AGENDA ITEM NO:

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 28 APRIL 2011

Title:	**DRAFT QUALITY REPORT/ACCOUNT FOR 2010/11**
Responsible Director:	David Rosser, Executive Medical Director
Contact:	Imogen Gray, Head of Quality Development, 13687

Purpose:	To present the Trust's draft Quality Report for 2010/11 for review.
Confidentiality Level & Reason:	
Medium Term Plan Ref:	1.1 To improve clinical quality outcomes for patients 1.2 To deliver the milestones and targets contained with the Commissioning for Quality and Innovation (CQUIN) indicators and the Quality Report.
Key Issues Summary:	• The Trust's draft Quality Report for 2010/11 is attached in Appendix A for review • The Board of Directors may wish to supplement the mandatory statements with explanatory wording and/or make changes to the draft content • The Trust must provide its draft report to NHS South Birmingham and Birmingham LINk by 30 April 2011 for official comment.
Recommendations:	The Board of Directors is asked to: 1. Discuss the proposed content of the Trust's 2010/11 Quality Report 2. Recommend supplementary wording and/or changes to the content 3. Approve the content of the Trust's 2010-11 Quality Report for review by NHS South Birmingham and Birmingham LINk.

Signed:	**Date:** 20 April 2011

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS
THURSDAY 28 APRIL 2011

DRAFT QUALITY REPORT FOR 2010/11

PRESENTED BY EXECUTIVE MEDICAL DIRECTOR

1. Introduction

The aim of this paper is to present the Trust's draft Quality Report for 2010/11 to the Board of Directors for review. The draft report has been produced in line with the guidance from Monitor and the Department of Health (DH) and is presented in Appendix A for review. The draft report will then be provided to NHS South Birmingham and the Birmingham Local Involvement Network (LINk) for review and comments by 30 April 2011.

2. Mandatory Content

2.1 The Trust's Quality Report must contain the following information (in order):

Part 1: Statement on quality from the Chief Executive
Part 2: Priorities for improvement and statements of assurance from the Board of Directors
Part 3: Other information on quality
Annex: Statements from primary care trusts, Local Involvement Networks and Overview and Scrutiny Committees.
Annex: Statement of directors' responsibilities

2.2 As for last year, the Trust has to include a number of mandatory statements in Part 2 of the report, some of which are at odds with the Trust's focused approach to the management of quality. For ease of reference, the content of the draft 2010/11 Quality Report at Appendix A is colour coded as follows:

Black text: Content decided by the Trust
Blue text: Mandatory content which requires no further explanation
Red text: Mandatory statement which the Board of Directors may wish to qualify

2.3 The Trust is required to include detailed information on participation in both national and local clinical audits in Part 2 (section 2.2.2) which has been provided by the Governance team. As for last year, a brief summary of the actions following **local** clinical audit is included with a link to a table of more detailed actions on the Quality web pages. Given the length of the report, it would be pragmatic to do this for the

national clinical audit actions too. A table of the specific actions UHB is taking in relation to the **national** clinical audits is shown in Appendix A of the draft Quality Report.

2.4 Part 2 (section 2.2.5) of the draft report contains a short summary of the actions underway following the Care Quality Commission (CQC) special review of stroke services which took place in 2010/11. The review focused on care across NHS South Birmingham and not just care provided at UHB.

2.5 The Board of Directors is requested to consider the mandatory statements in Part 2 of the report and suggest changes to the supplementary wording as necessary.

2.6 The final version of the Trust's 2010/12 Quality Report will be formatted for publication by Medical Illustration.

3. The Audience

3.1 In line with reports published by The King's Fund, Nuffield Trust and the Audit Commission, the format and content of the Trust's 2010/11 Quality Report has been slightly revised to make it more accessible to patients and the public. The body of the report is shorter than last year's and key changes include:

3.1.1 Inclusion of a section on learning from complaints
3.1.2 Actual examples of compliments received in addition to numbers
3.1.3 Inclusion of some Staff Survey data
3.1.4 Expanded section on Research and Development (R&D) to show the number of studies registered in individual specialties
3.1.5 Shorter section on national clinical audit actions
3.1.6 Shorter section on the specialty quality indicators

4. 2010/11 Data

The most recent data and information for 2010/12 is included within the draft report. Some of the data will need to be updated and additional information added into the final report which will be presented to the Board of Directors in May 2011 as follows:

Section 2.2.4:	Finalised CQUIN payment information will be available in May/June 2011
Section 3.2:	MRSA, *C.difficile* and readmissions data
Section 3.3:	Performance against the National Priorities for the full 2010/11 year will be available in May/June 2011
Section 3.9:	Glossary of Terms will be added at the end of the report
Annex 1:	Statements from NHS South Birmingham and the Birmingham LINk will be received in May 2011
Annex 2:	Statement of directors' responsibilities will be completed during the KPMG audit of the Quality Report in May 2011

5. **Specialty Quality Indicators**

5.1 The Trust's 2009/10 Quality Report included performance data for a wide range of the specialty indicators developed though the Quality and Outcomes Research Unit (QuORU). The 2010/11 report contains a summary of performance for the specialty indicators with a link to the detailed performance data for all indicators on the website, shown in Appendix B of the draft report. A table listing any changes made to indicator methodologies during 2010/11 will also be available on the Quality web pages for completeness.

5.2 Data for 2010/11 is included up to February 2011 for all indicators (data shown in bold for those up to March 2011) and will be updated in May 2011 following validation by clinicians. The goals for all indicators are currently being reviewed by clinicians to ensure they are both challenging and realistic for 2011/12.

6. **Next Steps**

The content of the Trust's draft Quality Report for 2010/11 will be finalised immediately after the Board of Directors meeting and provided to NHS South Birmingham and Birmingham LINk for review and comment. Birmingham City Council Overview and Scrutiny Committee (OSC) has opted not to provide a comment but will be provided with the Trust's draft report anyway.

7. **Recommendations**

The Board of Directors is asked to:

1. Discuss the proposed content of the Trust's 2010/11 Quality Report
2. Approve the supplementary wording and/or changes to the content
3. Approve the content of the Trust's 2010/11 Quality Report for review by NHS South Birmingham and Birmingham LINk.

Appendix A

University Hospitals Birmingham NHS

NHS Foundation Trust

2010/11
Quality Report

This report covers the period 1 April 2010 to 31 March 2011

Part 1: Chief Executive's Statement

The Vision of University Hospitals Birmingham NHS Foundation Trust (UHB) is "to deliver the best in care" to our patients. Quality in everything we do underpins this Vision in the overall Trust Strategy and the Corporate, Divisional and Specialty Strategies which underpin it. Clinical Quality and Patient Experience are two of the Trust's Core Purposes and provide the framework for the Trust's robust approach to managing quality.

UHB has made good progress in relation to all five quality improvement priorities for 2010/11 identified in last year's Quality Report: reducing medication errors, reducing delays in antibiotic delivery, completion of venous thromboembolism (VTE) risk assessments, improving patient experience and satisfaction and reducing infection. The Trust has chosen to continue with these priorities in 2011/12 to deliver further improvements for our patients alongside a new quality improvement priority: completeness of patient observations in the electronic observation chart.

That the Trust has managed to make significant improvements to the quality of care we provide during one of the biggest and most challenging hospital moves in NHS history, is a testament to the hard work and commitment of our staff. This is echoed in our excellent 2010 Staff Survey results which have shown a great improvement compared with previous years.

An essential part of driving up quality at UHB has been the scrutiny and challenge provided through proper engagement with staff and other stakeholders such as the Trust Board of Governors, the Birmingham Local Involvement Network and NHS South Birmingham. Clinical staff have continued to develop and use a wide range of specialty level quality indicators through the Trust's Quality and Outcomes Research Unit (QuORU), some of which are shown in Part 3 of this report.

A key part of UHB's commitment to quality is being open and honest with our staff, patients and the public, with published information not simply limited to good performance. The Quality web pages provide up to date information on the Trust's performance in relation to quality: http://www.uhb.nhs.uk/quality.htm. A wide range of information was published during 2010/11 including quarterly Quality Report updates, Trust-level patient experience data and performance for a greater number of specialty level indicators.

The Trust's focused approach to quality is driven by innovative and bespoke information systems which enable us to capture and use real-time data in ways which few other UK trusts are able to do. During 2010/11, UHB has used started to review whole pathway mortality using the interactive Healthcare Evaluation Data (HED) tool developed last year and further improvements have been made within the Prescribing Information and Communication System (PICS). These are described in Parts 2 and 3 of this report.

Data quality and the timeliness of data are fundamental aspects of UHB's management of quality. Data is provided to clinical and managerial teams as close to real-time as possible through various means such as the Trust's digital Clinical Dashboard. Information is subject to regular review and challenge at specialty, divisional and Trust levels, by the Clinical Quality Monitoring Group, Care Quality Group and Board of Directors for example.

During 2010/11, the Trust requested its internal auditors to review some of the processes through which data is extracted, checked and reported in different sections of the Quality Report: VTE risk assessment completion, reporting of falls and two of the specialty quality indicators. This review provided assurance over the accuracy of UHB's information reporting methods, with some minor recommendations for improvement which are being implemented. I can therefore confirm that to the best of my knowledge the information contained within this report is accurate.

Finally, the Trust's remaining services and departments will move into the new Queen Elizabeth Hospital Birmingham during 2011/12 which will allow us to continuously improve the quality of care we provide in a world-class environment.

……………………………..
Julie Moore, Chief Executive June 2, 2011

Part 2: Priorities for improvement and statements of assurance from the Board of Directors

2.1 Quality Improvement Priorities

2010/11

The Trust's 2009/10 Quality Report set out five key priorities for improvement during 2010/11:

Priority 1: Reducing errors (with a particular focus on medication errors)
Priority 2: Time from prescription to administration of first antibiotic dose
Priority 3: Venous thromboembolism (VTE) risk assessment on admission (within 24hrs)
Priority 4: Improve patient experience and satisfaction
Priority 5: Infection prevention and control

The Trust has made good progress in relation to four of these quality improvement priorities during 2010/11 which is detailed further below. The Board of Directors has chosen to continue with these improvement priorities for 2010/11 plus one additional one (shown in bold) as follows:

2011/12

Key Priorities:

Priority 1: Time from prescription to administration of first antibiotic dose
Priority 2: Completion of VTE (venous thromboembolism) risk assessments on admission
Priority 3: Improve patient experience and satisfaction
Priority 4: Electronic observation chart – completeness of observation sets (to produce an early warning score)

Ongoing Priorities:

Priority 5: Reducing medication errors (missed doses)
Priority 6: Infection prevention and control

The improvement priorities for 2011/12 were initially selected by the Trust's Clinical Quality Monitoring Group chaired by the Executive Medical Director, following consideration of performance in relation to patient safety, patient experience and effectiveness of care. These were then shared with the Trust's Governors and the Birmingham Local Involvement Network (LINk). The focus of the patient experience priority was decided by the Care Quality Group which is chaired by the Executive Chief Nurse and also has Governor representation. The priorities for 2011/12 were then finally approved by the Board of Directors.

The performance in 2010/11 and the rationale for selection of each priority are provided in detail below. This report should be read alongside the Trust's Quality Reports for 2009/10 and 2008/09.

Priority 1: Time from prescription to administration of first antibiotic dose

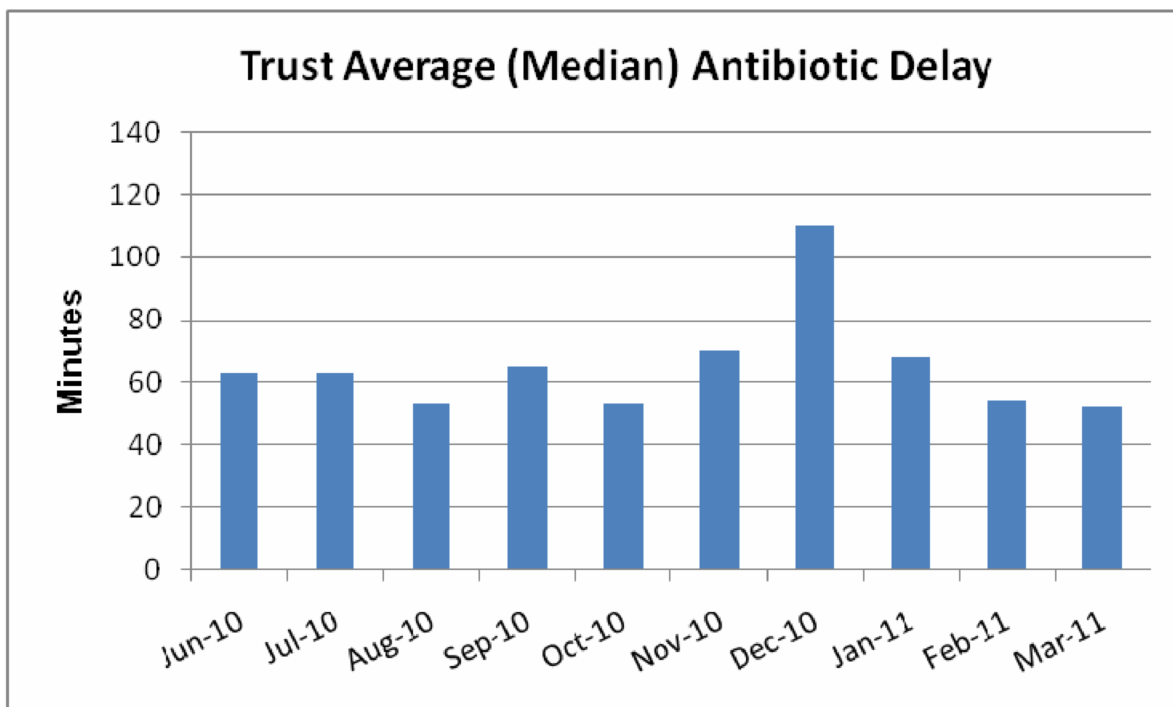
Performance

There is evidence within the clinical literature that rapid antibiotic delivery can reduce patient harm and improve outcomes. The recommended time from prescription to administration of first antibiotic dose for certain conditions should ideally be 60 minutes or less.

