Airedale NHS
NHS Foundation Trust

Report to:	Board of Directors				
Date of Meeting:	30 April 2014				
Report Title:	Finance Report for the Public Board of Directors for the Period Ending 31 March 2014				
Status:	**For information**	**Discussion**	**Assurance**	**Approval**	**Regulatory requirement**
Mark relevant box with X					X
Prepared by:	Amy Whitaker, Deputy Director of Finance				
Executive Sponsor (presenting):	Andrew Copley, Director of Finance				
Appendices (list if applicable):					

Purpose of the Report

To provide the Board of Directors with an overview of the Financial Position to date, key areas of risk, CIP position, and forecast.

Key points for discussion

- The financial position to date is a balanced position, against a plan of £822k, £823k worse than plan due to a technical impairment of £589k and increased agency costs.
- EBITDA is £112k better than plan, which is an improvement caused by increased income. This position continues to deliver a CoSR rating of 4;
- CIP gap is £1,481k. This is covered in full by the CIP Contingency. Recurrently this gap has been closed off through the Right Care Programmes.

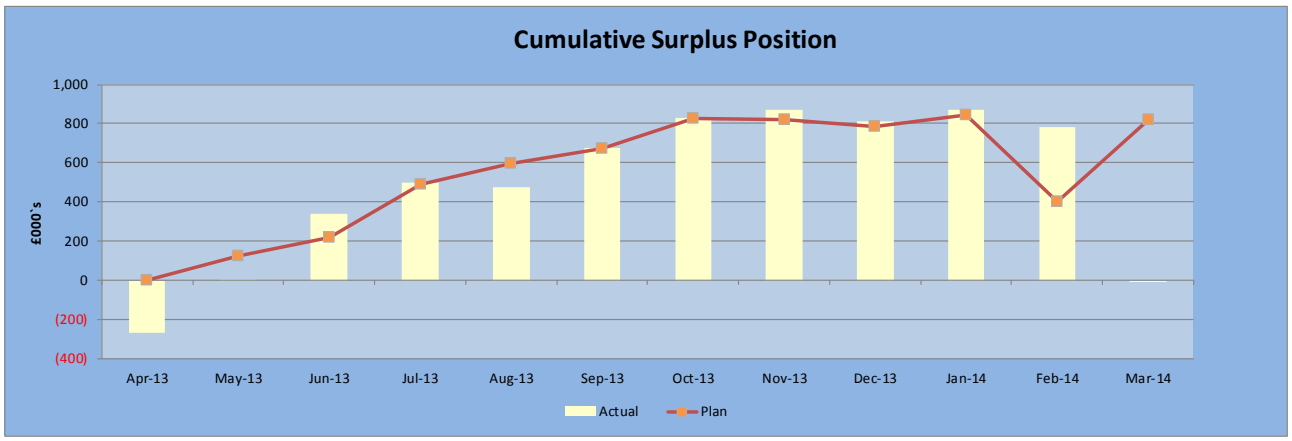
Recommendation

To receive and note the financial report and associated appendices.

FINANCE REPORT FOR THE BOARD OF DIRECTORS
FOR THE PERIOD ENDING 31 MARCH 2014

Financial Performance Summary

Area of Review	Key Highlights	Year to date Monitor Financial		
		March Plan	March Actual	Q4 Plan
Financial Summary ~ Overall Risk Rating	As at month 12 the overall (unaudited) position is a balanced position which is lower than the expected surplus due to a charge for a revaluation impariment. The FRR is 3.60 which is above the plan of 3.25 due to the positive EBITDA position. As at the end of the year, under the new Monitor Risk Rating, the Trust has a rating of 4 due to the strong levels of liquidity.	3.25	3.60	3.25
Operational Performance EBITDA Margin %	* At month 12 the EBITDA has a 4.03% margin which is lower than the plan of 5.04%. * The expenditure position is worse than forecast at month 11 due to a deterioration in the pay position. The poor EBITDA position has been offset by further improvements on depreciation following a revised forecast.	3	2	3
Operational Performance EBITDA % Achieved to plan	The EBITDA achieved is 85.46%, which is worse than planned 100% achievement.	5	5	5
Liquidity	* The liquidity ratio shows that working capital (cash + debtors- Creditors) is able to cover 26 days of the Trust`s operating expenses, which is in line with plan. Cash was £16.7m which is better than plan driven by capital slippage.	4	4	4
Use Of Assets (Return on Finance)	* The Trust's Return on Assets is 1.30% against a plan of 1.51%.	3	5	3
Income & Expenditure Position	The Income and Expenditure Margin is 0.40% against a plan of 0.60%.	2	3	2



Report to:	Public Board of Directors				
Date of Meeting:	30th April 2014				
Report Title:	Executive Performance Report March 2014				
Status:	**For information**	**Discussion**	**Assurance**	**Approval**	**Regulatory requirement**
Mark relevant box with X	X		X		X
Prepared by:	Stuart Shaw, Head of Planning and Performance				
Executive Sponsor (presenting):	Andrew Copley, Director of Finance				
Appendices (list if applicable):	Executive Performance Report March 2014 CQUINS Report March 2014 18 Weeks Backlog				

Purpose of the Report

1. Introduction

The attached Executive Performance Report shows the position to 31st March 2014 for three key areas;

- Monitor Risk Assessment Framework requirements for Service Performance as part of the Foundation Trusts quarterly Governance declaration
- CCG Contract Performance and Quality Schedule indicators
- CQUINS

Performance is shown against the required threshold or trajectory for each indicator assessed as part of a particular framework. Traffic light ratings are applied to show the level of risk using the following criteria;

Green	Performance achieving the required threshold/trajectory
Amber	Performance not achieving the required threshold/trajectory but within acceptable tolerances allowed
Red	Performance not achieving the required threshold/trajectory

Key points for discussion

2. Monitor Risk Assessment Framework

Key messages to March 2014 include;

- The indicative Quarter 4 rating for Service Performance is Green.
- Following pressures earlier in the quarter as a result of increases in demand, acuity and delays in first assessment, the position has improved and with sustained effort the standard was delivered for Quarter 4 (95.9%). This however continues to be a declared risk going forward in 2014/2015 and we have informed Monitor of our concerns through the Annual Planning cycle and our regular quarterly review discussions.
- The number of Clostridium Difficile infections year to date was 7 cases. This is below the national target of 9 and de minimis of 12 applied in the Risk Assessment Framework.
- Achievement of the Clostridium Difficile threshold for 2014/2015 however remains at risk and this was also declared to Monitor in the recent Annual Plan submission. The risk is based on the low centrally set target of 9 which, despite having reduced the number of infections from 235 to 7 over the previous seven years, the Board of Directors do not feel is achievable in the current year.
- All other standards (e.g. 18 Weeks and Cancer) were achieved or within de minimis limits and the overall Green rating is a significant achievement for the Foundation Trust given pressures that have occurred in year.

