

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Quality and Patient Standards Performance Report – November 2009	Trust Board
1. KEY ISSUES:	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 2. Department of Health Performance Framework 3. Existing and New National Targets 4. Finance 5. Access and efficiency 6. Patient Experience 7. Workforce 8. Clinical Quality 9. Other <p>BHRUT achieved improvement in A&E 4 hour waits (although year-to-date performance still falls below 98%), Cancelled Operations, Cancer Access 62 days Decision to Treat, 31 day subsequent Cancer treatments, Cancer Access 62 Day Referral to Treatment from Screening, Breast Screening proportion of those invited, Percentage of patients admitted to a Stroke Unit, Elective Mortality, Hospital Standardised Mortality Rate (both monthly and 12 month rolling average, although these are reported two months retrospectively), Choose and Book slot issues, First to Follow up ratios, DNA first and follow up rates and Day Case rates</p> <p>Both the inpatient and outpatient 18 weeks RTT indicators continue to perform above target and there were no reported 13 week outpatient or 26 week inpatient breaches.</p> <p>There was a decline in performance for Infection Control, Cancer Access Urgent Referrals seen within 2 weeks, Cancer Access 31 Day Diagnosis to Treatment, Delayed Transfers of Care, Non-elective Mortality, Elective and Non-elective Length of Stay, the proportion of incidents causing “severe” harm or</p>	<p><input type="checkbox"/> S&SIB <input type="checkbox"/> EPB</p> <p><input type="checkbox"/> FINANCE <input type="checkbox"/> AUDIT</p> <p><input type="checkbox"/> CLINICAL GOVERNANCE</p> <p><input type="checkbox"/> CHARITABLE FUNDS</p> <p><input checked="" type="checkbox"/> TRUST BOARD – December 2009</p> <p><input type="checkbox"/> REMUNERATION</p> <p><input type="checkbox"/> OTHER (please specify)</p> <p>CATEGORY:</p> <p><input checked="" type="checkbox"/> NATIONAL TARGET <input type="checkbox"/> CNST</p> <p><input type="checkbox"/> STANDARDS FOR BETTER HEALTH</p> <p><input type="checkbox"/> HEALTH & SAFETY</p> <p><input type="checkbox"/> ASSURANCE FRAMEWORK</p> <p><input checked="" type="checkbox"/> TARGET FROM COMMISSIONERS</p> <p><input type="checkbox"/> CORPORATE OBJECTIVE</p> <p>.....</p> <p><input type="checkbox"/> OTHER (please specify)</p> <p>AUTHOR/PRESENTER:</p> <p>Author(s): Steve Rubery, Director of Commissioning and Contracting and Acting Head of Business Delivery and Lee Hyde, Performance Manager</p> <p>Presenter: Neill Moloney, Director of Planning and Delivery</p>

<p>worse Elective Admissions on the day of surgery and Readmission rates.</p> <p>This report includes the key actions that are being undertaken to bring performance back in line with trajectory or target.</p>	<p>DATE:</p>
	<p>18th December 2009</p>

2. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:

Not applicable

3. ALTERNATIVES CONSIDERED/REASONS FOR REJECTION:

Not applicable

4. DELIVERABLES:

The delivery of the Trust wide objectives.

5. EVIDENCE :

The following table contains the indicators which show a material change in performance when compared to the previous monthly performance.

Indicator	Sep	Pct	Nov	Trend
Percentage of patients discharged within 4 hours in A&E	97.86%	96.16%	96.76%	Better
Cancer treatments started within 2 months of urgent GP referral	72.00%	81.32%	83.15%	Better
Cancer treatments 1 month subsequent treatment (surgery)	91.67%	73.91%	93.33%	Better
Cancelled Operations – Not readmitted within 28 days	0.64%	0.48%	0.36%	Better

6. RECOMMENDATION/ACTION REQUIRED:

The Trust Board is also asked to note the content of the report and support the actions to bring the performance back in line with trajectory/target.

<p>AGREED AT _____ MEETING OR REFERRED TO: _____</p>	<p>DATE: _____ DATE: _____</p>
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<p>REVIEW DATE _____ (if applicable)</p>	
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Quality and Patient Standards Performance Report November 2009

1. Care Quality Commission 2008/09 Annual Health Check and 2009/10 Forecast Results

Progress against the Quality and Patient Experience Improvement Programme is being monitored on a monthly basis and reported to the Service and Strategy Improvement Board (S&SIB) as well as NHS London. The progress update to the end of November 2009 is attached at Appendix 1.

Trust performance against the CQC standards continues to be measured in the Quality and Patient Standards Performance Dashboard (attached at appendix 2), particularly with regards to the Existing Commitments and National Priorities that feed into the overall assessment. At present, it is anticipated that the assessment will largely be similar to the Annual Health Check but will be called the Periodic Review. However, the CQC have not finalised the methodology they will use in 2009/10 and CQC staff themselves are still being trained on what has been made available.

A detailed action plan has been developed and implemented for each of the domains to improve performance. The Trust's current forecast of the 2009/10 CQC assessment is as follows:

- At its meeting on the 24th November 2009, the Trust Board approved the self assessment that the Trust is now compliant with all Core Standards;
- The Cancelled Operations target for 2009/10 will be "Achieved";
- The Inpatient and Outpatient Waiting Times for 2009/10 will be "Achieved";
- The Trust expects to see improvements in both Patient Experience and Staff Satisfaction scores, although we are predicting to "Underachieve" in Patient Experience and at this stage "Fail" in Staff Satisfaction.
- The Trust is currently failing to achieve the A&E 4 hour target. An action plan is in place to bring about change for the target to be met on an ongoing basis and be assessed as "achieved" in the 2009/10 Annual Health Check. However there is a significant risk to achieving this as the Trust has failed in-month to perform at 98% for the fourth time this year.
- Each local PCT has accepted their challenge to eliminate Delayed Transfers of Care (DTOCs) where the responsibility lies with the PCT. The Trust expects this target will be "achieved" for 2009/10;
- Stroke services targets will be "Achieved";
- The Trust is meeting the standards for 31 day diagnosis to treatment, 14 day GP urgent referral, 31 day subsequent treatment (drug), 62 day referral to treatment from a hospital specialist and the standard for Breast Other Symptoms (BOS) which becomes live on 31st December 2009. The main risks to the assessment in relation to the Cancer services targets are:
 - Achievement of the 62 day referral to first definitive treatment target;
 - Achievement of the 62 day referral to treatment from screening target;
 - Achievement of the 31 day subsequent treatment (surgery) target.

The Trust has a detailed action plan to improve performance for the three targets which are currently not being met and the RAG rating in relation to this target of “amber” is reflective of the level of risk at this stage.

- The Trust is currently not achieving the two new targets in 18 Week Referral to Treatment. An action plan has been implemented which will bring performance back into line by the end of Quarter 3 2009/10 and the Trust forecast position is that it will be assessed as having “achieved” against these targets. The new targets are in the admitted and non-admitted pathways at specialty level (excluding Orthopaedics), and the admitted and non-admitted pathways for Orthopaedics. Performance has continued to improve during November 2009 with 3 specialties not achieving the standard compared with 5 in October and 7 in September. The main risk to achievement of the specialty level target is in ENT. This risk is being mitigated by the outsourcing of activity to the independent sector.

The Trust is likely to be judged as “Weak” on Quality of Financial Management and “Fair” on Quality of services in the 2009/10 CQC assessments based on expected performance at the present time.

2. Department of Health Performance Framework

The Department of Health (DH) has introduced the NHS Performance Framework to assess 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 Performance Framework standards continues to be measured in the Quality and Patient Standards Performance Dashboard, as with the CQC Standards monitoring. This reflects current performance, particularly with regard to the Standards and Targets that feed into the overall assessment. It should be noted that the full scoring mechanisms are not be made available until the end of the year and the assessments are therefore made using the latest available guidance.

The Trust is currently assessed as “Performance Under Review” for Standards and Targets but is bordering on achievement of the higher “Performing” rating. With the limited months remaining for 2009/10 it is difficult to judge how close the Trust is to achieving this and so it is even more imperative that all efforts that can be made should be made to improve within all standards wherever possible.

Based on the total assessment, the Trust would be judged as “Underperforming” when all four areas are rated on a composite basis. As stated last month, the Performance Framework is an annual assessment and there is still the potential for the Trust to improve this score and thus finish the year in a stronger position.

The User Experience rating is heavily reliant on the Inpatient Survey which takes place annually with the 2009/10 survey results due to be published in May 2010. In the CQC Annual Health

Check 2008/09, the Trust received an amber rating in this area and as such this is reflected on the assessment sheet as "Performance Under Review". However, it should be noted that an improved rating in User Experience would not increase the Trust's overall rating and for the Trust to move from "Underperforming" to "Performance Under Review" overall there would need to be an improvement in the Finance element. This would remain the case even if the Trust were to be rated as "Performing" in Standards and Targets, Quality and Safety and User Experience.

3. Existing and New National Targets

3.1 Access Indicators

Performance against each of the Access Indicators at the end of November 2009 is detailed below:

- There were no 13 week outpatient or 26 week inpatient breaches reported during November 2009. Year to date there have been no outpatient breaches and one inpatient breach, which is within the tolerance for achievement of this target;
- The Trust continues to meet the Referral to Treatment Targets (RTT) for 2009/10 for both Admitted and Non-Admitted pathways. In November 2009, 91.4% of Admitted patients and 97.8% of Non-Admitted patients were seen within the 18 week target;
- 100.0% of Direct Referral patients in Audiology continue to be seen within 18 weeks;

Trusts are now measured against achievement of RTT standards for:

- Individual treatment functions (excluding Orthopaedics, but including Direct Access Audiology);
- Orthopaedics;

In Q1 the Trust did not achieve the standard in 10 specialties against a maximum tolerance of 9 and in Q2 the Trust did not achieve the standard in 7 specialties against a maximum tolerance of 4, not achieving the standard of 90.0% for Admitted patients and 95.0% of Non-Admitted patients within 18 weeks. An action plan has been implemented by the Divisional Manager for Surgery with the aim of bringing performance back into line with the individual treatment function targets by the end of Q3. These action plans have resulted in only 3 specialties failing at the present time (two thirds of the way through Q3). The main risk in achievement remains with ENT, due to previously reported capacity constraints. This is being mitigated by the outsourcing of some activity to the independent sector.

For Orthopaedics, the Trust failed to meet the target based on failures in the Admitted pathway. In respect of Admitted Orthopaedic patients, the Trust saw 80.0% within 18 weeks in November 2009, having achieved similar results for the previous three months. For Non-Admitted patients, the Trust achieved 96.6% in November 2009, meaning that this standard has been achieved for seven consecutive months.

3.2 Delayed Transfers Of Care

Delayed Transfers of Care (DTOCs) have risen from 4.01% in October 2009 to 4.68% in November 2009. In the absence of a DH Performance Framework target at the start of 2009/10, the Trust set an internal target of 2.5% which represented a 5.0% reduction on the 2008/09 outturn. A lower threshold target has now been set within the DH Performance Framework and at present is 3.5%. DTOCs are therefore currently above both targets. Poor performance has been attributed to a number of factors which remain similar to those identified in October 2009, namely:

- A high level of patients waiting for specialist community rehabilitation beds and in particular an increased pressure on Stroke beds;
- PCT provision of rehabilitation and services such as health funded placements and care packages;
- Limits in district nurses providing hospital bed mattresses are less frequent but this has remained a cause for delays;

The following actions are ongoing to improve performance with a stated objective of achieving zero DTOCs:

- Each local PCT has accepted their challenge to eliminate DTOCs where the responsibility lies with the PCT. This work is ongoing;
- The Trust has requested training support from PCTs to ensure that mechanisms are in place to reduce the time taken for decisions to be made on funding for placements. This work is ongoing;
- The ONEL Programme Director for Emergency Care has been allocated the specific task of reducing delayed transfer of care, focusing on those patients that require PCT intervention and those that are identified as 'shared' across organisational boundaries.
- Additional support has been provided by the ONEL Community Services team in completing the new continuing care documentation or Decision Support Tool (DST).
- A new electronic system is now in place for the completion of NHS Continuing Care Assessments and DST;
- PCTs are to act on behalf of each other for DST and Health Needs assessment sign off in order to hasten the process.

