Quality & Performance Report

Author: John Adler Sponsor: Chief Executive Date: IFPIC + QAC 27th August 2015

Executive Summary from CEO

For Information only

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: **Mortality** the SHMI for January 1 **C Diff** remains at 4 this month which is higher than the April and May lows but is on track with the year to date trajectory 4 to December 14 is 99, this is the best score that the Trust has achieved since the introduction of SHMI. **ED 4 hour** performance in the calendar month of July was 92.2%, the fourth month in a row in which it has been greater than 92%. It is 92.3% year to date compared to 88.4% this time last year. Attendances and admissions remain much higher than last year (4.0% and 7.6% respectively). **RTT admitted, non-admitted and incomplete** targets remain compliant. **62 Day Cancer** performance continues to improve with more patients treated within 62 days than ever before and more patients seen within two weeks than ever before. You will notice we now report the 62 day standard tumour site by tumour site in the Quality & Performance report. **Delayed transfers of care** remain well within the tolerance. **MRSA** and avoidable **Grade 4 pressure ulcers** remain at zero. Grade 2 **pressure ulcers** were within the upper limit for the month. **C Diff** remains at 4 this month which is higher than the April and May lows but is on track with the year to date trajectory.

Bad News:. **RTT 52+ week waits,** predominantly in Orthodontics and this is set to continue given the difficulties with locum consultant recruitment. As referenced last month, problems in endoscopy have had a big impact on **diagnostics 6 week wait** performance

which is not expected to regain compliance until September. The numbers have worsened as the longest waiting patients are being offered dates. **Fractured NOF** continues to struggle though this is subject of a separate report. **Cancelled operations on the day of surgery** deteriorated further in July as outlined with a number of factors including some estates issues but also a high number of patients cancelled due to ITU unavailability. **Cancer Standards** The screening standard and 31 day standards failed because of a small number of patients who were cancelled due to ITU. Reported **cleaning standards** remain poor in July but the Committee is already familiar with the action being taken in relation to the performance of the Interserve contract.

Input Sought

I recommend that the Committee:

- Commends the positive achievements noted under Good News
- Note the indicators highlighted in bold in the Conclusions section

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: 24/09/15

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

July 2015

One team shared values

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Dashboards

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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

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

DATE: **27TH AUGUST 2015**

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

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

1.0 Introduction

The following report provides an overview of the July 2015 Quality & Performance report highlighting TDA/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	4	22	7	0
Caring	5	10	3	0
Well Led	6	18	6	3
Effective	7	16	4	1
Responsive	8	19	1	6
Responsive Cancer	9	9	0	7
Research – UHL	11	6	6	0
Research - Network	11	13	0	3
Estates & Facilities	12	10	0	1
Total		123	27	21

3.0 New Indicators

Responsive

Cancer 62 day performance by tumour site is reported on the responsive cancer – page 9.

4.0 Indicators removed

None

5.0 Indicators where reporting methodology/thresholds have changed

Red RAG and Exception reporting thresholds have been amended to provide additional clarity.

Responsive

Ambulance Handover reported from CAD+ from June onwards - data quality issues identified with EMAS data in that data is incomplete and there are duplicate records.

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

	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	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-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	5	7	2	5	7	7	11	7	5	7	3	1	4	4	12
	S2a	MRSA Bacteraemias (All)	JS	DJ	0	TDA	Red if >0 ER if >0	3	6	0	0	0	1	1	0	2	0	1	1	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	0	0	1	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	0	0	1	0	1	1	0	0	0	0	0	0	0
	S4	Serious Incidents	JS	MD	Not within Highest Decile	TDA	TBC	60	41	3	7	2	3	4	2	4	3	2	1	2	8	1	5	16
	S5a	Proportion of reported safety incidents per 1000 beddays	JS	MD	TBC	TDA	TBC	37.5	39.1	40.4	41.1	35.6	41.8	38.9	40.3	40.4	35.0	38.2	36.3	34.6	37.3	39.6	39.9	37.8
	S5b	Proportion of reported safety incidents that are harmful	JS	MD	Not within Highest Decile	TDA	TBC	2.8%	1.9%	1.7%	2.2%			1.4%			2.3%			2.2%				2.2%
	S6	Overdue CAS alerts	JS	MD	0	TDA	Red if >0 in mth ER = in mth >0	2	10	2	3	0	0	0	0	0	0	0	1	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	1	2	2	1	2	2	1	0	3	2	0	6	0	0	6
	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%	94.2%	94.9%	94.4%	93.9%	94.9%	93.3%	94.1%	95.0%	92.1%	93.6%	93.7%	94.3%	95.6%	94.6%	94.5%
	S8b	Safety Thermometer % number of new harms	JS	EM	Not within Lowest Decile	TDA	TBC	New TDA Indicator		2.7%	2.4%	2.9%	2.5%	2.3%	3.3%	2.4%	2.5%	3.2%	2.7%	2.2%	2.6%	2.1%	1.9%	2.2%
	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%	95.9%	96.3%	95.5%	96.2%	95.4%	95.5%	95.0%	96.3%	96.2%	95.6%	96.0%	96.0%	96.5%	96.2%	96.2%
	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	7.1	7.3	7.3	5.9	6.4	7.5	6.9	7.1	6.7	6.3	5.6	5.8	5.1	5.7	5.5
	S12	Avoidable Pressure Ulcers - Grade 4	JS	MC	0	QS	Red / ER if Non compliance with monthly target	1	2	0	0	0	0	0	0	1	0	0	1	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	5	5	6	6	4	6	7	5	9	6	3	0	4	1	8
	S14	Avoidable Pressure Ulcers - Grade 2	JS	MC	<=8 a month	QS	Red / ER if Non compliance with monthly target	120	91	6	7	9	4	8	13	11	7	5	9	10	8	8	8	34
	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%	47.0%	>=60%			<65%			<75%							
	S16	Maternal Deaths	AF	IS	0	UHL	Red or ER if >0	3	1	0	0	0	0	0	0	0	1	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%	14.7%	16.9%	15.4%	17.4%	18.1%	17.4%	16.2%	17.7%	15.5%	15.8%	15.3%	18.8%	15.8%	15.8%	16.4%
	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	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-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%	97%	97%	96%	97%	96%	96%	96%	96%	96%	97%	96%	96%	97%	96%	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%	95%	96%	92%	95%	96%	96%	96%	96%	96%	97%	96%	96%	96%	96%	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%
	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%	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%	96%	96%	94%	96%	97%	95%	97%	96%	96%	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%	68.3%	67.2%			Q3 staff FFT not completed as National Survey carried out			71.4%			68.7%				68.7%
	C7a	Complaints Rate per 100 bed days	AF	MD	TBC	UHL	TBC	New Indicator	0.4	0.3	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
	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%	8%	11%	10%	9%	11%	11%	10%	17%	13%	11%	13%	7%	7%	7%	9%
	C9	Single Sex Accommodation Breaches (patients affected)	JS	HL	0	TDA	Red / ER if >0	2	13	0	0	0	0	0	5	0	1	0	0	0	0	0	0	0

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	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-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%	29.1%
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%	15.4%
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%	14.1%
W4	Outpatients Friends and Family Test - Coverage	JS	HL	Q1 3% Q2/3 4% Q4 5%	UHL	Red if <2.5% ER if 2 mths Red	NEW METHODOLOGY FOR CALCULATING COVERAGE INCLUDES ADULTS AND CHILDREN												1.3%	1.6%	1.2%	1.2%	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%	25.2%	29.2%	29.9%	18.7%	15.8%	21.7%	22.1%	25.8%	46.5%	40.2%	32.3%	35.8%	32.6%	25.6%	31.5%
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%	53.7%			Q3 staff FFT not completed as National Survey carried out			54.9%			52.5%				52.5%
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%	8.7%
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%	13.3%
W8	Turnover Rate	LT	LG	Not within Lowest Decile	TDA	Red = 11% or above ER = Red for 3 Consecutive Mths	10.0%	11.5%	10.2%	10.0%	10.5%	10.3%	10.8%	10.7%	10.3%	10.1%	10.1%	11.5%	10.4%	10.5%	10.5%	10.6%	10.6%
W9	Sickness absence	LT	KK	3%	UHL	Red if >4% ER if 3 consecutive mths >4.0%	3.4%	3.8%	3.3%	3.4%	3.4%	3.7%	4.0%	4.0%	4.4%	4.2%	4.1%	4.0%	3.6%	3.4%	3.6%		3.6%
W10	Temporary costs and overtime as a % of total paybill	LT	LG	TBC	TDA	TBC	New Indicator	9.4%	8.1%	8.5%	8.9%	8.5%	9.5%	9.0%	9.8%	10.5%	9.8%	11.5%	10.7%	10.2%	11.0%	10.8%	10.7%
W11	% of Staff with Annual Appraisal	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	91.3%	91.4%	90.6%	89.6%	88.6%	89.7%	91.8%	92.3%	92.5%	90.9%	91.0%	91.4%	90.1%	88.7%	89.0%	89.1%	89.1%
W12	Statutory and Mandatory Training	LT	BK	95%	UHL	TBC	76%	95%	79%	80%	83%	85%	86%	87%	89%	89%	90%	95%	93%	92%	92%	91%	91%
W13	% Corporate Induction attendance	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	94.5%	100%	92%	96%	98%	98%	98%	98%	100%	99%	100%	97%	97%	97%	98%	100%	100%
W14a	DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	Not within Lowest Decile	TDA	TBC	New Indicator	91.2%	92.6%	87.7%	87.9%	91.6%	92.9%	91.3%	92.7%	94.3%	91.8%	91.0%	93.6%	90.3%	91.2%	90.3%	91.4%
W14b	DAY Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	Not within Lowest Decile	TDA	TBC		94.0%	96.9%	93.0%	94.8%	90.3%	95.4%	94.4%	95.8%	95.4%	92.8%	92.5%	94.2%	91.2%	93.5%	91.3%	92.5%
W14c	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	Not within Lowest Decile	TDA	TBC		94.9%	93.1%	90.8%	91.4%	94.8%	97.4%	96.5%	96.4%	97.9%	96.5%	97.2%	98.9%	96.0%	96.2%	94.3%	96.3%
W14d	NIGHT Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	Not within Lowest Decile	TDA	TBC		99.8%	99.0%	97.9%	98.0%	97.8%	100.8%	101.2%	101.4%	103.6%	100.8%	103.2%	106.3%	98.7%	99.4%	101.2%	101.4%

