Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS
9th September 2013

TITLE	**Assurance Report**
EXECUTIVE SUMMARY	The Assurance report gives an overview of some of the key areas of internal focus for the Trust, areas of performance in terms of quality, operations and finance and a perspective on the external environment.
The Council is asked to:	Discuss the report.
Submitted by:	Andrew Liles, Chief Executive
Date:	August 2013
Decision	For Discussion

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

ASSURANCE REPORT

1 INTERNAL FOCUS

1.1 Managed Equipment Service for Imaging

The trust signed a new contract for a full replacement and maintenance service for imaging equipment and associated patient areas across the hospitals in the last quarter. This followed a rigorous tendering process, with high staff engagement from our imaging department. The new contract offers a high quality and cost effective service that will ensure patients and clinicians benefit from the very latest, high tech imaging equipment, delivered in an improved patient friendly environment. In year one we will see the total replacement of all our X-ray and ultra-sound equipment and associated building works (to improve the patient environment) at both our hospital sites, before moving to MRI and CT scanning at Ashford in year two.

Upgrading this vital diagnostic equipment brings other significant benefits including improved reporting and response times and less equipment 'downtime', meaning a reduction in cancellations and shorter waiting times, really important elements in improving the patient experience. Having access to the very latest technology will help us continue to develop our clinical services and ensure we continue to offer the very best care and treatment to our patients. The contract started on 1st August and runs for 10 years.

1.2 Developing a Nursing and Midwifery Strategy

At the end of last year the government launched a new vision and strategy for nursing, centred around six core values of care, compassion, competence, communication, courage and commitment. This has a real focus on caring and aims to bring together technical nursing skills with the warmth, empathy and kindness that characterises traditional nursing values.

At Ashford and St Peter's we are currently working on our own nursing and midwifery vision and strategy. 'Together we Care' incorporates the focus of the national agenda but also reflects our own local priorities and aspirations. Importantly this centres around safe care, professional competency, kindness, respect and understanding as well as reflecting the increasing focus on personal responsibility and developing a culture of openness and honesty, particularly in response to the Francis report. Our developing strategy is based on wide engagement with both nursing and midwifery staff but also with other staff across our organisation and will be published later this year.

1.3 Utilisation of imaging equipment at Ashford and St Peter's Hospitals

Background: Cross sectional imaging and ultrasound are in high demand and increasing year on year. The following provides some information on utilisation at the Trust.

CT scanning: The CT service comprises of one scanner on the SPH site and one on the AH site.

CT scanner at SPH:

- Operates a full service 8am to 8pm Monday to Friday. Between 8pm and 8am Monday to Friday the scanner is operated on an on-call basis for all urgent and emergency scans.
- Operates a full service between 9am and 5pm on Saturday and Sunday.
- Outside these hours at the weekend the scanner is operated on an on-call basis for all urgent and emergency scans.
- The scanner is over utilised during the week days with 48 slots and 55-60 scans undertaken.

- The scanner is utilised to capacity during the day on Saturday and Sunday.
- The scanner is utilised to its full potential for emergency scans at night.

CT scanner at AH:

- Operates a full service 9am-5pm Monday to Friday and is utilised to capacity with 4 patients per hour being scanned.
- Closed outside of these hours during the week and at weekends.
- Extended hours during the week and at weekends have been limited due to medical cover on the elective site and operator resource.
- From September 2013, the scanner will be opened three in every four Saturdays from 9am -5pm to accommodate outpatient appointments and to reduce waiting times.
- The scanner is due for replacement in 2014/15. A full weekend service (Sat and Sun 9am-5pm) will then be considered.

Ultrasound Service: The ultrasound service in imaging comprises four 'fixed' machines at SPH and three machines at AH.

Ultrasound service at SPH:

- Operates 8am to 5pm Monday to Friday – all machines utilised to capacity.
- 5pm-8pm – one room manned by Consultant Radiologist for urgent and emergency scans.
- No service between 8pm and 8am Monday to Friday.
- Operates 9am - 5pm Saturday and Sunday – all machines utilised to capacity.
- No service after 5pm at the weekends.

Ultrasound service at AH:

- Operates 9am to 5pm, Monday to Friday – all machines utilised at capacity.
- Closed outside of these hours during the week and at weekends.

Extending utilisation of equipment has been limited due to a national shortage of sonographers.

MRI service: The MRI service is operated by Alliance Medical. A fixed MRI unit is based at SPH (which operates 7am – 9pm Monday to Friday and 8am-8pm Saturday and Sunday) and a mobile scanner is based at AH (which operates 8am – 8pm 7 days per week). The units operate at capacity.

1.4 **Preventing Re-admissions**

Background: Readmissions are generally indicative of ineffective patient management and are markers of costly and suboptimal healthcare. In 2012/13 Ashford and St Peter's Hospitals NHS Foundation Trust lost £2.8 million income due to readmission penalties. In 2013/14 a new Commissioning for Quality and Innovation (CQUIN) payment will be attached to the achievement of a reduction in emergency – emergency readmissions with a potential income of £1.1 million.

Approach: Multiple factors usually contribute to readmissions, rather than a single, discrete cause. Frequent drivers include the quality of inpatient care, the transitions to community and primary care, the availability of community resources for follow-up care, the patient's characteristics and the home environment. Thus as an acute Trust faced with financial penalties and needing effective rapid change in readmission rates, ASPH has initiated a 'Readmission Prevention Programme' with dedicated programme management support, sponsored by Dr David Fluck, Medical Director and with stakeholders from both primary and secondary care represented on the Programme Board.

The planned outcome of the Programme is to:

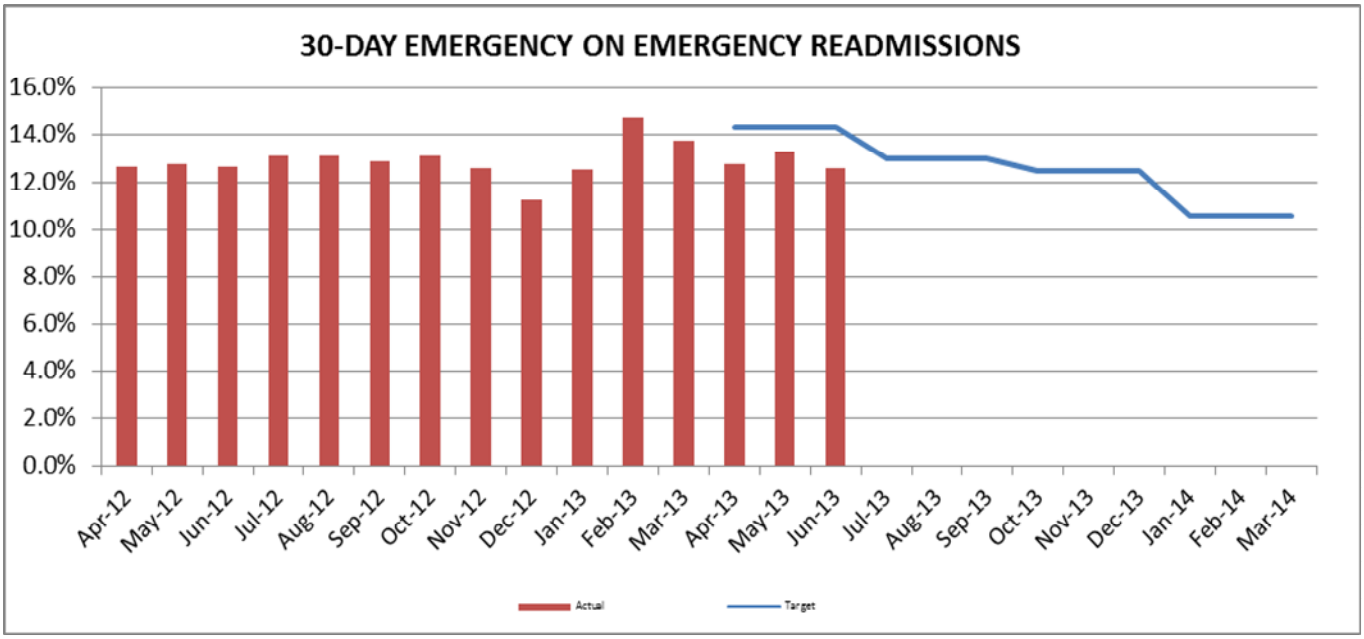
- Improve the quality of our inpatient care at ASPH, throughout the entire pathway, such that a patient's need to be readmitted following this initial episode is considerably reduced;
- The collection and analysis of our detailed readmission data enables us to understand the

diseases, clinical practices, patient characteristics and factors driving readmission trends; and
- The successful delivery of the project objectives in order to; support achievement of the 2013/2014 CQUIN target and maximise avoidance of commissioning fines.

