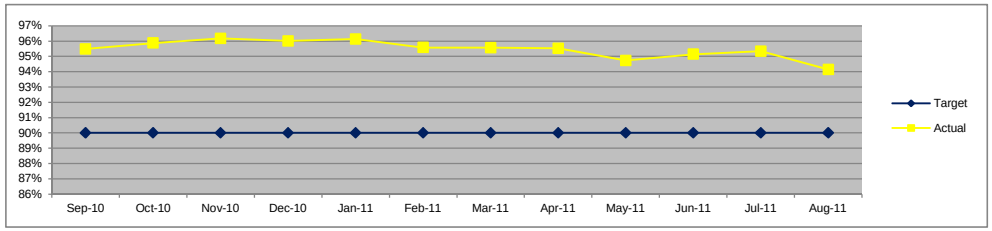
4)	EFFICIENCY AND EFFECTIVENESS					
4.1	Service Delivery					
4.1.1	18 week Referral to Treatment (RTT)	CQC N	PCT	QA	I	

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

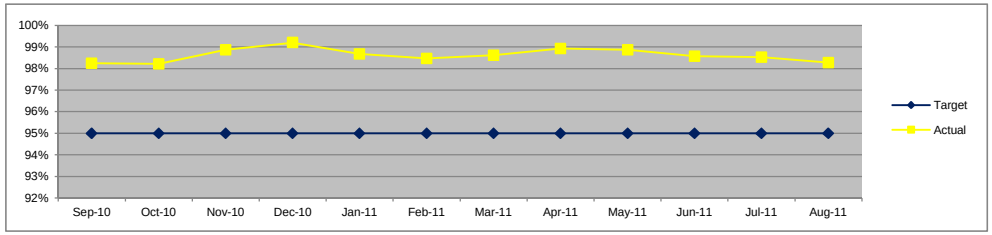
Admitted

Target	Aug-21
90%	94.15%



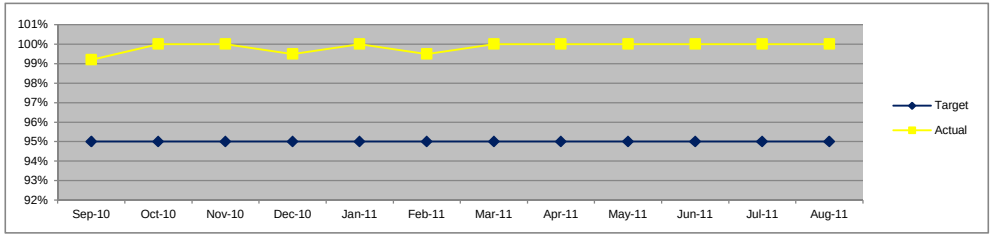
Non-admitted

Target	Aug-11
95%	98.27%



Non-admitted - Audiology (Community only)

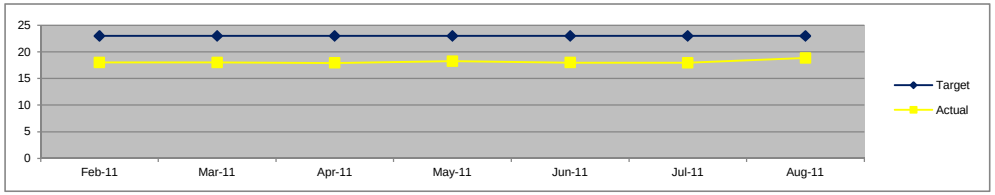
Target	Aug-11
95%	100.00%



Comments: All specialties achieved the target during August

Admitted - 95th Percentile within 23 weeks

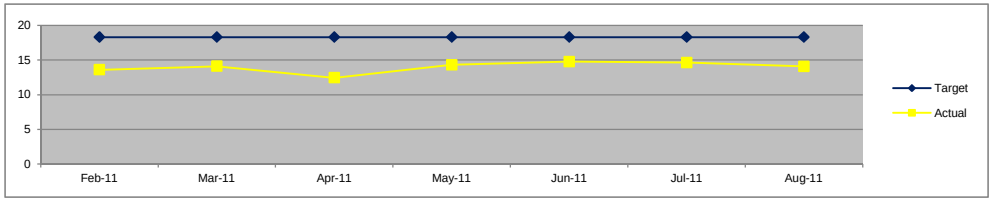
Target	Aug-11
< 23	18.86



Comments:

Non-admitted - 95th Percentile within 18.3 weeks

Target	Aug-11
< 18.3	14.09



Comments:

4.1.2 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 2% 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.

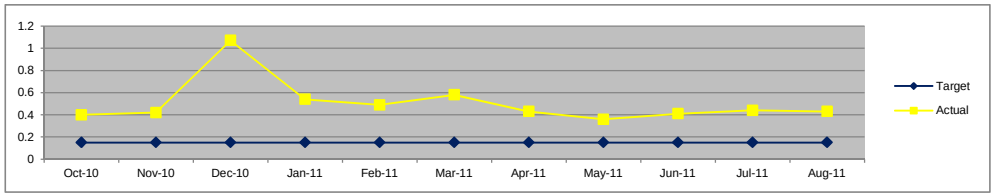
	Target	Aug-11	Variance	Cumulative	Variance
New Cross Hospital	95%	96.67%	1.67%	97.75%	2.75%
Walk-in & DOC	95%	100.00%	5.00%	100.00%	5.00%
Overall	95%	97.81%	2.81%	98.50%	3.50%

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	Aug-11	Variance
< 15 mins	43 Mins	28 mins

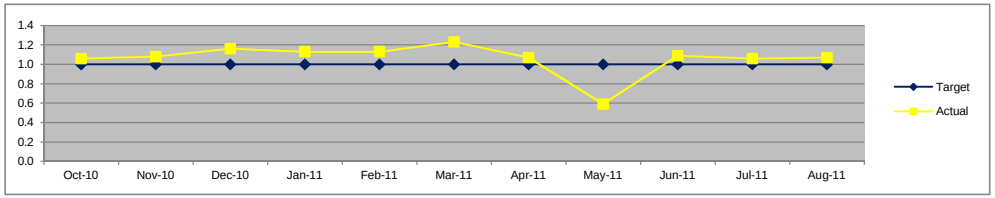


Analysis: This indicator has remained above target since shadow monitoring began in October 2010. Work continues within the department to work towards reducing the initial assessment for ambulance patients.

Time to Treatment Decision (Median) | **A**

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

Target	Aug-11	Variance
< 60 mins	01:07	7 mins

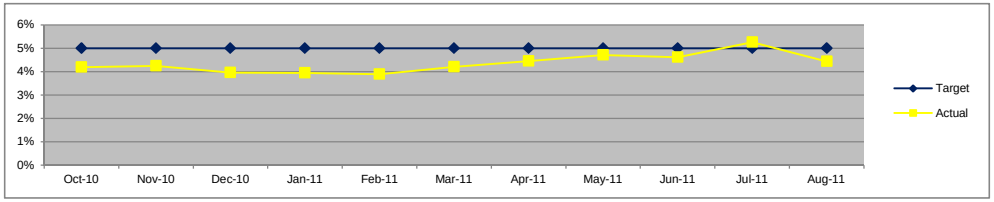


Analysis: With the exception of May 2011 this indicator has remained slightly above target since shadow monitoring began in October 2010. Work continues within the department to work towards reducing the time to treatment decision.

Unplanned Re-attendance Rate | **A**

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

Target	Aug-11	Variance
< 5%	4.44%	-0.56%

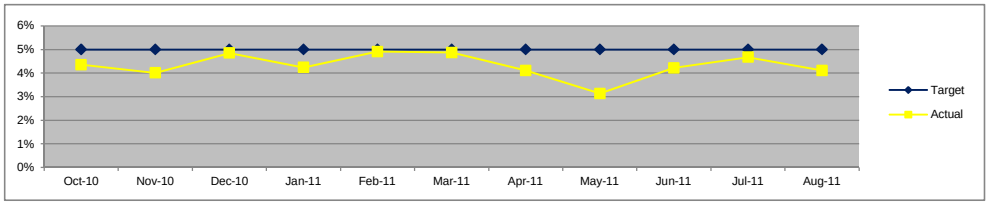


Analysis:

Left Without Being Seen | **A**

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

Target	Aug-11	Variance
< 5%	4.11%	-0.89%



Analysis:

4.1.3 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.

