University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper G

TRUST BOARD – 5th FEBRUARY 2015

QUALITY AND PERFORMANCE REPORT – DECEMBER 2014

DIRECTOR:	Rachel Overfield, Chief Nurse Kevin Harris, Medical Director Richard Mitchell, Chief Operating Officer Emma Stevens, Acting Director of Human Resources
AUTHOR:	
DATE:	5th February 2015
PURPOSE:	The following report provides an overview of the December 2014 Quality & Performance report highlighting NTDA/UHL key metrics and escalation reports where required. **For the first time it includes a CEO summary of key issues.**
PREVIOUSLY CONSIDERED BY:	**Integrated Finance, Performance and Investment Committee** **Quality Assurance Committee**
Objective(s) to which issue relates *	[X] 1. Safe, high quality, patient-centred healthcare [X] 2. An effective, joined up emergency care system [X] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [X] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [X] 5. Enhanced reputation in research, innovation and clinical education [X] 6. Delivering services through a caring, professional, passionate and valued workforce [X] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	
Organisational Risk Register/ Board Assurance Framework *	[X] **Organisational Risk Register** [X] **Board Assurance Framework** [ ] **Not Featured**
ACTION REQUIRED *	For decision [ ] For assurance [X] For information [ ]

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

CHIEF EXECUTIVE'S ISSUES TO HIGHLIGHT REPORT

There are a large number of exception reports this month. These are automatically triggered when pre-set thresholds are met. The issues that I wish to particularly highlight/comment on for December are as follows:

Clostridium Difficile (p 10)
For the first time this year, in December we were above our monthly trajectory for both our national and local stretch targets, although we remain within the yearly trajectory for the former. Although this slight deterioration may be related to bed pressures, concern has also been raised about cleaning standards, and in particular the arrangements in place to audit these. As a result these arrangements are to be revised.

Never Events (p 12)
There have been two never events, both related to surgical errors and apparently as a result of failure to adhere to established procedures. I would expect there to be forensic follow up of these events at both EQB and QAC, so as to minimise the chances of a recurrence.

Pressure Ulcers (p15)
It is very regrettable that there was an avoidable grade 4 ulcer in December as well as an increase in avoidable grade 2 ulcers. The former is subject to a full investigation by the Chief Nurse. The latter is most likely due to severe bed pressures in month and the resulting difficulties with maintaining appropriate staffing levels on our wards.

Fractured Neck of Femur (p21)
It is disappointing that we are not seeing any improvement in this key quality metric. This pathway is now the subject of a Listening into Action team approach and I will be watching closely to see if this manages to make progress where other approaches have not.

RTT Admitted (p23)
It will be seen that there was a further improvement in month to 86.8% (standard 90%). However, detailed analysis by our new Director of Performance and Information indicates that we are unlikely to reach the standard until April. The exception report gives more detail on this. Note that this trajectory is subject to further discussions with commissioners. Note also that we remain well above the incomplete (backlog) standard, indicating that we are appropriately managing our waiting lists in accordance with the rules.

Diagnostic waits (p25)
Performance was very disappointing at 2.2%. This figure was inflated by the failure of our single DEXA scanner. We are seeking to identify contingency arrangements to stop this happening again.

Cancer (p 26)
We are showing little sign of improvement in the key headline indicators. I have reinforced to CMGs the crucial importance of prioritising cancer patients, although to be fair there were significant numbers of cancelled cancer operations in December due to operational pressures. Improving this area is a key priority for our new Director of Performance.

Ambulance turnaround (p 30)
I am pleased to report that we have reached agreement with EMAS and our CCGs to introduce a new method for recording handover times from 1st April. This will eliminate the acknowledged deficiencies of the current recording system (which inflates the figures) and allow us to focus on reducing the delays themselves.

ED 4 Hour performance
There is no exception report for this standard as it the subject of a fuller report direct to the Board. However, for completeness, December was an exceptionally poor month, with performance at 83.1%, reflecting a major deterioration across the country. January to date (to 22/1) has been somewhat better at 88.6%, with the last 7 days very much better at 97.2%.

John Adler
Chief Executive

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

December 2014

One team shared values

CONTENTS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **5th FEBRUARY 2015**

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

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

1.0 Introduction

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

2.0 Performance Summary

Domain	Page Number	Number of Indicators	Indicators with target to be confirmed	Number of Red Indicators this month
Safe	3	19	2	8
Caring	4	15	1	1
Well Led	5	14	7	1
Effective	6	17	0	2
Responsive	7	26	0	13
Research	8	13	0	3
Estates & Facilities	9	10	0	0
Total		114	10	28

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	YTD
Safe	S1a	Clostridium Difficile	RO	DJ	FYE = 81	NTDA	Red / ER for Non compliance with cumulative target	66	5	10	0	4	4	6	5	7	2	5	7	7	9	52
	S1b	Clostridium Difficile (Local Target)	RO	DJ	FYE = 50	UHL	Red >5 per month, ER when YTD red	66	5	10	0	4	4	6	5	7	2	5	7	7	9	52
	S2a	MRSA Bacteraemias (All)	RO	DJ	0	NTDA	Red = >0 ER = 2 consecutive mths >0	3	0	0	0	0	0	0	0	0	0	1	1	0	2	4
	S2b	MRSA Bacteraemias (Avoidable)	RO	DJ	0	UHL	Red = >0 ER = 2 consecutive mths >0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	S3	Never Events	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	3	0	0	1	0	0	0	0	0	0	0	1	0	1	2
	S4	Serious Incidents	RO	MD	tbc	NTDA	tbc	60	4	3	4	5	4	6	3	7	2	3	4	2	4	35
	S5	Proportion of reported safety incidents that are harmful	RO	MD	tbc	NTDA	tbc	2.8%		2.3%			1.7%			2.2%						1.9%
	S6	Overdue CAS alerts	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	2	0	0	0	0	2	2	2	3	0	0	0	0	0	9
	S7	RIDDOR - Serious Staff Injuries	RO	MD	FYE = <47	UHL	Red / ER = non compliance with cumulative target	47	4	7	2	5	3	5	1	2	2	1	2	2	1	19
	S8	Safety Thermometer % of harm free care (all)	RO	EM	tbc	NTDA	Red = <92% ER = in mth <92%	93.6%	94.0%	93.8%	94.8%	93.6%	94.6%	94.7%	94.2%	94.9%	94.4%	93.9%	94.9%	93.3%	94.1%	94.3%
	S9	% of all adults who have had VTE risk assessment on adm to hosp	KH	SH	95% or above	NTDA	Red = <95% ER = in mth <95%	95.3%	96.1%	95.6%	95.0%	95.6%	95.7%	95.9%	95.9%	96.3%	95.5%	96.2%	95.4%	95.5%	94.7% (TBC)	95.7%
	S10	Medication errors causing serious harm	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	New NTDA Indicator - Definition to be confirmed														
	S11	All falls reported per 1000 bed stays for patients >65years	RO	EM	<7.1	QC	Red >= YTD >8.4 ER = 2 consecutive reds	7.1	7.0	6.6	7.0	6.9	6.6	7.4	7.0	8.2	7.4	5.6	5.6	6.6	9.1	7.1
	S12	Avoidable Pressure Ulcers - Grade 4	RO	EM	0	QS	Red / ER = Non compliance with monthly target	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
	S13	Avoidable Pressure Ulcers - Grade 3	RO	EM	<8 a month	QS	Red / ER = Non compliance with monthly target	71	5	7	3	6	5	5	5	5	6	6	4	6	7	49
	S14	Avoidable Pressure Ulcers - Grade 2	RO	EM	<10 a month	QS	Red / ER = Non compliance with monthly target	120	5	10	8	9	6	6	6	7	9	4	8	13	11	70
	S15	Compliance with the SEPSIS6 Care Bundle	RO	MD	All 6 >75% by Q4	QC	Red/ER = Non compliance with Quarterly target	27.0%		27.0%			47.0%			>=60%			Audit underway			47.0%
	S16	Nutrition and Hydration Metrics - Fluid Balance and Nutritional Assessment	RO	MD	Q2 80%, Q3 85%, Q4 90%	QC	Red >2% below threshold ER = 2 mths red						≥71%	≥77%	≥75%	Action Planning	≥74%	≥85%	≥84%	≥88%		≥88%
	S17	Maternal Deaths	KH	IS	0	UHL	Red / ER = Non compliance with monthly target	3	0	1	2	0	0	0	0	0	0	0	0	0	0	0

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	YTD
Caring	C1a	Inpatient Friends and Family Test - Score	RO	CR	72 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	68.8	68.7	71.8	69.0	69.9	69.6	71.0	74.5	73.8	73.8	76.1	71.1	70.3	72.1	72.4
	C1b	Inpatient Friends and Family Test - Score (Local Target)	RO	CR	75	UHL	Red/ ER =<=69.9 Green >74.9	68.8	68.7	71.8	69.0	69.9	69.6	71.0	74.5	73.8	73.8	76.1	71.1	70.3	72.1	72.4
	C2a	A&E Friends and Family Test - Score	RO	CR	54 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	58.5	67.4	67.6	58.7	65.5	69.4	66.0	71.4	71.7	56.3	66.1	71.1	72.3	72.8	68.3
	C2b	A&E Friends and Family Test - Score (Local Target)	RO	CR	75	UHL	Red/ ER =<=64.9 Green >74.9	58.5	67.4	67.6	58.7	65.5	69.4	66.0	71.4	71.7	56.3	66.1	71.1	72.3	72.8	68.3
	C3	Outpatients Friends and Family Test - Score	RO	CR	75	UHL	Red / ER =<=64.9	New Indicator												58.7	63.8	61.3
	C4	Daycase Friends and Family Test - Score	RO	CR	75	UHL	Red / ER =<=69.9	New Indicator					79.0	80.2	79.7	77.5	74.3	81.7	80.1	80.9	74.9	78.7
	C5	Maternity Friends and Family Test - Score	RO	CR	75	UHL	Red/ ER =<=61.9	64.3	63.7	67.3	62.1	66.7	61.2	63.5	69.5	69.7	67.3	63.0	64.1	67.7	63.8	65.6
	C6	Complaints Rate per 100 bed days	RO	MD	tbc	NTDA	tbc		0.3	0.3	0.5	0.4	0.4	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.3	0.4
	C7	Complaints Re-Opened Rate	RO	MD	<9%	UHL	Red = >10% ER = 3 mths Red or any month >15%	New Indicator for 14/15					8%	5%	8%	11%	10%	9%	11%	11%	10%	9%
	C8	Single Sex Accommodation Breaches (patients affected)	RO	CR	0	NTDA	Red = >0 ER = in mth >0	2	0	0	0	0	4	2	0	0	0	0	0	5	0	11
	C9	Improvements in the FFT scores for Older People (65+ year)	RO	CR	75	QC	Red / ER = End of Yr Targets non recoverable.	New Indicators for 14/15					73.7	73.2	75.7	76.1	78.5	83.0	76.4	72.9	76.7	76.1
	C10	Responsiveness and Involvement Care (Average score)	RO	CR	0.8 improve-ment	QC	tbc						87.6	87.5	87.5	87.8	88.1	88.4	87.4	87.9	87.8	87.9
	C10a	Q15. When you used the call button, was the amount of time it took for staff to respond generally:	RO	CR	FYE 89.7	QC	Red = <87.9 ER = Red or 3 mths deterioration						88.9	89.3	88.8	89.0	88.9	90.0	88.4	88.6	89.2	89.2
	C10b	Q16. If you needed help from staff getting to the bathroom or toilet or using a bedpan, did you get help in an acceptable amount of time?	RO	CR	FYE 92.9	QC	Red = <91.1 ER = Red or 3 mths deterioration						92.1	91.9	91.2	91.7	91.9	92.4	92.2	92.4	92.1	92.0
	C10c	Q11. Were you involved as much as you wanted in decisions about your care and treatment?	RO	CR	FYE 85.5	QC	Red = <83.6 ER = Red or 3 mths deterioration						84.6	84.3	84.9	84.9	85.6	85.2	84.6	85.1	84.8	85.0

