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

TRUST BOARD
31st OCTOBER 2013

TITLE	**Operational Performance Report**
EXECUTIVE SUMMARY	The Trust did not meet the 4 hour standard in September 2013. Performance for the month was **94.23%.** Although this represented a fall in performance against the A&E standard in-month, the performance for Q2 was 96.33% - an improvement on Q1 (95.42%). Whilst the Trust delivered the 4 hour standard in Q1 and Q2, it is recognised that sustained delivery remains a risk and 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. The RTT, 18-week standards for elective care were achieved in the month, and the key points to note are: 1. 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 General Surgery, as forecast, in September 2013 2. There is a risk that the 18 week target will not be delivered in General Surgery and Cardiology in October 3. The number of patients waiting more than 18 weeks for treatment increased further in September and the specific reasons for this are detailed in section 3.1 below. The paper also details the areas of note and the on-going improvement work underway in the operational teams.
BOARD ASSURANCE (Risk) / IMPLICATIONS	Compliance is reflected in the Board Assurance Framework. BAF Risk 1.1 National targets and priorities.
LINK TO STRATEGIC OBJECTIVE	**SO1:** To achieve the highest possible quality of care and treatment for our patients, in terms of outcome, safety and experience. **SO3**: To deliver the Trust's clinical strategy of joined up healthcare.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Patient expectations in terms of access are reflected in NHS performance targets.
EQUALITY AND DIVERSITY ISSUES	None identified
LEGAL ISSUES	The failure to meet the four hour standard for waiting times in A&E creates a potential regulatory issue for the Trust.
The Trust Board is asked to:	Review and discuss the report and seen additional assurance.
Submitted by:	Valerie Bartlett, Deputy Chief Executive
Date:	15th October 2013
Decision:	For Assurance

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

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 Compliance 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
- Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted
- Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway

The Trust met all of the 18 weeks compliance standards, but did not meet the 4 hour standard in A&E in September 2013. Details 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 did not meet the 4 hour standard in September 2013. Performance for the month was **94.23%.** Although this represented a fall in performance against the A&E standard in-month, the performance for Q2 was 96.33% - an improvement on Q1 (95.42%).

The table below shows a breakdown of performance by month. These demonstrate that there was a significant improvement in performance in July and August 2013 as compared with the previous quarter, but this improvement was not sustained in September 2013.

Period	% Patients admitted / transferred / discharged < 4 hours (SPH, EPU, GUM & ASH)
2012/13 Total	**95.30%**
April 2013	93.49%
May 2013	94.83%
June 2013	98.08%
Quarter 1 2013/2014	**95.44%**
July 2013	96.92%
August 2013	97.73%
September 2013	94.25%
Quarter 2 2013/2014	**96.33%**

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

The most significant challenges in the month were:

- A&E attendances continued to remain high in September following the trend documented in the report submitted for Q1

- The Trust experienced an increase in the acuity and complexity of patients attending the A&E department and, as a result, an increased number of admissions to the acute emergency care pathway (the admission rate from A&E increased to 23.6% in September, the highest figure since March 2013)

- In the week-ending 29th September 2013 a new IT system was implemented into the A&E department ('RealTime' provided by Allocate Software) and a number of issues were experienced in the first few days of use. The implementation has been paused and a full review is now underway

2.1 FORECAST FOR QUARTER 3

The 4 hour performance has improved in Q2 and the 4-hour standard has been achieved in both Q1 and Q2; and while the Trust is expecting to achieve the 4 hour standard in Q3, overall performance for the remainder of the year remains a risk.

Throughout Q2 and in advance of winter 2013/2014, the Trust has initiated further action to support future sustainability all of which has been supported by ECIST in their most recent assurance visits, including:

- Establishment and embedding of the new frail, elderly pathway
- Implementation of the Ambulatory Care Unit
- Extension and improvements in the Surgical Assessment Unit
- Design and implementation of consultant-led 7-day working

To facilitate delivery in Q3 and Q4 the additional performance management measures put in place will continue and a number of other initiatives will be implemented as part of the comprehensive winter plan.

