Quality & Performance Report

Author: John Adler Sponsor: Chief Executive Date: IFPIC + QAC 25th August 2016

Executive Summary from CEO

Paper K

Context

It has been agreed that I will provide a summary of the issues within the Q&P Report that I feel should particularly be brought to the attention of EPB, IFPIC and QAC. This complements the Exception Reports which are triggered automatically when identified thresholds are met.

Questions

1. What are the issues that I wish to draw to the attention of the committee?
2. Is the action being taken/planned sufficient to address the issues identified? If not, what further action should be taken?

Conclusion

Good News: **Mortality** – the latest published SHMI (covering the period January 2015 to December 2015) is **98** – below our Quality Commitment of **99**. **Moderate harms and above** – the first 3 reported months show a 60% reduction compared to the same period in 15/16. **Readmission rates** – are reducing with June's performance at the lowest rate since March 15. **Fractured NOF** – target delivered for the July following a dip in performance in June. **RTT** – the RTT incomplete target remains compliant. **Referral to Treatment 52+ week waits –** current number is 77 a reduction of over 50 in last month. However, there remains a risk that there might be more ENT 52+ week waits due to the high level of cancellations and long waits. **Diagnostics** performance has remained compliant from April 16. **Delayed transfers of care** remain within the tolerance although has delays are twice as high as this time last year. **MRSA** – 0 avoidable cases reported and 1 unavoidable case was reported this month. **C DIFF** – only 1 case reported in July and year to date remains within trajectory. **Pressure Ulcers** – 0 **Grade 4** pressure ulcers reported this year. **Grade 3 and Grade 2** are within the trajectory for month and the year. **Patient Satisfaction (FFT)** target of 97% maintained for Inpatients and Day Cases.

Bad News:

ED 4 hour performance – July performance was 76.9 % with year to date performance at 79.6%. Contributing factors are set out in the Chief Operating Officer's report. **Ambulance Handover 60+ minutes** – performance deteriorated to 9% in July, this is also examined in detail in the COO's report. **Cancelled operations** and **patients rebooked within 28 days** – continued to be non-compliant, due to ITU/HDU and emergency pressures. **Cancer Standards 62 day treatment** current cancer performance remains area of significant concern across UHL and focus on recovery is of the highest priority within the organisation. The **Cancer Two Week Wait** the target was missed attributed to capacity problems in Head & Neck but as

expected has been achieved in July. The aim is to achieve the **31 day standard** in August and **62 days** in September – both of these are vulnerable to ICU/HDU pressures**. Patient Satisfaction (FFT)** in ED dipped to an all-time low of 87%. This is most likely linked to ED performance but needs further investigation. **ED FTT coverage** and ED coverage remains below the threshold of 20%. **ESM nursing vacancies** continue to increase.

Input Sought

I recommend that the Committee:

- Commends the positive achievements noted under Good News
- Note the areas of Bad News and consider if the actions being taken are sufficient.

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes /~~No /Not applicable~~]
Effective, integrated emergency care	[Yes /~~No /Not applicable~~]
Consistently meeting national access standards	[Yes /~~No /Not applicable~~]
Integrated care in partnership with others	[~~Yes /No~~ /Not applicable]
Enhanced delivery in research, innovation & ed'	[Yes /~~No /Not applicable~~]
A caring, professional, engaged workforce	[Yes /~~No /Not applicable~~]
Clinically sustainable services with excellent facilities	[Yes /~~No /Not applicable~~]
Financially sustainable NHS organisation	[~~Yes /No~~ /Not applicable]
Enabled by excellent IM&T	[~~Yes /No~~ /Not applicable]

2. This matter relates to the following governance initiatives:

Organisational Risk Register	[~~Yes /No~~ /Not applicable]
Board Assurance Framework	[Yes /~~No /Not applicable~~]

3. Related Patient and Public Involvement actions taken, or to be taken: Not Applicable

4. Results of any Equality Impact Assessment, relating to this matter: Not Applicable

5. Scheduled date for the next paper on this topic: 29th September 2016.

Quality and Performance Executive Summary

Appendix 1

July 2016

Operational Delivery Unit

Domain - Safe

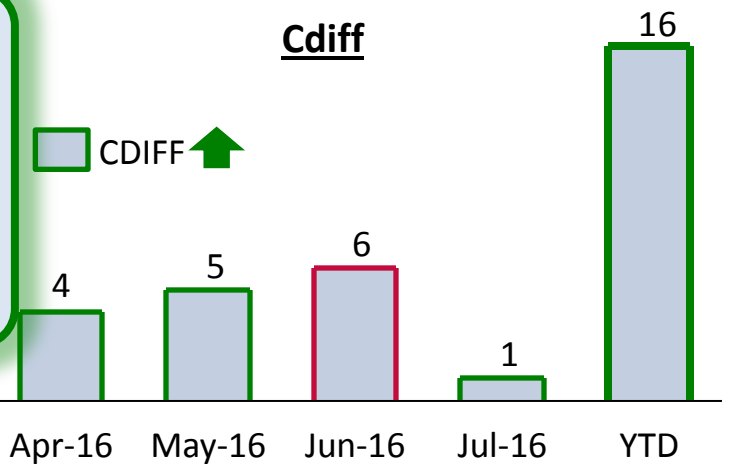
Arrows represent current month performance against previous month, upward arrow represents improvement, downward arrow represents deterioration.

ONE
Never Event YTD ↓

14
Serious Incidents YTD ↓

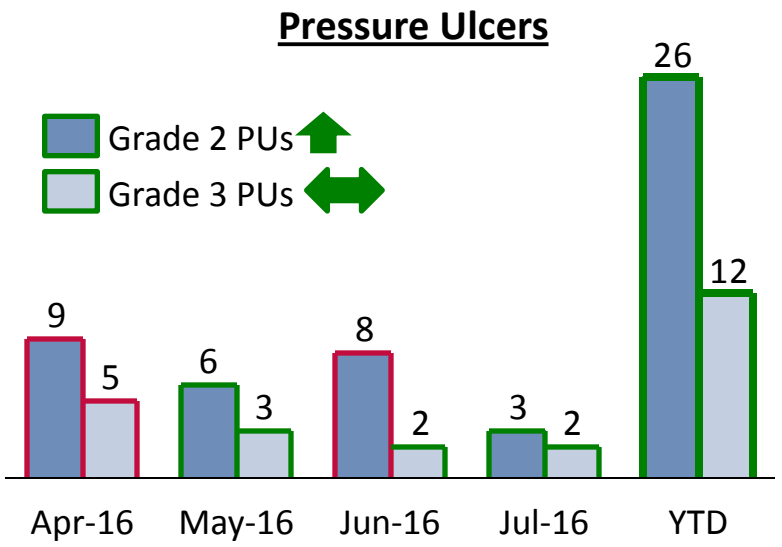
14
Moderate Harm and above YTD ↔

0
Avoidable MRSA YTD ↔



Executive Highlights

- 1 Never event due to incorrect administration of a strong potassium containing solution.
- Serious incidents remain well within the year to date trajectory and on a downward trend.
- This is supported by a 60% reduction in Moderate Harm and above Q1 this year Vs Q1 last year
- Infection control performance also remains strong with 0 Avoidable MRSA's and 1 Unavoidable. C Diff also showed an improving trend with only 1 in the month of July and this remains within trajectory.
- There were no Grade 4 Pressure ulcers and we are within trajectory for Grade 2 and 3 within trajectory



Domain - Caring

Arrows represent current month performance against previous month, upward arrow represents improvement, downward arrow represents deterioration.

Friends and Family Test YTD % Positive

Inpatients FFT 96% ↓

Day Case FFT 98% ↓

A&E FFT 94% ↓

Maternity FFT 94% ↑

Outpatients FFT 94% ↓

Staff FFT Quarter 1 2016

↑72.3% of staff would recommend UHL as a place to receive treatment

Executive Highlights

- Friends and family test (FFT) for Inpatient and Daycase care combined are compliant at 97%.
- A&E FFT for July was at 87% this is 10% lower than trajectory and a declining trend.
- There has been an encouraging 1.6% increase in FFT (STAFF) (Q4 to Q1) on staff who would recommend UHL as a place to receive treatment
- As previously reported we changed the way we are counting Single sex accommodation breaches in ITU in June 2016. This has resulted in an increase in breaches as anticipated.

Single sex accommodation breaches

5

YTD ↑

Domain – Well Led

Arrows represent current month performance against previous month, upward arrow represents improvement, downward arrow represents deterioration.

