To:	Trust Board
From:	Suzanne Hinchliffe, Chief Operating Officer/Chief Nurse
Date:	7 April 2011
CQC regulation:	

Title:	Commissioning for Quality Innovation (CQUIN) Schemes and Quality Schedules 2011/12

Author/Responsible Director:
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Purpose of the Report:
The attached paper covers the breadth of indicators for the 2011/12 Quality Schedule and CQUIN schemes for both the Primary Care Trust and the East Midlands Specialised Commissioning Group (EMSCG).

The Report is provided to the Board for:

Decision		Discussion	
Assurance	x	Endorsement	

Summary / Key Points:

Indicator Details

- There are nearly 200 individual indicators to be reported via the Quality Schedule or CQUIN scheme in 2011/12. Details of the indicator, the associated threshold and method of measurement are described, as are the parameters for each indicator's RAG rating. Also identified is a corporate and divisional lead plus a Senior Responsible Officer/Author.

Monitoring

- All the indicators will be subject to performance measures and the CQUIN indicators will also incur financial penalties when thresholds are not achieved.
- Performance against the 'schedules' will be reviewed internally prior to reporting to the monthly Clinical Quality Review Group (with commissioners) for 'RAG rating'.
- Areas where performance deteriorates or exposes the Trust to financial penalties will be subject to increased scrutiny at the monthly Confirm and Challenge meetings and at the Quality and Performance Management Group (QPMG).
- Quarterly reports, with details of RAG ratings, will be submitted to the Governance and Risk Management Committee.

CQUIN Payment

- In line with national guidance for CQUINs in 2011/12, both the PCT and EMSCG have confirmed that the CQUIN monies will equate to 1.5% of the contract value (estimated about £5,000,000 for PCTs and £2,800,000 for EMSCG).
- In order to support the delivery of the CQUINs, particularly those where achievement is at greatest risk, funding has been identified to provide support

for project set up.

Implementation

- A fuller version of the Schedules with details of Divisions/CBUs Management Team, plus reporting times for each indicator, has been sent out to all CBU and Lead Officers in order that they can ensure actions related to the indicators are either already in progress or plans put into place.
- Once the Schedule details have been finalised, the document will be available on Sharepoint.

Recommendations:

The Trust Board are asked to receive this report for information.

Strategic Risk Register	**Performance KPIs year to date**

Resource Implications (eg Financial, HR)

Assurance Implications

Patient and Public Involvement (PPI) Implications

Equality Impact

Information exempt from Disclosure

Requirement for further review ?

PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value[1]	x	Exec Lead	Div Lead(s)
PCT QS	IC1	MRSA bacteraemias Mandatory requirement - (HQU01)	9 cases	ICNet / APEX	Monthly	Red – over year to date trajectory Amber – over monthly trajectory Green – on/under trajectory	N/A	N/A		DIPAC	HoN (CBU Matrons/Ward Managers)
PCT QS	IC2	MSSA bacteraemias	Mandatory reporting on HCAI MESS system	ICNet / APEX	Monthly	Red - no data reported Green - data reported	N/A	N/A		DIPAC	HoN (CBU Matrons/Ward Managers)
PCT QS	IC3	E Coli bacteraemias	Mandatory reporting on HCAI MESS system	ICNet / APEX	Monthly	Red - no data reported Green - data reported	N/A	N/A		DIPAC	HoN (CBU Matrons/Ward Managers)
PCT QS	IC4	MRSA screens - Emergency and Elective Admissions	100% of all eligible patients	APEX & HISS	Monthly	Red – 89.9% or below Amber – between 90 -98.9% Green – between 99 -100%	N/A	N/A		DIPAC	HoN (CBU Matrons/Ward Managers)
PCT QS	IC5	C Diff Numbers Mandatory requirement (HQU02)	165 cases	ICNet / APEX	Monthly	Red – over year to date trajectory Amber – over monthly trajectory Green – on/under trajectory	N/A	N/A		DIPAC	HoN (CBU Matrons/Ward Managers)
PCT QS	IC6	C Diff care pathway- Returns	%age increase on outturn for return rate - set threshold March-11	ICNet & Audit	Bi-annually (Sept March)	TBC	N/A	N/A		DIPAC	HoN (CBU Matrons/Ward Managers)
PCT QS	IC7	C Diff care pathway - completion	%age increase on outturn for completion in the areas identified as critical for patient management of CDT - set threshold March-11	ICNet & Audit	Bi-annually (Sept March)	TBC	N/A	N/A		DIPAC	HoN (CBU Matrons/Ward Managers)
PCT QS	IC8	Compliance with latest versions of the Antimicrobial Duration Policy and Antimicrobial guidelines RB to confirm threshold	a) 90% compliance with the duration policy by end Q4 b) 95% compliance with the antibiotic guidelines by end Q4 Threshold tbc at beginning of April following discussion at AWP	Audit (minimum audit sample of 50 patients or one month period whichever is the greater) with associated action plans	Bi-annually unless audit has RED rating, when additional audit conducted 3 months after. Trust audit reports	a)/b) Red: < 84%/<89% Amber: 85 – 89.9%/90%-93.9% Green 90% and over TBC – based on threshold agreed	N/A	N/A		DIPAC	HoN (CBU Matrons/Ward Managers)
PCT QS	IC9	Source isolation - time to isolate within 4 hours of identification of need for isolation (MRSA/CDI)	Staggered trajectory:Q1 - 70% Q2 - 75% Q3 - 80% Q4 - 90%	Audit	Quarterly	Red – No progress or deteriorating position Amber – Progress made but threshold not met Green – Threshold achieved	N/A	N/A		DIPAC	HoN (CBU Matrons/Ward Managers)
PCT QS	IC10	HCAI Self Assessment Tool - Compliance with the Hygiene Code	90% in all areas of hygiene code	HCAI Self Assessment by CBUs	Quarterly	Red – 84.9% or below Amber – between 85 – 89.9% Green – between 90 -100%	N/A	N/A		DIPAC	HoN (CBU Matrons/Ward Managers)

[1] CQUIN Values - PCT CQUINs = % of total CQUIN monies. EMSCG = proportion of the 1.5% of the CQUIN monies)

PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value1	x	Exec Lead	Div Lead(s)
PCT QS	MS1	Maternity Dashboard RB to obtain draft dashboard CT/LM to indicate quality indicators to be used for RAG	Report progress against list of indictors and provision of appropriate action plans by exception	Maternity Dashboard - Euroking	Quarterly	Red – > 3 reds on dashboard Amber – any ambers or 1-2 red areas of performance against dashboard Green – performance against dashboard is 100%	N/A	N/A		W&C Divisional Director	Jane Porter, Head of Midwifery/Lead Nurse
PCT QS	MS2	Maternity 'Choice of Access' All women are provided with core choice offer appropriate to their needs • Antenatal Care • Choice of access • Choice of place of antenatal care • Type of Planned Care • Birth - Choice of place of Birth (home, MLU, Obstetric led) • Post-natal Care – Choice of post-natal care (home, community, MLU, GP practice)	Minimum 95% of pregnant women to be offered 'choice' in relation to all elements Threshold tbc based on out-turn	Audit and Patient Survey	Quarterly	TBC when threshold agreed	N/A	N/A		W&C Divisional Director	Jane Porter, Head of Midwifery/Lead Nurse
PCT QS	PE1	EMSA Compliance - (HQU08)	100% compliance, clinically justified/unjustified breaches to be reported locally and unjustified to be reported nationally via UNIFY	SSA Reports	Monthly	TBC	N/A	N/A		Director of Nursing	HoN (CBU Matrons/Ward Managers)
PCT QS	PE2	EMSA Compliance - Mandatory	Annual publication of EMSA declaration of compliance/non compliance	Self assessment	Annually	Red - No declaration Green - declaration	N/A	N/A		Director of Nursing	HoN (CBU Matrons/Ward Managers)
PCT QS	PE3	EMSA Compliance	Inform commissioner of any non-compliant areas	SSA Reports	Annually	Red - No declaration Green - declaration	N/A	N/A		Director of Nursing	HoN (CBU Matrons/Ward Managers)
PCT QS	PE4	EMSA Plan - Mandatory requirement	Production of plan relating to monitoring of estate (including bathroom facilities) and actions relating to non-compliance to ensure the highest possible standards are maintained. Plan to include clear milestones	Observational Audits	Annually	Red - no plan Green - plan received	N/A	N/A		Director of Nursing	HoN (CBU Matrons/Ward Managers)
PCT QS	PE5	EMSA Plan - Mandatory requirement	Progress against EMSA plan milestones	Progress Report	Quarterly	Red - milestones breach Green - no milestone breach	N/A	N/A		Director of Nursing	HoN (CBU Matrons/Ward Managers)
PCT QS	PE6	Pre-assessment PROMS - compliance with national requirements	Percentage of pre-assessment compliance to be in-line with national average in each of the following areas: □ Primary Unilateral Hip Replacement; □ Primary Unilateral Knee Replacement. □ Groin Hernia Repair □ Varicose Vein Procedures	HISS & NHSIA data	Aug, Nov, Feb, May	Average of all elements Red – below >5% of national average Amber – upto 5% below national average Green – In-line or above national average	N/A	N/A		Planned Care Divisional Director	Sarah Taylor, MSK and Fay Gordon, GI/Gen Surg & Urology CBU Managers
PCT QS	PE7	Outcome PROMS - evidence of service improvement utilising HES pre and post outcome data)	Evidence of service improvement by providing: □ Analysis of HES On-line data reports (Peer review) □ Production of associated action plans as required	NHSIA data	Aug, Nov, Feb, May	Red - no report or failure to produce applicable action plan Green - report received/action plan received (if applicable)	N/A	N/A		Planned Care Divisional Director	Andrew Brown, MSK and Adam Scott, GI/Gen Surg & Urology CBU Medical Leads

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PCT QS	PE8	Patient Experience survey of PROMS patients - evidence of service change based on outcome of EMPES data	Evidence of service improvement by providing: □ Analysis of EMPES data reports (Peer review) □ Production of associated action plans as required	EMSHA report	Aug, Nov, Feb, May	Red - no report or failure to produce applicable action plan Green - report received/action plan received (if applicable)	N/A	N/A		Planned Care Divisional Director	Sarah Taylor, MSK and Fay Gordon, GI/Gen Surg & Urology CBU Managers
PCT QS	PE9	Complaints numbers	monthly data	Datix	Monthly	Red – No report received Green – Provision of figures	N/A	N/A		Director of Safety & Risk	HoN (Patient Safety Managers)
PCT QS	PE10	Complaints response times	100% responded to in timescale agreed with complainant	Datix	Monthly	Red – 89.9% or below Amber – between 90 -94.9% Green – between 95 -100%	N/A	N/A		Director of Safety & Risk	HoN (Patient Safety Managers)
PCT QS	PE11	Learning from Complaints	Analysis of top 4 complaint themes to identify areas for improvement/action plans and provide evidence of learning. 1. Communication 2. Waiting times 3. Medical Care 4. Staff attitude	Narrative Report	Aug, Nov, Feb, May	Red - no report received Amber - Report received - no evidence of learning Grenn - Evidence of learning received	N/A	N/A		Director of Safety & Risk	HoN (Patient Safety Managers)
PCT QS	PE12	Complaints re-opened	%age improvement on 10/11 outturn for reopened complaints set threshold - May 2011	Datix	Aug, Nov, Feb, May	Red - % increase in reopened complaints Amber <5% reduction in reopened complaints Green – 5% or more reduction in reopened complaints	N/A	N/A		Director of Safety & Risk	HoN (Patient Safety Managers)
PCT QS	PE13	Complaints upheld by ombudsman	Report indicating upheld complaints and identify organisational learning	Datix	Annually	Red – No report Amber – Report received but no action plan Green – Report and action plan received	N/A	N/A		Director of Safety & Risk	HoN (Patient Safety Managers)
PCT QS	PE14	Work towards achieving 'You're Welcome' status	Complete the You're Welcome self assessment within one service Q2 - Self Assessment and production of plan Q4 - Progress against plan	Self assessment	Oct, Apr	Red - No report received Green - Report received	N/A	N/A		Director of Nursing	Hilliary Killer, Chidrens CBU Manager/Lead Nurse
PCT QS	PE15	A&E service experience (Indicator 5 of A&E Indicators)	Narrative description of what has been done to assess the experience of patients using A&E services and their carers, what the results were, and what has been done to improve services in light of the results Information on the experience of a wide range of patients, carers and staff, reflecting the 24 hour nature of the service, over the whole of the previous quarter, must be collected, analysed and acted upon by providers and commissioners.	ED Patient Survey / Handhelds	Aug, Nov, Feb, May	Red – No report Amber – Report received but no action plan Green – Report and action plan received	N/A	N/A		Acute Care Divisional Director	Sue Mason, Acute Care Division HoN

PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value1	x	Exec Lead	Div Lead(s)
PCT QS	PE16	Progress in respect of Trust Patient Experience work plan	Patient Experience work plan supported by Annual Work plan Quarterly Progress Reports and Divisional action plans plus Annual Report – Q4		Quarterly Narrative Report	Green - Report received Red - No report	N/A	N/A		Director of Nursing	HoN (CBU Matrons/Ward Managers)
PCT QS	PE17	Improvement in Patient and user reported measure of respect and dignity in their treatment Out-Pt - Next survey summer 2011	Thresholds to be agreed based on latest results 10/11 Target Out-patients 93 Inpatient (TBA when results published) Emergency Dept 87 (no national survey planned in 2011)	Annually - Dashboard (Frontsheet to include narrative for exceptions). National Patient Survey	Annually - Dashboard (Frontsheet to include narrative for exceptions). NPS	Green - Threshold achieved Amber - maintenance Red - deteriorating position	N/A	N/A		Director of Nursing	HoN (CBU Matrons/Ward Managers)
PCT QS	PE18	Improvement in Patient and user reported measure of overall satisfaction with care whilst in hospital Out-Pt - Next survey summer 2011	Thresholds to be agreed based on latest results 10/11 Target Out-patients 83 Inpatient (TBA when results published) Emergency Dept 79 (no national survey planned in 2011) *For Outpatients this is the 'overall satisfaction rather than 'experience score'	Annually - Dashboard (Frontsheet to include narrative for exceptions). National Patient Survey	Annually - Dashboard (Frontsheet to include narrative for exceptions). NPS	Green - Threshold achieved Amber - maintenance Red - deteriorating position	N/A	N/A		Director of Nursing	HoN (CBU Matrons/Ward Managers)
PCT QS	PE19	Improvement in Public confidence in the local NHS Out-Pt - Next survey summer 2011	Thresholds to be agreed based on latest results 2009/10 baselines Focus on Person score - 71 (TBA when results of NPS and Staff survey published) Focus on dignity & respect score-82 (TBA when results of NPS survey published) Focus on improving as an organisation - 38 (TBA when results of NPS and staff survey published) Overall score - 63.7 (TBA)	Annually - Dashboard (Frontsheet to include narrative for exceptions). National Patient Survey	Annually - Dashboard (Frontsheet to include narrative for exceptions). NPS	Green - Threshold achieved Amber - maintenance Red - deteriorating position	N/A	N/A		Director of Nursing	HoN (CBU Matrons/Ward Managers)
PCT QS	PE20	Improvement in Patient and user reported measure of respect and dignity in their treatment	11/12 thresholds Inpatient – Adults and Children (min 95) Outpatients (min 95) EDU (min 95)	Quarterly - Dashboard (frontsheet to include narrative for exceptions). Internal Patient Exp Survey	Quarterly - Dashboard (frontsheet to include narrative for exceptions). Internal Patient Exp Survey	Green - Threshold achieved in all areas Amber - 5 points below threshold in any one area Red - >5 points below threshold in any one area	N/A	N/A		Director of Nursing	HoN (CBU Matrons/Ward Managers)
PCT QS	PE21	Improvement in Patient and user reported measure of overall satisfaction with care whilst in hospital	11/12 thresholds Inpatient – Adults and Children 85 (Overall Care) Outpatients - Adults and Children 85 (Overall care) EDU – 78 (Overall Care)	Quarterly - Dashboard (frontsheet to include narrative for exceptions). Internal Patient Exp Survey	Quarterly - Dashboard (frontsheet to include narrative for exceptions). Internal Patient Exp Survey	Green - Threshold achieved in all areas Amber - 5 points below threshold in any one area Red - >5 points below threshold in any one area	N/A	N/A		Director of Nursing	HoN (CBU Matrons/Ward Managers)
PCT QS	PE22	DSSA patient perception survey results	Trend analysis	Quarterly - Dashboard (frontsheet to include narrative for exceptions). Internal Patient Exp Survey	Quarterly - Dashboard (frontsheet to include narrative for exceptions). Internal Patient Exp Survey	Green - Report received Red - No report	N/A	N/A		Director of Nursing	HoN (CBU Matrons/Ward Managers)

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PCT QS	PE23	Improvement in Trust's Carers Survey results	Carers Survey to be completed in Feb 2011. Q1 - Results of survey and work plan. Q3 - Progress against work plan. Re-survey Feb 2012.	Bi-annually (Jun & Dec). Narrative report - To include actions to improve areas of poor or below expected experience. CLASP survey results to identify top 2-3 key themes	Bi-annually (Jun & Dec). Narrative report - To include actions to improve areas of poor or below expected experience. CLASP survey results to identify top 2-3 key themes	Q1 Green - Survey results and work plan received Red - no report received Q2 Green - Progress against work plan Red - No progress	N/A	N/A		Director of Nursing	HoN (CBU Matrons/Ward Managers)
PCT QS	PE24	Improvement in Staff satisfaction - HR Lead	Improvement in: • Recognition for good work; • Support from their immediate manager and colleagues; • Freedom to choose methods of working; • Amount of responsibility; • Opportunities to use their abilities; • Extent to which the trust values their work' • Sickness absence (no more than 3.5% Areas above to be revised based on 10/11 results	Annually. Narrative report - To include actions to improve areas of poor or below expected experience	Annually. Narrative report - To include actions to improve areas of poor or below expected experience	TBC	N/A	N/A		Director of Human Resources	Divisional Managers (CBU Managers)
PCT QS	PS1	A&E Consultant Sign-off (Indicator 8 of A&E Indicators)	The percentage of patients presenting at type 1 and 2 (major) A&E departments in certain high-risk patient groups (adults with non-traumatic chest pain, febrile children less than 1 year old and patients making an unscheduled return visit with the same condition within 72 hours of discharge) who are reviewed by an emergency medicine consultant before being discharged. Q1-2 Baseline data and agree threshold Q3 - progress towards threshold and actions identified Q4 - progress against threshold	Patient Exp Survey	Aug, Nov, Feb, May	Q1&2 Red – No report/baseline Amber – Report received but no action plan/baseline Green – Report and action plan /baselinereceived Q3 - Red - No progress towards threshold or actions Amber - No progress towards threshold but evidence of work being carried out Green - Progress towards threshold Q4 Red - Threshold not met Amber - %< threshold tbc Green - Threshold met	N/A	N/A		Acute Care Divisional Director	David Anderson, ED CBU Lead Nurse/Manager
PCT QS	PS2	HIAs Metrics Nutrition	%age improvement on 10/11 outturn: Nutritional Assessment = 90% MUST = Quarterly	Metrics and MUST Audits	Monthly / Quarterly	Green - Threshold achieved Amber <tbc% achievement Red <tbc%	N/A	N/A		Director of Nursing	HoN (CBU Matrons/Ward Managers)
PCT QS	PS3	HIA Continence: %tbc of patients to have a continence assessment within 24hours of admission or commencement of care	%age improvement on 10/11 outturn:	Nursing Metrics	Quarterly	TBC	N/A	N/A		Director of Nursing	HoN (CBU Matrons/Ward Managers)
PCT QS	PS4	Serious Incidents - never events	Monthly reporting of all never events	Datix	Monthly	Red – 1 or more never events reported Green – No Never Events reported	N/A	N/A		Director of Safety & Risk	HoN (Patient Safety Managers)

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PCT QS	PS5	Serious Incidents - trends	Report trend analysis by incident type and clinical business unit where applicable	Datix	Quarterly	Red – report not received Amber – report received but not all elements included Green – report received and all elements included	N/A	N/A		Director of Safety & Risk	HoN (Patient Safety Managers)
PCT QS	PS6	Serious Incidents - progress against action plans	Commissioner to attend UHL monthly review meeting	Narrative Report	Monthly		N/A	N/A		Director of Safety & Risk	HoN (Patient Safety Managers)
PCT QS	PS7	Risk register	Real time (>15) risks as identified on risk register to be reported. Provide quarterly update in relation to actions taken via GRMC report detailing: -New risks opened -Risks closed -Changes to risk severity scores -Lengths of time risks have been on the register	Datix	Real Time plus quarterly update	Red - No report received Amber - Partial reporting Green - Reports received	N/A	N/A		Director of Safety & Risk	HoN (Patient Safety Managers)
PCT QS	PS8	Demonstrate compliance with Safeguarding Markers of Good Practice for both Children and Adults	a) Demonstrate compliance with UHL relevant Markers of Good Practice for Safeguarding Children (Markers 2) and production of appropriate action plan for areas of non-compliance b) Demonstrate compliance with Markers of Good Practice for Safeguarding Vulnerable Adults & 'Health care for All' action plan (either UHL or finalised regional Markers) & Health care for All' action plan c) Update of progress against all serious case review or Significant Incident learning process (SILP) action plans	Narrative Report	Monthly / Quarterly	a) Red – below 95% compliance Amber – between 95-99.9% compliance Green – 100% compliance b) Red – below 85% compliance Amber – between 85-89.9% compliance Green – between 90 - 100% compliance c) Red – No updates Green – Updates received	N/A	N/A		Director of Nursing	HoN (CBU Matrons/Ward Managers)
PCT QS	PS9	Provide assurance with regard to addressing existing and new guidance and recommendations from national and regional reports legislation and local developments in relation to any vulnerable patients and deprivation of liberty (i.e. safeguarding adults, safeguarding children, patients with learning disabilities and mental health problems)	a) Provide details of baseline assessments against published guidance and associated action plans where applicable b) Progress in implementation of action plans where applicable	Narrative Report	Bi-annually	a) Red – no baseline provided Green – baseline provided b) Red – No progress Amber – Progress but behind schedule Green –Progress and on schedule	N/A	N/A		Director of Nursing	HoN (CBU Matrons/Ward Managers)

PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value[1]	x	Exec Lead	Div Lead(s)
PCT QS	PS10	EWS - Improvement in recording of early warning score, observations and subsequent actions	EWS – Complete/scored set of EWS observations Threshold - minimum 90% in all divisions	Nursing Metrics	Quarterly	Red - <85% in any one division Amber – 85-89.9% in any one division Green - 90% in all divisions	N/A	N/A		Director of Nursing	Caroline Barclay, Senior Nurse - Outreach
PCT QS	PS11	RSVP (Reason, Story, Vitals, Plan)	Progress against work plan	Narrative Report	Quarterly	Red- no progress and no report Amber – Report received but no progress Green – Progress and on schedule	N/A	N/A		Director of Nursing	Caroline Barclay, Senior Nurse - Outreach
PCT QS	CE1	Report performance against best practice tariff: (a) time to surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an inpatient, to the start of anaesthesia RB to obtain benchmark data from National hip # database (b) admitted under the joint care of a consultant geriatrician and a consultant orthopaedic surgeon (c) admitted using an assessment protocol agreed by geriatric medicine, orthopaedic surgery and anaesthesia (d) assessed by a geriatrician in the perioperative period (within 72 hours of admission) (e) postoperative geriatrician-directed multi-professional rehabilitation team (f) fracture prevention assessments (falls and bone health)	a) 90% of all #NOFs to theatre within 36 hours set threshold following review of benchmark data/10/11 out-turn position b) Agree threshold in Q1 c) Submit a copy of assessment protocol d) Agree threshold in Q1 e) %tbc of #NoF: Staggered trajectory tbc following baseline April-11 f) Agree threshold in Q1	NHFD	Monthly	TBC Red – Amber – Green –	N/A	N/A		Planned Care Divisional Director	Andrew Brown, MSK CBU Medical Lead
PCT QS	CE2	Orthopaedics - Open fractures to theatre within 24hrs of admission	100% of patients	HISS	Monthly	Red – 89.9% or below Amber – between 90 -98.9% Green – between 99 -100%	N/A	N/A		Planned Care Divisional Director	Andrew Brown, MSK CBU Medical Lead
PCT QS	CE3	Orthopaedics - Shaft femur to theatre within 48 hours of admission	100% of patients	HISS	Monthly	Red – 89.9% or below Amber – between 90 -98.9% Green – between 99 -100%	N/A	N/A		Planned Care Divisional Director	Andrew Brown, MSK CBU Medical Lead

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PCT QS	CE4	Orthopaedics - hip infection rates - as reported to the HPA - Production on action plan based on out turn	%age reduction on Q4 10/11 data then again Q1 11/12	HPA submitted data	Annually	Red - No data/action/progress Amber – delayed data Green – data submitted/action plan (Q2)/progress against action plan	N/A	N/A		Planned Care Divisional Director	Andrew Brown, MSK CBU Medical Lead
PCT QS	CE5	Compliance with published NICE Technology Appraisals	100% compliance	Narrative Report	Sept, Dec, Mar, Jun	Red – below 95% compliance Amber – between 95-99.9% compliance Green – 100% compliance	N/A	N/A		Medical Director	Divisional Directors (CBU Medical Leads)
PCT QS	CE6	Compliance with all NICE Guidance	Position statement against implementation of all current NICE guidance	Narrative Report	Sept, Dec, Mar, Jun	Red – no position statement Green – position statement received	N/A	N/A		Medical Director	Divisional Directors (CBU Medical Leads)
PCT QS	CE7	Central Alerting System Patient Safety Alerts and Rapid Response Reports (NPSA PSA and RRR)	100% compliance compliance i.e. integration into clinical pathways and decision making.		Sept, Dec, Mar, Jun	Red – below 95% compliance Amber – between 95-99.9% compliance Green – 100% compliance	N/A	N/A		Director of Safety & Risk	Divisional Managers (CBU Managers)
PCT QS	CE8	Clinical Audit programme audit programme progress	Schedule of Priority 1* audits to be completed within agreed timescales *Priority 1 Audits are those that are part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP), or Audits required as a result of Care Quality Commission, CQUINs, Quality Schedule, Quality Accounts or other external regulatory bodies	Report from Audit Database	Jul, Oct, Jan, Apr	Red – Audits behind schedule, no clear plan in place or greater than 3 month delay Amber – Audits behind schedule but clear plan in place to address within 3 months Green – Audits on schedule for completion within agreed timescales	N/A	N/A		Director of Quality	Divisional Directors (CBU Medical Leads)
PCT QS	CE9	Clinical Audit assurance - progress against action plans	Demonstrate progress against all priority 1 audit action plans	Narrative Report	Quarterly	Red - no progress/no report Green - progress evidenced	N/A	N/A		Director of Quality	Divisional Directors (CBU Medical Leads)
PCT QS	CE10	External visits Schedule	a) Provide a schedule of planned review dates and inform the Director of Quality of any unannounced visits by regulatory or statutory bodies (listed below) by telephone on the day of the visit • DH (including NSTs) • CQC • SHA • HSE - relating to patient safety b) In addition NHS LCR require notification of visits from other agencies that resulted in removal of licence(s) and/or identified serious failings	Narrative Report	Real time reporting & monthly	Red – No schedule Amber – Schedule in place but fail to inform Director of Quality regarding unannounced visit Green – Schedule in place, Director of Quality informed of unannounced visits	N/A	N/A		Director of Quality	Divisional Managers (CBU Managers)

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PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value[1]	x	Exec Lead	Div Lead(s)
PCT QS	CE11	External visits report of any visits and action plans plus any removal of licences	External visit reports and action plans (where appropriate) following visits	Narrative Report	Real time reporting & monthly	Red – No plans received following visits Green – plans received	N/A	N/A		Director of Quality	Divisional Managers (CBU Managers)
PCT QS	CE12	CQC registration	Report mandatory CQC registration updates	Narrative Report	Annually	Red - no report Green - report received	N/A	N/A		Director of Quality	Divisional Managers (CBU Managers)
PCT QS	CE13	CQC registration	Report any internal areas of non-compliance	Narrative Report	May, Aug, Nov, Mar	Red – no report/below 95% of action plan progress in line with timescales Amber – between 95 -99.9% of action plan progress in line with timescales Green – 100% of action plan progress in line with timescales	N/A	N/A		Director of Quality	Divisional Managers (CBU Managers)
PCT QS	CE14	Mortality	Mortality ratios in overall relative risk mortality rates in UHL Board data and any associated actions	Dashboard and Narrative Report	Aug, Nov, Feb, May	Red - no report or failure to produce applicable action plan Green - report received/action plan received (where applicable)	N/A	N/A		Medical Director	Divisional Directors (CBU Medical Leads)
PCT QS	CE15	Reduction of hospital acquired venous thrombosis	09/10 Baseline = 0.23% To set improvement/maintenance target on 10/11 outturn Set baseline - May-11	Datix, eCRIS and narrative report	Jul, Oct, Jan, Apr	TBC	N/A	N/A		Medical Director	Divisional Directors (CBU Medical Leads)
PCT QS	CE16	Dialysis of a AV Fistula - definitive starts >90days before 1st RRT	% definitive starts (PD,HD with AVF or AVG or Renal transplant for subjects presenting more than 90 days before first RRT. Staggered trajectory to be agreed based on 10/11 results	PROTON and narrative	Aug, Nov, Feb, May	Red – achieved 80-89.9% of agreed quarterly target Amber – achieved 90-94.9% of agreed quarterly target Green – achieved 95-100% of agreed quarterly target	N/A	N/A		Acute Care Divisional Director	Nigel Brunskill, Neprhology HoS
PCT QS	CE17	Dialysis of a AV Fistula - prevalent patient definitive access	% of prevalent patient receiving dialytic therapy to provide definitive access (PD, HD with AVF or AVG) Staggered trajectory to be agreed based on 10/11 results	PROTON and narrative	Aug, Nov, Feb, May	Red – achieved 80-89.9% of agreed quarterly target Amber – achieved 90-94.9% of agreed quarterly target Green – achieved 95-100% of agreed quarterly target	N/A	N/A		Acute Care Divisional Director	Nigel Brunskill, Neprhology HoS
PCT QS	CE18	Acute Kidney Injury Improve the prevention, detection and management of acute kidney injury (AKI) in patients	Q1 – Baseline Audit and Work Programme Q2 – Progress against Work Programme Q3 – Progress against Work Programme and numbers of staff undertaken AKI training Q4 – Re-audit	APEX & HISS AND Audit	Aug, Nov, Feb, May	Red - relevant quarterly report/data not received Amber - relevant report/data received but no progress Green - relevant quarterly report/data received and progress made	N/A	N/A		Acute Care Divisional Director	tbc

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PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value1	x	Exec Lead	Div Lead(s)
PCT QS	CE19	Normalising Birth To improve the % of normal unassisted vaginal deliveries Reduce the elective c-section rate To reduce the non-elective c-section rates	Monthly figures to be submitted to CQRG % of unassisted vaginal births of all births % of elective C-section procedures of all deliveries % of non-elective c-section procedures of all deliveries plus: Q1 – Action plan Q2-Q3 – Progress against plan Q4 – 100% of C-sections to be clinically appropriate (Notes review)	Annual Audit and Quarter narrative report	Monthly / Quarterly	Red - monthly figures or quarterly report not received Amber - one element reported (monthly figures or quarterly report) Green - Monthly figures and quarterly report received	N/A	N/A		W&C Divisional Director	Ian Scudamore, Women's CBU Medical Lead (Cornelia Wiesender, Obstetric Head of Service)
PCT QS	CE20	Children's Services Dashboard	Report progress against list of indictors and provision of appropriate action plans by exception	Annual Audit and Quarter narrative report	Monthly / Quarterly	Red - monthly figures or quarterly report not received Amber - one element reported (monthly figures or quarterly report) Green - Monthly figures and quarterly report received	N/A	N/A		W&C Divisional Director	Michael Green, Childrens CBU Medical Lead
PCT QS	MM1	Report against Medicines Management dashboard RB to obtain feedback. LM to discuss MM10 with BW	Improved progress against list of indicators	Dashboard and Exception reports	Quarterly	Red – > 3 reds on dashboard Amber – any ambers or 1-2 red areas of performance against dashboard Green – performance against dashboard is 100%	N/A	N/A		Medical Director	Suzanne Khalid, Pharmacy CBU Lead/Manager
PCT QS	MM1a	Compliance with Leicester Medicines Code	98% compliance by all CBUs with all elements of the Medicines Code relating to Prescribing, Administration, Storage	Audit of all Wards/Depts	Bi-annually (quarterly if below 92%)	Red <92%; Amber 02-97%; Green 98% and above	N/A	N/A		Medical Director	Divisional Directors (CBU Medical Leads)
PCT QS	MM2a	Quantity of Medication Supplied a) on discharge - minimum of 28 days unless the patient has 14 days own supply of medicines suitable fo ruse	98% Compliance	Audit by hospital site covering all Wards	Annually (Quarterly where not met target, until compliance achieved)	Red <95%; Amber 95-97%; Green 98% and above	N/A	N/A		Medical Director	Suzanne Khalid, Pharmacy CBU Lead/Manager
PCT QS	MM2b	Quantity of Medication Supplied b) from outpatient clinic - minimum of 28 days within exceptions agreed between commissioner and provider at start of contract further to joint OPD T&F group recommendations	98% Compliance	Audit by hospital site covering all Outpatient Depts	Annually (Quarterly where not met target, until compliance achieved)	Red <95%; Amber 95-97%; Green 98% and above	N/A	N/A		Medical Director	Suzanne Khalid, Pharmacy CBU Lead/Manager
PCT QS	MM3	Compliance with Controlled Drugs regulations	100% compliance (all elements): Storage; Records; Access; Transfer (wards and hospitals); Descruction	Audit by all CBUs to include all Wards and Depts using CDs	Annually (Quarterly where not met target, until compliance achieved)	Red <95%; Amber 95-99%; Green 100%	N/A	N/A		Medical Director	Divisional Directors (CBU Medical Leads)

