

## EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
<p><b>Quality and Patient Standards Performance Report – September 2010</b></p>	<p>Trust Board</p>
1. PURPOSE:	REVIEWED BY (BOARD/COMMITTEE) and DATE:
<p>The Quality and Patient Standards Performance Report provides an analysis of performance against trajectory and Trust-wide targets for the following domains:</p> <ol style="list-style-type: none"> <li>1. CQC Periodic Review 2009/10 &amp; 2010/11 Registration</li> <li>2. Department of Health Performance Framework 2009/10 and 2010/11</li> <li>3. DH Framework Performance Targets</li> <li>4. Other Performance Indicators</li> <li>5. Contractual Key Performance Indicators (KPIs) and Commissioning for Quality and Innovation (CQUIN) Schedule</li> </ol> <p>Areas where performance is of concern for the month and/or for the year are discussed within the report are as follows:</p> <ul style="list-style-type: none"> <li>• Four-Hour Maximum Wait In A&amp;E From Arrival To Admission, Transfer Or Discharge</li> <li>• 62 Days Urgent Referral To Treatment Of All Cancers</li> <li>• Delayed Transfers Of Care</li> <li>• Mortality</li> <li>• Length of Stay</li> <li>• First to Follow Up Ratios</li> <li>• DNA Rates</li> <li>• Re-admission Rates</li> <li>• Freedom of Information</li> <li>• Data Quality Issues</li> <li>• MRSA Screening</li> <li>• Complaints</li> </ul> <p>This report includes the key actions that are being undertaken to bring performance back in line with trajectory or target.</p>	<p> <input type="checkbox"/> PEQ.....      <input type="checkbox"/> STRATEGY.....  <input type="checkbox"/> FINANCE .....      <input type="checkbox"/> AUDIT .....  <input type="checkbox"/> CLINICAL GOVERNANCE .....  <input type="checkbox"/> CHARITABLE FUNDS .....  <input checked="" type="checkbox"/> TRUST BOARD – 26<sup>th</sup> October 2010  <input type="checkbox"/> REMUNERATION .....  <input type="checkbox"/> OTHER ..... (please specify)         </p>

<b>2. DECISION REQUIRED:</b>	<b>CATEGORY:</b>
<p>The Trust Board is asked to note the content of the report and support the actions to bring the performance back in line with trajectory/target.</p>	<p> <input checked="" type="checkbox"/> <b>NATIONAL TARGET</b>    <input type="checkbox"/> <b>CNST</b>  <input type="checkbox"/> <b>CQC REGISTRATION</b>    <input type="checkbox"/> <b>HEALTH &amp; SAFETY</b>  <input type="checkbox"/> <b>ASSURANCE FRAMEWORK</b>  <input checked="" type="checkbox"/> <b>CQUIN/TARGET FROM COMMISSIONERS</b>  <input type="checkbox"/> <b>CORPORATE OBJECTIVE</b> .....  <input type="checkbox"/> <b>OTHER</b> ..... (please specify) </p> <p> <b>AUTHOR:</b> Steve Rubery, Head of Business Delivery  Lee Hyde, Performance Manager  <b>PRESENTER:</b> Neill Moloney, Director of Delivery </p> <p> <b>DATE:</b> 15<sup>th</sup> October 2010 </p>
<b>3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:</b>	
Not applicable.	
<b>4. DELIVERABLES</b>	
The delivery of the Trust wide objectives.	
<b>5. KEY PERFORMANCE INDICATORS</b>	
Please see attached Quality and Patient Standards Performance Dashboard.	
<b>AGREED AT</b> _____ <b>MEETING</b> <b>OR</b> <b>REFERRED TO:</b> _____	<b>DATE:</b> _____ <b>DATE:</b> _____
<b>REVIEW DATE</b> (if applicable) _____	

# Quality and Patient Standards Performance Report September 2010

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

The CQC have stated that they will no longer undertake an overall aggregated rating assessment of either Commissioners or Providers for 2009/10. This will mean that the Trust will no longer be rated as Poor, Adequate, Good or Excellent for its Quality of Services. However, the CQC have committed to publishing benchmarked data for each of the Existing Commitments and Tier 1 and Tier 2 Vital Signs in the autumn, similar to the previous timetable.

The Trust has fully complied with the ratification of data to the CQC which will be used in the autumn benchmarking process and it should be noted that there were no issues of concern with the data for the Trust.

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 recent revisions to the Framework 2010/11 set out a number of changes, which are reflected in the Dashboard. The indicators previously referred to as the 18 Week Referral to Treatment (RTT) indicators are now simply known as RTT and appear on the Service Performance Scorecard.

The Framework has also confirmed that the four-hour maximum wait in A&E from arrival to admission, transfer or discharge now has an upper threshold of 95% for 'Performing' and a lower threshold of 94% for 'Performance Under Review'. The Service Performance Scorecard section of the Dashboard displays the above thresholds as according to the DH Framework. The Trust has, however, elected to ensure that there is no deterioration in performance as it can be demonstrated that improved patient outcomes are achieved with shorter waiting times. 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 attendances<sup>1</sup> 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:

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 August 2010 in the following areas:

- Cancelled Operations - Breaches Of 28 Days Re-admission Guarantee As Percentage Of Cancelled Operations;
- MRSA;
- Clostridium Difficile (C Diff);
- 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.

