Quality & Performance Report

Author: John Adler Sponsor: Chief Executive Date: IFPIC & QAC 28th April 2016

Executive Summary from CEO Paper L

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 October 2014 to September 2015) is **96** – this compares to a peak of 105. **RTT** – the RTT incomplete target remains compliant, this is particularly good in the light of the continued high level of cancelled operations due to emergency pressures. **Diagnostics** performance is 1.1% reducing from a high of 13.4% August 2015 – compliance is now expected April. The **Cancer Two Week Wait** target was initially achieved in December for the first time this financial year and has also been delivered for February. **Delayed transfers of care** remain well within the tolerance reflecting the continuation of the good work that takes place across the system in this area. **MRSA** – avoidable remains at 0 for the year, however 1 unavoidable case was reported in March. **C DIFF** – the challenging annual threshold of 61 was achieved. **Pressure Ulcers** – 0 **Grade 4** pressure ulcers reported in March and **Grade 3** are 52% lower than 14/15. **Falls** performance has continued to show a big improvement on last year. **Patient Satisfaction (FFT)** achieved the Quarter 4 Quality Commitment target of 97% for Inpatients and Day Cases.

Bad News:

ED 4 hour performance- was 77.5% and the year to date performance has slipped to 86.9%. Contributing factors are set out in the Chief Operating Officer's report. **Ambulance Handover 60+ minutes**– sustained the improvements delivered in February (despite ED pressures) but remains a serious issue – this is also examined in detail in the COO's report. **Referral to Treatment 52+ week waits** has reduced by 29 over the last month – the first time since the problem came to light. An organised process of transferring patients to other providers is now in progress and we should see substantial reductions in these waits in the coming months. **Cancelled operations** and **patients rebooked within 28 days** – continued to be non-compliant, due to increased emergency pressures. **Cancer Standards -** the 62 day backlog continues to show signs of

improvement with the latest backlog down to 62 (from a peak of 116 in January). **Fractured NOF** – target not achieved in March – this has now reverted to a persistent failure. Compliance is expected in Quarter 2 2016, however this is dependent of theatre capacity. **Patient Satisfaction (FFT)** the target of 97% was not achieved for ED during March and **ED FTT coverage** remains low. The latter is not acceptable.

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: 26th May 2016

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

March 2016

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: **28th APRIL 2016**

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

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

1.0 Introduction

The following report provides an overview of TDA/UHL key quality and performance 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	2
Caring	5	10	3	1
Well Led	6	18	6	4
Effective	7	16	3	2
Responsive	8	17	2	9
Responsive Cancer	9	9	0	6
Research – UHL	11	6	6	0
Total		98	38	24

3.0 New Indicators

No new indicators.

4.0 Indicators removed

No indicators removed

5.0 Indicators where reporting methodology/thresholds have changed

Stroke performance has been updated from November 15 to reflect validated information.

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

	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	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
Safe	S1	Clostridium Difficile	JS	DJ	61	TDA	Red if >mthly threshold / ER if Red or Non compliance with cumulative target	66	73	7	5	7	3	1	4	4	6	6	6	4	6	7	7	6	60
	S2a	MRSA Bacteraemias (All)	JS	DJ	0	TDA	Red if >0 ER if >0	3	6	0	1	1	0	0	0	0	0	0	0	0	0	0	0	1	1
	S2b	MRSA Bacteraemias (Avoidable)	JS	DJ	0	UHL	Red if >0 ER if >0	1	1	0	1	0	0	0	0	0	0	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	1	0	0	0	0	0	0	0	1	0	0	0	0	0	1	2
	S4	Serious Incidents	JS	MD	Not within Highest Decile	TDA	TBC	60	41	3	2	1	2	8	1	5	3	5	3	4	3	5	6	4	49
	S5a	Proportion of reported safety incidents per 1000 beddays	JS	MD	TBC	TDA	TBC	37.5	39.1	35.0	38.2	36.3	38.0	39.8	40.7	40.7	38.9	36.4	40.7	36.5	37.4	37.4	34.6	35.7	38.1
	S5b	Proportion of reported safety incidents that are harmful	JS	MD	Not within Highest Decile	TDA	TBC	2.8%	1.9%	2.3%			1.6%			1.3%			1.1%			0.8%			1.2%
	S6	Overdue CAS alerts	JS	MD	0	TDA	Red if >0 in mth ER = in mth >0	2	10	0	0	1	0	0	0	0	0	0	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	0	3	2	0	6	0	0	2	3	7	2	5	3	2	2	32
	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%	95.0%	92.1%	93.6%	93.7%	94.3%	95.6%	94.6%	93.2%	94.0%	93.5%	94.4%	93.9%	94.2%	94.1%	94.4%	94.1%
	S8b	Safety Thermometer % number of new harms	JS	EM	Not within Lowest Decile	TDA	TBC	New TDA Indicator		2.5%	3.2%	2.7%	2.2%	2.6%	2.1%	1.9%	3.1%	2.4%	2.6%	2.7%	1.8%	2.3%	2.2%	2.0%	2.3%
	S9	% of all adults who have had VTE risk assessment on adm to hosp	AF	SH	95% or above	TDA	Red if <95% ER if in mth <95%	95.3%	95.8%	96.3%	96.2%	95.6%	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%
	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	7.1	6.7	6.3	5.9	6.1	5.1	5.8	5.9	5.0	5.2	4.8	5.7	5.4	4.9	5.2	5.4
	S12	Avoidable Pressure Ulcers - Grade 4	JS	MC	0	QS	Red / ER if Non compliance with monthly target	1	2	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	1
	S13	Avoidable Pressure Ulcers - Grade 3	JS	MC	<=6 a month	QS	Red / ER if Non compliance with monthly target	71	69	5	9	6	3	0	4	1	4	1	1	1	5	6	2	5	33
	S14	Avoidable Pressure Ulcers - Grade 2	JS	MC	<=8 a month	QS	Red / ER if Non compliance with monthly target	120	91	7	5	9	10	8	8	8	10	11	5	4	5	5	8	7	89
	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%	<75%			AUDIT IN PROGESS												
	S16	Maternal Deaths	AF	IS	0	UHL	Red or ER if >0	3	1	1	0	0	0	0	0	0	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%	17.7%	15.5%	15.8%	15.3%	18.8%	15.8%	15.8%	15.2%	16.5%	20.9%	19.7%	20.9%	17.0%	16.6%	17.3%	17.5%
	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																	

Caring

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C1	Inpatients (Including Daycases) Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <95% ER if 2 mths Red	New Indicator	96%	96%	96%	97%	96%	96%	97%	96%	97%	97%	97%	96%	97%	97%	96%	97%	97%*
C2	A&E Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <94% ER if 2 mths Red	New Indicator	96%	96%	96%	97%	96%	96%	96%	96%	97%	95%	95%	97%	95%	97%	97%	95%	96%*
C3	Outpatients Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <90% ER if 2 mths Red	NEW METHODOLOGY FOR CALCULATING %					94%	94%	93%	91%	93%	93%	93%	92%	94%	95%	95%	93%	94%*
C4	Daycase Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <95% ER if 2 mths Red						96%	97%	97%	98%	98%	97%	98%	98%	98%	98%	98%	98%	98%*
C5	Maternity Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <94% ER if 2 mths Red		96%	97%	96%	96%	95%	96%	95%	95%	96%	95%	95%	95%	94%	95%	95%	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%	71.4%			68.7%			71.9%			Q3 staff FFT not completed as National Survey carried out			69.4%			70.0%
C7a	Complaints Rate per 1000 bed days	AF	MD	TBC	UHL	TBC	New Indicator	0.4	0.3	0.3	0.4	2.8	2.8	3.3	2.9	3.0	3.1	2.7	2.6	1.8	2.0	3.1	2.6	2.7
C7b	Written Complaints Received Rate per 100 bed days	AF	MD	Not within Highest Decile	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	
C8	Complaints Re-Opened Rate	AF	MD	<=12%	UHL	Red if >=15% ER if >=15%	New Indicator	10%	17%	13%	11%	13%	6%	7%	7%	11%	12%	7%	8%	15%	7%	10%	10%	9%
C9	Single Sex Accommodation Breaches (patients affected)	JS	HL	0	TDA	Red / ER if >0	2	13	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1

