AGENDA ITEM NO: 12

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 28 OCTOBER 2010

Title:	**PERFORMANCE INDICATORS REPORT**
Responsible Director:	Executive Director of Delivery
Contact:	Andy Walker, Divisional Planning Manager Daniel Ray, Director of Informatics & Patient Administration

Purpose:	To update the Board of Directors on the Trust's performance against key indicators, including Care Quality Commission (CQC) targets, risk ratings against standards included in the Monitor Compliance framework, and performance against internal targets.
Confidentiality Level & Reason:	N/A
Medium Term Plan Ref:	Affects all strategic aims.
Key Issues Summary:	The following indicators are currently not in line with targets and therefore exception reports have been provided: • MRSA • *Clostridium difficile* • A&E 4 hour waits • Primary PCI • 62 Day Cancer – GP referral & screening referral • Delayed Transfers of Care • Quality of Stroke Care • Never Events • External agency and bank spend • Appraisal • Mandatory training • DNAs • Length of Stay • Cancelled follow-up outpatient appointments • Electronic Patient Survey response rate • Omitted drugs • Non-emergency mortality audit response rates Further details and action taken are included in Appendix B.
Recommendations:	The Board of Directors is requested to: **Accept** the report on progress made towards achieving performance targets and associated actions.

Signed:	**Date:** 15 October 2010

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 28 OCTOBER 2010

PERFORMANCE INDICATORS REPORT

PRESENTED BY THE EXECUTIVE DIRECTOR OF DELIVERY

1. Purpose

This paper updates the Board of Directors on the Trust's performance against key indicators, including Care Quality Commission (CQC) targets, risk ratings against standards included in the Monitor Compliance framework and internal targets. Performance against these indicators is shown in Appendix A.

2. Exception reports

For national targets exception reports are contained below. Monthly performance data for exceptions are contained in Appendix B. The number of post-48 hour MRSA bacteraemias was above trajectory in September and is also above the year to date trajectory. *Clostridium difficile* cases although below trajectory in August and September are above trajectory for the year to date. Performance against the A&E 4 hour wait target is below the internal threshold of 98% and is therefore considered an exception. Although the Primary PCI, 62 day GP referral and 62 day referral from screening targets were achieved in August they are below threshold for the year to date therefore exception reports are included for these indicators. Delayed transfers of care continue to be above the threshold. Performance in Quarter 2 was low for the length of stay element of the Quality of Stroke care indicator therefore this indicator is also included as an exception.

With regard to internal targets a Serious Incident Requiring Investigation (SIRI) which meets the criteria of a 'Never Event' has occurred within the Trust therefore an exception report about this incident is included. An exception report is also included for DNAs as although this indicator is 'Amber' it is currently a particular focus area for performance improvement. Both short-term and long-term sickness were below target in August therefore these are not exceptions. Slot unavailability was below target in September with performance of 6.1 unavailable slots per 100 successful bookings against the target of 10 and is therefore no longer an exception.

Exception reports and monthly data for these indicators as well as internal indicators that are currently red and those that have been amber for three consecutive months are contained in Appendix B. The following internal targets are therefore currently considered exceptions:

a) External agency and Bank spend
b) Appraisal
c) Mandatory training
d) DNAs
e) Length of Stay
f) Cancelled follow-up outpatient appointments
g) Electronic Patient Survey response rate
h) Omitted doses
i) Non-emergency mortality audits response rates

2.1 MRSA

There was 1 post 48 hour MRSA bacteraemia in August and there were 3 cases in September which has resulted in the Trust being 1 case over its trajectory for the year to date with a total of 7 cases against a trajectory of 6. Please refer to the Chief Nurse's Infection Control Report for further details and action taken.

2.2 Clostridium difficile

There were 8 post 48 hour C. diff cases in August and 10 cases in September. There have therefore been 86 cases in the year to date against a trajectory of 82. Please refer to the Chief Nurse's Infection Control Report for further details and action taken.

Performance has continued to improve in October with only 2 cases as at 15 October. Based on performance to that date, a straight line extrapolation forecasts that the Trust could expect around 163 cases by year end. This would be below the Trust's full year trajectory and consequently the Trust would not be subject to the non-negotiable financial penalty for failure of the C.difficile trajectory.

2.3 A&E 4 hour waits

Performance in September was below the internal threshold at 95.55% a fall from 96.78% in July. This has reduced year to date performance to 96.68%; it is however above the Government's new threshold of 95%. In September the median total wait increased to 3 hours 04 minutes from 2 hours 44 minutes in August.

The following actions are being taken or are already in place to improve performance:

a) A task and finish group is in place led by the Director of Operations for Divisions 3 to drive performance improvement.
b) The SHO rota has been changed to make additional medical staff available in the evening to match the increasing proportion of attendances at that time.

c) The Clinical Service Leads for Medicine and ED have agreed that General Medical Consultants will be made available to support ED at agreed peak times. The CDU team has also agreed responsibility for the management of a cohort of ED patients that are admitted to CDU.

d) Practices have been reviewed and more focus is to be given to ensure the see and treat area of the department is utilised more and that increased direction is given to the team by the Consultant and ED co-ordinator

e) Referral pathways for specialty patients are to be refined to ensure patients are reviewed in a timely manner and to agree clinical support for ED during out-of-hours periods.

f) Three consultant were recruited in September, 2.5 were replacement posts. One of the candidates will commence as a locum consultant at the beginning of October with the remainder to start in December.

g) Nursing staff are being trained to deliver extended roles to free-up junior medical staff and eventually to introduce nurse discharge.

h) Education and training for junior medical staff in conjunction with GPs is being arranged to focus on improving decision-making skills.

It is expected that these changes will lead to an improvement in performance over future months as they are implemented and each breach is being reviewed and reported to the Director of Operations and Chief Operating Officer.

2.4 Primary PCI

70% of Primary PCI patients in July and 80% in August had a call to balloon time of less than 150 minutes. Year to date performance is 68.6%.

There were 14 direct referrals to UHB in the two months of which 11 met the 150 minute target. Two of the breaches were outside of UHB's control where there was a lengthy ambulance delay and where one patient could not be treated in time because there was already another Primary PCI patient in the catheter lab. The third breach resulted from a 35 minute wait for an ECG in the Emergency Department. Division 2 is working with the Emergency Department to address the concerns relating to this delay so as to avoid a recurrence of this problem.

Performance is expected to increase further when Cardiology moves to the QEHB in January 2011. Performance will need to improve further above the level seen in these months if the Trust is to hit the target for the full year 2010/11.

2.5 62 day cancer targets

86.0% of urgent GP referrals (52 out of 62.5 accountable treatments) in July and 85.8% (51.5 out of 60) in August were treated within 62 days of referral against the target of 85%. GP referral performance now includes patients included in the 31 day Referral To Treatment target for rare cancers, in line with the DH and CQC definition. Further validation prior to the publication of the quarterly performance figures along with September performance means that the draft Quarter 2 performance is currently above target at 85.8%.

