

AGENDA ITEM NO:

**UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
FRIDAY 3 DECEMBER 2010**

Title:	Quality Account Update Report April-September 2010
Responsible Director:	David Rosser, Executive Medical Director
Contact:	Imogen Gray, Head of Quality Development, 13687

Purpose:	To provide the Board of Directors with the draft Quality Account update report for April-September 2010-11, prior to publication at the end of December 2010.
Confidentiality Level & Reason:	N/A
Medium Term Plan Ref:	Strategic Aim 1: To deliver the highest levels of quality evidenced by technology, information and benchmarking
Key Issues Summary:	<ul style="list-style-type: none">• The Quality Account update report for April-September 2010 is enclosed at Appendix A.• Performance data for the specialty indicators is included in the update report; performance for the Renal Surgery indicator has noticeably dropped since Quarter 1 2010/11.
Recommendations:	The Chief Executive is requested to: Approve the content of the Quality Account Update for April-September 2010 for external publication.

Signed:	Date: 23 November 2010
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UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS FRIDAY 3 DECEMBER 2010

QUALITY ACCOUNT UPDATE REPORT APRIL-SEPTEMBER 2010

PRESENTED BY THE EXECUTIVE MEDICAL DIRECTOR

1. Introduction

1.1. The aim of this paper is to provide the Board of Directors with the draft Quality Account update report for April-September 2010, prior to external publication at the end of December 2010. The report contains the latest data available for the quality improvement priorities, metrics and specialty indicators.

2. Quality Account Update for April-September 2010

2.1 The draft Quality Account update report for April-September 2010 was discussed by the Clinical Quality Monitoring Group in November 2010 and is shown at Appendix A. The report will be formatted by the Communications Team before publication at the end of December 2010.

2.2 The Trust is making progress towards the quality improvement priorities and there are no significant changes in performance to report for the selected metrics. Performance for the specialty quality indicators is discussed separately below. The methodology for Priority 2 (Time from prescription to administration of first antibiotic dose) has now been refined with clinicians; baseline data for June-September 2010 is therefore included in the report.

2.3 Specialty Quality Indicators

2.3.1 Changes to Specialty Indicators

The table below details the changes to indicators which have been made by clinicians and the QuORU Leads since the last update report:

Specialty	Indicator	Change/Issue
Emergency Surgery	Emergency admissions for non severe gall stone pancreatitis (no ITU admission) should have surgery within 2 weeks	The methodology and data are currently being revised by Mr J Whiting in response to a change in practice.

		This indicator will be re-included once the clinicians and QuORU Board have approved the changes.
Rheumatology	An indication of continuity of care - percentage of patients who saw the same health professional at least 3 times out of 5 previous visits	The indicator has been refined by Dr P Jobanputra. The indicator now focuses on the same health professional rather than same Consultant's clinic which is a better measure of continuity of care.
ITU	Intensive care readmission rate (Readmissions to ITU during the same inpatient admission)	The denominator data does not fully reflect activity; data is still being collated by the ITU team and should be updated before publication.
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.	This data is only updated annually following publication of the national annual report. Health Informatics are working with clinicians to ensure locally collected data can be included in future update reports.

2.3.2 Performance

Performance data for the specialty quality indicators for April-September 2010 is included in section 5 of the report. Performance remains either the same or better for the vast majority of the indicators. Performance for the specialty quality indicators is now being reported to the Clinical Quality Monitoring Group each month by exception. Clinicians can now view performance data for these indicators each month via the new internal QuORU website and are also being alerted to any drops in performance by email.

2.3.3 Performance has dropped for three indicators since Quarter 1 2010/11 as shown in the table below. Although some natural variation is to be expected, the performance for the Renal Surgery indicator has substantially dropped since Quarter 1 2010/11. This is currently being investigated by the QuORU Lead and Clinical Service Lead in conjunction with Health Informatics and the Head of Quality Development.

2.3.4 The median time delay for the A&E CT head with contrast scan indicator has increased alongside an increase in numbers but has reduced for CT head scans. This is currently being investigated by Dr B Boland.

Specialty	Indicator
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.
A&E	Average (median) delay from arrival in A&E to performance of emergency CT head with contrast scan
Gastro-enterology	Proportion of patients admitted with inflammatory bowel disease receiving low molecular weight (LMW) heparin.
Imaging	Proportion of Outpatients who have report turnaround time of less than 5 days for CT

2.3.5 Performance for the Max Fax indicator (Percentage of emergency admissions with fractured mandible who have surgery same day or the next day) remains stable but substantially below the goal. An audit is therefore being carried out to identify the reasons why some patients are not being treated within the target time period.

2.4 Benchmarking

The latest benchmarking data for the selected metrics and specialty indicators is included where available. In addition, the Quality and Outcomes Research Unit (QuORU) is focusing on identifying statistically significant changes in performance which will require a minimum of 50 data points for each indicator in order to be sufficiently robust. The unit is thus focusing on four indicators for which data is available for 30 data points (April 2008 to September 2010) as a starting point as listed in the table below:

Specialty	Indicator
Acute Medicine	7 day readmissions
Trauma & Orthopaedics	Proportion of patients who had surgery within 2 days of admission for fractured neck of femur (fractured hip)
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Patients on betablockers who were given them on the day of surgery
Respiratory Medicine	% of asthmatic patients are discharged on inhaled steroids

3. Quality Webpages

The Head of Quality Development is currently working with the Communications Team to review and refine the Quality Webpages. The plan is to develop a section specifically for clinicians, including GPs, and a simpler section for patients for each of the published indicators. Links to the specialty indicators will also be added to the existing patient information pages to make them more accessible for patients and the public.

4. **Recommendations**

The Board of Directors is requested to:

Approve the content of the Quality Account Update for April-September 2010 for external publication.

