University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper J

TRUST BOARD – 22nd DECEMBER 2014

QUALITY AND PERFORMANCE REPORT – NOVEMBER 2014

DIRECTOR:	Rachel Overfield, Chief Nurse Kevin Harris, Medical Director Richard Mitchell, Chief Operating Officer Kate Bradley, Director of Human Resources
AUTHOR:	
DATE:	22nd December 2014
PURPOSE:	The following report provides an overview of the November 2014 Quality & Performance report highlighting NTDA/UHL key metrics and escalation reports where required.
PREVIOUSLY CONSIDERED BY:	**In view of the timings of the meetings this month the Quality & Performance Report has been submitted directly to the Trust Board.**
Objective(s) to which issue relates *	☑ 1. Safe, high quality, patient-centred healthcare ☑ 2. An effective, joined up emergency care system ☑ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☑ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☑ 5. Enhanced reputation in research, innovation and clinical education ☑ 6. Delivering services through a caring, professional, passionate and valued workforce ☑ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	
Organisational Risk Register/ Board Assurance Framework *	☑ **Organisational Risk Register** ☑ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision ☐ For assurance ☑ For information ☐

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

November 2014

One team shared values

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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **22nd DECEMBER 2014**

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

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

1.0 Introduction

The following report provides an overview of the November 2014 Quality & Performance report highlighting NTDA/UHL key metrics and escalation reports where required.

Performance for RTT indicators are not due for submission until next week and are subject to validation. Any minor amendments will be reflected in next month's Q&P.

Estates and Finance KPI's for November were not available at the time of producing the Quality & Performance report.

2.0 Performance Summary

Domain	Page Number	Number of Indicators	Indicators with target to be confirmed	Number of Red Indicators this month
Safe	4	19	2	2
Caring	5	15	1	2
Well Led	6	14	7	2
Effective	7	17	0	1
Responsive	8	26	0	16
Research	9	13	0	2
Estates & Facilities	10	10	0	0
Total		114	10	25

Exception reports:

Safe – CDIFF local target and avoidable pressure ulcers grade 2

Effective - #NOF

Responsive – ED (separate report), RTT, diagnostic waits, cancer waits, cancelled operations, choose and book, delayed transfers and ambulance handovers.

Research - Proportion of NHS Trusts recruiting each year into non-commercial NIHR CRN Portfolio studies, Proportion of NHS Trusts recruiting each year into commercial NIHR CRN Portfolio studies

3.0 Research - NIHR Clinical Research Network: East Midlands

UHL is the Host Organisation for the CRN: East Midlands. As Host, UHL will receive £22.3 million from the National Institute of Health Research (NIHR) to fund NIHR CRN Portfolio research across the East Midlands. Funding for 2014/15 has been distributed through 16 NHS Trusts and 19 Clinical Commissioning Groups. The Trust has established a CRN: East Midlands Executive Group chaired by Dr Kevin Harris. The purpose of the group is to oversee and deliver good governance of the CRN: East Midlands as defined by the Host contract and CRN Performance and Operating Framework. The framework outlines the key performance metrics for the Network. These include seven High Level Objectives (HLOs) and 8 Host Performance Indicators.

The dashboard on page 9 shows current Network performance against these metrics. Only 1 Host Performance Indicator is included in the dashboard, the remaining 7 are not monitored in year but assessed at the end of the financial year. These will be included in future reports as data becomes available.

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	YTD
Safe	S1a	Clostridium Difficile	RO	DJ	FYE = 81	NTDA	Red / ER for Non compliance with cumulative target	66	6	5	10	0	4	4	6	5	7	2	5	7	7	43
	S1b	Clostridium Difficile (Local Target)	RO	DJ	FYE = 50	UHL	Red >5 per month, ER when YTD red	66	6	5	10	0	4	4	6	5	7	2	5	7	7	43
	S2a	MRSA Bacteraemias (All)	RO	DJ	0	NTDA	Red = >0 ER = 2 consecutive mths >0	3	0	0	0	0	0	0	0	0	0	0	1	1	0	2
	S2b	MRSA Bacteraemias (Avoidable)	RO	DJ	0	UHL	Red = >0 ER = 2 consecutive mths >0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	S3	Never Events	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	3	0	0	0	1	0	0	0	0	0	0	0	1	0	1
	S4	Serious Incidents	RO	MD	tbc	NTDA	tbc	60	8	4	3	4	5	4	6	3	7	2	3	4	2	31
	S5	Proportion of reported safety incidents that are harmful	RO	MD	tbc	NTDA	tbc	2.8%			2.3%			1.7%			2.2%					1.9%
	S6	Overdue CAS alerts	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	2	0	0	0	0	0	2	2	2	3	0	0	0	0	9
	S7	RIDDOR - Serious Staff Injuries	RO	MD	FYE = <47	UHL	Red / ER = non compliance with cumulative target	47	4	4	7	2	5	3	5	1	2	2	1	2	2	18
	S8	Safety Thermometer % of harm free care (all)	RO	EM	tbc	NTDA	Red = <92% ER = in mth <92%	93.6%	93.9%	94.0%	93.8%	94.8%	93.6%	94.6%	94.7%	94.2%	94.9%	94.4%	93.9%	94.9%	93.3%	94.9%
	S9	% of all adults who have had VTE risk assessment on adm to hosp	KH	SH	95% or above	NTDA	Red = <95% ER = in mth <95%	95.3%	96.7%	96.1%	95.6%	95.0%	95.6%	95.7%	95.9%	95.9%	96.3%	95.5%	96.2%	95.4%	95.5%	95.8%
	S10	Medication errors causing serious harm	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	New NTDA Indicator - Definition to be confirmed														
	S11	All falls reported per 1000 bed stays for patients >65years	RO	EM	<7.1	QC	Red >= YTD >8.4 ER = 2 consecutive reds	7.1	7.0	7.0	6.6	7.0	6.9	6.6	7.4	7.0	8.2	7.4	5.6	5.6	6.6	6.8
	S12	Avoidable Pressure Ulcers - Grade 4	RO	EM	0	QS	Red / ER = Non compliance with monthly target	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	S13	Avoidable Pressure Ulcers - Grade 3	RO	EM	<8 a month	QS	Red / ER = Non compliance with monthly target	71	4	5	7	3	6	5	5	5	5	6	6	4	6	42
	S14	Avoidable Pressure Ulcers - Grade 2	RO	EM	<10 a month	QS	Red / ER = Non compliance with monthly target	120	8	5	10	8	9	6	6	6	7	9	4	8	13	59
	S15	Compliance with the SEPSIS6 Care Bundle	RO	MD	All 6 >75% by Q4	QC	Red/ER = Non compliance with Quarterly target	27.0%			27.0%			47.0%			Audit underway					47.0%
	S16	Nutrition and Hydration Metrics - Fluid Balance and Nutritional Assessment	RO	MD	Q2 80%, Q3 85%, Q4 90%	QC	Red >2% below threshold ER = 2 mths red							≥71%	≥77%	≥75%	Action Planning	≥74%	≥85%	≥84%		≥84%
	S17	Maternal Deaths	KH	IS	0	UHL	Red / ER = Non compliance with monthly target	3	0	0	1	2	0	0	0	0	0	0	0	0	0	0

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	YTD
Caring	C1a	Inpatient Friends and Family Test - Score	RO	CR	72 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	68.8	70.3	68.7	71.8	69.0	69.9	69.6	71.0	74.5	73.8	73.8	76.1	71.1	70.3	72.4
	C1b	Inpatient Friends and Family Test - Score (Local Target)	RO	CR	75	UHL	Red/ ER =<=69.9 Green >74.9	68.8	70.3	68.7	71.8	69.0	69.9	69.6	71.0	74.5	73.8	73.8	76.1	71.1	70.3	72.4
	C2a	A&E Friends and Family Test - Score	RO	CR	54 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	58.5	58.6	67.4	67.6	58.7	65.5	69.4	66.0	71.4	71.7	56.3	66.1	71.1	72.3	67.7
	C2b	A&E Friends and Family Test - Score (Local Target)	RO	CR	75	UHL	Red/ ER =<=64.9 Green >74.9	58.5	58.6	67.4	67.6	58.7	65.5	69.4	66.0	71.4	71.7	56.3	66.1	71.1	72.3	67.7
	C3	Outpatients Friends and Family Test - Score	RO	CR	75	UHL	Red / ER =<=64.9	New Indicator													58.7	58.7
	C4	Daycase Friends and Family Test - Score	RO	CR	75	UHL	Red / ER =<=69.9	New Indicator						79.0	80.2	79.7	77.5	74.3	81.7	80.1		78.9
	C5	Maternity Friends and Family Test - Score	RO	CR	75	UHL	Red/ ER =<=61.9	64.3	62.1	63.7	67.3	62.1	66.7	61.2	63.5	69.5	69.7	67.3	63.0	64.1	67.7	65.8
	C6	Complaints Rate per 100 bed days	RO	MD	tbc	NTDA	tbc		0.3	0.3	0.3	0.5	0.4	0.4	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.4
	C7	Complaints Re-Opened Rate	RO	MD	<9%	UHL	Red = >10% ER = 3 mths Red or any month >15%	New Indicator for 14/15						8%	5%	8%	11%	10%	9%	11%	11%	9%
	C8	Single Sex Accommodation Breaches	RO	CR	0	NTDA	Red = >0 ER = in mth >0	2	2	0	0	0	0	4	2	0	0	0	0	0	0	6
	C9	Improvements in the FFT scores for Older People (65+ year)	RO	CR	75	QC	Red / ER = End of Yr Targets non recoverable.	New Indicators for 14/15						73.7	73.2	75.7	76.1	78.5	83.0	76.4	72.9	76.0
	C10	Responsiveness and Involvement Care (Average score)	RO	CR	0.8 improve-ment	QC	tbc							87.6	87.5	87.5	87.8	88.1	88.4	87.4	87.9	87.8
	C10a	Q15. When you used the call button, was the amount of time it took for staff to respond generally:	RO	CR	FYE 89.7	QC	Red = <87.9 ER = Red or 3 mths deterioration							88.9	89.3	88.8	89.0	88.9	90.0	88.4	88.6	89.0
	C10b	Q16. If you needed help from staff getting to the bathroom or toilet or using a bedpan, did you get help in an acceptable amount of time?	RO	CR	FYE 92.9	QC	Red = <91.1 ER = Red or 3 mths deterioration							92.1	91.9	91.2	91.7	91.9	92.4	92.2	92.4	92.0
	C10c	Q11. Were you involved as much as you wanted in decisions about your care and treatment?	RO	CR	FYE 85.5	QC	Red = <83.6 ER = Red or 3 mths deterioration							84.6	84.3	84.9	84.9	85.6	85.2	84.6	85.1	84.9