The CQC has announced that it will not be running the reallocation scheme in 2010/11 as following discussions with the Government it is not proceeding with Periodic Review and will not be publishing aggregate ratings for trusts. As Monitor continues to performance manage foundation trusts against this target in 2010/11 the Trust has asked it to clarify its position as the Compliance Framework makes explicit reference to the reallocation process and tertiary centres will be disadvantaged if reallocations cannot be made. Consequently previous months' figures have been revised to exclude reallocations. UHB will ask trusts referring patients who would have met the criteria for reallocation. This will allow the Trust to publish performance taking account of these adjustments or provide this information to Monitor if required.

In July 75% of referrals from screening (1 breach out of 4) were treated within 62 days of referral. In August this increased to 92.6% (1 breach out of 13.5). This performance along with draft 100% performance for September means that draft Quarter 2 performance is currently 91.8% against the 90% target.

Providing no further breaches are identified or added to the national Cancer Waiting Times system by other trusts the Trust should achieve both targets in Quarter 2. Consequently, as explained in the Quarterly Board Certification paper the Trust will not be declaring these targets as risks to Monitor and will not receive the penalty of a 'red' governance rating from Monitor for not achieving one or both of the targets over three consecutive quarters.

The Task and Finish Group and three subgroups established in August continue to meet. In addition Root Cause Analysis (RCA) meetings are being held each month where MDT teams led by the Group Manager for the relevant specialty present RCAs for breaches that have occurred. The common themes identified include failure to escalate delays to a pathway and delays in the transfer of patients between Trusts and teams. A feedback session has been arranged in November where the roles and responsibilities of Group Managers and Pathway Co-ordinators will be reaffirmed. Diagnostic delays have also been identified as a problem and internal targets are being established for diagnostics.

2.6 Delayed Transfers of Care

Delayed transfers of care rose from 4.9% in July to 5.5% in August and then fell in September back to 4.9%. The "sitrep" on which this indicator is based has been revised by the Department of Health to a monthly return. It therefore now only includes patients delayed at midnight on the last Thursday of the month. Previous performance has now been changed to reflect this definition and the year to date therefore now stands at 4.8%.

The Chief Operating Officer and Director of Partnerships attended the Overview and Scrutiny Committee in September as part of its review of delayed discharges. The review has identified the South Birmingham health economy as a particular outlier in this area. The review is expected to be completed in October. The Director of Partnerships now meets with the Discharge Team on a weekly basis to review all delayed discharges and escalate with other bodies where needed. A group has been established chaired by the Executive Chief Nurse to investigate the quality of discharge. Part of its remit will include the review of readmissions within 2 days.

The number of patients delayed has now reduced from a peak of 75 at the middle of September to 41 on 17 October.

2.7 Stroke

In September 64.8% of stroke patients spent greater than 90% of their length of stay on the Stroke Unit against the contractual target for the quarter of 74.2%. Quarter 2 performance does not currently include length of stay for patients transferred to Moseley Hall Hospital as this data has not yet been made available by South Birmingham Community Health. The following actions have been taken to improve performance:

a) A Task and Finish Group chaired by the Director of Operations, Division 3, and detailed action plan are in place to deliver improved performance against the national targets and other measures for stroke and TIA. A report on each patient who does not meet the target is submitted to the Director of Operations to review reasons and agree rectification plans.
b) All non-stroke patients on the Stroke Unit are flagged with the Bed Management Team and Support Manager by 9am as a priority to be moved off the Stroke Unit. The continued status of "protecting" 2 stroke admission beds is also a priority to ensure these are available.
c) The Stroke Co-ordinators are now based in the Clinical Decision Unit / ED to allow them to identify stroke patients and facilitate their rapid transfer to the Stroke Unit. They are now working 7 days a week between the hours of 08:00-20:00.

All patients referred to the Trust as high-risk TIAs in August and September were treated within 24 hours taking Quarter 2 performance to 87.5%. It is acknowledged that the current system whereby patients are seen on the Stroke Unit if there is insufficient capacity in clinic is only a short term solution and the business case to create a 7 day per week service is being developed. It has been agreed that where the Stroke Co-ordinator cannot contact the patient in working hours to arrange the appointment that the Booking Centre will perform this task between 5 and 8 pm.

2.8 Never Events

In August 2010 an incident occurred which is classified by the National Patient Safety Agency as a 'Never Event'. Please see the Executive Medical Director's Clinical Quality Report for details of this incident and action taken in response.

3. Benchmarking of National Indicators by CQC

The CQC has published benchmarking of individual trusts' performance in 2009/10 against a subset of the national indicators. This replaces the system of Periodic Review that was abandoned following discussions with the Coalition Government. The benchmarking shows the Trust to be in line with expected performance for all included indicators with the exception of three. The Trust's performance was much better than expected for 2 week waits for breast symptoms, better than expected for the percentage of cancelled operations not treated within 28 days and worse than expected for 62 day cancer waits from consultant upgrade to treatment. Further details of the background to the exercise, approach used by the CQC and results of benchmarking are included in Appendix C.

4. Recommendations

The Board of Directors is requested to:

Accept the report on progress made towards achieving performance targets and associated actions.

Tim Jones
Executive Director of Delivery

APPENDIX A

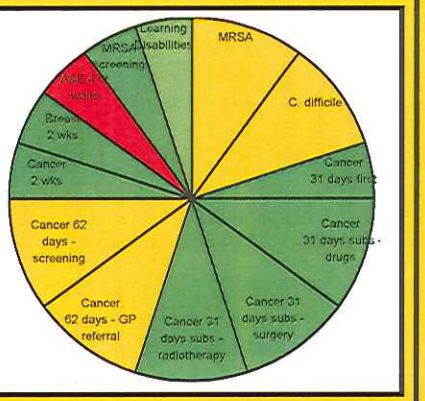
University Hospitals Birmingham NHS
NHS Foundation Trust

2010/11 Key Performance Indicator Report

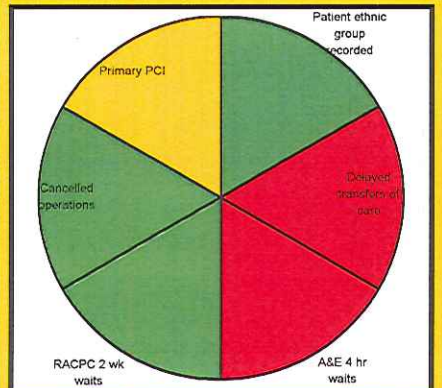
Where data is not currently available indicator names are in italics. These have been assigned 'amber' unless considered high risk where they have been assigned 'red'.

