UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 25 JULY 2013

Title:	**PERFORMANCE INDICATORS REPORT AND 2013/14 ANNUAL PLAN UPDATE**
Responsible Director:	Executive Director of Delivery
Contact:	Harvir Atkar, Head of Strategy & Performance, 13684 Andy Walker, Strategy & Performance Manager, 13685 Daniel Ray, Director of Informatics

Purpose:	To update the Board of Directors on the Trust's performance against the Monitor Compliance Framework targets and indicators, contractual targets, internal targets and CQUINs. To provide Quarter 1 performance against the agreed Annual Plan key tasks and strategic enablers for 2013/14.	
Confidentiality Level & Reason:	None	
Annual Plan Ref:	Affects all strategic aims.	
Key Issues Summary:	Exception reports have been provided on the following indicators where there are current or future risks to performance: • *Clostridium difficile* • A&E 4 Hour Waits • Stroke – Length of Stay • Hospital Standardised Mortality Ratio • Mandatory Training • External Agency Spend • Omitted Drugs Further details and action taken are included in the report. An update is also included on the Trust's CQUINs. For the 2013/14 Annual Plan year to date, 92% of key tasks are on plan, 8% of key tasks are slightly below plan, and there are no key tasks where remedial action is required.	
Recommendations:	The Board of Directors is requested to: **Accept** the report on progress made towards achieving performance targets and associated actions and risks. **Accept** the year to date 2013/14 performance update against the Trust Annual Plan.	
Approved by:	Tim Jones	16 July 2013

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS
THURSDAY 25 JULY 2013

PERFORMANCE INDICATORS REPORT AND 2013/14 ANNUAL PLAN UPDATE

PRESENTED BY EXECUTIVE DIRECTOR OF DELIVERY

1. Purpose

This paper updates the Board of Directors on the Trust's performance against national indicators and targets, including those in Monitor's Compliance Framework, as well as local priorities. Material risks to the Trust's Monitor Provider Licence or governance rating, finances, reputation or clinical quality resulting from performance against indicators are detailed below. An update is also included on the Trust's CQUINs for 2013/14; this is at Appendix A. An update is provided on year to date performance against the agreed Annual Plan key tasks and strategic enablers for the year 2013/14.

2. UHB Performance Framework

The Trust has a comprehensive performance framework that includes national targets set by the Department of Health and local indicators selected by the Trust as priority areas, some of which are jointly agreed with the Trust's commissioners. The Trust Performance Framework is agreed by the Board of Directors and is intended to give a view of overall performance of the organisation in a concise format and highlight key risks particularly around national and contractual targets as well as an overall indication of achievement of key objectives. Based on latest performance, targets are assessed as 'on target', 'on target but close to threshold', 'slightly below target', or 'remedial action required'. For national targets that fall into the latter three categories, these are reported in this paper as exceptions. Local targets are reported as exceptions where a remedial action plan is in place. Latest data for a number of quarterly indicators is currently not available due to the timescales for processing and validation and will be included in the next report to the Clinical Quality Committee.

3. National Targets

The Department of Health (DH) sets out a number of national targets for the NHS each year which are priorities to improve quality and access to healthcare. Monitor tracks the Trust's performance against a subset of these targets under its Compliance Framework. The remaining national targets that are part of the Everyone Counts document from the DH (previously called the Operating Framework) but not in Monitor's Compliance Framework are included in a separate section of the report.

Of the 15 indicators currently included in Monitor's Compliance Framework, 10 are currently on target, 3 are on target but close to the threshold (See Section 3.2 below) and 2 have a remedial action plan in place (See Section 3.1 for exception reports). Of the 17 national indicators not included in Monitor's Compliance Framework 14 are on target and fully validated data is awaited for the other 3.

3.1 Exception Reports

Exception reports are contained below for national targets where a remedial action plan is in place.

3.1.1 C. difficile

The Trust has a trajectory of 56 cases for 2013/14 that is used to assess the Trust's performance by Birmingham CrossCity Clinical Commissioning Group (CCG) and NHS England for contractual purposes and by Monitor as part of its Compliance Framework.

