Quality & Performance Report

Author: John Adler Sponsor: Chief Executive Date: IFPIC + QAC 24th March 2016

Executive Summary from CEO

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 June 2014 to June 2015) has fallen to **95** – this compares to a peak of 105. **RTT** – the RTT incomplete target remains compliant, this is particularly good in the light the high level of cancelled operations due to emergency pressures. **Diagnostics** performance is 1.8% with compliance of the standard expected to be achieved at the 31st March. The **Cancer Two Week Wait** target was achieved in December for the first time this year and although January performance dipped to 91.4% we have delivered for February. **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. **MRSA** – remains at zero for the year. **Falls** performance continues to show a big improvement on last year. Although there was a seasonal increase in Norovirus in February **C DIFF** – remains within year to date trajectory. **Patient Satisfaction (FFT)** achieved the target of 97% for ED despite the pressures in ED during the winter months (note my comment in the bad news section regarding poor coverage).

Bad News:

ED 4 hour performance- was 80.2% and the year to date performance has slipped to 87.8%. Contributing factors are set out in the Chief Operating Officer's report. **Ambulance Handover 60+ minutes**– showed a further improvement (despite ED pressures) but remains a serious issue – this is also examined in detail in the COO's report. **Referral to Treatment 52+ week waits** we continue to struggle to bring down these long waits, due to an inability to recruit additional consultants or to find capacity at other providers. The NTDA are now in the process of implementing an organised transfer of patients to other providers but this may provide only a partial solution. **Cancelled operations** and **patients rebooked within 28 days** – continued to

be non-compliant, predominantly due to increased emergency pressures. **Cancer Standards -** the 62 day backlog is showing signs of improvement with the latest backlog down to 61 (from a peak of 116 in January). **Fractured NOF** – target not achieved in February – this has now reverted to a persistent failure and needs to be examined further. **FFT coverage in ED** continues to be poor – this has been escalated to Head of Service and ED Matrons with plans in place to improve. **Pressure Ulcers** – after reporting 10 months of no avoidable **Grade 4** pressure ulcers, there was one reported in February. The case is subject to a serious incident review to be reported to the Nursing Executive Team. **Grade 2 and Grade 3** are within the monthly threshold. There was one **Single Sex Accommodation** breach during February.

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: 28th April 2016

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

February 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: **24th MARCH 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: **FEBRUARY 2016 QUALITY & PERFORMANCE SUMMARY REPORT**

1.0 Introduction

The following report provides an overview of TDA/UHL key quality and performance metrics and escalation reports where applicable.

2.0 Performance Summary

Domain	Page Number	Number of Indicators	Indicators with target to be confirmed	Number of Red Indicators this month
Safe	4	22	7	2
Caring	5	10	3	1
Well Led	6	18	6	4
Effective	7	16	3	2
Responsive	8	17	2	9
Responsive Cancer	9	9	0	6
Research – UHL	11	6	6	0
Total		98	38	24

3.0 New Indicators

No new indicators.

4.0 Indicators removed

No indicators removed

5.0 Indicators where reporting methodology/thresholds have changed

No indicators with a change in reporting.

	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	Dec-14	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	YTD
Safe	S1	Clostridium Difficile	JS	DJ	61	TDA	Red if >mthly threshold / ER if Red or Non compliance with cumulative target	66	73	11	7	5	7	3	1	4	4	6	6	6	4	6	7	7	54
	S2a	MRSA Bacteraemias (All)	JS	DJ	0	TDA	Red if >0 ER if >0	3	6	2	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0
	S2b	MRSA Bacteraemias (Avoidable)	JS	DJ	0	UHL	Red if >0 ER if >0	1	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
	S3	Never Events	JS	MD	0	TDA	Red if >0 in mth ER = in mth >0	3	3	1	1	0	0	0	0	0	0	0	1	0	0	0	0	0	1
	S4	Serious Incidents	JS	MD	Not within Highest Decile	TDA	TBC	60	41	4	3	2	1	2	8	1	5	3	5	3	4	3	5	6	45
	S5a	Proportion of reported safety incidents per 1000 beddays	JS	MD	TBC	TDA	TBC	37.5	39.1	40.4	35.0	38.2	36.3	38.0	39.8	40.7	40.7	38.9	36.4	40.7	36.5	37.4	37.4	34.6	38.3
	S5b	Proportion of reported safety incidents that are harmful	JS	MD	Not within Highest Decile	TDA	TBC	2.8%	1.9%	1.4%	2.3%			2.2%			1.9%			1.8%					2.0%
	S6	Overdue CAS alerts	JS	MD	0	TDA	Red if >0 in mth ER = in mth >0	2	10	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
	S7	RIDDOR - Serious Staff Injuries	JS	MD	FYE = <40	UHL	Red / ER if non compliance with cumulative target	47	24	1	0	3	2	0	6	0	0	2	3	7	2	5	3	2	30
	S8a	Safety Thermometer % of harm free care (all)	JS	EM	Not within Lowest Decile	TDA	Red if <92% ER = in mth <92%	93.6%	94.1%	94.1%	95.0%	92.1%	93.6%	93.7%	94.3%	95.6%	94.6%	93.2%	94.0%	93.5%	94.4%	93.9%	94.2%	94.1%	94.1%
	S8b	Safety Thermometer % number of new harms	JS	EM	Not within Lowest Decile	TDA	TBC	New TDA Indicator		2.4%	2.5%	3.2%	2.7%	2.2%	2.6%	2.1%	1.9%	3.1%	2.4%	2.6%	2.7%	1.8%	2.3%	2.2%	2.3%
	S9	% of all adults who have had VTE risk assessment on adm to hosp	AF	SH	95% or above	TDA	Red if <95% ER if in mth <95%	95.3%	95.8%	95.0%	96.3%	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%	96.0%
	S10	All Medication errors causing serious harm	AF	CE	0	TDA	Red if >0 in mth ER if in mth >0	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	
	S11	All falls reported per 1000 bed stays for patients >65years	JS	HL	<7.1	QC	Red if >8.4 ER if 2 consecutive reds	7.1	6.9	6.9	7.1	6.7	6.3	5.9	6.1	5.1	5.8	5.9	5.0	5.2	4.8	5.7	5.4	4.8	5.4
	S12	Avoidable Pressure Ulcers - Grade 4	JS	MC	0	QS	Red / ER if Non compliance with monthly target	1	2	1	0	0	1	0	0	0	0	0	0	0	0	0	0	1	1
	S13	Avoidable Pressure Ulcers - Grade 3	JS	MC	<=6 a month	QS	Red / ER if Non compliance with monthly target	71	69	7	5	9	6	3	0	4	1	4	1	1	1	5	6	2	28
	S14	Avoidable Pressure Ulcers - Grade 2	JS	MC	<=8 a month	QS	Red / ER if Non compliance with monthly target	120	91	11	7	5	9	10	8	8	8	10	11	5	4	5	5	8	82
	S15	Compliance with the SEPSIS6 Care Bundle	AF	JP	All 6 >75% by Q4	QC	Red/ER if Non compliance with Quarterly target	27.0%	<65%	<65%	<75%			AUDIT IN PROGESS											
	S16	Maternal Deaths	AF	IS	0	UHL	Red or ER if >0	3	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	S17	Emergency C Sections (Coded as R18)	IS	EB	Not within Highest Decile	TDA	Red / ER if Non compliance with monthly target	16.1%	16.5%	16.2%	17.7%	15.5%	15.8%	15.3%	18.8%	15.8%	15.8%	15.2%	16.5%	20.9%	19.7%	20.9%	17.0%	16.6%	17.5%
	S18	Potential under reporting of patient safety indicators	JS	MD	Not within Highest Decile	TDA	Red / ER if Non compliance with monthly target	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	
	S19	Potential under reporting of patient safety indicators resulting in death or severe harm	JS	MD	Not within Highest Decile	TDA	Red / ER if Non compliance with monthly target	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	

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Caring	C1	Inpatients (Including Daycases) Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <95% ER if 2 mths Red	New Indicator	96%	96%	96%	96%	97%	96%	96%	97%	96%	97%	97%	97%	96%	97%	97%	96%	97%*
	C2	A&E Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <94% ER if 2 mths Red	New Indicator	96%	96%	96%	96%	97%	96%	96%	96%	96%	97%	95%	95%	97%	95%	97%	97%	97%*
	C3	Outpatients Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <90% ER if 2 mths Red	NEW METHODOLOGY FOR CALCULATING %						94%	94%	93%	91%	93%	93%	93%	92%	94%	95%	95%	95%*
	C4	Daycase Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <95% ER if 2 mths Red							96%	97%	97%	98%	98%	97%	98%	98%	98%	98%	98%	98%*
	C5	Maternity Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <94% ER if 2 mths Red		96%	95%	97%	96%	96%	95%	96%	95%	95%	96%	95%	95%	95%	94%	95%	95%	95%*
	C6	Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment	LT	LT	Not within Lowest Decile	TDA	TBC	New Indicator	69.2%	Q3 staff FFT not completed as National	71.4%			68.7%			71.9%			Q3 staff FFT not completed as National Survey carried out					70.3%
	C7a	Complaints Rate per 1000 bed days	AF	MD	TBC	UHL	TBC	New Indicator	0.4	0.3	0.3	0.3	0.4	2.8	2.8	3.3	2.9	3.0	3.1	2.7	2.6	1.8	2.0	3.1	2.7
	C7b	Written Complaints Received Rate per 100 bed days	AF	MD	Not within Highest Decile	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	
	C8	Complaints Re-Opened Rate	AF	MD	<=12%	UHL	Red if >=15% ER if >=15%	New Indicator	10%	10%	17%	13%	11%	13%	6%	7%	7%	11%	12%	7%	8%	15%	7%	10%	9%
	C9	Single Sex Accommodation Breaches (patients affected)	JS	HL	0	TDA	Red / ER if >0	2	13	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1

