University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper K

TRUST BOARD – 7th MAY 2015

QUALITY AND PERFORMANCE REPORT – MARCH 2015

DIRECTOR:	Carol Ribbins, Acting Chief Nurse Andrew Furlong, Interim Medical Director Richard Mitchell, Chief Operating Officer Emma Stevens, Acting Director of Human Resources Darryn Kerr, Director of Estates and Facilities
AUTHOR:	
DATE:	7th May 2015
PURPOSE:	The following report provides an overview of the March Quality & Performance report highlighting NTDA/UHL key metrics and escalation reports where required. It includes a Chief Executive's 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 HIGHLIGHT REPORT – AN OVERVIEW OF 2014/15

For this report I have focussed on providing an overview of performance in the year just completed. Green indicates compliant performance or that good progress was made, yellow that there was some progress but there remains more to do and red that there was either no progress or performance actually deteriorated. All figures are for the whole year unless otherwise stated, and comparisons are with 2013/14.

It will be seen that whilst there has been progress in a range of areas, that progress is not universal and there remains work to be done to achieve consistently high performance.

Clostridium difficile
We ended the year on 73 cases against a "limit" of 81. However, in 2014/15 we had only 66 cases so although we met the target our performance deteriorated slightly.

MRSA
We had 6 cases compared with 3 in 2013/14. However, only one of those was avoidable.

Never events
There were 3 never events, the same number as in 2013/14.

Serious incidents
The number of serious incidents dropped from 60 to 41.

Falls
Our falls rate fell from 7.1 to 6.9, indicating some progress particularly in the second half of the year.

Pressure ulcers
The total number of Grade 2, 3, and 4 avoidable pressure ulcers fell by 16%, indicating the impact of work in this area. Evidence indicates that there is a direct correlation between pressure ulcer numbers and staffing levels, emphasising the need to maintain the programme of investment in nurse staffing.

Friends and Family Test
There was positive progress across all of the Inpatient, A&E and maternity tests. A&E was most striking, rising from 58.5 to 69.3. There were also major improvements in coverage, with a new high of 44.8% inpatient coverage achieved for March.

Staff Appraisal
Staff appraisal rates were maintained at a healthy 91.4% but judging by the staff survey there is more to do to make these more valued by staff themselves.

Mandatory Training
We met our target to achieve 95% compliance by the end of March 2015. This compares to 76% in March 2014.

Fractured Neck of Femur
There was no real progress on this issue during the year, with performance actually deteriorating from 65.2% to 61.4%. This area is subject to a Listening into Action intervention and should also benefit from investment in 2015/16 into a new trauma service model.

RTT Waiting Times
All three RTT standard showed in improvement in year. Both the non-admitted and incomplete targets were compliant by year end on a sustainable basis. Admitted backlog reduced by over 900 patients (63%) between March 2014 and March 2015 and admitted performance improved from 76.7% to 84.4% over the same period. This standard is planned to reach the 90% standard by May 2015.

Emergency Care 4 hour target
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.

Cancer
After a strong performance in 2013/14, we struggled all year to meet our cancer standards, only starting to make real progress in the second half of the year. We do not yet have full year validated data but the 14 and 31 day standards are expected to be met in March. 62 day compliance is expected to be achieved in July 2015.

Operations Cancelled on the Day for Non-Clinical Reasons
There percentage of operations cancelled on the day for non-clinical reasons reduced to 0.9% in 2014/15 compared to 1.6% in 2013/14, resulting in 736 fewer patients having their operation cancelled.

Delayed Transfers of Care
There was very good progress with DTOCs in the second half of the year, reaching a record low of 1.8% in March 2015. The overall rate for the year was 3.9% compared to 4.1% in 2013/14.

Ambulance Handover
There was a major deterioration in reported performance against this indicator in 2014/15. There were 3,067 over 60 minute delays compared to 868 in 2013/14 and there were 11,315 over 30 minute delays compared to 7,075. Although there have been concerns about data accuracy, this is clearly an unacceptable position and we need to focus our efforts on improving it significantly. This specific area has been identified as one of the Trust's corporate priorities for 2015/16.

Mortality Rates
The SHMI data for the most recent quarter has not yet been published. It is hoped that we will be able to give a verbal update at the Trust Board.

John Adler
23rd April 2015

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

March 2015

One team shared values

CONTENTS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **7th MAY 2015**

REPORT BY: **CAROL RIBBINS, ACTING CHIEF NURSE**
ANDREW FURLONG, INTERIM MEDICAL DIRECTOR
RICHARD MITCHELL, CHIEF OPERATING OFFICER
EMMA STEVENS, ACTING DIRECTOR OF HUMAN RESOURCES
DARRYN KERR, DIRECTOR OF ESTATES AND FACILITIES

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

1.0 Introduction

The following report provides an overview of the March 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	3	19	2	5
Caring	4	15	1	1
Well Led	5	14	7	2
Effective	6	17	0	1
Responsive	7	26	0	10
Research – UHL	9	5	5	0
Research - Network	9	13	0	3
Estates & Facilities	10	10	0	1
Total		119	15	23

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

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Mar-14	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
Safe	S1a	Clostridium Difficile	CR	DJ	FYE = 81	NTDA	Red / ER for Non compliance with cumulative target	66	4	4	6	5	7	2	5	7	7	11	7	5	7	73
	S1b	Clostridium Difficile (Local Target)	CR	DJ	FYE = 50	UHL	Red >5 per month, ER when YTD red	66	4	4	6	5	7	2	5	7	7	11	7	5	7	73
	S2a	MRSA Bacteraemias (All)	CR	DJ	0	NTDA	Red = >0 ER = 2 consecutive mths >0	3	0	0	0	0	0	0	1	1	0	2	0	1	1	6
	S2b	MRSA Bacteraemias (Avoidable)	CR	DJ	0	UHL	Red = >0 ER = 2 consecutive mths >0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1
	S3	Never Events	CR	MD	0	NTDA	Red = >0 in mth ER = in mth >0	3	0	0	0	0	0	0	0	1	0	1	1	0	0	3
	S4	Serious Incidents	CR	MD	tbc	NTDA	tbc	60	5	4	6	3	7	2	3	4	2	4	3	2	1	41
	S5	Proportion of reported safety incidents that are harmful	CR	MD	tbc	NTDA	tbc	2.8%		1.7%			2.2%			1.4%			2.3%			1.9%
	S6	Overdue CAS alerts	CR	MD	0	NTDA	Red = >0 in mth ER = in mth >0	2	0	2	2	2	3	0	0	0	0	0	0	0	1	10
	S7	RIDDOR - Serious Staff Injuries	CR	MD	FYE = <47	UHL	Red / ER = non compliance with cumulative target	47	5	3	5	1	2	2	1	2	2	1	0	3	2	24
	S8	Safety Thermometer % of harm free care (all)	CR	EM	tbc	NTDA	Red = <92% ER = in mth <92%	93.6%	93.6%	94.6%	94.7%	94.2%	94.9%	94.4%	93.9%	94.9%	93.3%	94.1%	95.0%	92.1%	93.6%	94.1%
	S9	% of all adults who have had VTE risk assessment on adm to hosp	AF	SH	95% or above	NTDA	Red = <95% ER = in mth <95%	95.3%	95.6%	95.7%	95.9%	95.9%	96.3%	95.5%	96.2%	95.4%	95.5%	95.0%	96.3%	96.2%	95.6%	95.8%
	S10	Medication errors causing serious harm	CR	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	CR	EM	<7.1	QC	Red >= YTD >8.4 ER = 2 consecutive reds	7.1	6.9	7.0	7.5	7.1	7.3	7.3	5.9	6.4	7.5	6.9	7.1	6.7	6.3	6.9
	S12	Avoidable Pressure Ulcers - Grade 4	CR	EM	0	QS	Red / ER = Non compliance with monthly target	1	0	0	0	0	0	0	0	0	0	1	0	0	1	2
	S13	Avoidable Pressure Ulcers - Grade 3	CR	EM	<8 a month	QS	Red / ER = Non compliance with monthly target	71	6	5	5	5	5	6	6	4	6	7	5	9	6	69
	S14	Avoidable Pressure Ulcers - Grade 2	CR	EM	<10 a month	QS	Red / ER = Non compliance with monthly target	120	9	6	6	6	7	9	4	8	13	11	7	5	9	91
	S15	Compliance with the SEPSIS6 Care Bundle	CR	MD	All 6 >75% by Q4	QC	Red/ER = Non compliance with Quarterly target	27.0%		47.0%			>=60%			<65%						<65%
	S16	Nutrition and Hydration Metrics - Fluid Balance and Nutritional Assessment	CR	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%	≥86%	≥83%	≥84%	≥82%	≥83%
	S17	Maternal Deaths	AF	IS	0	UHL	Red / ER = Non compliance with monthly target	3	0	0	0	0	0	0	0	0	0	0	1	0	0	1

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Mar-14	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
Caring	C1a	Inpatient Friends and Family Test - Score	CR	CR	72 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	68.8	69.9	69.6	71.0	74.5	73.8	73.8	76.1	71.1	70.3	72.1	70.8	71.7	74.4	72.4
	C1b	Inpatient Friends and Family Test - Score (Local Target)	CR	CR	75	UHL	Red/ ER =<=69.9 Green >74.9	68.8	69.9	69.6	71.0	74.5	73.8	73.8	76.1	71.1	70.3	72.1	70.8	71.7	74.4	72.4
	C2a	A&E Friends and Family Test - Score	CR	CR	54 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	58.5	65.5	69.4	66.0	71.4	71.7	56.3	66.1	71.1	72.3	72.8	72.4	73.1	71.3	69.3
	C2b	A&E Friends and Family Test - Score (Local Target)	CR	CR	75	UHL	Red/ ER =<=64.9 Green >74.9	58.5	65.5	69.4	66.0	71.4	71.7	56.3	66.1	71.1	72.3	72.8	72.4	73.1	71.3	69.3
	C3	Outpatients Friends and Family Test - Score	CR	CR	75	UHL	Red / ER =<=64.9	New Indicator									58.7	63.8	65.2	64.3	67.6	65.0
	C4	Daycase Friends and Family Test - Score	CR	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	78.5	78.7	79.5	78.7
	C5	Maternity Friends and Family Test - Score	CR	CR	75	UHL	Red/ ER =<=61.9	64.3	66.7	61.2	63.5	69.5	69.7	67.3	63.0	64.1	67.7	63.8	74.5	74.5	69.5	67.8
	C6	Complaints Rate per 100 bed days	CR	MD	tbc	NTDA	tbc		0.4	0.4	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.4	0.4
	C7	Complaints Re-Opened Rate	CR	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%	17%	13%	11%	10%
	C8	Single Sex Accommodation Breaches (patients affected)	CR	CR	0	NTDA	Red = >0 ER = in mth >0	2	0	4	3	0	0	0	0	0	5	0	1	0	0	13
	C9	Improvements in the FFT scores for Older People (65+ year)	CR	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	76.6	76.9	75.3	76.1
	C10	Responsiveness and Involvement Care (Average score)	CR	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	88.5	89.0	88.6	88.3
	C10a	Q15. When you used the call button, was the amount of time it took for staff to respond generally:	CR	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	88.7	89.9	90.1	89.3
	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?	CR	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	92.7	92.6	92.1	92.2
	C10c	Q11. Were you involved as much as you wanted in decisions about your care and treatment?	CR	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	86.1	86.7	85.9	85.6

