AGENDA ITEM NO:

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 3 JUNE 2010

Title:	**FINAL QUALITY REPORT/ACCOUNT FOR 2009-10**
Responsible Director:	David Rosser, Executive Medical Director
Contact:	Imogen Gray, Head of Quality Development, 4584

Purpose:	To present the Trust's final Quality Report for 2009-10 for review.
Confidentiality Level & Reason:	
Medium Term Plan Ref:	1.1 To improve clinical quality outcomes for patients 1.2 To deliver the milestones and targets contained with the Commissioning for Quality and Innovation (CQUIN) indicators and the Quality Report.
Key Issues Summary:	• The Trust's final Quality Report for 2009-10 is attached at Appendix A for review • Positive comments have been received from NHS South Birmingham and the Birmingham LINk which are included in the Annex of the report.
Recommendations:	The Board of Directors is asked to: **Approve** the content of the Trust's final 2009-10 Quality Report for submission to Monitor, the Department of Health and external publication during June 2010.

Signed:	**Date:** 25 May 2010

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS
THURSDAY 3 JUNE 2010

FINAL QUALITY REPORT FOR 2009-10

PRESENTED BY EXECUTIVE MEDICAL DIRECTOR

1. **Introduction**

The aim of this paper is to present the Trust's final Quality Report for 2009-10 to the Board of Directors for review prior to submission to Monitor, the Department of Health and external publication. The final report incorporates the changes recommended by the Board of Directors at its April 2010 meeting and is presented at Appendix A.

2. **Statements from External Stakeholders**

The Trust's draft Quality Report for 2009-10 was provided to NHS South Birmingham, the Birmingham LINk and Birmingham City Council's Overview and Scrutiny Committee on 30 April 2010 for comment. Positive comments have been received from NHS South Birmingham and the Birmingham LINk and included in the Annex of the final report. Birmingham City Council Overview and Scrutiny Committee has declined to provide comments on trusts' 2009-10 Quality Reports.

3. **Specialty Quality Indicators**

3.1 A few minor amendments have been made since the validated indicator data was tabled at the Board of Directors meeting on 29 April 2010, following validation by clinicians. The changes are included in section 3.4 of the report:

3.1.1 Goals included for many more indicators.
3.1.2 Validated data now included for Urology and ENT indicators.
3.1.3 Intensive Care readmissions indicator now only shows data for all units together (excluding Wellcome Building Critical Care)
3.1.4 Burns, Hand Surgery and Oncology indicators are now not included as the methodology and data for these are still being refined with the specialties. These can be included in future quarterly update reports.
3.1.5 Neurosurgery indicator now also includes percentages.

4. **Other Content Updates**

The Chief's Executive's Statement now highlights the Trust as being a high-volume institution and more recent data for 2009-10 is included within the final report as follows:

Priority 4:	Outpatients activity data in the Complaints table now relates to attendances, includes Therapy data and excludes Radiology (CRIS) data.
Section 2.2.4:	CQUIN payment information, subject to final confirmation from NHS South Birmingham due shortly
Section 3.2:	MRSA and *C.difficile* data up to March 2010
Section 3.2:	Readmissions data up to December 2010 which is the latest available
Section 3.2:	The Trust's 2009 National Inpatient Survey results which were published in May 2010.
Section 3.3:	National Target and Indicator data to March 2010. Data for the 62-day wait for first treatment from urgent GP referral cancer target will be included once the reallocations have been confirmed.

5. My Health at UHB

Section 3.10 of the Quality Report provides information about the prototype 'My health at UHB' website which will be piloted in Liver Medicine during 2010-11. A detailed paper will be provided to the Chief Executive's Advisory Group meeting on 9 June 2010 by the Director of Informatics and Patient Administration.

6. Internal/External Assurance

6.1 KPMG will be conducting a 'dry run' audit of the Trust's arrangements for producing the 2009-10 Quality Report during June 2010, as per the guidance from Monitor. This will involve interviews with key staff and testing the systems and processes for collecting and validating data for three indicators:

6.1.1 MRSA
6.1.2 Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers; and
6.1.3 18 weeks data.

6.2 The Trust's Internal Auditors will also be reviewing the arrangements in place for producing Quality Reports during 2010-11 to provide further assurance and to ensure they are as robust as possible.

7. Next Steps

7.1 The final Quality Report for 2009-10 will be submitted as part of the Trust's Annual Report and Accounts to Monitor by 8 June 2010. The Quality Report will then be sent to the Secretary of State and published

on the NHS Choices website as the Trust's Quality Account by 30 June 2010.

7.2 Quality Report update reports will produced at the end of each quarter and provided to the Board of Directors in August 2010, November 2010 and February 2011 before publication.

8. Recommendations

The Board of Directors is asked to:

Approve the content of the Trust's final 2009-10 Quality Report for submission to Monitor, the Department of Health and external publication during June 2010.

Appendix A: Final Quality Report for 2009-10

University Hospitals Birmingham NHS
NHS Foundation Trust

2009-2010
Quality Report

This report covers the period 1 April 2009 to 31 March 2010

Part 1: Chief Executive's Statement

The Vision of University Hospitals Birmingham NHS Foundation Trust (UHB) is "to deliver the best in care" to our patients. Quality in everything we do underpins this Vision in the overall Trust Strategy and the Corporate, Divisional and Specialty Strategies which underpin it. Clinical Quality and Patient Experience are two of the Trust's Core Purposes and provide the framework for the Trust's robust approach to managing quality.

UHB is a high volume institution for many complex surgical interventions such as gastro-intestinal (oesophagus, stomach and pancreas) and head and neck cancer surgery, liver surgery and heart surgery.

Research shows that complex surgical procedures carried out by hospitals which do high volumes are associated with better short-term patient outcomes and long-term survival rates, fewer complications (such as infection and reoperation), reduced length of stay and a more efficient use of resources[1] [2].

UHB has made good progress in relation to all three quality improvement priorities for 2009-10 identified in last year's Quality Report: reducing medication errors, reducing infection, and improving patient experience and satisfaction. The Trust has however chosen to continue with these priorities in 2010-11 to deliver further improvements for our patients, particularly around reducing omitted drug doses.

The Trust has also identified two further quality improvement priorities for 2010-11: completion of venous-thromboembolism (VTE) risk assessment on admission for all patients and improving timeliness of administration of first antibiotic doses.

The Trust has continued to communicate with and involve staff and stakeholders in delivering high quality services during 2009-10. For example, clinical staff and the Health Informatics team have developed a wide range of specialty level quality indicators, some of which are shown in Part 3 of this report.

A key part of UHB's commitment to quality is being open and honest about performance. The Quality web pages were launched in November 2009 and provide staff, patients, the public and other stakeholders with up to date information on the Trust's performance in relation to quality: http://www.uhb.nhs.uk/quality.htm Information provided includes regular Quality Report updates and performance for some of the specialty level indicators, which will be extended during 2010-11.

The Trust's focused approach to quality is driven by innovative and bespoke information systems which enable us to capture and use real-time data in ways which few other UK trusts are able to do. During 2009-10, the Trust has developed an interactive Healthcare Evaluation Data (HED) tool and further developments have been implemented within the Prescribing Information and Communication System (PICS) which are described in Part 3 of this report.

---

[1] Killeen, S.D., *et al.* (2005). Provider volume and outcomes for oncological procedures. *British Journal of Surgery*, 92**(4)**, pp.289-402.

[2] NHS Executive. (2001, January). Guidance on Commissioning Cancer Services: Improving Outcomes in Upper Gastro-intestinal Cancers. [Online]. (URL http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4080278.pdf)

Data quality and the timeliness of data are fundamental aspects of UHB's management of quality. Data is provided to clinical and managerial teams as close to real-time as possible through various means such as the Trust's digital Clinical Dashboard. Information is subject to regular review and challenge at specialty, divisional and Trust levels, by the Clinical Quality Monitoring Group, Care Quality Group and Board of Directors for example.

The Trust's internal auditors will also review some of the processes and mechanisms through which data is extracted and reported in the Quality Report during 2010-11 to provide further assurance. I can therefore confirm that to the best of my knowledge the information contained within this report is accurate.

Finally, the opening of the first phase of the Queen Elizabeth Hospital Birmingham in June 2010 will allow us to continuously improve the quality of care we provide in a world-class environment.

……..
Julie Moore, Chief Executive June 3, 2010

Part 2: Priorities for improvement and statements of assurance from the Board of Directors

2.1 Quality Improvement Priorities

The Trust's 2008-09 Quality Report set out three key priorities for improvement during 2009-10:

Priority 1: Reducing errors (with a particular focus on medication errors)
Priority 2: Infection prevention and control
Priority 3: Improve patient experience and satisfaction.

The Trust has made good progress in relation to all three quality improvement priorities during 2009-10 which is detailed further below. The Board of Directors has chosen to continue with these 3 improvement priorities for 2010-11 plus two additional ones (shown in bold) as follows:

Priority 1: Reducing errors (with a particular focus on medication errors)
Priority 2: Time from prescription to administration of first antibiotic dose
Priority 3: Venous thromboembolism (VTE) risk assessment on admission (within 24hrs)
Priority 4: Improve patient experience and satisfaction
Priority 5: Infection prevention and control

The improvement priorities for 2010-11 were initially selected by the Trust's Clinical Quality Monitoring Group chaired by the Executive Medical Director, following consideration of performance in relation to patient safety, patient experience and effectiveness of care. These were then shared with the Trust's Governors and the Birmingham Local Involvement Network (LINk). The focus of the patient experience priority was decided by the Care Quality Group which is chaired by the Executive Chief Nurse and also has Governor representation. The priorities for 2010-11 were then finally approved by the Board of Directors.

The performance in 2009-10 and the rationale for selection of each priority are provided in detail below. This report should be read alongside the Trust's Quality Report for 2008-09.

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

Performance

During 2008-09, the Trust developed the ability to report on the number of drugs prescribed to patients but not administered (omitted) on the Prescribing Information and Communication System (PICS). The system logs each drug administration relating to every single prescription. Baseline data for January-March 2009 showing the percentage of antibiotic and other drug doses prescribed to patients but not administered (omitted) on PICS was reported in the Trust's Quality Report for 2008-09. This data includes both drug doses which are appropriately omitted (by nursing staff making valid clinical decisions for example) and doses unintentionally omitted due to a variety of administrative reasons.

The percentage of omitted antibiotic and non-antibiotic drug doses is shown below for each month (October 2009-March 2010) and the full 2009-10 year. Whilst the Trust has reduced omitted antibiotic and non-antibiotic doses, performance remains unsatisfactory and this therefore remains a key improvement priority for 2010-11.