Friends and Family FFT YTD % Coverage

Inpatients FFT 37.0% ↓

Day Case FFT 25.9% ↑

A&E FFT 11.0% ↓

Maternity FFT 35.3% ↓

Outpatients FFT 1.7% ↓

Staff FFT Quarter 1 2016

↑ 60.3% of staff would recommend UHL as a place to work

Executive Highlights

- Inpatients and Daycase coverage above Trust target
- A&E coverage remains a challenge to get to Trust target of 20%
- Outpatient FFT will improve in July now that patients are invited for their views via text message
- There has also been an encouraging 1.4% increase on staff FFT (Q4 to Q1) on staff who would recommend UHL as a place to work
- Annual appraisals continues to improve and is currently 2.1% from the target
- Statutory & Mandatory training 2% off target.
- Please see the HR update for more information.

% Staff with Annual Appraisals

92.9% YTD ↑

Statutory & Mandatory Training

93% YTD ↓

Domain – Effective

Arrows represent current month performance against previous month, upward arrow represents improvement, downward arrow represents deterioration.

SHMI Jan15-Dec15

98
Jan15-Dec15 ↓

Stroke TIA clinic within 24hrs

56.6%
YTD ↑

80% of patients spending 90% stay on stoke unit

82.8%
YTD ↓

Emergency Crude Mortality Rate

2.2%
YTD ↔

30 Days Emergency Readmissions

8.6%
YTD 2016 ↑

NoFs operated on 0-35hrs

76.7%
YTD ↑

Executive Highlights

- UHL's SHMI remains lower than the England average at 98. This is encouraging and the trend is currently downward.
- Whilst performance is better than previous months Stroke TIA clinic has seen almost a 12% rise in referrals.
- Whilst not yet compliant it is encouraging that the 30 day readmission rate for June was at 8.5%, the lowest rate since March 2015.
- The treatment of hip fracture patients continues to improve with the requirement to operate on them in 0-35 hours, achieved above threshold of 72% in three of the latest four months this financial year.

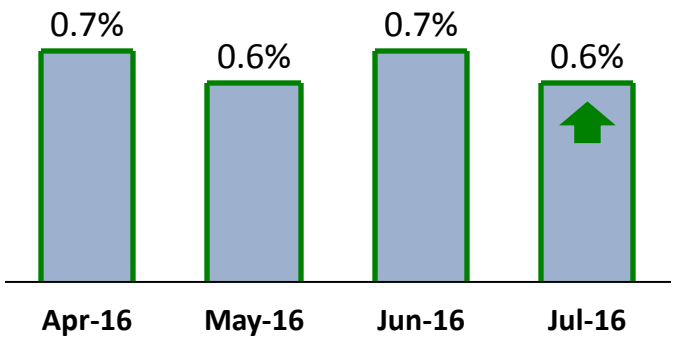
Domain – Responsive

Arrows represent current month performance against previous month, upward arrow represents improvement, downward arrow represents deterioration.

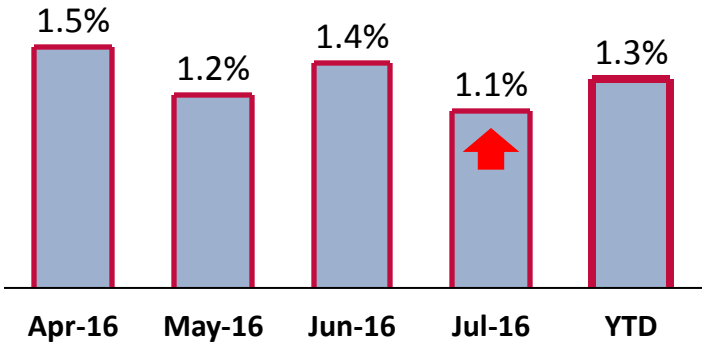
RTT - Incomplete 92% in 18 Weeks

92.4% ⟷

6 week Diagnostic Wait times



Cancelled Operations



RTT 52 week wait incompletes

77 ↑

ED 4Hr Wait

A&E 79.6% YTD ↓

Ambulance Handovers

7% > 60mins
12% 30-60mins
YTD ↓

Executive Highlights

- We have seen our biggest single month drop (53) in 52 week waiters to 77 patients and are now ahead of trajectory. This is predicted to be 65 by the end of August
- The diagnostic standard remains compliant for the longest run in the organisations history. The organisation has not managed to deliver in August in any previous years.
- RTT remains compliant despite the pressures in theatre capacity
- For ED 4hour wait and Ambulance Handovers please refer to Chief Operating Officers report

Domain – Responsive Cancer

Arrows represent current month performance against previous month, upward arrow represents improvement, downward arrow represents deterioration.

Cancer 2 week wait

90.4% YTD ↑ | 90.5% June

31 day wait

95.5% YTD ↑ | 95.6% June

62 day wait

75.8% YTD ↑ | 77.3% June

31 day backlog

19 YTD ↓

62 day backlog

71 YTD ↔

62 day adjusted backlog

61 YTD ↑

Executive Highlights

- Cancer 2 week wait was non compliant due to capacity problems in ENT. This recovered in July and recovery continue into August.
- 31 day wait non compliant due to emergency pressures and HDU capacity, monthly compliance expected from September 2016.
- 62 day lower GI, lung and Urology remain the most pressure tumour sites, monthly compliance expected from September 2016. The standard has been delivered in July. Adjusted performance where we remove those patients referred late from other hospitals is 80.5%.
- The adjusted backlog shows good progress towards delivery of the standard in September 2016.

Sustainability and Transformation Fund – Trajectories and Performance

Cancer 62 Day

5% of STF allocation

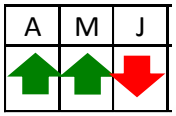
Standard: 85% of patients are treated within 62 days from urgent referrals

Timing: Best endeavours to deliver 85% from June 2016, Trust compliance expected from September 2016

June Performance (one month in arrears)
77.3% against a trajectory of 85.1%

Quarter 1 STF compliant: Trajectory agreed

July Performance: Expected to be achieved



Diagnostics

0% of STF allocation

Standard: At the end of the month less than 1% of all patients to be waiting more than 6 weeks for diagnostics across 15 key tests

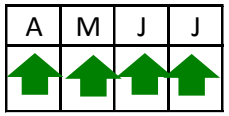
Timing: Required to deliver throughout the year

July Performance
Achieved the diagnostic standard with 0.6% of our patients waiting more than 6 weeks

Quarter 1 STF compliant: Trajectory agreed

July STF: Compliant

August Performance: Expected to be achieved



RTT 18 Week

12.5% of STF allocation

Standard: 92% of patients on an incomplete RTT pathway should be waiting less than 18 weeks

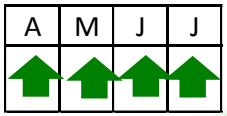
Timing: Required to deliver throughout the year

July Performance
Achieved the RTT standard with 92.4% of our patients waiting less than 18 weeks

Quarter 1 STF compliant: Trajectory agreed

July STF: Compliant

August Performance: Expected to be achieved



ED 4 hour

12.5% of STF allocation

Standard: 95% of patients attending the emergency departments must be seen, treated, admitted or discharged in under 4 hours

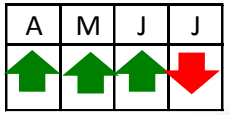
Timing: Required to achieve 91.2% during March 2017

July Performance
76.9% against a target of 79%

Quarter 1 STF compliant: Trajectory agreed

July STF: Non Compliant

August Performance: Expected to be achieved



Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

July 2016

Appendix 2

One team shared values

CONTENTS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

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

DATE: **25th AUGUST 2016**

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

SUBJECT: **JULY 2016 QUALITY & PERFORMANCE SUMMARY REPORT**

1.0 Introduction

The following report provides an overview of performance for NHS Improvement (NHSI) and UHL key quality commitment/performance metrics. Escalation reports are included where applicable.

The Trust's 16/17 Quality Commitment indicators are identified with 'QC' in the 'Target set by' column and appear at the top of the dashboard. Additional analysis is required for some of the Quality Commitment indicators which may change the methodology in reporting in future reports.

