University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper O

TRUST BOARD – 2nd APRIL 2015

QUALITY AND PERFORMANCE REPORT – FEBRUARY 2015

DIRECTOR:	Carol Ribbins, Acting Chief Nurse Kevin Harris, Medical Director Richard Mitchell, Chief Operating Officer Emma Stevens, Acting Director of Human Resources
AUTHOR:	
DATE:	2nd April 2015
PURPOSE:	The following report provides an overview of the February Quality & Performance report highlighting NTDA/UHL key metrics and escalation reports where required. It includes a Chief Executive's summary of key issues.
PREVIOUSLY CONSIDERED BY:	**Integrated Finance, Performance and Investment Committee** **Quality Assurance Committee**
Objective(s) to which issue relates *	[X] 1. Safe, high quality, patient-centred healthcare [X] 2. An effective, joined up emergency care system [X] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [X] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [X] 5. Enhanced reputation in research, innovation and clinical education [X] 6. Delivering services through a caring, professional, passionate and valued workforce [X] 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 *	[X] **Organisational Risk Register** [X] **Board Assurance Framework** [ ] **Not Featured**
ACTION REQUIRED *	For decision [ ] For assurance [X] 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

CHIEF EXECUTIVE'S ISSUES TO HIGHLIGHT REPORT

Exception reports are automatically triggered when pre-set national or local thresholds are met. The issues that I wish to particularly highlight/comment on for February are as follows:

Clostridium Difficile (page 11)
There was a continuation of the lower trend in month, with only 5 cases recorded.

Pressure Ulcers (page 3)
Similarly, the improved trend was also evident in pressure ulcers, with all categories within target.

Maternity Friends and Family Test (page 4)
The Board will wish to note the significant improvement in this score during the year (10 percentage points). This is the result of concerted work by the clinical teams who have paid detailed attention to what was driving the previous poor scores and taken action to address these issues.

Fractured Neck of Femur (page 14)
There was a significant improvement in performance in February, by 10 percentage points. Whilst very welcome, it is not clear if this was fortuitous or as a result of improvement activity. Funding for a new medical staffing model to improve resilience is under consideration as part of 2015/16 financial planning.

RTT Admitted (page 15)
There continues to be good progress with all aspects of RTT and with backlog (patients waiting over 18 weeks) in particular. Trajectories for achievement of the national standards have not changed since the last report. More detail is in the exception reports.

Diagnostic waits (page 7)
Following the very poor performance in January, focussed action ensured delivery of the target in February. The teams concerned are to be congratulated on this achievement, which we now need to ensure is sustained

Delayed Transfers of Care (page 7)
The recent improvement in the DTOC rate was sustained in February and reached a new low of 2.9% against a target of 3.5%. This is a clear indication of the effectiveness of the work that has been going on to streamline the discharge process.

Cancer (page 16)
The two week standard was not met in January, but it was met in February and is predicted to be met in March. The 31 and 62 Day targets are still forecast to be met in March and July respectively. However, given trends in January, the Board may wish to seek an update on the latest position and assurance that these trajectories are still achievable.

Ambulance Turnaround (page 19)
Our performance in this area remains very poor. Two specific actions which will be implemented over the coming month are a new recording system (which will improve the accuracy of the data) and the introduction of a new surge protocol within the LRI. This is designed to enable ED to release ambulance crews more quickly but will need to be complemented by a whole system response. This latter element is still to be finalised.

John Adler
Chief Executive

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

February 2015

One team shared values

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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **2nd APRIL 2015**

REPORT BY: **CAROL RIBBINS, ACTING CHIEF NURSE**
KEVIN HARRIS, MEDICAL DIRECTOR
RICHARD MITCHELL, CHIEF OPERATING OFFICER
EMMA STEVENS, ACTING DIRECTOR OF HUMAN RESOURCES

SUBJECT: **FEBRUARY 2015 QUALITY & PERFORMANCE SUMMARY REPORT**

1.0 Introduction

The following report provides an overview of the February 2015 Quality & Performance report highlighting NTDA/UHL key metrics and escalation reports where required.

2.0 Performance Summary

Domain	Page Number	Number of Indicators	Indicators with target to be confirmed	Number of Red Indicators this month
Safe	3	19	2	1
Caring	4	15	1	2
Well Led	5	14	7	1
Effective	6	17	0	1
Responsive	7	26	0	13
Research – UHL	9	5	5	0
Research - Network	9	13	0	3
Estates & Facilities	10	10	0	0
Total		119	15	21

Safe | Caring | Well Led | Effective | Responsive | Research | Estates and Facilities

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	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	YTD
Safe	S1a	Clostridium Difficile	CR	DJ	FYE = 81	NTDA	Red / ER for Non compliance with cumulative target	66	0	4	4	6	5	7	2	5	7	7	11	7	5	66
	S1b	Clostridium Difficile (Local Target)	CR	DJ	FYE = 50	UHL	Red >5 per month, ER when YTD red	66	0	4	4	6	5	7	2	5	7	7	11	7	5	66
	S2a	MRSA Bacteraemias (All)	CR	DJ	0	NTDA	Red = >0 ER = 2 consecutive mths >0	3	0	0	0	0	0	0	0	1	1	0	2	0	1*	5
	S2b	MRSA Bacteraemias (Avoidable)	CR	DJ	0	UHL	Red = >0 ER = 2 consecutive mths >0	1	0	0	0	0	0	0	0	0	0	0	0	0	0*	0*
	S3	Never Events	CR	MD	0	NTDA	Red = >0 in mth ER = in mth >0	3	1	0	0	0	0	0	0	0	1	0	1	1	0	3
	S4	Serious Incidents	CR	MD	tbc	NTDA	tbc	60	4	5	4	6	3	7	2	3	4	2	4	3	2	40
	S5	Proportion of reported safety incidents that are harmful	CR	MD	tbc	NTDA	tbc	2.8%			1.7%			2.2%			1.4%					1.8%
	S6	Overdue CAS alerts	CR	MD	0	NTDA	Red = >0 in mth ER = in mth >0	2	0	0	2	2	2	3	0	0	0	0	0	0	0	9
	S7	RIDDOR - Serious Staff Injuries	CR	MD	FYE = <47	UHL	Red / ER = non compliance with cumulative target	47	2	5	3	5	1	2	2	1	2	2	1	0	3	22
	S8	Safety Thermometer % of harm free care (all)	CR	EM	tbc	NTDA	Red = <92% ER = in mth <92%	93.6%	94.8%	93.6%	94.6%	94.7%	94.2%	94.9%	94.4%	93.9%	94.9%	93.3%	94.1%	95.0%	92.1%	94.2%
	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%	95.0%	95.6%	95.7%	95.9%	95.9%	96.3%	95.5%	96.2%	95.4%	95.5%	95.0%	96.3%	96.2%	95.8%
	S10	Medication errors causing serious harm	CR	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	CR	EM	<7.1	QC	Red >= YTD >8.4 ER = 2 consecutive reds	7.1	7.0	6.9	7.0	7.5	7.1	7.3	7.3	5.9	6.4	7.5	6.9	7.1	6.7	7.0
	S12	Avoidable Pressure Ulcers - Grade 4	CR	EM	0	QS	Red / ER = Non compliance with monthly target	1	0	0	0	0	0	0	0	0	0	0	1	0	0	1
	S13	Avoidable Pressure Ulcers - Grade 3	CR	EM	<8 a month	QS	Red / ER = Non compliance with monthly target	71	3	6	5	5	5	5	6	6	4	6	7	5	7	61
	S14	Avoidable Pressure Ulcers - Grade 2	CR	EM	<10 a month	QS	Red / ER = Non compliance with monthly target	120	8	9	6	6	6	7	9	4	8	13	11	7	5	82
	S15	Compliance with the SEPSIS6 Care Bundle	CR	MD	All 6 >75% by Q4	QC	Red/ER = Non compliance with Quarterly target	27.0%			47.0%			>=60%			<65%					<65%
	S16	Nutrition and Hydration Metrics - Fluid Balance and Nutritional Assessment	CR	MD	Q2 80%, Q3 85%, Q4 90%	QC	Red >2% below threshold ER = 2 mths red				≥71%	≥77%	≥75%	Action Planning	≥74%	≥85%	≥84%	≥88%	≥86%	≥83%		≥83%
	S17	Maternal Deaths	KH	IS	0	UHL	Red / ER = Non compliance with monthly target	3	2	0	0	0	0	0	0	0	0	0	0	1	0	1