Appendix A: Quality Account Update for April-September 2010

Quality Account Update for April-September 2010

Contents

Introduction

Mortality

Quality Improvement Priorities

- 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
- Priority 4: Improve patient experience and satisfaction
- Priority 5: Infection prevention and control

Selected Metrics

Specialty Quality Indicators

- Acute Medicine
- Anaesthetics, ITU and Ambulatory Care
- Clinical Support Services
- Other Medicine
- Outpatients
- Surgery

Quality Account Update for April-September 2010

1. Introduction

The Trust published its second Quality Account Report in June 2010 as part of the Annual Report and Accounts. The report contained an overview of the quality initiatives undertaken in 2009-10, performance data for selected metrics and 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

Priority 4: Improve patient experience and satisfaction

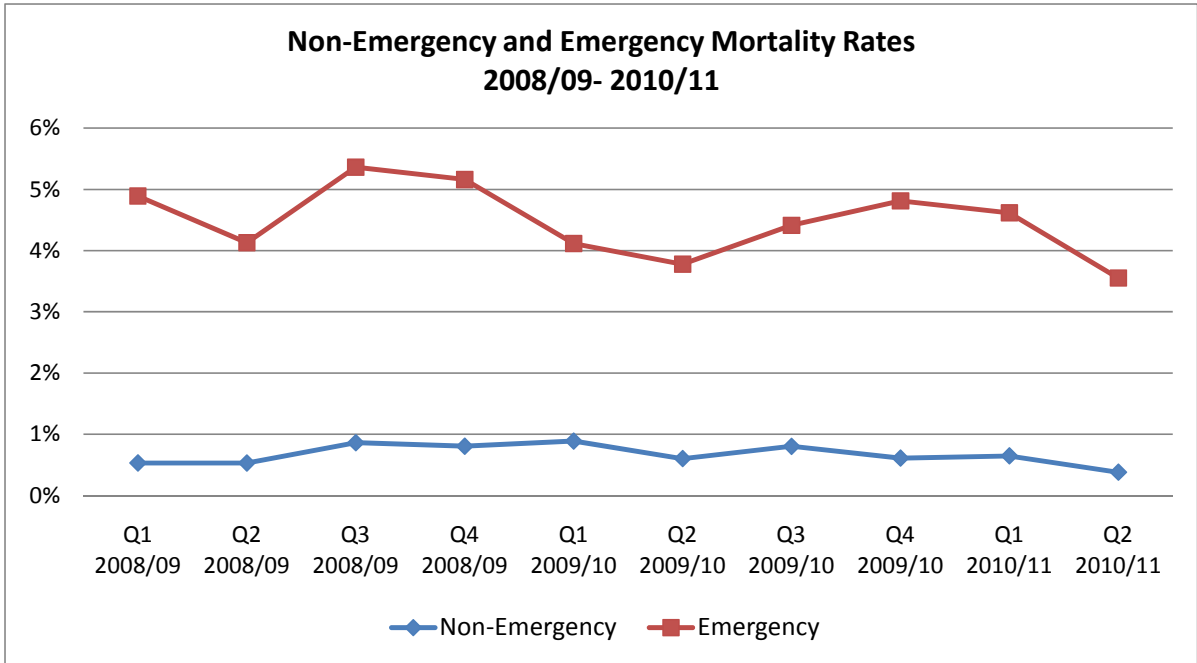
Priority 5: Infection prevention and control

This report provides an update on the progress made for the period April-September 2010 towards meeting these priorities and updated performance data for the selected metrics. This update report should be read alongside the Trust's Quality Account Report for 2009-10.

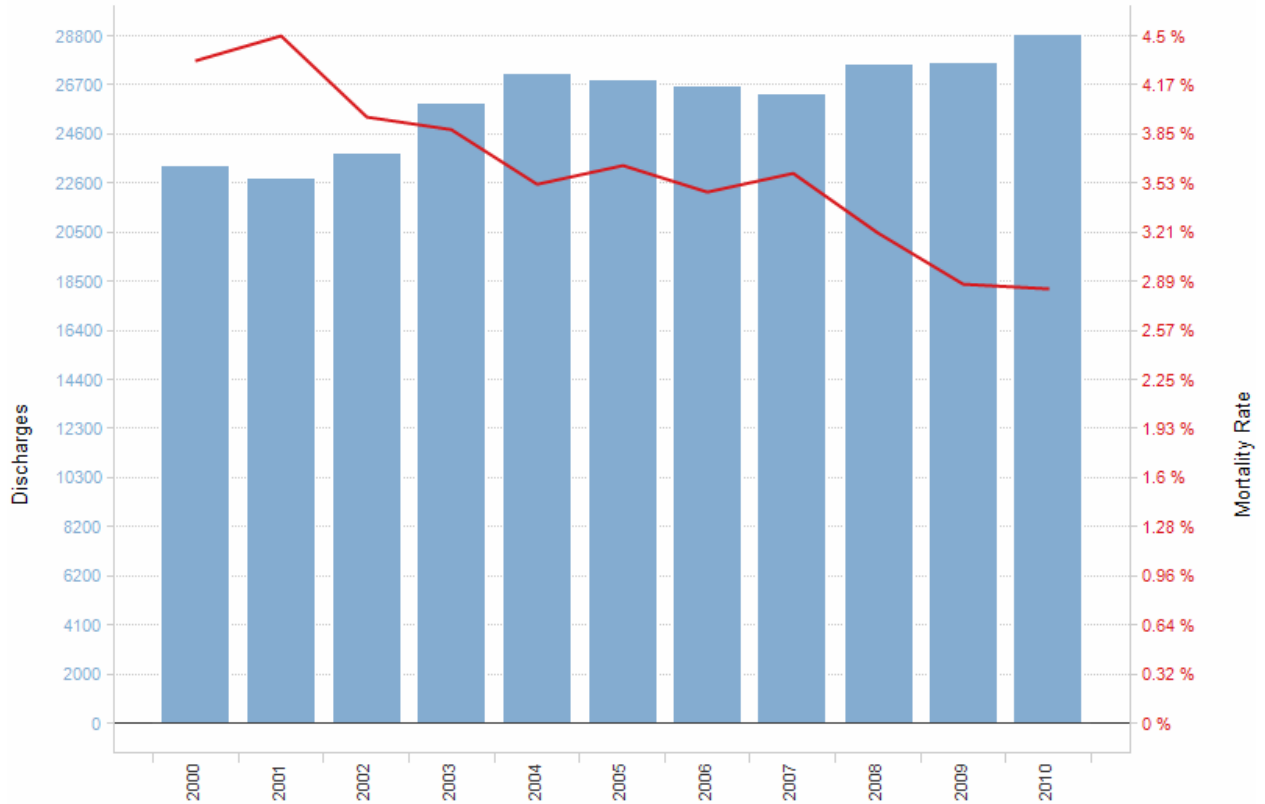
2. Mortality

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.