*** QTR 4 performance**

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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%	37.4%	38.2%	23.2%	29.3%	37.2%	36.1%	31.0%
	W2	Daycase Friends and Family Test - Coverage (Adults and Children)	JS	HL	20%	TDA	Red if <8% ER if 2 mths Red	NEW METHODOLOGY FOR CALCULATING COVERAGE INCLUDES ADULTS AND CHILDREN					12.5%	12.1%	15.5%	20.5%	23.8%	24.1%	27.2%	27.7%	18.7%	30.1%	26.2%	29.2%	22.5%
	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%	16.1%	12.4%	5.4%	7.3%	5.1%	7.0%	10.5%
	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%	1.5%	1.5%	1.4%	1.5%	1.6%	1.6%	1.4%
	W5	Maternity Friends and Family Test - Coverage	JS	HL	30%	UHL	Red if <26% ER if 2 mths Red	25.2%	28.0%	25.8%	46.5%	40.2%	32.3%	35.8%	32.6%	25.6%	30.5%	27.9%	27.2%	38.8%	30.0%	33.3%	34.3%	31.7%	31.6%
	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%	54.9%			52.5%			55.7%			Q3 staff FFT not completed as National Survey carried out			57.9%			55.4%
	W7a	Nursing Vacancies	JS	MM	5% by Mar 16	UHL	Separate report submitted to QAC	NEW UHL INDICATOR		6.3%	5.5%	6.5%	8.5%	8.0%	7.3%	8.7%	8.9%	8.5%	7.1%	7.6%	7.6%	7.7%	6.8%	8.4%	8.4%
	W7b	Nursing Vacancies in ESM CMG	JS	MM	5% by Mar 16	UHL	Separate report submitted to QAC	NEW UHL INDICATOR		12.8%	11.4%	14.0%	19.3%	13.0%	14.4%	13.3%	13.5%	13.5%	12.9%	14.6%	14.9%	16.4%	17.2%	18.5%	17.2%
	W8	Turnover Rate	LT	LG	Not within Lowest Decile	TDA	Red = 11% or above ER = Red for 3 Consecutive Mths	10.0%	11.5%	10.1%	10.1%	11.5%	10.4%	10.5%	10.5%	10.6%	10.4%	10.4%	10.2%	9.9%	10.0%	10.1%	10.0%	9.9%	9.9%
	W9	Sickness absence	LT	KK	3%	UHL	Red if >4% ER if 3 consecutive mths >4.0%	3.4%	3.8%	4.2%	4.1%	4.0%	3.6%	3.4%	3.5%	3.3%	3.2%	3.3%	3.5%	3.7%	3.9%	4.0%	4.5%		3.6%
	W10	Temporary costs and overtime as a % of total paybill	LT	LG	TBC	TDA	TBC	New Indicator	9.4%	10.5%	9.8%	11.5%	10.7%	10.2%	11.0%	10.8%	11.1%	9.9%	10.5%	10.5%	10.1%	11.0%	9.7%	13.9%	10.7%
	W11	% of Staff with Annual Appraisal	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	91.3%	91.4%	90.9%	91.0%	91.4%	90.1%	88.7%	89.0%	89.1%	88.8%	90.0%	90.4%	91.1%	92.7%	91.5%	91.6%	90.7%	90.7%
	W12	Statutory and Mandatory Training	LT	BK	95%	UHL	TBC	76%	95%	89%	90%	95%	93%	92%	92%	91%	91%	91%	92%	92%	93%	93%	92%	93%	93%
	W13	% Corporate Induction attendance	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	94.5%	100%	99%	100%	97%	97%	97%	98%	100%	97%	98%	98%	97%	92%	96%	98%	98%	97%
	W14a	DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	Not within Lowest Decile	TDA	TBC	New Indicator	91.2%	94.3%	91.8%	91.0%	93.6%	90.3%	91.2%	90.3%	90.2%	90.5%	91.4%	87.2%	91.0%	90.5%	89.5%	90.2%	90.5%
	W14b	DAY Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	Not within Lowest Decile	TDA	TBC		94.0%	95.4%	92.8%	92.5%	94.2%	91.2%	93.5%	91.3%	92.4%	93.1%	94.2%	93.2%	93.9%	92.1%	86.0%	88.7%	92.0%
	W14c	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	Not within Lowest Decile	TDA	TBC		94.9%	97.9%	96.5%	97.2%	98.9%	96.0%	96.2%	94.3%	94.3%	94.9%	96.1%	91.4%	94.8%	96.6%	95.0%	96.3%	95.4%
	W14d	NIGHT Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	Not within Lowest Decile	TDA	TBC		99.8%	103.6%	100.8%	103.2%	106.3%	98.7%	99.4%	101.2%	98.0%	100.0%	99.9%	98.4%	98.0%	100.2%	91.6%	94.7%	98.9%

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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	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
E1	Mortality - Published SHMI	AF	PR	Within Expected	TDA	Higher than Expected	105	103	105 (Jul13-Jun14)			103 (Oct13-Sep14)			99 (Jan14-Dec 14)			98 (Apr14-Mar15)			95 (Jul14-Jun15)		96 (Oct14-Sep15)	96
E2	Mortality - Rolling 12 mths SHMI (as reported in HED) Rebased	AF	PR	Within Expected	QC	Red if >expected ER if >Expected or 3 consecutive mths increasing SHMI >100	105	98	99	98	98	98	96	96	95	96	95	96	96	97	Awaiting HED Update			97
E3	Mortality HSMR (DFI Quarterly)	AF	PR	Within Expected	TDA	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	88	94	93			89			90			90			Awaiting DFI Update			90
E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	AF	PR	Within Expected	QC	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	99	94	95	95	94	94	94	93	93	93	93	94	95	95	94	Awaiting HED Update		94
E5	Mortality - Monthly HSMR (Rebased Monthly as reported in HED)	AF	PR	Within Expected	QC	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	91	94	99	98	86	82	95	99	83	93	101	106	96	96	97	Awaiting HED Update		95
E6	Mortality - HSMR ALL Weekend Admissions - (DFI Quarterly)	AF	PR	Within Expected	QC	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	96	100	106			98			87			95			Awaiting DFI Update			93
E7	Crude Mortality Rate Emergency Spells	AF	PR	Within Upper Decile	TDA	TBC	2.5%	2.4%	3.1%	2.7%	2.4%	2.1%	2.0%	2.3%	1.8%	2.0%	2.2%	2.4%	2.1%	2.5%	2.4%	2.4%	2.8%	2.3%
E8	Deaths in low risk conditions (Risk Score)	AF	PR	Within Expected	TDA	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	94	80	100	86	74	121	20	38	38	102	95	95	148	40	Awaiting DFI Update			78
E9	Emergency readmissions within 30 days following an elective or emergency spell	AF	JJ	Within Expected	UHL	Red if >7% ER if 3 consecutive mths >7%	7.9%	8.5%	8.2%	8.5%	8.5%	9.1%	9.1%	9.0%	8.8%	8.9%	8.7%	9.0%	8.3%	9.2%	8.8%	8.7%		8.9%
E10	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	AF	RP	72% or above	QS	Red if <72% ER if 2 consecutive mths <72%	65.2%	61.4%	57.9%	67.2%	61.5%	55.7%	42.6%	70.1%	60.3%	78.1%	72.0%	60.0%	70.9%	59.7%	66.7%	65.2%	65.1%	63.8%
E11	Stroke - 90% of Stay on a Stroke Unit	RM	IL	80% or above	QS	Red if <80% ER if 2 consecutive mths <80%	83.2%	81.3%	82.5%	87.6%	81.5%	83.7%	84.5%	84.5%	85.7%	90.9%	86.9%	81.1%	86.3%	87.0%	88.5%	86.2%		85.9%
E12	Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA)	RM	IL	60% or above	QS	Red if <60% ER if 2 consecutive mths <60%	64.2%	71.2%	80.6%	64.0%	77.3%	86.3%	79.6%	72.0%	78.9%	80.2%	88.1%	73.3%	67.1%	68.4%	71.3%	80.0%	67.3%	75.6%
E13	Published Consultant Level Outcomes	AF	SH	>0 outside expected	QC	Red if >0 Quarterly ER if >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
E14	Non compliance with 14/15 published NICE guidance	AF	SH	0	QC	Red if in mth >0 ER if 2 consecutive mths Red	New Indicator for 14/15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
E15	ROSC in Utstein Group	AF	PR	TBC	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	
E16	STEMI 150minutes	AF	PR	TBC	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	