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<sup>1</sup> 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.

### 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)<sup>2</sup> against the DH Framework and is also monitoring against its own internal targets. The Trust failed to achieve the national standard for September 2010 and has also failed to achieve its internal target.

Contributing factors to the deterioration in performance are noted as:

- The Trust remains unable to discharge patients early enough in the day to provide the flow required through the ED to deliver on the four waits;
- ED staffing levels, both medical and nursing, continue to prove difficult to maintain with a high reliance on locum staff. This challenges not only fill rates but also skill mix even when fill rates are met.

The required improvement in ED performance continues to be a priority for the Trust, the Sector and NHS London. The Trust is progressing with the Phase 2 plan which is being driven at CEO/Director level. However, the benefits of this plan will not be immediately realised and there is a genuine ongoing risk to performance and clinical safety given the current pressure that is being experienced at present prior to any winter surge in attendance numbers.

Further work is required to identify short term amelioration of the ongoing ED pressures. These include:

- Outline scoping of reconfiguration of ED services across two sites;
- Sign-off and agreement of ED Mitigation Plan for extreme pressure episodes;
- Trust-wide sign-up from clinical teams to alter practice in supporting the ED to deliver the required performance and clinical safety that flows from it;
- Renewed options for substantive recruitment;
- Deciding on a finance position for Emergency Care that recognises the challenges and provides a realistic financial framework. This may be intrinsically linked to the outline scoping of reconfiguration of ED services across two sites;
- Additional capacity planning including contingency beds and relocation of DTOC cohort.

It should be noted that the position remains extremely challenging and will require support from across the Trust to reconcile the current risk.

### 3.2 62 Days Urgent Referral To Treatment Of All Cancers

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

September's performance fell for the month to put the Trust back into a status of underachieving for this target. This was due to the continued concerns of the Breast, Haematology, Gynaecology and Urology pathways. All breaches within Haematology were due to the internal

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<sup>2</sup> Please note that there has been a change in nomenclature and A&E departments should be referred to as Emergency Departments.

referrals from Head & Neck being received after day 62 and the Trust's Service Improvement Facilitator is looking at reducing the turnaround time for the initial Fine Needle Aspiration result to ensure that there is more time at the end of the pathway. Gynaecology's drop in performance for the month was caused by 1 breach. There were fewer treatments to upload to the Open Exeter system so this 1 breach has had a significant impact.

The Urology breaches were caused by the prostate pathway being very difficult to achieve with the clinical delay needed between TRUS biopsy and MRI scan. Work is beginning on developing a pre-referral pathway for GPs to ensure that patients are referred once other tests have been performed, ensuring that there are no further delays in their pathway.

Work continues with the Intensive Support Team for CWT, reviewing previously implemented effective pathways and the plan to undertake demand and capacity exercises. The General Manager for Oncology has also met with the GP Cancer Leads from B&D and Havering to look at establishing an education programme for 2011 to gain the GPs assistance in make certain that patients referred under the 2ww rule understand the urgency of their referral and to facilitate smoother pathways.

### **3.3 Delayed Transfers Of Care**

Delayed Transfers of Care (DTOCs) performance is currently failing to meet all targets, both the 3.5% under the DH Performance Framework and in turn the stricter internal target of 1%.

A contributing factor to the increase in September from the previous month was the high level of sickness in the BHRUT Discharge Team. Skill levels within the team are being improved with the appointment of three band 6s.

Daily DTOC meetings are being put in place to focus efforts where they are needed, particularly Trust based delays. Daily Rehab and DTOC reviews are also being re-established with PCTs and Social Services which will be driven by KPIs monitored on a daily basis.

Discussions continue regarding the two PCT-funded DTOC wards. A ward has been identified at KGH for Barking & Dagenham and Redbridge patients who fit the non-rehab criteria and it is currently planned to have this operational in November. Decisions still need to be finalised regarding the location of the Havering DTOC ward. The decision will be made whether to locate this at Queen's or St George's Hospital.

Much work has been undertaken internally to ensure that those delays attributed to the Hospital are reduced and these are now at their lowest numbers for several months. This has been achieved by internal escalation processes to ensure that the relevant paperwork is completed in a timely manner. This work continues with focus on the rehab referral process to ensure patients are medically fit when referred and also that the correct processes are followed.

Further work has been carried out on the Winter Bed Requirement models and meetings are taking place to determine exactly what each of the PCTs will deliver. The result of these meetings will determine the additional actions the Trust must take.

