University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board paper N

TRUST BOARD – 30TH OCTOBER 2014

QUALITY AND PERFORMANCE REPORT – SEPTEMBER 2014

DIRECTOR:	Rachel Overfield, Chief Nurse Kevin Harris, Medical Director Richard Mitchell, Chief Operating Officer Kate Bradley, Director of Human Resources
AUTHOR:	
DATE:	30th October 2014
PURPOSE:	The following report provides an overview of the September 2014 Quality & Performance report highlighting NTDA/UHL key metrics and escalation reports where required.
PREVIOUSLY CONSIDERED BY:	**Finance & Performance Committee** **Quality Assurance Committee**
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

September 2014

One team shared values

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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **30TH OCTOBER 2014**

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

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

1.0 Introduction

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

Research metrics are reported for the first time in this month's Q&P. Clinical Education metrics are being developed for inclusion in next month's Q&P.

2.0 Performance Summary

18 of the 103 indicators were RAG rated Red for this month (20 last month).

Domain	Page Number	Number of Indicators	Indicators with target to be confirmed	Number of Red Indicators this month
Safe	4	18	0	1
Caring	5	15	1	0
Well Led	6	14	7	3
Effective	7	17	0	0
Responsive	8	26	0	12
Research	9	13	0	2
Total		103	8	18

Exception reports:

Well Led – Appraisal rates

Effective - #NOF

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

Research - the thresholds/exception reporting criteria are to be reviewed but that in the meantime exception reports have been included for amber and red indicators.

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.

Safe | Caring | Well Led | Effective | Responsive | Research

	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	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	YTD
Safe	S1a	Clostridium Difficile	RO	DJ	FYE = 81	NTDA	Red / ER for Non compliance with cumulative target	66	5	9	6	6	5	10	0	4	4	6	5	7	2	5	29
	S1b	Clostridium Difficile (Local Target)	RO	DJ	FYE = 50	UHL	Red >5 per month, ER when YTD red	66	5	9	6	6	5	10	0	4	4	6	5	7	2	5	29
	S2a	MRSA Bacteraemias (All)	RO	DJ	0	NTDA	Red = >0 ER = 2 consecutive mths >0	3	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1
	S2b	MRSA Bacteraemias (Avoidable)	RO	DJ	0	UHL	Red = >0 ER = 2 consecutive mths >0	1	0	1	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	1	0	0	0	0	1	0	0	0	0	0	0	0	0
	S4	Serious Incidents	RO	MD	tbc	NTDA	tbc	60	5	4	5	8	4	3	4	5	4	6	3	7	2	3	25
	S5	Proportion of reported safety incidents that are harmful	RO	MD	tbc	NTDA	tbc	2.8%	3.1%		2.3%			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	1	0	0	0	0	0	0	0	2	2	2	3	0	0	9
	S7	RIDDOR - Serious Staff Injuries	RO	MD	FYE = <47	UHL	Red / ER = non compliance with cumulative target	47	3	4	6	4	4	7	2	5	3	5	1	2	2	1	14
	S8	Safety Thermometer % of harm free care (all)	RO	EM	tbc	NTDA	Red = <92% ER = in mth <92%	93.6%	93.5%	93.1%	94.7%	93.9%	94.0%	93.8%	94.8%	93.6%	94.6%	94.7%	94.2%	94.9%	94.4%	93.9%	94.4%
	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%	95.2%	95.4%	95.5%	96.7%	96.1%	95.6%	95.0%	95.6%	95.7%	95.9%	95.9%	96.3%	95.5%	96.2%	95.9%
	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	<7.5	QC	Red >= YTD >8.4 ER = 2 consecutive reds	7.1	6.9	5.9	7.9	7.0	7.0	6.6	7.0	6.9	7.1	8.5	8.1	8.4	8.8	6.0	7.7
	S12	Avoidable Pressure Ulcers - Grade 4	RO	EM	0	QS	Red / ER = Non compliance with monthly target	1	0	0	1	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	8	5	5	4	5	7	3	6	5	5	5	5	6	6	32
	S14	Avoidable Pressure Ulcers - Grade 2	RO	EM	<10 a month	QS	Red / ER = Non compliance with monthly target	120	10	5	7	8	5	10	8	9	6	6	6	7	8	4	37
	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%			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		New Indicator for 14/15								≥71%	≥77%	≥75%	Action Planning	≥74%	≥85%	≥76.4%

	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	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-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	69.6	67.6	66.2	70.3	68.7	71.8	69.0	69.9	69.6	71.0	74.5	73.8	73.8	76.1	73.0
	C1b	Inpatient Friends and Family Test - Score (Local Target)	RO	CR	75	UHL	Red/ ER =<=69.9 Green >74.9	68.8	69.6	67.6	66.2	70.3	68.7	71.8	69.0	69.9	69.6	71.0	74.5	73.8	73.8	76.1	73.0
	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	59.6	57.6	58.8	58.6	67.4	67.6	58.7	65.5	69.4	66.0	71.4	71.7	56.3	66.1	66.4
	C2b	A&E Friends and Family Test - Score (Local Target)	RO	CR	75	UHL	Red/ ER =<=64.9 Green >74.9	58.5	59.6	57.6	58.8	58.6	67.4	67.6	58.7	65.5	69.4	66.0	71.4	71.7	56.3	66.1	66.4
	C3	Outpatients Friends and Family Test - Score	RO	CR	75	UHL	Red / ER =<=64.9	New Indicator Repoerted in November															
	C4	Daycase Friends and Family Test - Score	RO	CR	75	UHL	Red / ER =<=69.9	New Indicator									77.3	79.0	78.1	74.0	73.7	80.4	77.1
	C5	Maternity Friends and Family Test - Score	RO	CR	75	UHL	Red/ ER =<=61.9	64.3			64.8	62.1	63.7	67.3	62.1	66.7	61.2	63.5	69.5	69.7	67.3	63.0	65.7
	C6	Complaints Rate per 100 bed days	RO	MD	tbc	NTDA	tbc		0.4	0.4	0.4	0.3	0.3	0.3	0.5	0.4	0.4	0.3	0.3	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%	8%
	C8	Single Sex Accommodation Breaches	RO	CR	0	NTDA	Red = >0 ER = in mth >0	2	0	0	0	2	0	0	0	0	4	2	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
	C10	Responsiveness and Involvement Care (Average score)	RO	CR	0.8 improve-ment	QC	tbc										87.6	87.5	87.7	88.0	88.2	88.8	87.9
	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	89.0	89.2	89.0	90.3	89.3
	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	91.8	91.3	91.8	91.9	92.8	91.9
	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	84.4	85.2	85.4	85.9	85.6	85.1

