Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

June 2015

One team shared values

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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

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

DATE: **30th JULY 2015**

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ANDREW FURLONG, INTERIM MEDICAL DIRECTOR
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SUBJECT: **JUNE 2015 QUALITY & PERFORMANCE SUMMARY REPORT**

1.0 Introduction

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

2.0 Performance Summary

Domain	Page Number	Number of Indicators	Indicators with target to be confirmed	Number of Red Indicators this month
Safe	4	22	7	0
Caring	5	10	3	0
Well Led	6	18	6	3
Effective	7	16	4	1
Responsive	8	28	1	9
Research – UHL	10	6	6	0
Research - Network	10	13	0	3
Estates & Facilities	11	10	0	1
Total		123	27	17

3.0 New Indicators

Responsive

Cancer waiting 104 day

4.0 Indicators removed

Responsive

ED 4 Hour Waits UHL + UCC (SITREP month) – weekly SITREPs reporting has ceased and moved to monthly reporting

5.0 Indicators where reporting methodology/thresholds have changed

Caring

Inpatients (Including Day cases) Friends and Family Test - % positive – incremental thresholds set
A&E Friends and Family Test - % positive – incremental thresholds set
Outpatients Friends and Family Test - % positive – incremental thresholds set
Day case Friends and Family Test - % positive – incremental thresholds set
Maternity Friends and Family Test - % positive – incremental thresholds set

Well Led

Inpatients Friends and Family Test - Coverage (Adults and Children) – thresholds and RAG rating aligned to Quality Commitment
Day case Friends and Family Test - Coverage (Adults and Children) – thresholds and RAG rating aligned to Quality Commitment
A&E Friends and Family Test – Coverage – thresholds and RAG rating aligned to Quality Commitment
Outpatients Friends and Family Test – Coverage – thresholds and RAG rating aligned to Quality Commitment
Maternity Friends and Family Test – Coverage – thresholds and RAG rating aligned to Quality Commitment
Nursing Vacancies – 15/16 thresholds agreed

Effective

Mortality - Rolling 12 mths SHMI (as reported in HED) – rebasing has changed previously reported figures

Responsive

Choose and Book – renamed NHS e-Referral System
Ambulance Handover for June reported from CAD+ - data quality issues identified in that there is missing data and duplicate records

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

	KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
Safe	S1	Clostridium Difficile	CR	DJ	61	TDA	Red = >mthly threshold / ER if Red or Non compliance with cumulative target	66	73	6	5	7	2	5	7	7	11	7	5	7	3	1	4	8
	S2a	MRSA Bacteraemias (All)	CR	DJ	0	TDA	Red = >0 ER = >0	3	6	0	0	0	0	1	1	0	2	0	1	1	0	0	0	0
	S2b	MRSA Bacteraemias (Avoidable)	CR	DJ	0	UHL	Red = >0 ER = >0	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
	S3	Never Events	CR	MD	0	TDA	Red = >0 in mth ER = in mth >0	3	3	0	0	0	0	0	1	0	1	1	0	0	0	1	0	1
	S4	Serious Incidents	CR	MD	Not within Highest Decile	TDA	TBC	60	41	6	3	7	2	3	4	2	4	3	2	1	2	8	1	11
	S5a	Proportion of reported safety incidents per 1000 beddays	CR	MD	TBC	TDA	TBC	37.5	39.1	40.2	40.4	41.1	35.6	41.8	38.9	40.3	40.4	35.0	38.2	36.3	34.6	37.3	39.6	37.2
	S5b	Proportion of reported safety incidents that are harmful	CR	MD	Not within Highest Decile	TDA	TBC	2.8%	1.9%	1.7%		2.2%			1.4%			2.3%			2.2%			2.2%
	S6	Overdue CAS alerts	CR	MD	0	TDA	Red = >0 in mth ER = in mth >0	2	10	2	2	3	0	0	0	0	0	0	0	1	0	0	0	0
	S7	RIDDOR - Serious Staff Injuries	CR	MD	FYE = <40	UHL	Red / ER = non compliance with cumulative target	47	24	5	1	2	2	1	2	2	1	0	3	2	0	6	0	6
	S8a	Safety Thermometer % of harm free care (all)	CR	EM	Not within Lowest Decile	TDA	Red = <92% ER = in mth <92%	93.6%	94.1%	94.7%	94.2%	94.9%	94.4%	93.9%	94.9%	93.3%	94.1%	95.0%	92.1%	93.6%	93.7%	94.3%	95.6%	94.5%
	S8b	Safety Thermometer % number of new harms	CR	EM	Not within Lowest Decile	TDA	TBC	New TDA Indicator		1.7%	2.7%	2.4%	2.9%	2.5%	2.3%	3.3%	2.4%	2.5%	3.2%	2.7%	2.2%	2.6%	2.1%	2.3%
	S9	% of all adults who have had VTE risk assessment on adm to hosp	AF	SH	95% or above	TDA	Red = <95% ER = in mth <95%	95.3%	95.8%	95.9%	95.9%	96.3%	95.5%	96.2%	95.4%	95.5%	95.0%	96.3%	96.2%	95.6%	96.0%	96.0%	96.5%	96.2%
	S10	All Medication errors causing serious harm	AF	CE	0	TDA	Red = >0 in mth ER = in mth >0	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																
	S11	All falls reported per 1000 bed stays for patients >65years	CR	HL	<7.1	QC	Red >= YTD >8.4 ER = 2 consecutive reds	7.1	6.9	7.5	7.1	7.3	7.3	5.9	6.4	7.5	6.9	7.1	6.7	6.3	5.6	5.8	5.1	5.5
	S12	Avoidable Pressure Ulcers - Grade 4	CR	MC	0	QS	Red / ER = Non compliance with monthly target	1	2	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0
	S13	Avoidable Pressure Ulcers - Grade 3	CR	MC	<=6 a month	QS	Red / ER = Non compliance with monthly target	71	69	5	5	5	6	6	4	6	7	5	9	6	3	0	4	7
	S14	Avoidable Pressure Ulcers - Grade 2	CR	MC	<=8 a month	QS	Red / ER = Non compliance with monthly target	120	91	6	6	7	9	4	8	13	11	7	5	9	10	8	8	26
	S15	Compliance with the SEPSIS6 Care Bundle	AF	JP	All 6 >75% by Q4	QC	Red/ER = Non compliance with Quarterly target	27.0%	<65%	47.0%		>=60%			<65%			<75%						
	S16	Maternal Deaths	AF	IS	0	UHL	Red or ER =>0	3	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
	S17	Emergency C Sections (Coded as R18)	IS	EB	Not within Highest Decile	TDA	Red / ER = Non compliance with monthly target	16.1%	16.5%	16.0%	14.7%	16.9%	15.4%	17.4%	18.1%	17.4%	16.2%	17.7%	15.5%	15.8%	15.3%	18.8%	15.8%	16.7%
	S18	Potential under reporting of patient safety indicators	CR	MD	Not within Highest Decile	TDA	Red / ER = Non compliance with monthly target	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																
	S19	Potential under reporting of patient safety indicators resulting in death or severe harm	CR	MD	Not within Highest Decile	TDA	Red / ER = Non compliance with monthly target	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																

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Caring	C1	Inpatients (Including Daycases) Friends and Family Test - % positive	CR	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red <95% ER 2mths Red	New Indicator	96%	96%	97%	97%	96%	97%	96%	96%	96%	96%	96%	97%	96%	96%	97%	96%
	C2	A&E Friends and Family Test - % positive	CR	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red <94% ER 2mths Red	New Indicator	96%	97%	95%	96%	92%	95%	96%	96%	96%	96%	96%	97%	96%	96%	96%	96%
	C3	Outpatients Friends and Family Test - % positive	CR	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red <90% ER 2mths Red	NEW METHODOLOGY FOR CALCULATING %													94%	94%	93%	93%
	C4	Daycase Friends and Family Test - % positive	CR	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red <95% ER 2mths Red														96%	97%	97%	97%
	C5	Maternity Friends and Family Test - % positive	CR	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red <94% ER 2mths Red		96%	96%	96%	96%	96%	94%	96%	97%	95%	97%	96%	96%	95%	96%	95%	95%
	C6	Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment	ES	ES	Not within Lowest Decile	TDA	TBC	New Indicator	69.2%	68.3%		67.2%			Q3 staff FFT not completed as National Survey carried out			71.4%			68.7%			68.7%
	C7a	Complaints Rate per 100 bed days	AF	MD	TBC	UHL	TBC	New Indicator	0.4	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.4	0.3	0.3	0.3	0.3
	C7b	Written Complaints Received Rate per 100 bed days	AF	MD	Not within Highest Decile	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																
	C8	Complaints Re-Opened Rate	AF	MD	<=12%	UHL	Red = >=15% ER = >=15%	New Indicator	10%	5%	8%	11%	10%	9%	11%	11%	10%	17%	13%	11%	13%	7%	7%	9%
	C9	Single Sex Accommodation Breaches (patients affected)	CR	HL	0	TDA	Red = >0 ER = in mth >0	2	13	3	0	0	0	0	0	5	0	1	0	0	0	0	0	0

