

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
<p>Quality and Patient Standards Performance Report – November 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/or for the year 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 • MRSA • Clostridium Difficile (C Diff) • RTT Incomplete Pathways • 62 days urgent referral to treatment of all cancers • Delayed transfers of care • Mortality • Length of stay • DNA Rates • Day case rates • Re-admission Rates • Freedom of Information • Data Quality • Complaints <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 – December 2010 <input type="checkbox"/> REMUNERATION <input type="checkbox"/> OTHER (please specify) </p>

2. DECISION REQUIRED:	CATEGORY:
<p>The Trust Board is asked to note the content of the report and support the actions to bring the performance back in line with trajectory/target.</p>	<p> <input checked="" type="checkbox"/> 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) </p> <p>AUTHOR: Steve Rubery, Head of Business Delivery</p> <p>PRESENTER: Neill Moloney, Director of Delivery</p> <p>DATE: 17th December 2010</p>
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 OR REFERRED TO: _____	DATE: _____ DATE: _____
REVIEW DATE (if applicable) _____	

Quality and Patient Standards Performance Report November 2010

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

Following discussion with the Department of Health, the Care Quality Commission (CQC) has not undertaken the overall aggregated rating assessment within the planned Periodic Review 2009/10. As such, the Trust has not been rated as Poor, Adequate, Good or Excellent for its Quality of Services. However, the CQC have now published benchmarked data for each of the Existing Commitments and Tier 1 and Tier 2 Vital Signs.

The CQC are still discussing their work programme for 2010/11 with the Department of Health (DH) 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 Commissioners and Providers against minimum standards. The Quality and Patient Standards Performance Dashboard (the "Dashboard") is designed to guide the Trust Board in progress against this framework, which assesses Trusts in the areas of:

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

The revisions to the Framework 2010/11 set out a number of changes, which are reflected in the Dashboard and are noted in previous reports. Additionally, the Trust has, elected to ensure that there is no deterioration in Four-Hour Maximum Wait In A&E performance. To this end, the Internal Performance Scorecard displays the thresholds as 98% and 95% as 'Performing' and 'Performance Under Review' respectively. Additionally, this internal measure displays performance against the Type 1 attendances¹ only which is where the majority of breaches occur and is also the attendance type on which NHS London focuses its monitoring of Trust performance:

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.

Measure	Upper Threshold (Performing/ Green)	Lower Threshold (Performance Under Review/ Amber)	Attendance Types
DH Performance Framework	95%	94%	All Types
BHRUT Internal Target – All Types	98%	95%	All Types
BHRUT Internal Target – Type 1 Attendances	95%	94%	Type 1 Only

The revised DH Framework target of 95% came into effect from Q2 of 2010/11, with the Trust being monitored against the previous 98% target for Q1.

3. DH Framework Performance Targets

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

- Cancelled Operations - Breaches Of 28 Days Re-admission Guarantee As Percentage Of Cancelled Operations;
- RTT (Previously 18 Weeks RTT), admitted and non-admitted pathways;
- 2 Week GP Referral To 1st Outpatient;
- 2 Week GP Referral To 1st Outpatient - Breast Symptoms;
- 31 Day Second Or Subsequent Treatment – Surgery;
- 31 Day Second Or Subsequent Treatment – Drug;
- 31 Day Diagnosis To Treatment For All Cancers;
- 62 Day Referral To Treatment From Screening;
- 62 Day Referral To Treatment From Hospital Specialist;
- 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 continues to measure four hour waits in Emergency Departments (ED) against both the DH Framework and its own internal target of 95% against Type 1 Attendances. The Trust failed to achieve the national standard for November 2010 for all attendance types as well as its internal target.

The Trust's "Phase 2 Plan" for change continues, however it is recognised that the gains required from this are likely to show in the medium/long term rather than in the immediate future. An urgent list of remedial action was put in place mid-month. This included:

- Appointment of an Interim Head of Patient Flow (Operations) to directly manage and set-up systems to facilitate the timely move of patients from the ED into beds and maximise morning discharges;
- The Department of Health Intensive Support Team have been invited into the Trust to review bed flow and capacity for the emergency care pathway;
- A Tracker Nurse role to be appointed to in the ED to guide and drive the patient pathway through ED;
- A Matron has been identified to go round all medical wards to monitor discharges five days a week. The Duty Matron will undertake this role at weekends;
- Additional contingency capacity has been created on Sky A and Amber B Wards. Emergency beds in the theatre recovery area at Queen's have been set up to admit general surgical patients.

Overall the challenge remains:

- Securing bed capacity early in the day (before 12 noon) through prompt discharge;
- Supporting and motivating a largely locum workforce in the ED to deliver a service with sufficient pace and rhythm to ensure only clinical breaches occur.

It is not coincidental that the majority of breaches occur out of hours, at night and at weekends. Some of the later night breaches result from the bed pressures of the day and the residual patients not moved in the morning but also, as at weekends, there is an issue regarding supervision and direct management of the locum teams. In addition, securing buy-in to the aims and ambitions of the Trust is complex when the workforce is transient and non-substantive – 70% of the current medical workforce in the ED are locums. A new workforce plan is now ready to launch to try to address the ED issues although it should be noted that this does not necessarily offer quick wins. Consultant placement and rotas are being adjusted to try and maximise senior cover.

It should be noted that the position remains extremely challenging and will require support from across the Trust to reconcile the current risk. Mitigation, escalation and contingency plans are in place to ameliorate this risk.

