University Hospitals of Leicester NHS
NHS Trust

	TRUST BOARD
From:	Suzanne Hinchliffe Jeremy Tozer Andrew Seddon Kate Bradley
Date:	31st January 2013
CQC regulation	All

Title: **Quality & Performance Report**

Author/Responsible Director: S. Hinchliffe, Deputy Chief Executive /Chief Nurse
J Tozer, Interim Director of Operations
A. Seddon, Director of Finance
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 December 2012.

The Report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Endorsement	

Summary / Key Points:

Patient Safety, Quality and Patient Experience

- Mortality rate - UHL's crude in-hospital mortality rate continues to be 1.4% for 12/13. The HSMR for 12/13 (April to October) is 97.7 for 12/13.
- 5 Critical Safety Actions - This month has continued to see progress against the 5 Critical Safety Actions. The Boston Consultancy Group (BCG) quality commitment work has incorporated two of the five critical safety actions into its 2013 priorities and the remaining three actions into the fundamental priorities for the trust.
- Fracture Neck of Femur theatre time - December performance for time to surgery within 36 hours for fractured neck of femur patients is 75.4%. The year to date position is 72.0 % against a target of 70%.
- VTE - UHL's performance for December as reported to the DoH, is 94.1%, this figure includes the 'Renal Dialysis' patients. Without the dialysis patients, performance is still above the CQUIN threshold, when including other cohort patients – 90.1%.
- Theatres 100% WHO compliance - The current performance of the checklist stands at 99.6% with further work being undertaken to isolate and remedy the stage where compliance is not met.
- Safety Thermometer - The percentage of harm free care in UHL has fallen slightly to 92.69%. The number of new harms has also increased slightly from 40 to 45. Nevertheless, when comparing the number of new harms from April 2012 (107 in total) to December 2102 (45) significant progress has been made in reducing all four harms in our patients.
- MRSA – There are no MRSA cases reported for December. The year to date figure is 1 against a 2012/13 target of 6 cases.
- C Difficile – December reported 10 cases resulting in a cumulative position of 69 against a target of 83 for April to December.

Trust Board Paper Q

- Patient Experience - Net Promoter >10% inpatient coverage and an overall trust score of 57.5.
- All UHL wards and intensivist areas continue to offer Same Sex Accommodation (SSA) in line with the UHL SSA Matrix guidance and delivered 100% in November.

Operational Performance

- ED - Performance for December Type 1 & 2 is 89.8% and 92.0% including the Urgent Care Centre (UCC).
- Choose and Book - Choose and book slot availability performance for December was 8%.
- RTT - Admitted performance in December has been achieved with performance at 91.9%, with all specialties with the exception of Ophthalmology delivering above the 90% target. The non-admitted target for December has been achieved at 97.2% against a target of 95%.
- Cancelled Operations – December performance shows that the percentage of operations cancelled on/after the day of admissions of all elective activity for non clinical reasons was 1.1% against a target of 0.8%.
- Imaging Waits - In December diagnostic waiting times exceeded the 1% DoH threshold for the top 15 diagnostic procedures. Performance was 1.1%.
- Cancer - All of the cancer targets are delivering against performance thresholds for November (one month in arrears reporting) with the exception of the 2 week wait target.
- The percentage of eligible patients with acute myocardial infarction who received Primary PCI within 150 minutes of calling professional help in December was 96.6% against a target of 75%. The year to date cumulative performance is 92.5%.
- Stroke % stay on stroke ward - The percentage of patients spending 90% of their stay on a stroke ward in November (reported one month in arrears) is 75.0% against a target of 80%. The cumulative performance for the year to date is 80.0%.
- Appraisals – The appraisal rate is 90.8%.
- Sickness - The reported sickness rate December is 4.4%.

Financial Position

- The Trust is reporting a cumulative £7.3m deficit for the first 9 months, £7.1m adverse to Plan.
- Income ytd is £12.0m (2%) over Plan, which is stated net of a £2.8m marginal rate deduction for emergency inpatient income over the 2008/09 baseline.
- Operating costs cumulatively are £19.7m over Plan, with premium cost staff largely being used to deliver the additional activity

Recommendations: Members to note and receive the report

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: 31st JANUARY 2013

REPORT BY: SUZANNE HINCHLIFFE, DEPUTY CHIEF EXECUTIVE/CHIEF NURSE
JEREMY TOZER, INTERIM DIRECTOR OF OPERATIONS
KATE BRADLEY, DIRECTOR OF HUMAN RESOURCES
ANDREW SEDDON, DIRECTOR OF FINANCE

SUBJECT: DECEMBER 2012 QUALITY & PERFORMANCE SUMMARY REPORT

1.0 INTRODUCTION

The following paper provides an overview of the December 2012 Quality & Performance report highlighting key metrics and areas of escalation or further development where required.

2.0 QUALITY AND PATIENT SAFETY – SUZANNE HINCHLIFFE

2.1 Mortality Rates

UHL's crude in-hospital mortality rate continues to be 1.4% for 12/13. The HSMR for 12/13 (April to October) is 97.7 for 12/13.

The trust's risk adjusted mortality rates are 'within expected' for both the 'HSMR' and elective and non-elective Relative Risk.

UHL's SHMI for 11/12 was 105 and remains 'within expected'. The SHMI for July 11 to June 12 is due to be published at the end of January and is anticipated to remain at 105.

The CCG Quality Leads are liaising with Public Health and CCG GPs regarding the proposed interface audit, planned for Spring 2013. The audit will review care provided both within UHL and prior to admission/post discharge (where patients die post discharge from UHL).

Reducing mortality is one of the Quality & Safety Commitments and two of the work streams are:-

- improving the pathway for patients admitted with pneumonia
- improving the pathway of patients admitted at weekends and out of hours

An admission pathway is currently being drafted with input from both ED, Respiratory and Acute Medicine Physicians

At the last Reducing Mortality Steering Group meeting, it was noted that the '24/7 project' will obviously contribute to improving the pathway of patients admitted at weekends and out of hours. It was also felt that an observational audit was needed to confirm other priorities.

2.2 Patient Safety and 5 Critical Safety Actions

Although overall complaints activity remains high, the number of formal complaints relating to attitude of staff for December is at the lowest level for 13 months. Similarly, the number of complaints received relating to discharge and the number of re-opened complaints are at the lowest level for more than a year.

Incident reporting across the trust remains good and with a reduction in avoidable death and harm SUIs. Work to reduce this further is being progressed through the 'reduce harms ' work stream of the new Trust Quality and Safety Commitment.

Staffing and activity levels continue to be flagged by staff as areas of concern through the safety walkabout programme, the daily capacity report and through formal incidents reported on to Datix. This is reviewed by divisional heads of nursing and measures put in place to ensure safe, high quality care. Specific concerns raised by staff in the Emergency Department are being addressed through the 'Right Place' programme

This month has continued to see progress against the 5 Critical Safety Actions. The Boston Consultancy Group (BCG) quality commitment work has incorporated two of the five critical safety actions into its 2013 priorities and the remaining three actions into the fundamental priorities for the trust.

Health Care Assistant assessments for clinical observations have again increased and the children's division have achieved 100%. This is still behind target in acute, planned care and the women's divisions but should be achieved by end of Q4. Disappointingly Early Warning Score (EWS) incidents for December 2012 are higher than previous months. In Quarter 3, the number of EWS reported incidents is the highest number for the past two years with 86 % of these incidents occurring in the acute division. A report from action leads has been requested to review and act upon this performance.

5 Critical Safety Actions

1. **Improving Clinical Handover**.

Aim - To provide a systematic, safe and effective handover of care and to provide timely and collaborative handover for out of hours shifts

Actions:-

- UHL Shift Handover Guidelines sent to November and December Policy and Guideline Committee not approved, require minor amendment by authors for approval.
- Development work by IT on UHL web based handover system is now complete. Agreement of Go Live date for this to be agreed at Clinical Handover Leads meeting in early February.
- Further work with alternative handover system supplier to develop module has been completed. Agreement for pilot in surgery at LRI. Finalising audit and IT requirements for pilot and start date agreed for 1st February 2103.

2. Relentless attention to Early Warning Score triggers and actions

Aim - To improve care delivery and management of the deteriorating patient

Actions:-

- ❖ HCA competency programme being rolled out with support from divisional nursing and education leads. Aim to achieve 100% end of Q3. Childrens have achieved 100% and gynae have achieved 96%. Maternity, acute and planned care are still below 80%, but aim to achieve 100% by end of Q4.
- ❖ Outreach lead to continue drive with acute and planned care divisions to improve progress. This is behind target in acute and planned care divisions but will be achieved by the end of Q4.

3. Implement and Embed Mortality and Morbidity standard

Aim - To have a standardised process for reviewing in-hospital deaths and archiving of the completed reviews.

Actions:-

- ❖ 100% of specialities have confirmed that M&M meetings are taking place. Increasing number of specialities have saved Terms of Reference (ToR) to shared drive. Action lead to meet with all M&M leads over next month to ensure ToR are written.
- ❖ Specialities have commenced saving minutes onto shared drive. Increasing number have minutes saved and all have either Terms of Reference or minutes saved to the shared drive.
- ❖ Increased focus with work regarding use of criteria for patients reviewed at M&M meetings by action lead.

4. Acting upon Results

Aim - No avoidable death or harm as a failure to act upon results and all results to be reviewed and acted upon in a timely manner.

Actions

- ❖ Overarching Screening Policy resubmitted to December PGC was approved, with recommendation for minor alterations by policy author.
- ❖ Final draft of Diagnostic Testing overarching policy to include medical staff and AHP that undertake diagnostic testing out for final comments, to be submitted to February PGC for approval.
- ❖ Agreement that part of the Acting on Results action will be a focus for the BCG Quality Commitment work, as a priority for 2013.

5. Senior Clinical Review, Ward Rounds and Notation

Aim - To meet national standards for clinical documentation. To provide strong medical leadership and safe and timely senior clinical reviews and ensure strong clinical governance.

Actions

- ❖ Work undertaken in general surgery to pilot ward round standards in the form of ward round sticker. Audit results currently being collated by team.
- ❖ Lead identified excellent practice with ward round checklist in UCLH, London. Visit to UCLH in early December by action lead to review its use in clinical areas. Plan to adapt checklist tool in February 2013 for trial/use in UHL.

- ❖ Final draft of ward round template sheet as documentation for trial in medicine submitted for printing. Trial for Feb 2013 planned for Ward 24 at LRI.
- ❖ Agreement that Senior Clinical Review, Ward Rounds and Notation action will be a focus for the BCG Quality Commitment work as a priority for 2013.

