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	TRUST BOARD
From:	Rachel Overfield, Kevin Harris, Richard Mitchell Kate Bradley
Date:	**28th August 2014**
CQC regulation	All

Title:	**Quality & Performance Report**

Author/Responsible Director: R Overfield, Chief Nurse
K. Harris, Medical Director
R, Mitchell, Chief Operating Officer
K. Bradley, Director of Human Resources

Purpose of the Report:

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

The Report is provided to the Board for:

Decision			**Discussion**	√
Assurance	√		**Endorsement**	

Summary / Key Points:

This is the first Q&P with revised content and format following extensive review and consultation.

Thresholds, RAG rating and Exception Report criteria have been agreed for most indicators.

Finance is not included in the proposed new format and will be reported separately and following review by the Quality Assurance Committee, it was agreed that indicators relating to Facilities and IM&T did not need to be included in the Q&P as monitored elsewhere.

21 of the 75 indicators were RAG rated Red for the month of July.

Domain	Number of Indicators	Indicators with target to be confirmed	Number of Red Indicators
Safe	16	2	3
Caring	9	5	0
Well Led	14	7	3
Effective	14	1	0
Responsive	22	0	15

Exception reports were triggered for the following :

Safe

1) Overdue CAS alerts

Well Led

2) Emergency Department Friends & Family Participation

Responsive

3) Emergency Care – 4hr Wait – separate report
4) RTT – admitted, non-admitted and 52+ week waits
5) Cancer 31 and 62 day
6) Cancelled Operations on the day and rebooks within 28 days
7) Delayed Transfers
8) Ambulance Handovers

The 2014/15 NTDA Metrics and Weightings are included and following confirmation of the NTDA's methodology (expected September 2014) future reports will present UHL's NTDA scoring data.

The latest CQC Intelligent Monitoring Report for UHL is also included. Due to our recent inspection, the trust has not been given a Banding.

Also included is a summary of performance and RAG ratings received to date for both CCG and Specialised Services CQUINs and the CCG Quality Schedule.

Recommendations: Members to note and receive the report	
Strategic Risk Register	**Performance KPIs year to date** CQC/NTDA
Resource Implications (eg Financial, HR) Penalties for missing targets.	
Assurance Implications Underachieved targets will impact on the NTDA escalation level, CQC Intelligent Monitoring and FT application	
Patient and Public Involvement (PPI) Implications Underachievement of targets has a negative impact on patient experience and Trust reputation	
Equality Impact N/A	
Information exempt from Disclosure N/A	
Requirement for further review? Monthly review	

Caring at its best

University Hospitals of Leicester NHS

NHS Trust

Quality & Performance

Report – July 2014

One team shared values

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1.0 Introduction

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

A review has been undertaken of the Trust's monthly, Quality & Performance Report (Q&P) taking into account both the updated version of the NHS Trust Development Authority's Accountability Framework, *'Delivering for Patients: the 2014/15 Accountability Framework for NHS trust boards'* and the Care Quality Commission's *Intelligent Monitoring* process. This is the first Q&P with revised content and format following extensive consultation.

Thresholds, RAG rating and Exception Report criteria have been agreed for most indicators. The expectation is that any locally developed indicators will have all these confirmed for the September version of the Q&P and The NTDA have advised that the final version of the Accountability Framework Indicators and thresholds will be available in September.

Finance is not included in the proposed new format and will be reported separately and following review by the Quality Assurance Committee, it was agreed that indicators relating to Facilities and IM&T did not need to be included in the Q&P as monitored elsewhere.

2.0 Performance Summary for July

21 of the 75 indicators were RAG rated Red for the month of July and 8 exception reports triggered.

Domain	Number of Indicators	Indicators with target to be confirmed	Number of Red Indicators	Number of Exception Reports	Exception Report
Safe	16	2	3	1	Overdue CAS alerts
Caring	9	5	0	0	
Well Led	14	7	3	1	ED F&FT Participation
Effective	14	1	0	0	
Responsive	22	0	15	6	Emergency Care – 4hr Wait – separate report RTT – admitted, non-admitted and 52+ week waits Cancer 31 and 62 day Cancelled Operations on the day and rebooks within 28 days Delayed Transfers Ambulance Handovers

DASHBOARD KEY

14/15 Target: i.e.
Monthly,
Cumulative
End of Year

Target Set by:
NTDA = Trust Development Authority
QS = Quality Schedule
QC = Quality Commitment

Red RAG/ Exception Report Threshold (ER)
Red threshold follows NTDA criteria, where applicable.
Criteria for Exception Report (ER) may not always be the same as the Red RAG threshold.

NTDA/CQC area indicators are mapped to

Performance data:
- 13/14 Out-turn = 13/14 full year
- Mthly data for prev 12 mths
- YTD = 14/15 to date

Indicator Ref Nos – within each NTDA/CQC area

Safe | Caring | Well Led | Effective | Responsive

KPI Ref	Indicators	Board Director	Lead Director/ Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Aug-13	Apr-14	May-14	Jun-14	Jul-14	YTD
S1a	Clostridium Difficile	RO	DJ	FYE = 81	NTDA	Red / ER for Non compliance with cumulative target	66	5	4	6	5	6	21
S1b	Clostridium Difficile (Local Target)	RO	DJ	FYE = 50	UHL	Red = >5 per mth ER = YTD Red	66	5	4	6	5	6	21
S2a	MRSA Bacteraemias (All)	RO	DJ	0	NTDA	Red = >0	3	0	0	0	0	0	0
S2b	MRSA Bacteraemias (Unavoidable)	RO	DJ	0	UHL	Red = >0 in mth ER = in mth >0	1	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	0	0	0
S4	Serious Incidents	RO	MD	tbc	NTDA	tbc	New Indicator - Definition to be confirmed						
S5	Proportion of reported safety incidents that are harmful	RO	MD	tbc	NTDA	tbc	New Indicator - Definition to be confirmed						

Definition to be confirmed - Performance data included where NTDA definitions considered to be unlikely to change. Where definition unclear - NTDA guidance due in September

Key for Lead Directors/Officers:
CA=Chris Allsager; CC=Charlie Carr; CF=Catherine Free; MD=Moira Durbridge; SH=Sharron Hotson; SJ=Steve Jackson; DJ=David Jenkins; SK=Suzanne Khalid; EM=Eleanor Meldrum; MM=Matt Metcalf; RP=Richard Power; PR=Pete Rabey; CR=Carole Ribbins; JR =John Roberts; ES=Emma Stevens; PW=Phil Walmsley

	KPI Ref	Indicators	Board Director	Lead Director/ Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	YTD
Safe	S1a	Clostridium Difficile	RO	DJ	FYE = 81	NTDA	Red / ER for Non compliance with cumulative target	66	6	5	9	6	6	5	10	0	4	4	6	5	6	21
	S1b	Clostridium Difficile (Local Target)	RO	DJ	FYE = 50	UHL	Red >5 per month, ER when YTD red	66	6	5	9	6	6	5	10	0	4	4	6	5	6	21
	S2a	MRSA Bacteraemias (All)	RO	DJ	0	NTDA	Red = >0	3	0	0	1	0	0	0	0	0	0	0	0	0	0	0
	S2b	MRSA Bacteraemias (Unavoidable)	RO	DJ	0	UHL	Red = >0 in mth ER = in mth >0	1	0	0	1	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	1	0	0	0	0	1	0	0	0	0	0	0
	S4	Serious Incidents	RO	MD	tbc	NTDA	tbc	60	9	5	4	5	8	4	3	4	5	4	6	3	7	20
	S5	Proportion of reported safety incidents that are harmful	RO	MD	tbc	NTDA	tbc	2.8%	3.1%			2.3%			2.3%			1.9%				1.9%
	S6	Overdue CAS alerts	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	2	0	1	0	0	0	0	0	0	0	2	2	2	3	9
	S7	RIDDOR - Serious Staff Injuries	RO	MD	FYE = <47	UHL	Red / ER = non compliance with cumulative target	47	3	3	4	6	4	4	7	2	5	3	5	1	2	11
	S8	Safety Thermometer % of harm free care (all)	RO	EM	tbc	NTDA	Red = <92% ER = in mth <92%	93.6%	93.8%	93.5%	93.1%	94.7%	93.9%	94.0%	93.8%	94.8%	93.6%	94.6%	94.7%	94.2%	94.9%	94.6%
	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%	95.9%	95.2%	95.4%	95.5%	96.7%	96.1%	95.6%	95.0%	95.6%	95.7%	95.9%	95.9%	96.3%	95.9%
	S10	Medication errors causing serious harm	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	New Indicator - Definition to be confirmed														
	S11	Patient Falls	RO	EM	2270	QC	Red > 199 ER = 2 consecutive reds	2522	251	197	171	231	209	201	206	204	207	195	224	194	219	832
	S12	Avoidable Pressure Ulcers - Grade 4	RO	EM	0	QS	Red / ER = Non compliance with monthly target	1	0	0	0	1	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	7	8	5	5	4	5	7	3	6	5	5	5	6	21
	S14	Avoidable Pressure Ulcers - Grade 2	RO	EM	<10 a month	QS	Red / ER = Non compliance with monthly target	120	21	10	5	7	8	5	10	8	9	6	6	6	7	25
	S15	Compliance with the SEPSIS6 Care Bundle	RO	MD	All 6 >75% by Q4	QC	Red/ER = Non compliance with Quarterly target	27.0%	New Indicator						27.0%			47.0%				47.0%
	S16	Nutrition and Hydration Metrics	RO	MD	All 90% by Q3	QC	Red / ER for Non compliance with cumulative target	N/A	New Indicator									71.0%	67.0%	75.0%		71.0%

