**AGENDA ITEM NO:**

# UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
# BOARD OF DIRECTORS
# TUESDAY 7 SEPTEMBER 2010

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

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| **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:<br>• *Clostridium difficile*<br>• A&E 4 hour waits<br>• Primary PCI<br>• 62 Day Cancer – GP referral & screening referral<br>• Delayed Transfers of Care<br>• Quality of Stroke Care<br>• External agency spend<br>• Length of Stay<br>• Theatre list utilisation<br>• Cancelled follow-up outpatient appointments<br>• Slot unavailability<br>• Electronic Patient Survey response rate<br>• Omitted drugs<br>• Readmission & non-elective mortality audit response rates<br>Further details and action taken are included in Appendix B. |
| **Recommendations:** | The Board of Directors is requested to:<br>**Accept** the report on progress made towards achieving performance targets and associated actions. |

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| **Signed:** | **Date:** 19 August 2010 |

# UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

# BOARD OF DIRECTORS

# TUESDAY 7 SEPTEMBER 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. Post-48 hour *Clostridium difficile* cases are above threshold for July and the year to date. Performance against the A&E 4 hour wait target was below the internal threshold of 98% and is therefore considered an exception. Primary PCI, although above target in June, is still below target for the year to date therefore an exception report is included. The 62 day GP referral and referral screening targets are below threshold for the year to date and delayed transfers of care are above the threshold for both July and the year to date therefore exception reports are included for these indicators. Performance in July was low for both elements of the Quality of Stroke care indicator therefore this indicator is also included as an exception.

With regard to internal targets the exception report this month, in addition to containing reports for those internal indicators that are currently red, includes reports for theatre list utilisation which has been amber for three consecutive months and DNAs which is currently a focus area for performance improvement. Exception reports and monthly data are included Appendix B. The following internal targets are considered exceptions:

a) External agency rate
b) DNAs
c) Length of Stay
d) Theatre list utilisation
e) Cancelled follow-up outpatient appointments
f) Slot unavailability
g) Electronic Patient Survey response rate
h) Omitted non-antibiotic doses
i) Readmission & non-emergency mortality audits response rates

2.1 Clostridium difficile

There were 20 post 48 hour C. diff cases in July which is above the trajectory of 13.66 to meet the full year trajectory of 164. There have been 77 cases in the year to date. Please refer to the Chief Nurse's Infection Control Report for further details and action taken.

Performance has improved in August with only 8 cases as at 24 August. Based on performance to that date, a straight line extrapolation forecasts that the Trust could expect around 189 cases by year end. This would equate to being 15% above the expected trajectory, and the PCT could invoke the non-negotiable financial penalty for failure of the C.difficile trajectory.

As referenced in the Trust's Annual Financial Plan for 2010/11 received by the Board of Directors in April 2010, this penalty equates to 0.1% of total contract year revenue for each 1% by which the trust underachieves the target with a cap at 2% of total contract year revenue. A trajectory of 189 cases, based on extrapolated current performance, would affect 1.5% of the Trust's contract income for the year. This is a recognised risk which is being mitigated by the actions identified within the Chief Nurse's Infection Control Report. These actions will continue to improve on the current performance, and aim to bring the Trust back to the trajectory agreed. In order to do this the Trust must have an average of 11 or fewer cases per month for the remainder of the financial year.

2.2 A&E 4 hour waits

Performance in July was below the internal threshold at 96.35% taking year to date performance to 97.15%; it is however above the Government's new threshold of 95%. The median total wait which has been proposed by the Government as a replacement measure was 2 hours 52 minutes in July, a 4 minute increase on June's performance.

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 from August 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 A&E are identifying actions required to increase the speed of decision-making and to increase acute medical support in the Emergency Department.

d) Referral pathways for specialty patients are to be refined to ensure patients are reviewed in a timely manner – meetings with CSLs to take place in September.

e) Two and a half replacement consultant posts were proposed at CEAG in August. Proposals in this paper also included the reallocation of resources from junior medical staff to consultants to increase the availability of senior medical staff to make decisions by increasing their number and therefore the amount of time spent on the 'shop floor' are being refined.

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

g) Education and training for junior medical staff is focussed 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. Based on activity figures for August 2009 to March 2010 performance will need to be 98.45% for the remainder of the year if the full year is to exceed 98%.

2.3 Primary PCI

75% of Primary PCI patients in June 2010 had a call to balloon time of less than 150 minutes. Year to date performance is 72.2% due to lower performance in April.

Higher performance continues following the co-location of A&E and the catheter labs on the same site since move I. Performance is expected to increase further when Cardiology moves to the QEHB in January 2011 and patients can be taken directly to the catheter labs, bypassing the Emergency Department.

If performance continues to be above target on a monthly basis YTD performance is likely to be above target by September 2010 and will improve further from January 2011.

2.4 62 day cancer targets

86.0% of urgent GP referrals and 77.8% of referrals from screening were treated within 62 days of referral in June against the targets of 85% and 90% respectively.