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

Well Led

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Mar-14	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
W1	Inpatient Friends and Family Test - Coverage	CR	CR	30% - Q4. 40% - Mar 15	NTDA / CQUIN	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	24.3%	28.8%	36.8%	38.1%	32.6%	30.8%	28.9%	33.4%	36.3%	36.0%	31.9%	34.6%	41.0%	44.8%	40.1%*
W2	A&E Friends and Family Test - Coverage	CR	CR	15% Q1-Q3 20% for Q4	NTDA	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	14.9%	16.1%	15.2%	17.8%	14.9%	10.2%	16.1%	19.1%	15.9%	14.0%	18.7%	25.3%	21.2%	21.9%	22.8%*
W3	Outpatients Friends and Family Test - Valid responses	CR	CR	tbc	UHL	tbc	New Indicator available	271	175	286	1,879	1,535	785	927	1,255	1,506	1,053	1,259	1,245	1,280	13,185
W4	Maternity Friends and Family Test - Coverage	CR	CR	tbc	UHL	tbc	25.2%	23.9%	27.2%	36.4%	25.2%	29.2%	29.9%	18.7%	15.8%	21.7%	22.1%	25.8%	46.5%	40.2%	28.0%
W5	Friends & Family staff survey: % of staff who would recommend the trust as place to work	ES	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed		53.7%			53.7%			Q3 staff FFT not completed as National Survey carried out			54.9%			54.2%
W6	Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment	ES	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			71.4%			69.2%
W7	Data quality of trust returns to HSCIC	RM	JR	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed														
W8	Turnover Rate	ES	ES	<10.5%	UHL	Red = 11% or above ER = Red for 3 Consecutive Mths	10.0%	10.0%	9.9%	10.0%	10.2%	10.0%	10.5%	10.3%	10.8%	10.7%	10.3%	10.1%	10.1%	11.5%	11.5%
W9	Sickness absence	ES	ES	< 3.0%	UHL	Red = >3.5% ER = 3 consecutive mths >3.5%	3.4%	3.5%	3.5%	3.3%	3.3%	3.4%	3.4%	3.7%	4.0%	4.0%	4.5%	4.3%	4.2%		3.7%
W10	Total trust vacancy rate	ES	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed														
W11	Temporary costs and overtime as a % of total paybill	ES	ES	tbc	NTDA	tbc	New Indicator for 14/1		9.4%	9.4%	8.1%	8.5%	8.9%	8.5%	9.5%	9.0%	9.8%	10.5%	9.8%	11.5%	9.4%
W12	% of Staff with Annual Appraisal	ES	ES	95%	UHL	Red = <90% ER = 3 consecutive mths <90%	91.3%	91.3%	91.8%	91.0%	90.6%	89.6%	88.6%	89.7%	91.8%	92.3%	92.5%	90.9%	91.0%	91.4%	91.4%
W13	Statutory and Mandatory Training	ES	ES	Jun 80%, Sep 85%, Dec 90%, Mar 95%	UHL	Red / ER for Non compliance with Quarterly incremental target	76%	76%	78%	79%	79%	80%	83%	85%	86%	87%	89%	89%	90%	95%	95%
W14	% Corporate Induction attendance	ES	ES	95.0%	UHL	Red = <90% ER = 3 consecutive mths <90%	94.5%	95%	96%	94%	92%	96%	98%	98%	98%	98%	100%	99%	100%	97%	100%

* Quarter 4 Average

Effective

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Mar-14	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
E1	Mortality - Published SHMI	AF	PR	Within Expected	NTDA	Higher than Expected			106 (Oct12-Sept13)			106 (Jan13-Dec13)			105 (Apr13-Mar14)			105 (Jul13-Jun14)			105 (Jul13-Jun14)
E2	Mortality - Rolling 12 mths SHMI (as reported in HED)	AF	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive mths increasing SHMI >100	105	105	105	105	106	105	103	102	102	101	99	Awaiting HED Update			99
E3	Mortality HSMR (DFI Quarterly)	AF	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	88		99			93			88			Awaiting DFI Update			93
E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	AF	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	99	97	98	98	97	96	96	96	95	95	96	Awaiting HED Update		96
E5	Mortality - Monthly HSMR (Rebased Monthly as reported in HED)	AF	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	91	91	82	108	105	86	97	98	96	88	96	97	Awaiting HED Update		95
E6	Mortality - Rolling 12 mths HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	AF	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	100	100	98	99	99	97	96	95	95	95	95	95	Awaiting HED Update		95
E7	Mortality - Monthly HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	AF	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	100	94	85	98	109	84	91	99	95	90	97	94	Awaiting HED Update		95
E8	Mortality - rolling 12 mths HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	AF	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	99	95	98	97	96	97	97	97	97	97	100	Awaiting HED Update		100
E9	Mortality - Monthly HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	AF	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	82	69	135	93	93	121	99	107	89	98	110	Awaiting HED Update		101
E10	Deaths in low risk conditions (Risk Score)	AF	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	94	63	64	81	105	79	69	63	102	22	47	Awaiting DFI Update			71
E11	Emergency 30 Day Readmissions (No Exclusions)	AF	PR	Within Expected	NTDA	Higher than Expected	7.9%	8.8%	8.8%	8.8%	8.6%	8.4%	8.9%	8.4%	8.6%	8.9%	9.1%	8.2%	8.5%		8.6%
E12	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%	54.7%	56.9%	40.6%	60.3%	76.9%	59.0%	68.6%	69.6%	59.4%	57.3%	57.9%	67.2%	61.5%	61.4%
E13	Stroke - 90% of Stay on a Stroke Unit	RM	CF	80% or above	QS	Red = <80% ER = 2 consecutive mths <80%	83.2%	83.5%	91.8%	80.3%	87.1%	77.1%	84.5%	83.2%	70.4%	72.4%	75.2%	82.5%	83.5%		80.4%
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%	77.9%	79.7%	58.8%	71.3%	62.8%	65.5%	72.7%	67.8%	69.0%	83.5%	80.6%	64.0%	77.3%	71.2%
E15	Communication - ED, Discharge and Outpatient Letters - Compliance with standards	AF	SJ	90% or above	QS	Red = <80% ER = Qrtly ER if <90% and deterioration	New Indicator for 14/15						60% (InPt)	83% (ED)	Policy launch, audit not undertaken						
E16	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
E17	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

Responsive

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Mar-14	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
R1	ED 4 Hour Waits UHL + UCC (Sit Rep)	RM	CF	95% or above	NTDA	Red = <95% ER via ED TB report	88.4%	89.3%	86.9%	83.4%	91.3%	92.5%	90.9%	91.5%	90.1%	88.5%	83.0%	90.2%	89.2%	91.1%	89.1%
R2	12 hour trolley waits in A&E	RM	CF	0	NTDA	Red = >0 ER via ED TB report	5	0	0	1	1	0	0	0	1	0	0	1	0	0	4
R3	RTT Waiting Times - Admitted	RM	CC	90% or above	NTDA	Red /ER = <90%	76.7%	76.7%	78.9%	79.4%	79.0%	80.9%	82.2%	81.6%	84.4%	85.5%	86.9%	85.0%	85.9%	84.4%	*82.8%
R4	RTT Waiting Times - Non Admitted	RM	CC	95% or above	NTDA	Red /ER = <95%	93.9%	93.9%	94.3%	94.4%	95.0%	94.9%	95.6%	94.6%	94.9%	95.2%	96.0%	95.4%	95.3%	95.5%	*95.1%
R5	RTT - Incomplete 92% in 18 Weeks	RM	CC	92% or above	NTDA	Red /ER = <92%	92.1%	92.1%	93.9%	93.6%	94.0%	93.2%	94.0%	94.3%	94.8%	95.0%	95.1%	95.2%	96.2%	96.7%	*94.7%
R6	RTT 52 Weeks+ Wait (Incompletes)	RM	CC	0	NTDA	Red /ER = >0	0	0	0	0	0	15	1	3	3	2	0	0	0	0	0
R7	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	NTDA	Red /ER = >1%	1.9%	1.9%	0.8%	0.9%	0.8%	0.7%	1.0%	1.0%	0.7%	1.8%	2.2%	5.0%	0.8%	0.9%	*1.4%
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%	95.3%	88.5%	94.7%	93.5%	92.2%	92.0%	90.6%	92.0%	92.5%	93.0%	92.2%	93.5%		92.2%
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%	94.3%	80.0%	95.0%	98.9%	94.9%	94.4%	95.2%	98.6%	100.0%	93.0%	92.5%	91.5%		94.0%
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%	98.2%	97.2%	92.9%	93.6%	94.4%	97.9%	91.9%	95.9%	92.5%	95.2%	91.7%	95.1%		94.4%
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%	98.8%	100.0%	97.1%	100.0%	96.7%	100.0%	100.0%		99.3%
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%	98.6%	95.2%	97.0%	90.8%	90.1%	87.8%	94.0%	81.9%	82.4%	80.3%	89.2%	94.2%		89.1%
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%	99.1%	97.3%	95.6%	93.9%	97.3%	99.0%	96.5%	96.0%	94.7%	95.5%	87.6%	99.0%		95.8%
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%	92.4%	92.7%	88.5%	73.1%	85.6%	78.8%	75.5%	80.4%	77.0%	84.8%	79.3%	78.6%		81.1%
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%	91.7%	91.1%	67.4%	73.9%	73.0%	100.0%	87.5%	75.0%	94.4%	93.8%	88.9%	79.4%		84.1%
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	10	4	1	2	1	2	2	0	3	4	3	1	33
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	2	1	0	11
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%	1.5%	1.1%	0.8%	1.1%	0.7%	0.6%	0.8%	0.8%	1.2%	1.1%	0.8%	0.7%	1.0%	0.9%
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%	1.5%	0.6%	0.6%	0.3%	2.7%	0.0%	0.9%	1.0%	0.0%	0.8%	1.4%	0.0%	0.4%	0.9%
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%	0.8%	0.7%	0.9%	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	139	106	77	98	94	55	90	94	108	102	85	64	98	1071
R23	Delayed transfers of care	RM	PW	3.5% or below	NTDA	Red = >3.5% ER = Red for 3 consecutive mths	4.1%	3.8%	4.4%	4.2%	4.0%	3.9%	3.9%	4.5%	4.6%	5.2%	3.9%	3.2%	2.9%	1.8%	3.9%
R24	Choose and Book Slot Unavailability	RM	CC	4% or below	Contract	Red = >4% ER = Red for 3 consecutive mths	13%	19%	22%	25%	26%	25%	26%	25%	20%	17%	16%	13%	19%	26%	21%
R25	Ambulance Handover >60 Mins (CAD)	RM	PW	0	Contract	Red = >0 ER = Red for 3 consecutive mths	868	111	173	253	88	71	50	106	253	343	460	353	499	418	3,067
R26	Ambulance Handover >30 Mins and <60 mins (CAD)	RM	PW	0	Contract	Red = >0 ER = Red for 3 consecutive mths	7,075	601	720	951	671	591	805	736	1,147	1,364	1,170	1,167	970	1,023	11,315

