AGENDA ITEM NO:

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 22 JULY 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: • 62 day first cancer treatments • C. difficile • A&E 4 hour waits • Quality of Stroke Care • Delayed Transfers of Care • Short term sickness • External agency rate • DNAs • Cancelled follow up appointments • Electronic Patient Survey response rate • Omitted drugs • Readmission & non-emergency mortality audits 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:** 13 July 2010

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 22 JULY 2010

PERFORMANCE INDICATORS REPORT

PRESENTED BY THE EXECUTIVE DIRECTOR OF DELIVERY

1. **Purpose**

This paper presents an update 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**

Exception reports where monthly data are available are contained in Appendix B. A report has been provided for the cancer 62 day first treatment target as performance was below target in May. The number of post 48 hour C. difficile cases was below the threshold in June, however year to date performance is still above the threshold therefore an exception report is included. A&E 4 hour wait performance, although above the new national target of 95%, was below the internal target of 98% in June so an exception report for this indicator is included. Although the threshold for the stroke target is unknown, performance in June was low therefore is considered an exception. Delayed transfers of care were above target in June therefore this indicator is included.

The exception report this month also contains reports on those internal indicators that are red or have been amber consecutively for three months. Slot unavailability was green in June therefore no exception report is required. Appraisal and mandatory training continue to be amber; exception reports will be provided for these indicators next month if they have been amber for three consecutive months at that point.

The following internal targets are currently red or have been amber consecutively for three months:

a) Short term sickness
b) External agency rate
c) DNA rates
d) Cancelled follow up appointments
e) Electronic Patient Survey response rate
f) Omitted non-antibiotic doses
g) Readmission & non-emergency mortality audits response rates

3. Changes to CQC Periodic Review and Monitor Compliance Framework

It is understood that the Department of Health has instructed the Care Quality Commission not to publish single ratings for Trusts in October as part of the Periodic Review. Instead the CQC will publish the results of individual indicators as part of the Government's shift to measuring performance by outcomes rather than process measures.

Monitor has amended the Compliance Framework for 2010/11 to reflect the changes in the NHS Operating Framework outlined by the Department of Health in June resulting from the change in government. Consequently the 18 weeks targets have been removed at both an aggregate and treatment function level and the threshold for the A&E 4 hour wait target has been reduced from 98% to 95%.

These developments reflect the Government's intention to realign Monitor as the financial regulator for NHS Foundation Trusts and the CQC as the regulator for quality. Appendix A of this report has been amended to mirror the changes. 18 weeks performance has therefore been moved from the National Targets section to the 'Efficiency – Process' section of the report as the Trust has a continuing contractual requirement with commissioners to maintain performance against these targets.

4. CQC Ratification of Performance in 2009/10

The CQC is currently ratifying the information it holds on the Trust's performance for 2009/10 against national targets as part of its preparation to publish the Trust's performance, as detailed above. Following a change to the definition used by the CQC the Trust's performance against the Delayed Transfers of Care indicator is now above the threshold used by the CQC in 2008/09. The CQC has yet to publish the threshold it will use for 2009/10 but it is now more likely that the Trust will underachieve this indicator.

The Trust has submitted an extenuating circumstances request as part of ratification which highlights that under the definition for this indicator some of the Trust's activity is used in the numerator but not the denominator and therefore the reported percentage of delayed transfers of care is increased unfairly. A response is currently awaited from the CQC to this request.

5. 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

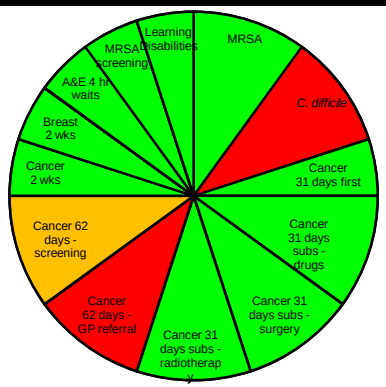
University Hospitals Birmingham NHS
NHS Foundation Trust

2010/11 Key Performance Indicator Report

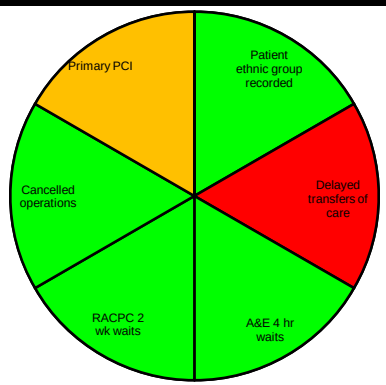
Where data is not currently available indicator names are in italics. These have been assigned 'amber' unless considered high risk where they have been assigned 'red'.