- As set out in the Risk Assessment Framework, the areas where the Foundation Trust could be subject to a potential red rated Governance override given current and recent performance are;
  If the number of Clostridium Difficile infections goes above the de minimis of 12; or
  If the A&E standard is not achieved in any two quarters over a 12 month period and then not achieved again in a quarter during the subsequent nine months, or for the full year.

3. CCG Contract Performance and Quality Schedule

This section of the report shows the performance indicators that the Foundation Trust is being monitored on through the Performance and Quality Schedule in the CCG Contract. The indicators with a potential financial penalty are highlighted by a yellow block on the left hand side. The 2014/2015 position shows good progress on most areas. There are a few areas where potential financial penalties could be applied;

MRSA

The Foundation Trust has had 2 MRSA bacteraemias for the year. Root Cause Analyses are completed and reported to the Infection Control Committee. As set out in the Standard National Contract, the CCG's are entitled to withhold payment for the Inpatient episode relating to these cases.

RTT

As highlighted previously, regrettably the Foundation Trust had a patient who had a Referral to Treatment time over 52 weeks in Quarter 3. This was discussed with the patient who was offered a date of their choice and they have subsequently been admitted and had their operation.

The reason for the delay was due to an isolated error. Staff involved have been supported with retraining. Contractually, this could potentially lead to a £5k financial penalty being applied.

The number of RTT backlog cases has now reduced down to 52 from the increase seen in February.

Cancelled Operations

The rate of cancelled operations for March was 1.17%. This was across a number of specialties and for various reasons (e.g. bed pressures, sickness and emergency cases). The overall rate for Quarter 4 however was 0.63% and so achieved the required <0.8% threshold.

A&E/Ambulance Handover

There continue to be a small number of breaches of the A&E/Ambulance handover standards which could potentially lead to a financial penalty being applied (estimated £70k if applied for this year to date). During the contract negotiations for 2013/2014, correspondence was received from the NHS North of England, suggesting there should be an initial period free from penalties to allow the respective Providers time to be able to implement processes to deliver the required standards, providing that progress could be evidenced. Work is ongoing with the CCG and Ambulance Provider on this. The main pressures continue to be during periods of peak demand. These standards are to be mandated from April 2014.

Cancer 62 Day Standard (Consultant Upgrade)

The standard for Consultant upgrade was lower than the required threshold for the quarter to date due to a small number of breaches.

Stroke

Unfortunately, due to some unexpected capacity pressures due to sickness absence, the Stroke indicator performance was 41.9% against the 80% threshold for March and 58.5% for Quarter 4. This is the first time for a while where we have not met the required standard. Plans are currently being worked on regarding service provision and hence delivery of the standard.

4. CQUINS

Attached to the Performance Report is the updated position for the 2013/2014 CQUINS Indicators. CQUINS are worth 2.5% of out turn value (approximately £3m) and are paid for delivery of specific objectives and indicators agreed as part of the CCG contract. The projected position (subject to validation from CCG's) shows good progress against the 2013/2014 objectives. The main areas to note are;

For the Friends and Family Test, following considerable effort, the Quarter 4 response achieved the 20% threshold required.

For Dementia, improvements made earlier in the year meant the Foundation Trust has now achieved the 90% level for all three standards for the three consecutive months required to receive payment. However delivery of this CQUIN across the three domains was ultimately completed through having some short term additional capacity in place and as this is currently not available, the position is now below the threshold for Quarter 4. Further work is ongoing to look at the process and support required to return the position to the target levels, given these are a national CQUINS indicator for 2014/2015.

For the Safety Thermometer, although the rate has improved in Quarter 4, we have struggled to reach the overall rate of pressure ulcers required as this does not differentiate between hospital and community acquired levels. This is also a national CQUINS indicator in 2014/2015.

The VTE standards have been achieved for the year, including over 95% of Inpatients being risk assessed each individual month.

The Ambulatory Care Standards are achieving the required thresholds, with 2461 patients seen in an ambulatory care setting and 35.7% of contacts to the ACU to date resulting in no admission.

Recommendation

The Trust Board of Directors is asked to receive the March 2014 Performance Report and note the areas where targeted actions are planned to maintain and/or improve performance.

Airedale NHS
NHS Foundation Trust

Executive Performance Report March 2014

Position as at 31st March 2014

Monitor Risk Assessment Framework - Service Performance

March 2014

Infection Prevention	**(Position as at 31st March 2014)**													
MRSA - Quarterly (Monitor Profile)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Weighting	Monitoring
Trajectory (Quarter to date)	1	1	1	2	2	2	1	1	1	2	2	2	1.0	Quarterly
Actual (Quarter to date)	0	0	0	0	0	0	1	1	1	0	1	1		
Rating	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		
MRSA - Annual (DH Set Target)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		Note: Only
Trajectory (Year to date)	0	0	0	0	0	0	0	0	0	0	0	0		quarterly
Actual (Year to date)	0	0	0	0	0	0	1	1	1	1	2	2		monitoring
Rating	Green	Green	Green	Green	Green	Green	Red	Red	Red	Red	Red	Red		applies here.

Monitor Risk Assessment Framework; MRSA standard not part of quarterly submission from 1st October 2013.

Clostridium Difficile - Annual (CCG Contract)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Weighting	Monitoring
Trajectory (Year to date)	1	2	3	4	5	5	6	7	7	8	9	9	1.0	Quarterly
Actual (Year to date)	2	3	3	3	4	4	5	7	7	7	7	7		
Rating	Red	Red	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		
Clostridium Difficile - Annual (Monitor Profile)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
Trajectory (Year to date)	1	2	3	4	5	6	7	8	9	10	11	12		
Actual (Year to date)	2	3	3	3	4	4	5	7	7	7	7	7		
Rating	Red	Red	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		
Clostridium Difficile - Quarterly (CCG Contract)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		Note: Only
Trajectory (Quarter to date)	1	2	3	1	2	2	1	2	2	1	2	2		quarterly
Actual (Quarter to date)	2	3	3	0	1	1	1	3	3	0	0	0		monitoring
Rating	Red	Red	Green	Green	Green	Green	Green	Red	Red	Green	Green	Green		applies here.
Clostridium Difficile - Quarterly (Monitor)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
Trajectory (Quarter to date)	1	2	3	1	2	3	1	2	3	1	2	3		
Actual (Quarter to date)	2	3	3	0	1	1	1	3	3	0	0	0		
Rating	Red	Red	Green	Green	Green	Green	Green	Red	Green	Green	Green	Green		

Monitor Risk Assessment Framework; De minimis rule of 12 applies for Clostridium Difficile (i.e. no penalty points are applied until the number of cases across the year exceeds 12).

RTT 18 Weeks
Admitted (Target 90% < 18 Weeks) **(Position as at 31st March 2014)**

Admitted Aggregate Quarterly	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Weighting	Monitoring
Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	1.0	Quarterly
Actual (Quarter to date)	91.8%	91.3%	91.7%	92.2%	91.8%	91.9%	91.8%	91.3%	91.9%	92.8%	92.3%	91.8%		(Not achieving
Rating	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		any individual
Admitted Aggregate Monthly	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		month leads to
Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%		quarterly
Actual	91.8%	91.5%	91.8%	92.2%	91.4%	92.2%	91.8%	90.8%	93.3%	92.8%	91.8%	90.6%		penalty points
Rating	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		being applied).

