West Hertfordshire Hospitals NHS
NHS Trust

2009/10 Quality Account Update Report

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- **Distribution:** Quality Accounts Steering Group, Clinical Quality and Governance Committee, Clinical Policy and Practice Group, Divisional Boards, Trust Board.

Contents

1. Background

High Quality Care for All – The Next Stage Review (June 2008) set out the move from an NHS that had rightly focused on increasing the quantity of care to one that now focuses on improving the quality of care.
The ambition of the next stage of the NHS's journey is to achieve the vision of an NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart.

The Next Stage Review defines the three domains of quality as:

- Patient safety;
- Patient experience;
- Effectiveness of care.

Monitor and NHS EoE required all NHS foundation trusts and all NHS providers in the East of England to produce quality reports in 2009.

2. 2009/10 priorities

Appendix A

West Hertfordshire Hospitals NHS Trust
Quality Report 2008/09

1. Introduction

NHS organisations across the East of England are required to prepared Quality Reports for the 2008/09 year for inclusion in their annual reports in advance of the legal requirement to produce a Quality Account from April next year, subject to legislation. West Hertfordshire has prepared its Quality Report taking account of the advice provided by the Department of Health. It has identified the key indicators of quality that are thought will be required at a national level together with those that provide information at a local level on the quality of the Trust's services.

Section One

An Over View of Quality in the Trust

The Trust has achieved much in the last year to improve the quality of care for patients.
Over the last year the Trust has made significant progress in a number of areas that impact on the overall quality of the services we provide. By placing a significant emphasis on reducing hospital acquired infection the Trust has delivered on its commitment to reduce the number of MRSA bacteraemias and levels of clostridium difficile. The Trust is now one of the best performing Trusts in the country in respect of CDiff, with the biggest reduction in the number of reportable cases than almost any other Trust. MRSA bacteraemias have been reduced in 2008/09, with only 13 being identified this year compared with 37 the previous year. These improvements are a consequence of hard work and dedication of our staff and responding to the feedback from our patients about the importance of making sure the hospitals are as near to infection free as we can make them. For the Trust this focus has been our number one priority in terms of improving the quality of care we provide within a safe patient environment. We will not reduce our vigilance in this as we aim to further improve our performance.

The Trust opened the new Acute Admissions Unit in March 2009 which provides a purpose built unit for the assessment and treatment of patients that are only likely to need a short stay in hospital. It provides for rapid assessment by a consultant led team who can make quick decisions about a patient's condition. This has greatly improved the overall quality of service we can provide to people and ensures that they do not stay in hospital longer than they need to.

The Trust continues to maintain one of the lowest peri-natal mortality rates in the country whilst being one of the busiest maternity units. In the last year more midwives and consultants have been appointed to further improve the services available.

The Trust still has things it wants to achieve and improve upon. Ensuring that patients only stay in hospital for as long as absolutely necessary and that good arrangements are in place when they are discharged is something we need to work

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In response, our *2009/10 Quality Account* was approved at the July 2009 Trust Board. In summary:

- The Trust Board agreed the following priorities for 2009/10 in respect of qualitative improvements that it wishes to see -

- **Priority 1:** To reduce further the numbers of patients who contract a MRSA bacteraemia or C-Diff in line with the aspirational targets set by the PCT.
- **Priority 2:** To continue to deliver services with a lower mortality level than would be expected for the patients we see and conditions we treat (a standardised mortality rate below 100 for all clinical divisions).
- **Priority 3:** increase the percentage of people who, through the national in-patient survey and other in house surveys, indicate that they have had a positive experience in respect of communication and privacy and dignity aspects of their care

- The Trust chose to measure performance against three groups of indicators; clinical indicators, patient indicators; and national requirements. The indicators are listed below -

Clinical indicators

- Peri-natal mortality
- Fractured Neck of Femur
  - Pre-operative length of wait
  - Post operative readmission rate
  - Mortality within 30 days of discharge
- Readmission rates with 28 days (medical and surgical)
- Hospital acquired grade 3 or 4 pressure ulcers
- Levels of Hospital Acquired Infection

Patient indicators

- Cancelled operations
- Average waiting time in A&E
- Telephone contact with patients
- Waiting time to see a healthcare professional

National requirements

- C Diff year on year reduction
- MRSA Target
- Cancer - 31 days from decision to start of treatment
- Cancer - 31 days
- Cancer - 62 days from referral to start of treatment
- 18 week - Admitted patients
- 18 week - Non-Admitted patients
- A&E - 4 hours target
- Urgent GP Cancer referral - Max 2 week wait
- National Core Standard non-compliance

3. Progress against priorities as at December 2009

3.1. **Priority 1:** To reduce further the numbers of patients who contract a MRSA bacteraemia or CDiff in line with the aspirational targets set by the PCT

Table 1 summarises our progress, as at December 2009, on implementing the priority 1 actions and initiatives detailed in our *2009/10 Quality Account.*

Table 1: Progress on reducing further the numbers of patients who contract a MRSA bacteraemia or C-Diff in line with the aspirational targets set by the PCT (Priority 1) as at December 2009

	Actions and Initiatives to be taken in 2009/10	Progress as at December 2009
1.	To consolidate the isolation facilities into a single ward	Isolation facilities consolidated on Letchmore Ward. Policy in place for those patients not meeting the criteria for Letchmore Ward to be isolated in single rooms on other wards.
2.	To implement MRSA screening for all planned surgery	Monthly performance monitored as part of the NHS East of England Provider Management Regime. We have not achieved 100%* for the current financial year to date. November 2009 performance was 93.6%.
3.	To take corrective action in instances where best practice is not being followed	Infection Control team, working in partnership with clinical leads, review clinical practice as part of day to day operations. Concerning elective screening, policy is being reviewed in order to achieve 100% elective screening across the Trust's clinical divisions.
4.	To continue to learn from the outcomes of root cause analyses undertaken on all cases reported in year	For every instance of MRSA bacteremia, route cause analysis is completed, actions plans are developed, which reflect the learning outcomes that need to be embedded in our day to day practice. In cases of hospital acquired C-diff, the microbiologist undertakes root cause analysis.