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Well Led	W1	Inpatient Friends and Family Test - Coverage	RO	CR	30% - Q4. 40% Mar 15	NTDA / CQUIN	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	24.3%	23.3%	24.5%	28.2%	28.8%	36.8%	38.1%	32.6%	30.8%	28.9%	33.4%	36.3%	36.0%	31.9%	33.8%
	W2	A&E Friends and Family Test - Coverage	RO	CR	15% Q1-Q3 20% for Q4	NTDA	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	14.9%	16.4%	15.6%	18.4%	16.1%	15.2%	17.8%	14.9%	10.2%	16.1%	19.1%	15.9%	14.0%	18.7%	15.8%
	W3	Outpatients Friends and Family Test - Valid responses	RO	CR	tbc	UHL	tbc	New Indicator available from October 2014				271	175	286	1879	1535	785	927	1255	1506	1053	9401
	W4	Maternity Friends and Family Test - Coverage	RO	CR	tbc	UHL	tbc	25.2%	24.8%	20.9%	23.7%	23.9%	27.2%	36.4%	25.2%	29.2%	29.9%	18.7%	15.8%	21.7%	22.1%	25.1%
	W5	Friends & Family staff survey: % of staff who would recommend the trust as place to work	KB	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed					53.6%			53.7%			Q3 staff FFT not completed as National Survey carried out			53.7%
	W6	Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment	KB	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed					68.3%			67.2%			Q3 staff FFT not completed as National Survey carried out			67.2%
	W7	Data quality of trust returns to HSCIC	KS	JR	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed														
	W8	Turnover Rate	KB	ES	<10.5%	UHL	Red = 11% or above ER = Red for 3 Consecutive Mths	10.0%	10.2%	10.6%	10.4%	10.0%	9.9%	10.0%	10.2%	10.0%	10.5%	10.3%	10.8%	10.7%	10.3%	10.3%
	W9	Sickness absence	KB	ES	> 3.0%	UHL	Red = >3.5% ER = 3 consecutive mths >3.5%	3.4%	3.8%	3.8%	3.7%	3.5%	3.4%	3.3%	3.3%	3.4%	3.5%	3.8%	4.3%	4.2%			3.7%
	W10	Total trust vacancy rate	KB	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed														
	W11	Temporary costs and overtime as a % of total paybill	KB	ES	tbc	NTDA	tbc	New Indicator for 14/15					9.4%	9.4%	8.1%	8.5%	8.9%	8.5%	9.5%	9.0%	9.8%	9.0%
	W12	% of Staff with Annual Appraisal	KB	ES	95%	UHL	Red = <90% ER = 3 consecutive mths <90%	91.3%	92.4%	91.9%	92.3%	91.3%	91.8%	91.0%	90.6%	89.6%	88.6%	89.7%	91.8%	92.3%	92.5%	92.5%
	W13	Statutory and Mandatory Training	KB	ES	Jun 80%, Sep 85%, Dec 90%, Mar 95%	UHL	Red / ER for Non compliance with Quarterly incremental target	76%	65%	69%	72%	76%	78%	79%	79%	80%	83%	85%	86%	87%	89%	89%
	W14	% Corporate Induction attendance	KB	ES	95.0%	UHL	Red = <90% ER = 3 consecutive mths <90%	94.5%	89%	93%	89%	95%	96%	94%	92%	96%	98%	98%	98%	98%	100%	100%

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	YTD
Effective	E1	Mortality - Published SHMI	KH	PR	Within Expected	NTDA	Higher than Expected			107 (Jul12-Jun13)			106 (Oct12-Sept13)			106 (Jan13-Dec13)			105 (Apr13-Mar14)			105 (Jan13-Dec13)
	E2	Mortality - Rolling 12 mths SHMI (as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive mths increasing SHMI >100	105	108	107	106	105	103	103	103	Awaiting HED Update						103
	E3	Mortality HSMR (DFI Quarterly)	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	88		83			87			80			Awaiting DFI Update			85
	E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	101	100	100	99	97	98	99	97	96	96	96	Awaiting HED Update		96
	E5	Mortality - Monthly HSMR (Rebased Monthly as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	91	94	89	103	91	83	110	107	87	99	98	92	Awaiting HED Update		97
	E6	Mortality - Rolling 12 mths HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	100	102	101	101	100	99	99	100	98	97	97	96	Awaiting HED Update		96
	E7	Mortality - Monthly HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	100	95	93	102	94	88	100	111	86	91	99	90	Awaiting HED Update		95
	E8	Mortality - rolling 12 mths HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	103	101	102	99	95	98	97	97	97	97	98	Awaiting HED Update		98
	E9	Mortality - Monthly HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	93	84	106	82	69	137	94	94	122	99	106	Awaiting HED Update		103
	E10	Deaths in low risk conditions (Risk Score)	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	94	129	164	35	63	48	60	78	59	47	Awaiting DFI Update				59
	E11	Emergency 30 Day Readmissions (No Exclusions)	KH	PR	Within Expected	NTDA	Higher than Expected	7.9%	8.0%	8.7%	9.0%	8.8%	8.8%	8.7%	8.6%	8.3%	8.9%	8.4%	8.6%	8.9%		8.7%
	E12	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	KH	RP	72% or above	QS	Red = <72% ER = 2 consecutive mths <72%	65.2%	72.2%	68.2%	73.7%	54.7%	56.9%	40.6%	60.3%	76.9%	59.0%	68.6%	69.6%	59.4%	57.3%	61.2%
	E13	Stroke - 90% of Stay on a Stroke Unit	RM	CF	80% or above	QS	Red = <80% ER = 2 consecutive mths <80%	83.2%	81.8%	89.3%	83.7%	83.5%	92.9%	80.3%	87.1%	78.1%	84.5%	83.2%	70.4%	73.1% TBC		80.7%
	E14	Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA)	RM	CF	60% or above	QS	Red = <60% ER = 2 consecutive mths <60%	64.2%	65.7%	60.5%	40.7%	77.9%	79.7%	58.8%	71.3%	62.8%	65.5%	72.7%	67.8%	69.0%	83.5%	70.2%
	E15	Communication - ED, Discharge and Outpatient Letters - Compliance with standards	KH	SJ	90% or above	QS	Red = <80% ER = Qrtly ER if <90% and deterioration	New Indicator for 14/15									60% (InPt)	83% (ED)	Poilcy out for consultation			83% (ED)
	E16	Published Consultant Level Outcomes	KH	SH	>0 outside expected	QC	Red = >0 Quarterly ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	E17	Non compliance with 14/15 published NICE guidance	KH	SH	0	QC	Red = in mth >0 ER = 2 consecutive mths Red	New Indicator for 14/15					0	0	0	0	0	0	0	0	0	0

Responsive

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	YTD
R1	ED 4 Hour Waits UHL + UCC	RM	CF	95% or above	NTDA	Red = <95% ER via ED TB report	88.4%	90.1%	93.6%	83.5%	89.3%	86.9%	83.4%	91.3%	92.5%	91.0%	91.6%	90.2%	88.6%	83.1%	88.7%
R2	12 hour trolley waits in A&E	RM	CF	0	NTDA	Red = >0 ER via ED TB report	5	0	0	0	0	0	1	1	0	0	0	1	0	0	3
R3	RTT Waiting Times - Admitted	RM	CC	90% or above	NTDA	Red /ER = <90%	76.7%	82.0%	81.8%	79.1%	76.7%	78.9%	79.4%	79.0%	80.9%	82.2%	81.6%	84.4%	85.5%	86.8%	86.8%
R4	RTT Waiting Times - Non Admitted	RM	CC	95% or above	NTDA	Red /ER = <95%	93.9%	92.8%	93.4%	93.5%	93.9%	94.3%	94.4%	95.0%	94.9%	95.6%	94.6%	94.9%	95.2%	96.0%	96.0%
R5	RTT - Incomplete 92% in 18 Weeks	RM	CC	92% or above	NTDA	Red /ER = <92%	92.1%	91.8%	92.0%	92.6%	92.1%	93.9%	93.6%	94.0%	93.2%	94.0%	94.3%	94.8%	95.0%	95.1%	95.1%
R6	RTT 52 Weeks+ Wait (Incompletes)	RM	CC	0	NTDA	Red /ER = >0	0	1	1	0	0	0	0	0	15	1	3	3	2	0	0
R7	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	NTDA	Red /ER = >1%	1.9%	1.4%	5.3%	1.9%	1.9%	0.8%	0.9%	0.8%	0.7%	1.0%	1.0%	0.7%	1.8%	2.2%	2.2%
R8	Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	RM	MM	93% or above	NTDA	Red = <93% ER = Red for 2 consecutive mths	94.8%	94.9%	95.3%	95.9%	95.3%	88.5%	94.7%	93.5%	92.2%	92.0%	90.6%	92.0%	92.5%		92.0%
R9	Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	RM	MM	93% or above	NTDA	Red = <93% ER = Red for 2 consecutive mths	94.0%	95.5%	96.8%	93.4%	94.3%	80.0%	95.0%	98.9%	94.9%	94.4%	95.2%	98.6%	100.0%		95.2%
R10	31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	RM	MM	96% or above	NTDA	Red = <96% ER = Red for 2 consecutive mths	98.1%	97.4%	97.2%	98.5%	98.2%	97.2%	92.9%	93.6%	94.4%	97.9%	91.9%	95.9%	92.5%		94.5%
R11	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	RM	MM	98% or above	NTDA	Red = <98% ER = Red for 2 consecutive mths	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0%	97.1%	100.0%		99.5%
R12	31-Day Wait For Second Or Subsequent Treatment: Surgery	RM	MM	94% or above	NTDA	Red = <94% ER = Red for 2 consecutive mths	96.0%	92.3%	94.8%	96.4%	98.6%	95.2%	97.0%	90.8%	90.1%	87.8%	94.0%	81.9%	82.4%		89.6%
R13	31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	RM	MM	94% or above	NTDA	Red = <94% ER = Red for 2 consecutive mths	98.2%	98.1%	94.8%	96.3%	99.1%	97.3%	95.6%	93.9%	97.3%	99.0%	96.5%	96.0%	94.7%		96.3%
R14	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	RM	MM	85% or above	NTDA	Red = <85% ER = Red in mth or YTD	86.7%	89.4%	89.1%	89.1%	92.4%	92.7%	88.5%	73.1%	85.6%	78.8%	75.5%	80.4%	77.0%		81.2%
R15	62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	RM	MM	90% or above	NTDA	Red = <90% ER = Red for 2 consecutive mths	95.6%	96.6%	97.1%	95.1%	91.7%	91.1%	67.4%	73.9%	73.0%	100.0%	87.5%	75.0%	94.4%		82.8%
R16	Urgent Operations Cancelled Twice	RM	PW	0	NTDA	Red = >0 ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
R17	Cancelled patients not offered a date within 28 days of the cancellations UHL	RM	PW	0	NTDA	Red = >2 ER = >0	85	8	9	2	8	10	3	1	1	1	2	2	1	3	24
R18	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	RM	PW	0	NTDA	Red = >2 ER = >0	New Indicator for 14/15					0	0	0	0	6	0	0	1	1	8
R19	% Operations cancelled for non-clinical reasons on or after the day of admission UHL	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	1.6%	1.7%	1.6%	2.1%	1.5%	1.1%	0.8%	1.1%	0.7%	0.6%	0.8%	0.8%	1.2%	1.1%	0.9%
R20	% Operations cancelled for non-clinical reasons on or after the day of admission ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	1.6%	1.7%	1.6%	2.1%	1.5%	0.6%	0.6%	0.3%	2.7%	0.0%	0.9%	1.0%	0.0%	0.8%	0.8%
R21	% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	New Indicator for 14/15					1.1%	0.8%	1.0%	0.9%	0.6%	0.8%	0.8%	1.1%	1.1%	0.9%
R22	No of Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	N/A	UHL	tbc	1739	141	152	178	139	106	77	98	94	55	90	94	108	102	824
R23	Delayed transfers of care	RM	PW	3.5% or below	NTDA	Red = >3.5% ER = Red for 3 consecutive mths	4.1%	3.6%	4.6%	4.3%	3.8%	4.4%	4.2%	4.0%	3.9%	3.9%	4.5%	4.6%	5.2%	3.9%	4.3%
R24	Choose and Book Slot Unavailability	RM	CC	4% or below	Contract	Red = >4% ER = Red for 3 consecutive mths	13%	14%	10%	16%	19%	22%	25%	26%	25%	26%	25%	20%	17%	17%	22%
R25	Ambulance Handover >60 Mins (CAD)	RM	CF	0	Contract	Red = >0 ER = Red for 3 consecutive mths	868	102	52	207	111	173	253	88	71	50	106	253	343	460	1,797
R26	Ambulance Handover >30 Mins and <60 mins (CAD)	RM	CF	0	Contract	Red = >0 ER = Red for 3 consecutive mths	7,075	722	573	818	601	720	951	671	591	805	736	1,147	1,364	1,170	8,155

