Trust Board paper E

	TRUST BOARD
From:	Suzanne Hinchliffe Andrew Seddon Kevin Harris Kate Bradley
Date:	28th May 2012
CQC regulation	All

Title:	Quality & Performance Report

Author/Responsible Director: S.Hinchliffe, Chief Operating Officer/Chief Nurse
A. Seddon, Director of Finance
K. Harris, Medical Director
K. Bradley, HR Director

Purpose of the Report:
To provide members with an overview of UHL financial position, performance and quality against national, regional and local indicators for the month of April 2012.

The Report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Endorsement	

Summary / Key Points:
Financial Position

- The Trust is reporting a £1.5m deficit at the end of April, which is £0.4m adverse to the planned £1.1m deficit.
- Year to date patient care income is £0.4m (1%) adverse to Plan.
- Expenditure for the year to date is £0.3m averse to Plan. This reflects a shortfall on the 2012/13 cost improvement programme savings of £0.2m

Performance Position:

- Performance for April Type 1 & 2 is 90.5% and 92.3% including the Urgent Care Centre (UCC). Whilst this meets the April trajectory set in the remedial plan, performance remains erratic.
- Admitted performance in April stands at 93.7%, with all specialties delivering above the 90% target as expected. The non-admitted target has also achieved at 97.1% against a target of 95%. All specialties with the exception of Ophthalmology have achieved.
- The percentage of eligible patients with acute myocardial infarction who received Primary PCI within 150 minutes of calling professional help in April was 93.0% (40 of 43 patients) against a target of 75%.
- Eight of the cancer targets are delivering against performance thresholds for March (one month in arrears reporting), including the 62 day from referral to treatment target. The 31 day subsequent surgery target – this has not been achieved in March primarily due to the availability of critical care and high dependency availability

- The provisional reported sickness rate for April is 3.9%. The 12 month rolling sickness rate is 3.5%.
- Appraisal rate for April is 93.7%.

Quality

- MRSA – a positive month with 0 MRSA cases reported for April for the third consecutive month. The target for 2012/13 is 6 cases.
- CDifficile – April is above trajectory with 14 cases reported and an annual target for 2012/13 of 113 cases. May incidences reported to date is 0.
- In April 2012 UHL breach data declared 3 unjustified SSA breaches affecting 7patients. All the breaches occurred on Acute Medical Unit (AMU).
- There were 22 grade 3 and 4 ulcers reported in March 2012. To date, ten pressure ulcers have been classified as avoidable and four were unavoidable but these decisions still need to be ratified by the commissioners.
- The NET Promoter score is 51.0% and data coverage has been achieved. The Trust overall Respect & Dignity score has improved for April and remains RAG rated Green.
- Mortality - There were fewer 'in-hospital deaths' in April than in the previous 2 months, however the crude mortality rate was higher due to the reduced number of admissions (2,500 patients less than in March).
- Quality/CQUIN - Of the 86 Quality Schedule indicators due to be reported in Q4:- 71 were fully met (Green),6 were partially met (Amber),6 were not met (Red),3 still to be confirmed
- Fractured Neck of Femur 'Time to Theatre' - There were 82 patients admitted with #NOF and of these 30 breached the target. Plans for establishing the #NOF ward, with an associated increased ratio of nursing and therapy staff, have been brought forward from August to end of June. The #NOF ward will allow for both surgical and ortho-geriatric care to be concentrated in one area.
- VTE - The national CQUIN threshold of 90% has been met for all 11/12 with 'full year' performance being 93.84%.
- The re-admission standard to achieve for 2012/13 is a further 5% reduction in the readmission rate.

Recommendations: Members to note and receive the report	
Previously considered at another UHL corporate Committee ? yes – GRMC 21 May 2012 and Finance and Performance Committee 23 May 2012	
Strategic Risk Register	**Performance KPIs year to date** ALE/CQC
Resource Implications (eg Financial, HR) N/A	
Assurance Implications Underachieved targets will impact on the Provider Management Regime and the FT application	
Patient and Public Involvement (PPI) Implications Underachievement of targets potentially has a negative impact on patient experience and Trust reputation	
Equality Impact N/A	
Information exempt from Disclosure N/A	
Requirement for further review? Monthly review	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **28th MAY 2012**

REPORT BY: **SUZANNE HINCHLIFFE, CHIEF OPERATING OFFICER/CHIEF NURSE**
KEVIN HARRIS, MEDICAL DIRECTOR
KATE BRADLEY, DIRECTOR OF HUMAN RESOURCES
ANDREW SEDDON, DIRECTOR OF FINANCE

SUBJECT: **APRIL 2012 PERFORMANCE SUMMARY REPORT**

1.0 Introduction

The following paper provides an overview of the Quality & Performance April 2012 report highlighting key performance metrics and areas of escalation where required.

2.0 April 2012 Operational Performance

2.1 Infection Prevention

MRSA – a positive month with 0 MRSA cases reported for April for the third consecutive month. The target for 2012/13 is 6 cases.

CDifficile – April is above trajectory with 14 cases reported and an annual target for 2012/13 of 113 cases. May incidences reported to date is 0.

MRSA elective and non-elective screening has continued to be achieved at 100% respectively.

2.2 RTT

Admitted performance in April stands at 93.7%, with all specialties delivering above the 90% target as expected.

The non-admitted target has also achieved at 97.1% against a target of 95%. All specialties with the exception of Ophthalmology have achieved. As part of an action plan to recover the Ophthalmology performance, additional outpatient activity is currently taking place which is anticipated to resume performance at the end of June.

New standards from April 2012 include the requirement that 92% of patients on an incomplete pathway (i.e. patients waiting for a decision to treat or treatment) should have been waiting no more than 18 weeks. UHL performance for April is 95.5%. Nationally at the end of January (latest report period) 92.3% of incomplete pathways were shown to be < 18 weeks.

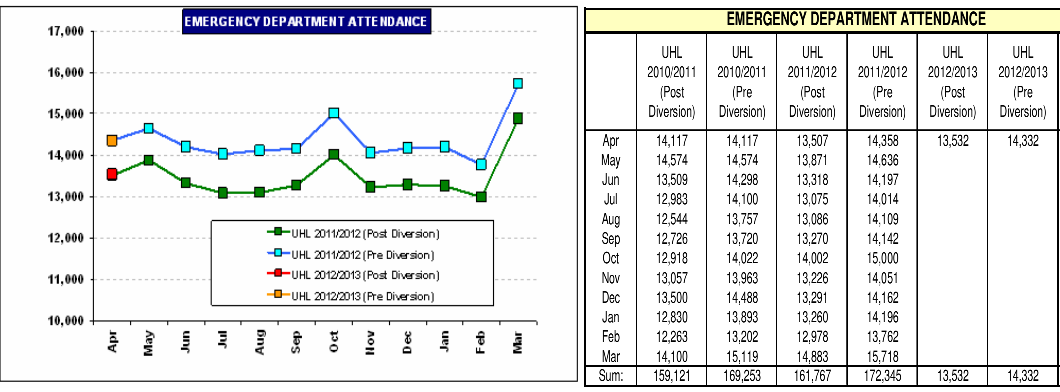
2.3 ED Activity

Performance for April Type 1 & 2 is 90.5% and 92.3% including the Urgent Care Centre (UCC). Whilst this meets the April trajectory set in the remedial plan, performance remains erratic.

Over the past few months, plans have been presented to commissioners, with the latest remedial action plan submitted in March which was shortly followed by an improvement notice as a result of continued underperformance. Despite updated plans being submitted and not accepted, these have been subsequently summarised at the Emergency Care Network and approved by UHL clinicians. Cross reference to related work streams regarding internal delays have also been made.

The following charts show attendance levels for the year and a summary overview of related performance. Further details regarding progress against the plans are appended to this report (Appendix A1 to A3).

Attendances for April are similar to last year's attendances.



EMERGENCY DEPARTMENT ATTENDANCE							
	UHL 2010/2011 (Post Diversion)	UHL 2010/2011 (Pre Diversion)	UHL 2011/2012 (Post Diversion)	UHL 2011/2012 (Pre Diversion)	UHL 2012/2013 (Post Diversion)	UHL 2012/2013 (Pre Diversion)	Overall % Change 12/13 vs 11/12
Apr	14,117	14,117	13,507	14,358	13,532	14,332	-0.2%
May	14,574	14,574	13,871	14,636			
Jun	13,509	14,298	13,318	14,197			
Jul	12,983	14,100	13,075	14,014			
Aug	12,544	13,757	13,086	14,109			
Sep	12,726	13,720	13,270	14,142			
Oct	12,918	14,022	14,002	15,000			
Nov	13,057	13,963	13,226	14,051			
Dec	13,500	14,488	13,291	14,162			
Jan	12,830	13,893	13,260	14,196			
Feb	12,263	13,202	12,978	13,762			
Mar	14,100	15,119	14,883	15,718			
Sum:	159,121	169,253	161,767	172,345	13,532	14,332	

Performance relating to breach analysis, presenting patient age profile and length of stay may be seen below.

Breach Category

Breach Category	Apr-12	%
Bed Breach	148	13%
ED Process	181	16%
ED Capacity (Cubicle Space)	60	5%
ED Capacity (Inflow)	316	28%
ED Capacity (Workforce)	90	8%
Clinical Reasons	166	15%
Specialist Assessment	33	3%
Specialist Decision	9	1%
Investigation (Imaging and Pathology)	61	6%
Transport	32	3%
Treatment	13	1%
Total	**1,109**	

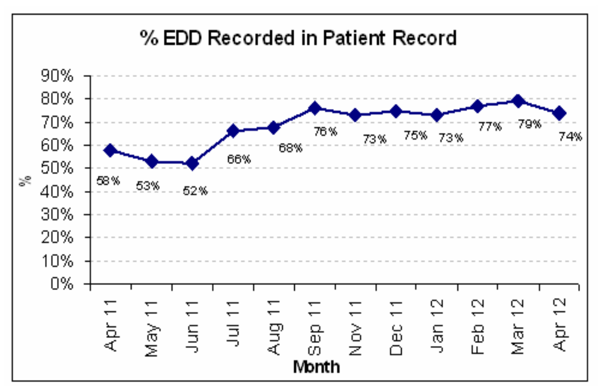
Length of Stay Comparison

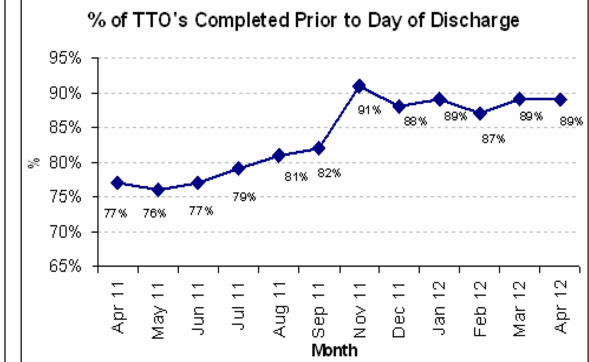
Age	Q4 09/10	Q4 10/11	Q4 11/12	% Change from 10/11
65-69 Years	6.9	7.2	6.2	-14%
70-74 Years	8.2	7.9	7.3	-8%
75-79 Years	8.9	8.9	8.1	-9%
80-84 Years	10.2	10.5	8.7	-17%
85-89 Years	11.2	11.2	9.7	-13%
90-94 Years	12.3	12.6	10.5	-17%
95-99 Years	12.1	13.0	8.6	-34%
100+ Years	7.4	10.2	10.4	2%

Presenting Age Group By Month

Age Group	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12
0-15 Years	496	568	578	640	585	567	535
16-24 Years	517	543	546	560	476	514	475
25-34 Years	534	557	554	590	609	615	614
35-44 Years	564	515	517	628	546	564	553
45-54 Years	604	635	653	664	575	599	670
55-64 Years	706	672	696	712	726	780	668
65-74 Years	820	805	947	928	922	919	936
75-84 Years	993	933	1,131	1,155	1,065	1,120	1,009
85-94 Years	602	631	751	702	697	730	709
95-104 Years	67	76	74	78	89	78	59
105+ Years			1	1		1	
Total	**5,903**	**5,935**	**6,448**	**6,658**	**6,290**	**6,487**	**6,228**

2.3.1 Quality Measures





Appendix B shows the results for the UHL Emergency Department Patient Report for April 2012.

The highlights are:

- The number of patients who have contacted their GP before coming to A&E has remained steady.
- Most patients only wait for "a few hours" before coming to A&E
- Most of the patients surveyed in ED are aware of the UCC.
- Feedback in most areas remained positive, but the number of positive responses in regards to waiting times remains low.
- 100% responses in regards to information received, and dignity and respect were positive.

2.4 Cancer Targets

Eight of the cancer targets are delivering against performance thresholds for March (one month in arrears reporting), including the 62 day from referral to treatment target.

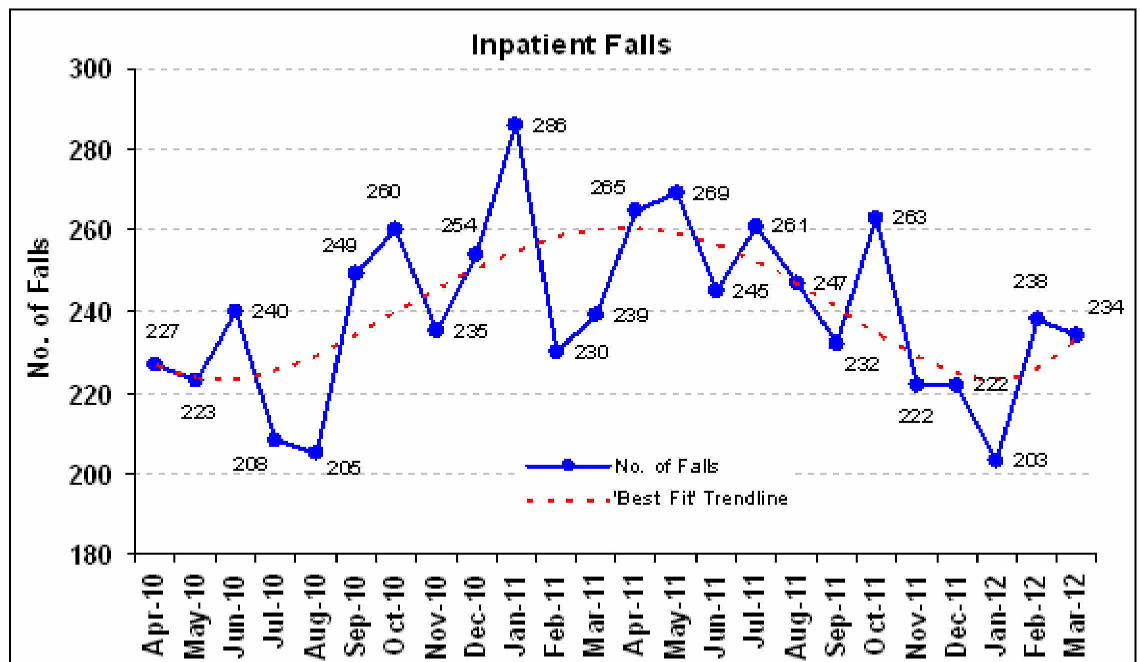
31 day subsequent surgery target – this has not been achieved in March (one month in arrears) primarily due to the availability of critical care and high dependency availability. A proposal has been received by the Executive Team for interim arrangements (Phase 1) involving the temporary increase of critical care and high dependency capacity which has

been supported. Further discussions are required with commissioners regarding any increases being sustained on a more permanent basis.

2.5 Falls

The number of inpatient falls has reduced slightly from February 2012. Recent scrutiny of the data by ward shows some significant reductions where there have been focused action plans.

All the wards have seen significant reduction in Q4 from Q1 in the number of inpatient falls. As with previous quarters the majority of incidents reported under this category relate to in-patient falls. The table below shows the number of falls reported by month/year.



An action plan was generated for the 3 wards with the highest number of falls in Q1. In addition a generic action plan to reduce falls was devised in Q2, and implemented in Q3 & Q4. All three wards have seen a significant reduction in the number of falls, comparing Q1 to Q4 data. There has also been 13% overall reduction in falls across all wards in the Trust, comparing Q1 to Q4 data.

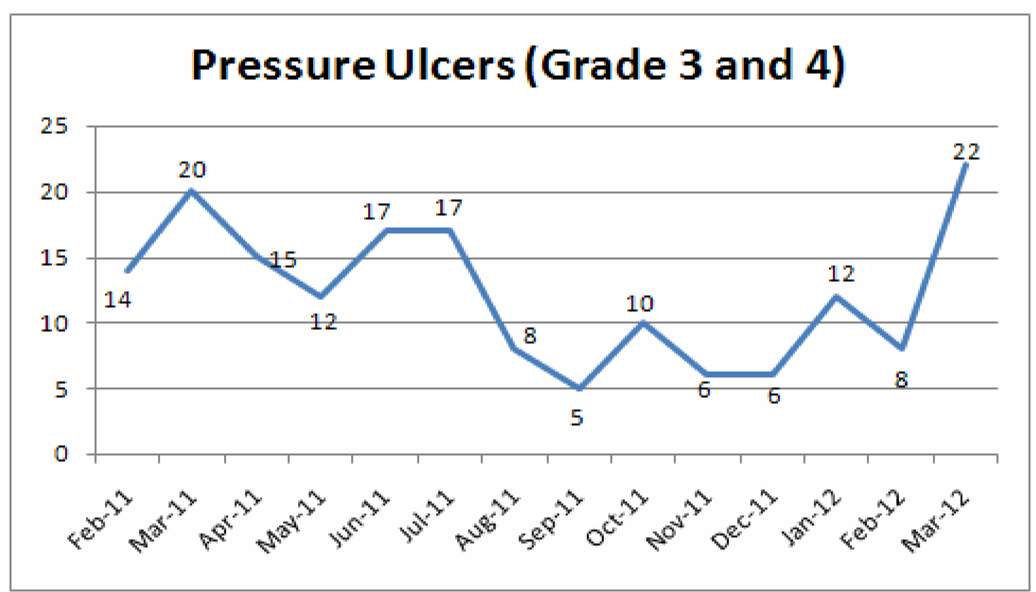
The recent introduction of the SHA Safety Thermometer across the Trust will provide benchmark data and further focus to the falls reduction programme.

As early indication of April information shows that the number of falls has reduced to 210.

2.6 Pressure Ulcers

There were 22 grade 3 and 4 ulcers reported in March 2012 which is a significant increase compared to previous months. Fifteen ulcers were reported in Acute Care and seven ulcers for Planned Care.

To date, ten pressure ulcers have been classified as avoidable and four were unavoidable but these decisions still need to be ratified by the commissioners. There are eight complex cases still awaiting review by the Tissue Viability Team. Full RCAs will now need to be completed for the majority of the incidents so it would be inappropriate to assume the reasons for the sudden increase. However, it was evident that this was a period of high intensity for the Trust with additional capacity putting a considerable strain on resources.



As part of the SHA ambition to eliminate all avoidable pressure ulcers by December 2012, an Intensive Pressure Ulcer Support Team will be visiting the Trust on the 31st May. The team, consisting of senior nurses and Tissue Viability Nurse Specialists, will review the systems and processes to eliminate pressure ulcers and highlight good practice.

An annual review of pressure ulcers for 2011/12 is being presented at the next GRMC. There has been a gradual reduction in the numbers of HAPUs across the Trust that began in July 2011 and continued throughout the year achieving an approximate 36% reduction in ulcers when comparing data from 2010/11.

The report has also identified key risk areas for the Trust in relation to the prevention and management of pressure ulcers and these include:-

- High incidence of heel ulcers as opposed to any other pressure areas.
- Insufficient patient education and involvement in pressure ulcer prevention strategies.
- Higher incidence of avoidable pressure ulcers in patients who have a degree of impaired mobility (as opposed to being completely immobile).
- Patients who have multiple transfers between wards (i.e. outlying and excluding transfers between assessment units and base wards).
- Over reliance in some ward areas on pressure relieving mattresses (possibly due to poor handover or staffing issues).

The key to successful and sustained pressure ulcer reduction has included:

- Targeted training and practice development sessions delivered by the Tissue Viability and Divisional Education teams.
- Supportive performance management processes with ward managers and matrons agreeing improvement thresholds and monitoring performance on a monthly basis.
- Effective nursing leadership, 'ownership' at ward level of pressure ulcer prevention strategies and ability of ward teams to learn from previous incidents.
- Sharing lessons learnt from RCA investigations.

Early indication for April shows 11 grade 3 and 4 ulcers.

2.7 Patient Polling

In April 2012, 1,854 Patient Experience Surveys were returned which is the largest number of surveys the Trust has ever received in one month and far exceeds the Trusts target.