3.3 Cancer Services

Performance against the two week waiting time target continues to remain high and above target at 99.5% in November 2009. Treatments started within 31 days (first treatment only) are now achieving the target and treatments started within 62 days, whilst not achieving, has seen a further improvement in performance this month. 31 day subsequent treatments remain below target for surgery, but are above target for drug treatments.

The Breast Other Symptoms (BOS) standard of 93.0% will become a live target on 31st December 2009. There is 99.6% compliance for November 2009 and thus performance is exceeding the target.

To address the issues in achieving the 62 day and 31 day subsequent treatment targets the following actions are being taken:

- Daily review of audited patients on the PTL to appropriately remove all benign patients and review "suspended" patients;
- Patients audited from the waiting list will be continuously reviewed to appropriately remove all benign patients. Suspended patients will also continue to be reviewed;
- Weekly PTL meetings to focus on escalating patients earlier than the current process;
- Continued expansion of the weekly Cancer Waiting Times meetings to include the MDT Coordinator, General Manager for Oncology, Cancer Waiting Times Coordinator and relevant service delivery General Managers;

- All tumour site pathways where breaches of the waiting time guarantee occur will be reviewed and discussed at the weekly Cancer Waiting Times meeting;
- Implementation of the Somerset Cancer Register (SCR) database is still in progress. At present, the order has been placed but it has yet to be accepted. The SCR will bring us in line with national cancer data collection standards. North East London Cancer Network (NELCN) has been advised of the delay;
- Development of the Cancer Waiting Times database reports, to ensure that information produced focuses the teams preventing breaches;
- Review of tumour specific performance.

3.4 Emergency Care

The Trust did not achieve the A&E 4 hour wait emergency care standard in November 2009 with Trust performance for November at 96.76%. This is the fourth month that the Trust has not met the target this year and the third month in succession. At site level, King George Hospital achieved the target at 98.17%, however Queen's Hospital performance remains significantly below the standard at 96.76%. To date, Queen's Hospital has only achieved the monthly target once this year, in July 2009.

Significantly year to date (YTD) performance against the A&E 4 hour wait emergency care standard remains below 98.00% and represents a reduced score in both the CQC assessments and DH Framework target. YTD performance is 97.72%.

The causes of breaches during the month have, in the main, been due to delays in patients receiving their first assessment although waits to see a specialist, waits for beds and delays in A&E processes have compounded the position to a lesser extent.

There have been some significant changes in response to the consistently poor performance in A&E and the Trust has submitted a short term action plan to NHS London which addresses the key issues to deliver the 4 hour target. Actions so far include the opening of a GP assessment unit in Medical Assessment Unit (MAU) and ambulance triage in A&E. Work remains to be done around embedding the Thursday weekend discharge handover with a clinical champion and ensuring that there is a consistent response to the early morning board rounds. In addition, a separate Paediatric action plan has been formulated within the short term plan.

To improve performance against all aspects of the emergency services access targets the following actions have been taken:

- A plan has been agreed with NHS Havering for the Urgent Care Centre (UCC) to manage the Minors area at Queen's Hospital from December 2009 onwards and for funding to be provided for administrative support. An additional GP has been agreed for Paediatrics and triage;
- A process has been agreed with the Women and Children's Division for Gynaecology patients to be streamed directly to Cornflower B;
- London Ambulance Service (LAS) will support faster turnaround in ambulance triage and assessment of patients;
- An additional "shop floor" Consultant will be available until 9pm 7 days a week;
- An additional staff grade will be placed in A&E on an evening shift to support the "shop floor" Consultant;
- Process and staffing has been agreed for a GP assessment area;

- Clinical Nurse Specialist will begin proactively “pulling” patients from the MAU;
- The weekend handover is to be brought forward to Thursday (although clinical handover will remain on Friday) with patients for a weekend discharge to be identified by senior ward nurses and registrars. Patients will be tracked for discharge at the weekend by senior nurses and discharge doctors. This process has been agreed and now needs embedding into “business as usual”;
- Surge capacity at King George Hospital and Queen’s Hospital will be vacated by Thursday each week and available to open from Saturday afternoon:
- A dedicated team will address Medical outliers to improve Length of Stay;
- Early morning rounds will be closely monitored by ward nurses and registrars. Two patients per ward will be discharged by 10am and targets will be set for each ward as to the number of discharges to be achieved by time of day. A monitoring system is to be agreed with bed managers.

3.5 Infection Control

There were five cases of MRSA this month, three of which were apportioned to the Trust. Two of the five cases had no recent hospital admissions and the source of the infection was unclear.

Of most concern is that the hospital acquired cases resulted from post-operative infection after emergency Orthopaedic surgery. This was the second such case in 2009/10 and the third this calendar year. A review of the data over the past three months suggests that there has been increased hospital acquisition of MRSA on the Orthopaedic wards during October and November 2009, particularly in emergency admissions. An outbreak meeting took place on Wednesday 9th December 2009. An action plan will follow.

There has been a sharp increase in reportable cases of Clostridium Difficile although the majority of these have been community-acquired infections. This information has been passed on to the PCTs for further investigation.

Outbreaks of Norovirus are continuing to occur, with 4 ward outbreaks in November 2009. However, this is in line with experience over the past few years.

3.6 Cancelled Operations

Indicators for Cancelled Operations and Operations Cancelled Not Re-Admitted Within 28 Days remain low and are below target. The rate of operations cancelled on or before the day of operation has dropped further from 0.46% in October 2009 to 0.36% in November 2009 and is well below the target of 0.80%. The rate of cancellations not re-admitted within 28 days is at 0.00% for the fourth month in a row.

There is a risk that current performance for cancelled operations will deteriorate as a direct result of emergency pressures on critical care facilities. Emergency admissions are accommodated in “outreach” areas i.e. theatre recovery beds. However, once these beds are filled, elective admissions may be cancelled on the day of procedure if there is an inability to “step” down patients from an outreach area or a critical care bed. This will inevitably lead to more than one cancellation per patient and limit the Trust’s ability to re-admit and operate within 28 days.

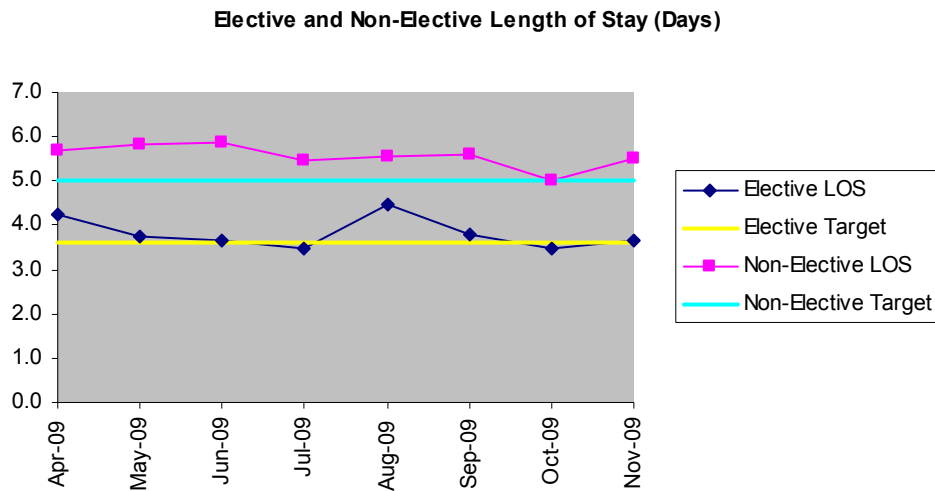
Emergency Bed Services will be contacted in order to support the transfer of patients out of the Trust wherever possible.

4. Finance

Please refer to the separate Finance Trust Board Report.

5. Access and Efficiency

5.1 Length of Stay (LOS)



The LOS Programme Board introduced a new programme management team in November 2009 to deliver the Trust LOS objectives. To achieve in narrow timescales, the team have scoped existing strategies alongside creating new ones and have consolidated these into two categories:

Strategies with greater short term impact	Strategies with medium term impact
Discharge Planning	Virtual Wards
MAU	IV Antibiotics
COPD	Reducing Pre-procedures LOS
Nurse led discharge	Children's Home Care Team
Pharmacy (TTA's)	7 day cover for Therapies
Paediatric Assessment Unit	Diagnostics

Elective LOS remains largely close to trajectory with a YTD figure of 3.8 days against a target of 3.6 days. A comparison on Dr Foster identifies BHRUT performance as 19th out of 55 acute providers within London, with performance below the national average of 4.0 days. Elective teams have identified opportunities for further efficiencies within patient pathways to improve quality of care and impact on LOS, such as effective discharge planning strategy, nurse-led discharge and reducing pre-procedure LOS. Details of each strategy have been collected and development of a robust project governance model has started in order to monitor performance and identify the impact these strategies have on LOS.

Non-elective LOS has increased to 5.5 days in November 2009 following previous achievement of the target in October 2009 at 5 days. The target itself is 5 days. A similar comparison on Dr

Foster identifies BHRUT performance as 21st of 51 acute providers within London and Trust performance is slightly above the national average of 5.5 days. The Trust is in a position to improve this standing through the implementation of new strategies including effective discharge planning and building on the implementation of existing strategies that have further delivery potential namely nurse-led discharge, 7 day cover for therapies, diagnostics, virtual ward, use of the Medical Assessment Unit (MAU) and a strategy on Chronic Obstructive Pulmonary Disease (COPD). As with elective LOS, these strategies are being consolidated into a programme plan which promises firm project governance and delivery.

Performance against plan for each strategy identified in the table above showing the short and medium term categories will be presented in next month's report.

6. Patient Experience

6.1 Mixed Sex Accommodation

There were six reported occurrences of mixed sex bay breaches during November 2009. All six breaches occurred on Sahara B ward at Queen's Hospital.

A meeting was held on 25th November 2009 to discuss the reporting of Mixed Sex Breaches using the DH guidance document "Principles of Delivering Same Sex Accommodation".

The Bed Management Team has confirmed that all mixed sex breaches are being recorded. At present, Matrons currently have responsibility for notifying Bed Managers of breaches however, in future this will become the sole responsibility of Bed Managers.

Intensive Therapy Unit (ITU) and High Dependency Unit (HDU) do technically experience breaches however these areas are to be exempt as the clinical condition of patients takes precedence over the mixed sex issue. There was discussion as to whether Harvest B ward should also be exempt however it was agreed that despite the level of clinical care required, Stroke areas will also need to comply. The Trust will discuss this with Commissioners in view of this being a specialist area with a high degree of monitoring and direct nurse observation.

6.2 Complaints

The Trust has set a complaint reduction target for 2009/10 of 40% on 2007/08 complaint numbers. To date, this target is highly likely to be achieved at year-end.

The Trust received 51 formal complaints during November 2009 which is a significant increase on the 32 received during October 2009, however this level remains slightly below the monthly target of 53. The increase seen during November 2009 has been in the Women & Children's and the Surgical Divisions. Medical complaints have fallen slightly since last month.

The number of complaints which have been dealt with informally (rather than formally) is also increasing. Had these informal complaints been dealt with under the previous formal system, the Trust would not have met the target in November 2009.

The Trust response rate for November 2009 is above target at 81.00%.

From December 2009 onwards, a weekly digest of all responses will be issued on a pilot basis to assist with the learning process from the formal complaints that are made. This will be circulated to senior Divisional and Trust management staff, with brief commentary on any trends and actions taken.

6.3 Incident Reporting

The number of severe incidents has risen during recent months due to the fact that the Trust has reassessed its position on what is considered to be a serious incident and Divisions have been asked to report and identify their own internally defined Never Events/red incidents. These may not necessarily be reportable under Serious Untoward Incident guidelines but are issues that the Divisions have themselves decided should not have happened.

An example of a Never Event/red incident in A&E is of any patient who has been in the department for over 12 hours and neither admitted nor discharged. Incidents have been identified by the A&E departments on both sites during November 2009 and will be investigated by the Division. There are no Trust deadlines for these investigations as these will be conducted by the Division and discussed at their Performance Meetings.