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PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value1	x	Exec Lead	Div Lead(s)
PCT QS	MM 4	Reporting and reduction in 10x or more and 10 x or less Medication Errors	a) 100% errors reported to NHS LCR CQR Group b) 100% action plans and completion prior to next report c) Continuous reduction in same type of error		a) and b) Quarterly c) Annually	a) and b) Red: <100% Green: 100% c) By error type Red: Equal or increase in errors Amber: Errors but a reduction Green: no errors	N/A	N/A		Medical Director	Divisional Directors (CBU Medical Leads)
PCT QS	MM 5	CQUIN - Prescribing of 1st line drugs in line with BCBV indicators	See CQUIN	See CQUIN	See CQUIN	See CQUIN	N/A	N/A		Medical Director	Divisional Directors (CBU Medical Leads)
PCT QS	MM 6	LMSG Traffic Light compliance Compliance with the LMSG Traffic Light Status of drugs and meeting local requirement for unlicensed drugs: • Black classified drugs not prescribed or transferred to primary care • RED classified drugs not transferred to primary care • AMBER classified drugs only when Shared Care Policy in place and GP has confirmed agreement • Prescribing of unlicensed drugs or drugs for unlicensed indications will not be transferred without prior GP agreement (children's BNF paediatric use excluded)	a) 0% Black drug prescribing (no exceptions) b) 0% Red drugs (excluding patient-specific exceptions agreed by GP consortium) c) 0% Amber drugs transferred to primary care without GP request and agreement d) 0% Unlicensed drugs transferred to primary care without GP agreement	a) Trust FP10 monitoring and exception report as % of total items b) and d) GP consortia exception reports as % of total items c) Trust-wide audit for Consortium specified drugs	a), b) and d) Quarterly c) Biannually (July and December)	a) b) d) Repeat of same drug prescribing or c) transfers without agreement: Red: > 0.05% Amber: 0.01 – 0.05 % Green: 0%	N/A	N/A		Medical Director	Divisional Directors (CBU Medical Leads)
PCT QS	MM 7	Medicines Reconciliation All medicines should be reconciled within 24 hours of admission to the hospital (based on NPSA guidance Level 1)	95% compliance	Trust Audit (Minimum audit sample of 50 patients for each admission unit)	Annually (before end September)	Red: < 90% Amber :90 -94.9% Green: 95% and above	N/A	N/A		Medical Director	Divisional Managers (CBU Managers)
PCT QS	MM 8	Medicines Reconciliation All medicines should be reconciled within 24 hours of admission to the hospital (based on NPSA guidance Level 1)	95% compliance	Trust Audit (Minimum audit sample of 50 patients for each admission unit)	Annually (before end September)	tbc	N/A	N/A		Medical Director	Divisional Managers (CBU Managers)
PCT QS	MM 9	Prescribing of antipsychotics for behavioural and psychological symptoms of dementia: Only atypical antipsychotic drugs (usually risperidone or olanzapine) are prescribed and only after non–drug interventions, in severe cases, at low starting doses with monthly review and usually for no more than 12 weeks	95% compliance	Trust prospective audit (all Trust patients prescribed atypical antipsychotics for a period of 1 week,)	Annually (before end September)	Red: <90% Amber: 90 – 94.9% Green: 95% and above	N/A	N/A		Medical Director	Divisional Managers (CBU Managers)

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PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value[1]	x	Exec Lead	Div Lead(s)
PCT QS	MM 10	Prescribing or recommendation to prescribe drugs which have not been approved in line with the local process Prescribers will not prescribe, ask GPs to prescribe, initiate and transfer prescribing or recommend to patients any new drug which has not been assessed/approved by the local process i.e.LMSG and funding agreed by commissioners (>£15K)	0% resquests	Consortia Exception reports as % of OP attendances	a) and b) Quarterly tbc	Red: > 0.05% Amber: 0.01-0.05% Green: 0%	N/A	N/A		Medical Director	Divisional Managers (CBU Managers)
PCT QS	MM 11	Monitored Dosage Systems are initiated and supplied only when patients demonstrate risk factors (as defined in LMSG Assessment tool) which demonstrate mental or physical impairment which will have a substantial and long term adverse effect on their ability to take or use their medicines		Trust retrospective audit (minimum audit sample of 50 patients including all CBUs where MDS routinely initiated)	Bi-annually	Audit to be repeated within 3 months if non-compliance Two consecutive RED ratings will result in the instigation of clause 31 and 32 Red- <95% Amber: 95 – 97.9% Green- 98% and above	N/A	N/A		Medical Director	Divisional Managers (CBU Managers)
PCT CPM	HQ U05, 06, 07	RTT Waits (95th percentile measures) - admitted 95th percentile - non-admitted 95th percentile - incomplete 95th percentile	23 weeks 18.3 weeks 28 weeks	RTT consultant led waiting times data collection			N/A	N/A		Chief Operating Officer/Chief Nurse	Divisional Managers (CBU Managers)
PCT CPM	SQ U24, 25, 26	RTT (Median wait measures) Median time waited for admitted and non-admitted Patients completing an RTT pathway, and for incomplete pathways	From Sarah Cooke	From Sarah Cooke			N/A	N/A		Chief Operating Officer/Chief Nurse	Divisional Managers (CBU Managers)
PCT CPM	CPM 1 (HQ U09, 10, 11, 12, 13)	A&E - % of unplanned re-attendances within 7 days of original attendances, as a proportion of A&E attendances (to include referral back by another health professional) >5% may trigger intervention	From Sarah Cooke	From Sarah Cooke			N/A	N/A		Acute Care Divisional Director	David Anderson, ED CBU Lead Nurse/Manager
PCT CPM	CP M 2	A&E - Total time spent in A&E Dept - the median, 95th percentile & single longest time spent by patients in A&E Dept for admitted & non-admitted patients - note data quality definition where time of departure is unknown >4 hours may trigger intervention	From Sarah Cooke	From Sarah Cooke			N/A	N/A		Acute Care Divisional Director	David Anderson, ED CBU Lead Nurse/Manager
PCT CPM	CP M 3	A&E - % of patients left A&E Dept without being seen >5% may trigger intervention	From Sarah Cooke	From Sarah Cooke			N/A	N/A		Acute Care Divisional Director	David Anderson, ED CBU Lead Nurse/Manager

PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value1	x	Exec Lead	Div Lead(s)
PCT CPM	CP M 4	A&E - Time to initial assessment - the longest time recorded from arrival at A&E to full initial assessment for patients >15 mins may trigger intervention	From Sarah Cooke	From Sarah Cooke			N/A	N/A		Acute Care Divisional Director	David Anderson, ED CBU Lead Nurse/Manager
PCT CPM	CP M 5	A&E - Time to treatment - time from arrival to start of definitive treatment from a decision making clinician > 60 mins may trigger intervention	From Sarah Cooke	From Sarah Cooke			N/A	N/A		Acute Care Divisional Director	David Anderson, ED CBU Lead Nurse/Manager
PCT CPM	CP M 6	A&E - Ambulatory Care - Proportion of emergency admissions via A&E where the primary diagnosis was for cellulitis	From Sarah Cooke	From Sarah Cooke			N/A	N/A		Acute Care Divisional Director	David Anderson, ED CBU Lead Nurse/Manager
PCT CPM	CP M 7	A&E - Ambulatory Care - Proportion of emergency admissions via A&E where the primary diagnosis was for DVT	From Sarah Cooke	From Sarah Cooke			N/A	N/A		Acute Care Divisional Director	David Anderson, ED CBU Lead Nurse/Manager
PCT CPM	CP M 8	A&E - Ambulatory Care - Admission rates per weighted head of population	From Sarah Cooke	From Sarah Cooke			N/A	N/A		Acute Care Divisional Director	David Anderson, ED CBU Lead Nurse/Manager
PCT CPM	CP M 9	Cancellation of elective care operation for non-clinical reasons either before or after Patient admission	From Sarah Cooke	From Sarah Cooke			N/A	N/A		Chief Operating Officer/Chief Nurse	Divisional Managers (CBU Managers)
PCT CPM	CP M 10	Provider failure to ensure that sufficient appointment slots are made available on the Choose & Book system	From Sarah Cooke	From Sarah Cooke			N/A	N/A		Chief Operating Officer/Chief Nurse	Divisional Managers (CBU Managers)
PCT CPM	CP M 11	Breach of clause 31.5 (re cancelled operations)	From Sarah Cooke	From Sarah Cooke			N/A	N/A		Chief Operating Officer/Chief Nurse	Divisional Managers (CBU Managers)
PCT CPM	CP M 12	Delayed Transfers of Care to be maintained at a minimal level	From Sarah Cooke	From Sarah Cooke			N/A	N/A		Chief Operating Officer/Chief Nurse	Divisional Managers (CBU Managers)
PCT CPM	CP M 13	Percentage of SUS data altered in period between (a) 5 operational days after month end, and (b) the Inclusion Point for the month in question	From Sarah Cooke	From Sarah Cooke			N/A	N/A		Chief Operating Officer/Chief Nurse	Divisional Managers (CBU Managers)
PCT CPM	CP M 14	Satisfaction of the Providers obligations under each A&E/Ambulance Services Handover Plan	From Sarah Cooke	From Sarah Cooke			N/A	N/A		Chief Operating Officer/Chief Nurse	David Anderson, ED CBU Lead Nurse/Manager
PCT QS	SIs	SUIs number and type	Report serious incidents to the NHS LCR within 24hrs of corporate team being informed via telephone, confidential email or standard reporting system		Monthly	tbc	N/A	N/A		Director of Safety & Risk	HoN (Patient Safety Managers)
PCT QS	SIs	SUIs timescales and progress against action plans	Completed incident reports with action plans submitted to NHS LCR in timescales set-out in SI Policy		Quarterly	tbc	N/A	N/A		Director of Safety & Risk	HoN (Patient Safety Managers)

PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value1	x	Exec Lead	Div Lead(s)
National CQUIN	Goal 1	VTE Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	% of all adult in-patients who have had a Venous-thromboembolism (VTE) risk assessment on admission to hospital Threshold = minimum 90% compliance in line with national guidance	Monthly UNIFY return Numerator: Number of adult inpatient admissions reported as having had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool Denominator: Number of adults who were admitted as inpatients (includes daycases, maternity and transfers; both elective and non-elective admissions)	Monthly	Green: threshold achieved >90% As per guidance 'for this indicator all payments must be based on achievement of at least 90%'	Q1 – Q4 payment triggered by achievement of 90% Where 90% is not achieved no payment for that month	13%		Medical Director	Divisional Directors (CBU Medical Leads)
National CQUIN	Goal 2	Patient Experience - Improve responsiveness to personal needs of patients based on 5 questions in NPS (Adult - Inpatients) a) composite score	CQC will publish full results in February 2011. This will enable Commissioners/Providers to assess if they have achieved CQUIN 10-11 goal and enable payment threshold for 11-12 Deadline to agree threshold March 2011	National Inpatient Survey Results - composite score	Annually		Q4 –target achieved – 100% of payment Improved position but target missed – 75% of payment Maintenance with evidence of work carried out – 50% Deteriorating position with evidence of work carried out – 25% payment Deteriorating position no evidence of work carried out – 0%	2%		Director of Nursing	HoN (CBU Matrons/Ward Managers)
National CQUIN	Goal 2	b) Involved in decisions about treatment/care	10/11 result = TBC 11/12 Target = TBC	National Inpatient Survey Result	Annually		Payment as above	1%		Director of Nursing	HoN (CBU Matrons/Ward Managers)
National CQUIN	Goal 2	c) Hospital staff available to talk about worries/concerns	10/11 result = TBC 11/12 Target = TBC	National Inpatient Survey Result	Annually		Payment as above	1%		Director of Nursing	HoN (CBU Matrons/Ward Managers)
National CQUIN	Goal 2	d) Privacy when discussing condition/treatment	10/11 result = TBC 11/12 Target = TBC	National Inpatient Survey Result	Annually		Payment as above	1%		Director of Nursing	HoN (CBU Matrons/Ward Managers)
National CQUIN	Goal 2	e) Informed about medication side effects	10/11 result = TBC 11/12 Target = TBC	National Inpatient Survey Result	Annually		Payment as above	1%		Director of Nursing	HoN (CBU Matrons/Ward Managers)

PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value1	x	Exec Lead	Div Lead(s)
National CQUIN	Goal 2	e) Informed who to contact if worried about condition after leaving hospital	10/11 result = TBC 11/12 Target = TBC	National Inpatient Survey Result	Annually		Payment as above	1%		Director of Nursing	HoN (CBU Matrons/Ward Managers)
Regional CQUIN	Acute 1 prev Acute 3)	Improve discharge planning (Planned and Unplanned Care) -a) Estimated Date of Discharge	% tbc of patients with an EDD set Use Jan and Feb 11 data for baseline and agree staggered trajectory	Use Nursing Metrics for discharge Numerator: Number of patients with an EDD set Denominator: Number of patients	Quarterly		100% - performance % tbc 75% - tbc% 50% - tbc% 25% - tbc% with evidence of work carried out to improve position 0% - <tbc%	2%		tbc	HoN (CBU Matrons/Ward Managers)
Regional CQUIN	Acute 1 prev Acute 3)	Improve discharge planning (Planned and Unplanned Care) -b) Carer/Relative identified for involvement in discharge planning	% tbc of patients with relative/carer identified for involvement in discharge planning Use Jan and Feb 11 data for baseline and agree staggered trajectory	Use Nursing Metrics for discharge Numerator: Number of patients with relative/carer identified where applicable Denominator: Number of patients discharged from Provider Trust	Quarterly		100% - performance % tbc 75% - tbc% 50% - tbc% 25% - tbc% with evidence of work carried out to improve position 0% - <tbc%	2%		tbc	HoN (CBU Matrons/Ward Managers)
Regional CQUIN	Acute 2 (prev Acute 4)	Smoking To improve the health of the population by ensuring that all patients who smoke are identified, provided with brief advice and referred to local stop smoking services a) Referral to Smoking Cessation Services in Pregnancy	a) % patients to be referred to stop smoking service (with consent) in: Pregnancy – 98%	Audit Numerator: % to be calculated from Number of referrals to stop smoking service (with consent) Denominator: Number of admitted patients who are smokers	Quarterly		100% payment if >98% or if only 1 patient missed 75% - 90-97.9% 50% - 80-89.9% 25% - 70-79% with evidence of work carried out to improve position 0% - <70%	1%		Director of Nursing	Jane Porter, Head of Midwifery/Lead Nurse
Regional CQUIN	Acute 2 (prev Acute 4)	Smoking Cessation b) Smoking Cessation Referral in Acute areas	b) 60% patients to be referred to stop smoking service (with consent) in the following areas: • Cardiac / respiratory wards (Medical or rehab) • Clinical Decisions Unit (GH) • CCU (GH) • Breast surgery • Surgical Acute Admission Areas • Diabetes clinic • TIA Clinic Review if further stretch appropriate for Q4 based on 10/11 out-turn	Audit Numerator: Number referred to local stop smoking services Denominator: Total number of patients Number of patients identified as smoking	Quarterly		100% payment if performance >60% 75% - 55-59.9% 50% - 50-54.9% 25% - 45-49.9% with evidence of work carried out to improve position 0% - <45% Revise if threshold changes	1%		Director of Nursing	HoN (CBU Matrons/Ward Managers)

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PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value1	x	Exec Lead	Div Lead(s)
Regional CQUIN	Acute 2 (prev Acute 4)	Smoking Cessation c) Smoking Cessation Services in Elective areas	c) Q4 threshold and staggered trajectory to be agreed on out-turn patients to be referred to stop smoking service (with consent) in: • Elective care	Audit Numerator: Number referred to local stop smoking services Denominator: Total number of patients Number of patients identified as smoking	Quarterly		100% if performance >60% 75% - 55-59.9% 50% - 50-54.9% 25% - 45-49.9% with evidence of work carried out to improve position 0% - <45%	1%		Director of Nursing	HoN (CBU Matrons/Ward Managers)
Regional CQUIN	Acute 2 (prev Acute 4)	Smoking Cessation d) Recording of smoking status in outpatients - Vascular, Breast, Head and Neck	Staggered trajectory: Q1-60% Q2-70% Q3-80% Q4-90%	Audit Numerator: Number of patients who have their smoking status recorded Denominator: Total number of patients	Quarterly		100% = quarterly trajectory achieved 75% - up to 5% under threshold 50% - up to 10% under threshold 25% - up to 20% under threshold 0% more than 20% under threshold	1%		Director of Nursing	HoN (CBU Matrons/Ward Managers)
Regional CQUIN	Acute 2 (prev Acute 4)	Smoking Cessation d) Brief Advice given to patients - Vascular, Breast, Head and Neck	%(tbc) of smokers given brief advice Q1 – Baseline and agree threshold for Q4	Audit Numerator: Number of smoking patients given brief advice Denominator: Total number of patients Number of patients identified as smoking	Quarterly		Q1 100% = Baseline data received 0% = no baseline data received Q2-Q4 100% = quarterly trajectory achieved 75% - up to 5% under threshold 50% - up to 10% under threshold 25% - up to 20% under threshold 0% more than 20% under threshold	1%		Director of Nursing	HoN (CBU Matrons/Ward Managers)
Regional CQUIN	Acute 2 (prev Acute 4)	Smoking Cessation d) Referral to Smoking Cessation Services - Vascular, Breast, Head and Neck	90% of smokers who consent to be referred to the stop smoking service by Q4	Audit Numerator: Number referred to local stop smoking services Denominator: Total number of patients Number of patients identified as smoking	Quarterly		100% = quarterly trajectory achieved 75% - up to 5% under threshold 50% - up to 10% under threshold 25% - up to 20% under threshold 0% more than 20% under threshold	1%		Director of Nursing	HoN (CBU Matrons/Ward Managers)

PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value[1]	x	Exec Lead	Div Lead(s)
Regional CQUIN	Acute 3 (prev Acute 5)	Stroke Implementation of quality statements 4 and 5 in the NICE Stroke Quality Standard a) patients weighed	a) 90% weighed at least once	Stroke Audit Database Numerator The number of patients with a new stroke episode who: • Weighed at least once Denominator Number of patients with a new stroke episode admitted to hospital	Quarterly			1%		Acute Care Divisional Director	Paul McNally, Medicine CBU Medical Lead (Martin Fotherby, Stroke Head of Service)
Regional CQUIN	Acute 3 (prev Acute 5)	Stroke Stroke Implementation of quality statements 4 and 5 in the NICE Stroke Quality Standard b) mood assessed	b) 80% mood assessed	Stroke Audit Database Numerator The number of patients with a new stroke episode who: • Have mood assessed Denominator Number of patients with a new stroke episode admitted to hospital	Quarterly			1%		Acute Care Divisional Director	Paul McNally, Medicine CBU Medical Lead (Martin Fotherby, Stroke Head of Service)
Regional CQUIN	Acute 3 (prev Acute 5)	Stroke Implementation of quality statements 4 and 5 in the NICE Stroke Quality Standard c) swallow screening within 4 hours	a) By Q4 87% Have their swallowing screened by a specially trained healthcare professional within 4 hours of admission before being given any oral food, fluid or medication and have an ongoing management plan for provision of adequate nutrition Q1 = Baseline data and agree staggered trajectory	Stroke Audit Database Numerator The number of patients with a new stroke episode who: • Have Swallow Screen within 4 hours of admission Denominator Number of patients with a new stroke episode admitted to hospital	Quarterly			1%		Acute Care Divisional Director	Paul McNally, Medicine CBU Medical Lead (Martin Fotherby, Stroke Head of Service)
Regional CQUIN	Acute 3 (prev Acute 5)	Stroke Implementation of quality statements 4 and 5 in the NICE Stroke Quality Standard d) assessed by 2 members of specialist stroke team	d) 80% Are assessed and managed by stroke nursing staff and at least one member of the specialised rehabilitation team within 24 hours of admission to hospital, and who	Stroke Audit Database Numerator The number of patients with a new stroke episode who: • Assessed and managed by stroke nursing staff plus one other member of specialised team Denominator Number of patients with a new stroke episode admitted to hospital	Quarterly			1%		Acute Care Divisional Director	Paul McNally, Medicine CBU Medical Lead (Martin Fotherby, Stroke Head of Service)

[1] CQUIN Values - PCT CQUINs = % of total CQUIN monies. EMSCG = proportion of the 1.5% of the CQUIN monies)

PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value[1]	x	Exec Lead	Div Lead(s)
Regional CQUIN	Acute 3 (prev Acute 5)	Stroke Implementation of quality statements 4 and 5 in the NICE Stroke Quality Standard e) assessed and managed by all relevant members of stroke MDT	e) 80% Are assessed and managed by all relevant members of the specialised rehabilitation team within 72 hours of admission to hospital, and who	Stroke Audit Database Numerator The number of patients with a new stroke episode who: • are assessed and managed by all relevant members of the team within 72 hours Denominator Number of patients with a new stroke episode admitted to hospital	Quarterly			1%		Acute Care Divisional Director	Paul McNally, Medicine CBU Medical Lead (Martin Fotherby, Stroke Head of Service)
Regional CQUIN	Acute 3 (prev Acute 5)	Stroke Implementation of quality statements 4 and 5 in the NICE Stroke Quality Standard f) documented multidisicplinary goals within 5 days of admission	f) 90% have documented multidisciplinary goals agreed within 5 days of admission to hospital	Stroke Audit Database Numerator The number of patients with a new stroke episode who: • have documented multidisciplinary goals with 5 days Denominator Number of patients with a new stroke episode admitted to hospital	Quarterly			1%		Acute Care Divisional Director	Paul McNally, Medicine CBU Medical Lead (Martin Fotherby, Stroke Head of Service)
Regional CQUIN	Acute 3 (prev Acute 5)	Stroke Implementation of quality statements 4 and 5 in the NICE Stroke Quality Standard g) brain scan within 1 hour	g) 50% of patients have brain scan within 1 hour (when suspected stroke on admission)	Stroke Audit Database Numerator The number of patients with a new stroke episode who: • have suspected stroke on admission and who have brain scan within 1 hour Denominator Number of patients with a new stroke episode admitted to hospital	Quarterly			1%		Acute Care Divisional Director	Paul McNally, Medicine CBU Medical Lead (Martin Fotherby, Stroke Head of Service)
Regional CQUIN	Acute 3 (prev Acute 5)	Stroke Implementation of quality statements 4 and 5 in the NICE Stroke Quality Standard h) joint care plans on discharge	h) 85% of patients with joint care plans on discharge from hospital by end Q	Stroke Audit Database Numerator The number of patients with a new stroke episode who: • have joint care plans on discharge Denominator Number of patients with a new stroke episode admitted to hospital	Quarterly			1%		Acute Care Divisional Director	Paul McNally, Medicine CBU Medical Lead (Martin Fotherby, Stroke Head of Service)

