

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
<p>Quality and Patient Standards Performance Report – July 2010</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"> 1. CQC Periodic Review 2009/10 & 2010/11 Registration 2. Department of Health Performance Framework 2009/10 and 2010/11 3. DH Framework Performance Targets 4. Other Performance Indicators 5. Contractual Key Performance Indicators (KPIs) and Commissioning for Quality and Innovation (CQUIN) Schedule <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"> • Four-Hour Maximum Wait In A&E From Arrival To Admission, Transfer Or Discharge • 62 Days Urgent Referral To Treatment Of All Cancers • 31 Day Second Or Subsequent Cancer Treatment – Drug • Delayed Transfers Of Care • Mortality • Length of Stay • DNA Rates • Day Case Rates (Basket of 25 Procedures) • Re-admission Rates • Freedom of Information • Data Quality Issues <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 – 31st August 2010 <input type="checkbox"/> REMUNERATION <input type="checkbox"/> OTHER (please specify) </p>

2. DECISION REQUIRED:	CATEGORY:
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.	<input checked="" type="checkbox"/> NATIONAL TARGET <input type="checkbox"/> CNST <input type="checkbox"/> CQC REGISTRATION <input type="checkbox"/> HEALTH & SAFETY <input type="checkbox"/> ASSURANCE FRAMEWORK <input checked="" type="checkbox"/> CQUIN/TARGET FROM COMMISSIONERS <input type="checkbox"/> CORPORATE OBJECTIVE <input type="checkbox"/> OTHER (please specify)
	AUTHOR: Lee Hyde, Performance Manager
	PRESENTER: Neill Moloney, Director of Delivery
	DATE: 13 th August 2010
3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
Not applicable.	
4. DELIVERABLES	
The delivery of the Trust wide objectives.	
5. KEY PERFORMANCE INDICATORS	
Please see attached Quality and Patient Standards Performance Dashboard.	
AGREED AT _____ MEETING	DATE: _____
OR	
REFERRED TO: _____	DATE: _____
REVIEW DATE (if applicable) _____	

Quality and Patient Standards Performance Report July 2010

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

Trust performance against the Care Quality Commission (CQC) 2009/10 Periodic Review 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 CQC have stated that, following conversations with Ministers, they will no longer undertake an overall aggregated rating assessment of either commissioners or providers for 2009/10. This will mean that the Trust will no longer be rated as Poor, Adequate, Good or Excellent for their quality of services. However, the CQC have committed to publishing benchmarked data for each of the Existing Commitments and Tier 1 and Tier 2 Vital Signs in the autumn, similar to the previous timetable.

The Trust continues to comply with the ratification of data to the CQC which will be used in the autumn benchmarking process. The existing deadlines for this process are expected to remain and so far there have been no issues of concern for the Trust.

The CQC are still discussing their work programme for 2010/11 with the Department of Health and have stated that they will keep the Trust informed of developments. In the meantime, NHS London will continue to assess organisations against national target expectations and Vital Signs plans. The Trust is therefore expected to continue to work towards delivering action plans that take it towards delivery of national target or Vital Signs plan levels.

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

2. Department Of Health (DH) Performance Framework 2009/10 and 2010/11

The 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.

Trust performance against the DH Performance Framework 2009/10 has been monitored during the year and reported 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.

The Performance Framework for 2010/11 set out the challenges facing the NHS over the coming year. While many of these challenges remain, the political landscape has changed and the new Government has communicated clear objectives and ambitions for the NHS to deliver and the health economy must respond accordingly. The revisions to the Framework for 2010/11 set out those changes which must happen during 2010/11 and those areas where change can be expected in the NHS Operating Framework for 2011/12. Nevertheless, standards and quality are expected to be maintained where existing targets are removed or adjusted pending the development of more outcome-focused measures. Patients must not expect a return to long waiting times for operations.

As discussed last month, the 18 week Referral to Treatment (RTT) indicators have now been moved to the Internal Performance Scorecard on the Quality and Patients Standards Performance Dashboard. Although performance management of the 18 week RTT targets has been removed from the revised DH Framework, the NHS Constitution still guarantees treatment within 18 weeks and so the expectation is that waiting times will not deteriorate.

Additionally, it was also discussed last month that the DH Framework has relaxed the standard from 98% to 95% for a four-hour maximum wait in A&E from arrival to admission, transfer or discharge. As it can be demonstrated that improved patient outcomes are achieved with shorter waiting times, the Trust has elected to ensure that there is no deterioration in performance. In light of this, performance between 95% and 98% will be reported as Amber rather than Green in recognition of the fact that the Trust is still striving to move patients through the A&E department as quickly as possible to achieve the best possible outcomes.

3. DH Framework Performance Targets

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

- Cancelled Operations - Breaches Of 28 Days Re-admission Guarantee As Percentage Of Cancelled Operations;
- MRSA;
- Clostridium Difficile (C Diff);
- 18 Weeks Admitted;
- 18 Weeks Non-Admitted;
- 18 Weeks Individual Specialties Achieving;
- 2 Week GP Urgent Referral To First Outpatient for Suspected Cancer;
- 2 Week GP Urgent Referral To First Outpatient - Breast Symptoms;
- 31 Day Second Or Subsequent Treatment – Surgery;
- 62 Day Referral To Treatment From Screening;
- 2 Week Rapid Access Chest Pain (RACP);
- 48 Hours GUM Access;
- Patients That Have Spent More Than 90% of Their Stay in Hospital on a Stroke Unit.

