Quality & Performance Report

Author: John Adler Sponsor: Chief Executive Date: IFPIC + QAC 17th December 2015

Executive Summary from CEO

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: **RTT** - The RTT incomplete target remains compliant. This is particularly good in the light of rising referrals. . The NHS has failed this target as a whole which makes our compliance increasingly rare. **DTOC** - Delayed transfers of care continues to remain well within the tolerance which reflects the good work that continues across the system in this area. **MRSA** - remains at zero for the year. **Annual appraisals rates** – continue to improve for the 3rd month in a row. **C DIFF** – within monthly and year to date trajectory. This continues to be closely monitored in respect of antibiotic prescribing controls and cleaning standards. **Pressure Ulcers** - there were zero avoidable **Grade 4** pressure ulcers reported for the 8th consecutive month. **Fractured NOF** – performance much improved at 72.5% after the dip in performance last month.

Bad News:

ED 4 hour performance- was 81.7% which for now the fourth month in a row was worse than the corresponding month the year before. It has slipped to 90.0% year to date. This continues to be primarily driven by record ED attendances and emergency admissions but has also been contributed to by staffing issues. Further detail is in the Chief Operating Officer's Emergency Care report. **Referral to Treament 52+ week waits.** We are struggling to bring down these long waits due to an inability to recruit additional consultants or to find capacity at other providers. This is an issue of national significance due to the numbers involved. **Diagnostics** - There has been slight improvement in month with performance estimated at 6.5%. This is behind the planned recovery trajectory and should be further explored by IFPIC. **Cancelled operations** and **patients rebooked within 28 days** - were both non-compliant, predominantly due to increased adult and children emergencies cancelling last minute cancellations. **Cancer Standards -** the 62

day backlog remains high. A Remedial Action Plan has been submitted to commissioners with a revised compliance date of June 2016, although we are aiming for March 2016. **Ambulance Handover** – again a very challenging month for Ambulance handovers, directly linked to the emergency demand referenced above. This remains a serious risk in the system.

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: 17th December 2015

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

November 2015

One team shared values

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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

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

DATE: **17th DECEMBER 2015**

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

SUBJECT: **NOVEMBER 2015 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	0
Caring	5	10	3	0
Well Led	6	18	6	2
Effective	7	16	3	1
Responsive	8	17	2	9
Responsive Cancer	9	9	0	5
Research – UHL	11	6	6	0
Total		98	38	17

3.0 New Indicators

None.

4.0 Indicators removed

None.

5.0 Indicators where reporting methodology/thresholds have changed

None.

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	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	YTD
Safe	S1	Clostridium Difficile	JS	DJ	61	TDA	Red if >mthly threshold / ER if Red or Non compliance with cumulative target	66	73	5	7	7	11	7	5	7	3	1	4	4	6	6	6	4	34
	S2a	MRSA Bacteraemias (All)	JS	DJ	0	TDA	Red if >0 ER if >0	3	6	1	1	0	2	0	1	1	0	0	0	0	0	0	0	0	0
	S2b	MRSA Bacteraemias (Avoidable)	JS	DJ	0	UHL	Red if >0 ER if >0	1	1	0	0	0	0	0	1	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	0	1	0	1	1	0	0	0	0	0	0	0	1	0	0	1
	S4	Serious Incidents	JS	MD	Not within Highest Decile	TDA	TBC	60	41	3	4	2	4	3	2	1	2	8	1	5	3	5	3	4	31
	S5a	Proportion of reported safety incidents per 1000 beddays	JS	MD	TBC	TDA	TBC	37.5	39.1	41.8	38.9	40.3	40.4	35.0	38.2	36.3	34.6	37.3	39.6	39.9	37.1	33.6	38.7	34.6	36.9
	S5b	Proportion of reported safety incidents that are harmful	JS	MD	Not within Highest Decile	TDA	TBC	2.8%	1.9%	2.2%	1.4%			2.3%			2.2%			1.9%					2.1%
	S6	Overdue CAS alerts	JS	MD	0	TDA	Red if >0 in mth ER = in mth >0	2	10	0	0	0	0	0	0	1	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	1	2	2	1	0	3	2	0	6	0	0	2	3	7	2	20
	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%	93.9%	94.9%	93.3%	94.1%	95.0%	92.1%	93.6%	93.7%	94.3%	95.6%	94.6%	93.2%	94.0%	93.5%	94.2%	94.2%
	S8b	Safety Thermometer % number of new harms	JS	EM	Not within Lowest Decile	TDA	TBC	New TDA Indicator		2.5%	2.3%	3.3%	2.4%	2.5%	3.2%	2.7%	2.2%	2.6%	2.1%	1.9%	3.1%	2.4%	2.6%	2.7%	2.4%
	S9	% of all adults who have had VTE risk assessment on adm to hosp	AF	SH	95% or above	TDA	Red if <95% ER if in mth <95%	95.3%	95.8%	96.2%	95.4%	95.5%	95.0%	96.3%	96.2%	95.6%	96.0%	96.0%	96.5%	96.2%	96.5%	96.1%	95.7%	96.0%	96.1%
	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	5.9	6.4	7.5	6.9	7.1	6.7	6.3	5.7	5.8	5.0	5.7	5.7	4.1	5.2	4.3	5.2
	S12	Avoidable Pressure Ulcers - Grade 4	JS	MC	0	QS	Red / ER if Non compliance with monthly target	1	2	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0
	S13	Avoidable Pressure Ulcers - Grade 3	JS	MC	<=6 a month	QS	Red / ER if Non compliance with monthly target	71	69	6	4	6	7	5	9	6	3	0	4	1	4	1	1	1	15
	S14	Avoidable Pressure Ulcers - Grade 2	JS	MC	<=8 a month	QS	Red / ER if Non compliance with monthly target	120	91	4	8	13	11	7	5	9	10	8	8	8	10	11	5	4	64
	S15	Compliance with the SEPSIS6 Care Bundle	AF	JP	All 6 >75% by Q4	QC	Red/ER if Non compliance with Quarterly target	27.0%	<65%	>=60%	<65%			<75%			AUDIT IN PROGESS								
	S16	Maternal Deaths	AF	IS	0	UHL	Red or ER if >0	3	1	0	0	0	0	1	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%	17.4%	18.1%	17.4%	16.2%	17.7%	15.5%	15.8%	15.3%	18.8%	15.8%	15.8%	15.2%	16.5%	20.9%	19.7%	17.3%
	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