	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	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-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%	22.0%	25.8%	21.7%	25.4%	23.3%	24.5%	28.2%	28.8%	36.8%	38.1%	32.6%	30.8%	28.9%	33.4%	33.3%
	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%	16.1%	11.1%	16.3%	18.4%	16.4%	15.6%	18.4%	16.1%	15.2%	17.8%	14.9%	10.2%	16.1%	19.1%	15.6%
	W3	Outpatients Friends and Family Test - Valid responses	RO	CR	tbc	UHL	tbc	New Indicator available from October 2014								271	34	187	1406	1305	642	730	4304
	W4	Maternity Friends and Family Test - Coverage	RO	CR	tbc	UHL	tbc	25.2%			27.7%	30.3%	24.8%	20.9%	23.7%	23.9%	27.2%	36.4%	25.2%	29.2%	29.9%	18.7%	27.8%
	W5	NHS 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									53.7%						53.7%
	W6	NHS 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%						68.3%
	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%	UHL	Red = >10% ER = 3 consecutive mths >10%	10.0%	9.3%	9.7%	9.6%	9.7%	10.2%	10.6%	10.4%	10.0%	9.9%	10.0%	10.2%	10.0%	10.5%	10.3%	10.2%
	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%	3.1%	3.1%	3.3%	3.5%	3.8%	3.8%	3.7%	3.5%	3.5%	3.4%	3.3%	3.6%	3.8%		3.5%
	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%	8.5%
	W12	% of Staff with Annual Appraisal	KB	ES	95%	UHL	Red = <90% ER = <90%	91.3%	92.7%	91.9%	91.0%	91.8%	92.4%	91.9%	92.3%	91.3%	91.8%	91.0%	90.6%	89.6%	88.6%	89.7%	90.2%
	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%	49%	55%	58%	60%	65%	69%	72%	76%	78%	79%	79%	80%	83%	85%	85%
	W14	% Corporate Induction attendance	KB	ES	95.0%	UHL	Red = <90% ER = <90%	94.5%	94.0%	94.0%	91.0%	87.0%	89.0%	93.0%	89.0%	94.5%	96.0%	94.0%	92.0%	96.0%	98.0%	98.0%	95.7%

Effective

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	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	YTD
E1	Mortality - Published SHMI	KH	PR	Within Expected	NTDA	Higher than Expected		104 (Jan12-Dec12)		106 (Apr12-Mar13)			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	105.3	108.9	107.5	107.5	107.4	108.0	106.7	106.4	105.3	103.5	102.9	102.8	Awaiting HED Update			102.8
E3	Mortality HSMR (DFI Quarterly)	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive mths >100	87.9	91.2		86.0			83.1			82.7			Awaiting DFI Update			82.7
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 mths >100	99.0	103.2	102.0	101.6	101.9	101.2	100.0	100.3	99.0	97.1	97.2	97.3	95.3	Awaiting HED Update		95.3
E5	Mortality - Monthly HSMR (Rebased Monthly as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive mths >100	90.9	105.8	96.8	96.5	100.6	93.9	89.3	102.9	90.9	82.9	103.2	101.5	83.1	Awaiting HED Update		92.5
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 mths >100	100.5	102.0	100.7	100.9	102.2	101.9	101.2	101.1	100.5	98.9	98.3	98.8	96.3	Awaiting HED Update		96.3
E7	Mortality - Monthly HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive mths >100	100.5	105.8	97.1	97.8	107.1	95.4	92.6	101.9	94.2	86.3	95.0	105.0	80.3	Awaiting HED Update		91.4
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 mths >100	98.7	109.1	108.6	106.8	105.0	103.2	101.0	102.4	98.7	95.5	97.5	96.0	95.4	Awaiting HED Update		95.4
E9	Mortality - Monthly HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive mths >100	98.7	116.2	99.0	98.2	93.4	93.4	84.1	106.2	81.5	70.6	128.0	87.2	92.8	Awaiting HED Update		94.9
E10	Deaths in low risk conditions	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive mths >100	93.6	123.3	103.0	98.0	51.5	129.2	163.8	35.1	63.3	47.5	60.4	78.0	Awaiting DFI Update			78.0
E11	Emergency 30 Day Readmissions (No Exclusions)	KH	PR	Within Expected	NTDA	Higher than Expected	7.9%	7.6%	7.8%	7.9%	7.8%	8.0%	8.7%	9.0%	8.8%	8.7%	8.7%	8.6%	8.4%	8.9%		8.7%
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%	67.1%	70.5%	73.6%	72.2%	68.2%	73.7%	54.7%	56.9%	40.6%	60.3%	76.9%	59.0%	68% Provisional	58.8%
E13	Stroke - 90% of Stay on a Stroke Unit	RM	CF	80% or above	QS	Red = <80% ER = 2 consecutive mths <80%	83.2%	88.5%	89.1%	83.7%	78.0%	81.8%	89.3%	83.7%	83.5%	92.9%	80.3%	87.1%	78.1%	84.5%		84.5%
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%	73.6%	64.6%	62.4%	76.8%	65.7%	60.5%	40.7%	77.9%	79.7%	58.8%	71.3%	62.8%	65.5%	72.7%	68.3%
E15	Communication - ED, Discharge and Outpatient Letters	KH	SJ	80% or above	QS	Red = <80% ER = 3 consecutive mths below <80%	New Indicator for 14/15													60% (InPt)	83% (ED)	71%
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	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

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	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	YTD
R1	ED 4 Hour Waits UHL + UCC	RM	CF	95% or above	NTDA	Red = <95% ER via ED TB report	88.4%	90.1%	89.5%	91.8%	88.5%	90.1%	93.6%	83.5%	89.3%	86.9%	83.4%	91.3%	92.5%	91.2%	91.7%	89.3%
R2	12 hour trolley waits in A&E	RM	CF	0	NTDA	Red = >0 ER via ED TB report	5	0	1	0	1	0	0	0	0	0	1	1	0	0	0	2
R3	RTT Waiting Times - Admitted	RM	CC	90% or above	NTDA	Red /ER = <90%	76.7%	85.7%	81.8%	83.5%	83.2%	82.0%	81.8%	79.1%	76.7%	78.9%	79.4%	79.0%	80.9%	82.2%	81.6%	81.6%
R4	RTT Waiting Times - Non Admitted	RM	CC	95% or above	NTDA	Red /ER = <95%	93.9%	95.5%	92.0%	92.8%	91.9%	92.8%	93.4%	93.5%	93.9%	94.3%	94.4%	95.0%	94.9%	95.6%	94.6%	94.6%
R5	RTT - Incomplete 92% in 18 Weeks	RM	CC	92% or above	NTDA	Red /ER = <92%	92.1%	92.9%	93.8%	92.8%	92.4%	91.8%	92.0%	92.6%	92.1%	93.9%	93.6%	94.0%	93.2%	94.0%	94.3%	94.3%
R6	RTT 52 Weeks+ Wait	RM	CC	0	NTDA	Red /ER = >0	0	0	0	0	0	1	1	0	0	3	0	2	16	9	17	17
R7	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	NTDA	Red /ER = >1%	1.9%	0.8%	0.7%	1.0%	0.8%	1.4%	5.3%	1.9%	1.9%	0.8%	0.9%	0.8%	0.7%	1.0%	1.0%	1.0%
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%	94.6%	93.0%	94.9%	95.7%	94.9%	95.3%	95.9%	95.3%	88.5%	94.7%	93.5%	92.2%	92.0%		92.1%
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%	92.0%	95.2%	93.0%	91.3%	95.5%	96.8%	93.4%	94.3%	80.0%	95.0%	98.9%	94.9%	94.4%		93.5%
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%	99.7%	99.1%	98.9%	96.2%	97.4%	97.2%	98.5%	98.2%	97.2%	92.9%	93.6%	94.4%	97.8%		95.2%
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%	98.8%		99.7%
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%	98.4%	88.6%	96.4%	97.1%	92.3%	94.8%	96.4%	98.6%	95.2%	97.0%	90.8%	89.9%	87.3%		91.9%
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%	100.0%	97.7%	97.5%	98.5%	98.1%	94.8%	96.3%	99.1%	97.3%	95.6%	93.9%	97.3%	99.0%		96.7%
R14	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	RM	MM	85% or above	NTDA	Red = <85% ER = Red in mth or YTD	86.7%	88.2%	87.4%	86.4%	85.7%	89.4%	89.1%	89.1%	92.4%	92.7%	88.5%	73.1%	85.6%	78.3%		83.3%
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%	97.2%	96.2%	100.0%	97.0%	96.6%	97.1%	95.1%	91.7%	91.1%	67.4%	73.9%	73.0%	100.0%		80.7%
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	0
R17	Cancelled patients not offered a date within 28 days of the cancellations UHL	RM	PW	0	NTDA	Red = >2 ER = >0	85	5	3	10	4	8	9	2	8	10	3	1	1	1	2	18
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	6
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%	1.4%	2.3%	1.7%	1.8%	1.7%	1.6%	2.1%	1.5%	1.1%	0.8%	1.1%	0.7%	0.6%	0.9%	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%	1.4%	2.3%	1.7%	1.8%	1.7%	1.6%	2.1%	1.5%	0.6%	0.6%	0.3%	2.7%	0.0%	0.9%	0.9%
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%	0.9%	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	124	208	171	172	141	152	178	139	101	72	96	71	55	87	482
R23	Delayed transfers of care	RM	PW	3.5% or below	NTDA	Red = >3.5% ER = Red for 3 consecutive mths	4.1%	3.9%	4.2%	4.6%	4.4%	3.6%	4.6%	4.3%	3.8%	4.6%	4.4%	4.2%	4.0%	4.1%	4.5%	4.3%
R24	Choose and Book Slot Unavailability	RM	CC	4% or below	Contract	Red = >4% ER = Red for 3 consecutive mths	13%	14%	11%	16%	17%	14%	10%	16%	19%	22%	25%	26%	25%	26%	25%	25%
R25	Ambulance Handover >60 Mins (based on weekly figures)	RM	CF	0	Contract	Red = >0 ER = Red for 3 consecutive mths	868	16	21	25	59	102	52	207	111	173	253	88	71	50	106	741
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	383	484	705	689	722	573	818	601	720	951	671	591	805	736	4,474