3.2 MRSA

The Trust had two hospital acquired MRSA bacteraemias in November 2010 which means that we are now one over the year-to-date trajectory. The target for hospital acquired MRSA bacteraemias is 11 for the year and the Trust position is now at 8 YTD, so achievement of this target will be challenging. We are continuing to undertake a root cause analysis of every hospital acquired case.

MRSA screening of all emergency admissions started on 13th December 2010, however it will be sometime before we can assess whether this will have a positive impact on the numbers of bacteraemias.

3.3 Clostridium Difficile (C Diff)

The Trust has had 28 cases in October and November 2010 against a target of 21 for these two months. This has tipped YTD performance from “Performing” to “Performance Under Review”. Following an agreement at the Infection Control Committee in November 2010 to performance manage the implementation of the Clostridium difficile policy, every new case has been individually reviewed by the Infection Control team and senior nurses. Any deficiencies are reviewed at the next available ward handover meeting and notified to senior clinical staff.

Although it is too early to fully assess the success of this strategy, in the last 4 weeks there have been only 5 new cases across the Trust which is a significant improvement on the preceding period. The Trust will achieve the target at the end of the year if this improvement is maintained.

3.4 RTT – Incomplete Pathways

The Trust has continued to achieve the 18 week performance standards for admitted and non-admitted patients, however is also continuing to fail the median waiting time standard for incomplete pathways. Performance is a median wait of 14.7 weeks compared to the national target of 7.2 weeks.

A validation exercise has been initiated to ensure that accuracy of the patients with an incomplete pathway. It is expected, however, that many of the patients on this list would need to be treated before the end of March in order to reduce the waiting times and deliver the target before the end of March 2011. The volume of patients that would require to be treated in the timescales available mean that it is very unlikely that the Trust could achieve this target. However the Acute Commissioning Unit (ACU) have indicated that the Trust will be allowed to not achieve one of the six standards in relation to RTT and have stated informally that they do not wish the Trust to undertake more activity in order to achieve the median wait standard for incomplete pathways.

The Planned Care Steering group are working collaboratively on demand management schemes in order to improve performance however at present, progress continues to be slower than anticipated by Commissioners. ENT and Pain Management activity will be directed to the Independent Sector Treatment Centre (ISTC) where possible. Furthermore, dental activity will be transferred to a community provider.

3.5 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)

Performance improved across the majority of the targets during November 2010, but unfortunately the 62-day target performance fell to 84.76%. YTD performance has, however, improved from 83.28% to 83.89%. This was due mainly to a fall in performance within Urology, Lung and Lower GI. In month, there have been improvements in the 62-day performance of Gynaecology, Haematology, Upper GI, and Head and Neck. Validation of the breaches is currently underway and the final upload to Open Exeter is due by the 10th January 2011.

The General Manager for Oncology along with the Clinical Lead for Urology have attended the Redbridge PTI to discuss 2WW referrals with the local GPs; the session was very positive with the GPs asking for a further clinical sessions on examining patients and reviewing the criteria for referral.

The Trust also went live with the new Somerset Database on the 7th December 2010, therefore the next upload will take place via the new system.

3.6 Delayed Transfers Of Care

DTOCs performance is currently failing to meet all targets, both the 3.5% under the DH Performance Framework and agreed local target of 1.0%. The increasing trend at the end of October 2010 continued into the first week of November with DTOCs hitting 8.0%. The situation was recovered and DTOCs reduced to 3.9% by the last week of November 2010 with an average of 4.8% for the month as shown in figure 11 overleaf. December performance is continuing at the lower level of 3.5 – 4.0%.

Through the daily DTOC meetings the Trust has continued to reduce its own DTOC responsibilities and is regularly in single figures. The daily sector report is focussing on poorly performing PCTs and Social Services and enables sector pressure to be brought to bear.

A DTOC ward has opened at KGH for Barking and Dagenham and Redbridge patients. Initial criteria proved too restrictive and the ward was left with empty beds, however the criteria are currently under review to increase utilisation of the ward. NHS Havering have provided four DTOC beds at St George's Hospital and discussions are continuing as to the final number of beds to be available.

The sector remains actively engaged with the PCTs to ensure capacity is available for the expected rise in rehabilitation requirements over the winter period.

Weekly Complex Discharge Partnership Board meetings continue to run involving PCTs, Social Services, Commissioners and CHS. It was through this board that a new rapid access process was developed to facilitate the early identification of rehabilitation/reablement patients and ensure smooth early onward transfer.

4. Other Performance Indicators

4.1 Mortality

The Dr Foster Hospital Guide was published at the end of November 2010. The Trust's position for 2009/10 is a Hospital Standardised Mortality Ratio (HSMR) of 115.7 (where 100 is the expected mortality ratio). In 2008/09 the Trust HSMR was 111 and prior to rebasing this had improved in 2009/10 to 102. However rebasing of the 2009/10 national data, where national performance improved at a faster rate than the 9 point performance improvement achieved by the Trust, resulted in what is effectively a deterioration in 2009/10 performance.

The Trust recognises that the 2009/10 HSMR figure in the Dr Foster Hospital Guide of 115 is a significant adverse outlier and has submitted a report to NHS London for upward briefing to the DH explaining the circumstances behind this and the actions being taken to improve the position for 2010/11. The analysis has looked at the main contributors to the adverse total picture, which include Pneumonia, Stroke, all Cancers and Urinary Tract Infections (UTI). Investigation of alerts has included perinatal deaths and complications of device, implant or graft, which have contributed to the position.

An additional coding issue relates to perinatal deaths. Review of the most recently available Dr Foster data (August 2010) shows that about half of our excess mortality is associated with perinatal deaths, which emerged as both an alert and a major contributor to our adverse position last year. Our work since has identified that the excess is due to coding information and the erroneous data is in the process of being removed/adjusted therefore putting the Trust in line with national coding processes.