* QTR 4 performance

Safe | Caring | Well Led | Effective | Responsive | Research

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Well Led

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	Dec-14	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	YTD
W1	Inpatients Friends and Family Test - Coverage (Adults and Children)	JS	HL	30%	TDA	Red if <26% ER if 2mths Red	NEW METHODOLOGY FOR CALCULATING 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%	30.8%
W2	Daycase Friends and Family Test - Coverage (Adults and Children)	JS	HL	20%	TDA	Red if <8% ER if 2 mths Red	NEW METHODOLOGY FOR CALCULATING 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%	22.3%
W3	A&E Friends and Family Test - Coverage	JS	HL	20%	TDA	Red if <10% ER if 2 mths Red	NEW METHODOLOGY FOR CALCULATING 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%	11.0%
W4	Outpatients Friends and Family Test - Coverage	JS	HL	Q1 3% Q2/3 4% Q4 5%	UHL	Red if <2.5% ER Qtrly	NEW METHODOLOGY FOR CALCULATING 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%	1.4%
W5	Maternity Friends and Family Test - Coverage	JS	HL	30%	UHL	Red if <26% ER if 2 mths Red	25.2%	28.0%	22.1%	25.8%	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%	31.6%
W6	Friends & Family staff survey: % of staff who would recommend the trust as place to work	LT	BK	Not within Lowest Decile	TDA	TBC	New Indicator	54.2%	Q3 staff FFT not complete	54.9%			52.5%			55.7%			Q3 staff FFT not completed as National Survey carried out					54.0%
W7a	Nursing Vacancies	JS	MM	5% by Mar 16	UHL	Separate report submitted to QAC	NEW UHL INDICATOR		6.0%	6.3%	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%	6.8%
W7b	Nursing Vacancies in ESM CMG	JS	MM	5% by Mar 16	UHL	Separate report submitted to QAC	NEW UHL INDICATOR		9.7%	12.8%	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%	17.2%
W8	Turnover Rate	LT	LG	Not within Lowest Decile	TDA	Red = 11% or above ER = Red for 3 Consecutive Mths	10.0%	11.5%	10.3%	10.1%	10.1%	11.5%	10.2%	10.4%	10.5%	10.5%	10.6%	10.4%	10.4%	10.2%	9.9%	10.0%	10.1%	10.0%
W9	Sickness absence	LT	KK	3%	UHL	Red if >4% ER if 3 consecutive mths >4.0%	3.4%	3.8%	4.4%	4.2%	4.1%	4.0%	3.6%	3.4%	3.5%	3.3%	3.2%	3.3%	3.5%	3.8%	4.0%	4.1%		3.6%
W10	Temporary costs and overtime as a % of total paybill	LT	LG	TBC	TDA	TBC	New Indicator	9.4%	9.8%	10.5%	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%	10.4%
W11	% of Staff with Annual Appraisal	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	91.3%	91.4%	92.5%	90.9%	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%	91.6%
W12	Statutory and Mandatory Training	LT	BK	95%	UHL	TBC	76%	95%	89%	89%	90%	95%	93%	92%	92%	91%	91%	91%	92%	92%	93%	93%	92%	92%
W13	% Corporate Induction attendance	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	94.5%	100%	100%	99%	100%	97%	97%	97%	98%	100%	97%	98%	98%	97%	92%	96%	98%	97%
W14a	DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	Not within Lowest Decile	TDA	TBC	New Indicator	91.2%	92.7%	94.3%	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%	90.5%
W14b	DAY Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	Not within Lowest Decile	TDA	TBC		94.0%	95.8%	95.4%	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%	92.3%
W14c	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	Not within Lowest Decile	TDA	TBC		94.9%	96.4%	97.9%	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%	95.3%
W14d	NIGHT Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	Not within Lowest Decile	TDA	TBC		99.8%	101.4%	103.6%	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%	99.3%

Effective

KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Dec-14	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	YTD
E1	Mortality - Published SHMI	AF	PR	Within Expected	TDA	Higher than Expected	105	103	105 (Apr13-Mar14)	105 (Jul13-Jun14)			103 (Oct13-Sep14)			99 (Jan14-Dec 14)			98 (Apr14-Mar15)			95 (Jul14-Jun15)		95
E2	Mortality - Rolling 12 mths SHMI (as reported in HED) Rebased	AF	PR	Within Expected	QC	Red if >expected ER if >Expected or 3 consecutive mths increasing SHMI >100	105	98	99	99	98	98	98	96	96	95	96	95	96	96	Awaiting HED Update			96
E3	Mortality HSMR (DFI Quarterly)	AF	PR	Within Expected	TDA	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	88	94	93	93			90			86			Awaiting DFI Update					88
E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	AF	PR	Within Expected	QC	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	99	94	94	95	95	94	94	94	93	93	93	93	94	95	95	Awaiting HED Update		95
E5	Mortality - Monthly HSMR (Rebased Monthly as reported in HED)	AF	PR	Within Expected	QC	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	91	94	95	99	98	86	83	96	99	84	93	101	106	96	94	Awaiting HED Update		95
E6	Mortality - HSMR ALL Weekend Admissions - (DFI Quarterly)	AF	PR	Within Expected	QC	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	96	100	96	106			98			83			Awaiting DFI Update					90
E7	Crude Mortality Rate Emergency Spells	AF	PR	Within Upper Decile	TDA	TBC	2.5%	2.4%	3.0%	3.1%	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%	2.2%
E8	Deaths in low risk conditions (Risk Score)	AF	PR	Within Expected	TDA	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	94	80	84	100	86	74	121	20	38	38	103	95	96	Awaiting DFI Update				73
E9	Emergency readmissions within 30 days following an elective or emergency spell	AF	JJ	Within Expected	UHL	Red if >7% ER if 3 consecutive mths >7%	7.9%	8.5%	9.1%	8.2%	8.5%	8.5%	9.1%	9.1%	9.0%	8.8%	8.9%	8.7%	9.0%	8.3%	9.2%	8.8%		8.9%
E10	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	AF	RP	72% or above	QS	Red if <72% ER if 2 consecutive mths <72%	65.2%	61.4%	57.3%	57.9%	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%	63.7%
E11	Stroke - 90% of Stay on a Stroke Unit	RM	IL	80% or above	QS	Red if <80% ER if 2 consecutive mths <80%	83.2%	81.3%	74.3%	82.5%	87.6%	81.5%	83.7%	84.5%	84.5%	85.7%	90.9%	86.9%	81.1%	83.5%	86.0%	92.0%		85.9%
E12	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%	64.2%	71.2%	83.5%	80.6%	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%	76.5%
E13	Published Consultant Level Outcomes	AF	SH	>0 outside expected	QC	Red if >0 Quarterly ER if >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
E14	Non compliance with 14/15 published NICE guidance	AF	SH	0	QC	Red if in mth >0 ER if 2 consecutive mths Red	New Indicator for 14/15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
E15	ROSC in Utstein Group	AF	PR	TBC	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	
E16	STEMI 150minutes	AF	PR	TBC	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	

Safe | Caring | Well Led | Effective | **Responsive** | Research

Responsive

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	Dec-14	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	YTD
R1	ED 4 Hour Waits UHL + UCC (Calendar Month)	RM	IL	95% or above	TDA	Red if <92% ER via ED TB report	88.4%	89.1%	83.0%	90.7%	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%	87.8%
R2	12 hour trolley waits in A&E	RM	IL	0	TDA	Red if >0 ER via ED TB report	5	4	0	1	0	0	0	0	0	0	0	0	0	1	1	0	0	2
R3	RTT - Incomplete 92% in 18 Weeks	RM	WM	92% or above	TDA	Red /ER if <92%	92.1%	96.7%	95.1%	95.2%	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%	93.2%
R4	RTT 52 Weeks+ Wait (Incompletes)	RM	WM	0	TDA	Red /ER if >0	0	0	0	0	0	0	0	66	242	256	258	260	265	263	267	269	261	261
R5	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	TDA	Red /ER if >1%	1.9%	0.9%	2.2%	5.0%	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%	1.8%
R6	Urgent Operations Cancelled Twice	RM	PW	0	TDA	Red if >0 ER if >0	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	TDA	Red if >2 ER if >0	85	33	3	4	3	1	2	0	1	1	5	1	0	3	6	6	10	35
R8	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	RM	PW	0	TDA	Red if >2 ER if >0	New Indicator for 14/15	11	1	2	1	0	0	0	1	0	0	0	0	0	0	0	0	1
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%	1.6%	0.9%	1.1%	0.8%	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%	1.0%
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%	1.6%	0.9%	0.8%	1.4%	0.0%	0.4%	1.2%	1.2%	1.0%	0.8%	--	1.0%	1.1%	--	1.1%	2.2%	0.2%	0.9%
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%	New Indicator for 14/15	0.9%	1.1%	0.8%	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%	1.0%
R12	No of Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	N/A	UHL	TBC	1739	1071	102	85	64	98	79	56	97	138	67	104	91	131	115	146	119	1143
R13	Outpatient Hospital Cancellation Rates	RM	PW	Within Upper Decile	UHL	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	
R14	Delayed transfers of care	RM	PW	3.5% or below	TDA	Red if >3.5% ER if Red for 3 consecutive mths	4.1%	3.9%	3.9%	3.2%	2.9%	1.8%	1.2%	1.0%	1.0%	0.9%	1.2%	1.3%	1.1%	1.5%	1.6%	1.8%	1.8%	1.3%
R15	NHS e-Referral (formally Choose and Book Slot Unavailability)	RM	WM	4% or below	Contract	Red if >4% ER if Red for 3 consecutive mths	13%	21%	16%	13%	19%	26%	34%	31%	Data Not Available									
R16	Ambulance Handover >60 Mins (CAD+ from June 15)	RM	PW	0	Contract	Red if >0 ER if Red for 3 consecutive mths	New Indicator for 14/15	5%	10%	6%	11%	9%	6%	7%	7%	8%	9%	18%	22%	27%	16%	12%	10%	13%
R17	Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)	RM	PW	0	Contract	Red if >0 ER if Red for 3 consecutive mths	New Indicator for 14/15	19%	25%	21%	21%	22%	22%	21%	17%	17%	17%	25%	26%	26%	23%	13%	13%	20%