2.0 Performance Summary

Domain	Page Number	Number of Indicators	Number of Red Indicators this month
Safe	3	16	2
Caring	4	11	2
Well Led	5	20	2
Effective	6	11	1
Responsive	7	15	8
Responsive Cancer	8	9	8
Research – UHL	11	6	0
Total		88	23

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

	KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	16/17 Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	YTD
Safe	S1	Reduction for moderate harm and above PSIs with finally approved status - One month lag in data for this indicator to ensure incidents finally approved	AF	MD	10% REDUCTION FROM FY 15/16 (<20 per month)	QC	Red if >20 in mth, ER if >20 for 2 consecutive mths	TBC	262	18	19	17	18	18	16	18	17	18	18	16	17	6	8	8		22
	S2	Serious Incidents - actual number escalated each month	AF	MD	<=49 by end of FY 16/17 (revised)	UHL	Red / ER if >8 in mth or >5 for 3 consecutive mths	41	50	2	9	1	5	4	6	3	3	3	4	6	4	5	5	1	3	14
	S3	Proportion of reported safety incidents per 1000 attendances (IP, OP and ED)	AF	MD	> FY 15/16	UHL	TBC		17.5	18.0	19.2	17.1	18.2	18.4	15.5	18.3	16.6	17.7	18.8	16.2	17.2	16.9	16.6	16.3	19.3	17.3
	S4	Overdue CAS alerts	AF	MD	0	NHSI	Red if >0 in mth ER = in mth >0	10	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
	S5	RIDDOR - Serious Staff Injuries	AF	MD	FYE <=40	UHL	Red / ER if non compliance with cumulative target	24	32	0	6	0	0	2	3	7	2	5	3	2	2	5	3	3	1	12
	S6	Never Events	AF	MD	0	NHSI	Red if >0 in mth ER = in mth >0	3	2	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	1	1
	S7	Clostridium Difficile	JS	DJ	61	NHSI	Red if >mthly threshold / ER if Red or Non compliance with cumulative target	73	60	3	1	4	4	6	6	6	4	6	7	7	6	4	5	6	1	16
	S8	MRSA Bacteraemias (All)	JS	DJ	0	NHSI	Red if >0 ER if >0	6	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	1
	S9	MRSA Bacteraemias (Avoidable)	JS	DJ	0	UHL	Red if >0 ER if >0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	S10	% of UHL Patients with No Newly Acquired Harms	JS	RB	Within expected (revised)	UHL	Red if <95% ER if in mth <95%		97.7%	97.9%	97.4%	98.1%	98.1%	97.0%	97.7%	97.4%	97.4%	98.2%	97.7%	97.9%	98.0%	96.9%	97.2%	98.4%	97.9%	97.9%
	S11	% of all adults who have had VTE risk assessment on adm to hosp	AF	SH	>=95%	NHSI	Red if <95% ER if in mth <95%	95.8%	95.9%	96.0%	96.0%	96.5%	96.2%	96.5%	96.1%	95.7%	96.0%	96.1%	95.5%	95.4%	95.1%	95.9%	96.1%	96.5%	96.1%	96.2%
	S12	All falls reported per 1000 bed stays for patients >65years	JS	HL	<=5.5 (revised)	UHL	Red if >=6.6 ER if 2 consecutive reds	6.9	5.4	5.9	6.1	5.1	5.8	5.9	5.0	5.2	4.8	5.7	5.4	4.9	5.2	6.3	5.4	5.3	4.9	5.5
	S13	Avoidable Pressure Ulcers - Grade 4	JS	MC	0	QS	Red / ER if Non compliance with monthly target	2	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
	S14	Avoidable Pressure Ulcers - Grade 3	JS	MC	<=4 a month (revised) with FY End <33	QS	Red / ER if Non compliance with monthly target	69	33	3	0	4	1	4	1	1	1	5	6	2	5	5	3	2	2	12
	S15	Avoidable Pressure Ulcers - Grade 2	JS	MC	<=7 a month (revised) with FY End <89	QS	Red / ER if Non compliance with monthly target	91	89	10	8	8	8	10	11	5	4	5	5	8	7	9	6	8	3	26
	S16	Maternal Deaths	AF	IS	0	UHL	Red or ER if >0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Caring

KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	16/17 Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	YTD
C1	Improvements in Patient Involvement Scores (Reported quarterly from Qtr2)	JS	HL	6% increase from Qtr 1 baseline (new)	QC	Red/ER if below Quarterly Threshold	NEW INDICATOR															
C2	Formal complaints rate per 1000 IP,OP and ED attendances	AF	MD	No Target	UHL	Monthly reporting	NEW INDICATOR		1.4	1.5	1.3	1.3	1.2	0.9	1.0	1.4	1.2	1.0	1.0	0.9	0.9	0.9
C3	Percentage of upheld PHSO cases	AF	MD	No Target	UHL	Quarterly reporting	NEW INDICATOR											10% (Quarter 1)				10%
C4	Published Inpatients and Daycase Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <95% ER if 2 mths Red		97%	96%	97%	97%	97%	96%	97%	97%	96%	97%	97%	97%	97%	97%	97%
C5	Inpatients only Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <95% ER if 2 mths Red	96%	97%	96%	97%	97%	97%	96%	97%	97%	96%	97%	97%	96%	97%	96%	96%
C6	Daycase only Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <95% ER if 2 mths Red		98%	98%	98%	97%	98%	98%	98%	98%	98%	98%	98%	98%	99%	98%	98%
C7	A&E Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <94% ER if 2 mths Red	96%	96%	96%	97%	95%	95%	97%	95%	97%	97%	95%	96%	95%	95%	87%	94%
C8	Outpatients Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <90% ER if 2 mths Red		94%	91%	93%	93%	93%	92%	94%	95%	95%	93%	95%	95%	95%	94%	95%
C9	Maternity Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <94% ER if 2 mths Red	96%	95%	95%	96%	95%	95%	95%	94%	95%	95%	95%	95%	94%	94%	95%	94%
C10	Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment	LT	LT	TBC	NHSI	TBC	69.2%	70.0%	71.9%			Q3 staff FFT not completed as National Survey carried out			70.7%			72.3%				72.3%
C11	Single Sex Accommodation Breaches (patients affected)	JS	HL	0	NHSI	Red / ER if >0	13	1	0	0	0	0	0	0	0	1	0	0	0	4	1	5