*Awaiting confirmation if avoidable

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	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	YTD
Caring	C1a	Inpatient Friends and Family Test - Score	CR	CR	72 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	68.8	69.0	69.9	69.6	71.0	74.5	73.8	73.8	76.1	71.1	70.3	72.1	70.8	71.7	72.2
	C1b	Inpatient Friends and Family Test - Score (Local Target)	CR	CR	75	UHL	Red/ ER =<=69.9 Green >74.9	68.8	69.0	69.9	69.6	71.0	74.5	73.8	73.8	76.1	71.1	70.3	72.1	70.8	71.7	72.2
	C2a	A&E Friends and Family Test - Score	CR	CR	54 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	58.5	58.7	65.5	69.4	66.0	71.4	71.7	56.3	66.1	71.1	72.3	72.8	72.4	73.1	69.3
	C2b	A&E Friends and Family Test - Score (Local Target)	CR	CR	75	UHL	Red/ ER =<=64.9 Green >74.9	58.5	58.7	65.5	69.4	66.0	71.4	71.7	56.3	66.1	71.1	72.3	72.8	72.4	73.1	69.3
	C3	Outpatients Friends and Family Test - Score	CR	CR	75	UHL	Red / ER =<=64.9	New Indicator										58.7	63.8	65.2	64.3	64.3
	C4	Daycase Friends and Family Test - Score	CR	CR	75	UHL	Red / ER =<=69.9	New Indicator			79.0	80.2	79.7	77.5	74.3	81.7	80.1	80.9	74.9	78.5	78.7	78.7
	C5	Maternity Friends and Family Test - Score	CR	CR	75	UHL	Red/ ER =<=61.9	64.3	62.1	66.7	61.2	63.5	69.5	69.7	67.3	63.0	64.1	67.7	63.8	74.5	74.5	67.6
	C6	Complaints Rate per 100 bed days	CR	MD	tbc	NTDA	tbc		0.5	0.4	0.4	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.3	0.3	0.4	0.4
	C7	Complaints Re-Opened Rate	CR	MD	<9%	UHL	Red = >10% ER = 3 mths Red or any month >15%	New Indicator for 14/15			8%	5%	8%	11%	10%	9%	11%	11%	10%	17%	13%	10%
	C8	Single Sex Accommodation Breaches (patients affected)	CR	CR	0	NTDA	Red = >0 ER = in mth >0	2	0	0	4	3	0	0	0	0	0	5	0	1	0	13
	C9	Improvements in the FFT scores for Older People (65+ year)	CR	CR	75	QC	Red / ER = End of Yr Targets non recoverable.	New Indicators for 14/15			73.7	73.2	75.7	76.1	78.5	83.0	76.4	72.9	76.7	76.6	76.9	76.2
	C10	Responsiveness and Involvement Care (Average score)	CR	CR	0.8 improve-ment	QC	tbc				87.6	87.5	87.5	87.8	88.1	88.4	87.4	87.9	87.8	88.5	89.0	88.1
	C10a	Q15. When you used the call button, was the amount of time it took for staff to respond generally:	CR	CR	FYE 89.7	QC	Red = <87.9 ER = Red or 3 mths deterioration				88.9	89.3	88.8	89.0	88.9	90.0	88.4	88.6	89.2	88.7	89.9	89.1
	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?	CR	CR	FYE 92.9	QC	Red = <91.1 ER = Red or 3 mths deterioration				92.1	91.9	91.2	91.7	91.9	92.4	92.2	92.4	92.1	92.7	92.6	92.2
	C10c	Q11. Were you involved as much as you wanted in decisions about your care and treatment?	CR	CR	FYE 85.5	QC	Red = <83.6 ER = Red or 3 mths deterioration				84.6	84.3	84.9	84.9	85.6	85.2	84.6	85.1	84.8	86.1	86.7	85.4

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	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	YTD
W1	Inpatient Friends and Family Test - Coverage	CR	CR	30% - Q4. 40% - Mar 15	NTDA / CQUIN	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	24.3%	28.2%	28.8%	36.8%	38.1%	32.6%	30.8%	28.9%	33.4%	36.3%	36.0%	31.9%	34.6%	41.0%	* 37.8%
W2	A&E Friends and Family Test - Coverage	CR	CR	15% Q1-Q3 20% for Q4	NTDA	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	14.9%	18.4%	16.1%	15.2%	17.8%	14.9%	10.2%	16.1%	19.1%	15.9%	14.0%	18.7%	25.3%	21.2%	* 23.25%
W3	Outpatients Friends and Family Test - Valid responses	CR	CR	tbc	UHL	tbc	New Indicator available from October 2014		271	175	286	1,879	1,535	785	927	1,255	1,506	1,053	1,259	1,245	11,905
W4	Maternity Friends and Family Test - Coverage	CR	CR	tbc	UHL	tbc	25.2%	23.7%	23.9%	27.2%	36.4%	25.2%	29.2%	29.9%	18.7%	15.8%	21.7%	22.1%	25.8%	46.5%	26.9%
W5	Friends & Family staff survey: % of staff who would recommend the trust as place to work	ES	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed			53.7%			53.7%			Q3 staff FFT not completed as National Survey carried out			54.9%		54.2%
W6	Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment	ES	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed			68.3%			67.2%			Q3 staff FFT not completed as National Survey carried out			71.4%		69.2%
W7	Data quality of trust returns to HSCIC	RM	JR	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed														
W8	Turnover Rate	ES	ES	<10.5%	UHL	Red = 11% or above ER = Red for 3 Consecutive Mths	10.0%	10.4%	10.0%	9.9%	10.0%	10.2%	10.0%	10.5%	10.3%	10.8%	10.7%	10.3%	10.1%	10.1%	10.1%
W9	Sickness absence	ES	ES	< 3.0%	UHL	Red = >3.5% ER = 3 consecutive mths >3.5%	3.4%	3.7%	3.5%	3.4%	3.3%	3.3%	3.4%	3.4%	3.7%	4.0%	4.0%	4.5%	4.5%		3.7%
W10	Total trust vacancy rate	ES	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed														
W11	Temporary costs and overtime as a % of total paybill	ES	ES	tbc	NTDA	tbc	New Indicator for 14/15			9.4%	9.4%	8.1%	8.5%	8.9%	8.5%	9.5%	9.0%	9.8%	10.5%	9.8%	9.2%
W12	% of Staff with Annual Appraisal	ES	ES	95%	UHL	Red = <90% ER = 3 consecutive mths <90%	91.3%	92.3%	91.3%	91.8%	91.0%	90.6%	89.6%	88.6%	89.7%	91.8%	92.3%	92.5%	90.9%	91.0%	91.0%
W13	Statutory and Mandatory Training	ES	ES	Jun 80%, Sep 85%, Dec 90%, Mar 95%	UHL	Red / ER for Non compliance with Quarterly incremental target	76%	72%	76%	78%	79%	79%	80%	83%	85%	86%	87%	89%	89%	90%	90%
W14	% Corporate Induction attendance	ES	ES	95.0%	UHL	Red = <90% ER = 3 consecutive mths <90%	94.5%	89%	95%	96%	94%	92%	96%	98%	98%	98%	98%	100%	99%	100%	100%

