The Royal Wolverhampton Hospitals NHS Trust	

Trust Board Report

Meeting Date:	28th May 2012
Title:	Performance Report
Executive Summary:	This report provides the Board with an update of performance against national and local performance indicators for April 2012/13. It also provides assurances to the Board of the actions taken for any indicator that is underperforming.
Action Requested:	To note: current progress To approve: any corrective actions identified.
Report of:	Chief Operating Officer
Author: **Contact Details:**	Head of Performance & Compliance Tel: 01902 694366 Email: simon.evans8@nhs.net
Resource Implications:	None
Public or Private: **(with reasons if private)**	Public Session
References: **(e.g. from/to other committees)**	Appendix 1 – Provider Management Regime (PMR) Appendix 2 – Full detailed Performance Report
Appendices/ **References/** **Background Reading**	Detailed Performance Report
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

Detail	
1	**Background** This report provides an overview of the performance of the Trust and covers national, regulatory and local performance indicators (PIs). The report contains a summary of all performance for both acute and community activity. Where possible performance is now integrated to give one measure.However, some indicators are required (nationally) to be reported separately whilst some indicators are solely for acute or community activity, in these instances the report clearly denotes whether the PI is either Acute Only (A), Integrated (I) or Community Only (C). In addition to the performance indicators in the Provider Management Regime the Board is required to provide compliance against a number of statements as part of the monthly self certification process. Following discussion by the Board in a formal meeting the Chairman and Chief Executive will sign the self certification and Board Statements on behalf of the Board.
2	**Report Contents** This report covers the following areas: • Performance Dashboard • Exception Reports (Red rated PIs) • Activity Dashboard (Community activity only) • Provider Management Regime (Appendix 1) • Full detailed performance report (Appendix 2)

3

Performance Report Dashboard

The summary report provides a dashboard using the themes within the detailed report to give an overview of performance. To accompany this, an exception report has been provided for any PI that has been reported as RED. This gives the Board an overview of performance and details the areas that are underperforming and the corrective actions that have been taken. The dashboard covers each of the PIs that are reported within the detailed report; however the dashboard simply covers the themes through which have previously been reported to Board. A legend which explicitly details which regulator monitors the PI is also found in appendix A.

Theme	Red	Amber	Green	Total
Monitor Compliance Framework There are 20 indicators measured in this section, covering C Difficile, MRSA, Cancer Waits, Accident & Emergency (4 hour), RTT and Data Completeness	**0**	**0**	**20**	**20**
Service Delivery There are 29 (2 of which is monitoring only) indicators in this section, covering Stroke/TIA, RTT, Delayed Transfers, Cancelled Operations, A&E Indicators, Cancer Upgrade, Diagnostic Waits, Correspondence, LOS, Day Case Rates, Theatre Utilisation, C&B, Smoking, End of Life and Health Check	**5**	**2**	**20**	**27**
Workforce This section is measured by 14 different indicators covering, Recruitment and Retention, Turnover, Sickness Absence, Temporary Staffing (agency), and Education & Training	**4**	**6**	**4**	**14**
Totals	**9**	**8**	**44**	**61**
Trend **(Trends are not possible this month due to the additions and removals of PIs)**				

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

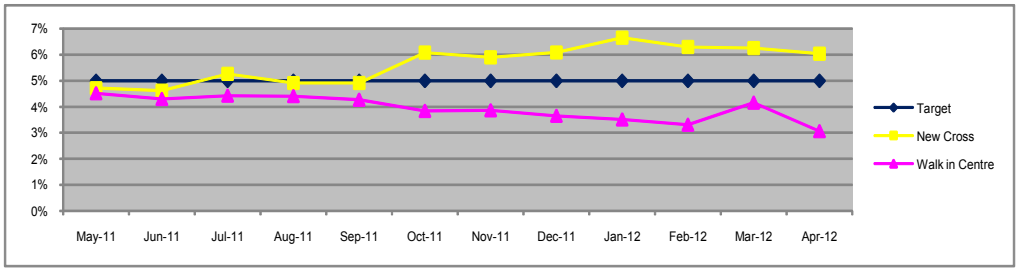
4

Exception Reports

A&E Unplanned Re-attendance Rate	I

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

	Target	Apr-12	Current Month Variance
New Cross Hospital	< 5%	6.04%	1.04%
Walk in Centre		3.06%	-1.94%
Combined Total		5.27%	0.27%

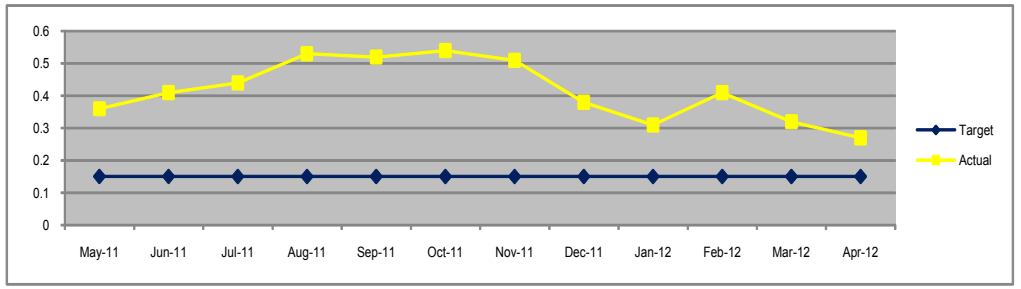


Analysis: This graph now also includes walk-in centre data. Also included is the combined organisation total which shows we are above target by 0.27%.

A&E Time to Initial Assessment (for ambulance patients)	A

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

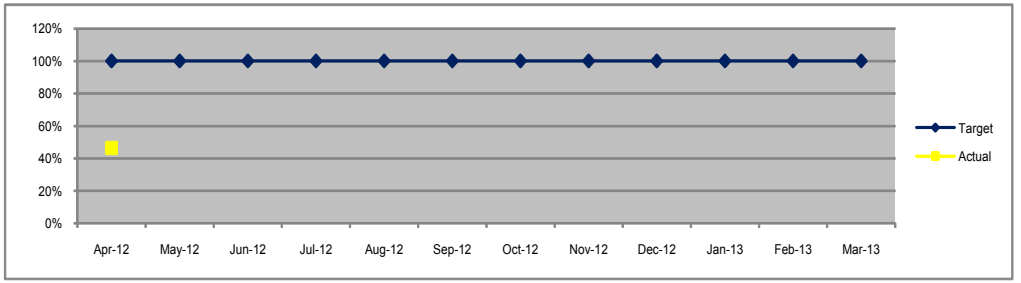
Target	Apr-12	Current Month Variance
< 15 mins	00:27	00:12



Analysis: The improvement in this indicator is a result of increased emphasis on the assessment target and ambulance turnaround time by the management team in A&E. This has been helped by the deployment of a nurse between 12 midday and 12 midnight whose main function is to provide assessment and care for patients who arrive by ambulance.

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

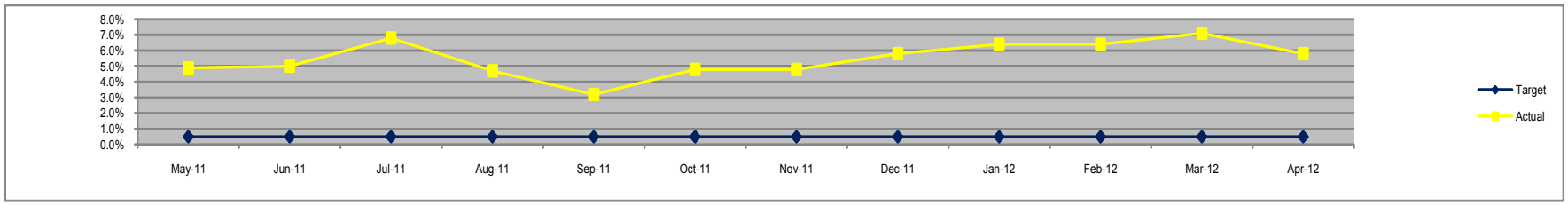
Target	Apr-12	Variance
100%	46.40%	-53.60%



Analysis: Work is underway across all areas within the trust, a roll-out plan has commenced and all in-patient areas are now live. Performance is monitored weekly at the Divisional Managers Meeting.

Temporary Staffing | L | I

Temporary Medical Staff (cumulative spend) - Agency Staff

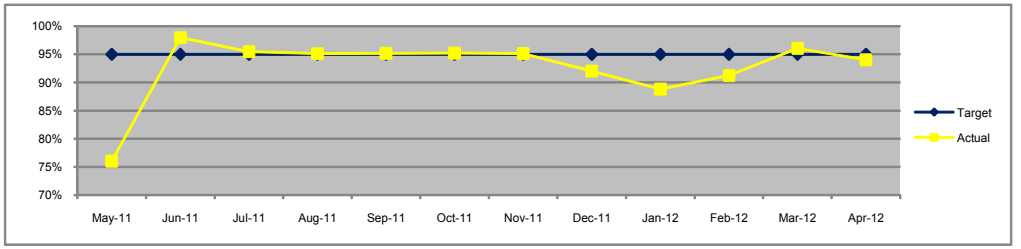


Analysis: There has been no agency expenditure for nursing staff during April. In terms of medical agency there has been a decrease in month from 7.1% in March to 5.8% in April. **Surgical Division** has seen a decrease in month from £79K in March to £66K in April. Agency expenditure in Critical Care and Ophthalmology had been high during April due to vacancies within the departments. **Medical Division also** saw a decrease in month from £237K in March to £222K in April. A&E has remained high due vacancies at Consultant level and middle grade and SHO rotas.