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	Dec-14	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	YTD
** 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	TDA	Red if <93% ER if Red for 2 consecutive mths	94.8%	92.2%	93.0%	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%	**	89.9%
RC2	Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	RM	MM	93% or above	TDA	Red if <93% ER if Red for 2 consecutive mths	94.0%	94.1%	93.0%	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%	**	94.3%
RC3	31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	RM	MM	96% or above	TDA	Red if <96% ER if Red for 2 consecutive mths	98.1%	94.6%	95.2%	91.7%	95.0%	97.0%	93.9%	97.9%	93.7%	97.2%	96.5%	94.7%	95.2%	95.6%	94.3%	91.4%	**	95.1%
RC4	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	RM	MM	98% or above	TDA	Red if <98% ER if Red for 2 consecutive mths	100.0%	99.4%	96.7%	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%	**	99.6%
RC5	31-Day Wait For Second Or Subsequent Treatment: Surgery	RM	MM	94% or above	TDA	Red if <94% ER if Red for 2 consecutive mths	96.0%	89.0%	80.3%	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%	**	86.4%
RC6	31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	RM	MM	94% or above	TDA	Red if <94% ER if Red for 2 consecutive mths	98.2%	96.1%	95.5%	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%	**	94.9%
RC7	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	RM	MM	85% or above	TDA	Red if <85% ER if Red in mth or YTD	86.7%	81.4%	84.8%	79.3%	78.9%	83.8%	75.7%	70.1%	84.2%	73.7%	81.7%	77.2%	77.0%	82.5%	80.9%	75.2%	**	77.9%
RC8	62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	RM	MM	90% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	95.6%	84.5%	93.8%	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%	**	91.1%
RC9	Cancer waiting 104 days	RM	MM	0	TDA	TBC	NEW TDA INDICATOR						12	10	12	20	12	12	17	13	23	23	17	17

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	Dec-14	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	Jan-16	YTD
RC10	Brain/Central Nervous System	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	100.0%	--	--	--	--	--	--	100.0%	--	--	--	--	--	--	--	--	**	100.0%
RC11	Breast	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	96.1%	92.6%	100.0%	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%	**	95.3%
RC12	Gynaecological	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	88.2%	77.5%	66.7%	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%	**	73.1%
RC13	Haematological	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	65.9%	66.5%	75.0%	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%	**	63.5%
RC14	Head and Neck	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	65.4%	69.9%	77.8%	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%	**	54.3%
RC15	Lower Gastrointestinal Cancer	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	71.3%	63.7%	92.9%	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%	**	63.1%
RC16	Lung	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	89.7%	69.9%	74.4%	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%	**	72.9%
RC17	Other	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	78.7%	95.0%	100.0%	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	TDA	Red if <90% ER if Red for 2 consecutive mths	82.9%	46.2%	0.0%	100.0%	--	0.0%	66.7%	--	100%	--	--	80.0%	50.0%	--	--	--	**	75.0%
RC19	Skin	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	96.8%	96.7%	94.1%	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%	**	94.1%
RC20	Upper Gastrointestinal Cancer	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	72.2%	73.9%	68.0%	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%	**	63.9%
RC21	Urological (excluding testicular)	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	89.3%	82.6%	85.7%	83.3%	66.7%	71.0%	62.1%	62.1%	74.7%	61.5%	86.1%	80.4%	80.0%	76.7%	75.0%	68.1%	**	73.2%
RC22	Rare Cancers	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	92.3%	84.6%	100.0%	100.0%	66.7%	100.0%	--	100%	100%	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	**	100.0%
RC23	Grand Total	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	86.7%	81.4%	84.8%	79.3%	78.9%	83.7%	75.7%	70.1%	84.2%	73.7%	81.7%	77.2%	77.0%	82.5%	80.9%	75.2%	**	77.9%

Compliance Forecast for Key Responsive Indicators

Standard	February actual/predicted	March predicted	Month by which to be compliant	RAG rating of required month delivery	Commentary
Emergency Care					
4+ hr Wait (95%) - Calendar month	80.2%				Unvalidated figure.
Ambulance Handover (CAD+)					
% Ambulance Handover >60 Mins (CAD+)	10%		Not Confirmed		CAD+ performance from EMAS monthly report.
% Ambulance Handover >30 Mins and <60 mins (CAD+)	13%		Not Confirmed		
RTT (inc Alliance)					
Incomplete (92%)	93.2%	93.0%			
Diagnostic (predicted)					
DM01 - diagnostics 6+ week waits (<1%)	1.8%	< 1%	Mar-16		Performance improving each month with compliance by March.
# Neck of femurs					
% operated on within 36hrs - admissions (72%)	65%	65%			Missing target due to high number of medically unfit patients.
Cancelled Ops (inc Alliance)					
Cancelled Ops (0.8%)	1.3%	1.1%	Apr-16		Target missed due to emergency pressures.
Not Rebooked within 28 days (0 patients)	9	8	May-16		Target missed due to emergency pressures.
Cancer (predicted)					
Two Week Wait (93%)	94%	93%	Feb-16		Achieved February.
31 Day First Treatment (96%)	92%	91%	May-16		
31 Day Subsequent Surgery Treatment (94%)	75%	72%	May-16		
62 Days (85%)	75%	75%	Sep-16		Backlog 61 as at 11th March.
Cancer waiting 104 days (0 patients)	17	13			

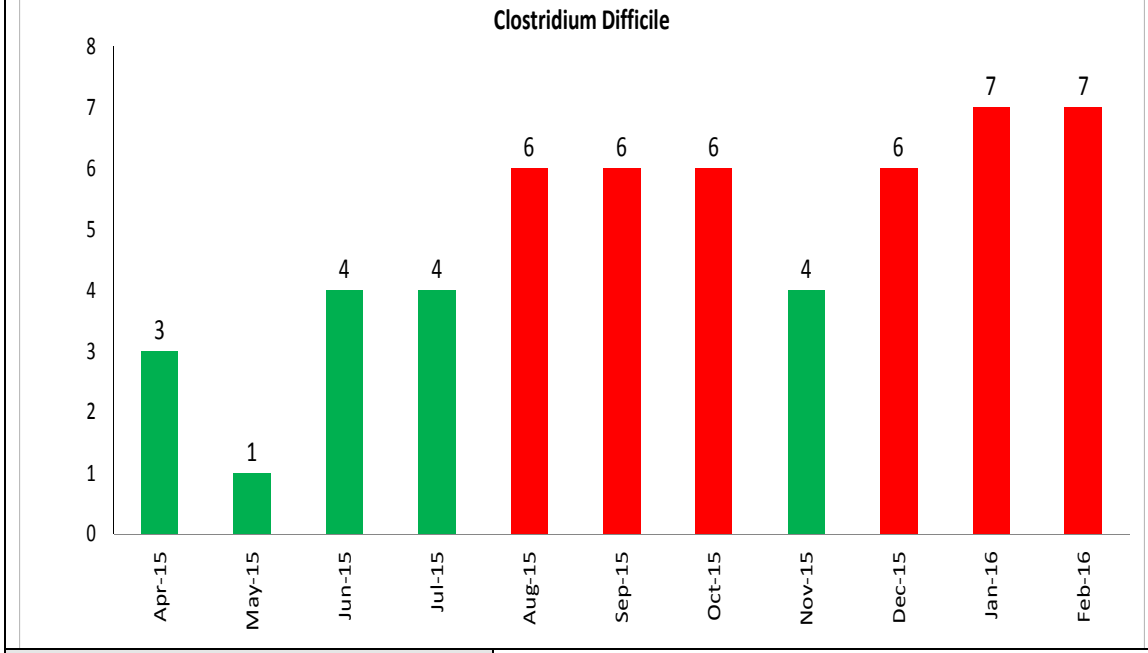
Research UHL

KPI Ref	Indicators	Board Director	Lead Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	YTD
RU1	Median Days from submission to Trust approval (Portfolio)	AF	NB	TBC	TBC	TBC	3.0		2.0			3.0			3.0			2.8	2.0			1.0			2.0			1.0
RU2	Median Days from submission to Trust approval (Non Portfolio)	AF	NB	TBC	TBC	TBC	2.0		3.5			2.0			1.0			2.1	4.0			1.0			1.0			1.0
RU3	Recruitment to Portfolio Studies	AF	NB	Aspirational target=10920/year (910/month)	TBC	TBC	1092	963	1075	1235	900	1039	1048	604	1030	1043	1298	12564	1078	869	1165	999	862	1004	1368	1306		8651
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%			(Apr14-Mar15) 86%				(Jul14-Jun15) 76%			(Oct14-Sep15) 92%						92%
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			(Apr14-Mar15) Rank 60/198				(Jul14-Jun15) Rank 108/210			(Oct14-Sep15) Rank 13/215						Rank 13/215
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%			(Apr14-Mar15) 38.6%				(Jul14-Jun15) 15.3%			(Oct14-Sep15) 46.8%						46.8%

Clostridium Difficile

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
There was a seasonal increase in Norovirus during February, as would be expected as normal seasonal activity. Several of the samples which proved to be positive for CDT were also Norovirus positive, and this was the true cause of diarrhoea. These patients have been reviewed by the MDT who did not feel infection markers were consistent with CDI. We are within the annual trajectory, and no performance issues have been identified.	Action not required.	**5**	**7**	**54**	Not yet agreed

	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
Trajectory 15/16	5	5	5	5	5	5	5	5	5	6	5	5	61
Actual Infections 15/16	3	1	4	4	6	6	6	4	6	7	7		54



Expected date to meet monthly target	March 2016
Lead Director / Lead Officer	Julie Smith, Chief Nurse Liz Collins, Lead Nurse Infection Prevention

Avoidable Pressure Ulcers – Grade 4

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
		0	1	1	0

There has been one reported avoidable Grade 4 pressure ulcer. Locally this is classed as a local never event.