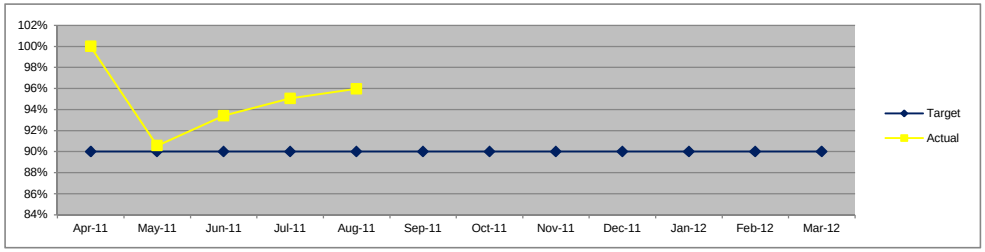
Indicator	Current	Indicator	Current
Access to Genito Urinary Medicine - 100% of patients will be offered an appointment within 48 hours	100.00%	In order to monitor the reduction of health inequalities related to ethnic diversity, it is essential that data quality on ethnic group is >/=90%	93.32%
Reducing 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	51	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%)	94.64%
Two Week Wait for symptomatic breast patients (cancer not initially suspected) (93%)	95.19%	31 day (diagnosis to treatment) Wait for first treatment - all cancers (96%)	98.24%
31 day wait for second or subsequent treatment: Surgery (94%)	97.22%	31 day wait for second or subsequent treatment: Anti Cancer Drug Treatment (98%)	100.00%
31 day wait for second or subsequent treatment: Radiotherapy Treatments (94%)	98.21%	62 days (traditional) from urgent GP referrals to first definitive cancer treatment - all cancers (85%)	87.07%
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%)	98.51%
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 - 12 breaches - 1 complex pathway, 2 further investigations, 9 tertiary referrals received at 48 days or more. We continue to see late referrals being received from other hospitals.

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

Target	Aug-11	Variance
90%	95.97%	5.97%

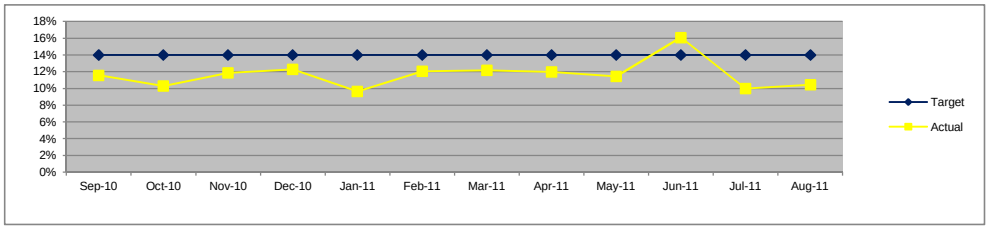


Comments: This measure is a percentage of the total number of patients in contact with the service who have died in their place of choice.

4.1.5	**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	Aug-11	Variance
14%	10.44%	-3.56%



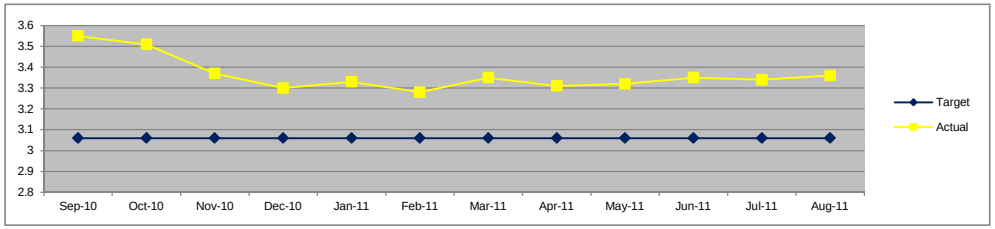
Analysis: Percentage of bed days spent pre-operatively has shown a slight deterioration from the position reported in July of 9.98%, however, we remain below target by 3.56%.

Actions:

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	Aug-11	Variance
3.06	3.36	0.30



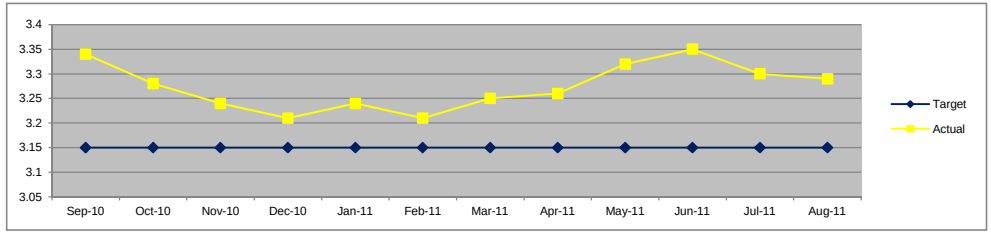
Analysis: This is a very slight deterioration from the position reported in July of 3.34%, remaining above target by 0.30%. To support the delivery of the Business Realisation Plan and Cost Improvement Programme schemes this target may change as a measurement of delivery.

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

Non-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	Aug-11	Variance
3.15	3.29	0.14



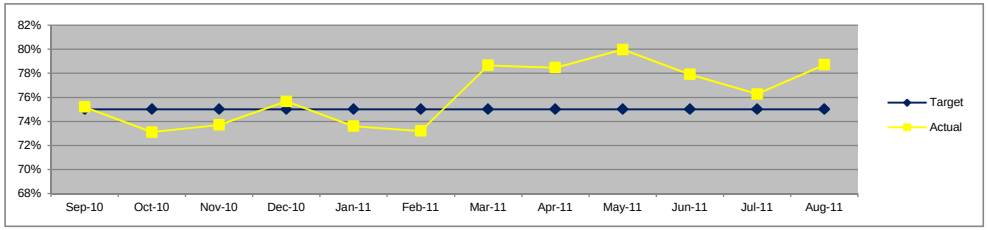
Analysis: This is a very slight improvement from the position reported in July (3.30%), remaining above target by 0.14%. One of the areas that has shown a significant increase during August is Neurology

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

4.1.6	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	Aug-11	Variance
75%	78.70%	3.70%



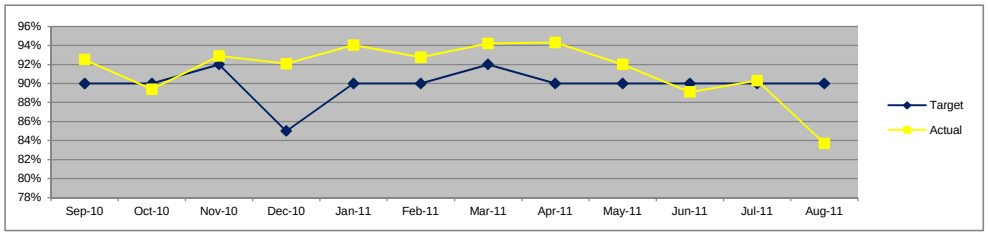
Analysis: This is an improvement from the position reported in July (76.27%) by 2.43%, we remain above target. The following specialties have an overall compliance rate of less than 75% - Breast Surgery (29%), ENT (50.7%), General Surgery (58.5%), Gynaecology (26.7%), Urology (66%) Vascular (45.9%) and Paediatric Surgery (65.9%). To support the delivery of the Business Realisation Plan and Cost Improvement Programme schemes this target may change as a measurement of delivery.

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

4.1.7	Theatre Utilisation	L	A	

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 this Month	Aug-11	Variance
90%	83.70%	-6.30%



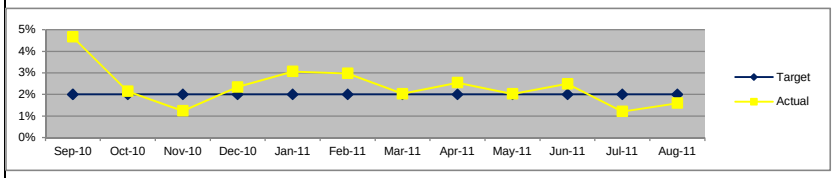
Analysis: The overall Trust position for theatre utilisation was below target for the month of August. The main reason for theatre down time during August was Consultant annual leave.

