# Quality & Performance Report

Author: John Adler Sponsor: Chief Executive Date: IFPIC + QAC 26th JANUARY 2017

# Executive Summary from CEO Paper K

## Context

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

## Questions

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

## Conclusion

**Good News:** **Moderate harms and above** – we remain well within the agreed Quality Commitment monthly thresholds. **Referral to Treatment 52+ week waits –** current number is 32 - 30 MSS (including 15 Orthodontics) and 2 CHUGGS. **Diagnostic 6 week wait –** remains complaint. **Cancer Two Week Wait** was achieved during December. Reported **delayed transfers of care** remain within the tolerance. However significant issues have arisen with Leicestershire social care packages. **MRSA** – 0 cases reported this month. **Never events** – 0 reported this month. **C DIFF – 0** cases reported in December and year to date now within trajectory. **Cancelled operations** achieved in December, however **patients rebooked within 28 days** – continued to be non-compliant, due high level of cancellations in the previous month. **Pressure Ulcers** – 0 **Grade 4** pressure ulcers reported this month. **Grade 3 and Grade 2** are within the trajectory for month. **Patient Satisfaction (FFT)** target of 97% maintained for Inpatients and Day Cases. Both **Stroke** indicators remain complaint, in month and for the year to date. **Estates and Facilities** are now reporting a suite of audit and performance KPI's in the Quality and Performance report.

**Bad News**: **Mortality** – the latest published SHMI (covering the period July 2015 to June 2016) has increased to **101.** A full report including detailed analysis and actions being taken is to be reported at the Executive Quality Board and the Quality Assurance Committee in January 2017. **ED 4 hour performance** – December performance was 75.5% with year to date performance at 78.9%. Contributing factors are set out in the Chief Operating Officer's report. **Ambulance Handover 60+ minutes** – performance deteriorated to 17% - similar to December 2015. **Single Sex Accommodation Breaches** – numbers have increased to 14 in December. **Fractured NOF** – target not achieved during December. The Medical Director has implemented a #NoF Steering Group and there are Weekly #NoF meetings chaired by the Clinical Director. **Cancer Standards 62 day treatment** - remains non-compliant. Although **Patient Satisfaction (FFT)** for ED

improved during December to 91%, coverage is very low. **Statutory & Mandatory Training** – performance remains at 83% against a target of 95%. Work is ongoing to improve compliance in Estates and Facilities.

## 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: 23rd February 2017

# Quality and Performance Executive Summary

December 2016

Operational Delivery Unit

# Domain - Safe

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

**TWO**
Never Events YTD

**30** ↑
Serious Incidents YTD

**84**
Moderate Harm and above YTD ↑

**0**
Avoidable MRSA YTD ↔

**43**
CDIFF Cases YTD ↑

## Headlines

- Serious incidents are well within the year to date trajectory. This is supported by a reduction in Moderate Harm and above compared to the same period last year.
- No C Diff cases reported in December, with year to date 2 below trajectory.
- There was Two Grade 3 and five Grade 2 Pressure ulcers for December and overall the year to dates are within trajectory.

## SEPSIS

| | |
|---|---|
| Patients with an Early Warning Score 3+ - % appropriate escalation | 88% YTD ↔ |
| Patients with EWS 3+ - % who are screened for sepsis | 93% YTD ↑ |
| ED - Patients who trigger with red flag sepsis - % that have their IV antibiotics within an hour | 73% YTD ↓ |
| Wards (including assessment units) Patients who trigger for Red Flag Sepsis - % that receive their antibiotics within an hour | 46% YTD ↑ |

# Domain - Caring

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

## Friends and Family Test YTD % Positive

Inpatients FFT 96% ⟷

Day Case FFT 98% ⟷

A&E FFT 90% ↑

Maternity FFT 94% ↓

Outpatients FFT 94% ↓

## Staff FFT Quarter 2 2016

↑76.0% of staff would recommend UHL as a place to receive treatment

## Single sex accommodation breaches

**49**

YTD ↓

## Headlines

- Friends and family test (FFT) for Inpatient and Daycase care combined are at 97% for December.
- Patient Satisfaction (FFT) for ED increased to 91% for December, the highest it has been for five months, however coverage was low. It is expected that patient satisfaction will increase when the 4 hour performance improves.
- Single Sex Accommodation Breaches – numbers have increased to 14 in December with 2 patients affected in ICU and 12 affected in the Ophthalmology suite.

# Domain – Well Led

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

## Friends and Family FFT YTD % Coverage

Inpatients FFT 35.9% ↓
Day Case FFT 24.3% ↓
A&E FFT 10.4% ↓
Maternity FFT 37.4% ↓
Outpatients FFT 2.1% ↑

## Staff FFT Quarter 2 2016

↑ 62.8% of staff would recommend UHL as a place to work

## Headlines

- Inpatients and Daycase coverage remains above Trust target
- A&E coverage remains a challenge to get to Trust target of 20%, further details in exception report.
- Appraisals are 3.3% off target for December (this excludes facilities staff that were transferred over from Interserve).
- Statutory & Mandatory is 12% off the 95% target, predominately due to the transfer of the facilities staff.
- Please see the HR update for more information.

## % Staff with Annual Appraisals

**91.7%** YTD ↓

## Statutory & Mandatory Training

**83%** YTD ↑

## BME % - Leadership

**26%** Qtr2
8A including medical consultants

**12%** Qtr2
8A excluding medical consultants

# Domain – Effective

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

**SHMI Apr15-Mar16**

**101**
Jul15-Jun16 ↓

**Stroke TIA clinic within 24hrs**

**65.6%**
YTD ↓

**80% of patients spending 90% stay on stoke unit**

**83.5%**
YTD ↑

**Emergency Crude Mortality Rate**

**2.7%**
YTD ↓

**30 Days Emergency Readmissions**

**8.5%**
YTD ↑

**NoFs operated on 0-35hrs**

**71.6%**
YTD ↓

**Headlines**

- UHL's SHMI has moved one point above the England average to 101. . A full report including detailed analysis and actions being taken is to be reported at the Executive Quality Board and the Quality Assurance Committee in January 2017
- Fractured NoF – December seen a fall to 60.3% of patients operated on within 0-35hours, 11.7% below the 72% target. The Medical Director has implemented a NoF Steering Group and there are Weekly NoF meetings chaired by the Clinical Director.

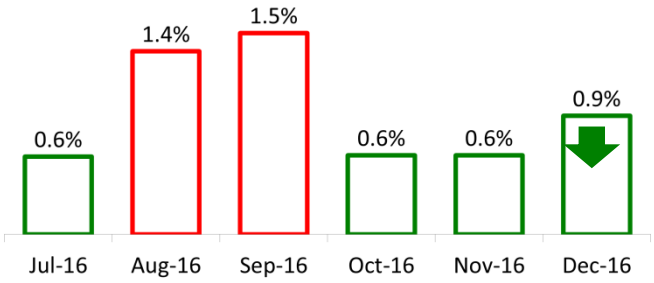
# Domain – Responsive

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

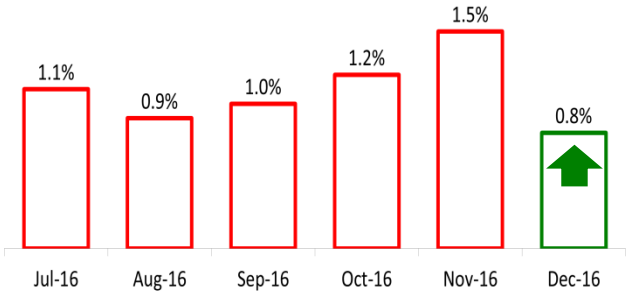
## RTT - Incomplete 92% in 18 Weeks

**91.3%** ↓

## 6 week Diagnostic Wait times




## Cancelled Operations




## RTT 52 week wait incompletes

**32** ↑
YTD

## ED 4Hr Wait

A&E **78.9%** ↓
YTD

## Ambulance Handovers

**9% > 60mins** ↓
**15% 30-60mins** ↔
YTD

## Headlines

- 52+ week waiters have reduce to 32 since the highs of April at 169.
- Diagnostic 6 week wait – we have now achieved three consecutive months below the 1% national target.
- For ED 4hour wait and Ambulance Handovers please refer to Chief Operating Officers report.

