AGENDA ITEM NO: 8

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 26 MAY 2011

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

Purpose:	To update the Board of Directors on the Trust's performance against national indicators and performance against internal targets.
Confidentiality Level & Reason:	N/A
Annual Plan Ref:	Affects all strategic aims.
Key Issues Summary:	The report adopts the revised format outlined in the March Performance Indicators Report. The following indicators are currently not in line with targets and therefore exception reports have been provided: • A&E Clinical Quality Indicators • Quality of Stroke Care • Delayed Transfers of Care • PICS red lines • HSMR • Non-Emergency Mortality Audit Responses • GU Medicine Access • Appraisal • Mandatory training • Local Induction • External Agency & Bank rate • Omitted Drugs Further details and action taken are included in Appendix B.
Recommendations:	The Board of Directors is requested to: **Accept** the report on progress made towards achieving performance targets and associated actions. **Accept** the revised format for this and future reports.

Signed:	**Date:** 17 May 2011

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 26 MAY 2011

PERFORMANCE INDICATORS REPORT

PRESENTED BY THE EXECUTIVE DIRECTOR OF DELIVERY

1. **Purpose**

This paper updates the Board of Directors on the Trust's performance against national indicators, including those incorporated in Monitor's Compliance Framework and performance against internal targets. Performance against these indicators is shown in Appendix A. This paper adopts the changes in format and indicators reported proposed in the March report as well as reflecting other changes resulting from the acute contract with NHS South Birmingham.

2. **Changes to Reports**

The changes to the format of the report and indicators reported, as outlined in the March report to the Board of Directors, have been made. There are some differences from the original proposals to further improve the clarity and comprehensiveness of the report. National indicators are now divided into those indicators included in the Monitor Compliance Framework and those from the Operating Framework that are not as this eliminates the duplication of indicators. For local indicators those which are linked to the Trust priorities are now in distinct sections. Mandatory training is now not separated out into its separate components, as planned, but is within the Education and Training section as a composite indicator. Some of the proposed indicators in this section relating to junior doctor education have been merged so as not to give undue weight to this one area of education and training.

A number of the indicators included in the Education and Training section and those in the Research and Innovation section will be reported on a quarterly basis. Performance for these indicators will therefore be included after quarter 1. A number of other indicators, including MSSA, E. Coli, GRE, readmissions and outpatient letters are currently being benchmarked to determine appropriate RAG ratings for each.

3. **Exception reports**

For national targets exception reports are contained below. Monthly performance data for exceptions are contained in Appendix B. The Trust is currently underachieving three of the new A&E Clinical Quality Indicators. Delayed transfers of care increased and continued to be above the threshold

in April. The length of stay element of the Quality of Stroke Care indicator was below the Trust's contractual target in April 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. DNAs is no longer included as an exception as a significant fall has been seen in the rate from its peak and this now seems to have levelled-off. This is in contrast to national data published by the NHS Information Centre which shows that the DNA rate nationally is rising year on year and by Q2 2010/11 the national annual rate had reached 14.6%. The rate for the West Midlands over this period was 11.4% so UHB is below both the national and West Midlands average. It is therefore proposed to revert the target rate for this indicator to 10%.

The following internal targets are therefore currently considered exceptions:

a) PICS red lines
b) HSMR
c) Non-Emergency Mortality Audit Response Rates
d) GU Medicine Access
e) Appraisal
f) Mandatory training
g) Local Induction
h) External Agency & Bank rate
i) Omitted Drugs

3.1 A&E Clinical Quality Indicators

From April 2011 the existing 4 hour A&E target has been replaced by eight clinical quality indicators. Of these five are reported on a monthly basis and are included in the Monitor Compliance Framework for 2011/12. However only one of the indicators, total time in the A&E department, which is broadly equivalent to the 4 hour target, will be included in the Trust's rating in Quarter 1.

Rather than being based on a monthly situation report by the Trust, information on the Trust's performance against these indicators will be calculated based on the Trust's Commissioning Data Set (CDS) submission which includes key data about each individual attendance at the Emergency Department (ED). The quality of the data included in this dataset is therefore crucial if the Trust's performance against the new indicators is to be calculated accurately. Considerable work has therefore been undertaken to validate the April submission and ensure that it accurately reflects the Trust's performance.