Research

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Sep-14	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%	92%
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%	67%
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%
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%	90.0%
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%
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%
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%
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	325
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% (*June)	100% (*June)

W12 – Appraisal Rates

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
1. There is a slight improvement in performance over the last month, from 88.62% to 89.67% (against a trajectory of 90%) 2. Feedback from Clinical Management Group and Directorates Leads indicates that the reduction in performance is caused by:- a. Line manager / appraiser omissions in data return b. Appraiser / senior staff sickness in some areas c. Service pressures preventing the release of staff to conduct or attend appraisal	1. Discussion at CMG / Directorate Boards and across services / areas 2. Circulation of breakdown of performance by cost centre covering review period 3. Performance management being pursued for areas that persistently remain below 95% 4. Recovery plans in place across all underperforming areas with trajectories set (at appraisee/ team level) 5. Review of management structures to ensure appropriate devolving and span of control for direct staff 6. Clear expectations set regarding reporting requirements 7. Data capture process re-circulated. 8. Close monitoring at a local level on a weekly basis	**95%**	**89.6%**	**90.2% (average)**	**92% (Oct)**

Performance by CMG

CMG	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Alliance Elective Care		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
CHUGGS	87.14%	87.85%	88.00%	87.65%	85.41%	82.09%	85.47%
Clinical Support & Imaging Services	95.09%	94.72%	94.12%	94.97%	93.24%	93.51%	90.80%
Emergency & Specialist Medicine	90.48%	90.24%	89.05%	86.68%	87.22%	88.76%	91.46%
ITAPS	92.80%	93.79%	91.09%	94.01%	94.03%	88.67%	88.44%
MSK & Specialist Surgery	94.11%	96.61%	95.19%	90.94%	92.59%	88.69%	88.31%
Renal, Respiratory & Cardiac	88.09%	89.62%	90.77%	91.90%	92.23%	93.46%	93.41%
Women's & Children's	89.22%	91.25%	90.14%	89.79%	85.92%	85.79%	89.19%
Corporate	94.3%	91.1%	89.9%	86.9%	85.5%	82.3%	86.9%

CMG Trajectories

CMG	Sept	Oct	Nov
CHUGGS	84%	87%	95%
Clinical Support & Imaging Services	94%	95%	95%
Emergency & Specialist Medicine	90%	95%	95%
ITAPS	92%	94%	95%
MSK & Specialist Surgery	89%	90%	95%
Renal, Respiratory & Cardiac	95%	95%	95%
Women's & Children's	88%	92%	95%
Corporate	83%	89%	95%

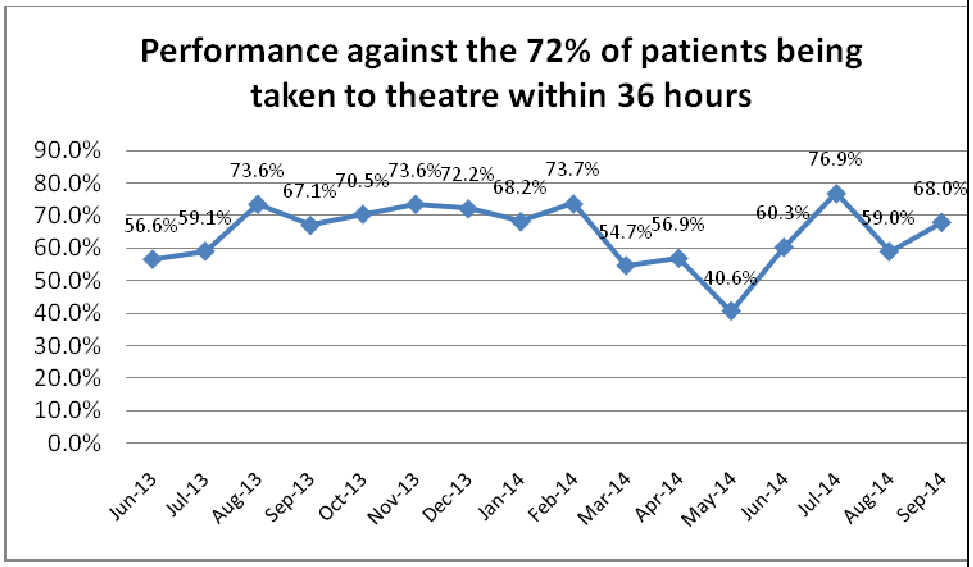
Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
91.3%	90.6%	86.3%		

Expected date to meet standard / target	Monthly Target
Revised date to meet standard	End November 2014
Lead Director / Lead Officer	Kate Bradley, Director of Human Resources Bina Kotecha, Assistant Director of Learning and OD

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 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 for Quarter 2 overall. Although the number of admissions for 14/15 to date is lower than this time last year, there is still significant in month variability with a peak in September of 9 admissions in one day. There is an average of 61 patients admitted with #NOF a month.	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 service had started to use one of the Bays on Ward 18 as a 'step down' from the dedicated #NOF Ward (W32) but was unable to take direct admissions due to lack of Orthogeriatrician cover. However it is envisaged that this Bay will become a direct admission area in the winter months when activity is predicted to increase. Orthogeriatrician input will also increase from October as the second post of the two ESM consultants will have started. It is hoped that this will reduce the current cover issues however it is recognised that this will still not be sufficient job planned input to cover the two wards fully.	**72%**	**68%**	**60.3%**	

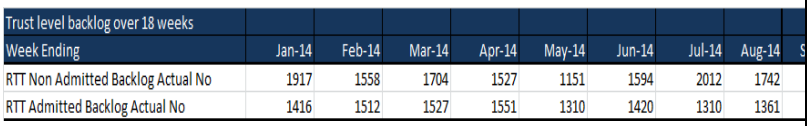


Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
65%	52%	68%		

Expected date to meet standard / target	Dec 14
Revised date to meet standard	
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