This impressive return rate is a result of the response to the newly revised Patient Experience Surveys and marketing & promotion of the new Friends and Family Test - "How likely is it that you would recommend this service to friends and family?". There are 6 possible responses to this question - Extremely likely (promoter), Likely (passive), Neither likely nor unlikely, Unlikely, Not at all, Don't know (detractors). The percentage of detractors is subtracted from the percentage of promoters to obtain the overall NET Promoter score.

The NET Promoter is a regional CQUIN, 25% of payment was dependant on the Trust establishing a baseline NET promoter score for 10% of adult inpatients discharged in April, this target has been achieved. Total number of NET promoter responses: 1,225

Number of Promoters:	743
Number of passives:	364
Number of detractors:	118
Overall NET promoter score:	51.02

NET promoter scores will be benchmarked across the region to define a top quartile standard. The SHA will then set each trusts target which will either be a 10 point improvement or achieving / maintaining top quartile performance for the year. This target will be applied by the end of May 2012

The Trust overall Respect & Dignity score has improved for April and remains RAG rated Green.

The Outpatient Patient Experience Survey illustrates improvements in both overall care & respect and dignity scores - both scores are now RAG rated as Green.

2.8 Same Sex Accommodation

All UHL wards and intensivist areas continue to offer Same Sex Accommodation (SSA) in line with the UHL SSA Matrix guidance.

However, in April 2012 UHL breach data declared 3 unjustified SSA breaches affecting 7 patients. All the breaches occurred on Acute Medical Unit (AMU). A Root Cause Analysis for all three breaches that occurred in April 2012 is to be completed.

The Brain Injury Unit, LGH, will continue to report clinically justified breaches locally.

2.9 Primary PCI

The percentage of eligible patients with acute myocardial infarction who received Primary PCI within 150 minutes of calling professional help in April was 93.0% (40 of 43 patients) against a target of 75%.

2.10 2012/13 Month Supplementary 1 Performance Areas

Performance Indicator	Target	April
MRSA Elective Screening	100%	100%
MRSA Non-elective Screening	100%	100%
Stroke % stay on stroke ward*	80%	80.4%
Stroke TIA	60%	62.7%
Primary PCI	75%	93.0%
Rapid Access Chest Pain	98%	98.5%
Operations cancelled on/after day of admission	0.8%	1.1%
Cancelled patients offered a date within 28 days of cancellation	95%	86.0%
Maternity Breast Feeding <48 hrs	67%	75.4%
Cytology Screening 7 day target	98%	99.8%
Day Case Basket	75%	71.6%
Same Sex Accommodation - Base	100%	100%
Same Sex Accommodation - ICU	100%	100%

2.11 Cancelled Operations

April performance shows that the percentage of operations cancelled on/after the day of admissions of all elective activity was 1.1% compared to 1.4% for 2011/12 against a target of 0.8%

The Trust is taking forward both short and longer term improvement actions (Appendix C) designed to tackle these issues.

2.12 Revised Quality and Performance report – proposed changes to content and format for 2012/13

A draft version of the Quality and Performance report for 2012/13 is attached (Appendix D) with proposed changes to content and format. The report covers the 2011/12 period for illustrative purposes.

To simplify the report, the 'UHL at a glance' section with year to date performance has been complimented with the monthly performance information. The 'data quality'

diamonds have been extended to cover all indicators and further work will continue with Divisions to provide evidence and assurance to improve the coverage.

The report has been updated to include the indicators in the 2012/13 Operating Framework and 2012/13 Provider Management Regime. Whilst duplication of the indicators may be apparent, it is important to note that monitoring periods and scoring may be different. Key changes also include:

- ❖ Inclusion of Trust key priorities for 2012/13
- ❖ Scoring of the DoH performance against the 2012/13 Operating Framework
- ❖ Integration of the Provider Management Regime
- ❖ CQUINs – value and risks
- ❖ Key performance indicators with risk of potential contractual penalty
- ❖ Supplementary detailed reports for key performance indicators

The aim is to start populating this report with May data in time for the June Trust Board.

3.0 Medical Director's Report – Kevin Harris

3.1 Mortality Rates

There were fewer 'in-hospital deaths' in April than in the previous 2 months, however the crude mortality rate was higher due to the reduced number of admissions (2,500 patients less than in March).

UHL's RAMI for the 12 months up to March 12 is 81 using the 2012 RAMI and remains below the trust's set threshold of 85. Benchmarked data is not yet complete for the financial year.

The trust now has access to the Dr Fosters Intelligence (DFI) clinical benchmarking system which uses the 'Hospital Standardised Mortality Rate' (HSMR). This mortality indicator appears to more closely correlate with the new national SHMI.

UHL's SHMI for 11/12 won't be published until September 12 at the earliest.

UHL's HSMR for the 12 months March 11 to Feb 12 is 93.2 which is better than expected when compared with the 'Better Care Better Value' Peers. However, all trusts' HSMRs will go up following the annual 'rebasing' at the end of the financial year.

3.2 UHL Quality Schedule /CQUIN

Of the 86 Quality Schedule indicators due to be reported in Q4:-

71 were fully met (Green)
6 were partially met (Amber)
6 were not met (Red)
3 still to be confirmed

Quarter 4's performance for CQUINs was reviewed at the Clinical Quality Review Group (CQRG) meeting on 17th May. The RAG and 'payment mechanism' are still to be confirmed for 12 of the 62 indicators. Additional information is to be submitted to the

commissioners before the end of the month in order the commissioners can finalise the RAG and confirm the Q4 CQUIN monies to be paid.

3.3 Stroke - 'Time to Scan for Urgent Patients' and 'TIA Clinic'

Although Quarter 4's performance improved slightly (47%) it was still well below the CQUIN threshold of '90% of suspected stroke patients meeting the 'urgent criteria' have a brain scan within 1 hour of arrival'.

81% of urgent patients had their brain scan within 2 hours and 89% within 3 hours.

Reassuringly nearly all patients suitable for thrombolysis (who are considered to be those 'most urgent') were scanned within an hour (94%) and all within 2 hours.

Key reason for not improving performance is believed to be around increased nursing pressures due to opening extra capacity in medicine as this meant the pilot of the 'stroke nurse presence in ED' was not possible. There were also delays with the proposed 'Nurse referral for CT protocols' and there have been inconsistencies with the interpretation of 'urgent criteria'.

Quarter 4's CQUIN performance for this indicator has therefore been RAG rated Red.

'Time to scan' is a Quality Schedule indicator for 12/13 and a revised trajectory for improving performance has been submitted to the Commissioners plus the 'urgent criteria' is to be reviewed in collaboration with the Clinical Leads for the CCGs.

3.4 Fractured Neck of Femur 'Time to Theatre'

There was a further deterioration in number and % of patients taken to theatre within 36 hours during March. There were 82 patients admitted with #NOF and of these 30 breached the target. There were 4 patients who needed a full hip replacement or had other complex hip surgery requirements. 13 patients were not fit enough for surgery within 36 hours and 13 patients were cancelled due to lack of theatre time, imaging capacity or availability of senior surgeon. All patients cancelled due to lack of theatre time followed peaks of increased numbers of #NOF admissions.

Following discussions between Commissioners and the Trust, a revised target for improving performance with 'theatre within 36 hrs' has been agreed. Commissioners have asked for a staggered trajectory to achieve 72% for Quarter 4

Plans for establishing the #NOF ward, with an associated increased ratio of nursing and therapy staff, have been brought forward from August to end of June. The #NOF ward will allow for both surgical and ortho-geriatric care to be concentrated in one area.

Due to the 11% increase in #NOF admissions over 11/12 plus the increase in overall trauma, MSK have identified a need for additional trauma theatre sessions Mondays to Thursdays. This is being discussed with the TAP CBU.

3.5 Venous Thrombo-embolism (VTE) Risk Assessment

The national CQUIN threshold of 90% has been met for all 11/12 with 'full year' performance being 93.84%. However, this performance is dependent on the 'cohort patients[1]' particularly renal dialysis patients and therefore one of the priorities for 12/13 will be to ensure that performance is also at 90% for the 'non cohort' patients.

As previously reported Q3 saw an increase in the UHL HAT rate from 0.18 to 0.22 but this is considered to be a seasonal variation as review of Q3 in 10/11 shows a similar increase for the same time period. Quarter 4's data is not yet complete but the rate for January was 0.19 and in February it fell further to 0.18.

3.6 Readmissions

The proportion of readmissions and therefore the rate in March continue to fall against December/January as expected. It fell back below the 10% ECN reduction target and achieved the reduction goal of the ECN. However, this was mainly due to the proportional change in readmissions i.e. in the wider context of increases in admissions rather than a reduction in the number of readmissions, which still needs to remain a priority.

The standard to achieve for 2012/13 is a further 5% reduction in the readmission rate.

As previously reported, agreement has been reached with commissioners on a holding threshold for the penalisation of readmissions for 2012/13. The threshold is 20%. This will lead to a reduction in the baseline readmissions penalty of £5.2m in 2012/13 from 2011/12. The clinical review, led by the University, commences on 19th May and is due to report in early July. The review of over 700 cases will not only validate the threshold for penalty, but will also identify avoidable groups where investment in the penalty can then be focussed by commissioners as per the operating policy.

The clinical review, focus and agreement on the investment of the penalty and the finalisation of the actions outstanding in the project plan are now the key focus for early 2012/13.

3.7 Patient safety

Ten Early Warning Score incidents were reported within the Trust in April, which represents a decrease from the previous months. Failure to recognise signs of deterioration, failure to communicate and staff issues remain themes.
The Senior Nurse, Critical Care Outreach Services continues to follow up on each incident and to share information with the Divisional Head of Nursing.

The 5 Critical Safety Actions programme developments continue with some audits having been undertaken and new systems being reviewed. Over the last month the links between this programme and the new NHSLA standards have been scoped, and thus there is better integration between this and the Trust's focus.

All safety concerns continue to be detailed at the QPMG and GRMC meetings and at Divisional Boards.

[1] Cohort patients are those considered to be at low risk of venous thromboembolism and therefore are risk assessed as a group.

4.0 Director of Human Resources – Kate Bradley

4.1 Appraisal

There was a decrease in the rolling twelve month average appraisal rate in April, however the number of appraisals which took place during the month was the highest for four months.

Human Resources continue to work closely with Divisions and Directorates in implementing targeted actions to continue to improve appraisal performance.

4.2 Sickness

Currently the sickness rate is higher than the previous 11 months but is likely to reduce (by around 0.5%) after the absence periods have been closed down. The 12 month rolling sickness has remained at 3.5%.

Human Resources are currently working with Divisions to performance manage areas with the highest sickness rates. The revised Sickness Absence Policy is being communicated and will be operational from 1st June.

5.0 Director of Finance – Andrew Seddon

5.0 Financial position

5.1 I&E summary

The Trust is reporting a £1.5m deficit at the end of April, which is £0.4m adverse to the planned £1.1m deficit**.** Table 1 outlines the current position and Table 2 the Financial Risk Rating.

Table 1 – I&E summary

	2012/13 Annual Plan £m	April 12 Plan £m	Actual £m	Var £m
Income				
Patient income	617.7	50.4	50.1	(0.4)
Teaching, R&D	75.5	6.2	6.2	0.0
Other operating Income	27.2	2.1	2.4	0.2
Total Income	**720.4**	**58.8**	**58.6**	**(0.2)**
Operating expenditure				
Pay	435.0	36.4	37.0	(0.5)
Non-pay	242.9	19.8	19.5	0.2
Total Operating Expenditure	**677.9**	**56.2**	**56.5**	**(0.3)**
EBITDA	**42.5**	**2.6**	**2.1**	**(0.4)**
Net interest	(0.0)	(0.0)	0.0	0.0
Depreciation	(31.2)	(2.6)	(2.6)	(0.0)
PDC dividend payable	(11.3)	(1.0)	(1.0)	-
Net deficit	**0.0**	**(1.1)**	**(1.5)**	**(0.4)**
EBITDA %	**5.9%**		**3.6%**	

Table 2 – Financial Risk Ratings

		April	Year To Date	
	Weighting	**Result**	**Result**	**Score**
EBITDA achieved (% of plan)	10.0%	82.7%	82.7%	3
EBITDA margin (%)	25.0%	3.6%	3.6%	2
Return on assets (%)	20.0%	-0.1%	-0.1%	2
I&E surplus (%)	20.0%	-2.6%	-2.6%	1
Liquidity ratio (days)	25.0%	16	16	3
Overall Financial Risk Rating				2

The **month end position** may be analysed as follows

5.2 Income

5.2.1 Year to date patient care income is £0.4m (1%) adverse to Plan. This reflects an under-performance on day cases of £0.1m, elective inpatients of £0.4m and ECMO / Bone Marrow Transplants of £0.3m. These adverse movements are offset to some extent by favourable variances for Emergencies £0.3m, and outpatients £0.1m

5.3 Expenditure

5.3.1 Expenditure for the year to date is £0.3m averse to Plan. This reflects a shortfall on the 2012/13 cost improvement programme savings of £0.2m; There are also 3 extra capacity wards that are still open in April (Wards 29 and 32 at the Glenfield and Ward 37 at the LRI). Pay spend on these three wards is £0.1m in April. The Acute Division is rostering

more doctors and nurses in Medicine and ED to ensure the flow of patients from ED to support the delivery of the 4 hour target.

5.3.2 Whilst premium payments were stable between September and February, the increase in March has continued in April. This reflects the extra capacity wards but also a significant reduction in the number of contracted wte. Chart 2 shows the contracted wte graphically – this clearly shows the reduction of almost 250wte since December.

5.3.3 To ensure safe staffing levels are maintained and to speed up the recruitment process it has been agreed that nursing posts within ward establishments, including Housekeepers, will no longer require a case of need or go through the vacancy panel process. With effect from the end of April posts will need a Workforce Change Form (WCF) followed by sign off within Divisions by the Divisional Head of Nursing and then forwarded to the Director of Nursing for final approval.

Chart 1

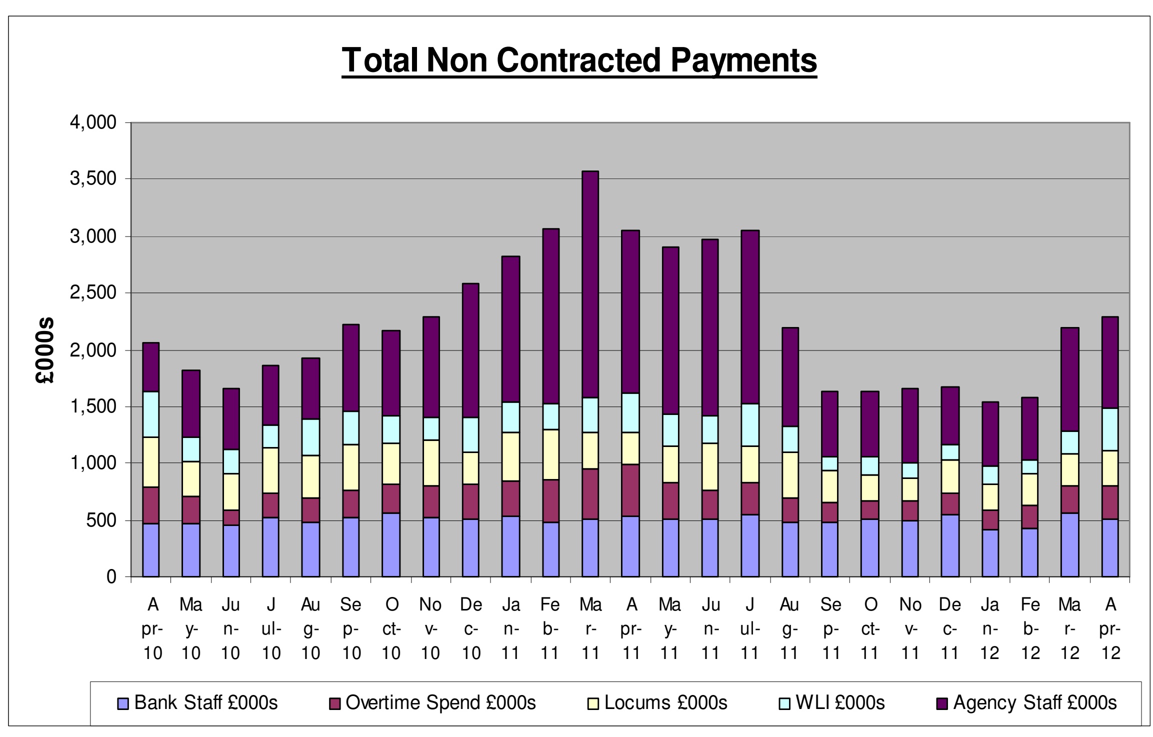
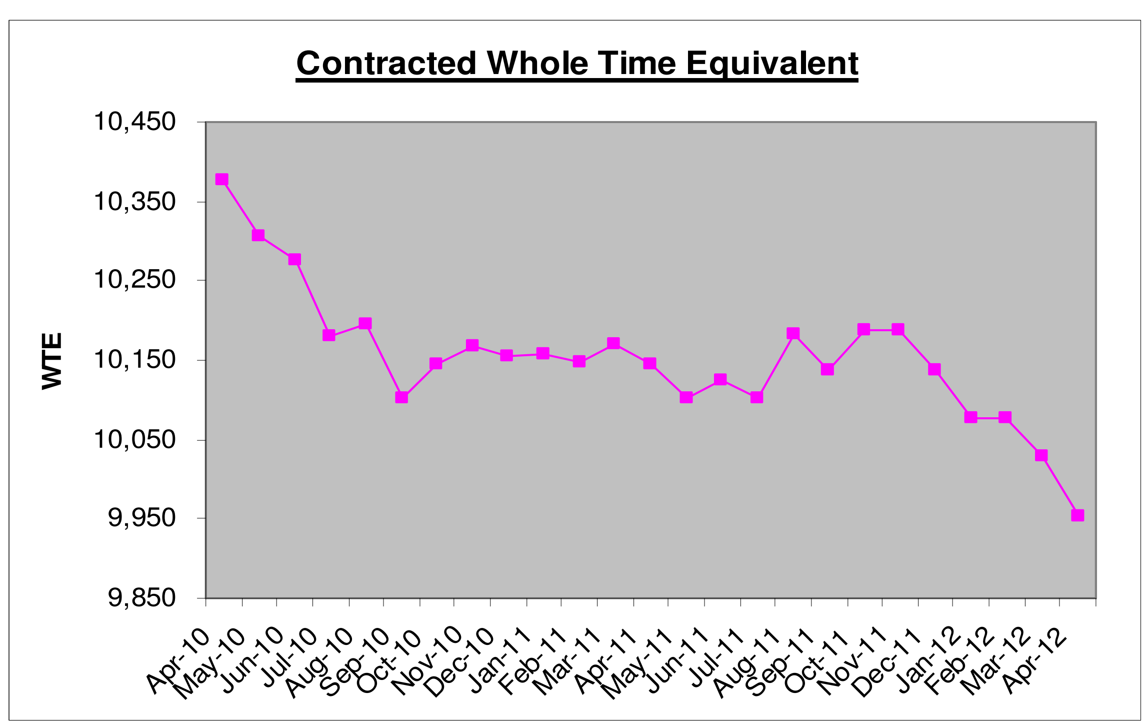


Chart 2



5.4 Divisional results

5.4.1 The table below summarises Divisional April positions:

Income and Expenditure Position for the Period Ended 30 April 2012

	Total Year to Date			
	Annual Plan £m	Plan to Date £m	Actual £m	Variance (Adv) / Fav £m
Acute Care	59.8	4.7	4.5	(0.2)
Clinical Support	(92.0)	(7.8)	(7.8)	(0.0)
Planned Care	77.6	5.3	4.7	(0.5)
Women's and Children's	22.0	1.8	1.6	(0.2)
Corporate Directorates	(85.4)	(7.2)	(7.0)	0.2
Sub-Total Divisions	(18.0)	(3.2)	(3.9)	(0.7)
Central Income	67.8	6.1	6.4	0.2
Central Expenditure	(49.7)	(4.0)	(4.0)	0.1
Grand Total	0.0	(1.1)	(1.5)	(0.4)

5.4.2 The month end position of a £1.5m deficit, (£0.4m adverse to plan) reflects a number of different factors;

Acute Care

- An under performance of £0.2m against adult ECMO (only 9 occupied adult ECMO bed days in April against a plan of 41).
- The costs of the extra capacity wards.

