Clinical Operations

Key Performance Indicators

Summary Report

Month 2
May 2012

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Key to Performance Traffic Lights

Key	Traffic Light	Performance
⊗	**Red**	Worse than plan
◆	**Amber**	Close to plan
✓	**Green**	= to or better than plan

Key to Direction of Travel

↑	Variation between actual performance and planned performance indicates an improvement since last month
→	Variation between actual performance and planned performance has remained constant since last month
↓	Variation between actual performance and planned performance indicates a deterioration since last month

SECTION 1 KEY PERFORMANCE INDICATORS - SUMMARY

Patient Safety	Quarter	KPI	Last	Last 4 Quarters	Current Quarter – Early View Data								Commentary
	Target	Source	FY	1 2 3 4	A M J	FOT	A	M	J	FOT	Travel	
MRSA (Acute >2 Day) Annual threshold = 1	0	Monitor	✓	✓ ✓ ✓ ✓	✓ ✓	✓	0,	0		0	→	
MRSA (East CHs >2 Day) Annual threshold = 1	0	Contract	✓	✓ ✓ ✓ ✓	✓ ✓	✓	0,	0		0	→	
MRSA (North CHs >2 Day) Annual threshold = 1	0	Contract	✓	✓ ✓ ✓ ✓	✓ ✓	✓	0,	0		0	→	
MRSA Screening Acute Elective	95%	Local	⊗	⊗ ⊗ ◆ ✓	✓ ✓	✓	96.6,	95.3		>95	↑	
MRSA Screening Acute Non-Elective	95%	Local	⊗	⊗ ⊗ ⊗ ⊗	⊗ ◆	⊗	88.6,	94.2		<95	→	
MSSA (Acute >2 Days) Annual threshold = 8	2	Contract	✓	✓ ⊗ ✓ ✓	✓ ✓	✓	0,	0		<2	→	
MSSA (East CHs >2 Days) Annual threshold = 1	0	Contract	✓	✓ ✓ ✓ ✓	✓ ✓	✓	0,	0		0	→	
MSSA (North CHs >2 Days) Annual threshold = 1	0	Contract	✓	✓ ✓ ✓ ✓	✓ ✓	✓	0,	0		0	→	
E.Coli (Acute >3 Days) Annual threshold = 21	5	Contract	✓	✓ ⊗ ✓ ✓	◆ ✓	✓	3,	1		5	↑	
E.Coli (East CHs >3 Days) Annual threshold = 2	0	Contract	✓	✓ ⊗ ⊗ ✓	✓ ✓	✓	0,	0		0	→	
E.Coli (North CHs >3 Days) Annual threshold = 1	0	Contract	✓	✓ ✓ ✓ ✓	✓ ✓	✓	0,	0		0	→	
C. Difficile (Acute only) Annual threshold 17	4	Monitor	✓	✓ ⊗ ⊗ ✓	✓ ✓	✓	0,	2		4	↓	
C.Difficile (East CH >3Day) Annual threshold = 32	8	Contract	✓	⊗ ✓ ⊗ ✓	✓ ✓	✓	1,	0		<8	→	
C.Difficile (Nth CH >3 Days) Annual threshold = 4	1	Contract	✓	✓ ⊗ ⊗ ✓	✓ ✓	✓	0,	0		1	→	
Hand Hygiene Compliance North	95%	Local	◆	◆ ◆ ◆ ◆	◆	◆	91			<95	→	Q1 90.2%, Q2 91.6% , Q3 92.8%, Q4 92.7%,
Compliance with Uniform Policy												Data being progressed
Cleanliness Scores												Data being progressed
Number of Wound Site Infections												Data being progressed