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	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	YTD
C1	Inpatients (Including Daycases) Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <95% ER if 2 mths Red	New Indicator	96%	97%	96%	96%	96%	96%	96%	97%	96%	96%	97%	96%	97%	97%	97%	96%	96%
C2	A&E Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <94% ER if 2 mths Red	New Indicator	96%	95%	96%	96%	96%	96%	96%	97%	96%	96%	96%	96%	97%	95%	95%	97%	96%
C3	Outpatients Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <90% ER if 2 mths Red	NEW METHODOLOGY FOR CALCULATING %									94%	94%	93%	91%	93%	93%	93%	92%	93%
C4	Daycase Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <95% ER if 2 mths Red										96%	97%	97%	98%	98%	97%	98%	98%	97%
C5	Maternity Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <94% ER if 2 mths Red		96%	94%	96%	97%	95%	97%	96%	96%	95%	96%	95%	95%	96%	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%		Q3 staff FFT not completed as National Survey carried out			71.4%			68.7%			71.9%					70.3%
C7a	Complaints Rate per 100 bed days	AF	MD	TBC	UHL	TBC	New Indicator	0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3
C7b	Written Complaints Received Rate per 100 bed days	AF	MD	Not within Highest Decile	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	
C8	Complaints Re-Opened Rate	AF	MD	<=12%	UHL	Red if >=15% ER if >=15%	New Indicator	10%	9%	11%	11%	10%	17%	13%	11%	13%	7%	7%	7%	11%	11%	8%	9%	9%
C9	Single Sex Accommodation Breaches (patients affected)	JS	HL	0	TDA	Red / ER if >0	2	13	0	0	5	0	1	0	0	0	0	0	0	0	0	0	0	0

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Well Led

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	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	YTD
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%	32.2%
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%	24.5%
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%	14.0%
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%
W5	Maternity Friends and Family Test - Coverage	JS	HL	30%	UHL	Red if <26% ER if 2 mths Red	25.2%	28.0%	18.7%	15.8%	21.7%	22.1%	25.8%	46.5%	40.2%	32.3%	35.8%	32.6%	25.6%	30.5%	27.9%	27.2%	38.8%	31.3%
W6	Friends & Family staff survey: % of staff who would recommend the trust as place to work	LT	BK	Not within Lowest Decile	TDA	TBC	New Indicator	54.2%	53.7%	Q3 staff FFT not completed as National Survey carried out			54.9%			52.5%			55.7%					54.0%
W7a	Nursing Vacancies	JS	MM	5% by Mar 16	UHL	Separate report submitted to QAC	NEW UHL INDICATOR		6.7%	6.7%	6.4%	6.0%	6.3%	5.5%	6.5%	8.5%	8.0%	7.3%	8.7%	8.9%	8.5%	7.1%	7.6%	7.6%
W7b	Nursing Vacancies in ESM CMG	JS	MM	5% by Mar 16	UHL	Separate report submitted to QAC	NEW UHL INDICATOR		10.8%	10.8%	10.7%	9.7%	12.8%	11.4%	14.0%	19.3%	13.0%	14.4%	13.3%	13.5%	13.5%	12.9%	14.6%	14.6%
W8	Turnover Rate	LT	LG	Not within Lowest Decile	TDA	Red = 11% or above ER = Red for 3 Consecutive Mths	10.0%	11.5%	10.3%	10.8%	10.7%	10.3%	10.1%	10.1%	11.5%	10.4%	10.5%	10.5%	10.6%	10.4%	10.4%	10.2%	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%	3.7%	4.0%	4.0%	4.4%	4.2%	4.1%	4.0%	3.6%	3.4%	3.4%	3.3%	3.2%	3.3%	3.7%		3.4%
W10	Temporary costs and overtime as a % of total paybill	LT	LG	TBC	TDA	TBC	New Indicator	9.4%	8.5%	9.5%	9.0%	9.8%	10.5%	9.8%	11.5%	10.7%	10.2%	11.0%	10.8%	11.1%	9.9%	10.5%	10.5%	10.4%
W11	% of Staff with Annual Appraisal	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	91.3%	91.4%	89.7%	91.8%	92.3%	92.5%	90.9%	91.0%	91.4%	90.1%	88.7%	89.0%	89.1%	88.8%	90.0%	90.4%	91.1%	91.1%
W12	Statutory and Mandatory Training	LT	BK	95%	UHL	TBC	76%	95%	85%	86%	87%	89%	89%	90%	95%	93%	92%	92%	91%	91%	91%	92%	92%	92%
W13	% Corporate Induction attendance	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	94.5%	100%	98%	98%	98%	100%	99%	100%	97%	97%	97%	98%	100%	97%	98%	98%	97%	97%
W14a	DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	Not within Lowest Decile	TDA	TBC	New Indicator	91.2%	91.6%	92.9%	91.3%	92.7%	94.3%	91.8%	91.0%	93.6%	90.3%	91.2%	90.3%	90.2%	90.5%	91.4%	87.2%	90.6%
W14b	DAY Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	Not within Lowest Decile	TDA	TBC		94.0%	90.3%	95.4%	94.4%	95.8%	95.4%	92.8%	92.5%	94.2%	91.2%	93.5%	91.3%	92.4%	93.1%	94.2%	93.2%	92.9%
W14c	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	Not within Lowest Decile	TDA	TBC		94.9%	94.8%	97.4%	96.5%	96.4%	97.9%	96.5%	97.2%	98.9%	96.0%	96.2%	94.3%	94.3%	94.9%	96.1%	91.4%	95.3%
W14d	NIGHT Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	Not within Lowest Decile	TDA	TBC		99.8%	97.8%	100.8%	101.2%	101.4%	103.6%	100.8%	103.2%	106.3%	98.7%	99.4%	101.2%	98.0%	100.0%	99.9%	98.4%	100.3%