	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	YTD
Research	RS1	Number of participants recruited in a reporting year into NIHR CRN Portfolio studies	KH	DR	England 650,000 East Midlands 50,000	NIHR CRN	Red / ER = <90%	92%	93%	94%	93%	93%
	RS2a	A: Proportion of commercial contract studies achieving their recruitment target during their planned recruitment period.	KH	DR	England 80% East Midlands 80%	NIHR CRN	Red / ER = <60%	67%	64%	68%	54%	54%
	RS2b	B: Proportion of non-commercial studies achieving their recruitment target during their planned recruitment period	KH	DR	England 80% East Midlands 80%	NIHR CRN	Red / ER = <60%	81.0%	81.0%	73%	77%	77%
	RS3a	A: Number of new commercial contract studies entering the NIHR CRN Portfolio	KH	DR	600	NIHR CRN	tbc					
	RS3b	B: Number of new commercial contract studies entering the NIHR CRN Portfolio as a percentage of the total commercial MHRA CTA approvals for Phase II-IV studies	KH	DR	75%	NIHR CRN	Red <75%					
	RS4	Proportion of eligible studies obtaining all NHS Permissions within 30 calendar days (from receipt of a valid complete application by NIHR CRN)	KH	DR	80%	NIHR CRN	Red <80%	90.0%	89.0%	84.0%	82.0%	82.0%
	RS5a	A: Proportion of commercial contract studies achieving first participant recruited within 70 calendar days of NHS services receiving a valid research application or First Network Site Initiation Visit	KH	DR	80%	NIHR CRN	Red <80%					
	RS5b	B: Proportion of non-commercial studies achieving first participant recruited within 70 calendar days of NHS services receiving a valid research application	KH	DR	80%	NIHR CRN	Red <80%					
	RS6a	A: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio studies	KH	DR	England 99% East Midlands 99%	NIHR CRN	Red <99%	81.0%	81.0%	81.0%	88.0%	88.0%
	RS6b	B: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio commercial contract studies	KH	DR	England 70% East Midlands 70%	NIHR CRN	Red <70%	56.0%	56.0%	56.0%	56.0%	56.0%
	RS6c	B: Proportion of General Medical Practices recruiting each year into NIHR CRN Portfolio studies	KH	DR	England 25% East Midlands 25%	NIHR CRN	Red <25%	45.0%	45.0%	51.0%	63.0%	63.0%
	RS7	Number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	KH	DR	England 13500 East Midlands 510	NIHR CRN	Red <510 Q4	325	438	448	532	532
	RS8	Deliver robust financial management using appropriate tools - % of financial returns completed on time	KH	DR	England 100% East Midlands 100%	NIHR CRN	Red <100%	100% *Q2	100.0%			100% *Q2

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Sep-14	Oct-14	Nov-14	Dec-14	YTD
Estates and Facilities	E&F1	Percentage of statutory inspection and testing completed in the Contract Month measured against the PPM schedule.	AC	GL	100%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F2	Percentage of non-statutory PPM completed in the Contract Month measured against the PPM schedule	AC	GL	100%	Contract KPI	Red = ≤ 80%	91.5%	81.2%	95.6%	80.5%	81.2%
	E&F3	Percentage of Estates Urgent requests achieving rectification time	AC	LT	95%	Contract KPI	Red = ≤ 75%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F4	Percentage of scheduled Portering tasks completed in the Contract Month	AC	LT	99%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F5	Number of Emergency Portering requests achieving response time	AC	LT	100%	Contract KPI	Red = >2	0.0%	0.0%	0.0%	0.0%	0
	E&F6	Number of Urgent Portering requests achieving response time	AC	LT	95%	Contract KPI	Red = ≤ 95%	95.1%	96.2%	97.3%	97.2%	96.2%
	E&F7	Percentage of Cleaning audits in clinical areas achieving NCS audit scores for cleaning above 90%	AC	LT	100%	Contract KPI	Red = ≤ 98%	100.0%	99.1%	100.0%	100.0%	99.1%
	E&F8	Percentage of Cleaning Rapid Response requests achieving rectification time	AC	LT	92%	Contract KPI	Red = ≤ 80%	99.6%	89.9%	93.3%	90.5%	89.9%
	E&F9	Percentage of meals delivered to wards in time for the designated meal service as per agreed schedules	AC	LT	97%	Contract KPI	Red = ≤ 95%	99.4%	99.5%	100.0%	100.0%	99.5%
	E&F10	Overall percentage score for monthly patients satisfaction survey for catering service	AC	LT	85%	Contract KPI	Red = ≤ 75%	96.7%	97.3%	97.3%	96.7%	97.3%

S1b – CDIFF local target

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
The cases of CDT have been the subject of Root Cause Analysis and there are no discernible factors that link these cases to date. Concerns in relation to compliance with the National Minimum Cleaning frequencies have been expressed from colleagues within all CMGs and have been identified by the IPT. Repeated requests for the current cleaning frequencies and hours aligned to each area to be made available have not been received to date. UHL is therefore not in a position to verify that the Interserve transformation team correctly implemented NCS Interserve audits previously carried out to date did not report 1st failures and therefore a false reassurance as to the standard of cleaning in some areas is felt to have been given. The CDT working party will be reviewed and the associated governance arrangements to ensure that this group is able to deliver the identified objectives	Action plans that have resulted from the RCA should be presented to the CMG Infection Prevention Groups and should follow the RCA process flow chart as described in the Infection Prevention Toolkit In line with the 'updated guidance in the diagnosis and reporting of Clostridium difficile' the cases have been sent to Commissioning Group that has been established to review each case individually. The comments from this group will be received within seven working days. This process commenced in October and sample positive cases that are the subject of RCA will be sent monthly for review. A thematic review of CDT cases will be undertaken with the results presented to the February EQB and CQRG meetings The number of cases to date mirrors last year's numbers at this time however we continue to strive for a further reduction in cases. The Chief Executive has requested that 1st audit results are used for subsequent environmental cleanliness audits. Infection Prevention Leads are to meet with the newly appointed Director of Facilities who in conjunction with the DIPAC will review current cleanliness forums in place to ensure these are fit for purpose and are monitoring and ensuring performance delivery effectively	5	7		N/A

	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Traj 14/15	7	8	5	7	6	7	7	7	6	7	7	7	81
Internal Traj 14/15	4	5	4	5	4	4	4	4	4	4	4	4	50
Actual Infections 14/15	4	6	5	7	2	5	7	7	11				55

Expected date to meet standard / target	TBA
Revised date to meet standard	TBA
Lead Director / Lead Officer	Elizabeth Collins

S2a MRSA bacteraemias (all)

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
The cases of MRSA bacteraemia have been the subject of the Post Infection Review process. All occurred in different locations within the trust and these cases are not connected. All occurred in patients with multiple co-morbidities and have been deemed unavoidable however lapses in care were identified in all cases.	Post Infection Reviews (PIR) are carried out by the CMGs with support from the Infection Prevention Team in accordance with the NHS Commissioning Board 'Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infection from April 2013' The PIR reviews and any identified action plans that have resulted from the investigation should be presented to the CMG Infection Prevention Groups and CMG Quality and Safety Boards and follow the RCA process flow chart as described in the Infection Prevention Toolkit	0	See table below	4	N/A

MRSA	Emergency & SM			CHUGS			MSK & SS			RRC			ITAPS		Women's & Children's			GRAND TOTAL
Reporting period	Emergency	Specialist Medicine	CMG Total	Cancer & Haem	Urology, Gastro & Surgery	CMG Total	Musculo-skeletal	Specialist Surgery	CMG Total	Renal Speciality	Respiratory & Cardiac	CMG Total	ITAPS	CMG Total	Women's	Children's	CMG Total	
Date reported to PHE																		
14th Jan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
January																		
Running Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
February																		
Running Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Month End Totals																		
Apr-14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
May-14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Jun-14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Jul-14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Aug-14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sep-14	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	1
Oct-14	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	1
Nov-14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dec-14	0	1	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	2
Jan-15			0			0			0			0		0			0	0
Feb-15			0			0			0			0		0			0	0
Mar-15			0			0			0			0		0			0	0
2014/15 Month Ends	0	1	1	0	2	2	0	0	0	0	1	1	0	0	0	0	0	4
2014/15 Running Total	0	1	1	0	2	2	0	0	0	0	1	1	0	0	0	0	0	4

Expected date to meet standard / target	TBA
Revised date to meet standard	TBA
Lead Director / Lead Officer	Elizabeth Collins

S3 Never events

		Target	Oct 14	YTD	Fore cast
What is causing underperformance?	**What actions have been taken to improve performance?**	**NIL**	**1**	**3**	**3**

Case One: During an operation in December to replace a femoral head which had been inserted during previous hip joint revision surgery it was identified that the femoral head was the incorrect size: a 32mm head had been inserted in a 28mm cup.
There are two ball sizes for the prosthesis in question: 28 mm and 32mm. The most common size (> 95%) is the 32mm size, and it had been "assumed" that the head removed was a 32mm diameter.

Case Two: A patient was listed for surgery at Melton Hospital by a Podiatric Surgeon to straighten the 3rd toe on her right foot.

On the morning of surgery (22 December 2014) the Podiatry Assistant confirmed with the patient the site and documented consent. She marked the patient's foot on the top with an arrow pointing towards the 3rd toe.

Whilst the latter was taking place the PodiatricSurgeon reviewed the MRI images for the patient and considered that the 2nd toe on the right foot required surgery.

The patient was brought into the theatre and the WHO checklist completed whilst the Surgeon was scrubbing up. He was not fully engaged in the check and the Podiatry Assistant was not present in Theatre to participate in the checks. Surgery was undertaken on the 2nd toe.

1. To avoid any such repetition, it is proposed that in the future, all diameter sizes of the components to be revised should be recorded at the beginning, or if not known pre-operatively, during revision procedures irrespective of which components are to be revised.

1. Change in practice: marking extending to digit implemented immediately.
2. Messages regarding WHO checklist reinforced at meeting on 6 January 2015 with teams involved.
3. Podiatry Assistant must be present in theatre when WHO checklist completed.

2013/14 Performance by Quarter

13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4
0	0	1	2

Three Never Events will trigger UHL as 'red' on this indicator for 2014/15

Expected date to meet standard	N/A
Revised date to meet standard	-
Lead Director	Director of Safety and Risk

Commentary:

1. The definition of a Never Event is: “Serious, largely preventable PSIs that should not occur if the available preventative measures have been implemented by healthcare providers”.

