NHS Nottingham North & East CCG

Monthly Quality & Performance Report

September 2017

Summary (Page 1)	• Key Issues and Concerns
Level 1 (Pages 2 to 3)	• Summary of CCG Performance
Level 2 (Pages 4 to 22)	• Summary of Provider Performance
Quality Premium (Page 23)	• CCG Quality Premium

CCG Performance Snapshot

Area	Indicator	Standard	Latest data period	Latest period data NNE	Latest period data NW	Latest period data Rush	YTD NNE	YTD NW	YTD Rush
A&E	4 Hour Standard % Achievement - A&E and Eye Cas	95%	Jul-17	86.94%	86.71%	87.45%	85.77%	85.69%	85.08%
Cancer Waiting Times	Cancer 2ww	93%	Jul-17	96.24%	97.84%	96.40%	94.57%	95.56%	94.44%
	Cancer 31d DTT	96%	Jul-17	98.36%	96.30%	98.25%	96.48%	94.36%	96.91%
	62d Urg RTT	85%	Jul-17	88.89%	88.89%	89.19%	82.53%	89.00%	81.71%
	Cancer 2ww - Breast Symptoms	93%	Jul-17	100.00%	100.00%	100.00%	98.41%	100.00%	94.87%
Diagnostics	% patients waiting longer than 6 weeks	1%	Jul-17	0.60%	0.98%	0.39%	0.77%	0.84%	0.45%
Ambulance	Red 1 calls responded to within 8 minutes	75%	Jun-17	63.41%	50.00%	58.82%	70.72%	63.64%	60.67%
	Red 2 calls responded to within 8 minutes	75%	Jun-17	43.61%	43.25%	37.41%	48.63%	47.55%	43.79%
	Red 1 calls responded to within 19 minutes	95%	Jun-17	95.12%	100.00%	100.00%	98.60%	98.58%	96.99%
	Red 2 calls responded to within 19 minutes	95%	Jun-17	91.07%	89.29%	80.94%	90.11%	91.82%	85.37%
HCAIs	MRSA	0	Jul-17	0	0	0	0	0	0
	C-Diff - YTD standard: NNE=16 NW=7 Rush=8	<<< notes	Jul-17	2	2	3	17	17	11
RTT	Admitted %	90%	Jul-17	85.80%	86.84%	83.78%	85.43%	84.32%	83.81%
	Non-Admitted %	95%	Jul-17	95.93%	94.83%	95.52%	96.14%	95.50%	95.64%
	Incomplete %	92%	Jul-17	95.73%	95.09%	95.22%	95.75%	95.40%	95.56%
	Incomplete number of 52 week waiters	0	Jul-17	0	0	1	0	2	5
Mental Health	Care Programme Approach: 7 day follow up	100%	Q1 2017-18	100%	94%	100%	100%	94%	100%
	Crisis Resolution Home Treatment: Gate kept by CR Teams	100%	Q1 2017-18	100%	100%	100%	100%	100%	100%
IAPT	IAPT - Standard: NNE = 2.50% NW = 2.51% Rush = 2.50%	<<< notes	May-17	1.43%	1.82%	1.63%	2.88%	3.23%	3.17%
EIP	Treated within two weeks %	50%	Jul-17	100.00%	100.00%		85.71%	66.67%	80.00%
	Incomplete waiting less than two weeks %	50%	Jul-17	66.67%			44.44%	100.00%	100.00%
Dementia	Dementia Diagnosis Rate	67%	Jul-17	69.99%	86.21%	74.02%			

Summary – Key issues and concerns

CCG - Indicators out of trajectory -

- **A&E** (Page 3) – CCG performance in July 2017 was 81.94% (standard = 95%)

NUH - Indicators out of trajectory -

- **Cancer** (Page 4-5) – The following pathways failed to meet their respective standards during July 2017 -
  - 62 Day Urgent RTT - 78.74% (standard = 85%)
- **RTT 52+ Week Waiters** (Page 6) - In July 2017, three incomplete pathways exceeded 52 weeks (standard = 0)
- **Cancelled Ops** (Page 6) **-** There were 3 cancelled ops not rebooked within 28 days in July 2017 (standard = 0)
- **A&E** (Page 7) – July 2017 A&E performance was 83.79% (standard = 95%)
- **Ambulance Handovers** (Page 8) - July 2017 performance was 212 handovers exceeding 30 minutes and 15 exceeding 60 minutes (standard = 0)
- **Appointment Slot Issues** (Page 8) - July 2017 - 0.18 slot issues per successful booking (standard = 0.04)
- **NHS E-Referrals** (Page 8) - Of patients waiting to arrange an appointment, 61% were waiting 7 working days or less breaching the 95% standard, 87% were waiting 14 working days or less breaching the 100% standard
- **Pressure Ulcers** (Page 10) - June 2017 performance was 0.40 per 1000 occupied bed days (threshold = 0.33)

Circle - Indicators out of trajectory -

- **Diagnostics** (Page 14) - June 2017 performance was 1.70% (Threshold = 1%)

EMAS - Indicators out of trajectory -

- **Response Times** (Page 18) - Nottingham North & East CCG continues to be below standard in June 2017 with 63.41% of Red 1 responses being met in 8 minutes, and 43.61% of Red 2 responses being met in 8 minutes

Level 1 – Summary of CCG Performance

1.1 Cancer - CCG

CCG	Description of Standard	Period	Target	CCG	Period Perf	Last 12 months	2017/18 YTD
Preventing people from dying prematurely	62d Urg RTT	Jul-17	85%	NNE	88.89%		82.53%
				NW	88.89%		89.00%
				Rush	89.19%		81.71%
	62d Urg RTT - Screening Service	Jul-17	90%	NNE	100.00%		82.35%
				NW	100.00%		94.44%
				Rush	100.00%		75.00%
	62d Urg RTT Cons Upgrade	Jul-17	N/A	NNE	50.00%	N/A	54.55%
				NW	66.67%	N/A	71.43%
				Rush	100.00%	N/A	85.71%
	Cancer 31d DTT	Jul-17	96%	NNE	98.36%		96.48%
				NW	96.30%		94.36%
				Rush	98.25%		96.91%
	Cancer 31d DTT - Subs: Surgery	Jul-17	94%	NNE	100.00%		96.05%
				NW	92.31%		97.37%
				Rush	100.00%		97.87%
	Cancer 31d DTT - Subs: Drugs	Jul-17	98%	NNE	100.00%		97.00%
				NW	100.00%		100.00%
				Rush	100.00%		98.68%
	Cancer 31d DTT - Subs: Radiotherapy	Jul-17	94%	NNE	96.30%		97.89%
				NW	100.00%		100.00%
				Rush	93.75%		96.61%
Positive experience of care	Cancer 2ww	Jul-17	93%	NNE	96.24%		94.57%
				NW	97.84%		95.56%
				Rush	96.40%		94.44%
	Cancer 2ww - Breast Symptoms	Jul-17	93%	NNE	100.00%		98.41%
				NW	100.00%		100.00%
				Rush	100.00%		94.87%

NHS Nottingham North & East CCG achieved all standards in July 2017.

Cancer 62 Day Urgent RTT - Long Waiters

CCG	Description of Standard	Period	Standard	CCG	Patients	Last 12 Months	2017/18 YTD
Positive Experience of Care	Cancer 62 Day Urg RTT - Patients Treated 104+ Days	Jul-17	0	NNE	1		7
				NW	0		0
				Rush	0		6

The indicator above displays the number of 62 Day Urgent RTT patients who have been waiting 104 days and longer. This is measured by CCG and encompasses patients being treated by all providers.

In July 2017, Nottingham North & East CCG had 1 patient treated in the month who was waiting 104 days or longer whilst on a 62 Day Urgent RTT pathway. The wait was due to being a complex case.

Level 1 – Summary of CCG Performance

1.2 Referral To Treatment (RTT) - CCG

CCG	Description of Standard	Period	Target	CCG	Period Perf	Last 12 months
Positive experience of care	RTT - Incomplete pathways (% within 18 weeks)	Jul-17	92%	NNE	95.73%	
				NW	95.09%	
				Rush	95.22%	

Nottingham North & East CCG achieved the 92% Incomplete standard in July 2017 with performance at 95.73%. However, two specialties did not meet this standard, General Medicine (89.70%) and General Surgery (89.19%).

1.3 A&E 4 hour waiting time standard - CCG

CCG	Description of Standard	Period	Target	CCG	Period Perf	Last 12 months	2017/18 YTD
Positive experience of care	A&E waiting time (Type 1 Only)	Jul-17	95%	NNE	81.94%		79.71%
				NW	80.84%		78.64%
				Rush	81.49%		78.89%

NUH performance for A&E Type 1 (consultant-led 24 hour service with full resuscitation facilities) waiting times was below standard during July 2017, which caused failure to achieve 95% for all three South Nottinghamshire CCGs. The performance above does not take into account performance in the Eye Casualty department. Please see Level 2 for details of actions to improve NUH performance.

1.4 Diagnostics Waiting Times - CCG

CCG	Description of Standard	Period	Target	CCG	Period Perf	Last 12 months
Positive experience of care	Diagnostics (% of patients waiting over six weeks)	Jul-17	1%	NNE	0.54%	
				NW	0.58%	
				Rush	0.31%	

In July 2017 Nottingham North & East CCG achieved the 1% national standard with performance at 0.54%. Nottingham West CCG and Rushcliffe CCG also achieved the standard with performance at 0.58% and 0.31% respectively.