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.

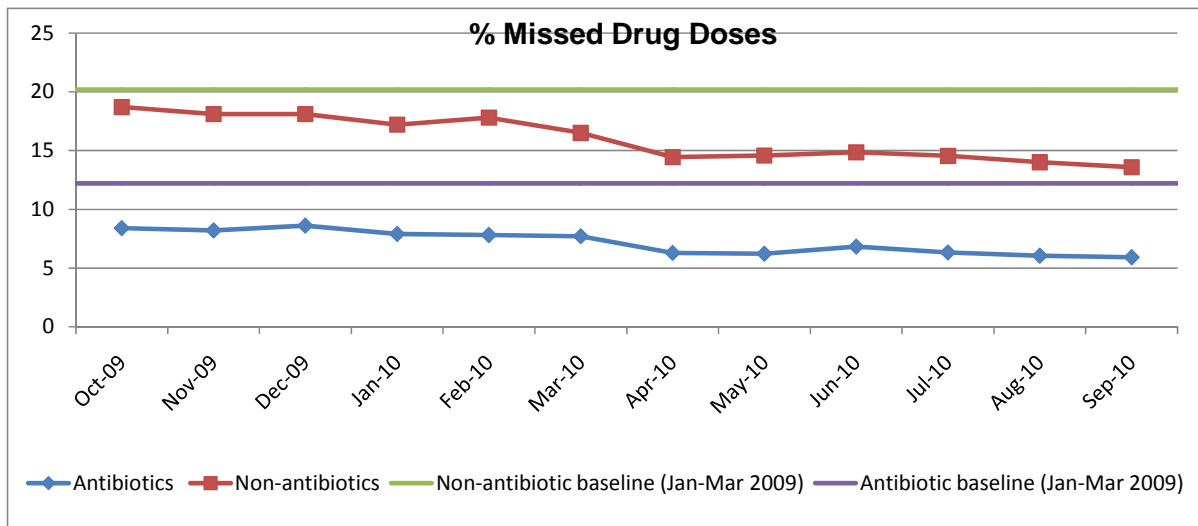


3. Quality Improvement Priorities

Priority 1: Reducing errors (with a particular focus on medication errors)

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. Omitted drug doses are monitored at divisional, specialty and ward levels and communicated daily to clinical staff via the Clinical Dashboard (which displays real-time quality information at ward-level). Performance is also 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.

The percentage of omitted antibiotic and non-antibiotic drug doses for the last 12 months is shown in the graph below. The Trust is continuing to reduce the number of missed antibiotic and non-antibiotic doses during 2010-11. Improvement actions are identified following monthly root cause analyses of selected missed dose cases by the Trust's Executive, divisional management and clinical teams.

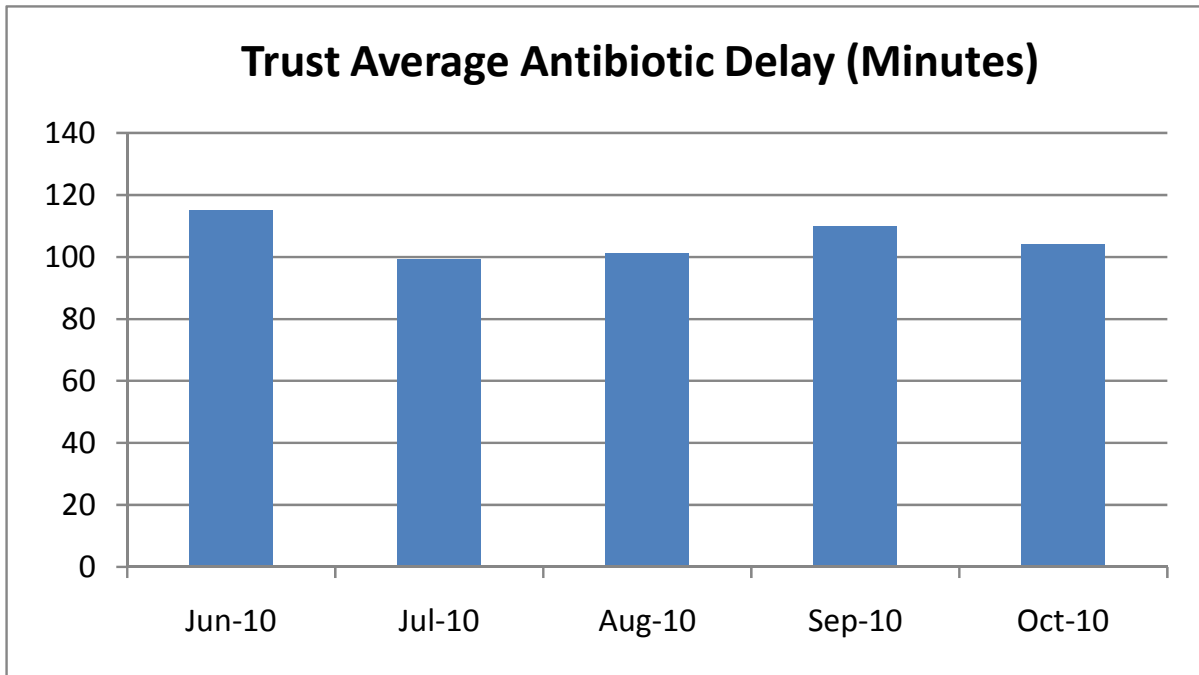


Priority 2: Time from prescription to administration of first antibiotic dose

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

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.

