# UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST BOARD OF DIRECTORS THURSDAY 24 OCTOBER 2013

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

Purpose:	To update the Board of performance against the Mor targets and indicators, contract and CQUINs.	nitor Compliance Framework ctual targets, internal targets
	To provide Quarter 2 perfor Annual Plan key tasks and stra	rmance against the agreed stegic enablers for 2013/14.
Confidentiality Level & Reason:	None	
Annual Plan Ref:	Affects all strategic aims.	
Key Issues Summary:	Exception reports have been indicators where there are performance:  • Clostridium difficile – All  • A&E 4 hour waits  • Stroke – Length of Stay  • Patient Observations  • External Agency Spend  • Delayed Transfers of Ca  • Pre-assessment  • Omitted Drugs - Antibioti Further details and action taker An update is also included on the For the 2013/14 Annual Plan yeare on plan, 6% of key tasks there are no key tasks where One key task has been remove	current or future risks to Cases  & TIA  ire ics & Non-antibiotics if are included in the report, the Trust's CQUINs, ear to date, 92% of key tasks are slightly below plan, and remedial action is required.
Recommendations:	Accept the report on progress performance targets and associated the pear to date 20 against the Trust Annual Plan.	ss made towards achieving lated actions and risks.
Approved by:	Tim Jones	15 October 2013

# UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

# BOARD OF DIRECTORS THURSDAY 24 OCTOBER 2013

#### PERFORMANCE INDICATORS REPORT

### PRESENTED BY EXECUTIVE DIRECTOR OF DELIVERY

## 1. Purpose

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

### 2. UHB Performance Framework

The Trust has a comprehensive performance framework that includes national targets set by the Department of Health and local indicators selected by the Trust as priority areas, some of which are jointly agreed with the Trust's commissioners. The Trust Performance Framework is agreed by the Board of Directors and is intended to give a view of overall performance of the organisation in a concise format and highlight key risks particularly around national and contractual targets as well as an overall indication of achievement of key objectives. Based on latest performance, targets are assessed as 'on target', 'on target but close to threshold', 'slightly below target', or 'remedial action required'. For national targets that fall into the latter three categories, these are reported in this paper as exceptions. Local targets are reported as exceptions where a remedial action plan is in place.

# 3. National Targets

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

Of the 15 indicators currently included in Monitor's Compliance Framework, 12 are currently on target, 1 is on target but close to the threshold (See Section 3.2 below), 1 is slightly below plan and 1 has a remedial action plan in place (See Section 3.1 for exception reports). Of the 13 national indicators not included in Monitor's Compliance Framework 11 are on target and fully validated data is awaited for the other 2.

# 3.1 Exception Reports

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

#### 3.1.1 C. difficile

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

Joint work has been undertaken with the CCG to produce a more meaningful measure for C. difficile as some cases are unavoidable. Agreement has therefore been reached that they will consider avoidability when applying the contractual penalty. Monitor, however, are continuing to use the same methodology as previous years, stating in its Risk Assessment Framework that trusts must include all cases in their trajectory, including those that are unavoidable. Consequently the Trust's trajectory of 56 cases for the year will apply to all cases for Monitor and only to avoidable cases for the contract with the CCG.

There were 5 cases of C. difficile in total in September. The Trust has therefore had a total of 45 cases to the end of August against a Monitor trajectory of 28. Following review by the joint Trust/CCG panel of the September cases it has been agreed all the cases were unavoidable. The process of judging the avoidability of outstanding case from June has now been completed and this was found to be unavoidable. In addition one case in August that was previously found avoidable has now been re-designated by the panel as unavoidable following the receipt of more detailed typing. The Trust's CCG trajectory therefore now stands at 9 cases.

The Trust declared a risk to achievement of this target in its Strategic Plan to Monitor. As the Trust has exceeded its trajectory for Quarters 1 and 2 of 28 cases, its governance rating for Quarter 2 will be affected. Please see the 'Monitor Quarterly Declaration' paper for further details

A large number of trusts are struggling to meet their trajectories – as of the end of August, 55% of foundation trusts are above trajectory for the year to date. The NHS in England as a whole is 16.5% above trajectory for the number of cases seen. Seven foundation or NHS trusts have already exceeded their year end trajectories after five months.

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

#### 3.1.2 <u>A&E 4 hour waits</u>

In September 94.1% of A&E patients left the Emergency Department (ED) within 4 hours of arrival against the national target of 95%. The target has been achieved for Quarter 2 as a whole with performance of 95.3% due to strong performance in July and August. Year to date performance against the target now stands at 94.7%.