Actions: In the future theatre utilisation will also be measured by percentage of theatre time used against planned theatre time available.

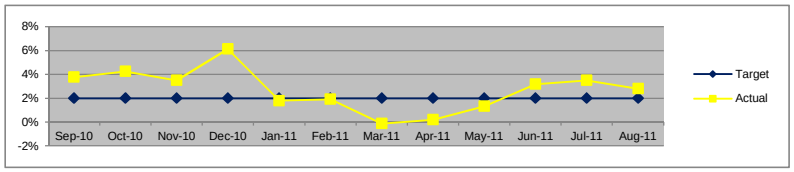
4.2	Workforce				
4.2.1	Recruitment and Retention	L	I		

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



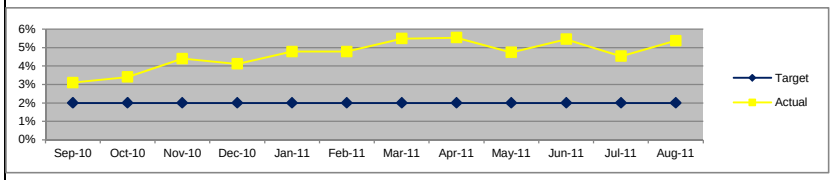
Vacancies - Non Trained Nursing Staff



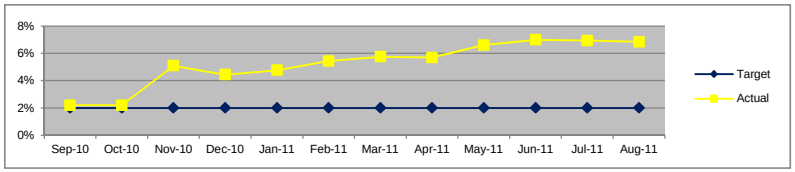
Analysis: Trained vacancies have increased slightly while untrained vacancies have decreased.

Actions: Targeted recruitment to Band 5 nursing posts continues in addition to recruitment to the winter wards.

Vacancies - Medical Training Grades



Vacancies - Non Medical Training Grades



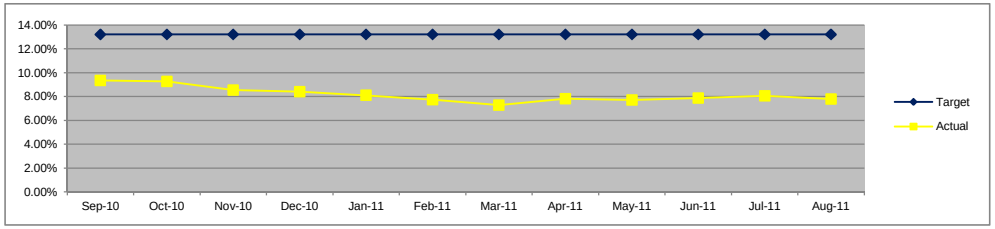
Analysis: Non-training vacancies have remained fairly constant this month while training vacancies have increased slightly. Vacancies are evident in Emergency Medicine, Cardiology and Paediatrics.

Actions: All vacant post are being advertised.

4.2.2 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	Aug-11	Variance
13.20%	7.80%	-5.40%

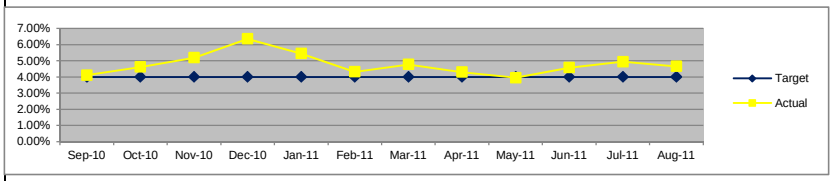


Analysis: We continue to achieve a much better turnover rate than the national NHS rate of 13.2%

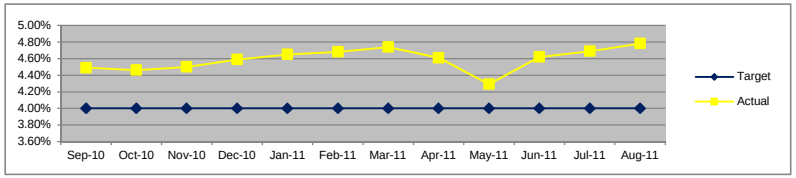
Actions:

4.2.3 Sickness Absence | **L** | **I**

In Month Actual - The Trust target is 4%



Moving Annual Average - The Trust target is 4%

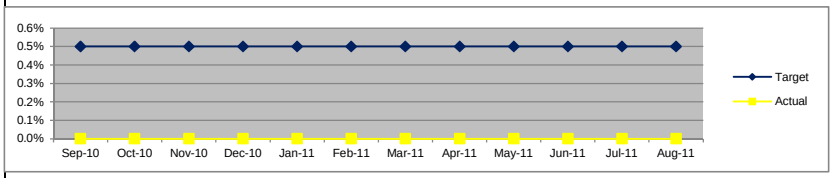


Analysis: Sickness absence for the month of August decreased by 0.29%; from 4.94% in July to 4.65% in August. This is an increase of 0.73% compared with the same period last year. During the month of August 2011 of the hours lost due to sickness absence 1.41% was due to short term absence and 3.24% was due to long term absence. The top three reasons for short term absence were, viral illness 14% of hours lost, diarrhoea and vomiting which equated to 12% of hours lost, and MSD Hip/lower limb which equated to 12% of hours lost. The top three reasons for long term sickness absence were operations/post operative recovery/other investigations 13% of absence, mental health (anxiety/stress) equated to 10% of absence and MSD Spine/Neck equated to 11% of absence.

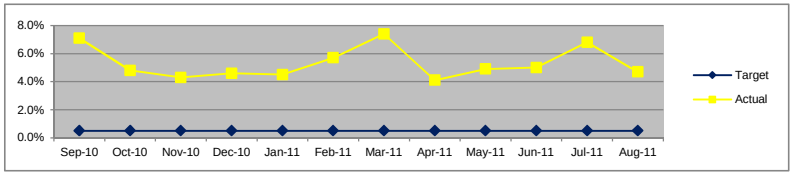
Actions: Monthly sickness absence workshops and management as per Trust policy continues to ensure managers are supported managing the absence.

4.2.4	**Temporary Staffing**	**L**	

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 August. In terms of medical agency there has been an reduction in month of 2.1% from 6.8% in July to 4.7% in August. **Surgical Division** has seen an reduction in month from £138K in July to £129K in August. Agency expenditure in Head & Neck remains high due to use of Locum's to maintain the service within the directorate. Cardiology expenditure also remains high due to the ongoing use of agency staff. **Medical Division also** saw a reduction in month from £151K in July to £76K in August. Neurology remains high due to the continuing use of Commercial services being used for Consultant Neurophysiologist work. Spend also remains high in Emergency Services due to ongoing vacancies.

Actions:

	Compliance with European Working Time Regulations	**L**	

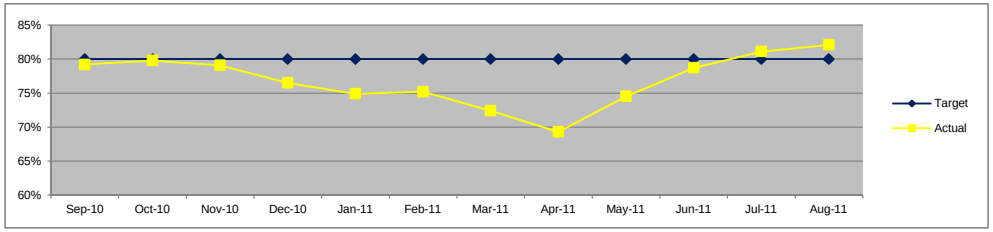
The European Working Time Directive lays down minimum requirements in relation to working hours, rest periods, annual leave and working arrangements for night workers. The EWTD is a legal requirement and leads to a better health and safety and work life balance for all employees.

