

**AGENDA ITEM NO:****UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST  
BOARD OF GOVERNORS  
TUESDAY 15 MARCH 2011**

<b>Title:</b>	<b>Quality Account Update Report April-December 2010</b>
<b>Responsible Director:</b>	David Rosser, Executive Medical Director
<b>Contact:</b>	Imogen Gray, Head of Quality Development, 13687

<b>Purpose:</b>	To provide the Board of Governors with the Quality Account update report for April-December 2010 scheduled for publication at the end of March 2011.
<b>Confidentiality Level &amp; Reason:</b>	N/A
<b>Medium Term Plan Ref:</b>	Strategic Aim 1: To deliver the highest levels of quality evidenced by technology, information and benchmarking
<b>Key Issues Summary:</b>	<ul style="list-style-type: none"><li>• The Quality Account update report for April-December 2010 is enclosed in Appendix A.</li><li>• The next of specialty quality indicator pages will go live on the Trust's website during March 2011.</li><li>• Trust-level patient experience data will be published externally during March 2011 as shown in Appendix B.</li></ul>
<b>Recommendations:</b>	The Board of Governors is requested to:  <b>Note</b> the content of the Quality Account Update for April-December 2010. <b>Note</b> the Trust-level patient feedback for external publication.

<b>Signed:</b>	<b>Date:</b> 4 March 2011
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# UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

## BOARD OF GOVERNORS TUESDAY 15 MARCH 2011

### QUALITY ACCOUNT UPDATE REPORT APRIL-DECEMBER 2010

#### PRESENTED BY THE EXECUTIVE MEDICAL DIRECTOR

#### 1. Introduction

- 1.1. The aim of this paper is to provide the Board of Governors with the Quality Account update report for April-December 2010 which will be published on the external website at the end of March 2011. The report contains the latest data available for the quality improvement priorities, metrics and specialty indicators.

#### 2. Quality Account Update for April-December 2010

- 2.1 The Quality Account update report for April-December 2010 was discussed by the Clinical Quality Monitoring Group in February 2011 and is shown in Appendix A. The report will be formatted by the Communications Team before publication at the end of March 2011.
- 2.2 The Trust is making progress towards the quality improvement priorities and there are no significant changes in performance to report for the selected metrics. Performance for the specialty quality indicators continues to be monitored via the Clinical Quality Monitoring Group with improvement actions identified as necessary.
- 2.3 Changes to Specialty Indicators

The data source used for the two Heart Failure specialty indicators has been refined since the last update report to ensure more activity is captured. The Liver transplant mortality indicator data is not yet available and will be updated as soon as possible, with sign off by the Executive Medical Director before publication.

#### 3. Specialty Metrics for External Publication

The next set of specialty quality indicator pages are due to go live on the external website by the end of March 2011 with explanatory commentary and graphs. All indicator data will be published around two months behind real time to allow any performance or reputation issues to be reported to the Board of Directors before publication. The layout of the specialty indicator pages is

being revised and improved in liaison with the Communications Team and data will continue to be updated monthly.

#### 4. **Patient Experience Data for External Publication**

- 4.1 The Trust will start publishing regular, Trust-level inpatient experience data on the Quality web pages alongside some brief explanatory text. An initial set of nine questions has been selected and is likely to be expanded in time. Example graphs showing response performance for April-December 2009 and 2010 are shown in Appendix B. This data comes from the electronic bedside survey data collated by the Informatics Team and reported through the Care Quality Group.
- 4.2 All data will be reported at Trust level and be published at least 2 months behind real time to enable the Board of Directors to be made aware of any issues before publication.
- 4.3 The final format of the graphs and accompanying text will be agreed with the Associate Director of Patient Affairs, Executive Chief Nurse and the Director of Communications prior to external publication.

#### 5. **Recommendations**

The Board of Governors is requested to:

**Note** the content of the Quality Account Update for April-December 2010.

**Note** the Trust-level patient feedback for external publication.

## **Appendix A: Quality Account Update for April-December 2010**

### **Quality Account Update for April-December 2010**

#### **Contents**

Introduction

Mortality

Quality Improvement Priorities

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

Selected Metrics

Specialty Quality Indicators

- Acute Medicine
- Anaesthetics, ITU and Ambulatory Care
- Clinical Support Services
- Other Medicine
- Outpatients
- Surgery

## Quality Account Update for April-December 2010

### 1. Introduction

The Trust published its second Quality Account Report in June 2010 as part of the Annual Report and Accounts. The report contained an overview of the quality initiatives undertaken in 2009-10, performance data for selected metrics and set out five key priorities for improvement during 2010-11:

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

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

**Priority 3:** Venous thromboembolism (VTE) risk assessment on admission

**Priority 4:** Improve patient experience and satisfaction

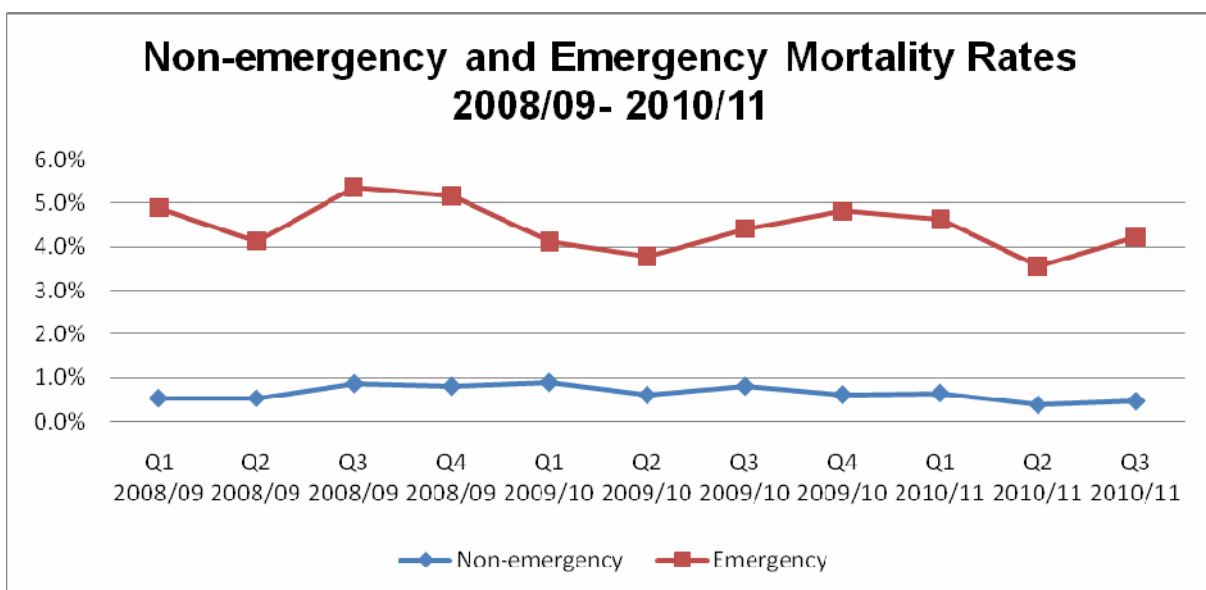
**Priority 5:** Infection prevention and control

This report provides an update on the progress made for the period April-December 2010 towards meeting these priorities and updated performance data for the selected metrics. This update report should be read alongside the Trust's Quality Account Report for 2009-10.

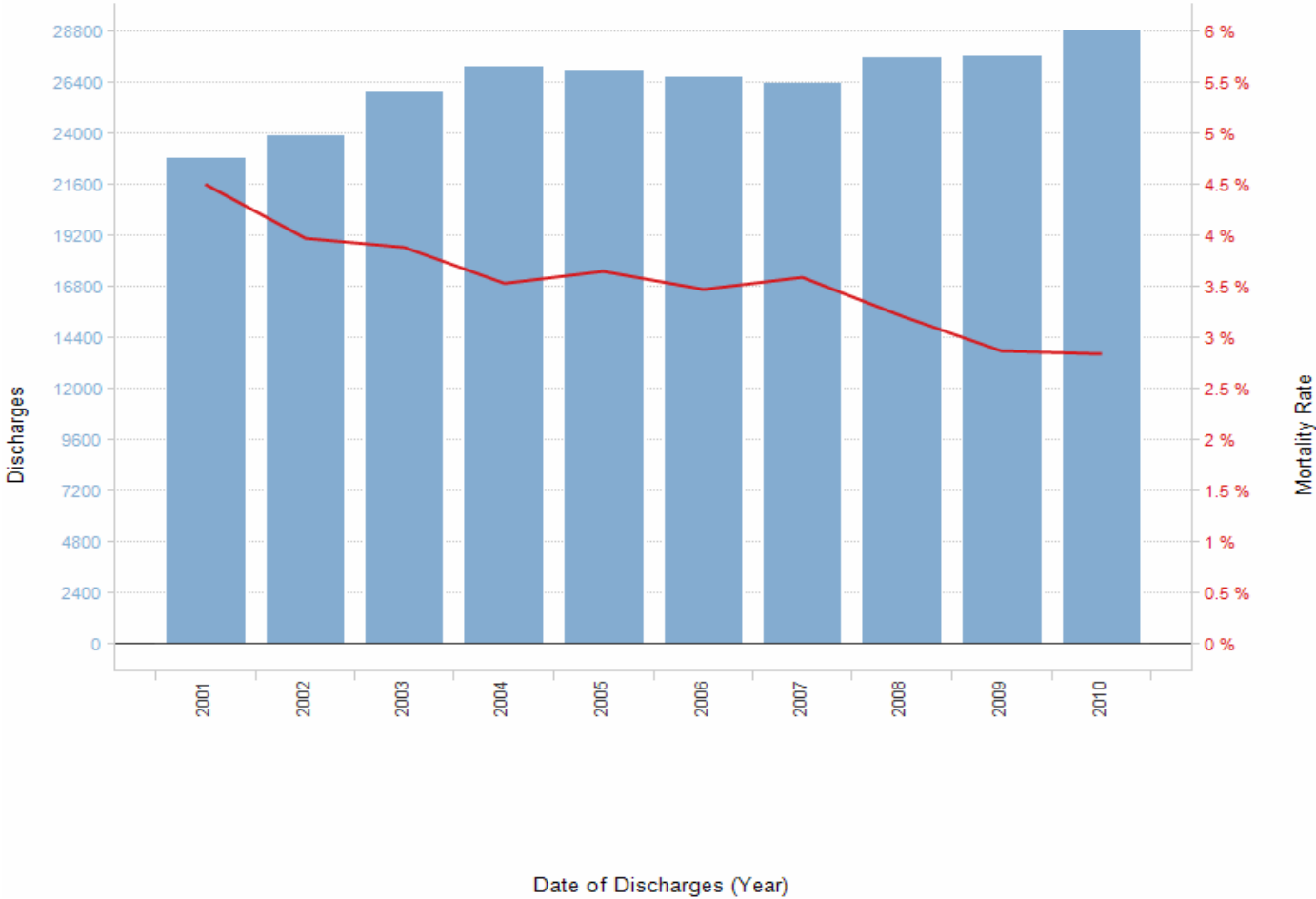
### 2. Mortality

The Trust continues to monitor mortality as close to real-time as possible with senior managers receiving daily emails detailing mortality information and on a longer term comparative basis via the Trust's Clinical Quality Monitoring Group. Any anomalies or unexpected deaths are promptly investigated.