Joint work has been undertaken with the CCG to produce a more meaningful measure for *C. difficile* as some cases are unavoidable. Agreement has therefore been reached that they will consider avoidability when applying the contractual penalty. Monitor, however, are continuing to use the same methodology as previous years, stating in the Compliance Framework that the Trust must include all cases in its trajectory, including those that are unavoidable. The Executive Chief Nurse has written to Monitor to challenge this position however Monitor have indicated that they are unwilling to vary this as they need to adopt a consistent approach across all Foundation Trusts. The Trust has therefore shared its methodology with Monitor with the aim of it being used more widely however it is likely that Monitor will remain with the current definition and the trajectory of 56 cases will stand. Consequently the Trust's trajectory of 56 cases for the year will apply to all cases for Monitor and for avoidable cases for contractual purposes.

There were 7 cases of *C. difficile* in total in June. The Trust has therefore had a total of 24 cases in Quarter 1 against a Monitor trajectory of 14. Following review of June cases with the CCG it has been agreed that 1 case was avoidable, 4 were unavoidable and 2 require further investigation before a decision can be made about avoidability. The Trust's total number of cases reported to the CCG will therefore be between 5 and 7 cases for the Quarter.

The Trust declared a risk to achievement of this target in its Strategic Plan to Monitor. The Trust's failure to achieve the in-year Monitor trajectory of 14 cases over Quarter 1 will affect the Trust's governance rating. In combination with the failure to achieve the A&E target this will result in a 'Red' Monitor governance rating for Quarter 1.

Please see the Executive Chief Nurse's Infection Prevention & Control Report for further details of action taken and planned to ensure recovery of the trajectory.

3.1.2 A&E 4 hour waits

The national target for A&E is that 95% of patients should spend 4 hours or less in the Emergency Department. Having met the target in May, in June 96.7% of patients attending the Emergency Department (ED) left within 4 hours therefore the target was achieved for the second consecutive month. This followed an extremely challenging period in the first three weeks of April where there were unprecedented emergency pressures nationwide and 90.1% of patients attending the ED met the target. Despite improved, above target, performance in May and June this led to the target being missed for Quarter 1 with performance of 94.1%.

The ED continues to see high numbers of emergency admissions but this pressure is being successfully managed due to the additional ward bed capacity currently open in the Trust. The Trust continues to outperform the majority of other West Midlands trusts and the national and West Midlands average for trusts with the same type of A&E. Performance for England, the West Midlands, local trusts and the other West Midlands tertiary providers over the Quarter is shown in Table 1 below:

Table 1: Type 1 A&E Performance for the period 1 April to 30 June 2013

	A&E Performance 1 April to 30 June 2013
Birmingham Children's Hospital NHS Foundation Trust	98.1%
Walsall Healthcare NHS Trust	94.6%
The Dudley Group NHS Foundation Trust	94.5%
University Hospitals Birmingham NHS Foundation Trust	**94.1%**
England	**93.6%**
The Royal Wolverhampton NHS Trust	93.5%
West Midlands	**92.0%**
Worcestershire Acute Hospitals NHS Trust	92.0%
Heart Of England NHS Foundation Trust	91.6%
Sandwell And West Birmingham Hospitals NHS Trust	91.1%
University Hospital Of North Staffordshire NHS Trust	90.0%
University Hospitals Coventry And Warwickshire NHS Trust	86.3%

As the target was not achieved in Quarter 1 2013/14 the Trust has been below target for three consecutive quarters. It is therefore expected that Monitor should give the Trust a 'Red' Monitor governance rating in line with the 2013/14 Compliance Framework and will consider escalation. Heart of England NHS Foundation Trust received a 'Red' Monitor governance rating in June for Quarter 4 2012/13 having failed to achieve the target

for three consecutive quarters. It is highly likely that a number of other trusts will be 'Red' rated by Monitor following Quarter 1 in the light of the below target performance seen nationwide over that period.

3.2. Early Warnings

Latest performance for the following national targets is on target but close to the threshold for the latest month:

a) Cancer – 2 week waits – 93.4% in May against national target of 93%.
b) Cancer – 31 day subsequent surgery – 94.2% in May against national target of 94%.
c) Cancer – 31 day subsequent chemotherapy – 98.3% in May against contractual target of 98%.