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	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	YTD
E1	Mortality - Published SHMI	AF	PR	Within Expected	TDA	Higher than Expected	105	103	106 (Oct12-Sept13)	106 (Jan13-Dec13)			105 (Apr13-Mar14)			103 (Oct13-Sep14)			99 (Jan14-Dec 14)				
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	97	105	104	103	103	102	102	100	101	100	Awaiting HED Update					
E3	Mortality HSMR (DFI Quarterly)	AF	PR	Within Expected	TDA	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	88	94	98	95			95			91			Awaiting DFI Update				
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	95	98	97	96	96	96	95	95	96	95	95	Awaiting HED Update				
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	95	105	86	97	98	96	88	96	99	98	85	Awaiting HED Update				
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	101	100	103			97			103			Awaiting DFI Update				
E7	Crude Mortality Rate Emergency Spells	AF	PR	Within Upper Decile	TDA	TBC	2.5%	2.4%	2.4%	2.0%	1.9%	2.3%	2.1%	2.3%	3.0%	3.1%	2.7%	2.4%	2.1%	2.0%	2.3%	1.8%	2.1%
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	81	105	80	64	59	113	60	85	101	87	75	100	20	Awaiting DFI Update		60
E9	Emergency readmissions within 30 days following an elective or emergency spell	AF	JJ	Within Expected	TDA	Higher than Expected	7.9%	8.5%	8.6%	8.4%	8.9%	8.4%	8.6%	8.9%	9.1%	8.2%	8.5%	8.5%	9.1%	9.0%	9.0%		9.1%
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%	60.3%	76.9%	59.0%	68.6%	69.6%	59.4%	57.3%	57.9%	67.2%	61.5%	55.7%	42.6%	70.1%	60.3%	57.4%
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%	87.1%	78.1%	84.5%	83.2%	70.4%	73.3%	75.2%	82.5%	87.6%	83.3%	83.7%	84.5%	82.0%		83.3%
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%	71.3%	62.8%	65.5%	72.7%	67.8%	69.0%	83.5%	80.6%	64.0%	77.3%	86.3%	79.6%	72.0%	78.9%	79.0%
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
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
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	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	YTD
R1	ED 4 Hour Waits UHL + UCC (Calendar Month)	RM	IL	95% or above	UHL	Red if <92% ER via ED TB report	88.4%	89.1%	91.0%	92.5%	91.3%	91.6%	89.8%	89.1%	83.0%	90.7%	89.6%	91.1%	92.0%	92.2%	92.6%	92.2%	92.3%
R2	12 hour trolley waits in A&E	RM	IL	0	TDA	Red if >0 ER via ED TB report	5	4	1	0	0	0	1	0	0	1	0	0	0	0	0	0	0
R3	RTT Waiting Times - Admitted	RM	WM	90% or above	TDA	Red /ER if <90%	76.7%	84.4%	79.0%	80.9%	82.2%	81.6%	84.4%	85.5%	86.9%	85.0%	85.9%	84.4%	88.0%	91.3%	90.8%	91.7%	91.7%
R4	RTT Waiting Times - Non Admitted	RM	WM	95% or above	TDA	Red /ER if <95%	93.9%	95.5%	95.0%	94.9%	95.6%	94.6%	94.9%	95.2%	96.0%	95.4%	95.3%	95.5%	95.6%	95.6%	95.7%	95.1%	95.1%
R5	RTT - Incomplete 92% in 18 Weeks	RM	WM	92% or above	TDA	Red /ER if <92%	92.1%	96.7%	94.0%	93.2%	94.0%	94.3%	94.8%	95.0%	95.1%	95.2%	96.2%	96.7%	96.6%	96.5%	96.2%	95.4%	95.4%
R6	RTT 52 Weeks+ Wait (Incompletes)	RM	WM	0	TDA	Red /ER if >0	0	0	0	15	1	3	3	2	0	0	0	0	0	66	242	256	256
R7	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	TDA	Red /ER if >1%	1.9%	0.9%	0.8%	0.7%	1.0%	1.0%	0.7%	1.8%	2.2%	5.0%	0.8%	0.9%	0.8%	0.6%	6.1%	10.9%	10.9%
R8	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
R9	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	1	2	2	0	3	4	3	1	2	0	1	1	4
R10	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	0	0	6	0	0	1	1	2	1	0	0	0	1	0	1
R11	% 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%	1.1%	0.7%	0.6%	0.8%	0.8%	1.2%	1.1%	0.8%	0.7%	1.0%	0.7%	0.5%	0.9%	1.3%	0.9%
R12	% 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%	0.3%	2.7%	0.0%	0.9%	1.0%	0.0%	0.8%	1.4%	0.0%	0.4%	1.2%	1.2%	1.0%	0.8%	1.0%
R13	% 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%	1.0%	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%	0.9%
R14	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	98	94	55	90	94	108	102	85	64	98	79	56	97	138	370
R15	Outpatient Hospital Cancellation Rates	RM	PW	Within Upper Decile	UHL	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																
R16	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%	4.0%	3.9%	3.9%	4.5%	4.6%	5.2%	3.9%	3.2%	2.9%	1.8%	1.2%	1.0%	1.5%	0.9%	1.2%
R17	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%	26%	25%	20%	17%	16%	13%	19%	26%	34%	31%	Data Not Available		33%
R18	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%	2%	2%	1%	2%	5%	6%	10%	6%	11%	9%	6%	7%	7%	8%	7%
R19	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%	12%	14%	15%	17%	25%	23%	25%	21%	21%	22%	22%	21%	17%	17%	19%

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	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-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%	93.5%	92.2%	92.0%	90.6%	92.0%	92.5%	93.0%	92.2%	93.5%	91.5%	91.2%	87.9%	91.1%	**	90.1%
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%	98.9%	94.9%	94.4%	95.2%	98.6%	100.0%	93.0%	92.5%	91.5%	96.0%	99.0%	98.8%	87.2%	**	94.9%
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%	93.6%	94.4%	97.9%	91.9%	95.9%	92.5%	95.2%	91.7%	95.0%	97.0%	93.9%	97.9%	93.7%	**	95.1%
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%	100.0%	100.0%	98.8%	100.0%	97.1%	100.0%	96.7%	100.0%	100.0%	100.0%	100.0%	100.0%	97.7%	**	99.2%
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%	90.8%	90.1%	87.8%	94.0%	81.9%	82.4%	80.3%	89.2%	94.4%	87.5%	86.3%	92.2%	89.6%	**	89.1%
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%	93.9%	97.3%	99.0%	96.5%	96.0%	94.7%	95.5%	87.6%	99.0%	100.0%	86.3%	98.1%	96.5%	**	94.3%
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%	73.1%	85.6%	78.8%	75.5%	80.4%	77.0%	84.8%	79.3%	78.9%	83.8%	75.7%	70.1%	84.2%	**	76.9%
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%	73.9%	73.0%	100.0%	87.5%	75.0%	94.4%	93.8%	88.9%	79.4%	89.3%	91.7%	82.4%	93.3%	**	89.0%
RC9	Cancer waiting 104 days	RM	MM	0	TDA	TBC	NEW TDA INDICATOR												12	10	12	20	20