* Yearly Average

Compliance Forecast for Key Responsive Indicators

Standard	March actual	April predicted	Month by which to be compliant	RAG rating of required month delivery	Commentary
Emergency Care					
4+ hr Wait (95%) - Calendar month	91.1%				
Ambulance Handover (CAD)					
Ambulance Handover >60 Mins (CAD)	418	320			
Ambulance Handover >30 Mins and <60 mins (CAD)	1023	1056			
RTT (inc Alliance)					
Admitted (90%)	84.4%	88.0%	May		87% current prediction for April. Will require significant improvement to deliver April. Informed TDA and CCG of slip to May due to Orthoapedics and ENT.
Non-Admitted (95%)	95.5%	95.6%	Continued Delivery		March including Alliance has achieved. Predicting ongoing compliance.
Incomplete (92%)	96.7%	96.2%	Continued Delivery		Backlog clearance improving sustainability. Performance is now29 out of 148 trusts.
Diagnostic (inc Alliance)					
DM01 (<1%)	0.9%	0.9%	March		March delivered. Predicted April delivery.
Cancelled Ops (inc Alliance)					
Cancelled Ops (0.8%)	0.9%	0.8%	Continued delivery		April currently being validated.
Not Rebooked within 28 days (0 patients)	1	2	March		April currently being validated.
Cancer (predicted)					
Two Week Wait (93%)	91.5%	91.2%	March		Patient choice now the dominant reason for failure all UHL tumour sites compliant for capacity and speed of offering patients dates.
31 Day First Treatment (96%)	93.6%	89.5%	May		Skin patients have chosen to wait longer and no clock pause can be applied in non-admitted setting. Currently reviewing the 20 breaches to understand the potential recovery actions in month.
31 Day Subsequent Surgery Treatment (94%)	81.0%	88.5%	April		Urology backlog clearance during March.
62 Days (85%)	83.3%	77.7%	July		62 Day backlog increasing in LOGI, Lung and Gynae. Urology reducing as per plan. All tumour sites have returned with confidence about return to trajectory.

Research UHL

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
RU1	Median Days from submission to Trust approval (Portfolio)	AF	NB	tbc	tbc	tbc	3.0			2.0			3.0						
RU2	Median Days from submission to Trust approval (Non Portfolio)	AF	NB	tbc	tbc	tbc	2.0			3.5			2.0						
RU3	Recruitment to Portfolio Studies	AF	NB	Aspirational target=10920/year (910/month)	tbc	tbc	941	1092	963	1075	1235	900	1039	1048	604	920	759		
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
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%	90%	90%
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%	54%	54%
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%	81.0%	81.0%	73%	77%	77%	86.0%	77%	77%
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%	90.0%	89.0%	84.0%	82.0%	83.0%	83.0%	88.0%	88.0%
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	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%	81.0%	81.0%	81.0%	88.0%	88.0%	88.0%	88.0%	88.0%
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%	56.0%	56.0%	56.0%	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	AF	DR	England 25% East Midlands 25%	NIHR CRN	Red <25%	45.0%	45.0%	51.0%	63.0%	54.0%	54.0%	61.0%	61.0%
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	954	954
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% *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	Jan-15	Feb-15	Mar-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%
	E&F2	Percentage of non-statutory PPM completed in the Contract Month measured against the PPM schedule	DK	GL	100%	Contract KPI	Red = ≤ 80%	91.5%	81.2%	95.6%	80.5%	86.6%	97.4%	99.5%	90.3%
	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%
	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%
	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
	E&F6	Number of Urgent Portering requests achieving response time	DK	LT	95%	Contract KPI	Red = ≤ 95%	95.1%	96.2%	97.3%	97.2%	97.2%	98.5%	98.1%	97.1%
	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%	99.1%	100.0%	100.0%	100.0%	94.4%	96.1%	98.5%
	E&F8	Percentage of Cleaning Rapid Response requests achieving rectification time	DK	LT	92%	Contract KPI	Red = ≤ 80%	99.6%	89.9%	93.3%	90.5%	91.1%	94.1%	96.9%	93.6%
	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%	99.4%	99.5%	100.0%	100.0%	98.9%	99.9%	100.0%	99.7%
	E&F10	Overall percentage score for monthly patients satisfaction survey for catering service	DK	LT	85%	Contract KPI	Red = ≤ 75%	96.7%	97.3%	97.3%	96.7%	93.8%	95.8%	97.5%	96.4%

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 Post Infection Reviews 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 Interserve has been instructed to stop reporting audits based on re-testing of cleaning inspections and to report only the result of the first inspection. This should give a more accurate picture of any inadequate cleaning practice, allowing focused attention on these areas with the intention that this will raise the standard of cleaning, including spore removal, in these areas.	Action plans that have resulted from the PIR should be presented to the CMG Infection Prevention Groups and should follow the PIR 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 PIR will be sent monthly for review. A thematic review of CDT cases with an action plan was presented to the February TIPAC. This will also be presented to the EQB and CQRG meetings in April. 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 Director of Facilities will chair a newly formed monthly Infection Prevention Operational Group who in conjunction with a quarterly TIPAC have as their remit the review of current cleanliness forums in place, to ensure these are fit for purpose and are monitoring cleanliness and ensuring performance delivery effectively.	5	7	73	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	7	5	7	73

Expected date to meet standard / target	TBA
Revised date to meet standard	TBA
Lead Director / Lead Officer	Carole Ribbins, Acting Chief Nurse Elizabeth Collins, Clinical Lead Infection Prevention

S2a/S2b - MRSA

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 5 of the six cases have been deemed unavoidable however lapses in care were identified in all cases. The sixth case was deemed avoidable however the source of the MRSA identified within this patient could not be identified.	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 PIR process flow chart as described in the Infection Prevention Toolkit	0	1	6	N/A

Indicators	13/14 Outturn	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
MRSA Bacteraemias (All)	3	0	0	0	0	0	1	1	0	2	0	1	1	6
MRSA Bacteraemias (Avoidable)	1	0	0	0	0	0	0	0	0	0	0	1	0	1

Expected date to meet standard / target	TBA
Revised date to meet standard	TBA
Lead Director / Lead Officer	Carole Ribbins, Acting Chief Nurse Elizabeth Collins, Clinical Lead Infection Prevention

S6 Overdue CAS alert

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
One NHS England NPSAS alert deadline was breached by Musculo-Skeletal and Specialist Surgery (MSS). This was due to unplanned absence of Head of Nursing and PA who would normally administer the alerts. All actions had been taken to comply with the alert however on day of deadline there were no staff in MSK/SS who could confirm the status of the alert to the UHL CAS team.	CMG has been requested to review its management arrangements for these alerts and to consider increasing the number of staff involved in managing the alerts in order to provide additional resilience for unplanned absences.	100% of alerts completed in deadline	1 breached deadline	10 breached deadlines	No breaches

CMG	No of external alerts received by UHL during 2015 (*not including EFN's)	External alerts distributed to CMGs	Breached deadlines during March 2015
CHUGS	71*	17	0
CSI	71*	18	0
Emergency and Specialist Medicine	71*	27	0
ITAPS	71*	27	0
MSK/SS	71*	18	1
RRC	71*	23	0
W&C	71*	29	0
Alliance	71*	52	0
NHS Horizons (including EFNs)	127	65	0

Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
2 breached deadlines	5 breached deadlines	4 breached deadlines	0 breached deadlines	1 breached deadline

Expected date to meet standard / target	30th April 2015
Revised date to meet standard	
Lead Director / Lead Officer	Moira Durbridge, Director of Safety and Risk Peter Cleaver, Risk and Assurance Manager

S12 and S13 Hospital Acquired Pressure Ulcers (Grade 4 and Grade 3)

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
S12 – In March 2015 there was a Grade 4 avoidable HAPU on R36, believed to be as a result of incorrect prescription and use of Anti-embolic stockings (AES). Lessons were identified for medical staff as well as the nursing staff ,around ensuring that all safety checks are undertaken prior to decision to use AES for VTE prevention Another lesson is around inconsistent approach to ensuring twice daily checks of pressure areas under the AE stockings. **S13** - During the April 2015 validation process 3 additional cases from February 2015 were confirmed as avoidable pressure ulcers (two grade 3s for R41 and R17 and one grade 2 for R17). These ulcers should have been reported and validated in March and therefore have been added retrospectively to the February HAPU figures (in red in the adjacent table) resulting in the number of Grade 3s going over trajectory. The themes are confirmed as inconsistent approaches to BEST SHOT skin checks resulting in poor quality skin inspection and failure to recognise deterioration in the pressure areas; staffs' inability to recognise pressure damage in a patient with dark skin; skin damage not reported in a timely manner; failure in MDT communication and failure to comply with UHL policy for reporting all Grade 3 Pressure Ulcers on Datix.	**S12** -The Acting Chief Nurse is holding a performance management meeting with staff in relation to the Grade 4 HAPU A robust action plan is in place, led by the ward sister and some of the actions have been already implemented e.g. bespoke Pressure Ulcer prevention and Tissue Viability update for all medical SpRs, additional AES trouble shooting training for all clinical staff on R36; review of the EPMA process. As avoidable Grade 4 HAPUs are considered to be 'local Never Event', a proper MDT meeting is being organised and will be led by the Quality and Safety team as per UHL Policy. **S13** - On-going actions via the CMG team and Head of Safeguarding to increase monitoring of documentation. The UHL podiatry team have also been involved in one of these cases (R41) and personal statements issued to ensure appropriate lessons have been learned. .	**S12 - G4 = 0** **S13 – G3= 7**	**G4 = 1** **G3 = 6 (below threshold). However, retrospective data submitted for February which increased incidence to 9 (above threshold)**	**G4 = 2** **G3 = 69**	**G4 = 0** **G3 = </= 7**