1.5 Healthcare Associated Infections (HCAIs) - CCG

CCG	Description of Standard	Period	CCG	Period Standard	Period Perf	Last 12 months	YTD Standard	2017/18 YTD
HCAIs	MRSA	Aug-17	NNE	0	**0**		0	**0**
		Aug-17	NW	0	**0**		0	**0**
		Aug-17	Rush	0	**0**		0	**0**
	C-Diff	Aug-17	NNE	2	4		14	17
		Aug-17	NW	1	2		6	17
		Aug-17	Rush	1	2		7	11

Nottingham North & East CCG experienced no cases of MRSA in August 2017.

August's standard for Clostridium Difficile infections amongst Nottingham North & East CCG patients breached the threshold with 4 cases against a standard of 2. Year-to-date, the CCG has experienced 17 cases of Clostridium Difficile infections against a standard of 14.

Level 2 – NUH Performance

NUH 2.1 Cancer Waiting Times

NUH	Description of Standard	Target	Period Jul-17	Period Q1 2017-18	Last 12 months	2017/18 YTD
Preventing people from dying prematurely	62d Urg RTT	85%	78.74%	77.09%		77.48%
	62d Urg RTT - Screening Service	90%	96.43%	88.05%		90.23%
	62d Urg RTT Cons Upgrade	N/A	76.92%	79.31%		78.87%
	Cancer 31d DTT	96%	97.98%	96.34%		96.75%
	Cancer 31d DTT - Subs: Surgery	94%	96.91%	96.88%		96.89%
	Cancer 31d DTT - Subs: Drugs	98%	99.18%	98.37%		98.57%
	Cancer 31d DTT - Subs: Radiotherapy	94%	98.66%	98.03%		98.20%
Positive experience of care	Cancer 2ww	93%	97.95%	93.87%		94.88%
	Cancer 2ww - Breast Symptoms	93%	99.00%	93.99%		95.19%

In July 2017, NUH failed to achieve the Cancer 62 day standard with performance at 78.74% against the national standard of 85%, the standard has not been achieved in any of the last 12 months.

NUH achieved all other cancer standards in July 2017.

62 Day Urgent RTT - 104+ Day Waiters—Patients seen during the month

NUH	Description of Standard	Period	Standard	Patients	Last 12 Months	2017/18 YTD
Positive Experience of Care	Cancer 62 Day Urg RTT - Patients Treated 104+ Days	Jun-17	0	14		34
	Cancer 62 Day Urg RTT - Patients Incomplete 104+ Days	Jun-17	0	21		67

During June 2017 NUH had seen 14 patients who had waited over 104 days. Reasons for the long waits were as follows -

- 8x Complex Case
- 5x Late Tertiary Referral
- 1x Patient Unfit

62 Day Urgent RTT - 104+ Day Waiters - Patients still waiting at the end of the month

The Governing Body is reminded that the CCG, via Nottingham City CCG, writes to NUH's Chief Executive on a monthly basis to inform them of the number of patients still waiting 104 days or more for their first definitive treatment. As at the end of June 2017 NUH had 21 patients waiting 104 days or more. This compares to 21 at the end of June 2017. Below is a table listing the number of 104+ day waiters at NUH by CCG:

CCG	Count
NHS Nottingham City CCG	9
NHS Nottingham North and East CCG	3
NHS Rushcliffe CCG	3
NHS Nottingham West CCG	2
NHS Southern Derbyshire CCG	2
NHS Lincolnshire East CCG	1
NHS Lincolnshire West CCG	1

Level 2 – NUH Performance

NUH 2.1 Cancer Waiting Times (cont.)

Cancer 62 day RTT Performance by Tumour Site

NUH	Tumour Site	Period	Standard	Latest Period		2017/18 YTD		
				Patients	%	Chart	Patients	%
Cancer 62 Day RTT Performance by Tumour Site for all CCG patients at NUH (Admitted & Non Admitted)	Brain/Central Nervous System	Jul-17	85%	0	N/A		0.5	100%
	Breast	Jul-17	85%	36.5	100%		157.5	94.92%
	Gynaecological	Jul-17	85%	11	86.36%		45.5	83.52%
	Haematological (Excluding Acute Leukaemia)	Jul-17	85%	7	57.14%		43	83.72%
	Head & Neck	Jul-17	85%	14	75.00%		54.5	77.06%
	Lower Gastrointestinal	Jul-17	85%	16	75.00%		57	65.79%
	Lung	Jul-17	85%	23	43.48%		89.5	53.07%
	Other	Jul-17	85%	0	N/A		1	0.00%
	Sarcoma	Jul-17	85%	2	50.00%		9	66.67%
	Skin	Jul-17	85%	1	100%		3.5	57.14%
	Upper Gastrointestinal	Jul-17	85%	14	82.14%		56	66.96%
	Urological (Excluding Testicular)	Jul-17	85%	26	86.54%		129	80.62%
	Total (Excluding Rare Cancers)	**Jul-17**	**85%**	**150.5**	**78.74%**		**646**	**77.48%**

The above table shows the performance of 62 day cancer (excluding rare cancers) at NUH for all patients by tumour site for July 2017. There is one tumour site where performance has been consistently below standard over the last 12 months — Lung.

Escalation

Due to continued below standard performance a Remedial Action Plan (RAP) is in place for 62 day, actions include -

- Focus on Lung, Upper GI, Lower GI
- Lung - Increase diagnostic and outpatient capacity
- Lung - Improve pathway management, reporting and escalation of patient pathways and administration
- UGI - Reduce new appointment waiting time to maximum of 10 days - offer increased 2ww slots
- UGI - Escalate patients wishing to book appointments outside of 10 days
- UGI - Secure additional capacity
- UGI - Provide NUH consultant presence at Kings Mill to help navigate patients towards NUH in a more timely fashion
- UGI - Increase cohort of endoscopists able to perform UGI endoscopies
- LGI - Implementation of 7 day testing for histo for GI patients.
- LGI - Recruit to administrative vacancies to reduce typing turnaround for all patients on 2ww pathway
- LGI - Increased capacity for flexi to support faster diagnostics pathways

Level 2 – NUH Performance

NUH 2.2 Referral To Treatment (RTT)

NUH	Description of Standard	Period	Target	Period Perf	Last 12 months
Positive experience of care	RTT - Incomplete pathways (% within 18 weeks)	Jul-17	92%	95.11%	
	RTT - Incomplete pathways with a Decision to Admit (% within 18 weeks)	Jul-17	N/A	85.50%	
	New RTT Periods During the Month	Jul-17	N/A	16473	
	Incomplete Pathways - 52 Week Waiters	Jul-17	0	3	

During July 2017 the 92% Incomplete standard was achieved for all but four specialties as shown below. Incomplete with Decision to Admit does not currently have a national standard, but does show that 85.50% of patients with a decision to admit are currently waiting under 18 weeks.

Number of patients waiting over 18 Weeks	Jul-17						
	Incomplete Standard = 92%			Incomplete With Decision to Admit			New RTT Periods
	Patients	18Wks+	Perf	Patients	18Wks+	Perf	Patients
General Surgery	333	35	89.49%	146	31	78.77%	174
ENT	3759	384	89.78%	680	210	69.12%	1384
Neurosurgery	378	31	91.80%	133	22	83.46%	192
Cardiology	1769	153	91.35%	549	130	76.32%	646

There were three patients reported as having waited over 52 weeks at the end of July. All three breaches of the 52+ week threshold were due to patient choice. One patient's pathway has been stopped in August following treatment and the other two pathways have treatment planned for October.

NUH 2.3 Diagnostics Waiting Times

NUH	Description of Standard	Period	Target	Period Perf	Last 12 months
	Diagnostics (% of patients waiting over six weeks)	Jul-17	1%	0.55%	

NUH achieved the Diagnostics standard during July 2017 with performance at 0.55%. There were 40 breaches in July with 15 relating to Audiological Assessment, 11 to Gastroscopy, 4 to Cystoscopy, 3 to Colonoscopy, 2 to Non-obstetric Ultrasound, 2 to Respiratory Physiology, and 1 each to DEXA Scan, Urodynamics, and Flexi Sigmoidoscopy.