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. Baseline performance data is shown in the graph below for June to October 2010. The Trust is focusing on reducing the time between prescription and administration of first doses of antibiotic for this group of patients. Delayed antibiotics are now being included in the monthly root cause analyses of selected missed dose cases by the Trust's Executive, divisional management and clinical teams.

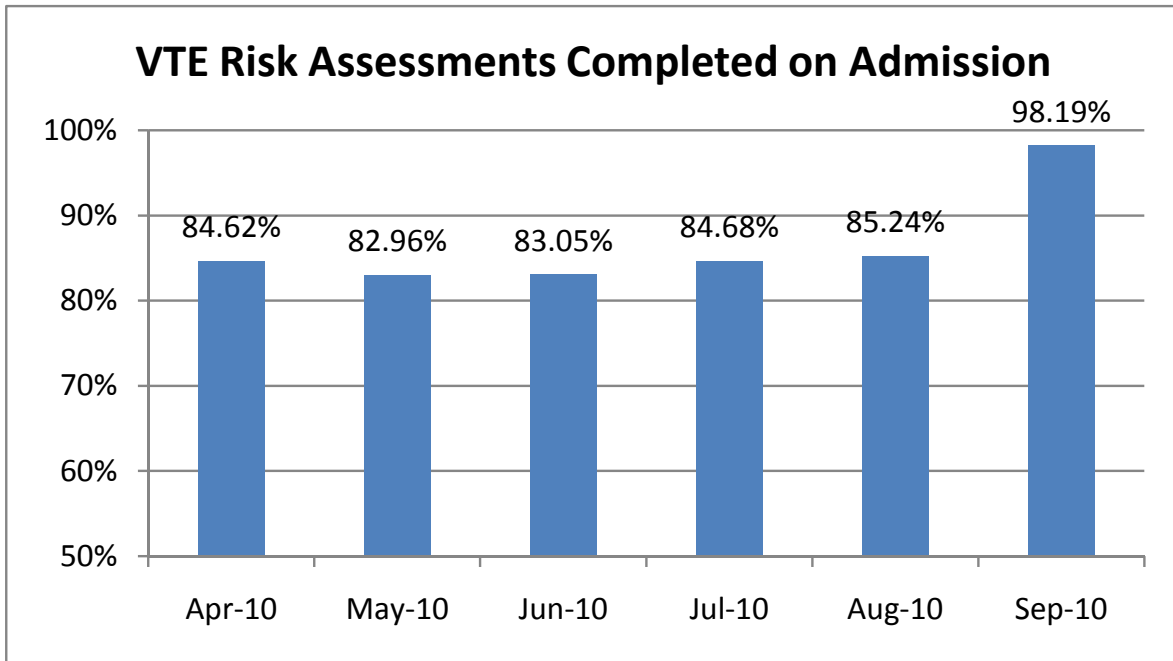


Priority 3: Venous thromboembolism (VTE) risk assessment on admission

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 Trust is continuing to monitor the completion of venous thromboembolism risk assessments to ensure that by the end of 2010-11, at least 90% of all our patients have a VTE risk assessment completed on admission.



Priority 4: Improve patient experience and satisfaction

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.

Time Period	Survey Questions	Answers	Performance
April-September 2010	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%
June-September 2010	Did you find someone on the hospital staff to talk about your worries and fears?	Yes, definitely	63%
		Yes, to some extent	26%
		No	12%
June-September 2010	Were you given enough privacy when discussing your care and treatment?	Yes, always	87%
		Yes, sometimes	11%
		No	2%
June-September 2010	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%
August-September 2010	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	16%
		No	25%

August-September 2010	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?*	Yes	84%
		No	16%

* Responses from Outpatient Survey which started in August 2010.

Complaints

The overall number of complaints received in Quarter 2 2010/11 was higher than Quarter 1 2010/11. This was mainly due to an increase in the number of complaints received in July 2010; the number of complaints received per month has since reduced.

	Q1 2010/11	Q2 2010/11
Total number of complaints	160	205
Response within deadline	97%	92%*
Referrals for independent review by referral date	4	5

*Final response rates for August and September 2010 are not yet available so the percentage shown relates to complaints received in July 2010.

Top 3 Complaint categories	Q1 2010-11	Q2 2010-11
Main category		
1. Clinical treatment	71	87
2. OPA (delay/cancellation)	22	31
3. = Communication/information	20	18
3. = Attitude of staff	15	18
All issues		
1. Clinical treatment	135	181
2. Communication/information	56	83
3. Attitude of Staff	29	50

Ratio of complaints to activity

		Q1 2010-11	Q2 2010-11
Inpatients	FCEs*	30 194	31 670
	Complaints	76	115
	Rate per 1000 FCEs*	2.52	3.63
Outpatients	Attendances**	126 554	131 577
	Complaints	69	76
	Rate per 1000 attendances	0.55	0.58
A&E	Attendances	21 401	20 794
	Complaints	15	14
	Rate per 1000 attendances	0.70	0.67

*FCE = finished consultant episode which denotes the time spent by a patient under the continuous care of a consultant.

** The Outpatients activity data relates to attendances only and also includes Therapy Outpatients data (physiotherapy, podiatry, dietetics, speech and language therapy and occupational therapy).

Compliments

The number of compliments received continue to show a sustained and significant increase in Quarter 2 2010/11. The majority of compliments received relate to treatment received, with a number specifically mentioning nursing care and friendliness of staff. Quarter 2 also saw an increase in the number of compliments relating to medical staff.

