Quality & Performance Report

Author: John Adler Sponsor: Chief Executive Date: IFPIC + QAC 24th Sept 2015

Executive Summary from CEO Paper Q

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 SHMI for January 14 to December 14 is 99, this is the best score that the Trust has achieved since the introduction of SHMI. **Fractured NOF** the standard has been achieved for the first time since July 2014 and the work of all involved should be commended. The **RTT incomplete** target remains compliant. **Delayed transfers of care** remain well within the tolerance. **MRSA** and avoidable **Grade 4 pressure ulcers** remain at zero. **Cancer standards** The 31 day treatment standard was achieved alongside the 62 day screening pathway. **Cancelled operations** was achieved in August, with half the number of operations cancelled on the day compared to July.

Bad News:
ED 4 hour performance in the calendar month of August was 90.6%, which has slipped slightly after being consistently over 92% for the last four months. It is 91.9% year to date. Grade 2 **pressure ulcers** were above the upper limit for the month. **C Diff** has increased to 6 this month, which is higher than the April and May lows but on track with the year to date trajectory. **RTT 52+ week waits** in Orthodontics continue given the difficulties with locum consultant recruitment. As referenced last month, problems in Endoscopy have had a big impact on **diagnostics 6 week wait** performance which is not expected to regain

compliance until October. The numbers have worsened as the longest waiting patients are being offered dates. **Cancer Standards** The 2 week wait standard was failed largely as a result of challenges in Endoscopy. **62 Day Cancer** has dropped considerably in July, however the number of backlog patients has reduced alongside this. You will notice we now report the 62 day standard tumour site by tumour site in the Quality & Performance report.

Input Sought

I recommend that the Committee:

- Commends the positive achievements noted under Good News
- Note the indicators highlighted in bold 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: 29/10/15

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

August 2015

One team shared values

CONTENTS

Dashboards

Exception Reports

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

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

DATE: 24TH SEPTEMBER 2015

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

SUBJECT: AUGUST 2015 QUALITY & PERFORMANCE SUMMARY REPORT

1.0 Introduction

The following report provides an overview of the August 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	6	3
Effective	7	16	3	1
Responsive	8	17	2	6
Responsive Cancer	9	9	1	3
Research – UHL	11	6	6	0
Research - Network	11	13	0	3
Estates & Facilities	12	10	0	1
Total		121	33	15

3.0 New Indicators

Responsive

Cancer 62 day performance by tumour site is reported on the responsive cancer – page 9.

4.0 Indicators removed

Admitted and non-admitted RTT indicators have been removed.

5.0 Indicators where reporting methodology/thresholds have changed

Red RAG and Exception reporting thresholds have been amended to provide additional clarity.

Effective

Emergency readmissions within 30 days following an elective or emergency spell, has now been RAG rated based on local peer group analysis.

Responsive

Ambulance Handover reported from CAD+ from June onwards - data quality issues identified with EMAS data in that data is incomplete and there are duplicate records.

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

-

	KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	YTD
Safe	S1	Clostridium Difficile	JS	DJ	61	TDA	Red if >mthly threshold / ER if Red or Non compliance with cumulative target	66	73	7	2	5	7	7	11	7	5	7	3	1	4	4	6	18
	S2a	MRSA Bacteraemias (All)	JS	DJ	0	TDA	Red if >0 ER if >0	3	6	0	0	1	1	0	2	0	1	1	0	0	0	0	0	0
	S2b	MRSA Bacteraemias (Avoidable)	JS	DJ	0	UHL	Red if >0 ER if >0	1	1	0	0	0	0	0	0	0	1	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	0	0	0	1	0	1	1	0	0	0	0	0	0	0	0
	S4	Serious Incidents	JS	MD	Not within Highest Decile	TDA	TBC	60	41	7	2	3	4	2	4	3	2	1	2	8	1	5	3	19
	S5a	Proportion of reported safety incidents per 1000 beddays	JS	MD	TBC	TDA	TBC	37.5	39.1	41.1	35.6	41.8	38.9	40.3	40.4	35.0	38.2	36.3	34.6	37.3	39.6	39.9	37.1	37.7
	S5b	Proportion of reported safety incidents that are harmful	JS	MD	Not within Highest Decile	TDA	TBC	2.8%	1.9%	2.2%			1.4%			2.3%			2.2%					2.2%
	S6	Overdue CAS alerts	JS	MD	0	TDA	Red if >0 in mth ER = in mth >0	2	10	3	0	0	0	0	0	0	0	1	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	2	2	1	2	2	1	0	3	2	0	6	0	0	3	9
	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%	94.9%	94.4%	93.9%	94.9%	93.3%	94.1%	95.0%	92.1%	93.6%	93.7%	94.3%	95.6%	94.6%	93.2%	94.3%
	S8b	Safety Thermometer % number of new harms	JS	EM	Not within Lowest Decile	TDA	TBC	New TDA Indicator		2.4%	2.9%	2.5%	2.3%	3.3%	2.4%	2.5%	3.2%	2.7%	2.2%	2.6%	2.1%	1.9%	3.1%	2.4%
	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%	96.3%	95.5%	96.2%	95.4%	95.5%	95.0%	96.3%	96.2%	95.6%	96.0%	96.0%	96.5%	96.2%	96.5%	96.2%
	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	7.3	7.3	5.9	6.4	7.5	6.9	7.1	6.7	6.3	5.6	5.8	5.1	5.7	5.7	5.6
	S12	Avoidable Pressure Ulcers - Grade 4	JS	MC	0	QS	Red / ER if Non compliance with monthly target	1	2	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0
	S13	Avoidable Pressure Ulcers - Grade 3	JS	MC	<=6 a month	QS	Red / ER if Non compliance with monthly target	71	69	5	6	6	4	6	7	5	9	6	3	0	4	1	4	12
	S14	Avoidable Pressure Ulcers - Grade 2	JS	MC	<=8 a month	QS	Red / ER if Non compliance with monthly target	120	91	7	9	4	8	13	11	7	5	9	10	8	8	8	10	44
	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%	>=60%			<65%			<75%								
	S16	Maternal Deaths	AF	IS	0	UHL	Red or ER if >0	3	1	0	0	0	0	0	0	1	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%	16.9%	15.4%	17.4%	18.1%	17.4%	16.2%	17.7%	15.5%	15.8%	15.3%	18.8%	15.8%	15.8%	15.2%	16.2%
	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																	

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	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	YTD
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%	97%	96%	97%	96%	96%	96%	96%	96%	97%	96%	96%	97%	96%	97%	96%
	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%	92%	95%	96%	96%	96%	96%	96%	97%	96%	96%	96%	96%	97%	96%
	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%
	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%
	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%	96%	96%	94%	96%	97%	95%	97%	96%	96%	95%	96%	95%	95%	96%	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%	67.2%			Q3 staff FFT not completed as National Survey carried out			71.4%			68.7%					68.7%
	C7a	Complaints Rate per 100 bed days	AF	MD	TBC	UHL	TBC	New Indicator	0.4	0.4	0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.4	0.3	0.3	0.3	0.3	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 if >=15% ER if >=15%	New Indicator	10%	11%	10%	9%	11%	11%	10%	17%	13%	11%	13%	7%	7%	7%	11%	9%
	C9	Single Sex Accommodation Breaches (patients affected)	JS	HL	0	TDA	Red / ER if >0	2	13	0	0	0	0	5	0	1	0	0	0	0	0	0	0	0