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	YTD
Well Led	W1	Inpatient Friends and Family Test - Coverage	RO	CR	30% - Q4. 40% - Mar 15	NTDA / CQUIN	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	24.3%	25.4%	23.3%	24.5%	28.2%	28.8%	36.8%	38.1%	32.6%	30.8%	28.9%	33.4%	36.3%	36.0%	34.0%
	W2	A&E Friends and Family Test - Coverage	RO	CR	15% Q1-Q3 20% for Q4	NTDA	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	14.9%	18.4%	16.4%	15.6%	18.4%	16.1%	15.2%	17.8%	14.9%	10.2%	16.1%	19.1%	15.9%	14.0%	15.4%
	W3	Outpatients Friends and Family Test - Valid responses	RO	CR	tbc	UHL	tbc	New Indicator available from October 2014					271	175	286	1879	1535	785	927	1255	1506	8348
	W4	Maternity Friends and Family Test - Coverage	RO	CR	tbc	UHL	tbc	25.2%	30.3%	24.8%	20.9%	23.7%	23.9%	27.2%	36.4%	25.2%	29.2%	29.9%	18.7%	15.8%	21.7%	25.5%
	W5	Friends & Family staff survey: % of staff who would recommend the trust as place to work	KB	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed						53.6%			53.7%				53.7%
	W6	Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment	KB	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed						68.3%			67.2%				67.2%
	W7	Data quality of trust returns to HSCIC	KS	JR	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed														
	W8	Turnover Rate	KB	ES	<10.5%	UHL	Red = 11% or above ER = Red for 3 Consecutive Mths	10.0%	9.7%	10.2%	10.6%	10.4%	10.0%	9.9%	10.0%	10.2%	10.0%	10.5%	10.3%	10.8%	10.7%	10.7%
	W9	Sickness absence	KB	ES	> 3.5%	UHL	Red = >3.5% ER = 3 consecutive mths >3.5%	3.4%	3.5%	3.8%	3.8%	3.7%	3.5%	3.4%	3.3%	3.3%	3.4%	3.5%	3.8%	4.3%		3.6%
	W10	Total trust vacancy rate	KB	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed														
	W11	Temporary costs and overtime as a % of total paybill	KB	ES	tbc	NTDA	tbc	New Indicator for 14/15						9.4%	9.4%	8.1%	8.5%	8.9%	8.5%	9.5%	9.0%	8.9%
	W12	% of Staff with Annual Appraisal	KB	ES	95%	UHL	Red = <90% ER = 3 consecutive mths <90%	91.3%	91.8%	92.4%	91.9%	92.3%	91.3%	91.8%	91.0%	90.6%	89.6%	88.6%	89.7%	91.8%	92.3%	92.3%
	W13	Statutory and Mandatory Training	KB	ES	Jun 80%, Sep 85%, Dec 90%, Mar 95%	UHL	Red / ER for Non compliance with Quarterly incremental target	76%	60%	65%	69%	72%	76%	78%	79%	79%	80%	83%	85%	86%	87%	87%
	W14	% Corporate Induction attendance	KB	ES	95.0%	UHL	Red = <90% ER = 3 consecutive mths <90%	94.5%	87%	89%	93%	89%	95%	96%	94%	92%	96%	98%	98%	98%	98%	98%

Effective

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	YTD
E1	Mortality - Published SHMI	KH	PR	Within Expected	NTDA	Higher than Expected				107 (Jul12-Jun13)			106 (Oct12-Sept13)			106 (Jan13-Dec13)					106 (Jan13-Dec13)
E2	Mortality - Rolling 12 mths SHMI (as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive mths increasing SHMI >100	105	107	108	107	106	105	103	103	103	Awaiting HED Update					103
E3	Mortality HSMR (DFI Quarterly)	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	88			83			87			Awaiting DFI Update					83
E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	102	101	100	100	99	97	97	97	95	Awaiting HED Update				95
E5	Mortality - Monthly HSMR (Rebased Monthly as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	91	101	94	89	103	91	83	103	101	83	Awaiting HED Update				93
E6	Mortality - Rolling 12 mths HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	100	102	102	101	101	100	99	98	99	96	Awaiting HED Update				96
E7	Mortality - Monthly HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	100	107	95	93	102	94	86	95	105	80	Awaiting HED Update				91
E8	Mortality - rolling 12 mths HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	105	103	101	102	99	96	97	96	95	Awaiting HED Update				95
E9	Mortality - Monthly HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	93	93	84	106	82	71	128	87	93	Awaiting HED Update				95
E10	Deaths in low risk conditions	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	94	52	129	164	35	63	48	60	78	59	47				59
E11	Emergency 30 Day Readmissions (No Exclusions)	KH	PR	Within Expected	NTDA	Higher than Expected	7.9%	7.8%	8.0%	8.7%	9.0%	8.8%	8.8%	8.7%	8.6%	8.3%	8.9%	8.4%	8.6%		8.6%
E12	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	KH	RP	72% or above	QS	Red = <72% ER = 2 consecutive mths <72%	65.2%	73.6%	72.2%	68.2%	73.7%	54.7%	56.9%	40.6%	60.3%	76.9%	59.0%	68.6%	69.6%	59.4%	61.8%
E13	Stroke - 90% of Stay on a Stroke Unit	RM	CF	80% or above	QS	Red = <80% ER = 2 consecutive mths <80%	83.2%	78.0%	81.8%	89.3%	83.7%	83.5%	92.9%	80.3%	87.1%	78.1%	84.5%	82.2%	69.4%		81.6%
E14	Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA)	RM	CF	60% or above	QS	Red = <60% ER = 2 consecutive mths <60%	64.2%	76.8%	65.7%	60.5%	40.7%	77.9%	79.7%	58.8%	71.3%	62.8%	65.5%	72.7%	67.8%	69.0%	68.4%
E15	Communication - ED, Discharge and Outpatient Letters - Compliance with standards	KH	SJ	90% or above	QS	Red = <80% ER = Qrtly ER if <90% and deterioration	New Indicator for 14/15										60% (InPt)	83% (ED)	Poilcy out for consultation		83% (ED)
E16	Published Consultant Level Outcomes	KH	SH	>0 outside expected	QC	Red = >0 Quarterly ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
E17	Non compliance with 14/15 published NICE guidance	KH	SH	0	QC	Red = in mth >0 ER = 2 consecutive mths Red	New Indicator for 14/15						0	0	0	0	0	0	0	0	0

Responsive

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	YTD
R1	ED 4 Hour Waits UHL + UCC	RM	CF	95% or above	NTDA	Red = <95% ER via ED TB report	88.4%	88.5%	90.1%	93.6%	83.5%	89.3%	86.9%	83.4%	91.3%	92.5%	91.0%	91.6%	90.2%	88.6%	89.3%
R2	12 hour trolley waits in A&E	RM	CF	0	NTDA	Red = >0 ER via ED TB report	5	1	0	0	0	0	0	1	1	0	0	0	1	0	3
R3	RTT Waiting Times - Admitted	RM	CC	90% or above	NTDA	Red /ER = <90%	76.7%	83.2%	82.0%	81.8%	79.1%	76.7%	78.9%	79.4%	79.0%	80.9%	82.2%	81.6%	84.4%	85.5% Early View	85.5% Early View
R4	RTT Waiting Times - Non Admitted	RM	CC	95% or above	NTDA	Red /ER = <95%	93.9%	91.9%	92.8%	93.4%	93.5%	93.9%	94.3%	94.4%	95.0%	94.9%	95.6%	94.6%	94.9%	95.2% Early View	95.2%
R5	RTT - Incomplete 92% in 18 Weeks	RM	CC	92% or above	NTDA	Red /ER = <92%	92.1%	92.4%	91.8%	92.0%	92.6%	92.1%	93.9%	93.6%	94.0%	93.2%	94.0%	94.3%	94.8%	95.0% Early View	95.0%
R6	RTT 52 Weeks+ Wait (Incompletes)	RM	CC	0	NTDA	Red /ER = >0	0	0	1	1	0	0	0	0	0	15	1	3	3	2	2
R7	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	NTDA	Red /ER = >1%	1.9%	0.8%	1.4%	5.3%	1.9%	1.9%	0.8%	0.9%	0.8%	0.7%	1.0%	1.0%	0.7%	1.8%	1.8%
R8	Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	RM	MM	93% or above	NTDA	Red = <93% ER = Red for 2 consecutive mths	94.8%	95.7%	94.9%	95.3%	95.9%	95.3%	88.5%	94.7%	93.5%	92.2%	92.0%	90.6%	92.0%		91.9%
R9	Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	RM	MM	93% or above	NTDA	Red = <93% ER = Red for 2 consecutive mths	94.0%	91.3%	95.5%	96.8%	93.4%	94.3%	80.0%	95.0%	98.9%	94.9%	94.4%	95.2%	98.6%		94.9%
R10	31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	RM	MM	96% or above	NTDA	Red = <96% ER = Red for 2 consecutive mths	98.1%	96.2%	97.4%	97.2%	98.5%	98.2%	97.2%	92.9%	93.6%	94.4%	97.9%	91.9%	95.9%		94.8%
R11	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	RM	MM	98% or above	NTDA	Red = <98% ER = Red for 2 consecutive mths	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0%	97.1%		99.4%
R12	31-Day Wait For Second Or Subsequent Treatment: Surgery	RM	MM	94% or above	NTDA	Red = <94% ER = Red for 2 consecutive mths	96.0%	97.1%	92.3%	94.8%	96.4%	98.6%	95.2%	97.0%	90.8%	90.1%	87.8%	94.0%	81.9%		90.6%
R13	31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	RM	MM	94% or above	NTDA	Red = <94% ER = Red for 2 consecutive mths	98.2%	98.5%	98.1%	94.8%	96.3%	99.1%	97.3%	95.6%	93.9%	97.3%	99.0%	96.5%	96.0%		96.6%
R14	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	RM	MM	85% or above	NTDA	Red = <85% ER = Red in mth or YTD	86.7%	85.7%	89.4%	89.1%	89.1%	92.4%	92.7%	88.5%	73.1%	85.6%	78.8%	75.5%	80.4%		81.8%
R15	62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	RM	MM	90% or above	NTDA	Red = <90% ER = Red for 2 consecutive mths	95.6%	97.0%	96.6%	97.1%	95.1%	91.7%	91.1%	67.4%	73.9%	73.0%	100.0%	87.5%	75.0%		80.6%
R16	Urgent Operations Cancelled Twice	RM	PW	0	NTDA	Red = >0 ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
R17	Cancelled patients not offered a date within 28 days of the cancellations UHL	RM	PW	0	NTDA	Red = >2 ER = >0	85	4	8	9	2	8	10	3	1	1	1	2	2	1	21
R18	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	RM	PW	0	NTDA	Red = >2 ER = >0	New Indicator for 14/15						0	0	0	0	6	0	0	1	7
R19	% Operations cancelled for non-clinical reasons on or after the day of admission UHL	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	1.6%	1.8%	1.7%	1.6%	2.1%	1.5%	1.1%	0.8%	1.1%	0.7%	0.6%	0.9%	0.8%	1.2%	0.9%
R20	% Operations cancelled for non-clinical reasons on or after the day of admission ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	1.6%	1.8%	1.7%	1.6%	2.1%	1.5%	0.6%	0.6%	0.3%	2.7%	0.0%	0.9%	1.0%	0.0%	0.8%
R21	% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	New Indicator for 14/15						1.1%	0.8%	1.0%	0.9%	0.6%	0.8%	0.8%	1.1%	0.9%
R22	No of Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	N/A	UHL	tbc	1739	172	141	152	178	139	106	77	98	94	55	90	94	108	722
R23	Delayed transfers of care	RM	PW	3.5% or below	NTDA	Red = >3.5% ER = Red for 3 consecutive mths	4.1%	4.4%	3.6%	4.6%	4.3%	3.8%	4.4%	4.2%	4.0%	3.9%	3.9%	4.5%	4.6%	5.2%	4.3%
R24	Choose and Book Slot Unavailability	RM	CC	4% or below	Contract	Red = >4% ER = Red for 3 consecutive mths	13%	17%	14%	10%	16%	19%	22%	25%	26%	25%	26%	25%	20%	17%	23%
R25	Ambulance Handover >60 Mins (based on weekly figures)	RM	CF	0	Contract	Red = >0 ER = Red for 3 consecutive mths	868	59	102	52	207	111	173	253	88	71	50	106	253	235	1,229
R26	Ambulance Handover >30 Mins and <60 mins (based on weekly figures)	RM	CF	0	Contract	Red = >0 ER = Red for 3 consecutive mths	7,075	689	722	573	818	601	720	951	671	591	805	736	1,147	1,072	6,693