Performance against these indicators will continue to be monitored closely and any potential underperformance addressed to ensure that the targets continue to be achieved on an ongoing basis.

4. Internal Performance Indicators

A framework of indicators has been selected as local priority areas for the Trust in assessing whether it is performing well. Some of these indicators are jointly agreed with commissioners whereas others have been selected as they reflect the Trust's local priorities.

Local indicators continue to be monitored that reflect the Trust's priorities and contractual obligations. Of the 50 indicators currently included 24 are on target, 18 are slightly below target and 8 have remedial action plans in place. Updated data is currently being validated for two indicators that already have remedial action plans in place (Completion of Drug Assessments and Time from Approval to Recruitment for Clinical Trials (70 day target)) and progress on these will be included in the next report to the Clinical Quality Committee.

4.1 Stroke – Length of Stay

The Trust has a contractual target that greater than 80% of stroke patients discharged in a month should have spent more than 90% of their length of stay on the stroke unit (including the Moseley Hall Hospital rehabilitation phase of the pathway). In May 57.7% of patients spent greater than 90% of their length of stay on the stroke unit including predicted Moseley Hall Hospital length of stay. Increased activity and general emergency bed pressures have led to difficulties meeting this target. Additional resource is being made available to aid delivery of the target including a fifth stroke consultant from September 2013 and additional bed capacity from December 2013.

4.2 Hospital Standardised Mortality Ratio

The Hospital Standardised Mortality Ratio for the Trust for the period April 2012 to February 2013 was 110.88 which is at the upper acceptable limit. Further details are included in the Executive Medical Director's Clinical Quality Monitoring Report.

4.3 Mandatory Training

The Trust mandates that its staff should carry out a number of types of training dependent on their job role in order to meet the requirements of the NHS Litigation Authority Risk Management Standards. The target for each is set at 90% of staff being up to date apart from Information Governance which is mandated at 95% by NHS Connecting for Health. Whilst good progress has been made with six indicators now above target; five indicators remain slightly below and four require remedial action to hit the Trust target. In May two indicators moved above target and one indicator improved from requiring remedial action to being slightly below target.

4.4 External Agency Spend

The Trust has a local target that external agency spend should be less than 3.1% of total pay spend. External agency spend in May was above target at 3.87% however this continues to be linked to the additional capacity open in the Trust. The Chief Operating Officer has held meetings with the divisions over recent weeks to review external agency spend to ensure it is appropriate, with the aim of reducing it where possible. New models of recruitment are also being explored including International Fellows to fill junior doctor vacancies and recruiting nursing staff from abroad to allow ongoing over-recruitment.

4.5 Omitted Drugs

The Trust's performance remained below the internal target in June for both omitted antibiotic and non-antibiotic doses. Trust performance remains better than any national comparator. Specialties and wards with higher levels of omitted doses continue to attend the Executive Root Cause Analysis (RCA) meetings to review their performance and identify actions for improvement.

5. CQUINs

The Trust's CQUINS for 2013/14 are valued at around £12.3 million. Appendix A provides details of these schemes. Issues of note are included below.

5.1 Friends and Family

Further improvement is required to increase the response rate to the Friends and Family survey in the Emergency Department. It has been identified that staff are aware of the requirements of the survey, however further emphasis is required to promote this to patients and encourage them to complete the survey. A meeting was held in July to develop an action plan focussing on the point at which patients are asked to complete the survey, the introduction of a post box within the department to return the completed surveys, the potential to obtain feedback to the survey via alternative methods such as text message, and increased education of nursing and medical staff to raise awareness of the need to ask patients for feedback.

5.2 Falls

An improvement trajectory of 80% by year end for the completion of falls assessments in ED has been agreed with commissioners against a 71% baseline. Work is planned to undertake education and training with the staff to ensure the assessments are completed and documented. The audit sample size will also be expanded from 40 a month to 120 a month to ensure broader coverage. The Department has 2 link nurses for falls in place who will support this work. Performance will continue to be tracked monthly.