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PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value1	x	Exec Lead	Div Lead(s)
Regional CQUIN	Acute 3 (prev Acute 5)	Stroke Implementation of quality statements 4 and 5 in the NICE Stroke Quality Standard i) patients presenting with stroke with AF have anticoagulation plan on discharge	i) 60% of patients presenting with stroke with AF have an anticoagulation plan on discharge	Stroke Audit Database Numerator The number of patients with a new stroke episode who: • have AF and who have anticoagulation plan on discharge Denominator Number of patients with a new stroke episode admitted to hospital	Quarterly			1%		Acute Care Divisional Director	Paul McNally, Medicine CBU Medical Lead (Martin Fotherby, Stroke Head of Service)
Regional CQUIN	Acute 4 - Part 1 (Prev Acute 6)	Falls - To improve patient safety and reduce the incidence of additional healthcare activity as a result of fall severity whilst in the care of the Trust i) screening for risk of falling whilst in hospital	a) %tbc Patients to receive an initial screening for likelihood of risk of falling by Q4. Agree threshold and staggered trajectory based on Q1 data	Nursing Metrics Numerator: All patients who have had an initial screen for likelihood of risk of falling Denominator: All patients within agreed areas	Quarterly		Q1 – 100% baseline and agreed work programme received 50% - baseline provided 0% - no baseline and no agreed work programme Q2-4 100% = quarterly trajectory achieved 75% - up to 5% under threshold 50% - up to 10% under threshold 25% - up to 20% under threshold 0% more than 20% under threshold	1%		Director of Nursing	HoN (CBU Matrons/Ward Managers)
Regional CQUIN	Acute 4 - Part 1 (Prev Acute 6)	Falls ii) full risk assessment where screening identified 'at risk'	b) %tbc of those patients identified as 'at risk' to receive a full risk assessment using a clinically appropriate evidenced based falls risk assessment tool within 24 hours of admission or commencement of care by Q4 (exclusions to be agreed locally) Agree threshold and staggered trajectory based on Q1 data	Nursing Metrics Numerator: Patients who have received a full risk assessment Denominator: All patients identified as requiring a full falls risks assessment	Quarterly		Payment as above	1%		Director of Nursing	HoN (CBU Matrons/Ward Managers)
Regional CQUIN	Acute 4 - Part 1 (Prev Acute 6)	Falls iii) care plan if found at risk to include ongoing assessment and bed rail assessment	c) Evidence to show those receiving a full risk assessment and found to be at risk have: • a care plan • ongoing assessment with identified timeframes • a bedrail assessment	Nursing Metrics Numerator: All patients having all three pieces of evidence Denominator: All patients identified as requiring a full falls risks assessment	Quarterly		Payment as above	1%		Director of Nursing	HoN (CBU Matrons/Ward Managers)

PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value1	x	Exec Lead	Div Lead(s)
Regional CQUIN	Acute 4 - Part 1 (Prev Acute 6)	Falls iv) postive reduction in falls for areas with high numbers	d) Leading to a positive reduction in high risk areas – timescales and thresholds to be agreed locally Focus on 3 areas – Agree threshold based on Q1 data Q1- baseline data and agree staggered trajectory (July 2011) Q2 – Action Plan Q3 - % threshold tbc Q4 % threshold tbc	Datix Query - Narrative report	Quarterly		Q1 – 100% baseline and agreed work programme received 0% - no baseline data Q2 100% action plan received 0% - no action plan Q3-4 100% = quarterly trajectory achieved 75% - up to 5% under threshold 50% - up to 10% under threshold 25% - up to 20% under threshold 0% more than 20% under threshold	1%		Director of Nursing	HoN (CBU Matrons/Ward Managers)
Regional CQUIN	Acute 4 - Part 2 (Prev Acute 6)	Catheters - To improve patient safety and reduce the incidence of additional healthcare activity as a result of urinary catheterisation whilst in the care of the Trust i) Evidence that ongoing reason for catheter is documented	a) Evidence that the ongoing reason for a catheter is documented. (To ensure that the replacement of a urinary catheter is clinically justified) Agree threshold based on Q1 data agreement July 2011	HII Audit / Catheter Surveillance Numerator: Number of patients with ongoing reason for catheter documented Denominator: Number of patients with	Quarterly		Q1 – 100% baseline and agreed work programme received 50% - baseline provided 0% - no baseline and no agreed work programme Q2-4 100% = quarterly trajectory achieved 75% - up to 5% under threshold 50% - up to 10% under threshold 25% - up to 20% under threshold 0% more than 20% under threshold	1%		DIPAC	HoN (CBU Matrons/Ward Managers)
Regional CQUIN	Acute 4 - Part 2 (Prev Acute 6)	ii) Evidence that correct catheter is inserted - as per UHL guidelines	b) Evidence that the correct catheter is inserted based on the recognised formula using locally.	HII Audits / Catheter Surveillance Numerator:Number of patients with correct catheter inserted Denominator: Number of patients with catheter	Quarterly		Payment as above	1%		DIPAC	HoN (CBU Matrons/Ward Managers)

PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value1	x	Exec Lead	Div Lead(s)
Regional CQUIN	Acute 4 - Part 2 (Prev Acute 6)	iii) positive reduction in proportion of catheter associated UTIs	c) Leading to a positive reduction pro-rata in the number of catheter associated UTI's. Q1- baseline data and agree staggered trajectory (July 2011) Q2 – Action Plan Q3 - % threshold tbc Q4 % threshold tbc	Narrative report	Quarterly		Q1 – 100% baseline and agreed work programme received 0% - no baseline data Q2 100% action plan received 0% - no action plan Q3-4 100% = quarterly trajectory achieved 75% - up to 5% under threshold 50% - up to 10% under threshold 25% - up to 20% under threshold 0% more than 20% under threshold	1%		DIPAC	HoN (CBU Matrons/Ward Managers)
Regional CQUIN	Acute 4 - Part 3 (Prev Acute 6)	Pressure Ulcers - To improve patient safety and reduce the incidence of additional healthcare activity as a result of pressure ulcers whilst in the care of the Trust i) screening for risk of pressure ulcers	a) %tbc of patients in the care of the trust to receive a screening to identify the need for a further risk assessment Trust threshold for grade 3 & 4 based on 2010/11 full year data By end April 2011	Nusing Metrics Numerator: All patients screened to identify the need for further risk assessment Denominator: All patients in the care of the trust	Quarterly		100% = quarterly trajectory achieved 75% - up to 5% under threshold 50% - up to 10% under threshold 25% - up to 20% under threshold 0% more than 20% under threshold	1%		Director of Nursing	HoN (CBU Matrons/Ward Managers)
Regional CQUIN	Acute 4 - Part 3 (Prev Acute 6)	ii) full risk assessment for patients at risk	b) %tbc of those identified as needing further assessment to be risk assessed using a locally agreed validated tool	Nursing Metrics Numerator: All patients risk assessed using agreed validated tool Denominator: All patients identified as need a further risk assessment	Quarterly		Payment as above	1%		Director of Nursing	HoN (CBU Matrons/Ward Managers)
Regional CQUIN	Acute 4 - Part 3 (Prev Acute 6)	iii) care plan and reassessment of care plan for those at risk	c) %tbc of those identified at risk to have evidence of: a. Care plan b. Reassessment as per plan	Nursing Metrics Numerator: All patients with a care plan and been reassessed as specified within plan Denominator: All patients identified as at risk	Quarterly		Payment as above	1%		Director of Nursing	HoN (CBU Matrons/Ward Managers)

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PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value1	x	Exec Lead	Div Lead(s)
Regional CQUIN	Acute 4 - Part 3 (Prev Acute 6)	iv) postive reduction of hospital acquired Grade 3/4 pressure ulcers and improved performance in assessment and actions needed to profile pressure ulcer incidence of all grades	d) Leading to a positive reduction in hospital acquired pressure ulcers (grade, threshold and timescales to be agreed locally) – timescales and thresholds to be agreed locally NBAreas with high numbers of pressure ulcers look for improvement performance in assessment & actions need to profile overall pressure ulcer incidence (all grades) Staggered trajectory tbc April 2011	Datix Query - Narrative report	Quarterly		Payment as above	1%		Director of Nursing	HoN (CBU Matrons/Ward Managers)
PCT CQUIN	Local 1	Communication - a) Discharge summaries to contain the specified minimum dataset to ensure the consistent completion of a comprehensive discharge summary to accompany the discharge or transfer of care	Minimum 90% compliance in all elements The suggested minimum dataset (MDS) is; • Patient information • Admission and discharge dates • Diagnosis, operations and procedures • Key test results including MRSA and C.difficile • Medication changes and medication on discharge • Actions and future plans	Audit Report	Quarterly		Q1 100% - >85% 75% - between 80-84.9% 50% - 75-79/9% 25% - 70-74.9% 0% - <70% Q2-Q4 100% –>90% 75% – between 85 - 89.9% 50% – 80% - 84.9% 25% - 75% - 79.9% 0% - less than 75%	1%		Medical Director	Divisional Directors (CBU Medical Leads)
PCT CQUIN	Local 1	Communication b) Discharge summaries to be completed and issued to patients GP within 24hrs of discharge in line with the Standard NHS Contract for acute service	b) Minimum 90% compliance Discharge information to be completed and issued to the GP practice and ongoing care provider (where appropriate) within 24 hours	Audit Report	Quarterly		100% –>90% 75% – between 85 - 89.9% 50% – 80% - 84.9% 25% - 75% - 79.9% 0% - less than 75%	1%		Medical Director	Divisional Directors (CBU Medical Leads)
PCT CQUIN	Local 1	Communication - c) Further audit where discharge letters >24 hours	c) Audit of discharge summaries to include analysis of those summaries not sent within 24 hours to include clinical complexity and risk	Audit Report	Quarterly		100% – Audit report and actions received 50% – report received no action plan 0% – no report received	4%		Medical Director	Divisional Directors (CBU Medical Leads)
PCT CQUIN	Local 1	Communication d) Outpatient letter to contain minimum dataset to ensure consistent completion	d) Outpatient letter – %tbc compliance with content bundles □ Patient information □ Date of attendance □ Diagnosis and Treatment □ Investigations and Results □ Medication Changes and medication on discharge □ Actions and future plans Agree staggered trajectory based on Q1 data agreement July 2011	Audit Report	Quarterly		100% –%tbc 75% – %tbc 50% – %tbc 25% - %tbc 0% - less than %tbc Confirm when threshold set	4%		Medical Director	Divisional Directors (CBU Medical Leads)

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PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value1	x	Exec Lead	Div Lead(s)
PCT CQUIN	Local 1	Communication e) Outpatient letter to be completed and issued to patients GP within x days	e) Outpatient letter to be completed and issued to patients GP within x days of appointment Q1 – Submit results of pilot and subsequent work programme Agree staggered trajectory - % outpatient letters sent to GP's within x days Q2-Q4 – Progress against work programme and agreed threshold	Audit Report	Quarterly	e) Q1 Green – results of pilot and comp. work programme received Red – incomplete report received Below minimum – no report received Q2-Q4 Green – progress on track and threshold met Amber – 1 element on track Below minimum – Progress not on track and threshold not met	Q1 100% – results of pilot and comp. work programme received 50% – incomplete report received 0% – no report received Q2-Q4 100% – progress on track and threshold met 50% – 1 element on track 0% – Progress not on track and threshold not met	4%		Medical Director	Divisional Directors (CBU Medical Leads)
PCT CQUIN	Local 1	Communication - f) ED Letter - content - standards to be agreed	f) Quality of content of ED letters Standard to be defined by Q1 Baseline data by Q2-Q3 Positive improvement Q4	Audit Report	Quarterly	f) Q1 Green – Content standard defined Below minimum – Standard not defined Q2-Q3 Green – Baseline data Below minimum – No baseline data Q4 Green – improvement evidenced Red – Maintenance Below minimum – deteriorating position	Q1 100% – Content standard defined 0% – Standard not defined Q2-Q3 100% – Baseline data 0% – No baseline data Q4 100% – improvement evidenced 50% – Maintenance 0% – deteriorating position	4%		Acute Care Divisional Director	David Anderson, ED CBU Lead Nurse/Manager
PCT CQUIN	Local 1	Communication - g) Response and Actions to Complaints by GPs relating to communication	g) Report on actions to improve performance relating to number of GP complaints (CASSIUS/other systems) and GP audit findings Deadline for agreeing threshold – based on Q2 (2011/12) data	Narrative report and action plan (as part of patient safety report)	Quarterly	Green – Report received includes clear SMART actions Red – Report received – no SMART actions Below minimum – No report	100% – Report received includes clear SMART actions 50% – Report received – no SMART actions 0% – No report	1%		Medical Director	Divisional Directors (CBU Medical Leads)