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Well Led	W1	Inpatients Friends and Family Test - Coverage (Adults and Children)	CR	HL	30%	TDA	Red <26% ER 2mths Red	NEW METHODOLOGY FOR CALCULATING COVERAGE INCLUDES ADULTS AND CHILDREN													29.2%	30.5%	29.0%	29.5%
	W2	Daycase Friends and Family Test - Coverage (Adults and Children)	CR	HL	20%	TDA	Red <8% ER 2mths Red	NEW METHODOLOGY FOR CALCULATING COVERAGE INCLUDES ADULTS AND CHILDREN													12.5%	12.1%	15.5%	13.5%
	W3	A&E Friends and Family Test - Coverage	CR	HL	20%	TDA	Red <10% ER 2mths Red	NEW METHODOLOGY FOR CALCULATING COVERAGE INCLUDES ADULTS AND CHILDREN													14.7%	14.9%	13.3%	14.3%
	W4	Outpatients Friends and Family Test - Coverage	CR	HL	Q1 3% Q2/3 4% Q4 5%	UHL	Red <2.5% ER 2mths Red	NEW METHODOLOGY FOR CALCULATING COVERAGE INCLUDES ADULTS AND CHILDREN													1.3%	1.6%	1.2%	1.3%
	W5	Maternity Friends and Family Test - Coverage	CR	HL	30%	UHL	Red <26% ER 2mths Red	25.2%	28.0%	36.4%	25.2%	29.2%	29.9%	18.7%	15.8%	21.7%	22.1%	25.8%	46.5%	40.2%	32.3%	35.8%	32.6%	33.6%
	W6	Friends & Family staff survey: % of staff who would recommend the trust as place to work	ES	BK	Not within Lowest Decile	TDA	TBC	New Indicator	54.2%	53.7%		53.7%			Q3 staff FFT not completed as National Survey carried out			54.9%			52.5%		52.5%
	W7a	Nursing Vacancies	CR	MM	5% by Mar 16	UHL	Separate report submitted to QAC	NEW UHL INDICATOR						6.7%	6.7%	6.4%	6.0%	6.3%	5.5%	6.5%	8.5%	8.0%	7.3%	7.3%
	W7b	Nursing Vacancies in ESM CMG	CR	MM	5% by Mar 16	UHL	Separate report submitted to QAC	NEW UHL INDICATOR						10.8%	10.8%	10.7%	9.7%	12.8%	11.4%	14.0%	19.3%	13.0%	14.4%	14.4%
	W8	Turnover Rate	ES	LG	Not within Lowest Decile	TDA	Red = 11% or above ER = Red for 3 Consecutive Mths	10.0%	11.5%	10.0%	10.2%	10.0%	10.5%	10.3%	10.8%	10.7%	10.3%	10.1%	10.1%	11.5%	10.4%	10.5%	10.5%	10.5%
	W9	Sickness absence	ES	KK	3%	UHL	Red = >4% ER = 3 consecutive mths >4.0%	3.4%	3.8%	3.3%	3.3%	3.4%	3.4%	3.7%	4.0%	4.0%	4.4%	4.2%	4.1%	4.0%	3.7%	3.6%		3.6%
	W10	Temporary costs and overtime as a % of total paybill	ES	LG	TBC	TDA	TBC	New Indicator	9.4%	9.4%	8.1%	8.5%	8.9%	8.5%	9.5%	9.0%	9.8%	10.5%	9.8%	11.5%	10.7%	10.2%	11.0%	10.7%
	W11	% of Staff with Annual Appraisal	ES	BK	95%	UHL	Red = <90% ER = 3 consecutive mths <90%	91.3%	91.4%	91.0%	90.6%	89.6%	88.6%	89.7%	91.8%	92.3%	92.5%	90.9%	91.0%	91.4%	90.1%	88.7%	89.2%	89.2%
	W12	Statutory and Mandatory Training	ES	BK	95%	UHL	TBC	76%	95%	79%	79%	80%	83%	85%	86%	87%	89%	89%	90%	95%	93%	92%	92%	92%
	W13	% Corporate Induction attendance	ES	BK	95%	UHL	Red = <90% ER = 3 consecutive mths <90%	94.5%	100%	94%	92%	96%	98%	98%	98%	98%	100%	99%	100%	97%	97%	97%	98%	98%
	W14a	DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	CR	MM	Not within Lowest Decile	TDA	TBC	New Indicator	91.2%	89.2%	92.6%	87.7%	87.9%	91.6%	92.9%	91.3%	92.7%	94.3%	91.8%	91.0%	93.6%	90.3%	91.2%	91.7%
	W14b	DAY Safety staffing fill rate - Average fill rate - care staff (%)	CR	MM	Not within Lowest Decile	TDA	TBC		94.0%	92.1%	96.9%	93.0%	94.8%	90.3%	95.4%	94.4%	95.8%	95.4%	92.8%	92.5%	94.2%	91.2%	93.5%	92.9%
	W14c	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	CR	MM	Not within Lowest Decile	TDA	TBC		94.9%	92.0%	93.1%	90.8%	91.4%	94.8%	97.4%	96.5%	96.4%	97.9%	96.5%	97.2%	98.9%	96.0%	96.2%	97.0%
	W14d	NIGHT Safety staffing fill rate - Average fill rate - care staff (%)	CR	MM	Not within Lowest Decile	TDA	TBC		99.8%	94.4%	99.0%	97.9%	98.0%	97.8%	100.8%	101.2%	101.4%	103.6%	100.8%	103.2%	106.3%	98.7%	99.4%	101.5%

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Effective

KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
E1	Mortality - Published SHMI	AF	PR	Within Expected	TDA	Higher than Expected	105	103	106 (Oct12-Sept13)		106 (Jan13-Dec13)			105 (Apr13-Mar14)			103 (Oct13-Sep14)			99 (Jan14-Dec 14)			
E2	Mortality - Rolling 12 mths SHMI (as reported in HED) Rebased	AF	PR	Within Expected	QC	Red = >expected ER = >Expected or 3 consecutive mths increasing SHMI >100	105	97	104	105	104	103	103	102	102	100	101	100	Awaiting HED Update				
E3	Mortality HSMR (DFI Quarterly)	AF	PR	Within Expected	TDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	88	94	98		95			95			91			Awaiting DFI Update			
E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	AF	PR	Within Expected	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	95	98	98	97	96	96	96	95	95	96	95	95	Awaiting HED Update			
E5	Mortality - Monthly HSMR (Rebased Monthly as reported in HED)	AF	PR	Within Expected	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	91	95	108	105	86	97	98	96	88	96	99	98	85	Awaiting HED Update			
E6	Mortality - HSMR ALL Weekend Admissions - (DFI Quarterly)	AF	PR	Within Expected	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	96	101	100		103			97			103			Awaiting DFI Update			
E7	Crude Mortality Rate Emergency Spells	AF	PR	Within Upper Decile	TDA	TBC	2.5%	2.4%	2.5%	2.4%	2.0%	1.9%	2.3%	2.1%	2.3%	3.0%	3.1%	2.7%	2.4%	2.1%	2.0%	2.0%	2.1%
E8	Deaths in low risk conditions (Risk Score)	AF	PR	Within Expected	TDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	94	81	81	105	80	64	59	113	60	85	101	87	75	Awaiting DFI Update			
E9	Emergency readmissions within 30 days following an elective or emergency spell	AF	JJ	Within Expected	TDA	Higher than Expected	7.9%	8.5%	8.8%	8.6%	8.4%	8.9%	8.4%	8.6%	8.9%	9.1%	8.2%	8.5%	8.5%	9.1%	9.0%		9.1%
E10	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	AF	RP	72% or above	QS	Red = <72% ER = 2 consecutive mths <72%	65.2%	61.4%	40.6%	60.3%	76.9%	59.0%	68.6%	69.6%	59.4%	57.3%	57.9%	67.2%	61.5%	55.7%	42.6%	70.1%	56.3%
E11	Stroke - 90% of Stay on a Stroke Unit	RM	IL	80% or above	QS	Red = <80% ER = 2 consecutive mths <80%	83.2%	81.3%	80.3%	87.1%	78.1%	84.5%	83.2%	70.4%	73.3%	75.2%	82.5%	87.6%	83.3%	83.7%	84.5%		84.1%
E12	Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA)	RM	IL	60% or above	QS	Red = <60% ER = 2 consecutive mths <60%	64.2%	71.2%	58.8%	71.3%	62.8%	65.5%	72.7%	67.8%	69.0%	83.5%	80.6%	64.0%	77.3%	86.3%	79.6%	72.0%	79.0%
E13	Published Consultant Level Outcomes	AF	SH	>0 outside expected	QC	Red = >0 Quarterly ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
E14	Non compliance with 14/15 published NICE guidance	AF	SH	0	QC	Red = in mth >0 ER = 2 consecutive mths Red	New Indicator for 14/15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
E15	ROSC in Utstein Group	AF	PR	TBC	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																
E16	STEMI 150minutes	AF	PR	TBC	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																