NUH 2.4 Cancelled Operations

NUH	Description of Standard	Period	Target	Period Perf	Last 12 months
Positive experience of care	Cancelled Ops (On the Day) - % of elect act	Jul-17	0.8%	0.59%	
	Cancelled Ops (Total Month) - % of elect act	Jul-17	N/A	3.50%	
	Cancelled Operations - Rebooked 28 days+	Jul-17	0	3	
	Number of urgent operations cancelled for a second time	Jul-17	0	0	

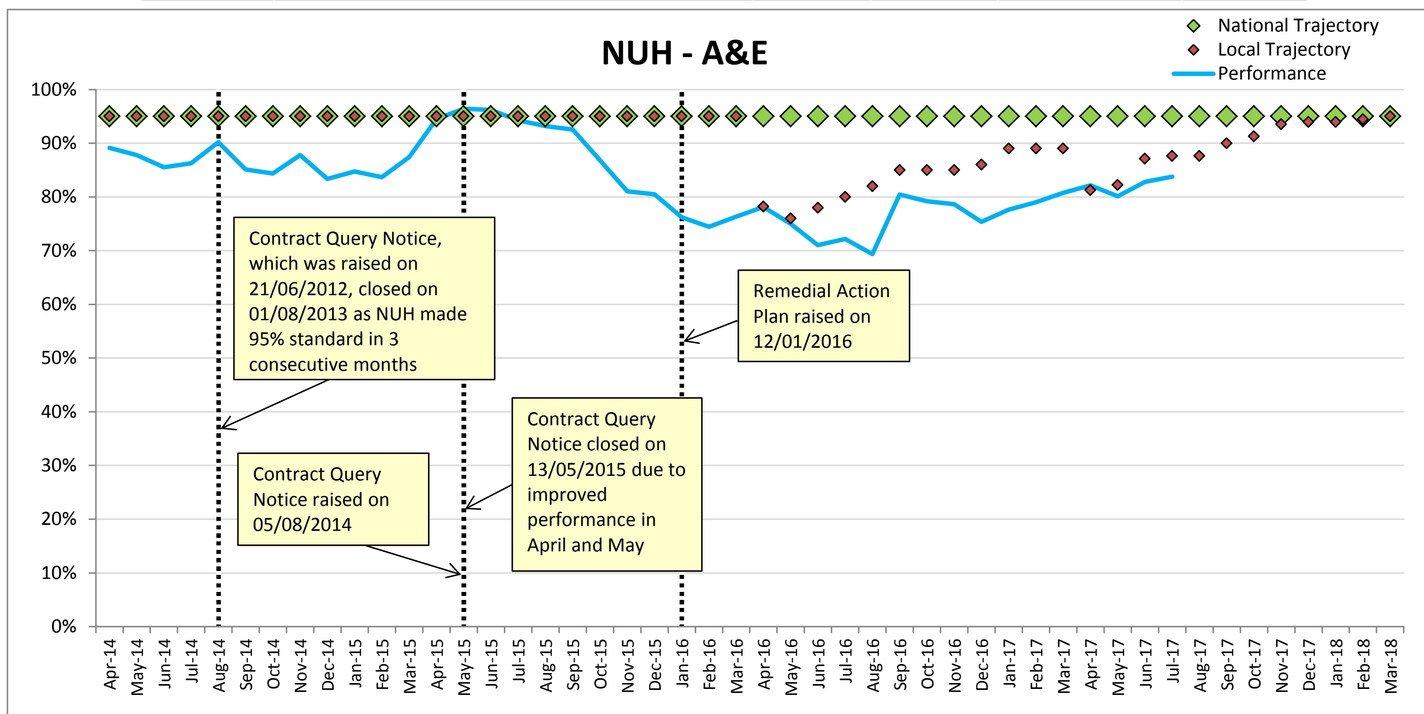
The cancelled operations national standard was achieved in July 2017 in which there were 50 'on the day' cancellations. Three 'on the day' cancelled operations were not rebooked within 28 days. During the month, 3.50% of elective activity was cancelled regardless of whether this was 'on the day' of procedure. This equates to 298 cancelled operations in July 2017. There is no national standard for this indicator.

Of these 50 'on the day' cancelled operations, 14 were due to list overrun - clinical reasons, 13 due to staffing, 9 due to equipment unavailable The remainder were due to a mixture of admin error, other, replaced by emergency patient, and ward bed unavailability.

Level 2 – NUH Performance

NUH 2.5.1 A&E 4 hour waiting time standard

Domain	Description of Standard	Target	Jul-17	Last 12 months	2017/18 YTD
Positive experience of care	A&E waiting time - QMC + Eye Cas	95%	83.79%		82.20%
	A&E waiting time - QMC only	95%	81.94%		80.19%
	A&E waiting time - Eye Cas only	95%	98.87%		99.08%



In July 2017 the national 95% performance level was not met with NUH performance at 83.79%, the standard has not been met in any of the last 12 months.

There is a Remedial Action Plan (RAP) in place. Actions being taken to improve performance are bulleted below -

- Deliver 95% non-admitted performance
- Reduce non-admitted breaches related to medical wait to be seen to less than 20%
- Revised pathways in place for 'GP expect' attendances to ED to reduce overcrowding within the department. Further modelling required to understand impact on performance
- Implementation of Band 7 at front door to deliver 'Luton model' to increase % of patients seen by primary care to 20%
- Review of function of 'Green team' following effective implementation of front door model and pathways for GP expects. Modelling will confirm breach reduction through reduction in WTBS caused by high department occupancy or cubicle space
- Adoption of 'Home First' mantra through effective engagement between acute and community teams
- Review of LJU model to ensure maximum impact on ability to reduce breaches. To be monitored by a reduction in admitted and non-admitted breaches with trajectory set once modelled
- Achievement against trajectories which will reduce the wait to be seen in the department through a reduction in handover time and time for IAU cycle to be completed
- Revision and implementation of ED consultant rotas to improve overnight and weekend cover

NUH 2.5.2 A&E 12 Hour Trolley Waits

NUH	Description of Standard	Period	Target	NUH Responsible Breaches in period	NUH Responsible Breaches: Last 12 months	NUH Responsible Breaches YTD	Non-NUH Responsible Breaches YTD
	Number of 12 hour trolley waits in A&E	Jul-17	0	0		0	0

During July 2017 there were no breaches of the 12 hour trolley wait standard at NUH.

Level 2 – NUH Performance

NUH 2.6 Ambulance Handovers

NUH	Description of Standard	Period	Target	Period Perf	Last 12 months
Ambulance Handovers	Ambulance A&E handovers over 30 minutes	Jul-17	0	212	
	Ambulance A&E handovers over 60 minutes	Jul-17	0	15	

Ambulance handovers to the Emergency Department (ED) remain above the national standards, the key reasons for this include:

- High levels of occupancy in ED cubicles
- Continuing increase in ambulance attendances
- There are a high proportion of vacancies

To improve performance there is an action plan in place.

NUH 2.7 Appointment Slot Issues

NUH	Description of Standard	Period	Target (Traj.)	Period Perf	Last 12 months	2017/18 YTD
	Ratio of slot issues per successful DBS booking	Jul-17	0.04 (0.12)	0.18		0.16

During the appointment booking process, the NHS e-Referral Service will allow the referral to enter the Appointment Slot Issues process if there are no slots available for booking at the time of the appointment search. The above indicator displays the ratio of slot issues per successful Directly Bookable Service (DBS) booking. It is not necessarily the same as the ratio of patients encountering slot issues, as some patients may encounter multiple issues.

NUH failed to meet the slot unavailability standard of 0.04 issues per successful DBS booking with performance at 0.18.

The specialties with the largest number of slot issues are:

- Ear, Nose, and Throat - 422 slot issues
- Neurology - 310 slot issues
- Ophthalmology - 171 slot issues
- Gastrointestinal and Liver - 122 slot issues
- Two week wait - 90 slot issues

NUH 2.8 NHS E-Referral Report

NUH	Description of Standard	Period	Target	Period Perf	Last 12 months
NHS E-Referral ASIs	Patients waiting less than 7 working days to arrange an appointment	Jul-17	95%	61%	
	Patients waiting less than 14 working days to arrange an appointment	Jul-17	100%	87%	

The NHS E-Referral report details how long it takes the Trust to contact patients who have had slot issues. During July 2017, 523 patients had slot issues with 320 patients waiting less than 7 working days. However, 203 were waiting longer than 7 working days and 69 patients were waiting beyond 14 working days.
The main issue is within ENT where 120 patients were waiting over 7 days and 54 over 14 days.

NUH 2.9 Delayed Transfers of Care

Domain	Description of Standard	Period	Target	Period Perf	Last 12 months
	DToC - % Rate of Occupied Bed Days	Jun-17	3.5%	3.5%	

There is a threshold of 3.5% for the rate of delays affecting occupied bed days during the month. NUH experienced delayed transfers of care in 3.5% of all occupied bed days in June 2017. This is the eighth consecutive month that NUH have achieved the standard.

Level 2 – NUH Performance

NUH 2.10 Healthcare Associated Infections

NUH	Description of Standard		Period	YTD Standard	Period Perf		Last 12 months	2017/18 YTD	
					All	Avoidable / Lapse	Avoidable / Lapse	All	Avoidable / Lapse
HCAIs	MRSA	(Full year standard = 0)	Aug-17	0	**1**	TBC		**2**	0
	C-Diff	(YTD standard = 36) (Current month standard = 7)	Aug-17	36	**5**	TBC		**34**	**9**

Please be aware that the trust will only be penalised for MRSAs that are considered avoidable and Clostridium Difficile infections that are considered to be due to lapses in care.

During August 2017 NUH had 10 Clostridium Difficile infections. Information is currently forthcoming as to how many of these were avoidable. Year to date there has been 29 Clostridium Difficile infections against a standard of 29.

NUH had 0 cases of MRSA during August 2017. Year to date there has been 0 cases of MRSA that were deemed clinically avoidable.

NUH 2.11 Mixed Sex Accommodation Breaches (MSA)

NUH	Description of Standard	Period	Target	Period Perf	Last 12 months
	Mixed Sex Accommodation Breaches	Jul-17	0	0	

During July 2017, there were no Mixed Sex Accommodation breaches at NUH.

NUH 2.12 Venous Thromboembolism (VTE)

NUH	Description of Standard	Period	Target	Period Perf	Last 12 months	2017/18 YTD
	Percentage of patients assessed for risk of VTE on admission	Jun-17	95%	95.39%		95.24%

June 2017 performance is above the standard with performance at 95.39% of eligible patients for VTE assessed within 24 hours.