This indicator focuses on the first prescription of antibiotics for patients identified as having likely infections (based on white blood cell counts) and measures the time delay between the antibiotic prescription being made and the first dose of this drug being given. All courses of antibiotics lasting for three days are included even where they include a discharge prescription.

The Trust has now identified clinical exception rules with clinicians and refined the methodology for measuring performance against this indicator. Data has been collected from the Trust's electronic Prescribing Information and Communication System (PICS) for patients admitted with acute illnesses. This does not however include Emergency Department referrals where prescribing data is not yet captured electronically.

Performance data is shown in the graph below for June 2010 to March 2011. Improving performance for this priority has proved challenging during 2010/11. The actions the Trust has put in place during the year have now started to make a difference with February and March 2011 data within the target of time of 60 minutes or less.



Initiatives implemented in 2010/11:

- Education has been provided to various levels of medical staff around medication errors and the need to ensure timely antibiotic delivery to acutely sick patients.
- A Pharmacy stock locator has been implemented within the Prescribing Information and Communication System. This is to enable nursing staff to locate drugs on another ward if needed so patients do not miss a drug dose.
- Delayed antibiotics are being included in the monthly root cause analyses of selected missed dose cases by the Trust's Executive, divisional management and clinical teams to drive improvements in practice.

New initiatives to be implemented in 2011/12:

- Plan for the implementation of the Prescribing and Communication System (PICS) into the Emergency Department to allow electronic prescribing data capture in the future.
- Refinement of the indicator so that more patients are included; Emergency Department prescribing data to be added when it becomes available.

- Consider adding an alert into PICS to make sure nurse are aware of any one-off antibiotic doses prescribed outside of normal drug round times, particularly during the night.

How progress will be monitored, measured and reported:

- Performance will continue to be measured and monitored at specialty and ward levels using PICS data and the Trust's usual reporting tools.
- Progress will be monitored by the Clinical Quality Monitoring Group and reported in the quarterly Quality Report updates published on the Trust's quality web pages.

Priority 2: Venous thromboembolism (VTE) risk assessment on admission

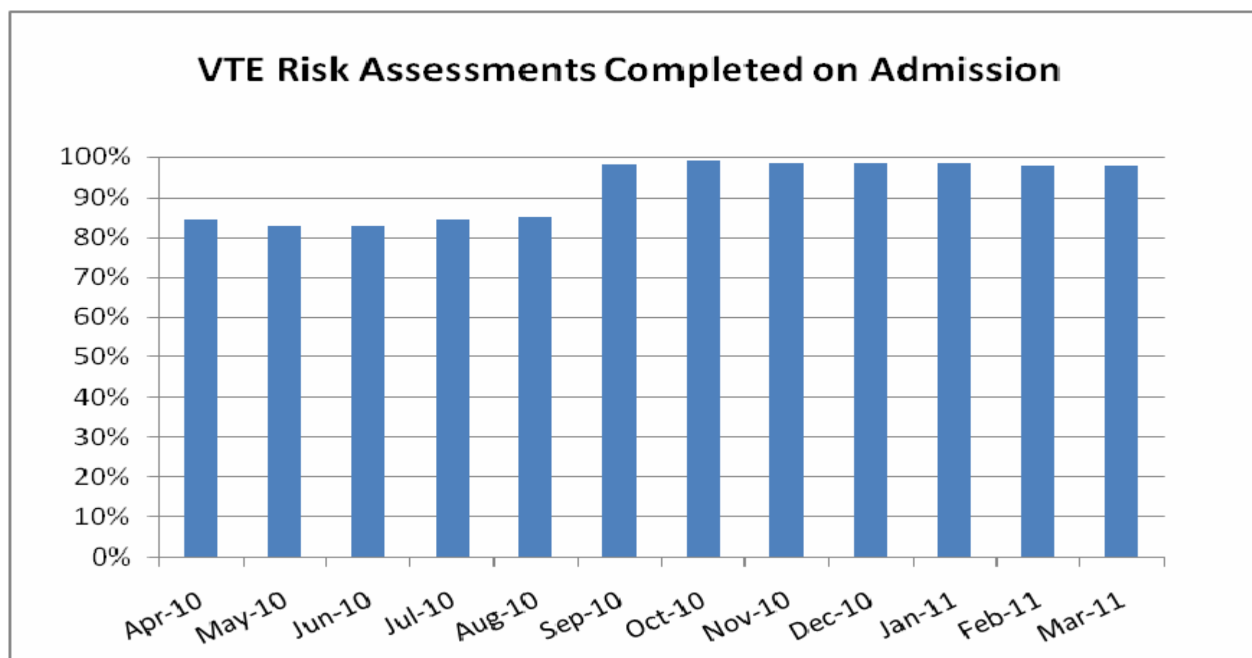
Performance

Venous thromboembolism (VTE) is the term used to describe deep vein thrombosis (blood clot occurring in a deep vein, most commonly in the legs) and pulmonary embolism (where such a clot travels in the blood and lodges in the lungs) which can cause considerable harm or death. VTE is associated with periods of immobility and can largely be prevented if appropriate preventative measures are taken.

Whilst most other trusts have to rely on a paper-based assessment of the risk of VTE for individual patients, the Trust has been using an electronic risk assessment tool within the Prescribing Information and Communication System since June 2008 for all inpatient admissions. The tool provides tailored advice regarding preventative treatment based on the assessed risk.

The Trust's electronic VTE risk assessment tool has been revised to reflect the latest guidance from the National Institute for Health and Clinical Excellence (NICE). In order to comply with this guidance, new mandatory questions for all inpatients admitted acutely or electively have been included as part of the risk assessment tool. In addition, ambulatory care (day case) admissions have been examined to determine which patients also require a full risk assessment within our systems. Both of these changes have produced a big improvement in VTE risk assessment completion on admission.

The graph shows performance for 2010/11. The Trust has achieved a VTE risk assessment completion rate of well over the 90% year-end target since September 2010.



Initiatives implemented during 2010/11:

- The Trust's electronic VTE risk assessment tool was revised to take into account the latest NICE guidance.
- Preparatory work has been undertaken so that the electronic VTE risk assessment tool can be implemented within ambulatory care during early 2011/12.

New initiatives to be implemented in 2011/12:

- PICS and the electronic VTE risk assessment tool will be implemented within ambulatory care during early 2011/12.
- Improve compliance with the outcomes of completed VTE risk assessments so that patients are actually given the preventative treatment (compression hosiery and/or enoxaparin medication) they require.

How progress will be monitored, measured and reported:

- Performance will continue to be measured using PICS VTE risk assessment data.
- The Trust's Thrombosis Group working closely with the PICS team will be responsible for providing education and feedback about performance throughout the Trust.
- Performance will be monitored by the Trust's Clinical Quality Monitoring Group and the Board of Directors.
- Progress will also be reported in the quarterly Quality Report updates published on the Trust's quality web pages.

Priority 3: Improve patient experience and satisfaction

Performance

During quarter 1 2010/11, the Trust started monitoring the feedback received from patients via the electronic bedside and telephone surveys for the questions set out in the Trust's 2009/10 Quality Account Report. The last two questions relate to discharge and were added into the telephone survey in August 2010.

Over 16,000 patients responded to the electronic patient survey during 2010/11 providing a wealth of information about their experience. The survey results show that the Trust has improved patient experience and satisfaction across many aspects of care during 2010/11:

Time Period	Survey Questions	Answers	Performance
April 2010-March 2011	Have you been involved as much as you want to be in decisions about your care and treatment?	Yes	**73%**
		Yes, to some extent	**21%**
		No	**6%**
April 2010-March 2011	Did you find someone on the hospital staff to talk about your worries and fears?	Yes, definitely	**62%**
		Yes, to some extent	**26%**
		No	**12%**
June 2010 – March 2011	Were you given enough privacy when discussing your care and treatment?	Yes, always	**87%**
		Yes, sometimes	**11%**
		No	**2%**
June 2010 – March 2011	Do you think that hospital staff do all they can to help control your pain?	Yes, definitely	**81%**
		Yes, to some extent	**16%**
		No	**3%**
		Yes, completely	**59%**

August 2010 – March 2011	Did a member of staff tell you about medication side effects to watch for when you went home?*	Yes, completely	**59%**
		Yes, to some extent	**13%**
		No	**28%**
August 2010 – March 2011	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?*	Yes	**86%**
		No	**14%**

The Trust's National Inpatient Survey results for 2010 are shown in Part 3 of this report.

Initiatives implemented during 2010/11:

- The outpatient telephone survey was implemented in July 2010, with around 70 surveys are completed each month. The results are reported to the Care Quality Group.
- More comprehensive reports on patient experience and satisfaction have been developed which provide detailed results by Division. These have enabled improvements to be made in relation to food, privacy and dignity and noise at night.
- Patient survey data is analysed to ensure responses are representative of the patient population with regard to age, gender and ethnicity.

Improving patient experience and satisfaction in 2011/12:
The Trust has chosen to focus on delivering improvements for the following 5 questions in the 2011 National Inpatient Survey:

1) Were you involved as much as you wanted to be in decisions about your care and treatment?
2) Did you find someone on the hospital staff to talk to about your worries and fears?
3) Were you given enough privacy when discussing your condition or treatment?
4) Did a member of staff tell you about medication side effects to watch for when you went home?
5) Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

In addition, the Trust will be focusing on delivering improvements for the following patient survey questions locally:

6) Do you think the hospital staff do all they can to help control your pain?
7) Overall how would rate the hospital food you have received?
8) Have you been bothered by noise at night from hospital staff?
9) Sometimes in hospital a member of staff says one thing and another says something quite different. Has this happened to you?
10) Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

These questions have been selected by the Trust's Care Quality Group which has Governor representation. They also include those covered by the nationally mandated Commissioning for Quality and Innovation (CQUIN) indicator for 2011/12.

New initiatives to be implemented in 2011/12:

- A Patient Experience Champion programme will be established to provide a framework within wards and departments to drive improvements through patient and carer feedback.

- A paper questionnaire will be introduced in the Emergency Department alongside a facility for patients to provide feedback via on-line methods.
- Implementation of an online patient survey to make it easier for patients to provide feedback.
- Introduction of a discharge survey for patients using the Discharge Lounge.
- Implementation of a 'Mystery Shopper' programme to audit customer care practices in various departments.

How progress will be monitored, measured and reported

- Feedback rates and responses will continue to be measured and communicated via the Clinical Dashboard.
- Performance will continue to be monitored as part of the Back to the Floor visits by the senior nursing team with action plans developed as required.
- Regular patient feedback reports will be provided to the Patient Experience Group, Care Quality Group and the Board of Directors.
- Progress will also be reported in the quarterly Quality Report updates published on the Trust's quality web pages.

Complaints

In 2010/11 there was an increase of 30.6% in the number of complaints, compared with the previous year. This peaked during January 2011 and has since reduced. The Trust had anticipated an increase in the number of complaints as a result of the move of services to the new hospital, in line with the experience of other Trusts.

	2010/11	2009/10	2008/09
Total number of complaints	840	643	609
Response within agreed deadline	93%	92.2%	88%

Top 3 subjects of complaints	2010/11	2009/10	2008/09
Clinical treatment	390	272	254
Outpatient appointment delay/cancellation	116	109	97
Communication/information		76	69
Attitude of staff	88		

Ratio of complaints to activity		2010/11	2009/10	2008/09
Inpatients	FCEs*	123,139	124,589	121,653
	Complaints	444	277	294
	Rate per 100 FCEs	0.36	0.22	0.24
Outpatients	Appointments**	517,516	499,981	454,514
	Complaints	312	309	263
	Rate per 100 appointments	0.06	0.06	0.06
A&E	Attendances	82,925	82,632	83,051
	Complaints	84	57	52
	Rate per 100 attendances	0.10	0.07	0.06

* FCE = Finished Consultant Episode – which denotes the time spent by a patient under the continuous care of a consultant.
** Outpatients activity data relates to fulfilled appointments only and also includes Therapies (Physiotherapy, Podiatry, Dietetics, Speech and Language Therapy and Occupational Therapy)

Independent Reviews

Following local resolution, complainants may request an independent review; a function carried out since April 2009 by the Parliamentary and Health Service Ombudsman. Cases received by the Ombudsman will receive an initial assessment, following which they will either be accepted for investigation or will be refused. Cases that are accepted for investigation may be upheld or not upheld.

The Ombudsman report for 2009/10 showed that 66 requests had been received in relation to UHB. Of those, 7 were accepted for investigation. During 2010/11, the Ombudsman upheld 5 complaints relating to previous years. These cases resulted in further investigations by the Trust and publication of action plans to demonstrate learning outcomes.

Learning from Complaints

The Trust is continuing to learn from complaints and make real improvements to services for future patients. Some of the key improvements made as a result of complaints received during 2010/11 are detailed below.