The cause of this incident is subject to a serious incident investigation, initial factors which are believed to have contributed to the incident, are

- poor handover between different clinical areas where the patient was moved to
- infrequent changing of position
- inaccurate risk assessment

The case is subject to a serious incident review, which will require a contribution from 3 CMGs.

Initial findings and themes have been shared with nursing executive members, and raising awareness about the requirement to fully reassess and review previous hospital records, has taken place. Especially if a patient is subject to multiple ward moves.

The full report will be shared with members of the nursing executive group.

This incident has been classed as a local never event, because the overall trend is to not have any grade 4 pressure ulcers.

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	YTD
Avoidable Pressure Ulcers - Grade 4	0	0	0	0	0	0	0	0	0	0	1	1
Avoidable Pressure Ulcers - Grade 3	3	0	4	1	4	1	1	1	5	6	2	28
Avoidable Pressure Ulcers - Grade 2	10	8	8	8	10	11	5	4	5	5	8	82

Expected date to meet monthly target	March 2016
Lead Director / Lead Officer	Julie Smith, Chief Nurse Michael Clayton, Head of Safe

Single Sex Accommodation Breaches (patients affected)

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	February	YTD performance	Forecast performance for next reporting period
Same-Sex Accommodation Matrix indicates that all patients should be cared for in single sex facilities. Patients requiring level two care and above are exempt. During February 2016, a female patient was stepped down from level two care but remained in a HDU facility with other level two patients. As the HDU facility had male and female patients all receiving level two and above care, this level one patient was considered a breach. The patient was not moved out of the HDU facility in a timely manner due to inadequate communication and escalation to senior managers or duty managers. As the correct escalation process was not followed the Trust has declared this a non-clinically justified breach.	Ward staff have been reminded of the Same-Sex Accommodation Matrix and expected future actions. Staff have been encouraged to identify early patients who are recovering and therefore may be not need level two care for a prolonged period of time, so plans can be put in place to reallocate them. Information has been displayed in the staff areas on informing staff of the correct process to follow in the event of another Same-Sex Accommodation breach. Information from this event has been shared with Ward Sisters, Matrons and Heads of Nursing across the Trust.	0	1 Breach and 1 person affected	1 Breach and 1 person affected	0
		Expected date to meet standard / target		March 2016	
		Revised date to meet standard			
		Lead Director / Lead Officer		Julie Smith, Chief Nurse Heather Leatham, Assistant Chief Nurse	

A&E Friends & Family Test - Coverage

QUALITY COMMITMENT WORK STREAM: To improve patients and their carers experience of care

QUALITY COMMITMENT PILLAR: Experience

KEY PERFORMANCE INDICATORS:

- Emergency department to achieve a minimal target of 20% submission levels of eligible population

REPORTING PERIOD: February 2016

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest performance	YTD performance	Forecast performance for next reporting period
The Emergency Department has 6 areas included in the overall footfall. Majors, Minors, Children's ED, EDU, Eye Casualty and since December 2015 the Urgent Care Centre has also been included. There has been a decrease in the submission levels of surveys in areas within the ED, however the levels of eligible patients due to the UCC being included has increased the minimal weekly target by nearly 300 surveys. The last few months have been increasingly busy in the emergency department resulting in the clinical teams focus being upon safety priorities. This has potentially shifted the focus of the staff and has resulted in a reduction of the collection and submission of surveys.	The senior Nursing team are aware of the reduction of collection and submission levels. Meetings have been held with the Matron team and the Head of service within the ED, there are plans in place to improve the collection and submission of surveys in all areas.	**20%**	**5.1%**	**11%**	**20%**

CURRENT RAG RATING:

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
ED - Majors	*13.0%*	*8.2%*	*3.7%*	*2.3%*	*1.7%*
ED - Minors	*9.5%*	*6.2%*	*3.5%*	*4.4%*	*4.0%*
Children's ED	*17.8%*	*13.2%*	*5.0%*	*14.2%*	*9.2%*
EDU	*22.2%*	*16.2%*	*10.3%*	*25.5%*	*20.7%*
UCC	-	-	*1.3%*	*0.7%*	*0.5%*
Main Ed	***15.1%***	***10.8%***	***3.5%***	***5.6%***	***4.4%***
Eye Casualty	*20.8%*	*20.7%*	*21.5%*	*20.9%*	*11.4%*
ED total	***16.1%***	***12.4%***	***5.4%***	***7.3%***	***5.1%***

Expected date to meet standard / target	End March 2016
Lead Director / Lead Officer	Julie Smith, Chief Nurse / Heather Leatham Assistant Chief Nurse

REPORT BY: Heather Leatham, Assistant Chief Nurse

DATE: 16/3/16

Emergency Readmissions within 30 days

What is causing underperformance?	What actions have been taken to improve performance?	Target	January performance	YTD performance	Forecast performance for next reporting period
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.	In January 2016, following some early teething problems, we commenced a 3-month pilot of the Readmissions Risk Tool (PARR30). The pilot is taking place across all adult in-patient areas (excluding maternity). A daily report has been set up which identifies patients with more than a 45% risk of readmission. Where possible, these patients are reviewed by one of the Specialist Discharge Sisters or Primary Care co-ordinators, the aim being to ensure patients have been given relevant advice on actions to prevent risk of readmission post discharge. Patients are from Leicester City CCG have been referred to the Re-ablement Team in the City (ICRS) for post discharge checks to ensure that packages of care are in place, equipment has been delivered, medication compliance, etc. Discussions are being held with Re-ablement Teams in the County and Rutland about their involvement in the pilot. Now that the reporting process has been embedded, one of the next steps will be to highlight the risk of readmission as part of the discharge communication to patients' GPs so they can look at the appropriateness of review and care planning. Work has also commenced between Urology and the District Nursing Team in the Leicestershire Partnership Trust, to look at the urinary catheter care pathway in the community as problems with urinary catheters is one of the top 10 patient groups for readmissions.	**Within Expected**	**8.8%**	**8.9%**	**9.0%**

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

Trust	Discharges	Readmisisons	Rate (%)	Relative Risk
University College London Hospitals NHS Foundation Trust	67031	3633	5.44	84.78
Hull and East Yorkshire Hospitals NHS Trust	62118	4390	7.09	93.62
Central Manchester University Hospitals NHS Foundation Trust	74448	5008	6.76	93.9
King's College Hospital NHS Foundation Trust	85257	5763	6.78	94.1
Leeds Teaching Hospitals NHS Trust	79932	6279	7.87	96.1
Barts Health NHS Trust	96132	7809	8.28	96.68
United Lincolnshire Hospitals NHS Trust	61280	4632	7.58	97.13
Norfolk and Norwich University Hospitals NHS Foundation Trust	75421	5219	6.94	97.42
Nottingham University Hospitals NHS Trust	86621	7524	8.73	99.95
Imperial College Healthcare NHS Trust	80227	5979	7.54	100.08
Pennine Acute Hospitals NHS Trust	79487	6792	8.57	101.77
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	91470	7023	7.69	102.71
Oxford University Hospitals NHS Foundation Trust	81777	6180	7.61	104.42
University Hospitals Of Leicester NHS Trust	103959	9045	8.76	107.5
University Hospitals Of North Midlands NHS Trust	83131	7652	9.3	107.96
East Kent Hospitals University NHS Foundation Trust	76537	6704	8.79	110.47
Sheffield Teaching Hospitals NHS Foundation Trust	93775	8109	8.66	112.18
Heart Of England NHS Foundation Trust	98526	9506	9.66	112.6

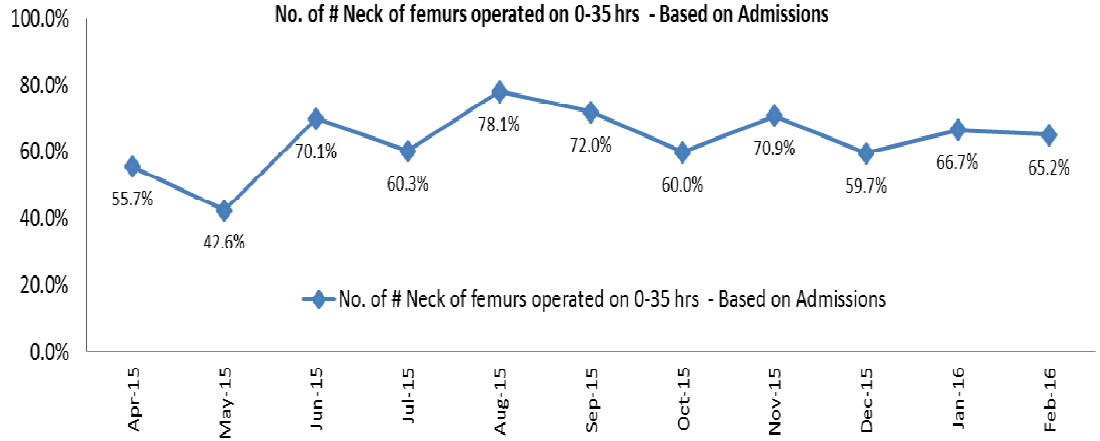
Expected date to meet standard / target	TBC - following implementation of actions.
Lead Director / Lead Officer	Andrew Furlong, Interim Medical Director John Jameson, Interim Deputy Medical Director

