AGENDA ITEM NO: 7

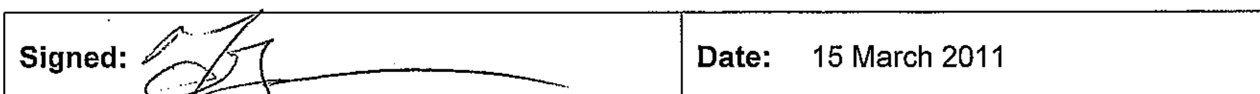
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 24 MARCH 2011

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

Purpose:	To update the Board of Directors on the Trust's performance against national indicators and performance against internal targets. To propose changes to the indicators reported in 2011/12.
Confidentiality Level & Reason:	N/A
Annual Plan Ref:	Affects all strategic aims.
Key Issues Summary:	The following indicators are currently not in line with targets and therefore exception reports have been provided: • Cancer: 62 day GP referral to treatment • A&E 4 hour waits • Primary PCI • Delayed Transfers of Care • Quality of Stroke Care • Never Events • Short Term Sickness • External Agency & Bank Spend • Mandatory Training • Local Induction • DNAs • Electronic Patient Survey Response Rate • Omitted Drugs • Non-Emergency Mortality Audit Response Rates Further details and action taken are included in Appendix B. The paper also incorporates the annual review of indicators reported to the Board of Directors and outlines the proposed amendments to the Trust's performance framework to ensure it better reflects national, local and Trust priorities.
Recommendations:	The Board of Directors is requested to: **Accept** the report on progress made towards achieving performance targets and associated actions. **Agree** the proposed changes to the performance framework for 2011/12.

Signed: 	**Date:** 15 March 2011

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 24 MARCH 2011

PERFORMANCE INDICATORS REPORT & ANNUAL REVIEW OF PERFORMANCE INDICATORS

PRESENTED BY THE EXECUTIVE DIRECTOR OF DELIVERY

1. Purpose

This paper updates Board of Directors on the Trust's performance against key indicators, including Care Quality Commission (CQC) targets, risk ratings against standards included in the Monitor Compliance Framework and internal targets. Performance against these indicators is shown in Appendix A. It also incorporates the annual performance indicator review and proposes changes to the Trust's performance framework for 2011/12 in response to proposed changes to the Monitor Compliance Framework, national priorities for the NHS set out in the Operating Framework for 2011/12 and local priorities for the Trust.

2. Exception reports

For national targets exception reports are contained below. Monthly performance data for exceptions are contained in Appendix B. The Trust did not achieve the 62 day GP referral to treatment cancer target in January. Performance against the A&E 4 hour wait target in February, although above the national threshold of 95% was below the internal threshold of 98% and is therefore also an exception. Primary PCI was above target in January, but remains below target for the year to date so continues to be an exception. Delayed transfers of care were above the threshold in February. The length of stay element of the Quality of Stroke Care indicator was below the Trust's contractual target in February and is therefore an exception.

Exception reports and monthly data for these indicators as well as internal indicators that are currently red are contained in Appendix B. An exception report is also included for DNAs as it continues to be a particular focus area for performance improvement.

A 'deep dive' based on the new indicator for Length of Stay was presented at the February Chief Operating Officer's Group meeting. A separate meeting is being arranged with the Chief Operating Officer, Divisional Directors of Operations, Informatics and Planning and Performance Team and this data will therefore be included from next month's Performance Indicators Report.

An incident was reported in December which has now been determined to be an incident classified by the National Patient Safety Agency as a 'Never Event'; an exception report regarding this is included below.

The following internal targets are therefore currently considered exceptions:

a) Never Events
b) Short Term Sickness
c) External Agency & Bank Spend
d) Mandatory Training
e) Local Induction
f) DNAs
g) Electronic Patient Survey Response Rate
h) Omitted Drugs
i) Non-Emergency Mortality Audit Response Rates

It has been agreed at the Clinical Quality Monitoring Group that the Trust's performance for venous thromboembolism risk assessment and the completion of patient observations should be reported to the Board of Directors. These measures which form part of the review of indicators have now been incorporated into the report. They are not currently exceptions but further details of the Trust's performance are contained below.

2.1 Cancer: 62 day GP referral to treatment

In January 83.0% of GP referrals for cancer were treated within 62 days against the 85% target. Until January the Trust had consistently met this target since June 2010 and year to date performance continues to be above target at 85.9%.

Particular problems were experienced in January, both with late referrals from other trusts and with patients choosing to defer their treatment over Christmas and therefore being treated after 62 days in January. Out of the 11 patients who breached in January, 5 were late referrals (2 after day 42 and 3 after day 62) and 4 patients breached due to patient choice (3 of these were also late referrals). The Trust is seeking to reallocate 4 of the late referrals but other trusts are now unwilling to accept reallocations since the formal CQC system was discontinued. Steps are now being taken to escalate these reallocation requests within the referring trusts.

The Task and Finish Group continues to meet to conduct Root Cause Analyses (RCAs) on breaches of the target and identify whether there are any trends that need to be addressed. January's breaches did not highlight any particular trends internally but emphasised the need for staff to be vigilant as to whether patients are on a cancer pathway prior to cancelling appointments or TCI dates.

Draft February performance shows an improvement with 86.8% of patients treated within 62 days.

2.2 A&E 4 hour waits

The percentage of patients meeting the 4 hour wait target in February fell to 96.53% from 96.91% in January. This is above the national threshold of 95% but below the internal threshold of 98%. When attendances at the GP-led health centre on Katie Road are included

the Trust's performance for the month is 97.73%. Year to date performance stands at 96.42% excluding Katie Road and 97.66% when it is included.

Performance in general over the month was improved but was affected by two days of high activity where the whole region fell under significant operational and capacity pressures. These two days saw 29% of the breaches over the month. Action has therefore been focused on improving capacity management across the Trust to ensure that there is sufficient capacity to allow patients to be transferred from the Emergency Department (ED) in a timely manner. Action taken includes:

a) Work to make capacity management on the QEHB site more robust with all divisions identifying a support manager per day to ensure a high level of attention and co-ordination is maintained on capacity management for all specialties.

b) Senior Physicians have been based in the ED during key periods to ensure that senior clinical reviews of patients take place within the ED before the patient is admitted to CDU. This has been a direct attempt at admission avoidance.

c) More senior clinical ward rounds have been put in place in ward areas to ensure patients are treated and discharged efficiently.

d) There has been a clear emphasis on wards being able to predict their potential capacity, 24 and 48 hours ahead to enable more proactive capacity manage to function.

e) Increased utilisation of the discharge lounge facility to ensure that ward beds are cleared as early in the day as possible in order to maintain capacity in CDU and the front door.

A group consisting of staff from the ED, Planning and Performance, Operational Performance and Informatics is working to develop the necessary operational processes to accurately collect the data required for the new A&E Quality Indicators in advance of the start of reporting in April.