Research

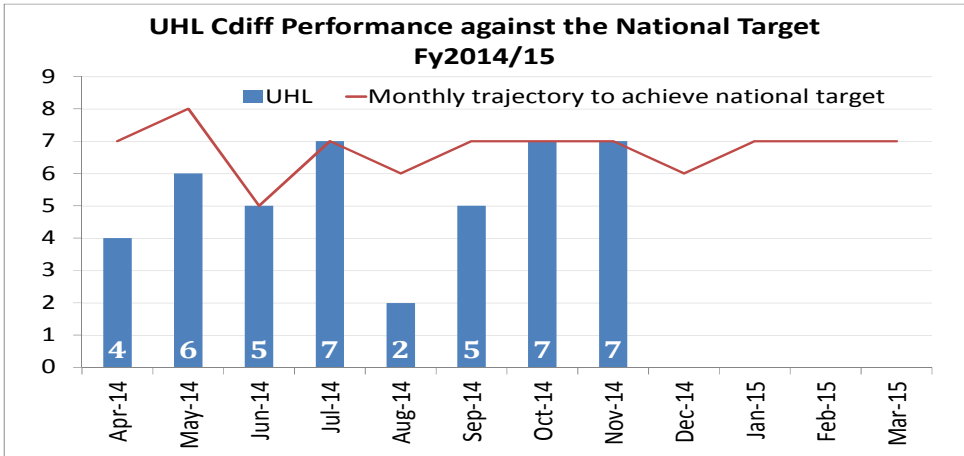
KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Sep-14	Oct-10	Nov-10	YTD
RS1	Number of participants recruited in a reporting year into NIHR CRN Portfolio studies	KH	DR	England 650,000 East Midlands 50,000	NIHR CRN	Red / ER = <90%	92%	93%	94%	94%
RS2a	A: Proportion of commercial contract studies achieving their recruitment target during their planned recruitment period.	KH	DR	England 80% East Midlands 80%	NIHR CRN	Red / ER = <60%	67%	64%	68%	68%
RS2b	B: Proportion of non-commercial studies achieving their recruitment target during their planned recruitment period	KH	DR	England 80% East Midlands 80%	NIHR CRN	Red / ER = <60%	81.0%	81.0%	73%	73%
RS3a	A: Number of new commercial contract studies entering the NIHR CRN Portfolio	KH	DR	600	NIHR CRN	tbc				
RS3b	B: Number of new commercial contract studies entering the NIHR CRN Portfolio as a percentage of the total commercial MHRA CTA approvals for Phase II-IV studies	KH	DR	75%	NIHR CRN	Red <75%				
RS4	Proportion of eligible studies obtaining all NHS Permissions within 30 calendar days (from receipt of a valid complete application by NIHR CRN)	KH	DR	80%	NIHR CRN	Red <80%	90.0%	89.0%	84.0%	84.0%
RS5a	A: Proportion of commercial contract studies achieving first participant recruited within 70 calendar days of NHS services receiving a valid research application or First Network Site Initiation Visit	KH	DR	80%	NIHR CRN	Red <80%				
RS5b	B: Proportion of non-commercial studies achieving first participant recruited within 70 calendar days of NHS services receiving a valid research application	KH	DR	80%	NIHR CRN	Red <80%				
RS6a	A: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio studies	KH	DR	England 99% East Midlands 99%	NIHR CRN	Red <99%	81.0%	81.0%	81.0%	81.0%
RS6b	B: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio commercial contract studies	KH	DR	England 70% East Midlands 70%	NIHR CRN	Red <70%	56.0%	56.0%	56.0%	56.0%
RS6c	B: Proportion of General Medical Practices recruiting each year into NIHR CRN Portfolio studies	KH	DR	England 25% East Midlands 25%	NIHR CRN	Red <25%	45.0%	45.0%	51.0%	51.0%
RS7	Number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	KH	DR	England 13500 East Midlands 510	NIHR CRN	Red <510 Q4	325	438	448	448
RS8	Deliver robust financial management using appropriate tools - % of financial returns completed on time	KH	DR	England 100% East Midlands 100%	NIHR CRN	Red <100%	100% *Q2			100% *Q2

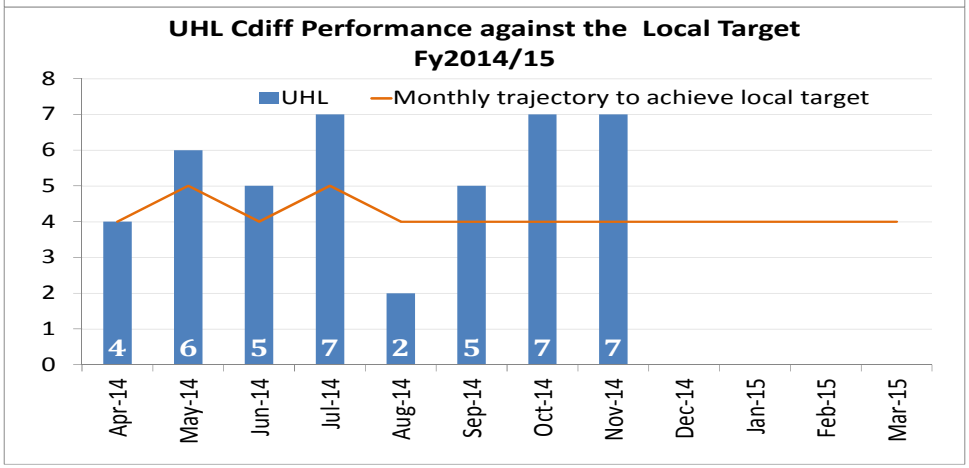
Estates and Facilities

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Sep-14	Oct-14	YTD
E&F1	Percentage of statutory inspection and testing completed in the Contract Month measured against the PPM schedule.	AC	GL	100%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	100.0%
E&F2	Percentage of non-statutory PPM completed in the Contract Month measured against the PPM schedule	AC	GL	100%	Contract KPI	Red = ≤ 80%	91.5%	81.2%	81.2%
E&F3	Percentage of Estates Urgent requests achieving rectification time	AC	LT	95%	Contract KPI	Red = ≤ 75%	100.0%	100.0%	100.0%
E&F4	Percentage of scheduled Portering tasks completed in the Contract Month	AC	LT	99%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	100.0%
E&F5	Number of Emergency Portering requests achieving response time	AC	LT	100%	Contract KPI	Red = >2	0	0	0
E&F6	Number of Urgent Portering requests achieving response time	AC	LT	95%	Contract KPI	Red = ≤ 95%	95.1%	96.2%	96.2%
E&F7	Percentage of Cleaning audits in clinical areas achieving NCS audit scores for cleaning above 90%	AC	LT	100%	Contract KPI	Red = ≤ 98%	100.0%	99.1%	99.1%
E&F8	Percentage of Cleaning Rapid Response requests achieving rectification time	AC	LT	92%	Contract KPI	Red = ≤ 80%	99.6%	89.9%	89.9%
E&F9	Percentage of meals delivered to wards in time for the designated meal service as per agreed schedules	AC	LT	97%	Contract KPI	Red = ≤ 95%	99.4%	99.5%	99.5%
E&F10	Overall percentage score for monthly patients satisfaction survey for catering service	AC	LT	85%	Contract KPI	Red = ≤ 75%	96.7%	97.3%	97.3%