Caring

KPI Ref	Indicators	Board Director	Lead Director/ Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	YTD
C1	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	66.0	69.6	67.6	66.2	70.3	68.7	71.8	69.0	69.9	69.6	71.0	74.5	73.8	72.2
C2	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	57.0	59.6	57.6	58.8	58.6	67.4	67.6	58.7	65.5	69.4	66.0	71.4	71.7	69.3
C3	Outpatients Friends and Family Test - Score	RO	CR	tbc	UHL	tbc	New Indicator available from October 2014														
C4	Maternity Friends and Family Test - Score	RO	CR	tbc	UHL	tbc	64.3				64.8	62.1	63.7	67.3	62.1	66.7	61.2	63.5	69.5	69.7	65.8
C5	Complaints Rate per 100 bed days	RO	MD	tbc	NTDA	tbc		0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.5	0.4	0.4	0.3	0.4	0.5	0.5
C6	Complaints Re-Opened	RO	MD	FYE = tbc	UHL	tbc	272	28	19	19	20	27	11	28	14	16	20	20	15	25	80
C7	Single Sex Accommodation Breaches	RO	CR	0	NTDA	Red = >0 ER = in mth >0	2	0	0	0	0	2	0	0	0	0	4	2	0	0	6
C8	Improvements in the FFT scores for Older People (65+ year)	RO	CR	75	QC	Red / ER = End of Yr Targets non recoverable.	New Indicator for 14/15 Information Available for August Report														
C9	Responsiveness and Involvement Care	RO	CR	0.8 improve-ment	QC	tbc	New Indicator for 14/15										88.6	88.5	88.5		88.6

Well Led

KPI Ref	Indicators	Board Director	Lead Director/ Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	YTD
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%	24.8%	22.0%	25.8%	21.7%	25.4%	23.3%	24.5%	28.2%	28.8%	36.8%	38.1%	32.6%	30.8%	34.5%
W2	A&E Friends and Family Test - Coverage	RO	CR	20% for Q4	NTDA	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	14.9%	14.6%	16.1%	11.1%	16.3%	18.4%	16.4%	15.6%	18.4%	16.1%	15.2%	17.8%	14.9%	10.2%	14.5%
W5	NHS staff survey: % of staff who would recommend the trust as place to work	KB	ES	tbc	NTDA	tbc	New Indicator - Definition to be confirmed														
W6	NHS staff survey: % of staff who would recommend the trust as place to receive treatment	KB	ES	tbc	NTDA	tbc	New Indicator - Definition to be confirmed														
W7	Data quality of trust returns to HSCIC	KS	JR	tbc	NTDA	tbc	New Indicator - Definition to be confirmed														
W8	Turnover Rate	KB	ES	<10%	UHL	Red = >10% ER = 3 consecutive mths >10%	10.0%	9.5%	9.3%	9.7%	9.6%	9.7%	10.2%	10.6%	10.4%	10.0%	9.9%	10.0%	10.2%	10.0%	10.0%
W9	Sickness absence - 12 mths rolling	KB	ES	3.5% rolling 12 mths post validation	UHL	Red = >3.5% ER = 3 consecutive mths >3.5%	3.4%	3.2%	3.1%	3.1%	3.3%	3.5%	3.8%	3.8%	3.7%	3.5%	3.5%	3.5%	3.6%		3.5%
W10	Total trust vacancy rate	KB	ES	tbc	NTDA	tbc	New Indicator - Definition to be confirmed														
W11	Temporary costs and overtime as a % of total paybill	KB	ES	tbc	NTDA	tbc	New Indicator										9.4%	9.4%	8.1%	8.5%	8.5%
W12	% of Staff with Annual Appraisal	KB	ES	95%	UHL	Red = <90% Amber = 90-95% ER = <90%	91.3%	92.4%	92.7%	91.9%	91.0%	91.8%	92.4%	91.9%	92.3%	91.3%	91.8%	91.0%	90.6%	90.0%	90.0%
W13	Statutory and Mandatory Training	KB	ES	Jun 80%, Sep 85%, Dec 90%, Mar 95%	UHL	Red / ER for Non compliance with incremental target	76%	48%	49%	55%	58%	60%	65%	69%	72%	76%	78%	79%	79%	80%	80%
W14	% Corporate Induction attendance	KB	ES	95.0%	UHL	Red = <90% Amber = 90-95% ER = <90%	94.5%	90.0%	94.0%	94.0%	91.0%	87.0%	89.0%	93.0%	89.0%	94.5%	96.0%	94.0%	92.0%	96.0%	96.0%

Effective

KPI Ref	Indicators	Board Director	Lead Director/ Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	YTD
E1	Mortality - Published SHMI	KH	PR	Within Expected	NTDA	Higher than Expected	88.6	104.9	104.9	104.9	106.4	106.4	106.4	107.1	107.1	107.1	106.0	106.0	106.0	106.0	106.0
E2	Mortality - Rolling 12 mths SHMI (as reported in HED)	KH	PR	100 or below	QC	Red = >expected Amber =>100 ER = >Expected or 3 consecutive mths >100	102.1	107.5	108.0	107.1	106.8	106.4	106.7	104.7	103.8	102.1	100.3	Awaiting HED Update			100.3
E3	Mortality HSMR (DFI Quarterly)	KH	PR	Within Expected	NTDA	Red = >expected Amber =>100 ER = >Expected or 3 consecutive mths >100	87.9	91.4			86.0			82.2			Awaiting DFI Update				
E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	KH	PR	100 or below	QC	Red = >expected Amber =>100 ER = >Expected or 3 consecutive mths >100	98.8	102.6	103.2	102.1	101.6	101.9	101.2	100.1	100.4	98.8	96.6	96.9	Awaiting HED Update		96.9
E5	Mortality HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected Amber =>100 ER = >Expected or 3 consecutive mths >100	100.2	111.5	105.8	97.1	97.9	107.1	95.4	92.7	102.5	90.7	82.7	98.2	Awaiting HED Update		90.3
E6	Mortality HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected Amber =>100 ER = >Expected or 3 consecutive mths >100	98.6	100.2	116.3	99.0	98.3	93.4	93.5	84.2	106.0	80.0	66.2	127.1	Awaiting HED Update		96.4
E7	Deaths in low risk conditions	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive mths >100	93.6	34.0	123.3	103.0	98.0	51.5	129.2	163.8	35.1	63.3	48.3	Awaiting DFI Update			48.3
E8	Emergency 30 Day Readmissions (No Exclusions)	KH	PR	Within Expected	NTDA	Higher than Expected	7.9%	7.5%	7.6%	7.8%	7.9%	7.8%	8.0%	8.7%	9.0%	8.8%	8.7%	8.7%	8.6%		8.7%
E9	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%	59.1%	73.6%	67.1%	70.5%	73.6%	72.2%	68.2%	73.7%	54.7%	56.9%	40.6%	60.3%	76.9%	58.8%
E10	Stroke - 90% of Stay on a Stroke Unit	RM	CF	80% or above	QS	Red = <80% ER = 2 consecutive mths <80%	83.2%	87.1%	88.5%	89.1%	83.7%	78.0%	81.8%	89.3%	83.7%	83.5%	92.9%	80.5%	87.1%		87.0%
E11	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%	60.5%	73.6%	64.6%	62.4%	76.8%	65.7%	60.5%	40.7%	77.9%	79.7%	58.8%	71.3%	62.8%	67.6%
E12	Communication - Outpatient, Discharge and Outpatient Letters	KH	SJ	tbc	QS	tbc	New Indicator for 14/15														
E13	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
E14	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