Drug Omissions								
Time Period/ Drug Type	**Oct 09**	**Nov 09**	**Dec 09**	**Jan 10**	**Feb 10**	**Mar 10**	**2009-10**	**Baseline (Jan-Mar 09)**
Antibiotics	8.4%	8.2%	8.6%	7.9%	7.8%	7.7%	**8.7%**	11.2%
Non-Antibiotics	18.7%	18.1%	18.1%	17.2%	17.8%	16.5%	**18.5%**	20.1%

Initiatives implemented during 2009-10

- The recording of reasons for drug omissions was reviewed and rationalised within PICS to improve the quality of data capture and reduce inappropriate omissions.
- Pause button implemented within PICS to allow Doctors to pause prescriptions e.g., when a patient has gone to theatre and to quickly re-start them again when required.
- Monthly root cause analyses (in-depth reviews) of selected missed antibiotic dose cases by the Trust's Executive, divisional management and clinical teams began in March 2010.
- A change was implemented within PICS to enable Parkinson's drugs to be prescribed at non-standard times to improve the timeliness of administration.

Initiatives to be implemented in 2010-11

- Nurse pause function will be implemented within the Prescribing Information and Communication System to enable Nursing staff to pause prescriptions for certain drugs where clinically appropriate.
- Potential expansion of the Executive root cause analysis meetings to include other missed drugs.

How progress will be monitored, measured and reported

- Progress will continue to be measured at ward, specialty, divisional and Trust levels using information recorded in the Prescribing Information and Communication System. This includes automatic email alerts to different levels of management staff where specialty performance is outside agreed targets.
- Omitted drug doses will continue to be communicated daily to clinical staff via the Clinical Dashboard (which displays real-time quality information at ward-level) and monitored at divisional, specialty and ward levels.
- Performance will continue to be reported to the Chief Executive's Advisory Group, the Chief Operating Officer's Group and the Board of Directors each month to ensure appropriate actions are taken.
- Progress will also be reported in the quarterly Quality Report updates published on the Trust's quality web pages.

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

Current Status

When treating certain conditions such as severe infections or sepsis, delays in administration of the first dose of antibiotic can result in considerable patient harm or even death. The National Patient Safety Agency released a Rapid Response Report in February 2010 which focuses on reducing harm from omitted or delayed medicines in hospital. There is evidence within the clinical literature that rapid antibiotic delivery can reduce patient harm and improve outcomes, and that the time from prescription to administration of first antibiotic dose for certain conditions should ideally be 60 minutes or less.

As outlined under Priority 1 above, the Trust is already focusing on omitted doses, and has extended this to specifically include delays in administration of first antibiotic doses. Although data on omitted doses is captured within the Prescribing Information and Communication System and timeliness of administration is an issue, it is currently difficult to assess delays. This is because some patients are prescribed antibiotics days or even weeks ahead at pre-admission clinics for example which inappropriately skews the prescription to administration time.

New initiatives to be implemented in 2010-11

- Identify clinical exception rules and refine methodology for indicator measurement.
- Establish process to undertake multi-disciplinary root cause analyses for reporting to the Executive Team.
- Provide education and training to improve communication and awareness of this issue.
- Establish baseline performance at Trust and specialty levels and identify trajectories to deliver reduction.

How progress will be monitored, measured and reported

- Performance will be measured and monitored against the Trust and specialty level trajectories (once they have been set) using PICS data and the Trust's usual reporting tools.
- Careful scrutiny of the data will also be undertaken to ensure that it does represent unintended delays.
- Progress will be monitored by the Clinical Quality Monitoring Group and reported in the quarterly Quality Report updates published on the Trust's quality web pages.

Priority 3: Venous thromboembolism (VTE) risk assessment on admission (within 24hrs)

Current Status

Venous Thromboembolism (VTE) is the term used to describe deep vein thrombosis (blood clot occurring in a deep vein, most commonly in the legs) and pulmonary embolism (where such a clot travels in the blood and lodges in the lungs) which can cause considerable harm or death. VTE is associated with periods of immobility and can largely be prevented if appropriate preventative measures are taken.

Whilst most other trusts have to rely on a paper-based assessment of the risk of VTE for individual patients, the Trust has been using an electronic risk assessment tool within the Prescribing Information and Communication System since June 2008 for all inpatient admissions. The tool provides tailored advice regarding preventative treatment based on the assessed risk. The Trust is therefore able to capture the data from all of these assessments which is shown in the table below for 2009-10:

Admission Year	Admission Month	Surgical and Non Surgical Combined	Postponed	Not Required	Surgical and Non Surgical assessments done within 24 hours of admission as a percentage of all assessments
2009	**April**	86.24%	6.06%	7.70%	73.52%
	May	86.95%	4.73%	8.32%	73.75%
	June	89.32%	5.06%	5.62%	75.00%
	July	86.83%	7.30%	5.87%	73.58%
	August	82.10%	9.52%	8.38%	69.42%
	September	81.63%	12.20%	6.17%	69.66%
	October	84.67%	8.24%	7.09%	72.89%
	November	84.71%	7.86%	7.43%	72.09%
	December	85.87%	8.20%	5.93%	72.89%
2009 Total		85.35%	7.71%	6.94%	72.53%
2010	**January**	84.63%	9.10%	6.26%	72.95%
	February	84.92%	8.69%	6.39%	73.66%
	March	84.97%	8.88%	6.15%	77.81%
2010 Total		**84.83%**	**8.90%**	**6.27%**	**74.64%**

Providing such tailored advice depends upon the level of information capture at admission, for example whether the patient is surgical or non-surgical where the preventative measures may be different. We also recognise that in some circumstances not all of the patient-specific information may be available immediately on admission (e.g., for unconscious or critically ill patients) and therefore other clinical priorities determine that the risk assessment may be postponed. In rare cases a risk assessment may not be required, such as for a patient who is being investigated for a VTE when treatment rather than prevention is required.

Considerable national attention has been given to this subject over the past few months by the Department of Health and the National Institute for Health and Clinical Excellence (NICE) which published new guidance in January 2010. Ensuring that 90% of all patients have a full VTE risk assessment completed within 24 hours of admission by the end of 2010-11 is now a mandatory, national Commissioning for Innovation and Quality (CQUIN) indicator which the Trust has agreed with NHS South Birmingham for 2010-11.

Initiatives implemented during 2009-10

- Automatic Doctor prompts at 24 hours for postponed risk assessments.
- Automatic reminders if preventative medication is not given despite advice from the assessment tool.
- Where elastic compression stockings are recommended for surgical patients, these are now automatically prescribed within PICS.

New initiatives to be implemented in 2010-11

- In the plans to update the risk assessment process in line with NICE recommendations, the option of 'not required' will be removed. An initial screening question will be used in the assessment tool instead that will determine for the clinician if a full risk assessment is actually not required (for example for a short stay patient who is likely to remain fully mobile).
- The electronic risk assessment tool will need to be implemented for day-case patients too.

How progress will be monitored, measured and reported

- Performance will be measured using PICS VTE risk assessment data and tracked against the year-end target.

- The Trust's Thrombosis Group working closely with the PICS team will be responsible for providing education and feedback about performance throughout the Trust.
- Performance will be monitored by the Trust's Clinical Quality Monitoring Group and the Board of Directors.
- Progress will also be reported in the quarterly Quality Report updates published on the Trust's quality web pages.

Priority 4: Improve patient experience and satisfaction

Performance

Ten times as many patients responded to the electronic patient survey during 2009-10 compared to 2008-09, providing a wealth of information about their experience:

Feedback method	**2009-10**	**2008-09**
Bedside TV	5,860	1,100
Hand-held devices	3,810	N/a
Discharge lounge	712	N/a
Total	**10,382**	**1,100**

The survey results show that the Trust has improved patient experience and satisfaction across all five aspects of care during 2009-10:

Electronic real-time patient survey responses

Time period/ Survey Questions		**2009-10**	**2008-09**
Dignity and respect	Percentage of patients who said they were always treated with dignity and respect	86.9%	67.2%
	Percentage of patients who said they were always or sometimes treated with dignity and respect	98.6%	92.8%
Privacy	Percentage of patients who said their privacy was always maintained whilst being examined or treated	92.5%	78.0%
	Percentage of patients who said their privacy was always or sometimes maintained whilst being examined or treated	98.7%	94.0%
Involvement in decisions	Percentage of patients who said they were always involved in decisions about their care and treatment	70.6%	47.0%
	Percentage of patients who said they were always involved, or involved to some extent, in decisions about their care and treatment	93.6%	83.9%
Cleanliness of hospital and ward	Percentage of patients who rated the hospital and ward as very clean	70.3%	45.7%
	Percentage of patients who rated the hospital and ward as very clean or fairly clean	97.7%	90.3%
Overall rating of care	Percentage of patients who rated their overall care as very good or excellent	84.9%	61.9%
	Percentage of patients who rated their overall care as good, very good or excellent	95.2%	79.4%

The Trust's National Adult Inpatient Survey results for 2009 are shown in Part 3 of this report.

Complaints

In 2009-10, there was a 5.6% increase in the number of complaints received by the Trust compared to the previous year, although the ratio of complaints to inpatient and outpatient activity has actually dropped.

	2009-10	**2008-09**
Total number of complaints	643	609
Response within deadline*	91%	88%
Referrals for independent review by referral date	27	6
Referrals for independent review by complaint date	6	4

* Response data for 2009/10 relates to complaints received up to and including 31 January 2010, the latest full month for which data is available.

Top 3 Complaint categories	**2009-10**	**2008-09**
Main category		
1. Clinical treatment	272	254
2. Out-patient appointment delay/cancellation	109	97
3. Communication/information	76	69
All issues		
1. Clinical treatment	595	732
2. Communication/information	315	408
3. Attitude of Staff	150	103

Ratio of Complaints to Activity

		2009-10	**2008-09**
Inpatients	FCEs*	124,589	121,653
	Complaints	277	294
	Rate per 1000 FCEs*	**2.22**	**2.42**
Outpatients	Attendances**	499,981	454,514
	Complaints	309	263
	Rate per 1000 appointments	**0.62**	**0.58**
A&E	Attendances	82,632	83,051
	Complaints	57	52
	Rate per 1000 attendances	**0.69**	**0.63**

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

** The Outpatients activity data for 2009-10 and 2008-09 relates to attendances only and also includes Therapy Outpatients data (physiotherapy, podiatry, dietetics, speech and language therapy and occupational therapy).

Compliments

Compliments are recorded by the Patient Advice and Liaison Service (PALS) on behalf of the Trust. The majority of compliments are received in writing – by letter, email or feedback leaflet – and the rest are received verbally via telephone or face to face.