2.3 Primary PCI

In January 80.0% of Primary PCI patients had a call to balloon time of less than 150 minutes. Year to date performance therefore now stands at 73.8% against the 75% target.

There were five direct referrals to UHB in January of which four met the 150 minute target. The one breach of the target was admitted prior to the move of Cardiology to the QEHB. This breach experienced both an extended ambulance travel time and delays prior to the activation of the PCI pathway. The three subsequent cases which took place after the move all met the target and saw considerably reduced door to balloon times compared to the average to date. It would therefore appear that

the benefits of the Emergency Department and catheter labs being located in the same building are now being realised.

2.4 Delayed Transfers of Care

An increased number of delayed transfers of care were seen in February with the national indicator showing performance of 5.97% compared to 5.12% in January. In the last week of February there were 57 inpatients whose discharge was delayed compared to 48 in the last week in January.

The Trust continues to move patients into interim care as part of the Care Home Select deal arranged by the Trust. In addition the Kenrick Centre is due to open as a re-enablement centre on 21 March with 16 beds open initially, expanding to 32 beds later. Patients admitted to the centre will be medically fit for discharge and will have a maximum six week length of stay to receive intensive therapist support to enable them to live independently and reduce their need for ongoing support.

2.5 Quality of Stroke Care – Length of Stay

In February 47.2% of patients spent 90% of their time on the Acute Stroke Unit (ASU) compared to 56.4% in January. The Trust's contractual target with NHS South Birmingham for Quarter 4 is 80%. Moseley Hall Hospital (MHH) length of stay has yet to be included in this performance. Four patients were discharged to MHH over the month; two of these have now hit the target with a third very close to it. If all three do hit the target, performance for the month will increase to 55.6% when MHH length of stay is included.

The ASU was increased from 18 to 20 beds for periods of high stroke activity which impacted on Neurology activity. Birmingham Community Healthcare continued to have an additional two rehabilitation stroke beds open at MHH however, due to increased patient dependency, there was an increased length of stay for rehabilitation which affected transfers from the ASU. The stroke consultant continues to facilitate the transfers off site. Work is underway to improve how patients with stroke symptoms are managed in the ED and CDU to avoid any unnecessary delays. The stroke co-ordinators have also been given access to the ED electronic system on the ASU to allow them to 'pull' patients onto the stroke pathway rather than waiting for them to be referred. Full RCAs will continue to be undertaken on those patients that did not achieve the target in order to improve performance.

The Royal College of Physicians released, under embargo, the results of the Sentinel Stroke Audit conducted in 2010 on 28 February 2011. These are shown in Table 1 below. An improvement was seen in all key scores where there was a comparable measure in the last audit conducted in 2008 with the exception of weighing patients. A weighing hoist has now been purchased for the stroke unit which will increase future performance in this area.

The other areas of poorer performance concerned length of stay and rapid and direct admission to the stroke unit with the majority of patients being admitted first to the Medical Assessment Unit (now Clinical Decision Unit) prior to the Acute Stroke Unit. The actions described above to improve the national 90% length of stay performance target should lead to improvement in these areas. The results from the audit shows that the Trust is providing high quality stroke care to those patients who are admitted to the stroke unit; this is backed up by the % of patients receiving all key indicators being higher than the national average, however there are problems identifying stroke patients and ensuring they are admitted directly to the ASU. Overall the Trust's results put it in the middle 50% of trusts nationally. An action plan is currently being developed to address the findings of the audit.

Table 1: National Sentinel Stroke Audit Results – UHB 2010 performance vs. 2008 and national 2010 results

Indicator	National 2010	UHB 2010	UHB 2008
Patient spent at least 90% of stay on a stroke unit * †	60%	57% ▲	44%
Patient initially admitted to a general assessment unit	70%	57%	
Patient initially admitted to a stroke unit *	36%	27%	
Admitted to stroke unit within 4 hrs	38%	25%	
Screening for swallowing disorders within 24 hrs of admission * †	83%	86% ▲	67%
Swallow assessment within 72 hrs *	86%	81%	
Brain scan within 24 hrs of stroke * †	70%	69% ▲	52%
Physiotherapy assessment within 72 hrs of admission * †	91%	100% ▲	73%
Occupational therapy assessment within 4 days of admission * †	83%	98% ▲	38%
Patient weighed during admission * †	85%	68% ▼	79%
Patient's mood assessed during admission * †	80%	90% ▲	60%
Rehabilitation goals agreed by discharge †	94%	100% ▲	94%
Rehabilitation goals agreed within 5 days *	78%	89%	
Aspirin or clopidogrel by 48 hrs after stroke * †	93%	100% ▲	95%
Diagnosis discussed with patient *	80%	74%	
Received all key indicators (12 in 2010, designated by *, 9 in 2008, designated by †)	16%	29% ▲	0%

2.6 Never Events

An incident was reported in December which has now been determined to be an incident classified by the National Patient Safety Agency as a 'Never Event'. Details of this incident and the action taken in response are contained in the Medical Director's Clinical Quality Monitoring Report.

2.7 Venous Thromboembolism Risk Assessment

Completion of venous thromboembolism risk assessments is a nationally mandated CQUIN with a target of 90% of patients being assessed. The Department of Health has now published comparative performance of all trusts against this requirement. Nationwide 68.4% of patients were assessed in Q3 2010/11 compared to UHB's performance of 98.9% over the same period. This performance was the

third best in the country and UHB was only outperformed by two single specialty trusts with considerably lower levels of activity than UHB.

2.8 Completion of Patient Observations

The completion of patient observations is an outcome measure as part of the Trust's CQUINs in 2010/11 and is currently being developed as a CQUIN for the 2011/12 contract. The target is currently under negotiation. Performance, as shown in Table 2 below, does however vary between wards with some areas requiring significant improvement. Performance on this measure has now been included in the Trust's clinical dashboard to allow individual wards to see their performance compared to the Trust average.