Responsive

KPI Ref	Indicators	Board Director	Lead Director/ Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	YTD
R1	ED 4 Hour Waits UHL + UCC	RM	CF	95% or above	NTDA	Red = <95% ER via ED TB report	88.4%	88.3%	90.1%	89.5%	91.8%	88.5%	90.1%	93.6%	83.5%	89.3%	86.9%	83.4%	91.3%	92.5%	88.4%
R2	12 hour trolley waits in a&e	RM	CF	0	NTDA	Red = >0 ER via ED TB report	5	0	0	1	0	1	0	0	0	0	0	1	0	0	1
R3	RTT Waiting Times - Admitted	RM	CC	90% or above	NTDA	Red /ER = <90%	76.7%	89.1%	85.7%	81.8%	83.5%	83.2%	82.0%	81.8%	79.1%	76.7%	78.9%	79.4%	79.0%	80.9%	80.9%
R4	RTT Waiting Times - Non Admitted	RM	CC	95% or above	NTDA	Red /ER = <95%	93.9%	96.4%	95.5%	92.0%	92.8%	91.9%	92.8%	93.4%	93.5%	93.9%	94.3%	94.4%	95.0%	94.9%	94.9%
R5	RTT - Incomplete 92% in 18 Weeks	RM	CC	92% or above	NTDA	Red /ER = <92%	92.1%	93.1%	92.9%	93.8%	92.8%	92.4%	91.8%	92.0%	92.6%	92.1%	93.9%	93.6%	94.0%	93.2%	93.2%
R6	RTT 52 Weeks+ Wait	RM	CC	0	NTDA	Red /ER = >0	0	0	0	0	0	0	1	1	0	0	3	0	2	16	16
R7	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	NTDA	Red /ER = >1%	1.9%	0.6%	0.8%	0.7%	1.0%	0.8%	1.4%	5.3%	1.9%	1.9%	0.8%	0.9%	0.8%	0.7%	0.7%
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%	94.2%	94.6%	93.0%	94.9%	95.7%	94.9%	95.3%	95.9%	95.3%	88.5%	94.7%	93.5%		92.2%
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%	93.6%	92.0%	95.2%	93.0%	91.3%	95.5%	96.8%	93.4%	94.3%	80.0%	95.0%	98.9%		92.4%
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%	98.3%	99.7%	99.1%	98.9%	96.2%	97.4%	97.2%	98.5%	98.2%	97.2%	92.9%	93.6%		94.6%
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%	100.0%	100.0%	100.0%		100.0%
R12	31-Day Wait For Second Or Subsequent Treatment: Surgery	RM	MM	94% or above	NTDA	Red = <94% ER = Red for 2 consecutive mths	98.2%	100.0%	98.4%	88.6%	96.4%	97.1%	92.3%	94.8%	96.4%	98.6%	95.2%	97.0%	90.8%		94.2%
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	96.0%	100.0%	100.0%	97.7%	97.5%	98.5%	98.1%	94.8%	96.3%	99.1%	97.3%	95.6%	93.9%		95.7%
R14	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	RM	MM	85% or above	NTDA	Red = <85% ER = Red for 2 consecutive mths	86.7%	85.8%	88.2%	87.4%	86.4%	85.7%	89.4%	89.1%	89.1%	92.4%	92.7%	85.5%	73.1%		84.1%
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%	90.6%	97.2%	96.2%	100.0%	97.0%	96.6%	97.1%	95.1%	91.7%	91.1%	67.4%	73.9%		78.0%
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 offered a date within 28 days of the cancellations	RM	PW	100%	NTDA	Red = <100% ER = <100%	95.1%	99.1%	96.0%	98.6%	94.2%	97.7%	94.3%	94.1%	98.9%	94.2%	90.6%	96.1%	99.0%	99.0%	96.0%
R18	% Operations cancelled for non-clinical reasons on or after the day of admission	RM	PW	0.8% or below	Contract	Red = >0.8% ER = >0.8%	1.6%	1.2%	1.4%	2.3%	1.7%	1.8%	1.7%	1.6%	2.1%	1.5%	1.1%	0.8%	1.0%	0.9%	0.9%
	No of Operations cancelled for non-clinical reasons on or after the day of admission	RM	PW	N/A	UHL		1739	114	124	208	171	172	141	152	178	139	106	77	98	96	377
R19	Delayed transfers of care	RM	PW	3.5% or below	NTDA	Red = >3.5% ER = Red for 3 consecutive mths	4.1%	4.0%	3.9%	4.2%	4.6%	4.4%	3.6%	4.6%	4.3%	3.8%	4.6%	4.4%	4.2%	4.1%	4.3%
R20	Choose and Book Slot Unavailability	RM	CC	4% or below	Contract	Red = >4% ER = Red for 3 consecutive mths	13%	15%	14%	11%	16%	17%	14%	10%	16%	19%	22%	25%	26%	25%	25%
R21	Ambulance Handover >60 Mins	RM	CF	0	Contract	Red = >0 ER = Red for 3 consecutive mths	868	55	16	21	25	59	102	52	207	111	188	253	89	63	593
R22	Ambulance Handover >30 Mins and <60 mins	RM	CF	0	Contract	Red = >0 ER = Red for 3 consecutive mths	7,075	566	383	484	705	689	722	573	818	601	822	1,014	644	625	3,105

S6 – OVERDUE CAS ALERTS

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 a decline in CMG performance during April - July 2014 culminating in a reduction of the number and percentage of CAS alerts closed within their deadlines. The data shows a reduction from 99% (to the end of 2013/14 Q4) to 81.3% (YTD to the end of July 2014). qThis can be accounted for by a number of This can be accounted for by a number of factors: • During Quarter 1, changes have been made to the CAS alert process, as result of the Management of Change of the Quality & Safety Managers. CAS alerts are now managed by Heads of Nursing and administered via CMG admin teams. • Change of UHL CAS process from 1/4/14 to include a move away from burdensome paper audit trails to electronic tracking leading to short term implementation issues but with longer term benefits.. • An increasing number of NHS England NPSAS alerts being issued (e.g. 1 alert received during 2013 and 13 received between 1/1/14 and 30/6/14).	Monthly reports are produced for EQB to show new National Patient Safety Alerting System (NPSAS) alerts received and to show any CAS alerts (which include NPSAS alerts) where a deadline has been missed. EQB will hold CMGs to account for the effective management of CAS alerts Quarterly reports are produced to demonstrate CAS performance. From September Monthly CAS reports will be produced to show individual CMG performance. Meetings between the UHL and CAS team and CMG CAS leads (HoN) are taking place during August/ September to address any outstanding issues in relation to the CAS process within UHL. Filtering of irrelevant alerts by CAS team to reduce burden on CMGs. CAS process guides developed and distributed for use in CMGs System of reminders for forthcoming CAS alert deadlines from UHL CAS team to CMG teams. Presentations from UHL CAS team to CMG management teams highlighting the importance of CAS alerts in relation to patient safety.	100% of alerts completed in deadline	4 missed deadlines (i.e. 55.5% compliance in July 2014)	9 missed deadlines (i.e. 81.3% compliance to end of July 2014)	1 missed alert (i.e.90% compliance in August)

CMG CAS Performance 01 Apr - 31 Jul 14	Alerts distributed	No of deadlines missed
CHUGS	6	0
CSI	8	0
Emergency and Specialist Medicine	11	2 (18%)
ITAPS	8	1 (13%)
MSK/SS	8	3 (38%)
RRC	6	1 (17%)
W&C	10	0
Alliance	23	0
NHS Horizons (including EFNs)	13	2 (15%)

Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
2 Missed deadlines (i.e. 99% compliance)	5 missed deadlines (i.e.87% compliance)			

Expected date to meet standard / target	October 2014
Revised date to meet standard	
Lead Director / Lead Officer	Moira Durbridge / Peter Cleaver

W2 – ED FRIENDS & FAMILY TEST PARTICIPATION

<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">Whilst the 13/14 15% threshold was achieved for both April and May, there was a drop in performance in June and then a further significant drop in July.

Review of the process has identified two key contributory factors:

In previous months, members of staff who are on ‘non clinical duties’ due to health reasons, have been leading on asking patients to complete the F&F survey. During July, there were no staff working ‘non clinically’.

During July there has been the Rapid Cycle Testing approach to the ED workstreams ie assessment bay, minors and majors. This has involved staff being focused on reviewing processes relating to each of the above workstreams which is considered to have impacted on F&FT.</td><td rowspan="5">Member of staff currently working non clinically due to eye sight problems.

All staff reminded of need to continue focus on F&FT in addition to the Rapid Cycle Testing work.