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	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-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%	85.7%	91.1%	84.4%	93.8%	96.3%	81.8%	100.0%	93.3%	97.4%	98.1%	92.3%	96.8%	97.8%	**	95.6%
RC12	Gynaecological	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	88.2%	77.5%	57.1%	88.9%	91.7%	77.8%	71.4%	75.0%	66.7%	54.5%	91.7%	75.0%	64.3%	55.6%	66.7%	**	62.5%
RC13	Haematological	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	65.9%	66.5%	42.1%	84.6%	87.5%	42.1%	######	73.3%	75.0%	66.7%	50.0%	80.0%	50.0%	55.0%	83.3%	**	59.6%
RC14	Head and Neck	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	65.4%	69.9%	80.0%	66.7%	83.3%	40.0%	######	33.3%	77.8%	70.0%	87.5%	62.5%	75.0%	54.5%	66.7%	**	63.0%
RC15	Lower Gastrointestinal Cancer	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	71.3%	63.7%	45.5%	81.8%	50.0%	50.0%	56.3%	62.5%	92.9%	65.0%	46.7%	63.2%	63.6%	55.6%	93.3%	**	70.5%
RC16	Lung	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	89.7%	69.9%	69.8%	70.0%	48.1%	56.8%	68.9%	64.1%	74.4%	67.7%	74.2%	88.6%	84.6%	50.9%	74.6%	**	69.2%
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%	66.7%	######	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100%	100%	**	66.7%
RC18	Sarcoma	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	82.9%	46.2%	100.0%	0.0%	--	--	--	0.0%	0.0%	100.0%	--	0.0%	66.7%	--	100%	**	80.0%
RC19	Skin	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	96.8%	96.7%	91.2%	100.0%	100.0%	97.3%	94.5%	98.4%	94.1%	100.0%	94.3%	95.6%	91.7%	94.0%	91.3%	**	92.4%
RC20	Upper Gastrointestinal Cancer	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	72.2%	73.9%	66.7%	52.6%	77.8%	75.0%	33.3%	64.7%	68.0%	85.7%	77.8%	81.8%	66.7%	55.0%	84.6%	**	66.7%
RC21	Urological (excluding testicular)	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	89.3%	82.6%	85.2%	89.2%	77.1%	86.1%	84.5%	81.5%	85.7%	83.3%	66.7%	71.0%	62.1%	62.1%	74.7%	**	66.8%
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%	0.0%	######	100.0%	100.0%	100.0%	66.7%	100.0%	--	100%	100%	**	100%
RC23	Grand Total	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	86.7%	81.4%	73.1%	85.6%	78.8%	75.5%	80.4%	77.0%	84.8%	79.3%	78.9%	83.7%	75.7%	70.1%	84.2%	**	76.9%

Compliance Forecast for Key Responsive Indicators

Standard	July actual/predicted	August predicted	Month by which to be compliant	RAG rating of required month delivery	Commentary
Emergency Care					
4+ hr Wait (95%) - Calendar month	92.2%				Weekly SITREPs have ceased from end of June. Future ED performance to be reported monthly.
Ambulance Handover (CAD)					
% Ambulance Handover >60 Mins (CAD+)	8%		Not Agreed		Further meeting arranged as DQ is still an issue with missing data and duplicate records.
% Ambulance Handover >30 Mins and <60 mins (CAD+)	17%		Not Agreed		
RTT (inc Alliance)					
Admitted (90%)	91.7%	90.3%	Continued Delivery		July confirmed delivery. We do have growing backlogs in the specialised surgery max fax and adult and paed ENT.
Non-Admitted (95%)	95.1%	95.3%	Continued Delivery		
Incomplete (92%)	95.4%	95.0%	Continued Delivery		July/August dip due to continuing growing pressure in ENT, General Surgery and Gastroenterology.
Diagnostic (inc Alliance)					
DM01 - diagnostics 6+ week waits (<1%)	10.9%	12.0%	September		Endoscopy the predominate cause of failure. Significant changes in endoscopy to support re-delivery. September plan confirmed.
# Neck of femurs					
% operated on within 36hrs (72%)	60.3%	60.0%	December		
Cancelled Ops (inc Alliance)					
Cancelled Ops (0.8%)	1.3%	0.8%	August		
Not Rebooked within 28 days (0 patients)	1	7	September		5 from Urology and 1 General Surgery and 1 HPB due to various capacity pressures
Cancer (predicted)					
Two Week Wait (93%)	87%	88%	September		
31 Day First Treatment (96%)	96%	96%	July		July and August expected to be compliant.
31 Day Subsequent Surgery Treatment (94%)	91%	90%	September		A one off issue in breast surgery has delayed recovery by 1 month.
62 Days (85%)	75%	78%	October		Plans to reduce backlog continue and are monitored weekly at the Cancer Action Board.

	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	YTD
Research UHL	RU1	Median Days from submission to Trust approval (Portfolio)	AF	NB	TBC	TBC	TBC	3.0			2.0			3.0			3.0			2.8	Data delayed as waiting for NIHR report and currently migrating data to a new system			
	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				
	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	1022				
	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%										
	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										
	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%										

	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	Mar-15	YTD	Apr-15	May-15	Jun-15
Research (CLINICAL RESEARCH NETWORK)	RS1	Number of participants recruited in a reporting year into NIHR CRN Portfolio studies	AF	DR	England 650,000 East Midlands 50,000	NIHR CRN	Red / ER if <90%	92%	93%	94%	93%	91%	90%	101%	101%	Currently reviewing reporting arrangements with the Trust Director of Corporate & Legal Affairs.		
	RS2a	A: Proportion of commercial contract studies achieving their recruitment target during their planned recruitment period.	AF	DR	England 80% East Midlands 80%	NIHR CRN	Red / ER if <60%	67%	64%	68%	54%	56%	47%	53%	53%			
	RS2b	B: Proportion of non-commercial studies achieving their recruitment target during their planned recruitment period	AF	DR	England 80% East Midlands 80%	NIHR CRN	Red / ER if <60%	81%	81%	73%	77%	77%	86%	75%	75%			
	RS3a	A: Number of new commercial contract studies entering the NIHR CRN Portfolio	AF	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	AF	DR	75%	NIHR CRN	Red if <75%											
	RS4	Proportion of eligible studies obtaining all NHS Permissions within 30 calendar days (from receipt of a valid complete application by NIHR CRN)	AF	DR	80%	NIHR CRN	Red if <80%	90%	89%	84%	82%	83%	83%	93%	93%			
	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	AF	DR	80%	NIHR CRN	Red if <80%											
	RS5b	B: Proportion of non-commercial studies achieving first participant recruited within 70 calendar days of NHS services receiving a valid research application	AF	DR	80%	NIHR CRN	Red if <80%											
	RS6a	A: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio studies	AF	DR	England 99% East Midlands 99%	NIHR CRN	Red if <99%	81%	81%	81%	88%	88%	88%	94%	94%			
	RS6b	B: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio commercial contract studies	AF	DR	England 70% East Midlands 70%	NIHR CRN	Red if <70%	56%	56%	56%	56%	56%	56%	56%	56%			
	RS6c	B: Proportion of General Medical Practices recruiting each year into NIHR CRN Portfolio studies	AF	DR	England 25% East Midlands 25%	NIHR CRN	Red if <25%	45%	45%	51%	63%	54%	54%	61%	61%			
	RS7	Number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	AF	DR	England 13500 East Midlands 510	NIHR CRN	Red if <510 Q4	325	438	448	532	624	729	1050	1050			
	RS8	Deliver robust financial management using appropriate tools - % of financial returns completed on time	AF	DR	England 100% East Midlands 100%	NIHR CRN	Red if <100%	100% *Q2	100.0%				100%	100%	100%			

	KPI Ref	Indicators	Board Director	Lead Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	YTD
Estates and Facilities	E&F1	Percentage of statutory inspection and testing completed in the Contract Month measured against the PPM schedule.	DK	GL	100%	Contract KPI	Red if ≤ 98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F2	Percentage of non-statutory PPM completed in the Contract Month measured against the PPM schedule	DK	GL	100%	Contract KPI	Red if ≤ 80%	100.0%	91.5%	81.2%	95.6%	80.5%	86.6%	97.4%	99.5%	99.0%	99.0%	98.0%	83.0%	94.8%
	E&F3	Percentage of Estates Urgent requests achieving rectification time	DK	LT	95%	Contract KPI	Red if ≤ 75%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F4	Percentage of scheduled Portering tasks completed in the Contract Month	DK	LT	99%	Contract KPI	Red if ≤ 98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F5	Number of Emergency Portering requests achieving response time	DK	LT	100%	Contract KPI	Red if >2	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
	E&F6	Number of Urgent Portering requests achieving response time	DK	LT	95%	Contract KPI	Red if ≤ 95%	95.0%	95.1%	96.2%	97.3%	97.2%	97.2%	98.5%	98.1%	99.0%	100.0%	100.0%	100.0%	99.8%
	E&F7	Percentage of Cleaning audits in clinical areas achieving NCS audit scores for cleaning above 90%	DK	LT	100%	Contract KPI	Red if ≤ 98%	100.0%	100.0%	99.1%	100.0%	100.0%	100.0%	94.4%	96.1%	97.0%	95.0%	95.0%	93.0%	95.0%
	E&F8	Percentage of Cleaning Rapid Response requests achieving rectification time	DK	LT	92%	Contract KPI	Red if ≤ 80%	92.0%	99.6%	89.9%	93.3%	90.5%	91.1%	94.1%	96.9%	95.0%	95.0%	100.0%	99.0%	97.3%
	E&F9	Percentage of meals delivered to wards in time for the designated meal service as per agreed schedules	DK	LT	97%	Contract KPI	Red if ≤ 95%	97.0%	99.4%	99.5%	100.0%	100.0%	98.9%	99.9%	100.0%	100.0%	100.0%	100.0%	99.0%	99.8%
	E&F10	Overall percentage score for monthly patients satisfaction survey for catering service	DK	LT	85%	Contract KPI	Red if ≤ 75%	85.0%	96.7%	97.3%	97.3%	96.7%	93.8%	95.8%	97.5%	96.0%	97.0%	91.0%	91.0%	93.8%