With regard to the 62 day target NHS South Birmingham has asked NHS Birmingham East & North, as Heart of England NHS Foundation Trust (HEFT)’s co-ordinating commissioner, to raise a formal contract query with HEFT to understand the reasons for the late referrals the Trust has been making to UHB. Although a significant percentage of

the breaches continue to be for late tertiary referrals from other trusts as well as other reasons outside the Trust's control such as patient choice and medical reasons, the Trust is taking the following actions to improve performance:

a) A Task and Finish Group, meeting twice monthly, led by the Director of Operations for Division 4, has been established to identify internal steps that could be taken to improve performance. This Group and its subgroups for pathways, roles and responsibilities and information have met for the first time.

b) Root Cause Analysis (RCA) is now undertaken for all breaches to identify the reason why the breach occurred and whether any action could have been taken to prevent it.

c) RCAs undertaken to date have identified problems with the escalation of diagnostic delays and with the tracking of patients between tumour sites and when they are referred to another Trust. Roles and responsibilities in these situations have been clarified to ensure patients are tracked effectively and action cards will be available for group managers, group support managers and pathway co-ordinators in September.

d) As part of the work on pathways diagnostic delays for imaging and labs are being investigated. Internal targets for these areas will be set by the end of September.

e) 5.5WTE additional patient pathway support co-ordinators have been recruited and will be in post in by the end of September. These posts will support the pathway co-ordinators in tracking patients along pathways and provide cover for leave.

f) The Trust continues to actively pursue the reallocation of breaches resulting from late referrals. A single reallocation has been accepted to date by South Warwickshire NHS Foundation Trust. A further four reallocations are outstanding and these have now been escalated to Board level for resolution.

Based on the average monthly activity of 51 cases seen in April to June, performance of 86.2% for July to March would be required to meet the target for the full year 2010/11. Performance for the screening target will need to be above 91.7% for rest of the year to meet the target for the full year. Further improvement will therefore be needed if the Trust is to meet the targets for the full year. Experience from previous years shows that performance in September and January is likely to be affected by the summer and Christmas holidays therefore performance in other months will need to compensate with higher performance if the Trust is to achieve the targets over the full year. If the Trust does not meet the 62 day targets overall for the period July to September it will be the third consecutive quarter that they will have

been declared as a risk to Monitor and consequently the Trust will receive a 'Red' rating for Governance.

July performance for GP referrals as at 24 August stands at 85.5% (9.5 breaches) and screening at 75% (1 breach) however additional validation has still to take place before these figures are uploaded in early September. The figure for GP referrals may therefore improve further however it is unlikely that the screening percentage, resulting from a single breach, will change.

2.5 Delayed Transfers of Care

Delayed transfers of care rose in July to 5.0% with 238 patients delayed over the month. Year to date performance is 4.6%. The following actions are in place to improve future performance:

a) East 2B continues to be open as a delayed discharge ward. The processes for both moving patients from acute wards to E2B to maximise acute capacity and also to prioritise discharge for patients on that ward now seem to be working well.

b) Regular meetings with both Birmingham Social Services and NHS South Birmingham continue to take place.

c) A South Birmingham Quadrant Discharge Group has been established to examine and redesign pathways and focus on partnership working. This Group will meet on a monthly basis.

d) In discussion with Social Services it has been established that sufficient capacity has been commissioned to be able to provide care for patients whose discharge is delayed, it is the processes of arranging care packages and obtaining funding that are leading to delays. Social Services is therefore investigating what is causing these delays and working to streamline processes. The Director of Partnerships has been meeting with senior staff at the City Council to resolve these issues.

f) The Director of Partnerships and Chief Operating Officer are also attending the Health & Adults Overview and Scrutiny Committee on 29 September as part of its scrutiny review of delayed discharges which has just commenced.

A number of patients with extremely delayed discharges have now been discharged or have discharge dates identified. Although delayed discharges continue to occur the processes are leading to a reduced length of stay on E2B.

In the second week of August delayed discharges were reduced by 20% compared to July and over half the patients on E2B were discharged. If Social Services can also improve its processes future

months will see improved performance. However, on current activity, performance would need to be below 2.9% for the remainder of the year for the Trust to hit the target of 3.5% for the full year 2010/11. Based on current performance, the limited influence UHB has to directly improve performance and the lack of progress made in reducing delayed discharges achievement of the target for the full year is unlikely.

2.6 Stroke

In July 48.5% of stroke patients spent greater than 90% of their length of stay on the Stroke Unit taking year to date performance to 52.1%. April to June figures now include length of stay on the Rehabilitation Stroke Unit at Moseley Hall Hospital.

There was only one patient referred to the Trust as a high-risk TIA to be treated as an outpatient in July. There was insufficient clinic capacity available to see the patient within 24 hours therefore the Trust's performance in July was 0%.

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.

b) All stroke patients outlying the Stroke Unit are now flagged at the 9am bed meeting as a priority to be moved to the Stroke Unit. The status of the 2 stroke admission beds on Stroke Unit is also checked to ensure they are not occupied by a non-stroke outlier.

c) From August patients whose discharge was delayed have been moved off the Stroke Unit to E2B as their acute episode was completed to ensure there is sufficient capacity for new admissions and this will be accounted for in the vital signs data return.

d) The Stroke Co-ordinators will be present on the Clinical Decision Unit from early September to identify stroke patients and facilitate their rapid transfer to the Stroke Unit.

e) An outline business case for a second stroke consultant has been developed for COOG in September. Alongside this post direct GP admissions to the stroke unit and 7 day a week TIA clinics should be implemented.

f) From August if there is insufficient clinic capacity available to see a high risk TIA patient within 24 hours of referral they are seen as an outpatient on the Stroke Unit. Performance has been 100% in August for this measure.

The Trust is contractually required to have 74.2% of patients spending 90% of their length of stay on the stroke unit in Quarter 2 2010/11. Based on current average monthly activity of 36 patients per month, performance of 87.5% would be required in August and September for the Trust to achieve this requirement for the quarter. Ongoing improved performance against the stroke length of stay element should be seen when the second stroke consultant is in post.

