

Trust Board Paper V

	TRUST BOARD									
From:	Suzanne Hinchliffe Jeremy Tozer Andrew Seddon Kate Bradley									
Date:	20th December 2012									
CQC regulation	All									
Title:	Quality & Performance Report									
Author/Responsible Director:	S. Hinchliffe, Deputy Chief Executive /Chief Nurse J Tozer, Interim Director of Operations A. Seddon, Director of Finance K. Bradley, HR Director									
Purpose of the Report:	To provide members with an overview of UHL financial position, performance and quality against national, regional and local indicators for the month of November 2012.									
The Report is provided to the Board for:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">Decision</td> <td style="width: 5%;"></td> <td style="width: 50%; padding: 5px;">Discussion</td> <td style="width: 5%; text-align: center;">√</td> </tr> <tr> <td style="padding: 5px;">Assurance</td> <td style="text-align: center;">√</td> <td style="padding: 5px;">Endorsement</td> <td></td> </tr> </table>		Decision		Discussion	√	Assurance	√	Endorsement	
Decision		Discussion	√							
Assurance	√	Endorsement								
Summary / Key Points:	<p><u>Patient Safety, Quality and Patient Experience</u></p> <ul style="list-style-type: none"> ❖ Mortality rate - UHL's crude in-hospital mortality rate continues to be 1.4% for 12/13. ❖ HSMR - The trust's risk adjusted mortality rates are 'within expected' for both the 'HSMR' and elective and non-elective Relative Risk. ❖ 5 Critical Safety Actions - This month has continued to see improvements against the 5 Critical Safety Actions. Early Warning Score (EWS) incidents are lower than at this point last year and no EWS SUIs were reported within the Trust in November ❖ Fracture Neck of Femur theatre time - October performance for time to surgery within 36 hours for fractured neck of femur patients is 80.3%, with initial performance for November at 76.3%. The year to date position is 74.5% against a target of 70%. ❖ VTE - UHL's performance for November as reported to the DoH, is 95.3%, this figure includes the 'Renal Dialysis' patients. Without the dialysis patients, performance is still above the CQUIN threshold, when including other cohort patients – 92.4%. ❖ CQC (LRI) - The Care Quality Commission (CQC) revisited the LRI on the 5th November 2012. They reviewed medicines management, support for staff and monitoring quality and found that we were compliant. ❖ CQC (GGH) - The CQC conducted an unannounced visit of the Glenfield General Hospital on the 22nd November reviewing medicines arrangement, support of staff and the management of complaints and found that we were compliant. ❖ CQC (LGH) - The CQC conducted an unannounced scheduled inspection at the Leicester General Hospital on the 5th December reviewing medicines management, support of staff and complaints and found that we were compliant. ❖ MRSA – There are no MRSA cases reported for November. The target for 2012/13 is 6 cases. ❖ C Difficile – November reported below trajectory with 4 cases resulting in a cumulative position of 59 against a target of 72 for April to November. ❖ Patient Experience - Net Promoter a >10% inpatient coverage and an overall trust score of 57.2. ❖ Safety Thermometer - The percentage of harm free care in UHL remains at 94% which 									

continues to be above the national percentage, which for November was 92.6%.

- ❖ Falls - The number of inpatient falls has risen from last month in the Acute Division. Each ward is being monitored following allocation of reduction trajectories.
- ❖ Pressure Ulcers - Based on monthly incidence data, it is confirmed that for November the number of avoidable grade 3 / 4 ulcers has reduced from 11 in October to 8 in November.
- ❖ All UHL wards and intensivists areas continue to offer Same Sex Accommodation (SSA) in line with the UHL SSA Matrix guidance and delivered 100% in November.

Operational Performance

- ❖ ED - Performance for November Type 1 & 2 is 90.0% and 92.0% including the Urgent Care Centre (UCC).
- ❖ RTT - Admitted performance in November has been achieved with performance at 91.7%, with all specialties with the exception of Orthopaedics delivering above the 90% target as expected. The non-admitted target has been achieved at 96.6% with all specialties delivering against a target of 95%.
- ❖ Imaging Waits - Diagnostic waiting times over 6 weeks is 0.6% and below the 1% threshold.
- ❖ Cancer - All of the cancer targets are delivering against performance thresholds for October (one month in arrears reporting).
- ❖ Choose and Book - For Qtr 3 (to date, i.e. October and November) UHL achieved 12% cumulatively, which is likely to miss the 8% trajectory set by commissioners. Performance during Qtr 4 onwards needs to be at less than 4%.
- ❖ Primary PCI within 150 minutes of calling professional help in November was 92.0% against a target of 75%.
- ❖ Cancelled Operations – November performance shows that the percentage of operations cancelled on/after the day of admissions of all elective activity for non clinical reasons was 1.6% against a target of 0.8%.
- ❖ Stroke % stay on stroke ward - The percentage of patients spending 90% of their stay on a stroke ward in October (reported one month in arrears) is 83.7% against a target of 80%. The cumulative performance for the year to date is 80.7%.
- ❖ Readmissions - The Interim Director of Operations will implement a Readmissions Project Board in January 2013 and discussions have commenced with commissioners (via the Emergency Care Network) with regards to how the £5.2m penalty applied against avoidable readmissions is spent.
- ❖ Appraisals – The appraisal rate is 91.2%.
- ❖ Sickness - The reported sickness rate November is 4.1%. The

Financial Position

- ❖ The Trust is reporting a cumulative £7.1m deficit for the first 8 months, £8.4m adverse to Plan.
- ❖ Year to date NHS patient care income is £7.2m (1.6%) favourable to Plan.
- ❖ Operating expenditure for the year to date is £16.9m (3.7%) adverse to Plan, comprising of pay at £7.5m (2.6%) adverse and non-pay £9.4m (5.9%) adverse.

Recommendations: Members to note and receive the report

Strategic Risk Register

Performance KPIs year to date ALE/CQC

Resource Implications (eg Financial, HR) N/A

Assurance Implications Underachieved targets will impact on the Provider Management Regime and the FT application

Patient and Public Involvement (PPI) Implications Underachievement of targets potentially has a negative impact on patient experience and Trust reputation

Equality Impact N/A

Information exempt from Disclosure N/A

Requirement for further review? Monthly review

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: TRUST BOARD

DATE: 20th DECEMBER 2012

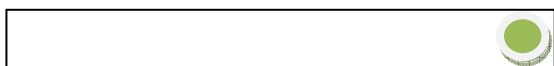
REPORT BY: SUZANNE HINCHLIFFE, DEPUTY CHIEF EXECUTIVE/CHIEF NURSE
JEREMY TOZER, INTERIM DIRECTOR OF OPERATIONS
KATE BRADLEY, DIRECTOR OF HUMAN RESOURCES
ANDREW SEDDON, DIRECTOR OF FINANCE

SUBJECT: NOVEMBER 2012 QUALITY & PERFORMANCE SUMMARY REPORT

1.0 INTRODUCTION

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

2.0 QUALITY AND PATIENT SAFETY – SUZANNE HINCHLIFFE



2.1 Mortality Rates

UHL's crude in-hospital mortality rate continues to be 1.4% for 12/13. The trust's risk adjusted mortality rates are 'within expected' for both the 'HSMR' and elective and non-elective Relative Risk.