The number of compliments recorded has risen significantly during 2009-10. The majority relate to treatment received although an increasing amount specifically mention medical or nursing care and friendliness of staff:

Compliments Subtype	Number Received in 2009-10	Number Received in 2008-09
Treatment received	132	141
Nursing care	85	10
Friendliness of staff	75	26
Efficiency of service	36	8
Medical care	20	7
Other	4	2
Facilities	4	11
Information provided	3	0
Comment	0	1
Totals:	**359**	**206***

* The number of compliments received in 2008-09 has increased slightly from that shown in the Trust's 2008-09 Quality Report due to some being received after year end which reflect care/treatment provided during 2008-09. Some of the 2008-09 compliments have also been re-categorised to provide more meaningful data e.g., moved from 'Treatment received' to a more specific category such as 'Nursing Care'.

Initiatives implemented during 2009-10

- Patient survey responses were uploaded every twelve hours onto the Clinical Dashboard for each ward, providing real-time feedback to wards to enable them to address any issues quickly. The Executive Chief Nurse and Associate Directors of Nursing have been alerted to the excellent and poor responses from patients.
- Patient experience surveys are currently being piloted in the Ophthalmology Outpatient Department using hand-held electronic tablets.
- A follow-up telephone survey has been developed for use with patients on discharge and staff have been recruited to conduct the surveys.
- The Patient Experience Analyst commenced in post at the end of August 2009 and provides a weekly patient feedback report to Divisions and a detailed quarterly report to the Care Quality Group.

Improving patient experience and satisfaction in 2010-11

The Trust has chosen to focus on measuring, monitoring and improving performance for the following National Adult Inpatient Survey questions during 2010-11:

- Involvement in decisions about treatment/care
- Hospital staff available to talk about worries/concerns
- Privacy when discussing condition/treatment
- Informed about medication side effects
- Informed who to contact if worried about condition after leaving hospital
- Did staff do all they could to control pain?

These questions have been selected by the Trust's Care Quality Group which has Governor representation. They also include those covered by the nationally mandated Commissioning for Quality and Innovation (CQUIN) indicator for 2010-11.

New initiatives to be implemented in 2010-11

- Implement telephone survey and roll out survey used in Ophthalmology to other Outpatient areas.
- Use of an electronic stand in the Emergency Department to gain feedback from ambulatory patients.
- Development of a comprehensive Divisional report that brings together all elements of patient feedback, including survey responses, Patient Advice and Liaison Service (PALS) contacts, complaints, comments and compliments.
- Analysis of data via demographic information to identify the experience of patients from a range of diverse backgrounds to identify potential areas of inequity.

How progress will be monitored, measured and reported

- Feedback rates and responses will continue to be measured and communicated via the Clinical Dashboard.
- Performance will continue to be monitored as part of the Back to the Floor visits by the senior nursing team with action plans developed as required.
- Regular patient feedback reports will be provided to the Patient Experience Group, Care Quality Group and the Board of Directors.
- Progress will also be reported in the quarterly Quality Report updates published on the Trust's quality web pages.

Priority 5: Infection prevention and control

Performance

2009-10 has been another excellent year with the numbers of both MRSA bloodstream infections and *C.difficile* cases more than halving compared with 2008-09 and well below the agreed trajectories:

Time Period/ Infection Type	2009-10	Agreed Trajectory for 2009-10	2008-09	Agreed Trajectory for 2008-09	2007-08	Agreed Trajectory for 2007-08
***C. difficile* (post-48 hour cases)**	176	348	357	526	658	N/a
MRSA bloodstream infections	13	30	35	48	76	48

Both of these organisms remain a high priority during 2010-11 as new trajectories come into play requiring even greater reductions. The Trust will need to reduce the number of MRSA bloodstream infections to 11 and *C.difficile* to 13 cases or less per month during 2010-11. *C.difficile* remains the greatest challenge due to the need to maintain a consistent performance across the year.

Initiatives implemented during 2009-10

- The Trust has continued to make good progress on the management of the High Impact Interventions and now completes root cause analyses for all MRSA blood stream infections and *C.difficile* cases, ensuring that learning is gained from each case.
- A high pressure wash decontamination unit has been implemented within the Trust. which has been associated with an overall reduction in MRSA bacteraemia and C diff cases during the past year. This will also be implemented in the new hospital.
- The National Patient Safety Agency (NPSA) Matching Michigan patient safety project commenced on 1 December 2009. Since 15 December 2009, UHB has been submitting monthly data to the NPSA from all four Intensive Care Units on bloodstream infections linked to the use of central venous catheters (CVCs).

Initiatives to be implemented in 2010-11

- Enhanced cleaning with vapour decontamination used as part of the standard terminal clean in the new hospital.
- Expansion of MRSA screening to include all admissions, including emergencies, and follow through to decolonisation in the community.
- Strengthening the use of learning outcomes from the root cause analyses for MRSA bacteraemia and C.difficile.
- Use of routine surveillance to identify those organisms which will be future priorities for reduction

How progress will be monitored, measured and reported

- The number of MRSA and C.difficile cases will be measured and monitored against the 2010-11 trajectories.
- Performance will be monitored daily via the Clinical Dashboard and daily/weekly email alerts.
- All MRSA bloodstream infections will continue to be reported as serious incidents requiring investigation (SIRIs) to NHS South Birmingham.
- Monthly root cause analyses will continue to be undertaken for MRSA bloodstream infections and C.difficile outbreaks.
- Progress will also be reported in the quarterly Quality Report updates published on the Trust's quality web pages.
- Performance will be reported monthly to the Trust's Infection Prevention and Control Committee and the Board of Directors.

2.2 Statements of assurance

2.2.1 Information on the review of services

During 2009/10 the University Hospitals Birmingham NHS Foundation Trust* provided and/or sub-contracted 61 NHS services.

The Trust has reviewed all the data available to them on the quality of care in 61 of these NHS services**.

The income generated by the NHS services reviewed in 2009/10 represents 100% per cent of the total income generated from the provision of NHS services by the Trust for 2009/10.

* University Hospitals Birmingham NHS Foundation Trust will be referred to as the Trust/UHB in the rest of the report.

** The Trust has appropriately reviewed the data available on the quality of care for all its services. Due to the sheer volume of electronic data the Trust holds in various information systems, this means that UHB uses automated systems and processes to prioritise which data

on the quality of care should be reviewed and reported on. These are described further in Part 3 of this report.

Data is reviewed and acted upon by clinical and managerial staff at specialty, divisional and Trust levels by various groups including the Clinical Quality Monitoring Group chaired by the Executive Medical Director.

2.2.2 Information on participation in clinical audits and national confidential enquiries

During 2009/10 36 national clinical audits and 3 national confidential enquiries covered NHS services that UHB provides.

During 2009/10 UHB participated in 83% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that UHB was eligible to participate in during 2009/10 are as follows: (see table below)

The national clinical audits and national confidential enquiries that UHB participated in during 2009/10 are as follows: (see table below)

The national clinical audits and national confidential enquiries that UHB participated in, and for which data collection was completed during 2009/10, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (see table below).

Audit Type	Audit UHB eligible to participate in	UHB Participation 2009-10	Percentage of required number of cases submitted
Part of the National Clinical Audit and Patient Outcomes Programme	Adult cardiac interventions (eg, angioplasty)	Yes	100%
	Adult cardiac surgery	Yes	100%
	Bowel Cancer (NBOCAP)	Yes	63.90%
	Cardiac Ambulance Services	Yes	N/A – specific number not required
	Cardiac rhythm management (Pacing/Implantable Defibrillators)	Yes	100%
	Congenital heart disease (children and adults)	Yes	N/A - data entry deadline May 2010
	Continence	Yes	105%
	Head & neck cancer (DAHNO)	Yes	Not available
	Heart failure	Yes	N/A – data entry deadline May 2010
	Hip Fracture	Yes	Not available

	Lung cancer (LUCADA)	Yes	92%
	Mastectomy & Breast Reconstruction	Yes	66%
	Myocardial Ischaemia (MINAP)	Yes	N/A – specific number not required
	National Carotid Interventions Audit	Yes	Not available
	National Diabetes Audit	Yes	99%
	National Kidney Care - vascular access	No – planning to participate during 2010	-
	National Pain Audit	Yes	N/A – specific number not required
	National Stroke Audit - organisational audit	Yes	N/A – specific number not required
	Oesophago-gastric (stomach) cancer	Yes	100%
Not part of the National Clinical Audit and Patient Outcomes Programme	Adult Critical Care (ICNARC) - Case Mix Programme	Yes for 2 of the 4 ITUs	100% for 2 units
	British Thoracic Society - Adult Community Acquired Pneumonia	Yes	N/A - data entry deadline May 2010
	British Thoracic Society - NIV (Adult)	Yes	N/A - data entry deadline May 2010
	British Thoracic Society - Adult Asthma	No	-
	British Thoracic Society - Emergency Oxygen	No	-
	National Comparative Audit of Blood Transfusion - Audit of Blood Collection	Yes	100%
	National Elective Surgery PROMS - hernia	Yes	55%
	National Elective Surgery PROMS - varicose veins	Yes	38%
	College of Emergency Medicine - Pain in children	No	-
	College of Emergency Medicine - Hip Fracture	Yes	70%
	College of Emergency Medicine - Severe and Moderate Asthma	No	-
	Potential donor audit	Yes	100%
	Renal Registry	Yes	100%

	Renal Transplant	Yes	N/A – specific number not required
	Severe Trauma	No, data for 09-10 to be entered	-
	UK Cardiothoracic Transplant Audit	Yes	100%
	UK Liver Transplant Audit	Yes	100%
National Confidential Enquiries (NCEPOD)	**National Confidential Enquiries (NCEPOD)**	**UHB Participation 09/10**	**Percentage of required number of cases submitted**
	Peri-Operative Study	Yes	47%
	Emergency and Elective Surgery in the Elderly	Yes	Casenotes 100% Surgical Questionnaires100% Anaesthetic Questionnaires 43%
	Parenteral nutrition	Yes	73%

Percentages given are latest available figures. 'Not available' indicates that data has been submitted but the number of cases submitted as a percentage of the number of required cases is not available. This could be because the Trust is awaiting confirmation of percentage by the national body or the precise number of required cases is not available.

UHB's audit strategy has been to prioritise support for participation in the national audits included in the National Clinical Audit and Patient Outcomes Programme (NCAPOP), as agreed by the Clinical Audit and Effectiveness Committee, which directs audit priorities in the Trust. The NCAPOP consists of a series of audits commissioned and managed by the Healthcare Quality Improvement Partnership (HQIP), under the guidance of the National Clinical Audit Advisory Group (NCAAG), and funded by the Department of Health. Not all of the audits listed above provide reports or recommendations back to the Trust. UHB is currently reviewing and prioritising its audit strategy for 2010-11 to reflect clinical priorities and available resources.

