# UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
# BOARD OF DIRECTORS
# THURSDAY 26 SEPTEMBER 2013

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| **Title:** | **PERFORMANCE INDICATORS REPORT** |
| **Responsible Director:** | Executive Director of Delivery |
| **Contact:** | Andy Walker, Strategy & Performance Manager, 13685<br>Daniel Ray, Director of Informatics |

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| **Purpose:** | To update the Board of Directors on the Trust's performance against the Monitor Compliance Framework targets and indicators, contractual targets, internal targets and CQUINs. | |
| **Confidentiality Level & Reason:** | None | |
| **Annual Plan Ref:** | Affects all strategic aims. | |
| **Key Issues Summary:** | Exception reports have been provided on the following indicators where there are current or future risks to performance:<br>• *Clostridium difficile* – UHB attributable – all cases<br>• Cancer – 62 days urgent GP referral to treatment<br>• Stroke – Length of Stay & TIA<br>• Patient Observations<br>• Slot Unavailability<br>• Mandatory Training<br>• External Agency Spend<br>• Delayed Transfers of Care<br>• Pre-assessment<br>• Omitted Drugs - Antibiotics & Non-antibiotics<br>Further details and action taken are included in the report.<br>An update is also included on the Trust's CQUINs. | |
| **Recommendations:** | The Board of Directors is requested to:<br>**Accept** the report on progress made towards achieving performance targets and associated actions and risks. | |
| **Approved by:** | Tim Jones | 17 September 2013 |

# UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

## BOARD OF DIRECTORS
## THURSDAY 26 SEPTEMBER 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.

### 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 the Compliance Framework and the recently published Risk Assessment Framework that replaces it from 1 October 2013 that the Trust must include all cases in its 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 for avoidable cases for the contract with the CCG.

There were 11 cases of *C. difficile* in total in August. The Trust has therefore had a total of 40 cases to the end of August against a Monitor trajectory of 23.3. Following review by the joint Trust/CCG panel of the August cases it has been agreed that 5 cases were avoidable and 6 were unavoidable. Of the 5 cases in July all were found to be unavoidable. The process of judging the avoidability of one case in June has not yet been completed as the joint Trust/CCG panel wished to see the outcome of the Executive Root Cause Analysis (RCA) – this is scheduled to take place at the end of September. The Trust's CCG trajectory therefore currently stands at either 10 or 11 cases.

The Trust declared a risk to achievement of this target in its Strategic Plan to Monitor. As the Trust has already exceeded its trajectory for Quarters 1 and 2 of 28 cases, its governance rating for Quarter 2 will be affected. Under the terms of the Monitor's new Risk Assessment Framework this is most likely to be a 'descriptive rating' explaining the issue and the action Monitor is taking. This type of rating replaces the 'Amber-Green' and 'Amber-Red' ratings that Monitor currently uses.

A large number of trusts are struggling to meet their trajectories – as of the end of July, 57% of foundation trusts are above trajectory for the year to date. The NHS in England as a whole is 15.7% above trajectory for the number of cases seen.

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 Cancer - 62 days urgent GP referral to treatment

In July the Trust treated 83.1% of cancer patients within 62 days of urgent referral from a GP against the national target of 85%. The Trust continues to receive a large number of referrals from other trusts late in the pathway (referred to the Trust 42 days or more after the initial referral from the GP). In July there were 20 patient breaches of the target. Of these 11 were late tertiary referrals from other trusts.

The Trust, in its contract negotiations for 2013/14 agreed with the CCG that the CCG would consider performance with late referrals reallocated to the referring trust when deciding whether or not a fine would be imposed if this target was not achieved. The target is also assessed quarterly for contractual purposes. The Trust's performance with late referrals reallocated was 90.4%. As performance including reallocations is above target it is unlikely that a fine would be applied. Monitor also state that breaches may be reallocated provided Monitor receives evidence of written agreement between the chief executives when the quarterly declaration is made to Monitor.

3.2. Early Warnings

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

a) A&E 4 hour waits – 95.2% in August against national target of 95%.

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 45 indicators currently included 24 are on target, 12 are slightly below target and 9 have remedial action plans in place. The Education & Training KPIs have been revised following discussion with the Head of Education and Executive Director of Delivery to ensure that only indicators with Trust-wide implications are reported. Progress has continued with the implementation of other new indicators.

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 July 75.7% of patients spent greater than 90% of their length of stay on the stroke unit including predicted Moseley Hall Hospital length of stay, an improvement from 63.2% in June. Lower levels of activity contributed to improved performance against the TIA target with 83.3% of patients seen and treated within 24 hours. Performance against the TIA target fell in August to 43.8% - four referrals were received over the Bank Holiday weekend all of which could not be seen in 24 hours under the current 5 day a week service. All patients were seen promptly over the next few days and treated appropriately with outcomes unaffected.