# Domain – Responsive Cancer

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

**Cancer 2 week wait**

92.9% YTD ↑ | 95.2% Nov

**31 day wait**

93.8% YTD ↑ | 94.2% Nov

**62 day wait**

77.4% YTD ↓ | 77.2% Nov

**31 day backlog**

13 Dec ↓

**62 day backlog**

57 Dec ↓

**62 day adjusted backlog**

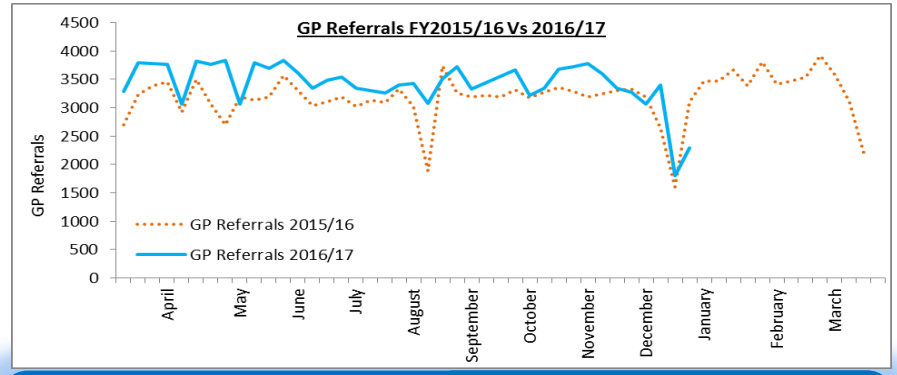
54 Dec ↓

**Headlines**

- Cancer Two Week Wait was achieved in November and is expected to remain compliant.
- 31 day wait non compliant due to emergency pressures and HDU capacity.
- Cancer Standards 62 day treatment - remains non-compliant. In discussion with NHSI and NHSE the Trust has stated that it cannot confirm recovery of the key cancer standards until there has been a sustained period of ring fenced capacity of elective beds, ie >2 months.

# UHL Activity Trends

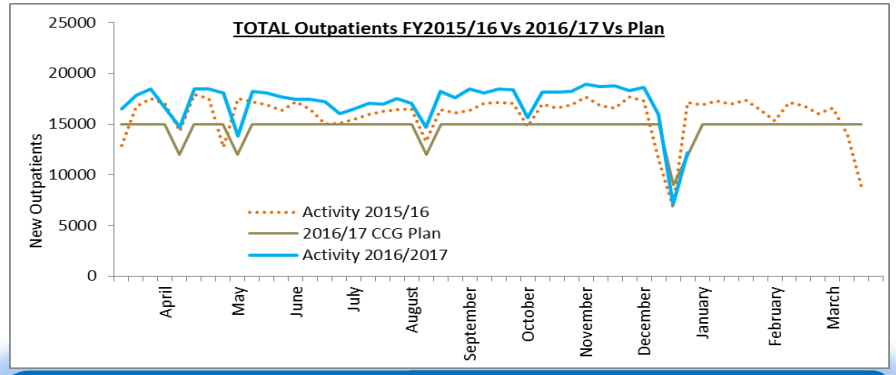
## Referrals (GP)




**April – December**
**16/17 Vs 15/16 +12,879 10%**

**Planned care workstream underway to reduce referrals.**

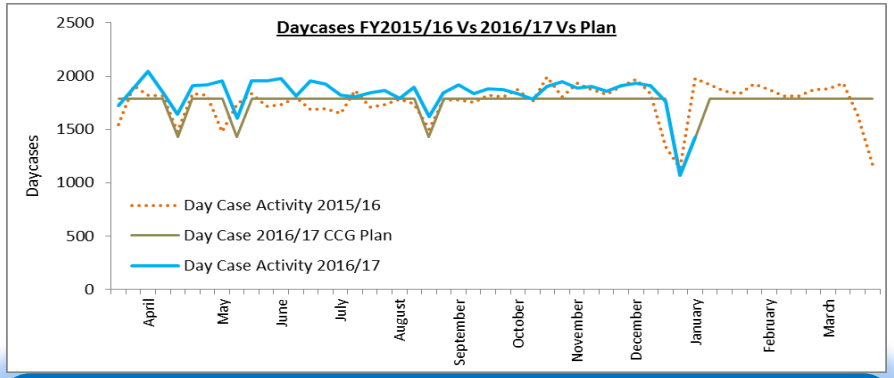
## TOTAL Outpatient Appointments




**April – December**
**16/17 Vs 15/16 +24,391 +4%**
**16/17 Vs Plan +24,346 +4%**

**Above plan – Dermatology, ENT, Rheumatology, Orthopaedics/Spinal and Ophthalmology.**
**Below plan – Paed Cardiology, Haematology and Plastics.**

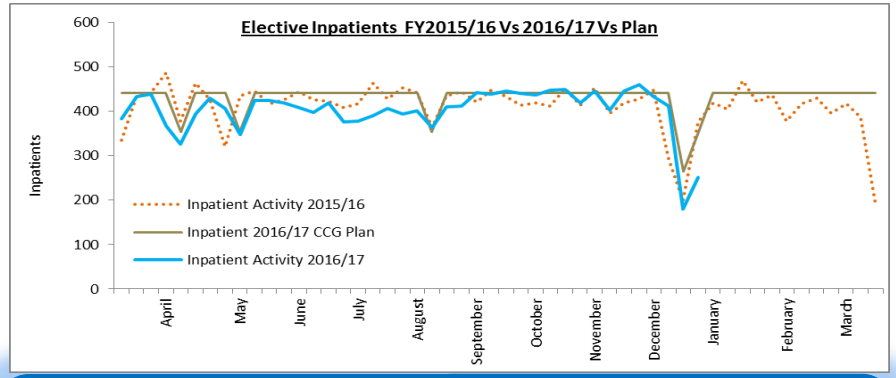
## Daycases




**April – December**
**16/17 Vs 15/16 +4,571 +7%**
**16/17 Vs Plan +3,849 +6%**

**Above plan - Clinical Onc. BMT, Int-Radiology Haematology.**
**Below plan - Ophth, Gen Surg, Ortho, Gastro and Int-medicine.**