Band 7 Nursing Team have been re-issued with their ‘F&FT quotas’

Daily review of numbers by Deputy CMG Head of Nursing

Discussion with Volunteers / Patient Advisor regarding their support of the F&FT process.</td><td>20% for Q4</td><td>10.2%</td><td>14.5%</td><td>>15% for August</td></tr>
<tr><td colspan="4">Performance by Quarter
<table><tr><th>13/14 FYE</th><th>14/15 Q1</th><th>14/15 Q2</th><th>14/15 Q3</th><th>14/15 Q4</th></tr><tr><td>14.9%</td><td>16%</td><td></td><td></td><td></td></tr></table></td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">September 14</td></tr>
<tr><td colspan="2">Revised date to meet standard</td><td colspan="2"></td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Rachel Overfield, Chief Nurse / Carole Ribbins, Deputy Chief Nurse</td></tr>
</table>

R3 – R6 REFERRAL TO TREATMENT – ADMITTED, NON-ADMITTED and 52+ WEEKS

Referral to Treatment		Target	Latest performance (July)	Year to date	Forecast for next reporting period
What is causing underperformance?	**What actions have been taken to improve performance?**	**95% Non Adm 90% Adm**	**94.9% 80.9%**	**NA**	**95.1% 81.0%**

Background

The reasons for UHL's deterioration in RTT performance are well documented. This report is the sixth monthly update. The high level trajectories are detailed in the attached Appendices.

For July the Trust is behind trajectory for admitted performance at a Trust Level, even when including Alliance activity.

For 'non admitted performance' the Trust is on trajectory although did not achieve the 95% as in the previous month (when including Alliance activity).

The Trust Development Authority have stipulated that they require Trust level performance to be delivered against both admitted and non admitted RTT standards by the end of September (September published data).

Admitted performance is expected to deliver in November 2014. The Trust in conjunction with CCG's have re submitted plans which anticipate best case position of 86% admitted performance in September.

Funding to support additional activity and additional costs incurred (including premium payments) is anticipated.

To support the delivery the following actions are being taken in addition to those already in place:

- Additional use of the independent sector both locally, Circle Nottingham and Ramsay health. This will be partly UHL sub contracting but CCGs have additionally agreed to the diverting of patients at receipt of referral for whole pathways of care. NB: UHL is seek full patient consent prior to diverting any referrals
- Validation of the UHL elective waiting list detailed in last month's report yielded the removal of 29 patients who no longer required their operation (all were reviewed clinically before the decision to take them off the waiting list).
- Additional administrative staff have being recruited to support these processes.

The Trust is continuing additional in house activity, mostly out of hours and at weekends.

Trust level backlog over 18 weeks Week Ending	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14
RTT Non Admitted Backlog Actual No	1917	1558	1704	1527	1151	1594	1400
RTT Admitted Backlog Actual No	1416	1512	1527	1551	1310	1420	1400

Risks

The key risks remain the same as in previous reports and are in summary:

- Ability to deliver agreed capacity improvements including theatre, bed and outpatient space and staffing resources within agreed timelines
- Changes to emergency demand
- Patients unable or unwilling to transfer their care to alternative providers

Recommendations

The board are asked to:

- Note the contents of the report
- Acknowledge the improvement trajectory
- Acknowledge the key risks.

Referral to Treatment		Referral to Treatment	Latest performance (July)	Year to date	Forecast for next reporting period
What is causing underperformance?	**What is causing underperformance?**	**95% Non Adm 90% Adm**	**94.9% 80.9%**	**NA**	**95.1% 86.2%**
Performance overview UHL's RTT performance is mainly challenged in four specialities; ENT, ophthalmology, orthopaedics and general surgery. The two Appendices go into greater detail showing performance at speciality level and waiting list sizes for both outpatient and electives (key indicators of RTT backlog reduction). Significant progress has been made in Ophthalmology and the elective waiting list size for adult ENT is reducing in size. The planned additional elective activity for general surgery has slipped, mainly due to staffing shortages both in the theatres and wards, this is now scheduled to progress from mid September onwards. There will be 18 breaches of the 52 week standard within Restorative Dentistry. These patients are waiting for either dentures or crowns. Treatment takes place across two to four visits, however for the purposes of RTT the treatment start date is recorded as their first visit. There has been no patient harm due to the excessive waits. A breach report has been provided, MSS CMG will be undertaking lessons learnt. There will be automatic financial penalties of circa £90k as a result,		**Expected date to meet standard**		Non admitted in August 2014 Admitted in November 2014	
		Revised date to meet standard		-	
		Lead Director		Richard Mitchell, Chief Operating Officer	
		Clinical Lead		CMG Clinical Directors	
		Managerial Lead		Charlie Carr , Head of Performance	

Specialty Level Trajectory

	Admitted Trust level RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	80.8%	80.5%	81.2%	81.2%	82.3%	84.3%	86.9%	87.7%	86.2%	89.5%	90.5%	90.5%	90.5%	90.4%	92.0%
Actual	81.8%	79.3%	76.7%	75.7%	76.8%	77%	78.6%								
UHL + Alliance				78.9%	79.4%	79%	80.86%								
	Non admitted Trust level RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	92.3%	92.7%	92.8%	93.1%	93.6%	94.1%	94.8%	95.1%	95.3%	95.3%	95.5%	96.1%	96.1%	96.1%	96.1%
Actual	93.4%	93.5%	93.9%	93.4%	93.9%	94.3%	94.4%								
UHL + Alliance				94.3%	94.4%	95.0%	94.9%								
	Adult Ophthalmology Admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	58.8%	61.0%	62.3%	63.1%	69.5%	80.4%	90.1%	90.2%	90.3%	90.6%	90.6%	90.5%	90.8%	90.7%	90.8%
Actual	57.8%	60.0%	53.6%	50.3%	52.5%	57.9%	65.6%								
	Adult Ophthalmology Non admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	83.7%	83.1%	82.3%	85.3%	88.8%	89.1%	93.5%	95.4%	95.1%	95.0%	95.2%	95.2%	95.1%	95.1%	95.1%
Actual	86.6	90.2	91.46	89.80%	92.3%	93.8%	97.3%								
	Paediatric Ophthalmology Admitted RTT (other category)														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	80.8%	80.5%	81.2%	81.2%	82.1%	84.4%	84.4%	86.6%	90.6%	90.2%	90.5%	90.5%	90.5%	90.4%	92.0%
Actual			80.1%	73.10%	72.5%	75.3%	65.3%								
	Paediatric Ophthalmology Non admitted RTT(other category)														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	92.3%	92.7%	92.8%	93.3%	92.7%	95.1%	95.4%	95.6%	95.6%	95.6%	95.7%	95.3%	95.3%	95.3%	95.3%
Actual			93%	93.20%	93.9%	94%	94.4%								
	Adult ENT Admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	62.6%	64.5%	61.3%	61.1%	66.1%	72.8%	75.0%	83.1%	90.5%	90.5%	90.4%	90.3%	90.3%	90.2%	90.4%
Actual	69.8%	56.3%	61.8%	61.90%	56.4%	59.2%	59.9%								
	Adult ENT Non admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	89.0%	90.7%	90.4%	93.3%	92.4%	92.4%	93.4%	95.1%	95.4%	95.3%	95.5%	95.5%	95.5%	95.5%	95.5%
Actual	86%	82.7%	86.3%	86.70%	85.1%	87.6%	88.8%								
	Paediatric ENT Admitted RTT (other category)														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	80.8%	80.5%	81.2%	81.2%	82.1%	84.4%	84.4%	86.6%	90.6%	90.2%	90.5%	90.5%	90.5%	90.4%	92.0%
Actual			80.1%	73.10%	72.5%	75.3%	65.3%								
	Paediatric ENT Non admitted RTT(other category)														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	92.3%	92.7%	92.8%	93.3%	92.7%	95.1%	95.4%	95.6%	95.6%	95.6%	95.7%	95.3%	95.3%	95.3%	95.3%
Actual			93.0%	93.20%	93.9%	94.0%	94.4%								
	Orthopaedics Admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	70.0%	69.7%	75.3%	75.5%	74.4%	76.2%	78.6%	75.9%	77.6%	79.7%	81.0%	82.3%	82.2%	82.3%	90.1%
Actual	70.1%	70.5%	66.5%	70.5%	71.5%	70.4%	80.1%								
	Orthopaedics Non admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	78.8%	79.3%	80.4%	78.4%	80.7%	81.2%	82.0%	83.4%	84.1%	85.0%	86.0%	95.2%	95.1%	95.1%	95.1%
Actual	78.3%	78.4%	80.5%	76.0%	80.2%	81.1%	72.7%								
	General surgery Admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	75.2%	72.8%	73.7%	74.4%	74.6%	73.3%	77.4%	82.5%	84.2%	88.2%	90.2%	90.2%	90.2%	90.2%	90.2%
Actual	65.9%	56.9%	66.2%	74.2%	71.6%	72.9%	67.9%								
	General surgery Non admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	95.1%	95.1%	95.9%	95.1%	95.3%	95.9%	95.1%	95.3%	95.2%	95.3%	95.6%	95.1%	95.1%	95.1%	95.1%
Actual	84%	75.1%	96.7%	95.9%	96.1%	95.1%	95.6%								