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	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	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	YTD
Effective	E1	Mortality - Published SHMI	AF	PR	Within Expected	TDA	Higher than Expected	105	103	106 (Jan13-Dec13)	105 (Apr13-Mar14)			105 (Jul13-Jun14)			103 (Oct13-Sep14)			99 (Jan14-Dec 14)			98 (Apr14-Mar15)		
	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	101	101	100	99	99	98	98	98	96	95	95	Awaiting HED Update				95
	E3	Mortality HSMR (DFI Quarterly)	AF	PR	Within Expected	TDA	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	88	94	92	93			93			85			Awaiting DFI Update					85
	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	95	95	94	94	94	93	93	93	Awaiting HED Update			93
	E5	Mortality - Monthly HSMR (Rebased Monthly as reported in HED)	AF	PR	Within Expected	QC	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	91	94	97	95	88	95	99	98	86	83	96	99	85	88	Awaiting HED Update			90
	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	99	96			106			93			Awaiting DFI Update					93
	E7	Crude Mortality Rate Emergency Spells	AF	PR	Within Upper Decile	TDA	TBC	2.5%	2.4%	2.3%	2.1%	2.3%	3.0%	3.1%	2.7%	2.4%	2.1%	2.0%	2.3%	1.8%	2.0%	2.2%	2.4%	2.1%	2.1%
	E8	Deaths in low risk conditions (Risk Score)	AF	PR	Within Expected	TDA	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	94	80	58	111	59	84	100	86	74	120	20	37	38	102	Awaiting HED Update			62
	E9	Emergency readmissions within 30 days following an elective or emergency spell	AF	JJ	Within Expected	UHL	Red if >7% ER if 3 consecutive mths >7%	7.9%	8.5%	8.4%	8.6%	8.9%	9.1%	8.2%	8.5%	8.5%	9.2%	9.1%	9.0%	8.8%	8.9%	8.7%	9.0%		9.0%
	E10	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	AF	RP	72% or above	QS	Red if <72% ER if 2 consecutive mths <72%	65.2%	61.4%	68.6%	69.6%	59.4%	57.3%	57.9%	67.2%	61.5%	55.7%	42.6%	70.1%	60.3%	78.1%	72.0%	60.0%	72.5%	64.1%
	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%	83.2%	69.4%	72.4%	74.3%	82.5%	87.6%	81.5%	83.7%	84.5%	84.5%	85.7%	90.9%	86.9%	81.1%		85.4%
	E12	Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA)	RM	IL	60% or above	QS	Red if <60% ER if 2 consecutive mths <60%	64.2%	71.2%	72.7%	67.8%	69.0%	83.5%	80.6%	64.0%	77.3%	86.3%	79.6%	72.0%	78.9%	80.2%	88.1%	73.3%	67.1%	78.0%
	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																	

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	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	YTD
R1	ED 4 Hour Waits UHL + UCC (Calendar Month)	RM	IL	95% or above	TDA	Red if <92% ER via ED TB report	88.4%	89.1%	91.6%	89.8%	89.1%	83.0%	90.7%	89.6%	91.1%	92.0%	92.2%	92.6%	92.2%	90.6%	90.3%	88.9%	81.7%	90.0%
R2	12 hour trolley waits in A&E	RM	IL	0	TDA	Red if >0 ER via ED TB report	5	4	0	1	0	0	1	0	0	0	0	0	0	0	0	0	1	1
R3	RTT - Incomplete 92% in 18 Weeks	RM	WM	92% or above	TDA	Red /ER if <92%	92.1%	96.7%	94.3%	94.8%	95.0%	95.1%	95.2%	96.2%	96.7%	96.6%	96.5%	96.2%	95.2%	94.3%	94.8%	93.6%	93.8%	93.8%
R4	RTT 52 Weeks+ Wait (Incompletes)	RM	WM	0	TDA	Red /ER if >0	0	0	3	3	2	0	0	0	0	0	66	242	256	258	260	265	263	263
R5	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	TDA	Red /ER if >1%	1.9%	0.9%	1.0%	0.7%	1.8%	2.2%	5.0%	0.8%	0.9%	0.8%	0.6%	6.1%	10.9%	13.4%	9.6%	7.7%	6.5%	6.5%
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	2	2	0	3	4	3	1	2	0	1	1	5	1	0	3	13
R8	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	RM	PW	0	TDA	Red if >2 ER if >0	New Indicator for 14/15	11	0	0	1	1	2	1	0	0	0	1	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%	0.8%	1.2%	1.1%	0.8%	0.7%	1.0%	0.7%	0.5%	0.9%	1.3%	0.7%	0.9%	0.8%	1.3%	0.9%
R10	% Operations cancelled for non-clinical reasons on or after the day of admission ALLIANCE	RM	PW	0.8% or below	Contract	Red if >0.9% ER if >0.8%	1.6%	0.9%	0.9%	1.0%	0.0%	0.8%	1.4%	0.0%	0.4%	1.2%	1.2%	1.0%	0.8%	--	1.0%	1.1%	--	0.8%
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%	0.8%	1.1%	1.1%	0.8%	0.7%	0.9%	0.8%	0.6%	0.9%	1.3%	0.7%	0.9%	0.8%	1.2%	0.9%
R12	No of Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	N/A	UHL	TBC	1739	1071	90	94	108	102	85	64	98	79	56	97	138	67	104	91	131	763
R13	Outpatient Hospital Cancellation Rates	RM	PW	Within Upper Decile	UHL	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	
R14	Delayed transfers of care	RM	PW	3.5% or below	TDA	Red if >3.5% ER if Red for 3 consecutive mths	4.1%	3.9%	4.5%	4.6%	5.2%	3.9%	3.2%	2.9%	1.8%	1.2%	1.0%	1.0%	0.9%	1.2%	1.3%	1.1%	1.3%	1.1%
R15	NHS e-Referral (formally Choose and Book Slot Unavailability)	RM	WM	4% or below	Contract	Red if >4% ER if Red for 3 consecutive mths	13%	21%	25%	20%	17%	16%	13%	19%	26%	34%	31%	Data Not Available						
R16	Ambulance Handover >60 Mins (CAD+ from June 15)	RM	PW	0	Contract	Red if >0 ER if Red for 3 consecutive mths	New Indicator for 14/15	5%	2%	5%	6%	10%	6%	11%	9%	6%	7%	7%	8%	9%	18%	22%	27%	13%
R17	Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)	RM	PW	0	Contract	Red if >0 ER if Red for 3 consecutive mths	New Indicator for 14/15	19%	17%	25%	23%	25%	21%	21%	22%	22%	21%	17%	17%	17%	25%	26%	26%	21%

