

**TRUST BOARD**  
**28<sup>th</sup> November 2013**

<b>TITLE</b>	<b>Performance Report</b>
	<p>The Trust met the 4 hour standard in October 2013. Performance for the month was <b>95.1%</b>. Although this represented an improvement in performance against the A&amp;E standard from September, sustained delivery remains a risk and the Trust is therefore progressing with a further programme of work to improve resilience, maintain capacity and flow and deliver a good patient experience in anticipation of further increases in demand in winter 2013/14.</p>
<b>EXECUTIVE SUMMARY</b>	<p>The RTT, 18-week standards for elective care were achieved in the month, and the key points to note are:</p> <ol style="list-style-type: none"> <li>1. The Trust met the 18 week waiting time standards for all 18 week RTT standards at an aggregate level. At specialty level, admitted patient care and incomplete pathways were compliant across all specialties and compliant for non-admitted patient care in all specialities other than Urology.</li> <li>2. The Trust has anticipated performance issues and forecasts a failure to deliver the 18 week target at specialty level only in General Surgery and Cardiology in November.</li> </ol> <p>The paper also details the areas of note and the on-going improvement work underway in the operational teams.</p>
<b>BOARD ASSURANCE (Risk) / IMPLICATIONS LINK TO STRATEGIC OBJECTIVE</b>	<p>Compliance is reflected in the Board Assurance Framework. BAF Risk 1.1 National targets and priorities.</p> <p><b>SO1:</b> To achieve the highest possible quality of care and treatment for our patients, in terms of outcome, safety and experience.</p> <p><b>SO3:</b> To deliver the Trust's clinical strategy of joined up healthcare.</p>
<b>STAKEHOLDER / PATIENT IMPACT AND VIEWS EQUALITY AND DIVERSITY ISSUES</b>	<p>Patient expectations in terms of access are reflected in NHS performance targets.</p> <p>None identified</p>
<b>LEGAL ISSUES</b>	None identified
<b>The Trust Board is asked to:</b>	Review and discuss the report and obtain additional assurance.
<b>Submitted by:</b>	Valerie Bartlett, Deputy Chief Executive
<b>Date:</b>	20 <sup>th</sup> November 2013
<b>Decision:</b>	For Assurance

## PERFORMANCE REPORT

### 1 INTRODUCTION

The purpose of this paper is to summarise key performance issues and the actions in place to address them. Specifically the paper addresses the targets and standards included in the Monitor Risk Assessment Framework:

- A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge
- Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted patients
- Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted patients
- Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway

In October 2013, the Trust met the 4 hour wait target in A&E and all of the above 18 weeks compliance standards. A more detailed explanation of performance in the month and the associated risks and issues are provided in the sections below.

### 2 FOUR HOUR STANDARD FOR WAITING TIMES IN A&E

The Trust met the 4 hour wait standard in October. Performance for the month was **95.1%**. This represents an improvement in performance from September and puts the Trust back into a compliant position against this target. However, with our performance very close to the compliance level of 95%, this does serve as reminder of the fragility of the position.

Period	% Patients admitted / transferred / discharged < 4 hours (SPH, EPU, GUM & ASH)
April 2013	93.6%
May 2013	94.8%
June 2013	98.1%
<b>(Quarter 1 2013/2014)</b>	<b>(95.4%)</b>
July 2013	96.9%
August 2013	97.7%
September 2013	94.3%
<b>(Quarter 2 2013/2014)</b>	<b>(96.3%)</b>
October 2013	<b>95.1%</b>

Performance against the planned trajectory for 2013/2014 is shown below as APPENDIX B

The key drivers of performance in the month were:

- Continued focus on the delivery of the 4 hour recovery plan within the Trust, including Executive-led weekly meetings to review all A&E breaches and well as a weekly, senior cross-divisional performance review
- Enhanced performance management of the 4-hour standard through implementation of a cross-divisional performance meeting
- Continued implementation and refinement of the Older Persons Assessment and Liaison (OPAL) team model.

The most significant challenges in the month were:

- A&E attendances remain high and October saw an increase in attendances compared with September.
- The Trust experienced an increased number of admissions to the acute emergency care pathway with the admission rate from A&E remaining at a high level of 23%, suggestive of a high level of acuity in patients presenting to A&E.

## **2.1 FORWARD LOOK AND FORECAST FOR QUARTER 3**

Performance against the 4-hour standard remains at significant risk as the Trust moves further into winter and Q3. National scrutiny of Trusts' performance against this standard is at unprecedented levels with heightened interest from commissioners, regulators and patient groups.

Throughout Q2 and in advance of winter 2013/2014, the Trust completed a range of actions to support future sustainability, including:

- Establishment and embedding of the new frail, elderly pathway (OPAL)
- Implementation of the Ambulatory Care Unit
- Extension and improvements in the Surgical Assessment Unit

However, in light of the fragility of performance in September and October, the Trust is now seeking to expedite a number of further actions to support the emergency care pathway, these include:

- Expansion of the opening hours of the Ambulatory Care Unit
- Introduction of Sunday ward rounds to aid discharge
- Continued support to maximise the impact of the OPAL team

A copy of the latest A&E recovery plan is appended and a further verbal update will be provided at the Board meeting.