S1b – CDIFF local target

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
The cases of CDT have been the subject of Root Cause Analysis and there are no discernible factors that link these cases. All occurred in different locations within the trust. In line with the 'updated guidance in the diagnosis and reporting of Clostridium difficile' the cases have been sent to Commissioning Group that has been established to review each case individually. The comments from this group will be received within seven working days. This process commenced in October and sample positive cases that are the subject of RCA will be sent monthly for review.	Action plans that have resulted from the RCA are to be presented to the CMG Infection Prevention Groups and will follow the RCA process flow chart as described in the Infection Prevention Toolkit	5	7	43	N/A





Expected date to meet standard / target	TBA
Revised date to meet standard	TBA
Lead Director / Lead Officer	Elizabeth Collins

S14 - Avoidable Pressure Ulcers – Grade 2

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
Grade 3 and Grade 4 pressure ulcers are within the agreed trajectory and are included in the exception report for information. There has been an increase in avoidable pressure Grade two pressure ulcers in Nov 14. (5 ESM, 3 RRC, 3 CHUGGS, 2 MSS) There are 4 Grade 2 pressure ulcers above trajectory, further analysis indicates that 3 are as a result of device damage ie oxygen tubing pressure to the ears and catheter tubing pressure to sacrum. There has been an increase in reporting of such pressure ulcers following an internal awareness campaign. All pressure ulcer incidents have been subject to internal validation. There is insufficient evidence in 6 cases to confirm whether the ulcer was unavoidable for this month due to insufficient evidence these have been reported as avoidable The common themes identified for November in the development of avoidable ulcers include:- • Gaps in documentation • Pressure damage as a result of medical devices x 3 • Limited or lack of analysis of patient factors, such as condition of the patient and external influences which affect the delivery of care. • Limited evidence that lessons from previous incidents has been Implemented	From November 2014, oversight and management of the tissue viability service transferred to the Head of Safeguarding. Keys messages from the November performance will be shared with Heads of Nursing. Further work to improve the quality of validation reports has commenced, and key learning is shared monthly across nursing forums. Work is ongoing to monitor performance, and if prevalence remains above trajectory a further plan of action will be developed	**G2 = ≤9 per mth** **G3 = ≤7 per mth** **G4 = 0 per mth**	**G2 = 13** **G3 = 6** **G4 = 0**	**G2 = 57** **G3 = 37** **G4 = 0**	**tbc**

Table one - Avoidable Grade 2 Pressure Ulcers April - November 2014

Trajectory for Grade 2 Avoidable Pressure Ulcers 2014/15													
Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Trajectory	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	
Incidence	6	6	6	7	9	4	8	13					**59**

Table two - Avoidable Grade 3 Pressure Ulcers April - November 2014

Trajectory for Grade 3 Avoidable Pressure Ulcers 2014/15													
Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Trajectory	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	
Incidence	5	5	5	5	6	6	4	6					**42**

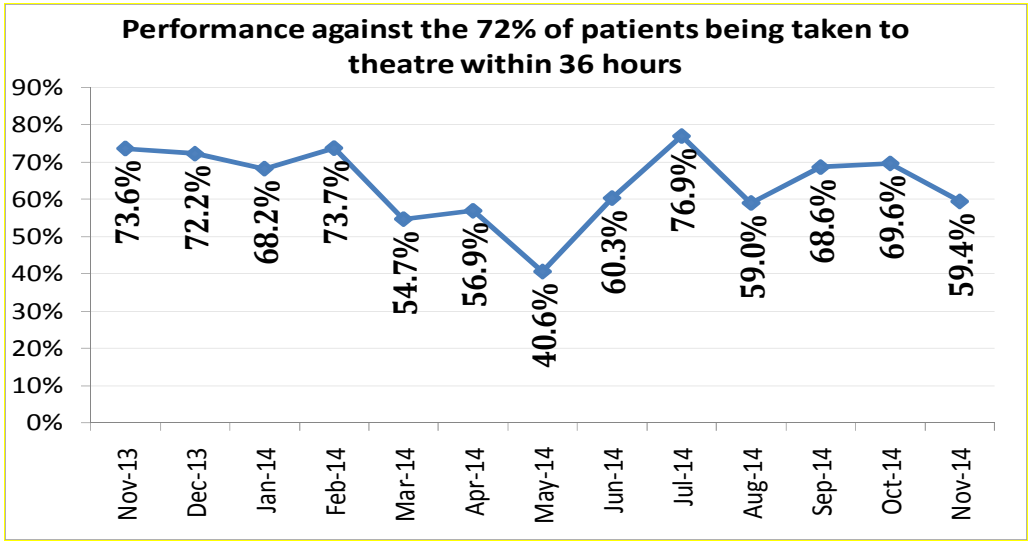
Table three - Avoidable Grade 4 Pressure Ulcers April - November 2014

Trajectory for Grade 4 Avoidable Pressure Ulcers 2014/15													
Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Trajectory	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Incidence	0	0	0	0	0	0	0	0					**0**

Expected date to meet standard / target	Dec 14
Revised date to meet standard	
Lead Director / Lead Officer	Carole Ribbins/Michael Clayton

E12 – No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
Whilst the 'time to surgery within 36 hours' threshold was achieved for July and there has been an improvement since Quarter 1, it is still below the 72% threshold year to date Admissions for September to December are high with October and November seeing admission of 144 patients. There is still significant in month variability with peak weeks in September, October and November seeing over 20 admissions with a large proportion arriving in one day. This sort of activity flux is difficult to plan for from a ward bed and theatre capacity point of view.	An action plan has been drafted which details the work that is currently being scoped and implemented. Specific blockers include Theatre List start and finish times, Orthogeriatric capacity and Theatre process delays. A Listening into Action application has been submitted in the hope that this will support the specialty and CMG with getting greater input and sign up from all of the pathway stakeholders and lead to quicker implementation of changes that are already recognised as essential. The specialty are looking at pathway improvements which reduce the demand in other areas such as fracture clinic which would positively impact on the ability to see patients in a more timely way when they are admitted with a fractured neck of femur. The influx of spinal activity has had an effect on the capacity to operate on other trauma cases including #NOF patients. Extension of theatre lists to accommodate displaced activity has been difficult to arrange at short notice due to anaesthetic and theatre staffing.	**72%**	**59.4%**	**61.8%**	



Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3 (Oct&Nov)	14/15 Q4
65%	52%	68%	63%	

Expected date to meet standard / target	December 2014
Revised date to meet standard	March 2015
Lead Director / Lead Officer	Richard Power, MSS CD / Maggie McManus, MMS Deputy CMG Manager

R3, R4 and R6 Referral to Treatment – Admitted, Non-Admitted and 52+ Weeks

Introduction

RTT plans in the Trust have made good progress but clearly there is more to do. Achievement of the RTT standards remains a priority for the organisation in a challenging environment. Speciality level plans have been shared with CCGs with the assumptions they are build on. A number of these remain at risk but are being worked through by the CMGs. The trajectories for both backlog reduction and future RTT performance is an output of these assumptions.

Progress made

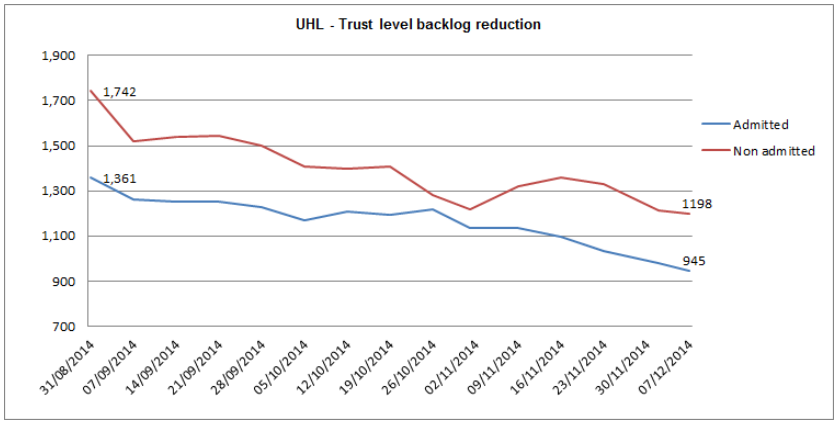
Performance at the end of November is as follows:

Performance	Target	UHL only	UHL and Alliance
Admitted	**90%**	**83.8%**	**85.5%**
Non admitted	**95%**	**94.7%**	**95.2%**
Incompletes	**92%**	**94.3%**	**94.9%**

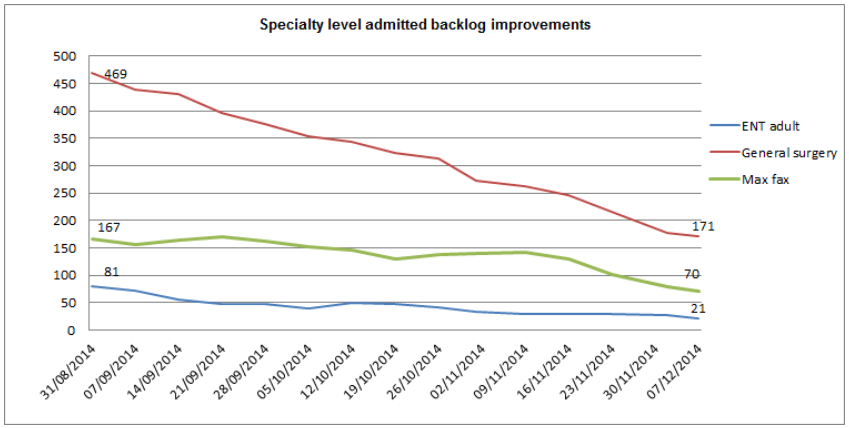
There were 2 patients waiting over 52 weeks at the end of November, both were treated in early December.

The graph below shows the total Trust level reductions in both non-admitted and admitted backlogs. These significant backlog reductions have been achieved by a combination of actions including the following:

- Additional elective and outpatient activity , within hours and at weekends at UHL
- A limited amount of outsourcing of both electives and outpatients to other providers
- Ongoing waiting list validation to 14 weeks



Speciality specific admitted backlog reductions are demonstrated in the graph below.