National Performance

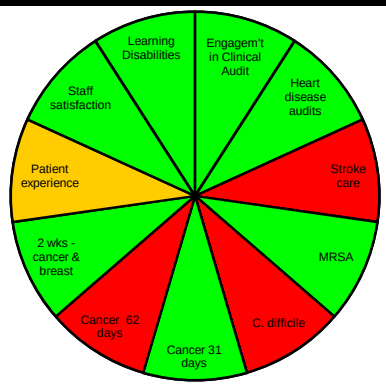
Monitor Governance Rating



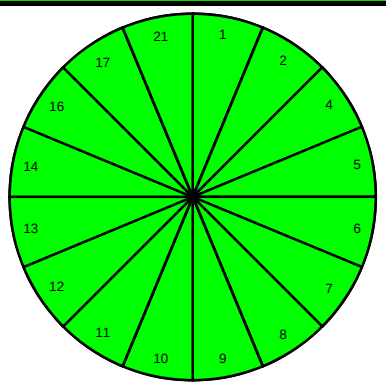
Care Quality Commission Existing Commitments



Care Quality Commission National Priorities

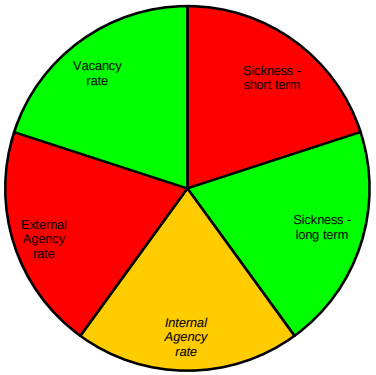


Registration Outcomes

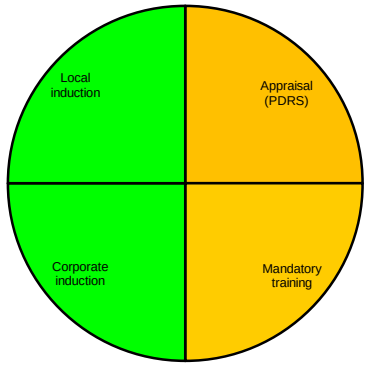


Workforce

Resources



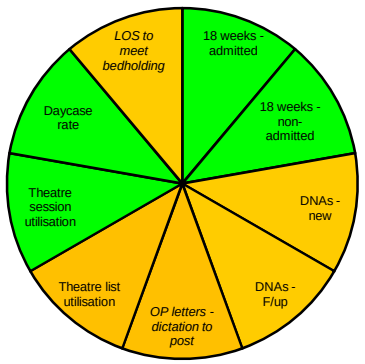
Capability



Efficiency

Innovation

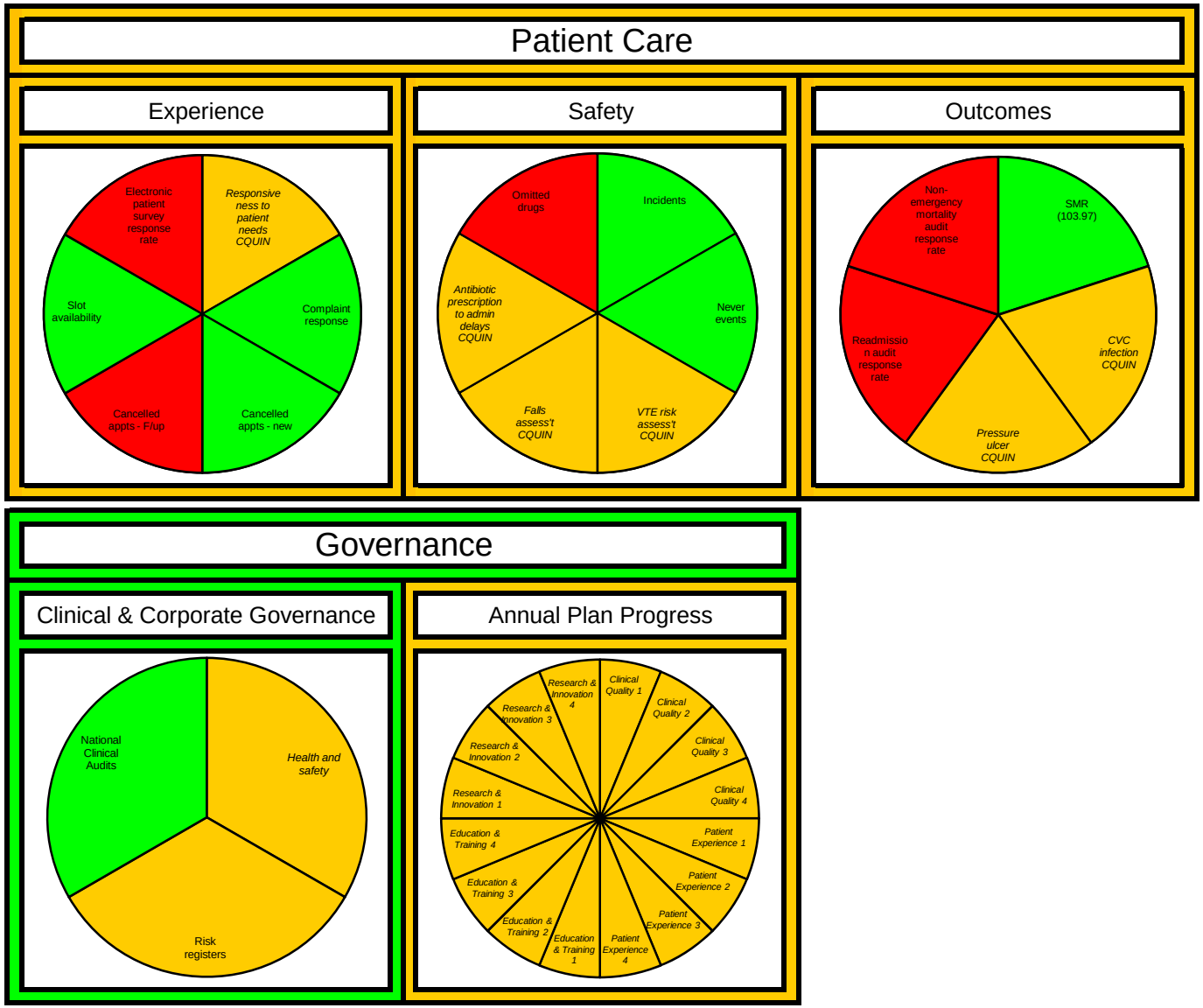
Process



13 July 2010

APPENDIX A

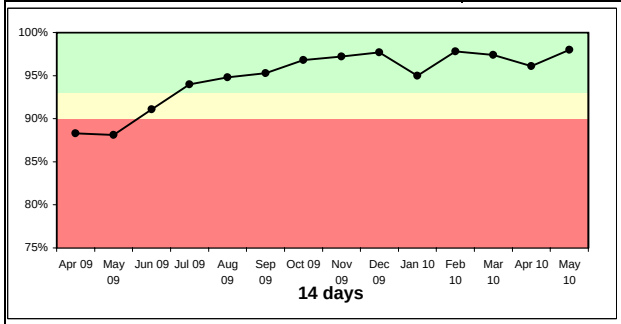
University Hospitals Birmingham NHS
NHS Foundation Trust



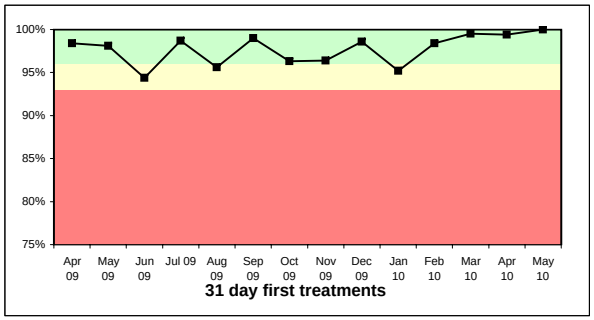
APPENDIX B