## Elective Inpatient Admissions

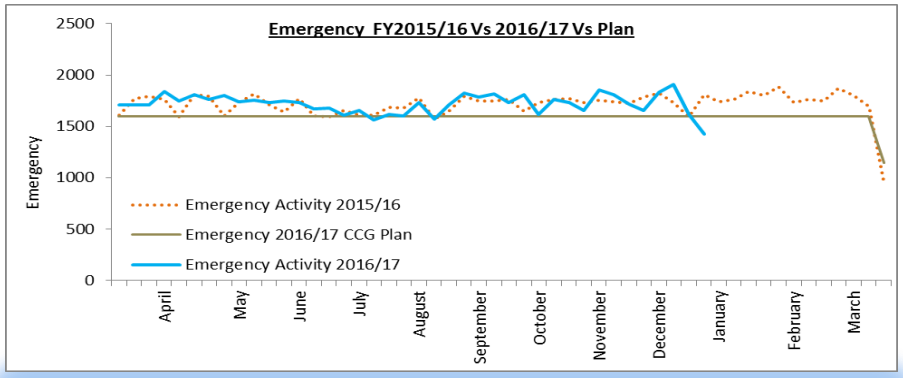



**April – December**
**16/17 Vs 15/16 -243 -1%**
**16/17 Vs Plan -813 -5%**

**Above plan - Gynaecology**
**Below plan – Orthopaedics, Cardiology**

# UHL Activity Trends

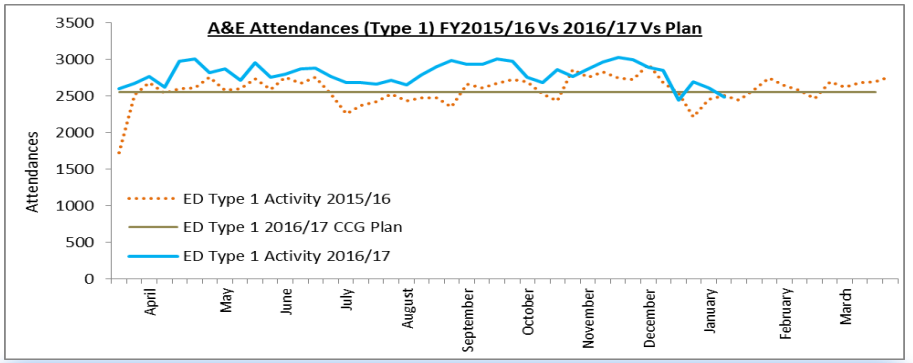
## Emergency Admissions




**April – December**
**16/17 Vs 15/16 +4,186 +6%**
**16/17 Vs Plan +5,329 +8%**

**Above plan – Cardiology, Thoracic Medicine and Gen Surgery**
**Below plan – Integrated Medicine, Trauma and Neurology.**

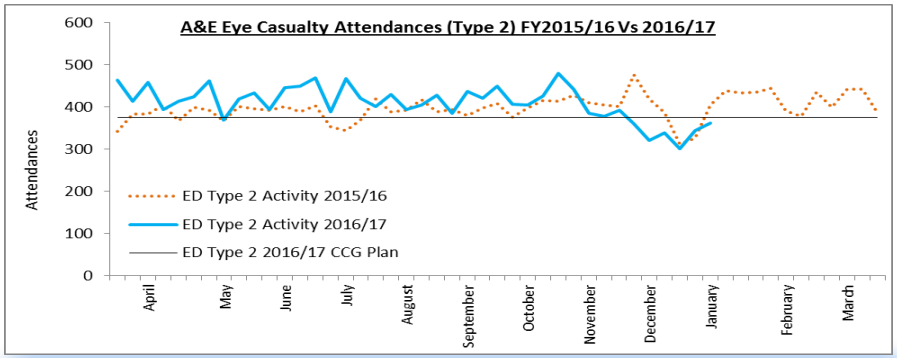
## A & E Attendances (ED Type 1 only)




**April – December**
**16/17 Vs 15/16 +9,329 +9%**
**16/17 Vs Plan +10,197 +10%**

**A&E attendances have been above plan and last year's outturn all year. RAP action for commissioners to get back to plan.**

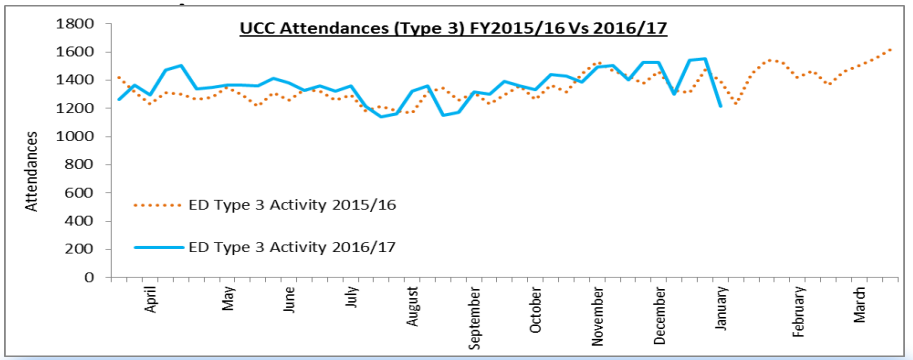
## Eye Casualty Attendances (ED Type 2only)




**April – December**
**16/17 Vs 15/16 +859 +6%**
**16/17 Vs Plan +1,488 +10%**

**Reduction in activity during December - requires further investigation with CMG**

## UCC Attendances (Type 3, excludes referred to ED)

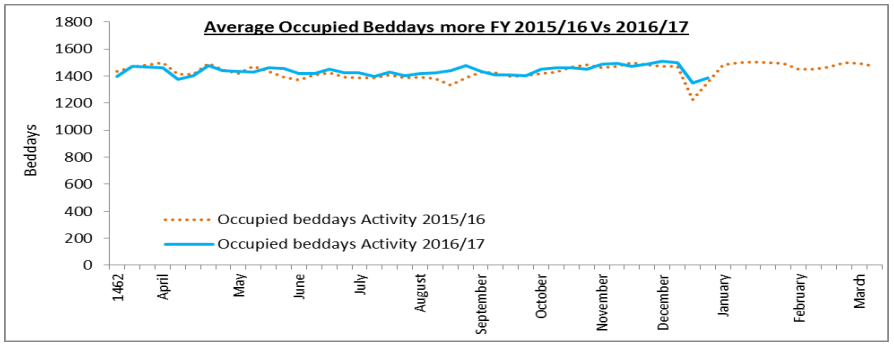



**April – December**
**16/17 Vs 15/16 +1,482 +3%**

**There is no plan for Urgent care (this excludes patients that are referred to ED)**

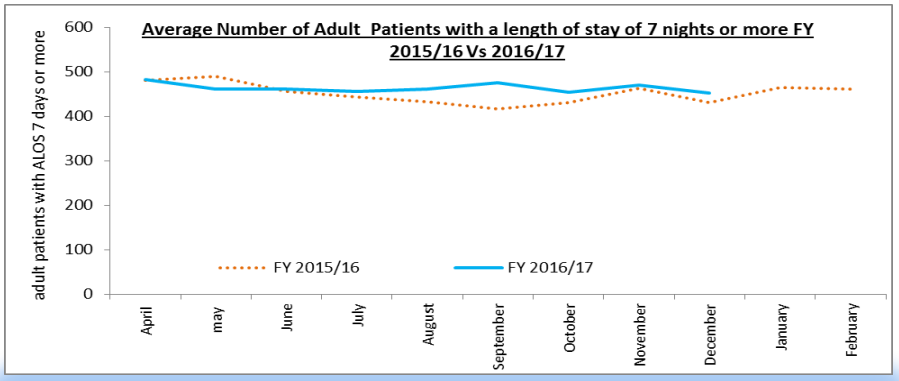
# UHL Bed Occupancy

## Occupied Beddays



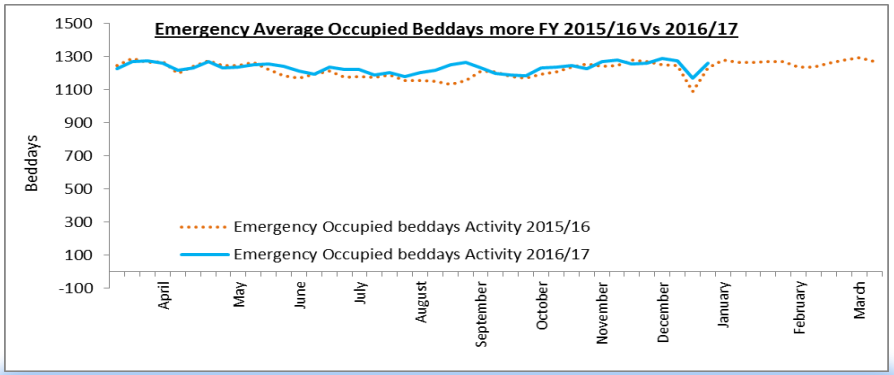

Number of inpatients beds General and Acute excluding Maternity and Obstetrics is 1684 as at December 2016. This includes additional winter capacity beds. Highest occupancy for 2016/17 was 93% this is increasing for the beginning of January.