The Trust's Clinical Governance Support Unit facilitates the reporting and monitoring of Trust participation in national audits and actions taken in accordance with recommendations of national audit reports. This activity is reported to the Clinical Audit and Effectiveness Committee and the Clinical Quality Monitoring Group which directs action to improve the quality of care. Exceptions are also reported to the Trust's Audit Committee.

The reports of 15 national clinical audits were reviewed by the provider in 2009/10 and UHB intends to take the following actions to improve the quality of healthcare provided:

Audit reports reviewed	Actions
Adult cardiac surgery	UHB demonstrated compliance with national recommendations and showed activity, surgical results and quality of care in line with the national data submitted around the country.
Adult Critical Care (ICNARC) - Case Mix	The data is used for regular review of mortality rates, benchmarking and comparison against similar units and local audit and research

Audit reports reviewed	Actions
Programme	projects.
Cardiac Ambulance Services	UHB is supporting ambulance services to make improvements by sharing information about the outcomes for patients having a heart attack, collected via the Myocardial Infarction National Audit Project (MINAP). The Ambulance outcomes audit aims to share MINAP data with the Ambulance Trusts by linking the ambulance job number with the relevant MINAP entry.
Congenital heart disease (children and adults)	UHB is working with the Birmingham Children's Hospital to ensure all the documentation for the surgical record contains the following information the NHS number, date of discharge, and mode of discharge. The action points following the recommendations of the inclusion of perfusion records in the patient notes are to be discussed.
Head & neck cancer (DAHNO)	The interval from biopsy to reporting should be less than 10 days; UHB achieved 92%. An audit has been carried out which has shown an improvement in waiting times. This will continue to be monitored.
Lung cancer (LUCADA)	Trust considered to meet all recommendations
Mastectomy & Breast Reconstruction	Trust considered to meet all recommendations
Myocardial Ischaemia (MINAP)	Improving primary angioplasty performance within 150 minutes reported at 73%. For patient quality improvement UHB has introduced 24/7 primary angioplasty. The facilities for primary Percutaneous Coronary Intervention (pPCI) are on a separate site to the A&E department. To improve on this figure close links with the ambulance service have been made so that crews can alert teams directly to activate the pPCI pathway more promptly, particularly during out of hours. A change to our system of pPCI activation is being introduced. All patients will be brought directly to the Percutaneous Coronary Intervention (PCI) site (QE cath labs) irrespective of time of presentation. If out of hours, the ambulance team have agreed to stay with the patient until the pPCI team arrive. This should avoid the additional delay caused by an out of hours inter hospital transfer. For those patients who do not get admitted to a cardiac facility a clinical pathway is in place that ensures all patients who are found to have a raised troponin are referred to the cardiologist.
National Falls and Bone Health in Older People	Improvements have been made to services for hip fracture patients. For example a trauma 'navigator' role has been put in place to speed up the whole patient journey including admission to theatre, new theatre sessions have been made available and where possible patients are cohorted together on one ward. Length of stay and mortality are regularly monitored.
National Kidney Care - Patient Transport Survey Report	The regional network in the West Midlands have put together a regional group. The first meeting of the Regional Transport Group will take place in April 2010. Each satellite unit has also set up regular meetings every two months with the transport department to discuss any issues, improvements etc. Each satellite unit is also working to set up a patient group.
National Stroke Audit	Improvements have been made to stroke services, such as direct admissions to the Acute Stroke Unit; re-design of Stroke Coordinator

Audit reports reviewed	Actions
	role; early multidisciplinary therapy assessments and patient centred goals; improved team communication about patients; improved written documentation of care and regular feedback sessions to all staff. Data on key indicators of quality is collected on an ongoing basis in order to monitor performance.
Renal Registry	Trust considered to meet all recommendations
Renal Transplant	Trust considered to meet all recommendations
Severe Trauma	Creation of an administrative post to assist with audit is in discussion. Specific cases highlighted to consultants for review - consultants to review major cases.
UK Cardiothoracic Transplant Audit	The audit reports centre-specific and total national data on outcomes for heart and lung transplantation in the UK. The unit was fully compliant with data collection and outcomes were comparable with other centres. No action points were raised specifically requiring this units attention apart from the need for continuous monitoring.

At UHB a wide range of local clinical audit is undertaken in clinical specialties and across the Trust. These may be highly specialised audits examining whether treatments or services for specific medical conditions, such as diabetes, are meeting standards of best practice; or they may be broader audits of particular aspects of services, such as monitoring staff compliance with infection control protocols or checking that standards of documentation are being met. A total of 677 clinical audits were registered with UHB's clinical audit team as having commenced or been completed at UHB during 2009-10.

The reports of 280 local clinical audits were reviewed by the provider in 2009/10 and UHB intends to take the following actions to improve the quality of healthcare provided:

This figure indicates that the results of 280 clinical audits were reported and fed back to staff within clinical areas and those reports were submitted to UHB's clinical audit team. At UHB, staff undertaking clinical audit are required to report any actions that should be implemented to improve service delivery and clinical quality. A list of examples of specific actions reported can be viewed on the Quality web pages: http://www.uhb.nhs.uk/quality.htm These include measures such as: updating patient information; developing new protocols or guidelines for staff; increasing staff awareness of required standards through training or education sessions; making changes to staff roles; implementing new care plans or assessment tools for patients; and purchasing equipment.

Each clinical specialty at UHB is required to plan a programme of audit for the year ahead, based on national audit priorities, areas of risk and locally determined priorities.

2.2.3 Patient participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by UHB that were recruited during that period to participate in research approved by a research ethics committee was 5271.

This data reflects active research studies during 2009-10, some of which were initiated prior to April 2009. The level of patient recruitment has therefore been averaged across the duration of each study to identify patient recruitment for 2009-10.

2.2.4 Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion of UHB's income in 2009/10 was conditional upon achieving quality improvement and innovation goals agreed between UHB and NHS South Birmingham, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2009/10 and for the following 12 month period are available on request from the Communications Team (Tel: 0121 627 2023 or email Communications@uhb.nhs.uk). This information is also listed on the Trust's quality web pages: http://www.uhb.nhs.uk/quality.htm

The amount of UHB's income in 2009/10 which was conditional upon achieving quality improvement and innovation goals was £1.85m and the Trust received £1.85m in payment.

This figure has been arrived at as a percentage of the healthcare income which will be included within the Trust's 2009-10 accounts and does not represent actual outturn (as an estimate has to be included for Month 12 income). The actual figure will not be known until June 2010 when we will have a final position as reconciled with the CBSA. Also whilst we have received payment throughout the year as each month has been agreed with CBSA, final payment of CQUIN will not take place until the June 2010 reconciliation point.

2.2.5 Care Quality Commission (CQC) registration status and periodic/special reviews

UHB is required to register with the Care Quality Commission and its current registration status is registered without compliance conditions. UHB has the following conditions on registration: provider conditions only which stipulate that the regulated activities the Trust has registered for may only be undertaken at Queen Elizabeth Medical Centre and Selly Oak Hospital.

The Care Quality Commission has not taken enforcement action against UHB during 2009/10.

UHB is subject to periodic review by the Care Quality Commission and the last review was on 13 October 2009 (date of publication of the Annual Health Check scores for 2008-09). The CQC's assessment of the Trust following that review was Excellent for Quality of Services and Excellent for Quality of Financial Management.

UHB intends to take the following actions to address the points made in the CQC's assessment:

The Trust underachieved on the national priority performance indicator for stroke care based on the results of the 2008 National Sentinel Stroke Audit and has invested funding to improve the service. Key quality indicators for stroke patients, such as brain scan with 24 hours, are now monitored on an ongoing basis and action is taken to improve service as required. Quarterly audits are also undertaken and reported internally and to the Primary Care Trust. The Trust will participate in the next national sentinel stroke audit in 2010.

Stroke indicators are reviewed monthly at the Clinical Quality Monitoring Group, chaired by the Executive Medical Director; and stroke data is part of the Trust's performance review process. There is also a Stroke Clinical Development multi-disciplinary team (MDT) group which meets on a monthly basis to review and implement actions required to improve the service.

UHB has made the following progress by 31 March 2010 in taking such action: the actions listed above were all in place by 31 March 2010.

UHB has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2009/10: Hygiene Code inspection on 22 October 2009. UHB intends to take the following action to address the conclusions or requirements reported by the CQC: no action required.

UHB has made the following progress by 31 March 2010 in taking such action: no action required.

The Trust received a letter from the Care Quality Commission in September 2009 about being a potential outlier in May 2009 in mortality for the primary diagnosis group 'Fluid and Electrolyte Disorders'. The Trust carried out a rigorous assessment of the mortality relating to this specific group of patients and found that the increased mortality rate was due to low activity and the complexity of patients treated. A review of the case notes for this group of patients was also undertaken to provide additional assurance; the Trust is satisfied that the care provided was appropriate.

2.2.6 Information on data quality

UHB submitted records during 2009/10 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was: 97.1% for admitted patient care; 97.7% for outpatient care; and 89.9% for accident and emergency care.
- which included the patient's valid General Practitioner Registration Code was: 100% for admitted patient care; 100% for outpatient care; and 100% for accident and emergency care.

The percentages above have been calculated using the latest available published Secondary Uses Service data (April 2009-January 2010) and the data which UHB has submitted to SUS for February-March 2010 which is not yet published.

UHB's score for 2009/10 for Information Quality and Records Management, assessed using the Information Governance Toolkit was 76%.

UHB was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

Primary Diagnoses Incorrect 4.3%
Secondary Diagnoses Incorrect 3.8%
Primary Procedures Incorrect 8.6%
Secondary Procedures Incorrect 4.7%

The results should not be extrapolated further than the actual sample audited; General Medicine and Ear, Nose and Throat (ENT) were reviewed within the sample.

Part 3: Other information

3.1 Overview of quality of care provided during 2009-10

The tables below show the Trust's performance in 2009-10 and 2008-09 for a selection of indicators for patient safety, clinical effectiveness and patient experience. The Board of Directors has chosen to include the same selection of indicators as reported in the Trust's 2008-09 Quality Report to enable patients and the public to judge performance over time.

The patient safety and clinical effectiveness indicators were originally selected by the Clinical Quality Monitoring Group because they represent a balanced picture of quality at UHB. The

patient experience indicators were selected in consultation with the Care Quality Group which has Governor representation to enable comparison with other NHS trusts.