Exception Report for July 2010 Board of Directors' Performance Report

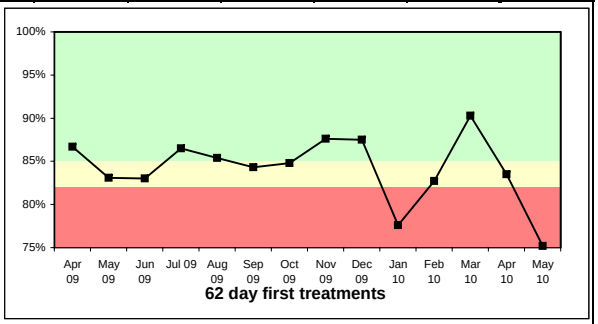
Expanded Cancer Targets												National Targets		
	Target	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
14 day cancer	93%	96.1%	98.0%											97.1%
14 day breast symptom	93%	98.9%	97.1%											98.0%
31 day first treatments	96%	99.4%	100.0%											99.7%
31 day subsequent treatments - Surgery	94%	100.0%	97.9%											99.3%
31 day subsequent treatments - Drugs	98%	100.0%	100.0%											100.0%
62 day first treatments	85%	83.5%	75.2%											78.8%
62 day consultant upgrades	No target set	100.0%	96.2%											98.0%
62 day referrals from screening	90%	80.0%	95.0%											88.6%