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	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	YTD
Well Led	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%	29.0%
	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%	15.4%
	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%	14.1%
	W4	Outpatients Friends and Family Test - Coverage	JS	HL	Q1 3% Q2/3 4% Q4 5%	UHL	Red if <2.5% ER if 2 mths Red	NEW METHODOLOGY FOR CALCULATING COVERAGE INCLUDES ADULTS AND CHILDREN											1.3%	1.6%	1.2%	1.2%	1.4%	1.3%
	W5	Maternity Friends and Family Test - Coverage	JS	HL	30%	UHL	Red if <26% ER if 2 mths Red	25.2%	28.0%	29.2%	29.9%	18.7%	15.8%	21.7%	22.1%	25.8%	46.5%	40.2%	32.3%	35.8%	32.6%	25.6%	30.5%	31.3%
	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%	53.7%			Q3 staff FFT not completed as National Survey carried out			54.9%			52.5%					
	W7a	Nursing Vacancies	JS	MM	5% by Mar 16	UHL	Separate report submitted to QAC	NEW UHL INDICATOR				6.7%	6.7%	6.4%	6.0%	6.3%	5.5%	6.5%	8.5%	8.0%	7.3%	8.7%	8.9%	8.9%
	W7b	Nursing Vacancies in ESM CMG	JS	MM	5% by Mar 16	UHL	Separate report submitted to QAC	NEW UHL INDICATOR				10.8%	10.8%	10.7%	9.7%	12.8%	11.4%	14.0%	19.3%	13.0%	14.4%	13.3%	13.5%	13.5%
	W8	Turnover Rate	LT	LG	Not within Lowest Decile	TDA	Red = 11% or above ER = Red for 3 Consecutive Mths	10.0%	11.5%	10.0%	10.5%	10.3%	10.8%	10.7%	10.3%	10.1%	10.1%	11.5%	10.4%	10.5%	10.5%	10.6%	10.4%	10.4%
	W9	Sickness absence	LT	KK	3%	UHL	Red if >4% ER if 3 consecutive mths >4.0%	3.4%	3.8%	3.4%	3.4%	3.7%	4.0%	4.0%	4.4%	4.2%	4.1%	4.0%	3.6%	3.4%	3.5%	3.5%		3.5%
	W10	Temporary costs and overtime as a % of total paybill	LT	LG	TBC	TDA	TBC	New Indicator	9.4%	8.5%	8.9%	8.5%	9.5%	9.0%	9.8%	10.5%	9.8%	11.5%	10.7%	10.2%	11.0%	10.8%	11.1%	10.8%
	W11	% of Staff with Annual Appraisal	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	91.3%	91.4%	89.6%	88.6%	89.7%	91.8%	92.3%	92.5%	90.9%	91.0%	91.4%	90.1%	88.7%	89.0%	89.1%	88.8%	88.8%
	W12	Statutory and Mandatory Training	LT	BK	95%	UHL	TBC	76%	95%	80%	83%	85%	86%	87%	89%	89%	90%	95%	93%	92%	92%	91%	91%	91%
	W13	% Corporate Induction attendance	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	94.5%	100%	96%	98%	98%	98%	98%	100%	99%	100%	97%	97%	97%	98%	100%	97%	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%	87.7%	87.9%	91.6%	92.9%	91.3%	92.7%	94.3%	91.8%	91.0%	93.6%	90.3%	91.2%	90.3%	90.2%	91.1%
	W14b	DAY Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	Not within Lowest Decile	TDA	TBC		94.0%	93.0%	94.8%	90.3%	95.4%	94.4%	95.8%	95.4%	92.8%	92.5%	94.2%	91.2%	93.5%	91.3%	92.4%	92.5%
	W14c	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	Not within Lowest Decile	TDA	TBC		94.9%	90.8%	91.4%	94.8%	97.4%	96.5%	96.4%	97.9%	96.5%	97.2%	98.9%	96.0%	96.2%	94.3%	94.3%	95.9%
	W14d	NIGHT Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	Not within Lowest Decile	TDA	TBC		99.8%	97.9%	98.0%	97.8%	100.8%	101.2%	101.4%	103.6%	100.8%	103.2%	106.3%	98.7%	99.4%	101.2%	98.0%	100.7%

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	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	YTD
Effective	E1	Mortality - Published SHMI	AF	PR	Within Expected	TDA	Higher than Expected	105	103	106 (Jan13-Dec13)			105 (Apr13-Mar14)			103 (Oct13-Sep14)			99 (Jan14-Dec 14)					
	E2	Mortality - Rolling 12 mths SHMI (as reported in HED) Rebased	AF	PR	Within Expected	QC	Red if >expected ER if >Expected or 3 consecutive mths increasing SHMI >100	105	97	104	103	103	102	102	100	100	100	99	99	97	Awaiting HED Update			97
	E3	Mortality HSMR (DFI Quarterly)	AF	PR	Within Expected	TDA	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	88	94	92			93			93			Awaiting DFI Update					
	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	95	97	96	96	96	95	95	95	95	94	94	93	93	Awaiting HED Update		93
	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	85	96	97	95	88	96	99	98	85	82	95	97	Awaiting HED Update		91
	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	101	103			97			103			Awaiting DFI Update					
	E7	Crude Mortality Rate Emergency Spells	AF	PR	Within Upper Decile	TDA	TBC	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%	2.3%	1.9%	2.0%	2.1%
	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	81	80	64	59	113	60	85	101	87	75	100	20	Awaiting HED Update			60
	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%	8.4%	8.9%	8.4%	8.6%	8.9%	9.1%	8.2%	8.5%	8.5%	9.2%	9.1%	9.0%	8.8%		9.0%
	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%	76.9%	59.0%	68.6%	69.6%	59.4%	57.3%	57.9%	67.2%	61.5%	55.7%	42.6%	70.1%	60.3%	78.1%	61.7%
	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%	78.1%	84.5%	83.2%	70.4%	73.3%	75.2%	82.5%	87.6%	83.3%	83.7%	84.5%	84.5%	84.8%		84.4%
	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%	62.8%	65.5%	72.7%	67.8%	69.0%	83.5%	80.6%	64.0%	77.3%	86.3%	79.6%	72.0%	78.9%	80.2%	79.2%
	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
	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
	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 | Estates and Facilities

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	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	YTD
R1	ED 4 Hour Waits UHL + UCC (Calendar Month)	RM	IL	95% or above	UHL	Red if <92% ER via ED TB report	88.4%	89.1%	91.0%	92.5%	91.3%	91.6%	89.8%	89.1%	83.0%	90.7%	89.6%	91.1%	92.0%	92.2%	92.6%	92.2%	90.6%	91.9%
R2	12 hour trolley waits in A&E	RM	IL	0	TDA	Red if >0 ER via ED TB report	5	4	1	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0
R3	RTT - Incomplete 92% in 18 Weeks	RM	WM	92% or above	TDA	Red /ER if <92%	92.1%	96.7%	94.0%	93.2%	94.0%	94.3%	94.8%	95.0%	95.1%	95.2%	96.2%	96.7%	96.6%	96.5%	96.2%	95.4%	94.6%	94.6%
R4	RTT 52 Weeks+ Wait (Incompletes)	RM	WM	0	TDA	Red /ER if >0	0	0	0	15	1	3	3	2	0	0	0	0	0	66	242	256	258	258
R5	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	TDA	Red /ER if >1%	1.9%	0.9%	0.8%	0.7%	1.0%	1.0%	0.7%	1.8%	2.2%	5.0%	0.8%	0.9%	0.8%	0.6%	6.1%	10.9%	13.4%	13.4%
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	1	2	1	2	2	0	3	4	3	1	2	0	1	1	5	9
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	0	0	6	0	0	1	1	2	1	0	0	0	1	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%	0.7%	0.6%	0.8%	0.8%	1.2%	1.1%	0.8%	0.7%	1.0%	0.7%	0.5%	0.9%	1.3%	0.7%	0.9%
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%	0.3%	2.7%	0.0%	0.9%	1.0%	0.0%	0.8%	1.4%	0.0%	0.4%	1.2%	1.2%	1.0%	0.8%	0.0%	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%	1.0%	0.9%	0.6%	0.8%	0.8%	1.1%	1.1%	0.8%	0.7%	0.9%	0.8%	0.6%	0.9%	1.3%	0.7%	0.9%
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	98	94	55	90	94	108	102	85	64	98	79	56	97	138	67	437
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%	4.0%	3.9%	3.9%	4.5%	4.6%	5.2%	3.9%	3.2%	2.9%	1.8%	1.2%	1.0%	1.5%	0.9%	1.2%	1.2%
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%	26%	25%	26%	25%	20%	17%	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%	2%	2%	1%	2%	5%	6%	10%	6%	11%	9%	6%	7%	7%	8%	9%	7%
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%	12%	14%	15%	17%	25%	23%	25%	21%	21%	22%	22%	21%	17%	17%	17%	19%

Responsive Cancer

KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	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%	92.2%	92.0%	90.6%	92.0%	92.5%	93.0%	92.2%	93.5%	91.5%	91.2%	87.9%	91.1%	87.5%	**	89.4%
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%	94.9%	94.4%	95.2%	98.6%	100.0%	93.0%	92.5%	91.5%	96.0%	99.0%	98.8%	87.2%	93.3%	**	94.6%
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%	94.4%	97.9%	91.9%	95.9%	92.5%	95.2%	91.7%	95.0%	97.0%	93.9%	97.9%	93.7%	97.2%	**	95.7%
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%	100.0%	98.8%	100.0%	97.1%	100.0%	96.7%	100.0%	100.0%	100.0%	100.0%	100.0%	97.7%	100.0%	**	99.3%
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%	90.1%	87.8%	94.0%	81.9%	82.4%	80.3%	89.2%	94.4%	87.5%	86.3%	92.2%	89.6%	92.2%	**	89.9%
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%	97.3%	99.0%	96.5%	96.0%	94.7%	95.5%	87.6%	99.0%	100.0%	86.3%	98.1%	96.5%	95.9%	**	94.7%
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%	85.6%	78.8%	75.5%	80.4%	77.0%	84.8%	79.3%	78.9%	83.8%	75.7%	70.1%	84.2%	73.7%	**	76.1%
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%	73.0%	100.0%	87.5%	75.0%	94.4%	93.8%	88.9%	79.4%	89.3%	91.7%	82.4%	93.3%	95.2%	**	90.8%
RC9	Cancer waiting 104 days	RM	MM	0	TDA	TBC	NEW TDA INDICATOR											12	10	12	20	12	12