Planned Care

- Patient care income adverse variance £0.3m is as a result of:
    - MSK phasing of full year plan driven by 5% increase year on year
    - Specialist Surgery reduction against plan of £100k due to cancellations which were driven by higher than planned levels of GI emergencies
- Pay overspend against plan £0.15m, main reasons;
    - GI overspend of £49k driven by the need to use medical agency whilst recruitment takes place for the new consultant posts (included in plan) however premium incurred in month
    - MSK higher than anticipated use of medical agency (premium of £48k) due to vacancies and sickness (see below) 3.
- Non pay overspend against plan £0.1m as a result of GI needing to continue sending some activity to the Independent Sector to address RTT backlog issues and avoid contract penalties.

Women's & Children's

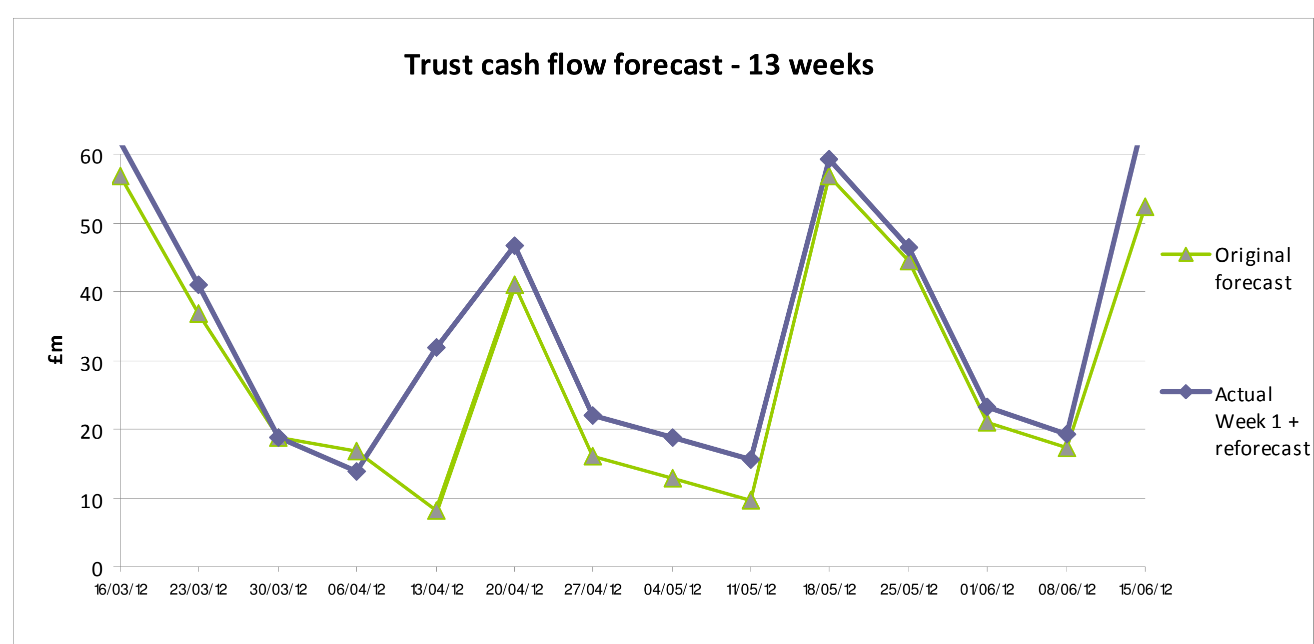
- Patient care income adverse variance of £0.2m across both CBU's, but predominately due to under performance in Obstetrics and Childrens HDU.

All Divisions are reviewing their patient care activity numbers and unit prices in light of the disappointing April position, in terms of comparisons to previous months, and April 2011. Progress on this will be verbally updated to the Committee.

5.5 Working capital and net cash

5.5.1 The Trust's closed the month of April with a cash balance £22.5m, reflecting an increase of over £4.1m from year end.

5.5.2 Cash continues to be monitored on a daily basis and to date we have maintained monthly balances in excess of £2m.



5.6 2012/13 forecast

5.6.1 In line with Department of Health timescales the Trust has the opportunity to resubmit the financials of the 2012/13 financial plan. The deadline for this resubmission is Thursday 24 May. The Divisions are currently working on these plans including the monthly phasing. Full divisional level forecasting against this revised and final plan will commence on a monthly basis thereafter (May reporting).

APPENDIX A1

IMPLEMENTING THE ACUTE CARE MODEL
DRAFT PROJECT PLAN MAY 2012

ED IMPROVEMENT PLAN - PROJECT PLAN MAY 2012

		Delivery date	MAY									JUNE																				
			21	22	23	24	25	28	29	30	31	1	4	5	6	7	8	11	12	13	14	15	18	19	20	21	22	25	26	27	28	29
LEADERSHIP																																
Appoint clinical lead for acute pathway review	D Skehan	25/05/2012																														
Identify persons	D Skehan	25/05/2012																														
Ensure appropriate skills and competencies	D Skehan	29/06/2012																														
Corporate and divisional support	D Skehan	21/05/2012																														
Report into ED Steering group	D Skehan	01/06/2021																														
EMERGENCY DEPARTMENT - WORKFORCE																																
Develop workforce strategy to fill the gaps	B Teasdale/J Halborg	Complete																														
Sign off job planning	D Skehan	27/07/2012																														
Complete full staffing review	B Teasdale/J Halborg	30/06/2012																														
Respnd to Deanery report	B Teasdale/J Halborg	Complete																														
Recruit education lead	B Teasdale/J Halborg	30/06/2012																														
Recruit OOPE	B Teasdale/J Halborg	Await ED Lead																														
Appoint ANP	J Halborg	29/06/2012																														
Acute physicians to support ED 6pm - 12 mn	P McNally	Complete																														
Provide additional registrar cover	C Shatford	wkly bookings																														
Fortnightly workforce planning meetings	J Halborg	fortnightly																														
EMERGENCY DEPARTMENT PROCESSES																																
Electronic handover from EMAS	M Watts	30/05/2012																														
Implement RAT (Rapid Assessment and Triage)	J Halborg	22/06/2012																														
Develop LEAN project plan	A Gough J Rockley	25/05/2012																														
Develop protocols for rapid transfer	B Teasdale	01/06/2012																														
Identify and recruit resources to support patient transfer (outflow nurse and dedicated transfer team)	M Watts	30/06/2012																														
Develop speciality in reach	D Skehan	15/06/2012																														
Improve robustness of data to measure performance	J Halborg	13/07/2012																														
Agree SOP for key roles and responsibilities	Lead Nurses	15/06/2012																														
Work towards 24/7 consultant cover	M Harris/D Skehan	Feb-13																														
Pilot risk based escalation policies	J Edyvean	30/06/2012																														
Pilot single clerking documentation	C Free	17/07/2012																														
Ensure access to urgent medical clinics	V Pillali	21/05/2012																														
Purchase trolleys and equipment	M Watts	15/06/2012																														
Maximise use of discharge lounge	M Watts	Daily Audit																														
Work with UCC to deflect patients further eg DVT	V Pillali	14/07/2012																														
EMERGENCY DEPARTMENT HIDDEN WAITS																																
Review of point of care testing	B Teasdale	Complete																														
Electronic requesting and reporting	M Weise	Aug-12																														
Rapid turnaround for imaging	Chris Reek	01/06/2012																														

APPENDIX A1

IMPLEMENTING THE ACUTE CARE MODEL
DRAFT PROJECT PLAN MAY 2012

Task	Lead	Date
Rapid turnaround for Pathology	Neil Doverty	01/06/2012
Agree standard turnaround & reporting times for diagnostics	N Doverty	01/06/2012
Air tube Zone 1 upgrade	Dave Finch	07/06/2012
Intallation of fast track airtube	Dave Finch	14/07/2012
Improve processes for patients attending for CT	M Watts/Lead nurses	30/06/2012
EMERGENCY DEPARTMENT FLOW		
Develop protocols for rapid transfer	B Teasdale	22/06/2012
Identify and recruit resources to support patient transfer (outflow nurse and dedicated transfer team)	M Watts	22/06/2012
Complete demand and capacity analysis/ regression analysis	S Sutherland	30/06/2012
Develop/review internal escalation plans	J Halborg	30/06/2012
Define criteria for monitored beds (ED & Medicine)	Lead nurses	07/06/2012
Develop and agree trggers for fast tracking patients	B Teasdale P McNally	01/06/2012
Develop processes to guarantee assessment unit beds	Div Leads	
EDIS installed on AMU/CDU		Complete
EDIS installed on SAU	J Ball	27/07/2012
EMERGENCY DEPARTMENT AMBULATORY CARE		
Define the ambulatory model	B Teasdale/M Weise	30/06/2012
Identify and develop ambulatory pathways	M Weise	work plan
Develop plans to release fracture clinic	J Edyvean	28/09/2012
AMU/EXTENSION OF EFU		
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SHORT STAY		
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BASE WARDS		
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DISCHARGE AND BACK DOOR		
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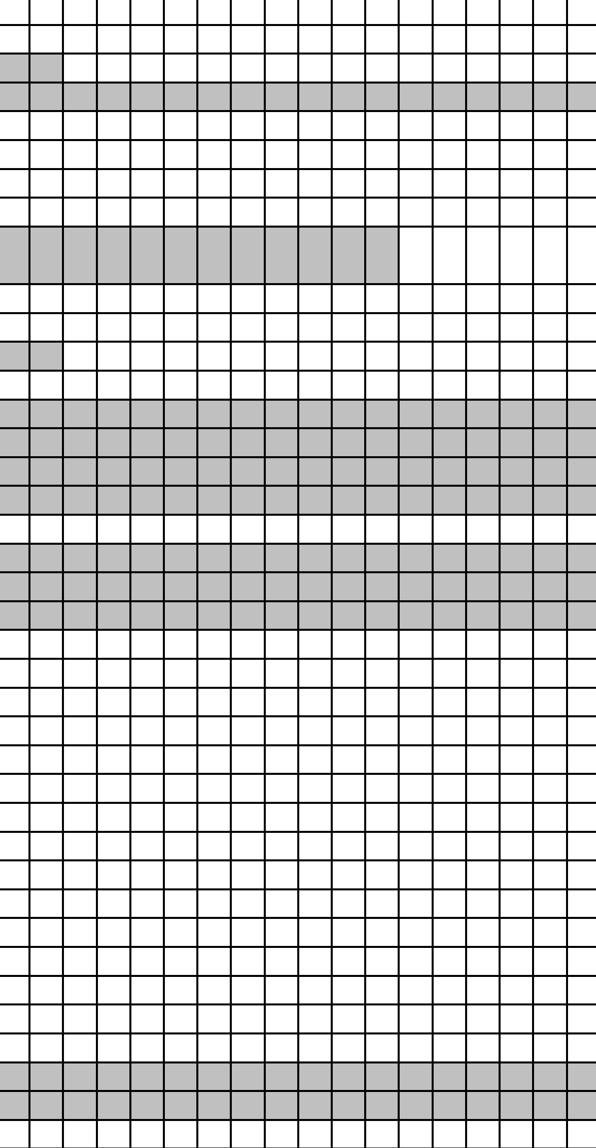
J:\Business Plans 2011-2016\Acute Division\Emergency Flow\Project Plans\Acute pathway.xlsx		
COMMUNICATION & ENGAGEMENT		
Staff communication update	J Edyvean	fortnightly
Briefing to all Divisions	M Harris	fortnightly
Briefing to Acute Division	M Harris	monthly
Feedback from Staff	Leads	weekly
Patient feedback	Lead nurses	weekly
Stakeholder engagement	D Skehan	monthly



MAY									JUNE																						JULY																					
21	22	23	24	25	28	29	30	31	1	4	5	6	7	8	11	12	13	14	15	18	19	20	21	22	25	26	27	28	29	2	3	4	5	6	9	10	11	12	13	16	17	18	19	20	23	24	25	26	27	30	31

Task	Lead	Priority
EMERGENCY DEPARTMENT		
Air tube Zone 1 upgrade	Dave Finch	H
Intallation of fast track airtube	Dave Finch	H
Implement STAT/RAT Process	Jeanette Halborg	H
Pilot risk based escalaltion policies	Jane Edyvean	H
Pilot single clerking	Catherine Free	H
Develop and agree trggers for fast tracking patients	Ben Teasdale	H
Ensure access to hot clinics	Vivek Pilali	H
24/7 cover	Ben Teasdale	H
Develop plans for emergency floor	Louise Naylor	H
Improve access to urgent clinics/imaging for UCC	Kim Wilde	H
LEVEL 1+ AREA		
Complete modelling to determine size	MH/JE	H
Identify location/beds	MH/JE/DS/SM	H
Confirm staffing	Nigel langford	H
Ensure equipment availability	Kerry Johnston	H
ASSESSMENT UNITS		
Complete bed modeling and size unit accordingly	MH/JE	H
Implement STAT process AMU (Nurse/Snr Clinician)	Nigel langford	H
Develop trigae model	Lee Walker	H
Expand monitored facilities	Ward sisters	M
Ensure rapid turnaround of diagnostics	Neil Doverty	H
Develop pharmacy supported ward rounds - AMU/CDU	Clare Ellwood	M
Develop protocols for 14 hour turnaround	Nigel langford	H
Communicate changes to staff	Chris Shatford	H
Strengthen cardiology input into CDU	Nick Moore	M
Develop protocols for admission to speciality areas	Nigel langford	H
Review internal professional standards	Simon Barton	M
Develop plans to implement profesional standards	Simon Barton	M
Senior staff presence AMU/CDU/EFU until 10pm	PMcN/JB/SC	H
Pilot risk based escalaltion policies	Jane Edyvean	H
Review OT/Physio and discharge support for CDU	Miriam Farr	M
ACUTE FRAILTY UNIT		
Complete bed modeling and size unit accordingly	MH/JE	H
Agree workforce model & recruit geriatricians	MH/JE/Simon Conro	H
Agree revised MDT staffing model	Sue Mason Neil Dove	H
Implement revised staffing model	Sue Mason Neil Doverty	
Develop and communicate protocols	Simon Conroy	H
Develop community in reach	Simon Conroy	M
Implement STAT process EFU (Nurse/Snr Clinician)	Simon Conroy	H
Ensure rapid turnaround of diagnostics	Neil Doverty	H
Develop pharmacy supported ward rounds - AMU/CDU	Clare Ellwood	M
Develop protocols for 14 hour turnaround	Simon Conroy	H
Communicate changes to staff	Simon Conroy	H
Develop protocols for admission to base wards	Simon Conroy	H
Review and agree internal professional standards	Simon Conroy	M

Task	Lead	Priority
SHORT STAY		
Review data /effectiveness of short stay unit W 37	Mei Mei Cheung	H
Complete modelling	MH/JE	H
Re circulate criteria for selection	Nigel langford	H
Educate bed management teams	Chris Shatford	H
Develop cardiology short stay GH	Luci Blackwell	L
Develop criteria for selection	N Langford	L
Educate bed management teams	Luci Blackwell	L
BASE WARDS		
Complete bed modeling and size unit accordingly	MH/JE	H
Review & realign workforce - Medical	D Skehan	H
- Nursing	Sue Mason	H
- Therapies/AHP	Neil Doverty	H
- Admin and clerica	Chris Shatford	H
- HR Management of change	Clare Blakemore	H
Implement electronic EDD	Andy Jones	M
Daily Board rounds 7/7	Andy Jones	M
Daily senior ward rounds	Paul Mc Nally	H
DISCHARGE		
BEDS Project	Andy Jones	H
Discharge 7/7	Andy Jones	H
Implement role of discharge coordinator	Andy Jones	H
Review TTO process	Simon Barton	H
Expand discharge lounge	Jane Edyvean	H
Review discharge lounge operational processes	Anna Duke	H
Engage EMAS/ARRIVA to work to new processes	Jane Edyvean	M
Work with community partners re dementia facilities	Monica Harris	M
Robust winter planning	Phil Walmsley	H
AMBULATORY CARE/Admission avoidance		
Consolidate urgent clinics LRI	C Shatford	H
Agree price for urgent clinics with commissioners	J Edyvean	H
Develop same day emergency care pathways	Lead clinicians	M
Ambulatory care pathway working group	Nigel Langford	H
Develop ambulatory care pathways - headache	Andy Palmer	M
- acute chest pain	A Farr	M
- Home IV	Phil Walmsley	M
-DVT 7/7	Julie Burdett	M
- Improve Celluitis pathw	Julie Burdett	M
Improve access to falls clinics in the community	Simon Conroy	M
CROSS DIVISIONAL PROJECTS		
Rapid turnaround for imaging	Chris Reek	H
Rapid turnaround for Pathology	Neil Doverty	H
Review of therapies workforce (7/7 provision)	Neil Doverty	M
Operational policies for air tube system	Neil Doverty	M
Robust winter planning	Phil Walmsley	H

Appendix A3
EMERGENCY PROCESS METRICS

Whilst this plan is predicated on UHL, it must be acknowledged that there are factors within this Emergency care plan where a wider LLR approach is need to facilitate delivery. The need to work in partnership is paramount to ensuring its successful implementation.

Examples in which UHL will need support include:
Discharge processes; EMAS delivery times, managing attendance, maintaining flows for dementia patients, mental health in-reach
Managing attendance to the most appropriate source is widely understood and the need to work with our partners including George Elliott - Urgent care, GP/community referrers for emergency care and the wider public is a key action.
UHL welcomes the opportunity to work closely with LLR in the joint and successful delivery of this plan.

Key to Grading

Red indicates that there is a delay in implementation due to difficulties being experienced – the reasons will be highlighted below the indictor

In process but is awaiting for completion of another action in the plan but does not necessarily mean it has been delayed or there is a delay due to complexity or concern of an unexpected happening – the reasons will be highlighted below the indictor

On target or met.

