University Hospitals of Leicester NHS
NHS Trust

	TRUST BOARD
From:	Rachel Overfield, Kevin Harris, Richard Mitchell Kate Bradley Peter Hollinshead
Date:	**27th March 2014**
CQC regulation	All

Title:	**Quality & Performance Report**

Author/Responsible Director: R Overfield, Chief Nurse
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R, Mitchell, Chief Operating Officer
K. Bradley, Director of Human Resources
P Hollinshead, Interim Director of Financial Strategy

Purpose of the Report:
To provide members with an overview of UHL quality, operational performance against national and local indicators and Finance for the month of February.

The Report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Endorsement	

Summary / Key Points:

Successes

- Theatres – 100% WHO compliant for the last 12 months.
- 62 day cancer – performance for January was 89.5% and year to date performance now delivering 85.9%,
- The percentage of stoke patients spending 90% of their stay on a stroke ward year to date position is 83.1%
- Friends and Family Test - performance for February is 69.0.
- VTE - The VTE risk assessment within 24 hours of admission threshold of 95% has been achieved since July 2013.

Areas to watch:-

- Diagnostic waiting times– the 1% threshold was missed in February.
- C&B – performance similar to this time last year and target is still not delivered.
- Pressure Ulcers – recovery action plan signed off and revised trajectory is being delivered.
- C Difficile – 0 cased reported in February - 62 reported year to date against a year to date target of 62.

Exceptions/Contractual Queries:-

- ED 4hr target - Performance for emergency care 4hr wait in February was 83.5%.
- Cancelled Operations – the remedial action plan has been signed off by commissioners. Percentage of short notice cancellations was 2.0% in February.

- RTT admitted and non-admitted – Commissioners have agreed to a significant financial investment during 2014-15 to reduce waiting times in key challenged specialties. The recovery action plan has been signed off by commissioners.

Finance key issue:

- The Trust will not deliver its Planned Surplus and as such will not meet its breakeven duty. The forecast position remains as a deficit of £39.8m.

Recommendations: Members to note and receive the report	
Strategic Risk Register	**Performance KPIs year to date** CQC/NTDA
Resource Implications (eg Financial, HR) N/A	
Assurance Implications Underachieved targets will impact on the NTDA escalation level, CQC Intelligent Monitoring 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
NHS Trust

Caring at its best

Quality and Performance – February 2014

Trust Board

Thursday 27th March 2014

One team shared values

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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **27th MARCH 2014**

REPORT BY: **KEVIN HARRIS, MEDICAL DIRECTOR**
RACHEL OVERFIELD, CHIEF NURSE
RICHARD MITCHELL, CHIEF OPERATING OFFICER
KATE BRADLEY, DIRECTOR OF HUMAN RESOURCES
PETER HOLLINSHEAD, INTERIM DIRECTOR OF FINANCIAL STRATEGY

SUBJECT: **FEBRUARY 2014 QUALITY & PERFORMANCE SUMMARY REPORT**

1.0 INTRODUCTION

The following paper provides an overview of the February 2014 Quality & Performance report highlighting key metrics and areas of escalation or further development where required.

2.0 2013/14 NTDA Oversight and Escalation Level

2.1 NTDA 2013/14 Indicators

Performance for the 2013/14 indicators in Delivering *High Quality Care for Patients: The Accountability Framework for NHS Trust Boards* was published by the NTDA early April.

The indicators to be reported on a monthly basis are grouped under the following headings:-

- Outcome Measures
- Quality Governance Measures
- Access Measures – see Section 5

Outcome Measures	Target	2012/13	Apr-13	May-13	Jun-13	Qtr1	Jul-13	Aug-13	Sep-13	Qtr2	Oct-13	Nov-13	Dec-13	Qtr 3	Jan-14	Feb-14	YTD
30 day emergency readmissions	7.0%	7.8%	7.5%	7.8%	7.7%	7.7%	7.5%	7.6%	7.8%	7.6%	7.9%	7.8%	8.0%	7.9%	8.7%		7.8%
Avoidable Incidence of MRSA	0	2	0	0	0	0	0	0	1	1	0	0	0	0	0	0	1
Incidence of C. Difficile	67	94	6	7	2	15	6	5	9	20	6	6	5	17	10	0	62
Incidence of MSSA		46	5	2	5	12	1	4	3	8	1	1	1	3	3	2	28
Safety Thermometer Harm free care		94.1%*	92.1%	93.7%	93.6%		93.8%	93.5%	93.1%		94.7%	93.9%	94.0%		93.8%	94.8%	
Never events	0	6	1	0	0	1	0	0	1	1	0	0	0	0	0	1	3
C-sections rates	25%	23.9%	23.8%	26.1%	26.1%	25.3%	25.0%	25.2%	24.6%	24.9%	25.6%	27.5%	25.2%	26.1%	23.9%	25.5%	25.3%
Maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	3
Avoidable Pressure Ulcers (Grade 3 and 4)*	0	98	10	4	8	22	7	8	5	20	5	4	5	14	7	3	66
VTE risk assessment	95%	94.5%	94.1%	94.5%	93.1%	93.9%	95.9%	95.2%	95.4%	95.3%	95.5%	96.7%	96.1%	96.1%	95.6%	95.0%	95.2%
Open Central Alert System (CAS) Alerts		13	14	9	15		36	10	10		14	15	12		11	14	
WHO surgical checklist compliance	100%	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	

*monthly target agreed with commissioners at 7 or less per month from November

Quality Governance Indicators	Target	2012/13	Apr-13	May-13	Jun-13	Qtr1	Jul-13	Aug-13	Sep-13	Qtr2	Oct-13	Nov-13	Dec-13	Qtr3	Jan-14	Feb-14	YTD
Patient satisfaction (friends and family)		64.5	66.4	73.9	64.9		66.0	69.6	67.6		66.2	70.3	68.7		71.8	69.0	68.6
Sickness/absence rate	3.0%	3.4%	3.3%	3.1%	3.0%	3.2%	3.2%	3.1%	3.1%	3.1%	3.3%	3.5%	3.8%	3.6%	4.0%		3.4%
Proportion temporary staff – clinical and non-clinical (WTE for Bank, Overtime and Agency)			5.6%	5.9%	5.6%		5.6%	5.5%	5.3%		6.0%	6.1%	6.0%		6.6%	6.6%	
Staff turnover (excluding Junior Doctors and Facilities)	10.0%	9.0%	8.8%	8.9%	9.2%		9.5%	9.3%	9.7%		9.6%	9.7%	10.2%		10.6%	10.4%	
Mixed sex accommodation breaches	0	7	0	0	0	0	0	0	0	0	0	2	0	2	0	0	2
% staff appraised	95%	90.1%	90.9%	90.2%	90.7%		92.4%	92.7%	91.9%		91.0%	91.8%	92.4%		91.9%	92.3%	
Statutory and Mandatory Training	75%		45%	46%	46%		48%	49%	55%		58%	60%	65%		69%	72%	
% Corporate Induction attendance rate	95%		87%	82%	95%		90%	94%	94%		91%	87%	89%		93%	89%	90%

2.2 UHL NTDA Escalation Level

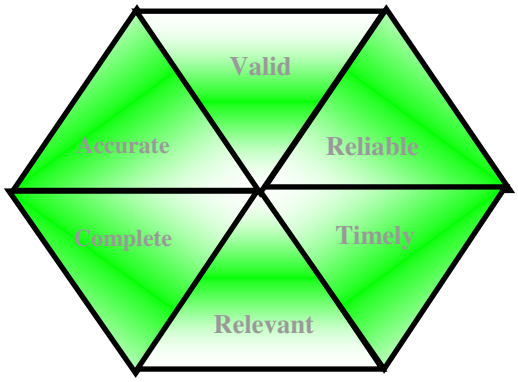
The Accountability Framework sets out five different categories by which Trust's are defined, depending on key quality, delivery and finance standards.

The five categories are (figures in brackets are number of non FT Trusts in each category as at July 2013):

1) No identified concerns (18 Trusts)
2) Emerging concerns (27 Trusts)
3) Concerns requiring investigation (21 Trusts)
4) Material issue (29 Trusts)
5) Formal action required (5 Trusts)

Confirmation was received from the NTDA during October that the University Hospitals of Leicester NHS Trust was escalated to Category 4 – Material issue. This decision was reached on the basis of the significant variance to financial plan for quarter one and continued failure to achieve the A&E 4hr operational standard.

3.0 DATA QUALITY DIAMOND



The UHL Quality Diamond has been developed as an assessment of data quality for high-level key performance indicators. It provides a level of assurance that the data reported can be relied upon to accurately describe the Trust's performance. It will eventually apply to each indicator in the Quality and Performance Reports. The process was reviewed by the Trust internal auditors who considered it 'a logical and comprehensive approach'. Full details of the process are available in the Trust Information Quality Policy.

The diamond is based on the 6 dimensions of data quality as identified by the Audit Commission:

- **Accuracy** – Is the data sufficiently accurate for the intended purposes?
- **Validity** – is the data recorded and used in compliance with relevant requirements?
- **Reliability** – Does the data reflect stable and consistent collection processes across collection points and over time?
- **Timeliness** – is the data up to date and has it been captured as quickly as possible after the event or activity?
- **Relevance** – Is the data captured applicable to the purposes for which they are used?
- **Completeness** – Is all the relevant data included?

The data quality diamond assessment is included in the January Quality and Performance report against indicators that have been assessed.

4.0 QUALITY AND PATIENT SAFETY – KEVIN HARRIS/RACHEL OVERFIELD

4.1 Quality Commitment

The Quality Commitment has been refreshed and a draft version and will be presented to the April Executive Quality Board. The final version will be used to populate the annual plan.

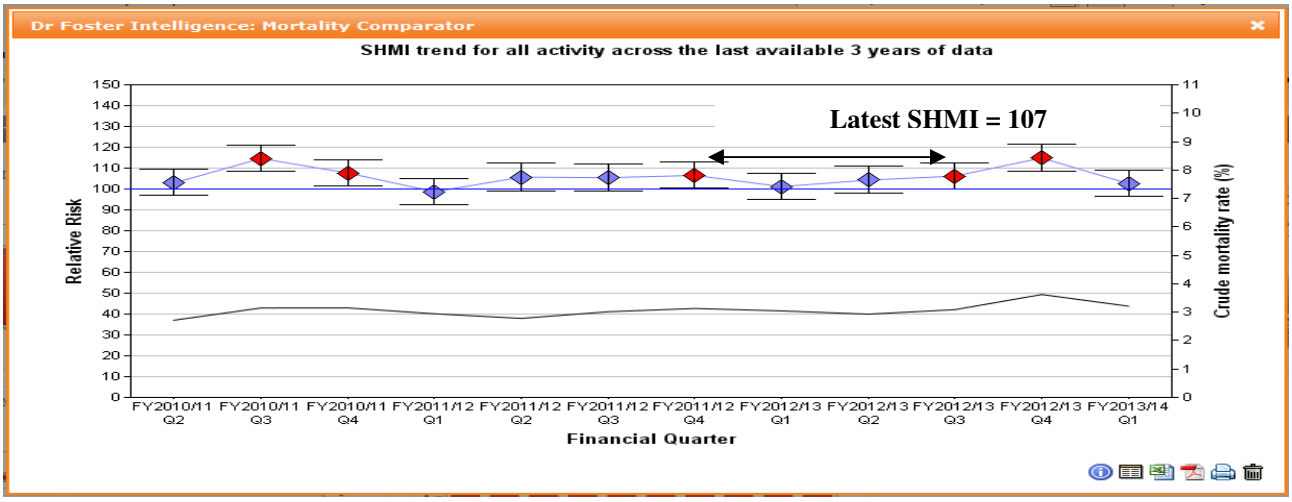
4.2 Mortality Rates

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

SUMMARY HOSPITAL MORTALITY INDEX (SHMI)

The SHMI is published as a rolling 12 month figure and the latest SHMI by the Health and Social Care Information Centre (HSCIC) was published at the end of January and covers the 12 month period July 12 to June 13. As anticipated UHL's SHMI has gone up from 106 to 107; however, it remains in Band 2 (i.e. within expected).

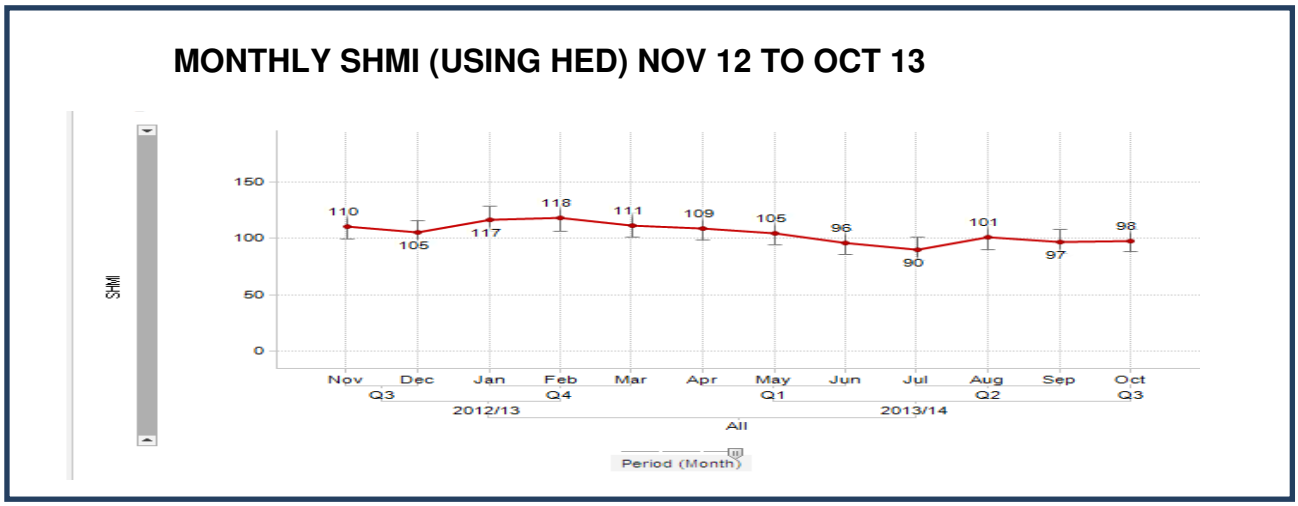
As can be seen from the Quarterly SHMI chart below, the slight increase is because Jul 12 to Jun 13 includes the higher SHMI period for January to March 13 whilst losing the Quarter of April to June 2012 which had a lower SHMI.



UHL is now able to use the Hospital Evaluation Dataset tool (HED) to internally monitor our SHMI on a monthly basis using more recent data.

For the most recent 12 months (Nov 12 to Oct 13) UHL's SHMI is 104 (this still includes the January to March 13 period).

Reassuringly, UHL's SHMI for the financial year 2013/14 (April to Oct 13) is currently predicted to be closer to 100. As can be seen from the run chart below, 4 out of the 7 months were below 100.



However, due to the published SHMI being based on a '12 month rolling figure', the trust's published SHMI is likely to remain above 100 until the Jan to April 13 period is not included.

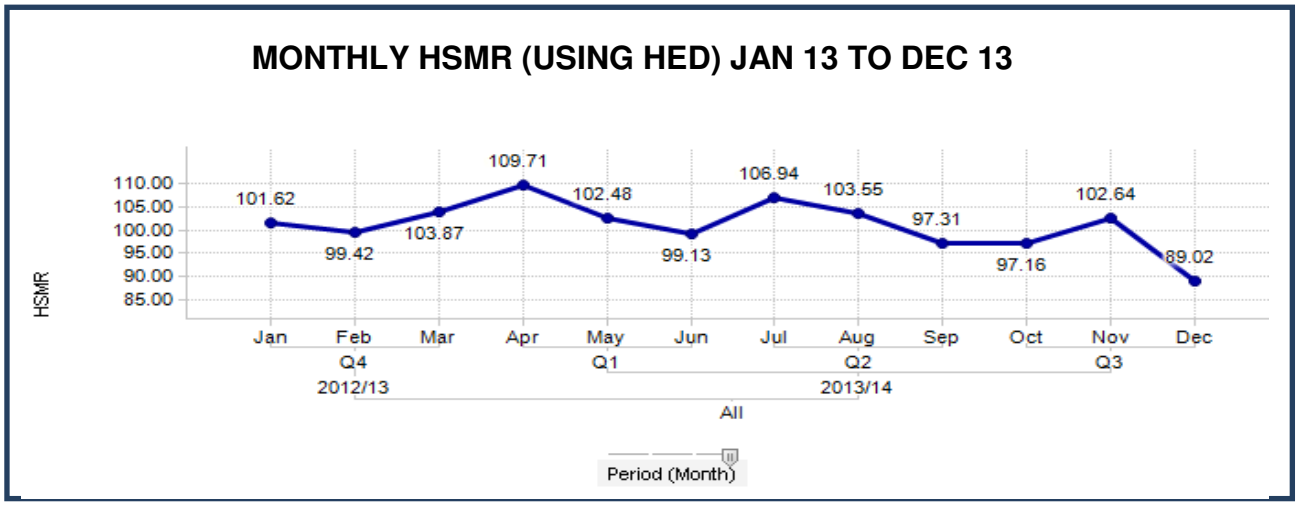
HOSPITAL STANDARDISED MORTALITY RATIO (HSMR)

Previous Q&P reports have presented UHL's 'in hospital' risk adjusted mortality (HSMR) using the Dr Foster tool. However, Dr Fosters do not rebase their HSMR until the end of each financial year and UHL's HSMR has gone up each time.

The HED tool includes HSMR (as well as SHMI) and this is rebased monthly. It was therefore agreed that UHL's monthly HSMR will now be reported using the HED data.

UHL's HSMR for the 12 months Jan to Dec 13 is 100.9 and for the financial year (Apr to Dec 13 it is 100.6.

It should be noted that although UHL's HSMR has been below 100 for Sept, Oct and Dec and HED rebase monthly, there may be an increase for these months as Trusts resubmit their coded data.



CRUDE MORTALITY

UHL's crude mortality rates are also monitored as these are available for the more recent time periods.

As can be seen from the table below, whilst there is 'month on month' variation, the overall rate for 13/14 (Apr 13 to Feb 14) is slightly lower than in 12/13.

Month	Feb-13	Mar-13	FY 2012/13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	FYTD 2013/14
No of Patients Disch/Died	17,321	18,439	221,146	17,870	18,692	17,734	19,135	17,890	18,199	19,673	18,683	17,898	19,596	17,983	203,257
No of in-hospital deaths	275	288	3,177	277	254	229	229	233	218	253	251	267	245	262	2,718
Crude Mortality Rate	1.60%	1.60%	1.40%	1.60%	1.40%	1.30%	1.20%	1.30%	1.20%	1.30%	1.30%	1.50%	1.30%	1.50%	1.30%

4.3 Maternal Deaths

The World Health Organisation (WHO 2014), defines maternal death as the death of a woman while pregnant or within 42 days of termination of pregnancy (giving birth) , irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

The Trust has reported 3 maternal deaths this year – 1 in January and 2 in February. One was an indirect maternal death and the other two were unavoidable and there is no identified maternity "cause".

4.4 Patient Safety

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

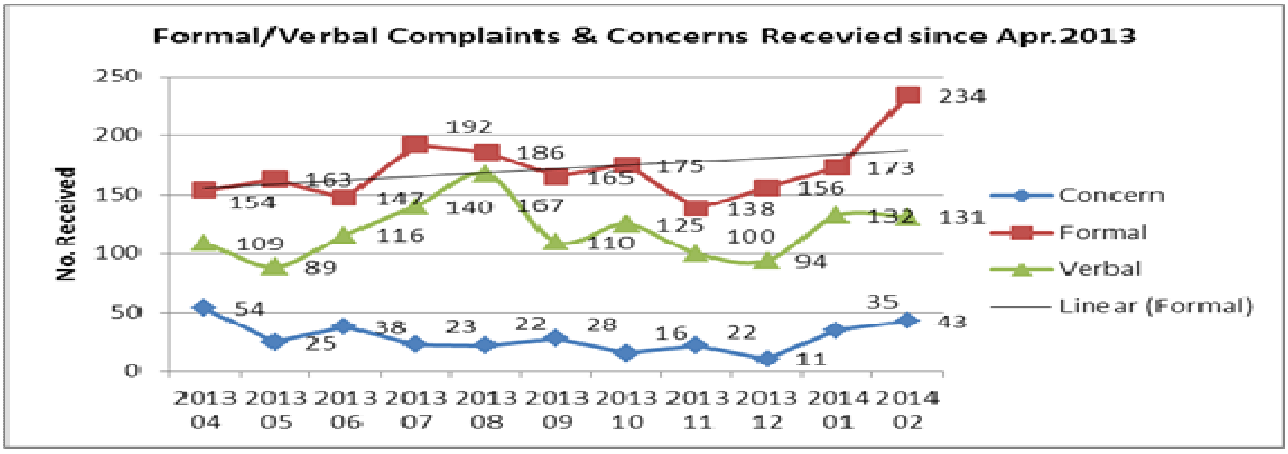
In February a total of 12 new Serious Untoward Incidents (SUIs) were escalated within the Trust, a reduction from 20 reported in January. 6 of these were patient safety incidents, 4 were Hospital Acquired Pressure Ulcers and 2 were Healthcare Acquired Infections. One Never Events was reported in the Trust in February relating to the unintentional retention of a vaginal swab post delivery. This Never Event was reported on in public at the February Trust Board meeting and escalated to commissioners in line with national requirements. Six patient safety root causes analysis (RCA) investigation reports were completed and signed off last month, the actions and learning of which have been shared internally. These will be further reviewed at the Trust's 'Learning from Experience Group'.

In February two calls were made to the 3636 Staff Concerns Reporting Line, one relating to care on outlying wards and the other relating to the transfer of patients from ED to the admissions ward. Both concerns have been fully investigated by a director and actions have been reported to the Executive Quality Board. A high level of compliance with deadlines for external CAS (Central Alerting System) alerts has been maintained - 100% for quarter three and 99% over a rolling 12 months.

February saw exceptionally high complaints activity with the top 5 themes of written complaints being:-

- Medical Care
- Waiting Times
- Communication
- Cancellations
- Discharge issues

Specialties have now been provided with a full breakdown of their complaints, clustered by CMG. Below is a trend graph which shows complaints activity over the past 10 months.



Point of Care Testing Devices (POCT devices):-

Empath has undertaken a scoping audit of all 3 hospitals within the Trust to determine the breadth of use of POCT devices in order to scope resources for underpinning the UHL POCT devices policy. This audit has identified a large number of POCT devices in use at UHL. The audit also revealed safety issues. These safety issues have been raised with users and a detailed report was presented to the March meeting of the Executive Quality Board where a number of recommendations were accepted. The quality assurance of all POCT devices is a fundamental aspect of their use and further work needs to be undertaken to ensure devices are maintained and monitored in line with UHL policy and national requirements.

Sepsis

Sepsis is a new workstream under the Critical Safety Action Programme. The Executive Quality Board received a paper in March from the programme lead detailing a benchmarking position.

Summary report of LRI audit of recognition and immediate care of adults with severe sepsis (UHL audit ref 6956)

A retrospective analysis of all adult ICU admissions to LRI during September 2013 was carried out by reviewing medical records. Existing UHL sepsis care package and antimicrobial policy were used as standards to measure against for recognition and immediate management of severe sepsis. Patients whose records fulfilled the criteria for severe sepsis were examined in detail.

There were 82 emergency admissions to LRI adult ICU. A total of 32 patients were identified as having severe sepsis with a further 3 patients' records unavailable for review.

Mean patient age was 62 (range 18-91 years) and 53% were male. Eighteen patients were general surgical, 9 were general medical and 2 haem/oncology. Nineteen were treated in ED, 6 on acute surgical wards, 4 on acute medical wards and 2 on haem/onc wards. Septic focus was identified as abdominal in 18, chest in 6 and central nervous system in 3. Average EWS was 5 (range 0-11) with 37.5% of patients scoring below 4 and only 50% patients had a temperature above 38C.

Documented evidence of recognition of severe sepsis was seen in 50% of patients. In these patients the average time taken to recognize severe sepsis (from the point where documented observations and blood results confirmed it) was 27 minutes (range 0-170 mins).

Recognition and management of severe sepsis scorecard

Sepsis Domain	Target	Sept13
Recognition of severe sepsis	*75%*	50%
Evidence of sepsis package use	*75%*	22%
Blood cultures in first hour	*75%*	40%
Antibiotics in first hour	*75%*	27%
Fluid challenge in first hour	*75%*	28%
Measure lactate in first hour	*75%*	72%
Senior clinical review	*75%*	58%
To theatre within 12 hours	*95%*	27%
Critically ill referred immediately	*95%*	69%
ICU admission Mean APACHE II score	*<15*	17
In-Hospital Mortality	*<15%*	16%

The medical notes review has flagged up a number of patterns associated with patient care and opportunities to improve delivery of a sepsis pathway. A detailed action plan has been developed to deliver immediate and longer term improvement in sepsis care. Regular updates on this will be provided to the Executive Quality Board and detailed in the Critical Safety Actions programme updates.

4.5 Critical Safety Actions

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

The aim of the 'Critical safety actions' (CSAs) programme is to see a reduction in avoidable mortality and morbidity. The key indicator being focused upon by commissioners is a reduction in Serious Untoward Incidents related to the CSAs.

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:-

- The Nerve Centre handover project steering group meets fortnightly. Server upgrade to permanent server completed on 24th February 2014.
- Plan to start training nursing staff in early March across LRI site first and then GH and LGH sites for go live in April.

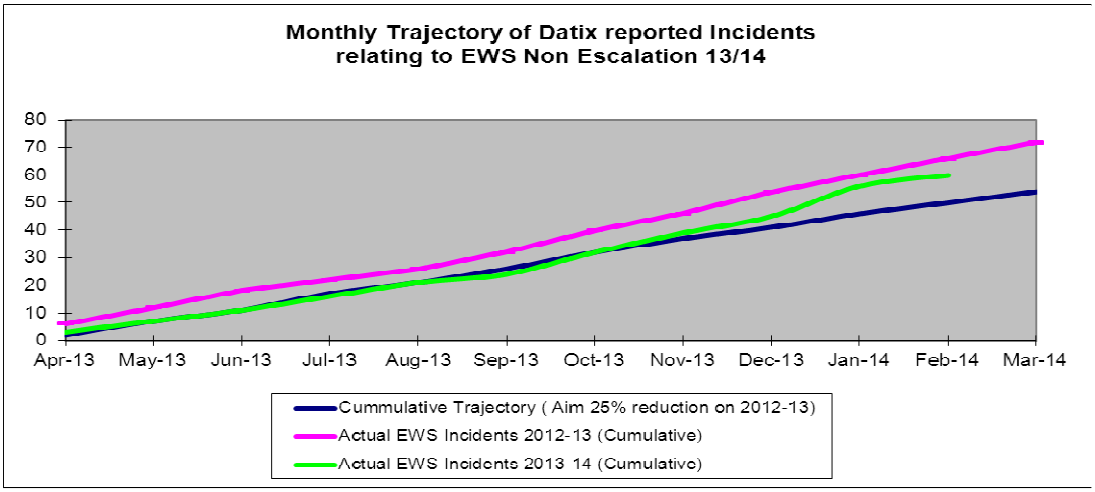
2. Relentless attention to Early Warning Score triggers and actions

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

Actions:-

- EWS Datix reported incidents related to non escalation are still being monitored this year. The internal aim was to reduce these by 25% against 2012-13 figures.