RTT 18 Weeks
Non-Admitted (Target 95% < 18 Weeks)

Non-Admitted Aggregate Quarterly	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Weighting	Monitoring
Trajectory	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	1.0	Quarterly
Actual (Quarter to date)	95.8%	95.8%	95.9%	95.4%	95.5%	95.8%	95.7%	95.6%	95.7%	96.5%	96.5%	96.4%		(Not achieving
Rating	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		any individual
Non-Admitted Monthly	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		month leads to
Trajectory	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%		quarterly
Actual	95.8%	95.7%	96.1%	95.4%	95.5%	96.9%	95.7%	95.3%	96.3%	96.5%	96.5%	96.2%		penalty points
Rating	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		being applied).

RTT 18 Weeks
Incomplete (Target 92% < 18 Weeks)

Incomplete Aggregate Quarterly	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Weighting	Monitoring
Trajectory	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	1.0	Quarterly
Actual (Quarter to date)	92.2%	92.2%	92.3%	92.2%	92.2%	92.3%	92.4%	92.9%	92.7%	93.5%	93.4%	93.1%		(Not achieving
Rating	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		any individual
Incomplete Monthly	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		month leads to
Trajectory	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%		quarterly
Actual	92.2%	92.0%	92.6%	92.2%	92.3%	92.3%	92.4%	93.0%	92.8%	93.5%	93.2%	92.6%		penalty points
Rating	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		being applied).

A&E **(Position as at 31st March 2014)**
Total Time In Department (95% Less than 4 Hours)

Quarterly	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Weighting	Monitoring
Trajectory	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	1.0	Quarterly
Actual (Quarter to date)	93.6%	92.3%	94.3%	96.9%	97.3%	97.3%	95.1%	96.0%	95.9%	93.9%	94.9%	95.9%		
Rating	Red	Red	Red	Green	Green	Green	Green	Green	Green	Red	Red	Green		

Airedale NHS Foundation Trust
Executive Performance Report

Monitor Risk Assessment Framework - Service Performance

March 2014

New Cancer Standards **(Position as at 31st March 2014)**

Quarterly (Quarter To Date Position Shown)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Weighting	Monitoring
Trajectory	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	1.0	Quarterly
31 day to subsequent treatment (surgery)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		(Not achieving
Rating	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		any individual
Trajectory	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%		part leads
31 day to subsequent treatment (drugs)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		to quarterly
Rating	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		penalty points
Trajectory	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	1.0	being applied).
62 day referral to treatment	95.8%	92.0%	94.4%	93.2%	92.4%	87.9%	90.9%	90.1%	90.9%	86.4%	88.3%	87.3%		
Rating	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		
Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%		
62 day referral to treatment (Screening)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.9%	93.3%	91.3%	87.5%	90.0%	91.7%		
Rating	Green	Green	Green	Green	Green	Green	Green	Green	Green	Red	Green	Green		

De minimis rule of 5 cases per quarter applies to all of the above individual standards.

Existing Cancer Standards **(Position as at 31st March 2014)**

Quarterly (Quarter To Date Position Shown)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Weighting	Monitoring
Trajectory	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	1.0	Quarterly
14 day referral to app (excl NFT breast)	98.4%	98.8%	98.3%	98.7%	98.8%	97.6%	99.3%	98.3%	98.4%	93.2%	95.9%	97.0%		(Not achieving
Rating	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		any part leads
Trajectory	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%		to Quarterly
14 day referral to app (symptomatic breast)	98.9%	99.5%	99.2%	99.1%	98.5%	98.5%	96.9%	97.6%	98.0%	98.6%	98.8%	97.8%		penalty points
Rating	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		being applied).
Trajectory	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	1.0	Quarterly
31 day diagnosis to treat	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Rating	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		

De minimis rule of 5 cases per quarter applies to all of the above individual standards.

Data completeness: Community Services **(Position as at 31st March 2014)**

Quarterly (Quarter To Date Position Shown)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Weighting	Monitoring
Trajectory	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	1.0	Quarterly
Referral to treatment information	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Rating	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		
Trajectory	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%		
Referral information	94.2%	93.6%	93.1%	92.3%	92.0%	91.8%	89.9%	90.2%	91.2%	91.8%	91.4%	91.9%		
Rating	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		
Trajectory	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%		
Treatment activity information	99.9%	99.8%	99.8%	99.9%	99.9%	99.9%	100.0%	99.8%	99.8%	99.7%	99.7%	99.8%		
Rating	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		

Overall Ratings

Rating	Threshold
Green	Score of 0 to 0.9
Amber	Score of 1.0 to 3.9
Red	Score of 4.0 and above

Rounding principle not to be utilised for any standard (i.e. for a target of 98% then performance must be 98.0% or above in order to achieve the standard).
Non-achievement of any standard weighted 1.0 for three or more consecutive quarters leads to 4.0 penalty points being applied and an automatic Red rating.

Service Performance Rating

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	Amb/Grn	Amb/Grn	Amb/Grn	Green	Green	Green	Green	Green	Green	Amber	Amber	Green