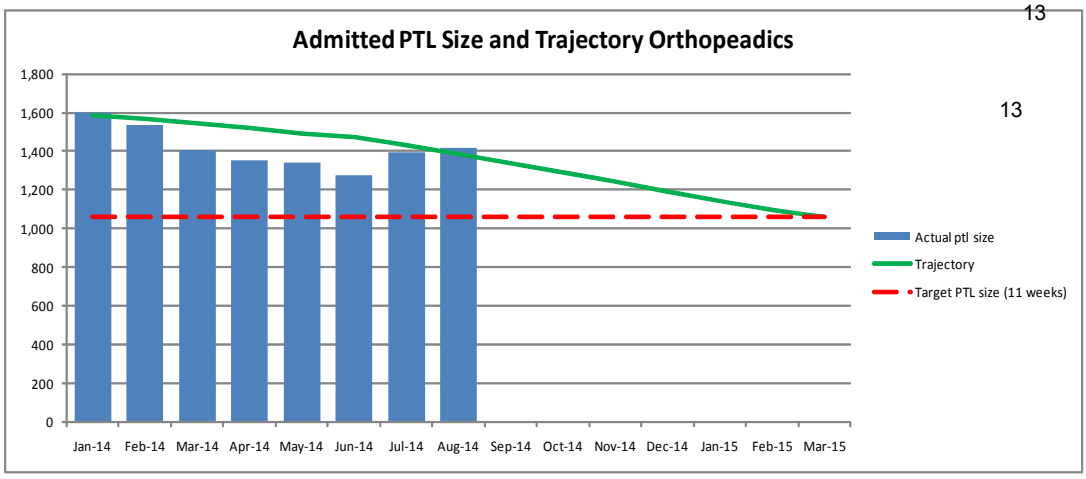
Inpatient Waiting List

Othopaedics

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	1,602	1,536	1,405	1,351	1,339	1,278	1,392	1,420	-						
Trajectory	1,587	1,565	1,542	1,518	1,491	1,476	1,431	1,383	1,336	1,288	1,241	1,193	1,145	1,098	1,062
Target PTL size (11 weeks)	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062

13

13



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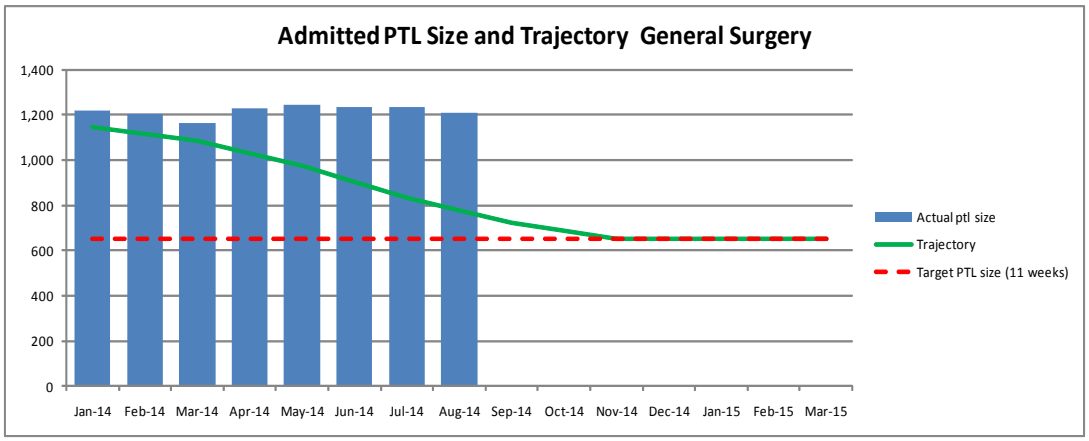
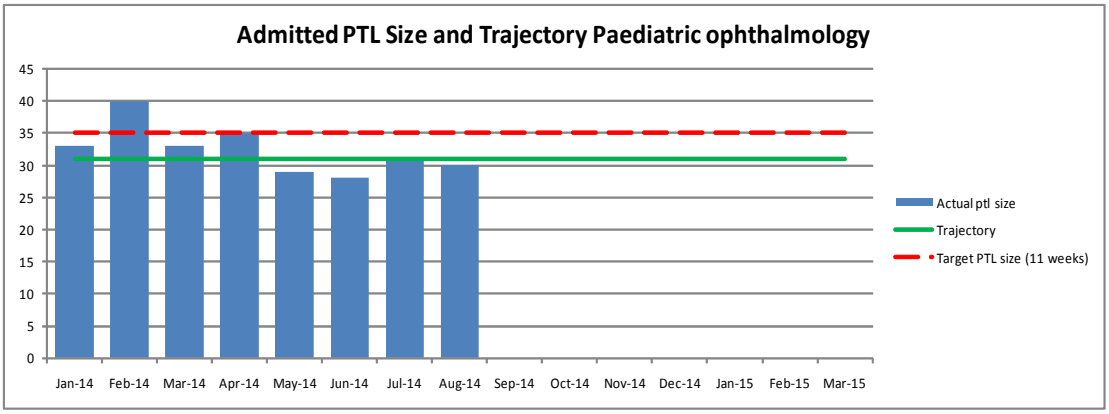
General surgery

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	1,220	1,205	1,162	1,227	1,242	1,236	1,236	1,209	-						
Trajectory	1,148	1,118	1,087	1,031	975	904	834	778	721	686	651	651	651	651	651
Target PTL size (11 weeks)	651	651	651	651	651	651	651	651	651	651	651	651	651	651	651



Paediatric ophthalmology

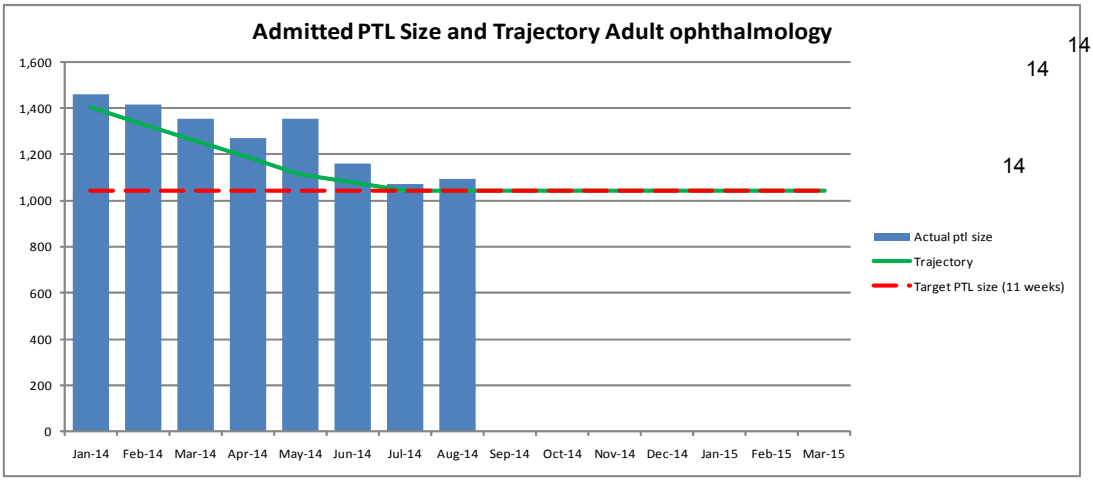
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	33	40	33	35	29	28	31	30	-						
Trajectory	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31
Target PTL size (11 weeks)	35	35	35	35	35	35	35	35	35	35	35	35	35	35	35



Inpatient Waiting List (continued)

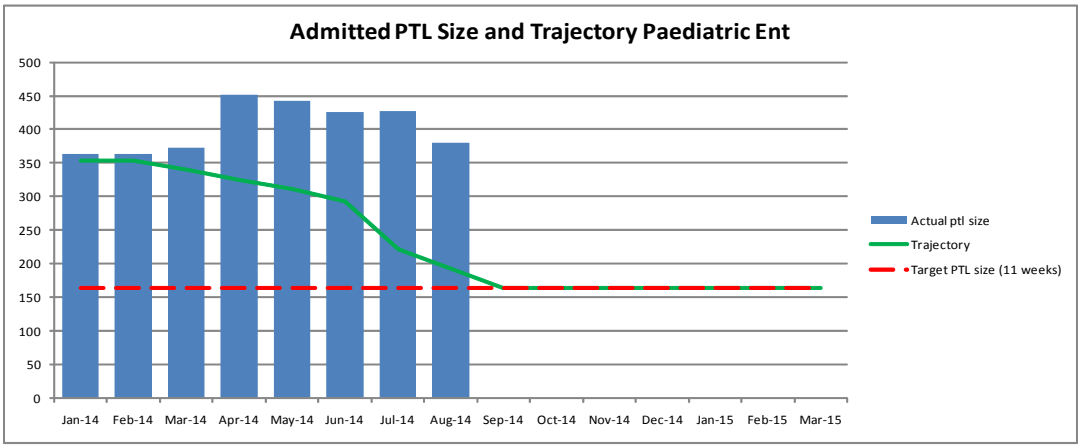
Adult ophthalmology

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	1,458	1,415	1,355	1,271	1,353	1,160	1,140	1,092	-						
Trajectory	1,402	1,330	1,258	1,186	1,114	1,078	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042
Target PTL size (11 weeks)	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042