Looking at the graph below we will not achieve a 25% reduction but we should still achieve a reduction in EWS incidents related to non escalation. To end of February 14 we have seen a 10% reduction to same point last year. Since last year there has been 2 new EWS chart implemented, one for post natal babies and a revised PEWS chart in Children's .This has meant the implementation of 2 new charts with one being additional to those in use last year which accounts for the decrease in expected reduction.



- Monthly data for response times to red calls which includes EWS>4 calls is captured from 24/7 system. As per EWS pathway, these should be responded to within 30 minutes.

Site	November 13	December 13	January 14
GH	100%	97%	98%
LGH	97%	98%	98%
LRI	98%	96%	99%

% of red calls within response time <30 minutes

The EWS response times < 30 mins **Green 95% and above, Amber 85%- 94% Red > 84%**

- Results from previous case note review showed that at the LRI site only 82% of escalated EWS >4 had a documented review in the notes with the LGH and GH site faring better.
- A meeting took place in February with the EWS medical lead, the outreach lead and the CSA lead to discuss these results and identify actions to improve this position and agree timeframe for a further validation exercise. It was agreed to repeat the exercise over a 3 day period in March and if this shows lack of documentation to feedback timely to both the junior doctor that did not document and the consultant of the ward where the patient is based.

3. Acting on 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:-

- Have received signed off processes for managing diagnostic tests for 88% of specialities now. The end of Q4 target threshold was at least 80%.
- Issue and risks highlighted from this work have been reviewed. Dr. Collett will be chairing a meeting in April with CMG deputy directors, pathology, imaging and IT

in attendance to discuss risk and agree actions that can be taken forward next year.

4. 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.

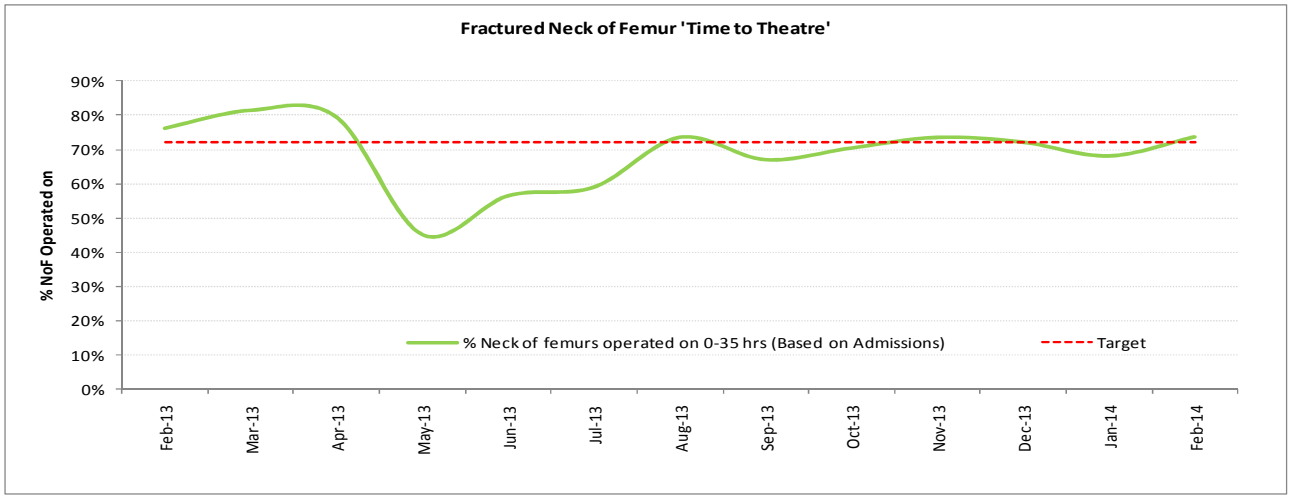
Actions:-

- ❖ Ward round safety checklists printed and being put out into clinical areas across the Trust. Small card versions for doctors on order. New continuation paper on order due into Trust early March. Communications plan in place.
- ❖ Meeting with medical education to identify existing doctors training sessions that the ward round work could be incorporated into on an on-going basis.

The Q3 CSA CQUIN was rag rated by the CCGs as green and received 100% funding.

4.6 Fractured Neck of Femur 'Time to Theatre'

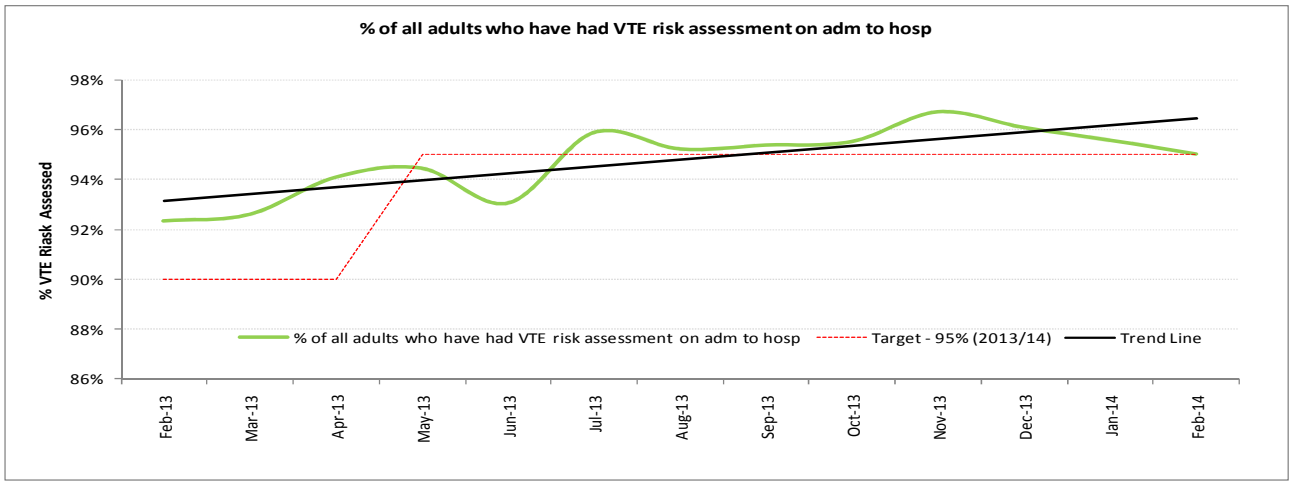
Mth | Qtr 1 | Qtr2 | Qtr3 | YTD



The percentage of patients admitted with fractured neck of femur during February who were operated on within 36hrs was 73.7% (42 out of 57 #NOF patients) against a target of 72%.

4.7 Venous Thrombo-embolism (VTE) Risk Assessment

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD



The 95% threshold for VTE risk assessment within 24 hours of admission was achieved in February, with the year to date performance is being achieved at 95.2%.

4.8 Quality Schedule and CQUIN Schemes

The table below summarises the anticipated RAG ratings for the Quality Schedule and CQUIN indicators in respect Quarter 4's performance.

An Amber RAG is anticipated for 7 of the Quality Schedule Indicators and 1 Red – rationale for RAGs and actions being taken to improve performance are summarised in the table below.

Good progress has been made against the Quarter 4 thresholds for each of the CQUIN indicators.

Sche-dule	Ref	Indicator Title and Detail	Q4 Predicted RAG	Rationale for RAG
QS	IP1 IP2 IP3	IP1: MRSA bacteraemias C Diff MRSA Screens (EI & Em) MSSA bacteraemias E Coli bacteraemias MRSA and C Diff Reduction Plan IP2: C Section Surveillance IP3: HII Audits	**G**	0 MRSAs reported for Jan/Feb 14 10 C Diff for Jan and 0 for Feb = 62 for 13/14 against end of year trajectory of 67. 100% MRSA Screening for Jan. 3 cases reported for Jan = 26 for 13/14 44 cases reported for Jan = 448 for 13/14
QS	PS1	Patient Safety Dashboard to include: SUIs Never Events Duty of Candour	**R – Never Events**	Never Event reported for Jan 14 (Retained Vaginal Pack)
QS	PS2	Safety Assurance Dashboard to include: Risk Register Central Alerting System	G	Dependent upon closure of Safer Practice Notice (SPN) 14: 'RIGHT PATIENT, RIGHT BLOOD
QS	PS4	Ward Health Check To include: Staffing / establishment, use of agency, Nursing Metrics F&FT etc	**G**	
QS	PS5	Compliance with letter content: ED and Discharge Letters: GP Actions; Follow up; Patient Information, Medication Changes and Consultant	**tbc**	Dependent on provision of audit data and achievement of Letter Content Standards

Sche-dule	Ref	Indicator Title and Detail	Q4 Predicted RAG	Rationale for RAG
		Outpatient Letters: GP Actions; Follow up; Patient Information, Medication Changes Absence of requests for GP to initiate treatment		
QS	PS6	Eliminating "avoidable" Grade 2, 3 and 4 Hospital Acquired Pressure Ulcers (HAPU)	**G**	Although 1 Grade 2 HAPU above monthly trajectory for January, commissioners agreed to defer financial penalty until February's data confirmed in recognition of improvements made and generally sustained.
QS	MM1	Medicines Management Dashboard to include: Compliance with - Leicester Medicines Code - Controlled Drugs Regs - Medicines Reconcilliation - Antipsychotics Prescribing - 'Traffic Lights' Policy - LLR Formulary Medication errors causing harm	**A – Controlled Drugs - Storage**	Medicines Code audit shows improvement for almost all areas. Controlled Drugs spot check audits still identified some areas of non compliance.
QS	PE1	Same Sex Accommodation	**G**	
QS	PE2	PE2b – Response Times PE2c – Reopened Complaints – improving response times PE2e – Actions being taken to reduce complaints relating to staff attitude, medical and nursing care	**A – Response Times**	25 day performance = 78% for January.
QS	PE3a	Patient Experience Bundle to include NPS Overall Score for Inpatients NPS 'Responsiveness to Personal Needs' Score Improvement with UHL PE Survey Questions score for Elderly Patients Discharge arrangements Improvement with FFT	**A – NPS Scores**	Anticipate 'composite score' will not have improved in the National Patient Survey results.
QS	PE4	Patient Experience in ED	**G**	
QS	CE1	Maternity Services Dashboard	**G**	
QS	CE2	Children's Services Dashboard	**G**	
QS	CE3	PROMS - Hip or Knee Replacement - Groin Hernia Surgery - Varicose Vein Repair a) Participation in PROMs b) Outcome PROMS - utilising HES pre and post outcome data	**G**	UHL's PROMs data is now 'within expected' for Groin Hernia Surgery.
QS	CE4	#NOF scorecard to include Time to theatre (36 hrs & 48 hrs) and Orthogeriatric / MDT related indicators	**A**	'time to theatre' below 72% for Jan 14.
QS	CE5	Stroke & TIA Clinic Indictors to include: 90% stay, Swallow Assessment, TIA referral within 24 hrs	**A – TIA Clinic for High Risk Patients**	'time to TIA clinic' for 'high risk patients' below 60% for Feb 14.
QS	CE6	Mortality Dashboard: SHMI, HSMR Perinatal Mortality Amenable Mortality (linked to Everyone counts) LTC Mortality - Alcoholic Liver Disease (linked to Everyone	**A - SHMI**	SHMI remains 'within expected' but above 100.

Sche-dule	Ref	Indicator Title and Detail	Q4 Predicted RAG	Rationale for RAG
		Counts')		
QS	CE7	Quality Assurance Dashboard to include: Compliance with NICE TAGs and other guidance Clinical Audit Programme progress External Visits Schedule	**G**	
QS	CE10	Consultant level survival rates as stated on the 'Everyone Counts' document	**G**	
QS	PR1	1.1 Digital First IOFM Advice for Carers of Pts with Dementia	**A - IOFM**	Deterioration in performance for IOFM identified to be due to problems with use of non-invasive monitoring. New process agreed to start in March.
		CQUIN SCHEMES		
Nat CQUIN	Nat 1	Implementation of Friends and Family Test: 1.1 Phased Expansion 1.2 Increased Response Rate 1.3 Increase score of Friends and Family Test question in 2013/15 Staff Survey from 2012/13 Survey Results	**tbc**	Improvement in Staff F&FT score tbc. Achieved 20% for combined inpatient/ED F&FT participation.
Nat CQUIN	Nat 2	2.1. To collect data on the following three elements of the NHS Safety Thermometer: pressure ulcers, falls UTI in patients with a catheter 2.2a Reduction in CAUTIs 2.2b Reduction in Falls	**G**	
Nat CQUIN	Nat 3	3.1 .Patients aged 75 and over admitted as an emergency are screened for dementia, where screening is positive they are appropriately assessed and where appropriate referred on to specialist services/GP.	**G**	
			tbc	Dependent upon achievement of Dementia Training Plan Milestones
		3.2. Ensuring sufficient clinical leadership of dementia within providers and appropriate training of staff. 3.3. Ensuring carers of people with dementia feel adequately supported	**G**	
Nat CQUIN	Nat 4	Reduce avoidable death, disability and chronic ill health from Venous thromboembolism(VTE) 1. VTE risk assessment 2. VTE RCAs	**tbc**	95% risk assessment achieved for January.
CCG CQUIN	Loc 1	Making Every Contact Count Increased advice and referral to STOP and ALW	**G**	
CCG CQUIN	Loc 2	Implementation of the AMBER care bundle to ensure patients and carers will receive the highest possible standards of end of life care	**G**	

Sche-dule	Ref	Indicator Title and Detail	Q4 Predicted RAG	Rationale for RAG
CCG CQUIN	Loc 3	Improve care pathway and discharge for patients with Pneumonia a) Admission directly to respiratory ward and piloting of 'pneumonia virtual clinic for patients admitted to LRI') b) Improving care pathway and discharge for patients with Pneumonia - Implementation of Pneumonia Care Bundle	G	Continued increase in numbers of patients seen by Pneumonia Nurses and care bundle used.
CCG CQUIN	Loc 4	Improving care pathway and discharge for patients with Heart Failure - Implementation of Care Bundle and discharge Check List and piloting of 'virtual ward'	G	Further increase in number of patients following care bundle.
CCG CQUIN	Loc 5	Critical Safety Actions – Clinical Handover Acting on Results Senior Review/Ward Round Standards Early Warning Score	tbc	Dependent upon Commissioners' Observational Visits.
CCG CQUIN	Loc 7	Implementation of DoH Quality Mark with specific focus on Dignity Aspects	G	
Spec Services CQUIN	SS1	Implementation of Specialised Service Quality Dashboards	G	
Spec Services CQUIN	SS2	Bone Marrow Transplant (BMT) – Donor acquisition measures	G	
Spec Services CQUIN	SS3	Fetal Medicine – Rapidity of obtaining a tertiary level fetal medicine opinion – within 3 working days.	G	
Spec Services CQUIN	SS4	Joint Pain Scores for Moderate/Severe Haemophilia Patients	G	
Spec Services CQUIN	SS5	Discharge planning is important in improving the efficiency of units and engaging parents in the care of their infants thereby improving carer satisfaction of NICU services.	G	
Spec Services CQUIN	SS6	Radiotherapy – Improving the proportion of radical Intensity modulated radiotherapy (excluding breast and brain) with level 2 imaging – image guided radiotherapy (IGRT)	G	
Spec Services CQUIN	SS7	Acute Kidney Injury	G	
Spec Services CQUIN	SS8	PICU - . To prevent and reduce unplanned readmissions to PICU within 48 hours	G	

The CQUIN indicators have been agreed with Specialised Services Commissioners and the indicators both the CCG Quality Schedule and CQUINs are almost finalised.

The Specialised Services CQUINs are:

- National Quality Dashboards (BMT, Burns, Cardiology Procedures, Cystic Fibrosis, Haemophilia, HIV, Medical Genetics, Neonatal Unit, Paediatric Intensive Care, IVIG, Renal Services, Radiotherapy)
- Patient Flow Improvement through clinical utilisation review (Critical Care)

- ❖ Improved access to breast milk in preterm infants (Neonatal Services)
- ❖ Consultant Assessment of Emergency Admissions within 14 hours. (Seven Day Services – joint Specialised Services and CCG CQUIN)
- ❖ Real time data capture of all adult in patients' acuity within our electronic handover system

4.9 Theatres – 100% WHO compliance

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

The National Patient Safety Agency endorsed WHO checklist consists of four stages and is monitored and reported every month to commissioners. For February the checklist compliance stands at 100% and has been fully compliant for over a year..

4.10 C-sections rate

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

The C-section rate for February is 25.5% against a target of 25%, with a year to date performance of 25.3%.

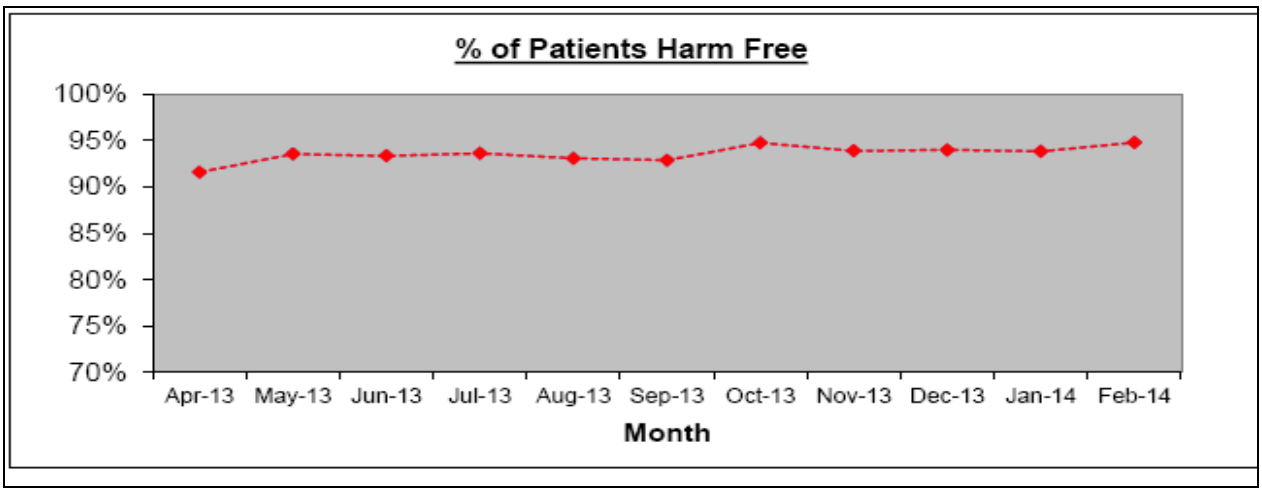
4.11 Safety Thermometer

Areas to note for the February Safety Thermometer:-

- ❖ Harm Free Care was 94.8%
- ❖ There was a decrease in the number of newly acquired harms; notably, falls and VTEs
- ❖ Hospital acquired thromboses (HATs) have reduced consecutively for the past two months from a peak in December 2013

		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14
	Number of patients on ward	1672	1686	1650	1514	1496	1579	1596	1662	1558	1616	1661
All Harms	Total No of Harms - Old (Community) and Newly Acquired (UHL)	150	117	113	100	108	121	85	102	102	104	91
	No of patients with no Harms	1531	1577	1540	1417	1392	1466	1512	1560	1464	1516	1574
	% Harm Free	91.57%	93.53%	93.33%	93.59%	93.05%	92.84%	94.74%	93.86%	93.97%	93.81%	94.76%
New Harms	Total No of Newly Acquired (UHL) Harms	73	58	56	49	59	46	42	40	41	46	36
	No of Patients with no Newly Acquired Harms	1600	1631	1596	1466	1438	1535	1555	1622	1519	1572	1624
	% of UHL Patients with No Newly Acquired Harms	95.69%	96.74%	96.73%	96.83%	96.12%	97.21%	97.43%	97.59%	97.50%	97.28%	97.77
Harm One	No of Patients with an OLD or NEWLY Acquired Grade 2, 3 or 4 PU	92	75	73	66	67	87	54	74	62	69	58
	No of Newly Acquired Grade 2, 3 or 4 PUs	26	27	26	19	25	16	19	17	13	21	21
Harm Two	No of Patients with falls in a care setting in previous 72 hrs resulting in harm	14	8	8	5	3	3	2	3	3	5	5
	No of patients with falls in UHL in previous 72 hrs resulting in harm	3	3	4	5	2	2	2	1	3	5	2
Harm Three	No of Patients with Urinary Catheter and Urine Infection (prior to or post admission)	36	27	27	25	31	25	22	15	24	14	22
	Number of New Catheter Associated UTIs	25	16	17	21	24	21	14	10	12	4	7
Harm Four	Newly Acquired community or hospital acquired VTE (DVT, PE or Other)	8	7	5	4	7	6	7	10	13	16	8
	Hospital Acquired Thrombosis (HAT)						2	1	6	7	4	2

Chart One – UHL Percentage of Harm Free Care April 2013 to February 2014



DETAILED ANALYSIS OF FOUR HARMS

a) Falls

There was no change in the prevalence of falls with harm, but there was a reduction the falls that occurred within UHL. Out of the five patients who had a fall resulting in harm, two of the reported falls occurred within UHL and three occurred prior to admission. Both of the patients that fell within UHL sustained a level 2 harm, a laceration to the head. Two of the patients that had a fall prior to admission fell within their own home and sustained bruising. The third patient fell at their residential home and sustained a hip fracture.

b) Pressure Ulcers

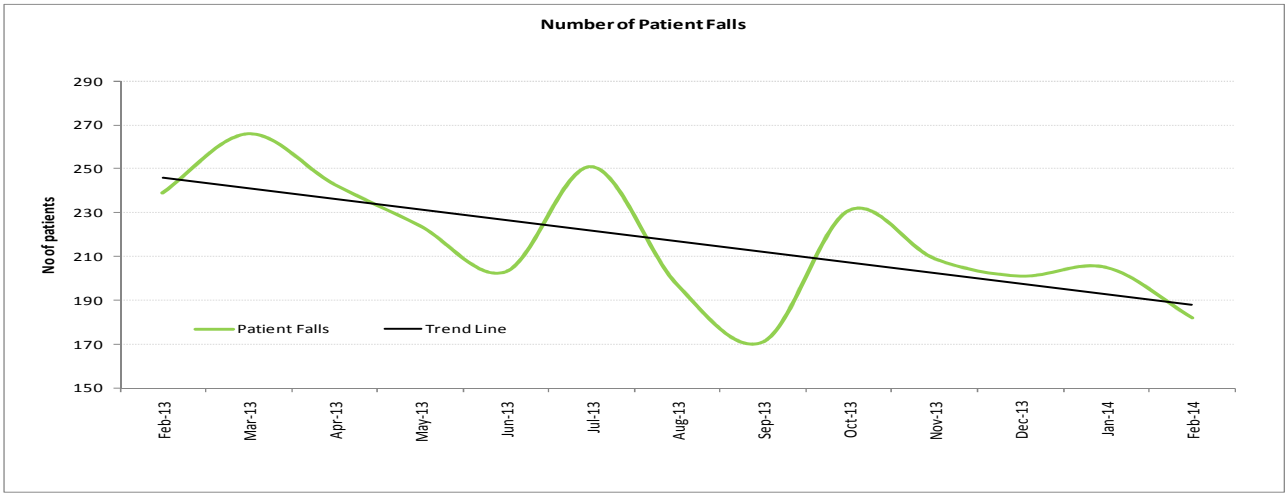
The prevalence of new pressure ulcers in February 2014 remains the same as the previous month. There was however a slight reduction in the number of patients admitted to UHL with pressure damage

c) VTE

On analysis of the ST data it remains evident that, with one monthly exception, the majority of the VTEs are 'old' followed by the next largest group of 'new' VTE patients arriving at UHL with their VTE and treatment commencing on arrival (community acquired). Hospital acquired thromboses (HATs) have reduced consecutively for the past two months from a peak in December 2013.

In terms of quality improvement through the ST audit; work is underway to more accurately identify potential HATs for root cause analysis (RCA) as it has become evident through ST that some VTEs are incidental findings discovered whilst scanning patients for other reasons. Discussions are underway regarding the feasibility of including all of the 'incidental findings' scan report codes in the search for HATs, though as the HAT report review is done manually and is already an arduous process, increasing its scope may make the existing process unmanageable.