Care Rounds

One of the trends identified following the move to the new hospital related to perceptions of nursing care on the new wards. The Trust has since introduced a system of Care Rounds across all 29 inpatient wards across the old and new hospital sites. Care Rounds involve nurses conducting hourly checks of patient where their concerns, comfort, hydration, nutrition, continence and environmental needs are assessed through direct interaction with the patient. These are then documented on a Care Round Checklist and actions taken to respond to issues as they arise.

Customer Care Training

In response to an increase in complaints relating to staff attitude and communication, the Trust has appointed a dedicated Customer Care Facilitator. Over 1,100 staff have received training in good customer care since January 2011 which include staff in areas highlighted through complaints. A Customer Care Strategy has been developed and further training will be delivered during 2011/12.

Executive Root Cause Analysis (RCA) Meetings

Some of the more serious or complex complaints the Trust receives are now being reviewed at the monthly root cause analysis meetings attended by Executive directors, Divisional management and clinical teams.

Compliments

Compliments are recorded by the Patient Advice and Liaison Service (PALS) on behalf of the Trust. PALS receive some compliments directly from patients and carers, others are forwarded to PALS by staff after being received in wards and departments throughout the Trust.

The majority of compliments are received in writing – by letter, card, email or feedback leaflet, the rest are received verbally via telephone or face to face.

With robust systems now in place for capturing positive feedback the number of recorded compliments continues to increase. Positive feedback is shared with staff and patients to promote and celebrate good practice as well as to boost staff morale.

Compliment Subcategories	**2010/11**	**2009/10**	**2008/9**
Nursing care	309	92	11
Friendliness of staff	306	76	26
Treatment received	251	130	142
Medical care	122	21	9
Other	54	4	2
Efficiency of service	47	37	8
Information provided	17	3	1
Facilities	9	4	11
Comment	0	0	1
Totals:	**1115**	**367**	**211**

Examples of compliments received during 2010/11:

Date Received	**Compliment**
June 2010	"At all times she was treated with respect, with fairness, with open friendliness, with care. She received these from all members of staff, from the time she arrived ….until she was discharged ….to her home"
July 2010	"Astounded by the excellent nursing and medical care"
August 2010	"Thank you to the doctors and especially the nursing staff on days and nights who looked after me when I was ill during the first days of my 12 day stay on the ward. All staff made my stay that bit more bearable and I shall eternally be grateful. Thank goodness for the NHS. "
August 2010	"Every single person I encountered during my stay, was extremely professional and caring, every time"
January 20 11	"The treatment was excellent, and all the staff, too many to name individually, were absolutely magnificent"
January 2011	"Your skills and dedication are breath taking! Your patience and care were invaluable during a very difficult time of my life. Thank you for getting me through the hardest part of my treatment"
February 2011	"Everyone associated with my treatment and care has been a credit to their profession. I really cannot thank them enough"
March 2011	"It is an extremely efficient service, you all made me feel very relaxed during a difficult time for me"

Feedback received through NHS Choices website:

The Trust has a system in place to routinely monitor feedback posted on external websites such NHS Choices/Patient Opinion. Feedback is forwarded to the relevant department manager for information and action. A response is posted to each comment received acknowledging the comment and providing generic information when appropriate. The response also promotes the Patient Advice and Liaison Service (PALS) as a mechanism for obtaining a more personalised response or to ensure a thorough investigation into any issues raised. The number of comments posted this way is relatively small but numbers are beginning to show a slight increase.

Priority 4: Electronic observation chart – completeness of observation sets (to produce an early warning score)

Current Status

The Trust has implemented an electronic observation chart during 2010/11 within the Prescribing Information and Communication System (PICS). 69.7% of inpatient wards are now using the electronic chart to record patient observations rather than the paper charts.

A full set of patient observations includes: temperature, blood pressure, oxygen saturation score, respiratory rate, pulse rate and level of consciousness. When nursing staff carry out patient observations, it is important that they complete the full set of observations. This is because the electronic tool enables an early warning score called the SEWS (Scottish Early Warning System) score to be triggered automatically if a patient's condition starts to deteriorate. This allows patients to receive appropriate clinical treatment as soon as possible.

This indicator measures the percentage of observation sets which are complete. The Trust's baseline performance was 79.7% for 2010/11 for those wards which were using the electronic observation chart in PICS. The Trust is aiming for at least 90% of all observation sets to be complete by the end of 2011/12.

New initiatives to be implemented in 2011/12:
- Roll out of the electronic observation chart to the remaining inpatient wards.
- Add this indicator to the Clinical Dashboard to enable clinical staff to monitor and benchmark performance against other similar wards.

How progress will be monitored, measured and reported:
- Progress will be measured using PICS data from the electronic observation charts.
- Progress will be monitored at ward, specialty and Trust levels through the Clinical Dashboard and other reporting tools.
- Progress will be reported monthly to the Clinical Quality Monitoring Group and quarterly to the Board of Directors through the quarterly Quality Report updates.

Ongoing Priorities

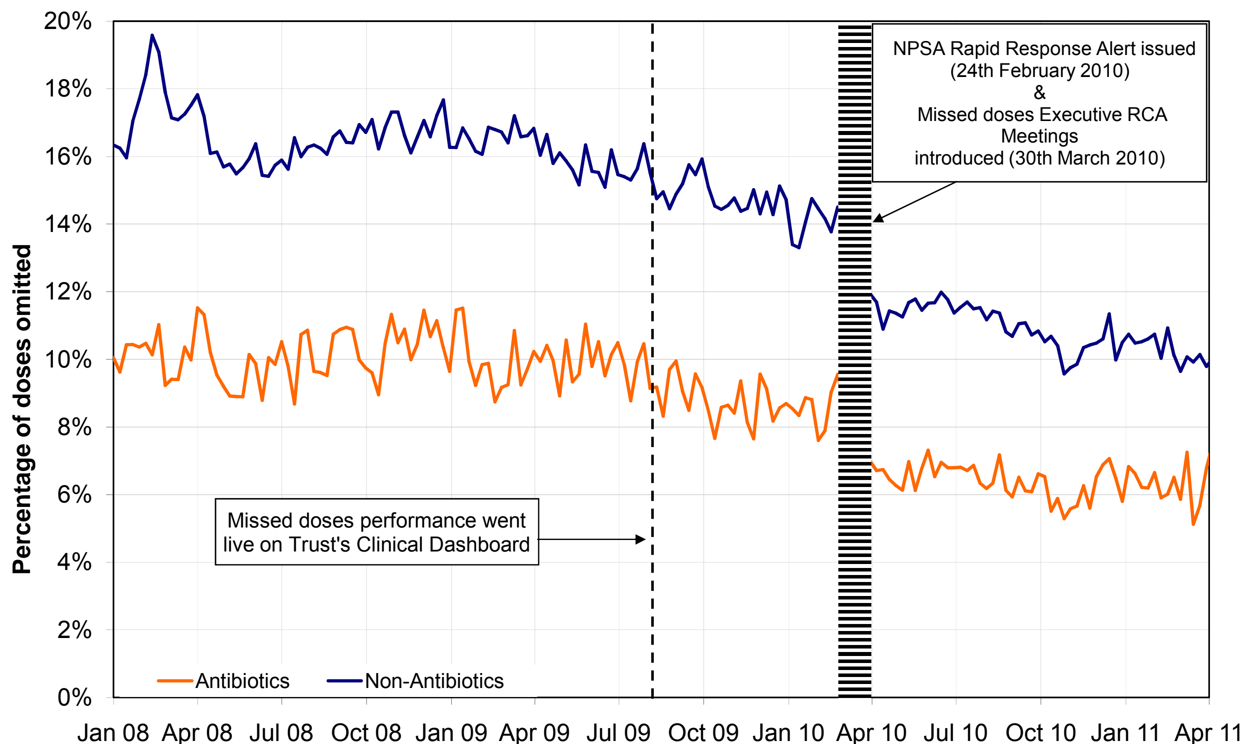
Priority 5: Reducing errors (with a particular focus on medication errors)

Performance

Since April 2009, the Trust has focused on reducing the percentage of drug doses prescribed but not recorded as administered (omitted) to patients on the Prescribing Information and Communication System.

The graph shows that the Trust has delivered significant and sustained reductions in the percentage of omitted antibiotics and non-antibiotics. The biggest step change improvements occurred when the Trust began reporting missed doses data on the Clinical Dashboard in August 2009 and the Executive root cause analysis (RCA) meetings were introduced at the end of March 2010.

The Trust has also made further significant reductions in the percentage of omitted antibiotic and non-antibiotic drug doses during 2010/11, although the rate of decline has now slowed as expected. UHB is aiming to make further reductions during 2011/12, particularly for non-antibiotics. It is however important to remember that some drug doses are appropriately missed due to the patient's condition at the time. The Trust will therefore be evaluating its target reductions in 2011/12 to ensure they are appropriate, in the absence of any national agreement on what constitutes an expected level of drug omissions.



Initiatives implemented during 2010/11:

- Monthly Executive root cause analysis (RCA) meetings have continued during 2010/11, covering a wide range of omitted drugs and associated medication issues.
- A nurse pause function has been introduced in the Prescribing Information and Communication System. This allows nursing staff to pause a limited number of symptomatic medications such as analgesics and laxatives as soon as they are not required.
- Training and education has been given to both nursing and medical staff around the prescribing and administration of antibiotics and non-antibiotics.
- The default screen which opens when nurses and medical staff log into PICS has been changed to the drug chart to focus attention on missed doses.

Initiatives to be implemented in 2011/12:

- Evaluation of reduction targets for antibiotics and non-antibiotics for 2011/12.
- The Trust will be focusing on improving prescribing practice and communication between medical and nursing staff.
- Monthly Executive RCA meetings will continue with enhanced monitoring of action plans to ensure improvements are sustained.

How progress will be monitored, measured and reported

- Progress will continue to be measured at ward, specialty, divisional and Trust levels using information recorded in the Prescribing Information and Communication System. This includes automatic email alerts to different levels of management staff where specialty performance is outside agreed targets.
- Omitted drug doses will continue to be communicated daily to clinical staff via the Clinical Dashboard (which displays real-time quality information at ward-level) and monitored at divisional, specialty and ward levels.

- Performance will continue to be reported to the Chief Executive's Advisory Group, the Chief Operating Officer's Group and the Board of Directors each month to ensure appropriate actions are taken.
- Progress will also be reported in the quarterly Quality Report updates published on the Trust's quality web pages.

Priority 6: Infection prevention and control

Performance

The Trust concluded 2010/11 under the agreed trajectory for *C. difficile* infections for 2010/2011. All staff have contributed to this improvement through a consistent focus on patient assessment, rapid isolation, appropriate hand hygiene, environmental decontamination and prudent antimicrobial prescribing.

The Trust however concluded the year one case over the agreed MRSA trajectory of 11 cases. The Trust will need to continue to reduce infection rates during 2011/12 to meet the agreed trajectories for 2011/12.

Time Period/ Infection Type	2010/11	Agreed Trajectory for 2010/11	2009/10	Agreed Trajectory for 2009/10	2008/09	Agreed Trajectory for 2008/09
***C. difficile* infection (post-48 hour cases)**	145	164	178	348	357	526
MRSA bloodstream infections	12	11	13	30	35	48

Initiatives implemented during 2010/11:

- Enhanced cleaning with vapour decontamination is used for patients with C. difficile toxin positive diarrhoea and multi-drug resistant Acinetobacter.
- MRSA screening has been expanded to cover all emergency and non-emergency patients admitted to UHB.
- An improved root cause analysis (RCA) process has been developed for reviewing MRSA bacteraemias and *C. difficile* infections to ensure improvements are sustained.

Initiatives to be implemented in 2011/12:

- Monthly reporting of other infections including meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemias and *Escherichia coli* (*E. coli*) bacteraemia to the Health Protection Agency (HPA) will start during 2011/12.
- Reduce the incidence of surgical site infection across all types of surgery.
- Reduce the incidence of urinary catheter associated infection.
- Reduce the incidence of blood culture contamination.
- Minimise the risk from healthcare associated infections to patients through better management of invasive devices.
- Ensure learning from healthcare associated infections is captured and disseminated across the Trust to minimise recurrence and improve patient safety.

How progress will be monitored, measured and reported:

- The number of MRSA and *C.difficile* infections will be measured against the 2011/12 trajectories.
- Performance will be monitored daily via the Clinical Dashboard and daily/weekly email alerts.
- All MRSA bloodstream infections will continue to be reported as serious incidents requiring investigation (SIRIs) to NHS South Birmingham.
- Root cause analyses will continue to be undertaken for MRSA bloodstream infections and *C.difficile* infections.
- Performance will be reported monthly to the Trust's Infection Prevention and Control Committee and the Board of Directors.
- Progress will also be reported in the quarterly Quality Report updates published on the Trust's quality web pages.

2.2 Statements of assurance from the Board of Directors

2.2.1 Information on the review of services

During 2010/11 the University Hospitals Birmingham NHS Foundation Trust* provided and/or sub-contracted 61 NHS services.

The Trust has reviewed all the data available to them on the quality of care in 61 of these NHS services**.

The income generated by the NHS services reviewed in 2010/11 represents 100% per cent of the total income generated from the provision of NHS services by the Trust for 2010/11.

In line with the Transforming Community Services Programme, the Trust will be integrating sexual health services from Heart of Birmingham Teaching Primary Care Trust as of 1 April 2011. Performance indicators will be developed and monitored during 2011/12 and considered as part of the Trust's 2011/12 Quality Report.