In April the Trust achieved two of the five indicators, total time in A&E and the percentage of patients who left without being seen. If this level of performance was seen in Quarter 2 or later the Trust's Monitor governance score would increase by 1.0. The following three indicators were not achieved:

3.1.1 Time to Treatment

April performance for this indicator shows a 95th percentile waiting time of 37 minutes against a target of 15 minutes. Work is ongoing to improve data quality for this indicator. The Informatics team are working to resolve a data capture error which is expected to improve performance. Division C are working with the clinical team to ensure that there is real time data capture as performance is being distorted by some retrospective data entry. The importance of data input at the time of care is being raised at all specialty and clinical team meetings.

3.1.2 Time to Assessment

Currently some retrospective data capture is distorting performance for this measure which currently shows 95th percentile performance of 166 minutes for April against the 60 minute target. The ED nursing team are currently working to improve the recording of the initial assessment in real time. The Dashboard is being used now on a daily basis to validate and correct any anomalies.

3.1.3 Unplanned Re-attenders

This indicator includes all re-attenders to the ED within 7 days for both related and unrelated attendances. In April 6.65% of patients re-attended against the target of a maximum of 5%. The number of "unrelated" attendances is minor and therefore an audit is planned of the "related" attendance data. This will improve performance by checking for appropriate treatment plans, trends in condition, reattendance and patients who re-attend despite contrary advice to return to Primary Care. Further work will be undertaken with the clinical teams to understand the patient flows for this indicator.

No monthly data are currently provided in Appendix B for these indicators as only April data has been validated and previous months are therefore not comparable. Monthly data will be provided in the appendix in future months.

The unplanned re-attenders and time to treatment indicators are being declared as risks to Monitor in the Annual Plan for 2011/12. The time to assessment is not being declared as the underachievement is more linked to poor data quality than actual performance.

3.2 Delayed Transfers of Care

There was an increase in the number of patients whose discharge was delayed in March. In the last week of April there were 50 patients

delayed compared to 40 in March. The national indicator therefore shows performance of 5.08% compared to 4.27% in March. This measure has also been affected by the lower number of beds open following the closure of the tidal-flow ward which has reduced the denominator and therefore increased the percentage.

There has been a significant change in the profile of patients whose discharge has been delayed over the last month. Following the opening of the Kenrick Centre the number of patients waiting for residential or nursing home care has fallen. Over half the delays are now for patients awaiting assessment. This follows changes in the rules by Social Services regarding the restarting of homecare packages. This means that every patient now has to be assessed before discharge even if a suitable package was already in place. Social Services staff worked overtime over the May Bank Holiday weekend to try and reduce the number of patients awaiting assessment but it has stayed relatively static. Social Services is undertaking a 'time and motion' study of its processes to identify whether they can be made more efficient.

The Kenrick Centre continues to accept patients for enablement. At the end of April 21 patients at the centre had been transferred from UHB and a further 8 patients who had been transferred have been discharged.

3.3 Quality of Stroke Care – Length of Stay

During April 23 out of 38 patients spent 90% of their total LOS on the Stroke Ward. This represents 60.5% against a target of 80% and is an improvement from 47.7% in March 2011. The figure does not yet include patients staying at Moseley Hall Hospital and it is anticipated that performance will improve further when this data is included.

Stroke services are now managed alongside Neurology within Division D. The Division has made a number of changes since taking over the service at the beginning of April and this has included appointing Dr Sims as the CSL for Stroke. A much stricter approach has now been adopted with managing bed capacity on the stroke ward with a minimum of one access bed being maintained at all times. The Division have also started a Stroke Task and Finish Group which will be reviewing and implementing the actions that have come out of the RCA process. The Trust is also working with the commissioners from NHS South Birmingham to develop a framework for early supported discharge in stroke which would free up additional inpatient stroke capacity on the acute stroke unit.

Monitor have indicated that they will be including stroke in the Compliance Framework for 2011/12 but have yet to produce a definition. It has been assumed, until a definition is developed, that they will adopt the existing 90% length of stay on a stroke unit and 24 hour referral to treatment for high risk TIA indicators.