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

4.2.6	**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	Aug-11	Variance
80%	82.10%	2.10%

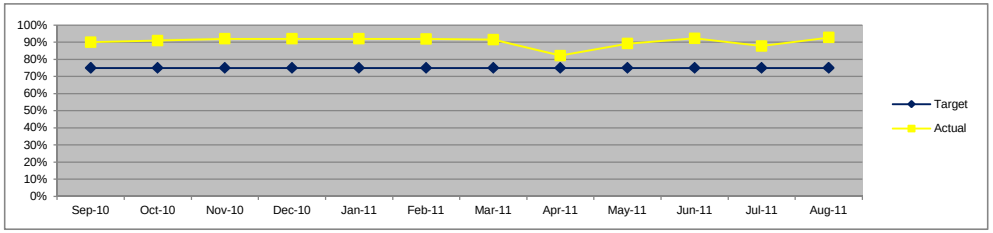


Analysis: August's position has seen an improvement from the one reported in July, the overall Trust position remains above the target set for 2011/2012. The following areas are showing as red i.e. <70% compliance, the number of staff with no appraisal in the last 12 months is shown in brackets. **Surgical Division** - Trauma & Orthopaedics (46), Dental Services (23) **Medical Division** - Accident & Emergency (41), Acute Medicine (39), Dermatology (12), Diabetes (27), Rheumatology (11), Social Workers Support (5), Divisional Management/Governance (12), Adult Services (107), Child & Young Peoples Services (77), Diabetic Nurses (7) **Estates and Facilities** - Catering (47), Domestic (144), Staff Accommodation (1), Transport (13), Estates/Facilities (3) **Corporate Services** - Finance (23), Medical Illustration (4), Nurse Training (6), Trust Management Team (8), Procurement (4)

Mandatory Training

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	Aug-11	Variance
75%	92.70%	17.70%

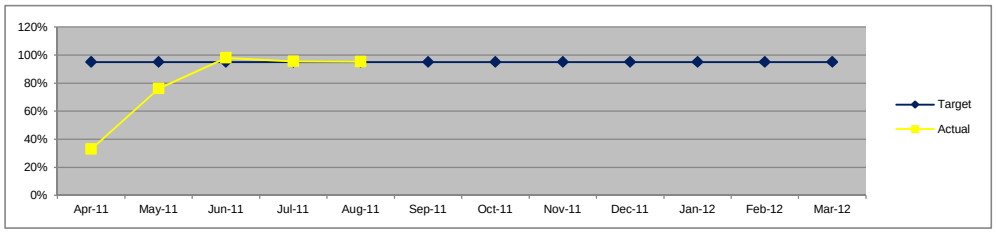


Analysis: There is an improvement from last months position of 87.8% in July to 92.7% in August, we continue to remain above target. This measure now fully includes all Community Staff. There are six areas with departments showing <65% compliance i.e. 'red' performance are; **Bullying & Harassment** (Rehab Services, Domestic and Linen Services) **Fire Safety** (Social Workers Support, Domestic and Medical Illustration), **Managing Complaints** (Social Workers Support and Rehab Services), **Risk Management** (Adult Services and Rehab Services), **Safeguarding Adults** (Finance), **Safeguarding Children** (Domestic and Transport)

Information Governance

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	Aug-11	Variance
95%	95.14%	0.14%



Analysis: There is a slight deterioration from last months position of 95.45%, however, we remain above target. All Community staff are now included in this measure. There is continued focus on improving the compliance for Information Governance which includes group training sessions for all staff to attend. There currently no areas showing as red i.e. <65% compliance.

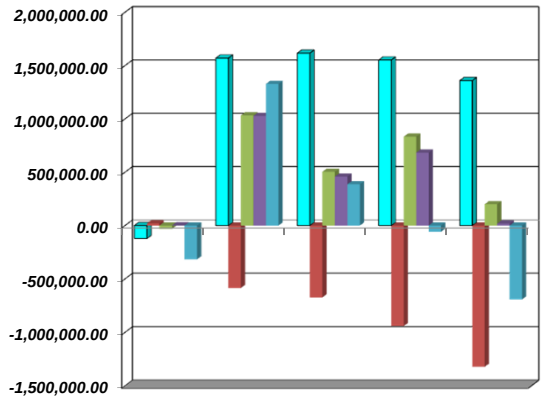
5) FINANCE

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 5



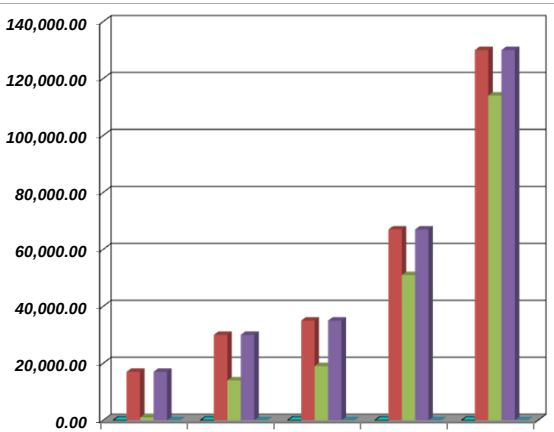
	Apr-11	May-11	Jun-11	Jul-11	Aug-11
5.1	-122,000	1,570,000	1,616,000	1,552,000	1,359,000
5.2	20,000	-585,000	-673,000	-941,000	-1,322,000
5.3	-31,000	1,033,000	504,000	834,000	200,000
5.4	1,000	1,028,000	459,000	684,000	18,000
5.5	-317,000	1,328,000	387,000	-58,000	-692,000

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 5



	Apr-11	May-11	Jun-11	Jul-11	Aug-11
5.1	0	0	0	0	0
5.2	17,000	30,000	35,000	67,000	130,000
5.3	1,000	14,000	19,000	51,000	114,000
5.4	17,000	30,000	35,000	67,000	130,000
5.5	0	0	0	0	0

5.6 Delivery of Cost Improvement Programme

	Jul-11	Aug-11
2011/12 Total CIP	£14,075	£14,075
Quarter 2 (60%)	£8,445	£8,445
Current Position	£6,303	£7,419
Variance against Q1 Plan	**-£2,142**	**-£1,026**

The table above shows year to date actual delivery of CIP against plan for Quarter 2. This equates to 52.7% removed from budgets against a plan of 60%.

5.7 Actual Performance against contract

	Plan	Actual	Variance
Emergency In-patients	17,340	17,419	**79**
Elective In-patients	4,129	4,020	**-109**
New Out-patients	40,888	42,192	**1,304**
All Out-patients	105,666	109,558	**3,892**

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
£20,240,000	£16,453,283	**-£3,786,717**

Analysis: Total forecasted annual is £3,786K under plan (18.7% under spend), this is mainly due to the delay in the Pathology Project which was due to commence on site in June 2011.