The graph below shows the non-emergency and emergency mortality rates by quarter for the last three financial years. Although the Trust is generally treating more elderly patients and patients with complex conditions, mortality continues to remain stable.



Non-emergency and emergency mortality has slightly decreased despite an increase in the complexity of patients and increased activity during 2010-11 as shown in the graph below. The graph shows the Trust’s crude mortality rate against activity (patient discharges) for April-September for each of the past 10 years.



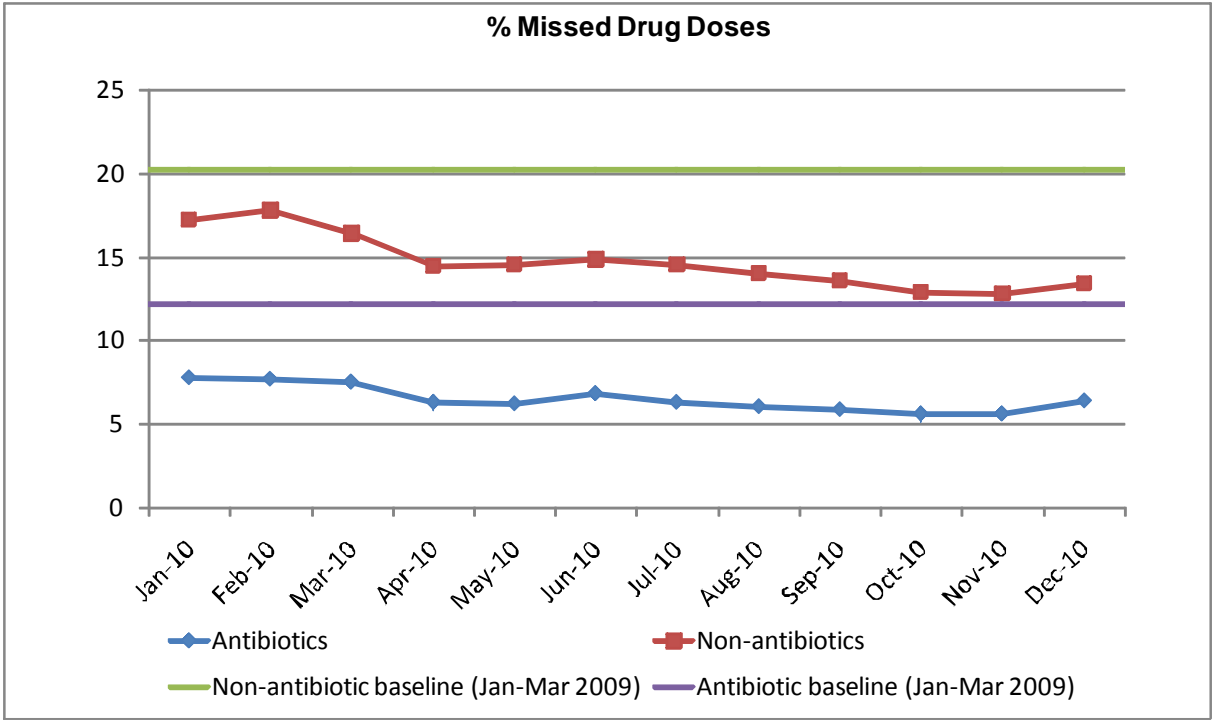
**3. Quality Improvement Priorities**

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

Since April 2009, the Trust has focused on reducing the percentage of drug doses prescribed but not recorded as administered (omitted) to patients on the Prescribing Information and Communication System. Omitted drug doses are monitored at divisional, specialty and ward levels and communicated daily to clinical staff via the Clinical Dashboard (which displays real-time quality information at ward-level). Performance is also reported to the Chief Executive’s Advisory Group, the Chief Operating Officer’s Group and the Board of Directors each month to ensure appropriate actions are taken.

The percentage of omitted antibiotic and non-antibiotic drug doses for the last 12 months is shown in the graph below. The Trust has managed to maintain performance during the first two phases of the move into the New Hospital which took place in June and November 2010. Further improvements are however still

required, particularly around omitted non-antibiotic doses. Improvement actions are identified following monthly root cause analyses of selected missed dose cases by the Trust’s Executive, divisional management and clinical teams.

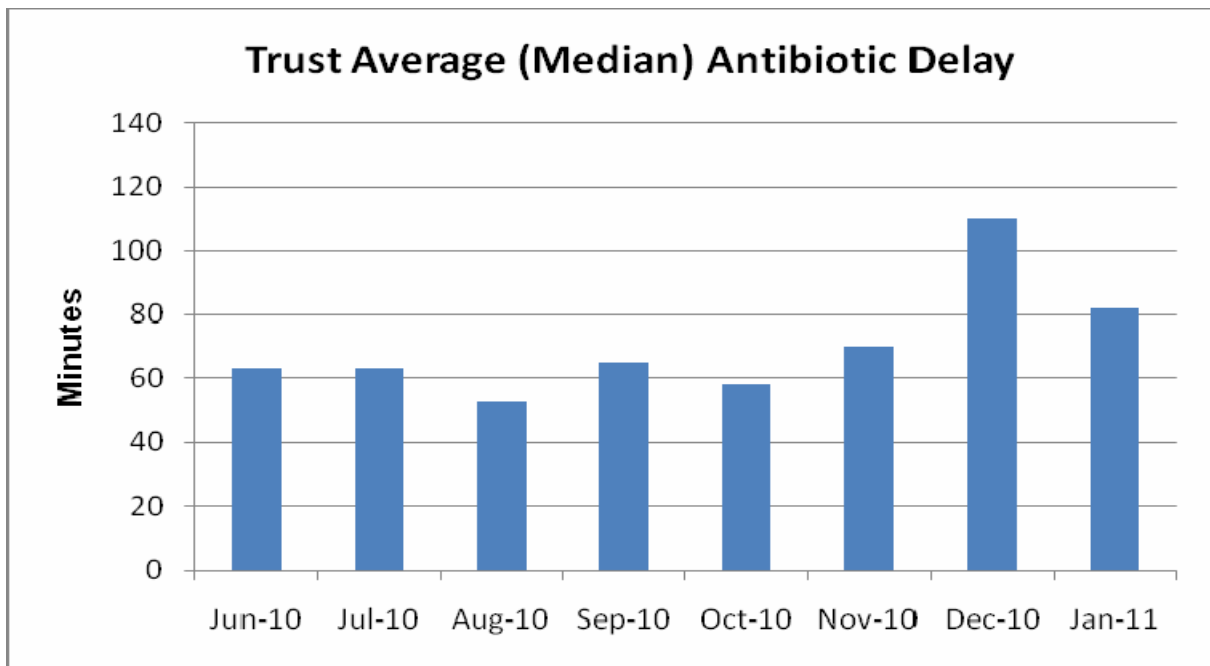


**Priority 2: Time from prescription to administration of first antibiotic dose**

There is evidence within the clinical literature that rapid antibiotic delivery can reduce patient harm and improve outcomes, and that the time from prescription to administration of first antibiotic dose for certain conditions should ideally be 60 minutes or less.

The Trust has now identified clinical exception rules with clinicians and refined the methodology for measuring performance against this indicator. Data has been collected from the Trust’s electronic Prescribing Information and Communication System (PICS) for patients admitted with acute illnesses. This does not however include Emergency Department referrals where prescribing data is not yet captured electronically.

This indicator focuses on the first prescription of antibiotics for patients identified as having likely infections (based on white blood cell counts) and measures the time delay between the antibiotic prescription being made and the first dose of this drug being given. All courses of antibiotics lasting for three days are included even where they include a discharge prescription. Performance data is shown in the graph below for June 2010 to January 2011. The Trust is focusing on reducing the time between prescription and administration of first doses of antibiotic for this group of patients. Delayed antibiotics are now being included in the monthly root cause analyses of selected missed dose cases by the Trust’s Executive, divisional management and clinical teams to drive improvements in practice.



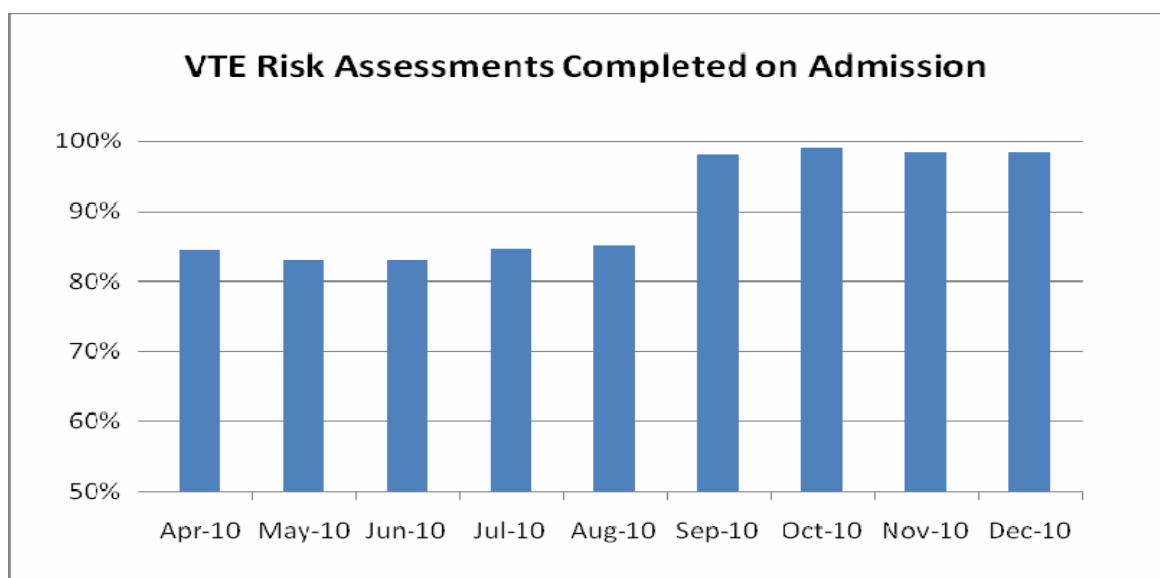
### Priority 3: Venous thromboembolism (VTE) risk assessment on admission

Whilst most other trusts have to rely on a paper-based assessment of the risk of VTE for individual patients, the Trust has been using an electronic risk assessment tool within the Prescribing Information and Communication System since June 2008 for all inpatient admissions. The tool provides tailored advice regarding preventative treatment based on the assessed risk.

