# Quality & Performance Report

Author: John Adler Sponsor: Chief Executive Date: IFPIC + QAC 29th October 2015

# Executive Summary from CEO Paper H

## 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:** **Fractured NOF** - the standard has been achieved for the second month running. The changes made are starting to have an impact. **RTT** - The RTT incomplete target remains compliant. This is particularly good in the light of rising referrals. **DTOC** - Delayed transfers of care remain well within the tolerance. **Cancer standards** - Six of the nine Cancer standards are now being achieved. **Diagnostics** - There has been a 3.8% improvement in month. This is the early signs of recovery from the issues in Endoscopy. **MRSA** - remains at zero for the seventh consecutive month running. There have been no **Grade 4 pressure ulcers** this financial year. **Annual appraisals rates** - are improving. **Stay on a Stroke Unit** - performance during August (90%) (latest reported period) was the best performance over the last 12 months and has been compliant for eight months. **C DIFF** - above monthly trajectory but still within year to date trajectory. **Pressure Ulcers** - the overall number is within the trajectory collectively as the trend is down for **Grade 3**, this is attributed to earlier detection, which is then increasing the number of **Grade 2 ulcers** (above plan) which is positive.

**Bad News**:
**ED 4 hour performance**- was 90.3% which for the second month in a row was worse than the corresponding month the year before. It has slipped to 91.7% year to date. **Cancelled operations** - was not achieved with 104 patients cancelled in September. This is partly as a result of increasing operational pressures linked to the emergency demand. **RTT 52+ -** week waits in Orthodontics continue given the difficulties with locum consultant recruitment. **Cancer Standards -** the 62 day backlog remains too high to confidently predict compliant performance. **Ambulance Handover - a**s widely reported September has been a very challenging month for Ambulance handovers. One **Never Event** reported for the first time in seven months.

## 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: 26th November 2015

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

# Quality and Performance Report

## September 2015

One team shared values

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**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST**

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

**DATE:** **29th OCTOBER 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:** **SEPTEMBER 2015 QUALITY & PERFORMANCE SUMMARY REPORT**

## 1.0 Introduction

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

## 2.0 Performance Summary

| Domain | Page Number | Number of Indicators | Indicators with target to be confirmed | Number of Red Indicators this month |
|---|---|---|---|---|
| Safe | 4 | 22 | 7 | 3 |
| Caring | 5 | 10 | 3 | 0 |
| Well Led | 6 | 18 | 6 | 2 |
| Effective | 7 | 16 | 3 | 1 |
| Responsive | 8 | 17 | 2 | 6 |
| Responsive Cancer | 9 | 9 | 1 | 3 |
| Research – UHL | 11 | 6 | 6 | 0 |
| Estates & Facilities | 12 | 10 | 10 | 0 |
| Total | | 108 | 38 | 15 |

## 3.0 New Indicators

No new indicators.

## 4.0 Indicators removed

The East Midlands Clinical Research Dashboard has been removed from the Q&P from this month. A revised process for reporting to the Trust has been agreed, with a separate Network Overview Dashboard plus narrative report presented to the Board on a quarterly basis.

## 5.0 Indicators where reporting methodology/thresholds have changed

Well Led

Outpatients Friends and Family Test – Coverage exception reporting has been amended from monthly to quarterly.

15/16 Quality Schedule and CQUIN Indicators

Quality Schedule and CQUIN Indicators reporting timeframe has been changed from monthly to quarterly from this month.

| | 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 | 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 | Sep-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 | 2 | 5 | 7 | 7 | 11 | 7 | 5 | 7 | 3 | 1 | 4 | 4 | 6 | 6 | 24 |
| | S2a | MRSA Bacteraemias (All) | JS | DJ | 0 | TDA | Red if >0 ER if >0 | 3 | 6 | 0 | 1 | 1 | 0 | 2 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | S2b | MRSA Bacteraemias (Avoidable) | JS | DJ | 0 | UHL | Red if >0 ER if >0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | S3 | Never Events | JS | MD | 0 | TDA | Red if >0 in mth ER = in mth >0 | 3 | 3 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| | S4 | Serious Incidents | JS | MD | Not within Highest Decile | TDA | TBC | 60 | 41 | 2 | 3 | 4 | 2 | 4 | 3 | 2 | 1 | 2 | 8 | 1 | 5 | 3 | 5 | 24 |
| | S5a | Proportion of reported safety incidents per 1000 beddays | JS | MD | TBC | TDA | TBC | 37.5 | 39.1 | 35.6 | 41.8 | 38.9 | 40.3 | 40.4 | 35.0 | 38.2 | 36.3 | 83.8 | | | 34.6 | | | 84 |
| | 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% | | | 1.9% | | | 2.1% |
| | S6 | Overdue CAS alerts | JS | MD | 0 | TDA | Red if >0 in mth ER = in mth >0 | 2 | 10 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | S7 | RIDDOR - Serious Staff Injuries | JS | MD | FYE = <40 | UHL | Red / ER if non compliance with cumulative target | 47 | 24 | 2 | 1 | 2 | 2 | 1 | 0 | 3 | 2 | 0 | 6 | 0 | 0 | 2 | 3 | 11 |
| | 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% | 94.4% | 93.9% | 94.9% | 93.3% | 94.1% | 95.0% | 92.1% | 93.6% | 93.7% | 94.3% | 95.6% | 94.6% | 93.2% | 94.0% | 94.2% |
| | S8b | Safety Thermometer % number of new harms | JS | EM | Not within Lowest Decile | TDA | TBC | New TDA Indicator | | 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% | 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% | 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% | 96.1% | 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 | 5.9 | 6.4 | 7.5 | 6.9 | 7.1 | 6.7 | 6.3 | 5.6 | 5.8 | 5.1 | 5.7 | 5.7 | 4.1 | 5.3 |
| | S12 | Avoidable Pressure Ulcers - Grade 4 | JS | MC | 0 | QS | Red / ER if Non compliance with monthly target | 1 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 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 | 6 | 6 | 4 | 6 | 7 | 5 | 9 | 6 | 3 | 0 | 4 | 1 | 4 | 1 | 13 |
| | S14 | Avoidable Pressure Ulcers - Grade 2 | JS | MC | <=8 a month | QS | Red / ER if Non compliance with monthly target | 120 | 91 | 9 | 4 | 8 | 13 | 11 | 7 | 5 | 9 | 10 | 8 | 8 | 8 | 10 | 11 | 55 |
| | 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% | | AUDIT IN PROGESS | | | | | | |
| | S16 | Maternal Deaths | AF | IS | 0 | UHL | Red or ER if >0 | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | S17 | Emergency C Sections (Coded as R18) | IS | EB | Not within Highest Decile | TDA | Red / ER if Non compliance with monthly target | 16.1% | 16.5% | 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% | 16.5% | 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 | | | | | | | | | | | | | | | | |