A copy of the current 4 hour recovery plan is included as APPENDIX C.

In order to facilitate improved system-wide input to improving compliance with the 4-hour standard, a whole system performance meeting has been implemented. The weekly meeting is led by the CCG and supported by information from all organisations, focussed on the delivery of 4-hour performance within the Trust.

3 REFERRAL TO TREATMENT TIMES (RTT)

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

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 General Surgery, as forecast, in September 2013.

Failure to meet the 18 week standard for General Surgery 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.

SEPTEMBER 2013 RTT PERFORMANCE

Speciality	Admitted patient care (target 90%)	Non-admitted patient care (target 95%)	Incomplete pathways (target 92%)
General Surgery	89.38%	96.14%	96.95%
Urology	90.29%	96.12%	97.86%
Trauma & Orthopaedics	91.45%	95.07%	97.24%
Ear, Nose & Throat (ENT)	96.10%	97.01%	98.16%
Ophthalmology	95.44%	98.89%	99.23%
Oral Surgery	90.85%	97.29%	98.88%
General Medicine	100.00%	97.49%	96.76%
Gastroenterology	98.31%	100.00%	99.47%
Cardiology	92.06%	95.09%	92.12%
Dermatology	n/a	99.59%	99.07%
Neurology	n/a	95.24%	96.53%
Rheumatology	n/a	97.78%	100.00%
Geriatric Medicine	n/a	100.00%	100.00%
Gynaecology	92.22%	99.77%	99.46%
Other	97.98%	99.80%	99.67%
Total	92.84%	97.54%	97.94%

3.1 SEPTEMBER PERFORMANCE

The 18 week target for admitted patients in General Surgery (Vascular, Colorectal, Upper GI and Breast) was not achieved in September (89.38%) and there is a risk that this will also miss the 90% standard in October.

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.

Performance in Cardiology improved in September; however there remains a risk to achieving the 18-week standards in the specialty as a result of the review of the planned waiting list which revealed patients were waiting longer than necessary for their treatment (cardioversion).

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

In August 2013 the Epsom Downs Integrated Care Services (EDICS) were placed into administration and approximately 300 elective patients previously being treated by EDICS and PIMS Pathways Ltd were transferred to the ASPH active waiting list.

The majority of these patients are on an orthopaedic pathway; however there are also a number in other specialties including urology, upper GI and dermatology. Many of the patients appear to have experienced long-waits on their existing pathways but manual validation is required to ensure that all patients that remain to be seen are added to the active waiting list appropriately.

In addition to the PIMS patients, there has been an increase in Orthopaedic activity since April 2013 which has added risk to the delivery of the admitted and non-admitted standards in the specialty. The active waiting list for Orthopaedics is currently over 3,500 patients, an increase from around 2,700 in April 2013.

The addition of the Cardiology patients to the active waiting list, along with the patient pathways taken on from EDICS/PIMS, has meant that the overall backlog (those patients waiting over 18 weeks for treatment) has continued to increase. Appendix A of this report includes a more detailed analysis of 18 week performance.

As a result of the increase in the number of patients waiting over 18 weeks for treatment, the issues described above have been escalated for enhanced performance management and a summary of progress against the action plans will be reviewed each month at Trust Executive Committee (TEC).

The number of patients waiting over 30 weeks for treatment has been significantly reduced. In September there were 4 patients that had been treated in the month in excess of 30 weeks on an admitted pathway and 2 patients on a non-admitted pathway.

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.

4 PLANNING FOR WINTER 2013/14

Whilst 4 hour performance has improved in Q2 and the 4-hour standard has been achieved in both Q1 and Q2, overall performance for the remainder of the year remains a risk.