The fifth Stroke consultant begins clinical duties in September which will allow an expanded TIA service and better prospective cover of clinics. Work continues to expand the capacity of the stroke unit as part of the wider reconfiguration of inpatient capacity that is currently being planned; this will aid delivery of the length of stay target.

4.2 Patient Observations

In August 94.8% of patients had a complete set of observations (sufficient to complete an Early Warning Score) taken every 12 hours against the target of 98%. This was the second full month since the definition for this indicator was changed from every 24 hours to every 12 hours. There are now seven wards above target for this indicator under the new definition. Under the previous definition which required a complete set of observations every 24 hours, performance for August would have been 99.1%. Individual ward performance on patient observations is included as a topic for executive RCAs where exceptions are identified. These will now be selected using the revised 12 hour criteria.

4.3 Slot Unavailability

In August the Trust exceeded the target of 10.0 unavailable slots per 100 successful bookings using Choose and Book with performance of 20.0. All the specialties experiencing problems in August had short term reductions in capacity due to consultants being absent or leaving the Trust. Work has been undertaken to resolve these problems by temporarily increasing the length of the slot window or publishing additional slots to Choose and Book. The Slot Unavailability Group continues to meet fortnightly and any specialties with high numbers of slot issues are requested to attend to account for and identify actions to improve performance.

4.4 Mandatory Training

The Trust mandates that its staff should carry out a number of types of training dependent on their job role in order to meet the requirements of the NHS Litigation Authority Risk Management Standards. The target for each is set at 90% of staff being up to date apart from Information Governance which is mandated at 95% by NHS

Connecting for Health. Significant progress has been made with ten indicators now above target, two indicators remaining slightly below and three requiring remedial action to hit the Trust target.

4.5 External Agency Spend

The Trust has a local target that external agency spend should be less than 3.1% of total pay spend. External agency spend in July was above target at 4.50%. The high levels of spend continue to predominantly be on nursing staff, linked to the additional capacity open in the Trust over the month.

4.6 Delayed Transfers of Care

The percentage of beds occupied by NHS and joint NHS/Social Services delayed transfers of care increased to 2.85% in August – this equates to 28 beds against the contractual target of 2.0%.

There are two categories of delayed transfers where the Trust has seen increased number of patients – patients awaiting assessment and patients exercising choice. Two additional temporary members of staff have been recruited to the UHB Community Care Team to allow prompt assessment. Patients exercising choice are discussed weekly to identify what care they feel they need to allow them to be discharged and these are escalated, as required including to the Director of Partnerships.

4.7 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 with a trajectory towards 70% being pre-assessed by year end. In July 44.2% of elective patients were pre-assessed between 1 and 30 days prior to their TCI date. The Trust's central Pre-Assessment Service is being reconfigured by case-mix from mid-October which will increase utilisation of pre-assessment clinics. Each specialty across the Trust has also developed an action plan to increase their pre-assessment rate. These include ensuring that all patients who are pre-assessed are recorded as having attended clinic, carrying out regular forward looks of patients due to be admitted to ensure they have been pre-assessed, reviewing processes to ensure there is consistency in booking pre-assessment between consultants and secretaries and regularly reviewing performance at specialty meetings.

4.8 Omitted Drugs

The Trust's performance remains better than any national comparator. In August 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.

## 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

Response rates for the Friends and Family survey in the Emergency Department have remained low. Plans to pilot an SMS text messaging system, which has proved successful at other Trusts, are underway. A three month pilot of the system will commence in September. The postcard system will remain in place for patients who do not have mobile phone access, or who prefer to complete the card.

### 5.2 Falls

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

### 5.3 Discharge Planning

A baseline of 20% has now been set and shared with the commissioners for the proportion of patients who are discharged before 1 pm. A detailed ward audit was undertaken in August of CDU and a ward on each floor for a week each. The audit involved tracking each patient discharge and observational analysis around discharge planning processes. A further meeting will be held with commissioners in October once the results of the audit are available in order to agree an improvement target. The action plan for improving TTO turnaround performance continues to be implemented and performance has increased from 47% in June to 88% in August.

### 5.4 Specialised Cancer Patient Survey

Work has been ongoing to implement the survey in September. The results will be reported to the Care Quality Group via the Division D Associate Director of Nursing.