2.3 Fractured Neck of Femur 'Time to Theatre'

December performance for time to surgery within 36 hours for fractured neck of femur patients is 75.4%. The year to date position is 72.0 % against a target of 70%.

2.4 Venous Thrombo-embolism (VTE) Risk Assessment

UHL's performance for December as reported to the DoH, is 94.1%, this figure includes the 'Renal Dialysis' patients. Without the dialysis patients, performance is still above the CQUIN threshold, when including other cohort patients – 90.1%.

2.5 Theatres – 100% WHO compliance

The National Patient Safety Agency endorsed WHO checklist consists of four stages and is monitored and reported every month to commissioners. Recent results have been found to be below the 100% requirement and reports to the Quality Assurance Committee and quality contract meeting are required.

The current performance of the checklist stands at 99.6% with further work being undertaken to isolate and remedy the stage where compliance is not met.

A report regarding current status and action is being provided to the Quality Assurance Committee in January by the Clinical Support Division.

2.6 CQUIN Schemes

LLR 12/13 CQUINs

Quarter 2's performance for each of the CQUINs was reviewed at the CQRG meeting on 21st November. Three of the CQUIN schemes will not be 'reconciled' until the end of the year (National Goal 1 – Responsiveness to Patients Needs; National Goal 2 'Dementia Screening' and Regional 1 – Net Promoter). Further information has been requested in respect of the 5 Critical Safety Actions CQUIN in order to finalise the Quarter 2 reconciliation.

Thresholds for all the other CQUINs were fully achieved with the exception of:

'ED Internal Standards 'which was RAG rated Amber (33% payment) due to non achievement of the 'review by decision maker within 1 hour and 'consultant sign' off'.

EMSCG 12/13 CQUINs

Performance for Quarter 2 of the 1213 EMSCG CQUIN schemes was reviewed by EMSCG at the beginning of November and the RAG rating agreed.

All but one of the indicators were RAG rated Green.

A red RAG was given to the Intravenous Chemotherapy and Performance Status[1] Recording CQUIN due to non achievement of the thresholds for 'PS recording prior to subsequent cycles'. A new process for assessing and recording of patients PS has now been implemented on the Chemotherapy Suite.

[1] Performance Status = assessment of patients' well being and suitability for treatment

Appendix 1 details each of the indicators to be reported in Q3 and the predicted RAG.

2.7 Safety Thermometer

Safety Thermometer (ST) progress to date for each of the four harms is given in the table below. The percentage of harm free care in UHL has fallen slightly to 92.69%. The number of new harms has also increased slightly from 40 to 45. Nevertheless, when comparing the number of new harms from April 2012 (107 in total) to December 2102 (45) significant progress has been made in reducing all four harms in our patients.

It is evident that some of the increase can be attributable to the new DH definitions for 'New' CAUTIs and VTEs. However, there was also a small increase in the prevalence of new hospital acquired pressure ulcers and this was also reflected in the incidence of pressure ulcers for December.

		Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec
	Number of patients on ward	1533	1570	1593	1551	1554	1475	1626	1617	1668
All Harms	Total No of Harms	189	181	141	160	137	109	98	99	126
	No of patients with no Harms	1359	1401	1457	1404	1426	1373	1533	1522	1546
	% Harm Free	88.65%	89.24%	91.46%	90.52%	91.76%	93.08%	94.28%	94.12%	92.69%
Newly Acquired Harms	Total No of New Harms	107	82	62	86	59	41	33	40	45
Harm One	All Pressure Ulcers (Grades 2, 3 or 4)	108	113	90	85	78	61	62	70	90
	New Pressure Ulcers (Grade 2, 3 or 4)	43	40	27	29	20	13	12	27	29
Harm Two	Harmful Fall	15	14	9	24	14	11	8	4	3
Harm Three	No of Patients with Urinary Catheter and Urine Infection (prior to or post admission)	28	40	32	34	29	33	23	19	26
	Newly Acquired UTIs with Catheter	11	14	16	16	9	13	9	3	6
Harm Four	Newly Acquired VTE (either DVT, PE or Other)	38	14	10	17	16	4	4	6	7

2.8 Nursing and Midwifery Council (NMC) Review of Women's & Children's Services

Further to a NMC review of services including interviews with students, mentors and managers, commendation was given for practice learning and mentorship across all areas. Feedback from students included positive learning opportunities and enthusiastic, engaged mentors. The trust mentor register was a particular note of good practice and placement leads praised for their roles in meeting the NMC standards and in maintaining practice links with De Montfort University.

3.0 PATIENT EXPERIENCE – SUZANNE HINCHLIFFE

3.1 Infection Prevention

MRSA – There are no MRSA cases reported for December. The year to date figure is 1 against a 2012/13 target of 6 cases.

C Difficile – December reported 10 cases resulting in a cumulative position of 69 against a target of 83 for April to December.

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

3.2 Patient Polling

Patient Experience Surveys continue across 88 clinical areas and have four bespoke surveys for adult inpatient, children's inpatient, adult day case and intensive care settings.

Over thirty questions are asked in this survey including all CQUINs and other key areas identified as priorities from local feedback. These include:

- help with eating and drinking,
- confidence and trust in staff,
- response to call buttons,
- help with toileting
- care and compassion

In December 2012, 1,391 Patient Experience Surveys were returned which is slightly below the Trusts target of 1,523

Share Your Experience – Electronic Feedback Platform

Main Outpatients on each site, Maternity Services and the Emergency Department owing to the patient group use Share Your Experience as the medium to gain feedback via email, touch screen and web. In December 2012, 202 surveys were completed:

Outpatient's visits: 105 surveys
Maternity Services: 19 surveys
Emergency department: 47 surveys
Children's Emergency department: 31 surveys

Share Your Experience was launched across the Neonatal Units on the 27th November 2012 using a bespoke survey within this specialised area. A total of 7 surveys were returned for the LRI Neonatal unit during December 2012, with the LGH Neonatal Unit expected to come online in early 2013.

Patient feedback continues to be accessible for all staff at Trust, Divisional, CBU and Ward level via Share point on the Patient Experience Page or via the 'Share your Experience' site. This includes all free text comments for each ward from patients.

Treated with Respect and Dignity

The Trust has maintained a GREEN rating for the question 'Overall do you think you were you treated with dignity and respect while in hospital' based on the scoring methodology used in the national survey.

Friends and Family Test

The surveys include the net promoter question; **How likely is it that you would recommend this service to friends and family?'** Of the 1,391 surveys, 1,343 surveys included a response to the Net Promoter Question and were considered inpatient activity

(excluding day case/ ED / outpatients) and therefore were included in the Net Promoter Score for the SHA.

Overall there were 12,298 inpatients in the relevant areas within the reporting period (25/11 to 29/12), giving a 10% footfall requirement of 1,230. The Trust easily met the SHA target with a total of 1,343 Net Promoter responses broken down to:

Number of Promoters:	885
Number of passives:	345
Number of detractors:	113
Overall NET promoter score	**57.5**

In April 2012 the Trust overall net promoter score was 51 with a target of 61 by March 2013. December 2012 score shows a 6.5 point improvement from baseline. The following actions will be initiated by the divisions to achieve the April 2013 target:

- Divisional review of Net Promoter Scores at ward level highlighting areas of underperformance and local plans to improve ward scores
- The Four Divisional Action Plans are now embedded within the Divisions and are driving development / improvement activity
- Patient Centred Care Quality Action Group has engaged patient representatives, local groups and clinical staff to focus improvement activity within key areas.

National Patient Survey results are to be submitted by 11th Jan 2013 and shortly after this date, once published by the CQC the trust will be in a position to compare internal survey results with this National data identifying similarities and differences.

3.3 Same Sex Accommodation

All UHL wards and intensivist areas continue to offer Same Sex Accommodation (SSA) in line with the UHL SSA Matrix guidance and delivered 100% in December.

4.0 OPERATIONAL PERFORMANCE – JEREMY TOZER

4.1 ED 4hr Wait Performance

Performance for December Type 1 & 2 is 89.8% and 92.0% including the Urgent Care Centre (UCC).

Further details focussing on the actions relating to the Emergency Department are included in the ED performance report.

4.2 Choose and Book slot availability

Commissioners have detailed contractual requirements for an incremental reduction in the % of Appointment Slot Issue (ASI) during 2012/13 as follows:-

- Quarter 1, ASI rate shall be no greater than 15% measured cumulatively
- Quarter 2, ASI rate shall be no greater than 11% measured cumulatively
- Quarter 3, ASI rate shall be no greater than 8% measured cumulatively
- Quarter 4, ASI rate shall be no greater than 5% measured monthly

During Quarter 4 2012/13 failure to comply with the ASI target will result in financial consequences. Which based on current performance could potentially be circa £100,000 per month.

Choose and book slot availability performance for December was 8%.

The Qtr 4 standard is being met following key actions taken in mid December, these included:

- ❖ Review of problem services at clinic level, additional C&B slots made
- ❖ Increased waiting times set on C&B where appropriate
- ❖ Provision of prospective C&B report to aid future slot availability

The following additional actions are being taken to ensure ongoing compliance:

- ❖ Weekly review of all service future capacity, by corporate operations
- ❖ Further reductions in waiting times for 1st OPD appointments for key specialties, including general & colorectal surgery and gastroenterology.

Further details can be found in the Choose and Book slot availability exception report.

4.3 RTT – 18 week performance

Admitted performance in December has been achieved with performance at 91.9%, with all specialties with the exception of Ophthalmology delivering above the 90% target.

The national admitted performance in November (most recent published data) was 92.7% and UHL achieved 91.7% with the upper quartile being 94.7%. 105 out of the 178 Trusts missed the target at specialty level and 72 Trust's had between 2 and 10 specialty failures.

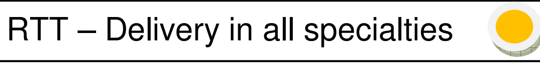
The non-admitted target for December has been achieved at 97.2% against a target of 95%.

The national non-admitted performance in November (most recent published DoH data), was 97.5% and UHL achieved 96.6% with the upper quartile being 99.1%. 91 out of the 207 Trusts missed the target at specialty level and 66 Trusts had between 2 and 16 specialty failures.

RTT Incomplete Pathways

The 2012/13 Operating Framework 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 was achieved in December at 93.8%. Confirmation has been received that this target will remain at 92% in 2013/14.