Number of Catheter Acquired Infections >72Hrs										Data being progressed

Patient Safety (continued)	Quarter	KPI	Last	Last 4 Quarters	Current Quarter – Early View Data								Commentary
	Target	Source	FY	1 2 3 4	A M J	FOT	A	M	J	FOT	Travel	
Never Events	0	DH	⊗	✓ ⊗ ✓ ⊗	✓ ✓	✓	0,	0		0	→	
Medication Errors Per 1000 Bed days		EMQO										Data being progressed
SMR Trust Overall	<100	SHA	⊗	⊗ ⊗ ⊗ ◆	◆ ◆	◆	109.5,	104.7		100	↑	Data = Apr11 – Mar12
SMR Acute Only	<100	SHA	◆	◆ ◆ ◆ ✓	◆ ✓	✓	103.8,	94.9		<100	↑	Data = Apr11 – Mar12
SMR North Community Hospitals	<100	SHA	⊗	⊗ ⊗ ◆ ✓	✓ ✓	✓	105.8,	98.5		<100	↑	Data = Apr11 – Mar12
SMR East Community Hospitals	<100	SHA	⊗	⊗ ⊗ ⊗ ⊗	⊗ ⊗	⊗	114,	115		>100	→	Data = Apr11 – Mar12
SHMI Trust overall	<100	DH	✓	✓ ✓			RYQ1 93.0	RYQ2 97.8			↓	Latest SHMI data is Oct10 – Sep11
SHMI Elective	<100	EMQO		⊗ ⊗			RYQ1 150	RYQ2 144			↑	Mainly due to incorrectly recorded community admissions
SHMI Non-Elective	<100	EMQO		✓ ✓			RYQ1 91.5	RYQ2 96.5			↓	
SHMI Stroke (66)	<100	EMQO		✓ ✓			RYQ1 78.4	RYQ2 77.9			→	
SHMI COPD (75)	<100	EMQO		◆ ◆			RYQ1 123	RYQ2 126			→	Within national expected range
SHMI MI (57)	<100	EMQO		✓ ✓			RYQ1 70.2	RYQ2 75.3			→	
SHMI #NOF (120)	<100	EMQO		✓ ✓			RYQ1 51.2	RYQ2 55.5			→	
SHMI Pneumonia (73)	<100	EMQO		◆ ◆			RYQ1 107	RYQ2 101			↑	Within national expected range
SHMI Renal (99)	<100	EMQO		✓ ✓			RYQ1 90.7	RYQ2 95.3			→	
SHMI CHF (65)	<100	EMQO		◆ ◆			RYQ1 115	RYQ2 117			→	Within national expected range
SHMI Diabetes (35)	<100	EMQO		✓ ✓			RYQ1 73.1	RYQ2 95.6			↓	Excludes 34 –(w/o complications) due to small numbers
VTE Risk Assessments	90%	DH	✓	◆ ✓ ✓ ✓	✓ ✓	✓	95.8,	95.9 Early Data		>90	→	Q1 88.3%, Q2 91.5% , Q3 94.3%, Q4 95.7%,
VTE Prophylaxis Prescribed	90%	Local										Data being progressed