* University Hospitals Birmingham NHS Foundation Trust will be referred to as the Trust/UHB in the rest of the report.

** The Trust has appropriately reviewed the data available on the quality of care for all its services. Due to the sheer volume of electronic data the Trust holds in various information systems, this means that UHB uses automated systems and processes to prioritise which data on the quality of care should be reviewed and reported on. These are described further in Part 3 of this report.

Data is reviewed and acted upon by clinical and managerial staff at specialty, divisional and Trust levels by various groups including the Clinical Quality Monitoring Group chaired by the Executive Medical Director.

2.2.2 Information on participation in clinical audits and national confidential enquiries

During 2010/11 42 national clinical audits and 2 national confidential enquiries covered NHS services that UHB provides.

During 2010/11 UHB participated in 88% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that UHB was eligible to participate in during 2010/11 are as follows: (see table below)

The national clinical audits and national confidential enquiries that UHB participated in during 2009/10 are as follows: (see table below)

The national clinical audits and national confidential enquiries that UHB participated in, and for which data collection was completed during 2010/11, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (see table below).

Audit type	Audit UHB eligible to participate in	UHB participation 2010/11	Percentage of required number of cases submitted
Part of the National Clinical Audit and Patient Outcomes Programme	Head & neck cancer (DAHNO)	Yes	100% of appropriate cases submitted
	Bowel cancer (NBOCAP)	Yes	65.2%
	Oesophago-gastric (stomach) Cancer	N/A - No current submission required	N/A
	IBD (Inflammatory Bowel Disease) Audit	Yes	N/A The third round audit has commenced in stages. Organisational data collection from September to October 2010 (submitted), Clinical Data September 2010 to August 2011 (in progress), Patient Experience September 2010 to September 2011(in progress)
	Adult cardiac surgery	Yes	100%
	Heart failure	Yes	100%
	Adult cardiac interventions (e.g., angioplasty)	Yes	100%
	Myocardial Infarction (MINAP)	Yes	Not available – specific number not required
	Cardiac rhythm management (Pacing / Implantable Defibrillators)	Yes	100%
	Congenital heart disease (children and adults) / Paediatric cardiac surgery	Yes	100%
	National Kidney Care Audit: Patient Transport	Yes	Not available – specific number not required
	National Audit of Continence Care	N/A - no audit in 2010/11	N/A
	Lung cancer (LUCADA)	Yes	100%
	National Falls and Bone Health Audit	Yes	89%
	National Sentinel Stroke Audit	Yes	100%
	National Audit of Dementia	Yes	100% - Plus enhanced audits
	Mastectomy & Breast Reconstruction	N/A - no audit in 2010/11	N/A
	Carotid Endarterectomy Audit	Yes	52%
	National Diabetes Audit	Yes	N/A - The submission of 2010/11 data is not due until October.

Audit type	Audit UHB eligible to participate in	UHB participation 2010/11	Percentage of required number of cases submitted
	Pain Database Audit (pilot)	N/A - no audit in 2010/11	N/A - Pain database audit due to start March 2011.
	Hip Fracture Database	Yes	Not available – specific number not required

Audit type	Audit UHB eligible to participate in	UHB participation 2010/11	Percentage of required number of cases submitted
Not part of the National Clinical Audit and Patient Outcomes Programme	National Cardiac Arrest Audit (NCAA)	No	N/A
	Adult Critical Care Case Mix Programme - ICNARC	Yes	100%
	National Elective Surgery Patient Reported Outcome Measures (PROMS): 1. Hernia	Yes	For April 2009-October 2010: Pre-operative questionnaire participation by patients: 42.7% Post-operative questionnaire participation by patients: 64.5%
	National Elective Surgery Patient Reported Outcome Measures (PROMS): 2. Varicose Veins	Yes	For April 2009-October 2010: Pre-operative questionnaire participation by patients: 22.2% Post-operative questionnaire participation by patients: 53.2%
	Potential Donor Audit	Yes	100%
	Renal Registry	Yes	100%
	UK Transplant registry: 1. Cardiothoracic	Yes	100%
	UK Transplant registry: 2. Liver	Yes	100%
	UK Transplant registry: 3. Kidney	Yes	100%
	British Thoracic Society: 1. Adult Asthma	Yes	Not available – specific number not required
	British Thoracic Society: 2. Emergency Oxygen	Yes	Not available – specific number not required
	British Thoracic Society: 3. National Pleural Procedures audit	Yes	Not available – specific number not required
	British Thoracic Society: 4. COPD	Yes	Not available – audit deadline 1st April 2011
	British Thoracic Society: 5. Adult Community Acquired Pneumonia	Yes	Not available – specific number not required
	British Thoracic Society: 6. NIV (Adult)	Yes	Not available – specific number not required
	British Thoracic Society: 7. Bronchiectasis	Yes	Not available – specific number not required
	College of Emergency Medicine:	No	N/A

Audit type	Audit UHB eligible to participate in	UHB participation 2010/11	Percentage of required number of cases submitted
	1. Renal colic		
	College of Emergency Medicine: 2. Fever in children	Yes	100%
	College of Emergency Medicine: 3. Vital signs in majors	Yes	100%
	Parkinson's Disease Audit	No	N/A
	SINAP (Stroke Improvement National Audit Programme)	No	N/A
	National Comparative Audit of Blood Transfusion: 1. Repeat use of 'O' Negative blood audit	Yes	100%
	National Comparative Audit of Blood Transfusion: 2. Re-audit of the use of platelets	Yes	100%
	National Clinical Audit of Management of Familial Hypercholesterolaemia	Yes	100%
	Peripheral Vascular Surgery	No	N/A
	Severe Trauma – TARN (Trauma Audit and Research Network)	Yes	100%

National Confidential Enquiries

National Confidential Enquiries	UHB participation 2010/11	Percentage of required number of cases submitted
Cardiac Arrest	Yes	100%
Peri-Operative Care	Yes	100%
Surgery in Children	N/A	-

Percentages given are latest available figures. 'Not available' indicates that data has been submitted but the number of cases submitted as a percentage of the number of required cases is not available. This could be because the Trust is awaiting confirmation of percentage by the national body or the precise number of required cases is not available.

The Trust has introduced a process during 2010/11 for considering participation in new national audits to ensure those we participate in are both clinically useful and cost effective. Any decisions to not participate in a national audit are made by the Chief Executive.

The reports of 23 national clinical audits were reviewed by the provider in 2009/10 and UHB intends to take the following actions to improve the quality of healthcare provided:

Actions reported from national clinical audits include measures such as: improvement in data capture including multi-professional care recording; streamlining of patient care pathways; appointment of new staff and changes to staff roles for improved training; education and

knowledge; creating and updating patient information and continued use of data for benchmarking purposes. A list of examples of specific actions for individual national clinical audits can be viewed on the Quality web pages: http://www.uhb.nhs.uk/quality.htm.

At UHB a wide range of local clinical audit is undertaken in clinical specialties and across the Trust. A total of 706 clinical audits were registered with UHB's clinical audit team as having commenced or been completed at UHB during 2010/11.

The reports of 314 local clinical audits were reviewed by the provider in 2010/11 and UHB intends to take the following actions to improve the quality of healthcare provided:

This figure indicates that the results of 314 clinical audits were reported within clinical areas and those reports were submitted to UHB's clinical audit team. At UHB, staff undertaking clinical audit are required to report any actions that should be implemented to improve service delivery and clinical quality. A list of examples of specific actions reported can be viewed on the Quality web pages: http://www.uhb.nhs.uk/quality.htm These include measures such as: updating patient information; reviewing or developing new protocols or guidelines for staff; arranging training or education sessions in order to increase staff awareness of required standards; making changes to staff roles; implementing new care plans or assessment tools for patients; and purchasing equipment.

Each clinical specialty at UHB is required to plan a programme of audit for the year ahead, based on national audit priorities, areas of risk and locally determined priorities.

2.2.3 Information on participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by UHB that were recruited during that period to participate in research approved by a research ethics committee was 7300.

The table below shows the number of clinical research projects registered with the Trust's Research and Development (R&D) Team during 2010/11. The number of studies which were abandoned is also shown for completeness. The main reason for studies being abandoned is that not enough patients were recruited due to the study criteria or patients choosing not to get involved.

Total number of projects registered with R&D in this period	181	
Out of the total number of projects registered in this period the number of studies currently abandoned	13	
Projects registered during this period broken down into disciplines	**Registered**	**Abandoned**
Cancer (Oncology:32; Haematology:4; Imaging:3; Clinical Biochemistry:2; Endocrinology:2; Radiotherapy: 2; Breast Services:1; ENT:1; Liver Medicine:1; Neuropsycology:1; Oral Surgery:1; Renal Medicine:1; Urology:1)	52	6
Heart and Vascular Disease (Cardiology:4; Cardiac Surgery:3; Endocrinology:3; Renal Medicine:2; Renal Surgery:2; Anaesthetics:1; Haematology:1; Rheumatology:1; Vascular	18	1

Surgery:1)		
Inflammation and Infection (Liver Medicine:8; Genito-Urinary Medicine:4; Haematology:4; Rheumatology:4; Neurology:3; Renal Medicine:3; Respiratory Medicine:3; Burns & Plastics:2; Oncology:2; Anaesthetics:1; GI Surgery:1; Trauma:1; Vascular Surgery:1)	37	2
Molecular & Genetic Basis for Disease (Diabetes:7; Endocrinology:6; Anaesthetics:3; Oncology:3; Renal Medicine:3; Haematology:2; Pharmacology:2; Respiratory Medicine:2; Burns & Plastics:1; GI Medicine:1; Neurology:1; Ophthalmology:1; Urology:1; Multi-disciplinary:1)	34	2
Neurosciences and Aging (Neurology:5; Audiology:4; Geriatric Medicine:4; Elderly Care:3; Endocrinology:2; Haematology:1; ITU:1; Neurosciences:1; Neurosurgery:1; Pain Service:1; Physiotherapy:1; Psychology:1; Oncology:1; Other:1)	27	1
Transplantation (Haematology:3; Liver Medicine:3; Renal Medicine:2; Cardiac Surgery:1; Critical Care:1; GI Surgery:1; Renal Surgery:1; Other:1)	13	1
Total	**181**	**13**

2.2.4 Information on the use of the Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion of UHB income in 2010/11 was conditional upon achieving quality improvement and innovation goals agreed between UHB and NHS South Birmingham, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2010/11 and for the following 12 month period are available online at http://www.uhb.nhs.uk/quality.htm.

The amount of UHB income in 2010/11 which was conditional upon achieving quality improvement and innovation goals was £5.96m* and the Trust received £5.96m in payment.

* This figure has been arrived at as a percentage of the healthcare income which will be included within the Trust's 2010/11 accounts and does not represent actual outturn (as an estimate has to be included for Month 12 income). The actual figure will not be known until June 2011 when we will have a final position as reconciled with the CBSA. Also whilst we have received payment throughout the year as each month has been agreed with CBSA, final payment of CQUIN will not take place until the June 2011 reconciliation point.

2.2.5 Information on Care Quality Commission (CQC) registration and periodic/special reviews

UHB is required to register with the Care Quality Commission and its current registration status is registered without compliance conditions. UHB has the following conditions on registration: provider conditions only which stipulate that the regulated activities the Trust has registered for may only be undertaken at Queen Elizabeth Medical Centre and Selly Oak Hospital.

The Care Quality Commission has not taken enforcement action against UHB during 2010/11.

UHB has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2010/11: review of services for people who have had a stroke and their carers.

This review looked at the pathway of care provided to people who experienced a stroke or a 'mini-stroke' (called a transient ischemic attack) and their carers. The review looked at different types of services involved in stroke care across the area covered by NHS South Birmingham and was not therefore limited to the care provided by UHB. The review focused in particular on transition of care from hospital to community settings, long term support and patient and carer information.

UHB intends to take the following action to address the conclusions or requirements reported by the Care Quality Commission:

- The results of the CQC review have been analysed by the medical and nursing stroke leads. Actions required across the pathway have been integrated into the existing Stroke Action Plan which aims to improve stroke performance more widely during 2011/12.
- Work with community services and local Commissioners to develop an Early Supported Discharge (ESD) service for stroke patients. UHB has conducted an audit and identified that around half of the Trust's stroke patients would benefit from such a service.
- Continue monitoring 30-day stroke mortality and readmissions through the Clinical Quality Monitoring Group chaired by the Executive Medical Director.

UHB has made the following progress by 31 March 2011 in taking such action: the actions are in progress as described above.

2.2.6 Information on the quality of data

UHB submitted records during 2010/11* to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS number was: 96.7% for admitted patient care; 98.1% for outpatient care; and 93.7% for accident and emergency care.

- which included the patient's valid General Practitioner Registration Code was: 100% for admitted patient care; 100% for outpatient care; and 100% for accident and emergency care.

* Percentages shown are for April 2010-January 2011 which is the latest period available on the Secondary Uses Service (SUS) Data Quality Dashboard.

UHB Information Governance Assessment Report overall score for 2010/11 was 77% and was graded green.

UHB will be taking the following actions to improve data quality:

- Inclusion of a Data Quality Improvement Plan, based on specified key data items, within the 2011/12 Contract currently under negotiation.
- Investigate the feasibility of creating a Coding Academy for the West Midlands.
- The new role of Data Quality Specialist has been created and will be used to facilitate the implementation of data quality initiatives and compliance with the Data Quality Policy across the Trust.