UHL's SHMI for 11/12 was 105 and remains 'within expected'. Following discussion with Public Health, an interface audit is planned for Spring 2013, subject to agreement from Primary Care colleagues. The audit will review care provided both within UHL and prior to admission/post discharge (where patients die post discharge from UHL).

In the meantime, an internal review is being carried out of deaths that occurred during November, in order to further inform the Quality Ambition 'reducing mortality' work stream.

At the recent Mortality Workshop, two priorities were identified:

- ❖ improving the pathway for patients admitted with pneumonia due to this diagnosis being the largest group within both the 'in' and 'out' of hospital deaths
- ❖ 'weekend and out of hours' mortality - as with other trusts, the mortality rates for patients admitted at weekends appears to be different to that of those admitted during the week

Further review of the 'perinatal mortality' data as reported by Dr Fosters has identified a discrepancy in both figures for both activity and deaths which appears to have artificially increased the mortality rate. In addition there is a difference in the ratio of patients within the diagnostic groups compared with similar trusts. Both of these issues are being reviewed with Dr Fosters. In the meantime, the case notes for all reported perinatal deaths in 2012/13 are being reviewed to confirm diagnosis and cause of death against coding.

2.2 5 Critical Safety Actions and Patient Safety



This month has continued to see improvements against the 5 Critical Safety Actions. Early Warning Score (EWS) incidents are lower than at this point last year and no EWS SUIs were reported within the Trust in November. Health Care Assistant assessments for clinical observations have again increased to almost 34% for acute and 59% planned care, and 74% for the women's and children's division. This is still behind target in acute and planned care divisions as should be 100% completed by end of Q3, but will be achieved by women's and children's division by the agreed deadline.

The UHL Shift Handover Guidelines and Screening policy are being resubmitted to PGC in December for approval following minor amendments.

CQUIN funding of 100% for the 5 CSAs has now been confirmed by the CCGs as achieved for Q2.

November saw a further increase in staffing level incidents reported with staff in ED, AMUs, acute medical wards and the labour wards continuing to raise concerns re activity, capacity and staffing levels.

Complaints

Complaints activity has increased in October and November within the Trust but during November there was some improvement in the number of re-opened complaints received. Pleasingly, the number of formal complaints received relating to attitude of staff dropped to its lowest level for over 13 months.

The table below shows the numbers and top themes of formal complaints received, by month, in 2012.

Formal Complaints Jan - Nov 2012 by Subject of Complaint

	2012 01	2012 02	2012 03	2012 04	2012 05	2012 06	2012 07	2012 08	2012 09	2012 10	2012 11	Total
Medical Care	35	25	37	30	33	32	29	34	22	29	44	350
Waiting times	25	26	34	30	23	20	19	14	17	14	16	238
Communication	10	17	20	15	22	19	17	22	13	6	15	176
Staff attitude	12	12	12	16	9	19	16	10	14	13	13	146
Nursing care	20	9	20	8	19	10	13	18	7	11	11	146
Cancellations	6	16	15	10	11	8	9	3	3	6	7	94
Discharge	8	9	7	5	6	6	6	11	7	3	6	74
Information	6	2	1	1	4	4	2	2	2	0	1	25
Complications	0	0	4	0	2	3	1	1	1	5	3	20
Medication	4	3	0	1	1	1	0	4	1	1	2	18
Administration	0	0	3	2	1	2	1	1	1	0	5	16
Beds	0	3	4	0	1	0	2	3	0	2	0	15
Car parking	3	1	3	0	3	0	1	1	0	2	0	14
Confidentiality	1	0	1	1	6	0	0	1	0	3	1	14
Dignity/Privacy	0	1	1	1	2	0	1	2	2	1	2	13
Medical Records	0	1	0	0	1	0	2	1	4	1	0	10
Security	1	1	0	2	0	3	3	0	0	0	0	10
Consent	0	1	0	0	2	1	2	2	1	0	0	9
Environment	0	0	3	2	0	1	1	1	0	0	0	8
Hotel Services	2	1	1	0	0	1	2	1	0	0	0	8
Clinical Care (Other Staff)	0	1	0	0	0	1	1	1	0	1	0	5
Funding	2	0	0	0	0	1	0	0	0	1	0	4
Infection Control	1	0	0	0	0	0	0	1	0	0	1	3
Telephones	0	0	0	0	0	1	0	0	0	2	0	3
Access	0	1	0	0	0	0	0	1	0	0	0	2
Equality and Diversity	0	0	0	0	0	1	0	1	0	0	0	2
Safeguarding issues	0	0	1	0	1	0	0	0	0	0	0	2
Policies	1	0	0	0	0	0	0	0	0	0	0	1
Transport	0	0	0	0	0	0	0	0	1	0	0	1
Totals:	137	130	167	124	147	134	128	136	96	101	127	1427

Patient Safety Training

Information and training sessions continue within the Trust and November saw bespoke sessions undertaken for groups of clinical staff on root cause analysis investigations and NHS complaint regulations. Further training is planned in the New Year on Never Events, Duty of Candour and learning from claims and inquests.

Never Events

No Never Events were reported within UHL in November 2012.

5 Critical Safety Actions

1. **Improving Clinical Handover.**

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

Actions:-

- ❖ Medical Handover - UHL Shift Handover Guidelines sent to November PGC not approved and have been revised by the author and resubmitted to December meeting.
- ❖ Development work by IT on UHL web based handover system is now complete. Meeting set for January 2013 to agree go live date for this.

- ❖ Further work with alternative handover system supplier to develop module has progressed. Initial version of E-Handover module to be reviewed, discussed and plans agreed for pilot sites in trust on 21st December 2012.

2. Relentless attention to Early Warning Score triggers and actions

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

Actions:-

- ❖ HCA competency programme being rolled out with support from divisional nursing and education leads. Aim to achieve 100% end of Q3. Figures for % HCA's assessed competent for each division up to the 30th November 2012 reported from e-UHL are: Acute - 34%, Planned - 59%, Women's and Children's - 73%.
- ❖ Outreach lead to continue drive with acute and planned care divisions to improve progress. This is behind target in acute and planned care divisions but will be achieved by the end of Q4. Will be achieved by women's and children's on target by end of Q3.

3. Implement and Embed Mortality and Morbidity standard

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

Actions:-

- ❖ 100% of specialities have confirmed that M&M meetings are taking place. Increasing number - 38% of specialities have saved Terms of Reference to shared drive.
- ❖ Specialities have commenced saving minutes onto shared drive. Increasing number - 47% have minutes saved and 56% have either Terms of Reference or minutes saved to the shared drive.
- ❖ Increased focus to chase up specialities to increase progress on saved minutes and terms of reference.

4. Acting upon Results

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

Actions

- ❖ Overarching Screening Policy sent to November PGC not approved, revised by author and resubmitted to December meeting.
- ❖ Finalising draft of Diagnostic Testing overarching policy to include medical staff and AHP that undertake diagnostic testing.
- ❖ Agreement that Acting on Results process for inpatients and outpatients will be documented as a Job Planning exercise for consultants against agreed CBU/Speciality process and this will be written into the Diagnostic Testing Policy.