Quality of Services	Quarter	KPI	Last	Last 4 Quarters	Current Quarter – Early View Data							Commentary
	Target	Source	FY	1 2 3 4	A M J	FOT	A M J			FOT	Travel	
Cancer 2 Week wait from referral to date first seen	93%	Monitor	✓	✓ ✓ ✓ ✓	✓ ✓	✓	95.7, 98.0			95	→	
2 Week wait from referral to seen Breast Symptomatic	93%	Monitor	✓	⊗ ✓ ✓ ✓	✓ ✓	✓	100, 100,			95	→	
Cancer 31day Diagnosis to treatment	96%	Monitor	✓	✓ ✓ ✓ ✓	✓ ✓	✓	98.1, 98.4,			98	→	
Cancer 31-day subsequent treatment - Surgery	94%	Monitor	✓	✓ ✓ ⊗ ✓	◆ ✓	✓	87.5, 100			>94	↑	1 Breach in April – due to need for involvement of visiting consultant
Cancer 31-day subsequent treatment - Drug	98%	Monitor	✓	✓ ✓ ✓ ✓	✓ ✓	✓	100, 100			100	→	
Cancer 62 day Urgent Referral from GP	85%	Monitor	✓	⊗ ✓ ⊗ ✓	◆ ✓	✓	84.8, 87.5			>85	→	20%(1/5) shared pathways April. May shared data not yet available
Cancer 62 day Referral from Screening Service	90%	Monitor	✓	✓ ✓ ⊗ ✓	✓ ✓	✓	100, 100			100	→	
Cancer 62 day Consultant Upgrade Referral	90%	Monitor	✓	✓ ✓ ✓ ✓	✓ ✓	✓	100, 100			100	→	
A&E Type 1 maximum waiting time of 4 hours	95%	SHA	⊗	✓ ✓ ⊗ ⊗	⊗ ✓	◆	92.1, 95.1			>95	↑	Need to achieve 98.5% for 8-30th June to achieve 95% for Q1
A&E Type 1 & MIU/WIC (Combined) Max. WT 4Hrs	95%	Monitor	✓	✓ ✓ ✓ ✓	✓ ✓	✓	98.0, 98.0			98	→	
Ambulance Handovers % > 15 Mins	<20%	Contract	■	■ ■ ■ ■	⊗ ⊗	⊗	37, 39			>20	↑	Trust average handover time is generally higher than SW average
Ambulance Handovers % > 30 Mins	<10%	Contract	✓	✓ ✓ ✓ ✓	◆ ✓	✓	12, 9			<10	↑	Q1 7.8%, Q2 5.6% , Q3 5.2%, Q4 8.1%,
Ambulance Handovers > 1 Hour	0	Contract	■	■ ■ ■ ■	⊗ ⊗	⊗	27, 6			40	↑	Main reason no physical capacity
Ambulance Handovers > 2 Hours	0	Contract	■	■ ■ ■ ■	⊗ ✓	◆	2, 0			2	↑	Reason - no physical capacity
Stroke Direct Admission to ASU	90%	Local	⊗	⊗ ⊗ ⊗ ⊗	⊗ ⊗	⊗	69.7, 48.6			70	↓	Q1 68.4%, Q2 67.5% , Q3 56.3%, Q4 54.8%,
Stroke >90% stay on Unit North Acute	80%	SHA	⊗	◆ ◆ ⊗ ⊗	⊗ ⊗	⊗	69.0, 65.0			<80	↓	Q1 72.0%, Q2 74.4%, Q3 59.2%, Q4 64.4%,
Stroke >90% stay on Unit North Super spell	80%	SHA	⊗	◆ ⊗ ⊗ ⊗	⊗ ⊗	⊗	69.0, 60.0			<80	↓	Q1 70.0%, Q2 69.8%, Q3 62.8%, Q4 59.8%,
Stroke >90% stay on Unit East Community Hospital	80%	SHA	◆	◆ ✓ ◆ ⊗	✓ ⊗	✓	94.4, 66.6			>80	↓	Q1 74.1%, Q2 83.8%, Q3 77.8%, Q4 69.4%,

Stroke Urgent Scan <1Hr	**90%**	**Local**	⊗	⊗◆◆⊗	✓✓	✓	**100, 100**	**<90**	➔	Q1 32.9%, Q2 80.8%, Q3 86.6%, Q4 60.3%,
Stroke Routine Scan <24Hr	**90%**	**Local**	⊗	⊗⊗⊗⊗	◆◆	◆	**89.5, 88.0**	**<90**	➔	Q1 72.7%, Q2 78.6%, Q3 75.2%, Q4 70.2%,
Fractured NOF operated on within 24 hrs of being ready	**90%**	**Local**	✓	✓✓✓✓			**Pending data**		➔	Q1 93.1% Q2 96.1% Q3 90.0% Q4 90.4%