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

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	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
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%	90.7%	89.6%	91.1%	92.0%	92.2%	92.6%	92.2%	90.6%	90.3%	88.9%	81.7%	85.1%	81.2%	80.2%	77.5%	86.9%
R2	12 hour trolley waits in A&E	RM	IL	0	TDA	Red if >0 ER via ED TB report	5	4	1	0	0	0	0	0	0	0	0	0	1	1	0	0	0	2
R3	RTT - Incomplete 92% in 18 Weeks	RM	WM	92% or above	TDA	Red /ER if <92%	92.1%	96.7%	95.2%	96.2%	96.7%	96.6%	96.5%	96.2%	95.2%	94.3%	94.8%	93.6%	93.8%	93.0%	92.9%	93.2%	92.6%	92.6%
R4	RTT 52 Weeks+ Wait (Incompletes)	RM	WM	0	TDA	Red /ER if >0	0	0	0	0	0	0	66	242	256	258	260	265	263	267	269	261	232	232
R5	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	TDA	Red /ER if >1%	1.9%	0.9%	5.0%	0.8%	0.9%	0.8%	0.6%	6.1%	10.9%	13.4%	9.6%	7.7%	6.5%	7.0%	4.1%	1.8%	1.1%	1.1%
R6	Urgent Operations Cancelled Twice	RM	PW	0	TDA	Red if >0 ER if >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
R7	Cancelled patients not offered a date within 28 days of the cancellations UHL	RM	PW	0	TDA	Red if >2 ER if >0	85	33	4	3	1	2	0	1	1	5	1	0	3	6	6	9	14	48
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	2	1	0	0	0	1	0	0	0	0	0	0	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%	0.8%	0.7%	1.0%	0.7%	0.5%	0.9%	1.3%	0.7%	0.9%	0.8%	1.3%	1.1%	1.3%	1.2%	1.5%	1.0%
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%	1.4%	0.0%	0.4%	1.2%	1.2%	1.0%	0.8%	0.0%	1.0%	1.1%	0.0%	1.1%	2.2%	0.2%	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%	0.8%	0.7%	0.9%	0.8%	0.6%	0.9%	1.3%	0.7%	0.9%	0.8%	1.2%	1.1%	1.4%	1.1%	1.4%	1.0%
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	85	64	98	79	56	97	138	67	104	91	131	115	146	119	156	1299
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%	3.2%	2.9%	1.8%	1.9%	1.0%	1.0%	0.9%	1.2%	1.3%	1.1%	1.5%	1.6%	1.8%	1.8%	2.0%	1.4%
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%	13%	19%	26%	34%	31%	Data Not Available										
R16	Ambulance Handover >60 Mins (CAD+ from June 15)	RM	SL	0	Contract	Red if >0 ER if Red for 3 consecutive mths	New Indicator for 14/15	5%	6%	11%	9%	6%	7%	7%	8%	9%	18%	22%	27%	16%	12%	10%	11%	13%
R17	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	New Indicator for 14/15	19%	21%	21%	22%	22%	21%	17%	17%	17%	25%	26%	26%	23%	13%	13%	13%	19%

Responsive Cancer

KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
** Cancer statistics are reported a month in arrears.																								
RC1	Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	RM	MM	93% or above	TDA	Red if <93% ER if Red for 2 consecutive mths	94.8%	92.2%	92.2%	93.5%	91.5%	91.2%	87.9%	91.1%	87.4%	86.8%	87.7%	89.9%	92.4%	93.0%	91.4%	93.9%	**	90.2%
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%	92.5%	91.5%	96.0%	99.0%	98.8%	87.2%	93.3%	98.7%	94.5%	94.6%	89.4%	93.5%	96.2%	99.3%	**	95.0%
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%	91.7%	95.0%	97.0%	93.9%	97.9%	93.7%	97.2%	96.5%	94.7%	95.2%	95.6%	94.3%	91.5%	92.4%	**	94.9%
RC4	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	RM	MM	98% or above	TDA	Red if <98% ER if Red for 2 consecutive mths	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	97.7%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	**	99.6%
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%	89.2%	94.4%	87.5%	86.3%	92.2%	89.6%	92.2%	81.1%	89.7%	90.7%	76.8%	91.4%	77.5%	77.9%	**	85.7%
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%	87.6%	99.0%	100.0%	86.3%	98.1%	96.5%	95.9%	99.0%	92.2%	94.1%	95.1%	94.3%	96.4%	92.9%	**	94.7%
RC7	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	RM	MM	85% or above	TDA	Red if <85% ER if Red in mth or YTD	86.7%	81.4%	79.3%	78.9%	83.8%	75.7%	70.1%	84.2%	73.7%	81.7%	77.2%	77.0%	82.5%	80.9%	75.3%	72.8%	**	77.4%
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%	88.9%	79.4%	89.3%	91.7%	82.4%	93.3%	95.2%	97.1%	81.4%	96.0%	96.2%	95.3%	77.3%	72.5%	**	89.8%
RC9	Cancer waiting 104 days	RM	MM	0	TDA	TBC	NEW TDA INDICATOR					12	10	12	20	12	12	17	13	23	23	17	21	21

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	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
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%	**	100.0%
RC11	Breast	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	96.1%	92.6%	93.3%	97.4%	98.1%	92.3%	96.8%	97.8%	91.4%	96.3%	97.5%	92.0%	100.0%	93.1%	94.6%	100.0%	**	95.8%
RC12	Gynaecological	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	88.2%	77.5%	54.5%	91.7%	75.0%	64.3%	55.6%	66.7%	100.0%	72.2%	80.0%	84.6%	80.0%	85.7%	50.0%	70.0%	**	72.9%
RC13	Haematological	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	65.9%	66.5%	66.7%	50.0%	80.0%	50.0%	55.0%	83.3%	37.5%	82.6%	66.7%	70.0%	50.0%	58.3%	100.0%	60.0%	**	63.3%
RC14	Head and Neck	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	65.4%	69.9%	70.0%	87.5%	62.5%	75.0%	54.5%	66.7%	36.4%	60.9%	50.0%	75.0%	42.9%	37.5%	62.5%	37.5%	**	52.9%
RC15	Lower Gastrointestinal Cancer	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	71.3%	63.7%	65.0%	46.7%	63.2%	63.6%	55.6%	93.3%	63.6%	60.0%	38.9%	70.6%	68.2%	77.8%	52.4%	31.3%	**	60.1%
RC16	Lung	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	89.7%	69.9%	67.7%	74.2%	88.6%	84.6%	50.9%	74.6%	81.8%	70.4%	73.5%	65.2%	88.6%	81.6%	73.7%	53.8%	**	71.0%
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%	50.0%	100%	100%	100%	100%	50.0%	60.0%	80.0%	--	66.7%	--	**	71.4%
RC18	Sarcoma	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	82.9%	46.2%	100.0%	--	0.0%	66.7%	--	100%	--	--	80.0%	50.0%	--	--	--	100.0%	**	76.9%
RC19	Skin	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	96.8%	96.7%	100.0%	94.3%	95.6%	91.7%	94.0%	91.3%	93.8%	94.1%	96.7%	91.1%	95.6%	94.9%	100.0%	92.1%	**	94.0%
RC20	Upper Gastrointestinal Cancer	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	72.2%	73.9%	85.7%	77.8%	81.8%	66.7%	55.0%	84.6%	51.4%	81.8%	45.7%	48.6%	84.6%	90.0%	42.9%	58.6%	**	63.4%
RC21	Urological (excluding testicular)	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	89.3%	82.6%	83.3%	66.7%	71.0%	62.1%	62.1%	74.7%	61.5%	86.1%	80.4%	80.0%	76.7%	75.0%	68.1%	78.7%	**	73.8%
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%	66.7%	100.0%	--	100%	100%	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	**	96.9%
RC23	Grand Total	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	86.7%	81.4%	79.3%	78.9%	83.7%	75.7%	70.1%	84.2%	73.7%	81.7%	77.2%	77.0%	82.5%	80.9%	75.3%	72.8%	**	77.4%