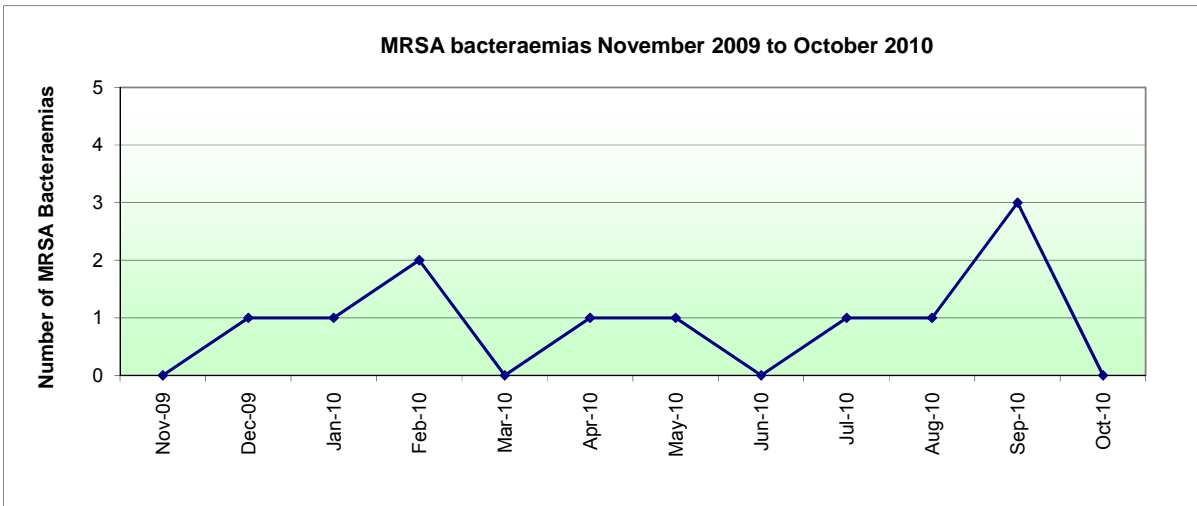
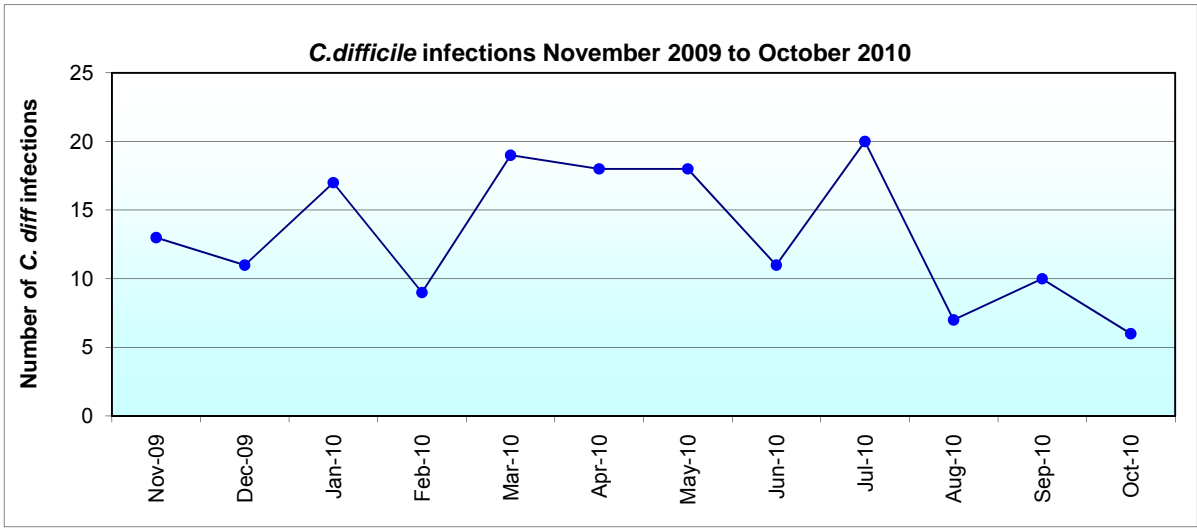
Compliment Subtype	Q1 2010-11	Q2 2010-11
Treatment received	81	57
Nursing care	29	49
Friendliness of staff	21	50
Efficiency of service	11	8
Medical care	5	21
Facilities	0	1
Other	3	7
Information provided	1	5
Total	151	198

Priority 5: Infection prevention and control

UHB is continuing to make good progress in relation to infection prevention and control during 2010-11:

- The Trust is now utilising vapour decontamination in standard terminal cleans since the move into the new building. There has also been an initiative to use hydrogen peroxide vaporising in the clinical areas identified as most susceptible to *C. difficile* infection to reduce the microbial load prior to use of the area by patients.
- The Trust's MRSA screening policy includes all elective and emergency patients except those that are excluded from the Department of Health criteria. A decolonisation project to follow cases through into the community is in the process of being agreed with NHS South Birmingham.
- Both MRSA bacteraemias and any episode of two or more *C.difficile* cases are subject to root cause analysis and then review by the Executive Team of the Board. The learning from these RCAs is shared divisionally and assurance on actions taken is reported via the Infection Prevention and Control Committee.
- The Trust has begun a process of surveillance for other key organisms to prepare to monitor and report on them monthly.