5. Senior Clinical Review, Ward Rounds and Notation

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

Actions

- ❖ Further work being undertaken in general surgery to pilot ward round standards in the form of ward round sticker. Audit results currently being collated.
- ❖ Leads identified excellent practice with ward round checklist in UCLH, London. Plan to visit UCLH in early December to observe its use in clinical areas and identify if would be appropriate to use similar in UHL.
- ❖ Final draft of ward round template sheet as documentation for trial in medicine submitted for printing. Trial for Jan/ Feb 2013 within SSU (high turnover ward) and ward 24 at the LRI.
- ❖ Trial of ward round template still ongoing in renal services.

2.3 **Fractured Neck of Femur ‘Time to Theatre’**

October performance for time to surgery within 36 hours for fractured neck of femur patients is 80.3%, with initial performance for November at 76.3%. The year to date position is 74.5% against a target of 70%.

2.4 **Venous Thrombo-embolism (VTE) Risk Assessment**

UHL’s performance for November as reported to the DoH, is 95.3%, this figure includes the ‘Renal Dialysis’ patients. Without the dialysis patients, performance is still above the CQUIN threshold, when including other cohort patients – 92.4%.

2.5 **Care Quality Commission Inspection**

The Care Quality Commission (CQC) revisited the LRI on the 5th November 2012. They reviewed medicines management, support for staff and monitoring quality and found that we were compliant. The report can be found on the UHL website. During this visit the CQC team visited wards and spoke to staff and patients. The full report is available on our internal and external website.

The CQC conducted an unannounced visit of the Glenfield General Hospital on the 22nd November reviewing medicines arrangement, support of staff and the management of complaints. They observed how people were being cared for, talked to people using our service and talked with carers/family members and members of staff. The CQC found that patients were protected against the risk of medicines as we had appropriate arrangements in place to manage medicines. They found that patients were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard. Staff reported they had timely appraisals, were informed of developments and consulted on any proposed improvements. Patients told the CQC that they felt confident to make a comment or complaint about the care and treatment they received. The full report is available on our internal and external website.

Finally the CQC conducted an unannounced scheduled inspection at the Leicester General Hospital on the 5th December reviewing medicines management, support of staff and complaints. Following observations of care, discussions with staff, patients and carers, a draft report has been received confirming that we are compliant with the CQC essential standards of quality and safety. Once the report is finalised by the CQC it will be placed on our website.

3.0 **PATIENT EXPERIENCE – SUZANNE HINCHLIFFE**

3.1 **Infection Prevention**

MRSA – There are no MRSA cases reported for November. The target for 2012/13 is 6 cases.

C Difficile – November reported below trajectory with 4 cases resulting in a cumulative position of 59 against a target of 72 for April to November.

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

3.2 Patient Polling



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

In November 2012, 1,621 Patient Experience Surveys were returned which exceeds the Trusts target of 1,523.

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

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

Share Your Experience – Electronic Feedback Platform

Main Outpatients on each site, Maternity Services and the Emergency Department owing to the patient group use Share Your Experience as the medium to gain feedback via email, touch screen and web. In November 2012, 265 surveys were completed:

Outpatient's visits: 111 surveys
Maternity Services: 11 surveys
Emergency department: 71 surveys
Children's Emergency department: 72 surveys

Share Your Experience was launched across the Neonatal Units on the 27th November 2012 using a bespoke survey within this specialised area. 7 surveys were returned during the last week of November 2012.

Patient feedback continues to be accessible for all staff at Trust, Divisional, CBU and Ward level via Share point on the Patient Experience Page or via the 'Share your Experience' site. This includes all free text comments for each ward from patients. Linked to the Quality Schedule, the trust is required to report on feedback relating to whether patients felt they were treated with respect and dignity which may be found below.

Treated with Respect and Dignity



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

Friends and Family Test



The surveys include the net promoter question; **How likely is it that you would recommend this service to friends and family?** Of these 1,621 surveys, 1,152 surveys included a response to the Net Promoter Question and were considered inpatient activity (excluding day case/ ED / outpatients) and therefore were included in the Net Promoter Score for the SHA.

Overall there were 10,135 inpatients in the relevant areas within the reporting period (28/10 to 24/11), giving a 10% footfall requirement of 1,014. The Trust easily met the SHA target with a total of 1,152 Net Promoter responses broken down to:

Number of Promoters:	752
Number of passives:	307
Number of detractors:	93
Overall NET promoter score	57.2

In April 2012 the Trust overall net promoter score was 51 with a target of 61 by March 2013. November 2012 score shows a 6 point improvement from baseline. The following actions will be initiated by the divisions to achieve the April 2013 target:

- ❖ Divisional review of Net Promoter Scores at ward level highlighting areas of underperformance and local plans to improve ward scores
- ❖ The Four Divisional Action Plans are now embedded within the Divisions and are driving development / improvement activity
- ❖ Patient Experience workshop engaged with divisional clinical staff to focus improvement activity within key areas

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

National Changes to Friends & Family Test (Net Promoter Score)

The Friends & Family Test has been used across Midlands & East SHA since April 2012. The DH has decided to adopt this simple headline metric while slightly changing the question to allow greater understanding in the NHS:

“How likely are you to recommend our ward /department to friends & family if they needed similar care or treatment”

This new Friends and Family Test question will be used nationally for all NHS funded Acute Services from April 2013 with a number of important changes:

- ❖ Initially groups to be surveyed are:
 1. Adult acute inpatients (stayed at least one night)
 2. Adult patients who have attended A&E and left without being admitted or seen in an Assessment Unit and then discharges (includes majors, minors, resus, eye casualty, EDU, AMU and CDU)
- ❖ Maternity service users, outpatients and patients under 16 years of age will not be included; however maternity services will start using this metric from October 2013.
- ❖ Form part of the Standard NHS Contracts.

- ❖ Process should be patient led and all patients within the target group should be given the opportunity to complete the survey question on discharge. Surveys should be anonymous and face to face interviewing should not be used due to response bias.
- ❖ Minimum response rate of 15% of patients discharged. This equates to approximately 900 surveys across ED and Eye casualty in addition to the present inpatient survey responses.
- ❖ Trust required to report externally a score by trust, site and ward by April 2013 ideally from January 2013.

3.3 Safety Thermometer

Safety Thermometer (ST) progress to date for each of the four harms is given below. The percentage of harm free care in UHL remains at 94% which continues to be above the national percentage, which for November was 92.6%. A summary of the prevalence data for the four harms is given below with additional analysis of the data undertaken at the newly formed UHL ST Steering Committee.