* Quarter 4 Average

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	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	YTD
E1	Mortality - Published SHMI	KH	PR	Within Expected	NTDA	Higher than Expected				106 (Oct12-Sept13)			106 (Jan13-Dec13)			105 (Apr13-Mar14)			105 (Jul13-Jun14)		105 (Jul13-Jun14)
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	106	105	105	105	106	105	103	102	102	101	Awaiting HED Update			101
E3	Mortality HSMR (DFI Quarterly)	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	88			92			87			84			Awaiting HED Update			88
E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	100	99	97	98	98	97	96	96	96	95	95	Awaiting HED Update			95
E5	Mortality - Monthly HSMR (Rebased Monthly as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	91	103	91	83	109	106	87	96	97	97	88	94	Awaiting HED Update			94
E6	Mortality - Rolling 12 mths HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	100	101	100	98	99	99	97	96	95	95	95	95	Awaiting HED Update			95
E7	Mortality - Monthly HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	100	102	94	86	110	106	83	94	87	93	95	98	Awaiting HED Update			95
E8	Mortality - rolling 12 mths HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	102	99	97	98	98	97	97	99	100	98	96	Awaiting HED Update			96
E9	Mortality - Monthly HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	106	82	70	107	107	101	107	123	116	75	83	Awaiting HED Update			98
E10	Deaths in low risk conditions (Risk Score)	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	94	35	63	63	80	103	78	63	57	110	19	Awaiting DFI Update				72
E11	Emergency 30 Day Readmissions (No Exclusions)	KH	PR	Within Expected	NTDA	Higher than Expected	7.9%	9.0%	8.8%	8.8%	8.8%	8.6%	8.4%	8.9%	8.4%	8.6%	8.9%	9.1%	8.2%			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%	73.7%	54.7%	56.9%	40.6%	60.3%	76.9%	59.0%	68.6%	69.6%	59.4%	57.3%	57.9%	67.2%	61.4%
E13	Stroke - 90% of Stay on a Stroke Unit	RM	CF	80% or above	QS	Red = <80% ER = 2 consecutive mths <80%	83.2%	83.7%	83.5%	92.9%	80.3%	87.1%	78.1%	84.5%	83.2%	70.4%	72.1%	75.2%	80.7%		79.8%
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%	40.7%	77.9%	79.7%	58.8%	71.3%	62.8%	65.5%	72.7%	67.8%	69.0%	83.5%	80.6%	64.0%	70.6%
E15	Communication - ED, Discharge and Outpatient Letters - Compliance with standards	KH	SJ	90% or above	QS	Red = <80% ER = Qrtly ER if <90% and deterioration	New Indicator for 14/15							60% (InPt)	83% (ED)	Policy launch, audit not undertaken					
E16	Published Consultant Level Outcomes	KH	SH	>0 outside expected	QC	Red = >0 Quarterly ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
E17	Non compliance with 14/15 published NICE guidance	KH	SH	0	QC	Red = in mth >0 ER = 2 consecutive mths Red	New Indicator for 14/15			0	0	0	0	0	0	0	0	0	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	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	YTD
R1	ED 4 Hour Waits UHL + UCC (Sit Rep)	RM	CF	95% or above	NTDA	Red = <95% ER via ED TB report	88.4%	83.5%	89.3%	86.9%	83.4%	91.3%	92.5%	90.9%	91.5%	90.1%	88.5%	83.0%	90.2%	89.2%	88.8%
R2	12 hour trolley waits in A&E	RM	CF	0	NTDA	Red = >0 ER via ED TB report	5	0	0	0	1	1	0	0	0	1	0	0	1	0	4
R3	RTT Waiting Times - Admitted	RM	CC	90% or above	NTDA	Red /ER = <90%	76.7%	79.1%	76.7%	78.9%	79.4%	79.0%	80.9%	82.2%	81.6%	84.4%	85.5%	86.9%	85.0%	85.9%	*82.7%
R4	RTT Waiting Times - Non Admitted	RM	CC	95% or above	NTDA	Red /ER = <95%	93.9%	93.5%	93.9%	94.3%	94.4%	95.0%	94.9%	95.6%	94.6%	94.9%	95.2%	96.0%	95.3%	95.2%	*95%
R5	RTT - Incomplete 92% in 18 Weeks	RM	CC	92% or above	NTDA	Red /ER = <92%	92.1%	92.6%	92.1%	93.9%	93.6%	94.0%	93.2%	94.0%	94.3%	94.8%	95.0%	95.1%	95.1%	96.2%	*94.4%
R6	RTT 52 Weeks+ Wait (Incompletes)	RM	CC	0	NTDA	Red /ER = >0	0	0	0	0	0	0	15	1	3	3	2	0	0	0	0
R7	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	NTDA	Red /ER = >1%	1.9%	1.9%	1.9%	0.8%	0.9%	0.8%	0.7%	1.0%	1.0%	0.7%	1.8%	2.2%	5.0%	0.8%	*1.4%
R8	Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	RM	MM	93% or above	NTDA	Red = <93% ER = Red for 2 consecutive mths	94.8%	95.9%	95.3%	88.5%	94.7%	93.5%	92.2%	92.0%	90.6%	92.0%	92.5%	93.0%	92.2%		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%	93.4%	94.3%	80.0%	95.0%	98.9%	94.9%	94.4%	95.2%	98.6%	100.0%	93.0%	92.5%		94.3%
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%	98.5%	98.2%	97.2%	92.9%	93.6%	94.4%	97.9%	91.9%	95.9%	92.5%	95.2%	91.7%		94.3%
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%	98.8%	100.0%	97.1%	100.0%	96.7%	100.0%		99.3%
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%	96.4%	98.6%	95.2%	97.0%	90.8%	90.1%	87.8%	94.0%	81.9%	82.4%	80.3%	89.2%		88.7%
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%	96.3%	99.1%	97.3%	95.6%	93.9%	97.3%	99.0%	96.5%	96.0%	94.7%	95.5%	87.6%		95.5%
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%	89.1%	92.4%	92.7%	88.5%	73.1%	85.6%	78.8%	75.5%	80.4%	77.0%	84.8%	79.3%		81.4%
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%	95.1%	91.7%	91.1%	67.4%	73.9%	73.0%	100.0%	87.5%	75.0%	94.4%	93.8%	88.9%		84.7%
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
R17	Cancelled patients not offered a date within 28 days of the cancellations UHL	RM	PW	0	NTDA	Red = >2 ER = >0	85	2	8	10	4	1	2	1	2	2	0	3	4	3	32
R18	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	RM	PW	0	NTDA	Red = >2 ER = >0	New Indicator for 14/15			0	0	0	0	6	0	0	1	1	2	1	11
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%	2.1%	1.5%	1.1%	0.8%	1.1%	0.7%	0.6%	0.8%	0.8%	1.2%	1.1%	0.8%	0.7%	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%	2.1%	1.5%	0.6%	0.6%	0.3%	2.7%	0.0%	0.9%	1.0%	0.0%	0.8%	1.4%	0.0%	0.8%
R21	% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	New Indicator for 14/15			1.1%	0.8%	1.0%	0.9%	0.6%	0.8%	0.8%	1.1%	1.1%	0.8%	0.7%	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	178	139	106	77	98	94	55	90	94	108	102	85	64	973
R23	Delayed transfers of care	RM	PW	3.5% or below	NTDA	Red = >3.5% ER = Red for 3 consecutive mths	4.1%	4.3%	3.8%	4.4%	4.2%	4.0%	3.9%	3.9%	4.5%	4.6%	5.2%	3.9%	3.2%	2.9%	4.1%
R24	Choose and Book Slot Unavailability	RM	CC	4% or below	Contract	Red = >4% ER = Red for 3 consecutive mths	13%	16%	19%	22%	25%	26%	25%	26%	25%	20%	17%	16%	13%	19%	21%
R25	Ambulance Handover >60 Mins (CAD)	RM	CF	0	Contract	Red = >0 ER = Red for 3 consecutive mths	868	207	111	173	253	88	71	50	106	253	343	460	353	499	2,649
R26	Ambulance Handover >30 Mins and <60 mins (CAD)	RM	CF	0	Contract	Red = >0 ER = Red for 3 consecutive mths	7,075	818	601	720	951	671	591	805	736	1,147	1,364	1,170	1,167	970	10,292

* RTT/Diagnostics Yearly Average

Month standard will be compliant

Standard	February predicted	March predicted	Month by which to be compliant	RAG rating of required month delivery	Commentary
Emergency Care					
4+ hr Wait (95%) - Calendar month	89.5%				
RTT (inc Alliance)					
Admitted (90%)	85.9%	84.0%	April		Delivery confidence for April has moved to Amber due to the size of the backlog in Orthopaedics. CMG is taking decisive action to improve the position but risk for organisation remains.
Non-Admitted (95%)	95.2%	95.2%	Continued Delivery		February including Alliance has achieved. Predicting ongoing compliance.
Incomplete (92%)	96.0%	96.2%	Continued Delivery		Backlog clearance improving sustainability
Diagnostic (inc Alliance)					
DM01 (<1%)	0.8%	0.9%	March		Significant improvement between January and February. Validation has improved February position with final submission delivering. March achievement predicted.
Cancelled Ops (inc Alliance)					
Cancelled Ops (0.8%)	0.8%	0.8%	Continued delivery		
Not Rebooked within 28 days (0 patients)	3	0	March		No breaches currently predicted
Cancer					
Two Week Wait (93%)	93.2%	93.2%	March		Patient choice now the dominant reason for failure all UHL tumour sites compliant for capacity and speed of offering patients dates.
31 Day First Treatment (96%)	93.2%	92.5%	March		Urology now predicting 0 in the 31 day backlog in April. This will allow for delivery from April (ceteris paribus).
31 Day Subsequent Surgery Treatment (94%)	93.1%	79.6%	April		February validation to be completed may have achieved in February once complete.
62 Days (85%)	78.7%	78.2%	July		62 Day backlog reduction in line with plan

Research UHL

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	YTD
RU1	Median Days from submission to Trust approval (Portfolio)	KH	NB	tbc	tbc	tbc	3.0			2.0			3.0					
RU2	Median Days from submission to Trust approval (Non Portfolio)	KH	NB	tbc	tbc	tbc	2.0			3.5			2.0					
RU3	Recruitment to Portfolio Studies	KH	NB	Aspirational target=10920/year (910/month)	tbc	tbc	941	1092	963	1075	1235	900	1039	1048	604			
RU4	% Adjusted Trials Meeting 70 day Benchmark (data sunbmitted for the previous 12 month period)	KH	NB	tbc	tbc	tbc	(Jul13-Jun14) 43.4%			(Oct13-Sep14) 70.5%								
RU5	Rank No. Trials Submitted for 70 day Benchmark (data submitted for the previous 12 month period)	KH	NB	tbc	tbc	tbc	(Jul13-Jun14) 17			(Oct13-Sep14) 18								
RU6	%Closed Commercial Trials Meeting Recruitment Target (data submitted for the previous 12 month period)	KH	NB	tbc	tbc	tbc	(Jul13-Jun14) 50%			(Oct13-Sep14) 52%								

Research (CLINICAL RESEARCH NETWORK)

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	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%	92.0%	93.0%	94.0%	93.0%	91.0%	90.0%	90.0%
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%	67.0%	64.0%	68.0%	54.0%	56.0%	47.0%	47.0%
RS2b	B: Proportion of non-commercial studies achieving their recruitment target during their planned recruitment period	KH	DR	England 80% East Midlands 80%	NIHR CRN	Red / ER = <60%	81.0%	81.0%	73.0%	77.0%	77.0%	86.0%	86.0%
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%	89.0%	84.0%	82.0%	83.0%	83.0%	82.0%
RS5a	A: Proportion of commercial contract studies achieving first participant recruited within 70 calendar days of NHS services receiving a valid research application or First Network Site Initiation Visit	KH	DR	80%	NIHR CRN	Red <80%							
RS5b	B: Proportion of non-commercial studies achieving first participant recruited within 70 calendar days of NHS services receiving a valid research application	KH	DR	80%	NIHR CRN	Red <80%							
RS6a	A: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio studies	KH	DR	England 99% East Midlands 99%	NIHR CRN	Red <99%	81.0%	81.0%	81.0%	88.0%	88.0%	88.0%	88.0%
RS6b	B: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio commercial contract studies	KH	DR	England 70% East Midlands 70%	NIHR CRN	Red <70%	56.0%	56.0%	56.0%	56.0%	56.0%	56.0%	56.0%
RS6c	B: Proportion of General Medical Practices recruiting each year into NIHR CRN Portfolio studies	KH	DR	England 25% East Midlands 25%	NIHR CRN	Red <25%	45.0%	45.0%	51.0%	63.0%	54.0%	54.0%	54.0%
RS7	Number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	KH	DR	England 13500 East Midlands 510	NIHR CRN	Red <510 Q4	325	438	448	532	624	729	729
RS8	Deliver robust financial management using appropriate tools - % of financial returns completed on time	KH	DR	England 100% East Midlands 100%	NIHR CRN	Red <100%	100% *Q2	100.0%				100%	100% *Q2