The Trust's electronic VTE risk assessment tool has been revised to reflect the latest guidance from the National Institute for Health and Clinical Excellence (NICE). In order to comply with this guidance, new mandatory questions for all inpatients admitted acutely or electively have been included as part of the risk assessment tool. In addition, ambulatory care (day case) admissions have been examined to determine which patients also require a full risk assessment within our systems. Both of these changes have produced a big improvement in VTE risk assessment completion on admission.

The Trust is continuing to monitor the completion of venous thromboembolism risk assessments to ensure that by the end of 2010-11, at least 90% of all our patients have a VTE risk assessment completed on admission.





#### Priority 4: Improve patient experience and satisfaction

During quarter 1 2010-11, the Trust started monitoring the feedback received from patients via the electronic bedside and telephone surveys for the questions set out in the Trust's 2009-10 Quality Account Report. The last two questions relate to discharge and were added into the telephone survey in August 2010.

Time Period	Survey Questions	Answers	Performance
<b>April-December 2010</b>	Have you been involved as much as you want to be in decisions about your care and treatment?	Yes	<b>73%</b>
		Yes, to some extent	<b>21%</b>
		No	<b>6%</b>
<b>June-December 2010</b>	Did you find someone on the hospital staff to talk about your worries and fears?	Yes, definitely	<b>62%</b>
		Yes, to some extent	<b>26%</b>
		No	<b>12%</b>
<b>June-December 2010</b>	Were you given enough privacy when discussing your care and treatment?	Yes, always	<b>87%</b>
		Yes, sometimes	<b>11%</b>
		No	<b>2%</b>
<b>June-December 2010</b>	Do you think that hospital staff do all they can to help control your pain?	Yes, definitely	<b>81%</b>
		Yes, to some extent	<b>16%</b>
		No	<b>3%</b>
<b>August-December 2010</b>	Did a member of staff tell you about medication side effects to watch for when you went home?*	Yes, completely	<b>59%</b>
		Yes, to some extent	<b>13%</b>
		No	<b>28%</b>
<b>August-September 2010</b>	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?*	Yes	<b>86%</b>
		No	<b>14%</b>

\* Responses from Outpatient Survey which started in August 2010.

## Complaints

The Trust has seen a higher number of complaints in Quarter 2 2010-11 and Quarter 3 2010-11 due to the first two phases of the move into the New Hospital which took place in June and November 2010. Actions have been taken to address the concerns raised and will continue to be monitored at ward and specialty levels.

### Ratio of complaints to activity at University Hospital Birmingham NHS Foundation Trust Q3 10/11 & Q2 10/11

	Q3 2010-11	Q2 2010-11
Total number of complaints	213	205
Referrals for independent review by referral date	3	5

Top 3 Complaint categories	Q3 2010-11	Q2 2010-11
<b>Main category</b>		
1. Clinical treatment	109	87
2. Attitude of staff	26	18
3. OPA (delay/cancellation)	25	31
<b>All issues</b>		
1. Clinical treatment	244	181
2. Communication/information	99	83
3. Attitude of Staff	66	50

		Q3 2010-11	Q2 2010-11
Inpatients	FCEs*	30 821	31 670
	Complaints	119	115
	<b>Rate per 1000 FCEs</b>	<b>3.86</b>	<b>3.63</b>
Outpatients	Attendances**	125 136	131 577
	Complaints	72	76
	<b>Rate per 1000 attendances</b>	<b>0.57</b>	<b>0.57</b>
A&E	Attendances	20 434	20 794
	Complaints	22	14
	<b>Rate per 1000 attendances</b>	<b>1.07</b>	<b>0.67</b>

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

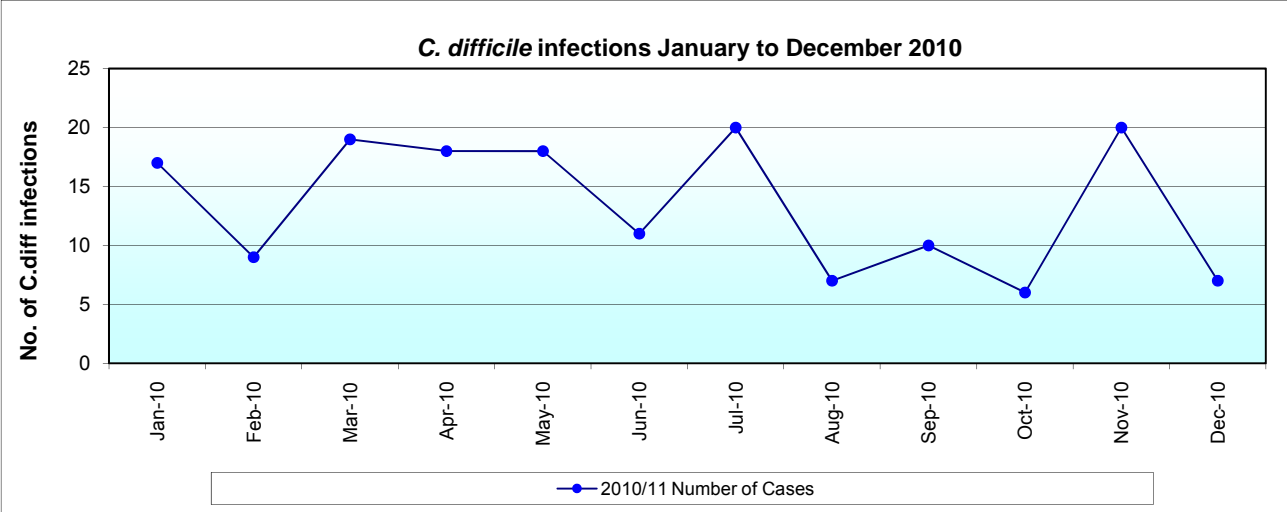
\*\* The Outpatients activity data relates to attendances only and also includes Therapy Outpatients data (physiotherapy, podiatry, dietetics, speech and language therapy and occupational therapy).

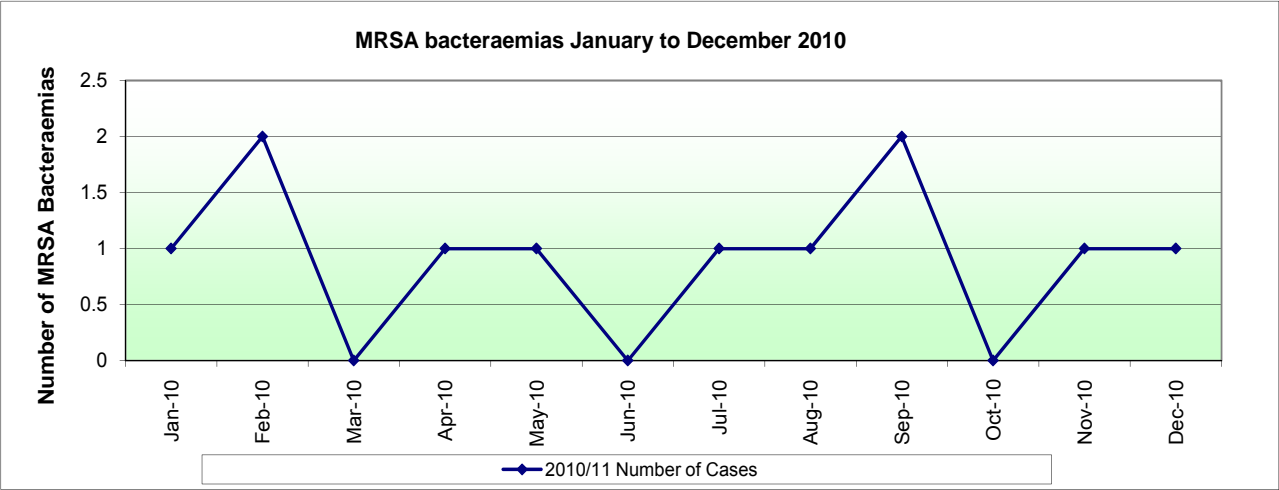
**Priority 5: Infection prevention and control**

UHB is continuing to make good progress in relation to infection prevention and control during 2010-11:

- The Trust is now utilising vapour decontamination in standard terminal cleans since the move into the new building. There has also been an initiative to use hydrogen peroxide vaporising in the clinical areas identified as most susceptible to *C. difficile* infection to reduce the microbial load prior to use of the area by patients.
- The Trust’s MRSA screening policy includes all elective and emergency patients except those that are excluded from the Department of Health criteria. A decolonisation project to follow cases through into the community is in the process of being agreed with NHS South Birmingham.
- Both MRSA bacteraemias and any episode of two or more *C.difficile* cases are subject to root cause analysis and then review by the Executive Team of the Board. The learning from these RCAs is shared divisionally and assurance on actions taken is reported via the Infection Prevention and Control Committee.
- The Trust has begun a process of surveillance for other key organisms to prepare to monitor and report on them monthly.