For 2010/11, the Quality and Patient Standards Performance Report provides 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 is now measuring four hour waits in A&E against the standard of 95% which has been relaxed by the DH from the previous target of 98%. The 95% target came into effect from Q2 of 2010/11, the Trust being monitored against the 98% target for Q1.

The DH is monitoring performance on all attendance types however, NHS London is measuring the Trust against 95% of patients attending A&E on a type 1¹ only basis. For this reason, the Quality and Patient Standards Performance Dashboard now shows all attendance types on the DH Performance Framework page and type 1 only on the page for BHRUT Internal Targets. The thresholds have been set so that performance will be rated as 'Performance Under Review' or Amber if it is above the new target of 95% but below the previous target of 98%.

Whilst the Trust achieved the national 95% standard for July 2010, the internal target of 98% was not achieved with a monthly performance of 96.60% on a whole economy basis. The year to date figure is now also below the internal target at 97.67% and the same is also true for type 1 performance only, with a YTD performance of 95.68% and performance in July 2010 at 93.98% did not achieve the 95% standard.

Contributing factors to the deterioration in performance are noted as:

- Attendance numbers continued to be high throughout July (with almost 800 more type 1 and 2 attendances and just over 3,200 type 3 attendances than seen during June 2010), with attendances subsiding only at the end of the month. The continued high number of attendance and admission numbers, combined with the planned ward reconfigurations in Medicine (reduction in medical bed base), resulted in the Trust being short of bed capacity at both hospital sites during the first 2 weeks of July 2010;
- Staffing levels for doctors was a major issue throughout the month. The number of staff grade vacancies (the middle tier of staff) is high and the rota is being supported by locum staff. It has proven increasingly difficult to maintain a full rota of middle grades which has caused major problems over the last four weeks. In particular, filling the night and weekend vacancies has been difficult resulting in large breach numbers during these times;
- Those medical staff that have been provided have been of variable quality and the skill mix available has been poor;
- Whilst overall bed capacity has not caused problems throughout July, the timing of bed availability still remains an issue for the Trust and further work is required to increase the numbers of discharges before midday.

The required improvement in the A&E performance continues to be managed via the Emergency Care Taskforce which meets weekly. All Divisions are represented at the meeting which seeks to implement and measure improvement plans across the Trust and bring together the different facets of work being undertaken in each Division. Many of these workstreams relate to the Strategy for Change Document as discussed in previous reports.

¹ The NHS Data Dictionary defines type 1 patients as "Emergency departments are a consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients." This therefore does not include services such as ophthalmology, dental, minor injury such as the Urgent Care Centre or NHS walk-in centres.

Specific actions that have occurred since the last report include:

- The Ambulatory Care Centre (ACC) became operational on 17th May 2010 and has now recruited 50% of the staff needed. The ACC operates from both sites. Five clinical protocols have been developed and other patients are having their treatment continued or finished in an out-of-hospital setting. Around 450 bed days were saved across the Trust in July as was the case in June. A key step for the Trust is to rapidly expand the team and to also expand the clinical pathways under which patients can be accepted into Ambulatory Care. A pathway development kit has been given to each Division and these must be facilitated through the Divisions;
- The Emergency Medical Decision Unit (EMDU) is now established in the Medical Assessment Unit (MAU) and is running under protocol led pathways. The number of protocols will rise as the ability and confidence of the A&E Consultants increases;
- 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. There are a number of workstreams to deliver this which are being monitored by the Emergency Care Taskforce;
- Medical and nursing recruitment is improving although large vacancies still appear in the middle grade rotation. Five middle grades are due to start in the coming months and a recent consultant advert attracted three consultants known to the Trust. The Divisional Director for Emergency Medicine is designing a 'preferred' workforce plan for the departments, although the workforce will have to be as flexible as possible between grades of staff that may be available at different times of the year;
- A plan has been established to decrease the number of Delayed Transfers of Care (DTC) in the Trust, which has a target of 1%. During July 2010, the weekly DTC levels reached their highest this year at 6.63%. Much effort has been put into reducing the hospital delays but this has moved many of these delays into other providers/agencies hands. The reduction in DTC numbers plays a major role in both the four hour access target and the Divisional plans on the reduction in Length of Stay. Along with staffing levels in A&E, the DTC position remains a high risk area for the Trust;
- A 'live' pilot is being carried out by the Bed and Site team to understand better the reasons behind the lack of morning discharges. This pilot is being called 'live' as it will seek to solve issues on a daily basis as they arise as well as informing the Trust of the process change needed to release beds early in the morning.

3.2 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)

The 62 Day Urgent Referral To Treatment target continues to be challenging with a slight improvement during June being partially offset by a further deterioration in July 2010.

The target was affected by a deterioration in performance in four of the specialties for the month: Breast, Haematology, Gynaecology and Urology. Many of these breaches were due to late referral of patients from other tumour sites and complex pathways in reaching a diagnosis. Staff are working with the MDT Co-ordinators to improve communications and to inform when there is a potential patient incoming. All breaches are reviewed and discussed weekly to identify opportunities for avoiding re-occurrences. If however poor performance persists then action plans will be drafted for these disciplines to remodel aspects of the service if system failures have been identified.

At present there are detailed action plans for Breast and Urology, with one being developed for the Gynaecology service. Further work is being carried out to address the issues. In addition to this the Trust has had a response from the Intensive Support Team for Cancer Waiting Times (CWT) following the visit discussed in last month's report. An action plan has also been developed from the recommendations which includes looking at wide ranging demand and capacity planning across the Trust which will benefit all disciplines.