The latest available data is shown below and has been subject to the Trust's usual data quality checks by the Health Informatics team. Benchmarking data has also been included where possible. Performance has been monitored and challenged during the past year by the Clinical Quality Monitoring Group and the Board of Directors. In addition, the Trust has reported on performance against these indicators during the past year in the Quality Report updates published on its quality web pages: http://www.uhb.nhs.uk/quality.htm

3.2 Performance of Trust against selected indicators

Indicators	2009-10	Peer Group Average (where available)	2008-09*
Patient safety indicators			
1(a). MRSA: Patients with MRSA infection/10,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	**0.42**	**0.39**	**1.15**
Time period	2009-10	2009-10	2008-09
Data source	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	HPA Website
Peer group		Acute trusts in West Midlands SHA	
1(b). MRSA: Patients with MRSA infection/10,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**0.43**	**0.45**	**1.18**
Time period	2009-10	2009-10	2008-09
Data source	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	HPA (MRSA data), HES data (bed days)
Peer group		Acute trusts in West Midlands SHA	
2(a). *C. difficile:* Patients with *C. difficile* infection/1,000 bed days (includes all bed	**0.53**	**0.38**	**1.62**

Indicators	2009-10	Peer Group Average (where available)	2008-09*
days from all specialties) *Lower rate indicates better performance*			
Time period	2009-10	2009-10	2008-09
Data source	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)	HPA Website
Peer group		Acute trusts in West Midlands SHA	
2(b). *C. difficile:* Patients with *C. difficile* infection/1,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**0.55**	**0.44**	**1.66**
Time period	2009-10	2009-10	2008-09
Data source	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)	HPA (C.diff data), HES data (Bed days)
Peer group		Acute trusts in West Midlands SHA	
3. Patient safety incidents (reporting rate per 100 admissions) *Higher rate indicates better reporting*	**8.5**	**5.8**	**10.2**
Time period	2009-10	April-September 2009	2008-09
Data source	Datix (incident data), Trust admissions data	National Patient Safety Agency	Datix (incident data), Trust admissions data
Peer group		Acute teaching trusts in West Midlands SHA	
4. Percentage of	**86.6%**	**69.6%**	**89%**

Indicators	2009-10	Peer Group Average (where available)	2008-09*
patient safety incidents which are no harm incidents *Higher % indicates better performance*			
Time period	2009-10	April-September 2009	2008-09
Data source	Datix (incident data)	National Patient Safety Agency	Datix (incident data)
Peer group		Acute teaching trusts in West Midlands SHA	
Clinical effectiveness indicators			
5(a). Readmissions: Readmission rate (Medical and surgical specialties - elective and emergency admissions aged >15) % *Lower % indicates better performance*	**7.59%**	**7.14%**	**8.5%**
Time period	April-Dec 09	April-Dec 09	2008-09
Data source	HES data	HES data	HES data
Peer group		University hospitals	
5(b). Readmissions: Readmission rate (all specialties) % *Lower % indicates better performance*	**7.69%**	**6.33%**	**8.57%**
Time period	April-Dec 09	April-Dec 09	2008-09
Data source	HES data	HES data	HES data
Peer group		University hospitals	
6. Falls (incidents reported as % of elective and emergency admissions) *Lower % indicates better performance*	**1.97%**	*Not available*	**1.99%**
Time period	2009-10		2008-09
Data source	Datix (incident data), Trust admissions data		Datix (incident data),

Indicators	2009-10	Peer Group Average (where available)	2008-09*
			Trust admissions data
7. Percentage of stroke patients (infarction) on aspirin, clopidogrel or warfarin *Higher % indicates better performance*	**99.7%**	**99.7%**	**98%**
Time period	2009-10	2008 Calendar year	2008-09
Data source	Trust PICS data	Cleveland Clinic website	Trust PICS data
Peer group		Cleveland Clinic, Ohio, U.S.A.	
8. Percentage of beta blockers given on the morning of the procedure for patients undergoing first time coronary artery bypass graft (CABG) *Higher % indicates better performance*	**93.3%**	**88%** NB This data is for all surgery patients with heart conditions who were on betablockers	**86.6%**
Time period	2009-10	Jan-Jun 09	2008-09
Data source	Trust PICS data	Cleveland Clinic website	Trust PICS data
Peer group		Cleveland Clinic, Ohio, U.S.A.	

* The data presented for 2008-09 is the latest available and therefore updates some of the data reported in the Trust's 2008-09 Quality Report.

Notes on clinical outcome measures

The data shown is subject to standard national definitions where appropriate. The Trust has also chosen to include infection and readmissions data which has been corrected to reflect specialty activity, taking into account that the Trust does not undertake paediatric, obstetric, gynaecology or elective orthopaedic activity. These specialties are known to be very low risk in terms of hospital acquired infection for example and therefore excluding them from the denominator (bed day) data enables a more accurate comparison to be made with peers.

6: The admissions data for 2009-10 and 2008-09 includes daycase patients as well as all elective and emergency admissions.

7: Aspirin, clopidogrel or warfarin are given to reduce the likelihood of recurrent stroke or transient ischaemic attack (TIA) in patients who have already suffered a stroke.

Any patients who are identified as not having been given aspirin, clopidogrel or warfarin during their stay are followed up to ensure they have been discharged on these drugs if clinically appropriate. The Cleveland Clinic, located in Ohio in the U.S.A., is a not-for-profit, multi-specialty academic medical centre that integrates patient care with research and education, and is widely regarded as being amongst the best healthcare providers in the U.S.A.

8: Beta blockers are given to reduce the likelihood of peri-operative myocardial infarction and early mortality. This indicator relates to patients already on beta blockers and whether they are given beta blockers on the day of their operation. All incidences of beta blockers not being given on the day of operation are investigated to understand the reasons why and to reduce the likelihood of future omissions.

We have chosen to measure our performance against the following metrics	2009-10	Comparison with other NHS trusts 2009-10	2008-09	Comparison with other NHS trusts 2008-09	2007-08	Comparison with other NHS trusts 2007-08
Patient experience indicators						
9. Overall were you treated with respect and dignity	**89**	**Intermediate 60% of trusts**	**88**	**Intermediate 60% of trusts**	**89**	**Intermediate 60% of trusts**
Time period & data source	Trust's 2009 Inpatient Survey Report, Care Quality Commission		Trust's 2008 Inpatient Survey Report, Care Quality Commission		Trust's 2007 Inpatient Survey Report, Healthcare Commission	
10. Involvement in decisions about care and treatment	**70**	**Intermediate 60% of trusts**	**70**	**Intermediate 60% of trusts**	**67**	**Worst performing 20% of trusts**
Time period & data source	Trust's 2009 Inpatient Survey Report, Care Quality Commission		Trust's 2008 Inpatient Survey Report, Care Quality Commission		Trust's 2007 Inpatient Survey Report, Healthcare Commission	
11. Did staff do all they could to control pain	**80**	**Worst performing 20% of trusts**	**85**	**Intermediate 60% of trusts**	**84**	**Intermediate 60% of trusts**
Time period & data source	Trust's 2009 Inpatient Survey Report, Care Quality Commission		Trust's 2008 Inpatient Survey Report, Care Quality Commission		Trust's 2007 Inpatient Survey Report, Healthcare Commission	

12. Cleanliness of room or ward Time period & data source	**84** Trust's 2009 Inpatient Survey Report, Care Quality Commission	**Worst performing 20% of trusts**	**83** Trust's 2008 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**	**80** Trust's 2007 Inpatient Survey Report, Healthcare Commission	**Intermediate 60% of trusts**
13. Overall rating of care Time period & data source	**78** Trust's 2009 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**	**78** Trust's 2008 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**	**79** Trust's 2007 Inpatient Survey Report, Healthcare Commission	**Intermediate 60% of trusts**

Notes on patient experience measures
9-13: The scores included in the table above are benchmark scores rather than percentages, calculated by converting responses to particular questions into scores. For each question in the survey, the individual responses were scored on a scale of 0 to 100. The higher the score for each question, the better the trust is performing.

3.3 Performance against key national priorities and Core Standards

Key national priorities and Core Standards	Time Period for 2009/10	2009-10	2009-10 Target	2008-09	2008-09 Target
The Trust has fully met the core standards	Apr 2009 – Mar 2010	44	44	44	44
Clostridium difficile year on year reduction (post-48 hour cases)	Apr 2009 – Mar 2010	176	348	357	526
MRSA – maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 level	Apr 2009 – Mar 2010	13	30	35	48
62-day wait for first treatment from urgent GP referral: all cancers[1]	Apr 2009 – Mar 2010		85%	82.7% (Jan - Mar 09)	85%
62-day wait for first treatment from consultant screening	Apr 2009 –	92.6%	90%	94.4%	90%

service referral: all cancers[1]	Mar 2010			(Jan - Mar 09)	
31-day wait from diagnosis to first treatment: all cancers[1]	Apr 2009 – Mar 2010	97.4%	96%	96.7% (Jan - Mar 09)	96%
31-day wait for second or subsequent treatment: surgery[1]	Apr 2009 – Mar 2010	96.6%	94%	95.3% (Jan - Mar 09)	94%
31-day wait for second or subsequent treatment: anti cancer drug treatments[1]	Apr 2009 – Mar 2010	99.1%	98%	98.4% (Jan - Mar 09)	98%
Two week wait from referral to date first seen: all cancers[1]	Apr 2009 – Mar 2010	94.6%	93%	92.8% (Jan - Mar 09)	93%
18-week maximum wait from point of referral to treatment (admitted patients)	Apr 2009 – Mar 2010	95.4%	90%	95.0% (Jan - Mar 09)	90%
18-week maximum wait from point of referral to treatment (non-admitted patients)	Apr 2009 – Mar 2010	98.1%	95%	97.3% (Jan - Mar 09)	95%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge [2]	Apr 2009 – Mar 2010	98.5%	98%	98.1%	98%
People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	N/A	No longer a target as Trust will have fewer than 20 cases in 2009/10.		75%	68%
Screening all elective in-patients for MRSA [3]	Apr 2009 – Mar 2010	121.4%	100%	135.3% (Jan - Mar 09)	100%

[1] The national targets for cancer were changed from 1 January 2010 so the Trust's performance for 2008-09 now uses the new definitions to aid comparison.

[2] Data includes patients who attended South Birmingham GP Walk In Centre (Katie Road) from July 2009.

[3] Some patients are screened more than once for MRSA.