- Newly Acquired Pressure Ulcers – the prevalence of newly acquired pressure ulcers increased for November but as previously advised, include both avoidable and unavoidable ulcers. Based on monthly incidence data, it is confirmed that for November the number of avoidable grade 3 / 4 ulcers has reduced from 11 in October to 8 in November. It should be noted that there has been an increase in the number of providers across the Midlands and East Region that have reported an increase in the number of hospital acquired pressure ulcers and may therefore, not achieve the SHA Ambition to eliminate all avoidable pressure ulcers by December 2012.
- Harmful Falls – The prevalence of falls reduced by 50% from eight to four falls
- Urinary Tract Infection (UTI) with Catheter – The prevalence continues to reduce with only three harms recorded for November.
- Newly Acquired VTE - A slight increase in prevalence with an additional two VTEs recorded in November.

The Trust has been informed that the Department of Health have reviewed the ST definitions of new harms for VTE, UTI and Falls. It has now been agreed that any patient who starts treatment for a UTI or VTE post admission will be considered as having a 'new' UTI or VTE, even if the patient was symptomatic prior to admission.

It has also been confirmed that any patient that has been admitted to UHL having had a fall in the previous 72 hrs in their own home (when under the care of the district nurse) or in a care setting – i.e. Nursing / Residential Home; Hospice, Community Hospital, is to be considered as having had a Hospital Fall. The only hospital fall that would not be included within this category are those where the patient fell in the street or in their own home (but are not currently under the care of the district nurses).

The rationale for these changes is to encourage organisations to work together in reducing harm. It is therefore advised that there is likely to be a significant increase in the number of harms reported within UHL for December 2012.

		Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12
Number of patients on ward		1533	1570	1593	1551	1554	1475	1626	1617
All Harms	Total No of Harms	189	181	141	160	137	109	98	99
	No of patients with no Harms	1359	1401	1457	1404	1426	1373	1533	1522

	% Harm Free	88.65%	89.24%	91.46%	90.52%	91.76%	93.08%	94.28%	94.12%
Newly Acquired Harms	Total No of New Harms	107	82	62	86	59	41	*33	40
	All 1 Harms	159	157	131	134	119	95	89	91
	All 2 Harms	15	12	5	13	9	7	8	4
	>2 Harms	0	0	0	0	0	0	0	8
Harm One	All Pressure Ulcers (Grades 2, 3 or 4)	108	113	90	85	78	61	62	70
	New Pressure Ulcers (Grade 2, 3 or 4)	43	40	27	29	20	13	12 (7 G2 5 G3)	27
Harm Two	Harmful Fall	15	14	9	24	14	11	8 (7 Low 1 Mod)	4
Harm Three	No of Patients with Urinary Catheter and Urine Infection (prior to or post admission)	28	40	32	34	29	33	23	19
	Newly Acquired UTIs with Catheter	11	14	16	16	9	13	9	3
Harm Four	Newly Acquired VTE (either DVT, PE or Other)	38	14	10	17	16	4	4	6

*Denotes amended figure from last month (amended from 32 to 33)

3.4 Same Sex Accommodation

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

3.5 Falls

The number of inpatient falls has risen from last month in the Acute Division. Each ward is being monitored following allocation of reduction trajectories. There has been one serious incident related to a patient fall that occurred in a medical ward in July 2012 and was escalated as an SUI following a complaint from the family in October 2012.

3.6 New principles set out for hospital food

New standards setting out what patients should expect from NHS hospital food have been announced by Health Secretary Jeremy Hunt.

A set of basic principles covering the quality of food, nutritional content and choice for patients will be backed up by new assessments led by patients.

The principles set out what patients can expect from good hospital food:

- nutritious and appetising hospital food and drink is essential
- patients to get a choice from a varied menu – including meals suitable for religious needs

- all patients should have access to fresh drinking water at all times, unless it contradicts clinical advice
- food and drink should be available at all times, not just planned mealtimes
- hospitals should promote healthy diets to staff and visitors
- the Government Buying Standards for Food should be adopted as standard whenever possible
- hospitals should regularly evaluate their food service and act on feedback from patients
- the NHS as a whole should look for and reward excellence in hospital food.

The principles are supported by Age UK, Patients Association, Hospital Caterers Association, Royal College of Nursing, Soil Association, British Association of Parenteral and Enteral Nutrition and the British Dietetic Association.

4.0 **OPERATIONAL PERFORMANCE – JEREMY TOZER**

4.1 **RTT – 18 week performance**

RTT Admitted performance

Admitted performance in November has been achieved with performance at 91.7%, with all specialties with the exception of Orthopaedics delivering above the 90% target as expected.

The national admitted performance in October (most recent published data) was 92.7% and UHL achieved 91.2% with the upper quartile being 94.9%. Out of a total of 178 providers when ranked from best to worst performing trust UHL was placed 119. 107 out of the 178 Trust's missed the target at specialty level and 72 Trust's had between 2 and 10 specialty failures

RTT Non Admitted performance

The non-admitted target has been achieved at 96.6% against a target of 95%.

The national non-admitted performance in October (most recent published DoH data), was 97.5% and UHL achieved 97.1% with the upper quartile being 98.9%. Out of the 210 providers in total ranked from best to worst performing trust then UHL was placed 131. 108 out of the 207 Providers missed the target at specialty level and 70 Providers had between 2 and 16 specialty failures.

RTT Incomplete Pathways

The 2012/13 Operating Framework requirement that 92% of patients on an incomplete pathway (i.e. patients waiting for a decision to treat or treatment) should have been waiting no more than 18 weeks was achieved in November at 93.9%.

The national incomplete pathways performance in October (most recent published DoH data) was 94.8% and UHL achieved 94.6% with the upper quartile being 97.9%. Out of the 209 providers in total ranked from best to worst performing trust then UHL was placed 139. 112 out of the 210 Providers missed the target at specialty level and 78 Providers had between 2 and 10 specialty failures.

RTT – Delivery in all specialties

Additional activity was undertaken in Orthopaedics to reduce the waiting time which increased following the unplanned closure of 2 Orthopaedic theatres during August and September, due to airflow and lighting system failures. The automatic financial penalty for failing to deliver the 90% target in November for this specialty is estimated to be £79,000. Commissioners have been asked to waive this penalty due to the fact that the reason for growth in backlog was due to unforeseen circumstances that the UHL could not plan for.

All specialties delivered for non-admitted patients.

4.2 Imaging Waiting Times 

Diagnostic waiting times over 6 weeks is 0.6% and below the 1% threshold.


The PWC Imaging Audit and subsequent management response was reported at the November Audit Committee. All planned actions detailed in the management response remain on target to deliver against agreed timeframes.

4.3 ED 4hr Wait Performance 

Performance for November Type 1 & 2 is 90.0% and 92.0% including the Urgent Care Centre (UCC).

Further detail focussing on the actions relating to the Emergency Department may be seen in the separate Interim Director of Operations report.

4.4 Cancer Targets

Two Week Wait 

The two week wait for both an urgent GP referral for suspected cancer to date first seen and symptomatic breast patients (cancer not initially suspected) have been achieved for October (reporting one month in arrears).

31 Day Target 

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

62 Day Target 

The 62 day urgent referral to treatment cancer target for October (reporting one month in arrears) was 85.5% against a target of 85%. The year to date cumulative performance is 84.8%.

The 85% threshold has been achieved since July and the YTD performance is expected to be delivered in November.

Divisions have been asked to develop plans to improve performance at tumour site where UHL's performance is below the benchmarked levels.

