Quality & Performance Report

Author: John Adler Sponsor: Chief Executive Date: IFPIC + QAC 25 June 2015

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: **ED 4 hour** performance in the calendar month of May was 92.2% compared to 83.1% in May 2014. This is a significant improvement although we need to do more to reach the required 95%. All **RTT** targets were hit for the first time in over 2 years and **diagnostics** and **cancelled operations** remained compliant. However, a serious issue with the recording of endoscopy waiting times has been identified and this is the subject of a separate report to IFPIC. There was only 1 **C. Diff** case in May and zero **MRSA** and avoidable Grade 3 and 4 **pressure ulcers**. Grade 2's **pressure ulcers** were within the upper limit. The **31 day cancer** target was achieved.

Bad News: Both the **cancer 14 and 62** day targets were not met and it is now anticipated that the 62 day target will not be met until September, rather than July. *This deterioration should be scrutinised by the Committee.* There was a **Never Event** in May related to a 10x drug error – the patient came to no harm but *QAC should review this in detail* to ensure that lessons are learned. **Fractured NoF** reached a new low of 42.6% and it is suggested that *IFPIC require a formal report* from the COO in July about plans to improve this position, now that it has been agreed that the CMG requires corporate support with this

issue. Reported **cleaning** standards deteriorated in May but the Committee is already familiar with the action being taken in relation to the performance of the Interserve contract.

Input Sought

I recommend that the Committee:

- Commends the positive achievements noted under Good News
- Follows the actions suggested in *italics* in the Conclusions section

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: 30/07/15

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

May 2015

One team shared values

CONTENTS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

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

DATE: **25th JUNE 2015**

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

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

1.0 Introduction

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

2.0 Performance Summary

Domain	Page Number	Number of Indicators	Indicators with target to be confirmed	Number of Red Indicators this month
Safe	4	22	7	2
Caring	5	10	3	0
Well Led	6	18	8	4
Effective	7	16	4	1
Responsive	8	29	1	11
Research – UHL	10	6	6	0
Research - Network	10	13	0	3
Estates & Facilities	11	10	0	1
Total		124	29	22

3.0 New Indicators

New indicators included in the May report are:

Well Led

DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)
DAY Safety staffing fill rate - Average fill rate - care staff (%)
NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)
NIGHT Safety staffing fill rate - Average fill rate - care staff (%)

Responsive

ED 4 Hour Waits UHL + UCC (Calendar Month)

4.0 Indicators removed

Well Led

Safety Staffing fill rate – replaced with 4 indicators

5.0 Indicators where reporting methodology has been changed

Well Led

Sickness Absence – Red RAG/Exception report threshold revised to >4% (previously >3.5%)

Responsive

Ambulance Handover >60 Mins (CAD) – now reported as %
Ambulance Handover >30 Mins and <60 mins (CAD) – now reported as a %

	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	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	YTD
Safe	S1	Clostridium Difficile	CR	DJ	61	TDA	Red = >mthly threshold / ER if Red or Non compliance with cumulative target	66	73	4	6	5	7	2	5	7	7	11	7	5	7	3	1	4
	S2a	MRSA Bacteraemias (All)	CR	DJ	0	TDA	Red = >0 ER = >0	3	6	0	0	0	0	0	1	1	0	2	0	1	1	0	0	0
	S2b	MRSA Bacteraemias (Avoidable)	CR	DJ	0	UHL	Red = >0 ER = >0	1	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
	S3	Never Events	CR	MD	0	TDA	Red = >0 in mth ER = in mth >0	3	3	0	0	0	0	0	0	1	0	1	1	0	0	0	1	1
	S4	Serious Incidents	CR	MD	Not within Highest Decile	TDA	TBC	60	41	4	6	3	7	2	3	4	2	4	3	2	1	2	8	10
	S5a	Proportion of reported safety incidents per 1000 beddays	CR	MD	TBC	TDA	TBC	37.5	39.1	40.8	40.2	40.4	41.1	35.6	41.8	38.9	40.3	40.4	35.0	38.2	36.3	34.6	37.3	35.9
	S5b	Proportion of reported safety incidents that are harmful	CR	MD	Not within Highest Decile	TDA	TBC	2.8%	1.9%	1.7%			2.2%			1.4%			2.3%					
	S6	Overdue CAS alerts	CR	MD	0	TDA	Red = >0 in mth ER = in mth >0	2	10	2	2	2	3	0	0	0	0	0	0	0	1	0	0	0
	S7	RIDDOR - Serious Staff Injuries	CR	MD	FYE = <40	UHL	Red / ER = non compliance with cumulative target	47	24	3	5	1	2	2	1	2	2	1	0	3	2	0	6	6
	S8a	Safety Thermometer % of harm free care (all)	CR	EM	Not within Lowest Decile	TDA	Red = <92% ER = in mth <92%	93.6%	94.1%	94.6%	94.7%	94.2%	94.9%	94.4%	93.9%	94.9%	93.3%	94.1%	95.0%	92.1%	93.6%	93.7%	94.3%	94.0%
	S8b	Safety Thermometer % number of new harms	CR	EM	Not within Lowest Decile	TDA	TBC	New TDA Indicator		1.7%	2.7%	2.4%	2.9%	2.5%	2.3%	3.3%	2.4%	2.5%	3.2%	2.7%	2.2%	2.7%	2.5%	
	S9	% of all adults who have had VTE risk assessment on adm to hosp	AF	SH	95% or above	TDA	Red = <95% ER = in mth <95%	95.3%	95.8%	95.7%	95.9%	95.9%	96.3%	95.5%	96.2%	95.4%	95.5%	95.0%	96.3%	96.2%	95.6%	96.0%	96.0%	96.0%
	S10	All Medication errors causing serious harm	AF	CE	0	TDA	Red = >0 in mth ER = in mth >0	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																
	S11	All falls reported per 1000 bed stays for patients >65years	CR	HL	<7.1	QC	Red >= YTD >8.4 ER = 2 consecutive reds	7.1	6.9	7.0	7.5	7.1	7.3	7.3	5.9	6.4	7.5	6.9	7.1	6.7	6.3	5.6	5.8	5.7
	S12	Avoidable Pressure Ulcers - Grade 4	CR	MC	0	QS	Red / ER = Non compliance with monthly target	1	2	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0
	S13	Avoidable Pressure Ulcers - Grade 3	CR	MC	<=6 a month	QS	Red / ER = Non compliance with monthly target	71	69	5	5	5	5	6	6	4	6	7	5	9	6	3	0	3
	S14	Avoidable Pressure Ulcers - Grade 2	CR	MC	<=8 a month	QS	Red / ER = Non compliance with monthly target	120	91	6	6	6	7	9	4	8	13	11	7	5	9	10	8	18
	S15	Compliance with the SEPSIS6 Care Bundle	AF	JP	All 6 >75% by Q4	QC	Red/ER = Non compliance with Quarterly target	27.0%	<65%	47.0%			>=60%			<65%			<75%					
	S16	Maternal Deaths	AF	IS	0	UHL	Red or ER =>0	3	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
	S17	Emergency C Sections (Coded as R18)	IS	EB	Not within Highest Decile	TDA	Red / ER = Non compliance with monthly target	16.1%	16.5%	16.9%	16.0%	14.7%	16.9%	15.4%	17.4%	18.1%	17.4%	16.2%	17.7%	15.5%	15.8%	15.3%	18.8%	17.2%
	S18	Potential under reporting of patient safety indicators	CR	MD	Not within Highest Decile	TDA	Red / ER = Non compliance with monthly target	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																
	S19	Potential under reporting of patient safety indicators resulting in death or severe harm	CR	MD	Not within Highest Decile	TDA	Red / ER = Non compliance with monthly target	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																