Outpatients Friends and Family Test – Coverage

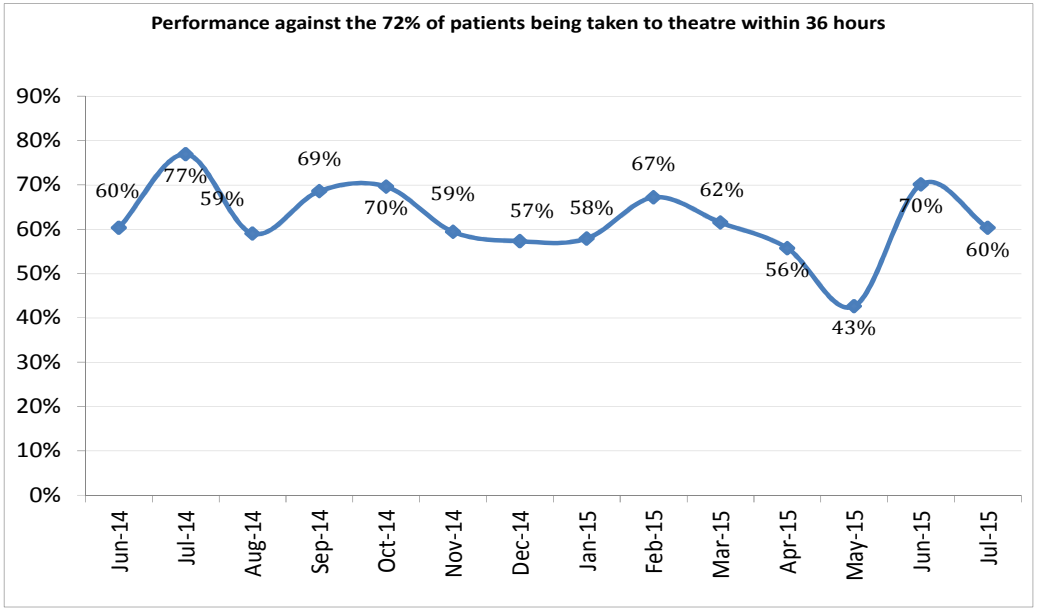
What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	July performance	YTD performance	Forecast performance for next reporting period
A clear system for the collection of Friends and Family test results has been established within the three main outpatients' departments as well as the majority of all stand-alone clinic facilities. Staff within these departments have been cited to the coverage requirements, to ensure success: • Improve ownership and monitoring of the Friends and Family Test within the Clinical Management Groups • Increase medical staff engagement and ownership Review Clinic Clerk activity and resource to ensure staff have time to direct patients to the touch screens to complete the Friends and Family Test	Clinical Management Group Senior Management Teams have been highlighted to these results and asked to increase coverage and respond directly to patient feedback at clinic level. Main clinic visited weekly to identify areas of concern and requiring action. Feedback highlighted to Clinical Management Groups through Nursing Executive Team and Executive Quality Board. Plans for improvement have been received from the following CMGs: • ITAPS • ESM	**Q1 – 3%** **Q2/3 – 4%** **Q4 – 5%**	**1.2%**	**1.3%**	**1.3%**

CMG	July 2015	
	% Recommend	% Coverage
CHUGS	83%	0.4%
CSI	96%	0.4%
ESM	89%	0.9%
ITAPS	82%	0.5%
MSKSS	92%	2.6%
RRCV	93%	1.9%
WC	84%	0.5%
The Alliance	89%	1.0%
UHL	91%	1.2%

Expected date to meet standard / target	Quarter 2 achieve target
Lead Director / Lead Officer	Julia Smith, Chief Nurse Heather Leatham, Assistant Chief Nurse

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 FY 15/16	Forecast performance for next reporting period
There were 63 NOF admissions in July 2015, 23 patients breached the 36 hr target to theatre as detailed below:- Medically Unfit – 6pts List over ran therefore pt cancelled – 9 Deemed high risk for over w.e – 1pt Transferred to LGH for THR – 1 pt Change of clinical management -1pt Poor inter team communication – 2 pts Bilat #'s – 1 pt High volume admitted on one day – 2pts Lack of theatre time due to Spines and lack of theatre time in times of peak admissions continues. As in previous months trauma capacity as 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.	It has been agreed that #NOF will be supported corporately by the Director of Performance and Information. The Trauma business case approved at the end of April aims to address the staffing gaps and these are currently being recruited to. 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. Clinical Resident has taken up post on August 13th. Breach dates of patients now included on theatre lists and on ORMIS by schedulers.	**72%**	**60.3%**	**57.4%**	**60%**



Performance by Month for 15/16

April	May	June	July	YTD
55.7%	42.6%	70.1%	60.3%	57.4%

Expected date to meet standard / target	October 2015
Revised date to meet standard	Quarter 3 2015/16
Lead Director / Lead Officer	Richard Power, MSS Clinical Director Sarah Taylor, Head of Operations

% of Staff with Annual Appraisal

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 a slight improvement over the last month, from 88.97% to 89.12% (against a target of 95%) 2. Feedback from Clinical Management Group and Directorates Leads indicates that the reduction in performance is caused by:- a. Line manager / appraiser omissions in data return b. Reporting issues across the nursing staff group c. Service pressures preventing the release of staff to conduct or attend appraisal d. Re alignment of appraisal date with incremental pay	1. Discussion at CMG / Directorate Boards and across services / areas 2. Circulation of breakdown of performance by cost centre covering review period 3. Confirm and Challenge meetings in the CMGs, performance reports cover appraisal performance and actions. 4. Performance management being pursued for areas that persistently remain below 95% 5. Recovery plans in place across all underperforming areas with trajectories set (at appraisee / team level) 6. Review of management structures to ensure appropriate devolving and span of control for direct staff 7. Clear expectations set regarding reporting requirements 8. Close monitoring at a local level on a weekly basis	**95%**	**89.12%**	**89.77% (average)**	**As shown below**

Performance by CMG

CMG	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
Alliance Elective Care	97.32%	96.27%	97.92%	82.85%	88.93%	89.93%	87.45%
CHUGGS	95.65%	94.83%	94.58%	95.20%	93.84%	94.18%	92.97%
Clinical Support & Imaging Services	93.69%	95.47%	97.21%	97.52%	96.80%	95.30%	94.07%
Emergency & Specialist Medicine	88.47%	86.41%	87.22%	84.96%	83.98%	83.75%	84.74%
ITAPS	94.03%	93.04%	94.00%	90.95%	89.22%	88.58%	88.94%
MSK & Specialist Surgery	93.94%	92.64%	94.21%	93.60%	90.70%	91.84%	94.12%
Renal, Respiratory & Cardiac	88.66%	88.04%	87.23%	87.26%	86.08%	90.86%	92.76%
Women's & Children's	85.93%	88.25%	88.08%	86.85%	85.28%	83.12%	81.89%
CMG Totals	**91.15%**	**91.18%**	**91.78%**	**90.55%**	**89.40%**	**89.56%**	89.60%
Corporate Total	**88.41%**	**89.52%**	**87.93%**	**84.89%**	**81.96%**	**82.91%**	84.16%
Grand Total	**90.91%**	**91.03%**	**91.44%**	**90.05%**	**88.74%**	**88.97%**	89.12%

CMG Forecast for the next 3 months

CMG	Sept	Oct	Nov
Alliance	90%	92%	95%
CHUGGS	94%	95%	95%
Clinical Support & Imaging Services	95%	95%	95%
Emergency & Specialist Medicine	90%	93%	95%
ITAPS	92%	94%	95%
MSK & Specialist Surgery	95%	95%	95%
Renal, Respiratory & Cardiac	95%	95%	95%
Women's & Children's	90%	92%	95%
Corporate	92%	95%	95%

Expected date to meet standard / target	Monthly Target
Revised date to meet standard	End November 2015
Lead Director / Lead Officer	Louise Tibbert, Director Of Workforce And Organisational Development Bina Kotecha, Assistant Director of Learning and OD