## 6. Recommendations

The Board of Directors is requested to:

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

**Tim Jones**
**Executive Director of Delivery**

**Appendix A**

# 2013/14 Commissioning for Quality and Innovation Indicators

## Total CQUIN Value £12,230,000

| CQUIN | Accountability | Ref | Indicator | Ref | Milestones | Value | Baseline | Target | Timescale | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Friends and Family Test (National) | Exec - CN Group - CQG Division - All | 1 | Patient Friends and Family | 1a | Increased response rate in the patient experience friends and family test (Emergency Department) | £312,500 | 2.19% | TBC | Qtr 4 2013/14 | 1.86% | 2.78% | 1.88% | 1.66% | | | | | | | | |
| | | | | 1b | Increased response rate in the patient experience friends and family test (Inpatient Wards) | | 29.64% | TBC | Qtr 4 2013/14 | 27.33% | 29.93% | 31.64% | 35.32% | | | | | | | | |
| | | | | 1c | Increased response rate in the patient experience friends and family test (ED + Inpatient Wards) | | 10.98% | TBC | Qtr 4 2013/14 | 10.27% | 11.44% | 11.16% | 12.36% | | | | | | | | |
| | Exec - DoD Group - SDG Division - All | 2 | Staff Friends and Family | 2a | Improved performance on the Staff Friends and Family Test (Key Factor 24 on survey) | £312,500 | 2010/11 = 3.81<br>2011/12 = 3.78<br>2012/13 = 3.93<br>Nat Avg = 3.57 | Improvement from 2012/13 or remain in top quartile | 2013/14 | To be confirmed when National Staff Survey results are published. | | | | | | | | | | | |
| Safety Thermometer (National) | Exec - CN Group - CQG Division - All | 1 | Data Collection | 1a | Submission of monthly data collection (pressure ulcers, falls, and urinary tract infection in those with a catheter) | £312,500 | Full compliance | Monthly data submission | 2013/14 | | | | | | | | | | | | |
| | | 2 | Pressure Ulcer Prevalence | 2a | Maintain quarterly performance at 1.1% or less over each quarter for all new pressure ulcers | £312,500 | 1.1 | 1.1 or less | Quarterly | 0.37% | 0.57% | 0.47% | 0.86% | 0.57% | | | | | | | |
| Dementia (National) | Exec - MD & CN Group - CQG & CQMG Division - All | 1 | Find, Assess, Investigate and Refer | 1a | Case finding on admission within 72 hours for emergency admission over 75 years | £375,000 | 97% | 90% | Monthly | 97% | 99% | 99% | 98% | 96% (tbc) | | | | | | | |
| | | | | 1b | Risk assessment (AMT10) | | 96% | 90% | Monthly | 97% | 98% | 96% | 100% | 97% (tbc) | | | | | | | |
| | | | | 1c | Referral for specialist diagnosis for those where diagnosis is positive or inconclusive | | 100% | 90% | Monthly | 100% | 100% | 100% | 100% | 100% (tbc) | | | | | | | |
| | | 2 | Clinical Leadership | 2a | Named lead clinician for dementia | £62,500 | N/A | Full compliance | 2013/14 | | | | | | | | | | | | |
| | | | | 2b | Delivery of staff training plan | | N/A | Full compliance | 2013/14 | | | | | | | | | | | | |
| | | 3 | Supporting Carers | 3a | Monthly audit of carers for people with dementia to test whether they feel supported | £187,500 | N/A | Full compliance | Monthly | | | | | | | | | | | | |
| | | | | 3b | Report Carer Survey results to the Board twice a year | | N/A | Full compliance | Biannually | | | | | | | | | | | | |
| VTE Risk Assessment (National) | Exec - MD Group - CQMG Division - All | 1 | Risk Assessment Completion | 1a | Admissions risk assessed within 24 hours | £312,500 | >99% monthly | 95% | Monthly | 99.3% | 98.9% | 99.1% | 99.2% | | | | | | | | |
| | | 2 | Root Cause Analysis Completion | 2a | Establish process for root cause analysis and baseline performance. Agree an indicative improvement trajectory with commissioners. | £78,125 | N/A | TBA | Q1 | | | | | | | | | | | | |
| | | | | 2b | Provide quarterly progress report and review indicative trajectory in light of any issues that arise over the quarter and renegotiate with commissioners if required. | £234,375 | 40.0% | TBA | Q2-Q3 | Baseline of 40% submitted to commissioners. | | | | | | | | | | | |