Information Governance Toolkit | I

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

Target	Apr-12	Current Month Variance
95%	94.02%	-0.98%

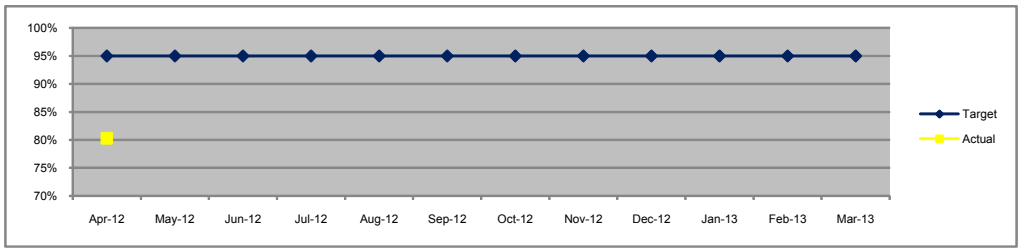


Analysis: This is a deterioration from the position reported last month 96.06% in March against 94.02% in April, this has taken us below target by 0.98%.

Induction

Corporate Induction

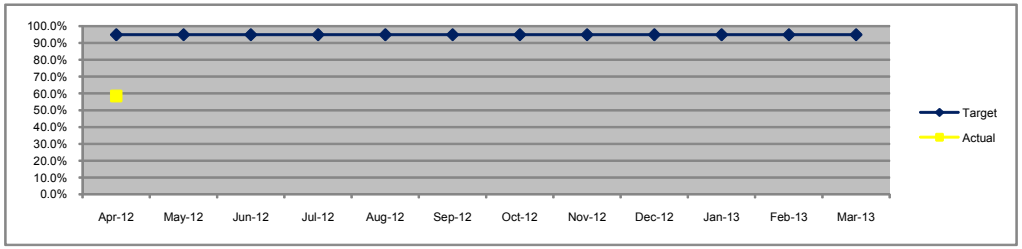
Target	Apr-12	Current Month Variance
95%	80.30%	-14.70%



Analysis: This is a new indicator for 2012/13. The following Divisions are showing as red i.e. <95% overall compliance with the number of staff not having attended Corporate Induction in brackets. **Surgical Division** - 84.5 % (43), **Medical Division** - 75.8% (81), **Estates & Facilities** - 82.4% (6) and **Corporate** - 83.5% (13)

Local Induction

Target	Apr-12	Current Month Variance
95%	58.50%	-36.50%



Analysis: This is a new indicator for 2012/13. The following Divisions are showing as red i.e. <95% overall compliance with the number of staff not having received a Local Induction in brackets. **Surgical Division** - 66.9% (92), **Medical Division** - 50.7% (165, **Estates & Facilities** - 67.6% (11) and **Corporate** - 58.2% (33)

5	**Activity Dashboard** (community activity only) It is important to note that the data for community activity only covers the period up to March.

Theme	Red	Amber	Green	Total
Rehabilitation Covering inpatient/outpatient clinics for services such as care of the elderly, rehabilitation and falls assessment	4	4	4	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	2	3	1	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	9	13	41
Last Month	19	7	15	41
Trend **(arrow indicates measure of improvement. i.e. ↑ is getting better)**	→	↓	↓	

Of the 19 RED rates service areas, 12 are operating above plan and 7 are operating below plan. Details for the 7 areas below plan are:

- Care of the Elderly Outpatients – Service review of follow up has resulted in a reduction in frequency of follow up appointments. Changes in practices due to TCS has reduced the number of appointments in Stroke, some appointments have been transferred to the stroke co-ordinators which has streamlined the patient pathway.
- Continence - A new team leader has been appointed into the service and has commenced a review of the service delivery options and caseload management approach.
- TB – The service is working with Commissioners to revise baseline activity levels and will deliver this through data capture and reporting.
- Health Visiting - Unusually high levels of high priority work which has resulted in less activity in month. Eg. Witness statement

	writing/case • HIV & Aids - The service has reviewed activity levels with the commissioner and re-profiled activity for 2012/13 following the baseline review. • Podiatry Assessment – Activity will continue to reduce due to no Podiatric surgery taking place. • Smoking Cessation (February data) – 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.
6	**<u>Overview Reports</u>** Full details of the Provider Management Regime can be found at Appendix 1.

NHS
Midlands and East

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

NHS Midlands & East
Provider Management Regime
2012/13

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

NHS Midlands and East

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

Name of Organisation:	Royal Wolverhampton Hospitals NHS Trust	Period:	April 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)	Green
Financial Risk Rating (Assign number as per NHS Midlands and East PMR guidance)	3.9
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
on behalf of the Trust Board	Acting in capacity as:		
Signed by :		Print Name :	Barry Picken
on behalf of the Trust Board	Acting in capacity as:		

If Declaration 2 has been signed:

Please identify which targets have led to the Board being unable to sign declaration 1. For each area such as Governance, Finance, Contractual, CQC Essential Standards, where the board is declaring insufficient assurance please state the reason for being unable to sign the declaration, and explain briefly what steps are being taken to resolve the issue. Please provide an appropriate level of detail.

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

ACUTE
GOVERNANCE RISK RATINGS 2011/12

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

Appendix 1

Ref	Area	Indicator	Sub Sections	Thresh-old	Weight-ing	Apr-12	May-12										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	Yes											
2	Safety	MRSA	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	Yes											
3	Quality	All cancers: 31-day wait for second or subsequent treatment, comprising either:	Surgery	94%	1.0	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											
			From consultant screening service referral	90%													
5a	Patient Experience	RTT waiting times – admitted	95th percentile	23 wks	1.0	Yes											
5b	Patient Experience	RTT waiting times – non-admitted	95th percentile	18.3 wks	1.0	Yes											
6	Quality	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes											
7	Quality	Cancer: 2 week wait from referral to date first seen, comprising either:	all cancers	93%	0.5	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											
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	2											Areas not met - Unplanned re-attendance rate and Time to initial assessment for ambulance patients
			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											
		CQC Registration															
A	Safety	CQC Registration	Are there any compliance conditions on registration outstanding.	0	1.0	No											
B	Safety	CQC Registration	Are there any restrictive compliance conditions on registration outstanding.	0	2.0	No											
C	Safety	Moderate CQC concerns regarding the safety of healthcare provision		0	1.0	No											
D	Safety	Major CQC concerns regarding the safety of healthcare provision		0	2.0	No											
E	Safety	Formal CQC Regulatory Action resulting in Compliance Action		0	2.0	No											
F	Safety	Formal CQC Regulatory Action resulting in Enforcement Action		0	4.0	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											
				TOTAL		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

COMMUNITY TRUST
GOVERNANCE RISK RATINGS 2012/13

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	Threshold	Weighting	Apr-12	May-12										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	Yes											
2	Safety	MRSA	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	Yes											
18	Quality	Delayed Transfers of Care	Are you below the ceiling for your monthly trajectory	Contract with PCT	0.5	Yes											
19	Patient Experience	GUM Access - within 48 hours	95th percentile	≤ 48 hrs	0.5	Yes											
20	Effectiveness	Chlamydia Screening		Contract with PCT	0.5	N/A											
21	Effectiveness	Smoking quitters		Contract with PCT	0.5	No											The contract reporting for this indicator is approximately 7 weeks after the month end (necessary as a 4 week quit period is required) the figure reported is February position
8a	Quality	Minor Injuries Unit / A&E (Q1):	Total time (95th percentile)	≤ 4 hrs	1.0	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	0											
			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%													
22	Patient Experience	6 week wait for diagnostic	100%	≤ 6 wks	0.5	Yes											
23	Safety	New birth visits		Contract with PCT	0.5	Yes											
24	Effectiveness	HPV (Human Papillomavirus) Uptake		Contract with PCT	0.5	Yes											
25	Patient Experience	Community equipment store response within seven days	100%	≤ 7 days	0.5	N/A											
26a	Safety	Urgent District Nurse response within 24 hours	100%	≤ 24 hrs	0.5	N/A											
26b	Patient Experience	Non-urgent District Nurse response within 48 hours	100%	≤ 48 hrs	0.5	N/A											
17	Patient experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes											
		CQC Registration															
A	Safety	CQC Registration	Are there any compliance conditions on registration outstanding.	0	1.0	No											
B	Safety	CQC Registration	Are there any restrictive compliance conditions on registration outstanding.	0	2.0	No											
C	Safety	Moderate CQC concerns regarding the safety of healthcare provision		0	1.0	No											
D	Safety	Major CQC concerns regarding the safety of healthcare provision		0	2.0	No											
E	Safety	Formal CQC Regulatory Action resulting in Compliance Action		0	2.0	No											
F	Safety	Formal CQC Regulatory Action resulting in Enforcement Action		0	4.0	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											
				TOTAL		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FINANCIAL RISK RATING 2012/13

Royal Wolverhampton Hospitals NHS Trust

			Risk Ratings					Insert the Score (1-5) Achieved for each Criteria Per Month												
Criteria	Indicator	Weight	5	4	3	2	1	Annual Plan 2011/12	Apr-12	May-12										Comments on Performance in Month
Underlying performance	EBITDA margin %	25%	11	9	5	1	<1		3											
Achievement of plan	EBITDA achieved %	10%	100	85	70	50	<50		5											
Financial efficiency	Return on assets %	20%	6	5	3	-2	<-2		5											
	I&E surplus margin %	20%	3	2	1	-2	<-2		3											
Liquidity	Liquid ratio days	25%	60	25	15	10	<10		4											
Average	Weighted Average	100%						0.0	3.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Overriding rules	Overriding rules																			
Overall rating	Final Overall rating							0.0	3.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	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 2012/13

Royal Wolverhampton Hospitals NHS Trust

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

	Criteria	Apr-12	May-12											Comments on Performance in Month
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No												
2	Quarterly self-certification by trust that the financial risk rating (FRR) may be less than 3 in the next 12 months	No												
3	FRR 2 for any one quarter	No												
4	Working capital facility (WCF) agreement includes default clause	N/A												
5	Debtors > 90 days past due account for more than 5% of total debtor balances	No												
6	Creditors > 90 days past due account for more than 5% of total creditor balances	No												
7	Two or more changes in Finance Director in a twelve month period	No												
8	Interim Finance Director in place over more than one quarter end	No												
9	Quarter end cash balance <10 days of operating expenses	No												
10	Capital expenditure < 75% of plan for the year to date	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 2012/13