Compliance Forecast for Key Responsive Indicators

Standard	March Actual/Predicted	April predicted	Month by which to be compliant	RAG rating of required month delivery	Commentary
Emergency Care					
4+ hr Wait (95%) - Calendar month	77.5%				YTD 15/16 - 86.9%
Ambulance Handover (CAD+)					
% Ambulance Handover >60 Mins (CAD+)	11%		Not Confirmed		CAD+ performance from EMAS monthly report.
% Ambulance Handover >30 Mins and <60 mins (CAD+)	13%		Not Confirmed		
RTT (inc Alliance)					
Incomplete (92%)	92.6%	91.0%	Jul-16		
Diagnostic (predicted)					
DM01 - diagnostics 6+ week waits (<1%)	1.1%	< 1%	Apr-16		
# Neck of femurs					
% operated on within 36hrs - admissions (72%)	65%	65%			Missing target due to high number of medically unfit patients.
Cancelled Ops (inc Alliance)					
Cancelled Ops (0.8%)	1.4%	1.3%	May-16		Target missed due to emergency pressures.
Not Rebooked within 28 days (0 patients)	14	12	Jun-16		Target missed due to emergency pressures. To be validated.
Cancer (predicted)					
Two Week Wait (93%)	93%	90%	May-16		
31 Day First Treatment (96%)	92%	89%	Jun-16		
31 Day Subsequent Surgery Treatment (94%)	82%	89%	Jun-16		
62 Days (85%)	78%	70%	Sep-16		Backlog 62.
Cancer waiting 104 days (0 patients)	21	16			

Research UHL

KPI Ref	Indicators	Board Director	Lead Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	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	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
RU1	Median Days from submission to Trust approval (Portfolio)	AF	NB	TBC	TBC	TBC	2.0			3.0			3.0			**2.8**	2.0			1.0			2.0					
RU2	Median Days from submission to Trust approval (Non Portfolio)	AF	NB	TBC	TBC	TBC	3.5			2.0			1.0			**2.1**	4.0			1.0			1.0					
RU3	Recruitment to Portfolio Studies	AF	NB	Aspirational target=10920/year (910/month)	TBC	TBC	1075	1235	900	1039	1048	604	1030	1043	1298	**12564**	1062	848	1163	1019	858	1019	1516	1875	815	926	983	
RU4	% Adjusted Trials Meeting 70 day Benchmark (data sunbmitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC	(Oct13-Sep14) 70.5%			(Nov13-Dec14) 70.5%			(Apr14-Mar15) 86%				(Jul14-Jun15) 76%			(Oct14-Sep15) 92%			(Jan15 - Dec15) 94%					
RU5	Rank No. Trials Submitted for 70 day Benchmark (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC	(Oct13-Sep14) Rank 18/60			(Nov13-Dec14) Rank 18/59			(Apr14-Mar15) 60/198			Rank	(Jul14-Jun15) Rank 108/210			(Oct14-Sep15) Rank 13/215			(Jan15 - Dec15) Rank 61/213					
RU6	%Closed Commercial Trials Meeting Recruitment Target (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC	(Oct13-Sep14) 52%			(Nov13-Dec14) 48%			(Apr14-Mar15) 38.6%				(Jul14-Jun15) 15.3%			(Oct14-Sep15) 46.8%			(Jan15 - Dec 15) 43.4%					

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 due to multiple chronic co-morbidities resulting in lifestyle issues which impair the patient's ability to maintain hygiene and nutritional standards. There were no lapses in care identified during the post infection review.	The Post Infection Review 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	April 2016		
		Lead Director / Lead Officer	Julie Smith, Chief Nurse Liz Collins, Lead Nurse Infection Prevention		

Never events

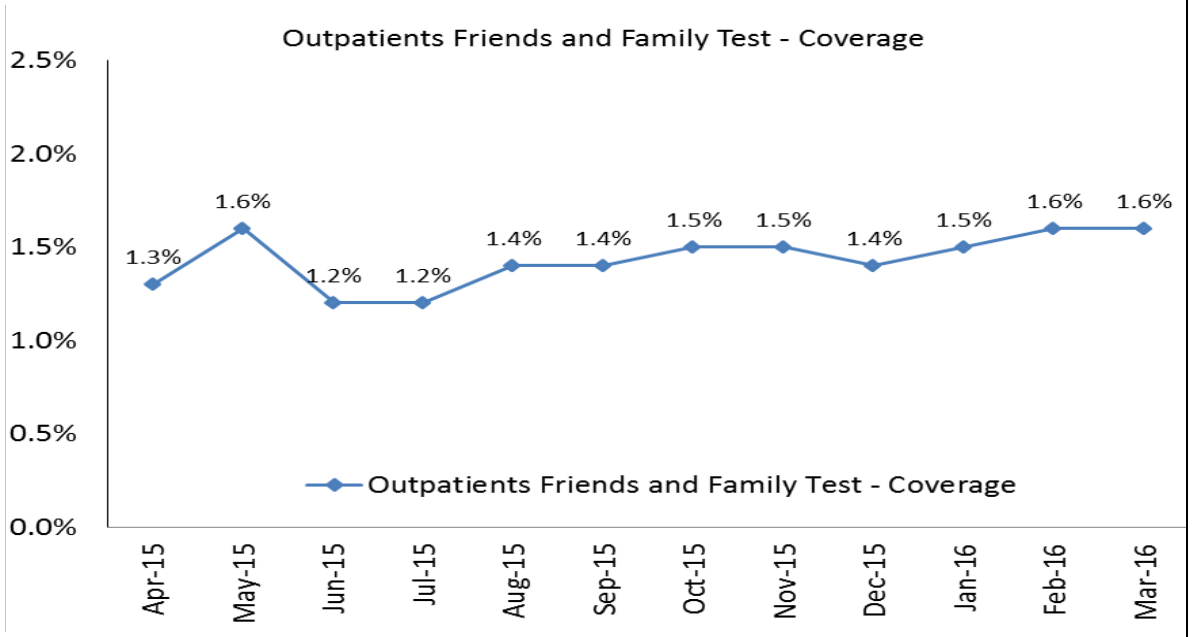
What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	March 2016	YTD performance	Forecast performance for next reporting period
Wrong site surgery to ear in dermatology escalated as Serious Incident in February 2016 and identified as a Never Event in March 2016. Patient was listed for surgery for excision of a BCC from anterior to the left ear. A copy of the clinic letter was sent to the patient's GP and the transplant coordinator, but not copied to the patient. The procedure was carried out on 16 March 2015 in the minor ops room in OPD 3 under a local anaesthetic. Consent was obtained on the day but the consent form states excision of lesion to right ear – albeit this is abbreviated rather than written out in full. The histology result was sent back to the Associate Specialist for dermatology as planned and this showed: "This specimen is composed of severely sun damaged skin. There are prominent sebaceous glands but these are consistent with the site of origin. The epidermis shows no evidence of dysplasia and there is no evidence of invasive tumour, despite extensive sampling." The Associate Specialist wrote to the patient and his GP informing him of the result and advising him to attend for his annual surveillance appointment on 18 November 2015. At this routine follow up it became apparent that the lesion to his left ear was still present and the scar from the surgery was anterior to his right ear.	Dr informed the patient and apologised to him during his consultation when the incident came to light. Definitive surgery booked and carried out. Full RCA investigation to be undertaken with following terms of reference; • To establish the facts • To identify why this incident was not identified when the histology results from the left ear excision undertaken in March 2015 were initially reviewed. • To identify why the service did not recognise this as a patient safety incident and potential 'Never Event'. • Review of the consent process within dermatology. • To identify system and/or individual failures • To establish how reoccurrence may be reduced or eliminated • To review current barriers • To formulate recommendations and an action plan • To provide a means of sharing the learning from the incident	**0**	**1**	**2**	**0**
		Expected date to meet standard / target	N/A		
		Revised date to meet standard	N/A		
		Lead Director / Lead Officer	Moira Durbridge, Director of Safety and Risk		

Outpatients Friends and Family Test - Coverage

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance FY 15/16	Forecast performance for next reporting period
The Friends and Family Test submission level in Outpatients for quarter four is 1.6% which is an improvement on the submission level in quarter three. Staff understanding of the importance of gaining and responding to patient feedback continues to be a possible cause for the underperformance in these areas.	Feedback is collected via electronic touch screen devices, QR scanning and the Trust web site. The methods used allow for real time feedback, allowing the staff to see the results immediately. The minimal level of coverage required has been highlighted to the Clinical Management Group Senior Management Teams and support has been offered. There are plans to commence SMS texting linked to the appointment reminder system already in place, as another mechanism for patients to give their feedback.	**5%**	**1.6%**	**1.4%**	**5%**