4.5 **Choose and Book slot availability**

For Qtr 3 (to date, i.e. October and November) UHL achieved 12% cumulatively, which is likely to miss the 8% trajectory set by commissioners. Performance during Qtr 4 onwards needs to be at less than 4%.

There are particular specialties that account for approximately 85% of the ASI (appointment slot issues). These are most significantly: ENT, General Surgery, Gastroenterology and Orthopaedics. Individual specialties have had to submit trajectories to correct the performance and these will be monitored via the Head of Performance Improvement to the Director of Operations. Monthly updates will need to be presented at the Confirm and Challenge meetings and any exceptions reported on subsequent Trust Q&P reports.

4.6 **Primary PCI**

The percentage of eligible patients with acute myocardial infarction who received Primary PCI within 150 minutes of calling professional help in November was 92.0% against a target of 75%. The year to date cumulative performance is 91.8%.

4.7 **Cancelled Operations**

November performance shows that the percentage of operations cancelled on/after the day of admissions of all elective activity for non clinical reasons was 1.6% against a target of 0.8%. The main reason for the increase in short notice cancellations during the month was due to an increase in emergency demand creating pressure on the bed capacity.

4.8 **Stroke % stay on stroke ward**

The percentage of patients spending 90% of their stay on a stroke ward in October (reported one month in arrears) is 83.7% against a target of 80%. The cumulative performance for the year to date is 80.7%.

Previous actions taken to sustain performance include:

- ❖ Improved bed utilisation on the ASU by running the two acute wards as one unit - Implemented
- ❖ The introduction of a bed co-ordinator role purely for stroke and neurology beds - Implemented with a current focus on stroke
- ❖ Improved timely completion of TTOs - At Induction, Junior Doctors informed that Discharge Letter/TTOs should commence on admission to Stroke Ward by Stroke Training Lead)
- ❖ Greater understanding of discharge options and planning - nursing staff to maintain ownership of the discharge process in collaboration with UHL Discharge Lead.
- ❖ Improved understanding of stroke targets - Communicated to all staff within the Unit and also across other affiliated specialities

4.9 **Stroke TIA**

The percentage of high risk suspected TIAs receiving relevant investigations and treatment within 24 hours of referral receipt (% of high risk referrals) is 72.5% against a contractual target of 62.1%. The year to date cumulative position is 66.1%.

From September, in-house referrals to the one-stop rapid access TIA clinic can be made on the UHL intranet. Referrals via this route will improve performance for patients at high risk of stroke receiving prompt specialist assessment. Once the on-line referral steps are completed, an appointment date is instantly generated which can be provided to the patient before they leave the Trust.

4.10 Readmissions



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

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

4.11 Maternity Breast Feeding <48 hrs



The November percentage of maternity breast feeding within 48hrs is 70.0% against a target of 74%, with a year to date cumulative performance of 73.9%. An audit of the November performance is taking place to identify and rectify any issues including potential data quality issues.

The Trust has submitted an application for Stage 2 assessment of the UNICEF UK Baby Friendly Initiative which focuses on the staff education programme. The planned accreditation has been deferred to February 2013.

4.12 Rapid Access Chest Pain



The percentage of patients seen within the rapid access chest pain clinic is 100% against a target of 98%.

4.13 Cytology Screening 7 day target



The percentage of cytology screening tests reported in the 7 day target is 100% against a local target of 98%.

4.14 Day Case Basket



The percentage of patients (with treatments in the day case basket) treated as day cases for November is 79.8% against a target of 75%, with a cumulative year to date figure of 74.7%.

4.15 Delayed Discharges



The number of delays due to assessment has dropped due to increased triage panels for CHC funding as well as a focus on getting assessments sorted. Further work is being done on reducing delays due to choice. Ward 2 is on track to open early in 2012 which will reduce the number of DTOCs as patients cared for on ward 2 will not be counted as

DTOC. Work will continue on reducing the causes of DTOCs in order to reduce the need for ward 2.

4.16 **NON EMERGENCY TRANSPORT CONTRACT**

There was a total of 3 rebeds in November. Discharge and Outpatient times continue to improve slowly yet remain behind planned expectations. Arriva have aligned their team leader posts so there is responsibility and increased communication with each respective hospital and discharge lounge in order to focus on patients that fall outside of the service KPI's and ensure they are prioritised in order to reduce waiting times for those patients waiting longest.

UHL has requested a contract variation of the times the 12 hour ED transfer resource operates; from 2pm - 2am to 12pm - 12am. This has been agreed in principle by both commissioners and Arriva and Arriva (and their staff) have waived the right to a notice period for consultation, just needing time to alter shift patterns. We await confirmation but it is intended to make this change early January 2013.

UHL continues to meet with commissioners and Arriva on a fortnightly basis. January 2013 see's the introduction of a monthly operational meeting with Arriva to review performance, common issues and performance improvement initiatives. All daily operational incidents are being directed through the Admissions and Discharge Manager and the Duty Management Team. The Admissions and Discharge Manager is in regular contact with Arriva Operational Management in reporting all daily issues that need attention as they occur. Resolving the above issues is being led by commissioners and is also reported at the monthly Emergency Care Network.

5.0 **HUMAN RESOURCES – KATE BRADLEY**

5.1 **Appraisal**



November appraisal rate is 92.1%. Human Resources continue to work closely with Divisions and CBUs to implement targeted actions to continue to improve appraisal performance. We will be corresponding with senior leads in reaching agreement on recovery action required in improving the position.

Appraisal performance continues to feature on Directorate, Divisional and CBU Board Meetings in monitoring the implementation of agreed actions. At the December Workforce and Organisational Development Committee Meeting a report was provided on action undertaken to improve staff experience including appraisal performance by the Women's and Children's Division. An in-depth analysis by Cost Centre has been undertaken in identifying areas with consistently low appraisal performance across the Trust. This data is used to target support interventions in improving overall appraisal performance.

5.2 **Sickness**



The reported sickness rate November is 4.1%. The actual rate is likely to be at around 0.5% lower as absence periods are closed. The 12 month rolling sickness has remained at 3.5%.

A number of training programmes continue which include the corporate @W4P training (delivered by staff side, HR and Occupational Health) and the 'Making it Happen' sessions, one hour programmes for managers.

Other training now includes:

- ❖ Emotional Resilience Workshops (run by AMICA and Occupational Health) the aim of which is to build up personal and management skills in terms of emotional resilience for the work environment.
- ❖ Self-Care at Work Workshop (delivered by Learning and OD and Occupational Health) is offered to staff with high levels of unrelated sickness absence.

6.0 FINANCIAL POSITION – ANDREW SEDDON

6.0 Financial position

6.1 I&E summary

The Trust is reporting a cumulative £7.1m deficit for the first 8 months, £8.4m adverse to Plan. Income ytd is £7.9m (1.6%) over Plan, which is stated net of a £4.0m marginal rate deduction for emergency inpatient income over the 2008/09 baseline. Operating costs cumulatively are £16.9m over Plan, with premium cost staff largely being used to deliver the additional activity.