Problems

Increased referral rates

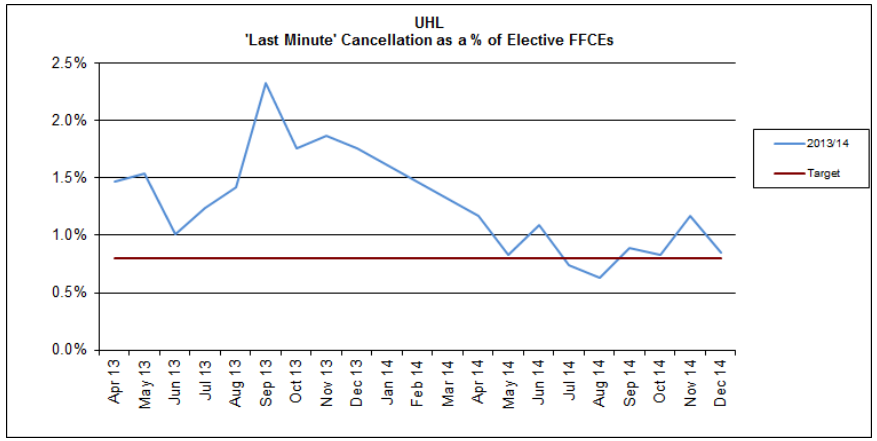
A number of RTT specialities have seen an increase in GP referrals which will have impacted on the ability of the speciality to deliver RTT performance. These are in the table below showing increases of greater than 3% (April to November 2013 v 2014)

Specialty	2013/2014	2014/2015	Variance	% Variance
ENT	5,622	5,859	237	4.20%
Gastroenterology	4,214	4,994	780	18.50%
General Surgery	4,786	5,285	499	10.40%
Maxillofacial Surgery	4,865	5,044	179	3.70%

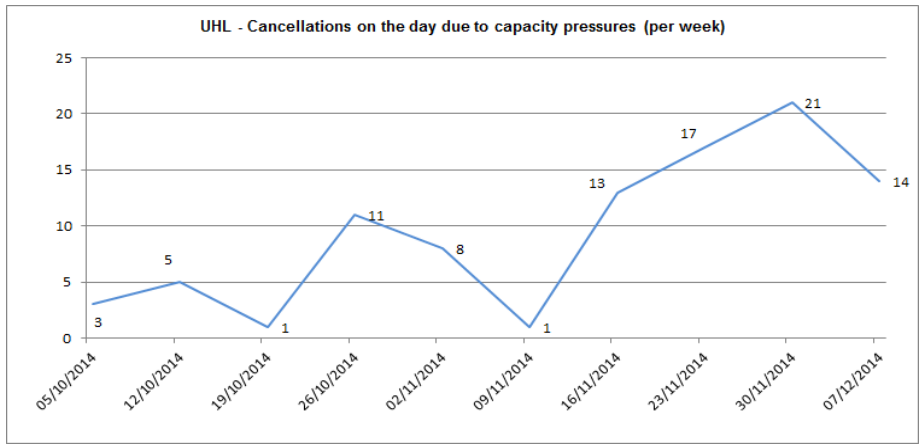
Although there has been no overall increase in MSK referrals during this period, during the 3 months September to November 2014, compared to the same period in 2013 there was an increase of 9%. This fluctuation in levels of referrals is difficult to manage on a month by month basis, the impact of increases is immediately felt on new OPD capacity, any impact on RTT backlog is clearly not seen until 18 weeks later.

Cancelled operations

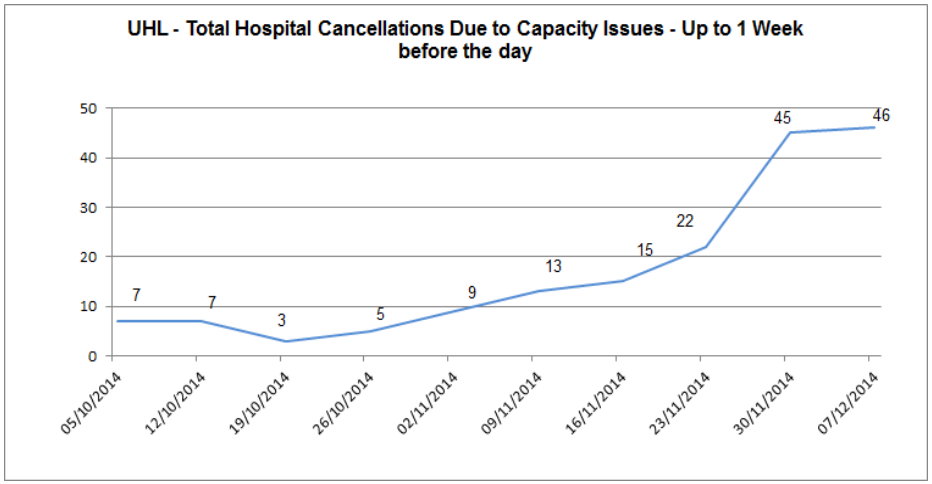
The Trust has made significant improvements in reducing the number of cancellations on the day over the past 12 months, this is demonstrated by the graph below.



Since October 1st there has been an increase in the number of operations cancelled on the day due to capacity pressures (94 in total), with a notable increase in November and into December. The impact of this being particularly on the paediatric specialities, a direct result of increased winter related admissions in paediatrics. See graph below.



The Trust has been proactively managing these cancellations by making earlier decisions to reduce elective capacity. There has been a marked increase of this in past 2 weeks, with 39 of the 91 patients cancelled within 1 week of TCI being paediatric patients. See graph below:



The impact of this during the winter period will be a growing backlog of the affected RTT specialities with increased waiting times.

Forecast recovery

The forecast is based on a number of assumptions within the speciality plans which the CMGs are working iteratively to firm up to reduce the risks associated with them.

	Dec-14	Jan-15	Feb-15	Mar-15
Admitted (including Alliance)	85%	83%	90%	90%
Non admitted (including Alliance)	95%	95%	95%	95%

The anticipated reduction in admitted performance in January is due to the anticipated continued backlog reduction

Further actions

- Ongoing additional inpatient and outpatient activity in UHL and within the Independent sector.
- All currently achieving specialities to continue to achieve at current rate or above.
- Specialities with small numbers of monthly breaches are tasked with eradicating backlogs in January.
- Specific targeting list to ensure patients booked beyond breach are brought forward wherever possible.
- Ongoing validation of all specialities to 14 weeks RTT.

R6 - 6 Week Diagnostics Tests Waiting Time

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Standard</th><th>November 2014</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="5">The Trust is measured on the waiting times of the top 15 diagnostic modalities reported at the end of each month.

NB: these modalities cross all CMG's

There are a number of factors that have caused this underperformance:

Imaging (accounting for 26% of breaches)

- Cardiac CT and MRI, there remains insufficient capacity – this is ongoing issue and these are supervised scans so need consultant radiologist availability
- MSK MRI , these are consultant specific test

Dexa (accounting for 36%of breaches)
- During November there was a system failure resulting in the breaching of the standard. No alternative capacity available

Endoscopy (accounting for 22% of breaches)
- Colonoscopy / Flexi sigmoidoscopy / Gastroscopy

Additionally, there were small volumes of breaches of the standard in a number of other modalities.

Collectively these have caused a breach of the standard a total of 219 patients waiting over 6 weeks.</td><td rowspan="5">Cardiac CT and MRI

Additional sessions being carried out by cardiologists during December to February. With a business case for substantive capacity increase going to the CMG board in January

MSK imaging capacity

New MSK radiologist starts in January 20I5

Dexa

Scanner now repaired. Contingency plan between Imaging and Rheumatology being finalised

All other modalities

Robust waiting list management, additional capacity where there is risk of breaching , dating patients in date order</td><td><1% over 6 weeks</td><td>1) UHL 2.0%
2) UHL and Alliance combined 1.8%</td><td>1.8%</td><td><1.0%</td></tr>
<tr><td colspan="4">Risks:
There remain risks to achievement of this standard due to the instability of a number of diagnostic modalities which collectively make up this standard.</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">November 2014</td></tr>
<tr><td colspan="2">Revised date to meet standard</td><td colspan="2">December 2014</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Richard Mitchell
Suzanne Khalid / Jo Fawcus / Jane Edyvean</td></tr>
</table>

R8, R10, R12, R14 and R15 - Cancer Waiting Times Performance

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance October	Performance to date 2014/15	Forecast performance for November
R8 1) There has been an annualised increase of 18% in 2WW suspected cancer referrals in 2014/15 to date 2) This is likely to continue to grow 3) This has not been matched by increased provision of carved out availability, nor sufficient response to individual cancer type awareness campaigns **R10, 12, 14, 15** The system for the integration of complex cancer pathways remains in place (**R14, R15**) Access to cancer diagnostics remains good. The delivery of timely treatments (**R10, R12**) lies within the gift of services for surgery, and the oncology department for chemotherapy and radiotherapy. Chemotherapy and radiotherapy treatments have remained timely for the most part. The issue is adequate access to surgical capacity. There is no shortage of overall surgical capacity, the poor performance results from the failure to appropriately prioritise cancer pathways in the face of competing priorities.	The actions recommended by the Cancer Centre to the trust are; 1) Build in 20% increase in capacity upon current demand year on year and carve this out for 2WW referrals 2) Direct CMGs and services to produce and work to SOPs which prioritise cancer 3) That weekly Cancer Action Board meetings are attended by CMG general managers or their deputies 4) That there is executive representation at the weekly Cancer Action Board The actions taken include; 1) Work streams with the commissioners to rationalise 2WW demand (interactive 2WW forms to improve compliance with guidelines and CCG policing of inappropriate referrals) 2) Focus on tumour site specific issues with the relevant CMG and service managerial and clinical leads **Addendum 15.12.14** Please note these actions now form the basis of the recommended response to the CCG contract query notice for cancer performance	**R8 2WW 93%**	**92%**	**91.9%**	**91.3%**
		R10 31 day 1st 96%	**95.9%**	**94.8%**	**89.7%**
		R12 31 day sub (Surgery) 94%	**81.9%**	**90.6%**	**68%**
		R14 62 day RTT 85%	**80.4%**	**81.8%**	**77.9%**
		R15 62 screening 90%	**75%**	**80.6%**	**85.7%**

Performance by Quarter

	13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
R8	94.8%	92.2%	91.6%		
R10	98.1%	94.6%	94.6%		
R12	98.2%	94.2%	90.5%		
R14	86.7%	84.1%	79.9%		
R15	95.6%	78%	85%		

Expected date to meet standard / target	R8 – Recovery possible December R10,12 – Recovery possible January '15 R14,15 – Recovery possible February '15
Revised date to meet standard	Each target has slipped one month since the last report
Lead Director / Lead Officer	Richard Mitchell Matt Metcalfe