6.2 Capital spend is managed within plan

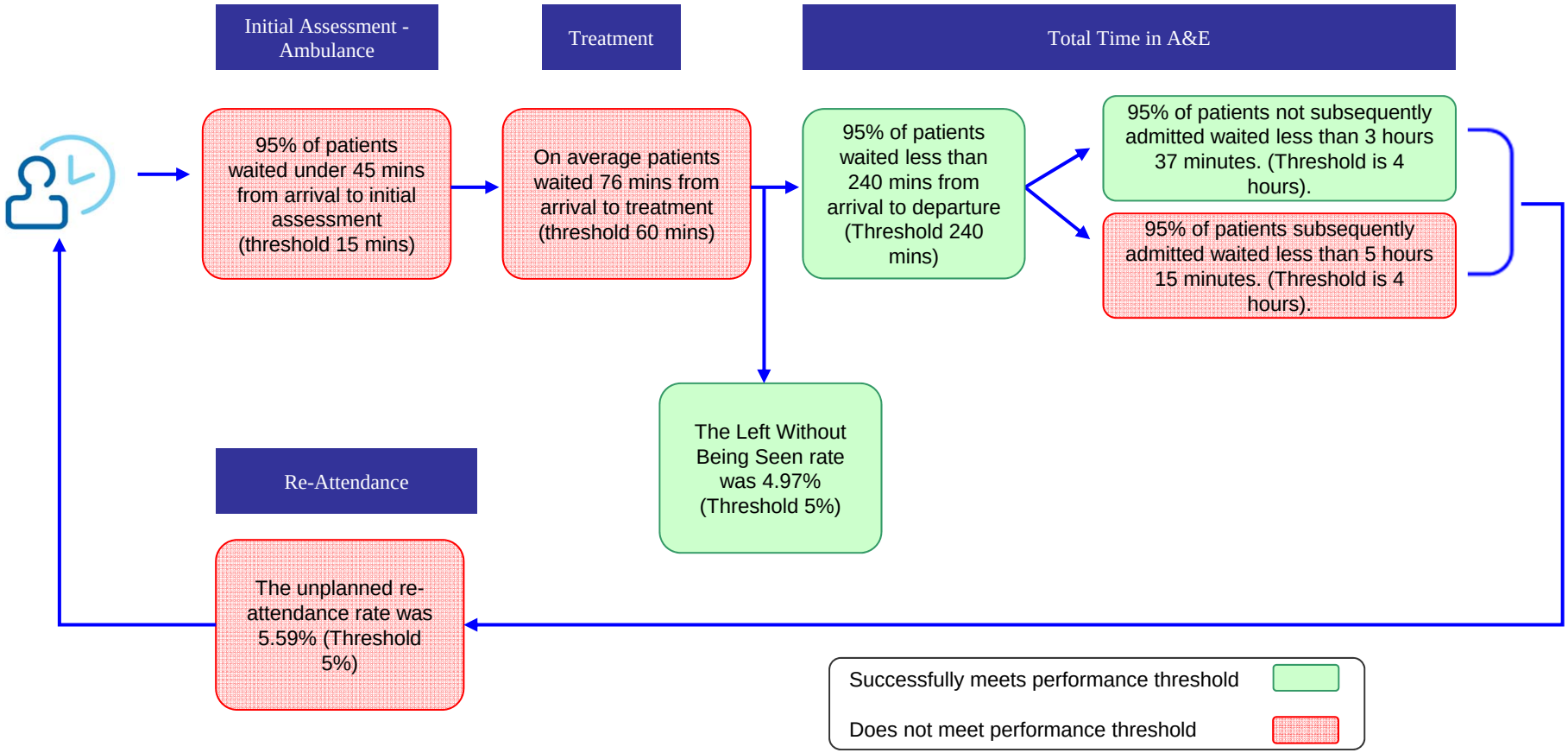
Cumulative Plan	Cumulative Actual	Variance
£3,194,487	£1,911,387	**-£1,283,100**

Analysis: Cumulative spend is £1,283K under plan (40.2% behind plan). The majority of this is due to Pathology spend which should have been incurred in July, however, this was delayed due to the delay in the purchase of a large piece of medical equipment, this now requires Trust Board approval for tender award which will not take place until September 2011.

A&E Clinical Quality Indicators

APPENDIX B

The Royal Wolverhampton Hospital Trust
August 2011



Admitted patients Patients who are admitted to hospital following their visit to A&E.

Initial assessment The initial assessment is when a patient is assessed by an emergency care medical or nursing professional to allow them to determine a priority for treatment (sometimes called triage). The assessment would normally include a brief history of the patient's condition, pain score and vital signs (blood pressure, temperature, pulse, etc).

Left without being seen A patient who leaves without being seen is one who registered with the receptionist in the A&E department but then left the department before they saw a clinical decision-maker.

Median The median time is the time that separates the upper half of all the times from the lower half. If all the times were put in order from shortest to longest the median would be the middle value.

National performance This is the overall performance across all A&E Departments in England for the latest month available.

Non-admitted patients Patients who are discharged from the A&E Department without requiring admission to hospital. This includes patients who may be transferred to another healthcare provider.

Performance thresholds A&E departments are expected to show continuous improvement against the new clinical quality indicators over time. The Department of Health has set minimum performance thresholds which trusts must aim to meet and exceed where possible.

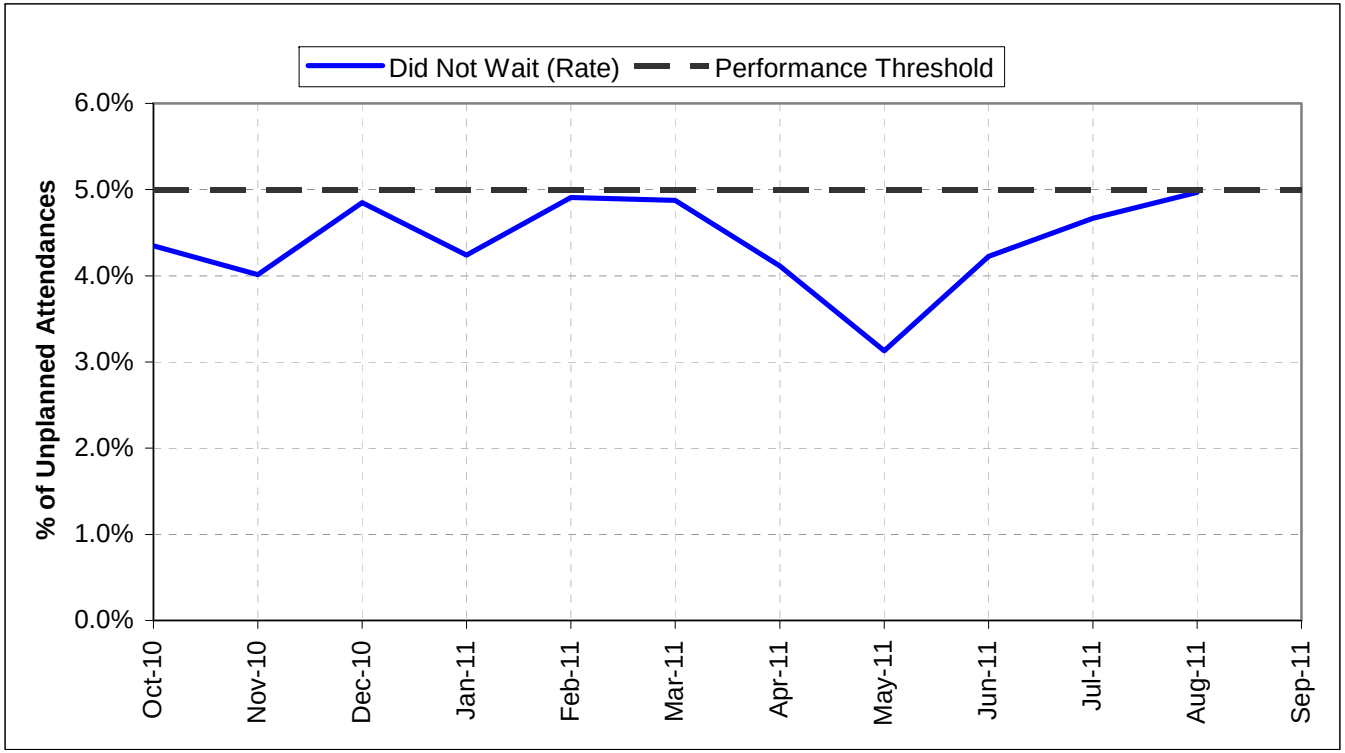
Treatment time The treatment time is the time when a patient is seen by a clinical decision-maker who can diagnose the problem, decide the management plan for the patient and arrange or start treatment if required.

Unplanned re-attendance An unplanned re-attendance is where a patient returns to an A&E Department within 7 days of a previous A&E attendance. This may be for the same condition or a different one.

95th percentile The 95th percentile time is the time below which the majority (95%) of times may be found. If all the times were put in order from shortest to longest, the 95th percentile would be 95% of the way down the list.

4 - Left Without Being Seen - August 2011

Run Chart of Performance



Description of Data

The percentage of (unplanned) people attending the department who subsequently leave without being seen. The performance threshold is **less than 5%.**

The **lower** the rate the **better** the performance. Monitored to improve the patient experience and reduce the clinical risk to patients who leave the A&E before receiving the care they need.