NUH 2.13 Never Events

NUH	Description of Standard	Period	Target	Period Perf	Last 12 months	2017/18 YTD
	Never Events	Jul-17	0	0		0

There were no Never Events reported in July 2017. Year-to-date NUH have experienced no Never Events.

NUH 2.14 Duty of Candour breaches

NUH	Description of Standard	Period	Target	Period Perf	Last 12 months	2016/17 YTD
	Duty of Candour Breaches	Mar-17	0	0		0

NUH have had no Duty of Candour breaches during 2016/17.

NUH 2.15 Summary Hospital Level Mortality Indicator (SHMI)

NUH	Description of Standard	Period	Target	Period Perf	Last 12 months	2016/17 YTD
	Summary Hospital Level Mortality Indicator (SHMI)	Mar-17	Not higher than expected	1.03		1.04

The Summary Hospital Level Mortality Indicator (SHMI) standard has been achieved during March 2017.

Level 2 – NUH Performance

NUH 2.16 Pressure Ulcers

NUH	Description of Standard	Period	Target	Period Perf	Last 12 months
Pressure Ulcers	Reduction of grade 2 Pressure Ulcers per 1000 Occupied Bed Days	Jun-17	0.33	0.40	
	Reduction of grade 3 Pressure Ulcers per 1000 Occupied Bed Days	Jun-17	0.06	0.05	
	Reduction of grade 4 Pressure Ulcers per 1000 Occupied Bed Days	Jun-17	0.00	0.00	

NUH failed to achieve the standard for the reduction of grade 2 pressure ulcers but did meet the target for the reduction in grade 3 and 4 pressure ulcers during June 2017.

NUH 2.17 Falls

NUH	Description of Standard	Period	Target	Period Perf	Last 12 months	2017/18 YTD
Falls	Falls per 1000 Occupied Bed Days resulting in harm	Jul-17	0.98	0.93		1.06

The Trust failed to achieve the Falls per 1000 Occupied Bed Days resulting in harm indicator for July 2017 with performance at 0.93 against a standard of 0.98.

NUH 2.18 Publication of Formulary

NUH	Description of Standard	Period	Target	Period Perf	Last 12 months
	Publication of Formulary	Mar-17	Yes	Yes	

The Trusts' formulary is published by the Nottinghamshire Area Prescribing Committee. The formulary aims to provide information on medicines available to prescribers in Nottinghamshire reflecting safe, evidence-based and cost-effective choices.

NUH 2.19 Mandatory Training

NUH	Description of Standard	Period	Target	Perf	Rolling 12 Months
	Mandatory Training	12 Months to Jul-17	90%	86%	

The Trust are failing to achieve the rolling 12 months standard of 90% to July 2017 with performance at 86%.
To improve performance, a new approach to mandatory training went live from April 2017 which will create more choice for individuals to complete their mandatory training. On-going monitoring at specialty level is also taking place.

NUH 2.20 Appraisals

NUH	Description of Standard	Period	Target	Perf	Rolling 12 Months	Rolling 12 Months
	Appraisals	Jul-17	90%	N/A		89%

The Trust has a target to deliver appraisals to 90% of staff over a rolling 12 month period. The past rolling twelve months from August 2016 — July 2017 period is achieving the 90% standard with performance at 90%.

Level 2 – NUH Performance

NUH 2.21 Friends & Family Test

The Friends and Family score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent.

NUH	Description of Standard		Target	Jun-17 Perf	Last 12 months	2017/18 YTD
Friends & Family Test	**A&E:** How likely are you to recommend our A&E department to friends and family if they needed similar care or treatment?	% Recommended	68%	94.29%		94.15%
		Number of Responses		1873		6047
		Response Rate	20%	20.48%		22.77%
	Inpatient: How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	% Recommended	68%	97.57%		97.74%
		Number of Responses		4288		12050
		Response Rate	30%	37.75%		37.27%
	Maternity Q1: How likely are you to recommend our antenatal service to friends and family if they needed similar care or treatment?	% Recommended		98.48%		99.23%
		Number of Responses		132		391
		Response Rate	25%	16.97%		17.33%
	Maternity Q2: How likely are you to recommend our labour ward to friends and family if they needed similar care or treatment?	% Recommended		97.62%		98.48%
		Number of Responses		126		328
		Response Rate	25%	16.20%		14.54%
	Maternity Q3: How likely are you to recommend our postnatal ward to friends and family if they needed similar care or treatment?	% Recommended		97.62%		97.47%
		Number of Responses		84		356
		Response Rate	25%	10.80%		15.78%
	Maternity Q4: How likely are you to recommend our postnatal community service to friends and family if they needed similar care or treatment?	% Recommended		99.62%		99.25%
		Number of Responses		263		663
		Response Rate	25%	33.80%		29.39%

NUH failed to achieve the Friends and Family Test response rate targets for Maternity Questions 1-3 during June 2017.

Level 2 – NUH Performance

NUH Peer Hospital Performance

Indicator	Target	Basis	Period	Cambridge University Hospitals FT	Central Manchester University Hospitals FT	Lancashire Teaching Hospitals FT	Leeds Teaching Hospitals	Nottingham University Hospitals	Oxford Radcliffe Hospitals	Royal Liverpool and Broadgreen University Hospitals	Sheffield Teaching Hospitals FT	Southampton University Hospitals	The New castle Upon Tyne Hospitals FT	University Hospital Birmingham FT	University Hospitals Bristol FT	University Hospitals of Leicester
A&E achievement	95%	Month	Jun-17	95.49%	94.66%	88.79%	87.69%	83.79%	80.76%	87.74%	90.99%	91.37%	95.71%	86.68%	90.53%	79.76%
Cancer 62d Urg RTT	85%	Month	Jun-17	77.21%	71.43%	81.23%	77.18%	77.08%	83.29%	86.36%	75.88%	87.29%	85.38%	61.96%	81.65%	77.68%
Cancer 62d Urg RTT-Screening Service	90%	Month	Jun-17	94.00%	0.00%	66.67%	93.42%	74.58%	89.19%	86.15%	96.67%	96.08%	91.80%	81.48%	100.00%	93.33%
Cancer 62d Urg RTT-Cons Upgrade	94%	Month	Jun-17	100.00%	82.86%	89.81%	91.30%	81.13%	92.00%	91.30%	77.08%	100.00%	83.33%	93.48%	87.04%	53.85%
Cancer 31d DTT	96%	Month	Jun-17	97.97%	96.84%	94.88%	97.31%	96.40%	97.54%	97.60%	98.13%	98.08%	98.71%	97.89%	95.08%	96.98%
Cancer 31d DTT - Subs: Surgery	94%	Month	Jun-17	95.45%	94.74%	97.44%	98.00%	100.00%	95.00%	96.88%	99.06%	98.20%	97.62%	98.92%	93.18%	88.89%
Cancer 31d DTT - Subs: Drugs	98%	Month	Jun-17	100.00%	100.00%	100.00%	100.00%	99.27%	100.00%	100.00%	100.00%	100.00%	99.34%	96.49%	98.68%	100.00%
Cancer 31d DTT - Subs: Radiotherapy	94%	Month	Jun-17	96.44%		98.02%	100.00%	98.59%	98.10%		95.50%	100.00%	99.04%	98.01%	95.89%	96.23%
Cancer 2w w	93%	Month	Jun-17	96.21%	94.67%	98.90%	95.17%	95.51%	96.78%	84.28%	95.89%	95.54%	93.93%	96.02%	94.31%	95.09%
Cancer 2w w - Breast Symptoms	93%	Month	Jun-17	97.16%		98.53%	96.39%	98.32%	98.11%	94.55%	96.36%	86.49%	95.00%	96.83%		89.55%
Diagnostic Test WT	1%	Month	Jun-17	1.26%	3.79%	1.59%	0.25%	0.60%	0.96%	18.32%	3.01%	0.97%	1.57%	0.33%	1.42%	0.69%
DToC - Acute/Non-Acute 18+	Minimum	Month	Jun-17	60	35	78	84	51	165	12	99	82	37	74	28	20
Friends & Family - A&E (% Recommended)	Local	Month	Jun-17	93.43%	88.78%	87.05%	86.70%	94.29%	84.64%	82.77%	88.42%	96.74%	92.14%	84.86%	84.41%	95.77%
Friends & Family - A&E (Response Rate)	20%	Month	Jun-17	21.38%	15.68%	10.04%	23.92%	20.48%	21.93%	20.51%	20.10%	1.19%	10.87%	15.49%	20.90%	9.40%
Friends & Family - IP (% Recommended)	Local	Month	Jun-17	95.96%	96.11%	92.28%	95.76%	97.58%	96.30%	93.06%	96.21%	96.71%	97.60%	97.21%	97.68%	97.20%
Friends & Family - IP (Response Rate)	20%	Month	Jun-17	8.52%	36.87%	24.00%	43.85%	37.89%	19.68%	27.28%	31.83%	22.82%	15.24%	17.11%	37.35%	27.71%
MRSA	Local	YTD	Jul-17	0	0	1	4	1	1	0	1	1	1	0	2	0
C-Diff	Local	YTD	Jul-17	23	30	24	40	29	23	11	26	19	21	32	17	20
MSA Breaches	Minimum	Month	Jul-17	2	0	0	0	0	0	0	0	0	0	0	10	2
MSA Breach Rate (per 1000 fin cons eps)	Minimum	Month	Jul-17	0.13	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.80	0.08
RTT - Admitted	90%	Month	Jun-17	74.27%	84.47%	71.68%	77.42%	81.80%	73.35%	74.24%	87.58%	81.92%	90.34%	86.83%	73.75%	73.81%
RTT - Non admitted	95%	Month	Jun-17	91.82%	90.72%	83.00%	89.06%	96.49%	86.48%	88.02%	94.76%	90.37%	96.53%	88.62%	90.58%	88.68%
RTT - Incomplete	92%	Month	Jun-17	92.06%	92.17%	85.07%	88.72%	95.73%	89.81%	87.29%	95.88%	92.01%	94.46%	92.22%	90.98%	92.29%

Peer Performance

Please note that the indicators in the table above may show different periods to the same indicators in the rest of Level 2, this is because data for peer hospitals is only available once it is made public, whereas we can obtain NUH data direct from the trust.