3.4 Specialty Quality Indicators

The Trust's Quality and Outcomes Research Unit (QuORU) was set up in 2008-09. The unit has linked a wide range of information systems together to enable all important elements of service delivery to be analysed and monitored in a sophisticated way. In 2009-10, the unit has focused on supporting clinical teams to develop useful and innovative quality indicators to use within their specialties to monitor and improve patient care, experience and outcomes. Clinical staff have proposed a huge number of specialty quality indicators across the three domains of quality – patient safety, clinical effectiveness and patient experience – which are at various stages of development:

Indicator Development Stage	**Number of Indicators**
Stage 3: Metric signed off by QuORU Board as an appropriate measure of quality	88
Stage 2: Data shared with clinical staff concerned for validation and refinement of methodology as necessary.	18
Stage 1: Health Informatics and clinical staff meet to understand the proposed indicator, check whether the data is recorded and can be extracted and to verify it makes sense.	57
In preliminary discussion	158
Total	**321**

The table below shows performance at a specialty level for a wide selection of the quality indicators developed by clinicians, Health Informatics and the Trust's Quality and Outcomes Research Unit. Performance is shown for 2009-10 and 2008-09 where possible (some of the data has only started to be recorded during 2009-10) and benchmarking data is also provided where possible. In line with the Trust's commitment to transparency, the data shown is not just limited to good performance; areas where performance can be improved will be taken forward by the specialties concerned during 2010-11. The methodology and data for all indicators have been checked and validated by the appropriate clinical staff to ensure they accurately reflect the quality of care provided.

The Trust has signed a contract with West Midlands Strategic Health Authority (SHA) to form a Quality Institute with the University of Birmingham to help provide support to the regional Quality Observatory. UHB has also mapped NHS diagnostic and procedural coding structures to those used in the U.S.A. which means we will be able to directly compare patient care provided at UHB with that provided by U.S.A. hospitals in the future.

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
A&E	**Average (median) delay from arrival in A&E to performance of emergency CT head scan**				2 hours (for 46 patients)			2 hours (for 37 patients	CRIS Symphony	
A&E	**Average (median) delay from arrival in A&E to performance of emergency CT head with contrast scan**				2 hours (for 1146 patients)			2 hours (for 750 patients)	CRIS Symphony	
Acute Medicine	**7 day readmissions to:** **Acute Medicine** **Medical Admissions Unit**	<4% for Acute Medicine	885 324	25724 7141	3% 5%	749 273	25637 7386	3% 4%	Lorenzo	
Ambulatory Care	**Proportion of patients who were intended to be treated as a daycase but were admitted to hospital as an inpatient**	<5%	712	16573	4.3%	686	16262	4.2%	Lorenzo Galaxy	
Anaesthetics	**Post operative nausea and vomiting** **All high risk patients (Ear, Nose and Throat, General Surgery and Laparoscopic Surgery) should be prescribed with antiemetics (anti-sickness medication) so they can be given promptly after the operation if they need them**	95%	2322	2822	82.3%	2476	3000	82.5%	Lorenzo PICS	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Anaesthetics	**Post operative Nausea & Vomiting High risk patients (Ear, Nose and Throat, General Surgery and Laparoscopic Surgery) given antiemetics (anti-sickness medication) after the operation**		1273	2822	45.1%	1395	3000	46.5%	Lorenzo PICS	
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Average post-operative length of stay**			313 patients	9.7 days		396 patients	10 days	PATS Lorenzo	
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Average total length of stay**			313 patients	14.5 days		396 patients	15 days	PATS Lorenzo	
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - C.difficile**	0	0	313	0.0%	4	396	1.0%	PATS Lorenzo	
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Emergency readmissions within 28 days**		15	307	4.9%	14	391	3.6%	PATS Lorenzo	
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Hospital survival**		307	313	98.1%	391	396	98.7%	PATS Lorenzo	Cleveland Clinic 95.3% (2008 calendar year)
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Median post-operative length of stay**			313 patients	7 days		396 patients	8 days	PATS Lorenzo	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Median total length of stay**			313 patients	10 days		396 patients	10 days	PATS Lorenzo	
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Patients discharged on angiotensin converting enzyme (ACE) inhibitors**	100% of eligible patients	275	307	89.6%	315	391	80.6%	PATS PICS	
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Patients discharged on antiplatelet therapy**	100% of eligible patients	306	307	99.7%	356	391	91.0%	PATS PICS	
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Patients discharged on statins**	100% of eligible patients	295	307	96.1%	344	391	88.0%	PATS PICS	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Patients on betablockers who were given them on the day of surgery**	100% of eligible patients	125	134	93.3%	162	192	84.4%	PATS PICS	Cleveland Clinic 88% (Jan- Jun 09) Average for all other hospitals in Ohio 89% (Jan- Jun 09) Average for all reporting hospitals in US 87% (Jan- Jun 09) NB This data is for all surgery patients with heart conditions who were on betablockers
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Post-operative stroke**		7	313	2.2%	4	396	1.0%	PATS Lorenzo	
Cardiac Surgery	**First-time isolated coronary artery bypass graft (CABG) - Re-operation (all causes)**		24	313	7.7%	28	396	7.1%	PATS Lorenzo	Cleveland Clinic 17% (2008 calendar year). This data also includes the referrals for reoperation from other hospitals.
Cardiac Surgery	**First-time, isolated coronary artery bypass graft (CABG) - MRSA bacteraemia**		0	313	0.0%	0	396	0.0%	PATS Lorenzo	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Cardiology	**Ensure all patients are discharged on clopidogrel or prasugrel following percutaneous coronary intervention (PCI)**	100%	792	792	100.0%	1052	1053	99.9%	Lorenzo PICS	Cleveland Clinic 99% (2008) Other US Hospitals 98% (2008) (This data relates to clopidogrel only as prasugrel is a new drug)
Dermatology	**Incidence of wound infection post skin graft**	0%	0	114	0%	0	106	0%	Lorenzo	
Dermatology	**Proportion of suspected skin cancer cases seen within 2 weeks by a Consultant**	93%	1414	1502	94.1%	1428	1499	95.3%	Cancer database	
Diabetes	**Percentage of patients under Diabetic Centre follow up (attending follow-up outpatient appointments) who have a lower limb amputation. Note: The Diabetes Team are also planning to develop a similar indicator for patients with diabetes not under Diabetic Centre follow up.**		12	3462	0.35%	19	3590	0.53%	Lorenzo	
Elderly Care	**Percentage of elderly care patients discharged to their normal place of residence**		4277	4705	90.9%	4379	4804	91.2%	Lorenzo	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Emergency Surgery	**Emergency admissions for non severe gall stone pancreatitis (no Intensive Care Unit admission) should have surgery (gallbladder removal) within two weeks**	90%	227	250	90.8%	203	221	91.9%	Lorenzo	
Endocrinology	**Fraction of patients discharged on hydrocortisone post pituitary surgery**	100%	63	63	100%	53	54	98%	Lorenzo PICS	
ENT	**To ensure all patients receiving treatment for head and neck cancer have seen the pre treatment assessment team.**	100%	40	92	43.5%				Head & Neck database Lorenzo	
Gastro-enterology	**Proportion of patients admitted with inflammatory bowel disease receiving low molecular weight (LMW) heparin**	90%	53	56	94.6%	43	51	84.3%	Lorenzo PICS	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Haematology	**Bone Marrow Transplant-related mortality:**								BMT database	
	During index (first) admission - autologous (patient's own bone marrow) transplants		0	66 (April 09-Mar 10)	0%	0	80	0%		
	During index (first) admission - allogeneic (donor bone marrow) transplants		0	74 (April 09-Mar 10)	0%	5	71	7%		
	Within 100 days - autologous (patient's own bone marrow) transplants		0	48 (April 09-Dec 09)	0%	2	80	3%		
	Within 100 days - allogeneic (donor bone marrow) transplants		3	55 (April 09-Dec 09)	5.5%	7	71	10%		
Heart Failure	**Percentage of heart failure patients discharged on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)**	93%	178	254	70%	257	359	72%	Heart Failure database PICS	Cleveland clinic 94% (July 08 - June 09) Average for all other US hospitals 90% (July 08 - June 09)
Heart Failure	**Percentage of patients with a primary diagnosis of acute heart failure who had an echocardiogram (ECHO) prior to discharge**	100%	196	254	77%	253	359	70%	Heart Failure Database PICS	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
HIV	**Uptake of HIV testing amongst inpatients when clinically indicated (for specific conditions which can be associated with HIV/AIDS)**	90%	1798	9709	19%	1940	10570	18.4%	Lorenzo PICS	
Imaging	**A&E - Report turnaround times for other radiology reports e.g. CT, MRI, ultrasound and angiography** **0 to < 2 days** **2 to < 5 days** **>= 5 days**		 1618 134 327	 2079	 77.8% 6.4% 15.7%	 714 52 164	 930	 76.8% 5.6% 17.6%	CRIS	
Imaging	**A&E - Report turnaround times for plain imaging (basic x-rays)** **0 to < 2 days** **2 to < 5 days** **>= 5 days**		 3388 5013 1333	 9734	 34.8% 51.5% 13.7%	 2376 1893 114	 4383	 54.2% 43.2% 2.6%	CRIS	
Imaging	**Inpatients - Report turnaround times for other radiology reports e.g. CT, MRI, ultrasound and angiography** **0 to < 2 days** **2 to < 5 days** **>= 5 days**		 13107 2817 1504	 17428	 75.2% 16.2% 8.6%	 5803 1304 940	 8047	 72.1% 16.2% 11.7%	CRIS	
Imaging	**Inpatients - Report turnaround times for plain imaging (basic x-rays)** **0 to < 2 days** **2 to < 5 days** **>= 5 days**		 14616 9817 2904	 27337	 53% 36% 11%	 6345 5595 1314	 13254	 47.9% 42.2% 9.9%	CRIS	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Imaging	**Outpatients - Report turnaround times for imaging (basic x-rays)** **0 to < 2 days** **2 to < 5 days** **>= 5 days**		 3968 5810 4779	 14557	 27.3% 39.9% 32.8%	 3349 2914 745	 7008	 47.8% 41.6% 10.6%	CRIS	
Imaging	**Outpatients - Report turnaround times for other radiology reports e.g. CT, MRI, ultrasound and angiography** **0 to < 2 days** **2 to < 5 days** **>= 5 days**		 15221 11625 13843	 40689	 37.4% 28.6% 34.0%	 8093 5408 6173	 19674	 41.1% 27.5% 31.4%	CRIS	
Intensive Care	**Intensive care readmission rate (Readmissions to ITU during the same inpatient admission)** **Excludes Wellcome Building Critical Care (WBCC) unit which does not submit data to the Intensive Care National Audit & Research Centre (ICNARC)**		April 09-Feb 10) 283	April 09-Feb 10) 2191	April 09-Feb 10) 12.9%	 335	 2418	 13.9%	 ICNARC	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Liver Medicine	**Percentage of patients who have endoscopic retrograde cholangio-pancreatography (ERCP) who develop pancreatitis. ERCP involves a doctor examining the common bile duct and pancreatic duct through a flexible tube which is passed down the mouth, stomach and into the small intestine (bowel).**	<5%	5	357	1.4%	7	420	1.7%	ERCP database Lorenzo PICS	
Liver Medicine/ Surgery	**90 day patient mortality (%) and graft loss (%), with 95% confidence intervals, for all adult patients who received a planned (non-emergency) first liver transplant.** **Number of Transplants** **90 day mortality (95% Confidence Intervals)** **90 day graft loss (95% Confidence Intervals)**				Time Period - Oct 08 - Sep 09 67 6.0 (2.3,15.1) 9.0 (4.1,18.9)			Time Period - Apr 07 - Mar 08 89 9.0 (4.6,17.2) 3.4 (6.2,19.9)	Annual NCG Report	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Liver Transplant	**Use of Valganciclovir in CMV (Cytomegalovirus) mismatched liver transplant patients. Valganciclovir is an antiviral medication used to prevent CMV infection in liver transplant patients who have not previously had CMV but the donor has.**	100%	62	62	100%	48	49	98%	Liver database PICS	
Max Fax	**Proportion of patients who had surgery for fractured mandible on the same day or day after emergency admission**	90%	157	224	70%	163	218	75%	Lorenzo	
Neurosurgery	**Time from emergency admission with subarachnoid haemorrhage (SAH) to surgery**	90% within 2 days			65% Average 3.28 days (150 patients)			72.3% Average 3.7 days (131 patients)	Lorenzo	
Ophthalmology	**Overall, how would you rate the care you received at the Outpatients Department today?*** **Excellent** **Very Good** **Good** **Fair** **Poor** **Very Poor**		1 March 10 - 10 April 10 11 10 2 0 0 0	1 March 10 - 10 April 10 23	1 March 10 - 10 April 10 48% 43% 9% 0% 0% 0%				Outpatient Survey	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Ophthalmology	**Was your appointment changed to a later date by the hospital?*** **No** **Yes, once** **Yes, 2 or 3 times** **Yes, 4 or more times**		1 March 10 - 10 April 10 186 34 6 1	1 March 10 - 10 April 10 227	1 March 10 - 10 April 10 82% 15% 3% 0%				Outpatient Survey	
Ophthalmology	**Would you recommend this Outpatients Department to your family and friends?*** **Yes, definitely** **Yes, probably** **No**		1 March 10 - 10 April 10 21 3 0	1 March 10 - 10 April 10 24	1 March 10 - 10 April 10 88% 13% 0%				Outpatient Survey	
Palliative Care	**100% of patients with palliative care diagnosis code who are receiving regular analgesic medication for background pain (Morphine Sulphate Tablets, Zomorph, Fentanyl, Oxycontin) should also be prescribed with analgesia (e.g. Oramorph, Oxynorm) for breakthrough pain.**	100%	145	148	98.0%	91	96	94.8%	Lorenzo PICS	
Palliative Care	**100 % of above patients (who were prescribed with both analgesic medication for background pain and analgesia for breakthrough pain) should also be prescribed with laxatives.**	100%	145	145	100%	91	91	100%	Lorenzo PICS	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Pathology	**Turnaround times Cholesterol - 100 % within 24 hours****	100% within 24 hours	7	7	100%	Jul 08 - Sep 08 3	Jul 08 - Sep 08 3	Jul 08 - Sep 08 100%	Pathology database	
Pathology	**Turnaround times C-Reactive Protein - 100 % within 24 hours****	100% within 24 hours	9005	9104	98.9%	Jul 08 - Sep 08 1848	Jul 08 - Sep 08 1858	Jul 08 - Sep 08 99.5%	Pathology database	
Pathology	**Turnaround times Full Blood Count - 100 % within 24 hours****	100% within 24 hours	18203	18265	99.7%	Jul 08 - Sep 08 4454	Jul 08 - Sep 08 4464	Jul 08 - Sep 08 99.8%	Pathology database	
Pathology	**Turnaround times Urine - 90% within 48 hours****	90% within 48 hours	2079	2368	87.8%	Jul 08 - Sep 08 757	Jul 08 - Sep 08 779	Jul 08 - Sep 08 97.2%	Pathology database	
Pharmacy	**Dispensing error rate (nationally these are measured as no of errors per 100,000 dispensed items)**		11.025	100000	0.01%	11.65	100000	0.01%	Pharmacy database	
Radiotherapy	**85% of patients should commence treatment (first dose of radiotherapy) within 14 calendar days from CT scan. Note: Some of the patients not treated within the target timeframe had chosen to delay their treatment.**	85% within 14 calendar days	Jul 09 - Mar 10 1820	Jul 09 - Mar 10 2317	Jul 09 - Mar 10 78.5%				Radio-therapy database	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Renal Medicine	**Percentage of patients on haemodialysis programme with a urea reduction ratio (URR) of >65%** **All patients on haemodialysis** **Patients who have been on haemodialysis for 90 days or more**	90%			89.8% 90.2%			85.6% 86.4%	MARS	Data from 57 UK dialysis centres in 2007 reported in the renal registry report of 2008 show that 81% of reported patients achieve a URR ≥ 65% (centre range 47%–97%).
Renal Medicine/ Surgery	**Percentage of patients attending the low clearance clinic (which aims to get patients ready for dialysis) who had had an arteriovenous fistula (to create access for dialysis) made before starting haemodialysis.**	80%	61	80	76.3%	72	98	73.5%	MARS Lorenzo	
Respiratory	**Percentage of asthmatic patients are discharged on inhaled steroids**	95%	236	272	86.8%	252	295	85.4%	PICS	
Rheumatology	**An indication of continuity of care, did the patient attend the same Consultant's clinic at least 5 times out of 6 previous visits**	100%	315	315	100%	221	221	100%	Lorenzo	
Routine Surgery / Care	**Unplanned return to theatre for all non-emergency surgical patients**	>2.5%	500	32762	1.5%	500	29538	1.7%	Galaxy	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Stroke Medicine	**30 day mortality following stroke**		77	324	23.8%	92	331	27.8%	Lorenzo	
Stroke Medicine	**Percentage of patients admitted with cerebral infarction who received aspirin, clopidogrel or warfarin**	98.8% (CQUIN target)	298	299	99.7%			98%	Lorenzo PICS	Cleveland Clinic 99.7% (2008 calendar year) US National Average 98.9% (2008 calendar year)
Therapy Services	**90% of inpatient referrals should be responded to by the Therapy Services on the same day they are identified to the service**	90% on same day	25449	26424	96.3%	23268	24065	96.7%	Therapy database	
Therapy Services	**95% of inpatient referrals are responded to by the Therapy Services within two working days of the patient being identified to the service**	95% within two working days	26105	26424	98.8%	23785	24065	98.8%	Therapy database	
Trauma & Orthopaedics	**Proportion of patients who had surgery within 2 days of admission for fractured neck of femur (fractured hip)**	90%	206	281	73%	243	353	69%	Lorenzo	
Urology	**All patients admitted with acute retention to be discharged on alpha blockers (if not put on waiting list for transurethral resection of the prostate (TURP))**	70%	34	70	48.6%	58	109	53.2%	Lorenzo PICS	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Vascular Surgery	**Rates of daycase versus inpatient varicose vein procedures** **Daycase** **Inpatients**	<5% in-patients	 485 28	 513 513	 94.5% 5.5%	 448 92	 540 540	 83% 17%	Lorenzo	