| | 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 | 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 | Sep-15 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Caring | C1 | Inpatients (Including Daycases) Friends and Family Test - % positive | JS | HL | Q1 95%<br>Q2/3 96%<br>Q4 97% | QC | Red if <95%<br>ER if 2 mths Red | New Indicator | 96% | 96% | 97% | 96% | 96% | 96% | 96% | 96% | 97% | 96% | 96% | 97% | 96% | 97% | 97% | 96% |
| | C2 | A&E Friends and Family Test - % positive | JS | HL | Q1 95%<br>Q2/3 96%<br>Q4 97% | QC | Red if <94%<br>ER if 2 mths Red | New Indicator | 96% | 92% | 95% | 96% | 96% | 96% | 96% | 96% | 97% | 96% | 96% | 96% | 96% | 97% | 95% | 96% |
| | C3 | Outpatients Friends and Family Test - % positive | JS | HL | Q1 95%<br>Q2/3 96%<br>Q4 97% | QC | Red if <90%<br>ER if 2 mths Red | NEW METHODOLOGY FOR CALCULATING % | | | | | | | | | | 94% | 94% | 93% | 91% | 93% | 93% | 93% |
| | C4 | Daycase Friends and Family Test - % positive | JS | HL | Q1 95%<br>Q2/3 96%<br>Q4 97% | QC | Red if <95%<br>ER if 2 mths Red | | | | | | | | | | | 96% | 97% | 97% | 98% | 98% | 97% | 97% |
| | C5 | Maternity Friends and Family Test - % positive | JS | HL | Q1 95%<br>Q2/3 96%<br>Q4 97% | QC | Red if <94%<br>ER if 2 mths Red | | 96% | 96% | 94% | 96% | 97% | 95% | 97% | 96% | 96% | 95% | 96% | 95% | 95% | 96% | 95% | 95% |
| | C6 | Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment | LT | LT | Not within Lowest Decile | TDA | TBC | New Indicator | 69.2% | | | Q3 staff FFT not completed as National Survey carried out | | | 71.4% | | | 68.7% | | | 71.9% | | | 70.3% |
| | C7a | Complaints Rate per 100 bed days | AF | MD | TBC | UHL | TBC | New Indicator | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 | 0.3 | 0.3 | 0.3 | 0.4 | 0.3 | 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%<br>ER if >=15% | New Indicator | 10% | 10% | 9% | 11% | 11% | 10% | 17% | 13% | 11% | 13% | 7% | 7% | 7% | 11% | 11% | 9% |
| | C9 | Single Sex Accommodation Breaches (patients affected) | JS | HL | 0 | TDA | Red / ER if >0 | 2 | 13 | 0 | 0 | 0 | 5 | 0 | 1 | 0 | 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 | 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 | Sep-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% | 28.9% | 28.9% |
| | W2 | Daycase Friends and Family Test - Coverage (Adults and Children) | JS | HL | 20% | TDA | Red if <8% ER if 2 mths Red | NEW METHODOLOGY FOR CALCULATING COVERAGE INCLUDES ADULTS AND CHILDREN | | | | | | | | | | 12.5% | 12.1% | 15.5% | 20.5% | 23.8% | 24.1% | 18.4% |
| | 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% | 13.1% | 13.9% |
| | W4 | Outpatients Friends and Family Test - Coverage | JS | HL | Q1 3% Q2/3 4% Q4 5% | UHL | Red if <2.5% ER Qtrly | NEW METHODOLOGY FOR CALCULATING COVERAGE INCLUDES ADULTS AND CHILDREN | | | | | | | | | | 1.3% | 1.6% | 1.2% | 1.2% | 1.4% | 1.4% | 1.3% |
| | W5 | Maternity Friends and Family Test - Coverage | JS | HL | 30% | UHL | Red if <26% ER if 2 mths Red | 25.2% | 28.0% | 29.9% | 18.7% | 15.8% | 21.7% | 22.1% | 25.8% | 46.5% | 40.2% | 32.3% | 35.8% | 32.6% | 25.6% | 30.5% | 27.9% | 30.7% |
| | 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% | | | 55.7% | | | 54.0% |
| | 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% | 8.5% | 8.5% |
| | 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% | 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% | 10.5% | 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% | 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% | 3.7% | 4.0% | 4.0% | 4.4% | 4.2% | 4.1% | 4.0% | 3.6% | 3.4% | 3.5% | 3.3% | 3.3% | | 3.4% |
| | W10 | Temporary costs and overtime as a % of total paybill | LT | LG | TBC | TDA | TBC | New Indicator | 9.4% | 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% | 9.9% | 10.6% |
| | W11 | % of Staff with Annual Appraisal | LT | BK | 95% | UHL | Red if <90% ER if 3 consecutive mths <90% | 91.3% | 91.4% | 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% | 90.0% | 90.0% |
| | W12 | Statutory and Mandatory Training | LT | BK | 95% | UHL | TBC | 76% | 95% | 83% | 85% | 86% | 87% | 89% | 89% | 90% | 95% | 93% | 92% | 92% | 91% | 91% | 91% | 91% |
| | W13 | % Corporate Induction attendance | LT | BK | 95% | UHL | Red if <90% ER if 3 consecutive mths <90% | 94.5% | 100% | 98% | 98% | 98% | 98% | 100% | 99% | 100% | 97% | 97% | 97% | 98% | 100% | 97% | 98% | 98% |
| | W14a | DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%) | JS | MM | Not within Lowest Decile | TDA | TBC | New Indicator | 91.2% | 87.9% | 91.6% | 92.9% | 91.3% | 92.7% | 94.3% | 91.8% | 91.0% | 93.6% | 90.3% | 91.2% | 90.3% | 90.2% | 90.5% | 91.1% |
| | W14b | DAY Safety staffing fill rate - Average fill rate - care staff (%) | JS | MM | Not within Lowest Decile | TDA | TBC | | 94.0% | 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% | 93.1% | 92.6% |
| | W14c | NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%) | JS | MM | Not within Lowest Decile | TDA | TBC | | 94.9% | 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% | 94.9% | 95.8% |
| | W14d | NIGHT Safety staffing fill rate - Average fill rate - care staff (%) | JS | MM | Not within Lowest Decile | TDA | TBC | | 99.8% | 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% | 100.0% | 100.6% |