RTT 52 Week Breaches

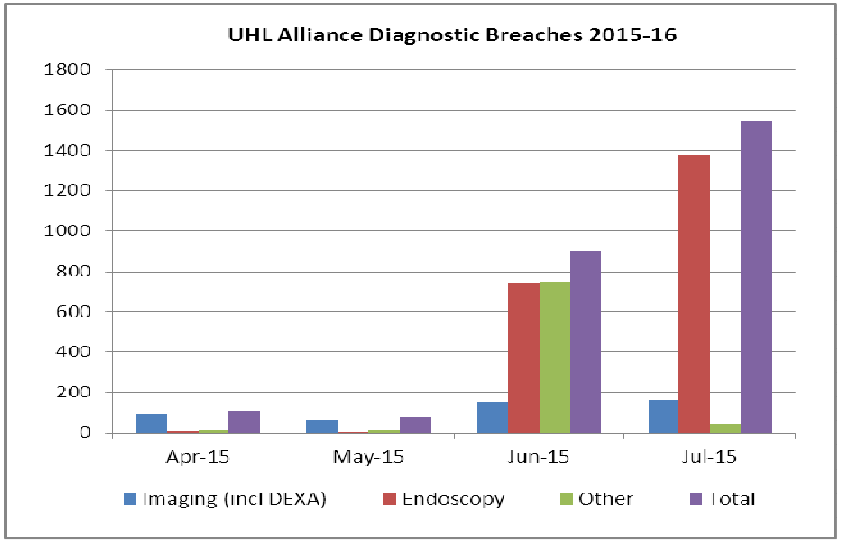
<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>July performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="4">279 52-week breaches have been identified in the Orthodontics department.

The reasons for this underperformance 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 12 patients on the waiting list between 40 and 51 weeks, who are likely to roll over to become 52 week breaches.</td><td rowspan="4">• All patients on the planned waiting list have been contacted to ask if they still require treatment. This has led to 23 pathways being closed (accounting for the non-admitted breaches).
• The service is now closed to new referrals with some clinical exceptions.
• Funding has been secured from NHS England for 2 WTE locums to clear backlog (currently out for advert).
• Should 1 WTE be in place by November, backlog will be cleared by end of February 2016. Should 2 WTE be recruited and in post by November, backlog should be cleared by end of December 2015.
• Clinical review of the service by Mr Matthew Metcalfe.
• The Orthodontics department at Northampton General Hospital has indicated they will be able to take c.60 patients to be treated there. The UHL Orthodontics team are currently in the process of identifying the 60 patients geographically closest to NGH, who will be contacted to ask if they would like to transfer.</td><td>0</td><td>Total = 279
Non admitted = 23
Incomplete = 256</td><td>Total = 296
Admitted = 7
Non admitted = 33
Incomplete = 256</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 Head of Ops meeting for assurance.
• Performance team to review all waiting list code returns and identify areas of risk.</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">TBC</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Will Monaghan, Director of Performance and Information
Charlie Carr, Head of Performance</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)	June performance (UHL + Alliance)	YTD performance (UHL Alliance)	Forecast performance for next reporting period
Imaging The majority of imaging diagnostics are delivered within 6 weeks; the exception to this has been a small volume of complex cardiac CT (c.10 per month) and complex cardiac MRI (c.100 per month). As a tertiary centre UHL is one of a small number of Trusts that provides this service. 123 MRI and CT breaches were reported in July 2015, which is close to the expected threshold. 38 patients awaiting DEXA scans breached in July 2015 as a result of receiving c. 500 referrals when the service has capacity for c. 400 scans. **Endoscopy** An issue with planned waiting lists in Endoscopy surfaced in May 2015. Following validation, the number of breaches was found to be higher than originally first thought, meaning that we have reported 1378 breaches for July 2015 across flexible sigmoidoscopy, gastroscopy and colonoscopy. 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 CT/ MRI issue by the end of September 2015. A number of DEXA breaches are expected in August 2015 but are being mitigated by extra sessions throughout the month, with efforts to procure more ongoing. **Endoscopy** In order to address long patient waits, UHL are working with Medinet to put on weekend lists, providing 60-90 additional scopes per weekend. Additional lists have also been put on by UHL's own Consultants and will run through the summer. 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. 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.	**<1%**	10.92%	10.92%	12%

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-15	May-15	Jun-15	Jul-15
UHL	0.92%	0.61%	6.97%	12.40%
UHL + Alliance	0.83%	0.59%	6.16%	10.92%

Expected date to meet standard / target	September 2015
Lead Director / Lead Officer	Will Monaghan, Director of Performance and Information Charlie Carr, Head of Performance

Cancer Waiting Times Performance

What is causing underperformance?	What actions have been taken to improve performance?
RC1: 2 Week Wait 2WW performance has improved by over 3% from the May position, but is still under target. The key reasons for underperformance are: • Increase in GP referrals; • Patient choice; • Capacity constraints. **RC3: 31 day 1st treatment** **RC5: 31 day subsequent (surgery)** Performance in both targets has reduced from the March position. 31 day 1st treatment was failed as a result of Skin and Urology performance. This was largely the result of patient choice; no adjustment is made for this in reporting. 31 day subsequent (surgery) was failed as a result of Urology performance. This has been attributed to a number of reasons key administrative gaps, theatre allocation and changes to the rota reducing SpR and SHO/ FY2 elective activity. **RC7/RC8 62 day** 62 day performance has improved considerably between May (70.1%) and June (84.2%) as a result of sustained focus from the organisation, but there is still more to do. Access to Cancer imaging remains good, but the number of patients waiting over 62 days remains too high in particular in Lower GI.	A revised overarching Cancer action plan has been jointly developed by the Cancer Centre Management team and CMGs. **RC1: 2 Week Wait** 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. **RC5: 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. **RC7/RC8: 62 day** Efforts to improve 31 day and 2WW performance will help to improve the 62 day position. Specific actions include efforts to introduce a standardised way of labelling pathology samples for Cancer patients and pathways between Breast screening and Breast services are being strengthened. A Cancer Navigator has been appointed to support Urology, meaning the specialty has more dedicated tracking time. The Endoscopy action plan is likely to improve performance, with daily conversations between service manager/ cancer navigator, and the authority for the service manager to prioritise 2WW patients before all other patients on waiting lists. The appointment of x3 band 7 staff with key responsibility for managing cancer pathways in our worst performing tumour sites will provide the key focus required. X1 is in post, interviews for the remaining two are on 21st August. The Trust has invited the IST to review the Trust Cancer processes. They are on site for two days w/c 17th August; their recommendations are expected within 3 weeks of their visit.

Target (mthly / end of year)	Latest month performance June	Performance to date 2015/16	Forecast performance for July
RC1: 2WW (Target: 93%)	91.1%	90.1%	87.3%
RC3: 31 day 1st (Target: 96%)	93.7%	95.1%	96.0%
RC5: 31 day sub – Surgery (Target: 94%)	89.6%	89.1%	90.9%
RC7: 62 day RTT (Target: 85%)	84.2%	79.9%	75.3%
RC8: 62 day screening (Target: 90%)	93.3%	89%	95.7%

Performance by Quarter

	14/15 FYE	15/16 Q1	15/16 Q2	15/16 Q3	15/16 Q4
RC1	92.2%	90.1%			
RC3	94.6%	95.1%			
RC5	89%	89.1%			
RC7	81.4%	76.9%			
RC8	84.5%	89%			

Expected date to meet standard / target	RC1: Recovery expected TBC RC3: Recovery expected July 15 RC5: Recovery expected September 15 RC7: Recovery expected Oct 15 RC8: Recovery expected June 15
Revised date to meet standard	
Lead Director / Lead Officer	Will Monaghan, Director of Performance and Information Metcalfe Matthew - Consultant Hepatobiliary and Pancreatic Surgeon

Cancer waiting 104 days

What is causing underperformance?

20 Cancer patients on the 62 day pathway breached 104 days at the end of July. 11 of these patients have confirmed Cancer, with 9 still awaiting a firm diagnosis.

Tumour site	Number of patients breaching 104 days
Head and Neck	2
Gynaecology	1
Urology	3
Lung	4
Skin	1
Lower GI	4
Upper GI	3
HPB	2

The following factors have significantly contributed to delays

Reason	Confirmed Cancer	Awaiting diagnosis
Patient choice	4	4
Patient unfit	1	
Pregnancy		1
Tertiary referral		2
Anaesthetic review	3	
Complex diag. pathway	1	
Diagnostic test delay		1
Awaiting EUS		1
Complex pathway bet. tumour sites	2	

What actions have been taken to improve performance?

A larger proportion of 104 day breaches than in previous months are linked to patient choice, demonstrating the impact of the holiday period.

Despite the impact of the holiday period, it is recognised that 62 day performance is particularly poor in Lower GI, Lung and Urology – 11 out of 20 104 day breaches can be attributed to these tumour sites. Therefore 3 band 7 Cancer Delivery Managers have either been appointed (Urology), or are in the process of being recruited (LOGI, Lung), specifically to support Cancer performance in these Tumour sites. Interviews will take place on 21st August. They will jointly report to CMG management teams and the Cancer Centre. This dedicated full-time service management will improve Cancer performance over the medium term.