Performance by Month for 2015-16

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
Outpatients Friends and Family Test - Coverage	1.3%	1.6%	1.2%	1.2%	1.4%	1.4%	1.5%	1.5%	1.4%	1.5%	1.6%	1.6%	1.4%



Expected date to meet standard / target	Quarter One 2016-17
Revised date to meet standard	Quarter One 2016-17
Lead Director / Lead Officer	Julie Smith, Chief Nurse Heather Leatham, Assistant Chief Nurse

A&E Friends and Family Test - Coverage

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest performance	YTD performance	Forecast performance for next reporting period
The Emergency Department (ED) eligible population has increased since November 2015, when the Urgent Care Centre (UCC) was included. This area has a footfall of approximately 6000 patients a month. ED is divided into two categories, the main ED and Eye Casualty. Majors, Minors, Childrens ED, EDU and the UCC are included in the main ED. EDU has achieved a 20% or above submission level in all 3 months of Q4, however Eye Casualty has only achieved this once and the other areas have not achieved the target. This has resulted in an overall coverage of less than 20% for Q4.	Feedback in ED is collected by various methods: • Paper, including easy read, language options and a Childrens survey • Electronic touch screen • SMS • Trust Web site The main ED and Eye casualty have been offered support and advised of their minimal targets. Meetings have been held with the Senior Nursing and Medical leads, highlighting the coverage required.	**20%**	**7%**	**10.5%**	**20%**
		CURRENT RAG RATING:			

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
ED - Majors	*13.0%*	*8.2%*	*3.7%*	*2.3%*	*1.7%*	*3.0%*
ED - Minors	*9.5%*	*6.2%*	*3.5%*	*4.4%*	*4.0%*	*6.1%*
Childrens ED	*17.8%*	*13.2%*	*5.0%*	*14.2%*	*9.2%*	*14.4%*
EDU	*22.2%*	*16.2%*	*10.3%*	*25.5%*	*20.7%*	*20.0%*
UCC	-	-	*1.3%*	*0.7%*	*0.5%*	*0.7%*
Main ED	***15.1%***	***10.8%***	***3.5%***	***5.6%***	***4.4%***	***6.3%***
Eye Casualty	*20.8%*	*20.7%*	*21.5%*	*20.9%*	*11.4%*	*13.8%*
ED total	***16.1%***	***12.4%***	***5.4%***	***7.3%***	***5.1%***	***7.0%***

Expected date to meet standard / target	Work will continue outside of the Quality Commitment
Lead Director / Lead Officer	Julie Smith, Chief Nurse Heather Leatham, Assistant Chief Nurse

REPORT BY: Heather Leatham, Assistant Chief Nurse | **DATE:** 19/4/16

Emergency Readmissions within 30 days

What is causing underperformance?	What actions have been taken to improve performance?	Target	February performance	YTD performance	Forecast performance for next reporting period
UHL's readmission rate has been increasing year on year and also during 2015/16. When compared with other trusts using the Dr Foster tool, UHL's 'readmissions within 28 days' rate has also been higher compared with other trusts and has been 'higher than expected' for the past 2 years.	A 3 month pilot using the PARR 30 Readmissions Risk Tool to guide specific interventions for patients with a readmission risk of greater than 45% has just been completed. Despite gaps in the provision of these interventions the early pilot results are encouraging. Specifically; 1. PARR 30 identifies patients with a high risk of readmission (115 readmissions from 171 patients identified by the tool). 2. A combination of UHL and variable community interventions (between CCGS) appears to reduce readmissions in this cohort of patients by up to 17% (although the numbers are relatively small). A reduction in readmissions in this cohort of patients of 10% would deliver the target in the Quality Commitment for 2016/17. Next steps need to include; 1. Expanding the pilot to provide 7 day cover across 3 sites within UHL for review of identified high risk patients through the discharge service. 2. Communicating to GPs the risk of readmission in the discharge letters. 3. Leicester city CCG are appointing 4 band 7 case managers to take UHL referrals. A meeting has been arranged between Urology, Infection prevention, CCGs and LPT to address urinary catheter related readmissions.	**8.5%**	**8.7%**	**8.9%**	**8.9%**

UHL'S READMISSION RATE FOR 15/16 (Apr-Dec) COMPARED WITH PEER TRUSTS (from Dr Foster and based on 28 day readmissions)

Peers (Acute)	Spells	Readmissions	Rate (%)	Relative Risk
University College London Hospitals NHS Foundation Trust	79972	4323	5.42	84.28
Hull and East Yorkshire Hospitals NHS Trust	74413	5211	7.02	92.36
Central Manchester University Hospitals NHS Foundation Trust	89528	6008	6.75	93.45
King's College Hospital NHS Foundation Trust	102805	6953	6.78	93.81
Leeds Teaching Hospitals NHS Trust	96359	7549	7.85	95.54
Norfolk and Norwich University Hospitals NHS Foundation Trust	90604	6276	6.95	97.08
United Lincolnshire Hospitals NHS Trust	73685	5592	7.61	97.3
Barts Health NHS Trust	115348	9484	8.39	97.56
Nottingham University Hospitals NHS Trust	104033	8942	8.64	98.84
Imperial College Healthcare NHS Trust	96941	7198	7.51	99.85
Pennine Acute Hospitals NHS Trust	95340	7983	8.4	100.06
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	110133	8418	7.65	102
Oxford University Hospitals NHS Foundation Trust	98611	7457	7.61	104.16
University Hospitals Of Leicester NHS Trust	125360	10839	8.71	107.05
University Hospitals Of North Midlands NHS Trust	100032	9243	9.33	107.65
East Kent Hospitals University NHS Foundation Trust	91784	7996	8.74	109.24
Heart Of England NHS Foundation Trust	118677	11448	9.66	112.13
Sheffield Teaching Hospitals NHS Foundation Trust	112350	9748	8.69	112.45

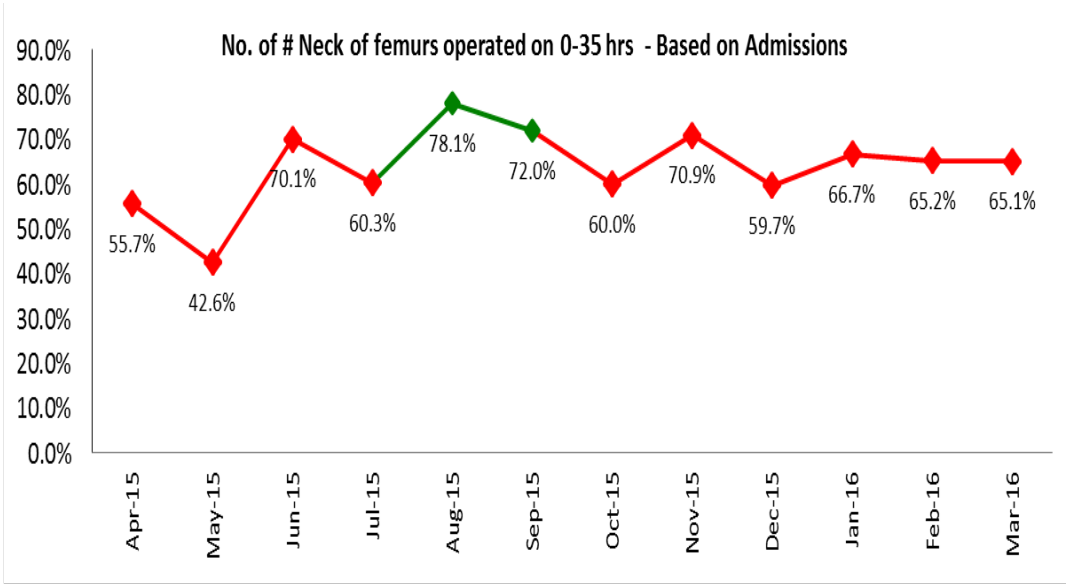
Expected date to meet standard / target	Q3 2016/17 subject to support for the next steps identified
Lead Director / Lead Officer	Andrew Furlong, Interim Medical Director Matt Metcalfe, Deputy Medical Director

