

## EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
<p><b>Quality and Patient Standards Performance Report – May 2010</b></p>	<p>Trust Board</p>
1. PURPOSE:	REVIEWED BY (BOARD/COMMITTEE) and DATE:
<p>The Quality and Patient Standards Performance Report provides an analysis of performance against trajectory and Trust-wide targets for the following domains:</p> <ol style="list-style-type: none"> <li>1. CQC Periodic Review 2009/10 &amp; 2010/11 Registration</li> <li>2. Department of Health Performance Framework 2009/10 and 2010/11</li> <li>3. DH Framework Performance Targets</li> <li>4. Other Performance Indicators</li> <li>5. Contractual Key Performance Indicators (KPIs) and Commissioning for Quality and Innovation (CQUIN) Schedule</li> </ol> <p>Areas where performance is of concern for the month and are discussed within the report are as follows:</p> <ul style="list-style-type: none"> <li>• Four-Hour Maximum Wait In A&amp;E From Arrival To Admission, Transfer Or Discharge</li> <li>• 18 Weeks - Individual Specialties Not Achieving</li> <li>• 62 Days Urgent Referral To Treatment Of All Cancers</li> <li>• Delayed Transfers Of Care</li> <li>• Mortality</li> <li>• Length of Stay</li> <li>• First to Follow Up Ratios</li> <li>• DNA Rates</li> <li>• Day Case Rates (Basket of 25 Procedures)</li> <li>• Re-admission Rates</li> <li>• Freedom of Information</li> <li>• Data Quality Issues</li> <li>• MRSA Screening</li> </ul> <p>This report includes the key actions that are being undertaken to bring performance back in line with trajectory or target.</p>	<p> <input type="checkbox"/> PEQ.....      <input type="checkbox"/> STRATEGY.....  <input type="checkbox"/> FINANCE .....      <input type="checkbox"/> AUDIT .....  <input type="checkbox"/> CLINICAL GOVERNANCE .....  <input type="checkbox"/> CHARITABLE FUNDS .....  <input checked="" type="checkbox"/> TRUST BOARD – 29<sup>th</sup> June 2010  <input type="checkbox"/> REMUNERATION .....  <input type="checkbox"/> OTHER ..... (please specify)         </p>

<b>2. DECISION REQUIRED:</b>	<b>CATEGORY:</b>
<p>The Trust Board is asked to note the content of the report and support the actions to bring the performance back in line with trajectory/target.</p>	<p> <input checked="" type="checkbox"/> <b>NATIONAL TARGET</b>    <input type="checkbox"/> <b>CNST</b>  <input type="checkbox"/> <b>CQC REGISTRATION</b>    <input type="checkbox"/> <b>HEALTH &amp; SAFETY</b>  <input type="checkbox"/> <b>ASSURANCE FRAMEWORK</b>  <input checked="" type="checkbox"/> <b>CQUIN/TARGET FROM COMMISSIONERS</b>  <input type="checkbox"/> <b>CORPORATE OBJECTIVE</b> .....  <input type="checkbox"/> <b>OTHER</b> ..... (please specify) </p> <p><b>AUTHOR:</b> Steve Rubery, Head of Business Delivery and Lee Hyde, Performance Manager</p> <p><b>PRESENTER:</b> Neill Moloney, Director of Delivery</p> <p><b>DATE:</b> 18<sup>th</sup> June 2010</p>
<b>3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:</b>	
Not applicable.	
<b>4. DELIVERABLES</b>	
The delivery of the Trust wide objectives.	
<b>5. KEY PERFORMANCE INDICATORS</b>	
Please see attached Quality and Patient Standards Performance Dashboard.	
<b>AGREED AT</b> _____ <b>MEETING</b> <b>OR</b> <b>REFERRED TO:</b> _____	<b>DATE:</b> _____ <b>DATE:</b> _____
<b>REVIEW DATE</b> (if applicable) _____	

## **Quality and Patient Standards Performance Report May 2010**

### **1. Care Quality Commission 2009/10 Periodic Review and 2010/11 Registration**

Trust performance against the Care Quality Commission (CQC) Periodic Review 2009/10 has been measured during the previous year in the Quality and Patient Standards Performance Dashboard, particularly with regard to the Existing Commitments and National Priorities domains. The finalised scoring methodology for both of these areas has now been made available at high level, although the CQC has still yet to publish the full thresholds for the individual indicators which provide the component scores for the Existing Commitments and National Priorities methodology.

The main data for the Periodic Review will be uploaded to the CQC ratification website across three phases in June, July and August 2010 with the first phase scheduled to go live on 16<sup>th</sup> June 2010. The full results will then be made available in November 2010, when the Trust will be able to assess performance against the expected ratings given in the Quality and Patient Standards Performance Dashboard.

The latest forecast for Trust performance against the Periodic Review 2009/10 appeared in the March 2010 Quality and Patient Standards Report and will be revisited towards November when the final results are released. This last forecast indicated that BHRUT would be rated as 'Underachieved' for MRSA where 39 cases were reported against an upper threshold of 36 cases for the year. This threshold of 36 cases was an agreed target with NHS London. However, the Department of Health have since confirmed that both they and the CQC will be measuring the Trust against a nationally-set target of 58 cases. This results in the Trust rating being moved from 'Underachieved' to 'Achieved' for MRSA.

Going forward into 2010/11, the Annual Health Checks and Periodic Review have been replaced by the system of registration under the Health and Social Care Act (2008). From April 2010, all health and adult social care providers who provide regulated activities will be required by law to be registered with the CQC. To do so, providers must show they are meeting new essential standards of quality and safety across all of the regulated activities they provide. The new system is focused on outcomes, rather than systems and processes and places the views and experience of people who use services at the centre.

The Trust has undertaken the process of registration and is working with the CQC to see which indicators, if any, will be appropriate for inclusion in the Quality and Patient Standards Performance Dashboard, in order to monitor progress. While confirmation of the exact monitoring process for 2010/11 is awaited from the CQC, the dashboard will continue to show performance against the 2009/10 National Priorities and Existing Commitments.