Table 2: Patients Who Get One Full Set of Observations per Day

Ward	Specialty	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11
BMT	Haematology	-	-	-	-	-	-	-	-	-	-	97.9%
E1DU		79.2%	85.3%	73.2%	62.7%	-	-	-	-	-	-	-
E4A	Renal	-	-	-	-	-	-	81.3%	80.9%	-	-	-
E4B	Renal	-	-	-	-	-	-	91.9%	90.9%	-	-	-
EGA	Neuro	84.7%	93.2%	91.9%	94.1%	94.3%	96.6%	93.5%	-	-	-	-
EGB	Neuro	-	-	-	-	55.0%	62.5%	82.9%	93.0%	93.1%	92.1%	88.9%
ELA	Neuro	84.6%	92.9%	94.4%	92.7%	86.8%	89.0%	89.8%	91.6%	91.4%	86.9%	85.6%
ELB	Neuro	89.6%	87.7%	93.1%	89.3%	90.4%	90.7%	91.6%	72.2%	73.9%	84.6%	87.5%
QARC	Renal	-	-	-	-	-	-	93.7%	98.4%	-	-	-
SPSB + WBU	Burns	98.7%	99.2%	96.8%	100.0%	100.0%	99.3%	98.8%	100.0%	98.3%	99.2%	97.2%
SS5 + W515	Multispeciality	93.4%	93.0%	91.3%	98.4%	87.5%	97.3%	95.0%	96.9%	96.2%	93.3%	95.5%
SS6 + W516	Multispeciality	87.5%	91.3%	88.7%	89.5%	91.1%	93.6%	93.2%	95.9%	94.2%	94.5%	93.5%
W302	Multispeciality/GI Med/Cardiology	-	-	-	-	-	-	-	75.0%	86.6%	81.2%	83.6%
W303	Renal Medicine	-	-	-	-	87.1%	84.1%	85.4%	84.2%	80.6%	89.1%	83.9%
W304	Cardiology	-	-	-	-	-	64.7%	76.7%	85.5%	-	-	-
W305	Renal Surgery/Vascular	-	-	-	-	-	-	-	93.2%	95.3%	95.9%	97.5%
W306	Cardiac Surgery	-	-	-	-	-	73.3%	84.6%	75.4%	77.3%	82.1%	82.4%
W408	ENT/Maxilliofacial	-	-	-	-	-	-	-	86.3%	90.2%	92.2%	91.8%
W409	*Tidal flow*	-	-	-	-	-	-	-	78.2%	88.1%	87.4%	89.6%
W411	Neuro/Stroke	-	-	-	-	91.2%	93.8%	95.0%	95.4%	93.1%	91.5%	97.7%
W412	Trauma	-	-	-	-	-	-	98.9%	97.9%	98.9%	97.3%	97.0%
W514	Multispeciality	-	-	-	-	-	-	-	93.7%	94.4%	94.7%	92.4%
W517	Multispeciality	-	-	-	-	97.5%	99.5%	99.2%	98.4%	95.1%	98.2%	99.1%
WW1	Urology	-	-	-	-	-	-	89.6%	90.8%	-	-	-
YPU	Oncology											81.1%
Overall Numerator		3761	4864	4704	4816	5731	7611	11738	13282	13537	14000	13799
Overall Denominator		4184	5261	5147	5196	6416	8441	13132	14841	14942	15416	15194
Overall Percentage		89.9%	92.5%	91.4%	92.7%	89.3%	90.2%	89.4%	89.5%	90.6%	90.8%	90.8%

Key:

90%+
80% - 89%
<80%

3. Proposed Changes to Indicators Reported in 2011/12

The Planning and Performance Team undertakes an annual review of indicators reported to the Board of Directors to ensure that the structure and content of the Trust's performance framework reflects the priorities of the Trust and the NHS nationally. This review has been undertaken and although there are a number of areas where national and local developments are unclear it is now possible to outline how the Performance Indicator Report will need to change in 2011/12 to ensure that this remains the case. To date Monitor has published the proposed changes to the Compliance Framework and the Department of Health has published the Operating Framework for 2011/12 and changes to reflect these documents have been made. The acute contract with NHS South Birmingham as the Trust's lead commissioner is currently still under negotiation and consequently there may need to be further changes before the first report for 2011/12 is presented at the May meeting of the Board of Directors.

3.1 Structure of UHB's Performance Framework

As Monitor has retained and included a number of new performance indicators and targets in its proposed Compliance Framework for 2011/12 this section has been retained. In line with the CQC decision to move away from performance management to becoming the quality regulator, the current sections for Existing Commitments and National Priorities have been removed.

The priorities for the NHS in 2001/12 are set out by the Department of Health in the Operating Framework and these have been structured into 'headline' and 'supporting' measures. To ensure that the Trust's performance framework continues to reflect national priorities for the NHS it is proposed to instead include two pie charts containing the indicators from the Operating Framework divided into the headline and supporting measures. Exception reports relating to the Monitor Compliance Framework and Operating Framework indicators will be included in the main text of future Performance Indicator Reports; those relating to local indicators will continue to be reported in Appendix B.

A number of indicators that were previously part of the CQC's performance framework are not included in the 2011/12 Operating Framework. Some of these are still priorities for the Trust and have been moved to other sections of the report. Others which are no longer priorities or which have consistently been met and are considered low risk have been discontinued. The details of which sections these have been moved to are detailed in section 3.2.3 below. This has necessitated the development of a new 'Clinical Quality and Outcomes' section of the report which incorporates the existing Outcomes pie and adds additional indicators, as outlined below.

New sections of the report, each with their own pie chart in Appendix A have been developed for Research and Development and for Education and Training to ensure that all the Trust's core purposes are fully encompassed. The two Workforce sections – Resources and Capability are to be merged. The indicator for mandatory training that was previously included in the Capability section will be split into its respective components which will be included in the most relevant section e.g. Fire Training will be moved to the Safety section and Information Governance to the Governance section.

The acute contract between the Trust and NHS South Birmingham as its lead commissioner includes a number of indicators that reflect priorities for the local health economy. To ensure that the Board has clear visibility of these contractual measures, including CQUINs, it is proposed that within Appendix A these will be identified within the relevant pie chart by suffixing an asterisk to the indicator name. Only contract measures that are high risk or that carry a financial penalty will be included.

Previously there was a three level hierarchy of indicators whereby a number of indicators were grouped into a pie chart and a number of pie charts were further grouped together. The top level hierarchy has

however proved to be of limited value and consequently it is proposed to only display the performance of individual indicators for each section.

3.2 Changes to Indicators Reported

3.2.1 Changes to Monitor Compliance Framework

At present Monitor intends to add 5 of the new A&E Clinical Quality indicators outlined in the January Performance Indicators Report to the Compliance Framework namely:

a) Unplanned reattendance rate
b) Total time in the A&E department
c) Left without being seen rate
d) Time to initial assessment
e) Time to treatment

Monitor is applying the existing escalation approach for A&E. Rather than considering whether it will escalate a trust after failing three consecutive quarters, it will instead consider escalation if a trust fails two or more measures in any two quarters over 12 months and then again fails a further two or more indicators in any quarter in the subsequent nine months.

Monitor is planning to add 95th percentile waiting times for admitted and non-admitted patients with a target of 23 and 18.3 weeks respectively. These will be self-certified on a quarterly basis but must be met monthly. These will carry scores of 1.0 each.

The consultation on changes to the Compliance Framework contained a proposal to introduce a stroke indicator with a score of 1.0 but did not contain details of what was proposed. It is assumed that this will consist of either the 90% length of stay target or this and the 24 hour TIA referral to treatment target.

Monitor proposes dropping the existing MRSA screening target. As, due to the methodology adopted, this is not a useful measure and it is not screening but the safe management of all patients that leads to a reduction in MRSA it is proposed to remove this target from the Trust's performance framework for 2011/12.