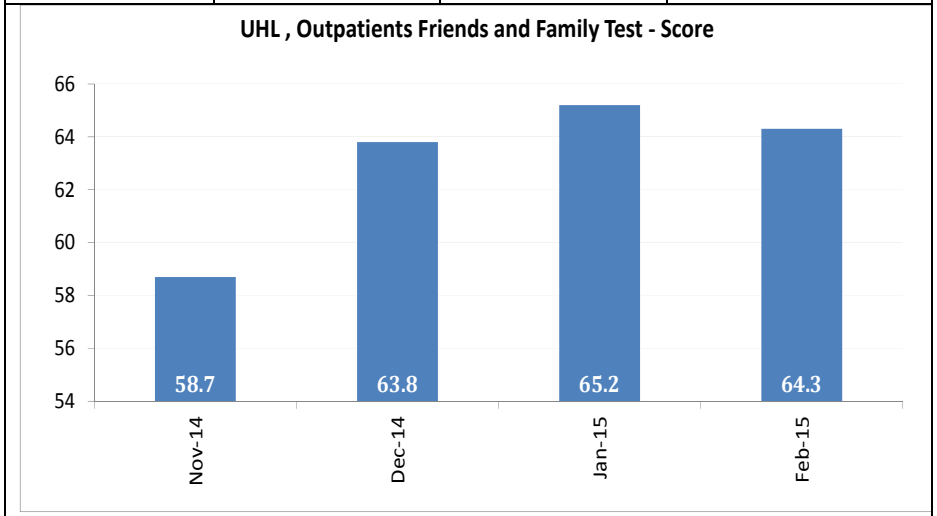
	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	YTD
Estates and Facilities	E&F1	Percentage of statutory inspection and testing completed in the Contract Month measured against the PPM schedule.	AC	GL	100%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F2	Percentage of non-statutory PPM completed in the Contract Month measured against the PPM schedule	AC	GL	100%	Contract KPI	Red = ≤ 80%	91.5%	81.2%	95.6%	80.5%	86.6%	97.4%	88.8%
	E&F3	Percentage of Estates Urgent requests achieving rectification time	AC	LT	95%	Contract KPI	Red = ≤ 75%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F4	Percentage of scheduled Portering tasks completed in the Contract Month	AC	LT	99%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F5	Number of Emergency Portering requests achieving response time	AC	LT	100%	Contract KPI	Red = >2	0	0	0	0	0	0	0
	E&F6	Number of Urgent Portering requests achieving response time	AC	LT	95%	Contract KPI	Red = ≤ 95%	95.1%	96.2%	97.3%	97.2%	97.2%	98.5%	96.9%
	E&F7	Percentage of Cleaning audits in clinical areas achieving NCS audit scores for cleaning above 90%	AC	LT	100%	Contract KPI	Red = ≤ 98%	100.0%	99.1%	100.0%	100.0%	100.0%	94.4%	98.9%
	E&F8	Percentage of Cleaning Rapid Response requests achieving rectification time	AC	LT	92%	Contract KPI	Red = ≤ 80%	99.6%	89.9%	93.3%	90.5%	91.1%	94.1%	93.1%
	E&F9	Percentage of meals delivered to wards in time for the designated meal service as per agreed schedules	AC	LT	97%	Contract KPI	Red = ≤ 95%	99.4%	99.5%	100.0%	100.0%	98.9%	99.9%	99.6%
	E&F10	Overall percentage score for monthly patients satisfaction survey for catering service	AC	LT	85%	Contract KPI	Red = ≤ 75%	96.7%	97.3%	97.3%	96.7%	93.8%	95.8%	96.3%

S1b – CDIFF local target

<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">The number of cases of C difficile infection this year is comparable to the number seen in 2013/14. This may indicate an irreducible minimum burden of C difficile within the current context of clinical practice (particularly antibiotic prescribing practice), hand hygiene and environmental hygiene. There has probably been little substantial change in practice in these areas this year compared with last year so it is not surprising that the outcome, number of C difficile infections, is much the same. In many regards, UHL antibiotic prescribing is very good and the room for improvement is limited given current constraints. A step change in prescribing practice is expected to follow once electronic prescribing is rolled out across the Trust, since this should allow greater scrutiny in real time of antibiotic prescribing practice. The one feature to highlight is the widely held perception that domestic cleaning has deteriorated over the last 1-2 years. This is difficult to prove objectively because cleanliness is very difficult to quantify directly. However, the practice of re-auditing cleaning until a satisfactory score is returned has been viewed as inappropriate and likely to lead to sub-optimal cleaning. Given the importance of physical removal of C difficile spores from the clinical environment as a C difficile control measure, it is clear that inadequate cleaning could significantly contribute to infection cases</td><td rowspan="5">Interserve has been instructed to stop reporting audits based on re-testing of cleaning inspections and to report only the result of the first inspection. This should give a more accurate picture of any inadequate cleaning practice, allowing focused attention on these areas with the intention that this will raise the standard of cleaning, including spore removal, in these areas.</td><td>Annual trajectory: 50 internal, 81 external</td><td>5</td><td>66</td><td>71 by end of March</td></tr>
<tr><td colspan="4"><table>
<tr><th></th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th><th>Tota</th></tr>
<tr><td>Traj 14/15</td><td>7</td><td>8</td><td>5</td><td>7</td><td>6</td><td>7</td><td>7</td><td>7</td><td>6</td><td>7</td><td>7</td><td>7</td><td>81</td></tr>
<tr><td>Internal Traj 14/15</td><td>4</td><td>5</td><td>4</td><td>5</td><td>4</td><td>4</td><td>4</td><td>4</td><td>4</td><td>4</td><td>4</td><td>4</td><td>50</td></tr>
<tr><td>Actual infections 14/15</td><td>4</td><td>6</td><td>5</td><td>7</td><td>2</td><td>5</td><td>7</td><td>7</td><td>11</td><td>7</td><td>5</td><td></td><td>66</td></tr>
</table></td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="3">Internal trajectory has already been passed.
Still within external trajectory and unlikely to be passed</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">Carole Ribbins, Acting Chief Nurse</td></tr>
</table>

C3 Outpatients Friends and Family Test

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
Since the launch of the FFT in outpatients clinics have been unsuccessful in collecting representative numbers of surveys. In February 2.1% patients who attended outpatients provided feedback (min target 5%). With this limited amount of feedback difficult to ascertain true picture of patients experience, however key themes for improvement are: 1. Long wait times in clinic 2. Long wait times for an appointment. 3. Car park availability 4. Lack of adequate communication	CMGs informed of underperformance and tasked with greater Service Manager engagement to ensure feedback collection. Meetings have been held with Clerical and clinical leads for Outpatient areas to encourage the sharing of patient feedback comments with junior staff. Clinics have been identified by Consultant name to encourage participation in Patient feedback.	75	64.3	64.3	



Expected date to meet standard / target	April 2015
Revised date to meet standard	April 2015
Lead Director / Lead Officer	Carole Ribbins, Acting Chief Nurse Heather Leatham, Assistant Chief Nurse

W9 Sickness absence

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 has been an increase in sickness absence from July 2014. (Table 1). 2. Sickness levels for January 2014 and January 2015 are broadly comparable. Sickness levels first reported for January 2014 were 4.48%, and subsequently reduced by 0.6% to 3.88% following late closures. 3. Sickness absence reporting highlights an adjustment of around 0.5% due to late closures. It is therefore expected the January 2015 sickness absence rate will be adjusted in the coming months. 4. In the last year the Trust has seen an increase in staff taking absence, 'triggers' and long term absences. (Table 2) 5. Feedback from Clinical Management Group and Directorates Leads indicates that the increased sickness absence is due to :- a. Increased operational pressures / activity b. Seasonal variations c. Inaccurate data – delays in closing absences d. Management changes / handovers e. Vacancies and other absences reducing management time Service pressures delaying sickness absence management	1. Improved data through weekly SMART reports and monthly ESR reports highlighting open absences, closed absences and triggers (3 episodes / more than 10 days / 2 working weeks) 2. Discussion at CMG / Directorate Boards and across services / areas with specific actions confirmed 3. Making it Happen Reviews, to discuss and agree actions for the management and support of open absences, 'triggers' and complex cases with line managers. 4. 6 monthly CMG Sickness Performance Reviews / Case reviews with Occupational Health and Senior and independent HR colleagues. 5. Sickness Absence training for managers and administrators **Further Actions:** 6. Local training is facilitated for CMG's / Directorates in response to specific needs – management of long term absence, documentation etc. 7. Local actions to address high sickness absence include CMG Management Team 'Hot Spot' meetings, Staff Engagement events to reduce sickness absence and improve the management of sickness absence. 8. Improvement plans including timescales are discussed and agreed at CMG / Directorate level to reduce sickness absence and increase performance in the management of sickness absence. 9. Specific staff support and targeted management of stress related absences. 10. Review of the UHL Sickness Absence in comparison with other NHS organisations.	UHL Stretch target 3% (previous SHA target 3.4%)	4.5%	3.7% (average)	3.5% average (April 2015)

Table 1: Monthly Trust Performance:

2014 Jul % Abs Rate (FTE)	2014 Aug % Abs Rate (FTE)	2014 Sep % Abs Rate (FTE)	2014 Oct % Abs Rate (FTE)	2014 Nov % Abs Rate (FTE)	2014 Dec % Abs Rate (FTE)	2015 Jan % Abs Rate (FTE)	Contracted WTE	Cumulative % Abs Rate (FTE)
3.4%	3.4%	3.7%	4.0%	4.0%	4.5%	4.5%	10754.78	3.7%