### 3 REFERRAL TO TREATMENT TIMES (RTT)

The table below shows performance against the RTT, 18-week standard by speciality for October 2013.

The Trust delivered for all 18 week RTT standards at an aggregate level. At specialty level, admitted patient care and incomplete pathways were compliant across all specialties and compliant in non-admitted patient care for all specialties other than Urology.

Failure to meet the 18 week standard for Urology does not have a performance implication with regard to the Compliance Framework, as the 90% standard for admitted pathways was achieved for the month for the Trust as a whole.

However, failure to achieve at speciality level will incur a financial penalty under the terms of the contract with North-West Surrey CCG.

#### 3.1 OCTOBER 2013 RTT PERFORMANCE

Speciality	Admitted patient care (target 90%)	Non-admitted patient care (target 95%)	Incomplete pathways (target 92%)
General Surgery	90.83%	97.50%	96.09%
Urology	95.45%	93.85%	98.46%
Trauma & Orthopaedics	90.54%	95.19%	96.55%
Ear, Nose & Throat (ENT)	95.45%	97.03%	97.51%
Ophthalmology	95.48%	98.42%	99.34%
Oral Surgery	92.18%	95.80%	98.02%
General Medicine	100.00%	96.70%	99.19%
Gastroenterology	100.00%	100.00%	99.34%
Cardiology	97.70%	96.09%	95.45%
Dermatology	0.00%	97.78%	98.94%
Neurology	0.00%	95.07%	95.94%
Rheumatology	0.00%	100.00%	100.00%
Geriatric Medicine	0.00%	100.00%	100.00%
Gynaecology	98.17%	99.59%	99.42%
Other	100.00%	99.57%	99.80%
<b>Total</b>	<b>94.11%</b>	<b>97.42%</b>	<b>97.89%</b>

#### 3.2 OCTOBER PERFORMANCE

The 18 week target for non-admitted patients in Urology was not achieved in October (93.85% against a target of 95%). The root cause behind this specialty failure has been identified and analysed. The patients breaching the standard in October are former patients of the Epsom Downs Integrated Care Services (EDICS) which were placed into administration in August 2013. The trust inherited a patient case load from this organisation and a number of patients who had already experienced an extended waiting time. The urology speciality treated a number of these patients in October and was obliged to record them as breaches. Had this not been the case, the specialty would have been compliant for this standard in October.

### 3.3 FORWARD LOOK

Performance in Cardiology was compliant in October despite the forecast in the last report to the Board; however there remains a risk to achieving the 18-week standard in this specialty as a result of the review of the planned waiting list which revealed patients were waiting longer than necessary for their treatment (cardioversion). It is forecast that clearing this backlog will adversely affect specialty level admitted performance in November which will lead the specialty to fail, however it is not presently anticipated to affect December's performance.

Within the General Surgery specialty, a number of capacity and operational issues have been identified that are currently affecting the surgical pathways and action plans have been developed to address these. The specialty is currently forecasting a failure for November and December and is conducting a detailed review of forecasted performance for January onwards.

A detailed analysis of the root causes of the issues in General Surgery has been undertaken and the specialty continues to work closely with the Intensive Support Team on demand and capacity modelling for the service. The major root causes identified are as follows:

- A move to chronological booking which resulted in an expected dip in performance as the backlog was addressed
- Staff turnover which effected the capacity for oversight of performance
- An underlying demand and capacity imbalance

Key actions identified to address the root causes include:

- Completion of the modelling of demand and capacity
- Realigning of capacity against demand
- Resolution of staffing vacancies

As part of the resolution of issues in General Surgery, the Trust is working hard to identify and implement best practice in terms of RTT performance management. As a result, should the Trust have further cause to adjust its processes in line with best practice, there remains an on-going risk that this work will produce further issues that may jeopardise short-term performance in the future.

Within the Trauma and Orthopaedic specialty, activity remains high and there is a sustained risk to the delivery of the admitted and non-admitted standards in this specialty. The active waiting list for Orthopaedics is currently over 3,500 patients, an increase from around 2,700 in April 2013. The Trust is in discussion with the CCG over pathway changes with a view to alleviating the pressure on this service.

The number of patients waiting over 30 weeks for treatment remains low. In October there were 4 patients that had been treated in the month in excess of 30 weeks on an admitted pathway and 7 patients on a non-admitted pathway across all specialties. Root-cause analysis of all patients who waited over 30 weeks for treatment is completed every month and reviewed by the divisional teams in order that relevant actions can be taken.

In overall terms, the size of the backlog (the number of patients not seen and already having breached 18 weeks) rose slightly by around 5% over the month of October, however each specialty continues to focus very heavily on clearing their backlog and this is monitored each week through both specialty level and trust-wide performance meetings.

Daily 18 weeks performance meetings take place to monitor real-time performance and the improvement action plans originally designed by the IST continue to be reviewed on a weekly basis.

#### **4 CONCLUSION**

Whilst the Trust is pleased with delivery of the 4 hour standard for October, it is recognised that sustained delivery remains a risk and performance against the standard remains fragile within an environment of heightened scrutiny. Work is on-going to improve resilience, maintain capacity and flow and deliver a good patient experience in anticipation of further increases in demand in winter 2013/14.