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

	KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	YTD
Caring	C1	Inpatients (Including Daycases) Friends and Family Test - % positive	CR	HL	95%	TDA	ER = <95%	New Indicator	96%	96%	96%	97%	97%	96%	97%	96%	96%	96%	96%	96%	97%	96%	96%	96%
	C2	A&E Friends and Family Test - % positive	CR	HL	95%	TDA	ER = <94%	New Indicator	96%	94%	97%	95%	96%	92%	95%	96%	96%	96%	96%	96%	97%	96%	96%	96%
	C3	Outpatients Friends and Family Test - % positive	CR	HL	90%	UHL	ER = <90%	NEW METHODOLOGY FOR CALCULATING %														94%	94%	94%
	C4	Daycase Friends and Family Test - % positive	CR	HL	Not within Lowest Decile	TDA	TBC															96%	97%	96%
	C5	Maternity Friends and Family Test - % positive	CR	HL	95%	TDA	ER = <94%	New Indicator	96%	95%	96%	96%	96%	96%	94%	96%	97%	95%	97%	96%	96%	95%	96%	95%
	C6	Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment	ES	ES	Not within Lowest Decile	TDA	TBC	New Indicator	69.2%	68.3%			67.2%			Q3 staff FFT not completed as National Survey carried out			71.4%					
	C7a	Complaints Rate per 100 bed days	AF	MD	TBC	UHL	TBC	New Indicator	0.4	0.4	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.4	0.3	0.3	0.3
	C7b	Written Complaints Received Rate per 100 bed days	AF	MD	Not within Highest Decile	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																
	C8	Complaints Re-Opened Rate	AF	MD	<=12%	UHL	Red = >=15% ER = >=15%	New Indicator	10%	8%	5%	8%	11%	10%	9%	11%	11%	10%	17%	13%	11%	13%	7%	10%
	C9	Single Sex Accommodation Breaches (patients affected)	CR	HL	0	TDA	Red = >0 ER = in mth >0	2	13	4	3	0	0	0	0	0	5	0	1	0	0	0	0	0

	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	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	YTD
Well Led	W1	Inpatients Friends and Family Test - Coverage	CR	HL	30% each quarter	TDA	Red = <26% ER = TBC	NEW METHODOLOGY FOR CALCULATING COVERAGE INCLUDES ADULTS AND CHILDREN														30.2%	33.1%	31.6%
	W2	Daycase Friends and Family Test - Coverage	CR	HL	20% each quarter	TDA	Red = <15% ER = TBC	NEW METHODOLOGY FOR CALCULATING COVERAGE INCLUDES ADULTS AND CHILDREN														11.3%	11.3%	11.3%
	W3	A&E Friends and Family Test - Coverage	CR	HL	20% each quarter	TDA	Red = <15% ER = TBC	NEW METHODOLOGY FOR CALCULATING COVERAGE INCLUDES ADULTS AND CHILDREN														14.6%	15.1%	14.9%
	W4	Outpatients Friends and Family Test - Coverage	CR	HL	5% by Q4	UHL	TBC	NEW METHODOLOGY FOR CALCULATING COVERAGE INCLUDES ADULTS AND CHILDREN														1.5%	1.3%	1.4%
	W5	Maternity Friends and Family Test - Coverage	CR	HL	30% each quarter	UHL	Red = <26% ER = TBC	25.2%	28.0%	27.2%	36.4%	25.2%	29.2%	29.9%	18.7%	15.8%	21.7%	22.1%	25.8%	46.5%	40.2%	32.3%	35.8%	34.1%
	W6	Friends & Family staff survey: % of staff who would recommend the trust as place to work	ES	BK	Not within Lowest Decile	TDA	TBC	New Indicator	54.2%	53.7%			53.7%			Q3 staff FFT not completed as National Survey carried out			54.9%					
	W7a	Nursing Vacancies	CR	MM	TBC	UHL	TBC	NEW UHL INDICATOR							6.7%	6.7%	6.4%	6.0%	6.3%	5.5%	6.5%	8.5%	8.0%	8.0%
	W7b	Nursing Vacancies in ESM CMG	CR	MM	TBC	UHL	TBC	NEW UHL INDICATOR							10.8%	10.8%	10.7%	9.7%	12.8%	11.4%	14.0%	19.3%	13.0%	13.0%
	W8	Turnover Rate	ES	LG	Not within Lowest Decile	TDA	Red = 11% or above ER = Red for 3 Consecutive Mths	10.0%	11.5%	9.9%	10.0%	10.2%	10.0%	10.5%	10.3%	10.8%	10.7%	10.3%	10.1%	10.1%	11.5%	10.4%	10.5%	10.5%
	W9	Sickness absence	ES	KK	3%	UHL	Red = >4% ER = 3 consecutive mths >4.0%	3.4%	3.8%	3.4%	3.3%	3.3%	3.4%	3.4%	3.7%	4.0%	4.0%	4.4%	4.2%	4.1%	4.0%	3.8%		3.8%
	W10	Temporary costs and overtime as a % of total paybill	ES	LG	TBC	TDA	TBC	New Indicator	9.4%	9.4%	9.4%	8.1%	8.5%	8.9%	8.5%	9.5%	9.0%	9.8%	10.5%	9.8%	11.5%	10.7%	10.2%	10.5%
	W11	% of Staff with Annual Appraisal	ES	BK	95%	UHL	Red = <90% ER = 3 consecutive mths <90%	91.3%	91.4%	91.8%	91.0%	90.6%	89.6%	88.6%	89.7%	91.8%	92.3%	92.5%	90.9%	91.0%	91.4%	90.1%	88.7%	89.4%
	W12	Statutory and Mandatory Training	ES	BK	95%	UHL	TBC	76%	95%	78%	79%	79%	80%	83%	85%	86%	87%	89%	89%	90%	95%	93%	92%	93%
	W13	% Corporate Induction attendance	ES	BK	95.0%	UHL	Red = <90% ER = 3 consecutive mths <90%	94.5%	100%	96%	94%	92%	96%	98%	98%	98%	98%	100%	99%	100%	97%	97%	97%	97%
	W14a	DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	CR	MM	Not within Lowest Decile	TDA	TBC	New Indicator	91.2%	New Indicator	89.2%	92.6%	87.7%	87.9%	91.6%	92.9%	91.3%	92.7%	94.3%	91.8%	91.0%	93.6%	90.3%	92.0%
	W14b	DAY Safety staffing fill rate - Average fill rate - care staff (%)	CR	MM	Not within Lowest Decile	TDA	TBC		94.0%		92.1%	96.9%	93.0%	94.8%	90.3%	95.4%	94.4%	95.8%	95.4%	92.8%	92.5%	94.2%	91.2%	92.7%
	W14c	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	CR	MM	Not within Lowest Decile	TDA	TBC		94.9%		92.0%	93.1%	90.8%	91.4%	94.8%	97.4%	96.5%	96.4%	97.9%	96.5%	97.2%	98.9%	96.0%	97.4%
	W14d	NIGHT Safety staffing fill rate - Average fill rate - care staff (%)	CR	MM	Not within Lowest Decile	TDA	TBC		99.8%		94.4%	99.0%	97.9%	98.0%	97.8%	100.8%	101.2%	101.4%	103.6%	100.8%	103.2%	106.3%	98.7%	102.5%