The graphs below show the number of post 48-hour *C. difficile* cases and MRSA bacteraemias by month for the period January to December 2010:





#### 4. Performance of the Trust against selected metrics

Indicators	2010-11	Peer Group Average (where available)	2009-10
<b>Patient safety indicators</b>			
<b>1(a). MRSA: Patients with MRSA infection/10,000 bed days (includes all bed days from all specialties)</b>  <i>Lower rate indicates better performance</i>	<b>0.36</b>	<b>0.23</b>	<b>0.42</b>
Time period	April-Sept 2010	April-Sept 2010	2009-10
Data source	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)
Peer group		Acute trusts in West Midlands SHA	
<b>1(b). MRSA: Patients with MRSA infection/10,000 bed days (aged &gt;15, excluding Obstetrics Gynaecology and elective Orthopaedics)</b>  <i>Lower rate indicates better performance</i>	<b>0.36</b>	<b>0.26</b>	<b>0.43</b>
Time period	April-Sept 2010	April-Sept 2010	2009-10

Indicators	2010-11	Peer Group Average (where available)	2009-10
Data source	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)
Peer group		Acute trusts in West Midlands SHA	
<b>2(a). <i>C. difficile</i>: Patients with <i>C. difficile</i> infection/1,000 bed days (includes all bed days from all specialties)</b>  <i>Lower rate indicates better performance</i>	<b>0.53</b>	<b>0.36</b>	<b>0.53</b>
Time period	April-Sept 2010	April-Sept 2010	2009-10
Data source	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)
Peer group		Acute trusts in West Midlands SHA	
<b>2(b). <i>C. difficile</i>: Patients with <i>C. difficile</i> infection/1,000 bed days (aged &gt;15, excluding Obstetrics Gynaecology and elective Orthopaedics)</b>  <i>Lower rate indicates better performance</i>	<b>0.53</b>	<b>0.41</b>	<b>0.55</b>
Time period	April-Sept 2010	April-Sept 2010	2009-10
Data source	Trust C.diff data reported	Trust C.diff data	Trust C.diff data reported

Indicators	2010-11	Peer Group Average (where available)	2009-10
	to HPA, HES data (bed days)	reported to HPA, HES data (bed days)	to HPA, HES data (bed days)
Peer group		Acute trusts in West Midlands SHA	
<b>3. Patient safety incidents (reporting rate per 100 admissions)</b>  <i>Higher rate indicates better reporting</i>	<b>9.0</b>	<i>Not available</i>	<b>9.7</b>
Time period	April-Dec 2010		2009-10
Data source	Datix (incident data), Trust admissions data		Datix (incident data), Trust admissions data
Peer group			
<b>4. Percentage of patient safety incidents which are no harm incidents</b>  <i>Higher % indicates better performance</i>	<b>82.7%</b>	<i>Not available</i>	<b>86.6%</b>
Time period	April-Dec 2010		2009-10
Data source	Datix (incident data), Trust admissions data		Datix (incident data)
Peer group			

Indicators	2010-11	Peer Group Average (where available)	2009-10
<b>Clinical effectiveness indicators</b>			
<b>5(a). Readmissions: Readmission rate (Medical and surgical specialties - elective and emergency admissions aged &gt;15) %</b>  <i>Lower % indicates better performance</i>	<b>9.7%</b>	<b>12.2%</b>	<b>8.47%</b>
Time period	April-Aug 2010	April-Aug 2010	April 2009-Mar 2010
Data source	HES data	HES data	HES data
Peer group		University hospitals	
<b>5(b). Readmissions: Readmission rate (all specialties) %</b>  <i>Lower % indicates better performance</i>	<b>9.7%</b>	<b>10.1%</b>	<b>8.69%</b>
Time period	April-Aug 2010	April-Aug 2010	April 2009-Mar 2010
Data source	HES data	HES data	HES data
Peer group		University hospitals	
<b>6. Falls (incidents reported as % of elective and emergency episodes)</b>	<b>2.0%</b>	Not available	<b>1.97%</b>



Indicators	2010-11	Peer Group Average (where available)	2009-10
<i>Lower % indicates better performance</i>			
Time period	April-Dec 2010		2009-10
Data source	Datix (incident data), Trust activity data		Datix (incident data), Trust activity data
<b>7. Percentage of stroke patients (infarction) on aspirin, clopidogrel or warfarin</b>  <i>Higher % indicates better performance</i>	<b>100%</b>	<b>99.7%</b>	<b>99.7%</b>
Time period	April-Dec 2010	2008 Calendar year	2009-10
Data source	Trust PICS data	Cleveland Clinic website	Trust PICS data
Peer group		Cleveland Clinic, Ohio, U.S.A.	
<b>8. Percentage of beta blockers given on the morning of the procedure for patients undergoing first time coronary artery bypass graft (CABG)</b>  <i>Higher % indicates better performance</i>	<b>94.1%</b>	<b>88%</b> NB This data is for all surgery patients with heart conditions who were on beta blockers	<b>93.3%</b>

Indicators	2010-11	Peer Group Average (where available)	2009-10
Time period	April-Dec 2010	Jan-Jun 09	2009-10
Data source	Trust PICS data	Cleveland Clinic website	Trust PICS data
Peer Group		Cleveland Clinic, Ohio, U.S.A.	

### Notes on clinical outcome measures

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

**3:** The data shown for 2009-10 in the Trust's 2009-10 Quality Account actually related to episodes of care rather than admissions. There can be multiple episodes of care during one patient admission. The data for 2009-10 has therefore been recalculated using admissions data.

**6:** The admissions data shown for 2009-10 in the Trust's 2009-10 Quality Account actually related to episodes of care rather than admissions. The data includes daycase patients as well as all elective and emergency admissions.

**7:** Aspirin, clopidogrel or warfarin are given to reduce the likelihood of recurrent stroke or transient ischaemic attack (TIA) in patients who have already suffered a stroke. Any patients who are identified as not having been given aspirin, clopidogrel or warfarin during their stay are followed up to ensure they have been discharged on these drugs if clinically appropriate.

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

## 5. Specialty Quality Indicators

The following table shows performance at a specialty level for a wide selection of the quality indicators developed by clinicians, Health Informatics and the Trust's Quality and Outcomes Research Unit. Performance data is shown for April-December 2010 and 2009-10, and benchmarking data is provided where possible. In line with the Trust's commitment to transparency, the data shown is not just limited to good performance; areas where performance can be improved are being taken forward by the specialties concerned as appropriate. The methodology and data for all indicators have been checked and validated by the appropriate clinical staff to ensure they accurately reflect the quality of care provided.

### Acute Medicine

Speciality	Indicator	Goal	Numerator (Apr 10 - Dec 10)	Denominator (Apr 10 – Dec 10)	% (Apr 10 – Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
A&E	<b>Average (median) time from arrival in A&amp;E to performance of CT head with contrast scan</b>				2 hours (for 66 patients)			2 hours (for 46 patients)	CRIS Symphony	
A&E	<b>Average (median) time from arrival in A&amp;E to performance of CT head scan</b>				2 hours (for 1483 patients)			3 hours (for 1146 patients)	CRIS Symphony	

Speciality	Indicator	Goal	Numerator (Apr 10 - Dec 10)	Denominator (Apr 10 – Dec 10)	% (Apr 10 – Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Acute Medicine	<b>7 day readmissions to: Acute Medicine Medical Admissions Unit</b>	<4% for Acute Medicine	540 249	20852 6980	2.5% 3.5%	885 324	25724 7141	3% 5%	Lorenzo	
Cardiology	<b>Ensure all patients are discharged on aspirin and clopidogrel or prasugrel following percutaneous coronary intervention (PCI)</b>	100%	616	616	100.0%	790	790	100.0%	Lorenzo PICS	Cleveland Clinic 99% (2009) Other US Hospitals 98% (2009) (This data relates to Thieno- pyridines given at discharge)
Diabetes	<b>Percentage of patients under Diabetic Centre follow up (attending follow-up outpatient appointments) who have a lower limb amputation. Note: The Diabetes Team are also planning to develop a similar indicator for patients with diabetes not under Diabetic Centre follow up.</b>		9	3067	0.2%	12	3462	0.35%	Lorenzo	

Speciality	Indicator	Goal	Numerator (Apr 10 - Dec 10)	Denominator (Apr 10 – Dec 10)	% (Apr 10 – Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Elderly Care	Percentage of elderly care patients discharged to their normal place of residence		3189	3471	91.9%	4278	4705	90.9%	Lorenzo	
Elderly Care	Percentage of elderly care patients discharged to other NHS/ non-NHS providers		213	3472	6.1%	355	4705	7.5%	Lorenzo	
Gastro- enterology	Proportion of patients admitted with inflammatory bowel disease receiving low molecular weight (LMW) heparin	90%	34	37	91.9%	53	56	95%	Lorenzo PICS	
Heart Failure	Percentage of heart failure patients discharged on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)	93%	134	208	64.4%	178	254	70%	Heart Failure database PICS	Cleveland clinic 99% (Jan 10 - Mar 10) Average for all other US hospitals 90% (Oct 08 - Sep 09) This relates to ACE/ARBs given to heart failure patients

Speciality	Indicator	Goal	Numerator (Apr 10 - Dec 10)	Denominator (Apr 10 – Dec 10)	% (Apr 10 – Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
										with LVSD
Heart Failure	<b>Percentage of patients with a primary diagnosis of acute heart failure who had an echocardiogram (ECHO) prior to discharge</b>	100%	161	208	77.4%	196	254	77%	Heart Failure database PICS	
Respiratory Medicine	<b>% of asthmatic patients are discharged on inhaled steroids</b>	95%	211	238	88.7%	236	272	86.8%	PICS	
Stroke Medicine	<b>% of patients admitted with cerebral infarction who received aspirin, clopidogrel or warfarin</b>	98.8% (CQUIN target for 2009-10)	207	207	100.0%	298	299	99.7%	Lorenzo PICS	Cleveland Clinic : 100% (Jan 10 -Mar 10) US National Average : 85% Ischemic stroke patients discharged on Blood Clot Reducing Medication
Stroke Medicine	<b>30 day mortality following stroke</b>		43	308	14.0%	77	324	23.8%	Lorenzo	

## Anaesthetics, ITU and Ambulatory Care

Speciality	Indicator	Goal	Numerator (Apr 10 – Dec 10)	Denominator (Apr 10 – Dec 10)	% (Apr 10 – Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Ambulatory Care	<b>Proportion of patients who were intended to be treated as a daycase but were admitted to hospital as an inpatient</b>	<5%	418	11653	3.6%	712	16573	4.3%	Lorenzo Galaxy	
Anaesthetics	<b>Post operative nausea and vomiting All high risk patients (Ear, Nose and Throat, General Surgery and Laparoscopic Surgery) should be prescribed with antiemetics (anti-sickness medication) so they can be given promptly after the operation if they need them</b>		1407	1825	77.1%	2322	2822	82.3%	Lorenzo PICS	