Clinical Commissioning Group (CCG) Performance and Quality Schedule 2013/2014

No.	Operational Standards	Threshold (2013/14)	Method of Measurement (2013/14)	Consequence of Breach	Quarter 1		Quarter 2		Quarter 3		January		February		March		Quarter 4		Year to Date	
					Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
	Infection Prevention																			
1	Zero tolerance MRSA	>0	Review of monthly Service Quality Performance Report	Non-payment of inpatient episode	0		0		1		0		1		0		1		2	
2	Rates of Clostridium difficile	9	Review of monthly Service Quality Performance Report	As set out in Schedule 4 Part H	3		1		3		0		0		0		0		7	
	RTT waiting times for non-urgent consultant led treatment																			
3	Percentage of admitted patients starting treatment within a maximum of 18 weeks from referral	Operating standard of 90%	Review of monthly Service Quality Performance Report	As set out in Service Condition 21 and Schedule 4 Part G	2399	2616	2658	2892	2665	2899	1025	1105	920	1002	891	983	2836	3090	10558	11497
					91.7%		91.9%		91.9%		92.8%		91.8%		90.6%		91.8%		91.8%	
4	Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from referral	Operating standard of 95%	Review of monthly Service Quality Performance Report	As set out in Service Condition 21 and Schedule 4 Part G	2555	2665	2999	3136	3432	3585	1165	1207	1007	1044	1015	1055	3187	3306	12173	12692
					95.9%		95.6%		95.7%		96.5%		96.5%		96.2%		96.4%		95.9%	
5	Percentage of patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	Operating standard of 92%	Review of monthly Service Quality Performance Report	As set out in Service Condition 21 and Schedule 4 Part G	18713	20277	18641	20204	19463	20993	6718	7186	6761	7253	6875	7423	20354	21862	77171	83336
					92.3%		92.3%		92.7%		93.5%		93.2%		92.6%		93.1%		92.6%	
6	Zero tolerance RTT waits over 52 weeks	>0	Review of monthly Service Quality Performance Report	£5,000 per patient waiting over 52 weeks	0		0		1		0		0		0		0		1	
	Diagnostic test waiting times																			
7	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test Operating standard of >99%	Review of monthly Service Quality Performance Report	Review of monthly Service Quality Performance Report	2% of revenue derived from the provision of the locally defined service line in the month of the under-achievement.	6888	6898	7217	7220	7530	7532	2400	2400	2446	2446	2520	2520	7366	7366	29001	29016
					99.9%		99.96%		99.97%		100.0%		100.0%		100.0%		100.0%		99.9%	
	A&E waits & Ambulance Handover																			
8	Percentage of A & E attendances where the patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	Operating standard of 95%	Review of monthly Service Quality Performance Report	2% of revenue derived from the provision of the locally defined service line in the quarter of the under-achievement	13068	13860	13649	14032	12346	12880	3899	4153	3726	3881	4482	4593	12107	12627	51170	53399
					94.3%		97.3%		95.9%		93.9%		96.0%		97.6%		95.9%		95.8%	
9	All handovers between ambulance and A & E must take place within 15 minutes (Only YAS information available)	Handover >30-60 minutes	Review of monthly Service Quality Performance Report	£200 per patient waiting over 30 minutes	85	2254	43	3173	49	3339	29	1217	14	1067	22	1135	65	3419	242	12185
					3.8%		1.4%		1.5%		2.4%		1.3%		1.9%		1.9%		2.0%	
10	All handovers between ambulance and A & E must take place within 15 minutes (Only YAS information available)	Handover > 60 minutes	Review of monthly Service Quality Performance Report	£1,000 per patient waiting over 60 minutes (in total, not aggregated with CB_57a consequence)	6	2254	4	3173	3	3339	5	1217	1	1067	2	1135	8	3419	21	12185
					0.3%		0.1%		0.1%		0.4%		0.1%		0.2%		0.2%		0.2%	
11	Trolley waits in A&E	Any trolley wait > 12 hours	Review of monthly Service Quality Performance Report	£1,000 per breach	0	13860	0	14032	0	12880	0	4153	0	3881	0	4593	0	12627	0	53399
					0		0		0		0		0		0		0		0	
	Cancer waits																			
12	Percentage of patients referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment	Operating standard of 93%	Review of monthly Service Quality Performance Report	2% of revenue derived from the provision of the locally defined service line in the quarter of the under-achievement	1066	1083	1057	1083	1195	1215	397	426	354	356	440	446	1191	1228	4509	4609
					98.4%		97.6%		98.4%		93.2%		99.4%		98.7%		97.0%		97.8%	
13	Percentage of patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment	Operating standard of 93%	Review of monthly Service Quality Performance Report	2% of revenue derived from the provision of the locally defined service line in the quarter of the under-achievement	251	253	255	259	251	256	73	74	94	95	95	99	262	268	1019	1036
					99.2%		98.5%		98.0%		98.6%		98.9%		96.0%		97.8%		98.4%	
14	Percentage of patients waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	Operating standard of 96%	Review of monthly Service Quality Performance Report	2% of revenue derived from the provision of the locally defined service line in the quarter of the under-achievement	167	167	160	160	193	193	60	60	49	49	68	68	177	177	697	697
					100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%	
15	Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is surgery	Operating standard of 94%	Review of monthly Service Quality Performance Report	2% of revenue derived from the provision of the locally defined service line in the quarter of the under-achievement	14	14	31	31	34	34	11	11	9	9	11	11	31	31	110	110
					100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%	
16	Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regimen	Operating standard of 98%	Review of monthly Service Quality Performance Report	2% of revenue derived from the provision of the locally defined service line in the quarter of the under-achievement	48	48	32	32	56	56	26	26	14	14	21	21	61	61	197	197
					100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%	
17	Percentage of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	Operating standard of 85%	Review of monthly Service Quality Performance Report	2% of revenue derived from the provision of the locally defined service line in the quarter of the under-achievement	83.5	88.5	94	107	105	115.5	28.5	33	29	32.5	38.5	44.5	96	110	378.5	421
					94.4%		87.9%		90.9%		86.4%		89.2%		86.5%		87.3%		89.9%	
19	Percentage of patients waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers	Operating standard of 90%	Review of monthly Service Quality Performance Report	2% of revenue derived from the provision of the locally defined service line in the quarter of the under-achievement	2	2	6	6	10.5	11.5	3.5	4	1	1	1	1	5.5	6	24	25.5
					100.0%		100.0%		91.3%		87.5%		100.0%		100.0%		91.7%		94.1%	
20	Percentage of patients waiting no more than 62 days for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	95%	Review of monthly Service Quality Performance Report	2% of revenue derived from the provision of the locally defined service line in the quarter of the under-achievement	6.5	8	1	1	6.5	7.5	1.5	2	4.5	6	1.5	2.5	7.5	10.5	21.5	27
					81.3%		100.0%		86.7%		75.0%		75.0%		60.0%		71.4%		78.6%	
	Mixed sex accommodation breaches																			
21	Sleeping Accommodation Breach	>0	Verification of the monthly data provided pursuant to Schedule 6 Part C in accordance with the Professional Letter	£250 per day per patient affected	0		0		0		0		0		0		0		0	