3.4 Hospital Standardised Mortality Rate (HSMR)

Dr Foster's published HSMR for UHB now shows an overall 3 year mortality rate of 108.52. As detailed in previous reports UHB disputes the methodology of this indicator but it is included as it constitutes a reputational risk for the Trust. The Trust has been involved in the development of a new mortality indicator for the NHS, the Summary Hospital-level Mortality Indicator (SHMI) however this is now not expected to be available before the end of 2011. Patient mortality is considered regularly at the Clinical Quality Monitoring Group and no organisation-level concerns have been identified.

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 **Accept** the revised format for this and future reports.

Tim Jones
Executive Director of Delivery

APPENDIX A

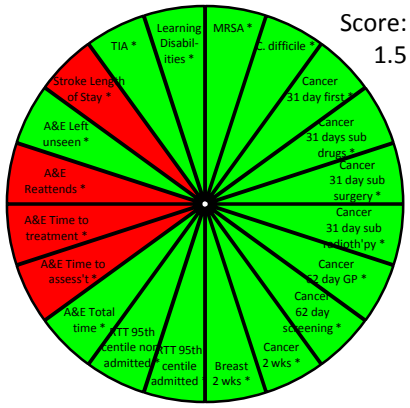
University Hospitals Birmingham NHS
NHS Foundation Trust

2011/12 Key Performance Indicator Report

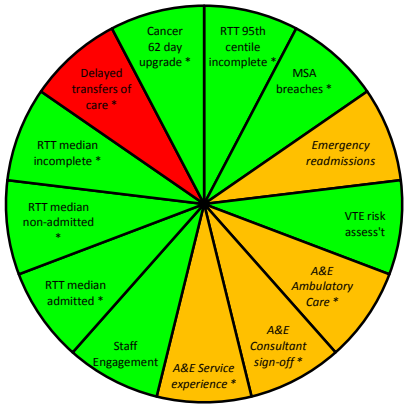
Where data is not currently available or performance is being benchmarked indicator names are in italics. These have been assigned 'amber' unless considered high risk where they have been assigned 'red'.
* Indicators included in the acute contract.