Local trajectories for post-48 hour MRSA and C. difficile cases of 7 and 114 cases respectively have been agreed with NHS South Birmingham and these will be used by Monitor in 2011/12.

3.2.2 Operating Framework – Headline Measures & Supporting Measures

It is proposed that these new sections of the report will contain the indicators included in the Operating Framework for 2011/12, as shown in Table 3 below:

Table 3: National Indicators Included in Headline Measures and Supporting Measures Sections

Headline Measures	Supporting Measures
• HCAI Measure: MRSA	• VTE Risk Assessment
• HCAI Measure: C. difficile	• Cancer Waits – 2 week cancer
• RTT 95th percentile – admitted	• Cancer Waits – 2 week breast
• RTT 95th percentile – non-admitted	• Cancer Waits – 62 day first
• RTT 95th percentile – incomplete	• Cancer Waits – 62 day upgrade
• Mixed sex accommodation breaches	• Cancer Waits – 62 day referral from screening
• A&E Clinical Quality – Unplanned Re-attendance rate	• Cancer Waits – 31 day first
• A&E Clinical Quality – Total Time in A&E	• Cancer Waits – 31 day subsequent – surgery
• A&E Clinical Quality – Left Without Being Seen rate	• Cancer Waits – 31 day subsequent – anti-cancer drugs
• A&E Clinical Quality – Time to Initial Assessment	• Cancer Waits – 31 day subsequent – radiotherapy
• A&E Clinical Quality – Time to Treatment	• Stroke Indicator
• Cancer 2 week (aggregate measure)	• Staff Engagement
• Cancer 62 Day Waits (aggregate measure)	• PROMS Scores
• Emergency Readmissions	• RTT median waits – admitted
	• RTT median waits – non-admitted
	• RTT median waits – incomplete pathways

3.2.3 National Indicators Moved or Removed

A number of indicators previously included in the CQC performance framework are not included in either the Monitor Compliance Framework or the Operating Framework for 2011/12. Some of these indicators will continue to provide a useful insight into the Trust's performance and will be retained. Primary PCI will be moved to the new Clinical Quality and Outcomes section and Delayed Transfers of Care will be moved to Efficiency. With the transfer of the Birmingham Sexual Health service to the Trust from 1 April the GUM access targets would have been applicable to the Trust however these are not included in the 2011/12 Operating Framework. However as a new service for which the Trust has few indicators currently it has been decided to retain this as a local indicator for the time being. These indicators are also included in the acute contract.

The Rapid Access Chest Pain Clinic and Cancelled Operations indicators are not included in the 2011/12 Operating Framework. The Trust has consistently achieved these targets for a number of years and they are thought to be low risk. It is therefore proposed that reporting to the Board in relation to these indicators should cease. They will continue to be monitored and if performance in these areas drops significantly or the risk associated with these should change then reporting could then be recommenced.

3.2.4 New Local Indicators

Reporting of cases of Meticillin-Sensitive *Staphylococcus Aureus* (MSSA) bacteraemia to the Health Protection Agency was made mandatory from 1 January 2011 and reporting of *Escherichia coli* will be mandated from 1 April 2011. Trajectories for these new indicators will be determined based on the first

quarter of reporting for each. It is proposed that these will be adopted as local indicators and will form part of the Clinical Quality and Outcomes section. Also new in this section is an indicator relating to the number of 'red lines' on PICS which indicate that a patient who should have been discharged from the system has not and an indicator measuring the percentage of patient observations that have been carried out. The current indicator for the rate of feedback for the electronic patient survey will be replaced by a composite indicator for patient experience which will move the focus from the level of feedback to the nature of the feedback received.

As discussed above there will be new sections for Research and Development (R&D) and Education and Training (E&T) to ensure that the all the Trust's core purposes are fully reflected in its performance framework. The indicators proposed for R&D are completely new and are intended to encompass the Trust's processes for approval, success rate of proposal applications and quality assurance. The proposal for E&T includes a number of indicators that have been moved from the existing Workforce Capability section and is intended to cover key aspects of the Trust's work in this area including staff training and education of nursing students, medical students and postgraduate medics. It is proposed that the indicators for both these sections will be reported on a quarterly basis. The proposed indicators are shown in Table 4 below:

Table 4: Proposed Indicators for R&D and E&T

Research and Development	Education and Training
• Turnaround of commercial feasibility questionnaires within 5 days • Time from point of receipt of valid study documentation to completion of NHS permissions process • Time between NHS permissions approval to recruitment of first patient • Success rate of research proposal applications to NIHR • Number of studies which are internally audited • Percentage of annual safety reports (as required by MHRA) submitted on time	• Appraisal • Corporate induction • Local induction • DNA rate for mandatory training • Completion of preceptorship by newly qualified nurses • Completion of drug assessments by new starters within six weeks • Foundation Programme trainees with a named educational supervisor • Foundation programmed teaching sessions evaluate at satisfactory or above • Foundation trainees are able to attend the required 70% of protected teaching time. • Core Medical Training (CMT) trainees have a named educational supervisor • CMT trainees are able to attend the required 70% of protected teaching time • Core Surgical Training (CST) trainees have a named educational supervisor

3.3 Timetable for Changes

The percentage of patients who have had a venous thromboembolism (VTE) risk assessment completed and the percentage of patients with a full set of observations completed for each day of their admission have been incorporated with immediate effect, as agreed by the

Clinical Quality Monitoring Group. Currently these have been included in the Patient Care - Safety section and will be moved to their final sections when the new structure for the report is finalised. It is intended that the new structure will be adopted, along with all other changes to the indicators reported from the May 2011 report which will be the first to cover 2011/12 performance.

4. Recommendations

The Board of Directors is requested to:

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

4.2 **Agree** the proposed changes to the performance framework for 2011/12.

Tim Jones
Executive Director of Delivery

APPENDIX A

University Hospitals Birmingham
NHS Foundation Trust

2010/11 Key Performance Indicator Report

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

National Performance

Monitor Governance Rating

A&E 4 hr waits; MRSA screening; Learning Disabilities; MRSA; C difficile; Cancer 31 days first; Cancer 31 days subs - drugs; Cancer 31 days subs - surgery; Cancer 31 days subs - radiotherapy; Cancer 62 days - GP referral; Cancer 62 days - screening; Cancer 2 wks; Breast 2 wks

Care Quality Commission Existing Commitments

Primary PCI; Patient ethnic group recorded; Delayed transfers of care; A&E 4 hr waits; RACPC 2 wk waits; Cancelled operations

Care Quality Commission National Priorities

Learning Disabilities; Engagement in Clinical Audit; Heart disease audits; Stroke care; MRSA; C difficile; Cancer 31 days; Cancer 62 days; 2 wks - cancer & breast; Patient experience; Staff satisfaction