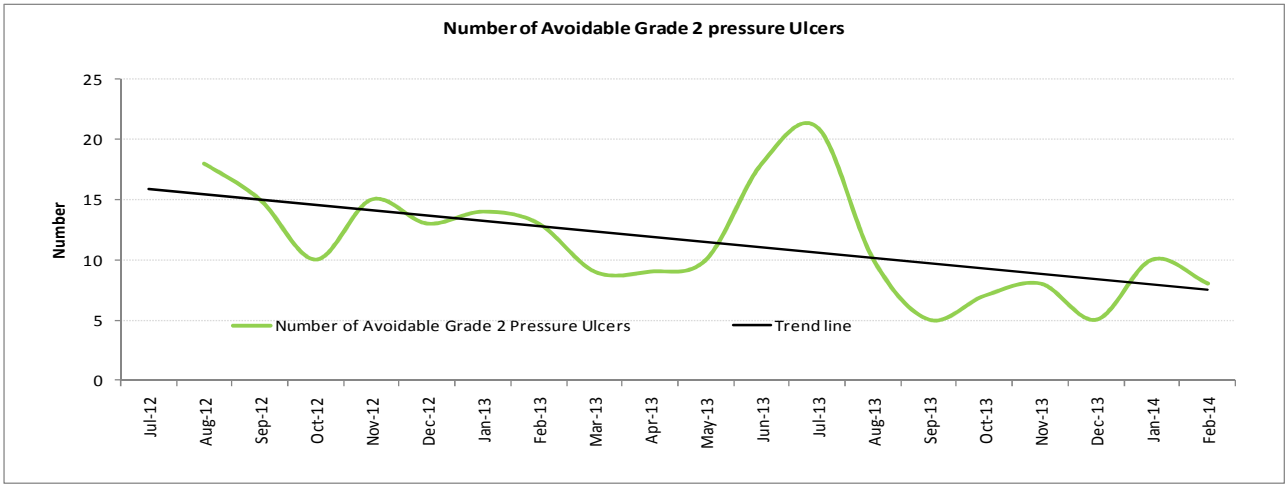
Patient Falls

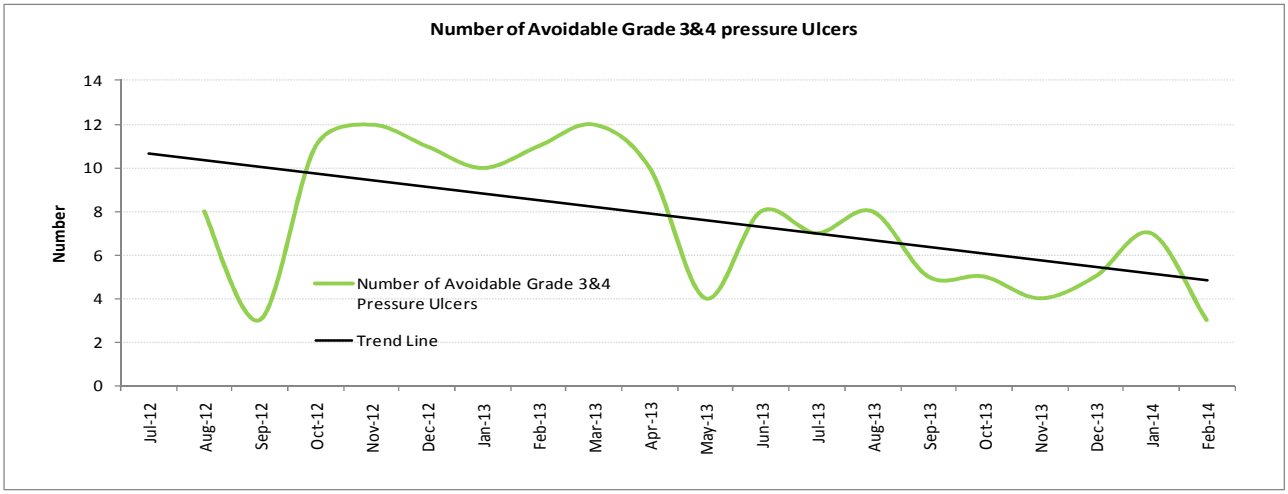


Falls incidence for February 2013 was 182, this may be subject to change due to outstanding Datix incidents being closed by ward managers.

Pressure Ulcer Incidence

The number of avoidable grade 3 pressure ulcers for February was 3 (threshold 7 or less) and 8 grade 2 ulcers (threshold 9 or less).





5.0 PATIENT EXPERIENCE – RACHEL OVERFIELD

5.1 Infection Prevention

a) MRSA

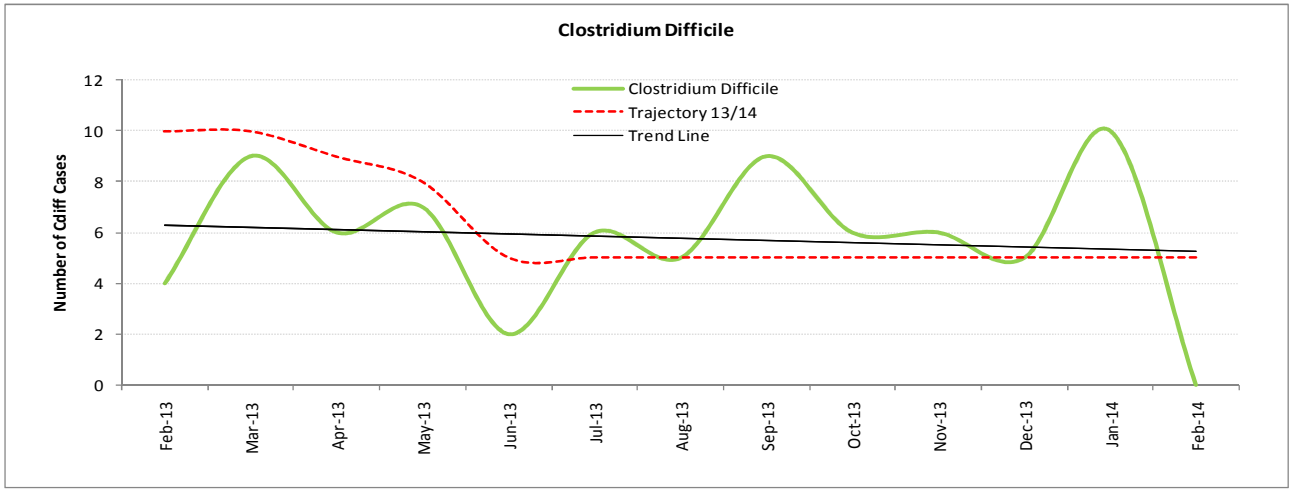
Mth	Qtr 1	Qtr 2	Qtr 3	YTD

There were no avoidable MRSA cases reported in February.

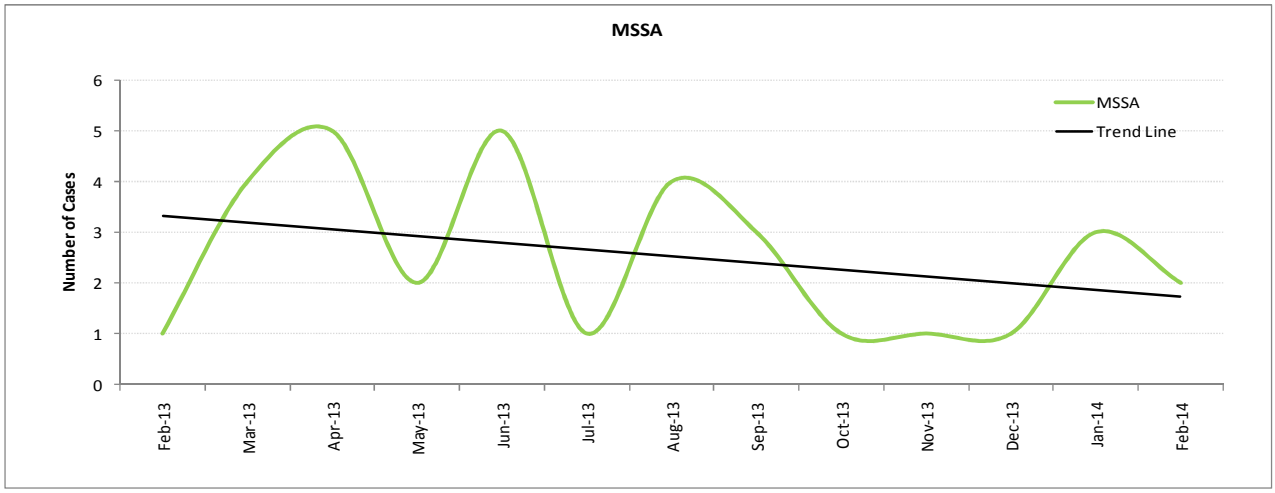
b) CDT

Mth	Qtr 1	Qtr2	Qtr3	YTD

There were no cases reported during February. The year to date position is 62 cases against a year to date target of 62 with a full year target of 67.



c) The number of MSSA cases reported during February was 2, with a year to date figure of 28.



5.2 Patient Experience

Patient Experience Surveys are offered to patients, carers, relatives and friends across the trust in the form of four paper surveys for adult inpatient, children's inpatient, adult daycase and intensive care settings and eleven electronic surveys identified in the table below.

In February 2014, 4,256 Patient Experience Surveys were returned this is broken down to:

- 2,527 paper inpatient/day case surveys
- 968 electronic surveys
- 616 ED paper surveys
- 145 maternity paper surveys

Share Your Experience – Electronic Feedback Platform

In February 2014, a total of 968 electronic surveys were completed via email, touch screen, SMS Text, our Leicester's Hospitals web site or handheld devices.

A total of 127 emails were sent to patients inviting them to complete a survey. The table below shows how this breaks down across the trust:

SHARE YOUR EXPERIENCE SURVEY	Email	Touch Screen	SMS Text	Handheld	QR Scan/Web	Total Surveys	Emails sent
A&E Department	0	77	0	0	7	84	0
Carers Survey	0	0	0	0	0	0	0
Children's Urgent and ED Care	0	15	0	0	0	15	0
FFT Eye Casualty	0	9	0	247	0	256	0
Glenfield CDU	0	21	0	0	0	21	0
Glenfield Radiology	5	0	0	0	0	5	15
IP and Children's IP	0	0	38	0	19	19	0
Maternity Survey	0	0	0	347	1	348	0
Neonatal Unit Survey	0	0	0	0	23	23	0
Outpatient Survey	29	5	43	154	2	190	112
Windsor Eye Clinic	0	3	0	4	0	7	0
Total	34	130	81	752	52	968	127

Treated with Respect and Dignity

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

This month has been rated GREEN for the question 'Overall do you think you were treated with dignity and respect while in hospital' based on the Patient Experience Survey trust wide scores for the last 12 months.

This new threshold scheme will be refreshed on a quarterly basis. A green score at trust level will mean that a new high score (based on the previous 12 months) and an improvement has been achieved. Conversely a red score will mean a new low score has been given by patients. The amber score has been replaced by blue and reflects 'an expected score' as scores will not be outside this blue range unless there is a significant improvement / deterioration.

Friends and Family Test

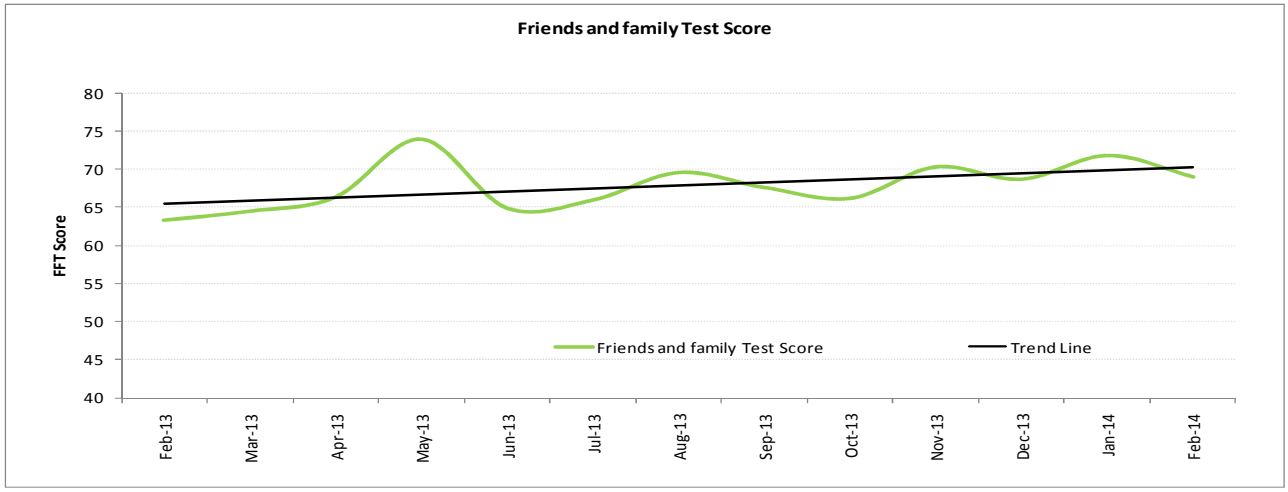
Inpatient

The inpatient surveys include the Friends and Family Test question; **How likely are you to recommend this ward to friends and family if they needed similar care or treatment?'** Of all the surveys received in February, 1,803 surveys included a response to this question and were considered inpatient activity (excluding day case / outpatients) and therefore were included in the Friends and Family Test score for NHS England.

Overall there were 6,397 patients in the relevant areas within the month of February 2014. The Trust easily met the 15% target achieving coverage of **28.2%.**

The Friends & Family Test responses broken down to:

Extremely likely:	1,298
Likely:	419
Neither likely nor unlikely:	53
Unlikely	8
Extremely unlikely	6
Don't know:	19
Overall Friends & Family Test Score	**69.0**



January 2014 Data Published Nationally

The National Table reports the scores and responses for 170 Trusts

If we filter out the Private and Single Speciality Trusts, and those that achieved less than 20% footfall, the UHL score of **72** ranks 70th out of **128** Trusts.

The overall National Inpatient Score (not including independent sector Trusts) was **72**.

Friends and Family Test Scores by CMG

Emergency and Specialist Medicine improved their FFT score again this month and have shown a steady improvement in their score since June.

CHUGS showed an 8.5 percentage point improvement in their FFT score this month, with an increase in both promoters and passive respondents, and a reduction in detractors.

The FFT score for Renal, Respiratory and Cardiac has declined this month, but their overall performance on the FFT score is strong and their score has consistently been above the UHL level FFT performance.

Musculoskeletal and Specialist Surgery also showed a drop in their FFT score compared to January performance but have shown consistently good performance over the year in line with UHL trust scores. This month however there was a small increase in the number of detractors of 2 percentage points, and a reduction in promoters.

Women's and Children's showed a large decline in their FFT score this month as a higher proportion of passive responses were received. The drop is primarily due to a fall in the score for the LRI GAU Ken L1 ward, which fell from 69.7 last month to 48.1 this month.

This ward also had around 50% fewer responses this month which may explain why the score has fluctuated so significantly.

The FFT score for the Emergency Department fell this month by 9 percentage points as respondents switched to being passive and detractors in place of promoters.

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Point Change in FFT Score (Jan - Feb 14)
UHL Trust Level Totals	**66.4**	**73.9**	**64.9**	**66.0**	**69.6**	**67.6**	**66.2**	**70.3**	**68.7**	**71.8**	**69.0**	**-2.8**
Renal, Respiratory and Cardiac	70	76	73	80	80	79	70	78	74	81	73	**-8.9**
Emergency and Specialist Medicine	64	72	57	62	63	68	63	68	73	72	75	**2.6**
CHUGS	59	70	57	53	61	53	58	59	56	54	62	**8.5**
Musculoskeletal and Specialist Surgery	72	75	73	66	68	69	69	70	66	71	67	**-4.1**
Women's and Children's	78	80	74	68	76	77	70	76	76	73	59	**-13.7**
Emergency Department	43	47	61	57	60	58	59	59	67	68	59	**-9.0**

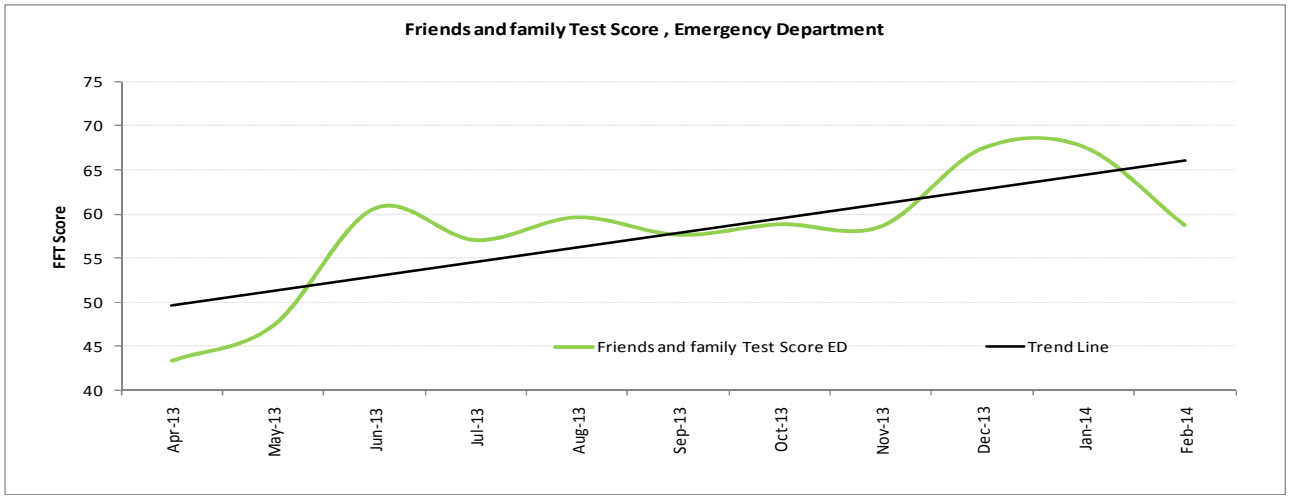
Details at hospital and ward level for those wards included in the Friends and Family Test Score are included in Appendix 1.

Emergency Department & Eye Casualty

Electronic and paper surveys are used to offer the Friends and Family Test question; **How likely are you to recommend this A&E department to friends and family if they needed similar care or treatment?'** in A&E Minors, Majors and Eye Casualty.

Overall there were 5,459 patients who were seen in A&E and then discharged home within the month of February 2014. The Trust surveyed 1,005 eligible patients meeting **18.4%** of the footfall. The Friends & Family test responses break down to:

Extremely likely:	667
Likely:	251
Neither likely nor unlikely:	44
Unlikely	23
Extremely unlikely	14
Don't know:	6
Overall Friends & Family Test Score	**58.7**



Breakdown by department	No. of responses	FFT Score	Total no. of patients eligible to respond
Emergency Dept Majors	215	51.6	1,349
Emergency Dept Minors	406	57.2	2,211
Emergency Dept – not stated	18	61.1	-
Emergency Decisions Unit	115	65.2	700
Eye Casualty	251	63.7	1199

January 2014 Data Published Nationally

The National Table reports the scores and responses for 143 Trusts

If we filter out the Trusts that achieved less than 15% footfall, the UHL score of **68** ranks 22nd out of the remaining 84 Trusts

The overall National Accident & Emergency Score was **57**.

(NB previously only trusts that met 20% were included in the A&E ranking – however the CQUIN 2014/15 national target for ED has been reset to 15% Q1-3 and will increase to 20% only in Q4).

Maternity Services

Electronic and paper surveys are used to offer the Friends and Family Test question to ladies at different stages of their Maternity journey. A slight variation on the standard question: **How likely are you to recommend our <service> to friends and family if they needed similar care or treatment?** is posed to patients in antenatal clinics following 36 week appointments, labour wards or birthing centres at discharge, postnatal wards at discharge and postnatal community follow-up at 10 days after birth.

Overall there were 3,214 patients in total who were eligible within the month of February 2014. The Trust surveyed 761 eligible patients meeting **23.7%** of the footfall. The Friends & Family test responses break down to:

Extremely likely:	490
Likely:	247
Neither likely nor unlikely:	12
Unlikely	3
Extremely unlikely	5

Don't know: 4

Overall Maternity Friends & Family Test Score 62.1

Breakdown by maternity journey stage	No. of responses	FFT Score	Total no. of patients eligible to respond
Antenatal following 36 week appointment	103	65.0	868
Labour Ward/Birthing centre following delivery	312	63.7	823
Postnatal Ward at discharge	276	59.5	604
Postnatal community – 10 days after birth	70	60.9	919

January 2014 Data Published Nationally

Maternity

NHS England has begun publishing all trust's Maternity Friends and Family Test scores and the results are split into each of the four Maternity Care Stages. January data was published at the beginning of March.

Antenatal

The average Friend and Family Test score for England (excluding independent sector providers) was **67**.

If we filter out the Trusts that are single speciality or achieved less than 20% footfall, then we are left with 35 Trusts. However our UHL Score of **70** does not feature among these as the 20% footfall was not achieved.

Birth

The average Friend and Family Test score for England (excluding independent sector providers) was **78**.

With single speciality and Trusts that achieved less than a 20% footfall excluded, the UHL Friends and Family Test score of **59** ranks the Trust 56th out of the remaining 70 Trusts.

Postnatal Ward

The average Friend and Family Test score for England (excluding independent sector providers) was **65**.

With single speciality and Trusts that achieved less than a 20% footfall excluded, the UHL Friends and Family Test score of **63** ranks the Trust 49th out of the remaining 73 Trusts.

Postnatal Community Provision

The average Friend and Family Test score for England (excluding independent sector providers) was **75**.

If we filter out the Trusts that are single speciality or achieved less than 20% footfall, then we are left with 30 Trusts. However our UHL Score of **71** does not feature among these as the 20% footfall was not achieved.

5.3 Nursing workforce

5.3.1 Vacancies

There are 238wte are vacancies - 220wte RN vacancies and 18wte HCA.

The sum of budgeted wte's in February 2014 is reported as	4,985wte
The sum of nurses in post in February 2014 is reported as	4,499wte
The sum of nurses waiting to start in February is reported as	331wte
The sum of nurses waiting to leave in February is reported as	84wte
Therefore the sum of total reported vacancies for February is	238wte

There are 271wte RN's waiting to start and 60wte HCA's waiting to start. Therefore the 'felt vacancies 'are at 419wte RN and 66wte HCA's. The detail is in the below table.

CMG	Felt RN Vacant	Felt HCA Vacant	Total
CHUGS	57.58	26.19	**83.77**
CSI	0	0	**0**
ED & SM	184.46	-16.51	**167.95**
ITAPs	47.89	13.92	**61.81**
MSK & SS	34.05	0.72	**34.77**
RRC	41.70	22.63	**64.33**
W & C	53.68	19.71	**73.39**
Total	**419.36**	**66.66**	**486.02**

5.3.2 Real Time Staffing

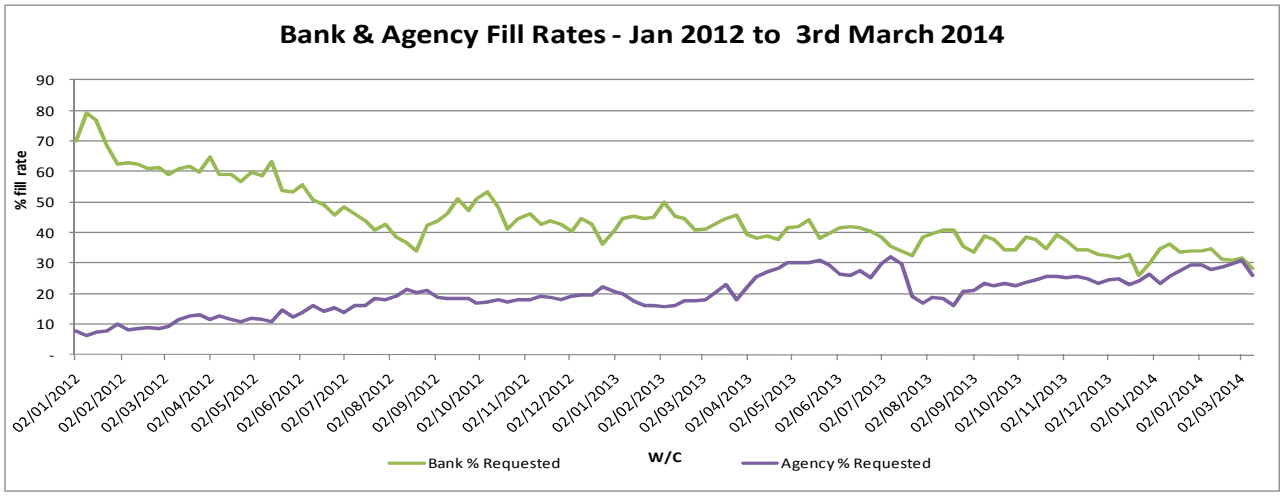
Following the review of ward establishments earlier this year and the trust board sign off for additional funding each ward sister and matron met with Heads of Nursing to agree and sign off minimum safe staffing levels for each area. It was also agreed that this information would be on display in each ward sister's office so that it is available to all staff for information.

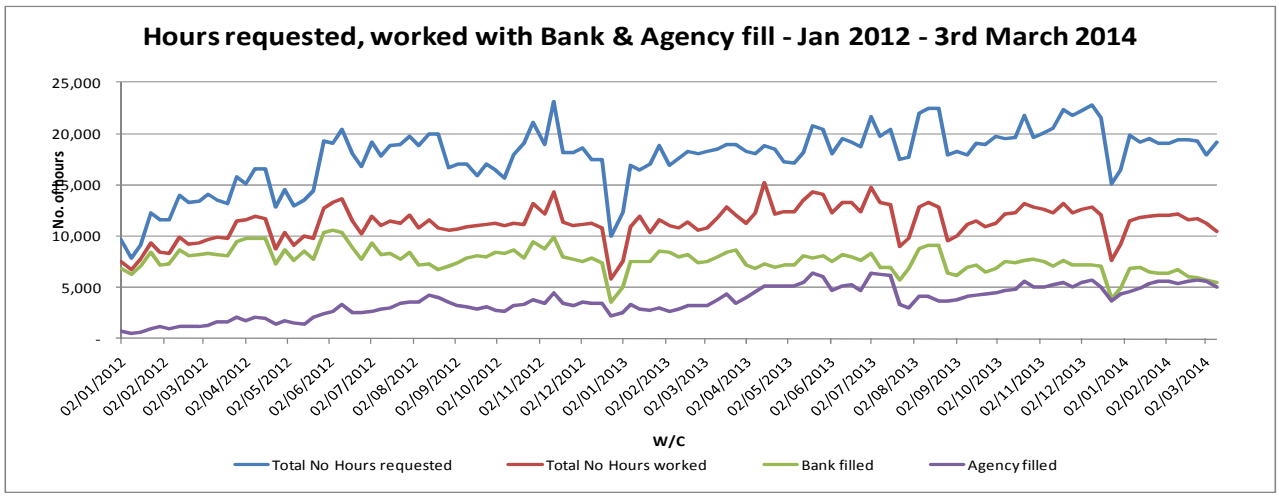
Future workforce reports will detail real time staffing for the previous month, how many shifts have been made amber or red, and whether there is any trending with this in relation to wards and CMG's.