A number of specialty-specific work-streams have been identified. These include:
- Respiratory – Implementing a Post Exacerbation Pulmonary rehabilitation (PEPR) programme for in-patients with Chronic Obstructive Pulmonary Disease (COPD);
- Cardiology – Heart failure readmission prevention, focussing on specialist nurse telephone support and advice service and out-patient clinics. Along with an action plan based on analysis of root causes of last year's heart failure readmissions;
- Emergency to emergency readmission prevention – readmission risk stratification tool (LACE index) supported by readmission prevention interventions; and
- Performance - accurate capture of readmission data, benchmarking exercise, reporting of readmission data is clean and accurate.

***Current performance*:**

Emergencies re-admitted within 30 days following an emergency spell are detailed in the table below. The Trust has achieved the target since its introduction at the beginning of 2013/14. July data has not yet been validated.



2 EXTERNAL OUTLOOK

2.1 Keogh Mortality Review

The Keogh Mortality Review was published in July and set out the findings of the review by the NHS England Medical Director, Sir Bruce Keogh, of Trusts which had been outliers for two consecutive years on either the Standard Hospital-Level Mortality Index or the Hospital Standardised Mortality Ratio. 11 of the 14 trusts have now been placed in special measures, and their progress will be overseen by the NHS Trust Development Authority or Monitor.

The response to the Keogh review has been positive with the methodologies adopted by the Keogh review team to be taken forward by the new Chief Inspector of Hospitals in inspections announced at the time of the publication of the Keogh review. The first of these inspections using the new approach began in August, with 18 hospital trusts selected as pilots. These 18 include our neighbouring hospitals Royal

Surrey County Hospital and Frimley Park Hospital.

As a response to the Keogh review the Government announced its plans to legislate to make sure failed managers can no longer get new jobs elsewhere in the NHS. It will also develop a programme to identify, support and train outstanding leaders. It will use the new role of Chief Inspector of Hospitals (created in response to the Francis Inquiry findings with Professor Sir Mike Richards appointed) to ensure that a failing hospital will be put into special measures with a limited time period to sort out problems.

2.2 A promise to learn – a commitment to act: Improving the safety of patients in England (Don Berwick, National Advisory Group on the Safety of Patients in England)

Professor Don Berwick, former Obama health adviser, undertook a review, at the request of the Government, into patient safety following the Francis Report. The report was published on 6th August and distils the lessons learned and specifies the changes needed. Some of the key findings included:

• Patient safety problems exist throughout the NHS as with every health care system in the world;
• NHS staff are not to blame with the vast majority of staff wishing to do a good job, to reduce suffering and to be proud of their work;
• Incorrect priorities do damage: the central focus must always be on patients;
• Clear warning signals have not always been heeded;
• When responsibility is diffused, it is not clearly owned: with too many in charge, no-one is;
• There needs to be a considered, resourced and driven agenda of capability-building in order to deliver continuous improvement; and
• Fear is toxic to both safety and improvement.

Report recommendations

The overarching goal
1. The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning.

Leadership
2. All leaders concerned with NHS healthcare – political, regulatory, governance, executive, clinical and advocacy – should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support.

Patient and Public Involvement
3. Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts.

Staff
4. Government, Health Education England and NHS England should assure that sufficient staff are available to meet the NHS's needs now and in the future. Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported.

Training and Capacity-Building
5. Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executives.
6. The NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS.

Measurement and Transparency
7. Transparency should be complete, timely and unequivocal. All data on quality and safety, whether assembled by government, organisations, or professional societies, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public.

8. All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.

Structures
9. Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of staff. All incentives should point in the same direction.

Enforcement
10. We support responsive regulation of organisations, with a hierarchy of responses. Recourse to criminal sanctions should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or mistreatment.

2.3 **Publication of the first Friends and Family Test data**

Background
At the end of July NHS England published the first results from the Friends and Family Test (FFT), also made available on NHS Choices. The results cover inpatients and patients discharged from Accident and Emergency for the months of April, May and June 2013.

The FFT is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. The responses are used to produce a score that can be aggregated to ward, site, specialty, trust and national levels.
The test is being rolled out to other services, including introduction in maternity services in October. The implementation of FFT and measures for increasing scores and response rate are also a requirement within national CQUIN arrangements for 2013/4.

The scores are calculated using the 'net promoter methodology' which means responses are analysed and categorised into promoters, detractors and neutral responses. The proportion of detractors is then subtracted from the proportion of promoters to provide an overall 'net promoter' score. The highest score available is therefore 100.

Headline figures
- Inpatient data was submitted by all 157 acute trusts and independent sector providers, A&E data by all 144 NHS providers of A&E services.
- Response rates rose over the three month period from 5.6% to 10.3% for A&E, from 21.5% to 27% for inpatient services. 117 NHS trusts showed an improvement in coverage between April and June.
- Nationally the combined overall England score for NHS trusts increased from 62 to 63 over the three month period. The inpatient score increased from 70 to 71 and the A&E score increased from 49 to 54
- The results for A&E show a considerable range from -13 (from one trust with 515 respondents) to 100 (from two trusts, each with 15 or fewer respondents).
- The results for impatient services also show considerable range: 43 (two trusts) to 100 (15 responses in an NHS specialist foundation trust)
- The independent sector performs well in scores for inpatient care, ranging from 67 (3 respondents) to 100 (two providers, each with under 20 respondents).

Further detail on the Trust's performance is included within the Quality section of this report.

3 STRATEGY

3.1 Partnership Agreement with The Royal Surrey County Hospital

The Trust continue to develop our partnership with The Royal Surrey County Hospital NHS Foundation Trust, looking at areas where it would be beneficial to work more closely together. In the current NHS, more and more Trusts are starting to work closer together - this is partly about pooling resources and doing some things more efficiently but, more importantly for patients, it's about taking advantage of the latest clinical developments and treatments so hospitals can provide the most specialist services across larger catchment areas.

Part of our strategic plan is to become a leading provider of the most specialist hyper-acute services in Surrey within the next three years, increasing our catchment population to around 800,000 for certain specialties. Part of our joint work with The Royal Surrey County Hospital is to look at where we might develop some of these services together – for example, improving 24/7 stroke care and to see if we can jointly develop a Surrey renal service. We are also looking to see if we can deliver further savings in corporate areas such as finance and HR and already have plans to bring our Occupational Health Services together.

4 REGULATION

4.1 CQC consultation on a new regime for quality regulation

The CQC's consultation, 'A new start' was published in June 2013 and includes proposals for new fundamental standards, ratings and a single failure regime. Pilot inspections will begin in the acute sector as early as October 2013.