**Effective**

| KPI Ref | Indicators | Board Director | Lead Officer | 15/16 Target | Target Set by | Red RAG/ Exception Report Threshold (ER) | 13/14 Outturn | 14/15 Outturn | 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 | Sep-15 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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<br>ER if >Expected or 3 consecutive mths increasing SHMI >100 | 105 | 97 | 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<br>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<br>ER if >Expected or 3 consecutive increasing mths >100 | 99 | 95 | 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<br>ER if >Expected or 3 consecutive increasing mths >100 | 91 | 94 | 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<br>ER if >Expected or 3 consecutive increasing mths >100 | 96 | 101 | 103 | | 97 | | | 103 | | | 84 | | | Awaiting DFI Update | | | 84 |
| E7 | Crude Mortality Rate Emergency Spells | AF | PR | Within Upper Decile | TDA | TBC | 2.5% | 2.4% | 1.9% | 2.3% | 2.1% | 2.3% | 3.0% | 3.1% | 2.7% | 2.4% | 2.1% | 2.0% | 2.3% | 1.8% | 2.0% | 2.2% | 2.1% |
| E8 | Deaths in low risk conditions (Risk Score) | AF | PR | Within Expected | TDA | Red if >expected<br>ER if >Expected or 3 consecutive increasing mths >100 | 94 | 81 | 64 | 59 | 113 | 60 | 85 | 101 | 87 | 75 | 121 | 20 | 38 | Awaiting DFI Update | | | 59 |
| E9 | Emergency readmissions within 30 days following an elective or emergency spell | AF | JJ | Within Expected | UHL | Red if >7%<br>ER if 3 consecutive mths >7% | 7.9% | 8.5% | 8.9% | 8.4% | 8.6% | 8.9% | 9.1% | 8.2% | 8.5% | 8.5% | 9.2% | 9.1% | 9.0% | 8.8% | 8.9% | | 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%<br>ER if 2 consecutive mths <72% | 65.2% | 61.4% | 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% | 72.0% | 63.5% |
| E11 | Stroke - 90% of Stay on a Stroke Unit | RM | IL | 80% or above | QS | Red if <80%<br>ER if 2 consecutive mths <80% | 83.2% | 81.3% | 84.5% | 83.2% | 70.4% | 73.3% | 75.2% | 82.5% | 87.6% | 83.3% | 83.7% | 84.5% | 84.5% | 85.7% | 90.9% | | 85.9% |
| E12 | Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA) | RM | IL | 60% or above | QS | Red if <60%<br>ER if 2 consecutive mths <60% | 64.2% | 71.2% | 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% | 88.1% | 80.7% |
| E13 | Published Consultant Level Outcomes | AF | SH | >0 outside expected | QC | Red if >0<br>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<br>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 | | | | | | | | | | | | | | | | |

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 | 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 | Sep-15 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| R1 | ED 4 Hour Waits UHL + UCC (Calendar Month) | RM | IL | 95% or above | TDA | Red if <92% ER via ED TB report | 88.4% | 89.1% | 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% | 90.3% | 91.7% |
| R2 | 12 hour trolley waits in A&E | RM | IL | 0 | TDA | Red if >0 ER via ED TB report | 5 | 4 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 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% | 94.3% | 94.8% | 95.0% | 95.1% | 95.2% | 96.2% | 96.7% | 96.6% | 96.5% | 96.2% | 95.2% | 94.3% | 94.9% | 94.9% |
| R4 | RTT 52 Weeks+ Wait (Incompletes) | RM | WM | 0 | TDA | Red /ER if >0 | 0 | 0 | 1 | 3 | 3 | 2 | 0 | 0 | 0 | 0 | 0 | 66 | 242 | 256 | 258 | 259 | 259 |
| R5 | 6 Week - Diagnostic Test Waiting Times | RM | SK | 1% or below | TDA | Red /ER if >1% | 1.9% | 0.9% | 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% | 9.6% | 9.6% |
| 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 |
| 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 | 2 | 0 | 3 | 4 | 3 | 1 | 2 | 0 | 1 | 1 | 5 | 1 | 10 |
| 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 | 6 | 0 | 0 | 1 | 1 | 2 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| R9 | % Operations cancelled for non-clinical reasons on or after the day of admission UHL | RM | PW | 0.8% or below | Contract | Red if >0.9% ER if >0.8% | 1.6% | 0.9% | 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% | 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% | 0.0% | 0.9% | 1.0% | 0.0% | 0.8% | 1.4% | 0.0% | 0.4% | 1.2% | 1.2% | 1.0% | 0.8% | 0.0% | 1.0% | 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% | 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% | 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 | 55 | 90 | 94 | 108 | 102 | 85 | 64 | 98 | 79 | 56 | 97 | 138 | 67 | 104 | 541 |
| R13 | Outpatient Hospital Cancellation Rates | RM | PW | Within Upper Decile | UHL | TBC | NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED | | | | | | | | | | | | | | | | |
| R14 | Delayed transfers of care | RM | PW | 3.5% or below | TDA | Red if >3.5% ER if Red for 3 consecutive mths | 4.1% | 3.9% | 3.9% | 4.5% | 4.6% | 5.2% | 3.9% | 3.2% | 2.9% | 1.8% | 1.2% | 1.0% | 1.0% | 0.9% | 1.2% | 1.3% | 1.1% |
| 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% | 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% | 1% | 2% | 5% | 6% | 10% | 6% | 11% | 9% | 6% | 7% | 7% | 8% | 9% | 18% | 9% |
| 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% | 15% | 17% | 25% | 23% | 25% | 21% | 21% | 22% | 22% | 21% | 17% | 17% | 17% | 25% | 20% |