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Responsive

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R1	ED 4 Hour Waits UHL + UCC (Calendar Month)	RM	IL	95% or above	UHL	Red = <92% ER via ED TB report	88.4%	89.1%	83.1%	91.0%	92.5%	91.3%	91.6%	89.8%	89.1%	83.0%	90.7%	89.6%	91.1%	92.0%	92.2%	92.6%	92.3%
R2	12 hour trolley waits in A&E	RM	IL	0	TDA	Red = >0 ER via ED TB report	5	4	1	1	0	0	0	1	0	0	1	0	0	0	0	0	0
R3	RTT Waiting Times - Admitted	RM	WM	90% or above	TDA	Red /ER = <90%	76.7%	84.4%	79.4%	79.0%	80.9%	82.2%	81.6%	84.4%	85.5%	86.9%	85.0%	85.9%	84.4%	88.0%	91.3%	90.8%	90.8%
R4	RTT Waiting Times - Non Admitted	RM	WM	95% or above	TDA	Red /ER = <95%	93.9%	95.5%	94.4%	95.0%	94.9%	95.6%	94.6%	94.9%	95.2%	96.0%	95.4%	95.3%	95.5%	95.6%	95.6%	95.7%	95.7%
R5	RTT - Incomplete 92% in 18 Weeks	RM	WM	92% or above	TDA	Red /ER = <92%	92.1%	96.7%	93.6%	94.0%	93.2%	94.0%	94.3%	94.8%	95.0%	95.1%	95.2%	96.2%	96.7%	96.6%	96.5%	96.2%	96.2%
R6	RTT 52 Weeks+ Wait (Incompletes)	RM	WM	0	TDA	Red /ER = >0	0	0	0	0	15	1	3	3	2	0	0	0	0	0	66	242	242
R7	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	TDA	Red /ER = >1%	1.9%	0.9%	0.9%	0.8%	0.7%	1.0%	1.0%	0.7%	1.8%	2.2%	5.0%	0.8%	0.9%	0.8%	0.6%	6.2%	6.2%
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	TDA	Red = <93% ER = Red for 2 consecutive mths	94.8%	92.2%	94.7%	93.5%	92.2%	92.0%	90.6%	92.0%	92.5%	93.0%	92.2%	93.5%	91.5%	91.2%	87.9%		89.5%
R9	Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	RM	MM	93% or above	TDA	Red = <93% ER = Red for 2 consecutive mths	94.0%	94.1%	95.0%	98.9%	94.9%	94.4%	95.2%	98.6%	100.0%	93.0%	92.5%	91.5%	96.0%	99.0%	98.8%		98.9%
R10	31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	RM	MM	96% or above	TDA	Red = <96% ER = Red for 2 consecutive mths	98.1%	94.6%	92.9%	93.6%	94.4%	97.9%	91.9%	95.9%	92.5%	95.2%	91.7%	95.0%	97.0%	93.7%	97.8%		95.8%
R11	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	RM	MM	98% or above	TDA	Red = <98% ER = Red for 2 consecutive mths	100.0%	99.4%	100.0%	100.0%	100.0%	98.8%	100.0%	97.1%	100.0%	96.7%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%
R12	31-Day Wait For Second Or Subsequent Treatment: Surgery	RM	MM	94% or above	TDA	Red = <94% ER = Red for 2 consecutive mths	96.0%	89.0%	97.0%	90.8%	90.1%	87.8%	94.0%	81.9%	82.4%	80.3%	89.2%	94.4%	87.5%	86.3%	92.2%		88.9%
R13	31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	RM	MM	94% or above	TDA	Red = <94% ER = Red for 2 consecutive mths	98.2%	96.1%	95.6%	93.9%	97.3%	99.0%	96.5%	96.0%	94.7%	95.5%	87.6%	99.0%	100.0%	86.1%	98.1%		92.9%
R14	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	RM	MM	85% or above	TDA	Red = <85% ER = Red in mth or YTD	86.7%	81.4%	88.5%	73.1%	85.6%	78.8%	75.5%	80.4%	77.0%	84.8%	79.3%	78.9%	83.8%	75.5%	70.5%		72.9%
R15	62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	RM	MM	90% or above	TDA	Red = <90% ER = Red for 2 consecutive mths	95.6%	84.5%	67.4%	73.9%	73.0%	100.0%	87.5%	75.0%	94.4%	93.8%	88.9%	79.4%	89.3%	91.7%	82.4%		87.1%
R16	Cancer waiting 104 days	RM	MM	0	TDA	TBC	NEW TDA INDICATOR													12	10	12	12
R17	Urgent Operations Cancelled Twice	RM	PW	0	TDA	Red = >0 ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
R18	Cancelled patients not offered a date within 28 days of the cancellations UHL	RM	PW	0	TDA	Red = >2 ER = >0	85	33	4	1	2	1	2	2	0	3	4	3	1	2	0	1	3
R19	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	RM	PW	0	TDA	Red = >2 ER = >0	New Indicator for 14/15	11	0	0	0	6	0	0	1	1	2	1	0	0	0	1	1
R20	% Operations cancelled for non-clinical reasons on or after the day of admission UHL	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	1.6%	0.9%	0.8%	1.1%	0.7%	0.6%	0.8%	0.8%	1.2%	1.1%	0.8%	0.7%	1.0%	0.7%	0.5%	0.9%	0.7%
R21	% Operations cancelled for non-clinical reasons on or after the day of admission ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	1.6%	0.9%	0.6%	0.3%	2.7%	0.0%	0.9%	1.0%	0.0%	0.8%	1.4%	0.0%	0.4%	1.2%	1.2%	1.0%	1.1%
R22	% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	New Indicator for 14/15	0.9%	0.8%	1.0%	0.9%	0.6%	0.8%	0.8%	1.1%	1.1%	0.8%	0.7%	0.9%	0.8%	0.6%	0.9%	0.8%
R23	No of Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	N/A	UHL	TBC	1739	1071	77	98	94	55	90	94	108	102	85	64	98	79	56	97	232
R24	Outpatient Hospital Cancellation Rates	RM	PW	Within Upper Decile	UHL	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																
R25	Delayed transfers of care	RM	PW	3.5% or below	TDA	Red = >3.5% ER = Red for 3 consecutive mths	4.1%	3.9%	4.2%	4.0%	3.9%	3.9%	4.5%	4.6%	5.2%	3.9%	3.2%	2.9%	1.8%	1.2%	1.0%	1.5%	1.2%
R26	NHS e-Referral (formally Choose and Book Slot Unavailability)	RM	WM	4% or below	Contract	Red = >4% ER = Red for 3 consecutive mths	13%	21%	25%	26%	25%	26%	25%	20%	17%	16%	13%	19%	26%	34%	31%		33%
R27	Ambulance Handover >60 Mins (CAD+ from June 15)	RM	PW	0	Contract	Red = >0 ER = Red for 3 consecutive mths	New Indicator for 14/15	5%	6%	2%	2%	1%	2%	5%	6%	10%	6%	11%	9%	6%	7%	7%	7%
R28	Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)	RM	PW	0	Contract	Red = >0 ER = Red for 3 consecutive mths	New Indicator for 14/15	19%	21%	12%	14%	15%	17%	25%	23%	25%	21%	21%	22%	22%	21%	17%	20%

Compliance Forecast for Key Responsive Indicators

Standard	June actual/predicted	July predicted	Month by which to be compliant	RAG rating of required month delivery	Commentary
Emergency Care					
4+ hr Wait (95%) - Calendar month	92.6%				Weekly SITREPs have ceased from end of June. Future ED performance to be reported monthly.
Ambulance Handover (CAD)					
% Ambulance Handover >60 Mins (CAD+)	7%		Not Agreed		First data extract from CAD+ following meeting with EMAS on the 16th July. DQ is still an issue with missing data and duplicate records.
% Ambulance Handover >30 Mins and <60 mins (CAD+)	17%		Not Agreed		First data extract from CAD+ following meeting with EMAS on the 16th July. DQ is still an issue with missing data and duplicate records.
RTT (inc Alliance)					
Admitted (90%)	90.8%	90.5%	Continued Delivery		June confirmed delivery and July looks healthy. We do have growing backlogs in the specialised surgery max fax and adult and paed ENT.
Non-Admitted (95%)	95.7%	95.3%	Continued Delivery		
Incomplete (92%)	96.2%	95.8%	Continued Delivery		July dip due to continuing growing pressure in ENT, General Surgery and Gastroenterology.
Diagnostic (inc Alliance)					
DM01 (<1%)	6.2%	5.5%	September		Endoscopy the predominate cause of failure. Significant changes in endoscopy to support re-delivery. September plan confirmed.
Cancelled Ops (inc Alliance)					
Cancelled Ops (0.8%)	0.9%	1.0%	August		With the weather at the start of July being very hot resulting in further problems with theatres estate, we are at risk of failing July.
Not Rebooked within 28 days (0 patients)	2	1			June 1 UHL and 1 Alliance. July requires validation.
Cancer (predicted)					
Two Week Wait (93%)	91.0%	92.0%	September		Issues with NHS E-referrals system (formerly choose and book) continue to cause delays. This is a national problem. We've briefed commissioners and the TDA about the challenge with the system.
31 Day First Treatment (96%)	93.5%	96.0%	July		Q1 Compliant July expected to be compliant.
31 Day Subsequent Surgery Treatment (94%)	82.5%	92.0%	August		This is purely a Urology issue. August still likely with agreed actions to reduce backlog during July.
62 Days (85%)	81.5%	81.0%	October		Backlog Reduction continues. June performance significantly improved on May.