The consultation sets out proposals to:

- inspect all care services, NHS trusts and foundation trusts and independent acute hospitals;
- develop clear standards of care that health and social care services must meet;
- make better use of information and evidence received to decide when, where and what to expect;
- introduce Chief Inspectors to lead national teams of expert inspectors which will include people who receive care, clinical experts and others;
- develop a ratings system to help people choose between services and to encourage services to make improvements;
- make sure that directors or leaders of organisations have made legal commitments to provide safe and high-quality care, and are personally held to account for it;
- create indicators that will be used to trigger action in NHS acute hospitals; and
- develop a programme for failing hospitals that ensures immediate action is taken to protect people and to hold those responsible to account.

4.2 Monitor: Your statutory duties: A reference guide for NHS foundation trust governors

Monitor published their new revised guide on 6th August. The guide sets out the statutory duties for governors of NHS foundation trusts, as provided by the National Health Service Act 2006 and amended by the Health and Social Care Act 2012. It is written for governors and is advisory only with no requirement to 'comply or explain'. The guide is limited to commenting on the statutory duties common to all governors. It does not seek to prescribe how governors should work day-to-day; noting that NHS foundation trust boards and governors will agree this between themselves.

Monitor has stated that they intend to publish a summary of the guide, with key details on how governors can expect to work with Monitor and the Care Quality Commission later in 2013. This document is expected to be published in partnership with the Care Quality Commission, Foundation Trust Network and Foundation Trust Governors' Association.

5 PERFORMANCE

5.1 Quality

Quality Dashboard and Commentary

1. To achieve the highest possible quality of care and treatment for our patients

	Patient Safety & Quality		Outturn 12/13	YTD Target 13/14	Monthly Target 13/14	Annual Target 13/14	Jul Actual	Performance			YTD 13/14
								May	Jun	Jul	
1-01	Summary Hospital-level Mortality Indicator (SHMI)	N	60	<72	<72	<72	58	◄►	◄►	▲	62
1-02	Actual deaths (Includes Neonatal Intensive Care)	L	1160	<315	<78	<945	84	▲	▼	▲	352
1-03	MRSA (Hospital only)	N	2	0	0	0	0	◄►	◄►	◄►	0
1-04	C.Diff (Hospital only)	N	15	<=4	<=1	<13	0	▲	◄►	◄►	1
1-05	VTE (hospital associated with PE or DVT)	L	24	<8	<2	<24	3	▼	▲	▼	11
1-06	Serious Incidents Requiring Investigation (SIRI)	L	71	<25	<6	<75	7	▼	▲	◄►	27
1-07	Average Bed Occupancy (inc escalation)	L	88.6%	<92%	<92%	<92%	84.9%	▲	▲	▲	87.6%
1-08	Patient Moves (ward changes >=3)	L	7.4%	<7.5%	<7.5%	<7.5%	6.3%	▲	▲	▼	5.9%
1-09	Formal complaints (Total Number)	L	485	<150	<37	<450	43	▲	▲	▼	175
1-10	Friends & Family test score - InPatients	L	-	70	70	70	77.4	▲	▲	▲	73.2
1-10a	Friends & Family test score - A&E	L	-	70	70	70	47.6	▼	▼	▲	47.8
1-11	Falls (Total Number)	L	766	<233	<58	<700	89	▼	▲	▼	283
1-12	Falls - resulting in significant injury (grade 3)	L	18	<5	<1	<15	2	▼	▼	▼	10
1-13	Hospital acquired pressure ulcers grade 2 and above	L	164	<46	<11	<139	6	▲	▲	▲	41
1-14	Catheter associated UTI *	L	-	<1.2%	<1.2%	<1.2%	0.43%	▲	▼	▼	0.67%

1-01 IN-HOSPITAL (SHMI) Monthly figure is a rolling 3 month position, 1 month in arrears & YTD figure is a rolling 12 Month position, 1 Month in arrears
1-08 Patients Moves excluded: To the Discharge Lounge, MAUV-MAU and SAUV-SAU, between Theatres, between Endoscopy
1-14 *Achieved by 6 months then maintained

(T*) Target Type: N, National; L, Local

Delivering or exceeding Target		Improvement Month on Month
Underachieving Target		Month in Line with Last Month
Failing Target		Deterioration Month on Month

Scorecard Commentary: Attention is drawn to the following items for the four months ending July 2013:

In July there were 89 falls reported, with cumulative year-to-date falls of 283. This reflects an excess of 50 falls in a 4 month period. The level of falls is of considerable concern. To build upon information from previous reviews the Chief Nurse has commissioned a refresh of the existing falls prevention plan to include the Falls Steering Group reviewing:

- NICE guidance and improvement strategies;
- The documentation care pathway; and
- A possible falls bundle.

Actual deaths of 352 year-to-date and 84 in July exceed those forecast. The Trust reviews every death and learning is shared across teams to influence patient outcome.

Hospital acquired venous thromboembolism of 11 year-to-date exceeds prediction by 4 cases.

Serious incidents requiring investigation of 27 year-to-date exceeds forecast by 3 cases.

Formal complaints of 175 cumulatively exceeds forecast by 26 cases year-to-date.

The A&E Friends and Family test score of 47 remains below the required value of 70.

Friends and Family Test: An important development this month was the publication on 29th July of national benchmarked results for the Friends and Family test for Quarter 1 ending June 2013. A summary is detailed below.

Quarter 1 ending June 2013	**ASPH Response Rate (%)**	**National Response Rate (%)**
Emergency Department	10.1	7.8
Inpatients	40.6	24.2
Combined	**18.2**	**13.1**
	ASPH Net Promoter Score	**National Net Promoter Score**
Emergency Department	49	53
Inpatients	72	70
Combined	**63**	**63**

The key points from the national benchmarked results are:

Our inpatients promoter score of 72 is ahead of the national average of 70. Our combined promoter score of 63 is in line with national average.

Nationally, Emergency Department (ED) promoter scores ranged from 4 to 81. ASPH's ED promoter score of 49 was marginally below the national average of 53. We ranked above 19 other Trusts (among the 66 who achieved over 10% response rate).

Our ED is using the comments provided to inform improvement and an early action has been to review the choice of waiting area refreshments. In July our ED score of 48 is consistent with the first quarter.

Chart A below shows a dip in response rate in both inpatient and A&E areas for July. The June result partially reflects a major communication campaign undertaken. Specific reasons for the dip require further evaluation with assessment of August data to see if this dip will reverse. Chart B below shows a sustained trajectory of improvement for the inpatient net promoter score (NPS). Workshops are planned to support staff to use the comments provided by patients to improve patient experience.