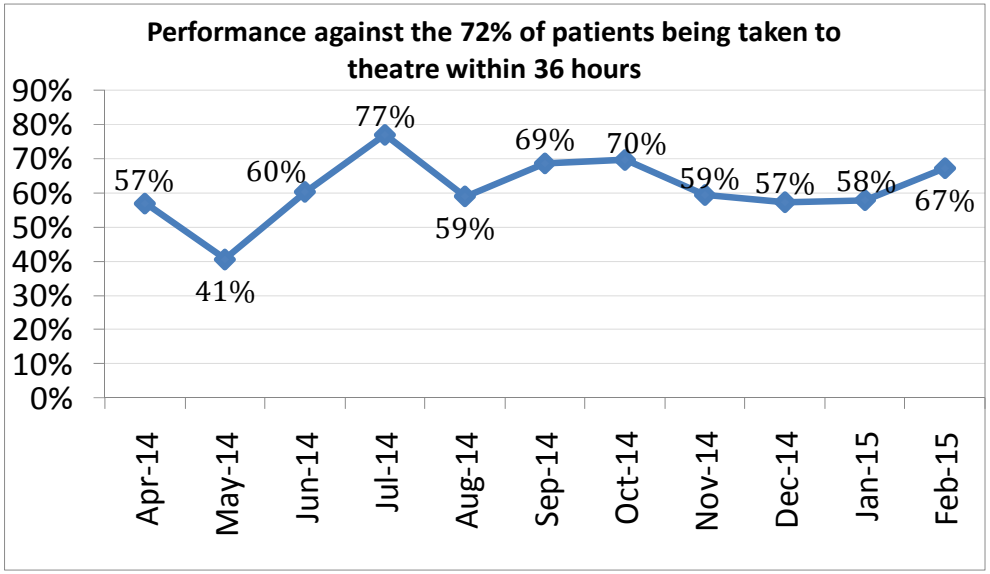
Table 2: Annual performance

January	Staff taking absence	Staff 'triggering'	% absences over 28 days
2013	67.7	39.7	8.1
2014	64.9	37.6	7.78
2015	65.8	39.2	8.28

Expected date to meet standard / target	Monthly Target
Revised date to meet standard	April 2015
Lead Director / Lead Officer	Emma Stevens, Acting Director of Human Resources Kalwant Khaira, CMG HR Lead (HR Sickness Absence Lead)

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

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
All of the issues set out in previous reports continue in the service and are exacerbated at times of heightened activity. Significant increases in activity though December and January have had an impact on delivery of the target and ability to operate on patients within target. The current scheduled theatre capacity is insufficient to cope with this level of trauma demand and increasing spinal work. Short notice additional operating sessions continue to be arranged as necessary. The acceptance of out of area elective and emergency spinal work is having a detrimental effect on the main trauma capacity as spinal patients are medically prioritised over 'other' trauma which has a knock on effect on #NOF capacity.	An action plan is to be presented to the CMG board in April which details the work that is currently being scoped and implemented from the various outputs of the LiA and other improvement projects within the specialty. Specific blockers include Theatre List start and finish times, Orthogeriatric capacity and Theatre process delays. The listening into action process continues the themes and detailed actions will be published in the action plan to be presented to the CMG board in April. Work continues within the spinal network with regards to capacity across the region and how UHL fits into the future plans.	**72%**	**67.2%**	**61.4%**	**62%**



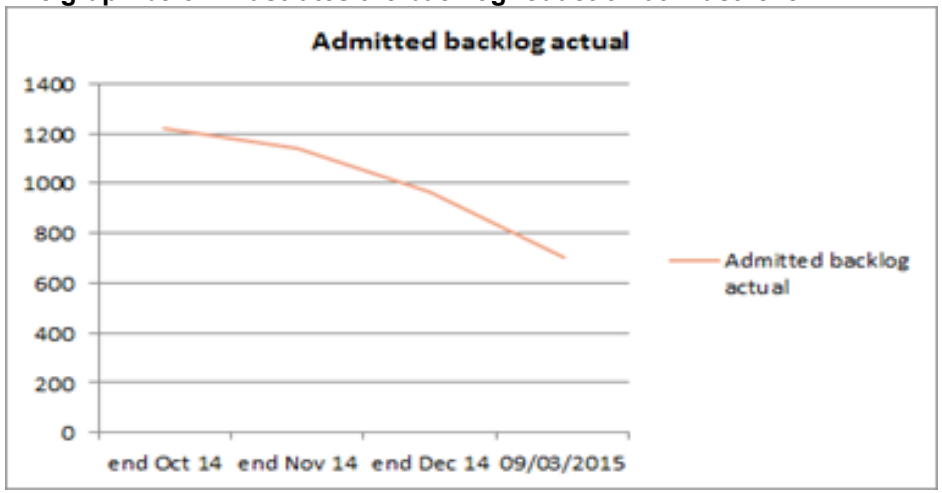
Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
65%	52%	68%	63%	

Expected date to meet standard / target	December 2014
Revised date to meet standard	Quarter 3 2015/16
Lead Director / Lead Officer	Richard Power, MSS CD Maggie McManus, MSS Deputy Head of Operations

R3 – RTT Waiting Time - Admitted

<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 performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="3">The Trust commitment to deliver the admitted standard from April 2015 onwards remains, but this is not without its risks due to the level of backlog remaining.
The graph opposite illustrates the significant admitted backlog reduction achieved from end October 2014 (1218) to the present day (702). This has been achieved by additional in house activity and outsourcing to the local independent sector providers. During this period the longest admitted waiters (26 week+ RTT) have been reduced by 49% from 339 at end of October to 166 in March 2015 and the commitment to ensure that the longest waiters are treated remains our priority.
By key speciality:
• General surgery, backlog continues to reduce as planned with weekend working in March
• Urology the backlog has reduced significantly.
• Paediatric Max fax and ENT have been hampered by lack of paediatric elective capacity.
• paediatric surgery and urology are on track to deliver their target reductions
• Gynaecology, is on track to deliver its target reduction.
• Orthopaedics, backlog has remained static. It is a significant risk due to the unsustainable non admitted backlog position</td><td rowspan="3">The Trust is achieving 2 of the 3 RTT standards: Non-admitted and incompletes performance are both compliant. The backlog reduction agreed by the TDA for the end of February has been achieved.
The actions been taken in admitted are clearly the right actions evidenced by the backlog reductions seen in recent weeks and months.
The revised weekly access meeting is working well as is the predictive ability of ensuring delivery.

• Additional activity at weekends
• Urology additional in house and independent sector
• Additional weekend work across the paediatric specialities
• Additional work in house but also with the local independent sector.
• Orthopaedics remains the greatest risk to the Trust RTT performance. Weekend working continues, additional outsourcing to the local Independent sector for electives</td><td>90% treated within 18 weeks</td><td>85.8%
(UHL and Alliance)</td><td>85%</td><td>86%</td></tr>
<tr><td colspan="4">The graph below illustrates the backlog reduction at Trust level
 

Risks to delivery of the admitted 90% standard in April
The single speciality that poses the greatest risk to delivery of the Trust level admitted standard in April is orthopaedics due to the residual backlog volumes:

Mitigation
All key speciality plans being reviewed by Director of Performance and Information.
Orthopaedics on daily reporting of key improvement metric.
Orthopaedics on daily reporting of key improvement metric.
Re modelling of anticipated performance.
Ongoing additional activity in key specialities.
Additional outsourcing of activity in March, supported by TDA additional funding.</td></tr>
<tr><td colspan="4"><table>
<tr><td>Expected date to meet standard / target</td><td>April 2015</td></tr>
<tr><td>Lead Director / Lead Officer</td><td>W Monaghan, Director of Performance and Information
C Carr, Head of Performance</td></tr>
</table></td></tr>
</table>

R8-15 Cancer Waiting Times Performance

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance January	Performance to date 2014/15	Forecast performance for February
R8 – 2WW 1) There has been an annualised increase of 18% in 2WW suspected cancer referrals in 2014/15 to date 2) This is likely to continue to grow 3) LLR has a conversion rate from referral to cancer diagnosis significantly below the national average, raising concerns around the quality of 2WW referrals **R10, 12 – 31 day standards** Achieving these standards are now essentially a single service issue. The service concerned is in receipt of significant support to turn performance around, with encouraging indicators of success in cancer backlog reductions. **R14, 15 – 62 day standards** The system for the integration of complex cancer pathways remains in place (**R14, R15**) Access to cancer diagnostics remains good. The delivery of timely treatments (**R10, R12**) lies within the gift of services for surgery, and the oncology department for chemotherapy and radiotherapy. Chemotherapy and radiotherapy treatments have remained timely for the most part. The issue is adequate access to surgical capacity. There is no shortage of overall surgical capacity. There are challenges with the complex nature of these pathways. The overall backlog size is reducing and we have an agreed trajectory.	**R8 – 2WW** The trust have reliably and consistently delivered rapid processing of referrals and released adequate capacity quickly to meet the 2WW demand consistently for 3 months. Overwhelmingly breaches are due to patient choice. Joint work streams with the CCGs, requiring their leadership regarding (1) correct process (2) use of appropriate clinical criteria and (3) preparation of patients for urgency of appointments are needed to achieve this standard. **R10, 12 – 31 day standards** As across, a single service issue. Support and monitoring in place and delivering improvement. **R14, 15** Trajectory for recovery by tumour site agreed with CMGs to deliver recovery of the standard at trust level monthly by month 4 15/16 and cumulatively by month 6 15/16. Decision on Business Case for the administrative staff required to deliver the enhanced support to services awaited.	**R8 2WW 93%**	**92.2%**	**92.1%**	**93.2%**
		R10 31 day 1st 96%	**91.7%**	**94.3%**	**93.2%**
		R12 31 day sub (Surgery) 94%	**89.2%**	**88.7%**	**93.1%**
		R14 62 day RTT 85%	**79.3%**	**81.4%**	**78.7%**
		R15 62 screening 90%	**88.9%**	**84.7%**	**77.1%**