Patient Experience	Quarter	KPI	Last	Last 4 Quarters	Current Quarter – Early View Data							Commentary
	Target	Source		1 2 3 4	A M J	FOT	A M J	FOT	Travel	
RTT Waiting Time Admitted <18Wks	90%	Monitor	✓	✓✓✓✓	✓✓	✓	95.8, 94.8	>90	→	
RTT Waiting Time Non-Admitted <18Wks	95%	Monitor	✓	✓✓✓✓	✓✓	✓	99.5, 99.6	>95	→	
RTT Waiting Time Incompletes <18Wks	92%	Monitor	✓	✓✓✓✓	✓✓	✓	98.5, 98.7	>92	→	
RTT Waiting Time >52Wk Waiters	0	SHA	■	■■■■	◆	✓	3,	<12	→	
RTT Admitted Median - Weeks	<11.1	DH	✓	✓✓✓✓	✓✓	✓	8.4, 7.8	<11	→	
RTT Admitted 95th Percentile - Weeks	<23.0	DH	✓	✓✓✓✓	✓✓	✓	17.9, 18.2	<23	→	
RTT Non-Admitted Median Weeks	<6.6	DH	✓	✓✓✓✓	✓✓	✓	3.3, 3.4	<6.6	→	
RTT Non-Admitted 95th Percentile - Weeks	<18.3	DH	✓	✓✓✓✓	✓✓	✓	9.8, 10.1	<18	→	
Outpatients GP Referred Waiting >11 wks	2	Local	✓	✓✓✓✓	✓✓	✓	0, 0	0	→	
Elective patients Waiting >20 wks	2	Local	✓	✓✓✓✓	✓✓	✓	0, 0	0	→	
Diagnostics Waiting >6 wks	99%	DH	✓	✓✓✓✓	✓✓	✓	4, 2	>99	→	
Breach of EMSA General Wards - Number	0	DH	⊗	⊗⊗◆⊗	⊗◆	⊗	20, 4	30	→	4 x MAU Breaches in May
Breach of EMSA (NDDH) Breaches per 1000 FCE	0	DH	⊗	⊗⊗◆⊗	⊗◆	⊗	4.4, 0.8	>1.0	↑	National mean 0.43 at Feb 12
Access for people with learning disability – 6 criteria	Yes All	Monitor	⊗	⊗⊗⊗⊗	⊗⊗	✓	Part, Part	Part	→	Plan is to complete by end June.
Cancelled Operations As % of Electives	<0.8%	Contract	✓	✓✓✓◆	◆◆	✓	1.5, 1.4	<0.8	→	List Overuns significant, other reasons varied Apr/May
Cancelled Operations Rebooked <28 day	100%	DH	✓	✓✓✓✓	✓✓	✓	100, 100	100	→	
GUM Offer <48Hrs (East & North)	100%	SHA	✓	✓✓✓✓	✓✓	✓	100, 100	100	→	
Delayed Transfer of Care (Acute)	<3.5%	DH	✓	✓✓✓✓	✓✓	✓	2.3, 3.2	<3.5	→	
Delayed Transfer of Care (Northern CHs)	<3.5%	DH	⊗	⊗⊗⊗⊗	⊗⊗	⊗	7.1, 10.5	>3.5	↓	
Delayed Transfer Care (Eastern CHs)	<3.5%	DH	⊗	⊗⊗⊗⊗	◆⊗	⊗	4.3, 9.7	>3.5	↓	Q1 Q2 Q3 Q4 4.9, 7.2, 8.2, 6.9,
28 Day Emergency Readmissions	<100	Local	✓	✓✓✓✓	◆◆	✓	95.1, 95.4	<100	↓	Data = Jan11 – Dec11

Following Previous Elective Admission	<100	Local	✓	✓✓✓◆	◆◆	✓	88.8, 89.7	<100	🡻	Data = Dec10 – Nov11
Following Previous Emergency Admission	<100	Local	✓	✓✓✓✓	◆◆	✓	97.3, 97.5	<100	🡻	Data = Dec10 – Nov11

Effectiveness	Quarter	KPI	Last	Last 4 Quarters				Current Quarter – Early View Data							Commentary
	Target	Source		1	2	3	4	A	M	J	FOT	A	M	J	FOT	Travel	
Data Completeness Referral to Treatment	50%	Monitor	NA	NA				✓	✓		✓	93%	87%		>80	➔	Refers to data completeness levels for community services (CIDS). Each indicator scores 1.0 but max impact capped at 1.0. Failure of same measure for 3 quarters = Red-rating.
Data Completeness Referral Information	50%	Monitor	NA	NA				✓	✓		✓	90%	88%		>80	➔	
Data Completeness Treatment Activity Info.	50%	Monitor	NA	NA				✓	✓		✓	90%	88%		>80	➔	
Patient Identifier Information (Not yet defined by Monitor)	50%	Monitor						NYA			NYA	NYA			NYA	NYA	May be applied later in 2012/13. Each scores 0.5 but max impact capped at 1.0 with above.
Patients Dying at Home (Not yet defined by Monitor)	50%	Monitor						NYA			NYA	NYA			NYA	NYA	