NUH have achieved the target for 11 of the 16 indicators that have national targets.

Of the indicators NUH failed, the following number of other trusts also failed that indicator – A&E Achievement = 10 out of 12, Cancer 62 day Urgent RTT = 9 out of 12, Cancer 62 day Urgent RTT - Screening Service = 5 out of 12, Cancer 62 day Urgent RTT - Consultant Upgrade = 10 out of 12, RTT Admitted = 11 out of 12.

Level 2 – Circle Performance

Circle 2.1 Cancer

Domain	Description of Standard	Target	Jul-17	Q1 2017-18	Last 12 months	2017/18 YTD
Preventing people from dying prematurely	62d Urg RTT	85%	92.98%	85.84%		87.67%
	Cancer 31d DTT	96%	98.31%	97.31%		97.55%
	Cancer 2ww	93%	94.50%	94.05%		94.17%

Circle achieved all three cancer standards during July 2017. The table below shows a breakdown of the main 62 Day RTT tumour site performance at Circle. Please note, for the 62 day standard a patient recorded as 0.5 is one that has been treated at multiple providers.

Circle	Tumour Site	Period	Standard	Latest Period		Last 12 Months	2017/18 YTD	
				Patients	%		Patients	%
Cancer 62 Day RTT Performance by Tumour Site for all CCG Patients (Admitted & Non-Admitted)	Gynaecological	Jul-17	85%	3	100.00%		13.5	85.19%
	Haemotological	Jul-17	85%	0	N/A		0.5	100.00%
	Head & Neck	Jul-17	85%	0.5	0.00%		0.5	0.00%
	Lower Gastrointestinal	Jul-17	85%	7	92.86%		21	66.67%
	Lung	Jul-17	85%	0	N/A		0.5	0.00%
	Other	Jul-17	85%	0	N/A		1	100.00%
	Sarcoma	Jul-17	85%	0	N/A		0.5	0.00%
	Skin	Jul-17	85%	34.5	97.10%		138	96.74%
	Upper Gastrointestinal	Jul-17	85%	4.5	100.00%		15.5	74.19%
	Urological	Jul-17	85%	7.5	73.33%		32	73.44%
	All Cancers (Excl. Rare Cancers)	**Jul-17**	**85%**	**57**	92.98%		**223**	87.67%

Cancer 31 Day DTT year to date is performing above standard, with 98.31% of patients waiting less than 31 days from diagnosis to treatment against a national standard of 96%. The table below shows a breakdown of the main 31 day DTT tumour site performance at Circle

Circle	Tumour Site	Period	Standard	Latest Period		Last 12 Months	2017/18 YTD	
				Patients	%		Patients	%
Cancer 31 Day DTT Performance by Tumour Site for all CCG Patients at Circle (Admitted & Non-Admitted)	Gynaecological	Jul-17	96%	1	100.00%		7	100.00%
	Lower Gastrointestinal	Jul-17	96%	2	100.00%		12	91.67%
	Other	Jul-17	96%	0	N/A		1	100.00%
	Skin	Jul-17	96%	53	98.11%		219	97.72%
	Upper Gastrointestinal	Jul-17	96%	1	100.00%		2	100.00%
	Urological	Jul-17	96%	2	100.00%		4	100.00%
	All Cancers	**Jul-17**	**96%**	**59**	98.31%		**245**	97.55%

Level 2 – Circle Performance

Circle 2.2 RTT

Circle	Description of Standard	Period	Target	Period Perf	Last 12 months
Positive experience of care	RTT - Incomplete pathways (% within 18 weeks)	Jul-17	92%	94.60%	
	RTT - Incomplete pathways with a Decision to Admit (% within 18 weeks)	Jul-17	N/A	92.62%	
	New RTT Periods During the Month	Jul-17	N/A	5683	
	Incomplete Pathways - 52 Week Waiters	Jul-17	0	0	

During July 2017 Circle achieved the 92% RTT Incomplete national standard with performance at 94.60%, the standard has been achieved in each of the last twelve months. Two specialties were below the standard, these were Gastroenterology at 91.37% and Thoracic Medicine at 89.56%.

Circle 2.3 Diagnostics Waiting Times

Circle	Description of Standard	Period	Target	Period Perf	Last 12 months
	Diagnostics (% of patients waiting over six weeks)	Jun-17	1%	1.70%	

Circle failed to achieve the Diagnostics standard in June 2017 with performance at 1.70% against a national requirement of no more that 1% of patients waiting over six weeks for a diagnostic test. During the month there were 32 breaches of the six week standard, 28 of these breaches were within MRI and the result of equipment failure.

Circle 2.4 Cancelled Operations

Circle	Description of Standard	Period	Target	Period Perf	Last 12 months	2017/18 YTD
Positive experience of care	Cancelled Ops - % of elect act	Jul-17	0.8%	0.25%		0.37%
	Cancelled Operations - Rebooked 28 days+	Jul-17	5%	0.00%		0.00%
	Number of urgent operations cancelled for a second time	Jul-17	0	0		0

During July 2017 Circle achieved the 0.8% national standard with 0.25% of operations cancelled. There were four operations cancelled during July 2017. Three of these were due to administrative errors with the remaining one listed as 'Other'.

Circle 2.5 Complaints

Circle	Description of Standard	Period	Standard	Period Perf	Last 12 months	2017/18 YTD
Patient Experience	Number of Complaints	Jul-17	Minimum	17		71

Circle had 17 complaints during July 2017. Circle have a culture of encouraging patients to raise concerns and any complaints made are used to increase the quality of clinical care and provide the best possible patient experience.

Circle 2.6 HCAIs

Circle	Description of Standard	Period	Standard	Period Perf	Last 12 months
HCAIs	MRSA Bacteraemia	Jul-17	0	0	
	C Difficile	Jul-17	0	0	

Circle have not had any cases of MRSA or C-Diff during the last 12 months.

Level 2 – Circle Performance

Circle 2.7 Venous Thromboembolism (VTE) Risk Assessment

Circle	Description of Standard	Period	Target	Period Perf	Last 12 months	2017/18 YTD
	Percentage of patients assessed for risk of VTE on admission	Jun-17	95%	95.97%		98.38%

Circle achieved the VTE risk assessment standard in June 2017 with performance at 95.97%.

Circle 2.8 Never Events

Circle	Description of Standard	Period	Target	Period Perf	Last 12 months	2017/18 YTD
	Never Events	Jul-17	0	0		0

There were no Never Events reported during July 2017.

Circle 2.9 Friends & Family Test (FFT)

Circle	Description of Standard	Period	Basis	Standard	Performance	Last 12 months
Friends & Family Test (FFT)	FFT - Inpatient Score	Jun-17	Monthly	N/A	**91.4**	
	FFT - Inpatient Response Rate	Jun-17	Monthly	N/A	**65.39%**	
	FFT - Outpatient Score	Jun-17	Monthly	N/A	**81.1**	
	FFT - Outpatient Response Rate	Jun-17	Monthly	N/A	**18.39%**	

There are currently no national standards for the FFT. However, Circle are consistently achieving high scores amongst both inpatients and outpatients.

Level 2 – NHCT Performance

NHCT 2.1 IAPT

NHCT	Description of Standard	CCG	Target	May-17	Last 12 months
IAPT	The percentage of people who have depression and/or anxiety disorders who receive psychological therapies	NNE	2.80%	2.27%	
		NW	2.80%	2.63%	
		Rush	2.80%	2.00%	

The CCGs have set a target for 4.20% of patients who have depression and/or anxiety disorders to be seen each quarter during 2017/18. This equates to 275 patients per month for Nottingham North & East, 172 for Nottingham West and 226 for Rushcliffe.

Nottingham North & East CCG are not achieving the required quarter to date standard of 2.80% for the first two months of Quarter 1 with performance at 2.27% . The CCG is averaging 223 patients treated per month during the quarter, this is in line with the Quarter 1 2016/17 performance when the CCG averaged 220 patients treated per month.

IAPT - Patient Moving Towards Recovery (Recovery Rate)

NHCT	Description of Standard	CCG	Target	May-17	Last 12 months
IAPT	IAPT Recovery Rates	NNE	50%	62.38%	
		NW	50%	58.49%	
		Rush	50%	64.23%	

The recovery rate is the number of people moving to recovery, divided by the number of people who have completed treatment, minus the number of people who have completed treatment who were not at "caseness" at initial assessment. An individual is at caseness when their outcome score exceeds the accepted threshold for a standardised measure of symptoms.

The CCG has an IAPT recovery rate standard of 50%. During May 2017, Nottingham North & East CCG achieved the 50% standard with performance at 62.38%.

