Quality & Performance Report

Author: John Adler Sponsor: Chief Executive Date: IFPIC + QAC 26th May 2016

Executive Summary from CEO Paper K

Context

It has been agreed that I will provide a summary of the issues within the Q&P Report that I feel should particularly be brought to the attention of EPB, IFPIC and QAC. This complements the Exception Reports which are triggered automatically when identified thresholds are met.

Questions

1. What are the issues that I wish to draw to the attention of the committee?
2. Is the action being taken/planned sufficient to address the issues identified? If not, what further action should be taken?

Conclusion

Good News: **Mortality** – the latest published SHMI (covering the period October 2014 to September 2015) is **96** – this compares to a peak of 105. **RTT** – the RTT incomplete target remains compliant which is much better than early forecasts that the target would not be achieved in April. **Diagnostics** performance has been delivered and is expected to be delivered for the rest of the financial year. . **Delayed transfers of care** remain well within the tolerance reflecting the continuation of the good work that takes place across the system in this area. **Referral to Treatment 52+ week waits** has reduced by over 60 over the last month. An organised process of transferring patients to other providers is now in progress and we should see substantial reductions in these waits in the coming months. **Ambulance Handover 60+ minutes** – 6% lowest level for 12 months - this is also examined in detail in the COO's report. **MRSA** – 0 avoidable cases reported for 14 months and 0 unavoidable cases were reported in April. **C DIFF** – a good start to the year with only 4 cases reported during. **Pressure Ulcers** – 0 **Grade 4** pressure ulcers. **Fractured NOF** – target delivered and performance expected to be maintained during May. **Patient Satisfaction (FFT)** Quality Commitment target of 97% maintained for Inpatients and Day Cases.

Bad News:

ED 4 hour performance- was 81.2% a slight improvement on March performance. Contributing factors are set out in the Chief Operating Officer's report. **Cancelled operations** and **patients rebooked within 28 days** – continued to be non-compliant, due to increased emergency pressures. **Cancer Standards the 62 day backlog** current cancer performance is an area of significant concern across UHL and focus on recovery is of the highest priority within the organisation. The **Cancer Two Week Wait** the target was missed by 1 patient, attributed to on-going problems in Head & Neck. Following the success of last year the targets for **Grade 3 and Grade 2** pressure ulcers have been reduced – these were both missed this month. **Patient**

Satisfaction (FFT) the target of 97% was not achieved for ED during April and although **ED FTT coverage** has improved the agreed threshold of20% has not yet been achieved.

Input Sought

I recommend that the Committee:

- Commends the positive achievements noted under Good News
- Note the areas of Bad News and consider if the actions being taken are sufficient.

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes /~~No /Not applicable~~]
Effective, integrated emergency care	[Yes /~~No /Not applicable~~]
Consistently meeting national access standards	[Yes /~~No /Not applicable~~]
Integrated care in partnership with others	[~~Yes /No~~ /Not applicable]
Enhanced delivery in research, innovation & ed’	[Yes /~~No /Not applicable~~]
A caring, professional, engaged workforce	[Yes /~~No /Not applicable~~]
Clinically sustainable services with excellent facilities	[Yes /~~No /Not applicable~~]
Financially sustainable NHS organisation	[~~Yes /No~~ /Not applicable]
Enabled by excellent IM&T	[~~Yes /No~~ /Not applicable]

2. This matter relates to the following governance initiatives:

Organisational Risk Register	[~~Yes /No~~ /Not applicable]
Board Assurance Framework	[Yes /~~No /Not applicable~~]

3. Related Patient and Public Involvement actions taken, or to be taken: Not Applicable

4. Results of any Equality Impact Assessment, relating to this matter: Not Applicable

5. Scheduled date for the next paper on this topic: 30 June 2016

Caring at its best

Quality and Performance Report

April 2016

One team shared values

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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

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

DATE: 26th MAY 2016

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

SUBJECT: APRIL 2016 QUALITY & PERFORMANCE SUMMARY REPORT

1.0 Introduction

The following report provides an overview of performance for NHS Improvement (NHSI) and UHL key quality commitment/performance metrics. Escalation reports are included where applicable.

The Trust's 16/17 Quality Commitment indicators are identified with 'QC' in the 'Target set by' column and appear at the top of the dashboard. Additional analysis is required for some of the Quality Commitment indicators which may change the methodology in reporting in future reports. Due to these changes the KPI references have changed for the majority of indicators.

2.0 Performance Summary

Domain	Page Number	Number of Indicators	Number of Red Indicators this month
Safe	5	18	3
Caring	6	10	0
Well Led	7	19	2
Effective	8	11	2
Responsive	9	15	8
Responsive Cancer	10	9	6
Research – UHL	12	6	0
Total		89	21

3.0 New Indicators

Safe

Reduction for moderate harm and above PSIs with finally approved status - One month lag in data for this indicator to ensure incidents finally approved
Proportion of reported safety incidents per 1000 attendances (IP, OP and ED)
% of UHL Patients with No Newly Acquired Harms

Caring

Improvements in Patient Involvement Scores
Formal complaints rate per 1000 IP,OP and ED attendances
Percentage of upheld PHSO cases

Well Led

Outpatient letters – Quarterly

Effective

No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions (excluding medically unfit patients)

4.0 Indicators removed

Safe

Proportion of reported safety incidents per 1000 bed days
Proportion of reported safety incidents that are harmful
Safety Thermometer % of harm free care (all)
Safety Thermometer % number of new harms
All Medication errors causing serious harm
Emergency C Sections (Coded as R18)
Potential under reporting of patient safety indicators
Potential under reporting of patient safety indicators resulting in death or severe harm

Caring

Complaints Rate per 1000 bed days
Written Complaints Received Rate per 100 bed days
Complaints Re-Opened Rate

Effective

Mortality HSMR (DFI Quarterly)
Mortality - Monthly HSMR (Rebased Monthly as reported in HED)
Deaths in low risk conditions (Risk Score)
ROSC in Utstein Group
STEMI 150minutes

Responsive

Outpatient Hospital Cancellation Rates
NHS e-Referral (formally Choose and Book Slot Unavailability)

5.0 Indicators where reporting thresholds have changed

Safe

Avoidable Pressure Ulcers - Grade 3
Avoidable Pressure Ulcers - Grade 2
All falls reported per 1000 bed stays for patients >65years

Effective

Mortality - Published SHMI 16/17 target
Mortality - Rolling 12 mths SHMI (as reported in HED) Rebased
Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)
Emergency readmissions within 30 days following an elective or emergency spell

6.0 Indicators where methodology has changed

Published Clinical Outcomes - data submission and outcome results
Compliance with NICE Guidance (15/16 and 16/17)

Safe

KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	16/17 Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
S1	Reduction for moderate harm and above PSIs with finally approved status - One month lag in data for this indicator to ensure incidents finally approved	AF	MD	10% REDUCTION FROM FY 15/16 (<=262)	QC	Red / ER if >30 in mth or >20 for 3 consecutive mths	TBC	262			18	19	17	18	18	16	18	17	18	18	16	17	
S2	Serious Incidents - actual number escalated each month	AF	MD	<=49 by end of FY 16/17 (revised)	UHL	Red / ER if >8 in mth or >5 for 3 consecutive mths	41	49	2	1	2	8	1	5	3	5	3	4	3	5	6	4	5
S3	Proportion of reported safety incidents per 1000 attendances (IP, OP and ED)	AF	MD	> FY 15/16	UHL	TBC		17.5			18.0	19.2	17.1	18.2	18.4	15.5	18.3	16.6	17.7	18.2	15.9	17.1	17.4
S4	Overdue CAS alerts	AF	MD	0	NHSI	Red if >0 in mth ER = in mth >0	10	1	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0
S5	RIDDOR - Serious Staff Injuries	AF	MD	FYE <=40	UHL	Red / ER if non compliance with cumulative target	24	32	3	2	0	6	0	0	2	3	7	2	5	3	2	2	5
S6	Never Events	AF	MD	0	NHSI	Red if >0 in mth ER = in mth >0	3	2	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0
S7	Clostridium Difficile	JS	DJ	61	NHSI	Red if >mthly threshold / ER if Red or Non compliance with cumulative target	73	60	5	7	3	1	4	4	6	6	6	4	6	7	7	6	4
S8	MRSA Bacteraemias (All)	JS	DJ	0	NHSI	Red if >0 ER if >0	6	1	1	1	0	0	0	0	0	0	0	0	0	0	0	1	0
S9	MRSA Bacteraemias (Avoidable)	JS	DJ	0	UHL	Red if >0 ER if >0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
S11	% of UHL Patients with No Newly Acquired Harms	JS	RB	Within expected (revised)	UHL	Red if <95% ER if in mth <95%	NEW NHS INDICATOR	97.7%	96.8%	97.3%	97.9%	97.4%	98.1%	98.1%	97.0%	97.7%	97.4%	97.4%	98.2%	97.7%	97.9%	98.0%	96.9%
S12	% of all adults who have had VTE risk assessment on adm to hosp	AF	SH	>=95%	NHSI	Red if <95% ER if in mth <95%	95.8%	95.9%	96.2%	95.6%	96.0%	96.0%	96.5%	96.2%	96.5%	96.1%	95.7%	96.0%	96.1%	95.5%	95.4%	95.1%	95.9%
S14	All falls reported per 1000 bed stays for patients >65years	JS	HL	<=5.5 (revised)	UHL	Red if >=6.6 ER if 2 consecutive reds	6.9	5.4	6.7	6.3	5.9	5.9	5.0	5.8	5.9	4.9	5.1	4.8	5.7	5.4	4.8	5.1	5.9
S15	Avoidable Pressure Ulcers - Grade 4	JS	MC	0	QS	Red / ER if Non compliance with monthly target	2	1	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0
S16	Avoidable Pressure Ulcers - Grade 3	JS	MC	<=4 a month (revised) with FY End <33	QS	Red / ER if Non compliance with monthly target	69	33	9	6	3	0	4	1	4	1	1	1	5	6	2	5	5
S17	Avoidable Pressure Ulcers - Grade 2	JS	MC	<=7 a month (revised) with FY End <89	QS	Red / ER if Non compliance with monthly target	91	89	5	9	10	8	8	8	10	11	5	4	5	5	8	7	9
S18	Maternal Deaths	AF	IS	0	UHL	Red or ER if >0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Caring

KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	16/17 Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
C1	Improvements in Patient Involvement Scores (Reported quarterly from Qtr2)	JS	HL	6% increase from Qtr 1 baseline (new)	QC	Red/ER if below Quarterly Threshold	NEW INDICATOR																
C2	Formal complaints rate per 1000 IP,OP and ED attendances	AF	MD	No Target	UHL	Monthly reporting	NEW INDICATOR				1.4	1.4	1.4	1.4	1.5	1.3	1.3	1.2	0.9	1.0	1.4	1.2	
C3	Percentage of upheld PHSO cases	AF	MD	No Target	UHL	Quarterly reporting	NEW INDICATOR																16%
C4	Inpatients (Including Daycases) Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <95% ER if 2 mths Red	96%	97%*	96%	97%	96%	96%	97%	96%	97%	97%	97%	96%	97%	97%	96%	97%	97%
C5	A&E Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <94% ER if 2 mths Red	96%	96%*	96%	97%	96%	96%	96%	96%	97%	95%	95%	97%	95%	97%	97%	95%	96%
C6	Outpatients Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <90% ER if 2 mths Red		94%*			94%	94%	93%	91%	93%	93%	93%	92%	94%	95%	95%	93%	95%
C7	Daycase Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <95% ER if 2 mths Red		98%*			96%	97%	97%	98%	98%	97%	98%	98%	98%	98%	98%	98%	98%
C8	Maternity Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <94% ER if 2 mths Red	96%	95%*	96%	96%	95%	96%	95%	95%	96%	95%	95%	95%	94%	95%	95%	95%	95%
C9	Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment	LT	LT	TBC	NHSI	TBC	69.2%	70.0%	71.4%		68.7%			71.9%			Q3 staff FFT not completed as National Survey carried out			69.4%			
C10	Single Sex Accommodation Breaches (patients affected)	JS	HL	0	NHSI	Red / ER if >0	13	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0

* Quarter 4 Performance

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Well Led

KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	16/17 Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
W1	Outpatient Letters sent within 14 days of attendance (Reported Quarterly)	RM	WM	11% Improvement (new)	QC	Red/ER = Below 9% Improvement in Q4		40.0%	NEW INDICATOR														
W2	Inpatients Friends and Family Test - Coverage (Adults and Children) excl Daycase	JS	HL	30%	NHSI	Red if <26% ER if 2mths Red		31.0%	NEW METHODOLOGY COVERAGE INCLUDES ADULTS AND CHILDREN		29.2%	30.5%	29.0%	27.7%	28.9%	28.9%	37.4%	38.2%	23.2%	29.3%	37.2%	36.1%	35.6%
W3	Daycase Friends and Family Test - Coverage (Adults and Children)	JS	HL	20%	NHSI	Red if <8% ER if 2 mths Red		22.5%	NEW METHODOLOGY COVERAGE INCLUDES ADULTS AND CHILDREN		12.5%	12.1%	15.5%	20.5%	23.8%	24.1%	27.2%	27.7%	18.7%	30.1%	26.2%	29.2%	27.3%
W4	A&E Friends and Family Test - Coverage	JS	HL	20%	NHSI	Red if <10% ER if 2 mths Red		10.5%	NEW METHODOLOGY COVERAGE INCLUDES ADULTS AND CHILDREN		14.7%	14.9%	13.3%	14.1%	13.3%	13.1%	16.1%	12.4%	5.4%	7.3%	5.1%	7.0%	13.0%
W5	Outpatients Friends and Family Test - Coverage	JS	HL	>=5%	UHL	Red/ER if <1.4%		1.4%	NEW METHODOLOGY COVERAGE INCLUDES ADULTS AND CHILDREN		1.3%	1.6%	1.2%	1.2%	1.4%	1.4%	1.5%	1.5%	1.4%	1.5%	1.6%	1.6%	1.5%
W6	Maternity Friends and Family Test - Coverage	JS	HL	30%	UHL	Red if <26% ER if 2 mths Red	28.0%	31.6%	46.5%	40.2%	32.3%	35.8%	32.6%	25.6%	30.5%	27.9%	27.2%	38.8%	30.0%	33.3%	34.3%	31.7%	27.9%
W7	Friends & Family staff survey: % of staff who would recommend the trust as place to work	LT	BK	Not within Lowest Decile	NHSI	TBC	54.2%	55.4%	54.9%		52.5%			55.7%			Q3 staff FFT not completed as National Survey carried out			57.9%			
W8	Nursing Vacancies	JS	MM	TBC	UHL	Separate report submitted to QAC		8.4%	5.5%	6.5%	8.5%	8.0%	7.3%	8.7%	8.9%	8.5%	7.1%	7.6%	7.6%	7.7%	6.8%	8.4%	
W9	Nursing Vacancies in ESM CMG	JS	MM	TBC	UHL	Separate report submitted to QAC		17.2%	11.4%	14.0%	19.3%	13.0%	14.4%	13.3%	13.5%	13.5%	12.9%	14.6%	14.9%	16.4%	17.2%	18.5%	
W10	Turnover Rate	LT	LG	TBC	NHSI	Red = 11% or above ER = Red for 3 Consecutive Mths	11.5%	9.9%	10.1%	11.5%	10.4%	10.5%	10.5%	10.6%	10.4%	10.4%	10.2%	9.9%	10.0%	10.1%	10.0%	9.9%	9.7%
W11	Sickness absence	LT	KK	3%	UHL	Red if >4% ER if 3 consecutive mths >4.0%	3.8%	3.6%	4.1%	4.0%	3.6%	3.4%	3.5%	3.3%	3.2%	3.3%	3.5%	3.7%	3.9%	4.0%	4.3%	4.2%	
W12	Temporary costs and overtime as a % of total paybill	LT	LG	TBC	NHSI	TBC	9.4%	10.7%	9.8%	11.5%	10.7%	10.2%	11.0%	10.8%	11.1%	9.9%	10.5%	10.5%	10.1%	11.0%	9.7%	13.9%	10.5%
W13	% of Staff with Annual Appraisal	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	91.4%	90.7%	91.0%	91.4%	90.1%	88.7%	89.0%	89.1%	88.8%	90.0%	90.4%	91.1%	92.7%	91.5%	91.6%	90.7%	91.5%
W14	Statutory and Mandatory Training	LT	BK	95%	UHL	TBC	95%	93%	90%	95%	93%	92%	92%	91%	91%	91%	92%	92%	93%	93%	92%	93%	92%
W15	% Corporate Induction attendance	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	100%	97%	100%	97%	97%	97%	98%	100%	97%	98%	98%	97%	92%	96%	98%	98%	94%
W16	DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	TBC	NHSI	TBC	91.2%	90.5%	91.8%	91.0%	93.6%	90.3%	91.2%	90.3%	90.2%	90.5%	91.4%	87.2%	91.0%	90.5%	89.5%	90.2%	91.6%
W17	DAY Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	TBC	NHSI	TBC	94.0%	92.0%	92.8%	92.5%	94.2%	91.2%	93.5%	91.3%	92.4%	93.1%	94.2%	93.2%	93.9%	92.1%	86.0%	88.7%	92.5%
W18	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	TBC	NHSI	TBC	94.9%	95.4%	96.5%	97.2%	98.9%	96.0%	96.2%	94.3%	94.3%	94.9%	96.1%	91.4%	94.8%	96.6%	95.0%	96.3%	97.6%
W19	NIGHT Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	TBC	NHSI	TBC	99.8%	98.9%	100.8%	103.2%	106.3%	98.7%	99.4%	101.2%	98.0%	100.0%	99.9%	98.4%	98.0%	100.2%	91.6%	94.7%	98.3%