National Performance

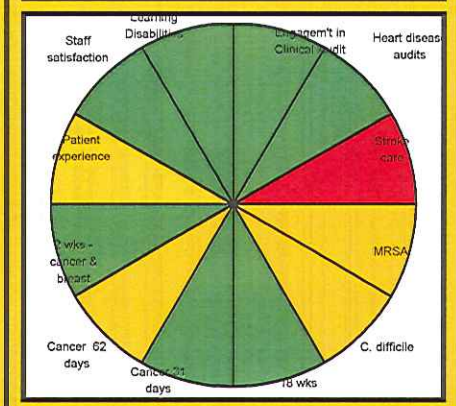
Monitor Governance Rating



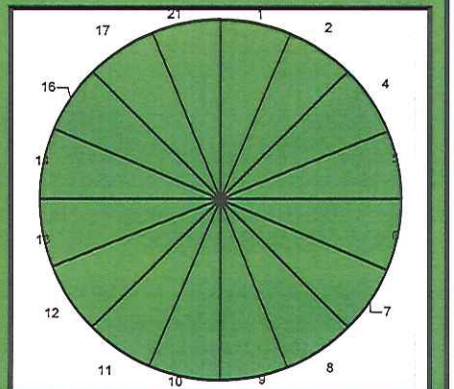
Care Quality Commission Existing Commitments



Care Quality Commission National Priorities

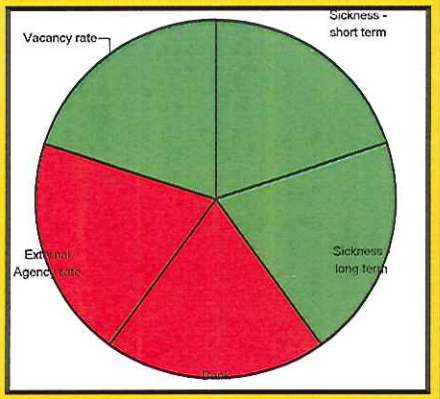


Registration Outcomes

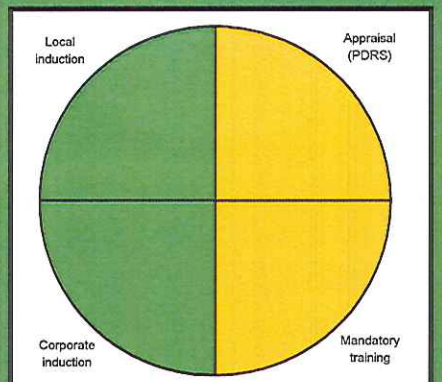


Workforce

Resources

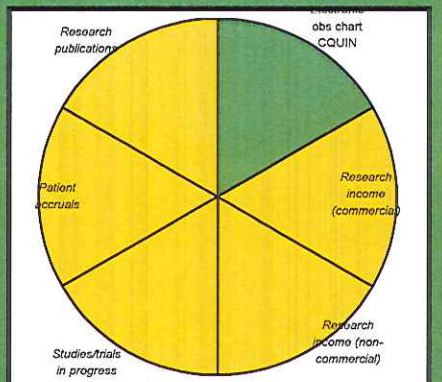


Capability

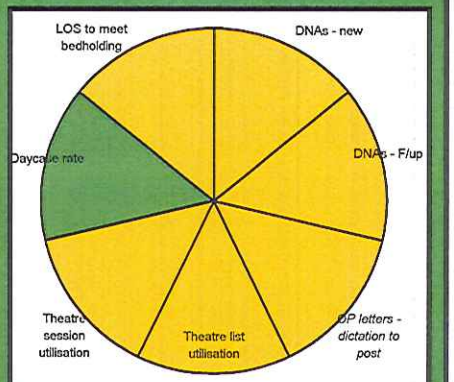


Efficiency

Innovation



Process



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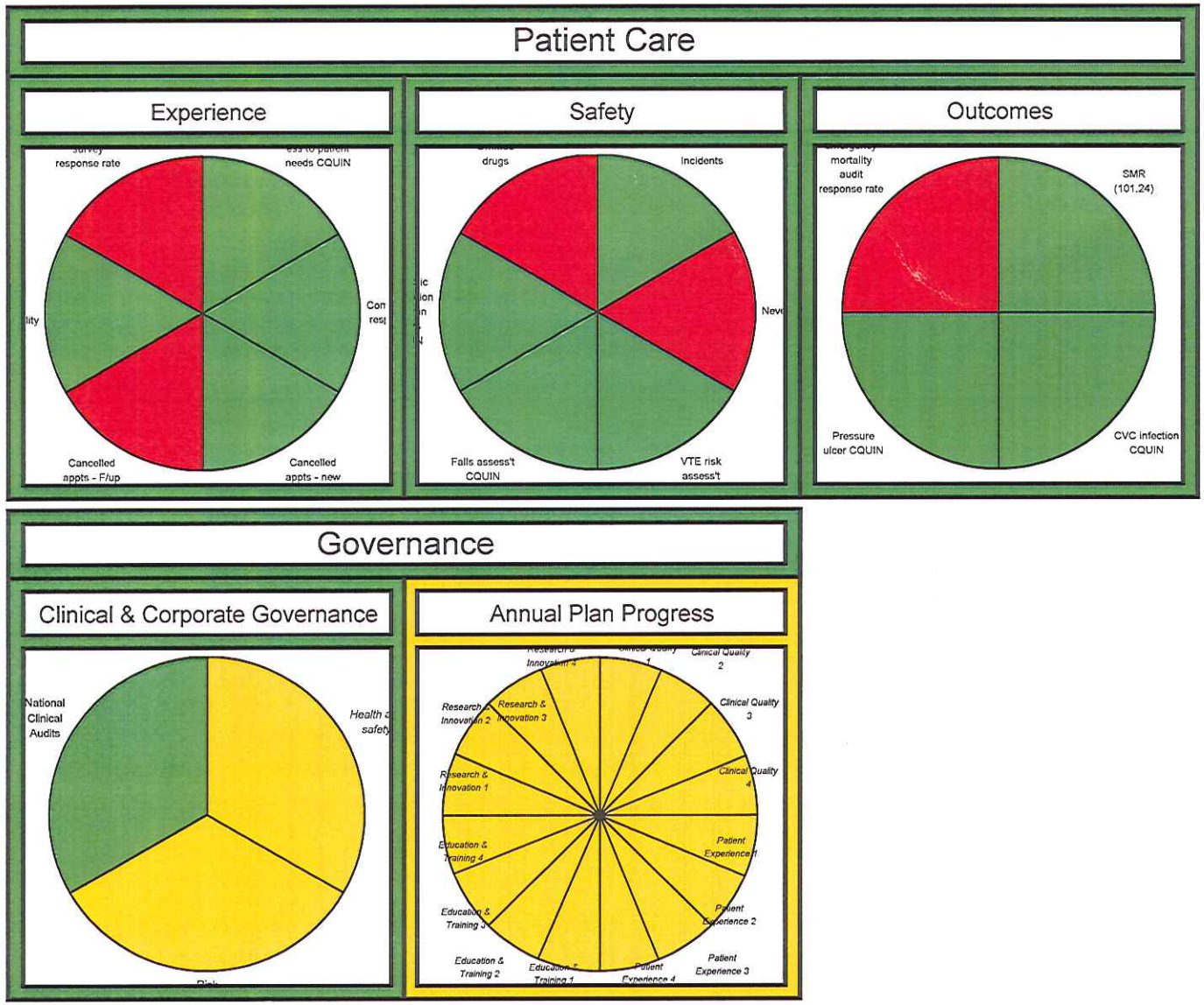
University Hospitals Birmingham NHS
NHS Foundation Trust