## Number of Adult Emergency Patients with a stay of 7 nights or more



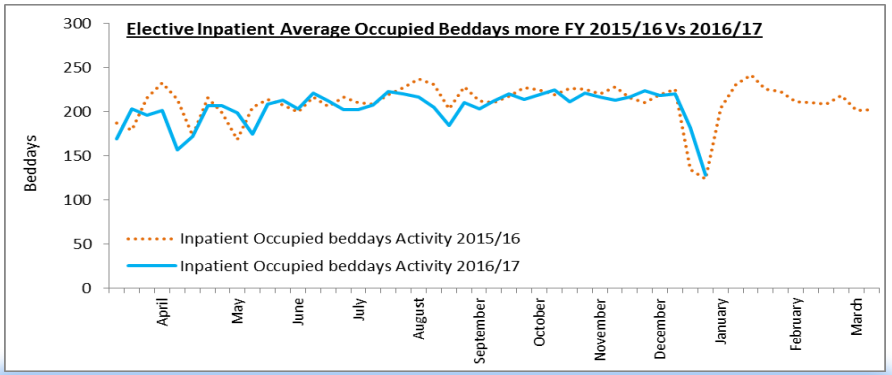

The number of patients staying in excess of 7 days for FY 2016/17 is running higher than FY2015/16.

## Emergency Occupied beddays




Emergency occupied beddays for 2016/17 during the summer months are higher than the same period last year. During December 2016 bed occupancy was running slightly higher than the same period last year.

## Elective Inpatient Occupied beddays




Bed occupancy is slightly lower for 2016/17 compared to 2015/16, most likely reflective of the emergency pressures and cancelled operations.

# Sustainability and Transformation Fund – Trajectories and Performance

## Cancer 62 Day

5% of STF allocation

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

**Timing**: Best endeavours to deliver 85% from June 2016.

**November Performance (one month in arrears)**
72.2% against a trajectory of 85.1%

| S | O | N |
|---|---|---|
| | | |

December Performance: Expected to be non-compliant.

## Diagnostics

0% of STF allocation

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

**Timing**: Required to deliver throughout the year.

**December Performance**
0.9% of our patients waiting more than 6 *weeks*

| O | N | D |
|---|---|---|
| | | |

January Performance: Expected to be complaint

## RTT 18 Week

12.5% of STF allocation

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

**Timing**: Required to deliver throughout the year

**December Performance**
91.3% of our patients waiting less than 18 weeks

January Performance: Expected to be non-compliant

| O | N | D |
|---|---|---|
| | | |

## ED 4 hour

12.5% of STF allocation

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

**Timing**: Required to achieve 91.2% during March 2017

**December Performance**
75.5% against a target of 85.0%

January Performance: Expected to be non-compliant

| O | N | D |
|---|---|---|
| | | |

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

# Quality and Performance Report

## December 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:** **26th JANUARY 2017**

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

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

## 1.0 Introduction

The following report provides an overview of performance for NHS Improvement (NHSI) and UHL key quality commitment/performance metrics. Escalation reports are included where applicable. The NHSI have recently published the 'Single Oversight Framework' which sets out NHSI's approach to overseeing both NHS Trusts and NHS Foundation Trusts and shaping the support that NHSI provide.

NHSI will use the 39 indicators listed in the 'Single Oversight Framework - Appendix 2 Quality of care (safe, effective, caring and responsive)' of monitoring metrics to supplement CQC information to identify where providers may need support under the theme of quality. All the metrics in Appendix 2 have been reported in the Quality and Performance report with the exception of:-

- Aggressive cost reduction plans – NHSI to provide further detail
- C Diff – infection rate – C Diff numbers vs plans included
- Potential under-reporting of patient safety incidents – NHSI to provide further detail

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

## 2.0 Performance Summary

| Domain | Page Number | Number of Indicators | Number of Red Indicators this month |
|---|---|---|---|
| Safe | 4 | 21 | 2 |
| Caring | 5 | 11 | 3 |
| Well Led | 6 | 24 | 3 |
| Effective | 7 | 11 | 4 |
| Responsive | 8 | 15 | 7 |
| Responsive Cancer | 9 | 9 | 5 |
| Research – UHL | 15 | 6 | 0 |
| Total | | 97 | 24 |

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

| | KPI Ref | Indicators | Board Director | Lead Officer | 16/17 Target | Target Set by | 16/17 Red RAG/ Exception Report Threshold (ER) | 14/15 Outturn | 15/16 Outturn | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Safe | S1 | Reduction for moderate harm and above PSIs with finally approved status - reported 1 month in arrears | AF | MD | 10% REDUCTION FROM FY 15/16 (<20 per month) | QC | Red if >20 in mth, ER if >20 for 2 consecutive mths | | 262 | 18 | 18 | 16 | 17 | 9 | 10 | 8 | 12 | 10 | 12 | 12 | 11 | | 84 |
| | S2 | Serious Incidents - actual number escalated each month | AF | MD | <=49 by end of FY 16/17 (revised) | UHL | Red / ER if >8 in mth or >5 for 3 consecutive mths | 41 | 50 | 3 | 4 | 6 | 4 | 5 | 5 | 1 | 3 | 4 | 2 | 4 | 4 | 2 | 30 |
| | S3 | Proportion of reported safety incidents per 1000 attendances (IP, OP and ED) | AF | MD | > FY 15/16 | UHL | TBC | | 17.5 | 17.7 | 18.8 | 16.2 | 17.2 | 17.1 | 16.8 | 16.3 | 19.3 | 18.2 | 16.3 | 16.1 | 15.1 | 19.7 | 17.2 |
| | S4 | SEPSIS - Patients with an Early Warning Score 3+ - % appropriate escalation | AF | SH | 95% | UHL | TBC | New Indicator | | | | | | | | | | 86% | 91% | 86% | 89% | 88% | 88% |
| | S5 | SEPSIS - Patients with EWS 3+ - % who are screened for sepsis | AF | SH | 95% | UHL | TBC | New Indicator | | | | | | | | | | 65% | 91% | 95.0% | 98.9% | 98.9% | 93% |
| | S6 | SEPSIS - ED - Patients who trigger with red flag sepsis - % that have their IV antibiotics within an hour | AF | SH | 90% | UHL | TBC | New Indicator | | | | | | 63% | 71% | 71% | 66% | 69% | 75% | 79% | 82% | 76% | 73% |
| | S7 | SEPSIS - Wards (including assessment units) Patients who trigger for Red Flag Sepsis - % that receive their antibiotics within an hour | AF | SH | 90% | UHL | TBC | New Indicator | | | | | | 33% | 50% | 21% | 42% | 23% | 45% | 61% | 67% | 76% | 46% |
| | S8 | Overdue CAS alerts | AF | MD | 0 | NHSI | Red if >0 in mth ER = in mth >0 | 10 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | S9 | RIDDOR - Serious Staff Injuries | AF | MD | FYE <=40 | UHL | Red / ER if non compliance with cumulative target | 24 | 32 | 5 | 3 | 2 | 2 | 5 | 3 | 3 | 1 | 0 | 2 | 4 | 3 | 2 | 23 |
| | S10 | Never Events | AF | MD | 0 | NHSI | Red if >0 in mth ER = in mth >0 | 3 | 2 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 2 |
| | S11 | Clostridium Difficile | JS | DJ | 61 | NHSI | Red if >mthly threshold / ER if Red or Non compliance with cumulative target | 73 | 60 | 6 | 7 | 7 | 6 | 4 | 5 | 6 | 1 | 7 | 8 | 5 | 7 | 0 | 43 |
| | S12 | MRSA Bacteraemias (All) | JS | DJ | 0 | NHSI | Red if >0 ER if >0 | 6 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| | S13 | MRSA Bacteraemias (Avoidable) | JS | DJ | 0 | UHL | Red if >0 ER if >0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | S14 | % of UHL Patients with No Newly Acquired Harms | JS | RB | Within expected (revised) | UHL | Red if <95% ER if in mth <95% | | 97.7% | 98.2% | 97.7% | 97.9% | 98.0% | 96.9% | 97.2% | 98.4% | 97.9% | 98.6% | 97.9% | 98.0% | 97.3% | 98.0% | 97.8% |
| | S15 | % of all adults who have had VTE risk assessment on adm to hosp | AF | SH | >=95% | NHSI | Red if <95% ER if in mth <95% | 95.8% | 95.9% | 96.1% | 95.5% | 95.4% | 95.1% | 95.9% | 96.1% | 96.5% | 96.1% | 96.0% | 95.7% | 96.3% | 96.3% | 95.1% | 96.0% |
| | S16 | All falls reported per 1000 bed stays for patients >65years | JS | HL | <=5.5 (revised) | UHL | Red if >=6.6 ER if 2 consecutive reds | 6.9 | 5.4 | 5.7 | 5.4 | 4.9 | 5.2 | 6.6 | 5.9 | 6.1 | 5.7 | 6.5 | 6.3 | 5.5 | 5.9 | 5.7 | 6.0 |
| | S17 | Avoidable Pressure Ulcers - Grade 4 | JS | MC | 0 | QS | Red / ER if Non compliance with monthly target | 2 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| | S18 | Avoidable Pressure Ulcers - Grade 3 | JS | MC | <=4 a month (revised) with FY End <33 | QS | Red / ER if Non compliance with monthly target | 69 | 33 | 5 | 6 | 2 | 5 | 5 | 3 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 22 |
| | S19 | Avoidable Pressure Ulcers - Grade 2 | JS | MC | <=7 a month (revised) with FY End <89 | QS | Red / ER if Non compliance with monthly target | 91 | 89 | 5 | 5 | 8 | 7 | 9 | 6 | 8 | 3 | 13 | 6 | 9 | 10 | 5 | 69 |
| | S20 | Maternal Deaths | AF | IS | 0 | UHL | Red or ER if >0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 2 |
| | S21 | Emergency C Sections (Coded as R18) | IS | EB | Not within Highest Decile | NHSI | Red / ER if Non compliance with monthly target | 16.5% | 17.5% | 20.9% | 17.0% | 16.6% | 17.3% | 17.8% | 16.8% | 17.2% | 17.0% | 15.0% | 18.1% | 16.9% | 15.3% | 16.3% | 16.7% |