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	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	YTD
E1	Mortality - Published SHMI	AF	PR	Within Expected	TDA	Higher than Expected	105	103	106 (Oct12-Sept13)			106 (Jan13-Dec13)			105 (Apr13-Mar14)			103 (Oct13-Sep14)			103 (Oct13-Sep14)		
E2	Mortality - Rolling 12 mths SHMI (as reported in HED)	AF	PR	Within Expected	QC	Red = >expected ER = >Expected or 3 consecutive mths increasing SHMI >100	105	99	93	107	105	88	89	102	97	102	97	107	105	Awaiting HED Update			
E3	Mortality HSMR (DFI Quarterly)	AF	PR	Within Expected	TDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	88	93	99			95			93			Awaiting DFI Update					
E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	AF	PR	Within Expected	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	95	97	98	98	97	96	96	96	95	95	96	95	95	Awaiting HED Update		
E5	Mortality - Monthly HSMR (Rebased Monthly as reported in HED)	AF	PR	Within Expected	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	91	95	82	108	105	86	97	98	96	88	96	99	98	85	Awaiting HED Update		
E6	Mortality - rolling 12 mths HSMR ALL Weekend Admissions - (DFI Quarterly)	AF	PR	Within Expected	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	95		100			103.4			97			Awaiting DFI Update					
E7	Crude Mortality Rate Emergency Spells	AF	PR	Within Upper Decile	TDA	TBC	2.5%	2.4%	2.0%	2.5%	2.4%	2.0%	1.9%	2.3%	2.1%	2.3%	3.0%	3.1%	2.7%	2.4%	2.1%	2.0%	2.1%
E8	Deaths in low risk conditions (Risk Score)	AF	PR	Within Expected	TDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	94	83	64	81	105	79	63	58	112	59	85	121	87	Awaiting DFI Update			
E9	Emergency readmissions within 30 days following an elective or emergency spell	AF	JJ	Within Expected	TDA	Higher than Expected	7.9%	8.5%	8.8%	8.8%	8.6%	8.4%	8.9%	8.4%	8.6%	8.9%	9.1%	8.2%	8.5%	8.5%	9.1%		9.1%
E10	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	AF	RP	72% or above	QS	Red = <72% ER = 2 consecutive mths <72%	65.2%	61.4%	56.9%	40.6%	60.3%	76.9%	59.0%	68.6%	69.6%	59.4%	57.3%	57.9%	67.2%	61.5%	55.7%	42.6%	49.6%
E11	Stroke - 90% of Stay on a Stroke Unit	RM	IL	80% or above	QS	Red = <80% ER = 2 consecutive mths <80%	83.2%	81.3%	92.9%	80.3%	87.1%	78.1%	84.5%	83.2%	70.4%	73.3%	75.2%	82.5%	87.6%	83.3%	82.7%		82.7%
E12	Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA)	RM	IL	60% or above	QS	Red = <60% ER = 2 consecutive mths <60%	64.2%	71.2%	79.7%	58.8%	71.3%	62.8%	65.5%	72.7%	67.8%	69.0%	83.5%	80.6%	64.0%	77.3%	86.3%	79.6%	82.5%
E13	Published Consultant Level Outcomes	AF	SH	>0 outside expected	QC	Red = >0 Quarterly ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
E14	Non compliance with 14/15 published NICE guidance	AF	SH	0	QC	Red = in mth >0 ER = 2 consecutive mths Red	New Indicator for 14/15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
E15	ROSC in Utstein Group	AF	PR	TBC	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																
E16	STEMI 150minutes	AF	PR	TBC	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																