2. In relation to UHL performance:

   - In 2012/13, UHL reported 6 Never Events
   - In 2013/14, UHL reported 3 Never Events
   - For Quarters 1 and 2 in 2014/15, there were no Never Events reports and good compliance with the regulatory framework was demonstrated. However, in Quarter 3, 2014/15, 1 Never Event was reported and in Quarter 4, 2 Never events have been reported to date.

3. Case One Never Event occurred because the surgeon made an assumption rather than undertaking a definitive check.

4. Case Two Never Event occurred because of non-compliance in respect of certain elements of the Safer Surgery Policy.

INDICATOR: S9 % of all adults who have had VTE risk assessment on admission to hospital

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly)	Latest performance	YTD performance	Forecast performance for next reporting period
UHL's performance in respect of the VTE risk assessment indicator is calculated on the number of patients who are risk assessed for venous-thromboembolism (VTE), either on an individual basis or as a patient group (cohort). Cohorts are patients belonging to a diagnosis or procedural group which is considered to have a very low risk of VTE and therefore are considered to have been risk assessed on admission. One of the largest cohort groups are those patients attending for haemodialysis. Performance data is submitted on a monthly basis to UNIFY via UHL's data warehouse and is either taken from the ePrescribing System (on ePMA wards - patients have to have a VTE risk assessment before any drugs can be prescribed) or from Patient Centre (for non ePMA wards, data is taken from the patients' case notes and manually inputted into Patient Centre by ward/audit clerks). UHL has managed to achieve the 95% threshold each month since Q2 in 13/14 but 'cohort' patients have always significantly contributed to performance. Provisional review of December's data has identified a reduction in the number of 'cohort' admissions plus an increase in the number of 'missing data' for those patients requiring individual risk assessment (i.e. non cohorts). 'Blanks' (missing data), has been a constant challenge in respect of achieving the 95% target, i.e. patients are being risk assessed but this data is not then being inputted into patient centre. For areas using ePMA this is not an issue. The greatest number of blanks in December were in CDU and Urology.	The 95% threshold was missed in December by 85 patients and therefore a retrospective notes review is being undertaken for approximately 100 'non cohort' patients who have 'blanks' in respect of VTE risk assessment on Patient Centre. Audit Clerks, supervised by the Thrombosis Nurse, will then check whether the VTE risk assessment documentation has been completed in order to retrospectively input this data into Patient Centre. The aim is to complete this work before the UNIFY submission deadline of 29th January in order to be able to report achievement of the 95% threshold. In the meantime, further discussions are being held with the CDU and Urology teams to identify what support is required to improve data inputting prospectively. Confirmation of plans for the continued roll out of ePMA is also being sought as this would then obviate the need for manual data inputting.	**95%**	**94.7% (Provisional)**	**95.67%**	**>95%**

Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
95.67%	95.88%	95.92%	96.27%	95.54%	96.17%	95.40%	95.45%	94.70% (tbc)

VTE Risk Assessments on Admission to Hospital December's performance due to be reported via UNIFY	December
I The number of adult inpatients (ordinary admission and day case) admitted in the month who have been risk assessed for VTE using the National Tool.	26774
ii. Total number of adult inpatients (ordinary admission and day case) admitted in the month.	28272
Iii Percentage of adult patients admitted in the month who were assessed for risk of VTE on admission to hospital.	**94.70% (tbc)**

Expected date to meet standard / target	January 15 – post retrospective data inputting and data validation.
Lead Director / Lead Officer	Kevin Harris, Medical Director / Simon Rudge, Thrombosis Nurse

S14 - Avoidable 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 were 11 Grade 2 avoidable Hospital acquired pressure ulcers (HAPUs) in December (i.e. 2 above the monthly threshold of 9), which followed 13 in November. December also saw the first Grade 4 avoidable HAPU and, as agreed with commissioners, this will be treated as a 'local Never Event'. G4 HAPU - Initial analysis indicates that insufficient checks and care interventions were provided, to minimise the risk of pressure ulcer development. A full root cause analysis is underway In respect of the Grade 2 and 3 HAPUs, all pressure ulcer incidents have been subject to internal validation. It has been noted by Heads of Nursing that the increased activity, leading to the need to create additional capacity is likely to have contributed to the continued higher number of HAPUs. Other common themes identified include:- •Gaps in documentation that nursing care interventions took place consistently to minimise the risk of pressure ulcers •Pressure damage as a result of medical devices •Limited or lack of recognition of patient risk factors.	From November 2014, oversight and management of the tissue viability service transferred to the Head of Safeguarding. Keys messages from the December performance will be shared with Heads of Nursing and the Chief Nurse. Further work to improve the quality of validation reports has commenced and key learning is shared monthly across nursing forums. Work is ongoing to monitor performance and discussions are taking place through the Nursing Executive to determine further initiatives and actions to prevent avoidable pressure ulcers and to learn from national best practice. The Chief Nurse is holding a performance management meeting with staff in relation to the grade 4 HAPU.	**G4 = 0 G2= 9**	**G4 = 1 G2 = 11**	**G4 = 1 G2 = 70**	**G4 = 0 G2 = </= 9**

Table one - Avoidable Grade 2 Pressure Ulcers April - December 2014

Threshold for Grade 2 Avoidable Pressure Ulcers 2013/14													
Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Threshold	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	
Incidence	6	6	6	7	8 Plus 1	4	7 plus 1	13	11				**70**

Table two - Avoidable Grade 3 Pressure Ulcers April – December 2014

Threshold for Grade 3 Avoidable Pressure Ulcers 2013/14													
Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Threshold	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	
Incidence	5	5	5	5	6	6	4	6	7				**44**

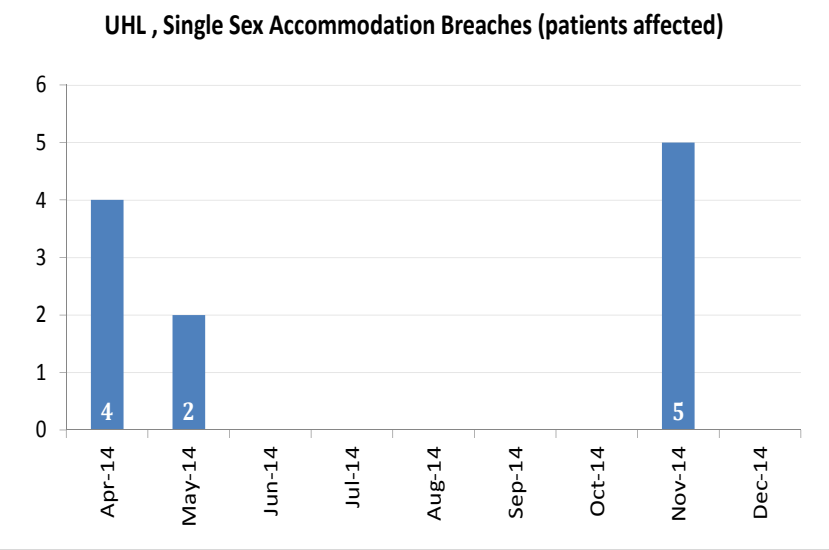
Table three - Avoidable Grade 4 Pressure Ulcers April - December 2014

Threshold for Grade 4 Avoidable Pressure Ulcers 2013/14													
Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Threshold	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Incidence	0	0	0	0	0	0	0	0	1				**0**

Expected date to meet standard / target	January 15
Revised date to meet standard	TBA
Lead Director / Lead Officer	Carole Ribbins, Deputy Chief Nurse/Michael Clayton, Head of Nursing

C8 Single sex accommodation breaches

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
During the month of November there were five patients affected by two occasions when the Same-Sex policy was breached. On both occasions the events occurred in the HDU bay on ward 30 at the Leicester Royal Infirmary. the causes of this underperformance were: • Limited availability of base beds to move patients no longer needing HDU care. • Lack of understanding of the Same-Sex Matrix and escalation policy by staff. • Bed pressures resulting from pressure in the Emergency Department to admit patients.	Extra bed capacity has been opened in the Trust to accommodate more patients. Meetings have been held with Nursing and Duty Management leads, this information has then been cascaded to the clinical staff. A Route Cause Analysis has been completed following each episode, addressing learning needs and looking at preventing future breaches.	**0**	**0**	**11**	**0**



Expected date to meet standard / target	December 2014
Revised date to meet standard	N/A
Lead Director / Lead Officer	Heather Leatham, Assistant Chief Nurse

W9 Sickness absence

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
1. Sickness absence is reported a month in arrears. 2. There has been an increase in sickness absence from July 2014 of 0.91%. 3. Sickness levels for November 2014 are reported at 4.20% and were at 4.12% in November 2013. 4. Sickness absence reporting highlights an adjustment of around 0.5% due to late closures. It is therefore expected the November 2014 sickness absence rate will be adjusted in the coming months. 5. In the last two years November 2012 to November 2014 we have seen: a. A reduction in staff taking sickness absence (November 2012 – 66.7%, November 2014 – 64.4%) b. An increase in staff taking sickness	1. Improved data through weekly SMART (Sickness Monitoring and Reporting Team) reports forwarded to lead managers 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. Circulation of breakdown of CMG performance by cost centre covering monthly and cumulative sickness absence. 4. Making it Happen Reviews, to discuss and agree actions for the management and support of open absences, 'triggers' and complex cases with line managers. 5. 6 monthly CMG Sickness Performance Reviews / Case reviews with Occupational Health and Senior and independent HR colleagues. 6. Sickness Absence training continues for line managers, and a new programme has been introduced for those administering the sickness absence paperwork.	**UHL Stretch target 3% (previous SHA target 3.4%)**	**4.2%**	**3.65% (average)**	**3.50% average (April 2015)**

Performance by CMG:

	2014 06	2014 07	2014 08	2014 09	2014 10	2014 11	Contracted Wte	Cumulative % Abs Rate (FTE)
	% Abs Rate (FTE)	% Abs Rate (FTE)	% Abs Rate (FTE)	% Abs Rate (FTE)	% Abs Rate (FTE)	% Abs Rate (FTE)		
Finance & Procurement	2.89%	2.86%	3.03%	2.44%	2.64%	6.23%	128.76	2.67%
Operations	5.63%	5.57%	5.87%	5.62%	6.61%	6.13%	104.30	5.78%
Corporate Nursing	3.07%	4.21%	4.00%	4.74%	4.60%	5.58%	186.29	3.44%
Alliance Elective Care	3.94%	3.36%	2.29%	3.02%	5.00%	5.55%	210.68	3.81%
Women's & Children's	3.43%	3.13%	3.19%	3.75%	4.43%	4.70%	1619.17	3.89%
Corporate & Legal	2.13%	1.35%	4.17%	4.74%	5.01%	4.65%	23.53	2.96%
Emergency & Specialist Medicine	4.02%	4.25%	3.77%	3.89%	3.97%	4.59%	1535.11	4.08%
ITAPS	3.20%	3.31%	3.91%	4.31%	4.17%	4.37%	1133.85	3.81%
Renal, Respiratory & Cardiac	3.00%	3.59%	3.81%	3.94%	4.38%	4.35%	1477.27	3.77%
Research CRN EM	0.22%	2.13%	6.69%	6.44%	2.48%	4.07%	40.10	2.96%
Strategy Directorate	2.25%	3.26%	1.66%	2.99%	3.64%	3.98%	51.39	2.77%
Clinical Support & Imaging Services	3.30%	3.22%	3.35%	3.58%	3.89%	3.86%	1796.59	3.62%
CHUGGS	3.64%	3.75%	3.69%	3.63%	4.01%	3.76%	1073.23	3.62%
MSK & Specialist Surgery	2.65%	2.86%	2.62%	3.35%	3.58%	3.35%	1010.88	2.98%
Human Resources & Training	1.35%	0.91%	0.46%	0.62%	2.57%	2.09%	146.94	1.86%
IM & T	0.00%	0.00%	0.00%	0.56%	0.00%	1.53%	15.80	0.74%
Research UHL	0.00%	3.54%	2.33%	0.00%	0.00%	1.45%	16.89	3.03%
Corporate Medical	0.42%	0.82%	1.14%	1.48%	2.65%	0.60%	67.96	1.72%
Communications & Ext Relations	0.00%	0.56%	0.36%	0.00%	0.19%	0.17%	20.60	0.58%
Facilities	0.00%	0.00%	0.00%	0.00%	0.41%	0.00%	23.97	0.23%
Divisional Management Codes	3.32%	4.39%	6.08%	6.67%	0.00%	0.00%	n/a	1.87%
University Hospitals of Leicester NHS Trust	3.29%	3.40%	3.43%	3.71%	4.06%	4.20%	10683.29	3.65%