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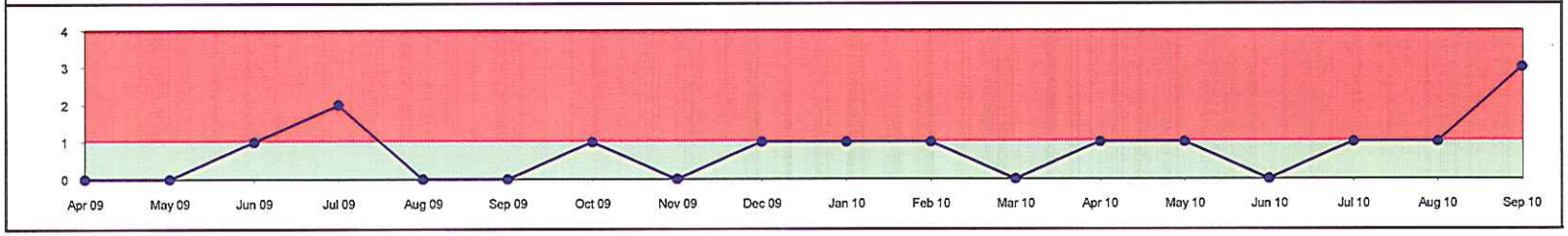
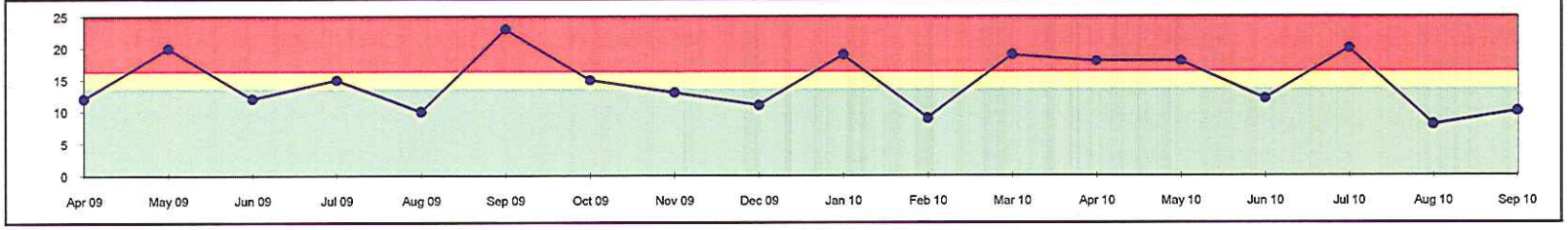
APPENDIX B

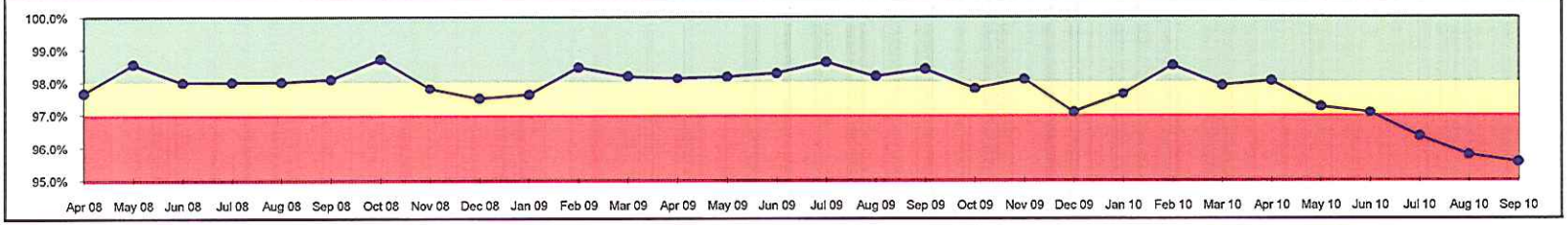
MRSA - Post 48 hour cases	Monitor & CQC National Priorities										> 14	≤ 14	≤ 11
	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
MRSA	1	1	0	1	1	3							7



C. difficile - Post 48 hour cases	Monitor & CQC National Priorities										> 193	≤ 193	≤ 164
	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
C. difficile	18	18	12	20	8	10							86



A&E 4 hour waits	Monitor & CQC Existing Commitments										< 97%	97-98%	≥ 98%
	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
4 hr waits	98.04%	97.24%	97.06%	96.35%	95.78%	95.55%							96.68%



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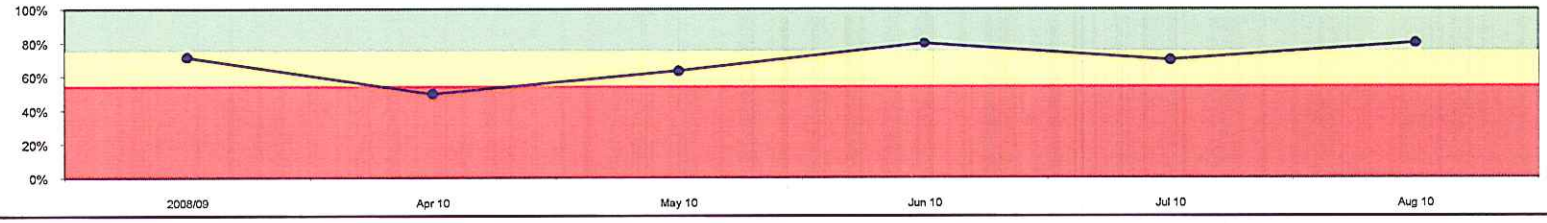
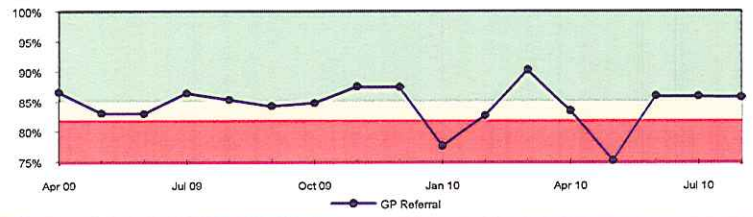
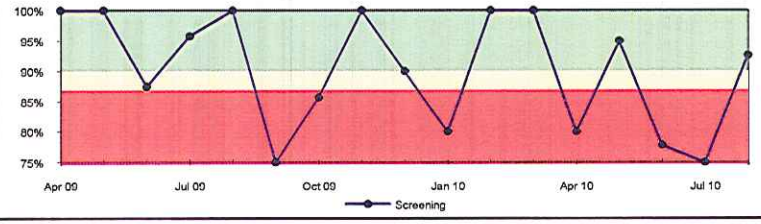
Primary PCI					Monitor & CQC Existing Commitments						< 55%	55-75%	≥ 75%
	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
150 mins	50.0%	63.6%	80.0%	70.0%	80.0%								68.6%