Clinical Commissioning Group (CCG) Performance and Quality Schedule 2013/2014

No.	Operational Standards	Threshold (2013/14)	Method of Measurement (2013/14)	Consequence of Breach	Quarter 1		Quarter 2		Quarter 3		January		February		March		Quarter 4		Year to Date	
					Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
	Cancelled operations																			
22	All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice	Number of patients who are not offered another binding date within 28 days >0	Review of monthly Service Quality Performance Report	Non- payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care																
					0		0		0		0		0		0		0		0	
23	No urgent operation should be cancelled for a second time	Number of urgent operations cancelled for a second time	Review of monthly Service Quality Performance Report	Non-payment of costs associated with cancellation and non-payment/ reimbursement of costs (as applicable) of rescheduled episode of care.																
					0		0		0		0		0		0		0		0	
24	Provider cancellation of Elective Care operation for non-clinical reasons either before or after Patient admission	0.80% of total elective admissions or less	Local monthly contract reporting QMCO return	**Breach**: >0.8% in any individual quarter. **Consequence:** Contract management process as set out in general Conditions GC9 to be applied	31	6999	16	7333	24	7308	14	2626	4	2313	29	2484	47	7423	118	29063
					0.44%		0.22%		0.33%		0.53%		0.17%		1.17%		0.63%		0.41%	
	Delayed Transfers of Care																			
25	Delayed transfers of care to be maintained at a minimal level	<=3.5%	Local monthly contract reporting.	**Breach:** >3.5% cumulative YTD Consequence: 1) Initial breach Report and action plan to be provided and reviewed as part of agreed contract management process. 2) 2nd breach Contract management process as set out in general Conditions GC9 to be applied	69	3922	80	4674	76	6118	22	2277	37	1982	76	2110	135	6369	360	21083
					1.76%		1.71%		1.24%		0.97%		1.87%		3.60%		2.12%		1.71%	
	Stroke Care																			
26	Implementation of the stroke strategy - patients who spend at least 90% of their time on a stroke unit	80%	Local monthly contract reporting. Quarterly data submitted to CCGs	**Breach:** Below 80% in 2 consecutive months. Consequence: Issue of a 1st Exception report and withholding of £30,000 for each month the target is not achieved 3 months consecutive breaches. Issue of a 2nd Exception report and all withheld sums being retained	45	84	67	79	67	81	19	23	16	28	13	31	48	82	227	326
					53.6%		84.8%		82.7%		82.6%		57.1%		41.9%		58.5%		69.6%	
27	Implementation of the stroke strategy - % of higher risk TIA cases who are treated within 24 hours	60%	Local monthly contract reporting. Quarterly data submitted to CCGs	**Breach:** Below 60% in 2 consecutive months **Consequence:** Report and action plan to be provided and reviewed as part of agreed contract management process	74	80	64	86	50	60	21	24	25	29	14	17	60	70	248	296
					92.5%		74.4%		83.3%		87.5%		86.2%		82.4%		85.7%		83.8%	
	Maternity & Gynaecology																			
28	% mothers smoking at delivery	Year on Year improvement Rate <2012/13 or 2012/13 target whichever is lower. **13.5%**	Local monthly contract reporting	**Breach:** Mothers smoking at delivery >2012/13 or 2012/13 target whichever is lower in quarter **Consequence:** Report and action plan to be provided and reviewed as part of agreed contract management process	79	535	76	607	69	555	26	196	20	187	26	195	72	578	296	2275
					14.8%		12.5%		12.4%		13.3%		10.7%		13.3%		12.5%		13.0%	
29	% of mothers who are smokers who receive CO monitoring at first assessment	95%	Local monthly contract reporting Reporting to commence from Q2	**Breach:** < 100% in quarter **Consequence: Initial breach.** Report and action plan to be provided and reviewed as part of agreed contract management process																
30	% of referrals to smoking cessation for pregnant smokers with CO reading of 6 or more	95%	Local monthly contract reporting Reporting to commence from Q2	**Breach:** < 95% in quarter **Consequence: Initial breach** Report and action plan to be provided and reviewed as part of agreed contract management process																
31	Increase breastfeeding rates (baby received breast milk within 48 hours)	Year on Year Improvement in % mothers breastfeeding Rate >2012/13 or 2012/13 target whichever is greater. **76.9%**	Local monthly contract reporting	**Breach:** Breastfeeding rate < 2012/13 or 2012/13 target whichever is greater in quarter Consequence: Report and action plan to be provided and reviewed as part of agreed contract management process	408	535	473	607	438	555	152	196	140	187	154	195	446	578	1765	2275
					76.3%		77.9%		78.9%		77.6%		74.9%		79.0%		77.2%		77.6%	
32	Percentage of women who have seen a midwife or a maternity healthcare professional, for assessment of health and social care needs, risks and choices by 12 completed weeks of pregnancy.	90%	Local contract reporting. Quarterly data submitted to CCGs	**Breach:** Below 90% in 2 consecutive months **Consequence:** Report and action plan to be provided and reviewed as part of agreed contract management process	587	636	590	636	578	625	227	243	195	210			422	453	2177	2350
					92.3%		92.8%		92.5%		93.4%		92.9%				93.2%		92.6%	
33	Midwifery quality indicator 1) Maintaining current quality and care threshold within Maternity Services a) 1:1 performance b) Midwifery staffing ratio c) Diverts	1a) 1:1 performance 1b) Ratio of 1:30 to be maintained 1c) Report on diverts within 48 working hours of the divert	1a & b) Reported monthly (from Evolution) 1c) To be reported direct to AWC within 48 hours of divert	**Breach:** 1) 1a) 1:1 performance not reported monthly 1b) Ratio > 1:30 1c) Report on diverts not received within 48 working hours of the divert **Consequence: Initial breach** Report and action plan to be provided and reviewed as part of agreed contract management process							a) 1:1 performance = **83%** b) Staffing ratio = **1:28** c) Diverts = **0**		a) 1:1 performance = **81%** b) Staffing ratio = **1:28** c) Diverts = **1**							
34	2) Number of antenatal appointments received by women.	2) baseline to be determined by end of Q1 in terms of average number of AN appointments per woman and quality indicator for Q3 & Q4 to be developed and agreed by end of Q2	Full report to be provided on all diverts	2) Q1 baseline not provided and quality indicator not agreed by Q2. **Consequence: Initial breach** Report and action plan to be provided and reviewed as part of agreed contract management process																
35	Chlamydia screening: % of TOPS	100% Offered 95% Screened	% of TOPS screened for Chlamydia local report Local monthly contract reporting	**Breach**: <100% (offered) and/or <95% (screened) in any individual month (local reporting to be agreed) **Consequence:** Report and action plan to be provided and reviewed as part of agreed contract management process	25	25	19	19	8	8	4	4	6	6	4	4	14	14	66	66
					100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%	