- Maintaining Level 2 compliance with the Information Toolkit Data Quality Initiatives and working towards Level 3 compliance.

UHB was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.

Part 3: Other information

3.1 Overview of quality of care provided during 2010/11

The tables below show the Trust's performance for 2010/11 and the last two financial years for a selection of indicators for patient safety, clinical effectiveness and patient experience. The Board of Directors has chosen to include the same selection of indicators as reported in the Trust's previous Quality Reports to enable patients and the public to understand performance over time.

The patient safety and clinical effectiveness indicators were originally selected by the Clinical Quality Monitoring Group because they represent a balanced picture of quality at UHB. The patient experience indicators were selected in consultation with the Care Quality Group which has Governor representation to enable comparison with other NHS trusts.

The latest available data for 2010/11 is shown below and has been subject to the Trust's usual data quality checks by the Health Informatics team. Benchmarking data has also been included where possible. Performance has been monitored and challenged during the past year by the Clinical Quality Monitoring Group and the Board of Directors. In addition, the Trust has reported on performance against these indicators during the past year in the Quality Report updates published on its quality web pages: http://www.uhb.nhs.uk/quality.htm

3.2 Performance of Trust against selected indicators

Indicators	**2010/11**	**Peer Group Average (where available)**	**2009/10***	**2008/09***
Patient safety indicators				
1(a). MRSA: **Patients with MRSA infection/10,000 bed days (includes all bed days from all specialties)** *Lower rate indicates better performance*	**0.31**	**0.22**	**0.42**	**1.15**
Time period	April 2010-November 2011	April 2010-November 2011	2009/10	2008/09
Data source	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	HPA Website
Peer group		Acute trusts in West		

Indicators	2010/11	Peer Group Average (where available)	2009/10*	2008/09*
		Midlands SHA		
1(b). MRSA: **Patients with MRSA infection/10,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics)** *Lower rate indicates better performance*	**0.31**	**0.26**	**0.43**	**1.18**
Time period	April 2010-November 2011	April 2010-November 2011	2009/10	2008/09
Data source	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	HPA (MRSA data), HES data (bed days)
Peer group		Acute trusts in West Midlands SHA		
2(a). ***C. difficile:*** **Patients with** ***C. difficile*** **infection/1,000 bed days (includes all bed days from all specialties)** *Lower rate indicates better performance*	**0.51**	**0.34**	**0.53**	**1.62**
Time period	April 2010-November 2011	April 2010-November 2011	2009/10	2008/09
Data source	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)	HPA Website
Peer group		Acute trusts in West Midlands SHA		

Indicators	2010/11	Peer Group Average (where available)	2009/10*	2008/09*
2(b). *C. difficile:* Patients with *C. difficile* infection/1,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**0.51**	**0.39**	**0.55**	**1.66**
Time period	April 2010-November 2011	April 2010-November 2011	2009/10	2008/09
Data source	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)	HPA (C.diff data), HES data (Bed days)
Peer group		Acute trusts in West Midlands SHA		
3. Patient safety incidents (reporting rate per 100 admissions) *Higher rate indicates better reporting*	**11.3**	**6.1**	**9.7**	**10.7**
Time period	2010/11	April-September 2010	2009/10	2008/09
Data source	Datix (incident data), Trust admissions data	Based on data provided in National Patient Safety Agency National Reporting and Learning System report	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data
Peer group		Acute teaching organisations		

Indicators	2010/11	Peer Group Average (where available)	2009/10*	2008/09*
4. Percentage of patient safety incidents which are no harm incidents *Higher % indicates better performance*	**81.3%**	**73.5%**	**89.9%**	**89.2%**
Time period	2010/11	April-September 2010	2009/10	2008/09
Data source	Datix (incident data)	National Patient Safety Agency National Reporting and Learning System report	Datix (incident data)	Datix (incident data)
Peer group		Acute teaching organisations		
Clinical effectiveness indicators				
5(a). Readmissions: Readmission rate (Medical and surgical specialties - elective and emergency admissions aged >15) % *Lower % indicates better performance*	**Tbc**	**Tbc**	**Tbc**	**Tbc**
Time period	April-September 2010	April-September 2010	2009/10	2008/09
Data source	HED tool	HED tool	HED tool	HED tool
Peer group		University hospitals		

Indicators	2010/11	Peer Group Average (where available)	2009/10*	2008/09*
5(b). Readmissions: Readmission rate (all specialties) % *Lower % indicates better performance*	**8.37%**	**8.57%**	**8.59%**	**8.44%**
Time period	April-September 2010	April-September 2010	2009/10	2008/09
Data source	HED tool	HED tool	HED tool	HED tool
Peer group		University hospitals		
6. Falls (incidents reported as % of elective and emergency admissions) *Lower % indicates better performance*	**2.5%**	*Not available*	**1.9%**	**2.0%**
Time period	2010/11		2009/10	2008/09
Data source	Datix (incident data), Trust admissions data		Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data
7. Percentage of stroke patients (infarction) on aspirin, clopidogrel or warfarin *Higher % indicates better performance*	**100%**	**Tbc**	**99.7%**	**98%**
Time period	April 2010-February 2010	Tbc	2009/10	2008/09
Data source	Trust PICS data	Cleveland Clinic website	Trust PICS data	Trust PICS data

Indicators	2010/11	Peer Group Average (where available)	2009/10*	2008/09*
Peer group		Cleveland Clinic, Ohio, U.S.A.		
8. Percentage of beta blockers given on the morning of the procedure for patients undergoing first time coronary artery bypass graft (CABG) *Higher % indicates better performance*	**92.4%**	**Tbc** NB This data is for all surgery patients with heart conditions who were on betablockers	**93.3%**	**86.6%**
Time period	April 2010-February 2010	Tbc	2009/10	2008/09
Data source	Trust PICS data	Cleveland Clinic website	Trust PICS data	Trust PICS data
Peer group		Cleveland Clinic, Ohio, U.S.A.		

* The data presented for 2009/10 and 2008/09 is the latest available and therefore updates some of the data reported in the Trust's previous Quality Reports.

Notes on clinical outcome measures

The data shown is subject to standard national definitions where appropriate. The Trust has also chosen to include infection and readmissions data which has been corrected to reflect specialty activity, taking into account that the Trust does not undertake paediatric, obstetric, gynaecology or elective orthopaedic activity. These specialties are known to be very low risk in terms of hospital acquired infection for example and therefore excluding them from the denominator (bed day) data enables a more accurate comparison to be made with peers.

4: The decrease in 2010/11 is largely due to the reporting of all grades of pressure ulcer as incidents. The Trust began reporting pressure ulcers in April 2010 and they now account for 11.5% of reported patient safety incidents which are classed as harm.

5(a), 5(b): This indicator relates to patients who are readmitted to hospital within 28 days of being discharged from UHB. The methodology has been revised to include patients who are readmitted both to UHB and any other acute trust in England. The data source is the readmission module in the Trust's Healthcare Evaluation Data (HED) Tool which uses national Hospital Episode Statistics (HES) data.

6: The admissions data includes daycase patients as well as all elective and emergency admissions. The increase in 2010/11 is due to a higher number of falls being reported as a result of increased awareness.

7: Aspirin, clopidogrel or warfarin are given to reduce the likelihood of recurrent stroke or transient ischaemic attack (TIA) in patients who have already suffered a stroke. Any patients who are identified as not having been given aspirin, clopidogrel or warfarin during their stay are followed up to ensure they have been discharged on these drugs if clinically appropriate.

The Cleveland Clinic, located in Ohio in the U.S.A., is a not-for-profit, multi-specialty academic medical centre that integrates patient care with research and education, and is widely regarded as being amongst the best healthcare providers in the U.S.A.

8: Beta blockers are given to reduce the likelihood of peri-operative myocardial infarction and early mortality. This indicator relates to patients already on beta blockers and whether they are given beta blockers on the day of their operation. All incidences of beta blockers not being given on the day of operation are investigated to understand the reasons why and to reduce the likelihood of future omissions.

We have chosen to measure our performance against the following metrics	2010/11	Comparison with other NHS trusts 2010/11	2009/10	Comparison with other NHS trusts 2009/10	2008/09	Comparison with other NHS trusts 2008/09
9. Overall were you treated with respect and dignity Time period & data source	**88** Trust's 2010 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**	**89** Trust's 2009 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**	**88** Trust's 2008 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**
10. Involvement in decisions about care and treatment Time period & data source	**69** Trust's 2010 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**	**70** Trust's 2009 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**	**70** Trust's 2008 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**
11. Did staff do all they could to control pain Time period & data source	**79** Trust's 2010 Inpatient Survey Report, Care Quality Commission	**Worst performing 20% of trusts**	**80** Trust's 2009 Inpatient Survey Report, Care Quality Commission	**Worst performing 20% of trusts**	**85** Trust's 2008 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**

12. Cleanliness of room or ward Time period & data source	**89** Trust's 2010 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**	**84** Trust's 2009 Inpatient Survey Report, Care Quality Commission	**Worst performing 20% of trusts**	**83** Trust's 2008 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**
13. Overall rating of care Time period & data source	**78** Trust's 2010 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**	**78** Trust's 2009 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**	**78** Trust's 2008 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**

Notes on patient experience measures:
9-13: The scores included in the table above are benchmark scores rather than percentages, calculated by converting responses to particular questions into scores. For each question in the survey, the individual responses were scored on a scale of 0 to 100. The higher the score for each question, the better the trust is performing.

3.3 Performance against key national priorities

Key National Priorities	Time Period for 2010/11	2010/11	2010/11 Target	2009/10	2009/10 Target
Clostridium difficile (post-48 hour cases)	Apr 2010 – Feb 2011	132	150 for 11 months	178	348
MRSA (post-48 hour cases)	Apr 2010 – Feb 2011	10	11 for 11 months	13	30
62-day wait for first treatment from urgent GP referral: all cancers	Apr 2010 – Feb 2011	86.6%	85%	85.4%	85%
62-day wait for first treatment from consultant screening service referral: all cancers	Apr 2010 – Feb 2011	93.2%	90%	92.6%	90%
31-day wait from diagnosis to first treatment: all cancers	Apr 2010 – Feb 2011	98.7%	96%	97.4%	96%
31-day wait for second or subsequent treatment: surgery	Apr 2010 – Feb 2011	97.7%	94%	96.6%	94%
31-day wait for second or subsequent treatment: anti cancer drug treatments	Apr 2010 – Feb 2011	99.8%	98%	99.1%	98%

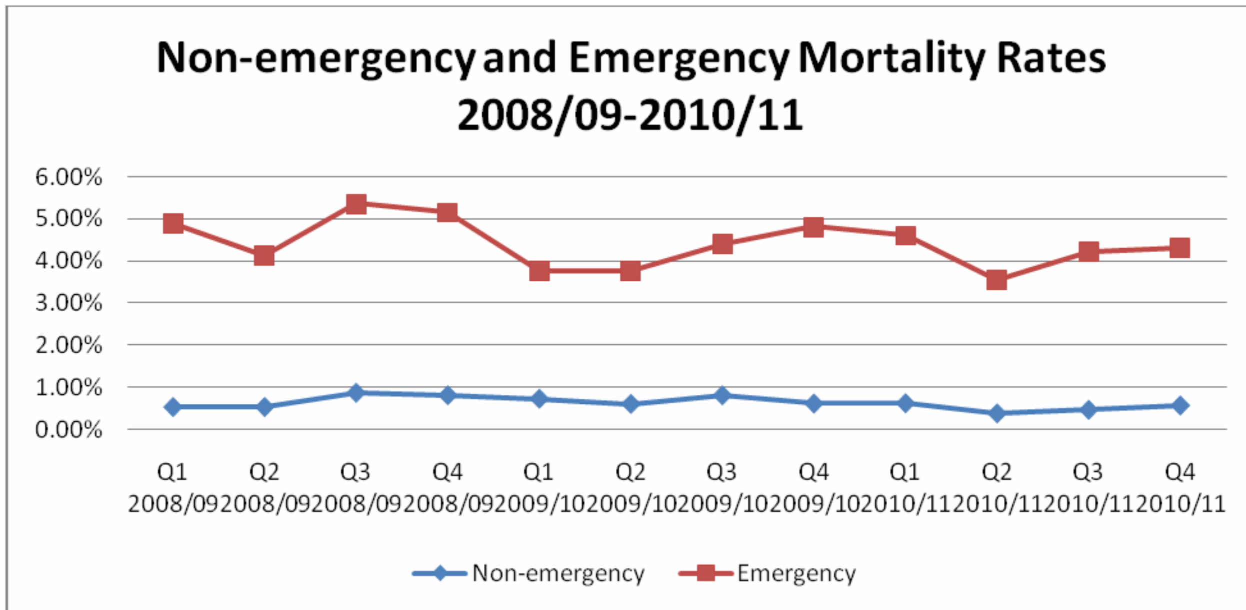
31-day wait for second or subsequent treatment: radiotherapy	Jan 2011 – Feb 2011	100%	94%	Target introduced in January 2011	
Two week wait from referral to date first seen: all cancers	Apr 2010 – Feb 2011	85.9%	93%	94.6%	93%
Two week wait from referral to date first seen: breast symptoms	Apr 2010 – Feb 2011	98.3%	93%	98.6% (Jan – Mar 2010)	93%
18-week maximum wait from point of referral to treatment (admitted patients)	Apr 2010 – Feb 2011	95.7%	No longer a target	95.4%	90%
18-week maximum wait from point of referral to treatment (non-admitted patients)	Apr 2010 – Feb 2011	98.7%	No longer a target	98.5%	95%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge*	Apr 2010 – Feb 2011	97.7%	95%	98.5%	98%
Screening all elective in-patients for MRSA**	Apr 2010 – Feb 2011	118.1%	100%	121.8%	100%
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	Apr 2010 – Mar 2011	Certification made	N/A	Certification made	N/A

* Data includes patients who attended South Birmingham GP Walk In Centre (Katie Road) from July 2009.
** Some patients are screened more than once for MRSA.