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

KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	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%	91.1%	84.4%	93.8%	96.3%	81.8%	100.0%	93.3%	97.4%	98.1%	92.3%	96.8%	97.8%	91.4%	**	94.6%
RC12	Gynaecological	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	88.2%	77.5%	88.9%	91.7%	77.8%	71.4%	75.0%	66.7%	54.5%	91.7%	75.0%	64.3%	55.6%	66.7%	100.0%	**	70.0%
RC13	Haematological	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	65.9%	66.5%	84.6%	87.5%	42.1%	100.0%	73.3%	75.0%	66.7%	50.0%	80.0%	50.0%	55.0%	83.3%	37.5%	**	54.4%
RC14	Head and Neck	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	65.4%	69.9%	66.7%	83.3%	40.0%	100.0%	33.3%	77.8%	70.0%	87.5%	62.5%	75.0%	54.5%	66.7%	36.4%	**	55.3%
RC15	Lower Gastrointestinal Cancer	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	71.3%	63.7%	81.8%	50.0%	50.0%	56.3%	62.5%	92.9%	65.0%	46.7%	63.2%	63.6%	55.6%	93.3%	63.6%	**	69.1%
RC16	Lung	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	89.7%	69.9%	70.0%	48.1%	56.8%	68.9%	64.1%	74.4%	67.7%	74.2%	88.6%	84.6%	50.9%	74.6%	81.8%	**	71.4%
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%	66.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100%	100%	100%	**	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%	--	--	--	0.0%	0.0%	100.0%	--	0.0%	66.7%	--	100%	--	**	80.0%
RC19	Skin	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	96.8%	96.7%	100.0%	100.0%	97.3%	94.5%	98.4%	94.1%	100.0%	94.3%	95.6%	91.7%	94.0%	91.3%	93.8%	**	92.8%
RC20	Upper Gastrointestinal Cancer	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	72.2%	73.9%	52.6%	77.8%	75.0%	33.3%	64.7%	68.0%	85.7%	77.8%	81.8%	66.7%	55.0%	84.6%	51.4%	**	62.3%
RC21	Urological (excluding testicular)	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	89.3%	82.6%	89.2%	77.1%	86.1%	84.5%	81.5%	85.7%	83.3%	66.7%	71.0%	62.1%	62.1%	74.7%	61.5%	**	65.3%
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%	0.0%	100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	--	100%	100%	100%	**	100%
RC23	Grand Total	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	86.7%	81.4%	85.6%	78.8%	75.5%	80.4%	77.0%	84.8%	79.3%	78.9%	83.7%	75.7%	70.1%	84.2%	73.7%	**	76.1%

Compliance Forecast for Key Responsive Indicators

Standard	August actual/ predicted	September predicted	Month by which to be compliant	RAG rating of required month delivery	Commentary
Emergency Care					
4+ hr Wait (95%) - Calendar month	90.6%				Weekly SITREPs have ceased from end of June. Future ED performance to be reported monthly.
Ambulance Handover (CAD)					
% Ambulance Handover >60 Mins (CAD+)			Not Agreed		Further meeting to be arranged as DQ is still an issue with missing data and duplicate records.
% Ambulance Handover >30 Mins and <60 mins (CAD+)			Not Agreed		
RTT (inc Alliance)					
Incomplete (92%)	94.6%	94.0%	Continued Delivery		July/August dip due to continuing growing pressure in ENT, General Surgery and Gastroenterology.
Diagnostic (inc Alliance)					
DM01 - diagnostics 6+ week waits (<1%)	13.4%	4.5%	October		Endoscopy the predominate cause of failure. Significant changes in endoscopy to support re-delivery. September predicted circa 4.5%.
# Neck of femurs					
% operated on within 36hrs (72%)	78.1%	72.0%	October		
Cancelled Ops (inc Alliance)					
Cancelled Ops (0.8%)	0.7%	0.8%	August		
Not Rebooked within 28 days (0 patients)	5	1	September		5 from Urology and 1 General Surgery and 1 HPB due to various capacity pressures
Cancer (predicted)					
Two Week Wait (93%)	88%	85%	November		
31 Day First Treatment (96%)	96%	96%	July		July and August expected to be compliant.
31 Day Subsequent Surgery Treatment (94%)	90%	92%	October		A one off issue in breast surgery has delayed recovery by 1 month.
62 Days (85%)	78%	75%	October (at risk)		Plans and backlog numbers are monitored weekly at the Cancer Action Board.

Research UHL

KPI Ref	Indicators	Board Director	Lead Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD	Apr-15	May-15	Jun-15	YTD
RU1	Median Days from submission to Trust approval (Portfolio)	AF	NB	TBC	TBC	TBC	3.0			2.0			3.0			3.0			2.8	2.0			2.0
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			4.0
RU3	Recruitment to Portfolio Studies	AF	NB	Aspirational target=10920/year (910/month)	TBC	TBC	941	1092	963	1075	1235	900	1039	1048	604	1030	1043	1298	1022	1071	807	1025	968
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%							
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							
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%							

Research (CLINICAL RESEARCH NETWORK)

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD	Apr-15	May-15	Jun-15
RS1	Number of participants recruited in a reporting year into NIHR CRN Portfolio studies	AF	DR	England 650,000 East Midlands 50,000	NIHR CRN	Red / ER if <90%	92%	93%	94%	93%	91%	90%	101%	101%	To be presented at the UHL Executive Performance Board on 22/09/2015		
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 if <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 if <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 if <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 if <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 if <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 if <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 if <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 if <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 if <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 if <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 if <100%	100% *Q2	100.0%				100%	100%	100%			

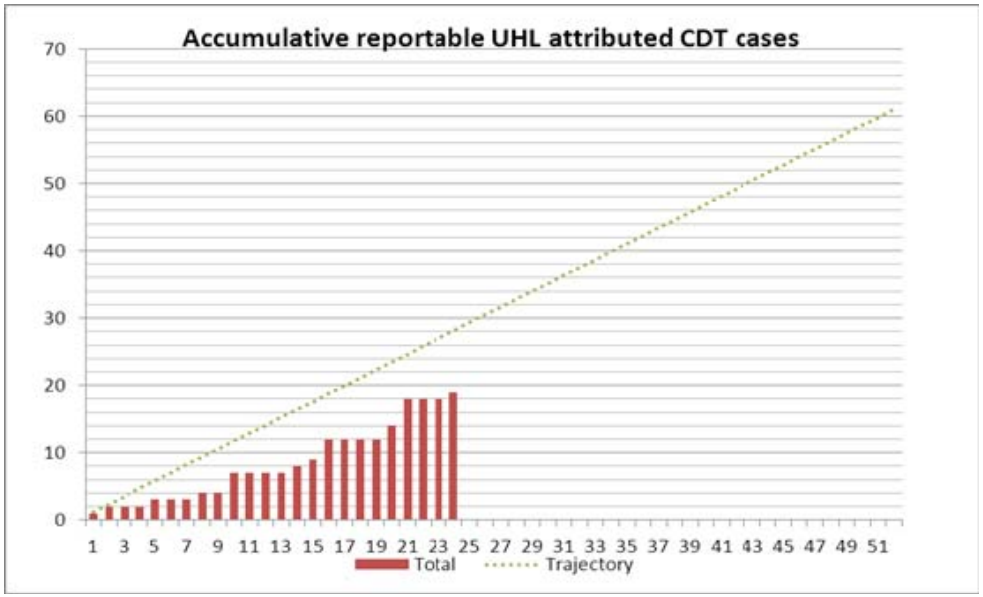
Safe | Caring | Well Led | Effective | Responsive | Research | **Estates and Facilities**