For the month of November, the position is an actual I&E deficit of £0.7m, £0.5m adverse to the planned position of a £0.2m deficit.

Table 1 outlines the current position and Table 2 outlines the Financial Risk Rating.

Table 1 – I&E summary

	November 12			April - November 2012		
	Plan	Actual	Var	Plan	Actual	Var
	£m	£m	£m	£m	£m	£m
Income						
Patient income	51.4	54.2	2.8	413.2	420.9	7.7
Teaching, R&D	6.3	6.2	(0.1)	50.2	49.8	(0.4)
Service Income	57.7	60.4	2.7	463.4	470.7	7.2
Other operating Income	2.5	2.5	(0.0)	18.5	19.2	0.7
Total Income	60.2	62.8	2.6	481.9	489.8	7.9
Operating expenditure						
Pay	36.7	38.2	(1.5)	293.4	300.9	(7.5)
Non-pay	20.1	21.7	(1.6)	158.7	168.1	(9.4)
Total Operating Expenditure	56.8	59.9	(3.1)	452.1	468.9	(16.9)
EBITDA	3.4	3.0	(0.5)	29.9	20.9	(9.0)
Net interest	-	0.0	0.0	0.0	0.0	0.0
Depreciation	(2.7)	(2.7)	(0.0)	(21.2)	(20.8)	0.5
PDC dividend payable	(0.9)	(0.9)	-	(7.4)	(7.3)	0.2
Net deficit	(0.2)	(0.7)	(0.5)	1.3	(7.1)	(8.4)
EBITDA %		4.7%			4.3%	

Table 2 – Financial Risk Ratings

Criteria	Indicator	Weight						Year to Date
			5	4	3	2	1	
Underlying performance	EBITDA margin %	25%	11	9	5	1	<1	2
Achievement of plan	EBITDA achieved %	10%	100	85	70	50	<50	2
Financial efficiency	Net return after financing %	20%	>3	2	-0.5	-5	<-5	2
	I&E surplus margin %	20%	3	2	1	-2	<-2	2
Liquidity	Liquid ratio days	25%	60	25	15	10	<10	3
Weighted Average		100%						2.3

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

6.2 Income

6.2.1 Year to date NHS patient care income is £7.2m (1.6%) favourable to Plan. This reflects under-performance on day cases of £1.1m and elective inpatients of £2.3m. These adverse movements are offset by favourable variances for emergency activity, £6.3m, net of a £3.9m reduction for the marginal rate emergency threshold and outpatients £2.6m. Emergency inpatient activity to the end of November was 5,445 spells (7%) above Plan.

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

6.2.3 The YTD position also assumes £1.5m of income relating to reimbursement of income as a consequence of the emergency activity threshold.

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

6.2.5 The key points to highlight within Table 3 are:

- The 7% increase in emergency activity takes the Trust above the 2008/09 activity threshold, thereby accruing income at only 30% of the full tariff. This marginal rate (MRET) accounts for a reduction in income of approximately £3.9m in the first 8 months. The MRET baseline is determined on a Commissioner basis and so the concentration of additional emergency activity in the County and not the City has exacerbated the impact on us as a provider. Commissioners hold the balance of 70% and are tasked to invest this to alleviate the pressures.
- The Emergency Department price variance reflects the impact of the 2011/12 year end settlement. A Commissioner-led review of the ED casemix is currently underway. Our ED team consider that the average tariff of £99 does not reflect the complexity of the casemix and intend to re-address this in the 2012/13 counting and coding proposals.
- The elective inpatient volume shortfall of 5.6% equates to 886 spells. This reduction is largely as a consequence of the increased emergency activity encroaching on elective

beds, ITU capacity and theatre sessions. This has had a knock-on effect of reducing elective capacity

Table 3 – Patient Care Activity – Price and Volume Movements

	Price Variance YTD %	Volume Variance YTD %	Price / Mix Variance (£000)	Volume Variance (£000)	Variance YTD (£000)
Average tariff					
Day Case	(1.0)	(2.1)	(341)	(718)	(1,059)
Elective Inpatient	0.8	(5.6)	372	(2,695)	(2,323)
Emergency / Non-elective Inpatient	1.3	7.3	1,612	8,572	10,184
Marginal Rate Emergency Threshold (MRET)			(3,869)	0	(3,869)
Outpatient	3.2	(0.1)	1,902	(42)	1,860
Emergency Department	(3.6)	4.5	(399)	486	87
Other			0	2,149	2,149
Grand Total	(3.2)	5.1	(723)	7,751	7,028

6.3 Expenditure

6.3.1 Operating expenditure for the year to date is £16.9m (3.7%) adverse to Plan, comprising of pay at £7.5m (2.6%) adverse and non-pay £9.4m (5.9%) adverse. November performance against Plan is £1.5m adverse for pay and £1.6m adverse for non-pay.

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

6.3.3 Whilst premium payments were stable between September 2011 and February 2012, the increase in March 2012 continued into this financial year with the stepped increase seen in August continuing through to November – we are now running at pay costs double the level of the same period last year (an extra £1.5m per month), despite the increase in contracted staff in November (see Chart 2).