As to the remainder of the excess, a coding disparity has been identified, namely the coding of co-morbidities. Review of our position relative to other local Trusts with lower HSMRs shows that our expected mortality rate, which is significantly dependent on co-morbidities, is considerably less than theirs. Reviews took place in November 2010 of deaths in a number of diagnoses back to April to bring our coding of co-morbidities in line with practice elsewhere. It is expected that this will further reduce our current HSMR.

Collectively, Cancers were the largest single contributor to our adverse variance at mid-year 2009/10, being around a third of our excess yet a full audit of all Cancer deaths indicated that care standards were at or better than expected levels. Further analysis showed that the Trust had an exceptionally low rate of coding of palliative care for Cancer cases – about 70% below the national rate. That was in turn having a major effect on our HSMR. Following review of local

Trusts' coding practice, the major impact of palliative care coding on mortality has been identified as applying across all diagnoses, not just Cancer as previously thought. Some local Trusts are coding 35% of all deaths as palliative compared to the Trust's 3%.

Palliative coding increases Trusts' "expected" mortality rate against their actual rate thus reducing any excess of the latter over the former on which the HSMR is based. Low palliative care coding consequently increases any excess and because of its own palliative care coding the Trust currently has the lowest expected mortality rate in the area with the highest actual rate. It can be shown that by coding all diagnoses at the national palliative care coding rate the Trust would increase its expected mortality rate to a level which for April – August 2010 would reduce its HSMR to 100 or less. From April 2011 a new Trust specific HSMR is to be published by the NHS rather than Dr Foster. The problems of variations in palliative care coding have been recognised and the new HSMR will avoid them by not taking palliative care into account.

The report also identified that the Trust has been very active in introducing systems and processes to identify and address the significant variation in the mortality data. These include:

- Training – continuous training programmes on the interrogation of Dr Foster data have been run throughout the year for consultant staff and senior managers;
- Audit – the Clinical Governance and Performance teams have been meeting on a monthly basis to identify "red bell alerts" by procedure and diagnosis. The patient's notes are then reviewed by the responsible clinician to audit and identify required changes in practice;
- Data Analysis – real time data is used to support consultants to continuously review their mortality on a month by month basis;
- Corporate Audit – the audit of mortality data is a corporate audit topic and 10 audits to specifically review mortality have been registered with the clinical audit department since January this year;
- Monitoring – the Trust Board and key committees review the Dr Foster data analysis through the monthly dashboard and the Clinical Governance Committee monitors and reviews the audits and their outcomes;
- Review Outcomes – through the above methods, the Trust has undertaken a review of every Dr Foster excess mortality alert since April which equates to 16 reviews, some of which are still in the process of completion. An independent audit of all mortality for September is being carried out to identify a range of issues including where the documentation is not providing sufficient evidence for coding all of the co-morbidities;
- CompStat approach – this process started in late October and currently reviews 7 major clinical pathways and an additional one in Emergency Medicine which started in mid-November. It functions by agreeing on best practice pathways then weekly reviews are held by clinicians on patients who have gone through the pathway to identify deviations from the pathway and provide feedback for change in real time;
- Weekend Mortality – the Dr Foster data indicates that there is a quality issue for patient care at the weekends, a rise in mortality for patients admitted at the weekend has been identified. The Trust is taking a range of steps to ensure a consistent approach to the quality of patient care 24/7 and the key to this has been an extensive review of the junior doctors' rotas which has been completed.

4.2 Length Of Stay

Elective Length of Stay (LOS) is now below target on a YTD basis, although non-elective LOS continues to be outside of the target.

The Non Elective (NEL) specialty ward LOS plans are now in place and are narrowly managing to maintain the LOS reduction seen this year and for Medical specialties in November there was an improvement. It is expected that with the reduction in DTOCs in November, as well as the implementation of the KGH DTOC ward to be taken over by North East London Foundation Trust (NELFT) from 6th December 2010, this figure will further improve.

The Acute Medical floor continues to work well with all nursing and medical teams aligned to the specialty wards. In general, the Medical take now manages within its own bed base which, when compared to 2009, is a substantial improvement from when medical patients were in Angelica, surge capacity and in other specialty beds on a regular basis. This equates to over 60 beds that are now not used. The next actions to reduce LOS, which include improving patient pathways through the CompStat approach, are aimed to improve the quality of patient care. This is expected to also reduce LOS and release beds.

The Acute Elderly Unit (AEU) at QH continues to function well and patients who require admission to this unit are being transferred in a timely manner. This had relieved a previous bottleneck in MAU and is ensuring that complex elderly patients are being managed in an appropriate environment. The LOS for these patients can be demonstrated as having been reduced by 2 days.

An AEU was also opened at KGH on 6th September 2010 with similar results in reducing LOS as seen at QH, although there was a delay to implementing Therapy support which has now been resolved for progress to continue.

Work with the Complex Partnership Board has started to work at individual patient level to effect discharges and as part of the Emergency Pathway work patients staying over 20 days are being reviewed. Plans to address this through Divisions comprise high level work at the senior management level for complex discharges, MDT reviews of over 40 day stayers and a targeted review by Matrons/GMs and CDs to try to achieve some quicker wins by identifying themes for the 20-29 day stayers. This is reported through to the Divisional Boards.

4.3 DNA Rates

There has been a significant deterioration in follow-up appointment DNA rates during the month and this is also a deterioration against the year end position for 2009/10. There has been a small improvement in the first appointment DNA rates.

