Quality & Performance Report

Author: John Adler Sponsor: Chief Executive Date: IFPIC + QAC 26th November 2015

Executive Summary from CEO

Paper K

Context

It has been agreed that I will provide a summary of the issues within the Q&P Report that I feel should particularly be brought to the attention of EPB, IFPIC and QAC. This complements the Exception Reports which are triggered automatically when identified thresholds are met.

Questions

1. What are the issues that I wish to draw to the attention of the committee?
2. Is the action being taken/planned sufficient to address the issues identified? If not, what further action should be taken?

Conclusion

Good News: **RTT** - The RTT incomplete target remains compliant. This is particularly good in the light of rising referrals. **DTOC** - Delayed transfers of care continues to remain well within the tolerance which reflects the good work that continues across the system in this area. **Diagnostics** - There has been further improvement in month with performance at 7.7%. There has been steady progress in tackling endoscopy waits and the target of having no more than 1% of patients waiting over 6 weeks for any diagnostic test/procedure should be met by December. **Cancelled operations** and **patients rebooked within 28 days**- were both compliant, which is remarkable given current pressures. **MRSA** - remains at zero. **Annual appraisals rates** – continue to improve. **Stay on a Stroke Unit** - performance has been compliant for eight months. **C DIFF** - above monthly trajectory by one but this is still within year to date trajectory. This is being closely monitored in respect of antibiotic prescribing controls and cleaning standards. **Pressure Ulcers** – a good month - there were zero avoidable **Grade 4** pressure ulcers reported and 6 **Grade 3** and **Grade 2** pressure ulcers reported. **Friends and Family Test Inpatients - % positive** – achieved Quality Commitment target of 97% for the last 3 months.

Bad News:

Fractured NOF – after delivering the standard for 2 consecutive months performance dipped to 60% during October. **ED 4 hour performance**- was 88.9% which for the third month in a row was worse than the corresponding month the year before. It has slipped to 91.3% year to date. This is primarily driven by record ED attendances and emergency admissions but has also been contributed to by staffing issues. Further detail is in the Chief Operating Officer's Emergency Care report. **Referral to Treatment 52+ week waits.** We are struggling to bring down these long waits due to an inability to recruit additional consultants

or to find capacity at other providers. This is an issue of national significance due to the numbers involved. **Cancer Standards -** the 62 day backlog remains high. A Remedial Action Plan has been submitted to commissioners with a revised compliance date of March 2016. **Ambulance Handover** – October continues to be a very challenging month for Ambulance handovers, directly linked to the emergency demand referenced above. This remains the most serious risk in the system.

Input Sought

I recommend that the Committee:

- Commends the positive achievements noted under Good News
- Note the areas of Bad News and consider if the actions being taken are sufficient.

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes /~~No /Not applicable~~]
Effective, integrated emergency care	[Yes /~~No /Not applicable~~]
Consistently meeting national access standards	[Yes /~~No /Not applicable~~]
Integrated care in partnership with others	[~~Yes /No~~ /Not applicable]
Enhanced delivery in research, innovation & ed’	[Yes /~~No /Not applicable~~]
A caring, professional, engaged workforce	[Yes /~~No /Not applicable~~]
Clinically sustainable services with excellent facilities	[Yes /~~No /Not applicable~~]
Financially sustainable NHS organisation	[~~Yes /No~~ /Not applicable]
Enabled by excellent IM&T	[~~Yes /No~~ /Not applicable]

2. This matter relates to the following governance initiatives:

Organisational Risk Register	[~~Yes /No~~ /Not applicable]
Board Assurance Framework	[Yes /~~No /Not applicable~~]

3. Related Patient and Public Involvement actions taken, or to be taken: Not Applicable

4. Results of any Equality Impact Assessment, relating to this matter: Not Applicable

5. Scheduled date for the next paper on this topic: 17th December 2015

Caring at its best

Quality and Performance Report

October 2015

One team shared values

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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: INTEGRATED FINANCE, PERFORMANCE AND INVESTMENT COMMITTEE
QUALITY ASSURANCE COMMITTEE

DATE: 26TH NOVEMBER 2015

REPORT BY: ANDREW FURLONG, INTERIM MEDICAL DIRECTOR
RICHARD MITCHELL, DEPUTY CHIEF EXECUTIVE/CHIEF OPERATING OFFICER
JULIE SMITH, CHIEF NURSE
LOUISE TIBBERT, DIRECTOR OF WORKFORCE AND ORGANISATIONAL DEVELOPMENT

SUBJECT: OCTOBER 2015 QUALITY & PERFORMANCE SUMMARY REPORT

1.0 Introduction

The following report provides an overview of TDA/UHL key quality and performance metrics and escalation reports where applicable.

2.0 Performance Summary

Domain	Page Number	Number of Indicators	Indicators with target to be confirmed	Number of Red Indicators this month
Safe	4	22	7	2
Caring	5	10	3	0
Well Led	6	18	6	2
Effective	7	16	3	2
Responsive	8	17	2	6
Responsive Cancer	9	9	0	3
Research – UHL	11	6	6	0
Total		98	38	15

3.0 New Indicators

No new indicators.

4.0 Indicators removed

The Estates and Facilities dashboard has been removed as a standing agenda item covering the Interserve contract is presented at the Trust Board.

Intelligent Monitoring (IM) for NHS acute and specialist trusts – CQC have written to inform Trusts that CQC will not be publishing any further updates of Intelligent Monitoring (IM) for NHS acute and specialist trusts.

5.0 Indicators where reporting methodology/thresholds have changed

Responsive Cancer

Cancer waiting 104 days – target set at 0.

	KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	YTD
Safe	S1	Clostridium Difficile	JS	DJ	61	TDA	Red if >mthly threshold / ER if Red or Non compliance with cumulative target	66	73	2	5	7	7	11	7	5	7	3	1	4	4	6	6	6	30
	S2a	MRSA Bacteraemias (All)	JS	DJ	0	TDA	Red if >0 ER if >0	3	6	0	1	1	0	2	0	1	1	0	0	0	0	0	0	0	0
	S2b	MRSA Bacteraemias (Avoidable)	JS	DJ	0	UHL	Red if >0 ER if >0	1	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
	S3	Never Events	JS	MD	0	TDA	Red if >0 in mth ER = in mth >0	3	3	0	0	1	0	1	1	0	0	0	0	0	0	0	1	0	1
	S4	Serious Incidents	JS	MD	Not within Highest Decile	TDA	TBC	60	41	2	3	4	2	4	3	2	1	2	8	1	5	3	5	3	27
	S5a	Proportion of reported safety incidents per 1000 beddays	JS	MD	TBC	TDA	TBC	37.5	39.1	35.6	41.8	38.9	40.3	40.4	35.0	38.2	36.3	34.6	37.3	39.6	39.9	37.1	33.6	38.7	37.3
	S5b	Proportion of reported safety incidents that are harmful	JS	MD	Not within Highest Decile	TDA	TBC	2.8%	1.9%	2.2%		1.4%			2.3%			2.2%			1.9%				2.1%
	S6	Overdue CAS alerts	JS	MD	0	TDA	Red if >0 in mth ER = in mth >0	2	10	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
	S7	RIDDOR - Serious Staff Injuries	JS	MD	FYE = <40	UHL	Red / ER if non compliance with cumulative target	47	24	2	1	2	2	1	0	3	2	0	6	0	0	2	3	7	18
	S8a	Safety Thermometer % of harm free care (all)	JS	EM	Not within Lowest Decile	TDA	Red if <92% ER = in mth <92%	93.6%	94.1%	94.4%	93.9%	94.9%	93.3%	94.1%	95.0%	92.1%	93.6%	93.7%	94.3%	95.6%	94.6%	93.2%	94.0%	93.5%	94.1%
	S8b	Safety Thermometer % number of new harms	JS	EM	Not within Lowest Decile	TDA	TBC	New TDA Indicator		2.9%	2.5%	2.3%	3.3%	2.4%	2.5%	3.2%	2.7%	2.2%	2.6%	2.1%	1.9%	3.1%	2.4%	2.6%	2.4%
	S9	% of all adults who have had VTE risk assessment on adm to hosp	AF	SH	95% or above	TDA	Red if <95% ER if in mth <95%	95.3%	95.8%	95.5%	96.2%	95.4%	95.5%	95.0%	96.3%	96.2%	95.6%	96.0%	96.0%	96.5%	96.2%	96.5%	96.1%	95.7%	96.1%
	S10	All Medication errors causing serious harm	AF	CE	0	TDA	Red if >0 in mth ER if in mth >0	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	
	S11	All falls reported per 1000 bed stays for patients >65years	JS	HL	<7.1	QC	Red if >8.4 ER if 2 consecutive reds	7.1	6.9	7.3	5.9	6.4	7.5	6.9	7.1	6.7	6.3	5.6	5.8	5.1	5.7	5.7	4.1	5.2	5.6
	S12	Avoidable Pressure Ulcers - Grade 4	JS	MC	0	QS	Red / ER if Non compliance with monthly target	1	2	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0
	S13	Avoidable Pressure Ulcers - Grade 3	JS	MC	<=6 a month	QS	Red / ER if Non compliance with monthly target	71	69	6	6	4	6	7	5	9	6	3	0	4	1	4	1	1	14
	S14	Avoidable Pressure Ulcers - Grade 2	JS	MC	<=8 a month	QS	Red / ER if Non compliance with monthly target	120	91	9	4	8	13	11	7	5	9	10	8	8	8	10	11	5	60
	S15	Compliance with the SEPSIS6 Care Bundle	AF	JP	All 6 >75% by Q4	QC	Red/ER if Non compliance with Quarterly target	27.0%	<65%	>=60%		<65%			<75%			AUDIT IN PROGESS							
	S16	Maternal Deaths	AF	IS	0	UHL	Red or ER if >0	3	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
	S17	Emergency C Sections (Coded as R18)	IS	EB	Not within Highest Decile	TDA	Red / ER if Non compliance with monthly target	16.1%	16.5%	15.4%	17.4%	18.1%	17.4%	16.2%	17.7%	15.5%	15.8%	15.3%	18.8%	15.8%	15.8%	15.2%	16.5%	20.9%	16.9%
	S18	Potential under reporting of patient safety indicators	JS	MD	Not within Highest Decile	TDA	Red / ER if Non compliance with monthly target	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	
	S19	Potential under reporting of patient safety indicators resulting in death or severe harm	JS	MD	Not within Highest Decile	TDA	Red / ER if Non compliance with monthly target	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	

	KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	YTD
Caring	C1	Inpatients (Including Daycases) Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <95% ER if 2 mths Red	New Indicator	96%	96%	97%	96%	96%	96%	96%	96%	97%	96%	96%	97%	96%	97%	97%	97%	96%
	C2	A&E Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <94% ER if 2 mths Red	New Indicator	96%	92%	95%	96%	96%	96%	96%	96%	97%	96%	96%	96%	96%	97%	95%	95%	96%
	C3	Outpatients Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <90% ER if 2 mths Red	NEW METHODOLOGY FOR CALCULATING %										94%	94%	93%	91%	93%	93%	93%	93%
	C4	Daycase Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <95% ER if 2 mths Red											96%	97%	97%	98%	98%	97%	98%	97%
	C5	Maternity Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <94% ER if 2 mths Red		96%	96%	94%	96%	97%	95%	97%	96%	96%	95%	96%	95%	95%	96%	95%	95%	95%
	C6	Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment	LT	LT	Not within Lowest Decile	TDA	TBC	New Indicator	69.2%			Q3 staff FFT not completed as National Survey carried out			71.4%			68.7%			71.9%				70.3%
	C7a	Complaints Rate per 100 bed days	AF	MD	TBC	UHL	TBC	New Indicator	0.4	0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3
	C7b	Written Complaints Received Rate per 100 bed days	AF	MD	Not within Highest Decile	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	
	C8	Complaints Re-Opened Rate	AF	MD	<=12%	UHL	Red if >=15% ER if >=15%	New Indicator	10%	10%	9%	11%	11%	10%	17%	13%	11%	13%	7%	7%	7%	11%	11%	8%	9%
	C9	Single Sex Accommodation Breaches (patients affected)	JS	HL	0	TDA	Red / ER if >0	2	13	0	0	0	5	0	1	0	0	0	0	0	0	0	0	0	0

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Well Led

KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	YTD
W1	Inpatients Friends and Family Test - Coverage (Adults and Children)	JS	HL	30%	TDA	Red if <26% ER if 2mths Red	NEW METHODOLOGY FOR CALCULATING COVERAGE INCLUDES ADULTS AND CHILDREN										29.2%	30.5%	29.0%	27.7%	28.9%	28.9%	37.4%	30.6%
W2	Daycase Friends and Family Test - Coverage (Adults and Children)	JS	HL	20%	TDA	Red if <8% ER if 2 mths Red	NEW METHODOLOGY FOR CALCULATING COVERAGE INCLUDES ADULTS AND CHILDREN										12.5%	12.1%	15.5%	20.5%	23.8%	24.1%	27.2%	23.8%
W3	A&E Friends and Family Test - Coverage	JS	HL	20%	TDA	Red if <10% ER if 2 mths Red	NEW METHODOLOGY FOR CALCULATING COVERAGE INCLUDES ADULTS AND CHILDREN										14.7%	14.9%	13.3%	14.1%	13.3%	13.1%	16.1%	14.2%
W4	Outpatients Friends and Family Test - Coverage	JS	HL	Q1 3% Q2/3 4% Q4 5%	UHL	Red if <2.5% ER Qtrly	NEW METHODOLOGY FOR CALCULATING COVERAGE INCLUDES ADULTS AND CHILDREN										1.3%	1.6%	1.2%	1.2%	1.4%	1.4%	1.5%	1.3%
W5	Maternity Friends and Family Test - Coverage	JS	HL	30%	UHL	Red if <26% ER if 2 mths Red	25.2%	28.0%	29.9%	18.7%	15.8%	21.7%	22.1%	25.8%	46.5%	40.2%	32.3%	35.8%	32.6%	25.6%	30.5%	27.9%	27.2%	30.2%
W6	Friends & Family staff survey: % of staff who would recommend the trust as place to work	LT	BK	Not within Lowest Decile	TDA	TBC	New Indicator	54.2%	53.7%		Q3 staff FFT not completed as National Survey carried out			54.9%			52.5%			55.7%				54.0%
W7a	Nursing Vacancies	JS	MM	5% by Mar 16	UHL	Separate report submitted to QAC	NEW UHL INDICATOR			6.7%	6.7%	6.4%	6.0%	6.3%	5.5%	6.5%	8.5%	8.0%	7.3%	8.7%	8.9%	8.5%	7.1%	7.1%
W7b	Nursing Vacancies in ESM CMG	JS	MM	5% by Mar 16	UHL	Separate report submitted to QAC	NEW UHL INDICATOR			10.8%	10.8%	10.7%	9.7%	12.8%	11.4%	14.0%	19.3%	13.0%	14.4%	13.3%	13.5%	13.5%	12.9%	12.9%
W8	Turnover Rate	LT	LG	Not within Lowest Decile	TDA	Red = 11% or above ER = Red for 3 Consecutive Mths	10.0%	11.5%	10.5%	10.3%	10.8%	10.7%	10.3%	10.1%	10.1%	11.5%	10.4%	10.5%	10.5%	10.6%	10.4%	10.4%	10.2%	10.2%
W9	Sickness absence	LT	KK	3%	UHL	Red if >4% ER if 3 consecutive mths >4.0%	3.4%	3.8%	3.4%	3.7%	4.0%	4.0%	4.4%	4.2%	4.1%	4.0%	3.6%	3.4%	3.4%	3.3%	3.2%	3.5%		3.4%
W10	Temporary costs and overtime as a % of total paybill	LT	LG	TBC	TDA	TBC	New Indicator	9.4%	8.9%	8.5%	9.5%	9.0%	9.8%	10.5%	9.8%	11.5%	10.7%	10.2%	11.0%	10.8%	11.1%	9.9%	10.5%	10.6%
W11	% of Staff with Annual Appraisal	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	91.3%	91.4%	88.6%	89.7%	91.8%	92.3%	92.5%	90.9%	91.0%	91.4%	90.1%	88.7%	89.0%	89.1%	88.8%	90.0%	90.4%	90.4%
W12	Statutory and Mandatory Training	LT	BK	95%	UHL	TBC	76%	95%	83%	85%	86%	87%	89%	89%	90%	95%	93%	92%	92%	91%	91%	91%	92%	92%
W13	% Corporate Induction attendance	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	94.5%	100%	98%	98%	98%	98%	100%	99%	100%	97%	97%	97%	98%	100%	97%	98%	98%	98%
W14a	DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	Not within Lowest Decile	TDA	TBC	New Indicator	91.2%	87.9%	91.6%	92.9%	91.3%	92.7%	94.3%	91.8%	91.0%	93.6%	90.3%	91.2%	90.3%	90.2%	90.5%	91.4%	91.1%
W14b	DAY Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	Not within Lowest Decile	TDA	TBC		94.0%	94.8%	90.3%	95.4%	94.4%	95.8%	95.4%	92.8%	92.5%	94.2%	91.2%	93.5%	91.3%	92.4%	93.1%	94.2%	92.8%
W14c	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	Not within Lowest Decile	TDA	TBC		94.9%	91.4%	94.8%	97.4%	96.5%	96.4%	97.9%	96.5%	97.2%	98.9%	96.0%	96.2%	94.3%	94.3%	94.9%	96.1%	95.8%
W14d	NIGHT Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	Not within Lowest Decile	TDA	TBC		99.8%	98.0%	97.8%	100.8%	101.2%	101.4%	103.6%	100.8%	103.2%	106.3%	98.7%	99.4%	101.2%	98.0%	100.0%	99.9%	100.5%