Royal Wolverhampton Hospitals NHS Trust

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

Criteria	RAG	Apr-12	May-12											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												
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

Royal Wolverhampton Hospitals NHS Trust

Insert Performance in Month

	Criteria	Unit	Apr-12	May-12											Comments on Performance in Month
1	SHMI - latest data	Ratio	108.5												October 10 to September 11 position for SHMI. HSMR Doctor Foster data 92 rebased 100 April 11 to February 12
2	Venous Thromboembolism (VTE) Screening	%	96.25												
3a	Elective MRSA Screening	%	100												
3b	Non Elective MRSA Screening	%	100												
4	Single Sex Accommodation Breaches	Number	0												
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	102												SHA Open figure, includes SUI and reportable as per SHA criteria. Figure includes 26 to be closed by PCT.
6	"Never Events" in month	Number	0												
7	CQC Conditions or Warning Notices	Number	0												
8	Open Central Alert System (CAS) Alerts	Number	12												6 MDA, 3 EFA, 3 NPSA
9	RED rated areas on your maternity dashboard?	Number	N/A												
10	Falls resulting in severe injury or death	Number	0												
11	Grade 3 or 4 pressure ulcers	Number	10												
12	100% compliance with WHO surgical checklist	Y/N	No												Used in all Theatres, 75% compliance in outpatient areas, full compliance will be achieved by end of May 2012.
13	Formal complaints received	Number	26												
14	Agency and bank spend as a % of turnover	%	3.1												
15	Sickness absence rate	%	4.46												

Board Statements

Royal Wolverhampton Hospitals NHS Trus

April 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.	
5	Be satisfied that the Trust is embedding patient experience into the service design, improvement and delivery cycle.	

	For SERVICE PERFORMANCE, that:	Response
6	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
7	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	✓
8	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	✓
9	The necessary planning, performance management and risk management processes are in place to deliver the annual plan	✓
10	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)	✓
11	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
12	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*
13	The Board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the Board	✓
14	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	✓
15	The selection process and training programmes in place ensure that the non-executive directors have appropriate experience and skills	✓
16	The management team have the capability and experience necessary to deliver the annual plan	✓
17	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**	**28/05/2012**
Chair		**Barry Picken**	**28/05/2012**

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

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) FOUNDATION TRUST - Monitor Compliance Framework

Performance Indicator	Threshold	Weighting	Year End 2011/12				Apr-12			
New Cross			Numerator	Denominator	Result	Weighted Score	Numerator	Denominator	Result	Weighted Score
Clostridium Difficile year on year reduction	57	1.0	88	57	31	1.0	2	4.75	-2.75	0.0
MRSA year on year reduction (year end target)	1	1.0	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	756.5	863	87.66%	0.0	60.5	69.5	87.05%	0.0
62 day wait for first treatment - from Consultant Screening service referral	90%		96.5	100.5	96.02%		6.5	6.5	100.00%	
31 day wait for second or subsequent treatment - Surgery	94%	1.0	465	474	98.10%	0.0	40	42	95.24%	0.0
31 day wait for second or subsequent treatment - Anti cancer drug treatments	98%		904	905	99.89%		58	58	100.00%	
31 day wait for second or subsequent treatment - Radiotherapy	94%		1861	1880	98.99%		95	97	97.94%	
31 day wait from diagnosis to first treatment - All cancers	96%	0.5	2102	2134	98.50%	0.0	158	162	97.53%	0.0
Two week wait from referral to date first seen - All cancers	93%	0.5	6620	6970	94.98%	0.0	529	564	93.79%	0.0
Two week wait from referral - Symptomatic Breast	93%		1543	1622	95.13%		131	139	94.24%	
RTT - 18 weeks - Admitted	90%	1.0	27017	28637	94.34%	0.0	2211	2361	93.65%	0.0
RTT - 18 weeks - Non-Admitted	95%	1.0	93853	95583	98.19%	0.0	6641	6785	97.88%	0.0
RTT - 18 weeks - Patients on incomplete pathway	92%	1.0					19753	20622	95.79%	0.0
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	95%	1.0	97701	101298	96.45%	0.0	7991	8196	97.50%	0.0
Patient experience - Learning Disabilities	-	0.5				0.0				0.0
Screening all elective in-patients for MRSA		0.5	79073	52997	149.20%	0.0	6470	4077	158.70%	0.0
				Total		**1.0**		**Total**		**0.0**

Performance Indicator	Threshold	Weighting	Year End 2011/12				Apr-12			
Community			Numerator	Denominator	Result	Weighted Score	Numerator	Denominator	Result	Weighted Score
Clostridium Difficile	12	1.0	7	12	-5	0.0	0	1	-1	0.0
MRSA (year end target)	0	1.0	0	0	0	0.0	0	0	0	0.0
A&E - Total waiting time of four hours	95%	1.0	29848	29848	100.0%	0.0	2820	2820	100.0%	0.0
Patient Experience - Learning Disabilities						0.0				0.0
Data Completeness - Community - Referral to treatment information	50%	1.0							Compliant	
Data Completeness - Community - Referral information	50%								Compliant	
Data Completeness - Community - Treatment Activity information	50%								Compliant	
				Total		**0.0**		**Total**		**0.0**

<1 = Green

>1 - <2 = Amber - Green

>2 - <4 = Amber - Red

>4 = Red

The Trust overall performance for April 12 is rated as 0.0, this gives us an overall Governance risk rating of Green

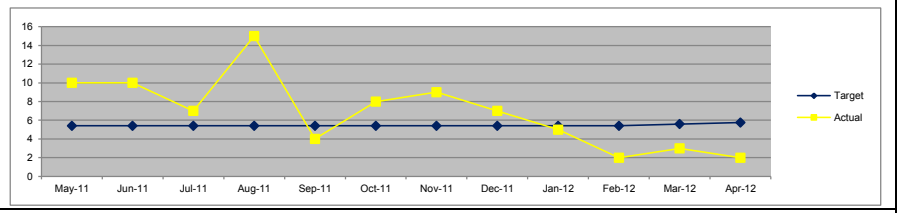
Healthcare Acquired Infections (HCAI's)

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 Clostridium Difficile - hospital acquired for ages >2 years

PCT | SHA | L | M | I

Number of C Diff Cases (Target)	Cum Plan	Cum Actual	Cum Variance
69	5.75	2	-3.75

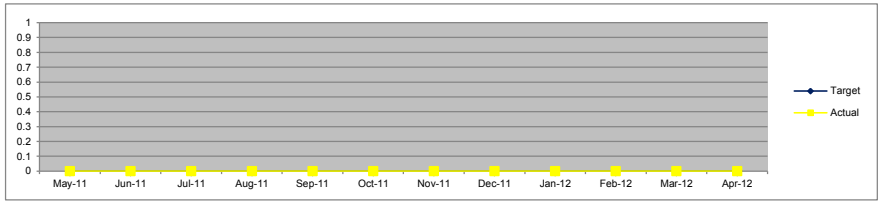


Analysis:

1.2 MRSA Bacteraemia

PCT | SHA | L | M | I

Number of MRSA Cases (Target)	Cum Plan	Cum Actual	Cum Variance
0	0	0	0



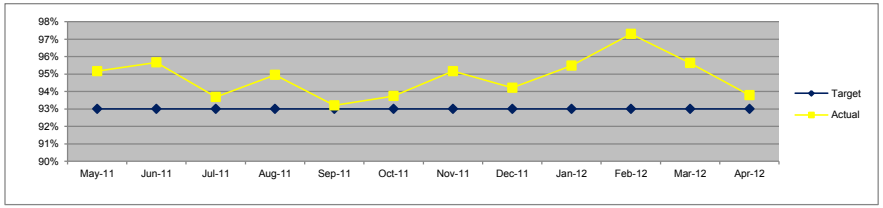
Analysis: This is the 34th consecutive month without an MRSA Bacteraemia

1.3 Cancer

M | A

1.3.1 All Cancer 2 Week Wait

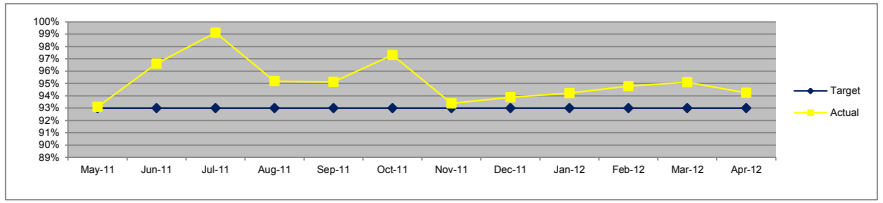
Target	Apr-12	Variance
93%	93.79%	0.79%



Analysis:

1.3.2	2 Week Wait for Breast Symptomatic Patients	M	A

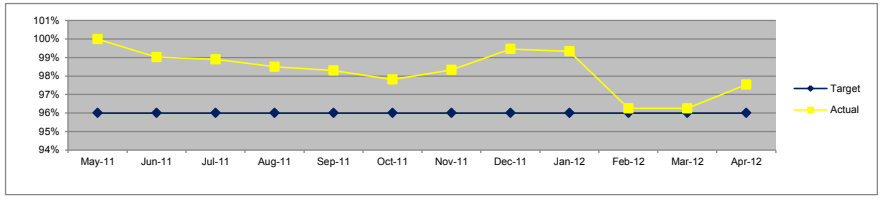
Target	Apr-12	Variance
93%	94.24%	1.24%



Analysis:

1.3.3	31 Day Diagnosis to First Treatment - All Cancers	M	A

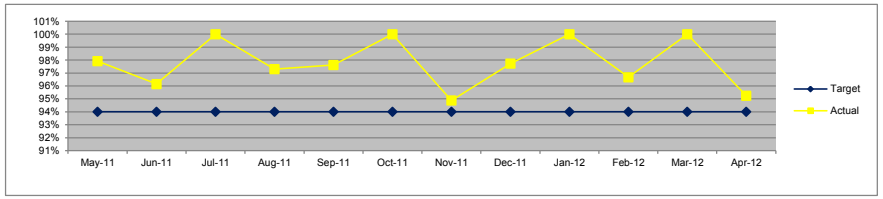
Target	Apr-12	Variance
96%	97.53%	1.53%



Analysis:

1.3.4	31 Day Wait for Second or Subsequent Treatment: Surgery	M	A

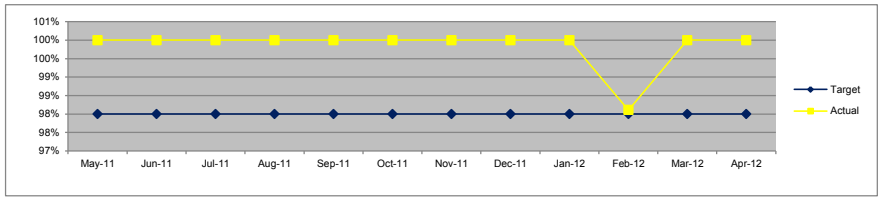
Target	Apr-12	Variance
94%	95.24%	1.24%



Analysis:

1.3.5	31 Day Wait for Second or Subsequent Treatment: Anti Cancer Drug Treatment	M	A	

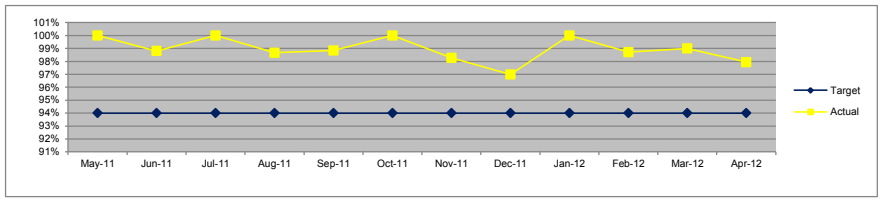
Target	Apr-12	Variance
98%	100.00%	2.00%



Analysis:

1.3.6	31 Day Wait for Second or Subsequent Treatment: Radiotherapy Treatment	M	A	

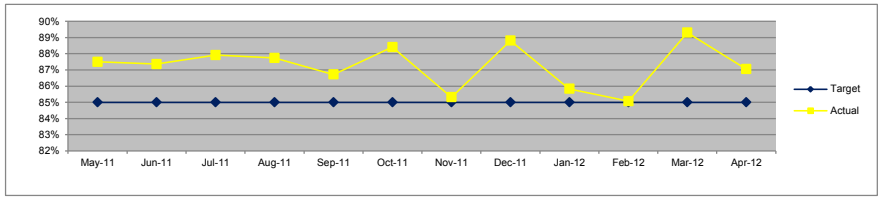
Target	Apr-12	Variance
94%	97.94%	3.94%



Analysis:

1.3.7	62 Days from Urgent GP Referral to First Definitive Cancer Treatment - All Cancers	M	A	

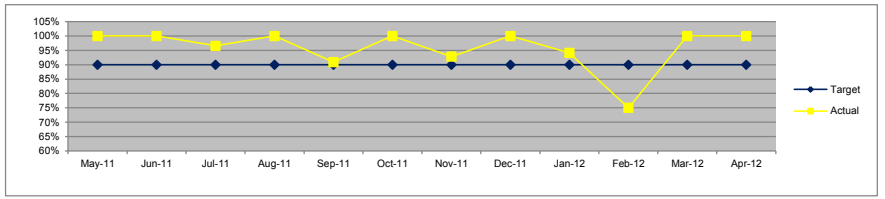
Target	Apr-12	Variance
85%	87.05%	2.05%



Analysis: 11 breaches - 5 x tertiary referrals received at 53 days or more, 5 x patient initiated and 1 x further investigations. Late referrals from other hospitals continue to be a problem with referrals arriving as late as 100 days.

1.3.8	62 Day Wait for First Treatment from Consultant Screening - All Cancers	M	A	

Target	Apr-12	Variance
90%	100.00%	10.00%



Analysis:

1.4	Accident & Emergency - 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.

	Target	Apr-12	Current Month Variance	Cumulative	Current Month Variance
New Cross Hospital	95%	97.50%	2.50%	96.52%	1.52%
Walk-in & DOC	95%	100.00%	5.00%	100.00%	5.00%
Overall	95%	98.14%	3.14%	97.76%	2.76%

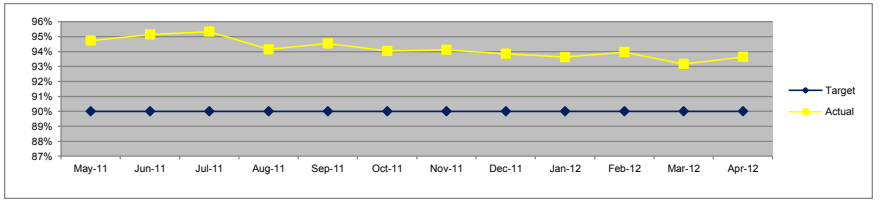
Analysis: The analysis above shows RWHT internal performance, Walk-in Centre performance and the overall health economy position both in month and cumulatively. Quarter 4 has been achieved for this indicator.

1.5	18 week Referral to Treatment (RTT)	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 2012/13 and will measure the number and percentage of patients on an incomplete pathway.

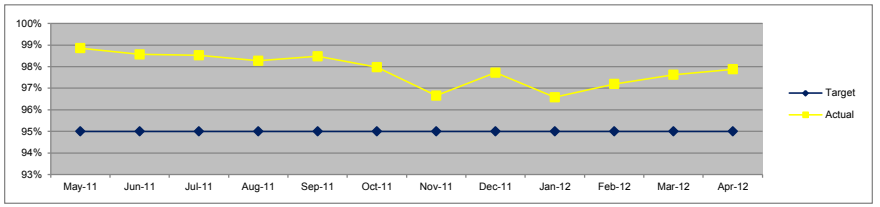
1.5.1	18 week Referral to Treatment - Admitted

Target	Apr-12
90%	93.65%



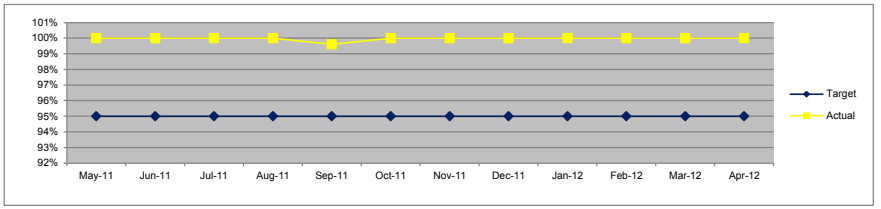
1.5.2 18 week Referral to Treatment - Non-admitted

Target	Apr-12
95%	97.88%



Audiology (Community only)

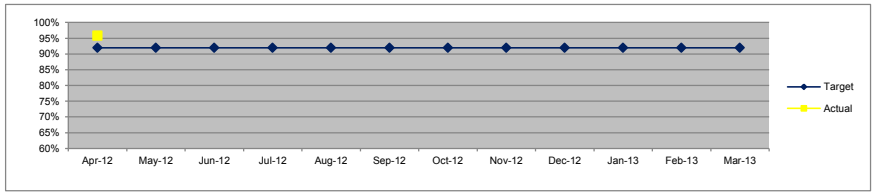
Target	Apr-12
95%	100.00%



Comments: All specialties achieved the target during April. This includes Consultant led elements of Community led services where 18 week pathways apply. These targets have been achieved consistently since they were first introduced in 2007, including achieving by specialty since 2009

1.5.3 18 week Referral to Treatment - Percentage of Patients on an Incomplete Pathway

Target	Apr-12
92%	95.79%

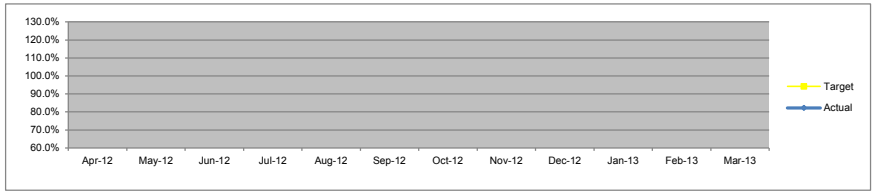


Analysis: This is a new indicator included this year in the Monitor Compliance Framework.

18 week Referral to Treatment - Data Completeness: Community Services

1.5.4 Referral to Treatment Information

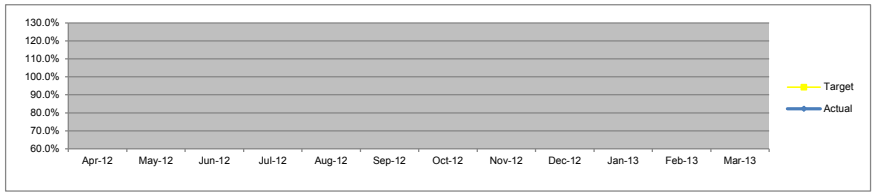
Target	Apr-12
50%	Compliant



Analysis: This is a new indicator included this year in the Monitor Compliance Framework.

1.5.5	Referral Information

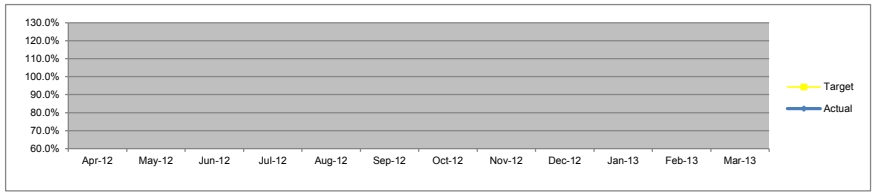
Target	Apr-12
50%	Compliant



Analysis: This is a new indicator included this year in the Monitor Compliance Framework.