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	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	YTD
** Cancer statistics are reported a month in arrears.																							
RC1	Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	RM	MM	93% or above	TDA	Red if <93% ER if Red for 2 consecutive mths	94.8%	92.2%	92.0%	92.5%	93.0%	92.2%	93.5%	91.5%	91.2%	87.9%	91.1%	87.4%	86.8%	88.7%	90.0%	**	88.9%
RC2	Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	RM	MM	93% or above	TDA	Red if <93% ER if Red for 2 consecutive mths	94.0%	94.1%	98.6%	100.0%	93.0%	92.5%	91.5%	96.0%	99.0%	98.8%	87.2%	93.3%	98.7%	94.5%	94.6%	**	95.1%
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%	95.9%	92.5%	95.2%	91.7%	95.0%	97.0%	93.9%	97.9%	93.7%	97.2%	96.5%	94.7%	95.2%	**	95.6%
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%	97.1%	100.0%	96.7%	100.0%	100.0%	100.0%	100.0%	100.0%	97.7%	100.0%	98.3%	100.0%	100.0%	**	99.4%
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%	81.9%	82.4%	80.3%	89.2%	94.4%	87.5%	86.3%	92.2%	89.6%	92.2%	81.1%	89.7%	90.6%	**	88.8%
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%	96.0%	94.7%	95.5%	87.6%	99.0%	100.0%	86.3%	98.1%	96.5%	95.9%	99.0%	92.2%	94.0%	**	94.8%
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%	80.4%	77.0%	84.8%	79.3%	78.9%	83.8%	75.7%	70.1%	84.2%	73.7%	81.7%	77.2%	77.0%	**	77.2%
RC8	62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	RM	MM	90% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	95.6%	84.5%	75.0%	94.4%	93.8%	88.9%	79.4%	89.3%	91.7%	82.4%	93.3%	95.2%	97.1%	81.4%	96.2%	**	91.1%
RC9	Cancer waiting 104 days	RM	MM	0	TDA	TBC	NEW TDA INDICATOR								12	10	12	20	12	12	17	13	13

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	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	YTD
RC10	Brain/Central Nervous System	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	100.0%	--	--	--	--	--	--	--	--	100.0%	--	--	--	--	--	**	100.0%
RC11	Breast	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	96.1%	92.6%	96.3%	81.8%	100.0%	93.3%	97.4%	98.1%	92.3%	96.8%	97.8%	91.4%	96.3%	97.5%	92.0%	**	95.0%
RC12	Gynaecological	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	88.2%	77.5%	71.4%	75.0%	66.7%	54.5%	91.7%	75.0%	64.3%	55.6%	66.7%	100.0%	72.2%	80.0%	84.6%	**	74.1%
RC13	Haematological	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	65.9%	66.5%	100.0%	73.3%	75.0%	66.7%	50.0%	80.0%	50.0%	55.0%	83.3%	37.5%	82.6%	66.7%	70.0%	**	63.5%
RC14	Head and Neck	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	65.4%	69.9%	100.0%	33.3%	77.8%	70.0%	87.5%	62.5%	75.0%	54.5%	66.7%	36.4%	60.9%	50.0%	75.0%	**	56.7%
RC15	Lower Gastrointestinal Cancer	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	71.3%	63.7%	56.3%	62.5%	92.9%	65.0%	46.7%	63.2%	63.6%	55.6%	93.3%	63.6%	60.0%	38.9%	70.6%	**	62.9%
RC16	Lung	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	89.7%	69.9%	68.9%	64.1%	74.4%	67.7%	74.2%	88.6%	84.6%	50.9%	74.6%	81.8%	70.4%	73.5%	65.2%	**	70.4%
RC17	Other	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	78.7%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100%	100%	100%	100%	50.0%	60.0%	**	70.4%
RC18	Sarcoma	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	82.9%	46.2%	--	0.0%	0.0%	100.0%	--	0.0%	66.7%	--	100%	--	--	80.0%	50.0%	**	75.0%
RC19	Skin	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	96.8%	96.7%	94.5%	98.4%	94.1%	100.0%	94.3%	95.6%	91.7%	94.0%	91.3%	93.8%	94.1%	96.7%	91.1%	**	93.3%
RC20	Upper Gastrointestinal Cancer	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	72.2%	73.9%	33.3%	64.7%	68.0%	85.7%	77.8%	81.8%	66.7%	55.0%	84.6%	51.4%	81.8%	45.7%	48.6%	**	60.4%
RC21	Urological (excluding testicular)	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	89.3%	82.6%	84.5%	81.5%	85.7%	83.3%	66.7%	71.0%	62.1%	62.1%	74.7%	61.5%	86.1%	80.4%	80.0%	**	73.3%
RC22	Rare Cancers	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	92.3%	84.6%	100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	--	100%	100%	100%	100.0%	100.0%	100.0%	**	100%
RC23	Grand Total	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	86.7%	81.4%	80.4%	77.0%	84.8%	79.3%	78.9%	83.7%	75.7%	70.1%	84.2%	73.7%	81.7%	77.2%	77.0%	**	77.2%