3.3 31 Day Second Or Subsequent Treatment – Drug

*(Note: Please see section **Error! Reference source not found.**, 62 Days Urgent Referral To Treatment, for notes on references to cancer data)*

31 Day Second Or Subsequent Drug Treatment performance has fallen below target in July and subsequent validation has shown that June's performance is now also below target. The July data is currently being validated to ensure that none of these breaches were as a result of administrative delays.

The deterioration in performance has been attributed to a lack of capacity in Oncology, where patients are unaware of what treatments are appropriate and available until the discussion with an Oncologist can take place. The Trust is looking at whether it can introduce nurse-led Clinical Nurse Specialist (CNS) clinics to increase capacity in the absence of recruiting additional Oncologists.

3.4 Delayed Transfers Of Care

Delayed Transfers of Care (DTC) have risen from 4.27% in June to 5.41% in July 2010. The lower threshold target is 3.5% from the DH and BHRUT has an internal target of 1%.

As discussed in section **Error! Reference source not found.**, the weekly DTC levels reached their highest this year of 6.63% during July 2010 although it has since declined. This was due to the ongoing work within the Trust as it strives to reduce the proportion of DTCs which occur at Trust involvement in the pathway to zero. This figure at the start of July was 50% and ended on 40% with the declining trend expected to continue into August. This will ensure that any problems within the discharge pathway do not occur at Trust level.

Substantial reconfiguration continues to be undertaken within the Trust which has been attributed as the cause for both the peak in July as well as the subsequent decline, which is expected to continue throughout August.

The opening of the Acute Elderly Unit is ensuring that Social Services, Physiotherapists and Occupational Therapists are involved early on in the patient pathway. This will in turn ensure that all documentation is completed earlier and should reduce the DTC level.

Based on the 1% internal target, individual targets have been developed for each PCT and Social Service within the four boroughs. These have been refined throughout July 2010 with a view to remove the “shared” category which does not provide sufficiently clear daily management information. Suitable management information will be prepared, issued and reviewed daily with PCTs and Social Services commencing with Barking & Dagenham and Havering. Once the final adjustments have been made, this information will be shared with the Chief Executive Officers of these stakeholders.

Daily reviews with the PCTs are continuing in order to maintain the accuracy of reviewed information around rehabilitation and interim bed requirements. Daily KPI reports have been agreed with the PCTs and these are being implemented. Initial winter bed capacity models have been developed and will be discussed with the PCTs as part of the development of the Trust and health economy winter contingency plans.

A dossier is being compiled regarding the refused rehabilitation referrals and categorised as either an “Unsatisfactory Refusal” or an “Inappropriate Referral”. A meeting has been arranged for 20th August 2010 to discuss referral criteria with Barking & Dagenham and Havering PCTs. This will further clarify these criteria and identify potential further requirements of the PCTs to refine the ways in which patients are accepted. The meeting will explore what Grays Court and St George’s can do to accept more patients from the Trust once patients are medically fit and stable.

Once compiled, this dossier will also be used internally at Queen’s Hospital to identify and quantify inappropriate referrals and take the necessary corrective action, i.e. taking the referral back to the wards and ensuring that the wards refer correctly.

4. Other Performance Indicators

4.1 Mortality

The latest Dr Foster Hospital Standardised Mortality Ratio (HSMR) data (which relates to May 2010) shows that the 12 month rolling figure remains static and neither this nor the monthly figure are considered to be negative outliers. It should be noted therefore that mortality is not yet an area of exception in the Dr Foster system.

The discussion for July relates to the annual rebasing of HSMR by Dr Foster which will take place in September 2010, as discussed in the May 2010 report. Although BHRUT has made improvements in its HSMR across 2009/10, these improvements have not been as significant as other Trusts compared to the national rate. This will therefore result in the Trust position being rebased as a negative outlier once published in the Dr Foster Hospital Guide 2010. To address this, Clinical Governance and Performance Team staff have met with the Trust’s local Dr Foster representative to determine what actions can be taken.

The data for 2009/10 is now set and cannot be adjusted, so the rebased position will remain. However, the Trust is able to make the following improvements to the April 2010 data onwards so that a similar issue can be avoided for 2010/11. These actions include:

- Recording dementia in patient notes. HSMR is calculated by assigning each patient a risk of death according to co-morbidities using what is known as the Charlson Index. This index carries a weighting depending on each co-morbidity and dementia has one of the highest weightings which will increase the death expectancy and have the same positive effect on HSMR as detailed above;
- Analysing patient deaths within the Trust where there is a higher number of episodes. Auditing these patients may well suggest deficiencies in care where a correct diagnosis was not given early enough in the patient pathway (known as a spell or superspell in Dr

Foster) resulting in the patient being transferred between more clinicians than was necessary;

- Most importantly, ensuring that the primary diagnosis is correctly recorded in the patient notes so that the Clinical Coding team are able to record this on PAS. Dr Foster uses the primary diagnosis to assess the risk of death on which HSMR is based. Where the first diagnosis is being recorded as the primary diagnosis (instead of clearly identifying what the actual primary diagnosis is), the risk assessment for whether each death was expected is incorrect which again inflates Trust HSMR. This has been highlighted in recent audits such as that centring on Urinary Tract Infections (UTI), a diagnosis of which a patient is unlikely to have died but was nevertheless recorded in the notes as a primary diagnosis and risk-assessed as such by Dr Foster.

4.2 Length Of Stay

Length of Stay (LoS) decreased in July 2010 for both elective and non-elective stays. Both these indicators are now shown as Amber where non-elective LOS was previously rated as Red on a YTD basis.