Work continues to reduce the number of specialty breaches by establishing clearer and more efficient pathways for these patients. The Strategy and Performance Team are currently collating the results of the work undertaken with the ED regarding the flow of specialty patients. This will be presented to the Department in November.

The CCG can penalise the Trust financially if it does not achieve the target overall for a quarter. The penalty will therefore not apply for Quarter 2 as the Trust achieved the target for the Quarter.

#### 3.2. Early Warnings

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

a) Referral to Treatment Time – Admitted Patients – 90.2% in August against national target of 90%.

Performance against this indicator continues to be monitored closely and any potential underperformance will be addressed to ensure that the target continues to be achieved on an ongoing basis.

#### 4. Internal Performance Indicators

Local indicators continue to be monitored that reflect the Trust's priorities and contractual obligations. Of the 46 indicators currently included 26 are on target, 13 are slightly below target and 7 have remedial action plans in place.

#### 4.1 Stroke - Length of Stay & TIA

The Trust has a contractual target that greater than 80% of stroke patients discharged in a month should have spent more than 90% of their length of stay on the stroke unit (including the Moseley Hall Hospital rehabilitation phase of the pathway). In August 70.7% of patients spent greater than 90% of their length of stay (LoS) on the stroke unit including predicted Moseley Hall Hospital length of stay. Performance against the TIA target of high risk referrals being seen within 24 hours of referral was 45.0% in September against the 60% target.

The fifth stroke consultant began clinical duties on 23 September which will allow better prospective cover of TIA clinics. Work continues to establish a 7 day a week TIA clinic for high risk patients. Planning also continues on the wider reconfiguration of inpatient capacity in November that will see the Unit move to Ward 514 and expand from 18 to 26 beds. These changes will lead to an increase in performance against the two measures.

#### 4.2 Patient Observations

In September 95.4% of patients had a complete set of observations (sufficient to complete an Early Warning Score) taken every 12 hours against the target of 98%. Under the previous definition of 24 hours, performance for September would have been 98.8%. Automatic incident reporting where patient observations have not been completed within 24 hours will be introduced from 2nd week of November. This will be launched at Team Brief in October and is expected to improve performance. Individual wards continue to be invited for Executive RCA where exceptions are identified.

## 4.3 External Agency Spend

The Trust has a local target that external agency spend should be less than 3.1% of total pay spend. The percentage of total staff spend used for external agency staff continued to be above target in August but fell to 3.74% from 4.50% in July. The high levels of spend continue to predominantly be on nursing staff, linked to the additional capacity open in the Trust over the month. Spend should fall as agency staff are replaced by permanent staff following recent recruitment initiatives.

# 4.4 Delayed Transfers of Care

The percentage of beds occupied by NHS and joint delayed transfers of care increased to 2.97% in September.

There has been a reduction in the number of patients awaiting assessment from 9 at the end of August to 7 at the end of September. There have been increases in the number of patients waiting for residential or nursing homes and for continuing non-acute NHS care. These are thought to be due to case mix rather than any other reason. An additional member of staff joined the Community Care Team from 14 October which will provide additional capacity to carry out assessments. Prioritisation of the workload within the Team has also released additional staff time for assessing patients.

# 4.5 Pre-Assessment

As an efficiency measure the Trust has set an objective in the 2013/14 Annual Plan to increase the percentage of elective patients pre-assessed, if appropriate, before admission. In August 43.2% of elective patients were pre-assessed between 1 and 30 days prior to their "To Come In" date. Work continues to deliver the new configuration of the central Pre-Assessment Service by case-mix on 21 October which will ensure increased utilisation of the pre-assessment clinics.

## 4.6 Omitted Drugs - Antibiotics & Non-antibiotics

The Trust's performance remains better than any national comparator. In September performance was not in line with the challenging internal target for both omitted antibiotic and non-antibiotic doses. Specialties and wards with higher levels of omitted doses continue to attend the Executive RCA meetings to review their performance and identify actions for improvement. CDU has the largest number of occurrences where a drug being out of stock is given as the reason for not giving a dose. Work has been undertaken with the CDU matron to review the drugs held in stock and identify whether processes can be changed to improve performance. Further analysis is being undertaken of patient refusals of drugs on multiple occasions to identify the reasons and what action can be taken to reduce this.