A copy of the current 4-hour recovery plan, which documents progress in the programme of work, is included as APPENDIX C.

#### **5 ACTION REQUIRED**

The Trust Board is asked to note delivery of all of the performance targets associated with the Monitor Risk Assessment Framework in October 2013 and seek further assurance as appropriate.

#### **Appendices:**

Appendix A – RTT Dashboard

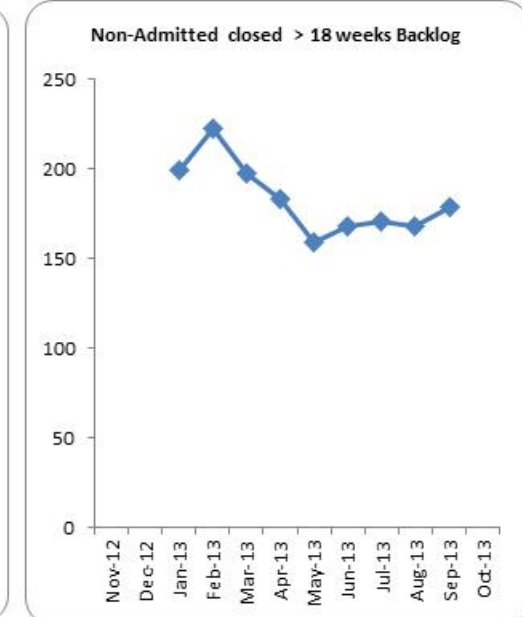
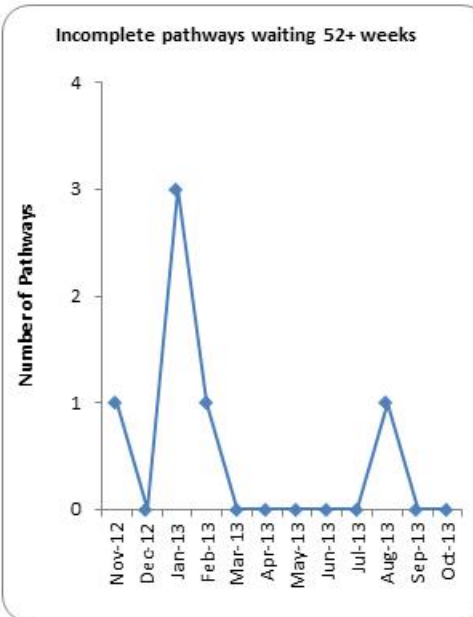
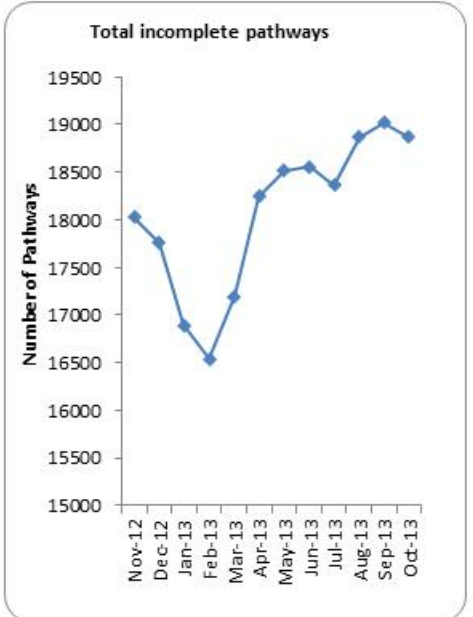
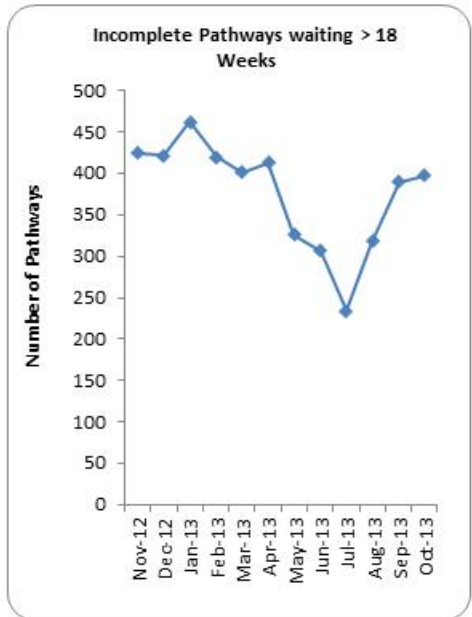
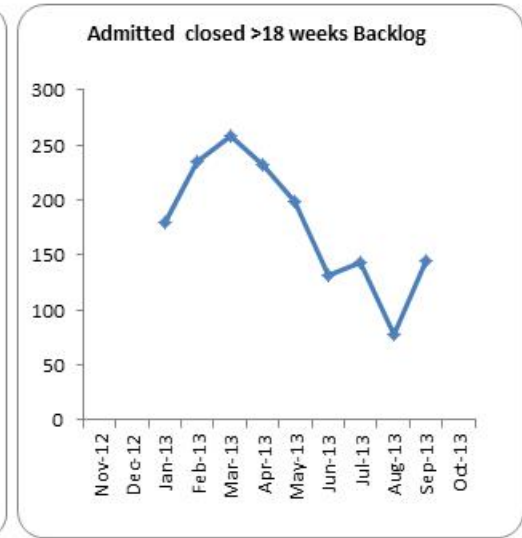
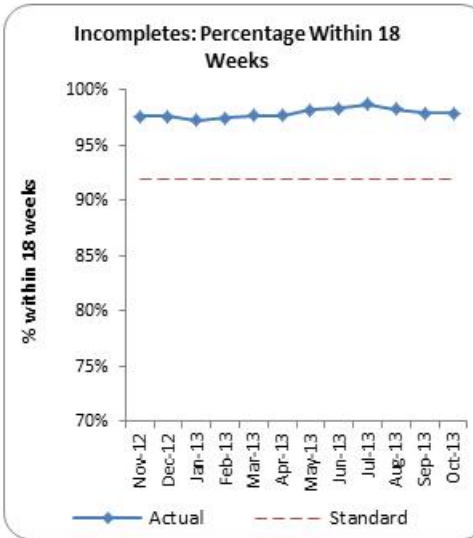
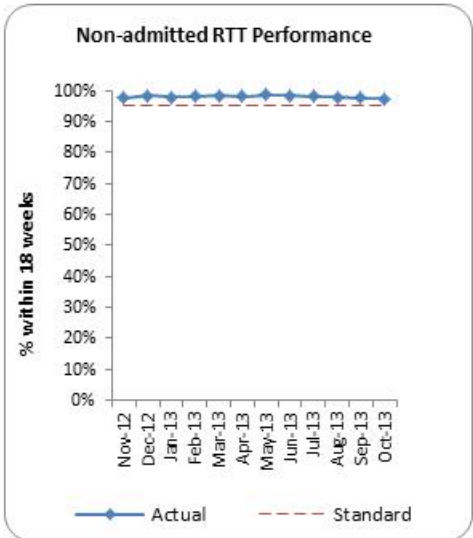
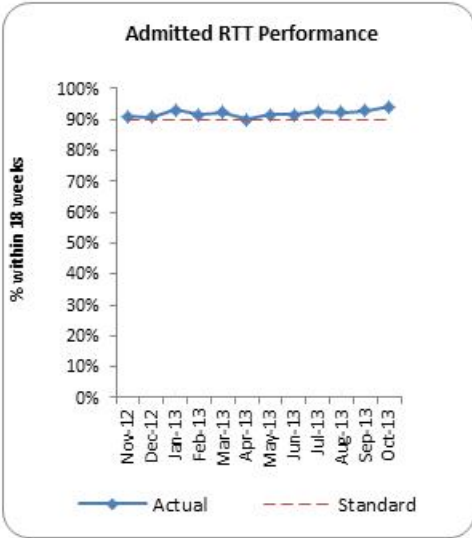
Appendix B – A&E performance versus trajectory