6.4 Outpatient Improvement

6.4.1 Choose and Book

The Trust's position in relation to slot unavailability has improved during November with the November month end standing at 0.11%. This is partly due to the use of the Choose and Book Capacity Management Toolkit which commenced during the month. The forecast is that the figure will reduce again in December 2009 bringing the Trust within the 0.04% target in the New Year.

The Trust has been made aware that the national performance figures reporting BHRUT slot unavailability figures have been incorrect since 21st September 2009. This has meant that the number of slot availability issues has been reported at twice their actual rate and this has been confirmed by an NHS London (NHSL) consultant. BHRUT is the only Trust affected by the error. Last month it was reported that Trust performance was 0.26% where in fact it was only 0.13% and so the number of slot availability issues has therefore been improving more than first thought. NHSL are considering whether to amend the incorrect figures and the Trust is keen for this, given the view that may be taken as a part of the Full Electronic Booking Pilot. The corrected figures will be reflected in the Quality and Patient Standards Performance Dashboard once this decision has been made.

6.4.2 First to Follow-up Ratios

The Trust has agreed with Commissioners to reduce the 2008/09 outturn of first to follow-up ratios by 5.00% as part of the Service Level Agreement Key Performance Indicators (SLA KPIs). This is with the exception of Obstetrics, Midwifery and Dermatology Phototherapy follow-ups which have been excluded from the indicator. The Trust Dashboard now displays two first to follow-up ratio indicators, one Trust-wide and one for the KPI agreed with Commissioners:

First to Follow-Up Ratios	08/09 Outturn	5% Reduction	09/10 YTD
All Trust	2.38	2.26	2.62
Trust minus Midwifery, Obstetrics and Phototherapy	2.59	2.46	2.35

Last month it was noted that Dermatology Phototherapy activity was not excluded in the SLA KPI calculation due to the complexities in determining a reduction for a specific clinic. The Performance Team have now finalised the method to accurately calculate this and this will be used going forward, with previous figures recalculated.

BHRUT therefore continues to overachieve the 5.00% reduction on first to follow-up ratios in relation to those areas included within the SLA KPIs – current performance is a reduction of 9.27% over the outturn, or 4.47% over target and this will attract a financial incentive from the Commissioners.

The Trust continues to liaise with Commissioners to identify services that may be appropriately provided in the community which will allow the Trust to reduce unnecessary follow-ups being undertaken in the acute setting.

The revised Short Notice Clinic Changes Policy and process introduced in June 2009 continues to ensure that the number of short notice cancellations is being reduced when compared to previous years. The current position is that the number of short notice cancellations has been reduced by 75.00% since the introduction of the new policy.

The Partial Booking of Follow-ups (PBFUs) is scheduled to be piloted in December 2009. The pilot specialties are still to approve the PBFU Process to ensure it is fit for purpose.

When implemented, PBFUs should reduce DNAs, patient/hospital cancellations and complaints. Patient choice and experience will also be improved and outpatient capacity optimised to achieve the 18 Week RTT target. Partial booking is also expected to improve cost efficiency, reducing the volume of staff resource required to cancel/change clinics and should ensure that follow-up patients are seen when clinically appropriate and in chronological order.

6.4.3 DNAs

DNA rates for first appointments have reduced from 10.09% in October 2009 to 9.03% in November 2009. Similarly, DNA rates for follow-up appointments fell from 10.75% to 10.16% over the same period. The Trust is not achieving the overall targets for DNA rates on a YTD basis although November's figures are the lowest reported so far during 2009/10.

The recent short term addition to the Call Centre of three staff/lines and a central voicemail box, which launched at the end of September 2009, continues to significantly reduce previously unanswered calls by 95%+.

The Business Case for the new telephony system has been approved by the Business Case Review Panel (BCRP) and Capital Planning Group and will be submitted to S&SIB for final approval in December 2009. It is envisaged that, subject to approval, the new system will be in place by the end of the financial year.

The online facility for patients to contact the Trust via the website continues to be used on average approximately once per day. This facility continues to be advertised on text messages sent to patients as a part of the SMS Texting Pilot. The use of the online form has increased with circa 80% of patients suggesting that they have used the online facility as a result of receiving a text reminder.

7. Workforce

The separate Human Resources Trust Board Report is now bi-monthly and will report in December 2009.

8. Clinical Quality

8.1 Mortality

Mortality rates for elective cases remain stable and fell slightly from 0.13% in October 2009 to 0.11% in November 2009. Non-elective mortality has risen from 3.30% to 4.34% over the same

period however these figures, in terms of both actual rates and percentage change month on month, are similar in pattern to 2008/09 so should not be any cause for initial alarm and could be interpreted as seasonal.

In addition to the Hospital Standardised Mortality Ratios (HSMRs) on a monthly basis introduced in the October 2009 report, figures will also be shown on a 12 month rolling basis. This will give an overall picture of the Trust position as well as any monthly variation. As recommended by Dr Foster themselves, who provide the data for HSMRs, these figures should be used in addition to other mortality indicators such as the elective and non-elective mortality rate rather than in isolation.

HSMRs are only available historically and as such, data reported is two months behind the present month.

The Trust dashboard also shows two further figures of an upper and lower confidence interval and this is the range that Dr Foster is 95.00% confident that the HSMR falls within. For example:

HSMR	Confidence Interval (Low)	Confidence Interval (High)	Interpretation
100	98	102	Performance is as expected. The HSMR falls within a tight range and has a statistically high chance of being accurate.
105	102	112	The number of deaths is 5% higher than expected. The slightly wider range in confidence intervals suggest a greater range of numbers that the actual HSMR could actually be, however given that the low confidence interval is above 100, there is a 95% confidence that the HSMR will be above 100 regardless.
97	78	150	The number of deaths is lower than expected, however there is a wide range in confidence intervals which are also significantly either side of 100. Therefore, the HSMR should be considered less reliable.

Therefore, the Board is asked to note that there is a level of subjectivity involved in the use of HSMRs in addition to a level of variation.

9. Other

9.1 Data Quality Issues

The Maternity issue is now in the process of being resolved following the successful PAS upgrade last month. Mandatory fields on SUS (Secondary User Service) for Maternity data are not being sent by the Trust and a workaround on an initial field will be deployed during early December 2009. Staff will determine the success of this workaround by the end of the month and report on progress next month.

McKesson have made an upgrade available to the CDS (Commissioning Data Set), which is the rule set for submitting data on SUS, from version 6 to version 6.1. McKesson have advised that this upgrade may resolve the delivery of all mandatory fields although the Information Team are sceptical this will provide the solution. In light of this, Information Team staff are working internally to build a test database which will simulate correct data being sent for the initial field referred to above, rather than use the workaround. If this is successful then the solution to other fields will hopefully follow. This work will require collaboration with the PAS Management Team

who have identified mid-January for being able to apply the 6.1 upgrade and late January for developing the test database.

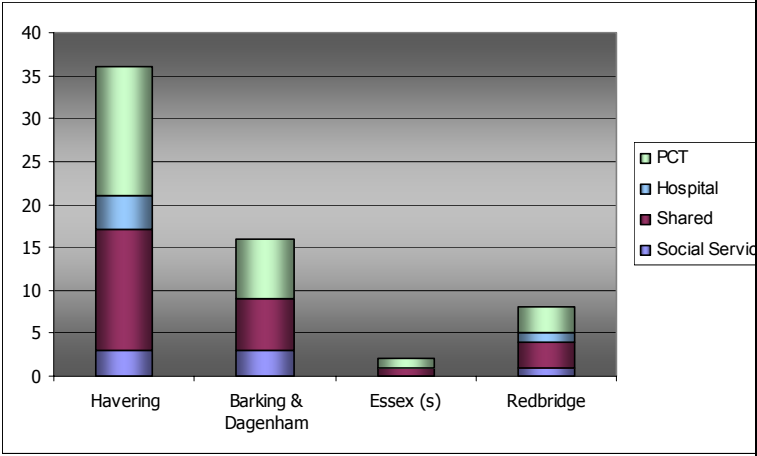
Quality and Patient Experience Improvement Programme – Update as of 30th November 2009

Performance Area	Update November 2009	Ref	Lead	Recovery Target Date	Current RAG Status	Target Recovery Date RAG Status	2009/10 Year End Forecast Assessment
1. Core Standards - 2008/9 Declaration C5c, Clinician training, declared as 'not met'	At its meeting on 24th November 2009, the Trust Board approved the self assessment that the Trust is now compliant with all Core Standards	CQC	Director of Clinical Governance	March 2010	Green	Green	Green
2. Core Standards - 2008/9 Declaration C11c, Appraisals, declared as "insufficient evidence"	At its meeting on 24th November 2009, the Trust Board approved the self assessment that the Trust is now compliant with all Core Standards	CQC	Deputy Director of HR	November 2009	Green	Green	Green
3. A&E – Non Achievement of 4 Hour Target	<p>Although the Trust met the A&E standard for the first two quarters of 2009/10, it has had significant problems during November 2009 and year to date performance remains below 98% after falling below the standard in October. It is unlikely that the Trust will achieve the standard for Quarter 3.</p> <p>A revised activity/performance scenario has been calculated that shows the number of breaches allowed to bring the performance back to 98%.</p> <p>Breach analysis for the weeks in November show that the main causes for breaches are:</p> <ul style="list-style-type: none"> • Waiting for 1st assessment; • Waiting for bed; • Waiting for specialty assessment. 	CQC/ DH Assurance Framework	Divisional Director Medicine	1st December 2009 (Trust-wide)	Red	Red	Green

Performance Area	Update November 2009	Ref	Lead	Recovery Target Date	Current RAG Status	Target Recovery Date RAG Status	2009/10 Year End Forecast Assessment
	<p>The improvement plan focuses on three main areas:</p> <ul style="list-style-type: none"> • Reducing the numbers of patients who need to be seen within the majors area, thus creating A&E capacity to assess patients quicker; • Getting specialty teams to assess patients in areas outside of A&E; • Freeing up beds earlier in the morning to create the assessment space. <p>Progress in November 2009:</p> <ul style="list-style-type: none"> • A standard for the Urgent Care Centre to see 40% of attendances has been set. At Queen's a single flow for minor illness is being set up. NHS Havering are supporting the change. This will begin on 08.12.2009 • Emergency triage/Rapid Assessment and Treatment (RAT) – Consultant staff have been trained and Specialties informed. Extended Consultant hours on shop floor have been implemented – 2 consultants until 10pm at Queen's Hospital; • An A&E escalation process has been agreed, based on delay to medical review. This incorporates the RAT process; • Escalations agreed with specialties to improve specialty response. This is managed by A&E; • MAU/SAU is in place at Queen's and has resulted in reduced breaches due to waiting for specialty. KGH MAU will be operational from 1.12.09; • SLAs between diagnostics and A&E, MAU and In-Patients are now in place ensuring faster turnaround of investigations; <p>Year to date performance is as follows:</p> <ul style="list-style-type: none"> • Trust 97.71% • King George 99.11% • Queen's 96.65% 						

Performance Area	Update November 2009	Ref	Lead	Recovery Target Date	Current RAG Status	Target Recovery Date RAG Status	2009/10 Year End Forecast Assessment
	<p>Additional recovery actions based on last 4 weeks performance:</p> <ul style="list-style-type: none"> • Introduction of the virtual ward at Queens –rolled out at KGH on 16.11.09; MAU at Queen’s is now accepting direct GP referrals in dedicated area of 5 trolleys and 9 chairs • Appointment of Director Emergency care ; • Dedicated 2 week programme to improve nurse leadership in A&E; • Head of Winter Capacity in place from 16th November to robust daily response to winter pressures. • Use of contingency capacity at KGH • A short term action plan has been produced with the following actions: <ul style="list-style-type: none"> ○ Urgent Care Centre to manage Minors; ○ Gynaecology patients streamed directly to Cornflower B Ward Ambulance triage; ○ Additional shop floor Consultant till 9 p.m. 7 days a week Staffing Review highlighted need for additional staff grades to be put in A&E on evening shift to support shop floor consultant; ○ Establishment of a GP assessment area; ○ Additional porters put into discharge lounge, MAU and A&E to improve patient movement; ○ CNS's proactively 'pulling' patients from MAU; ○ Close beds down on Sky A and Erica by Friday to provide surge capacity for Sunday/Monday; ○ Weekend handover to be brought forward to Thursday (clinical handover remains on Fridays). Patients for weekend discharge to be identified by senior ward nurse and registrar. Patients tracked for discharge at weekend by senior nurse and discharge doctor; ○ Paediatric bed capacity: increased bed capacity on Tropical Lagoon with increased nursing levels by 4 						