Progress towards CQC registration is the subject of a separate report to the Trust Board.

### **2. Department Of Health Performance Framework 2009/10 and 2010/11**

The Department of Health (DH) NHS Performance Framework assesses the performance of NHS Providers and Commissioners against minimum standards. The Quality and Patient

Standards Performance Dashboard is designed to guide the Trust Board in progress against this framework, which assesses Trusts in the areas of:

- Standards and Targets;
- Finance;
- Quality and Safety;
- User Experience.

The Trust has been measured against the DH Performance Framework 2009/10 during the year in the Quality and Patient Standards Performance Dashboard, particularly with regard to the Standards and Targets domains. The final results from the DH will be made available later in the year, when the Trust will be able to assess performance against the expected ratings given in the Quality and Patient Standards Performance Dashboard.

As with the CQC Periodic Review, the latest 2009/10 forecast showed that BHRUT would be rated as 'Performance Under Review' for MRSA. As the DH have confirmed that both they and the CQC will be measuring the Trust against the nationally-set target, the Trust will move from a rating of 'Performance Under Review' to 'Performing' for MRSA.

The first release of indicators and thresholds for 2010/11 are now available and these have been incorporated into the revised dashboard. It should be noted that the full scoring mechanisms are not finalised nor published until the year has ended and the assessments are therefore always made using the latest available guidance.

The format of the Quality and Patient Standards Performance Dashboard has been revised to allow easier understanding of the components within the DH Framework, whilst continuing to allow monitoring of performance against it. The local indicators section of the Dashboard now contains selected measures drawn from the Commissioning for Quality and Innovation (CQUIN) indicator set.

As the Trust will be assessed under the DH Framework on an annual basis, indicators will be measured on the Quality and Patient Standards Performance Dashboard as 'Performing', 'Performance Under Review' or 'Underperforming' by using the year to date (YTD) rather than monthly figures.

### **3. DH Framework Performance Targets**

The Trust is achieving the published performance targets for May 2010 in the following areas:

- Cancelled Ops - Breaches Of 28 Days Readmission Guarantee As % Of Cancelled Ops;
- MRSA;
- Clostridium Difficile (C Diff);
- 18 Weeks Admitted;
- 18 Weeks Non-Admitted;
- 2 Week GP Referral To 1st Outpatient;
- 2 Week GP Referral To 1st Outpatient - Breast Symptoms;
- 31 Day Second Or Subsequent Treatment – Surgery;
- 31 Day Second Or Subsequent Treatment – Drug;

- 62 Day Referral To Treatment From Screening;
- 2 Week RACP;
- 48 Hours GUM Access;
- Patients That Have Spent More Than 90% of Their Stay in Hospital on a Stroke Unit.

Previously the Quality and Patient Standards Report has provided a commentary on all areas whether standards have been achieved or not. For 2010/11, the report has been revised to provide a focus on areas where the published standards are not being achieved or fully achieved.

### **3.1 Four-Hour Maximum Wait In A&E From Arrival To Admission, Transfer Or Discharge**

The Trust did not achieve the A&E four hour standard for the month of May, narrowly missing the 98% target with a performance of 97.91% on a whole economy basis (although the year to date (YTD) figure remains above target at 98.39%). Despite the continued pressure from NHS London to improve the Type 1 performance across London, BHRUT is achieving less than 98% on these attendances only with May's figure at 95.68% and a YTD of 96.63%.

Weekly exception reports are written when the target is not met and submitted to NHS London, which outline the issues and corrective measures when the Trust fails to hit the target.

As described in the April report, the Trust has adopted the 'Strategy for Change - Emergency Care' report, which details the required medium term and sustainable changes to the emergency care pathway to improve clinical outcomes and adherence to the 98% standard. As part of this strategy, an Emergency Care Division has been established and the appointment of the Director of Emergency Care has been extended. The Division is directly accountable to the Chief Executive and is responsible for much of the work of the Emergency Care Transformation Team, notably:

- A&E;
- Ambulatory Care;
- The establishment of an Emergency Medical Decision Unit (EMDU);
- Bed and Site Management.

Detailed plans exist across both the Emergency Medicine Division and the Medical Division that bring together the work streams in the Strategy document. A daily operational meeting is taking place to allow issues to be swiftly resolved, and the Emergency Taskforce continues to monitor and drive forward these plans weekly. Key Performance Indicators (KPIs) have been established and more are being added as the operational plans unfold.

Specific actions being undertaken include:

- The Ambulatory Care Centre (ACC) became operational on 17th May 2010, with staff having been recruited for both the KGH and QH sites. This is still in its implementation phase, and increased benefits will be seen as the clinical pathways are further developed and patient numbers being treated via this route increase;
- An Emergency Medicine Decision Unit (EMDU) will open on the Medical Assessment Unit (MAU) now that Sky Ward has closed. This will facilitate the expansion of the Intensive Care Unit (ITU) as well as creating a 12 hour space for patients to be assessed for discharge. The medical staffing for this area has been worked up by the Director of Emergency Care and the A&E consultants. The expansion of ITU is a key step in

increasing the ability of the Trust to create additional resuscitation space in A&E, and will help improve the Type 1 performance;

- Length of Stay (LOS) is an important KPI for the Trust and a decrease in LOS is a pivotal outcome to the reconfiguration of wards in the Emergency Care Strategy for Change Document. This is being monitored by the Emergency Care Task Force;
- Recruitment to key medical and nursing staff is improving, with far fewer vacancies at all levels of medical staff. A recent nursing open day has proved successful in filling the nursing vacancies, which will be vital for the long term stability of the Emergency Department. Fill rates for vacant shifts are also being monitored to assess the success of the new 'in-house' bank system;
- A plan has been established to decrease the number of Delayed Transfers of Care (DTC) in the hospital, which has a target of 1%.