Effective

KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	16/17 Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
E1	Emergency readmissions within 30 days following an elective or emergency spell	AF	MM	Monthly <8.5% (revised)	QC	Red if >8.6% ER if >8.6%	8.5%	8.9%	8.5%	8.5%	9.1%	9.1%	9.0%	8.8%	8.9%	8.7%	9.0%	8.3%	9.2%	8.8%	8.7%	8.8%	
E2	Mortality - Published SHMI	AF	RB	<=99 (revised)	QC	Red if >100 ER if >100	103	96	105 (Jul13-Jun14)		103 (Oct13-Sep14)			99 (Jan14-Dec 14)			98 (Apr14-Mar15)			95 (Jul14-Jun15)		96 (Oct14-Sep15)	
E3	Mortality - Rolling 12 mths SHMI (as reported in HED) Rebased	AF	RB	<=99 (revised)	QC	Red if >100 ER if >100	98	97	98	98	98	96	96	95	96	95	97	97	97	96	Awaiting HED Update		
E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	AF	RB	<=99 (revised)	UHL	Red if >100 ER if >100	94	96	95	94	94	94	93	93	93	93	94	95	95	96	95	Awaiting HED Update	
E5	Crude Mortality Rate Emergency Spells	AF	RB	No Threshold	UHL	Monthly Reporting	2.4%	2.3%	2.7%	2.4%	2.1%	2.0%	2.3%	1.8%	2.0%	2.2%	2.4%	2.1%	2.5%	2.4%	2.4%	2.7%	2.3%
E6	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	AF	AC	72% or above	QS	Red if <72% ER if 2 consecutive mths <72%	61.4%	63.8%	67.2%	61.5%	55.7%	42.6%	70.1%	60.3%	78.1%	72.0%	60.0%	70.9%	59.7%	66.7%	65.2%	65.1%	78.0%
E7	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions (excluding medically unfit patients)	AF	AC	72% or above	UHL	Red if <72% ER if 2 consecutive mths <72%	NEW INDICATOR															73.2%	86.8%
E8	Stroke - 90% of Stay on a Stroke Unit	RM	IL	80% or above	QS	Red if <80% ER if 2 consecutive mths <80%	81.3%	85.6%	87.6%	81.5%	83.7%	84.5%	84.5%	85.7%	90.9%	84.4%	81.1%	86.3%	87.0%	88.5%	86.2%	84.1%	
E9	Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA)	RM	IL	60% or above	QS	Red if <60% ER if 2 consecutive mths <60%	71.2%	75.6%	64.0%	77.3%	86.3%	79.6%	72.0%	78.9%	80.2%	88.1%	73.3%	67.1%	68.4%	71.3%	80.0%	67.3%	53.5%
E10	Published Clinical Outcomes - data submission and outcome results	AF	RB	0 delayed /outside expected (revised)	UHL	ER if Red Quarterly ER if >0	Revised Indicator		Revised Indicator														
E11	Compliance with NICE Guidance (15/16 and 16/17)	AF	RB	0 Non compliance and no actions or actions delayed (revised)	UHL	Red if in mth >0 ER if Red	Revised Indicator		Revised Indicator														

Responsive

KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
R1	ED 4 Hour Waits UHL + UCC (Calendar Month)	RM	IL	95% or above	NHSI	Red if <92% ER via ED TB report	89.1%	86.9%	89.6%	91.1%	92.0%	92.2%	92.6%	92.2%	90.6%	90.3%	88.9%	81.7%	85.1%	81.2%	80.2%	77.5%	81.2%
R2	12 hour trolley waits in A&E	RM	IL	0	NHSI	Red if >0 ER via ED TB report	4	2	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0
R3	RTT - Incomplete 92% in 18 Weeks	RM	WM	92% or above	NHSI	Red /ER if <92%	96.7%	92.6%	96.2%	96.7%	96.6%	96.5%	96.2%	95.2%	94.3%	94.8%	93.6%	93.8%	93.0%	92.9%	93.2%	92.6%	92.7%
R4	RTT 52 Weeks+ Wait (Incompletes)	RM	WM	0	NHSI	Red /ER if >0	0	232	0	0	0	66	242	256	258	260	265	263	267	269	261	232	169
R5	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	NHSI	Red /ER if >1%	0.9%	1.1%	0.8%	0.9%	0.8%	0.6%	6.1%	10.9%	13.4%	9.6%	7.7%	6.5%	7.0%	4.1%	1.8%	1.1%	0.7%
R6	Urgent Operations Cancelled Twice	RM	PW	0	NHSI	Red if >0 ER if >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
R7	Cancelled patients not offered a date within 28 days of the cancellations UHL	RM	PW	0	NHSI	Red if >2 ER if >0	33	48	3	1	2	0	1	1	5	1	0	3	6	6	9	14	25
R8	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	RM	PW	0	NHSI	Red if >2 ER if >0	11	1	1	0	0	0	1	0	0	0	0	0	0	0	0	0	5
R9	% Operations cancelled for non-clinical reasons on or after the day of admission UHL	RM	PW	0.8% or below	Contract	Red if >0.9% ER if >0.8%	0.9%	1.0%	0.7%	1.0%	0.7%	0.5%	0.9%	1.3%	0.7%	0.9%	0.8%	1.3%	1.1%	1.3%	1.2%	1.5%	1.5%
R10	% Operations cancelled for non-clinical reasons on or after the day of admission ALLIANCE	RM	PW	0.8% or below	Contract	Red if >0.9% ER if >0.8%	0.9%	0.9%	0.0%	0.4%	1.2%	1.2%	1.0%	0.8%	0.0%	1.0%	1.1%	0.0%	1.1%	2.2%	0.2%	1.0%	0.5%
R11	% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	0.8% or below	Contract	Red if >0.9% ER if >0.8%	0.9%	1.0%	0.7%	0.9%	0.8%	0.6%	0.9%	1.3%	0.7%	0.9%	0.8%	1.2%	1.1%	1.4%	1.1%	1.4%	1.5%
R12	No of Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	N/A	UHL	TBC	1071	1299	64	98	79	56	97	138	67	104	91	131	115	146	119	156	154
R13	Delayed transfers of care	RM	PW	3.5% or below	NHSI	Red if >3.5% ER if Red for 3 consecutive mths	3.9%	1.4%	2.9%	1.8%	1.9%	1.0%	1.0%	0.9%	1.2%	1.3%	1.1%	1.5%	1.6%	1.8%	1.8%	2.0%	1.9%
R14	Ambulance Handover >60 Mins (CAD+ from June 15)	RM	SL	0	Contract	Red if >0 ER if Red for 3 consecutive mths	5%	5%	11%	9%	6%	7%	7%	8%	9%	18%	22%	27%	16%	12%	10%	11%	6%
R15	Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)	RM	SL	0	Contract	Red if >0 ER if Red for 3 consecutive mths	19%	19%	21%	22%	22%	21%	17%	17%	17%	25%	26%	26%	23%	13%	13%	13%	11%

Responsive Cancer

KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16
** Cancer statistics are reported a month in arrears.																									
RC1	Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	RM	MM	93% or above	NHSI	Red if <93% ER if Red for 2 consecutive mths	94.8%	92.2%	92.2%	93.5%	91.5%	91.2%	87.9%	91.1%	87.4%	86.8%	87.7%	89.9%	92.4%	93.0%	91.4%	93.9%	93.0%	90.5%	**
RC2	Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	RM	MM	93% or above	NHSI	Red if <93% ER if Red for 2 consecutive mths	94.0%	94.1%	92.5%	91.5%	96.0%	99.0%	98.8%	87.2%	93.3%	98.7%	94.5%	94.6%	89.4%	93.5%	96.2%	99.3%	95.7%	95.1%	**
RC3	31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	RM	MM	96% or above	NHSI	Red if <96% ER if Red for 2 consecutive mths	98.1%	94.6%	91.7%	95.0%	97.0%	93.9%	97.9%	93.7%	97.2%	96.5%	94.7%	95.2%	95.6%	94.3%	91.5%	92.6%	94.1%	94.8%	**
RC4	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	RM	MM	98% or above	NHSI	Red if <98% ER if Red for 2 consecutive mths	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	97.7%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.7%	**
RC5	31-Day Wait For Second Or Subsequent Treatment: Surgery	RM	MM	94% or above	NHSI	Red if <94% ER if Red for 2 consecutive mths	96.0%	89.0%	89.2%	94.4%	87.5%	86.3%	92.2%	89.6%	92.2%	81.1%	89.7%	90.7%	76.8%	91.4%	77.5%	77.9%	80.3%	85.3%	**
RC6	31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	RM	MM	94% or above	NHSI	Red if <94% ER if Red for 2 consecutive mths	98.2%	96.1%	87.6%	99.0%	100.0%	86.3%	98.1%	96.5%	95.9%	99.0%	92.2%	94.1%	95.1%	94.3%	96.4%	92.9%	96.4%	94.9%	**
RC7	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	RM	MM	85% or above	NHSI	Red if <85% ER if Red in mth or YTD	86.7%	81.4%	79.3%	78.9%	83.8%	75.7%	70.1%	84.2%	73.7%	81.7%	77.2%	77.0%	82.5%	80.9%	75.1%	73.4%	77.6%	77.5%	**
RC8	62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	RM	MM	90% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	95.6%	84.5%	88.9%	79.4%	89.3%	91.7%	82.4%	93.3%	95.2%	97.1%	81.4%	96.0%	96.2%	95.3%	77.3%	72.5%	81.3%	89.1%	**
RC9	Cancer waiting 104 days	RM	MM	0	NHSI	TBC	NEW INDICATOR					12	10	12	20	12	12	17	13	23	23	17	21	21	12