The graphs below show the number of post 48-hour *C. difficile* cases and MRSA bacteraemias by month for the period November 2009 to October 2010:



4. Performance of the Trust against selected metrics

Indicators	2010-11	Peer Group Average (where available)	2009-10
Patient safety indicators			
1(a). MRSA: Patients with MRSA infection/10,000 bed days (includes all bed days from all specialties) <i>Lower rate indicates better performance</i>	0.24	0.15	0.42
Time period	April-June 2010	April-June 2010	2009-10
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)
Peer group		Acute trusts in West Midlands SHA	
1(b). MRSA: Patients with MRSA infection/10,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics) <i>Lower rate indicates better performance</i>	0.25	0.17	0.43
Time period	April-June 2010	April-June 2010	2009-10

Indicators	2010-11	Peer Group Average (where available)	2009-10
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)
Peer group		Acute trusts in West Midlands SHA	
2(a). <i>C. difficile</i>: Patients with <i>C. difficile</i> infection/1,000 bed days (includes all bed days from all specialties) <i>Lower rate indicates better performance</i>	0.69	0.45	0.53
Time period	April-June 2010	April-June 2010	2009-10
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)
Peer group		Acute trusts in West Midlands SHA	
2(b). <i>C. difficile</i>: Patients with <i>C. difficile</i> infection/1,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics) <i>Lower rate indicates better performance</i>	0.71	0.53	0.55
Time period	April-June 2010	April-June 2010	2009-10
Data source	Trust C.diff data reported	Trust C.diff data	Trust C.diff data reported

Indicators	2010-11	Peer Group Average (where available)	2009-10
	to HPA, HES data (bed days)	reported to HPA, HES data (bed days)	to HPA, HES data (bed days)
Peer group		Acute trusts in West Midlands SHA	
3. Patient safety incidents (reporting rate per 100 admissions) <i>Higher rate indicates better reporting</i>	11.0	<i>Not available</i>	9.7
Time period	April-Sept 2010		2009-10
Data source	Datix (incident data), Trust admissions data		Datix (incident data), Trust admissions data
Peer group			
4. Percentage of patient safety incidents which are no harm incidents <i>Higher % indicates better performance</i>	76.7%	<i>Not available</i>	86.6%
Time period	April-Sept 2010		2009-10
Data source	Datix (incident data), Trust admissions data		Datix (incident data)
Peer group			

Indicators	2010-11	Peer Group Average (where available)	2009-10
Clinical effectiveness indicators			
5(a). Readmissions: Readmission rate (Medical and surgical specialties - elective and emergency admissions aged >15) % <i>Lower % indicates better performance</i>	8.98%	8.24%	8.47%
Time period	April-May 2010	April-May 2010	April 2009-Mar 2010
Data source	HES data	HES data	HES data
Peer group		University hospitals	
5(b). Readmissions: Readmission rate (all specialties) % <i>Lower % indicates better performance</i>	9.19%	7.32%	8.69%
Time period	April-May 2010	April-May 2010	April 2009-Mar 2010
Data source	HES data	HES data	HES data
Peer group		University hospitals	
6. Falls (incidents reported as % of elective and emergency episodes)	2.4%	Not available	1.97%

Indicators	2010-11	Peer Group Average (where available)	2009-10
<i>Lower % indicates better performance</i>			
Time period	April-Sept 2010		2009-10
Data source	Datix (incident data), Trust activity data		Datix (incident data), Trust activity data
7. Percentage of stroke patients (infarction) on aspirin, clopidogrel or warfarin	98.6%	99.7%	99.7%
<i>Higher % indicates better performance</i>			
Time period	April-Sept 2010	2008 Calendar year	2009-10
Data source	Trust PICS data	Cleveland Clinic website	Trust PICS data
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)	93.8%	88% NB This data is for all surgery patients with heart conditions who were on beta blockers	93.3%
<i>Higher % indicates better performance</i>			
Time period	April-Sept 2010	Jan-Jun 09	2009-10

Indicators	2010-11	Peer Group Average (where available)	2009-10
Data source	Trust PICS data	Cleveland Clinic website	Trust PICS data
Peer Group		Cleveland Clinic, Ohio, U.S.A.	

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.

3: The data shown for 2009-10 in the Trust's 2009-10 Quality Account actually related to episodes of care rather than admissions. There can be multiple episodes of care during one patient admission. The data for 2009-10 has therefore been recalculated using admissions data.

6: The admissions data shown for 2009-10 in the Trust's 2009-10 Quality Account actually related to episodes of care rather than admissions. The data includes daycase patients as well as all elective and emergency admissions.

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.

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.

5. Specialty Quality Indicators

The following table shows performance at a specialty level for a wide selection of the quality indicators developed by clinicians, Health Informatics and the Trust's Quality and Outcomes Research Unit. Performance data is shown for April-September 2010 and 2009-10, and benchmarking data is provided where possible. In line with the Trust's commitment to transparency, the data shown is not just limited to good performance; areas where performance can be improved are being taken forward by the specialties concerned as appropriate. The methodology and data for all indicators have been checked and validated by the appropriate clinical staff to ensure they accurately reflect the quality of care provided.

Acute Medicine

Speciality	Indicator	Goal	Numerator (Apr 10 - Sept 10)	Denominator (Apr 10 – Sept 10)	% (Apr 10 – Sept 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
A&E	Average (median) delay from arrival in A&E to performance of emergency CT head with contrast scan				3 hours (for 44 patients)			2 hours (for 46 patients)	CRIS Symphony	
A&E	Average (median) delay from arrival in A&E to performance of emergency CT head scan				2 hours (for 847 patients)			3 hours (for 1146 patients)	CRIS Symphony	

Speciality	Indicator	Goal	Numerator (Apr 10 - Sept 10)	Denominator (Apr 10 – Sept 10)	% (Apr 10 – Sept 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Acute Medicine	7 day readmissions to: Acute Medicine Medical Admissions Unit	<4% for Acute Medicine	361 163	13585 4178	2.6% 3.9%	885 324	25724 7141	3% 5%	Lorenzo	
Cardiology	Ensure all patients are discharged on aspirin and clopidogrel or prasugrel following percutaneous coronary intervention (PCI)	100%	404	404	100.0%	790	790	100.0%	Lorenzo PICS	Cleveland Clinic 99% (2009) Other US Hospitals 98% (2009) (This data relates to Thieno- pyridines given at discharge)
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.		2	3809	0.1%	12	3462	0.35%	Lorenzo	