Effective

KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	YTD
E1	Mortality - Published SHMI	AF	PR	Within Expected	TDA	Higher than Expected	105	103	106 (Jan13-Dec13)		105 (Apr13-Mar14)			105 (Jul13-Jun14)			103 (Oct13-Sep14)			99 (Jan14-Dec 14)			98 (Apr14-Mar15)	
E2	Mortality - Rolling 12 mths SHMI (as reported in HED) Rebased	AF	PR	Within Expected	QC	Red if >expected ER if >Expected or 3 consecutive mths increasing SHMI >100	105	98	102	101	101	100	99	99	98	98	98	96	95	95	Awaiting HED Update			95
E3	Mortality HSMR (DFI Quarterly)	AF	PR	Within Expected	TDA	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	88	94	92		93			93			85			Awaiting DFI Update				85
E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	AF	PR	Within Expected	QC	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	99	94	95	95	95	94	94	95	95	94	94	94	93	93	93	Awaiting HED Update		93
E5	Mortality - Monthly HSMR (Rebased Monthly as reported in HED)	AF	PR	Within Expected	QC	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	91	94	97	97	95	88	95	99	98	86	83	96	99	85	88	Awaiting HED Update		90
E6	Mortality - HSMR ALL Weekend Admissions - (DFI Quarterly)	AF	PR	Within Expected	QC	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	96	100	99		96			106			93			Awaiting DFI Update				93
E7	Crude Mortality Rate Emergency Spells	AF	PR	Within Upper Decile	TDA	TBC	2.5%	2.4%	1.9%	2.3%	2.1%	2.3%	3.0%	3.1%	2.7%	2.4%	2.1%	2.0%	2.3%	1.8%	2.0%	2.2%	2.4%	2.1%
E8	Deaths in low risk conditions (Risk Score)	AF	PR	Within Expected	TDA	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	94	80	63	58	111	59	84	100	86	74	121	20	38	38	Awaiting DFI Update			54
E9	Emergency readmissions within 30 days following an elective or emergency spell	AF	JJ	Within Expected	UHL	Red if >7% ER if 3 consecutive mths >7%	7.9%	8.5%	8.9%	8.4%	8.6%	8.9%	9.1%	8.2%	8.5%	8.5%	9.2%	9.1%	9.0%	8.8%	8.9%	8.7%		8.9%
E10	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	AF	RP	72% or above	QS	Red if <72% ER if 2 consecutive mths <72%	65.2%	61.4%	59.0%	68.6%	69.6%	59.4%	57.3%	57.9%	67.2%	61.5%	55.7%	42.6%	70.1%	60.3%	78.1%	72.0%	60.0%	63.0%
E11	Stroke - 90% of Stay on a Stroke Unit	RM	IL	80% or above	QS	Red if <80% ER if 2 consecutive mths <80%	83.2%	81.3%	84.5%	83.2%	69.4%	72.4%	74.3%	82.5%	87.6%	81.5%	83.7%	84.5%	84.5%	85.7%	90.9%	86.1%		86.0%
E12	Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA)	RM	IL	60% or above	QS	Red if <60% ER if 2 consecutive mths <60%	64.2%	71.2%	65.5%	72.7%	67.8%	69.0%	83.5%	80.6%	64.0%	77.3%	86.3%	79.6%	72.0%	78.9%	80.2%	88.1%	73.3%	79.5%
E13	Published Consultant Level Outcomes	AF	SH	>0 outside expected	QC	Red if >0 Quarterly ER if >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
E14	Non compliance with 14/15 published NICE guidance	AF	SH	0	QC	Red if in mth >0 ER if 2 consecutive mths Red	New Indicator for 14/15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
E15	ROSC in Utstein Group	AF	PR	TBC	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	
E16	STEMI 150minutes	AF	PR	TBC	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	

Responsive

KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	YTD
R1	ED 4 Hour Waits UHL + UCC (Calendar Month)	RM	IL	95% or above	TDA	Red if <92% ER via ED TB report	88.4%	89.1%	91.3%	91.6%	89.8%	89.1%	83.0%	90.7%	89.6%	91.1%	92.0%	92.2%	92.6%	92.2%	90.6%	90.3%	88.9%	91.3%
R2	12 hour trolley waits in A&E	RM	IL	0	TDA	Red if >0 ER via ED TB report	5	4	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0
R3	RTT - Incomplete 92% in 18 Weeks	RM	WM	92% or above	TDA	Red /ER if <92%	92.1%	96.7%	94.0%	94.3%	94.8%	95.0%	95.1%	95.2%	96.2%	96.7%	96.6%	96.5%	96.2%	95.2%	94.3%	94.8%	93.6%	93.6%
R4	RTT 52 Weeks+ Wait (Incompletes)	RM	WM	0	TDA	Red /ER if >0	0	0	1	3	3	2	0	0	0	0	0	66	242	256	258	260	265	265
R5	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	TDA	Red /ER if >1%	1.9%	0.9%	1.0%	1.0%	0.7%	1.8%	2.2%	5.0%	0.8%	0.9%	0.8%	0.6%	6.1%	10.9%	13.4%	9.6%	7.7%	7.7%
R6	Urgent Operations Cancelled Twice	RM	PW	0	TDA	Red if >0 ER if >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
R7	Cancelled patients not offered a date within 28 days of the cancellations UHL	RM	PW	0	TDA	Red if >2 ER if >0	85	33	1	2	2	0	3	4	3	1	2	0	1	1	5	1	0	10
R8	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	RM	PW	0	TDA	Red if >2 ER if >0	New Indicator for 14/15	11	6	0	0	1	1	2	1	0	0	0	1	0	0	0	0	1
R9	% Operations cancelled for non-clinical reasons on or after the day of admission UHL	RM	PW	0.8% or below	Contract	Red if >0.9% ER if >0.8%	1.6%	0.9%	0.6%	0.8%	0.8%	1.2%	1.1%	0.8%	0.7%	1.0%	0.7%	0.5%	0.9%	1.3%	0.7%	0.9%	0.8%	0.9%
R10	% Operations cancelled for non-clinical reasons on or after the day of admission ALLIANCE	RM	PW	0.8% or below	Contract	Red if >0.9% ER if >0.8%	1.6%	0.9%	0.0%	0.9%	1.0%	0.0%	0.8%	1.4%	0.0%	0.4%	1.2%	1.2%	1.0%	0.8%	0.0%	1.0%	1.1%	0.9%
R11	% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	0.8% or below	Contract	Red if >0.9% ER if >0.8%	New Indicator for 14/15	0.9%	0.6%	0.8%	0.8%	1.1%	1.1%	0.8%	0.7%	0.9%	0.8%	0.6%	0.9%	1.3%	0.7%	0.9%	0.8%	0.9%
R12	No of Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	N/A	UHL	TBC	1739	1071	55	90	94	108	102	85	64	98	79	56	97	138	67	104	91	632
R13	Outpatient Hospital Cancellation Rates	RM	PW	Within Upper Decile	UHL	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	
R14	Delayed transfers of care	RM	PW	3.5% or below	TDA	Red if >3.5% ER if Red for 3 consecutive mths	4.1%	3.9%	3.9%	4.5%	4.6%	5.2%	3.9%	3.2%	2.9%	1.8%	1.2%	1.0%	1.0%	0.9%	1.2%	1.3%	1.5%	1.2%
R15	NHS e-Referral (formally Choose and Book Slot Unavailability)	RM	WM	4% or below	Contract	Red if >4% ER if Red for 3 consecutive mths	13%	21%	26%	25%	20%	17%	16%	13%	19%	26%	34%	31%	Data Not Available					
R16	Ambulance Handover >60 Mins (CAD+ from June 15)	RM	PW	0	Contract	Red if >0 ER if Red for 3 consecutive mths	New Indicator for 14/15	5%	1%	2%	5%	6%	10%	6%	11%	9%	6%	7%	7%	8%	9%	18%	22%	11%
R17	Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)	RM	PW	0	Contract	Red if >0 ER if Red for 3 consecutive mths	New Indicator for 14/15	19%	15%	17%	25%	23%	25%	21%	21%	22%	22%	21%	17%	17%	17%	25%	26%	21%