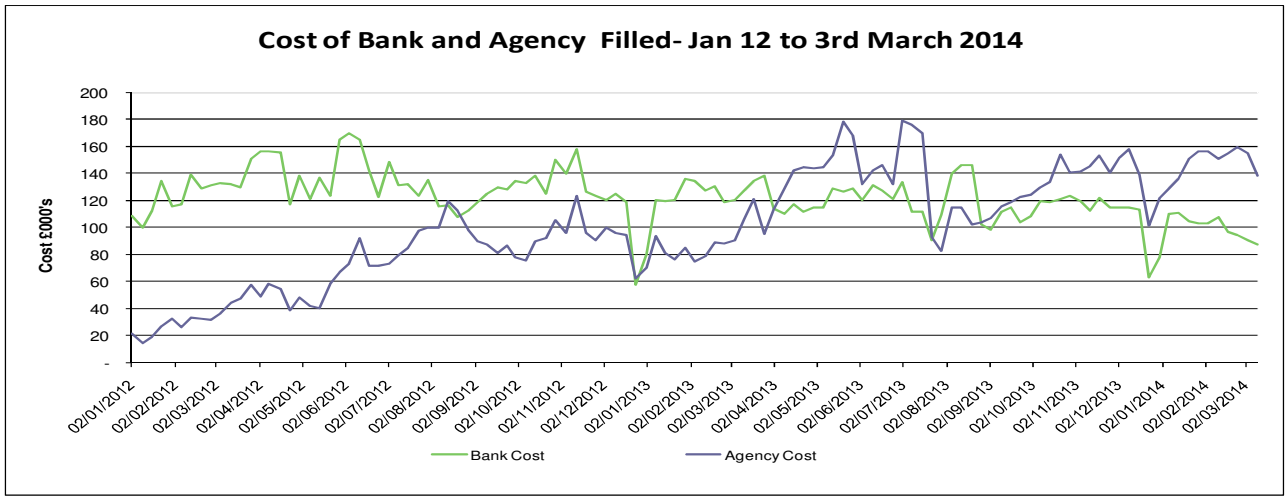
The report will also detail the compliancy in relation to completion of the information per ward area/CMG.

5.3.3 Bank and Agency

Bank and agency information is shown in the following graphs.







5.4 Ward Performance and Ward Alerting Concerns

The dashboard (Appendix 2) represents February data. The dashboard suggests that the following wards are showing early signs of deterioration/challenge and need observation by the CMG leadership:

LRI	*LGH*	*GH*
*5 **	*15 **	*CDU **
*7 **	*28 * (CR)*	*16*
*15 **		
*16 **		
*17 **		
*18 **		
*24 **		
*29 * (CR)*		
*33 **		
*36 **		

Ward marked with * have been previously highlighted for CMG or targeted additional support which is ongoing. If next month, these wards continue to show no sign of improvement, we will consider a 'special measures' approach.

Wards marked with (CR) have now alerted for the third month in a row and will be subject to a condition report and Corporate Nursing Review with potential special measures approach

5.5 Same Sex Accommodation

Mth	Qtr 1	Qtr 2	Qtr 3	YTD

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

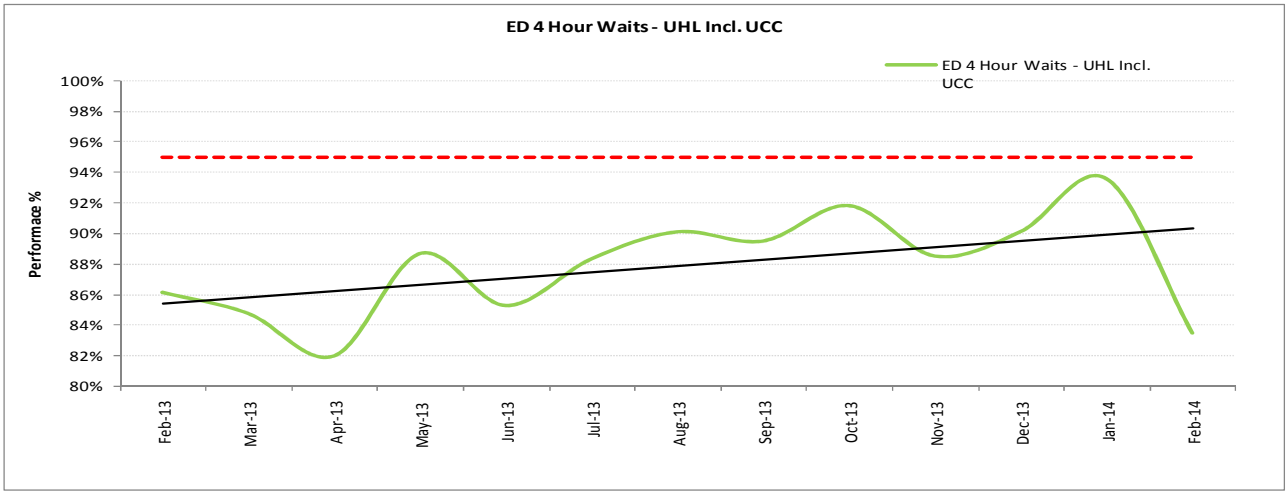
6 OPERATIONAL PERFORMANCE – RICHARD MITCHELL

Outcome Measures

Performance Indicator	Target	Jan-13	Feb-13	Mar-13	Q4	Apr-13	May-13	Jun-13	Q1 2013	Jul-13	Aug-13	Sep-13	Q2 2013	Oct-13	Nov-13	Dec-13	Q3 2013	Jan-14	Feb-14	YTD
A&E - Total Time in A&E (UHL+UCC)	95%	84.9%	86.1%	84.7%	85.2%	82.0%	88.7%	85.3%	85.3%	88.3%	90.1%	89.5%	89.3%	91.8%	88.5%	90.1%	90.2%	93.6%	83.5%	88.2%
RTT waiting times – admitted	90%	92.2%	91.9%	91.3%		88.2%	91.3%	85.6%		89.1%	85.7%	81.8%		83.5%	83.2%	82.0%		81.8%	79.1%	
RTT waiting times – non-admitted	95%	97.3%	97.0%	97.0%		97.0%	95.9%	96.0%		96.4%	95.5%	92.0%		92.8%	91.9%	92.8%		93.4%	93.5%	
RTT - incomplete 92% in 18 weeks	92%	93.4%	93.5%	92.6%		92.9%	93.4%	93.8%		93.1%	92.9%	93.8%		92.8%	92.4%	91.8%		92.0%	92.6%	
RTT - 52+ week waits	0	0	0	0		0	0	0		0	0	0		0	0	1		1	0	
Diagnostic Test Waiting Times	<1%	0.7%	1.0%	0.5%		1.6%	0.6%	0.6%		0.6%	0.8%	0.7%		1.0%	0.8%	1.4%		5.3%	1.9%	
Cancelled operations re-booked within 28 days	100%	97.1%	92.3%	94.2%	94.6%	90.4%	91.0%	86.4%	89.8%	99.1%	96.0%	98.6%	98.0%	94.2%	97.7%	94.3%	95.5%	94.0%	98.8%	95.3%
Cancelled operations on the day (%)	0.8%	1.6%	1.6%	1.6%	1.6%	1.5%	1.5%	1.0%	1.3%	1.2%	1.4%	2.3%	1.6%	1.7%	1.8%	1.7%	1.8%	1.6%	2.0%	1.6%
Cancelled operations on the day (vol)		137	130	137	404	125	134	81	340	114	124	208	446	171	172	141	484	149	172	1591
Urgent operation being cancelled for the second time	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2 week wait - all cancers	93%	89.8%	95.9%	95.2%	93.7%	93.0%	95.2%	94.8%	94.4%	94.2%	94.6%	93.0%	94.0%	94.9%	95.7%	94.9%	95.2%	95.3%		94.6%
2 week wait - for symptomatic breast patients	93%	93.6%	93.1%	95.4%	94.0%	94.0%	94.8%	93.2%	94.1%	93.6%	92.0%	95.2%	93.8%	93.0%	91.3%	95.5%	93.3%	96.8%		94.1%
31-day for first treatment	96%	96.6%	97.6%	98.8%	97.6%	97.5%	97.0%	99.0%	97.8%	98.3%	99.7%	99.1%	99.0%	98.9%	96.2%	97.4%	97.6%	97.1%		98.0%
31-day for subsequent treatment - drugs	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%
31-day wait for subsequent treatment - surgery	94%	94.6%	94.1%	92.7%	94.0%	97.2%	94.4%	97.5%	96.4%	100.0%	98.4%	88.6%	95.9%	96.4%	97.1%	92.3%	95.3%	94.8%		95.7%
31-day wait subsequent treatment - radiotherapy	94%	99.1%	98.9%	99.1%	99.0%	100.0%	97.8%	99.1%	98.8%	100.0%	100.0%	97.7%	99.4%	97.5%	98.5%	98.1%	98.0%	94.7%		98.3%
62-day wait for treatment	85%	79.5%	75.4%	81.5%	78.8%	80.9%	80.3%	85.9%	82.3%	85.8%	88.2%	87.4%	87.1%	86.4%	85.7%	89.4%	87.1%	89.5%		85.9%
62-day wait for screening	90%	91.7%	95.7%	95.8%	94.4%	98.6%	94.3%	95.0%	95.9%	90.6%	97.2%	96.2%	94.1%	100.0%	97.0%	96.6%	97.9%	97.1%		96.2%
Stroke - 90% of Stay on a Stroke Unit	80%	77.8%	81.4%	82.3%	80.6%	77.4%	80.7%	78.7%	78.5%	87.1%	88.6%	89.1%	88.3%	83.5%	78.0%	80.2%	80.6%	88.5%		83.1%
Stroke - TIA Clinic within 24 Hours (Suspected TIA)	60%	60.8%	85.1%	77.0%	73.1%	51.1%	69.2%	72.0%	63.9%	60.5%	73.6%	64.6%	66.0%	62.4%	76.8%	65.7%	68.4%	60.5%	40.7%	63.1%
Choose and Book Slot Unavailability	4%	5%	10%	9%		7%	9%	13%		15%	14%	11%		16%	17%	14%		9%	14%	12%
Delayed transfers of care	3.5%	2.8%	2.7%	3.7%	3.0%	3.7%	3.9%	3.1%	3.6%	3.6%	3.1%	3.9%	3.5%	3.1%	4.6%	2.8%	3.5%	3.7%	4.5%	3.6%

6.3 Emergency Care 4hr Wait Performance

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD



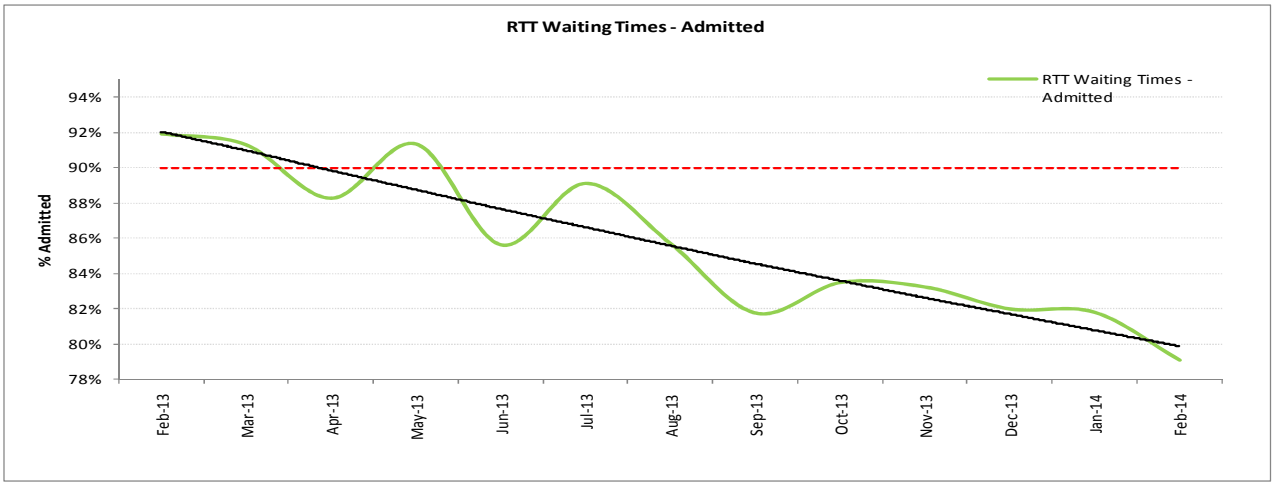
Performance for emergency care 4hr wait in February was 83.5%. Actions relating to the emergency care performance are included in the ED exception report.

UHL was ranked 142 out of 144 Trusts with Type 1 Emergency Departments in England for the four weeks up to 9th March 2014. Over the same period 67 out of 144 Acute Trusts delivered the 95% target.

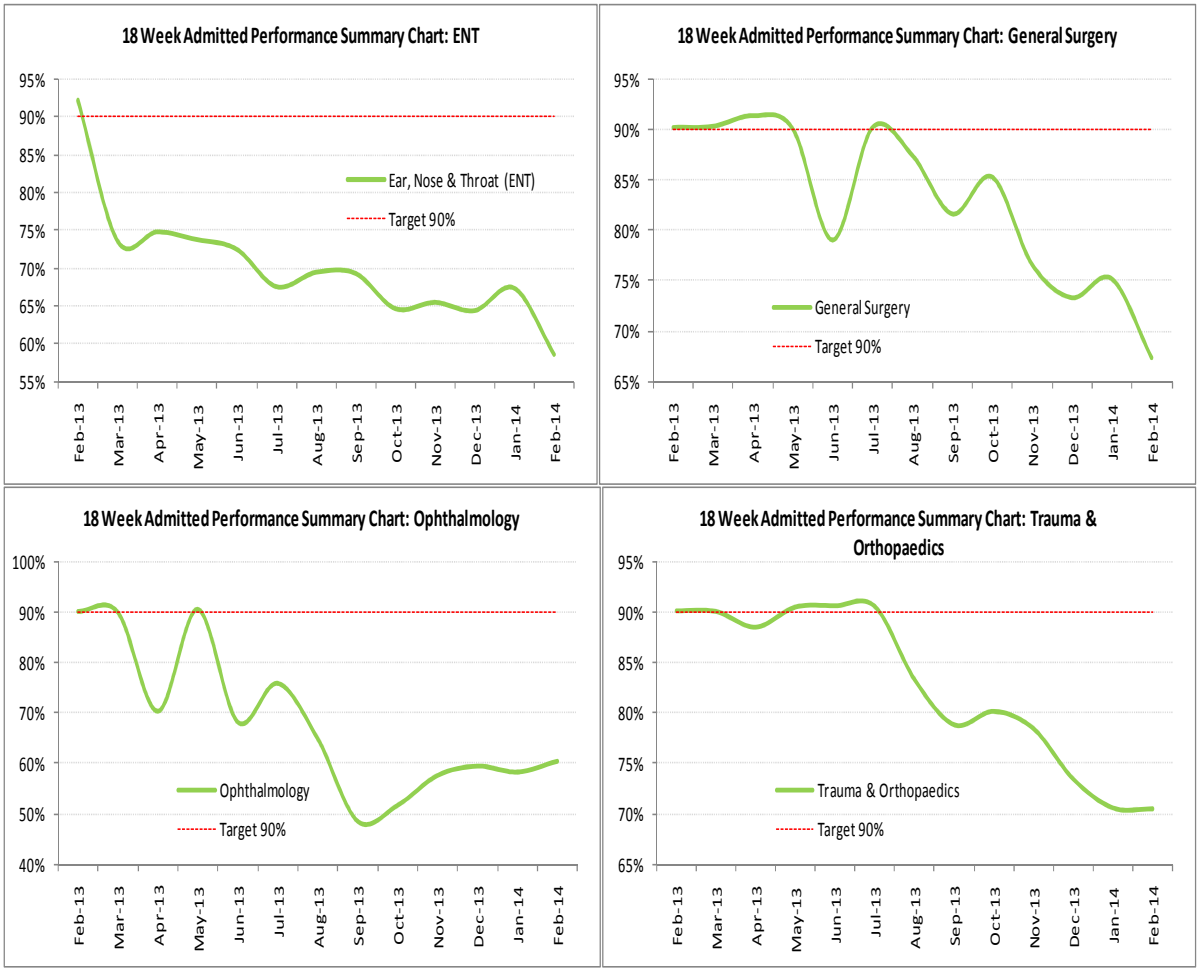
6.4 RTT – 18 week performance

a) RTT Admitted performance

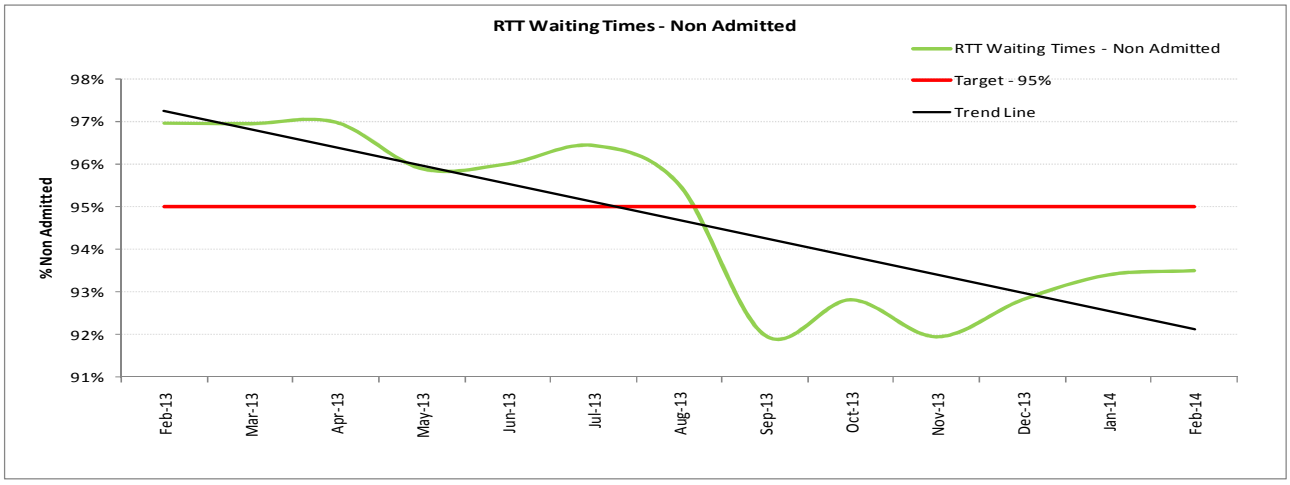
Mth | Qtr 1 | Qtr 2 | Qtr 3 | YTD



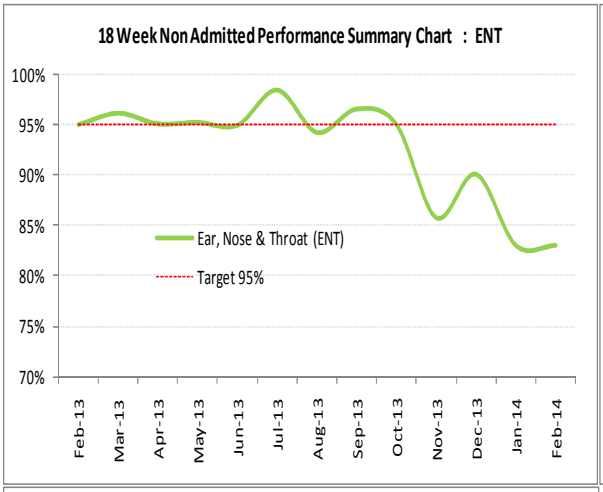
RTT admitted performance for February was 79.3% with significant speciality level failures in ENT, General Surgery, Ophthalmology and Orthopaedics. The Trust recovery action plan has been formally accepted by commissioners. Weekly performance meetings are being held by the Chief Operating Officer with the key specialties to monitor compliance with detailed action plans.

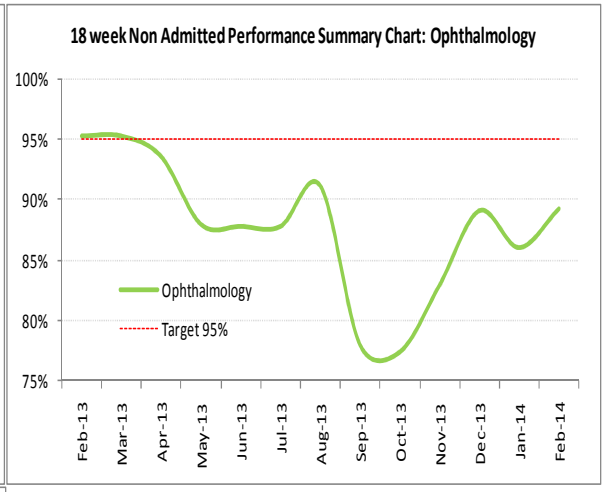


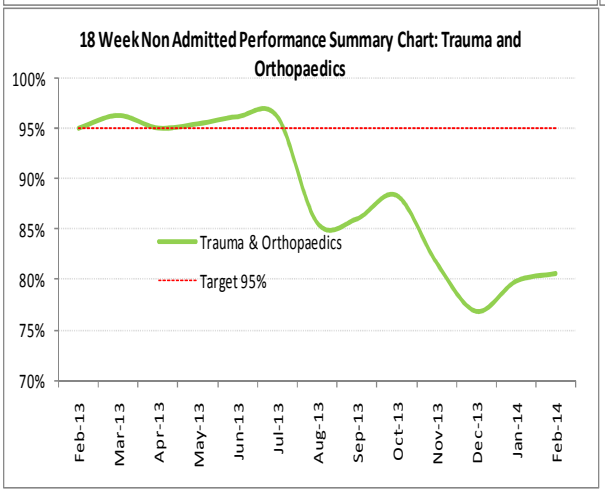
b) RTT Non Admitted performance



Non-admitted performance during January was 93.5%, with the significant specialty level failures in ENT, Orthopaedics and Ophthalmology. Weekly performance meetings are being held by the Chief Operating Officer with the key specialties to monitor compliance with detailed action plans.

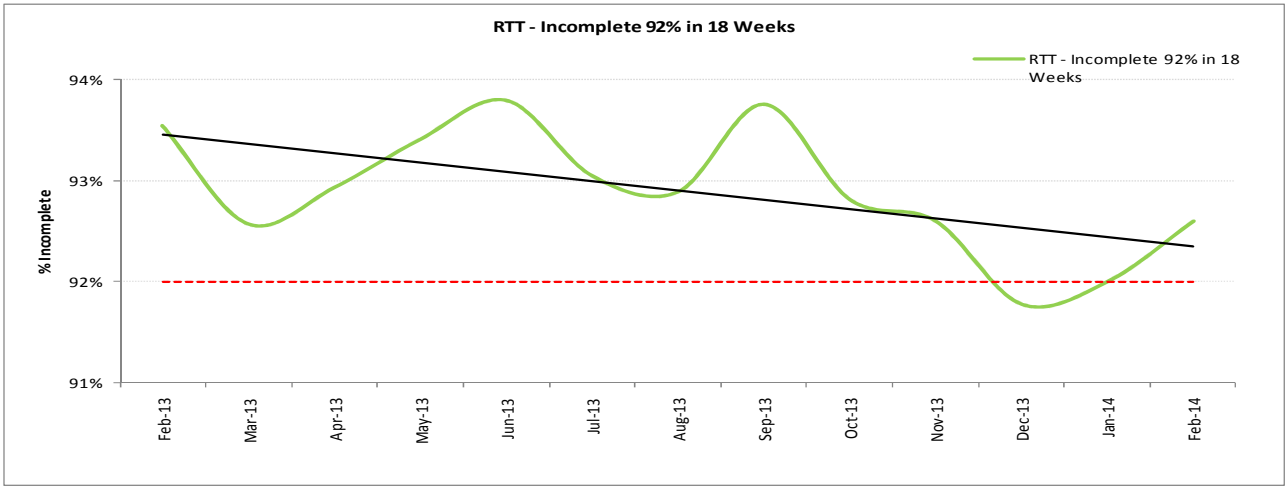






c) RTT Incomplete Pathways

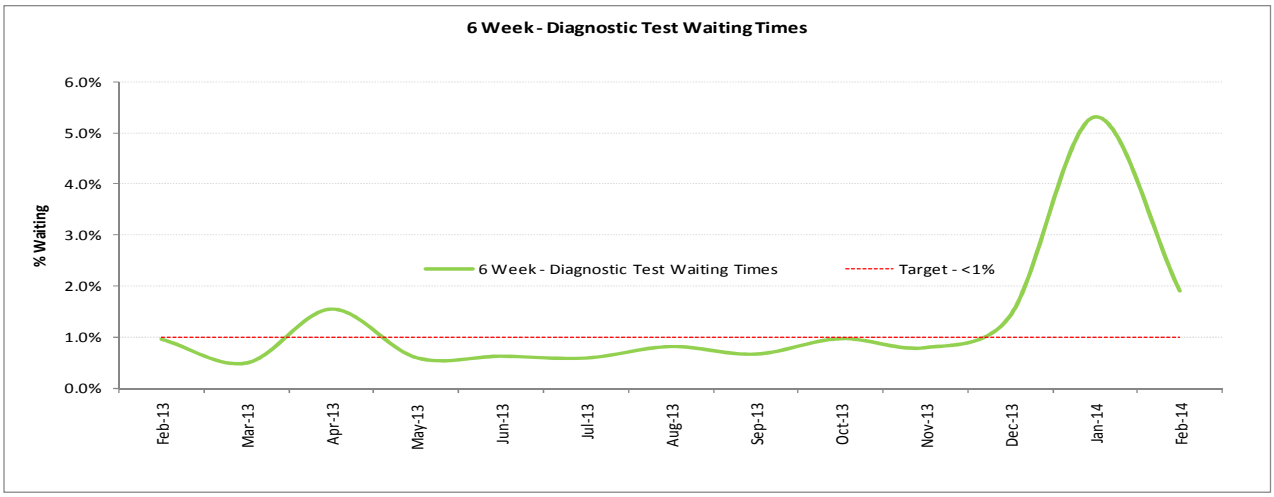
Mth | Qtr 1 | Qtr2 | Qtr3 | YTD



RTT incomplete (i.e. 18+ week backlog) performance achieved the target at 92.6%. In numerical terms the total number of patients waiting 18+ weeks for treatment (admitted and non-admitted) at the end of February was 2,937 down 257 from January (3,194).

6.5 Diagnostic Waiting Times

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD



At the end of February 1.9% of patients were waiting for diagnostic tests longer than 6 weeks. Further details are included in appendix 3 - diagnostic exception report.

6.6 Cancer Targets

a) Two Week Wait 

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

January performance for the 2 week to be seen for an urgent GP referral for suspected cancer was achieved at 95.3% (national performance 93.9%).

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

January performance for the 2 week symptomatic breast patients (cancer not initially suspected) was achieved at 96.8% (national performance 94.2%).