Speciality	Indicator	Goal	Numerator (Apr 10 – Dec 10)	Denominator (Apr 10 – Dec 10)	% (Apr 10 – Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Anaesthetics	<b>Post operative Nausea &amp; Vomiting High risk patients (Ear, Nose and Throat, General Surgery and Laparoscopic Surgery) given antiemetics (anti-sickness medication) after the operation</b>		815	1825	44.7%	1273	2822	45.1%	Lorenzo PICS	
ITU	<b>Intensive care readmission rate (Readmissions to ITU during the same inpatient admission)  Excludes Wellcome Building Critical Care (WBCC) unit which does not submit data to the Intensive Care National Audit &amp; Research Centre (ICNARC)</b>		119	1232	9.7%	283	2191	12.90%	ICNARC	



## Clinical Support Services

Speciality	Indicator	Goal	Numerator (Apr 10 – Dec 10)	Denominator (Apr 10 – Dec 10)	% (Apr 10 - Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Imaging	<b>Proportion of A&amp;E patients who have report turnaround time of less than 2 days for CT scan</b>		2608	2740	95.2%	2078	2111	98%	CRIS	
Imaging	<b>Proportion of GP Direct Access patients who have report turnaround time of less than 5 days for plain imaging</b>		18678	21148	88.3%	21307	23622	90%	CRIS	
Imaging	<b>Proportion of GP Direct Access patients who have report turnaround time of less than 5 days for Ultrasound</b>		4760	4811	98.9%	6031	6071	99%	CRIS	Cleveland clinic 94% (July 08 - June 09) Average for all other US hospitals 90% (July 08 - June 09)

Speciality	Indicator	Goal	Numerator (Apr 10 – Dec 10)	Denominator (Apr 10 – Dec 10)	% (Apr 10 - Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Imaging	Proportion of Inpatients who have report turnaround time of less than 2 days for CT		8053	9773	82.4%	8969	11055	81%	CRIS	
Imaging	Proportion of Inpatients who have report turnaround time of less than 2 days for MRI		1531	2768	55.3%	1111	2786	40%	CRIS	
Imaging	Proportion of Inpatients who have report turnaround time of less than 2 days for Ultrasound		6600	6752	97.7%	7160	7320	98%	CRIS	
Imaging	Proportion of Outpatients who have report turnaround time of less than 5 days for CT		7664	11004	69.6%	9348	12625	74%	CRIS	
Imaging	Proportion of Outpatients who have report turnaround time of less than 5 days for MRI		4344	12656	34.3%	4838	13849	35%	CRIS	

Speciality	Indicator	Goal	Numerator (Apr 10 – Dec 10)	Denominator (Apr 10 – Dec 10)	% (Apr 10 - Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Imaging	<b>Proportion of Outpatients who have report turnaround time of less than 5 days for Ultrasound</b>		10679	11158	95.7%	12844	13494	95%	CRIS	
Pathology	<b>Turnaround times C-Reactive Protein - 100 % within 24 hours</b>	100% within 24 hours	117365	117972	99.5%	151706	152131	99.7%	Pathology database	
Pathology	<b>Turnaround times Cholesterol - 100 % within 24 hours</b>	100% within 24 hours	18062	18397	98.2%	24352	24714	98.5%	Pathology database	

Speciality	Indicator	Goal	Numerator (Apr 10 – Dec 10)	Denominator (Apr 10 – Dec 10)	% (Apr 10 - Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Pathology	<b>Turnaround times Urine - 90% within 48 hours</b>	90% within 48 hours	24785	27813	89.1%	32311	36652	88.2%	Pathology database	
Pathology	<b>Turnaround times Full Blood Count - 100 % within 24 hours</b>	100% within 24 hours	217111	218721	99.3%	284846	288662	98.7%	Pathology database	
Pharmacy	<b>Dispensing error rate (nationally these are measured as no of errors per 100,000 dispensed items)</b>		16.9	100000	0.02%	11.025	100000	0.01%	Pharmacy database	

Speciality	Indicator	Goal	Numerator (Apr 10 – Dec 10)	Denominator (Apr 10 – Dec 10)	% (Apr 10 - Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Radiotherapy	<b>85% of patients should commence treatment (first dose of radiotherapy) within 14 calendar days from CT scan. Note: Some of the patients not treated within the target timeframe had chosen to delay their treatment.</b>		2002	2412	83.0%	Jul 09 - Mar 10 1820	Jul 09 - Mar 10 2317	Jul 09 - Mar 10 78.5%	Radio- therapy database	
Therapy Services	<b>90% of In-patient referrals are responded to by each of the Therapy Services on the same day</b>	90% on same day	20657	21475	96.2%	25449	26424	96.3%	Therapy database	
Therapy Services	<b>95% of In-patient referrals are responded to by each of the Therapy Services within two working days of the patient being identified to the service.</b>	95% within two working days	20963	21475	97.6%	26105	26424	98.8%	Therapy database	

## Other Medicine

Speciality	Indicator	Goal	Numerator (Apr 10 - Dec 10)	Denominator (Apr 10 - Dec 10)	% (Apr 10 - Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Dermatology	<b>Incidence of wound infection post skin graft</b>	0%	0	85	0.0%	0	114	0%	Lorenzo	
Dermatology	<b>Proportion of suspected cancer cases seen within 2 weeks by a consultant</b>	93%	1214	1228	98.9%	1414	1502	94.1%	Cancer database	
Haematology	<b>Bone Marrow Transplant-related mortality:</b>									
	<b>During index (first) admission - autologous (patient's own bone marrow) transplants</b>		4	73	5.5%	0	66	0%	BMT database	
<b>During index (first) admission - allogeneic (donor bone marrow) transplants</b>		0	65	0%	0	74	0%			

Speciality	Indicator	Goal	Numerator (Apr 10 - Dec 10)	Denominator (Apr 10 - Dec 10)	% (Apr 10 - Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Liver Medicine	Percentage of patients who have endoscopic retrograde cholangio-pancreatography (ERCP) who develop pancreatitis. ERCP involves a doctor examining the common bile duct and pancreatic duct through a flexible tube which is passed down the mouth, stomach and into the small intestine (bowel).	<5%	1	330	0.3%	5	357	1.4%	ERCP database Lorenzo PICS	
Liver Medicine/ Surgery	90 day patient mortality (%) and graft loss (%), with 95% confidence intervals, for all adult patients who received a planned (non-emergency) first liver transplant.  Number of Transplants 90 day mortality (95% Confidence Intervals) 90 day graft loss (95% Confidence Intervals)		Latest Annual Report not yet available	Latest Annual Report not yet available	Latest Annual Report not yet available			Time Period - Oct 08 - Sep 09  67 6.0 (2.3,15.1) 9.0 (4.1,18.9)	Annual NCG Report	

Speciality	Indicator	Goal	Numerator (Apr 10 - Dec 10)	Denominator (Apr 10 - Dec 10)	% (Apr 10 - Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Liver Transplant	<b>Use of Valganciclovir in CMV (Cytomegalovirus) mismatched liver transplant patients. Valganciclovir is an antiviral medication used to prevent CMV infection in liver transplant patients who have not previously had CMV but the donor has.</b>	100%	56	56	100.0%	62	62	100.0%	Liver database PICS	
Palliative Care	<b>100 % of patients with palliative care diagnosis code (using KMR) who are receiving regular analgesic background pain medications (Morphine Sulphate Tablets (MST), Zomorph, Fentanyl, Oxycontin) should also be prescribed with breakthrough analgesia (e.g. oramorph, oxynorm)</b>	100%	184	186	98.9%	145	148	98.0%	Lorenzo PICS	



Speciality	Indicator	Goal	Numerator (Apr 10 - Dec 10)	Denominator (Apr 10 - Dec 10)	% (Apr 10 - Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Palliative Care	<b>100 % of above patients (who were prescribed with both analgesic medication for background pain and analgesia for breakthrough pain) should also be prescribed with laxatives.</b>	100%	184	184	100%	145	145	100%	Lorenzo PICS	
Renal Medicine	<b>Percentage of patients on haemodialysis programme with a urea reduction ratio (URR) of &gt;65%</b>  <b>All patients on haemodialysis</b>  <b>Patients who have been on haemodialysis for 90 days or more</b>	90%			88.2%  88.7%			89.8%  90.1%	MARS	Data from 57 UK dialysis centres in 2007 reported in the renal registry report of 2008 show that 81% of reported patients achieve a URR ≥ 65% (centre range 47%–97%).
Rheumatology	<b>An indication of continuity of care - percentage of patients who saw the same staff member at least 3 times out of 5 previous visits</b>		291	430	67.7%	315	315	100.0%	Lorenzo	

## Outpatients

Speciality	Indicator	Goal	Numerator (Apr 10 - Dec 10)	Denominator (Apr 10 - Dec 10)	% (Apr 10 - Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Ophthalmology	Overall, how would you rate the care you received at the Outpatients Department today? Excellent Very Good Good Fair Poor Very Poor		37 22 9 0 0 0	68	54.4% 32.4% 13.2% 0% 0% 0%	11 10 2 0 0 0	1 March -10 April 2010 23	1 March -10 April 2010 48% 43% 9% 0% 0%	Outpatient Survey	
Ophthalmology	Would you recommend this Outpatients Department to your family and friends? Yes, definitely Yes, probably No		63 5 0	68	92.6% 7.4% 0%	21 3 0	24	88% 13% 0%	Outpatient Survey	
Ophthalmology	Was your appointment changed to a later date by the hospital? No Yes, once Yes, 2 or 3 times Yes, 4 or more times		102 19 2 4	127	80.3% 15.0% 1.6% 3.1%	186 34 6 1	227	82% 15% 3% 0%	Outpatient Survey	

## Surgery

Speciality	Indicator	Goal	Numerator (Apr 10 – Dec 10)	Denominator (Apr 10 - Dec 10)	% (Apr 10 – Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Cardiac Surgery	<b>First-time, isolated coronary artery bypass graft (CABG) - MRSA bacteraemia</b>		0	209	0.0%	0	313	0.0%	PATS Lorenzo	
Cardiac Surgery	<b>First-time isolated coronary artery bypass graft (CABG) - C.difficile</b>	0	0	209	0.0%	0	313	0.0%	PATS Lorenzo	
Cardiac Surgery	<b>First-time isolated coronary artery bypass graft (CABG) - Emergency readmissions within 28 days</b>		5	199	2.5%	15	307	4.9%	PATS Lorenzo	

Speciality	Indicator	Goal	Numerator (Apr 10 – Dec 10)	Denominator (Apr 10 - Dec 10)	% (Apr 10 – Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Cardiac Surgery	<b>First-time isolated coronary artery bypass graft (CABG) - Patients discharged on angiotensin converting enzyme (ACE) inhibitors</b>	100% of eligible patients	184	189	97.4%	275	307	89.6%	PATS PICS	
Cardiac Surgery	<b>First-time isolated coronary artery bypass graft (CABG) - Patients discharged on antiplatelet therapy</b>	100% of eligible patients	196	197	99.5%	306	307	99.7%	PATS PICS	
Cardiac Surgery	<b>First-time isolated coronary artery bypass graft (CABG) - Patients discharged on statins</b>	100% of eligible patients	187	189	98.9%	295	307	96.1%	PATS PICS	
Cardiac Surgery	<b>First-time isolated coronary artery bypass graft (CABG) - Patients on betablockers who were given them on the day of surgery</b>	100% of eligible patients	86	92	93.5%	125	134	93.3%	PATS PICS	Cleveland Clinic 90% (Jan 09- Dec 09) Average for all other hospitals in Ohio 90% (Jan 09 - Dec 09) Average for all

Speciality	Indicator	Goal	Numerator (Apr 10 – Dec 10)	Denominator (Apr 10 - Dec 10)	% (Apr 10 – Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
										reporting hospitals in US 87% (Jan 09- Dec 09) N.B. This data is for all surgery patients with heart conditions who were on betablockers
Cardiac Surgery	<b>First-time isolated coronary artery bypass graft (CABG) - Post-operative stroke</b>		2	201	1.0%	7	313	2.2%	PATS Lorenzo	
Cardiac Surgery	<b>First-time isolated coronary artery bypass graft (CABG) - Re-opening (all causes)</b>		16	201	8.0%	24	313	7.7%	PATS Lorenzo	Cleveland Clinic 11% (2009 calendar year). This data also includes the referrals for reoperation from other hospitals.