	KPI Ref	Indicators	Board Director	Lead Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-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 if ≤ 98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	New dashboard currently under development	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 if ≤ 80%	100.0%	91.5%	81.2%	95.6%	80.5%	86.6%	97.4%	99.5%	99.0%	99.0%	98.0%	83.0%		94.8%
	E&F3	Percentage of Estates Urgent requests achieving rectification time	DK	LT	95%	Contract KPI	Red if ≤ 75%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%
	E&F4	Percentage of scheduled Portering tasks completed in the Contract Month	DK	LT	99%	Contract KPI	Red if ≤ 98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%
	E&F5	Number of Emergency Portering requests achieving response time	DK	LT	100%	Contract KPI	Red if >2	0	0	0	0	0	0	0	0	0	0	0	0		0
	E&F6	Number of Urgent Portering requests achieving response time	DK	LT	95%	Contract KPI	Red if ≤ 95%	95.0%	95.1%	96.2%	97.3%	97.2%	97.2%	98.5%	98.1%	99.0%	100.0%	100.0%	100.0%		99.8%
	E&F7	Percentage of Cleaning audits in clinical areas achieving NCS audit scores for cleaning above 90%	DK	LT	100%	Contract KPI	Red if ≤ 98%	100.0%	100.0%	99.1%	100.0%	100.0%	100.0%	94.4%	96.1%	97.0%	95.0%	95.0%	93.0%		95.0%
	E&F8	Percentage of Cleaning Rapid Response requests achieving rectification time	DK	LT	92%	Contract KPI	Red if ≤ 80%	92.0%	99.6%	89.9%	93.3%	90.5%	91.1%	94.1%	96.9%	95.0%	95.0%	100.0%	99.0%		97.3%
	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 if ≤ 95%	97.0%	99.4%	99.5%	100.0%	100.0%	98.9%	99.9%	100.0%	100.0%	100.0%	100.0%	99.0%		99.8%
	E&F10	Overall percentage score for monthly patients satisfaction survey for catering service	DK	LT	85%	Contract KPI	Red if ≤ 75%	85.0%	96.7%	97.3%	97.3%	96.7%	93.8%	95.8%	97.5%	96.0%	97.0%	91.0%	91.0%		93.8%

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
The cases of CDT are currently subject to Post Infection Reviews as C difficile infection reported on the death certificate have been identified recently. There are no discernible factors that link the 6 cases in August to people and place, and they should be viewed in the context of being only 35% of the cases reported in August, and the trust is still below trajectory overall. Additionally upon clinical review 2 of the cases were deemed not be true infection and coincidental identification of C difficile which may represent colonisation. Concerns in relation to compliance with the National Minimum Cleaning frequencies have been expressed from colleagues within all CMGs and continue to be reported to the facilities management team and monitored locally.	Any learning following the outcome of the PIRs should be presented to the CMG Infection Prevention Groups and should follow the PIR process flow chart as described in the Infection Prevention Toolkit. Action plans with named local leads will be produced if the PIR feels action is required to reduce further cases. The number of cases to date mirrors last year's numbers at this time however we continue to strive for a further reduction in cases. The Director of Facilities will chair a newly formed monthly Infection Prevention Operational Group who in conjunction with a quarterly TIPAC have as their remit the review of current cleanliness forums in place, to ensure these are fit for purpose and are monitoring cleanliness and ensuring performance delivery effectively.	**5 (monthly)** **61 (end of year)**	**6**	**18**	**N/A**

	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
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								**18**



Expected date to meet standard / target	TBA
Revised date to meet standard	TBA
Lead Director / Lead Officer	Julie Smith, Chief Nurse David Jenkins, Consultant

Avoidable Pressure Ulcers – Grade 2

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly)	Latest month performance	YTD performance	Forecast performance for next reporting period
The incidence of pressure ulcers for August is out of trajectory targets for Grade 2 avoidable pressure ulcers. Key findings from this month's validation events are that increased acuity and inadequate staffing levels have resulted in interventions to avoid pressure ulcers were not completed consistently. A higher number of heel damage related pressure sores, appears to be due to inadequate heel protection mostly when the patients were nursed in chair. Some clinical areas reported not elevating legs through a lack of footstools. A strong theme this month is also inappropriate use of anti embolic stockings.	In response to these findings, Heads of Nursing will be requested to review the provision of footstools and heel protection equipment at ward level. The pressure ulcer prevention team together with the Anti-coagulation CNS will also focus work with nursing and medical staff, to ensure the staff from the clinical areas with avoidable HAPUs related to inappropriate use of anti embolic stockings (AES) have had update / training on correct use of AES and contraindications. Matrons will be auditing and promoting the use of the UHL DVT prevention checklist to ensure safe use of anti-embolic stockings.	**G2= 8**	**G2 = 10**	**G2 = 44**	**G2 = </= 8**

Table one - Avoidable Grade 2 Pressure Ulcers April –August 2015

Threshold for Grade 2 Avoidable Pressure Ulcers 2015/16													
Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Threshold	**8**	**8**	**8**	**8**	**8**	**8**	**8**	**8**	**8**	**8**	**8**	**8**	**96**
Incidence	10	8	8	8	10								**44**

Table two - Avoidable Grade 3 Pressure Ulcers April – August 2015

Threshold for Grade 3 Avoidable Pressure Ulcers 2015/16													
Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Threshold	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**72**
Incidence	3	0	4	1	4								**12**

Table three - Avoidable Grade 4 Pressure Ulcers April – August 2015

Threshold for Grade 4 Avoidable Pressure Ulcers 2015/16													
Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Threshold	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Incidence	0	0	0	0	0	0							**0**

Expected date to meet standard / target	September 2015
Revised date to meet standard	TBA
Lead Director / Lead Officer	Julie Smith, Chief Nurse Michael Clayton, Head of Nursing

Outpatients Friends and Family test – Coverage

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	August performance	YTD performance	Forecast performance for next reporting period
A clear system for the collection of Friends and Family Test results has been established within the three main outpatients' departments as well as the majority of all stand-alone clinic facilities. Staff within these departments have been cited to the coverage requirements, to ensure success: • Improve ownership and monitoring of the Friends and Family Test within the Clinical Management Groups • Increase medical staff engagement and ownership Review Clinic Clerk activity and resource to ensure staff have time to direct patients to the touch screens to complete the Friends and Family Test	Clinical Management Group Senior Management Teams have been highlighted to these results and asked to increase coverage and respond directly to patient feedback at clinic level. Senior Clinical Management Groups management teams are increasing staff awareness of the requirement to collect feedback. Feedback highlighted to Clinical Management Groups through Executive Team meetings and Executive Quality Board. CHUGGS, MSKSS, Alliance and W&C have all shown improvement in coverage from July to August with ESM, RRCV and CSI showing deterioration.	**Q1 – 3%** **Q2/3 – 4%** **Q4 – 5%**	**1.4%**	**1.3%**	**1.3%**

CMG	August 2015	
	% Recommend	% Coverage
CHUGGS	91%	1.1%
CSI	97%	0.3%
ESM	94%	0.5%
ITAPS	100%	0.5%
MSKSS	92%	3.6%
RRCV	97%	1.2%
WC	96%	1.4%
The Alliance	-	-
UHL	93%	1.4%

Expected date to meet standard / target	Quarter 3
Lead Director / Lead Officer	Julie Smith, Chief Nurse Heather Leatham, Assistant Chief Nurse

% staff with an annual appraisal

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
1. There has been a slight deterioration over the last month, from 89.12% to 88.78 % (against a target of 95%) 2. Feedback from Clinical Management Group and Directorates Leads indicates that the reduction in performance is caused by:- a. Line manager / appraiser omissions in data return b. Reporting issues across some staff groups and Alliance c. Service pressures preventing the release of staff to conduct or attend appraisal d. Re alignment of appraisal date with incremental pay	1. Discussion at CMG / Directorate Boards and across services / areas 2. Circulation of breakdown of performance by cost centre covering review period 3. Making It All Happen meetings are being held in all areas. 4. Confirm and Challenge meetings in the CMGs, performance reports cover appraisal performance and actions. 5. Performance management being pursued for areas that persistently remain below 95% 6. Recovery plans in place across all underperforming areas with trajectories set (at appraisee / team level) 7. Recovery plans monitored against set trajectories 8. Review of management structures to ensure appropriate devolving and span of control for direct staff 9. Clear expectations set regarding reporting requirements 10. Close monitoring at a local level on a weekly basis	**95%**	**88.78%**	**88.8%**	**As shown below**