NHCT 2.2 Early Intervention in Psychosis

CCG	Description of Standard	Period	Target	CCG	Monthly Referrals	Monthly Perf	Last 12 months	Rolling 3 Months
Positive Experience of Care	Early Intervention in Psychosis (% of patients starting treatment with a NICE-recommended package of care within 2 weeks of referral)	Jul-17	50%	NNE	2	100.00%		100.00%
				NW	1	100.00%		50.00%
				Rush	0	N/A		100.00%
	Early Intervention in Psychosis (% of patients awaiting treatment with a NICE-recommended package of care within 2 weeks of referral)	Jul-17	50%	NNE	3	66.67%		57.14%
				NW	0	N/A		N/A
				Rush	0	N/A		100.00%

There is a national target for 50% of patients referred onto the early intervention in psychosis pathway to be treated within 2 weeks with a NICE-recommended package of care. In July 2017, 100% of Nottingham North & East CCG patients were reported as waiting less than two weeks to begin treatment. Meanwhile 66.67% awaiting treatment had waited less than 2 weeks.

The three months rolling performance for Nottingham North & East CCG shows that 100% of patients started treatment within two weeks following referral.

NHCT 2.3 Delayed Transfers of Care

NHCT	Description of Standard	Period	Standard	Period Perf	Last 12 months
	DToC - Number of Days Delayed	Jun-17	Minimum	**320**	

NHCT had a total of 320 days where patients' transfers of care were delayed in June 2017. This compares to 917 in June 2016.

Level 2 – NHCT Performance

NHCT 2.4 Children and Young Person's Mental Health - Eating Disorder

NHCT	Description of Standard	Rolling six months to	Standard (By 2020)	CCG	No. of Referrals	6 Month Rolling Perf	Previous Perf
Positive Experience of Care	CYP ED pathways (routine cases) completed (< 4 weeks)	Q1 17-18	95%	NNE	2	0.00%	
		Q1 17-18	95%	NW	2	50.00%	
		Q1 17-18	95%	Rush	2	50.00%	
	CYP ED pathways (routine cases) incomplete (< 4 weeks)	Q1 17-18	95%	NNE	3	100.00%	
		Q1 17-18	95%	NW	6	33.33%	
		Q1 17-18	95%	Rush	5	80.00%	
	CYP ED pathways (urgent cases) completed (< 1 week)	Q1 17-18	95%	NNE	0	N/A	
		Q1 17-18	95%	NW	1	0.00%	
		Q1 17-18	95%	Rush	0	N/A	
	CYP ED pathways (urgent cases) incomplete (< 1 week)	Q1 17-18	95%	NNE	0	N/A	
		Q1 17-18	95%	NW	0	N/A	
		Q1 17-18	95%	Rush	1	0.00%	

Children and Young Person's Mental Health - Eating Disorder is a new quarterly collection. Due to the low volume of referrals for these services, CCGs performance is to be measured on a rolling 6 months basis. The expectation is that by 2020, CCGs will have achieved a minimum of 95% of referrals waiting less than 1 week for urgent referrals, and 4 weeks for routine cases.

In the six months to the end of Quarter 1 2017-18, 0% of completed routine cases for Nottingham North & East CCG were seen within 4 weeks. Meanwhile, 100% of incomplete routine cases were currently waiting less than 4 weeks at the time of reporting.

NHCT 2.5 Care Programme Approach

NHCT	Description of Standard	Period	Standard	Period Perf	Last 12 months
CPA	% of patients having a review last 12 months	Feb-17	95.0%	96.20%	
	% of patients receiving follow-up contact within 7 days of discharge	Feb-17	95.0%	91.10%	

CPA is usually for patients that have severe mental health problems and is a particular way of assessing, planning and reviewing their mental health needs. There should be a formal written care plan outlining any risks and including details of what should happen in an emergency or crisis, this should be reviewed annually.

The Trust failed to achieve the percentage of patients receiving follow-up contact within 7 days of discharge during February 2017, this is the eighth time the standard has not been achieved in the last twelve months. The primary reason for the below standard performance has been patients not responding to communication from services to enable follow-up to take place within required timeframe. The Trust maintain a proactive and committed approach to ensure that patients are followed up within a timely manner. During February 2017 all patients not communicated with inside 7 days were successfully followed up after.

NHCT 2.6 Dementia

During the planning round completed by CCGs in December 2016, Nottingham North & East CCG set ambitions to maintain their Dementia Diagnosis Rate at a minimum of 67% throughout 2017/18.

The table below shows that as at the end of July 2017 Nottingham North & East CCG has a Dementia Diagnosis Rate of 70%, which is above the 67% plan.

NHCT	Description of Standard	Plan	Jul-17	Last 12 months
Dementia Diagnosis Rate	Nottingham North & East	67%	70%	
	Nottingham West	67%	86%	
	Rushcliffe	67%	74%	

Level 2 – EMAS Performance

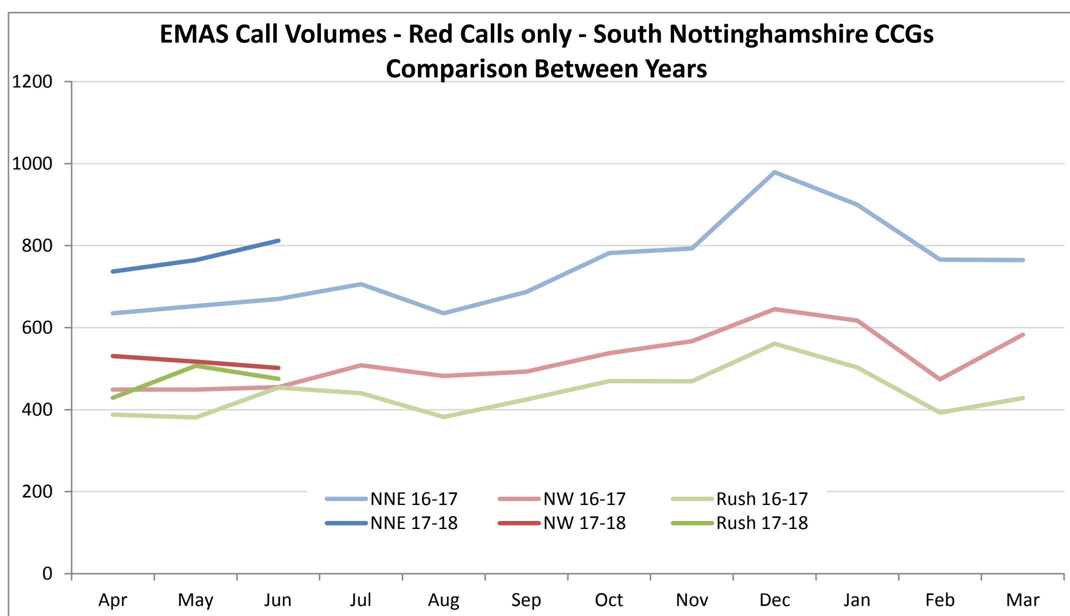
Monthly Performance of the Ambulance Indicators Red 8 minutes and Red 19 minutes

Performance against standard for Red 1 and Red 2 calls.

CCG Level	Description of Standard	Target	CCG	June 2017		Last 12 months performance	Year to Date	
				Responses	Performance		Responses	Performance
Red 1 - Life threatening requiring defibrillation Call timer starts when the 999 call is connected to the switchboard	8 Minute Response Time	75%	M&A	87	74.71%		222	76.13%
			N&S	35	48.57%		114	53.51%
			City	142	83.80%		427	84.54%
			NNE	41	63.41%		111	73.87%
			NW	22	50.00%		79	59.49%
			Rush	17	58.82%		63	63.49%
	19 Minute Response Time	95%	M&A	87	100%		221	100%
			N&S	35	91.43%		114	90.35%
			City	142	99.30%		427	99.77%
			NNE	41	95.12%		111	98.20%
			NW	22	100%		79	97.47%
			Rush	17	100%		63	100%
Red 2 - Life threatening Call timer starts at earliest of the following 1. The point at which the chief complaint of the call has been identified; 2. A vehicle has been assigned to the call; 3. A 60 second cap from the Call Connect time	8 Minute Response Time	75%	M&A	1038	52.60%		3255	56.34%
			N&S	599	42.74%		1841	42.21%
			City	2079	66.14%		6249	65.07%
			NNE	720	43.61%		2109	43.10%
			NW	467	43.25%		1445	45.26%
			Rush	409	37.41%		1266	40.52%
	19 Minute Response Time	95%	M&A	1038	91.23%		3252	92.10%
			N&S	596	68.46%		1836	70.21%
			City	2074	94.46%		6236	94.19%
			NNE	717	91.07%		2105	90.45%
			NW	467	89.29%		1445	91.14%
			Rush	404	80.94%		1253	85.24%

The table above shows the EMAS performance for local CCGs against the Red 1 and Red 2 standards. As of July 2017, national standards have been altered to reflect the newly implemented Ambulance Response Programme. The information team at EMAS are currently updating reporting systems to reflect this change. Therefore, the following reflects the latest data available to us at CCG level.

During June 2017 Nottingham North & East CCG failed to achieve the Red 1 8 minute 75% standard with performance at 63.41% from 41 responses. The CCG has achieved the standard five times in the last twelve months. The CCG also failed to achieve the Red 2 8 minute 75% standard. During June 2017 there were 720 responses of which 43.61% arrived within 8 minutes, 91.07% arrived within 19 minutes which is below the standard of 95%.