## 3. 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**

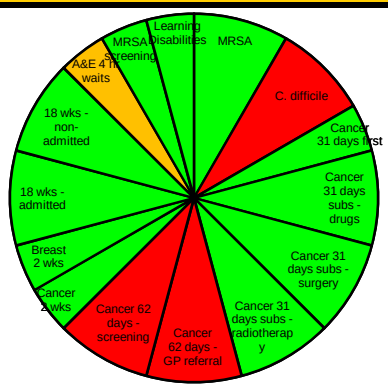
University Hospitals Birmingham NHS
NHS Foundation Trust

# 2010/11 Key Performance Indicator Report

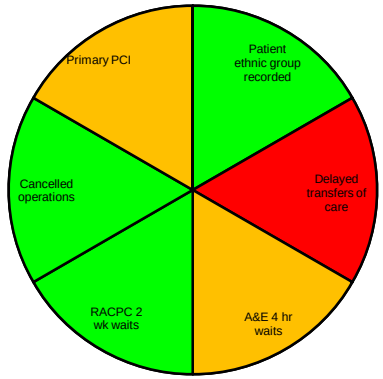
Where data is not currently available indicator names are in italics. These have been assigned 'amber' unless considered high risk where they have been assigned 'red'.

## National Performance

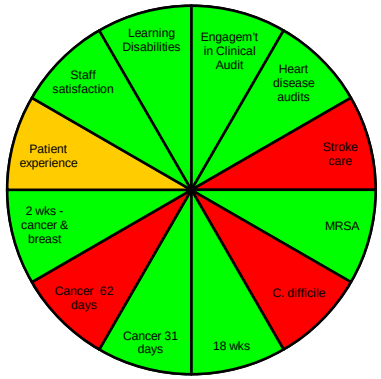
### Monitor Governance Rating



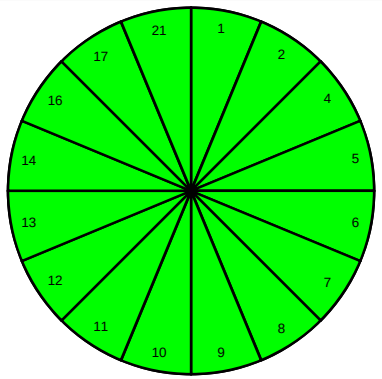

### Care Quality Commission Existing Commitments




### Care Quality Commission National Priorities

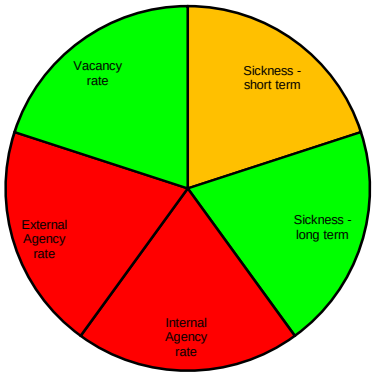