As noted in last month's report, Angelica ward closed on 20th July 2010 with 30 beds being taken out of the bed base. This followed a decision to manage patients who are DTOC within the original specialty team rather than incurring potential delays by transferring to a DTOC ward, previously Angelica. This has caused some pressure in non-medical specialties such as Stroke and Orthopaedics although this will need to be quantified to fully assess the impact.

As discussed in section **Error! Reference source not found.**, around 450 bed days were saved across the Trust in July as was the case in June.

The Acute Medical floor achieved its reconfiguration by 4th August 2010. This involved complete re-alignment of medical teams including training doctors and is likely to be deemed a success.

The Hyper Acute Medical Unit opened on 5th July 2010 at KGH on Gardenia ward and pathways are being actively developed to improve the quality of care of unwell medical patients.

The Acute Elderly Unit (AEU) which opened at Queen's Hospital during June 2010 is functioning well and patients who require admission to this unit are being transferred in a timely manner which has released a previous bottleneck on MAU and is ensuring that complex elderly patients are being managed in an appropriate environment. The Trust has benefitted from the secondment of an Associate Director of Nursing, with previous experience in elderly care, with a specific remit to improve pathways in dementia care. Increased provision of psychiatry input for older people commenced on site in July.

As part of a visit to the Trust, Havering councillors visited the AEU on the 28th July 2010 and gave very positive feedback. The AEU is enabling the Trust to make significant improvements in the 10 High Impact Nursing Challenges.

As discussed last month, the Hyper Acute Medical Unit at KGH opened on 5th July 2010, one week behind schedule due to the need to swap Gentian and Foxglove wards to enable the unit to be co-located to the Respiratory ward (which is now Gentian).

As also previously noted, the Emergency Medicine Decision Unit (EMDU) opened on 7th July 2010 although the nine beds to support it were closed from the MAU bed base from mid-June to enable the unit to be set up.

Specific actions to further reduce LoS (or alternatively the requirement for beds) include:

- Progression of ambulatory care pathways to reduce short stay admissions for specific conditions and increase the use of the Virtual Ward;
- Plans to duplicate the Admission Prevention Team currently in the A&E department at Queen's to KGH;
- Involvement in frail elderly pathway work including management of patients with dementia in the community;
- An Acute Elderly Unit is due to open at King George in September 2010;
- The actions to increase the number of patients transferred from site and into community placements, as discussed in section 3.4 are also expected to have an impact on reducing LoS.

4.3 DNA Rates

The Trust is currently falling short of its target DNA rates for both first and follow-up appointments. There has been a deterioration in first appointment DNA rates during July 2010 and the General Manager for Outpatients is undertaking further investigations to understand the reasons for this. There is an ongoing review of every DNA to assess trends, along with efforts to send out appointment letters at an earlier date and increased attempts to contact the patient by telephone. With the roll-out of full electronic booking at the end of July it is expected that there will be an improvement in the DNA rate for first appointments from next month onwards.

There have been delays in the implementation of the new telephony system in addition to the new patient information system due to a lack of IT resource. The Trust is looking at patient booking protocols again to ensure the pathway is as efficient as possible.

Staff are undertaking the post pilot review of partial booking which will give further insight into changes that can be made to improve the booking process and reduce the level of DNAs. There are steps in place to clear the backlog from the pilot and recommendations coming out of this review however the implementation of these are reliant on overcoming the lack of IT resource as discussed. In the meantime, the Trust continues to send text message reminders for all outpatient appointments.

4.4 Day Case Rates (Basket of 25 Procedures)

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

- For Trans Urethral Resection of Bladder Tumours (TURBT), a Business Case is being developed to purchase equipment to enable more of these to be completed as a day case procedure. This will enable a significant improvement from the current day case rate of less than 3% for this type of surgery (however limited capital monies presents a risk to this action);
- An escalation process has now been established so that all patients are admitted on the day on their operation, unless there are clinical exceptions that cannot be resolved by attending the hospital prior to their procedure;
- The Trust has established an Ambulatory Care Unit that is now supporting the attendance of elective patients as day attenders;
- Where possible, elective lists are organised so that day cases are at the start of the list to ensure discharge is on the same day;

- Those patients operated on during an evening session are being discharged home when clinically appropriate.

4.5 Re-admission Rates

Re-admission rates both overall and to the same specialty fell from May to June (which are a month in arrears to other indicators) and are at their lowest so far this year. Nevertheless, they both remain above target.

The AEU (Acute Elderly Unit) is a pilot site for Electronic Discharge Summaries (EDS) which will improve early communication to GPs and play a part in reducing re-admissions to the Trust. This pilot has taken place and was completed in July 2010. The Divisional Director for Medicine has reported that there was excellent clinical engagement in this pilot. The EDS pilot will therefore now be rolled out across the Trust starting in August 2010 with a project plan currently extending work through to March 2011.

4.6 Freedom of Information

The Freedom of Information (FOI) response rate continues to remain below 50% and is therefore significantly below the target of 100%. There has been a steady increase in the number of FOI requests and several departments have received multiple numbers placing pressure on resources. At present, there is no specific pattern to this increase which has been identified however, trends can be identified in those departments most consistently falling below the standard.