No. of # Neck of femurs operated on < 36 hrs

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance FY 15/16	Forecast performance for next reporting period
Februarys performance:- Causes of breaches were – 12pts clinically unfit Pt needed THR – 4pts Theatre capacity weekday – 4pts Theatre capacity weekend – 1 pt Pts who did not have surgical intervention – 3pts. . February had 4 occasions where high numbers of NOF patients were admitted on one day. As can be seen these were on consecutive days on 3 of those occasions. Giving a total of 16 NOF pts over 3 days. 24th Feb - 5 NOF's 26th Feb – 5 NOF's 27th Feb – 6 NOF's 28th Feb – 5 NOF's This admission clustering was the primary factor in this month's performance. These patients were frail and vulnerable on admission and required clinical stabilisation. Once clinically fit theatres capacity was an issue. Ortho Geriatrician services stretched to capacity and no backfill when pulled to medicine.	It has been agreed that #NOF will be supported corporately by the Director of Performance and Information. The Chief Resident / Trauma schedulers/Clinical aides are now all in post. Additional anaesthetic PA's have been scheduled to provide pre op assessment. New prioritisation pathways and check lists have been implemented. Discussion with HOS anaesthesia regarding weekend list capacity. Theatre utilisation is being tracked monthly to optimise usage and reduce downtime between cases. Rose via CMG board OG cover and gaps in service.	**72.0%**	**65.2%**	**63.7%**	**68% due to pts frailty**

Performance by Month for 15/16

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	YTD
No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	55.7%	42.6%	70.1%	60.3%	78.1%	72.0%	60.0%	70.9%	59.7%	66.7%	65.2%	63.7%



Expected date to meet standard / target	December 2015
Revised date to meet standard	TBC
Lead Director / Lead Officer	Richard Power, MSS CD Sarah Taylor, Head of Operations

52 week breaches (incompletes)

<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>February performance</th><th>YTD performance</th><th>Forecast performance for next period</th></tr>
<tr><td rowspan="4">The Trust had 261 patients on an incomplete pathway breaching 52 weeks at the end of February. 260 patients were from the Orthodontics Department and one patient was from General Surgery.

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.
The General Surgery breach occurred because the service did not follow the reasonableness policy. The patient was offered two short notice dates, which he then cancelled. He cancelled the third (reasonable) date and at this point stated he needed 4-6 weeks' notice for work, taking him beyond 52 weeks. He was dated for 1st March 2016 (patient choice), but this TCI was then cancelled by the hospital because the patient did not attend two pre-assessment appointments. He is now re-dated for 26th April 2016.</td><td rowspan="4">Orthodontics
The Orthodontics service is now closed to new referrals with some clinical exceptions.
NHS England has agreed funding for 2 WTE locums to clear the backlog. So far, recruitment has been unsuccessful.
The SUI report was published in October 2015. Recommendations included a clearly defined SOP for the administration of planned waiting lists and that all administrative and clinical staff running outpatient clinics should have RTT training.
Resolution to this ongoing problem is being led by the Chief Executive, NHSE and the TDA.
A regional Orthodontic Capacity Meeting on 22nd February identified capacity for 80 patients across other NHS providers in the Midlands, including Northampton, NUH and ULHT; however when taking into account those patients identified as suitable for treatment in a community provider, this still leaves a capacity gap of 102. The Trust continues to explore further options within other providers to ensure these patients are treated.
General Surgery
Recommendations from the breach report identifies RTT refresher training for the waiting list team, to highlight the importance of booking patients from the PTL in date order and better insight into the reasonableness policy.</td><td>0</td><td>261</td><td>261</td><td>TBC</td></tr>
<tr><td colspan="4">The problem which surfaced in Orthodontics has 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 Richard Mitchell;
Weekly review at Heads of Operations meeting for assurance;
Performance team to review all waiting list code returns and identify areas of risk.
Looking forward
There will be a small number of incomplete breaches at the end of March across ENT and General Surgery as a result of administrative errors and the impact of emergency pressures.</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">TBC</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Richard Mitchell, Chief Operating Officer
Will Monaghan, Director of Performance and Information</td></tr>
</table>

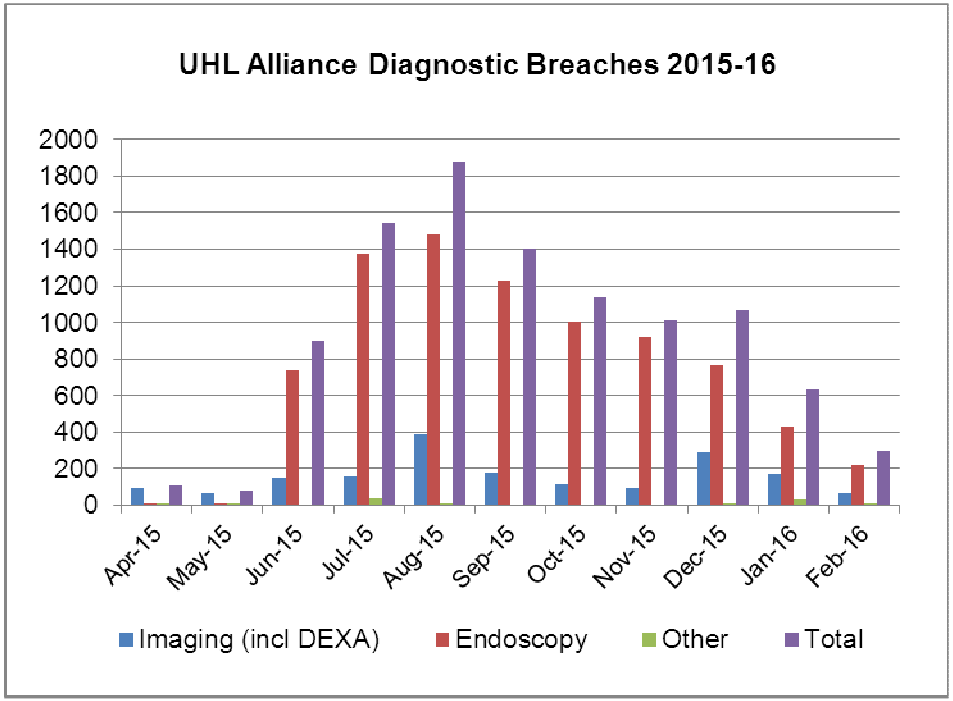
6 Week Diagnostic Test Waiting Times

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>Latest month performance (UHL Alliance)</th><th>YTD performance (UHL Alliance)</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="3">Imaging
For February 2016, across UHL and the Alliance there were 3 CT, 66 MRI and 7 ultrasound breaches. This marks significant improvement from the end of January, when there were 173 Imaging breaches.

Endoscopy
An issue with planned waiting lists in Endoscopy surfaced in May 2015. There were 221 breaches at the end of February across flexible sigmoidoscopy, gastroscopy and colonoscopy, an improvement of 208 from the January position. Capacity and demand review in Endoscopy has identified that the Trust is short of approximately 8-10 lists per week.</td><td rowspan="3">The diagnostic backlog has more than halved from the end of January position.

Imaging
Machine stability remains an issue; all extra capacity is being utilised in MRI to minimise the number of breaches. An MRI van was on site for nine days in February, extra sessions were been arranged and some outpatient sessions ran up to midnight.

Endoscopy
The Trust is working with independent sector providers to obtain extra capacity, including Medinet, Your World Doctors, Fully Staffed and the Alliance. Your World Doctors are also backfilling lists during the week, which would otherwise be cancelled.

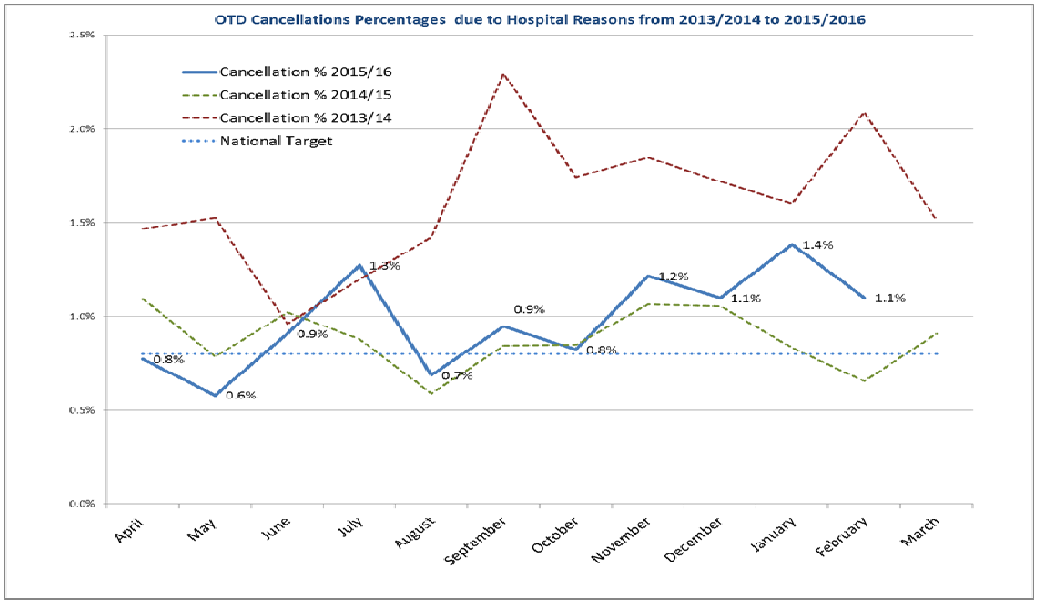
The extra capacity is complemented by a robust action plan addressing general performance issues in the service, with particular focus on ensuring that all lists are fully booked and efforts to improve cancer performance via access to Endoscopy tests. The Trust invited the IST to assist with capacity analysis; this has confirmed the shortfall that exists. In addition NHSIQ have been working in the endoscopy units alongside our teams on process improvements.</td><td><1%</td><td>1.84%</td><td>1.84%</td><td><1%</td></tr>
<tr><td colspan="4">The following graph outlines the total number of diagnostic breaches per month for 15-16:
 

The Trust is confident that the overall diagnostic position will be recovered in March 2016.</td></tr>
<tr><td colspan="4"><table>
<tr><td>Expected date to meet standard / target</td><td>March 2016</td></tr>
<tr><td>Lead Director / Lead Officer</td><td>Richard Mitchell, Chief Operating Officer
Suzanne Khalid, Clinical Director CSI</td></tr>
</table></td></tr>
</table>