The chart above shows EMAS Red call volumes for the three South Nottinghamshire CCGs, comparing 2017-18 volumes to the same periods of 2016-17. All three South Nottinghamshire CCGs have seen an increase in call volumes; Nottingham North & East has increased by 18.18%, Nottingham West by 14.56% and Rushcliffe by 15.37%.

Level 2 – EMAS Performance

Non-Conveyance Rates

CCG	Description of Standard	Period	CCG	Target	Period Perf	Last 12 months	17/18 YTD	16/17 YTD
Ambulance	Proportion of calls closed by telephone advice (%)	Jun-17	NNE	Increase Proportion	11.90%		12.88%	14.60%
			NW		13.67%		12.86%	14.51%
			Rush		13.50%		13.88%	15.12%
	Proportion of incidents managed without need for transport to Accident and Emergency Departments (%)	Jun-17	NNE	Increase Proportion	28.55%		28.62%	32.10%
			NW		30.71%		30.30%	34.99%
			Rush		32.28%		32.34%	35.52%

The table above shows the proportion of EMAS responses resulting in non-conveyance for the three South Nottinghamshire CCGs. There is a target to increase the proportion of emergency calls closed by telephone advice, and the number of incidents to be treated at the scene or conveyed to a destination that is not A&E.

In June 2017, Nottingham North & East CCG saw 11.90% of calls closed by telephone advice and 28.55% of incidents managed without the need for transport to A&E. Year to date the CCG has seen a decrease of 1.72% in the proportion of calls closed by telephone advice compared to the previous year. There has also been a 3.48% decrease in the proportion of incidents not resulting in conveyance to A&E compared to the previous year.

Remedial Action Plan

To improve EMAS performance, a Remedial Action Plan (RAP) which details issues and actions is in place. These are shown below -

Issue - Demand - Increased Red Activity

Actions

- Level of clinical input into the Clinical Assessment Team (CAT) desk to be increased
- CAT desk ability to triage Red 999 calls to be protected , this will enable more calls to be downgraded to Green
- Collaboration with Derbyshire Health United to pilot a Ambulance Liaison Desk in NHS 111, utilising EMAS Clinical Hub staff, to reduce number of calls transferred to EMAS
- Peer review of current activity/demand to identify any additional actions required

Issue - Resources - Resource Availability

Actions

- Increase utilisation of Private and Voluntary Ambulance Services, whilst ensuring patient safety - Ongoing collaboration with Police and Fire services to provide additional Community First Responders
- Development of a workforce plan and trajectory to ensure 2193 WTE staff trained and operational by March 2017 - this has been aided by an overseas recruitment campaign that took place in early October
- Reduction of the number of staff on alternative duties to support operational delivery
- Devolve resource planning function to the responsibility of the divisional management teams
- Dispatch to Disposition allows up to an additional 180 seconds for calls (excluding Red 1s) to be triaged allowing extra time to determine the most clinically appropriate response required for the patient

Issue - Quality & Performance - Improved Performance

Actions

- Analysis of the impact of revised Ambulance Quality Indicators on Red performance
- Monitor impact of capacity management plan on performance and quality

Issue - Handovers - Handover Delays

Actions

- Work with commissioners and providers in Leicestershire to implement actions specific to that area
- Ensure rollout programme of 164 defibrillators matches requirements of each division, reduce vehicle downtime

Level 2 – EMAS Performance

Ambulance Service Performance Comparison

System Indicators

Area	Indicator (Latest Month = Jun-17)		Period	Target	EMAS Rank (out of 11) 1 = Best 11 = Worst	East Midlands Ambulance Service	East of England Ambulance Service	Isle of Wight	London Ambulance Service	North East Ambulance Service	North West Ambulance Service	South Central Ambulance Service	South East Coast Ambulance Service	South Western Ambulance Service	West Midlands Ambulance Service	Yorkshire Ambulance Service
Category A Calls	Proportion of Red 1 calls responded to within 8 minutes		Month	75%	4	72.53%	70.26%	65.91%	73.30%	75.45%	62.50%	74.70%	63.91%			
			YTD	75%	5	72.07%	72.18%	68.85%	75.34%	73.48%	66.13%	75.52%	67.54%			
	95th centile of response time for Red 1 calls (in minutes)		Month		4	14.7	15.2	15.8	12.8	13.1	19.0	13.2	16.0			
	Proportion of Red 2 calls responded to within 8 minutes		Month	75%	7	56.38%	60.00%	71.88%	69.68%	56.95%	64.67%	71.80%	46.44%			
			YTD	75%	7	57.40%	62.43%	73.57%	71.68%	58.21%	65.97%	72.70%	51.56%			
	Proportion of Category A calls responded to within 19 minutes		Month	95%	8	85.02%	90.49%	94.01%	94.30%	87.51%	89.39%	94.37%	86.08%			
			YTD	95%	8	85.57%	91.28%	93.66%	94.93%	88.37%	90.64%	94.91%	88.98%			
Call Abandonment	Proportion of calls abandoned before being answered		Month		5	0.9%	1.1%	3.4%	1.4%	0.4%	4.5%	0.4%	2.5%	3.6%	0.7%	0.2%
			YTD		5	0.7%	1.0%	2.8%	0.8%	0.6%	2.7%	0.3%	1.9%	2.3%	0.5%	0.3%
Timeliness	Time to answer call (in seconds)	Median	Month		8	2	1	1	0	1	1	3	3	3	1	1
		95th Percentile	Month		7	29	28	5	55	20	82	16	108	101	10	5
		99th Percentile	Month		6	85	86	27	110	67	197	79	194	255	44	50
	Time to treatment for Category A calls (in minutes)	Median	Month		8	12	8	4	6	8	7	6	9			
		95th Percentile	Month		5	24	23	16	18	28	29	20	26			
		99th Percentile	Month		5	40	34	24	39	47	64	32	42			

Ambulance Service Performance Comparison: System Indicators

Out of 11 Ambulance service' EMAS are ranked 9th or worse in 0 out of the 11 monthly indicators and 0 out of the 4 year to date indicators shown above. EMAS are failing to achieve the standards for Proportion of Red 1 calls responded to within 8 minutes monthly (72.53%), Proportion of Red 2 calls responded to within 8 minutes monthly (56.38%), and Proportion of Category A calls responded to within 19 minutes monthly (85.02%).

Level 2 – EMAS Performance

Ambulance Service Performance Comparison

Clinical Outcomes

Area	Indicator (Latest Month = Mar-17)		Period	EMAS Rank (out of 11) 1 = Best 11 = Worst	East Midlands Ambulance Service	East of England Ambulance Service	Isle of Wight	London Ambulance Service	North East Ambulance Service	North West Ambulance Service	South Central Ambulance Service	South East Coast Ambulance Service	South Western Ambulance Service	West Midlands Ambulance Service	Yorkshire Ambulance Service
Cardiac Arrest (Utstein group)	Return of Spontaneous Circulation	Proportion of patients who were resuscitated who had return of spontaneous circulation on arrival at hospital	Month	10	34.29%	63.41%	75.00%	59.09%	44.44%	50.00%	27.03%	62.86%	51.02%	48.39%	68.75%
			YTD	7	46.83%	56.93%	39.13%	54.38%	59.31%	56.96%	39.76%	52.45%	46.38%	46.00%	55.89%
	Survival to Discharge	Proportion of patients who were discharged from hospital alive following resuscitation by ambulance service following a cardiac arrest	Month	11	13.79%	48.72%	50.00%	25.81%	17.65%	24.39%	15.15%	16.67%	29.79%	32.26%	47.73%
			YTD	10	21.30%	31.38%	30.43%	24.68%	34.25%	24.10%	22.84%	21.01%	23.03%	23.97%	36.86%
Stroke	Proportion of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyperacute stroke unit within 60 minutes		Month	9	50.35%	57.56%	85.71%	67.84%	54.96%	53.19%	57.46%	59.65%	39.41%	57.57%	41.03%
			YTD	8	52.02%	50.59%	67.44%	62.08%	56.31%	52.56%	54.16%	63.89%	36.94%	57.08%	44.38%
	Proportion of suspected stroke patients assessed face to face who received an appropriate care bundle		Month	4	99.36%	99.45%	100.00%	98.07%	97.70%	99.40%	98.73%	94.11%	96.89%	97.95%	98.64%
			YTD	4	98.76%	99.09%	98.39%	96.77%	97.74%	99.68%	98.78%	95.76%	95.10%	97.26%	98.55%
Acute STEMI	Proportion of patients with definite ST-elevation myocardial infarction who received primary angioplasty within 150 minutes of call connecting to ambulance service		Month	4	91.01%	92.04%	25.00%	90.55%	96.15%	82.98%	82.76%	91.67%	79.86%	86.30%	80.36%
			YTD	1	91.80%	91.69%	36.84%	90.04%	90.87%	79.87%	86.84%	89.65%	72.88%	86.76%	84.12%
	Proportion of patients with ST-elevation myocardial infarction who received an appropriate care bundle		Month	7	79.34%	91.93%	75.00%	71.43%	94.87%	86.70%	83.49%	65.59%	60.95%	83.92%	80.00%
			YTD	5	84.02%	91.46%	63.01%	71.75%	84.52%	86.60%	76.26%	67.24%	73.65%	81.48%	85.76%

Ambulance Service Performance Comparison: Clinical Outcomes

Only the Utstein group is shown in the Cardiac Arrest indicators. The 'Utstein comparator group' provides a comparable and specific measure of the management of cardiac arrests for the subset of patients where timely and effective emergency care can particularly improve survival (e.g. 999 calls where the arrest was not witnessed and the patient may have gone into arrest several hours before the 999 call are excluded from the Utstein comparator group figure).