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	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	YTD
R1a	ED 4 Hour Waits UHL + UCC (SITREP month)	RM	IL	95% or above	TDA	Red = <92% ER via ED TB report	88.4%	89.1%	86.9%	83.4%	91.3%	92.5%	90.9%	91.5%	90.1%	88.5%	83.0%	90.2%	89.2%	91.1%	92.4%	91.8%	92.1%
R1b	ED 4 Hour Waits UHL + UCC (Calendar Month)	RM	IL	95% or above	UHL	Red = <92% ER via ED TB report	88.4%	89.1%	86.9%	83.1%	91.0%	92.5%	91.3%	91.6%	89.8%	89.1%	83.0%	90.7%	89.6%	91.1%	92.0%	92.2%	92.1%
R2	12 hour trolley waits in A&E	RM	IL	0	TDA	Red = >0 ER via ED TB report	5	4	0	1	1	0	0	0	1	0	0	1	0	0	0	0	0
R3	RTT Waiting Times - Admitted	RM	WM	90% or above	TDA	Red /ER = <90%	76.7%	84.4%	78.9%	79.4%	79.0%	80.9%	82.2%	81.6%	84.4%	85.5%	86.9%	85.0%	85.9%	84.4%	88.0%	91.3%	91.3%
R4	RTT Waiting Times - Non Admitted	RM	WM	95% or above	TDA	Red /ER = <95%	93.9%	95.5%	94.3%	94.4%	95.0%	94.9%	95.6%	94.6%	94.9%	95.2%	96.0%	95.4%	95.3%	95.5%	95.6%	95.6%	95.6%
R5	RTT - Incomplete 92% in 18 Weeks	RM	WM	92% or above	TDA	Red /ER = <92%	92.1%	96.7%	93.9%	93.6%	94.0%	93.2%	94.0%	94.3%	94.8%	95.0%	95.1%	95.2%	96.2%	96.7%	96.6%	96.5%	96.5%
R6	RTT 52 Weeks+ Wait (Incompletes)	RM	WM	0	TDA	Red /ER = >0	0	0	0	0	0	15	1	3	3	2	0	0	0	0	0	66	66
R7	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	TDA	Red /ER = >1%	1.9%	0.9%	0.8%	0.9%	0.8%	0.7%	1.0%	1.0%	0.7%	1.8%	2.2%	5.0%	0.8%	0.9%	0.8%	0.6%	0.6%
R8	Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	RM	MM	93% or above	TDA	Red = <93% ER = Red for 2 consecutive mths	94.8%	92.2%	88.5%	94.7%	93.5%	92.2%	92.0%	90.6%	92.0%	92.5%	93.0%	92.2%	93.5%	91.5%	91.2%		91.2%
R9	Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	RM	MM	93% or above	TDA	Red = <93% ER = Red for 2 consecutive mths	94.0%	94.1%	80.0%	95.0%	98.9%	94.9%	94.4%	95.2%	98.6%	100.0%	93.0%	92.5%	91.5%	96.0%	99.0%		99.0%
R10	31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	RM	MM	96% or above	TDA	Red = <96% ER = Red for 2 consecutive mths	98.1%	94.6%	97.2%	92.9%	93.6%	94.4%	97.9%	91.9%	95.9%	92.5%	95.2%	91.7%	95.0%	97.0%	93.7%		93.7%
R11	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	RM	MM	98% or above	TDA	Red = <98% ER = Red for 2 consecutive mths	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0%	97.1%	100.0%	96.7%	100.0%	100.0%	100.0%	100.0%		100.0%
R12	31-Day Wait For Second Or Subsequent Treatment: Surgery	RM	MM	94% or above	TDA	Red = <94% ER = Red for 2 consecutive mths	96.0%	89.0%	95.2%	97.0%	90.8%	90.1%	87.8%	94.0%	81.9%	82.4%	80.3%	89.2%	94.4%	87.5%	86.3%		86.3%
R13	31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	RM	MM	94% or above	TDA	Red = <94% ER = Red for 2 consecutive mths	98.2%	96.1%	97.3%	95.6%	93.9%	97.3%	99.0%	96.5%	96.0%	94.7%	95.5%	87.6%	99.0%	100.0%	86.1%		86.1%
R14	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	RM	MM	85% or above	TDA	Red = <85% ER = Red in mth or YTD	86.7%	81.4%	92.7%	88.5%	73.1%	85.6%	78.8%	75.5%	80.4%	77.0%	84.8%	79.3%	78.9%	83.8%	75.5%		75.5%
R15	62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	RM	MM	90% or above	TDA	Red = <90% ER = Red for 2 consecutive mths	95.6%	84.5%	91.1%	67.4%	73.9%	73.0%	100.0%	87.5%	75.0%	94.4%	93.8%	88.9%	79.4%	89.3%	91.7%		91.7%
R16	Cancer waiting 104 days RTT	RM	MM	0	TDA	TBC	NEW TDA INDICATOR - FURTHER GUIDANCE REQUESTED FROM TDA																
R17	Urgent Operations Cancelled Twice	RM	PW	0	TDA	Red = >0 ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
R18	Cancelled patients not offered a date within 28 days of the cancellations UHL	RM	PW	0	TDA	Red = >2 ER = >0	85	33	10	4	1	2	1	2	2	0	3	4	3	1	2	0	2
R19	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	RM	PW	0	TDA	Red = >2 ER = >0	New Indicator for 14/15	11	0	0	0	0	6	0	0	1	1	2	1	0	0	1	1
R20	% Operations cancelled for non-clinical reasons on or after the day of admission UHL	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	1.6%	0.9%	1.1%	0.8%	1.1%	0.7%	0.6%	0.8%	0.8%	1.2%	1.1%	0.8%	0.7%	1.0%	0.7%	0.5%	0.6%
R21	% Operations cancelled for non-clinical reasons on or after the day of admission ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	1.6%	0.9%	0.6%	0.6%	0.3%	2.7%	0.0%	0.9%	1.0%	0.0%	0.8%	1.4%	0.0%	0.4%	1.2%	1.2%	1.2%
R22	% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	New Indicator for 14/15	0.9%	1.1%	0.8%	1.0%	0.9%	0.6%	0.8%	0.8%	1.1%	1.1%	0.8%	0.7%	0.9%	0.8%	0.6%	0.7%
R23	No of Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	N/A	UHL	TBC	1739	1071	106	77	98	94	55	90	94	108	102	85	64	98	79	56	135
R24	Outpatient Hospital Cancellation Rates	RM	PW	Within Upper Decile	UHL	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																
R25	Delayed transfers of care	RM	PW	3.5% or below	TDA	Red = >3.5% ER = Red for 3 consecutive mths	4.1%	3.9%	4.4%	4.2%	4.0%	3.9%	3.9%	4.5%	4.6%	5.2%	3.9%	3.2%	2.9%	1.8%	1.2%	1.0%	1.1%
R26	Choose and Book Slot Unavailability	RM	WM	4% or below	Contract	Red = >4% ER = Red for 3 consecutive mths	13%	21%	22%	25%	26%	25%	26%	25%	20%	17%	16%	13%	19%	26%	34%	31%	34%
R27	Ambulance Handover >60 Mins (CAD)	RM	PW	0	Contract	Red = >0 ER = Red for 3 consecutive mths	New Indicator for 14/15	5.2%	4.0%	5.6%	1.6%	1.7%	0.9%	2.4%	5.4%	5.8%	9.8%	6.4%	11.0%	9.0%	6.2%	6.6%	6.4%
R28	Ambulance Handover >30 Mins and <60 mins (CAD)	RM	PW	0	Contract	Red = >0 ER = Red for 3 consecutive mths	New Indicator for 14/16	19.3%	16.6%	21.0%	12.4%	13.8%	14.9%	16.6%	24.6%	22.9%	24.9%	21.0%	21.3%	22.0%	22.3%	21.2%	21.8%

Compliance Forecast for Key Responsive Indicators

Standard	May actual/predicted	June predicted	Month by which to be compliant	RAG rating of required month delivery	Commentary
Emergency Care					
4+ hr Wait (95%) - Calendar month	92.2%				
Ambulance Handover (CAD)					
% Ambulance Handover >60 Mins (CAD)	7%		Not Agreed		Data from new reporting Mechanism is not yet available.
% Ambulance Handover >30 Mins and <60 mins (CAD)	21%		Not Agreed		Data from new reporting Mechanism is not yet available.
RTT (inc Alliance)					
Admitted (90%)	91.2%	90.0%	May		May delivered - the first time for over 2 years. June at risk but within expected range
Non-Admitted (95%)	95.3%	95.5%	Continued Delivery		UHL achieved in own right. Alliance added. Sustained performance.
Incomplete (92%)	96.5%	96.3%	Continued Delivery		June dip due to additions of orthodontics and continuing growing pressure in ENT & General Surgery
Diagnostic (inc Alliance)					
DM01 (<1%)	0.6%	4.6%	September		May delivered. Endoscopy planned list incorrectly managed expected to recover from September.
Cancelled Ops (inc Alliance)					
Cancelled Ops (0.8%)	0.7%	0.8%	Continued delivery		
Not Rebooked within 28 days (0 patients)	0	0	May		May confirmed as delivered.
Cancer (predicted)					
Two Week Wait (93%)	88.3%	91.5%	July		Patient choice now the dominant reason for failure all UHL tumour sites compliant for capacity and speed of offering patients dates. CCG's developing action plan to reduce patient cancellations.
31 Day First Treatment (96%)	96.6%	92.1%	July		Breach review predicting May compliance. Breaches in breast for first time.
31 Day Subsequent Surgery Treatment (94%)	78.3%	79.0%	July		Agreed with CCG due to pressure on 62 day delivery. Issue is confined to urology.
62 Days (85%)	71.3%	80.8%	September		Rephased following agreement given off track with recovery plan. Improving through month.