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PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value1	x	Exec Lead	Div Lead(s)
PCT CQUIN	Local 2	Surgical wound surveillance a) 30 day post operative surveillance and monitoring pre and post operative actions to prevent wound infections	%age of wards involved in 30 day post operative surveillance and monitoring pre and post operative actions to prevent wound infections: Q1 - baseline data for wards involved in surveillance scheme Agree staggered trajectory for roll out to additional wards Q2 – Q4 – progress against quarterly trajectory	Quarterly 30 day post operative surveillance data	Quarterly		Q1 100% - baseline data provided 0% no baseline data Q2-Q4 100% = quarterly trajectory achieved 75% - up to 5% under threshold 50% - up to 10% under threshold 25% - up to 20% under threshold 0% more than 20% under threshold	4%		DIPAC	Divisional Directors (CBU Medical Leads)
PCT CQUIN	Local 2	Surgical wound surveillance b) Pre and post operative actions to prevent wound infections	%tbc compliance with pre and post operative actions to prevent wound infections Q1 – Baseline and agree staggered trajectory		Quarterly		Q1 100% - baseline data provided 0% no baseline data Q2-Q4 100% = quarterly trajectory achieved 75% - up to 5% under threshold 50% - up to 10% under threshold 25% - up to 20% under threshold 0% more than 20% under threshold	3%		DIPAC	Divisional Directors (CBU Medical Leads)
PCT CQUIN	Local 2	Surgical wound surveillance c) Increased compliance with HIIs within areas of wound surveillance	%tbc compliance with HIIs Q1 – Baseline and agree staggered trajectory	Quarterly HII data Trust report	Quarterly		Q1 100% - baseline data provided 0% no baseline data Q2-Q4 100% = quarterly trajectory achieved 75% - up to 5% under threshold 50% - up to 10% under threshold 25% - up to 20% under threshold 0% more than 20% under threshold	1%		DIPAC	HoN (CBU Matrons/Ward Managers)
PCT CQUIN	Local 3	Community Acquired Pneumonia - a) Reduction in 30 day mortality for CURB 2 patients	a) outcome at 30 days Mortality rate baseline TBC on outturn Deadline for agreeing threshold – based on 2010/11 data	Quarterly report Q1 & Q3 – Narrative progress report Q2 & Q4 – Audit report	Quarterly		Q1&Q3 100% - Progress evidenced 0% - no report or no progress Q2&Q4 TBC when threshold agreed	2%		Acute Care Divisional Director	Jon Bennett, Respiratory & Paul McNally, Medicine CBU Medical Leads

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PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value1	x	Exec Lead	Div Lead(s)
PCT CQUIN	Local 3	Community Acquired Pneumonia - b) patients to receive first dose of antibiotics within 6 hours of hospital arrival	b) %TBC pneumonia patients to receive first dose of antibiotics within a maximum of six hours after hospital arrival TBC on outturn	Quarterly report Q1 & Q3 – Narrative progress report Q2 & Q4 – Audit report	Quarterly		Q1&Q3 100% - Progress evidenced 0% - no report or no progress Q2&Q4 TBC when threshold agreed	1%		Acute Care Divisional Director	Jon Bennett, Respiratory & Paul McNally, Medicine CBU Medical Leads
PCT CQUIN	Local 3	Community Acquired Pneumonia - c) documented assessment using CURB 65	c) %TBC of patients to have documented CURB-65 assessment TBC on outturn	Quarterly report Q1 & Q3 – Narrative progress report Q2 & Q4 – Audit report	Quarterly		Q1&Q3 100% - Progress evidenced 0% - no report or no progress Q2&Q4 TBC when threshold agreed	1%		Acute Care Divisional Director	Jon Bennett, Respiratory & Paul McNally, Medicine CBU Medical Leads
PCT CQUIN	Local 4	Urgent care - a) Implementation of Internal Professional Standards	Q1 Confirm Standards, implementation Plan and baseline audit Agree Q2-4 thresholds when baseline received	Narrative and Audit Report	Quarterly		Q1 100% - evidence of all elements of threshold submitted 50% partial evidence submitted 0% - no evidence submitted Q2-Q4 TBC when thresholds agreed in Q1	5%		Chief Operating Officer/Chief Nurse	Divisional Directors (CBU Medical Leads)
PCT CQUIN	Local 4	Urgent Care - b) Implementation of Ambulatory Care Pathways	b) Implementation of Ambulatory Care Pathways Q1 Confirm Pathways, implementation Plan and baseline audit Agree Q2-4 thresholds when baseline received	Narrative and Audit Report	Quarterly		Payment as above	5%		Chief Operating Officer/Chief Nurse	Divisional Directors (CBU Medical Leads)
PCT CQUIN	Local 4	Urgent Care - c) Improved ED/Ambulance Handover	c) Improve ED/Ambulance Handover Q1 Baseline Audit and Action Plan Agree Q2-Q4 thresholds when baseline received	Narrative and Audit Report	Quarterly		Payment as above	5%		Acute Care Divisional Director	David Anderson, ED CBU Lead Nurse/Manager
PCT CQUIN	Local 4	Urgent Care - d) Improved Timing and Timeliness of Discharge	d) Improving 'time and timeliness of discharge' Q1 Baseline Audit and agree patient groups and time frames for threshold. Action Plan Agree Q2-Q4 thresholds when baseline received	Narrative and Audit Report	Quarterly		Payment as above	5%		Chief Operating Officer/Chief Nurse	Divisional Managers (CBU Managers)

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PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value1	x	Exec Lead	Div Lead(s)
PCT CQUIN	Local 5	Improved compliance with Leicester, Leics & Rutland Formulary / Prescribing QIPP adherence, (including all current national Better Care Better Value Indicators) for UHL initiated prescribing	%tbc compliance with first line drug(s) for each of PCT top 10 drug groups. (target % determined after baseline assessment) BCBV compliance in line with PCT productivity targets □ Statins (BCBV) - % simva/prava of total □ PPIs (BCBV) - % omep/lansop of total □ ACE/ARB (BCBV) - %ACEI of total ACEI/ARB and % formulary 1st line for each group (Losartan/candesartan as % total A2RB most important) □ Ezetimibe - % of all statins + ezetimibe + combinations □ Antidiabetic drugs - % met/ sulphonylureas and met/gliclazide of total □ NSAIDs - % ibup/ naproxen and % Coxibs of total NSAIDs/coxibs □ Inhaled corticosteroids and combinations - % first choice □ Clopidogrel - % generic □ Long acting Insulin analogues - % long acting analogue (detemir/ glargine) of total intermediate/long acting but excluding mixtures (Hopefully we can agree a list of first line when we meet with diabetologists in April) □ Alendronate % of all bisphosphonates	Trust dispensing report of % compliance Corrective work plan for each non compliant drug group	tbc	RAG TBD for each target drug group	100% - 90% 75% - 85-89.9% 50% - 80- 84.9% 25% - 75 – 79.9% 0% - <75% Proportional Payment will be made based on performance of each drug	4%		Medical Director	Divisional Directors (CBU Medical Leads)
EMSCG CQUIN	Scheme 6	Cancer - a) Improved documentation of Performance Score prior to Chemotherapy	tbc % increase by Q4 in number of patients with Performance Score recorded prior to IV Chemotherapy. (% to be agreed end of Q1)	Chemo Care / Audit Report Numerator Proportion of intravenous chemotherapy cycles where the patients performance score was recorded prior to the delivery of treatment Denominator Number of cycles of intravenous chemotherapy delivered within the quartile	Quarterly		tbc	0.2		Planned Care Divisional Director	Nicky Rudd, C&H CBU Medical Lead
EMSCG CQUIN	Scheme 6	Cancer - b) 30 day post Chemotherapy Mortality Rate	Provision of 30 day mortality post chemotherapy report	M&M Narrative Report	Quarterly		N/A	0		Planned Care Divisional Director	Nicky Rudd, C&H CBU Medical Lead

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PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value1	x	Exec Lead	Div Lead(s)
EMSCG CQUIN	Scheme 6	Cancer - c) Increased provision of Home Chemotherapy	tbc % increase by Q4 in number of patients receiving home care chemotherapy. (% to be agreed end of Q1)	Chemo Care / Audit Report Numerator Proportion of patients receiving home care chemotherapy Denominator Number of patients receiving chemotherapy	Quarterly		tbc	0.05		Planned Care Divisional Director	Nicky Rudd, C&H CBU Medical Lead
EMSCG CQUIN	Scheme 6	Cancer - d) To improved cancer patients' experience	Improvement in scores on 10/11 baseline in National Cancer Patient Experience Survey and in the 3 mandatory Peer Review questions. (improvement to be agreed end of Q1)	National or Local Patient Survey	Quarterly		tbc	0.1		Planned Care Divisional Director	Jane Pickard, C&H CBU Matron
EMSCG CQUIN	Scheme 1	Reduction in cardiac excess bed days/Reducing length of stay - The proportion of patients referred as urgent, to have cardiac surgery as an in-patient (with or without transfer) within 7 days of decision to accept.	• % increase in patients being treated within 7 days following quarter 4 CQUIN performance (to be locally agreed) • No patients to wait 11 days and above	Audit	Quarterley		tbc	0.15		Acute Care Divisional Director	Nick Moore, CRCC CBU Medical Lead
EMSCG CQUIN	Scheme 2	Reduce delays in discharge planning for children on Long term ventilation a) MDT meeting	100% of children having MDT meeting within 4 weeks of decision for Long Term Ventilation	Audit	Quarterley		tbc	0.1		W&C Divisional Director	Michael Green, Childrens CBU Medical Lead
EMSCG CQUIN	Scheme 2	Reduce delays in discharge planning for children on Long term ventilation b) Documentation of 'medically fit for discharge'	100% of children on LTV have a documented 'medically fit for discharge data' statement in their notes when this agreement has been reached.	Audit	Quarterley		tbc	0.1		W&C Divisional Director	Michael Green, Childrens CBU Medical Lead
EMSCG CQUIN	Scheme 3	Neonatal - a) Increase in Cranial ultrasound	% increase (tbc) in number of neonates undergoing cranial ultrasound. % tbc by end of Q1	Badger Database/Audit	Quarterley		tbc	0.075		W&C Divisional Director	Ian Scudamore, Women's CBU Medical Lead (Andy Currie, Neonatology Head of Service)
EMSCG CQUIN	Scheme 3	Neonatal - b) Increase screening rate for retinopathy of maturity for non transferred babies < 31 weeks	increased % screening rate for retinopathy of maturity of non transferred babies <31 weeks (ie 30 weeks and 6 days) or 1251grams birth weight %tbc by end of Q1	Badger Database/Audit	Quarterley		tbc	0.075		W&C Divisional Director	Ian Scudamore, Women's CBU Medical Lead (Andy Currie, Neonatology Head of Service)
EMSCG CQUIN	Scheme 4	Burns- a) Improvemements in Pain assessment of burns patients attending outpatients clinic (adult and children)	Q1 Baseline Audit and Action Plan Q2 Progress towards threshold Q3 Progress against Action Plan By end of Q4 - 95% of Adults and Children have documented pain assessment and analgesia/advice given	Audit via Burns Network / Narrative Report on Action Plan Progress	Quarterley		tbc	0.075		Planned Care Divisional Director	Peter Conboy, Surgical Specialties and Michael Green, Children's CBU Medical Lead