This is complemented by an overarching action plan aimed at improving Cancer performance across the Trust involving central actions from the Cancer Centre management/ ODU as well as improvements at tumour site level. Key central actions include:

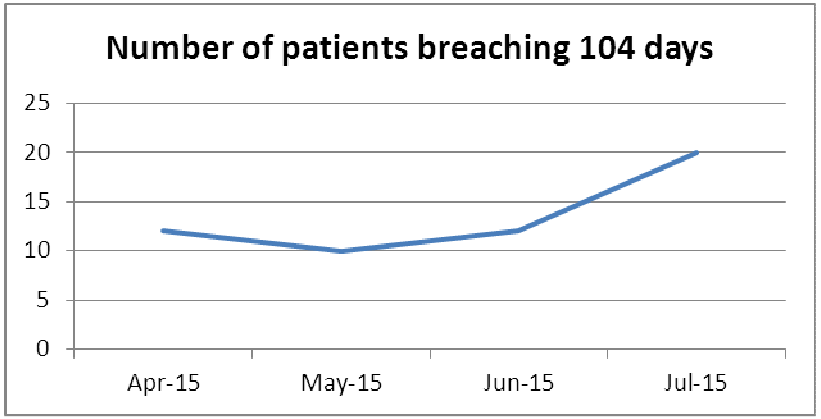
- Introduction of stamps to ensure that Cancer patients' Pathology samples are appropriately prioritised;
- Escalation of any pathway delays of more than 96 hours to the Director of Performance and Information;
- All Cancer patients coming into theatre to be escalated to the General Manager for Theatres;
- To establish CMG / Cancer Centre agreement on a Standard Operating Procedure.

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-15	May-15	Jun-15	Jul-15
Number of patients breaching 104 days	12	10	12	20*

*not all patients confirmed Cancer



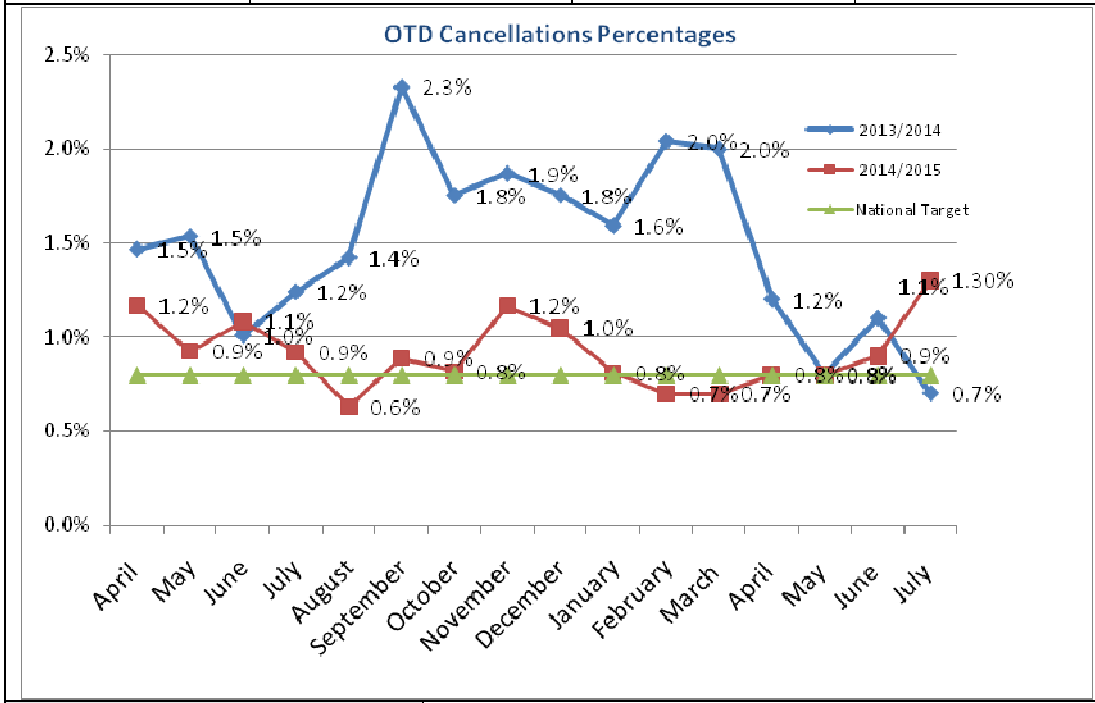
NB: all patients breaching 104 days undergo a formal 'harm review' process and these are reviewed by commissioners

Expected date to meet standard / target	N/A
Revised date to meet standard	N/A
Lead Director / Lead Officer	Will Monaghan, Director of Performance and Information Metcalfe Matthew - Consultant Hepatobiliary and Pancreatic Surgeon

Cancelled operations not booked within 28 days

INDICATORS: 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

What is causing underperformance?	What actions have been taken to improve performance?	Target (monthly)	Latest month performance – July 15	YTD performance (inc Alliance)	Forecast for next reporting period
The reason for OTD cancellations this month were mainly due to: • Theatre list over runs (42), Cooling system failure in LRI on July 1st (27), • Patient delayed due to high priority patients (22), • Critical care bed unavailability (12), • lack of paediatric bed unavailable (7) • Lack of staffing surgeons, anaesthetics, theatre staffing (18). Across the 42 cancellations due to list over runs there were: 19 CHUGGS (10 Gen Surg, 9 Urology), 14 MSS (Max fax 6 and others 8) 9 Woman's and Children's (Gynaecology 7, Paediatric Surgery 2). There was one 28 day breach due to a paediatric patient undergoing complex surgery and the specific surgeons not being available to perform the operations within 28 days.	List over runs form a significant risk to OTD performance. The process of exception reporting is now better to identify any over booked lists by the theatre managers working with theatre staff. To reduce risks of cancellations number of actions identified and in the process of implementation. <u>Risks to delivery of recovery plan</u> The key risk remains failure of escalation of patients at risk of cancellation on the day, following the UHL cancelled escalation policy. The number of failures is decreasing due to continued work from the Project Manager for On the day cancellations but it remains clear that the process of escalating to CMG Head of Operations for resolution, prior to agreeing any cancellations must be maintained.	**1) On day=0.8%**	*1)* 1.3% (1.3% - UHL & 0.8% Alliance)	1) 0 .9% (0.9% - UHL & 1.0% Alliance)	1) 0.8 %
		2) 28 day = 0	2) 1 (UHL)	2) 5	2) 7 (4 from Urology and 3 General Surgery)



Expected date to meet standard / target	August - On the day 28 day - September
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Phil Walmsley. Head of Operations, ITAPS

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>July 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.

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

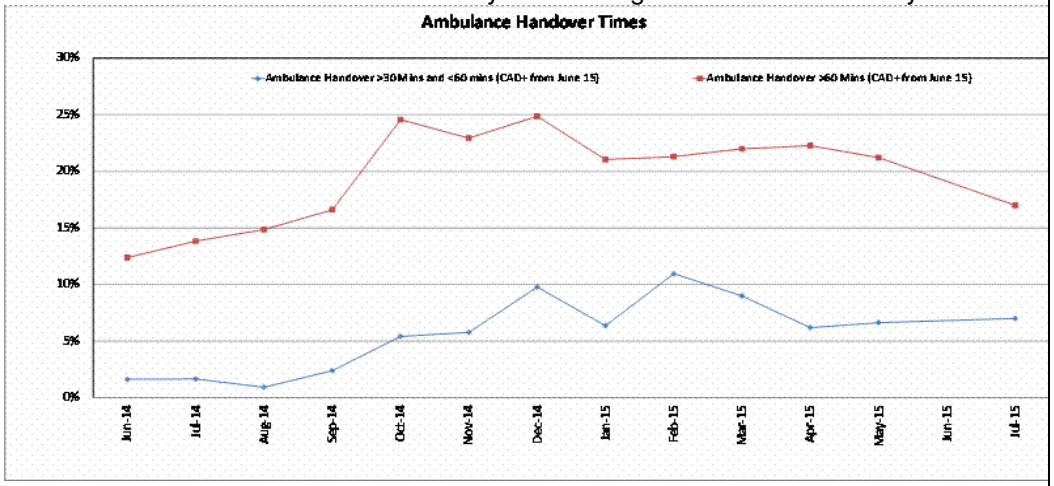
Transition to new e-Referral System:
• Choose and Book migrated to the new e-Referral System on Monday 15th June;
The challenges experienced in the period after the cut-over have calmed down considerably with installation of Google chrome improving the speed of the system.</td><td rowspan="4">Action 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 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.