Chart 1

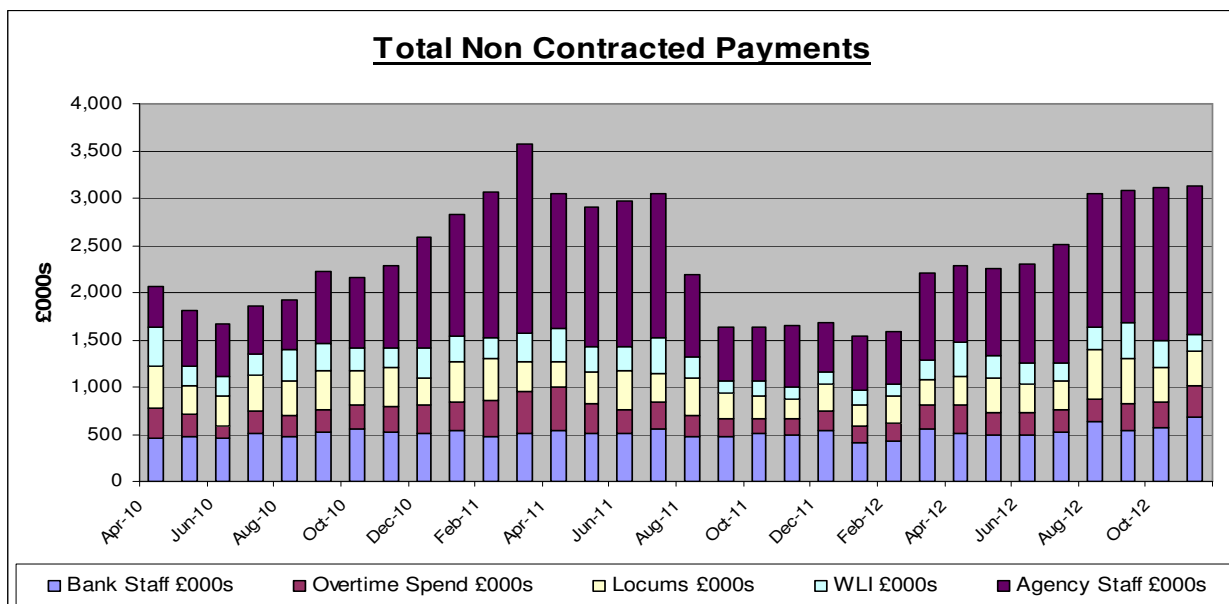
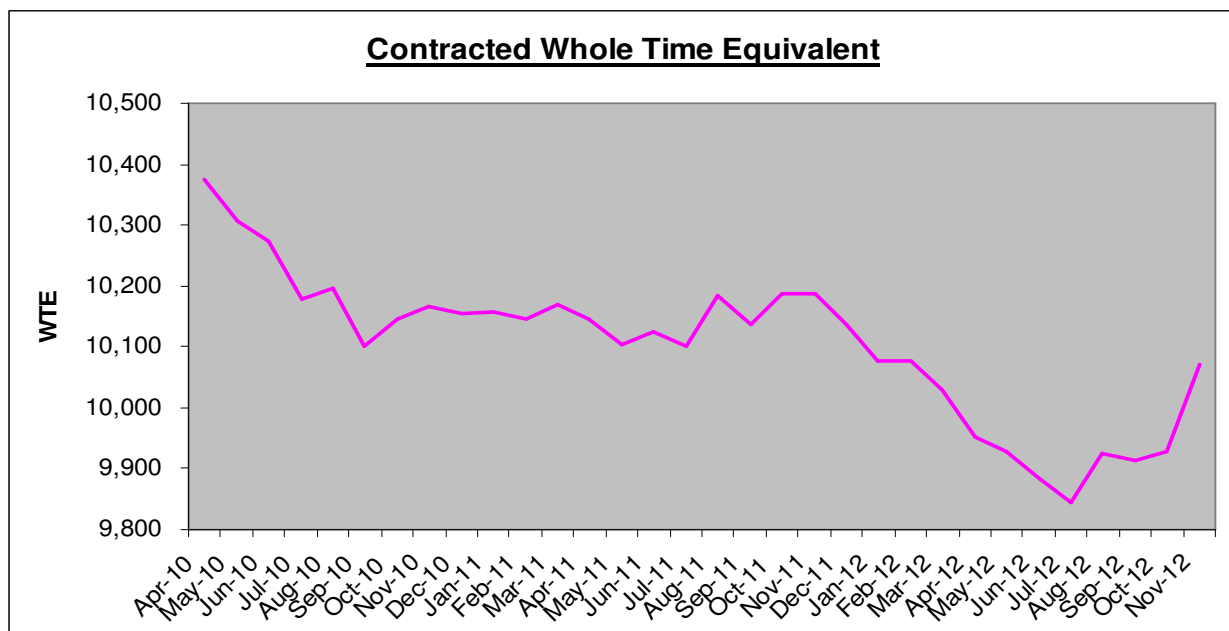


Chart 2



6.3.4 Whilst contracted staff reduced continuously since November 2011 until July 2012, we saw a small increase in August, stability in September and October, but a significant

increase in November reflecting the new nursing and midwifery starters (142 WTE additional contracted staff in November).

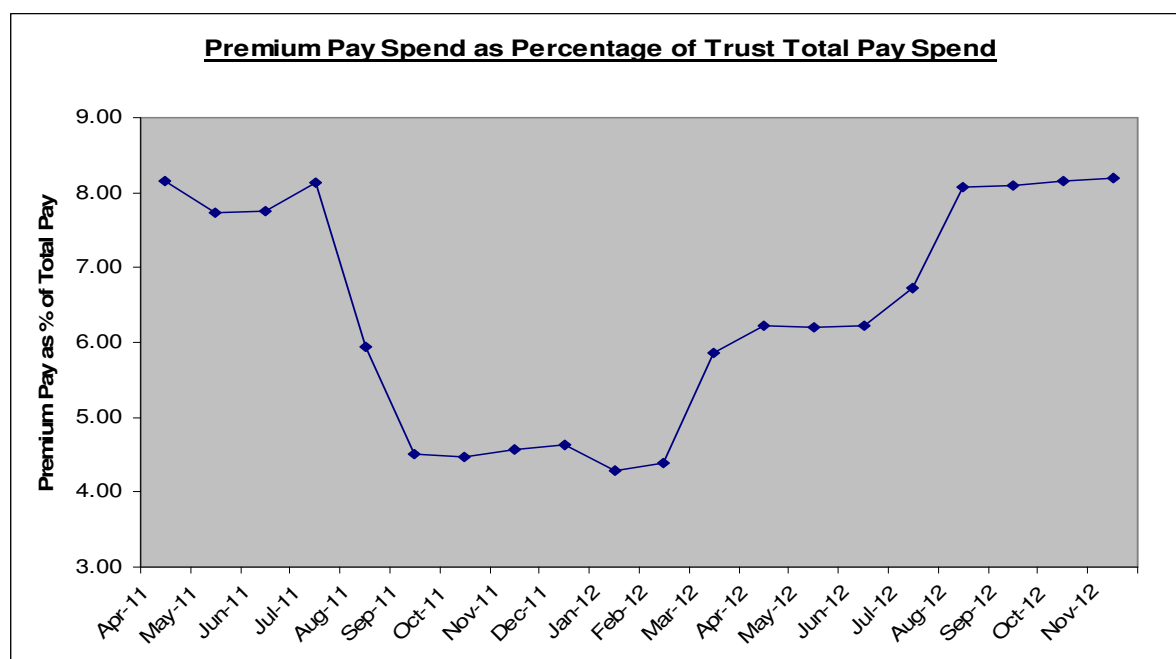
6.3.5 The Trust is still using a significant number of non contracted workforce (618 WTE, which is 5.9% of the total worked WTE but 8.2% of the pay costs). This is shown by Division in Table 4 below. This must fall as a result of the increased substantive recruitment.

Table 4 – Worked WTE

UHL/Division	November 2012 worked wte (Actual)					Total wte
	Contracted wte	Bank wte	Overtime wte	Agency wte	Other wte	
Acute Care	3,305	146	35	105	(71)	3,520
Clinical Support	2,393	43	24	38	(52)	2,446
Planned Care	1,869	67	15	22	(40)	1,933
Womens & Children	1,445	19	9	2	(23)	1,452
Corporate	1,060	48	24	21	(35)	1,118
UHL Total	10,072	323	107	188	(221)	10,469

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

Chart 3



6.3.7 It is important to highlight that although we have seen changes in the mix of permanent and temporary staff from an overall workforce total, we have now seen a 1.7% increase in total workforce over the past 14 months – see below.

TOTAL STAFFING

	WTE	(%)	Nov 12 WTE	March 12 WTE	Sept 11 WTE
MEDICAL & NURSING	229	3.4	7,041	6,878	6,812
OTHER STAFF GROUPS	(50)	(1.4)	3,650	3,615	3,700
TOTAL	179	1.7	10,690	10,493	10,512

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

6.3.8 Whilst showing a 1.7% increase in total numbers, we have seen a significant 229 WTE 3.4% increase in our medical and nursing numbers and a corresponding decrease in other staffing.