No. of # Neck of femurs operated on < 36 hrs

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	March performance	YTD performance FY 15/16	Forecast performance for next reporting period
There were 63 NOF admissions in March 2016, 17 patients breached the 36 hr target to theatre as detailed below:- Medically Unfit – 7pts List over ran therefore pt cancelled Weekend – 4pts LGH transfer for THR – 2pts Higher priority pt – 1 pt ITU Issue– 1pt List over ran weekday – 1pt Required hip surgeon – 1pt Medication issues – 2pts There were also patients who are included in the denominator who did not have surgery in their pathway / RIP'd. Increased number of patients admitted who were not clinically fit for surgery despite ortho geri intervention. These patients were frail and vulnerable on admission and required extensive stabilisation. OG services stretched to capacity and no backfill when pulled to medicine. Reduced numbers of junior medical staff on the NOF ward also affected performance.	The Chief Resident / Trauma schedulers/Clinical aides are now all in post. Additional anaesthetic PA's have been scheduled to provide pre op assessment on certain days. New prioritisation pathways and check lists have been implemented. Discussions ongoing with anaesthesia re additional weekend NOF list cover to extend hours. Breach dates of patients now included on theatre lists and on ORMIS by schedulers. Theatre utilisation is being tracked monthly to optimise usage and reduce downtime between cases. THR's to be undertaken at LRI – training of theatre staff commenced. Raised via CMG board OG cover and gaps in service.	**72.0%**	**65.1%**	**63.8%**	**68%**

Performance by Month for 15/16

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	55.7%	42.6%	70.1%	60.3%	78.1%	72.0%	60.0%	70.9%	59.7%	66.7%	65.2%	65.1%	63.8%



Expected date to meet standard / target	Quarter 2 2016 /2017 dependant on theatre capacity
Revised date to meet standard	
Lead Director / Lead Officer	Richard Power, MSS CD Catherine Chadwick,Head of Operations

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>March performance</th><th>YTD performance</th><th>Forecast performance for next period</th></tr>
<tr><td rowspan="3">The Trust had 232 patients on an incomplete pathway breaching 52 weeks at the end of March. 227 patients were from the Orthodontics Department, one patient was from General Surgery and four patients were from the ENT department.

Orthodontics
The reasons for underperformance in Orthodontics are as follows:
• Incorrect use and management of a planned waiting list.
• Inadequate capacity within the service to see patients when they are ready for treatment.

General Surgery
The General Surgery patient breached due to an administrative error, which meant that a separate pathway was created when the patient was referred from Gastroenterology for treatment of the same condition. This was exacerbated by extremely long waits for first OP appointments in both services and multiple diagnostics, as well as two failed attempts at MRCP.

ENT
The ENT patients breached as a result of administrative errors and the impact of severe winter pressures, which exacerbated the existing fundamental mismatch between demand and capacity in the service.</td><td rowspan="3">Orthodontics
• The Orthodontics service is now closed to referrals with some clinical exceptions.
• With the TDA 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 and are in talks with two further providers, which would guarantee capacity for all patients to be treated in the East Midlands area either in a community provider or a secondary care trust. The service team are in the process of transferring patients to these providers, explaining the drop in reported numbers from the end of February (261). The Trust is reporting weekly to the TDA.

General Surgery
• Both Gastro and General Surgery have reduced their first OP wait through use of IS providers/ super weekends.
• RTT refresher training has been recommended for General Surgery administrative staff.
• This patient was treated on 2nd April.

ENT
• ENT will begin OP clinics using Medinet from 23rd April. The longer term plan will include IP lists as well.
• Recruitment initiatives continue to increase the service's capacity as well as outsourcing some patient cohorts, including Balance.</td><td>0</td><td>232</td><td>232</td><td>197</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 Richard Mitchell;
• Weekly review at Heads of Operations meeting for assurance.

Looking forward
• The Trust is forecasting non-compliance with the RTT standard in quarter 1 of 2016-17 due to the significant impact of winter pressures on the admitted position as well as the deterioration in performance in ENT. While this should not mean that more patients breach 52 weeks, General Surgery and ENT remain very high risk due to the high number of cancellations both services are experiencing, in addition to the impact of the junior doctor strike days.</td></tr>
<tr><td colspan="4">Expected date to meet standard / target</td><td colspan="2">May for non-orthodontic patients</td></tr>
<tr><td colspan="4">Lead Director / Lead Officer</td><td colspan="2">Richard Mitchell, Chief Operating Officer
Will Monaghan, Director of Performance and Information</td></tr>
</table>

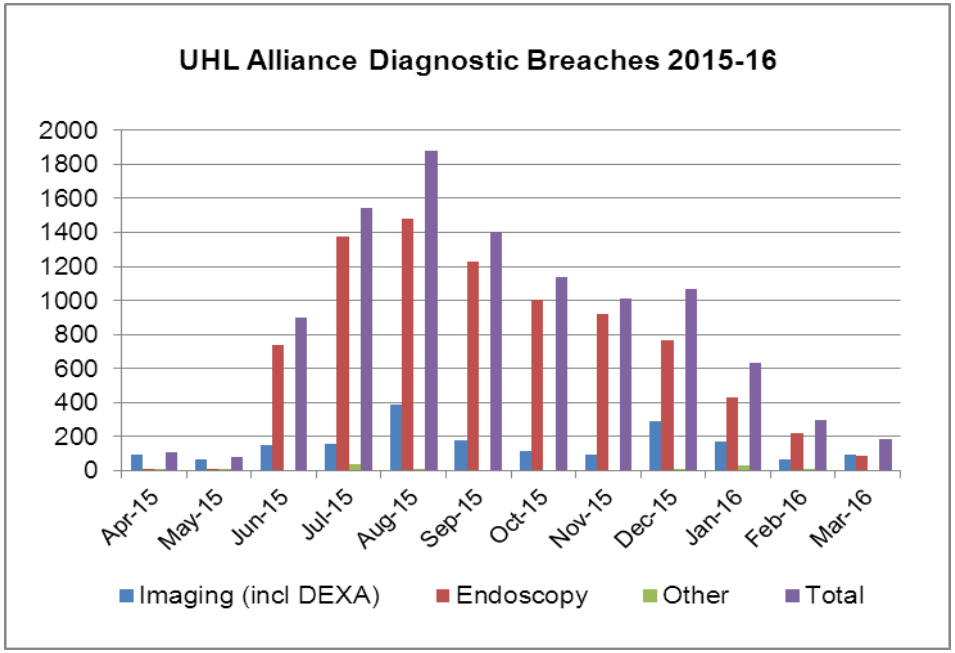
6 Week Diagnostic Test Waiting Times

<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 (UHL Alliance)</th><th>YTD performance (UHL Alliance)</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="3">Imaging
There were 92 Imaging breaches at the end of March with a breakdown of 55 MRIs, 34 CTs, 2 ultrasounds and 1 barium enema. While a proportion of these were cardiac, the position was exacerbated by a high volume of annual leave during March, which could not be covered, as well as unplanned machine down time meaning a small number of patients breached unexpectedly.

Endoscopy
In total there were 88 breaches across UHL and Alliance, the majority of which 35 were endocapsules with no capacity to be booked within month. The rest of the breaches were either propofol patients who could not be booked in month or consultant-only patients for which there was no capacity. All of the Alliance Endoscopy breaches were UHL long waiters.</td><td rowspan="3">The diagnostic backlog has continued to improve from the end of February position with an overall reduction of 1,694 patients breaching 6 weeks from the August high.

Imaging
Machine stability remains an issue; all extra capacity is being utilised in MRI to minimise the number of breaches. Some extra sessions continue that run up to midnight.

Endoscopy
Twice-weekly phone calls are taking place between the Performance function and the Endoscopy service team to ensure momentum and help problem solving. While IS capacity is now being scaled back, there will be 2 Medinet and one Your World list in April to ensure that the capacity lost through the junior doctor strikes is accounted for.