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

Well Led

KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	16/17 Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	YTD
W1	Outpatient Letters sent within 14 days of attendance (Reported Quarterly)	RM	WM	11% Improvement (new)	QC	Red/ER = Below 9% Improvement in Q4		40.0%														
W2	Published Inpatients and Daycase Friends and Family Test - Coverage (Adults and Children)	JS	HL	Not Appicable		Not Appicable		27.4%	23.7%	25.9%	26.5%	30.9%	32.4%	23.5%	31.9%	32.8%	32.9%	31.7%	32.0%	31.6%	31.9%	31.8%
W3	Inpatients only Friends and Family Test - Coverage (Adults and Children)	JS	HL	30%	QS	Red if <26% ER if 2mths Red		31.0%	27.7%	28.9%	28.9%	37.4%	38.2%	23.2%	29.3%	37.2%	36.1%	35.6%	36.7%	38.1%	36.9%	37.0%
W4	Daycase only Friends and Family Test - Coverage (Adults and Children)	JS	HL	20%	QS	Red if <8% ER if 2 mths Red		22.5%	20.5%	23.8%	24.1%	27.2%	27.7%	18.7%	30.1%	26.2%	29.2%	27.3%	26.5%	24.5%	26.2%	25.9%
W5	A&E Friends and Family Test - Coverage	JS	HL	20%	NHSI	Red if <10% ER if 2 mths Red		10.5%	14.1%	13.3%	13.1%	16.1%	12.4%	5.4%	7.3%	5.1%	7.0%	13.0%	10.2%	12.0%	8.7%	11.0%
W6	Outpatients Friends and Family Test - Coverage	JS	HL	>=5%	UHL	Red/ER if <1.4%		1.4%	1.2%	1.4%	1.4%	1.5%	1.5%	1.4%	1.5%	1.6%	1.6%	1.5%	1.7%	1.8%	1.7%	1.7%
W7	Maternity Friends and Family Test - Coverage	JS	HL	30%	UHL	Red if <26% ER if 2 mths Red	28.0%	31.6%	25.6%	30.5%	27.9%	27.2%	38.8%	30.0%	33.3%	34.3%	31.7%	27.9%	38.3%	39.3%	38.2%	35.3%
W8	Friends & Family staff survey: % of staff who would recommend the trust as place to work	LT	BK	Not within Lowest Decile	NHSI	TBC	54.2%	55.4%	55.7%			Q3 staff FFT not completed as National Survey carried out			58.9%			60.3%				60.3%
W9	Nursing Vacancies	JS	MM	TBC	UHL	Separate report submitted to QAC		8.4%	8.7%	8.9%	8.5%	7.1%	7.6%	7.6%	7.7%	6.8%	8.4%	8.2%	8.5%	8.9%	9.2%	8.9%
W10	Nursing Vacancies in ESM CMG	JS	MM	TBC	UHL	Separate report submitted to QAC		17.2%	13.3%	13.5%	13.5%	12.9%	14.6%	14.9%	16.4%	17.2%	18.5%	18.1%	18.9%	19.8%	20.1%	20.1%
W11	Turnover Rate	LT	LG	TBC	NHSI	Red = 11% or above ER = Red for 3 Consecutive Mths	11.5%	9.9%	10.6%	10.4%	10.4%	10.2%	9.9%	10.0%	10.1%	10.0%	9.9%	9.7%	9.6%	9.4%	9.4%	9.5%
W12	Sickness absence	LT	BK	3%	UHL	Red if >4% ER if 3 consecutive mths >4.0%	3.8%	3.6%	3.3%	3.2%	3.3%	3.5%	3.7%	3.9%	4.0%	4.3%	4.2%	4.0%	3.5%	3.7%		3.7%
W13	Temporary costs and overtime as a % of total paybill	LT	LG	TBC	NHSI	TBC	9.4%	10.7%	10.8%	11.1%	9.9%	10.5%	10.5%	10.1%	11.0%	9.7%	13.9%	10.5%	9.5%	10.9%	10.2%	10.4%
W14	% of Staff with Annual Appraisal	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	91.4%	90.7%	89.1%	88.8%	90.0%	90.4%	91.1%	92.7%	91.5%	91.6%	90.7%	91.5%	92.2%	92.4%	92.9%	92.9%
W15	Statutory and Mandatory Training	LT	BK	95%	UHL	TBC	95%	93%	91%	91%	91%	92%	92%	93%	93%	92%	93%	92%	93%	94%	93%	93%
W16	% Corporate Induction attendance	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	100%	97%	100%	97%	98%	98%	97%	92%	96%	98%	98%	94%	96%	97%	100%	97%
W17	DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	TBC	NHSI	TBC	91.2%	90.5%	90.3%	90.2%	90.5%	91.4%	87.2%	91.0%	90.5%	89.5%	90.2%	91.6%	91.3%	91.4%	89.7%	91.0%
W18	DAY Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	TBC	NHSI	TBC	94.0%	92.0%	91.3%	92.4%	93.1%	94.2%	93.2%	93.9%	92.1%	86.0%	88.7%	92.5%	93.7%	93.8%	92.0%	93.0%
W19	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	TBC	NHSI	TBC	94.9%	95.4%	94.3%	94.3%	94.9%	96.1%	91.4%	94.8%	96.6%	95.0%	96.3%	97.6%	97.2%	96.6%	94.5%	96.5%
W20	NIGHT Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	TBC	NHSI	TBC	99.8%	98.9%	101.2%	98.0%	100.0%	99.9%	98.4%	98.0%	100.2%	91.6%	94.7%	98.3%	99.1%	96.7%	97.1%	97.8%

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Effective

KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	16/17 Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	YTD
2	Emergency readmissions within 30 days following an elective or emergency spell	AF	MM	Monthly <8.5% (revised)	QC	Red if >8.6% ER if >8.6%	8.5%	8.9%	8.8%	8.9%	8.7%	9.0%	8.3%	9.2%	8.8%	8.7%	8.8%	8.6%	8.6%	8.5%		8.6%
E2	Mortality - Published SHMI	AF	RB	<=99 (revised)	QC	Red if >100 ER if >100	103	96	99 (Jan14-Dec 14)			98 (Apr14-Mar15)			95 (Jul14-Jun15)		96 (Oct14-Sep15)		98 (Jan15-Dec15)			98 (Jan15-Dec15)
E3	Mortality - Rolling 12 mths SHMI (as reported in HED) Rebased	AF	RB	<=99 (revised)	QC	Red if >100 ER if >100	98	97	95	96	95	97	98	99	98	97	98	98	Awaiting HED Update			98
E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	AF	RB	<=99 (revised)	UHL	Red if >100 ER if >100	94	96	93	93	93	94	95	95	95	95	97	99	Awaiting HED Update			99
E5	Crude Mortality Rate Emergency Spells	AF	RB	No Threshold	UHL	Monthly Reporting	2.4%	2.3%	1.8%	2.0%	2.2%	2.4%	2.1%	2.5%	2.4%	2.4%	2.7%	2.4%	2.2%	2.2%	2.2%	2.2%
E6	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	AF	AC	72% or above	QS	Red if <72% ER if 2 consecutive mths <72%	61.4%	63.8%	60.3%	78.1%	72.0%	60.0%	70.9%	59.7%	66.7%	65.2%	65.1%	78.0%	78.1%	64.6%	86.0%	76.7%
E7	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions (excluding medically unfit patients)	AF	AC	72% or above	UHL	Red if <72% ER if 2 consecutive mths <72%	NEW INDICATOR										73.2%	86.8%	87.7%	73.2%	90.0%	84.4%
E8	Stroke - 90% of Stay on a Stroke Unit	RM	IL	80% or above	QS	Red if <80% ER if 2 consecutive mths <80%	81.3%	85.6%	85.7%	90.9%	86.9%	81.1%	84.4%	87.0%	90.6%	87.0%	86.5%	72.7%	93.5%	83.8%		82.8%
E9	Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA)	RM	IL	60% or above	QS	Red if <60% ER if 2 consecutive mths <60%	71.2%	75.6%	78.9%	80.2%	88.1%	73.3%	67.1%	68.4%	71.3%	80.0%	67.3%	53.5%	68.2%	50.4%	54.8%	56.6%
E10	Published Clinical Outcomes - data submission and outcome results	AF	RB	0 delayed /outside expected (revised)	UHL	ER if Red Quarterly ER if >0	Revised Indicator															
E11	Compliance with NICE Guidance (15/16 and 16/17)	AF	RB	0 Non compliance and no actions or actions delayed (revised)	UHL	Red if in mth >0 ER if Red	Revised Indicator															

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	KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	YTD
Responsive	R1	ED 4 Hour Waits UHL + UCC (Calendar Month)	RM	IL	95% or above	NHSI	Red if <92% ER via ED TB report	89.1%	86.9%	92.2%	90.6%	90.3%	88.9%	81.7%	85.1%	81.2%	80.2%	77.5%	81.2%	79.9%	80.6%	76.9%	79.6%
	R2	12 hour trolley waits in A&E	RM	IL	0	NHSI	Red if >0 ER via ED TB report	4	2	0	0	0	0	1	1	0	0	0	0	0	0	0	0
	R3	RTT - Incomplete 92% in 18 Weeks	RM	WM	92% or above	NHSI	Red /ER if <92%	96.7%	92.6%	95.2%	94.3%	94.8%	93.6%	93.8%	93.0%	92.9%	93.2%	92.6%	92.7%	92.7%	92.4%	92.4%	92.4%
	R4	RTT 52 Weeks+ Wait (Incompletes)	RM	WM	0	NHSI	Red /ER if >0	0	232	256	258	260	265	263	267	269	261	232	169	134	130	77	77
	R5	6 Week - Diagnostic Test Waiting Times	RM	WM	1% or below	NHSI	Red /ER if >1%	0.9%	1.1%	10.9%	13.4%	9.6%	7.7%	6.5%	7.0%	4.1%	1.8%	1.1%	0.7%	0.6%	0.7%	0.6%	0.6%
	R6	Urgent Operations Cancelled Twice	RM	GH	0	NHSI	Red if >0 ER if >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	GH	0	NHSI	Red if >2 ER if >0	33	48	1	5	1	0	3	6	6	9	14	24	16	18	20	78
	R8	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	RM	GH	0	NHSI	Red if >2 ER if >0	11	1	0	0	0	0	0	0	0	0	0	5	0	0	0	5
	R9	% Operations cancelled for non-clinical reasons on or after the day of admission UHL	RM	GH	0.8% or below	Contract	Red if >0.9% ER if >0.8%	0.9%	1.0%	1.3%	0.7%	0.9%	0.8%	1.3%	1.1%	1.3%	1.2%	1.5%	1.5%	1.2%	1.4%	1.1%	1.3%
	R10	% Operations cancelled for non-clinical reasons on or after the day of admission ALLIANCE	RM	GH	0.8% or below	Contract	Red if >0.9% ER if >0.8%	0.9%	0.9%	0.8%	0.0%	1.0%	1.1%	0.0%	1.1%	2.2%	0.2%	1.0%	0.8%	0.3%	0.8%	1.4%	0.8%
	R11	% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	GH	0.8% or below	Contract	Red if >0.9% ER if >0.8%	0.9%	1.0%	1.3%	0.7%	0.9%	0.8%	1.2%	1.1%	1.4%	1.1%	1.4%	1.5%	1.2%	1.4%	1.1%	1.3%
	R12	No of Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	GH	Not Applicable		Not Applicable	1071	1299	138	67	104	91	131	115	146	119	156	156	123	154	114	547
	R13	Delayed transfers of care	RM	SL	3.5% or below	NHSI	Red if >3.5% ER if Red for 3 consecutive mths	3.9%	1.4%	0.9%	1.2%	1.3%	1.1%	1.5%	1.6%	1.8%	1.8%	2.0%	1.9%	1.8%	2.2%	2.9%	2.2%
	R14	Ambulance Handover >60 Mins (CAD+ from June 15)	RM	SL	0	Contract	Red if >0 ER if Red for 3 consecutive mths	5%	5%	8%	9%	18%	22%	27%	16%	12%	10%	11%	6%	6%	6%	9%	7%
	R15	Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)	RM	SL	0	Contract	Red if >0 ER if Red for 3 consecutive mths	19%	19%	17%	17%	25%	26%	26%	23%	13%	13%	13%	11%	12%	10%	15%	12%