| | KPI Ref | Indicators | Board Director | Lead Officer | 16/17 Target | Target Set by | 16/17 Red RAG/ Exception Report Threshold (ER) | 14/15 Outturn | 15/16 Outturn | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Caring | C1 | Keeping Inpatients Informed (Reported quarterly from Qtr3) | JS | HL | 6% increase from Qtr 1 baseline (new) | QC | Red/ER if below Quarterly Threshold | NEW INDICATOR | | | | | | 64% | | | Next survey to be done in Q3 | | | | | | 64% |
| | C2 | Formal complaints rate per 1000 IP,OP and ED attendances | AF | MD | No Target | UHL | Monthly reporting | NEW INDICATOR | | 0.9 | 1.0 | 1.4 | 1.2 | 1.0 | 1.0 | 0.9 | 0.8 | 1.2 | 1.4 | 1.1 | 1.2 | 1.5 | 1.1 |
| | C3 | Percentage of upheld PHSO cases | AF | MD | No Target | UHL | Quarterly reporting | NEW INDICATOR | | | | | | 10% (1 out of 10 cases) | | | 0% (0 out of 7 cases) | | | 0% (0 out of 3 cases) | | | 5% |
| | C4 | Published Inpatients and Daycase Friends and Family Test - % positive | JS | HL | 97% | UHL | Red if <95% ER if 2 mths Red | | 97% | 97% | 97% | 96% | 97% | 97% | 97% | 97% | 97% | 96% | 97% | 96% | 97% | 97% | 97% |
| | C5 | Inpatients only Friends and Family Test - % positive | JS | HL | 97% | UHL | Red if <95% ER if 2 mths Red | 96% | 97% | 97% | 97% | 96% | 97% | 97% | 96% | 97% | 96% | 95% | 96% | 96% | 96% | 96% | 96% |
| | C6 | Daycase only Friends and Family Test - % positive | JS | HL | 97% | UHL | Red if <95% ER if 2 mths Red | | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 99% | 98% | 98% | 98% | 98% | 98% | 98% | 98% |
| | C7 | A&E Friends and Family Test - % positive | JS | HL | 97% | UHL | Red if <94% ER if 2 mths Red | 96% | 96% | 95% | 97% | 97% | 95% | 96% | 95% | 95% | 87% | 87% | 84% | 87% | 84% | 91% | 90% |
| | C8 | Outpatients Friends and Family Test - % positive | JS | HL | 97% | UHL | Red if <90% ER if 2 mths Red | | 94% | 94% | 95% | 95% | 93% | 95% | 95% | 95% | 94% | 94% | 95% | 95% | 95% | 92% | 94% |
| | C9 | Maternity Friends and Family Test - % positive | JS | HL | 97% | UHL | Red if <94% ER if 2 mths Red | 96% | 95% | 94% | 95% | 95% | 95% | 95% | 94% | 94% | 95% | 95% | 95% | 95% | 94% | 93% | 94% |
| | C10 | Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment | LT | LT | TBC | NHSI | TBC | 69.2% | 70.0% | | 70.7% | | | 72.3% | | | 76.0% | | | | | | 74.2% |
| | C11 | Single Sex Accommodation Breaches (patients affected) | JS | HL | 0 | NHSI | Red / ER if >0 | 13 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 4 | 1 | 2 | 20 | 7 | 1 | 14 | 49 |