1.5.6	Treatment Activity Information

Target	Apr-12
50%	Compliant

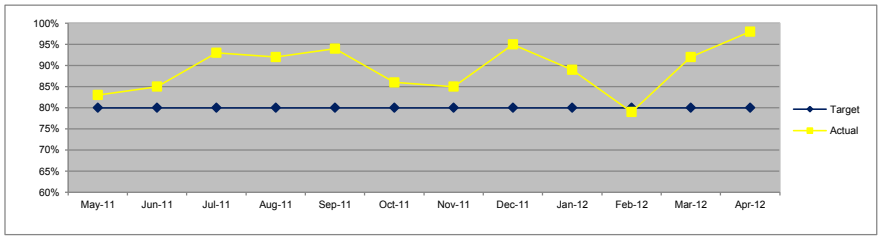


Analysis: This is a new indicator included this year in the Monitor Compliance Framework.

2)	Service Delivery		
2.1	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

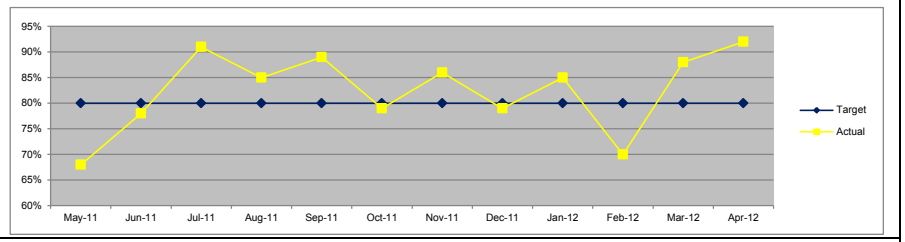
Target per Month	Apr-12	Current Month Variance
80%	98%	18%



Analysis: This is an improvement from last months position remaining above target by 18%.

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

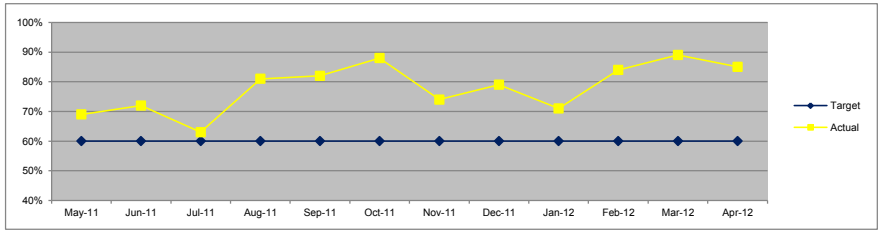
Target per Month	Apr-12	Current Month Variance
80%	92%	12%



Analysis: This is an improvement from last months position remaining above target by 12%.

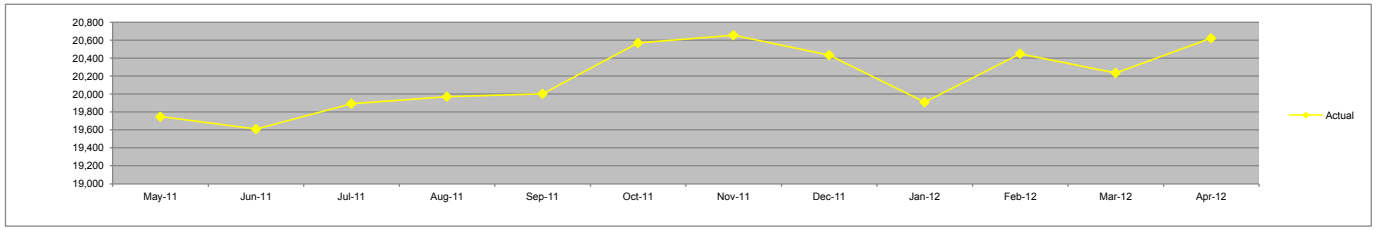
This indicator shows the TIA Service - High risk patients will be assessed and treated within 24 hours

Target per Month	Apr-12	Current Month Variance
60%	85%	25%



Analysis: This indicator remains above target by 25%.

2.2 Referral to Treatment - Number of Patients on an Incomplete Pathway



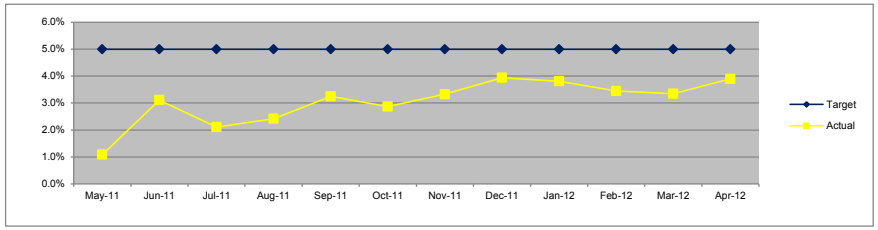
Analysis: This indicator is for surveillance purposes only - the patients who are currently on an incomplete pathway are as follows:- 95.33% of patients are under 18 weeks, 3.23% of patients are between 18-25 weeks, 1.38% of patients are between 26-50 weeks and 0.06% of patients are currently over 50 weeks. Of the patients who are currently over 18 weeks patient choice is the single biggest factor.

2.3 Reduce Delays in Transfer of Care

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

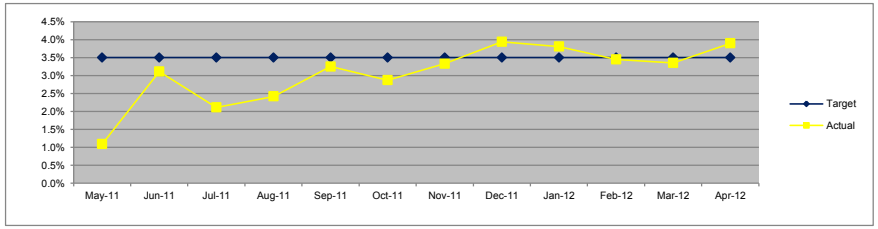
National Target

	Target	Apr-12	Variance
New Cross	5%	3.90%	1.10%
West Park	28	29	1



Local Target

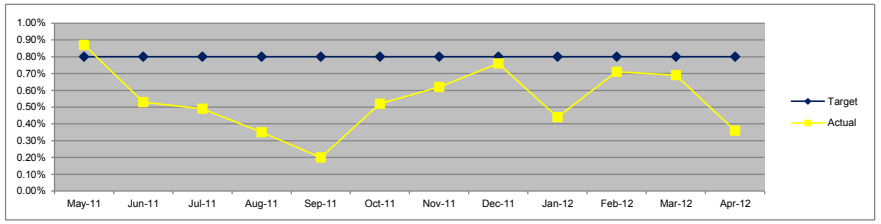
	Target	Apr-12	Variance
New Cross	3.5%	3.90%	-0.40%



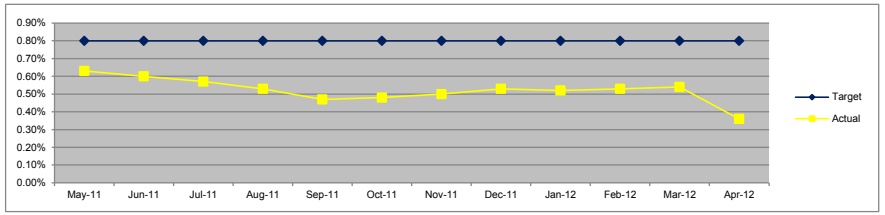
2.4	**Short Notice Cancellation of Operations**	**L**	**A**	

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

Monthly Target	Feb 12 Actual	Mar 12 Actual	Apr 12 Actual
0.80%	0.71%	0.69%	0.36%



Cumulative	Feb-12	Mar-12	Apr-12
Cancellations	370	404	21
Elec Procedures	69296	74210	5893
Cumulative %	0.53%	0.54%	0.36%



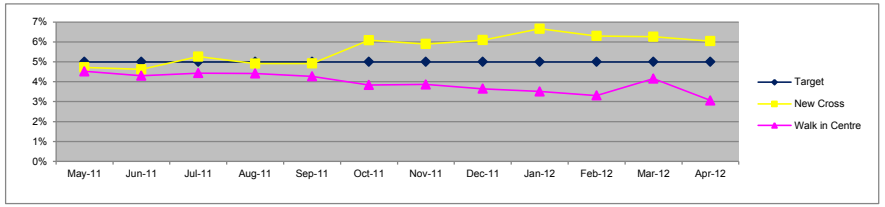
	Equipment not Avail	Norovirus on Ward	Ran out of theatre time	More urgent case(s)	No beds	Electrical Fault	No ITU Bed	Total
Urology	1				2			**3**
Gen Surg	1		1		3			**5**
Cardiac			1	3				**4**
Gynae			2					**2**
Ortho			4					**4**
Cardiology								**0**
H&N				1		1		**2**
Ophthal					1			**1**
Total	**2**	**0**	**8**	**4**	**6**	**1**	**0**	**21**

Actions: 21 operations were cancelled during April, this an improvement from 34 in March. 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.

2.5	Accident & Emergency	PCT	SHA	M	QA	
2.5.1	A&E Unplanned Re-attendance Rate	I				

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

	Target	Apr-12	Current Month Variance
New Cross Hospital	< 5%	6.04%	1.04%
Walk in Centre		3.06%	-1.94%
Combined Total		5.27%	0.27%

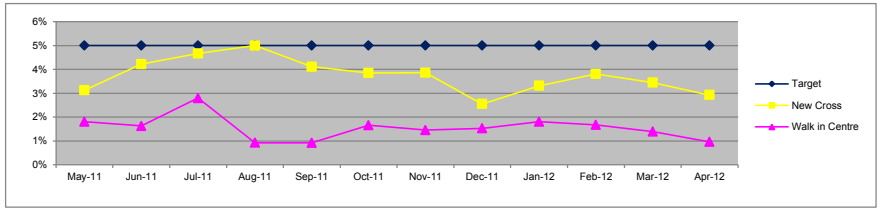


Analysis: This graph now also includes walk-in centre data. Also included is the combined organisation total which shows we are above target by 0.27%.