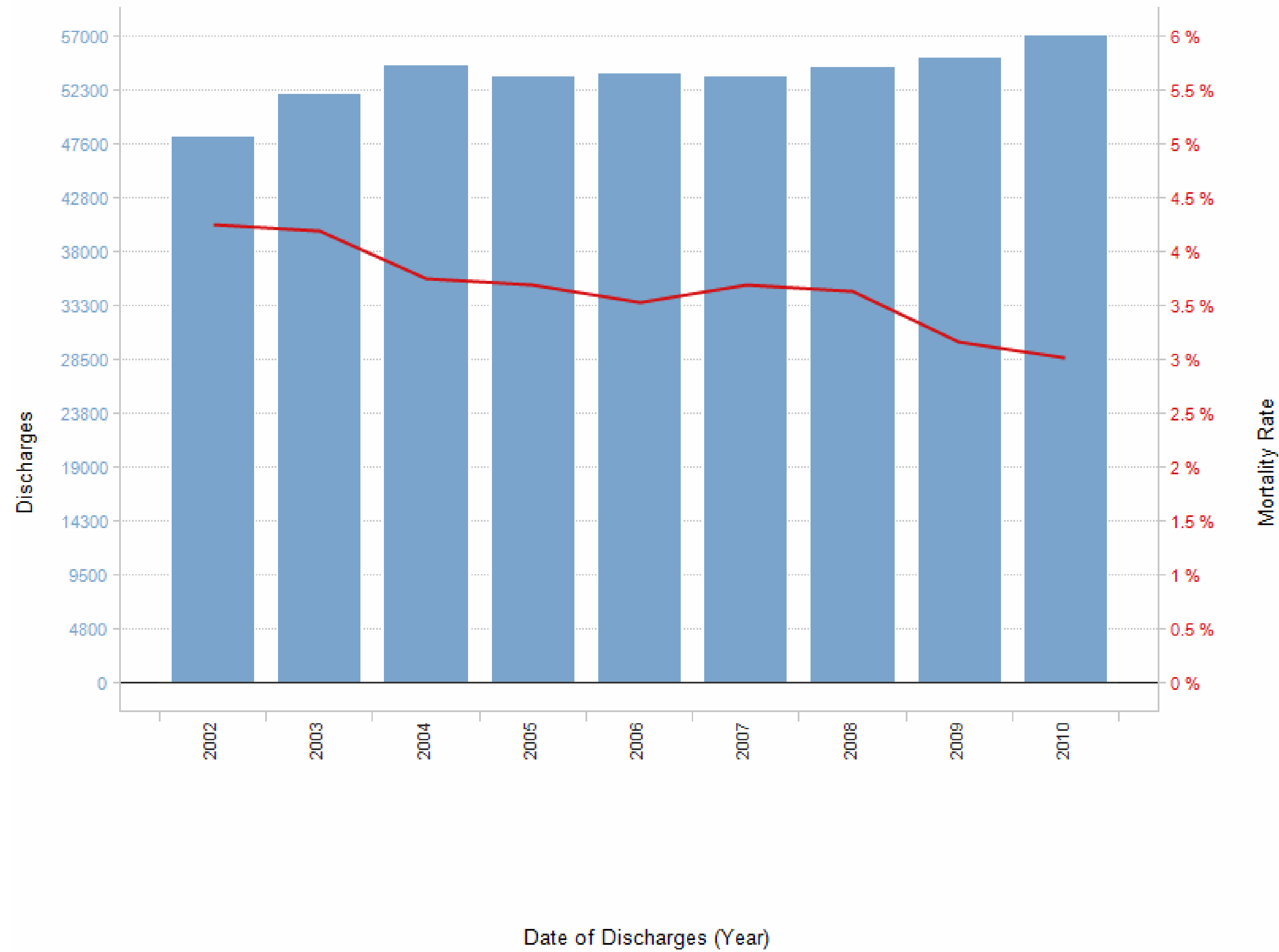
3.4 Mortality

The Trust continues to monitor mortality as close to real-time as possible with senior managers receiving daily emails detailing mortality information and on a longer term comparative basis via the Trust's Clinical Quality Monitoring Group. Any anomalies or unexpected deaths are promptly investigated with thorough clinical engagement.

The graph below shows the non-emergency and emergency mortality rates by quarter for the last three financial years. Although the Trust is generally treating more elderly patients and patients with complex conditions, mortality continues to remain stable.



Non-emergency and emergency mortality has slightly decreased despite an increase in the complexity of patients and increased activity during 2010/11 as shown in the graph below. The graph shows the Trust's crude mortality rate against activity (patient discharges) for each of the past 9 calendar years.



3.5 Staff Survey

The Trust's Staff Survey results for 2010 have shown significant improvement compared to 2009, with over half of the findings in the highest 20% of acute trusts. The results are based on responses from 370 staff which represents a 45% response rate; the national response rate was 52%.

The results for the Staff Survey questions which most closely relate to quality of care are shown in the table below. The main focus for 2011/12 will be on improving the response rate and the availability of handwashing materials across the Trust.

	2010/11	Comparison with other acute NHS trusts 2010/11	2009/10
1. Percentage feeling satisfied with the quality of work and patient care they are able to deliver	**79%**	**Highest (best) 20%**	**83%**
Time period & data source	Trust's 2010 Staff Survey Report, Care Quality Commission		Trust's 2009 Staff Survey Report, Care Quality Commission
2. Percentage agreeing their role makes a difference to patients	**93%**	**Highest (best) 20%**	**93%**
Time period & data source	Trust's 2010 Staff Survey Report, Care Quality Commission		Trust's 2009 Staff Survey Report, Care Quality Commission
3. Staff recommendation of the trust as a place to work or receive treatment	**3.81**	**Highest (best) 20%**	**3.79**
Time period & data source	Trust's 2010 Staff Survey Report, Care Quality Commission		Trust's 2009 Staff Survey Report, Care Quality Commission
4. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	**95%**	**Average**	**95%**
	Trust's 2010 Staff Survey Report, Care Quality Commission		Trust's 2009 Staff Survey Report, Care Quality Commission

5. Percentage of staff saying hand washing materials are always available	**62%**	**Below (worse than) average**	**71%**
Time period & data source	Trust's 2010 Staff Survey Report, Care Quality Commission		Trust's 2009 Staff Survey Report, Care Quality Commission

Notes on staff survey
4. Possible scores range from 1 to 5, with a higher score indicating better performance.

3.6 Specialty Quality Indicators

The Trust's Quality and Outcomes Research Unit (QuORU) was set up in September 2009. The unit has linked a wide range of information systems together to enable different aspects of patient care, experience and outcomes to be measured and monitored.

During 2010/11, the unit has continued to support clinical staff in the development of innovative quality indicators. Performance for a wide selection of the quality indicators developed by clinicians, Health Informatics and the Quality and Outcomes Research Unit was included in the Trust's 2009/10 Quality Report. The Trust focused on embedding these indicators within the specialties during 2010/11 and implemented a web-based tool to enable clinical staff to track performance on a monthly basis. The tool allows clinical staff to drill down to patient level data to facilitate validation, audit and research activity.

In addition, the Trust has significantly expanded the number of specialty quality indicator web pages during 2010/11 to enable patients and the public to track performance. These pages include graphs showing performance and explanatory text which are updated regularly.

Table 1 shows the performance for those specialty quality indicators where the most notable improvements have been made during 2010/11. The data has been checked by the appropriate clinical staff to ensure it accurately reflects the quality of care provided. Benchmarking data has been included where possible. Table 2 shows performance for those indicators where performance has deteriorated during 2010/11 compared with 2009/10. Some natural variation is to be expected, particularly for Haematology bone marrow transplant mortality. The specialties concerned will be focusing on these during 2011/12. Performance for the remaining 62 indicators has stayed about the same during 2010/11 and can be viewed on the Quality web pages: http://www.uhb.nhs.uk/quality.htm. The goals for all indicators have been reviewed by the clinicians involved to ensure they are both challenging and realistic for 2011/12.

Table 1

Speciality	Indicator	Goal	Numerator Apr 10-Feb 11	Denominator Apr 10-Feb 11	Percentage Apr 10 Feb 11	Percentage Apr 09-Mar 10	Percentage Apr 08-Mar 09	Data Sources	Benchmarking

Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Patients discharged on angiotensin converting enzyme (ACE) inhibitors	100% of eligible patients	214	219	97.7%	275	89.6%	PATS PICS	
Dermatology	Proportion of suspected cancer cases seen within 2 weeks by a consultant	93%	1436	1454	98.8%	94.1%	95.3%	Cancer database	
Max Fax	Percentage of emergency admissions with fractured mandible who have surgery same day or the next day	90%	156	200	78.0%	70.1%	74.3%	Lorenzo	
Stroke Medicine	30 day mortality following stroke	>20%	42	381	11.0%	16.5%	16.7%	Lorenzo	
Trauma & Orthopaedics	Proportion of patients who had surgery within 48 hours of admission for fractured neck of femur (fractured hip)	90%	195	248	78.6%	66.1%	60.9%	Lorenzo Galaxy	

Table 2

Speciality	Indicator	Goal	Numerator Apr 10-Feb 11	Denominator Apr 10-Feb 11	Percentage Apr 10 Feb 11	Percentage Apr 09-Mar 10	Percentage Apr 08-Mar 09	Data Sources	Benchmarking
Acute Medicine	7 day readmissions to: Acute Medicine Medical Admissions Unit	<4% for Acute Medicine	904 409	18387 6463	4.9% 6.3%	3.4% 4.5%	3.0% 3.7%	Lorenzo	

Ambulatory Care	**Proportion of patients who were intended to be treated as a daycase but were admitted to hospital as an inpatient**	<5%	850	14963	5.70%	4.3%	4.2%	Lorenzo Galaxy	
Anaesthetics	**Post operative nausea and vomiting** **All high risk patients (Ear, Nose and Throat, General Surgery and Laparoscopic Surgery) should be prescribed with antiemetics (anti-sickness medication) so they can be given promptly after the operation if they need them**		1686	2344	71.93%	79.56%	80.37%	Lorenzo PICS	
Haematology	**Bone Marrow Transplant-related mortality:** **During index (first) admission - autologous (patient's own bone marrow) transplants** **Within 100 days – autologous (patient's own bone marrow) transplants**		**5** **(Apr 10 – Dec 10) 5**	**96** **(Apr 10 – Dec 10) 73**	**5.2%** **(Apr 10 – Dec 10) 6.8%**	0% 0%	0% 3%	BMT database	

3.7 Quality Web Pages

The Trust first launched the Quality web pages on its website in November 2009 to provide patients and the public with up to date information on quality of care: http://www.uhb.nhs.uk/quality.htm

Information published includes:

- Quality Reports: this includes the Trust's annual Quality Reports plus quarterly progress reports
- Patient Experience Data: graphs showing Trust-level, electronic patient experience data collected locally through bedside televisions and telephone surveys.
- Specialty Quality Indicators: graphs showing performance and explanatory text for specialty quality indicators which are updated monthly
- Other information: this includes some Annual Reports on specialised services such as HIV and national audit reports for example.

The Trust is currently reviewing the content and layout of the Quality web pages to ensure they are user friendly and accessible. Further information and specialty quality indicator pages are likely to be added during 2011/12.

3.8 Healthcare Evaluation Data (HED) Tool

The Trust developed the interactive healthcare evaluation data (HED) tool during 2009/10 which enables clinical and managerial staff to evaluate the quality of healthcare delivery and operational efficiency in comparison to acute and mental health trusts in England.

The tool uses national Hospital Episode Statistics (HES) data and incorporates advanced methodologies which account for casemix and other variables, incorporate all care delivered and include anonymised patient level data.

The tool covers a number of different aspects of care delivery: activity, mortality, length of stay, DNAs (number of patients who did not attend their appointments), new to follow-up ratios and market share (GP referrals).

The Trust has taken part in the Department of Health's Technical Work Group to develop a more robust standardised mortality indicator to be used nationally called the summary hospital mortality indicator (SHMI). The new indicator will include deaths which occur out of hospital.

In line with the NHS Outcomes Framework, UHB has also focused on developing methodologies for reviewing whole pathway mortality for particular disease groups, rather than just in-hospital mortality.

3.9 Glossary of Terms

Tbc

Annex 1: Statements from stakeholders

The Trust has shared its 2010/11 Quality Report with the commissioning Primary Care Trust, NHS South Birmingham, the Birmingham Local Involvement Network (LINk) UHB Action Group and Birmingham City Council Overview and Scrutiny Committee.

NHS South Birmingham and the Birmingham LINk UHB Action Group have reviewed the Trust's Quality Report for 2010/11 and provided the statements below. Birmingham City Council Overview and Scrutiny Committee has chosen not to provide a statement.