#### 5. CQUINS

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

## 5.1 Friends and Family

The overall response rate for the Friends and Family (F&F) survey in the Emergency Department has remained low over September. The SMS text messaging pilot was introduced part-way through September and has delivered an increase in the response rate since its implementation although further improvement is required to hit the 20% target. The postcard system remains in place for patients who do not have mobile phone access, or who prefer to complete the card.

Additional CQUIN guidance for the F&F test has recently been published to clarify the requirements of the CQUIN. The guidance states that baseline performance over Quarter 1 needs to be at 15% or above for the wards and ED combined to avoid financial penalty. This was not made clear in the original guidance and the additional guidance was published after Quarter 1. This may result in a financial penalty. A meeting is being held with the CCG to explore options to minimise this financial impact and identify whether a local agreement can be included in the contract.

# 5.2 Falls

An improvement trajectory of 80% by year end for the completion of falls assessments in ED has been agreed with commissioners against a 71% baseline. Performance has improved from 60% in July to 75% in August. September cases are being audited at present and performance will continue to be tracked monthly. The Indicator relating to notification of repeat fallers is still outstanding as the commissioners are yet to confirm the process for notification to the GP practice.

### 5.3 Discharge Planning

With regard to the rate of discharges before 1 pm, a meeting was held with the CCG to share the findings of the ward discharge audit. The CCG praised the detailed work the Trust has undertaken to understand its discharge processes and the potential barriers to prompt discharge. The Trust will enhance its process of recording of discharge times on electronic systems as well as some other actions that came out of the initial baseline audit and re-establish the baseline performance. Once a revised baseline is confirmed, a target improvement will be discussed with the CCG. It is likely that this CQUIN is carried over into 2014/15.

In relation to the "To Take Out" drugs turnaround, performance has been at 88% or above in August and September against a year end target of 80%. Due to the improvement in performance, it has been agreed with the CCG that if performance falls below 80% in any month between October and March, that additional assurance around actions being taken will be provided to the CCG.

## 5.4 Haemophilia

Performance is slightly below trajectory for the percentage of patients signed up to the Haemtrack system due to a full in signing patients up over the summer holidays, but this is now expected to increase in the Autumn to bring the Trust back in line with trajectory.

# 6. 2013/14 Annual Plan Progress to Date

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

Progress	Qtr1	Qtr 2	Qtr3	Qtr 4
On plan	59 (92%)	59 (92%)		
Slightly below plan	5 (8%)	4 (6%)		
Remedial action required	D (0%)	0 (0%)		
Removed from plan	0 (0%)	1 (2%)		
Total	64 (100%)	64 (100%)		

Year to date, 92% of key tasks are on plan, 6% of key tasks are slightly below plan, and there are no key tasks where remedial action is required. One key task has been removed due to external factors outside the Trust's control. A high number of key tasks have been assessed as on plan at this stage in the year. This is due to the delivery of outcome measures being back-loaded towards the second half of the financial year. The majority of key tasks have an initial developmental/planning phase. As the Trust moves towards the outcome monitoring phase of the key tasks later in the year, it will become clearer whether they are on track.

The 4 key tasks that are slightly below plan are detailed in the following table with an explanation of the actions being taken to bring performance back in line. Of these key tasks, none have been identified as risking the delivery of the overall strategic aim or enabler.

Key Task	Outcome Measure	Actions
1.1: Further develop PICS functionality	e) Design and agree requirements to implement an ulternative coding system (ICD10 to SNOMED GT)  f) Design and develop modules to allow recording and review of electronically signed consent	The PICS Development Team continues to progress the work programme however progress against the specific outcome measures included has been constrained by the competing priorities for the Team
3.2: Ensure an effective and	a) Achieve 100%	As of September 2013 performance
robust pre-assessment service is in place.	target of patients who are admitted for elective procedures receiving an appropriate level of pre-assessment	continues to be under larget. Each specially has produced an action plan to improve utilisation. The central Pre-Assessment Service will be reconfigured from October which will increase clinic utilisation.
A.1: Work collaboratively with Clinical Commissioning Groups and the Academic Health Science Network to ensure the best drugs and technologies are adopted.	a. Compliance with clinically agreed standards including NICE Guidance and Technology.	Compliance is currently 57%. The percentage of compliance is highlighted in the compliance and assurance report to BoD. The Care Quality Commission are consulting on changes to the way NHS Trusts are regulated; compliance with NICE guidance will be used to inform an outstanding rating. The Risk and Compliance Unit have mapped the current CQC assurance to the new fundamental and expected standards and are mapping NICE guidance and quality standards to the new standards, this will be completed by the end of Q3.
14.1: Establish a programme of training to ensure that trust staff are aware of how to identify and progress opportunities for intellectual property and commercialisation.	Deliver a minimum     of one training     session per quarter.	Only one training session has been completed for the year to date. A new post has been appointed to from January 2014 which will oversee IP strategy development and implementation.