Compliance Forecast for Key Responsive Indicators

Standard	November actual/predicted	December predicted	Month by which to be compliant	RAG rating of required month delivery	Commentary
Emergency Care					
4+ hr Wait (95%) - Calendar month	81.7%		March, 2016		
Ambulance Handover (CAD+)					
% Ambulance Handover >60 Mins (CAD+)	27%		Not Confirmed		An eight-week action plan has been agreed to speed up the time it takes for EMAS crews to pass patients to A&E staff at Leicester Royal Infirmary. November data expected this week.
% Ambulance Handover >30 Mins and <60 mins (CAD+)	26%		Not Confirmed		
RTT (inc Alliance)					
Incomplete (92%)	93.8%	93.5%			
Diagnostic (predicted)					
DM01 - diagnostics 6+ week waits (<1%)	6.5%		February, 2016		NHS IQ Work progressing.
# Neck of femurs					
% operated on within 36hrs - admissions (72%)	72.0%	72.0%			August and September delivered for the first time in over a year.
Cancelled Ops (inc Alliance)					
Cancelled Ops (0.8%)	1.2%	0.8%	December		November target missed due to increased emergency pressures.
Not Rebooked within 28 days (0 patients)	3	4	January, 2016		December at risk - to be validated.
Cancer (predicted)					
Two Week Wait (93%)	93%	93%	November		At risk for November.
31 Day First Treatment (96%)	92%	85%	February, 2016		Delivery rephased.
31 Day Subsequent Surgery Treatment (94%)	88%	90%	January, 2016		Delivery rephased.
62 Days (85%)	78%	80%	June, 2016		The rephasing of delivery has been revised to June 2016, given the challenge we and other centres are experiencing and the backlog not being where we need it to be. Nationally this target hasn't been achieved since April 2014.
Cancer waiting 104 days (0 patients)	13	13			

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)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	YTD
Research UHL	RU1	Median Days from submission to Trust approval (Portfolio)	AF	NB	TBC	TBC	TBC	3.0			2.0			3.0			3.0			2.8	2.0			1.0				2.0
	RU2	Median Days from submission to Trust approval (Non Portfolio)	AF	NB	TBC	TBC	TBC	2.0			3.5			2.0			1.0			2.1	4.0			1.0				4.0
	RU3	Recruitment to Portfolio Studies	AF	NB	Aspirational target=10920/year (910/month)	TBC	TBC	941	1092	963	1075	1235	900	1039	1048	604	1030	1043	1298	12564	1078	869	1165	999	862	979	1255	7207
	RU4	% Adjusted Trials Meeting 70 day Benchmark (data sunbmitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC	(Jul13-Jun14) 43.4%			(Oct13-Sep14) 70.5%			(Nov13-Dec14) 70.5%			(Apr14-Mar15) 86%				(Jul14-Jun15) 76%			NIHR Report not yet available				76%
	RU5	Rank No. Trials Submitted for 70 day Benchmark (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC	(Jul13-Jun14) Rank 17/61			(Oct13-Sep14) Rank 18/60			(Nov13-Dec14) Rank 18/59			(Apr14-Mar15) Rank 60/198				ul14-Jun15) 108/2			NIHR Report not yet available				108/210
	RU6	%Closed Commercial Trials Meeting Recruitment Target (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC	(Jul13-Jun14) 50%			(Oct13-Sep14) 52%			(Nov13-Dec14) 48%			(Apr14-Mar15) 38.6%				(Jul14-Jun15) 15.3%			NIHR Report not yet available				15.3%

Emergency Readmissions within 30 days

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	October performance	YTD performance	Forecast performance for next reporting period
UHL's readmission rate has increased during 15/16 and when compared with other Trusts (using the Dr Foster tool) our 'risk adjusted readmission rate' has been higher than expected for the past 3 years.	A 'Readmissions Review' CQUIN was agreed with Commissioners for 15/16 and the Review has now been complete. This highlighted a need for: Better identification of patients at risk of readmission, in order to inform discharge planning and community follow up and support. Following review of the different Readmission Risk tools available, it has been agreed to proceed with the PARR30 tool as this can be automated from data available in the Trust's data warehouse. Discussions are taking place with the City and County Integrated Community Response Services to confirm what support can be provided for patients identified as being at risk. Further data needed to inform this discussion. Joint care planning for patients with Long Term Conditions and End of Life Care Needs. Actions being taken are to investigate the most effective IT solution for sharing care planning between LLR organisations. Long term catheter service in the community. At a meeting with LPT nursing services, a project plan has been agreed to commence 1st Jan.. Further review of internal data has identified some Speciality shows some 'hot spots', some of whom have plans in place to reduce their rates – eg 'Hot Gall Bladder Service' in General Surgery and 'Ambulatory Care Clinic' in CDU.	**Within Expected**	**9.0%**	**9.0%**	**9.0%**

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

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

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

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

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

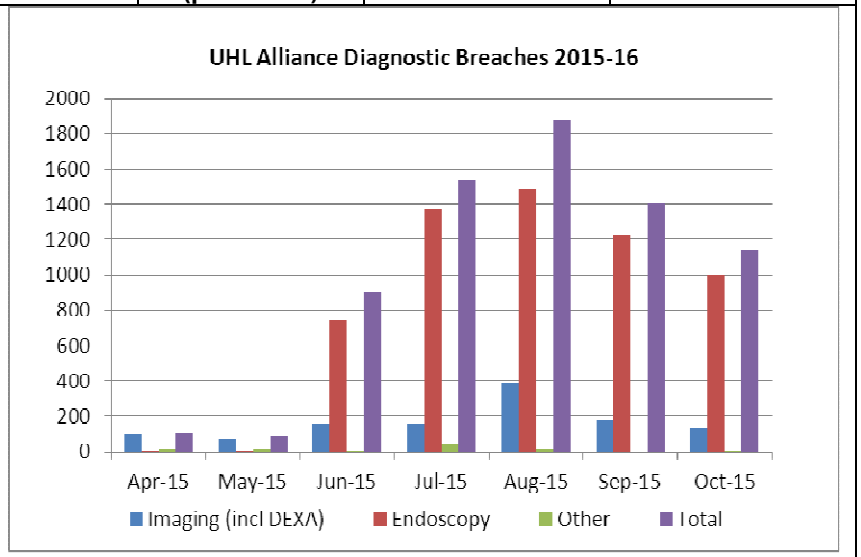
52 week breaches (incompletes)

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>November performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="4">The Trust had 263 patients on an incomplete pathway that breached 52 weeks at the end of October 2015. All patients were from the Orthodontics Department.