## Well Led

| KPI Ref | Indicators | Board Director | Lead Officer | 16/17 Target | Target Set by | 16/17 Red RAG/ Exception Report Threshold (ER) | 14/15 Outturn | 15/16 Outturn | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| W1 | Outpatient Letters sent within 14 days of attendance (Reported Quarterly) | RM | WM | 11% Improvement (new) | QC | Red/ER = Below 9% Improvement in Q4 | | 40.0% | | | | | Achieved | | | Achieved | | | Achieved | | | Achieved |
| W2 | Published Inpatients and Daycase Friends and Family Test - Coverage (Adults and Children) | JS | HL | Not Appicable | | Not Appicable | | 27.4% | 23.5% | 31.9% | 32.8% | 32.9% | 31.7% | 32.0% | 31.6% | 31.9% | 28.5% | 27.8% | 31.6% | 31.6% | 27.5% | 30.5% |
| W3 | Inpatients only Friends and Family Test - Coverage (Adults and Children) | JS | HL | 30% | QS | Red if <26% ER if 2mths Red | | 31.0% | 23.2% | 29.3% | 37.2% | 36.1% | 35.6% | 36.7% | 38.1% | 36.9% | 36.5% | 33.1% | 36.6% | 37.0% | 31.9% | 35.9% |
| W4 | Daycase only Friends and Family Test - Coverage (Adults and Children) | JS | HL | 20% | QS | Red if <8% ER if 2 mths Red | | 22.5% | 18.7% | 30.1% | 26.2% | 29.2% | 27.3% | 26.5% | 24.5% | 26.2% | 19.8% | 21.6% | 25.9% | 25.7% | 22.3% | 24.3% |
| W5 | A&E Friends and Family Test - Coverage | JS | HL | 20% | NHSI | Red if <10% ER if 2 mths Red | | 10.5% | 5.4% | 7.3% | 5.1% | 7.0% | 13.0% | 10.2% | 12.0% | 8.7% | 9.9% | 11.7% | 9.8% | 11.4% | 7.1% | 10.4% |
| W6 | Outpatients Friends and Family Test - Coverage | JS | HL | >=5% | UHL | Red/ER if <1.4% | | 1.4% | 1.4% | 1.5% | 1.6% | 1.6% | 1.5% | 1.7% | 1.8% | 1.7% | 1.6% | 1.5% | 1.5% | 1.8% | 5.7% | 2.1% |
| W7 | Maternity Friends and Family Test - Coverage | JS | HL | 30% | UHL | Red if <26% ER if 2 mths Red | 28.0% | 31.6% | 30.0% | 33.3% | 34.3% | 31.7% | 27.9% | 38.3% | 39.3% | 38.2% | 38.7% | 37.8% | 38.3% | 41.1% | 37.1% | 37.4% |
| W8 | Friends & Family staff survey: % of staff who would recommend the trust as place to work | LT | BK | Not within Lowest Decile | NHSI | TBC | 54.2% | 55.4% | | 58.9% | | | 60.3% | | | 62.8% | | | | | | 61.6% |
| W9 | Nursing Vacancies | JS | MM | TBC | UHL | Separate report submitted to QAC | | 8.4% | 7.6% | 7.7% | 6.8% | 8.4% | 8.2% | 8.5% | 8.9% | 9.2% | 8.2% | 8.7% | 10.3% | 9.7% | 7.1% | 7.1% |
| W10 | Nursing Vacancies in ESM CMG | JS | MM | TBC | UHL | Separate report submitted to QAC | | 17.2% | 14.9% | 16.4% | 17.2% | 18.5% | 18.1% | 18.9% | 19.8% | 20.1% | 20.3% | 21.4% | 20.0% | 20.2% | 14.5% | 14.5% |
| W11 | Turnover Rate | LT | LG | TBC | NHSI | Red = 11% or above ER = Red for 3 Consecutive Mths | 11.5% | 9.9% | 10.0% | 10.1% | 10.0% | 9.9% | 9.7% | 9.6% | 9.4% | 9.4% | 9.3% | 9.2% | 9.1% | 9.2% | 9.3% | 9.2% |
| W12 | Sickness absence | LT | BK | 3% | UHL | Red if >4% ER if 3 consecutive mths >4.0% | 3.8% | 3.6% | 3.9% | 4.0% | 4.3% | 4.2% | 3.9% | 3.4% | 3.4% | 3.3% | 3.1% | 3.4% | 3.5% | 3.8% | | 3.5% |
| W13 | Temporary costs and overtime as a % of total paybill | LT | LG | TBC | NHSI | TBC | 9.4% | 10.7% | 10.1% | 11.0% | 9.7% | 13.9% | 10.5% | 9.5% | 10.9% | 10.2% | 10.5% | 10.7% | 10.9% | 10.9% | 10.1% | 10.5% |
| W14 | % of Staff with Annual Appraisal (excluding facilities Services) | LT | BK | 95% | UHL | Red if <90% ER if 3 consecutive mths <90% | 91.4% | 90.7% | 92.7% | 91.5% | 91.6% | 90.7% | 91.5% | 92.2% | 92.4% | 92.9% | 92.4% | 91.5% | 91.4% | 91.9% | 91.7% | 91.7% |
| W15 | Statutory and Mandatory Training | LT | BK | 95% | UHL | TBC | 95% | 93% | 93% | 93% | 92% | 93% | 92% | 93% | 94% | 93% | 91% | 82% | 82% | 82% | 83% | 83% |
| W16 | % Corporate Induction attendance | LT | BK | 95% | UHL | Red if <90% ER if 3 consecutive mths <90% | 100% | 97% | 92% | 96% | 98% | 98% | 94% | 96% | 97% | 100% | 97% | 92% | 96% | 95% | 99% | 99% |
| W17 | BME % - Leadership (8A – Including Medical Consultants) | LT | DB | 28% | UHL | 4% improvement on Qtr 1 baseline | | | | | | | 24% | | | 25% | | | 26% | | | 26% |
| W18 | BME % - Leadership (8A – Excluding Medical Consultants) | LT | DB | 28% | UHL | 4% improvement on Qtr 1 baseline | | | | | | | 12% | | | 12% | | | 12% | | | 12% |
| W19 | Executive Team Turnover Rate - Executive Directors (rolling 12 months) | LT | DB | TBC | UHL | TBC | | | | | | | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | | 0% |
| W20 | Executive Team Turnover Rate - Non Executive Directors (rolling 12 months) | LT | DB | TBC | UHL | TBC | | | | | | | 14% | 14% | 29% | 43% | 43% | 43% | 43% | 43% | | 43% |
| W21 | DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%) | JS | MM | TBC | NHSI | TBC | 91.2% | 90.5% | 91.0% | 90.5% | 89.5% | 90.2% | 91.6% | 91.3% | 91.4% | 89.7% | 89.4% | 89.9% | 90.0% | 89.3% | 90.4% | 90.3% |
| W22 | DAY Safety staffing fill rate - Average fill rate - care staff (%) | JS | MM | TBC | NHSI | TBC | 94.0% | 92.0% | 93.9% | 92.1% | 86.0% | 88.7% | 92.5% | 93.7% | 93.8% | 92.0% | 94.7% | 91.0% | 91.9% | 93.2% | 91.9% | 92.7% |
| W23 | NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%) | JS | MM | TBC | NHSI | TBC | 94.9% | 95.4% | 94.8% | 96.6% | 95.0% | 96.3% | 97.6% | 97.2% | 96.6% | 94.5% | 95.0% | 95.1% | 96.7% | 95.9% | 96.9% | 96.2% |
| W24 | NIGHT Safety staffing fill rate - Average fill rate - care staff (%) | JS | MM | TBC | NHSI | TBC | 99.8% | 98.9% | 98.0% | 100.2% | 91.6% | 94.7% | 98.3% | 99.1% | 96.7% | 97.1% | 98.2% | 96.8% | 94.2% | 95.6% | 98.5% | 97.2% |