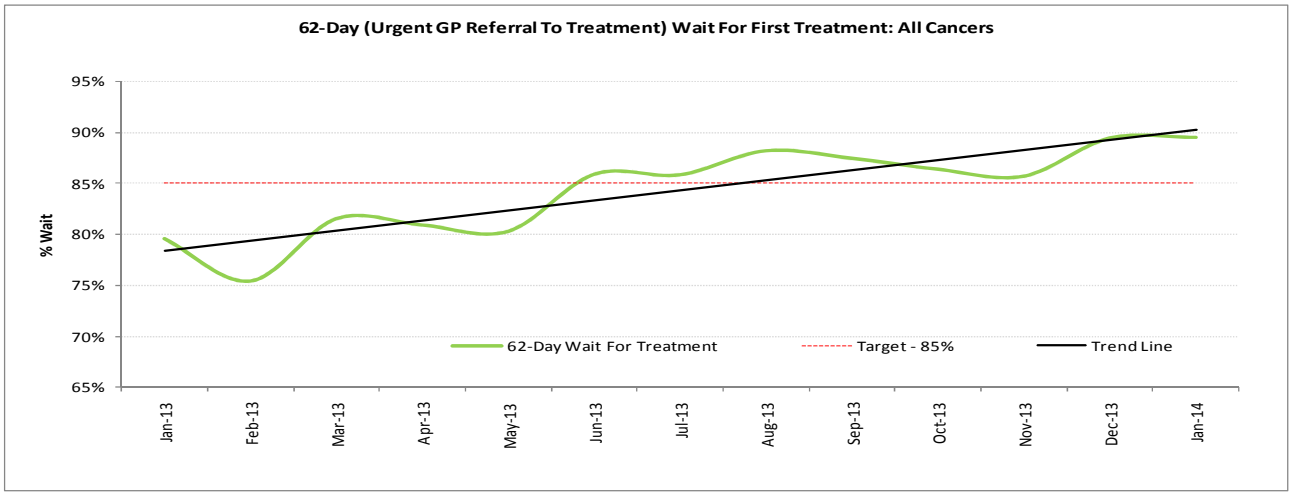
b) 31 Day Target 

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

All four of 31 day cancer targets have been achieved in January (latest reported month).

c) 62 Day Target 

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD



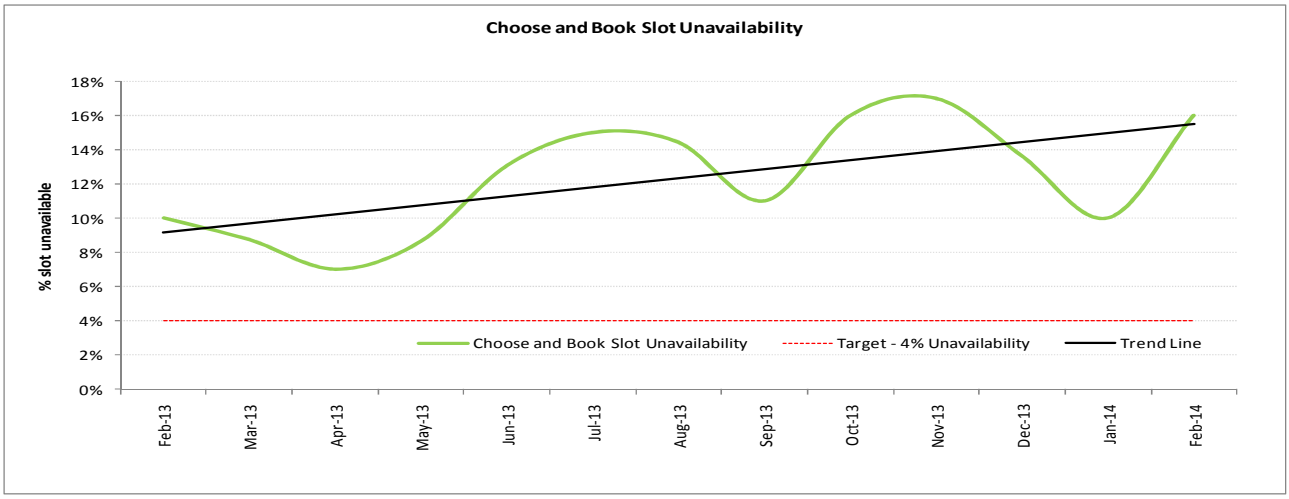
The 62 day urgent referral to treatment cancer performance in January was 89.5% (national performance was 83.4%) against a target of 85%. The year to date position is now also being delivered at 85.9%.

The Cancer Action Board continues to meet weekly, it is responsible for monitoring the Trusts Cancer Action Plan to ensure that actions are being delivered and there is representation from all the key tumour sites including Radiology and theatres. This meeting is chaired by the Cancer Centre Clinical Lead.

The key points to note as at mid March are:-

- Current volume over 62 days = 21 patients
- Waits > 100 days = 1 Urology patient

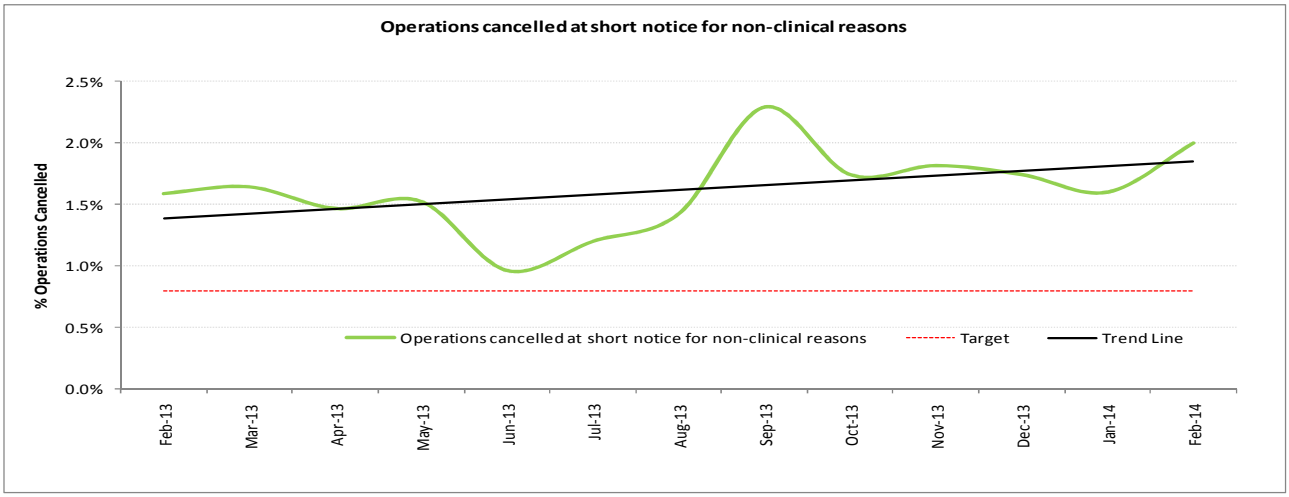
6.7 Choose and Book slot availability



Choose and book slot availability performance for February is 16% a deteriorated position from January (10%) with the national average at 9%. Resolution of slot unavailability requires a reduction in waiting times for 1st outpatient appointments in key specialties. For ENT and Orthopaedics, this forms part of the 18 week remedial action plan, the effect of these plans will be seen quarter 2 and quarter 3 of 2014-15. Neurology have appointed a locum consultant, in post from January providing additional outpatient capacity.

6.8 Short Notice Cancelled Operations

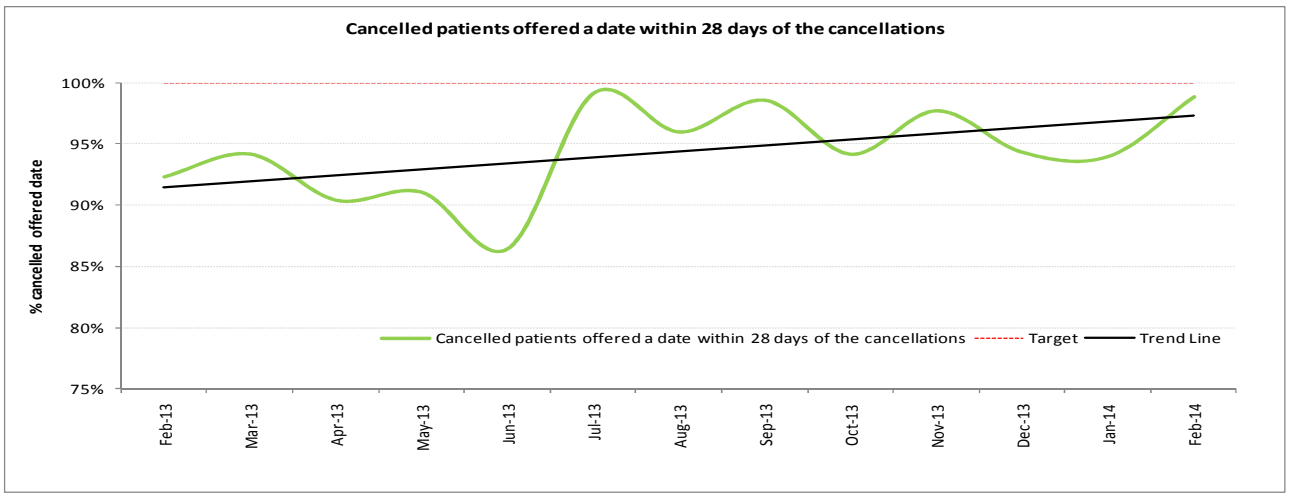
Mth | Qtr 1 | Qtr 2 | Qtr 3 | YTD



The percentage of operations cancelled on/after the day activity for non-clinical reasons during February was 2.0% a deteriorated position compared to January (1.5%) The year to date performance is 1.6%. A remedial action plan has been formally accepted by commissioners. An exception report is provided as Appendix 4.

Cancelled patients offered a date within 28 days

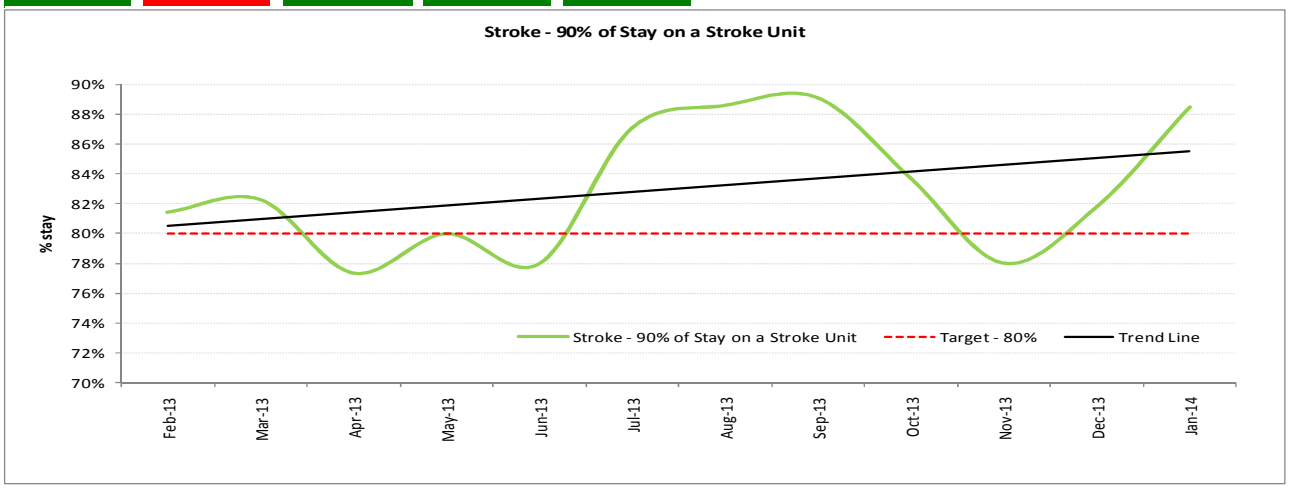
Mth | Qtr 1 | Qtr 2 | Qtr 3 | YTD



The threshold has been amended from 95% to 100% to reflect that every breach of this standard is subject to a financial penalty. The number of patients breaching this standard in February was 2 with 98.8% offered a date within 28 days of the cancellation. This is an improved position on January.

6.9 Stroke % stay on stroke ward

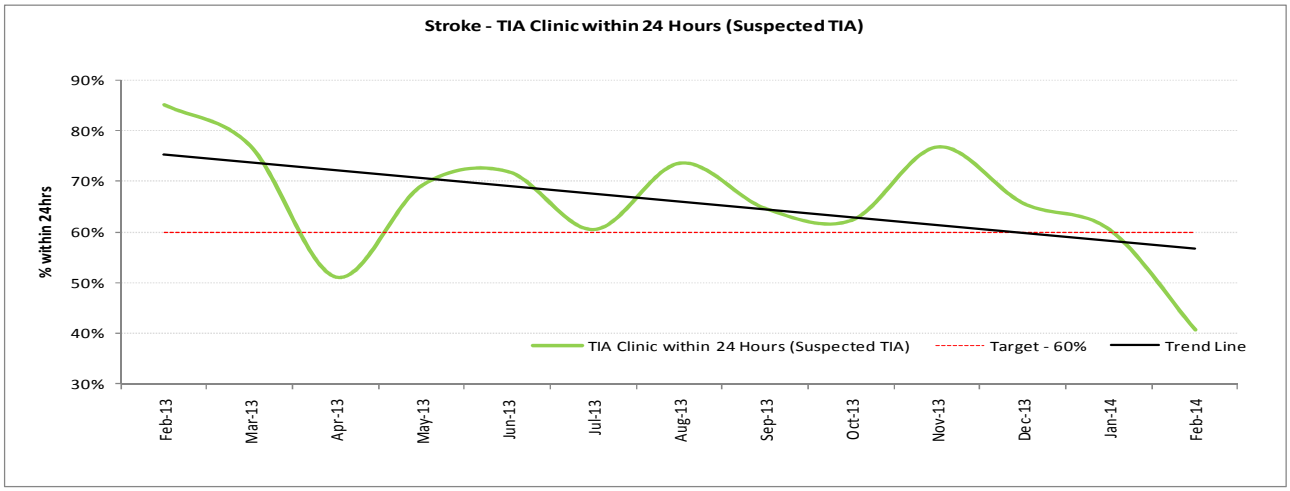
Mth | Qtr 1 | Qtr 2 | Qtr 3 | YTD



The percentage of stoke patients spending 90% of their stay on a stroke ward in January (reported one month in arrears) is 88.5% against a target of 80%. The year to date position is 83.1%.

6.10 Stroke TIA

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

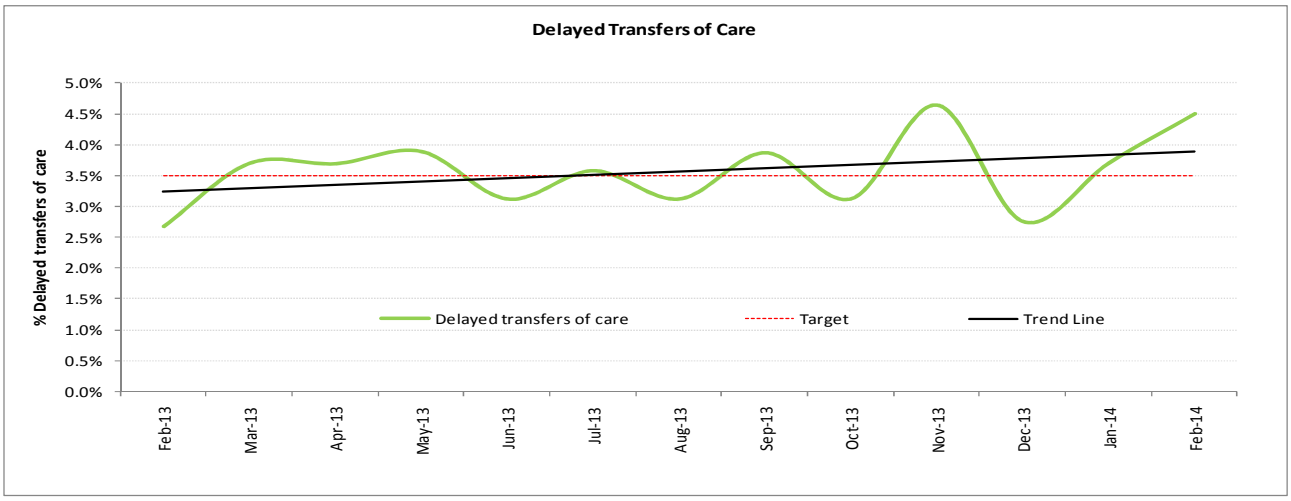


The percentage of high risk suspected TIAs receiving relevant investigations and treatment within 24 hours of referral receipt is 40.7% against a national target of 60.0%. The fall in performance in February was due to a high influx of patients in the first part of the month, in one 24 hour period there were 16 referrals to the service which equates to 10% of all referrals in February. Also, 13 patients out of the 86 high risk group chose to wait longer than 24 hours. Performance in March has improved and is currently at 75%.

The year to date performance is 63.1%.

6.11 Delayed Transfers of Care

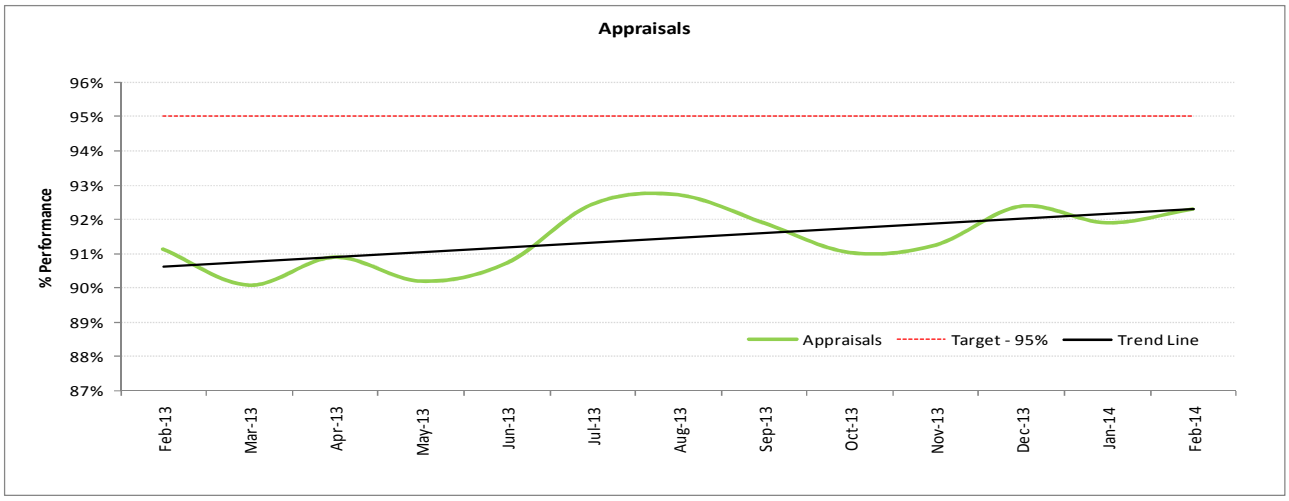
The February delayed transfer of care position was 4.5% with a year to date position of 3.6% against a target of 3.5%. February was a difficult month with an increase in the DTOCs in middle of the month, leading up to 70 plus DTOCs at some points. Action has been taken from external partners leading to a considerably improved position.



7 HUMAN RESOURCES – KATE BRADLEY

7.1 Appraisal

Mth	Qtr 1	Qtr 2	Qtr 3	YTD



There continues to be considerable appraisal activity over the last month, between January and February the Appraisal rate has increased to 92.3% at the end of February. There are increasing numbers of corporate areas meeting the 95% target

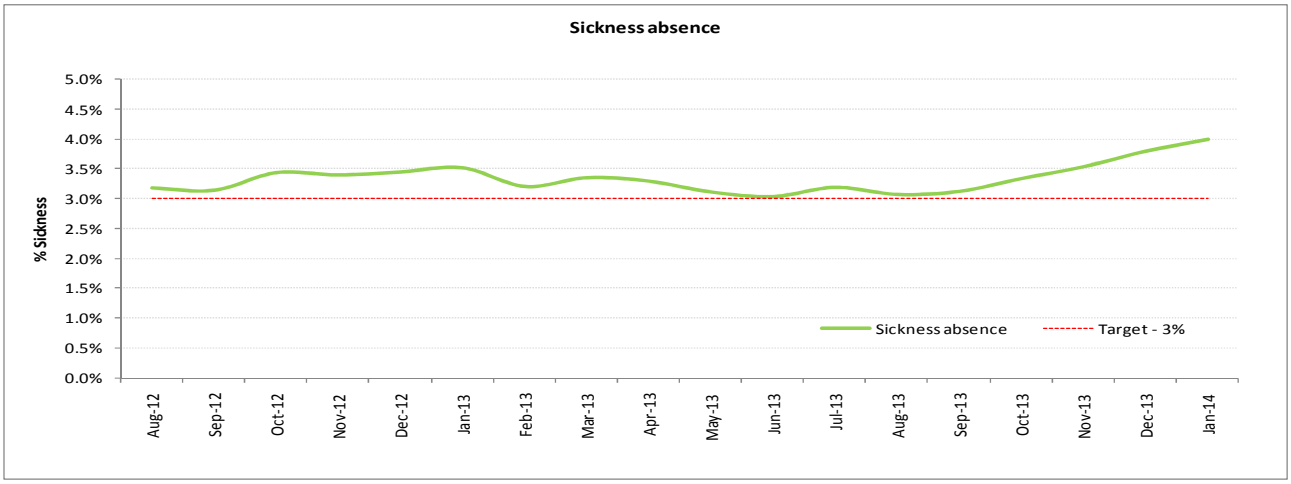
Appraisal performance and quality remains high on the CMG business agenda and a commitment to achieve 95%. HR and CMG Leads will focus on non– compliant teams.

We will be carrying out our third annual Appraisal Quality Audit in April/May and audit results will be collated and analysed for each CMG and Directorate area, and where required, actions will be identified to improve the appraisal experience and support will be given to enable this.

Work continues with IBM, IM&T & OCB Media in developing the new e-appraisal system to improve reporting functionality.

7.2 Sickness

Mth | Qtr 1 | Qtr 2 | Qtr 3 | YTD

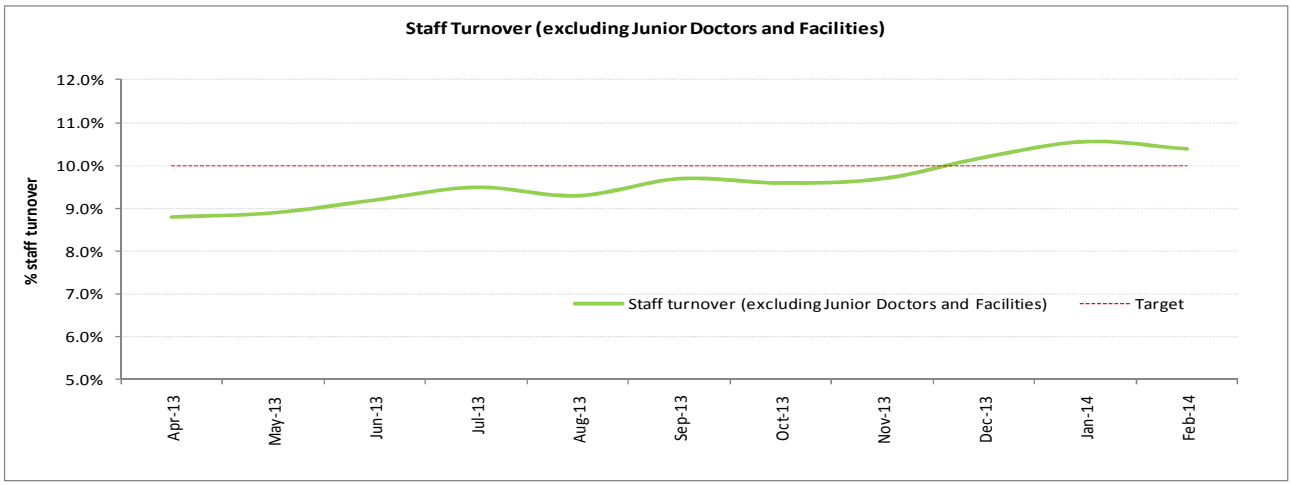


The sickness rate for January is 3.95% and the December figure has now adjusted to 3.8% to reflect closure of absences. The overall cumulative sickness figure is 3.34%. This is below the previous SHA's target of 3.4% but slightly above the Trust stretch target of 3%. The figures for February 2014 will be reported in March 2014 as advised in last month's Quality and Performance Report.

Emotional resilience workshops continue to be rolled out together with the 'Self Care at Work' programme. Revised sickness absence training programmes are being delivered to support operational and other managers with responsibility for the management of sickness absence.

7.3 Staff Turnover

Mth | Qtr 1 | Qtr 2 | Qtr 3 | YTD



The cumulative Trust turnover figure (excluding junior doctors) has decreased slightly from 10.6% to 10.4%. The latest figure includes the TUPE transfer of 27 IM &T staff to IBM on 30 November 2013 and the transfer of 65 sexual health services staff to Staffordshire and Stoke on Trent Partnership NHS Trust and therefore skews the overall turnover figures.

7.4 Statutory and Mandatory Training

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

At the end of February, we were reporting against nine core subjects in relation to Statutory and Mandatory Training. These were Fire Safety Training, Moving & Handling, Infection Prevention, Hand Hygiene, Equality & Diversity, Information Governance, Safeguarding Children, Conflict Resolution, Safeguarding Adults and Resuscitation (BLS Equivalent).

The period between January and February staff compliance against Statutory and Mandatory Training has increased from 69% to 72% across these nine core areas.