The reasons for underperformance in Orthodontics are as follows:
• Incorrect use and management of a planned waiting list for outpatients.
• Inadequate capacity within the service to see patients when they are ready for treatment.
• There are currently 10 patients on the waiting list between 40 and 51 weeks, who are likely to roll over to become 52 week breaches.</td><td rowspan="4">• The service is now closed to new referrals with some clinical exceptions. Adherence to this is being monitored by the Director of Performance and Information.
• Funding has been secured from NHS England for 2 WTE locums to clear the backlog. So far, recruitment attempts have been unsuccessful.
• The Serious Untoward Incident (SUI) report was recently published. Recommendations included a clearly defined SOP to be put in place for the administration of planned waiting lists and that all administrative and clinical staff running outpatient clinics should have RTT e-learning training.
• UHL are exploring capacity for Orthodontics patients within both community and acute providers in the local area. Around 24 patients will transfer to Northampton General Hospital, approximately 20 are expected to be treated at Oakham Dental Studio and 77 patients will go to Clearly Orthodontics once contracts have been signed. Additional capacity is being explored with Hallcross Dental, Manor House, United Lincolnshire Hospitals NHS Trust and Ramsay Healthcare</td><td>0</td><td>263</td><td>263</td><td>c. 260</td></tr>
<tr><td colspan="4">The problem which surfaced in Orthodontics has prompted a deliberate, Trust-wide review of planned waiting lists at specialty level. Therefore the following actions have been taken Trust-wide:
• Communication around planned waiting list management to all relevant staff;
• System review of all waiting list codes;
• All General Managers and Heads of Service have signed a letter confirming review and assurance of all waiting lists, to be returned to Richard Mitchell;
• Weekly review at Heads of Ops meeting for assurance;
• Performance team to review all waiting list code returns and identify areas of risk.</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">TBC</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Richard Mitchell, Chief Operating Officer
Will Monaghan, Director of Performance and Information</td></tr>
</table>

6 Week Diagnostic Test Waiting Times

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance (UHL Alliance)	YTD performance (UHL Alliance)	Forecast performance for next month
Imaging Although final validated numbers for November are not yet confirmed, we are expecting c.100 MRI breaches for November. This was due to unplanned scanned downtime. **Endoscopy** An issue with planned waiting lists in Endoscopy surfaced in May 2015. There were 682 breaches for November 2015 across flexible sigmoidoscopy, gastroscopy and colonoscopy, an improvement from the October position. Capacity and demand review in Endoscopy has identified that the Trust is short of approximately 8-10 lists per week.	**Imaging** Machine stability remains an issue; all extra capacity is being utilised in MRI to minimise the number of breaches. An MRI van will be on site for two weeks in January and we are currently exploring the feasibility of extending outpatient MRI times to beyond the current end of 8pm. Approximately 100 MRIs are being sent to Nuffield each month. **Endoscopy** The Trust is working with a number of IS providers to obtain extra capacity, including Medinet, Circle, Your World Doctors and Nuffield. Your World Doctors are also backfilling lists during the week, which would otherwise be cancelled. The Trust will also be part of an initiative led by the Tripartite around securing extra capacity within the Independent Sector and other NHS Trusts for Endoscopy, UHL has submitted its requirements for this process but so far has obtained no extra capacity via this route. The extra capacity is complemented by a robust action plan aimed at addressing general performance issues in Gastroenterology, with particular focus on ensuring that all lists are fully booked and efforts to improve Cancer performance via access to Endoscopy tests. There has also been a management review in the department and an Endoscopy Manager has been appointed to focus solely on the service, in post since early September. The Trust invited the IST to assist with capacity analysis, this has confirmed the shortfall that exists. In addition NHSIQ have been working in the endoscopy units alongside our teams on process improvements.	**<1%**	**6.5% (predicted)**	**6.5% (predicted)**	**TBC**



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

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

	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
UHL	0.9%	0.6%	6.97%	12.40%	14.92%	10.82%	8.85%	**8.85%**
UHL Alliance	0.8%	0.5%	6.16%	10.92%	13.37%	9.60%	7.75%	**9.60%**

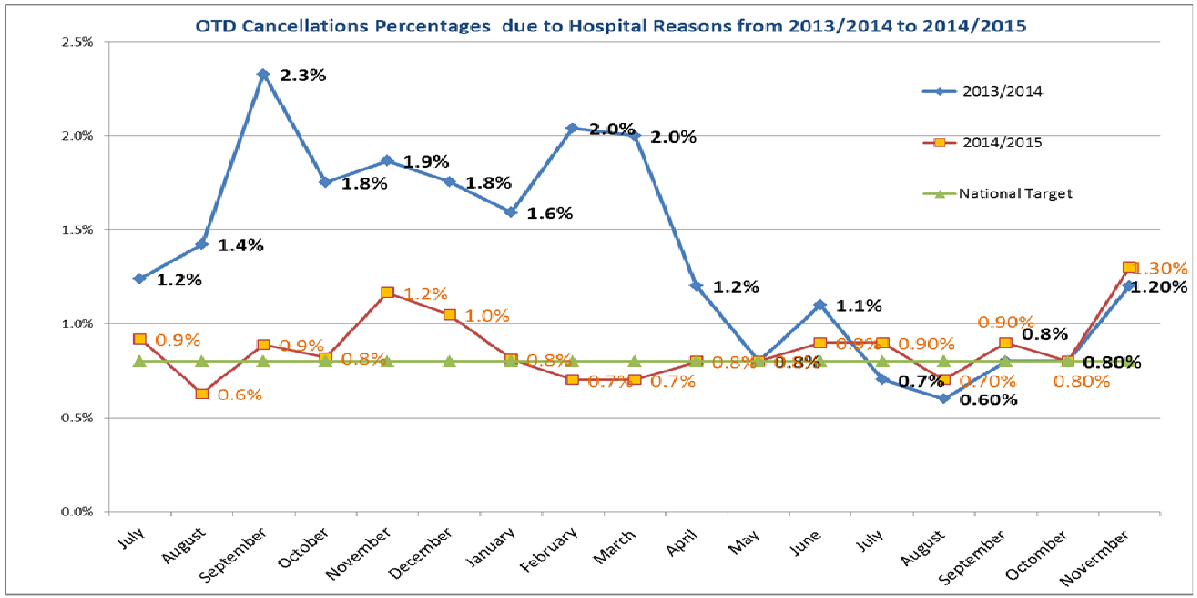
NB: The graph and table above have not been updated for November 2015 as performance is not confirmed.