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

**Effective**

| KPI Ref | Indicators | Board Director | Lead Officer | 16/17 Target | Target Set by | 16/17 Red RAG/ Exception Report Threshold (ER) | 14/15 Outturn | 15/16 Outturn | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| E1 | Emergency readmissions within 30 days following an elective or emergency spell | AF | MM | Monthly <8.5% (revised) | QC | Red if >8.6%<br>ER if >8.6% | 8.5% | 8.9% | 9.2% | 8.8% | 8.7% | 8.8% | 8.7% | 8.7% | 8.6% | 8.3% | 8.4% | 8.5% | 8.5% | 8.1% | | 8.5% |
| E2 | Mortality - Published SHMI | AF | RB | <=99 (revised) | QC | Red if >100<br>ER if >100 | 103 | 96 | 95 (Jul14-Jun15) | | | 96 (Oct14-Sep15) | | | 98 (Jan15-Dec15) | | | 99 (Apr15-Mar16) | | | 101 (Jul15-Jun16) | 101 |
| E3 | Mortality - Rolling 12 mths SHMI (as reported in HED) Rebased | AF | RB | <=99 (revised) | QC | Red if >100<br>ER if >100 | 98 | 97 | 100 | 100 | 100 | 101 | 102 | 102 | 102 | 103 | 103 | 102 | Awaiting HED Update | | | 102 |
| E4 | Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED) | AF | RB | <=99 (revised) | UHL | Red if >100<br>ER if >100 | 94 | 96 | 95 | 95 | 95 | 97 | 99 | 99 | 100 | 102 | 103 | 102 | Awaiting HED Update | | | 102 |
| E5 | Crude Mortality Rate Emergency Spells | AF | RB | No Threshold | UHL | Monthly Reporting | 2.4% | 2.3% | 2.5% | 2.4% | 2.4% | 2.7% | 2.4% | 2.2% | 2.2% | 2.2% | 2.2% | 2.0% | 2.2% | 2.3% | 2.7% | 2.3% |
| E6 | No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions | AF | AC | 72% or above | QS | Red if <72%<br>ER if 2 consecutive mths <72% | 61.4% | 63.8% | 59.7% | 66.7% | 65.2% | 65.1% | 78.0% | 78.1% | 64.6% | 86.0% | 65.8% | 69.4% | 64.1% | 78.0% | 60.3% | 71.6% |
| E7 | No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions (excluding medically unfit patients) | AF | AC | 72% or above | UHL | Red if <72%<br>ER if 2 consecutive mths <72% | NEW INDICATOR | | | | | 73.2% | 86.8% | 87.7% | 73.2% | 90.0% | 82.0% | 87.2% | 78.2% | 89.0% | 79.5% | 83.7% |
| E8 | Stroke - 90% of Stay on a Stroke Unit | RM | IL | 80% or above | QS | Red if <80%<br>ER if 2 consecutive mths <80% | 81.3% | 85.6% | 87.0% | 90.6% | 87.0% | 86.5% | 72.7% | 93.5% | 83.8% | 80.7% | 88.0% | 83.7% | 83.1% | 84.8% | | 83.5% |
| E9 | Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA) | RM | IL | 60% or above | QS | Red if <60%<br>ER if 2 consecutive mths <60% | 71.2% | 75.6% | 68.4% | 71.3% | 80.0% | 67.3% | 53.5% | 68.2% | 50.4% | 54.8% | 71.7% | 65.3% | 83.8% | 75.9% | 69.2% | 65.6% |
| E10 | Published Clinical Outcomes - data submission and outcome results | AF | RB | 0 delayed /outside expected (revised) | UHL | ER if Red<br>Quarterly ER if >0 | Revised Indicator | | | | | | | | | | | | | | | |
| E11 | Compliance with NICE Guidance (15/16 and 16/17) | AF | RB | 0 Non compliance and no actions or actions delayed (revised) | UHL | Red if in mth >0<br>ER if Red | Revised Indicator | | | | | | | | | | | | | | | |

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

**Responsive**

| KPI Ref | Indicators | Board Director | Lead Officer | 16/17 Target | Target Set by | Red RAG/ Exception Report Threshold (ER) | 14/15 Outturn | 15/16 Outturn | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| R1 | ED 4 Hour Waits UHL + UCC (Calendar Month) | RM | IL | 95% or above | NHSI | Red if <92% ER via ED TB report | 89.1% | 86.9% | 85.1% | 81.2% | 80.2% | 77.5% | 81.2% | 79.9% | 80.6% | 76.9% | 80.1% | 79.9% | 78.3% | 77.6% | 75.5% | 78.9% |
| R2 | 12 hour trolley waits in A&E | RM | IL | 0 | NHSI | Red if >0 ER via ED TB report | 4 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| R3 | RTT - Incomplete 92% in 18 Weeks UHL+ALLIANCE | RM | WM | 92% or above | NHSI | Red /ER if <92% | 96.7% | 92.6% | 93.0% | 92.9% | 93.2% | 92.6% | 92.7% | 92.7% | 92.4% | 92.4% | 92.1% | 91.7% | 91.5% | 92.2% | 91.3% | 91.3% |
| R4 | RTT 52 Weeks+ Wait (Incompletes) UHL+ALLIANCE | RM | WM | 0 | NHSI | Red /ER if >0 | 0 | 232 | 267 | 269 | 261 | 232 | 169 | 134 | 130 | 77 | 57 | 53 | 38 | 34 | 32 | 32 |
| R5 | 6 Week - Diagnostic Test Waiting Times (UHL+ALLIANCE) | RM | WM | 1% or below | NHSI | Red /ER if >1% | 0.9% | 1.1% | 7.0% | 4.1% | 1.8% | 1.1% | 0.7% | 0.6% | 0.7% | 0.6% | 1.4% | 1.5% | 0.6% | 0.6% | 0.9% | 0.9% |
| R6 | Urgent Operations Cancelled Twice (UHL+ALLIANCE) | RM | GH | 0 | NHSI | Red if >0 ER if >0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 3 |
| R7 | Cancelled patients not offered a date within 28 days of the cancellations UHL | RM | GH | 0 | NHSI | Red if >2 ER if >0 | 33 | 48 | 6 | 6 | 9 | 14 | 24 | 16 | 18 | 20 | 19 | 10 | 9 | 13 | 18 | 147 |
| R8 | Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE | RM | GH | 0 | NHSI | Red if >2 ER if >0 | 11 | 1 | 0 | 0 | 0 | 0 | 5 | 0 | 0 | 0 | 6 | 0 | 0 | 0 | 0 | 11 |
| R9 | % Operations cancelled for non-clinical reasons on or after the day of admission UHL | RM | GH | 0.8% or below | Contract | Red if >0.9% ER if >0.8% | 0.9% | 1.0% | 1.1% | 1.3% | 1.2% | 1.5% | 1.5% | 1.2% | 1.4% | 1.1% | 0.9% | 1.0% | 1.2% | 1.5% | 0.8% | 1.2% |
| R10 | % Operations cancelled for non-clinical reasons on or after the day of admission ALLIANCE | RM | GH | 0.8% or below | Contract | Red if >0.9% ER if >0.8% | 0.9% | 0.9% | 1.1% | 2.2% | 0.2% | 1.0% | 0.8% | 0.3% | 0.8% | 1.4% | 3.2% | 0.9% | 2.0% | 0.5% | 0.1% | 1.0% |
| R11 | % Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE | RM | GH | 0.8% or below | Contract | Red if >0.9% ER if >0.8% | 0.9% | 1.0% | 1.1% | 1.4% | 1.1% | 1.4% | 1.5% | 1.2% | 1.4% | 1.1% | 1.0% | 1.0% | 1.2% | 1.4% | 0.8% | 1.2% |
| R12 | No of Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE | RM | GH | Not Applicable | | Not Applicable | 1071 | 1299 | 115 | 146 | 119 | 156 | 156 | 123 | 154 | 114 | 110 | 109 | 134 | 164 | 82 | 1146 |
| R13 | Delayed transfers of care | RM | SL | 3.5% or below | NHSI | Red if >3.5% ER if Red for 3 consecutive mths | 3.9% | 1.4% | 1.6% | 1.8% | 1.8% | 2.0% | 1.9% | 1.8% | 2.2% | 2.9% | 2.5% | 2.1% | 2.0% | 2.7% | 2.8% | 2.3% |
| R14 | Ambulance Handover >60 Mins (CAD+ from June 15) | RM | SL | 0 | Contract | Red if >0 ER if Red for 3 consecutive mths | 5% | 5% | 16% | 12% | 10% | 11% | 6% | 6% | 6% | 9% | 7% | 9% | 9% | 11% | 17% | 9% |
| R15 | Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15) | RM | SL | 0 | Contract | Red if >0 ER if Red for 3 consecutive mths | 19% | 19% | 23% | 13% | 13% | 13% | 11% | 12% | 10% | 15% | 14% | 15% | 18% | 18% | 18% | 15% |