CMG / Corporate Directorates	Fire Training	Moving & Handling	Infection Prevention	Equality & Diversity	Informat'nGov er'ce	Safeguard Children	Conflict Resolution	Safeguard Adults	Resus - BLS Equivalent	Average Compliance
CHUGS	66%	67%	67%	61%	72%	74%	53%	67%	71%	66%
CSI	76%	88%	83%	80%	84%	87%	69%	78%	69%	79%
Emergency & Speciality Medicine	65%	69%	71%	63%	63%	71%	47%	55%	55%	62%
ITAPS	72%	83%	86%	78%	80%	85%	66%	79%	69%	78%
Musculoskeletal & Specialist Surgery	66%	75%	76%	72%	75%	80%	66%	71%	71%	72%
Renal, Respiratory & Cardiac	71%	74%	81%	75%	75%	81%	67%	72%	64%	73%
Womens and Childrens	74%	77%	75%	70%	71%	91%	57%	51%	74%	71%
Corporate Directorates	73%	76%	79%	76%	74%	79%	62%	67%	60%	72%
Total compliance by subject	71%	77%	77%	72%	74%	82%	61%	67%	67%	
UHL staff are this compliant with their mandatory & statutory training from the key 9 subjects										72%
Performance Against Trajectory (Set at 70% at 28th Feb 14)										2% ahead

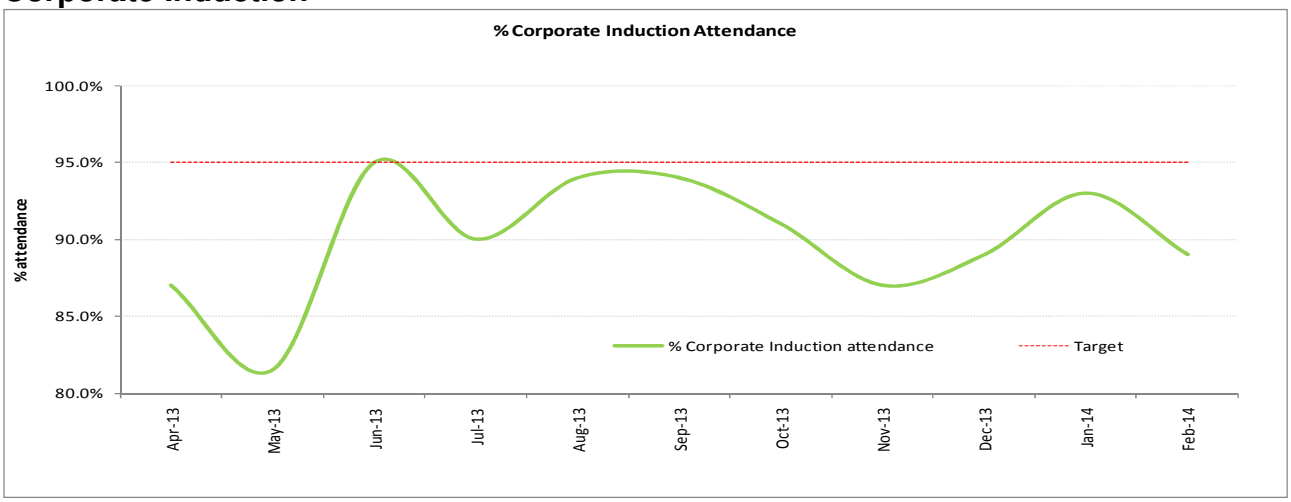
Compliance Levels below 60%
Compliance Levels 60% to 75%
Compliance Levels at or exceeding target

The Health & Safety eLearning module went live on the eUHL system in early March and sees the total number of Statutory and Mandatory subjects rise to 10. This last package is a requirement for all clinical and non- clinical staff every 3 years.

We continue to communicate progress, essential training requirements and follow up on non-compliance at an individual and team level. During April a final version of the 'UHL Statutory and Mandatory Training Guide' will be released containing the Health and Safety package details.

Work continues with IBM, IM&T & OCB Media in developing the new Learning Management System to improve reporting functionality, programme access and data accuracy.

7.5 Corporate Induction



Performance has deteriorated marginally at the end of February. The figures continue to reflect numbers booked onto Corporate Induction against actual attendance. The process for following-up non-attendees continues to be implemented at a local level in line with the Induction Policy.

The new weekly Corporate Induction Programme will be delivered from 31st March 2014. Working in collaboration with key stakeholders the internal processes have been improved and strengthened.

8 UHL - FACILITIES MANAGEMENT– RACHEL OVERFIELD

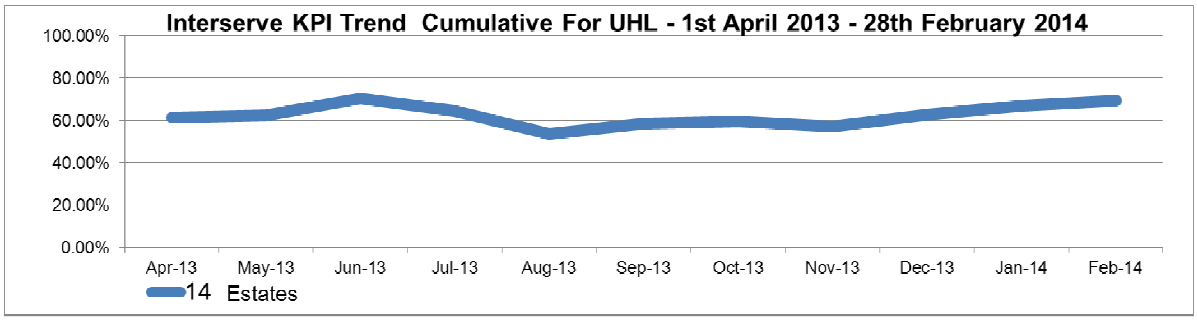
8.1 Introduction

This report covers a review of overall performance on the Facilities Management (FM) service delivery provided by Interserve FM (IFM) and contract managed by NHS Horizons for the month of February which is month 12 of the UHL contract period.The FM contract providing 14 different services to the Trust is underpinned by 83 Key Performance Indicators (KPIs) and the summary information and trend analysis below details a snapshot of 6 key Indicators over the last Twelve months.

8.2 Key Performance Indicators

KPI 14 – Estates

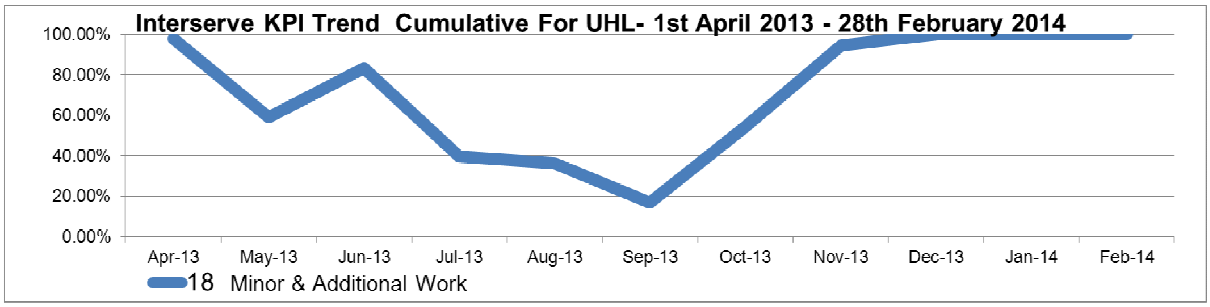
Percentage of routine requests achieving response time



KPI 14 This KPI measures the response by estates for routine requests. The trend of improving results for this KPI has been maintained for February showing some consistency. As previously reported the move to 24/7 covers over all 3 acute sites and recruitment to vacant posts appear to be having a positive impact. There are still on-going issues to be resolved with electronic working however it is anticipated that this improvement can be sustained and improved upon going forward into the second year of the contract.

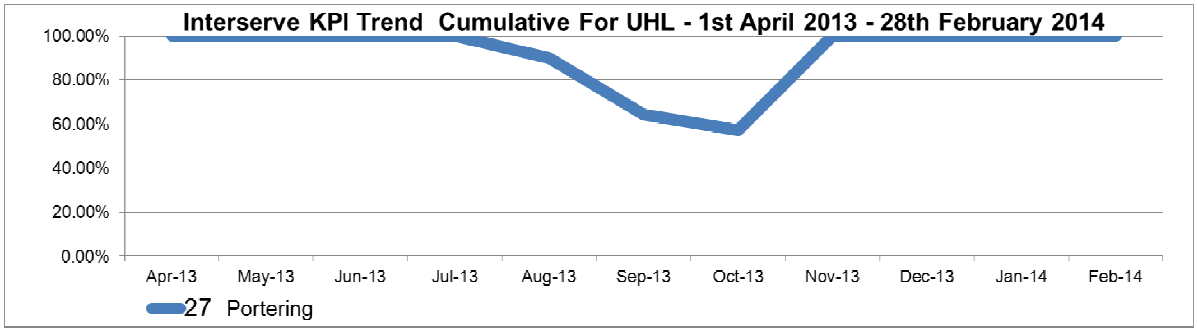
KPI 18 – Minor & Additional Work

Percentage of Minor works quoted and priced within 10 working days



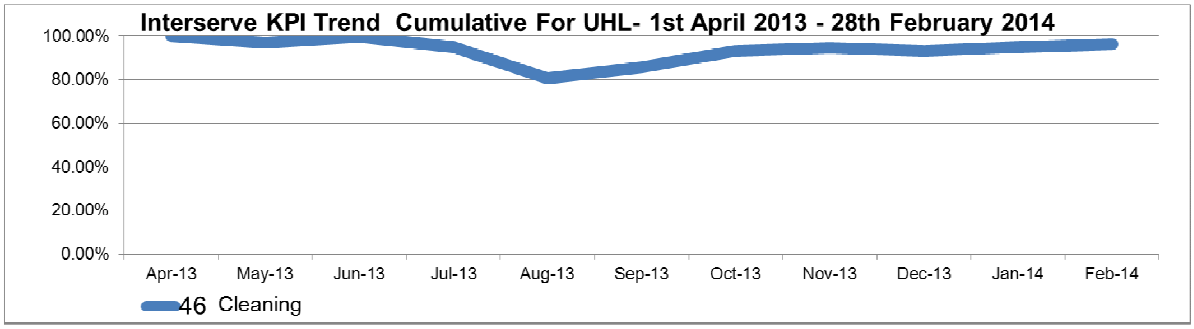
KPI 18 The evidence for February indicates that the 100% target has been maintained. There has been an improved response time since Interserve has been using Interserve Construction for quotations. The protocols for approval within UHL have continued to be complied with since they were introduced in December 2013.

KPI 27 – Portering
Percentage of emergency portering tasks achieving response time



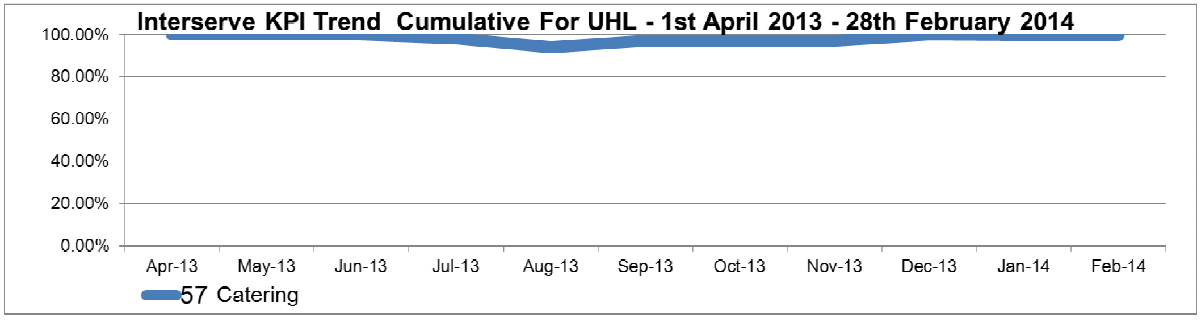
KPI 27 IFM has maintained their 100% achievement of response times for February 2014.

KPI 46 – Cleaning
Percentage of audits in clinical areas achieving National Specification for cleaning audit scores for cleaning above 90%



KPI 46 This KPI shows a slight improvement for February with a percentage average of 94.87%. There is further improvement required in several areas to ensure that standards are continuously maintained.

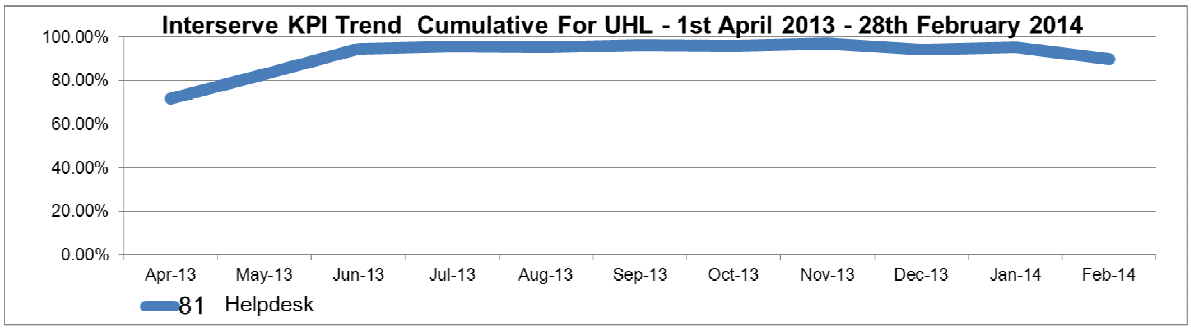
KPI 57 – Catering
Percentage of meals delivered to wards in time for the designated meal service as per agreed schedules



KPI 57 The result for this KPI in February shows a sustained improvement at 99.46% as last month. It is noted that there are far fewer complaints in relation to late meal deliveries.

KPI 81 -Helpdesk

Percentage of telephone calls to the helpdesk answered within 5 rings using a non-automated solution



KPI 81 A recorded dip in the number of calls being answered within the KPI from 95.34% in January to 89.72% this month, IFM have not recorded any particular reason for this reduction.

8.3 General Summary

The recorded performance for February, when measured against the 14 services and 83 KPI's shows a consistent levelling out of services with some small improvements in specific areas when compared to previous months. It is anticipated that the additional recruitment, specifically focussed on cleaning and estates, will sustain improvements within those services.

Electronic works and management systems are still yet to be fully established across the UHL and once these are fully operational should lead to improved performance relating to response and rectification times.

9 IM&T Service Delivery Review

9.1 IT Service Review

There were 7894 (8977 previous month) incidents logged during February, out of which 5696 (6473 previous month) were resolved. Incidents logged via X8000, email and self-service.

There were 5646 telephone calls to X8000,1344 (1589 previous month) incidents were closed on first contact

Performance against service level agreements is as expected and follows the flight path for service level agreements.

Number of official complaints relating to service has increased to 7 in month (1 in previous month).

There were 732 (812 previous month) incidents logged out of hours via the 24/7 service desk function.

9.2 Future Action

Desktop

Desktop Transformation workshops being setup

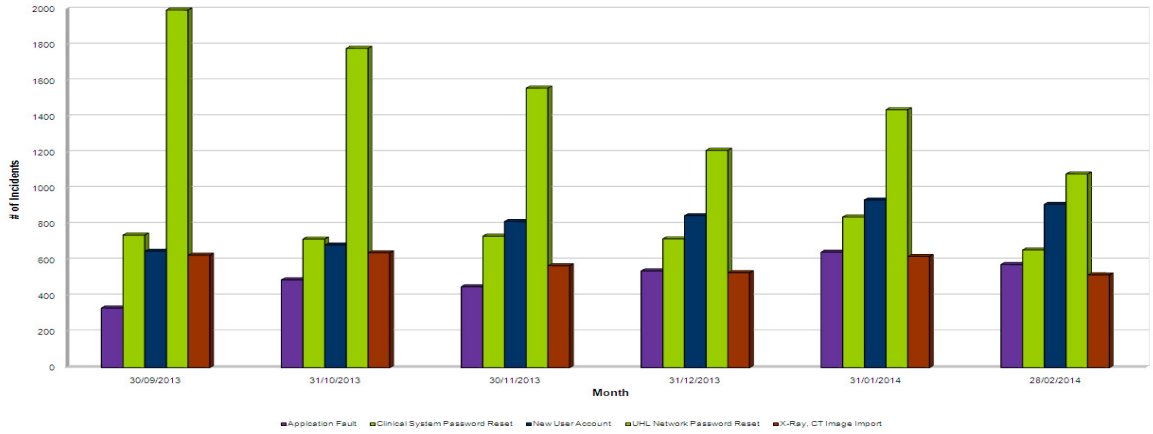
EDRM

Stakeholder update meetings ARANGED with MSK and Clinical Genetics.
Finalise benefits catalogue.
Execute user / admin training.
Project board review meeting.

Managed Print

Schedule week 4 installations and drive pre-requisite work

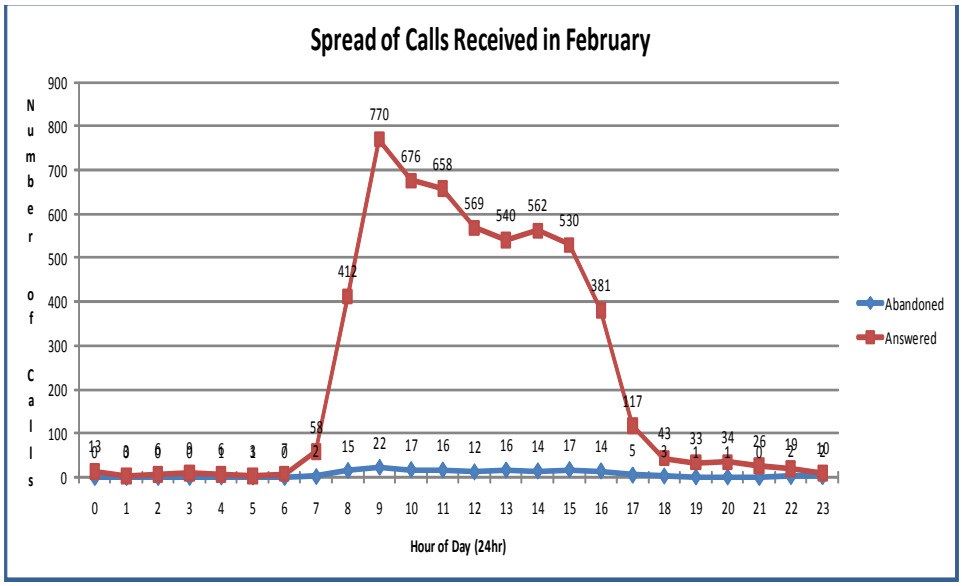
9.3 IM&T Service Desk top 5 issues



9.4 IM&T February Heatmap

Telephone	Metric	
	Total Calls Answered	5485
	Total Calls Abandoned	161
	Total Calls Received	5646
	Answered in 30secs (SLA 90%)	93.64%

NOTE	Incident Logging Route
	SD Request email - email to sdrequest@uhl-tr.nhs.uk
	SelfService Portal - LANDesk web portal for end user
	Service Desk - call to x8000
	SS/WebDesk - Resolving Analysts logged own incident



Incident Logging Route

	SD Request email		Self Service Portal		Service Desk		SS/WebDesk		Total Logged
	Logged	%	Logged	%	Logged	%	Logged	%	
February 2013	1018	20.28%	496	9.88%	2974	59.25%	531	10.58%	5019
March 2013	956	21.60%	362	8.18%	2587	58.46%	520	11.75%	4425
April 2013	1217	21.49%	506	8.94%	3300	58.28%	639	11.29%	5662
May 2013	1078	21.10%	479	9.38%	3095	60.59%	456	8.93%	5108
June 2013	1113	23.13%	733	15.24%	2580	53.63%	385	8.00%	4811
July 2013	1391	23.65%	643	10.93%	3097	52.66%	750	12.75%	5881
August 2013	1737	23.44%	385	5.19%	3788	51.11%	1501	20.25%	7411
September 2013	1609	21.86%	458	6.22%	3830	52.04%	1463	19.88%	7360
October 2013	1735	22.19%	702	8.98%	4195	53.66%	1186	15.17%	7818
November 2013	1961	25.36%	654	8.46%	4059	52.50%	1058	13.68%	7732
December 2013	2178	27.17%	685	8.55%	4350	54.27%	802	10.01%	8015
January 2014	2697	29.75%	776	8.56%	4676	51.58%	912	10.06%	9066
February 2014	2685	34.01%	598	7.58%	3944	49.96%	667	10.06%	7894

Incidents Resolved when Logged

	AD Password Reset	Contact/ Technical Query	RA Services	Total	% of Total Logged
February 2013	1317	1251	0	2568	51%
March 2013	1008	1050	0	2058	47%
April 2013	1656	1410	0	3066	54%
May 2013	1353	855	0	2208	43%
June 2013	951	777	0	1728	36%
July 2013	1788	2082	0	3870	66%
August 2013	2397	4116	0	6513	88%
September 2013	2352	3618	0	5970	81%
October 2013	2253	3090	0	5343	68%
November 2013	1956	2718	0	4674	60%
December 2013	1629	1995	0	3624	45%
January 2014	660	654	279	1593	18%
February 2014	580	501	263	1344	17%

NOTE

Incidents resolved when logged.

The following incidents have been resolved at the time of logging and **are included in the total calls logged**. The majority come into the Service Desk through the x8000 number with some being logged through Self Service or the SD request mailbox.

AD Pasword Reset - Network login password reset
Query Incident - Technical question or request for contact details
RA Services - Registration Authority/Smartcard activity (recorded from 1/1/2014)

10 FINANCE – PETER HOLLINSHEAD

10.1 Introduction

This purpose of this report is to provide the Trust Board and Finance & Performance Committee with an update on performance against the Trust's key financial duties as follows:

- Delivery against the planned surplus
- Achieving the External Financing Limit (EFL)
- Achieving the Capital Resource Limit (CRL)

The paper also provides further commentary on the year-end forecast based on the Month 11 results, key risks and the main financial statements.

10.2 Financial Duties

The following table summarises the year to date position and full year forecast against the financial duties of the Trust:

Financial Duty	YTD Plan £'Ms	YTD Actual £'Ms	Forecast Plan £'Ms	Forecast Actual £'Ms	RAG
Delivering the Planned Surplus	2.4	(38.4)	3.7	(39.8)	R
Achieving the EFL	n/a	n/a	20.7	20.0	G
Achieving the Capital Resource Limit	31.1	20.6	36.7	34.7	G

As well as the key financial duties, a subsidiary duty is to ensure suppliers invoices are paid within 30 days – the Better Payment Practice Code (BPPC). The year to date performance is shown in the table below:

Better Payment Practice Code	April - February 14	
	Number	Value £000s
Total bills paid in the year	119,986	490,704
Total bills paid within target	57,961	357,942
Percentage of bills paid within target	**48.3**	**72.9**

Key Issues

- The Trust will not deliver its Planned Surplus and as such will not meet its breakeven duty. The forecast position remains as a deficit of £39.8m.
- The Trust has formally had its EFL target reset by the Department of Health for Month 11 reporting from a negative £1.4m to £20.7m. This will result in the Trust having between £0.2m - £0.7m in the bank at 31st March 2014

10.3 The detailed financial report is a separate item on the agenda.

APPENDIX 1

Friends & Families Test

What is the Friends & Family test?

The Friends & Family score is obtained by asking patients a single question, *"How likely are you to recommend our <ward/A&E department> to friends and family if they needed similar care or treatment"*

Patients can choose from one of the following answers:

Answer	Group
Extemely	Promoter
Likely	Passive
Neither likely or	Detractor
Unlikely	Detractor
Extremel	Detractor
Don't	Excluded

Friends & Family score is calculated as : % promoters minus % detractors.
*((promoters-detractors)/(total responses-'don't know' responses))*100*

Patients to be surveyed:
- Adult Acute Inpatients (who have stayed at least one night in hospital)
- Adult patients who have attended A&E and left without being admitted to hospital or were transferred to a Medical Assesment Unit and then discharged

Exceptions:
- Daycases
- Maternity Service Users
- Outpatients
- Patients under 16 yrs old

NB. Wards with fewer than 5 survey responses per month are excluded from this information to maintain patient confidentiality

Response Rate:
It is expected that responses will be received from at least 15% of the Trusts survey group - this will increase to 20% by the end of the financial year

Current methods of collection:
- Paper survey
- Online : either via web-link or email
- Kiosks
- Hand held devices

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FRIENDS AND FAMILY TEST : September - February '14

									FEBRUARY SCORE BREAKDOWN				
			Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Total Responses	Promoters	Passives	Detractors	Score
GLENFIELD HOSPITAL	GH WD 15	F15	82	91	73	70	85	95	20	19	1	0	95
	GH WD 16 Respiratory Unit	F16	80	80	87	100	83	81	31	26	4	1	81
	GH WD 20	F20	-	59	56	79	62	56	43	28	11	4	56
	GH WD 23A	F23A	80	55	82	0	89	80	10	8	2	0	80
	GH WD 26	F26	93	87	80	94	91	90	30	27	3	0	90
	GH WD 27	F27	67	54	74	25	96	86	21	18	3	0	86
	GH WD 28	F28	76	89	80	87	68	69	26	20	4	2	69
	GH WD 29	F29	68	74	90	88	82	85	26	24	0	2	85
	GH WD 32	F32	81	74	79	84	96	84	31	26	5	0	84
	GH WD 33	F33	76	77	79	76	83	77	39	30	9	0	77
	GH WD 33A	F33A	67	80	87	95	95	95	20	19	1	0	95
	GH WD Clinical Decisions Unit	FCDU	50	44	65	28	66	58	201	127	55	13	58
	GH WD Coronary Care Unit	FCCU	91	100	89	79	94	78	49	39	9	1	78

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FRIENDS AND FAMILY TEST : September - February '14

								FEBRUARY SCORE BREAKDOWN				
		Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Total Responses	Promoters	Passives	Detractors	Score
LEICESTER GENERAL HOSPITAL	LGH WD 10	50	56	70	100	70	73	11	8	3	0	73
	LGH WD 14	61	78	46	74	88	71	31	22	9	0	71
	LGH WD 15N Nephrology	38	60	86	0	100	60	12	6	4	0	60
	LGH WD 16	50	94	70	74	83	76	29	23	5	1	76
	LGH WD 17 Transplant	88	86	79	82	78	90	31	28	3	0	90
	LGH WD 18	71	81	85	81	69	83	48	40	8	0	83
	LGH WD 18	71	81	85	81	69	83	48	40	8	0	83
	LGH WD 22	79	46	42	52	45	55	20	13	5	2	55
	LGH WD 26 SAU	46	52	60	67	71	57	54	31	18	2	57
	LGH WD 27	55	58	60	33	50	74	23	18	4	1	74
	LGH WD 28 Urology	24	51	60	68	65	50	37	20	14	2	50
	LGH WD 31	83	89	79	76	80	75	44	33	11	0	75

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FRIENDS AND FAMILY TEST : September - February '14