Responsive Cancer

KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jul-16	YTD
** Cancer statistics are reported a month in arrears.																							
RC1	Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	RM	DB	93% or above	NHSI	Red if <93% ER if Red for 2 consecutive mths	92.2%	90.5%	87.4%	86.8%	87.7%	89.9%	92.4%	93.0%	91.4%	93.9%	93.0%	90.5%	91.1%	89.5%	90.5%	**	90.4%
RC2	Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	RM	DB	93% or above	NHSI	Red if <93% ER if Red for 2 consecutive mths	94.1%	95.1%	93.3%	98.7%	94.5%	94.6%	89.4%	93.5%	96.2%	99.3%	95.7%	95.1%	96.1%	88.7%	94.9%	**	93.5%
RC3	31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	RM	DB	96% or above	NHSI	Red if <96% ER if Red for 2 consecutive mths	94.6%	94.8%	97.2%	96.5%	94.7%	95.2%	95.6%	94.3%	91.5%	92.6%	94.1%	94.8%	95.4%	95.5%	95.6%	**	95.5%
RC4	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	RM	DB	98% or above	NHSI	Red if <98% ER if Red for 2 consecutive mths	99.4%	99.7%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.7%	100.0%	100.0%	97.9%	**	99.1%
RC5	31-Day Wait For Second Or Subsequent Treatment: Surgery	RM	DB	94% or above	NHSI	Red if <94% ER if Red for 2 consecutive mths	89.0%	85.3%	92.2%	81.1%	89.7%	90.7%	76.8%	91.4%	77.5%	77.9%	80.3%	85.3%	90.3%	91.6%	84.7%	**	89.0%
RC6	31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	RM	DB	94% or above	NHSI	Red if <94% ER if Red for 2 consecutive mths	96.1%	94.9%	95.9%	99.0%	92.2%	94.1%	95.1%	94.3%	96.4%	92.9%	96.4%	94.9%	98.8%	93.6%	87.3%	**	92.5%
RC7	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	RM	DB	85% or above	NHSI	Red if <85% ER if Red in mth or YTD	81.4%	77.5%	73.7%	81.7%	77.2%	77.0%	82.5%	80.9%	75.1%	73.4%	77.6%	77.5%	75.8%	74.5%	77.3%	**	75.8%
RC8	62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	RM	DB	90% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	84.5%	89.1%	95.2%	97.1%	81.4%	96.0%	96.2%	95.3%	77.3%	72.5%	81.3%	89.1%	94.6%	96.0%	85.0%	**	91.2%
RC9	Cancer waiting 104 days	RM	DB	0	NHSI	TBC			20	12	12	17	13	23	23	17	21	21	12	7	15	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)	14/15 Outturn	15/16 Outturn	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jun-16	YTD
RC10	Brain/Central Nervous System	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	--	100.0%	--	--	--	--	--	--	--	100.0%	--	100.0%	--	--	--	**	--
RC11	Breast	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	92.6%	95.6%	91.4%	96.3%	97.5%	92.0%	100.0%	93.1%	94.6%	100.0%	94.1%	95.6%	93.3%	95.3%	97.1%	**	95.3%
RC12	Gynaecological	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	77.5%	73.4%	100.0%	72.2%	80.0%	84.6%	80.0%	85.7%	50.0%	70.0%	78.6%	73.4%	72.7%	78.6%	75.0%	**	75.7%
RC13	Haematological	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	66.5%	63.0%	37.5%	82.6%	66.7%	70.0%	50.0%	58.3%	100.0%	60.0%	60.0%	63.0%	14.3%	61.5%	72.7%	**	54.8%
RC14	Head and Neck	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	69.9%	50.7%	36.4%	60.9%	50.0%	75.0%	42.9%	37.5%	62.5%	37.5%	35.7%	50.7%	35.7%	45.5%	100.0%	**	44.4%
RC15	Lower Gastrointestinal Cancer	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	63.7%	59.8%	63.6%	60.0%	38.9%	70.6%	68.2%	77.8%	52.4%	31.3%	57.1%	59.8%	62.5%	45.0%	64.5%	**	56.3%
RC16	Lung	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	69.9%	71.0%	81.8%	70.4%	73.5%	65.2%	88.6%	81.6%	73.7%	53.8%	71.1%	71.0%	66.7%	46.7%	64.2%	**	60.9%
RC17	Other	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	95.0%	71.4%	100%	100%	50.0%	60.0%	80.0%	--	66.7%	--	--	71.4%	0.0%	50.0%	100.0%	**	50.0%
RC18	Sarcoma	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	46.2%	81.3%	--	--	80.0%	50.0%	--	--	--	100.0%	100.0%	81.3%	0.0%	50.0%	16.7%	**	27.3%
RC19	Skin	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	96.7%	94.1%	93.8%	94.1%	96.7%	91.1%	95.6%	94.9%	100.0%	92.5%	94.6%	94.1%	95.2%	100.0%	96.8%	**	97.3%
RC20	Upper Gastrointestinal Cancer	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	73.9%	63.9%	51.4%	81.8%	45.7%	48.6%	84.6%	90.0%	42.9%	57.1%	76.5%	63.9%	74.3%	70.0%	46.9%	**	64.5%
RC21	Urological (excluding testicular)	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	82.6%	74.4%	61.5%	86.1%	80.4%	80.0%	76.7%	75.0%	67.4%	78.7%	83.6%	74.4%	83.7%	73.1%	77.8%	**	78.3%
RC22	Rare Cancers	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	84.6%	100.0%	100%	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%
RC23	Grand Total	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	81.4%	77.5%	73.7%	81.7%	77.2%	77.0%	82.5%	80.9%	75.1%	73.4%	77.6%	77.5%	75.8%	74.5%	77.3%	**	75.8%

The Sustainability and Transformation Fund Trajectories and Performance

ED trajectory

	Submitted on a "best endeavours" basis											
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Performance	78%	78%	79%	79%	80%	85%	85%	85%	85%	89%	89%	91.2%
Actual	**81.2%**	**79.9%**	**80.6%**	**76.9%**								

Cancer

			Submitted on a "best endeavours" basis									
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Performance	70.2%	74.0%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%
Actual	**75.9%**	**74.9%**	**77.3%**									

Diagnostics

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Performance	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%
Actual	**0.7%**	**0.6%**	**0.7%**	**0.6%**								

RTT

	Submitted on a "best endeavours" basis April - June											
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Performance	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Actual	**92.7%**	**92.7%**	**92.4%**	**92.4%**								