Speciality	Indicator	Goal	Numerator (Apr 10 – Dec 10)	Denominator (Apr 10 - Dec 10)	% (Apr 10 – Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Cardiac Surgery	<b>First-time isolated coronary artery bypass graft (CABG) - Average post-operative length of stay</b>			201 patients	9 days		313 patients	9.7 days	PATS Lorenzo	
Cardiac Surgery	<b>First-time isolated coronary artery bypass graft (CABG) - Median post-operative length of stay</b>			201 patients	7 days		313 patients	7 days	PATS Lorenzo	
Cardiac Surgery	<b>First-time isolated coronary artery bypass graft (CABG) - Hospital survival</b>		199	201	99.0%	307	313	98.1%	PATS Lorenzo	Cleveland Clinic 98.8% (2009 calendar year)
Endocrinology	<b>Fraction of patients discharged on hydrocortisone post pituitary surgery</b>	100%	39	41	95.1%	63	63	100%	Lorenzo PICS	
Max Fax	<b>Percentage of emergency admissions with fractured mandible who have surgery same day or the next day</b>	90%	124	160	77.5%	157	224	70%	Lorenzo	

Speciality	Indicator	Goal	Numerator (Apr 10 – Dec 10)	Denominator (Apr 10 - Dec 10)	% (Apr 10 – Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Neurosurgery	<b>Time from emergency admission with sub-arachnoid haemorrhage to surgery or coiling - including cases where intervention was deferred, for medical reasons.</b>	90% within 2 days			1.79 days (58 pts)			3.28 days (150 patients)	Lorenzo	
Neurosurgery	<b>Percentage of emergency admission with sub-arachnoid haemorrhage patients who had surgery or coiling within 2 days - including cases where intervention was deferred, for medical reasons.</b>	90% within 2 days	47	58	81.0%	117	157	74.5%		
Renal Surgery	<b>Percentage of patients attending the low clearance clinic (which aims to get patients ready for dialysis) who had had an arteriovenous fistula (to create access for dialysis) made before starting haemodialysis.</b>	80%	31	44	70.5%	61	80	76.3%	MARS Lorenzo	

Speciality	Indicator	Goal	Numerator (Apr 10 – Dec 10)	Denominator (Apr 10 - Dec 10)	% (Apr 10 – Dec 10)	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Data Source	Benchmarking
Routine Surgery / Care	<b>Unplanned return to theatre for all non-emergency surgical patients</b>	>2.5%	479	20893	2.3%	500	32762	1.5%	Galaxy	
Trauma & Orthopaedics	<b>Proportion of patients who had surgery within 2 days of admission for fractured neck of femur (fractured hip)</b>	90%	59	71	83.0%	206	281	73%	Lorenzo	
Urology	<b>All patients admitted with acute retention to be discharged on alpha blockers (if not put on waiting list for transurethral resection of the prostate (TURP))</b>	70%	37	64	57.8%	58	109	53.2%	Lorenzo PICS	
Vascular Surgery	<b>Rates of daycase versus inpatient varicose vein procedures</b> Daycases Inpatients	<5% done as inpatients	484 26	510 510	94.9% 5.0%	485 28	513 513	94.5% 5.5%	Lorenzo	

**Notes on data sources:**

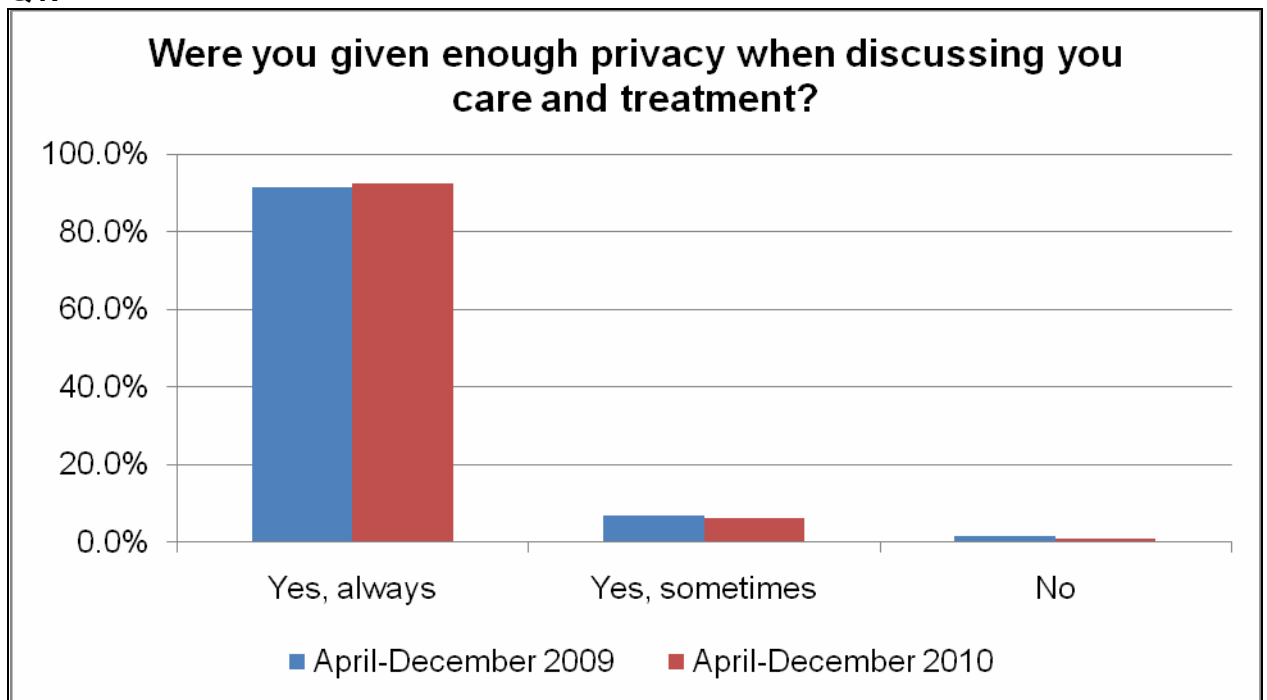
Cleveland Clinic and US data = published on Cleveland Clinic website



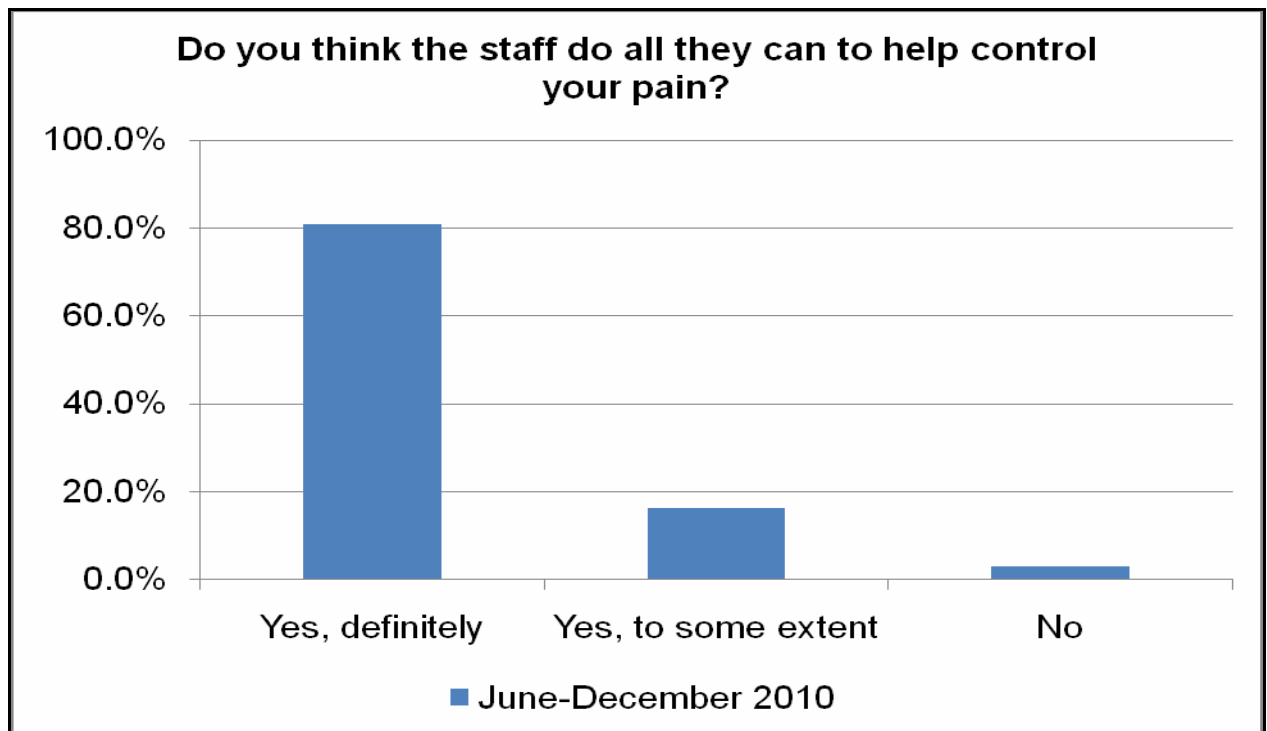
CRIS = Radiology database  
Galaxy = Theatres database  
ICNARC = Intensive Care National Audit & Research Centre  
Lorenzo = Patient administration system  
MARS = Renal database  
NCG = National Commissioning Group  
PATS = Cardiac database  
Symphony = A&E patient management system