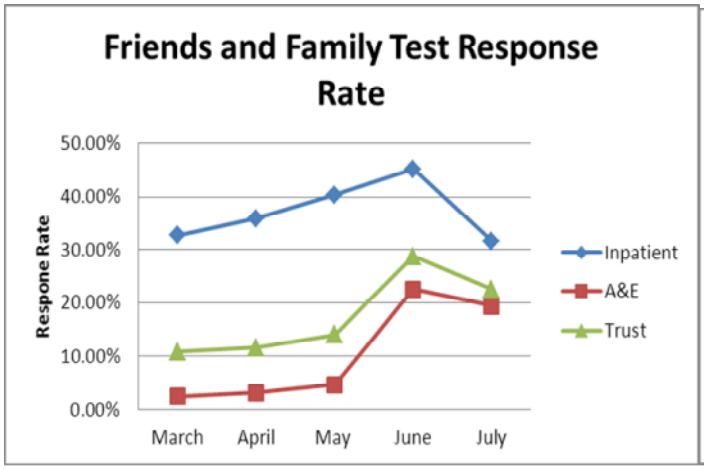


Chart A

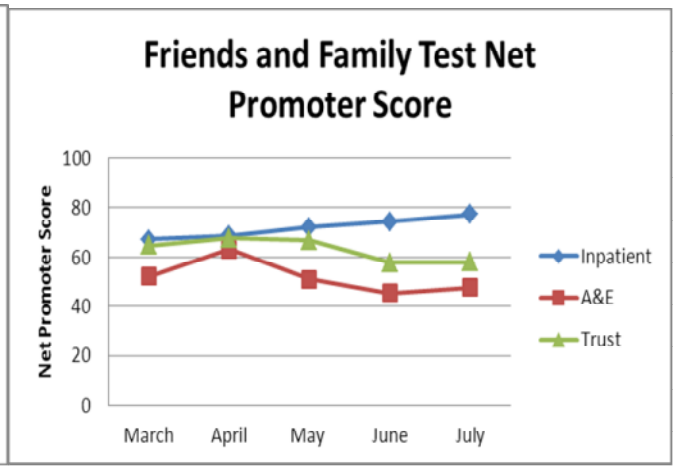


Chart B

Quality Account: Results for the key quality priorities were shared with stakeholders at a workshop on 23 July. Key themes from the priority areas are outlined below to give a snapshot of the meeting.

Dementia: The Trust is achieving and exceeding the targets (90%) set for screening and assessing patients for dementia. The survey of dementia carers is due to start in July.

Discharge: The Trust aims to discharge approximately 50% of patients before 15:00h. The work of the Senior Discharge Co-Ordinator surrounding complex discharges was outlined.

The increase in numbers of discharge summaries being sent out electronically to GP practices within 24h was acknowledged as a significant impromement.

Communication: The Head of Patient Engagement & Experience informed the group that Family and Friends Test response rates were the highest in the region.

Harm-free Care: Discussion points included potential seasonal variations in results. A suggestion included the possibility of a similar tool for mental health.

Falls: The Head of Clinical Quality Improvement highlighted actions including a steering group to incorporate recent NICE[1] guidance, and review equipment prevent patient falls e.g., sensor alarms.

Pressure ulcers: The newly employed specialist nurse for prevention of pressure ulcers provided insight into working across the acute community interface. Improvement work is being further supported by the addition of a specialist nutrition nurse to the wound care team.

VTE[2]: The Trust VTE study day was held in May. Root cause analysis includes identifying reasons for thrombosis developments. There are plans for a national thrombosis registry to track all cases of hospital-associated thrombosis.

Improve the Safety Culture: It was highlighted that patient and staff experience are closely related. Improvements in the staff safety culture should have a positive impact on the patient experience and reduce complaints.

Diabetes: Regarding assessment for diabetes on admission a pilot audit of diabetes testing has shown that ~11% of inpatients were diabetic and that a further 11% have raised blood glucose.

The Chief Nurse informed the group that patients with high levels on initial testing would have further tests in hospital. It was emphasized that new patients should be referred back to their GPs.

Readmissions at 28 days: This is a key focus area for the Trust. A risk predictor tool is being implemented to identify patients who need extra support following discharge.

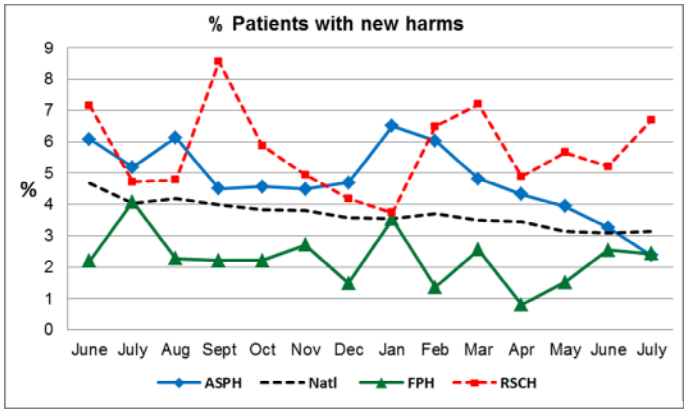
NHS Safety Thermometer (National CQUIN): The Safety Thermometer[3] programme aims to reduce avoidable harm during episodes of health care: pressure ulcers, falls, catheter associated urinary tract infections (CAUTI) and venous thromboembolism (VTE). Data is collected on all inpatients on one day per month to provide a 'snapshot' of harms.

There has been a sustained decrease in the percentage of patients with harm at ASPH since January and, for July, ASPH sits below the national acute Trust value (Chart 1). The July report from the Department of Health confirms that ASPH has shown a 25% reduction in all of the harms for the period June 2012 to June 2013, both community-acquired and hospital-acquired harms. Hospital-acquired harms has reduced by ~50%.

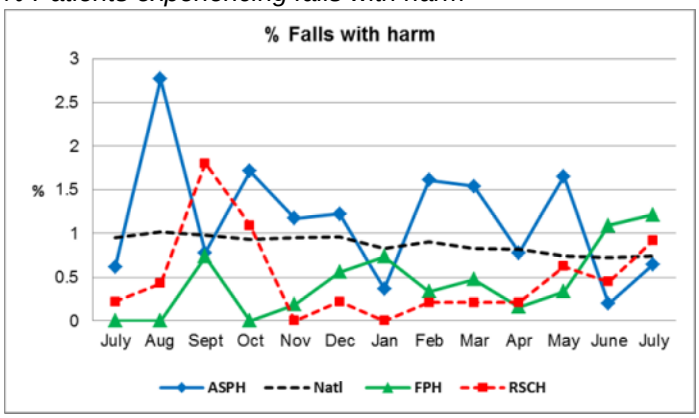
Catheter Associatated Urinary Tract Infection remains very low at 0.4% in July (under limit). The improvments with safe care are due to maintained vigilance by ward staff and ongoing training, support and surveillance by Trust specialist nurses.

[1] NICE National Institute for Health and Clinical Excellence
[2] VTE venous thromboembolism
[3]The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. http://www.ic.nhs.uk/services/nhs-safety-thermometer

Percentage with new harms



% Patients experiencing falls with harm



Complaints/Ombudsman Reports: Chart C highlights there were 43 complaints received this month compared to 36 in June and 40 in May.