Research UHL

KPI Ref	Indicators	Board Director	Lead Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD	Apr-15	May-15	Jun-15	YTD
RU1	Median Days from submission to Trust approval (Portfolio)	AF	NB	TBC	TBC	TBC	3.0			2.0			3.0			3.0			2.8	Data delayed as waiting for NIHR report and currently migrating data to a new system			
RU2	Median Days from submission to Trust approval (Non Portfolio)	AF	NB	TBC	TBC	TBC	2.0			3.5			2.0			1.0			2.1				
RU3	Recruitment to Portfolio Studies	AF	NB	Aspirational target=10920/year (910/month)	TBC	TBC	941	1092	963	1075	1235	900	1039	1048	604	1030	1043	1298	1022				
RU4	% Adjusted Trials Meeting 70 day Benchmark (data sunbmitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC	(Jul13-Jun14) 43.4%			(Oct13-Sep14) 70.5%			(Nov13-Dec14) 70.5%										
RU5	Rank No. Trials Submitted for 70 day Benchmark (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC	(Jul13-Jun14) Rank 17/61			(Oct13-Sep14) Rank 18/60			(Nov13-Dec14) Rank 18/59										
RU6	%Closed Commercial Trials Meeting Recruitment Target (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC	(Jul13-Jun14) 50%			(Oct13-Sep14) 52%			(Nov13-Dec14) 48%										

Research (CLINICAL RESEARCH NETWORK)

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD	Apr-15	May-15	Jun-15
RS1	Number of participants recruited in a reporting year into NIHR CRN Portfolio studies	AF	DR	England 650,000 East Midlands 50,000	NIHR CRN	Red / ER = <90%	92%	93%	94%	93%	91%	90%	101%	101%	Currently reviewing reporting arrangements with the Trust Director of Corporate & Legal Affairs.		
RS2a	A: Proportion of commercial contract studies achieving their recruitment target during their planned recruitment period.	AF	DR	England 80% East Midlands 80%	NIHR CRN	Red / ER = <60%	67%	64%	68%	54%	56%	47%	53%	53%			
RS2b	B: Proportion of non-commercial studies achieving their recruitment target during their planned recruitment period	AF	DR	England 80% East Midlands 80%	NIHR CRN	Red / ER = <60%	81%	81%	73%	77%	77%	86%	75%	75%			
RS3a	A: Number of new commercial contract studies entering the NIHR CRN Portfolio	AF	DR	600	NIHR CRN	TBC											
RS3b	B: Number of new commercial contract studies entering the NIHR CRN Portfolio as a percentage of the total commercial MHRA CTA approvals for Phase II-IV studies	AF	DR	75%	NIHR CRN	Red <75%											
RS4	Proportion of eligible studies obtaining all NHS Permissions within 30 calendar days (from receipt of a valid complete application by NIHR CRN)	AF	DR	80%	NIHR CRN	Red <80%	90%	89%	84%	82%	83%	83%	93%	93%			
RS5a	A: Proportion of commercial contract studies achieving first participant recruited within 70 calendar days of NHS services receiving a valid research application or First Network Site Initiation Visit	AF	DR	80%	NIHR CRN	Red <80%											
RS5b	B: Proportion of non-commercial studies achieving first participant recruited within 70 calendar days of NHS services receiving a valid research application	AF	DR	80%	NIHR CRN	Red <80%											
RS6a	A: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio studies	AF	DR	England 99% East Midlands 99%	NIHR CRN	Red <99%	81%	81%	81%	88%	88%	88%	94%	94%			
RS6b	B: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio commercial contract studies	AF	DR	England 70% East Midlands 70%	NIHR CRN	Red <70%	56%	56%	56%	56%	56%	56%	56%	56%			
RS6c	B: Proportion of General Medical Practices recruiting each year into NIHR CRN Portfolio studies	AF	DR	England 25% East Midlands 25%	NIHR CRN	Red <25%	45%	45%	51%	63%	54%	54%	61%	61%			
RS7	Number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	AF	DR	England 13500 East Midlands 510	NIHR CRN	Red <510 Q4	325	438	448	532	624	729	1050	1050			
RS8	Deliver robust financial management using appropriate tools - % of financial returns completed on time	AF	DR	England 100% East Midlands 100%	NIHR CRN	Red <100%	100% *Q2	100.0%				100%	100%	100%			

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

	KPI Ref	Indicators	Board Director	Lead Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
Estates and Facilities	E&F1	Percentage of statutory inspection and testing completed in the Contract Month measured against the PPM schedule.	DK	GL	100%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F2	Percentage of non-statutory PPM completed in the Contract Month measured against the PPM schedule	DK	GL	100%	Contract KPI	Red = ≤ 80%	100.0%	91.5%	81.2%	95.6%	80.5%	86.6%	97.4%	99.5%	99.0%	99.0%	98.0%	98.7%
	E&F3	Percentage of Estates Urgent requests achieving rectification time	DK	LT	95%	Contract KPI	Red = ≤ 75%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F4	Percentage of scheduled Portering tasks completed in the Contract Month	DK	LT	99%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F5	Number of Emergency Portering requests achieving response time	DK	LT	100%	Contract KPI	Red = >2	0	0	0	0	0	0	0	0	0	0	0	0
	E&F6	Number of Urgent Portering requests achieving response time	DK	LT	95%	Contract KPI	Red = ≤ 95%	95.0%	95.1%	96.2%	97.3%	97.2%	97.2%	98.5%	98.1%	99.0%	100.0%	100.0%	99.7%
	E&F7	Percentage of Cleaning audits in clinical areas achieving NCS audit scores for cleaning above 90%	DK	LT	100%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	99.1%	100.0%	100.0%	100.0%	94.4%	96.1%	97.0%	95.0%	95.0%	95.7%
	E&F8	Percentage of Cleaning Rapid Response requests achieving rectification time	DK	LT	92%	Contract KPI	Red = ≤ 80%	92.0%	99.6%	89.9%	93.3%	90.5%	91.1%	94.1%	96.9%	95.0%	95.0%	94.0%	94.7%
	E&F9	Percentage of meals delivered to wards in time for the designated meal service as per agreed schedules	DK	LT	97%	Contract KPI	Red = ≤ 95%	97.0%	99.4%	99.5%	100.0%	100.0%	98.9%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F10	Overall percentage score for monthly patients satisfaction survey for catering service	DK	LT	85%	Contract KPI	Red = ≤ 75%	85.0%	96.7%	97.3%	97.3%	96.7%	93.8%	95.8%	97.5%	96.0%	97.0%	91.0%	94.7%

W4 - Outpatients Friends and Family Test – Coverage

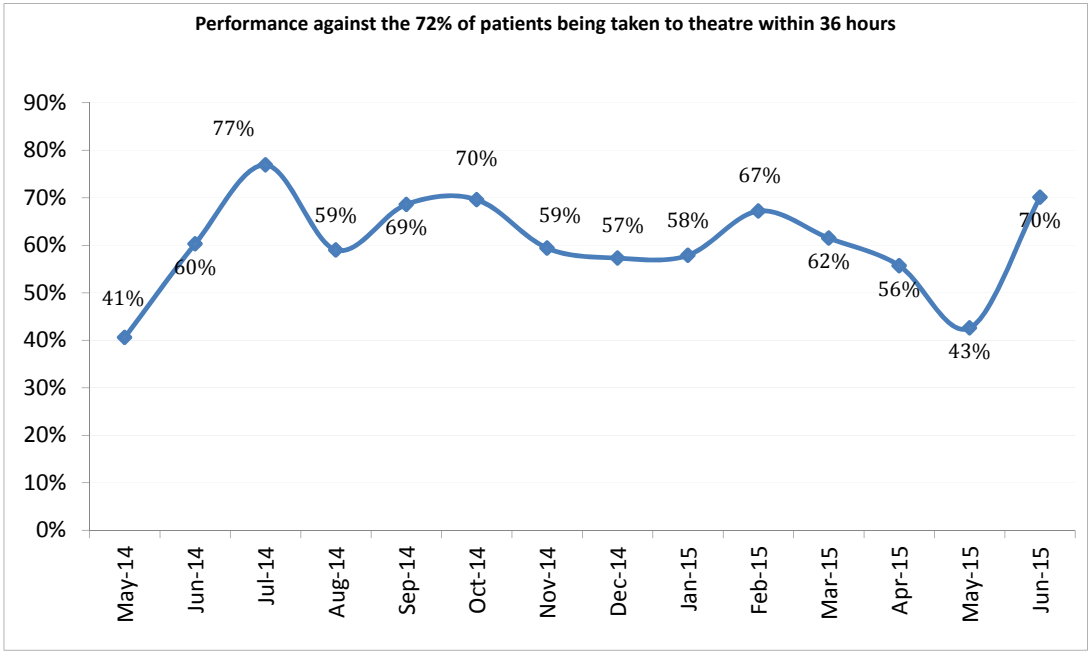
What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	June performance	YTD performance	Forecast performance for next reporting period
Outpatients - year to date is 1.3% coverage for collection of the Friends and Family test. A clear system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