Division/Department	Jan-10		Feb-10		Mar-10			Apr-10		May-10		Jun-10		
	Number Received	Response rate	Number Received	Response rate	Number Received	Response rate	Number Frozen*	Number Received	Response rate	Number Received	Response rate	Number Received	Number Frozen	Response rate
Clinical Governance	6	67%	0	-	2	100%	0	0	-	1	0%	3	1	100%
Clinical Support	0	-	1	0%	2	100%	0	0	-	3	33%	1	0	100%
Commissioning/Contracting	0	-	0	-	0	-	0	1	100%	1	-	0	-	-
Communications	0	-	1	100%	1	100%	0	0	-	1	-	0	-	-
Education & Learning	1	-	1	-	1	-	0	2	0%	1	-	0	-	-
Emergency	0	-	0	-	0	-	0	1	0%	1	100%	0	-	-
Estates/Facilities	1	100%	2	100%	1	0%	1	3	0%	3	33%	4	0	0%
Executive Offices	0	-	0	-	0	-	0	1	100%	1	-	0	-	-
Finance	4	50%	5	40%	3	0%	0	3	33%	0	-	2	0	100%
HR	1	100%	5	60%	4	25%	0	4	75%	8	25%	7	0	14%
Information/Planning/Performance	2	50%	1	100%	4	100%	0	0	-	1	-	3	0	100%
IT	3	100%	1	100%	0	-	0	2	50%	1	-	2	0	50%
Medical Division	2	100%	1	0%	1	100%	0	0	-	1	-	0	-	-
Nursing	2	100%	1	0%	3	67%	0	3	67%	2	50%	0	-	-
Procurement	2	100%	1	100%	0	-	0	0	-	0	-	0	-	-
Research & Development	0	-	0	-	2	0%	0	0	-	1	-	0	-	-
Surgical Division	4	75%	1	100%	1	0%	0	0	-	1	100%	2	0	50%
Women and Children Division	1	100%	3	100%	1	100%	0	0	-	2	100%	3	0	33%
TOTAL	28	79%	23	65%	25	56%	1	20	45%	21	48%	27	1	46%

The Trust is now assigning responsibility for meeting the target to the Executive Directors within each area who will in turn ensure that staff within their department are complying with responding to each request.

It has been recognised that the initial processing of FOI requests is delayed when the FOI Lead is on extended annual leave, for which cover has now been identified.

The document for PEQ as discussed in the previous report has been approved and will be posted onto the FOI intranet page. This will inform staff of the agreed process which respondents must follow and therefore increase awareness.

The FOI Lead is currently working with departments to resolve issues on the outstanding FOI requests. In addition, when future FOI requests are sent out to the appropriate staff, the FOI lead will attach a process flowchart with instructions to staff on how to complete each request.

4.7 Data Quality Issues

The Quality and Patient Standards Performance Dashboard continues to display a single data quality issue of interest to the Trust Board for July 2010. 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. The version 20.1 upgrade was successfully completed on the 27th July 2010. As per the agreed Trust priorities, and in line with available PAS support resourcing, the next task is to complete the PAS version 21 upgrade which is aimed for completion during September/October 2010. Once this upgrade has been completed, the work to make the required changes to the identification of delivery episodes will begin.

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

Progress against each of the CQUIN schemes and KPIs is monitored on a monthly basis with exception reports being submitted to the Productivity PEQ meeting.

	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%	97.31%	96.60%									97.67%	98.0%	95.0%	Performance Under Review	Standards and Targets	Performing	Underperforming
	Cancelled Ops - Breaches Of 28 Days Readmission Guarantee As % Of Cancelled Ops	0.00%	0.00%	0.00%	0.00%									0.00%	5.0%	15.0%	Performing			
	MRSA	1	1	1	0									3	0SD	>1SD	Performing			
	C Diff	11	4	11	10									36	0SD	>1SD	Performing			
	2 Week GP Referral To 1st Outpatient	99.89%	99.90%	99.91%	99.91%									99.90%	93.0%	88.0%	Performing			
	2 Week GP Referral To 1st Outpatient - Breast Symptoms	99.44%	100.00%	99.49%	100.00%									99.75%	93.0%	88.0%	Performing			
	31 Day Second Or Subsequent Treatment - Surgery	100.00%	100.00%	100.00%	100.00%									100.00%	94.0%	89.0%	Performing			
	31 Day Second Or Subsequent Treatment - Drug	100.00%	100.00%	96.30%	94.74%									97.73%	98.0%	93.0%	Performance Under Review			
	62 Day Referral To Treatment From Screening	93.33%	95.65%	100.00%	90.00%									94.44%	90.0%	85.0%	Performing			
	62 Day Referral To Treatment From Hospital Specialist	89.47%	87.88%	100.00%	83.33%									89.25%	85.0%	80.0%	Performing			
	62 Days Urgent Referral To Treatment Of All Cancers	83.98%	79.89%	83.11%	80.53%									81.86%	85.0%	80.0%	Performance Under Review			
	2 Week RACP	100.00%	100.00%	100.00%	100.00%									100.00%	98.0%	95.0%	Performing			
	48 Hours GUM Access	100.00%	100.00%	100.00%	100.00%									100.00%	98.0%	95.0%	Performing			
	Delayed Transfers Of Care	3.85%	4.12%	4.27%	5.41%									4.40%	3.5%	5.0%	Performance Under Review			
Patients That Have Spent More Than 90% Of Their Stay In Hospital On A Stroke Unit	81.82%	86.44%	83.58%	87.32%									84.92%	60.0%	30.0%	Performing				
Finance ¹	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	Receivable Days	Payable Days			Creditor Days				
User Experience ²	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 ³	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	-	King George Hospital, Queen's Hospital, Sydenham Centre																	

Notes:

¹ For detail please see separate Finance Report

² 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.