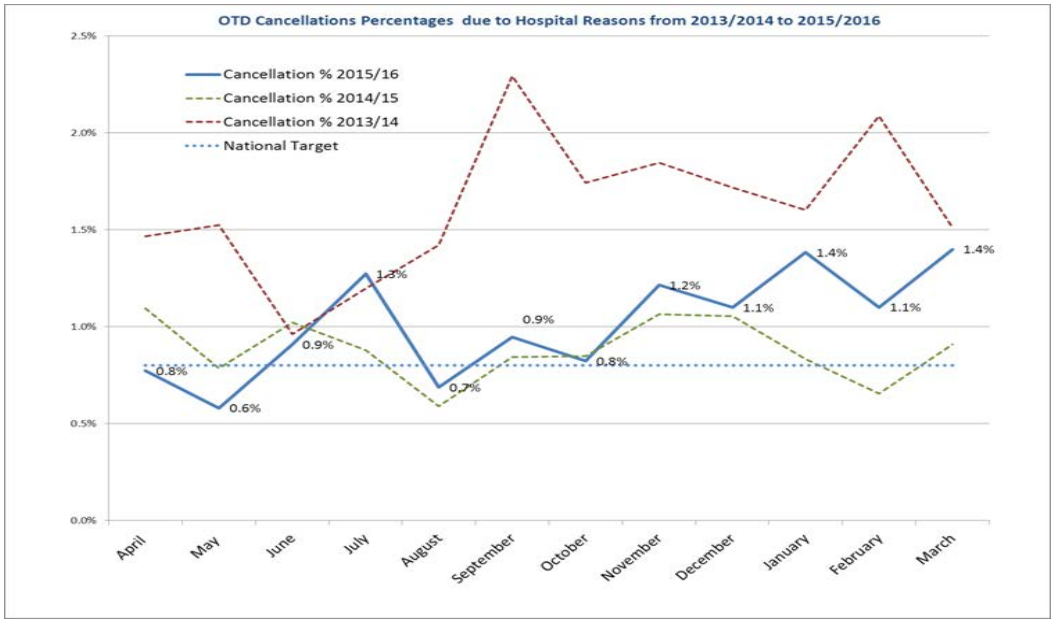
The extra capacity is complemented by a robust action plan addressing general performance issues in the service, with particular focus on ensuring that all lists are fully booked and efforts to improve cancer performance via access to Endoscopy tests.</td><td><1%</td><td>1.1%</td><td>1.1%</td><td><1%</td></tr>
<tr><td colspan="4">The following graph outlines the total number of diagnostic breaches per month for 15-16:
 

The Trust is confident that the overall diagnostic position will be recovered for the end of April 2016.</td></tr>
<tr><td colspan="4"><table>
<tr><td>Expected date to meet standard / target</td><td>April 2016</td></tr>
<tr><td>Lead Director / Lead Officer</td><td>Richard Mitchell, Chief Operating Officer
Suzanne Khalid, Clinical Director CSI</td></tr>
</table></td></tr>
</table>

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	YTD performance (inc Alliance)	Forecast performance for next reporting period
In UHL 60.5% (*90/149)* of cancellations were cancelled due to capacity pressures. The five main reasons for cancellations in UHL were: • Ward bed unavailability (56) • Lack of theatre time due to list over runs (32) • Critical care bed unavailability (26) • Sickness of Surgeons and theatre staff (11) • Patient delayed due to admission of a higher priority patient(8) This month, increasing capacity pressures due to lack of ward beds in LRI, and critical care beds, have impacted on the number of cancellations. The capacity pressures were caused mainly by increase in emergency admissions. A high amount of medical outliers in LRI on the Day ward and the ward 7 led to cancellations. The high outlier numbers also led patient being cancelled the day before which led to a significant increase in 28 day breaches. Due to the adult ward bed and critical care pressures, it is likely that we will see around eight, 28 day breaches next month. Alliance already reported five 28 day breaches for April.	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 high numbers of medical outliers created OTD cancellations and 28 day rebooking of patients. The availability of beds, particularly those in ITU is monitored daily and interventions will be made where necessary. The planned opening of an additional 6 ITU beds at the LRI is anticipated before the end of April. Theatre Managers have increased theatre capacity for the increased cancer demand by making additional lists available. Theatre capacity planning for 2016/17 is well underway and incorporates the increased demand The day ward has now been allocated exclusively for surgical patients in order to try to increase the elective throughput.	1) 0.8% 2) 0	1. 1.4%(1.5% UHL & 1.0% Alliance) 2. 14 (ENT– 6, General Surg -3, Urology 3, Ophthalmology – 1, Maxfax 1)	1) 1.0% (1.0% - UHL & 0.9% Alliance) 2) 49	1) 1.1 % 2) 13



Expected date to meet standard / target	On the day – May 2016 28 day – June 2016
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer 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.

UHL has not met the required standard of <4% for approximately two years. When it has been able to reach this standard, it has not been sustainable.

The two most significant factors causing underperformance are:
• Shortage of outpatient capacity;
• Inadequate training and education of administrative staff in the set up and use of the NHS e-Referral System (ERS).

The specialties with the highest number of ASIs are:
• General Surgery;
• Orthopaedics;
• Paediatric and Adult ENT;
• Gastroenterology;
• Gynaecology.</td><td rowspan="4">Action plan
• An action plan has been written outlining steps for recovering performance. This has been shared with commissioners.

Capacity
• Additional capacity in key specialties is part of RTT recovery and sustainability plans.

Training and Education
• Training and education of staff in key specialties continues, to ensure that the system is adequately set up and administrative processes are fit for purpose;
• Meetings are taking place with the specialties experiencing the highest rate of ASIs, focusing on awareness raising and seeking named accountability.
• Current focus is on working with specialties with no known capacity problems, but high ASI rates to raise awareness and promote accountability.

Additional resource to support the e-Referral System
• The ERS administrator is 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 further notice. A date for publication of these reports has not been confirmed. This means that the Trust is currently unable to track and report on progress in the usual manner.

New Appointment Slot Issue (ASI) Process
In light of the difficulties experienced by services in managing their ASIs on ERS, a new process is being rolled out across all specialties, following a pilot. This process aims to simplify the UHL administrative processes related to ERS as well as promote standardised practice.

Advice and Guidance (A&G)
The Advice and Guidance service within ERS allows a GP to seek clinical advice from a service rather than directly referring into the hospital. Analysis of the last year's A&G requests has found that in 84% of these cases, a referral into UHL is then avoided. This means that of the 460 requests made via A&G, only 68 patients required an outpatient appointment in that specialty.

Advice and Guidance for suspected LOGI cancer patients
A new A&G service launched on 29th March as an alternative to 2ww for LOGI patients. This service allows GPs to request an urgent A&G opinion as opposed to as a 2ww with outpatient clinics running fortnightly for these patients to be seen in if required.</td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="3">To be confirmed</td></tr>
<tr><td>Lead Director / Lead Officer</td><td colspan="3">Richard Mitchell, Chief Operating Officer
Will Monaghan, Director of Performance and Information</td></tr>
</table>

Ambulance handover > 30 minutes and>60 minutes

<table>
<tr><th colspan="2"></th><th>Target</th><th>Mar 16</th><th>YTD</th><th>Forecast</th></tr>
<tr><td>What is causing underperformance?</td><td>What actions have been taken to improve performance?</td><td>0 delays over 15 minutes</td><td>>60 min – 10 11%

30-60 min – 13%</td><td>>60 min - 13%

30-60 min – 19%</td><td>> 60 min - 9%

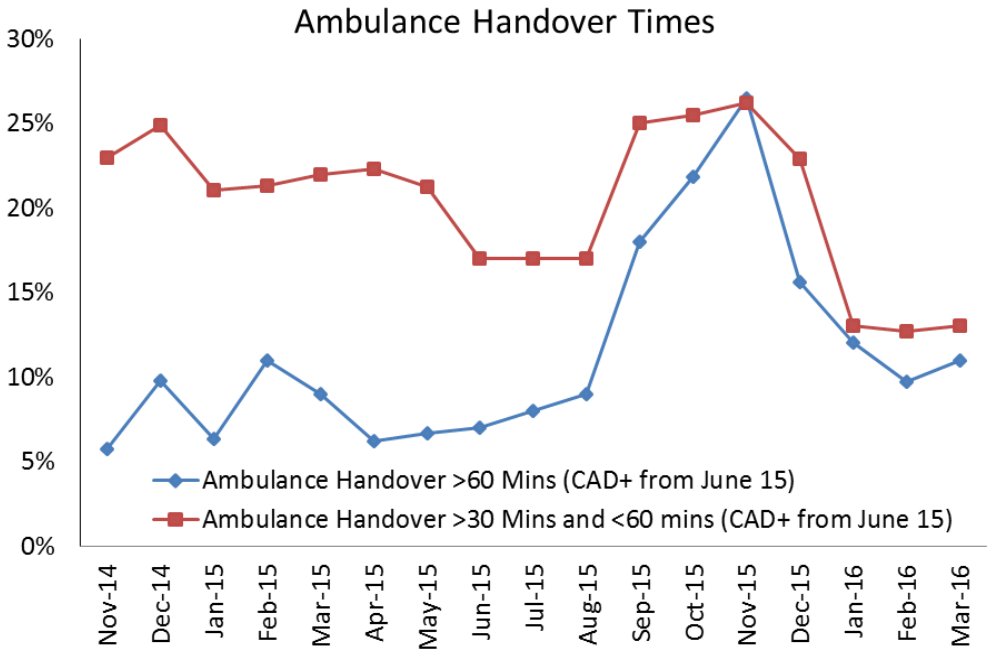
30-60 min – 10%</td></tr>
<tr><td>Difficulties continue in accessing beds and high occupancy in ED leading to congestion in the assessment area and delays ambulance handover.</td><td>CCG's, EMAS and UHL continue to work together to improve ambulance handover times. EMAS and UHL have weekly conference calls to progress actions and identify further opportunities for improvement.