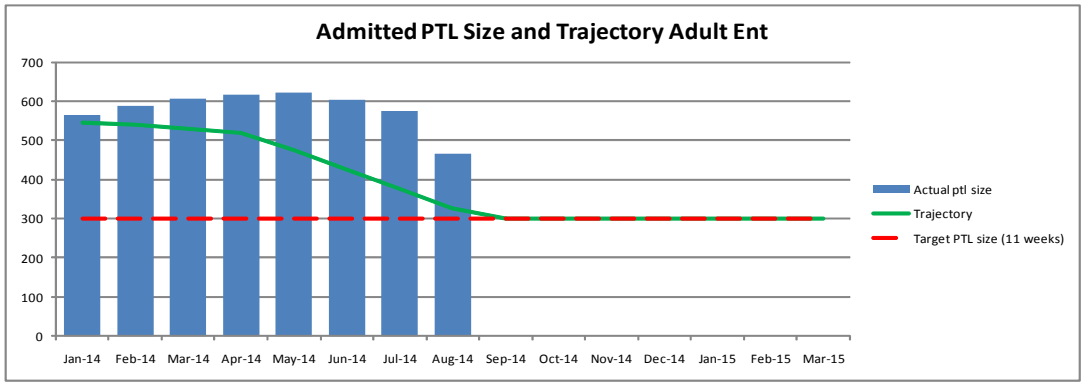
Paediatric ENT

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	364	364	372	452	442	425	428	380	-						
Trajectory	354	354	340	325	311	293	221	192	163	163	163	163	163	163	163
Target PTL size (11 weeks)	163	163	163	163	163	163	163	163	163	163	163	163	163	163	163



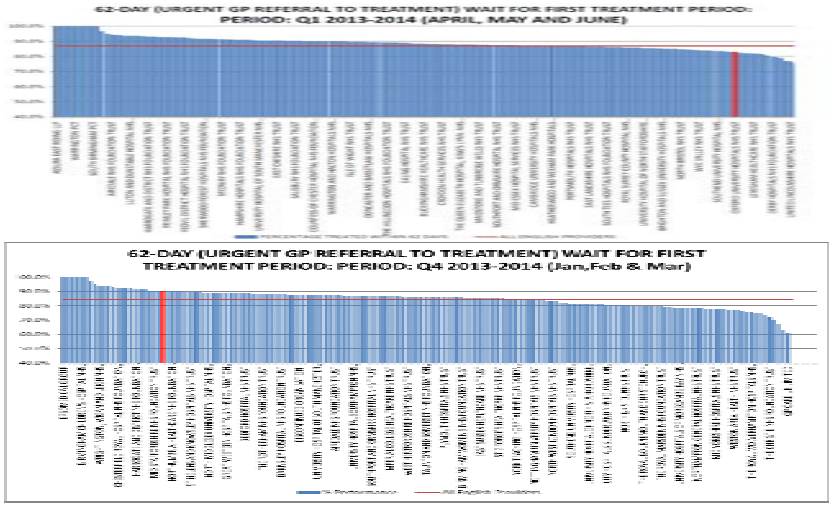
Adult Ent

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	565	589	606	618	621	604	575	467	-						
Trajectory	545	540	529	518	475	425	375	326	300	300	300	300	300	300	300
Target PTL size (11 weeks)	300	300	300	300	300	300	300	300	300	300	300	300	300	300	300



R10 and R14 CANCER WAITING TIMES PERFORMANCE

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance (June 2014)	YTD performance	Forecast performance for next reporting period (July 2014)
The measures instigated to address performance during 2013/14 which resulted in a Q1 to Q4 in-year transformation from lower to upper quartile performance when benchmarked nationally (see right) remain in operation. These delivered 12 consecutive months of performance exceeding target. The responsible factors for the abrupt deterioration by M3 of 14/15 are multiple and vary from one type of cancer to another. The overarching internal contributory factors to this are likely to relate to focus on competing priorities for the trust, including RTT recovery plans, Emergency performance and Finance. Externally there has been a very large increase in demand generated by 2WW referrals. This has particularly related to Breast Cancer.This has now translated to a very significant increase in activity required to service the relevant tumour sites. 2WW referrals were 13% higher per month in Q1 14/15 than the average for 13/14. July 14 2WW referrals are 25% higher than the average 13/14 levels. 62 day activity levels did not rise in Q1 compared with 13/14, but have jumped 20% in July, despite which the backlog has grown as a reflection of heavily increased demand. For 31 day the main reason for failure has been surgical capacity in breast.	The CMGs have analysed breach maps and delayed patient pathway tracking reports and derived evidence based recovery plans for the cancer types they host. CMGs have confirmed these plans to return performance by end of Q2 14/15. CSI has produced a supporting plan to continue improvements to delivery of cancer diagnostics to facilitate recovery. CMG and Cancer Centre to adopt joint ownership of Cancer Pathways through CMG Cancer Action Boards. Clinical engagement strengthened through revision of membership and TOR of clinical Cancer Board. Series of individual meetings between CMGs, Cancer Centre and COO, focussing on those hosting tumour sites with most challenged performance. Weekly high level cancer performance dashboard circulated to CMG managers/directors and COO with real time information to allow intervention in addition to scrutiny. This also standing item on Executive Performance Board. Establish work streams with CMGs to manage demand through appropriate policy, process and education. Surgical capacity in breast has been increased.	**62 day 85%**	**73.2%**	**84.1%**	**86.2%**
		31 day 96%	**93.6%**	**94.6%**	**91.4**



62 day Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
86.7%	84.1%	83%	85%	86%

Expected date to meet standard / target	September 2014
Revised date to meet standard	October 2014
Lead Director / Lead Officer	Richard Mitchell/Matt Metcalfe

R17 and R18 OPERATIONS CANCELLED ON THE DAY AND PATIENTS REBOOKED WITHIN 28 DAYS

Operations cancelled on the day for non clinical reasons			**July**		
What is causing underperformance?	**What actions have been taken to improve performance?**	**Target (mthly) 1)On day= 0.8% 2) 28 day = 0**	**Latest month performance**	**YTD performance**	**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 % 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. Cancellations on the day as a result of bed related issues has significantly reduced during July. Whereas non bed related issues have remained static.	The key action to ensure on going good performance is the daily expediting of patients at risk of cancellation on the day, following the UHL cancelled operations policy. For those cancelled on the day, adhering to the Trust policy of escalating to CMG Directors and General Managers for resolution. The 'Cancelled Operations' manager starts in post at the end of September. The key focus of their role will be to ensure both bed and non bed related cancellations continue to reduce and that all patients cancelled are rebooked within 28 days. Risks to delivery of recovery plan There are risks to delivery of the plan to reduce cancellations on the day. These are mainly associated with bed availability. Circa 75% of cancellations on the day are due to no bed.		1) UHL: 0.72% UHL & Alliance: 0.9% 2) 2 patients	UHL & Alliance: 1.0%	0.8%

UHL performance

1. The percentage of operations cancelled on/after the day for non-clinical reasons during July was 0.72% against a target of 0.8%.
2. The number of patients cancelled who breached the standard of being offered another date within 28 days in July was 2 with 97.2% offered a date within 28 days of the cancellation.
3. The number of urgent operations cancelled for a second time ; Zero

Combined UHL and Alliance performance

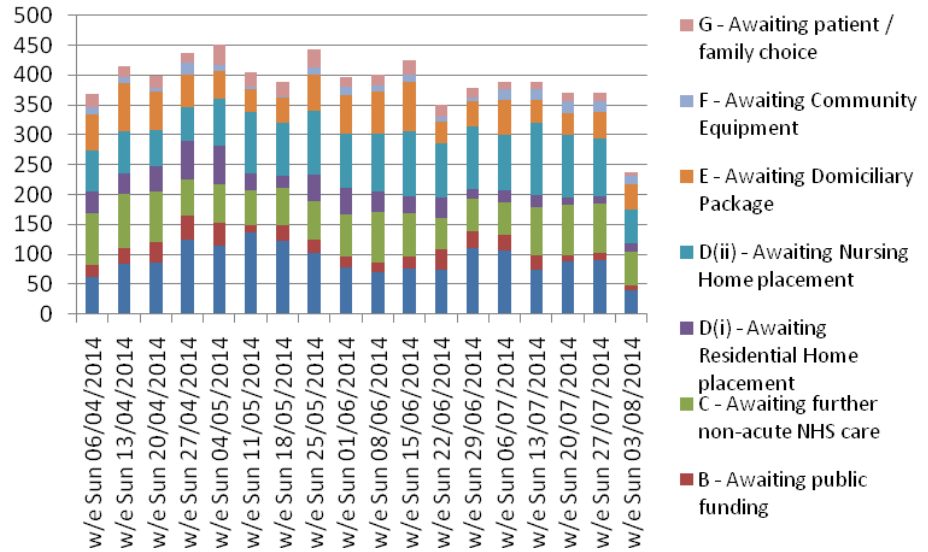
Due to exceptional circumstances during July a total of 23 patients were cancelled in the community hospitals for non clinical reasons (usually no more than 5 per month). Factors included equipment failure which resulted in high volume lists being cancelled.