2.5.2	A&E 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	Apr-12	Current Month Variance
New Cross Hospital	< 5%	2.93%	-2.07%
Walk in Centre		0.97%	-4.03%
Combined Total		2.42%	-2.58%

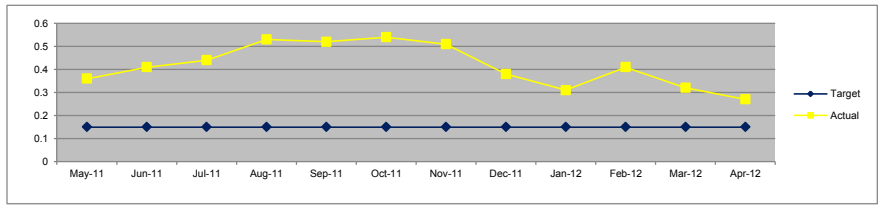


Analysis: This graph now also includes walk-in centre data.

2.5.3	A&E Time to Initial Assessment (for ambulance patients)	A				

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

Target	Apr-12	Current Month Variance
< 15 mins	00:27	00:12

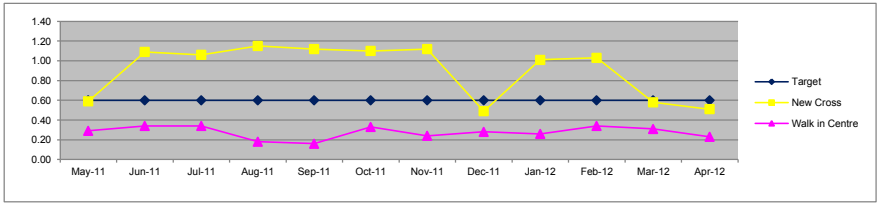


Analysis: The improvement in this indicator is a result of increased emphasis on the assessment target and ambulance turnaround time by the management team in A&E. This has been helped by the deployment of a nurse between 12 midday and 12 midnight whose main function is to provide assessment and care for patients who arrive by ambulance.

2.5.4	A&E Time to Treatment Decision (Median)	I				

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

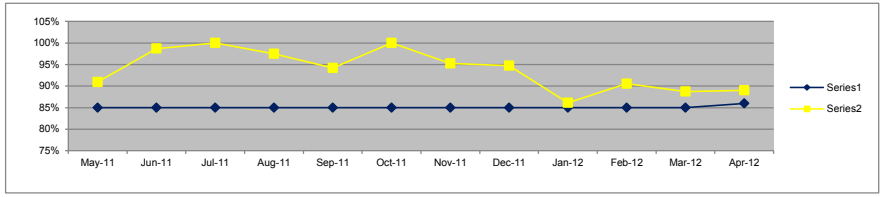
	Target	Apr-12	Current Month Variance
New Cross Hospital	< 60 mins	00:51	-9
Walk in Centre		00:23	-37
Combined Total		00:40	-20



Analysis: This is a signficiant improvement and has now taken us below target by 9 minutes for New Cross. This graph now also includes walk-in centre data. Also included is the combined organisation total in which we remain below target by 20 minutes.

2.6 62 Days for First Treatment for Patients who are Upgraded with a Suspicion of Cancer

Target	Apr-12	Variance
86%	89.02%	3.02%

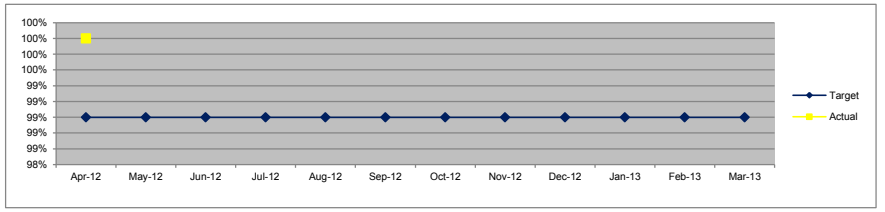


Analysis: This is a national indicator with a local stretch target applied.

2.7 Percentage of Patients Waiting 6 Weeks or more for Diagnostic Test

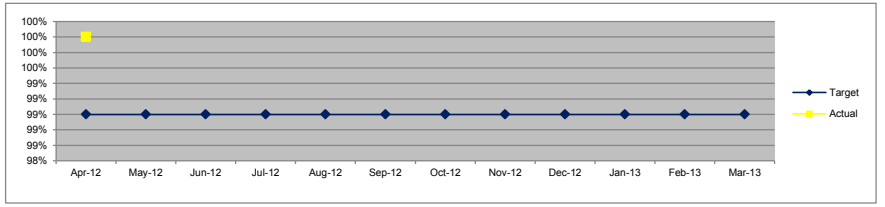
15 Key Diagnostic Tests

Target	Apr-12	Variance
>99%	100.00%	1.00%



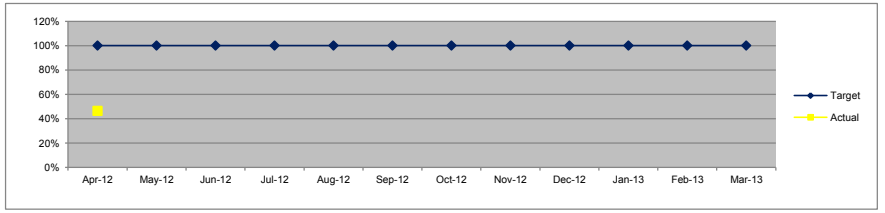
Audiology

Target	Apr-12	Variance
>99%	100.00%	1.00%



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

Target	Apr-12	Variance
100%	46.40%	-53.60%



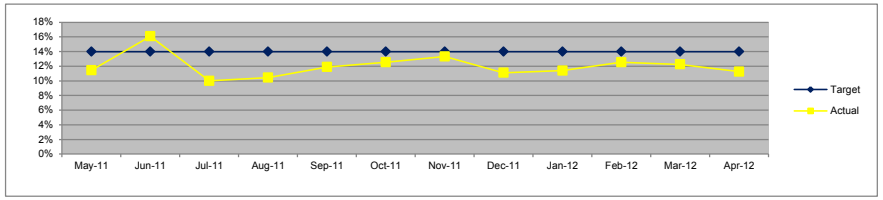
Analysis: Work is underway across all areas within the trust, a roll-out plan has commenced and all in-patient areas are now live. Performance is monitored weekly at the Divisional Managers Meeting.

2.9	Length of Stay	L	BCBV	A	

Pre-Op Length of Stay

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	Apr-12	Current Month Variance
14%	11.25%	-2.75%



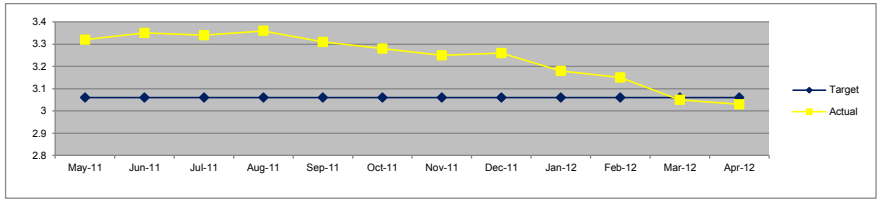
Analysis: Percentage of bed days spent pre-operatively has shown an improvement from the position reported in March of 12.25%, we remain below target by 2.75%.

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	Apr-12	Current Month Variance
3.06	3.03	-0.03



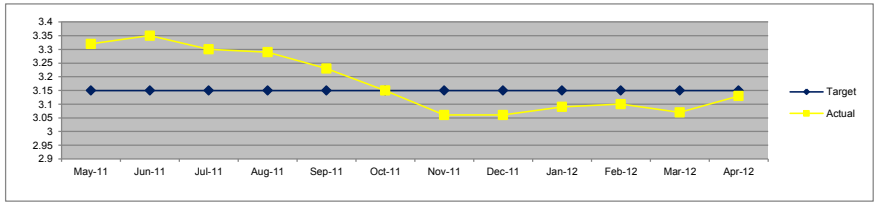
Analysis: This indicator has seen a steady improvement over the last few months, and this is the second consecutive month that the Trust has achieved this challenging internal target.

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	Apr-12	Current Month Variance
3.15	3.13	-0.02



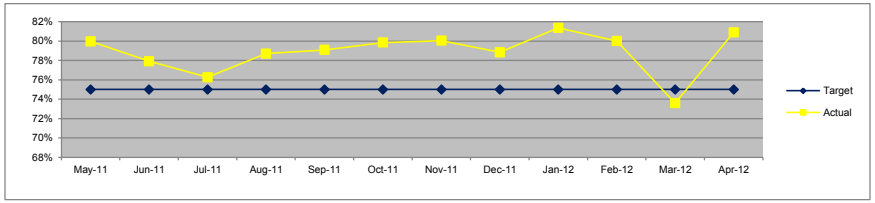
Analysis: This is the seventh consecutive month that Trust has achieved this target. We will continue to focus on timely discharge and admission avoidance

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

2.10	**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	Apr-12	Current Month Variance
75%	80.89%	5.89%



Analysis: This is a significant improvement from the position reported in March (73.6%), this has brought us back above target by 5.89%. The following specialties have an overall compliance rate of less than 75% - Breast Surgery (25.8%), ENT (58.7%), General Surgery (66.6%) and Vascular (64.7%).

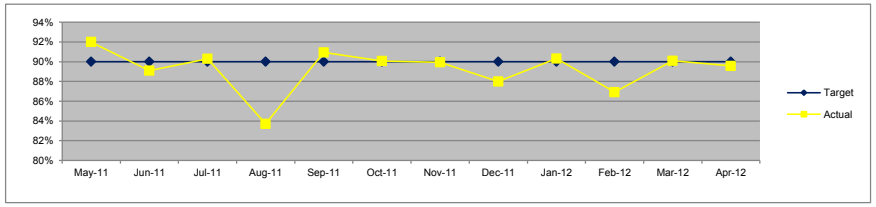
Actions: We are continuing to look at any specialties that are significantly below expectation

2.11	**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	Apr-12	Current Month Variance
90%	89.58%	-0.42%



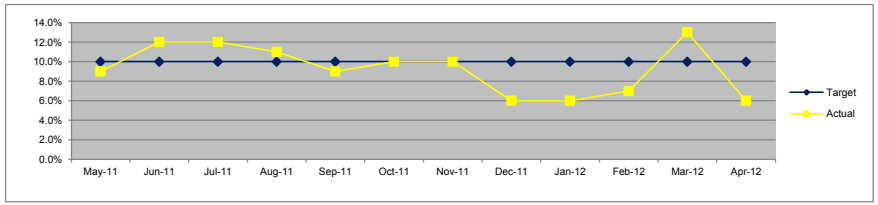
Analysis: The overall Trust position for theatre utilisation was dropped slightly below the target for the month of April by 0.42%.