Appointment reminder letters continue to be sent and increased attempts to contact the patient by telephone take place. However, vacancies (covered by the in-House Bank) and the delay in implementation of the new telephony system, have not helped. A review of the staffing requirements within the call centre and other initiatives to release pressure on this staff group are under way such as working with the PCTs to reduce the number of written referrals and changing the way that follow-up appointments are booked. It is anticipated that there should be some improvement in these rates by the end of the year.

4.4 Day Case Rates (basket of 25 procedures)

For the basket of 25 procedures the day case rates for November was 80.8% against a target of 83%.

Whilst day case rates are higher than Dr Foster peer in many procedures, for laparoscopic cholecystectomy and hernia repairs performance is lower than anticipated. It has been recognised by the National Audit Office that the transfer of non complex procedures to the Independent treatment Centre will have an impacted on the Trust's day case performance. Performance against all procedures is currently 86.48% against a target of 75%.

4.5 Re-admission Rates within 28 days

(Note: Re-admissions rates are reported one month in arrears to other indicators)

Re-admission rates decreased overall in October but high admission rates remain within some specialties. Key specialties where re-admission rates are high are General Medicine and Geriatric Medicine.

A piece of work is currently being undertaken to understand the implications of the proposed Operating Framework changes for 2011/12 on readmissions and this will inform the development of a targeted action plan.

The AEU has now started using Electronic Discharge Summaries (EDS) which will improve early communication to GPs and therefore play a part in reducing re-admissions to the Trust.

There is also targeted work with Nursing Homes to prevent re-admission and through the Complex Discharge Partnership Board work is ongoing with Community partners to promote re-ablement into patients own homes which not only supports safe discharge but will also prevent re-admission.

4.6 Freedom of Information

There continued to be an improvement in the overall Trust response rate for FOI requests received in October 2010. Since June 2010 the response rate has steadily risen from 44% to over 90%, which represents a significant improvement in Departments/Divisions returning responses within deadline. This is a reflection of many Senior Managers using the weekly reminder report of FOI requests due within 7 days, to ensure their staff resolve pending requests before the deadline expires. In addition the number of FOI requests which remain overdue and outstanding has fallen within the last few months, from 17 to 5 as a result of Departments/Divisions actively working to complete these requests.

Division/Department	May-10		Jun-10		Jul-10		Aug-10		Sep-10		Oct-10		Total number outstanding (including frozen)	Number frozen
	Number Received	% responded to within deadline	Number Received	% responded to within deadline	Number Received	% responded to within deadline	Number Received	% responded to within deadline	Number Received	% responded to within deadline	Number Received	% responded to within deadline		
Caldicott Guardian	0	0%	0	0%	1	0%	0	0%	0	0%	0	0%	0	0
Clinical Governance	1	0	3	67%	0	0%	0	0%	2	100%	2	100%	0	0
Clinical Support	3	33%	1	100%	4	100%	6	83%	4	75%	3	100%	0	0
Communications	0	0	0	0%	1	100%	0	0%	0	0%	0	0%	0	0
Education	0	0	0	0%	0	0%	1	100%	0	0%	0	0%	0	0
Emergency	1	1	0	0%	1	100%	3	0%	0	0%	0	0%	0	0
Estates & Facilities	3	67%	4	0%	6	100%	1	100%	1	100%	0	0%	0	0
Finance Other	0	0	2	100%	5	40%	4	100%	2	50%	2	100%	2	0
Human Resources	8	25%	7	14%	8	38%	5	40%	1	0%	3	67%	3	0
Information Governance	0	0%	1	100%	1	100%	0	0%	0	0%	0	0%	0	0
IT	0	0%	2	50%	0	0%	3	100%	2	100%	0	0%	0	0
Medical	0	0%	0	0%	2	0%	0	0%	1	100%	0	0%	0	0
Nursing Other	2	50%	0	0%	0	0%	1	100%	1	100%	2	100%	0	0
Performance/Information	0	0%	2	100%	3	100%	1	100%	1	100%	3	100%	0	0
Surgical	1	100%	2	50%	0	0%	0	0%	1	100%	0	0%	0	0
Women and Children	2	1	3	33%	3	33%	1	100%	0	0%	2	100%	0	0
Executive Offices	0	0%	0	0%	0	0%	0	0%	1	100%	0	0%	0	0
Catalyst	0	0%	0	0%	0	0%	0	0%	0	0%	1	100%	0	0
Education & Learning	0	0%	0	0%	0	0%	0	0%	0	0%	1	100%	0	0
A&E	0	0%	0	0%	0	0%	0	0%	3	100%	0	0%	0	0
Procurement	0	0%	0	0%	0	0%	0	0%	1	100%	0	0%	0	0
Resuscitation Services	0	0%	0	0%	0	0%	0	0%	1	100%	0	0%	0	0
Grand Total	21	48%	27	44%	35	63%	26	73%	22	86%	19	95%	5	0

4.7 Data Quality Issues

The PAS team are currently working with the application vendor to configure Maternity Delivery Diagnosis codes to correctly identify PAS delivery episodes. The diagnosis codes that would identify a 'delivery' have been identified and these have now been set in the PAS QA area to enable the functionality to be tested.

It is intended to progress with the testing in December and, providing that the testing is successful, we will look to implement the change in the PAS live area following the ICT change freeze that ends on 4th January 2011. The actual implementation date will be agreed with the Business Delivery team taking into consideration any impact on planned January SUS extracts.

4.8 Complaint Numbers and complaints responded to within 30 days

(Note: Complaints responded to are reported one month in arrears)

The number of complaints received for the month of November 2010 was 61. This is a 61% increase on the previous month (where 38 complaints were received). Almost a third of these (21) are in the Women and Children's Directorate and this represents a 133% increase on last month (9). The Directorate are investigating the reason for this increase.