What is causing underperformance?	What actions have been taken to improve performance?				
in excess of 28 days (November 2012 – 7.5%, November 2014 – 8.28%) 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	**Further Actions:** 7. In addition to the corporate sickness absence training, local training is facilitated for CMG's / Directorates in response to specific needs – management of long term absence, documentation etc. 8. 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. 9. 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.				
		Expected date to meet standard / target	Monthly Target		
		Revised date to meet standard	April 2015		
		Lead Director / Lead Officer	Emma Stevens, Acting Director of Human Resources Kalwant Khaira, CMG HR Lead (HR Sickness Absence Lead)		

INDICATOR: Statutory and Mandatory Training W13

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
We note that Statutory and mandatory Training is underperforming for the first time in 2014/15 and organisationally we have seen a significant improvement in month by month performance. This minimal underperformance (1%) results primarily from a slight reduction in attendance at face to face training sessions and completion of eLearning during December 2014 given service demands and pressures. We recognise that attendance at face to face training relies on staff being covered to attend, particularly in clinical areas and therefore generally completion rates for fire, resuscitation and manual handling training are lower than previous months.	1,200 team leaders (as recorded on the eUHL System) with access to the 'Team Builder' function have been contacted directly and requested to focus upon Fire Safety, Resuscitation and Infection Prevention Training (lowest performing areas). The Core Training Team has liaised with the Moving & Handling team to improve engagement and clarity regarding attendance and access to their training sessions. The ITAP and CSI CMGs have been restructured on the eUHL System to increase the number of areas within each CMG that are reported upon. These changes have been made to maximise engagement from the Heads of Service and service leads. All Subject Matter Experts are being contacted to identify and share across the group successful strategies. A new guide to 'Checking your Required Training' will be distributed to all staff over coming weeks to improve compliance levels and increase awareness of the targets and the necessity of training completion.	**31st, Dec, 2014 – 90%** **31st March, 2015 – 95%**	**9th Jan, 2015 – 89%**	**89%**	**95% at end of Quarter 4 / Year End**

*This section to incude Commentary on perforamance / benchmarking data or performance by CMG etc – (***SEE BELOW***)*

Expected date to meet standard / target	90% - 31ST, January 2015 95% - 31st March 2015
Lead Director / Lead Officer	Emma Stevens, Acting Director of Human Resources Bina Kotecha, Assistant Director of Learning and OD

UHL Statutory & Mandatory Training Summary – 09/01/15

CMG / Corporate Directorates	Fire Training	Moving & Handling	Infection Prevention	Equality & Diversity	Informat'n Gover'ce	Safeguard Children	Conflict Resolution	Safeguard Adults	Health & Safety	Resus - BLS Equivalent	Average Compliance
CHUGS	81%	80%	86%	93%	84%	93%	91%	92%	89%	83%	87%
CSI	87%	90%	89%	95%	91%	93%	94%	91%	93%	76%	90%
Emergency & Specialist Medicine	85%	85%	84%	90%	83%	92%	90%	90%	86%	86%	87%
ITAPS	87%	94%	91%	95%	88%	96%	95%	95%	93%	89%	92%
Musculoskeletal & Specialist Surgery	80%	81%	83%	92%	85%	92%	91%	90%	90%	77%	86%
Renal, Respiratory & Cardiac	82%	86%	87%	93%	88%	92%	90%	91%	90%	87%	89%
Womens & Childrens	82%	81%	81%	90%	86%	94%	90%	87%	87%	84%	86%
The Alliance	93%	88%	92%	92%	91%	94%	91%	91%	92%	87%	91%
Corporate Directorates	84%	88%	85%	95%	89%	96%	93%	93%	89%	80%	89%
Total compliance by subject	84%	86%	86%	93%	87%	94%	92%	91%	89%	84%	
UHL staff are this compliant with their mandatory & statutory training from the key 10 subjects											89%
Performance Against Trajectory (Set at 95% by March 31st, 2015)											6% behind

Compliance Levels below 90%
Compliance Levels 90% upto 95%
Compliance Levels 95% and above

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

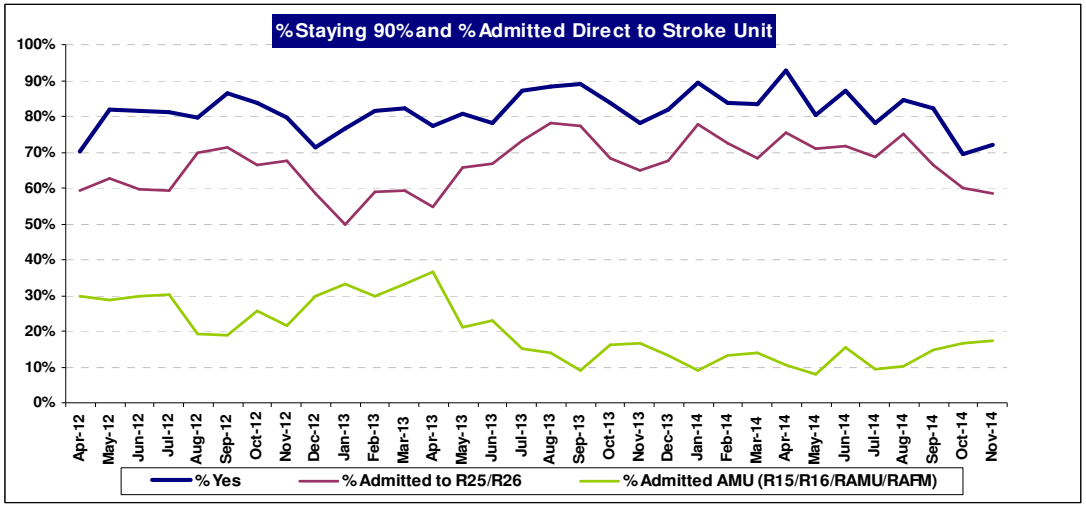
INDICATOR: E 13 Patients who spend at least 90% of their stay on a stroke unit.

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
A recent audit performed by Dr Rachel Marsh has highlighted a number of issues (a full report is available) Main issues: Lack of stroke beds at times of high in flow in terms of both stroke patients and all admissions Insufficient access to therapy services leading to longer lengths of stay Delays in transfers of care Social care delays Diagnostic confusion at first presentation. Referral delays	**Actions taken thus far:** Support from executive leads including the CE to ring fence beds. Daily list of patients awaiting rehabilitation beds emailed to bed bureau and bed managers to support better 'out flow'. Monthly audit of notes to confirm presence of stroke where 90% not achieved Recruitment of fixed term occupational therapist to cover maternity leave **Actions planned:** Introduce daily record of any non stroke patients on the stroke unit and reason Monthly audit of coding plus reason for patients not achieving 90% stay Develop a business plan with therapy services to increase physiotherapy and occupational therapists Review of LPT contract to increase Speech and Language therapists Escalate delays in transfers of care. Ensure the stroke bed policy is robustly enforced and re-issue the policy via senior management. Review bed usage across the stroke unit to ensure capacity is maximised. Review exclusion criteria regarding 90% stay including ITU and surgical stays.	**80%**	**72.1%**	**80.3%**	**75.0%**

All Commissioners

Apr-14	6	12.3	79	13.3	85	13.2	92.9%
May-14	15	7.7	61	12.2	76	11.3	80.3%
Jun-14	11	7.2	74	13.6	85	12.7	87.1%
Jul-14	21	12.3	75	14.9	96	14.3	78.1%
Aug-14	15	6.9	82	15.2	97	13.9	84.5%
Sep-14	18	12.1	83	15.4	101	14.8	82.2%
Oct-14	33	11.6	75	10.0	108	10.5	69.4%
Nov-14	29	9.9	75	15.7	104	14.0	72.1%

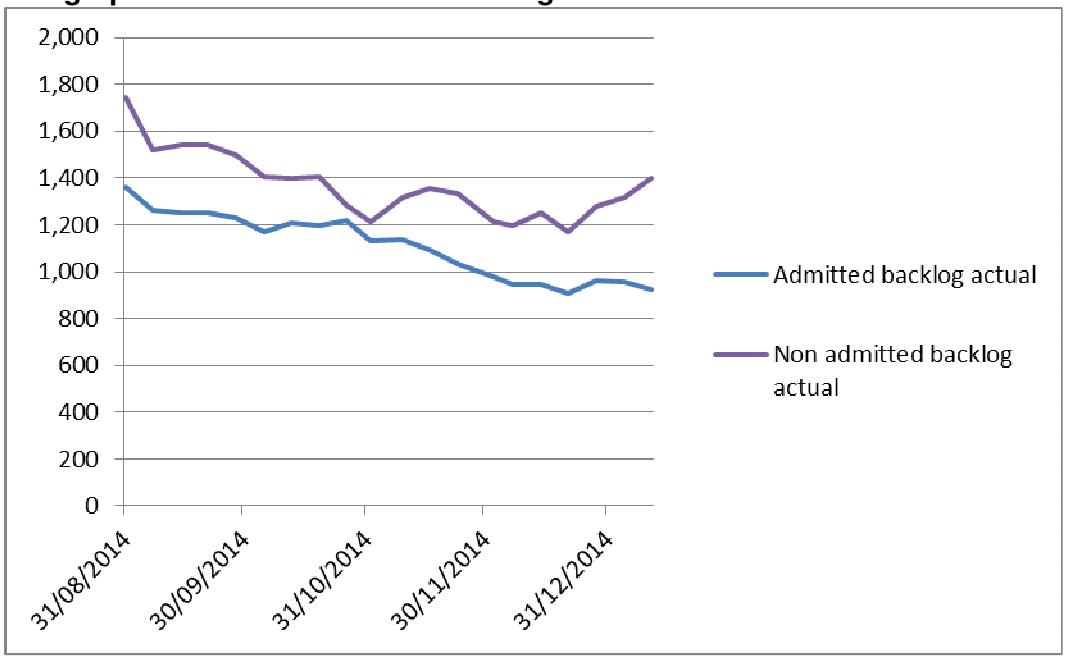
2014/15	**148**	**10.0**	**604**	**13.8**	**752**	**13.1**	**80.3%**



Expected date to meet standard / target	January 2015.
Lead Director / Lead Officer	Dr Ian Lawrence, Clinical Director for ESM / Dr Rachel Marsh, Head of Stroke Services

INDICATOR: R3 RTT waiting times - 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**
Although the admitted backlog has reduced significantly as illustrated in the graph in this report, further significant backlog reduction needs to take place in order for the Trust to achieve and sustain the admitted standard. **By key speciality:** -Ophthalmology, continues to perform well - ENT adult , achieved the standard in December a significant development - General surgery, backlog continues to reduce as planned - Urology, backlog has remained static - Max fax backlog has reduced but the paediatric element has been hampered by lack of paediatric elective capacity as have both paediatric surgery and urology - Gynaecology, has seen a steady reduction in the backlog -Orthopaedics, backlog has steadily reduced , but is continually a risk due to the unstainable non admitted backlog position	The Trust is achieving 2 of the 3 RTT standards: Non admitted performance is 96% against a target of 95%. Incomplete performance 95% against a target of 92%. The weekly access meeting is changing as is the predictive ability of ensuring delivery. - Additional activity at weekends until the end of March - Urology additional in house and independent sector activity will start in January - Additional weekend work across the paediatric specialities is planned from January onwards - Additional work in house but also with the local independent sector - Orthopaedics and Urology remain the greatest risk to the Trust RTT performance. Weekend working continues, additional outsourcing to the local Independent sector for elective activity has been agreed and will start mid January. Outsourcing of referrals for outpatients will continue.	90% of patients treated within 18 weeks	86.8% (UHL and Alliance)	86.8%	86%

The graph below illustrates the backlog reduction at Trust level



Risks

Orthopaedics and Urology backlog sizes are a risk to the Trust. Overall the level of admitted backlog reduction required by the end of February to assure achievement of the admitted standard in March is very significant. (Circa 400 admitted reduction)

Mitigation

All key speciality plans being reviewed by Director of Performance and Information.
Re modelling of anticipated performance.
Ongoing additional activity in key specialities.
Additional outsourcing of activity in January to March, supported by TDA additional

		funding. Weekly CCG RTT meetings. There is currently a signficant revision to the performance management around 18 weeks which will ensure more conistent delivery as well as supporting earlier corrective actions.	
		Expected date to meet standard / target	March 2015
		Lead Director / Lead Officer	W Monaghan C Carr

R7: 6 week diagnostics tests waiting time

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Standard</th><th>December 2014</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="5">The Trust is measured on the waiting times of the top 15 diagnostic modalities, these are reported at the end of each month.