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 | Aug-14 | Oct-14 | Nov-14 | Dec-14 | Jan-15 | Feb-15 | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-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% | 92.0% | 92.0% | 92.5% | 93.0% | 92.2% | 93.5% | 91.5% | 91.2% | 87.9% | 91.1% | 87.4% | 86.8% | ** | 88.9% |
| RC2 | Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected) | RM | MM | 93% or above | TDA | Red if <93% ER if Red for 2 consecutive mths | 94.0% | 94.1% | 94.4% | 98.6% | 100.0% | 93.0% | 92.5% | 91.5% | 96.0% | 99.0% | 98.8% | 87.2% | 93.3% | 98.7% | ** | 95.3% |
| RC3 | 31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers | RM | MM | 96% or above | TDA | Red if <96% ER if Red for 2 consecutive mths | 98.1% | 94.6% | 97.9% | 95.9% | 92.5% | 95.2% | 91.7% | 95.0% | 97.0% | 93.9% | 97.9% | 93.7% | 97.2% | 96.5% | ** | 95.8% |
| 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% | 98.8% | 97.1% | 100.0% | 96.7% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 97.7% | 100.0% | 98.3% | ** | 99.2% |
| 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% | 87.8% | 81.9% | 82.4% | 80.3% | 89.2% | 94.4% | 87.5% | 86.3% | 92.2% | 89.6% | 92.2% | 81.1% | ** | 88.2% |
| 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% | 99.0% | 96.0% | 94.7% | 95.5% | 87.6% | 99.0% | 100.0% | 86.3% | 98.1% | 96.5% | 95.9% | 99.0% | ** | 95.6% |
| 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% | 78.8% | 80.4% | 77.0% | 84.8% | 79.3% | 78.9% | 83.8% | 75.7% | 70.1% | 84.2% | 73.7% | 81.4% | ** | 77.2% |
| 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% | 100.0% | 75.0% | 94.4% | 93.8% | 88.9% | 79.4% | 89.3% | 91.7% | 82.4% | 93.3% | 95.2% | 97.1% | ** | 92.0% |
| RC9 | Cancer waiting 104 days | RM | MM | 0 | TDA | TBC | NEW TDA INDICATOR | | | | | | | | | 12 | 10 | 12 | 20 | 12 | 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 | Aug-14 | Oct-14 | Nov-14 | Dec-14 | Jan-15 | Feb-15 | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-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% | 84.4% | 96.3% | 81.8% | 100.0% | 93.3% | 97.4% | 98.1% | 92.3% | 96.8% | 97.8% | 91.4% | 96.3% | ** | 94.9% |
| RC12 | Gynaecological | RM | MM | 85% or above | TDA | Red if <90% ER if Red for 2 consecutive mths | 88.2% | 77.5% | 91.7% | 71.4% | 75.0% | 66.7% | 54.5% | 91.7% | 75.0% | 64.3% | 55.6% | 66.7% | 100.0% | 72.2% | ** | 70.7% |
| RC13 | Haematological | RM | MM | 85% or above | TDA | Red if <90% ER if Red for 2 consecutive mths | 65.9% | 66.5% | 87.5% | 100.0% | 73.3% | 75.0% | 66.7% | 50.0% | 80.0% | 50.0% | 55.0% | 83.3% | 37.5% | 82.6% | ** | 61.5% |
| RC14 | Head and Neck | RM | MM | 85% or above | TDA | Red if <90% ER if Red for 2 consecutive mths | 65.4% | 69.9% | 83.3% | 100.0% | 33.3% | 77.8% | 70.0% | 87.5% | 62.5% | 75.0% | 54.5% | 66.7% | 36.4% | 60.0% | ** | 56.3% |
| RC15 | Lower Gastrointestinal Cancer | RM | MM | 85% or above | TDA | Red if <90% ER if Red for 2 consecutive mths | 71.3% | 63.7% | 50.0% | 56.3% | 62.5% | 92.9% | 65.0% | 46.7% | 63.2% | 63.6% | 55.6% | 93.3% | 63.6% | 56.3% | ** | 66.2% |
| RC16 | Lung | RM | MM | 85% or above | TDA | Red if <90% ER if Red for 2 consecutive mths | 89.7% | 69.9% | 48.1% | 68.9% | 64.1% | 74.4% | 67.7% | 74.2% | 88.6% | 84.6% | 50.9% | 74.6% | 81.8% | 70.4% | ** | 71.1% |
| RC17 | Other | RM | MM | 85% or above | TDA | Red if <90% ER if Red for 2 consecutive mths | 78.7% | 95.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 50.0% | 100% | 100% | 100% | 100% | ** | 77.8% |
| 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% | 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% | 94.5% | 98.4% | 94.1% | 100.0% | 94.3% | 95.6% | 91.7% | 94.0% | 91.3% | 93.8% | 94.1% | ** | 93.1% |
| RC20 | Upper Gastrointestinal Cancer | RM | MM | 85% or above | TDA | Red if <90% ER if Red for 2 consecutive mths | 72.2% | 73.9% | 77.8% | 33.3% | 64.7% | 68.0% | 85.7% | 77.8% | 81.8% | 66.7% | 55.0% | 84.6% | 51.4% | 81.8% | ** | 66.5% |
| RC21 | Urological (excluding testicular) | RM | MM | 85% or above | TDA | Red if <90% ER if Red for 2 consecutive mths | 89.3% | 82.6% | 77.1% | 84.5% | 81.5% | 85.7% | 83.3% | 66.7% | 71.0% | 62.1% | 62.1% | 74.7% | 61.5% | 86.1% | ** | 69.6% |
| RC22 | Rare Cancers | RM | MM | 85% or above | TDA | Red if <90% ER if Red for 2 consecutive mths | 92.3% | 84.6% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 66.7% | 100.0% | -- | 100% | 100% | 100% | 100.0% | ** | 100% |
| RC23 | Grand Total | RM | MM | 85% or above | TDA | Red if <90% ER if Red for 2 consecutive mths | 86.7% | 81.4% | 78.8% | 80.4% | 77.0% | 84.8% | 79.3% | 78.9% | 83.7% | 75.7% | 70.1% | 84.2% | 73.7% | 81.4% | ** | 77.2% |

## Compliance Forecast for Key Responsive Indicators

| Standard | September actual/predicted | October predicted | Month by which to be compliant | RAG rating of required month delivery | Commentary |
|---|---|---|---|---|---|
| Emergency Care | | | | | |
| 4+ hr Wait (95%) - Calendar month | 90.3% | | Not Confirmed | | Nationally the 95% target has not been achieved for last 12 month. |
| Ambulance Handover (CAD+) | | | | | |
| % Ambulance Handover >60 Mins (CAD+) | 18% | | Not Confirmed | | An eight-week action plan has been agreed to speed up the time it takes for EMAS crews to pass patients to A&E staff at Leicester Royal Infirmary. |
| % Ambulance Handover >30 Mins and <60 mins (CAD+) | 25% | | Not Confirmed | | |
| RTT (inc Alliance) | | | | | |
| Incomplete (92%) | 94.9% | 94.7% | Continued Delivery | | |
| Diagnostic (predicted) | | | | | |
| DM01 - diagnostics 6+ week waits (<1%) | 9.6% | 8.0% | November/December | | NHS IQ Work progressing but current progress suggests more likely to be at 4% in November rather than the required 1% |
| # Neck of femurs | | | | | |
| % operated on within 36hrs (72%) | 72.0% | 72.0% | October | | August and September delivered for the first time in over a year. |
| Cancelled Ops (inc Alliance) | | | | | |
| Cancelled Ops (0.8%) | 0.9% | 0.8% | October | | |
| Not Rebooked within 28 days (0 patients) | 1 | 0.0% | October | | |
| Cancer (predicted) | | | | | |
| Two Week Wait (93%) | 87% | 87% | November | | NHS IQ coming to support endoscopy work. |
| 31 Day First Treatment (96%) | 96.0% | 96.0% | On-going | | This has now been delivered for 5 of the last 6 months. |
| 31 Day Subsequent Surgery Treatment (94%) | 92% | 94.0% | November | | Subsequent in Radiotherapy and Drugs on track and achieving. |
| 62 Days (85%) | 75% | 75% | March | | The rephasing of delivery is being looked at currently given the challenge we and other centres are experiencing and the backlog not being where we need it to be. Nationally this target hasn't been achieved since April 2014. |