*With the exception of: day case ophthalmology; day case dental; day case endoscopy; minor dermatology procedures; children/paediatrics unless already in a high risk group; maternity/ obstetrics except for elective caesareans and any high risk cases; and mental health patients.

3.2. Priority 2: To continue to deliver services with a lower mortality level that would be expected for the patients we see and conditions we treat (a standardised mortality rate below 100 for all clinical divisions)

Table 2 summarises our progress, as at December 2009, on implementing the priority 2 actions and initiatives detailed in our *2009/10 Quality Account.*

Table 2: Progress on continuing to deliver services with a lower mortality level that would be expected for the patients we see and conditions we treat (Priority 2) as at December 2009

	Actions and Initiatives to be taken in 2009/10	Progress against priorities as at December 2009
1.	To continue to maintain performance in those specialties where mortality is low	- Mortality level data by specialty circulated monthly to divisional directors and divisional managers. Any score above 100 to be reviewed by clinical subspecialty lead and divisional director and manager. - Proforma to be developed, to detail actions arising from the meeting, and to be signed by Divisional Director and Clinical Lead. Divisional manager logs and returns to clinical governance manager. Update on log and associated actions reviewed by Divisional Board. Clinical governance manager collates cross divisional report, which is presented to the Clinical Governance Committee for review.
2.	To review performance in those specialities where performance is above peer group average and take appropriate actions in line with best practice to reduce levels of mortality	
3.	To engage with the clinical body across the Trust to ensure that they continually monitor mortality data within their teams	

3.3. Priority 3: Increase the percentage of people who, through the national in-patient survey and other in house surveys, indicate that they have had a positive experience in respect of communication and privacy and dignity aspects of their care

Table 3 summarises our progress, as at December 2009, on implementing the priority 3 actions and initiatives detailed in our *2009/10 Quality Account.*

Table 3: Progress on increasing the percentage of people who, through the national in-patient survey and other in house surveys, indicate that they have had a positive experience in respect of communication and privacy and dignity aspects of their care (Priority 3) as at December 2009

	Actions and Initiatives to be taken in 2009/10	Progress against priorities as at December 2009
1.	To reconfigure ward areas to ensure that they comply with national requirements for separate bathroom and toilet facilities for men and women in areas adjacent to their bedded bays	- A dedicated weekly Delivering same Sex Accommodation (DSSA) 'Task and Finish' Project Group was established to monitor and ensure that the work programme based on the DoH Definition of Same Sex Accommodation (May 2009) was completed by 30th June 2009. - The programme involved the refurbishment of over 100 bathrooms in 16 operational wards, on 3 sites over a 9 week period, while mitigating against the loss of side rooms (and reduction in bed capacity); changes to operational processes; noise impacts and dust impacts resulting from the works. - The programme was successfully completed on the 23rd June 2009. 29 clinical areas are now compliant. - Phase 2 of the programme is focusing on the remaining non-compliant areas, which include A/E department, Endoscopy Unit, Day surgery Unit, Respiratory, Cardiac and Stroke high dependency areas and the imaging departments. - This phase focuses strongly on service redesign, innovative ways of working to address gender flow and sustainable change. The aim is for all areas to be compliant in accordance with the DoH's end of March 2010 deadline. - The key challenges to the achievement of full compliance with DSSA by March 2010 are the Day Surgery Unit at SACH, Watford Radiology and the A&E Department at Watford. Provided sufficient capital is made available before the end of January 2010 it is expected that the Trust will be compliant against the Department of Health DSSA directive by March 2010. - Phase 3 is planned for April 2010 focusing on sustainability, compliance monitoring and promoting a culture, which promotes dignified care.

2.	To roll out the pilot project of calling people 48 hours after discharge to discuss their experience and any issues arising	- In November 2008 we established a project to call patients 48 hours after their discharge. This was initially focussed on two medical wards. It has since been extended to cover eight wards including levels 1 & 3 on the Acute Admissions Unit (AAU) given the high volume of patients discharged directly from the AAU. This has identified areas of both good practice and where improvements are needed. - Joint work in January 2010 had been to align the 48hr calls to support the Releasing Time to Care Initiative (RTTC) initiative and therefore there are plans to incorporate telephoning patients, carers and parents of children/young people discharged from Starfish ward. Previously Cassio, Aldenham and Langley had been part of the discharge project and data previously collected will be used to benchmark the RTTC initiative. - The wards currently being telephoned for the 48hr discharge are now Starfish, Cleves, Croxley, Discharge Lounge and both levels 1 & 3 of the Acute Admissions Unit (AAU). - Both positive and negative comments are fed back to the appropriate Divisional Managers, Ward Clerks and Ward Managers. - Weekly reports are highlighted at the Chief Executive's meetings with trends and themes discussed. This is also an opportunity to audit that all patients are receiving the 'pink' hospital discharge leaflets.
3.	To utilise data from the Patient Experience Trackers to improve services based on patient feedback	- Fifteen Patient Experience Trackers (PET) were introduced into the Trust on 18th July 2008 in OPD's, UCC, Maternity, AAU levels 1 & 3 and wards Trust-wide. - Each PET is allocated five questions referenced to the key themes highlighted National Inpatient/Outpatient surveys - Each PET has a ward/department lead. Monthly meetings are held with leads, together with a representative from Dr. Foster and Medirest. - Weekly electronic data is received into the Trust and feedback is given to leads, Divisional/Ward Managers and Matrons. - Quarterly data is also presented through the Complaints, Litigation, Incidents & PALS Report (CLIP) to the Trust Board, giving trends and themes - Feedback from the trackers are highlighted by the Wards and Departments to patients, the public and staff by their recording onto wall charts how they have improved or where there are still areas for improvement and how they plan to take those actions forward. - Monthly meetings are carried out with the PET Leads, together with a Dr. Foster representative and the Medirest management and the Director of Hotel Services. Examples of listening to the patient's feedback through the results has seen improvements to the way we provide food, and how staff communicate with patients.