Referral to Treatment		Target	Latest performance (September)	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**	**93.9% 79.5%**	**NA**	**95% 80%**
Background The reasons for UHL's deterioration in RTT performance are well documented. This report is the eighth monthly update. UHL's RTT performance is mainly challenged in the following specialities; ENT, orthopaedics and general surgery. The high level trajectories are detailed in the attached Appendices. **Performance overview** For September the Trust is behind trajectory for admitted performance at a Trust Level, even when including Alliance activity. However this reduced performance is as a result of doing additional activity during the month to reduce backlog over 18 weeks. This is set to continue during October and into November. This is particularly in: General surgery, Orthopaedics, ENT and Maxillofacial. For 'non admitted performance' the Trust is also behind trajectory even with the Alliance included. This is as a result of reducing backlog in max fax and other specialities. There are ongoing risks to non admitted performance with orthopaedics and restorative dentistry being of particular concern. The Trust aims to deliver admitted performance in November 2014. Funding to support additional activity and additional costs incurred has been confirmed by CCGs.	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 • Additional MRI activity to reduce non admitted waits for orthopaedics • Ongoing validation of all RTT records, from mid October validation is of all records at 14+ weeks. The Trust is continuing additional in house activity, mostly out of hours and at weekends, notably general surgery with between 8-10 additional lists each weekend for 10 weeks.	 Trust level backlog over 18 weeks Week Ending | Jan-14 | Feb-14 | Mar-14 | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 RTT Non Admitted Backlog Actual No | 1917 | 1558 | 1704 | 1527 | 1151 | 1594 | 2012 | 1742 RTT Admitted Backlog Actual No | 1416 | 1512 | 1527 | 1551 | 1310 | 1420 | 1310 | 1361 **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 and additional admitted clock s tops compared to this period last year • Acknowledge the key risks.			

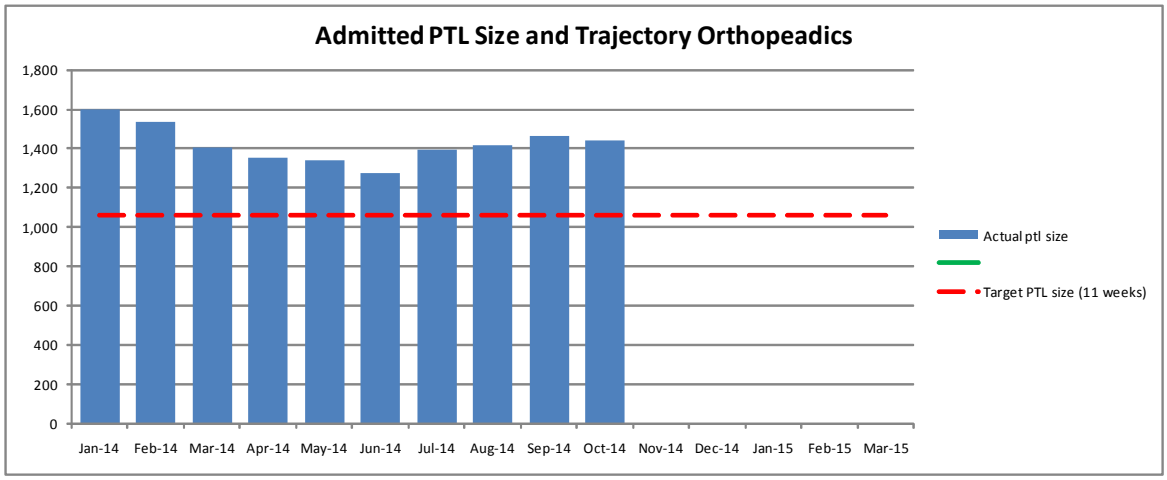
Referral to Treatment		Referral to Treatment	Latest performance	Year to date	Forecast for next reporting period
What is causing underperformance?	**What actions have been taken to improve performance?**	**95% Non Adm 90% Adm**	**As above**	**NA**	**As above**
Ophthalmology continues to perform strongly on both admitted and non admitted. ENT admitted backlogs have continued to reduce in the past month. The planned additional elective activity for general surgery started (mid September) and is set to continue for 10 weeks, with the anticipated treatment of an additional circa 500 cases. This work is taking place at weekends. The effect of this work can be seen in the reduction in total admitted waiting list size. Appendix 2. All of the restorative dentistry patients who breached the 52 week standard have now been treated. There has been no patient harm due to the excessive waits. During September further 9, 52 week patients were identified in Paediatrics, the cause of this was incorrect waiting list management. 5 have been treated the remaining patients will be treated by end of November. All have been clinically reviewed and there have been no reports of harm.	An ongoing programme of training and education is being provided to staff.	**Expected date to meet standard**		Admitted in November 2014 Non admitted in August 2014	
		Revised date to meet standard		Admitted November Non admitted October	
		Lead Director		Richard Mitchell, Chief Operating Officer	
		Clinical Lead		CMG Clinical Directors	
		Managerial Lead		Charlie Carr , Head of Performance	

Specialty Level Trajectory

Inpatient Waiting List

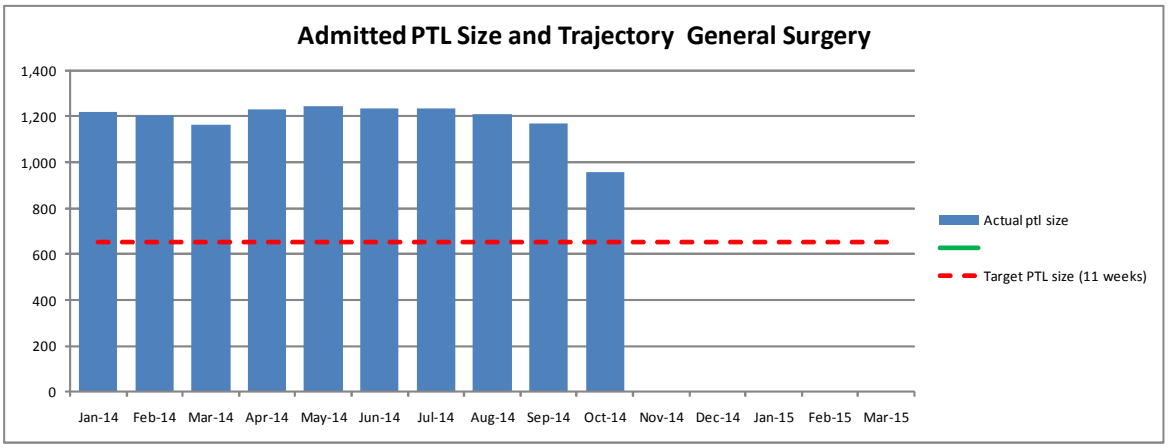
Othopaedics

	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	1,465	1442					
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