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EMSCG CQUIN	Scheme 4	Burns - b) Improvements in therapy referral of burns patients attending outpatients clinic (adult & children)	Q1 Baseline Audit and Action Plan Q2 Progress towards threshold Q3 Progress against Action Plan By end of Q4 - 95% of Adults and Children have had needs reviewed and been referred for therapy assessment, where indicated	Audit via Burns Network / Narrative Report on Action Plan Progress	Quarterley		tbc	0.075		Planned Care Divisional Director	Peter Conboy, Surgical Specialties and Michael Green, Children's CBU Medical Lead
EMSCG CQUIN	Scheme 5	Renal Replacement Therapy - Increase proportion of patients offered/receiving Home Dialysis	% increase in ratio of adult renal dialysis patients being offered/receiving Home Dialysis 30% of patients by March 2013 11/12 threshold to be agreed end of Q1	Proton Report and Audit	Quarterly		tbc	0.2		Acute Care Divisional Director	Nick Moore, CRCC CBU Medical Lead (Nigel Brunskill, Nephrology Head of Service)
EMSCG CQUIN	Scheme 7	HIV - a) Increase proportion of patients commencing antiretrovial therapy with CDF count <350	% increase tbc in proportion of patients offered/receiving ARV treatment. % tbc end of Q1	Audit Numerator Number of patients who have/offered ARV treatment (locally agree target) Denominator No of patients who have had consecutive CD4 counts < 350	Quarterly		tbc	0.05		Acute Care Divisional Director	Paul McNally, Medicine and Ian Scudamore, Women's CBU Medical Leads (Iain Stephenson, Clinical Lead and Adrian Palfreeman, GU Head of Service)
EMSCG CQUIN	Scheme 7	HIV - b) Proportion of patients achieving an undetectable viral load after 1 year	% increase tbc in proportion of patients achieving an undetectable viral load after 1 year % tbc end of Q2 (excludes 'retreats')	Audit Numerator Number of patients who undetectable viral load (excludes 'retreats') Denominator No of patients who have been on ART for 12 months	Quarterly		tbc	0.05		Acute Care Divisional Director	Paul McNally, Medicine and Ian Scudamore, Women's CBU Medical Leads (Iain Stephenson, Clinical Lead and Adrian Palfreeman, GU Head of Service)
EMSCG CQUIN	Scheme 7	HIV - c) Proportion of patients offered/receiving Home delivery of ART	% increase tbc in proportion receiving home care ART % tbc end of Q3	Audit Numerator Number of patients receiving home care ART (locally agree target) Denominator Number of patients on ART	Quarterly		tbc	0.05		Acute Care Divisional Director	Paul McNally, Medicine and Ian Scudamore, Women's CBU Medical Leads (Iain Stephenson, Clinical Lead and Adrian Palfreeman, GU Head of Service)

[1] CQUIN Values - PCT CQUINs = % of total CQUIN monies. EMSCG = proportion of the 1.5% of the CQUIN monies)

PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value1	x	Exec Lead	Div Lead(s)
EMSCG CQUIN	Scheme 7	HIV - d) Testing for HIV of patients under age of 80 admitted to MAU	By end of Q4, 25% of patients under age of 80 years admitted to the MAU to be offered HIV screening	APEX Report / Audit Numerator Number of patients <80 yrs agreeing/having HIV screening test Denominator Number of patients <80 yrs admitted to MAU	Quarterly		tbc	0.05		Acute Care Divisional Director	Paul McNally, Medicine CBU Medical Lead (Mark Ardron, Emergency Medicine Head of Service)
EMSCG CQUIN	Scheme 8	Hepatitis - a) improved compliance with treatment	% increase in proportion of patients who complete the optimum course of treatment spilt by genotype group (1,4/2,3) (locally agree target)	Audit Report Numerator Number of patients completing course Denominator Number of patients on treatment	Quarterly		tbc	0.1		Acute Care Divisional Director	Paul McNally, Medicine CBU Medical Lead (Allister Grant, Clinical Lead)
EMSCG CQUIN	Scheme 8	Hepatitis- b) improved outcomes associated with Hep C treatment	tbc % increase in proportion of patients who achieve a sustained virological response split by genotype group (1,4/2,3) (excludes 'retreats')	Audit Report Numerator Number of patients achieving a sustained virological response Denominator Number of patients on treatment (excludes 'retreats')	Quarterly		tbc	0.1		Acute Care Divisional Director	Paul McNally, Medicine CBU Medical Lead (Mark Ardron, Emergency Medicine Head of Service)
EMSCG QS	EMSCGQ01	EMSCG to be fully informed of any 'never events' and 'significant adverse events'	Real time reporting	Via PCTs	Real time	tbc				Director of Safety & Risk	HoN (Patient Safety Managers)
EMSCG QS	EMSCGQ02	EMSCG to be fully informed of all specialised services currently on the provider risk register	Real time reporting	Via PCTs	Real time	tbc				Director of Safety & Risk	HoN (Patient Safety Managers)
EMSCG QS	EMSCGQ03	Neonates - Implementation of the NICE neonatal standards	Evidence working towards NICE neonatal standards	Neonatal Network assessment completed. Provider Action Plans in place	Annually		tbc			W&C Divisional Director	Ian Scudamore, Women's CBU Medical Lead (Andy Currie, Neonatology Head of Service)
EMSCG QS	EMSCGQ04	Neonates - All babies born have their temperature taken within 1st hour of delivery. All babies admitted to the neonatal unit to have a temperature ≥36C	100% of admitted babies	Via Network Quality Dashboard (CleverMed System)	Quarterly		tbc			W&C Divisional Director	Ian Scudamore, Women's CBU Medical Lead (Andy Currie, Neonatology Head of Service)
EMSCG QS	EMSCGQ05	Neonates - All parents and carers have a consultation with a senior member of medical staff in the first 24 hours	90%	Via Network Quality Dashboard (CleverMed System)	Quarterly		tbc			W&C Divisional Director	Ian Scudamore, Women's CBU Medical Lead (Andy Currie, Neonatology Head of Service)

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PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value1	x	Exec Lead	Div Lead(s)
EMSCG QS	EMSCGQ06	Haematology - BMT - Adult Survival 1 year (95% confidence interval). 100 day mortality by type	No more than 5% below national average	A report of 100 day survival post-BMT rolling cumulative figures and summarised as quarterly figures for autologous and allogeneic/unrelated transplant procedures has been repeated for Q2 Data available	Six monthly rolling programme	tbc				Planned Care Divisional Director	Nicky Rudd C&H CBU Medical Lead (Ann Hunter, Clinical Lead)
EMSCG QS	EMSCGQ07	Hamoglobinopathy - All patients should have an annual review supported by a specialist haemoglobinopathy centre. All eligible patients should have an annual TCD Screen.	100% offered.	Through East Midlands Sickle Cell and Thalassaemia Network (data manager to coordinate).	Annually	tbc				Planned Care Divisional Director	Nicky Rudd, C&H CBU Medical Lead (Clare Chapman, Clinical Lead)
EMSCG QS	EMSCGQ08	Haematology - Haemophillia - All patients using (or anticipated to use) in excess of 300,000 units of factor product annually management will be discussed at the East Midlands Haemophilia Management Group.	100% offered. 80% achieved.	Through East Midlands Haemophilia Management Group.	Annually	tbc				Planned Care Divisional Director	Nicky Rudd, C&H CBU Medical Lead (Sue Pavord, Clinical Lead)
EMSCG QS	EMSCGQ09a	Cardiac - TAVI - In hospital, 30 day and 1 year mortality rates.	Below national average as reported in National TAVI Database.	Report through Quarterly TAVI Audit Meeting.	Quarterly	tbc				Acute Care Divisional Director	Nick Moore, CRCC CBU Medical Lead (Leon Hadjinikolaou, Cardiac Surgery Head of Service)
EMSCG QS	EMSCGQ09b	Cardiac - ICD - 30 day and 1 year mortality rates.	Monitor trends across region	Report through regional ICD Group.	Annually	tbc				Acute Care Divisional Director	Nick Moore, CRCC CBU Medical Lead (Ian Hudson, Cardiology Head of Service)
EMSCG QS	EMSCGQ09c	Cardiac - Radiofrequency Catheter ablation for Atrial Fibrillation - recurrence rates post ablation (12 months).	Less than 20%	Report to EMSCG.	Annually	tbc				Acute Care Divisional Director	Nick Moore, CRCC CBU Medical Lead (Ian Hudson, Cardiology Head of Service)
EMSCG QS	EMSCGQ10a	Cancer - All Sites - Participation in randomised controlled trials.	Minimum of 7.5% of all patients by tumour site	Report	Annually	tbc				Director of R&D	Divisional Directors (CBU Medical Leads)
EMSCG QS	EMSCGQ10b	Cancer - Enhanced recovery to be in place for patient groups identified by individual Network Site Specific Group (NSSG).	Rates to be discussed at individual NSSG.	Report through NSSG.	Annually	tbc				Planned Care Divisional Director	Divisional Directors (CBU Medical Leads)
EMSCG QS	EMSCGQ10c	Cancer - Upper GI - 7 and 30 day post operative mortality by procedure type	Mortality to be within expected range compared to national outcomes	Trust report	Annually	tbc				Planned Care Divisional Director	Adam Scott, GI/Gen Surg & Urol CBU Medical Lead (John Jameson, Clinical Lead)

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PCT / EMSCG	Indicator Ref	Indicator Title and Detail	Threshold	Method of Measurement	Frequency of Reporting	RAG	Payment mechanism for Quarterly Performance	CQUIN Indicator Value1	x	Exec Lead	Div Lead(s)
EMSCG QS	EMSCGQ 10d	Cancer - HPB Surgery - Additional 60 day post-operative mortality	Mortality to be within expected range compared to national outcomes.	Audit report through Upper GI NSSG	Annually	tbc				Planned Care Divisional Director	Adam Scott, GI/Gen Surg & Urol CBU Medical Lead (John Jameson, Clinical Lead)
EMSCG QS	EMSCGQ 10e	Cancer - Colorectal - Rate of curative resections.	Less than 10% open and closed cases.	Trust report	Annually	tbc				Planned Care Divisional Director	Adam Scott, GI/Gen Surg & Urol CBU Medical Lead (John Jameson, Clinical Lead)
EMSCG QS	EMSCGQ 10f	Cancer - Colorectal - Rate of anastomosis leak.	Less than 10%	Trust Report	Annually	tbc				Planned Care Divisional Director	Adam Scott, GI/Gen Surg & Urol CBU Medical Lead (John Jameson, Clinical Lead)
EMSCG QS	EMSCGQ 10g	Cancer - Colorectal Cancer - Laparoscopic surgery	30% of colorectal surgery for cancer should be laparoscopic assisted.	Report through Colorectal NSSG	Annually	tbc				Planned Care Divisional Director	Adam Scott, GI/Gen Surg & Urol CBU Medical Lead (John Jameson, Clinical Lead)
EMSCG QS	EMSCGQ 10h	Cancer - PROMS to be agreed for all cancer sites on a regional basis and used every centre	To be reported by March 2012		Annually	tbc				Planned Care Divisional Director	Divisional Directors (CBU Medical Leads)
EMSCG QS	EMSCGQ 10i	Cancer - Prostate / Head & Neck - Improve access to IMRT for patients	5% of patients to receive IMRT.	Report through Radiotherapy NSSG.	Annually	tbc				Planned Care Divisional Director	tbc
EMSCG QS	EMSCGQ 11	Infertility Treatment - Patient satisfaction	Evidence of annual patient satisfaction survey & actions taken as a result	Report and feedback to EMSCG	Annually	tbc				W&C Divisional Director	Ian Scudamore, Women's CBU Medical Lead