### **3.2 18 Weeks - Individual Specialties Not Achieving**

There continues to be one specialty not achieving the 18 Week specialty-specific pathways, this being Ear, Nose & Throat (ENT) in the Admitted pathway. However, performance has improved from 80% in April to 85% in May.

A number of actions have been and are being put into place to enable performance in ENT to achieve and maintain this standard:

- Rejection of referrals of low clinical value;
- Working in collaboration with the Independent Sector Treatment Centre (ISTC) to establish ENT theatre lists and outpatient sessions;
- Agreeing the approach with the Commissioners to manage patients who have exceeded their waiting times;
- Agreeing a maximum six week polling range for Choose & Book with the Commissioners;
- Maximising theatre productively by monitoring through the Theatre Efficiency Operational Group.

### **3.3 62 Days Urgent Referral To Treatment Of All Cancers**

*(Note: Latest cancer data is not complete and fully validated until 25 days past the end of the month reported on and uploaded to the Open Exeter national cancer database. The most recent figures in the month reported on should therefore be treated with caution and looked at in the context of previous validated months)*

62 Days Urgent Referral to Treatment of All Cancers is currently the only cancer indicator for which the Trust is underperforming on a YTD basis. Urology is the main specialty which has affected performance in this area. There were 20 breaches in May 2010 which largely related to administrative issues.

The General Manager for Oncology has now assumed the role of attending the Patient Targeted List (PTL) meetings and is ensuring that robust PTL follow-through, tracking and chasing is in place by asking the Multi-Disciplinary Team (MDT) co-ordinator for escalations when there has not been a response from General or Service Managers. The department now has two MDT coordinators working and additional support is in place, as at the end of May.

### **3.4 Delayed Transfers Of Care**

Delayed Transfers of Care (DTC) have risen from April 3.85% to May 4.15%. A substantial amount of reconfiguration is being undertaken in DTC which has seen the figure increase and improvements being made to the service will run beyond June. More accurate Stroke information is also filtering through as part of the monitoring process which has increased the numbers being reflected in DTC figures.

The primary focus to bring performance within target is on a change in process, so that occupational therapy, physiotherapy and social services are brought onto the wards on the first or second day of the pathway. An initial meeting with Matrons to re-confirm the responsibilities of ward staff in the discharge process has been completed in May. In addition, reference packs have been completed for each ward, with training needs identified and programmes having commenced.

The opening of the Acute Elderly Unit is expected to help reduce DTC numbers, in addition to Length of Stay, as the majority of patients who become delayed are over 70 years old and the change in process on wards will help speed up pathways for these patients.

KPIs have been developed to monitor accurate and timely completion of Section 2s, Section 5s, Rehabilitation Referrals, Checklists, Health Needs Assessments (HNAs) & Decision Support Templates (DSTs) from June 2010 onwards. In addition, Social Services KPIs have also been developed also to monitor their involvement.

June will also see Social Service involvement be formalised and agreed, with the initial focus placed on the new three Elderly Care wards. The review of Therapies is continuing with the Clinical Support Divisional Manager.

Daily reviews with the PCTs and Commissioners are continuing in order to maintain the accuracy of reviewed information around Rehabilitation & Interim bed requirements. Daily KPI reports have been agreed with the PCTs and are being implemented.

There are concerns over both the Havering and Barking & Dagenham (B&D) Rehabilitation and Interim bed strategies, with regards to Havering's refurbishment of Canvey ward and B&D's reduction of 12 beds at Grays Court. This will be monitored on a daily basis and escalated where appropriate.

## **4. Other Performance Indicators**

### **4.1 MSSA Screening and E. Coli Bacteraemias**

The Secretary of State for Health has written to Trusts regarding improving the information made available to patients and the public on healthcare provider. Data on MRSA and Clostridium difficile will initially be published on a monthly basis via [www.data.gov.uk](http://www.data.gov.uk), which will then move to weekly from July 2010 onwards. MRSA and Clostridium difficile rates already appear on the Quality and Patient Standards Dashboard. However, as the Secretary of State is likely to later include monitoring on MSSA and E. coli bacteraemias, these two additional indicators will appear on the Dashboard from next month onwards. These are not considered areas of exception for the May 2010 report.

### **4.2 Mortality**

The latest Dr Foster HSMR data (as of March) shows that the 12 month rolling figure has continued to fall and that neither this nor the monthly figure are considered to be negative outliers. Nevertheless, Trust monitoring of mortality data has been strengthened with regular

monthly meetings between Clinical Governance and Performance Management staff now taking place. These meetings have been initiated to monitor any 'red bell' or relative risk alerts from Dr Foster at both a specialty and diagnosis level, and the investigation of any alerts each month will be reported to the Board.

There is an automatic assumption that any alert must be investigated and will never be attributed to data errors or other factors which may be beyond the Trust's control. This was demonstrated in an alert within February's data which flagged several stillbirths as unexpected. Although this was later corrected by Dr Foster in their March refresh, the mortality meeting still obtained the records for these patients for audit. As such, the Board should be aware that some alerts may subsequently be identified as false but that the outcome will still be reported each month even if this later turns out to be the case.

The March data has identified seven of 111 patients with a diagnosis of subcutaneous skin infections who were classified as having unexpected deaths according to their casemix. The patient records for these patients have been pulled and the outcome of their audit will be reported to the Board for June 2010.

Internal training sessions in Dr Foster are continuing and 39 members of staff have so far attended, of whom 19 have been clinicians or matrons. There are a further 49 staff members booked onto upcoming sessions of whom 31 are clinicians or matrons.

Dr Foster undertake an annual refresh of the national dataset in which HSMR can increase despite having shown improvement across the previous year. Although the HSMR for the Trust has been steadily decreasing, with the latest March figure showing as 102, the rebasing is expected to increase this to 115 and be marked with 95% confidence as a negative outlier. Dr Foster make it clear that this may not necessarily indicate a cause for concern and can instead indicate that a Trust has not made improvements as quickly as others at the national level, but this will nevertheless be investigated by the Trust. A full and detailed report will be presented to the Board for July on the risks and implications faced by the Trust following the rebasing of HSMR by Dr Foster.