Appendix C – Four hour emergency pathway recovery plan

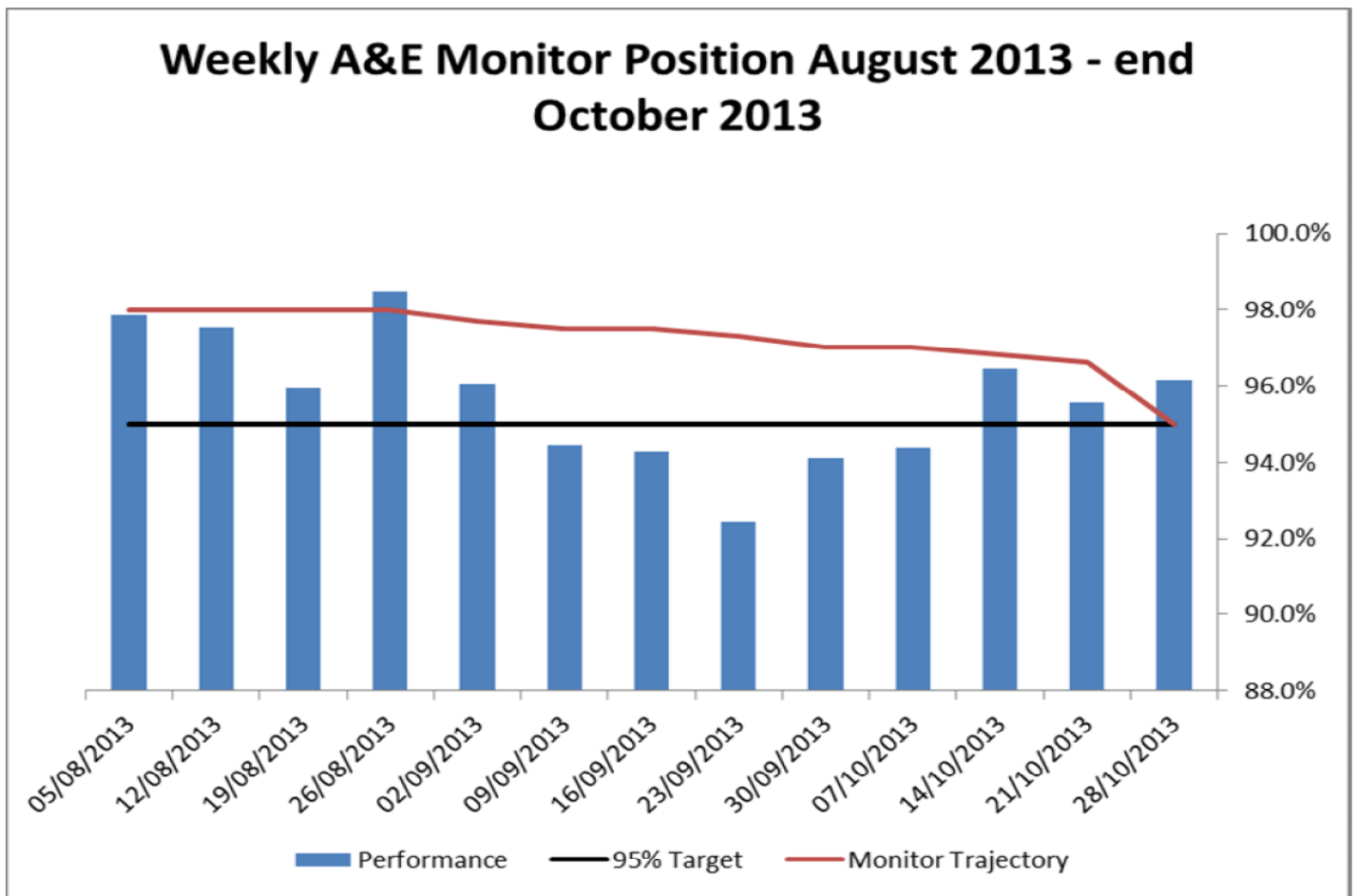
Appendix D – Trust Operational Performance Report