R17 – R22 Operations Cancelled on the Day and 28 Day Re-books

Operations cancelled on the day for Non-clinical reasons					
Performance indicators	**What actions have been taken to improve performance?**	**Target (mthly) 1)On day= 0.8% 2) 28 day = 0**	**Latest month performance – Oct 14**	**YTD performance (inc Alliance)**	**Forecast performance for next reporting period**
The cancelled operations target comprises of three components: 1.The % of cancelled operations for non clinical reasons on the day of admission 2.The number of patients cancelled who are offered another date within 28 days of the cancellation 3. The number of urgent operations cancelled for a second time.	The key action is to ensure on-going performance is the daily expediting of patients at risk of cancellation on the day, following the UHL cancelled escalation policy. For those cancelled on the day, it is vital that they adhere to the Trust policy of escalating to CMG General Managers for resolution prior to agreeing any cancellations. A number of work streams have started to reduce cancellations including a LIA project. 29% (31/108) of the on the day cancellations were due to ward bed unavailability. High emergency pressures 18 paediatric patients to be cancelled in November. <u>Risks to delivery of recovery plan</u> Paediatric bed availability is still a high risk to on the day cancellations. The situation has been monitored on a daily basis to prevent on the day cancellations, by cancelling patients electively whenever possible. There are significant risks to reducing cancellations on the day. These are mainly associated with bed availability and emergency patients taking priority. The high number of paediatric cancellations on November is a high risk to 28 day breaches in December.	UHL 1) 1.2% 2) 1	UHL 1) 0.8% 2) 2	UHL + Alliance 1) 0.89% 2) 28	UHL 1) 0.8% 2) 0

UHL performance against standards

1. The percentage of operations cancelled on/after the day for non-clinical reasons during November 2014 was 1.2% *(108/9271)* against a target of 0.8%.

2. One patient breached on the 28 day target in November 2014. The patient was a complex case required a very rare drug. The patients is booked for treatment in December.

3. The number of urgent operations cancelled for a second time ; zero

Alliance performance

0.0% *(0/875)* cancelled on the day. One breaches of the 28 day standard.

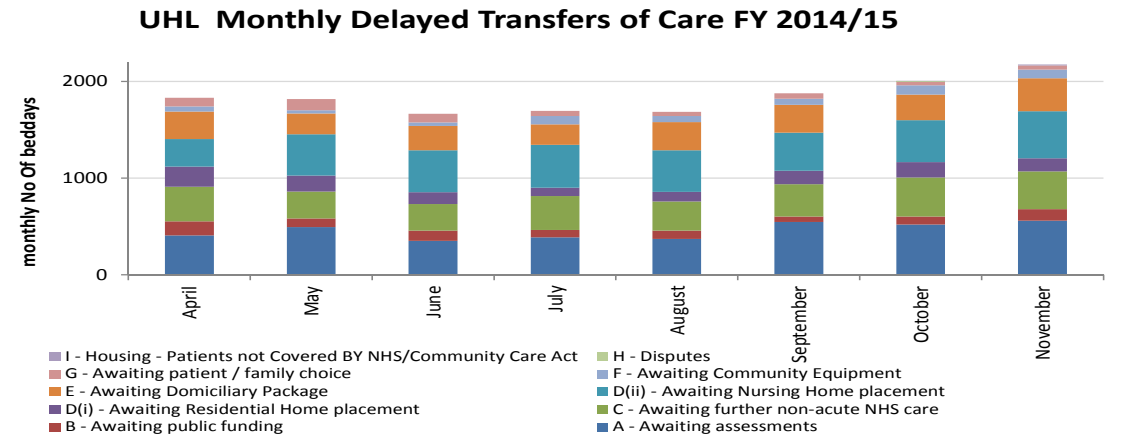
13/14 FYE	**14/15 Q1**	**14/15 Q2**	**14/15 Q3**	**14/15 Q4**
1.6%	0.97%	0.8%		

Expected date to meet standard / target	1) December 2014 2) December 2014
Revised date to meet standard	2) December 2014
Lead Director / Lead Officer	Richard Mitchell Phil Walmsley

R23 Delayed Transfers of Care

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
There has been an increase in delays due to DTOC in November. There remain concerns over availability of packages of care in the County Local Authority. This can be seen with the increase in bed days allocated to 'Awaiting domiciliary care'. There continue to be a number of DTOCs due to slow discharges to care homes. This is caused by families being slow to find appropriate care homes, care homes being slow to come in to assess the patient as suitable or waiting for a bed to become available.	ICRS and ICS teams continue to attend wards to identify patients that they could take directly in to their home based services. This has been particularly successful with the City services and lessons learnt are being discusses with county colleagues Further discussions are taking taken place with local commissioners regarding extending current actions to reduce the rate of DTOC. A team of staff have been commissioned by UHL to provide interim care for patients waiting to go home, starting in December. This has been an on-going issue with progressing discharges so it is expected that this will help speed up discharges	3.5%	5.2%	4.3%	4.8%

Row Labels	A - Awaiting assessments	B - Awaiting public funding	C - Awaiting further non-acute NHS care	D(i) - Awaiting Residential Home placement	D(ii) - Awaiting Nursing Home placement	E - Awaiting Domiciliary Package	F - Awaiting Community Equipment	G - Awaiting patient / family choice	H - Disputes	I - Housing - Patients not Covered BY NHS/Community Care Act	Grand Total
April	407	148	356	207	285	285	55	87			1830
May	494	90	277	166	425	218	34	113			1817
June	353	103	277	122	433	253	36	89			1666
July	387	77	353	82	444	215	85	54			1697
August	371	87	302	98	430	294	61	41			1684
September	546	57	333	141	394	286	65	57			1879
October	520	84	402	159	434	266	95	40	4	3	2007
November	561	119	392	134	484	343	88	46		9	2176
Grand Total	**3639**	**765**	**2692**	**1109**	**3329**	**2160**	**519**	**527**	**4**	**12**	**14756**



Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3 to date	14/15 Q4
4.1%	4.2%	4.1%	4.9%	

Expected date to meet standard / target	TBA
Revised date to meet standard	TBA
Lead Director / Lead Officer	Richard Mitchell/Phil Walmsley

R24 Choose and Book

<table>
<tr><td></td><td></td><td>Target</td><td></td><td></td><td></td></tr>
<tr><td>What is causing underperformance?</td><td>What actions have been taken to improve performance?</td><td><4% ASI</td><td>October</td><td>YTD performance</td><td>Forecast performance for next reporting period</td></tr>
<tr><td rowspan="5">The Trust is measured on the % of Appointment Slot Unavailability (ASI) per month.

The Trust has not met the required the <4% standard for circa 2 years and where it has met this standard it has been unable to maintain it for consecutive months.

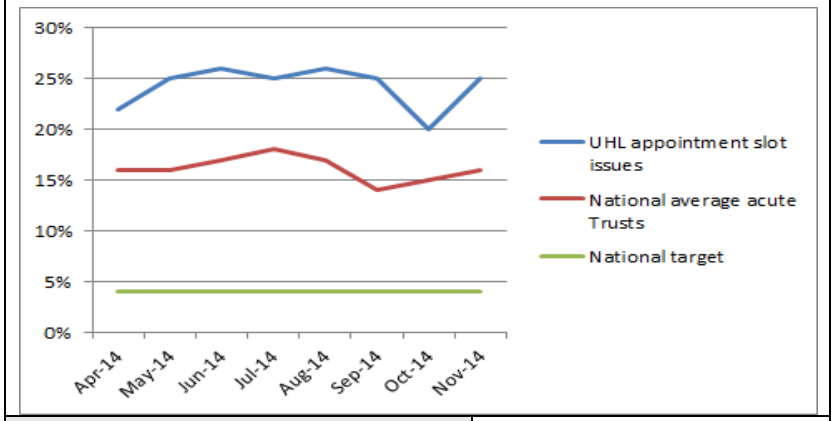
The two most significant factors causing underperformance are:

- Shortage of capacity in outpatients
- Inadequate recurrent training and education of administrative staff in the set up and use of the choose and book process

The appointment slot issues have increased in November after a promising reduction on October Notably: General Surgery and orthopaedics.
.</td><td rowspan="5">Capacity

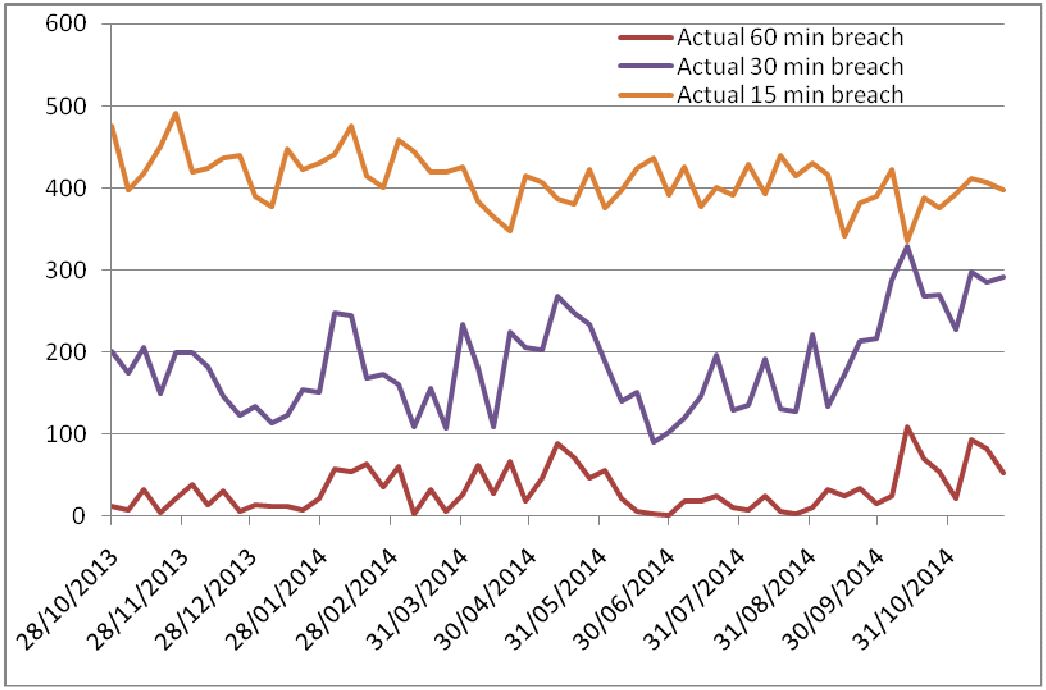
Additional capacity in key specialties is part of the RTT recovery plans