Department	Action	Enablers	Short term Achievement Q1	Metrics	Progress against action	Overall lead	RAG
Leadership	Dedicated clinical and managerial leader for the full Acute pathway review	• Established, and experienced leaders able to engage and motivate teams to deliver	Identify persons Ensure appropriate skills and competencies – Identify training needs Corporate and divisional support Report into ED Steering group	Clinician and manager identified Achievement of project plan to timescales set Evidence of engagement and feedback Staff and patient satisfaction	**New structure for CBU agreed – Discussed arrangements with medical workforce wider discussion underway.** **Seconded CBU clinical leader internal advert 28th if required – possible leaders identified**	D Skehan	In process of rebasing CBUs
All	Establish Single Clerking notes	• Agreement on single paperwork	Implementation of single clerking paperwork in medicine	100% used for patients on the acute pathway on all sites	Final draft to be agreed 4.5.12 1 Month Pilot June 2012	C Free	

Appendix A3
EMERGENCY PROCESS METRICS

Ambulatory	Develop Ambulatory services to support in-reach for GPs and an alternative to admission- OPD assessment and treatment service	• Clinic space (longer term strategy of acute floor). • Expand on current PE,DVT, Chest Pain, etc ambulatory pathways • Manpower multi-disciplinary – demand and capacity requirements – Nurse led/consultant led services	Define the ambulatory model – plan environment FBC complete in May	• Number of clinics established • Utilisation of ambulatory care • Patient, consultant and GP feedback • Benchmark national trends and compare services • Implementation for developing services – monitored at subgroup of steering group	Project group to be established to agree future work streams and inform plans for the Emergency floor Ambulatory pathways already in place: • Low risk chest pain (ED) • Pleural effusion (GH) • Pulmonary embolus (GH) • Ambulatory BB clinics (AMU) • Cellulitis • DVT	J Edyvean N Langford	

Appendix A3
EMERGENCY PROCESS METRICS

Emergency Department	Full workforce review	• Workforce strategy to support difficult recruiting to medical and nursing posts	• Define workforce strategy to bridge the gaps • Undertake full staffing review including job planning and a review of all support services • Acute physicians to support Senior consultant cover in Majors • Re-advertise ANP/ENP, Jnrs and Senior Trust grade • Use GPs within ED	• Formal review of staffing levels • Monitor vacancies • Full recruitment of consultants • Full recruitment to ANP/ENP • Extend working hours to 24hrs • Recruitment Where short falls occur look to support with acute physicians for additional medical cover and other supporting professionals	Presentation to F&P committee to agree strategy to address challenges of national shortfall in posts Job planning completed by CBU. Awaiting divisional sign off Educational lead post out to advert 28/5/12 Deanery report action plan complete OOPE posts to be advertised once Educational Lead appointed 1 ANP recruited CT1 posts out to advert Fortnightly workforce planning meetings continue Acute physicians continue to support ED with 6pm – midnight. Additional registrar cover on late shift – fill rate inconsistent.	B Teesdale J Halborg	Good recruitment medical Jnrs Generally ANP poor Concerned if applicants pull out
	Patient handover from Ambulance team by Nurse in the red/blue team	• Review roles of red and blue teams to enable them to take handover • Review of co-ordinator role	Completed within one month	• Handover time <10 minutes • 15minutes to first assessment	Electronic handover from EMAS go live – successful completion 21/5/12. Process re-design undertaken implementing change within next two weeks (1/6/12)	M Watts	A system has been agreed awaiting implementati on in 2 weeks

Appendix A3
EMERGENCY PROCESS METRICS

	STAT and treatment plan devised	• Review of hybrid STAT system and signposting • 24/7 Consultant available within the department at all times • Acute Physician presence in majors with allocated juniors • Geriatric In-reach • Surgical in-reach • In-reach of other specialities	• Immediate review and implementation • Locum Acute physician in majors • Protocol for transfer • Establish data collection to measure performance	• Assessment within 15mins • Evidence of signposting within 30 minutes • Monitor assessment time • Minimum staffing levels maintained • Evidence of Multi-disciplinary staffing which reflect demand • Physician and Geriatrician provide in reach • National Quality indictor time to assessment achieved (NQI) Q1 • National Quality indictor time to treatment (NQI Q1	Plans for experienced RN and HCA in place to support RAT process within majors– current risk as shifts requested remain unfilled. RAT already in place for Minors, paediatrics and Resus – needs to be rolled out to Majors Data accuracy of reporting addressed by department Education continues to support new systems and processes Acute physician continues 6pm – midnight Protocols for transfer will be negotiated as part of tendering process (Serco contract)	B Teasdale	Awaiting roll out in Majors - Also awaiting external assessment of clinical processes

Appendix A3
EMERGENCY PROCESS METRICS

	Diagnostics – hidden waits removed.	• Clinical reporting of diagnostic tests within 30 minutes with full • Formal reporting within 2 hours • Tube working 95% if the time • Define tests which need to be reported on and those that do not • Rationalise diagnostics by implementing protocols to ensure request based on need rather than uncertainty • Agreement to and monitoring against internal professional standards • Electronic requesting	• Review of point of care testing • Rationalisation of tests via protocol • Diagnostics being undertaken 45 minutes of being requested • Additional PSAs to compensate for when tube non functional • Electronic requesting and reporting delivered by end of April	• Diagnostics undertaken within 30 minutes from the time of being requested • Reporting of diagnostic tests within 30 minutes • Clinical reporting • National Quality indictor (NQI) achieved for arrival to treatment • Tube working 95% if the time	Additional air tube blower operational first week in June. Express air tube to be installed – Operational early July Improvements to breach reporting highlighting issues. ***Time to Initial Assessment (Minutes) - 95th Percentile*** *Target* *April* *May* *<= 15* *34* *29* ***Time from arrival to treatment (Minutes)*** *Target* *April* *May* *60* *45* *46* Discussions underway with diagnostics to improve imaging turnaround times Electronic ordering of diagnostics due for implementation August 2012 following known delays with supplier – supplier dependent	J Edyvean N Doverty Lead Nurse BTeasda	Work is on going but there are challenges installing electronic ordering - this will improve process and monitor performance

Appendix A3
EMERGENCY PROCESS METRICS

	• Patients have a definitive plan and plan for discharge or admission arranged within 180 minutes	• Patients have a decision after being 180 mins in the department • PSA attendance 100% • Access to transport within one hour of being requested • All requests for radiology are responded to within 30 minutes • Patient arrives on assessment unit within 30minutes of request • Return to community services within one hour of request • NQI total time in department admitted and non admitted	• Patients have a decision after being 180 mins in the department • PSAs report to the main ED to book in and are based within • Establish talks with EMAS to agree short term standard • Transfer within 30minutes • NQI non admitted target met	• Patients have a decision after being 180 mins in the department • PSA attendance 100% • Access to transport within one hour of being requested • Patient arrives on assessment unit within 30minutes of request • Return to community services within one hour of request • Achievement of NQI performance compliance	Cumulative Last 28 days Arrival to bed request 170mins – position same as previously reported	B Teasdale	

Appendix A3
EMERGENCY PROCESS METRICS

Flow	Patients are moved within 30 minutes of • a non monitored bed being identified • a discharge being identified • a monitored bed (non ITU) within 30 minutes of request	• Having sufficient staff to be able to transfer patients in times of high demand • Having available capacity in the appropriate destination • Escalation when difficulties in meeting requirement • Availability to monitored beds • Development of fast track clinical protocols	• Transfer team established • Demand and capacity to ensure capacity is in the right place • Escalation in times of difficulty clearly established • Define criteria for monitored beds • Clinical Protocols developed	• Transfer time compliance times monitored • 95% accuracy when requesting a monitored bed • Patient moved within 30minutes of request. • Reduced delays due to monitored or AEB beds	Significant operational and managerial support in place to maintain flow whilst processes are changed Escalation plans to be piloted w/c 28/5/12 Additional Monitored beds agreed x4	Lead Nurse for each area	Not always the bed base Awaiting demand and capacity Some delays with discharges
	Speciality pull	• Acute physician allocated to majors with supporting juniors • Signposting/fast track appropriate medical patients to assessment area • Medical and Surgical opinion within 30minutes of request	• Acute physician allocated to majors with supporting juniors • Medical Assessment unit open • Protocol to move patients to assessment units where medical in-reach is not possible	• Monitor variation and practice and performance • Responsiveness of medical and surgical opinion	Acute physicians continue to support majors 6m – midnight. Medical Registrar support agreed some problems with covering shifts Fast track processes in place for AMU's	N Langford	Not always the bed base Awaiting demand and capacity

Appendix A3
EMERGENCY PROCESS METRICS

	To assess patients within 30 minutes of arrival on fast track Assessment Unit (FTAU)	• Ability to accept patients that have not been worked up in ED • Appropriate staffing to enable assessment • Diagnostics able to respond to assessment unit (AU) • Maximum time within the unit is 90 minutes • All receiving areas to take patients within 30mins of request • Patients on trolleys must by monitored to include the time in ED	• Patients signposted and transferred to AU • Undertake staffing review • Diagnostics able to respond in 45 minutes • EDIS installed within AMU/(FTAU)	• Time to transfer from ED from request • Time for diagnostics to be returned to the clinician • Time spent in the unit > 90mins • Time to transfer to ongoing ward • Assessment time • Treatment plan with EDD	EDIS in place on CDU and AMU's	N Langford	Process in place Not always the bed base to transfer patients awaiting demand & capacity beds 1/6/12
Medical Admissions Units **Extension of EFU**	Patient stay no longer than14 hours on medical admissions	• Base wards have the capacity to accept the patients • Discharge lounge able to take beds/trolleys • No delays in discharge • Senior medical assessment available 24/7	• Aim to have 10 beds free by 11 am and 15 beds free by 4pm • Transport, TTOs and GP letter completed the day before discharge • Discharge lounge able to accept trolleys opened • Speciality in-reach established	• EDD identified for 98% patients • Patient stay<14hrs • Time to review • All patients have treatment plans • Evidence of nurse discharge according to protocol • Transport and TTO's and GP letter organised the day before	Significant management and operational effort continues to ensure capacity on base wards and AMU Ability to achieve 10 beds consistently available on AMU is challenging. TTO's and ambulances organised for known discharges the day before	C Shatford K Johnston	Awaiting demand & capacity beds 1/6/12

Appendix A3
EMERGENCY PROCESS METRICS

		• Speciality in-reach for opinions • Escalation and risk • Ability to maintain flow • Access to therapy as/when necessary to support discharge from MAU / EFU /EDU			Discharge pilot established on 2 wards LRI and 1 ward GH Discharge before 11am 8.5% Discharge before 1pm 24.2% Revised model of care supports extension of EFU model on a further ward - agreed with Geriatricians. Bed modelling due for completion w/c 21/5/12		
	Accepts patients from the assessment unit within 30 minutes of request	• Ability to maintain patient flow essential • Availability to discharge lounge • Speciality in-reach • 24/7 consultant availability	• Formalise an escalation policy re bed availability • Review workforce and requirements of multi-disciplinary team	• Time to transfer • Use of discharge lounge • Monitor variation in response times	Communication between teams managing flow and capacity improved. AMU and CDU continuously aware of bed availability on base wards. Bed modelling commenced as a precursor to workforce remodelling	K Johnston	

Appendix A3
EMERGENCY PROCESS METRICS

Short Stay	Accepts patients from within 30 minutes of request	• Have the capacity to accept patients • Twice Daily board rounds and multiple ward rounds with Senior review	• Establish bed base requirements and implement	Monitor bed requested to move time	Short stay implemented Daily board and ward rounds established Early evaluation of effectiveness completed – actions to improve concept underway	N Langford	
	Maximum 48hr stay following which they are transferred a base ward.	• Consultant ward rounds 8am and late afternoon daily • Availability to physiotherapy and OT early • Discharge by 10am where possible	• Review workforce and requirements of multi-disciplinary team • Early discharge process in place • TTO, Transport and GP letter prepared the night before • EDD	• Evidence of documented ward rounds • EDD • Discharge dates	Short stay implemented Daily board and ward rounds established Early evaluation of effectiveness completed – actions to improve concept underway SOP agreed - not always beds available – undertaking demand and capacity which will be completed by 1/6/12	N Langford	Process in place – do not always have enough beds – awaiting demand & capacity beds 1/6/12

Base wards (including sub specialities)	Accepts patients from the assessment or admission unit within 30 minutes	• Discharge lounge able to take beds • Plans for discharge created in advance • EDD monitoring • Transport order day before • TTO's written the day before • Medicine Discharge team to work 24/7	• Discharge lounge available • Discharge planning undertaken	• EDD identified for 98% patients • 25% patients in discharge lounge by 10am moving to a stretch target of 40% • 90% patients transported by EMAS on 10am vehicles • 50% TTO's written the day before and 100% before 11am on the day	See above Odames ward being used for beds/stretcher patients as an interim solution Discharge before 11am 8.5% Discharge before 1pm 24..2%	K Johnston	Process in place – do not always have enough beds – awaiting demand & capacity beds 1/6/12

Appendix A3
EMERGENCY PROCESS METRICS

		• Discharge planning and EDD linked to nurse handover					
	Specialities manage their own patients within their allocated bed base. Focus on expediting discharge	• Remodelling of sub speciality bed base • Concept of outliers removed • Clinicians responsible for managing their own patients if bed base exceeded and patients need to be cared for in another bed base • Daily consultant ward rounds – prospectively covered • Nurse discharge	• Demand and capacity undertaken • Plan to rebase beds • Review workforce and requirements of multi-disciplinary team • Senior review on every ward	• 0% Outliers • Bed base matches demand by speciality • % Patients managed outside speciality bed base • 95% consultant ward rounds • Discharge performance	Bed base remodelling based on HRG groupings due for delivery end of w/c 21/5/12	J Edyvean	Re-modelling in progress completed 1/6/12
	Create capacity to deal with seasonal variation	• Winter capacity planning and regression analysis • Flexible staffing to manage variation in demand Proactively identify potential discharge delays • Promptly manage delays in	• Clinical sign off for speciality plans • Winter summer modelling • Divisional discharge group established to manage medical needs • Escalation policy agreed and implemented	• Operating within financial plan • Additional/seasonal capacity matches demand	High level seasonal variation modelled – this will form part of the winter planning Escalation and ability to flex is being investigated tested	M Harris S Mason J Edyvean	

		discharge • Escalation and risk • Clinical sign off for speciality plans					
Discharge and Back door	Improve capacity to minimise occupation of acute facilities when not needed	• Work in partnership with Commissioners so that there is appropriate capacity to meet patient demand • Work in partnership across the whole health economy to deliver this • Ensure access criteria meets demands • Agree protocol to establish access to admit to community hospitals • Establish a divisional discharge team which directly links to primary care professionals • Establish a concentrated discharge facility	• Agree SLA/expectation • Review need to establish discharge facility within UHL – develop plans	• Agreed capacity numbers • Utilisation • Criteria meets demand • Application process to access services timely (metrics to be defined)f • Stay in discharge facility • Accuracy of EDD dates • Discharge letters are received by GPs electronically on the day • No patients moved wards more than twice • No patient is delayed greater than 24hrs in an acute bed • Daily discharge figures set	EDD dates to be updates after board rounds Daily lists Ward Matrons supporting wards to prepare day before to ensure early discharge Establish a plan that defines capacity required in the community. Current work being undertaken to review options to resolve issues of delays in acute beds Plan and timelines to be monitored via steering group and this action plan	Matron J Edyvean Discharge team	Heavily reliant on partners Unsure of their buy in

		with LOS <36hrs stay (if appropriate) • Escalation of delayed discharges to community partners • Review of Choice issues and effective management • Senior medical decision makers/medical review available 7/7					
The whole system	Continuous monitoring of risk and escalation as a means to mitigate risk to promote safety	• Maintain change	• Emergency Steering Group (ESG) with sub-groups ED, Ambulatory care, Tertiary Flows, Discharge flows, Acute Floor and internal waits. • Link to ECN	• Progress against plan • Iterative process • Monitoring long term performance • Involvement across divisions • Linking with external stakeholders	Steering group has been established TOR in draft Working groups to be set up and established with appropriate TOR and membership	D Skehan J Edyvean	Not all groups established
LLR Partnership working	To provide seamless care across health boundaries To ensure the right care is delivered in the right setting by the right health care professionals.	• The need to be transparent to support delivery • The need to be able to flex resources in response to demand • Minimize delayed discharge	• Establish capacity requirements • Devise action plan/ key contacts/actions/dates and milestones	•	Attendance at various external groups – network, SOG, CCG. Demand and capacity underway will determine requirements from our partners. Separate action plan will be developed, agreed and circulated with partners – Timelines in plan will then be monitored as part of	D Skehan M Harris P Walmsley	Plan to be agreed Awaiting demand and capacity to be completed

Appendix A3
EMERGENCY PROCESS METRICS

					this plan		

Appendix A3
EMERGENCY PROCESS METRICS

Appendix A – Estimating the impact of actions identified in the Remedial Plan

There are numerous issues which contribute to the number of breaches which occur, there is an interdependency of many independent variables and hence it is difficult to pinpoint one action that is responsible directly for reducing breaches.

In the table below it recognises these independent variables and tries to estimate the impact on the number of breaches occurring based on the assumptions which are made in the last column.

The table below identifies incrementally, the potential reduction of breaches, on a monthly basis, based on the actions and assumptions identified.

Improvement	10%	20%	40%	60%	80%	90%	100%	Assumptions	Metric
Action A Rapid assessment on all patients in 30 minutes with plan within 90 minutes **(potential reduction of breaches by month)**									
Reduction in breaches <u>Maximum Impact – low inflow</u> Attendance is below 8 per hour, paeds below 6, majors less than 16 Rhesus 4 <u>Medium Impact – medium inflow</u> Attendance is below 12 per hour, paeds below 6, majors less than 22 Rhesus 5	-30 -15	-60 -30	-120 -60	-180 -90	-240 -120	-270 -135	-300 -150	• There are beds available in the system • Full staffing complement with appropriate skill mix • ITU/HDU/monitored delays minimal </=2 in 24hrs • There are no patients delayed in the discharge process .i.e. assessment, placements, equipment, refusal of placements etc • Diagnostic meet the internal waiting time Calculations based on the average breaches per month	• <% breaches attributed to ED • Number of hours delays in accessing monitored beds • Inflow

Appendix A3
EMERGENCY PROCESS METRICS

Minimum Impact Attendance is below >20 per hour, paeds > 6, majors >30 Rhesus 6	-5	-12	-25	-35	-50	-60	-65		
Action B Acute physician in Majors – with development of assessment area for medicine **(Potential reduction of breaches by month)**									
	-8	-16	-32	-50	-66	-72	-84	• Beds available in the system • Full staffing complement with appropriate skill mix • ITU/HDU/monitored delays minimal </=2 in 24hrs • Attendance is below 8 per hour • Increased discharges and faster admission	Number of patient discharged by consultant
Action C Cohort patients ready for discharge in non acute beds **(Potential reduction of breaches by month)**									
	-15	-30	-60	-90	-120	-135	-150	No rapid assessment but available beds in the system	Patient flow
Action D Reducing Inflow by development of ambulatory pathways**(Potential reduction of breaches by month)**									
	-3	-6	-12	-18	-24	-27	-30	This assumes that patients will be referred directly and appropriately to ambulatory care and not attend ED.	% utilisation of same day and next date clinics Number of appropriate referrals
Action E Discharge planning(**Potential reduction of breaches by month)**									
	-2	-4	-6	-8	-10	-12	-15	Enable beds to be free and improves flow	
Action F Discharge Lounge that accepts beds**(Potential reduction of breaches by month)**									

	-4	-8	-16	-25	-33	-35	-42	Enable beds to be free and improves flow	

Appendix B

Emergency Department *Front Door Audit* *May 11 - April 12*

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

Data Source: Front Door Audit Completed by Patient

	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	12 months
Number of patients interviewed	78	100	100	100	98	100	99	100	100	100	97	99	1078
1. Why Have you come into A&E today?													
Minor illness.	36% ▲	15% ▼	11% ▼	10% ▼	10% —	19% ▲	16% ▼	27% ▲	15% ▼	15% —	22% ▲	21% ▼	18%
Chronic pain.	5% ▼	19% ▲	23% ▲	10% ▼	2% ▼	7% ▲	1% ▼	4% ▲	9% ▲	0% ▼	0% —	12% ▲	8%
Minor injury.	42% ▼	46% ▲	33% ▼	38% ▲	63% ▲	45% ▼	59% ▲	55% ▼	61% ▲	63% ▲	47% ▼	37% ▼	49%
Breathing problems.	1% ▼	4% ▲	1% ▼	3% ▲	3% —	2% ▼	1% ▼	2% ▲	0% ▼	3% ▲	2% ▼	4% ▲	2%
Renewal of Medication.	0% —	0% —	0% —	0% —	1% ▲	0% ▼	0% —	0% —	0% —	0% —	0% —	0% —	0%
Other.	12% ▼	15% ▲	26% ▲	29% ▲	18% ▼	26% ▲	20% ▼	12% ▼	11% ▼	19% ▲	29% ▲	24% ▼	20%
No response.	4% ▲	1% ▼	6% ▲	10% ▲	2% ▼	1% ▼	3% ▲	0% ▼	4% ▲	0% ▼	0% —	1% ▲	3%
2. How long has this problem been going on for?													
Few hours.	35% ▼	46% ▲	44% ▼	40% ▼	47% ▲	42% ▼	47% ▲	41% ▼	45% ▲	43% ▼	47% ▲	40% ▼	43%
1 day.	13% ▼	12% ▼	16% ▲	19% ▲	19% —	22% ▲	26% ▲	18% ▼	23% ▲	22% ▼	19% ▼	18% ▼	19%
2 days.	19% ▲	12% ▼	12% —	9% ▼	7% ▼	10% ▲	6% ▼	6% —	6% —	11% ▲	6% ▼	9% ▲	9%
3 days.	6% ▲	7% ▲	2% ▼	7% ▲	2% ▼	3% ▲	4% ▲	7% ▲	8% ▲	3% ▼	7% ▲	10% ▲	6%
4 - 6 days.	9% ▲	6% ▼	8% ▲	4% ▼	3% ▼	8% ▲	3% ▼	8% ▲	7% ▼	7% —	3% ▼	6% ▲	6%
1 week.	4% —	3% ▼	5% ▲	3% ▼	3% —	3% —	3% —	6% ▲	1% ▼	0% ▼	2% ▲	7% ▲	3%
More than a week.	10% ▼	7% ▼	11% ▲	2% ▼	4% ▲	9% ▲	6% ▼	5% ▼	9% ▲	4% ▼	8% ▲	5% ▼	7%
No response.	4% ▲	7% ▲	2% ▼	16% ▲	14% ▼	3% ▼	4% ▲	9% ▲	1% ▼	10% ▲	7% ▼	4% ▼	7%
3. Patients registered with a GP													
Patients registered with a GP.	86% ▲	83% ▼	85% ▲	87% ▲	79% ▼	88% ▲	90% ▲	89% ▼	92% ▲	89% ▼	82% ▼	93% ▲	87%
Patients not registered with a GP.	12% ▼	4% ▼	15% ▲	2% ▼	15% ▲	12% ▼	10% ▼	11% ▲	6% ▼	9% ▲	18% ▲	7% ▼	10%
No response.	3% ▲	13% ▲	0% ▼	11% ▲	6% ▼	0% ▼	0% —	0% —	2% ▲	2% —	0% ▼	0% —	3%
4. Have you tried to see your GP before coming in?													
Yes.	38% ▲	6% ▼	25% ▲	23% ▼	18% ▼	31% ▲	24% ▼	22% ▼	23% ▲	23% —	30% ▲	29% ▼	24%
No.	45% ▼	64% ▲	53% ▼	63% ▲	45% ▼	55% ▲	60% ▲	48% ▼	55% ▲	64% ▲	48% ▼	53% ▲	54%
No response.	17% ▲	30% ▲	22% ▼	14% ▼	37% ▲	14% ▼	16% ▲	30% ▲	22% ▼	13% ▼	22% ▲	18% ▼	21%