The key task that has been removed is 3.3: Participate in tendering for GP Pathology activity and secure this for the Trust. Although good progress was made against all outcome measures the tender for these services was being terminated in August 2013 before the Invitation to Tender was issued. The decision to end the tender was made by the CCGs at the project board meeting in August 2013. This key task will therefore be removed from the Annual Plan from Quarter 3 and replaced with a new objective.

## 7. Recommendations

The Board of Directors is requested to:

- 7.1 Accept the report on progress made towards achieving performance targets and associated actions and risks.
- 7.2 Accept the year to date 2013/14 performance update against the Trust Annual Plan.

# 2013/14 Commissioning for Quality and Innovation Indicators

# Total CQUIN Value

£12,230,000

COUN	Accountability	Ref	Indicator	Rof	Assessmen	Value	Baseline	Target	Timescale	Apr-11	May-17	Jun-11	Jul-12	Aug-13	Sep-13	Oct-11	Novi-13	Dep-13	Jány-14	Feb-14	Mar-14		
Friends and Foreign Test (Notional)	1000			10	humaned proposes the in the patient experience blocks and tently test (Emergency Department)		2.10%	TBC	Qt 4. 2013/14	1,895	2.79%	1,59%	1,55%	250%	2.76%								
	Exec - CN Group - CQG Division - AB	ì	Patient Priorits and Family	16	Increased response rate of the patient expendence historia and family lost (inpotient Wards)	E912,500	29,64%	TBC	Q9:4 2015/14	27.23%	29.53%	21.64%	28.02%	25.00%	24.42%								
	areane sa			†e	Independ response cate in the patient expendence friends and family sent (ED = (noalest Wards)		10.99%	THC	Qfr4 2013/14	10.27%	13,466	51,984	12,38%	11,52%	9.52%								
	Exec - DeO Group - SDG Division - A8	2	Staff Friends and Family	211	Improved performance on the Staff French and Flerilly Test (Key Factor 24 on survey)	oved performance on the State Frames and Flamily Text 2312.500 (2017/2 = 3.76 (approver 24 on curvey) (2017/2 = 3.57 (approver 24 on curvey) (2017/2 = 3.57 (appell) (2017/2 =									Tip be combrated which National Staff Survey resists are published.								
Safety Thermometer (National)	Ewec - CN	1	Duta Collection	ta	Submission of monthly data-sollection (principle uloins, falls, and unitary tout ministral in these with a califoliary)	£312,600	Full compliance	Monthly data submission	2013/14											Ī			
	Group - CQG Division - AB	2	Pressure Ulcer Prevalence	25	Maintain quarterly performance as 1.1% or lines over welch quarter for all new pressure ulcom	2312,500	3,10%	1,1% of less	Duestorty	0.37%	0.57%	0.47%	0.06%	0.5754	0.47%								
		П	Find, Assets,	53	Case froing an advision within 72 hours for entirigency advisation over 75 years.	£575,000	£7%	50%	Monthly	07%	0016	9994	nèni	9856	(00) (00)								
		1	investigate and	13	Risk assessment (AMT10)		95%	90%	Monthly	97%	1975	96%	300%	97%	(little)								
	Exec - MD &		Refer	10	Referral for openiest chargons for those where stagnosa is positive or incombusive.		100%	.00%	Morately	100%	100%	100%	100%	100%	100% (IBC)								
National)	Group - COG		Clinical	25	Named leas clinician for domintia	PRO 800	NA	Full pomphance	2013/14				_	_									
,,,,,,,,,,	& COMG Division - All	2	Leadership	25	Delivery of staff braining plan	E67,500	N/A	Pull companies	2015/14														
			Supporting	33	Monthly audit of corers for people with dementic to fest whether they feel supported.	W147,500	74/8	Put compliance	Monthly														
		*	Carries	àь	Report Carer Survey results to the Board twice a year		594	Pull compliance	parmuly														
VTE face Assumement (National)	200	+	Nisk Assessment Completion	ta	Agriculors resi assessed within 24 hours	E312,500	×99% monthly	95%	Monthly	99.3%	36.9%	DC 1%	39.2%	20.4%	29,416 (2001								
	Group - COMG		Root Coune	23	Establish process for root cause analysis and bisseline poncernance. Agree on indicative improvement trajectory with commissioners.	\$78,125	269	TSA	On:														
	División - All	2	Completion	26	Provide quarterly progress report and teview including tractions in light of any liquid that arise over the quarter and renegotiate with convincionness of requiries.	1204.375	40,0%	TEA	02-05	Books													