5.3 Pressure ulcers

A target reduction of 10% has been agreed with commissioners against the 2012/13 baseline. Performance for Quarter 1 is currently below the 2012/13 average and therefore within target. The contract also contains a performance indicator for the reduction of grade 3 and 4 avoidable hospital acquired ulcers. An improvement trajectory for this will be agreed at the start of September once the RCA outcomes around avoidability are finalised for the Quarter 1 cases.

5.4 Formulary adherence

A meeting is being arranged with commissioners to agree an improvement trajectory. Actions are in place to deliver an improvement through the development of PICS templates for certain drugs and education of junior medical staff via the junior doctor monitoring clinics.

5.5 Discharge planning

A Steering Group has now been established and is chaired by the Chief Operating Officer. This group is responsible for delivering the improvement in the percentage of patients discharged before 1 pm. The group are currently working through the data to establish the baseline. A two week audit will also be carried out in August to understand in more detail reasons for delayed discharges.

A number of actions are planned to improve TTO turnaround performance and it is expected that performance will be more in line with target by September 2013. These include managing sickness in the team, reviewing the skill mix in the dispensary, implementing a change in working hours following an organisational change process which is currently underway, a review of the roles of the Medicines Management Technician to support the discharge process, review of the clinical pharmacy service, and scoping of options for alternative provision of discharge dispensary services.

5.6 Neurosurgery Shunt Revision

April performance against this measure will be undergoing validation at the next Neurosurgery Mortality & Morbidity (M&M) Meeting in July. There is a time lag with obtaining the validated data due to the need for cases to be reviewed at the M&M meeting. Performance is measured over the quarter as a whole to mitigate the risk of low numbers of cases. If performance is above 10% for the quarter the Trust will be required to produce an action plan.

6. 2013/14 Annual Plan Progress to Date

An assessment of progress has been made against all key tasks using the following categories.

Progress	Qtr 1	Qtr 2	Qtr 3	Qtr 4
On plan	59 (92%)			
Slightly below plan	5 (8%)			
Remedial action required	0 (0%)			
Total	**64 (100%)**			

Year to date, 92% of key tasks are on plan, 8% of key tasks are slightly below plan, and there are no key tasks where remedial action is required. A high number of key tasks have been assessed as on plan at this stage in the year. This is due to the delivery of outcome measures being back-loaded towards the second half of the financial year. The majority of key tasks have an initial developmental/planning phase. As the Trust moves towards the outcome monitoring phase of the key tasks later in the year, it will become clearer whether they are on track.

The 5 key tasks that are slightly below plan are detailed in the following table with an explanation of the actions being taken to bring performance back in line. Of these key tasks, none have been identified as risking the delivery of the overall strategic aim or enabler.

Key Task	Outcome Measure	Actions
1.1: Further develop PICS functionality.	e) Design and agree requirements to implement an alternative coding system (ICD10 to SNOMED CT) f) Design and develop modules to allow recording and review of electronically signed consent documentation.	These outcome measures have made limited progress due to other PICS work being prioritised as acknowledged during the Annual Plan development process due to other priorities. For point e) discussions with key clinical staff have continued, to explore new areas of clinical coding in PICS after conversion to SNOMED CT. For point f) feasibility work has already been completed and demonstrated to the EPR Executive Board. The next step will establish an implementation approach.
3.2: Ensure an effective and robust pre-assessment service is in place.	a. Achieve 100% target of patients who are admitted for elective procedures receiving an appropriate level of pre-assessment	Initial analysis shows that performance is under target. Work is underway to reorganise clinics by casemix rather than specialty to allow more flexible use of capacity. Work is also being undertaken to identify specialties in which there is a mis-match between pre-assessment capacity and appointments requested.
4.1: Work collaboratively with Clinical Commissioning Groups and the Academic Health Science Network to ensure the best drugs and technologies are adopted.	a. Compliance with clinically agreed standards including NICE Guidance and Technology.	a. The Trust is 50% compliant. Compliance is expected to rise from 50% in Q2 as the number of pieces of guidance categorised as 'under review' are due for completion following successful clinical audit outcomes. Please refer to the Compliance and Assurance Report from the Director of Corporate Affairs.
8.4: Ensure the Trust identifies areas for delivering its areas of social responsibility.	a. Implement a carbon reduction performance framework for use both corporately and at divisional level. b. Regular analysis of data to identify progress against the Government's target of a 10% reduction in CO2 by 2015 from a 2007 base.	RSM Tenon has provided yearly comparisons of carbon emissions. Nationally, there is ambiguity about the measurement of the 10% carbon reduction target for the NHS. However, given increased patient numbers and an increased use of the retained estate it is unlikely that the target will be achieved. It should be noted however that nationally the baseline of 2007 is being used. This is not a comparable baseline for the Trust as the New Hospital was not open at this point and a number of major site changes have taken place since 2007.
10.4: Ensure policies and procedures, developed in partnership with Staff Side, are in place to support the workforce and management of staff.	b. Reduce turnaround time for policy agreement.	Turnaround time remains heavily dependent upon Staff Side's ability to meet, discuss and feedback in a timely manner. The Trust continues to work with Staff Side to improve performance in this area.