## Appendix B: Trust-level Inpatient Feedback for External Website

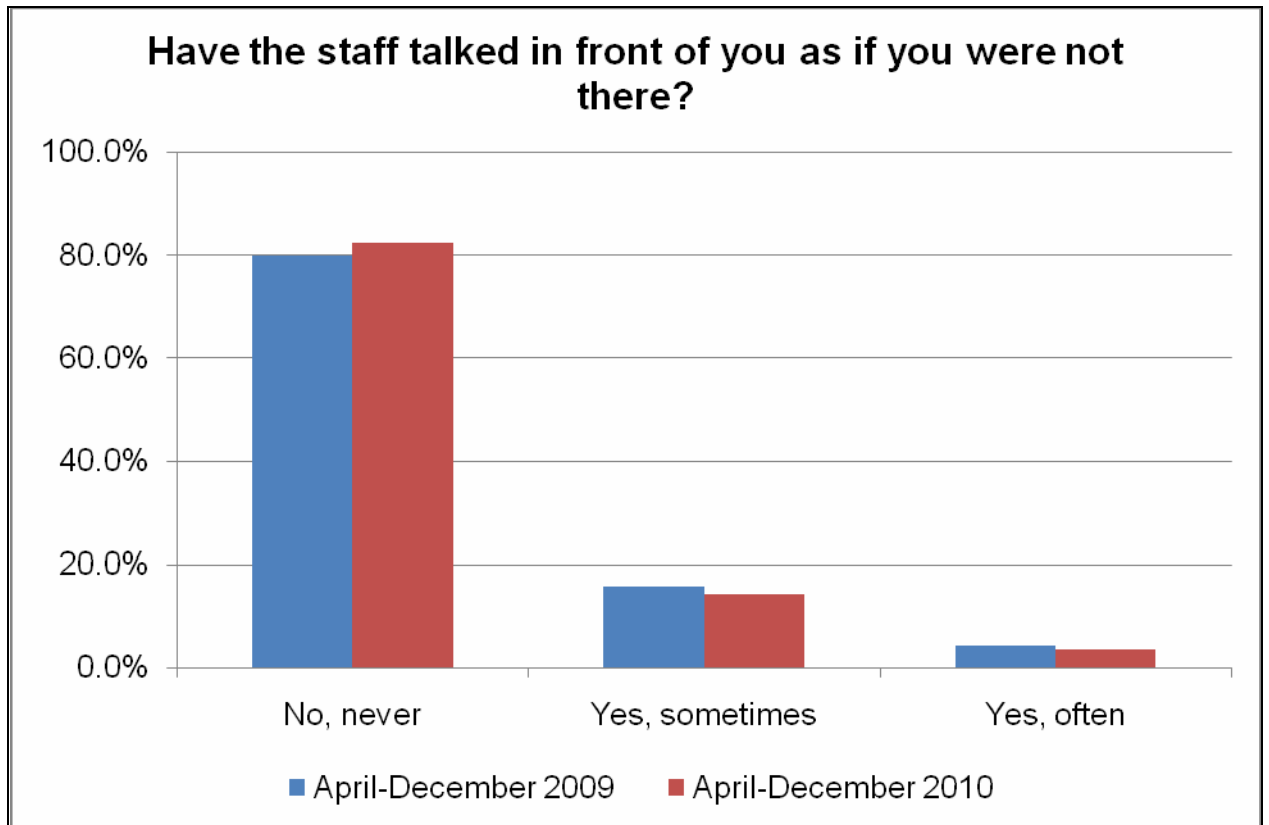
Q1.



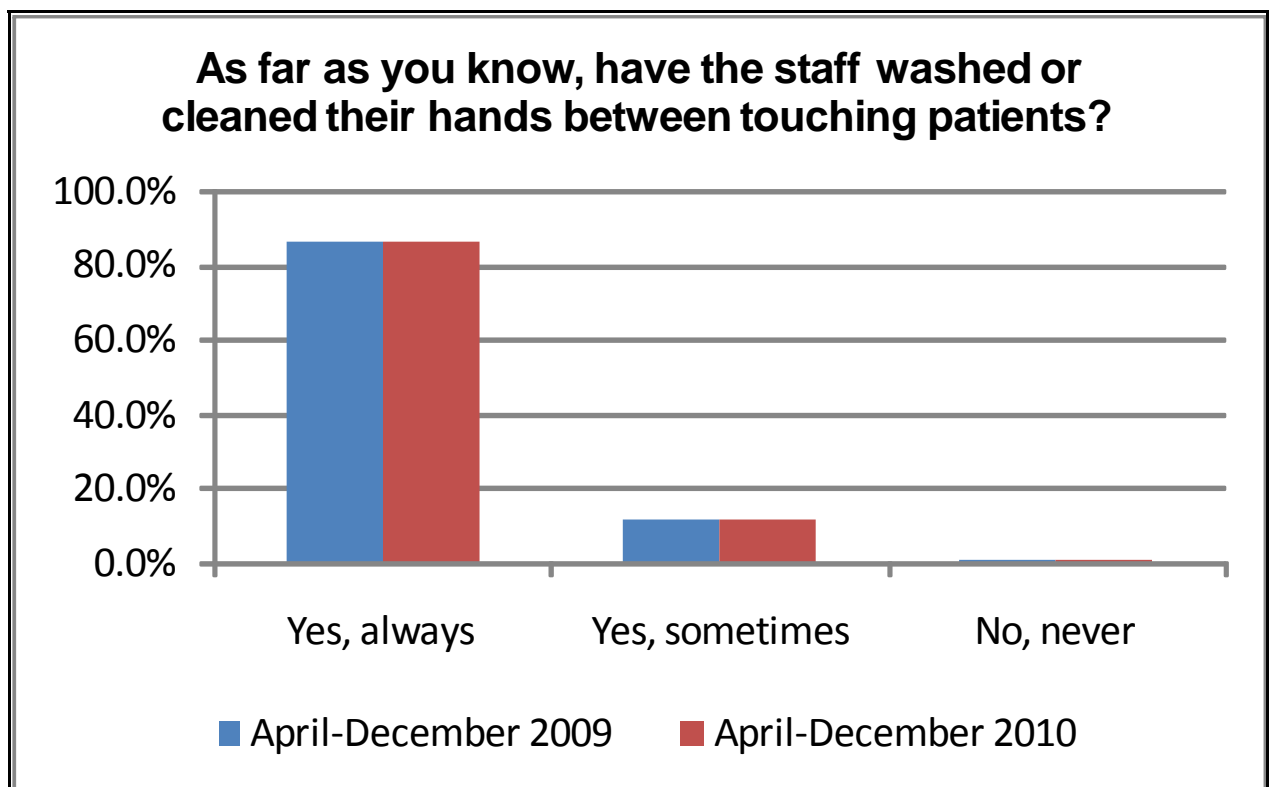
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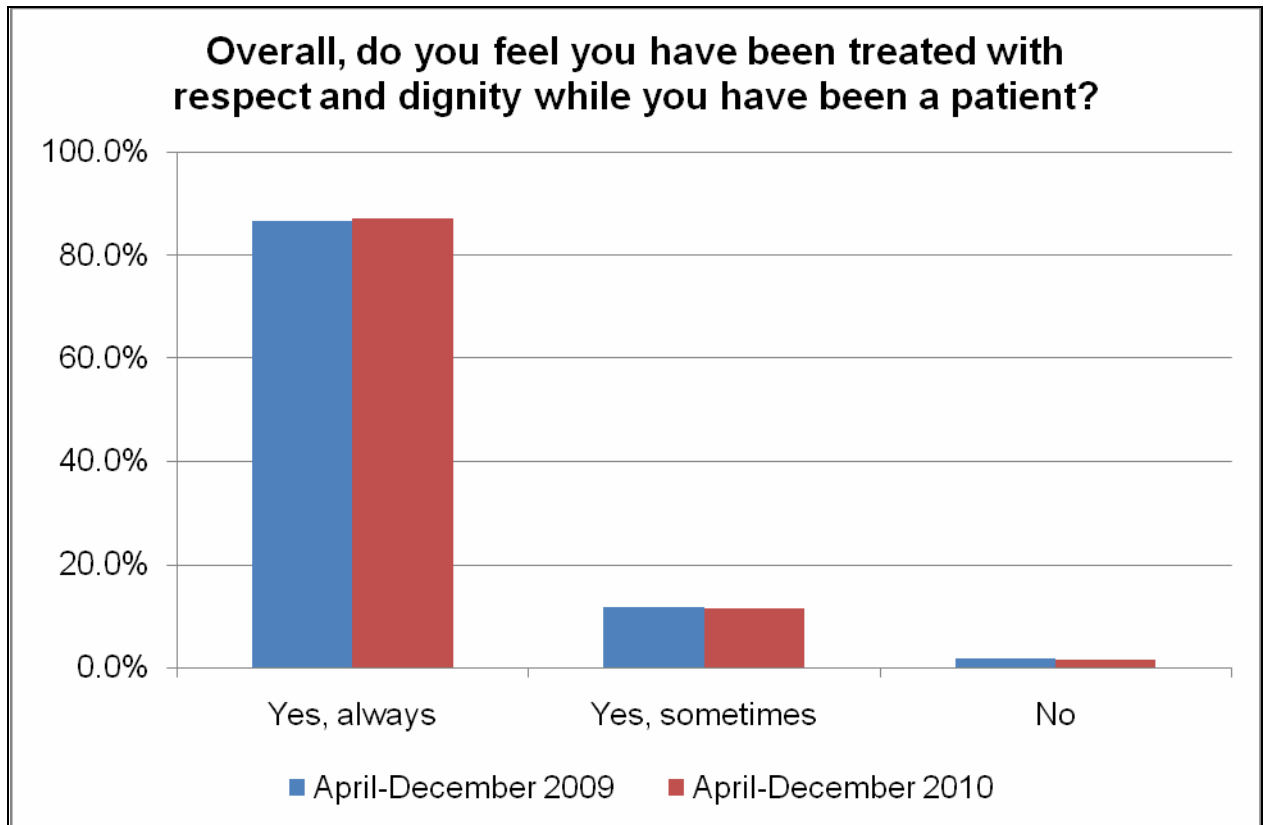
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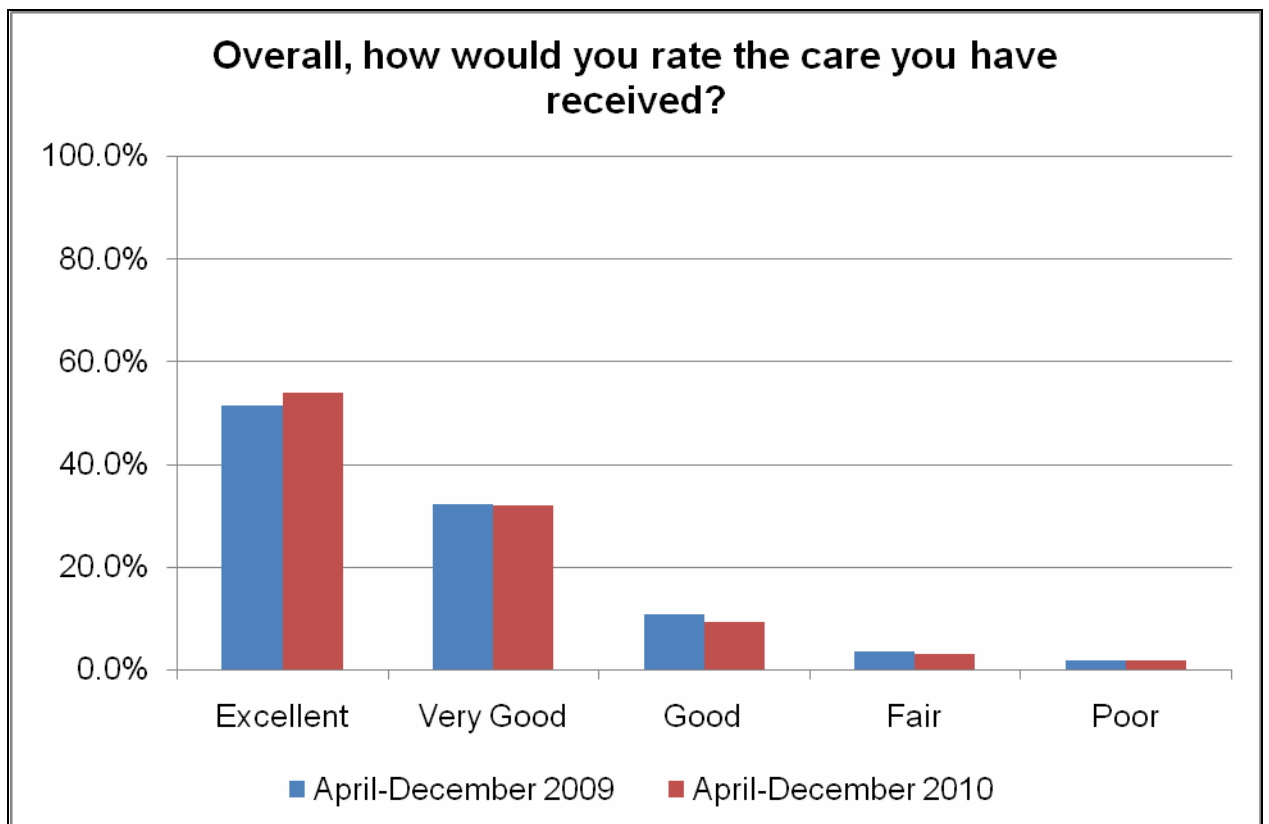
Q4.