4.	To provide better communications training for all staff through the Leadership Academy	- In May 2009, staff and practitioners from across the Trust met to discuss how to create a more aligned approach to the design and delivery of communication skills development programmes. An outcome of this event, is that all communications skills training is aligned, or being aligned to the Trust Pledge. Work is continuing to build a framework for coordinating development offers. Improving the quality of the patient and staff experience underpins all Leadership Academy activities. - The Leadership Academy offers accredited programmes at certificate, degree and Masters level together with support to staff to deliver service improvements. Individual support is underpinned by coaching and mentoring. The Academy also hosts conferences, networking events and workshops, all of which have a focus upon service improvements, communications and patient experience. - In January 2010, a new corporate welcome (induction) programme is being launched with a focus on quality standards, improving the patient and staff experience. - In April 2010, we will be launching a new competency framework, the Passport to Practice, that will progressively align with staff appraisals and personal development plans. The Passport to Practice is a framework of core competencies and development, built around the six core *NHS Knowledge and Skills* dimensions that includes communications. The aim is that all staff work towards and evidence achievement of competency in the core standards appropriate to their role. - In April 2010, we will be launching a new Leadership Academy intranet site. This will be the hub for information, advice and learning resources.

3.4. Progress against quality metrics

Table 4 summarises our progress, as at December 2009, against the clinical indicators as detailed in our *2009/10 Quality Account.*

Table 4: Progress against clinical indicators as at December 2009

		2008-09				2009-10			
	Source	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Clinical Indicators									
Perinatal deaths	S Clarke	7	8	5	9	7	8		
Total births (live + still)	S Clarke	1494	1455	1438	1342	1456	1400		
Perinatal mortality rate per 1,000 births (2008 UK = 7.6, EoE = 6.5)	ratio	4.7	5.5	3.5	6.7	4.8	5.7		
Fractured neck of femur - % operation < 48 hours (excludes patients no operation)	iReporter	62.5%	73.9%	80.7%	78.5%	73.8%	67.2%	69.8%	
Fractured neck of femur - post-operative re-admission rate within 28 days	iReporter	12.5%	17.1%	10.7%	17.5%	13.5%	8.6%	16.9%	
Fractured neck of femur - mortality within 30 days of admission (target < 10%)	iReporter	6.4%	8.8%	8.5%	10.0%	8.6%	11.3%	2.7%	
Re-admission rates within 28 days - medical	CHKS	7.2%	7.5%	5.5%	6.3%	6.8%	6.7%	6.2%	
Re-admission rates within 28 days - medical - CHKS peer group	CHKS	9.3%	5.9%	9.1%	8.3%	9.1%	8.0%	7.0%	
Re-admission rates within 28 days - surgical	CHKS	2.6%	3.0%	2.6%	2.1%	3.0%	3.2%	2.8%	
Re-admission rates within 28 days - surgical - CHKS peer group	CHKS	4.6%	4.5%	4.3%	4.1%	4.4%	4.1%	3.4%	
Hospital acquired pressure ulcers - grade 3 or 4 (count of ulcers rather than patients)	P Gilroy	7	14	11	6	7	7		
Hospital acquired infection - MRSA bacteremia	D Dover	4	4	2	3	2	2	2	
Hospital acquired infection - Clostridium difficile	D Dover	20	11	22	10	17	14	11	
Standardised mortality rate - risk adjusted mortality 2008 - Trust	CHKS	83	85	71	75	68	56	60	
Standardised mortality rate - risk adjusted mortality 2008 - Peer group	CHKS	85	81	87	86	72	70	74	

Trend graphs are provided in **Appendix A**.

Table 5 summarises our progress, as at December 2009, against the patient indicators as detailed in our *2009/10 Quality Account.*

Table 5: Progress against patient indicators as at December 2009

Patient Indicators	Source	2008-09 Q1	2008-09 Q2	2008-09 Q3	2008-09 Q4	2009-10 Q1	2009-10 Q2	2009-10 Q3	2009-10 Q4
Cancelled operations - all (at pre-op assessment)	iReporter	1070	1194	918	1111	813	849	1032	
Cancelled operations - on day of admission - number	QMCO	175	92	131	129	67	108	94	
Elective admissions (general & acute FFCEs)	MMR	8908	8486	9103	8910	9178	9836	9356	
Cancelled operations - all - % of elective admissions		12.0%	14.1%	10.1%	12.5%	8.9%	8.6%	11.0%	
Cancelled operations - on day of admission - % of elective admissions (target < 0.8%)		1.96%	1.08%	1.44%	1.45%	0.73%	1.10%	1.00%	
Waiting time in A&E - % <= 4 hours (target >=98%)	QMAE	99.2%	98.8%	97.4%	96.7%	98.4%	98.4%	96.9%	
Telephone contact with patients - % calls being answered by ContactPortal within 30 secs	J Jones						100.0%	100.0%	
Average waiting time from GP referral to first outpatient attendance (weeks)	iReporter	4.4	4.8	4.8	4.9	5.1	5.4	5.4	
Average waiting time from direct access GP referral to diagnostic test (weeks)	A Webb	3.7	3.8	3.5	2.9	3.3	2.9	3.5	

Table 6 summarises our progress, as at December 2009, against the national requirements as detailed in our *2009/10 Quality Account.*