7. Recommendations

The Board of Directors is requested to:

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

7.2 **Accept** the year to date 2013/14 performance update against the Trust Annual Plan.

Tim Jones
Executive Director of Delivery

Appendix A

2013/14 Commissioning for Quality and Innovation Indicators

Total CQUIN Value £12,230,000

CQUIN	Accountability	Ref	Indicator	Ref	Milestones	Value	Baseline	Target	Timescale	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Friends and Family Test (National)	Exec - CN Group - CQG Division - All	1	Patient Friends and Family	1a	Increased response rate in the patient experience friends and family test	£312,500	TBC for Q1 2013/14	> baseline and 20% +	Qtr 4 2013/14	12.75%	11.80%	10.17%									
	Exec - DoD Group - SDG Division - All	2	Staff Friends and Family	2a	Improved performance on the Staff Friends and Family Test (Key Factor 24 on survey)	£312,500	2010/11 = 3.81 2011/12 = 3.78 2012/13 = 3.93 Nat Avg = 3.57	Improvement from 2012/13 or remain in top quartile	2013/14	To be confirmed when National Staff Survey results are published											
Safety Thermometer (National)	Exec - CN Group - CQG Division - All	1	Data Collection	1a	Submission of monthly data collection (pressure ulcers, falls, and urinary tract infection in those with a catheter)	£312,500	Full compliance	Monthly data submission	2013/14												
		2	Pressure Ulcer Prevalence	2a	Maintain quarterly performance at 1.1 or less over each quarter for all new pressure ulcers	£312,500	1.1	1.1 or less	Quarterly	0.37	0.56	0.47									
Dementia (National)	Exec - MD & CN Group - CQG & CQMG Division - All	1	Find, Assess, Investigate and Refer	1a	Case finding on admission within 72 hours for emergency admission over 75 years	£375,000	97%	90%	Monthly	97%	99%	98% (tbc)									
				1b	Risk assessment (AMT10)		96%	90%	Monthly	97%	98%	93% (tbc)									
				1c	Referral for specialist diagnosis for those where diagnosis is positive or inconclusive		100%	90%	Monthly	100%	100%	100% (tbc)									
		2	Clinical Leadership	2a	Named lead clinician for dementia	£62,500	N/A	Full compliance	2013/14												
				2b	Delivery of staff training plan		N/A	Full compliance	2013/14												
		3	Supporting Carers	3a	Monthly audit of carers for people with dementia to test whether they feel supported	£187,500	N/A	Full compliance	Monthly												
				3b	Report Carer Survey results to the Board twice a year		N/A	Full compliance	Biannually												
VTE Risk Assessment (National)	Exec - MD Group - CQMG Division - All	1	Risk Assessment Completion	1a	Admissions risk assessed within 24 hours	£312,500	>99% monthly	95%	Monthly	99.3%	98.9%	99.46% (draft)									
		2	Root Cause Analysis Completion	2a	Establish process for root cause analysis and baseline performance. Agree an indicative improvement trajectory with commissioners.	£78,125	N/A	TBA	Q1												
				2b	Provide quarterly progress report and review indicative trajectory in light of any issues that arise over the quarter and renegotiate with commissioners if required.	£234,375	TBC for Q1 2013/14	TBA	Q2-Q3												