Responsive Cancer

KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Aug-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	YTD
** Cancer statistics are reported a month in arrears.																							
RC1	Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	RM	MM	93% or above	TDA	Red if <93% ER if Red for 2 consecutive mths	94.8%	92.2%	92.0%	92.0%	92.5%	93.0%	92.2%	93.5%	91.5%	91.2%	87.9%	91.1%	87.4%	86.8%	88.7%	**	88.9%
RC2	Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	RM	MM	93% or above	TDA	Red if <93% ER if Red for 2 consecutive mths	94.0%	94.1%	94.4%	98.6%	100.0%	93.0%	92.5%	91.5%	96.0%	99.0%	98.8%	87.2%	93.3%	98.7%	94.5%	**	95.2%
RC3	31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	RM	MM	96% or above	TDA	Red if <96% ER if Red for 2 consecutive mths	98.1%	94.6%	97.9%	95.9%	92.5%	95.2%	91.7%	95.0%	97.0%	93.9%	97.9%	93.7%	97.2%	96.5%	94.7%	**	95.7%
RC4	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	RM	MM	98% or above	TDA	Red if <98% ER if Red for 2 consecutive mths	100.0%	99.4%	98.8%	97.1%	100.0%	96.7%	100.0%	100.0%	100.0%	100.0%	100.0%	97.7%	100.0%	98.3%	100.0%	**	99.3%
RC5	31-Day Wait For Second Or Subsequent Treatment: Surgery	RM	MM	94% or above	TDA	Red if <94% ER if Red for 2 consecutive mths	96.0%	89.0%	87.8%	81.9%	82.4%	80.3%	89.2%	94.4%	87.5%	86.3%	92.2%	89.6%	92.2%	81.1%	89.7%	**	88.5%
RC6	31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	RM	MM	94% or above	TDA	Red if <94% ER if Red for 2 consecutive mths	98.2%	96.1%	99.0%	96.0%	94.7%	95.5%	87.6%	99.0%	100.0%	86.3%	98.1%	96.5%	95.9%	99.0%	92.2%	**	95.0%
RC7	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	RM	MM	85% or above	TDA	Red if <85% ER if Red in mth or YTD	86.7%	81.4%	78.8%	80.4%	77.0%	84.8%	79.3%	78.9%	83.8%	75.7%	70.1%	84.2%	73.7%	81.7%	77.2%	**	77.3%
RC8	62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	RM	MM	90% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	95.6%	84.5%	100.0%	75.0%	94.4%	93.8%	88.9%	79.4%	89.3%	91.7%	82.4%	93.3%	95.2%	97.1%	81.4%	**	90.5%
RC9	Cancer waiting 104 days	RM	MM	0	TDA	TBC	NEW TDA INDICATOR									12	10	12	20	12	12	17	17

62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers Inc Rare Cancers

KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Aug-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	YTD
RC10	Brain/Central Nervous System	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	100.0%	--	--	--	--	--	--	--	--	--	100.0%	--	--	--	--	**	100.0%
RC11	Breast	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	96.1%	92.6%	84.4%	96.3%	81.8%	100.0%	93.3%	97.4%	98.1%	92.3%	96.8%	97.8%	91.4%	96.3%	97.5%	**	95.4%
RC12	Gynaecological	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	88.2%	77.5%	91.7%	71.4%	75.0%	66.7%	54.5%	91.7%	75.0%	64.3%	55.6%	66.7%	100.0%	72.2%	80.0%	**	72.1%
RC13	Haematological	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	65.9%	66.5%	87.5%	100.0%	73.3%	75.0%	66.7%	50.0%	80.0%	50.0%	55.0%	83.3%	37.5%	82.6%	66.7%	**	62.3%
RC14	Head and Neck	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	65.4%	69.9%	83.3%	100.0%	33.3%	77.8%	70.0%	87.5%	62.5%	75.0%	54.5%	66.7%	36.4%	60.9%	50.0%	**	55.5%
RC15	Lower Gastrointestinal Cancer	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	71.3%	63.7%	50.0%	56.3%	62.5%	92.9%	65.0%	46.7%	63.2%	63.6%	55.6%	93.3%	63.6%	60.0%	38.9%	**	61.4%
RC16	Lung	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	89.7%	69.9%	48.1%	68.9%	64.1%	74.4%	67.7%	74.2%	88.6%	84.6%	50.9%	74.6%	81.8%	70.4%	73.5%	**	71.5%
RC17	Other	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	78.7%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100%	100%	100%	100%	50.0%	**	72.7%
RC18	Sarcoma	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	82.9%	46.2%	--	--	0.0%	0.0%	100.0%	--	0.0%	66.7%	--	100%	--	--	80.0%	**	80.0%
RC19	Skin	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	96.8%	96.7%	100.0%	94.5%	98.4%	94.1%	100.0%	94.3%	95.6%	91.7%	94.0%	91.3%	93.8%	94.1%	96.7%	**	93.7%
RC20	Upper Gastrointestinal Cancer	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	72.2%	73.9%	77.8%	33.3%	64.7%	68.0%	85.7%	77.8%	81.8%	66.7%	55.0%	84.6%	51.4%	81.8%	45.7%	**	62.6%
RC21	Urological (excluding testicular)	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	89.3%	82.6%	77.1%	84.5%	81.5%	85.7%	83.3%	66.7%	71.0%	62.1%	62.1%	74.7%	61.5%	86.1%	80.4%	**	71.9%
RC22	Rare Cancers	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	92.3%	84.6%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	--	100%	100%	100%	100.0%	100.0%	**	100%
RC23	Grand Total	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	86.7%	81.4%	78.8%	80.4%	77.0%	84.8%	79.3%	78.9%	83.7%	75.7%	70.1%	84.2%	73.7%	81.7%	77.2%	**	77.3%

Compliance Forecast for Key Responsive Indicators

Compliance Forecast for Key Responsive Indicators

Standard	October actual/predicted	November predicted	Month by which to be compliant	RAG rating of required month delivery	Commentary
Emergency Care					
4+ hr Wait (95%) - Calendar month	88.9%		March, 2016		
Ambulance Handover (CAD+)					
% Ambulance Handover >60 Mins (CAD+)	22%		Not Confirmed		An eight-week action plan has been agreed to speed up the time it takes for EMAS crews to pass patients to A&E staff at Leicester Royal Infirmary.
% Ambulance Handover >30 Mins and <60 mins (CAD+)	26%		Not Confirmed		
RTT (inc Alliance)					
Incomplete (92%)	93.6%	93.0%			November likely to deliver following validation.
Diagnostic (predicted)					
DM01 - diagnostics 6+ week waits (<1%)	7.7%	5.0%	December		NHS IQ Work progressing but current progress suggests more likely to be at 5% in November rather than the required 1%
# Neck of femurs					
% operated on within 36hrs - admissions (72%)	60.0%	72.0%			August and September delivered for the first time in over a year.
Cancelled Ops (inc Alliance)					
Cancelled Ops (0.8%)	0.8%	1.4%	December		At risk for November due to increased emergency pressures.
Not Rebooked within 28 days (0 patients)	0	2	Continued Delivery		November at risk - to be validated.
Cancer (predicted)					
Two Week Wait (93%)	87%	93%	November		At risk for November.
31 Day First Treatment (96%)	96%	96%	Continued Delivery		
31 Day Subsequent Surgery Treatment (94%)	94%	94%	November		
62 Days (85%)	78%	78%	March, 2016		The rephasing of delivery is being looked at currently given the challenge we and other centres are experiencing and the backlog not being where we need it to be. Nationally this target hasn't been achieved since April 2014.
Cancer waiting 104 days (0 patients)	17	15			