coun	Accountability	Ref	Indicator	Ref	Milestones	Value	Gaseline	Target	Timescale	Apr-53	litay-13	Jun-13	-66-12	Aug-13	Sep-13	Det-13	New-13	Dec-13	Jan-14	Feb-14	Mar-1A
	Exec - MD & CN Group - CQMG & CQG Division - All	,	Falls rink assessment populated on discharge letter for impatients	381	underskip RICS transcall work to pull in detail of the falls risk statestiment outcome onto the discharge letter.	1267-500	AVA	Full compliants	101												
	Exec - MD & CN Group - COMG & CDG	2	Completion of falls risk assessment for potionts	241	Undertake Scelline anapohot audit to establish fili of ES alternazione, who have a table liek associational completed within the audit sample. Agrice a trajectory for improvement with commissioner. Provide action plan for distincting improvement.	EB6,250	N/A	Full complication	01	71% baseline over quoter 5 improvement trajectory of 80% agreed											
	Division - C		attending ED	25	Provide quarterly progress update against implementation of the action plan and performance against Implicative.	\$291,250	77%	10%	02:04				100	75%							
Falls Vanagement and Presention	Exec - MD & CN Group - COMS & COG Division - C	2	Patient attending ED due to fall communicated on ED discharge letter to GP practice		implement apgrace in Cossino to refine the casegones for the mechanism of talls injury. Undertake technical development is extend this information into the ED doctoring letter. Undertake education and training programme with EO staff to ensure this information is captured accurately.	t287.50b	N/A	Full compliance	01												
	Exec - MD & CN Group -	4	patients who have faller 2 times or more over a 30 day	41	Exception process to aspectly the repeat failure and since the Falls Prevention Team. Agree with commissioner who the information on repeat failure needs to be communicated to six telephone at the relevant CP practice.	£115,000	NIA	Full compliance	01	denims to	In progress. Awaring contact desire for each OP practice from parametischers.										
	Division - C		period and communicati this to the Gi practice	40	Provide commissionars with a quarterly progress update report which includes the number of reposit fallows that haive been communicated to GP practices.	£177,500	NW	Full compainte	02-05				contr	g commis m the pro nethodic							
		T	Reduction in 5	18	Develop baseline of grade 2 hospital acquired avoidable ulcors, and improvement trajectory.	£575,000	0.42%	160.	2013/14	Baselre	rate is 0.43	tis (patients)	with a light frust) and	no 2 hondi a 10% ned	Eal acquire Supton tar	ed pyckto per truns	ione Goard	ter it prope	stion of	acressio	94.50 (29)
Pressure Ulcurs	Eyec - CN Group - CQG Division - All		Grade 2 Hospital Acquired	10	Deliver 10% reduction trajectory in the proportion of patients with grade 2 hospital accounted avoidable pressure utions (monthly).	(575,000	9.42W	0.29m	2013/14	0.27%	6,21%	0.27%	0.38%	THE							
	Daymon - As		Avoidable Pressure Ulcers	13	Deliver 10% reduction fragicities of the proportion of policinits with grade 2 hospital acquired avelocible pressure closes (cumulative).			Sate			0.		THO						_		
	Exec-MD	1	Prescriptions		Agree dušt sample size and methodology with commissioner, undertake baseline audit, and agree trajectory for improvement, with commissioner for reduction in type in closes.	£345,000	RM.	Put compliance	01	Maire aigrai	Maintenance target of 0.52% agreed with commissioners.										
Formularly adherence	COMG	. 1	in line with local formular	-	Second progress, recorded with inclamentation of improvement	E345,000	- NA	Pul compliano	02-04					-	Ten	-		_	-	-	T
200010000	Division - Al	١.	1	10	Deliver agreed trajectory for impotents.	£460,000	2.62%	0.62%	3,640	0.52%	0.50%	0.55%	0.43%	0.42%	0.27%						