Performance Area	Update November 2009	Ref	Lead	Recovery Target Date	Current RAG Status	Target Recovery Date RAG Status	2009/10 Year End Forecast Assessment
	<ul style="list-style-type: none"> beds; o Dedicated team to address Medical outliers to improve LoS; o Early morning Board rounds 'policed' by Ward nurse and registrars with 2 patients per ward discharged by 10 a.m and targets set for each ward as to number of discharges by time of day; o Paediatric assessment unit with dedicated senior input. <p>The following progress has been made against this plan:</p> <ul style="list-style-type: none"> o Plan agreed with PCT for them to manage a combined minors/UCC and funding for admin support agreed; o Additional GP for Paediatrics also agreed for triage; o Process agreed with the Women & Children's Division so that Gynaecology patients are admitted straight to Cornflower for assessment; o Process agreed with LAS to support faster turnaround and assessment of patients; o Process and staffing for a GP assessment area has been agreed. 						
4. Cancelled Operations	<p>YTD performance for cancelled operations is 0.64% against a target of 0.8% and YTD performance against the 28 day re-admission target is 1.30% against a target of 5% (October 2009).</p> <p>The Trust expects this target to be achieved for 2009/10</p>	CQC/ DH Assurance Framework	Divisional Director Surgery	May 2009	Green	Green	Green
5. Delayed Transfers of Care	<ul style="list-style-type: none"> • Integrated discharge team has been implemented; • The daily MDT process reinforced using Jonah tool to ensure discharge date setting. Facilitation of daily MDT in key ward areas; • DST/HC needs assessment – change in form and process have 	CQC/ DH Assurance Framework	Divisional Director Medicine BHRUT/ Whole	A recovery date of October 2009 was set against	Red	Red	Amber

Performance Area	Update November 2009	Ref	Lead	Recovery Target Date	Current RAG Status	Target Recovery Date RAG Status	2009/10 Year End Forecast Assessment																														
	<p>delayed discharge pathway;</p> <ul style="list-style-type: none"> • There are daily panels in place which are meant to review and make decisions on all patients irrespective of PCT; • Discharge team – increase support to team to manage any backlog; • Cross buffer meetings in place which concentrates on reducing delayed transfers of care and reducing LOS for complex discharges; • Single referral form for community rehab has been implemented across whole economy from 9.11.09 <p>Year to date performance is 3.62% as at 31/10/09, with the performance for October 2009 at 4.01% against an internal target of 2.5%</p> <p>Total number of DTOCs per responsible organisation per Borough as at 19th November 2009 is shown in the graph below:</p>  <table border="1"> <caption>Data from the stacked bar chart: Total number of DTOCs per responsible organisation per Borough as at 19th November 2009</caption> <thead> <tr> <th>Borough</th> <th>Social Services</th> <th>Shared</th> <th>Hospital</th> <th>PCT</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>Havering</td> <td>3</td> <td>14</td> <td>4</td> <td>15</td> <td>36</td> </tr> <tr> <td>Barking & Dagenham</td> <td>3</td> <td>6</td> <td>0</td> <td>7</td> <td>16</td> </tr> <tr> <td>Essex (s)</td> <td>0</td> <td>0</td> <td>0</td> <td>2</td> <td>2</td> </tr> <tr> <td>Redbridge</td> <td>1</td> <td>2</td> <td>1</td> <td>3</td> <td>7</td> </tr> </tbody> </table>	Borough	Social Services	Shared	Hospital	PCT	Total	Havering	3	14	4	15	36	Barking & Dagenham	3	6	0	7	16	Essex (s)	0	0	0	2	2	Redbridge	1	2	1	3	7		Economy Programme Director	this target. Although systems have been put in place and actions taken, progress has been slower than expected. The Trust now expects performance to improve by the end of November 2009			
Borough	Social Services	Shared	Hospital	PCT	Total																																
Havering	3	14	4	15	36																																
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Performance Area	Update November 2009	Ref	Lead	Recovery Target Date	Current RAG Status	Target Recovery Date RAG Status	2009/10 Year End Forecast Assessment
	<p>Additional actions to improve performance:</p> <ul style="list-style-type: none"> Discharge co-ordinators recruited; Handheld desktops to be used on wards to improve efficiency of completing DSTs; Training sessions run to support use of new DST form; Agreement from ONEL PCTs to eliminate PCT related delays for implementation by 1 December. DTOCs are currently running at 4-5% of the bed base. Reductions being pursued through increased rehabilitation capacity with Stroke rehab at King George, the removal of general rehab delays and a 24 hour turnaround of Panel decisions; Head of Winter capacity to work with Whole Economy Programme Director to discharge DTOCs more efficiently; 						
6. In-Patient Waiting Times	No breaches of standard have been reported during November 2009, so year to date performance remains at one breach of the target (which was due to an administrative error), this is within the tolerances applied and the Trust expects to achieve this target in 2009/10.	CQC/ DH Assurance Framework	Divisional Director Surgery	December 2008	Green	Green	Green
7. Patient Experience	<ul style="list-style-type: none"> Assistant Director of Patient Experience Improvement has been appointed and started on 30th November 2009. Patient Experience Board established but more comprehensive membership being agreed. Introduction of real time patient surveying system business plan underway and systems being reviewed. Trust representation on LIPEC; Roll out of Medical Early Warning System (MEWS) and PEWS (Paediatrics) following pilot and audit. Monthly observation audits via the Matrons have been established and establishment of an Observations Steering Group to improve compliance with the undertaking of vital sign observations and appropriate escalation of deteriorating patients, thus prevention of failure to rescue cases; Discussion re the above took place at the November Senior 	CQC/ DH Assurance Framework	Acting Director of Nursing	<p>Nov 09 Achieved</p> <p>April 2010</p> <p>Nov 09 Achieved</p> <p>Nov 09</p>	Red	Amber	Amber

Performance Area	Update November 2009	Ref	Lead	Recovery Target Date	Current RAG Status	Target Recovery Date RAG Status	2009/10 Year End Forecast Assessment
	<p>Sisters and Matrons' Forums with engagement to improve staff competency and auditing</p> <ul style="list-style-type: none"> • Audit results both locally, ad hoc senior managers and to the Matrons Forum 2 monthly • Sexes are separated in acute areas of generic wards in accordance with guidelines. • User groups established with contractor and clinical staff and two weekly meal service and cleaning audits are in place; • More comprehensive development of adult and children safeguarding policies underway to include dementia, learning disabilities and DOLS - to complete by end of November; • Nursing vacancies reduced from 380 WTE in January 2009 to 174 WTE with aggressive recruitment ongoing; • Reduced rates of infection – monthly hand hygiene audits and mandatory training; • Review of common themes in relation to complaints ongoing. Gradual reduction in number of complaints and severity, with rag rating level of complaints. The number of complaints received in October 2009 was 32; • Mandatory training ongoing in relation to Communication and customer care. Content reviewed during November, and topics altered including presentation format to include current high profile issues Topics planned include Safeguarding for both adult as well as children. Liaison with boroughs to achieve suitable training through experts in learning disabilities and DOLS/MCA Discussion with community partners underway 			<p>Achieved</p> <p>Aug 09</p> <p>Dec 09</p> <p>mid Dec 09</p> <p>Ongoing</p> <p>Ongoing</p> <p>Nov 09 Achieved</p> <p>Nov 09 Achieved</p>			
8. Stroke Care	<ul style="list-style-type: none"> • Consultant posts have been successfully recruited and recruitment is ongoing for Junior and Middle Grade Doctors with the expectation that these posts will be filled by the end of March 2010; • National and International recruitment for nursing staff has commenced; • Funding for a Consultant Allied Health Professional has been agreed; 	CQC/ DH Assurance Framework	Divisional Director Surgery	March 2010	Amber	Amber	Green

Performance Area	Update November 2009	Ref	Lead	Recovery Target Date	Current RAG Status	Target Recovery Date RAG Status	2009/10 Year End Forecast Assessment
	<ul style="list-style-type: none"> • Funding for additional Therapy and Nursing staff has been agreed and is in budgets; • >70% of patients are now spending >90% of their time on a stroke unit; • Daily multi-disciplinary team meetings are in place to ensure early decision making and appropriate bed use; • All TIA clinics have been centralised onto the Queen's site with new administrative processes implemented in order to ensure compliance with the standards; • 24 hour access to CT scanning is in place: • Additional training for swallow assessments and for the initial stroke assessment have commenced in A&E with the support of the stroke network; • Training has commenced for thrombolysis with the anticipation that a Monday to Friday, 9am to 5pm service will commence mid November 2009; • A 24/7 Consultant-led on-call service is expected to commence during the first week of January 2010; • The Network have agreed an external validation against the Performance Standards in order that the Trust can secure the 70% tariff uplift. This will take place in mid January 2010. <p>RAG rating remains amber as we do not yet demonstrate that we are using < 15% agency staff for therapists. Active recruitment underway</p> <p>The main challenges to achieving the core standards are 95% of patients having direct admission to a stroke unit and timeliness of carotid endarterectomies. Pathways are being continually reviewed to improve access and the increase in medical staff will further facilitate this. There are weekly MDTs held by the vascular team during which newly presented appropriate stroke patients are discussed and listed for surgery. The Trust is awaiting further guidance from the Network in relation to timeliness of procedure.</p>						

<p>9. Cancer Waiting Times</p>	<ul style="list-style-type: none"> • Additional MDT co-ordinators recruited to expedite patient pathways; • General and Service Managers to assist MDT Coordinators to review all patients on PTL to remove genuine benign patients; • Additional capacity for Breast in place – all patients now seen within 10 days; • Additional Endoscopy capacity in place; • Access policy reviewed; • DTT clinics set up for Urology; • Establishing 14-day turnaround for urology biopsies to enable diagnosis to be determined earlier in the patients pathway; • GPs Education and appropriate reports on 2 weeks referrals to be established; • Cervical screening records now being reported. <p>YTD performance is as follows:</p> <ul style="list-style-type: none"> • 14 Day 99.63% • Breast Other Symptoms 14 Day 99.50% (November performance – target live from 31.12.09) • 31 Day (to first treatment) 96.01% • 62 Day 79.72% • 31 Day (subsequent treatments) 92.54% <p>The main risks to the recovery target date are surrounding one-stop clinics for Head and Neck, with the appointment of a locum histopathologist these clinics will be set up as a priority, Urology capacity, where additional theatre capacity is being put in place from December 2009 .</p>	<p>CQC/ DH Assurance Framework</p>	<p>Divisional Director Clinical Support Services</p>	<p>31st March 2010</p>	<p>Red</p>	<p>Amber</p>	<p>Amber</p>
<p>10. Staff Survey</p>	<p>The survey taken in 2008 reflects the opinions of a randomly selective sample of 824 members of staff of which 44% responded. The main findings are listed which are significant and compared to the average for all acute Trusts are below:</p> <p>The survey revealed positively that overall staff believed they were less likely to come to harm or witness errors at work. They also felt that the quality of their work had a direct impact on patient care. The scores that showed a negative impact were appraisal levels and</p>	<p>CQC</p>	<p>Director of HR</p>	<p>2009 Staff Survey</p>	<p>Red</p>	<p>Red</p>	<p>Red</p>