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 | Jul-15 | Aug-15 | Sep-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 | 12564 | 1071 | 807 | 1025 | 992 | 819 | 604 | 5513 |
| RU4 | % Adjusted Trials Meeting 70 day Benchmark (data sunbmitted for the previous 12 month period) | AF | NB | TBC | TBC | TBC | (Jul13-Jun14 ) 43.4% | | | (Oct13-Sep14 ) 70.5% | | | (Nov13-Dec14 ) 70.5% | | | (Apr14-Mar15) 86% | | | | (Jul14-Jun15) 76% | | | | | | |
| RU5 | Rank No. Trials Submitted for 70 day Benchmark (data submitted for the previous 12 month period) | AF | NB | TBC | TBC | TBC | (Jul13-Jun14 ) Rank 17/61 | | | (Oct13-Sep14 ) Rank 18/60 | | | (Nov13-Dec14 ) Rank 18/59 | | | (Apr14-Mar15) Rank 60/198 | | | | (Jul14-Jun15) 108/210 | | | | | | |
| RU6 | %Closed Commercial Trials Meeting Recruitment Target (data submitted for the previous 12 month period) | AF | NB | TBC | TBC | TBC | (Jul13-Jun14 ) 50% | | | (Oct13-Sep14 ) 52% | | | (Nov13-Dec14 ) 48% | | | (Apr14-Mar15) 38.6% | | | | (Jul14-Jun15) 15.3% | | | | | | |

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 | Sep-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.<br><br>There are no discernible factors that link the 6 cases in September to people and place, and the trust is still below trajectory overall. | 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. | **5** | **6** | **24** | **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 | 6 | | | | | | | **24** |

| | |
|---|---|
| **Expected date to meet monthly target** | October 2015 |
| **Revised date to meet standard** | |
| **Lead Director / Lead Officer** | Julie Smith, Chief Nurse<br>Liz Collins, Lead Nurse Infection Prevention |

Never Events

| What is causing underperformance? | What actions have been taken to improve performance? | Target (mthly / end of year) | September | YTD performance | Forecast performance for next reporting period |
|---|---|---|---|---|---|
| Patient suffering post-op delirium managed to manoeuvre out of a top opening window on ward 27 at the LGH falling from the first floor onto a hard surface and sustaining fractures. Patient transferred to Walsgrave hospital.<br><br>Windows in Ward 27 at LGH were fitted with restrictors that allowed opening to 160mm (100 mm restrictors are recommended). However the risk was previously identified as low as the windows were deemed to be 'safe by position' (ie bottom of opening 1700mm above floor level). | All windows on ward 26 and 27at the LGH have now been fitted with restrictors.<br><br>A full survey of windows across UHL has been commissioned by Facilities to identify the type of restrictors fitted (if any). This will enable the trust to identify where further modification to reduce risk may be required. Survey is expected to take approximately 100 days.<br><br>A risk assessment has been carried out by the Estates and Facilities senior Statutory Compliance manager that identifies a moderate risk in relation to a future incident occurring across the UHL site<br><br>Clinical colleagues will be asked to further advise where patients at risk of post-operative delirium may be located (ED, theatres and recovery areas have previously been identified and fitted with non-opening windows or with restrictors that limit the opening to 100mm). | **0** | **1** | **1** | **0** |
| | | **Expected date to meet standard / target** | October 2015 | | |
| | | **Revised date to meet standard** | | | |
| | | **Lead Director / Lead Officer** | Moria Durbridge, Director of Safety and Risk | | |

## 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 avoidable pressure ulcers for September is above trajectory for Grade 2 avoidable pressure ulcers.<br><br>The overall number is within the trajectory collectively as the trend is down for Grade 3, this is attributed to earlier detection, which is then increasing the number of Grade two ulcers which is positive.<br><br>There are two clinical areas Ward 14 LGH and Ward 34 LRI where between them there have been 5 avoidable grade 2 pressure ulcers. The theme behind this is that there is a lack of documented evidence that care plans have been followed to avoid. | The Nursing Executive team receive monthly reports and detail of pressure ulcer prevalence<br><br>Targeted support is in place to support Wards 34 and 14 to make the required improvements. | **G2= 8** | **G2 = 11** | **G2 = 55** | **G2 = </= 8** |

*Table one - Avoidable Grade 2 Pressure Ulcers April – September 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 | 11 | | | | | | | **55** |

*Table two - Avoidable Grade 3 Pressure Ulcers April – September 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 | 1 | | | | | | | **13** |

*Table three - Avoidable Grade 4 Pressure Ulcers April – September 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** | November 2015 |
| **Revised date to meet standard** | |
| **Lead Director / Lead Officer** | Carole Ribbins, Deputy Chief Nurse<br>Michael Clayton, Head of Nursing |

## Readmissions within 30 days

| 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 |
|---|---|---|---|---|---|
| UHL's readmission rate has increased during 15/16 and when compared with other Trusts (using the Dr Foster tool) our 'risk adjusted readmission rate' has been higher than expected for the past 3 years. | A 'Readmissions Review' CQUIN was agreed with Commissioners for 15/16 and the Review has now been complete.<br><br>This highlighted a need for:<br><br>Better identification of patients at risk of readmission, in order to inform discharge planning and community follow up and support. Work is underway to confirm which 'tool' would be most appropriate for UHL and how this would link with the Integrated Community Response Service'.<br><br>Joint care planning for patients with Long Term Conditions and End of Life Care Needs. Actions being taken are to investigate the most effective IT solution for sharing care planning between LLR organisations.<br><br>Long term catheter service in the community. A pilot 'outreach service' has been proposed.<br><br>Further review of internal data has identified some Speciality shows some 'hot spots', some of whom have plans in place to reduce their rates – e.g. 'Hot Gall Bladder Service' in General Surgery and 'Ambulatory Care Clinic' in CDU. | **To be within** | **8.9%** | **9.0%** | **9.0%** |

**UHL'S READMISSION RATE 12/13 to 14/15 (as measured by Dr Foster Intelligence)**

| F/Y | Super Spells | Observed | Rate (%) | Relative Risk |
|---|---|---|---|---|
| 2012/13 | 220024 | 17414 | 7.91 | 103.15 |
| 2013/14 | 220346 | 17294 | 7.85 | 102.45 |
| 2014/15 | 242563 | 20418 | 8.42 | 106.39 |

**UHL'S READMISSION RATE FOR 14/15 COMPARED WITH OTHER TRUSTS**

| TRUST | Discharges | ReAdm | % | RELATIVE RISK |
|---|---|---|---|---|
| University Hospitals Bristol NHS Foundation Trust | 130778 | 8446 | 6.46 | 88.51 |
| Leeds Teaching Hospitals NHS Trust | 191790 | 14650 | 7.64 | 95.14 |
| Central Manchester University Hospitals | 178044 | 12541 | 7.04 | 97.02 |
| Coventry and Warwickshire NHS Trust | 147190 | 11849 | 8.05 | 98.92 |
| South Tees Hospitals NHS Foundation Trust | 153427 | 12636 | 8.24 | 100.65 |
| Oxford University Hospitals NHS Trust | 198372 | 14779 | 7.45 | 102.77 |
| Nottingham University Hospitals NHS Trust | 204619 | 18603 | 9.09 | 103.06 |
| University Hospitals Birmingham NHS Foundation | 108166 | 10330 | 9.55 | 105.23 |
| **University Hospitals Of Leicester NHS Trust** | **242268** | **20375** | **8.41** | **106.4** |
| University Hospital Of North Staffordshire NHS | 176781 | 16220 | 9.18 | 106.77 |
| Sheffield Teaching Hospitals NHS Foundation | 221048 | 18764 | 8.49 | 111.66 |
| University Hospital Southampton NHS Foundation | 134319 | 12991 | 9.67 | 112.74 |