Actions:

2.12	**Choose and Book**

Sufficient appointment slots made available on the Choose and Book System

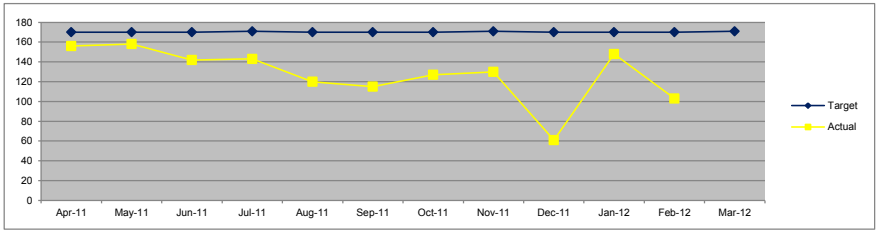
Target	Apr-12	Current Month Variance
10%	6.00%	-4.00%



Analysis: A new suite of indicators around choose and book will be added during Q1 following final agreement and sign off with the commissioner, this represents the on-going commitment to ensure consultant led services, with advice and guidance is available to patients when making bookings is provided through the choose and book service.

2.13	Smoking Quitters	C	

Monthly Target	Cum Plan	Cum Actual	Cum Variance
170	1872	1403	-469

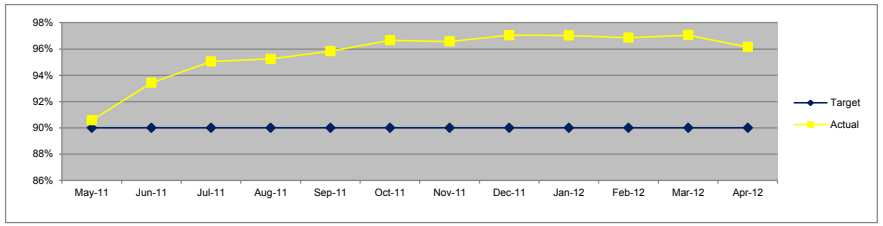


Analysis: Current target was based on the 2009/10 baseline which was a record year for the service. This was largely based on a national and local media campaign. The national campaign has not run this year and there has been very limited local media. This culminates in a significantly reduced interest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

Actions: Service increasing clinic capacity and advertising to maximise achievement of YTD target. Corrective action plan in place

2.14	Patients Dying in Place of Choice	C	

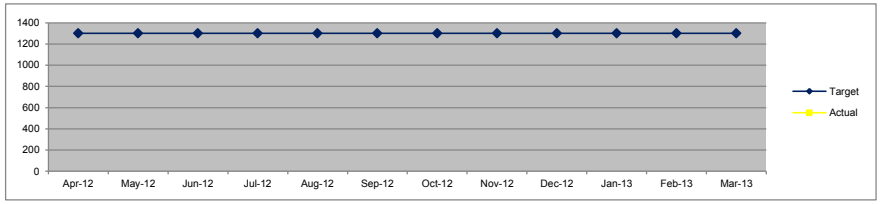
Target	Apr-12	Current Month Variance
90%	96.15%	6.15%



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.

2.15	Number of People offered an NHS Health Check

Target	Apr-12	Current Month Variance
1300	0	-1300

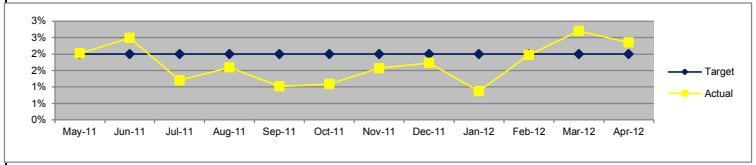


Analysis: This is a new indicator and will be included from may once the target has been confirmed with the commissioner.

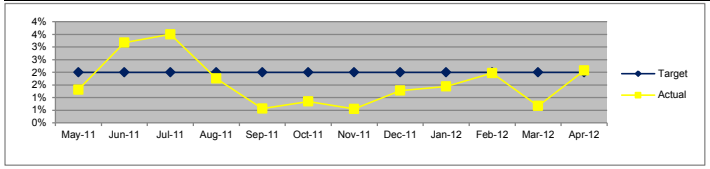
3)	Workforce		
3.1	**Recruitment and Retention**	**L**	**I**

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



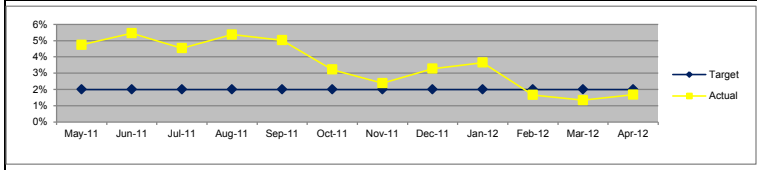
Vacancies - Non Trained Nursing Staff



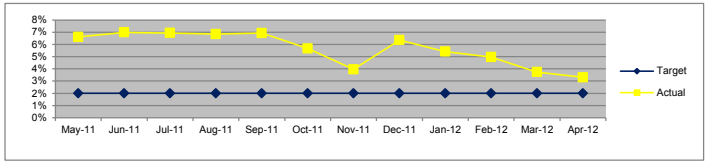
Analysis: Trained vacancies have decreased slightly while non-trained vacancies have increased.

Actions: Targeted recruitment to Band 5 nursing posts continues.

Vacancies - Medical Training Grades



Vacancies - Non Medical Training Grades



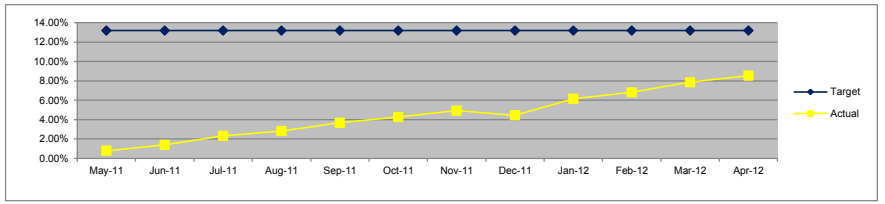
Analysis: Both training and non-training vacancies have remained static across both Divisions. The main area for vacancies continues to be in Emergency Medicine.

Actions: All vacant posts are being advertised.

3.2	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	Apr-12	Current Month Variance
13.20%	8.54%	-4.66%

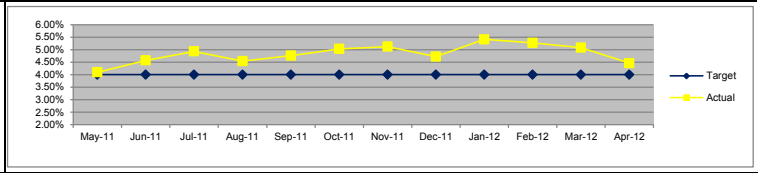


Analysis: We continue to achieve a much better turnover rate than the national NHS rate of 13.2%

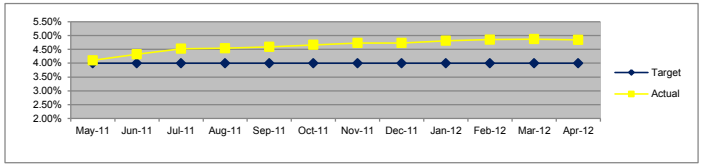
Actions:

3.3	Sickness Absence	L	I	

In Month Actual - The Trust target is 4%



Moving Annual Average - The Trust target is 4%

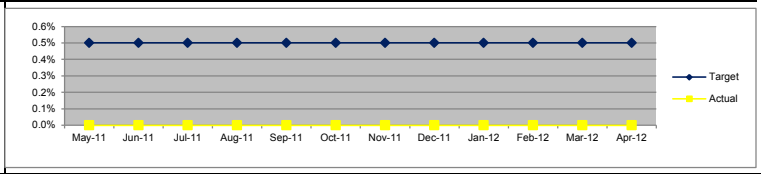


Analysis: Sickness absence overall for the Trust in April 2012 saw a decrease to 4.46% (5.08% in March 2012). The top four reasons were:- Anxiety/stress/depression (15.17%), Other Musculoskeletal (12.27%), Gastrointestinal problems (10.99%) and Other known causes - not elsewhere specified (10%)

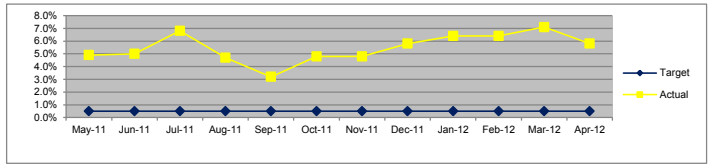
Actions: Sickness absence workshops continue and additional support is provided for those areas where sickness absence is high. The Trust is currently piloting in 15 areas across the Trust a Health and Wellbeing Call-back System in an attempt to provide support and intervention at an early stage of absence by fast tracking to Occupational Health and expediting other support if required. Initial results show a reduction in all areas in the first phase.

4.2.4	Temporary Staffing	L	I	

Temporary Nursing Staff (cumulative spend) - Agency Staff



Temporary Medical Staff (cumulative spend) - Agency Staff



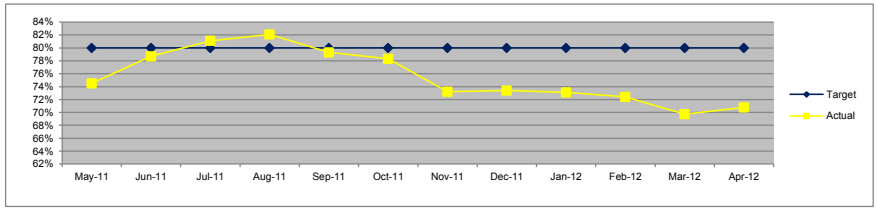
Analysis: There has been no agency expenditure for nursing staff during April. In terms of medical agency there has been a decrease in month from 7.1% in March to 5.8% in April. **Surgical Division** has seen a decrease in month from £79K in March to £66K in April. Agency expenditure in Critical Care and Ophthalmology had been high during April due to vacancies within the departments. **Medical Division also** saw a decrease in month from £237K in March to £222K in April. A&E has remained high due vacancies at Consultant level and middle grade and SHO rotas.