Research UHL

KPI Ref	Indicators	Board Director	Lead Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
RU1	Median Days from submission to Trust approval (Portfolio)	AF	NB	TBC	TBC	TBC	3.0			2.0			3.0			3.0			2.8
RU2	Median Days from submission to Trust approval (Non Portfolio)	AF	NB	TBC	TBC	TBC	2.0			3.5			2.0			1.0			2.1
RU3	Recruitment to Portfolio Studies	AF	NB	Aspirational target=10920/year (910/month)	TBC	TBC	941	1092	963	1075	1235	900	1039	1048	604	1030	1043	1298	1022.0
RU4	% Adjusted Trials Meeting 70 day Benchmark (data sunbmitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC	(Jul13-Jun14) 43.4%			(Oct13-Sep14) 70.5%			(Nov13-Dec14) 70.5%						
RU5	Rank No. Trials Submitted for 70 day Benchmark (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC	(Jul13-Jun14) Rank 17/61			(Oct13-Sep14) Rank 18/60			(Nov13-Dec14) Rank 18/59						
RU6	%Closed Commercial Trials Meeting Recruitment Target (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC	(Jul13-Jun14) 50%			(Oct13-Sep14) 52%			(Nov13-Dec14)48%						

Research (CLINICAL RESEARCH NETWORK)

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

	KPI Ref	Indicators	Board Director	Lead Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	YTD
Estates and Facilities	E&F1	Percentage of statutory inspection and testing completed in the Contract Month measured against the PPM schedule.	DK	GL	100%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F2	Percentage of non-statutory PPM completed in the Contract Month measured against the PPM schedule	DK	GL	100%	Contract KPI	Red = ≤ 80%	100.0%	91.5%	81.2%	95.6%	80.5%	86.6%	97.4%	99.5%	99.0%	99.0%	99.0%
	E&F3	Percentage of Estates Urgent requests achieving rectification time	DK	LT	95%	Contract KPI	Red = ≤ 75%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F4	Percentage of scheduled Portering tasks completed in the Contract Month	DK	LT	99%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F5	Number of Emergency Portering requests achieving response time	DK	LT	100%	Contract KPI	Red = >2	0	0	0	0	0	0	0	0	0	0	0
	E&F6	Number of Urgent Portering requests achieving response time	DK	LT	95%	Contract KPI	Red = ≤ 95%	95.0%	95.1%	96.2%	97.3%	97.2%	97.2%	98.5%	98.1%	99.0%	100.0%	99.5%
	E&F7	Percentage of Cleaning audits in clinical areas achieving NCS audit scores for cleaning above 90%	DK	LT	100%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	99.1%	100.0%	100.0%	100.0%	94.4%	96.1%	97.0%	95.0%	96.0%
	E&F8	Percentage of Cleaning Rapid Response requests achieving rectification time	DK	LT	92%	Contract KPI	Red = ≤ 80%	92.0%	99.6%	89.9%	93.3%	90.5%	91.1%	94.1%	96.9%	95.0%	95.0%	95.0%
	E&F9	Percentage of meals delivered to wards in time for the designated meal service as per agreed schedules	DK	LT	97%	Contract KPI	Red = ≤ 95%	97.0%	99.4%	99.5%	100.0%	100.0%	98.9%	99.9%	100.0%	100.0%	100.0%	100.0%
	E&F10	Overall percentage score for monthly patients satisfaction survey for catering service	DK	LT	85%	Contract KPI	Red = ≤ 75%	85.0%	96.7%	97.3%	97.3%	96.7%	93.8%	95.8%	97.5%	96.0%	97.0%	96.5%

S3 – Never Event

<table>
<tr><th colspan="2"></th><th>Target</th><th>May 15</th><th>YTD</th><th>Forecast performance for next reporting period</th></tr>
<tr><td>What is causing underperformance?</td><td>What actions have been taken to improve performance?</td><td>NIL</td><td>1</td><td>1</td><td>0</td></tr>
<tr><td rowspan="2">The patient, an insulin dependent diabetic, normally receives two doses of insulin a day. The prescription was written on the patient's Adult Insulin Prescribing Chart which is a paper prescription chart designed solely for prescription and administration of insulin. The doctor had written both the morning dose and the evening dose in an abbreviated form – 10U and 6U respectively on this chart, rather than writing out in full as units. The insulin was also prescribed on the Electronic Prescribing Medication Administration (ePMA) system, with a clear prescription for 10 units for the morning dose and 6 units for the evening dose.

The patient received an evening dose of 64 units of insulin instead of 6 units as according to the staff involved they interpreted 6U as 64 units. The medication was administered at the incorrect dose on two occasions the evening of 29th and 30th April 2015 before the error was identified.</td><td rowspan="2">All relevant staff involved in incident notified and reflection being undertaken

RCA meeting held on 11 June 2015, using timeline and change analysis tools

IDTs undertaken on staff involved

A pharmacist has been identified to review all insulin prescribing errors and provide feedback to prescriber.

From the end of June 2015, EPMA will be changed to stop dosages of insulin being prescribed on EPMA. EPMA will only refer staff to look at the green insulin chart, which is the working document for insulin management.

The prescriber has been advised to undertake the e:learning package in relation to diabetes.

The nurse administrator has undertaken the "Think glucose" training.

The EPMA pharmacist has contacted IM&T to stop them giving out passwords to doctors for EPMA unless the required training has been undertaken.

Pharmacy are planning to attend a Physicians' meeting to provide feedback to them regarding issues encountered with regard to prescription of insulin, to enable them to work closely with the junior medical staff to reduce poor prescribing.</td><td colspan="4">UHL performance regarding Never Events:

<table><tr><td>2012/13</td><td>6</td></tr><tr><td>2013/14</td><td>3</td></tr><tr><td>2014/15</td><td>2</td></tr><tr><td>2015/16</td><td>1 (to date)</td></tr></table></td></tr>
<tr><td colspan="2">Expected date to meet standard</td><td colspan="2">N/A</td></tr>
<tr><td colspan="2">Revised date to meet standard</td><td colspan="2">-</td></tr>
<tr><td colspan="2">Lead Director</td><td colspan="2">Moira Durbridge, Director of Safety and Risk</td></tr>
</table>

S7 RIDDOR – Serious Staff Injuries

<table>
<tr><td colspan="2"></td><td>Target</td><td>May 15</td><td>Forecast performance for next reporting period Forecast</td></tr>
<tr><td>What is causing underperformance?</td><td>What actions have been taken to improve performance?</td><td><40 RIDDORS during 2015/16 (ie approx. 3.3 per month)</td><td>6</td><td>3 (during next reporting period)</td></tr>
<tr><td>The number and type of RIDDOR reported through affected CMGs are listed below. RIDDOR incidents are not controllable centrally but rely upon appropriate controls in place at a local level and are therefore difficult to predict with accuracy.