³ For detail please see separate CQC Action Plan

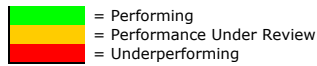
Indicator	2009/10		2010/11												YTD		Thresholds		YTD Performance
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD				
A&E (Type 1 Only)	93.03%	96.74%	97.86%	96.03%	95.03%	93.98%									95.68%	98.00%	95.00%	Performance Under Review	
18 Weeks RTT	18 Weeks Admitted		94.15%	94.67%	94.82%	#N/A									N/A	90.0%	85.0%	Performing	
	18 Weeks Non-Admitted		98.40%	99.16%	99.00%	#N/A									N/A	95.0%	90.0%	Performing	
	18 Weeks Individual Specialities Not Achieving		1	1	0										N/A	0	>0	Performance Under Review	
Mortality (HSMR Data is from Dr Foster and two months in arrears)	Hospital Standardised Mortality Ratio (Monthly)	92.1	94.3	97.5	96.1											N/A	N/A		
	HSMR Relative Risk (Low)	78.9	81.5	84.1	82.3											N/A	N/A		
	HSMR Relative Risk (High)	106.9	108.6	112.4	111.5											N/A	N/A		
	Hospital Standardised Mortality Ratio (Rolling 12 Monthly)	103.3	102.2	100.8	100.8												N/A	N/A	
	HSMR Relative Risk Rolling 12 Monthly (Low)	99.1	98.0	96.7	96.7												N/A	N/A	
	HSMR Relative Risk Rolling 12 Monthly (High)	107.6	106.5	105.1	105.0												N/A	N/A	
	Mortality rate - elective cases (%)	0.20%	0.02%	0.04%	0.10%	0.12%	0.12%									0.10%	N/A	N/A	
Mortality rate - non-elective cases (%)	3.62%	3.79%	3.83%	3.47%	3.64%	3.64%									3.65%	N/A	N/A		
C&B	C&B Slot issues per successful DBS booking	0.03	0.02	0.02	0.03	0.03	0.03								0.03	0.04	0.10	Performing	
Length of Stay	LOS (Elective)	3.7	3.8	4.1	3.6	3.9	3.3								3.7	3.6	4.2	Performance Under Review	
	LOS (Non-Elective)	5.7	5.5	5.5	5.3	5.8	5.3								5.5	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	2.17	2.15	2.14								2.19	2.22	2.27	Performing	
DNA	DNA First	8.57%	9.03%	10.05%	9.82%	10.18%	10.51%								10.01%	9.70%	10.20%	Performance Under Review	
	DNA Follow-Up	11.49%	10.99%	11.96%	11.48%	12.13%	11.89%								11.16%	10.30%	10.80%	Underperforming	
Day Case Rates	Basket of 25 procedures	75.24%	78.59%	77.48%	80.17%	79.59%	82.06%								79.79%	83.00%	70.00%	Performance Under Review	
	All procedures	85.30%	86.11%	85.92%	84.88%	87.03%	86.44%								86.10%	75.00%	70.00%	Performing	
Elective Admissions	Elective Admissions on Day of Surgery	89.42%	88.20%	87.42%	87.23%	90.00%	89.44%								88.57%	85.00%	80.00%	Performing	
Readmission Rates within 28 Days	Readmission Rates	7.89%	7.36%	7.92%	7.89%	7.50%									7.69%	7.00%	7.35%	Underperforming	
	Readmission Rates to same speciality	3.93%	3.76%	4.11%	4.09%	3.84%									3.99%	3.50%	4.00%	Performance Under Review	
FOI	FOI Requests responded to within 20 working days	65%	56%	45%	48%	46%									46%	100%	-	Underperforming	
Data Quality	Significant SUS-SEM Data Quality Issues	1	1	1	1	1	1								1	0	2	Performance Under Review	
Infection Control	MRSA Screening	79.44%	73.33%	81.12%	76.93%	70.39%	75.84%								75.90%	100.00%	80.00%	Underperforming	
	MSSA Infection Rates					2	6								8	TBC	TBC		
Safety Reporting	Incident reporting rate per 100 admissions	6.48%	5.51%	5.73%	5.64%	5.13%	4.98%								5.37%	TBC	TBC		
	Serious Untoward Incidents (SUI) as a % of incidents reported	0.60%	0.31%	0.33%	0.17%	0.52%	1.41%								0.61%	TBC	TBC		

Indicator	2009/10		2010/11												YTD		YTD Performance		
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Thresholds			
Complaints	Complaint Numbers (excluding enquiries)	44	56	42	35	45	46									168	456	475	Underperforming
	Complaints responded to within 30 working days	79%	79%	81%	89%	82%										84%	80%	75%	Performing
Mixed Sex Breaches	No. of patients in mixed sex wards	86	52	0	0	0	0									0	0	1	Performing
Ambulance Handover	LAS Arrival to Patient Handover Time - % Greater than 15 minutes			45.60%	46.00%	49.00%										45.80%	85.00%	75.00%	Underperforming
Chief Nursing Officer High Impact Changes	Increase in permanent nursing and midwifery staffing ratios			87.97%												87.97%	84.40%		
	Reduction in in-hospital Pressure Ulcer rates			0.07%												0.07%	See Note ¹		
	Reduction in the rate of in-hospital catheter-related Urinary Tract Infections			Awaiting DoH guidance on recording data - TBC end of July													TBC		
Critical Care	Transfers out of ICU Department between 22:00 and 08:00			5.70%	20.00%	22.90%										16%	5 per Quarter		
Fractured Neck of Femur (#NOF)	Decrease 30 day mortality for #NOF			5.73%												5.73%	See Note ²		
Maternity	Decrease Caesarean Section (CS) rates			23.25%												23.25%	See Note ³		
	Increase the percentage of women provided with 1:1 care in Labour			89.50%												89.50%	See Note ⁴		
	% 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.			76.56%												76.56%	See Note ⁵		