Compliance Forecast for Key Responsive Indicators

Standard	July	August (predicted)	Month by which to be compliant	RAG rating of required month delivery	Commentary
Emergency Care					
4+ hr Wait (95%) - Calendar month	76.9%		Not Confirmed		July final position
Ambulance Handover (CAD+)					
% Ambulance Handover >60 Mins (CAD+)	9%		Not Confirmed		EMAS monthly report
% Ambulance Handover >30 Mins and <60 mins (CAD+)	15%		Not Confirmed		
RTT (inc Alliance)					
Incomplete (92%)	92.4%	92.4%			
Diagnostic					
DM01 - diagnostics 6+ week waits (<1%)	0.6%	0.9%			Includes Alliance.
# Neck of femurs					
% operated on within 36hrs - all admissions (72%)	86%	72%			
% operated on within 36hrs - pts fit for surgery (72%)	90%	78%			
Cancelled Ops (inc Alliance)					
Cancelled Ops (0.8%)	1.1%	1.0%	Sep-16		
Not Rebooked within 28 days (0 patients)	20	10	Sep-16		
Cancer (predicted)					
Two Week Wait (93%)	94%	93%			
31 Day First Treatment (96%)	89%	94%	Sep-16		Revised compliance date.
31 Day Subsequent Surgery Treatment (94%)	73%	92%	Sep-16		Revised compliance date.
62 Days (85%)	85%	80%	Sep-16		Current unadjusted backlog 75 and adjusted backlog 64.
Cancer waiting 104 days (0 patients)	12	10			

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

	KPI Ref	Indicators	Board Director	Lead Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Research UHL	RU1	Median Days from submission to Trust approval (Portfolio)	AF	NB	TBC	TBC	TBC	2.8	1.0	1.0			2.0			1.0			1.0			
	RU2	Median Days from submission to Trust approval (Non Portfolio)	AF	NB	TBC	TBC	TBC	2.1	1.0	1.0			1.0			1.0			1.0			
	RU3	Recruitment to Portfolio Studies	AF	NB	Aspirational target=10920/year (910/month)	TBC	TBC	12564	13479	1019	858	1019	1516	1875	815	926	983	947	788	797	803	607
	RU4	% Adjusted Trials Meeting 70 day Benchmark (data sunbmitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC			(Oct14-Sep15) 92%			(Jan15 - Dec15) 94%			(Apr15 - Mar16) 94%						
	RU5	Rank No. Trials Submitted for 70 day Benchmark (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC			(Oct14-Sep15) Rank 13/215			(Jan15 - Dec15) Rank 61/213			(Apr15 - Mar16) Rank 16/222						
	RU6	%Closed Commercial Trials Meeting Recruitment Target (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC			(Oct14-Sep15) 46.8%			(Jan15 - Dec 15) 43.4%			(Apr15 - Mar16) 65.8%						

Never Events

		Target	Latest Month	YTD	Forecast performance for next month
What is causing underperformance?	What actions have been taken to improve performance?	0	1 (July)	1	0

Incident declared on 15th July 2016 meets Never Event Criteria No 4:

Mis – selection of a strong potassium containing solution

Mis - selection refers to:
When a patient intravenously receives a strong potassium solution rather than an intended different medication.

Incident

On 7/7/16, Nurse A was 1: 1with patient on Intensive Care Unit (ITU) at Leicester General Hospital (LGH). She checked out 3 ampoules of potassium with nurse B from the CD cupboard and signed for this. At the same time Nurse A & B put 1 vial of antibiotic plus water for injection and normal saline into the medication tray to carry back to the bedspace.

On returning to the bedspace nurse B was called away to help another member of staff. Nurse A continued to draw up medications. Nurse A then administered what she presumed was antibiotic mixed with water for injection. During this administration, the patient's monitored alarmed as asystole (the patient was in cardiac arrest). Nurse A alerted the team to the cardiac arrest in the appropriate way. During the arrest an arterial blood gas was completed showing a potassium reading of 8.9. The patient was previously being treated for a low potassium on a potassium pre arrest.

The patient was given corrective treatment to lower this potassium and arrest procedures followed. The patient returned to a viable cardiac rhythm and was stabilised. Once stabilised, it was noted that there were empty ampoules of potassium present in the tray that had been used to give the antibiotics. The use of this could not be accounted for. It is possible that the antibiotic was mixed with potassium rather than water for injection, thus causing a cardiac arrest.

Actions Taken

Communication going out through pharmacy channels regarding Controlled Drugs being drawn up on the CD bench and not at the patient's bedside.

Red trays to be used in the ITU and the PACU/Advanced area for all controlled drugs.

In Clinical Handover introduce daily safety briefings regarding lessons from these incidents.

Review of clinical environment to allow a designated clean treatment area to allow for the preparation of IV drugs – This is defined in the Trust IV policy

Pharmacy procurement have contacted UK suppliers to investigate the availability of alternative potassium chloride packaging and prefilled syringes.

A risk assessment has been completed to risk assess staffing and acuity. This has scored a 9 (moderate risk).

Performance:

	Jul-15	Aug-15	Sep-15	Oct-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Never Events	0	0	1	0	0	0	0	1	0	0	0	1

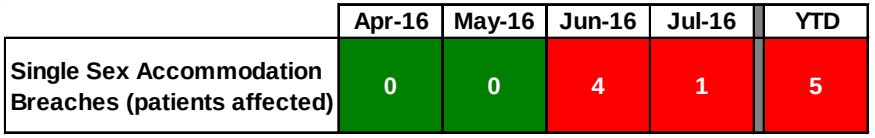
Expected date to meet standard	N/A
Revised date to meet standard	N/A
Lead Director	Moira Durbridge, Director of Safety and Risk

MRSA – Unavoidable

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
This bacteraemia was deemed to be unavoidable. The cause of the bacteraemia was related to chronic pancreatic due to lifestyle issues. There were no lapses in care identified during the post infection review.	A Post Infection Report determined no actions or omissions led to this bacteraemia, therefore no action to improve performance is required	**0**	**1**	**1**	**0**
		Expected date to meet monthly target			
		Lead Director / Lead Officer	Julie Smith, Chief Nurse Liz Collins, Lead Nurse Infection Prevention		

Single Sex Accommodation Breaches (patients affected)

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	July 2016	YTD performance	Forecast performance for next reporting period
In line with the Same-Sex Accommodation Matrix it is not acceptable for patients to be undressed with members of the opposite sex in any clinical area, except in specific circumstances. Mixing of sexes in patients requiring level 2 or 3 care in Intensive Care Units (ICU) can be justified. Due to lack of appropriate specialist urology bed capacity in the Trust, a patient had to remain in the ICU following the time they were identified for discharge. Privacy and dignity was maintained to the highest standards. Apologises were given to the patient and relatives.	Escalation process to be followed at all times when a patient is identified for discharge from ICU. All staff to be aware of the escalation process and act accordingly. Meetings have been held with ICU sisters advising them of the process. Duty Managers Team to make every effort to ensure that a bed is made available when a patient is identified for discharge from the ICU.	0	1	5	0



	Apr-16	May-16	Jun-16	Jul-16	YTD
Single Sex Accommodation Breaches (patients affected)	0	0	4	1	5

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

Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA)

		Target	Latest Month	YTD	Forecast
What is causing underperformance?	What actions have been taken to improve performance?	>=60%	54.8%	56.6%	56.7%

The main cause is a 11.7% rise in referrals over the last 11 months. Average monthly referral Sep-Nov 2015 221. May-July 2016 247.

1. Increase the number of high risk slots mid week and reduce low risk slots. This was done for July and initially seemed to be sufficient however there was a surge of referrals in the last 2 weeks and will further review the template when Dr Eveson has returned from leave

2. To divert referrals where symptoms are over a month ago after consultant screening to OPD clinic.

3. To send out a communication reminding staff to alert the clinic if patient is admitted so slot is freed up.

4. To send out a communication reminding staff that inpatients only to be referred on discharge and if need advice in hospital to liaise with on call stroke team.

   Points 2-4 were agreed at the stroke physicians meeting on August 10th .

5. Once clinical lead is back to further review referral patterns,whilst the final diagnosis of cerebrovascular disease remains consistent around 43% which compares with national average there is a significant variation in referrers with some practices referrals are over 80% with a cerebrovascular diagnosis whilst others only 0%.

Performance:

Apr-16	May-16	Jun-16	Jul-16	YTD
53.5%	68.2%	50.4%	54.8%	56.6%

Expected date to meet standard	November 2016
Revised date to meet standard	
Lead Director	Dr Rachel Marsh, Consultant

52 week breaches (incompletes)

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>July performance</th><th>YTD performance</th><th>Forecast performance for next period</th></tr>
<tr><td rowspan="4">UHL had 77 patients breaching 52 weeks at the end of July, consisting of 74 Orthodontics patients, 1 Urology patients and 1 Paediatric ENT patient and 1 General Surgery patient.