Registration Outcomes

21; 1; 2; 4; 5; 6; 7; 8; 9; 10; 11; 12; 13; 14; 16; 17

Workforce

Resources

Vacancy rate; Sickness - short term; Sickness - long term; Bank; External Agency rate

Capability

Local induction; Appraisal (PDRS); Mandatory training; Corporate induction

Efficiency

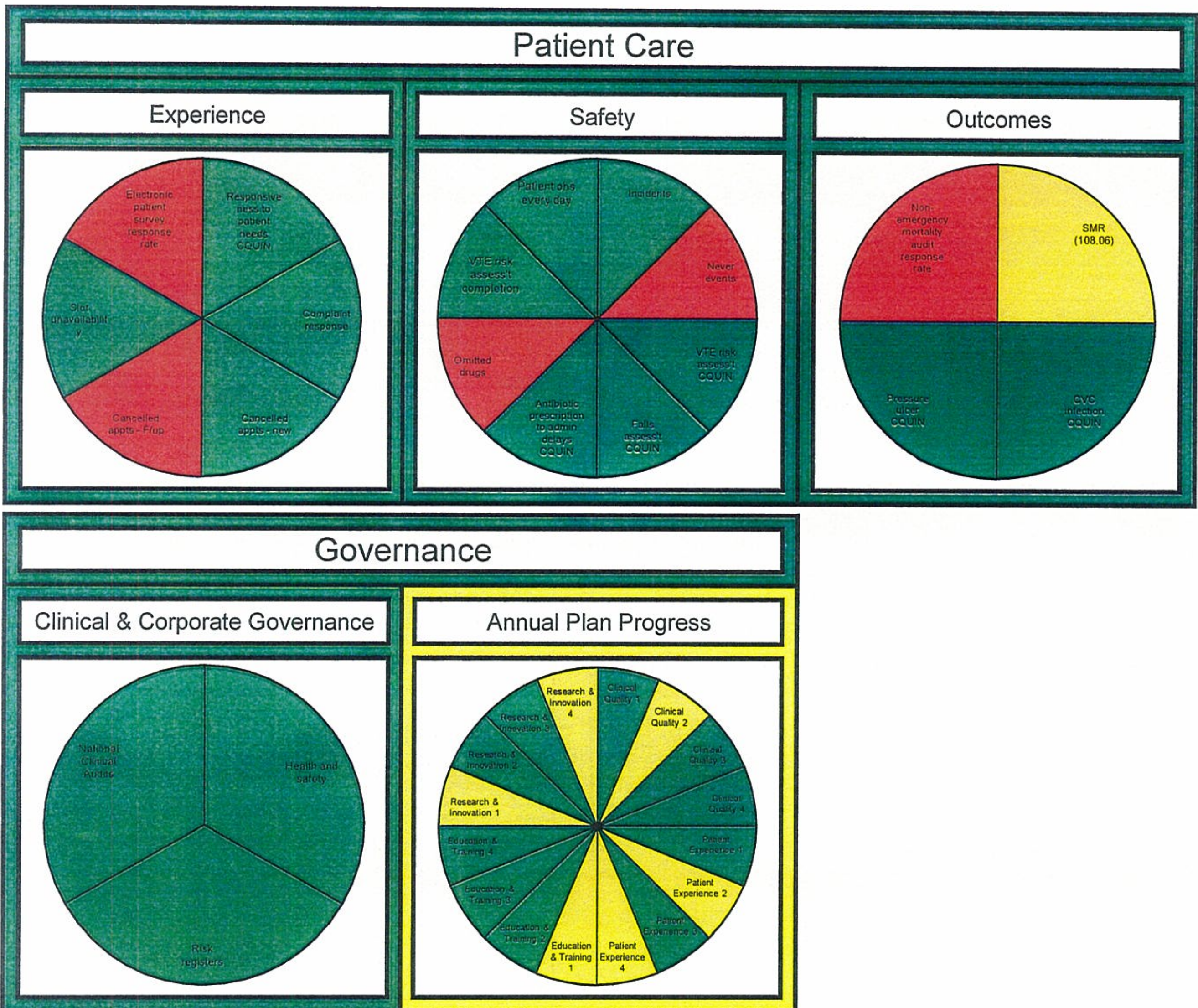
Innovation

Research publications; Electronic obs chart CQUIN; *Research income (commercial)*; *Research income (non-commercial)*; *Studies/trials in progress*; *Patient accruals*

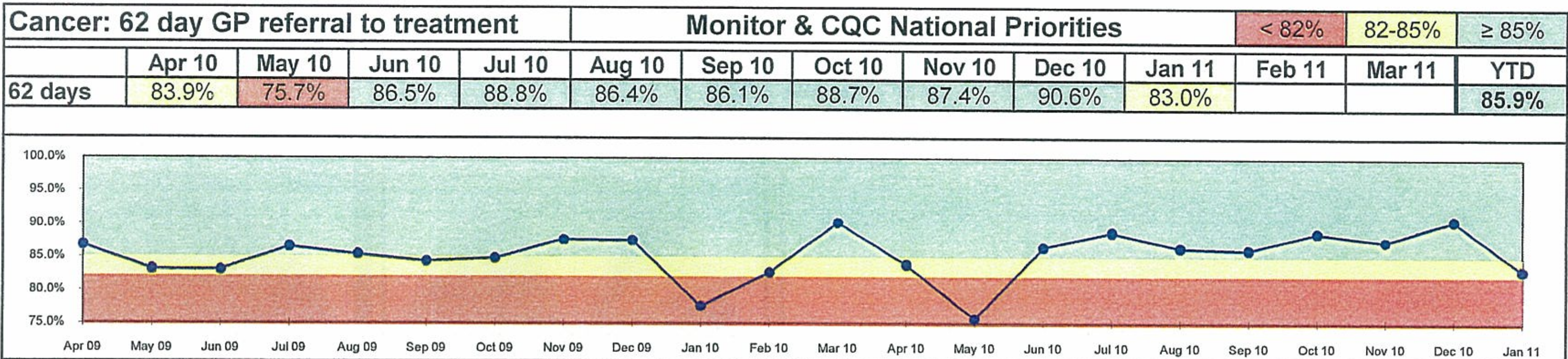
Process

18 weeks - non-admitted; DNAs - new; DNAs - F/up; *OP letters - dictation to post*; Theatre list utilisation; Theatre session utilisation; Daycase rate; LOS to meet bedholding; 18 weeks - admitted