### Registration Outcomes

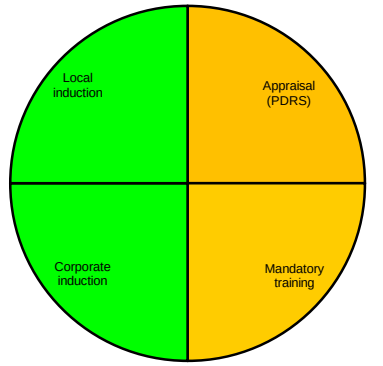



## Workforce

### Resources

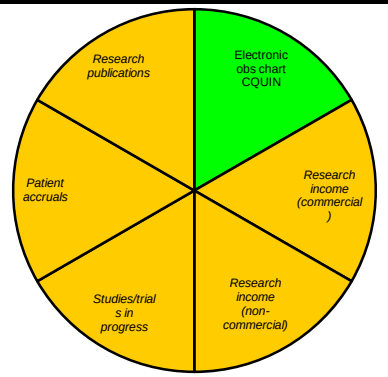



### Capability

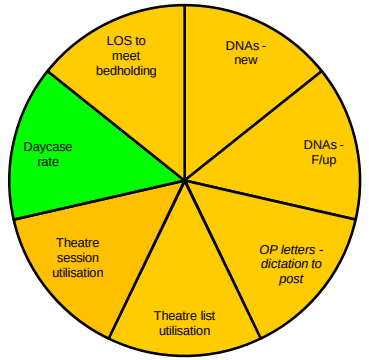



## Efficiency

### Innovation




### Process




27 August 2010

**APPENDIX A**

University Hospitals Birmingham NHS
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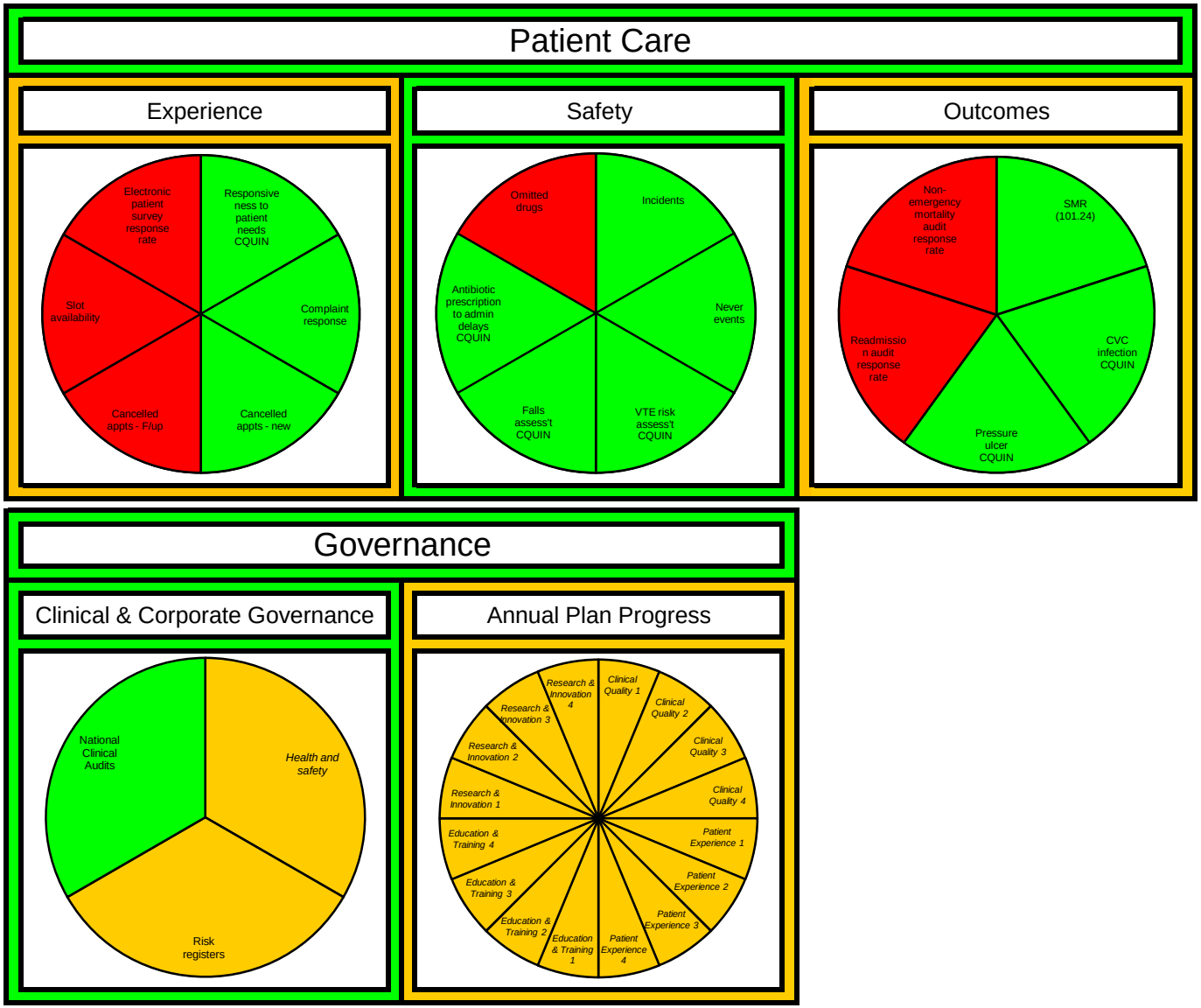
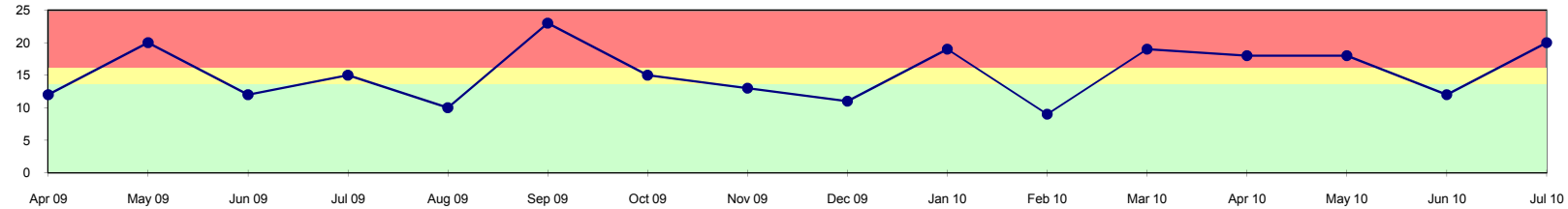


**APPENDIX B**

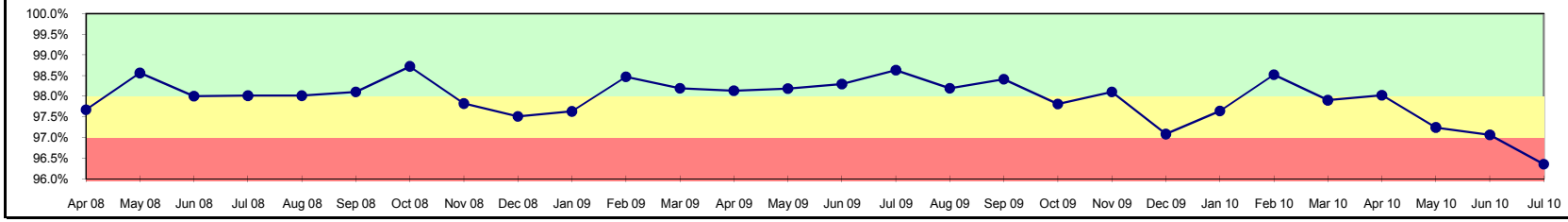
| *C. difficile* - Post 48 hour cases | Monitor & CQC National Priorities | > 193 | ≤ 193 | ≤ 164 |
|---|---|---|---|---|

| | 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 | | | | | | | | | **68** |