coun	Accountability	Ref	Indicator	Ref	Missiones	Yes	Baseline	Target	Timescale	Apoli	May-13	Jun-13	Jul-13	Aup-13	Sep-13	Oct-12	Nov-13	Doc-12	Jan-14	Feb-14	Mar-M
	Exec-MO &	П	Reduction in	19	Submit baseline to correspondent and option plan for delivering the improvement.	£138,000	1404	Pull compliance	01		13 орнайли и од 10. солоти										
17.	Group -	1	TTO tumeround sinc	10	Quantity progress report against implementation of the oction	2138.000	N/A	Full compliance	02504								_				
	Division - All			10	Delivery of the 80% within 2 hours larger.	E184.000	55%	50% in 2 hours	Mar-14	149%	40%	47%	(0%)	875	19%						
Discharge Planning	Exec-MD &		bicrease in	20	Establish a basisine of performance, refine methodology, agree a trapiciony for improvement with continuationisms. and submit on action for delivering the improvement.	E207.000	NA.	Full compliance	121		13 pandino na sa comma										
	Comb v coc	2	discharges before tem	20	Quartery progress report against implementation of the acach-	1207,000	NA.	Full compliance	60/04												
	Division - All		-	26	Colvery of the anospument stojectory.	1276,000	27%	TRA	Mar-14	Tago indipensent too other word build nompoles.		26%	24%	24%							
Clinical Dashboards	Exec+MD Group- COMG Division- BAD	1	Dashboard Issage	15	To embed and demonstrate routine use of the use of specialises services of most deshboarts and submit data qualifierly.	1964,000	NEA	Full compliance	Quantity							(					
		Li		in	The percentage use of UK coners rather than European or US	£210,000	NA	Data provided	Quantity	20%	50%	5016	25W	50%						1	-
Bone Marrow	Exec - MD Group -	2	Donor ecquisition		The measur number of Confirmatory Typing (CT)/ Extended Typing (ET) Note per patient.	6216,000	MP.	Data provided	Diamery	0	2.	2	1.5							-	
Transplant	Division - B	4	data provision		The motion number of searches undertaken per transition. The average Tumoround Time (TAT) from the case of the search request to the delivery of the colors.	£216,000	1804 5004	Data provised	Quarterly	44 gtays			71 days								
	Base-CN	7	Patient	110	Uncertake patient experience survey for Santama.	,0208,000	128	Sovey	2013/14	Auror	no survivos lies	mptate publi	silion by I	Vistoria C	Srical.	Surveyo					
Specialised Career	Group - COS Division -	2	experience survey for 3	28	Undertake patient experience survey for Teslis list:	£285,000	1886	Survey	2015/14	Rafare	el and due	to be	pediate (local								
- Californ	BAD	2	rare earloses		Undertake potient experience survey for Brain	1255,000	NAM.	Survey	22/19/14			12.50				purvey)					
	Exce - NO Group -	1	Joint score	1.73	Proportion of regulared severa and moderate haemophilis A and til patients who have had their joint score assessed by a trained chysiotheraport within the pact 17 months.	£405,000	SEA	52%	2012/14	22,22%	26.67%	29.67%	30.77%	32.56%	25719						
Haimophilla	CQMG Division - D	2	Use of Hanntrack	20	Propertion of sewers and moderate hearingshills A and II. patents managing their own treatment, whose clinical data is recorded onto Haemirpox in the provider unit.	E405,000	1664	50%	2013/14	41.11%	41.11% 42.22% 43.90%			43.60%	ZAJON		,				
	Exec - MD	1	Disclosure to GPs	10	Progenier of secents diagnosed with HIV registered with and disclosed to their CP	\$402,000	8614	70%	2015/14	67%	65%	95%	65%	167%	M25%						
· ew	COMG Division - C	2	GP communicatio	26	Adminal (all limits) communication with Citis spous the carry of His colorial who are registered with and disclosed to a Citi	£432,000	100%	100%	2013/14	150%	100%	500%	30276	150%	100%						
Newsamper) Street Revision	Group - COMG Division - D	,	Shart re-lists	15	Proportion of new shurter requiring revisions within 50 days of execution que to infliction.	£964.000	NA	10% or lens.	04	2%	046	0%	TBC	TBC							

Key IN - Employ Deaf Name COO - Care Survey Group, COMO - Care County Montaining Group, Cert - Research County MO - Employed Dearway Street, SOC - Street or Colored County Montainer, Soc - Street or County Montainer, Soc - Street or County