Performance by CMG

CMG	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Alliance Elective Care	96.27%	97.92%	82.85%	88.93%	89.93%	87.45%	84.19%
CHUGGS	94.83%	94.58%	95.20%	93.84%	94.18%	92.97%	92.97%
Clinical Support & Imaging Services	95.47%	97.21%	97.52%	96.80%	95.30%	94.07%	94.00%
Emergency & Specialist Medicine	86.41%	87.22%	84.96%	83.98%	83.75%	84.74%	84.89%
ITAPS	93.04%	94.00%	90.95%	89.22%	88.58%	88.94%	92.30%
MSK & Specialist Surgery	92.64%	94.21%	93.60%	90.70%	91.84%	94.12%	95.50%
Renal, Respiratory & Cardiac	88.04%	87.23%	87.26%	86.08%	90.86%	92.76%	90.45%
Women's & Children's	88.25%	88.08%	86.85%	85.28%	83.12%	81.89%	79.22%
CMGS	**91.18%**	**91.78%**	**90.55%**	**89.40%**	**89.56%**	89.60%	89.18%
Corporate Areas	**89.52%**	**87.93%**	**84.89%**	**81.96%**	**82.91%**	84.16%	84.69%
Total	**91.03%**	**91.44%**	**90.05%**	**88.74%**	**88.97%**	89.12%	88.78%

CMG Forecast for the next 3 months

CMG	Sept	Oct	Nov
Alliance	90%	92%	95%
CHUGGS	94%	95%	95%
Clinical Support & Imaging Services	95%	95%	95%
Emergency & Specialist Medicine	90%	93%	95%
ITAPS	92%	94%	95%
MSK & Specialist Surgery	95%	95%	95%
Renal, Respiratory & Cardiac	95%	95%	95%
Women's & Children's	90%	92%	95%
Corporate	92%	95%	95%

Expected date to meet standard / target	November 2015
Revised date to meet standard	
Lead Director / Lead Officer	Louise Tibbert, Director Of Workforce And Organisational Development Bina Kotecha, Assistant Director of Learning and OD

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>July performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="4">261 patients have breached/ continue to breach 52 weeks in the Orthodontics department. 258 patients are on an incomplete pathway; 3 patients' non-admitted pathways ended in August.

The reasons for this underperformance are as follows:
Incorrect use and management of a planned waiting list for outpatients.
Inadequate capacity within the service to see patients when they are ready for treatment.
There are currently 11 patients on the waiting list between 40 and 51 weeks, who are likely to roll over to become 52 week breaches.</td><td rowspan="4">The service is now closed to new referrals with some clinical exceptions.
Funding has been secured from NHS England for 2 WTE locums to clear backlog. 1 application has been received; while this individual is not suitable for a consultant post, they will be interviewed for a middle grade post.
NHS England contacting pathway providers to see if able to treat any of these patients in the community.
Clinical review of the service by Mr Matthew Metcalfe.
A Serious Untoward Incident (SUI) investigation has taken place and recommendations will be published in the next few weeks.
The Orthodontics department at Northampton General Hospital has indicated they will be able to take c.60 patients to be treated there. So far 55 patients have agreed to transfer their treatment to NGH, with efforts to identify another 5 continuing.</td><td>0</td><td>258</td><td>258</td><td>c. 260</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 Head of Ops meeting for assurance;
Performance team to review all waiting list code returns and identify areas of risk.</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

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	July performance (UHL Alliance)	YTD performance (UHL Alliance)	Forecast performance for next reporting period
		<1%	13.37%	13.37%	4.5%

Imaging
The majority of imaging diagnostics are delivered within 6 weeks; the exception to this has been a small volume of complex cardiac CT (c.10 per month) and complex cardiac MRI (c.100 per month). As a tertiary centre UHL is one of a small number of Trusts that provides this service. 239 MRI and CT breaches were reported in August 2015; this inflated number is due to capacity constraints in particular cardiac MRI.

152 patients awaiting DEXA scans breached six weeks at the end of August as a result of receiving c.500 referrals when the service has capacity for c.400 scans, this was compounded by some unplanned scanner downtime during the month.

Endoscopy
An issue with planned waiting lists in Endoscopy surfaced in May 2015. Following validation, the number of breaches was found to be higher than originally first thought, meaning that we have reported 1479 breaches for August 2015 across flexible sigmoidoscopy, gastroscopy and colonoscopy. Capacity and demand review in Endoscopy has identified that the Trust is short of approximately 8-10 lists per week.

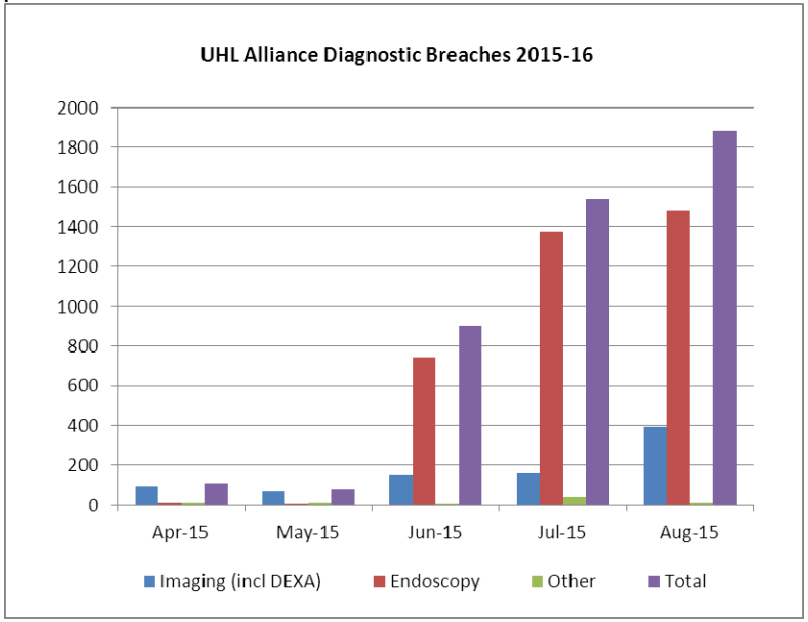
Imaging
A plan is well developed and part implemented to eradicate the Cardiac CT/ MRI issue by the end of September 2015.

The DEXA service has created 35 additional slots weekly by employing a healthcare assistant, allowing the service to reduce appointment lengths. Therefore no breaches are expected in September.

Endoscopy
In order to address long patient waits, UHL are working with Medinet to put on weekend lists, providing 60-90 additional scopes per weekend. The department is also in the process of transferring 300 patients to Circle, as well as approximately 100 patients to Nuffield. Additional lists have also been put on by UHL's own consultants. The Trust will also be part of an initiative led by the Tripartite around securing extra capacity within the Independent Sector and other NHS Trusts for Endoscopy, UHL has submitted its requirements for this process but awaits the implementation.

The extra capacity is complemented by a robust action plan aimed at addressing general performance issues in Gastroenterology, with particular focus on ensuring that all lists are fully booked and efforts to improve Cancer performance via access to Endoscopy tests. There has also been a management review in the department and an Endoscopy Manager has been appointed to focus solely on the service.

The following graph outlines the total number of diagnostic breaches per month for 15-16:



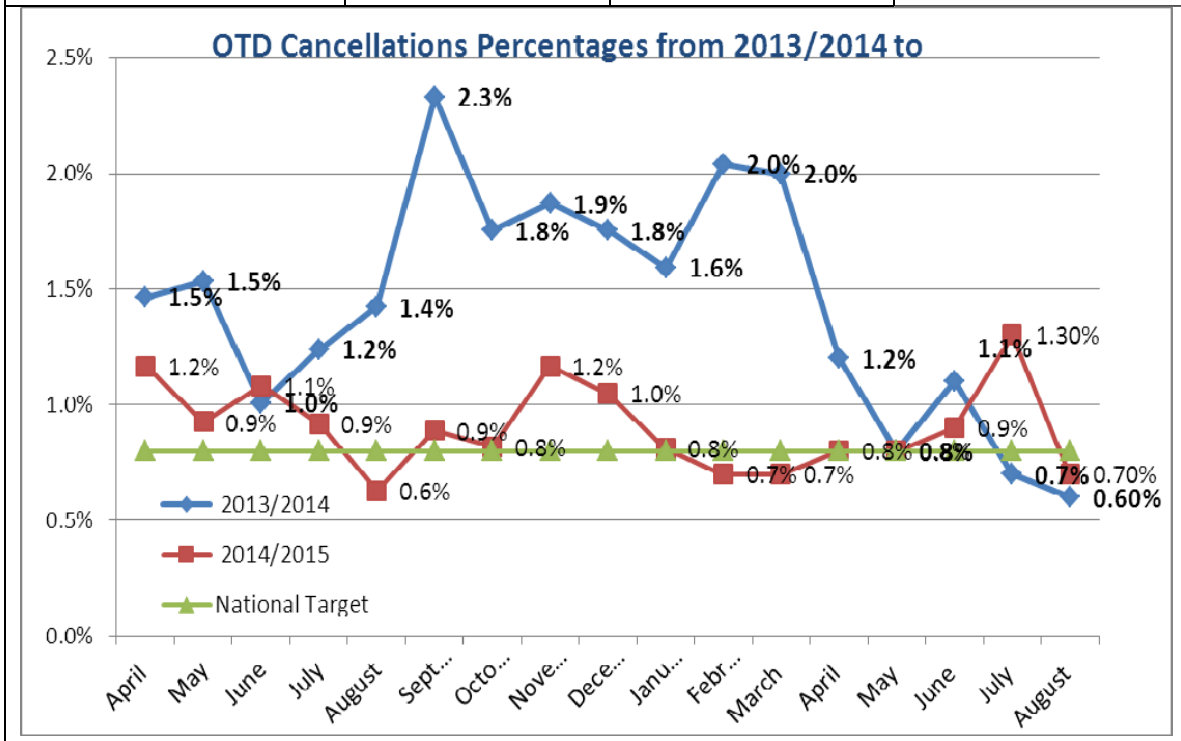
The table below outlines the percentage of breaches as shared between UHL and Alliance:

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	YTD
UHL	0.92%	0.61%	6.97%	12.40%	14.92%	**14.92%**
UHL Alliance	0.83%	0.59%	6.16%	10.92%	13.37%	**13.37%**

Expected date to meet standard / target	October 2015
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Suzanne Khalid, Clinical Director CSI

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

What is causing underperformance?	What actions have been taken to improve performance?	Target (monthly) 1)On day=0.8% 2) 28 day = 0	Latest month performance – June 15	YTD performance (inc Alliance)	Forecast performance for next reporting period
Despite capacity pressures, the OTD cancellation percentage significantly compared to last month (0.7%). The main five reasons for cancellation were: • Lack of theatre time(30) • Equipment failure(7) • Paediatric bed unavailability(6) • Critical care bed Unavailability (6) • Staff unavailability(5) There were four Urology patients and General Surgery patients who breached the 28 day rebooking target. This was due to an increase in the number of cancer cases that created capacity problems in ITU. Four patients have now had their operations and one patient is waiting to have their surgery on the week commencing 16th September.	List over runs form a significant risk to OTD performance. The process of exception reporting is now better able to identify any over booked lists by the theatre managers working with theatre staff. To reduce risks of cancellations a number of actions have been identified and are in the process of implementation. Theatre managers have increased theatre capacity for the increased cancer demand by making additional lists available. The ITAPS and CHUGGS Senior Managers are working together to improve theatre capacity in the long term. <u>Risks to delivery of recovery plan</u> The key risk remains failure to escalation of patients at risk of cancellation on the day, following the UHL cancelled escalation policy. For those cancelled on the day, it is vital that they adhere to the Trust policy of escalating to CMG, Head of Operations for resolution, prior to agreeing any cancellations.	1) *0.7% (0.7% -UHL & 0.0% Alliance)* 2) *5 (4 from Urology and 1 General Surgery)*	1) 1.3% (1.3%-UHL &1.0% Alliance) 2)1UHL	1) 0.9% (0.9% - UHL & 0.9% Alliance) 2) 9	1) 0.8 % 2) 1



Expected date to meet standard / target	On the day – September 28 day – October
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Phil Walmsley, Deputy Director of Operations

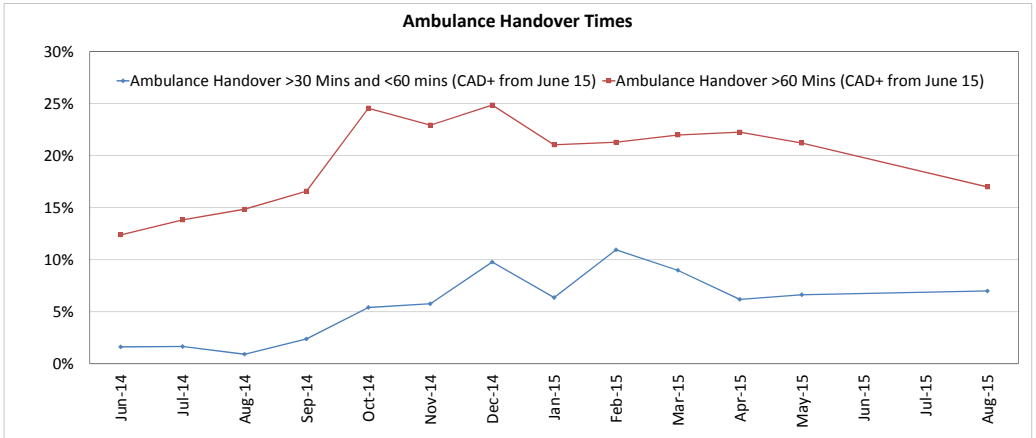
NHS e-Referral System (formerly known as Choose and Book)

<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>August 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.
The specialties with the highest number of ASIs are:
General Surgery;
Gastroenterology;
Rheumatology;
Orthopaedics;
ENT;
Gynaecology.
Transition to new e-Referral System:
Choose and Book migrated to the new e-Referral System on Monday 15th June;
The challenges experienced in the period after the cut-over have calmed down considerably with installation of Google chrome improving the speed of the system.</td><td rowspan="4">Action plan
An action plan has been written outlining steps for recovering performance;
This has been shared with commissioners.
Capacity
Additional capacity in key specialties is part of RTT recovery plans.
Training and Education
Training and education of staff in key specialties continues, to ensure that the system is adequately set up and administrative processes are fit for purpose;
Meetings are taking place with the specialties experiencing the highest rate of ASIs, focusing on awareness raising and seeking named accountability.
Current focus is on working with specialties with no known capacity problems, but high ASI rate to raise awareness and promote accountability.
Additional resource to support the e-Referral System
An NHS e-Referral System administrator has been in post since May;
She will be working with key specialties to help reduce their ASIs and promote administrative housekeeping.</td><td><4%</td><td>Unable to report</td><td>Unable to report</td><td>No forecast as unable to measure</td></tr>
<tr><td colspan="4">As a result of the significant challenges experienced post-cut over from Choose and Book, the HSCIC have indicated that they will not be releasing weekly ASI data until at least October 2015. The latest data available is from the week ending 7th June and therefore is out of date. This means that the Trust is currently unable to track and report on progress in the usual manner.</td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="3">December 2015</td></tr>
<tr><td>Lead Director / Lead Officer</td><td colspan="3">Richard Mitchell, Chief Operating Officer
Will Monaghan, Director of Performance and Information</td></tr>
</table>

Ambulance handover > 30 minutes and>60 minutes

		Target	August	YTD	Forecast
What is causing underperformance?	**What actions have been taken to improve performance?**	0 delays over 30 minutes	>60 min 9% 30-60 min – 17%	>60 min 7% 30-60 min – 19%	> 60 min 6% 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.	The UNIPART, EMAS and UHL report has been published and is being reviewed by all stakeholders for further actions. Meetings are planned with UHL and EMAS as only 1 set of data has been seen re CAD+ This data is still requiring validation. There has been difficulties in arranging these meetings Validation of data continues and shows large discrepancies between EMAS and UHL findings which lowers handover waits in favour of UHL	Please see chart below. Ambulance delays remain higher than this time last year. 		
		Expected date to meet standard	TBC		
		Revised date to meet standard	TBC		
		Lead Director/Lead Officer	Richard Mitchell, Chief Operating Officer, Phil Walmsley, Deputy Director of Operations		

Cancer Waiting Times Performance

What is causing underperformance?	What actions have been taken to improve performance?
R8: 2 Week Wait 2WW performance dropped by 3.6% from the July position and remains under target. The key reason for underperformance is Endoscopy; if 2WW performance for Upper and Lower GI were removed from the Trust position, this standard would have been achieved. **R12: 31 day subsequent (surgery)** 31 day subsequent (surgery) was failed predominantly as a result of Urology performance. The main factor is inadequate elective capacity. **R14: 62 day RTT** 62 day performance has dropped by 10.5% between June (84.2%) and July (73.7%), however more positively the number of the patients in the 62 day backlog has reduced by 12% over the same period.	**R8: 2 Week Wait** The Trust is working intensively with the Endoscopy Department in order to address the current underperformance with a robust action plan. More broadly, the Trust is working with CCGs to improve the quality of 2WW referrals, specifically in relation to correct process, use of appropriate clinical criteria, and preparation of patients for the urgency of appointments. **R12: 31 day subsequent (surgery)** It has been agreed that all 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 address the step-down of patients from Intensive Care, in order to pull Cancer patients through the system more quickly. It also includes significant investment in more clinical staff, including a nurse specialist in Urology and consultants in Head and Neck and Dermatology. This additional capacity will impact positively on performance. **R14: 62 day RTT** Efforts to improve 31 day and 2WW performance will help to improve the 62 day position. The Endoscopy action plan will 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. The appointment of 3 band 7 staff with key responsibility for managing cancer pathways in our worst performing tumour sites will provide the key focus required. One is in post, one appointed (starting in November) and interviews for the third will be in September. The IST review was generally positive about the structures and processes that UHL has and is planning to have in place, with a number of key recommendations which will be implemented. Weekly executive scrutiny of 62 day backlog reduction plans was initiated in September, led by the COO.