CMG	June 2015	
	% Recommend	% Coverage
CHUGS	67%	0.2%
CSI	94%	0.6%
ESM	83%	0.2%
ITAPS	80%	0.5%
MSKSS	94%	2.8%
RRCV	96%	1.5%
WC	89%	1.1%
The Alliance	93%	0.9%
UHL	93%	1.1%

Expected date to meet standard / target	Quarter 2 achieve target
Lead Director / Lead Officer	Carole Ribbins, Acting Chief Nurse Heather Leatham, Assistant Chief Nurse

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

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance FY 0 14/15	Forecast performance for next reporting period
There were 66 NOF admissions in June 2015, the main reasons for breach of the 36 hr target to theatre were:- Medically Unfit – 4pts List over ran therefore pt cancelled – 5 Deemed high risk for over weekend – 2pts Transferred to LGH for THR – 4 pts Conservative treatment -1pt Refused surgery – 1 pt Lack of theatre time due to Spines and lack of theatre time in times of peak admissions continues. As in previous months the acceptance of out of area elective and emergency spinal work continues to have a detrimental effect on the main trauma capacity as spinal patients are medically prioritised over 'other' trauma which has a knock on effect on #NOF capacity. Patients admitted who are not clinically fit for surgery despite orthopaedic geriatrician intervention.	It has been agreed that #NOF will be supported corporately by Will Monaghan. The Trauma business case approved at the end of April aims to address the staffing gaps and these are currently being recruited to. Work continues within the spinal network with regards to capacity across the region and how UHL fits into the future plans. New prioritisation pathways have been implemented.	**72%**	**70.1%**	**56.3%**	**55%**



Performance by Month for 15/16

April	May	June	YTD
55.7%	42.6%	70.1%	56.3%

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

R6– RTT 52 Week Breaches

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>June performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="4">52-week breaches have been identified in the following areas:
• Orthodontics (248);
• Allergy/ Immunology (3);
• Urology (1).

Orthodontics (248):
• Incorrect use and management of a planned waiting list for outpatients.
• Inadequate capacity within the service to see patients ready for treatment.

Allergy/ Immunology (3):
• These patients emerged following review of planned waiting lists.

Urology (1):
• Patients' clock incorrectly suspended on two occasions.
• Start date of the clock incorrectly adjusted.
• Error undiscovered until 52-week breach had occurred.</td><td rowspan="4">Key actions for Orthodontics:
• All patients on the planned waiting list have been contacted to ask if they still require treatment.
• Service closed to new referrals with some clinical exceptions.
• Funding for 2 WTE locums to clear backlog (currently out for advert).
• Should 1 WTE be in place by November, backlog will be cleared by end of February 2016. Should 2 WTE be recruited and in post by November, backlog should be cleared by end of December 2015.
• Review of service's future.

Key actions for Allergy/ Immunology:
• Service review to define roles and responsibilities of all staff.
• Training for clinical staff as to appropriate patient pathways.

Key actions for Urology:
• All admin staff within Urology to have refreshed RTT training.
• Detailed SOPs to be developed with the RTT team to form part of 'Urology Academy' portfolio for all staff.</td><td>0</td><td>Total = 252
Admitted = 1
Non admitted = 9
Incomplete = 242</td><td>Total = 259
Admitted = 7
Non admitted = 10
Incomplete = 242</td><td>c. 250</td></tr>
<tr><td colspan="4">The majority of these 52 week breaches have occurred as a result of a deliberate, Trust-wide review of planned waiting lists at specialty level. Therefore the following actions will be taken Trust-wide:
• Communication around planned waiting list management to all relevant staff;
• System review of all waiting list codes;
• All General Managers and Heads of Service to sign a letter confirming review and assurance of all waiting lists, to be returned to Richard Mitchell.
• Weekly review at Head of Ops meeting for assurance.</td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="3">TBC</td></tr>
<tr><td>Lead Director / Lead Officer</td><td colspan="3">Will Monaghan, Director of Performance and Information
Charlie Carr, Head of Performance</td></tr>
</table>

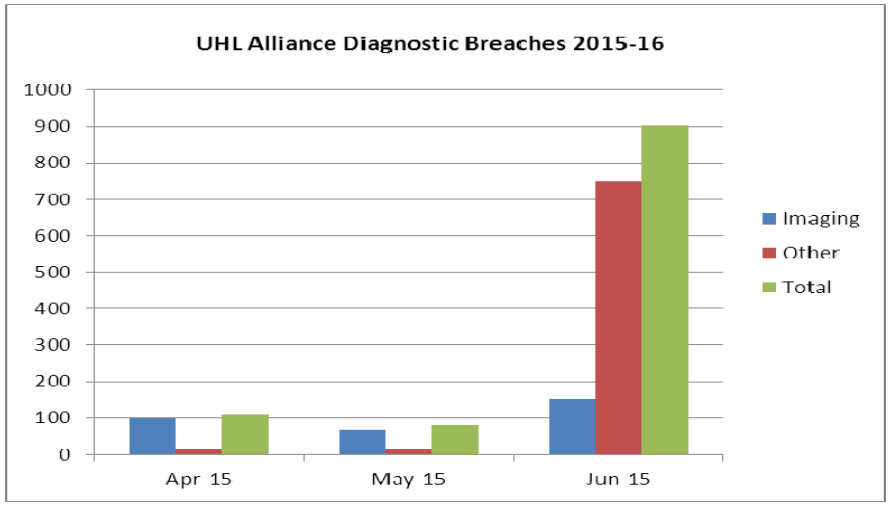
R7 6 Week - Diagnostic Test Waiting Times

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>June performance (UHL Alliance)</th><th>YTD performance (UHL Alliance)</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="4">Imaging
The majority of imaging diagnostics are delivered within 6 weeks; the exception to this has been a small volume of complex cardiac CT (c.10 per month) and complex cardiac MRI (c.100 per month). As a tertiary centre UHL is one of a small number of Trusts that provides this service. A plan is well developed and part implemented to eradicate this issue by the end of September 2015.

For June it was anticipated that this volume of imaging diagnostics would breach the standard, but this is within the threshold and therefore we expected the Trust to deliver the bottom line. However there were three half-day power outages within the last two weeks, this has resulted in the cancellation of 50 MRI/ CT patients. The result is 154 imaging breaches.

Endoscopy
An issue with planned waiting lists in Endoscopy surfaced in May 2015. Following validation, this can be quantified as c.600 patients who we know are now overdue their planned date and should have been on the live diagnostic waiting list. Capacity and demand review in endoscopy has identified that the Trust is short of approximately 8-10 lists per week.</td><td rowspan="4">Imaging
We are likely to breach imaging in July 2015 with c. 20 CTs and c. 120 MRIs. This is mostly as a result of the known capacity problems within Cardiac MRI/ CT.

Endoscopy
In order to address long patient waits, UHL are working with Medinet to put on weekend lists, providing 60-90 additional scopes per weekend. The Trust will also be part of an initiative led by the Tripartite around securing extra capacity within the Independent Sector and other NHS Trusts for endoscopy. UHL will be involved in designing the process.