National Performance

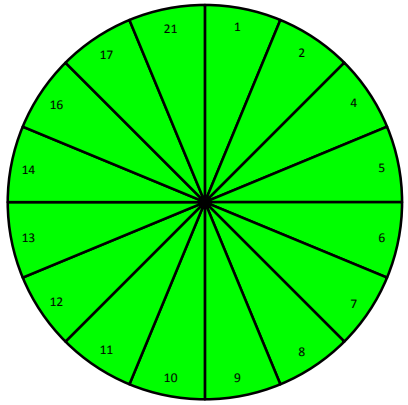
Monitor Governance Rating



Operating Framework Indicators not Used by Monitor

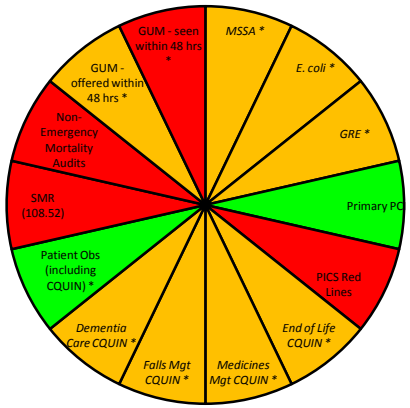


CQC Registration Outcomes

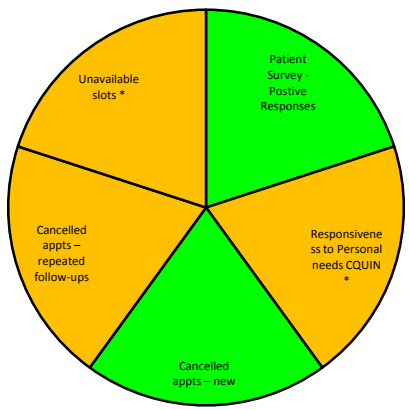


Trust Priorities

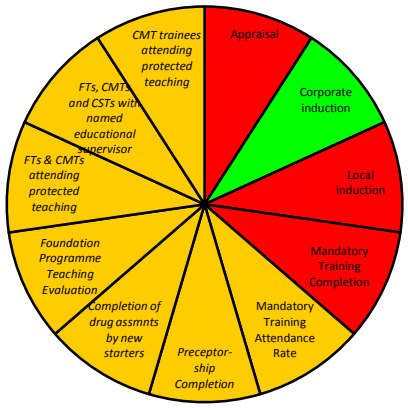
Clinical Quality & Outcomes



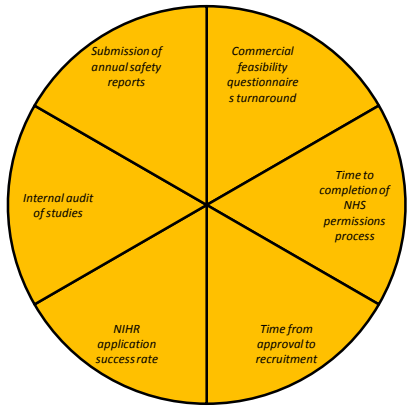
Patient Experience



Education & Training



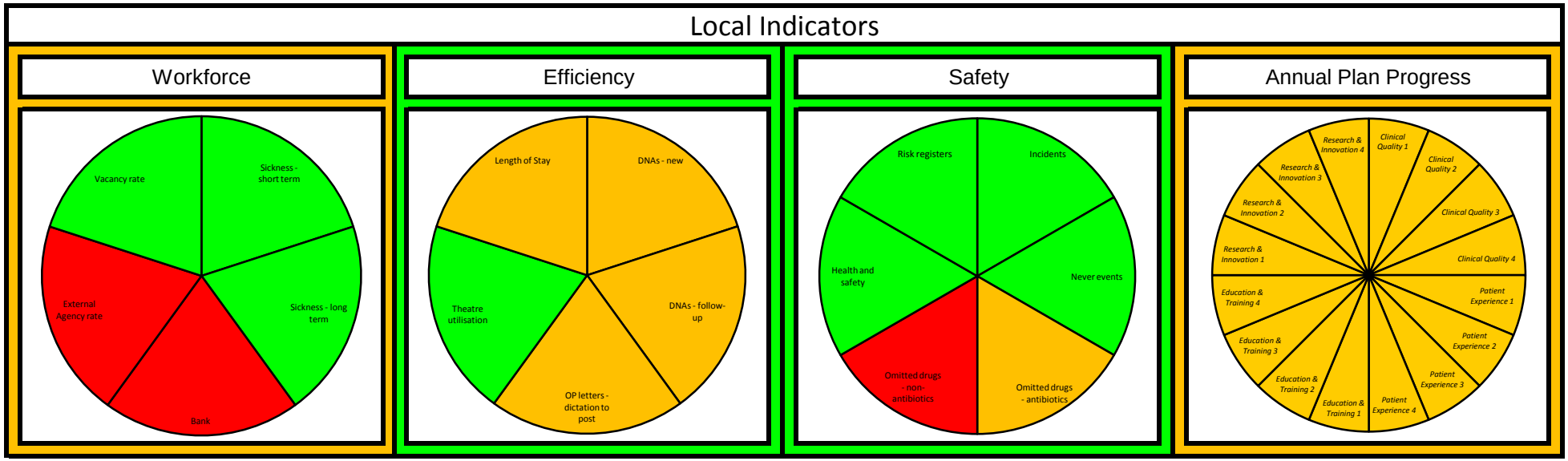
Research & Innovation



17 May 2011

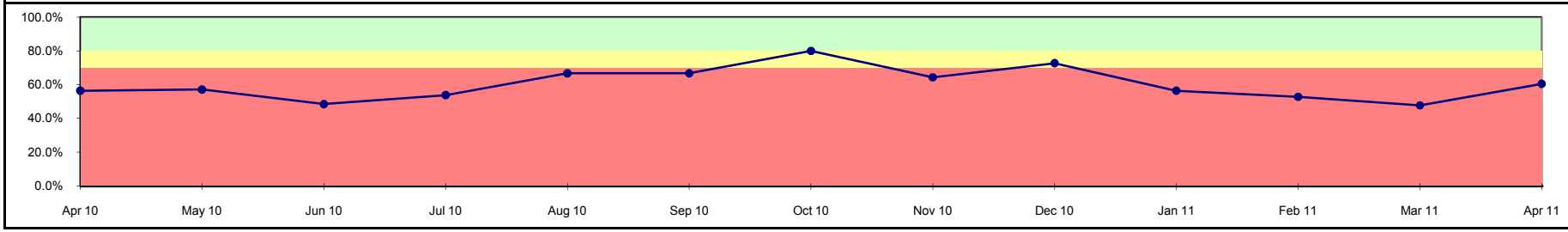
APPENDIX A

University Hospitals Birmingham NHS
NHS Foundation Trust

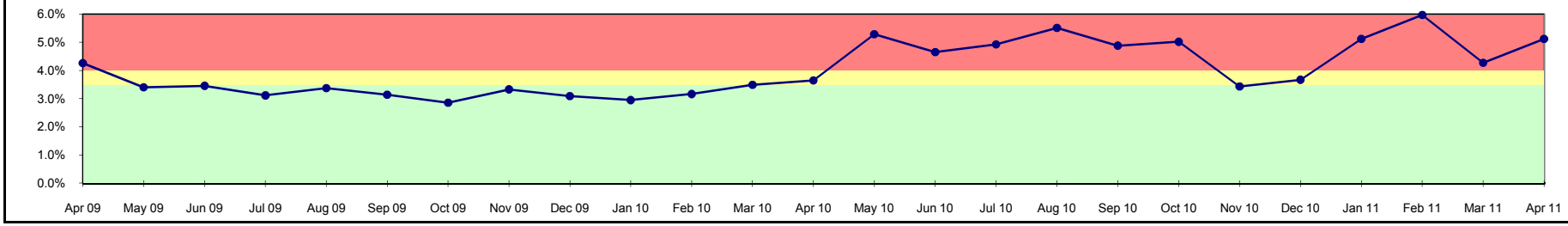


APPENDIX B

Quality of Stroke Care								Monitor Governance			< 70%	70-80%	≥ 80%
	Apr 11	May 11	Jun 11	Jul 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	YTD
Stroke LOS	60.5%												60.5%