	<p>personal development opportunities that lead to the view that career development may be limited.</p> <p>Appraisal</p> <ul style="list-style-type: none"> ▪ Each division to map the numbers of staff and plan appraisal dates onto a calendar for coming year 09/10. ▪ HR Divisional Advisor will monitor calendar against appraisal plan. ▪ Working group to review paperwork and process. ▪ Front sheet to state return data. ▪ Process to be written up and published in Vital Signs to increase awareness. ▪ Formal letter to go to DMs stating process. ▪ Appraisal rates to be part of Divisional Performance Meetings as a KPI. ▪ HR Divisional Advisors to support Divisional Managers in delivering appraisal through coaching and mentorship. ▪ Monthly dashboard reports to reflect divisional rates and staff groups. <p>Personal Learning Plans</p> <ul style="list-style-type: none"> • A revised and relaunched education Board has been established to take the lead in designing an annual development plan based on training needs assessment • This Board will review training needs across the organisation and respond with funding for development • The Board is multidisciplinary and has membership from different levels within the organisational structure <p>Leadership Strategy</p> <ul style="list-style-type: none"> • The Directors of Education and HR will develop a leadership strategy for the organisation • The strategy will be presented to the Education Board in February for approval and implementation • Talent management will feature in this strategy and the Trust hopes to become a SHA pilot in the development of talent management <p>Other Actions being addressed</p> <ul style="list-style-type: none"> • The number of staff experiencing physical violence has increased although the percentage is very low at 4%. 		<p>Director of HR and Director of Education</p>	<p>Oct '09</p> <p>Completed November 09 And on going</p> <p>Feb 09 and ongoing</p> <p>Oct 09</p>			
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	<ul style="list-style-type: none"> Action: Work around bullying and harassment with awareness stands and training sessions for managing conflict are being delivered. 							
11. 18 Weeks	<ul style="list-style-type: none"> The Trust continues to meet the Referral to Treatment Targets (RTT) for 2009/10 for both Admitted and Non-Admitted pathways. In October 2009, 90.8% of Admitted patients and 97.3% of Non-Admitted patients were seen within the 18 week target; 100% of Direct Referral patients in Audiology continue to be seen within 18 weeks; In Q1 the Trust did not meet the standard in 10 specialties against a maximum tolerance of 9 and in Q2 the Trust did not meet the standard in 7 specialties against a maximum tolerance of 4, failing to meet the standard of 90% for Admitted patients and 95.0% of Non-Admitted patients within 18 weeks. An action plan has been implemented by the Divisional Manager for Surgery with the aim of bringing performance back into line with the individual treatment function targets by the end of Q3. The main risk in achievement lies in ENT due to capacity constraints although this is being mitigated by outsourcing some activity to the independent sector. For Orthopaedics, the Trust did not meet the standard based on not achieving the Admitted pathway. In respect of Admitted Orthopaedic patients, the Trust saw 77.0% within 18 weeks in August 2009 and 81.8% in September 2009, with 82.7% achieved in October. For Non-Admitted patients, the Trust achieved 98.6% in October, meaning that for six consecutive months this standard has been achieved. 	CQC/ DH Assurance Framework	Divisional Manager Surgery	1 st January 2010		Amber	Green	Green

Key to RAG Rating

Green	On target to recover performance by target date
Amber	Recovery by target date at risk due to problems implementing Action Plan
Red	Target recovery date unlikely to be achieved, further actions required over and above those identified in 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	Yellow
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	Red
Stroke care	Yellow
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	TBC
Participation in heart disease audits	Green

RAG Ratings for the above:

Achieved	Green
Underachieved	Yellow
Failed	Red
Not Applicable	White

Core Standards

Existing Commitments

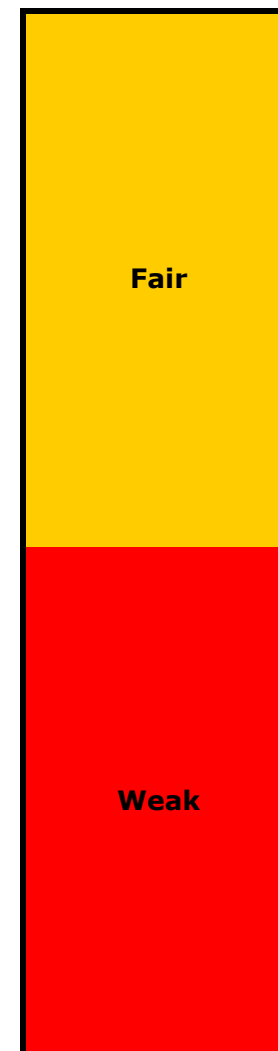
National Priorities

RAG Ratings for the above:

Fully Met	Green
Almost Met	Blue
Partly Met	Yellow
Not Met	Red

Quality of Services

Quality of Financial Management



RAG Ratings for the above:

Excellent	Green
Good	Blue
Fair	Yellow
Weak	Red

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

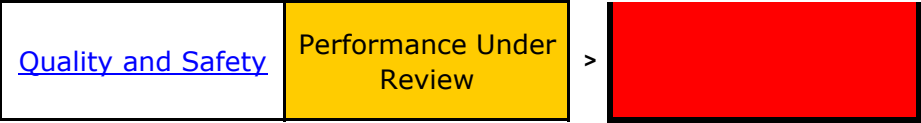
Indicator	YTD	Thresholds		Performance	DOMAIN	Performance	TRUST ASSESSMENT
A&E	97.7%	98.0%	97.0%	Performance Under Review	<u>Standards and Targets</u>	Performance Under Review	Underperforming
Cancelled Ops	1.1%	5.0%	15.0%	Performing			
MRSA		0	>1SD	Performing			
Cdiff		0%	>1SD	Performing			
18 Weeks Admitted	91.2%	90.0%	85.0%	Performing			
18 Weeks Non-Admitted	96.1%	95.0%	90.0%	Performing			
18 Weeks Individual Specialties		<2	>2	Underperforming			
18 Weeks Orthopaedics		0	0	Underperforming			
Cancer - 2 Week GP Referral	99.6%	93.0%	88.0%	Performing			
Cancer - 31 Day Subs Treatment (Surgery)	87.6%	94.0%	89.0%	Underperforming			
Cancer - 31 Day Subs Treatment (Drug)	99.2%	98.0%	93.0%	Performing			
Cancer - 31 Day 1st Treatment	96.1%	96.0%	91.0%	Performing			
Cancer - 62 Day Referral from Screening	83.9%	90.0%	85.0%	Underperforming			
Cancer - 62 Day Referral from Specialist	79.4%	85.0%	80.0%	Underperforming			
Cancer - 62 Day RTT All Cancers	80.1%	85.0%	80.0%	Performance Under Review			
2 Week RACP	100.0%	98.0%	95.0%	Performing			
48 Hours Gum Access	100.0%	98.0%	95.0%	Performing			
DTOCs	3.7%	3.5%	5.0%	Performance Under Review			
90% of stay in stroke unit	69.0%	70.0%	50.0%	Performance Under Review			
OP Breaches		0.0%	0.15%	Performing			
IP Breaches		0.03%	0.15%	Performing			
					<u>Finance</u>	Underperforming	
					<u>User Experience</u>	Performance Under Review	

Note: Results obtained using the latest DH Performance Framework guidance and thresholds which are subject to change.

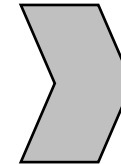
The Trust is assessed as **Performance Under Review** for Standards and Targets. Achieving 98% A&E 4 Hour Waits, or improvement in 18 Weeks, would take us to **Performing** for this category, as we were in Q1.

The User Experience rating is based on 08/09 data as the 09/10 Inpatient Survey will not be available until May 2010. It is believed that these results will improve upon 08/09. However, the Overall Trust assessment is the same regardless of any potential improvements in User Experience that may transpire.

For the Trust to achieve **Performance Under Review** overall, we would need to reach **Performance Under Review** in the Finance section. This is true even if we are rated as **Performing** in all three other sectors.



Assessment Area	Area Performance Against Target*
Financial Performance	Underperforming
Operational Standards & Targets	Performance Under Review
Quality & Safety	Performance Under Review
User Experience	Performance Under Review



Trust Assessment
Underperforming

*Estimated Ratings under the NHS Performance Framework assessment

A: FINANCE SUMMARY

Financial Performance	Current Month - Nov 09			Year to Date			Annual		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Income	(33,387,448)	(36,374,234)	2,986,786	(267,167,969)	(266,137,977)	(1,029,992)	(380,972,560)	(399,414,788)	18,442,229
Pay	22,409,101	21,068,117	1,340,984	182,441,285	171,497,111	10,944,174	266,244,929	258,817,106	7,427,824
Non-Pay	10,690,818	9,616,538	1,074,280	81,428,571	77,141,411	4,287,160	117,563,282	115,440,951	2,122,330
Depreciation	1,091,641	1,005,614	86,027	8,730,487	8,043,106	687,381	13,068,592	12,065,564	1,003,028
Impairments	-	-	-	13,909,689	13,889,689	20,000	18,998,689	13,889,689	5,109,000
Other Non Operating Items	1,976,413	1,991,789	(15,376)	15,815,369	15,934,312	(118,943)	24,008,149	23,901,479	106,670
Net (Surplus) / Deficit	2,780,525	(2,692,176)	5,472,701	35,157,432	20,367,652	14,789,780	58,911,082	24,700,001	34,211,081
CIP/ Turnaround Programme	2,122,583	3,280,623	(1,158,040)	11,417,998	20,312,018	(8,894,020)	32,915,591	33,509,860	(594,269)
Capital Expenditure	2,210,411	700,000	1,510,411	7,351,795	700,000	6,651,795	11,600,000	14,200,000	(2,600,000)

Monthly Trend	Target	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Yr to date	Trend
Net (Surplus) / Deficit (£m)	Month	2.128	18.439	2.042	4.334	1.664	1.814	6.089	(2.004)	2.781				35.157	Better
	Yr to date	19.785	18.439	20.481	24.815	24.815	28.292	34.381	32.377	35.157					N/A
	Full Year Forecast	24.700	24.700	32.771	32.771	33.381	33.385	40.834	32.125	58.911					N/A
Cash in bank, in hand and investment (£m)		1.329	1.820	1.217	2.358	1.740	0.554	1.496	(0.888)					N/A	Better
Borrowings		-	-	-	-	-	-	-	-					N/A	Same
CIP/ Turnaround savings to date (£m)		(0.563)	(1.341)	(2.652)	(4.761)	(5.768)	(7.436)	(9.287)	(11.418)					N/A	Better
Bad debt provisions (Non-NHS) (£m)		2.348	2.323	2.428	2.422	2.630	2.600	2.599	2.624					N/A	Same
EBITDA ² % achieved - Year to date (%)		(270.38)%	(1520.87)%	(83.84)%	(5.33)%	10.50 %	(28.44)%	25.49 %	18.85 %					N/A	Worse
EBITDA ² margin Year to date (%)		(4.71)%	(0.59)%	(1.72)%	(0.19)%	0.44 %	(1.08)%	1.29 %	1.23 %					N/A	Better
Return on assets (%)		(0.57)%	(0.56)%	(1.08)%	(1.06)%	(1.05)%	(2.04)%	(1.09)%	(1.28)%					N/A	Same
I&E surplus - YTD (%)		(58.56)%	(31.39)%	(25.49)%	(20.01)%	(17.02)%	(17.52)%	(13.85)%	(13.16)%					N/A	Better
Liquidity ratio (days)		385.2	401.6	394.5	370.3	382.1	368.6	371.0	368.7					N/A	Better

B: Financial Risk Rating & Auditor's Evaluation

		April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Overall Weighted Risk Score ³	Month	1.45	1.28	1.25	1.15	1.40	1.35	1.50	1.30	-	-	-	-
ALE ⁴ Rating	In Year	1	1	1	1	1	1	1	1				

C: Finance Processing Key Performance indicators

	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Average Debtor days	14.4	22.2	24.3	45.5	25.145	25.890	26.129	27.324				
Average Creditor days	215.7	150.8	88.6	130.8	42.731	39.259	38.931	33.647				
YTD PSPP by Volume - NHS	86.32 %	86.32 %	57.53 %	60.94 %	63.85 %	68.64 %	70.80 %	70.28 %				
YTD PSPP by Volume - Non NHS	92.62 %	88.63 %	88.17 %	85.13 %	85.37 %	87.15 %	85.53 %	81.45 %				
PO Invoices Received in Month %	24.200%	36.100%	36.100%	36.100%	32.900%	33.100%	37.000%	32.800%				
Unallocated Cash - Volume	11.900%	13.300%	13.300%	11.110%	11.750%	14.290%	15.500%	14.220%				
Unallocated Cash - Value £'k	220.00	203.00	203.00	230.00	62.00	560.00	1,066.00	5,555.00				
Contract Volumes - Annualised Volumes/Contract Volumes	116.900%	114.115%	114.115%	101.600%	103.700%	108.578%	105.646%	103.909%				

¹ PSPP refers to Public Sector Payments Policy <http://www.info.doh.gov.uk/doh/finman.nsf/072561aa006322660725618c006b09a0/b66087b4fb6a2000802568ac00382291?OpenDocument>

² EBITDA means Earnings Before Interest, Tax, Depreciation and Amortisation

³ Overall Weighted risk score : Weighted score used by NHS London to monitor Trusts' overall financial risk. (1.0 is highest risk 3.0 is lowest risk) - (see accompanying sheet)

⁴ ALE rating :- Auditor's Local Evaluation, 1 = lowest rating ; 4= highest rating.