Table 6: Progress against the national requirements as at December 2009

	Source	2008-09 Q1	2008-09 Q2	2008-09 Q3	2008-09 Q4	2009-10 Q1	2009-10 Q2	2009-10 Q3	2009-10 Q4
					New cancer definitions and targets from Jan 2009				
Cancer - 14 days from urgent GP referral to first outpatient attendance (new target 93%) - Trust	Open Exeter	99.9%	100.0%	99.9%	94.0%	92.4%	93.4%	92.4%	
Cancer - 14 days from urgent GP referral to first outpatient attendance (new target 93%) - England	Open Exeter	99.9%	99.7%	99.8%	94.5%	94.1%	94.4%		
Cancer - 31 days from decision to start of treatment (new target 96%) - Trust	Open Exeter	100.0%	100.0%	100.0%	98.9%	97.9%	97.2%	98.7%	
Cancer - 31 days from decision to start of treatment (new target 96%) - England	Open Exeter	99.6%	99.6%	99.5%	98.2%	98.1%	98.0%		
Cancer - 62 days from referral to start of treatment - (new target 85%) Trust	Open Exeter	99.3%	99.7%	100.0%	95.9%	86.2%	88.9%	91.5%	
Cancer - 62 days from referral to start of treatment (new target 85%) - England	Open Exeter	97.1%	96.9%	96.9%	91.5%	86.0%	85.7%		
18 week referral to treatment - admitted patients (target 90%) - Trust	18 week	85.6%	85.7%	86.5%	93.5%	92.2%	94.4%	92.8%	
18 week referral to treatment - admitted patients (target 90%) - England	18 week	87.8%	89.9%	91.1%	92.7%	92.4%	93.2%		
18 week referral to treatment - non-admitted patients (target 95%) - Trust	18 week	96.5%	98.2%	98.8%	99.1%	99.0%	98.7%	98.4%	
18 week referral to treatment - non-admitted patients (target 95%) - England	18 week	93.7%	95.4%	96.6%	97.3%	97.7%	97.7%		

Trend graphs are provided in **Appendix B**.

4. Outstanding issues and risks

Tables 7 and 8 summarise the outstanding issues and risks and our mitigation plans for the three priority areas detailed in our our *2009/10 Quality Account,* as at December 2009.

Table 7: Priority 1 and Priority 2 outstanding issues and risks

Priority	Outstanding issues and risks	Mitigation	By when	Lead
Priority 1: To reduce further the numbers of patients who contract a MRSA bacteraemia or CDiff in line with the aspirational targets set by the PCT	Delivery of MRSA elective screening target (From April 2009, all elective admissions must be screened for MSRA in line with Department of Health guidance) Looking forward a key issue for 2010/11 will be the 'screening of all relevant emergency admissions for MRSA as soon as possible – and definitely by 2011' (*The Operating Framework for the NHS in England 2010/11*)	Infection Control Committee Weekly Chief Executive Performance Reviews	Quarter 4 2009/10	Dr Johnston, Medical Director
Priority 2: To continue to deliver services with a lower mortality level that would be expected for the patients we see and conditions we treat (a standardised mortality rate below 100 for all clinical divisions).	In instances of a score above 100 review to be undertaken by clinical subspecialty lead and divisional director and manager. For actions arising to be collated, reported, and monitored at divisional level and corporate clinical governance forums.	Governance and Risk Team to develop and embed reporting process.	By Quarter 1 2010/2011	Dr Johnston, Medical Director

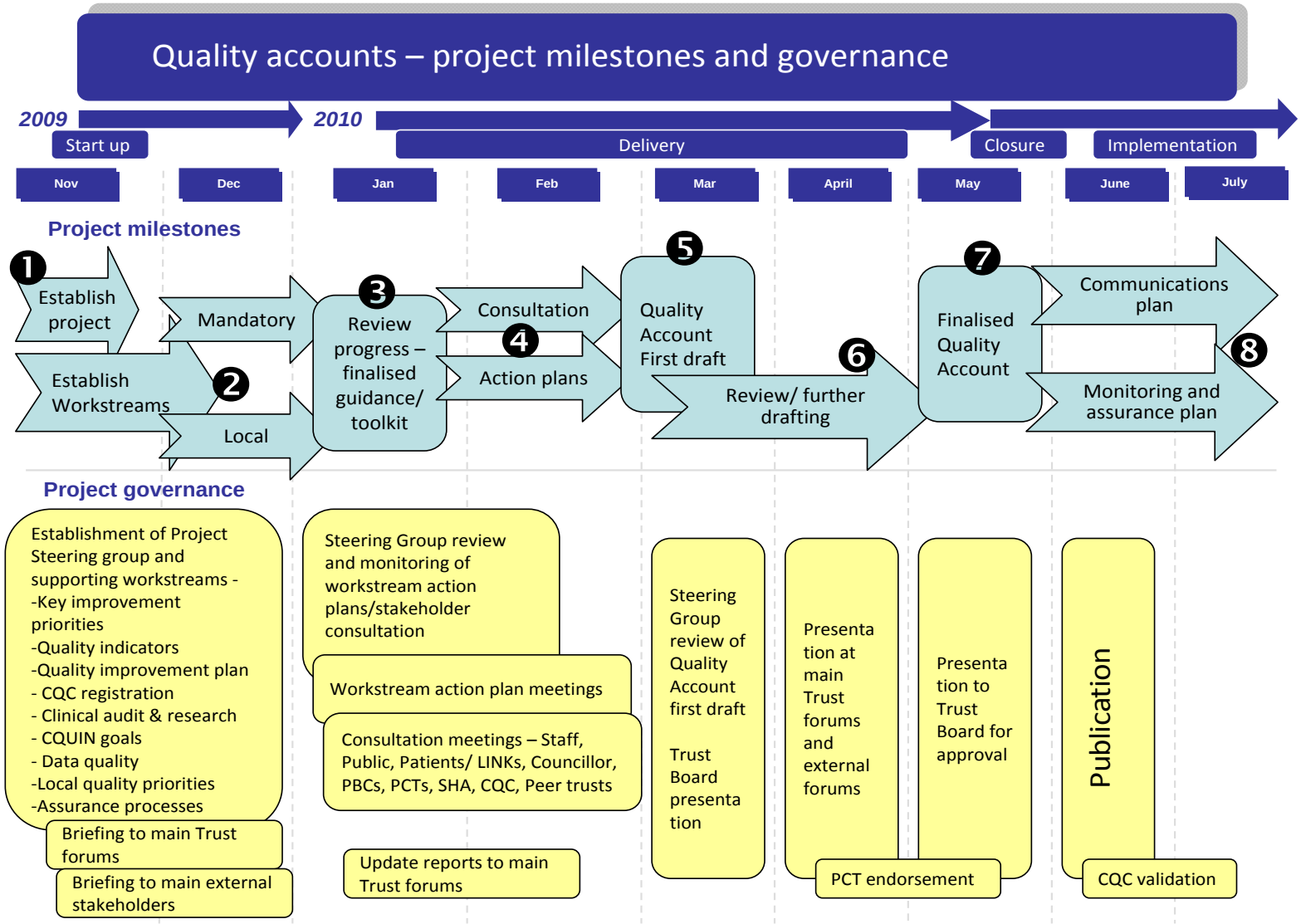
Table 8: Priority 3 outstanding issues and risks