Appendix E – Monitor indicators

# APPENDIX A: RTT DASHBOARD



## APPENDIX B – A&E 4-HOUR PERFORMANCE AGAINST TRAJECTORY





**REF: 1.0**    **ITEM**    **7-DAY WORKING ON THE EMERGENCY CARE PATHWAY**

REF	OBJECTIVE	ACTIONS	OWNER	COMPLETE DATE	UPDATE / COMPLETE
1.1	Ensure consultant presence on medical inpatient wards 7-days a week	Interim plans for 7-day working on emergency care pathway from December 2013 to be developed by medicine division	Tom Smerdon	15 November 2013	
		Amend medical consultant rotas to ensure every patient is seen by a consultant during a ward round, every day of the week from April 2014	Tom Smerdon	31 January 2014	
		Redistribute junior staffing levels in order to provide more appropriate cover based on bed numbers and the timing of proposed consultant ward rounds	Tom Smerdon	1 April 2014	
		Interim diagnostics, therapies and pharmacy 7-day cover to be implemented from December 2013	Cathy Parsons	1 December 2013	
		Enhanced diagnostics, therapies and pharmacy weekend cover proposals for 2014/2015 to be completed	Cathy Parsons	31 January 2014	
		Additional investments required to achieve 7-day consultant coverage on all medical wards from 2014/2015 to be identified	Tom Smerdon	1 December 2013	
1.2	Increase the number of weekend discharges for patients with LoS > 7 days	Increase senior specialist consultant and registrar cover at weekends.	Tom Smerdon	1 April 2014	
		Revitalise discharge hub via RIE approach to increase weekend cover and discharge support on ward rounds.	Tom Smerdon/Shelly Head (SCC)	1 January 2014	

RISKS	MITIGATION	OWNER	UPDATE
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A&E 4-HOUR RECOVERY PLAN

<p>There is a risk that existing consultants will be reluctant to deliver interim rotas and provide 7-day cover without additional payment or formal consultation</p>	<p>Ensure best HR practice is followed in all cases. Fully engage the LNC/BMA in the formal decision making process. Fully consult with affected staff, formally and informally Thoroughly assess the financial impact of any proposals to enable the necessary resources to be allocated.</p>	<p>Louise McKenzie</p>	
<p>There is a risk that ability to increase the number of weekend discharges for patients staying greater than 7 days due to limited social services capacity at weekends</p>	<p>Develop plans for 7 day coverage by the Discharge Hub as part of the RIE process. Assess the financial impact of this and bid for additional resources as required.</p>	<p>Tom Smerdon/Shelly Head (SCC)</p>	