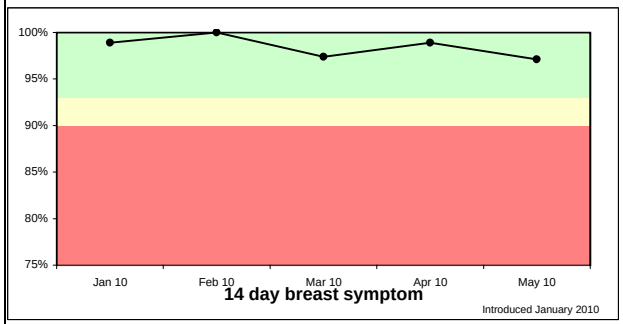
14 days



31 day first treatments

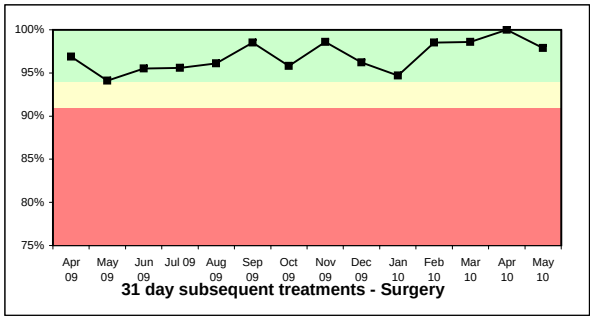


62 day first treatments

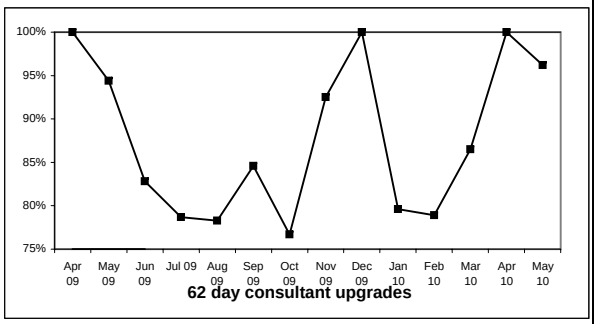


14 day breast symptom

Introduced January 2010

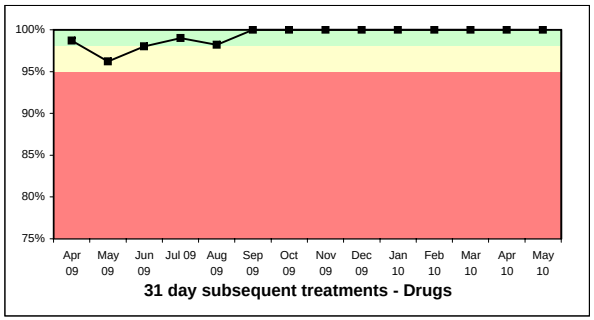


31 day subsequent treatments - Surgery

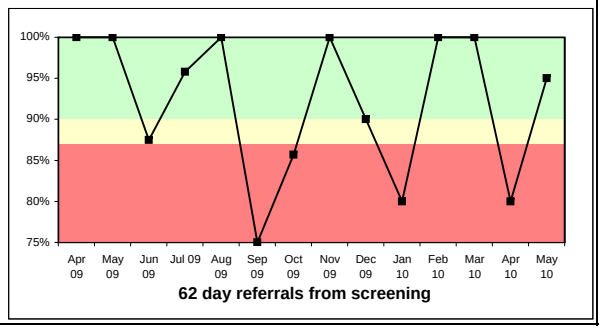


62 day consultant upgrades

The Trust did not achieve the 62 day GP referral target in May 2010. Performance against 62 day GP referral is below target for the year to date. All the other cancer targets were met in May, including the 62 day referral from screening target. There were 64 patients treated during May for the 62 day GP referral target which translated to 56.5 accountable treatments. There were 14 accountable breaches in total of which 3.5 breaches were late referrals. Electronic reports showing a forward look for the targets are now available on Reporting Services which will allow the Divisions to track patients and take action if they are likely to breach. Meetings will be held weekly to review performance and address potential breaches. Problems with diagnostic capacity for EUS and operating capacity for Urology have been identified and additional capacity has been added. The Trust is also working with Heart of England NHS Foundation Trust to increase capacity for guided lung biopsies.