Performance by Quarter

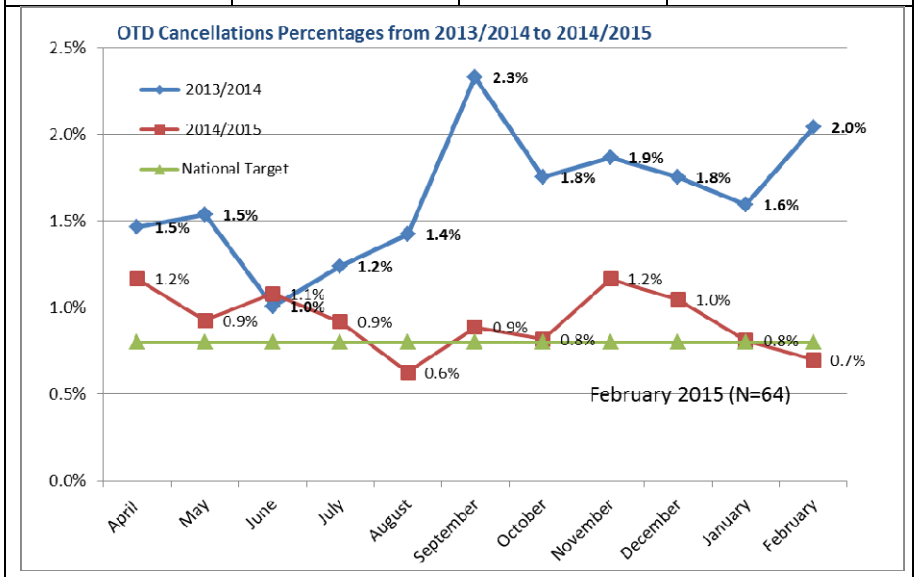
	13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
R8	94.8%	92.2%	91.6%	92.5%	
R10	98.1%	94.6%	94.6%	94.6%	
R12	98.2%	94.2%	90.5%	81.5%	
R14	86.7%	84.1%	80.1%	80.8%	
R15	95.6%	78.0%	85.0%	89.2%	

Expected date to meet standard / target	R8 – Recovered December R10,12 – Recovery expected M12 2014/15 R14,15 – Recovery expected M6 2015/16
Revised date to meet standard	As Above, 2WW vulnerable to patient choice
Lead Director / Lead Officer	Will Monaghan Matt Metcalfe

R17 - cancelled operations not booked within 28 days

INDICATOR: The cancelled operations target comprises of three components:
1. The % of cancelled operations for non-clinical reasons On The Day(OTD) of admission
2.The number of patients cancelled who are offered another date within 28 days of the cancellation
3. The number of urgent operations cancelled for a second time.

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
For the second consecutive month the 0.8% national target has been achieved. This target has not been achieved in winter since 2010. In February 2014 UHL had 174 cancellations (2%). There were 110 fewer cancellations in February 2015. The OTD cancellation reasons remain similar to last month. 13 out of 64 were patients cancelled due to Adult HDU/ITU bed unavailability. Emergency admissions to the LRI critical care unit increased significantly this year compared to the last three years adding pressures to OTD cancellations and 28 days breaches in January. There were three 28 day breaches from UHL (excluding the Alliance): due to ITU/HDU pressures second time cancellations, complex procedures requiring specific medical input and complex equipment issue. All three occasions relevant escalations are followed.	A number of work streams have started aimed at reducing OTD cancellations including a LIA project. A successful LIA event was completed with participation of 48 staff in all three sites. Lots of useful feedback and a number of new ideas were provided by the staff to reduce cancellations. The LIA team are working to implement the changes suggested. <u>Risks to delivery of recovery plan</u> HDU and ITU bed availability is still a significant risk to OTD cancellations and 28 day breaches. The situation is monitored on a daily basis to try to ensure there is sufficient capacity to manage the emergency and elective flows to prevent OTD cancellations. Improvements have been made to the patient booking processes to try to establish a stable number of patients who will require critical care electively post operatively.	1)On day=0.8% 2) 28 day = 0 3)urgent second time=0	1) 0.7% 2) 4 (3 UHL + 1 Alliance) 3) 0	1) 0.9% 2) 43 3) 0	1) 0.8% 2) 1 3) 0



Expected date to meet standard / target	April - On the day April – 28 day
Revised date to meet standard	
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Phil Walmsley, ITAPs Head of Operations

R24 Choose and Book

<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">The Trust is measured on the % of Appointment Slot Unavailability (ASI) per month.

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

The two most significant factors causing underperformance are:

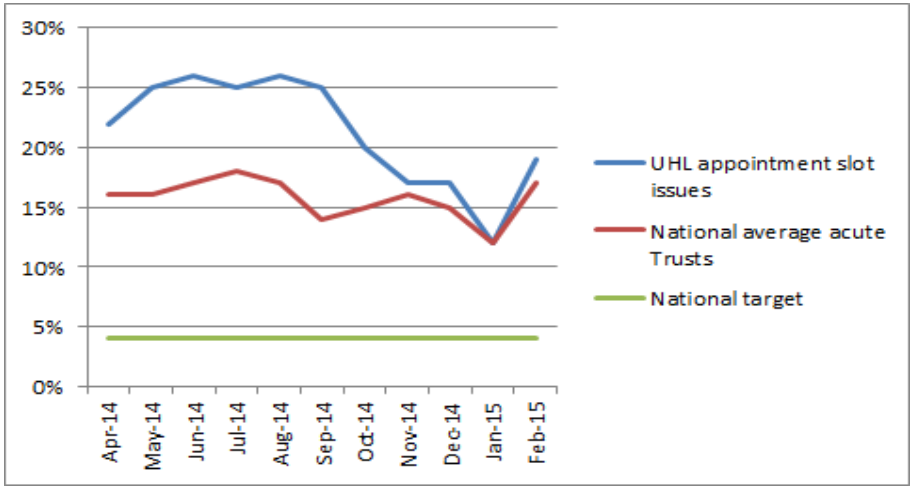
- Shortage of capacity in outpatients
- Inadequate recurrent training and education of administrative staff in the set up and use of the choose and book process

The issues are notably: General Surgery and orthopaedics, Urology, paediatrics</td><td rowspan="5">Capacity

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

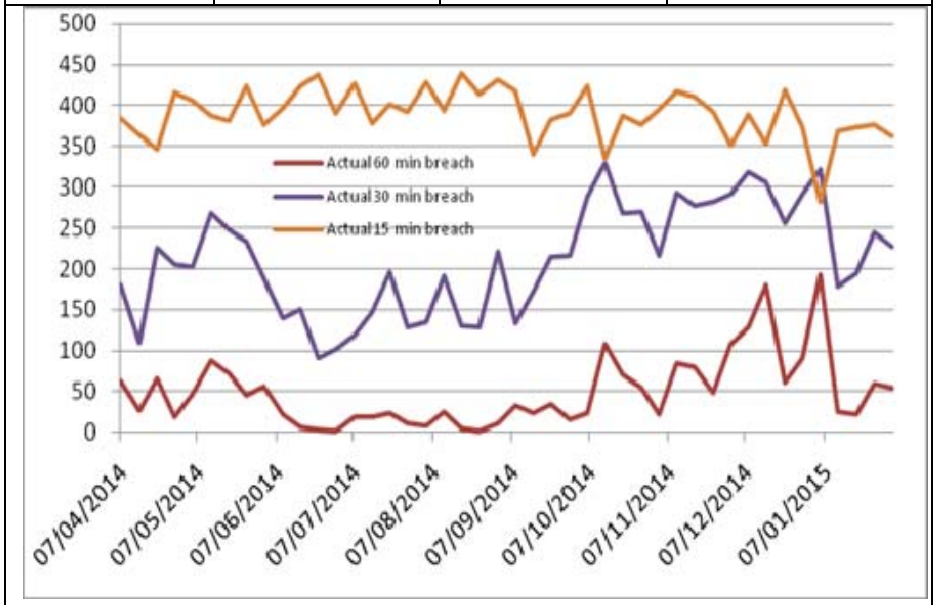
Training and education

The comprehensive training and education of relevant staff in key specialties continues, to ensure that choose and book is correctly set up and that supporting administrative purposes are fit for purpose.
A speciality level ‘score card’ to highlight areas required for improvement is being distributed weekly to CMGs. This highlights areas for concern and actions required.</td><td><4%</td><td>19%</td><td>21%</td><td>20%</td></tr>
<tr><td colspan="4">National performance varies significantly by Trust, with average performance of Acute Trusts nationally at 17% in November

 
</td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="3">January 2015</td></tr>
<tr><td>Revised date to meet standard</td><td colspan="3">Yet to be confirmed</td></tr>
<tr><td>Lead Director / Lead Officer</td><td colspan="3">Will Monaghan, Director of Performance and Information
Charlie Carr, Head of Performance</td></tr>
</table>

R25 and R26 Ambulance handover > 30 minutes and >60 minutes

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
Difficulties in accessing medical beds continue to lead to a backlog in the assessment area of ED. This delays movement out of the assessment area and delays handover. January's performance improved due to consistently having beds in AMU so improving flow out of the ED. It should be noted that the overall attendances in January via ambulance have gone down by 27 compared to December	A second meeting took place with EMAS in February. There are a series of actions that are being progressed to manage delays in handover,screens displaying in bound and vehicles on the stack. Monthly RCA of 60+ mins delays continues to identify reasons for delays Initial meeting with EMAS re implementation of CAD+.	0 delays over 30 minutes	> 60 min 6% 30-60 min – 24% 15-30 min – 33%	> 60 min 3% 30-60 min – 17% 15-30 min – 36%	