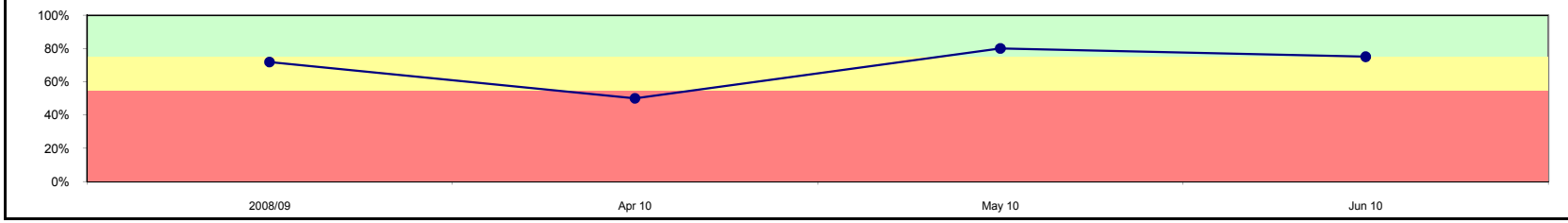

| A&E 4 hour waits | Monitor & CQC Existing Commitments | < 97% | 97-98% | ≥ 98% |
|---|---|---|---|---|

| | 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 | 98.02% | 97.24% | 97.06% | 96.35% | | | | | | | | | **97.15%** |




| 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% | 80.0% | 75.0% | | | | | | | | | | **72.2%** |



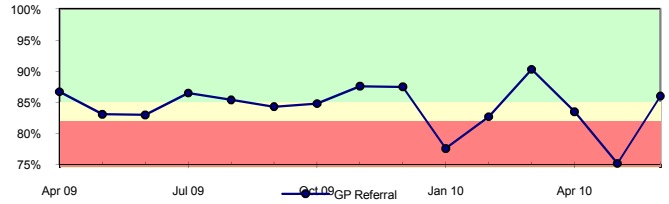
**APPENDIX B**

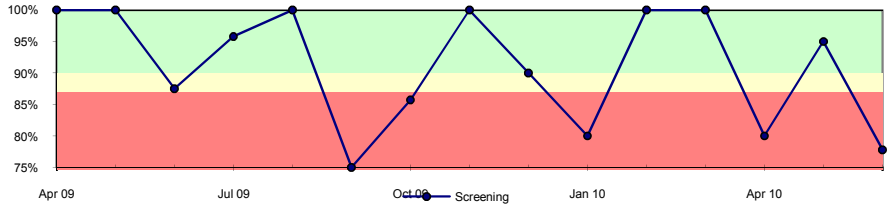
## 62 Day Cancer

**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% | 75.9% | 86.0% | | | | | | | | | | **81.6%** |
| **Screening** | 80.0% | 95.0% | 77.8% | | | | | | | | | | **86.4%** |

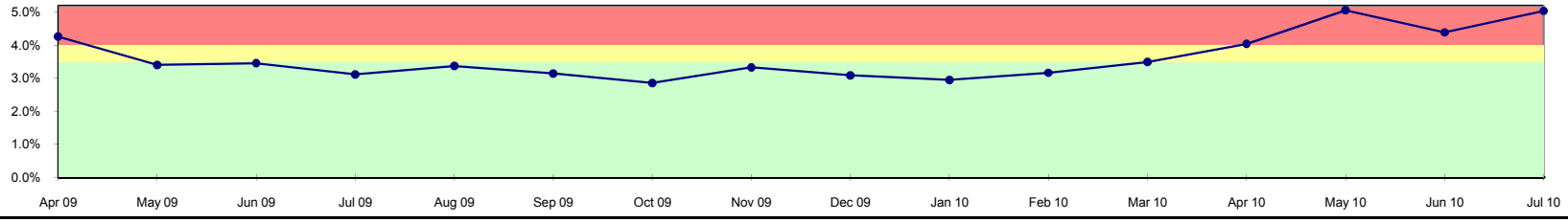



## Delayed Transfers of Care

CQC Existing Commitments | > 4.0% | ≤ 4.0% | ≤ 3.5%

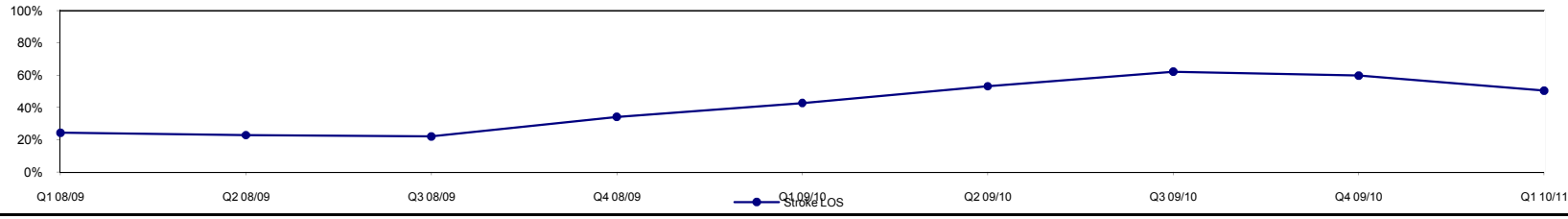
| | Apr 10 | May 10 | Jun 10 | Jul 10 | Aug 10 | Sep 10 | Oct 10 | Nov 10 | Dec 10 | Jan 11 | Feb 11 | Mar 11 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **DToC** | 4.04% | 5.06% | 4.39% | 5.04% | | | | | | | | | **4.63%** |




## 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% | 48.6% | | | | | | | | | **52.1%** |
| **TIA** | 42.9% | | | 0.0% | | | | | | | | | **40.0%** |