Appendix B

Emergency Department *Front Door Audit* *May 11 - April 12*

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

Data Source: Front Door Audit Completed by Patient	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	12 months
Number of patients interviewed	78	100	100	100	98	100	99	100	100	100	97	99	1078
5. If yes, how many times have you tried in last week?													
Once.	67% ▲	50% ▼	56% ▲	43% ▼	72% ▲	74% ▲	67% ▼	64% ▼	52% ▼	48% ▼	48% —	66% ▲	59%
Twice.	10% ▼	17% ▲	8% ▼	9% ▲	0% ▼	10% ▲	17% ▲	9% ▼	13% ▲	0% ▼	21% ▲	3% ▼	10%
Three times.	0% ▼	0% —	4% ▲	0% ▼	0% —	0% —	0% —	5% ▲	0% ▼	0% —	7% ▲	0% ▼	1%
Four times.	0% —	0% —	0% —	0% —	0% —	0% —	0% —	0% —	0% —	4% ▲	3% ▼	0% ▼	1%
More than four occasions.	7% ▲	0% ▼	8% ▲	4% ▼	0% ▼	3% ▲	0% ▼	0% —	9% ▲	4% ▼	7% ▲	0% ▼	4%
No response.	17% ▼	33% ▲	24% ▼	43% ▲	28% ▼	13% ▼	17% ▲	23% ▲	26% ▲	43% ▲	14% ▼	31% ▲	26%
6. If no, why not?													
My GP is always too busy.	0% —	0% —	0% —	0% —	1% ▲	0% ▼	0% —	0% —	5% ▲	0% ▼	3% ▲	1% ▼	1%
I couldn't get an appointment until...%.	3% ▲	0% ▼	0% —	0% —	1% ▲	3% ▲	3% —	1% ▼	0% ▼	3% ▲	0% ▼	4% ▲	1%
I thought this problem needs a hospital doctor.	9% ▲	24% ▲	32% ▲	47% ▲	53% ▲	45% ▼	43% ▼	49% ▲	56% ▲	64% ▲	32% ▼	43% ▲	41%
It's easier for me to come to A&E.	38% —	47% ▲	27% ▼	19% ▼	4% ▼	6% ▲	19% ▲	16% ▼	9% ▼	8% ▼	33% ▲	17% ▼	20%
My GP advised me to come to A&E.	23% ▲	7% ▼	8% ▲	9% ▲	18% ▲	3% ▼	14% ▲	14% —	22% —	21% ▼	26% ▲	35% ▲	17%
The ambulance took me in.	1% —	1% —	1% —	0% ▼	0% —	0% —	0% —	0% —	0% —	0% —	0% —	0% —	0%
NHS direct advised me to come to A&E.	0% ▼	12% ▲	5% ▼	4% ▼	1% ▼	1% —	3% ▲	5% ▲	1% ▼	1% —	3% ▲	1% ▼	3%
My friend took me here.	1% ▼	2% ▲	12% ▲	4% ▼	5% ▲	14% ▲	4% ▼	14% ▲	6% ▼	1% ▼	3% ▲	0% ▼	6%
The police took me here.	0% ▼	0% —	1% ▲	0% ▼	0% —	1% ▲	0% ▼	0% —	1% ▲	3% ▲	0% ▼	0% ▼	1%
Other.	0% —	0% —	3% ▲	3% —	4% ▲	0% ▼	13% ▲	0% ▼	0% —	0% —	0% —	0% ▼	2%
No response.	24% ▼	6% ▼	11% ▲	14% ▲	14% —	26% ▲	0% ▼	0% —	0% —	0% —	0% —	0% ▼	8%
7. NEW: Were you aware of the urgent care centre?													
Aware	51% ▲	33% ▼	42% ▲	29% ▼	33% ▲	32% ▼	31% ▼	41% ▲	48% ▲	45% ▼	52% ▲	44% ▼	40%
Not aware	47% ▲	34% ▼	52% ▲	55% ▲	56% ▲	56% —	49% ▼	39% ▼	45% ▲	48% ▲	39% ▼	36% ▼	46%
No response	1% ▼	33% ▲	6% ▼	16% ▲	11% ▼	12% ▲	19% ▲	20% ▲	7% ▼	7% —	9% ▲	19% ▲	13%

Appendix A

Emergency Department *Patient Experience* *April 11 - March*

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

Data Source: Front Door Audit Completed by Patient	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	12 months
Number of patients participating	99	100	91	100	100	100	94	75	67	97	50	98	1071
Which area of ED is the patient in?													
Majors	74% ▼	70% ▼	66% ▼	67% ▲	65% ▼	52% ▼	55% ▲	65% ▲	60% ▼	53% ▼	64% ▲	61% ▼	62%
Minors	3% ▼	12% ▲	10% ▼	11% ▲	9% ▼	9% —	10% ▲	23% ▲	6% ▼	32% ▲	24% ▼	20% ▼	15%
EDU	12% ▲	3% ▼	1% ▼	5% ▲	14% ▲	22% ▲	11% ▼	4% ▼	0% ▼	5% ▲	2% ▼	5% ▲	7%
Paeds	2% ▲	9% ▲	3% ▼	3% —	6% ▲	5% ▼	4% ▼	1% ▼	0% ▼	1% ▲	6% ▲	3% ▼	4%
Resus	5% ▲	3% ▼	4% ▲	8% ▲	6% ▼	0% ▼	4% ▲	0% ▼	3% ▲	3% —	2% ▼	3% ▲	3%
Not stated	4% ▲	3% ▼	15% ▲	6% ▼	0% ▼	12% ▲	16% —	7% ▼	31% ▲	6% ▼	2% ▼	7% ▲	10%
Gender													
Male	62% ▲	42% ▼	51% ▲	49% ▼	39% ▼	47% ▲	43% ▼	43% —	45% ▲	47% ▲	40% ▼	55% ▲	45%
Female	36% ▼	55% ▲	45% ▼	51% ▲	45% ▼	52% ▲	56% ▲	56% —	52% ▼	53% ▲	54% ▲	41% ▼	51%
Not stated	2% ▲	3% ▲	4% ▲	0% ▼	16% ▲	1% ▼	1% —	1% —	3% ▲	0% ▼	6% ▲	4% ▼	4%
Age													
17 yrs or younger	6% ▲	12% ▲	4% ▼	4% —	7% ▲	0% ▼	0% —	0% —	0% —	2% ▲	6% ▲	5% ▼	4%
18-25	12%	5% ▼	11% ▲	12% ▲	10% ▼	8% ▼	10% ▲	17% ▲	10% ▼	11% ▲	10% ▼	7% ▼	10%
26-35	11%	18% ▲	12% ▼	16% ▲	6% ▼	7% ▲	14% ▲	8% ▼	12% ▲	10% ▼	14% ▲	13% ▼	12%
36-50	18%	15% ▼	23% ▲	14% ▼	8% ▼	20% ▲	20% —	19% ▼	16% ▼	15% ▼	14% ▼	20% ▲	17%
51-64	12%	11% ▼	18% ▲	17% ▼	12% ▼	14% ▲	13% ▼	12% ▼	13% ▲	16% ▲	12% ▼	15% ▲	14%
18-64	54% —	49% ▼	64% ▲	59% ▼	36% ▼	49% ▲	56% ▲	56% —	52% ▼	54% ▲	50% ▼	56% ▲	53%
65-74	8%	16% ▲	8% ▼	14% ▲	14% —	13% ▼	11% ▼	9% ▼	18% ▲	10% ▼	18% ▲	10% ▼	13%
75-84	14%	14% —	12% ▼	12% —	19% ▲	16% ▼	21% ▲	19% ▼	10% ▼	21% ▲	14% ▼	12% ▼	15%
85 yrs or older	16%	6% ▼	8% ▲	11% ▲	10% ▼	16% ▲	5% ▼	11% ▲	16% ▲	12% ▼	8% ▼	12% ▲	11%
65 yrs or older	38% ▼	36% ▼	27% ▼	37% ▲	43% ▲	45% ▲	37% ▼	39% ▲	45% ▲	43% ▼	40% ▼	35% ▼	39%
Not stated	2% ▲	3% ▲	4% ▲	0% ▼	14% ▲	6% ▼	6% —	5% ▼	3% ▼	1% ▼	4% ▲	4% —	5%
Ethnicity													
White	79% ▼	74% ▼	73% ▼	72% ▼	66% ▼	86% ▲	86% —	68% ▼	81% ▲	79% ▼	74% ▼	62% ▼	75%
Mixed	1% ▼	3% ▲	0% ▼	0% —	4% ▲	3% ▼	5% ▲	4% ▼	0% ▼	2% ▲	0% ▼	3% ▲	2%
Asian or Asian British	11% ▲	14% ▲	15% ▲	17% ▲	10% ▼	8% ▼	6% ▼	11% ▲	10% ▼	10% —	14% ▲	14% —	12%
Black or Black British	2% ▲	1% ▼	3% ▲	1% ▼	0% ▼	0% —	1% ▲	3% ▲	4% ▲	1% ▼	6% ▲	0% ▼	2%
Chinese	1% ▲	0% ▼	0% —	1% ▲	0% ▼	0% —	0% —	0% —	0% —	0% —	0% —	0% —	0%
Other	5% ▲	0% ▼	3% ▲	4% ▲	1% ▼	3% ▲	0% ▼	4% ▲	0% ▼	0% —	0% —	2% ▲	2%
Not stated	1% ▲	8% ▲	5% ▼	5% —	19% ▲	0% ▼	1% ▲	11% ▲	4% ▼	7% ▲	6% ▼	18% ▲	8%

Emergency Department
Patient Survery

University Hospitals of Leicester NHS Trust

Caring at its best

Emergency Department *Patient Experience* *April 11 - March*

Data Source: Front Door Audit Completed by Patient	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	12 months
Number of comments received	495	500	454	499	499	500	469	500	500	500	250	250	5416
Overall													
Positive	93% ▲	93% —	95% ▲	90% ▼	94% ▲	93% ▼	94% ▲	97% ▲	97% —	97% —	97% —	97% —	95%
Neutral	5% ▼	4% ▼	1% ▼	9% ▲	3% ▼	4% ▲	4% —	2% ▼	2% —	2% —	2% —	2% —	3%
Negative	2% ▼	3% ▲	4% ▲	1% ▼	3% ▲	3% —	2% ▼	1% ▼	1% —	1% —	1% —	1% —	2%
Care Received													
Positive	88% ▲	89% ▲	100% ▲	94% ▼	92% ▼	92% —	94% ▲	93% ▼	96% ▲	91% ▼	92% ▲	96% ▲	93%
Neutral	9% ▼	7% ▼	0% ▼	6% ▲	5% ▼	5% —	4% ▼	5% ▲	3% ▼	8% ▲	8% —	4% ▼	5%
Negative	3% —	4% ▲	0% ▼	0% —	3% ▲	3% —	2% ▼	1% ▼	1% —	1% —	0% ▼	0% —	1%
Information Received													
Positive	92% ▲	99% ▲	96% ▼	96% —	99% ▲	100% ▲	99% ▼	99% —	100% ▲	100% —	100% —	100% —	99%
Neutral	6% ▼	1% ▼	0% ▼	4% ▲	1% ▼	0% ▼	1% ▲	1% —	0% ▼	0% —	0% —	0% —	1%
Negative	2% ▼	0% ▼	4% ▲	0% ▼	0% —	0% —	0% —	0% —	0% —	0% —	0% —	0% —	0%
Waiting Times													
Positive	88% ▲	92% ▲	90% ▼	78% ▼	86% ▲	84% ▼	91% ▲	97% ▲	91% ▼	88% ▼	86% ▼	87% ▲	88%
Neutral	8% ▲	4% ▼	2% ▼	20% ▲	8% ▼	9% ▲	5% ▼	3% ▼	4% ▲	5% ▲	8% ▲	13% ▲	7%
Negative	4% ▼	4% —	8% ▲	2% ▼	6% ▲	7% ▲	3% ▼	0% ▼	4% ▲	7% ▲	6% ▼	0% ▼	4%
NEW - Privacy													
Positive	99%	97% ▼	99% ▲	92% ▼	95% ▲	100% ▲	98% ▼	97% ▼	99% ▲	99% —	100% ▲	97% ▼	98%
Neutral	0%	2% ▲	0% ▼	8% ▲	1% ▼	0% ▼	2% ▲	0% ▼	0% —	1% ▲	0% ▼	2% ▲	1%
Negative	1%	1% —	1% —	0% ▼	3% ▲	0% ▼	0% —	3% ▲	1% ▼	0% ▼	0% —	1% ▲	1%
NEW - Dignity and Respect													
Positive	99%	99% —	96% ▼	96% —	99% ▲	100% ▲	99% ▼	99% —	100% ▲	100% —	100% —	100% —	99%
Neutral	1%	1% —	0% ▼	4% ▲	1% ▼	0% ▼	1% ▲	1% —	0% ▼	0% —	0% —	0% —	1%
Negative	0%	0% —	4% ▲	0% ▼	0% —	0% —	0% —	0% —	0% —	0% —	0% —	0% —	0%

Reducing hospital cancelled operations – revised action plan (as at May 2012)

Objective: to reach 0.8% contract threshold by end Sept 2012

Issue	Action(s) required	Enablers / key delivery steps	Action monitoring leads	Initiated actions by	Completed by & current RAG rating	Anticipated outcomes / outputs
Trust internal monitoring framework for revised action plan	Improved weekly tracking and formal monthly Board reporting of status	• Performance reporting on hospital cancelled operations included in weekly metrics and discussed with Executives • Weekly analysis report of all cancelled operations /reasons to be circulated • Weekly performance to be discussed at DATUM group with all CBUs represented • Monthly formal report update to Q&P Report for Trust Board and to Divisional Management Boards	Divisional Managers Trust Informatics Team Divisional Head of Nursing, CSD Divisional Managers	5th Nov 2011 6th May 2012 16th May 2012 Monthly & ongoing		Evidence of weekly reporting and actions arising from cross-Divisional joint working Provides breakdown of factors affecting hospital cancelled operations – enabling attention to root causes Surgical specialties most at risk of cancellations remain focus of attention Executive and Trust Board accountability
Escalation procedure	Adherence to new procedure for alerting of cancellation	• Reinforcement of instruction that Divisional tier to be contacted prior to cancellation	Divisional Managers	14th May 2012		All staff aware of new escalation procedure and to ensure Divisional team is consulted and all options appraised
Lack of critical care capacity	Additional critical care bed capacity across Trust sites Additional Recovery / PACU capacity in LRI Theatres Additional emergency theatre funded capacity required	• Business case for Phase 1 expansion to Exec Team for endorsement and approval to proceed with ITU recruitment • Staff recruitment plans in place • Business case for redevelopment of existing Recovery Unit is now in progress, at design stage • Trust capital allocation FY12/13 set aside • Prepare bid for Transformation	Head of Service & CBU Manager (CRCC) Divisional Head of Nursing, CSD Capital Group Divisional Head of Nursing, CSD	8th May 2012 28th May 2012 7th May 2012		Phase1 – increase Level 3 beds by 8 in total Expansion and redevelopment plans approved Submission of bid paper to Cluster team for review and funding support

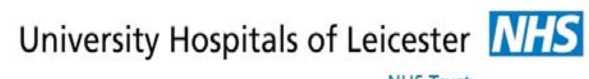
	Additional fractured NOF trauma capacity	Fund to increase emergency theatre by 5 sessions per week • Bid paper submitted to PCT presenting case for underlying demand with implementation plan jointly between MSK/TAPS	CBU Mgr MSK CBU Med Lead MSK TAPS CBU	26th April 2012		Proposal submitted; funding with tariff
Lack of timely ward bed capacity	Improved communication, active demand management for elective volume and escalation plans across CBUs	• Joint Divisional bed planning on site by site basis following on from weekly activity meetings • Complete management of change consultation for day case ward staff opening times to increase capacity	CBU Managers via DATUM group reps Divisional Manager Planned Care	28th May 2012 2nd July 2012		Theatre flow continues without disruption whilst sufficient ward bed capacity is made ready – no cancellations incurred due to unconfirmed ward beds Enhanced hours of operation in day case services, enabling later scheduling
Capacity planning and optimization	Improved theatre scheduling	• Weekly DATUM group meeting to plan ahead with each specialty • Review scope for more all day theatre lists with user CBUs • Detailed capacity planning per specialty with TAPS CBU for entire year ahead • Feasibility scoping and implementation plan for ORMIS theatre list "lock down" 72hrs prior to elective activity • Theatre T/L performance report against late starting	Divisional Head of Nursing, CSD Divisional Managers All CBU Managers with DHoN, CSD TAPS CBU S/M TAPS CBU S/M	Weekly & ongoing 28th May 2012 26th April 2012 18th June 2012 21st June 2012		Review elective plan for week ahead; review realistic lists scheduled; identify risk of under-utilisation and take action Maximise planned list activity Smoothing of elective flow and demand over calendar year; early identification of supply-demand problems allows affordable resolution with user CBUs Prevents late notice changes to list run Managed reduction achieved in late starts
Improvements with process controls	Improved pre-assessment for anaesthesia / planned surgery Avoidance of prolonged Theatre patient turnaround times and delays	• Development plan to pilot pre-op anaesthetic assessment team including self-assess checklist • Project plan for piloting new dedicated Theatre transfer team of nursing and escort staff to support Wards / Recovery	TAPS CBU Mgr TAPS CBU Mgr	28th May 2012 28th May 2012		Reduced cancellations on the day due to poor health, further tests required Minimise time delays between patients on the theatre list; minimise extended delays in Recovery Unit pending retrieval

		• Theatre staff team briefings continue in accordance with WHO policy guidelines to ensure list run order is discussed re any potential problems considered in time	Divisional Head of Nursing, CSD supported by Theatre Matrons	14th May 2012	Green	
Equipment & kit availability	Procurement of additional equipment and surgical instrumentation	• Paper requesting capital allocation for purchase of additional surgical instruments submitted to Capital Group	Divisional Manager CSD	8th May 2012	Green	Surgical sets replenished with required instruments – managed reduction with incomplete trays
		• Purchase and delivery of additional / replacement Stryker stack systems and lap sets	Theatre Resources Manager, supported by MEE committee	18th June 2012	Amber	Appropriate equipment and instruments available on demand to each Theatre

RAG Legend **Red** – indicates behind trajectory, will definitely not meet deadline **Amber** – on trajectory but requires enhanced monitoring **Green** – on plan and will remain on trajectory

DATUM – Divisional Activity & Theatre Utilisation Meeting
TAPS – Theatres, Anaesthesia Pain & Sleep services
MSK – Musculo-skeletal services
CSD – Clinical Support Division
CBU – Clinical Business Unit
WHO – World Health Organisation
S/M – Service Manager

Appendix D



Caring at its best

Quality and Performance

Trust Board

Monday 28th May 2012

March 2012

One team shared values

DRAFT 1 FOR COMMENTS

University Hospitals of Leicester
NHS Trust

QUALITY and PERFORMANCE REPORT

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UHL at a Glance - Month 12 - 2011/12

PATIENT SAFETY	Standard	Month Actual	YTD	Annual Forecast	YTD versus Target	Monthly RAG	Data Quality	Current Data	PMR	DoH
MRSA Bacteraemias	9	0	7					Mar-12	✓	✓
CDT Isolates in Patients (UHL - All Ages)	165	11	108					Mar-12	✓	✓
% of all adults who have had VTE risk assessment on adm to hosp	90%	93.7%	93.8%					Mar-12		✓
Reduction of hospital acquired venous thrombosis	0.175	0.22						Qtr 3 11/12		✓
Never Events	0	0	2					Mar-12	✓	
Serious Incidents Requiring Investigation	TBC	165	465					Mar-12	✓	
Formal Complaints Received	TBC	165	1740					Mar-12	✓	
Incidents of Patient Falls	TBC	231	2659					Mar-12	✓	
Falls resulting in severe injury or death	TBC	1	6					Mar-12	✓	
Pressure Ulcers (Grade 3 and 4)	197	22	138					Mar-12	✓	