## **4. Other Performance Indicators**

### **4.1 Mortality**

As discussed in previous months, Dr Foster has now undertaken the rebasing of Hospital Standardised Mortality Ratio (HSMR) data. This has resulted in the Trust being classified as a

negative outlier<sup>3</sup> for 2009/10 with a relative risk of 115.7 (where 100 is the expected mortality based on casemix). Although performance improved during 2009/10, improvements were not at the same rates as seen in other Trusts nationally. This position cannot be changed and will be published in the Dr Foster Hospital Guide, however the Trust is permitted to publish commentary explaining the circumstances behind this and the actions being taken to improve the position for 2010/11. Clinical Governance and Performance staff will be meeting with Dr Foster representatives at the end of October to discuss this further and ensure that the improvements being made by the Trust are fully represented.

Concentrations of deaths in coronary atherosclerosis, leukaemia and 'other perinatal conditions' have been identified in recent data and each concentration is being investigated by the relevant division. Concentrations of this kind may prompt enquiry from the CQC, and of the three identified, 'other perinatal conditions' is the potentially the likeliest for attention. All the deaths involve the diagnosis 'fetal death of unspecified cause' and the division has been made aware.

Discussions have taken place that future audits involve not only clinicians to investigate the quality of care given by looking at the notes, but also that staff with a knowledge of coding collaborate with these clinicians to ensure that the electronic records reflect the physical ones to identify improvements in the entire process. If the Coding Team do not have details of, for example, all co-morbidities related a patient, then the HSMR may be unnaturally inflated.

Identifying patients as being on a palliative care pathway within patient notes will also positively impact HSMR and help to reduce the Trust's relative risk. Staff are continuing to work to ensure that palliative care is being appropriately recorded in patient notes for the Coding Team to transfer these details onto the electronic records which Dr Foster ultimately use to calculate the HSMR.

#### **4.2 Length Of Stay**

The management of DTOCs has had an adverse effect on patient flow. Therefore, Erica ward has opened as a DTOC ward until the PCTs are able to put the 60 beds for DTOCs in place. The first 30 of these will be placed at KGH to relieve pressure on patient flow. The ward will be staffed by North East London Foundation Trust (NELFT) who will manage the discharge into the community. This is due to go live during October 2010, however in order to start this process DTOC patients are currently being cohorted in Erica ward.

The Acute Medical floor achieved its reconfiguration by 4th August 2010. This involved complete re-alignment of medical teams including training doctors and although there have been some teething problems, it is anticipated that the final re-alignment will be successful once Clementine A ward is closed. This ward closure is currently delayed on account of the pressure on beds and the speed at which LoS is reducing.

A Length of Stay summit meeting was held on 14th September 2010 to work with clinicians to address improving patient care in hospital by reducing delays to discharge. The actions from this have now been integrated into an overall plan consisting of six work streams with the most significant being Capacity and Patient Flow. This is monitored at the weekly Taskforce meetings. In addition the Compstat approach is being adopted with the first meetings due to start imminently using live data.

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 has relieved a previous bottleneck in MAU and is ensuring that complex elderly patients are being managed in an

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<sup>3</sup> A Negative Outlier is classified as an organisation that, with 95% confidence, has performance outside of the expected norm given its case mix

appropriate environment. The LoS for these patients can be demonstrated as having been reduced by 2 days.

An Acute Elderly Unit was also opened at KGH on 6th September 2010 and it is expected that there will be similar results in reducing LoS as seen at QH, although there was a delay to implementing the Therapy support which has now been resolved for progress to continue.

### **4.3 First to Follow-up Ratios**

The Trust continues to achieve its overall target reduction of 5% with a figure of 2.21 although a high in-month figure for the second month running is in danger of pushing the year to date figure above target.

There were improvements with Trauma and Orthopaedics, Dermatology and Gynaecology achieving the reduction of 5% year to date. Significant progress has also been made in General Surgery. Anti-Coagulation continues to consistently achieve year to date target.

The performance across the other specialities is being monitored and the action plans that have been drawn up for the top 10 specialties have undergone more stringent monitoring against year to date targets led by the Divisional Managers. Additional reporting at the Local Planned Care Taskforce will ensure that progress and best practice is shared across all disciplines.

The implementation of Procedures of Limited Clinical Effectiveness (POLCE) since July has led to a reduction in referrals. This has had an impact on the ratios in month.

### **4.4 DNA Rates**

The overall DNA rate for first outpatient appointments improved during September 2010. Choose & Book (CAB) referrals account for over 70% of first appointment attendance with a DNA rate consistently at 2% below target. The additional services added to the CAB electronic booking system now include audiology, obstetrics, physiotherapy, rapid access chest pain, allergy, anti-coagulation, symptomatic breast, and two week wait services.

The overall DNA rate for follow-up appointments remains above target with deterioration in Paediatrics, Neurology, Respiratory Medicine, Endocrinology, Gastroenterology, General Medicine and General Surgery, but improvements in Cardiology, Pain Management, Dermatology and Vascular Surgery.

Appointment reminder letters continue to be sent and increased attempts to contact the patient by telephone are taking place. However, vacancies (covered by the In-House Bank) and the delay in implementation of the new telephony system have negatively impacted on performance. A review of staffing requirements within the call centre and other initiatives to release pressure on this staff group are under way. Actions include 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. The Trust is currently reviewing the priorities for the IT service to determine whether the telephone system can be installed any sooner.