*Table 1 - Avoidable **Grade 4** Pressure Ulcers April - March 2015*

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**	**0**
Incidence	0	0	0	0	0	0	0	0	1	0	0	1	**2**

*Table 2 - Avoidable **Grade 3** Pressure Ulcers April – March 2015*

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	5	9	6	**69**

*Table 3 - Avoidable **Grade 2** Pressure Ulcers April – March 2015*

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	9	4	8	13	11	7	5	9	**91**

Expected date to meet standard / target	May 1st 2015
Revised date to meet standard	May 1st 2015
Lead Director / Lead Officer	Carole Ribbins, Acting Chief Nurse Michael Clayton, Head of Nursing (Safeguarding)

S16 Nutrition and Hydration Metrics - Fluid Balance and Nutritional Assessment

What is causing underperformance?	What actions have been taken to improve performance?	Target	Latest performance	YTD performance	Forecast performance
The Nutrition and Hydration metric is made up of a suite of indicators which include both nutritional assessment, care planning, monitoring of fluid balance. For the Quality Commitment, staff knowledge is also included. Following a baseline period in Q1 it was agreed that improvement threshold would be to achieve 90% by Q4 across all the metrics within each bed holding CMG. There has been an improvement from the Q1 baseline for all CMGs with all metrics (with the exception of CHUGS for Fluid Balance Chart). However, the 90% threshold has not been achieved for ESM in respect of the Nutritional Assessment metric for any month within Quarter 4 and therefore the Indicator is RAG rated Red for the Trust as a whole. The specific metrics that are not being achieved include the Fluid Balance Chart (patient assessment) and Nutrition and Hydration (patient assessment). It is the acute medical wards and assessment unit that appear to need additional support.	Nutrition training was completed across all CMGs with the exception of ITAPs in November last year. One of the actions will be to revisit ESM wards and assessment areas for 'refresher' training. Nutrition training has also been delivered to • HCA Induction Programme • International nurses • Preceptorship. • Housekeeper forums • Volunteers Further nutrition education sessions are delivered to specialised areas such as Tissue Viability, renal, critical care, and nutrition link nurses as requested. There is intensive work being undertaken across all CMGs Priority in Q1 will be to support ESM with specific actions around nutritional assessment and maintaining fluid balance charts.	90% across all metrics within each CMG for Q4	83% for Nutritional Assessment for ESM 89% for Fluid Balance Charts for CHUGS, ESM & MSS >/= to 90% for all other metrics	3 CMGs have achieved 90% for all metrics.	>90% across all metrics within each CMG

FLUID BALANCE CHART

CMG	CHUGS	ESM	ITAPS	MSS	RRC	W&C
Q1	90%	83%	100%	83%	85%	90%
Q2	90%	88%	100%	92%	92%	99%
Q3	93%	89%	98%	95%	89%	95%
Q4	89%	89%	100%	89%	90%	96%

NUTRITIONAL SSESSMENT

CMG	CHUGS	ESM	ITAPS	MSS	RRC	W&C
Q1	85%	75%	93%	88%	83%	83%
Q2	88%	84%	85%	83%	91%	88%
Q3	90%	86%	97%	92%	92%	93%
Q4	92%	83%	91%	91%	90%	100%

STAFF KNOWLEDGE

CMG	CHUGS	ESM	ITAPS	MSS	RRC	W&C
Q1	98%	93%	99%	98%	93%	100%
Q2	99%	96%	95%	100%	96%	100%
Q3	100%	98%	100%	97%	96%	100%
Q4	99%	98%	97%	100%	98%	99%

Expected date to meet standard / target	Q1 in 15/16
Lead Director / Lead Officer	Carole Ribbins, Acting Chief Nurse Eleanor Meldrum, Asst Chief Nurse

C7 Complaints Re-opened Rate

		Target	Mar 15	Forecast
What is causing underperformance?	**What actions have been taken to improve performance?**	**<9%**	**11%**	**10%**

170 Formal complaints were received in March 2015 and **18 (11%)** were re-opened. The thresholds for an exception are >10% of complaints re-opened 3 months in a row or any month over 15%.

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

CMG 1- Cancer, Haematology, Urology, Gastroenterology and Surgery (CHUGGS)	8
CMG 3- Emergency and Specialist Medicine	6
CMG 5- Musculoskeletal and Specialist Surgery	4
Totals:	18

Overall the number of re-opened complaints have continued to reduce month on month and it is anticipated that a target of <9% will be reached next month (April). There is no theme to those complaints which have re-opened.

Continued greater scrutiny of the complaint and response prior to re-opening to establish if anything further can be contributed. Complaints lead to review the final responses of a select number of re-opened complaints and consider if these were fit for purpose.

Previous Months performance

	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
No. of Formal Complaints Received	197	162	142	157	158	170
No. Re-opened	20	15	13	25	21	18
% re-opening	10%	9%	9%	16%	13%	11%

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

W9 Sickness absence

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
1. There has been an increase in sickness absence from July 2014. (Table 1). 2. We have seen a reduction in sickness absence in February to 4.17 % 3. Sickness absence reporting highlights an adjustment of around 0.5% due to late closures. The January rate has now reduced from 4.53% to 4.27%. It is therefore expected the February 2015 sickness absence rate will be reduce next month to 4% or below. 4. In the last year the Trust has seen an increase in staff taking absence, 'triggers' and long term absences. (Table 2) 5. Feedback from Clinical Management Group and Directorates Leads indicates that the increased sickness absence is due to :- a. Increased operational pressures / activity b. Seasonal variations c. Inaccurate data – delays in closing absences d. Management changes / handovers e. Vacancies and other absences reducing management time f. Service pressures delaying sickness absence management	1. Improved data through weekly SMART reports and monthly ESR reports highlighting open absences, closed absences and triggers (3 episodes / more than 10 days / 2 working weeks) 2. Discussion at CMG / Directorate Boards and across services / areas with specific actions confirmed 3. Making it Happen Reviews, to discuss and agree actions for the management and support of open absences, 'triggers' and complex cases with line managers. 4. 6 monthly CMG Sickness Performance Reviews / Case reviews with Occupational Health and Senior and independent HR colleagues. 5. Sickness Absence training for managers and administrators **Further Actions:** 6. Local training is facilitated for CMG's / Directorates in response to specific needs – management of long term absence, documentation etc. 7. Local actions to address high sickness absence include CMG Management Team 'Hot Spot' meetings, Staff Engagement events to reduce sickness absence and improve the management of sickness absence. 8. Improvement plans including timescales are discussed and agreed at CMG / Directorate level to reduce sickness absence and increase performance in the management of sickness absence. 9. Specific staff support and targeted management of stress related absences. 10. Review of the UHL Sickness Absence in comparison with other NHS organisations in the region. From the information available, UHL has set the lowest sickness absence target and has the second lowest sickness absence levels in the region.	**UHL Stretch target 3%** **(previous SHA target 3.4%)**	**4.53% (February 2015)**	**3.75% (average)**	**3.50% average (April 2015)**

Table 1: Monthly Trust Performance:

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
3.5%	3.3%	3.3%	3.4%	3.4%	3.7%	4.0%	4.0%	4.5%	4.3%	4.2%		3.7%

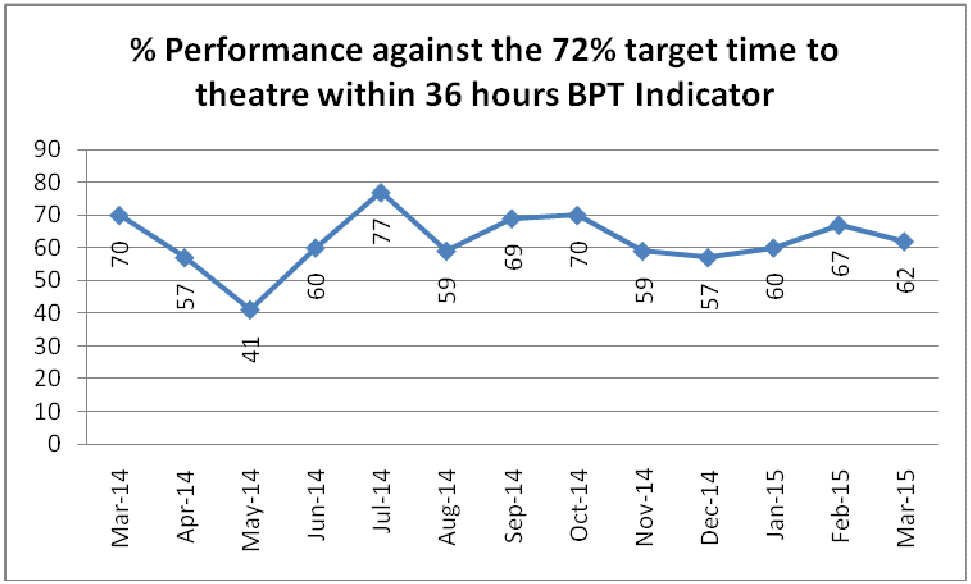
Table 2: Annual performance

February	Staff taking absence %	Staff 'triggering' %	% absences over 28 days
2013	67.2%	38.7%	7.4%
2014	64.5%	37.1%	7.7%
2015	66.3%	39.1%	8.06%

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)

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	Forecast performance for next reporting period
All of the issues set out in previous reports continue in the service and are exacerbated at times of heightened activity. Significant increases in activity though December and January have had an impact on delivery of the target and ability to operate on patients within target. The current scheduled theatre capacity is insufficient to cope with this level of trauma demand and increasing spinal work. Short notice additional operating sessions continue to be arranged as necessary. The acceptance of out of area elective and emergency spinal work continues to have a detrimental effect on the main trauma capacity as spinal patients are medically prioritised over 'other' trauma which has a knock on effect on #NOF capacity.	An action plan is to be presented to the CMG board in April which details the work that is currently being scoped and implemented from the various outputs of the LiA and other improvement projects within the specialty. Specific blockers include Theatre List start and finish times, Orthogeriatric capacity and Theatre process delays. The listening into action process continues the themes and detailed actions will be published in the action plan to be presented to the CMG board in April. Work continues within the spinal network with regards to capacity across the region and how UHL fits into the future plans.	**72%**	**63%**	**62%**	**62%**



Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4	14/15 FYE
65%	52%	68%	63%	63%	62%

Expected date to meet standard / target	December 2014
Revised date to meet standard	Quarter 3 2015/16
Lead Director / Lead Officer	Richard Power, MSS CD Maggie McManus, MSS Deputy Head of Operations