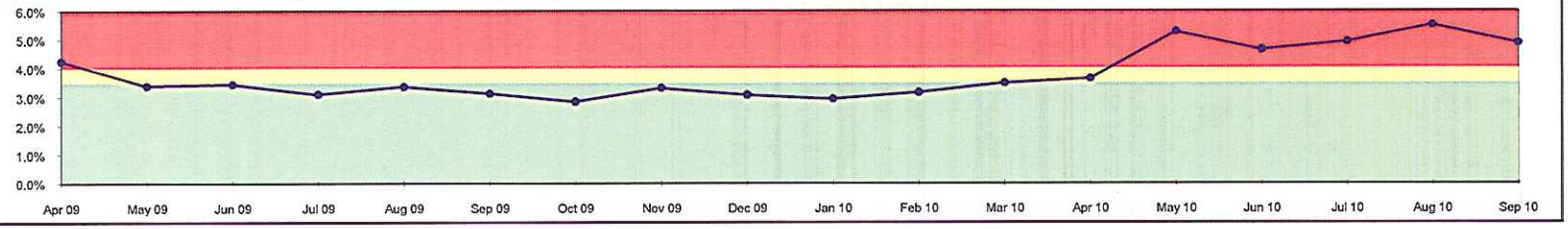


62 Day Cancer							CQC National Priorities				GP Referral	< 82%	82 - 85%	≥ 85%
											Screening	< 87%	87 - 90%	≥ 90%
	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD	
GP Referral	83.5%	75.2%	86.0%	86.0%	85.8%								83.3%	
Screening	80.0%	95.0%	77.8%	75.0%	92.6%								87.3%	





Delayed Transfers of Care								CQC Existing Commitments			> 4.0%	≤ 4.0%	≤ 3.5%
	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
DToC	3.65%	5.29%	4.65%	4.93%	5.51%	4.88%							4.80%



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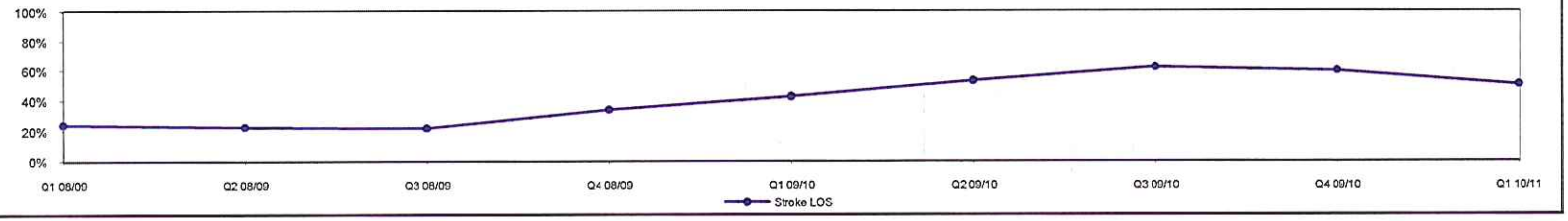
Quality of Stroke Care								CQC National Priorities			Thresholds not available		
	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
Stroke LOS	56.4%	57.1%	45.5%	51.3%	63.3%	64.9%							56.3%
TIA	42.9%			87.5%									40.0%



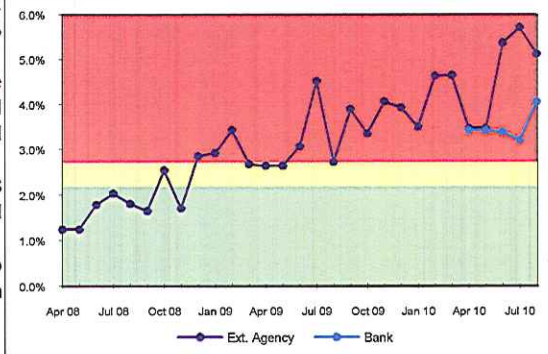
Percentage of total staff costs spent on agency & bank staffing								Workforce - Resources			> 2.7%	2.2 - 2.7%	≤ 2.2%
	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
Ext. Agency	3.48%		5.37%	5.71%	5.12%								4.64%
Bank	3.43%		3.40%	3.21%	4.06%								3.51%

The percentage of the pay budget spent on external agency in August was 5.12%, a fall from 5.71% in July. The highest costs continue to be associated with Divisions 3 and 5. The spend on bank staff rose from 3.21% in July to 4.06% in August. The total monthly spend on agency and bank rose from £2,142m to £2,181m.

Division 3 is currently having to backfill 3 consultant posts in the Emergency Department whilst awaiting the start date of those recruited; the Division also have a waiting list initiative in Neuro and a number of unfilled junior doctor slots. One of the Dermatology consultants appointed in Division 5 has a delayed start date and therefore this post must be filled in the meantime.

The provision of additional capacity in the Trust has contributed significantly to nursing agency spend. East 2B continues to be open and the opening of trolley bays on the Clinical Decision Unit as required have contributed to Division 3's spend, as has the opening of additional beds for Trauma for Division 5.

The Trust has a large amount of nursing vacancies and is currently advertising nationally for these. It is also planned to over-recruit in preparation for the winter months. A CEAG paper has been approved for the creation of a nursing pool of 30 staff to be utilised in areas of understaffing without the use of agency staff.



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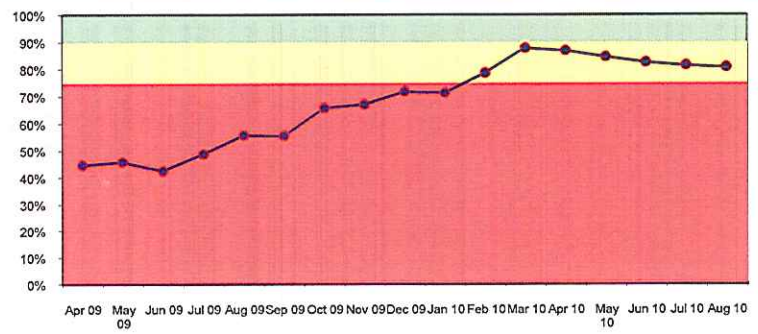
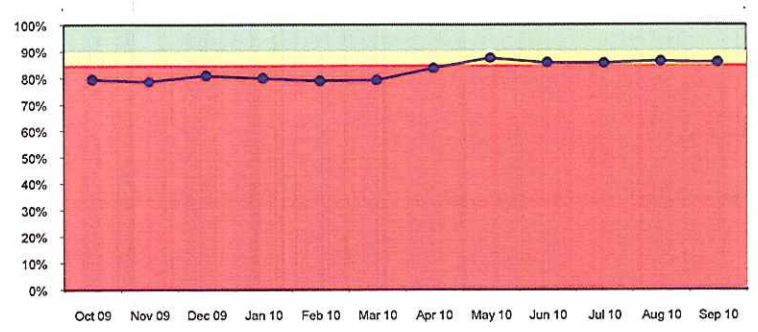
Percentage of staff who have had an appraisal in last 12 months								Workforce - Capability			< 75%	75 - 90%	≥ 90%
	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	12 mths
PDRS	86.9%	84.6%	82.6%	81.5%	80.8%								80.8%