### **4.5 Re-admission Rates**

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

Re-admission rates are reported at both Trust and specialty level. Rates increased in August from July which was quite low in comparison to previous months and performance remains outside the target at both Trust and specialty level.

Key specialties where re-admission rates are high are General Medicine and Geriatric Medicine. As the AEU (Acute Elderly Unit) becomes embedded at Queen's and is rolled out at King George, it is anticipated that there should be a positive impact on the re-admission rate on account of safe effective discharge being planned on admission. Furthermore, a working group has been established, led by the Deputy Director of Nursing, to support local nursing homes in the management of simple conditions e.g. dehydration, in order that these can be dealt with in the home therefore negating the requirement for admission via the A&E department.

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.

#### 4.6 Freedom of Information

The recent improvements in the Freedom of Information (FOI) response rate have continued in August 2010. Early indications are that this improvement will continue for requests received in September 2010.

The weekly reminder report of FOI requests due within seven days has had a positive impact on the response rate, as Divisional Directors/Managers and Departmental Directors have then been more able to work to resolve those outstanding in their area before the deadline expires.

Although the majority of overdue requests have been attributed to the HR Department, this has been highlighted to the relevant Executive Directors for resolution.

Division/Department	Apr-10		May-10		Jun-10		Jul-10		Aug-10		Total number outstanding (excl frozen)	Number frozen
	Number Received	Response rate	Number Received	Response rate	Number Received	Response rate	Number Received	Response rate	Number Received	Response rate		
Caldicott Guardian	0	0%	0	0%	0	0%	1	0%	0	0%	0	0
Clinical Governance	0	0%	1	0%	3	67%	0	0%	0	0%	0	0
Clinical Support	0	0%	3	33%	1	100%	4	100%	6	83%	0	0
Commissioning	1	100%	0	0%	0	0%	0	0%	0	0%	0	0
Communications	0	0%	0	0%	0	0%	1	100%	0	0%	0	0
Education	2	0%	0	0%	0	0%	0	0%	1	100%	0	0
Emergency	1	0%	1	100%	0	0%	1	100%	1	0%	1	0
Estates & Facilities	3	0%	3	67%	4	0%	6	100%	1	100%	0	0
Finance Other	3	33%	0	0%	2	100%	5	40%	5	80%	1	0
Human Resources	4	75%	8	25%	7	14%	8	38%	4	50%	7	0
Infection Control	1	100%	0	0%	0	0%	0	0%	0	0%	0	0
Information Governance	0	0%	0	0%	1	100%	1	100%	0	0%	0	0
IT	2	50%	0	0%	2	50%	0	0%	3	100%	0	0
Medical	0	0%	0	0%	0	0%	2	0%	0	0%	0	0
Nursing Other	2	50%	2	50%	0	0%	0	0%	1	100%	0	0
Performance/Information	0	0%	0	0%	2	100%	3	100%	2	50%	0	0
Research & Development	0	0%	0	0%	0	0%	0	0%	0	0%	0	0
Surgical	0	0%	1	100%	2	50%	0	0%	0	0%	0	0
Women and Children	0	0%	2	100%	3	33%	3	33%	1	100%	0	0
Executive Offices	1	100%	0	0%	0	0%	0	0%	0	0%	0	0
Discharge Team	0	0%	0	0%	0	0%	0	0%	1	0%	0	0
<b>Grand Total</b>	<b>20</b>	<b>45%</b>	<b>21</b>	<b>48%</b>	<b>27</b>	<b>44%</b>	<b>35</b>	<b>63%</b>	<b>26</b>	<b>73%</b>	<b>9</b>	<b>0</b>

#### **4.7 Data Quality Issues**

The Dashboard continues to display a single data quality issue of interest to the Trust Board for August 2010. This continues to relate to a requested change from the Information and Performance team in PAS to correctly identify delivery episodes.

Information Management & Technology (IM&T) have assigned a higher priority to other areas of work with this issue graded as 'low risk'. As such, the correct identification of delivery episodes will be possible following other works such as upgrades to the Trust's PAS system. As per the agreed Trust priorities, and in line with available PAS support resourcing, the next task is to complete the PAS version 21 upgrade which is currently on schedule for completion at the end of October 2010. Once this upgrade has been completed, the work to make the required changes to the identification of delivery episodes will begin.

#### **4.8 MRSA Screening**

Investigation into the MRSA screening rates have indicated that the data is not an accurate reflection of true screening rates, which anecdotal evidence suggests is much higher than shown. Staff will be working from this month onwards

#### **4.9 Complaints**

The Complaints Department have stated that the fall in complaints performance coincides with the seasonal pattern due to incidence of leave amongst responding and Complaints staff. However, rates are down more this year than those previously. A significant contribution to this appears to be the pressure caused by substantially increased complaint volumes in A&E.

The Complaints Department have signalled that they intend to review with the Emergency Services Division how best to address the situation.