R3 – RTT Waiting Time - Admitted

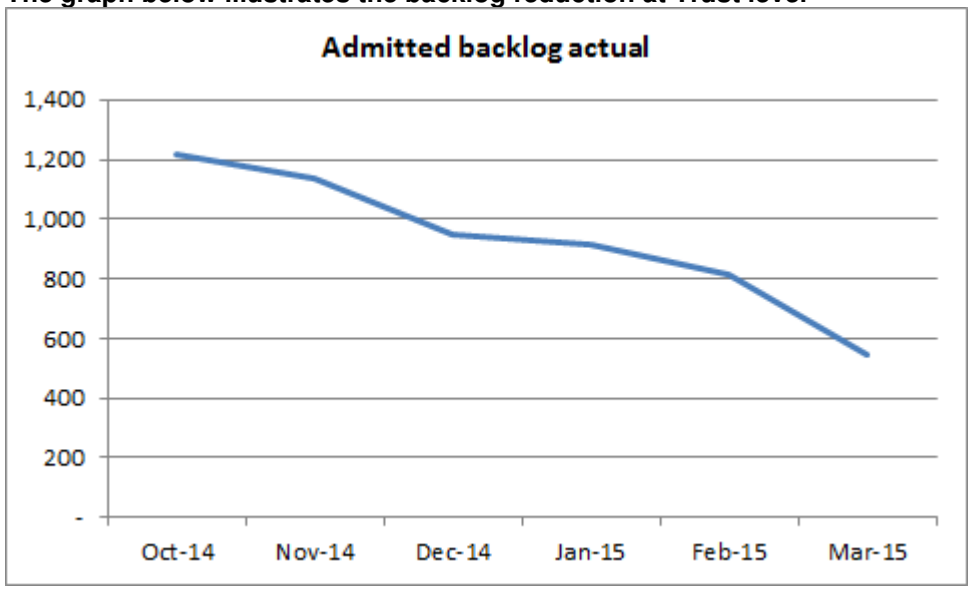
<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>Latest performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="3">The Trust commitment to deliver the admitted standard from May 2015 onwards remains, but this is not without its risks due to the level of backlog remaining.
The graph opposite illustrates the significant admitted backlog reduction achieved from end October 2014 (1218) to the end of March (546). This has been achieved by additional in house activity and outsourcing to the local independent sector providers. The commitment to ensure that the longest waiters are treated remains our priority.

By key speciality:
• General surgery, backlog continues to reduce as planned with weekend working in March
• Urology the backlog has reduced significantly
• Paediatric Max fax and ENT have been hampered by lack of paediatric elective capacity.
• Adult ENT, the residual backlog has increased
• paediatric surgery and urology delivered their target reductions
• Gynaecology, is on track to deliver its target reduction.
• Orthopaedics, backlog has remained static. It is a significant risk due to the unstainable non admitted backlog position</td><td rowspan="3">The Trust is achieving 2 of the 3 RTT standards: Non admitted and incompletes performance are both compliant.
The actions been taken in admitted are clearly the right actions evidenced by the backlog reductions seen in recent weeks and months.
The revised weekly access meeting is working well as is the predictive ability of ensuring delivery.

• Additional activity at weekends continues in April

• Urology additional in house and independent sector
• Additional weekend work across the paediatric specialities

• Additional in house activity

• Additional work in house but also with the local independent sector.
• Orthopaedics remains a significant risk to the Trust. Weekend working continues, additional outsourcing to the local Independent sector.</td><td>90% treated within 18 weeks</td><td>84.4%
(UHL and Alliance)</td><td>85%</td><td>86%</td></tr>
<tr><td colspan="4">The graph below illustrates the backlog reduction at Trust level
 

Risks to delivery of the admitted 90% standard in May
There are now 2 specialities that poses the greatest risk to delivery of the Trust level admitted standard in May orthopaedics (as detailed in last month's report) and ENT adult and paediatric due to the residual backlog volumes:
Mitigation
All key speciality plans being reviewed by Director of Performance and Information.
ENT is undergoing a detailed review of their admitted pathways with input from corporate team
Orthopaedics on daily reporting of key improvement metric.
Re modelling of anticipated performance.
Ongoing additional activity in key specialities.
Additional outsourcing of activity in orthopaedics</td></tr>
<tr><td colspan="4"><table>
<tr><td>Expected date to meet standard / target</td><td>May 2015</td></tr>
<tr><td>Lead Director / Lead Officer</td><td>W Monaghan, Director of Performance and Information
C Carr, Head of Performance</td></tr>
</table></td></tr>
</table>

R8-15 Cancer Waiting Times Performance

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance February	Performance to date 2014/15	Forecast performance for March
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) LLR has a conversion rate from referral to cancer diagnosis significantly below the national average, raising concerns around the quality of 2WW referrals **R10, 12** Difficulties in achieving prioritisation of surgical cases in general, although significantly improved. Dermatology capacity issues. **R14, 15** The system for the integration of complex cancer pathways remains in place (**R14, R15**) Access to cancer diagnostics remains good. The delivery of timely treatments (**R10, R12**) lies within the gift of services for surgery, and the oncology department for chemotherapy and radiotherapy. Chemotherapy and radiotherapy treatments have remained timely for the most part. The issue is adequate access to surgical capacity. There is no shortage of overall surgical capacity, the poor performance results from the failure to appropriately prioritise cancer pathways in the face of competing priorities.	**R8** The trust have reliably and consistently delivered rapid processing of referrals and released adequate capacity quickly to meet the 2WW demand consistently for 3 months. Overwhelmingly breaches are due to patient choice. Joint workstreams with the CCGs, requiring their leadership regarding (1) correct process (2) use of appropriate clinical criteria and (3) preparation of patients for urgency of appointments are needed to achieve this standard. **R10, 12** Backlog of 31 day cases almost eliminated. Attendance to cancer prioritisation by the services with the support of the cancer centre navigators. **R14, 15** Trajectory for recovery by tumour site agreed with CMGs to deliver recovery of the standard at trust level monthly by month 4 and cumulatively by month 6. Additional administrative appointments to Cancer Centre to support services pulling patients through pathways. Development of SOP for cancer pathway management between cancer centre and services to commence in June 15.	**R8 2WW 93%**	93.5%	92.2%	90.7%
		R10 31 day 1st 96%	95.1%	94.4%	93.4%
		R12 31 day sub (Surgery) 94%	94.2%	89.1%	80.3%
		R14 62 day RTT 85%	78.6%	81.1%	85.0%
		R15 62 screening 90%	79.4%	84.1%	96.5%

Performance by Quarter

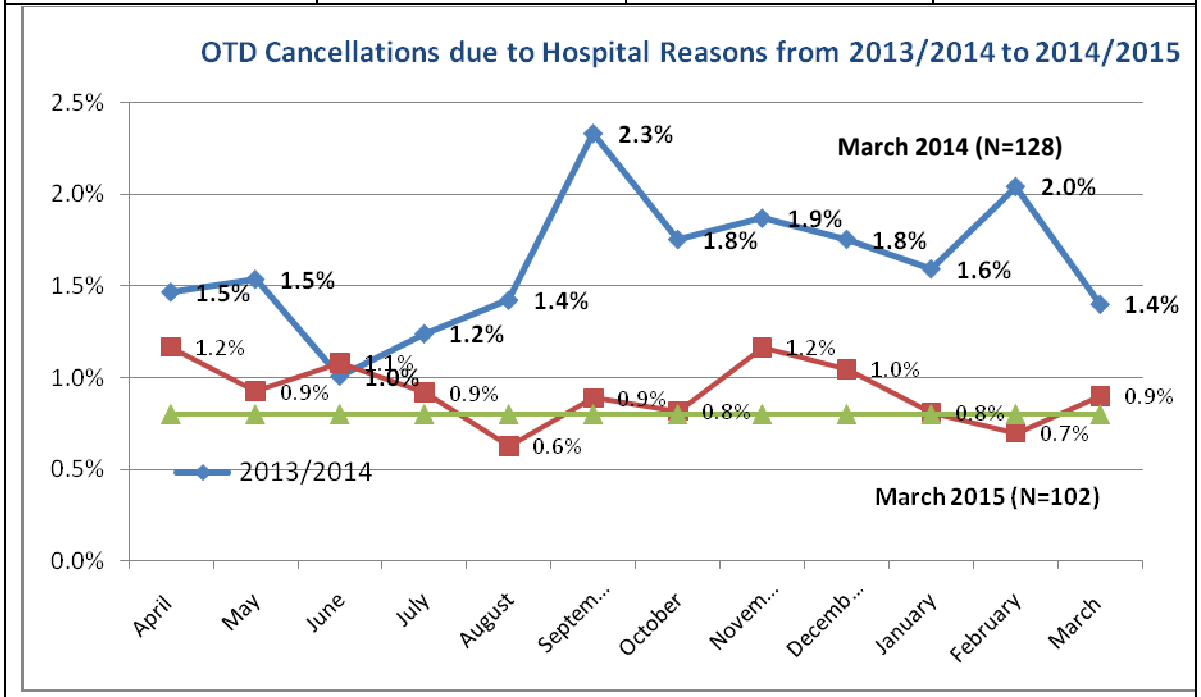
	13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
R8	94.8%	92.2%	91.6%	92.5%	
R10	98.1%	94.6%	94.6%	94.6%	
R12	98.2%	94.2%	90.5%	81.5%	
R14	86.7%	84.1%	79.9%	80.8%	
R15	95.6%	78%	85%	89.2%	

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

R17 - cancelled operations not booked within 28 days

INDICATORS: The cancelled operations target comprises of three components: 1. The % of cancelled operations for non-clinical reasons On The Day (OTD) of admission **2.**The number of patients cancelled who are offered another date within 28 days of the cancellation
3. The number of urgent operations cancelled for a second time.