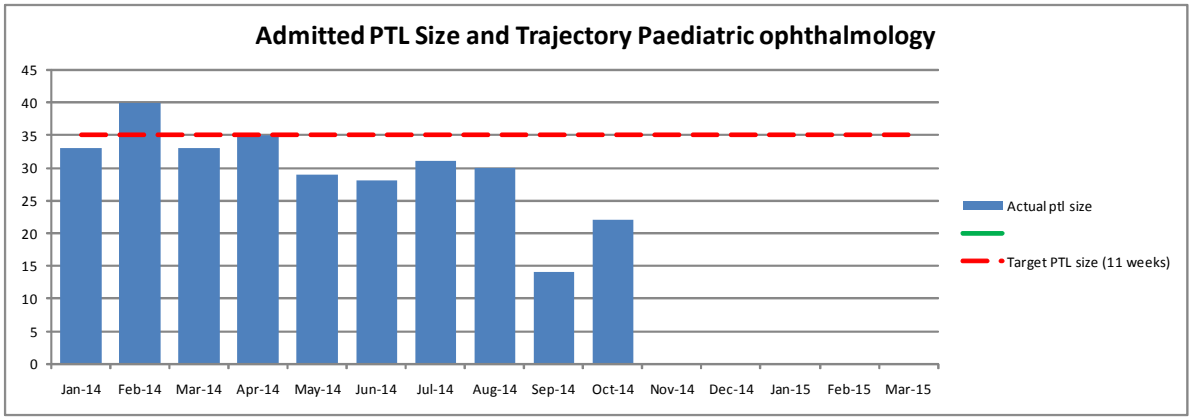
General surgery

	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	1,168	957					
Target PTL size (11 weeks)	651	651	651	651	651	651	651	651	651	651	651	651	651	651	651



Paediatric ophthalmology

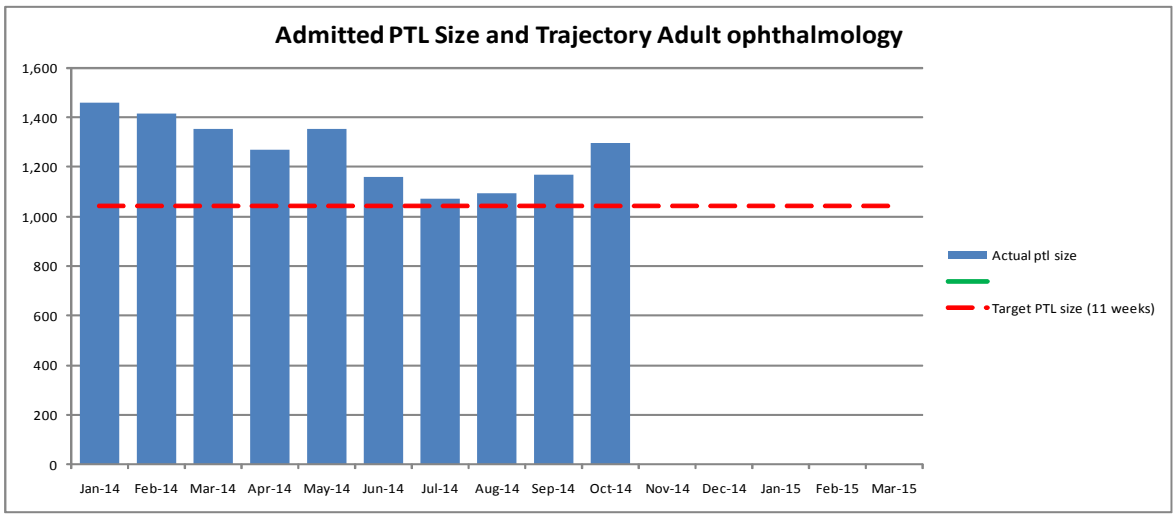
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	33	40	33	35	29	28	31	30	14	22					
Target PTL size (11 weeks)	35	35	35	35	35	35	35	35	35	35	35	35	35	35	35



Inpatient Waiting List (continued)

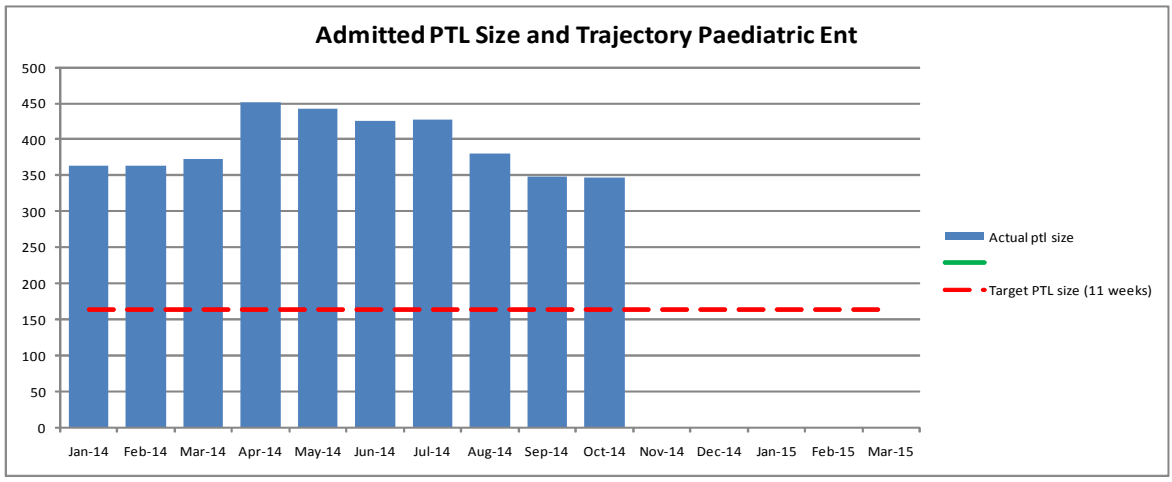
Adult ophthalmology

	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	1,070	1,092	1,168	1296					
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