Priority	Outstanding issues and risks	Mitigation	By when	Lead
Priority 3: Increase the percentage of people who, through the national in-patient survey and other in house surveys, indicate that they have had a positive experience in respect of communication and privacy and dignity aspects of their care	Privacy and Dignity - DSSA - Financial penalties for failure to provide same sex accommodation from 1st April 2010 - Construction works could impact on operational delivery of target - 100% same sex accommodation compliance by March 2010 is subject to capital funding being available for current non-compliant areas. Improving our patient survey scores - We have now established a number of in house information gathering systems to compliment the national patient surveys. Analysis of this information has resulted in a number of key improvement initiatives. We need to ensure that initiatives are sustainable and continue to improve in line with ongoing feedback.	- Phase 2 Delivering Same Sex Accommodation Task and Finish Group meeting fortnightly to drive and monitor progress - Monthly DSSA audit - Reporting of decision to mix when not clinically justified reported on weekly -cause and mitigating actions reviewed - Monthly report of all reported decisions to mix - Clinical leads consulted and involved in all decision making - Visit by PCT 27th October 2009 communicated the Trusts DSSA achievements and current challenges to 100% compliance by March 2010 - Ongoing engagement and consultation with PCT DSSA lead - Lead Nurse ICU coordinating introduction dignity gowns across the Trust - Investment in portable screens to support privacy and dignity when clinical decision to mix is made - Patient Survey Steering Group - Ongoing implementation of the Trust's Pledge - Dedicated workstreams to address identified high risk areas - Roll out of individualised follow up calls to all within 48 hours of discharge to embed a culture of continuous learning	Quarter 4 2009/10 Ongoing programme	Tracy Moran, Interim Director of Nursing

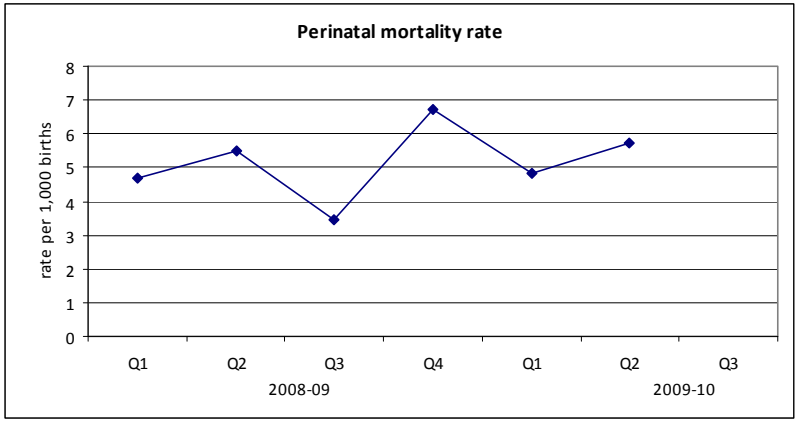
5. Development of our 2010 quality account

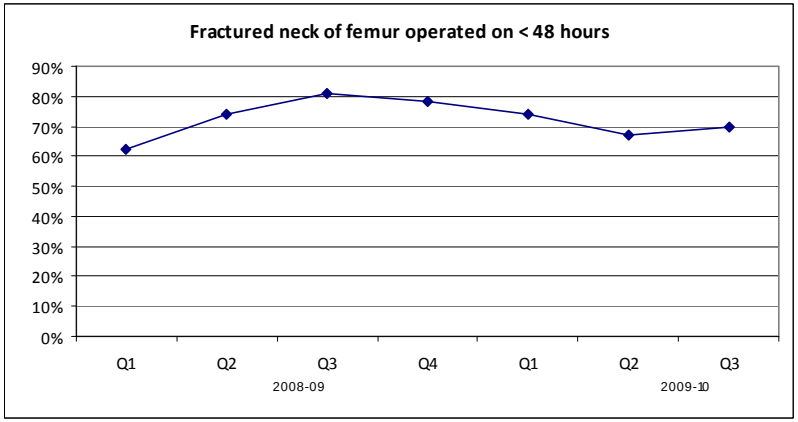
Quality accounts will be a core NHS priority in 2010. In response we have established a Steering Group constituted of the Chief Executive, Medical Director, Director of Partnerships, Director of Nursing and Midwifery, and the Head of Planning and Performance.