Statement provided by NHS South Birmingham:

Statement provided by Birmingham LINk:

QUALITY ACCOUNT STATEMENT
Birmingham LINk UHB Action Group

Annex 2: Statement of directors' responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010/11;

- the content of the Quality Report is not inconsistent with internal and external sources of information including:

  - Board minutes and papers for the period April 2010 to June 2011
  - Papers relating to Quality reported to the Board over the period April 2010 to June 2011
  - Feedback from the commissioners dated XX/XX/20XX
  - Feedback from governors dated XX/XX/20XX
  - Feedback from LINks dated XX/XX/20XX

- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX;
- The [latest] national patient survey XX/XX/20XX
- The [latest] national staff survey XX/XX/20XX
- The Head of Internal Audit's annual opinion over the trust's control environment dated XX/XX/20XX
- CQC quality and risk profiles dated XX/XX/20XX

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitornhsft.gov.uk/annualreportingmanual).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

..............................Date..Chairman

..............................Date...Chief Executive

Appendix A: Specific Actions from National Clinical Audits (to go on the Quality web pages)

Audit reports reviewed	Actions
Head and Neck Cancer (DAHNO)	Improvements have been made to ensure recording cancer site and staging is collected and documented with the target to achieve 100%. Action has been taken to ensure that all care discussions are made at multidisciplinary team meetings and a Clinical Audit Coordinator was appointed in 2010 to improve multiprofessional care recording. All staff record data on the Cancer Register as recommended.
Oesophago-gastric (stomach) cancer	All patients who are candidates for curative treatment undergo a CT-scan plus an EUS (if oesophageal / upper junctional tumour) or a staging laparoscopy (if gastric / lower junctional tumour). The surgical team monitor their pathology outcomes and are working on an action plan to improve data on inpatient complications. The team do record their outcomes and compare them nationally for discussion amongst the multidisciplinary team.
Adult Cardiac Surgery	The Cardiac Surgery Specialty have a monthly governance away day where quality, yearly national audit data, mortality and morbidity is discussed amongst the multidisciplinary team. UHB demonstrated compliance with national recommendations and showed activity, surgical results and quality of care in line with the national data submitted around the country.
Heart Failure	UHB participate fully in the Heart Failure audit. The audit processes have recently been reviewed by an internal audit team and data quality checks are in place. There are indicators for the Heart Failure Service which help to drive quality improvement. UHB has a specialist team who streamline the care pathway to ensure all patients have access to the service and recommended medication. The Heart Failure Service are currently working towards analysing their survival data at recommended regular intervals.
Adult cardiac interventions (e.g., angioplasty)	Outcome data is reviewed and discussed amongst the clinical team and used to drive quality improvement. Where areas for improvement are identified audits are undertaken locally and reported at both Divisional and Trust level.
Myocardial Infarction (MINAP)	Data is reviewed regularly by the clinical team and results are comparable with other centres.
Cardiac rhythm management (Pacing / Implantable Defibrillators)	Data is used for regular review of benchmarking and comparison against similar units amongst the clinical team and results are comparable with other centres.
Congenital heart disease (children and adults) / Paediatric cardiac surgery	UHB participates and actively provides data via the CCAD Congenital Heart Disease Database. Reviews of the submission of data are carried out by a Consultant Cardiologist ensuring accuracy. There is an action plan in place to facilitate further improvements in the audit process.

Audit reports reviewed	Actions
National Audit of Continence Care	UHB has a network of Continence Leads reviewing practice against the standards of Continence Care. Training is in place for junior doctors and information available for patients, relatives and carers. There are also champions for dignity and older People across UHB. Matron rounds include monitoring dignity on the wards and action plans are in place for areas of improvement.
National Audit of Dementia	Two new Dementia Educators are in post, and a new Senior Clinical Educator for Mental Health has also been appointed. Their roles are to promote dementia knowledge and awareness, as well as providing training. Dementia awareness training, which includes safeguarding training, is available for all nursing staff who work with dementia patients. Training is also widely available on the Mental Capacity Act. Guidelines on management of agitation and confusion have been updated. Work is in progress with the team who manage the Prescribing Information and Communication System (PICS) to highlight patients who have delirium during their admission. A patient leaflet is available on all wards containing information regarding discharge and support. A care rounds initiative commenced on March 16th following comprehensive training for nurses and therapists. Communication boxes are being piloted on ten wards and plan to be rolled out to the rest of UHB. There is an 'All About Me' document which records patient's condition, abilities, needs and behaviour. It is available on the Trust intranet for all staff to print and complete with the patient. Spot checks are carried out on these documents and particularly on the medical and frailty wards. The 'Acute Confusion/Agitation Care Plan', and 'Chronic Confusion Care Plan' are available to print on intranet and to order from the Print Room.
Mastectomy & Breast Reconstruction	The report demonstrates that services and outcomes for patients treated at Trusts within the Pan Birmingham Cancer Network are good compared with the national average. UHB will participate in the proposed prospective audit of current practice with respect to immediate reconstruction. The breast clinical team ensure that all patients who are eligible for breast reconstruction are offered the opportunity to discuss in details the options and ensure that all women who require information on breast reconstruction have access to appropriate information. The Pathway Coordinator and Assistant will ensure data capture for reconstruction activity.
Carotid Endarterectomy Audit	A number of surgeons contribute to the National Vascular Database. Patients are reviewed by the operating surgeon as part of their personal audit cycle.
National Diabetes Audit	To address the needs of patients with Type 1 Diabetes UHB runs a structured education course which has been approved by the National Institute of Clinical Excellence (NICE). The Trust also runs dedicated carbohydrate counting sessions and insulin pump clinics. UHB has developed Diabetes Renal Clinics with trained renal diabetes nursing staff to enhance care for renal diabetic patients. UHB continues to build and enhance its partnership working with GP's and PCT's and this will be extended to GP consortia to ensure the consistency of patient care. The Trust now has a dedicated clinical nurse for young people with diabetes who is partly based at Birmingham Children's Hospital. This also provides continuity of care on transfer. There is also a Joint Paediatric and Adult Transitional Clinic.

Audit reports reviewed	Actions
Hip Fracture Database	A dedicated Trauma Auditor is in post with responsibility for the hip fracture database. Robust relationships are forged with orthogeriatricians which has contributed greatly to service enhancement. A specialist doctor has been appointed at sub consultant grade for fracture of neck of femur (NOF) patients. Weekly hip multidisciplinary team meetings now take place. There is a plan in place to continually improve patients going to theatre within 36 hours of admission.
Potential Donor Audit	Donor Specialist Nurses analyse the data and report to the Trust's Donation Committee on a quarterly basis. A current project is underway to review all deaths pre and post introduction of a 'trigger' to analyse the effectiveness of utilising such a tool. This research project is believed to be one of the biggest analyses of data within the UK of its kind.
UK Transplant registry: 1. Cardiothoracic	Outcome data is reviewed regularly by the clinical team. Outcomes are comparable with other centres.
UK Transplant registry: 2. Liver	Outcome data is reviewed regularly by the clinical team. Survival results are comparable with other centres.
UK Transplant registry: 3. Kidney	Outcome data is reviewed regularly by the clinical team. Results are compared yearly and in comparison with other centres. Results are comparable against national benchmark guidance.
British Thoracic Society: 2. Emergency Oxygen	Results of the audit are presented at the specialty audit meeting and improvements have been made to formulary and pharmacists on the wards. There is an Induction Education Programme in place. There is also a Trust-wide Medical Gas Committee.
British Thoracic Society: 3. National Pleural Procedures audit	Results were presented at the specialty audit meeting and recommendations include working with Radiology regarding capacity, the identification of a ward based procedure room, training in ultrasound for the respiratory team and formal training in chest drain insertion for core medical trainees and registrars.
British Thoracic Society: 5. Adult Community Acquired Pneumonia	Results were presented at the specialty audit meeting. There is an action plan to ensure that the electronic prescribing and patient information system (PICS) "prompt" to fill in CURB-65 score when diagnosis details are entered. Update West Mercia guidelines in line with trust antibiotic protocol. Feed back results to trust executive. Results of audit to be disseminated to medical/A&E staff. The majority of patients should continue to be seen at the earliest opportunity by a senior physician (consultant or SPR).
British Thoracic Society: 6. NIV (Adult)	Results were presented at the specialty audit meeting. Agreed recommendations were improved documentation of patient and relative involvement, and more set-ups on respiratory beds.

Audit reports reviewed	Actions
Severe Trauma – TARN (Trauma Audit and Research Network)Trauma	UHB is home to the UK's National Institute for Health Research (NIHR) Centre for Surgical Reconstruction and Microbiology Chaired by Sir Keith Porter, the UK's only Professor of Clinical Traumatology. The findings of the Severe Trauma – TARN (Trauma Audit and Research Network) Audits are including in the research and audit initiatives of the Centre

Appendix B: Specialty Quality Indicators (to go on the Quality web pages)

Acute Medicine

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11)	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 – Mar 10)	% (Apr 08 - Mar 09)	Data Sources	Benchmarking
A&E	**Average (median) time from arrival in A&E to performance of CT head with contrast scan**			79	3 hours	2 hours (for 46 patients)	2 hours (for 37 patients)	CRIS Symphony	
A&E	**Average (median) time from arrival in A&E to performance of CT head scan**			1901	2 hours	2 hours (for 1155 patients)	2 hours (for 749 patients)	CRIS Symphony	
Acute Medicine	**7 day readmissions to: Acute Medicine Medical Admissions Unit**	<4% for Acute Medicine	904 409	18387 6463	4.9% 6.3%	3.4% 4.5%	3.0% 3.7%	Lorenzo	
Cardiology	**Ensure all patients are discharged on aspirin and clopidogrel or prasugrel following percutaneous coronary intervention (PCI)**	100%	720	720	100.0%	100.0%	99.6%	Lorenzo PICS	Cleveland Clinic 99% (2008) Other US Hospitals 98% (2008) (This data relates to clopidogrel only as prasugrel is a new drug)

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11)	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 – Mar 10)	% (Apr 08 - Mar 09)	Data Sources	Benchmarking
Diabetes	**Percentage of patients under Diabetic Centre follow up (attending follow-up outpatient appointments) who have a lower limb amputation. Note: The Diabetes Team are also planning to develop a similar indicator for patients with diabetes not under Diabetic Centre follow up.**	0%	12	3401	0.4%	0.35%	0.53%	Lorenzo	
Elderly Care	**Percentage of elderly care patients discharged to their normal place of residence**	95%	TBC	TBC	TBC	91.20%	90.9%	Lorenzo	
Elderly Care	**Percentage of elderly care patients discharged to other NHS/ non-NHS providers**		TBC	TBC	TBC	6.40%	7.5%	Lorenzo	
Elderly Care	**Percentage of elderly care patients discharged to other residential homes**		TBC	TBC	TBC	1.70%	2.50%	Lorenzo	
Gastro-enterology	**Proportion of patients admitted with inflammatory bowel disease receiving low molecular weight (LMW) heparin**	90%	44	47	93.6%	94.6%	84.3%	Lorenzo PICS	
Heart Failure	**Percentage of heart failure patients discharged on angiotensin converting**	93%	188	285	66.0%	69.7%	71.6%	Heart Failure database PICS	Cleveland clinic 94% (July 08 - June 09) Average for all

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11)	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 – Mar 10)	% (Apr 08 - Mar 09)	Data Sources	Benchmarking
	enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)								other US hospitals 90% (July 08 - June 09)
Heart Failure	**Percentage of patients with a primary diagnosis of acute heart failure who had an echocardiogram (ECHO) prior to discharge**	100%	221	285	77.5%	79.2%	70.5%	Heart Failure database PICS	
Respiratory Medicine	**% of asthmatic patients are discharged on inhaled steroids**	95%	242	272	89.0%	87.79%	85%	PICS	
Stroke Medicine	**% of patients admitted with cerebral infarction who received aspirin, clopidogrel or warfarin**	98.8% (CQUIN target for 2009-10)	250	250	100.0%	99.7%	98.0%	Lorenzo PICS	Cleveland Clinic (2006 - 96.2%, 2007 - 98.6%, 2008 - 99.7%) US National Average : 98.9% (Page 30 of Cleveland's Neurological outcome book)
Stroke Medicine	**30 day mortality following stroke**		42	381	11.0%	16.5%	16.7%	Lorenzo	

Anaesthetics, ITU and Ambulatory Care

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 – Mar 10)	% (Apr 08 – Mar 09)	Data Sources	Benchmarking
Ambulatory Care	**Proportion of patients who were intended to be treated as a daycase but were admitted to hospital as an inpatient**	<5%	850	14963	5.70%	4.3%	4.2%	Lorenzo Galaxy	
Anaesthetics	**Post operative nausea and vomiting All high risk patients (Ear, Nose and Throat, General Surgery and Laparoscopic Surgery) should be prescribed with antiemetics (anti-sickness medication) so they can be given promptly after the operation if they need them**		1686	2344	71.93%	79.56%	80.37%	Lorenzo PICS	
Anaesthetics	**Post operative Nausea & Vomiting High risk patients (Ear, Nose and Throat, General Surgery and Laparoscopic Surgery) given antiemetics (anti-sickness medication) after the operation**		740	2344	31.57%	33.30%	34.13%	Lorenzo PICS	

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 – Mar 10)	% (Apr 08 – Mar 09)	Data Sources	Benchmarking
ITU	**Intensive care readmission rate (Readmissions to ITU during the same inpatient admission)** **Excludes Wellcome Building Critical Care (WBCC) unit which does not submit data to the Intensive Care National Audit & Research Centre (ICNARC)**		**197**	**1970**	**10.0%**	12.90%	13.9%	ICNARC	