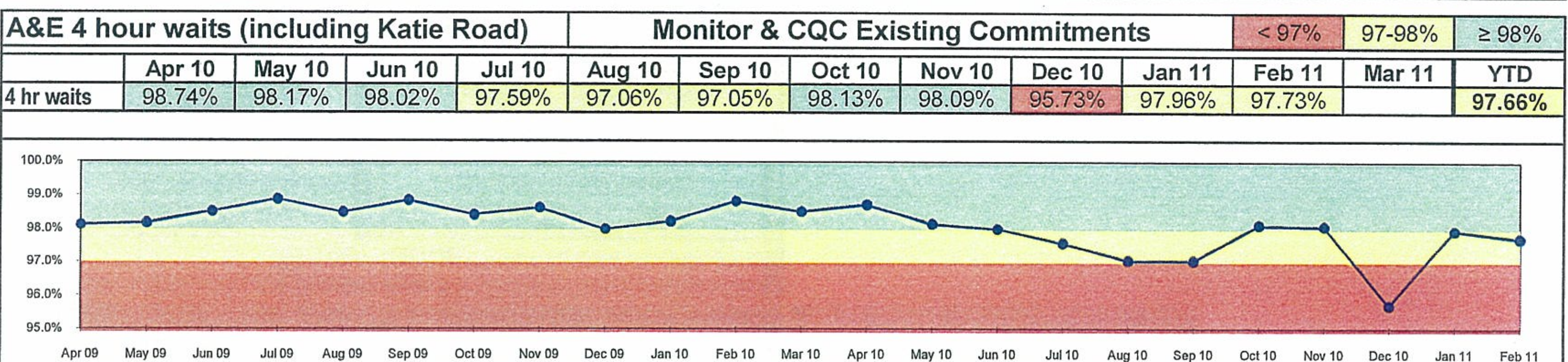
APPENDIX A



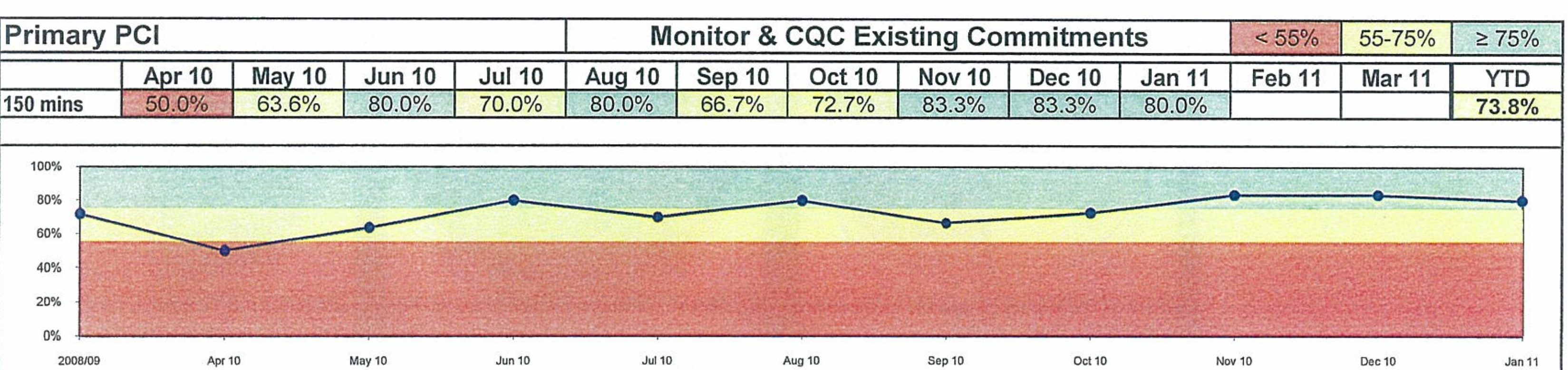
APPENDIX B



Cancer: 62 day GP referral to treatment					Monitor & CQC National Priorities					< 82%	82-85%	≥ 85%
	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
62 days	83.9%	75.7%	86.5%	88.8%	86.4%	86.1%	88.7%	87.4%	90.6%	83.0%			85.9%



A&E 4 hour waits (including Katie Road)					Monitor & CQC Existing Commitments					< 97%	97-98%	≥ 98%
	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
4 hr waits	98.74%	98.17%	98.02%	97.59%	97.06%	97.05%	98.13%	98.09%	95.73%	97.96%	97.73%		97.66%



Primary PCI					Monitor & CQC Existing Commitments					< 55%	55-75%	≥ 75%
	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
150 mins	50.0%	63.6%	80.0%	70.0%	80.0%	66.7%	72.7%	83.3%	83.3%	80.0%			73.8%

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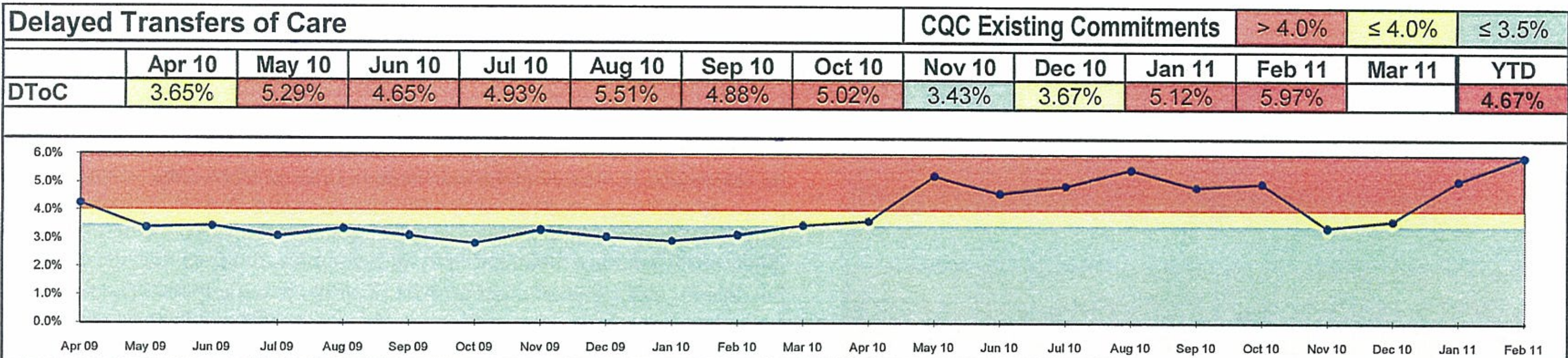
Delayed Transfers of Care