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

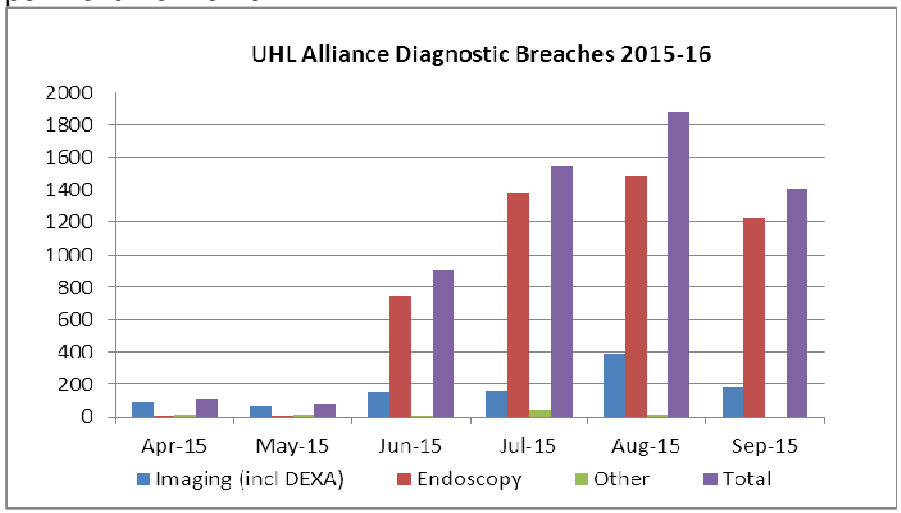
## 52 week breaches – incompletes

<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>September performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="4">The Trust had 260 patients on an incomplete pathway that breached 52 weeks at the end of September 2015. 259 of these are Orthodontics patients and 1 is a Urology patient.<br><br>The reasons for underperformance in Orthodontics are as follows:<ul><li>Incorrect use and management of a planned waiting list for outpatients.</li><li>Inadequate capacity within the service to see patients when they are ready for treatment.</li><li>There are currently 10 patients on the waiting list between 40 and 51 weeks, who are likely to roll over to become 52 week breaches.</li></ul>The Urology breach was caused by inadequate staff knowledge, which meant a patient's pathway was incorrectly stopped.</td><td rowspan="4">Orthodontics:<ul><li>The service is now closed to new referrals with some clinical exceptions. Adherence to this is being monitored by the Director of Performance and Information.</li><li>Funding has been secured from NHS England for 2 WTE locums to clear backlog. The posts were re-advertised with a mid-October closing date.</li><li>The Serious Untoward Incident (SUI) report was recently published. Recommendations included a clearly defined SOP to be put in place for the administration of planned waiting lists and that all administrative and clinical staff running outpatient clinics should have RTT e-learning training.</li><li>UHL are exploring capacity for Orthodontics patients within community both community and acute providers within the local area. Approximately 120 patients have agreed to transfer their care to Northampton General Hospital or local community providers.</li></ul>Urology:<ul><li>The RTT Team delivered a refresher training session for the Urology admin staff on 19th October. They will also be developing some flow charts and SOPs relating to different scenarios to support their learning.</li></ul></td><td>0</td><td>260</td><td>260</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:<ul><li>Communication around planned waiting list management to all relevant staff;</li><li>System review of all waiting list codes;</li><li>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;</li><li>Weekly review at Head of Ops meeting for assurance;</li><li>Performance team to review all waiting list code returns and identify areas of risk.</li></ul></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<br>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) | Latest month performance (UHL Alliance) | YTD performance (UHL Alliance) | Forecast performance for next reporting period |
|---|---|---|---|---|---|
| **Imaging**<br>The majority of imaging diagnostics are delivered within 6 weeks; the exception to this has been a small volume of complex cardiac MRI (c.100 per month). As a tertiary centre UHL is one of a small number of Trusts that provides this service. 81 MRI breaches were reported in September 2015 and all relate to cardiac MRI. 36 Alliance patients for Imaging breached the standard.<br><br>61 patients awaiting DEXA scans breached six weeks at the end of September as a result of some unplanned scanner downtime in the final week of the month.<br><br>**Endoscopy**<br>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 1226 breaches for September 2015 across flexible sigmoidoscopy, gastroscopy and colonoscopy, an improvement of c.250 from the August position. Capacity and demand review in Endoscopy has identified that the Trust is short of approximately 8-10 lists per week. | **Imaging**<br>A plan is well developed and part implemented to eradicate the Cardiac MRI issue and the impact of this are beginning to be felt.<br><br>The DEXA service has created 35 additional slots weekly through introducing a healthcare assistant to support the lists, and 'fire break' clinics have been planned from October onwards to absorb any potential scanner downtime.<br><br>**Endoscopy**<br>The Trust is working with a number of IS providers to obtain extra capacity, including Medinet, Circle and Nuffield. Talks have recently begun with a fourth provider, Your World Doctors. 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.<br><br>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, beginning in early September. | **<1%** | **9.6%** | **9.6%** | **8%** |

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:

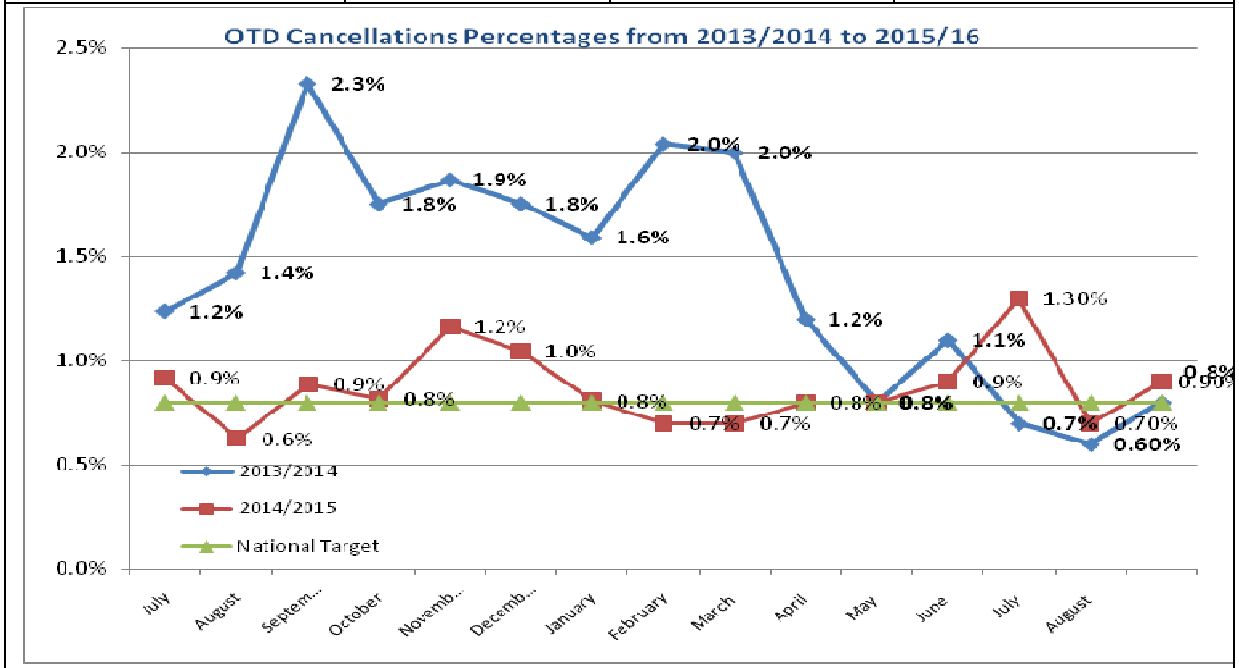
| | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | YTD |
|---|---|---|---|---|---|---|---|
| **UHL** | 0.92% | 0.61% | 6.97% | 12.40 % | 14.92% | 10.82% | **10.82%** |
| **UHL Alliance** | 0.83% | 0.59% | 6.16% | 10.92 % | 13.37% | 9.60% | **9.60%** |