Orthodontics – The 74 Orthodontics patients have breached 52 weeks as a result of incorrect use and management of a planned waiting list, as well as inadequate capacity within the service. (NB; this is a significant reduction from the original 270, March 2016).

ENT – the ENT patient breaching 52 weeks, delays can be attributed to administrative errors; however this has been exacerbated by the mismatch between capacity and demand in ENT. This patient is now treated.

Urology – As part of an in depth investigation into the admitted waiting list following on from a previous 52 week breach, this patient was identified as breaching 52 weeks. The delay can be attributed to administrative errors, with pathways being incorrectly ended and new pathways started. The patient has now been treated.

General Surgery – one patient has breached 52 weeks in this speciality, the patient will be treated in August.</td><td rowspan="4">Orthodontics – The Orthodontics service is now closed to referrals with some clinical exceptions. With NHS Improvement and NHS England, UHL have identified treatment opportunities from across the regional health economy for the majority of the patients on the Orthodontics waiting list. The service team are in the process of transferring patients to these providers. The numbers over 52 weeks have reduced significantly.

ENT – The RTT Team delivered a bespoke education and training course for the ENT administrative team and continues to provide support. This training is reiterated regularly to the waiting list team by the service management. Extra capacity has been identified for both outpatients and inpatients via Medinet weekend clinics and theatre lists.

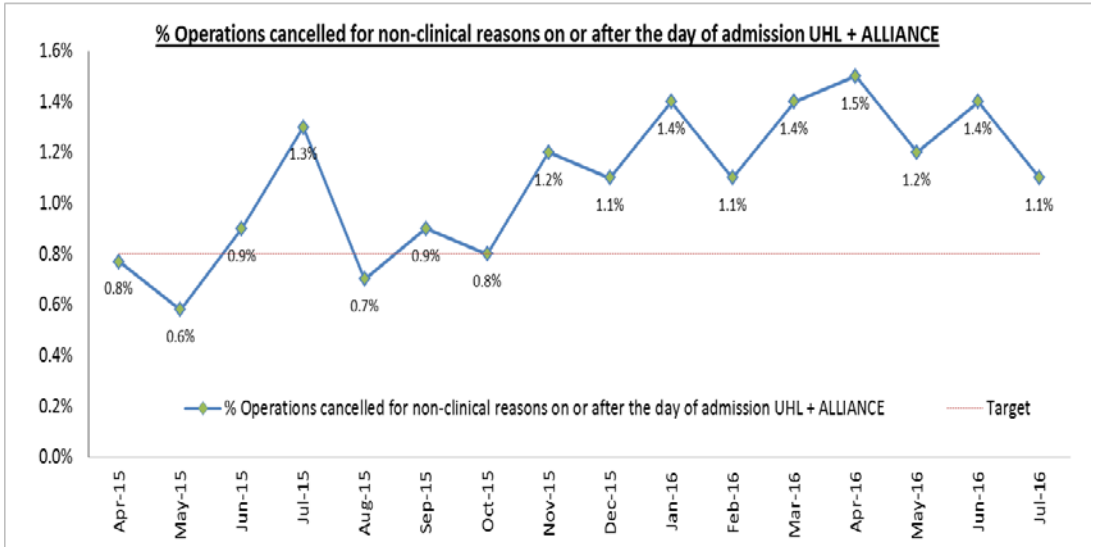
Urology – Following on from the discovery of these patients, a full review of waiting list management in Urology will be undertaken, with responsibility for validation and booking assigned to the administration manager.

General surgery – it is not anticipated that there will be further 52 week breaches in this speciality , although surgical capacity remains an ongoing concern.</td><td>0</td><td>77</td><td>77</td><td>65</td></tr>
<tr><td colspan="4">The problem which surfaced in Orthodontics prompted a deliberate, Trust-wide review of planned waiting lists at specialty level. Therefore the following actions have been taken Trust-wide:
Communication around planned waiting list management to all relevant staff;
System review of all waiting list codes;
All General Managers and Heads of Service have signed a letter confirming review and assurance of all waiting lists, to be returned to Chief Operating Officer;
Weekly review at Heads of Operations meeting for assurance.
Looking forward
UHL is forecasting ongoing achievement of RTT, however achievement of the standard remains at risk. This is the culmination of the significant impact of cancellations on the admitted position as well as the deterioration of performance in ENT and other key specialties such as Allergy. RTT was failed nationally in April 2016 for the first time since 2012, reflecting the pressures felt across the acute sector. ENT remains very high risk due to the high number of cancellations the service has experienced and the number of patients with long waits. There are likely to be more 52 week breaches.</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">January 2017</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Richard Mitchell, Chief Operating Officer
Will Monaghan, Director of Performance and Information</td></tr>
</table>

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

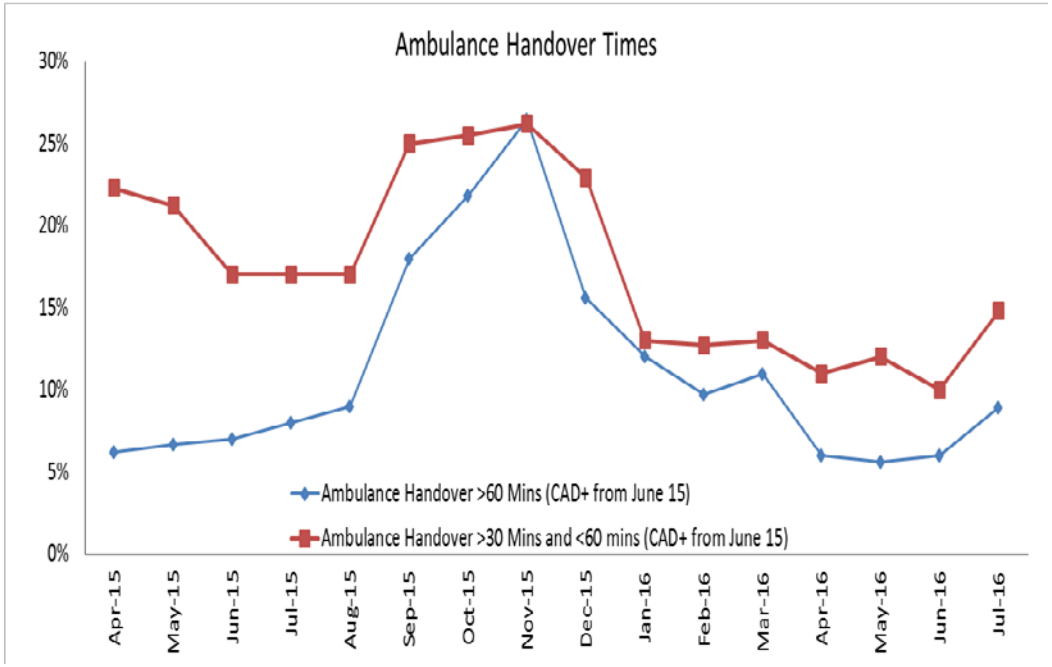
INDICATORS: The cancelled operations target comprises of two components: 1. The % of cancelled operations for non-clinical reasons On The Day (OTD) of admission **2**.The number of patients cancelled who are not offered another date within 28 days of the cancellation

What is causing underperformance?	What actions have been taken to improve performance?	Target (monthly)	Latest month	YTD performance (inc Alliance)	Forecast performance for next reporting period
Across UHL, 45% of all cancellations (48//107) were due to capacity pressures. The five key reasons for cancellations were: 1. HDU bed availability (19 patients) 2. Lack of theatre time / lists overrunning (30 patients) 3. Ward bed availability (11 patients) 4. ITU bed unavailability (6 patients) 5. Patient delayed to admit a higher priority patient (12 patients) Of the 48 patients cancelled for capacity pressures, 36 of the cancellations related to availability of beds (HDU, ITU or ward).	List over runs: the process of exception reporting is now better able to identify any over booked operation lists by the theatre managers working with theatre staff. The number of cancellations due to ward bed availability has improved considerably as a result of the ring fencing of ASU/ Ward 7 for surgical patients. (July 11, down from 35 in May) In June In light of the significant proportion of patients being cancelled as a result of no HDU bed being available, the ITAPS team opened an additional four HDU beds at the General. So far, this is working well. The plan is to open an additional six HDU beds at the Royal in August; however a specific date to open has yet to be confirmed, the reason for delaying this in the anesthetic cover required to keep patients safe. Theatre managers have increased theatre capacity for the cancer demand by making additional lists available.. In order to support pressured cancer tumour sites, the Trust is currently exploring use of Medinet theatre staff for weekend lists. This has started with Urology so far.	1) 0.8% 2) 0	1) 1.1% (UHL 1.1% & Alliance 1.4%) 2) 20 (11 CHUGGS, 4 MSS, 3 RRCV, 2 W&C)	1) 1.3% 2) 89	1) 1.0% 2) 15