### **4.3 Length Of Stay**

Length of Stay (LOS) decreased in May both for elective and non-elective stays. Elective LOS in May fell to within target although it still underperforming on a YTD basis. Non-elective LOS fell is between the 'Green' and 'Amber' tolerance both in-month for May and also YTD.

Specifically for the Medical Division, there was a drop in non-elective LOS stay by 0.5 days on across an average of 2,500 admissions per month.

A trajectory for LOS reduction will be available by the June report.

Sky A Ward closed on 24<sup>th</sup> May 2010. Erica Ward was closed but needed to reopen to manage temporary ward closures due to reasons of infection control. Erica Ward is now once again closed.

As part of the sustainability programme, Unscheduled Ambulatory Care developments continued with the recruitment of nursing staff to support the Virtual Ward and the Ambulatory Care facility. Staff numbers have increased from two to five, with more potentially being recruited. Increased volumes of patients referred to the virtual ward saved 127 bed days in May with more expected to be saved in June. This is expected to reduce LOS in some instances although in others will reduce admissions.

- The Acute Elderly Unit at QH, as discussed in section 3.4, Delayed Transfers Of Care, will open on the 16th June and is expected to reduce LOS;

- The Hyper Acute Medical unit at KGH will open on 30th June, and although this is not expected to improve LOS, it will improve the quality of care;
- The Acute Rehab Unit at KGH will be open from 16th June and will support the acute elderly pathway;
- The Emergency Medicine Decision Unit, as discussed in section 3.1, Four-Hour Maximum Wait In A&E From Arrival To Admission, Transfer Or Discharge, is due to open in mid-June. This will potentially have an adverse effect on LOS as it will reduce the number of short stay admissions and therefore increase the average length of stay, but will also reduce the number of admissions overall;
- The ward reconfiguration programme is scheduled to be 70% in place by the end of June with the remainder into mid-August. This is due to staff consultations and the programme is on track against project plan.

#### 4.4 First to Follow Up Ratios

The Trust is narrowly underperforming against the PCT-agreed KPI for First to Follow Up (FFU) ratios on outpatient appointments. The target is for a 5% reduction on the 2009/10 outturn for the Trust as a whole, in addition to a reduction of the same percentage for the top 10 specialties by activity. Although the YTD figure for FFU is 2.23 against a target of 2.22, the monthly figure for May was significantly below target at 2.18 thus helping to bring the YTD closer towards the required level of performance.

The top 10 specialties under the KPI are as follows:

- Trauma & Orthopaedics;
- Gynaecology;
- General Medical;
- Gen Surgery;
- Paediatrics;
- Cardiology;
- Urology;
- Dermatology;
- ENT;
- Gastroenterology.

Comprehensive action plans have been drawn up for each of these specialties. These are being closely monitored and involve a range of actions which differ between each specialty. A summary of these plans is as follows:

- Trust-wide - Divisions are primarily focusing on developing Discharge Protocols in relation to patient status and those for junior medical staff. Where appropriate, patients are given relevant clinical information (such as wound care or exercise regimes) by letter instead of being provided in a follow-up appointment. Investigations and diagnostics are being undertaken prior to, or on, the day of appointments, and patients are also being discharged to primary care;
- Surgery - Discharge Protocols of patients from clinics are being reviewed in terms of condition status and of the protocols for junior medical staff. Early discharge is being considered where clinically safe, and observation protocols are being developed alongside the roll out of one-stop clinics;

- Medicine - Discharge Protocols of patients from clinics are being reviewed in terms of condition status and protocols for junior medical staff. Areas where patients may be discharged or have a transfer of care to primary care are also being explored. The discharge practice from wards is being examined and the follow-up requirements are being reviewed if a patient is to be booked beyond 9 months;
- Women and Children - The discharge protocols of patients from clinics in terms of condition status are being reviewed (e.g. benign pathology) and the protocols for junior medical staff. Investigations are being undertaken with appointments (e.g. ultrasound scans) prior to or on the day of appointments. The conditions and patient status suitable for discharge or transfer of care to primary care are being considered. There is also a general review of systems and processes being undertaken to identify efficiencies. Clinic profiles with a view to reducing follow-ups are being reviewed and alternative methods to telephone clinics (e.g. a letter and/or guidance where appropriate) are being developed.

Remedial action will be taken in the event of any deviation against the expected trajectories for these plans, which will be tailored to the specific specialty. The target is expected to be achieved for the end of the year 2010/11 although actual improvement should be expected much sooner, with performance being monitored against the final trajectories at the Planned Care Meeting once they have been finalised.

#### **4.5 DNA Rates**

The Trust is currently falling short of its target DNA rates for both first and follow-up appointments. The pilot of the partial booking system has been completed and the post pilot review is underway. The review will be completed by the end of June 2010 with implementation dates established within that review. This will inform the changes that will need to be implemented before it is rolled out. A new telephony system and dedicated staff will be part of the remaining actions to be undertaken prior to full implementation.

In the meantime, the Trust continues to send text message reminders for all outpatient appointments.

Over 75% of all first outpatient appointments are agreed with the patient via the C&B system continues with the roll out to Cancer two week waits and standard services e.g. Physiotherapy, Anticoagulation and Audiology from July 2010.

#### **4.6 Day Case Rates (Basket of 25 Procedures)**

The Trust is seeking to improve day case rates by putting the following actions in place:

- The Enhanced Recovery Project will enable more patients planned as Day Cases to go home rather than be admitted, particularly with breast lumps (which currently performs at less than 75%);
- For Trans Urethral Resection of Bladder Tumours (TURBT), a Business Case is being considered to purchase equipment to enable more of these to be completed as a Day Cases. This will enable a significant improvement from the current Day Case rate of less than 3% for this type of surgery.