Delayed Transfers of Care								Operating Framework			> 4.0%	≤ 4.0%	≤ 3.5%
	Apr 11	May 11	Jun 11	Jul 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	YTD
DToC	5.08%												5.08%



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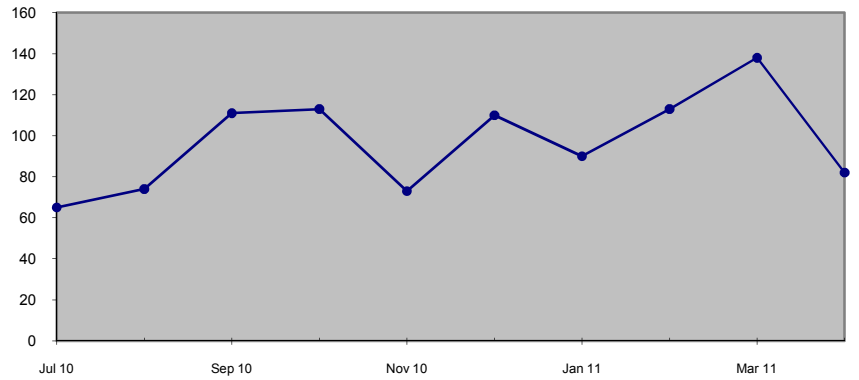
PICS Red Lines								Clinical Quality & Outcomes			Not set		
	Apr 11	May 11	Jun 11	Jul 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	Latest
Red Lines	82												82

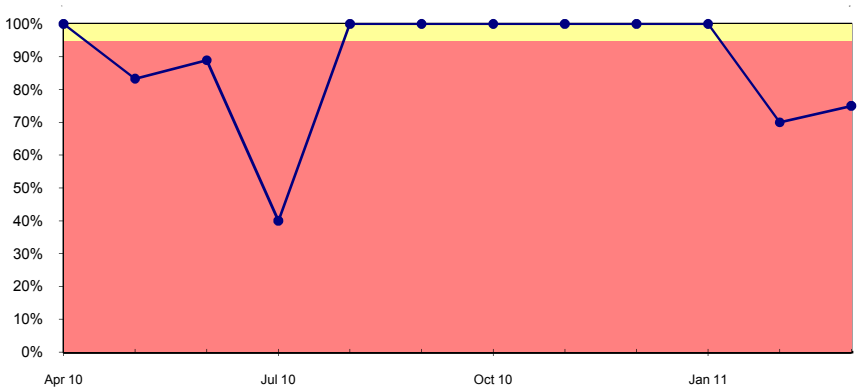
PICS red lines indicate patients on PICS whose record has not changed for 24 hours. It is therefore likely that the patient is no longer an inpatient and should have been discharged from the system. This constitutes a clinical risk if the patient is re-admitted to the Trust and the previous episode of care has not been concluded on PICS.