Throughout Q2 and in advance of winter 2013/2014, the Trust has initiated further action to support future sustainability all of which has been supported by ECIST in their most recent assurance visits, including:

- Establishment and embedding of the new frail, elderly pathway
- Implementation of the Ambulatory Care Unit
- Extension and improvements in the Surgical Assessment Unit
- Design and implementation of consultant-led 7-day working
- Expansion of Paediatric A&E and recruitment of two paediatric A&E consultants
- ‘Ready to Go’ Project (reducing length of stay and implementing the ‘patient-flow bundle’ as recommended as best practice by ECIST)

4.1 OPAL

One of the most significant service developments underway ahead of winter 2013/2014 is the frail, elderly pathway and the new model of care for older people in the Trust.

The model of care facilitates the screening of patients for frailty at the front door, and referral of patients to the Older Persons Assessment and Liaison Team (OPAL) where they will receive a Comprehensive Geriatric Assessment (CGA) and a comprehensive plan of care developed by the OPAL team. The OPAL was implemented in the medical assessment unit at St Peter's Hospital on 1st October 2013.

Although the in-hospital OPAL team will bring significant benefits, it is recognised that the whole-system solution could not be achieved by the hospital alone. The Trust has been leading the development of services with community and social care partners to be support the OPAL team and the whole frail, elderly pathway.

Specifically, the Trust has been working with partner organisations to define and implement an OPAL-Plus service to deliver the on-going care for patients post-discharge and into the community, which must be in place and effective in order for the OPAL model to achieve maximum benefits.

The OPAL-Plus service will include admission avoidance through a Rapid Response team; extended use of Rapid Access clinics at Walton, Woking & Ashford Hospital including timely access to diagnostics; and the extension of existing Community Health and Social Care Services.

4.2 PLANNING FOR 2014/2015

To assure performance in the longer term the Trust has initiated two programmes of work to identify the future capacity requirements of the St. Peter's site. These include the Capacity Allocation Programme and Health Planner.

The Capacity Allocation Programme was initiated in 2012 as a follow on to the redesign of the medical emergency care pathway carried out in partnership with ECIST.

The Capacity Allocation Programme is charged with delivering the following objectives with a view to improving the pathway for emergency surgical care and reviewing the make-up of the specialty-based wards across the Trust, to ensure that capacity meets demand and patients receive care in the right place:

- Establishing a co-located Cardiology Ward with the Angiography Suite
- Establishing dedicated Stroke Unit
- Expansion of Care of the Elderly capacity
- Creating an identified winter escalation area
- Developing a functional Surgical Assessment Unit (SAU) and Surgical short-stay unit
- Establishing specialty-based medical and surgical wards

A number of the objectives outlined above have already been met and plans are in place to deliver those outstanding within the next 12-18 months.

The Trust has also appointed a healthcare planner to undertake a review of the long-term clinical services and estates requirements at St Peter's Hospital over a 10 year horizon. The analysis will be undertaken in three stages and the following outputs are expected:

- A detailed model of future service needs on the St Peter's site
- A detailed schedule of space requirements to meet the identified service needs

- Supporting reports and recommendations that fit with the framework of the Trust's existing 20 year Master-plan

4.3 CONCLUSION

Whilst the Trust is pleased with delivery of the 4 hour standard for Q1 and Q2, it is recognised that sustained delivery remains a risk and has therefore initiated 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.

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

To facilitate delivery in Q3 and Q4 the additional performance management measures put in place will continue and a number of other initiatives will be implemented as part of the comprehensive winter plan.

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 September 2013.

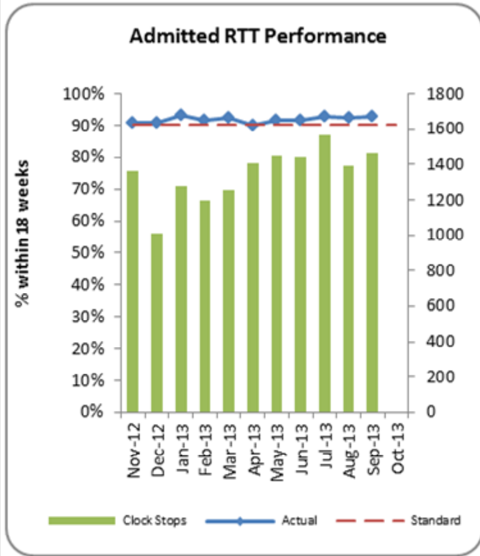
Appendices:

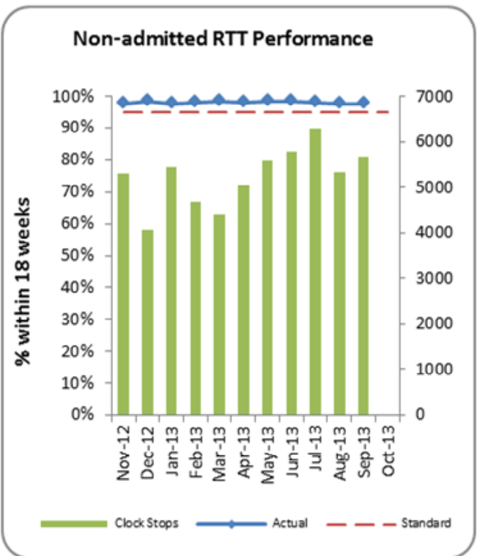
Appendix A – RTT Dashboard
Appendix B – A&E performance versus trajectory
Appendix C – Four hour emergency pathway recovery plan
Appendix D – Trust Operational Performance Report

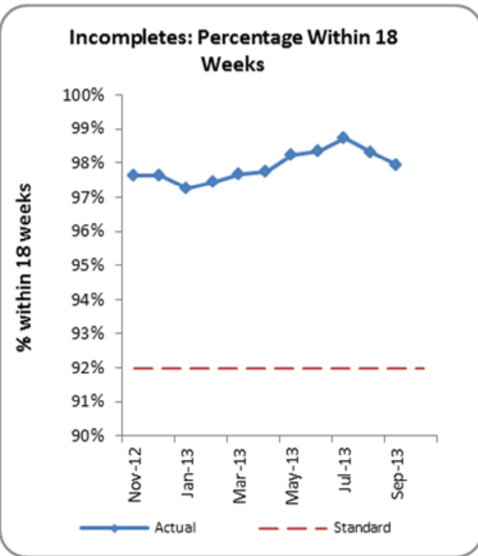
APPENDIX A: RTT DASHBOARD

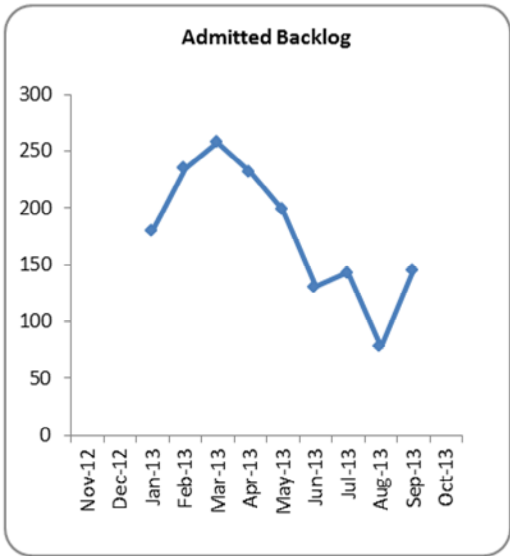
Ashford and St. Peter's Hospitals NHS

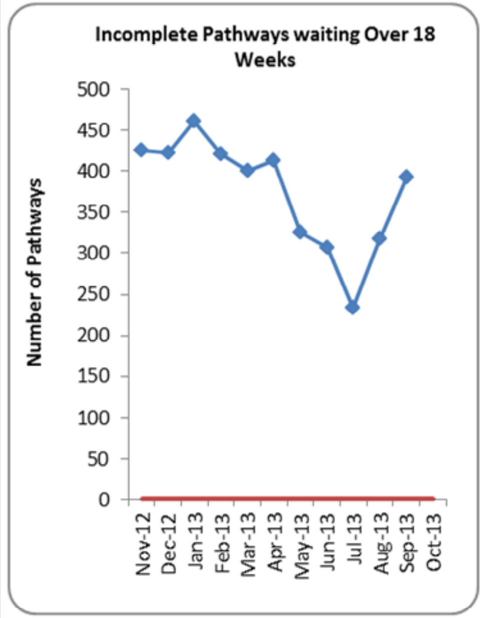
NHS Foundation Trust

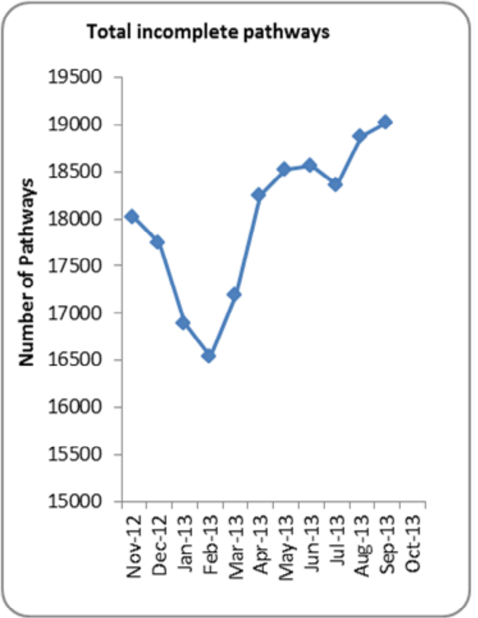


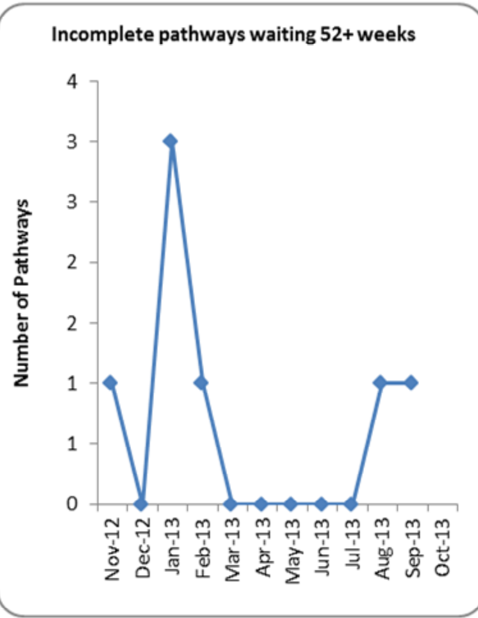


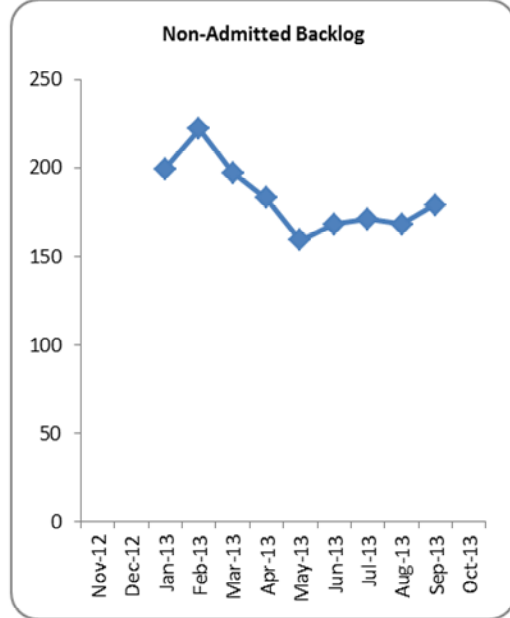




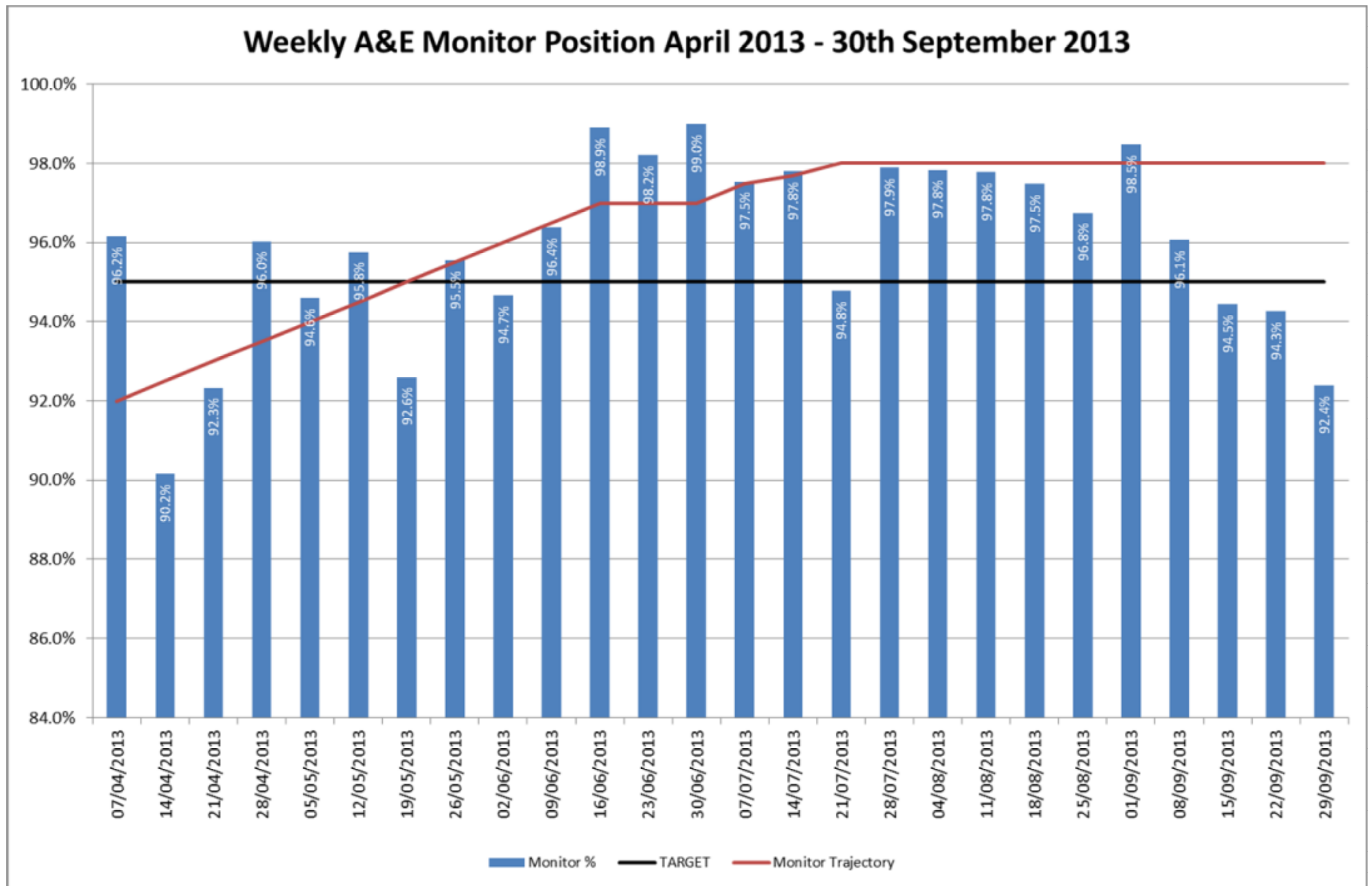








APPENDIX B – A&E 4-HOUR PERFORMANCE AGAINST TRAJECTORY



Objective	Actions required	Accountability	Update / Actions
1. Seven-day working across the emergency care pathway	• Interim plans for 7-day working on emergency care pathway from December 2013 to be developed by medicine division • Additional investments required to achieve 7-day consultant coverage on all medical wards to be identified	Tom Smerdon/ Gulam Patel	Determine additional investment required to achieve 7 day Consultant coverage on all wards Amend medical consultant rotas to ensure every patient is seen by a consultant during a ward round, every day of the week from December 2013 Redistribute junior staffing levels in order to provide more appropriate cover based on bed numbers and the timing of proposed consultant ward rounds Ensure ward rounds are accompanied by an SPR and SHO, who have time allocated also in the afternoon to carry out tasks resulting from the round plus general ward cover