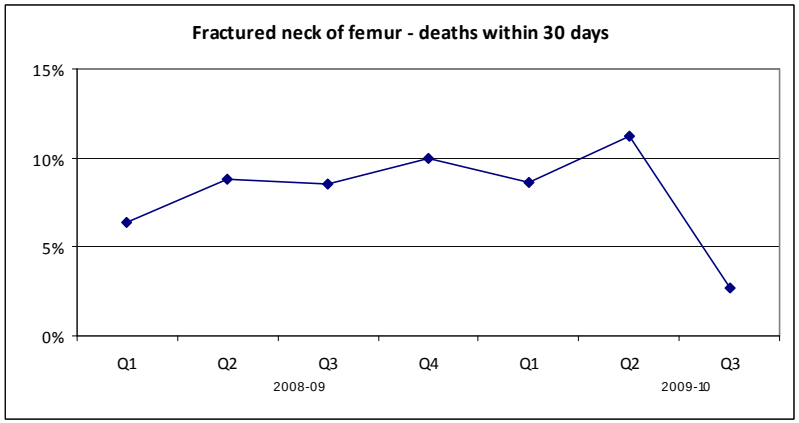
Our project milestones are highlighted opposite.

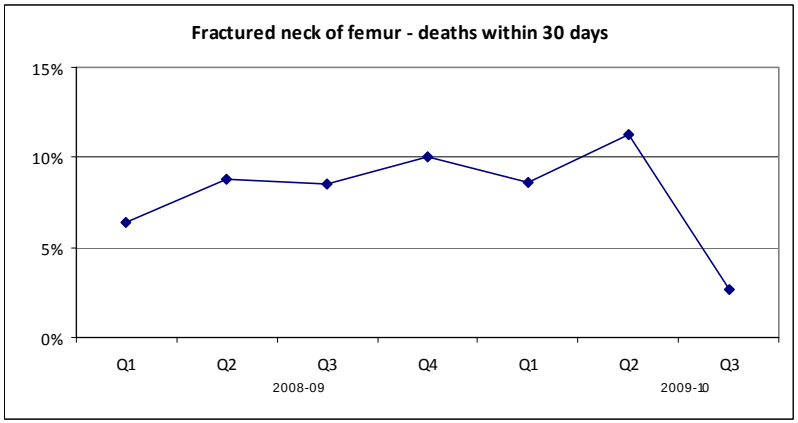


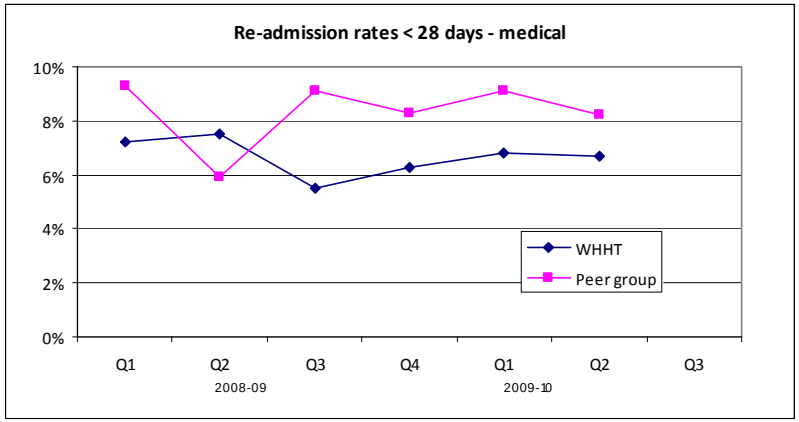
Appendix A – Clinical indicators trend graphs