Left Without Being Seen varies between 4% and 5% of attendances. May's low value correlates with reduced waiting times in this month.

Narrative

Work is now underway to identify what time of day people leave without being seen and to see if there are certain conditions that make it more likely.

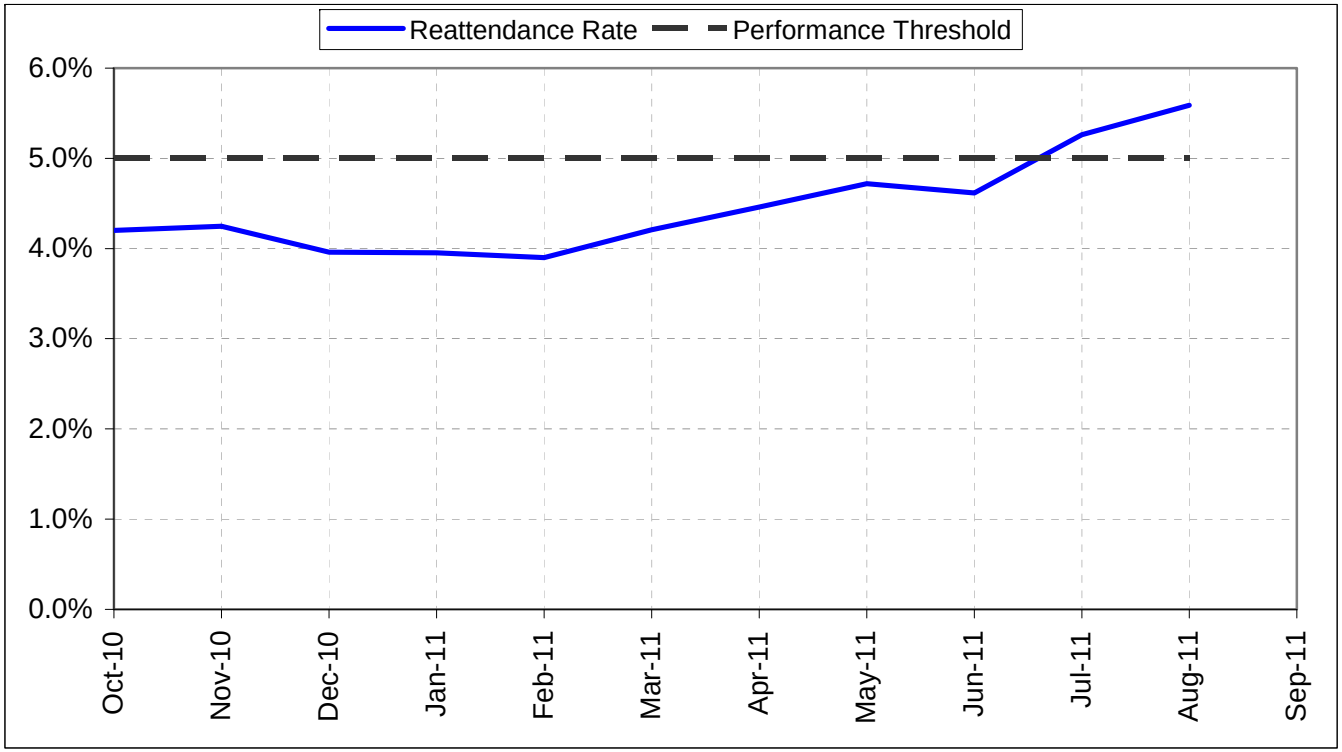
The English rate for April was 3.4% (RWHT 4.1%).

Month Overall

4.97%	Rate this month
Higher	Compared to last month
95% +	Data Quality

2- Unplanned Re-attendance Rate - August 2011

Run Chart of Performance



Description of Data

Unplanned re-attendances at A&E within 7 days of discharge from A&E for the original attendance. The performance threshold is **less than 5%.**

The **lower** the value the **better** the performance. Reduction in avoidable re-attendances demonstrates care and communication delivered during the original attendance.

Our performance on this metric has steadily worsened since Feb 2011. July & August 2011 showed a significant negative change.

Narrative

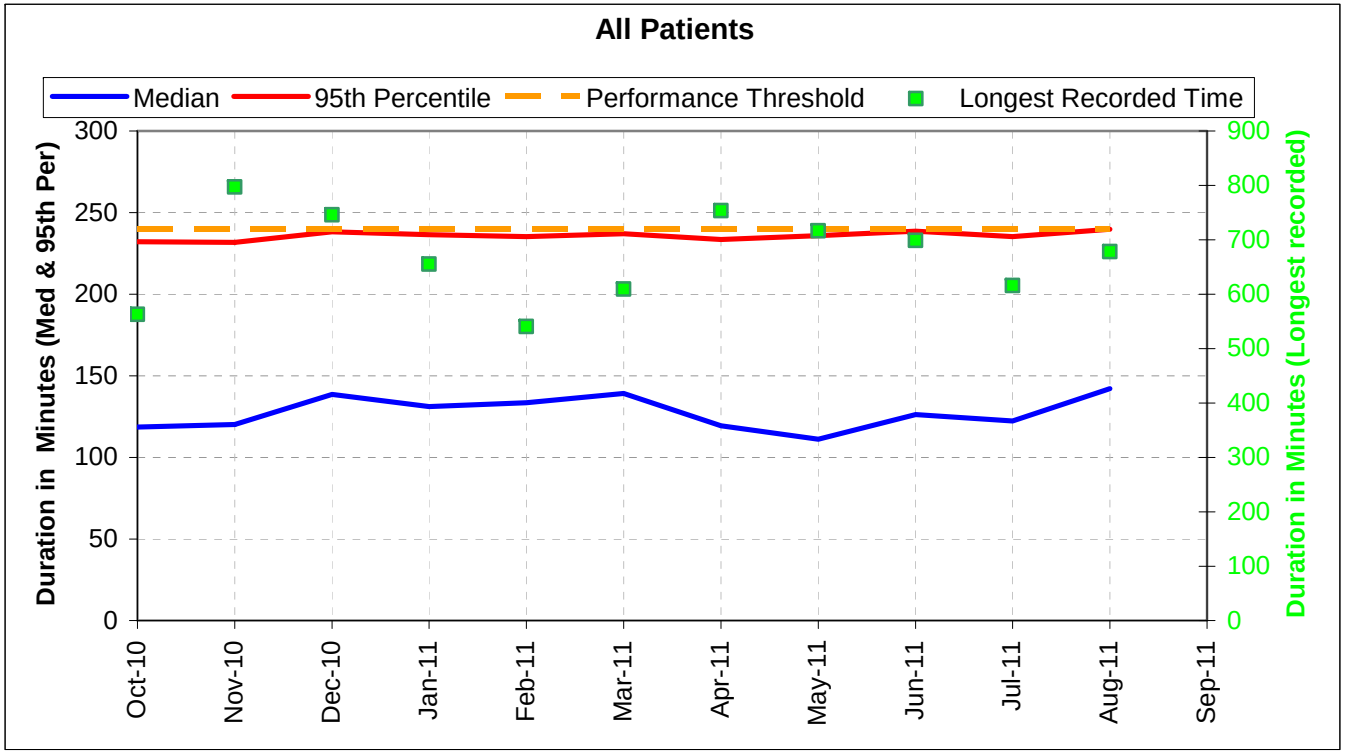
Work underway to identify who re-attends (what conditions) and what times of day. Key conditions now identified and possible reasons for re-attendance being examined. Out of hours processes for eye patients currently under design (inc internal training).

Month Overall

5.59%	Rate this month
Higher	Compared to last month
95% +	Data Quality

3 - Total Time Spent in the A&E Department - All Patients - August 2011

Run Chart of Performance



Description of Data

The median, 95th percentile and single longest total time spent by patients in the A&E department, for admitted patients.

The **lower** the values the **better** the performance. This metric shows our timeliness and monitoring of care to ensure patients do not have excessive waits before leaving the department.

Narrative

The department consistently performs below the 4 hour (240 min) performance threshold for the 95th percentile.