The national incomplete pathways performance in November (most recent published DoH data) was 94.0% and UHL achieved 94.6% with the upper quartile being 97.6%. 109 out of the 210 Providers missed the target at specialty level and 78 Providers had between 2 and 10 specialty failures.



The automatic financial penalty for failing to deliver the 90% target in Orthopaedics admitted performance during November has been confirmed as £73,700. Commissioners were asked to waive this penalty due to the fact that the reason for growth in backlog was due to unforeseen circumstances that the UHL could not plan for. The LLR Performance

Collaborative have confirmed that although they understood the issues were outside UHL's direct control this request could not be granted, as local commissioners do not have authority to deviate from nationally determined automatic contract consequences.

Ophthalmology failed to achieve the admitted 90% target during December and therefore will have an automatic penalty of £35,000 (estimated). Further details can be found in the RTT exception report.

All specialties delivered for non-admitted patients.

4.4 Cancelled Operations

December performance shows that the percentage of operations cancelled on/after the day of admissions of all elective activity for non clinical reasons was 1.1% against a target of 0.8%. The main reason for the increase in short notice cancellations during the month was due to an increase in emergency demand creating pressure on the bed capacity.

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	YTD
Operations cancelled for non-clinical reasons on or after the day of admission	1.1%	1.2%	1.2%	0.9%	0.5%	0.9%	1.1%	1.6%	1.1%	1.1%

The percentage offered a date within 28 days of the cancellation was 88.2% against a threshold of 95%.

Plans are in place to report both urgent operations cancelled twice (new indicator for 2013/14 and operations cancelled a week before the operation date.

Further details can be found in the Cancelled Operation exception report.

4.5 Day Case Basket

The percentage of patients (with treatments in the day case basket) treated as day cases for December is 80.0% against a target of 75%, with a cumulative year to date figure of 75.2%.

4.6 Imaging Waiting Times

In December diagnostic waiting times exceeded the 1% DoH threshold for the top 15 diagnostic procedures. Performance was 1.1%.

The outlying areas were within imaging: MRI, CT and non obstetric ultrasound (a total of 89 patients). The cause was a combination of equipment failure, staff sickness and vacancies. Additional activity is being carried out during January to recover the position to below the 1% threshold and to reduce the total number waiting over 6 weeks by the end of January 2013.

Further details can be found in the Imaging Waiting times exception report.

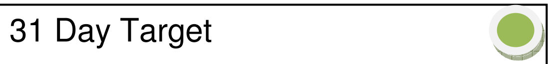
4.7 Cancer Targets

Two Week Wait

The two week wait urgent GP referral for suspected cancer to date first seen target of 93% was missed in November, with performance at 90.6% and a year to date cumulative

performance of 93.1%. Further details can be found in the 2 week cancer wait exception report.

The symptomatic breast patients (cancer not initially suspected) have been achieved for November (reporting one month in arrears).



All four 31 day cancer targets – diagnosis to treatment for first treatment, second or subsequent treatment anti cancer drug, second or subsequent treatment surgery and second or subsequent treatment radiotherapy have been achieved for October (reporting one month in arrears).

The 62 day urgent referral to treatment cancer target for November (reporting one month in arrears) was 85.8% against a target of 85%. The year to date cumulative performance is 84.9%. Commissioners have confirmed the penalty relating to this indicator will be repaid at the yearend if performance is above 85%.

4.8 Primary PCI

The percentage of eligible patients with acute myocardial infarction who received Primary PCI within 150 minutes of calling professional help in December was 96.6% against a target of 75%. The year to date cumulative performance is 92.5%.

4.9 Stroke % stay on stroke ward

The percentage of patients spending 90% of their stay on a stroke ward in November (reported one month in arrears) is 75.0% against a target of 80%. The cumulative performance for the year to date is 80.0%. Further details can be found in the stroke performance exception report.

4.10 Stroke TIA

The percentage of high risk suspected TIAs receiving relevant investigations and treatment within 24 hours of referral receipt (% of high risk referrals) is 68.7% against a contractual target if 62.1%. The year to date cumulative position is 66.4%.

4.11 Readmissions

The Interim Director of Operations will implement a Readmissions Project Board in January 2013 and discussions continue with commissioners (via the Emergency Care Network) with regards to how the £5.2m penalty applied against avoidable readmissions is spent.

Planned Care has instigated a number of additional audits to identify where the main focus for improvement should be targeted.

4.12 Delayed Discharges

During this month there has been an improvement in the overall performance for both city and county patients, compared to last month.

Reason	Assessment		Awaiting Public funding		Availability of non acute NHS Care		Awaiting care home placement		Awaiting domiciliary package of care		Awaiting community equipment		Patient /Family choice		TOTAL	
	City	Co	City	Co	City	Co	City	Co	City	Co	City	Co	City	Co	City	Co
April	10	8	4	5	5	19	10	9	2	3	1	0	2	7	34	51
May	6	14	13	23	20	51	18	60	3	7	7	6	5	23	72	184
June	9	13	10	14	26	48	15	42	3	6	12	14	2	20	77	157
July	10	12	7	14	25	35	13	42	2	9	12	10	9	19	78	141
Aug	12	23	10	20	38	55	23	52	2	8	13	9	5	39	103	206
Sept	11	24	9	18	16	26	16	36	5	8	7	16	9	19	73	147
Oct	17	12	10	19	16	34	23	43	0	3	11	12	3	15	80	138
Nov	20	23	6	5	44	38	25	56	3	5	11	14	15	25	124	166
Dec	7	7	6	6	16	29	21	44	2	4	11	10	3	11	66	111

The number of delays due to assessment has dropped due to increased triage panels for CHC funding as well as a focus on getting assessments sorted.

Ward 2 opened the week commencing 14th January which will reduce the number of DTOCs as patients cared for on ward 2 will not be counted as DTOC. Work will continue on reducing the causes of DTOCs in order to reduce the need for ward 2.

4.13 Non Emergency Transport Contract

Discharge and Outpatient times continue to improve slowly yet remain behind planned expectations. Arriva have been asked to provide a trajectory for performance improvement which will be monitored by the Trust.

The contract variation of the times the 12 hour ED transfer resource requested by UHL has been enacted and the changed hours are now in use (12pm - 12am).

The first monthly meeting occurred and a variety of issues were raised by UHL. The main areas of focus were communication and complaints management. A series of actions were agreed and further meetings are taking place to ensure improvements occur.

5.0 HUMAN RESOURCES – KATE BRADLEY

5.1 Appraisal

The December appraisal rate is 90.8%. The recent national staff survey results (December 2012) indicate 94% of respondents have had an annual appraisal review which is an increase by 4% (compared to 2011 results) and 12% above the Quality Health average for Acute Trusts. Human Resources continue to work closely with Divisions and CBUs to implement targeted actions to continue to improve appraisal performance. We will be corresponding with senior leads in reaching agreement on recovery action required in improving the position.

Appraisal performance continues to feature on Directorate, Divisional and CBU Board Meetings in monitoring the implementation of agreed actions. Training is provided for new appraisers based on delivering an effective appraisal. To maximise on consistency in approach, generic appraisal training components have also been incorporated within medical appraisal training which has positively.

5.2 Sickness

The reported sickness rate for the month of December is 4.4 % against an internal UHL target of 3%. The actual rate is likely to be at around 0.5% lower as absence periods are closed. The 12 month rolling sickness has remained at 3.5%. The East Midlands SHA has

a national target to achieve 3.55% absence by March 2013 and 3.4% by March 2014 to meet their share of the NHS savings target. The SHA have therefore given East Midlands Trusts a target based on their current position. In terms of UHL (who retain the position of first in terms of lowest Acute Trust absence in the East Midlands) the target set is 3.4% for 2013 and 3.2% for 2014. Based on our March 2013 SHA target and the rolling sickness absence figure, the Trust is on target.

Occupational Health have purchased a software management system (Cohort) that allows their staff to make and send appointments, interface with current ESR systems, provide accurate and timely data with trend identification and use SMS text facilities for reminders to help reduce DNAs and waiting times. Occupational Health, with assistance from our IT dept and colleagues in ESR, are currently having their 14 databases mapped to transfer on to the new system in March. Training will take place in March/April and the aim is that Cohort will be used from May 2013.This software will enable the Occupational Health department to provide accurate and timely data and to identify areas with specific needs that can assist the Trust to act proactively to reduce risk and target wellbeing/health initiatives. Eventually managers will also be able to send electronic referrals via a web based system

6.0 FINANCIAL POSITION – ANDREW SEDDON

6.1.1 The Trust is reporting a cumulative £7.3m deficit for the first 9 months, £7.1m adverse to Plan. Income ytd is £12.0m (2.2%) over Plan, which is stated net of a £2.8m marginal rate deduction for emergency inpatient income over the 2008/09 baseline. Operating costs cumulatively are £19.7m over Plan, with premium cost staff largely being used to deliver the additional activity.

6.1.2 For the month of December, the position is an actual I&E deficit of £0.2m, £1.2m favourable to the planned position of a £1.4m deficit.

6.1.3 Table 1 outlines the current position and Table 2 outlines the Financial Risk Rating:

Table 1 – I&E Summary

	December 12			April - December 2012		
	Plan £m	Actual £m	Var £m	Plan £m	Actual £m	Var £m
Income						
Patient income	50.0	54.5	4.5	463.2	475.3	12.2
Teaching, R&D	6.2	6.0	(0.3)	56.4	55.8	(0.7)
Other operating Income	2.5	2.4	(0.2)	21.0	21.5	0.5
Total Income	**58.7**	**62.8**	**4.1**	**540.6**	**552.6**	**12.0**
Operating expenditure						
Pay	36.7	38.0	(1.4)	330.1	338.9	(8.8)
Non-pay	19.8	21.2	(1.4)	178.4	189.3	(10.8)
Total Operating Expenditure	**56.5**	**59.3**	**(2.8)**	**508.5**	**528.2**	**(19.7)**
EBITDA	**2.2**	**3.5**	**1.3**	**32.1**	**24.4**	**(7.7)**
Net interest	-	0.0	0.0	0.0	0.0	0.0
Depreciation	(2.7)	(2.7)	(0.1)	(23.9)	(23.5)	0.4
PDC dividend payable	(0.9)	(0.9)	(0.0)	(8.4)	(8.2)	0.2
Net deficit	**(1.4)**	**(0.2)**	**1.2**	**(0.2)**	**(7.3)**	**(7.1)**
EBITDA %		**5.6%**			**4.4%**	

The patient income line includes both NHS and non-NHS patient care income

Table 2 – Financial Risk Ratings

			Risk Ratings					Reported Position	
Criteria	**Indicator**	**Weight**	**5**	**4**	**3**	**2**	**1**	**Year to Date**	**Forecast Outturn**
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	2	3
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	3	4
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	2	3
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	2
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	3
Weighted Average		**100%**						**2.4**	**2.9**
Overriding rules								2	
Overall rating								**2**	**3**

The **year to date position** may be analysed as follows.