* The Outpatient survey comprises two parts: one for patients to complete on arrival to the department and one for patients to complete after their appointment. The survey has only been piloted since 1 March 2010 so increasing the number of responses, particularly for the second part of the survey, will be a priority during 2010-11.

** Data shown relates to Royal Orthopaedic Hospital patients' specimens which are processed by UHB; turnaround times are indicative of all specimens processed by UHB.

Notes on data sources:

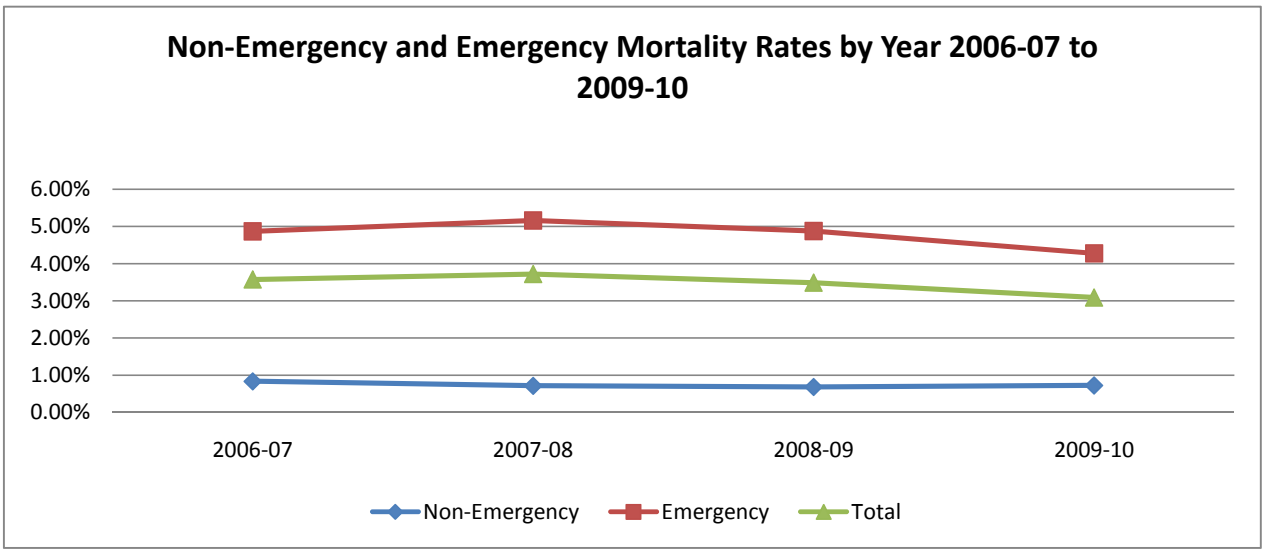
Cleveland Clinic and US data = published on Cleveland Clinic website
CRIS = Radiology database
Galaxy = Theatres database
ICNARC = Intensive Care National Audit & Research Centre
Lorenzo = Patient administration system
MARS = Renal database
NCG = National Commissioning Group
PATS = Cardiac database
Symphony = A&E patient management system

3.5 Mortality

The Trust continues to monitor mortality as close to real-time as possible with senior managers and clinicians receiving regular communication detailing mortality information, more retrospective and longer term comparative analysis is reported monthly to the Trust's Clinical Quality Monitoring Group. Any anomalies or unexpected elevated death rates are promptly investigated with thorough clinical engagement.