The response rate for this Directorate and Clinical Support are at 100% achievement. Medicine achieved 88%, Surgery 75% and A&E 75% bringing the average response time for October to 83% - this is an improvement on the previous month which was 64%.

From 1st November 2010, the complaints and PALS management function transferred to the Directorate of Nursing and a review of processes has commenced.

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

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										
Four-Hour Maximum Wait In A&E From Arrival To Admission, Transfer Or Discharge ¹	98.91%	97.97%	97.37%	97.04%	96.12%	94.62%	95.00%	94.47%					95.21%	95.0%	94.0%	Performing	Standards and Targets	Performing	Underperforming										
Cancelled Ops - Breaches Of 28 Days Readmission Guarantee As % Of Cancelled Ops	0.00%	0.00%	0.00%	10.53%	0.00%	0.00%	0.00%	0.00%					1.32%	5.0%	15.0%	Performing													
MRSA	1	1	1	0	1	1	1	2					8	0SD	>1SD	Performance Under Review													
C Diff	11	4	11	10	12	14	16	12					90	0SD	>1SD	Performance Under Review													
RTT Admitted - Median	6.2	5.8	6.7	6.3	6.4	8.1	7.3	7.3					N/A	<=11.1		Performing													
RTT Admitted - 95th Percentile	18.9	18.5	18.0	17.1	16.9	20.6	22.1	22.5					N/A	<=27.7		Performing													
RTT Non-Admitted - Median	4.5	4.5	5.1	4.2	5.1	5.6	3.9	3.7					N/A	<=6.6		Performing													
RTT Non-Admitted - 95th Percentile	13.6	14.0	14.5	14.7	13.1	13.9	13.8	15.0					N/A	<=18.3		Performing													
RTT Incomplete - Median	12.6	13.5	13.2	13.5	13.8	13.4	14.3	14.7					N/A	<=7.2		Underperforming													
RTT Incomplete - 95th Percentile	31.9	30.0	30.6	30.1	32.8	32.7	30.4	29.8					N/A	<=36		Performing													
2 Week GP Referral To 1st Outpatient	99.89%	99.90%	99.91%	99.91%	99.80%	99.67%	99.90%	99.59%					99.80%	93.0%	88.0%	Performing													
2 Week GP Referral To 1st Outpatient - Breast Symptoms	99.44%	100.00%	99.49%	100.00%	98.22%	99.42%	100.00%	100.00%					99.46%	93.0%	88.0%	Performing													
31 Day Second Or Subsequent Treatment - Surgery	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.43%	100.00%					99.56%	94.0%	89.0%	Performing													
31 Day Second Or Subsequent Treatment - Drug	100.00%	100.00%	96.30%	95.83%	100.00%	100.00%	100.00%	100.00%					98.99%	98.0%	93.0%	Performing													
31 Day Diagnosis To Treatment For All Cancers	98.98%	98.48%	98.40%	98.72%	98.57%	99.53%	100.00%	100.00%					99.11%	96.0%	91.0%	Performing													
62 Day Referral To Treatment From Screening	93.33%	95.65%	100.00%	90.00%	92.31%	94.29%	100.00%	81.82%					92.98%	90.0%	85.0%	Performing													
62 Day Referral To Treatment From Hospital Specialist	89.47%	87.88%	100.00%	85.71%	100.00%	79.41%	89.36%	100.00%					89.50%	85.0%	80.0%	Performing													
62 Days Urgent Referral To Treatment Of All Cancers	83.98%	79.89%	83.11%	81.74%	85.15%	81.31%	88.79%	85.71%					83.83%	85.0%	80.0%	Performance Under Review													
2 Week RACP	100.00%	100.00%	100.00%	100.00%	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%	99.45%	97.76%	98.29%	99.41%					99.31%	98.0%	95.0%	Performing													
Patients That Have Spent More Than 90% Of Their Stay In Hospital On A Stroke Unit	81.82%	86.44%	83.58%	86.11%	86.79%	77.78%	85.29%	73.90%					72.70%	60.0%	30.0%	Performing													
Delayed Transfers Of Care	3.85%	4.12%	4.27%	5.41%	3.82%	5.64%	5.77%	4.95%					4.74%	3.5%	5.0%	Performance Under Review													
Finance ²	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														
User Experience ³	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 ⁴	CQC Registration Status												Quality and Safety	Performance Under Review															
	BHRUT has conditions on CQC Registration for: <table border="0"> <tr> <td>Diagnostic and Screening Procedures</td> <td>-</td> <td>Victoria Hospital</td> </tr> <tr> <td>Family Planning</td> <td>-</td> <td>Sydenham Centre</td> </tr> <tr> <td>Maternity and Midwifery Services</td> <td>-</td> <td>King George Hospital, Queen's Hospital</td> </tr> <tr> <td>Surgical Procedures</td> <td>-</td> <td>Queen's Hospital</td> </tr> <tr> <td>Termination of Pregnancies</td> <td>-</td> <td>Queen's Hospital</td> </tr> <tr> <td>Treatment of Disease, Disorder or Injury</td> <td>-</td> <td>King George Hospital, Queen's Hospital, Sydenham Centre</td> </tr> </table>														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
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 The Trust will be assessed from Q2 onwards and this is reflected in the YTD figure