Research UHL

KPI Ref	Indicators	Board Director	Lead 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	Mar-15	YTD	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	YTD
RU1	Median Days from submission to Trust approval (Portfolio)	AF	NB	TBC	TBC	TBC		3.0			2.0			3.0			3.0		2.8		2.0			Data not available			2.0
RU2	Median Days from submission to Trust approval (Non Portfolio)	AF	NB	TBC	TBC	TBC		2.0			3.5			2.0			1.0		2.1		4.0			Data not available			4.0
RU3	Recruitment to Portfolio Studies	AF	NB	Aspirational target=10920/year (910/month)	TBC	TBC	941	1092	963	1075	1235	900	1039	1048	604	1030	1043	1298	12564	1078	869	1165	999	862	979	1255	7207
RU4	% Adjusted Trials Meeting 70 day Benchmark (data sunbmitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC		(Jul13-Jun14) 43.4%			(Oct13-Sep14) 70.5%			(Nov13-Dec14) 70.5%			(Apr14-Mar15) 86%				(Jul14-Jun15) 76%			Data not available			76%
RU5	Rank No. Trials Submitted for 70 day Benchmark (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC		(Jul13-Jun14) Rank 17/61			(Oct13-Sep14) Rank 18/60			(Nov13-Dec14) Rank 18/59			(Apr14-Mar15) Rank 60/198				(Jul14-Jun15)108/210			Data not available			108/210
RU6	%Closed Commercial Trials Meeting Recruitment Target (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC		(Jul13-Jun14) 50%			(Oct13-Sep14) 52%			(Nov13-Dec14) 48%			(Apr14-Mar15) 38.6%				(Jul14-Jun15) 15.3%			Data not available			15.3%

Clostridium Difficile

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
The cases of CDT are currently subject to Post Infection Reviews. There are no discernible factors that link the 6 cases in October to people and place, and the trust is still below trajectory overall.	Any learning following the outcome of the PIRs should be presented to the CMG Infection Prevention Groups and should follow the PIR process flow chart as described in the Infection Prevention Toolkit. Action plans with named local leads will be produced if the PIR feels action is required to reduce further cases.	**5**	**6**	**30**	**5**

	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Trajectory 15/16	5	5	5	5	5	5	5	5	5	6	5	5	**61**
Actual Infections 15/16	3	1	4	4	6	6	6						**30**

Expected date to meet monthly target	November 2015
Revised date to meet standard	
Lead Director / Lead Officer	Julie Smith, Chief Nurse Liz Collins, Lead Nurse Infection Prevention

RIDDOR - Serious Staff Injuries

<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>October</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="4">The number and type of RIDDOR reported through affected CMGs are listed below. RIDDOR incidents are not controllable centrally but rely upon appropriate controls in place at a local level and are therefore difficult to predict with accuracy.

ITAPS x 2
ED & Specialist Medicine x 1
Women’s & Children’s x 1
RRC x 1
MSK & SS x 1
Arriva x 1

<table>
<tr><th>Type of incident</th><th>Injury</th><th>Location</th></tr>
<tr><td>Slip/trip/fall</td><td>Damage to nervous system (over 7 days)</td><td>Theatre 17 LRI (ITAPS)</td></tr>
<tr><td>Major</td><td>Fractured ankle (S/T/F)</td><td>Theatre 9 GH (ITAPS)</td></tr>
<tr><td>Physical assault</td><td>Contusions & bruising (over 7 days)</td><td>Ward 33 LRI (ED & SM)</td></tr>
<tr><td>Slip/Trip/Fall</td><td>Contusions & bruising (over 7 days)</td><td>Labour ward LRI (W&C)</td></tr>
<tr><td>Manual Handling</td><td>Pushing/pulling (over 7 days)</td><td>Ward 28 GH (RRC)</td></tr>
<tr><td>Slip/Trip/Fall</td><td>Contusions & bruising (over 7 days)</td><td>Ward 19 LGH (MSK & SS)</td></tr>
<tr><td>Impact</td><td>Contusions & bruising (member of public taken to hospital)</td><td>Hospital grounds LRI (Arriva vehicle but reported by UHL)</td></tr>
</table></td>
<td rowspan="4">A complete root cause analysis for each RIDDOR has been completed with recommendations as to how the risk of recurrence within affected CMGs can be reduced.</td>
<td><40 RIDDORS during 2015/16 (i.e. approx. 3.3 per month)</td><td>7</td><td>18</td><td>3</td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="3">November 2015</td></tr>
<tr><td>Revised date to meet standard</td><td colspan="3">November 2015</td></tr>
<tr><td>Lead Director / Lead Officer</td><td colspan="3">Moira Durbridge, Director of Safety and Risk</td></tr>
</table>

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 FY 15/16	Forecast performance for next reporting period
There were 70 NOF admissions in October 2015, 23 patients breached the 36 hr target to theatre as detailed below:- Medically Unfit – 8pts List over ran therefore pt cancelled Weekend – 11pts List over ran therefore pt cancelled weekday – 3pts Required specific Hip surgeon to perform op – 1 pt October saw 3 occasions where high numbers of NOF patients were admitted on one day 2nd Oct = 5 NOF's 16th and 17th Oct = 7 and 3 NOF's 28th Oct = 6 NOF's As in previous months spinal patients are medically prioritised over 'other' trauma which has a knock on effect on #NOF capacity. Patients admitted who are not clinically fit for surgery despite ortho geri intervention within 36hrs. Reduced numbers of Junior medical staff with heavy reliance on Locums.	It has been agreed that #NOF will be supported corporately by Will Monaghan. The Trauma business case approved at the end of April aimed to address staffing gaps. The Chief Resident / Trauma schedulers/Clinical aides are now all in post. Additional anaesthetic PA's have been scheduled to provide pre op assessment. Work continues within the spinal network with regards to capacity across the region and how UHL fits into the future plans. New prioritisation pathways and check lists have been implemented. Breach dates of patients now included on theatre lists and on ORMIS by schedulers. Theatre utilisation is being tracked monthly to optimise usage and reduce downtime between cases.	72%	60%	63%	70%

Performance against the 72% of patients being taken to theatre within 36 hours

Month	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
%	59%	69%	70%	59%	57%	58%	67%	62%	56%	43%	70%	60%	78%	72%	60%

Performance by Month for 15/16

Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	YTD
55.7%	42.6%	70.1%	60.3%	78.1%	72.0%	60.0%	63.0%

Expected date to meet standard / target	December 2015
Revised date to meet standard	Quarter 4 2015/16
Lead Director / Lead Officer	Richard Power, MSS Clinical Director Sarah Taylor, Head of Operations

Emergency Readmissions within 30 days

Target (mthly / end of year)	September performance	YTD performance	Forecast performance for next reporting period
Within Expected	8.7%	8.9%	9.0%

What is causing underperformance?

UHL's readmission rate has increased during 15/16 and when compared with other Trusts (using the Dr Foster tool) our 'risk adjusted readmission rate' has been higher than expected for the past 3 years.

What actions have been taken to improve performance?

A 'Readmissions Review' CQUIN was agreed with Commissioners for 15/16 and the Review has now been complete.

This highlighted a need for:
Better identification of patients at risk of readmission, in order to inform discharge planning and community follow up and support. Work is underway to confirm which 'tool' would be most appropriate for UHL and how this would link with the Integrated Community Response Service'.

Joint care planning for patients with Long Term Conditions and End of Life Care Needs. Actions being taken are to investigate the most effective IT solution for sharing care planning between LLR organisations.

Long term catheter service in the community. A pilot 'outreach service' has been proposed.

Further review of internal data has identified some Speciality shows some 'hot spots', some of whom have plans in place to reduce their rates – e.g. 'Hot Gall Bladder Service' in General Surgery and 'Ambulatory Care Clinic' in CDU.