Training and education

The comprehensive training and education of relevant staff in key specialties continues, to ensure that choose and book is correctly set up and that supporting administrative purposes are fit for purpose.
A speciality level ‘score card’ to highlight areas required for improvement is now being distributed weekly to CMGs.</td><td><4%</td><td>UHL - 25%</td><td>UHL -25%</td><td>UHL - 20%</td></tr>
<tr><td colspan="4">National performance varies significantly by Trust, with average performance of Acute Trusts nationally at 16% in November
 
</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">January 2014</td></tr>
<tr><td colspan="2">Revised date to meet standard</td><td colspan="2">March 2014</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Richard Mitchell
Charlie Carr</td></tr>
</table>

R25 and R26 Ambulance Handover > 30 Minutes and > 60 Minutes

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
Pressures in accessing beds continue to lead to a backlog in the assessment area of ED. This delays movement out of the assessment area and delays handover. This has been made worse by higher number of acutely unwell patients. Patterns of ambulance attendance continue to show grouping of arrivals. This also compounds the issue	An audit of patients being handed over in resuscitation is currently under way. This will inform the time that EMAS can be allocated for handover after a patient has been in resuscitation. New processes in ED regarding booking in patient are being reinforced with EMAS. A review of the over 60 minute delays on the 14th October shows considerable discrepancy with the EMAS data. This audit will be repeated in the w/c 22/12/15 with EMAS present to agree where the issues may lie. The discrepancy may lie with different collection points in the patient journey, but it appears that there are also significant issues with difference in times recorded against handover. The ambulance audit staff in ED will be working closely with the Hospital Ambulance Liaison Officer to highlight best practice and ensure that this is applied across all ambulance staff.	0 delays over 30 minutes	> 60 min 6% 30-60 min – 24%	> 60 min 3% 30-60 min – 17%	



Expected date to meet standard / target	
Revised date to meet standard	
Lead Director / Lead Officer	Richard Mitchell

RS6A : Proportion of NHS Trusts recruiting each year into non-commercial NIHR CRN Portfolio studies

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
Proportion of NHS Trusts recruiting each year into non-commercial NIHR CRN Portfolio studies There are 16 Trusts within the East Midlands region, with 13 Trusts currently reporting recruitment. The three who have not reported any recruitment are: • East Midlands Ambulance Service NHS Trust (EMAS) • Derbyshire Community Health Services NHS Foundation Trust (DCHS) • Lincolnshire Community Health Services (LCHS)	1. EMAS: have received funding for a Research Paramedic. This post currently supports two NIHR Portfolio studies that do not report recruitment in the traditional way due to patient assent taken rather than consent. EMAS have four studies in the pipeline that are due to open this financial year that will report participant recruitment. 2. DCHS: this Trust is unlikely to have recruitment directly attributed as all the studies that are supported by funded staff, occur in primary care settings. Therefore the recruitment will be allocated to a Clinical Commissioning Group within the East Midlands. 3. LCHS: this Trust supports several studies however the consent event occurs in the primary care setting so the recruitment is attributed to Clinical Commissioning. There is scope for research within the community services (paediatrics, district nursing) that is being investigated.	**99%**	**81% (red)**	**81% (red)**	**81%**

Expected date to meet standard / target	It is unlikely we will make the 99% target due to the nature of the services provided by DCHS and LCHS. We are likely to reach 85% by April 2015.
Revised date to meet standard	
Lead Director / Lead Officer	Elizabeth Moss, Chief Operating Officer

RS6b Proportion of NHS Trusts recruiting each year into commercial NIHR CRN Portfolio studies

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>Latest month performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="5">HLO6B: Proportion of NHS Trusts recruiting each year into commercial NIHR CRN Portfolio studies

There are 16 Trusts within the East Midlands region, with 9 Trusts currently recruiting to commercial studies. The seven who have not reported any recruitment are:
East Midlands Ambulance Service NHS Trust (EMAS)
Derbyshire Community Health Services NHS Foundation Trust (DCHS)
Lincolnshire Community Health Services (LCHS)
Leicestershire Partnership NHS Trust (LePT)
Lincolnshire Partnership NHS Trust (LiPT)
Nottinghamshire Healthcare NHS Foundation Trust (NHFT)
Derbyshire Healthcare NHS Foundation Trust (DHFT)</td><td rowspan="5"><ol start="4">
EMAS: Currently no open commercial studies nationally run by ambulance services on the NIHR portfolio, therefore unlikely that EMAS will open a commercial study this financial year. Industry team currently reviewing studies previously run at other ambulance services across the country to gain insight.
DCHS: due to the nature of research within this Trust, they are unlikely to be involved in commercial research, Have met with Trust and a preliminary plan is in place to take this forward.
LCHS: due to the nature of research within this Trust, they are unlikely to be involved in commercial research. Meeting on the 18th December with Trust to discuss and plan.
LePT: Selected for one study, due to open by the end of 2014. One study also being taken forward with sponsor and awaiting confirmation if selected
LiPT: have been involved in commercial research in the past and the site is actively seeking commercial opportunities
NHFT: One trial initiated at the end of November 2014, 2nd UK site to open
DHFT: One trial recently opened to recruitment, yet to recruit</td><td>70%</td><td>56% (red)</td><td>56% (red)</td><td>62%</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="3">April 2015</td></tr>
<tr><td>Revised date to meet standard</td><td colspan="3">April 2015</td></tr>
<tr><td>Lead Director / Lead Officer</td><td colspan="3">Daniel Kumar, Industry Delivery Manager</td></tr>
</table>

2014/15 NTDA METRICS AND WEIGHTINGS

Responsiveness Domain

Metric	Standard	Weighting
Referral to Treatment Admitted	90	10
Referral to TreatmentNon Admitted	95	5
Referral to Treatment Incomplete	92	5
Referral to Treatment Incomplete 52+ Week Waiters	0	5
Diagnostic waiting times	1	5
A&E All Types Monthly Performance	95	10
12 hour Trolley waits	0	10
Two Week Wait Standard	93	2
Breast Symptom Two Week Wait Standard	93	2
31 Day Standard	96	2
31 Day Subsequent Drug Standard	98	2
31 Day Subsequent Radiotherapy Standard	94	2
31 Day Subsequent Surgery Standard	94	2
62 Day Standard	85	5
62 Day Screening Standard	90	2
Urgent Ops Cancelled for 2nd time (Number)	0	2
Proportion of patients not treated within 28 days of last minute cancellation	0	2
Delayed Transfers of Care	3.5	5
TOTAL - 18 Indicators		78

Effectiveness Domain

Metric	Standard	Weighting
Hospital Standardised Mortality Ratio (DFI)		5
Deaths in Low Risk Conditions		5
Hospital Standardised Mortality Ratio - Weekday		5
Hospital Standardised Mortality Ratio - Weekend		5
Summary Hospital Mortality Indicator (HSCIC)		5
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust		5
TOTAL - 6 Indicators		30

Safe Domain

Metric	Standard	Weighting
Clostridium Difficile - Variance from plan		10
MRSA bactaraemias	0	10
Never events	0	5
Serious Incidents rate	0	5
Patient safety incidents that are harmful		5
Medication errors causing serious harm	0	5
CAS alerts	0	2
Maternal deaths	1	2
VTE Risk Assessment	95	2
Percentage of Harm Free Care	92	5
TOTAL - 11 Indicators		51

Caring Domain

Metric	Standard	Weighting
Inpatient Scores from Friends and Family Test	60	5
A&E Scores from Friends and Family Test	46	5
Complaints		5
Mixed Sex Accommodation Breaches	0	2
Inpatient Survey Q 68 - Overall, I had a very poor/good experience		2
TOTAL - 5 Indicators		19

Well Led Domain

Metric	Standard	Weighting
Inpatients response rate from Friends and Family Test	30	2
A&E response rate from Friends and Family Test	20	2
NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work		2
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment		2
Data Quality of Returns to HSCIC		2
Trust turnover rate		3
Trust level total sickness rate		3
Total Trust vacancy rate		3
Temporary costs and overtime as % of total paybill		3
Percentage of staff with annual appraisal		3
TOTAL - 10 Indicators		25

CQC – Intelligent Monitoring Report

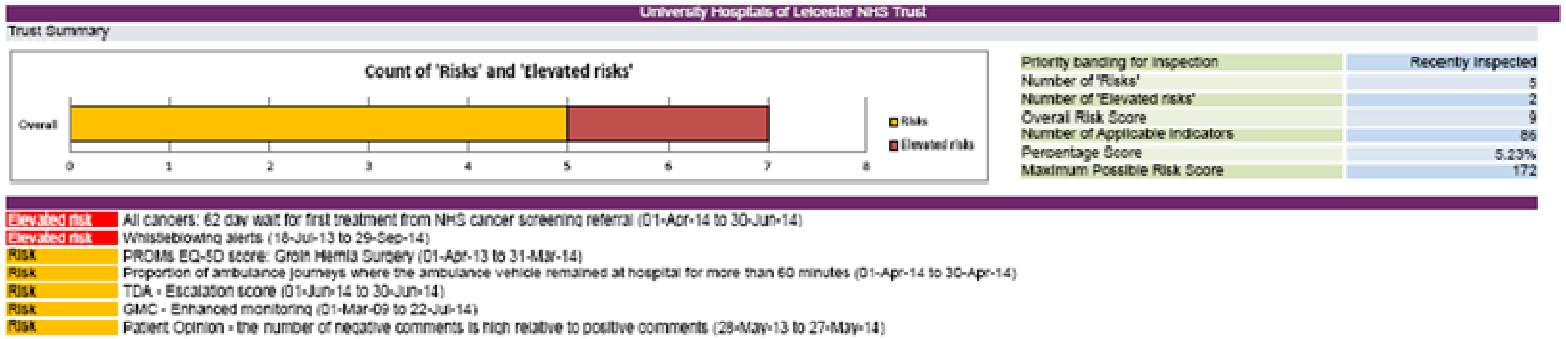
The latest CQC Intelligent Monitoring Report (IMR) was published on 3rd December 2014.

The IMR evaluates against a range of indicators relating to the five key questions used by the CQC as part of their inspections - is the organisation safe, effective, caring, responsive, and well-led?