Expected date to meet standard / target	
Revised date to meet standard	
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer, Phil Walmsley, ITAPS Head of Operations

RS2A Proportion of commercial contract studies achieving their recruitment target during their planned recruitment period

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
East Midlands is currently 12th of the 15 LCRNs for this metric with no LCRN currently achieving the 80% target, highest is currently 68% and lowest 45% Historic targets set in a previous structure where this measure was not applicable, of the 127 closed studies for this measure only 6 entered the system after 1st April 2014 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	• Recovery plan produced identifying the divisions (1,2 & 5) with high volume and low performance and prioritised 2 weekly meetings with Research Delivery Managers to improve performance • Migration of the performance data for all open and closed commercial research onto one internet based system to track performance for 2014/15. • Implementation of a performance management process involving the Industry Team and Delivery Managers to escalate studies not recruiting to target within 24 hours and to align targets. • 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. • Collation of local information to report on the actual figure to take account for the lag in National reporting. Feedback to national team highlighting numerous discrepancies in the report • Contacting sponsors direct to analyse the reasons for under-performance.	80%	56%	47%	54%

Closed Studies

Division No closed studies	RTT	Activity as % of EMCRN closed	No red	No green	Rationale for underperformance	No open studies	% of open activity
1 21 studies	43%	17%	12	9	Low numbers of recruits required for individual studies and narrowly missed targets Studies that struggled nationally	71	29%
2 30 studies	37%	24%	19	11	Low numbers of recruits required for individual studies and narrowly missed targets Studies that struggled nationally Diabetes UHL 7 closed 7 red	66	27%
3 10 studies	30%	8%	7	3	Came on board late to support. Short recruitment window as closed globally quicker than anticipated Imp issues so suspended but still included in CAR	23	9%
4 9 studies	56%	7%	4	5	Just missed target or came on board late to support trial and not enough time	20	8%
5 20 studies	35%	16%	13	7	Studies failed at a national level	16	7%
6 37 studies	70%	29%	11	26	Studies failed at a national level	50	20%
127 studies	47%	100%	67	60		246	100%

Data from CAR end Feb 2015 Total 127 studies 61 green locally but 1 (SRN029) went over time nationally so 60 total green of 127 gives 47% RTT

Expected date to meet standard / target	May 2015
Revised date to meet standard	May 2015
Lead Director / Lead Officer	Daniel Kumar, Industry Delivery Manager, CRN: East Midlands

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">The NIHR Clinical Research Network has an HLO with the Department of Health for 99% of Trusts in England to recruit to CRN Portfolio research each year. This has been passed down to local research networks.

There are 16 Trusts within the East Midlands region, with 14 Trusts currently reporting recruitment. The two who have not reported any recruitment are:
● East Midlands Ambulance Service NHS Trust (EMAS)
Lincolnshire Community Health Services (LCHS)</td><td rowspan="5">1. EMAS: have received funding in 2014/15 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 in 2015/16 including the AIRWAYS 2 study. Therefore it is unlikely that EMAS will report any recruitment before April 2015.

2. LCHS: this Trust supports several CRN Portfolio 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, however it is unlikely that this Trust will report recruitment this financial year.</td><td>99%</td><td>88% (Red)</td><td>88% (Red)</td><td>88%</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="3">This target will not be met in 2014/15.</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 CRN: East Midlands</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">HLO6B: Proportion of NHS Trusts recruiting each year into commercial NIHR CRN Portfolio studies

There are 16 Trusts within the East Midlands region, with 9 Trusts currently recruiting to commercial studies. The seven who have not reported any recruitment are:

● East Midlands Ambulance Service NHS Trust (EMAS)
● Derbyshire Community Health Services NHS Foundation Trust (DCHS)
● Lincolnshire Community Health Services (LCHS)
● Leicestershire Partnership NHS Trust (LePT)
● Lincolnshire Partnership NHS Trust (LiPT)
● Nottinghamshire Healthcare NHS Foundation Trust (NHFT)
Derbyshire Healthcare NHS Foundation Trust (DHFT)</td><td rowspan="4">1. EMAS: Currently no open commercial studies nationally run by ambulance services on the NIHR portfolio, therefore unlikely that EMAS will open a commercial study this financial year. Industry team currently reviewing studies previously run at other ambulance services across the country to gain insight. Met and sending potential examples to review
2. DCHS: Due to the nature of research within this Trust, they are unlikely to be involved in commercial research, Have met with Trust and a preliminary plan is in place to take this forward.
3. LCHS: Due to the nature of research within this Trust, they are unlikely to be involved in commercial research. Met on the 18th December and a preliminary plan is in place to take this forward.
4. LePT: Selected for one study,logistics being explored.
5. LiPT: Have been involved in commercial research in the past and the site is actively seeking commercial opportunities. One sponsor in touch looking to take a study forward.
6. NHFT: One trial initiated at the end of November 2014, 2nd UK site to open no recruits to date. One further site selection visit completed in March 2015
7. DHFT: 2 potential studies in the pipeline. One had site selection visit in February 2015</td><td>70%</td><td>56% (Red)</td><td>56% (Red)</td><td>56%</td></tr>
<tr><td colspan="4" rowspan="3"></td></tr>
<tr><td>Expected date to meet standard / target</td><td>July 2015</td></tr>
<tr><td>Revised date to meet standard</td><td>July 2015</td></tr>
<tr><td>Lead Director / Lead Officer</td><td>Daniel Kumar, Industry Delivery Manager, CRN: East Midlands</td></tr>
</table>

2014/15 NTDA METRICS AND WEIGHTINGS

Responsiveness Domain

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

Effectiveness Domain

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

Safe Domain

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

Caring Domain

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

Well Led Domain

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

CQC – Intelligent Monitoring Report

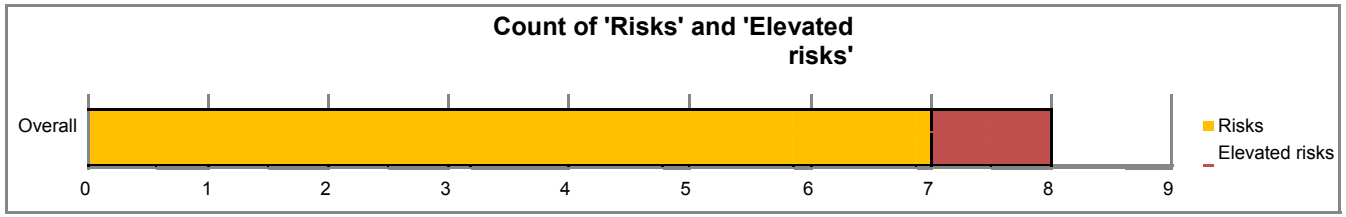
The latest CQC Intelligent Monitoring Report (IMR) was published on the CQC website on the 3rd December 2014.

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

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

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

The next publication date is May 2015.



Priority banding for inspection	Recently inspected
Number of 'Risks'	7
Number of 'Elevated risks'	1
Overall Risk Score	9
Number of Applicable Indicators	94
Percentage Score	4.79%
Maximum Possible Risk Score	188

Elevated risk	Whistleblowing alerts (18-Jul-13 to 29-Sep-14)
Risk	PROMs EQ-5D score: Groin Hernia Surgery (01-Apr-13 to 31-Mar-14)
Risk	Composite indicator: A&E waiting times more than 4 hours (01-Jul-14 to 30-Sep-14)
Risk	All cancers: 62 day wait for first treatment from NHS cancer screening referral (01-Apr-14 to 30-Jun-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	TDA - Escalation score (01-Jun-14 to 30-Jun-14)
Risk	GMC - Enhanced monitoring (01-Mar-09 to 22-Jul-14)
Risk	Patient Opinion - the number of negative comments is high relative to positive comments (28-May-13 to 27-May-14)