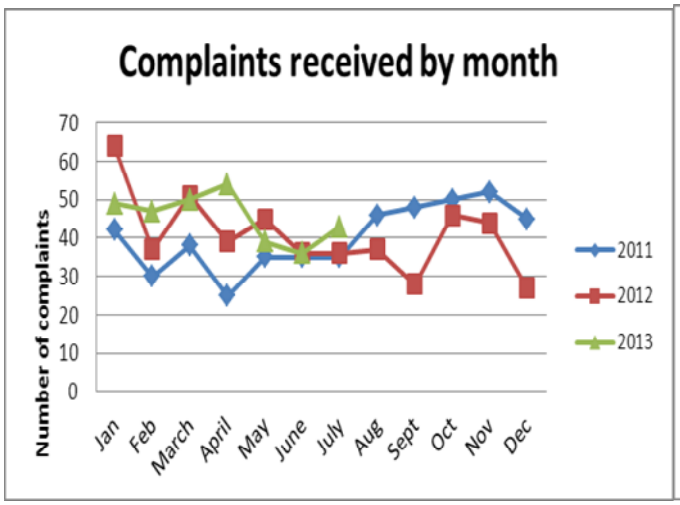


Chart C

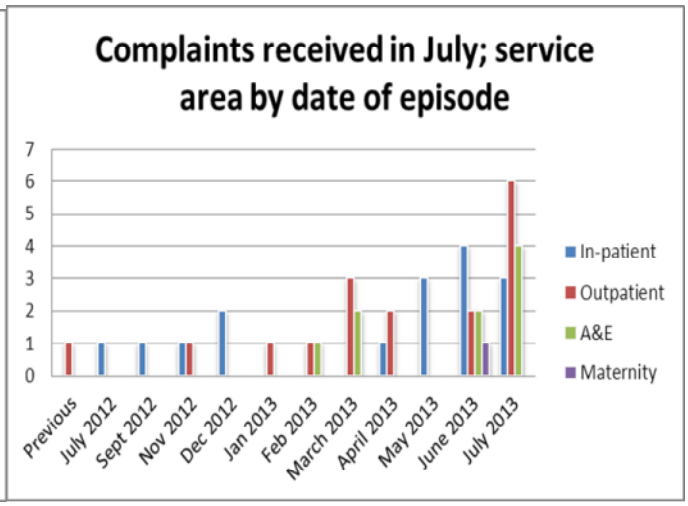


Chart D

Chart D shows a breakdown of complaints by Service Area and the date of the episode relating to each complaint. Themes of complaints include care and communication.

Chart E below shows discharge related complaints by month.

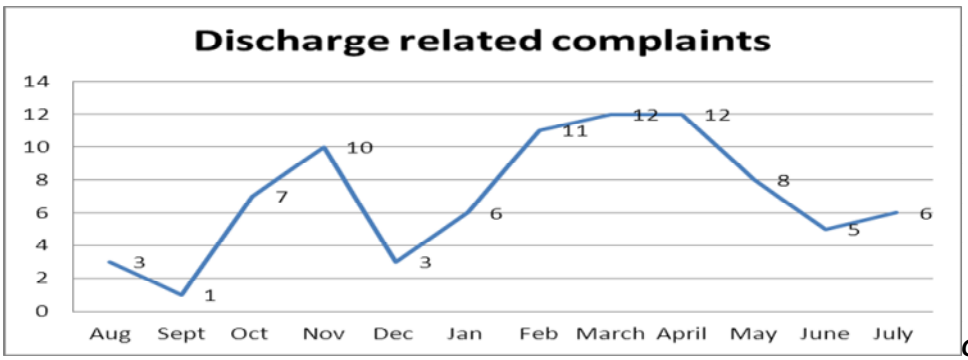


Chart E

There were six formal discharge related complaints in July, compared with five in June and eight in May. Of these one relates to an episode in July. The main issue raised was that discharge was too early.

Compliments: The Trust received 22 formal compliments during July. All formal compliments received in the Executive Offices are responded to personally in writing. Positive feedback is noted below:

NHS Choices website: the patient gave a 5 out of 5 star rating to the Jasmin Breast Clinic

"I recently attended the Jasmin Breast Clinic at Ashford Hospital. I was very worried about a lump in my breast and somewhat nervous about treatment. All the staff I saw were very reassuring and helpful. The unit itself was quiet and peaceful. I just could not have had better attention anywhere".

NHS Choices - User Rating: The table below identifies the 'user rating' on NHS Choices for a number of hospitals close to our catchment area. ASPH continues to be the only trust in the surrounding area with a 5 star rating although the ratings are now split with St. Peter's being rated as 5 stars whereas Ashford is 4.5.

Hospital	User rating (out of 5) Feb 2013	User rating (out of 5) May 2013	User rating (out of 5) Aug 2013
Ashford & St Peter's ***(ratings split by site from August)***	5 (81)*	5 (118)	SPH: 5 (125) AH: 4.5 (22)
Frimley Park	4.5 (102)	4.5 (117)	4.5 (146)
Epsom	4.5 (28)	4.5 (32)	4.5 (42)
Royal Berkshire	4 (100)	4 (119)	4.5 (131)
Royal Surrey	4 (21)	4 (33)	4 (43)
Kingston	4 (28)	4 (39)	4 (58)
West Middlesex	4 (48)	4 (69)	4 (86)
St George's	4 (69)	4 (93)	4 (106)
Wexham Park	3.5 (51)	3.5 (75)	3.5 (92)
Chelsea & Westminster	3.5 (22)	3.5 (31)	3.5 (33)

* the figure in brackets is the number of ratings submitted.

5.2 Operational Performance

The Trust met all of the performance targets associated with the Monitor Compliance Framework in quarter 1 and for the month of July 2013.

Referral to Treatment Time: The Trust met the 18 week waiting time standards for non-admitted patient care and incomplete pathways at speciality level and for admitted patient care for all specialities other than Ophthalmology and Urology, as forecast, in July 2013. Failure to meet the 18 week standard for Ophthalmology and Urology does not have a performance implication with regard to Monitor's 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.

- *Ophthalmology*: The backlog (those patients waiting over 18 weeks for treatment) in Ophthalmology has been significantly reduced since June/July, and the 90% standard for admitted patients is expected to be achieved in August and subsequent months.
- *Urology*: Work continues to clear the backlog of patients in Urology and this speciality is not forecast to achieve the 90% target for admitted patient care in August 2013, but is projected to return to meeting the standard from September.

- *General Surgery*: There is a risk that the 18 week target for admitted patient care will not be delivered in General Surgery in August and September. A number of capacity issues and the reinforcement of the practice of booking all patients in chronological order has meant that there are a number of patients that have already waited in excess of 18 weeks in General Surgery that will require treatment in the next two months.

- *Cardiology*: An issue in Cardiology has been identified after a review of the planned waiting list revealed patients were waiting longer than necessary for their treatment (cardioversion) because they were incorrectly listed on a planned list instead of an 18 week pathway. On advice from the Intensive Support Team (IST) the listing issue has now been resolved and work is underway to accommodate the patients (approximately 70) that are waiting for treatment. However a number of patients have already waited in excess of 18 weeks and it is therefore likely that, as the patients are treated from September onwards, the 18 week standard for patient care in Cardiology will be at risk.

The overall backlog (those patients waiting over 18 weeks for treatment) has reduced from by over 50% since April 2013 to be 224 patients at the end of July.

Four hour waiting time target: The Trust met the 4 hour standard for waiting times in A&E in July 2013. Performance for the month was 96.90%. This was an improvement in performance compared with the Q1 which was 95.43%. The table below shows a breakdown of performance by month. These demonstrate that there was a significant improvement in performance in July 2013 as compared with the previous quarter.

Period	St Peter's only	St Peter's and Ashford (Monitor reporting)
April	90.81%	93.55%
May	92.71%	94.77%
June	97.26%	98.08%
Quarter 1	**93.55%**	**95.43%**
July	95.65%	96.90%

The key drivers of performance in July were:

- Ensuring clinical capacity is amended in order to match demand of the emergency care pathway and further improvement of processes and communication on the medical short-stay unit; and
- Continued focus on the delivery of the 4 hour recovery plan within the Trust including Executive-led weekly meetings and formal cross-divisional review of all breaches.

The most significant challenges in the month were:

- A&E attendances continued to remain high in July following the trend identified in Q1; and
- The heat wave conditions experienced in mid-July contributed to the effect on performance in the week commencing 21st July.

Whilst 4 hour performance improved in July it remains a risk. To facilitate delivery in Q2 the additional performance management measures put into place in Q1, led by the Chief Executive and Deputy Chief Executive, will continue.

Planning for winter 2013/14: The Trust remains concerned about the ability of the local health economy to withstand the pressure of winter 2013/14 whilst maintaining capacity, flow, patient experience and performance standards throughout.

Throughout Q2, and in advance of winter 2013/2014, the Trust has initiated further action to support future sustainability including establishment and embedding of the frail, elderly pathway, the Ambulatory Care Unit and significant improvements to the Surgical Assessment Unit – all of which has been supported by ECIST in their most recent assurance visit.