REF: 2.0 ITEM A&E PERFORMANCE IMPROVEMENT

REF	OBJECTIVE	ACTIONS	OWNER	COMPLETE DATE	UPDATE / COMPLETE
2.1	Improve time-to-assessment by a senior decision maker for patients attending A&E	Establish current data collection and baseline for time-to-assessment by senior decision maker in A&E	Philip Kemp	1 December 2013	
		Agree a trajectory for improvement in time-to-assessment-by-senior-decision-maker standard	Philip Kemp	1 December 2013	
		'Surge-plan' for times of peak-attendance to be developed with A&E and on-call specialist consultants	Philip Kemp	1 December 2013	
		Work with all specialty teams to eliminate delays to review patients in A&E, setting standard that patients should be seen by specialist within an hour of referral and before 3 hours in A&E.	Philip Kemp	1 December 2013	
2.2	Reduce the number of non-admitted breaches in A&E	Reduce number of delays to senior assessment by piloting additional Registrar overnight	Tom Smerdon	Complete	Model to be implemented from January 2014
		Implementation of enhanced out-of-hours cover provided by Psychiatric Liaison Services to cover a Twilight service to A&E as agreed in the recent business case	Sam Goonnaih	Complete	
		Transport - escalation of performance issues to CCG	Tom Smerdon	In place	
2.3	Increase the adult A&E consultant workforce	New consultant recruited and due to start in post on 10/01/2014	Philip Kemp	10/01/2014	
		Interview panel arranged for 4 <sup>th</sup> December for further 2 consultant posts (3 applicants)	Philip Kemp	04/12/2014	

## A&amp;E 4-HOUR RECOVERY PLAN

2.4	Expansion of Paediatric A&E	Temporary extension to the unit to create additional capacity and increase in assessment space within Paediatric A&E	Helen Sibley	1 January 2014?	
		Recruitment of an additional 2 Paediatric A&E Consultants to support senior cover to 10pm (weekdays) and weekends	Helen Sibley	Complete	

RISKS	MITIGATION	OWNER	UPDATE
There is a risk to the Trusts ability to reduce the number of non-admitted breaches in A&E due to the poor response and service from transport provided by SECAMB	<ul style="list-style-type: none"> <li>- Internal professional standards for SECAMB are being reviewed through Capacity and Resilience group</li> <li>- Philip Kemp to attend task and finish group</li> <li>- A&amp;E now recording ambulance breaches</li> </ul>	Philip Kemp	E-booking and training for block-booking has not happened as training has been cancelled on multiple occasions
There is a risk to the Trusts ability to reduce the number of non-admitted breaches in A&E due to poor response times from the Psyche Liaison Services	Twilight service up to midnight starts 28/10/2013	Philip Kemp	
There is a risk that it will not be possible to recruit the required additional A&E consultants into substantive posts	Awaiting outcome of interview panel in January 2014	Philip Kemp	

## REF: 3.0 ITEM IMPROVING HOSPITAL FLOW

REF	OBJECTIVE	ACTIONS	OWNER	COMPLETE DATE	UPDATE / COMPLETE
3.1	Reduce average time of day of discharge on inpatient wards to closer to midday	Best-practice ward rounds that facilitate timely completion of TTOs to be implemented on inpatient wards; led by divisional director for medicine	Gulam Patel	1 January 2014	
		Revitalise discharge hub via RIE approach to increase weekend cover and discharge support on ward rounds.	Tom Smerdon/Shelly Head (SCC)	1 January 2014	
3.2	Continue Ready to Go project and length of stay reviews	Continue roll-out of Ready to Go project to medical wards, starting on May (Gastro) ward focussing on implementation of Patient Flow bundle	Mark Hinchcliffe	31/12/2013	Initial stage and data collection on May ward has completed and PDSA work underway from 28/10/2013
		Implementation of Expected Date of Discharge (EDD) protocol on all inpatient wards	Suzanne Rankin	31/03/2014	EDD policy and protocol has been approved by TEC Implementation plan is being developed with Chief Nurse
		Roll-out of executive and consultant-led length of stay reviews on medical inpatient wards	Suzanne Rankin	1 December 2014	
3.3	Increase escalation capacity at St Peters	Complete refurb and expansion of Kingfisher and Falcon (surgical) wards in order to vacate Swift ward by 1 <sup>st</sup> December	Victoria Griffiths	1 December 2014	
		20 additional, planned escalation beds to be made available on Swift ward	Tom Smerdon	1 December 2013	

A&E 4-HOUR RECOVERY PLAN

3.4	Implement Ambulatory Care Unit	Creation of dedicated Ambulatory Care unit in close proximity to the ED	Tom Smerdon	Complete	
		Confirmation of resources required to support Ambulatory Care unit	Tom Smerdon	Complete	
		Plan for implementation of Ambulatory Care Unit by November 2013	Tom Smerdon	5 November 2013	
		Go-live with Ambulatory Care Unit	Tom Smerdon	5 November 2013	
3.5	Transfer of Elective Surgery to Ashford Hospital	All vacant theatre lists at Ashford Hospital to be reviewed and transfer of surgery where possible following identification of risks and appropriate mitigation form all specialities	Victoria Griffiths	31/12/2013	Currently developing action plan with specialties. Full stakeholder event on 08/11/2013
		Day surgery team to ensure that as much day surgery as possible is carried out at Ashford hospital	Victoria Griffiths	31/12/2013	Currently developing action plan with specialties
		Daily scrutiny of all theatre lists to ensure fully booked and appropriate patients operated on at appropriate site	Victoria Griffiths	on going	

RISKS	MITIGATION	OWNER	UPDATE
Continuing difficulties with timely PTS service leading to unexpected failures of discharge	Continue to book extra ambulance. Block book PTS slots at busy times. Include PTS team in discharge hub RIE activity.	Tom Smerdon	
Limited social services capacity	Improve the effectiveness of multi-agency discharge team via RIE to mitigate any shortage in capacity.	Tom Smerdon/Shelly Head (SCC)	