² For detail please see separate Finance Report

³ 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

⁴ 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 1,2)	93.03%	96.74%	97.86%	96.03%	95.03%	93.98%	92.36%	89.12%	90.01%	88.73%					90.46%	98.00%	95.00%	Underperforming	
Mortality (HSMR Data is from Dr Foster and two months in arrears)	Hospital Standardised Mortality Ratio (Monthly)	105.1	109.4	110.8	109.5	104.2	97.7	118.3	101.0								N/A	N/A	
	HSMR Relative Risk (Low)	90.2	94.7	95.7	93.9	89.0	82.9	101.1	86.6								N/A	N/A	
	HSMR Relative Risk (High)	121.8	125.7	127.6	127.0	121.2	114.4	137.6	117.1								N/A	N/A	
	Hospital Standardised Mortality Ratio (Rolling 12 Monthly)	115.6	115.7	114.2	114.2	112.4	110.2	111.5	110.8								N/A	N/A	
	HSMR Relative Risk Rolling 12 Monthly (Low)	110.9	111.0	109.6	109.5	107.8	105.7	107.0	106.3								N/A	N/A	
	HSMR Relative Risk Rolling 12 Monthly (High)	120.5	120.6	119.1	119.0	117.1	114.9	116.2	115.4								N/A	N/A	
	Mortality rate - elective cases (%)	0.20%	0.02%	0.04%	0.10%	0.12%	0.12%	0.06%	0.02%	0.07%	0.11%					0.07%	N/A	N/A	
	Mortality rate - non-elective cases (%)	3.62%	3.79%	3.83%	3.47%	3.64%	3.64%	3.28%	3.60%	3.49%	3.42%					3.47%	N/A	N/A	
C&B Slot issues per successful DBS booking	0.03	0.02	0.02	0.03	0.03	0.03	0.02	0.01	0.02	0.02					0.02	0.04	0.10	Performing	
Length of Stay	LOS (Elective)	3.7	3.8	4.1	3.6	3.9	3.3	4.2	3.1	2.9	3.5				3.5	3.6	4.2	Performing	
	LOS (Non-Elective)	5.7	5.5	5.5	5.3	5.7	5.3	5.0	5.3	5.3	5.3				5.3	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	2.13	2.28	2.27	2.19	2.31				2.21	2.22	2.27	Performing	
DNA	DNA First	8.22%	8.96%	9.71%	9.34%	9.55%	9.91%	10.88%	10.62%	10.05%	9.84%				10.07%	9.70%	10.20%	Performance Under Review	
	DNA Follow-Up	10.64%	10.88%	11.38%	10.62%	11.10%	11.24%	11.27%	12.27%	11.94%	12.45%				11.51%	10.30%	10.80%	Underperforming	
Day Case Rates	Basket of 25 procedures	75.24%	78.59%	77.43%	78.93%	79.43%	81.61%	83.97%	84.28%	82.43%	80.08%				80.84%	83.00%	70.00%	Performance Under Review	
	All procedures	85.30%	86.11%	85.92%	84.88%	87.03%	86.44%	88.21%	86.53%	86.07%	86.48%				86.44%	75.00%	70.00%	Performing	
Elective Admissions	Elective Admissions on Day of Surgery	89.42%	88.20%	87.39%	87.18%	89.98%	90.02%	90.16%	90.46%	88.81%	86.85%				88.96%	85.00%	80.00%	Performing	
Readmission Rates within 28 Days	Readmission Rates	7.89%	7.36%	7.94%	7.69%	7.27%	7.49%	7.85%	8.14%	8.04%					7.74%	7.00%	7.35%	Underperforming	
	Readmission Rates to same speciality	3.93%	3.76%	4.12%	4.03%	3.79%	3.91%	3.91%	4.00%	4.22%					3.99%	3.50%	4.00%	Performance Under Review	
FOI	FOI Requests responded to within 20 working days	65%	56%	45.00%	47.62%	44.44%	62.86%	73.08%	86.36%	94.74%					64.87%	100%	-	Underperforming	
Data Quality	Significant SUS-SEM Data Quality Issues	1	1	1	1	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%	85.71%	84.53%	81.38%	75.55%				79.12%	TBC	TBC		
	MSSA Infection					2	6	11	3	5	3				30	TBC	TBC		
Safety Reporting	Incident reporting rate per 100 admissions	6.48%	5.51%	5.69%	5.61%	5.10%	4.96%	5.55%	4.95%	5.94%	5.13%				5.36%	TBC	TBC		
	Serious Untoward Incidents (SUI) as a % of incidents reported	0.60%	0.31%	0.33%	0.17%	0.52%	1.41%	0.34%	1.70%	0.91%	1.57%				0.85%	TBC	TBC		

		2009/10		2010/11												YTD		YTD Performance	
Indicator		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	45	31	44	38	61					341	456	475	Underperforming
	Complaints responded to within 30 working days	79%	79%	81%	89%	82%	64%	65%	64%	83%						75%	80%	75%	Performance Under Review
Mixed Sex Breaches	No. of patients in mixed sex wards	86	52	0	0	0	0	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%	52.70%	58.60%	53.10%	0.00%	0.00%	0.00%				50.83%	85.00%	75.00%	Underperforming
Chief Nursing Officer High Impact Changes	Increase in permanent nursing and midwifery staffing ratios			87.97%			84.90%			0.00%						86.44%	84.40%		
	Reduction in in-hospital Pressure Ulcer rates			0.07%			0.11%			0.00%						0.09%	See Note ²		
	Reduction in the rate of in-hospital catheter-related Urinary Tract Infections			Awaiting DoH guidance on recording data - TBC end of July			Still awaiting DoH guidance										TBC		
Critical Care	Transfers out of ICU Department between 22:00 and 08:00			14.10%	22.65%	19.90%	11.25%	20.10%	17.14%	0.00%	0.00%	0.00%				17.52%	5 per Quarter		
Fractured Neck of Femur (#NOF)	Decrease 30 day mortality for #NOF			7.23%			3.16%			0.00%						5.25%	See Note ³		
Maternity	Decrease Caesarean Section (CS) rates			23.25%			20.00%			0.00%						21.63%	See Note ⁴		
	Increase the percentage of women provided with 1:1 care in Labour			89.50%			Not yet available										See Note ⁵		
	% 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.			77.00%			85.84%			0.00%						81.42%	See Note ⁶		