What is causing underperformance?	What actions have been taken to improve performance?	Target (monthly)	Latest month performance – Mar 14	YTD performance (inc Alliance)	Forecast performance for next reporting period
Causes of OTD cancellations changed this month due to paediatric bed pressures and emergency/high priority admissions. Thirteen paediatric patients were cancelled due to paediatric ward bed unavailability in LRI. Patients cancelled due to admissions of emergency/high priority admissions went up to 20 this month which is an increased of 13 compared to last month. Seven patients were cancelled due to adult ward beds unavailability in LRI (6) and LGH (1). There was one, 28 day breach. The patient was given a date for treatment within 28 days but due to ITU/HDU pressures the patient was cancelled for a second time. The patient had the operation on the 22nd of March. In March 2014, UHL had 128 OTD cancellations (1.4%). There were 26 fewer cancellations in March 2015.	A number of work streams have started aimed at reducing OTD cancellations including a LIA project. A successful LIA event was completed with participation of 48 staff in all three sites. Lots of useful feedback and a number of new ideas were provided by the staff to reduce cancellations. The LIA team are working to implement the changes suggested which include changes to the existing escalation policy and minimising number of list overruns. <u>Risks to delivery of recovery plan</u> The key action to ensure on-going performance is the daily escalation of patients at risk of cancellation, on the day as part of the UHL escalation policy. For those who may be cancelled on the day, it is vital that staff adhere to the Trust policy of escalating to CMG General Managers for resolution prior to agreeing any cancellations.	*1)* **0.8%** *2)* **0** **3) 0**	**1) 0.9%** **2) 1 (UHL)** **3) 0**	**1) 0 .9%** **2) 44** **3) 0**	**1) 0.8%** **2) 2** **3) 0**



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

R24 Choose and Book

<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="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

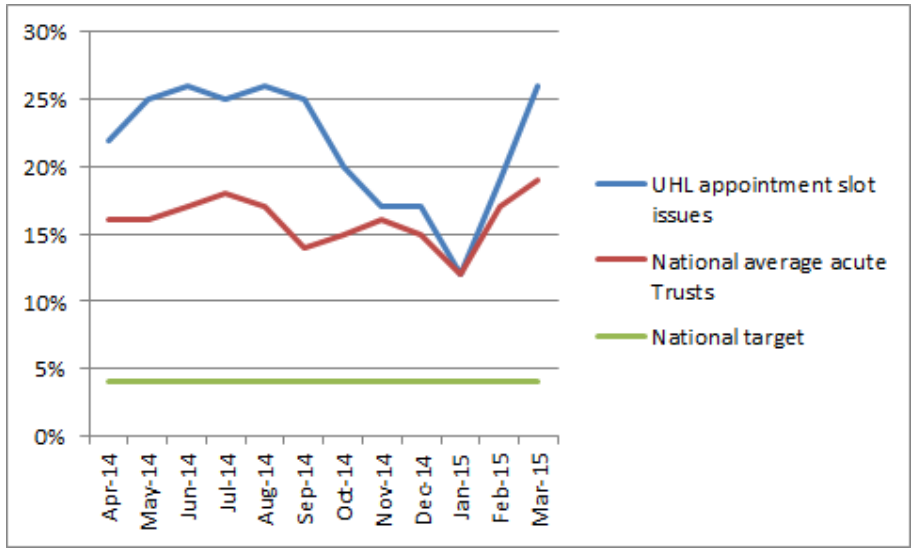
The issues are notably: General Surgery and orthopaedics, Urology, paediatrics and ENT</td><td rowspan="5">Capacity

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

Training and education

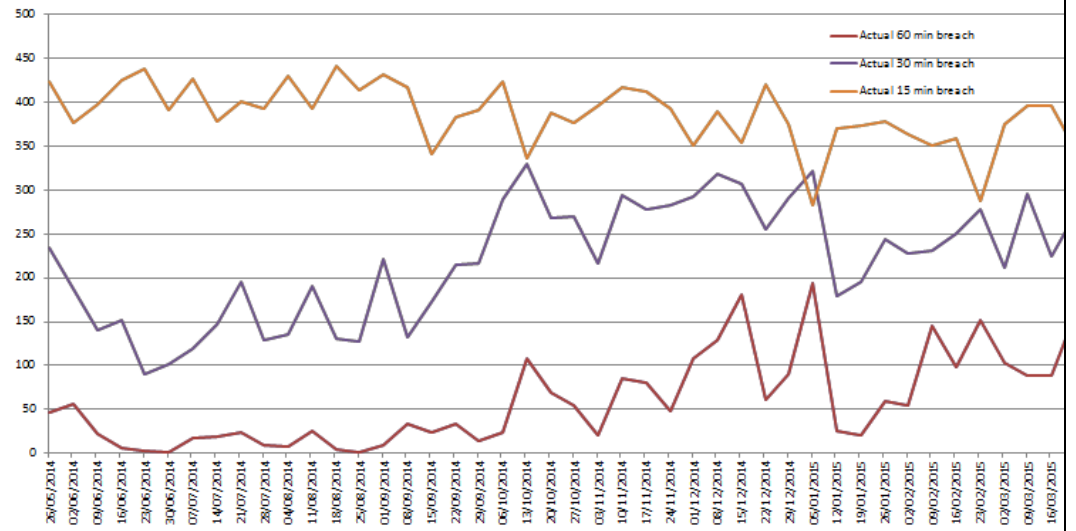
The comprehensive training and education of relevant staff in key specialties continues, to ensure that choose and book is correctly set up and that supporting administrative purposes are fit for purpose.
A speciality level ‘score card’ to highlight areas required for improvement is being distributed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

Interviews for a permanent post of Choose and Book Administrator are on 1st May. The new Deputy Head of Performance starts on 11th May, they will have a lead role in overseeing the improvement of this standard</td><td><4%</td><td>26%</td><td>21%</td><td>25%</td></tr>
<tr><td colspan="4">National performance varies significantly by Trust, with average performance of Acute Trusts nationally at 17% in November

 
</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">To be confirmed</td></tr>
<tr><td colspan="2">Revised date to meet standard</td><td colspan="2">Yet to be confirmed</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Will Monaghan, Director of Performance and Information
Charlie Carr, Head of Performance</td></tr>
</table>

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

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
Difficulties continue in accessing beds continue which leads to delays in movement out of the ED. This delays movement out of the assessment area and delays handover. March's performance remained similar to the preceding months. It should be noted that the overall attendances in March via ambulance have increased compared to Februarys activity	The CAD+ system has been demonstrated to ED via screen shots and equipment ordered for implementation. EMAS and UHL have discussed places for the equipment to be stored to enable easy access for use. Information sharing document is completed by UHL . The Training package is available once the equipment is ready for use in the Assessment Bay .	0 delays over 30 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, Chief Operating Officer, Phil Walmsley, ITAPS Head of Operations

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

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
HLO2A: Proportion of commercial contract studies achieving their recruitment target during their planned recruitment period East Midlands is currently 11th of the 15 LCRNs for this metric with no LCRN currently achieving the 80% target, highest is currently 71% and lowest 47% Historic targets set in a previous structure where this measure was not applicable, of the 127 closed studies for this measure only 6 entered the system after 1st April 2014 A lot of variables impact on recruitment achieved, after the recruitment target is set, for example: • Impact of global performance and earlier end dates giving less time to recruit • Changes in UK practice during set up/ recruitment • Protocol changes prior to initiation • Understanding of targets and alignment on the source of the target sites are measured on	1. Recovery plan produced identifying the divisions (1,2 & 5) with high volume and low performance and prioritised 2 weekly meetings with Research Delivery Managers to improve performance 2. Collation of local information to report on the actual performance figure for 2014/15, this data gives a figure of 62% 3. Implementation of a performance management process involving the Industry Team and Delivery Managers to escalate studies not recruiting to target within 24 hours and to align targets. 4. Meetings with key research teams to discuss the importance of target setting and aligning the approach across the region so the target is reflective of the contract figure. 5. Escalation to national team highlighting numerous discrepancies in the report and inconsistencies as a national level that has lead to a review. Lack of confidence in the figure of 53%. 6. Contacting sponsors direct to analyse the reasons for under-performance. 7. Summary of key reasons per division in table below for February	**80%**	**47%**	**53%**	**53%**

Breakdown of activity from Commercial Activity Report end of February 2015

Division No closed studies	RTT	Activity as % of EMCRN closed	No red	No green	Rationale for underperformance	No open studies	% of open activity
1 - 21 studies	43%	17%	12	9	Low numbers of recruits required for individual studies and narrowly missed targets Studies that struggled nationally	71	29%
2 - 30 studies	37%	24%	19	11	Low numbers of recruits required for individual studies and narrowly missed targets Studies that struggled nationally Diabetes UHL 7 closed 7 red	66	27%
3 - 10 studies	30%	8%	7	3	Came on board late to support. Short recruitment window as closed globally quicker than anticipated Imp issues so suspended but still included in CAR	23	9%
4 - 9 studies	56%	7%	4	5	Just missed target or came on board late to support trial and not enough time	20	8%
5 - 20 studies	35%	16%	13	7	Studies failed at a national level	16	7%
6 - 37 studies	70%	29%	11	26	Studies failed at a national level	50	20%
127 studies	47%	100%	67	60		246	100%

Expected date to meet standard / target	May 2015
Revised date to meet standard	May 2016
Lead Director / Lead Officer	Daniel Kumar, Industry Delivery Manager, CRN: East Midlands

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

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
Proportion of 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 in 2015/16 including the AIRWAYS 2 study. Therefore it is unlikely that EMAS will report any recruitment before April 2015. 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%**	**88% (red)**	**88% (red)**	**88%**

Expected date to meet standard / target	This target will not be met in 2014/15.
Revised date to meet standard	
Lead Director / Lead Officer	Elizabeth Moss, Chief Operating Officer CRN: East Midlands

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

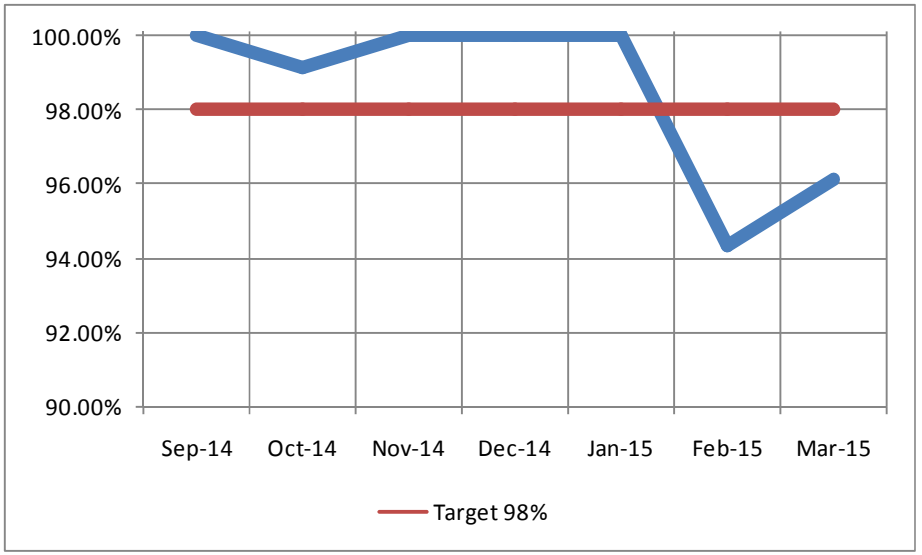
<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (monthly / end of year)</th><th>Latest month performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="4">Proportion 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)</td><td rowspan="4">1. 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. Met and sent potential examples to review
2. DCHS: Due to the nature of research within this Trust, they are unlikely to be involved in commercial research, Have met with Trust and a preliminary plan is in place to take this forward.
3. LCHS: Due to the nature of research within this Trust, they are unlikely to be involved in commercial research. Met on the 18th December and a preliminary plan is in place to take this forward.
4. LePT: Selected for one study,logistics being explored but study now suspended globally
5. LiPT: Have been involved in commercial research in the past and the site is actively seeking commercial opportunities. One sponsor in touch looking to take a study forward.
6. NHFT: One trial initiated at the end of November 2014, 2nd UK site to open no recruits to date as study now suspended globally but did have recruits lined up. One further site selection visit completed in March 2015 and site now selected
7. DHFT: 2 potential studies in the pipeline. One had site selection visit in February 2015 awaiting confirmation if selected.</td><td>70%</td><td>56% (red)</td><td>56% (red)</td><td>56%</td></tr>
<tr><td colspan="4" rowspan="3"></td></tr>
<tr><td>Expected date to meet standard / target</td><td>July 2015</td></tr>
<tr><td>Revised date to meet standard</td><td>September 2015</td></tr>
<tr><td>Lead Director / Lead Officer</td><td>Daniel Kumar, Industry Delivery Manager, CRN: East Midlands</td></tr>
</table>