6.2 Income

6.2.1 Year to date NHS patient care income is 11.4m (2%) favourable to Plan. This reflects under-performance on daycases of £1.1m and elective inpatients of £1.8m. These adverse movements are offset by favourable variances for emergency activity, £7.8m, net of a £2.8m reduction for the marginal rate emergency threshold and outpatients £2.2m. Emergency inpatient activity to the end of December was 5,758 spells (7%) above Plan.

6.2.2 The YTD position includes an income reduction of £0.6m to reflect the non delivery of performance targets, where we would not be able to recover this income e.g. Emergency Department.

6.2.3 The YTD position also assumes £2.0m of income relating to reimbursement of income as a consequence of the emergency activity threshold.

6.2.4 Table 3 below highlights the impact of price and volume changes in year to date activity across the major "points of delivery". This shows the increased activity across all emergency areas – with a consequential adverse impact on elective inpatients and daycase activity. We have also seen a reduction in the price/case mix for daycases, emergencies and ED activity.

Table 3 – Patient Care Activity – Price and Volume Movements

Average tariff	**Price Variance YTD %**	**Volume Variance YTD %**	**Price / Mix Variance (£000)**	**Volume Variance (£000)**	**Variance YTD (£000)**
Day Case	(1.3)	(1.6)	(481)	(600)	(1,080)
Elective Inpatient	2.0	(5.2)	1,000	(2,756)	(1,757)
Emergency / Non-elective Inpatient	1.1	6.9	1,527	9,072	10,599
Marginal Rate Emergency Threshold (MRET)			(2,797)	0	(2,797)
Outpatient	3.4	(0.1)	2,244	(58)	2,187
Emergency Department	(3.5)	4.0	(437)	478	41
Other			0	4,246	4,246
Grand Total	**4.1**	**(1.5)**	**1,055**	**10,383**	**11,439**

6.2.5 The key points to highlight within Table 3 are:

- The 7% increase in emergency activity takes the Trust above the 2008/09 activity threshold, thereby accruing income at only 30% of the full tariff. This marginal rate (MRET) accounts for a reduction in income of approximately £2.8m in the first 9 months. The MRET baseline is determined on a Commissioner basis and so the concentration of additional emergency activity in the County and not the City has

exacerbated the impact on us as a provider. Commissioners hold the balance of 70% and are tasked to invest this to alleviate the pressures.

- The Emergency Department price variance reflects the impact of the 2011/12 year end settlement. Our ED team consider that the average tariff of £99 does not reflect the complexity of the casemix and intend to re-address this in the 2013/14 counting and coding proposals.
- The elective inpatient volume shortfall of 5.2% equates to 906 spells. This reduction is largely as a consequence of the increased emergency activity encroaching on elective beds, ITU capacity and theatre sessions. This has had a knock-on effect of reducing elective capacity (both inpatient and day case due to the imperfections of the day case model, especially at the LRI).

6.3 Expenditure

6.3.1 **Operating expenditure** for the year to date is £19.7m (3.9%) adverse to Plan, comprising of pay at £8.8m (2.7%) adverse and non-pay £10.8m (6.0%) adverse. December performance against Plan is £1.4m adverse for pay and £1.4m adverse for non-pay.

6.3.2 CIP continues to perform below Plan - £3.6m adverse YTD to the Plan of £23.1m (see CIP paper for further details).

6.3.3 **The pay position**, both year to date and in December, reflects the continued use of extra capacity wards (Wards 29 and 32 at GGH and Ward 37 at LRI) to meet the emergency activity levels. Pay spend on these 3 wards is in excess of £3.5m YTD. The Acute Care Division is also rostering more doctors and nurses in Medicine and ED to ensure the flow of patients from ED to support the 4 hour target.

6.3.4 Whilst premium payments were stable between September 2011 and February 2012, the increase in March 2012 has continued during this financial year with the stepped increase seen in August continuing through to November. December has seen a small reduction mainly due to a fall in agency spend by £0.4m compared to the previous 3 months – despite this fall, we are running at premium pay costs double the level of the same period last year (an extra £1.5m per month).

Chart 1

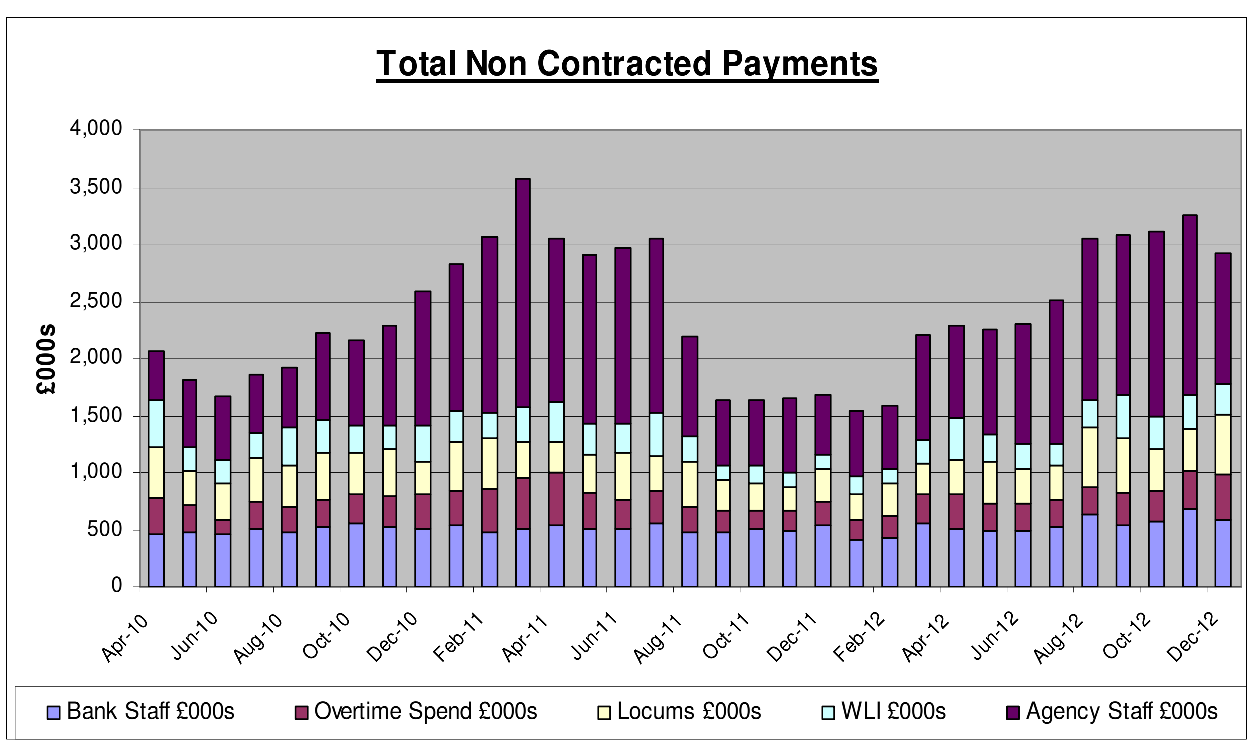
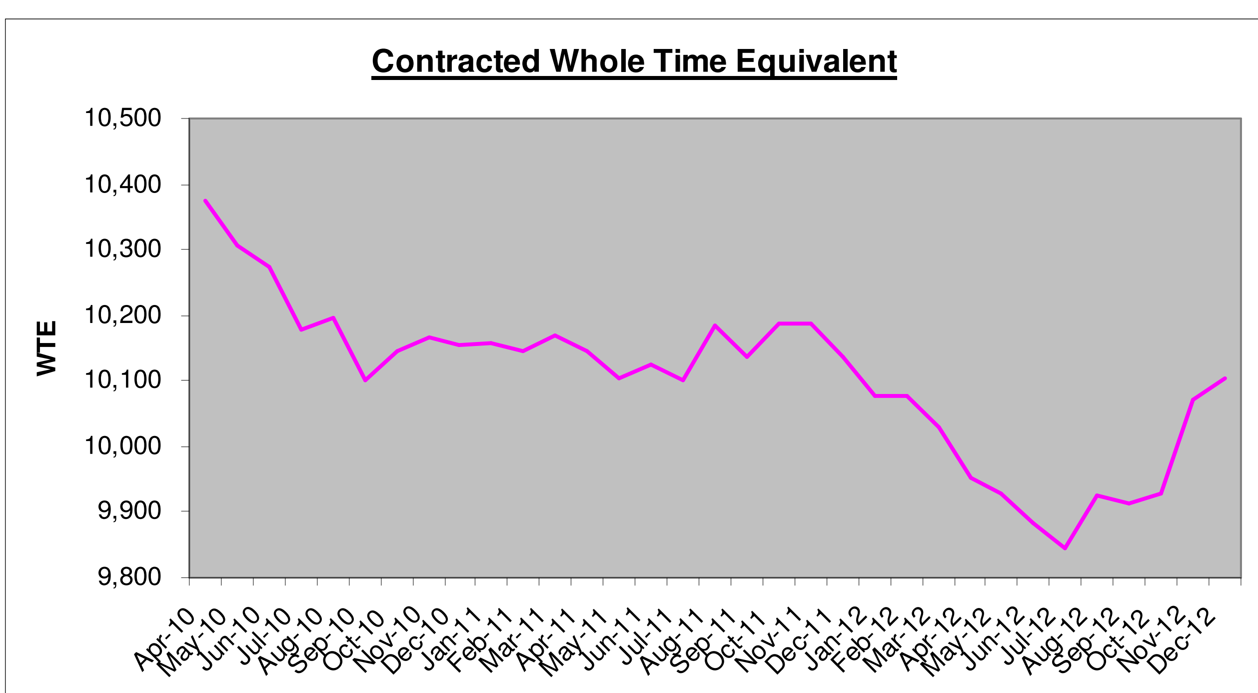


Chart 2



6.3.5 Whilst contracted staff reduced continuously from November 2011 until July 2012, we saw a small increase in August, stability in September and October, but a significant increase in November and December reflecting the new nursing and midwifery starters (176 WTE additional contracted staff now in post as compared to October).