13/14 FYE	**14/15 Q1**	**14/15 Q2**	**14/15 Q3**	**14/15 Q4**
1.6%	1.0%			

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

R19 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
Currently there are significant delays in DTOCs due to slow discharges to care homes. This is caused by families being slow to find appropriate care homes, carehomes being slow to come in to assess the patient as suitable or waiting for a bed to become available There are also delays in getting patients assessed using the CHC assessment package. There continue to be patients waiting for community hospital beds and home support.	We are currently looking at an external company to assess their ability to support transferring patients to their own homes or to carehomes more efficiently. Work is being done on increasing the number of available CHC assessors available within the trust. Whilst there is often community hospital capacity it is often in the wrong hospital geographically, so patients refuse to move out of UHL.	3.5%	4.1%	4.3%	4.1%



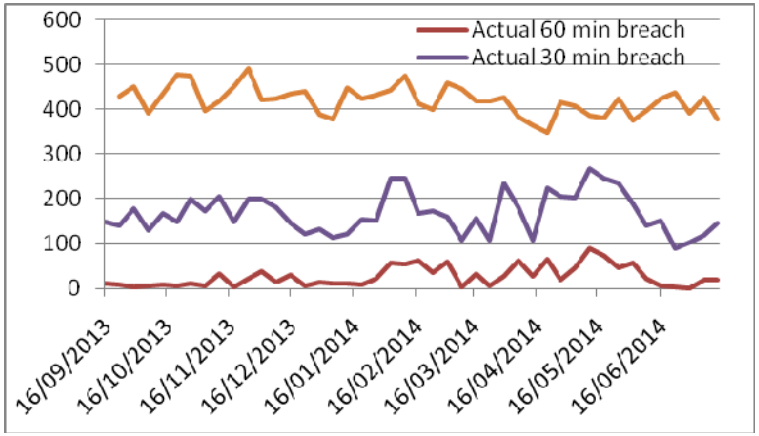
Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
		4.4%		

Expected date to meet standard / target	To be confirmed
Revised date to meet standard	
Lead Director / Lead Officer	Richard Mitchell/Phil Walmsley

R21 and R22 AMBULANCE HANDOVER >30 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
Delays in moving patients out of the assessment bay leads to delays in ambulance staff handing over to ED staff. The delays in the assessment bay in ED is caused by lack of capacity, which is mainly due to patients not flowing out of ED or a slow assessment process.	Work across the health economy, led by Dr I Sturgess is leading to improved flow from majors to the wards. A review of the assessment process in ED has led to changes that should see faster assessment bay processes. This will mean that there are more bays available as long as they flow out of majors is maintained. There has also been agreement that all patients going to resuscitation are assumed to be a 0 delay which commenced in August. This should lead to a small improvement in performance in the August figures.	0 delays over 30 minutes	> 60 min 1% 30-60 min – 12% 15-30 min – 38%	> 60 min 3% 30-60 min – 16% 15-30 min – 36%	



The target performance is to have no over 30 minute delays.

There has been a small improvement in reducing delays in the last months figures.

Expected date to meet standard / target	
Revised date to meet standard	To be confirmed.
Lead Director / Lead Officer	Richard Mitchell Phil Walmsley

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 - 15 Indicators		78

Effective Domain

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

Caring Domain

Metric	Standard	Weighting
Inpatient Scores from Friends and Family Test	80	5
A&E Scores from Friends and Family Test	46	5
Complaints	tbc	5
Mixed Sex Accommodation Breaches	0	2
Inpatient Survey Q 68 - Overall, I had a very poor/good experience	tbc	2
TOTAL - 5 Indicators		19

Safe Domain

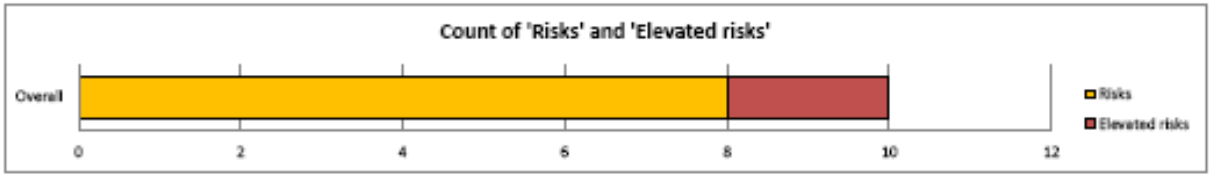
Metric	Standard	Weighting
Clostridium Difficile - Variance from plan	tbc	10
MRSA bactaraemias	0	10
Never events	0	5
Serious Incidents rate	0	5
Patient safety incidents that are harmful		5
Medication errors causing serious harm	0	5
CAS alerts	0	2
Maternal deaths	1	2
VTE Risk Assessment	95	2
Percentage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

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	tbc	2
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment	tbc	2
Data Quality of Returns to HSCIC	tbc	2
Trust turnover rate	tbc	3
Trust level total sickness rate	tbc	3
Total Trust vacancy rate	tbc	3
Temporary costs and overtime as % of total paybill	tbc	3
Percentage of staff with annual appraisal	tbc	3
TOTAL - 10 Indicators		25

University Hospitals of Leicester NHS Trust

Trust Summary



Priority banding for inspection	Recently Inspected
Number of 'Risks'	6
Number of 'Elevated risks'	2
Overall Risk Score	12
Number of Applicable Indicators	95
Percentage Score	6.32%
Maximum Possible Risk Score	190

Elevated risk	Composite Indicator: A&E waiting times more than 4 hours (05-Jan-14 to 30-Mar-14)
Elevated risk	Whistleblowing alerts (22-Mar-13 to 02-Jun-14)
Risk	Never Event Incidence (01-May-13 to 30-Apr-14)
Risk	Composite of Central Alerting System (CAS) safety alerts indicators (01-Apr-04 to 30-Apr-14)
Risk	SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator (01-Oct-13 to 31-Dec-13)
Risk	Composite Indicator: Referral to treatment (01-Mar-14 to 31-Mar-14)
Risk	Proportion of ambulance journeys where the ambulance vehicle remained at hospital for more than 60 minutes (01-Apr-14 to 30-Apr-14)
Risk	Composite of PLACE indicators (01-Apr-13 to 30-Jun-13)
Risk	TDA - Escalation score (01-Nov-13 to 30-Nov-13)
Risk	GMC - Enhanced monitoring (01-Mar-09 to 21-Apr-14)

QUALITY SCHEDULE AND CQUIN SCHEMES PERFORMANCE REPORT FOR Q1 AND ANTICIPATED RAGS FOR JULY 14

Ref	Indicator Title	Q1 RAG	July RAG	Commentary
	QUALITY SCHEDULE			
PS01	Infection Prevention and Control Reduction.	G	G	C Diff Threshold for 14/15 is 81. UHL is aiming to achieve a reduction on last year's total of 66. UHL's IP Annual Programme has been shared with Commissioners.
PS02	HCAI Monitoring - MRSA	0	0	0 MRSA bacteraemias for Q1 or July 14.
PS03	Patient Safety – compliance with NHS SI framework and demonstrate lessons learnt and actions taken	0	0	There were no Never Events in Q1 or July. Q1 Patient Safety report presented with details of learning and actions taken
PS04	Duty of Candour	0	tbc	All patients have been notified of any moderate or serious incidents in Q1, where applicable. One justified breach in May. June's performance tbc.
PS05	Complaints and user feedback Management (excluding patient surveys).	A	tbc	Responses to NHS Choices/Patient Opinion being met. Complaints responses performance still below the 95% threshold following significant increase in numbers of complaints. All CMGs working towards improving performance in Q2. Performance slightly improved for GP concerns 25 day responses.
PS06	Risk Assurance / CAS Alerts	A	A	All Risks reviewed and actions on Track. Some delays with CAS alerts. Expected to be all closed by September.
PS07	Safeguarding	G	G	Assurance documentation sent to CCG Safeguarding leads for their review ahead of their observational visit to the Trust. – Reported to Safeguarding Cttee.
PS08	Reduction in Hospital Acquired Pressure Ulcer incidence.	G	G	Monthly thresholds achieved for both Grade 2 and Grade 3 HAPUs. 0 Grade 4s.
PS09	Medicines Management Optimisation	A	A	Deterioration in Controlled Drugs Audit results. Reaudit due in September. Progress made with development of LLR Medicines Optimisation Strategy.
PS10	Medication Errors	G	G	Increased reporting of medication errors. Actions being monitored by Medicines Optimisation Committee
PS11	Venous Thromboembolism (VTE)	95.7%	95.7%	Performance continues to be just above the national set threshold of 95% for all CMGs except CHUGs which are at 94%. RAG deferred until reporting of RCAs delayed to September CQRG
PS12	Nutrition and Hydration	G	G	Nursing Metrics amended to better monitor fluid and nutritional care. Work commenced to review Fluid Management Guidelines, taking into account the NICE IV Fluid Management guidelines. End of year threshold agreed.
PE1	Same Sex Accommodation Compliance	6	0	No breaches for July.
PE2	Patient Experience, Equality and Listening to and Learning from Feedback.	G	G	Triangulation of patient feedback completed and confirms 'waiting times' continue to be highest theme both in respect of complaints and Friends and Family 'detractors' free text comments
PE3	Improving Patient Experience of Hospital Care (NPS)	N/A	N/A	Not due to be reported until March 15
PE4	Equality and Human Rights	G	G	Progress report due for the August Trust Board.