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

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
Percentage of audits in clinical areas achieving NCS audit scores for cleaning above 90% Feb 15 – 94% Mar 15 - 96% 7 Audits failed to achieve the required standard in the following areas Leicester General - Hydro Pool Leicester Royal Infirmary - Balmoral Ward 22, Test Centre, OP Clinic 3; Windsor Building - Ward 37; Kensington Building – Gynae Theatres; Osborne Building – Palliative Care. The key reason for failure was the noted presence of dust. Each of these issues was rectified and subsequent audits passed. Under the current Management of Change process, there is potential impact that may be felt from staff consultation that is underway, however we are actively managing this process to limit impact on morale.	The current review of cleaning rosters and tasks across the Acute Estate is underway and this process alongside investment in equipment will support cleaning standards within the UHL. This review and changes have been documented and shared with the EFMC. We have addressed the site based failings with our staff through team meetings and to individuals working within the ward / department. We will continue to monitor and drive performance forward.	100%	96.1%	98.5%	100%



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

2015/16 TDA METRICS COMPARED TO 2014/15

Responsiveness Domain		
Metric	**2014/15**	**2015/16**
Referral to Treatment Admitted	✓	✓
Referral to TreatmentNon Admitted	✓	✓
Referral to Treatment Incomplete	✓	✓
Referral to Treatment Incomplete 52+ Week Waiters	✓	✓
Diagnostic waiting times	✓	✓
A&E All Types Monthly Performance	✓	✓
12 hour Trolley waits	✓	✓
Two Week Wait Standard	✓	✓
Breast Symptom Two Week Wait Standard	✓	✓
31 Day Standard	✓	✓
31 Day Subsequent Drug Standard	✓	✓
31 Day Subsequent Radiotherapy Standard	✓	✓
31 Day Subsequent Surgery Standard	✓	✓
62 Day Standard	✓	✓
62 Day Screening Standard	✓	✓
Urgent Ops Cancelled for 2nd time (Number)	✓	✓
Proportion of patients not treated within 28 days of last minute cancellation	✓	✓
Delayed Transfers of Care	✓	✓
% of acute trusts with an effective model of liaison psychiatry (all ages, appropriate to the size, acuity and specialty of the hospital		✓
Provider outpatient cancellation rates		✓
TOTAL	18	20

Effectiveness Domain		
Metric	**2014/15**	**2015/16**
Hospital Standardised Mortality Ratio (DFI)	✓	✓
Deaths in Low Risk Conditions	✓	
Hospital Standardised Mortality Ratio - Weekday	✓	
Hospital Standardised Mortality Ratio - Weekend	✓	✓
Summary Hospital Mortality Indicator (HSCIC)	✓	✓
Crude mortality rate (non-elective ordinary admissions only)		✓
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	✓	✓
Emergency re-admissions within seven days following an elective or emergency spell at the trust		✓
Emergency re-admissions within 14 days following an elective or emergency spell at the trust		✓
Emergency re-admissions within 28 days following an elective or emergency spell at the trust		✓
Stroke 60 mins		✓
Stroke Care		✓
STeMI 150 mins		✓
TOTAL	6	11

Caring Domain		
Metric	**2014/15**	**2015/16**
Inpatient Scores from Friends and Family Test	✓	
A&E Scores from Friends and Family Test	✓	
Staff FFT Percentage Recommended – Care		✓
Staff FFT Percentage Not Recommended – Care		✓
Inpatient Scores from Friends and Family Test – % positive		✓
Inpatient Scores from Friends and Family Test – % negative		✓
A&E Scores from Friends and Family Test – % positive		✓
A&E Scores from Friends and Family Test – % negative		✓
FFT – Daycases		✓
FFT – A&E departments, Walk-in Centres (WiCs) and Minor Injury Units (MIUs)		✓
FFT composite		✓
Written Complaints Rate	✓	✓
Mixed Sex Accommodation Breaches	✓	✓
Inpatient Survey Q 68 - Overall, I had a very poor/good experience	✓	
TOTAL	5	11

Safe Domain		
Metric	**2014/15**	**2015/16**
Clostridium Difficile - Variance from plan	✓	✓
Clostridium Difficile – incidence rate		✓
MRSA bactaraemias	✓	✓
Never events	✓	✓
Never events – incidence rate		✓
Never events – time since last event		✓
Never events – repeat events		✓
Serious Incidents rate	✓	✓
Medication errors causing serious harm	✓	✓
Patient safety incidents that are harmful	✓	✓
Composite of patient safety (MyNHS)		✓
Potential under-reporting of patient safety incidents		✓
Potential under-reporting of patient safety incidents resulting in death or severe harm		✓
Consistency of reporting to the National Reporting and Learning System (NRLS)		✓
NHS Staff Survey – KF15. The proportion of staff who stated that the incident reporting procedure was fair and effective		✓
CAS alerts	✓	✓
CAS alerts outstanding – time to closure		✓
Maternal deaths	✓	
VTE Risk Assessment	✓	✓
Percentage of Harm Free Care	✓	✓
Percentage of new Harms		✓
Emergency c-section rate		✓
TOTAL	10	21

Well Led Domain		
Metric	**2014/15**	**2015/16**
Temporary staff spend on nurse and medical staffing		✓
Composite risk rating of ESR items relating to staff sickness rates		✓
Individual elements of Composite risk rating of ESR items relating to staff sickness rates		✓
Composite risk rating of ESR items relating to staff registration		✓
Individual elements of Composite risk rating of ESR items relating to staff sickness rates		✓
Composite risk rating of ESR items relating to staff turnover		✓
Individual elements of Composite risk rating of ESR items relating to staff turnover		✓
Composite risk rating of ESR items relating to staff stability		✓
Individual elements of Composite risk rating of ESR items relating to staff stability		✓
Composite risk rating of ESR items relating to staff support/ supervision		✓
Individual elements of Composite risk rating of ESR items relating to staff support/ supervision		✓
Composite risk rating of ESR items relating to ratio: Staff vs bed occupancy		✓
Individual elements of Composite risk rating of ESR items relating to ratio: Staff vs bed occupancy		✓
Trust level total sickness rate	✓	✓
Trust turnover rate	✓	✓
Staff FFT response rate		✓
Inpatients response rate from Friends and Family Test	✓	✓
A&E response rate from Friends and Family Test	✓	✓
Daycases FFT response rates		✓
FFT – A&E departments,Walk-in Centres (WiCs) and Minor Injury Units (MIUs) response rate		✓
Composite FFT response rate		✓
Staff FFT Percentage Recommended – Work	✓	✓
Staff FFT Percentage Not Recommended – Work		✓
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment	✓	
Data Quality of Returns to HSCIC	✓	
Total Trust vacancy rate	✓	
Temporary costs and overtime as % of total paybill	✓	
Percentage of staff with annual appraisal	✓	
Overall safe staffing fill rate		✓
Safe staffing fill rate – wards with <80% fill rate		✓
Safe staffing fill rate – fill rate variance		✓
TOTAL	10	26

CQC – Intelligent Monitoring Report

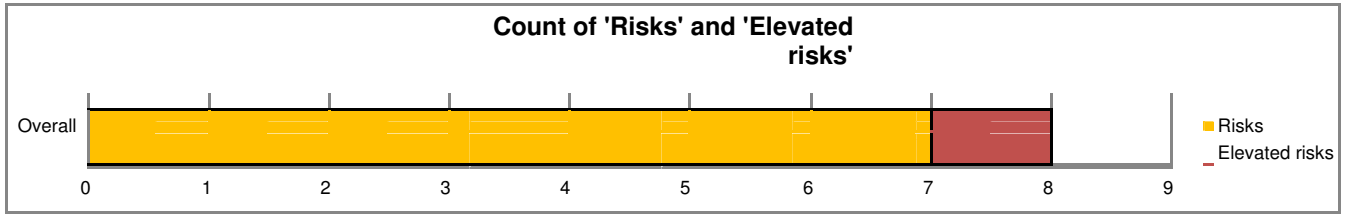
The latest CQC Intelligent Monitoring Report (IMR) was published on the CQC website on the 3rd December 2014.

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'

The next publication date is May 2015.



Priority banding for inspection	Recently inspected
Number of 'Risks'	7
Number of 'Elevated risks'	1
Overall Risk Score	9
Number of Applicable Indicators	94
Percentage Score	4.79%
Maximum Possible Risk Score	188

Elevated risk	Whistleblowing alerts (18-Jul-13 to 29-Sep-14)
Risk	PROMs EQ-5D score: Groin Hernia Surgery (01-Apr-13 to 31-Mar-14)
Risk	Composite indicator: A&E waiting times more than 4 hours (01-Jul-14 to 30-Sep-14)
Risk	All cancers: 62 day wait for first treatment from NHS cancer screening referral (01-Apr-14 to 30-Jun-14)
Risk	Proportion of ambulance journeys where the ambulance vehicle remained at hospital for more than 60 minutes (01-Apr-14 to 30-Apr-14)
Risk	TDA - Escalation score (01-Jun-14 to 30-Jun-14)
Risk	GMC - Enhanced monitoring (01-Mar-09 to 22-Jul-14)
Risk	Patient Opinion - the number of negative comments is high relative to positive comments (28-May-13 to 27-May-14)