31 day subsequent treatments - Drugs



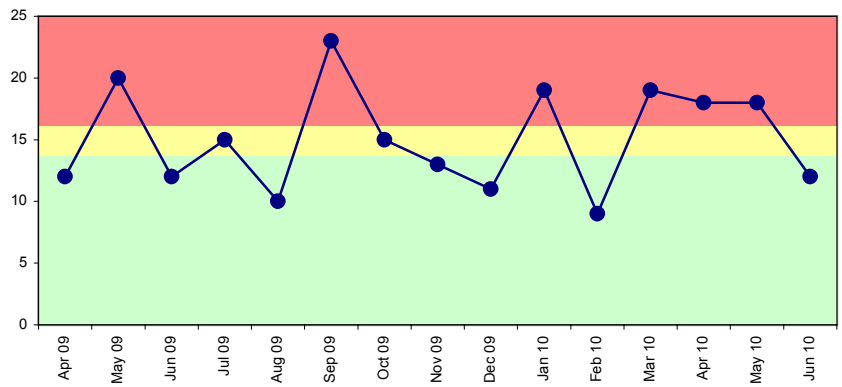
62 day referrals from screening

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										**48**

There were 12 post 48 hour *C. diff* cases in June which is below the trajectory of 13.66 to meet the full year trajectory of 164. However due to above trajectory performance in April and May the Trust is above trajectory for the year to date. Please refer to Chief Nurse's Infection Control Report for further details and action taken.

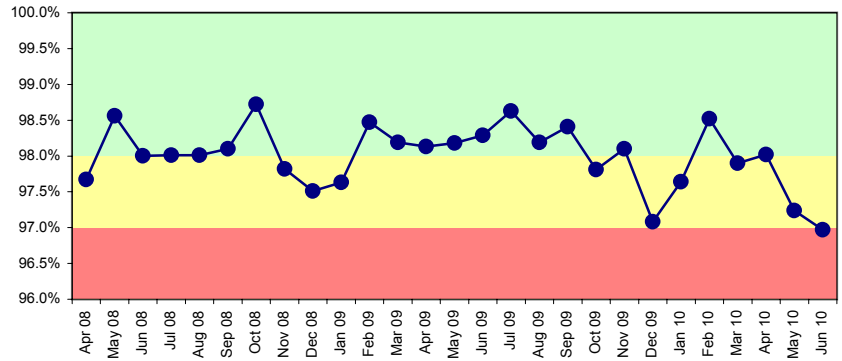


A&E 4 hour waits	Monitor & CQC Existing Commitments	< 97%	97-98%	≥ 98%

	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%	96.97%										**97.40%**

The Department of Health and Monitor have now indicated that the threshold for this target is to be reduced to 95% for 2010/11. However the existing threshold of 98% is being retained internally. Performance in June was below the internal threshold at 96.97%. Performance including Katie Road walk-in centre in June was 97.96%. Year to date performance is also below the internal threshold at 97.4%. With Katie Road included performance for the year to date stands at 98.28%. Performance continues to be significantly affected by the capacity problems seen across the Trust which impacts on the capability of the Emergency Department to move patients to wards.

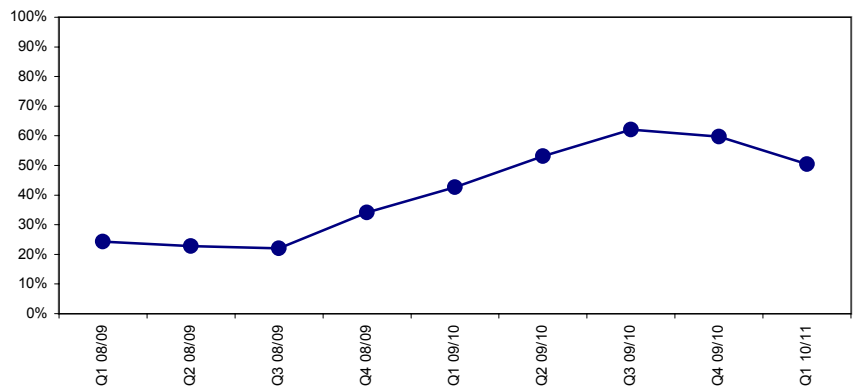
Although the move to the New Hospital was successful it has been clear that there has been some disruption to day to day processes within the new environment. Division 3 management are therefore working with medical and nursing teams at all levels to ensure that there is a continuing focus on process and clinical quality.



APPENDIX B

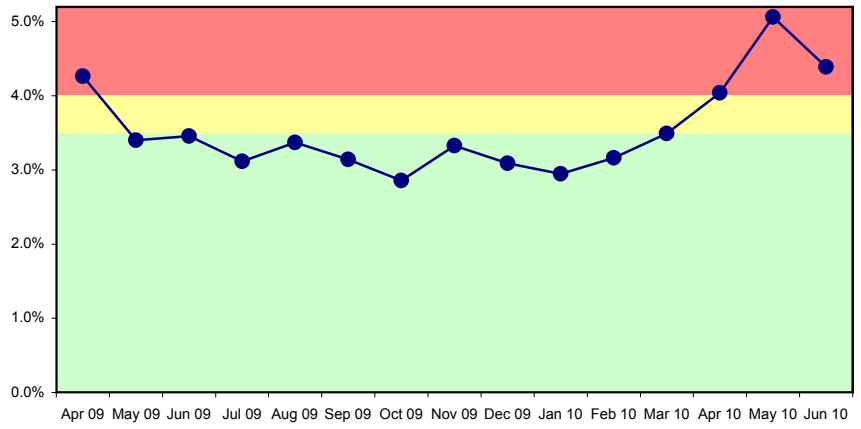
Quality of Stroke Care								CQC National Priorities			Thresholds not available		
	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
Stroke	51.3%	54.3%	45.5%										50.4%