Expected date to meet standard / target	February 2016
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Suzanne Khalid, Clinical Director CSI

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

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

What is causing underperformance?	What actions have been taken to improve performance?	Target (monthly)	Latest month performance	YTD performance (inc Alliance)	Forecast performance for next reporting period
The OTD cancellation percentage in UHL was 1.3% (131). The Alliance recorded no cancellations for this month. The five main reasons for cancellations were: • Lack of theatre time due to list over runs (44) • Ward bed unavailability (38) • Critical care bed Unavailability (11) • Patient delayed to admission of a higher priority patient(11 • Theatre and Anaesthetic staff unavailability (11). During this month 60 operations were cancelled due to capacity pressures in UHL. This is a significantly higher number of OTD cancellation compared to last month. 34 out of 38 cancellations due to ward bed unavailability were paediatric. This was caused by staff shortages and increase in emergency admission. Due to the paediatric capacity pressures it is likely that we will see around six 28 day breaches.	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 number of emergency admissions are a significant risk to OTD cancellations and 28 day rebooking of patients. The availability of beds is monitored daily and interventions will be made where necessary. A ongoing review of staffing for ITU is taking place to ensure that best use of staff to maintain beds in all three ITUs. Theatre managers have increased theatre capacity for the increased cancer demand by making additional lists available to reduce 28 breaches. The ITAPS and CHUGGS Senior Managers are working together to improve theatre capacity in the long term.	1) 0.8% 2) 0	1) 1.2% (1.3% UHL & 0.0% Alliance) 2) 3 (Gen Sur, Paediatric Sur and Paediatric ENT	1) 0.9% (0.9% - UHL & 0.8% Alliance) 2) 14	1) 0.8 % 2) 6



Expected date to meet standard / target	On the day – December 2015 28 day – January 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;
• ENT;
• Gynaecology.

Transition to ERS:
• Choose and Book migrated to the new e-Referral System on Monday 15th June;
• The challenges experienced in the period after the cut-over have calmed down considerably with installation of Google chrome improving the speed of the system.</td><td rowspan="4">Action plan
• An action plan has been written outlining steps for recovering performance. This has been shared with commissioners.

Capacity
• Additional capacity in key specialties is part of RTT recovery 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
• An ERS administrator has been in post since May;
• She will be working with key specialties to help reduce their ASIs and promote administrative housekeeping.</td><td><4%</td><td>Unable to report</td><td>Unable to report</td><td>No forecast as unable to measure</td></tr>
<tr><td colspan="4">As a result of the significant challenges experienced post-cut over from Choose and Book, the HSCIC have indicated that they will not be releasing weekly ASI data until further notice. A date for publication of these reports has not been confirmed. The latest data available is from the week ending 7th June and therefore is out of date. This means that the Trust is currently unable to track and report on progress in the usual manner.

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 a servicerather 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.(can we give a number to show the scale of this)The ERS team is working with specialties including Orthopaedics, Rheumatology, Urology and Respiratory Medicine to expand the number of A&G services available, a local tariff has been agreed for this</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">March 2016</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>

Ambulance handover > 30 minutes and>60 minutes

<table>
<tr><th colspan="2"></th><th>Target</th><th>Nov 15</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 - 27%

30-60 min – 26%</td><td>>60 min - 13%

30-60 min – 21%</td><td>> 60 min - 15%

30-60 min – 20%</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>An eight-week action plan has been agreed to speed up the time it takes for EMAS crews to pass patients to A&E staff at Leicester Royal Infirmary. It was drawn up following a meeting between managers from EMAS, UHL, the TDA and CCG's.

Additional actions taken include:-

• embedding assessment bay process with help of Unipart.
• Ambulance crews to assess patients for streaming at point of arrival eg ambulatory streaming - lakeside or assessment bay
• Bed bureau patients direct to ward if beds available.
• Dynamic priority score in 15 mins to assess those of a high clinical need to be seen ASAP carried out by by UHL and EMAS.</td><td colspan="4">Performance:

<table>
<tr><th></th><th>Apr-15</th><th>May-15</th><th>Jun-15</th><th>Jul-15</th><th>Aug-15</th><th>Sep-15</th><th>Oct-15</th><th>Nov-15</th><th>YTD</th></tr>
<tr><td>Ambulance Handover >60 Mins (CAD+ from June 15)</td><td>6%</td><td>7%</td><td>7%</td><td>8%</td><td>9%</td><td>18%</td><td>22%</td><td>27%</td><td>13%</td></tr>
<tr><td>Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)</td><td>22%</td><td>21%</td><td>17%</td><td>17%</td><td>17%</td><td>25%</td><td>26%</td><td>26%</td><td>21%</td></tr>
</table>

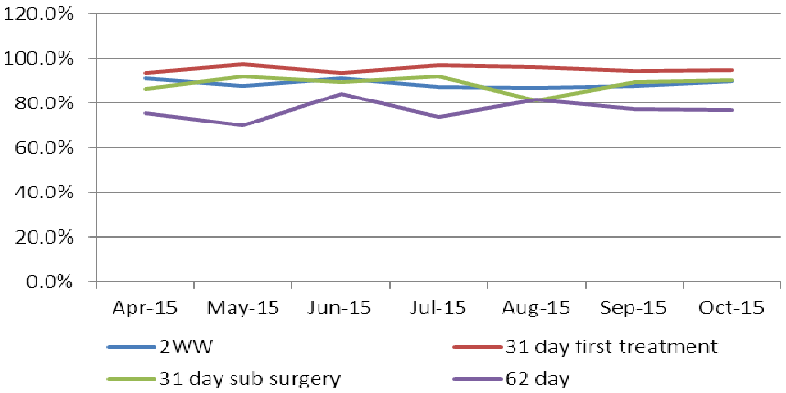
<table>
<tr><td>Expected date to meet standard</td><td>TBC</td></tr>
<tr><td>Revised date to meet standard</td><td>TBC</td></tr>
<tr><td>Lead Director</td><td>Richard Mitchell, Chief Operating Officer</td></tr>
</table>
</td></tr>
</table>