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

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 <sup>1</sup>	98.91%	97.97%	97.37%	97.04%	96.12%	93.23%							95.95%	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%	4.55%							2.51%	5.0%	15.0%	Performing			
MRSA	1	1	1	0	1	1							5	0SD	>1SD	Performing			
C Diff	11	4	11	10	12	14							62	0SD	>1SD	Performing			
RTT Admitted - Median	6.2	5.8	6.7	6.3	6.4	8.1							N/A	<=11.1		Performing			
RTT Admitted - 95th Percentile	18.9	18.5	18.0	17.1	16.9	20.6							N/A	<=27.7					
RTT Non-Admitted - Median	4.5	4.5	5.1	4.2	5.1	5.6							N/A	<=6.6		Performing			
RTT Non-Admitted - 95th Percentile	13.6	14.0	14.5	14.7	13.1	13.9							N/A	<=18.3					
RTT Incomplete - Median	12.6	13.5	13.2	13.5	13.8	13.4							N/A	<=7.2		Underperforming			
RTT Incomplete - 95th Percentile	31.9	30.0	30.6	30.1	32.8	32.7							N/A	<=36					
2 Week GP Referral To 1st Outpatient	99.89%	99.90%	99.91%	99.91%	99.80%	99.67%							99.83%	93.0%	88.0%	Performing			
2 Week GP Referral To 1st Outpatient - Breast Symptoms	99.44%	100.00%	99.49%	100.00%	98.23%	99.42%							99.46%	93.0%	88.0%	Performing			
31 Day Second Or Subsequent Treatment - Surgery	100.00%	100.00%	100.00%	100.00%	100.00%	96.67%							99.43%	94.0%	89.0%	Performing			
31 Day Second Or Subsequent Treatment - Drug	100.00%	100.00%	96.30%	95.83%	100.00%	100.00%							98.65%	98.0%	93.0%	Performing			
31 Day Diagnosis To Treatment For All Cancers	98.98%	98.48%	98.40%	98.72%	98.48%	99.50%							98.72%	96.0%	91.0%	Performing			
62 Day Referral To Treatment From Screening	93.33%	95.65%	100.00%	90.00%	91.67%	94.12%							93.75%	90.0%	85.0%	Performing			
62 Day Referral To Treatment From Hospital Specialist	89.47%	87.88%	100.00%	85.71%	100.00%	81.25%							89.61%	85.0%	80.0%	Performing			
62 Days Urgent Referral To Treatment Of All Cancers	83.98%	79.89%	83.11%	81.74%	85.05%	81.25%							83.00%	85.0%	80.0%	Performance Under Review			
2 Week RACP	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%	100.00%	99.45%							99.91%	98.0%	95.0%	Performing			
Delayed Transfers Of Care	3.85%	4.12%	4.27%	5.41%	3.82%	5.64%							4.29%	3.5%	5.0%	Performance Under Review			
Patients That Have Spent More Than 90% Of Their Stay In Hospital On A Stroke Unit	81.82%	86.44%	83.58%	86.11%	86.79%	77.14%							83.51%	60.0%	30.0%	Performing			
Finance <sup>2</sup>	Initial Planning	Year to Date		Forecast Outturn			Underlying Financial Position		Finance Processes & Balance Sheet Efficiency				Finance	Underperforming					
	Planned Outturn as a proportion of Turnover	YTD Operating Performance	YTD EBITDA	Forecast Operating Performance	Forecast EBITDA	Rate of Change in Forecast Surplus or Deficit.	Underlying Position %	EBITDA Margin (%)	Better Payment Practice Code Value %	Better Payment Practice Code Volume %	Current Ratio	Receivable Days			Payable Days				
User Experience <sup>3</sup>	Experience of Patients						Public Confidence			User Experience	Performance Under Review								
	Access and waiting	Safe, high quality, coordinated care		Better information, more choice	Building closer relationships	Clean, friendly, comfortable place to be	Focus on the person	Learning organisation	Dignity and respect										
Quality and Safety <sup>4</sup>	CQC Registration Status												Quality and Safety	Performance Under Review					
	BHRUT has conditions on CQC Registration for:			At the following sites:															
Diagnostic and Screening Procedures			- Victoria Hospital																
Family Planning			- Sydenham Centre																
Maternity and Midwifery Services			- King George Hospital, Queen's Hospital																
Surgical Procedures			- Queen's Hospital																
Termination of Pregnancies			- Queen's Hospital																
Treatment of Disease, Disorder or Injury			- King George Hospital, Queen's Hospital, Sydenham Centre																

Notes:

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

<sup>2</sup> For detail please see separate Finance Report

<sup>3</sup> The 'Experience of patients' scores are derived from the adult inpatient survey, while the indicators for 'Public confidence' are from a number of sources including the NHS national patient survey programme, the NHS national staff survey programme and written complaints data. As some of this data is not yet available to the Trust, staff are developing internal surveying methods according to the Patient Experience