Quality Schedule and CQUIN Schemes

Confirmed RAG's for Quarter 3 and predicted RAG's for Quarter 4.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
	QUALITY SCHEDULE					
PS01	Infection Prevention and Control Reduction. - C Diff	G	A	A	tbc	Q2 and Q3 remain as Amber RAG'd as not all additional information provided around CMG IP Plan updates. Q4 RAG will be dependent upon submission of all required information to include thematic review findings for C Diff cases and MRSA and MSSA bacteraemias. C Diff. threshold achieved with 73 reported cases for 14/15 which is below the NTDA trajectory (81) but above UHL's own threshold.
PS02	HCAI Monitoring - MRSA	0	1	3	2	1 'avoidable' Bacteraemia in February and 1 'unavoidable' in March
PS03	Patient Safety – SIs, Never Events	G	G	2 G	1 (Jan) G	Q3 & Q4 Red RAG for Never Events. (relating to 'wrong sized hip prosthesis, retained Swab ties and wrong site surgery) Number of incidents reported continues to rise. But there has been a reduction in number that resulted harm.
PS04	Duty of Candour	0	0	0	0	No breaches during 14/15.
PS05	Complaints and user feedback Management (excluding patient surveys).	A	A	G	G	Complaints responses performance improved and achieved for December. Commissioners noted improvement made with response times in Q3 and Green RAG given. Improved performance sustained in Q4.
PS06	Risk Assurance and CAS Alerts	A	A	G	G 1	Amber RAG for Q2 relates to overdue CAS alerts for July. All risks scoring 15 or above have been reviewed within their required timeframe and have up to date action plans. Breach due to delayed receipt of confirmation that all actions completed in response to NPSA alert.
PS07	Safeguarding – Adults and Children	G	G	G	G	Assurance documentation due to be sent to CCG Safeguarding leads for their review ahead of their observational visit to the Trust.
PS08	Reduction in Pressure Ulcer incidence.	G	G	R (Nov & Dec)	R (Feb & Mar)	Monthly thresholds met for G2 HAPUs during Q4. Above the monthly trajectory of 7 for Grade 3 HAPUs in Feb following further validation (9). Grade 4 HAPU identified for March – related to use of Anti-embolic stockings.
PS09	Medicines Management Optimisation	A	G	A	G	Commissioners noted improvement in Controlled Drugs audit report and also Medicines Code but thresholds not fully achieved. Progress made with developing LLR Medicines Optimisation Strategy.
PS10	Medication Errors	G	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%	95.2%	96.1%	RCAs in progress for Hospital Acquired Thrombosis. Q4 RAG dependent upon achievement of 100% threshold .
PS12	Nutrition and Hydration	G	>80%	>85%	>83%	Work programme on track for nutrition, some delays with hydration actions. 90% threshold for Nutrition Assessment not achieved for any month in Quarter 4 in ESM and therefore overall Red RAG.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
PE1	Same Sex Accommodation Compliance and Annual Estates Monitoring	2	0	2	1 (Jan)	Jan breach relates to patient on HDU at Glenfield. No breaches reported for Feb or March.
PE2	Patient Experience, Equality and Listening to and Learning from Feedback.	G	G	G	G	Good progress made with triangulation of data. Waiting time main area for improvement.
PE3	Improving Patient Experience of Hospital Care (NPS)	N/A	N/A	N/A	tbc	Not due to be reported until March 15. RAG dependent upon results in the National Patient Survey.
PE4	Equality and Human Rights	G	G	G	G	Progress reported to the September CQRG with further information provided in October – relating to actions being taken to capture BME data
CE01	Communication – Content (ED, Discharge & Outpatient Letters)	A	A	A	tbc	Clinical Problem Solving Group held to agree key priorities. Letters policy launched end of Jan 15. Amber RAG as audit not undertaken so unable to demonstrate improved compliance with Letter standards.
CE02	Intra-operative Fluid Management	G	>80%	<80%	tbc	Performance deteriorated during Oct/Nov. 80% achieved for December. Remedial actions in place to maintain. Q4 data to be confirmed.
CE03	Clinical Effectiveness Assurance – NICE and Clinical Audit	A	A	G	G	Responses for NICE Clinical Guideline / Quality Standards documents on track and actions being taken where audits behind schedule
CE04	Women's Service Dashboard	A	A	A	tbc	Amber RAG for Q2 relates to increase in C Section Rate. Q3 Amber RAG due to not achieving thresholds for Medical Staff Core Skills Training and C Section Rate.
CE05	Children's Service Dashboard	A	A	A	tbc	Q2 Amber RAG relates to SpR training Q3 Amber RAG due to non achievement of thresholds for SpR training and Management plans within 2 hours on the assessment unit.
CE06	Patient Reported and Clinical Outcomes (PROMs and Everyone Counts)	A	A	G	G	Groin Hernia PROMs improved, although still below the national average. Varicose Vein and Hip/Knee Replacement PROMS better or same as national. Consultant Outcomes published and all consultants in line with national average.
CE07	#NOF - Dashboard	51%	67.9%	62.1%	62.2%	72% threshold not met for any month in Q3. Mainly relates to peaks in activity and spinal patients. Improvement in February ((62.7%) from 57.9% in Jan. L/A programme in place and business case submitted to support increased theatre capacity.
CE08a	Stroke monitoring	G	G	72% Avge tbc	82.5 (Jan 15)	Improvements made for Stroke indicators (time to Scan, admission to stroke unit, thrombolysis). Green RAG for Q4 will be dependent upon achievement of the 90% stay (Jan performance >80%) and improvement in SSNAP Domain Scores.
CE08b	TIA monitoring	76%	67%	73.4%	74%	Threshold exceeded for high risk patients and performance improved for low risk patients being seen within 7 days.
CE09	Mortality (SHMI, HSMR)	A	A	A	A	Latest published SHMI = 105 (104.7) and is slowly reducing but is still above 100 (albeit within expected).
CE10	Making Every Contact Count (MECC)	A	G	G	G	Referrals to STOP and ALW continue. 'Healthy Eating and Physical Activity publicity campaign due to commence in General Surgery and Sleep Clinics. Commissioners noted all the Staff Wellbeing initiatives

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
AS01	Cost Improvement Programme (CIP) Assurance	A	G	G	G	Q4 RAG dependent upon provision of sufficient assurance that quality and safety issues being reviewed and actions taken where applicable..
AS02	Ward Healthcheck (Nursing Establishment, Clinical Measures Scorecard)	G	G	G	G	Recruitment of additional nurses continues. Not all wards meeting 'Nurse to bed Ratio' but actions in place. Support being provided to those wards not meeting thresholds in the Clinical Measures Scorecard.
AS03	Staffing governance	A	A	A	A	Internal thresholds not met for Appraisal, Sickness and Corporate Induction or Turnover although improvement noticed. Medical Staffing Strategy submitted.
AS04	Involving employees in improving standards of care. (Whistleblowing)	G	G	G	G	Actions taken to address concerns raised.
AS05	Staff Satisfaction	G	G	G	G	Work undertaken through the L*i*A process noted.
AS06	External Visits and Commissioner Quality Visits	G	G	G	G	Actions in response to Reviews being taken.
AS07	CQC Registration	A	G	A	G	2 Actions in response to CQC visit findings behind schedule – remedial actions being taken.
	NATIONAL CQUINS					
Nat 1.1a	F&FT 1a - Staff	G	G	G	G	Implemented during Q1/2
Nat 1.1b	F&FT 1b - OutPt & Day Case	G	G	G	G	F&FT already happening in Day Case and has started in Outpatients.
Nat 1.2	F&FT 1.2 - Increased participation - ED	16.%	15.1%	16.2%	22.8% (Avge)	20% Q4 threshold achieved to date
Nat 1.3	F&FT 1.3 - Inpt increase in March	35.8%	31%	34.7%	44.8% (Mar)	Both the Q4 30% threshold and also the 40% threshold for March 15 achieved.
Nat 2.1	ST 2.1 - ST data submission	G	G	G	G	Data collection continues for all 4 harms.
Nat 2.2	ST 2.2 - LLR strategy	G	G	G	tbc	UHL contributing to the LLR Pressure Ulcer group and workstreams. Q4 RAG to be confirmed upon review of UHL's actions.
Nat 3.1	Dementia 3.1 - FAIR	G	G	G	G	90% thresholds met for all parts of the Dementia FAIR CQUIN.
Nat 3.2	Dementia 3.2 - Training & Leadership	G	N/A	N/A	G	Nicky Morgan is new Clinical Lead Dementia Training Programme reviewed and revised. Q4 RAG dependent on evidence of increased staff attending training.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
Nat 3.3	Dementia 3.3 - Carers	G	G	G	G	Surveys carried out and evidence of actions being taken
	LOCAL CQUINS					
Loc 1	Urgent Care 1 (Discharge)	G	G	G	tbc	Further reductions in length of stay achieved. Q4 threshold to be confirmed.
Loc 2	Urgent Care 2 (Consultant Assessment)	G	G	A	tbc	65% threshold exceeded for AMU but not achieved in other assessment areas. Audit data not felt to accurately reflect practice. Q4 audit to have increased clinical input to ensure accuracy but unlikely to achieve the 75% threshold across all areas.
Loc 3	Improving End of Life Care (AMBER)	G	G	G	G	
Loc 4	Quality Mark	G	G	G	tbc	Quality Mark achieved for 6 out of the 8 wards to date. Although remaining 2 wards on track to achieve the QM, will be outside the agreed timescale for Q4.
Loc 5	Pneumonia	A	G	G	G	Q3 threshold achieved for all aspects of CQUIN scheme and work continues to achieve end of year thresholds. Q4 data to be validated.
Loc 6	Think Glucose	G	G	G	G	Think Glucose programme on track.
Loc 7	Sepsis Care pathway	≥47%	≥60%	<65%	tbc	Not all 6 aspects of the Sepsis6 Care Bundle thresholds achieved in Q3. Remedial actions in place for Q4 and data to be validated.
Loc 8	Heart Failure	≥49.5 %	≥63%	≥65%	>75%	Q4 threshold achieved.
Loc 9	Medication Safety Thermometer	G	G	G	G	All wards submitting data.
	SPECIALISED CQUINS*					
SS1	National Quality Dashboards	G	G	G	G	Dashboards now open for data submission at end of Q3
SS2	Breast Feeding in Neonates	61%	66%	55%	65%	Q4 threshold achieved.
SS3	Clinical Utilisation Review of Critical Care	N/A*	G	G	G	CCMDS and ICNARC data now being collected for all satellite HDUs.
SS4	Acuity Recording	N/A*	G	G	G	Acuity recording in place for all areas. Q4 RAG dependent upon being able to demonstrate effective use of Acuity data.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
SS5	Critical Care Standards - Discharge	N/A*	G	G	G	Reduction in delays but increase in out of hours transfers during December – related to increased activity in Critical Care.
SS6	Critical Care Outreach Team 'time to response'	N/A*	G	G	G	Q3 threshold (increase data collection around 'time from referral to response) not fully achieved. Remedial actions in place.
SS7	Consultant Assessment	G	G	A	tbc	Links to the CCG CQUIN.
SS8	Highly Specialised Services Collaborative Workshop	G	G	G	G	Both ECMO and PCO participating in the national collaborative workshop.