Out of 11 Ambulance service' EMAS are ranked 9th or worse in 3 out of the 6 monthly indicators and 1 out of the 6 year to date indicators shown above.

Level 2 – Arriva Performance

Arriva Patient Transport Services

Nottinghamshire Patient Transport Service (PTS) Summary			Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
KPI 1	Time on Vehicle - Patients within a certain radius of the point of care	Patients within 10 miles spend no longer than 60 mins on the vehicle	96.0%	95.7%	96.7%	95.8%	96.1%	96.3%	96.4%	96.7%	96.5%	95.7%	96.2%	96.1%
		10-35 miles spend no longer than 90 minutes on the vehicle	95.0%	95.0%	95.2%	94.1%	94.6%	95.5%	95.9%	96.0%	95.6%	95.5%	95.6%	96.5%
		35-80 miles spend no longer than 120 minutes on the vehicle	96.0%	91.8%	92.5%	90.2%	90.1%	93.6%	90.5%	91.6%	95.5%	93.8%	91.0%	93.9%
KPI 2	Arrival Times at Point of Care	Patients shall arrive within 60 minutes prior to their appointment/zone time at the point of care	76.0%	74.4%	78.2%	72.0%	70.1%	69.6%	69.5%	73.4%	72.5%	67.2%	70.3%	73.2%
KPI 3	Departure times from Point of Care	OP Return patients shall be collected within 60 mins of request or agreed transport/or zone time	68.0%	68.1%	71.0%	65.0%	64.1%	65.4%	63.9%	66.3%	68.9%	62.0%	64.2%	66.3%
		Discharge patients shall be collected within 120 mins of request or agreed transport/or zone time	56.0%	62.0%	60.0%	53.6%	52.2%	55.2%	53.1%	52.5%	59.1%	48.4%	45.6%	50.3%
KPI 5	Customer Service	Calls requesting PTS answered within 10 seconds by a booking agent, not an automated message	55.0%	29.3%	32.1%	46.1%	49.7%	33.6%	58.9%	50.7%	59.0%	60.8%	59.8%	64.3%
		Maximum percentage of calls requesting Non-Emergency PTS are abandoned	12.0%	26.7%	28.4%	16.3%	15.1%	22.1%	9.4%	11.1%	11.2%	8.5%	10.8%	8.8%

The table above shows the Arriva Patient Transport Service (PTS) performance over the past 12 months for the 5 KPIs for Nottinghamshire.

The performance for KPI1, the time in which a patient spends in the vehicle split by the distance that the patient lives from the point of care, has achieved each standard for this month. This includes the standard that patients within 10 miles of the point of care spend no longer than 60 minutes on the vehicle. Prior to this, this standard had failed once in the previous twelve months. KPI2, KPI3 and KPI5 have been below their relevant standards every recorded month over the last year.

To improve performance Arriva have created a Service Improvement Plan for Nottinghamshire which has identified several areas for improvement -

- Improve partnership working along the patient pathway
  - Improve partnership working with points of care
  - Reduce number of aborted journeys at hospital for hospital triggered reason codes
  - Reduction in Crew wait times for patient at pick up from Unit
  - On the day patient transport changes - changes to patient clinic locations and patient collection points
  - Support the discharge pathway to improve the co-ordination of transport & TTOs
  - Improve understanding of mobility types when booking journeys
  - Confirmation required on the Patient support provided when a clinic has closed but the patient is not yet due to be collected by transport
- Renal transport
  - Improve Renal performance
- Improve call centre performance
  - Improve site/HPs access to Cleric to book transport and making patients ready for collection
  - Reduce the number of abandoned calls and call waiting times into the Call Centre
- Improve performance of patient inward KPIs
  - Patients travelling in on crews first run not always meeting KPIs
- Improve internal performance management processes
  - The resource vs. demand peaks are only escalated on the day of travel, resulting in third party resources being engaged too late to be optimised efficiently and meet demand
  - More focus needed on how individual roles support and impact the KPIs
- Internal communication
  - Improve the internal communication & resolution of reoccurring service delivery issues that impact the KPIs

Quality Premium

The Quality Premium is £5 per head of running cost population and will be payable to CCGs in 2016/17 based on the quality of health services commissioned during 2015/16. This will be based on several measures that cover a combination of national and local priorities.

This initial value will be reduced if providers, from which the CCG commissions services, are unable to meet the 4 key areas of the NHS Constitution and pledges for its population.

As well as achieving the above there are 3 prerequisites for the Quality Premium to be payable. A CCG will not achieve a quality premium if it:

a. is not considered in a manner that is consistent with Managing Public Money during 2015/16; or

b. Incurs an unplanned deficit during 2015/16, or requires unplanned financial support to avoid being in this position; or

c. Incurs a qualified audit in respect of 2015/16.

The table below provides an overview of the Quality Premium for the CCG.

CCG Name	Nottingham North & East
Quality Premium Forecast	£130,535

Measure			**Percentage of Quality Premium**	**Potential Value**	**Performance Needed**		**Achieve by**	**Latest Performance**	**Latest Period Available**	**Trend**	**Award**
Premature Mortality	Reducing Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare over time		10%	£72,520	Less than or equal to	1984.6	2015 Calendar Year	2116.9	2014		£0
Urgent & Emergency Care Menu	Composite Measure	Unplanned hospitalisation for chronic ambulatory care sensitive conditions	N/A	N/A	Less than or equal to	1000	2015/16	788.6	2015/16		N/A
		Unplanned hospitalisation for asthma, diabetes and epilepsy in children			Less than or equal to	1000	2015/16	164.9	2015/16		
		Emergency admissions for acute conditions that should not usually require hospital admission			Less than or equal to	1000	2015/16	1137.1	2015/16		
		Emergency admissions for children with lower respiratory tract infection			Less than or equal to	1000	2015/16	388.2	2015/16		
		Avoidable Emergency Admissions Composite	10%	£72,520	Less than or equal to	1000	2015/16	887.5	2015/16		£72,520
	An increase in the level of discharges at weekends and bank holidays		10%	£72,520	More than or equal to	22.52%	2015/16	23.39%	Apr-15 - Mar-16		£72,520
	Reducing NHS-responsible delayed transfers of care (days delayed per 100,000 population)		10%	£72,520	Less than	2709	2015/16	2421	Mar-16		£72,520
Mental Health Menu	A&E	Improvement in coding of patients attending A&E	5%	£36,260	More than or equal to	90%	2015/16	98.60%	Apr-15 - Mar-16		£0
		Reduction in the number of patients with A&E 4 hour breaches who have attended with a mental health need			More than or equal to	89.63%	2015/16	72.12%	Apr-15 - Mar-16		
	Improvement in the health-related quality of life for people with a long-term mental health condition		10%	£72,520	Less than	0.157	2015/16	0.228	2015/16		£0
	Reduction in the number of people with severe mental illness who are smokers		10%	£72,520	Less than	37.3%	31-Mar-16	37.3%	2014/15		£72,520
	Increase the proportion of adults with secondary mental health conditions who are in paid employment		5%	£36,260	More than or equal to	6.5	Q4 2015/16	5	2015/16		£0
Improving Antibiotic Prescribing	Reduction in the number of antibiotics prescribed in primary care		5%	£36,260	Less than or equal to	1.10	2015/16	1.11	2013/14		£0
	Reduction in the proportion of broad spectrum antibiotics prescribed in primary care		3%	£21,756	Less than	12.23%	2015/16	13.51%	2013/14		£0
	Secondary care providers validating their total antibiotic prescription data		2%	£14,504	Validated	Yes	2015/16				
Local Measure 1	C3.9	Patients who have had an acute stroke who spend 90% or more of their stay on a stroke unit	10%	£72,520	More than	89.2%	2015/16	90.2%	2015/16		£72,520
Local Measure 2	C5.4	Incidence of healthcare associated infection (HCAI) Clostridium Difficile	10%	£72,520	Less than (YTD)	47	Less than 47 by 2015/16	32	Apr-15 - Mar-16		£72,520
Total			**100%**	**£725,195**							**£435,117**

NHS Constitution Right and Pledges		**Percentage of Quality Premium**	**Potential Reduction**	**Performance Needed**		**Achieve by**	**Latest Performance**	**Latest Period Available**	**Trend**	**Reduction**
RTT	Patients on incomplete pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	-30%	-£130,535	More than or equal to	92%	2015/16	97.33%	Apr-15 - Mar-16		£0
A&E	Patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department	-30%	-£130,535	More than or equal to	95%	2015/16	89.55%	Apr-15 - Mar-16		-£130,535
Cancer	Maximum two week (14-day) wait from urgent GP referral to first outpatient appointment for suspected cancer	-20%	-£87,023	More than or equal to	93%	2015/16	91.67%	Apr-15 - Mar-16		-£87,023
Ambulance	Red 1 ambulance calls resulting in an emergency response arriving within 8 minutes (Total EMAS not CCG)	-20%	-£87,023	More than or equal to	75%	2015/16	69.12%	Apr-15 - Mar-16		-£87,023
Total		**-100%**	**-£435,117**							**-£304,582**