CLINICAL EFFECTIVENESS	Standard	Month Actual	YTD	Annual Forecast	YTD versus Target	Monthly RAG	Data Quality	Current Data	PMR	DoH
Cancer: 2 week wait from referral to date first seen - all cancers	93%	93.1%	94.0%					Mar-12	✓	✓
Cancer: 2 week wait from referral to date first seen, for symptomatic breast patients (cancer not initially suspected)	93%	94.8%	95.9%					Mar-12	✓	✓
All Cancers: 31-day wait from diagnosis to first treatment	96%	97.0%	97.4%					Mar-12	✓	✓
All cancers: 31-day for second or subsequent treatment - anti cancer drug treatments	98%	100.0%	99.9%					Mar-12	✓	✓
All Cancers: 31-day wait for second or subsequent treatment - surgery	94%	91.2%	94.5%					Mar-12	✓	✓
All Cancers: 31-day wait for second or subsequent cancer treatment - radiotherapy treatments	94%	[illegible]	[illegible]					Mar-12	✓	✓
All Cancers:- 62-day wait for first treatment from urgent GP referral	85%	[illegible]	83.8%					Mar-12	✓	✓
All Cancers:- 62-day wait for first treatment from consultant screening service referral	90%	91.3%	93.8%					Mar-12	✓	✓
All Cancers:- 62-Day Wait For First Treatment From Consultant Upgrade	85%	100.0%	87.5%					Mar-12	✓	✓
Mortality HSMR - OVERALL	85	90.6	81.0					Feb-12		
Delayed Transfers of Care	[illegible]	1.5%	1.5%					Mar-12		✓

PATIENT EXPERIENCE	Standard	Month Actual	YTD	Annual Forecast	YTD versus Target	Monthly RAG	Data Quality	Current Data	PMR	DoH
Net Promoter Trust Score	TBC	New				New O/F target April 2012		Mar-12		
Net Promoter - Coverage	10%	New				New O/F target April 2012		Mar-12		
Single Sex Accommodation Breaches	0	2	2					Mar-12		
ED Waits (2011/12 - Type 1 and 2 plus Urgent Care Centre)	95%	90.4%	93.9%					Mar-12	✓	✓
ED Waits - UHL (Type 1 and 2)	95%	88.0%	92.2%					Mar-12		

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UHL at a Glance - Month 12 - 2011/12

PATIENT EXPERIENCE	Standard	Month Actual	YTD	Annual Forecast	YTD versus Target	Monthly RAG	Data Quality	Current Data	PMR	DoH
RTT waiting times – admitted	90%	83.5%						Mar-12	✓	✓
RTT waiting times – non-admitted	95%	95.9%						Mar-12	✓	✓
RTT - incomplete 92% in 18 weeks		9.9		9.9				Mar-12	Mar-12	✓
RTT delivery in all specialties		25.5		25.5				Mar-12	Mar-12	✓
Diagnostic Test Waiting Times		5.9		5.9				Mar-12	Mar-12	✓
RTT Non-Admitted 95th Percentile (Weeks)	<=18.3	17.7		17.7				Mar-12	Mar-12	✓
RTT Incomplete Median Wait (Weeks)	<=7.2	5.6		5.6				Mar-12	Mar-12	✓
RTT Incomplete 95th Percentile (Weeks)	<=28.0	17.7		17.7				Mar-12	Mar-12	✓
RTT - incomplete 92% in 18 weeks	92%	New				New O/F target April 2012		Mar-12		✓
RTT delivery in all specialties	0%	New				New O/F target April 2012		Mar-12		✓
6 Week - Diagnostic Test Waiting Times	<1%	New				New O/F target April 2012		Mar-12		✓
Outlying (daily average)	5	5						Mar-12		
Operations cancelled for non-clinical reasons on or after the day of admission	0.8%	1.3%	1.4%					Mar-12		

STAFF EXPERIENCE / WORKFORCE	Standard	Month Actual	YTD	Annual Forecast	YTD versus Target	Monthly RAG	Data Quality	Current Data	PMR	DoH
Sickness absence	3.0%	4.3%	3.5%					Mar-12		
Appraisals	100%	94.4%	94.4%					Mar-12		

VALUE FOR MONEY	Standard	Month Actual	YTD	Annual Forecast	YTD versus Target	Monthly RAG	Data Quality	Current Data	PMR	DoH
Income (£000's)	681,756	68,3[illegible]6	711,076					Mar-12		
Operating Cost (£000's)	635,6[illegible]	61,152	667,823					Mar-12		
Surplus / Deficit (as EBIDTA) (£000's)	46,063	7,164	43,253					Mar-12		
CIP (£000's)	38,245	2,995	25,226					Mar-12		
Cash Flow (£000's)	[illegible],200	18,369	18,369					Mar-12		
Financial Risk Rating	3	3	3					Mar-12		
Pay - Locums (£ 000s)		277	3,532					Mar-12		
Pay - Agency (£ 000s)		923	11,175					Mar-12		
Pay - Bank (£ 000s)		556	6,004					Mar-12		
Pay - Overtime (£ 000s)		252	2,878					Mar-12		
Total Pay Bill (£ millions)	420,410	37.1	436					Mar-12		

Data Quality Key : **Procedure & Process Fully Documented** **Patient Level** **Audit** **Director Sign Off**

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DoH PERFORMANCE/OPERATING FRAMEWORK - 2012/13 INDICATORS

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	Performance Indicator	Performing	Under-performing	Weighting	Monitoring Period	April	May	June	Qtr 1
	A&E - Total Time in A&E	95%	94%	1.0	QTR				
Infection Control	MRSA	0	>1SD	1.0	YTD				
Infection Control	Clostridium Difficile	0	>1SD	1.0	YTD				
Access - 18 week wait	RTT waiting times – admitted	90%	85%	1.0	Monthly				
Access - 18 week wait	RTT waiting times – non-admitted	95%	[illegible]	1.0	Monthly				
Access - 18 week wait	RTT - incomplete 92% in 18 weeks	92%	87%	1.0	Monthly				
Access - 18 week wait	RTT delivery in all specialties	0	>20	1.0	Monthly				
Access - 18 week wait	Diagnostic Test Waiting Times	<1%	5%	1.0	Monthly				
Access -Cancer	Cancer: 2 week wait from referral to date first seen - all cancers	93%	88%	0.5	Monthly				
Access -Cancer	Cancer: 2 week wait from referral to date first seen, for symptomatic breast patients (cancer not initially suspected)	93%	88%	0.5	Monthly				
Access -Cancer	All Cancers: 31-day wait from diagnosis to first treatment	96%	91%	0.25	Monthly				
Access -Cancer	All Cancers: 31-day wait for second or subsequent treatment - surgery	94%	89%	0.25	Monthly				
Access -Cancer	All cancers: 31-day for second or subsequent treatment - anti cancer drug treatments	98%	93%	0.25	Monthly				
Access -Cancer	All Cancers: 31-day wait for second or subsequent cancer treatment - radiotherapy treatments	94%	89%	0.25	Monthly				
Access -Cancer	All Cancers:- 62-day wait for first treatment from urgent GP referral	85%	80%	0.5	Monthly				
Access -Cancer	All Cancers:- 62-day wait for first treatment from consultant screening service referral	90%	85%	0.5	Monthly				
	Delayed transfers of care	3.5%	5%	1.0	QTR				
	Single Sex Accommodation Breaches	0.0%	0.5%	1.0	QTR				
	Venous Thromboembolism (VTE) Screening	90%	80%	1.0	QTR				

Sum of weights	14.00	

Scoring values

Underperforming	0
Performance under review	1
Performing	3

Overall performance score threshold

Underperforming	2.1
Performance under review	2.1 and 2.4
Performing	>2.4

PROVIDER MANAGEMENT REGIME - ACUTE GOVERNANCE RISK RATINGS 2011/12

Ref	Area	Indicator	Sub Sections	Thresh-old	Weight-ing	April 2011	May 2011	Jun 2011	July 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012
1	Safety	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	
2	Safety	MRSA	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	NO	YES	YES	NO	YES	YES	YES	YES	YES	YES	YES	Yes	
3	Quality	All cancers: 31-day wait for second or subsequent treatment, comprising either:	Surgery Anti cancer drug treatments Radiotherapy	94% 98% 94%	1.0	YES	YES	YES	YES	YES	YES	YES	YES	NO	NO	YES	NO	
4	Quality	All cancers: 62-day wait for first treatment, comprising either:	From urgent GP RTT From consultant screening service referral	85% 90%	1.0	YES	YES	NO	NO	NO	NO	NO	NO	NO	YES	YES	YES	
5a	Patient Experience	RTT waiting times – admitted	95th percentile	23 wks	1.0	NO	NO	NO	YES	YES	YES	YES	NO	NO	NO	NO	NO	
5b	Patient Experience	RTT waiting times – non-admitted	95th percentile	18.3 wks	1.0	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	
6	Quality	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	
7	Quality	Cancer: 2 week wait from referral to date first seen, comprising either:	all cancers for symptomatic breast patients (cancer not initially suspected)	93% 93%	0.5	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	
8a	Quality	A&E: Total time in A&E	Total time in A&E (95%)	≤ 4 hrs	1.0	NO	NO	YES	YES	NO	NO	NO	NO	YES	YES	NO	NO	
8b	Quality	A&E:	Total time in A&E Time to initial assessment (95th percentile) Time to treatment decision (median) Unplanned re-attendance rate Left without being seen	≤4 hrs ≤15 mins ≤60 mins ≤5% ≤5%	No weighting	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	
17	Patient experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	
		CQC Registration																
A	Safety	CQC Registration	Are there any compliance conditions on registration outstanding	0	1.0	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	
B	Safety	CQC Registration	Are there any restrictive compliance conditions on registration outstanding.	0	2.0	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	
C	Safety	Moderate CQC concerns regarding the safety of healthcare provision		0	1.0	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	
D	Safety	Major CQC concerns regarding the safety of healthcare provision		0	2.0	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	YES	
E	Safety	Formal CQC Regulatory Action resulting in Compliance Action		0	2.0	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	
F	Safety	Formal CQC Regulatory Action resulting in Enforcement Action		0	4.0	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	YES	
G	Safety	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative		0	2.0	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	
				TOTAL		3.0	2.0	2.0	2.0	2.0	2.0	2.0	3.0	3.0	2.0	2.0	9.0	0.0

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PROVIDER MANAGEMENT REGIME - FINANCIAL RISK RATING 2011/12

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Annual Plan 2011/12	Apr 2011	May 2011	June 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012
									Insert the Score (1-5) Achieved for each Criteria Per Month												
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	3	2	1	1	1	1	1	1	2	2	3	3	3	
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	5	1	2	2	2	2	2	2	2	2	3	3	4	
Financial efficiency	**Return on assets %**	20%	6	5	3	-2	<-2	3	2	2	2	2	2	2	2	2	2	2	2	3	
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	1	1	1	1	1	1	1	1	1	2	2	3	
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	2	1	1	1	1	1	1	2	2	2	3	3	
Average	**Weighted Average**	**100%**						**3.0**	**1.7**	**1.3**	**1.3**	**1.3**	**1.3**	**1.3**	**1.3**	**1.8**	**1.8**	**2.4**	**2.6**	**3.1**	**0.0**
Overriding rules	**Overriding rules**								2	1	1	1	1	1	1	2	2	2	3		
Overall rating	**Final Overall rating**							**3**	**2**	**1**	**1**	**1**	**1**	**1**	**1**	**2**	**2**	**2**	**3**	**3**	**0**

	Annual Plan 2011/12	Apr 2011	May 2011	June 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012
Underlying Performance	3	2	1	1	1	1	1	1	2	2	3	3	3	0
Achievement of Plan	5	1	2	2	2	2	2	2	2	2	3	3	4	0
Financial Efficiency	3	2	2	2	2	2	2	2	2	2	2	2	3	0
Liquidity	3	2	1	1	1	1	1	1	2	2	2	3	3	0

Overriding Rules :

Max Rating	Rule		Annual Plan	Apr 2011	May 2011	June 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012
3	Plan not submitted on time	No														
3	Plan not submitted complete and correct	No														
2	PDC dividend not paid in full	No														
2	One Financial Criterion at "1"			2												
3	One Financial Criterion at "2"													3		
1	Two Financial Criteria at "1"				1	1	1	1	1	1						
2	Two Financial Criteria at "2"			2	2	2	2	2	2	2	2	2	2			

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PROVIDER MANAGEMENT REGIME - FINANCIAL RISK TRIGGERS 2011/12

	Criteria	Apr 2011	May 2011	June 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	
2	Quarterly self-certification by trust that the financial risk rating (FRR) may be less than 3 in the next 12 months	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
3	FRR 2 for any one quarter	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
4	Working capital facility (WCF) agreement includes default clause	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
5	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	
6	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	No	No	No	No	No	No	No	No	No	
7	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No	No	No	No	No	No	No	No	
8	Interim Finance Director in place over more than one quarter end	No	No	No	No	No	No	No	No	No	No	No	No	
9	Quarter end cash balance <10 days of operating expenses	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	
10	Capital expenditure < 75% of plan for the year to date	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No	
	TOTAL	**5**	**5**	**5**	**4**	**4**	**4**	**4**	**5**	**5**	**4**	**4**	**4**	**0**

RAG RATING :

GREEN = Score between 0 and 1

AMBER = Score between 2 and 4

RED = Score over 5

PROVIDER MANAGEMENT REGIME - CONTRACTUAL RISK RATINGS 2011/12

	Apr 2011	May 2011	Jun 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012
Contractual Risk Rating	G	G	G	G	G	G	G	G	G	G	A	G	

G	All key contracts are agreed and signed. Both the NHS Trust and commissioner are fulfilling the terms of the contract. There are no disputes or performance notices in place.
A	The NHS Trust and commissioner are in dispute over the terms of the contract.Performance notices have been issued by one or both parties.
R	One or more key contract is not signed by the start of the period covered by the contract. There is a dispute over the terms of the contract which might, or will, necessitate SHA intervention or arbitration.The parties are already in arbitration.

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PROVIDER MANAGEMENT REGIME - QUALITY

	Criteria	Unit	Apr 2011	May 2011	June 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012
1	SHMI - latest data	Ratio	84.8	85.9	74.8	80.7	80.1	87.1	78.5	75.0	74.1	82.0	90.6		
2	Venous Thromboembolism (VTE) Screening	%	92.7	93.5	93.5	94.5	93.8	93.8	93.8	94.5	94.3	94.1	93.8	93.7	
3a	Elective MRSA Screening	%	100	100	100	100	100	100	100	100	100	100	100	100	
3b	Non Elective MRSA Screening	%	100	100	100	100	100	100	100	100	100	100	100	100	
4	Single Sex Accommodation Breaches	Number	0	0	0	0	0	0	0	0	0	0	0	2	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	6	4	6	1	8	3	3	8	7	118	136	165	
6	"Never Events" in month	Number	0	1	0	0	1	0	0	0	0	0	0	0	
7	CQC Conditions or Warning Notices	Number	0	0	0	0	0	0	0	0	0	0	0	1	
8	Open Central Alert System (CAS) Alerts	Number	1	2	1	1	1	1	2	4	4	3	3	15	
9	RED rated areas on your maternity dashboard?	Number	2	3	2	3	2	4	5	5	7	2	5	4	
10	Falls resulting in severe injury or death	Number	2	0	1	0	0	1	0	0	0	1	0	1	
11	Grade 3 or 4 pressure ulcers	Number	15	12	17	17	8	5	10 (6)	6 (6)	6 (2)	12 (9)	8 (4)		
12	100% compliance with WHO surgical checklist	Y/N	Y	Y	N	Y	Y	N	Y	Y	N	Y	Y	Y	
13	Formal complaints received	Number	132	133	147	119	144	165	149	178	123	145	140	165	
14	Agency and bank spend as a % of turnover	%	3.5	3.6	3.6	3.7	2.4	1.8	1.8	1.9	1.7	1.6	1.6	2.1	
15	Sickness absence rate	%	3.2	3.0	3.4	3.3	3.1	3.2	3.4	3.8	3.8	3.7	3.9	4.3	

DRAFT 1 FOR COMMENTS

LLR 2012/13 CQUIN - Quarterly performance

Area	Title in Brief	% of CQUIN Total LLR	Indicator Value LLR	Monthly risk rating	Qtr1	Qtr2	Qtr3	Qtr4
National 1	VTE risk assessment	1%	£96,171					
National 2	Responsiveness to Patient Needs	5%	£480,855					
National 3a	Dementia - Screening	1%	£96,171					
National 3b	Dementia - Risk Assessment	2%	£192,342					
National 3c	Dementia - Referrral	2%	£192,342					
National 4	Safety Thermometer	5%	£480,855					
Regional 1	NET Promoter	3%	£288,513					
Regional 2	MECC	10%	£961,709					
Local 1a	Int Prof Standards - ED	6%	£577,026					
Local 1b	Int Prof Standards - Assessment Units & Imaging	6%	£577,026					
Local 1c	ED/EMAS Handover	6%	£577,026					
Local 2	Disch B4 11am	2%	£192,342					
Local 2	Disch B4 1pm	6%	£577,026					
Local 2	7 Day Disch	4%	£384,684					
Local 2	TTOs pre disch	3%	£288,513					
Local 2	Disch Diagnosis & Plan	2%	£192,342					
Local 3	End of Life Care	5%	£480,855					
	COPD Admission	5%	£480,855					
Local	COPD care bundle	10%	£961,709					
Local 7a	Clinical Handover	3.2%	£307,747					
Local 7b	Responding to EWS	3.2%	£307,747					
Local 7c	M&M	3.2%	£307,747					
Local 7d	Acting on Results	3.2%	£307,747					
Local 7e	Ward Round Notation Standards	3.2%	£307,747					
Total		**100%**	**£9,617,097**					

Specialised Services 2012/13 CQUIN - Quarterly performance

Area	Title in Brief	% of CQUIN Total Specialised Services	Indicator Value - Specialist Service	Monthly risk rating	Qtr1	Qtr2	Qtr3	Qtr4
National 1	VTE risk assessment	5%	£206,487					
National 2	Responsiveness to Patient Needs	5%	£206,487					
National 3a	Dementia - Screening	1.66%	£68,829					
National 3b	Dementia - Risk Assessment	1.66%	£68,829					
National 3c	Dementia - Referrral	1.66%	£68,829					
National 4	Safety Thermometer	5%	£206,487					
SS 1	Spec Dashboards	10%	£412,973					
SS 2	Home Dialysis	10%	£412,973					
SS 3	Increased IMRT	15%	£619,459					
SS 4	Perf Status [illegible]	15%	£619,459					
SS 5	Hep C	10%	£412,973					
SS 6	NNU Infections	10%	£412,973					
SS 7	PICU Extubations	10%	£412,973					
Total			**£4,129,731**					

KEY
NO ISSUES
PERFORMANCE DETERIORATING
FINANCIAL RISK

DRAFT 1 FOR COMMENTS

2012/13 Contractual Penalties - risk areas

The 2012/13 contract sets out the Trust's performance requirements and the financial penalties if these are not met. These penalties are:

Issue	**Penalty**
milestones	2% of total contract value for that month
Issuing of 1st Exception Notice	2% of total contract value to be withheld until resolved
Issuing of a 2nd Exception Notice	Withholding could become permanent

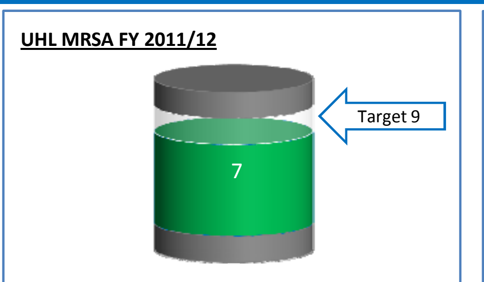
PERFORMANCE AREAS AT RISK OF CONTRACTUAL

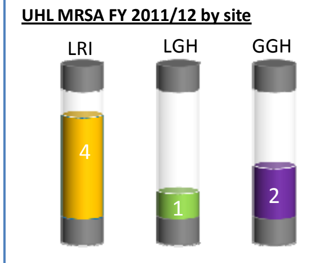
Nationally Specified Event	Threshold	Consequence per breach	Current Contractual Status	Financial Implication
A&E - Total Time in A&E	95% of patients waiting less than 4 hours	As per Section E of the contract, Clause 47 Contract Management	2nd Exception Notice issued 30th April 2012	Dependent on which Associates the target is failed the maximum penalty could be 2% of total Contract Value
Operations cancelled for non-clinical reasons on or after the day of admission	Maximum 0.8% of operations	As per Section E of the contract, Clause 47 Contract Management	Contract Query Issued on the 8th July 2011. Remedial Action Plan to be Shared with Commissioners on 18 May 2012	Need commissioners to accept action plan otherwise escalation to exception notice.
Breast screening age extension	To start by 30 June 2012 - 50% of additional women in the cohort to be screened by 31 December 2012	As per Section E of the contract, Clause 47 Contract Management	Contract Query Issued on the 7th March. Remedial action plan shared on the 9th May.	Awaiting acceptance of RAP from commissioners otherwise escalation to exception notice
Proportion of patients receiving first definitive treatment for cancer within 62 days of	Operating standard of 85%	2% of the Actual Outturn Value of the service line revenue	1st Exception Notice issued on the 24th Feb. Remedial Action Plan already in effect and performance recovered in Q4 of 11-12	Exception Notice should be lifted. Commissioners now querying performance at tumour site. No contractual levers to impose this performance measure.
Single Sex Accommodation Breaches	> 0	Retention of £250 per day per patient affected as may be varied pursuant to Guidance	3 breaches in April affecting 7patients	7 x £250 = £1,750
Serious Incidents - never events	> 0	As per section E of the contract, Clause 47 Contract Management	2 breaches in April	2 x spell cost (plus any additional costs incurred)

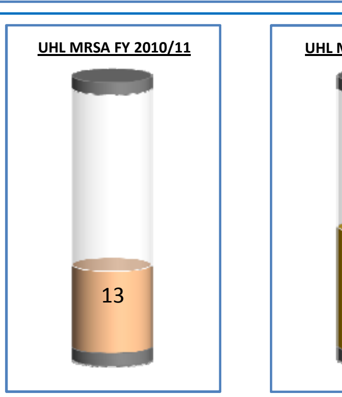
DRAFT 1 FOR COMMENTS

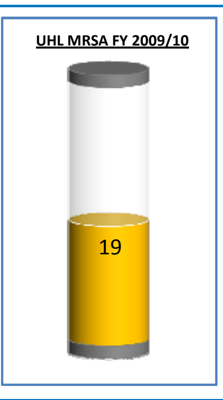
INFECTION PREVENTION

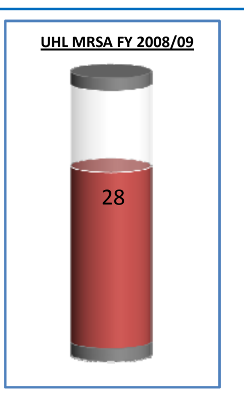
MRSA BACTERAEMIA











Performance Overview

MRSA – no cases of MRSA were reported during March and the year end position is 7 against a target of 9.