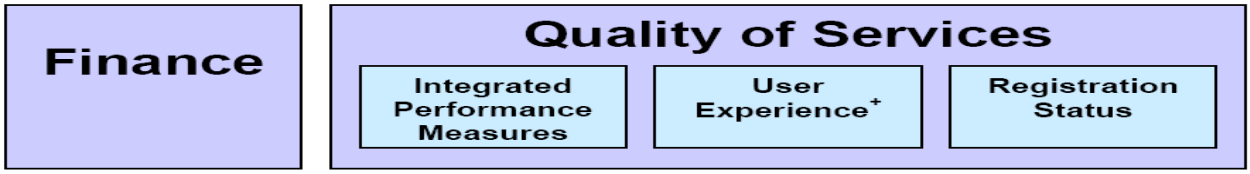
SECTION 2 NHS PERFORMANCE FRAMEWORK

Background

This assessment is published by the Department of Health in The Quarter bulletin and is reported only for NHS Trusts that have not yet gained Foundation status.

Rating Categories are: Performing
Performance Under Review
Under Performing

Performance is assessed across the following key domains of organisational function:



Each domain is underpinned by a series of weighted indicators with associated performance thresholds, and a scoring system to determine performance for the domain

Overall Achievement

The Trust has been assessed in the top category of 'performing' for every domain in each of the last seven quarters.

(Source DH The Quarter)

	Overall Financial Score	Overall Q of S Score	Performance Rating after Escalation		Quality: Standards & Integrated Performance Measures		Quality User Experience		Quality CQC Registration
2010/11			Finance	Q of S	Score	Rating	Score	Rating	Rating
Q1	Performing	Performing			2.61	Performing	5	Performing	Performing
Q2	Performing	Performing			2.66	Performing	5	Performing	Performing
Q3	Performing	Performing			2.68	Performing	5	Performing	Performing
Q4	Performing	Performing			2.45	Performing	5	Performing	Performing
2011/12									
Q1	Performing	Performing			2.66	Performing	5	Performing	Performing
Q2	Performing	Performing			2.53	Performing	5	Performing	Performing
Q3	Performing	Performing			2.40	Performing	5	Performing	Performing
					Max 3		Max 5		

Quality User Experience

Within the overall 'performing' achievement the Trust has consistently been awarded the maximum score for Quality User Experience.

Quality: Standards & Integrated Performance Measures

In respect of Quality: Standards & Integrated Performance Measures the Trust score has varied from a high of 2.68 to a low of 2.40.

For 2011/12 this section of the assessment included indicators covering:

- Total time in A&E
- A&E indicators data quality
- Cancelled operations
- MRSA
- C. Difficile
- Referral to treatment
- Cancer waiting times
- % Stay on stroke unit
- Delayed transfer of care

Some of these indicators have differing weightings allocated within the scoring system.

Within this section performance thresholds are:

- < 2.1 Under performing
- 2.1- 2.4 Performance under review
- >2.4 Performing

The Trust's benchmarked position against the national co-hort of non FT Trusts varied as follows for the first 3 quarters of 2011/12.

Quarter	Score	Rank Position
Q1 2011/12	2.66	30/72
Q2 2011/12	2.53	36/71
Q3 2011/12	2.40	49/67

Performance relative to the national co-hort deteriorated during 2011/12 and in Q3 NDHT was the lowest ranked Trust within the 'performing' category.

Particular indicators facing adverse pressure during the period have included:

- Total time in A&E
- Cancer waiting times
- % Stay on stroke unit
- Delayed transfer of care

SECTION 3 CQUIN INDICATORS - SUMMARY

3.1 CQUINS - Acute

		Latest Month							Executive Director
Ref	Indicator	Mth	Plan	Actual	Var		Dir	£K	
1	**VTE** Risk Assessment (DoH mandated).	May	90%	95.9%	+5.9%	✓	⇔	107.3	Alison Diamond
2	**Patient Needs** (DoH mandated).	May	69-75	69.8	0	✓	⇔	107.3	Carolyn Mills
3A	**Dementia** Screening	Apr	90%	N/A	Baseline setting Q1	◆	⇔	35.8	Kate Lyons
3B	**Dementia** Risk Assessment	Apr	90%	N/A	Baseline setting Q1	◆	⇔	35.8	Kate Lyons
3C	**Dementia** Referral to Specialist	Apr	90%	N/A	Baseline setting Q1	◆	⇔	35.8	Kate Lyons
4	**NHS Safety Thermometer**	Apr	Submit Data	N/A	Report from July	◆	⇔	107.3	Carolyn Mills
5A	**High Impact Innovation** Oesophageal Monitoring	Apr	Submit Report	N/A	By end Sept	✓	⇔	53.7	Alison Diamond
5B	**High Impact Innovation** Child in Chair in a Day	Apr	Submit Report	N/A	By end Sept	✓	⇔	53.7	Kate Lyons
5C	**High Impact Innovation** Telehealth	Apr	Submit Report	N/A	By end Dec	✓	⇔	53.7	Andy Robinson
5D	**High Impact Innovation** E- Discharge Summaries	Apr	Submit Report	N/A	By end Dec	✓	⇔	53.7	Andy Robinson
6A	**End of life** TEP in Place	Apr	90%	N/A	Baseline setting Q1	◆	⇔	107.3	Alison Diamond