Notes:

¹ The Trust will be assessed from Q2 onwards and this is reflected in the YTD figure

² Decreased % of grade 3 and grade 2 pressure ulcers by end of Q4 2010/11

³ Target is for the 75th centile as compared to Dr Foster figures on 01/03/2010

⁴ Aim for 20% for end of 2010/11

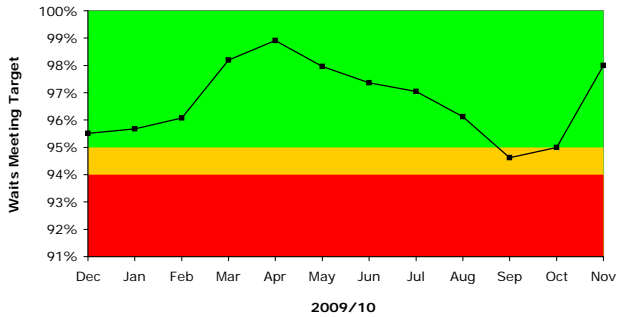
⁵ 95% by end of Q4. Trajectory to be confirmed

⁶ 90% by end of Q2 2011/12

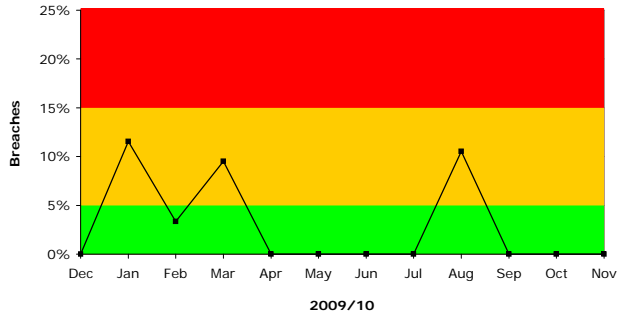
Key:

- = Performing
- = Performance Under Review
- = Underperforming

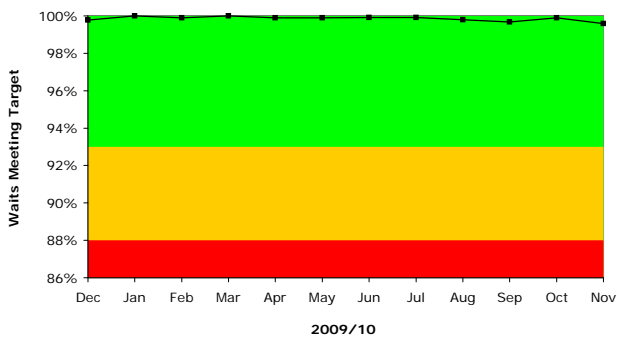
Four-Hour Maximum Wait In A&E From Arrival To Admission, Transfer Or Discharge (All Attendances)



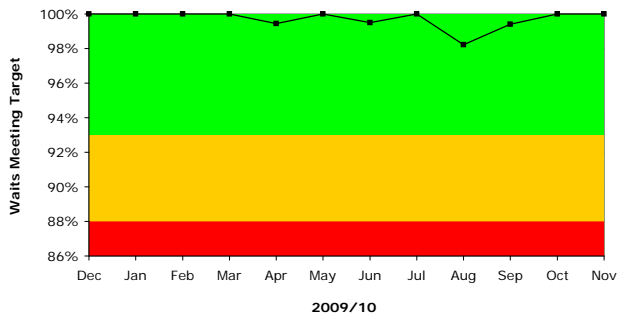
Cancelled Ops - Breaches Of 28 Days Readmission Guarantee As % Of Cancelled Ops



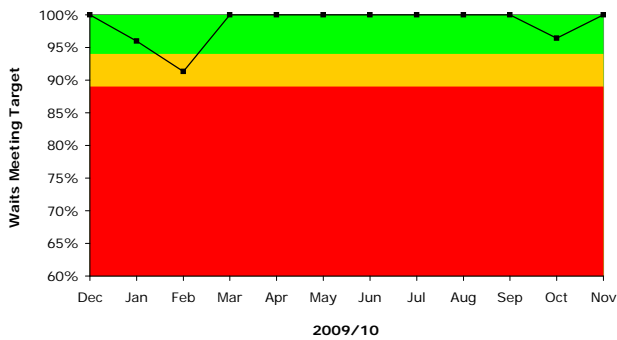
2 Week GP Referral To 1st Outpatient



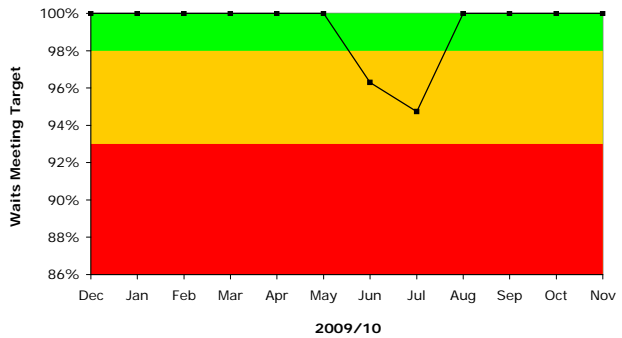
2 Week GP Referral To 1st Outpatient - Breast Symptoms (Live from December 2009 Onwards)