Quality Schedule and CQUIN Schemes

Confirmed RAG's for Quarter 3 and predicted RAG's for Quarter 4.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
	QUALITY SCHEDULE					
PS01	Infection Prevention and Control Reduction. - C Diff	G	A	tbc	G	Q2 Amber RAG remains as Multi Drug Resistant data not submitted. Monthly reporting of C Diff. 66 cases to date which is below the NTDA trajectory (81) but above UHL's own threshold. Q3 RAG to be confirmed at the March CQRG
PS02	HCAI Monitoring - MRSA	0	1	3	1 (Feb)	1 Bacteraemia in February – to be confirmed whether avoidable.
PS03	Patient Safety – SIs, Never Events	G	G	2 tbc	1 (Jan) G	Q3 & Q4 Red RAG for Never Events. (relating to 'wrong sized hip prosthesis, retained Swab ties and wrong site surgery) Q3 Patient Safety Report to be presented to the March CQRG. Number of incidents reported continues to rise. But there has been a reduction in number that resulted harm.
PS04	Duty of Candour	0	0	0	0	No breaches to date.
PS05	Complaints and user feedback Management (excluding patient surveys).	A	A	G	G	Complaints responses performance improved and achieved for December. Q3 RAG to be confirmed at the March CQRG.
PS06	Risk Assurance and CAS Alerts	A	A	G	G	Amber RAG for Q2 relates to overdue CAS alerts for July. All risk reviews back on track for Q3. No overdue CAS alerts and all risk reviews and actions on Track
PS07	Safeguarding – Adults and Children	G	G	G	G	Assurance documentation due to be sent to CCG Safeguarding leads for their review ahead of their observational visit to the Trust.
PS08	Reduction in Pressure Ulcer incidence.	G	G	R	G	Monthly thresholds met for G3 HAPUs. Above the monthly trajectory for Grade 2 HAPUs in both Nov (13) and Dec (11) and 1 x Grade 4. Within trajectory for both G2 and G3 for Jan and February and No Grade 4 HAPUs.
PS09	Medicines Management Optimisation	A	G	A	G	Commissioners noted improvement in Controlled Drugs audit report and also Medicines Code but thresholds not fully achieved. Progress made with developing LLR Medicines Optimisation Strategy.
PS10	Medication Errors	G	G	G	G	Increased reporting of errors and actions being taken.
PS11	Venous Thromboembolism (VTE) and RCAs of Hospital Acquired Thrombosis	95.7%	96.1%	95.2%	96.3%	Preliminary data suggested Dec performance below 95% for VTE risk assessment but case note review confirmed actual performance above 95% and Q3 performance overall = 95.6%. RCAs in progress for Q3 Hospital Acquired Thrombosis. RAG
PS12	Nutrition and Hydration	G	>80%	>85%	tbc	Work programme on track for nutrition, some delays with hydration actions. Threshold achieved for all measures across all CMGs with exception of ESM for 'Protected Mealtimes'.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
PE1	Same Sex Accommodation Compliance and Annual Estates Monitoring	2	0	2	1 (Jan)	Jan breach relates to patient on HDU at Glenfield.
PE2	Patient Experience, Equality and Listening to and Learning from Feedback.	G	G	G	G	Good progress made with triangulation of data. Waiting time main area for improvement.
PE3	Improving Patient Experience of Hospital Care (NPS)	N/A	N/A	N/A	tbc	Not due to be reported until March 15. RAG dependent upon results in the National Patient Survey.
PE4	Equality and Human Rights	G	G	G	G	Progress reported to the September CQRG with further information provided in October – relating to actions being taken to capture BME data
CE01	Communication – Content (ED, Discharge & Outpatient Letters)	A	A	tbc	G	Clinical Problem Solving Group held to agree key priorities. Letters policy finalised launched end of Jan 15. RAG tbc at March CQRG
CE02	Intra-operative Fluid Management	G	>80%	<80%	G	Performance deteriorated during Oct/Nov. 80% achieved for December. Remedial actions in place to maintain.
CE03	Clinical Effectiveness Assurance – NICE and Clinical Audit	A	A	tbc	G	Responses for NICE Clinical Guideline / Quality Standards documents on track and actions being taken where audits behind schedule RAG tbc at March CQRG
CE04	Women's Service Dashboard	A	A	tbc	tbc	Amber RAG for Q2 relates to increase in C Section Rate. Q3 RAG to be confirmed at the March CQRG but anticipate Amber RAG due to not achieving thresholds for Medical Staff Core Skills Training and C Section Rate.
CE05	Children's Service Dashboard	A	A	tbc	tbc	Q2 Amber RAG relates to SpR training Q3 RAG to be confirmed at the March CQRG but anticipated to be Amber due to non achievement of thresholds for SpR training and Management plans within 2 hours on the assessment unit.
CE06	Patient Reported and Clinical Outcomes (PROMs and Everyone Counts)	A	A	tbc	G	Groin Hernia PROMs improved, although still below the national average. Consultant Outcomes published and all consultants in line with national average. Q3 RAG to be confirmed at the March CQRG.
CE07	#NOF - Dashboard	51%	67.9%	62.1%	62.6% (Avge)	72% threshold not met for any month in Q3. Mainly relates to peaks in activity and spinal patients. Improvement in February ((62.7%) from 57.9% in Jan. LiA programme in place and business case submitted to support increased theatre capacity.
CE08a	Stroke monitoring	G	G	72% Avge G	tbc	Red for '90% stay on Stroke Unit not achieved for any month in Q3. TIA Clinic thresholds exceeded and improvements made for other Stroke indicators (time to Scan, admission to stroke unit, thrombolysis). SSNAP data for Q3 to be confirmed. Green RAG for Q4 will be dependant upon achievement of the 90% stay (Jan performance >80%) and improvement in SSNAP Domain Scores.
CE08b	TIA monitoring	76%	67%	73.4%	72.3% (Avge)	Threshold achieved for high risk patients and performance improved for low risk patients being seen within 7 days.
CE09	Mortality (SHMI, HSMR)	A	A	A	A	Latest published SHMI = 105 (104.7) and is slowly reducing but is still above 100.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
CE10	Making Every Contact Count (MECC)	A	G	tbc	G	Referrals to STOP and ALW continue. 'Healthy Eating and Physical Activity publicity campaign due to commence in General Surgery and Sleep Clinics. Q3 RAG to be confirmed at March CQRG.
AS01	Cost Improvement Programme (CIP) Assurance	A	G	tbc	G	Q3 RAG to be revised upon review of additional assurance.
AS02	Ward Healthcheck (Nursing Establishment, Clinical Measures Scorecard)	G	G	G	G	Recruitment of additional nurses continues. Not all wards meeting 'Nurse to bed Ratio' but actions in place. Support being provided to those wards not meeting thresholds in the Clinical Measures Scorecard.
AS03	Staffing governance	A	A	A	A	Internal thresholds not met for Appraisal, Sickness and Corporate Induction or Turnover although improvement noticed. Medical Staffing Strategy submitted.
AS04	Involving employees in improving standards of care. (Whistleblowing)	G	G	G	G	Actions taken to address concerns raised.
AS05	Staff Satisfaction	G	G	G	G	Work undertaken through the L*i*A process noted.
AS06	External Visits and Commissioner Quality Visits	G	G	G	G	Actions in response to Reviews being taken.
AS07	CQC Registration	A	G	A	G	2 Actions in response to CQC visit findings behind schedule – remedial actions being taken.
	NATIONAL CQUINS					
Nat 1.1a	F&FT 1a - Staff	G	G	G	G	Implemented during Q1/2
Nat 1.1b	F&FT 1b - OutPt & Day Case	G	G	G	G	F&FT already happening in Day Case and has started in Outpatients.
Nat 1.2	F&FT 1.2 - Increased participation - ED	16.%	15.1%	16.2%	23.3% (Avge)	20% Q4 threshold achieved to date
Nat 1.3	F&FT 1.3 - Inpt increase in March	35.8%	31%	34.7%	40% (Feb)	On track to achieve Q4 30% threshold and also the 40% threshold for March 15 for additional CQUIN monies.
Nat 2.1	ST 2.1 - ST data submission	G	G	G	G	Data collection continues for all 4 harms.
Nat 2.2	ST 2.2 - LLR strategy	G	G	tbc	G	UHL contributing to the LLR Pressure Ulcer group and workstreams. Q3 RAG to be confirmed upon receipt of LLR Group minutes.
Nat 3.1	Dementia 3.1 - FAIR	G	G	G	G	90% thresholds met for all parts of the Dementia FAIR CQUIN.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
Nat 3.2	Dementia 3.2 - Training & Leadership	G	N/A	N/A	G	Nicky Morgan is new Clinical Lead Dementia Training Programme reviewed and revised. Q4 RAG dependent on evidence of increased staff attending training.
Nat 3.3	Dementia 3.3 - Carers	G	G	G	G	Surveys carried out and evidence of actions being taken
	LOCAL CQUINS					
Loc 1	Urgent Care 1 (Discharge)	G	G	G	tbc	Although no improvement in 'discharges before 11am/1pm' in Q3, Commissioners' noted increased capacity issues and work undertaken in Q3.
Loc 2	Urgent Care 2 (Consultant Assessment)	G	G	A	tbc	65% threshold exceeded for AMU but not achieved in other assessment areas. Audit data not felt to accurately reflect practice. Q4 audit to have increased clinical input to ensure accuracy but unlikely to achieve the 75% threshold across all areas.
Loc 3	Improving End of Life Care (AMBER)	G	G	G	G	New facilitators in post and Q3 threshold achieved.
Loc 4	Quality Mark	G	G	G	tbc	Quality Mark achieved for 6 out of the 8 wards to date. Although remaining 2 wards on track to achieve the QM, will be outside the agreed timescale for Q4.
Loc 5	Pneumonia	A	G	G	G	Q3 threshold achieved for all aspects of CQUIN scheme.
Loc 6	Think Glucose	G	G	G	G	Think Glucose programme on track.
Loc 7	Sepsis Care pathway	≥47%	≥60%	<65%	G	Not all 6 aspects of the Sepsis6 Care Bundle thresholds achieved in Q3. Remedial actions in place for Q4.
Loc 8	Heart Failure	≥49.5 %	≥63%	≥65%	tbc	Q3 65% threshold achieve and actions on track. Q4 RAG dependent upon achievement of 75% threshold.
Loc 9	Medication Safety Thermometer	G	G	G	G	All wards submitting data.
	SPECIALISED CQUINS*					
SS1	National Quality Dashboards	G	G	G	G	Dashboards now open for data submission at end of Q3
SS2	Breast Feeding in Neonates	61%	66%	tbc	G	Threshold not fully achieved for Q3 with remedial actions in place.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
SS3	Clinical Utilisation Review of Critical Care	N/A*	G	G	G	CCMDS and ICNARC data now being collected for all satellite HDUs.
SS4	Acuity Recording	N/A*	G	G	G	Acuity recording in place for all areas. Q4 RAG dependent upon being able to demonstrate effective use of Acuity data.
SS5	Critical Care Standards - Discharge	N/A*	G	tbc	G	Reduction in delays but increase in out of hours transfers during December – related to increased activity in Critical Care.
SS6	Critical Care Outreach Team 'time to response'	N/A*	G	tbc	G	Q3 threshold (increase data collection around 'time from referral to response) not fully achieved. Remedial actions in place.
SS7	Consultant Assessment	G	G	A	tbc	Links to the CCG CQUIN.
SS8	Highly Specialised Services Collaborative Workshop	G	G	G	G	Q3 threshold is to provide update regarding participation in Clinical Benchmarking for both ECMO and PCO.