The percentage of stroke patients spending greater than 90% of their length of stay on a stroke unit in June was 45.5%. Following additional discharges in April and May, performance has improved for these months. The Q1 figures do not include Moseley Hall Hospital length of stay which is only available on a quarterly basis as agreed contractually with NHS South Birmingham but the percentage should improve when it is included. The capacity problems seen at Selly Oak have made it difficult to protect the stroke admission beds on the unit but Division 3 has taken steps to ensure that these are only used when all other capacity has been exhausted to ensure that, as far as possible, the unit is always able to take patients admitted following a stroke. Performance was also affected by the closure of stroke unit to admissions for a week in May due to an outbreak of norovirus.



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%										4.46%

Delayed transfers of care fell in June to 4.39% from 5.06% in May against a target of 3.5%. Previous months' performance has increased due to the change in the indicator definition as detailed in section 4 of the main report. There were 162 delays over the month. There continue to be delays in Social Services carrying out assessments once the Section 2 notice has been given and putting care packages into place. 25 beds are now open on East 2B which are for patients who are medically fit for discharge for whom external support is awaited.
A daily conference call between the DDOps Division 3 and NHS South Birmingham continues to take place. 7 additional interim care beds in the community are in the process of being provided. No further additional social worker support has been provided by Birmingham City Council. UHB's Discharge Team is reviewing all medical patients to identify whether there are any blockages to discharge that can be readily resolved (e.g. provision of equipment).



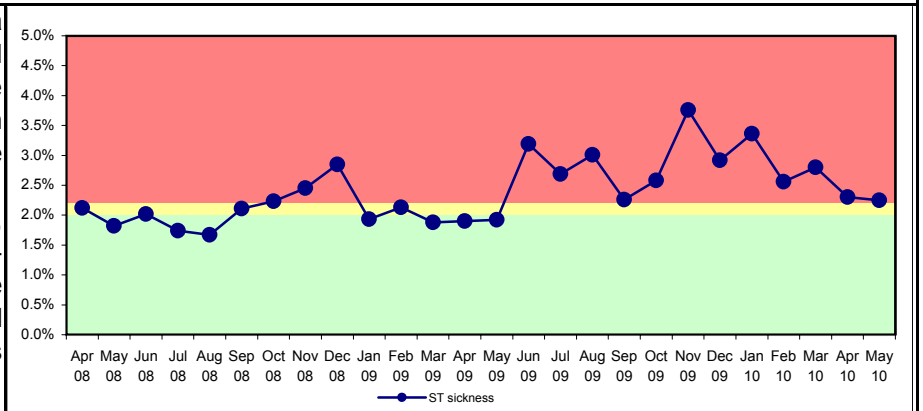
APPENDIX B

Sickness rate - short term	Workforce - Resources	> 2.2%	2.0-2.2%	≤ 2.0%
Sickness rate - long term		> 2.6%	2.3-2.6%	≤ 2.3%

	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
ST sickness	2.30%	2.25%											2.25%
LT sickness	2.00%	1.90%											1.90%

For the month of May 2010 the Trust sickness absence rate was 4.15%; a fall from 4.30% in April. Short term absence fell from 2.30% to 2.25% and long term absence fell from 2.00% to 1.90%. The action plan to tackle sickness has been in place since February and appears to have had an impact on the absence rates; the May 2010 short term absence was the lowest rate seen since May 2009.

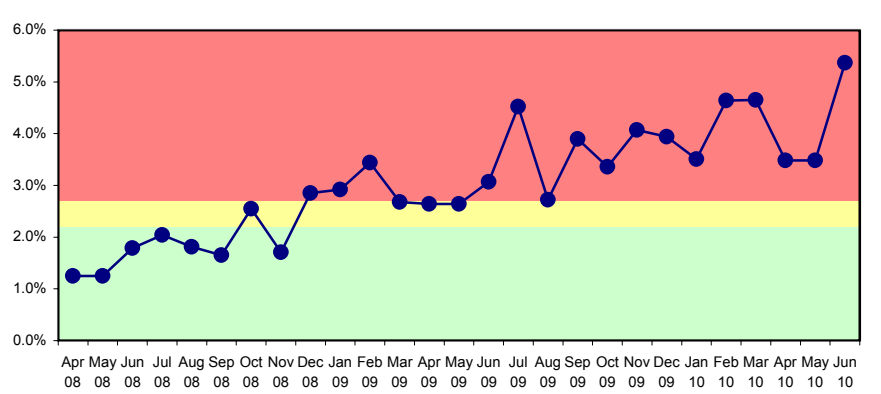
The hotspot areas are Theatres, QE Coronary Care, E2A, E2B, West 2, West 4, S8, Phlebotomy, D4, C3 and S3. Reasons include D&V, post-surgery recovery, stress and musculoskeletal issues. The majority of these hotspot areas were involved in the move to the QEHB and it is envisaged that after the move some current hotspots may increase whilst others decrease; these areas will be closely monitored.