62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers Inc Rare Cancers

KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Mar-16
RC10	Brain/Central Nervous System	RM	MM	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	100.0%	--	--	--	--	--	100.0%	--	--	--	--	--	--	--	--	100.0%	--	100.0%	**
RC11	Breast	RM	MM	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	96.1%	92.6%	93.3%	97.4%	98.1%	92.3%	96.8%	97.8%	91.4%	96.3%	97.5%	92.0%	100.0%	93.1%	94.6%	100.0%	94.1%	95.6%	**
RC12	Gynaecological	RM	MM	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	88.2%	77.5%	54.5%	91.7%	75.0%	64.3%	55.6%	66.7%	100.0%	72.2%	80.0%	84.6%	80.0%	85.7%	50.0%	70.0%	78.6%	73.4%	**
RC13	Haematological	RM	MM	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	65.9%	66.5%	66.7%	50.0%	80.0%	50.0%	55.0%	83.3%	37.5%	82.6%	66.7%	70.0%	50.0%	58.3%	100.0%	60.0%	60.0%	63.0%	**
RC14	Head and Neck	RM	MM	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	65.4%	69.9%	70.0%	87.5%	62.5%	75.0%	54.5%	66.7%	36.4%	60.9%	50.0%	75.0%	42.9%	37.5%	62.5%	37.5%	35.7%	50.7%	**
RC15	Lower Gastrointestinal Cancer	RM	MM	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	71.3%	63.7%	65.0%	46.7%	63.2%	63.6%	55.6%	93.3%	63.6%	60.0%	38.9%	70.6%	68.2%	77.8%	52.4%	31.3%	57.1%	59.8%	**
RC16	Lung	RM	MM	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	89.7%	69.9%	67.7%	74.2%	88.6%	84.6%	50.9%	74.6%	81.8%	70.4%	73.5%	65.2%	88.6%	81.6%	73.7%	53.8%	71.1%	71.0%	**
RC17	Other	RM	MM	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	78.7%	95.0%	100.0%	100.0%	100.0%	50.0%	100%	100%	100%	100%	50.0%	60.0%	80.0%	--	66.7%	--	--	71.4%	**
RC18	Sarcoma	RM	MM	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	82.9%	46.2%	100.0%	--	0.0%	66.7%	--	100%	--	--	80.0%	50.0%	--	--	--	100.0%	100.0%	81.3%	**
RC19	Skin	RM	MM	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	96.8%	96.7%	100.0%	94.3%	95.6%	91.7%	94.0%	91.3%	93.8%	94.1%	96.7%	91.1%	95.6%	94.9%	100.0%	92.5%	94.6%	94.1%	**
RC20	Upper Gastrointestinal Cancer	RM	MM	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	72.2%	73.9%	85.7%	77.8%	81.8%	66.7%	55.0%	84.6%	51.4%	81.8%	45.7%	48.6%	84.6%	90.0%	42.9%	57.1%	76.5%	63.9%	**
RC21	Urological (excluding testicular)	RM	MM	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	89.3%	82.6%	83.3%	66.7%	71.0%	62.1%	62.1%	74.7%	61.5%	86.1%	80.4%	80.0%	76.7%	75.0%	67.4%	78.7%	83.6%	74.4%	**
RC22	Rare Cancers	RM	MM	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	92.3%	84.6%	100.0%	66.7%	100.0%	--	100%	100%	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	**
RC23	Grand Total	RM	MM	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	86.7%	81.4%	79.3%	78.9%	83.7%	75.7%	70.1%	84.2%	73.7%	81.7%	77.2%	77.0%	82.5%	80.9%	75.1%	73.4%	77.6%	77.5%	**

Compliance Forecast for Key Responsive Indicators

Standard	April actual/predicted	May predicted	Month by which to be compliant	RAG rating of required month delivery	Commentary
Emergency Care					
4+ hr Wait (95%) - Calendar month	81.2%				Actual
Ambulance Handover (CAD+)					
% Ambulance Handover >60 Mins (CAD+)	6%		Not Confirmed		CAD+ performance from EMAS monthly report.
% Ambulance Handover >30 Mins and <60 mins (CAD+)	11%		Not Confirmed		
RTT (inc Alliance)					
Incomplete (92%)	92.7%	92.0%	Jul-16		April delivered.
Diagnostic (predicted)					
DM01 - diagnostics 6+ week waits (<1%)	0.7%	0.9%			
# Neck of femurs					
% operated on within 36hrs - all admissions (72%)	78%	72%			A factor which influenced the performance this month was that the NOF admissions were in the main spread across the month.
% operated on within 36hrs - pts fit for surgery (72%)	87%	77%			April - 6 of the 13 breaches were for clinical reasons
Cancelled Ops (inc Alliance)					
Cancelled Ops (0.8%)	1.5%	1.1%	Jun-16		Target missed due to emergency pressures.
Not Rebooked within 28 days (0 patients)	30	13	Jun-16		Target missed due to emergency pressures.
Cancer (predicted)					
Two Week Wait (93%)	90%	93%	May-16		
31 Day First Treatment (96%)	89%	92%	Jun-16		
31 Day Subsequent Surgery Treatment (94%)	89%	91%	Jun-16		
62 Days (85%)	70%	74%	Sep-16		Current backlog 79.
Cancer waiting 104 days (0 patients)	12	12			

	KPI Ref	Indicators	Board Director	Lead Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Research UHL	RU1	Median Days from submission to Trust approval (Portfolio)	AF	NB	TBC	TBC	TBC	2.0			3.0			3.0			**2.8**	2.0			1.0			2.0					
	RU2	Median Days from submission to Trust approval (Non Portfolio)	AF	NB	TBC	TBC	TBC	3.5			2.0			1.0			**2.1**	4.0			1.0			1.0					
	RU3	Recruitment to Portfolio Studies	AF	NB	Aspirational target=10920/year (910/month)	TBC	TBC	1075	1235	900	1039	1048	604	1030	1043	1298	**12564**	1062	848	1163	1019	858	1019	1516	1875	815	926	983	
	RU4	% Adjusted Trials Meeting 70 day Benchmark (data sunbmitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC	(Oct13-Sep14) 70.5%			(Nov13-Dec14) 70.5%			(Apr14-Mar15) 86%				(Jul14-Jun15) 76%			(Oct14-Sep15) 92%			(Jan15 - Dec15) 94%					
	RU5	Rank No. Trials Submitted for 70 day Benchmark (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC	(Oct13-Sep14) Rank 18/60			(Nov13-Dec14) Rank 18/59			(Apr14-Mar15) Rank 60/198				(Jul14-Jun15) Rank 108/210			(Oct14-Sep15) Rank 13/215			(Jan15 - Dec15) Rank 61/213					
	RU6	%Closed Commercial Trials Meeting Recruitment Target (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC	(Oct13-Sep14) 52%			(Nov13-Dec14) 48%			(Apr14-Mar15) 38.6%				(Jul14-Jun15) 15.3%			(Oct14-Sep15) 46.8%			(Jan15 - Dec 15) 43.4%					

Grade 2 and 3 Pressure Ulcers

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
From April 2016, a revised trajectory was agreed as part of the Trusts continuous aim to reduce the number of avoidable pressure ulcers. The new targets are based on the outturn for the 15/16 with a lower monthly threshold. The revised targets are challenging and for April the Trust has not achieved the revised monthly target for Grade 2 and 3 pressure ulcers. The main causation of avoidable pressure ulcers for this month is related to failure to use appropriate heel protection for patients' at risk. Inconsistent evidence of patients' position being changed and insufficient risk assessment.	Through the nursing executive meeting, awareness and information will be shared to ensure all clinical areas are aware of the importance of heel protection and the use of repose boots. We will monitor areas in next month's validation to ensure that the themes are not recurring, and take action to put in target support from the Pressure ulcer team if required. Through validation Ward managers and their teams have been reminded about the deficits in care for each case, and been requested to ensure their teams are aware of the issues. And monitor compliance.	**Grade 3 target <=4 with FY end <33** **Grade 2 target <=7 with FY end <89**	**G3 = 5** **G2 = 9**	**14**	Work is focussed to achieve the ambitious new targets, as part of a continuous improvement plan.