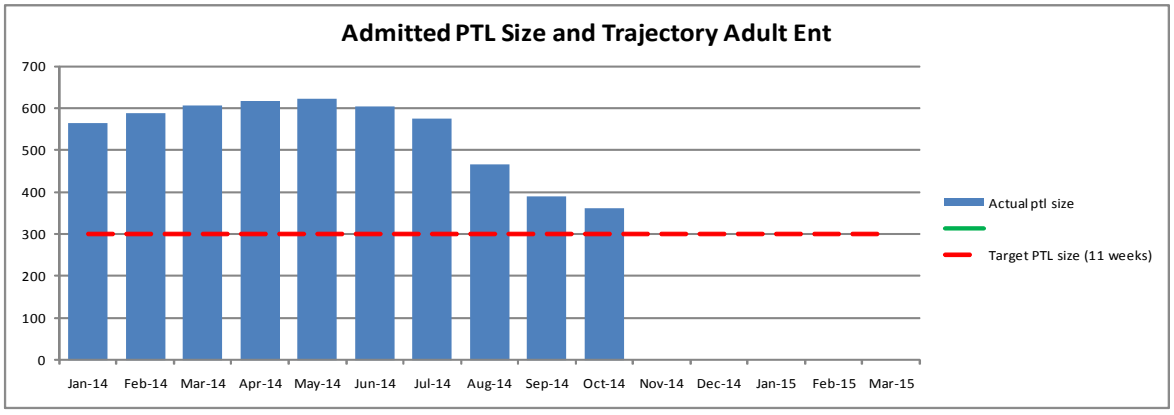
Paediatric ENT

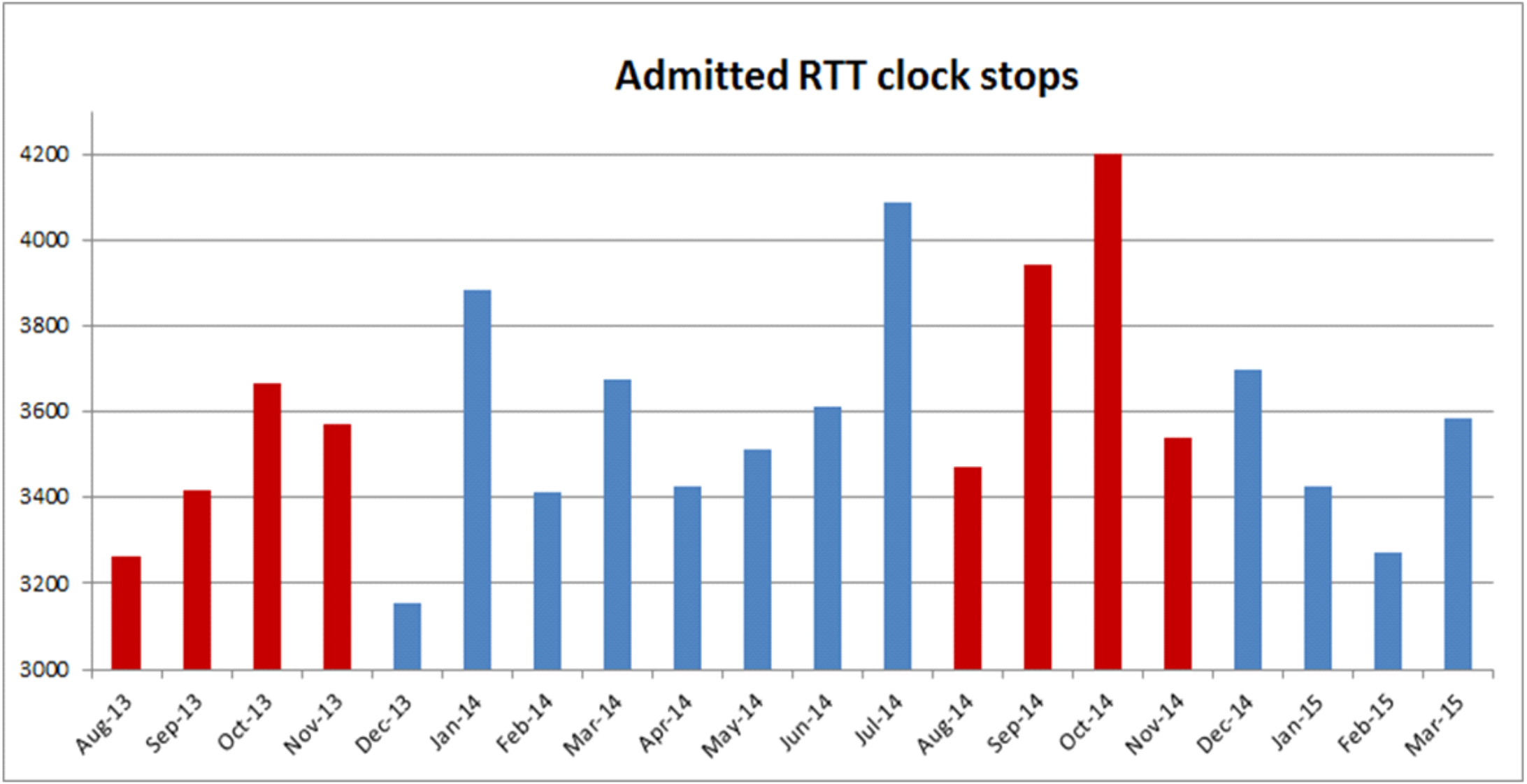
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	364	364	372	452	442	425	428	380	348	347					
Target PTL size (11 weeks)	163	163	163	163	163	163	163	163	163	163	163	163	163	163	163



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	390	361					
Target PTL size (11 weeks)	300	300	300	300	300	300	300	300	300	300	300	300	300	300	300




Admitted RTT clock stops
4200
4000
3800
3600
3400
3200
3000
Aug-13
Sep-13
Oct-13
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
Dec-14
Jan-15
Feb-15
Mar-15

R7 - 6 Week Diagnostic Waiting Time

<table>
<tr><td></td><td></td><td></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 colspan="2">Standard</td><td>August</td><td>YTD performance</td><td>Forecast performance for next reporting period</td></tr>
<tr><td rowspan="5">The Trust is measured on the waiting times of the top 15 diagnostic modalities, these are 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:

In volume terms imaging accounts for circa 70% of the top 15 diagnostics reported. Key issues were:

- CT insufficient cardiac CT capacity – this is ongoing issue and these are supervised scans so need consultant radiologist availability
- MRI -Some specific hotspots cardiac stress and heart. Linked to PET CT slot availability. Work is ongoing to explore a fixed site scanner of mobile scanner and is linked in with national spec commissioning review of PET CT

Additionally, there were small volumes of breaches of the standard in a number of other modalities including: Endoscopy , Cystoscopy , sleep studies, in both adult and paediatric services

However collectively these have caused a breach of the standard. A total of 127 patients waiting over 6 weeks.</td><td rowspan="5">Cardiac CT

The manpower to support cardiac CT is currently under review as well as a review of whether any scans can be unsupervised

MRI

Additional van and agency staff to cover is ongoing

Other modalities

Robust waiting list management, additional capacity where there is risk of breaching , dating patients in date order

Risks:

There remain risks to achievement of this standard due to the instability of a number of diagnostic modalities w which collectively make up this standard.</td><td><1% over 6 weeks</td><td colspan="2">1) UHL 1.09%
2) UHL and Alliance combined 1.0%</td><td>1.0%</td><td><1.0%</td></tr>
<tr><td colspan="5"></td></tr>
<tr><td colspan="3">Expected date to meet standard / target</td><td colspan="2">September 2014</td></tr>
<tr><td colspan="3">Revised date to meet standard</td><td colspan="2">November 2014</td></tr>
<tr><td colspan="3">Lead Director / Lead Officer</td><td colspan="2">Richard Mitchell
Suzanne Khalid / Jo Fawcus / P Walmsley / D Yeomanson</td></tr>
</table>

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

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly)	Latest month performance (September 14)	YTD	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 (R19-R22) 2. The number of patients cancelled who are offered another date within 28 days of the cancellation (R17-R18) 3. The number of urgent operations cancelled for a second time. (R16) The Trust achieved the target for <0.8% cancellations on the day in August but not in September.	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 started 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 within UHL. <u>Risks to delivery of recovery plan</u> 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.	**R19-22)** **On day= 0.8%** **R17+R18)** **28 day = 0**	R19-R22 0.9% UHL only, R21) 0.89% UHL and Alliance R17+R18) UHL= 2 patients Alliance= 0 patients	(UHL and Alliance) R21) = 0.88% R17+18) = 24	0.8% R17+R18 = 2

UHL performance against standards

1. The percentage of operations cancelled on/after the day for non-clinical reasons during September was 0.9% 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 September was 2. One was treated in September the other in early October.
3. The number of urgent operations cancelled for a second time ; Zero

Alliance performance

R21 - 0.9% cancelled on the day. R18+18 and Alliance)□□ No breaches of the 28 day standard.