The extra capacity is complemented by a robust action plan aimed at addressing general performance issues in Gastroenterology, with particular focus on efforts to improve Cancer performance via access to Endoscopy tests.</td><td><1%</td><td>6.16%</td><td>6.16%</td><td>5.5%</td></tr>
<tr><td colspan="4">The following graph outlines the total number of diagnostic breaches per month for 15-16:
 

The graph below outlines the percentage of breaches as shared between UHL and Alliance:
<table>
<tr><th></th><th>Apr-15</th><th>May-15</th><th>Jun-15</th><th>YTD</th></tr>
<tr><td>UHL</td><td>0.92%</td><td>0.61%</td><td>6.97%</td><td>6.97%</td></tr>
<tr><td>UHL Alliance</td><td>0.83%</td><td>0.59%</td><td>6.16%</td><td>6.16%</td></tr>
</table></td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="3">September 2015</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="3">Will Monaghan, Director of Performance and Information
Charlie Carr, Head of Performance</td></tr>
</table>

R8-R15 Cancer Waiting Times Performance

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance May	Performance to date 2015/16	Forecast performance for June
R8: 2 Week Two week wait performance continues to be challenged. The most significant factor behind this is underperformance in Lower GI and Upper GI. GP referrals have increased and there are significant changes in admin which are making a positive impact. The CCG action plan is now in place supporting patients to attend their appointments. **R12: 31 day subsequent (surgery)** 31 day subsequent (surgery) failed as a result of Urology and Skin. Urology performance has been attributed to a number of reasons including lack of tracking resource, key administrative gaps, theatre allocation and changes to the rota reducing SpR and SHO/ FY2 elective activity. Skin's performance was largely the result of patient choice; no adjustment is made for this in reporting. The 31 sub backlog is now at a record low. **R14: 62 day RTT / R15: 62 day** As expected performance remains low whilst backlog patients are treated. The significant pressure points are Lower GI, Lung, Urology and Head and Neck. Access to Cancer imaging remains good; however capacity in Pathology is proving a problem, with difficulties in some cases with appropriately pulling Cancer patients through the system due to inaccurate labelling of specimens.	A revised overarching Cancer action plan has been jointly developed by the Cancer Centre Management team and CMGs and has been shared with commissioners. **R8: 2 Week Wait** The Trust is working with CCGs to improve the quality of 2WW referrals, specifically in relation to correct process, use of appropriate clinical criteria, and preparation of patients for the urgency of appointments. **R12: 31 day subsequent (surgery)** It has been agreed that all Cancer patients coming into theatre should be escalated to the General Manager for Theatres to ensure that they are appropriately prioritised. The Cancer action plan aims to look at the step-down of patients from Intensive Care, in order to pull Cancer patients through the system more quickly. Clinical capacity: an extra Dermatologist will be recruited. An additional CNS will also be recruited for Skin and a Macmillan bid will be pulled together for another CNS in Urology. **R14: 62 day RTT / R15: 62 day screening** Efforts to improve 31 day and 2WW performance will help to improve the 62 day position. All tumour sites now have stamps with which to label Pathology samples for Cancer patients. Pathways between Breast screening and Breast services are being strengthened, a Cancer Navigator has been appointed to support Urology, meaning the specialty has more dedicated tracking time. The Endoscopy action plan is likely to improve performance over time, with daily conversations between service manager/ cancer navigator, and the authority for the service manager to prioritise 2WW patients before all other patients on waiting lists. 3 Band 7 'Cancer Tsars' have been appointed or advertised specifically to work with LOGI, Urology and Lung.	**R8: 2WW (Target: 93%)**	**87.9%**	**89.5%**	**91%**
		R10: 31 day 1st (Target: 96%)	**97.8%**	**95.8%**	**93.5%**
		R12: 31 day sub – Surgery (Target: 94%)	**92.2%**	**88.9%**	**82.5%**
		R14: 62 day RTT (Target: 85%)	**70.5%**	**72.9%**	**81.5%**
		R15: 62 day screening (Target: 90%)	**82.4%**	**87.1%**	**90%**

Performance by Quarter – Q1 (Apr and May)

	14/15 FYE	15/16 Q1	15/16 Q2	15/16 Q3	15/16 Q4
R8	**92.2%**	**89.5%**			
R10	**94.6%**	**95.8%**			
R12	**89%**	**88.9%**			
R14	**81.4%**	**72.9%**			
R15	**84.5%**	**87.1%**			

Expected date to meet standard / target	R8: Recovery expected September 2015 R10: Recovery expected July 2015 R12: Recovery expected August 2015 R14: Recovery expected October 2015 R15: Recovery expected October 2015
Lead Director / Lead Officer	Will Monaghan, Director of Performance and Information Metcalfe Matthew - Consultant Hepatobiliary and Pancreatic Surgeon

R16 Cancer waiting 104 days

What is causing underperformance?

12 patients on a 62 day pathway breached a waiting time of more than 104 days in June 2015. The breakdown by tumour site is set out below:

Tumour site	Number of patients
Breast	1
Head & Neck	1
Lung	3
Urology	7

What actions have been taken to improve performance?

It is recognised that 62 day performance is particularly poor in Lower GI, Lung and Urology and this is reflected by the fact that 10 out of 12 104 day breaches can be attributed to these tumour sites. Therefore 3 band 7 Cancer Delivery Managers ('Cancer Tsars') have either been appointed, or are in the process of being recruited, specifically to support Cancer performance in these Tumour sites.. They will report to CMG management as well as informally to Head of Performance in the Operational Delivery Unit. This dedicated full-time service management will improve Cancer performance over the medium term.

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

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

Month by month breakdown of patients breaching 104 days

The following table outlines the number of Cancer patients breaching 104 days by month for 15-16:

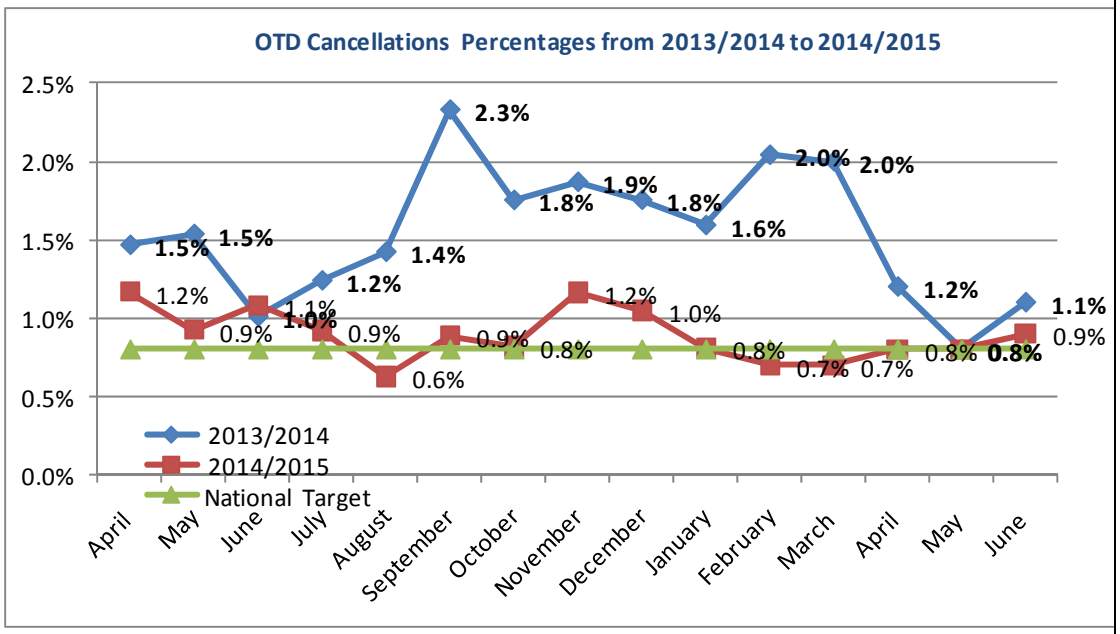
	April 2015	May 2015	June 2015
Number of patients breaching 104 days	12	10	12

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

R18,R19 and R22 - cancelled operations not booked within 28 days

INDICATORS: The cancelled operations target comprises of three components:
1. The percentage of operations cancelled on the day of admissions for non-clinical reasons.
2.The number of patients cancelled who are offered another date within 28 days of the cancellation
3. Urgent operations cancelled twice

What is causing underperformance?	What actions have been taken to improve performance?	Target (monthly) 1)On day=0.8% 2) 28 day = 0	Latest month performance – May 15	YTD performance (inc Alliance)	Forecast performance for next reporting period
The reason for OTD cancellation changed this month. The main factors were; Critical care bed availability in LGH, lack of theatre staff and heating and electrical problems at the Glenfield site. 8 patients were cancelled due to lack of critical care bed availability in LGH. 9 patients were cancelled due to lack of theatre staff. Due to issues with the cooling units at both the Glenfield and the LRI there were 7 patients cancelled at Glenfield. There were 8 patients cancelled due to Maxfax list overruns this month which included a second time cancellation. There were two 28 day breaches; one each from UHL and Alliance. The UHL patient was a paediatric case awaiting complex surgery. The surgeons were not available to perform the operations within 28 days of the first cancellation. The Alliance cancellation is being investigated	A number of work streams have started aimed at mitigating the risks for OTD cancellations including a LIA project. Lack of critical care beds in LGH remains an on-going problem and remains a significant risk to OTD performance - ITAPS Head of Operations is working together with specialities to understand the demand across the whole clinical pathways to mitigate the risk. To reduce the risk of cancellations a number of actions have been identified and are in the process of implementation. <u>Risks to delivery of recovery plan</u> The key risk remains failure to follow the UHL cancelled escalation policy for patients at risk of cancellation on the day. For those who may be cancelled on the day, all staff have been reminded that that must adhere to the Trust policy of escalating to CMG Head of Operations for resolution, prior to agreeing any cancellations.	*1)* 0.9% (0.9% UHL & 1.0% Alliance) 2) *2(1-UHL, 1Alliance)*	1) 0.6% (0.5% - UHL & 1.2% alliance) 2) 0	1) 0 .8%(0.7% - UHL & 1.1% Alliance) 2) 4	1) 1.5 % 2) 2



Expected date to meet standard / target	August - On the day (1st of July cooling system failure led to 27 cancellations and not expected to make target for July) August – 28 day
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Phil Walmsley. Head of Operations, ITAPS

R26 NHS e-Referral System (formerly known as Choose and Book)

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

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

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

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

Transition to new e-Referral System:
• Choose and Book migrated to the new e-Referral System on Monday 15th June;
• This has caused significant problems at a national level, with the system being made unavailable for maintenance.
• This has impacted on all services including the 2WW office.</td><td rowspan="4">Action plan
• An action plan has been written outlining steps for recovering performance;
• This has been shared with commissioners.