Avoidable Grade 3 Ulcers = 5

Site	Ward
LRI	Ward 42 x 1
	Ward 15 and 24 Joint x 1
	Ward 37 x 1
	Ward 17 x 1
LGH	Ward 29 x 1
GH	0

Total Avoidable Grade 2 Ulcers = 9

Site	Ward
LRI	CICU x 2
	Ward 17 x 1
	Ward 15 x 1
LGH	Ward 26 x 2
GH	Ward 31 and ITU Joint x 1
	Ward 15 and CDU Joint x 1
	Ward 20 x 1

Expected date to meet standard / target	May 2016
Revised date to meet standard	
Lead Director / Lead Officer	Julie Smith, Chief Nurse Carole Ribbins, Deputy Chief Nurse Michael Clayton, Head of Nursing

Emergency Readmissions within 30 days

Target	March performance	YTD performance	Forecast performance for next reporting period
8.5%	8.8%	8.9%	8.9%

What is causing underperformance?

UHL's readmission rate has been increasing year on year and also during 2015/16.

When compared with other trusts using the Dr Foster tool, UHL's 'readmissions within 28 days' rate has also been higher compared with other trusts and has been 'higher than expected' for the past 2 years.

What actions have been taken to improve performance?

A reducing readmissions Board has been agreed to have overarching responsibility for coordinating the various work streams planned to meet the quality commitment.

These work streams include;

1. Use of PARR30 scores to identify high risk patients
2. Targeting specialist discharge resources on this high risk cohort
3. Assurance of adequate discharge planning for high risk patients through the 11am bed meetings
4. Disease specific work streams for Urology and Respiratory
5. Improved liaison with CCG support services and care homes

The preliminary results from a pilot of steps 1 & 2 suggest that the quality commitment is realistically achievable, subject to focussing discharge resources on the right patients and system wide support for actions.

UHL'S READMISSION RATE FOR 15/16 (Apr-Jan) COMPARED WITH PEER TRUSTS (from Dr Foster and based on 28 day readmissions)

Peers (Acute)	Spells	Readmissions	Rate (%)	Relative Risk
University College London Hospitals NHS Foundation Trust	93309	5045	5.42	84.33
Hull and East Yorkshire Hospitals NHS Trust	86995	6095	7.03	92.31
King's College Hospital NHS Foundation Trust	120895	8141	6.75	93.7
Central Manchester University Hospitals NHS Foundation Trust	105060	7104	6.8	94.04
Leeds Teaching Hospitals NHS Trust	113465	8932	7.89	95.84
Barts Health NHS Trust	134967	10951	8.28	96.41
Norfolk and Norwich University Hospitals NHS Foundation Trust	106486	7391	6.96	97.59
United Lincolnshire Hospitals NHS Trust	86207	6561	7.63	97.66
Nottingham University Hospitals NHS Trust	121956	10438	8.6	98.62
Imperial College Healthcare NHS Trust	113964	8357	7.42	99.29
Pennine Acute Hospitals NHS Trust	111702	9329	8.38	100.11
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	129362	9778	7.57	100.97
Oxford University Hospitals NHS Foundation Trust	115272	8708	7.61	103.99
University Hospitals Of Leicester NHS Trust	147129	12765	8.74	107.56
University Hospitals Of North Midlands NHS Trust	117618	11023	9.47	108.73
East Kent Hospitals University NHS Foundation Trust	107844	9389	8.74	109
Sheffield Teaching Hospitals NHS Foundation Trust	132108	11324	8.58	111.72
Heart Of England NHS Foundation Trust	139711	13464	9.65	112.01

Expected date to meet standard / target	Q3 2016/17
Lead Director / Lead Officer	Andrew Furlong, Interim Medical Director Matt Metcalfe, Deputy Medical Director

52 week breaches (incompletes)

What is causing underperformance?

The Trust had 169 patients on an incomplete pathway breaching 52 weeks at the end of April. 167 patients were from the Orthodontics Department, one patient was from General Surgery and one patient was from the ENT department.

Orthodontics
The reasons for underperformance in Orthodontics are as follows:

- Incorrect use and management of a planned waiting list.
- Inadequate capacity within the service to see patients when they are ready for treatment.

General Surgery
The General Surgery patient who breached 52 weeks was a complex patient for one consultant only. The patient was then cancelled on the day of their surgery due to an ITU bed not being available. The patient has been re-dated for 18th May.

ENT
The ENT patient breached as a result of an administrative error, which meant that their waiting time was calculated from the date they were added to the waiting list as opposed to when they were referred into the service by their GP.

What actions have been taken to improve performance?

Orthodontics

- The Orthodontics service is now closed to referrals with some clinical exceptions.
- With NHS Improvement and NHS England, UHL have identified treatment opportunities from across the regional health economy for the majority of the patients on the Orthodontics waiting list. The service team are in the process of transferring patients to these providers, explaining the drop in reported numbers from the end of March (232). The Trust is reporting weekly to NHS Improvement. Reported number of breaches at the end of May is expected to be c.100.

General Surgery

- The ITU annexe is due to open at the end of May subject to staffing, increasing the number of beds by 6.
- The Director of Performance and Information is working closely with CHUGGS CMG in light of the elevated cancellations they have experienced over winter.

ENT

- The RTT Team recently delivered a bespoke education and training course for the ENT administrative team and continues to provide support.
- Extra capacity has been identified for outpatients via Medinet weekend clinics. The longer term plan will include IP lists as well. Recruitment initiatives continue to increase the service's capacity as well as outsourcing some patient cohorts, including Balance.

Target (mthly / end of year)	March performance	April performance	Forecast performance for next period
0	232	169	100

The problem which surfaced in Orthodontics prompted a deliberate, Trust-wide review of planned waiting lists at specialty level. Therefore the following actions have been taken Trust-wide:

- Communication around planned waiting list management to all relevant staff;
- System review of all waiting list codes;
- All General Managers and Heads of Service have signed a letter confirming review and assurance of all waiting lists, to be returned to Chief Operating Officer;
- Weekly review at Heads of Operations meeting for assurance.

Looking forward

- While UHL achieved the RTT (92%) standard in April 2016 and anticipates doing so for May, the Trust is forecasting non-compliance with the target in quarter 1 of 2016-17 due to the significant impact of winter pressures on the admitted position as well as the deterioration in performance in ENT. RTT was failed nationally in April 2016 for the first time since 2012, reflecting the pressures felt across the acute sector. While this should not mean that more patients breach 52 weeks, General Surgery and ENT remain very high risk due to the high number of cancellations both services have experienced, in addition to the impact of the junior doctor strike days.

Expected date to meet standard / target	May for non-Orthodontics breaches
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Will Monaghan, Director of Performance and Information

Cancelled patients not offered a date within 28 days of the cancellations

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 not offered another date within 28 days of the cancellation

What is causing underperformance?	What actions have been taken to improve performance?	Target (monthly)	Latest month	YTD performance (inc Alliance)	Forecast performance for next reporting period
In UHL 58.9% (*89/151)* of cancellations were cancelled due to capacity pressures. The five main reasons for cancellations in UHL were: • Ward bed unavailability (45) • Lack of theatre time due to list over runs (35) • Critical care bed unavailability (34) • Sickness of Surgeons and theatre staff (16) • Patient delayed due to admission of a higher priority patient(10) This month, increasing capacity pressures due to lack of ward beds in LRI and critical care beds have impacted on the number of cancellations. The capacity pressures were caused mainly by increase in emergency admissions. A number of medical outliers in the LRI on Ward 7 led to cancellations. The outlier numbers also led patients being cancelled the day before. This has led to a significant increase in 28 day breaches. Due to the adult ward bed and critical care pressures, it is likely that we will see around thirteen, 28 day breaches next month.	List over runs - The process of exception reporting is now better able to identify any over booked operation lists by the theatre managers working with theatre staff. The high numbers of medical outliers created OTD cancellations and problems with rebooking of patients within 28 day. The availability of beds, particularly those in ITU is monitored daily and interventions were made where necessary. The opening of an additional 6 ITU beds at the LRI is anticipated before the end of May staffing permitting. Theatre Managers have increased theatre capacity for the increased cancer demand by making additional lists available. Theatre capacity planning for 2016/17 is well underway and incorporates the increased demand The day ward has now been allocated exclusively for surgical patients in order to try to increase the elective throughput.	1) 0.8% 2) 0	1. 1.5% (UHL -1.5% & Alliance 0.5%) 2. 30 (Alliance 5 & UHL – ENT 6, Vascular 5, Cardiac Surgery 3, Max fax 4, Urology 2, General Surgery 2, HPB 1, Spinal Surgery 1, Orthopaedic 1)	1) 1.5% 2) 30	1) 1.1 % 2) 13

Expected date to meet standard / target	On the day – June 2016 28 day – June 2016
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Phil Walmsley. Head of Operations, ITAPS