As of 30 April there were 82 red line patients on PICS, a significant fall from 138 as of 31 March. The responsible consultants for all patients who should have been discharged prior to February 2011 have been sent a reminder of the need to discharge their patients along with the patients' medical notes to give them the necessary information to do so.



Non-emergency mortality audit response rate								Clinical Quality & 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%	100.0%	81.8%	75.0%	**90.1%**
Forms sent out	9	6	9	5	7	4	7	4	9	6	11	4	**81**
Forms completed	9	5	8	2	7	4	7	4	9	6	9	3	**73**

Completion of non-emergency mortality surveys for the year to date has increased to 90.1% from 89.5% reported last month. Trust-wide there is 1 outstanding survey from March, 2 from February and 8 for the full year 2010/11. Feedback to the surveys continues to be reviewed and actions developed based upon feedback at the Executive Medical Directors' monthly Clinical Quality Monitoring Group.



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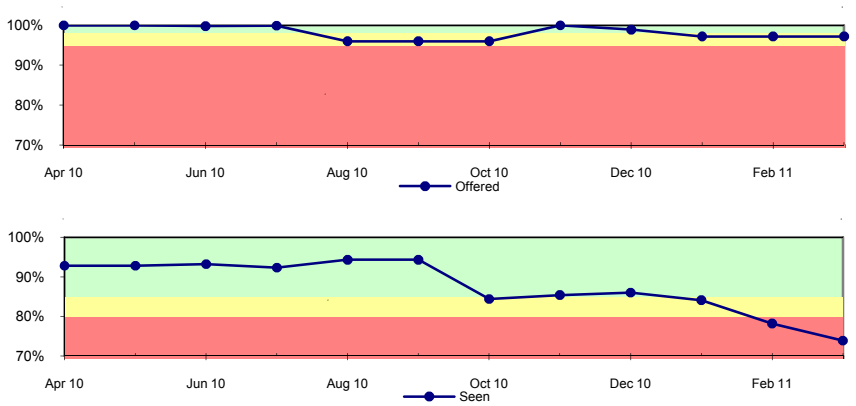
Genito-Urinary Medicine - Patient Offered Appointment in 48 hours Genito-Urinary Medicine - Patient Seen in 48 hours													
Patient Safety											< 95% < 80%	95-98% 80-85%	≥ 98% ≥ 85%
	Apr 10	**May 10**	**Jun 10**	**Jul 10**	**Aug 10**	**Sep 10**	**Oct 10**	**Nov 10**	**Dec 10**	**Jan 11**	**Feb 11**	**Mar 11**	**YTD**
Offered	100.0%	100.0%	99.8%	99.9%	96.0%	96.0%	96.0%	100.0%	98.9%	97.2%	97.2%	97.2%	**98.1%**
Seen	92.8%	92.8%	93.2%	92.3%	94.3%	94.3%	84.4%	85.4%	86.0%	84.1%	78.2%	73.9%	**87.6%**

These indicators have become relevant to the Trust following the transfer of Sexual Health Services from Heart of Birmingham Teaching PCT on 1 April 2011. The previous national target was that 98% of patients should be offered an appointment within 48 hours; this has been retained contractually for 2011/12. There is also a local contractual target that 85% of patients should be seen within 48 hours. March 2011 performance shows the service to be underachieving these measures.

Demand was 9% above plan in Quarter 4 and therefore additional capacity is being added through a change in the mix of walk-in and booked patients. A patient flow and skill mix review is in progress to ascertain where capacity can be increased to meet increased demand.