								FEBRUARY SCORE BREAKDOWN				
		Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Total Responses	Promoters	Passives	Detractors	Score
LEICESTER ROYAL INFIRMARY	LRI WD 19 Bal L6	59	44	63	53	41	88	25	21	3	0	88
	LRI WD 21 Bal L6	100	91	82	64	100	85	20	17	3	0	85
	LRI WD 22 Bal 6	38	63	58	42	17	52	29	17	10	2	52
	LRI WD 24 Win L3	38	25	18	28	62	36	22	12	6	4	36
	LRI WD 25 Win L3	88	73	85	80	90	95	19	18	1	0	95
	LRI WD 26 Win L3	0	69	86	71	95	100	10	10	0	0	100
	LRI WD 29 Win L4	65	75	67	75	71	79	19	15	4	0	79
	LRI WD 31 Win L5	23	72	40	65	90	75	16	12	4	0	75
	LRI WD 32 Win L5	58	54	69	64	86	62	13	10	1	2	62
	LRI WD 33 Win L5	58	81	77	81	79	66	40	27	9	2	66
	LRI WD 34 Windsor Level 5	55	55	70	68	81	71	22	16	4	1	71
	LRI WD 36 Win L6	60	57	63	95	84	60	20	12	8	0	60
	LRI WD 38 Win L6	100	82	92	86	96	93	28	25	2	0	93
	LRI WD 39 Osb L1	88	81	76	44	70	86	28	24	4	0	86
	LRI WD 40 Osb L1	71	56	61	72	63	68	19	14	4	1	68
	LRI WD 41 Osb L2	50	75	86	83	56	73	11	9	1	1	73
	LRI WD 7 Bal L3	61	75	61	59	48	53	58	33	21	3	53
	LRI WD 8 SAU Bal L3	56	14	40	44	39	56	27	17	8	2	56
	LRI WD Bone Marrow	33	25	86	100	0	77	13	10	3	0	77
	LRI WD Fielding John Vic L1	86	81	82	83	85	69	29	20	9	0	69
	LRI WD GAU Ken L1	65	53	71	0	70	48	78	43	28	6	48
	LRI WD IDU Infectious Diseases	48	67	25	73	71	53	15	9	5	1	53
	LRI WD Kinmonth Unit Bal L3	89	74	76	73	81	74	19	15	3	1	74
	LRI WD Osborne Assess Unit	88	73	76	85	56	69	13	9	4	0	69

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FRIENDS AND FAMILY TEST : September - February '14

								FEBRUARY SCORE BREAKDOWN				
		Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Total Responses	Promoters	Passives	Detractors	Score
EMERGENCY DEPARTMENT	ED - Majors	23	48	59	64	58	52	215	135	53	25	52
	ED - Minors	31	66	62	69	64	57	406	264	104	34	57
	ED - (not stated)	65	69	69	69	69	61	18	11	7	0	61
	Eye Casualty	44	50	51	69	83	64	251	175	61	15	64
	Emergency Decisions Unit	81	57	61	65	58	65	115	82	26	7	65

APPENDIX 2 - MONTHLY CLINICAL MEASURES DASHBOARD: February '14

																					NURSING METRICS											
		Budgeted Qualified %	Total vacancies %	Total vacancies (WTE)	Current appraisal Rate % (rolling 12 months)	Sickness Absence % (month in arrears)	Friends & Family score	No. of complaints	Safety Thermometer - No new harms %	Hand Hygiene %	Pressure Ulcers - Grade 2 (avoidable)	Pressure Ulcers - Grade 3 (avoidable)	Pressure Ulcers - Grade 4 (avoidable)	No. MRSA Bacteraemias (post 48 hrs)	MRSA Screening - Non elective %	MRSA Screening - Elective %	No. of C Diff cases (post 48 hrs)	No. of falls	No. of patient safety SUI's (severe)	No. Patient safety incidents (moderate)	No. Patient safety incidents (low)	No. of medication errors	Continence	Controlled Medicines	Discharge	Falls Assessment	Infection Prevention & Control	Medicine Prescribing & Administration	Nutritional Assessment	Pain Management	Patient Dignity	Patient Observations	Pressure Area Care	Resuscitation Equipment
	GREEN THRESHOLD	> = 60%	0 - 4.9%	< = 5	> = 95%	< = 3%	> = 75.0	< = 1	> = 95%	> = 90%	0	0	0	0	> = 100%	> = 100%	0	0	0	0	0	0												
	AMBER THRESHOLD	-	5 - 10 %	-	-	3.1% - 3.9%	56 - 74	2	-	-	-	-	-	-	-	-	-	1 - 3	-	1	1 - 4	-	RED: < 80 AMBER: 80 - 90 GREEN: >90										
	RED THRESHOLD	< 60%	> 10%	> 5	< 95%	> = 4%	< = 55.0	> 2	< 95%	< 90%	> = 1	> = 1	> = 1	> = 1	< 100%	< 100%	> = 1	> = 4	> = 1	> 1	> = 5	> = 1												
GLENFIELD HOSPITAL	F15	↔ 60%	↔ 7.5%	↔ 2.97	↓ 93%	↓ 4.2%	↑ 95.0	↑ 1	↑ 100%	↑ 95%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↓ 0	↓ 3	↔ 0	↔ 0	↓ 1	↓ 0	↔ 100	↔ 100	↑ 76	↓ 80	↑ 96	↓ 89	↑ 100	↓ 83	↑ 100	↔ 56	↓ 93	↔ 100
	F16	↔ 63%	↑ 12.4%	↑ 4.50	↓ 62%	↑ 5.7%	↓ 80.6	↔ 1	↓ 90%	↑ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 4	↔ 0	↑ 1	↓ 1	↔ 0	↑ 100	↔ 100	↓ 60	↓ 67	↓ 73	↓ 86	↑ 92	↑ 75	↑ 94	↑ 72	↓ 93	↔ 100
	F17	↔ 75%	↓ 3.0%	↓ 1.20	↓ 59%	↓ 1.4%	↓ 69.2	↔ 1	↓ 90%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↔ 0	↔ 0	↑ 2	↔ 0	↔ 100	↔ 100	↑ 71	↔ 100	↓ 88	↓ 89	↑ 100	↔ 78	↓ 88	↓ 28	↑ 93	↔ 100
	F17H	↔ 75%	↓ 3.0%	↓ 1.20	↓ 59%	↓ 1.4%	-	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	F20	-	-	-	-	-	↓ 55.8	↑ 3	↔ 93%	↑ 40%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↑ 1	↓ 0	↓ 0	↓ 93	↔ 100	↓ 93	↔ 100	↓ 85	↓ 97	↓ 94	↔ 100	↑ 95	↓ 94	↔ 100	↔ 100
	F23A	↔ 45%	↓ -73.3%	↓ -11.04	↓ 68%	↑ 6.1%	↓ 80.0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↓ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100	↔ 100	↓ 94	↔ 100	↓ 85	↑ 100	↑ 97	↑ 100	↑ 100	↓ 90	↑ 96	↔ 100
	F24	↑ 65%	↑ 10.4%	↑ 1.74	↑ 100%	↓ 0.0%	↓ 80.0	↑ 1	↔ 100%	↑ 97%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 1	↔ 0	↓ 0	↓ 1	↔ 0	↔ 100	↔ 100	↓ 95	↓ 87	↓ 92	↓ 78	↓ 94	↑ 100	↓ 94	↓ 67	↔ 100	↓ 0
	F26	↔ 77%	↑ 2.9%	↑ 0.88	↓ 97%	↑ 9.0%	↓ 90.0	↓ 0	↔ 100%	↑ 100%	↔ 0	↔ 0	↔ 0	↔ 0	86%	↓ 90%	↔ 0	↑ 1	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100	↔ 100	↔ 100	↔ 100	↓ 98	↔ 100	↔ 100	↔ 100	↓ 99	↔ 100	↔ 100	↔ 100
	F26H	↔ 77%	↑ 2.9%	↑ 0.88	↓ 97%	↑ 9.0%	-	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↑ 1	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	F27	↔ 62%	↓ 4.7%	↓ 1.48	↔ 100%	↓ 3.1%	↓ 85.7	↓ 0	↓ 96%	↑ 94%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 4	↔ 0	↔ 0	↓ 2	↔ 0	↓ 93	↔ 100	↑ 95	↔ 100	↓ 88	↑ 100	↑ 100	↓ 78	↑ 97	↓ 89	↔ 100	↔ 100
	F28	↔ 60%	↓ 7.6%	↓ 2.62	↑ 100%	↑ 2.1%	↑ 69.2	↔ 1	↔ 100%	↔ 94%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↓ 0	↓ 0	↓ 0	↑ 4	↓ 0	-	-	-	-	-	-	-	-	-	-	-	-
	F29	↔ 61%	↓ 8.9%	↓ 2.72	↓ 73%	↑ 6.3%	↑ 84.6	↑ 3	↓ 95%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 5	↔ 0	↑ 1	↑ 4	↓ 0	↔ 100	↔ 100	↓ 89	↓ 95	↓ 88	↔ 100	↓ 96	↔ 100	↓ 91	↓ 88	↔ 100	↔ 100
	F30	↔ 86%	↑ 2.2%	↑ 0.41	↑ 80%	↓ 0.1%	-	↔ 0	↔ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 0	↑ 1	↔ 0	↓ 0	↓ 0	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↓ 88	↔ 100	↑ 100	↑ 100	↔ 100	↔ 100	↔ 100
	F31	↔ 77%	↑ 4.6%	↑ 2.02	↑ 96%	↓ 3.1%	↔ 100.0	↔ 0	↑ 100%	↓ 64%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	↑ >= 100%	↔ 0	↑ 2	↔ 0	↔ 0	↔ 0	↓ 0	↔ 100	↔ 100	↔ 100	↔ 100	↓ 88	↓ 78	↔ 100	↔ 100	↑ 97	↓ 72	↑ 100	↔ 100
	F31H	↔ 77%	↑ 4.6%	↑ 2.02	↑ 96%	↓ 3.1%	-	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	F32	↔ 75%	↓ 22.5%	↓ 4.57	↑ 89%	↑ 7.0%	↓ 83.9	↓ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↓ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100	↔ 100	↓ 95	↑ 87	↑ 96	↓ 83	↔ 100	↓ 83	↓ 91	↑ 94	↔ 93	↔ 100
	F33	↔ 70%	↑ 5.8%	↑ 1.97	↓ 83%	↑ 5.6%	↓ 76.9	↔ 1	↓ 96%	↓ 80%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 2	↔ 0	↓ 0	↔ 2	↔ 0	↔ 100	↔ 100	↓ 82	↑ 100	↓ 91	↑ 100	↑ 100	↔ 100	↑ 93	↓ 92	↓ 90	↔ 100
	F33A	↔ 64%	↓ 4.0%	↓ 1.05	↑ 100%	↓ 8.9%	↑ 95.0	↓ 0	↑ 95%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↓ 0	↓ 4	↔ 0	↔ 0	↔ 4	↓ 0	↔ 100	↔ 100	↑ 93	↔ 100	↓ 88	↔ 100	↓ 50	↔ 100	↓ 86	↔ 100	↔ 100	↔ 100
	F34	-	-	-	-	-	-	↔ 0	↔ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	FCCU	↔ 76%	↓ 2.8%	↓ 1.47	↑ 98%	↓ 4.1%	↓ 77.6	↔ 0	↓ 80%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↓ 0	↔ 0	↔ 0	↔ 5	↑ 1	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↓ 91	↓ 94	↔ 100	↔ 100
	FCDU	↔ 63%	↑ 7.5%	↑ 7.20	↓ 91%	↓ 4.2%	↓ 58.5	↓ 1	↑ 100%	↓ 40%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 2	↔ 0	↑ 4	↑ 12	↔ 0	↔ 100	↔ 100	↓ 88	↓ 80	↑ 98	↔ 100	↓ 94	↑ 100	↑ 98	↑ 94	↓ 83	↔ 100
	FCHD	↔ 70%	↑ 5.8%	↑ 1.97	↓ 83%	↑ 5.6%	-	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	FCIC	-	-	-	-	-	-	↔ 0	-	↑ 91%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↓ 0	↔ 0	↔ 0	↔ 0	↓ 0	↓ 0	-	-	-	-	-	-	-	-	-	-	-	-
	FCID	-	-	-	↓ 85%	↓ 3.8%	-	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	FDIS	↔ 50%	↑ 9.3%	↑ 1.01	↔ 92%	↑ 0.9%	-	↓ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	FITU	↔ 92%	↑ -2.7%	↑ -3.40	↑ 100%	↓ 5.4%	↑ 95.0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↑ 5	↔ 0	↔ 100	↔ 100	↔ 100	↑ 80	↓ 93	↔ 100	↓ 97	↓ 97	↓ 91	↓ 90	↔ 100	↔ 100
	FPIC	↔ 95%	↓ 12.5%	↓ 5.71	↓ 93%	↑ 4.9%	↓ 88.9	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↓ 0	↓ 1	↑ 2	↓ 0	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↓ 94	↔ 100	↔ 100	↔ 100
	FREC	↔ 92%	↔ 12.7%	↔ 3.26	↑ 96%	↓ 5.5%	-	↔ 0	-	↑ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
LEICESTER GENERAL HOSPITAL	G10	↔ 61%	↑ 6.2%	↑ 2.39	↔ 79%	↓ 2.0%	↑ 72.7	↔ 0	↓ 95%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 2	↔ 0	↔ 0	↔ 1	↔ 0	↔ 100	↔ 100	↓ 77	↔ 100	↓ 93	↔ 100	↔ 100	↔ 100	↔ 100	↑ 97	↔ 100	↓ 0
	G14	↔ 67%	↓ -1.1%	↓ -0.26	↔ 100%	↓ 0.3%	↓ 71.0	↔ 0	↑ 100%	↓ 86%	↔ 0	↓ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↓ 4	↔ 0	↔ 0	↓ 1	↑ 1	↔ 100	↔ 100	↓ 89	↔ 96	↔ 100	↔ 100	↑ 97	↔ 97	↔ 100	↔ 93	↑ 96	↔ 100
	G15A	↔ 86%	↓ 13.3%	↓ 3.69	↓ 86%	↓ 2.8%	↑ 100.0	↔ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↓ 0	↓ 0	↑ 1	↔ 2	↔ 0	↔ 100	↔ 100	↑ 100	↓ 87	↔ 100	↓ 97	↓ 81	↓ 81	↓ 92	↓ 92	↔ 100	↔ 100
	G15N	↔ 63%	↓ 10.1%	↓ 3.22	↔ 100%	↑ 1.0%	↓ 60.0	↔ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↓ 0	↑ 2	↔ 0	↑ 1	↔ 1	↓ 0	↔ 100	↔ 100	↑ 86	↓ 90	↑ 97	↔ 100	↔ 100	↔ 100	↑ 98	↑ 96	↔ 100	↔ 100
	G16	↔ 65%	↓ 2.1%	↓ 0.47	↔ 100%	↑ 10.8%	↓ 75.9	↔ 0	↔ 100%	↓ 80%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↓ 1	↔ 0	↔ 0	↓ 0	↔ 0	↔ 100	↔ 100	↑ 89	↑ 100	↔ 100	↑ 100	↑ 100	↑ 100	↑ 100	↑ 93	↑ 100	↔ 100
	G17	↔ 70%	↓ -0.7%	↓ -0.14	↑ 95%	↓ 2.6%	↑ 90.3	↔ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	↑ >= 100%	↔ 0	↓ 0	↔ 0	↑ 1	↓ 0	↓ 0	↑ 100	↔ 100	↑ 93	↑ 100	↑ 100	↔ 100	↑ 100	↑ 92	↓ 98	↑ 100	↔ 100	↔ 100
	G18	↔ 59%	↓ 10.8%	↓ 2.89	↔ 100%	↓ 1.1%	↑ 83.3	↔ 0	↔ 100%	↑ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 2	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100	↔ 100	↔ 91	↑ 100	↔ 100	↔ 100	↔ 100	↔ 100	↓ 90	↔ 100	↔ 100	↔ 100
	G19	↔ 77%	↓ 28.2%	↓ 3.74	↔ 100%	↔ 0.0%	↑ 80.0	↓ 0	↔ 100%	↓ 83%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↓ 0	↔ 0	↔ 100	↔ 100	↔ 97	↑ 100	↓ 98	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↑ 100	↔ 100
	G2	↔ 60%	↑ 22.3%	↑ 6.19	↑ 100%	↑ 17.0%	-	↑ 2	↔ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↓ 0	↔ 0	↔ 100	↔ 100	↔ 100	↔ 96	↔ 100	↑ 100	↔ 97	↔ 80	↔ 100	↔ 100	↔ 100	↔ 100
	G20	↔ 62%	↓ 28.0%	↓ 4.72	↔ 100%	↑ 1.4%	-	↓ 1	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↑ 1	↔ 0	↔ 100	↑ 100	↑ 97	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100
	G22	↔ 62%	↑ 6.3%	↑ 1.67	↔ 95%	↑ 11.5%	↑ 55.0	↓ 0	↔ 100%	↑ 90%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↔ 0	↔ 0	↔ 1	↔ 0	↔ 100	↔ 100	↓ 63	↔ 100	↓ 98	↑ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100
	G26	↔ 66%	↑ 6.0%	↑ 1.67	↑ 85%	↓ 6.3%	↓ 56.9	↔ 1	↔ 100%	↑ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↔ 0	↔ 0	↓ 0	↓ 0	↓ 96	↔ 100	↑ 66	↔ 100	↓ 95	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↑ 100	↓ 0
	G27	↔ 61%	↔ 8.1%	↔ 1.97	↓ 93%	↑ 5.9%	↑ 73.9	↑ 2	↔ 100%	↑ 86%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 1	↔ 0	↔ 0	↑ 2	↔ 0	↓ 60	↔ 100	↓ 93	↓ 93	↓ 75	↓ 96	↑ 96	↑ 100	↔ 91	↔ 94	↓ 50	↔ 100
	G28	↔ 62%	↔ 14.8%	↔ 5.23	↓ 76%	↑ 14.2%	↓ 50.0	↑ 4	↔ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 1	↔ 0	↔ 0	↑ 6	↔ 0	↑ 100	↔ 100	↓ 80	↔ 100	↑ 100	↔ 100	↔ 100	↑ 87	↑ 91	↓ 80	↔ 100	↔ 100
	G3	↔ 60%	↔ 5.0%	↔ 1.37	↑ 96%	↓ 11.7%	-	↑ 1	↓ 88%	↔ 98%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 3	↔ 0	↔ 0	↑ 1	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	G30	↔ 76%	↓ -4.8%	↓ -5.53	↓ 95%	0.05	-	↓ 0	↔ 100%	↑ 70%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 1	↑ 2	100	100	100	-	100	100	100	100	100	100	92	100
	G31	↔ 61%	↓ 1.0%	↓ 0.30	↑ 97%	↓ 1.3%	↓ 75.0	↑ 1	↔ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↔ 0	↔ 0	↑ 3	↔ 0	↔ 100	↔ 100	↔ 100	↓ 93	↑ 100	↔ 100	↓ 94	↔ 100	↔ 100	↔ 100	↓ 97	↔ 100
	GBIU	↔ 70%	↑ -0.7%	↑ -0.16	↓ 77%	↑ 13.2%	↑ 100.0	↔ 0	↑ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↓ 0	↔ 0	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↑ 94	↔ 100	↓ 83	↔ 100	↔ 100	↔ 100	↔ 100
	GDCM	↔ 95%	↔ -1.6%	↔ -0.94	↔ 94%	↑ 7.5%	↔ 90.0	↔ 0	-	↑ 80%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↑ 1	↓ 0	↓ 0	96	100	100	60	100	100	100	100	85	100	100	100
	GSAC	↔ 68%	↔ 6.4%	↔ 1.06	↑ 100%	↑ 2.7%	↑ 62.5	↔ 0	-	↑ 93%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100	↔ 100	↓ 86	↑ 100	↔ 100	↔ 100	↔ 100	↔ 100	↑ 100	↔ 100	↔ 100	↔ 100
	GSM	↔ 100%	↔ 0.0%	↔ 0.00	↔ 100%	↔ 0.0%	-	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	GUEA	↔ 58%	↔ 16.3%	↔ 6.25	↑ 93%	↓ 2.0%	↑ 54.2	↓ 0	-	↑ 80%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	↓ 88%	↔ 0	↔ 0	↔ 0	↓ 0	↓ 0	↔ 0	↑ 100	↔ 100	↓ 89	↔ 100	↑ 100	↔ 100	↓ 58	↑ 89	↔ 91	↑ 100	↑ 96	↔ 100
	GYDU	↔ 60%	↓ 1.1%	↓ 0.21	↑ 90%	↓ 1.1%	-	↔ 0	↔ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 4	↓ 0	↔ 0	↓ 0	↔ 0	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 89	↔ 100	↔ 100	↑ 100	↔ 100