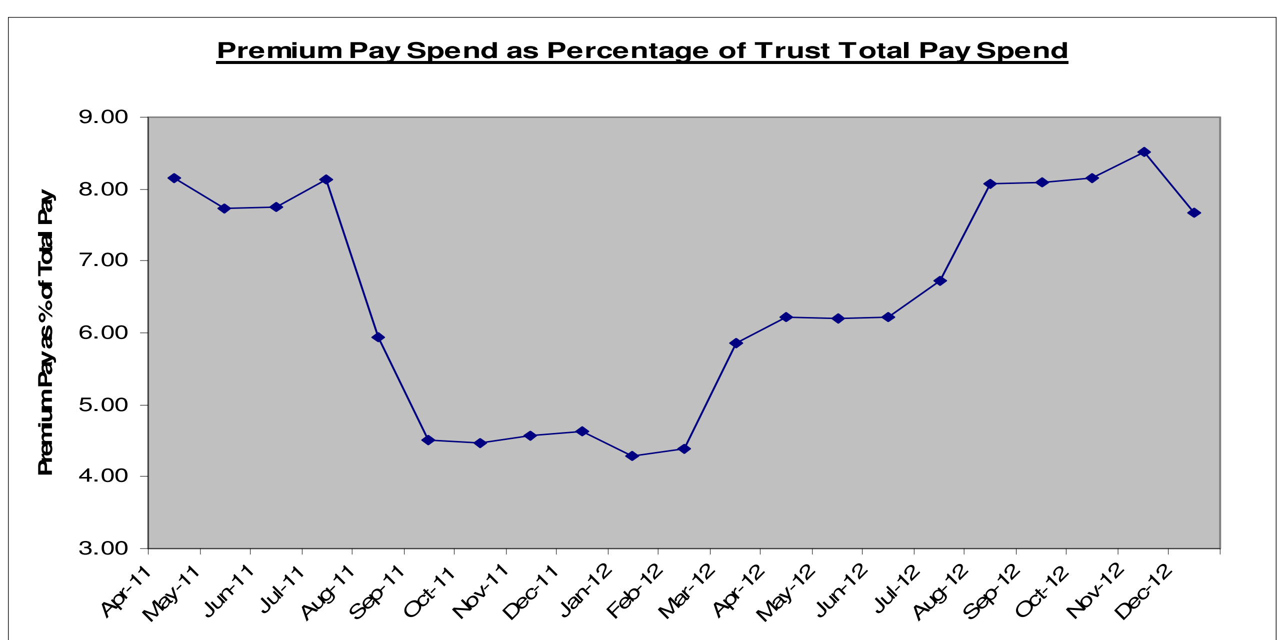
6.3.6 The Trust is still using a significant number of non contracted staff (547 WTE, which is 5.2% of the total worked WTE but 7.7% of the pay costs). This is shown by Division in Table 4 below. This must fall as a result of the increased substantive recruitment.

Table 4 – Worked WTE

	December 2012 worked wte (Actual)					
UHL/Division	**Contracted wte**	**Bank wte**	**Overtime wte**	**Agency wte**	**Other wte**	**Total wte**
Acute Care	3,314	131	39	88	(21)	3,551
Clinical Support	2,408	34	31	43	(46)	2,470
Planned Care	1,881	52	17	11	(27)	1,935
Womens & Children	1,435	16	12	8	(9)	1,462
Corporate	1,067	21	25	20	(14)	1,118
UHL Total	**10,105**	**254**	**123**	**170**	**(117)**	**10,536**

6.3.7 The consequence of the increased premium staff is illustrated in the chart below which shows premium staff costs as a percentage of total staff costs.

Chart 3



6.3.8 It is important to highlight that, although we have seen changes in the mix of permanent and temporary staff, from an overall workforce total, we have now seen a 1.3% increase in total workforce over the past 15 months – see below.

TOTAL STAFFING

	WTE	(%)	Dec 12 WTE	March 12 WTE	Sept 11 WTE
MEDICAL & NURSING	231	3.4	7,043	6,878	6,812
OTHER STAFF GROUPS	(90)	(2.4)	3,610	3,615	3,700
TOTAL	**140**	**1.3**	**10,652**	**10,493**	**10,512**

The above WTE's exclude the "other" adjustment as reflected in table 4.

6.3.9 Whilst showing a 1.3% increase in total numbers, we have seen a significant 231 WTE 3.4% increase in our medical and nursing numbers and a corresponding decrease in other staffing.

6.3.10 To support this analysis, the following two tables provide further details as to the changes by staff type and premium payment type.

Contracted Staffing (WTE)

Staff Type	Movement Dec 12 - Sept 11		Contracted Staff		
	WTE	(%)	Dec 12 WTE	March 12 WTE	Sept 11 WTE
ADMIN & CLERICAL	(121)	(6.4)	1,767	1,827	1,888
ALLIED HEALTH PROFESSIONALS	(24)	(5.0)	454	459	478
CAREER GRADES	2	3.8	69	70	66
CONSULTANT	16	3.0	554	533	538
HEALTHCARE ASSISTANTS	(26)	(5.6)	441	447	467
HEALTHCARE SCIENTISTS	(23)	(3.0)	728	741	751
MAINTENANCE & WORKS	1	1.0	61	61	60
NURSING QUALIFIED	32	1.0	3,341	3,348	3,310
NURSING UNQUALIFIED	87	7.2	1,291	1,195	1,203
OTHER MEDICAL & DENTAL STAFF	1	0.2	933	899	931
OTHER SCIEN, THERAP & TECH	28	10.0	303	274	276
SENIOR MANAGERS	(6)	(3.7)	165	175	171
TOTAL	**(33)**	**(0.3)**	**10,105**	**10,029**	**10,138**

MEDICAL & NURSING	113	1.7	6,628	6,492	6,515
OTHER STAFF GROUPS	(146)	(4.0)	3,477	3,538	3,623
TOTAL	**(33)**	**(0.3)**	**10,105**	**10,029**	**10,138**

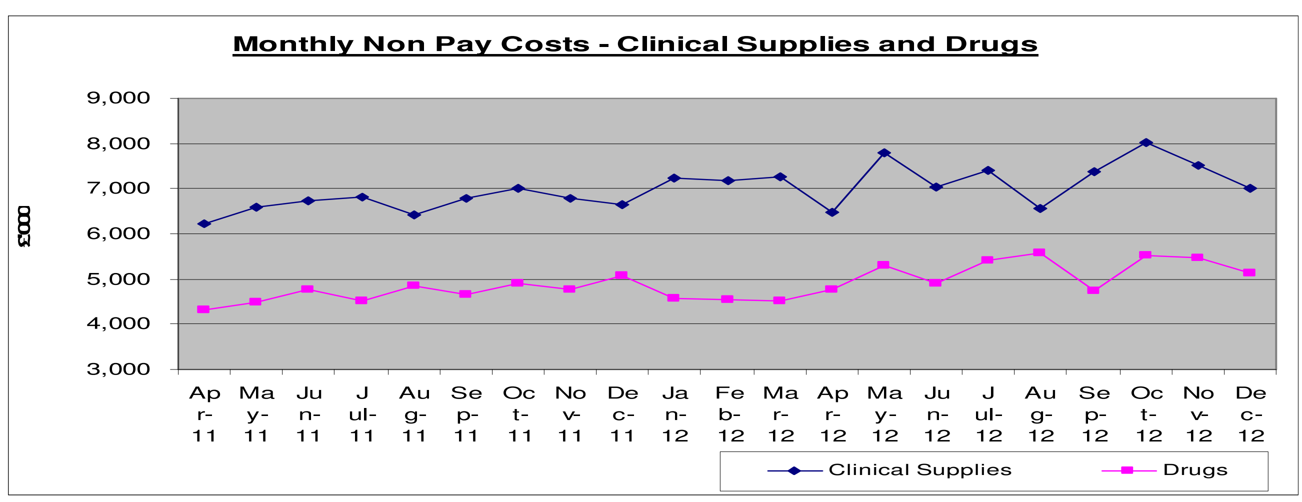
PREMIUM STAFFING

	WTE	(%)	Dec 12 WTE	March 12 WTE	Sept 11 WTE
BANK	12	4.9	254	274	242
OVERTIME	60	94.3	123	84	63
AGENCY	102	149.6	170	106	68
TOTAL	**174**	**46.5**	**547**	**464**	**373**

6.3.11 The clear challenge to the Trust is to reduce the requirement for this premium staffing, whilst maintaining the quality of care.

6.3.12 **Non-pay costs** - the key areas are drugs, £2.2m adverse to Plan, and clinical supplies, £4.2m adverse, with variances in both categories driven in part by increased activity levels. The chart below shows the actual monthly costs for clinical supplies and drugs from April 2011 to November 2012.

Chart 4 – Clinical Supplies and Drugs Costs



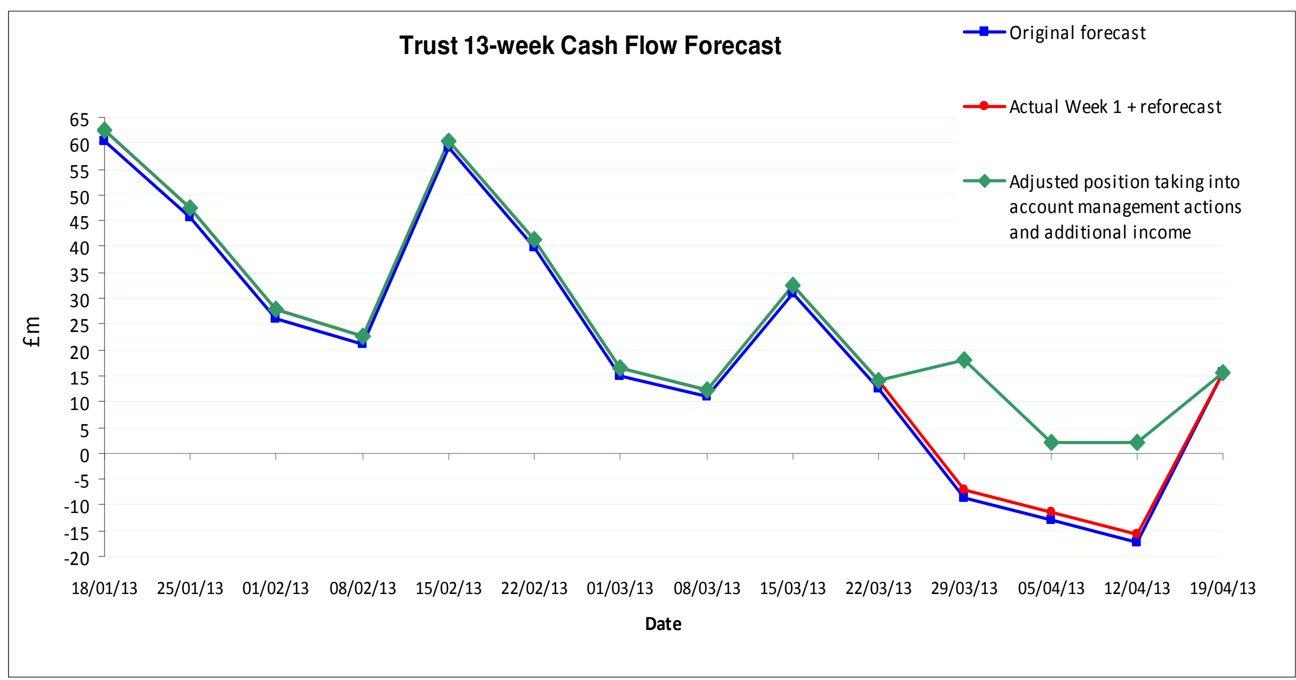
6.3.13 In addition to the variances in drugs and clinical supplies, YTD results are also adverse in utilities (£0.5m), use of independent sector (£1.0m – primarily endoscopy), hotel services and security (£0.8m) and legal fees (£0.3m).