At August 2010, 80.78% of eligible staff had completed an appraisal within the last 12 months which is a slight decrease from July (81.48%). All Divisions now are outside of the Trust target of 90% with the lowest percentages in Corporate (77.98%), Division 3 (78.92%) and Division 4 (78.19%).
Process mapping has commenced on the Learning and Development System which will enable managers and staff to complete their appraisal on-line and view their compliance in line with their responsibilities; this is due to go live in April 2011. Automated e-mails to managers are sent out by Informatics where the appraisal is overdue or due in the next 3 months. In addition Directors of Operations are to have access to a workforce dashboard where they will be able to review all out of date staff. It is envisaged that this should lead to increased performance in future months.



Mandatory Training								Workforce - Capability			< 85%	85-90%	≥ 90%
	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	Latest
% Trained	83.6%	87.4%	85.7%	85.5%	86.2%	85.8%							86.2%

As at 30 September 85.8% of staff had completed fire training within the last 12 months. The Divisions continue to receive lists of all out of date staff to allow them to ensure that all staff receive this training on an annual basis. In addition the Learning and Development puts on regular mandatory training days for clinical and non-clinical staff which contain up to four types of mandatory training.
The Learning and Development Department is currently mapping the requirements for the different types of mandatory training to different staff groups across the Trust. This will be used to measure performance for other types of mandatory training in future months. This is expected to initially lead to a significant drop in the percentage of staff who are fully trained but this should improve once this information is available to managers to allow them to ensure that their staff have received all required training.



APPENDIX B

DNA rate								Efficiency - Process			>15%	9-15%	<9%
	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
New	10.2%	11.0%	11.7%	10.9%	11.4%								11.0%
Follow-up	9.9%	9.9%	10.7%	10.0%	10.6%								10.2%

The DNA rate for new appointments rose from 10.9% in July to 11.4% in August and for follow-ups from 10.0% to 10.6%. The actual number of DNAs fell from 1346 to 1325 for new appointments and from 3831 to 3178 for follow-ups. The rise in the percentage was therefore caused by a fall in activity in August. The overall year to date rate stands at 10.2%. Action taken includes:

a) The Taskforce, chaired by the Director of Operations, Division 5 continues to meet fortnightly.

b) The Group has analytically reviewed the data and have broken down the data by specialty and clinic code. The group has drilled down on the data to understand the percentages in terms of actual numbers of DNAs and to identify the hotspots within each Division.

c) Specialties have been agreed target numbers of DNAs rather than percentage rates; this will ensure that specialties with high numbers of DNAs (and not necessarily a high %) will also contribute to reducing the overall rate.

d) The DNA algorithm project has been rolled out to ENT, Trauma and Maxillofacial Surgery from August 2010.

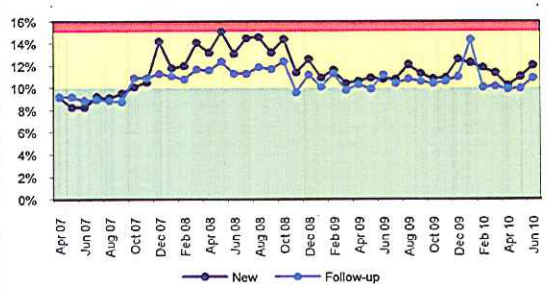
e) The use of interactive text messaging whereby the patient can reply to the reminder SMS to say whether or not they are going to attend the appointment is being explored.

f) Telephony has been audited and this shows that telephone call pick-up rates in some clinics is poor. This means that patients who are trying to telephone to cancel their appointments may not be able to contact the Trust. Therefore, the use of e-mail for patients to confirm or to cancel their appointments is also being investigated as a possible pilot.

g) The introduction of partial-booking is currently being scoped to reduce DNAs for long-term follow-ups.

h) Each division has now submitted an action plan to achieve reduction in DNA rates. DNA rates are now being monitored on a weekly basis and the fortnightly meetings are scheduled to continue until December.

The objective of the Task and Finish Group is to see the new 9% target delivered on a monthly basis from January 2011.



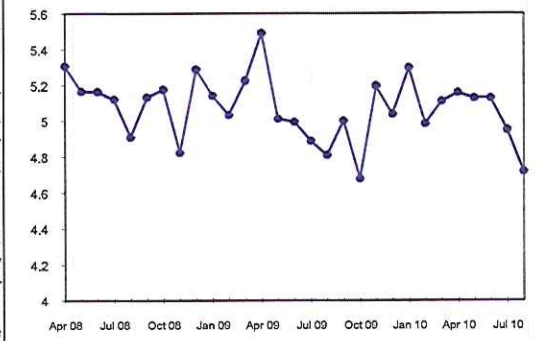
Length of Stay								Efficiency - Process			Thresholds to be agreed		
	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
AVLOS	5.16	5.13	5.13	4.95	4.72								5.00

Overall length of stay fell across the Trust in August from an average of 4.95 days in July to 4.72 days. Length of stay fell in Aggregations 1 (Cardiac Surgery, Cardiology & Vascular Surgery) from 5.42 to 4.91 days, 3 (Urology, Renal Medicine & Surgery) from 5.54 to 5.35 days, 4 (Burns & Plastics, Maxillofacial, ENT & Trauma) from 5.13 to 5.00 days and 6 (Multispecialty Medicine) from 5.90 to 5.50 days.

Aggregation 2 (General Surgery, GI Medicine & Surgery and Liver Medicine & Surgery) saw its average length of stay increase from 5.32 to 5.43 days. There was a significant fall in activity from 861 to 764 episodes which accompanied this increase caused by lower elective activity due to the summer holiday. The overall RVU score for the aggregation fell slightly from 2.20 to 2.13. As from September 75% of liver transplant assessment will take place in the outpatient setting. Other work within the aggregation to reduce length of stay is primarily focussed on reducing pre-operative length of stay including increasing the number of admission trolleys.