Further discussion and analysis of Emergency Care is detailed within paper 7.3 on the agenda.

Refer to Appendix 5 for detailed year to date performance of targets, indicators and activity.

5.3 2013/14 Financial Position - Month 4 and Forecast Outturn

The month 4 and forecast financial position for 2013/14 is set out below:

Finance Scorecard					
	Annual Plan	Forecast	YTD Plan	YTD Actual	YTD Variance
Monitor Financial Risk Rating	3	3	4	3	
Total income excluding interest (£000)	£232,320	£240,839	£78,255	£80,654	£2,398
Total expenditure (£000)	£214,966	£223,527	£71,789	£74,985	-£3,196
EBITDA (£000)	£17,354	£17,312	£6,466	£5,668	-£797
I&E net operational surplus (£000)	£3,000	£3,000	£2,126	£1,351	-£774
CIP Savings achieved (£000)	£11,839	£10,814	£4,399	£3,603	-£796
CQUINs (£000)	£4,950	£4,950	£1,650	£1,650	£0
Month end cash balance (£000)	£12,845	£12,845	£16,546	£14,077	-£2,469
Capital Expenditure Purchased (£000)	£17,036	£18,704	£3,622	£2,794	-£828
Emergency threshold/readmissions penalties	£3,692	£4,292	£1,231	£1,431	-£200

Monitor Metrics						
		Weighting	Current	Forecast	Current Score	Forecast Score
EBITDA	EBITDA Margin	25%	7.0%	7.2%	3.0	3.0
	EBITDA % of Plan	10%	87.7%	99.8%	4.0	4.0
Financial Efficiency	Net return after financing (%)	20%	2.4%	2.0%	4.0	4.0
	I&E Surplus Margin (%)	20%	1.7%	1.5%	3.0	3.0
	Liquidity Ratio (days)	25%	24.6	22.3	3.0	3.0
		Weighted Total Score			3.30	3.30
		Capped Total Score			3	3

Monitor published its Risk Assessment Framework on 27th August 2013 which will replace the current Compliance Framework from 1st October 2013. As a result the five financial metrics set out above, scoring from 1 to 5, will be replaced by two new metrics making up a Continuity of Services risk rating. This will be assessed from 1 (high risk) to 4 (low risk). Against these shadow metrics the Trust currently scores:

Shadow Monitor Metrics					
	Weighting	Current	Forecast	Current Score	Forecast Score
Debt Service Cover	50%	3.09x	2.84x	4	4
Liquidity	50%	0.6	-1.89	4	3
Continuity of Service Risk Rating				4	4

Year to Date

Key issues are: -

- Clinical income was £2.5m ahead of budget with most activity streams being ahead of plan, but in particular day case, outpatient and emergency activity. As the Trust has now exceeded its baseline, relevant emergency activity is only being paid at 30% of tariff;
- The higher than planned activity levels has had a knock on effect on the Trust cost base with additional staff costs incurred as well as increased clinical supplies costs. In addition delivery of the emergency pathway has seen increased pay costs as the Trust utilises escalation beds to cope with demand and achieve the A&E 4 hour target;
- Cost improvement plans are £0.8m behind plan at month 4; and
- Overall performance shows that a surplus of £1.4m has been delivered to date,

however that is £0.8m behind plan and delivers an FRR of 3 at month 4, against a plan of 4.

Forecast

The Trust is forecasting that it will recover the budget deficit in the remaining eight months and meet its plan for 2013/14 of a surplus of £3.0m and FRR of 3 (or 4 under the shadow metrics). However there is pressure on income and costs and the Trust is taking various actions to get the budget back on track.

The forecast includes a significant level of over-performance against income plans with commissioners, in particular NW Surrey CCG and Specialist Commissioners. The assumption built in is these organisations will pay for their over-performance.

Cost saving targets, which are budgeted at £11.8m for the full year, are currently projected to yield £10.8m. The outturn could improve further as the Trust looks to start the transformation programme for future years as early as possible.

APPENDIX 1 Quality and Safety Balanced Scorecard Indicator Definitions

Table 1 is made up of 9 main columns:

1. Description of Measure

1-01 The SHMI is a ratio of the observed number of deaths to the expected number of deaths for a provider. The observed number of deaths is the total number of patient admissions to the hospital which resulted in a death either in-hospital or within 30 days post discharge from the hospital. The expected number of deaths is calculated from a risk adjusted model with a patient case-mix of age, gender admission method, year index, Charleston Comorbidity Index and diagnosis grouping. A three year datase is used to create the risk adjusted models. A one year dataset is used to score the indicator. The one yea dataset used for scoring is a full 12 months up to, and including, the most recently available data. The three years used for creating the dataset is a full 36 months up to, and including, the most recently available data.

1-02 The total number of deaths.

1-03 Number of Hospital acquired MRSA

1-04 Number of Hospital acquired C-Diff

1-05 The number of patients with a VTE (Venous Thromboembolism) assessment who then had a Pulmonary Embolism or Deep Vein Thrombosis (during their stay)

1-06 The total number of Serious Incidents Requiring Investigation

1-07 Average number of beds available (including escalation beds) in the month against the

average number of beds occupied taken at midnight from PAS

1-08 The percentage of patients who were transferred between wards, 3 or more times during thei admission.

1-09 The number of formal complaints

1-10 Friends and Family Test score for Inpatients

(Test asks following standardised question: "how likely are you to recommend our ward to friends and family if they needed similar care or treatment?"

1-10a Friends and Family Test score for A&E

(Test asks following standardised question: "how likely are you to recommend our A&E department to friends and family if they needed similar care or treatment?"

1-11 The total number of falls

1-12 The total number of falls resulting in significant injury grade 3 or above

1-13 The number of hospital-acquired pressure ulcers grade 2 or above

1-14 New Catheters and UTI's as a rate of total sampled patients

2. Target (T*) - where possible a national (N) or local (L) strategic health authority target has been used where not available, we have used a percentage improvement on the 2012/13 year end total.

3. Outturn 12/13 – the overall results for 2012-13.

4. YTD (Year-to-date) Target 13/14 – the sum of the monthly target from the beginning of the financia year (April).

5. Monthly Target 13/14 – the target for each month

6. Annual Target 13/14 – the target for the entire year.

7. Actual - this is the actual achievement for the month

8. Performance - Monthly Trend Indicator - The arrows represent one of three states, improvement on the previous month, deterioration on the previous month, or the same. It must be noted that this does not necessarily mean that higher numbers are represented by an ‘up’ arrow as higher numbers may be worse and thus will be represented by a ‘down’ arrow.

9. YTD 13/14 - The sum of the actual activity from the beginning of the financial year (April).

APPENDIX 2 Quality Account Dashboard Definitions

Priority 1: Improving the care of patients with dementia and their carers
All emergency patients aged over 75 who have a length of stay longer than 72 hours should be screened for dementia (exclusions apply e.g. patient in a coma); those patients identified through the screening are then referred on to the team for full assessment. Survey of dementia carers is due to start by the 1st July. There is no requirement around response rates or scoring.

Priority 2: Providing safe, high quality discharge for patients
Electronic discharge summaries are created when patients are ready to leave hospital; these can be printed and posted or sent electronically to GP practices.