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

Training and Education
• Training and education of staff in key specialties continues, to ensure that the system is adequately set up and administrative processes are fit for purpose;
• Meetings are taking place with the specialties experiencing the highest rate of ASIs, focusing on awareness raising and seeking named accountability.

Additional resource to support the e-Referral System
• An NHS e-Referral System administrator has been in post since May;
• She will be working with key specialties to help reduce their ASIs and promote administrative housekeeping.</td><td><4%</td><td>Unable to report</td><td>Unable to report</td><td>No forecast as unable to measure</td></tr>
<tr><td colspan="4">As a result of the significant challenges experienced post-cut over from Choose and Book, the HSCIC have indicated that they will not be releasing weekly ASI data until at least August 2015. The latest data available is from the week ending 7th June and therefore is out of date. This means that the Trust is currently unable to track and report on progress in the usual manner.</td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="3">December 2015</td></tr>
<tr><td>Lead Director / Lead Officer</td><td colspan="3">Will Monaghan, Director of Performance and Information
Charlie Carr, Head of Performance</td></tr>
</table>

R27 and R28 Ambulance handover > 30 minutes and >60 minutes

		Target	June 15	YTD	Forecast
What is causing underperformance?	What actions have been taken to improve performance?	0 delays over 30 minutes	>60 min 7% 30-60 min 17%	>60 min 7% 30-60 min 20%	> 60 min 5% 30-60 min 17%

Difficulties in accessing in-patient beds leads to delays in patient movement out of the ED. This delays movement out of the ED assessment area and therefore, delays handover. March's performance remained similar to the preceding months.

It should be noted that the average, weekly attendances in April were very similar to ambulance attendances in March

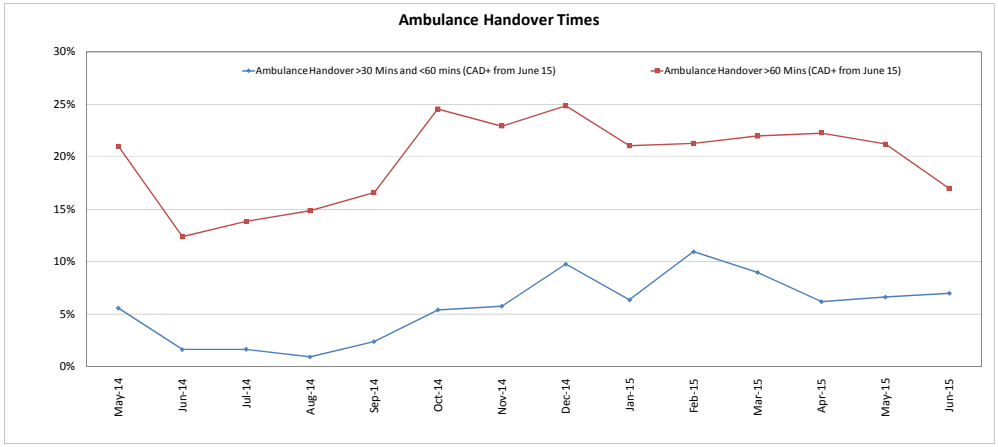
The CAD+ system connection has been trialled in ED and Equipment agreed for suitability. June's data has been submitted by EMAS and included in this report. There are still data quality issues that need resolving, including missing data and duplicate records.

The Training package is available once the equipment is ready for use in the Assessment Bay.

Update meetings are held with EMAS x3 pr week with an action log for CAD+ implementation

There are still data discrepancies between EMAS and validation from UHL at 15 mins, 15-30 and 60+ min handover times. e.g. an Audit on 18/4/15 looking at 15-30 handovers out of 66 patients in this timeframe 17 had actually achieved the below 15 mins.

An Audit on 20/4/15 EMAS stated 37 over 60 min waits and UHL can confirm 27 occurred this shows a 20.5% difference and in fact 1 patient's handover was 16 minutes only



Note: June 15 data reported from CAD+ - data quality is still an issue with missing data and duplicate records.

Expected date to meet standard	
Revised date to meet standard	
Lead Director	Richard Mitchell, Chief Operating Officer, Rachel Williams, ESM General Manager

E&F 7- Percentage of Cleaning audits in clinical areas achieving NCS audit scores for cleaning above 90%

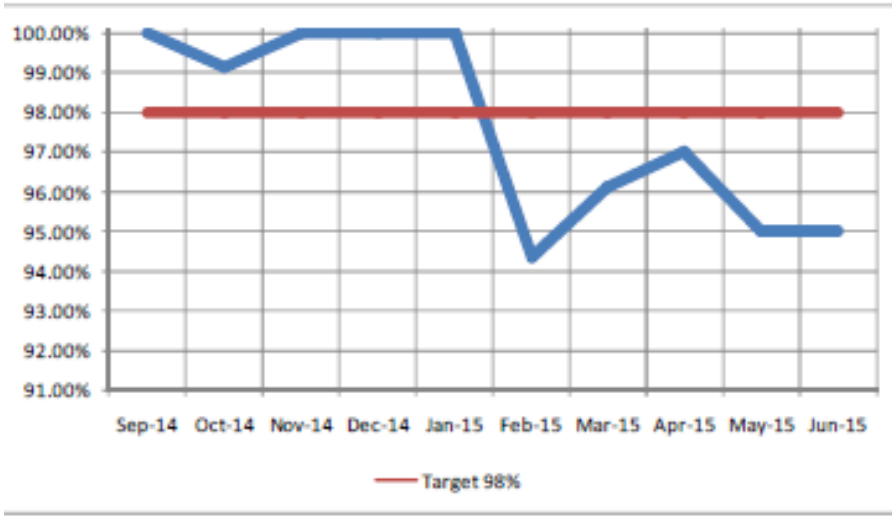
<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>Latest month performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="4">Percentage of audits in clinical areas achieving NCS audit scores for cleaning above 90%

Feb 15 – 94%
Mar 15 - 96%
Apr 15 – 97%
May 15 – 95%
Jun 15 – 95%</td><td rowspan="4">Interserve have reported that the score represents a total of 14 audits which did not achieve the contract KPI of 90%, this was of a total of 282 audits across the three acute hospitals.

Local management liaise with ward managers to rectify issues which require attention.

Interserve reported that any reduction in standards noted at Glenfield and the Leicester General followed the implementation of new roster patterns and multi-skilled roles.

The Estate & Facilities Management Collaborative (EFMC) have recorded their concerns that both their own auditors and nursing colleagues have challenged audit results during the last few weeks as the high results do not appear to reflect the standards being seen.

EFMC have commissioned independent external audits across the three acute hospital sites and these results will be reported to the Committee in the coming weeks.</td><td>100%</td><td>95%</td><td>95%</td><td>100%</td></tr>
<tr><td colspan="4"> 
</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">July 31st 2015</td></tr>
<tr><td colspan="2">Revised date to meet standard</td><td colspan="2">July 31st 2015</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Darryn Kerr, Director of Estates & Facilities</td></tr>
</table>

CQC – Intelligent Monitoring Report

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

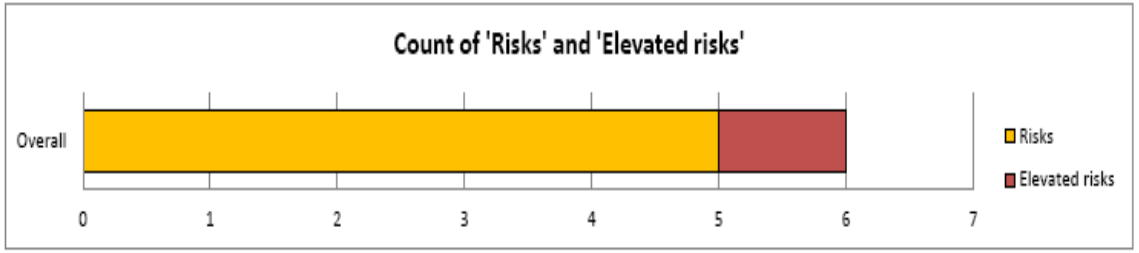
The IMR evaluates against a range of indicators relating to the five key questions used by the CQC as part of their inspections - is the organisation safe, effective, caring, responsive, and well-led?