Clinical Commissioning Group (CCG) Performance and Quality Schedule 2013/2014

No.	Operational Standards	Threshold (2013/14)	Method of Measurement (2013/14)	Consequence of Breach	Quarter 1		Quarter 2		Quarter 3		January		February		March		Quarter 4		Year to Date	
					Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
36	Termination of Pregnancy Waiting Time. All service users should be offered an assessment appointment within 7 calendar days of referral or self referrals	100%	Local monthly contract reporting. TOPs Local dataset elements of Date of referral and consultation used to validate CCG patients	**Breach:** < 95% within 7 calendar days in 2 consecutive months. **Consequence:** Contract management process as set out in general Conditions GC9 to be applied	41	41	36	36	22	22	13	13	8	8	9	9	30	30	129	129
					100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%	
37	Termination of Pregnancy Waiting Times. All service users choosing to proceed with a termination should be offered an appointment for the procedure within 7 calendar days after the decision to proceed has been taken	100%	Local monthly contract reporting. TOPs Local dataset to be extended to include "Decision to proceed" data field.	**Breach:** < 95% within 7 calendar days in 2 consecutive months. **Consequence**: Contract management process as set out in general Conditions GC9 to be applied	41	41	36	36	22	22	13	13	8	8	9	9	30	30	129	129
					100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%	
38	Contraception provided at surgical TOP procedure	70%	Local monthly contract reporting. Numerator: Number of women choosing LARC post surgical TOP within the reporting period. Denominator:	**Breach:** < 70% **Consequence:** Full detailed report on how contraception services are delivered in TOPs services with data to support the number of LARCs offered and reasons for rejection of LARC	31	41	36	36	22	22	13	13	8	8	9	9	30	30	119	129
					75.6%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		92.2%	
39	Number of women who are given 4 bottle of healthy start vitamins	90% of women who are registered as booked-in	Local monthly contract reporting.	**Breach:** <90% **Consequence:** Report and action plan to be provided and reviewed as part of agreed contract management process																
					93%		97%		96%		100%		100%		100%		100%		95%	
	Community																			
40	% of referrals seen within 2 weeks in MS specialist / Neuro rehab service	95%	Local monthly contract reporting	**Breach**: <95% in quarter Consequence: Report and action plan to be provided and reviewed as part of agreed contract management process	25	25	31	31	51	51	4	4	2	2	4	4	10	10	117	117
					100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%	
41	% referrals seen within 2 weeks in Heart Failure Nurse Specialist Service	Not < 90% of new patients to be assessed within 2 weeks	Local monthly contract reporting	**Breach**: <90% in quarter Consequence: Report and action plan to be provided and reviewed as part of agreed contract management process	22	37	26	26	24	34	18	25	7	7	9	9	34	41	106	138
					59.5%		100.0%		70.6%		72.0%		100.0%		100.0%		82.9%		76.8%	
42	% referrals seen within 2 weeks in Cardiac Rehabilitation Team	100%	Local monthly contract reporting	**Breach**: <100% in quarter Consequence: Report and action plan to be provided and reviewed as part of agreed contract management process	89	108	86	86	110	110	41	41	39	39	54	54	134	134	419	438
					82.4%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		95.7%	
43	ACCT: % patients referred for Crisis Intervention or admission avoidance seen within 2 hours of referral	<95%	Local monthly contract reporting. Quarterly activity report to commissioner	**Breach**: <95% in quarter. **Consequence:** Report and action plan to be provided and reviewed as part of agreed contract management process	534	534	501	501	519	519	171	171	155	155	189	189	515	515	2069	2069
					100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%	
44	ACCT: Bed utilisation - % step up and % step down in each period	70% step up expected bed utilisation	Local monthly contract reporting. Quarterly activity report to commissioner	**Breach**: 10% shift in step up/step down ratio in quarter. **Consequence:** Report and action plan to be provided and reviewed as part of agreed contract management process	436	534	404	501	397	519	120	171	110	155	147	189	377	515	1614	2069
					81.6%		80.6%		76.5%		70.2%		71.0%		77.8%		73.2%		78.0%	
		30% step down expected bed utilisation			98	534	97	501	108	519	31	171	38	155	30	189	99	515	402	2069
					18.4%		19.4%		20.8%		18.1%		24.5%		15.9%		19.2%		19.4%	
	E-communications with GPs																			
45	E-communications with GPs following inpatient discharge and outpatient attendance	80% of letters sent to GPs following inpatient discharge are sent electronically	Local monthly contract reporting	**Breach**: <80% of inpatient discharge letters in quarter and <25% (Q1), 30% (Q2), 40% (Q3) and 70% (Q4) outpatient letters sent electronically. **Consequence:** Report and action plan to be provided and reviewed as part of agreed contract management process	7342	7809	7544	7968	7977	8334	2775	2906	2546	2689	2681	2831	8002	8426	30865	32537
					94.0%		94.7%		95.7%		95.5%		94.7%		94.7%		95.0%		94.9%	
		50% of letters sent to GPs following each outpatient attendance are sent electronically by Q4			16949	30374	18237	30872	19543	29570	6496	10256	5532	9367	5710	9276	17738	28899	72467	119715
					54.5%		59.1%		66.1%		63.3%		59.1%		61.6%		61.4%		60.5%	
	Reduce face to face follow-up contacts																			
46	Reduce face to face follow-up contacts	Reduce face to face follow-up contacts in general surgery, gynaecology, orthopaedics and urology by TBA % by Q4 2013/14	Local monthly contract reporting	**Breach**: Reduction in face to face follow-up contacts < x% (Q1), x% (Q2), x% (Q3) and x% (Q4). **Consequence:** Report and action plan to be provided and reviewed as part of agreed contract management process	74	21171	116	21570	153	20848	64	7728	50	6651	55	6709	169	21088	512	84677
					0.35%		0.54%		0.73%		0.83%		0.75%		0.82%		0.80%		0.60%	
	Emergency Re-admissions																			
47	Emergency Re-admissions	Planning assumption made for percentage of re-admissions which are avoidable is 10%. Therefore re-admission rate for 2013/14 will be 10% pending clinical review after which the agreed percentage will be applied for the full contract year.	SUS reporting. Local monthly contract reporting. Clinical review to be complete by end of Q2 2013/14	Provider should not be reimbursed above the agreed threshold for emergency re-admissions. Providers should not be reimbursed for the proportion of readmissions judged to have been avoidable by any agency. The Provider should co-operate with the Commissioner in a clinical review of re-admissions within an agreed period. This review to be complete by end of Q2 2013/14.	407	3458	606	4754	623	5302	253	1863	275	1798	246	1824	774	5485		
					11.8% (validation required as to the split between avoidable /unavoidable admissions)		12.7% (validation required as to the split between avoidable /unavoidable admissions)		11.7% (validation required as to the split between avoidable /unavoidable admissions)		13.5% (validation required as to the split between avoidable /unavoidable admissions)		15.3% (validation required as to the split between avoidable /unavoidable admissions)		13.4% (validation required as to the split between avoidable /unavoidable admissions)		14.1% (validation required as to the split between avoidable /unavoidable admissions)			
	SBAR & PAWs																			
48	Safe care – children. Rate of patients who arrested with a paediatric advanced warning score (PAWs) track and trigger system in place	95%	Local monthly contract reporting	**Breach:** <95% in quarter. Consequence: Report and action plan to be provided and reviewed as part of agreed contract management process	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
					100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%	
49	Safe care – Adults. Rate of patients who had a situation background assessment recommendation (SBAR) or equivalent used to communicate	95%	Local monthly contract reporting	**Breach:** <95% in quarter. Consequence: Report and action plan to be provided and reviewed as part of agreed contract management process	253	257	237	242	313	320	95	95	122	122	105	105	322	322	1125	1141
					98.4%		97.9%		97.8%		100.0%		100.0%		100.0%		100.0%		98.6%	