	• Short/medium-term changes to surgical consultants rota to be made to deliver comprehensive ward round cover 7 days a week	Victoria Griffiths / John Hadley	Amend surgical consultants rota to deliver comprehensive ward round cover 7 days a week Add additional junior Dr as an interim measure to support the weekend services
	• Enhanced diagnostics, therapies and pharmacy weekend cover proposals to be completed	Cathy Parsons / Andrew Laurie	

Objective	Actions	Accountability	Update
2. Rapid implementation of new frail elderly pathway	• Completion and approval of business case supporting the new model of care for older people • Recruitment of additional consultant geriatrician(s) • Recruitment of OPAL team and implementation of new model of care	Gulam Patel/ Tom Smerdon/ David Fluck	New in-hospital OPAL team, pathway and model of care implemented, and substantive team members starting in post in November 2013 Recruitment of additional geriatricians underway Working with community and social services to implement OPAL-Plus services which will enable extension of the model of care into the community
3. Increasing consultant leadership	• Review of Consultant leadership on all wards, 7 days a week and exploring options to close the gap • Escalation pathways to be reviewed to ensure there is consultant involvement and leadership throughout • Documenting and sharing Consultant location, contacts (bleeps) and contingency contacts (for example, when in theatre) • Producing and sharing concise, Consultant-specific KPIs – using hard-data that Consultant's own	David Fluck/ Divisional Directors	Escalation pathways reviewed, amended and circulated Consultant leadership on all wards, 7 days a week to be strengthened through seven-day working

Objective	Actions	Accountability	Update
4. Extension of Ambulatory Care	• Creation of dedicated Ambulatory Care unit in close proximity to the ED • Confirmation of resources required to support Ambulatory Care unit and identify an Acute Physician to lead the service • Plan for implementation Ambulatory Care unit by October 2013	Gulam Patel/ Justine Hillier/ Tom Smerdon	ED / MAU team visited Milton Keynes to review Ambulatory Care Unit in July 2013 Weekly meeting now in place to implement ACU. A location has been identified and a business case has been completed New Ambulatory Care unit to go live in November 2013
5. Roll out of Ready to Go project	• Completion of Ready to Go on Medical Short Stay and embedding of improvements with divisional team • Scope for fast-track roll-out of Ready to Go on surgical wards • Forensic focus on discharge on specialty wards	Valerie Bartlett	Ready to Go project successfully completed on Medical Short stay unit: - Average LoS reduced by 0.5 days - Increased proportion of patients staying on the unit for < 72 hours - Improved cardiology in-reach process implemented Ready to Go project commenced focusing on implementation of ‘patient-flow bundle’ on Gastro ward Executive Director-led reviews of length of stay underway