ITAPS x 3
ED & Specialist Medicine x 1
Women’s & Children’s x 1
RRC x 1

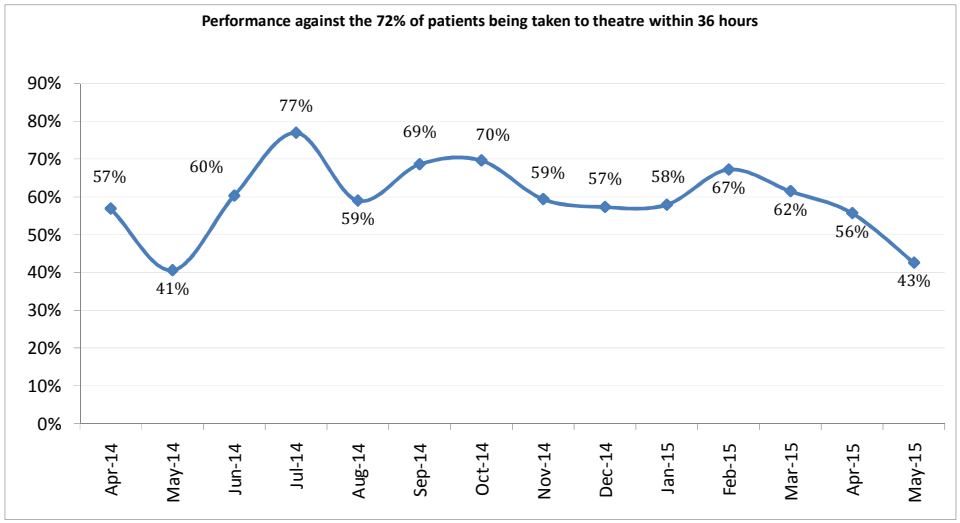
<table>
<tr><th>Type of incident</th><th>Injury</th><th>Location</th></tr>
<tr><td>Manual Handling</td><td>Sprained back (over 7 days)</td><td>Theatre 11, LGH (ITAPS)</td></tr>
<tr><td>Occupational disease</td><td>Dermatitis</td><td>Theatre 3, LGH (ITAPS)</td></tr>
<tr><td>Manual Handling</td><td>Twisted knee (over 7 days)</td><td>ITU, LRI (ITAPS)</td></tr>
<tr><td>Physical assault</td><td>Contusions & bruising (over 7 days)</td><td>Ward 33, LGH (ED & Specialist Medicine)</td></tr>
<tr><td>Manual Handling</td><td>Sprained shoulder (over 7 days)</td><td>Ward 31, LGH (Women’s & Children’s)</td></tr>
<tr><td>Major</td><td>Fractured foot</td><td>Corridor near room CS078 (RRC)</td></tr>
</table>
</td><td>A complete root cause analysis for each RIDDOR has been completed with recommendations as to how the risk of recurrence within affected CMGs can be reduced.</td><td colspan="3">Comment:

To provide a more useful performance indicator in future we may wish to consider using the same measure as used in industry (i.e. number and type of RIDDOR injuries per 1000 employees).

<table>
<tr><td>Expected date to meet standard</td><td>June 2015</td></tr>
<tr><td>Revised date to meet standard</td><td>June 2015</td></tr>
<tr><td>Lead Director</td><td>Moira Durbridge, Director of Safety and Risk</td></tr>
</table>
</td></tr>
</table>

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

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance FY 0 14/15	Forecast performance for next reporting period
There were 67 admission in May 2015, the main reasons for delay were medically unfit patients:- Cancelled from list due to other cases x 16 Unstable INR x 5 Medically unfit x 8 Transfer to LGH for THR x 2 Conservative Treatment x 2 Aw Echo x 1 No suitable fixation device x 1 Lack of theatre time due to Spines and lack of theatre time in times of peak admissions The acceptance of out of area elective and emergency spinal work continues to have a detrimental effect on the main trauma capacity as spinal patients are medically prioritised over 'other' trauma which has a knock on effect on #NOF capacity.	It has been agreed that #NOF will be supported corporately by the Director of Performance and Information. The Trauma business case approved at the end of April aims to address the staffing gaps and these are currently being recruited to. Work continues within the spinal network with regards to capacity across the region and how UHL fits into the future plans.	72%	42.6%	49.6%	62%



Performance by Month for 15/16

April	May	YTD
55.7%	42.6%	49.6%

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

R6– RTT 52 Week Breaches

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

Orthodontics (66):
• Incorrect use and management of a planned waiting list for outpatients.
• Inadequate capacity within the service to see patients ready for treatment.

Maxillofacial (6):
• These patients emerged following the review of a planned waiting list.

Urology (1):
• Patients' clock incorrectly stopped in December 2014;
• Error undiscovered until 52-week breach had occurred.</td><td rowspan="4">Key actions for Orthodontics:
• All patients contacted by letter to ask whether they still require treatment;
• All outstanding patients to be contacted by telephone;
• Service closed to new referrals;
• Refreshed business case for additional investment;
• Review of service's future.

Key actions for Maxillofacial:
• Training for administrative and clinical staff around planned waiting lists;
• Regular review of planned waiting lists by service manager;
• No patient added to planned list unless authorised by the service manager.

Key actions for Urology:
• The individual's pathway was very slow due to numerous patient cancellations. RTT pathway was stopped in error;
• Two opportunities to stop/ suspend the clock due to patient cancellations and holidays missed;
• Since this event, Urology now has more management time and has received intensive RTT training both internally and externally.</td><td>0</td><td>Total = 73
Admitted = 0
Non admitted = 7
Incomplete = 66</td><td>Total = 73
Admitted = 0
Non admitted = 7
Incomplete = 66</td><td>c. 215</td></tr>
<tr><td colspan="4">The majority of these 52 week breaches have occurred as a result of a deliberate, Trust-wide review of planned waiting lists at specialty level. Therefore the following actions will be taken Trust-wide:
• Communication around planned waiting list management to all relevant staff;
• System review of waiting list codes;
• Weekly review at Head of Ops meeting for assurance.

On the horizon for June 2015:
• A significant number of additional 52-week breaches for Orthodontics will be reported in June 2015 as the validation exercise continues. These patient delays are part of the same planned waiting list issue.
• 4 52-week breaches have been discovered in Allergy as a result of review of planned waiting lists.</td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="3">TBC</td></tr>
<tr><td>Lead Director / Lead Officer</td><td colspan="3">Will Monaghan, Director of Performance and Information
Charlie Carr, Head of Performance</td></tr>
</table>