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

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

University Hospitals of Leicester NHS Trust

Trust Summary



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

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

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

15/16 Quality Schedule and CQUIN Indicators - Predicted RAGs for Quarter 1 2015

Schedule Ref	Indicator Title	Q1 RAG	Commentary
	QUALITY SCHEDULE		
PS01	Infection Prevention and Control Reduction.	**G**	C Diff numbers below threshold,
PS02	HCAI Monitoring	**G**	
PS03	Patient Safety	**G**	1 Never Event in May - relates to prescribing of insulin dosage being wrongly written and subsequently administered.
PS04	Duty of Candour (DoC)	**G**	0 Breaches in respect of Moderate or Serious Incidents. Details of audit plans to be shared as part of Q1 report
PS05	Complaints and user feedback Management (excluding patient	**G**	Improved performance against response times.
PS06	Risk Assurance	**G**	Further assurance provided where Risks not reviewed at time of reporting to EPB
PS07	Safeguarding	**G**	Anticipate increased focus of commissioners around UHL's plans for implementing PREVENT training.
PS08	Reduction in Pressure Ulcer incidence.	**G**	0 G4s and x G3s but x G2s and > mthly threshold in April.
PS09	Medicines Management Optimisation	**A**	Amber RAG anticipated as Controlled Drugs Audit results below 100% threshold
PS10	Medication Errors	**G**	Dependent upon increased reporting of Medication Errors
PS11	Safety Thermometer	**G**	Improved % for Harm Free Care and 95% standard met for June 15. In the middle of the funnel plot for Harm Free care for Jun 14 to May 15
AS01	Cost Improvement Programme (CIP) Assurance	**G**	Dependent upon of Commissioners being suitably assured about UHL's process for ongoing monitoring of the impact of CIPs on quality.
AS02	Ward Health-check	**G**	Evidence of actions being taken where Wards either below agreed staffing levels or not meeting Clinical Measures Scorecard targets
AS03	Nurse Revalidation Programme	**G**	Assurance provided about plans in place to meet revalidation requirements
AS04	Staffing governance	**A**	Dependent upon June's performance and whether improvement over the 3 months of Q1
AS05	Involving employees in improving standards of care.	**G**	
AS06	Staff Satisfaction	**G**	Dependent upon submission of data and OD report

Schedule Ref	Indicator Title	Q1 RAG	Commentary
AS07	External Visits and Commissioner Quality Visits	**G**	Dependent upon Actions (in response to recommendations made) being on track.
AS08	CQC Registration	**A**	Dependent upon completion of outstanding CQC visit actions (Children's Day Case and CDU)
CE01(a)	Communication - Content - Medical	**G**	Audit Schedule drafted - ED letters Q1. Disch Letters Q1 - Q4. OutPt Letters - Q2-Q3.
CE01(b)	Communication - Content - Nursing	**G**	Nursing letter standards to be incorporated into Letters Policy and audit planned for Q3
CE02	Intra-operative Fluid Management	**A**	Threshold not achieved for Q1.
CE03a	Clinical Effectiveness Assurance - Audit	**G**	Audit plan for 15/16 reviewed at UHL Clinical Audit Ctte
CE03b	Clinical Effectiveness Assurance - NICE	**tbc**	NICE guidance published in Q1 sent out to relevant clinical leads for responses around compliance.
	Women's Service Dashboard	**A**	Obstetrician training and C Sections thresholds not met for April. May/June's data tbc.
CE05	Children's Service Dashboard	**A**	SpR training threshold not achieved in April. Significant improvement in performance in May for 'timing of Assessment on CAU'
CE06a	PROMS - Patient Reported Outcomes	**G**	No data published since reported for Q4. UHL's participation within expected for both participation and outcomes.
CE06b	Consultant Clinical Outcomes	**G**	No outcomes published since reported for Q4. UHL outcomes better than average or within expected.
CE07	#NOF - Dashboard	**A**	time to theatre' not achieved for April or May. Increase in spinal activity putting all #NOF indicators at risk. Performance improved in June but still below the 72% threshold
CE08	Stroke and TIA monitoring	**G**	Improvement in '90% stay' and also in overarching SSNAP Domain. Further improvements to be made for Therapy related targets - business case approved to recruit additional staff
CE09	Mortality	**G**	Published SHMI remains above 100. On track with plans to meet NTDA requirement to screen all deaths.
CE10	VTE Risk Assessment	**G**	95% threshold achieved for April, May and June
CE11	VTE RCA	**G**	Dependent upon meeting requirement to review all Hospital Acquired VTEs (both inpt and post discharge)

Schedule Ref	Indicator Title	Q1 RAG	Commentary
CE12	Nutrition and Hydration	**G**	Dependent upon commissioners noting improvements made during the Quarter for ESM
CE13	Food Strategy	**G**	Dependent upon provision of UHL Food Strategy
CE14	Community Acquired Pneumonia (CAP)	**G**	Q4 performance anticipated to be maintained through continued input by Pneumonia Nurses, albeit increased activity.
CE15	Improving End of Life (EoL) care.	**G**	Continued embedding of AMBER care bundle.
CE16	Heart Failure	**G**	Dependent upon maintenance of Q4 performance (75%)
PE01	Same Sex Accommodation Compliance and Annual Estates	**G**	0 Breaches in Q1
PE02	Patient Experience, Equality and Listening to and Learning from Feedback.	**G**	Continued triangulation of patient feedback and actions being taken in response
PE04	Equality and Human Rights	**G**	
PE5	MECC	**G**	Dependent upon maintenance of referral numbers
PE6	Friends and Family Test	**G**	Thresholds met for Adult patients and improvement seen for Children's response rates in Inpatients and very slightly for ED
	SPECIALISED SERVICES QUALITY SCHEDULE INDICATORS		
SQ01	National Quality Dashboards	**tbc**	Confirmation being sought that all relevant Specialities are submitting data
SQ02	National Clinical Registries	**tbc**	Confirmation being sought that all relevant Specialities are submitting data
SQ03	HIV: GP registration and communication	**G**	Letters are sent at each medical clinic (at least once per year)
z	**NATIONAL CQUIN SCHEMES**		
Nat 1	AKI Discharge Care Bundle	**G**	Quarter 1 is to provide baseline data about number/% of discharge letters containing details of AKI Stage and actions taken
Nat 2a	Sepsis - Screening	**G**	Q1 is to provide baseline data on number/% of em patients screened for sepsis. Provisional data shows small number of em patients in sample meeting criteria for screening with few being screened.

Schedule Ref	Indicator Title	Q1 RAG	Commentary
Nat 2b	Sepsis - IV Antibiotics	**G**	Q1 is to provide baseline data on number/% of pts with severe sepsis receiving IV antibiotics within hour of arrival. Provisional data shows small number of patients in sample meeting criteria for IV antibiotics with only a few then receiving within the standard.
Nat 3a	Dementia - FAIR	**G**	90% threshold achieved for April and May
Nat 3b	Dementia Training	**G**	New clinical lead confirmed and training programme agreed.
Nat 3c	Dementia Carers	**G**	Surveys undertaken and actions carried out in response to feedback received
Nat 4	Amb Care	**G**	Q1 threshold is to confirm scope of scheme and improvement thresholds. Proposed to implement ACP in CDU.
	LOCAL CCG CQUIN SCHEME		
Loc 5	Readmissions	**G**	Following review of Readmissions data, focused case note review undertaken and actions agreed.
Loc 6	CHC	**tbc**	Baseline data being collected
Loc 7a	Safety Briefings	**G**	Commissioners looking to agree outcome measures for Q4.
Loc 7b	Increase 'Near Miss' Reporting	**G**	
Loc 8	Think Glucose	**G**	Continued roll out of the Think Glucose programme
Loc 9	Bereavement F/U	**G**	Bereavement Follow Up Service Leads appointed and scoping of service being undertaken
Loc 10	Learning Disabilities - Pt Exp	**G**	Baseline data being collected
	SPECIALISED SERVICES CQUINS SCHEMES		
SS1/CUR	CUR Tool	**G**	Requirements for Q1 agreed with Local Area Team. Q4 payment at risk due to lack of flexibility at a national level with the Q4 thresholds
SS2/C6	Oncotype Testing	**G**	Oncotype tests requested for 2 patients to date
SS3/TH4	Critical Care Delayed Discharges	**G**	Q1 requirement is to provide baseline data and action plan
SS4/IM2	Vascular Network - Amputation Outcomes	**G**	Q1 requirement is to submit data to National Registry
SS6/IM7	Rheumatic Diseases Network	**G**	Q1 requirement is to submit plan

Schedule Ref	Indicator Title	Q1 RAG	Commentary
SS7/TH7	Complex Orthopaedic Surgery Network	G	Q1 requirement is to confirm agreement of network and submit terms of reference
SS8/HSS	ECMO/PCO Collaborative Workshop	G	Q1 requirement is to confirm participation in HSS workshops
SS10/CB5	Haemoglobinopathy Network	G	Q1 threshold is to hold network meeting and agree plan
SS11/WC1	<28 Week Neonates 2 yr follow up	G	Q1 requirement is to provide baseline data and action plan