UHL'S READMISSION RATE 12/13 to 14/15 (as measured by Dr Foster Intelligence)

F/Y	Super Spells	Observed	Rate (%)	Relative Risk
2012/13	220024	17414	7.91	103.15
2013/14	220346	17294	7.85	102.45
2014/15	242563	20418	8.42	106.39

UHL'S READMISSION RATE FOR 14/15 COMPARED WITH OTHER TRUSTS

TRUST	Discharges	ReAdm	%	RELATIVE RISK
University Hospitals Bristol NHS Foundation Trust	130778	8446	6.46	88.51
Leeds Teaching Hospitals NHS Trust	191790	14650	7.64	95.14
Central Manchester University Hospitals	178044	12541	7.04	97.02
Coventry and Warwickshire NHS Trust	147190	11849	8.05	98.92
South Tees Hospitals NHS Foundation Trust	153427	12636	8.24	100.65
Oxford University Hospitals NHS Trust	198372	14779	7.45	102.77
Nottingham University Hospitals NHS Trust	204619	18603	9.09	103.06
University Hospitals Birmingham NHS Foundation	108166	10330	9.55	105.23
University Hospitals Of Leicester NHS Trust	**242268**	**20375**	**8.41**	**106.4**
University Hospital Of North Staffordshire NHS	176781	16220	9.18	106.77
Sheffield Teaching Hospitals NHS Foundation	221048	18764	8.49	111.66
University Hospital Southampton NHS Foundation	134319	12991	9.67	112.74

Expected date to meet standard / target	TBC - following implementation of actions.
Lead Director / Lead Officer	Andrew Furlong, Interim Medical Director John Jameson, Interim Deputy Medical Director

52 week breaches (incompletes)

<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>October performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="4">The Trust had 261 patients on an incomplete pathway that breached 52 weeks at the end of October 2015. 260 of these are Orthodontics patients and 1 is an interventional Radiology patient.

The reasons for underperformance in Orthodontics are as follows:
• Incorrect use and management of a planned waiting list for outpatients.
• Inadequate capacity within the service to see patients when they are ready for treatment.
• There are currently 10 patients on the waiting list between 40 and 51 weeks, who are likely to roll over to become 52 week breaches.

The Interventional Radiology patient breached as a result of a period of unavailability over the summer, poor management of patient cancellations/ DNAs and a complicated pathway over three services (Max Fax, Vascular and Interventional Radiology). They were treated on 13th November 2015.</td><td rowspan="4">Orthodontics:
• The service is now closed to new referrals with some clinical exceptions. Adherence to this is being monitored by the Director of Performance and Information.
• Funding has been secured from NHS England for 2 WTE locums to clear backlog. So far, recruitment attempts have been unsuccessful.
• The Serious Untoward Incident (SUI) report was recently published. Recommendations included a clearly defined SOP to be put in place for the administration of planned waiting lists and that all administrative and clinical staff running outpatient clinics should have RTT e-learning training.
• UHL are exploring capacity for Orthodontics patients within community both community and acute providers within the local area. A small number of patients have agreed to transfer their care to Northampton General Hospital or local community providers.

Interventional Radiology:
• A full investigation into the specifics of the Interventional Radiology patient's pathway and areas for improvement has not yet been completed, but following on from this, actions will be developed, looking specifically at transfers between different specialties.</td><td>0</td><td>261</td><td>261</td><td>c. 260</td></tr>
<tr><td colspan="4">The problem which surfaced in Orthodontics has prompted a deliberate, Trust-wide review of planned waiting lists at specialty level. Therefore the following actions have been taken Trust-wide:
• Communication around planned waiting list management to all relevant staff;
• System review of all waiting list codes;
• All General Managers and Heads of Service have signed a letter confirming review and assurance of all waiting lists, to be returned to Richard Mitchell;
• Weekly review at Heads of Ops meeting for assurance;
• Performance team to review all waiting list code returns and identify areas of risk.</td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="3">TBC</td></tr>
<tr><td>Lead Director / Lead Officer</td><td colspan="3">Richard Mitchell, Chief Operating Officer
Will Monaghan, Director of Performance and Information</td></tr>
</table>

6 Week Diagnostic Test Waiting Times

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance (UHL Alliance)	YTD performance (UHL Alliance)	Forecast performance for next reporting period
Imaging UHL reported 89 MRI breaches, 12 CT breaches and 6 ultrasound breaches for October. The imaging position was affected by unplanned cardiac MRI scanner down time (4 ½ days) and 1 day of down time for a CT scanner, with the ultrasound breaches relating to capacity and staff sickness late in the month. The Alliance reported 7 MRI breaches. **Endoscopy** An issue with planned waiting lists in Endoscopy surfaced in May 2015. There were 1003 breaches for October 2015 across flexible sigmoidoscopy, gastroscopy and colonoscopy, an improvement of 223 from the September position. Capacity and demand review in Endoscopy has identified that the Trust is short of approximately 8-10 lists per week.	**Imaging** A plan is well developed and part implemented to eradicate the Cardiac MRI issue and the impact of this are beginning to be felt. Unfortunately this was not felt in full in October due to challenges with the scanners. In order to mitigate the impact of unplanned down time, the Imaging team are focusing on booking as early as possible in the month. **Endoscopy** The Trust is working with a number of IS providers to obtain extra capacity, including Medinet, Circle, Your World Doctors and Nuffield. The Trust will also be part of an initiative led by the Tripartite around securing extra capacity within the Independent Sector and other NHS Trusts for Endoscopy, UHL has submitted its requirements for this process but so far has obtained no extra capacity via this route. The extra capacity is complemented by a robust action plan aimed at addressing general performance issues in Gastroenterology, with particular focus on ensuring that all lists are fully booked and efforts to improve Cancer performance via access to Endoscopy tests. There has also been a management review in the department and an Endoscopy Manager has been appointed to focus solely on the service, in post since early September.	**<1%**	**7.7%**	**7.7%**	**5%**

The following graph outlines the total number of diagnostic breaches per month for 15-16:

The table below outlines the percentage of breaches as shared between UHL and Alliance:

	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
UHL	0.9%	0.6%	6.97%	12.40%	14.92%	10.82%	8.85%	**8.85%**
UHL Alliance	0.8%	0.5%	6.16%	10.92%	13.37%	9.60%	7.7%	**7.7%**

Expected date to meet standard / target	December 2015
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Suzanne Khalid, Clinical Director CSI

NHS e-Referral System (formerly known as 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="4">The Trust is measured on the % of Appointment Slot Unavailability (ASI) per month.

UHL has not met the required standard of <4% for approximately two years. When it has been able to reach this standard, it has not been sustainable.

The two most significant factors causing underperformance are:
• Shortage of outpatient capacity;
• Inadequate training and education of administrative staff in the set up and use of the NHS e-Referral System (ERS).

The specialties with the highest number of ASIs are:
• General Surgery;
• Orthopaedics;
• ENT;
• Dermatology.

Transition to ERS:
• Choose and Book migrated to the new e-Referral System on Monday 15th June;
• The challenges experienced in the period after the cut-over have calmed down considerably with installation of Google chrome improving the speed of the system.</td><td rowspan="4">Action plan
• An action plan has been written outlining steps for recovering performance. This has been shared with commissioners.

Capacity
• Additional capacity in key specialties is part of RTT recovery and sustainability plans.

Training and Education
• Training and education of staff in key specialties continues, to ensure that the system is adequately set up and administrative processes are fit for purpose;
• Meetings are taking place with the specialties experiencing the highest rate of ASIs, focusing on awareness raising and seeking named accountability.
• Current focus is on working with specialties with no known capacity problems, but high ASI rate to raise awareness and promote accountability.

Additional resource to support the e-Referral System
• An ERS administrator has been in post since May;
• She will be working with key specialties to help reduce their ASIs and promote administrative housekeeping.</td><td><4%</td><td>Unable to report</td><td>Unable to report</td><td>No forecast as unable to measure</td></tr>
<tr><td colspan="4">As a result of the significant challenges experienced post-cut over from Choose and Book, the HSCIC have indicated that they will not be releasing weekly ASI data until at least October 2015. The latest data available is from the week ending 7th June and therefore is out of date. This means that the Trust is currently unable to track and report on progress in the usual manner.