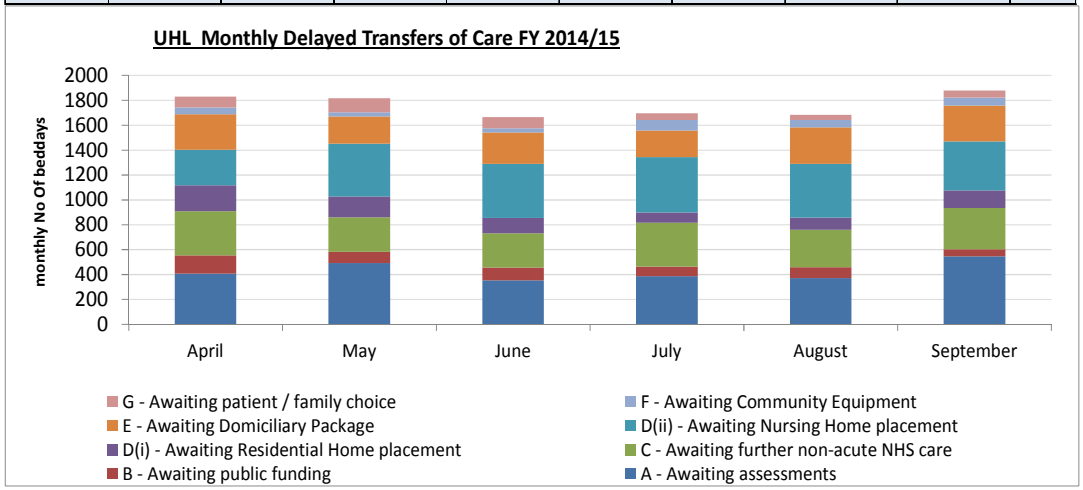
13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
1.6%	0.97%	0.8%		

Expected date to meet standard / target	R19-21) August 2014 R17-18) July 2014
Revised date to meet standard	November 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 was an increase in delays due to DTOC across UHL in September. 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. There has also been a significant reduction in the number of community hospital beds available. This has been evidenced through reduced community hospital bed availability. Discussions are taking place with LPT regarding this. Social care support. – Due to an on-going demand in the number and size of package there have been difficulties and delays in POC availability within the County. UHL is currently looking at an external company to assess their ability to support transferring patients to their own homes or to care homes more efficiently.	The ICRS and ICS teams are attending wards to identify patients that they could take directly in to their home based services. Whilst there is often community hospital capacity it is often in the wrong hospital geographically, so patients refuse to move out of UHL. Choice letters are now issued following refusal of an identified rehab bed. Discussions take place with therapists regarding reducing the required package of care to try to ensure faster discharge. This links in to the joint working between Social Care and health therapy teams to risk assess package sizing.	3.5%	4.5%	4.3%	4.0%

	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	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
Grand Total	2558	562	1898	816	2411	1551	336	441	10573



Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2 to date	14/15 Q3	14/15 Q4
4.1%	4.4%	4.4%		

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

		Target			
What is causing underperformance?	**What actions have been taken to improve performance?**	**<4% ASI**	**September**	**YTD performance**	**Forecast performance for next reporting period**
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	**Capacity** Additional capacity in key specialties is part of the RTT recovery plans Notably: Ophthalmology, ENT, General Surgery and Orthopaedics. But additionally other specialities as and when required. **Training and education** The comprehensive training and education of all relevant staff in all specialties is required, to ensure that choose and book is correctly set up and that supporting administrative purposes are fit for purpose. An interim Project Manager is in post (15th September) with the specific remit of managing the recovery plan and ensuring that a robust recurrent education programme is in place. The recovery plan is currently on track. It is anticipated that recovery will take circa 3 months due to the complexity and volume of work required.	<4%	25%	25%	23%
		National performance varies significantly by Trust, with average performance at circa 10%			
		Expected date to meet standard / target	December 2014		
		Revised date to meet standard			
		Lead Director / Lead Officer	Richard Mitchell Charlie Carr		

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

<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="4">Delays in moving patients out of the assessment bay leads to delays in ambulance staff handing over to ED staff.

Delays in the assessment bay remain due to lack of capacity in majors. This remains an issue with processing in majors and patients not flowing out of ED

Delays in booking patients onto EDIS is also a factor attributed to the delays in assessment bay

Data quality issues with the ‘time to handover’ data provided by EMAS.</td><td rowspan="4">An audit of handover occurred in Aug/Sept. The results of the audit are being finalised. Preliminary results show a discrepancy in data of timings from time on site to handover being different from the calculated time of 1.43 minutes to 4-5 minutes.

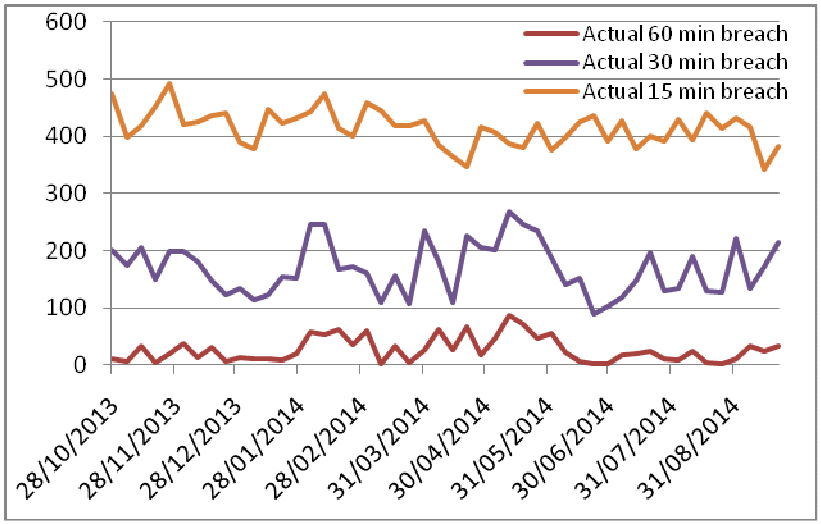
There is a discrepancy in completed handover times up to 20 minutes difference. The audit also showed a discrepancy of 6-30 minutes difference when UHL saw the crew leave the department to EMAS data. The audits displayed that around 18.30 on one audit day 10 crews arrived within 18 minutes.

All patients going to resuscitation are now coded as a zero delay which commenced in August. EMAS data shows 1-3 patients that arrive by ambulance from Resus are missing from the ambulance data.

3 band 4 audit staff recruited to ensure that the audit of handovers continues in a sustainable way.

An Audit is looking at direct admissions to the acute medical unit as these should also be coded as no delay.

A scanner is being sought in order to scan paper handover documents to speed up the process of booking patients onto EDIS. Reception ways of working are being reviewed in order to reduce queues in Assessment Bay.

In reviewing the hour+ delays there is a discrepancy of up to 30 minutes when handover was completed.</td><td>0 delays over 30 minutes</td><td>> 60 min 3%
30-60 min – 16%
15-30 min – 35%</td><td>> 60 min 3%
30-60 min – 16%
15-30 min – 37%</td><td></td></tr>
<tr><td colspan="4"> 
</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2"></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">Richard Mitchell</td></tr>
</table>

RS1 Number of participants recruited into 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
CRN: EM is the 5th highest recruiting LCRN in England (out of 15). This is a very aspirational target that was set with the aim of ensuring we receive an increase in funding from NIHR in the 2015/16 financial year. NIHR CRN's annual allocation for local Clinical Research Networks is a capped budget issued to the 15 LCRNs based on a series of criteria, but predominately influenced by retrospective participant recruitment numbers. Whether your recruitment target is met does not influence funding allocation, relative performance against other LCRNs does. Setting a high target was to ensure that the network did not reach target early on and become complacent, and to ensure that we always strive to increase recruitment. Due to the aspirational target, the network is satisfied with our current progress, especially as since this, the LCRN transitioned from ten smaller research networks into one East Midlands-wide network.	1. Division structure within the LCRN that is responsible for the performance management of studies that fall within their specialty areas. 2. Each Division has a Clinical Lead and individual clinical Specialty Leads to promote engagement amongst clinical staff. 3. Reports have been produced for our Partner organisations (Trusts in receipt of NIHR CRN funding) to illustrate areas of good and poor performance. These are used as a performance management tool by both Partners and Network staff, and to receive useful feedback to improve data quality. 4. Regular engagement events attended by Partners to discuss any overarching performance issues and concerns.	**24,038 / 50,000**	**92%**	**92%**	**92% (Nov)**

Expected date to meet standard / target	Expect performance of 90% and above Quarter 3.
Revised date to meet standard	
Lead Director / Lead Officer	Elizabeth Moss, Chief Operating Officer