6. Implementation of new SAU model	• Fast track implementation of new surgical assessment model • Recruitment to new posts	John Hadley/ Victoria Griffiths/ Sue Sexton	New unit to go-live in October 2013 Operational policy and pathways agreed by clinical leads Recruitment to new posts completed

Objective	Actions	Accountability	Update
7. Implement Enhanced Performance Management	• Weekly formal cross-divisional review • Implement 7-day analysis tool for A&E • Weekly dashboard on urgent care (performance and quality) • Enhanced internal A&E performance process	Valerie Bartlett/ Simon Marshall	7-day breech analysis meetings in place each week Patient-level review of weekly performance against 4-hour standard in place System-wide urgent care dashboard implemented
8. Consultant job planning	• Complete Care of The Elderly job planning • Initiate review of job plans with Acute physicians	Valerie Bartlett / Gulam Patel / David Fluck	Care of The Elderly job planning underway in-line with implementation of OPAL team and new model of care for older people
9. Winter planning	• Winter planning workshop / review of 2012/2013 • Calm Ordered Care meeting reconvened 2-weekly to review winter plan and implementation	Valerie Bartlett	Weekly reviews of winter planning progress underway with Deputy Chief Executive Winter plans presented to Trust Executive Committee and Trust Board for approval in September 2013