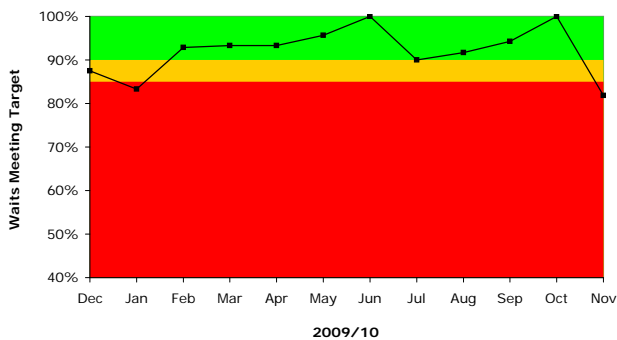
31 Day Second Or Subsequent Treatment - Surgery



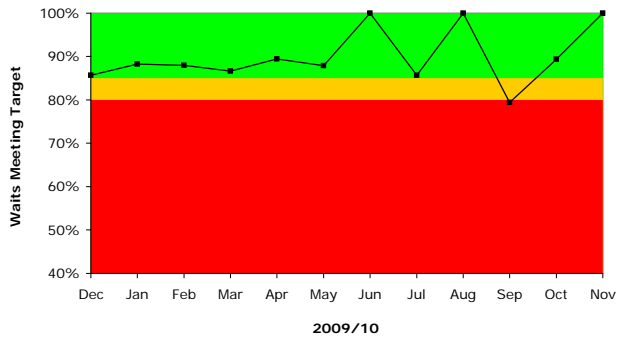
31 Day Second Or Subsequent Treatment - Drug



62 Day Referral To Treatment From Screening



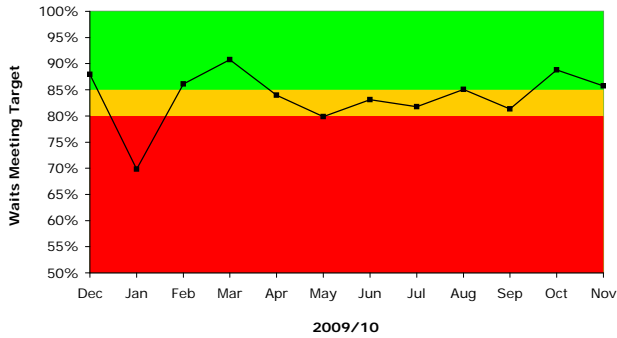
62 Day Referral To Treatment From Hospital Specialist



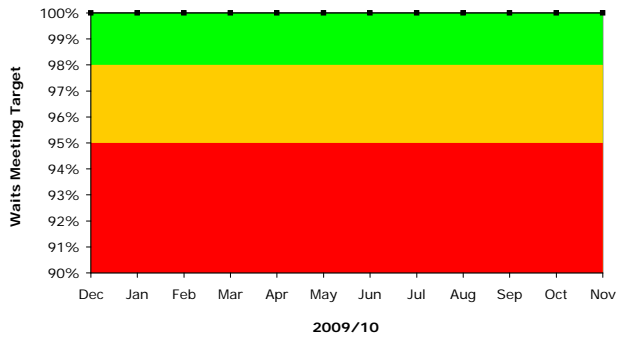
Key:

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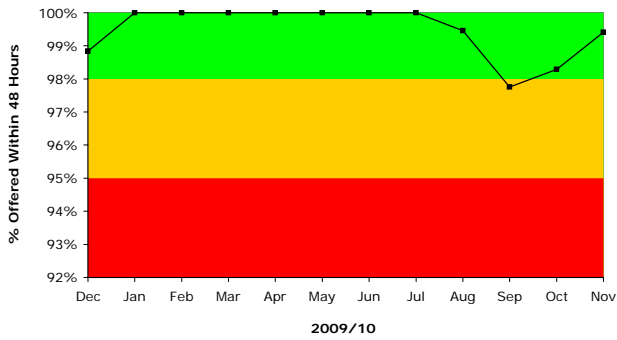
62 Days Urgent Referral To Treatment Of All Cancers



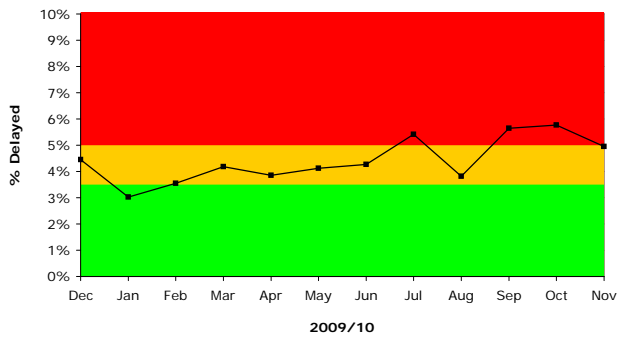
2 Week RACP



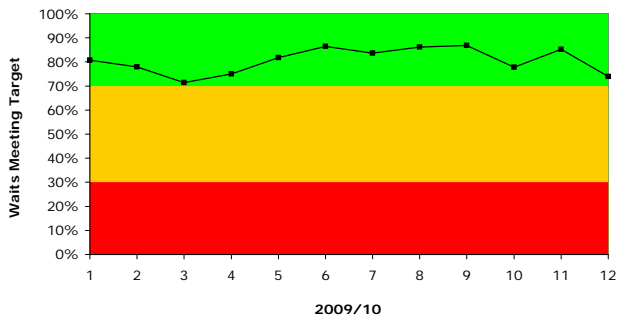
48 Hours GUM Access



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