R8-R15 Cancer Waiting Times Performance

What is causing underperformance?	What actions have been taken to improve performance?
R8: 2 Week Wait 2WW performance has reduced. The key reasons for underperformance are: • Increase in GP referrals; • Patient choice. **R10: 31 day 1st treatment** **R12: 31 day subsequent (surgery)** Performance in both targets has reduced from the March position. 31 day 1st treatment was failed as a result of Dermatology performance. This was largely the result of patient choice; no adjustment is made for this in reporting. 31 day subsequent (surgery) was failed as a result of Urology performance. This has been attributed to a number of reasons including lack of tracking resource, key administrative gaps, theatre allocation and changes to the rota reducing SpR and SHO/ FY2 elective activity. **R14: 62 day RTT** 62 day performance has dropped by 8.2% between March and April 2015. Access to Cancer imaging remains good; however capacity in Pathology is proving a problem, with difficulties in some cases with appropriately pulling Cancer patients through the system due to inaccurate labelling of specimens. There has been significant reduction of 62 day the backlog from 98 to 81 patients over the last 5 weeks, which in part explains the reduction in performance.	A revised overarching Cancer action plan is being finalised jointly developed by the Cancer Centre Management team and CMGs. **R8: 2 Week Wait** The Trust is working with CCGs to improve the quality of 2WW referrals, specifically in relation to correct process, use of appropriate clinical criteria, and preparation of patients for the urgency of appointments. **R10: 31 day 1st treatment** **R12: 31 day subsequent (surgery)** 31 day 1st treatment is forecast to recover in June. It has been agreed that all escalated Cancer patients coming into theatre should be escalated to the General Manager for Theatres to ensure that they are appropriately prioritised. The Cancer action plan aims to look at the step-down of patients from Intensive Care, in order to pull Cancer patients through the system more quickly. Clinical capacity: Interviews for a new Head and Neck consultant took place w/c 15th June and job descriptions for 2 new Dermatologists are currently out for RCP approval. **R14: 62 day RTT** Efforts to improve 31 day and 2WW performance will help to improve the 62 day position. Specific actions include efforts to introduce a standardised way of labelling pathology samples for Cancer patients and pathways between Breast screening and Breast services are being strengthened. A Cancer Navigator has been appointed to support Urology, meaning the specialty has more dedicated tracking time. The Endoscopy action plan is likely to improve performance, with daily conversations between service manager/ cancer navigator, and the authority for the service manager to prioritise 2WW patients before all other patients on waiting lists.

Target (mthly / end of year)	Latest month performance April	Performance to date 2015/16	Forecast performance for May
R8: 2WW (Target: 93%)	91.2%	91.2%	88.3%
R10: 31 day 1st (Target: 96%)	93.7%	93.7%	96.6%
R12: 31 day sub – Surgery (Target: 94%)	86.3%	86.3%	78.3%
R14: 62 day RTT (Target: 85%)	75.5%	75.5%	71.3%
R15: 62 day screening (Target: 90%)	91.7%	91.7%	85.1%

Performance by Quarter

	14/15 FYE	15/16 Q1	15/16 Q2	15/16 Q3	15/16 Q4
R8	92.2%	91.2%			
R10	94.6%	93.7%			
R12	89%	86.3%			
R14	81.4%	75.5%			
R15	84.5%	91.7%			

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

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

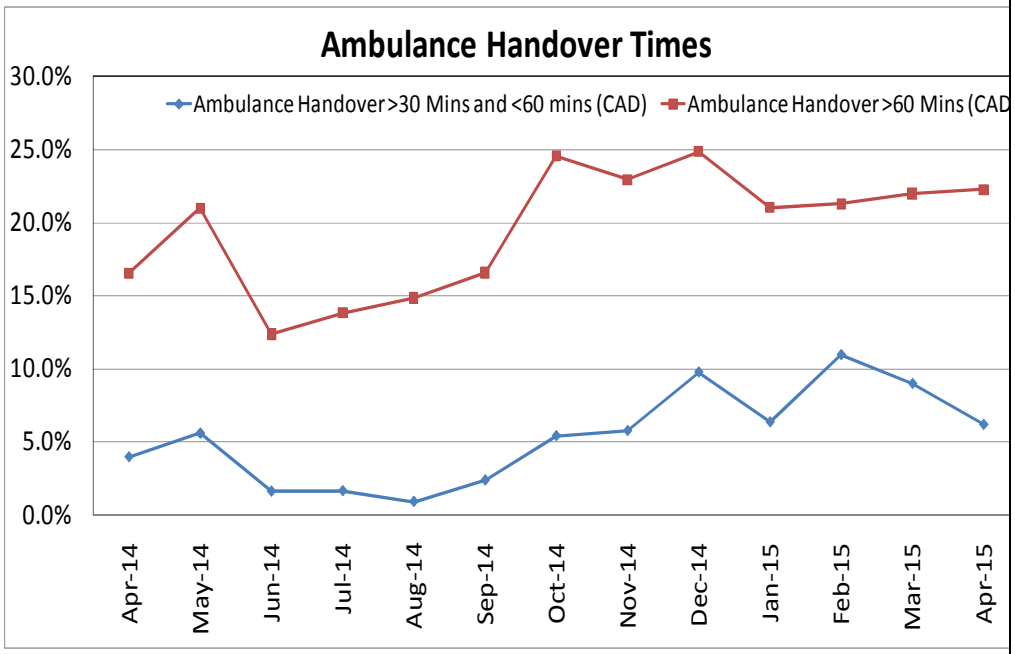
What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	May performance	YTD performance	Forecast performance for next reporting period
The Trust is measured on the % of Appointment Slot Unavailability (ASI) per month. UHL has not met the required standard of <4% for approximately two years. When it has been able to reach this standard, it has not been sustainable. The two most significant factors causing underperformance are: • Shortage of capacity in outpatients; • Inadequate training and education of administrative staff in the set up and use of the NHS e-Referral System. The specialties with the highest number of ASIs are: • General Surgery; • Orthopaedics; • ENT; • Gynaecology. Transition to new e-Referral System: • Choose and Book migrated to the new e-Referral System on Monday 15th June; • This has caused significant problems at a national level, with the system being made unavailable for maintenance. • This has impacted all services including the 2WW office.	**Action plan** • An action plan has been written outlining steps for recovering performance; • This has been shared with commissioners. **Capacity** • Additional capacity in key specialties is part of RTT recovery plans. **Training and Education** • Training and education of staff in key specialties continues, to ensure that the system is adequately set up and administrative processes are fit for purpose; • A specialty level ASI scorecard is distributed weekly to CMGs, highlighting areas for concern and actions required. **Additional resource to support the e-Referral System** • An NHS e-Referral System administrator has been in post since May; • She will be working with key specialties to help reduce their ASIs and promote administrative housekeeping.	**<4%**	31%	32.5%	30%

National performance varies significantly by provider. The table below outlines UHL's performance amongst peer trusts. While clearly many providers are facing the same problems as UHL, the Trust is one of the worst performers.

Provider	Monthly volume of bookings	% of slot issues
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	2548	0.07
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	6842	0.08
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	7251	0.09
OXFORD UNIVERSITY HOSPITALS NHS TRUST	6249	0.09
HEART OF ENGLAND NHS FOUNDATION TRUST	5116	0.11
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	4551	0.18
HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	4461	0.18
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	2837	0.21
BARTS HEALTH NHS TRUST	6998	0.23
CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	5593	0.26
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	9007	0.26
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	3750	0.26
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	4026	0.27
LEEDS TEACHING HOSPITALS NHS TRUST	5302	0.3
PENNINE ACUTE HOSPITALS NHS TRUST	10071	0.31
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	9437	0.31
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	3607	0.39
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	5170	0.51

Expected date to meet standard / target	December 2015
Lead Director / Lead Officer	Will Monaghan, Director of Performance and Information Charlie Carr, Head of Performance