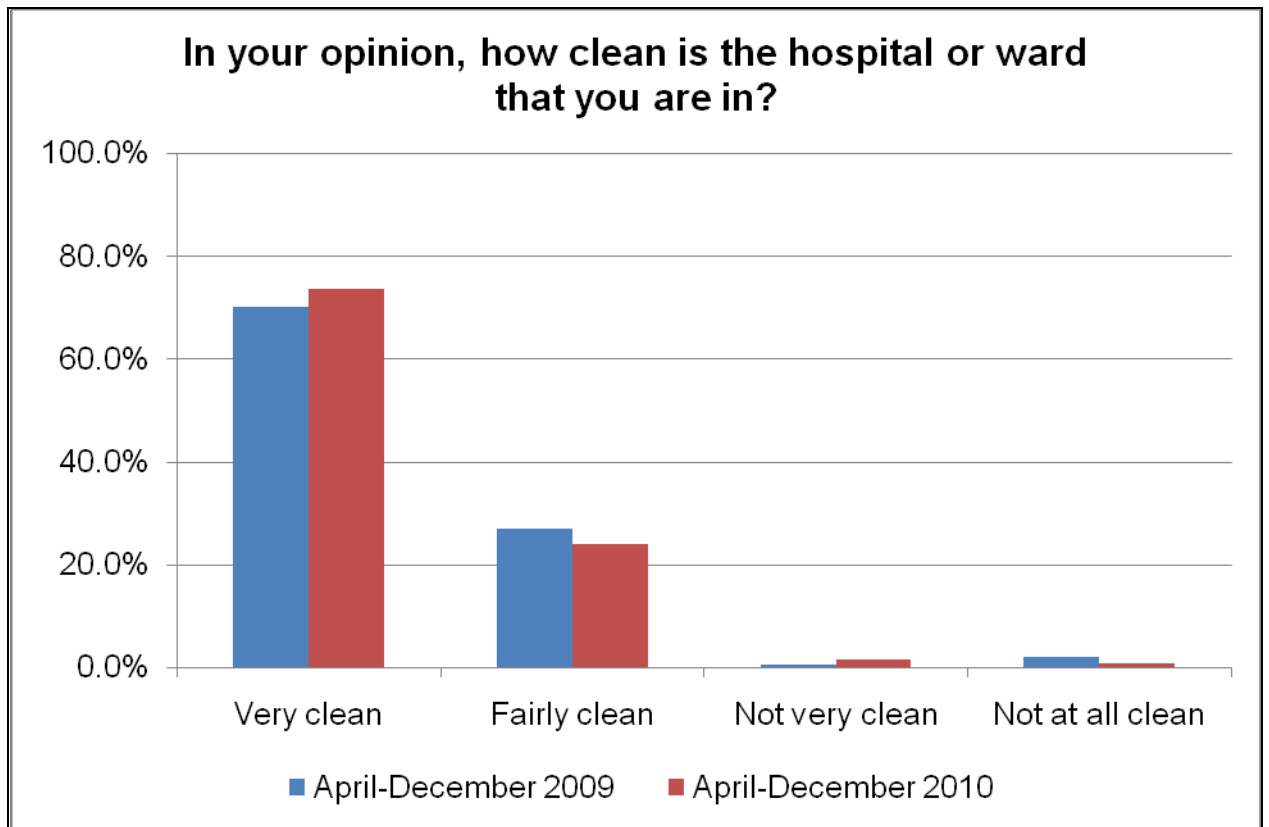
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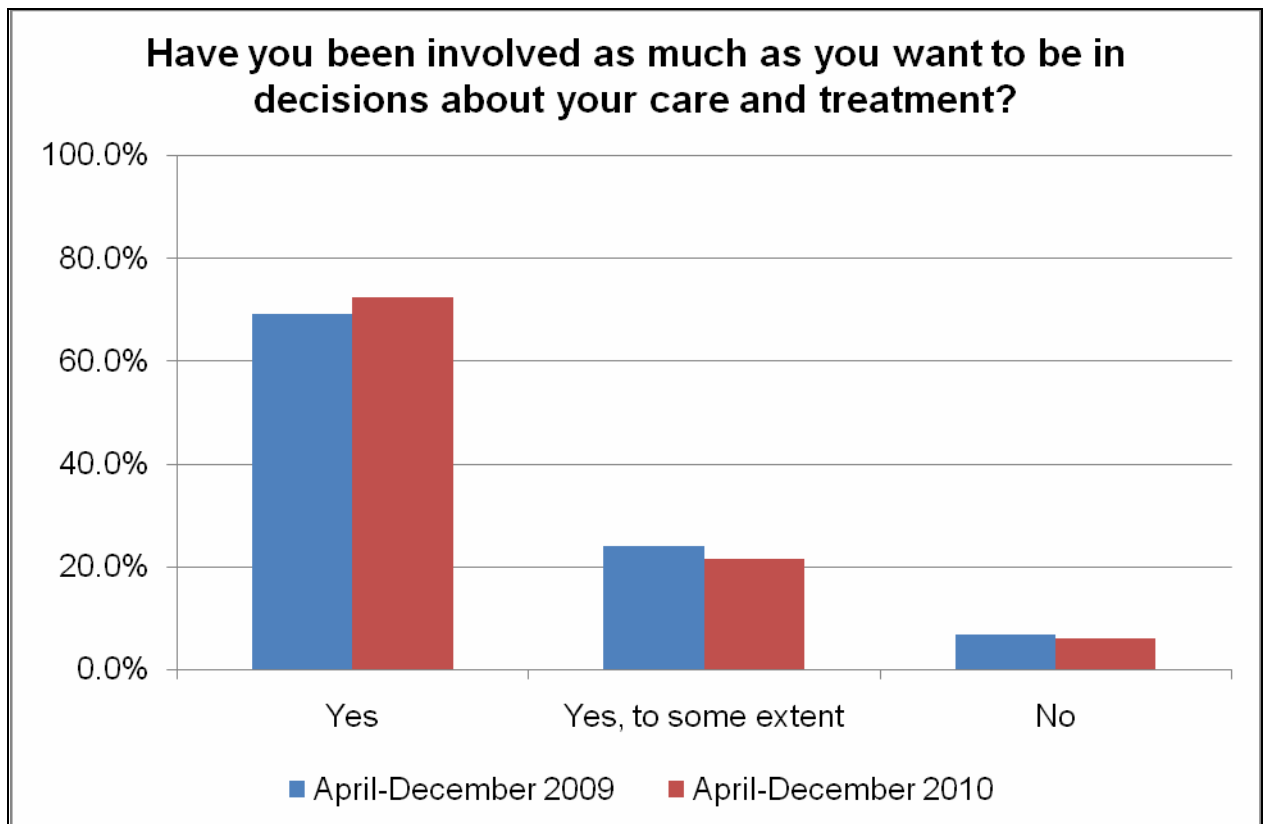
**Q6.**



**Q7.**



**Q8.**



Q9.