6.4 Cash

6.4.1 The Trust currently has sufficient cash levels until late March when the cash balances reduce significantly. However, the Trust is planning to deliver the £18m year end cash target.

6.4.2 Chart 5 below is the Trust's 13 week cash forecast, which shows the year end cash position.

Chart 5 – Trust 13 week Cash-flow forecast



6.4.3 The current cash level is sufficient due to the Trust securing the early receipt of several items of income, including a total of £15m SIFT and MADEL funds in advance of the remainder of the year and £18m cash relating to March SLAs from the local PCTs. The Trust has also been managing the value of its payment runs to ensure the daily levels of operational cash remain above £2m at all times.

6.4.4 The reported current position is therefore inflated as it includes cash that we have received in advance and will not be receiving in the remainder of the year. The underlying year end cash position is currently minus £7.4m, and this position has arisen due primarily to the impact that the deficit position of the Trust has had on the level of creditor payments.

6.4.5 There are several factors and planned management actions which will increase the year end cash to planned levels, including:

- a temporary change of payment terms to 60 days for suppliers who currently benefit from 30 day payment terms, which will give us a one-off cash benefit of approximately £13m
- an estimated £3m due to the timing of cash payments moving from March to April following the commencement of the Facilities Management outsourcing contract. This is due to differences in the value and timing of payments between Interserve and our current suppliers
- a reduction of £1.5m in cash terms of the March payroll run due to the transfer of UHL staff to Interserve
- assumed additional income of £8.5m relating to MRET reallocation (£3.5m), readmission reinvestment (£2.5m) and transformation funding/winter pressures (£2.5m).

6.4.6 We will continue to monitor each of the above areas and will take additional action if there is an indication that any of the potential benefits will not be realised.

6.5 2012/13 forecast and risks

6.5.1 The Trust is still forecasting to deliver the planned £46k surplus. It is clear that the inherent risk in this year position increases as the year progresses as the Trust continues to incur operating costs ahead of the associated income – and has not completely identified savings to cover the full year CIP target.

6.5.2 The details behind the revised forecasts and financial recovery actions plans will be contained within the “Financial Forecast Recovery” paper.

6.5.3 The key areas of focus continue to be:

- Improved grip on costs (internal)
- Discussions with CCGs and the Local Area Team (LAT)/SHA to secure funding for re- admissions, emergency activity and transformational funding (external).

UHL 2012/13 Quality Schedule and CQUIN Schemes - Quarter 3 Predicted RAG Rating

Ref	Indicator Title and Detail	Threshold	Predicted Q3 RAG	Q3 Commentary
IC1a	MRSA bacteraemias	6 cases	G	1 YTD
IC1b	Cdiff Numbers	113 cases	G	YTD 59 (to end Nov).
IC1c	MRSA screens (Emergency & Elective admissions)	100%	G	100% compliance
IC1d	MSSA bacteraemias	Monthly reporting of numbers and report on themes/root causes of E Coli	G	31 YTD (end Nov). Thematic review submitted in Q2
IC1e	E Coli bacteraemias	Monthly reporting of numbers and report on themes/root causes of MSSA	G	353 YTD. Thematic review due to be reported in March 13
IC2	Identify and agree plans for reducing MRSA & Cdiff infections in line with national objectives	Q1 - Production of plan Q2-Q4 - Progress against agreed plan	G	Action plan revised as requested and being reviewed by commissioners
IC3	Surgical wound surveillance a) Pre and peri operative actions to prevent wound infections b) Increased compliance with HIIs within areas of wound surveillance	a) 90% compliance with pre and post operative actions to prevent wound infections b) 90% compliance in following areas by quarter 4: -Cannulas -Urinary Catheters NB Areas already achieving 90% must maintain 90%throughout 12/13	tbc	Performance below 90% for Q2
MS1	Maternity Dashboard	Report progress against list of indictors and provision of appropriate action plans by exception	G	
PE1	EMSA Monthly Compliance - (PHQ26) SSA Breaches	100% compliance, clinically justified/unjustified breaches to be reported locally and unjustified to be reported nationally via UNIFY	R	Non clinically justified breach in December
PE2b	EMSA 'Estates' Plan 'Monitoring Report' - Mandatory requirement	b) Progress against EMSA plan milestones Annual report to include actions taken following Commissioner Quality Visits	G	

UHL 2012/13 Quality Schedule and CQUIN Schemes - Quarter 3 Predicted RAG Rating

Ref	Indicator Title and Detail	Threshold	Predicted Q3 RAG	Q3 Commentary
PE3a	a) Pre-assessment PROMS - compliance with national requirements	Percentage of pre-assessment compliance to be in-line with national average in each of the following areas: Primary Unilateral Hip Replacement; Primary Unilateral Knee Replacement. Groin Hernia Repair Varicose Vein Procedures	A	Improvements in participation both for VV and Groin Hernia but still below the national average
PE3b	b) Outcome PROMS - evidence of service improvement utilising HES pre and post outcome data)	Evidence of service improvement by providing: Analysis of HES On-line data reports (Peer review) Production of associated action plans as required	G	
PE4a	Complaints numbers Single complaints report to include numbers, response times	monthly data 95% responded to in timescale agreed with complainant	A	Not achieved 95% threshold for all response timescales
PE4b	Reduction in complaints relating to staff attitude	0 Red rated metrics	G	Increase in number of complaints during Oct - reduction in November so overall achieved for Q3
PE4c	Reduction in re-opened complaints	0 Amber/Red rated metrics	G	Increase in number of complaints during Oct - reduction in November so overall achieved for Q4
PE5	A&E service experience (Indicator 5 of A&E Indicators) A&E service experience (Indicator 5 of A&E Indicators) Priority themes: Q2 Overall cleanliness of the dept/How clean was the area you were in? Q6 Did the Drs and Nurses listen to what you had to say/Did you have someone to discuss your worries and fears with? Q10 Medication side effects Q12 Did staff introduce themselves/welcomed you? Q15 While you were in ED, did you feel threatened or bothered by other patients?	Narrative description of what has been done to assess the experience of patients using A&E services and their carers, what the results were, and what has been done to improve services in light of the results Information on the experience of a wide range of patients, carers and staff, reflecting the 24 hour nature of the service, over the whole of the previous quarter, must be collected, analysed and acted upon by providers and commissioners.	tbc	
PE6	Progress in respect of Trust Patient Experience work plan To include: -participation in National Patient Surveys as required by the NHS Outcomes Framework -Carers survey results and actions - dignity in care (giving staff appropriate training to incorporate learning from the experience of patients and carers into their work) - Use of external PE data (e.g. EMPES, Patient Opinion) and actions taken	Patient Experience work plan supported by Annual Work plan Quarterly Progress Reports and Divisional action plans plus Annual Report – Q4	G	

UHL 2012/13 Quality Schedule and CQUIN Schemes - Quarter 3 Predicted RAG Rating

Ref	Indicator Title and Detail	Threshold	Predicted Q3 RAG	Q3 Commentary
PE7	Improvement in Overall Score (PHQ18)	2011 Results: Access and waiting 8.6 Safe, High Quality Co-ordinated care 5.9 Better information, More choice 6.7 Building Better relationships 8.2 Clean Comfortable, friendly Place to Be 7.9 Composite for 2011 - 7.5 Improvement Threshold for 8.0	N/A	
PE8	Improvement in Staff satisfaction	Improvement in: • Care of patients/ service users is my trusts top priority •I would recommend my trust as a place to work • If a friend or relative needed treatment I would be happy with the standard of care provided by this trust • I look forward to going to work • I am enthusiastic about my job • Time passes quickly when I am at work	N/A	
PE9	Trust to adopt new priorities on Equality and Human Rights -in line with the Equality Act 2010, and as part of the LLR integrated Equality and Human Rights Strategy	Trust to demonstrate progress against agreed action plan	G	Report submitted to Jan CQRG. All actions on track
PS1	Quarterly Patient Safety report to include: -Learning from Complaints -upheld complaints from ombudsman and learning -number and % of re-opened complaints Serious Incident numbers, type and trends	Analysis of complaints, Incidents and Serious Incident themes by CBU to identify areas for improvement/action and provide evidence of learning.	G	
PS3	Never Events	Monthly reporting of all never events	R	Retained Needle in Oct-12.also retained vaginal swab in December
PS5	Risk register - Board Assurance Framework report	Real time (>15) risks as identified on risk register to be reported. Provide quarterly update in relation to actions taken via GRMC report detailing: -New risks opened -Risks closed -Changes to risk severity scores -Lengths of time risks have been on the register	G	