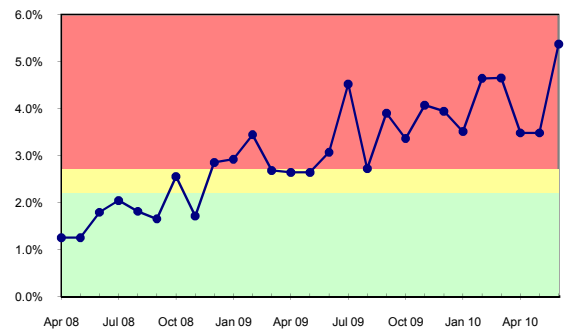
**APPENDIX B**

| Percentage of total staff costs spent on agency 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Agency % | 3.48% | | 5.37% | 5.71% | | | | | | | | | 4.12% |

The percentage of staff costs spent on external agency rose to 5.71% in July. Year to date spend stands at 4.52%. Internal agency spend fell from 3.40% in June to 3.21% with year to date spend at 3.37%. There continue to be significant costs associated with locum medical staff in Divisions 3 and 5 and also nursing agency in Division 3.

Both internal and external nursing agency spend is high in Division 3 due to the opening of additional beds on the Clinical Decision Unit and also the staffing of the delayed discharge ward on E2B. Action being taken to reduce length of stay and delayed discharges should eventually lead to a reduction in the need for agency in these areas. In Division 5 there have been two locum consultant dermatologists in post; one substantive has now been appointed and is starting in September. A substantive appointment has also been made to a locum Associate Specialist post covering the Orthopaedic Assessment and Treatment Service in the community. There have been 8 Junior Doctors vacancies across Trauma, Burns and Plastics and Vascular since April filled by locums. Pending clearances it is expected that this will be reduced to 2 by September 2010. There are also plans to recruit to two additional SpRs, one for Trauma and one for Burns and Plastics to cover any gaps on the rota and therefore reduce the requirement for external locums. It is expected that these actions should lead to reduced agency spend from Quarter 3.




| 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% | 11.1% | | | | | | | | | 11.0% |
| Follow-up | 9.9% | 9.9% | 10.7% | 10.1% | | | | | | | | | 10.2% |

The DNA rate for new appointments fell from 11.7% in June to 11.1% in July and for follow-ups from 10.7% to 10.1%. The overall year to date rate stands at 10.2%. Action taken includes:

a) A fortnightly Task and Finish Group has been established, chaired by the Director of Operations, Division 5. This will have its first meeting on 1 September.

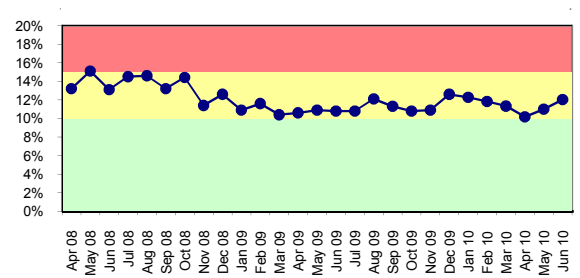
b) Preparatory work by the Group has focussed on the collection and processing of DNA data with the aim of improving data quality by October 2010.

c) Specialties are to be given target numbers of DNAs rather than percentage rates; this will ensure that specialties with high numbers of DNAs (and not necessarily a high rate) which contribute most to the Trust rate must 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.

A new internal target for DNAs of 9% has been set and the objective of the Task and Finish Group is to see this delivered on a monthly basis from January 2011.



**APPENDIX B**

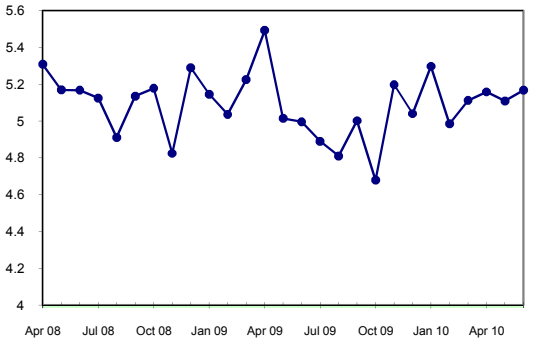
| Length of Stay | | | | | | | | Efficiency - Process | | | Thresholds to be agreed | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr 10 | May 10 | Jun 10 | Jul 10 | Aug 10 | Sep 10 | Oct 10 | Nov 10 | Dec 10 | Jan 11 | Feb 11 | Mar 11 | YTD |
| AVLOS | 5.22 | 5.11 | 5.17 | | | | | | | | | | 5.17 |

Overall length of stay fell across the Trust in July from an average of 5.15 days in June to 5.10 days. Length of stay fell in Aggregations 3 (down from 6.37 to 5.53 days), 5 (from 7.79 to 6.19 days), 6 (from 4.29 to 4.15 days) and 7 (from 5.90 to 5.50 days).

Aggregation 1 (Cardiac Surgery, Cardiology & Vascular Surgery) saw length of stay increase from 5.72 days in June to 6.21 days in July. Both Cardiothoracic Surgery and Vascular Surgery saw significant increases in length of stay in the month, however the complexity of patients treated during July compared to June was significantly higher. In addition Cardiac Surgery saw a number of patients with very long lengths of stay discharged in July whose entire length of stay would have been attributed to the month. Within Cardiac Surgery the focus is on improving efficiency to reduce length of stay and Vascular Surgery has been working to improve pre-assessment to reduce pre-operative length of stay.