New pilot
In light of the difficulties experienced by services in managing their ASIs on ERS, a new process is being piloted by the internal ERS team in Gastro, Gynae and Rheumatology, this process aims to simplify the UHL administrative processes.
Advice and Guidance (A&G)
The Advice and Guidance service within ERS allows a GP to contact someone within the service for advice rather than directly referring into the hospital. Analysis of the last year’s A&G requests has found that in 84% of these cases, a referral into UHL is then avoided. The ERS team is working with specialties including Orthopaedics, Rheumatology, Urology and Respiratory Medicine to expand the number of A&G services available.</td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="3">March 2016</td></tr>
<tr><td>Lead Director / Lead Officer</td><td colspan="3">Richard Mitchell, Chief Operating Officer
Will Monaghan, Director of Performance and Information</td></tr>
</table>

Ambulance handover > 30 minutes and>60 minutes

	Target	Oct 15	YTD	Forecast
	0 delays over 15 minutes	>60 min - 22% 30-60 min – 26%	>60 min - 11% 30-60 min – 21%	> 60 min - 9% 30-60 min – 17%

What is causing underperformance?	What actions have been taken to improve performance?
Difficulties continue in accessing beds from ED leading to congestion in the assessment area and delays ambulance handover.	An eight-week action plan has been agreed to speed up the time it takes for EMAS crews to pass patients to A&E staff at Leicester Royal Infirmary. It was drawn up following a meeting between managers from EMAS, UHL, the TDA and CCG's Proposals include: • Improving processes at A&E and in the assessment bays. • Improving the flow of patients through the hospital and making every effort to reduce numbers attending A&E • Attempting to speed up discharge processes. • Continued work to tell patients the importance of getting medical help before their condition worsens and ends up being an emergency. The UNIPART, EMAS and UHL work has begun with scoping of the patient journey. Meeting took place with EMAS and UHL re Data Quality and a plan re validation is under development. A joint LiA meeting at Senior level has taken place scoping for new ideas for ambulance handover.

Performance:

Indicators	14/15 Outturn	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	YTD
Ambulance Handover >60 Mins (CAD+ from June 15)	5%	6%	7%	7%	8%	9%	18%	22%	11%
Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)	19%	22%	21%	17%	17%	17%	25%	26%	21%

Expected date to meet standard	TBC
Revised date to meet standard	TBC
Lead Director	Richard Mitchell, Chief Operating Officer

Cancer Waiting Times Performance

What is causing underperformance?	What actions have been taken to improve performance?
2WW performance remains under target. The key reason for underperformance is Endoscopy, which has significant impact on both Lower and Upper GI 2WW performance. However Head and Neck performance was also very poor due to inadequate clinical capacity across the whole service. **31 day subsequent (surgery)** was failed predominantly as a result of Urology performance. The main factor is inadequate elective capacity. **62 day performance** remains below target and has not been achieved nationally since April 2014. Lower/ Upper GI, Lung, Head and Neck, Gynae and Urology remain the most pressured tumour sites. The main pressures on achievement are performance challenges in Endoscopy, inadequate theatre capacity and shortages in consultant staff. However, more positively, the backlog at the end of September was 21 patients less than the end of August.	**2 Week Wait -**The Trust is working intensively with the Endoscopy Department to address the current underperformance. More broadly, the Trust is working with CCGs to improve the quality of 2WW referrals, specifically in relation to correct process, use of appropriate clinical criteria, and preparation of patients for the urgency of appointments. Implementation of the CT colon process is due in November; this aims to provide a better diagnostic test which is less invasive for patients. **31 day subsequent (surgery) -** It has been agreed that all escalated Cancer patients coming into theatre should be escalated to the General Manager for Theatres to ensure that they are appropriately prioritised. The Cancer action plan aims to address the step-down of patients from Intensive Care, in order to pull Cancer patients through the system more quickly. It also includes significant investment in more clinical staff, including a nurse specialist in Urology and consultants in Head and Neck and Dermatology. This additional capacity will impact positively on performance; however while the recruitment processes are underway, staff recruitment has been problematic with a shortage of appropriate candidates. **62 day RTT -** Efforts to improve 31 day and 2WW performance will help to improve the 62 day position. Improvements in Endoscopy will significantly help performance in Lower/ Upper GI. Additionally the appointment of three band 7 service managers with responsibility for managing cancer pathways in our worst performing tumour sites will provide the key focus required; all are now in post. Weekly executive scrutiny of 62 day backlog reduction plans was initiated in September, led by the COO. The Commissioners requested a Remedial Action Plan via the formal contracting process (October 2015) to support improvement of the 62 day standard; this has been submitted and will be monitored through the joint Cancer and RTT board with commissioners.

Target	Latest month September	Performance to date 2015/16	Forecast performance for October
2WW (Target: 93%)	87.7%	88.7%	87%
31 day 1st (Target: 96%)	94.7%	95.7%	96%
31 day sub – Surgery (Target: 94%)	89.7%	88.5%	94%
62 day RTT (Target: 85%)	77.2%	77.3%	78%
62 day screening (Target: 90%)	81.4%	90.5%	90%

8 of the breaches of this standard were tertiary referrals, 4 of these received after day 42, application of the EMSCN inter provider transfer guidance would mean that UHL's performance would improve and would be 78% for September.

Expected date to meet standard / target	2WW: November 2015 31 day sub – Surgery: October 2015 62 day pathway: March 2016
Revised date to meet standard	
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Matt Metcalfe, Clinical Lead for Cancer

Cancer Patients Breaching 104 days

What is causing underperformance?

17 Cancer patients on the 62 day pathway breached 104 days at the end of October across four tumour sites.

Tumour site	Number of patients breaching 104 days
Lung	2
Lower GI	4
HPB	2
Urology	9

The following factors have significantly contributed to delays:

Reason	No. patients
Complex case	5
Patient initiated delay	3
Endoscopy delays	2
Delay in imaging request	1
Patient comorbidity required treatment before cancer	1
Complex diagnostic pathway	1
Tertiary referral	3
Decision around eligibility for NHS treatment	1

What actions have been taken to improve performance?

The number of patients breaching 104 days on a 62 day pathway has risen from the end of September, but remains below the July peak. Following on from last month, there are now no Gynaecology patients breaching 104 days.

Given the poor 62 day performance specifically in Lung, Lower GI and Urology, funding for three band 7 Cancer Delivery Managers has been identified to support them. All three are now in post and they will jointly report to the Cancer Centre and the CMG management teams. This dedicated full-time service management will improve Cancer performance over the medium term.

In light of poor performance against the 62 day pathway, local commissioners have requested a remedial action plan for Cancer, which will be monitored through the Contract Performance Meetings. The plan is based around emerging themes from the first four months' of 62 day breach analysis and will aim to resolve known delays in Cancer pathways. Undoubtedly, this collective piece of work will impact positively on the number of patients breaching 104 days.

Month by month breakdown of patients breaching 104 days

The table and graph below outline the number of Cancer patients breaching 104 days by month for 15-16:

	Apr	May	Jun	Jul	Aug	Sept	Oct
No. patients breaching 104 days	12	10	12	20	12	13	17

NB: not all patients confirmed Cancer

Number of patients breaching 104 days

NB: all patients breaching 104 days undergo a formal 'harm review' process and these are reviewed by commissioners

Expected date to meet standard / target	N/A
Revised date to meet standard	N/A
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Matt Metcalfe, Clinical Lead for Cancer