Objective	Actions	Accountability	Update
10. Maximise transfer of surgical activity to Ashford Hospital	• Move more surgical work to Ashford • Move more complex orthopaedics procedures to Ashford • Maximising theatre utilisation at Ashford Hospital	John Hadley/ Victoria Griffiths/ Sue Sexton/ Cathy Parsons/ David Elliot	All vacant theatre lists at Ashford Hospital are being reviewed and work is being transferred on a weekly basis Poor utilisation is being tackled, theatre manager now residing at Ashford Hospital 3 days a week Weekly theatre utilisation performance meeting starting on October 7th Day surgery team are continuing to ensure that as much day surgery as possible is carried out at Ashford hospital

Trust Operational Performance Report - September 201		2012/13												2013/14									
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	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%	100%	100%	98%	2.0%	
	Surgery	100%	95.7%	100%	100%	90%	100%	100%	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%	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%	87.3%	91.0%	86.5%	91.0%	85%	6.0%	
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%	99%	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%	96.6%	95.5%	96.6%	93%	3.6%	
	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%	100.0%	93.2%	95.7%	93.2%	93%	0.2%	
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%	92.30%	92.84%	91.86%	90.00%	1.9%	
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%	97.77%	97.54%	98.08%	95.00%	3.1%	
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%	98.31%	97.94%	98.22%	92.00%	6.2%	
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%	97.7%	94.2%	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%	96.8%	92.0%	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	00:31	00:24	00:30	-	< 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	00:49	00:55	-	< 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%	5.3%	5.0%	5.5%	-	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	2	2	13	-85%	
MRSA Bacteraemia (hospital acquired)		1	0	0	0	0	0	1	0	0	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	74.2	68.1	72.5	70	3.5%	
	Inpatient (Response Rate)										11.18%	21.04%	32.68%	35.89%	40.39%	47.40%	31.58%	37.00%	40.89%	38.83%	15%	158.9%	
	A&E (Test Score)										-	71.4	52.3	63.1	51.1	45.3	47.6	49.6	38.9	46.4	70	-33.7%	
	A&E (Response Rate)										-	0.37%	2.48%	3.17%	4.73%	21.80%	19.17%	19.18%	19.99%	14.64%	15%	-2.4%	
Breach of Same Sex Accommodation		0	0	0	0	0	0	0	2	0	0	2	0	1	0	0	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%	95.68%	95.68%	91.82%	94.79%	95.0%	-0.21%	
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%	82.76%	80.00%	79.30%	85.00%	-5.70%	
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%	6.96%	5.35%	7.0%	8.2%	-1.2%	
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%	86.2%	86.7%	85.5%	80.0%	5.5%	
Activity																							
Acute Bed Capacity		559	555	559	548	537	542	548	543	543	553	553	553	530	530	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	4.0	3.5	4.7	3.9	3.32	0.57	
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	6.4	6.5	6.6	6.99	-0.35	
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%	83.5%	84.0%	83.8%	84.6%	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%	1.9%	1.3%	1.4%	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	8,410	8,522	7,953	8,594	7,742	5,423	46,644	-	-	
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	5,233	5,392	5,561	6,012	5,171	3,771	31,140	-	-	
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	27,749	28,428	27,008	30,731	24,873	27,667	166,456	161,817	2.9%	
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	3,022	3,137	3,119	3,317	2,955	3,055	18,605	17,114	8.7%	
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	3,093	3,170	3,255	3,228	3,141	3,258	19,144	18,909	1.2%	
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	7,611	7,525	46,571	46,196	0.8%	

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	Aug	Sep	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%	80.7%	81.8%	82.1%	82.5%	83.9%	81.1%	85.0%	-3.9%	
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%	6.7%	9.4%	12.3%	10.8%	9.2%	7.2%	9.3%	10.0%	-0.7%	

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