<sup>4</sup> For detail please see separate CQC Action Plan

		2009/10	2010/11	2010/11	2010/11	2010/11	2010/11	2010/11	2010/11	2010/11	2010/11	2010/11	2010/11	2010/11	2010/11	2010/11	YTD	Thresholds		YTD Performance
Indicator		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD				
A&E (Type 1 Only)	Four-Hour Maximum Wait In A&E From Arrival To Admission, Transfer Or Discharge <sup>1</sup>	93.03%	96.74%	97.86%	96.03%	95.03%	93.98%	92.09%	85.75%							91.69%	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	111.8	109.5	102.9	95.2										N/A	N/A		
	HSMR Relative Risk (Low)	90.2	94.7	96.6	93.9	87.9	80.6										N/A	N/A		
	HSMR Relative Risk (High)	121.8	125.7	128.7	127.0	119.8	111.7											N/A	N/A	
	Hospital Standardised Mortality Ratio (Rolling 12 Monthly)	115.6	115.7	114.2	114.2	112.4	110.2											N/A	N/A	
	HSMR Relative Risk Rolling 12 Monthly (Low)	110.9	111.0	109.6	109.5	107.8	105.7											N/A	N/A	
	HSMR Relative Risk Rolling 12 Monthly (High)	120.5	120.6	119.1	119.0	117.1	114.9											N/A	N/A	
	Mortality rate - elective cases (%)	0.20%	0.02%	0.04%	0.10%	0.12%	0.12%	0.06%	0.02%								0.08%	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%								3.58%	N/A	N/A	
C&B	C&B Slot issues per successful DBS booking	0.03	0.02	0.02	0.03	0.03	0.03	0.02	0.01							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							3.7	3.6	4.2	Performance Under Review	
	LOS (Non-Elective)	5.7	5.5	5.5	5.3	5.7	5.3	5.0	5.3							5.4	5.0	5.5	Performance Under Review	
First to Follow-Up Ratios	FFU Ratio (Less Midwifery, Ophthalmology and Rheumatology)	2.29	2.30	2.29	2.17	2.15	2.13	2.28	2.27							2.21	2.22	2.27	Performing	
DNA	DNA First	8.57%	9.03%	9.98%	9.77%	9.78%	10.43%	11.54%	10.79%							10.37%	9.70%	10.20%	Underperforming	
	DNA Follow-Up	11.49%	10.99%	11.15%	10.57%	11.04%	11.35%	11.76%	12.77%							11.34%	10.30%	10.80%	Underperforming	
Day Case Rates	Basket of 25 procedures	75.24%	78.59%	77.48%	80.17%	79.59%	82.06%	84.63%	84.64%							81.18%	83.00%	70.00%	Performance Under Review	
	All procedures	85.30%	86.11%	85.92%	84.88%	87.03%	86.44%	88.18%	86.55%							86.49%	75.00%	70.00%	Performing	
Elective Admissions	Elective Admissions on Day of Surgery	89.42%	88.20%	87.39%	87.18%	89.98%	90.04%	90.15%	89.83%							89.11%	85.00%	80.00%	Performing	
Readmission Rates within 28 Days	Readmission Rates	7.89%	7.36%	7.94%	7.68%	7.27%	7.49%	8.10%								7.69%	7.00%	7.35%	Underperforming	
	Readmission Rates to same speciality	3.93%	3.76%	4.12%	4.02%	3.79%	3.91%	4.00%								3.96%	3.50%	4.00%	Performance Under Review	
FOI	FOI Requests responded to within 20 working days	65%	56%	45%	48%	44%	65%	73%								55%	100%	-	Underperforming	
Data Quality	Significant SUS-SEM Data Quality Issues	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%							79.38%	100.00%	80.00%	Underperforming	
	MSSA Infection Rates					2	6	11	3							22	TBC	TBC		
Safety Reporting	Incident reporting rate per 100 admissions	6.48%	5.51%	5.73%	5.64%	5.14%	4.96%	5.55%	4.95%							5.33%	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%							0.74%	TBC	TBC		

Indicator	Feb	Mar	2009/10			2010/11			Oct	Nov	Dec	Jan	Feb	Mar	YTD	Thresholds		YTD Performance
			Apr	May	Jun	Jul	Aug	Sep								456	475	Performance Under Review
Complaints	Complaint Numbers (excluding enquiries)	44	56	42	35	45	45	31	39						237	456	475	Performance Under Review
	Complaints responded to within 30 working days	79%	79%	81%	89%	82%	64%	65%							76%	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	1	Performing
Ambulance Handover	LAS Arrival to Patient Handover Time - % Greater than 15 minutes			45.60%	46.00%	49.00%	52.70%	58.60%	Not yet available						50.38%	85.00%	75.00%	Underperforming
Chief Nursing Officer High Impact Changes	Increase in permanent nursing and midwifery staffing ratios			87.97%			84.90%								86.44%	84.40%		
	Reduction in in-hospital Pressure Ulcer rates			0.07%			0.11%								0.09%	See Note <sup>2</sup>		
	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 (KGG Only)			5.70%	20.00%	22.90%	12.50%	13.00%	15.38%						14.91%	5 per Quarter		
Fractured Neck of Femur (#NOF)	Decrease 30 day mortality for #NOF			7.23%			3.16%								5.25%	See Note <sup>3</sup>		
Maternity	Decrease Caesarean Section (CS) rates			23.25%			20.00%								21.63%	See Note <sup>4</sup>		
	Increase the percentage of women provided with 1:1 care in Labour			89.50%			Not yet available									See Note <sup>5</sup>		
	% of women who have seen a midwife or maternity healthcare professional, for assessment of health and social care needs, risk and choices by 12 completed weeks of pregnancy.			77.00%			85.84%								81.42%	See Note <sup>6</sup>		