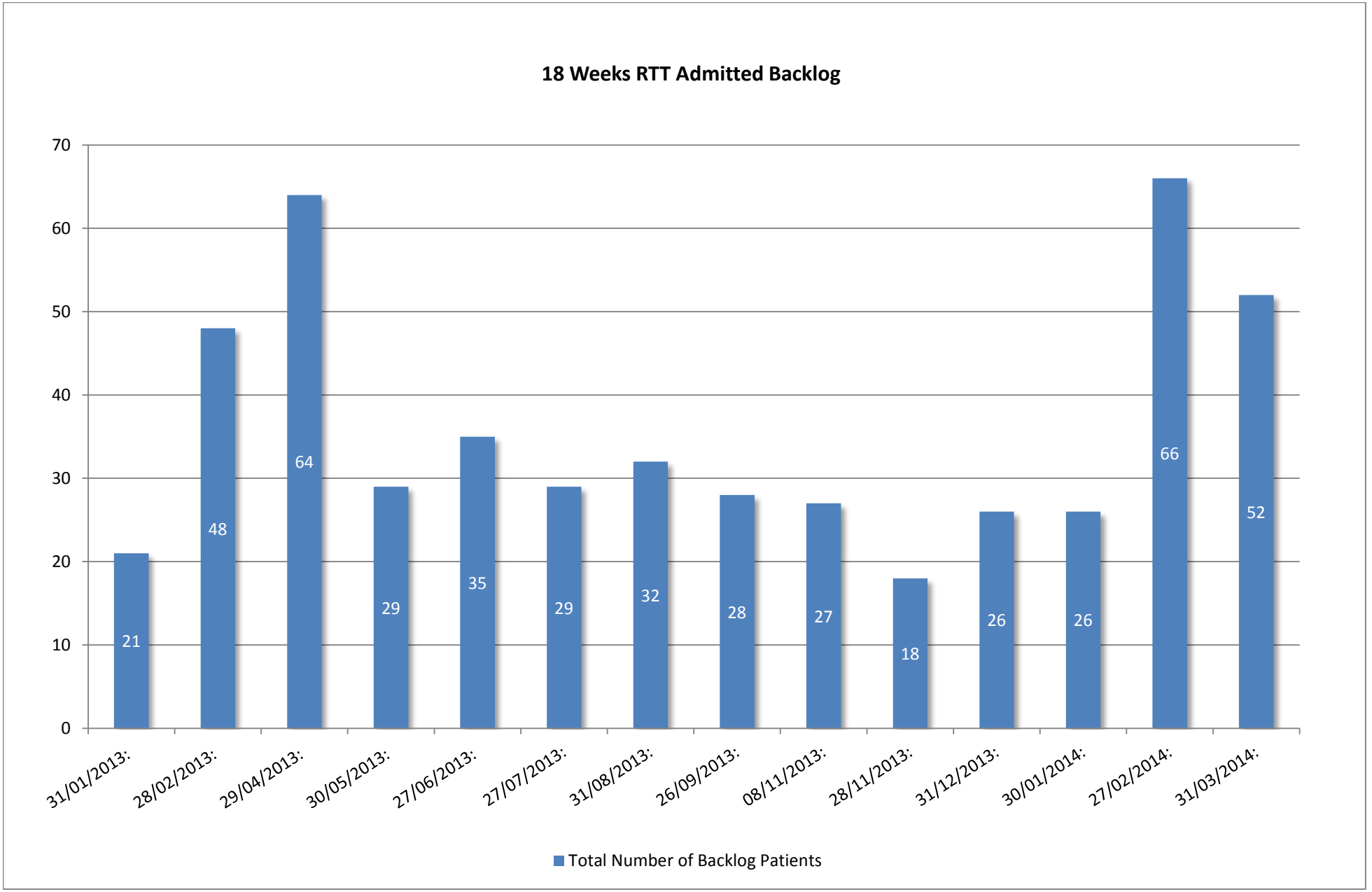
Clinical Commissioning Group (CCG) Performance and Quality Schedule 2013/2014

No.	Operational Standards	Threshold (2013/14)	Method of Measurement (2013/14)	Consequence of Breach	Quarter 1		Quarter 2		Quarter 3		January		February		March		Quarter 4		Year to Date	
					Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
	Training & Education																			
50	Safeguarding **adults & children**	100% of all new staff will undergo safeguarding adults and children training as part of induction and within 3 months of taking up post. Identified staff member(s) should not work with adults or children without direct supervision, until training completed	Local monthly contract reporting.	**Breach:** < 95% compliance in 2 consecutive months in either adult or children training. **Consequence:** 1) 1st breach Report and remedial action plan to be provided and reviewed as part of agreed contract management. 2) 2nd breach Contract management process as set out in general Conditions GC9 to be applied	70	70	121	121	89	89	24	24	34	34	25	25	83	83	363	363
					100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%	
51	Infection prevention & control	100% of all new staff will undergo infection prevention and control training as part of induction and within 3 months of taking up post.	Local monthly contract reporting	**Breach:** < 95% training compliance in 2 consecutive months. **Consequence:** 1) 1st breach Report and remedial action plan to be provided and reviewed as part of agreed contract management. 2) 2nd breach Contract management process as set out in general Conditions GC9 to be applied	70	70	121	121	89	89	24	24	34	34	25	25	83	83	363	363
					100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%	
52	100% of all new staff who provide care and treatment will have undergone Mental Capacity Act awareness training at the part of induction and within 3 months of taking up post.	95% compliance	Local monthly contract reporting.	**Breach:** < 95% training compliance in 2 consecutive months. **Consequence: 1) 1st breach** Report and remedial action plan to be provided and reviewed as part of agreed contract management. **2) 2nd breach** Contract management process as set out in general Conditions GC9 to be applied	195	195	207	207	200	200	51	51	46	46	74	74	171	171	773	773
					100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%	
	Published Formulary																			
53	Failure to publish Formulary	Yes/No	Publication on Provider's website	Withholding of up to 1% of the monthly sums payable by the Commissioners under Service Condition 36 (*Payment Terms*) per month until	Completed		Completed		Completed		Completed		Completed		Completed		Completed		Completed	
	Duty of Candour																			
54	Duty of Candour	Each failure to notify the Relevant Person of a suspected or actual Reportable Patient Safety Incident (as per Guidance)	Provider to include a paragraph within their quarterly patient safety report indicating that they have met the Duty of Candour and any exception to this	Recovery of the cost of the episode of care or £10,000 if the cost of the episode of care is unknown.	100%		100%		100%		100%		100%		100%		100%		100%	
	Never Events	**Threshold (2013/14)**	**Method of Measurement (2013/14)**	**Consequence of Breach**	**Quarter 1**		**Quarter 2**		**Quarter 3**		**January**		**February**				**Quarter 4**		**Year to Date**	
	SURGICAL																			
55	Wrong site surgery	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care (not discretionary)	0		1		0		0		0		0		0		1	
56	Wrong implant/prosthesis	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care (not discretionary)	0		0		0		0		0		0		0		0	
57	Retained foreign object post-operation	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care (not discretionary)	0		0		0		0		0		0		0		0	
	MEDICATION																			
58	Wrongly prepared high-risk injectable medication	>0	Review of reports submitted to NRLS/Serious Incidents reports and	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective	0		0		0		0		0		0		0		0	
59	Maladministration of potassium-containing solutions	>0	Review of reports submitted to NRLS/Serious Incidents reports and	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective	0		0		0		0		0		0		0		0	
60	Wrong route administration of chemotherapy	>0	Review of reports submitted to NRLS/Serious Incidents reports and	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective	0		0		0		0		0		0		0		0	
61	Wrong route administration of oral/enteral treatment	>0	Review of reports submitted to NRLS/Serious Incidents reports and	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective	0		0		0		0		0		0		0		0	
62	Intravenous administration of epidural medication	>0	Review of reports submitted to NRLS/Serious Incidents reports and	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective	0		0		0		0		0		0		0		0	
63	Maladministration of Insulin	>0	Review of reports submitted to NRLS/Serious Incidents reports and	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective	0		0		0		0		0		0		0		0	
64	Overdose of midazolam during conscious sedation	>0	Review of reports submitted to NRLS/Serious Incidents reports and	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective	0		0		0		0		0		0		0		0	
65	Opioid overdose of an opioid-naive Patient	>0	Review of reports submitted to NRLS/Serious Incidents reports and	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective	0		0		0		0		0		0		0		0	
66	Inappropriate administration of daily oral methotrexate	>0	Review of reports submitted to NRLS/Serious Incidents reports and	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective	0		0		0		0		0		0		0		0	
	GENERAL HEALTHCARE																			
67	Falls from unrestricted windows	>0	Review of reports submitted to NRLS/Serious Incidents reports and	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective	0		0		0		0		0		0		0		0	
68	Entrapment in bedrails	>0	Review of reports submitted to/Serious Incidents reports and	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective	0		0		0		0		0		0		0		0	
69	Transfusion of ABO incompatible blood components	>0	Review of reports submitted to NRL /Serious Incidents reports and	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective	0		0		0		0		0		0		0		0	