NB: these modalities cross all CMG's
There are a number of factors that have caused this underperformance:

Imaging (accounting for 31% of breaches)

- Cardiac CT and MRI, there remains insufficient capacity – this is ongoing issue and these are supervised scans so need consultant radiologist availability
- MSK MRI , these are consultant specific test

Dexa (accounting for 35%of breaches)
- During November there was a system failure resulting in the breaching of the standard. No alternative capacity available

Endoscopy (accounting for 19% of breaches)
- Colonoscopy / Flexi sigmoidoscopy / Gastroscopy

Additionally, there were small volumes of breaches of the standard in a number of other modalities.

Collectively these have caused a breach of the standard a total of 219 patients waiting over 6 weeks.</td><td rowspan="5">Cardiac CT and MRI
Additional sessions being carried out by cardiologists during December to February. With a business case for substantive capacity increase going to the CMG board in January
MSK imaging capacity
New MSK radiologist starts in January 20I5

Dexa
Scanner now repaired. Contingency plan between Imaging and Rheumatology being finalised. Dealing with the backlog of patients waiting over 6 weeks should be completed in February.
Endoscopy
Additional endoscopy work is being carried out by Medinet on UHL site from mid January

All other modalities
Robust waiting list management, additional capacity where there is risk of breaching , dating patients in date order</td><td><1% over 6 weeks</td><td>1) UHL and Alliance combined 2.2%</td><td>2.2%</td><td><1.8%</td></tr>
<tr><td colspan="4">Risks:
There remain risks to achievement of this standard due to the instability of a number of diagnostic modalities which collectively make up this standard.</td></tr>
<tr><td colspan="3">Expected date to meet standard / target</td><td colspan="2">November 2014</td></tr>
<tr><td colspan="3">Revised date to meet standard</td><td colspan="2">March 2015</td></tr>
<tr><td colspan="3">Lead Director / Lead Officer</td><td colspan="2">Richard Mitchell
Suzanne Khalid / Jo Fawcus / Jane Edyveane</td></tr>
</table>

Cancer Waiting Times Performance R8 – R 15

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance November	Performance to date 2014/15	Forecast performance for December
R8 1) There has been an annualised increase of 18% in 2WW suspected cancer referrals in 2014/15 to date 2) This is likely to continue to grow 3) This has not been matched by increased provision of carved out availability, nor sufficient response to individual cancer type awareness campaigns 4) December performance additionally impaired by patient choice over Christmas period **R10, 12, 14, 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.	The Cancer Centre has taken the following actions to further strengthen the support offered to the CMGs in delivering cancer performance; 1) All 2WW referrals processed within 24 hours of receipt since December 2014 2) Revision to Monday CAB meetings to ensure that patient level management may be expedited whilst reducing the time commitment of the meeting 3) Cancer tracking reaching earlier into pathways to flag delays to services empowered to expedite "next steps" maximising opportunities for host services to deliver treatment dates within breach. These corporate actions are facilitating. Delivery of cancer performance will continue to depend upon CMGs prioritising cancer patient pathways in recognition of their complexity and the tight time lines compared with other elective care standards. The Cancer Centre and Director of Performance will meet with the CMGs to review how best they can be supported in the delivery of these standards.	**R8 2WW 93%**	**92.5%**	**92%**	**92.1%**
		R10 31 day 1st 96%	**92.5%**	**94.5%**	**93%**
		R12 31 day sub (Surgery) 94%	**82.4%**	**89.6%**	**81.5%**
		R14 62 day RTT 85%	**77%**	**81.2%**	**81.8%**
		R15 62 screening 90%	**94.4%**	**82.8%**	**93.3%**

Performance by Quarter

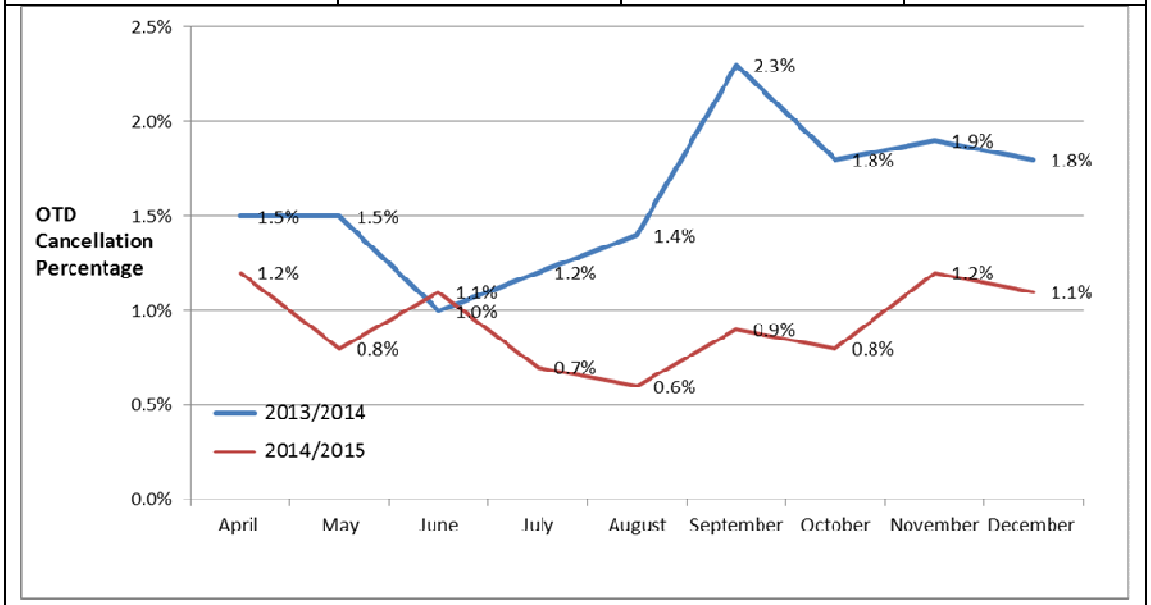
	13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
R8	**94.8%**	**92.2%**	**91.6%**		
R10	**98.1%**	**94.6%**	**94.6%**		
R12	**98.2%**	**94.2%**	**90.5%**		
R14	**86.7%**	**84.1%**	**79.9%**		
R15	**95.6%**	**78%**	**85%**		

Expected date to meet standard / target	R8 – Recovery possible December R10,12 – Recovery possible January '15 R14,15 – Recovery possible February '15
Revised date to meet standard	Each target has slipped one month since the last report
Lead Director / Lead Officer	Will Monaghan Matt Metcalfe

R16-R22 : cancelled operations

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 (mthly) 1)On day=0.8% 2) 28 day = 0	Latest month performance – Dec14	YTD performance (inc Alliance)	Forecast performance for next reporting period
The reasons for OTD cancellations changed in December. Out of 97 cancellations there were 26 patients cancelled due to HDU and ITU bed unavailability. 23 of these was adult HDU and ITU bed unavailability. This ITU capacity issue was on all sites – LRI (9), GGH (9) and LGH (5). Emergency admissions to the ITU at LRI increased significantly this year compared to the last three years. This added pressure to elective activity causing OTD cancellations and 28 days breaches in December. There were 21 OTD cancellations due to ward bed unavailability. On 17 of these occasions, cancellations occurred due to emergency bed pressures. There were three, 28 day breaches. This was as a result of last month's paediatric OTD cancellations. Two patients have already been treated and the other patient is listed for 27 of January.	The key action to ensure on-going performance is the daily tracking of patients at risk of cancellation and following the UHL cancelled escalation policy. For those cancelled on the day, it is vital that they adhere to the Trust policy of escalating to CMG General Managers for resolution, prior to agreeing any cancellations. A number of work streams have started aimed at reducing OTD cancellations including a LIA project. <u>Risks to delivery of recovery plan</u> Limited HTU and ITU bed availability for elective work due to emergency admissions is still a risk to OTD cancellations and 28 day breaches. The situation has been monitored on a daily basis to prevent OTD cancellations. Plans are on placed to improve the patient booking processes to maintained realistic number of elective bookings in critical care in the winter months when there is most pressure to admit emergency patients.	1) 1.1% 2) 3	1) 1.1% 2) 3	1) 0.9% 2) 33	1) 1.0% 2) 5

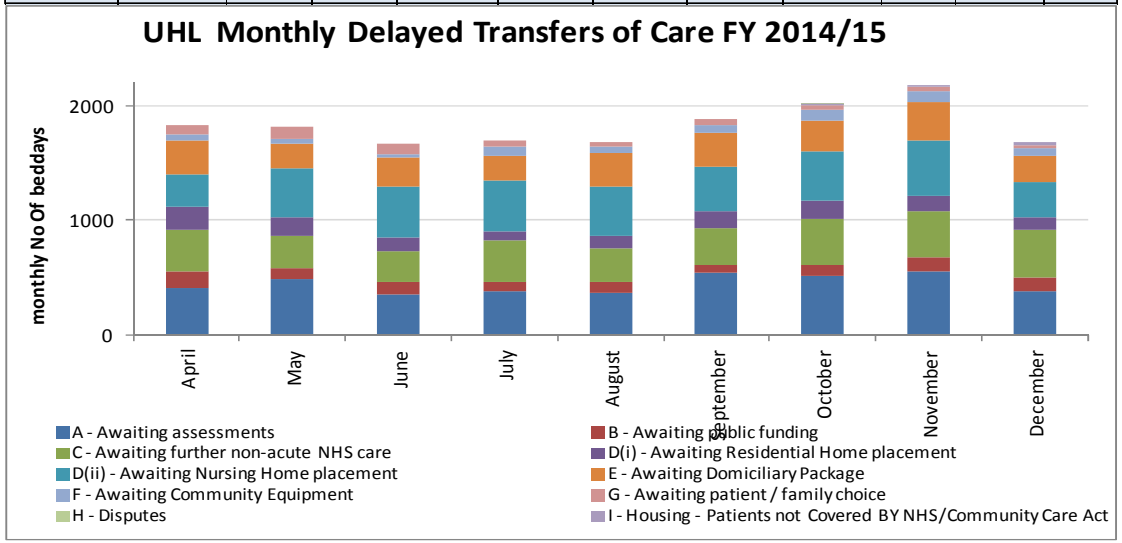


Expected date to meet standard / target	On the day cancellations – January 2015 28 day rebooking - February
Lead Director / Lead Officer	Richard Mitchell/Phil Walmsley