Within each area of questions a set of indicators has been developed and each indicator has then been analysed to identify the following levels of risk for each organisation:

- 'no evidence of risk'
- 'risk'
- 'elevated risk'

One elevated risk remains unchanged (whistleblowing alerts), one new elevated risk has been added (cancer waiting times), three indicators are unchanged at risk (ambulance times, TDA and GMC) and PROMs (groin hernia surgery) and patient opinion comments are new risks (not flagged in the previous IMR).



Quality Schedule and CQUIN Performance Summary – Predicted RAG for Quarter 3

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Commentary
	QUALITY SCHEDULE				
PS01	Infection Prevention and Control Reduction. - C Diff	G	A	G	Monthly reporting of C Diff. Threshold for 14/15 is 81. UHL is aiming to achieve a reduction on last year's total of 66 and has given itself a Target of 50 . 43 cases as at end of November which is below the NTDA trajectory (54 YTD) Amber RAG to be revised upon receipt of MultiDrug Resistant Bacteraemia data.
PS02	HCAI Monitoring - MRSA	0	1	1	1 in September and 1 in October. Reviews confirmed both Unavoidable.
PS03	Patient Safety – SIs, Never Events	G	1	tbc	0 Never Events in Q1. 1 in October relating to 'Retained Swab ties). Reduction in Patient Safety Incidents but increase in % causing harm. Further increase in number of PSIs awaiting review. Increase in GP concerns
PS04	Duty of Candour	0	0	0	No breaches.
PS05	Complaints and user feedback Management (excluding patient surveys).	A	tbc	tbc	Complaints responses performance improved slightly although still below threshold. Deterioration for responding to 're-opened complaints.
PS06	Risk Assurance and CAS Alerts	A	A	G	Amber RAG for Q2 relates to overdue CAS alerts for July. No overdue CAS alerts and all risk reviews and actions on Track
PS07	Safeguarding – Adults and Children	G	G	G	Assurance documentation due to be sent to CCG Safeguarding leads for their review ahead of their observational visit to the Trust. Discussions underway regarding CONI requirements (Care of Next Infant) and changes proposed to the SAAF.
PS08	Reduction in Pressure Ulcer incidence.	G	G	A	Monthly thresholds met for G3 HAPUs and no G4s, however 4 above the monthly trajectory for Grade 2 HAPUs in November.
PS09	Medicines Management Optimisation	A	G	G	Commissioners noted improvement in Controlled Drugs audit report. Progress made with developing LLR Medicines Optimisation Strategy.
PS10	Medication Errors	G	G	G	Increased reporting of errors and actions being taken.
PS11	Venous Thromboembolism (VTE) and RCAs of Hospital Acquired Thrombosis	95.7%	96.1%	95.4%	Performance continues to be above the national set threshold of 95% RCAs in progress for Q2 Hospital Acquired Thrombosis.
PS12	Nutrition and Hydration	G	>80%	tbc	Nursing Metrics amended to better monitor fluid and nutritional care. Work programme on track for nutrition, some delays with hydration actions. On track to achieve 90% across all CMGs by Q4
PE1	Same Sex Accommodation Compliance and Annual Estates Monitoring	2	0	0	0 breaches reported for Q2 or Q3 to date.
PE2	Patient Experience, Equality and Listening to and Learning from Feedback.	G	G	G	Good progress made with triangulation of data. Waiting time main area for improvement.
PE3	Improving Patient Experience of Hospital Care (NPS)	N/A	N/A	N/A	Not due to be reported until March 15
PE4	Equality and Human Rights	G	G	G	Progress reported to the September CQRG with further information provided in October – relating to actions being taken to capture BME data
CE01	Communication – Content (ED, Discharge & Outpatient Letters)	A	A	A	ED letters audit undertaken and identified 29% of letters did not contain relevant information. Several specialities experiencing backlogs with outpatient letters. Meeting held to discuss D/N letters on ICE. Clinical Problem Solving Group held to agree key priorities.
CE02	Intra-operative Fluid Management	G	>80%	tbc	Q4 RAG dependent upon confirmation of 80% trajectory being maintained.
CE03	Clinical Effectiveness Assurance – NICE and Clinical Audit	A	A	tbc	Responses outstanding for several NICE Clinical Guideline / Quality Standards documents. Reported to EQB separately. Actions being taken where audits behind schedule National Quality Dashboard no longer being published.
CE04	Women's Service Dashboard	A	A	tbc	Amber RAG anticipated due to increase in C Section Rate. 3 SIs reported all related to perinatal death – 1 baby imm after transfer from St Mary's.
CE05	Children's Service Dashboard	A	G	tbc	Assurance provided to Commissioners in respect of SpR training

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Commentary
CE06	Patient Reported and Clinical Outcomes (PROMs and Everyone Counts)	A	A	G	Groin Hernia PROMs deteriorated and reported as a Risk in the embargoed CQC Intelligent Monitoring Report. Individual patient data now obtained. Initial review against patient case notes not identified any clinical issues. Consultant Outcomes published and all consultants in line with national average
CE07	#NOF - Dashboard	51%	67.9%	64.5%	72% threshold not met for any month in Q2. Action plan in place. – Appendix 3.
CE08a	Stroke monitoring	86%	81.6	tbc	**69.4%** in October - Head of Service reviewing notes to confirm whether patients wrongly coded and why stroke patients not admitted to Stroke Unit.
CE08b	TIA monitoring	76%	67%	68.4%	Threshold achieve for each month for high risk patients and performance improved for low risk patients being seen within 7 days.
CE09	Mortality (SHMI, HSMR)	A	A	A	UHL's SHMI remains above 100. Mortality alert reviews completed on track and MRC work programme is on schedule.
CE10	Making Every Contact Count (MECC)	A	G	G	Referrals to STOP and ALW continue. 'Healthy Eating and Physical Activity publicity campaign due to commence in General Surgery and Sleep Clinics.
AS01	Cost Improvement Programme (CIP) Assurance	A	tbc	G	Q2 RAG to be reviewed upon receipt of QAC report.
AS02	Ward Healthcheck (Nursing Establishment, Clinical Measures Scorecard)	Report Submitted	Report Submitted	Report Submitted	Recruitment of additional nurses continues. Not all wards meeting N2BR but actions in place.
AS03	Staffing governance	A	A	A	Thresholds not met for Appraisal, Sickness and Corporate Induction or Turnover although improvement noticed.
AS04	Involving employees in improving standards of care. (Whistleblowing)	G	G	G	Actions taken to address concerns raised.
AS05	Staff Satisfaction	G	G	G	
AS06	External Visits and Commissioner Quality Visits	G	G	G	
AS07	CQC Registration	A	G	G	
	NATIONAL CQUINS				
Nat 1.1a	F&FT 1a - Staff	G	G	G	Implemented
Nat 1.1b	F&FT 1b - OutPt & Day Case	G	G	G	F&FT already happening in Day Case and has started in Outpatients.
Nat 1.2	F&FT 1.2 - Increased participation - ED	16.%	15.1%	15.%	Performance dropped significantly in July but back on track with an YTD rate of 15.6% .
Nat 1.3	F&FT 1.3 - Inpt increase in March	35.8%	31%	36.2%	Performance dropped to 28% for August but still achieved the end of year threshold in Q2.
Nat 2.1	ST 2.1 - ST data submission	G	G	G	Data collection continues.
Nat 2.2	ST 2.2 - LLR strategy	G	G	G	UHL contributing to the LLR Pressure Ulcer group and workstreams
Nat 3.1	Dementia 3.1 - FAIR	G	G	G	90% thresholds met for all parts of the Dementia FAIR CQUIN.
Nat 3.2	Dementia 3.2 - Training & Leadership	G	G	tbc	Nicky Morgan is new Clinical Lead Dementia Training Programme reviewed and revised. Q3 RAG dependent on evidence of increased staff attending training.
Nat 3.3	Dementia 3.3 - Carers	G	G	G	Surveys carried out and evidence of actions being taken
	LOCAL CQUINS				
Loc 1	Urgent Care 1 (Discharge)	G	G	G	Thresholds to be revised in order to reflect 2 year timescale of CQUIN scheme

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Commentary
Loc 2	Urgent Care 2 (Consultant Assessment)	G	G	A	60% Q2 threshold achieved due to significant improvement in AMU. Audit underway to confirm performance for other units.
Loc 3	Improving End of Life Care (AMBER)	G	G	G	AMBER implemented on 4 wards during Q2 and progress made with training. New facilitators in post and so should be back on track by end of Q3
Loc 4	Quality Mark	G	G	G	Quality Mark achieved for 6 out of the 8 wards to date.
Loc 5	Pneumonia	A	G	tbc	CQUIN payments reapportioned and so reduced loss of income for Q1. Q2 threshold achieved for all aspects of CQUIN scheme
Loc 6	Think Glucose	G	G	G	Think Glucose programme on track.
Loc 7	Sepsis Care pathway	≥47%	≥60%	tbc	Care Bundle thresholds achieved and good progress made against action plan.
Loc 8	Heart Failure	≥49.5 %	≥63%	tbc	Commissioner reviewed progress with both the Care Bundle and also IV diuretic Service.
Loc 9	Medication Safety Thermometer	G	G	G	90% of Wards participating in the Medication Safety Thermometer
	SPECIALISED CQUINS				
SS1	National Quality Dashboards	G	G	t of CQUIN scheme.Q1 as although threshold just missed, acknowledged increased activity and good progress made with other aspect bc	Dashboards now open for data submission at end of Q3
SS2	Breast Feeding in Neonates	61%	66%	tbc	Thresholds achieved for Q2 and on track for Q3.
SS3	Clinical Utilisation Review of Critical Care	N/A*	G	tbc	CCMDS and ICNARC data now being collected for ACB
SS4	Acuity Recording	N/A*	G	G	Acuity recording in place for all areas.
SS5	Critical Care Standards - Disch	N/A*	G	tbc	4 hr delays baseline data provided for Critical Care Units
SS6	Critical Care Outreach Team	N/A*	G	tbc	Baseline data partially provided and improvement thresholds agreed
SS7	Consultant Assessment	G	G	tbc	Links to the CCG CQUIN.
SS8	Highly Specialised Services Collaborative Workshop	G	G	G	Update provided regarding participation in Clinical Benchmarking workshops in November for both ECMO and PCO.