**Appendix A**

| CQUIN | Accountability | Ref | Indicator | Ref | Milestones | Value | Baseline | Target | Timescale | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Falls Management and Prevention | Exec - MD & CN Group - CQMG & CQG Division - All | 1 | Falls risk assessment populated on discharge letter for inpatients | 1a | Undertake PICS technical work to pull in detail of the falls risk assessment outcome onto the discharge letter. | £287,500 | N/A | Full compliance | Q1 | | | | | | | | | | | | |
| | Exec - MD & CN Group - CQMG & CQG Division - C | 2 | Completion of falls risk assessment for patients attending ED | 2a | Undertake baseline snapshot audit to establish % of ED attendances who have a falls risk assessment completed within the audit sample. Agree a trajectory for improvement with commissioner. Provide action plan for delivering improvement. | £86,250 | N/A | Full compliance | Q1 | 71% baseline over quarter 1. Improvement trajectory of 80% agreed | | | | | | | | | | | |
| | | | | 2b | Provide quarterly progress update against implementation of the action plan and performance against trajectory. | £201,250 | 71% | 80% | Q2-Q4 | | | | 60% | 77% (14 further cases to be audited) | | | | | | | |
| | Exec - MD & CN Group - CQMG & CQG Division - C | 3 | Patient attending ED due to fall communicated on ED discharge letter to GP practice | 3a | Implement upgrade in Oceano to refine the categories for the mechanism of falls injury.<br>Undertake technical development to extract this information into the ED discharge letter.<br>Undertake education and training programme with ED staff to ensure this information is captured accurately. | £287,500 | N/A | Full compliance | Q1 | | | | | | | | | | | | |
| | Exec - MD & CN Group - CQMG & CQG Division - C | 4 | Identify patients who have fallen 2 times or more over a 30 day period and communicate this to the GP practice | 4a | Establish process to identify the repeat fallers and alert the Falls Prevention Team.<br>Agree with commissioner who the information on repeat fallers needs to be communicated to via telephone at the relevant GP practice. | £115,000 | N/A | Full compliance | Q1 | In progress. Awaiting contact details for each GP practice from commissioners. | | | | | | | | | | | |
| | | | | 4b | Provide commissioners with a quarterly progress update report which includes the number of repeat fallers that have been communicated to GP practices. | £172,500 | N/A | Full compliance | Q2-Q3 | | | | Work underway to clarify process to alert practices. | | | | | | | | |
| Pressure Ulcers | Exec - CN Group - CQG Division - All | 1 | Reduction in % Patients with Grade 2 Hospital Acquired Avoidable Pressure Ulcers | 1a | Develop baseline of grade 2 hospital acquired avoidable ulcers and improvement trajectory. | £575,000 | 0.43% | N/A | 2013/14 | Baseline rate is 0.43% (patients with a grade 2 hospital acquired avoidable ulcer as a proportion of admissions to the Trust) and a 10% reduction target translates to 0.39% | | | | | | | | | | | |
| | | | | 1b | Deliver 10% reduction trajectory in the proportion of patients with grade 2 hospital acquired avoidable pressure ulcers (monthly). | | | | | 0.27% | 0.21% | 0.27% | 0.38% | | | | | | | | |
| | | | | 1b | Deliver 10% reduction trajectory in the proportion of patients with grade 2 hospital acquired avoidable pressure ulcers (cumulative). | | | | | 0.28% | | | | | | | | | | | |
| Formulary adherence | Exec - MD Group - CQMG Division - All | 1 | Prescriptions in line with local formulary | 1a | Agree audit sample size and methodology with commissioner, undertake baseline audit, and agree trajectory for improvement with commissioner for reduction in type in doses. | £345,000 | N/A | Full compliance | Q1 | In progress. Baseline submitted to commissioners. Target to be agreed. | | | | | | | | | | | |
| | | | | 1b | Report progress quarterly with implementation of improvement plan. | £345,000 | N/A | Full compliance | Q2-Q4 | | | | | | | | | | | | |
| | | | | 1c | Deliver agreed trajectory for inpatients. | £460,000 | 0.52% | TBA | Mar-14 | 0.40% | 0.40% | 0.46% | 0.33% | 0.35% | | | | | | | |
| | | | | 1d | Deliver agreed trajectory for outpatients. | | | | | 2.05% | 1.59% | 1.44% | 1.49% | 1.19% | | | | | | | |