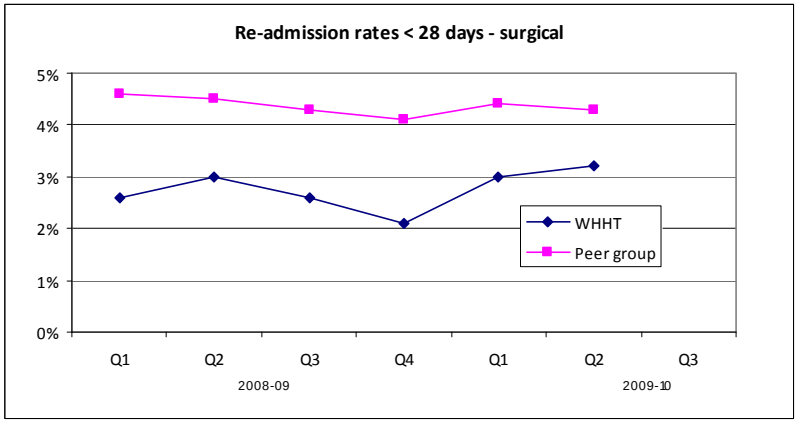


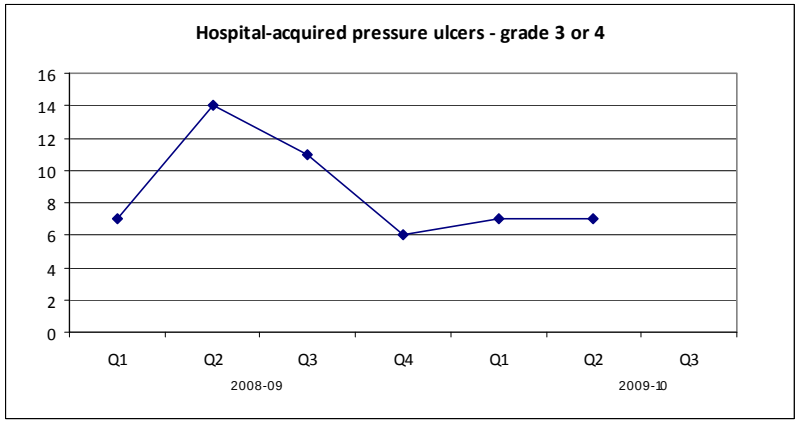


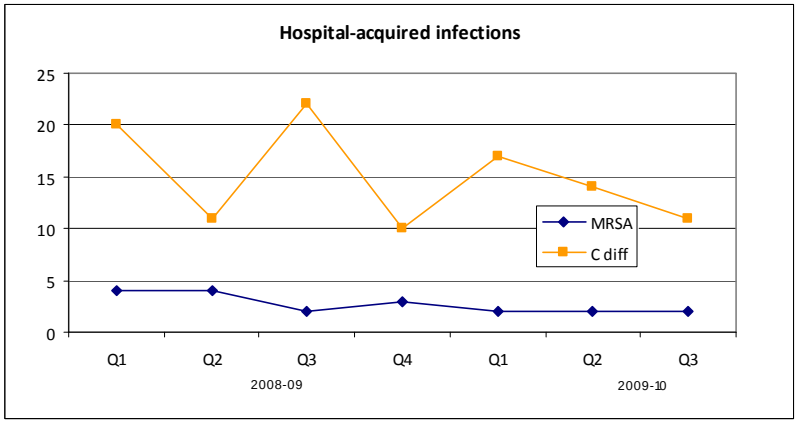





Re-admission rates < 28 days - medical
10%
8%
6%
4%
2%
0%
WHHT
Peer group
Q1
Q2
Q3
Q4
Q1
Q2
Q3
2008-09
2009-10


Re-admission rates < 28 days - surgical
5%
4%
3%
2%
1%
0%
WHHT
Peer group
Q1
Q2
Q3
Q4
Q1
Q2
Q3
2008-09
2009-10


Hospital-acquired pressure ulcers - grade 3 or 4
16
14
12
10
8
6
4
2
0
Q1
Q2
Q3
Q4
Q1
Q2
Q3
2008-09
2009-10


Hospital-acquired infections
25
20
15
10
5
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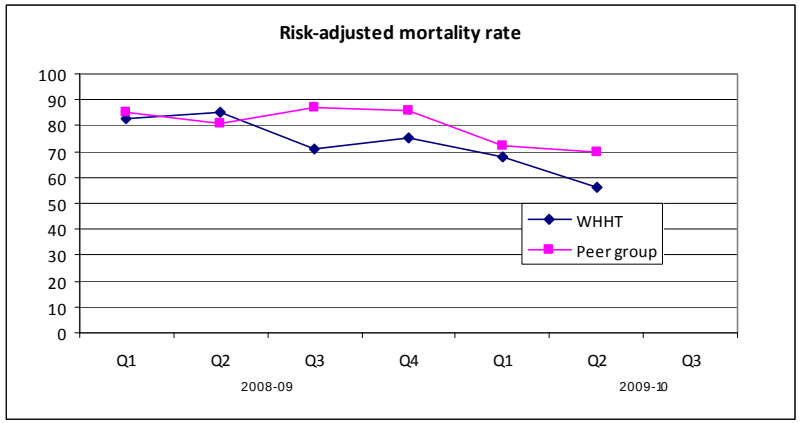
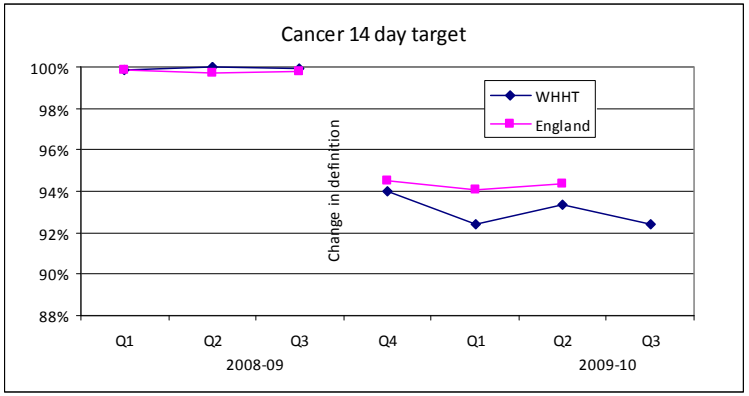
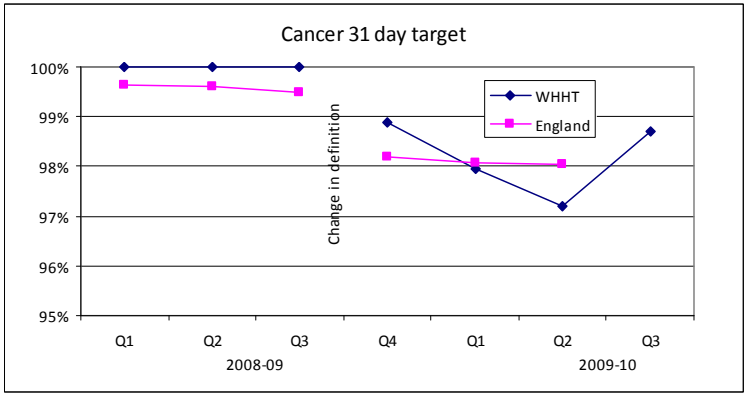
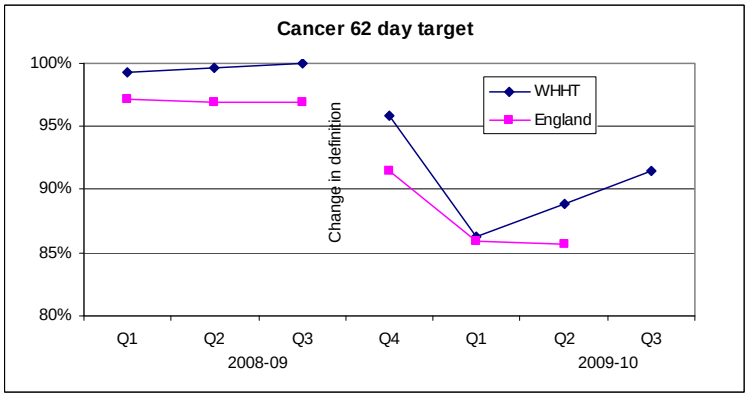
MRSA
C diff
Q1
Q2
Q3
Q4
Q1
Q2
Q3
2008-09
2009-10