Aggregation 2 (GI Medicine & Surgery, Liver Medicine & Surgery and General Surgery) saw its average length of stay increase from 4.68 to 5.67 days however a the case mix was more complex. Liver Medicine saw a number of patients with long lengths of stay discharged in the month. Liver Surgery and General Surgery both had a more complex case mix than in June. Liver continues to expand outpatient transplant assessment; currently 50% of assessments are done in an outpatient setting but from September this will increase to 75%. Two beds on West 3 Liver Unit have been replaced by admission trolleys to facilitate admission on the day of surgery.

Within Aggregation 4 (Burns & Plastic Surgery, ENT, Maxillofacial and Trauma) the average length of stay rose from 5.15 days in June to 5.44 days in July. Increased length of stay was seen in Plastic Surgery and Maxillofacial Surgery. Both specialties saw an increase in complexity, particularly in Maxillofacial. With the move to the New Hospital Maxillofacial Surgery has a reduced number of inpatient beds and has transferred a large percentage of activity to Ambulatory Care. As it is the most complex work that has remaining inpatient a rise in both complexity and length of stay for the activity included in the indicator, which excludes ambulatory care, was expected.

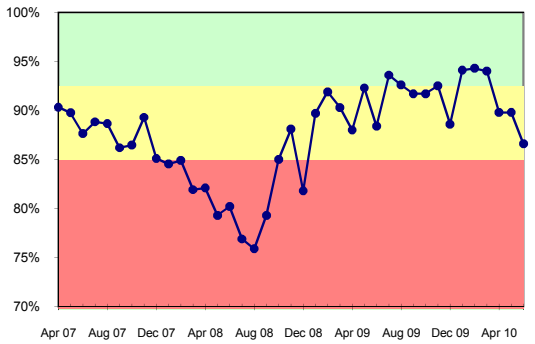



| Theatre list utilisation | | | | | | | | Efficiency - Process | | | <85% | 85-92.5% | ≥92.5% |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr 10 | May 10 | Jun 10 | Jul 10 | Aug 10 | Sep 10 | Oct 10 | Nov 10 | Dec 10 | Jan 11 | Feb 11 | Mar 11 | YTD |
| Lists used | 89.8% | 89.8% | 86.6% | | | | | | | | | | 88.6% |

Theatre list utilisation in June 2010 was 86.6% which reduced the year to date performance to 88.6%.

Performance was affected by the move to the New Hospital; although the closures of theatres to allow them to move have been accounted for in the figures some specialties cancelled lists around the time of the move to facilitate the inpatient move and this led to a reduction in utilisation.

The Theatres Group Manager continues to proactively reallocate all cancelled lists to specialties requesting additional theatre lists to maximise efficiency. Performance is expected to improve in July and subsequent months although a similar effect may be seen in November due to the theatres moving from the Queen Elizabeth Hospital in Move 2. Performance of 93.8% would be required for the remainder of the year in order for the target of 92.5% to be met over the full year.

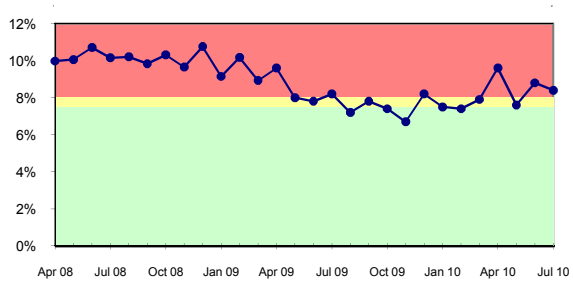


**APPENDIX B**

| 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% | 8.4% | | | | | | | | | 8.7% |

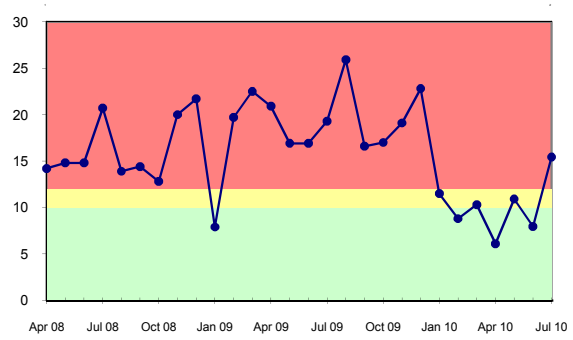
Cancellations of follow-up outpatient appointments fell in July to 8.4% from 8.8% in June.
Action has been taken in response to two specific concerns; that clinics are being cancelled when not all options to ensure that they could take place have been explored and that the construction of the indicator does not accurately reflect the reasons for cancellation.
a) A fortnightly Task and Finish Group, chaired by the Director of Operations, Division 2, has been established and met twice.
b) The Operational Performance Team has now developed a standardised pathway to ensure that cancellations are only taking place once all other options for the clinic have been examined and only with Divisional Director of Operations approval.
c) The Group is undertaking analysis of both the accuracy of recording and the definition used for reporting the cancellation of appointments.
d) The new definition for the indicator will focus on the patient experience and focus on reducing the inconvenience to patients of changes in appointment made by the Trust.
Future performance will be subject to the final choice of indicator definition. New thresholds will be proposed to reflect the new baseline that will result.




| Slot unavailability | Patient Experience | > 12.0 | 10.0-12.0 | ≤ 10.0 |
|---|---|---|---|---|

| | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Slot issues | 6.1 | 10.9 | 8.0 | 15.4 | | | | | | | | | 15.4 |