Ambulance handover > 30 minutes and>60 minutes

		Target	Apr 16	YTD	Forecast
What is causing underperformance?	What actions have been taken to improve performance?	0 delays over 15 minutes	>60 min – 10 6% 30-60 min – 11%	>60 min - 6% 30-60 min – 11%	> 60 min - 6% 30-60 min – 11%
Difficulties continue in accessing beds and high occupancy in ED leading to congestion in the assessment area and delays ambulance handover.	CCG's, EMAS and UHL continue to work together to improve ambulance handover times. EMAS and UHL have weekly conference calls to progress actions and identify further opportunities for improvement. UHL have put in place a Service manager to work with EMAS in hours to ensure handovers are as efficient as possible, with an internal CMG escalation to address any in hour issues. Out of hours a management and escalation process with DOC and CEO is in place. EMAS have provided staffing to care for patients in the red zones in ED to enable crews to be released earlier to improve handover times. This is in conjunction with other recommendations from the Unipart report. UHL have implemented a Sop which ensures that patients attend the right location in ED or are redirected as required. . UHL have put into place a member of staff to triage patients should they be waiting on the back of ambulances to identify the acuity of patients along with EMAS stating their DPS of the patient on booking into ED. 3 trials have taken place in April to increase major's capacity. This had a positive result on ambulance handovers and as such an extended trial is being planned on 1st June .	Performance: Ambulance Handover Times 30%, 25%, 20%, 15%, 10%, 5%, 0% Apr-15, May-15, Jun-15, Jul-15, Aug-15, Sep-15, Oct-15, Nov-15, Dec-15, Jan-16, Feb-16, Mar-16, Apr-16 Ambulance Handover >60 Mins (CAD+ from June 15) Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)			

Expected date to meet standard	Internal standard 1 – 0 waits above 60 mins July 2016
Revised date to meet standard	TBC
Lead Director	Sam Leak, Director of Emergency Care and ESM CMG

Cancer Waiting Times Performance

What is causing underperformance?

2ww – The Trust failed the 2ww standard by a small margin – 0.03% (1 patient). This can be attributed to the continuing problems with capacity in Head and Neck (ENT specifically).

31 day first treatment – UHL's performance against this standard was 94.1%, an improvement of 1.5% from February. 21 patients were treated after the 31 day target. This target was predominantly failed as a result of performance in Lower GI (7 patients) and Urology. Lower GI has suffered significantly as a result of cancellations due to HDU/ITU unavailability and Urology has inadequate elective capacity. While RTT lists are regularly taken down to prioritise cancer patients, the tumour site still had five 31 day breaches in February, however this is a significant improvement as there were thirteen in February. There were also 3 patients who breached in Head and Neck, a tumour site with known challenges around capacity.

31 day subsequent (surgery) –Performance against this standard in February was 80.3%. This marks a slight improvement of 2.4% from March and this performance can be attributed to the emergency pressures experienced at UHL throughout the month, as well as known capacity gaps in Head and Neck, Urology and Gynaecology.

62 day RTT – 62 day performance remains below target at 77.6% in March; however 42 patients from the backlog were treated. The main pressures remain robust patient pathways and supporting processes, inadequate theatre capacity and shortages in consultant staff. The only tumour sites to achieve the standard were Breast, Skin and Sarcoma. Head and Neck, Urology, Lower GI and Lung all treated a significant number of backlog patients.

What actions have been taken to improve performance?

2ww – The key challenge to 2ww performance at Trust level is Head and Neck. Extra clinics are being put on when capacity is available, locum consultant interviews take place next week (17th May) to help stabilise the service. Dermatology also have experienced capacity constraints but have secured additional capacity which will also help the overall Trust position.

31 day first treatment – Reduced emergency pressures and recovery in Urology are key to the achievement of this standard. Urology has a known shortage of theatre capacity; additional long term capacity is in the process of being identified and current arrangements are being complemented by extra sessions/ weekend working.

31 day subsequent (surgery) – Across all tumour sites cancer patients are being prioritised over RTT patients, however cancellations due to emergency pressures are having an impact. Significant investment in more clinical staff has also been planned, including a nurse specialist in Urology and an ENT locum consultant, which will help improve performance. The key issue in Urology is inadequate elective capacity; as mentioned above plans to increase their theatre capacity are ongoing.

62 day RTT – Lower GI, Head and Neck, Lung and Urology remain the most pressured tumour sites. Several services are advertising for additional consultant staff including Head and Neck and Skin; however successful recruitment cannot be guaranteed due to shortages of suitable candidates. Three band 7 service managers with responsibility for managing cancer pathways in our worst performing tumour sites are providing the key focus required. Although 62 day backlog reduction has steadily been taking place, but there are increasing pressures in Urology. A Remedial Action Plan has been submitted to commissioners; this is updated weekly via the Trust's Cancer Action Board and monitored monthly via the joint Cancer and RTT Board. Daily phone calls are taking place with Urology and Head and Neck and the corporate performance team.

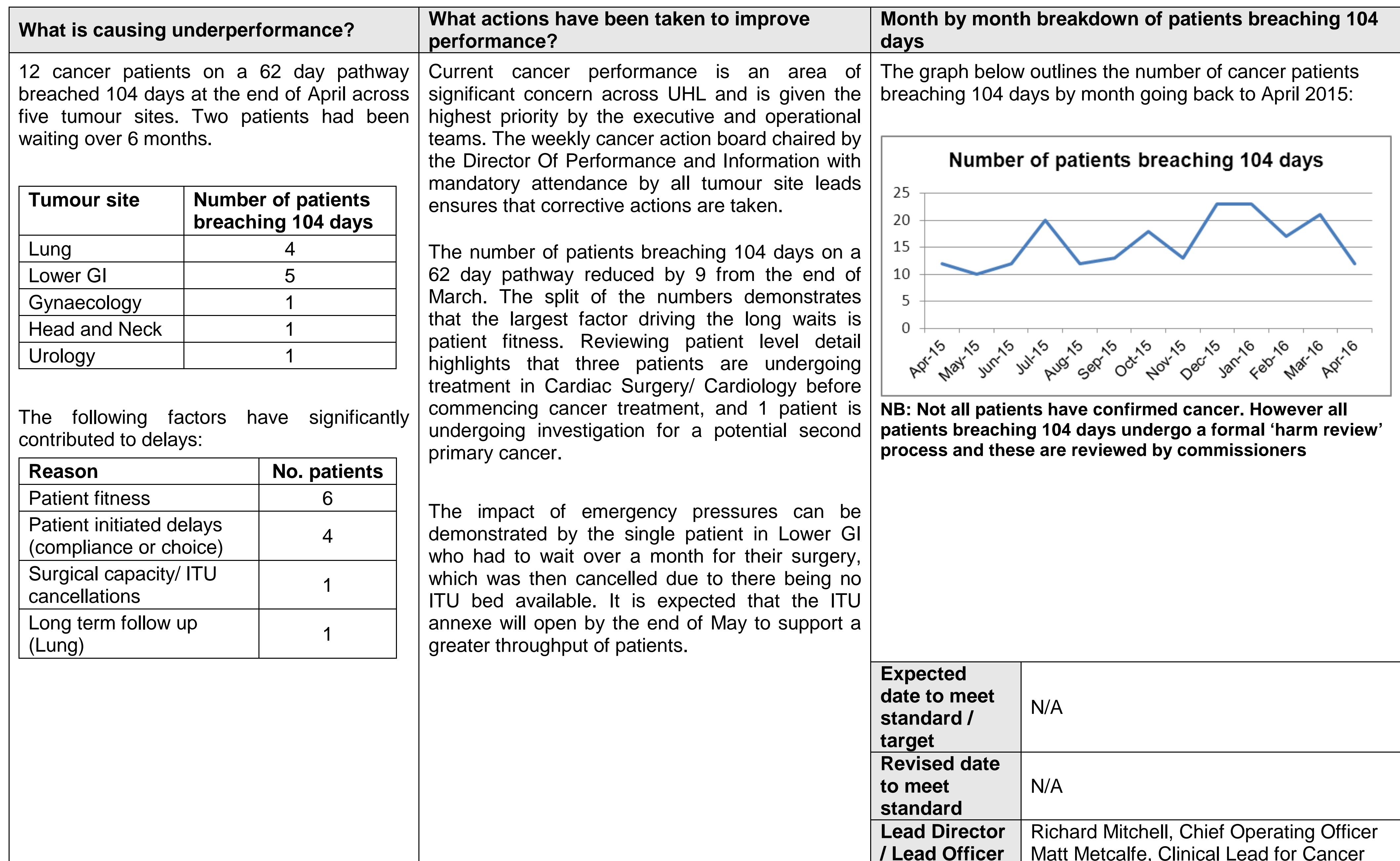
Target (mthly / end of year)	Latest month performance March	Performance 2015/16	Forecast performance for April
2WW (Target: 93%)	92.97%	90.5%	91%
31 day 1st (Target: 96%)	94.1%	94.8%	94%
31 day sub – Surgery (Target: 94%)	80.3%	85.3%	90%
62 day RTT (Target: 85%)	77.6%	77.5%	76%
62 day screening (Target: 90%)	81.3%	89.1%	92%

Current cancer performance is an area of significant concern across UHL and focus on recovery is of the highest priority within the organisation. The weekly cancer action board chaired by the Director Of Performance and Information with mandatory attendance by all tumour site leads ensures that corrective actions are taken.