#### **4.7 Re-admission Rates**

Development of the Acute Elderly Unit, as discussed in section 3.4, Delayed Transfers Of Care, is one of the workstreams which is designed to focus on readmissions. The Trust is in the process of appointing a clinical lead and to provide case management of recurrent re-attenders within community services. Newham University Hospital NHS Trust has an 'active case

management' process in place which takes place for re-attenders and BHRUT is looking at this as a model for managing its own readmission rates.

Staff are being assigned to audit Trust re-admissions to the same specialty in order to gain an understanding of the reasons behind these figures and what actions can be taken, either by the Trust or community partners, to prevent such re-admissions occurring. Use of the Dr Foster tool will inform areas of focus. This will report to the Medical Division by the end of June. Quarterly audits will be undertaken by the Division to monitor progress.

#### **4.8 Freedom of Information**

The response rate for Freedom of Information (FOI) requests received has reduced to from 56% in March to 45% in April. Therefore, further initiatives have been implemented to improve this rate.

To continue to raise the profile and ownership of FOI requests within the organisation, Divisional Directors and Executive Directors will now also be copied into requests, in addition to Divisional Managers or Directors.

Within the HR Department, one staff member now has the responsibility of co-ordinating FOI requests and obtaining Executive Director approval to release responses. This is intended to streamline the service and is expected to have a positive impact on requests being answered within the legal deadlines.

The introduction of unique numbers for FOI requests is also expected to improve the response rate next month. In addition to assisting the FOI Lead in linking replies and queries to the appropriate request, it is also designed to particularly help those departments with numerous requests manage the process more effectively.

The poor coordination between departments where a joint response is necessary continues to be a cause of performance issues and so it is now being clearly highlighted in emails where a joint response is required.

#### **4.9 Data Quality Issues**

The Trust Board is informed of any data quality issues from external sources as the Trust will be rated on its data quality by the Connecting for Health Information Governance Regime. Continuing to report these issues to the Trust Board will improve the Trust's rating from 1 to 2.

The Quality and Patient Standards Performance Dashboard continues to display a single data quality issue of interest to the Trust Board for May. This continues to relate to a requested change from the Information and Performance team in PAS to correctly identify delivery episodes.

Information Management & Technology (IM&T) have assigned a higher priority to other areas of work with this issue graded as 'low risk'. As such, the correct identification of delivery episodes will be possible following other works such as upgrades to the Trust's PAS system, which is currently scheduled for the end of July 2010.

#### **4.10 MRSA Screening**

Figures for MRSA screening rates continue to show that performance is below the 100% target. However, anecdotal evidence from staff suggests that some data may not be accurately captured and this will be investigated for the report next month.

## **5. Contractual Key Performance Indicators (KPIs) and Commissioning for Quality and Innovation (CQUIN) Schedule**

Progress against each of the CQUIN schemes and KPIs will be monitored on a monthly basis with exception reports being submitted to the Productivity PEQ meeting. Progress will be reported quarterly to the Trust Board via the Quality and Patient Standards Dashboard.

	Indicator	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Thresholds		Performance	DOMAIN	Performance	TRUST ASSESSMENT
Standards and Targets	Four-Hour Maximum Wait In A&E From Arrival To Admission, Transfer Or Discharge	98.89%	97.91%											98.40%	98.0%	97.0%	Performing	Standards and Targets	Performing	Underperforming
	Cancelled Ops - Breaches Of 28 Days Readmission Guarantee As % Of Cancelled Ops	0.00%	0.00%											0.00%	5.0%	15.0%	Performing			
	MRSA	1	1											2	0SD	>1SD	Performing			
	C Diff	11	4											15	0SD	>1SD	Performing			
	18 Weeks Admitted	94.15%	94.67%											N/A	90.0%	85.0%	Performing			
	18 Weeks Non-Admitted	98.40%	99.16%											N/A	95.0%	90.0%	Performing			
	18 Weeks Individual Specialities Not Achieving	1	1											N/A	0	>0	Underperforming			
	2 Week GP Referral To 1st Outpatient	99.89%	99.90%											99.89%	93.0%	88.0%	Performing			
	2 Week GP Referral To 1st Outpatient - Breast Symptoms	99.44%	100.00%											99.73%	93.0%	88.0%	Performing			
	31 Day Second Or Subsequent Treatment - Surgery	100.00%	100.00%											100.00%	94.0%	89.0%	Performing			
	31 Day Second Or Subsequent Treatment - Drug	100.00%	100.00%											100.00%	98.0%	93.0%	Performing			
	62 Day Referral To Treatment From Screening	93.33%	95.45%											94.59%	90.0%	85.0%	Performing			
	62 Day Referral To Treatment From Hospital Specialist	89.47%	75.00%											85.19%	85.0%	80.0%	Performing			
	62 Days Urgent Referral To Treatment Of All Cancers	83.98%	79.76%											81.95%	85.0%	80.0%	Performance Under Review			
	2 Week RACP	100.00%	100.00%											100.00%	98.0%	95.0%	Performing			
	48 Hours GUM Access	100.00%	100.00%											100.00%	98.0%	95.0%	Performing			
	Delayed Transfers Of Care	3.85%	4.12%											3.99%	3.5%	5.0%	Performance Under Review			
	Patients That Have Spent More Than 90% Of Their Stay In Hospital On A Stroke Unit	83.02%	88.24%											85.58%	60.0%	30.0%	Performing			
Finance <sup>1</sup>	Initial Planning	Year to Date		Forecast Outturn			Underlying Financial Position		Finance Processes & Balance Sheet Efficiency					Finance	Underperforming					
	Planned Outturn as a proportion of Turnover	YTD Operating Performance	YTD EBITDA	Forecast Operating Performance	Forecast EBITDA	Rate of Change in Forecast Surplus or Deficit.	Underlying Position %	EBITDA Margin (%)	Better Payment Practice Code Value %	Better Payment Practice Code Volume %	Current Ratio	Receiv-able Days	Payable Days			Creditor Days				
User Experience <sup>2</sup>	Experience of Patients						Public Confidence					User Experience	Performance Under Review							
	Access and waiting	Safe, high quality, coordinated care		Better information, more choice	Building closer relationships	Clean, friendly, comfortable place to be	Focus on the person	Learning organisation	Dignity and respect											
Quality and Safety <sup>3</sup>	CQC Registration Status														Quality and Safety	Performance Under Review				
	BHRUT has conditions on CQC Registration for:		At the following sites:																	
	Diagnostic and Screening Procedures	- Victoria Hospital																		
	Family Planning	- Sydenham Centre																		
	Maternity and Midwifery Services	- King George Hospital, Queen's Hospital																		
	Surgical Procedures	- Queen's Hospital																		
	Termination of Pregnancies	- Queen's Hospital																		
	Treatment of Disease, Disorder or Injury	- Sydenham Centre, King George Hospital, Queen's Hospital																		