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

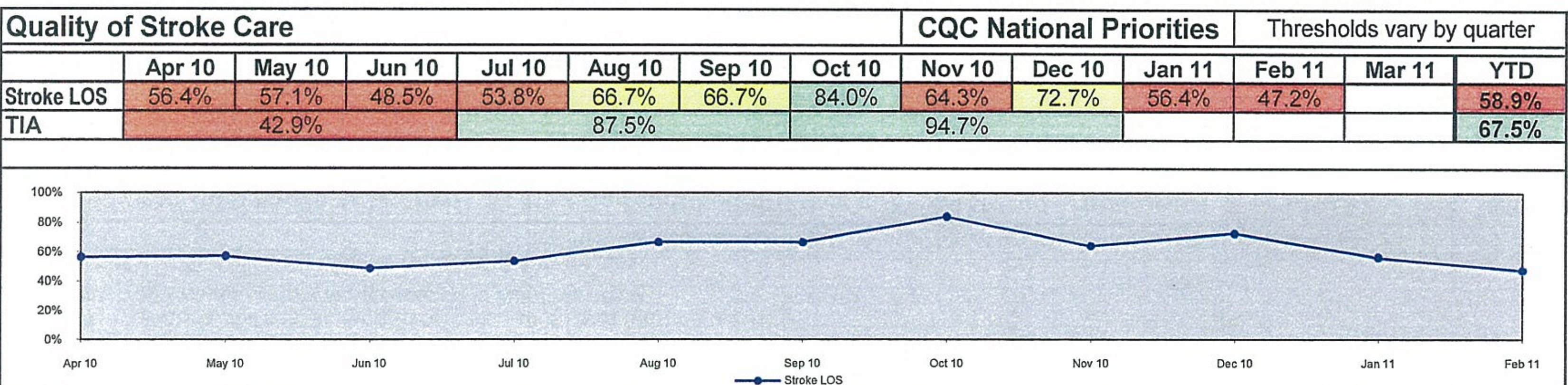
	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
DToC	3.65%	5.29%	4.65%	4.93%	5.51%	4.88%	5.02%	3.43%	3.67%	5.12%	5.97%		4.67%



Quality of Stroke Care

CQC National Priorities: Thresholds vary by quarter

	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
Stroke LOS	56.4%	57.1%	48.5%	53.8%	66.7%	66.7%	84.0%	64.3%	72.7%	56.4%	47.2%		58.9%
TIA		42.9%			87.5%			94.7%					67.5%



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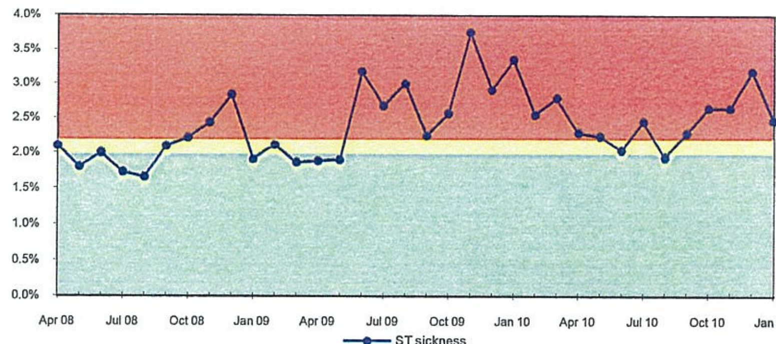
Sickness rate - short term	Workforce - Resources	> 2.2%	2.0-2.2%	≤ 2.0%
Sickness rate - long term		> 2.6%	2.3-2.6%	≤ 2.3%

	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	Latest
ST sickness	2.30%	2.25%	2.05%	2.46%	1.95%	2.29%	2.65%	2.65%	3.19%	2.48%			2.48%
LT sickness	2.00%	1.90%	1.74%	1.90%	2.24%	2.13%	1.92%	1.95%	1.98%	2.08%			2.08%

In January short term sickness fell to 2.48% from 3.19% in December and long term sickness rose to 2.08% from 1.98%. Total sickness absence therefore fell to 4.56%.

Hotspot areas include: Unregistered nursing (8.55%), Clinical Coding (9.02%), Domestics (8.15%), Porters (8.35%), Switchboard (14.08%), Theatres (majority of areas are over 7%), Cardiac Care – Ward 304 (7.18%), Coronary Care Unit (14.48%), GI-Medicine Ward 726 (16.97%), Renal – Ward 305 (11.03%), Multi-speciality Medicine – Ward 516 (12.02%), Ward 302 (8.49%), Clinical Decision Unit (8.85%), Pharmacy (15.4%), Trauma/Plastics- Ward 410 (13.84%), Outpatients (7.01%), Fracture Clinic (12.36%). The range of illnesses tend to be those of a short term nature i.e. colds, D&V, back problems and headaches.

The action plan included in last month's report is currently being



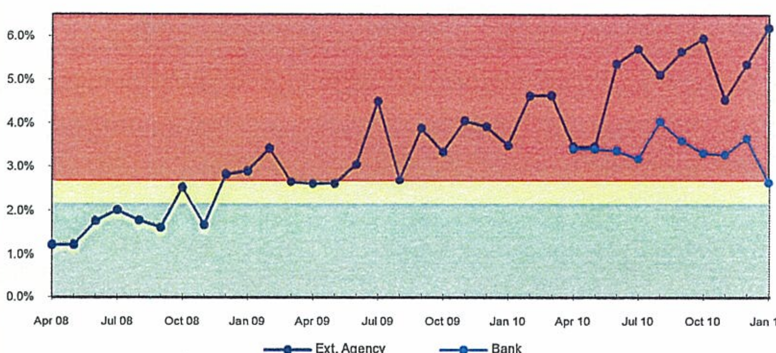
Percentage of total staff costs spent on agency & bank staffing	Workforce - Resources	> 2.7%	2.2 - 2.7%	≤ 2.2%

	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
Ext. Agency	3.48%		5.37%	5.71%	5.12%	5.65%	5.96%	4.56%	5.36%	6.20%			4.98%
Bank	3.43%		3.40%	3.21%	4.06%	3.62%	3.34%	3.31%	3.67%	2.67%			3.50%

The percentage of the pay budget spent on external agency in January was £1,558k (6.20%) an increase on £1,315k (5.36%) in December. In January the highest divisional spends were in Divisions 2 of £286k (6.14%) and 3 of £739k (17.02%). Division 5 has continued to see a reduced spend, particularly for medical staff.

Across all Divisions for the year to date 5.25% of total staff spend on Qualified Nursing staff has been used for external agency, 8.06% for Nursing Auxiliaries and 6.93% for medical staff. In contrast the spend on bank decreased in January to £670k (2.67%) from 900k (3.67%) in December.

The continued high levels of short term sickness and periods of high levels of activity which have required the opening of additional beds have contributed significantly to the reliance on agency and bank staff.



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Mandatory Training

Workforce - Capability: < 85% | 85-90% | ≥ 90%

	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	Latest
Fire	83.6%	87.4%	85.7%	85.5%	86.2%	85.8%	86.1%	86.1%	80.3%	75.8%			75.8%
Info Gov								21.5%	24.0%	31.8%	41.0%		50.2%

As of 31 January 75.8% of staff had received fire training in the last 12 months, a fall from 80.3% at the end of December. As of 28 February, 41.0% of staff had received information governance training in the current financial year. By 14 March this had increased to 50.2%. NHS Connecting for Health, following pressure from trusts nationally in relation to this requirement have extended the deadline for staff to complete this training to 31 July from 31 March. At the current rate of increase completion it is expected that the required 95% of staff will be trained by the end of May.