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 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 February 16	YTD performance (inc Alliance)	Forecast performance for next reporting period
During this month, 58% (68/117) of cancellations were cancelled due to capacity pressures. The five main reasons for cancellations in UHL were: Ward bed unavailability(43) Lack of theatre time due to list over runs (26) Critical care bed unavailability (15) Sickness of Surgeons and theatre staff (12) Patient delayed due to admission of a higher priority patient(10) This month increasing capacity pressures due to ward adult ward beds in LRI, and critical care beds impact on the cancellations. This was caused mainly by increase in emergency admissions. High amount of medical outliers in LRI on the Day ward and the ward 7 led to cancellations. The high outlier numbers, also led patient being cancelled the day before which led to an increase in 28 day breaches. Due to the adult ward bed pressures, it is likely that we will see around eight, 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 create significant risks to OTD cancellations and 28 day rebooking of patients. The Availability of beds, particularly those in ITU is monitored daily and interventions will be made where necessary. The planned opening of an additional 6 ITU beds at the LRI is anticipated before the end of March. Theatre Managers have increased theatre capacity for the increased cancer demand by making additional lists available and cancer cases are being prioritised. Theatre capacity planning for 2016/17 is well underway.	1) 0.8% 2) 0	1. 1.1%(1.2% UHL & 0.2% Alliance) 2. 9 (General Sur– 4, Ophthalmology – 2, Max fax 1, Urology 1,Vascular1)	1) 1.0% (1.0% - UHL & 0.9% Alliance) 2) 35	1) 1.1 % 2) 8



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

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

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

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

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

The specialties with the highest number of ASIs are:
• General Surgery;
• Orthopaedics;
• Paediatric and Adult ENT;
• Gastroenterology;
• Gynaecology.</td><td rowspan="4">Action plan
• An action plan has been written outlining steps for recovering performance. This has been shared with commissioners.

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

Training and Education
• Training and education of staff in key specialties continues, to ensure that the system is adequately set up and administrative processes are fit for purpose;
• Meetings are taking place with the specialties experiencing the highest rate of ASIs, focusing on awareness raising and seeking named accountability.
• Current focus is on working with specialties with no known capacity problems, but high ASI rates to raise awareness and promote accountability.

Additional resource to support the e-Referral System
• An ERS administrator has been in post since May;
• She will be working with key specialties to help reduce their ASIs and promote administrative housekeeping.</td><td><4%</td><td>Unable to report</td><td>Unable to report</td><td>No forecast as unable to measure</td></tr>
<tr><td colspan="4">As a result of the significant challenges experienced post-cut over from Choose and Book, the HSCIC have indicated that they will not be releasing weekly ASI data until further notice. A date for publication of these reports has not been confirmed. This means that the Trust is currently unable to track and report on progress in the usual manner.

New Appointment Slot Issue (ASI) Process
In light of the difficulties experienced by services in managing their ASIs on ERS, a new process is being rolled out across all specialties, following a pilot. This process aims to simplify the UHL administrative processes related to ERS as well as promote standardised practice.

Advice and Guidance (A&G)
The Advice and Guidance service within ERS allows a GP to seek clinical advice from a service rather than directly referring into the hospital. Analysis of the last year's A&G requests has found that in 84% of these cases, a referral into UHL is then avoided. This means that of the 460 requests made via A&G, only 68 patients required an outpatient appointment in that specialty. The ERS team is working with specialties including Orthopaedics, Rheumatology, Urology and Respiratory Medicine to expand the number of A&G services available, a local tariff has been agreed for this. A new A&G service for Renal, requested by GPs, went live on 14th January.</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="3">To be confirmed</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="3">Richard Mitchell, Chief Operating Officer
Will Monaghan, Director of Performance and Information</td></tr>
</table>

Ambulance handover > 30 minutes and>60 minutes

<table>
<tr><th colspan="2"></th><th>Target</th><th>Feb 16</th><th>YTD</th><th>Forecast</th></tr>
<tr><td>What is causing underperformance?</td><td>What actions have been taken to improve performance?</td><td>0 delays over 15 minutes</td><td>>60 min – 10 %

30-60 min – 13%</td><td>>60 min - 13%

30-60 min – 20%</td><td>> 60 min - 8%

30-60 min – 15%</td></tr>
<tr><td>Difficulties continue in accessing beds and high occupancy in ED leading to congestion in the assessment area and delays ambulance handover.</td><td>CCG's, EMAS and UHL have worked together to define a valid data set and have arranged a number of audits. They have agreed that patient numbers will be reported and not resources with regard to fines. UHL continue to validate reports and the results are made available weekly.

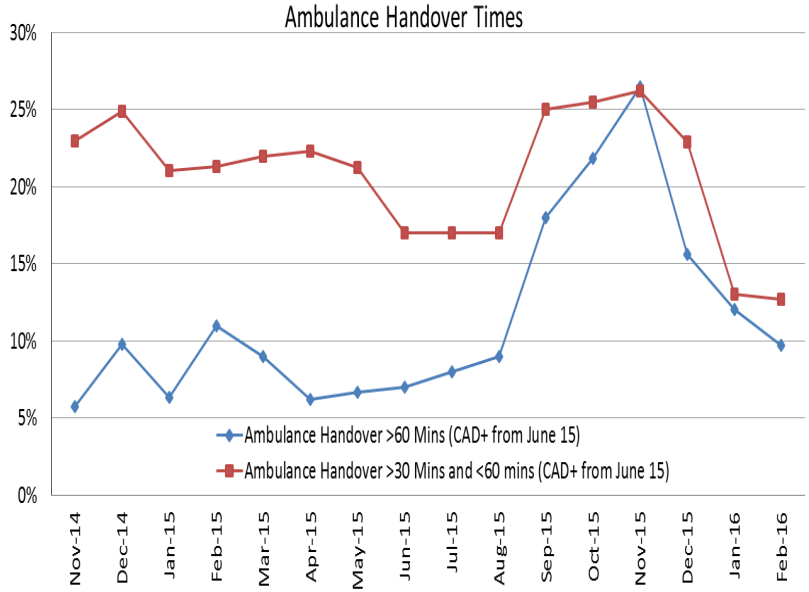
UHL currently are conducting an ad-hoc/weekly live full 24 hour Audit & Validation called Super-handover days within the Emergency Department. These days help us maintain improvement and also identify any further areas we can improve.

EMAS have provided further training on CAD+ for crews and this will continue.

UHL and EMAS are looking for staffing resource to care for patients in the red zones in ED to enable crews to be released earlier to improve handover times and working in collaboration with HALO. This is in conjunction with other recommendations from the Unipart report.

UHL have implemented a full capacity protocol for the use of areas outside ED when ED is full to enable crews to offload patients and handover.

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.

The escalation protocol to cohort patients has resulted in fewer delays with handover.</td><td colspan="4">Performance:
 

<table>
<tr><td>Expected date to meet standard</td><td>TBC</td></tr>
<tr><td>Revised date to meet standard</td><td>TBC</td></tr>
<tr><td>Lead Director</td><td>Richard Mitchell, Chief Operating Office</td></tr>
</table></td></tr>
</table>

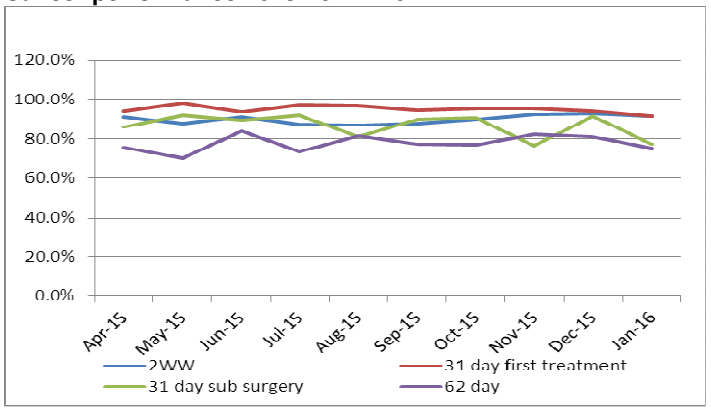
Cancer Waiting Times Performance

What is causing underperformance?	What actions have been taken to improve performance?
2 week wait UHL's performance in January 2016 was 91.4%. Non-compliance with the standard occurred as a result of dealing with a backlog of CT colons from the Christmas period. Predicted performance for February is 94% and continued compliance is expected going forward. **31 day first treatment** UHL's performance against this standard was 91.4%. This was predominantly failed as a result of Urology performance; the service has inadequate elective capacity and while RTT lists are regularly taken down to prioritise cancer patients, the service still had a high number of 31 day breaches in January. **31 day subsequent (surgery)** Performance against this standard in January was 77.5%. This significant dip in performance can be attributed to severe emergency pressures experienced at UHL throughout January, as well as known capacity gaps in both Urology and Gynae. **62 day RTT** 62 day performance remains below target at 75.2% in January. While momentum is growing with regards to backlog reduction, 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, Haematology and Skin. However, Gynae and Lower GI both treated a large number of backlog patients, which is reflected by their improved backlogs in recent weeks.	Current cancer performance is an area of significant concern across UHL and focus on recovery is one of the Trust's highest priorities. Since September, there have been weekly meetings chaired by the Chief Operating Officer, attended by the CMG Heads of Ops, where they are required to account for their tumour site performance. The Chief Operating Officer hosted a LiA event to focus on Cancer in November, which was very well attended by clinical and administrative/ management staff both internal and external to the Trust. Actions developed from the tablecloth exercise will be pulled into the Cancer RAP. The key message from this was the patient needed to leave every appointment knowing what the next step is and having it booked). The Trust has initiated a programme 'Next Steps' for cancer patients in 3 key tumour sites, this will start in April, initially with one tumour site to be rapidly rolled out to all three. **31 day first treatment** Recovery in Gynae and Urology are key to the achievement of this standard. Gynae and Urology both have a 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, 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. An additional Urology consultant started in February 2016. **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. Improvements in Endoscopy and CT colon implementation are starting to improve performance in Lower/ Upper GI. Three band 7 service managers with responsibility for managing cancer pathways in our worst performing tumour sites are all in post and are providing the key focus required. Weekly executive scrutiny of 62 day backlog reduction plans was initiated in September, led by the COO. 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.