| | |
|---|---|
| **Expected date to meet standard / target** | Revised to November/December 2015 |
| **Lead Director / Lead Officer** | Richard Mitchell, Chief Operating Officer<br>Suzanne Khalid, Clinical Director CSI |

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

**INDICATORS: The cancelled operations target comprises of three components: 1.** The % of cancelled operations for non-clinical reasons On The Day (OTD) of admission **2**.The number of patients cancelled who are offered another date within 28 days of the cancellation

| What is causing underperformance? | What actions have been taken to improve performance? | Target (monthly) | Latest month performance | YTD performance (inc Alliance) | Forecast performance for next reporting period |
|---|---|---|---|---|---|
| The OTD cancellation percentage in UHL was 0.9% (93) and Alliance1.0 %( 11) for this month.<br><br>The main five reasons for cancellations were:<br><br>• Lack of theatre time due to list over runs (21)<br>• Paediatric ward bed unavailability (15)<br>• Sickness of surgeons (15)<br>• Adult critical care bed Unavailability (8)<br>• Lack of Theatre and Anaesthetic staff unavailability (7).<br><br>Six operations (3 Orthopaedic and 3 General Surgery) were cancelled due to infrastructure problems.<br><br>During this month 35 operations were cancelled due to capacity pressures in UHL. This is nearly four times the number of cancellations compared to last month. | List over runs. The process of exception reporting is now better able to identify any over booked operation lists by the theatre managers working with theatre staff.<br><br>Paediatric ward beds in LRI, and Paediatric and Adult critical care. There is on-going work to address the paediatric ward bed unavailability due to staff shortages and reduce elective activity on Monday. The paediatric emergency pressures are a significant risk to OTD cancellations. The availability of beds is monitored daily and interventions will be made where necessary.<br>A review of staffing for ITU is taking place to ensure that there is best use of staff to maintain beds in all hospitals.<br><br>Theatre managers have increased theatre capacity for the increased cancer demand by making additional lists available to reduce 28 breaches. The ITAPS and CHUGGS Senior Managers are working together to improve theatre capacity in the long term. | 1) On day=0.8%<br><br>2) 28 day = 0 | 1) 0.9% (0.9% UHL & 1.0% Alliance)<br><br>2) 1 Gen Sur Pt | 1) 0.9% (0.9% - UHL & 0.9% Alliance)<br><br>2) 11 | 1) 0.8 %<br><br>2) 0 |




| | |
|---|---|
| **Expected date to meet standard / target** | On the day – October 2015<br>28 day – October 2015 |
| **Lead Director / Lead Officer** | Richard Mitchell, Chief Operating Officer<br>Phil Walmsley. Head of Operations, ITAPS |

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

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>Latest month performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="4">The Trust is measured on the % of Appointment Slot Unavailability (ASI) per month.<br><br>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.<br><br>The two most significant factors causing underperformance are:<br>• Shortage of outpatient capacity;<br>• Inadequate training and education of administrative staff in the set up and use of the NHS e-Referral System.<br><br>The specialties with the highest number of ASIs are:<br>• Allergy;<br>• General Surgery;<br>• Gastroenterology;<br>• Rheumatology;<br>• Orthopaedics;<br>• ENT;<br>• Gynaecology.<br><br>Transition to new e-Referral System:<br>• Choose and Book migrated to the new e-Referral System on Monday 15th June;<br>• 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<br>• An action plan has been written outlining steps for recovering performance. This has been shared with commissioners.<br><br>Capacity<br>• Additional capacity in key specialties is part of RTT recovery plans.<br><br>Training and Education<br>• 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;<br>• Meetings are taking place with the specialties experiencing the highest rate of ASIs, focusing on awareness raising and seeking named accountability.<br>• Current focus is on working with specialties with no known capacity problems, but high ASI rate to raise awareness and promote accountability.<br><br>Additional resource to support the e-Referral System<br>• An NHS e-Referral System administrator has been in post since May;<br>• 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<br>Will Monaghan, Director of Performance and Information</td></tr>
</table>

## Ambulance handover > 30 minutes and>60 minutes

| | | Target | Sept 15 | YTD | Forecast |
|---|---|---|---|---|---|
| What is causing underperformance? | What actions have been taken to improve performance? | 0 delays over 15 minutes | >60 min 18%<br>30-60 min – 25% | >60 min 9%<br>30-60 min – 20% | > 60 min 9%<br>30-60 min – 17% |

**What is causing underperformance?**

Difficulties continue in accessing beds from ED leading to congestion in the assessment area and delays ambulance handover.

**What actions have been taken to improve performance?**

An eight-week action plan has been agreed to speed up the time it takes for EMAS crews to pass patients to A&E staff at Leicester Royal Infirmary.

It was drawn up following a meeting between managers from EMAS, UHL, the TDA and CCG's

Proposals include:

- Improving processes at A&E and in the assessment bays.
- Improving the flow of patients through the hospital and making every effort to reduce numbers attending A&E
- Attempting to speed up discharge processes.
- Continued work to tell patients the importance of getting medical help before their condition worsens and ends up being an emergency.

The UNIPART, EMAS and UHL report has been published and is being reviewed by all stakeholders for further actions.

A joint meeting is planned with UHL and EMAS to review the CAD+ data. Validation of data continues and shows large discrepancies between EMAS and UHL findings which lower handover waits in favour of UHL.

A joint LiA meeting at Senior and Junior level is being arranged.