RS2a Proportion of commercial contract studies achieving their recruitment target during their planned recruitment period

<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">East Midlands is currently the top performing of the 15 LCRNs for this metric with no LCRN currently achieving the 80% target

A lot of variables impact on recruitment achieved, after the recruitment target is set, for example:

• Impact of global performance and earlier end dates giving less time to recruit
• Changes in UK practice during set up/ recruitment
• Protocol changes prior to initiation
• Understanding of targets and alignment on the source of the target sites are measured on</td><td rowspan="5">1. Migration of the performance data for all open and closed commercial research onto one internet based system to track performance for 2014/15

2. Implementation of a provisional performance management process involving the Industry Team and Delivery Managers to escalate studies not recruiting to target within 24 hours and to align targets

3. Meetings with key research teams to discuss the importance of target setting and aligning the approach across the region so the target is reflective of the contract figure</td><td>80%</td><td>68% (Amber)</td><td>68%</td><td>68% (Nov)</td></tr>
<tr><td colspan="4" rowspan="4"></td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="2">April 2015</td></tr>
<tr><td>Revised date to meet standard</td><td colspan="2">April 2015</td></tr>
<tr><td>Lead Director / Lead Officer</td><td colspan="2">Daniel Kumar, Industry Delivery Manager</td></tr>
</table>

RS6A : Proportion of NHS Trusts recruiting each year into non-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">HLO5A: 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)</td><td rowspan="5">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.
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.
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.</td><td>99%</td><td>81% (red)</td><td>81% (red)</td><td>81% (Nov)</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="3">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.</td></tr>
<tr><td>Revised date to meet standard</td><td colspan="3"></td></tr>
<tr><td>Lead Director / Lead Officer</td><td colspan="3">Elizabeth Moss, Chief Operating Officer</td></tr>
</table>

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="4">HLO5B: 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="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.
DCHS: due to the nature of research within this Trust, they are unlikely to be involved in commercial research.
LCHS: due to the nature of research within this Trust, they are unlikely to be involved in commercial research.
LePT: Selected for one study, due to open by the end of 2014.
LiPT: have been involved in commercial research in the past and the site is actively seeking commercial opportunities
NHFT: One trial in set up, due to open at the end of November 2014
DHFT: One trial recently opened to recruitment, yet to recruit</td><td>70%</td><td>56% (red)</td><td>56% (red)</td><td>62% (Nov)</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">April 2015</td></tr>
<tr><td colspan="2">Revised date to meet standard</td><td colspan="2">April 2015</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">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 - 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	60	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

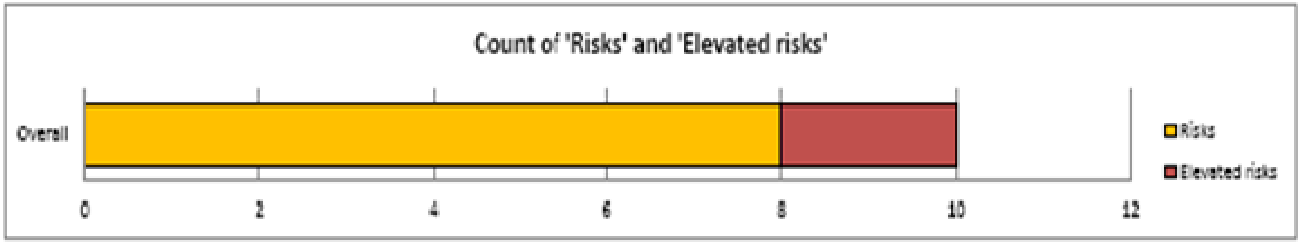
Well Led Domain

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

CQC – Intelligent Monitoring Report

University Hospitals of Leicester NHS Trust

Trust Summary



Priority banding for inspection	Recently inspected
Number of 'Risks'	8
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-Mar-14 to 31-Mar-14)
Risk	GMC - Enhanced monitoring (01-Mar-09 to 21-Apr-14)

Quality Schedule and CQUIN Performance Summary

CONFIRMED Q1 RAGs AS REVIEWED AT THE OCTOBER CQRG AND ANTICIPATED Q2 RAGS FOR MONTHLY REPORTED INDICATORS

Ref	Indicator Title	Q1 RAG	Sept RAG	Commentary
	QUALITY SCHEDULE			
PS01	Infection Prevention and Control Reduction.	G	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. 29 cases as at end of September which is below the NTDA trajectory.
PS02	HCAI Monitoring - MRSA	0	1	1 unavoidable MRSA bacteraemias in September
PS03	Patient Safety – compliance with NHS SI framework and demonstrate lessons learnt and actions taken	0	0	0 Never Events to date.
PS04	Duty of Candour	0	0	All patients have been notified of any moderate or serious incidents where applicable to end of September
PS06	Risk Assurance	A	G	All Risks reviewed and actions on Track. Some delays with CAS alerts in Q1 but none now overdue.. 5 new risks reported for September.
PS08	Reduction in Hospital Acquired Pressure Ulcer incidence.	G	G	Monthly thresholds achieved for both Grade 2 and Grade 3 HAPUs for all of Quarter 2. 0 Grade 4s.
PS09	Medicines Management Optimisation	A	G	Controlled Drugs Reaudit reported to Oct CQRG and improved compliance noted.. Progress made with development of LLR Medicines Optimisation Strategy.
PS11a	Venous Thromboembolism (VTE)	95.7%	96.2%	Q2 average = 96% which is above the national threshold of 95%.
PS11b	RCAs of Hospital Acquired Thrombosis (HAT)	A	G	RCAs completed for all Q1 inpatient HATs. . On track to achieve the Q2 Threshold = 100% inpatient and 60% post discharge
PE1	Same Sex Accommodation Compliance	6	0	No breaches for Q2
PE4	Equality and Human Rights	G	G	Additional assurance provided around actions being taken to collect Protected Characteristics data, as per Commissioners request.
CE07	#NOF - Dashboard	51%	A	72% 'time to theatre' threshold not met for any month in Q1. For Q2 indicators green except for:% of # NOFs to theatre within 36 hours = 68%
CE08a	Stroke monitoring	86%	83.4%	81.3% of stroke patients in Quarter 2 had 90% Stay on the Stroke Unit with

Ref	Indicator Title	Q1 RAG	Sept RAG	Commentary
CE08b	TIA monitoring	70%	66%	67% of patients with suspected 'High Risk TIA' being seen within 24 hour of referral.
AS02	Nursing Workforce and Ward Health-check	G	G	Recruitment of additional nurses continues and assurance provided about actions taken to address 'fill rates'.
AS03	Staffing governance	A	A	Due to non achievement of internal thresholds. September's performance - Appraisal = 88.6% Sickness = 3.9 (Jul) Staff Turnover = 10.5% Statutory & Mandatory Training =83% Corporate Induction = 98%
	NATIONAL CQUINS			
Nat 1.2	F&FT 1.2 - Increased participation	G	G	Q2 participation for Inpatients = 31% which is above end of year threshold. Q2 for ED is 15.1% which is above baseline but below the 20% end of year target significant drop in performance in July (10%). September = 19.1%.
	LOCAL CQUINS			
Loc 5	**Pneumonia**	A	G	Full CQUIN payment received for Pneumonia Care Bundle part of CQUIN scheme. 50% payment received for 'Virtual Respiratory Clinic' as whilst ICM referral process not live, patients being identified and reviewed by pneumonia nurses. No payment received for either 'post discharge telephone follow up service' or '6 week xray follow up' due to lack of baseline data.