Notes:

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

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

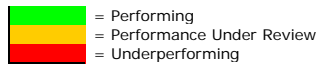
<sup>3</sup> Target is for the 75th centile as compared to Dr Foster figures on 01/03/2010

<sup>4</sup> Aim for 20% for end of 2010/11

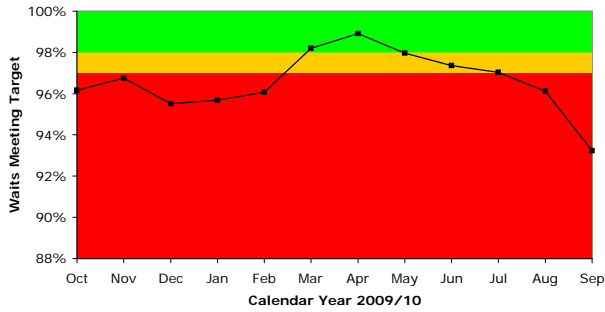
<sup>5</sup> 95% by end of Q4. Trajectory to be confirmed

<sup>6</sup> 90% by end of Q2 2011/12

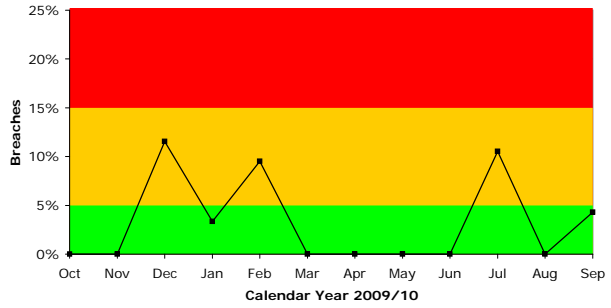
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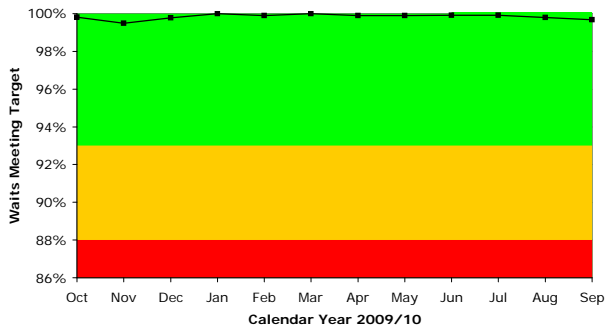
**Four-Hour Maximum Wait In A&E From Arrival To Admission, Transfer Or Discharge (All Attendances)**



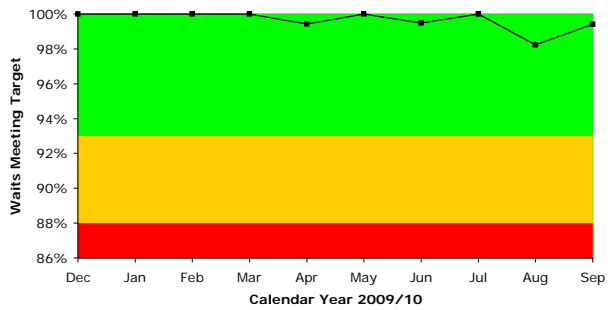
**Cancelled Ops - Breaches Of 28 Days Readmission Guarantee As % Of Cancelled Ops**



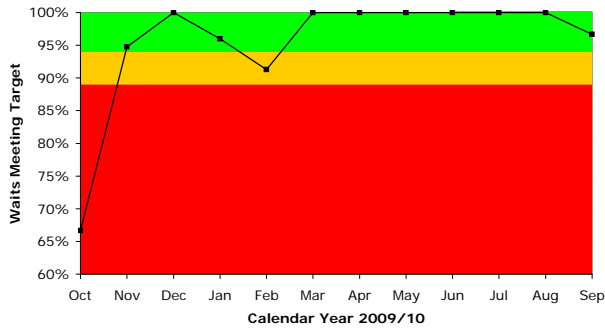
**2 Week GP Referral To 1st Outpatient**



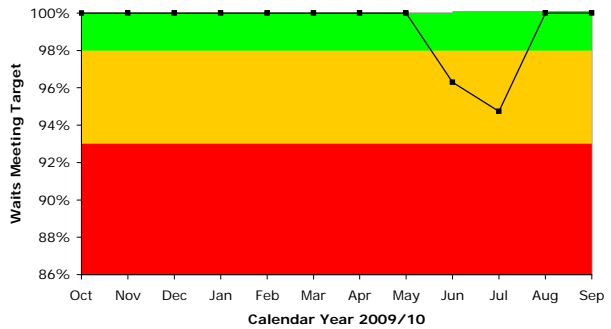
**2 Week GP Referral To 1st Outpatient - Breast Symptoms (Live from December 2009 Onwards)**