R23 Delayed Transfers of Care

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
There has been a reduction in delays due to DTOC in December compared to the preceding three months. Areas of concern remain availability of packages of care in the County Local Authority. Interim placements in care homes are offered to patients but are not always accepted. There continue to be a number of DTOCs due to slow discharges to care homes. This is caused by families being slow to find appropriate care homes, carehomes being slow to come in to assess the patient as suitable or waiting for a bed to become available.	There has been a considerable reduction in the number of patients waiting, which will be partly due to the increased external support to get patients out of hospital over the Christmas period. Community teams continue to attend wards to identify patients that they could take directly in to their home based services. This has extended to supporting Glenfield with positive results	3.5%	3.9%	4.3%	4.0%

Row Labels	A - Awaiting assessments	B - Awaiting public funding	C - Awaiting further non-acute NHS care	D(i) - Awaiting Residential Home placement	D(ii) - Awaiting Nursing Home placement	E - Awaiting Domiciliary Package	F - Awaiting Community Equipment	G - Awaiting patient / family choice	H - Disputes	I - Housing - Patients not Covered BY NHS/Community Care Act	Grand Total
April	407	148	356	207	285	285	55	87			1830
May	494	90	277	166	425	218	34	113			1817
June	353	103	277	122	433	253	36	89			1666
July	387	77	353	82	444	215	85	54			1697
August	371	87	302	98	430	294	61	41			1684
September	546	57	333	141	394	286	65	57			1879
October	520	84	402	159	434	266	95	40	4	3	2007
November	561	119	392	134	484	343	88	46		9	2176
December	384	120	408	113	312	222	74	26		21	1680
Grand Total	**4023**	**885**	**3100**	**1222**	**3641**	**2382**	**593**	**553**	**4**	**33**	**16436**



Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
4.1%	4.2%	4.1%	4.6%	

Expected date to meet standard / target	TBA
Revised date to meet standard	TBA
Lead Director / Lead Officer	Richard Mitchell/Phil Walmsley

R24 Choose and Book

<table>
<tr><td></td><td></td><td>Target</td><td></td><td></td><td></td></tr>
<tr><td>What is causing underperformance?</td><td>What actions have been taken to improve performance?</td><td><4% ASI</td><td>December</td><td>YTD performance</td><td>Forecast performance for next reporting period</td></tr>
<tr><td rowspan="5">The Trust is measured on the % of Appointment Slot Unavailability (ASI) per month.

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

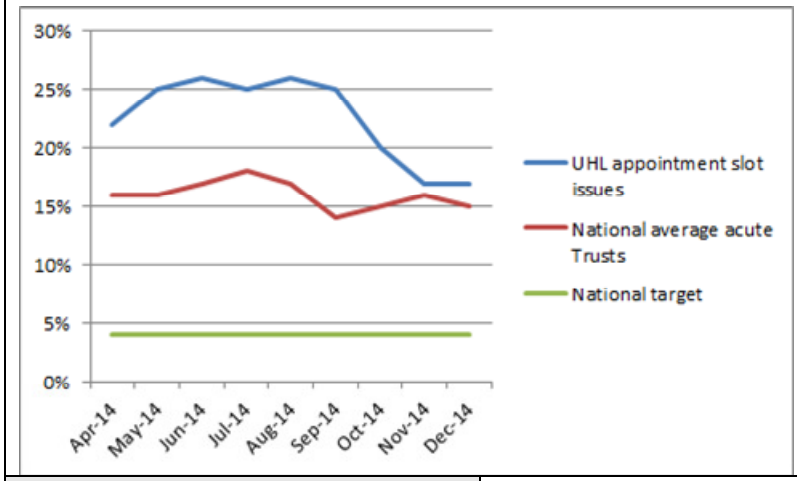
The two most significant factors causing underperformance are:

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

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

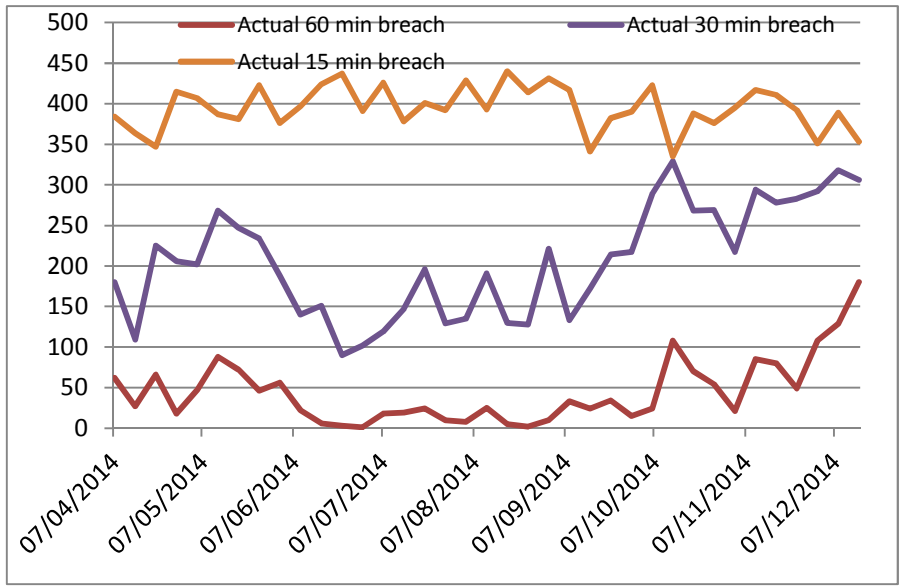
Additional capacity in key specialties is part of the RTT recovery plans

Training and education

The comprehensive training and education of relevant staff in key specialties continues, to ensure that choose and book is correctly set up and that supporting administrative purposes are fit for purpose.
A speciality level ‘score card’ to highlight areas required for improvement is being distributed weekly to CMGs. This highlights areas for concern and actions required.</td><td><4%</td><td>17%</td><td>22%</td><td>15%</td></tr>
<tr><td colspan="4">National performance varies significantly by Trust, with average performance of Acute Trusts nationally at 15% in November
 
</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">January 2015</td></tr>
<tr><td colspan="2">Revised date to meet standard</td><td colspan="2">March 2015</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Richard Mitchell
Charlie Carr</td></tr>
</table>

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

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
Pressures in accessing beds continue to lead to a backlog in the assessment area of ED. This delays movement out of the assessment area and delays handover. December was difficult from a bed occupancy perspective and this is evidenced in the handover performance for over 60 minutes which has deteriorated significantly. It should be noted that the overall attendances via ambulance have gone up by around 100 per week in December	**Resuscitation** An audit of patients being handed over in resuscitation has been completed. This shows that all patients going in to resuscitation are handed over within the 15 minute timeline. EMAS need to reinforce the new processes with their staff regarding back timing the point of handover. UHL audit in December indicates that numbers achieving 15 minutes is being under reported. EMAS response to this audit is awaited. **Paediatrics** Audit taking place to validate data on Paeds patients - this is indicating all arrive and handed over in 15 mins **60 minutes** The audit of over 60 minutes delays has not been repeated yet due to difficulties in meeting with EMAS. This has been escalated to the CCG. This audit showed discrepancies between UHL and EMAS data. (Audit from 14th Oct 60 min plus showed only 8 agreed by UHL and these were due to GGH capacity and evacuation of EDU due to fire alarm). Discussions are taking place over the method of collecting information on handover times. This is to be agreed with EMAS and taken back to the CCGs as an agreed approach for February.	0 delays over 15 minutes	> 60 min 6% 30-60 min – 24% 15-30 min – 33%	> 60 min 3% 30-60 min – 17% 15-30 min – 36%	



Expected date to meet standard / target	
Revised date to meet standard	
Lead Director / Lead Officer	Richard Mitchell/Phil Walmsley

RS2A

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
HLO2A: Proportion of commercial contract studies achieving their recruitment target during their planned recruitment period East Midlands is currently 6th of the 15 LCRNs for this metric with no LCRN currently achieving the 80% target, highest is currently 65% 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	Migration of the performance data for all open and closed commercial research onto one internet based system to track performance for 2014/15. Implementation of a provisional performance management process involving the Industry Team and Delivery Managers to escalate studies not recruiting to target within 24 hours and to align targets. 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. 6 to 8 weekly performance meetings with delivery managers have been introduced to address this issue from the start of December. Collation of local information to report on the actual figure to take account for the lag in National reporting.	**80%**	**68% (Amber)**	**54%**	**54%**
		Expected date to meet standard / target			
		Revised date to meet standard	April 2015		
		Lead Director / Lead Officer	May 2015		

RS6A

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
HLO6A: Proportion of NHS Trusts recruiting each year into non-commercial NIHR CRN Portfolio studies The NIHR Clinical Research Network has an HLO with the Department of Health for 99% of Trusts in England to recruit to CRN Portfolio research each year. This has been passed down to local research networks. There are 16 Trusts within the East Midlands region, with 14 Trusts currently reporting recruitment. The two who have not reported any recruitment are: ● East Midlands Ambulance Service NHS Trust (EMAS) ● Lincolnshire Community Health Services (LCHS)	1. **EMAS**: have received funding in 2014/15 for a Research Paramedic. This post currently supports two NIHR Portfolio studies that do not report recruitment in the traditional way due to patient assent taken rather than consent. EMAS have four studies in the pipeline that are due to open this financial year. One of those studies, AIRWAYS II, may report report participant recruitment this financial year. 2. **LCHS**: this Trust supports several CRN Portfolio studies, however the consent event occurs in the primary care setting so the recruitment is attributed to Clinical Commissioning. There is scope for research within the community services (paediatrics, district nursing) that is being investigated, however it is unlikely that this Trust will report recruitment this financial year.	**99%**	**81% (red)**	**88% (red)**	**88%**
		Expected date to meet standard / target			
		Revised date to meet standard	It is unlikely we will make the 99% target due to the nature of the services provided by LCHS. We may reach 94% by April 2015.		
		Lead Director / Lead Officer			

RS6b

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
HLO6B: Proportion of NHS Trusts recruiting each year into commercial NIHR CRN Portfolio studies There are 16 Trusts within the East Midlands region, with 9 Trusts currently recruiting to commercial studies. The seven who have not reported any recruitment are: • East Midlands Ambulance Service NHS Trust (EMAS) • Derbyshire Community Health Services NHS Foundation Trust (DCHS) • Lincolnshire Community Health Services (LCHS) • Leicestershire Partnership NHS Trust (LePT) • Lincolnshire Partnership NHS Trust (LiPT) • Nottinghamshire Healthcare NHS Foundation Trust (NHFT) • Derbyshire Healthcare NHS Foundation Trust (DHFT)	**EMAS**: Currently no open commercial studies nationally run by ambulance services on the NIHR portfolio, therefore unlikely that EMAS will open a commercial study this financial year. Industry team currently reviewing studies previously run at other ambulance services across the country to gain insight. Meeting with Trust and RDM for Division 6 to discuss this month **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. **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. **LePT**: Selected for one study, due to open by the end of 2014. One study also being taken forward with sponsor and awaiting confirmation if selected **LiPT**: have been involved in commercial research in the past and the site is actively seeking commercial opportunities **NHFT**: One trial initiated at the end of November 2014, 2nd UK site to open **DHFT**: One trial recently opened to recruitment closed early prior to recruitment. 2 studies in the pipeline	**70%**	**56% (red)**	**56% (red)**	**56%**
		Expected date to meet standard / target			
		Revised date to meet standard	April 2015		
		Lead Director / Lead Officer	June 2015		

2014/15 NTDA METRICS AND WEIGHTINGS

Responsiveness Domain

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

Effectiveness Domain

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

Safe Domain

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

Caring Domain

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

Well Led Domain

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

CQC – Intelligent Monitoring Report

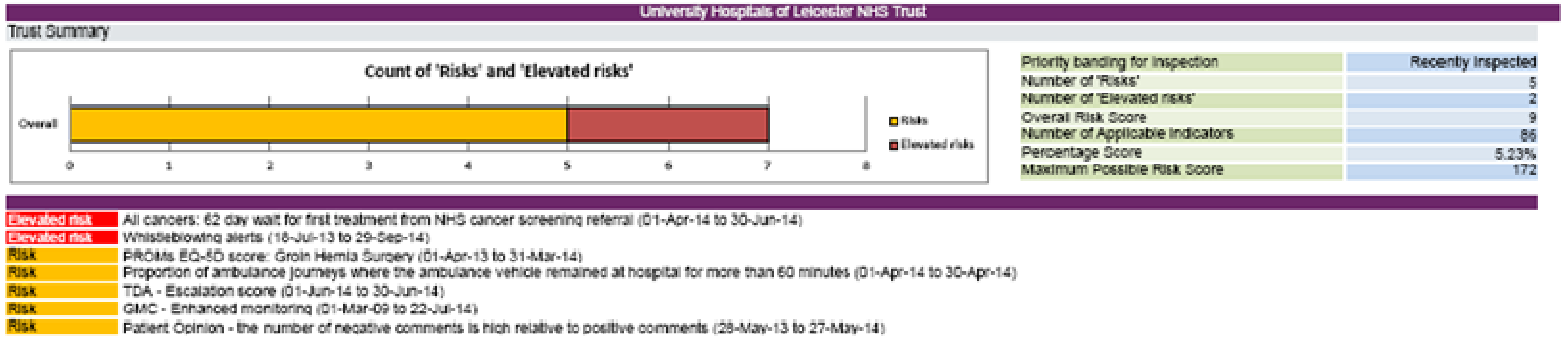
The latest CQC Intelligent Monitoring Report (IMR) was published on 3rd December 2014.