Priority 3: Improve all aspects of communications with patients
From April 2013, all patients are being asked a simple question to identify if they would recommend a particular A&E department or ward to their friends and family. For further details see:
https://www.gov.uk/government/news/guidance-for-nhs-trusts-on-the-nhs-friends-and-family-test

Priority 4: Improve harm-free care
Each month all inpatients are assessed on one day for four avoidable harms that patients might experience whilst in hospital using an audit tool called the Safety Thermometer; results can be compared with other trusts and nationally. For further details see:
http://www.ic.nhs.uk/services/nhs-safety-thermometer

Priority 5: Improve nursing care
The incidence of hospital acquired pressure ulcers and falls are considered to be good indicators of the quality of nursing care. Although measured within the Safety Thermometer this is the full data for these indicators for the month.

Priority 6: Provide effective risk assessment and prophylaxis for VTE
'Venous thromboembolism' (VTE) is a collective term for both 'deep vein thrombosis' (DVT) and 'pulmonary embolism' (PE). VTE can be difficult to diagnose. Most hospital-associated VTE occur after discharge; the average DVT after surgery is on day seven, the average PEis on day 21.

Root Cause Analysis (RCA) is a method of problem solving that looks closely at the details of a fault or problem to try to identify the root causes and solve them.

Priority 7: Improve the safety culture
Patient and staff feedback are being measured using the Friends & Family Test (FFT) see Priority 3 above re patient FFT. More detailed feedback from staff is also being collated relating to patient safety in their ward or department.

Priority 8: Improve the care of patients with diabetes
On admission to hospital, all appropriate, adult inpatients should be screened for diabetes. Patients identified to be at risk will be referred on to the diabetes team for investigation. The frequency of the audit is to be confirmed. *? Will this be captured electronically – currently on a form?*

Priority 9: Reduce emergency and elective re-admission rates
These are being measured as re-admissions within 28 days of discharge either following an elective procedure or an emergency admission. The rate of re-admissions is calculated based on the number of admissions. Indicator 9 was recalculated in July 2013 to reflect Monitor guidelines. April to June 2013 data has therefore been restated. This reduced June YTD elective rate by 0.5% and emergency rate by 0.8%.

Appendix 3: Quality Account Dashboard – July 2013/14

Quality Account 2013/14	Target / Limit	Apr	May	June	July	YTD
1. Improve the care of patients with dementia and their carers						
% emergency admissions aged ≥75 screened (los > 72h; exclusions apply e.g. coma)	90%	97.0%	98.5%	99.3%	99.4%	98.1%
% patients appropriately assessed	90%	97.0%	98.1%	100.0%	97.7%	98.0%
2. Provide safe, high quality discharge for patients						
Increase timely discharge of patients (before 15:00h).	66%	49.2%	49.9%	52.1%	48.3%	49.9%
Reduce complaints relating to discharge by 5% of 12/13 value (=72)	68 /y	11	8	5	6	30
Increase electronic discharge summaries sent within 24 hours pt discharge	TBC					
3. Improve all aspects of communication with patients						
% Response rates for the NHS Friends and Family Test (target = 20% by Q4)	15%	11.7%	14.1%	29%	23%	19%
Promoter score for the NHS Family and Friends Test (target by end of year)	70	68	67	58	58	61
Reduce formal complaints re communication by 10% value 12/13	<196	29	22	14	6	71
4. Improve harm free care						
Improve harm free care - Safety Thermometer by reducing new hospital acquired harms	<6%	4.3%	3.9%	3.5%	2.4%	3.5%
Reduce hospital acquired CAUTI (ST monthly measures)	<1.2%	1.6%	0.2%	0.4%	0.4%	0.66%
5. Improve nursing care						
Reduce patient falls (total falls)	<700	43	75	66	89	273
Reduce patient falls resulting in harm (grade 3 and above)	<15	0	2	6	2	10
Reduce hospital acquired pressure ulcers (stage 2 and above)	<139	10	16	9	10	45
6. Provide effective risk assessment & prophylaxis for VTE						
Improve % patients risk-assessed for VTE	> 95%	95.09%	95.40%	95.08%	90.49%	93.94%
Reduce hospital associated VTE	<24	1	6	1	3	11
7. Improve the safety culture						
Promoter score for the NHS Family and Friends Test (target by end of year)	70	68	67	58	58	61
Reduce formal complaints (rate per discharge, inpatients)	<450/Y	54	40	36	43	173
8. Improve care of patients with diabetes						
% patients assessed for diabetes (100% by end of year) [quarterly data]	100%			71%		71%
Reduce length of stay (establish a baseline) [quarterly data]	TBC			3.8		3.8
9. Reduce readmission rates						
Reduce elective readmissions (28 days)	2.7%	2.2%	2.2%	2.3%	2.6%	2.3%
Reduce emergency readmissions (28 days)	12.6%	12.6%	13.5%	12.9%	15.1%	13.6%

Appendix 4: Patient Experience Dashboard: July 2013

Jul-13	EMED	YTD		Fac (per month)	YTD		TASCC (per month)	YTD		TODT (per month)	YTD		WH & P (per month)	YTD		A&E FFT		Inpt FFT			Trust (per month)	YTD	YTD target	Annual target
Complaints Rec'd	15	74		2	2	▲	12	43	▲	5	21	▲	9	30	▲					▲	43	172	150	<450
Discharge related complaints	1	20	▼	0	0		3	6	▲	1	3		1	2	▲					▲	6	30	23	<68
% Response timescales met	80%	89%	▼	n/a	n/a		67%	68%	▼	67%	84%	▼	88%	88%	▼					▼	78%	84%	95%	>95%
PALS Concerns	40	138	▲	2	16	▼	20	108	▼	25	78	▲	6	21	▲					▲	96	373	tba	tba
FFT* returns	36%		▼				30%		▼	23%		▼				20%	▼	32%	▼			18%	15%	20%
FFT* Score	74		▲				81		▲	81		▼				48	▲	77	▲			62.2	70%	70%
Intimations of claims	1	8	▼	0	0		3	8	▲	3	8	▲	3	8	▲						10	19	tba	tba
Reported claims	0	1	▼	0	0		3	6	▲	0	2	▼	1	2							4	11	tba	tba

Decrease compared to previous month	▼
Increase compared to previous month	▲
Improvement compared to previous month/100% target	
Same or no change	
Deterioration compared to previous month or risk to targ	
Not applicable	

**Friends and Family Test. Consolidate score of response to the question "how likely are you to recommend our Ward [A&E department] to friends and family if they needed similar care or treatment?" For FFT results A&E is reported seperately - therefore EMED excludes A&E for this measure only.