**Appendix A**

| CQUIN | Accountability | Ref | Indicator | Ref | Milestones | Value | Baseline | Target | Timescale | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Discharge Planning | Exec - MD & CN Group - CQMG & CQG Division - All | 1 | Reduction in TTO turnaround time | 1a | Submit baseline to commissioners and action plan for delivering the improvement. | £138,000 | N/A | Full compliance | Q1 | 2012/13 baseline of 55% submitted to commissioners. | | | | | | | | | | | |
| | | | | 1b | Quarterly progress report against implementation of the action plan. | £138,000 | N/A | Full compliance | Q2-Q4 | | | | | | | | | | | | |
| | | | | 1d | Delivery of the 80% within 2 hours target. | £184,000 | 55% | 80% in 2 hours | Mar-14 | 49% | 46% | 47% | 69% | 88% | | | | | | | |
| | Exec - MD & CN Group - CQMG & CQG Division - All | 2 | Increase in discharges before 1pm | 2a | Establish a baseline of performance, refine methodology, agree a trajectory for improvement with commissioners, and submit an action for delivering the improvement. | £207,000 | N/A | Full compliance | Q1 | 2012/13 baseline of 20% submitted to commissioners. | | | | | | | | | | | |
| | | | | 2b | Quarterly progress report against implementation of the action plan. | £207,000 | N/A | Full compliance | Q2-Q4 | | | | | | | | | | | | |
| | | | | 2c | Delivery of the improvement trajectory. | £276,000 | 20% | TBA | Mar-14 | Target improvement tbc after ward audit completed. | | | 24% | 24% | | | | | | | |
| Clinical Dashboards | Exec - MD Group - CQMG Division - B&D | 1 | Dashboard usage | 1a | To embed and demonstrate routine use of the use of specialised services clinical dashboards and submit data quarterly | £864,000 | N/A | Full compliance | Quarterly | | | | | | | | | | | | |
| Bone Marrow Transplant | Exec - MD Group - CQMG Division - D | 1 | Donor acquisition measures - data provision | 1a | The percentage use of UK donors rather than European or US | £216,000 | N/A | Data provided | Quarterly | 20% | 50% | 50% | 25% | 50% | | | | | | | |
| | | 2 | | 2a | The median number of Confirmatory Typing (CT)/ Extended Typing (ET) tests per patient | £216,000 | N/A | Data provided | Quarterly | 3 | 3 | 3 | 3.5 | | | | | | | | |
| | | 3 | | 3a | The median number of searches undertaken per transplant | £216,000 | N/A | Data provided | Quarterly | 1 | 1 | 1 | 1 | | | | | | | | |
| | | 4 | | 4a | The average Turnaround Time (TAT) from the date of the search request to the delivery of the donor report | £216,000 | N/A | Data provided | Quarterly | 44 days | | | 71 days | | | | | | | | |
| Specialised Cancer | Exec - CN Group - CQG Division - B&D | 1 | Patient experience survey for 3 rare cancers | 1a | Undertake patient experience survey for Sarcoma | £288,000 | N/A | Survey undertaken | 2013/14 | Awaiting survey template publication by National Clinical Reference Group. Local survey developed and due to be implemented. | | | | | | | | | | | |
| | | 2 | | 2a | Undertake patient experience survey for Testicular | £288,000 | N/A | Survey undertaken | 2013/14 | | | | | | | | | | | | |
| | | 3 | | 3a | Undertake patient experience survey for Brain | £288,000 | N/A | Survey undertaken | 2013/14 | | | | | | | | | | | | |
| Haemophilia | Exec - MD Group - CQMG Division - D | 1 | Joint score assessment | 1a | Proportion of registered severe and moderate haemophilia A and B patients who have had their joint score assessed by a trained physiotherapist within the past 12 months | £405,000 | N/A | 50% | 2013/14 | 22.22% | 26.67% | 29.67% | 30.77% | 32.98% | | | | | | | |
| | | 2 | Use of Haemtrack | 2a | Proportion of severe and moderate haemophilia A and B patients managing their own treatment, whose clinical data is recorded onto Haemtrack in the provider unit | £405,000 | N/A | 50% | 2013/14 | 41.11% | 42.22% | 43.96% | 43.96% | 43.62% | | | | | | | |
| HIV | Exec - MD Group - CQMG Division - C | 1 | Disclosure to GPs | 1a | Proportion of patients diagnosed with HIV registered with and disclosed to their GP | £432,000 | 86% | 70% | 2013/14 | 85% | 84% | 85% | 87% | | | | | | | | |
| | | 2 | GP communication | 2a | Annual (at least) communication with GPs about the care of HIV patients who are registered with and disclosed to a GP | £432,000 | 100% | 100% | 2013/14 | 100% | 100% | 100% | 100% | | | | | | | | |
| Neurosurgery Shunt Revision | Exec - MD Group - CQMG Division - D | 1 | Shunt revision | 1a | Proportion of new shunts requiring revisions within 30 days of insertion due to infection. | £864,000 | N/A | 10% or less | Q4 | 0% | 0% | | | | | | | | | | |

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