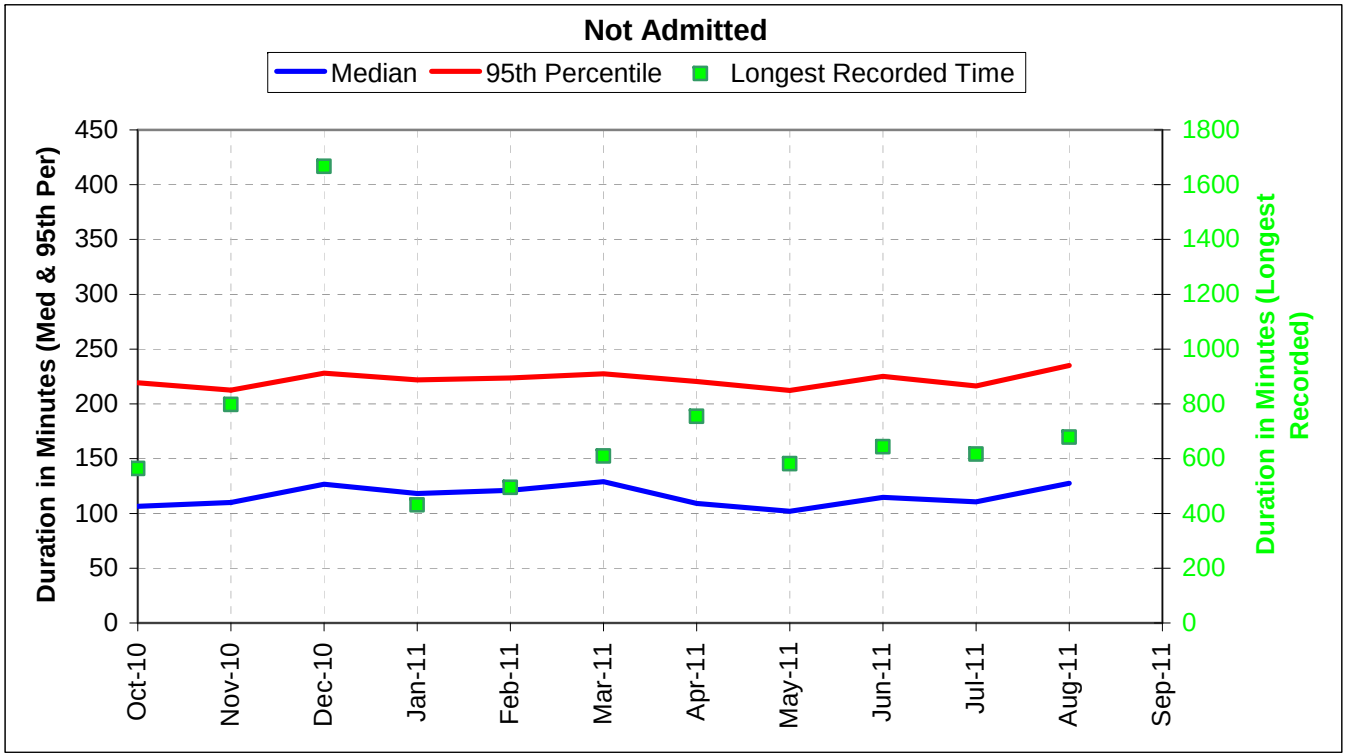
The English median for April was 131mins (RWHT was 119) and the 95th percentile was 258 mins (RWHT was 234).

Month Overall

2 hr 22 mins	Median time
4 hrs	95th Percentile
Higher	Compared to last month median
Higher	Compared to last month 95th percentile

3 - Total Time Spent in the A&E Department - Non-Admitted Patients - August 2011

Run Chart of Performance



Description of Data

The median, 95th percentile and single longest total time spent by patients in the A&E department, for non-admitted patients.

The **lower** the values the **better** the performance. This metric shows our timeliness and monitoring of care to ensure patients do not have excessive waits before leaving the department.

Median time in department is consistent at around 2 hours. The 95th percentile is consistent at around 3 hours 40 minutes.

Narrative

Data suggests that the very long waits (green points on chart) are due to social care or mental health assessment. 95th percentile of patients is consistently below the 240 mins / 4 hrs performance threshold.

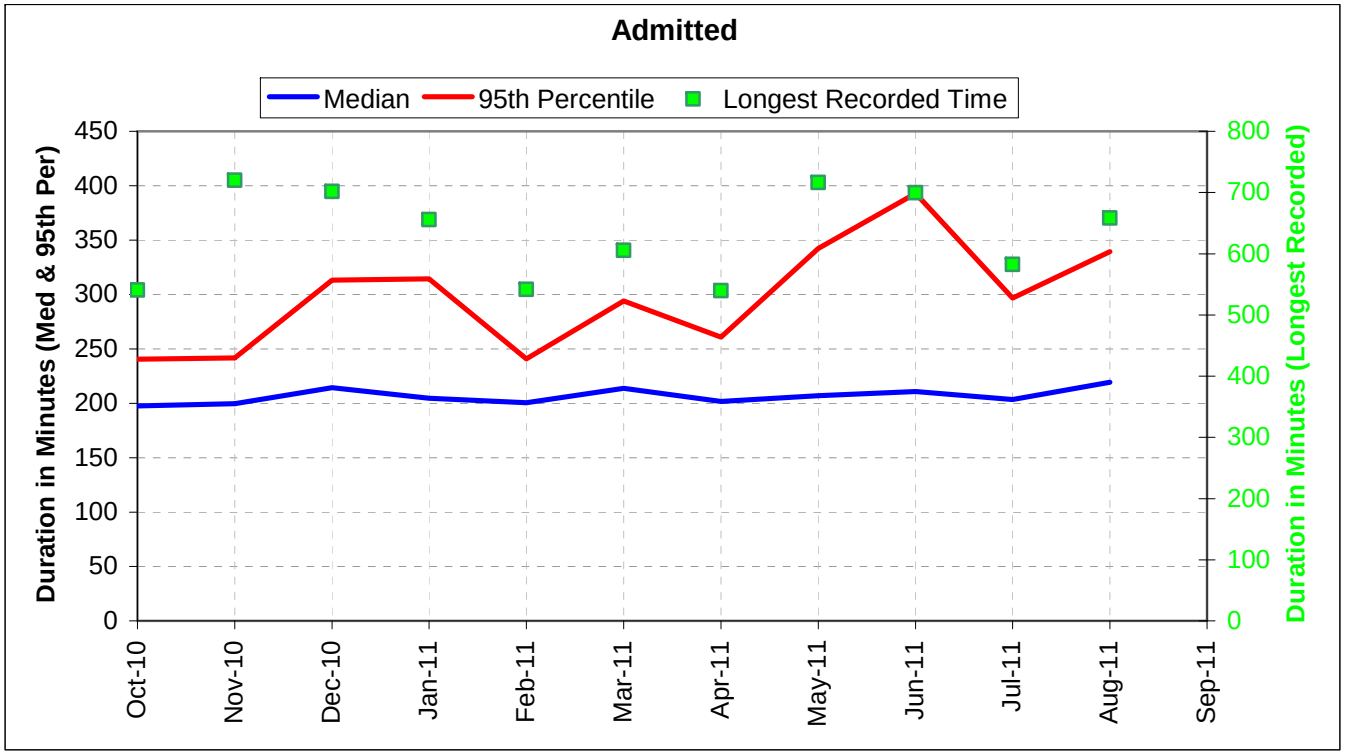
Published data for England does not yet include this.

Month Overall

2 hrs 8 mins	Median time
3 hrs 55 mins	95th Percentile
Higher	Compared to last month median
Higher	Compared to last month 95th percentile

3 - Total Time Spent in the A&E Department - Admitted Patients - August 2011

Run Chart of Performance



Description of Data

The median, 95th percentile and single longest total time spent by patients in the A&E department, for admitted patients.

The **lower** the values the **better** the performance. This metric shows our timeliness and monitoring of care to ensure patients do not have excessive waits before leaving the department.

Median time in department is consistent at around 3 hrs 20 mins. There was a large spike in the 95th percentile in Jun 2011.