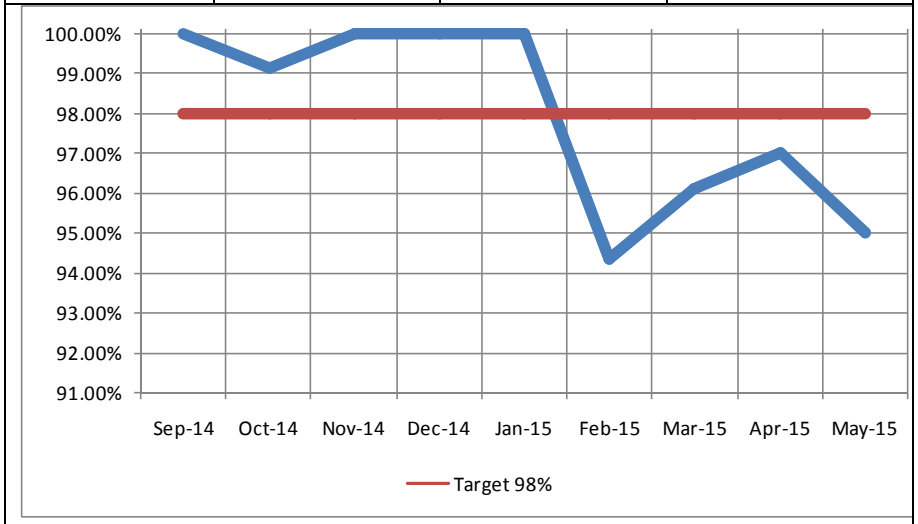
R27 and R28 Ambulance handover > 30 minutes and >60 minutes

		Target	May 15	YTD	Forecast
What is causing underperformance?	What actions have been taken to improve performance?	0 delays over 30 minutes	>60 min 6.6% 30-60 min 21.2%	>60 min 6.4% 30-60 min 21.8%	> 60 min 3% 30-60 min 17%
Difficulties continue in accessing beds from ED leading to congestion in the assessment area and delays ambulance handover. May's performance remained similar to the preceding month but an improvement on the Q4 performance.	CAD+ training took place for the new system to be implemented 1st June via a training film. Liaison meeting occurred x3 per week with EMAS project manage to ensure project on track for implementation. Validation of data continues and shows large discrepancies between EMAS and UHL findings which lowers handover waits in favour of UHL.			

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

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

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
KPI 46: Percentage of audits in clinical areas achieving NCS audit scores for cleaning above 90% Feb 15 – 94% Mar 15 - 96% Apr 15 – 97% May 15 – 95%	The current review of cleaning rosters and tasks across the Acute Estate is underway and this process alongside investment in equipment will support cleaning standards within the UHL. This review and changes have been documented and shared with the EFMC. Interserve conduct joint audits in accordance with the Trust Policy. These audits must be carried out at the appropriate time to ensure normal use of facilities does not lead to undue degradation of standards, unfairly impacting audit scores.	100%	95%	96%	100%



Expected date to meet standard / target	July 31st 2015
Revised date to meet standard	July 31st 2015
Lead Director / Lead Officer	Darryn Kerr, Director of Estates and Facilities Mike Hotson,

CQC – Intelligent Monitoring Report

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

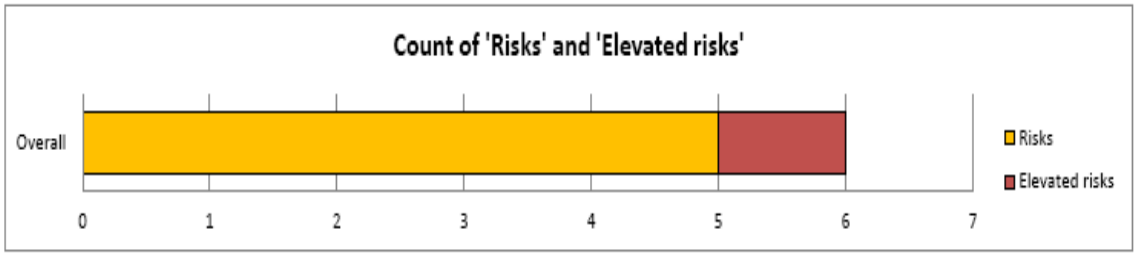
The IMR evaluates against a range of indicators relating to the five key questions used by the CQC as part of their inspections - is the organisation safe, effective, caring, responsive, and well-led?

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

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

University Hospitals of Leicester NHS Trust

Trust Summary



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

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

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

Monthly Reported 15/16 Quality Schedule and CQUIN Indicators - Performance and RAG Ratings

Indicator	Monthly Dashboard Metric	Threshold	14/15	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	Commentary
Infection Prevention and Control Reduction.	Hospital acquired C Diff	<6 per month	73	3	1											4	
HCAI Monitoring	MRSA Bacteraemia	0	6	0	0											0	
Patient Safety	Never Events	0	3	0	1											1	NE in May relates to prescribing of insulin dosage being wrongly written and subsequently administered.
Duty of Candour (DoC)	Duty of Candour Breaches	0	0	0	0											0	
Risk Assurance	Number of New Risks		32	4	tbc											4	
Staffing governance	Statutory and Mandatory Training	95%	95%	93%	92%											93%	
	Corporate Induction	95%	96.%	97%	97%											97%	
	Appraisal	95%	94.1%	90.1%	88.7%											89%	
	Staff Sickness	3%	3.8%	3.8%	tbc											3.8%	
	Turnover Rate	11%	11.5%	10.4%	10.5%											10.5%	
Reduction in Pressure Ulcer incidence.	Grade 4	0	2	0	0											0	
	Grade 3	<=6	69	3	0											3	

Indicator	Monthly Dashboard Metric	Threshold	14/15	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	Commentary
	Grade 2	<=8	91	10	8											18	
Medicines Management Optimisation	Publication of Formulary	Published	Published	Published	Published											Published	
Same Sex Accommodation Compliance and Annual Estates Monitoring	Same Sex Breaches	0	13	0	0											0	
#NOF - Dashboard	Time to Theatre within 36 hours	72%	61.4%	55.7%	42.6%											49%	Further deterioration in peformance. 67 admissions, main reason for 'time to theatre being >36 hrs' was around theatre capacity and also increase in number of spinal patients.
Stroke and TIA monitoring	90% stay on Stroke ward **3.** Improve performance with the SSNAP Data.	80%	81.3%	82.7%	tbc											82.7%	
	High Risk TIA patients seen within 24 hours of referral **3.** Improve performance with the SSNAP Data.	60%	79.7%	86.3%	79.6%											83%	
	Low Risk TIA patients seen within 7 days of referral	85%		100%	99%											100%	
Venous Thromboembolism (VTE)	Patients risk assessed for VTE within 24 hours of admission	95%	95.8%	96.0%	96.0%											96%	

Indicator	Monthly Dashboard Metric	Threshold	14/15	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	Commentary
Nutrition and Hydration	All aspects of Nutrition and Hydration Metrics met by all CMGs	90%	<90%	Quarterly	Quarterly												
Friends and Family Test	Inpatient Response rate	30%	40.1%	30.2%	33.1%											32%	Includes both adult and children
	ED Response rate	15%	22.8%	14.7%	15.1%											15%	Includes both adult and children. Performance for adults = 20%.
Safety Thermometer	Harm free care	95%	94.1%	93.7%	94.3%											94%	
Dementia - FAIR	Screening	90%	>90%	91.3%	tbc											91.3%	
	Risk Asesssment	90%	>90%	100.0%	tbc											100%	