Within Aggregation 5 (Neurology, Neurosurgery, Ophthalmology & Stroke) the average length of stay rose from 6.18 days in July to 6.89 days in August. A particular increase in length of stay was seen in Stroke Medicine which saw length of stay increase to 6.23 days in August from 3.25 days in July. Stroke activity was relatively low in August which allowed a longer length of stay which also contributed to improved performance against the 90% length of stay target.

Aggregation 7 (Oncology, Haematology, Breast and Pain) saw average length of stay increase from 5.48 to 5.61 days. The average RVU score in the aggregation rose from 1.86 to 2.16 and activity fell from 424 to 361 episodes. Clinical Haematology saw a high level of transplant activity in August which led to a significant increase in both length of stay from 7.32 to 8.53 and RVU score from 1.83 to 2.23. Breast Surgery also saw an increase in the complexity of work, reflected in an increased average RVU score from 1.92 to 2.20 and increased length of stay from an average of 3.45 to 4.68 days.

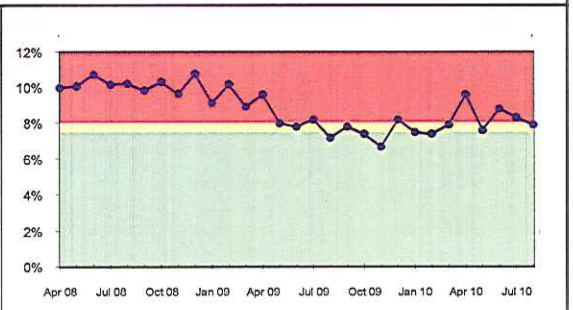


APPENDIX B

Follow-up outpatient appointments cancelled by UHB	Patient Experience	≥ 8%	7.5%-8%	< 7.5%

	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
Follow-up	9.6%	7.6%	8.8%	8.3%	7.9%	8.7%							8.5%

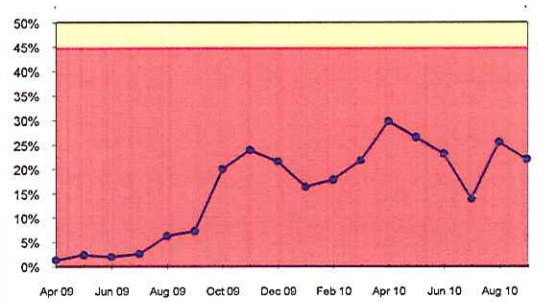
Cancellations of follow-up outpatient appointments fell from 8.3% in July to 7.9% in August and rose again to 8.7% in September. Year to date performance currently stands at 8.5%.
The Task and Finish Group continues to meet fortnightly. The new pathway for cancellations has now been agreed and circulated to Divisional Directors of Operations to ensure that cancellations in future are appropriately managed. The new definition for this indicator is expected to be agreed by the end of October and future performance will be reported using this definition. The new definition will focus on the inconvenience caused to patients by rearranged appointments with the aim of increasing patient satisfaction. It is also planned to look at the number of patients whose appointment was rearranged on more than one occasion so that multiple changes can be minimised.



Electronic Patient Survey Response Rate	Patient Experience	< 45%	45 - 50%	≥ 50%

	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	Latest
% Response	29.9%	26.7%	23.3%	14.1%	25.7%	22.1%							22.1%

Patient feedback rose from 14.1% in July to 25.7% in August but fell back to 22.1% in September. Division 4 continues to be the only Division with greater than 50% feedback. The re continued to be an increased focus on patient feedback following the first move to QEHB and the recruitment of additional volunteers to assist patients in feeding back which should increase the response rate in future months. Additional wards have now had bedside TVs installed and additional volunteers have been recruited to support patients in completing the survey.

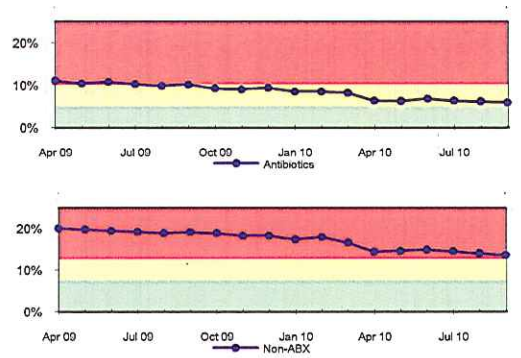


APPENDIX B

Omitted drugs - Antibiotics Omitted drugs - Non-antibiotics	Patient Safety	> 10% > 12.5%	5-10% 7.5-12.5%	≤ 5% ≤ 7.5%

	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
Antibiotics	6.3%	6.2%	6.8%	6.3%	6.1%	5.9%							6.3%
Non-ABX	14.4%	14.6%	14.9%	14.5%	14.0%	13.6%							14.3%

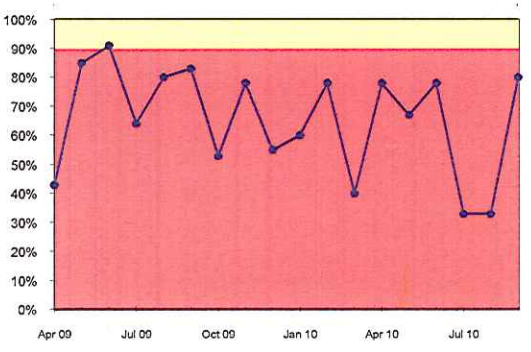
The percentage of both omitted antibiotic and non-antibiotic doses continued their downward trends in August and September. The percentage of omitted antibiotic doses fell to 5.9% in September and the percentage of omitted non-antibiotic doses also fell to 13.6%.
At the October Root Cause Analysis meeting a number of actions to reduce the number of omitted doses were identified. An audit of nursing practice is to take place of painkillers as it is felt these are often not prescribed as PRN by medical staff for fear that nursing staff will not offer them to patients. There are ongoing problems with the reasons for omissions sometimes being recorded incompletely and nil by mouth being used as a reason for omission inappropriately. Nursing staff are to be reminded of the need to raise patient refusals with medical staff after 2 refusals to, for example, change the drug route. Medical staff need to increase the use of the pause button, particularly post-operatively, when patients may not require certain drugs to be given in the early post-operative phase. Both consultants and junior doctors need to ensure that drug charts are being appropriately reviewed and changed daily in PICS to reflect decisions made on ward rounds. Pharmacists need to have greater role in checking and querying potentially unsuitable prescriptions e.g., via inappropriate route or when there is a national supply issue for a drug.
The implementation of these changes is expected to lead to a further reduction in omitted doses.