Ref	Indicator Title and Detail	Threshold	Predicted Q3 RAG	Q3 Commentary
PS6	Demonstrate compliance with local, regional and National guidance relating to Safeguarding of both Children and Adults e.g - Markers of good practice, DOLs, SCR's and SILP's, PREVENT, Domestic Violence	Demonstrate compliance with UHL relevant • Markers of Good Practice for Safeguarding Children and • the Dept. of Health Safeguarding Adults Assurance Framework • Update of progress against all serious case reviews or Significant Incident learning process (SILP) action plans, • Compliance with DOLs •Participation in the regional PREVENT programme • Reference to domestic violence requirements (training/recognition/referral pathways) in Trust safeguarding policies.	G	
PS7	EWS - Improvement in recording of early warning score, observations and subsequent actions	EWS – Complete/scored set of EWS observations Threshold - minimum 90% in all divisions	G	
PS8	Provide reports on Nurse to Bed ratio's/vacancy rates (funded v's actual)	Provision of data	G	
PS9a	Compliance with letter content (minimum data set) for: - Discharge Summaries -Outpatient letters -ED letters	Minimum 90% compliance	tbc	Will need to provide clarity as to what actions taken to improve performance
PS9b	Compliance with timing of: - Discharge Summaries within 24hrs - Outpatient letters within 7days	Minimum 90% compliance Discharge information to be completed and issued to the GP practice and ongoing care provider (where appropriate)	tbc	Will need to provide clarity as to what actions taken to improve performance
PS10	Eliminating avoidable Grade Two, Three and Four pressure ulcers (Regional Ambition 1): The Provider is required to a) develop, agree and implement an action plan ensuring delivery of Quality Requirements RA1(a) and RA1(b) through assessment, prevention and treatment activities with set monthly milestones for delivery and; b) report on the implementation of the plan on a quarterly basis.	a) provision action plan by end of Q1 2012/13; b) Quarterly, by the 10th working day following the end of the reporting period	A	Although actions undertaken, due to lack of reduction in PU, anticpate this will get Amber RAG for 'lack of progress'.
PS10a	Three and Four pressure ulcers (Regional Ambition 1) – RA1(a): Reduce category 3 and 4 'avoidable' pressure ulcers. 100% reduction from agreed baseline in incidence in acute care by March 2013	Average over Q3: 75% reduction on March 2012 baseline;	R	Although there has been an overall reduction in number of Pressure Ulcers since April, the 75% reduction was not achieved. Confirmation of thresholds to be applied are to be discussed given the 'in year SHA ambition' vs contractual agreement for 2012/13.

UHL 2012/13 Quality Schedule and CQUIN Schemes - Quarter 3 Predicted RAG Rating

Ref	Indicator Title and Detail	Threshold	Predicted Q3 RAG	Q3 Commentary
PS10b	Eliminating avoidable Grade Two, Three and Four pressure ulcers (Regional Ambition 1) – RA1(b): Reduce category 2 'avoidable' pressure ulcers. 100% reduction from agreed baseline in incidence in acute care by March 2013	Average over Q3: 75% reduction on March 2012 baseline;	R	As above
CE1	Report performance against best practice tarriff for #NOF.	Compliance with all thresholds within #NOF dashboard (to include all BPT indicators and time to theatre within 48hrs)	A	Although improved for 'time to theatre', deteriorated in respect of Orthogeriatric led MDT rehab and below threshold for MMT
CE3	Report performance against the NICE Quality standards for Stroke	Compliance with all thresholds within the Stroke Dashboard	A	Discussion held with GPs re clinical definition of 'Urgent' and agreed to keep indicator as is. Improvement made with 'CT scan within 1 hr' but still below threshold, also below Q3 threshold for 'swallow assessment'.
CE4a	Compliance with published NICE Technology Appraisals	100% compliance	G	
CE4b	Compliance with all NICE Guidance	Position statement against implementation of all current NICE guidance	G	
CE5	Central Alerting System Patient Safety Alerts and Rapid Response Reports (NPSA PSA and RRR)	100% compliance compliance i.e. integration into clinical pathways and decision making.	G	
CE6	Clinical Audit programme audit programme progress to include progress against action plans To include participation in National Audits as required by the NHS Outcomes Framework and Participation and publication of national clinical audits relating to services for older people.	Schedule of Priority 1* audits to be completed within agreed timescales *Priority 1 Audits are those that are part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP), or Audits required as a result of Care Quality Commission, CQUINs, Quality Schedule, Quality Accounts or other external regulatory bodies Demonstrate progress against all priority 1 audit action plans	G	
CE7	External visits schedule and report of any visits and action plans plus any removal of licences (Single report only)	External visit reports and action plans (where appropriate) following visits	G	

Ref	Indicator Title and Detail	Threshold	Predicted Q3 RAG	Q3 Commentary
CE8	Report against the Midlands and East Provider Management Regime notifying commissioners of the following:- • Compliance conditions on CQC registration • Restrictive compliance conditions on CQC registration • Moderate CQC concerns regarding the safety of healthcare provision • Major CQC concerns regarding the safety of healthcare provision • Failure to rectify a compliance or restrictive condition(s) by the date set by the CQC with the condition(s).	Update Report	G	
CE9	Mortality Rate (To include SHMI and Comparable e.g. RAMI/HSMR) and Perinatal Mortality Rate	Mortality ratios in overall relative risk mortality rates in UHL Board data and any associated actions	G	
CE10	Hospital acquired venous thrombosis RCAs.	Evidence of learning and actions taken following RCAs being carried out into incidents of VTE	G	
CE11	Children's Services Dashboard	Report progress against list of indictors and provision of appropriate action plans by exception	G	
CE12	Acute Kidney Injury Improve the prevention, detection and management of acute kidney injury (AKI) in patients	Q1-Q3 – Progress against Work Programme (ageed in Q4 2011/12) Q4 – Re-audit	G	Further progress made with action plan
CE13	Completion of the Acute Liaison Nurse evaluation matrix	Provision of audit results and appropriate actions to be incorporated in to the Trusts 6 lives action plan	N/A	Due to reaudit in Jan 13
MM1	Compliance with Leicester Medicines Code (safe handling of medicines)	98% compliance by all CBUs with all elements of the Medicines Code relating to Prescribing, Administration, Storage	tbc	Not due for reporting but additional assurance requested due to non achievement of thresholds in Q2
MM3a	LMSG Traffic Light compliance Compliance with the LMSG Traffic Light Status of drugs and meeting local requirement for unlicensed drugs:	a) 0% Black drug prescribing (no exceptions)	G	

Ref	Indicator Title and Detail	Threshold	Predicted Q3 RAG	Q3 Commentary
MM3b	• BLACK drugs not prescribed or transferred to primary care • RED drugs not transferred to primary care (includes unlicensed drugs/use not in either of current BNFs; excludes specials as subject to specific indicator below) • FULL AMBER drugs in line with LMSG standard	b) 0% Red drugs	G	
MM3c		c) 0% Full Amber drugs transferred to primary care without GP prior written agreement	G	
MM4	Medicines Reconciliation All medicines should be reconciled within 48 hours of medical admission to the hospital (in line with NPSA guidance **Level 2**) To include weekend admissions as these pose higher risk.	90% compliance	tbc	Not due for reporting but additional assurance requested due to non achievement of thresholds in Q2
MM5	Antipsychotic drugs are prescribed in line with the EM SHA prescribing guideline: managing behaviour problems in patients with dementia	95% compliance	N/A	
MM6	Monitored Dosage Systems are initiated and supplied in line with criteria stated in the LMSG-agreed assessment tool	98% of patients meet criteria for monitored dosage systems	G	reaudit results presented to Dec meeting. Although % below threhshold - this is due to small numbers. RAG rating should be revised accordingly
MM7	a) Statins (excludes atorvastatin 40mg and 80mg) >85% b) Ezetimibe (as % of all statins+ezetimibe+ Combinations) < 5% c) Inhaled corticosteroids (beclometasone) > 85% d) Corticosteroid and LABA combination inhalers (symbicort and seretide 500 accuhaler) > 67% e) Long acting insulin analogues (% total intermediate/long acting insulins, excluding mixtures) < 45%	Refer to Indicator detail	A	Compliant for all but Long Acting Insulin Analogues in Q2 due to small numbers of patients affecting %. More detailed audit underway
WF1	Compliance with Workforce Assurance Metrics (TBC April 2012)	4 elements: - Workforce Plan and Action Plan - Human Resource Management - Training and Development - Culture Detail to be agreed in April-12	G	Reported to Dec meeting. Action plan provided.
National 1	Reduce avoidable death,disability and chronic illhealth from Venous thromboembolism(VTE) Threshold 90%	90% of all adult inpatients to have had a VTE risk assessment within 24 hrs of admission to hospital using the clinical criteria of the national tool	G	Although meeting the National threshold of 90% this is because of the cohort patients. Under 90% for patients who require individual risk assessment

UHL 2012/13 Quality Schedule and CQUIN Schemes - Quarter 3 Predicted RAG Rating

Ref	Indicator Title and Detail	Threshold	Predicted Q3 RAG	Q3 Commentary
National 2	Improve responsiveness to personal needs of patients Threshold to be based on results of 11/12 NPS 5 questions for inclusion remain unchanged	tbc - based on 11/12 out - turn	N/A	End of Year RAG
National 3a	Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting Emergency Patients aged 75 and over screened for dementia within 72 hours of admission	90% compliance in each of the three dementia CQUIN indicators in any three consecutive months of the year. OR 90% compliance in quarter 4	N/A	Although CQUIN won't be RAG rated until end of the year, Need to be at 90% for Jan to March 13. Documentation now in place for all assessment units and Dementia section made mandatory field on discharge letter
National 3b	Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting Patients aged 75 and over, who have scored positive for screening who undertake a dementia diagnostic assessment including investigations	90% compliance in each of the three dementia CQUIN indicators in any three consecutive months of the year. OR 90% compliance in quarter 4	N/A	As above
National 3c	Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting Patients aged 75 and over, who have had a diagnostic assessment (in whom the outcome is either "positive" or "inconclusive") who are referred on for further diagnostic advice and/or further follow up	90% compliance in each of the three dementia CQUIN indicators in any three consecutive months of the year. OR 90% compliance in quarter 4	N/A	As above
National 4	Improve collection of data in relation to pressure ulcers, falls, urinary tract infections in those with a catheter, and VTE	100% of patients' Safety Thermometer data entered each month	G	October's data submitted after deadline but has now been uploaded into national tool.
Regional 1	Net Patient Score Include a single question to assess Patient Experience (“How likely is it that you would recommend this service to friends and family?) a) Established question and baseline Net Promoter Score for 10% of inpatients b) Evidence of board ownership of improving patient experience c) Demonstration of the ability to report the Net Promoter Score on a weekly basis (exclusions for those who can evidence that they are in the top quartile of performance) d) Delivery of agreed improvement trajectory (minimum of at least 10 points on baseline score)	**Month 1** Establish Question and Baseline Net Promoter Score for 10% of inpatients **Quarter 1** Monthly report to Board and Commissioner at organisational, specialty and ward level, including plans for improvement **Quarter 2 O**rganisations can report the Net Promoter Score on a weekly basis (exclusions for those who can evidence that they are in the top quartile of performance) **2012/13** Achieve a 10 point improvement in Net Promoter Score or achieve or maintain top quartile performance (targets and top quartile will be calculated using M1 baseline data)	N/A	Although 'end of year RAG' - '10 point improvement in score' will be extremely challenging