Clinical Commissioning Group (CCG) Performance and Quality Schedule 2013/2014

No.	Operational Standards	Threshold (2013/14)	Method of Measurement (2013/14)	Consequence of Breach	Quarter 1		Quarter 2		Quarter 3		January		February		March		Quarter 4		Year to Date	
					Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
70	Transplantation of ABO incompatible organs as a result of error	>0	Review of reports submitted to NRLS/Serious Incidents reports and	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective	0		0		0		0		0		0		0		0	
71	Misplaced naso- or oro-gastric tubes	>0	Review of reports submitted to NRLS/Serious Incidents reports and	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective	0		0		0		0		0		0		0		0	
72	Wrong gas administered	>0	Review of reports submitted to NRLS/Serious Incidents reports and	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective	0		0		0		0		0		0		0		0	
73	Failure to monitor and respond to oxygen saturation	>0	Review of reports submitted to NRLS/Serious Incidents reports and	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective	0		0		0		0		0		0		0		0	
74	Air embolism	>0	Review of reports submitted to NRLS/Serious Incidents reports and	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective	0		0		0		0		0		0		0		0	
75	Misidentification of Patients	>0	Review of reports submitted to NRLS/Serious Incidents reports and	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective	0		0		0		0		0		0		0		0	
76	Severe scalding of Patients	>0	Review of reports submitted to NRLS/Serious Incidents reports and	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective	0		0		0		0		0		0		0		0	
	MATERNITY																			
77	Maternal death due to post-partum haemorrhage after elective caesarean section	>0	Review of reports submitted to NRLS/Serious Incidents reports and	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective	0		0		0		0		0		0		0		0	

No.	Goal and Indicator	Weighting	Required Performance	Quarter 1 Total			Quarter 2 Total			Quarter 3 Total			January			February			March			Quarter 4 Total			Comments
				num	den	%	num	den	%	num	den	%	num	den	%	num	den	%	num	den	%	num	den	%	
1	**FRIENDS AND FAMILY TEST**																								
1.1	Friends and Family Test: phased expansion	1.5%	Roll out to Maternity October 2013	Quarter 3 and Quarter 4			Quarter 3 and Quarter 4			515	2100	24.5%	196	744	26.3%	170	720	23.6%	161	703	22.9%	527	2167	24.3%	Rolled out to Maternity (maternity numbers)
1.2	Friends and Family Test: increased response rate	2.0%	Q1 15% Q4 20%	1735	11545	15.0%	2492	12321	20.2%	2458	11781	20.9%	655	3755	17.4%	672	3484	19.3%	1018	3976	25.6%	2345	11215	20.9%	Excluding Maternity
1.3	Friends and Family Test: improved performance on the staff Friends and Family Test	1.5%	Annual Staff Survey	Annual Reconciliation			Annual Reconciliation			Annual Reconciliation			Annual Reconciliation												
2	**NHS SAFETY THERMOMETER**																								
2.1	NHS Safety Thermometer: Improvement in Pressure Ulcers	5.0%	6.6%	114	1356	8.4%	101	1302	7.8%	101	1339	7.5%	33	487	6.8%	36	499	7.2%	32	519	6.2%	101	1505	6.7%	Discussion required regarding split between hospital and community acquired
3	**DEMENTIA**																								
3.1	Dementia; find assess, investigate & refer																								
3.1.1	A&E admitted Patients >75 know to have dementia or delirium	3.0%	90%	623	811	76.8%	562	651	86.3%	707	817	86.5%	238	303	78.55%	209	272	76.8%	220	288	76.4%	667	863	77.3%	Requirement to achieve an average of 90% or greater in each of the three elements each month for any three consecutive months (delivered September, October and November).
3.1.2	Diagnostic assessment including investigation		90%	116	171	67.8%	117	143	81.8%	127	181	70.2%	39	82	47.56%	21	57	36.8%	27	61	44.3%	87	200	43.5%	
3.1.3	Referred for further diagnostic advice		90%	5	8	62.5%	13	17	76.5%	8	8	100.0%										1	1	100.0%	
3.2	Dementia: clinical leadership	0.5%	Annual evidence	Annual Reconciliation			Annual Reconciliation			Annual Reconciliation			Achieved												
3.3	Dementia: supporting carers of people with Dementia	1.5%	Monthly audit of carers (bi-annual)	Quarter 2 and Quarter 4			Achieved			Report due Quarter 4			Achieved (Subject to CCG approval)												
4	**VTE**																								
4.1	VTE: Risk Assessments	2.5%	95%	11933	12465	95.7%	12462	12882	96.7%	12605	12864	98.0%	4552	4723	96.4%	4165	4267	97.6%	4003	4207	95.2%	12720	13197	96.4%	
4.2	VTE: root cause analysis	2.5%	6 RCAs conducted each quarter	10	10	100.0%	15	15	100%	9	9	100%	Quarterly reconciliation									6	6	100%	
5	**AMBULATORY CARE**																								
5.1	Ambulatory care patients seen	48.0%	1500 patients seen in ambulatory care (annual)			585			560			631			252			204			229			685	Year to date 2461
5.2	Proportion of patients where contact made to agreed care environment and not admitted	32.0%	20%/450 cases resulting in no admission (annual)	121	386	31.3%	155	493	31.4%	168	460	36.5%	93	201	46.3%	81	189	42.9%	TBC	TBC	TBC	174	390	44.6%	Year to date 618 / (35.7%)


18 Weeks RTT Admitted Backlog
70
60
50
40
30
20
10
0
21
48
64
29
35
29
32
28
27
18
26
26
66
52
31/01/2013:
28/02/2013:
29/04/2013:
30/05/2013:
27/06/2013:
27/07/2013:
31/08/2013:
26/09/2013:
08/11/2013:
28/11/2013:
31/12/2013:
30/01/2014:
27/02/2014:
31/03/2014:
Total Number of Backlog Patients