Notes:

<sup>1</sup> For detail please see separate Finance Report

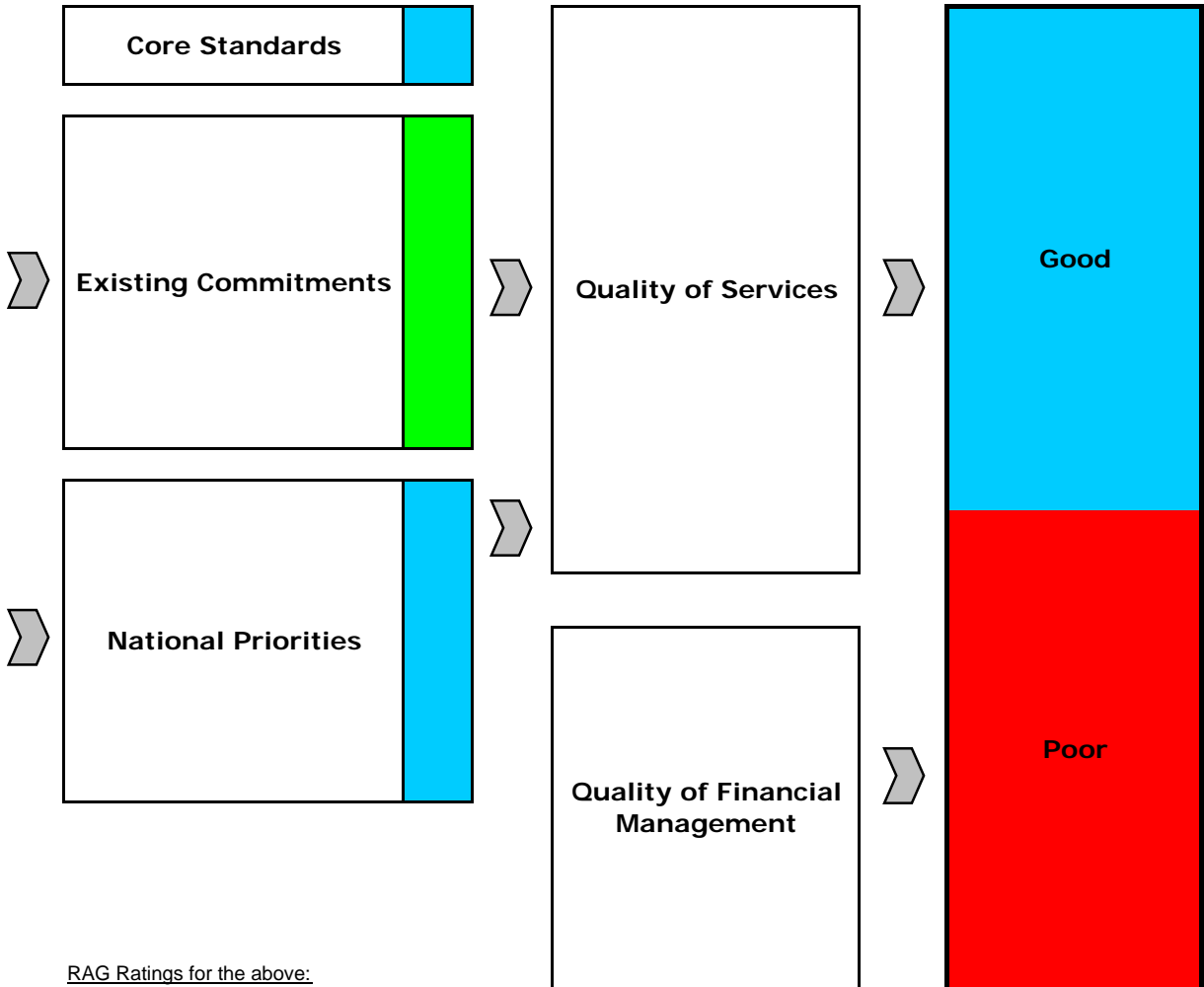
<sup>2</sup> The 'experience of patients' scores are derived from the adult inpatient survey, while the indicators for 'public confidence' are from a number of sources including the NHS national patient survey programme, the NHS national staff survey programme and written complaints data. As some of this data is not yet available to the Trust, staff are developing internal surveying methods according to the Patient Experience Action Plan

<sup>3</sup> For detail please see separate CQC Action Plan

**Assessment with YTD Figures**

Access to GUM clinics	Green
Cancelled operations and those not admitted within 28 days	Green
Data quality on ethnic group	Green
Delayed transfers of care	Yellow
Inpatients waiting longer than the 26 week standard	Green
Outpatients waiting longer than the 13 week standard	Green
Patients waiting longer than three months (13 weeks) for revascularisation	White
Time to reperfusion for patients who have had a heart attack	White
Total time in A&E: Four hours or less	Green
Waiting times for rapid access chest pain clinic	Green