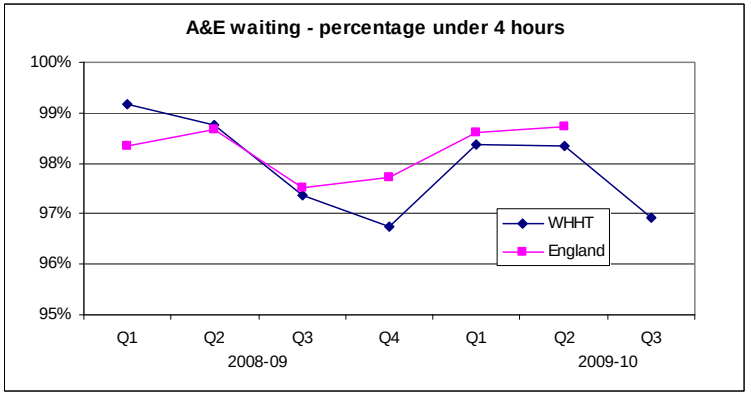

Risk-adjusted mortality rate
100
90
80
70
60
50
40
30
20
10
0
Q1
Q2
Q3
Q4
Q1
Q2
Q3
2008-09
2009-10
WHHT
Peer group

Appendix B – National requirements trend graphs









- Cancer 14 day target (Old target: 99%, New target: 93%)

Under the old definition only breaches that were caused by our Trust were reportable. The new definition (Jan 09) all breaches are reportbale except for DNA's. At WHHT the issue remains the volume of patients who decline first offer. Since our capacity does not allow us to book patients at the beginning of their journey, we offer the first appt towards the day 14. Hence, when patients cannot accept the first offer, the alternative falls outside of the 14 days and they are declared as breaches.

- Cancer 31 day target (Old target: 98%, New target: 96%)

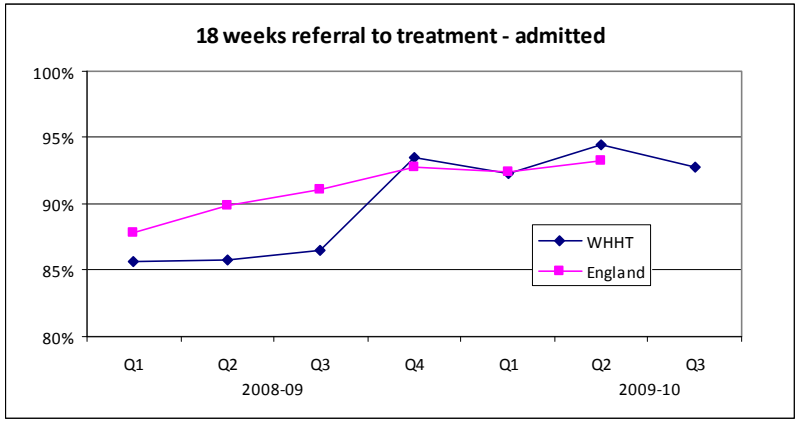
The Trust continues to achieve the 31 Day target as it did for most of the time under the old definition. The target is measured from decision to treat to first definitive treatment.

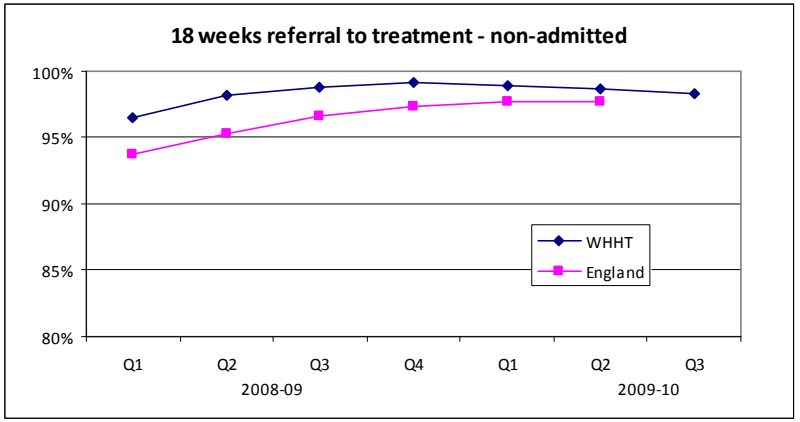
- Cancer 62 day target (Old Target: 95%, New target: 85%)

Under the old definition, the clock stopped

- if a patient chose not to have their treatment at the offered date
- if the patient was unsuitable for treatment due to medical reasons
- any breaches due to hospital reasons i.e lack of capacity.

Under the new definition, only (admitted) patients who chose to defer treatment for personal reasons are exempt. All other reason such as capacity, medical suspension, **patients choice to delay their diagnostic tests are reportable as breaches.**


18 weeks referral to treatment - admitted
100%
95%
90%
85%
80%
Q1
Q2
Q3
Q4
Q1
Q2
Q3
2008-09
2009-10
WHHT
England


18 weeks referral to treatment - non-admitted
100%
95%
90%
85%
80%
Q1
Q2
Q3
Q4
Q1
Q2
Q3
2008-09
2009-10
WHHT
England

Version	Date	Circulation and Review:
V0.1 to 0.8	3rd December 2009 to 15th January 2010	Drafting with divisional and corporate leads
V0.8, v0.9	15th January 2010	Reviewed by the 18th January 2010 Quality Accounts Steering Group
V1.0/V1.1	18th January 2010	Finalised version submitted for inclusion in January 2010 Trust Board papers - V1.0 date error updated > v1.1.