Although the Trust is generally treating more elderly patients and patients with complex conditions, mortality remains stable. In line with the national trend, emergency and overall mortality rates have reduced slightly over the last four financial years as shown in the graph below.

A statistical review of the Trust's mortality rates for 2008-09 was completed during 2009-10 by senior clinical statisticians at the Cleveland Clinic in the U.S.A., and the analysis showed no cause for concern.



3.6 Clinical Portal

During 2009-10, the Trust has developed the first stage of an in-house electronic patient record (EPR) solution called the Clinical Portal in conjunction with clinical and managerial staff, overseen by the Trust's EPR Executive Group. The Clinical Portal brings together a wide range of patient information sources including the Trust's Prescribing Information and Communication System (PICS), iPM (patient administration system), imaging, laboratory results and Outpatient clinical correspondence in an electronic format. The aim of the Clinical Portal is to significantly reduce organisational reliance on paper records alongside the opening of the new hospital. The Clinical Portal is currently being rolled out across specialties to be used for Outpatient services. The plan is for the Clinical Portal to eventually be implemented for all inpatients in the longer term.

3.7 Prescribing Information and Communication System (PICS)

The Trust's electronic, rules-based clinical information, drug prescribing and administration system has been in use and continuously developed over the past ten years and supports clinical decision-making for all inpatients. A significant amount of work has been done during

2009-10 with clinical staff to develop a version of PICS for Outpatients and Daycase patients which will be implemented during 2010-11. The Trust is also developing a version of PICS for use in A&E which will take longer as it is dependent upon integration with other systems such as Symphony (the patient management system used in A&E).

An electronic observation chart was developed during 2009-10 within PICS which has been successfully piloted in multi-specialty medicine and Burns, and will be implemented across another twelve wards during 2010-11. The electronic observation chart incorporates a standardised early warning score so that when observation data indicates a patient is deteriorating, an electronic message is automatically sent to the Outreach Team *Blackberry* smartphone. Ward order communications have also been implemented during 2009-10 which enable staff to request services within PICS for patients from ten departments such as x-ray and physiotherapy. This function has been widely used as shown in the table below and will be rolled out to other departments during 2010-11:

Service Request Type	**Number Requested**
Diabetes	248
Endocrinology	20
Gastro-intestinal Endoscopy	32
Gastro-intestinal Physiology	1
Imaging (x-ray, MRI, CT scans, ultrasound)	44,918
Nutrition and Dietetics	1,050
Occupational therapy	784
Physiotherapy	363
Respiratory	142
Speech therapy	647
Grand Total	**48,205**

3.8 Healthcare Evaluation Data (HED) tool

The Trust has developed an interactive tool which enables clinical and managerial staff to evaluate the quality of healthcare delivery and operational efficiency in comparison to acute and mental health trusts in England. The tool uses Hospital Episode Statistics (HES) data and applies an advanced methodology which accounts for casemix and other variables, incorporates all care delivered and can drill down to a patient level (anonymised).

A wide range of aspects of care delivery are included in the tool: activity, mortality, length of stay, DNAs (number of patients who did not attend their outpatient appointments), new to follow-up appointment ratios and market share (GP referrals).

The Care Quality Commission (CQC) is currently reviewing the Trust's HED tool and UHB has already entered into commercial contracts to provide the tool to a range of interested providers.

3.9 Clinical Dashboard

The Trust's ward-level digital Clinical Dashboard has been widely used by clinical and managerial staff during 2009-10: more than 1,600 users have logged into the system over 19,000 times in total. A number of developments have been made to the Clinical Dashboard over the past year which include:

- A dial showing the percentage of nutritional supplements prescribed but not administered for individual wards has been added.
- Nursing dependencies have been added to the dashboard for each ward to show patient complexity in relation to the number of nursing staff on the ward.
- A visual bed management tool has been piloted on five wards (medical, multi-specialty and admissions unit) to enable staff to see at a glance bed occupancy, patients' length of stay, gender, infection status, whether the patient is waiting for TTOs (drugs to take home) and whether beds need cleaning. The plan is to eventually implement this for all wards in the new hospital.

3.10 My Health at UHB

The Trust has developed a secure, prototype website called 'My Health at UHB' where patients with chronic long-term conditions can view information about their condition, appointments, blood results (within certain parameters), how to contact other patients with the same condition and to access advice. The Trust intends to pilot this within Liver Medicine during 2010-11, and potentially within other specialties as appropriate. Access to the website will be only be granted following discussion between individual patients and their Consultants to ensure appropriate Governance arrangements are in place.

3.11 Quality Web Pages

The Trust launched the Quality web pages on its website in November 2009 which provide information relating to quality for patients and the public: http://www.uhb.nhs.uk/quality.htm

Information published includes:
- Quality Reports: this includes the Trust's 2008-09 Quality Report plus quarterly update reports on progress.
- Specialty Quality Indicators: graphs showing performance and explanatory text for specialty quality indicators which are updated monthly
- Department of Health Quality Indicators: graphs showing performance for some of the indicators suggested by the DH which are updated quarterly
- Other information: this includes some Annual Reports on specialised services such as HIV and national audit reports for example.

The Trust intends to publish regular data for more of the specialty quality indicators during 2010-11 on the new website due to be launched in June 2010 with the opening of the new hospital.

3.12 Incident Reporting

An electronic reporting system ensures a more efficient and effective means of reporting incidents. The Risk Management Team have focused on the roll out of the electronic DatixWeb system in 2009/10. The electronic system enables staff, when submitting an online form, to select which line manager the form should be sent to for completion and provides assurance to staff that the form will be processed. From 1 April 2010, DatixWeb will be the principal medium used across the Trust for incident reporting; in areas where staff do not have access to a PC a paper report can still be completed, however the responsible line manager will be expected to input the form into the electronic reporting system. The system enables improved monitoring of reporting across the Trust and ensures early detection of areas or individuals who are experiencing difficulties with the process providing a focused approach to support and additional training from the Risk team.

3.13 Risk Dashboard

To supplement the electronic incident reporting system a Risk Dashboard has been developed which provides clinical staff with access to real time data from incident reports submitted within their clinical area and Division. The Risk Dashboard uses the live online data from the DatixWeb reporting system to identify information regarding the top 5 incident types reported, the rate of reporting as well as allowing direct access to incident summaries. The Risk Team will work with clinical teams, using the dashboard to analyse trends and to formulate action plans to mitigate any risk. Actions identified from serious incidents requiring investigation (SIRIs) will also be included in the action plan to ensure that recommendations from these investigations are implemented appropriately. The action plans are an integral part of the dashboard and will form a monitoring and assurance tool for the Risk Department. The introduction of the Risk Dashboard is a relatively new development for the Trust which will be regularly reviewed and refined throughout 2010-11.

Annex: Statements from stakeholders

The Trust has shared its 2009-10 Quality Report with the commissioning Primary Care Trust, NHS South Birmingham, the Birmingham Local Involvement Network (LINk) UHB Action Group and Birmingham City Council Overview and Scrutiny Committee.

NHS South Birmingham and the Birmingham LINk UHB Action Group have reviewed the Trust's Quality Report for 2009-10 and provided the statements below. Birmingham City Council Overview and Scrutiny Committee has chosen not to provide a statement but plans to do so for the 2010-11 Quality Report.

Statement provided by NHS South Birmingham:

NHS South Birmingham welcomes the opportunity to contribute to the Quality Account through this corroborated statement with regards to the existing contracts it holds with the Trust and any associated information. The whole commissioning organisation has had an opportunity to provide feedback, including the Public Involvement Action Group.

This is a comprehensive technical account providing a detailed presentation of performance throughout the year including monitoring, measuring and reporting arrangements. There is evidence to support quality as a theme through all of the strategic developments within the account, inclusive of audit, performance and quality improvement. There is evidence of participation in clinical audits and examples of how this has led to service improvements.

We have an on-going quality monitoring process with the Trust which includes monthly contract meetings, quality reviews and quarterly performance meetings. This provides the PCT with a good understanding of the issues facing the Trust, its internal systems and processes that are in place to provide assurance. Given the significant challenges that lie ahead across South Birmingham's health economy it is imperative that University Hospitals Birmingham Foundation Trust strengthens engagement with the PCT to ensure a consistent targeted approach to delivering the QIPP agenda.

NHS South Birmingham can verify the reported MRSA and Clostridium Difficile infection rates within the Trust and acknowledges the improvements made during the last year from previous years. The Trust has achieved the performance of the 4 elements of the CQUIN.

The Account reflects a number of innovative and bespoke systems to capture and use data, including an electronic patient record, collection of real time patient experience information and others, all supporting quality improvement. The PCT acknowledges the publication of quality information on the Trusts website, allowing continual publication of quality improvement throughout the year.

In summary, the Quality Account provides a balanced view of both the Trust's achievements throughout 2009-10 and has set clear priorities for quality improvement in 2010-11as the Trust moves into the new hospital from June 2010.

Statement provided by Birmingham LINk:

QUALITY ACCOUNT STATEMENT
Birmingham LINk UHB Action Group

The Trust has demonstrated improvements in care in the three priority areas identified in the 2008 – 2009 Quality Report to address during 2009 – 2010.

Priority 1 – Reducing errors (particularly medication errors)
Priority 2 – Infection prevention and control.
Priority 3 – Improve patient experience and satisfaction.

As well as evidencing improvements relating to the above, the Trust has not only decided to continue these priorities but has identified two additional priorities for 2010 – 2011:-

Time from prescription to administration of first antibiotic.
Venous thromboembolism (VTE) risk assessment on admission (within 24 hours).

The priorities were based on sound quality measures / monitoring processes and took account of patients' views relating to their experience of care.

Birmingham LINk via UHB Action Group has been informed of the targets and improvements in a timely fashion as were the Trust Governors. Additionally, one UHB Action Group LINk member is a serving member of the Trust's Care Quality Group chaired by the Chief Executive Nurse. A wide variety of sound evidence related to patient care and patient experience came from this group.

The Quality Report gives evidence of sound and robust systems for measuring progress in relation to the stated priorities for improvement and has provided this information in a transparent way throughout the year. Birmingham LINk members at UHB have received timely information and been consulted on their views throughout the year. The Trust has been open about areas of weakness and how these might be improved and incorporated this into the data provided.

The Associate Director of Patient Affairs has been a helpful and useful conduit for information between LINk members and the Trust. There is scope for this to be strengthened by involving LINk members in matters related to patient care / satisfaction e.g. Surveys, campaigns such as 'Hand-washing' and nutrition. This might well be achieved through collaborative ventures with Patient Councils and other groups.

Birmingham LINk
University Hospital Action Group