Trust Operational Performance Report - July 2013

		2012/13												2013/14							
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD 13/14	13/14 Plan	Var	Trend
Cancer indicators and																					
All cancers: 31-day wait for second or subsequent treatment	Anti Cancer Drug Treatments	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%	2.0%	
	Surgery	100%	95.7%	100%	100%	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%	6.0%	
All cancers: 62-day wait for first treatment	From Consultant Screening Service Referral	100%	100%	100%	100%	89%	100%	0%	100%	100%	100%	83%	100%	100%	-	-	100%	100%	90%	10.0%	
	Urgent GP Referral To Treatment	85.1%	92.6%	92.8%	92.1%	91.5%	90.7%	97.0%	92.5%	92.5%	87.5%	88.4%	90.8%	87.9%	87.7%	94.8%	86.2%	89.0%	85%	4.0%	
31-Day Wait For First Treatment	All Cancers	97.5%	100.0%	100.0%	100%	100%	100%	100%	100%	98%	98%	99%	100.0%	100.0%	100%	100%	100%	100.0%	96%	4.0%	
Two week wait from referral to date first seen	All Cancers	95.5%	96.0%	95.2%	98.2%	98.0%	98.0%	97.6%	97.8%	98.7%	96.3%	98.8%	98.7%	96.4%	98.3%	97.1%	97.9%	97.5%	93%	4.5%	
	For symptomatic breast patients	96.1%	97.6%	93.0%	98.1%	95.8%	96.8%	98.9%	97.7%	96.1%	97.5%	97.3%	98.7%	96.4%	98.0%	99.0%	99.2%	98.3%	93%	5.3%	
Referral to Treatment wait																					
Referral to treatment waiting times - admitted		94.62%	95.10%	94.56%	95.35%	94.70%	94.11%	93.46%	92.83%	93.17%	92.97%	91.49%	92.39%	90.08%	91.60%	91.56%	92.70%	91.51%	90.00%	1.5%	
Referral to treatment waiting times - Non-admitted		97.87%	98.05%	97.46%	98.14%	98.50%	98.32%	97.63%	97.39%	98.12%	97.49%	97.95%	98.26%	98.15%	98.55%	98.39%	98.03%	98.29%	95.00%	3.3%	
Referral to treatment waiting times - Incomplete		98.11%	98.61%	97.96%	99.04%	98.58%	98.27%	97.39%	97.49%	97.48%	97.06%	97.25%	97.48%	97.74%	98.24%	98.35%	98.73%	98.27%	92.00%	6.3%	
A&E Clinical Quality																					
Total time in A&E (95%) - Monitor Position		93.1%	96.8%	96.9%	98.5%	96.5%	96.2%	96.7%	95.0%	95.9%	93.3%	92.0%	92.1%	93.6%	94.8%	98.1%	96.9%	95.8%	>95%	0.8%	
Total time in A&E (95%) - Unify & Contract Monitoring Position		89.8%	95.3%	95.4%	97.8%	94.9%	94.6%	95.2%	92.7%	94.0%	90.5%	88.6%	88.7%	90.8%	92.7%	97.3%	95.7%	94.1%	>95%	-0.9%	
Time to initial assessment (95th percentile)		00:07	00:07	00:41	00:39	00:55	00:14	00:13	00:14	00:13	00:11	00:52	00:51	00:29	00:30	00:26	00:33	-	< 15 min	-	
Time to treatment decision (Median)		00:42	00:48	00:53	00:48	00:55	00:59	00:54	00:59	00:57	00:57	00:56	01:03	0:59	00:49	00:47	00:46	-	< 60 min	-	
Unplanned reattendance rate		2.9%	2.0%	5.5%	5.3%	5.0%	4.8%	4.7%	4.5%	4.7%	4.6%	5.7%	4.3%	4.2%	4.7%	5.5%	5.4%	-	1% - 5%	-	
Quality & Safety																					
C.Diff (hospital acquired)		3	3	0	1	2	0	1	0	1	0	2	2	1	0	0	0	1	13	-92%	
MRSA Bacteraemia (hospital acquired)		1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	-100%	
Friends and Family Test	Inpatients (Test Score)										66.7	60.8	67.2	68.8	72.1	74.5	77.4	73.2	70	4.5%	
	Inpatient (Response Rate)										11.18%	21.04%	32.68%	35.89%	40.39%	45.23%	32.39%	38.54%	15%	156.9%	
	A&E (Test Score)										-	71.4	52.3	63.1	51.1	45.3	47.6	47.8	70	-31.6%	
	A&E (Response Rate)										-	0.37%	2.48%	3.17%	4.73%	22.46%	19.45%	12.57%	15%	-16.2%	
Breach of Same Sex Accommodation		0	0	0	0	0	0	0	2	0	0	2	0	1	0	0	0	1	0	0	
VTE Risk Assessment *		90.9%	90.1%	90.3%	91.3%	91.3%	91.1%	94.2%	93.7%	93.1%	95.5%	95.5%	96.1%	95.1%	95.40%	95.08%	90.72%	95.09%	95.0%	0.09%	
Stroke Pts - 90% time on Stroke Unit		86.11%	89.74%	84.91%	90.70%	80.00%	81.40%	75.68%	83.78%	84.85%	77.14%	71.43%	80.70%	82.93%	66.67%	75.51%	85.37%	78.48%	85.00%	-6.52%	
Smoking During Pregnancy		10.1%	8.9%	6.8%	5.7%	8.2%	5.4%	5.6%	7.8%	8.07%	7.85%	5.46%	9.7%	8.28%	8.06%	5.59%	8.21%	7.5%	8.2%	-0.7%	
Breastfeeding Initiation		84.2%	82.1%	85.5%	85.1%	84.5%	83.8%	85.6%	82.3%	86.67%	84.80%	86.01%	85.76%	85.7%	82.0%	86.6%	85.5%	84.9%	80.0%	4.9%	
Activity																					
Acute Bed Capacity		559	555	559	548	537	542	548	543	543	553	553	553	530	530	530	530	530	-	-	
Avg. Length of Stay - Elective (Acute) **		2.8	3.0	2.8	3.1	2.7	3.4	2.7	2.9	3.1	2.5	2.9	2.7	3.7	3.3	4.2	3.7	3.7	2.95	0.79	
Avg. Length of Stay - Emergency (Acute) **		5.8	5.0	4.6	4.9	5.0	4.6	5.0	5.0	4.7	5.1	5.2	5.2	7.3	6.8	6.6	6.3	6.8	4.80	1.95	
Daycase Rate		81.2%	79.6%	79.5%	80.8%	80.2%	81.6%	81.3%	81.1%	83.1%	84.8%	83.0%	82.2%	84.2%	83.4%	83.6%	84.0%	83.8%	84.0%	-4.0	
Delayed Transfers of Care – Acute & MH		3.2%	2.7%	2.2%	2.1%	2.7%	3.5%	2.3%	2.9%	2.1%	2.4%	2.5%	2.4%	1.4%	1.7%	1.5%	0.9%	1.3%	3.5%	-4.8	
GP Written Referrals to Hospital		7,697	8,876	7,447	8,409	7,663	7,054	8,232	7,402	5,992	7,554	6,950	6,827	8,387	8,465	7,864	8,262	32,978	-	-	
Other Referrals For a First Outpatient Appointment		4,683	5,591	4,897	5,264	5,127	4,995	6,006	5,212	4,291	5,355	4,538	4,580	5,237	5,386	5,521	5,647	21,791	-	-	
All Outpatient Attendances		26,890	33,657	27,158	30,537	29,352	28,024	34,020	32,521	25,408	32,637	27,307	26,762	27,742	28,439	26,977	30,575	113,733	113,341	0.3%	
Elective Spells		2,742	3,130	2,670	3,033	2,774	2,736	3,075	2,995	2,464	2,899	2,856	2,884	3,021	3,137	3,118	3,291	12,567	11,741	7.0%	
Non-elective (inc maternity & transfers)		3044	3,377	3,389	3,442	3,381	3,292	3,416	3,269	3,392	3,447	2,985	3,407	3,098	3,177	3,256	3,384	12,914	13,166	-1.9%	
A&E Attendances		7,557	8,302	8,035	8,004	7,575	7,573	7,391	7,797	7,581	7,383	6,995	8,025	7,793	7,875	7,658	8,109	31,435	30,808	2.0%	

Old Better Care Better Value (not transferred to Operating Framework)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD 12/13	12/13 Plan	Var	Trend
BADS Procedures	80.4%	79.8%	80.3%	82.0%	80.9%	81.8%	79.5%	79.2%	82.6%	83.1%	80.6%	83.8%	81.1%	80.6%	82.2%	85.5%	80.2%	85.0%	-4.8%	
Inpatients Admitted before day of Operation	7.7%	5.7%	6.8%	7.4%	5.6%	5.3%	7.5%	6.3%	7.3%	7.2%	5.7%	4.9%	6.5%	9.2%	11.2%	7.1%	8.5%	10.0%	-1.5%	

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