6B	**End of Life** TEP Training	Apr	90%	N/A	Baseline setting Q1	◆	⇔	107.3	Alison Diamond
6C	**End of Life** Access to Registry	Apr	Submit Report	N/A	Report by End June	◆	⇔	107.3	Alison Diamond
7A	**Smoking cessation**	Apr	90%	N/A	Data for Pre-Op by end June	◆	⇔	107.3	Carolyn Mills
7B	**Alcohol Reduction support**	Apr	90%	N/A		◆	⇔	107.3	Carolyn Mills
8	**Discharge Practices & Processes**	May	18%	18%	0%	✓	⇧	321.9	Kate Lyons
9A	**Medicines Management** – INRs >6 with RCAs	Apr	90%	N/A	Baseline setting Q1	◆	⇔	107.3	Alison Diamond
9B	**Medicines Management** – prescribing errors	Apr	0%	N/A	Baseline setting Q1	◆	⇔	107.3	Alison Diamond
9C	**Medicines Management** – 4 RCAs in year	Apr	1	N/A	Baseline setting Q1	◆	⇔	107.3	Alison Diamond
10	**Intentional Rounding**	Apr	80%	N/A	Baseline setting Q1	◆	⇔	321.9	Carolyn Mills
							TOTAL	**2146.3**	

Acute CQUIN Trends

To be provided when available

3.2 CQUINS – Eastern Community

		Latest Month							Exec Director
Ref	**Indicator**	**Mth**	**Plan**	**Actual**	**Var**		**Dir**	**£K**	
1	**VTE** Risk Assessment (DoH mandated).	Apr	90%	91.9%	+1.9%	✓	⇔	77.6	Alison Diamond
2	**Patient Needs** (DoH mandated).	Apr	69-75	84.1	+9.1	✓	⇔	77.6	Carolyn Mills
3A	**Dementia** Screening	Apr	90%	N/A	Baseline setting Q1	◆	⇔	25.9	Kate Lyons

3B	**Dementia** Risk Assessment	Apr	90%	N/A	Baseline setting Q1	◆	⇔	25.9	Kate Lyons
3C	**Dementia** Referral to Specialist	Apr	90%	N/A	Baseline setting Q1	◆	⇔	25.9	Kate Lyons
4	**NHS Safety Thermometer**	Apr	Submit Data	N/A	Report from July	◆	⇔	77.6	Carolyn Mills
5A	**High Impact Innovation** ComPAS/CIDS rollout	Apr	60%	TBC	TBC		⇔	77.6	Kate Lyons
5B	**High Impact Innovation** E-Discharge in each CH	May	80%	TBC	TBC		⇔	77.6	Andy Robinson
6A	**End of life** TEP in Place	Apr	90%	N/A	Baseline setting Q1	◆	⇔	77.6	Alison Diamond
6B	**End of Life** Access to Registry	Apr	Submit Report	N/A	Report by End June	◆	⇔	77.6	Alison Diamond
7A	**Smoking cessation**	Apr	90%	N/A	Baseline setting Q1	◆	⇧	77.6	Carolyn Mills
7B	**Alcohol Reduction Support**	Apr	90%	N/A	Baseline setting Q1	◆	⇧	77.6	Carolyn Mills
9A	**Medicines Management** – INRs >6 with RCAs	Apr	90%	N/A	Baseline setting Q1	◆	⇔	77.6	Alison Diamond
9B	**Medicines Management** – prescribing errors	Apr	0%	N/A	Baseline setting Q1	◆	⇔	77.6	Alison Diamond
9C	**Medicines Management** – 4 RCAs in year	Apr	1	N/A	Baseline setting Q1	◆	⇔	77.6	Alison Diamond
10	**Intentional Rounding**	Apr	80%	N/A	Baseline setting Q1	◆	⇔	155.3	Carolyn Mills
11A	**Community CCT –** Less admission, earlier discharge	May	Submit Report	N/A	Report in Q3	◆	⇔	77.6	Kate Lyons
11B	**Community Hospitals** Scope 7 day discharging	May	N/A	N/A	Baseline setting Q1	◆	⇔	77.6	Kate Lyons
12A	**Carer's Assessment Referrals**	Apr	N/A	N/A	Baseline setting Q1	◆	⇔	38.8	Carolyn Mills
12B	**Carer's Assessment Survey Completed**	Apr	N/A	N/A	By Dec	✓	⇔	38.8	Carolyn Mills