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

CONTRACTED STAFFING

Staff Type	Movement Nov 12 -		Contracted Staff		
	WTE	(%)	Nov 12 WTE	March 12 WTE	Sept 11 WTE
ADMIN & CLERICAL	(125)	(6.6)	1,763	1,827	1,888
ALLIED HEALTH PROFESSIONALS	(28)	(6.0)	449	459	478
CAREER GRADES	4	5.7	70	70	66
CONSULTANT	16	3.0	554	533	538
HEALTHCARE ASSISTANTS	(28)	(6.0)	439	447	467
HEALTHCARE SCIENTISTS	(17)	(2.2)	734	741	751
MAINTENANCE & WORKS	1	0.9	61	61	60
NURSING QUALIFIED	(14)	(0.4)	3,296	3,348	3,310
NURSING UNQUALIFIED	110	9.2	1,314	1,195	1,203
OTHER MEDICAL & DENTAL STAFF	(5)	(0.5)	926	899	931
OTHER SCIEN, THERAP & TECH	26	9.3	301	274	276
SENIOR MANAGERS	(7)	(3.9)	164	175	171
TOTAL	(67)	(0.7)	10,071	10,029	10,138

MEDICAL & NURSING	84	1.3	6,599	6,492	6,515
OTHER STAFF GROUPS	(151)	(4.2)	3,473	3,538	3,623
TOTAL	(67)	(0.7)	10,071	10,029	10,138

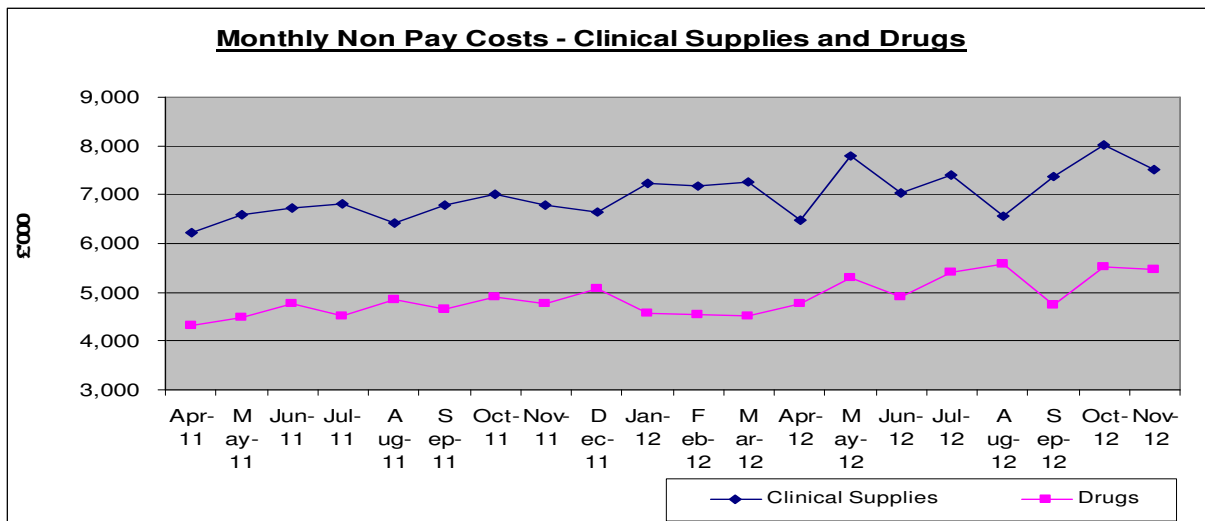
PREMIUM STAFFING

	WTE	(%)	Nov 12 WTE	March 12 WTE	Sept 11 WTE
BANK	81	33.4	323	274	242
OVERTIME	45	70.6	108	84	63
AGENCY	120	176.1	188	106	68
TOTAL	246	65.8	619	464	373

6.3.10 The clear challenge to the Trust is to reduce the requirement for this premium staffing, whilst maintaining, if not increasing, the quality of care.

6.3.11 Non-pay costs - the key areas are drugs, £2.0m adverse to Plan, and clinical supplies, £3.7m adverse, with variances in both categories driven in part by increased activity levels. The chart below shows the actual monthly costs for clinical supplies and drugs from April 2011 to November 2012.

Chart 4 – Clinical Supplies and Drugs Costs



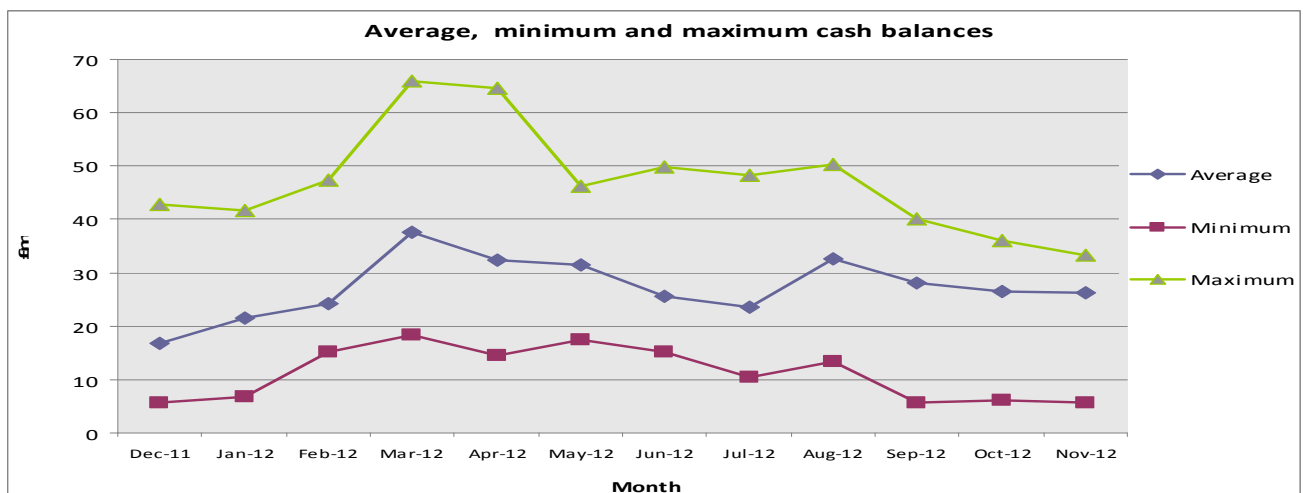
6.3.12 In addition to the variances in drugs and clinical supplies, YTD results are also adverse in utilities (£0.4m), use of independent sector (£0.9m – primarily endoscopy), hotel services and security (£0.7m) and legal fees (£0.2m).

6.3.13 Further detailed analysis detailing the reasons for the non pay adverse variance to plan will be provided.

6.4 Working capital and net cash

6.4.1 The Trust closed the month of November cash balance of £6.7m, compared to £35.9m at the end of October. The main reason for this was the prepayment of the monthly SLAs via the CCGs reducing from £28m to less than £4m.

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



6.5 2012/13 forecast and risks

6.5.1 The Trust is still forecasting to deliver the planned £46k surplus.

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