Non-emergency mortality audit response rate	Patient Outcomes	< 90%	90-100%	100%

	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
Non-Em Mortality	78.0%	67.0%	78.0%	33.0%	33.0%	80.0%							65.9%
Forms sent out	9	6	9	6	6	5							41
Forms completed	8	4	7	2	2	4							27

Completion of non-emergency mortality surveys for the year to date has increased from 45.0% at the last report to 65.9%. Additional reminders to consultants of uncompleted surveys have been sent out and Divisional Directors have received a list of all outstanding surveys to allow them to ensure that these are completed.
It has been decided to cease the readmissions audit in its current form. In future the discharging and readmitting consultant will still receive notification of a readmission to allow them to co-operate in the patient's care, if appropriate, but they will not be required to complete an audit. To allow the linking of discharging and readmitting diagnoses an audit will carried out by Clinical Governance after the readmission episode is coded. Cases will only be audited in future where there is a link between the diagnoses based on ICD10 code. It is expected that by only examining linked diagnoses the number of cases that need to be audited will be reduced by at least two thirds.



Appendix C

CQC Benchmarking Comparative Tool

Background to Benchmarking

As detailed in the July 2010 Performance Indicators Report, following the publication of the revisions to the NHS Operating Framework for 2010/11 the CQC agreed with the Government that further work should halt on the Periodic Review of NHS organisations for 2009/10. The CQC instead agreed to publish benchmarking data for 2009/10 for a subset of the indicators in the NHS Operating Framework relating to providers. The CQC will not publish aggregated scoring for trusts in 2009/10 or 2010/11.

The 2009/10 benchmarking tool was published on 15 October 2010 and is intended to help trusts to identify how their performance compares with that of other trusts and decide which areas they should prioritise for improvement. The CQC has published data on most national commitment and national priority indicators for acute and specialist trusts. Due to the nature of the construction of some indicators or the spread of the data values nationally some indicators are unsuitable for benchmarking. In these instances, CQC has decided either to exclude the indicator from the benchmarking report or to only show the actual trust data values.

Results

The results of all the indicators the CQC has published for UHB's performance in 2009/10, including those for which it has undertaken benchmarking, are shown in Table 1 below. There are three indicators where UHB's performance was significantly different from the expected (i.e. average national performance). These were 2 week waits for breast symptoms where performance was much better than expected, the percentage of cancelled operations not treated within 28 days which was better than expected and 62 day cancer waits from consultant upgrade to treatment which were worse than expected.

The Trust achieved all indicators for which thresholds were published before the CQC stopped development on Periodic Review with the exception of Delayed Transfers of Care. For the remaining indicators UHB's performance in 2009/10 was in line with the national average with the exception of 62 day consultant upgrades. At present the DH has still to set an operational standard for this indicator therefore the CQC would not have been able to set a threshold for 2009/10. It is therefore likely that this indicator would have been excluded from any scoring of trusts for 2009/10. Consequently the Trust would have probably scored Excellent for both the National Commitments and National Priorities in 2009/10 had Periodic Review not been discontinued.

Appendix C

Table 1: 2009/10 UHB Performance against National Indicators and Z-Scores

Indicator	UHB 2009/10 performance*	UHB rank of all included trusts	Number of trusts included	Z score	Best performance nationally	Worst performance nationally
A&E waiting times	98.64%	44	154	Not benchmarked	99.98%	96.06%
Rapid access chest pain clinic waiting times	100.00%	1=	148	Not benchmarked	100.00%	96.02%
Cancelled operations - Percentage of operations cancelled	0.64%	46	165	1.00	0.09%	1.97%
Cancelled operations - Percentage of cancelled ops not treated within 28 days	0.00%	1=	165	1.90	0.00%	16.82%
Delayed transfers of care	3.67%	126	162	-0.85	0.00%	10.93%
Inpatients waiting longer than the 26 week standard	0.00%	1=	167	Not benchmarked	0.00%	2.06%
Outpatients waiting longer than the 13 week standard	0.00%	1=	167	Not benchmarked	0.00%	0.31%
Ethnic coding data quality	92.13%	86	166	0.17	100.00%	43.09%
Patient experience	372.01	109	162	-0.70	429.75	342.81
Clostridium difficile infections	179 against trajectory of 348	83	167	Not benchmarked	0 against trajectory of 4	12 against trajectory of 10
MRSA Bacteraemia	13 against trajectory of 32	120	167	Not benchmarked	0 against trajectory of 5	3 against trajectory of 0
Quality of stroke care	64.61%	60	147	0.36	95.68%	0.00%
18 week referral to treatment times - Admitted patients	95.31%	37	167	Not benchmarked	100.00%	83.92%
18 week referral to treatment times - Non-admitted patients	98.01%	72	167	Not benchmarked	99.73%	88.78%
Cancer diagnosis to treatment waiting times - 31 day first treatments	97.44%	133	162	-0.69	100.00%	90.97%
Cancer diagnosis to treatment waiting times - 31 day subsequent surgery	96.57%	98	143	0.09	100.00%	86.16%
Cancer diagnosis to treatment waiting times - 31 day subsequent chemotherapy	99.05%	101	116	-0.99	100.00%	95.91%

Appendix C

Indicator	UHB 2009/10 performance*	UHB rank of all included trusts	Number of trusts included	Z score	Best performance nationally	Worst performance nationally
Cancer urgent referral to first outpatient appointment waiting times - GP referral	94.55%	91	154	-0.24	100.00%	89.76%
Cancer urgent referral to first outpatient appointment waiting times - Breast symptoms	98.63%	11	138	2.11	100.00%	32.47%
Cancer urgent referral to treatment waiting times - GP	85.36%	113	155	-0.36	99.13%	72.10%
Cancer urgent referral to treatment waiting times - Screening	92.61%	91	122	-0.41	100%	76.60%
Cancer urgent referral to treatment waiting times - Consultant upgrade	85.68%	94	104	-1.92	100.00%	66.67%
Access to healthcare for people with a learning disability	21	20=	167	Not benchmarked	24	7
Staff satisfaction	3.51	64	167	0.52	3.68	3.28

*** Key for Performance (where threshold known prior to discontinuation of Periodic Review):**

Target met	Target underachieved	Target not met

† Key and Explanation for Z-scores

UHB much worse than expected performance	UHB worse than expected performance	UHB in line with expected performance	UHB better than expected performance	UHB much better than expected performance

For the majority of the indicators shown in the report both the actual data values (numerator, denominator and percentage value) and standardised scores (z scores) are shown. Z scores show how the performance of an individual trust against a specific indicator differs from an expected level of performance, as measured in standard deviations. The CQC has set the expected level of performance as the average performance of all the organisations measured against each indicator.

For this benchmarking, the closer a z score is to 0, the closer it is to the average performance. Positive z scores represent performance that is above the expected level of performance and negative z scores represent performance that is below the expected level. Where a z score is not between -1.6 and 1.6, the CQC has deemed the trust's performance against the indicator to be either 'worse than' or 'better than' the expected range of performance. Z scores that do not fall between -2 and 2 are considered either 'much worse than' or 'much better than' expected.

Indicators that were due to be scored using CQC's published statistical banding methodology (Patient Experience, Staff Satisfaction, MRSA and C. difficile) have been benchmarked according to that methodology. The CQC has not currently published details of trusts' performance in the Primary PCI element of the reperfusion indicator.