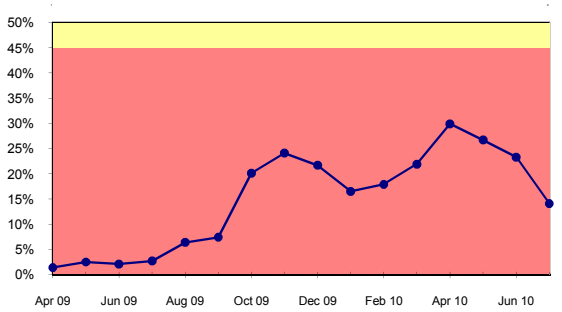
Slot unavailability in July increased to 15.4 unavailable slots per 100 successful bookings.
The majority of bookings made during July would have been for appointments in August when capacity is reduced due to clinicians being on holiday.
The main problem areas continue to be Urology, ENT and Upper GI Surgery. These specialties experienced reduced capacity caused by annual leave and Urology and ENT also experienced staff sickness over this period, further limiting capacity. Additional clinics have been put on in these three specialties to create additional capacity. ENT has also employed a locum consultant to further increase capacity. Urology has increased the length of the booking window as a short-term measure.
Performance in early August continued to deteriorate further but has improved towards the middle of the month as bookings are now being made for September when fewer staff are away.



**APPENDIX B**

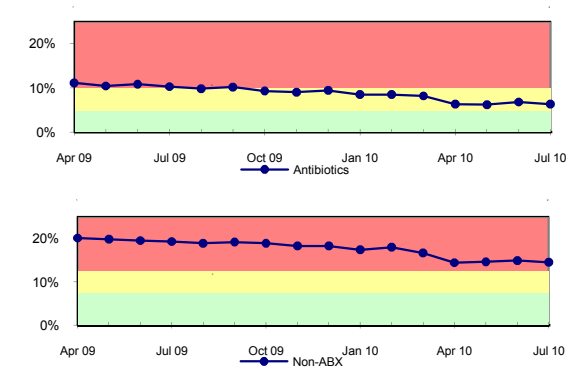
| Electronic Patient Survey Response Rate | | | | | | | | Patient Experience | | | < 45% | 45 - 50% | ≥ 50% |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr 10 | May 10 | Jun 10 | Jul 10 | Aug 10 | Sep 10 | Oct 10 | Nov 10 | Dec 10 | Jan 11 | Feb 11 | Mar 11 | Latest |
| % Response | 29.9% | 26.7% | 23.3% | 14.1% | | | | | | | | | **14.1%** |

Patient feedback fell from 23.3% in June to 14.1% in July.
July was the first full month in the New Hospital and the drop in performance reflects the smaller percentage of beds in the QEHB that currently have bedside televisions than Selly Oak Hospital. The fall is being addressed trust wide with a renewed focus on completion of the survey. Additional wards have now had bedside TVs installed and additional volunteers have been recruited to support patients in completing the survey.
It is expected that the response rate will improve from now on as the full complement of TVs is progressively installed and the volunteers have an effect; the response rate for the first half of August shows an improvement of at least 50%. Although lessons have been learned from move 1 that should mitigate the effect it is possible that the remaining moves may also lead to temporary drops in performance; future performance will depend on whether or not the wards involved are pre-equipped with bedside TVs.




| Omitted drugs - Antibiotics<br>Omitted drugs - Non-antibiotics | | | | | | | | Patient Safety | | | > 10%<br>> 12.5% | 5-10%<br>7.5-12.5% | ≤ 5%<br>≤ 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% | | | | | | | | | **6.4%** |
| Non-ABX | 14.4% | 14.6% | 14.9% | 14.5% | | | | | | | | | **14.6%** |

The percentage of omitted antibiotic doses fell to 6.3% in July from 6.8% in June. The percentage of omitted non-antibiotic doses also fell from 14.9% to 14.5%.
At the August Root Cause Analysis meeting a number of actions to reduce the number of omitted doses were identified. These included the development of an alert within PICS for missed doses and a one-off pause function which will allow the pause function to be used in new situations which should increase its use. The recording of drugs as omitted whilst the patient is in theatre continues to be a problem and the introduction of PICS for theatre is being investigated. Other proposed changes to PICS include the matching of drug rounds to the working day within Neurosciences and the administration of drugs which must be given with food to mealtimes to ensure that doses are given whenever possible. A problem was also identified where a patient was allowed ward leave but this was not recorded in PICS and consequently all doses whilst the patient was out of hospital were recorded as omitted; nursing staff are to be reminded of the ward leave functionality within PICS.
The implementation of these changes is expected to lead to a further reduction in omitted doses.



**APPENDIX B**

| Readmission audit response rate<br>Non-emergency mortality audit response rate | Patient Outcomes | < 80%<br>< 90% | 80-90%<br>90-100% | > 90%<br>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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Readmissions | 27.5% | 20.3% | 22.6% | 15.1% | | | | | | | | | **21.7%** |
| Non-Em Mortality | 77.8% | 33.3% | 33.3% | | | | | | | | | | **50.0%** |
| Forms sent out | 9 | 6 | 9 | | | | | | | | | | **24** |
| Forms completed | 7 | 2 | 3 | | | | | | | | | | **12** |

The response rate for readmission audits for June 2010 is 15.1% which takes the percentage for the year completed to 21.7%. The highest performance continues to be in Division 3.
Completion of non-emergency mortality surveys for June stands at 33.3% with 3 out of 9 surveys completed. The overall completion rate for the year to date is therefore 50%.
Divisional Directors have been notified of all outstanding surveys and asked to ensure that they are completed as soon as possible.