Speciality	Indicator	Goal	Numerator (Apr 10 - Sept 10)	Denominator (Apr 10 – Sept 10)	% (Apr 10 – Sept 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Elderly Care	Percentage of elderly care patients discharged to their normal place of residence		2096	2269	92.4%	4278	4705	90.9%	Lorenzo	
Elderly Care	Percentage of elderly care patients discharged to other NHS/ non-NHS providers		142	2269	6.3%	355	4705	7.5%	Lorenzo	
Gastro- enterology	Proportion of patients admitted with inflammatory bowel disease receiving low molecular weight (LMW) heparin	90%	23	26	88.5%	53	56	95%	Lorenzo PICS	
Heart Failure	Percentage of heart failure patients discharged on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)	93%	70	100	70.0%	178	254	70%	Heart Failure database PICS	Cleveland clinic 99% (Jan 10 - Mar 10) Average for all other US hospitals 90% (Oct 08 - Sep 09) This relates to ACE/ARBs given to heart failure patients

Speciality	Indicator	Goal	Numerator (Apr 10 - Sept 10)	Denominator (Apr 10 – Sept 10)	% (Apr 10 – Sept 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
										with LVSD
Heart Failure	Percentage of patients with a primary diagnosis of acute heart failure who had an echocardiogram (ECHO) prior to discharge	100%	78	100	78%	196	254	77%	Heart Failure database PICS	
Respiratory Medicine	% of asthmatic patients are discharged on inhaled steroids	95%	115	129	89.1%	236	272	86.8%	PICS	
Stroke Medicine	% of patients admitted with cerebral infarction who received aspirin, clopidogrel or warfarin	98.8% (CQUIN target for 2009-10)	146	147	99.3%	298	299	99.7%	Lorenzo PICS	Cleveland Clinic : 100% (Jan 10 -Mar 10) US National Average : 85% Ischemic stroke patients discharged on Blood Clot Reducing Medication
Stroke Medicine	30 day mortality following stroke		30	208	144	77	324	23.8%	Lorenzo	

Anaesthetics, ITU and Ambulatory Care

Speciality	Indicator	Goal	Numerator (Apr 10 – Sept 10)	Denominator (Apr 10 – Sept 10)	% (Apr 10 – Sept 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Ambulatory Care	Proportion of patients who were intended to be treated as a daycase but were admitted to hospital as an inpatient	<5%	288	7795	3.7%	712	16573	4.3%	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		991	1254	79.0%	2322	2822	82.3%	Lorenzo PICS	

Speciality	Indicator	Goal	Numerator (Apr 10 – Sept 10)	Denominator (Apr 10 – Sept 10)	% (Apr 10 – Sept 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
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		585	1254	46.7%	1273	2822	45.1%	Lorenzo PICS	
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)		54	503	10.7%	283	2191	12.90%	ICNARC	

Clinical Support Services

Speciality	Indicator	Goal	Numerator (Apr 10 – Sept 10)	Denominator (Apr 10 – Sept 10)	% (Apr 10 - Sept 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Imaging	Proportion of A&E patients who have report turnaround time of less than 2 days for CT scan		1574	1669	94.3%	2078	2111	98%	CRIS	
Imaging	Proportion of GP Direct Access patients who have report turnaround time of less than 5 days for plain imaging		13162	14698	89.5%	21307	23622	90%	CRIS	
Imaging	Proportion of GP Direct Access patients who have report turnaround time of less than 5 days for Ultrasound		3225	3256	99.0%	6031	6071	99%	CRIS	Cleveland clinic 94% (July 08 - June 09) Average for all other US hospitals 90% (July 08 - June 09)

Speciality	Indicator	Goal	Numerator (Apr 10 – Sept 10)	Denominator (Apr 10 – Sept 10)	% (Apr 10 - Sept 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Imaging	Proportion of Inpatients who have report turnaround time of less than 2 days for CT		5576	6658	83.7%	8969	11055	81%	CRIS	
Imaging	Proportion of Inpatients who have report turnaround time of less than 2 days for MRI		1077	1823	59.1%	1111	2786	40%	CRIS	
Imaging	Proportion of Inpatients who have report turnaround time of less than 2 days for Ultrasound		4369	4462	97.9%	7160	7320	98%	CRIS	
Imaging	Proportion of Outpatients who have report turnaround time of less than 5 days for CT		5041	7305	69.0%	9348	12625	74%	CRIS	
Imaging	Proportion of Outpatients who have report turnaround time of less than 5 days for MRI		2804	8132	34.5%	4838	13849	35%	CRIS	

Speciality	Indicator	Goal	Numerator (Apr 10 – Sept 10)	Denominator (Apr 10 – Sept 10)	% (Apr 10 - Sept 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Imaging	Proportion of Outpatients who have report turnaround time of less than 5 days for Ultrasound		7149	7457	95.9%	12844	13494	95%	CRIS	
Pathology	Turnaround times C-Reactive Protein - 100 % within 24 hours	100% within 24 hours	77456	77872	99.5%	151706	152131	99.7%	Pathology database	
Pathology	Turnaround times Cholesterol - 100 % within 24 hours	100% within 24 hours	12396	12635	98.1%	24352	24714	98.5%	Pathology database	

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Pathology	Turnaround times Urine - 90% within 48 hours	90% within 48 hours	16288	8806	89.3%	32311	36652	88.2%	Pathology database	
Pathology	Turnaround times Full Blood Count - 100 % within 24 hours	100% within 24 hours	145955	147049	99.3%	284846	288662	98.7%	Pathology database	
Pharmacy	Dispensing error rate (nationally these are measured as no of errors per 100,000 dispensed items)		15.5	100000	0.02%	11.025	100000	0.01%	Pharmacy database	

Speciality	Indicator	Goal	Numerator (Apr 10 – Sept 10)	Denominator (Apr 10 – Sept 10)	% (Apr 10 - Sept 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
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.		1264	1601	79.0%	Jul 09 - Mar 10 1820	Jul 09 - Mar 10 2317	Jul 09 - Mar 10 78.5%	Radio- therapy database	
Therapy Services	90% of In-patient referrals are responded to by each of the Therapy Services on the same day	90% on same day	13549	13972	97.0%	25449	26424	96.3%	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	12614	12747	99.0%	26105	26424	98.8%	Therapy database	