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%										**4.12%**

The percentage of staff costs spent on external agency rose to 5.37% in June. There continue to be significant costs associated with locum medical staff in Divisions 3 and 5 however a permanent appointment has now been made to replace one of the locum dermatologists so costs should fall in future months. The operation of the delayed discharge ward on E3A over this period has also contributed to agency spend. The organisational change process for the New Hospital has also led to vacancies being held open to allow the process to progress. Agency staff have been used to fill these vacancies until the process is complete.

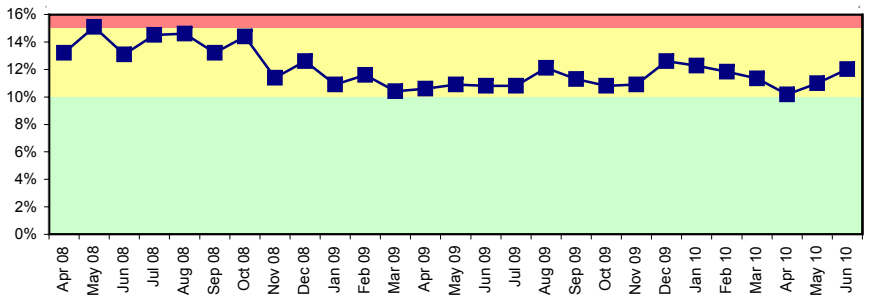


APPENDIX B

DNA rate								Efficiency - Process			>15%	10-15%	<10%
	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%	12.0%										11.1%
Follow-up	9.9%	9.9%	10.9%										10.2%

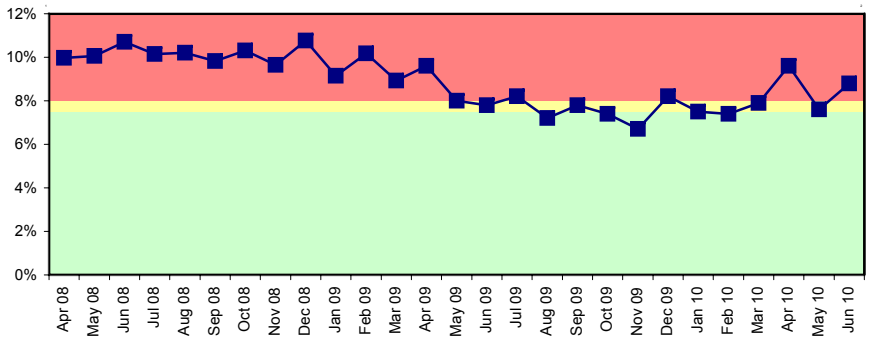
The DNA rate for new appointments and follow up appointments in June have shown a 1% increase compared to May. DNAs continue to be a focus of the Operational Performance and Data Quality Meeting. Work has been planned to review the pathway from a patients appointment being booked through to sending the appointment letter in order to identify and address any delays and ensure patients are receiving adequate notice. The potential for using the text message service to notify patients of new appointments is also being scoped. Pilot specialties are currently being identified by the Divisions.

The predictive DNA algorithm project continues to progress and is currently focussing on Diabetes, Ophthalmology, and ENT.



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%										8.7%

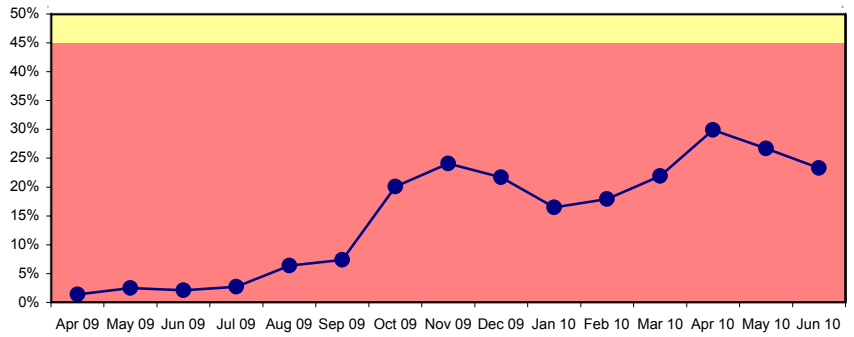
Cancellations of follow-up outpatient appointments increased in June to 8.8% from 7.6% in May. The Operational Performance Team has mapped each Division's processes for the sign off of cancellations within 6 weeks which has shown that there are varying processes across the Divisions. A standardised pathway will be implemented 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. This will be supported with the implementation of the appropriate documentation to ensure a robust audit trail. Cancellations also continue to be the focus of the Operational Performance and Data Quality meeting.