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

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

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

One elevated risk remains unchanged (whistleblowing alerts), one new elevated risk has been added (cancer waiting times), three indicators are unchanged at risk (ambulance times, TDA and GMC) and PROMs (groin hernia surgery) and patient opinion comments are new risks (not flagged in the previous IMR).



Quality Schedule and CQUIN Performance Summary – Predicted RAG for Quarter 3

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Commentary
	QUALITY SCHEDULE				
PS01	Infection Prevention and Control Reduction. - C Diff	G	A	G	Monthly reporting of C Diff. Threshold for 14/15 is 81. UHL is aiming to achieve a reduction on last year's total of 66 and has given itself a Target of 50 . 52 cases as at end of November which is below the NTDA trajectory. Amber RAG for Q3 to be revised upon receipt of Multi-Drug Resistant Bacteraemia data.
PS02	HCAI Monitoring - MRSA	0	1	2	1 in October and 2 in December. All reviews to date confirm these were unavoidable..
PS03	Patient Safety – SIs, Never Events	G	G	2	0 Never Events in Q1 in Q2. 1 in October (relating to 'Retained Swab ties) and 1 in December (wrong site surgery). Reduction in Patient Safety Incidents but increase in % causing harm. Further increase in number of PSIs awaiting review. Increase in GP concerns
PS04	Duty of Candour	0	0	0	No breaches.
PS05	Complaints and user feedback Management (excluding patient surveys).	A	A	A	Complaints responses performance improved slightly although still below threshold. Deterioration for responding to 're-opened complaints.
PS06	Risk Assurance and CAS Alerts	A	A	G	Amber RAG for Q2 relates to overdue CAS alerts for July. No overdue CAS alerts and all risk reviews and actions on Track
PS07	Safeguarding – Adults and Children	G	G	G	Assurance documentation due to be sent to CCG Safeguarding leads for their review ahead of their observational visit to the Trust. Discussions underway regarding CONI requirements (Care of Next Infant) and changes proposed to the SAAF.
PS08	Reduction in Pressure Ulcer incidence.	G	G	A	Monthly thresholds met for G3 HAPUs and no G4s, however 4 above the monthly trajectory for Grade 2 HAPUs in November and 2 above for December.
PS09	Medicines Management Optimisation	A	G	G	Commissioners noted improvement in Controlled Drugs audit report. Progress made with developing LLR Medicines Optimisation Strategy.
PS10	Medication Errors	G	G	G	Increased reporting of errors and actions being taken.
PS11	Venous Thromboembolism (VTE) and RCAs of Hospital Acquired Thrombosis	95.7%	96.1%	tbc	Performance above the national set threshold of 95% for Oct and Nov. Provisional data shows performance below 95% for December. Predominantly due to missing data. Retrospective review of case notes in progress and 95% threshold expected to be confirmed in time for reporting to DoH. RCAs in progress for Q3 Hospital Acquired Thrombosis.
PS12	Nutrition and Hydration	G	>80%	>85% tbc	Work programme on track for nutrition, some delays with hydration actions. December data to be validated.
PE1	Same Sex Accommodation Compliance and Annual Estates Monitoring	2	0	2	0 breaches reported for Q2. 2 breaches in November with 5 patients affected – relates to non Level 2 patients being in mixed sex accommodation in HDU.
PE2	Patient Experience, Equality and Listening to and Learning from Feedback.	G	G	tbc	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	Not due to be reported until March 15
PE4	Equality and Human Rights	G	G	G	Progress reported to the September CQRG with further information provided in October – relating to actions being taken to capture BME data
CE01	Communication – Content (ED, Discharge & Outpatient Letters)	A	A	A	Clinical Problem Solving Group held to agree key priorities. Letters policy finalised and due to be launched end of Jan 15.
CE02	Intra-operative Fluid Management	G	>80%	tbc	Q3 RAG dependent upon confirmation of 80% trajectory being maintained.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Commentary
CE03	Clinical Effectiveness Assurance – NICE and Clinical Audit	A	A	tbc	Small number of outstanding responses for NICE Clinical Guideline / Quality Standards documents. Actions being taken where audits behind schedule
CE04	Women's Service Dashboard	A	A	tbc	Amber RAG for Q2 relates to increase in C Section Rate. .
CE05	Children's Service Dashboard	A	A	tbc	Q2 Amber RAG relates to SpR training
CE06	Patient Reported and Clinical Outcomes (PROMs and Everyone Counts)	A	A	G	Groin Hernia PROMs deteriorated and reported as a Risk in the embargoed CQC Intelligent Monitoring Report. Individual patient data now obtained. Initial review against patient case notes not identified any clinical issues. Consultant Outcomes published and all consultants in line with national average
CE07	#NOF - Dashboard	51%	67.9%	62.1%	72% threshold not met for any month in Q3. Mainly relates to peaks in activity and spinal patients.
CE08a	Stroke monitoring	86%	81.6	71.7% tbc	Although '90% stay on stroke Unit' not achieved for October and potentially below threshold for November, improvements made for other stroke indicators (time to scan, admission to stroke unit, thrombolysis)
CE08 b	TIA monitoring	76%	67%	73.4%	Threshold achieve for each month for high risk patients and performance improved for low risk patients being seen within 7 days.
CE09	Mortality (SHMI, HSMR)	A	A	A	UHL's SHMI remains above 100. Mortality alert reviews completed on track and MRC work programme is on schedule.
CE10	Making Every Contact Count (MECC)	A	G	G	Referrals to STOP and ALW continue. 'Healthy Eating and Physical Activity publicity campaign due to commence in General Surgery and Sleep Clinics.
AS01	Cost Improvement Programme (CIP) Assurance	A	G	G	Q2 RAG revised upon receipt of additional assurance.
AS02	Ward Healthcheck (Nursing Establishment, Clinical Measures Scorecard)	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	Thresholds not met for Appraisal, Sickness and Corporate Induction or Turnover although improvement noticed. Medical Staffing Strategy submitted.
AS04	Involving employees in improving standards of care. (Whistleblowing)	G	G	G	Actions taken to address concerns raised.
AS05	Staff Satisfaction	G	G	G	
AS06	External Visits and Commissioner Quality Visits	G	G	G	
AS07	CQC Registration	A	G	G	
	NATIONAL CQUINS				
Nat 1.1a	F&FT 1a - Staff	G	G	G	Implemented during Q1/2. No Staff F&FT survey undertaken in Q3 as National Staff Survey.
Nat 1.1b	F&FT 1b - OutPt & Day Case	G	G	G	F&FT already happening in Day Case and has started in Outpatients.
Nat 1.2	F&FT 1.2 - Increased participation - ED	16.%	15.1%	16.2%	Performance dropped significantly in November but up to 18.7% in December and YTD rate of 15.8% . Need to achieve 20% for Q4 to meet CQUIN requirements.
Nat 1.3	F&FT 1.3 - Inpt increase in March	35.8%	31%	34.7%	Drop in December from 36% to 31.9% but still on track to achieve Q4 30% threshold. Need to achieve 40% for March 15 for additional CQUIN monies.
Nat 2.1	ST 2.1 - ST data submission	G	G	G	Data collection continues for all 4 harms.
Nat 2.2	ST 2.2 - LLR strategy	G	G	G	UHL contributing to the LLR Pressure Ulcer group and workstreams
Nat 3.1	Dementia 3.1 - FAIR	G	G	G	90% thresholds met for all parts of the Dementia FAIR CQUIN.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Commentary
Nat 3.2	Dementia 3.2 - Training & Leadership	G	G	tbc	Nicky Morgan is new Clinical Lead Dementia Training Programme reviewed and revised. Q3 RAG dependent on evidence of increased staff attending training.
Nat 3.3	Dementia 3.3 - Carers	G	G	G	Surveys carried out and evidence of actions being taken
	LOCAL CQUINS				
Loc 1	Urgent Care 1 (Discharge)	G	G	tbc	RAG dependent upon commissioners' support for work undertaken in Q3. Thresholds revised in order to reflect 2 year timescale of CQUIN scheme
Loc 2	Urgent Care 2 (Consultant Assessment)	G	G	tbc	60% Q2 threshold achieved due to significant improvement in AMU. Q3 audit being undertaken to see if Q3 threshold of 65% achieved.
Loc 3	Improving End of Life Care (AMBER)	G	G	G	AMBER implemented on 4 wards during Q2 and progress made with training. New facilitators in post and so should be back on track by end of Q3
Loc 4	Quality Mark	G	G	G	Quality Mark achieved for 6 out of the 8 wards to date.
Loc 5	Pneumonia	A	G	tbc	CQUIN payments reapportioned and so reduced loss of income for Q1. Q2 threshold achieved for all aspects of CQUIN scheme. Q3 audit being undertaken.
Loc 6	Think Glucose	G	G	G	Think Glucose programme on track.
Loc 7	Sepsis Care pathway	≥47%	≥60%	tbc	Care Bundle thresholds achieved and good progress made against action plan.
Loc 8	Heart Failure	≥49.5%	≥63%	tbc	Commissioner reviewed progress with both the Care Bundle and also IV diuretic Service.
Loc 9	Medication Safety Thermometer	G	G	G	90% of Wards participating in the Medication Safety Thermometer
	SPECIALISED CQUINS				
SS1	National Quality Dashboards	G	G	t of CQUIN scheme.Q 1 as although threshold just missed, acknowled ged increased activity and good progress made with other aspectbc	Dashboards now open for data submission at end of Q3
SS2	Breast Feeding in Neonates	61%	66%	tbc	Thresholds achieved for Q2 and on track for Q3.
SS3	Clinical Utilisation Review of Critical Care	N/A*	G	tbc	CCMDS and ICNARC data now being collected for ACB and plans in place to commence in other HDUs by end of March 15.
SS4	Acuity Recording	N/A*	G	G	Acuity recording in place for all areas. RAG dependant upon being able to demonstrate effective use of Acuity data.
SS5	Critical Care Standards - Disch	N/A*	G	tbc	RAG dependant on being able to demonstrate reduction in 4 hr discharge delays from Critical Care Units
SS6	Critical Care Outreach Team	N/A*	G	tbc	RAG dependant upon being able to demonstrate increased data collection for Outreach response times.
SS7	Consultant Assessment	G	G	tbc	Links to the CCG CQUIN.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Commentary
SS8	Highly Specialised Services Collaborative Workshop	G	G	G	Q3 threshold is to provide update regarding participation in Clinical Benchmarking for both ECMO and PCO.