Other Medicine

Speciality	Indicator	Goal	Numerator (Apr 10 - Sept 10)	Denominator (Apr 10 - Sept 10)	% (Apr 10 - Sept 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Dermatology	Incidence of wound infection post skin graft	0%	0	49	0.0%	0	114	0%	Lorenzo	
Dermatology	Proportion of suspected cancer cases seen within 2 weeks by a consultant	93%	888	895	99.2%	1414	1502	94.1%	Cancer database	
Haematology	Bone Marrow Transplant-related mortality:									
	During index (first) admission - autologous (patient's own bone marrow) transplants		2	50	4%	0	66	0%	BMT database	
During index (first) admission - allogeneic (donor bone marrow) transplants		0	38	0%	0	74	0%			

Speciality	Indicator	Goal	Numerator (Apr 10 - Sept 10)	Denominator (Apr 10 - Sept 10)	% (Apr 10 - Sept 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
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%	1	219	0.5%	5	357	1.4%	ERCP database Lorenzo PICS	
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)	Annual NCG Report	

Speciality	Indicator	Goal	Numerator (Apr 10 - Sept 10)	Denominator (Apr 10 - Sept 10)	% (Apr 10 - Sept 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
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%	30	30	100.0%	62	62	100.0%	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%	120	122	98.4%	145	148	98.0%	Lorenzo PICS	

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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%	120	120	100%	145	145	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%			88.4% 88.8%			89.8% 90.1%	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		148	244	60.7%	315	315	100.0%	Lorenzo	

Outpatients

Speciality	Indicator	Goal	Numerator (Apr 10 - Sept 10)	Denominator (Apr 10 - Sept 10)	% (Apr 10 - Sept 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	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		20 13 7 0 0 0	40	50% 32.5% 17.5% 0% 0% 0%	11 10 2 0 0 0	1 March -10 April 2010 23	1 March -10 April 10 48% 43% 9% 0% 0%	Outpatient Survey	
Ophthalmology	Would you recommend this Outpatients Department to your family and friends? Yes, definitely Yes, probably No		35 5 0	40	87.5% 12.5% 0%	21 3 0	24	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		102 19 2 4	127	80.3% 15.0% 1.6% 3.1%	186 34 6 1	227	82% 15% 3% 0%	Outpatient Survey	

Surgery

Speciality	Indicator	Goal	Numerator (Apr 10 - Sept 10)	Denominator (Apr 10 - Sept 10)	% (Apr 10 - Sept 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Cardiac Surgery	First-time, isolated coronary artery bypass graft (CABG) - MRSA bacteraemia		0	135	0.0%	0	313	0.0%	PATS Lorenzo	
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - C.difficile	0	0	135	0.0%	0	313	0.0%	PATS Lorenzo	
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Emergency readmissions within 28 days		5	134	3.7%	15	307	4.9%	PATS Lorenzo	

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Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Patients discharged on angiotensin converting enzyme (ACE) inhibitors	100% of eligible patients	122	127	96.1%	275	307	89.6%	PATS PICS	
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Patients discharged on antiplatelet therapy	100% of eligible patients	131	132	99.2%	306	307	99.7%	PATS PICS	
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Patients discharged on statins	100% of eligible patients	125	126	99.2%	295	307	96.1%	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	61	65	93.8%	125	134	93.3%	PATS PICS	Cleveland Clinic 90% (Jan 09- Dec 09) Average for all other hospitals in Ohio 90% (Jan 09 - Dec 09) Average for all

Speciality	Indicator	Goal	Numerator (Apr 10 - Sept 10)	Denominator (Apr 10 - Sept 10)	% (Apr 10 - Sept 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
										reporting hospitals in US 87% (Jan 09- Dec 09) N.B. 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		2	135	1.5%	7	313	2.2%	PATS Lorenzo	
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Re-opening (all causes)		10	135	7.4%	24	313	7.7%	PATS Lorenzo	Cleveland Clinic 11% (2009 calendar year). This data also includes the referrals for reoperation from other hospitals.

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Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Average post-operative length of stay			135 patients	9 days		313 patients	9.7 days	PATS Lorenzo	
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Median post-operative length of stay			135 patients	7 days		313 patients	7 days	PATS Lorenzo	
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Hospital survival		134	135	99.3%	307	313	98.1%	PATS Lorenzo	Cleveland Clinic 98.8% (2009 calendar year)
Endocrinology	Fraction of patients discharged on hydrocortisone post pituitary surgery	100%	26	27	96.3%	63	63	100%	Lorenzo PICS	
Max Fax	Percentage of emergency admissions with fractured mandible who have surgery same day or the next day	90%	75	102	73.5%	157	224	70%	Lorenzo	

Speciality	Indicator	Goal	Numerator (Apr 10 - Sept 10)	Denominator (Apr 10 - Sept 10)	% (Apr 10 - Sept 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Neurosurgery	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			2.25 days (32 pts)			3.28 days (150 patients)	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	24	32	75.0%	117	157	74.5%		
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%	17	28	60.7%	61	80	76.3%	MARS Lorenzo	

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Routine Surgery / Care	Unplanned return to theatre for all non- emergency surgical patients	>2.5%	349	13666	2.6%	500	32762	1.5%	Galaxy	
Trauma & Orthopaedics	Proportion of patients who had surgery within 2 days of admission for fractured neck of femur (fractured hip)	90%	69	84	82.1%	206	281	73%	Lorenzo	
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%	25	40	62.5%	58	109	53.2%	Lorenzo PICS	
Vascular Surgery	Rates of daycase versus inpatient varicose vein procedures Daycases Inpatients	<5% done as inpatients	293 13	306 306	95.7% 4.2%	485 28	513 513	94.5% 5.5%	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