Clinical Support Services

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11)	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 - Mar 10)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Imaging	**Proportion of A&E patients who have report turnaround time of less than 2 days for CT scan**		**3687**	**3859**	**95.5%**	98.4%	93.7%	CRIS	

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11)	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 - Mar 10)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Imaging	**Proportion of GP Direct Access patients who have report turnaround time of less than 5 days for plain imaging**		**25323**	**28439**	**89.0%**	90.2%	95.4%	CRIS	
Imaging	**Proportion of GP Direct Access patients who have report turnaround time of less than 5 days for Ultrasound**		**6247**	**6334**	**98.6%**	99.3%	99.2%	CRIS	
Imaging	**Proportion of Inpatients who have report turnaround time of less than 2 days for CT**		**10495**	**12851**	**81.7%**	81.1%	72.4%	CRIS	
Imaging	**Proportion of Inpatients who have report turnaround time of less than 2 days for MRI**		**1974**	**3716**	**53.1%**	39.9%	18.9%	CRIS	
Imaging	**Proportion of Inpatients who have report turnaround time of less than 2 days for Ultrasound**		**8836**	**9040**	**97.7%**	97.8%	96.3%	CRIS	

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11)	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 - Mar 10)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Imaging	**Proportion of Outpatients who have report turnaround time of less than 5 days for CT**		**10032**	**14620**	**68.6%**	74.0%	69.7%	CRIS	
Imaging	**Proportion of Outpatients who have report turnaround time of less than 5 days for MRI**		**5766**	**18316**	**31.5%**	34.9%	31.3%	CRIS	
Imaging	**Proportion of Outpatients who have report turnaround time of less than 5 days for Ultrasound**		**14290**	**14896**	**95.9%**	95.2%	94.0%	CRIS	
Pathology	**Turnaround times C-Reactive Protein - 100 % within 24 hours**	100% within 24 hours	**159416**	**160296**	**99.5%**	99.7%	99.6%	Pathology database	
Pathology	**Turnaround times Cholesterol - 100 % within 24 hours**	100% within 24 hours	**24320**	**24778**	**98.2%**	98.5%	99.1%	Pathology database	

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11)	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 - Mar 10)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Pathology	**Turnaround times Urine - 90% within 48 hours**	90% within 48 hours	**33346**	**37417**	**89.1%**	88.2%	92.0%	Pathology database	
Pathology	**Turnaround times Full Blood Count - 100 % within 24 hours**	100% within 24 hours	**290849**	**293177**	**99.2%**	98.7%	98.6%	Pathology database	
Pharmacy	**Dispensing error rate (nationally these are measured as no of errors per 100,000 dispensed items)**		**16.3**	**100000**	**0.02%**	0.01%	0.01%	Pharmacy database	
Radiotherapy	**85% of patients should commence treatment (first dose of radiotherapy) within 14 calendar days from CT scan. Note: Some of the patients not treated within the target timeframe had chosen to delay their treatment.**		**2731**	**3298**	**82.8%**	Jul 09 - Mar 10 78.5%	-	Radio-therapy database	

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11)	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 - Mar 10)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Therapy Services	**90% of In-patient referrals are responded to by each of the Therapy Services on the same day**	90% on same day	24765	26472	93.60%	96.3%	96.7%	Therapy database	
Therapy Services	**95% of In-patient referrals are responded to by each of the Therapy Services within two working days of the patient being identified to the service.**	95% within two working days	25418	26472	96.00%	98.8%	98.8%	Therapy database	

Other Medicine

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11)	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 - Mar 10)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Dermatology	**Incidence of wound infection post skin graft**	0%	0	121	0.0%	0.0%	0%	Lorenzo	
Dermatology	**Proportion of suspected cancer cases seen within 2 weeks by a consultant**	93%	1436	1454	98.8%	94.1%	95.3%	Cancer database	
Haematology	**Bone Marrow Transplant-related mortality:**								

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11)	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 - Mar 10)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
	During index (first) admission - autologous (patient's own bone marrow) transplants		**5**	**96**	**5.2%**	0%	0%	BMT database	
	During index (first) admission - allogeneic (donor bone marrow) transplants		**0**	**82**	**0.0%**	0%	7%		
	Within 100 days – autologous (patient's own bone marrow) transplants		**(Apr 10 – Dec 10) 5**	**(Apr 10 – Dec 10) 73**	**(Apr 10 – Dec 10) 6.8%**	0%	3%		
	Within 100 days – allogeneic (donor bone marrow) transplants		**(Apr 10 – Dec 10) 1**	**Apr 10 – Dec 10) 65**	**(Apr 10 – Dec 10) 1.5%**	4.1%	10%		
Liver Medicine	**Percentage of patients who have endoscopic retrograde cholangio-pancreatography (ERCP) who develop pancreatitis. ERCP involves a doctor examining the common bile duct and pancreatic duct through a flexible tube which is passed down the mouth, stomach and into the small intestine (bowel).**	<5%	3	384	0.8%	1.4%	1.7%	ERCP database Lorenzo PICS	

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11)	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 - Mar 10)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Liver Medicine/ Surgery	**90 day patient mortality (%) and graft loss (%), with 95% confidence intervals, for all adult patients who received a planned (non-emergency) first liver transplant.** **Number of Transplants** **90 day mortality (95% Confidence Intervals)** **90 day graft loss (95% Confidence Intervals)**		Latest Annual Report not yet available	Latest Annual Report not yet available	Latest Annual Report not yet available	Time Period - Oct 08 - Sep 09 67 6.0 (2.3,15.1) 9.0 (4.1,18.9)	Time Period - Apr 07 – Mar 08 89 9.0 (4.6,17.2) 3.4 (6.2,19.9)	Annual NCG Report	
Liver Transplant	**Use of Valganciclovir in CMV (Cytomegalovirus) mismatched liver transplant patients. Valganciclovir is an antiviral medication used to prevent CMV infection in liver transplant patients who have not previously had CMV but the donor has.**	100%	65	66	98.5%	100.0%	98.0%	Liver database PICS	
Palliative Care	**100 % of patients with palliative care diagnosis code (using KMR) who are receiving regular analgesic background pain medications (Morphine Sulphate Tablets (MST), Zomorph, Fentanyl, Oxycontin) should also be prescribed with breakthrough analgesia (e.g.oramorph,oxynorm)**	100%	186	190	97.9%	98.0%	98.4%	Lorenzo PICS	

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11)	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 - Mar 10)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Palliative Care	**100 % of above patients (who were prescribed with both analgesic medication for background pain and analgesia for breakthrough pain) should also be prescribed with laxatives.**	100%	186	186	100%	100%	100%	Lorenzo PICS	
Renal Medicine	**Percentage of patients on haemodialysis programme with a urea reduction ratio (URR) of >65%** **All patients on haemodialysis** **Patients who have been on haemodialysis for 90 days or more**	90%			 88.94% 89.46%	 89.7% 90.0%	 85.5% 86.3%	MARS	Data from 57 UK dialysis centres in 2007 reported in the renal registry report of 2008 show that 81% of reported patients achieve a URR ≥ 65% (centre range 47%–97%).
Rheumatology	**An indication of continuity of care - percentage of patients who saw the same staff member at least 3 times out of 5 previous visits**	60%	380	551	69.0%	-	-	Clinical Portal	

Outpatients

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11)	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 - Mar 10)	% (Apr 08 - Mar 09)	Data Source	Benchmarking

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11)	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 - Mar 10)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Ophthalmology	**Overall, how would you rate the care you received at the Outpatients Department today?** **Excellent** **Very Good** **Good** **Fair** **Poor** **Very Poor**		**37** **22** **9** **0** **0** **0**	**68**	**54.4%** **32.4%** **13.2%** **0%** **0%** **0%**	March 10 – 10th April 10 48% 43% 9% 0% 0% 0%	-	Outpatient Survey	
Ophthalmology	**Would you recommend this Outpatients Department to your family and friends?** **Yes, definitely** **Yes, probably** **No**		**63** **5** **0**	**68**	**92.6%** **7.4%** **0%**	88% 13% 0%	-	Outpatient Survey	
Ophthalmology	**Was your appointment changed to a later date by the hospital?** **No** **Yes, once** **Yes, 2 or 3 times** **Yes, 4 or more times**		**103** **19** **2** **4**	**128**	**80.5%** **14.8%** **1.6%** **3.1%**	82% 15% 3% 0%	-	Outpatient Survey	

Surgery

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11)	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 - Mar 10)	% (Apr 08 - Mar 09)	Data Source	Benchmarking

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11)	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 - Mar 10)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Cardiac Surgery	**First-time, isolated coronary artery bypass graft (CABG) - MRSA bacteraemia**		0	234	0.0%	0.0%	0.0%	PATS Lorenzo	
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - C.difficile**	0	0	234	0.0%	0.0%	1.0%	PATS Lorenzo	
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Emergency readmissions within 28 days**		10	232	4.3%	4.9%	3.6%	PATS Lorenzo	
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Patients discharged on angiotensin converting enzyme (ACE) inhibitors**	100% of eligible patients	214	219	97.7%	275	89.6%	PATS PICS	

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11)	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 - Mar 10)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Patients discharged on antiplatelet therapy**	100% of eligible patients	229	230	99.6%	99.7%	91.0%	PATS PICS	
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Patients discharged on statins**	100% of eligible patients	220	222	99.1%	96.1%	88.0%	PATS PICS	
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Patients on betablockers who were given them on the day of surgery**	100% of eligible patients	97	105	92.4%	93.3%	84.4%	PATS PICS	Cleveland Clinic 88% (Jan- Jun 09) Average for all other hospitals in Ohio 89% (Jan- Jun 09) Average for all reporting hospitals in US 87% (Jan- Jun 09) NB This data is for all surgery patients with heart conditions who were on betablockers
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Post-operative stroke**		3	234	1.3%	2.2%	1.0%	PATS Lorenzo	

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11)	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 - Mar 10)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Re-opening (all causes)**		17	234	7.3%	7.7%	7.1%	PATS Lorenzo	Cleveland Clinic 17% (2008 calendar year). This data also includes the referrals for reoperation from other hospitals.
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Average post-operative length of stay**			234 patients	9 days	9.7 days	10 days	PATS Lorenzo	
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Median post-operative length of stay**			234 patients	7 days	7 days	8 days	PATS Lorenzo	
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Hospital survival**		232	234	99.1%	98.1%	98.7%	PATS Lorenzo	Cleveland Clinic 95.3% (2008 calendar year)
Emergency Surgery	**Emergency admissions for non severe gall stone pancreatitis (no ITU admission) should have surgery within 2 weeks**	90%	5	5	100.0%	100.0%	100.0%	Lorenzo	
Endocrinology	**Fraction of patients discharged on hydrocortisone post pituitary surgery**	100%	52	54	96.3%	100%	100%	Lorenzo PICS	

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11)	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 - Mar 10)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Max Fax	**Percentage of emergency admissions with fractured mandible who have surgery same day or the next day**	90%	156	200	78.0%	70.1%	74.3%	Lorenzo	
Neurosurgery	**Median time from emergency admission with sub-arachnoid haemorrhage to surgery or coiling - including cases where intervention was deferred, for medical reasons.**	90% within 2 days		123	1 day	1 day	1 day	Lorenzo	
Neurosurgery	**Average time from emergency admission with sub-arachnoid haemorrhage to surgery or coiling - including cases where intervention was deferred, for medical reasons.**			123	3.19 days	3.28 days	3.09 days	Lorenzo	
Neurosurgery	**Percentage of emergency admission with sub-arachnoid haemorrhage patients who had surgery or coiling within 2 days - including cases where intervention was deferred, for medical reasons.**	90% within 2 days	89	123	72.4%	72.0%	71.8%	Lorenzo	

Speciality	Indicator	Goal	Numerator (Apr 10 – Feb 11)	Denominator (Apr 10 – Feb 11)	% (Apr 10 – Feb 11)	% (Apr 09 - Mar 10)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Renal Surgery	**Percentage of patients attending the low clearance clinic (which aims to get patients ready for dialysis) who had had an arteriovenous fistula (to create access for dialysis) made before starting haemodialysis.**	80%	37	56	66.1%	76.3%	73.5%	MARS Lorenzo	
Routine Surgery / Care	**Unplanned return to theatre for all non-emergency surgical patients**	<2.5%	681	25361	2.6%	2.4%	1.7%	Galaxy	
Trauma & Orthopaedics	**Proportion of patients who had surgery within 48 hours of admission for fractured neck of femur (fractured hip)**	90%	195	248	78.6%	66.1%	60.9%	Lorenzo Galaxy	
Urology	**All patients admitted with acute retention to be discharged on alpha blockers (if not put on waiting list for transurethral resection of the prostate (TURP))**	70%	34	74	45.9%	53.2%	48.6%	Lorenzo PICS	
Vascular Surgery	**Rates of daycase versus inpatient varicose vein procedures** **Daycases** **Inpatients**	<5% done as inpatients	578 28	606 606	95.4% 4.6%	94.5% 5.5%	83% 17%	Lorenzo	

Notes on data sources:

Cleveland Clinic and US data = published on Cleveland Clinic website
CRIS = Radiology database
Galaxy = Theatres database
ICNARC = Intensive Care National Audit & Research Centre
Lorenzo = Patient administration system
MARS = Renal database
NCG = National Commissioning Group
PATS = Cardiac database
Symphony = A&E patient management system