QUALITY SCHEDULE AND CQUIN SCHEMES PERFORMANCE REPORT FOR Q1 AND ANTICIPATED RAGS FOR JULY 14

Ref	Indicator Title	Q1 RAG	July RAG	Commentary
CE01	Communication - Content	tbc	tbc	Commissioners agreed to defer reporting of Q1 performance until September in order to allow time for actions to be taken. Audit undertaken
CE02	Intra-operative Fluid Management	G	G	Clinical and Managerial Leads identified. Action Plan revised and performance on trajectory.
CE03	Clinical Effectiveness Assurance	G	G	Green RAG for Audit Programme - Reduction in number of audits behind schedule or action plans not on track National Quality Dashboard no longer being published. Compliance responses not received for all 13/14 published NICE Clinical Guidelines and Quality Standards. Responses/Compliance for 14/15 published guidance all on track.
CE04	Women's Service Dashboard	tbc	tbc	RAG to be confirmed at the September CQRG upon review of the updated dashboard and receipt of updated HIE report.
CE05	Children's Service Dashboard	A	A	Thresholds for Registrar training not met. Increased number of mediation errors reported following work undertaken by clinical lead.
CE06	Patient Reported and Clinical Outcomes	tbc	tbc	Publication of 13/14 PROMs data due later this month. Reporting to CQRG deferred until Oct meeting. Amber RAG anticipated due to delays in submission of data for DAHNO and Bariatric Surgery for 2014.
CE07	#NOF - Dashboard	51%	77%	72% threshold not met for any month in Q1. AMT and Orthogeriatric Assessment threshold not met. Commissioners requested to defer reporting of Action Plan till October meeting in order to allow time for recent changes to take impact.
CE08a	Stroke monitoring	86%	tbc	90% Stay on Stroke Unit performance just below 80% for May but overall achieved threshold for Q1. TIA performance below 60% for May but again achieved for Q1. Action Plans submitted and also proposed plans for increasing capacity within the TIA clinic and improvement in SSNAP.
CE08b	TIA monitoring	70%	62.8%	
CE09	Mortality	A	A	UHL's SHMI remains above 100. Mortality alert reviews completed on track and MRC work programme is on schedule.
CE10	MECC	tbc	tbc	STOP 'Bedside Project' commenced, Alcohol Liaison team weekend working continues. Little progress made with using Patient Centre to capture smoking status.
AS01	Cost Improvement Programme (CIP) Assurance	A	tbc	Assurance required that systems and on going monitoring processes in place. Audit trail in place for CIP schemes but lack of evidence about on-going assessment of risks associated with those schemes. – **Agenda Item 5.9 – Paper L**
AS02	Nursing Workforce and Ward Health-check	G	G	Recruitment of additional nurses continues.
AS03	Staffing governance	A	A	Due to non achievement of internal thresholds relating to Sickness and Appraisal.
AS04	Involving employees in improving standards of care.	G	G	
AS05	Staff Satisfaction	G	G	
AS06	External Visits and Commissioner Quality Visits	G	G	July CCG Quality Visits report received Action Plans to be submitted to Sept EQB meeting.
AS07	CQC Registration	G	G	Actions on track to achieve compliance. July 14 CQC IMR also identifies areas of risk –
	NATIONAL CQUINS			

QUALITY SCHEDULE AND CQUIN SCHEMES PERFORMANCE REPORT FOR Q1 AND ANTICIPATED RAGS FOR JULY 14

Ref	Indicator Title	Q1 RAG	July RAG	Commentary
Nat 1.1a	F&FT 1a - Staff	G	G	Implemented during May. National report expected in September. On track for next Staff F&FT before end of Q2.
Nat 1.1b	F&FT 1b - OutPt & Day Case	G	G	F&FT already happening in Day Case and has started in Outpatients.
Nat 1.2	F&FT 1.2 - Increased participation	16.5%	10%	Whilst the participation rate has continued at 15% for Q1. Participation dropped in July and the threshold for 14/15 CQUIN is to be at 20% by March 15.
Nat 1.3	**F&FT 1.3 - Inpt increase in March**	37.5%	37.5%	The participation rate for inpatients continues to increase and currently on track to achieve the March 15 40% threshold..
Nat 2.1	**ST 2.1 - ST data submission**	G	G	Data collection continues.
Nat 2.2	**ST 2.2 - LLR strategy**	tbc	G	LLR Strategy and Action Plan to be reviewed at the September CQRG. Continued progress with collaborative working across the health economy.
Nat 3.1	**Dementia 3.1 - FAIR**	G	tbc	90% threshold met for Q1. July data tbc.
Nat 3.2	**Dementia 3.2 - Training & Leadership**	G	G	Nicky Morgan is new Clinical Lead Dementia Category C Training Module reviewed and Training Programme to be amended following discussion with Commissioners
Nat 3.3	**Dementia 3.3 - Carers**	G	G	Survey Schedule agreed with Commissioners and implemented in Q1.
	LOCAL CQUINS			
Loc 1	**Urgent Care 1 (Discharge)**	tbc	tbc	Dependent upon agreement of definition and thresholds with Commissioners.
Loc 2	**Urgent Care 2 (Consultant Assessment)**	tbc	tbc	Dependent upon delivery of audit data and implementation plans.
Loc 3	**Improving End of Life Care (AMBER)**	G	tbc	On track to achieve the Q1 threshold but Q2 at risk due to both Facilitators leaving. Recruitment underway but likely to be a one month gap before both posts filled
Loc 4	**Quality Mark**	G	G	Provisional data received that Quality Mark achieved for 7 out of 8 wards.
Loc 5	**Pneumonia**	tbc	tbc	Q1 threshold is provision of baseline data and improvement plan. New CQUIN nurses appointed to replace previous post holders.
Loc 6	**Think Glucose**	G	G	Recruitment in progress. Q1 thresholds met and on track to achieve Q2 requirements.
Loc 7	**Sepsis Care pathway**	G	G	Good progress made with actions. Sepsis Nurse appointed. Audit confirmed achievement of the Q1 thresholds.
Loc 8	**Heart Failure**	G	G	Q1 threshold missed by 0.5% due to higher than usual number of admissions and annual leave. Commissioners given Green RAG in recognition of work undertaken.

QUALITY SCHEDULE AND CQUIN SCHEMES PERFORMANCE REPORT FOR Q1 AND ANTICIPATED RAGS FOR JULY 14

Ref	Indicator Title	Q1 RAG	July RAG	Commentary
Loc 9	**Medication Safety Thermometer**	41%	tbc	Q1 40% threshold achieved (44/105 wards commenced Think Glucose Programme)
	NATIONAL CQUINS			
SS1	National Quality Dashboards	G	G	Data collected for submission once confirmation of external provider received.
SS2	Breast Feeding in Neonates	73%	tbc	Q1 threshold exceeded.
SS3	Clinical Utilisation Review of Critical Care*			Full scope of CQUIN being finalised*
SS4	Acuity Recording*			Relates to implementation of eHandover and use of the system to capture Acuity scores for all patients.
SS5	Critical Care Standards – Disch*			Relates to reduction in delayed discharge for patients no longer needing Level 2 or Level 1 beds
SS6	Critical Care Outreach Team*			Relates to improved response times for Critical Care
SS7	Consultant Assessment			Links to the CCG CQUIN. Dependent upon provision of baseline data and implementation plan to improve performance
SS8	Highly Specialised Services Collaborative Workshop			Scope of CQUIN confirmed between Specialised Services and ECMO and PCO clinical leads

* Specialised CQUIN monies will be allocated over Q2-4 due to changes made to Schemes during Q1 in collaboration with Commissioners