Expected date to meet standard / target	On the day – Sept 2016 28 day – Sept 2016
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Gaby Harris, ITAPs Head of Operations

Ambulance handover > 30 minutes and>60 minutes

		Target	Latest Month	YTD	Forecast
What is causing underperformance?	What actions have been taken to improve performance?	0 delays over 15 minutes	>60 min – 9% 30-60 min –15%	>60 min - 7% 30-60 min –12%	> 60 min – 8% 30-60 min – 10%
Difficulties continue in accessing beds and high occupancy in ED leading to congestion in the assessment area and delays to ambulance handover.	EMAS and UHL continue to work together to do all they can to improve ambulance handover times however the main driver for the deterioration in position is an increase in EMAS attendances at UHL and the difficulties caused when inflow is high over a limited period of time. The above has been discussed at ORG and the CCG's are trying to determine the reasons for the increase in conveyance so they can develop an action plan. On the 22nd July 16 UHL and EMAS agreed that due to the number of crews held at UHL and the serious impact it was having on EMAS response times to red calls 4-5 undifferentiated pts (depending on acuity) would be cohorted in the main corridor (from majors). These patients will be looked after by an EMAS crew. Following the opening of yellow zone and the initial problems using this area as intended (staffing and patients waiting for beds) we are now starting to see a benefit which will improve the position into August.	Performance:  		

Expected date to meet standard	May 2017
Revised date to meet standard	
Lead Director	Sam Leak, Director of Emergency Care and ESM CMG

Cancer Waiting Times Performance

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance June	Performance 2015/16	Forecast performance for July
2ww – The Trust failed the 2ww standard by 2.5%. This can be attributed to the continuing problems with capacity in Head and Neck (ENT specifically),	**2ww –** ENT/ Head and Neck remains a significant organisational focus. Predictions for July onwards are for a recovery of performance against this standard.	**2WW (Target: 93%)**	**90.5%**	**90.4%**	**94.4%**
31 day first treatment – UHL's performance against this standard was 95.6%. 16 patients were treated after the 31 day target. Gynae, Lower GI, Lung, Sarcoma and Upper GI all failed to meet the standard in the month. Continuing elective capacity and patient choice are the main factors contributing to under performance	**31 day first treatment –** Reduced emergency pressures and recovery in Urology/Lower GI/Gynae are key to the achievement of this standard. Urology has a known shortage of theatre capacity; additional long term capacity is in the process of being identified with extra sessions/ weekend working. Additional HDU capacity at the LGH site is expected from July 2016.	**31 day 1st (Target: 96%)**	**95.6%**	**95.5%**	**89%**
		31 day sub – Surgery (Target: 94%)	**84.7%**	**89%**	**73.1%**
31 day subsequent (surgery) – Performance against this standard in June was 84.7% - a 6.9% deterioration from May, the issues remain with inadequate theatre capacity in key tumour sites (Urology, Gynae) and the impact of cancellations due to HDU/ITU bed availability (UGI, LOGI).	**31 day subsequent (surgery) –** Across all tumour sites cancer patients are being prioritised over RTT patients, however cancellations due to emergency pressures are having an impact. The key issue in Urology is inadequate elective capacity; as mentioned above plans to increase their theatre capacity are ongoing. The Theatre Programme board are reviewing demand and capacity analysis across the 3 sites.	**62 day RTT (Target: 85%)**	**77.3%**	**75.8%**	**85.4%**
62 day – 62 day performance remains below target at 77.3% in June, slight increase of 2.8% from May; 45 patients from the backlog were treated. The main pressures remain robust patient pathways and supporting processes, inadequate theatre capacity and shortages in consultant staff. The only tumour sites to achieve the standard were Breast, Head & Neck, and Skin.	**62 day RTT –** Lower GI, Lung and Urology remain the most pressured tumour sites. Three band 7 service managers with responsibility for managing cancer pathways in our worst performing tumour sites are providing the key focus required. Although 62 day backlog reduction has steadily been taking place, there are increasing pressures in Urology. A Remedial Action Plan has been submitted to commissioners; this is updated weekly via the Trust's Cancer Action Board and monitored monthly via the joint Cancer and RTT Board. Daily phone calls are taking place with Urology, Lung and Head and Neck and the corporate performance team.	**62 day screening (Target: 90%)**	**77.8%**	**89.5%**	**92.5%**
		Current cancer performance is an area of significant concern across UHL and focus on recovery is of the highest priority within the organisation. The weekly cancer action board chaired by the Director Of Performance and Information with mandatory attendance by all tumour site leads ensures that corrective actions are taken. The Trust has initiated a programme 'Next Steps' for cancer patients in 3 key tumour sites. The pilot started in the Prostate pathway in early April and has since rolled out to Lower GI and Lung. Further roll out to other tumour sites will happen in June.			
		Expected date to meet standard / target	62 day pathway: September 2016 31 day sub – Surgery: September 2016		
		Revised date to meet standard	31 day 1st treatment: September 2016		
		Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Dan Barnes, Clinical Lead for Cancer		

Cancer Patients Breaching 104 days

What is causing underperformance?

12 cancer patients on a 62 day pathway breached 104 days at the end of June across 5 tumour sites, all of which are confirmed cancer. Three of these patients had been waiting over 6 months from initial referral.

Tumour site	Number of patients breaching 104 days
Lung	4
Lower GI	2
Skin	1
UGI	1
Urology	4

The following factors have significantly contributed to delays:

Reason	No. patients
Patient fitness	3
LTFU/PSA Surveillance	4
Patient initiated delays (compliance or choice)	4
Late Tertiary Referrals	1

What actions have been taken to improve performance?

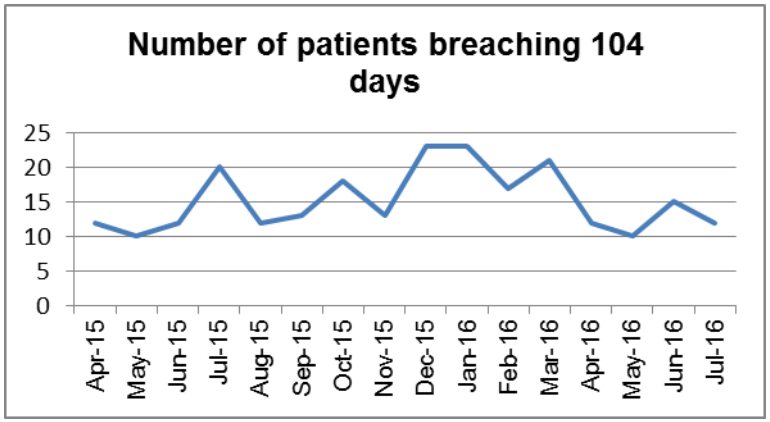
Current cancer performance is an area of significant concern across UHL and is given the highest priority by the executive and operational teams. The weekly cancer action board chaired by the Director Of Performance and Information with mandatory attendance by all tumour site leads ensures that corrective actions are taken.

The number of patients breaching 104 days on a 62 day pathway reduced by 3 from the end of June. The split of the numbers demonstrates patient fitness and patient initiated delays are the main delay factors. Ongoing monthly backlog summary reports and delay reasons are produced in conjunction with the services for thematic review and root cause resolution where appropriate. Long term follow up (Lung) and PSA Surveillance (Urology) patients where active monitoring without cancer exclusion retains these patients on a 62 day pathway are significant contributory factors for the number of patients waiting over 104 days. Lung are seeking to implement a local policy for improved pathway management to enable appropriate patients to be removed from active cancer monitoring.

The impact of emergency pressures has reduced but is still a pressure, the proposed opening of 6 additional HDU beds at the LRI site is currently delayed due to staffing issues. At the time of reporting, the ITAPS CMG are not in a position to provide a date by which this will be available due to both medical and nursing gaps.

Month by month breakdown of patients breaching 104 days

The graph below outlines the number of cancer patients breaching 104 days by month going back to April 2015:



NB: Not all patients have confirmed cancer. However 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 Dan Barnes, Clinical Lead for Cancer