Target (mthly / end of year)	Latest month performance July	Performance to date 2015/16	Forecast performance for August
R8: 2WW (Target: 93%)	87.5%	89.4%	88%
R10: 31 day 1st (Target: 96%)	97.2%	95.7%	96%
R12: 31 day sub – Surgery (Target: 94%)	92.2%	89.9%	90%
R14: 62 day RTT (Target: 85%)	73.7%	76.1%	78%
R15: 62 day screening (Target: 90%)	95.2%	90.8%	90%

Performance by Quarter

	14/15 FYE	15/16 Q1	15/16 Q2	15/16 Q3	15/16 Q4
R8	92.2%	90.1%	87.5%		
R10	94.6%	95.1%	97.2%		
R12	89%	89.1%	92.2%		
R14	81.4%	76.9%	73.7%		
R15	84.5%	89%	95.2%		

Expected date to meet standard / target	R8: Recovery expected November 2015 R10: Recovery expected July 2015 R12: Recovery expected September 2015 R14: Recovery expected October 2015 (at risk) R15: Recovery expected June 2015
Revised date to meet standard	
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Matt Metcalfe, Clinical Lead for Cancer

Cancer Patients Breaching 104 days

What is causing underperformance?

12 Cancer patients on the 62 day pathway breached 104 days at the end of July, which is much improved from the end of August position.

Tumour site	Number of patients breaching 104 days
Urology	3
Lung	1
Lower GI	5
Upper GI	2
Breast	1

The following factors have significantly contributed to delays

Reason	No. patients
Patient initiated delays	2
Patient unfit	3
Tertiary referral	1
Patient co-morbidities/ requiring high risk assessment	2
Endoscopy delays	2
Patient receiving other treatment first	2

What actions have been taken to improve performance?

The number of patients breaching 104 days on a 62 day pathway is at 60% of the August level, marking a significant improvement. The most improved tumour site is Lung.

Given the poor 62 day performance specifically in Lung, Lower GI and Urology, funding for three band 7 Cancer Delivery Managers has been identified to support them. The Urology manager is in place, the Lower GI manager will start in November and the Lung post is currently being re-advertised. They will jointly report to CMG management teams and the Cancer Centre. This dedicated full-time service management will improve Cancer performance over the medium term.

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

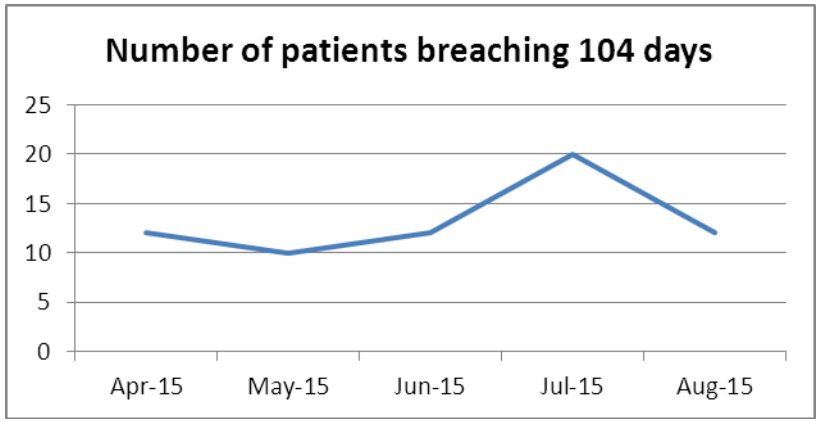
- Introduction of stamps to ensure that Cancer patients' Pathology samples are appropriately prioritised;
- Escalation of any pathway delays of more than 96 hours to the Director of Performance and Information;
- All Cancer patients coming into theatre to be escalated to the General Manager for Theatres;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

Month by month breakdown of patients breaching 104 days

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

	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Number of patients breaching 104 days	12	10	12	20	12

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

CQC – Intelligent Monitoring Report

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

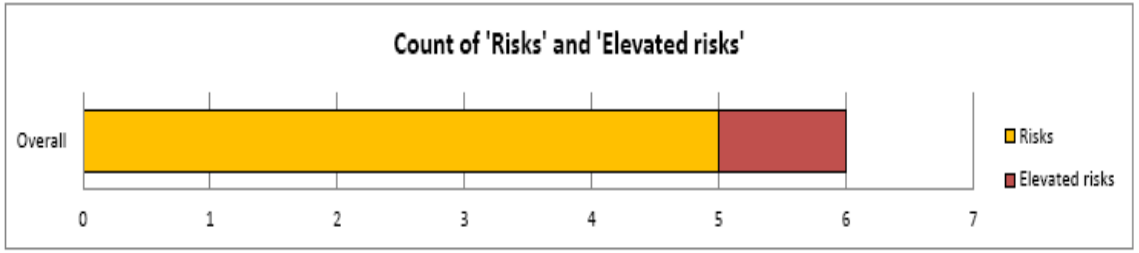
The IMR evaluates against a range of indicators relating to the five key questions used by the CQC as part of their inspections - is the organisation safe, effective, caring, responsive, and well-led?

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

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

University Hospitals of Leicester NHS Trust

Trust Summary



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

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

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

15/16 Quality Schedule and CQUIN Indicators - Confirmed RAGs for Q1 and Anticipated RAGs for Q2 15/16

Schedule Ref	Indicator Title	Q1 RAG	Predicted Q2 RAG	Commentary
	QUALITY SCHEDULE			
PS01	Infection Prevention and Control Reduction.	G	G	Although C Diff above monthly threshold for Aug by one case, still on track to achieve end of year threshold
PS02	HCAI Monitoring	G	G	0 MRSA Bacteraemias
PS03	Patient Safety	G tbc	G	0 Never Events. Full patient safety report to be submitted to the Sept CQRG meeting.
PS04	Duty of Candour (DoC)	G	G	0 Breaches in respect of Moderate or Serious Incidents. Details of audit plans submitted to commissioners
PS05	Complaints and user feedback Management (excluding patient surveys).	G tbc	G	Improved performance against response times. Full Complaints Management report to be submitted to the Sept CQRG meeting
PS06	Risk Assurance	G	G	Further assurance provided where Risks not reviewed at time of reporting to EPB. All CAS alerts responses and actions on track.
PS07	Safeguarding	tbc	tbc	Reports submitted – for review by the CCG Safeguarding team – further assurance requested relating to Mental Capacity Act actions.
PS08	Reduction in Pressure Ulcer incidence.	G	A	0 G4s and G3s below threshold. Above G2 threshold in August. Exception report submitted.
PS09	Medicines Management Optimisation	G	tbc	Q1 Red RAG for Controlled Drugs Audit as results below 95% but commissioners noted improvements made. Green for other parts of Indicator. Q2 RAG dependent upon Medicines Code audit results showing improvement.
PS10	Medication Errors	A	G	Less reported errors in Q1 compared to Q4 and threshold is to report increased number of Medication Errors. Agreed to review UHL's reporting rate with other trusts. Actions being taken to reduce harm noted.
PS11	Safety Thermometer	G	tbc	% for Harm Free Care below 95% standard in July and August and below Q1 average.
AS01	Cost Improvement Programme (CIP) Assurance	A	G	Commissioners noted UHL's plans for ongoing monitoring of the impact of CIPs on quality but Red RAG for Q1 as several delays with implementation of proposed process.
AS02	Ward Health-check	G	G	Evidence of actions being taken where Wards either below agreed staffing levels or not meeting Clinical Measures Scorecard targets
AS03	Nurse Revalidation Programme	G	G	Assurance provided about plans in place to meet revalidation requirements
AS04	Staffing governance	A	A	Progress against OD Plans noticed but Amber RAG due to non achievement of