FINANCIAL RISK RATING : Detailed metrics and scores

<i>Initial Planning (5% weighting)</i>	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Risk Metric : Planned Deficit/Turnover %	-2.729%	-2.729%	-2.729%	-2.727%	-2.742%	-2.740%	-2.707%	-2.707%				
Raw Risk Score : Initial Planning (highest risk 1, lowest risk 3)	1	1	1	1	1	1	1	1				
Weighted Risk Score : Initial Planning (highest risk 0.05m lowest risk 0.15)	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05				

<i>Year To Date (25% weighting)</i>	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Risk Metric : YTD Op surplus/ YTD Turnover %	-14.385%	-10.070%	-11.202%	-9.496%	-8.653%	-10.433%	-7.899%	-7.953%				
Risk Metric YTD EBITDA/YTD Turnover %	-4.710%	-0.591%	-1.716%	-0.193%	0.444%	-1.079%	1.288%	1.234%				
Raw Risk Score : Year to Date (highest risk 2, lowest risk 6)	2	2	2	2	2	2	3	3				
Weighted Risk Score : Year to Date (highest risk 0.25, lowest risk 0.75)	0.25	0.25	0.25	0.25	0.25	0.25	0.30	0.30				

<i>Forecast Out-turn Metrics (40% weighting)</i>	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Risk Metric : FOT Op surplus/ FOT Turnover %	-6.244%	-8.300%	-8.737%	-8.350%	-8.345%	-10.178%	-10.178%	-15.463%				
Risk Metric FOT EBITDA/FOT Turnover %	-6.359%	-4.386%	-4.012%	-4.300%	-4.340%	3.749%	3.749%	-0.744%				
Risk Metric : Mvt in Forecast Outturn in Mth £	0	-8,071,000	-1,858,000	1,247,893	-3,837	0	0	0				
Raw Risk Score : F'cast Out-Turn (highest risk 3, lowest risk 9)	4	3	3	3	4	4	4	3				
Weighted Risk Score : F'cast Out-Turn (highest risk 0.4, lowest risk 1.2)	0.55	0.40	0.40	0.40	0.55	0.45	0.45	0.40				

<i>Underlying Financial Position (10% weighting)</i>	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Risk Metric : Underlying Deficit/ Underlying income %	-6.244%	-8.300%	-8.737%	-8.350%	-8.345%	-10.178%	-10.178%	-15.463%				
Risk Metric Underlying EBITDA/Underlying Turnover %	-6.359%	-4.386%	-4.012%	-4.300%	-4.340%	3.749%	3.749%	-0.744%				
Raw Risk Score : Underlying Position (highest risk 2, lowest risk 6)	2	2	2	2	2	3	3	2				
Weighted Risk Score (10%): Underlying Position (highest risk 0.1, lowest risk 0.3)	0.10	0.10	0.10	0.10	0.10	0.15	0.15	0.10				

<i>Finance Processes and Balance Sheet efficiency (20% weighting)</i>	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Risk Metric : Prompt Payment - all invs Value	96.285%	90.179%	85.417%	82.531%	82.193%	84.972%	85.894%	81.810%				
Risk Metric : Prompt Payment - all invs Volume	92.449%	88.580%	87.403%	84.475%	84.741%	86.620%	85.103%	81.074%				
Risk Metric : Current Assets/Current Liabs	118.249%	115.088%	100.362%	91.886%	93.227%	82.435%	86.331%	80.425%				
Risk Metric : Debtor days	13.97	21.92	23.98	45.49	25.00	25.69	26.09	27.34				
Risk Metric : Creditor days	215.65	150.79	88.64	130.81	43.00	39.26	38.93	33.65				
Raw Risk Score : Balance Sheet (highest risk 5, lowest risk 15)	13	12	11	9	11	11	11	11				
Weighted Risk Score (20%) : Balance Sheet (highest risk 0.1, lowest risk 0.6)	0.50	0.48	0.45	0.35	0.45	0.45	0.45	0.45				

Overall Weighted Risk Score (100%) (highest risk 1.0, lowest risk 3.0)	1.45	1.28	1.25	1.15	1.40	1.35	1.40	1.30				
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The financial risk rating is a blended measure of overall risk taken across the above categories and weighted. The rating shown is that used by NHS London and the Department of Health to monitor the Trusts overall financial performance.

Quality and Patient Standards Dashboard November 2009

Operational Standards & Targets

Indicator	Performance Against Target*	
Total time in A&E	Failing, Stable	NHS Performance Framework
Cancelled Operations	Meeting, Stable	
Infection Control	Meeting, Stable	
18 Week Referral to Treatment times	Meeting, Stable	
Cancer Access	Mixed, Improving	
Two Week Rapid Access to Chest Pain Clinic	Exceeding, Stable	
GUM Access	Meeting, Stable	
Delayed Transfers of Care	Failing, Stable	
Stroke	Mixed, Improving	
Inpatient & Outpatient Access	Meeting, Stable	
Data quality on ethnic group	Meeting, Stable	Additional CQC Targets
Call to Needle	Meeting, Stable	
Engagement in clinical audits	Exceeding, Stable	
Participation in heart disease audits	No Data	
Mortality Rates	Meeting, Stable	Other BHRT Targets
Choose & Book Slot Issues	Meeting, Improving	
Length of Stay	Failing, Stable	
First to Follow Up ratio	Meeting (Against KPI), Stable	
DNA Rates	Meeting, Improving	
Waiting Lists	Failing, Stable	
Day Case Rates	Mixed, Stable	
Elective Admissions on Day of Surgery	Meeting, Stable	
Readmissions	Failing, Stable	
Workforce	Mixed, Stable	

*Assessed overall ratings as at Q3 YTD figures under the NHS Performance Framework, Care Quality Commission and internal standards

Quality and Patient Standards Dashboard November 2009
Operational Standards & Targets

[Return to Op Standards & Targets](#)

[Return to Balanced Scorecard](#)

Indicator	Target	08/09		09/10												YTD
		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
A&E	Total time in A&E	98.00%	98.24%	98.22%	98.00%	97.87%	98.81%	98.16%	97.68%	96.16%	96.76%					97.72%
Cancelled Operations	Cancelled Operations - % Elective operations cancelled on or before day of operation	0.80%	0.73%	0.57%	0.70%	0.69%	0.70%	0.70%	0.64%	0.46%	0.36%					0.60%
	Cancelled Operations - Cancellations not re-admitted within 28 days	5.00%	0.00%	3.57%	2.94%	0.00%	2.56%	0.00%	0.00%	0.00%	0.00%					1.13%
Infection Control	Clostridium Difficile (CDIFF) Episodes - Excluding those not apportioned to Trust	12	6	6	4	8	6	7	7	4	8					50
	MRSA bacteraemia episodes - Excluding those not apportioned to Trust	2	1	2	2	2	2	1	3	1	3					16
	Total number of Clostridium Difficile (CDIFF) episodes reported to HPA inc Community Acquired	12	17	7	7	11	10	11	13	8	22					89
	Total number of MRSA bacteraemia episodes reported to HPA inc Community Acquired	3	1	2	4	3	2	2	4	1	5					23
	MRSA Screening	100%	11.05%	98.38%	95.92%	80.70%	81.64%	82.52%	80.41%	92.95%	77.25%					86.22%
18 Weeks RTT	18 Weeks Referral to Treatment Times - Inpatients	90.00%	93.90%	92.30%	91.60%	93.10%	90.72%	91.23%	90.60%	90.80%	91.35%					91.24%
	18 Weeks Referral to Treatment Times - Outpatients	95.00%	96.90%	97.90%	95.50%	96.10%	95.91%	96.20%	97.10%	97.30%	97.83%					96.11%
	Achievement of standards in all specialities	Pass	N/A	Borderline	Borderline	Borderline	Fail	Fail	Fail	Fail	Fail					Fail
	Achievement of standards in Orthopaedics	Pass	N/A	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail					Fail
	18 Weeks - Direct Access to Audiology	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%					100.00%
Cancer Access	2 Week GP Referral to 1st Outpatient	93.00%	83.59%	99.80%	99.45%	99.90%	99.90%	98.84%	99.69%	99.81%	99.49%					99.61%
	31 Day 2nd or Subsequent Treatment - Surgery	94.00%		90.00%	88.89%	87.50%	93.33%	82.14%	91.67%	73.91%	93.33%					87.60%
	31 Day 2nd or Subsequent Treatment - Drug	98.00%		93.33%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%					99.17%
	31 Day Diagnosis to Treatment - All Cancers	96.00%	95.38%	96.57%	95.95%	96.89%	96.33%	94.51%	93.40%	97.95%	97.16%					96.09%
	62 Referral to Treatment from Screening	90.00%		83.33%	83.33%	90.91%	80.00%	77.78%	100.00%	66.67%	88.89%					83.86%
	62 Referral to Treatment from a Hospital Specialist	85.00%		62.50%	100.00%	77.78%	71.43%	83.33%	40.00%	100.00%	100.00%					79.38%
	62 Urgent Referral to Treatment - All Cancers	85.00%	82.14%	80.00%	80.56%	83.48%	81.56%	79.00%	72.00%	81.32%	83.15%					80.13%
	Breast Screening - number screened as percentage of number invited	90.00%	57.00%	65.00%	81.00%	74.00%	59.00%	65.00%	63.70%	61.00%	67.00%					66.96%
RACP	Two Week Rapid Access to Chest Pain Clinic	98.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%					100.00%
GUM	GUM Access - Patients offered an appointment within 48 hours	98.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%					100.00%
DTOC	Delayed Transfers of Care - % of Inpatients with delayed transfer of care	3.50%	1.91%	1.67%	2.83%	3.39%	4.50%	4.01%	5.03%	4.01%	4.68%					3.74%
Stroke	% Admitted Direct to Stroke Unit	95.00%	31.51%	47.21%	50.00%	35.09%	35.00%	38.64%	35.00%	42.86%	53.25%					42.13%
	% Spending 90% of Time in Stroke Unit	70.00%	58.90%	66.67%	66.00%	69.09%	58.30%	66.04%	69.09%	81.00%	76.00%					69.02%
Inpatient & Outpatient Access	Outpatients waiting longer than 13 weeks	0	0	0	0	0	0	0	0	0	0					0
	Inpatients waiting longer than 26 weeks	0	1	0	0	1	0	0	0	0	0					1
Ethnic Coding	Data Quality of Ethnic Group	95.00%	95.71%	96.31%	96.10%	95.48%	96.09%	96.48%	96.32%	96.37%	96.66%					96.23%
Call to Needle	Call to Needle Emergency Thrombolysis	68.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%					100.00%
Audits	Engagement in Clinical Audits	90.00%	98.00%	98.50%	98.88%	97.25%	99.13%	99.53%	99.20%	96.80%	98.40%					98.46%