APPENDIX B

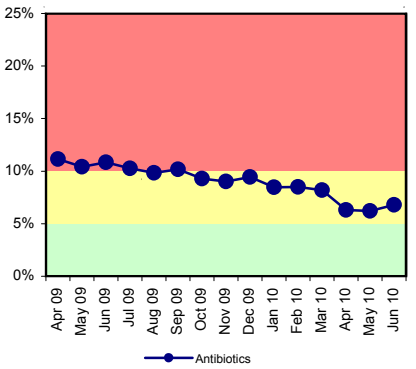
Electronic Patient Survey Response Rate								Patient Experience			< 45%	45 - 50%	≥ 50%
	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	Latest
% Response	29.9%	26.7%	23.3%										**23.3%**

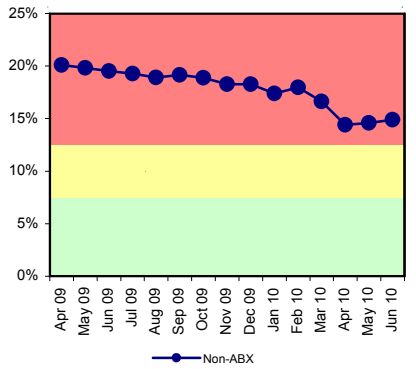
Patient feedback fell to 23.3% in June from 26.7% in May. The move to the New Hospital has contributed to this fall as a smaller percentage of beds in the New Hospital have bedside televisions than Selly Oak Hospital. Until the full complement of bedside televisions is installed feedback in these areas will have to be collected by PDA which, as they are shared rather than at every bedside will lead to lower completion. In addition the focus of volunteers is currently on wayfinding rather than helping patients to feed back. Consequently lower levels of feedback are expected over coming months.



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%										**6.4%**
Non-ABX	14.4%	14.6%	14.9%										**14.6%**

The percentage of omitted antibiotic doses rose in June to 6.8% from 6.2% in May. The percentage of omitted non-antibiotic doses also rose from 14.6% to 14.9%. The June root cause analysis meeting identified continuing problems with patients who are nil by mouth (NBM) not being given drugs when they could be. Problems were also identified with pre-operative drugs not being routinely checked or administered before a patient goes to theatre, with the accuracy and consistency of free text comments entered for drug omissions and in patient notes, with the delivery of drugs ordered from Pharmacy to the wards, with nursing and medical staff not responding to patient refusals to take medication, with drugs not being paused by nursing staff or paused/stopped by medical staff and with patients not being discharged from PICS in a timely fashion. Appropriate action is being taken by the divisions in each case.





APPENDIX B

Readmission audit response rate Non-emergency mortality audit response rate	Patient Outcomes	< 80% < 90%	80-90% 90-100%	> 90% 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%										**24.0%**
Non-Em Mortality	77.8%	33.3%											**60.0%**
Forms sent out	9	6											**15**
Forms completed	7	2											**9**

The response rate for readmission audits for June 2010 is 22.6%, a increase from 20.3% in May. The highest performance continues to be in Division 3 where consultants are supported in obtaining notes to review readmissions. Divisional Management Teams are to be provided with a list of outstanding audits for 2010/11 to allow them to ensure that these are completed. A new readmission module of Healthcare Evaluation Data (HED) tool has been developed by Informatics which shows comparative data for readmissions for the whole of England. It also allows readmissions to other hospitals to be tracked as well as patients readmitted to UHB following discharge from other hospitals. The tool identifies patients with a readmitting diagnosis that is potentially similar to the discharge diagnosis. Analysis on readmissions is particularly pertinent as the revision to the Operating Framework states that hospitals will not be paid for the treatment of patients readmitted within 30 days of discharge due to poor quality care.

An additional non-emergency mortality audit has been sent out which has reduced the completion rate for April 2010 to 77.8%. This patient died at the end of April therefore the survey was not sent out until the beginning of May. Completion for May stands at 33.3% with 2 out of 6 surveys completed. The overall completion rate for the year to date is therefore 60%. Consultants are being reminded of outstanding surveys, although where there is an outstanding inquest the survey will not be able to completed until this is concluded. An audit survey completed has identified a patient death of concern which is being reviewed with the clinician supported by Clinical Governance. An action plan is being developed to address issues identified.