Appendix A

CQUIN	Accountability	Ref	Indicator	Ref	Milestones	Value	Baseline	Target	Timescale	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Falls Management and Prevention	Exec - MD & CN Group - CQMG & CQG Division - All	1	Falls risk assessment populated on discharge letter for inpatients	1a	Undertake PICS technical work to pull in detail of the falls risk assessment outcome onto the discharge letter.	£71,875	N/A	Full compliance	Q1												
				1b	Undertake snapshot audit of letters to validate that the PICS technical development is translating into the discharge letter.	£215,625	N/A	Full compliance	Q2-Q4												
	Exec - MD & CN Group - CQMG & CQG Division - C	2	Completion of falls risk assessment for patients attending ED	2a	Undertake baseline snapshot audit to establish % of ED attendances who have a falls risk assessment completed within the audit sample. Agree a trajectory for improvement with commissioner. Provide action plan for delivering improvement.	£86,250	N/A	Full compliance	Q1	71% baseline over quarter 1. Improvement trajectory of 80% agreed											
				2b	Provide quarterly progress update against implementation of the action plan and performance against trajectory.	£201,250	71%	80%	Q2-Q4												
	Exec - MD & CN Group - CQMG & CQG Division - C	3	Patient attending ED due to fall communicated on ED discharge letter to GP practice	3a	Implement upgrade in Oceano to refine the categories for the mechanism of falls injury. Undertake technical development to extract this information into the ED discharge letter. Undertake education and training programme with ED staff to ensure this information is captured accurately.	£71,875	N/A	Full compliance	Q1												
				3b	Undertake snapshot audit of letters to validate that the Oceano technical development is translating into the ED discharge letter.	£215,625	N/A	Full compliance	Q2-Q4												
	Exec - MD & CN Group - CQMG & CQG Division - C	4	Identify patients who have fallen 3 times or more over a 30 day period and communicate this to the GP practice	4a	Establish process to identify the repeat fallers and alert the Falls Prevention Team. Agree with commissioner who the information on repeat fallers needs to be communicated to via telephone at the relevant GP practice.	£115,000	N/A	Full compliance	Q1	In progress											
				4b	Provide commissioners with a quarterly progress update report which includes the number of repeat fallers that have been communicated to GP practices.	£172,500	N/A	Full compliance	Q2-Q3												
Pressure Ulcers	Exec - CN Group - CQG Division - All	1	Reduction in Grade 2 Hospital Acquired Avoidable Pressure Ulcers	1a	Develop baseline of grade 2 hospital acquired avoidable ulcers and improvement trajectory.	£345,000	2012/13	N/A	2013/14	Baseline is 476 cases (average of 40 per month)											
				1b	Provide quarterly progress update against implementation of the action plan and performance against trajectory.	£345,000	2012/13	N/A	2013/14	In progress											
				1c	Deliver 10% reduction trajectory in the number of patients with grade 2 hospital acquired avoidable pressure ulcers.	£460,000	476 cases	10% reduction (428 cases)	2013/14	26 cases (35% reduction)	21 cases (48% reduction)	25 cases (38% reduction)									
Formulary adherence	Exec - MD Group - CQMG Division - All	1	Prescriptions in line with local formulary	1a	Agree audit sample size and methodology with commissioner, undertake baseline audit, and agree trajectory for improvement with commissioner for reduction in type in doses.	£345,000	N/A	Full compliance	Q1	In progress											
				1b	Report progress quarterly with implementation of improvement plan.	£345,000	N/A	Full compliance	Q2-Q4												
				1c	Deliver agreed trajectory for inpatients.	£460,000	TBC for Q1 2013/14	TBA	Mar-14	0.40%	0.40%	0.46%									
				1d	Deliver agreed trajectory for outpatients.					2.05%	1.59%	1.41%									