Narrative

We are currently investigating which patients wait the longest and what times of day this occurs. This data will allow us to plan for busy periods.

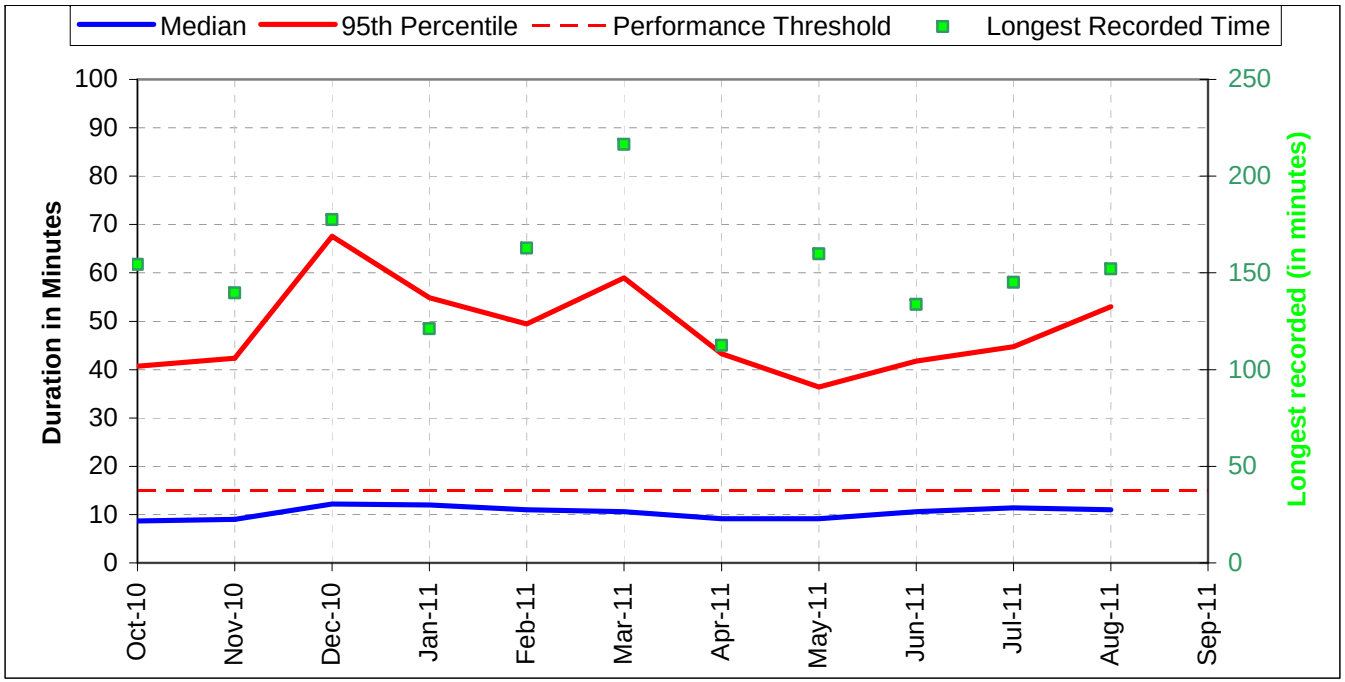
Published data for England does not yet include this.

Month Overall

3 hrs 39 mins	Median time
5 hrs 39 mins	95th Percentile
Higher	Compared to last month median
Higher	Compared to last month 95th percentile

6 - Time to Initial Assessment (Ambulance Arrivals based on Triage) - August 2011

Run Chart of Performance



Description of Data

Time from arrival to start of full initial assessment, which includes a brief history, pain and early warning scores (including vital signs), for all patients arriving by emergency ambulance. 95th Percentile performance threshold is **15 mins**.

The **lower** the duration the **better** the performance. Monitored to reduce the clinical risk associated with the time the patient spends unassessed in A&E.

Narrative

We are investigating which patients wait the longest and why. We are undertaking a piece of work to understand the destination of patients within department and what effect this has upon their waiting time. We need to determine a new process for recording the patient information / times for resuscitation patients.

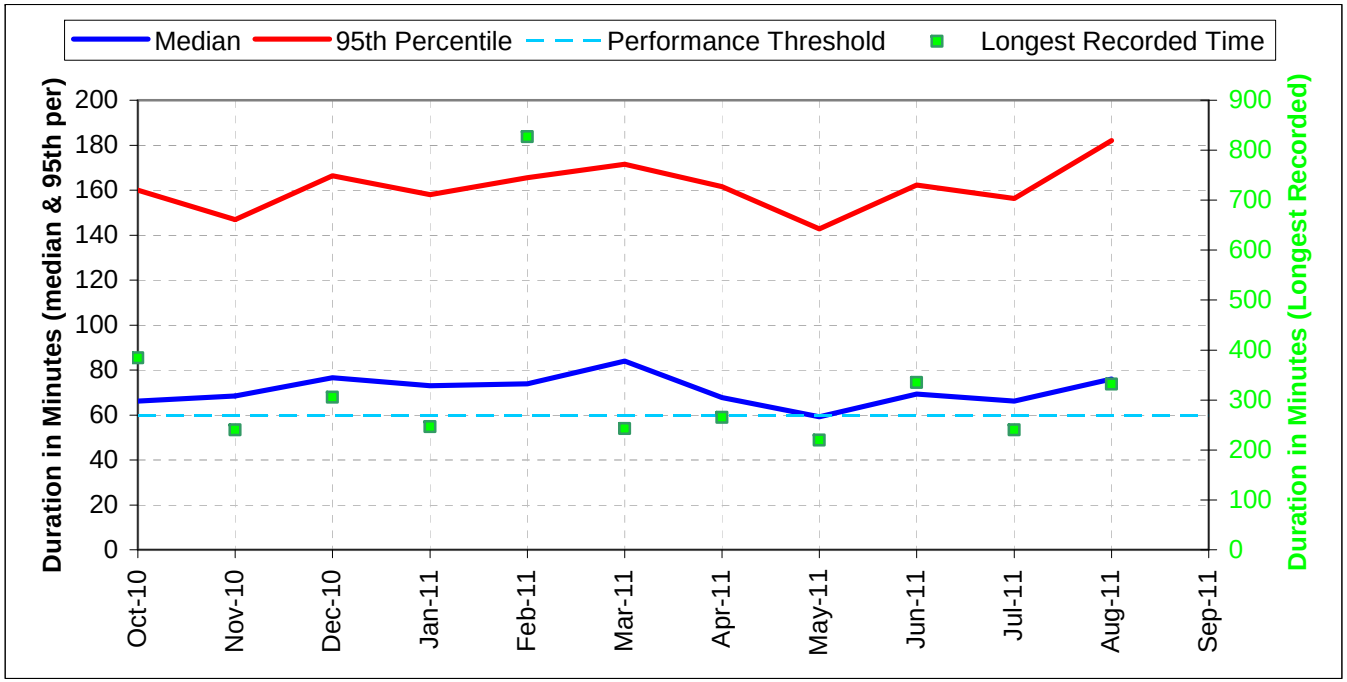
The English Median for April was 6 mins (RWHT 9 mins) and the 95th percentile was 116 mins (RWHT 43 mins).

Month Overall

11 mins	Median time
45 mins	95th Percentile
Same	Compared to last month median
Higher	Compared to last month 95th percentile

7 - Time to Treatment - August 2011

Run Chart of Performance



Description of Data

Time from arrival to start of definitive treatment from a decision making clinician (someone who can define the management plan and discharge the patient). **Median** performance threshold is **60 mins**.

The **lower** the duration the **better** the performance. Monitored to reduce the clinical risk associated with the time the patient spends unassessed in A&E.

Narrative

We are currently undertaking a piece of work to identify variations in time to be treatment based upon the time of arrival. If pressure points are identified in this way we will look at adapting the staffing rota.

The English median for April was 57 mins (RWHT 68 mins) and the 95th percentile was 198 mins (RWHT 162 mins)

Month Overall

76 mins	Median time
3 hrs 2 mins	95th Percentile
Higher	Compared to last month median
Higher	Compared to last month 95th percentile