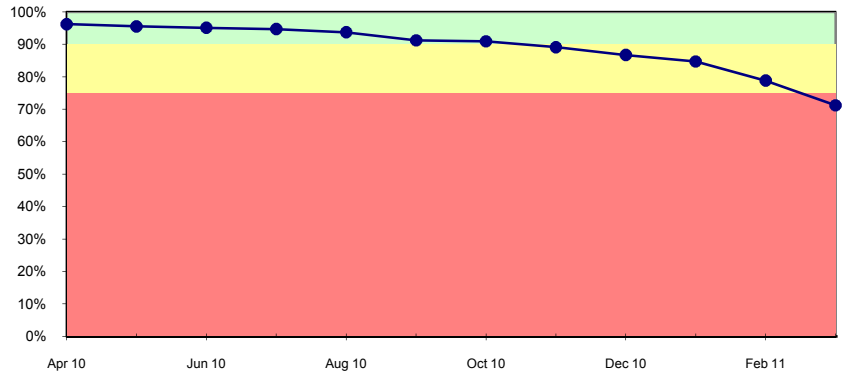
To improve the patients seen rate, staff are being trained and performance managed in the accurate recording of patients choosing to decline access offered within 48 hours. A review of the DNA rate is also taking place.



Percentage of staff who have had an appraisal in last 12 months													
Education & Training											< 75% < 75%	75 - 90% 75 - 90%	≥ 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**
Appraisal	96.2%	95.5%	95.1%	94.7%	93.7%	91.2%	91.0%	89.2%	86.8%	84.8%	79.1%	72.0%	**72.0%**

As of 31 March 72.0% of staff had received an appraisal in the last 12 months. Since April 2011 automated reminder emails that show all the areas where staff are not compliant, thereby eliminating the need to send out individual reminders for each area that is not compliant have been sent out. The Learning Management System will be introduced in June 2011 which will automate the current appraisal process and allow the automatic updating of records.

The action plan outlined in last month's report continues to be implemented.



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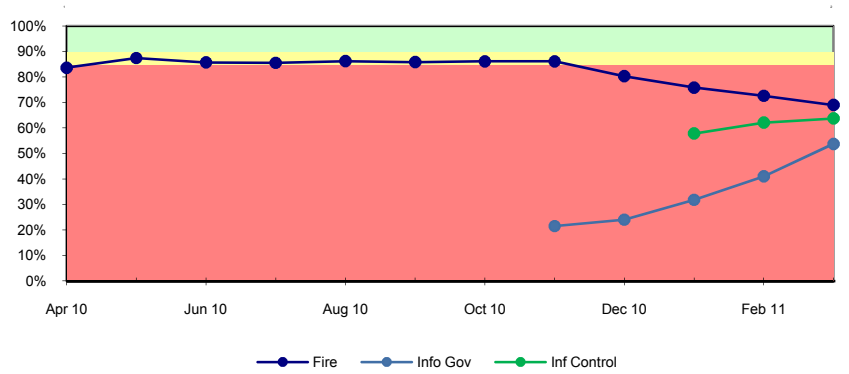
Mandatory Training								Education & Training		< 85%	85-90%	≥ 90%	
	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	Latest
Fire	83.6%	87.4%	85.7%	85.5%	86.2%	85.8%	86.1%	86.1%	80.3%	75.8%	72.6%	69.0%	**69.0%**
Info Gov								21.5%	24.0%	31.8%	41.0%	53.7%	**57.3%**
Inf Control										57.8%	62.1%	63.7%	**63.7%**

As of 31 March 69.0% of staff had received fire training in the last 12 months, a fall from 72.6% at the end of February. As of 31 March 53.7% of staff had received information governance training in the current financial year and as of end of April this had increased to 60.6%. For infection control training 63.7% of staff have been trained in the last 12 months. The infection control team has identified that sufficient capacity is available to train all staff but large numbers of staff are not attending their booked training due to operational pressures.