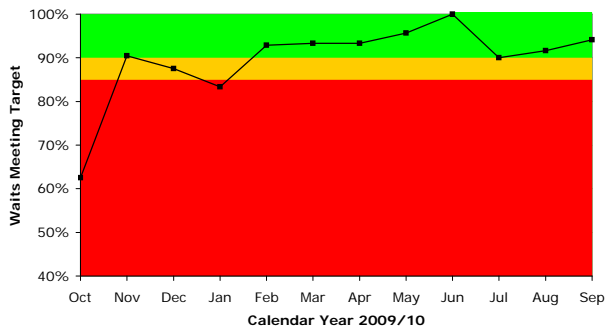
**31 Day Second Or Subsequent Treatment - Surgery**



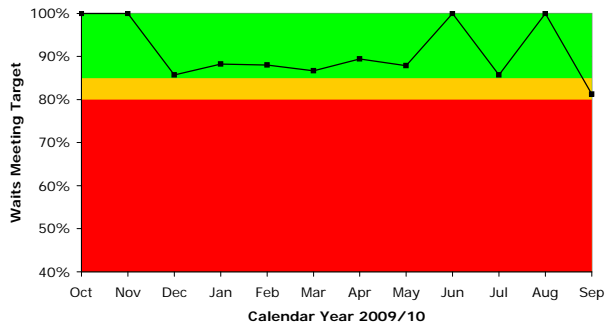
**31 Day Second Or Subsequent Treatment - Drug**



**62 Day Referral To Treatment From Screening**



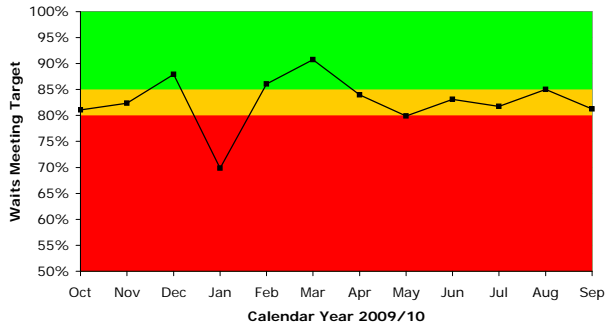
**62 Day Referral To Treatment From Hospital Specialist**



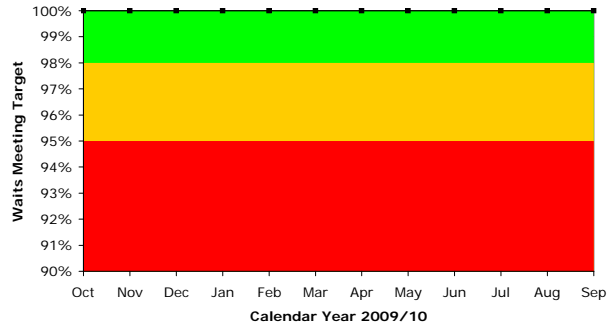
Key:

- = Performing
- = Performance Under Review
- = Underperforming

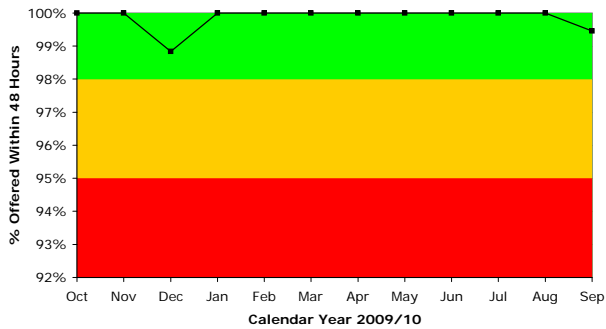
62 Days Urgent Referral To Treatment Of All Cancers



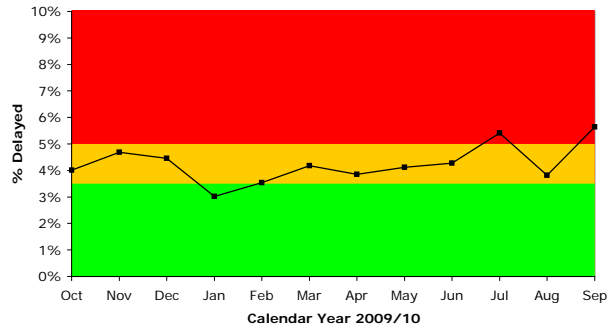
2 Week RACP



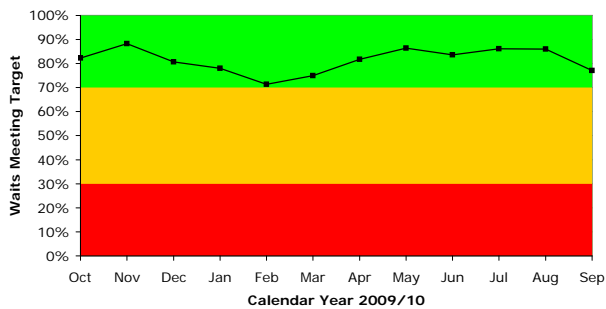
48 Hours GUM Access



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