CDifficile – 11 cases indentified in March bringing the year end total to 108 against a target of 165.

MRSA elective and non-elective screening has been achieved at 100% respectively

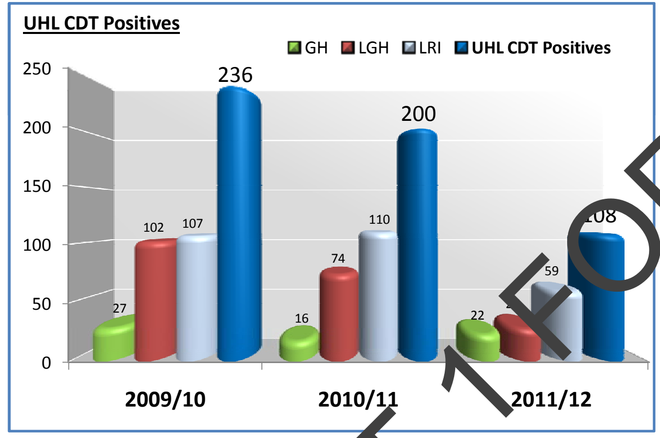
Key Actions

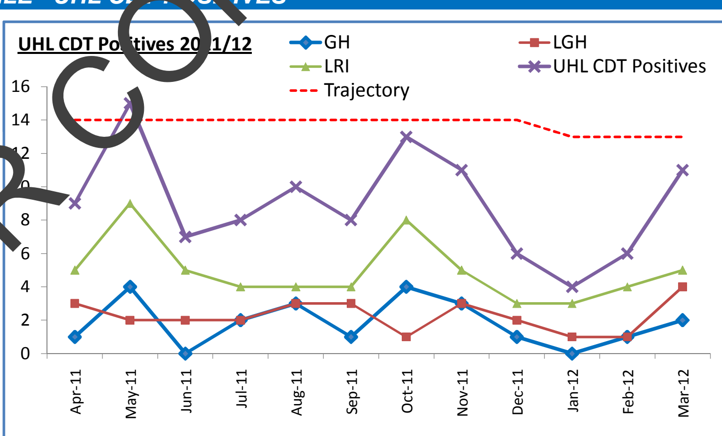
Correspondence has been forwarded to all clinicians regarding expectations and compliance with recommended infection prevention procedures.

Full Year

MRSA - 7 (target 9)
CDiff - 108 (target 165)

CLOSTRIDIUM DIFFICILE - UHL CDT POSITIVES





TARGET / STANDARD

	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	YTD	Target
MRSA	1	2	0	0	1	1	0	0	1	1	1	0	0	7	9
C. Diff	14	[illegible]	15	7	8	10	8	13	11	6	4	6	11	108	165
Rate / 1000 Adm's	[illegible]	1.2	2.0	0.9	1.0	1.3	1.1	1.8	1.4	0.8	0.5	0.8	1.3	1.2	

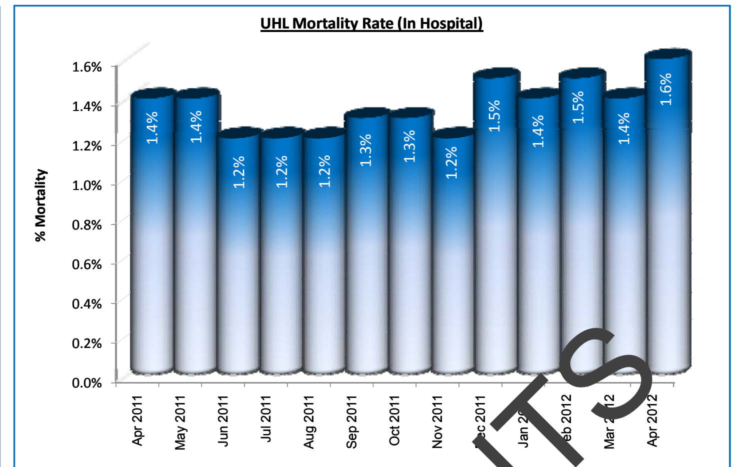
	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	YTD	Target
GRE	1	3	4	2	4	2	1	0	2	1	3	3	1	26	TBC
MSSA		1	4	2	5	2	6	4	3	2	0	5	5	39	No National Target
E-Coli				38	39	42	39	41	45	38	37	35	46	400	No National Target

DRAFT 1 FOR COMMENTS

MORTALITY

UHL CRUDE MORTALITY

Performance Overview



UHL CRUDE DATA TOTAL SPELLS	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	YTD
UHL Crude Data - TOTAL Spells	16896	17539	18897	18386	18184	18005	17954	18540	18381	19145	[illegible]	[illegible]	[illegible]	17344
UHL Crude Data - TOTAL Deaths	243	254	230	224	211	235	231	229	271	272	[illegible]	284	277	277
UHL %	1.4%	1.4%	1.2%	1.2%	1.2%	1.3%	1.3%	1.2%	1.5%	1.4%	[illegible]	[illegible]	1.6%	1.6%

UHL CRUDE DATA ELECTIVE SPELLS	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	YTD
UHL Crude Data - ELECTIVE Spells	7761	8098	9238	8570	8810	8761	8691	9251	8450	[illegible]	[illegible]	9829	7855	7855
UHL Crude Data - ELECTIVE Deaths	4	5	7	11	11	5	4	6	12	[illegible]	5	8	5	5
%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%	[illegible]	[illegible]	0.1%	0.1%	0.1%	0.1%

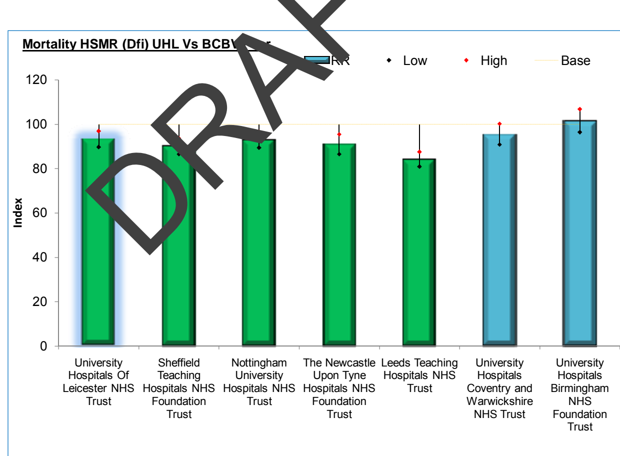
UHL CRUDE DATA NON ELECTIVE SPELLS	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	YTD
UHL Crude Data - NON ELECTIVE Spells	9135	9441	9659	9816	9374	9244	9263	[illegible]	[illegible]	10230	9501	10065	9489	9489
UHL Crude Data - NON ELECTIVE Deaths	239	249	223	213	200	230	227	223	[illegible]	268	280	276	272	272
%	2.6%	2.6%	2.3%	2.2%	2.1%	2.5%	2.5%	2.4%	[illegible]	2.6%	2.9%	2.7%	2.9%	2.9%

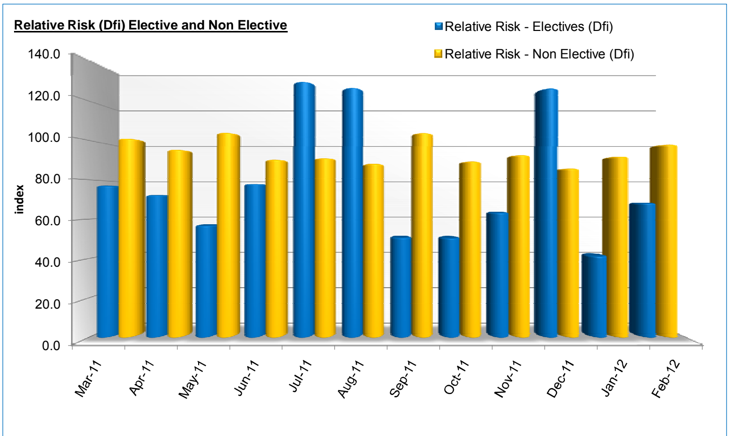
CBU Details

Clinical Business Unit	Apr 11	May 11	Jun 11	Jul 11	Aug 11	[illegible]	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	Apr 12
Specialist Surgery	0.2%	0.7%	0.3%	0.2%	[illegible]	0.1%	0.1%	0.4%	0.5%	0.2%	0.3%	0.3%	0.1%
GI Medicine, Surgery and Urology	1.2%	0.7%	0.7%	[illegible]	[illegible]	0.9%	1.0%	0.8%	0.9%	0.8%	1.1%	0.8%	1.1%
Cancer, Haematology and Oncology	0.9%	1.3%	0.8%	[illegible]	[illegible]	0.7%	0.5%	0.6%	1.0%	0.9%	1.1%	1.0%	0.8%
Musculo-Skeletal	0.7%	0.6%	1.0%	0.2%	0.8%	1.0%	0.5%	1.1%	0.7%	0.9%	1.0%	0.5%	0.4%
Medicine	3.9%	4.9%	[illegible]	[illegible]	[illegible]	4.3%	4.5%	4.0%	4.4%	5.4%	4.5%	5.2%	6.0%
Respiratory	4.3%	2.8%	[illegible]	3.4%	[illegible]	3.4%	3.7%	3.3%	3.8%	3.0%	4.3%	3.3%	2.7%
Cardiac, Renal & Critical Care	3.5%	3.5%	[illegible]	2.6%	2.9%	2.8%	2.4%	2.5%	3.4%	2.9%	3.9%	2.9%	3.5%
Emergency Department	0.1%	0.2%	[illegible]	[illegible]	0.1%	0.3%	0.2%	0.2%	0.2%	0.2%	0.1%	0.3%	0.3%
Women's		[illegible]	[illegible]	[illegible]		0.1%			0.1%	0.2%	0.1%	0.1%	0.2%
Children's	0.4%						0.6%	0.3%	1.0%	0.3%			
Anaesthesia and Theatres													
Imaging	40.0%	37.5%	[illegible]	15.4%	20.0%	44.4%	33.3%	62.5%	20.0%	53.3%	50.0%	40.0%	12.5%
UHL %	**[illegible]**	**1.4%**	**1.2%**	**1.2%**	**1.2%**	**1.3%**	**1.3%**	**1.2%**	**1.5%**	**1.4%**	**1.5%**	**1.4%**	**1.6%**

HSMR and RELATIVE RISK March 2011 - Feb 2012

	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	YTD
HSMR (Dfi)	100.9	92.4	101.5	91.5	96.9	90.8	98.1	89.8	85.6	82.6	89.1	99.5	93.1



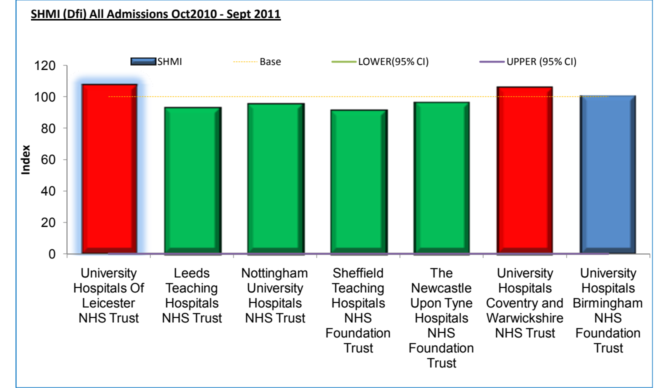


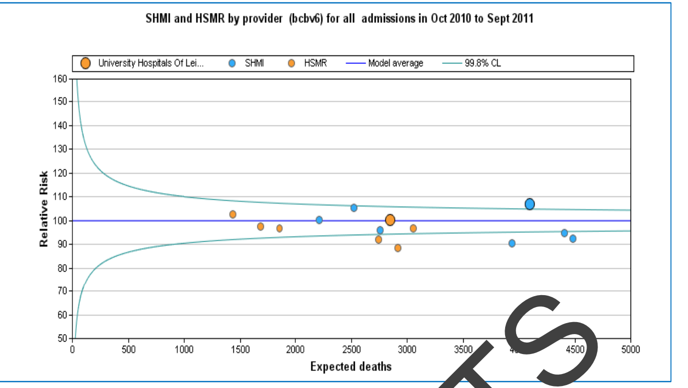
DRAFT 1 FOR COMMENTS

MORTALITY

UHL CRUDE MORTALITY

SHMI, Oct 2011 - Sept 2011



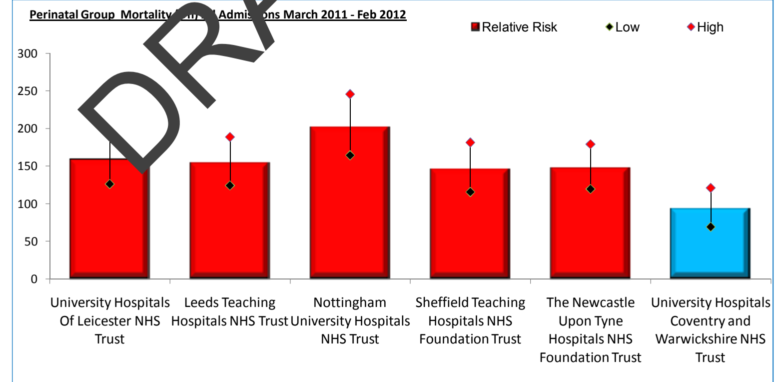


SHMI - High/low relative risk positions

CCS Group	Spells	Relative Risk	95% Confidence interval
High relative risks			
Chronic renal failure	356	296.3	189.8 - 440.8
HIV infection	96	257.7	128.5 - 461.1
Influenza	283	540.5	302.3 - 891.5
Intrauterine hypoxia and birth asphyxia	77	1,733.10	466.2 - 4,437.0
Other complications of pregnancy	4257	1,638.70	184.0 - 5,916.5
Other infections, including parasitic	63	751.2	151.0 - 2,194.9
Other non-traumatic joint disorders	636	180.8	113.3 - 273.8
Peritonitis and intestinal abscess	41	221.7	110.5 - 396.7
Pneumonia	2313	112.4	103.2 - 122.2
Short gestation, low birth weight, and fetal growth retardation	554	204.8	134.9 - 298.0
Low relative risks			
Fracture of lower limb	825	42.1	13.6 - 98.2
Other screening for suspected conditions	3130	0	0.0 - 62.7
Other skin disorders	482	23.5	2.6 - 84.9
Paralysis	363	58.4	31.1 - 99.8
Rehabilitation care, fitting of prostheses, and adjustment of devices	831	11.5	1.3 - 41.4

Perinatal - Mortality Details, March 2011 - Feb 2012

Perinatal Group	Spells	Deaths	%	Expected	%	Relative Risk	Low	High
University Hospitals Of Leicester NHS Trust	**10497**	**85**	**0.80%**	**53.8**	**0.50%**	**157.9**	**126.1**	**195.2**
Nottingham University Hospitals NHS Trust	10248	93	0.90%	60.4	0.60%	153.9	124.2	188.6
Leeds Teaching Hospitals NHS Trust	9988	100	1.00%	49.5	0.50%	201.8	164.2	245.5
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	7478	80	1.10%	54.9	0.70%	145.6	115.5	181.2
Sheffield Teaching Hospitals NHS Foundation Trust	7077	99	1.40%	67.3	1.00%	147	119.5	179
University Hospitals Coventry and Warwickshire NHS Trust	6003	53	0.90%	57.4	1.00%	92.4	69.2	120.9



Performance Overview

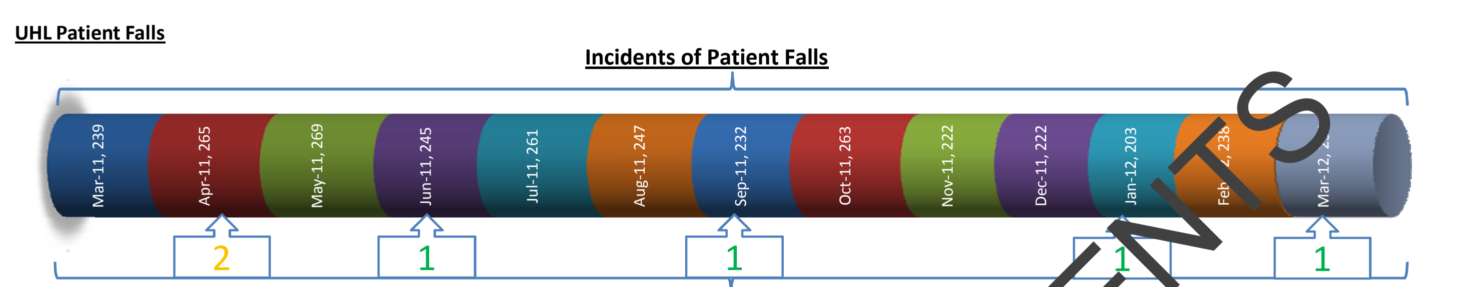
Full Year

DRAFT 1 FOR COMMENTS

FALLS

TARGET / STANDARD Incidents of Patient Falls	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	YTD	Target
UHL	**239**	**265**	**269**	**245**	**261**	**247**	**232**	**263**	**222**	**222**	**203**	**238**	**234**	**2901**	**TBC**
Planned Care	*83*	*55*	*60*	*55*	*60*	*59*	*67*	*67*	*50*	*54*	*49*	*55*	*52*	*683*	*TBC*
Acute Care	*145*	*198*	*196*	*174*	*193*	*171*	*154*	*186*	*163*	*163*	*148*	*173*	*177*	*2096*	*TBC*
Women's and Children's	*2*	*4*	*2*	*5*	*6*	*7*	*5*	*4*	*5*	*3*	*1*	*4*	*4*	*50*	*TBC*
Clinical Support	*9*	*8*	*11*	*11*	*2*	*10*	*6*	*6*	*4*	*2*	*5*	*6*	*1*	*72*	*TBC*
Falls Resulting in Severe Injury or Death	**0**	**2**	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**0**	**1**	**6**	**12**

UHL Patient Falls



Performance Overview

The data for February 2012 highlights that the number of in patient falls shows a slight increase . Weekly reviews of falls data by the Heads of Nursing and Lead Nurses continue to focus on specific wards.