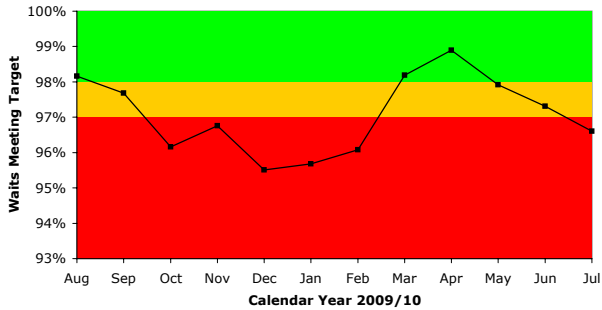
Notes:

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

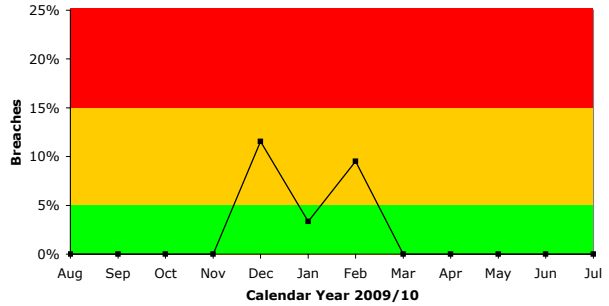
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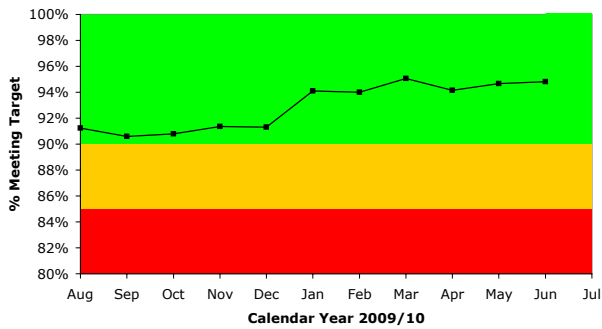
Four-Hour Maximum Wait In A&E From Arrival To Admission, Transfer Or Discharge (All Attendances)



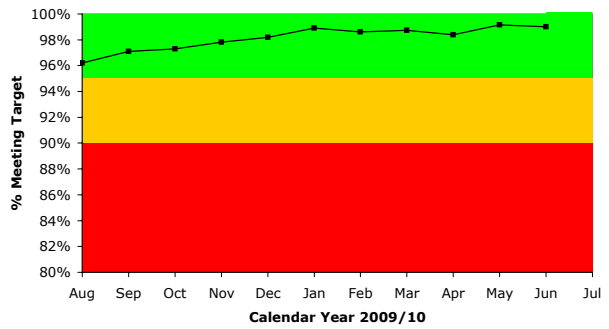
Cancelled Ops - Breaches Of 28 Days Readmission Guarantee As % Of Cancelled Ops



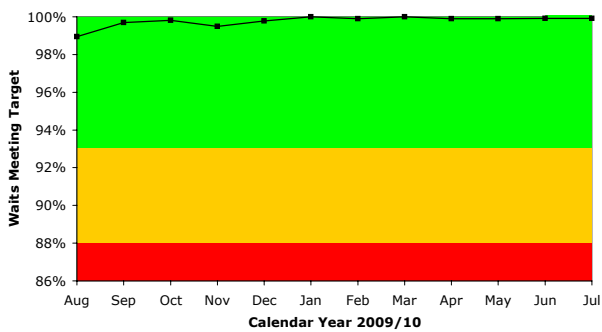
18 Weeks Admitted



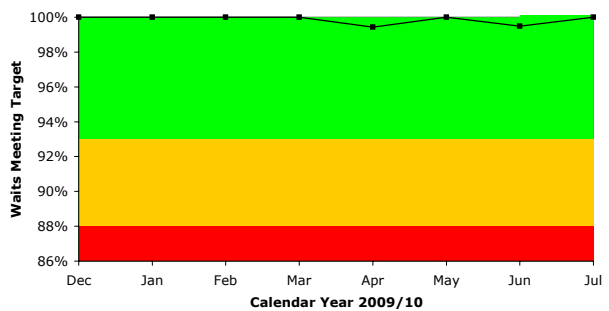
18 Weeks Non-Admitted



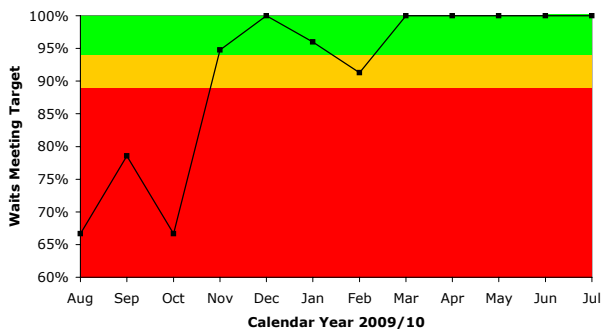
2 Week GP Referral To 1st Outpatient



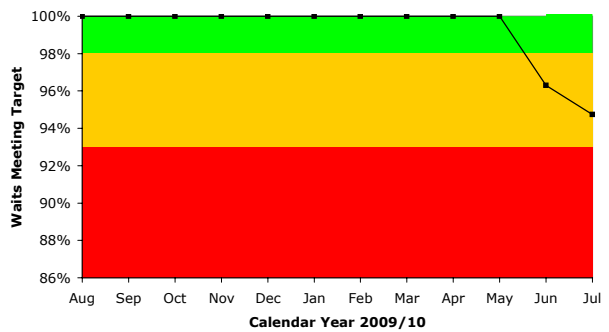
2 Week GP Referral To 1st Outpatient - Breast Symptoms (Live from December 2009 Onwards)