Ref	Indicator Title and Detail	Threshold	Predicted Q3 RAG	Q3 Commentary
Regional 2	Making Every Contact Count To improve the health of the population by using every contact with an individual to maintain or improve their mental and physical health and wellbeing Q1 - Evidence of sign off by the board, e.g. extracts from board minutes indicating intent and Trust to provide MECC implementation plan signed off by commissioner public health leads, to include: - Named Board level lead - Named Implementation lead - Evidence of LLR wide engagement - Reference to specific specialty areas for inclusion - MECC Skills for staff training strategy including: * Identified training lead * Training materials/package * Numbers of staff to be trained * Timescales of training - Investment plan - Data collection and reporting requirements - Completed sustainability checklist - Proposed referral system to enable staff to refer appropriate clients into local lifestyle/behavioural change services e.g. stop smoking, Alcohol, weight management, physical activiity - Timescales and milestones should be clearly identified throughout the MECC i Q2 - Q3 Progress against the implemen	Q1 - Implementation plan, progress report and Board papers to be submitted Q2 - Progress against implemtentation plan (specific milestones to be agreed on receipt of plan in Q1) Q3 - Progress against implemtentation plan (specific milestones to be agreed on receipt of plan in Q1) Q4 - Progress against implemtentation plan (specific milestones to be agreed on receipt of plan in Q1)	G	MECC Advisort appointed. Public Health approved Q2's progress.
Local 1a	Improve compliance with internal professional standards - ED -Patients with recorded observations within 15mins of arrival - Patients seen by a Clinical decision maker within 1 hour - Consultant sign-off (National quality indicator 8)	Q2-Q4 90% Patients with recorded observations within 15mins of arrival Q2 55% Q3 60% Q4 70% Patients seen by a Clinical decision maker within 1 hour Q2 35% Q3 40% Q4 45% Consultant sign-off (National quality indicator 8)	tbc	audit currently underway
Local 1b i	b) Improve compliance with internal professional standards on the Assessment Wards - Observations, Initial Assessment and Plan, Senior Review,	Q3 87% Patients with recorded observations within 15mins of arrival 75% Patients with an initial assessment and management plan within 2 hrs 75% Senior review and signed off management plan within 6hrs	tbc	audit currently underway - thresholds increased for Q3

Ref	Indicator Title and Detail	Threshold	Predicted Q3 RAG	Q3 Commentary
Local 1b ii	b) Increase % of CTs being reported within 4 hrs of request for patients on Assessment units at the LRI and GH	Q3 40% of LRI Assessment Unit patients have CT scans within 1 hr of request	**tbc**	Initial report did not show any improvement for Q3 overall. Report being re-run as agreed that threshold would apply to Dec only.
Local 1c	c) Number of ED/Ambulance handovers completed within agreed timescale for quarter	Quarter 1 0 handovers >60minutes Quarter 2 0 handovers > 50minutes Quarter 3 0 handovers > 40minutes Quarter 4 0 handovers > 40minutes	**tbc**	40 minute threshold fin Q3 - EMAS report has identified patients waiting more than 40 minutes. Validation being undertaken of individual patient level data from EMAS report against EDIS records.
Local 2a	a) Discharge before 11 am	Months 1 and 2 for each Quarter – Data submission Month 3 of each Quarter - % increase of patients discharged before 11am Minimum 30% by end of Q4 as per SHA ambition - TBC when baseline known	**tbc**	End of year threshold being reviewed with the ECN
Local 2b	b) Discharge before 1pm	tbc - based on 11/12 out-turn - % increase in number of patients discharged before 1pm Quarter 1- Quarter 2 - Quarter 3 - Quarter 4 -	**tbc**	End of year threshold being reviewed with the ECN
Local 2c	c)7 Day Discharge	tbc - based on 11/12 out-turn - % increase in number of patients discharged at weekends Quarter 1- Quarter 2 - Quarter 3 - Quarter 4 -	**tbc**	End of year threshold being reviewed with the ECN
Local 2d	d) Proportion of TTO's prescribed 24hrs prior to planned discharge (to facilitate earlier discharge)	tbc based on 11/12 out-turn - % increase in number of patients TTOs prescribed 24 hrs before discharge Quarter 1- Quarter 2 - Quarter 3 - Quarter 4 -	**tbc**	Threshold to be agreed following revised baseline
Local 2e	e) Number of patients discharged with definitive diagnosis including details of an appropriate management plan signed off by a consultant / Senior Registrar	Quarter 1 Policy review and amended letter template agreed with commissioners and agree compliance thresholds Quarter 2 tbc Quarter 3 tbc Quarter 4 tbc	**tbc**	Threshold to be agreed following Q2 discussions with GPs

Ref	Indicator Title and Detail	Threshold	Predicted Q3 RAG	Q3 Commentary
Local 3	Patients and carers will receive the highest possible standards of end of life care To develop and implement a EOL care implementation plan with milestones and demonstration of progress	Quarter 1 Presentation of EOLC plan with clear measurable milestones Quarter 2 Progress against plan Quarter 3 Progress against plan Quarter 4 End of year progress report demonstrating improvements made to EOLC and positive outcomes following implementation of EOLC plan.	G	
Local 4a	Improve care pathway and discharge for patients with COPD a) Admission directly to respiratory ward (Glenfield site)	Quarter 1 Complete baseline data and agreed thresholds Quarter 2 %tbc increase Quarter 3 %tbc increase Quarter 4 %tbc increase	tbc	Highlighted will be more difficult to maintain in the winter months if signficantly increased admissions but commissioners agreed to review performance against activity
Local 4b	Improving care pathway and discharge for patients with COPD b) All patients discharged using the discharge bundle	% of COPD patients discharged using the agreed discharge bundle	G	
Local 7a	5 Critical Actions for Safety • Clinical Handover	Q1 - Implementation plan/gantt chart signed off by joint commissioner and UHL governance committee Q2 - Q4 - Progress against plan (evidence of changes in practice from narrative report and commissioner visit)	tbc	RAG post Commissioner visit
Local 7b	5 Critical Actions for Safety • Responding to EWS triggers	Q1 - Implementation plan/gantt chart signed off by joint commissioner and UHL governance committee Q2 - Q4 - Progress against plan (evidence of changes in practice from narrative report and commissioner visit)	tbc	RAG post Commissioner visit
Local 7c	5 Critical Actions for Safety • Mortality & Morbidity Process	Q1 - Implementation plan/gantt chart signed off by joint commissioner and UHL governance committee Q2 - Q4 - Progress against plan (evidence of changes in practice from narrative report and commissioner visit)	tbc	RAG post Commissioner visit
Local 7d	5 Critical Actions for Safety • Acting on abnormal Results	Q1 - Implementation plan/gantt chart signed off by joint commissioner and UHL governance committee Q2 - Q4 - Progress against plan (evidence of changes in practice from narrative report and commissioner visit)	tbc	RAG post Commissioner visit

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Ref	Indicator Title and Detail	Threshold	Predicted Q3 RAG	Q3 Commentary
Local 7e	5 Critical Actions for Safety • Ward round notation standards	Q1 - Implementation plan/gantt chart signed off by joint commissioner and UHL governance committee Q2 - Q4 - Progress against plan (evidence of changes in practice from narrative report and commissioner visit)	tbc	RAG post Commissioner visit
1	Implementation of National Quality Dashboards for each Specialised Service	Q1: Identification of overall dashboard lead Individual dashboard leads Provision of plans for implementation of dashboards Q2 & Q3 Routine reporting against dashboards for all services Provision of brief update for each area detailing any specific comments/issues End of Q4: Continued routine reporting on all relevant dashboards AND Evidence that all relevant dashboards have been considered by front line clinical staff with documented evidence of consideration of current performance and identification of plans for improvement, where appropriate	tbc	Specialities have until 20th January to submit data. Cardiology have raised concerns about timescales for submission.
2	Increase number of patients receiving dialysis at home. Each Trust to progress towards the East Midlands Renal Network strategy standard of 30% of patients receiving dialysis at their home (composite of PD and HD) by end March 2013.	Q1 Network progress report to EMSCG from monthly data submitted by renal unit Q2 Provider report to network on progress, issues, challenges and actions being undertaken to meet year end target Q3 Network progress report to EMSCG from monthly data submitted by renal unit Q4 Provider report to network on year end achievement	G	
3	Increased access to IMRT 33% of all episodes of radiotherapy treatment should be delivered using IMRT	Requirements for end of Quarter 1: SCGs need to negotiate with Trusts a target % of episodes to be delivered using IMRT by March 2013 and quarterly trajectories. These discussions must take into account the starting position of Trusts Q2-Q4 - Progress against Quarterly thresholds as agreed in Quarter 1	G	Good progress made in Q2

Ref	Indicator Title and Detail	Threshold	Predicted Q3 RAG	Q3 Commentary
4	Performance status recorded and monitored with appropriate action taken for oncology patients receiving IV chemotherapy. Above 90% compliance on performance status recorded for all oncology patients receiving IV chemotherapy and evidence regarding appropriate continuation of treatment. AND Total number of patient deaths reported within 30 days of receiving intravenous chemotherapy	1. TBC Proportion of intravenous chemotherapy cycles where the patients performance status was recorded prior to the delivery of treatment 2. TBC No of patients who had documented evidence regarding appropriateness of continuation of treatment whose performance status was 2 or more	G	90% threshold achieved for both parts of CQUIN.
6	Hepatitis c 1. The proportion of patients who complete the optimum course of treatment spilt by genotype group (1,4/2,3) (locally agree target) 2. The proportion of patients who achieve a sustained virological response split by genotype group (1,4/2,3)	tbc - based on 11/12 out - turn	G	
7	CONS infection Number of low birthweight (<1500g) infants (inborn and outborn) admitted to the neonatal service at XXX within 28 days of birth who develop late-onset CONS infection in a central venous line.	Reduction (% of an agreed number) on baseline number value	G	
8	To minimise the number of patients accidently extubated	The proportion of unplanned extubations for which a review (and action plan if necessary) were completed	G	