Target (mthly / end of year)	Latest month performance January	Performance to date 2015/16	Forecast performance for February
2WW (Target: 93%)	**91.4%**	**89.9%**	**94%**
31 day 1st (Target: 96%)	**91.4%**	**95.1%**	**92%**
31 day sub – Surgery (Target: 94%)	**77.5%**	**86.4%**	**75%**
62 day RTT (Target: 85%)	**75.2%**	**77.9%**	**75%**
62 day screening (Target: 90%)	**77.3%**	**91.1%**	**80%**

UHL is planning for a growth of 11% in 2WW referrals during 2016-17 and a growth of 9% in patients treated with cancer.

Cancer performance 2015-16 M1-10



Expected date to meet standard / target	2WW: February 2016 62 day pathway: September 2016
Revised date to meet standard	31 day 1st treatment/ 31 day sub – Surgery: May 2016 (prev. March 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?

17 Cancer patients on the 62 day pathway breached 104 days at the end of February across six tumour sites.

Tumour site	Number of patients breaching 104 days
Lung	4
Lower GI	6
HPB	1
Skin	2
Head and Neck	3
Urology	1

The following factors have significantly contributed to delays:

Reason	No. patients
Endoscopy delays	2
Patient initiated delays	7
Patient fitness	4
Complex diagnostic pathway	2
LTFU patients (Lung)	3
Appointment delays	3
Change in treatment decision	1
Clinical reasons/ complexity	1

8 patients had a decision to treat; 9 patients did not have a decision to treat.

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. Since September, there have been weekly meetings chaired by the Chief Operating Officer, attended by the CMG Heads of Ops, where they are required to account for their tumour site performance.

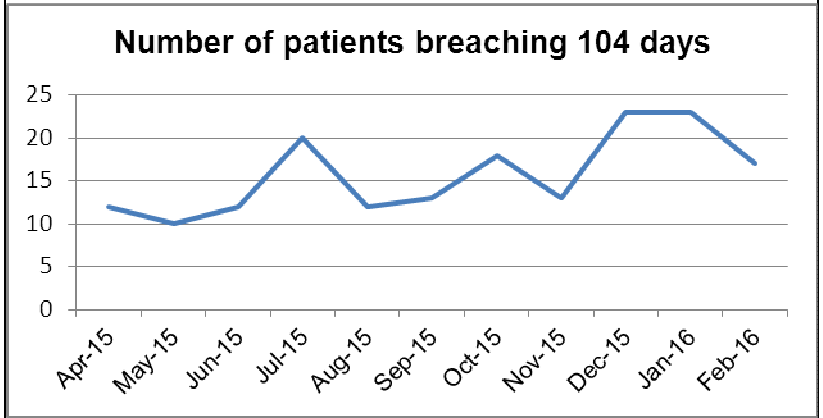
The number of patients breaching 104 days on a 62 day pathway has dropped by 6 from the end of January. This is in line with the reduction in the 62 day backlog.

Month by month breakdown of patients breaching 104 days

The table and graph below outline the number of Cancer patients breaching 104 days by month for 15-16:

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
12	10	12	20	12	12	17	13	23	23	17

NB: not all patients confirmed Cancer



NB: 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

QUALITY SCHEDULE AND CQUIN INDICATORS –PERFORMANCE AND RAGS FOR Q3 (where confirmed)

Schedule Ref	Indicator Title (brief)	Indicator Title and Detail	Q3	Commissioner's Comments on Q3 performance
		CCG QUALITY SCHEDULE		
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**	Q3 Thematic review of all Cdiff cases for Q1-3 received, including themes and actions. Catheter audit report received. The establishment of a 'Urinary Catheter and Continence Committee' in the context of the wider LLR healthcare economy to be discussed in CQRG. Jan 16 7 Cdiff cases reported for both Jan and Feb which is above monthly threshold but still within annual target.
PS02	HCAI Monitoring	Monitoring of MRSA against Zero tolerance.	**G**	0 MRSA bacteraemias
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.	**G**	Report received and reduction in moderate and major incidents seen. Details provided of themes of incidents and the actions which have been taken in response to them.
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 resulting in moderate, severe harm or death as per the conditions set out in the NHS Standard Contract (see SC35).	**A**	Q3 Whilst no breaches reported, the audit undertaken in Q2 identified a need to improve documentation of apology being offered. Jan/Feb 16 No breaches reported.
PS05	Complaints and user feedback Management	Management of Complaints (including re-opened and those referred to Ombudsman).	**G**	Complaints performance thresholds met. Actions in place provided following complaints split by CMG. Improvements in EOLC.
PS06	Risk Assurance	Risk register report. Central Alerting System Patient Safety Alerts / National Patient Safety Alerting System Alerts.	**G**	0 CAS alerts outstanding. All risks reviewed and actions on track.
PS07	Safeguarding	Demonstrate compliance with Local, Regional and National guidance	**tbc**	Below threshold for training in respect of MOGP,SAAF, PREVENT and MCA. Require further information evidence to be submitted - for review by CCG Safeguarding Lead
PS08	Reduction in Pressure Ulcer incidence.	Reducing "avoidable" Grade 2, 3 and 4 Hospital Acquired Pressure Ulcers	**G**	Incidents within thresholds with: 5 Grade 2's 6 Grade 3's 0 Grade 4 in Q3 Grade 4 to be reported for February 16
PS09	Medicines Management Optimisation	Demonstrate effective Medicines Optimisation processes and compliance with medicines management policies.	**tbc**	Improvements made in compliance made with Controlled Drugs Policy standard. For review at the April CQRG
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.	**A**	Reduction in medication errors reported in successive quarters. Information provided on actions being taken from moderate incidents, however no information provided on actions being taken to increase reporting.
PS11	Safety Thermometer	Provider collection and reporting of NHS Safety Thermometer data.	**G**	94.2% harm free care reported against the national average of 94.25%, - no areas of declining performance.
AS01	Cost Improvement Programme	Demonstrate quality assurance systems and processes are applied to all Cost Improvement Programmes	**A**	Further clarification required on the process being used to risk assess CIPs and the outcomes for programmes which may have potential risks on quality

Schedule Ref	Indicator Title (brief)	Indicator Title and Detail	Q3	Commissioner's Comments on Q3 performance
	(CIP) Assurance			
AS02	Ward Health-check	Staffing Establishment and Impact on Service Delivery	**G**	6 mthly Nursing Establishment Review - no CMG's require an increase in establishment, Recruitment programme continues to reduce vacancies.
AS03	Nurse Revalidation Programme	Provider preparedness for the implementation of Nurse Revalidation	**G**	Implementation plan in place.
AS04	Staffing governance	Staffing governance to include information relating to the Organisational Development Plan (OD) update and Workforce metrics (WM) and development of the Organisational Health Dashboard.	**G**	Increase seen in sickness rates in December to 4.1%. Medical staffing strategy received highlighting hot spots and areas and recruitment action plans.
AS05	Involving employees in improving standards of care.	The organisation demonstrates openness and responsiveness to feedback from staff received whether internally or externally, including information from anonymous concerns and a Whistle Blowing Policy is implemented within the organisation.	G	Report received and actions identified in response to concerns raised.
AS06	Staff Satisfaction	Improve staff engagement	G	Staff Friends and Family report received and Learning into action staff leaflet. Organisational development plan received
AS07	External Visits and Commissioner Quality Visits	External visits schedule and report of any visits and action plans plus any removal of licences (Single report only) to include Commissioner Quality Visits and action plans resulting from these Quality Visits.	**A**	Annual Report received, 9 visit action plans with delays, and 1 with no action plan in place.
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**	The action plan from the previous CQC visit has been closed. A more recent visit was conducted on 30th November 2015 to ED following which 2 risk summits were held. The CQC's report is still awaited but remedial actions are in place.
CE01 (a)	Communication - Content - Medical	Compliance with UHL Discharge, Out-patient and Emergency Department letter policy and standards to include:	**tbc**	Review deferred to the May CQRG. RAG dependent upon completion of audits.
CE01 (b)	Communication - Content - Nursing	Referral and letters to District Nurses and Practice Nurses - Consent to share information, treatment required, start date and provision of dressings and patient information (for handwritten and electronic letters).	**tbc**	Review deferred to the May CQRG. RAG dependent upon completion of audits.
CE02	Intra-operative Fluid Management	Use of Intraoperative Fluid Management .	**A**	Q2 performance at 80% Q3 performance 78% .
CE03a	Clinical Effectiveness Assurance - Audit	Demonstrate that there is a Clinical Audit Programme of National and locally prioritised audits	**tbc**	Improvements seen in clinical audit compliance across all CMG'