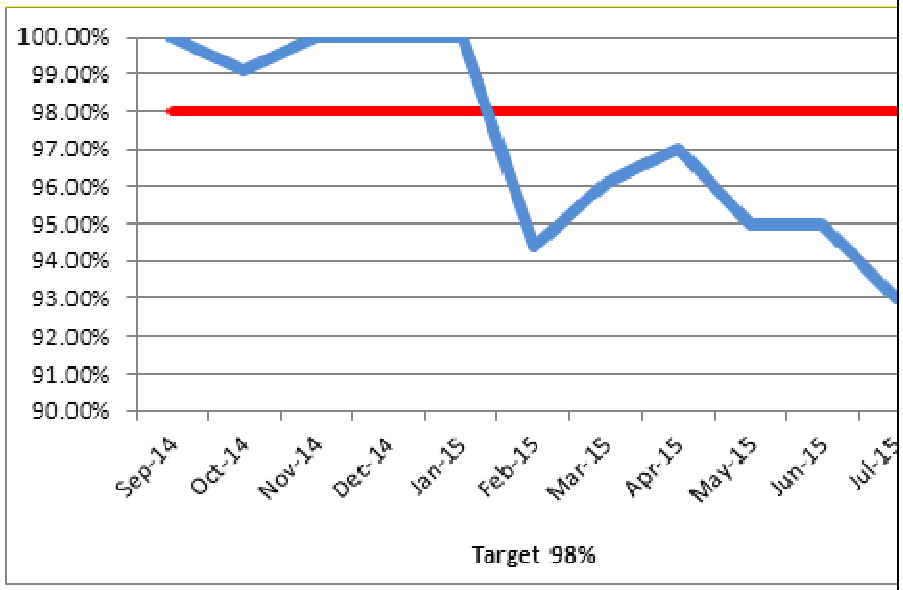
Additional resource to support the e-Referral System
• An NHS e-Referral System administrator has been in post since May;
• She will be working with key specialties to help reduce their ASIs and promote administrative housekeeping.</td><td><4%</td><td>Unable to report</td><td>Unable to report</td><td>No 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 August 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.</td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="4">December 2015</td></tr>
<tr><td>Lead Director / Lead Officer</td><td colspan="4">Will Monaghan, Director of Performance and Information
Charlie Carr, Head of Performance</td></tr>
</table>

Ambulance handover > 30 minutes and >60 minutes

		Target	July	YTD	Forecast
What is causing underperformance?	What actions have been taken to improve performance?	0 delays over 30 minutes	>60 min 8% 30-60 min – 17%	>60 min 7.0% 30-60 min – 19%	> 60 min 6% 30-60 min – 17%
Difficulties continue in accessing beds from ED leading to congestion in the assessment area and delays ambulance handover. Data quality and data capture of CAD+ data impact on performance.	Working group set up with UNIPART, EMAS and UHL to review whole handover process awaiting report re findings to commence an action plan for improvements across all both stakeholders. Meetings are planned with UHL and EMAS as only 1 set of data has been seen re CAD+. This data is still requiring validation. Validation of data continues and shows large discrepancies between EMAS and UHL findings, which reduce the handover waits in favour of UHL.	Comment: Please see chart below. Ambulance delays remain higher than this time last year. 		
		Expected date to meet standard			
		Revised date to meet standard			
		Lead Director/Lead Officer	Richard Mitchell, Chief Operating Officer, Rachel Williams, ESM General Manager		

Percentage of Cleaning audits in clinical areas achieving NCS audit scores for cleaning above 90%

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
KPI 46: Percentage of audits in clinical areas achieving NCS audit scores for cleaning above 90% Feb 15 – 94% Mar 15 - 96% Apr 15 – 97% May 15 – 95% Jun 15 – 95% Jul 15 – 93%	The score represents a total of 21 audits which did not achieve the contract standard of a total of 280 audits completed. Where issues have been raised the local management team are liaising closely with the Ward managers to rectify the issues The EFMC have continued to raise their concerns with IFM that standards are not being met. During July EFMC receive high volumes of Datix reports and emails from nursing colleagues relating to both cleaning standards and the availability of cleaning staff. EFMC have commissioned independent external audits across the three acute hospital sites and these results will be reported to the Committee in the coming weeks.	100%	93%		100%



Expected date to meet standard / target	TBC
Revised date to meet standard	TBC
Lead Director / Lead Officer	Darryn Kerr, Director of Estates & Facilities

CQC – Intelligent Monitoring Report

The latest CQC Intelligent Monitoring Report (IMR) was published on the CQC website on the 29th May 2015.

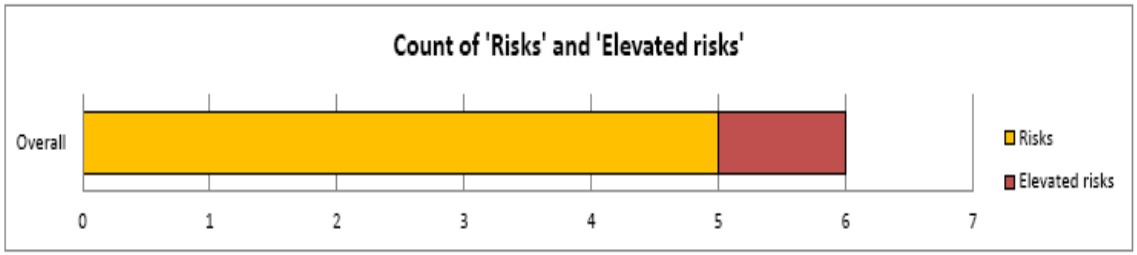
The IMR evaluates against a range of indicators relating to the five key questions used by the CQC as part of their inspections - is the organisation safe, effective, caring, responsive, and well-led?

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'

University Hospitals of Leicester NHS Trust

Trust Summary



Priority banding for inspection	4
Number of 'Risks'	5
Number of 'Elevated risks'	1
Overall Risk Score	7
Number of Applicable Indicators	95
Percentage Score	3.68%
Maximum Possible Risk Score	190

Safe	Never Event incidence	Risk
Effective	PROMs EQ-5D score: Groin Hernia Surgery	Risk
	SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator	Risk
Responsive	Composite indicator: A&E waiting times more than 4 hours	Elevated risk
Well-led	TDA - Escalation score	Risk
	GMC - Enhanced monitoring	Risk

CQC Indicator	Risk Level in latest IMR	UHL Response
Compose indicator: A&E waiting times more than 4 hours (01-Oct-14 to 31-Dec-15)	Elevated risk (Risk in the last report)	Overall performance for the year was 89.1% compared to 88.4% in 2013/14. Although our absolute performance was broadly stable, our relative performance improved markedly, moving us from the bottom 10 of the 140 A&E providers to mid-table. Nevertheless, the standard is 95% and we need to do more to get there, hence the continued focus on emergency care in our priorities for 2015/16. Work has started on building a larger ED to meet demand. This is due to be completed by December 2016. Full action plan monitored at Urgent Care Board.
Never Event incidence (01-Feb-14 to 31-Jan-15	Risk (New risk since last report)	There were 4 Never Events escalated during this period, these were: • Wrong site surgery – wrong toe • Wrong size implant/prosthesis – hip implant • Retained foreign object post-procedure - swab tie • Retained foreign object post-procedure -vaginal swab All four received a full RCA investigation with robust action plans. Actions will be monitored through to completion by the Adverse Events Committee.
PROMs EQ/5D Score: Groin Hernia Surgery (01-Apr-13 to 31-Mar-14	Risk (No change from last report)	We've improved our patient information and more recent data is in line.
SSNAP Domain 2: Overall team-centred rating score for key stroke unit indicator (01-Jul-14 to 30-Sep-14)	Risk (New risk since last report)	This remains at a D and showed some deterioration. This was primarily due to not getting the patients to the stroke unit in 4 hours and not meeting 80% having 90% stay on the stroke unit. This was partly due to the global pressures on emergency care. We have since updated our bed management policy with support from the trust and aim to have 4 beds available overnight and be the last medical outlying ward on the unit with pts due to be discharged the next day. This is reaping results as shown by the DIY Q4 result. Work has also been ongoing on our discharge process and we now have a coordinated conference call with all rehab stroke units and ESDS which is working well.
TDA Escalation score (01-Nov-14 to 30-Nov-14)	Risk (Unchanged since last report)	Continue to implement the remedial actions to achieve compliance with the NHS TDA Accountability Framework 2015-16 in line with the timescales stipulated in the Trust's oversight self-certification return to work which is reviewed and confirmed monthly by the Trust Board at its public meetings and submitted to the NHS TDA.
GMC enhances monitoring (case status as at 23-Mar-15	Risk (Unchanged since last report)	Emergency Medicine and Renal Medicine remain under enhanced monitoring. Ophthalmology is also under enhanced monitoring but as a region-wide issue, which happens to include Leicester.

15/16 Quality Schedule and CQUIN Indicators - Confirmed RAGs for Q1 2015

Schedule Ref	Indicator Title	Q1 RAG	Commentary
	QUALITY SCHEDULE		
PS01	Infection Prevention and Control Reduction.	**G**	C Diff numbers below threshold,
PS02	HCAI Monitoring	**G**	0 MRSA Bacteraemias
PS03	Patient Safety	**G**	0 Never Events. Full patient safety report to be submitted to the Sept CQRG meeting.
PS04	Duty of Candour (DoC)	**G**	0 Breaches in respect of Moderate or Serious Incidents. Details of audit plans submitted to commissioners
PS05	Complaints and user feedback Management (excluding patient surveys).	**tbc**	Improved performance against response times. Full Complaints Management report to be submitted to the Sept CQRG meeting
PS06	Risk Assurance	**G**	Further assurance provided where Risks not reviewed at time of reporting to EPB. All CAS alerts responses and actions on track.
PS07	Safeguarding	**tbc**	Reports submitted – for review by the CCG Safeguarding team.
PS08	Reduction in Pressure Ulcer incidence.	**G**	0 G4s and G3s below threshold. Above G2 threshold in April but on track for May and June.
PS09	Medicines Management Optimisation	**R** **G**	Red RAG for Controlled Drugs Audit as results below 95% but commissioners noted improvements made. Green for other parts of Indicator.
PS10	Medication Errors	**A**	Threshold is to report increased number of Medication Errors. To review UHL's reporting rate with other trusts. Actions being taken to reduce harm noted.
PS11	Safety Thermometer	**G**	Improved % for Harm Free Care and 95% standard met for June 15. In the middle of the funnel plot for Harm Free care for Jun 14 to May 15
AS01	Cost Improvement Programme (CIP) Assurance	**A**	Commissioners noted UHL's plans for ongoing monitoring of the impact of CIPs on quality but Amber RAG as implementation behind schedule.
AS02	Ward Health-check	**G**	Evidence of actions being taken where Wards either below agreed staffing levels or not meeting Clinical Measures Scorecard targets
AS03	Nurse Revalidation Programme	**G**	Assurance provided about plans in place to meet revalidation requirements
AS04	Staffing governance	**A**	Progress against OD Plans noticed but Amber RAG due to non achievement of Appraisal and Mandatory Training
AS05	Involving employees in improving standards of care.	**G**	Report received and actions noted.
AS06	Staff Satisfaction	**G**	Staff satisfaction received with action plans in place and on track for areas of poor response.
AS07	External Visits and Commissioner Quality Visits	**tbc**	Dependent upon Actions (in response to recommendations made) being on track.

Schedule Ref	Indicator Title	Q1 RAG	Commentary
AS08	CQC Registration	**A**	Due to UHL not being reported as not fully compliant with CQC standards, however noted that action plan following the most recent visit is on track
CE01(a)	Communication - Content - Medical	**G**	Audit Schedule reported - ED letters Q1. Disch Letters Q1 - Q4. OutPt Letters - Q2-Q3.
CE01(b)	Communication - Content - Nursing	**G**	Nursing letter standards to be incorporated into Letters Policy and audit planned for Q3
CE02	Intra-operative Fluid Management	**R**	Threshold not achieved for Q1. Improved performance for July – now above thresholds
CE03a	Clinical Effectiveness Assurance - Audit	**A**	Audit plan for 15/16 reviewed at UHL Clinical Audit Committee. Amber due to audits being behind schedule
CE03b	Clinical Effectiveness Assurance - NICE	**tbc**	UHL Compliant with all NICE TAGs. Reporting on Clinical Guidelines etc deferred to the October meeting.
	Women's Service Dashboard	**tbc**	For reporting to the September CQRG. Obstetrician training and C Sections thresholds not met for April. May/June's data tbc.
CE05	Children's Service Dashboard	**tbc**	For reporting to the September CQRG. SpR training threshold not achieved in April, improved for July. Significant improvement in performance in May for 'timing of Assessment on CAU'
CE06a	PROMS - Patient Reported Outcomes	**A**	UHL's participation in line with national average for both participation and outcomes for all procedures with the exception of Groin Hernia where participation is below average.
CE06b	Consultant Clinical Outcomes	**G**	No outcomes published since reported for Q4. UHL outcomes better than average or within expected.
CE07	#NOF - Dashboard	**R**	time to theatre' not achieved for any Month in Q1. Performance improved in June but still below the 72% threshold
CE08	Stroke and TIA monitoring	**G**	Improvement in '90% stay' and also in overarching SSNAP Domain. Further improvements to be made for Therapy related targets - business case approved to recruit additional staff
CE09	Mortality	**G**	Published SHMI for Jan to Dec 2014 = 99 (ie below 100). Progress being made with plans to meet NTDA requirement to screen all deaths.
CE10	VTE Risk Assessment	**G**	95% threshold achieved for April, May and June
CE11	VTE RCA	**tbc**	For reporting to the September CQRG. RAG dependent upon meeting requirement to review all Hospital Acquired VTEs (both inpt and post discharge)
CE12	Nutrition and Hydration	**R**	Thresholds achieved for all CMGs with the exception of ESM. Actions in place to address and CMG implementing several initiatives to support patients' nutritional needs but not necessarily captured by the metrics.
CE13	Food Strategy	**deferred**	
CE14	Community Acquired Pneumonia	**A**	CURB and Chest Xray achieved but Timing of Antibiotics just below threshold. Increased activity seen in Q1.
CE15	Improving End of Life (EoL) care.	**G**	Continued embedding of AMBER care bundle.
CE16	Heart Failure	**A**	Threshold not achieved. Plans in place to address in Q2.

Schedule Ref	Indicator Title	Q1 RAG	Commentary
PE01	Same Sex Accommodation Compliance and Annual Estates Monitoring	**G**	0 Breaches in Q1
PE02	Patient Experience, Equality and Listening to and Learning from Feedback.	**tbc**	For reporting to the September CQRG. Continued triangulation of patient feedback and actions being taken in response
PE04	Equality and Human Rights	**A**	Due to lack of progress with capturing demographic data for patients with Learning Disability.
PE5	MECC	**G**	Referrals to STOP and Alcohol Liaison continue.
PE6	Friends and Family Test	**tbc**	Thresholds met for Adult patients and improvement seen for Children's response rates in Inpatients but drop in participation for ED.
	SPECIALISED SERVICES QS		
SQ01	National Quality Dashboards	**tbc**	Confirmation being sought that all relevant Specialities are submitting data
SQ02	National Clinical Registries	**tbc**	Confirmation being sought that all relevant Specialities are submitting data
SQ03	HIV: GP registration and communication	**G**	Letters are sent at each medical clinic (at least once per year)
z	**NATIONAL CQUINS**		
Nat 1	AKI Discharge Care Bundle	**G**	Quarter 1 is to provide baseline data about number/% of discharge letters containing details of AKI Stage and actions taken
Nat 2a	Sepsis - Screening	**G**	Q1 is to provide baseline data on number/% of em patients screened for sepsis. Provisional data shows small number of em patients in sample meeting criteria for screening with few being screened. 66% screened.
Nat 2b	Sepsis - IV Antibiotics	**G**	N/A – for reporting in Q2
Nat 3a	Dementia - FAIR	**G**	90% threshold achieved for April and May
Nat 3b	Dementia Training	**A**	New clinical lead confirmed and training programme agreed. % of Medical Staff undertaking Category A/B training is low.
Nat 3c	Dementia Carers	**G**	Surveys undertaken and actions carried out in response to feedback received
Nat 4	Amb Care	**G**	Q1 threshold is to confirm scope of scheme and improvement thresholds. Proposed to implement ACP in CDU.
	LOCAL CQUINS		
Loc 5	Readmissions	**G**	Following review of Readmissions data, focused case note review undertaken and actions agreed.
Loc 6	CHC	**A**	Baseline data being collected. Below 95% for completion of CHC assessment process.
Loc 7a	Safety Briefings	**G**	Commissioners looking to agree outcome measures for Q4.

Schedule Ref	Indicator Title	Q1 RAG	Commentary
Loc 7b	Increase 'Near Miss' Reporting	G	
Loc 8	Think Glucose	G	Continued roll out of the Think Glucose programme
Loc 9	Bereavement F/U	G	Bereavement Follow Up Service Leads appointed and scoping of service being undertaken
Loc 10	Learning Disabilities - Pt Exp	G	Baseline data for patients who DNA appointments reported and progress with actions.
	SPECIALISED CQUINS		
SS1/CUR	CUR Tool	G	Requirements for Q1 agreed with Local Area Team. Q4 payment at risk due to lack of flexibility at a national level with the Q4 thresholds
SS2/C6	Oncotype Testing	G	Oncotype tests requested.
SS3/TH4	Critical Care Delayed Discharges	G	Baseline data submitted and action plan to improve
SS6/IM7	Rheumatic Diseases Network	G	Details of proposed network reported.
SS7/TH7	Complex Orthopaedic Surgery Network	G	Details of proposed network reported.
SS8/HSS	ECMO/PCO Collaborative Workshop	G	Participation in HSS workshops confirmed
SS10/CB5	Haemoglobinopathy Network	G	Network meeting held.
SS11/WC1	<28 Week Neonates 2 yr follow up	G	Baseline data submitted and action plan to improve.