13	**Improving IT data collection**	Apr	95%		Baseline setting Q1	◆	⇔	155.3	Andy Robinson
						Total		**1552.3**	

East Community CQUIN Trends
To be provided when available

3.3 CQUINS – Northern Community									
		Latest Month							**Exec Director**
Ref	**Indicator**	**Mth**	**Plan**	**Actual**	**Var**		**Dir**	**£K**	
1	**VTE** Risk Assessment (DoH mandated).	May	90%	92.6%	+2.6%	✓	⇔	27.7	Alison Diamond
2	**Patient Needs** (DoH mandated).	May	69-75	69.8	0	✓	⇔	27.7	Carolyn Mills
3A	**Dementia** Screening	Apr	90%	N/A	Baseline setting Q1	◆	⇔	9.2	Kate Lyons
3B	**Dementia** Risk Assessment	Apr	90%	N/A	Baseline setting Q1	◆	⇔	9.2	Kate Lyons
3C	**Dementia** Referral to Specialist	Apr	90%	N/A	Baseline setting Q1	◆	⇔	9.2	Kate Lyons
4	**NHS Safety Thermometer**	Apr	Submit Data	N/A	Report from July	◆	⇔	27.7	Carolyn Mills
5A	**High Impact Innovation** ComPAS/CIDS rollout	Apr	60%	TBC	TBC		⇔	27.7	Kate Lyons
5B	**High Impact Innovation** E-Discharge in each CH	Apr	TBC	TBC	TBC		⇔	27.7	Andy Robinson
6A	**End of life** TEP in Place	Apr	90%	N/A	Baseline setting Q1	◆	⇔	27.7	Alison Diamond
6B	**End of Life** Access to Registry	Apr	Submit Report	N/A	Report by End June	◆	⇔	27.7	Alison Diamond
7A	**Smoking cessation**	Apr	90%	N/A	Baseline setting Q1	◆	⇔	27.7	Carolyn Mills

7B	**Alcohol Reduction Support**	Apr	90%	N/A	Baseline setting Q1	◆	⇔	27.7	Carolyn Mills
9A	**Medicines Management** – INRs >6 with RCAs	Apr	90%	N/A	Baseline setting Q1	◆	⇔	27.7	Alison Diamond
9B	**Medicines Management** – prescribing errors	Apr	0%	N/A	Baseline setting Q1	◆	⇔	27.7	Alison Diamond
9C	**Medicines Management** – 4 RCAs in year	Apr	1	N/A	Baseline setting Q1	◆	⇔	27.7	Alison Diamond
10	**Intentional Rounding**	Apr	80%	N/A	Baseline setting Q1	◆	⇔	55.5	Carolyn Mills
11	**To Be Agreed**							55.5	
12A	**Carer's Assessment Referrals**	Apr	N/A	N/A	Baseline setting Q1	◆	⇔	13.9	Carolyn Mills
12B	**Carer's Assessment Survey Completed**	Apr	N/A	N/A	By Dec	✓	⇔	13.9	Carolyn Mills
13	**Improving IT data collection**	Apr	95%		Baseline setting Q1	◆	⇔	55.5	Andy Robinson
						Total		**554.3**	