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CE03b	Clinical Effectiveness Assurance - NICE	Demonstrate compliance with NICE Technology Appraisals and NICE guidance published 2015/16	tbc	Report to be submitted to the April CQRG
CE04	Women's Service Dashboard	Maternity Dashboard as agreed to demonstrate quality standards monitoring and evidence of actions to improve services as required.	A	W&C subgroup March Thresholds not met for numerous indicators, however summary papers provides details of actions being taken to further investigate/improve
CE05	Children's Service Dashboard	Children's Dashboard as agreed to demonstrate quality standards monitoring and evidence of actions to improve services as required.	R	Dashboard and summary report received. Decline in performance seen in Q3 for patient observations within 15 mins and patients with clinical management plan within 2 hours. Summary provides details of the reasons for this and actions being taken.
CE06a	PROMS - Patient Reported Outcomes	Patient Reported Outcomes (PROMs) for Hips, Knees, Groin Hernia and Varicose Vein Surgery	N/A	Latest data not yet available.
CE06b	Consultant Clinical Outcomes	Consultant level survival rates as stated on the 'Everyone Counts' document.	N/A	Backlog of BAETS data to be submitted and work in progress to address. Outcomes not yet published for all Specialities so end of year RAG not yet predicted.
CE07	#NOF - Dashboard	Improve delivery of best practice tariff indicators for #NOF Patients	R	36 hour performance below threshold for all 3 months of Q3. Details of actions being taken provided and discussed with commissioners.
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.	G	Q2 SSNAP data reviewed and performance improved with an overall SSNAP level of a high C. Anticipated slight drop for Q3 but 90% stay on stroke unit and TIA clinic thresholds still achieved.
CE09	Mortality	Mortality Reporting to include: SHMI, HSMR, M&M Reviews Mortality Alerts (including perinatal mortality) MRC work programme progress	G	Concerns raised over the capacity to complete screening of all deaths within the trust as per TDA requirements but actions in place to address. Current performance at 57%. Published SHMI below national average at 95. NHSE Mortality self assessment shows trust as "expected" in respect of 'avoidable mortality'
CE10	VTE Risk Assessment	Demonstrate compliance with NICE guidance and compliance with VTE risk assessment and provision of thromboprophylaxis..	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.	R	100% of inpatients and 96% outpatient VTE RCA's completed
CE12	Nutrition and Hydration	Implementation of educational programme supported by the revised Nursing Metrics in respect of meeting nutritional and hydration needs of inpatients in order to prevent avoidable weight loss and dehydration.	G	All CMG's showing quarterly compliance above 90% for all standards
CE13	Food Strategy	Provider to have food strategy	G	Final Strategy submitted
CE14	Community Acquired Pneumonia	Improving care pathway and discharge for patients admitted with acute episode of community acquired pneumonia (CAP) using Care Bundle and post discharge enhanced follow up.	A	Q3 performance: CURB: 91% CXR: 90% Antibiotics: 89% (just below threshold)

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CE15	Improving End of Life (EoL) care.	Maintenance of the use of the Amber Care Bundle to ensure that patients are identified and supported a the end of life, enabling transfer to their preferred place of care and high standard care delivery.	**G**	Report received with details of performance against thresholds and the progression with elements of 15/16 CQUIN scheme.
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**	Increased number of patients receiving the Heart Failure care bundle and plans in place to further increase
PE01	Same Sex Accommodation Compliance and Annual Estates Monitoring	Demonstrate same sex accommodation compliance in line with Department of Health Guidance and EMSA "Estates Plan" monitoring programme and monitoring report.	**A**	Q3 2 breaches reported, affecting 6 patients on the brain injury unit. Breaches reported as clinically justifiable, need to be reviewed. 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 from patients, carers, public, external bodies, Clinical Commissioning Groups, Complaints, F&FT, Patient Opinion and Healthwatch (not an inclusive list) that the organisation is learning from feedback and improving services (for ED, outpatients, in patients) taking into account protected characteristics where available.	**G**	Report received detailing themes of patient feedback broken down by CMG and patient type. Actions taken in response provided.
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.	**N/A**	End of Year Review - RAG dependent upon national results
PE04	Equality and Human Rights	Compliance with the Equality Act 2010 and implementation of EDS2 and National Workforce Race Equality Standard and annual report on progress in implementing the Standard.	**A**	Feedback received from the CCG Equality Lead. Concerns raised around the lack of improvement in terms of the collection of data by protected characteristics beyond age, gender and ethnicity and the lack of development with the accessible information standard and that the Trust are unlikely to compliant with this by July 16 as specified by NHSE.
PE5	MECC	To deliver brief advice on healthy lifestyle behaviours to reduce preventable ill health and premature death; smoking, alcohol misuse, healthy weight (meaning overweight and obesity in this context) and physical activity and to signpost patients and staff to appropriate behaviour change services.	**G**	MECC data received. Decline in referrals to STOP Smoking Cessation Service
PE6	Friends and Family Test	Maximise Friends and Family Test response rates	**R**	Increase in inpatient response rate to above threshold: 31.9%. ED response rate below threshold at 7.3%
		SPECIALISED SERVICES QUALITY SCHEDULE		
SQ01	National Quality Dashboards	Submission of data to the National Specialised Services Dashboards, where applicable	**G**	Data submitted
SQ02	National Clinical Registries	Submission of data to National Clinical Registries, where applicable	**tbc**	
SQ03	HIV: GP	HIV patients registered with and disclosed to GP with annual	**G**	Threshold 1 = 94%.

Schedule Ref	Indicator Title (brief)	Indicator Title and Detail	Q3	Commissioner's Comments on Q3 performance
	registration and communication	communication with GP where patient consent has been received.		Threshold 2 = 100%
z	z			
Nat 1	AKI Discharge Care Bundle	By end of Q4 - 90% of patients with AKI - the discharge summary states 1. Stage of AKI (a key aspect of AKI diagnosis); 2. Evidence of medicines review having been undertaken (a key aspect of AKI treatment); 3. Type of blood tests required on discharge for monitoring (a key aspect of post discharge care); 4. Frequency of blood tests required on discharge for monitoring (a key aspect of post discharge care).	**R**	Threshold 40% not achieved. Q4 threshold = 90% and whilst hoping to improve in March 16 following launch of new guidelines and care bundle, threshold is for the full Quarter.
Nat 2a	Sepsis - Screening	By Q4 90% of patients presenting to emergency departments and assessment units, with sepsis receive IV antibiotics within 1 hr of arrival	**R**	Q3 threshold of 80% not met. Q3 performance 61%. Full sample of 50 patients audited in Q3 as per National Guidance. 78% performance achieved in December 2015. Action plan received – all implemented in December 2015. Potential 80%+ achievement for screening in Q4
Nat 2b	Sepsis - IV Antibiotics	By Q4 90% of patients presenting to emergency departments and assessment units, with infection are screened for sepsis.	**R**	Threshold for Q3 70%. Performance 38.7%. Whilst improvements made in ED, still below the 90% threshold and indicator also includes assessment units.
Nat 3a	Dementia - FAIR	90% of patients meeting the criteria are screened, risk assessed for dementia and are referred where positive or inconclusive	**G**	Performance 96.3% for Q3 Q4 threshold also requires audit to be undertaken.
Nat 3b	Dementia Training	To ensure that appropriate dementia training is available to staff through a locally determined training programme.	**G**	Achieved an increase in number of staff trained and on target to achieve 90% internal target in Q4.
Nat 3c	Dementia Carers	Ensure carers of people with dementia and delirium feel adequately supported.		On track to achieve end of year threshold
Nat 4	Amb Care	To decrease the proportion of Avoidable Emergency Admissions to Hospital.	**A**	Delays in implementation of CQUIN related to recruitment and scheme not running fully at present. Coding change in SLAM implemented from M10 January. Unable to recruit to consultant post.
Loc 5	Readmissions	Clinical Readmissions Review	**A**	Delays in implementation for Q3. Readmission Risk tool pathway implemented in Jan but capacity of the Specialist Discharge Team and Primary Care Co-ordinators means variable ability to respond and review patients prior to discharge.
Loc 6	CHC	Improving the timeliness and accuracy of the Continuing Healthcare -Assessment	**A**	Q3 Improved compliance with DST but decrease in accuracy of DST assessments. . Anticipate continued challenges in Q4 with meeting the 90% threshold for patients on the D2A pathway.
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.	**G**	Further information requested - submitted
Loc 7b	Increase 'Near Miss'	Promotion of near miss reporting and undertake a thematic analysis of near miss incidents to identify learning and actions	**G**	Thematic review of data completed.

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	Reporting	to prevent patient harm.		
Loc 8	Think Glucose	Implementation of ThinkGlucose Education Programme across 70 Clinical areas in UHL	G	Only 4/10 areas completed programme and initially concerns raised about ability of team to get back on track by end of Q4 Team has subsequently confirmed that threshold has been met.
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.	A	Audits not completed and number of patients utilising activity equipment, risk assessment and number used for. Delay in Easy read audit meeting not scheduled till March 16.
SS1/ CUR	CUR Tool	Clinical Utilisation Review Tool	G	'Pre engagement event held' and further discussions held with company that appeared to meet specification but would now appear they are not prepared to make changes to their software to allow full integration with NerveCentre. NHSE have advised they carry over any loss of CQUIN monies to 16/17 if necessary.
SS2/ C6	Oncotype Testing	Eligible patients receiving a NICE DG10 compliant test with provision of monitoring data	G	Data being collated. To be submitted at end of year.
SS3/ TH4	Critical Care Delayed Discharges	Reduction in delayed discharges from ICU to ward level care	G	Report submitted and reduction in delayed discharges seen.
SS6/I M7	Rheumatic Diseases Network	Multi-system auto-immune rheumatic diseases network	R	Evidence provided in support of this CQUIN is weak and the provided protocols are not detailed enough to meet the established criteria. RAG to be reviewed upon submission of further information
SS7/ TH7	Complex Orthopaedic Surgery Network	Specialised Orthopaedics (Adults) Network Development: regional audit and governance, regional MDT for complex cases.	G	1st Network meeting held and patients discussed. RAG to be reviewed upon submission of further information as part of Q4 report
SS8/ HSS	ECMO/PCO Collaborative Workshop	Highly specialised services clinical outcome collaborative audit workshop		National ECMO collaborative workshop being held at Glenfield on 5th Nov
SS10/ CB5	Haemoglobinopathy Network	Define and develop networks of care for patients with haemoglobin disorders.	R	Limited evidence of progress submitted. RAG to be reviewed upon submission of further information
SS11/ WC1	<28 Week Neonates 2 yr follow up	2 Year outcomes for infants <28 weeks gestation (3 year scheme)	G	Data anomalies need to be reviewed and rectified.