APPENDIX 2 - MONTHLY CLINICAL MEASURES DASHBOARD: February '14

																					NURSING METRICS											
		Budgeted Qualified %	Total vacancies %	Total vacancies (WTE)	Current appraisal Rate % (rolling 12 months)	Sickness Absence % (month in arrears)	Friends & Family score	No. of complaints	Safety Thermometer - No new harms %	Hand Hygiene %	Pressure Ulcers - Grade 2 (avoidable)	Pressure Ulcers - Grade 3 (avoidable)	Pressure Ulcers - Grade 4 (avoidable)	No. MRSA Bacteraemias (post 48 hrs)	MRSA Screening - Non elective %	MRSA Screening - Elective %	No. of C Diff cases (post 48 hrs)	No. of falls	No. of patient safety SUI's (severe)	No. Patient safety incidents (moderate)	No. Patient safety incidents (low)	No. of medication errors	Continence	Controlled Medicines	Discharge	Falls Assessment	Infection Prevention & Control	Medicine Prescribing & Administration	Nutritional Assessment	Pain Management	Patient Dignity	Patient Observations	Pressure Area Care	Resuscitation Equipment
	GREEN THRESHOLD	> = 60%	0 - 4.9%	< = 5	> = 95%	< = 3%	> = 75.0	< = 1	> = 95%	> = 90%	0	0	0	0	> = 100%	> = 100%	0	0	0	0	0	0											
LEICESTER ROYAL INFIRMARY	R01	97.5%	-0.12	-3.67	↑ 93%	↑ 8.0%	-	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↓ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-
	R05	↔ 60%	↓ 3.2%	↓ 1.28	↑ 65%	↓ 6.0%	-	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 1	↔ 0	↔ 0	↑ 1	↓ 0	↔ 100	↓ 50	↔ 100	-	↑ 100	↔ 100	↔ 100	↓ 86	↔ 100	↔ 100	↔ 100	↔ 100
	R06	↔ 63%	↑ 2.5%	↑ 1.06	↓ 84%	↓ 3.5%	-	↓ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↑ 2	↓ 1	↔ 100	↔ 100	↓ 55	-	↓ 95	↔ 96	↑ 100	↑ 100	↔ 100	↓ 95	↔ 100	↔ 100
	R07	↔ 58%	↓ 6.0%	↓ 2.06	↔ 100%	↑ 10.0%	↑ 52.6	↔ 0	-	↔ 100%	↔ 0	↓ 0	↔ 0	↔ 0	>= 100%	↔ >= 100%	↔ 0	↑ 2	↔ 0	↔ 0	↓ 0	↓ 1	↔ 100	↔ 100	↔ 100	↑ 100	↓ 98	↓ 90	↓ 80	↔ 100	↔ 100	↓ 97	↔ 100	↔ 100
	R10	↔ 69%	↔ 13.0%	↔ 3.58	↓ 96%	↑ 5.9%	↑ 57.1	↓ 1	↔ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 1	↔ 0	↔ 0	↑ 2	↓ 1	↔ 100	↔ 100	↑ 100	↔ 100	↔ 100	↑ 100	↑ 100	↔ 100	↑ 97	↔ 100	↔ 100	↔ 100
	R11	↔ 70%	↑ 7.1%	↑ 2.51	↑ 97%	↓ 4.2%	↑ 100.0	↓ 0	↔ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↑ 1	↓ 1	↓ 0	↔ 100	↔ 100	↑ 95	↔ 100	↔ 100	↑ 100	↓ 95	↔ 100	↑ 100	↔ 100	↔ 100	↔ 100
	R12	↔ 83%	↓ 1.3%	↓ 0.38	↔ 79%	↓ 1.5%	-	↔ 0	↓ 86%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↓ 1	↔ 1	↔ 100	↔ 100	↑ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↑ 100	↔ 100	↔ 100	↔ 100
	R12A	↔ 83%	↓ 1.3%	↓ 0.38	↔ 79%	↓ 1.5%	-	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-
	R14	↔ 70%	↔ 11.3%	↔ 3.06	↔ 97%	↓ 3.6%	↑ 85.0	↔ 0	↔ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 2	↔ 0	↔ 0	↑ 3	↔ 0	↔ 100	↔ 100	↑ 83	↑ 100	↔ 100	↑ 93	↑ 91	↔ 100	↑ 92	↔ 100	↑ 100	↔ 100
	R15	↓ 60%	↑ 11.6%	↑ 13.35	↑ 96%	↑ 1.9%	-	↑ 4	↔ 100%	-	↔ 0	↓ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 4	↑ 1	↓ 0	↑ 9	↑ 3	↓ 72	↔ 100	↔ 100	↑ 100	↑ 100	↔ 100	↓ 87	↑ 97	↑ 100	↔ 100	↔ 100	↔ 100
	R16	↓ 60%	↑ 11.6%	↑ 13.35	↑ 96%	↑ 1.9%	-	↔ 1	↑ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 4	↔ 0	↓ 0	↓ 5	↓ 2	-	-	-	-	-	-	-	-	-	-	-
	R17	↔ 57%	↑ 3.4%	↑ 1.45	↔ 100%	↓ 2.2%	↑ 50.0	↓ 0	↑ 97%	↔ 80%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	↑ >= 100%	↔ 0	↓ 4	↔ 0	↔ 0	↓ 0	↓ 1	↔ 100	↔ 100	↑ 86	↓ 76	↑ 100	↓ 97	↓ 80	↑ 100	↑ 98	↓ 83	↑ 100	↔ 100
	R18	↔ 55%	↔ 7.4%	↔ 3.14	↔ 100%	↓ 3.3%	↑ 56.7	↑ 1	↑ 97%	↓ 80%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	↓ 86%	↔ 0	↓ 2	↔ 0	↔ 3	↔ 2	↔ 1	↔ 100	↔ 100	↑ 86	↓ 96	↑ 98	↑ 100	↑ 100	↔ 87	↑ 95	↑ 97	↑ 100	↔ 100
	R19	↔ 60%	↑ 11.3%	↑ 4.78	↑ 100%	↓ 0.0%	↑ 87.5	↓ 0	↑ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↓ 0	↓ 3	↔ 0	↔ 0	↑ 6	↔ 0	↔ 100	↔ 100	↓ 71	↑ 92	↓ 88	↔ 100	↑ 83	↓ 77	↓ 85	↔ 90	↓ 92	↔ 100
	R21	↔ 61%	↑ 9.0%	↑ 3.02	↔ 97%	↓ 2.2%	↓ 85.0	↓ 0	↔ 96%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 4	↔ 0	↑ 1	↔ 4	↑ 1	↓ 84	↔ 100	↓ 89	↑ 100	↓ 88	↔ 100	↓ 83	↔ 100	↔ 100	↓ 93	↑ 80	↔ 100
	R22	↔ 63%	↑ 4.3%	↑ 1.56	↓ 86%	↓ 5.6%	↑ 51.7	↑ 3	↑ 100%	↑ 98%	↔ 0	↔ 0	↔ 0	↔ 0	-	↑ >= 100%	↔ 0	↑ 4	↔ 0	↔ 0	↑ 5	↓ 0	↔ 100	↔ 100	↑ 48	↔ 100	↓ 92	↔ 100	↔ 100	↑ 100	↓ 98	↔ 100	↔ 100	↔ 100
	R23	↔ 60%	↑ 22.8%	↑ 9.03	↑ 100%	↓ 2.3%	↑ 100.0	↔ 1	↑ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 3	↔ 0	↑ 1	↓ 0	↓ 0	↔ 96	↔ 100	↑ 100	↑ 100	↓ 98	↔ 100	↔ 100	↑ 97	↑ 100	↓ 80	↔ 100	↔ 100
	R24	↔ 60%	↑ 31.9%	↑ 12.33	↓ 68%	↑ 11.2%	↓ 36.4	↑ 1	↑ 96%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↓ 0	↓ 0	↔ 0	↔ 0	↔ 8	↔ 0	↔ 100	↓ 50	↓ 71	↓ 68	↓ 88	↔ 100	↑ 90	↓ 90	↑ 91	↓ 73	↓ 92	↓ 0
	R25	↔ 69%	↑ -3.0%	↑ -1.74	↑ 98%	↑ 7.5%	↑ 94.7	↓ 0	↑ 100%	-	↔ 0	↓ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 7	↓ 0	↓ 0	↑ 8	↑ 3	↔ 100	↔ 100	↓ 66	↓ 80	↔ 100	↔ 100	↓ 73	↓ 93	↓ 91	↔ 100	↔ 100	↓ 0
	R26	↔ 69%	↑ -3.0%	↑ -1.74	↑ 98%	↑ 7.5%	↑ 100.0	↑ 1	↔ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 5	↔ 0	↔ 0	↑ 5	↔ 0	↔ 100	↔ 100	↓ 89	↑ 92	↔ 100	↔ 100	↔ 100	↑ 90	↑ 100	↓ 93	↓ 88	↔ 100
	R27	↔ 80%	↑ 14.9%	↑ 4.27	↑ 96%	↑ 4.9%	↔ 100.0	↔ 0	↔ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↓ 0	↓ 0	↔ 0	↔ 0	↓ 0	↔ 1	↔ 100	↔ 100	↑ 75	↔ 100	↔ 100	↑ 100	↑ 96	↔ 100	↑ 97	↓ 95	↔ 100	↔ 100
	R27A	↔ 80%	↑ 14.9%	↑ 4.27	↑ 96%	↑ 4.9%	-	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-
	R28	↔ 74%	↓ 10.5%	↓ 2.73	↔ 96%	↓ 4.7%	↑ 55.0	↔ 0	↔ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↓ 0	↓ 0	↓ 2	↔ 100	↔ 100	↑ 100	↑ 100	↓ 96	↑ 96	↓ 79	↑ 92	↓ 93	↑ 93	↔ 100	↔ 100
	R29	↔ 60%	↑ 19.2%	↑ 7.07	↓ 97%	↓ 8.2%	↑ 78.9	↑ 3	↓ 97%	↑ 86%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 1	↔ 0	↓ 0	↑ 4	↓ 1	↔ 100	↔ 100	↑ 81	↔ 100	↓ 83	↔ 100	↑ 94	↑ 89	↑ 77	↑ 94	↔ 100	↔ 100
	R30	↔ 60%	↓ 13.4%	↓ 5.32	↑ 91%	↓ 6.1%	↑ 55.6	↓ 0	↓ 96%	↑ 76%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 2	↔ 0	↔ 1	↓ 0	↔ 0	↔ 100	↔ 100	↑ 74	↑ 100	↓ 77	↓ 97	↔ 100	↑ 89	↓ 97	↑ 92	↔ 100	↔ 0
	R30H	↔ 60%	↓ 13.4%	↓ 5.32	↑ 91%	↓ 6.1%	-	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↑ 6	↔ 0	-	-	-	-	-	-	-	-	-	-	-
	R31	↔ 60%	↔ 9.7%	↔ 4.10	↓ 97%	↓ 2.2%	↓ 75.0	↓ 0	↑ 100%	-	↔ 0	↓ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 6	↔ 0	↓ 0	↑ 6	↓ 0	↔ 100	↔ 100	↑ 100	↔ 100	↔ 100	↔ 100	↔ 100	↑ 100	↑ 100	↑ 93	↔ 100	↔ 100
	R32	↔ 56%	↔ 2.6%	↔ 0.99	↔ 100%	↑ 3.0%	↓ 61.5	↔ 0	↓ 96%	↑ 90%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	>= 100%	↔ 0	↓ 3	↔ 0	↔ 1	↓ 1	↓ 0	↓ 88	↔ 100	↓ 71	↔ 100	↓ 90	↓ 93	↑ 97	↓ 57	↑ 100	↑ 93	↔ 100	↔ 100
	R33	↓ 57%	↓ -1.9%	↓ -0.91	↓ 97%	↑ 7.7%	↓ 65.8	↓ 2	↔ 100%	↑ 83%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 6	↔ 0	↔ 0	↔ 6	↓ 2	↔ 100	↔ 100	↔ 100	↑ 100	↑ 100	↔ 100	↔ 100	↑ 100	↔ 100	↔ 100	↔ 100	↔ 100
	R34	↔ 60%	↓ -18.8%	↓ -6.19	↓ 97%	↓ 5.3%	↓ 71.4	↑ 2	↔ 100%	↑ 96%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 1	↔ 0	↑ 1	↓ 0	↑ 1	↑ 100	↔ 100	↓ 77	↓ 80	↔ 100	↓ 97	↓ 37	↓ 90	↓ 91	↓ 90	↓ 80	↓ 0
	R36	↔ 60%	↔ 10.1%	↔ 3.97	↓ 97%	↑ 2.7%	↓ 60.0	↔ 0	↓ 81%	↑ 94%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 9	↔ 0	↑ 1	↑ 10	↑ 1	↔ 100	↔ 100	↓ 83	↓ 60	↓ 85	↑ 100	↓ 70	↔ 100	↑ 93	↓ 70	↔ 100	↓ 0
	R37	↔ 60%	↔ 11.2%	↔ 4.12	↑ 100%	↓ 3.5%	↑ 100.0	↔ 2	↑ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 4	↓ 0	↔ 0	↑ 6	↑ 1	↔ 100	↔ 100	↓ 71	↔ 100	↓ 88	↑ 100	↓ 83	↓ 80	↓ 87	↑ 83	↔ 100	↑ 100
	R38	↔ 60%	↓ 10.9%	↓ 3.96	↓ 97%	↓ 8.4%	↓ 92.6	↓ 0	↓ 89%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 9	↔ 0	↓ 0	↑ 5	↑ 1	↔ 100	↔ 100	↓ 94	↔ 100	↔ 98	↓ 93	↔ 83	↔ 100	↑ 100	↓ 70	↔ 100	↔ 100
	R39	↔ 66%	↑ 20.1%	↑ 4.90	↑ 100%	↓ 0.0%	↑ 85.7	↔ 0	↑ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↓ 0	↓ 3	↔ 0	↔ 0	↑ 3	↔ 0	↑ 100	↔ 100	↑ 91	↔ 100	↔ 100	↔ 100	↔ 100	↑ 93	↓ 87	↔ 93	↔ 100	↓ 0
	R40	↔ 72%	↔ 3.3%	↔ 0.80	↓ 79%	↓ 0.3%	↑ 68.4	↔ 0	↑ 100%	↑ 94%	↔ 0	↑ 1	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↔ 0	↔ 0	↓ 4	↓ 0	↑ 80	↔ 100	↑ 90	↑ 100	↑ 100	↔ 100	↑ 100	↑ 97	↑ 100	↔ 83	↑ 100	↔ 100
	RACB	↓ 57%	↓ -1.9%	↓ -0.91	↓ 97%	↑ 7.7%	-	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-
	RAMB	↔ 100%	↔ 0.0%	↔ 0.00	↔ 100%	↑ 66.7%	-	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-
	RBMT	↔ 97%	↔ 2.0%	↔ 0.30	↔ 100%	↑ 2.4%	↑ 76.9	↔ 0	-	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↑ 1	↔ 0	↔ 100	↔ 100	↑ 93	↓ 96	↑ 100	↔ 100	↔ 100	↓ 97	↔ 100	↓ 87	↔ 100	↔ 100
	RCAU	↔ 69%	↓ 8.9%	↓ 2.30	↔ 100%	↓ 6.5%	↓ 47.1	↑ 2	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↓ 0	↓ 0	↔ 0	↔ 100	↔ 100	↑ 100	↔ 100	↔ 100	↑ 100	↑ 100	↔ 100	↓ 89	↔ 100	↔ 100	↔ 100
	RCIC	↔ 95%	↓ 12.5%	↓ 5.71	↓ 93%	↑ 4.9%	↔ 100.0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↓ 0	↑ 2	↓ 1	↔ 100	↔ 100	↑ 100	↔ 100	↑ 100	↔ 100	↔ 100	↔ 100	↓ 94	↔ 100	↔ 100	↔ 100
	REDU	↔ 67%	↓ 2.0%	↓ 0.57	↑ 100%	↓ 4.3%	-	↓ 1	↔ 100%	↑ 85%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 5	↔ 0	↔ 0	↓ 2	↓ 0	↓ 88	↔ 100	↔ 100	↓ 84	↑ 98	↔ 100	↓ 93	↑ 100	↑ 100	↔ 100	↔ 100	↔ 100
	REFU	-	-	-	-	-	-	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-
	RFJW	↔ 60%	↑ 15.6%	↑ 5.00	↓ 89%	↑ 2.4%	↓ 69.0	↔ 0	↑ 96%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 4	↔ 0	↔ 0	↑ 4	↑ 1	↔ 100	↔ 100	↑ 94	↔ 100	↔ 100	↑ 100	↔ 100	↓ 83	↓ 91	↑ 87	↔ 100	↔ 100
	RGAU	↔ 69%	↑ 14.5%	↑ 4.03	↓ 89%	↓ 3.4%	↓ 48.1	↑ 1	↔ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	↔ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↑ 2	↔ 0	↔ 100	↔ 100	↓ 98	↔ 100	↓ 96	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100
	RIDU	↔ 60%	↑ -1.4%	↑ -0.33	↑ 100%	↑ 10.3%	↓ 53.3	↔ 0	↑ 94%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 2	↓ 0	↓ 0	↓ 0	↓ 0	↑ 100	↔ 100	↑ 94	↔ 100	↔ 100	↓ 97	↔ 100	↑ 100	↔ 100	↑ 100	↔ 100	↓ 0
	RITU	↔ 89%	↓ -10.7%	↓ -10.82	↓ 90%	↓ 5.7%	↑ 88.2	↔ 0	↔ 100%	↓ 93%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↓ 0	↓ 0	↔ 0	↔ 0	↑ 4	↑ 2	↔ 100	↔ 100	↓ 29	↓ 43	↔ 100	↓ 43	↑ 88	↑ 100	↓ 90	↑ 100	↔ 100	↔ 100
	RKIN	↔ 65%	↓ 1.7%	↓ 0.43	↑ 100%	↑ 5.9%	↓ 73.7	↔ 0	-	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	↑ 82%	-	↓ 0	↑ 2	↔ 0	↔ 0	↑ 6	↑ 3	↓ 88	↔ 100	↑ 100	↔ 100	↔ 100	↓ 97	↓ 93	↓ 97	↔ 100	↑ 100	↔ 100	↔ 100
	RODA	↔ 72%	↑ 15.9%	↑ 5.30	↑ 96%	↓ 4.8%	-	↑ 1	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 2	↔ 0	↔ 0	↑ 4	↓ 0	-	-	-	-	-	-	-	-	-	-	-
	ROMO	↔ 62%	↔ 6.1%	↔ 1.96	↑ 97%	↓ 0.7%	-	↔ 0	-	↑ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-
	ROND	↔ 67%	↑ 11.0%	↑ 1.35	↑ 100%	↑ 0.9%	↑ 69.2	↔ 0	-	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-
	RPAC	↔ 83%	↓ 10.1%	↓ 4.14	↔ 100%	↓ 2.9%	-	↔ 0	-	↑ 97%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-
	RPSS	-	-	-	-	-	-	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-
	RSAU	↔ 56%	↑ 12.7%	↑ 5.73	↑ 81%	↓ 0.8%	↑ 55.6	↔ 0	-	↑ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↑ 3	↓ 3	↓ 0	↔ 100	↔ 100	↑ 93	↑ 100	↓ 88	↔ 100	↑ 100	↔ 100	↔ 100	↔ 86	↔ 100	↓ 0
	RSCB	↔ 90%	↑ 12.6%	↑ 11.35	↓ 85%	↓ 1.0%	-	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↓ 0	↓ 0	↓ 1	↓ 2	-	-	-	-	-	-	-	-	-	-	-

Appendix 3

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OPERATIONAL PERFORMANCE EXCEPTION REPORT

REPORT TO:	**TRUST BOARD**
DATE:	**27 March 2014**
REPORT BY:	**Richard Mitchell, Chief Operating Officer**
AUTHOR:	**Cathy Lea, Manager, Imaging**
CMG GENERAL MANAGER:	**Nigel Kee, CSI**
SUBJECT:	**Diagnostic Imaging 6 week waits**

Introduction

Imaging failed to meet the diagnostic 6 week target for February 2014 with performance exceeding 2.2% of breaches. The resultant impact on the Trust performance is that it failed the 1% threshold, with performance of 1.9% over 6 weeks.

Investigation

The breaches relate to MRI lost capacity over the Christmas period and loss of equipment (the impact of the MRI replacement programme) and equipment breakdown during January.

Imaging sourced an MRI van for February (and March) to deliver the remedial additional activity required and has reached the agreed trajectory for February. Performance at the end of March was forecasted to deliver <1% however a significant increased referral rate for February has put March's delivery at risk.

Conclusion and Resolution

In December 2013, Imaging had diagnostic breaches in MRI totalling 1.6%. This was above the required threshold due to a number of factors but predominately the effects of the equipment replacement programme.

In January the target was breached by 6%. This was again due to the replacement programme but the increase also contributed to by equipment breakdowns and the inability to secure additional external activity to resolve the demand / capacity gap. A mobile MRI van was sourced in February and March to deliver the remedial additional activity.

In February Performance against the target is 2.28% which is an improvement on the 2.6% trajectory.

Increased demand in February has impacted on performance for March. We are therefore forecasting a <2% breach for March with performance forecast to be back within target (1%) by April 2014. This will remain a challenge as any loss of service could impact on delivery given our lack of spare capacity in MRI.
Cardiac MRI has been identified as a potential risk, the clinical Team are engaged in developing a plan to maintain the 6 week position for April.

Details of senior responsible officer

CMG SRO: Nigel Kee

Appendix A The University Hospitals of Leicester NHS Trust

	Issue	Priority 1= High	Actions	Responsible Officer(s)	Due Date	Evidence	New or pre-existing action	Status	RAG
1	**Lack of theatre time / List over run**	3	a) Establish a project team to look at reasons for late starts - develop an action plan in response to findings	GH	15.3.14	Meeting notes/ plan	New	cancelled ops operat ional group has met twice , in Feb and March. Meeting now every 2 weeks	5
		3	b) Review of frequent overrun commenced and will be rolled out through weekly activity reviews	DT	16.2.14	Reduction in overuns	Refreshed	Complex agenda – resolution relies on many other things Changed reporting to increase awareness. Process is embedding. Regular/frequent overuns reviewed through theatre activity with team leaders and service managers	5
		3	c) Monitoring of any late starts and agreed escalation in place (transformational)	MT	16.2.14 ongoing	Reduction in late starts	Refreshed	Monitoring in place, theatre KPIs	5
		2	d) Speciality Confirm and challenge with each speciality to manage late starts – these will involve all specialities on a monthly basis. (transformational)	MH	30.11.13	Reduction in late starts	New	Already started – these are ongoing and are repeated every 6 weeks approx	5
		1	e) Weekly reporting of activity	AM	23.11.13	Weekly reports	New	completed , reports go to each speciality	5
		2	f) Internal theatre escalation to authorise a cancellation on the day , see also Cancelled operations policy and escallation process	MH	23.11.13	Reduced cancelled ops	New	in place but reinforcing process. Further work started to ensure this is embedded with all junior staff, G Harris leading on	5
		1	g) Develop a robust escalation process to prevent on the day cancellations – Trust wide	MH / PW/CC	31.1.14	Reduced cancelled ops	New	Re instate , re enforce cancellation policy	5
		1	H) Operationalise and embed cancelled operations Trust wide policy	GH/ PW/CC	31.3.14 and ongoing	Reduced cancelled ops	New	Policy re issued to Trust , MH to present at Cross CMG meeting. Further work started to ensure this is embedded with all junior staff, G Harris leading on	4
		1	I) Develop a team leader score card to performance manage system to hold teams to account(transformational)	DT	25.1.14	Reduced cancelled ops	New	Draft in discussion. Test 25 Feb 14. go live 1 March 14. see 1c	5
2	**Patient delayed due to admission of a higher priority patient**	3	a) Review of emergency list policy to ensure it supports effective running of the session b) Review the advantages of combining of all emergency lists as a means to improve access(transformational) c) Review the advantages of combining of all emergency lists as a means to improve access(transformational)	DT/MH/PR	15.12.13	Improved access to emergency lists	Pre-existing	Review of emergency sessions on Monday and Friday to prevent backlog of emergencies building up – discussions with specialities with regards to loading these lists pre weekend. In Jan 1 additional list per week converterd to emergency. Completed 5 additional sessions per week embedded. Full compliance achieved.	5

3	**Lack of Theatre equipment**	3	a) Issues escalated to Synergy and equipment lead	EF	On-going	Issues raised	Pre-existing	Good performance from synergy. UHL performance included in Team Leader scorecard	5
		3	b) pre-plan to ensure equipment available – to ensure all lists are loaded onto ORMIS >2 weeks -	DT/KD	13-Jan	Pre booking monitored weekly	New	Progress been made - Score card being developed to monitor performance (see 1j). Escalation of ORMIS performance undertaken through weekly activity meetings	5
		3	c) 48hour requests for equipment so synergy can manage expectations	KD	13.1.13 and ongoing	Issues raised	New	Cessation of fast track without Matron authorisation	5
		3	d) Evaluate upgrade of Ormis	MH	14.2.14	na	New	Meeting with Ormis planned mid Feb. Initial meeting held , but full review not yet taken place , due by mid April	4
			e) Take forward actions from evaluation of Ormis upgrade options	MH/LW	TBC	TBC	New	Laura Wilcox leading review of theatre systems, awaiting d) above	1
4	**Lack of Anaesthetic staff/Lack of theatre staff (non-medical)**	1	a) New scheduling system (CLW) to be rolled out which will enable increased visability of Clinical Pa's	DT	28.11.13	na	New	CLW rolled out better transparency of where PAs are being allocated - completed	5
		3	b) Incremental move to six week planning of capacity: - 2weeks -3 weeks -4 weeks -5 weeks -6 weeks	MT	 14.1.13 31.3.14 31.5.14 31.7.14 31.9.14	weekly theatre meetings	New	Currently at 2 weeks , feb 14. Actual booking of patients more than 3 weeks ahead under review due to knock on impact to 28 day day rebooking ie no capacity to book 28 day rebooks into.	4
		2	c) Review waiting list payments	PS	ongoing	Finance reports	New	Daily monitoring of WLI. Job paln review in progress. WL payments in line with corporate workforce plan developed	4
		3	d) Matrons to undertake Floor Control to release Band 7 to clinical team if possible	Matrons/Floor Control	On-going	na	New	Floor walker daily update complete	5
		2	e) Cancel any non-critical management duties.	Matrons/Floor Control	On-going	na	New	Daily review	5
		1	f) Active recruitment program nationally for theatre staff -advert date -interview dates -appointment dates	JH	On-going	numbers appointed	New	Recruitment underway and progressing well - international recruitment - some are starting in Feb and some March - we have had Jan starters - we are going after more international recruits and GB adverts - not sure date for next set of interviews - possibly May/June. Recruitment applies to the now position and does not include future developments as we are not sure of the inpact as yet	4
		1	g) Retention review – to encourage staff to stay, plan to reduce turnover to below national average which is 6%	JH	13.1.13 and ongoing	% turnover	New	Working with HR to establish recruitment and retention strategy. Current turnover = 7.5%	5

5	**Ward bed unavailable**	1	a) Review of urology day-case to transfer where possible patients to an OPD with procedure out of Daycase	CMG team	November	na	New	Discussions undertaken and action being taken to transfer cases to OPD with procedure	5
		2	b) Review number of day case beds	MH	16.12.13	na	New	Ongoing , linked to 23 hr unit -	5
		1	c) Review the ability to establish a 23 hour facility at: the LGH site in March 2014 - LRI for specialist surgery , date TBC	MH / LG	31.12.13 31.3.14 TBC	opening of 23 hr facility, reduced cancellations	New	23hr – general surgery facility aimed to be open march 14 awaiting confirmation of specialist surgery	4
		1	d) Confirm arrangements for outsourcing to IS , elective surgery	CC	31.12.13	IS waiting list report	New	Cases being transferred – further work underway to increase numbers. ENT . Ophthalmology. Orthopaedics. General surgery	5
		2	e) Previous day, review of capacity to allow earlier cancellations	PW/GH	16.12.13	Reduced cancelled on day	New	Embedding practice via daily bed meetings	5
		2	f) Data accuracy to ensure reasons are correct	MT	30.11.13	na	New	daily report to floor coordinators of any incomplete data	5
		1	g) Clinical lead for day surgery	PS	31.1.14	na	New	Advertised role, appointed to post for each site but no identified overall lead as yet. Clinical Director has stood down , re appointment awaited	2
		1	h) Develop a robust escalation process to prevent on the day cancellations – corporate	MH / PW	31.1.14	Reduced cancelled on day	New	Re instate , re enforce cancellation policy , as 1F above	5
			i) Cross CMG weekly planing meeting to assess capacity based on emergency flows	GH	1.4.14	Reduced cancelled on day	New	Capacity meeting to be operationalised when admission destination is confirmed	1
			j) Identify admission destination and intended management at POA	GH	1.4.14	Reduced cancelled on day	New	Meetings set up with operational teams within service. Pre admission to identify and capture intended admission location to better manage day case facility daily. A Rasterick / G Harris leading on	4
			k) Develop predicting modelling tool to determine likely empty beds on daily basis , taking into accound EDD (estimated discharge dates) to plan admission numbers	MH / PW /CC	30.4.14	Reduced cancelled on day	New	Initial scoping of what this tool will aim to do is underway via the operationsl group , CCarr leading on	1
			L) maximise day ward access at LRI , in line with BADS guidance and patient population	GH / Speck	1.4.14	Reduced cancelled on day	New	See J above	1
			M) Conversion of LRI day case unit into 23 hr facility to enable overnight stays for complex patients	S Taylor	30.6.14	Reduced cancelled on day	New	Agreement to go out to advert for additional nursing staff for overnight care Mid march 2014	4
6	**Lack of surgeon**	1	a) Aligning job plans with theatre sessions (transformational)	CMG team	~~13.2.14~~	reduced cancellations duelack to surgeon	New	Work underway. Workforce plan completed and job plan review in progress. This is ongoing	5
		2	b) Review surgeon availability for emergency lists (transformational) see section 2	CMG team	13.2.14 ongoing	reduced cancellations duelack to surgeon	New	Completed - 5 additional sessions	5

7	**HDU / critical care bed unavailable**	1	a) Flexible staffing across all three sites	JH	Dec-13	reduced cancellations in this category	completed	Flexible staffing established	5
		1	b) Service requirements for CC beds to be reviewed on the Thursday capacity meeting	MT	Nov-13	reduced cancellations in this category	New	Being included as part of the agenda – need to embed process to 6-4-2 - completed	5
		2	c) Electronic planner reflecting elective demand	PV	Nov-13	reduced cancellations in this category	New	In place - completed	5
		1	d) PACU on LRI site to be completed in 2014 increasing capacity	KD	Sep-14	reduced cancellations in this category	New	On track with project plan	4
		1	e) Daily review of level one beds in CC to prioritise their moves	PW / DM	Nov-13	reduced cancellations in this category	on-going	In place	5
		2	f) Improvement in access to timely high risk anaeshetic assessment to ensure appropriate booking of HDU beds	Speck / GH	1.3.14	reduced cancellations in this category	New	Currently reviewing existing service. Update required	3
8	**Cancellation and Re booking within 28 days (max) of cancellation**	1	a) Institute new Trust standard of requirement to contact patient within 48 hrs of cancellation and rebook TCI date within 21 days, and associated escallation process	CC / SP	31.1.14	Patients booked within 21 days	New	Cancelled ops flow chart revised, includes local standard and process to rebook within 21 days. During February this started , early indications positive	5
		1	b) daily cancelled operations patient level report to be e mailed via automated route to service and operational managers , highlighting 21 day re book date	CC/ SL	31.1.14 and ongoing	Patients booked within 21 days	New	process now live	5
		1	c) Weekly monitoring of performance against Trust 21 day / national 28 day standard, capturing of reasons for failure against the standard	CC / SP	31.1.14 and ongoing	Patients booked within 21 days	New	process now live	5
9	**Monitoring arrangements**	1	a) Implement CMG level reporting of reasons for breaching of 28 day standard -	MH / CC	15.3.14	Patient level report	New	1st reports will be on Feb data, by mid March	5
		1	b) Root case analysis by speciality of previous months breaches of 28 day standard - monthly report to CPM	MH / CC	15.3.14	Patient level report	New	1st reports will be on Feb data, by mid March	5
		1	c) Agree reporting and performance monitoring arrangements with Commissioners for (d) and e below	MH / CC	28.2.14	na	New	Agree at meeting with Commissioners 10 February 2014. Requirement will be for reporting at specialty level for both indicators. However breach consequences will only be applied at Trust level.	5
		1	d) Agree trajectory for recovery of 28 day standard (of less than or = to no more than 3 breaches per quarter).	MH / CC	31.1.14		New	Absolute numbers required at Trust level to enable a fixed proportionate penalty to be applied against monthly milestones with agreed tolerance levels	5
		1	e) Agree trajectory for recovery of cancelled ops on the day standard.	MH / CC	31.1.14		New	Absolute numbers required at Trust level to enable a fixed proportionate penalty to be applied against monthly milestones with agreed tolerance levels	5