The Trust has initiated a programme 'Next Steps' for cancer patients in 3 key tumour sites. The pilot started in the Prostate pathway in early April and has since rolled out to Lower GI and Lung. Further roll out to other tumour sites will happen in June.

Expected date to meet standard / target	62 day pathway: September 2016 31 day sub – Surgery: July 2016
Revised date to meet standard	31 day 1st treatment: July 2016
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Matt Metcalfe, Clinical Lead for Cancer

Cancer Patients Breaching 104 days



What is causing underperformance?

12 cancer patients on a 62 day pathway breached 104 days at the end of April across five tumour sites. Two patients had been waiting over 6 months.

Tumour site	Number of patients breaching 104 days
Lung	4
Lower GI	5
Gynaecology	1
Head and Neck	1
Urology	1

The following factors have significantly contributed to delays:

Reason	No. patients
Patient fitness	6
Patient initiated delays (compliance or choice)	4
Surgical capacity/ ITU cancellations	1
Long term follow up (Lung)	1

What actions have been taken to improve performance?

Current cancer performance is an area of significant concern across UHL and is given the highest priority by the executive and operational teams. The weekly cancer action board chaired by the Director Of Performance and Information with mandatory attendance by all tumour site leads ensures that corrective actions are taken.

The number of patients breaching 104 days on a 62 day pathway reduced by 9 from the end of March. The split of the numbers demonstrates that the largest factor driving the long waits is patient fitness. Reviewing patient level detail highlights that three patients are undergoing treatment in Cardiac Surgery/ Cardiology before commencing cancer treatment, and 1 patient is undergoing investigation for a potential second primary cancer.

The impact of emergency pressures can be demonstrated by the single patient in Lower GI who had to wait over a month for their surgery, which was then cancelled due to there being no ITU bed available. It is expected that the ITU annexe will open by the end of May to support a greater throughput of patients.

Month by month breakdown of patients breaching 104 days

The graph below outlines the number of cancer patients breaching 104 days by month going back to April 2015:

NB: Not all patients have confirmed cancer. However all patients breaching 104 days undergo a formal 'harm review' process and these are reviewed by commissioners

Expected date to meet standard / target	N/A
Revised date to meet standard	N/A
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Matt Metcalfe, Clinical Lead for Cancer

UHL Quality Schedule and CQUIN Scheme Performance for 15/16 Quarter 4

Schedule Ref	Indicator Title (brief)	Indicator Title and Detail	Q4	Comments
PS01	Infection Prevention and Control Reduction.	Infection Prevention and Control in Acute Services will be managed in accordance with the Health and Social Care Act 2008 and the Code of Practice on the Prevention and Control of Infections.	G	Commissioner noted achievement of the C Diff threshold and that actions are being taken to improve compliance with with IP precautions
PS02	HCAI Monitoring	Monitoring of MRSA against Zero tolerance.	R	1 bacteraemia reported for March 16. PIR deemed to be unavoidable due to multiple chronic co-morbidities resulting in lifestyle issues which impaired the patient's ability to maintain hygiene and nutritional standards. No lapses in care identified during the post infection review.
PS03	Patient Safety	Patient Safety to demonstrate compliance with NHS Serious Incident Framework and demonstration of lessons learned and actions taken to prevent recurrence of such incidents.	R G	Red RAG for Never Event reported for March relating to 'wrong site surgery' in 2015 which was retrospectively confirmed as a Never Event after being presented at the Dermatology M&M meeting. Quarterly RAG to be confirmed at June CQRG but Green RAG anticipated as thresholds achieved..
PS04	Duty of Candour (DoC)	The Trust demonstrates openness and ensures patients and/or relatives and carers are informed of actual or suspected notifiable patient safety incidents	A	0 breaches reported in 15/16 but Amber RAG due to audit of case notes identified lack of documentation to evidence all aspects of the Duty of Candour requirements being met.
PS05	Complaints and user feedback Management	Management of Complaints (including re-opened and those referred to Ombudsman).	G	RAG to be confirmed at June CQRG but Green RAG anticipated as thresholds achieved.
PS06	Risk Assurance	Risk register report. Central Alerting System Patient Safety Alerts / National Patient Safety Alerting System Alerts.	G	0 CAS alerts outstanding. Amber RAG given for Feb 16 due to Risk reviews being behind schedule.
PS07	Safeguarding	• Demonstrate compliance with Local, Regional and National guidance	G	Assurance Framework completed
PS08	Reduction in Pressure Ulcer incidence.	Reducing "avoidable" Grade 2, 3 and 4 Hospital Acquired Pressure Ulcers	R G	Monthly threshold achieved throughout Quarter 4 except for Grade 4 reported for February 16 Reduction in G2, G3 and G4 HAPUs on 14/15. 89 Grade 2's; 33 Grade 3's; 1 Grade 4
PS09	Medicines Management Optimisation	Demonstrate effective Medicines Optimisation processes and compliance with medicines management policies.	R G	Red RAG for Controlled Drugs audit results which showed areas of non compliance. Also deterioration in Medicines Reconciliation. Compliance with Shared Care Policy Green
PS10	Medication Errors	Increased reporting of medication errors, and continued reporting of medication errors causing moderate or serious harm and 10 x drug errors resulting in harm.	tbc	For review at June CQRG. Actions taken where medication errors reported. Commissioners previously agreed to Green RAG despite not meeting nationally directed threshold for increase in reporting. Children's have introduced new system which should increase numbers reported.
PS11	Safety Thermometer	Provider collection and reporting of NHS Safety Thermometer data.	G	94.1% harm free care reported against the national average of 94.2%. Commissioners aware that UHL does not consider the ST adds any value due to our monitoring of incidence.
AS01	Cost Improvement Programme (CIP) Assurance	Demonstrate quality assurance systems and processes are applied to all Cost Improvement Programmes	G	Commissioners met with Director of CIP and assurance given in both CIP programme and in its quality assurance process.
AS02	Ward Health-check	Staffing Establishment and Impact on Service Delivery	G	Challenges with recruitment and work being taken to address noted.
AS03	Nurse Revalidation Programme	Provider preparedness for the implementation of Nurse Revalidation	tbc	Due to be reported to the June CQRG Implementation plan in place.
AS04	Staffing governance	Staffing governance to include information relating to the Organisational Development Plan (OD) update	A	Reflects drop in appraisal rates, particularly for medical staff. Assurance given about actions being taken to address.
AS05	Involving employees in	The organisation demonstrates openness and	G	Report received and requirements met.

Schedule Ref	Indicator Title (brief)	Indicator Title and Detail	Q4	Comments
	improving standards of care.	responsiveness to feedback from staff received whether internally or externally.		
AS06	Staff Satisfaction	Improve staff engagement	A	Amber RAG due to the trust being below national average for a number of measures e.g. recommend organisation as a place to work; recommend to friends and family; listening into action in bottom 20% of all acute trusts. Commissioners noted that the trust has seen some improvements in a number of questions since last year's survey.
AS07	External Visits and Commissioner Quality Visits	External visits schedule and report of any visits and action plans plus any removal of licences	**G**	
AS08	CQC Registration	CQC registration and compliance updates.Report to include any areas of non-compliance (real-time reporting by exception) and details of actions following inspections.	**A**	Following CQC unannounced visit to ED.
CE01 (a)	Communication - Content - Medical	Compliance with UHL Discharge, Out-patient and Emergency Department letter policy and standards	**tbc**	Dependent upon completion of audits - to be presented to the June CQRG
CE01 (b)	Communication - Content - Nursing	Referral and letters to District Nurses and Practice Nurses -	**tbc**	Dependent upon completion of audits - to be presented to the June CQRG
CE02	Intra-operative Fluid Management	Use of Intraoperative Fluid Management .	**G**	80% threshold met
CE03a	Clinical Effectiveness Assurance - Audit	Demonstrate that there is a Clinical Audit Programme of National and locally prioritised audits	**G**	Improvements seen in clinical audit compliance across all CMG'
CE03 b	Clinical Effectiveness Assurance - NICE	Demonstrate compliance with NICE Technology Appraisals and NICE guidance published 2015/16	**tbc**	Report to be submitted to the June CQRG but Amber RAG anticipated for delays in responses to NICE Guidelines/Quality Standards
CE04	Women's Service Dashboard	Maternity Dashboard as agreed to demonstrate quality standards monitoring and evidence of actions	**tbc**	Dependent upon number of Red RAGs within the Dashboard – due to be presented to the June CQRG
CE05	Children's Service Dashboard	Children's Dashboard as agreed to demonstrate quality standards monitoring and evidence of actions	**tbc**	Dependent upon number of Red RAGs within the Dashboard – due to be presented to the June CQRG
CE06 a	PROMS - Patient Reported Outcomes	Patient Reported Outcomes (PROMs) for Hips, Knees, Groin Hernia and Varicose Vein Surgery	**tbc**	Dependent upon Groin Hernia PROM outcomes being in line with the National average For reporting to the June CQRG meeting.
CE06 b	Consultant Clinical Outcomes	Consultant level survival rates as stated on the 'Everyone Counts' document.	**tbc**	Dependent upon all outcomes being in line with national average. For reporting to the June CQRG meeting.
CE07	#NOF - Dashboard	Improve delivery of best practice tariff indicators for #NOF Patients	**R**	36 hour performance below threshold for all 3 months of Q4..
CE08	Stroke and TIA monitoring	**1.** Compliance with 90% stay on Stroke ward for 80% of patients. **2.** Sustained or Improved performance with TIA high risk and low risk performance. **3.** Improve performance with the SSNAP Data.	**tbc**	Performance dropped in Q3. Awaiting final Q4 results to be published from SSNAP TIA thresholds and 90% stay on stroke unit thresholds met for all of 15/16.
CE09	Mortality	Mortality Reporting to include: SHMI, HSMR, M&M Reviews Mortality Alerts (including perinatal mortality) MRC work programme progress	**tbc**	SHMI remains below 100. Progress made with 'screening of all deaths. Due to be reported to the June meeting.
CE10	VTE Risk Assessment	Reduce avoidable death, disability and chronic ill health from VTE	**G**	95.5% VTE risk assessments completed.
CE11	VTE RCA	All confirmed cases inpatient and post discharge Hospital Acquired Thrombosis (HAT) as detailed in SC 20 to undergo RCA within 3 months of identification.	**tbc**	Antiicipate non achievement of the 100% threshold for RCAs of post discharge HATs. Also latest audit identified lack of documentation around thromboprophylaxis.
CE12	Nutrition and Hydration	Implementation of educational programme supported by the revised Nursing Metrics in respect of meeting	**A**	Not all CMG's achieved 90% across all metrics.