Actions:

3.5	Education and Training	L	NHS C	I	
3.5.1	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 2012/13 the target remains at 80%.

Target	Apr-12	Current Month Variance
80%	70.80%	-9.20%

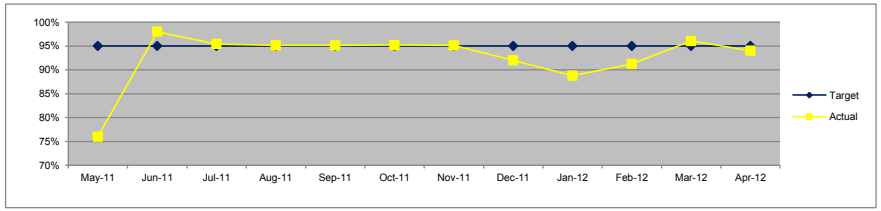


Analysis: April's position has seen a slight improvement from the position reported in March, the overall Trust position is below the target set for 2012/13. The following Divisions are showing as red i.e. <70% overall compliance. **Medical Division** - of a total of 2,271 staff of which 819 staff do not have an up to date appraisal giving the division a compliance rate of 63.9% **Corporate Services** - of a total of 690 staff of which 285 staff do not have an up to date appraisal giving the division a compliance rate of 58.7%

3.5.2	Information Governance Toolkit	I	

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

Target	Apr-12	Current Month Variance
95%	94.02%	-0.98%

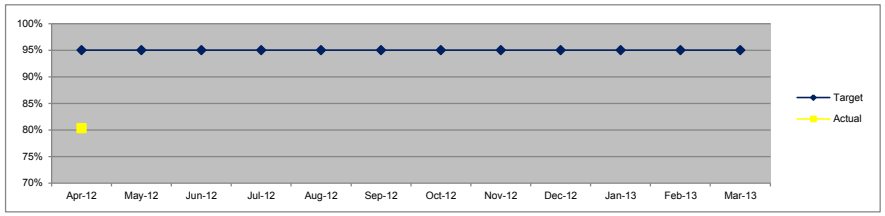


Analysis: This is a deterioration from the position reported last month 96.06% in March against 94.02% in April, this has taken us below target by 0.98%.

3.5.3 Induction

Corporate Induction

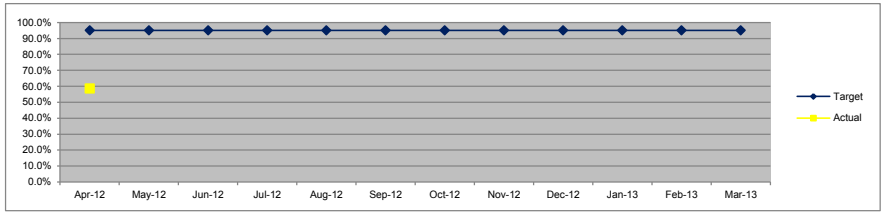
Target	Apr-12	Current Month Variance
95%	80.30%	-14.70%



Analysis: This is a new indicator for 2012/13. The following Divisions are showing as red i.e. <95% overall compliance with the number of staff not having attended Corporate Induction in brackets. **Surgical Division** - 84.5 % (43), **Medical Division** - 75.8% (81), **Estates & Facilities** - 82.4% (6) and **Corporate** - 83.5% (13)

Local Induction

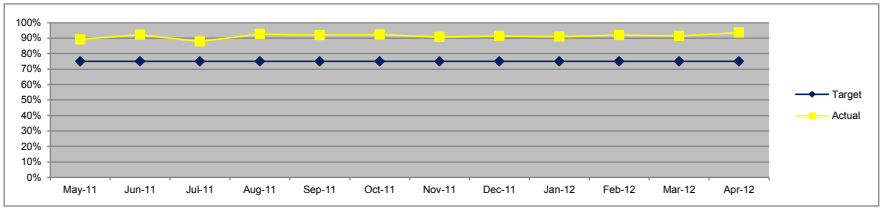
Target	Apr-12	Current Month Variance
95%	58.50%	-36.50%



Analysis: This is a new indicator for 2012/13. The following Divisions are showing as red i.e. <95% overall compliance with the number of staff not having received a Local Induction in brackets. **Surgical Division** - 66.9% (92), **Medical Division** - 50.7% (165, **Estates & Facilities** - 67.6% (11) and **Corporate** - 58.2% (33)

3.5.4 Mandatory Training | I

Target	Apr-12	Current Month Variance
75%	93.60%	18.60%



Analysis: This is a slight improvement from last months position of 91.4% in March to 93.5% in April, we continue to remain above target. There are three areas with departments showing <65% compliance i.e. 'red' performance are; **Bullying & Harassment** (Trust Management Team) and **Fire Safety** (Capacity & Emergency Planning, Endoscopy, Social Workers Support, Hospital Services Management and Trust Management Team)

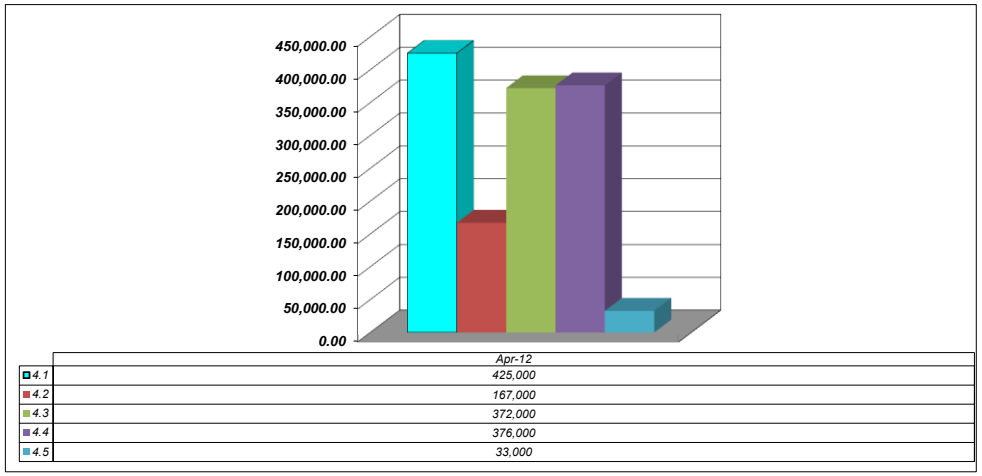
4) FINANCE

A

RWHT

4.1 Income variance vs. Plan
4.2 Expenditure variance vs. Plan
4.3 EBITDA is in line with plan
4.4 Achieve income and expenditure net surplus
4.5 SLA income against plan

Analysis: All areas are reporting a favourable position at Month 1



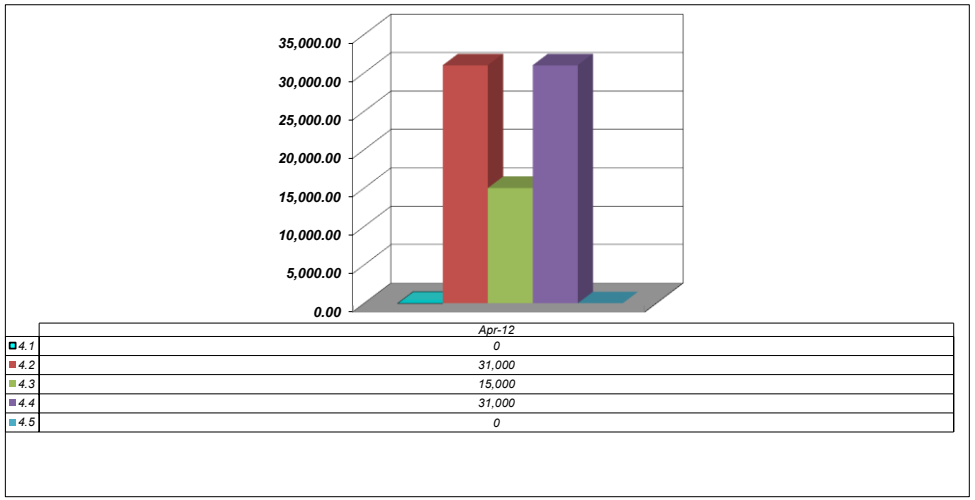
	Apr-12
4.1	425,000
4.2	167,000
4.3	372,000
4.4	376,000
4.5	33,000

C

Community

4.1 Income variance vs. Plan
4.2 Expenditure variance vs. Plan
4.3 EBITDA is in line with plan
4.4 Achieve income and expenditure net surplus
4.5 SLA income against plan

Analysis: All areas are reporting a favourable position at Month 1



	Apr-12
4.1	0
4.2	31,000
4.3	15,000
4.4	31,000
4.5	0

4.6 Delivery of Cost Improvement Programme

	Mar-12	Apr-12
2012/13 Total CIP	£14,075	£16,742
Quarter 1 (25%)	£14,075	£4,186
Current Position	£13,318	£3,792
Variance against Q3 Plan	**-£757**	**-£394**

The table above shows year to date actual delivery of CIP against plan for Quarter 1. This equates to 22.7% removed from budgets against a plan of 25% for Q1. The figures represent the 2012/13 actuals plus the 2011/12 brought forwards.

4.7 Actual Performance against contract

	Plan	Actual	Variance
Emergency In-patients	3,609	3,481	**-128**
Elective In-patients	742	749	**7**
New Out-patients	8,204	9,704	**1,500**
All Out-patients	21,478	21,436	**-42**

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