QUALITY SCHEDULE AND CQUIN INDICATORS – ANTICIPATED PERFORMANCE AND RAGS FOR Q2

Schedule Ref	Indicator Title	Q2 Predicted RAGs	Q2 Perf Commentary
PS01	Infection Prevention and Control Reduction.	**G**	92.15% overall compliance with H&SC Self Assessment & IPP toolkit. Below C Diff cumulative trajectory.
PS02	HCAI Monitoring	**G**	0 MRSA bacteraemias
PS03	Patient Safety	**G**	1 NE reported for Sept. Agreed reporting timescales met for all but one SI
PS04	Duty of Candour (DoC)	**G**	No breaches reported. Audit of case notes completed for Q1 and data being analysed.
PS05	Complaints and user feedback Management (excluding patient surveys).	**tbc**	Improvement in response times maintained. 45 day data tbc.
PS06	Risk Assurance	**tbc**	Dependent upon confirmation that all Risks have been reviewed within agreed timescales.
PS07	Safeguarding	**tbc**	Evidence submitted - for review by CCG Safeguarding Lead
PS08	Reduction in Pressure Ulcer incidence.	**tbc**	Reduction in overall HAPU although exceeded G2 thresholds.
PS09	Medicines Management Optimisation	**tbc**	Medicines Reconciliation and Allergy Status thresholds not achieved as reported by Safety Thermometer
PS10	Medication Errors	**tbc**	Actions taken where medication errors reported but Amber RAG as not met nationally directed threshold for increase in reporting. Children's have introduced new system which should increase numbers reported.
PS11	Safety Thermometer	**G**	All areas continue to participate in the ST. All areas of harms covered by other work streams.
AS01	Cost Improvement Programme (CIP) Assurance	**tbc**	For review at December CQRG
AS02	Ward Health-check	**G**	Plans in place to reduce agency spent. Actions being taken where Wards Level 1 or Level 2 Concern.
AS03	Nurse Revalidation Programme	**tbc**	Implementation plan in place. Reporting deferred to January meeting to allow for review of latest national guidance.
AS04	Staffing governance	**tbc**	Monthly RAG for Q2 = Amber due to non achievement of Appraisal, Sickness and Statutory & Mandatory training thresholds
AS05	Involving employees in improving standards of care.	tbc	For review at December CQRG
AS06	Staff Satisfaction	tbc	Theming being analysed. For reporting to Dec CQRG

Schedule Ref	Indicator Title	Q2 Predicted RAGs	Q2 Perf Commentary
AS07	External Visits and Commissioner Quality Visits	tbc	For review at December CQRG
AS08	CQC Registration	G	
CE01 (a)	Communication - Content - Medical	tbc	Disch letter audit completed for Q1 and spot ED and Inpt Disch letter reaudits in progress. For review at December CQRG
CE01 (b)	Communication - Content - Nursing	tbc	Nursing Letters standards agreed at NET. . For review at December CQRG
CE02	Intra-operative Fluid Management	G	80% threshold achieved for Q2 overall.
CE03 a	Clinical Effectiveness Assurance - Audit	A	Some audits behind schedule - mainly in completion of actions following audits. Unlikely all will be on track by end of year. Reviewed by Audit Committee and at CMG Q&S Boards.
CE03 b	Clinical Effectiveness Assurance - NICE	A	Improvements made with compliance responses but some responses incomplete or risk assessments needed as not fully compliant due to capacity issues. Significant improvements made during Q2.
CE04	Women's Service Dashboard	tbc	Improvements made with Obstetric 'skills drills attendance'.
CE05	Children's Service Dashboard	tbc	Senior Review within 2 hrs threshold not achieved.
CE06 a	PROMS - Patient Reported Outcomes	N/A	Latest data not yet available.
CE06 b	Consultant Clinical Outcomes	A	Backlog of BAETS data to be submitted and work in progress to address. Outcomes not yet published for all Specialities so end of year RAG not yet predicted.
CE07	#NOF - Dashboard	tbc	Q2 average 'time to theatre' = 70% which is still below threshold but improvement. Ortho-geriatric related indicators below threshold due to lack of capacity in August
CE08	Stroke and TIA monitoring	A	Commissioners noted improvement within individual domains but overall Domain Score remains a D
CE09	Mortality	G	Latest published SHMI is 97.
CE10	VTE Risk Assessment	G	95% threshold achieved including 'cohort' patients. Actions being taken to ensure 90% achieved within 'non cohort' groups.
CE11	VTE RCA	tbc	Good progress made with RCAs for both in-hospital and post discharge Hospital Acquired Thromboses. For review at December CQRG
CE12	Nutrition and Hydration	A	Although overall 90% threshold achieved, threshold is to achieve within

Schedule Ref	Indicator Title	Q2 Predicted RAGs	Q2 Perf Commentary
			each CMG and below 90% for ESM and CHUGGS Education and awareness raising continues and will be incorporated into Food and Drink Strategy work programme.
CE13	Food Strategy	**tbc**	Strategy drafted. For Review at January CQRG.
CE14	Community Acquired Pneumonia (CAP)	**tbc**	Below threshold for antibiotic aspect of Care Bundle. Continued improvement with SHMI
CE15	Improving End of Life (EoL) care.	**G**	Increased use of AMBER in several areas and where support / education requested from areas where improvements needed
CE16	Heart Failure	**G**	Significant increase in use of Care bundle for both patients at Glenfield and LRI
PE01	Same Sex Accommodation Compliance and Annual Estates Monitoring	**G**	No breaches
PE02	Patient Experience, Equality and Listening to and Learning from Feedback.	**tbc**	Green RAG anticipated as all areas can demonstrate listening to feedback and actions taken - For review at Dec CQRG
PE03	Improving Patient Experience of Hospital Care	**N/A**	End of Year Review - RAG dependent upon national results
PE04	Equality and Human Rights	**N/A**	Bi-annual review
PE5	MECC	**G**	Continued referral to STOP and Alcohol Liaison and evidence of MECC for staff
PE6	Friends and Family Test	**tbc**	Participation thresholds being reviewed in light of change in national requirements
SQ01	National Quality Dashboards	**G**	Data submitted for 14/15 dashboards and plans in place to submit for new dashboards, eg Haemglobinopathy
SQ02	National Clinical Registries	**tbc**	Confirmation being sought
SQ03	HIV: GP registration and communication	**G**	Threshold 1 = 94%. Threshold 2 = 100%
z	z		
Nat 1	AKI Discharge Care Bundle	**G**	Improvement from Q1 performance. AKI nurse now in post but unlikely to achieve end of year 90% threshold
Nat 2a	Sepsis - Screening	**R**	Provisional data shows 19% patients screened for sepsis, which is below Q2 threshold and deterioration from the Q1 performance
Nat 2b	Sepsis - IV Antibiotics	**G**	Baseline audit data collected. Plans in place to improve performance but unlikely to achieve 90% end of year threshold.

Schedule Ref	Indicator Title	Q2 Predicted RAGs	Q2 Perf Commentary
Nat 3a	Dementia - FAIR	G	90% threshold achieved for both Screening and Risk Assessment. Q4 threshold to be discussed with commissioners
Nat 3b	Dementia Training	G	On track to 90% of permanent staff trained in Q4
Nat 3c	Dementia Carers	G	On track to achieve end of year threshold
Nat 4	Amb Care	tbc	Scope and process for CQUIN Amb Care Pathway agreed and recruitment process commenced.
Loc 5	Readmissions	tbc	Review completed and reported. Actions being taken forward.
Loc 6	CHC	A	Data to be validated but unlikely to achieve the 90% threshold for CHC assessments completed within agreed timescales for pts 'discharged to assess'.
Loc 7a	Safety Briefings	G	Next phase due to commence in Children's & Children's ED. The protocol for the huddles has been developed
Loc 7b	Increase 'Near Miss' Reporting	G	Validation and theming of prevented patient safety incidents in progress for Q2.
Loc 8	Think Glucose	G	End of year thresholds agreed. On track with roll out of TG programme.
Loc 9	Bereavement F/U	G	On track for Service to commence in December.
Loc 10	Learning Disabilities - Pt Exp	tbc	Some delays with completing the reasonable adjustments and DNA data but commissioners noted improvements made and contingencies taken
SS1/ CUR	CUR Tool	G	Data submitted and discussions held with National lead. End of year requirements agreed.
SS2/ C6	Oncotype Testing	G	Tests being requested and Data being collated.
SS3/ TH4	Critical Care Delayed Discharges	G	Improvements made across all 3 Units.
SS6/I M7	Rheumatic Diseases Network	G	Participation in network and protocols being developed. Data submission required to achieve Q4 threshold and admin support needed
SS7/	Complex Orthopaedic Surgery Network	G	1st Network meeting held and patients discussed.

Schedule Ref	Indicator Title	Q2 Predicted RAGs	Q2 Perf Commentary
TH7			
SS8/ HSS	ECMO/PCO Collaborative Workshop	**G**	National ECMO collaborative workshop being held at Glenfield on 5th Nov
SS10 /CB5	Haemoglobinopathy Network	**G**	Threshold achieved. Evidence of pathways and meeting minutes to be submitted to commissioners
SS11 /WC1	<28 Week Neonates 2 yr follow up	**G**	Thresholds achieved.