Schedule Ref	Indicator Title (brief)	Indicator Title and Detail	Q4	Comments
		nutritional and hydration needs of inpatients		
CE13	Food Strategy	Provider to have food strategy	G	Final Strategy submitted
CE14	Community Acquired Pneumonia (CAP)	Improving care pathway and discharge for patients admitted with acute episode of community acquired pneumonia (CAP) using Care Bundle	A	86% for antibiotics within 4 hrs (threshold = 90%). Good progress made with implementation of the '6 week chest xray follow up service'.
CE15	Improving End of Life (EoL) care.	Maintenance of the use of the Amber Care Bundle to ensure that patients are identified and supported at the end of life,	G	Thresholds achieved
CE16	Heart Failure	Improving care pathway and process for patients with heart failure. Continuing the use of the Heart Failure care bundle, and supporting patients discharged.	G	Increases made in numbers of patients seen by Heart Failure nurses and receiving care bundle.
PE01	Same Sex Accommodation and Annual Estates Monitoring	Demonstrate same sex accommodation compliance in line with DoH Guidance and EMSA "Estates Plan" monitoring programme	R	Feb 16 – Same Sex 'non clinically justified breach' reported.
PE02	Patient Experience, Equality and Listening to and Learning from Feedback.	Demonstrate by improving openness and transparency through listening to and acting on all available feedback) that the organisation is learning from feedback and improving services	tbc	Report received detailing themes of patient feedback broken down by CMG and patient type. Actions taken in response provided. Report to be presented to the June CQRG
PE03	Improving Patient Experience of Hospital Care	Demonstrate a reduction in the proportion of people reporting poor patient experience of inpatient care as reported in the National Inpatient Survey.	NA	Indicator discontinued.
PE04	Equality and Human Rights	Compliance with the Equality Act 2010 and implementation of EDS2 and National Workforce Race Equality Standard	tbc	Dependent upon commissioners being sufficiently assured about UHLs plans to meet national requirements. For review at the June CQRG
PE5	MECC	To deliver brief advice on healthy lifestyle behaviours to reduce preventable ill health and premature death;	tbc	For review at the June CQRG
PE6	Friends and Family Test	Maximise Friends and Family Test response rates	A	Further deterioration in ED response rate during Q4 but actions being taken to address.
Nat 1	AKI Discharge Care Bundle	By end of Q4 - 90% of patients with AKI - the discharge summary states AKI stage, medication review, post discharge U&Es, frequency	R	Q4 threshold not achieved and deterioration in performance from Q3. AKI guideines and care bundle launched and ICE letter template changed to support documentation about AKI within discharge letters. Continues as a local CQUIN for 16/17.
Nat 2a	Sepsis - Screening	Patients presenting to emergency departments and assessment units, with infection are screened for sepsis	R	59% of patients screened. Continues as a national CQUIN for 16/17
Nat 2b	Sepsis - IV Antibiotics	. Patients presenting with sepsis receive IV antibiotics within 1 hr of arrival	R	63% of patients received IV antibiotics in 1 hour. Continues as a national CQUIN for 16/17
Nat 3a	Dementia - FAIR	90% of patients meeting the criteria are screened, risk assessed for dementia and are referred where positive or inconclusive	G	Screening and Assessment thresholds achieved. Audit undertaken.
Nat 3b	Dementia Training	To ensure that appropriate dementia training is available to staff through a locally determined training programme.	tbc	90% threshold just missed for medical staff. RAG to be confirmed at the June CQRG
Nat 3c	Dementia Carers	Ensure carers of people with dementia and delirium feel adequately supported.	G	Survey results presented to EQB.
Nat 4	Amb Care	To decrease the proportion of Avoidable Emergency Admissions to Hospital.	tbc	Increase in number of patients being seen through ambulatory care pathway has increased. RAG to be confirmed at the June CQRG

Schedule Ref	Indicator Title (brief)	Indicator Title and Detail	Q4	Comments
Loc 5	Readmissions	Clinical Readmissions Review	tbc	Pilot of readmission tool implemented. RAG dependent upon commissioners RAG to be confirmed at the June CQRG
Loc 6	CHC	Improving the timeliness and accuracy of the Continuing Healthcare -Assessment	A	Threshold not achieved for patients on the 'Discharge to Assess' pathway but improvement on Q3 performance. RAG to be confirmed at the June CQRG
Loc 7a	Safety Briefings	The development of 'safety briefings' in clinical settings. Specific areas are: ED, Maternity (Delivery suite), Care of the Elderly and Paediatrics.	tbc	Report submitted. RAG to be confirmed at the June CQRG
Loc 7b	Increase 'Near Miss' Reporting	Promotion of near miss reporting and undertake a thematic analysis of near miss incidents to identify learning and actions to prevent patient harm.	G	Report submitted. RAG to be confirmed at the June CQRG
Loc 8	Think Glucose	Implementation of ThinkGlucose Education Programme across 70 Clinical areas in UHL	G	Programme completed. RAG dependent upon commissioners considering outcomes demonstrate benefit. RAG to be confirmed at the June CQRG
Loc 9	Bereavement F/U	The establishment of a Bereavement Service to support the relatives and carers of patients who die in hospital.	G	Bereavement Service Fully implemented and number of contacts provided and detailed information on scheme
Loc 10	Learning Disabilities - Pt Exp	Improving the care experience and health outcomes of patients with learning disabilities in acute care settings.	tbc	Progress made with implementation plan and positive feedback received from patients. RAG to be confirmed at the June CQRG
SS1/ CUR	CUR Tool	Clinical Utilisation Review Tool	R	Second pre-engagement event but none of the CUR companies are prepared to make changes to their software to allow full integration with NerveCentre. NHSE have advised they will carry over any loss of CQUIN monies to 16/17. Continues as a CQUIN for 16/17
SS2/ C6	Oncotype Testing	Eligible patients receiving a NICE DG10 compliant test with provision of monitoring data	tbc	Data being collated.
SS3/ TH4	Critical Care Delayed Discharges	Reduction in delayed discharges from ICU to ward level care	tbc	Reduction in delayed discharges seen. Continues as a CQUIN for 16/17
SS6/IM7	Rheumatic Diseases Network	Multi-system auto-immune rheumatic diseases network	tbc	Data not being submitted for 90% of patients. – Continues as a CQUIN for 16/17
SS7/ TH7	Complex Orthopaedic Surgery Network	Specialised Orthopaedics (Adults) Network Development: regional audit and governance, regional MDT for complex cases.	tbc	MDT process implemented.
SS8/ HSS	ECMO/PCO Collaborative Workshop	Highly specialised services clinical outcome collaborative audit workshop	tbc	National ECMO collaborative workshop held at Glenfield on 5th Nov
SS10/ CB5	Haemoglobinopathy Network	Define and develop networks of care for patients with haemoglobin disorders.	tbc	Continues as a CQUIN for 16/17
SS11/ WC1	<28 Week Neonates 2 yr follow up	2 Year outcomes for infants <28 weeks gestation (3 year scheme)	tbc	