NHS Performance Framework

COC
Periodic Review

Indicator		Target	08/09		09/10												
			Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	
Mortality	Hospital Standardised Mortality Ratio (Monthly)	100		113.8	96.7	111.2	108.1	98.0	96.2								102.3
	HSMR Relative Risk (Low)	N/A		99.0	82.1	96.0	92.7	83.2	81.5								99.4
	HSMR Relative Risk (High)	N/A		130.2	113.2	128.0	125.5	114.6	112.9								113.5
	Hospital Standardised Mortality Ratio (Rolling 12 Monthly)	100		110.9	109.8	109.9	110.4	110.1	109.8								N/A
	HSMR Relative Risk Rolling 12 Monthly (Low)	N/A		106.6	105.5	105.6	106.1	105.8	105.4								N/A
	HSMR Relative Risk Rolling 12 Monthly (High)	N/A		115.3	114.2	114.4	114.9	114.6	114.3								N/A
	Mortality rate - elective cases (%)	N/A	0.60%	0.10%	0.04%	0.02%	0.02%	0.04%	0.04%	0.04%	0.13%	0.11%					0.06%
	Mortality rate - non-elective cases (%)	N/A	3.94%	4.35%	3.13%	3.65%	3.57%	3.53%	3.42%	3.30%	4.34%						3.56%
Choose & Book	C&B Slot issues per successful DBS booking	0.04	0.33	0.22	0.12	0.18	0.14	0.18	0.27	0.26	0.11						0.19
Length of Stay	LOS Elective	3.6	3.6	4.3	3.7	3.7	3.5	4.5	3.8	3.5	3.7						3.8
	LOS Non-Elective	5.0	5.6	5.7	5.8	5.9	5.5	5.5	5.6	5.0	5.5						5.6
FFU	First to Follow-Up Ratio - All Trust	2.26	2.33	2.49	2.44	2.39	2.64	2.75	2.75	2.75	2.73						2.62
	FFU Ratio (Less Midwifery, Obstetrics and Phototherapy)	2.46		2.40	2.33	2.37	2.37	2.38	2.37	2.30	2.29						2.35
DNA Rates	DNA First	9.70%	9.53%	10.52%	10.30%	10.59%	11.16%	11.03%	10.88%	10.09%	9.03%						10.39%
	DNA Follow-Up	10.30%	13.79%	12.34%	12.11%	12.00%	11.24%	11.17%	11.42%	10.75%	10.16%						11.30%
Waiting Lists	Outpatient Waiting Lists (% under 4 weeks)	100.00%	60.93%	56.85%	53.83%	58.50%	58.89%	51.20%	50.27%	50.12%	52.42%						54.01%
	Inpatient Waiting Lists (% under 7 weeks)	100.00%	73.67%	68.67%	70.29%	70.17%	70.42%	61.03%	59.92%	63.16%	64.93%						66.08%
Day Case Rates	Basket of 25 procedures	83.00%	67.98%	70.85%	70.76%	74.12%	71.20%	76.85%	72.73%	69.05%	70.48%						71.76%
	All procedures	75.00%	82.39%	84.30%	83.79%	85.78%	84.24%	84.92%	85.60%	84.56%	84.32%						84.70%
Admissions	Elective Admissions on Day of Surgery	85.00%	84.92%	86.49%	85.52%	85.84%	86.73%	86.62%	86.09%	88.26%	88.04%						86.71%
Readmissions	Readmission Rates	7.00%	7.81%	7.97%	7.23%	7.38%	7.45%	8.05%	7.95%	8.29%							7.72%
	Readmission Rates to same specialty	3.50%	3.89%	4.08%	3.59%	3.87%	3.92%	4.43%	4.21%	4.47%							4.07%
Data Quality	Significant SUS-SEM Data Quality Issues	0						1	1	1	1						1
Workforce	Bank/Agency Spend (£mil)	-	£2.8	£3.1	£3.5	£4.0	£3.9	£4.0	£3.7	£3.3	£2.8						£3.6
	Staff Turnover	12.00%	11.80%	11.50%	12.70%	12.30%	12.50%	13.80%	13.50%	13.50%	13.30%						12.89%
	Sickness Absence (WTE days loss in month)	4.00%	5.67%	4.87%	3.74%	5.09%	6.88%	6.41%	5.27%	5.74%	5.59%						5.45%

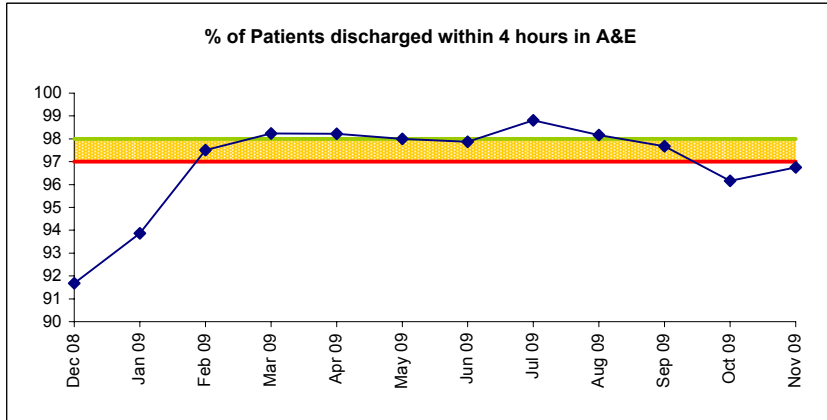
Other BHRT Targets

Overall ratings as at YTD figures under the NHS Performance Framework, Care Quality Commission and internal standards for Standards and Targets

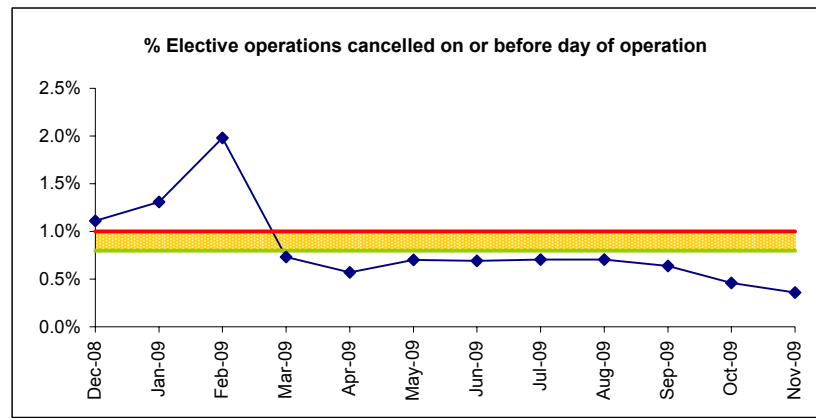


[Return to Op Standards & Targets Data](#)

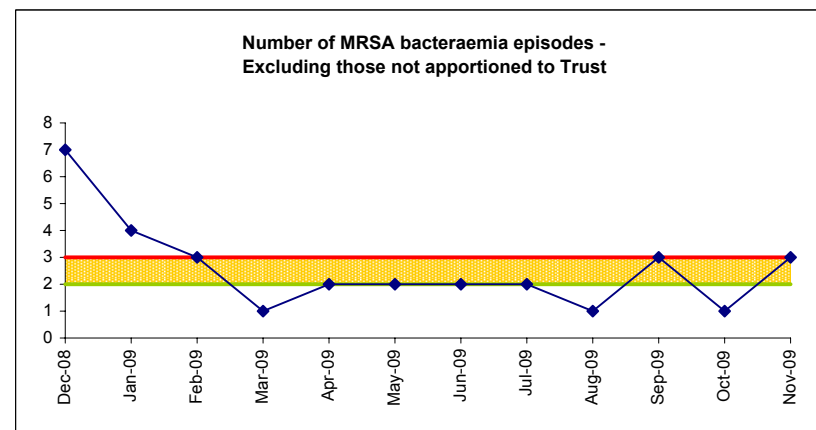
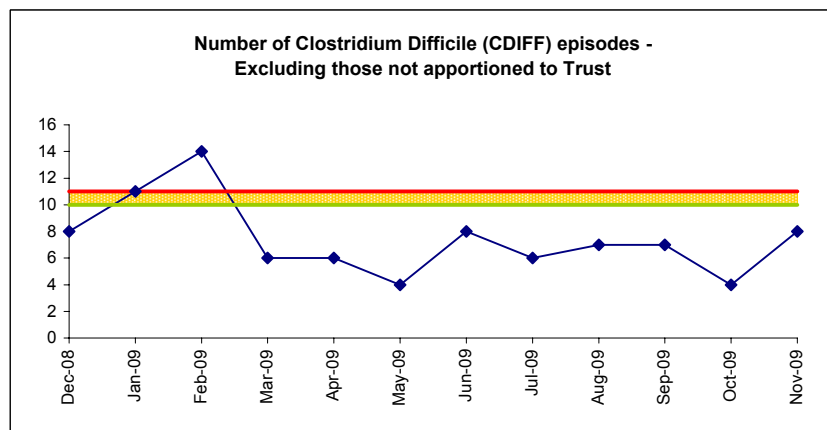
A&E Targets



Cancelled Operations



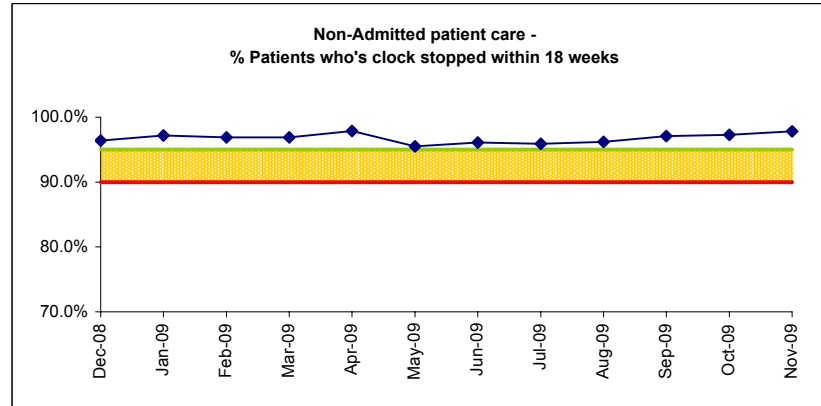
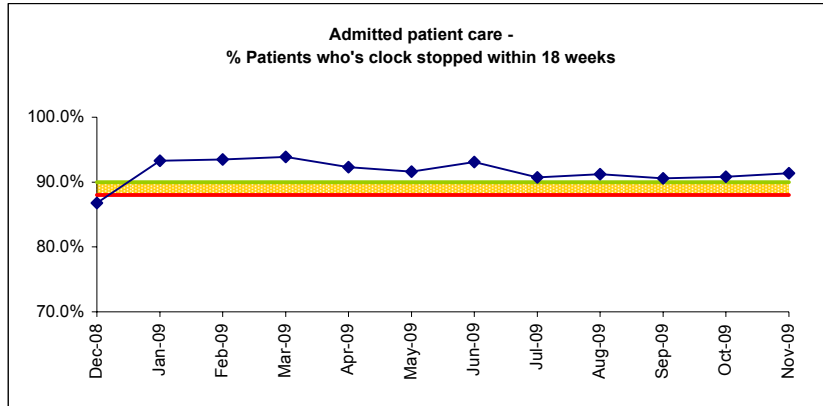
Infection Control