North Community CQUIN Trends
To be provided when available

3.4 CQUINS - Specialist Commissioning									
		Latest Month							**Exec Director**
Ref	**Indicator**	**Mth**	**Plan**	**Actual**	**Var**		**Dir**	**£K**	
1	**VTE** Risk Assessment (DoH mandated) = Acute	May	90%	95.9%	+5.9%	✓	⇔	2.16	Alison Diamond
2	**Patient Needs** (DoH mandated) = Acute	May	69-75	69.8	0	✓	⇔	2.16	Carolyn Mills

3A	**Dementia** Screening = Acute	May	90%	N/A	Baseline setting Q1	◆	⇔	0.72	Kate Lyons
3B	**Dementia** Risk Assessment = Acute	May	90%	N/A	Baseline setting Q1	◆	⇔	0.72	Kate Lyons
3C	**Dementia** Referral to Specialist = Acute	May	90%	N/A	Baseline setting Q1	◆	⇔	0.72	Kate Lyons
4	**NHS Safety Thermometer** = Acute	Apr	Submit Data	N/A	Report from July	◆	⇔	2.16	Carolyn Mills
5A	**Clinical Dashboard** HIV, Haemophilia,CF, Neonatal	May	Q1	On Plan	Leads + Plans	✓	⇔	2.16	TBC
5B	**Clinical Dashboard** HIV, Haemophilia,CF, Neonatal	May	Q2	N/A	Start Reporting		⇔	2.16	TBC
5C	**Clinical Dashboard** HIV, Haemophilia,CF, Neonatal	May	Q3	N/A	Continue Reporting		⇔	2.16	TBC
5D	**Clinical Dashboard** HIV, Haemophilia,CF, Neonatal	May	Q4	N/A	Evidence front line		⇔	2.16	TBC
6	**Increase Therapeutic Hypothermia Treatment**	May	Q1	N/A	Baseline setting Q1	◆	⇔	4.31	TBC
8	**Increase HIV Drugs Home Delivery**	May	Q1	N/A	Baseline setting Q1	◆	⇔	10.78	TBC
9A	**HIV – Failing Therapy Re-supressed <6mths**	May	Q1	N/A	Baseline setting Q1	◆	⇔	5.39	TBC
9B	**HIV Optimise Therapy where CD4<200**	May	Q1	N/A	Baseline setting Q1	◆	⇔	5.39	TBC
						Total		**43.15**	

Specialist Commissioning CQUIN Trends

To be provided when available

SECTION 4 GLOSSARY OF TERMS

A&E	Accident and Emergency Department
ASU	Acute Stroke Unit
CCU	Coronary Care Unit
C.DIFF	Clostridium Difficile
CHD	Coronary Heart Disease
CONS	Consultant
CTN	Call To Needle time
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
CUM	Cumulative
CWT	Cancer Waiting Times
DC	Day Case
DGH	District General Hospital
DIR	Direction
EM	Emergency
FST	First (New Outpatient Attendance)
FUP	Follow Up (Outpatient Attendance)
G&A	General and Acute specialties only (excludes Obstetrics & Midwifery)
GU	Genito Urinary Medicine
HSMR	Hospital Standardised Mortality Ratio (56 Nationally defined Diagnoses)
ICU	Intensive Care Unit
IP	In Patient
IT	Information Technology
MAT	Maternity
MAU	Medical Assessment Unit
MRSA	Methicillin Resistant Staphylococcus Aureus
MSSA	Methicillin-Sensitive Staphylococcus Aureus
NDHT	Northern Devon Healthcare NHS Trust
NICE	National Institute for Clinical Excellence
#NOF	Fractured Neck of Femur
OP	Out Patient
PCT	Primary Care Trust
Q1	Quarter 1 (IE April – June)
QIPP	Quality, Innovation, Productivity & Prevention
Q of S	Quality of Service
RD&E	Royal Devon & Exeter NHS Foundation Trust
RTM	Real Time Monitoring (Benchmarking System)
RTT	Referral To Treatment (Time)
SMR	Standardised Mortality Ratio (All Diagnoses)
SWAST	South West Ambulance Services Trust
SWSHA	South West Strategic Health Authority
TBC	To Be Confirmed
TYPE 1	A&E department located at main hospital
VTE	Venous-thromboembolism
WL	Waiting List

WTE	Whole Time Equivalent (number of staff)
YTD	Year To Date