UHL have put in place a Service manager to work with EMAS in hours to ensure handovers are as efficient as possible, with an internal CMG escalation to address any in hour issues. Out of hours a management and escalation process with DOC and CEO is in place.

EMAS have provided staffing to care for patients in the red zones in ED to enable crews to be released earlier to improve handover times. This is in conjunction with other recommendations from the Unipart report.

UHL have implemented a Standard Operating Procedure which ensures that patients attend the right location in ED or are redirected as required. .

UHL have put into place a member of staff to triage patients should they be waiting on the back of ambulances to identify the acuity of patients along with EMAS stating their DPS of the patient on booking into ED.

Two trials have taken place in April to increase major's capacity. This had a positive result on ambulance handovers and as such an extended trial is being planned.</td><td colspan="4">Performance:
 

<table>
<tr><td>Expected date to meet standard</td><td>Internal standard 1 – 0 waits above 60 mins July 2016</td></tr>
<tr><td>Revised date to meet standard</td><td>TBC</td></tr>
<tr><td>Lead Director</td><td>Sam Leak, Director of Emergency Care and ESM CMG</td></tr>
</table></td></tr>
</table>

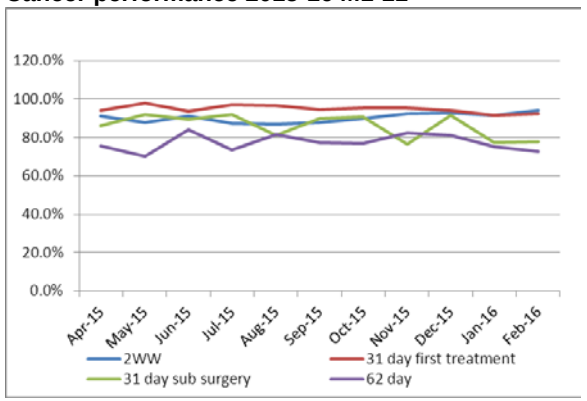
Cancer Waiting Times Performance

What is causing underperformance?	What actions have been taken to improve performance?
31 day first treatment UHL's performance against this standard was 92.4%. This target was predominantly failed as a result of Urology performance; this service has inadequate elective capacity and while RTT lists are regularly taken down to prioritise cancer patients, the tumour site still had thirteen 31 day breaches in February. This accounts for more than half of the Trust's total breaches. **31 day subsequent (surgery)** Performance against this standard in February was 77.9%. This dip in performance has continued from January and can be attributed to severe emergency pressures experienced at UHL throughout February, as well as known capacity gaps in both Urology and Gynae. **62 day RTT** 62 day performance remains below target at 72.8% in February. While this performance is very low, it does mean that a high volume of backlog patients were treated during the month – 51 in total, which is the second highest number of any month in 15-16. 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 and Skin. However, Lower GI, Lung and Urology all treated a large number of backlog patients, which is reflected by their improved backlogs in recent weeks.	Current cancer performance is an area of significant concern across UHL and focus on recovery is one of the Trust's highest priorities. 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 Chief Operating Officer hosted an LiA event to focus on Cancer in November, which was very well attended by clinical and administrative/ management staff both internal and external to the Trust. The key message from this was the patient needed to leave every appointment knowing what the next step is and having it booked. 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. **31 day first treatment:** Recovery in Gynae and Urology are key to the achievement of this standard. Gynae and Urology both have a shortage of theatre capacity; additional long term capacity is in the process of being identified and current arrangements are being complemented by extra sessions/ weekend working. **31 day subsequent (surgery):** Across all tumour sites cancer cases are prioritised over RTT patients, however cancellations due to emergency pressures are having an impact. This is likely to get worse in April due to the four strike days. Significant investment in more clinical staff has also been planned, including a nurse specialist in Urology, which will help improve performance. The key issue in Urology is inadequate elective capacity; as mentioned above plans to increase their theatre capacity are ongoing. **62 day RTT:** Lower GI, Head and Neck, Lung and Urology remain the most pressured tumour sites. Several services are advertising for additional consultant staff including Head and Neck and Skin; however successful recruitment cannot be guaranteed due to shortages of suitable candidates. Improvements in Endoscopy and CT colon implementation are starting to improve performance in Lower/ Upper GI. Three band 7 service managers with responsibility for managing cancer pathways in our worst performing tumour sites are in post and providing the key focus required. 62 day backlog reduction is steadily taking place. 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.

Target (mthly / end of year)	Latest month performance February	Performance to date 2015/16	Forecast performance for March
2WW (Target: 93%)	**93.9%**	**90.2%**	**93%**
31 day 1st (Target: 96%)	**92.4%**	**94.9%**	**91%**
31 day sub – Surgery (Target: 94%)	**77.9%**	**85.7%**	**82%**
62 day RTT (Target: 85%)	**72.8%**	**77.4%**	**77%**
62 day screening (Target: 90%)	**72.5%**	**89.8%**	**88%**

UHL is planning for a growth of 11% in 2WW referrals during 2016-17 and a growth of 9% in patients treated with cancer.

Cancer performance 2015-16 M1-11



Expected date to meet standard / target	62 day pathway: September 2016
Revised date to meet standard	31 day 1st treatment/ 31 day sub – Surgery: June 2016 (prev. May 2016)
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Matt Metcalfe, Clinical Lead for Cancer

Cancer Patients Breaching 104 days

What is causing underperformance?

21 cancer patients on the 62 day pathway breached 104 days at the end of March across five tumour sites.

Tumour site	Number of patients breaching 104 days
Lung	6
Lower GI	6
Gynaecology	2
Head and Neck	2
Urology	5

The following factors have significantly contributed to delays:

Reason	No. patients
Patient fitness	8
Patient compliance	2
Patient choice	2
Anaesthetic review delay	1
Complex diagnostic pathway	4
Patient thinking time	1
Tertiary referral	1
PSA surveillance (Urology)	1
LTFU (Lung)	1

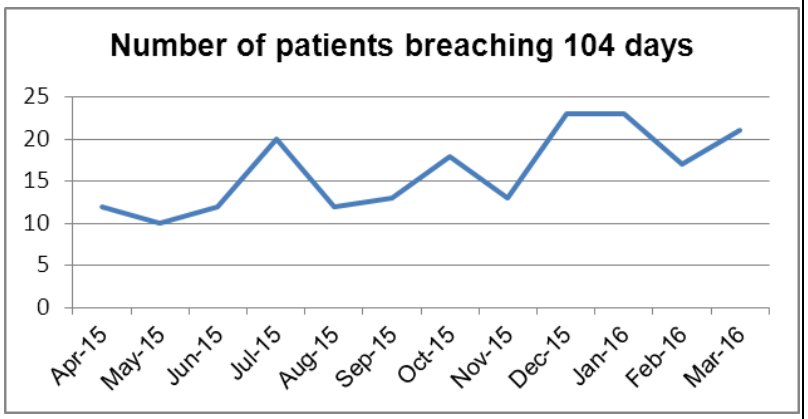
What actions have been taken to improve performance?

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 has increased by 4 from the end of February; however this is driven by over a third of the patients having their treatment delayed due to fitness reasons. A number of these patients are very unwell with either two primary cancers or require cardiac surgery before commencing cancer treatment.

Month by month breakdown of patients breaching 104 days

The graph below outlines the number of cancer patients breaching 104 days by month for 15-16:



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 Matt Metcalfe, Clinical Lead for Cancer