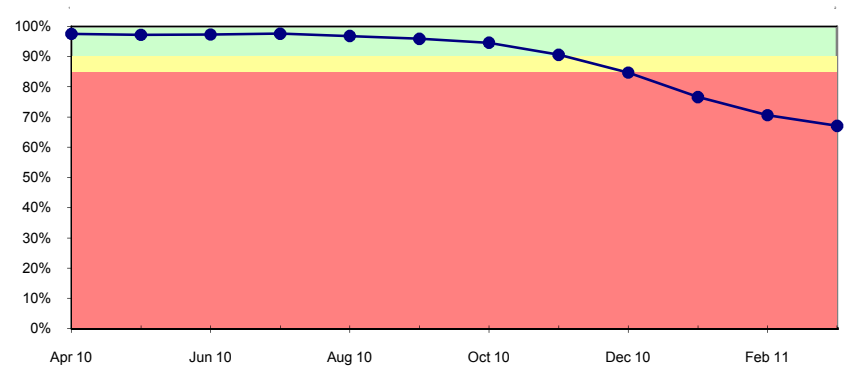
In April 2011 only 73.8% of staff who had booked to attend a mandatory training session actually attended their training. The Learning and Development department is setting up a programme of regular meetings with the divisional management teams to address completion rates, DNA rates and to determine prioriry areas for training.



Percentage of new staff who have completed induction								Education & Training		< 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%	94.5%	91.4%	88.3%	82.5%	78.6%	67.1%	**67.1%**

As of 31 March 67.1% of staff recruited in the last 12 months had received local induction.

The action plan outlined in last month's report is currently being implemented. Automatic reminders to staff who have not completed induction continue to be sent. An electronic induction checklist is expected to be introduced by the end of July. This, along with the implementation of the Learning Management System is expected to lead to an improvement in data quality and consequently reported performance.



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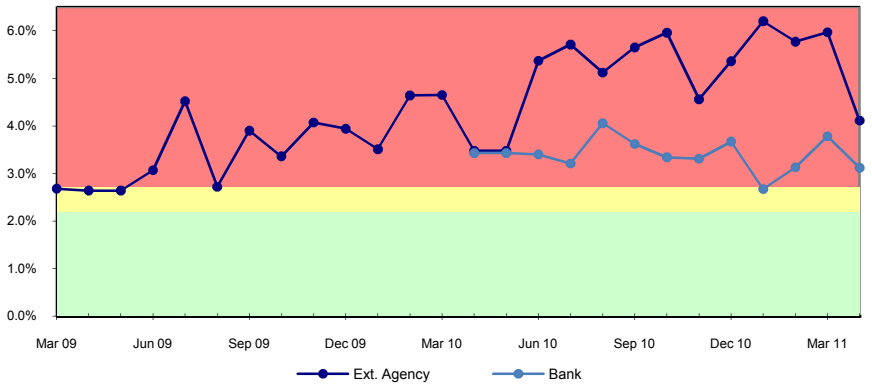
Percentage of total staff costs spent on agency & bank staffing	Workforce	> 2.7%	2.2 - 2.7%	≤ 2.2%

	Apr 11	May 11	Jun 11	Jul 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	YTD
Ext. Agency	4.11%												**4.11%**
Bank	3.12%												**3.12%**

The external agency spend in April 2011 was £1.01m (4.11%), the lowest rate since May 2010. The bank spend over the same period was £765k (3.12%). This was the second lowest monthly bank spend since the indicator was introduced.

The closure of additional capacity that has been open since the beginning of the winter has led to a significant drop in the need for agency nursing staff. In addition there has been adjustment of the junior doctor rotas for the Emergency Department and Neurosciences where agency spends have been high. These changes have been introduced from April so that the rotas can be covered without the need for agency staff to cover vacancies and have contributed to reduced spend.



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

	Apr 11	May 11	Jun 11	Jul 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	YTD
Antibiotics	5.9%												**5.9%**
Non-ABX	12.6%												**12.6%**

The rate of omitted antibiotic doses rose to 5.9% in April from 5.5% in March. The rate for non-antibiotics also rose from 12.4% to 12.6%.

The latest Executive RCA meeting took place on 10 May reviewing cases from Division C. Actions identified include reviewing skill mix to ensure there is a nurse on every shift who is able to do cannulation. Education is required to ensure all nursing staff understand and implement the NBM policy correctly for all patients, including patients with different or more unusual conditions so that drugs are not missed. All junior nursing and medical staff are also to be reminded of the correct escalation process through the Nurse in Charge, the Night Sister and Consultant on call, as required, to ensure that all patients get the right care at the right time, including in the middle of the night.