Schedule Ref	Indicator Title	Q1 RAG	Predicted Q2 RAG	Commentary
				Appraisal and Mandatory Training
AS05	Involving employees in improving standards of care.	**G**	**G**	Q1 Report received and actions noted.
AS06	Staff Satisfaction	**G**	**G**	Staff satisfaction received with action plans in place and on track for areas of poor response.
AS07	External Visits and Commissioner Quality Visits	**G**	**G**	Q2 RAG dependent upon Actions (in response to recommendations made) being on track.
AS08	CQC Registration	**A**	**G**	Q1 Amber due to UHL not being reported as not fully compliant with CQC standards, however noted that action plan following the most recent visit is on track
CE01(a)	Communication - Content - Medical	**G**	**G**	Audit Schedule reported - ED letters Q1. Disch Letters Q1 - Q4. OutPt Letters - Q2-Q3.
CE01(b)	Communication - Content - Nursing	**G**	**G**	Nursing letter standards to be incorporated into Letters Policy and audit planned for Q3
CE02	Intra-operative Fluid Management	**R**	**G**	Threshold not achieved for Q1. Improved performance for July – now above thresholds
CE03a	Clinical Effectiveness Assurance - Audit	**A**	**G**	Audit plan for 15/16 reviewed at UHL Clinical Audit Ctte . Q1 Amber due to audits being behind schedule
CE03b	Clinical Effectiveness Assurance - NICE	**G tbc**	**G**	UHL Compliant with all NICE TAGs. Reporting on Clinical Guidelines etc deferred to the October meeting.
	Women's Service Dashboard	**A tbc**	**G**	For reporting to the September CQRG. Q1 RAG anticipated to be Amber due to Obstetrician training and C Sections thresholds not being met.
CE05	Children's Service Dashboard	**G tbc**	**G**	For reporting to the September CQRG. SpR training threshold improved. Significant improvement in performance in May for 'timing of Assessment on CAU'
CE06a	PROMS - Patient Reported Outcomes	**A**	**G**	UHL's participation in line with national average for both participation/outcomes for all procedures with exception of Groin Hernia where participation is below average.
CE06b	Consultant Clinical Outcomes	**G**	**G**	No outcomes published since reported for Q4. UHL outcomes better than average or within expected.
CE07	#NOF - Dashboard	**R**	**A**	time to theatre' not achieved for any Month in Q1. Performance improved in June but still below the 72% threshold. Below threshold for July but above in August
CE08	Stroke and TIA monitoring	**G**	**G**	Improvement in '90% stay' and also in overarching SSNAP Domain. Further improvements to be made for Therapy related targets - business case approved to recruit additional staff
CE09	Mortality	**G**	**G**	Published SHMI for Jan to Dec 2014 = 99 (ie below 100). Progress being made with plans to meet NTDA requirement to screen all deaths.
CE10	VTE Risk Assessment	**G**	**G**	95% threshold achieved for Q1 and July/August.
CE11	Venous Thrombo-embolism – Hospital Acquired RCAs	**G tbc**	**G**	For reporting to the September CQRG. RAG dependent upon commissioners agreeing to revised threshold for RCAs of post discharge Hospital Acquired VTEs.

Schedule Ref	Indicator Title	Q1 RAG	Predicted Q2 RAG	Commentary
				requirement to review all Hospital Acquired VTEs (both inpt and post discharge)
CE12	Nutrition and Hydration	**R**	**A**	Q1 Thresholds achieved for all CMGs with the exception of ESM. Actions in place to address and CMG implementing several initiatives to support patients' nutritional needs but not necessarily captured by the metrics.
CE13	Food Strategy	**deferred**	**N/A**	Delays with finalising Food and Drink Strategy due to capacity issues with lead authors.
CE14	Community Acquired Pneumonia	**A**	**G**	CURB and Chest Xray achieved but Timing of Antibiotics just below threshold. Increased activity seen in Q1.
CE15	Improving End of Life (EoL) care.	**G**	**G**	Continued embedding of AMBER care bundle.
CE16	Heart Failure	**A**	**G**	Q1 Threshold not achieved. Plans in place to address in Q2.
PE01	Same Sex Accommodation Compliance and Annual Estates Monitoring	**G**	**G**	0 Breaches in Q1 or to date in Q2
PE02	Patient Experience, Equality and Listening to and Learning	**G tbc**	**G**	For reporting to the September CQRG. Continued triangulation of patient feedback and actions being taken in response
PE04	Equality and Human Rights	**A**	**G**	Q1 RAG due to lack of progress with capturing demographic data for patients with Learning Disability.
PE5	MECC	**G**	**G**	Referrals to STOP and Alcohol Liaison continue. MECC activities within Well-being at work continue.
PE6	Friends and Family Test	**tbc**	**G**	Thresholds met for Adult patients and improvement seen for Children's response rates in Inpatients but drop in participation for ED.
	SPECIALISED SERVICES QS			
SQ01	National Quality Dashboards	**G**	**G**	Confirmation being sought that all relevant Specialities are submitting data
SQ02	National Clinical Registries	**G**	**G**	Confirmation being sought that all relevant Specialities are submitting data
SQ03	HIV: GP registration and communication	**G**	**G**	Letters are sent at each medical clinic (at least once per year)
	NATIONAL CQUINS			
Nat 1	AKI Discharge Care Bundle	**G**	**G**	Quarter 1 is to provide baseline data about number/% of discharge letters containing details of AKI Stage and actions taken. Q2 RAG dependent upon threshold set.
Nat 2a	Sepsis - Screening	**G**	**G**	Q1 is to provide baseline data on number/% of em patients screened for sepsis. Provisional data shows small number of em patients in sample meeting criteria for screening with few being screened. 66% screened.

Schedule Ref	Indicator Title	Q1 RAG	Predicted Q2 RAG	Commentary
Nat 2b	Sepsis - IV Antibiotics	**N/A**	**G**	No threshold for Q1. Q2 threshold relates to provision of baseline data.
Nat 3a	Dementia - FAIR	**G**	**G**	90% threshold achieved for April and May
Nat 3b	Dementia Training	**G**	**G**	New clinical lead confirmed and training programme agreed. % of Medical Staff undertaking Category A/B training is low. Agreed to review threshold relating to junior doctors.
Nat 3c	Dementia Carers	**G**	**G**	Surveys undertaken and actions carried out in response to feedback received
Nat 4	Ambulatory Care - CDU	**G**	**G**	Q1 threshold is to confirm scope of scheme and improvement thresholds. Proposed to implement ACP in CDU – Q2 RAG dependent upon clinical staff capacity to continue with pilot.
	LOCAL CQUINS			
Loc 5	Readmissions	**G tbc**	**G**	Following review of Readmissions data, focused case note review undertaken and actions agreed. RAG tbc following review of Report submitted.
Loc 6	CHC Assessments completed	**G**	**A**	Baseline data submitted. Q2 performance anticipated to be below 95% threshold.
Loc 7a	Safety Briefings	**G**	**G**	Commissioners looking to agree outcome measures for Q4.
Loc 7b	Increase 'Near Miss' Reporting	**G**	**G**	
Loc 8	Think Glucose	**G**	**G**	Continued roll out of the Think Glucose programme
Loc 9	Bereavement F/U	**G tbc**	**G**	Bereavement Follow Up Service Leads appointed and scoping of service being undertaken. Further information requested for Q1.
Loc 10	Learning Disabilities - Pt Exp	**G**	**G**	Baseline data for patients who DNA appointments reported and progress with actions.
	SPECIALISED CQUINS			
SS1/CUR	CUR Tool	**G**	**G**	Requirements for Q1 agreed with Local Area Team. On track to achieve Q2 threshold. Q4 payment at risk if not able to negotiate amended implementation plan with National Team.
SS2/C6	Oncotype Testing	**G**	**G**	Oncotype tests requested.
SS3/TH4	Critical Care Delayed Discharges	**G**	**G**	Baseline data submitted and action plan to improve
SS6/IM7	Rheumatic Diseases Network	**G**	**G**	Details of proposed network reported.
SS7/TH7	Complex Orthopaedic Surgery Network	**G**	**G**	Details of proposed network reported.

Schedule Ref	Indicator Title	Q1 RAG	Predicted Q2 RAG	Commentary
SS8/HSS	ECMO/PCO Collaborative Workshop	G	G	Participation in HSS workshops confirmed
SS10/CB5	Haemoglobinopathy Network	G	G	Network meeting held.
SS11/WC1	<28 Week Neonates 2 yr follow up	G	G	Baseline data submitted and action plan to improve.