Cancer Waiting Times Performance

What is causing underperformance?	What actions have been taken to improve performance?
2 Week Wait 2WW performance remains under target. The key reason for underperformance is Endoscopy, which has significant impact on both Lower and Upper GI 2WW performance. However Head and Neck performance was also very poor due to inadequate clinical capacity across the whole service. **31 day subsequent (surgery)** 31 day subsequent (surgery) was failed predominantly as a result of Urology performance. The main factor is inadequate elective capacity. **62 day RTT** 62 day performance remains below target and has not been achieved nationally since April 2014. Lower/ Upper GI, Lung, Head and Neck, Gynae and Urology remain the most pressured tumour sites. The main pressures on achievement are performance challenges in Endoscopy, inadequate theatre capacity and shortages in consultant staff.	Current Cancer performance is an area of significant concern across UHL and is being given the highest priority by the executive and operational teams. Since September, there have been weekly meetings chaired by the Chief Operating Officer, attended by the CMG Heads of Ops, where they are required to account for their tumour site performance. **2 Week Wait** The CT Colon pathway for Lower and Upper GI Cancer patients began in November and the impact of this will be seen in the next reporting period. Head and Neck are planning to appoint a fellow, which would create 40 more 2WW slots a week. More broadly, the Trust is working with CCGs to improve the quality of 2WW referrals, specifically in relation to correct process, use of appropriate clinical criteria, and preparation of patients for the urgency of appointments. **31 day subsequent (surgery)** All Cancer patients coming into theatre should be escalated to the General Manager for Theatres to ensure that they are appropriately prioritised. The Cancer action plan aims to address the step-down of patients from Intensive Care, in order to pull Cancer patients through the system more quickly. It also includes significant investment in clinical staff, including a nurse specialist in Urology and consultants in Head and Neck and Dermatology. This additional capacity will help performance; yet while recruitment processes are underway, successful recruitment has been problematic due to a shortage of appropriate candidates. **62 day RTT** Efforts to improve 31 day and 2WW performance will help to improve the 62 day position. The appointment of three band 7 service managers with responsibility for managing cancer pathways in our worst performing tumour sites will provide the key focus required; all are now in post. Commissioners requested a Remedial Action Plan via the formal contracting process (October 2015) to support improvement of the 62 day standard; this has been submitted and is monitored through the joint Cancer and RTT board. During December there is additional focus on cancer, with the COO and Heads of Ops present at the weekly Cancer action board in order to unblock issues that prevent patient flow and treatment. A cancer LIA event in late November was well attended (90+ delegates) from both primary and secondary care, outputs from this will be part of the recovery action plan.

Target (mthly / end of year)	Latest month performance October	Performance to date 2015/16	Forecast performance for November
2WW (Target: 93%)	**90%**	**88.9%**	**93%**
31 day 1st (Target: 96%)	**95.2%**	**95.6%**	**92%**
31 day sub – Surgery (Target: 94%)	**90.6%**	**88.8%**	**88%**
62 day RTT (Target: 85%)	**77%**	**77.2%**	**78%**
62 day screening (Target: 90%)	**96.2%**	**91.1%**	**90%**

Cancer waiting times performance M1-7 2015-16:



Expected date to meet standard / target	2WW: November 2015 31 day pathway: February 2016 31 day sub – Surgery: January 2016 62 day pathway: June 2016
Revised date to meet standard	
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Matt Metcalfe, Clinical Lead for Cancer

Cancer Patients Breaching 104 days

What is causing underperformance?

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

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

The following factors have significantly contributed to delays:

Reason	No. patients
Complex case	2
Patient initiated delay	4
Endoscopy delays	2
Complex diagnostic pathway	2
Tertiary referral	1
Appointment delay	1
Repeat diagnostic required	1

What actions have been taken to improve performance?

Current Cancer performance is an area of significant concern across UHL and isgiven the highest priority by the executive and operational teams . Since September, there have been weekly meetings chaired by the Chief Operating Officer, attended by the CMG Heads of Ops, where they are required to account for their tumour site performance.

The number of patients breaching 104 days on a 62 day pathway has dropped by four since the end of October.

Given the poor 62 day performance specifically in Lung, Lower GI and Urology, funding for three band 7 Cancer Delivery Managers has been identified to support them. All three are now in post and they will jointly report to the Cancer Centre and the CMG management teams. This dedicated full-time service management will improve Cancer performance over the medium term.

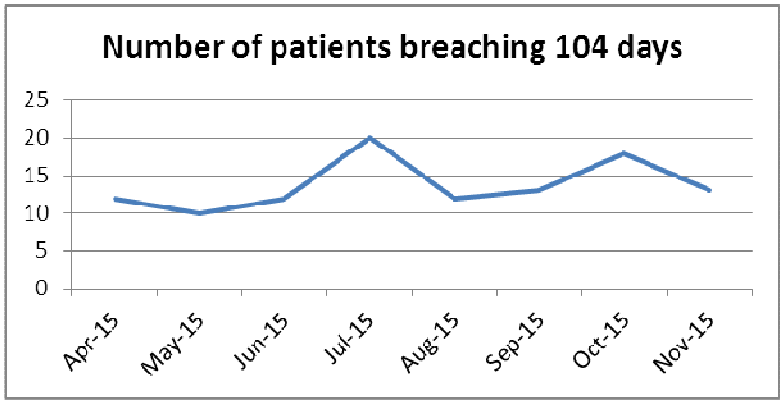
In light of poor performance against the 62 day pathway, local commissioners have requested a remedial action plan for Cancer, which will be monitored through the Contract Performance Meetings. The plan is based around emerging themes from the first four months' of 62 day breach analysis and will aim to resolve known delays in Cancer pathways. Undoubtedly, this collective piece of work will impact positively on the number of patients breaching 104 days.

Month by month breakdown of patients breaching 104 days

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

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Patients breaching 104 days	12	10	12	20	12	13	17	13

NB: not all patients confirmed Cancer



NB: all patients breaching 104 days undergo a formal 'harm review' process and these are reviewed by commissioners

Expected date to meet standard / target	N/A
Revised date to meet standard	N/A
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Matt Metcalfe, Clinical Lead for Cancer