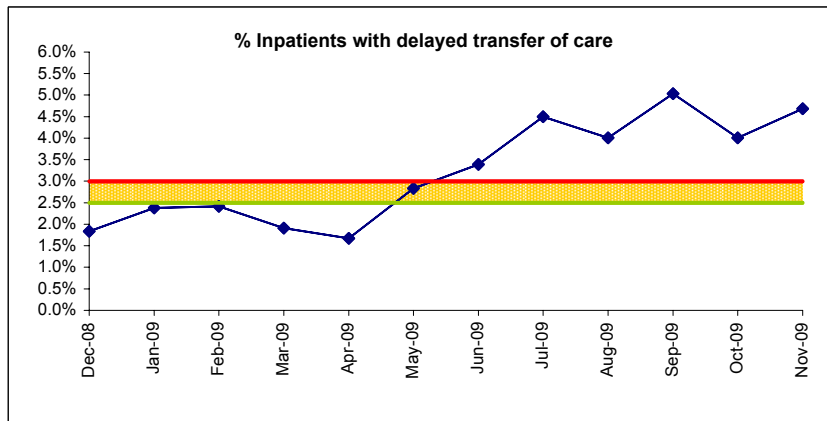


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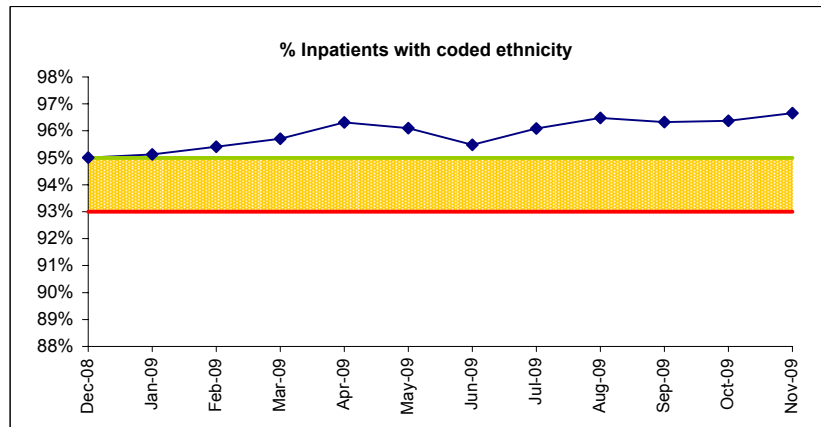
18 Week Milestones



Transfers of Care



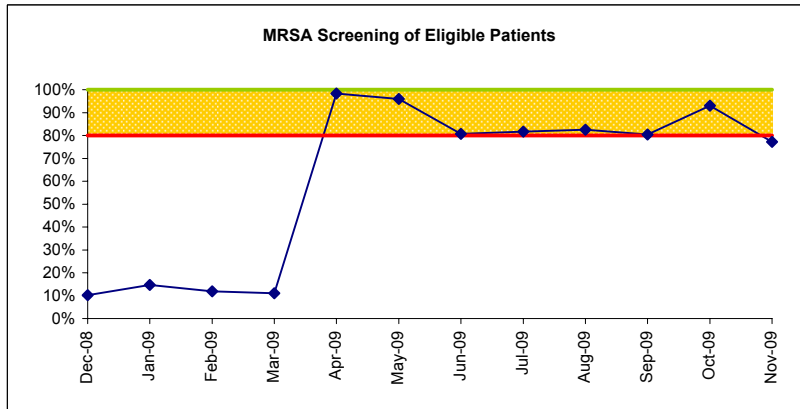
Ethnic Coding



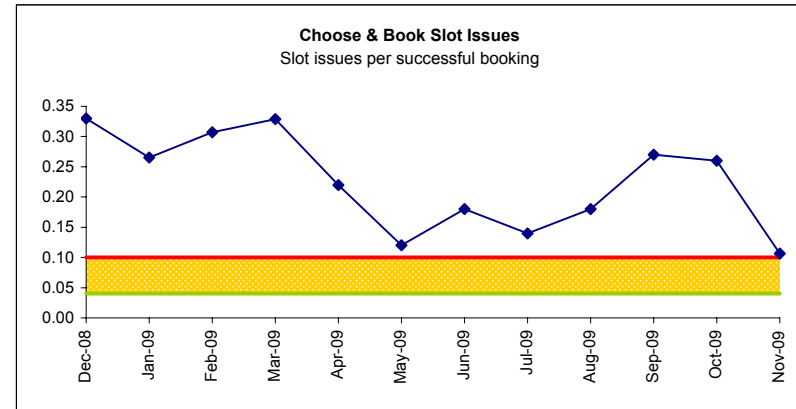


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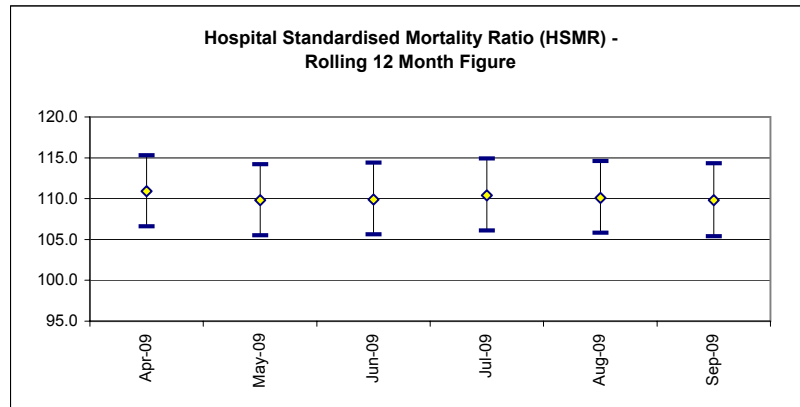
MRSA screening



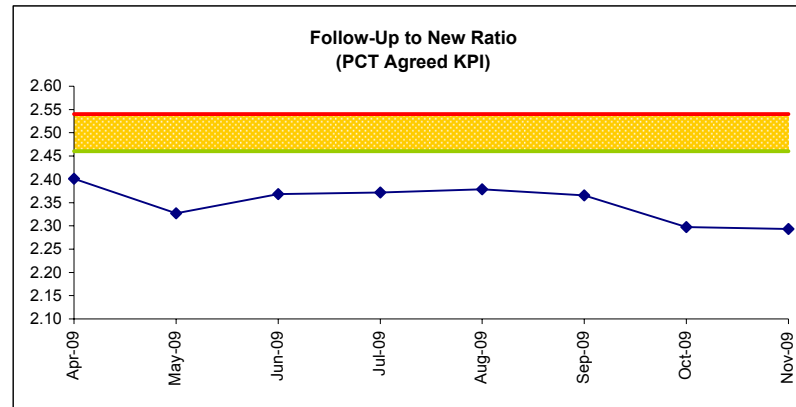
C&B Slot issues



Mortality



Follow-up to New ratio

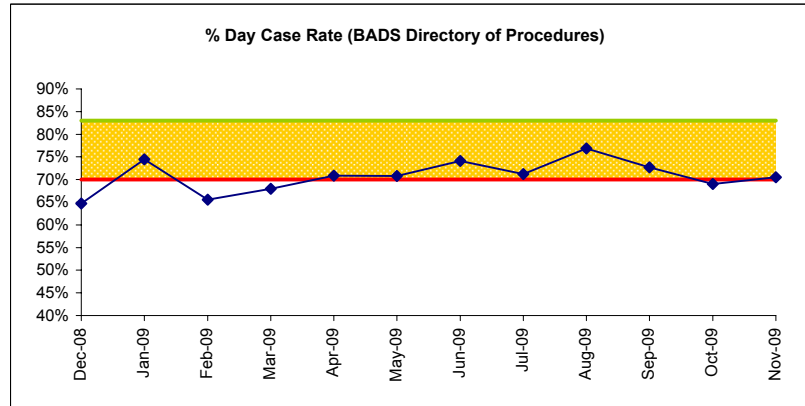


Quality and Patient Standards Dashboard November 2009
Internal Indicators

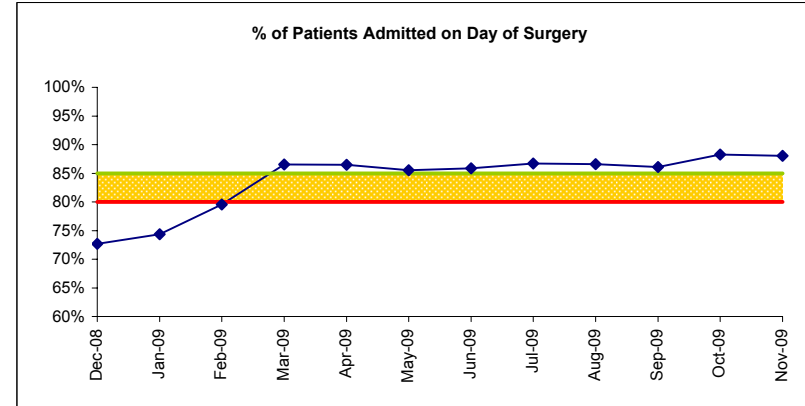


[Return to Op Standards & Targets Data](#)

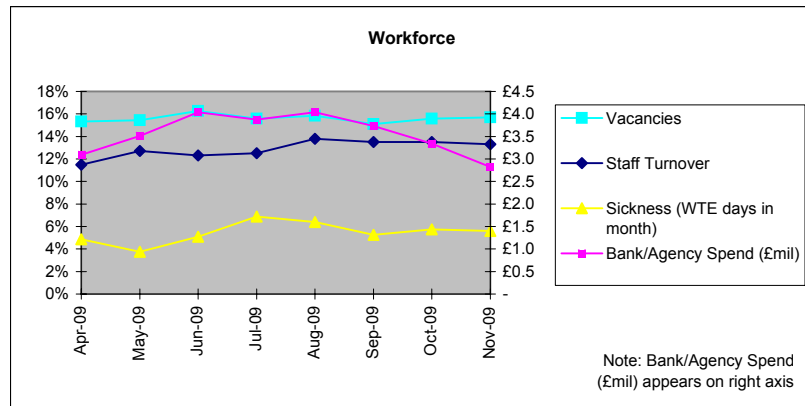
Day Case Rate (Basket of 25)



Admitted on Day of Surgery



Workforce



Quality & Safety

		08/09	09/10													
Indicator		Target	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Incident Reporting	Safety - Incident reporting rate per 100 admissions	5.80%	4.50%	7.02%	7.64%	8.15%	7.90%	6.72%	5.63%	6.23%	5.92%					6.90%
	Safety - Proportion of incidents causing "severe" harm or worse	0.9%*	1.19%	1.36%	1.27%	1.99%	1.60%	1.86%	2.52%	5.97%*	7.57%*					1.77%
Infection Control	Clostridium Difficile (CDIFF) Episodes - Excluding those not apportioned to Trust	12	6	6	4	8	6	7	7	4	8					50
	MRSA bacteraemia episodes - Excluding those not apportioned to Trust	2	1	2	2	2	2	1	3	1	3					16
	Total number of Clostridium Difficile (CDIFF) episodes reported to HPA inc Community Acquired	12	17	7	7	11	10	11	13	8	22					89
	Total number of MRSA bacteraemia episodes reported to HPA inc Community Acquired	3	1	2	4	3	2	2	4	1	5					23
	MRSA Screening	100.00%	11.05%	98.38%	95.92%	80.70%	81.64%	82.52%	80.41%	92.95%	77.25%					86.22%

*Target relates to reporting mechanism prior to September 2009. Updated targets to be determined in light of revised DH guidelines.

The NHS Performance Framework rates BHRUT as 'Performance Under Review' for Quality & Safety.

Quality & Safety within the NHS Performance Framework will be assessed using several criteria. Firstly, CQC's ongoing judgement as to compliance with HCIA's. This will be in addition with results of providers self-certification against relevant core standards in the Annual Health Check. There are additional indicators on which we are judged for which the bandings have not been made fully available. Please see the balanced scorecard for an indication of our expected assessment.

Quality and Patient Standards Dashboard November 2009
User Experience

Indicator		08/09		09/10													
		Target	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	
Complaints	Complaint Numbers (excluding enquiries)	53	93	65	82	50	50	27	30	32	51					387	
	Complaints responded to within 25 working days	80.00%	63.00%	67.00%	78.0%	76.0%	82.0%	77.0%	87.0%	81.0%						78.29%	
Mixed Sex Breaches	No. of patients on mixed sex wards	0	0	0	1	9	5	0	0	3	6					24	
Patient Environment Action Team Assessments (PEAT) 2009	King George Hospital - Food				Acceptable												
	King George Hospital - Environment				Good												
	King George Hospital - Privacy and Dignity				Acceptable												
	Queen's Hospital - Food				Excellent												
	Queen's Hospital - Environment				Good												
	Queen's Hospital - Privacy and Dignity				Good												

Note: Not shown above is data from NHS Patient Survey which is a key component in the DH Performance Framework and CQC assessment

User Experience within the NHS Performance Assessment Framework will be rated using indicators derived from five standard

- Access and waiting;
- Safe, high quality coordinated care;
- Building closer relationships;
- Clean, friendly comfortable place to be; and
- Better information, more choice.

This will be in conjunction with Vital Signs around user experience and public confidence in the local NHS. We will present indicators to best show our performance in the meantime.