Engagement in Clinical Audits	Green
Incidence of Clostridium difficile infection	Green
Incidence of MRSA Bacteraemia	Green
Infant health & inequalities: smoking during pregnancy and breastfeeding initiation	Yellow
Stroke care	Green
All Cancers: 1 month diagnosis (decision to treat) to treatment including new cancer strategy commitment	Green
All Cancers: 2 month urgent referral to treatment (including new cancer strategy commitment)	Yellow
All Cancers: 2 Week Wait	Green
18 Week Referral to Treatment Times	Yellow
NHS Staff satisfaction	Red
Experience of patients	Yellow
Maternity HES: Data quality indicator	Green
Access to healthcare for people with a learning disability	White
Participation in heart disease audits	Green



RAG Ratings for the above:

RAG Ratings for the above:

Achieved	Green
Underachieved	Yellow
Failed	Red
Not Applicable	White

Existing Commitments / National Priorities

Fully Met	/	Excellent	Green
Almost Met	/	Good	Blue
Partly Met	/	Adequate	Yellow
Not Met	/	Poor	Red

RAG Ratings for the above:

Excellent	Green
Good	Blue
Adequate	Yellow
Poor	Red

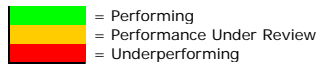
\*Results have been predicted using a combination of 2008/09 thresholds and those currently made available for 2009/10

Indicator	2009/10		2010/11													YTD		Thresholds		YTD Performance
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD					
Mortality (HSMR Data is from Dr Foster and two months in arrears)	Hospital Standardised Mortality Ratio (Monthly)	92.1	94.3															N/A	N/A	
	HSMR Relative Risk (Low)	78.9	81.5															N/A	N/A	
	HSMR Relative Risk (High)	106.9	108.6															N/A	N/A	
	Hospital Standardised Mortality Ratio (Rolling 12 Monthly)	103.3	102.2															N/A	N/A	
	HSMR Relative Risk Rolling 12 Monthly (Low)	99.1	98.0															N/A	N/A	
	HSMR Relative Risk Rolling 12 Monthly (High)	107.6	106.5															N/A	N/A	
	Mortality rate - elective cases (%)	0.20%	0.02%	0.04%	0.10%												0.04%	N/A	N/A	
Mortality rate - non-elective cases (%)	3.62%	3.79%	3.83%	3.47%												3.83%	N/A	N/A		
C&B	C&B Slot issues per successful DBS booking	0.03	0.02	0.02	0.03											0.03	0.04	0.10	Performing	
Length of Stay	LOS (Elective)	3.7	3.8	4.1	3.6											3.8	3.6	4.2	Performance Under Review	
	LOS (Non-Elective)	5.7	5.5	5.5	5.3											5.4	5.0	5.5	Performance Under Review	
First to Follow-Up Ratios	FFU Ratio (Less Midwifery, Ophthalmology and Rheumatology)	2.29	2.30	2.29	2.18											2.23	2.22	2.27	Performance Under Review	
DNA	DNA First	8.57%	9.03%	10.05%	9.82%											9.90%	9.70%	10.20%	Performance Under Review	
	DNA Follow-Up	11.49%	10.99%	11.96%	11.48%											11.30%	10.30%	10.80%	Underperforming	
Day Case Rates	Basket of 25 procedures	75.24%	78.59%	77.48%	80.17%											78.78%	83.00%	70.00%	Performance Under Review	
	All procedures	85.30%	86.11%	85.92%	84.88%											85.41%	75.00%	70.00%	Performing	
Elective Admissions	Elective Admissions on Day of Surgery	89.42%	88.20%	87.12%	85.36%											86.24%	85.00%	80.00%	Performing	
Readmission Rates within 28 Days	Readmission Rates	7.89%	7.36%	7.92%												7.92%	7.00%	7.35%	Underperforming	
	Readmission Rates to same speciality	3.93%	3.76%	4.11%												4.11%	3.50%	4.00%	Underperforming	
FOI	FOI Requests responded to within 20 working days	65%	56%	45%												45%	100%	-	Underperforming	
Data Quality	Significant SUS-SEM Data Quality Issues	1	1	1	1											1	0	2	Performance Under Review	
MRSA	MRSA Screening	79.44%	73.33%	81.12%	76.93%											79.03%	100.00%	80.00%	Underperforming	
Safety Reporting	Incident reporting rate per 100 admissions	6.48%	5.51%	5.72%												5.72%	TBC	TBC		
	Serious Untoward Incidents (SUI) as a % of incidents reported	0.60%	0.31%	0.33%												0.33%	TBC	TBC		
Complaints	Complaint Numbers (excluding enquiries)	44	56	42	33											75	456	475	Performing	
	Complaints responded to within 30 working days	79%	79%	81%												81%	80%	75%	Performing	
Mixed Sex Breaches	No. of patients in mixed sex wards	86	52	0	0											0	0	1	Performing	
Ambulance Handover	LAS Arrival to Patient Handover Time - % Greater than 15 minutes			45.60%	46.00%											45.80%	85.00%	75.00%	Underperforming	
Chief Nursing Officer High Impact Changes	Increase in permanent nursing and midwifery staffing ratios																TBC			
	Reduction in in-hospital Pressure Ulcer rates																See Note <sup>1</sup>			
	Reduction in the rate of in-hospital catheter-related Urinary Tract Infections																TBC			
Critical Care	Transfers out of ICU Department between 22:00 and 08:00																5 per Quarter			
Fractured Neck of Femur (#NOF)	Decrease 30 day mortality for #NOF																See Note <sup>2</sup>			
Maternity	Decrease Caesarean Section (CS) rates																See Note <sup>3</sup>			
	Increase the percentage of women provided with 1:1 care in Labour																See Note <sup>4</sup>			
	% of women who have seen a midwife or maternity healthcare professional, for assessment of health and social care needs, risk and choices by 12 completed weeks of pregnancy.																See Note <sup>5</sup>			