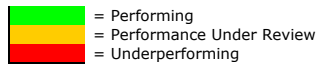
31 Day Second Or Subsequent Treatment - Surgery



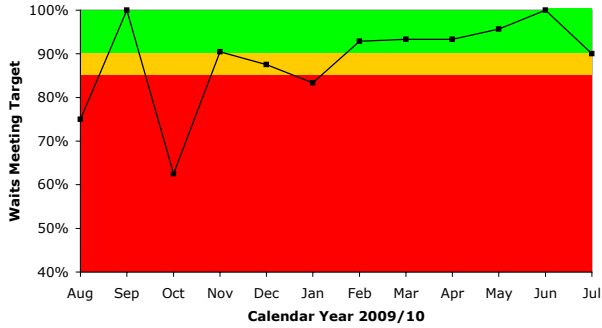
31 Day Second Or Subsequent Treatment - Drug



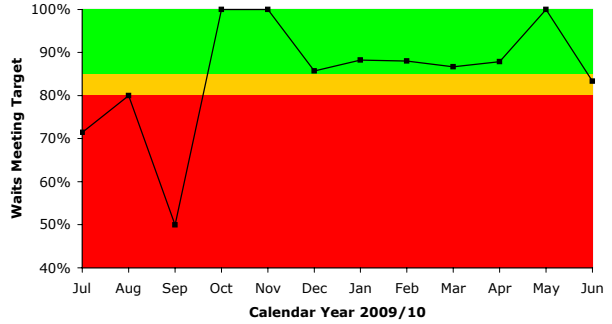
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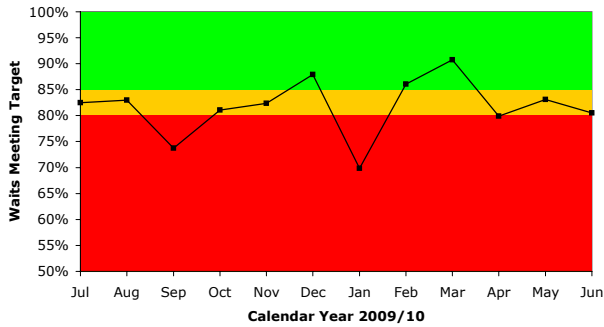
62 Day Referral To Treatment From Screening



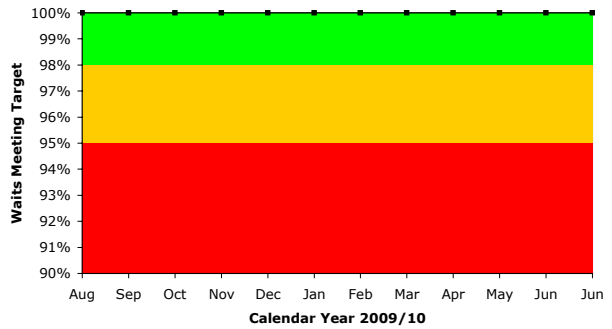
62 Day Referral To Treatment From Hospital Specialist



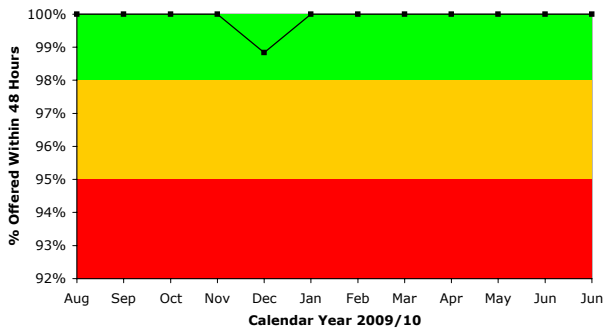
62 Days Urgent Referral To Treatment Of All Cancers



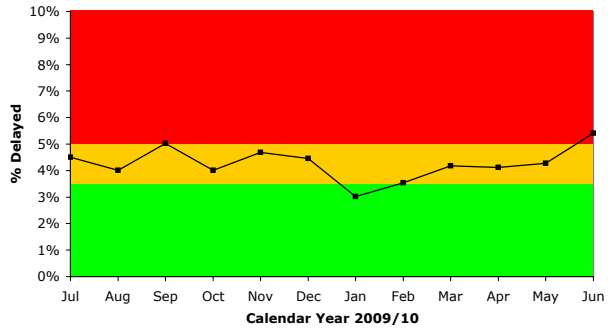
2 Week RACP



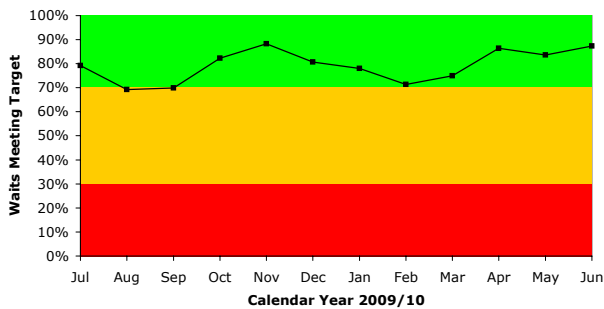
48 Hours GUM Access



Delayed Transfers Of Care



Patients That Have Spent More Than 90% Of Their Stay In Hospital On A Stroke Unit



Hospital Standardised Mortality Ratio (HSMR) - Rolling 12 Month Figure