**REF: 4.0**    **ITEM**    IMPLEMENTING NEW FRAIL / ELDERLY PATHWAY

REF	OBJECTIVE	ACTIONS	OWNER	COMPLETE DATE	UPDATE / COMPLETE
4.1	Implement in-hospital OPAL (Older Persons Assessment Liaison) team and pathway	Agreement and implementation of OPAL pathway	Mark Hinchcliffe	01/10/2013	Complete
		Identification and agreement of performance measures	Mark Hinchcliffe	01/10/2013	Baselines and measures identified; final indicators to be agreed with Strategic Delivery TEC
		Internal OPAL team go-live (Consultant, Specialist Nurse, Therapists, Therapy Assistant, Pharmacist, Dietician)	Mark Hinchcliffe	01/10/2013	Internal team in place covered by existing staff
		Recruitment to substantive OPAL team posts	Mark Hinchcliffe	01/11/2013	Nursing, therapist, therapy assistant, pharmacist and dietician roles all starting in November 2013 Consultant recruitment is outstanding and aim to be completed by January 2014
4.2	Implement OPAL-Plus team and pathway	Additional community services to be provided by Virgin Care, including Rapid Response and facilitating discharge from A&E	Kerry O'Hara	30 November 2013	
		Additional social services capacity to be provided as part of the OPAL-Plus team	Kerry O'Hara	30 November 2013	

RISKS	MITIGATION	OWNER	UPDATE
<p>There is a risk that Virgin Care will not have the capacity to implement the required OPAL-Plus services in timescales required to support the in-hospital team</p>	<p>Support VC as much as possible via:</p> <ul style="list-style-type: none"> <li>• Access to ASPH staff bank</li> <li>• Offering secondments to ASPH staff to work with VC</li> <li>• Providing access to staff accommodation for VC</li> </ul>	<p>Kerry O’Hara</p>	
<p>There is a risk that Social Services will not have the capacity to implement the required OPAL-Plus services in timescales required to support the in-hospital team</p>	<p>Review via weekly OPAL meetings and provide support as necessary.</p>	<p>Kerry O’Hara</p>	



**REF: 5.0** ITEM IMPLEMENTING NEW SURGICAL ASSESSMENT AND SHORT STAY

REF	OBJECTIVE	ACTIONS	OWNER	COMPLETE DATE	UPDATE / COMPLETE
5.1	Implement new surgical assessment unit (SAU) and short-stay unit	Business case for new SAU and associated pathway approved	Victoria Griffiths	Complete	
		Operational policy and pathways agreed by clinical leads	Victoria Griffiths	Complete	
		Complete capital works required to establish new unit	Victoria Griffiths	Complete	
		Recruitment to nursing posts associated with extended SAU	Victoria Griffiths	Complete	
		Implementation of new surgical rota	Victoria Griffiths	Complete	
		Go-live with new SAU	Victoria Griffiths	Complete	

RISKS	MITIGATION	OWNER	UPDATE
Inability to recruit to ward manager post.	Review ward structure if required to ensure that appropriate leadership post can be appointed to.	Sue Sexton	
Inability of surgical team to cover all areas (SAU, theatres, A&E, wards) may inhibit flow.	Keep operational model under review. One additional emergency surgeon has been appointed	Victoria Griffiths	

**Trust Operational Performance Report - October 2013**

	2012/13												2013/14								YTD 13/14	13/14 Plan	Var	Trend
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct					
<b>Cancer indicators and</b>																								
All cancers: 31-day wait for second or subsequent treatment	Anti Cancer Drug Treatments												100%								100%	98%	2.0%	
	Surgery												100%								100%	94%	6.0%	
All cancers: 62-day wait for first treatment	From Consultant Screening Service Referral												100%								100%	90%	10.0%	
	Urgent GP Referral To Treatment												85.1%								91.0%	85%	6.0%	
31-Day Wait For First Treatment	All Cancers												97.5%								100.0%	96%	4.0%	
Two week wait from referral to date first seen	All Cancers												95.5%								96.6%	93%	3.6%	
	For symptomatic breast patients												96.1%								93.2%	93%	0.2%	
<b>Referral to Treatment wait</b>																								
Referral to treatment waiting times - admitted																								
Referral to treatment waiting times - Non-admitted																								
Referral to treatment waiting times - Incomplete																								
<b>A&amp;E Clinical Quality</b>																								
Total time in A&E (95%) - Monitor Position																								
Total time in A&E (95%) - Unify & Contract Monitoring Position																								
Time to initial assessment (95th percentile)																								
Time to treatment decision (Median)																								
Unplanned reattendance rate																								
<b>Quality &amp; Safety</b>																								
C.Diff (hospital acquired)																								
MRSA Bacteraemia (hospital acquired)																								
Friends and Family Test	Inpatients (Test Score)												66.7								72.6	70	3.7%	
	Inpatient (Response Rate)												11.18%								39.83%	15%	165.5%	
	A&E (Test Score)												-								46.6	70	-33.5%	
	A&E (Response Rate)												0.37%								15.03%	15%	0.2%	
Breach of Same Sex Accommodation																								
VTE Risk Assessment *																								
Stroke Pts - 90% time on Stroke Unit																								
Smoking During Pregnancy																								
Breastfeeding Initiation																								
<b>Activity</b>																								
Acute Bed Capacity																								
Avg. Length of Stay - Elective (Acute) **																								
Avg. Length of Stay - Emergency (Acute) **																								
Daycase Rate																								
Delayed Transfers of Care – Acute & MH																								
GP Written Referrals to Hospital																								
Other Referrals For a First Outpatient Appointment																								
All Outpatient Attendances																								
Elective Spells																								
Non-elective (inc maternity & transfers)																								
A&E Attendances																								
<i>Old Better Care Better Value (not transferred to Operating Framework)</i>																								
BADs Procedures																								
Inpatients Admitted before day of Operation																								

\* VTE Assessment unvalidated  
 \*\* Avg. length of stay from 2013/14 - RealTime LOS

Monitor Risk Assessment Framework - Governance Indicators Financial Risk Ratings as at October 2013

Safety:		13/14 Threshold	Weighting	Monitoring Period	13/14 YTD Plan	Q1	Q2	Q3	Q4	YTD
Clostridium Difficile - meeting the Clostridium Difficile objective		13	1.0	Quarterly	7	1	3	0		4
Quality:		Threshold	Weighting	Monitoring Period	13/14 Plan	Q1	Q2	Q3	Q4	YTD
All Cancers: 31 day wait for second or subsequent treatment (surgery)		Surgery anti-cancer drug treatments 94% 98%	1.0	Quarterly	94% 98%	100% 100%	100% 100%	100% 100%		100% 100%
All Cancers: 62 day wait for first treatment from urgent GP referral to treatment		urgent GP referral NHS Cancer Screening Service 85% 90%	1.0	Quarterly	85% 90%	90.2% 100%	88.1% 100.0%	89.4% 97.6%		91.0% 100%
All Cancers: 31 day wait from diagnosis to first treatment			0.5	Quarterly	96%	100.0%	99.6%	100.0%		100.0%
Cancer: 2 week wait from referral to date first seen		all urgent referrals (cancer suspected) symptomatic breast patients 93% 93%	0.5	Quarterly	93% 93%	97.3% 97.9%	96.7% 97.0%	97.1% 97.1%		96.6% 93.2%
A&E (maximum wait time of 4 hours from arrival to admission/ transfer/ discharge)			1.0	Quarterly	95%	95.43%	96.33%	95.15%		95.78%
Patient Experience:		Threshold	Weighting	Monitoring Period	13/14 Plan	Q1	Q2	Q3	Q4	YTD
Referral to treatment waiting times - admitted		90%	1.0	Quarterly	90%	91.08%	92.62%	94.11%		92.22%
Referral to treatment waiting times - non admitted		95%	1.0	Quarterly	95%	98.39%	97.79%	97.42%		97.89%
Referral to treatment waiting times - Incomplete pathways		92%	1.0	Quarterly	92%	98.11%	98.33%	97.89%		98.17%
Governance:		Weighting	Monitoring Period	13/14 Plan	Q1	Q2	Q3	Q4	Yr End	
Failure to comply with requirements regarding access to healthcare for people with a learning disability		0.5	Quarterly	No	No	No	No			
Risk of, or actual, failure to deliver mandatory services		4.0	Quarterly	No	No	No	No			
CQC compliance action outstanding (as at 31st Mar 2013)		Monitor Discretion	Quarterly	No	No	No	No			
CQC enforcement action within last 12 months (up to 31st Mar 2013)		Monitor Discretion	Quarterly	No	No	No	No			
CQC enforcement notice currently in effect (as at 31st Mar 2013)		4.0	Quarterly	No	No	No	No			
Minor CQC concerns or impacts regarding the safety of healthcare provision (as at 31st Mar 2013)		Monitor Discretion	Quarterly	No	No	No	No			
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at 31st Mar 2013)		Monitor Discretion	Quarterly	No	No	No	No			
Major CQC concerns or impacts regarding the safety of healthcare provision (as at 31st Mar 2013)		2.0	Quarterly	No	No	No	No			
Unable to maintain, or certify, a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		2.0	Quarterly	No	No	No	No			
Trust unable to declare ongoing compliance with minimum standards of CQC registration		Monitor Discretion	Quarterly	No	No	No	No			
Has the Trust has been inspected by CQC (in the quarter ending 31st Mar 2013)		Monitor Discretion	Quarterly	No	No	No	No			
If so, did the CQC inspection find non compliance with 1 or more essential standards		Monitor Discretion	Quarterly	No	No	No	No			
Indicative Governance risk rating					G	G	G			
Financial Risk Score		Forcast Score	Weighting	Monitoring Period	Current Score	Q1	Q2	Q3	Q4	Yr End Forecast
1. Debt Service Cover		2.51	50%	Annual	2.83			4		4
2. Liquidity		-2.74	50%	Annual	0.35			4		3
Continuity of Service Risk Rating			100					4		4