An update paper submitted to the GRMC at the end of March 2012 shows significant progress has been made with a 17% reduction in falls from December 2011 to February 2012 when compared with previous data. There has been particular progress in Cardiac, Renal, Critical Care and Musculoskeletal CBU's.

The recent introduction of the SHA Safety Thermometer across the Trust will provide benchmark data and further focus to the falls reduction programme.

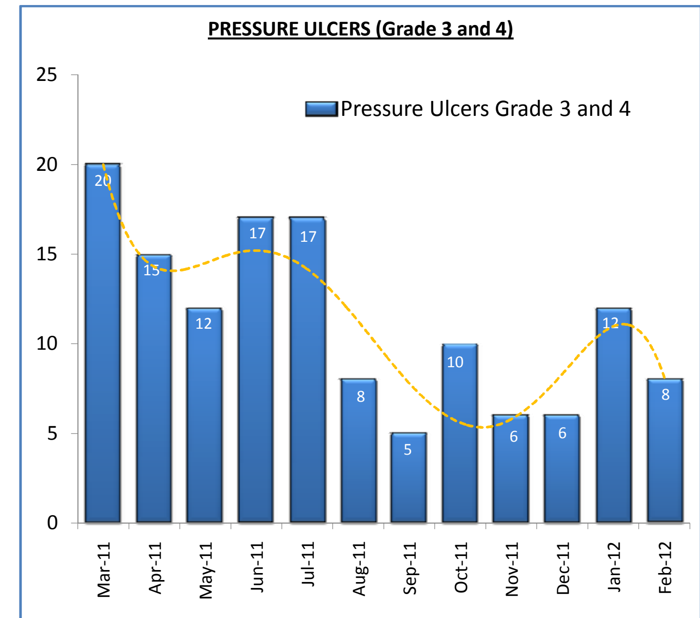
PRESSURE ULCERS (Grade 3 and 4)

Performance Overview

There were eight grade 3 and 4 ulcers reported in February 2012 which is is slight decrease from the previous month. Seven ulcers were reported in Acute Care and one ulcer for Planned Care. Again, there has been a slight decrease in incidences when comparing similar data from February 2011 when 14 ulcers were reported.

Four of the pressure ulcers have been classified avoidable and four were unavoidable but these decisions still need to be ratified by the commissioners.

The Tissue Viability Team and Nursing Directorate are actively involved with the actions required to achieve the SHA Ambition - elimination of all avoidable pressure ulcers by December 2012. Progress will be reported at the GRMC in May, together with an annual report on pressure ulcers reductions in UHL for 2011/12.



TARGET / STANDARD	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	YTD	Target
Pressure Ulcers Grade 3 and 4	**20**	**15**	**12**	**17**	**17**	**8**	**5**	**10**	**6**	**6**	**12**	**8**	**22**	**138**	**197**
Attributable to Trust								6	6	2	10	4	10	38	
Not Attributable to Trust								3	0	4	2	4	4	17	

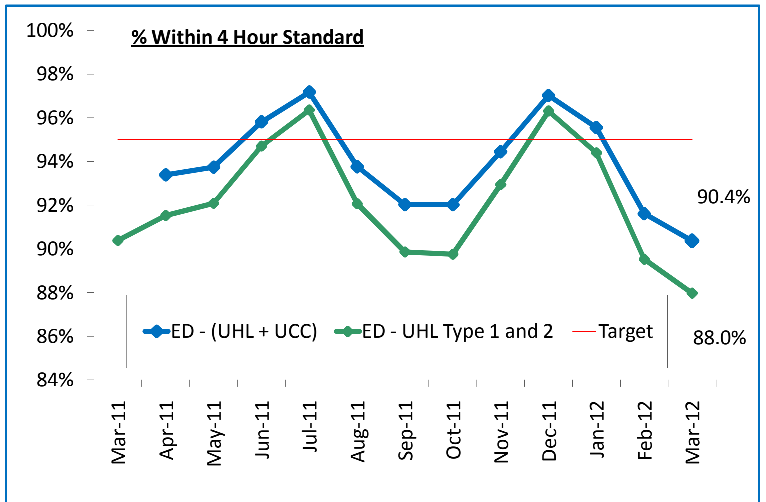
DRAFT 1 FOR COMMENTS

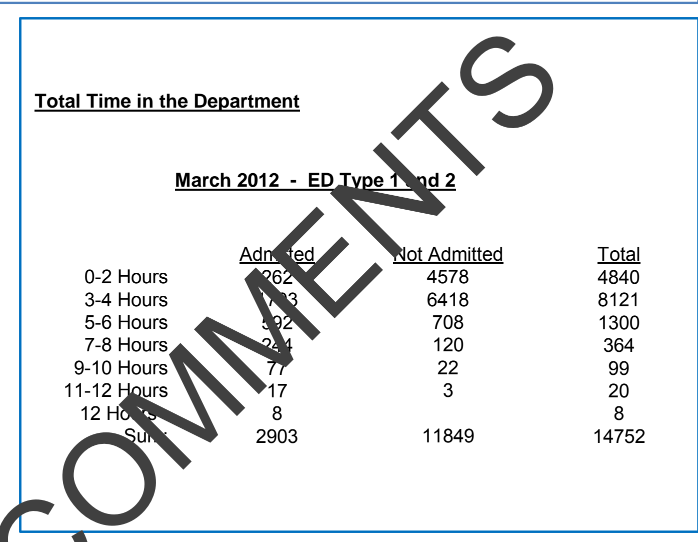
EMERGENCY DEPARTMENT

Performance Overview
Performance for March Type 1, 2 is 88.0% and 90.4% including the Urgent Care Centre (UCC). The year to date performance for ED (UHL+UCC) is 93.9%.

Key Actions
Confirmation has been received from the DoH that the data coverage issue reported in the October and December Trust Board papers, has been resolved from Quarter 2 as expected. The UCC are now in a position to submit patient level data sets as well as aggregate submissions.

Full Year
ED + UCC 4 hr performance - 93.9%





Total Time in the Department

March 2012 - ED Type 1 and 2

	Admitted	Not Admitted	Total
0-2 Hours	262	4578	4840
3-4 Hours	[illegible]	6418	8121
5-6 Hours	592	708	1300
7-8 Hours	244	120	364
9-10 Hours	77	22	99
11-12 Hours	17	3	20
12 Hours	8		8
Sum:	2903	11849	14752

CLINICAL QUALITY INDICATORS

PATIENT IMPACT

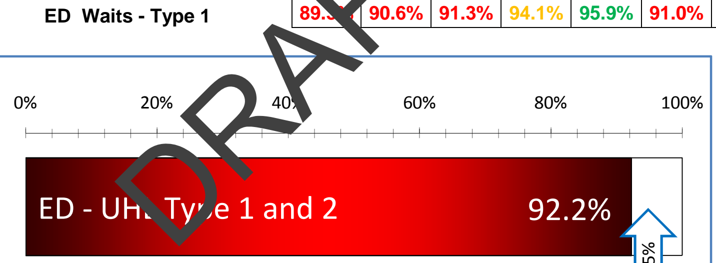
	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	TARGET
Left without being seen %	2.5%	2.5%	2.2%	2.0%	2.1%	[illegible]	[illegible]	2.9%	2.0%	2.3%	2.1%	2.4%	3.6%	<=5%
Unplanned Re-attendance %	6.3%	6.6%	5.6%	5.2%	5.9%	[illegible]	5.5%	6.0%	5.7%	5.4%	6.1%	6.1%	6.6%	< 5%

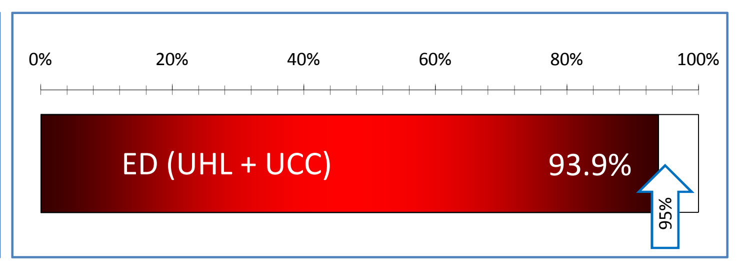
TIMELINESS

	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	TARGET
Time in Dept (95th centile)	343	306	307	[illegible]	239	304	338	341	288	240	264	331	331	< 240 Minutes
Time to initial assessment (95th)	63	70	56	41	39	48	48	61	48	42	32	34	41	<= 15 Minutes
Time to treatment (Median)	58	59	[illegible]	50	34	34	39	44	43	42	42	54	61	<= 60 Minutes

4 HOUR STANDARD

	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	YTD	TARGET
ED - (UHL + UCC)		93.4%	93.7%	95.8%	97.2%	93.8%	92.0%	92.0%	94.4%	97.0%	95.5%	91.6%	90.4%	93.9%	95.0%
ED - UHL Type 1 and 2	90.4%	91.5%	92.1%	94.7%	96.4%	92.1%	89.9%	89.8%	92.9%	96.3%	94.4%	89.5%	88.0%	92.2%	95.0%
ED Waits - Type 1	[illegible]	90.6%	91.3%	94.1%	95.9%	91.0%	88.7%	88.5%	92.1%	96.0%	93.7%	88.3%	86.6%	91.3%	95.0%





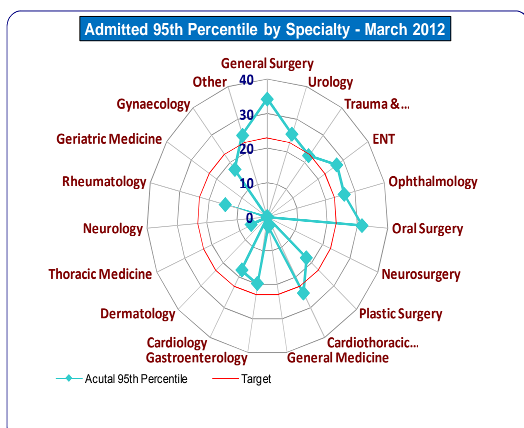
DRAFT 1 FOR COMMENTS

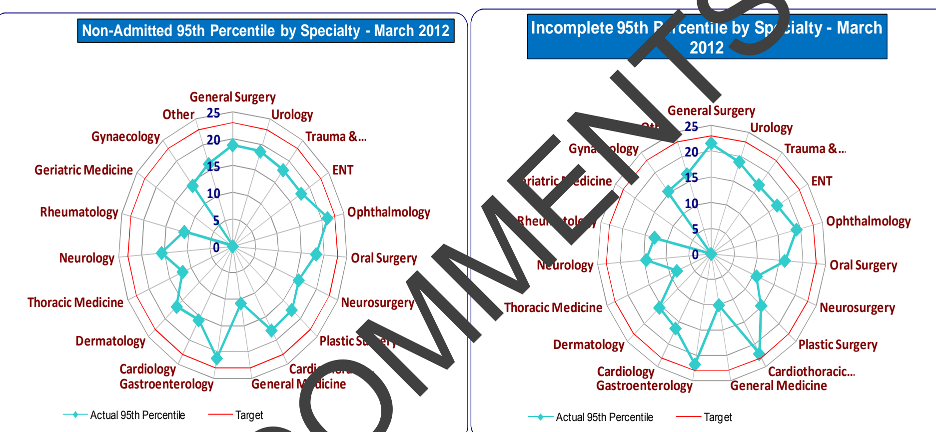
18 WEEK REFERRAL TO TREATMENT

Performance Overview
Admitted performance in March stands at 83.5% in accordance with the planned reduction agreed with commissioners. The non-admitted target has been achieved at 95.9%.

Key Actions
Admitted pathways are those that end in an admission to hospital (either inpatient or day case) for treatment. The Trust agreed a plan with the commissioners to increase activity in Quarter 3 and Quarter 4 to reduce the number of patients on an 18 week backlog and 26 week backlog.

Non-admitted pathways are those that end in treatment that did not require admission to hospital or where no treatment is required. Additional focus has been placed on validating patients that are waiting over 18+ weeks and 26+.

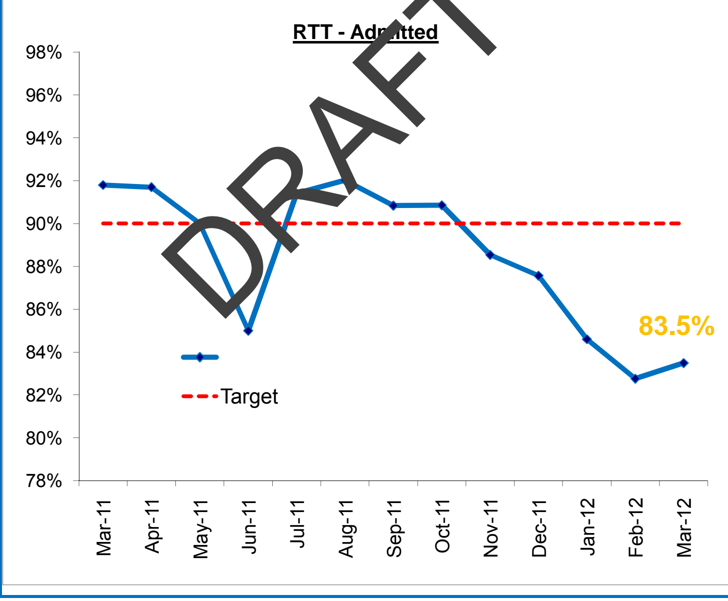


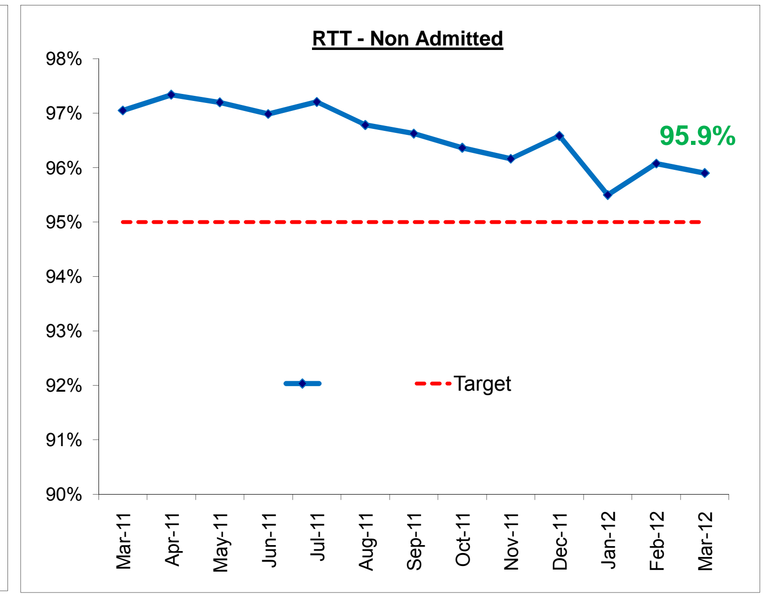


TARGET / STANDARD

RTT	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Target
RTT waiting times – admitted	91.8%	91.7%	90.0%	85.0%	91.4%	[illegible]	90.8%	90.9%	88.5%	87.6%	84.6%	82.8%	83.5%	90%
RTT waiting times – non-admitted	97.1%	97.3%	97.2%	97.0%	97.2%	[illegible]	96.6%	96.4%	96.2%	96.6%	95.5%	96.1%	95.9%	95%

	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Target
RTT - incomplete 92% in 18 weeks	New O/F target April 2012									92%
RTT delivery in all specialties	New O/F target April 2012									0
Diagnostic Test Waiting Times	New O/F target April 2012									<1%





DRAFT 1 FOR COMMENTS

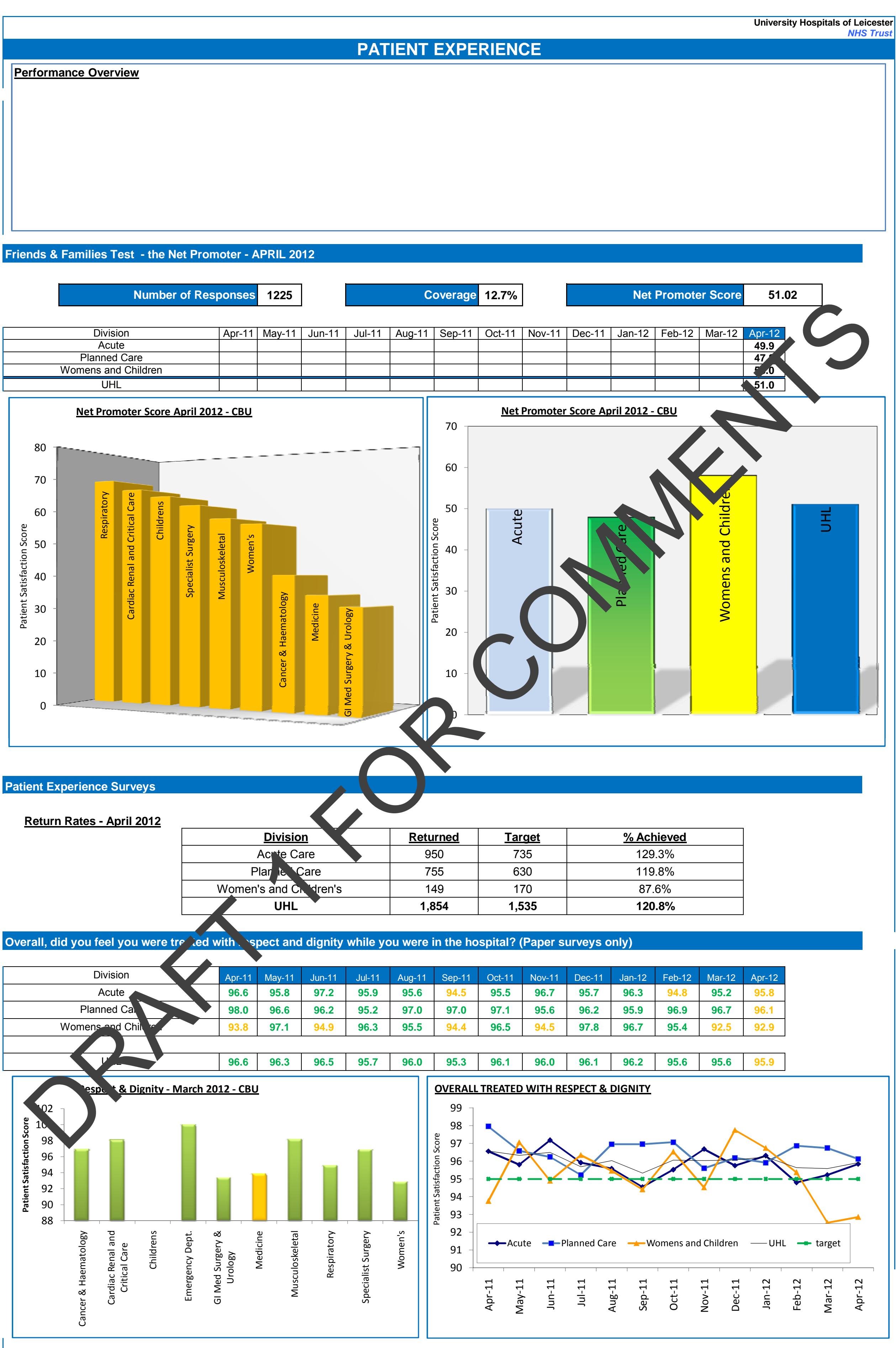
PATIENT EXPERIENCE

Performance Overview

Friends & Families Test - the Net Promoter - APRIL 2012

Number of Responses	1225	Coverage	12.7%	Net Promoter Score	51.02

Division	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12
Acute													49.9
Planned Care													[illegible]
Womens and Children													[illegible]
UHL													51.0



Patient Experience Surveys

Return Rates - April 2012

Division	Returned	Target	% Achieved
Acute Care	950	735	129.3%
Planned Care	755	630	119.8%
Women's and Children's	149	170	87.6%
UHL	**1,854**	**1,535**	**120.8%**

Overall, did you feel you were treated with respect and dignity while you were in the hospital? (Paper surveys only)

Division	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12
Acute	96.6	95.8	97.2	95.9	95.6	94.5	95.5	96.7	95.7	96.3	94.8	95.2	95.8
Planned Care	98.0	96.6	96.2	95.2	97.0	97.0	97.1	95.6	96.2	95.9	96.9	96.7	96.1
Womens and Children	93.8	97.1	94.9	96.3	95.5	94.4	96.5	94.5	97.8	96.7	95.4	92.5	92.9
UHL	96.6	96.3	96.5	95.7	96.0	95.3	96.1	96.0	96.1	96.2	95.6	95.6	95.9