Performance:

| Indicators | 14/15 Outturn | 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 | Sep-15 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ambulance Handover >60 Mins (CAD+ from June 15) | 5% | 1% | 2% | 5% | 6% | 10% | 6% | 11% | 9% | 6% | 7% | 7% | 8% | 9% | 18% | 9% |
| Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15) | 19% | 15% | 17% | 25% | 23% | 25% | 21% | 21% | 22% | 22% | 21% | 17% | 17% | 17% | 25% | 20% |

| | |
|---|---|
| **Expected date to meet standard** | TBC |
| **Revised date to meet standard** | TBC |
| **Lead Director** | Richard Mitchell, Chief Operating Officer |

## Cancer Waiting Times Performance

| What is causing underperformance? | What actions have been taken to improve performance? | Target (mthly / end of year) | Latest month performance August | Performance to date 2015/16 | Forecast performance for September |
|---|---|---|---|---|---|
| **2 Week Wait**<br>2WW performance remains under target. The key reason for underperformance is Endoscopy, which has significant impact on both Lower and Upper GI 2WW performance. However Head and Neck performance was also very poor due to inadequate clinical capacity across the whole service.<br><br>**31 day subsequent (surgery)**<br>31 day subsequent (surgery) was failed predominantly as a result of Urology performance. The main factor is inadequate elective capacity.<br><br>**62 day RTT**<br>62 day performance has improved by 7.7% between July (73.7%) and August (81.4%). Additionally, between the end of July and the end of August the number of 62 day backlog patients had reduced by 12. The Urology tumour site also achieved the 62 day standard for the first time this financial year. | **2 Week Wait**<br>The Trust is working intensively with the Endoscopy Department to address the current underperformance. 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. Additional ENT consultants are being interviewed for w/c 19th October.<br><br>**31 day subsequent (surgery)**<br>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.<br><br>**62 day RTT**<br>Efforts to improve 31 day and 2WW performance will help to improve the 62 day position; however the 62 day standard has not been achieved nationally since April 2014. Improvements in Endoscopy will significantly help performance in Lower/ Upper GI. Additionally 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 and two have been appointed. 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. | **2WW (Target: 93%)** | **86.8%** | **88.9%** | **87%** |
| | | **31 day 1st (Target: 96%)** | **96.5%** | **95.8%** | **96%** |
| | | **31 day sub – Surgery (Target: 94%)** | **81.1%** | **88.2%** | **92%** |
| | | **62 day RTT (Target: 85%)** | **81.4%** | **77.2%** | **75%** |
| | | **62 day screening (Target: 90%)** | **97.1%** | **92%** | **90%** |
| | | **Expected date to meet standard / target** | 2WW: November 2015<br>31 day sub – Surgery: October 2015<br>62 day pathway: October 2015 (at risk) | | |
| | | **Revised date to meet standard** | 62 day pathway revised to March 2016 | | |
| | | **Lead Director / Lead Officer** | Richard Mitchell, Chief Operating Officer<br>Matt Metcalfe, Clinical Lead for Cancer | | |

## Cancer Patients Breaching 104 days

### What is causing underperformance?

13 Cancer patients on the 62 day pathway breached 104 days at the end of September across three tumour sites.

| Tumour site | Number of patients breaching 104 days |
|---|---|
| Urology | 7 |
| Lower GI | 4 |
| Gynaecology | 2 |

The following factors have significantly contributed to delays

| Reason | No. patients |
|---|---|
| Patient non-compliance (consultant has written to GP) | 3 |
| Patient choice/ thinking time | 4 |
| Delays in Gastro | 1 |
| Administrative error | 1 |
| Patient unfit | 1 |
| Repeat diagnostic tests | 1 |
| TCI cancelled twice (once patient unfit; once for hospital reasons) | 1 |
| High risk anaesthetic assessment | 1 |

### What actions have been taken to improve performance?

The number of patients breaching 104 days on a 62 day pathway remains steady, with one patient more than the August level. Notably, there are no Lung patients waiting more than 104 days, a significant improvement.

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 has been appointed to. 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:

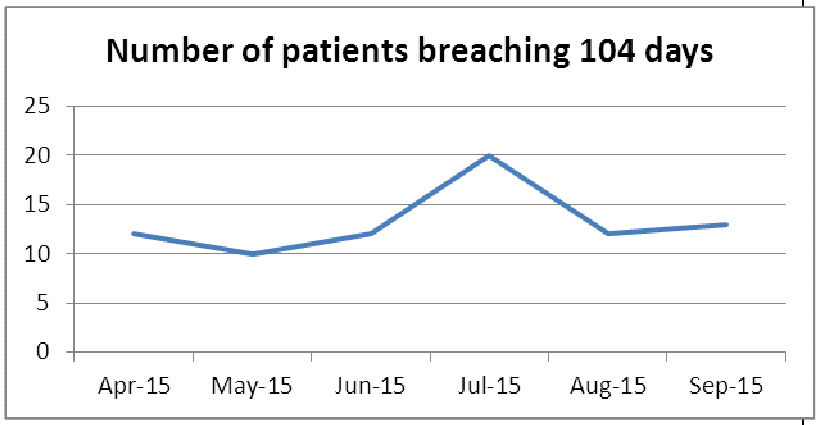
- Introduction of stamps to ensure that Cancer patients' Pathology samples are appropriately prioritised;
- Escalation of any pathway delays of more than 96 hours to the Director of Performance and Information;
- All Cancer patients coming into theatre to be escalated to the General Manager for Theatres;
- 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 | May | Jun | Jul | Aug | Sept |
|---|---|---|---|---|---|---|
| No. patients breaching 104 days | 12 | 10 | 12 | 20 | 12 | 13 |

**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<br>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.

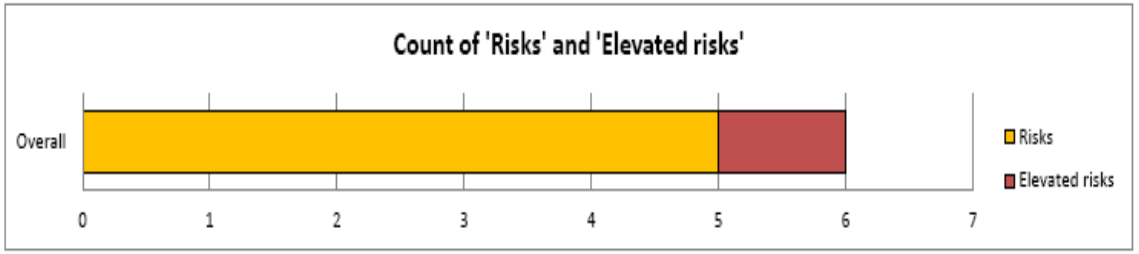
The IMR evaluates against a range of indicators relating to the five key questions used by the CQC as part of their inspections - is the organisation safe, effective, caring, responsive, and well-led?

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<br><br>(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<br><br>(New risk since last report) | There were 4 Never Events escalated during this period, these were:<br>• Wrong site surgery – wrong toe<br>• Wrong size implant/prosthesis – hip implant<br>• Retained foreign object post-procedure - swab tie<br>• Retained foreign object post-procedure -vaginal swab<br><br>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<br><br>(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<br><br>(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<br><br>(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<br><br>(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. |