Appendix A

CQUIN	Accountability	Ref	Indicator	Ref	Milestones	Value	Baseline	Target	Timescale	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Discharge Planning	Exec - MD & CN Group - CQMG & CQG Division - All	1	Reduction in TTO turnaround time	1a	Submit baseline to commissioners and action plan for delivering the improvement.	£138,000	N/A	Full compliance	Q1	In progress											
				1b	Quarterly progress report against implementation of the action plan.	£138,000	N/A	Full compliance	Q2-Q4												
				1d	Delivery of the 80% within 2 hours target.	£184,000	TBC for 2012/13	80% in 2 hours	Mar-14	49%	46%	47%									
	Exec - MD & CN Group - CQMG & CQG Division - All	2	Increase in discharges before 1pm	2a	Establish a baseline of performance, refine methodology, agree a trajectory for improvement with commissioners, and submit an action for delivering the improvement.	£207,000	N/A	Full compliance	Q1	In progress											
				2b	Quarterly progress report against implementation of the action plan.	£207,000	N/A	Full compliance	Q2-Q4												
				2c	Delivery of the improvement trajectory.	£276,000	TBC for Q1 2013/14	TBA	Mar-14	Target tbc											
Clinical Dashboards	Exec - MD Group - CQMG Division - B&D	1	Dashboard usage	1a	To embed and demonstrate routine use of the use of specialised services clinical dashboards and submit data quarterly	£864,000	N/A	Full compliance	Quarterly												
Bone Marrow Transplant	Exec - MD Group - CQMG Division - D	1	Donor acquisition measures - data provision	1a	The percentage use of UK donors rather than European or US	£216,000	N/A	Data provided	Quarterly	20%	50%										
		2		2a	The number of Confirmatory Typing (CT)/ Extended Typing (ET) tests per patient	£216,000	N/A	Data provided	Quarterly	Methodology queries submitted to commissioners											
		3		3a	The number of searches undertaken per transplant	£216,000	N/A	Data provided	Quarterly												
		4		4a	The Turnaround Times (TAT) from the date of the search request to the delivery of the donor report	£216,000	N/A	Data provided	Quarterly												
Specialised Cancer	Exec - CN Group - CQG Division - B&D	1	Patient experience survey for 3 rare cancers	1a	Undertake patient experience survey for Sarcoma	£288,000	N/A	Survey undertaken	2013/14	Awaiting survey template publication by National Clinical Reference Group. Local survey developed.											
		2		2a	Undertake patient experience survey for Testicular	£288,000	N/A	Survey undertaken	2013/14												
		3		3a	Undertake patient experience survey for Brain	£288,000	N/A	Survey undertaken	2013/14												
Haemophilia	Exec - MD Group - CQMG Division - D	1	Joint score assessment	1a	Proportion of registered severe and moderate haemophilia A and B patients who have had their joint score assessed by a trained physiotherapist within the past 12 months	£405,000	TBC for 2012/13	50%	2013/14	22.22%	26.67%	29.67%									
		2	Use of Haemtrack	2a	Proportion of severe and moderate haemophilia A and B patients managing their own treatment, whose clinical data is recorded onto Haemtrack in the provider unit	£405,000	TBC for 2012/13	50%	2013/14	41.11%	42.22%	43.96%									
HIV	Exec - MD Group - CQMG Division - C	1	Disclosure to GPs	1a	Proportion of patients diagnosed with HIV registered with and disclosed to their GP	£432,000	TBC for 2012/13	70%	2013/14	Data being validated	Data being validated	Data being validated									
		2	GP communication	2a	Annual (at least) communication with GPs about the care of HIV patients who are registered with and disclosed to a GP	£432,000	TBC for 2012/13	TBA	2013/14	Data being validated	Data being validated	Data being validated									
Neurosurgery Shunt Revision	Exec - MD Group - CQMG Division - D	1	Shunt revision	1a	Proportion of new shunts requiring revisions within 30 days of insertion due to infection.	£864,000	TBC for 2012/13	10% or less	Q4	10% (tbc once validated)											

Key: CN - Executive Chief Nurse, CQG - Care Quality Group, CQMG - Care Quality Monitoring Group, DoD - Executive Director of Delivery, MD - Executive Medical Director, SDG - Strategic Delivery Group