Reports on completion of both fire and information governance continue to be available on the Trust's workforce dashboard to allow managers to review completion for their staff. With the introduction of the Me@UHB system there will be clearer mapping of what mandatory training is required for each member of staff and managers will be able to see for each member of staff what training is required because it is out of date or about to expire.

Percentage of new staff who have completed induction

Workforce - Capability: < 85% | 85-90% | ≥ 90%

	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	12 mths
Local	97.5%	97.2%	97.3%	97.6%	96.8%	95.9%	94.6%	90.6%	84.7%	76.6%			76.6%

As of 31 January, 76.6% of staff who commenced employment in the last 12 months had completed local induction. From March 2011 the responsibility for the monitoring of local induction moved from Human Resources to the Learning and Development team. The current local induction checklist has been reviewed and an electronic form for completion is currently being developed. A system is to be introduced whereby new starters and their managers are e-mailed with a link to the electronic form. Once this is completed a message will be sent to update the Trust records. Automatic reminders to complete local induction sent via Informatics will also be introduced.

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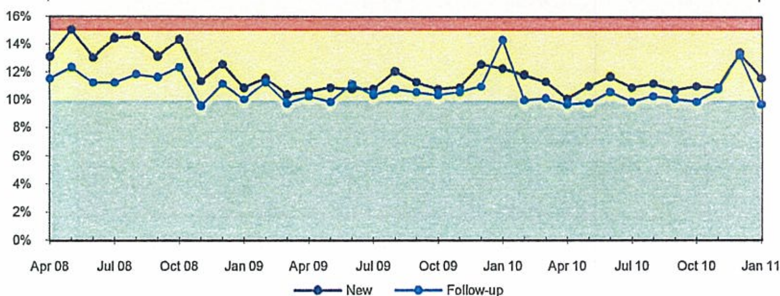
DNA rate — Efficiency - Process

	>15%	9-15%	<9%

	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
New	10.1%	11.0%	11.7%	10.9%	11.2%	10.7%	11.0%	10.9%	13.4%	11.6%	10.0%		**11.1%**
Follow-up	9.7%	9.8%	10.6%	9.9%	10.3%	10.1%	9.9%	10.8%	13.3%	9.7%	9.6%		**10.3%**

The DNA rate for both new and follow-up appointments fell in February compared to January. The rate for new appointments fell from 11.6% to 10.0% and that for follow-ups from 9.7% to 9.6%. The overall year to date rate including both new and follow-up appointments has fallen to 10.5%.
Preparation for the pilot of the electronic patient reminder services continues with implementation expected to take place in May. Data quality checks have been undertaken on telephone numbers of patients due to attend in May to ensure that as many as possible can be contacted using the system. In addition the telephone numbers of contacts for all clinics are currently being verified to ensure that patients can be transferred to someone who can rearrange their appointment if they tell the service they are unable to attend when they are reminded.

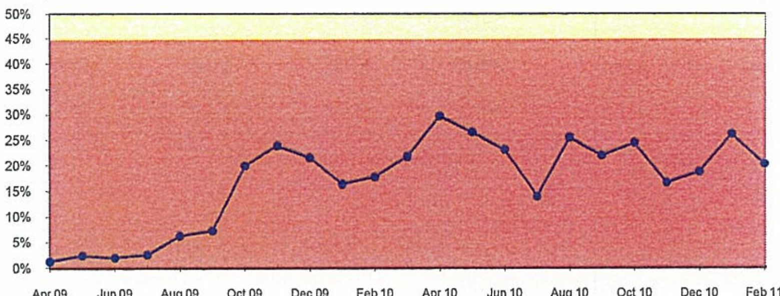


Electronic Patient Survey Response Rate — Patient Experience

	< 45%	45 - 50%	≥ 50%

	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	Latest
% Response	29.9%	26.7%	23.3%	14.1%	25.7%	22.1%	24.6%	16.7%	18.9%	26.3%	20.4%		**20.4%**

The response rate for the electronic patient survey fell from 26.3% in January to 20.4% in February. The response rate fell due to technical problems in gathering the data via both the bedside TVs and handheld computers. The Patient Experience Team will be providing additional support and advice to the wards in March to ensure that the response rate increases in future.



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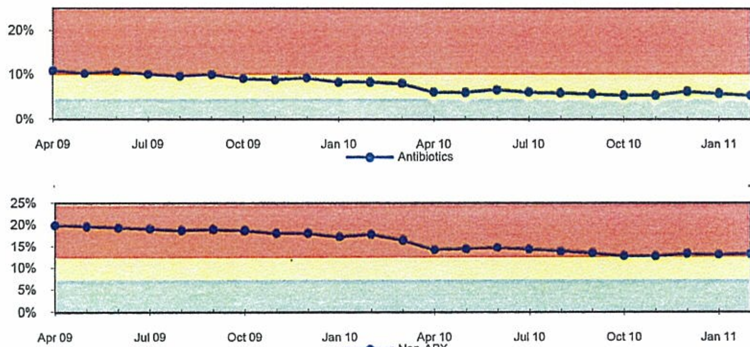
Omitted drugs - Antibiotics / Omitted drugs - Non-antibiotics						Patient Safety					> 10% / > 12.5%	5-10% / 7.5-12.5%	≤ 5% / ≤ 7.5%

	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
Antibiotics	6.3%	6.2%	6.8%	6.3%	6.1%	5.9%	5.6%	5.6%	6.4%	6.0%	5.6%		**6.1%**
Non-ABX	14.4%	14.6%	14.9%	14.5%	14.0%	13.6%	12.9%	12.8%	13.4%	13.2%	13.3%		**13.8%**

In February omitted doses for antibiotics fell to 5.6% from 6.0% in January. The rate for non-antibiotics however rose from 13.2% to 13.3%.
The latest Executive RCA meeting took place on 25 February and existing actions were followed up at this meeting to ensure they are completed. New actions included: the timing of drug round reviews, patients allergies to drugs clearly communicated, prescribing of suppliments reviewed, improving communication around one-off doses, timely PICS discharge, ED drug administration reviewed in the context of communication with CDU and re-implementing the pre-admission of patients onto PICS in CDU by ward clerks.



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

	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
Non-Em Mortality	100.0%	83.3%	88.9%	40.0%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%			**89.2%**
Forms sent out	9	6	9	5	7	4	7	3	9	6			**65**
Forms completed	9	5	8	2	7	4	7	3	9	4			**58**

Completion of non-emergency mortality surveys for the year to date has increased to 89.2% from the 86.4% reported last month. There is now a 100% response rate for the period August to December 2010. Trust-wide there are 2 outstanding surveys from January and the number outstanding for the year to date has reduced from 11 reported last month to 7. Divisional Directors have been sent the details of all outstanding audits and the consultants concerned have been reminded of the need to complete these. Feedback to the surveys continues to be reviewed and actions developed based upon feedback at the Executive Medical Directors' monthly Clinical Quality Monitoring Group.