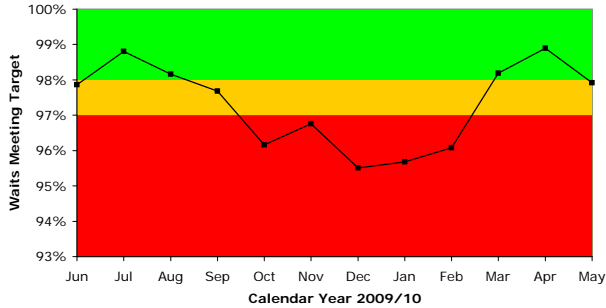
Notes:

- <sup>1</sup> Decreased % of grade 3 and grade 2 pressure ulcers by end of Q4 2010/11
- <sup>2</sup> Target is for the 75th centile as compared to Dr Foster figures on 01/03/2010
- <sup>3</sup> Aim for 20% for end of 2010/11
- <sup>4</sup> 95% by end of Q4. Trajectory to be confirmed
- <sup>5</sup> 90% by end of Q2 2011/12

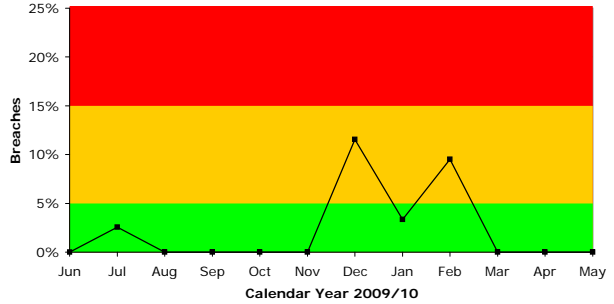
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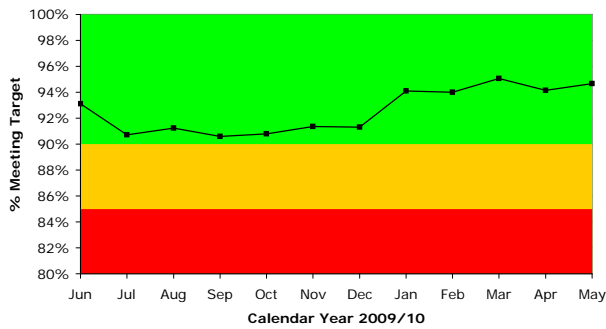
**Four-Hour Maximum Wait In A&E From Arrival To Admission, Transfer Or Discharge**



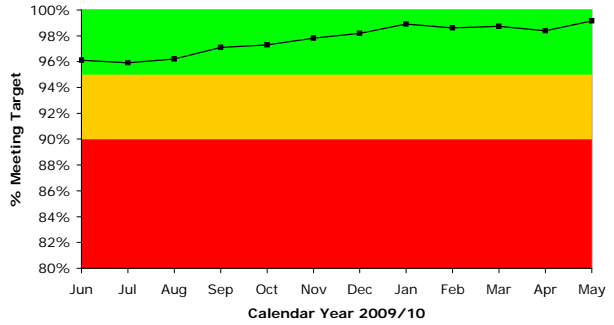
**Cancelled Ops - Breaches Of 28 Days Readmission Guarantee As % Of Cancelled Ops**



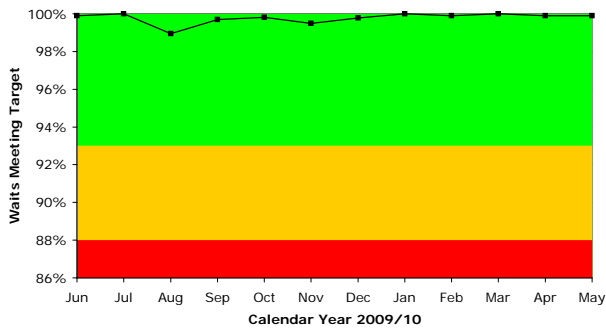
**18 Weeks Admitted**



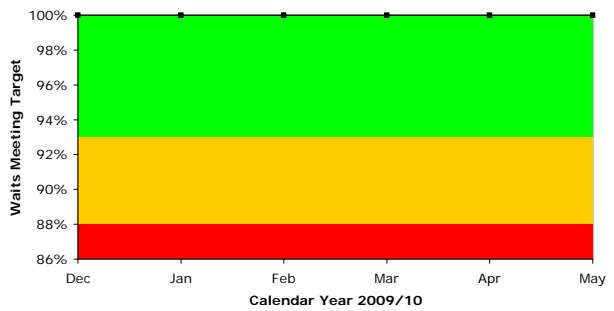
**18 Weeks Non-Admitted**



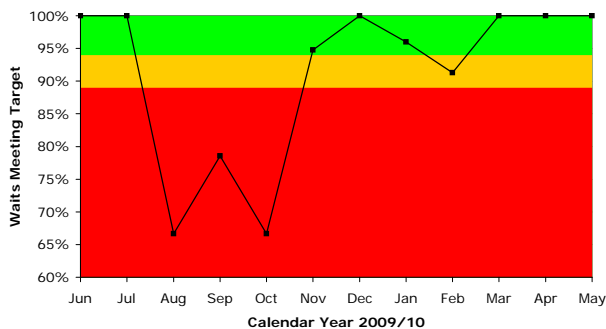
**2 Week GP Referral To 1st Outpatient**



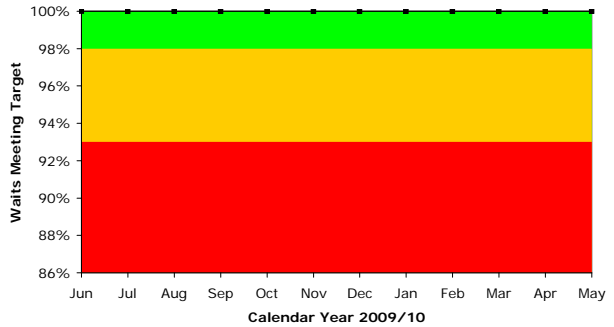
**2 Week GP Referral To 1st Outpatient - Breast Symptoms (Live from December 2009 Onwards)**



**31 Day Second Or Subsequent Treatment - Surgery**



**31 Day Second Or Subsequent Treatment - Drug**



Key:

