Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

April 2015

One team shared values

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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **4th JUNE 2015**

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

1.0 Introduction

The following report provides an overview of the April 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	5	22	7	1
Caring	6	10	8	1
Well Led	7	15	9	0
Effective	8	16	4	1
Responsive	9	28	1	10
Research – UHL	11	6	6	0
Research - Network	11	13	0	3
Estates & Facilities	12	10	0	1
Total		120	35	17

3.0 New Indicators

The TDA published the 2015/16 Accountability Framework for Trust Boards at the beginning of April 2015. The framework includes the way in which the NHS TDA measures and scores the quality and sustainability of the services and how the NHS TDA holds Trusts to account. For 2015/16 the TDA continues to the five domains used by CQC in their regime for assessing the quality of service: Caring, Effective, Responsive, Safe and Well-led. Details of the proposed indicators that will be used to monitor the five domains were also included. The TDA released their final list of indicators mid May which also included the thresholds and methodology for calculating the

indicator. Where possible these have been replicated in the April Quality and Performance report, however further work/analysis is required before all the new indicators can be populated with performance and further clarification is required from the TDA.

The new indicators included in the April report are:

Safe Domain

Safety Thermometer % number of new harms – TDA
Maternal Deaths - TDA
Emergency C Sections (Coded as R18) - TDA
Potential under reporting of patient safety indicators - TDA
Potential under reporting of patient safety indicators resulting in death or severe harm - TDA

Caring

Day case Friends and Family Test - % positive - TDA
Written Complaints Received Rate per 100 bed days – TDA

Well Led

Day case Friends and Family Test – Coverage - TDA
Nursing Vacancies - UHL
Nursing Vacancies in ESM CMG – UHL
Safety staffing fill rate – TDA

Effective

ROSC in Utstein Group - TDA
STEMI 150minutes – TDA

Responsive

Cancer waiting 104 days RTT - TDA
Outpatient Hospital Cancellation Rates - TDA

4.0 Indicators removed

The following indicators have been removed from the Quality & Performance report:

Safe Domain

Clostridium Difficile (Local Target) - UHL
Nutrition and Hydration Metrics - Fluid Balance and Nutritional Assessment – UHL

Caring

Inpatient Friends and Family Test - Score (Local Target) – UHL
A&E Friends and Family Test - Score (Local Target) - UHL

Improvements in the FFT scores for Older People (65+ years) - UHL
Responsiveness and Involvement Care (Average score) - UHL
Q15. When you used the call button, was the amount of time it took for staff to respond generally:
Q16. If you needed help from staff getting to the bathroom or toilet or using a bedpan, did you get help in an acceptable amount of time?
Q11. Were you involved as much as you wanted in decisions about your care and treatment?

Well Led

Data quality of trust returns to HSCIC – TDA
Total trust vacancy rate – TDA

Effective

Mortality - Rolling 12 mths HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly - UHL
Mortality - Monthly HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly – UHL
Communication - ED, Discharge and Outpatient Letters - Compliance with standards – UHL

5.0 Indicators where reporting methodology has been changed

There are a number of indictors where the methodology for reporting performance has been changed:

New FFT scoring

% Recommended - Number of Extremely Likely + Number of Likely / Total number of responses
% Not recommended - Number of Extremely Unlikely + Number of Unlikely / Total number of responses

FFT Coverage (Inpatient& Day Cases)

Previously excluded - patients aged under 16,day case patients, patients that did not stay one night as an inpatient (mainly Assessment Unit patients) are now included in the FFT submission. Also included now are the Alliance Hospitals.

COVERAGE (A&E)

Previously excluded patients aged under 16 are now included in the submission.

	KPI Ref	Indicators	Board Director	Lead Director/Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	YTD
Safe	S1	Clostridium Difficile	CR	DJ	61	TDA	Red / ER for Non compliance with cumulative target	66	73	4	6	5	7	2	5	7	7	11	7	5	7	3	3
	S2a	MRSA Bacteraemias (All)	CR	DJ	0	TDA	Red = >0 ER = 2 consecutive mths >0	3	6	0	0	0	0	0	1	1	0	2	0	1	1	0	0
	S2b	MRSA Bacteraemias (Avoidable)	CR	DJ	0	UHL	Red = >0 ER = 2 consecutive mths >0	1	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0
	S3	Never Events	CR	MD	0	TDA	Red = >0 in mth ER = in mth >0	3	3	0	0	0	0	0	0	1	0	1	1	0	0	0	0
	S4	Serious Incidents	CR	MD	Not within Highest Decile	TDA	TBC	60	41	4	6	3	7	2	3	4	2	4	3	2	1	2	2
	S5a	Proportion of reported safety incidents per 1000 beddays	CR	MD	TBC	TDA	TBC	37.5	39.1	40.8	40.2	40.4	41.1	35.6	41.8	38.9	40.3	40.4	35.0	38.2	36.3	34.6	34.6
	S5b	Proportion of reported safety incidents that are harmful	CR	MD	Not within Highest Decile	TDA	TBC	2.8%	1.9%	1.7%			2.2%			1.4%			2.3%				
	S6	Overdue CAS alerts	CR	MD	0	TDA	Red = >0 in mth ER = in mth >0	2	10	2	2	2	3	0	0	0	0	0	0	0	1	0	0
	S7	RIDDOR - Serious Staff Injuries	CR	MD	FYE = <40	UHL	Red / ER = non compliance with cumulative target	47	24	3	5	1	2	2	1	2	2	1	0	3	2	0	0
	S8a	Safety Thermometer % of harm free care (all)	CR	EM	Not within Lowest Decile	TDA	Red = <92% ER = in mth <92%	93.6%	94.1%	94.6%	94.7%	94.2%	94.9%	94.4%	93.9%	94.9%	93.3%	94.1%	95.0%	92.1%	93.6%	93.7%	93.7%
	S8b	Safety Thermometer % number of new harms	CR	EM	Not within Lowest Decile	TDA	TBC	New TDA Indicator		1.7%	2.7%	2.4%	2.9%	2.5%	2.3%	3.3%	2.4%	2.5%	3.2%	2.7%	2.2%	2.2%	
	S9	% of all adults who have had VTE risk assessment on adm to hosp	AF	SH	95% or above	TDA	Red = <95% ER = in mth <95%	95.3%	95.8%	95.7%	95.9%	95.9%	96.3%	95.5%	96.2%	95.4%	95.5%	95.0%	96.3%	96.2%	95.6%	96.0%	96.0%
	S10	All Medication errors causing serious harm	CR	MD	0	TDA	Red = >0 in mth ER = in mth >0	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED															
	S11	All falls reported per 1000 bed stays for patients >65years	CR	EM	<7.1	QC	Red >= YTD >8.4 ER = 2 consecutive reds	7.1	6.9	7.0	7.5	7.1	7.3	7.3	5.9	6.4	7.5	6.9	7.1	6.7	6.3	5.6	5.6
	S12	Avoidable Pressure Ulcers - Grade 4	CR	EM	0	QS	Red / ER = Non compliance with monthly target	1	2	0	0	0	0	0	0	0	0	1	0	0	1	0	0
	S13	Avoidable Pressure Ulcers - Grade 3	CR	EM	<=6 a month	QS	Red / ER = Non compliance with monthly target	71	69	5	5	5	5	6	6	4	6	7	5	9	6	3	3
	S14	Avoidable Pressure Ulcers - Grade 2	CR	EM	<=8 a month	QS	Red / ER = Non compliance with monthly target	120	91	6	6	6	7	9	4	8	13	11	7	5	9	10	10
	S15	Compliance with the SEPSIS6 Care Bundle	CR	MD	All 6 >75% by Q4	QC	Red/ER = Non compliance with Quarterly target	27.0%	<65%	47.0%			>=60%			<65%							
	S16	Maternal Deaths	AF	IS	0	UHL	Red / ER = Non compliance with monthly target	3	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
	S17	Emergency C Sections (Coded as R18)	IS	EB	Not within Highest Decile	TDA	Red / ER = Non compliance with monthly target	16.1%	16.5%	16.9%	16.0%	14.7%	16.9%	15.4%	17.4%	18.1%	17.4%	16.2%	17.7%	15.5%	15.8%	15.3%	15.3%
	S18	Potential under reporting of patient safety indicators	CR	MD	Not within Highest Decile	TDA	Red / ER = 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	CR	MD	Not within Highest Decile	TDA	Red / ER = Non compliance with monthly target	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED															

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

	KPI Ref	Indicators	Board Director	Lead Director/Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	YTD
Caring	C1	Inpatients (Including Daycases) Friends and Family Test - % positive	CR	CR	Not within Lowest Decile	TDA	TBC	New Indicator	96%	96%	96%	97%	97%	96%	97%	96%	96%	96%	96%	96%	97%	96%	96%
	C2	A&E Friends and Family Test - % positive	CR	CR	Not within Lowest Decile	TDA	TBC	New Indicator	96%	94%	97%	95%	96%	92%	95%	96%	96%	96%	96%	96%	97%	96%	96%
	C3	Outpatients Friends and Family Test - % positive	CR	CR	TBC	UHL	TBC	NEW METHODOLOGY FOR CALCULATING %														94%	94%
	C4	Daycase Friends and Family Test - % positive	CR	CR	Not within Lowest Decile	TDA	TBC															Definition to be confirmed	
	C5	Maternity Friends and Family Test - % positive	CR	CR	Not within Lowest Decile	TDA	TBC	-	96%	95%	96%	96%	96%	96%	94%	96%	97%	95%	97%	96%	96%	95%	95%
	C6	Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment	ES	ES	TBC	TDA	TBC	New Indicator	69.2%	68.3%			67.2%			Q3 staff FFT not completed as National Survey carried out			71.4%				
	C7a	Complaints Rate per 100 bed days	CR	MD	TBC	UHL	TBC	New Indicator	0.4	0.4	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.4	0.3	0.3
	C7b	Written Complaints Received Rate per 100 bed days	CR	MD	Not within Highest Decile	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED															
	C8	Complaints Re-Opened Rate	CR	MD	<9%	TDA	Red = >10% ER = 3 mths Red or any month	New Indicator	10%	8%	5%	8%	11%	10%	9%	11%	11%	10%	17%	13%	11%	13%	13%
	C9	Single Sex Accommodation Breaches (patients affected)	CR	CR	0	TDA	Red = >0 ER = in mth >0	2	13	4	3	0	0	0	0	0	5	0	1	0	0	0	0

Well Led

KPI Ref	Indicators	Board Director	Lead Director/Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	YTD
W1	Inpatients (including Daycases) Friends and Family Test - Coverage	CR	CR	Not within Lowest Decile	TDA	TBC	24.3%	40.1%*	NEW METHODOLOGY FOR CALCULATING COVERAGE												22.0%	22.0%
W2	Daycase Friends and Family Test - Coverage	CR	CR	Not within Lowest Decile	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED															
W3	A&E Friends and Family Test - Coverage	CR	CR	Not within Lowest Decile	TDA	TBC	14.9%	22.8%*	NEW METHODOLOGY FOR CALCULATING COVERAGE												14.7%	14.7%
W4	Outpatients Friends and Family Test - Valid responses	CR	CR	Not within Lowest Decile	UHL	TBC	New Indicator	13,185	175	286	1,879	1,535	785	927	1,255	1,506	1,053	1,259	1,245	1,280	1,341	1,341
W5	Maternity Friends and Family Test - Coverage	CR	CR	Not within Lowest Decile	UHL	TBC	25.2%	28.0%	27.2%	36.4%	25.2%	29.2%	29.9%	18.7%	15.8%	21.7%	22.1%	25.8%	46.5%	40.2%	32.3%	32.3%
W6	Friends & Family staff survey: % of staff who would recommend the trust as place to work	ES	ES	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%				
W7a	Nursing Vacancies	CR	MM	TBC	UHL	TBC	NEW UHL INDICATOR							6.7%	6.7%	6.4%	6.0%	6.3%	5.5%	6.5%	8.5%	8.5%
W7b	Nursing Vacancies in ESM CMG	CR	MM	TBC	UHL	TBC	NEW UHL INDICATOR							10.8%	10.8%	10.7%	9.7%	12.8%	11.4%	14.0%	19.3%	19.3%
W8	Turnover Rate	ES	ES	Not within Lowest Decile	TDA	Red = 11% or above ER = Red for 3 Consecutive Mths	10.0%	11.5%	9.9%	10.0%	10.2%	10.0%	10.5%	10.3%	10.8%	10.7%	10.3%	10.1%	10.1%	11.5%	10.4%	10.4%
W9	Sickness absence	ES	ES	3%	UHL	Red = >3.5% ER = 3 consecutive mths >3.5%	3.4%	3.8%	3.4%	3.3%	3.3%	3.4%	3.4%	3.7%	4.0%	4.0%	4.4%	4.2%	4.1%	4.0%		
W10	Temporary costs and overtime as a % of total paybill	ES	ES	TBC	TDA	TBC	New Indicator	9.4%	9.4%	9.4%	8.1%	8.5%	8.9%	8.5%	9.5%	9.0%	9.8%	10.5%	9.8%	11.5%	10.7%	10.7%
W11	% of Staff with Annual Appraisal	ES	ES	95%	UHL	Red = <90% ER = 3 consecutive mths <90%	91.3%	91.4%	91.8%	91.0%	90.6%	89.6%	88.6%	89.7%	91.8%	92.3%	92.5%	90.9%	91.0%	91.4%	90.1%	90.1%
W12	Statutory and Mandatory Training	ES	ES	95%	UHL	TBC	76%	95%	78%	79%	79%	80%	83%	85%	86%	87%	89%	89%	90%	95%	93%	93%
W13	% Corporate Induction attendance	ES	ES	95.0%	UHL	Red = <90% ER = 3 consecutive mths <90%	94.5%	100%	96%	94%	92%	96%	98%	98%	98%	98%	100%	99%	100%	97%	97%	97%
W14	Safety staffing fill rate	CR	MM	Not within Lowest Decile	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED															

* Quarter 4 Average

KPI Ref	Indicators	Board Director	Lead Director/Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	YTD
E1	Mortality - Published SHMI	AF	PR	Within Expected	TDA	Higher than Expected	105		106 (Oct12-Sept13)			106 (Jan13-Dec13)			105 (Apr13-Mar14)			103 (Oct13-Sep14)			103 (Oct13-Sep14)	
E2	Mortality - Rolling 12 mths SHMI (as reported in HED)	AF	PR	Within Expected	QC	Red = >expected ER = >Expected or 3 consecutive mths increasing SHMI >100	105		105	105	106	105	103	102	102	101	99	Awaiting HED Update				
E3	Mortality HSMR (DFI Quarterly)	AF	PR	Within Expected	TDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	88	93	99			95			93			Awaiting DFI Update				
E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	AF	PR	Within Expected	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	#REF!	96	97	98	98	97	96	96	96	95	95	96	Awaiting HED Update			
E5	Mortality - Monthly HSMR (Rebased Monthly as reported in HED)	AF	PR	Within Expected	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	#REF!	95	82	108	105	86	97	98	96	88	96	97	Awaiting HED Update			
E6	Mortality - rolling 12 mths HSMR ALL Weekend Admissions - (DFI Quarterly)	AF	PR	Within Expected	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	95		100			103.4			97			Awaiting DFI Update				
E7	Crude Mortality Rate Emergency Spells	AF	PR	Within Upper Decile	TDA	TBC	2.5%	2.4%	2.0%	2.5%	2.4%	2.0%	1.9%	2.3%	2.1%	2.3%	3.0%	3.1%	2.7%	2.4%	2.1%	2.1%
E8	Deaths in low risk conditions (Risk Score)	AF	PR	Within Expected	TDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	94		97	81	105	79	69	63	102	22	47	Awaiting DFI Update				
E9	Emergency readmissions within 30 days following an elective or emergency spell	AF	PR	Within Expected	TDA	Higher than Expected	7.9%	8.5%	8.8%	8.8%	8.6%	8.4%	8.9%	8.4%	8.6%	8.9%	9.1%	8.2%	8.5%	8.5%		
E10	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	AF	RP	72% or above	QS	Red = <72% ER = 2 consecutive mths <72%	65.2%	61.4%	56.9%	40.6%	60.3%	76.9%	59.0%	68.6%	69.6%	59.4%	57.3%	57.9%	67.2%	61.5%	55.7%	55.7%
E11	Stroke - 90% of Stay on a Stroke Unit	RM	IL	80% or above	QS	Red = <80% ER = 2 consecutive mths <80%	83.2%	81.3%	92.9%	80.3%	87.1%	78.1%	84.5%	83.2%	70.4%	73.3%	75.2%	83.3%	87.6%	83.3%		
E12	Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA)	RM	IL	60% or above	QS	Red = <60% ER = 2 consecutive mths <60%	64.2%	71.2%	79.7%	58.8%	71.3%	62.8%	65.5%	72.7%	67.8%	69.0%	83.5%	80.6%	64.0%	77.3%	86.3%	86.3%
E13	Published Consultant Level Outcomes	AF	SH	>0 outside expected	QC	Red = >0 Quarterly ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
E14	Non compliance with 14/15 published NICE guidance	AF	SH	0	QC	Red = in mth >0 ER = 2 consecutive mths Red	New Indicator for 14/15	0	0	0	0	0	0	0	0	0	0	0	0	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 Director/Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	YTD
R1	ED 4 Hour Waits UHL + UCC (Sit Rep)	RM	IL	95% or above	TDA	Red = <95% ER via ED TB report	88.4%	89.1%	86.9%	83.4%	91.3%	92.5%	90.9%	91.5%	90.1%	88.5%	83.0%	90.2%	89.2%	91.1%	92.4%	92.4%
R2	12 hour trolley waits in A&E	RM	IL	0	TDA	Red = >0 ER via ED TB report	5	4	0	1	1	0	0	0	1	0	0	1	0	0	0	0
R3	RTT Waiting Times - Admitted	RM	WM	90% or above	TDA	Red /ER = <90%	76.7%	*82.8%	78.9%	79.4%	79.0%	80.9%	82.2%	81.6%	84.4%	85.5%	86.9%	85.0%	85.9%	84.4%	88.0%	88.0%
R4	RTT Waiting Times - Non Admitted	RM	WM	95% or above	TDA	Red /ER = <95%	93.9%	*95.1%	94.3%	94.4%	95.0%	94.9%	95.6%	94.6%	94.9%	95.2%	96.0%	95.4%	95.3%	95.5%	95.6%	95.6%
R5	RTT - Incomplete 92% in 18 Weeks	RM	WM	92% or above	TDA	Red /ER = <92%	92.1%	*94.7%	93.9%	93.6%	94.0%	93.2%	94.0%	94.3%	94.8%	95.0%	95.1%	95.2%	96.2%	96.7%	96.9%	96.9%
R6	RTT 52 Weeks+ Wait (Incompletes)	RM	WM	0	TDA	Red /ER = >0	0	0	0	0	0	15	1	3	3	2	0	0	0	0	0	0
R7	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	TDA	Red /ER = >1%	1.9%	*1.4%	0.8%	0.9%	0.8%	0.7%	1.0%	1.0%	0.7%	1.8%	2.2%	5.0%	0.8%	0.9%	0.8%	0.8%
R8	Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	RM	MM	93% or above	TDA	Red = <93% ER = Red for 2 consecutive mths	94.8%	92.2%	88.5%	94.7%	93.5%	92.2%	92.0%	90.6%	92.0%	92.5%	93.0%	92.2%	93.5%	91.5%		
R9	Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	RM	MM	93% or above	TDA	Red = <93% ER = Red for 2 consecutive mths	94.0%	94.1%	80.0%	95.0%	98.9%	94.9%	94.4%	95.2%	98.6%	100.0%	93.0%	92.5%	91.5%	96.0%		
R10	31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	RM	MM	96% or above	TDA	Red = <96% ER = Red for 2 consecutive mths	98.1%	94.6%	97.2%	92.9%	93.6%	94.4%	97.9%	91.9%	95.9%	92.5%	95.2%	91.7%	95.0%	97.0%		
R11	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	RM	MM	98% or above	TDA	Red = <98% ER = Red for 2 consecutive mths	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0%	97.1%	100.0%	96.7%	100.0%	100.0%	100.0%		
R12	31-Day Wait For Second Or Subsequent Treatment: Surgery	RM	MM	94% or above	TDA	Red = <94% ER = Red for 2 consecutive mths	96.0%	89.0%	95.2%	97.0%	90.8%	90.1%	87.8%	94.0%	81.9%	82.4%	80.3%	89.2%	94.4%	87.5%		
R13	31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	RM	MM	94% or above	TDA	Red = <94% ER = Red for 2 consecutive mths	98.2%	96.1%	97.3%	95.6%	93.9%	97.3%	99.0%	96.5%	96.0%	94.7%	95.5%	87.6%	99.0%	100.0%		
R14	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	RM	MM	85% or above	TDA	Red = <85% ER = Red in mth or YTD	86.7%	81.4%	92.7%	88.5%	73.1%	85.6%	78.8%	75.5%	80.4%	77.0%	84.8%	79.3%	78.9%	83.8%		
R15	62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	RM	MM	90% or above	TDA	Red = <90% ER = Red for 2 consecutive mths	95.6%	84.5%	91.1%	67.4%	73.9%	73.0%	100.0%	87.5%	75.0%	94.4%	93.8%	88.9%	79.4%	89.3%		
R16	Cancer waiting 104 days RTT	RM	MM	0	TDA	TBC	NEW INDICATOR															
R17	Urgent Operations Cancelled Twice	RM	PW	0	TDA	Red = >0 ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
R18	Cancelled patients not offered a date within 28 days of the cancellations UHL	RM	PW	0	TDA	Red = >2 ER = >0	85	33	10	4	1	2	1	2	2	0	3	4	3	1	2	2
R19	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	RM	PW	0	TDA	Red = >2 ER = >0	New Indicator for 14/15	11	0	0	0	0	6	0	0	1	1	2	1	0	0	0
R20	% Operations cancelled for non-clinical reasons on or after the day of admission UHL	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	1.6%	0.9%	1.1%	0.8%	1.1%	0.7%	0.6%	0.8%	0.8%	1.2%	1.1%	0.8%	0.7%	1.0%	0.7%	0.7%
R21	% Operations cancelled for non-clinical reasons on or after the day of admission ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	1.6%	0.9%	0.6%	0.6%	0.3%	2.7%	0.0%	0.9%	1.0%	0.0%	0.8%	1.4%	0.0%	0.4%	1.2%	1.2%
R22	% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	New Indicator for 14/15	0.9%	1.1%	0.8%	1.0%	0.9%	0.6%	0.8%	0.8%	1.1%	1.1%	0.8%	0.7%	0.9%	0.8%	0.8%
R23	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	106	77	98	94	55	90	94	108	102	85	64	98	79	79
R24	Outpatient Hospital Cancellation Rates	RM	PW	Within Upper Decile	UHL	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED															
R25	Delayed transfers of care	RM	PW	3.5% or below	TDA	Red = >3.5% ER = Red for 3 consecutive mths	4.1%	3.9%	4.4%	4.2%	4.0%	3.9%	3.9%	4.5%	4.6%	5.2%	3.9%	3.2%	2.9%	1.8%	1.2%	1.2%
R26	Choose and Book Slot Unavailability	RM	WM	4% or below	Contract	Red = >4% ER = Red for 3 consecutive mths	13%	21%	22%	25%	26%	25%	26%	25%	20%	17%	16%	13%	19%	26%	34%	34%
R27	Ambulance Handover >60 Mins (CAD)	RM	PW	0	Contract	Red = >0 ER = Red for 3 consecutive mths	868	3,067	173	253	88	71	50	106	253	343	460	353	499	418	286	286
R28	Ambulance Handover >30 Mins and <60 mins (CAD)	RM	PW	0	Contract	Red = >0 ER = Red for 3 consecutive mths	7,075	11,315	720	951	671	591	805	736	1,147	1,364	1,170	1,167	970	1,023	1,029	1,029

* Yearly Average

Compliance Forecast for Key Responsive Indicators

Standard	April Actual/Predicted	May predicted	Month by which to be compliant	RAG rating of required month delivery	Commentary
Emergency Care					
4+ hr Wait (95%) - Calendar month	92.0%				
Ambulance Handover (CAD)					
Ambulance Handover >60 Mins (CAD)	245	280	Not Agreed		
Ambulance Handover >30 Mins and <60 mins (CAD)	882	960	Not Agreed		
RTT (inc Alliance)					
Admitted (90%)	88.0%	90.0%	May		May delivery currently on track.
Non-Admitted (95%)	95.6%	95.7%	Continued Delivery		UHL achieved in own right. Alliance added. Sustained performance.
Incomplete (92%)	96.9%	96.7%	Continued Delivery		Backlog clearance improving sustainability. Performance is now 29 out of 148 trusts.
Diagnostic (inc Alliance)					
DM01 (<1%)	0.8%	0.9%	Continued Delivery		April delivered. Predicted May delivery
Cancelled Ops (inc Alliance)					
Cancelled Ops (0.8%)	0.8%	0.7%	Continued delivery		
Not Rebooked within 28 days (0 patients)	2	0	March		
Cancer (predicted)					
Two Week Wait (93%)	91.6%	90.2%	March		Patient choice now the dominant reason for failure all UHL tumour sites compliant for capacity and speed of offering patients dates. This is exacerbated by May bank holiday issues.
31 Day First Treatment (96%)	92.4%	90.8%	May		Skin patients remains an issue to be picked up with the CMG. Cancer centre teams phoning skin patients directly to understand issue.
31 Day Subsequent Surgery Treatment (94%)	87.5%	77.0%	June		Agreed with CCG due to pressure on 62 day delivery.
62 Days (85%)	77.6%	78.0%	July		62 Day backlog increasing in LOGI, Lung and Gynae. Urology reducing as per plan. All tumour sites have returned with confidence about return to trajectory.

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
Research UHL	RU1	Median Days from submission to Trust approval (Portfolio)	AF	NB	TBC	TBC	TBC	3.0			2.0			3.0			TO BE UPDATED IN MAY'S Q&P			
	RU2	Median Days from submission to Trust approval (Non Portfolio)	AF	NB	TBC	TBC	TBC	2.0			3.5			2.0						
	RU3	Recruitment to Portfolio Studies	AF	NB	Aspirational target=10920/year (910/month)	TBC	TBC	941	1092	963	1075	1235	900	1039	1048	604				
	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
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 = <90%	92%	93%	94%	93%	91%	90%	101%	101%
	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 = <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 = <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 <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 <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 <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 <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 <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 <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 <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 <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 <100%	100% *Q2	100.0%				100%	100%	100%

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

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-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 = ≤ 98%	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 = ≤ 80%	100.0%	91.5%	81.2%	95.6%	80.5%	86.6%	97.4%	99.5%	99.0%	99.0%
	E&F3	Percentage of Estates Urgent requests achieving rectification time	DK	LT	95%	Contract KPI	Red = ≤ 75%	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 = ≤ 98%	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 = >2	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 = ≤ 95%	95.0%	95.1%	96.2%	97.3%	97.2%	97.2%	98.5%	98.1%	99.0%	99.0%
	E&F7	Percentage of Cleaning audits in clinical areas achieving NCS audit scores for cleaning above 90%	DK	LT	100%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	99.1%	100.0%	100.0%	100.0%	94.4%	96.1%	97.0%	97.0%
	E&F8	Percentage of Cleaning Rapid Response requests achieving rectification time	DK	LT	92%	Contract KPI	Red = ≤ 80%	92.0%	99.6%	89.9%	93.3%	90.5%	91.1%	94.1%	96.9%	95.0%	95.0%
	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 = ≤ 95%	97.0%	99.4%	99.5%	100.0%	100.0%	98.9%	99.9%	100.0%	100.0%	100.0%
	E&F10	Overall percentage score for monthly patients satisfaction survey for catering service	DK	LT	85%	Contract KPI	Red = ≤ 75%	85.0%	96.7%	97.3%	97.3%	96.7%	93.8%	95.8%	97.5%	96.0%	96.0%

S14 Hospital Acquired Pressure Ulcers (Grade 2)

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly)	Latest month performance	YTD performance	Forecast performance for next reporting period
There is an increase in grade 2 pressure ulcers for April. The Trust trajectory was breached by three cases. This month codes have been used to analyse the common causes of avoidable pressure ulcers. The top three causes are Failure to follow all elements of the SSKIN bundle, gaps in repositioning and lack of evaluation of care strategies Failure to follow guidelines and polices Delays in the delivery of pressure ulcer relieving mattresses. In response to this, an action plan has been developed for approval at the Nursing and Midwifery executive . In addition the Head of Safeguarding has requested that through contract review meetings, discussions take place to seek assurance that mattress delivery times meet contractual requirement.	An action plan has been developed for approval at the nursing and midwifery executive An alert has been raised to ensure that the matter of mattress delays is urgently reviewed with medstrom	**7**	**10**	**10**	**To achieve below trajectory target of 7**

Avoidable **Grade 2** Pressure Ulcers

Month	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	14/15	Apr-15
Threshold	9	9	9	9	9	9	9	9	9	9	9	9		7
Incidence	6	6	6	7	9	4	8	13	11	7	5	9	91	10

Expected date to meet standard / target	June 15
Revised date to meet standard	
Lead Director / Lead Officer	Carole Ribbins, Acting Chief Nurse Michael Clayton, Head of Nursing (Safeguarding)

C8 Complaints Re-opened Rate

	Target	Apr 15	Forecast
What is causing underperformance?	<9%	13%	<10%

137 Formal complaints were received in April 2015 and **18 (13%)** were re-opened. The thresholds for an exception are >10% of complaints re-opened 3 months in a row or any month over 15%.

The following table shows the number of re-opened complaints in April '15 by CMG

No. of formal complaints received and re-opened	No. of formal Complaints received	No. of Complaints re-opened	% Re-opened
CMG 1- Cancer, Haematology, Urology, Gastroenterology and Surgery (CHUGGS)	20	2	10%
CMG 2- Renal, Respiratory and Cardiac (RRC)	12	3	25%
CMG 3- Emergency and Specialist Medicine	28	6	21%
CMG 4- Intensive Care, Theatres, Anaesthesia, Pain Management, Sleep (ITAPS)	5	1	20%
CMG 5- Musculoskeletal and Specialist Surgery	28	3	11%
CMG 6- Clinical Support and Imaging	10	3	30%
CMG 7- Women's and Children's	27	0	0
CMG - The Alliance (Community Hospitals) NOT UHL	5	0	0
Estates and Facilities Management Collaborative	1	0	0
Operations Directorate	1	0	0
Totals:	137	18	13%

What actions have been taken to improve performance?

-Continued greater scrutiny of the complaint and response prior to re-opening to establish if anything further can be contributed.
-Complaints lead to review the final responses and re-opened letters of all complaints re-opened in May and consider if there are any themes.

Previous Months performance

	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15
No. of Formal Complaints Received	162	142	157	158	170	137
No. Re-opened	15	13	25	21	18	18
% re-opening	9%	9%	16%	13%	11%	13%

Expected date to meet standard	April 2015
Revised date to meet standard	May 2015
Lead Director	Moira Durbridge, Director of Safety and Risk

W9 Sickness absence

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
1. There has been an increase in sickness absence from July 2014. (Table 1). 2. Sickness absence reporting highlights an adjustment due to late closures. The February has now reduced from 4.17% to 4.07% . 3. UHL has seen a reduction in sickness absence for the third consecutive month and in March to 3.96%. 4. In March all CMG's have seen a reduction in sickness absence. 5. In the last year the Trust has seen an increase in staff taking absence, 'triggers' and long term absences. (Table 2) 6. Feedback from Clinical Management Group and Directorates Leads indicates that the increased sickness absence is due to : a. Increased operational pressures / activity b. Seasonal variations c. Inaccurate data – delays in closing absences d. Management changes / handovers e. Vacancies and other absences reducing management time f. Service pressures delaying sickness absence management	1. Improved data through weekly SMART reports and monthly ESR reports highlighting open absences, closed absences and triggers (3 episodes / more than 10 days / 2 working weeks) 2. Discussion at CMG / Directorate Boards and across services / areas with specific actions confirmed 3. Making it Happen Reviews, to discuss and agree actions for the management and support of open absences, 'triggers' and complex cases with line managers. 4. 6 monthly CMG Sickness Performance Reviews / Case reviews with Occupational Health and Senior and independent HR colleagues. 5. Sickness Absence training for managers and administrators **Further Actions:** 6. Local training is facilitated for CMG's / Directorates in response to specific needs – management of long term absence, documentation etc. 7. Local actions to address high sickness absence include CMG Management Team 'Hot Spot' meetings, Staff Engagement events to reduce sickness absence and improve the management of sickness absence. 8. Improvement plans including timescales are discussed and agreed at CMG / Directorate level to reduce sickness absence and increase performance in the management of sickness absence. 9. Specific staff support and targeted management of stress related absences. 10. Review of the UHL Sickness Absence in comparison with other NHS organisations in the region. From the information available, UHL has set the lowest sickness absence target and has the second lowest sickness absence levels in the region.	**UHL Stretch target 3%** **Previous SHA target 3.4%**	**3.96% (March 2015)**	**3.76% (average)**	**3.70% average (July 2015)**

Table 1: Monthly Trust Performance:

2014 07 % Abs Rate (FTE)	2014 08 % Abs Rate (FTE)	2014 09 % Abs Rate (FTE)	2014 10 % Abs Rate (FTE)	2014 11 % Abs Rate (FTE)	2014 12 % Abs Rate (FTE)	2015 01 % Abs Rate (FTE)	2015 02 % Abs Rate (FTE)	2015 03 % Abs Rate (FTE)	Contracted WTE	Cumulative % Abs Rate (FTE)
3.39%	3.42%	3.68%	3.97%	3.95%	4.42%	4.22%	4.07%	3.96%	10875.5	3.76%

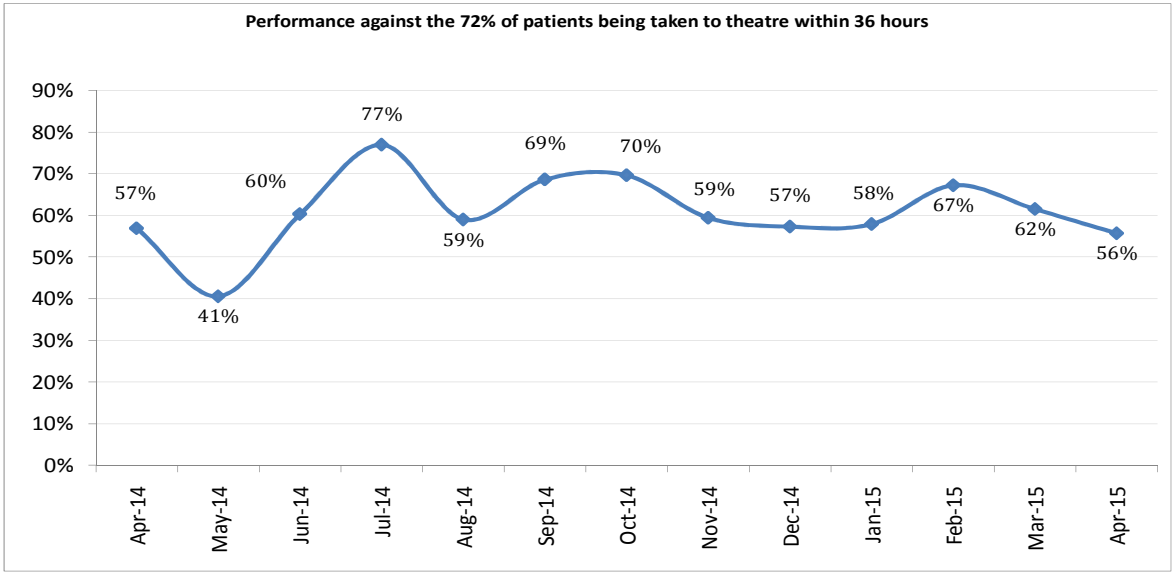
Table 2: Annual performance

March	Staff taking absence %	Staff 'triggering' %	% absences over 28 days
2013	68.7	38.9	7.6
2014	64.5	36.8	8.06
2015	66.6	39.0	8.12

Expected date to meet standard / target	Monthly Target
Revised date to meet standard	April 2016
Lead Director / Lead Officer	Emma Stevens, Acting Director of Human Resources Kalwant Khaira, CMG HR Lead (HR Sickness Absence Lead)

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

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance FY 14/15	Forecast performance for next reporting period
All of the issues set out in previous reports continue in the service and are exacerbated at times of heightened activity. There were 72 admission in April 2015, the main reasons for delay were unfit patients, lack of theatre time due to Spines and lack of theatre time in times of peak admissions The acceptance of out of area elective and emergency spinal work continues to have a detrimental effect on the main trauma capacity as spinal patients are medically prioritised over 'other' trauma which has a knock on effect on #NOF capacity.	An action plan was presented to the CMG board in May which details the work that is currently being scoped and implemented from the various outputs of the LiA and other improvement projects within the specialty. Specific blockers include Theatre List start and finish times, Orthogeriatric capacity and Theatre process delays. The listening into action process continues the themes and detailed actions were published in the action plan presented to the CMG board in April. Work continues within the spinal network with regards to capacity across the region and how UHL fits into the future plans.	72%	55.7%	61.4%	62%



Performance by Quarter

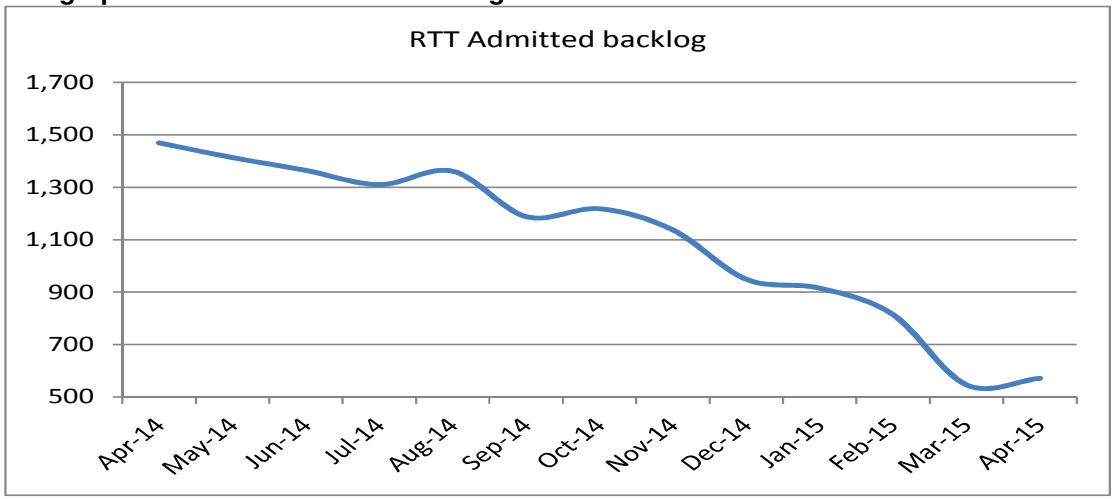
13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4	14/15 FYE
65%	52%	68%	63%	63%	61.4%

Expected date to meet standard / target	December 2014
Revised date to meet standard	Quarter 3 2015/16
Lead Director / Lead Officer	Richard Power, MSS Clinical Director Sarah Taylor, MSS Head of Operations

R3 – RTT Waiting Time - Admitted

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest performance	YTD performance	Forecast performance for next reporting period
The Trust commitment to deliver the admitted standard from May 2015 onwards remains. There is growing confidence that this is achievable based on the improved performance in April and the prospective indicators seen in May. However this is not without its risks due to the level of backlog remaining. The graph opposite illustrates the significant admitted backlog reduction achieved from end October 2014 (1218) to the end of April (571). This has been achieved by additional in house activity and outsourcing to the local independent sector providers. The commitment to ensure that the longest waiters are treated remains our priority. **By key speciality:** • The General Surgery backlog has remained static in the past month. • The Urology backlog has remained static following significant reduction in March 2015. • Paediatric Max Fax and ENT have been hampered by lack of paediatric elective capacity. • In adult ENT, the backlog has increased significantly from March position. • The Paediatric Surgery and urology backlog trend is reducing • The Orthopaedics backlog reduced slightly by 11%, but the specialty remains a significant risk due to the unsustainable non-admitted backlog position.	The Trust is achieving two of the three RTT standards: non-admitted and incompletes performance is compliant. The actions been taken in admitted are clearly the right actions evidenced by the backlog reductions seen in recent months. The revised weekly access meeting is working well as is the predictive ability of ensuring delivery. • General Surgery weekend working continues and specific consultants are being targeted; most patients remaining on the backlog are complex. • Urology continues to use additional in house capacity. • There is additional weekend work across the Paediatric specialities. • There is additional in house activity for ENT. • Additional work in house but also with the local independent sector • Orthopaedics remains a significant risk to the Trust. Weekend working continues, as well as additional outsourcing to the local independent sector.	90% treated within 18 weeks	88% (UHL and Alliance)	88%	90%

The graph below illustrates the backlog reduction at Trust level



Risks to delivery of the admitted 90% standard in May

There are now 2 specialities that continue to pose the greatest risk to delivery of the Trust level admitted standard in May: Orthopaedics (as detailed in previous reports) and ENT (adult and paediatric) due to residual backlog volumes.

Mitigation

ENT and Orthopaedics are both having weekly performance meetings involving the Clinical Director, Head of Service and the Director of Performance and Information.
Additional activity in key specialities is ongoing.
Additional outsourcing of activity in Orthopaedics.

Additional update

There have been a number of patients identified as potentially waiting longer than one year. A paper will be sent to IFPC in May outlining the issue and these patients will start to show in the May position.

Expected date to meet standard / target	May 2015
Lead Director / Lead Officer	W Monaghan, Director of Performance and Information C Carr, Head of Performance

R8-15 Cancer Waiting Times Performance

What is causing underperformance?	What actions have been taken to improve performance?
R8 1) There has been an annualised increase of 18% in 2WW suspected cancer referrals in 2014/15 to date 2) This continues to grow 3) LLR has a conversion rate from referral to cancer diagnosis significantly below the national average, raising concerns around the quality of 2WW referrals **R10, 12** Difficulties in achieving prioritisation of surgical cases in general, although significantly improved. Dermatology capacity issues. **R14, 15** The system for the integration of complex cancer pathways remains in place (**R14, R15**) Access to cancer diagnostics remains good. The delivery of timely treatments (**R10, R12**) lies within the gift of services for surgery, and the oncology department for chemotherapy and radiotherapy. Chemotherapy and radiotherapy treatments have remained timely for the most part. The issue is adequate access to surgical capacity. There is no shortage of overall surgical capacity, the poor performance results from the failure to appropriately prioritise cancer pathways in the face of competing priorities.	**R8** The trust have reliably and consistently delivered rapid processing of referrals and released adequate capacity quickly to meet the 2WW demand consistently for 4 months. Overwhelmingly breaches are due to patient choice. Joint workstreams with the CCGs, requiring their leadership regarding (1) correct process (2) use of appropriate clinical criteria and (3) preparation of patients for urgency of appointments are needed to achieve this standard. An audit of the latter is currently in progress. **R10, 12** Backlog of 31 day cases almost eliminated. Attendance to cancer prioritisation by the services with the support of the cancer centre navigators. **R14, 15** Trajectory for recovery by tumour site agreed with CMGs to deliver recovery of the standard at trust level monthly by month 4 and cumulatively by month 6. Additional administrative appointments to Cancer Centre to support services pulling patients through pathways. Recruitment proceeding. Development of SOP for cancer pathway management between cancer centre and services to commence in June 15. Revised draft shared with HoOps.

Target (mthly / end of year)	Latest month performance March	Performance to date 2014/15	Forecast performance for April
R8 2WW 93%	91.5%	92.2%	91.6%
R10 31 day 1st 96%	97.0%	94.7%	92.7%
R12 31 day sub (Surgery) 94%	87.5%	90.2%	88.6%
R14 62 day RTT 85%	83.7%	80.7%	76.3%
R15 62 screening 90%	89.3%	84.5%	92.1%

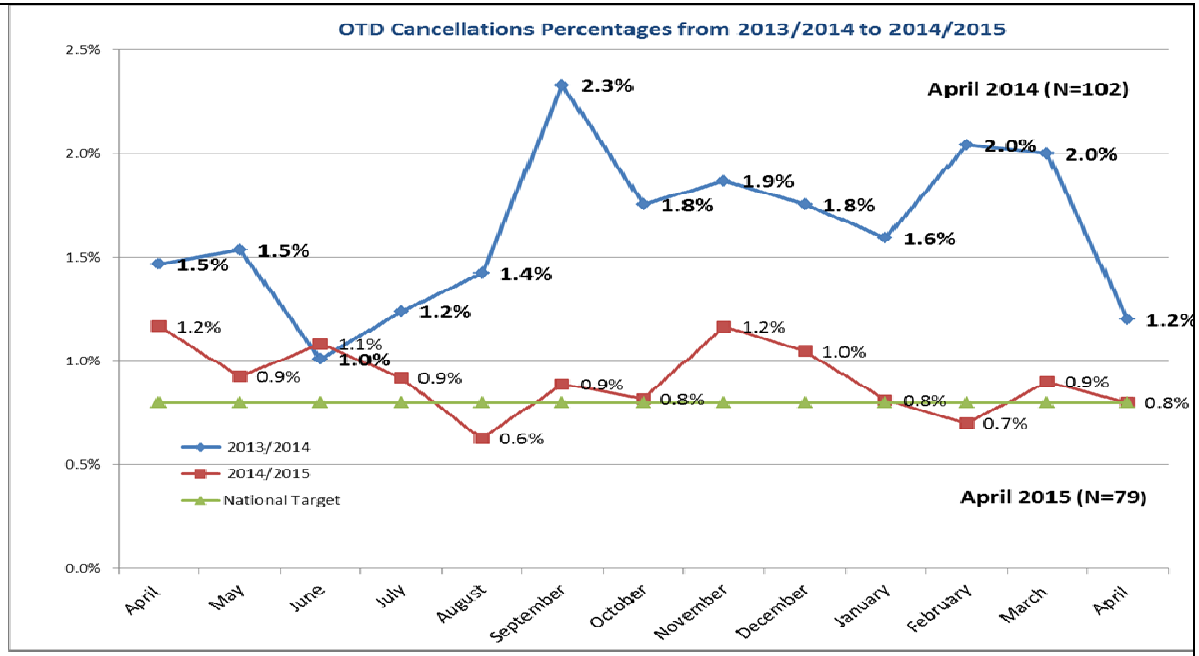
Performance by Quarter

	13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
R8	94.8%	92.2%	91.6%	92.5%	92.3%
R10	98.1%	94.6%	94.6%	94.6%	94.6%
R12	98.2%	94.2%	90.5%	81.5%	89.0%
R14	86.7%	84.1%	79.9%	80.8%	81.4%
R15	95.6%	78%	85%	89.2%	85.4%

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

R17 - Cancelled Operations Not Booked Within 28 days

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 **3**. The number of urgent operations cancelled for a second time.					
What is causing underperformance?	**What actions have been taken to improve performance?**	**Target (monthly)** **1)On day=0.8%** **2) 28 day = 0**	**Latest month performance – March 14**	**YTD performance (inc Alliance)**	**Forecast performance for next reporting period**
For the second consecutive month UHL (without Alliance) OTD cancellations are below the national target (0.7%). Lack of Paediatric ward beds is still an on-going problem and remains a significant risks to OTD performance. Five paediatric patients were cancelled due to paediatric ward bed unavailability in LRI. Fifteen patients were cancelled due to lack of staff unavailability - nine due to surgeons and six due to lack of theatre staff. There were two 28 day breaches from UHL: Both patients were undergoing complex surgery which required specific surgeons. On	A number of work streams have started aimed at reducing OTD cancellations including a LIA project. A successful LIA event was completed with participation of 48 staff in all three sites. Lots of useful feedback and a number of new ideas were provided by the staff to reduce cancellations. The LIA team are working to implement the changes suggested which include changes to the existing escalation policy and actions to minimise the number of list overruns. <u>Risks to delivery of recovery plan</u> The key risk remains failure to escalation of patients at risk of cancellation on the day, following the UHL cancelled escalation policy. For	*1)* 0.8% (0.7%UHL &1.2% Alliance) *2)* 2 *(2-UHL)*	1) 0.9% 2) 20.8ecance 1 ward beds unavaialbility,y .o year before. 191919191919 191919191919 191919191919 191919191919 191919191919 191919191919 191919191919 191919191919 191919191919 191919191919 191919191919 19	1) 0 .8% 2) 2	1) 0.8% 2) 0

both occasions the surgeons were not available to perform the operations within 28 days. In 2014 UHL had 102 (1.2%) OTD cancellations. There were 23 fewer cancellations in April 2015.	those cancelled on the day, it is vital that they adhere to the Trust policy of escalating to CMG Head of Operations for resolution, prior to agreeing any cancellations.		
		Expected date to meet standard / target	April - On the day May – 28 day
		Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Phil Walmsley. Head of Operations, ITAPS

R24 Choose and Book

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 Trust is measured on the % of Appointment Slot Unavailability (ASI) per	**Capacity**	**<4%**	34%	34%	30%

month.

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

The two most significant factors causing underperformance are:

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

The issues are notably: General Surgery and orthopaedics, and ENT

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

Training and education

The comprehensive training and education of relevant staff in key specialties continues, to ensure that choose and book is correctly set up and that supporting administrative purposes are fit for purpose.
A speciality level 'score card' to highlight areas required for improvement is being distributed weekly to CMGs. This highlights areas for concern and actions required.

The Trust has appointed a Choose and Book Administrator and a the new Deputy Head of Performance both started in post on 11th May, They will have a lead role in overseeing the improvement of this standard

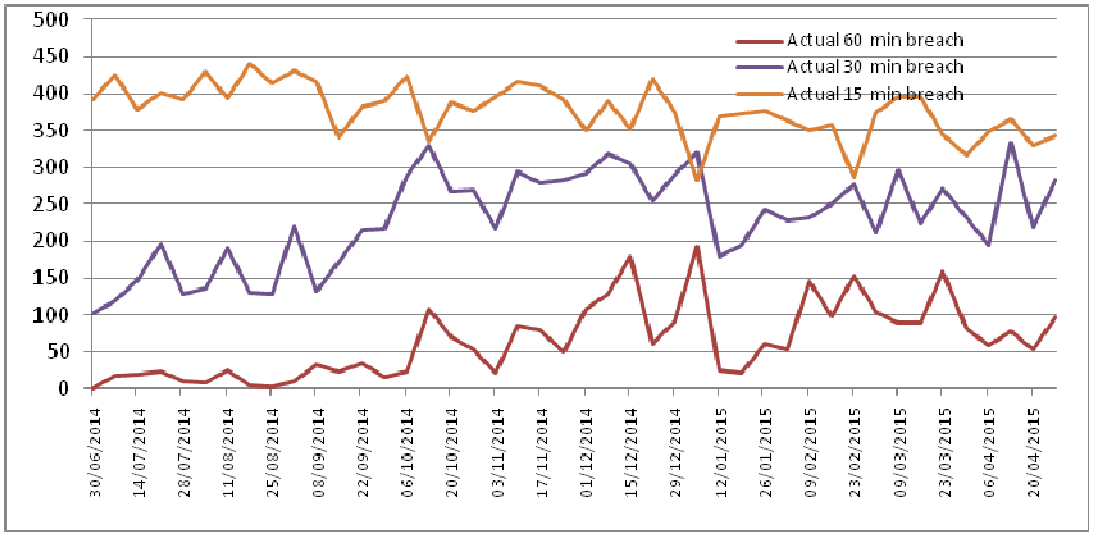
National performance varies significantly by Trust. The table below details performance in April of our peer Trusts. From this it is clear that other organisations are facing the same challenges as UHL.

Peer acute Trusts	Monthly volumes of bookings	% of slot issue
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	2539	7%
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	4232	31%
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	7391	9%
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	7627	9%
HEART OF ENGLAND NHS FOUNDATION TRUST	5364	10%
OXFORD UNIVERSITY HOSPITALS NHS TRUST	6028	10%
HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	4916	19%
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	9921	21%
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	2636	24%
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	4340	25%
CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	5922	26%
PENNINE ACUTE HOSPITALS NHS TRUST	10268	29%
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	3734	29%
BARTS HEALTH NHS TRUST	6777	31%
LEEDS TEACHING HOSPITALS NHS TRUST	5534	31%
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	9785	34%
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	4322	37%
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	5222	53%

Expected date to meet standard / target	To be confirmed
Revised date to meet standard	Yet to be confirmed
Lead Director / Lead Officer	Will Monaghan, Director of Performance and Information Charlie Carr, Head of Performance

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

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
Difficulties in accessing in-patient beds leads to delays in patient	The CAD+ system has been demonstrated to ED via screen shots and	0 delays over 30 minutes	> 60 min 6.2% 30-60 min – 22.3% 15-30 min – 30%	> 60 min 3.2% 30-60 min – 22.3% 15-30 min – 30%	

movement out of the ED. This delays movement out of the ED assessment area and therefore, delays handover. March's performance remained similar to the preceding months. It should be noted that the average, weekly attendances in April were very similar to ambulance attendances in March	equipment ordered for implementation. EMAS and UHL have discussed places for the equipment to be stored to enable easy access for use. Information sharing document is completed by UHL. The Training package is available once the equipment is ready for use in the Assessment Bay.	

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

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

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
Proportion of commercial contract studies achieving their recruitment target during their planned recruitment period	1. Recovery plan produced identifying the divisions (1,2 & 5) with high volume and low performance	80%	47%	53%	53%

East Midlands is currently 11th of the 15 LCRNs for this metric with no LCRN currently achieving the 80% target, highest is currently 71% and lowest 47% Historic targets set in a previous structure where this measure was not applicable, of the 127 closed studies for this measure only 6 entered the system after 1st April 2014 A lot of variables impact on recruitment achieved, after the recruitment target is set, for example: ● Impact of global performance and earlier end dates giving less time to recruit ● Changes in UK practice during set up/ recruitment ● Protocol changes prior to initiation ● Understanding of targets and alignment on the source of the target sites are measured on	and prioritised 2 weekly meetings with Research Delivery Managers to improve performance 2. Collation of local information to report on the actual performance figure for 2014/15, this data gives a figure of 62% 3. Implementation of a performance management process involving the Industry Team and Delivery Managers to escalate studies not recruiting to target within 24 hours and to align targets. 4. Meetings with key research teams to discuss the importance of target setting and aligning the approach across the region so the target is reflective of the contract figure. 5. Escalation to national team highlighting numerous discrepancies in the report and inconsistencies as a national level that has lead to a review. Lack of confidence in the figure of 53%. 6. Contacting sponsors direct to analyse the reasons for under-performance.	**Expected date to meet standard / target**	May 2015
		Revised date to meet standard	May 2016
		Lead Director / Lead Officer	Daniel Kumar, Industry Delivery Manager, CRN: East Midlands

RS6A : Proportion of NHS Trusts recruiting each year into non-commercial NIHR CRN Portfolio studies

What is causing under performance?	What actions have been taken to improve performance?	Target (monthly / end of year)	Latest month performance	Year To Date performance	Forecast performance for next reporting period
Proportion of NHS Trusts recruiting each year into non-commercial NIHR CRN Portfolio studies	1. EMAS: have received funding in 2014/15 for a Research Paramedic. This post currently supports two NIHR Portfolio studies that do	99%	94% (red)	94% (red)	<94%

The NIHR Clinical Research Network has an HLO with the Department of Health for 99% of Trusts in England to recruit to CRN Portfolio research each year. This has been passed down to local research networks. There are 16 Trusts within the East Midlands region, with 15 Trusts currently reporting recruitment. The one who has not reported any recruitment is: • East Midlands Ambulance Service NHS Trust (EMAS)	not report recruitment in the traditional way due to patient assent taken rather than consent. EMAS have four studies in the pipeline that are due to open in 2015/16 including the AIRWAYS 2 study. Therefore it is unlikely that EMAS will report any recruitment before April 2015.	Expected date to meet standard / target	This target has not be met in 2014/15.
		Revised date to meet standard	
		Lead Director / Lead Officer	Elizabeth Moss, Chief Operating Officer CRN: East Midlands

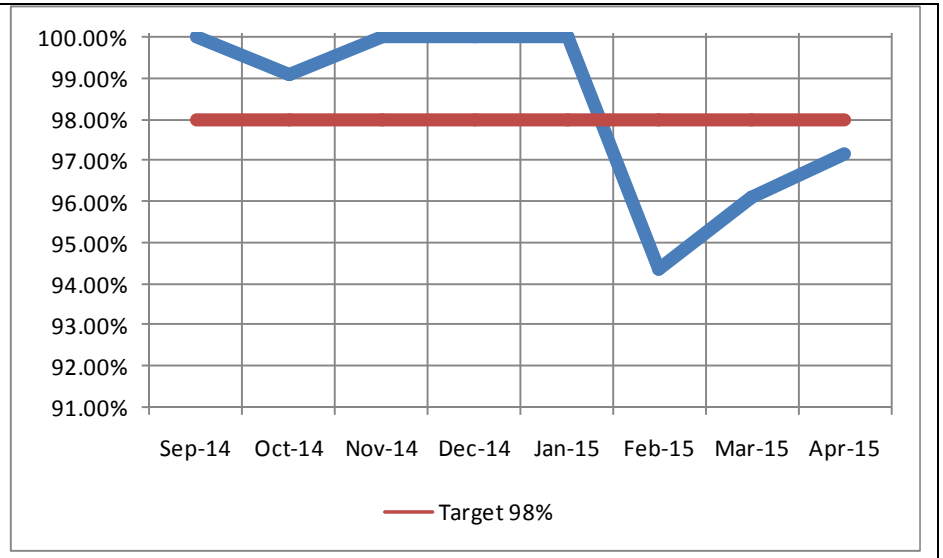
RS6b Proportion of NHS Trusts recruiting each year into commercial NIHR CRN Portfolio studies

What is causing underperformance?	What actions have been taken to improve performance?	Target (monthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
Proportion of NHS Trusts recruiting each year into commercial NIHR CRN Portfolio studies	1. **EMAS**: Currently no open commercial studies nationally run by ambulance services on the NIHR portfolio, therefore unlikely that EMAS will open a commercial	70%	56% (red)	56% (red)	56%

There are 16 Trusts within the East Midlands region, with 9 Trusts currently recruiting to commercial studies. The seven who have not reported any recruitment are: ● East Midlands Ambulance Service NHS Trust (EMAS) ● Derbyshire Community Health Services NHS Foundation Trust (DCHS) ● Lincolnshire Community Health Services (LCHS) ● Leicestershire Partnership NHS Trust (LePT) ● Lincolnshire Partnership NHS Trust (LiPT) ● Nottinghamshire Healthcare NHS Foundation Trust (NHFT) ● Derbyshire Healthcare NHS Foundation Trust (DHFT)	study this financial year. Industry team currently reviewing studies previously run at other ambulance services across the country to gain insight. Met and sent potential examples to review 2. **DCHS**: Due to the nature of research within this Trust, they are unlikely to be involved in commercial research, Have met with Trust and a preliminary plan is in place to take this forward. 3. **LCHS**: Due to the nature of research within this Trust, they are unlikely to be involved in commercial research. Met on the 18th December and a preliminary plan is in place to take this forward. 4. **LePT**: Selected for one study,logistics being explored but study now suspended globally 5. **LiPT**: Have been involved in commercial research in the past and the site is actively seeking commercial opportunities. One sponsor in touch looking to take a study forward. 6. **NHFT**: One trial initiated at the end of November 2014, 2nd UK site to open no recruits to date as study now suspended globally but did have recruits lined up. One further site selection visit completed in March 2015 and site now selected 7. **DHFT**: 2 potential studies in the pipeline. One had site selection visit in February 2015 awaiting confirmation if selected.		
		Expected date to meet standard / target	July 2015
		Revised date to meet standard	September 2015
		Lead Director / Lead Officer	Daniel Kumar, Industry Delivery Manager, CRN: East Midlands

E&F 7- 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
Percentage of audits in clinical areas	The current review of cleaning rosters and tasks	100%	97%	98%	100%

achieving NCS audit scores for cleaning above 90%. Feb 15 – 94% Mar 15 - 96% Apr 15 – 98% 7 Audits failed to achieve the required standard in the following areas LRI: Balmoral - A&E Minors LRI: Balmoral - A&E Children's LRI: Balmoral - A&E Reus LRI: Balmoral - A&E Majors LRI: Windsor Building - Ward 30 LRI: Kensington Building - Ward 5 Glenfield – PICU Under the current Management of Change process, there is potential impact that may be felt from staff consultation that is underway, however we are actively managing this process to limit impact on morale.	across the Acute Estate is underway and this process alongside investment in equipment will support cleaning standards within the UHL. This review and changes have been documented and shared with the EFMC.	

Expected date to meet standard / target	June 30th 2015
Revised date to meet standard	July 31st 2015
Lead Director / Lead Officer	Darryn Kerr, Director of Estates and Facilities Mike Hotson,

CQC – Intelligent Monitoring Report

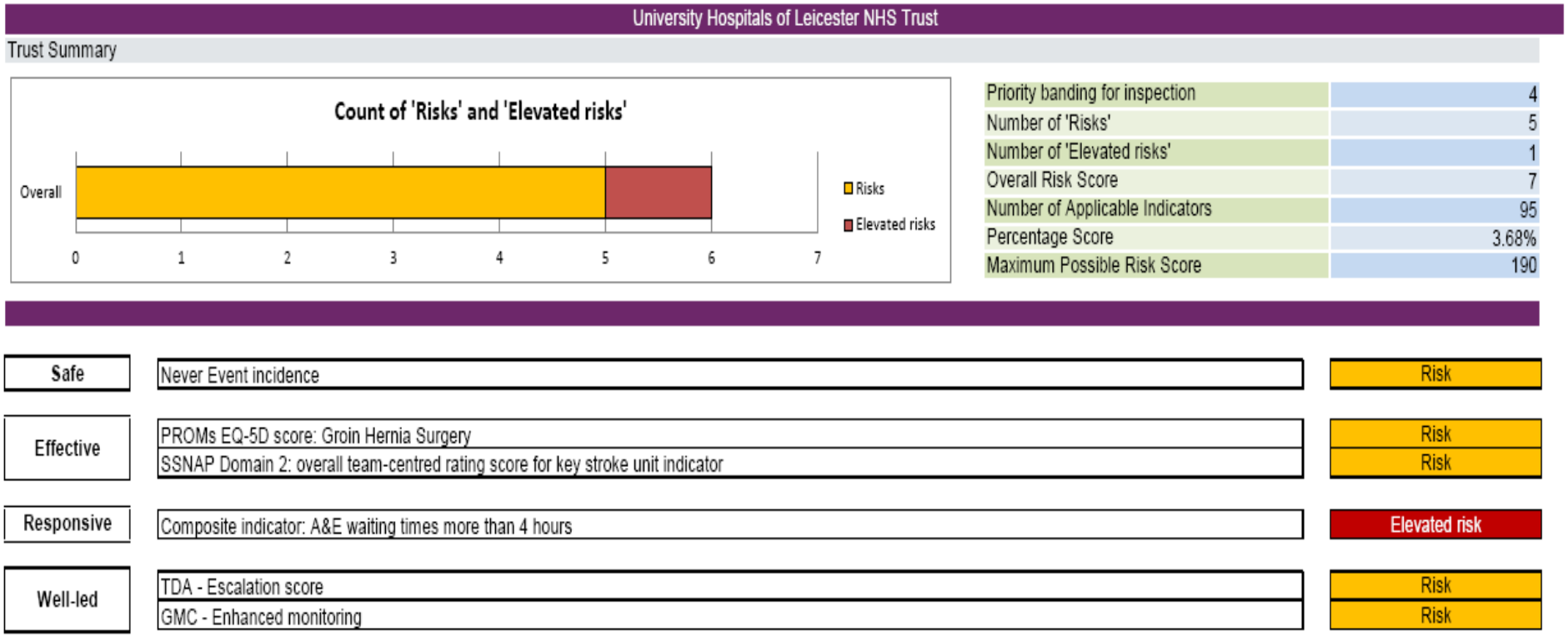
The latest CQC Intelligent Monitoring Report (IMR) was published on the CQC website on the 29th May 2015.

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’



CQC Indicator	Risk Level in latest IMR	UHL Response	Response by
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.	William Monaghan, Director of Performance and Information
Never Event incidence (01-	Risk	There were 4 Never Events escalated during this period, these were:	Claire Rudkin, Senior

Feb-14 to 31-Jan-15	(New risk since last report)	• 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.	Patient Safety Manager
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.	Rebecca Broughton, Head of Outcomes and Effectiveness
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.	Rachel Marsh - Consultant
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.	Stephen Ward, Director of Corporate & Legal Affairs
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.	Sue Carr, Consultant Nephrologist

Quality Schedule and CQUIN Schemes – Quarter 4 Performance and RAG ratings

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG	Commentary
	QUALITY SCHEDULE					
PS01	Infection Prevention and Control Reduction. - C Diff	G	A	A	A	Amber RAGs for Q2-4 due to not providing sufficient information as to actions being taken where CMG IPP self-assessments Amber. IP reviews to be undertaken as part of CMG Quality Performance Review meetings and monthly summary to be included in TIPAC report to EQB. C Diff. threshold achieved with 73 reported cases for 14/15 which is below the NTDA trajectory (81) but above UHL's own threshold.
PS02	HCAI Monitoring - MRSA	0	1	3	2	1 'avoidable' Bacteraemia in February and 1 'unavoidable' in March Thematic review undertaken of MRSA PIRs carried out in 14/15 and actions agreed for 15/16.
PS03	Patient Safety – SIs, Never Events	G	G	2 G	1 (Jan) tbc	Q3 & Q4 Red RAG for Never Events. (relating to 'wrong sized hip prosthesis, retained Swab ties and wrong site surgery) Number of incidents reported continues to rise. But there has been a reduction in number that resulted harm. Due for review at the June CQRG - Green RAG anticipated
PS04	Duty of Candour	0	0	0	0	No breaches during 14/15.
PS05	Complaints and user feedback Management (excluding patient surveys).	A	A	G	tbc	Complaints responses performance improved and achieved for December. Commissioners noted improvement made with response times in Q3 and Green RAG given. Improved performance sustained in Q4. Due for review at the June CQRG - Green RAG anticipated
PS06	Risk Assurance and CAS Alerts	A	A	G	G 1	All risks scoring 15 or above have been reviewed within their required timeframe and have up to date action plans. Red RAG relates to the one NPSA alert which will be considered as being a breach due to a delay in response of confirmation that all actions had been taken. CMG CAS Alert process revised.
PS07	Safeguarding – Adults and Children	G	G	G	tbc	Assurance documentation sent to CCG Safeguarding leads for their review ahead of their observational visit to the Trust. Green RAG to be agreed upon confirmation that WRAP3 training put on hold at request of Regional PREVENT co-ordinator.
PS08	Reduction in Pressure Ulcer incidence.	G	G	R (Nov & Dec)	R (Feb & Mar)	Monthly thresholds met for G2 HAPUs during Q4. Above the monthly trajectory of 7 for Grade 3 HAPUs in Feb following further validation (9). Grade 4 HAPU identified for March – related to use of Anti-embolic stockings.
PS09	Medicines Management Optimisation	A	G	A	A	Commissioners noted improvement in Controlled Drugs audit report and also Medicines Code but thresholds not fully achieved. LLR Medicines Optimisation Strategy development behind schedule and Medicines Reconciliation below agreed threshold. UHL Medicines Optimisation Strategy being developed in 15/16 and increased pharmacy input agreed for assessment areas which will improve medicines reconciliation performance.
PS10	Medication Errors	G	G	G	G	Increased reporting of errors and actions being taken to reduce harm.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG	Commentary
PS11	Venous Thromboembolism (VTE) and RCAs of Hospital Acquired Thrombosis	95.7%	96.1%	95.2%	96.1% tbc	RCAs in progress for Hospital Acquired Thrombosis. Q4 RAG dependent upon achievement of 100% threshold . Green RAG anticipated for RCA aspect of indicator – to be reported to the June CQRG
PS12	Nutrition and Hydration	G	>80%	>85%	>83%	Work programme on track for nutrition, some delays with hydration actions. 90% threshold for Nutrition Assessment not achieved for any month in Quarter 4 in ESM and therefore overall Amber RAG. Additional support and education programme being provided for ESM wards.
PE1	Same Sex Accommodation Compliance and Annual Estates Monitoring	2	0	2	1 (Jan)	Jan breach relates to patient on HDU at Glenfield. No breaches reported for Feb or March.
PE2	Patient Experience, Equality and Listening to and Learning from Feedback.	G	G	G	G	Good progress made with triangulation of data. Waiting time main area for improvement.
PE3	Improving Patient Experience of Hospital Care (NPS)	N/A	N/A	N/A	tbc	Not due to be reported nationally until Sept 15. RAG dependent upon results in the National Patient Survey.
PE4	Equality and Human Rights	G	G	G	G	Progress reported to the September CQRG with further information provided in October – relating to actions being taken to capture BME data
CE01	Communication – Content (ED, Discharge & Outpatient, District/Practice Nurse Letters)	A	A	A	A	Clinical Problem Solving Group held to agree key priorities. Letters policy launched end Jan 15. Improvements made to DN and PN letters. Amber RAG as audit not completed for ED letters so unable to demonstrate improved compliance with Letter standards. 15/16 work programme to include audits of all types of letters.
CE02	Intra-operative Fluid Management	G	>80%	<80%	79%	Performance deteriorated during Oct/Nov. Performance below 80% standard for Q4. Remedial actions in place to maintain and performance being monitored by the ITAPS Q&S Board.
CE03	Clinical Effectiveness Assurance – NICE and Clinical Audit	A	A	G	A	Confirmation of compliance statements for NICE Clinical Guideline / Quality Standards documents behind schedule due to delays in dissemination of guidance requests for responses (resulting from staff sickness). Temporary staff in place to address backlog. Actions being taken where audits behind schedule
CE04	Women's Service Dashboard	A	A	A	A	Amber RAG for Q2 relates to increase in C Section Rate. Q3 Amber RAG due to not achieving internal thresholds for Medical Staff Core Skills Training and C Section Rate. Q4 Amber RAG relates to continued increases in Em C Section Rates, Core Skills Training.
CE05	Children's Service Dashboard	A	A	A	A	Q2 Amber RAG relates to SpR training Q3 and Q4 Amber RAGs due to non-achievement of internal thresholds for SpR training and Management plans within 2 hours on the assessment unit. Data issues believed to be contributing to performance figures. CMG taking action to address.
CE06	Patient Reported and Clinical Outcomes (PROMs and Everyone Counts)	A	A	G	tbc	Performance to be reviewed at the June CQRG. Groin Hernia PROMs improved, although still below the national average. Varicose Vein and Hip/Knee Replacement PROMS better or same as national. Consultant Outcomes published and all consultants in line with national average.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG	Commentary
CE07	#NOF - Dashboard	51%	67.9%	62.1%	62.2%	72% threshold not met for any month in Q4. Mainly relates to peaks in activity and spinal patients. Improvement in February ((62.7%) from 57.9% in Jan. L*i*A programme in place and business case submitted to support increased theatre capacity.
CE08a	Stroke Monitoring	G	G	72% Avge tbc	tbc	Improvements made for Stroke Care indicators (time to Scan, admission to stroke unit, thrombolysis) and 90% stay threshold achieved all 3 months of Q4. Performance to be reviewed at the June CQRG.
CE08b	TIA monitoring	76%	67%	73.4%	74%	Threshold exceeded for high risk patients and performance improved for low risk patients being seen within 7 days.
CE09	Mortality (SHMI, HSMR)	A	A	A	A	Latest published SHMI = 103 and is slowly reducing but is still above 100 (albeit within expected**)** Reducing mortality continues as a Quality Commitment work stream in 15/16.
CE10	Making Every Contact Count (MECC)	A	G	G	tbc	Referrals to STOP and ALW continue. Commissioners noted all the Staff Wellbeing initiatives in Q3. Performance to be reviewed at the June CQRG.
AS01	Cost Improvement Programme (CIP) Assurance	A	G	G	A	Amber RAG due to not providing sufficient information about Quality Impact Assessments being undertaken of Cost Improvement Programmes, on an on-going basis. New process agreed for 15/16.
AS02	Ward Healthcheck (Nursing Establishment, Clinical Measures Scorecard)	G	G	G	G	Recruitment of additional nurses continues. Not all wards meeting 'Nurse to bed Ratio' but actions in place. Support being provided to those wards not meeting thresholds in the Clinical Measures Scorecard.
AS03	Staffing governance	A	A	A	A	Internal thresholds not met for Appraisal, Sickness and Corporate Induction or Turnover although improvement noticed. Reviews of internal thresholds for 15/16. Medical Staffing Strategy submitted.
AS04	Involving employees in improving standards of care. (Whistleblowing)	G	G	G	G	Actions taken to address concerns raised.
AS05	Staff Satisfaction	G	G	G	A	Work undertaken through the L*i*A process noted but no improvement in overarching National Staff Survey score.
AS06	External Visits and Commissioner Quality Visits	G	G	G	G	Actions in response to Reviews being taken.
AS07	CQC Registration	A	G	A	A	2 Actions in response to CQC visit findings behind schedule – remedial actions being taken.
	NATIONAL CQUINS					
Nat 1.1a	F&FT 1a - Staff	G	G	G	G	Implemented during Q1/2
Nat 1.1b	F&FT 1b - OutPt& Day Case	G	G	G	G	F&FT already happening in Day Case and has started in Outpatients.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG	Commentary
Nat 1.2	F&FT 1.2 - Increased participation - ED	16.%	15.1%	16.2%	22.8% (Avge)	20% Q4 threshold achieved to date
Nat 1.3	F&FT 1.3 - Inpt increase in March	35.8%	31%	34.7%	44.8% (Mar)	Both the Q4 30% threshold and also the 40% threshold for March 15 achieved.
Nat 2.1	ST 2.1 - ST data submission	G	G	G	G	Data collection continues for all 4 harms.
Nat 2.2	ST 2.2 - LLR strategy	G	G	G	A	UHL contributing to the LLR Pressure Ulcer group and work-streams but some delays in completion of agreed actions relating to publicity campaign and data collection where patients admitted from nursing homes.
Nat 3.1	Dementia 3.1 - FAIR	G	G	G	G	90% thresholds met for all parts of the Dementia FAIR CQUIN.
Nat 3.2	Dementia 3.2 - Training & Leadership	G	N/A	N/A	A	Nicky Morgan is new Clinical Lead Dementia Training Programme reviewed and revised. Q4 RAG Amber due to non-achievement of threshold for medical staff training. Improvements noted by Commissioners and that threshold achieved for all other staff groups
Nat 3.3	Dementia 3.3 - Carers	G	G	G	G	Surveys carried out and evidence of actions being taken
	LOCAL CQUINS					
Loc 1	Urgent Care 1 (Discharge)	G	G	G	tbc	Increase in % of patients being discharged in the morning not achieved. Q4 RAG dependent upon Commissioners accepting improvement as being further reductions in length of stay and increased numbers of discharges.
Loc 2	Urgent Care 2 (Consultant Assessment)	G	G	A	tbc	Q4 audit still in progress. Delayed due to staff sickness and challenges in accessing case notes. Unlikely to achieve the 75% threshold across all areas.
Loc 3	Improving End of Life Care (AMBER)	G	G	G	G	
Loc 4	Quality Mark	G	G	G	A	Quality Mark achieved for 6 out of the 8 wards to date. Although remaining 2 wards on track to achieve the QM, this will be outside the agreed timescale for Q4.
Loc 5	Pneumonia	A	G	G	G	Q3 threshold achieved for all aspects of CQUIN scheme and work continues to achieve end of year thresholds. Q4 data to be validated but good progress made in all aspects and therefore Green RAG predicted
Loc 6	Think Glucose	G	G	G	tbc	30 areas now been through the Think Glucose programme. RAG to be confirmed upon review of 'Day of Surgery Admission' data.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG	Commentary
Loc 7	Sepsis Care pathway	≥47%	≥60%	<65%	5/6 >75%	Not all 6 aspects of the Sepsis6 Care Bundle thresholds achieved in Q3 or Q4 but good progress made with all other aspects and improvements seen in outcomes.. Continues as a Quality Commitment and National CQUIN for 15/16.
Loc 8	Heart Failure	≥49.5 %	≥63%	≥65%	>75%	Q4 threshold achieved.
Loc 9	Medication Safety Thermometer	G	G	G	G	All wards submitting data.
	SPECIALISED CQUINS*					
SS1	National Quality Dashboards	G	G	G	G	Dashboards now open for data submission at end of Q3
SS2	Breast Feeding in Neonates	61%	66%	55%	65%	Q4 threshold achieved.
SS3	Clinical Utilisation Review of Critical Care	N/A*	G	G	G	CCMDS and ICNARC data now being collected for all satellite HDUs.
SS4	Acuity Recording	N/A*	G	G	G	Acuity recording in place for all areas. Q4 RAG dependent upon being able to demonstrate effective use of Acuity data.
SS5	Critical Care Standards - Discharge	N/A*	G	G	G	Reduction in delays but increase in out of hours transfers during December – related to increased activity in Critical Care.
SS6	Critical Care Outreach Team 'time to response'	N/A*	G	G	G	Improvements made with recording of time from 'referral to review' for the outreach team.
SS7	Consultant Assessment	G	G	A	tbc	Links to the CCG CQUIN.
SS8	Highly Specialised Services Collaborative Workshop	G	G	G	G	Both ECMO and PCO participating in the national collaborative workshop.