## Responsive Cancer

| KPI Ref | Indicators | Board Director | Lead Officer | 15/16 Target | Target Set by | Red RAG/ Exception Report Threshold (ER) | 14/15 Outturn | 15/16 Outturn | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ** Cancer statistics are reported a month in arrears. | | | | | | | | | | | | | | | | | | | | | | |
| RC1 | Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers | RM | DB | 93% or above | NHSI | Red if <93% ER if Red for 2 consecutive mths | 92.2% | 90.5% | 93.0% | 91.4% | 93.9% | 93.0% | 91.1% | 89.5% | 90.5% | 94.3% | 94.9% | 94.5% | 93.3% | 95.2% | ** | 92.9% |
| RC2 | Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected) | RM | DB | 93% or above | NHSI | Red if <93% ER if Red for 2 consecutive mths | 94.1% | 95.1% | 93.5% | 96.2% | 99.3% | 95.7% | 96.1% | 88.7% | 94.9% | 98.7% | 95.9% | 95.0% | 90.7% | 96.0% | ** | 94.4% |
| RC3 | 31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers | RM | DB | 96% or above | NHSI | Red if <96% ER if Red for 2 consecutive mths | 94.6% | 94.8% | 94.3% | 91.5% | 92.6% | 94.1% | 95.4% | 95.5% | 95.6% | 90.4% | 91.3% | 93.8% | 94.8% | 94.2% | ** | 93.8% |
| RC4 | 31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments | RM | DB | 98% or above | NHSI | Red if <98% ER if Red for 2 consecutive mths | 99.4% | 99.7% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 97.9% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | ** | 99.7% |
| RC5 | 31-Day Wait For Second Or Subsequent Treatment: Surgery | RM | DB | 94% or above | NHSI | Red if <94% ER if Red for 2 consecutive mths | 89.0% | 85.3% | 91.4% | 77.5% | 77.9% | 80.3% | 90.3% | 91.6% | 84.7% | 74.4% | 72.7% | 83.5% | 90.4% | 83.3% | ** | 83.8% |
| RC6 | 31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments | RM | DB | 94% or above | NHSI | Red if <94% ER if Red for 2 consecutive mths | 96.1% | 94.9% | 94.3% | 96.4% | 92.9% | 96.4% | 98.8% | 93.6% | 87.3% | 92.5% | 81.4% | 90.9% | 97.8% | 94.8% | ** | 91.5% |
| RC7 | 62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers | RM | DB | 85% or above | NHSI | Red if <85% ER if Red in mth or YTD | 81.4% | 77.5% | 80.9% | 75.1% | 73.4% | 77.6% | 75.8% | 74.5% | 77.3% | 83.6% | 78.4% | 77.9% | 74.4% | 77.2% | ** | 77.4% |
| RC8 | 62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers | RM | DB | 90% or above | NHSI | Red if <90% ER if Red for 2 consecutive mths | 84.5% | 89.1% | 95.3% | 77.3% | 72.5% | 81.3% | 94.6% | 96.0% | 85.0% | 92.3% | 78.9% | 81.5% | 84.2% | 88.0% | ** | 87.9% |
| RC9 | Cancer waiting 104 days | RM | DB | 0 | NHSI | TBC | | | 23 | 23 | 17 | 21 | 12 | 7 | 15 | 12 | 9 | 7 | 7 | 9 | 10 | 10 |

**62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers Inc Rare Cancers**

| KPI Ref | Indicators | Board Director | Lead Officer | 15/16 Target | Target Set by | Red RAG/ Exception Report Threshold (ER) | 14/15 Outturn | 15/16 Outturn | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RC10 | Brain/Central Nervous System | RM | DB | 85% or above | NHSI | Red if <90% ER if Red for 2 consecutive mths | -- | 100.0% | -- | -- | 100.0% | -- | -- | -- | -- | -- | -- | 100.0% | -- | -- | ** | 100.0% |
| RC11 | Breast | RM | DB | 85% or above | NHSI | Red if <90% ER if Red for 2 consecutive mths | 92.6% | 95.6% | 93.1% | 94.6% | 100.0% | 94.1% | 93.3% | 95.3% | 97.1% | 100.0% | 100.0% | 95.8% | 100.0% | 95.8% | ** | 97.3% |
| RC12 | Gynaecological | RM | DB | 85% or above | NHSI | Red if <90% ER if Red for 2 consecutive mths | 77.5% | 73.4% | 85.7% | 50.0% | 70.0% | 78.6% | 72.7% | 78.6% | 75.0% | 62.5% | 66.7% | 66.7% | 78.6% | 66.7% | ** | 70.5% |
| RC13 | Haematological | RM | DB | 85% or above | NHSI | Red if <90% ER if Red for 2 consecutive mths | 66.5% | 63.0% | 58.3% | 100.0% | 60.0% | 60.0% | 14.3% | 61.5% | 72.7% | 100.0% | 85.7% | 28.6% | 58.3% | 77.8% | ** | 65.3% |
| RC14 | Head and Neck | RM | DB | 85% or above | NHSI | Red if <90% ER if Red for 2 consecutive mths | 69.9% | 50.7% | 37.5% | 62.5% | 37.5% | 35.7% | 35.7% | 45.5% | 100.0% | 42.9% | 44.4% | 0.0% | 38.5% | 66.7% | ** | 43.8% |
| RC15 | Lower Gastrointestinal Cancer | RM | DB | 85% or above | NHSI | Red if <90% ER if Red for 2 consecutive mths | 63.7% | 59.8% | 77.8% | 52.4% | 31.3% | 57.1% | 62.5% | 45.0% | 64.5% | 58.8% | 64.4% | 47.1% | 38.1% | 61.5% | ** | 55.2% |
| RC16 | Lung | RM | DB | 85% or above | NHSI | Red if <90% ER if Red for 2 consecutive mths | 69.9% | 71.0% | 81.6% | 73.7% | 53.8% | 71.1% | 66.7% | 46.7% | 64.2% | 60.9% | 64.2% | 68.0% | 79.4% | 67.5% | ** | 64.6% |
| RC17 | Other | RM | DB | 85% or above | NHSI | Red if <90% ER if Red for 2 consecutive mths | 95.0% | 71.4% | -- | 66.7% | -- | -- | 0.0% | 50.0% | 100.0% | 100.0% | 33.3% | 0.0% | 66.7% | -- | ** | 50.0% |
| RC18 | Sarcoma | RM | DB | 85% or above | NHSI | Red if <90% ER if Red for 2 consecutive mths | 46.2% | 81.3% | -- | -- | 100.0% | 100.0% | 0.0% | 50.0% | 16.7% | -- | -- | 100.0% | 50.0% | 100.0% | ** | 45.0% |
| RC19 | Skin | RM | DB | 85% or above | NHSI | Red if <90% ER if Red for 2 consecutive mths | 96.7% | 94.1% | 94.9% | 100.0% | 92.5% | 94.6% | 95.2% | 100.0% | 96.8% | 97.4% | 95.9% | 97.7% | 100.0% | 92.3% | ** | 97.1% |
| RC20 | Upper Gastrointestinal Cancer | RM | DB | 85% or above | NHSI | Red if <90% ER if Red for 2 consecutive mths | 73.9% | 63.9% | 90.0% | 42.9% | 57.1% | 76.5% | 74.3% | 70.0% | 46.9% | 66.7% | 82.0% | 70.3% | 43.8% | 100.0% | ** | 67.9% |
| RC21 | Urological (excluding testicular) | RM | DB | 85% or above | NHSI | Red if <90% ER if Red for 2 consecutive mths | 82.6% | 74.4% | 75.0% | 67.4% | 78.7% | 83.6% | 83.7% | 73.1% | 77.8% | 96.3% | 74.5% | 83.5% | 88.2% | 75.0% | ** | 81.5% |
| RC22 | Rare Cancers | RM | DB | 85% or above | NHSI | Red if <90% ER if Red for 2 consecutive mths | 84.6% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | ** | 100.0% |
| RC23 | Grand Total | RM | DB | 85% or above | NHSI | Red if <90% ER if Red for 2 consecutive mths | 81.4% | 77.5% | 80.9% | 75.1% | 73.4% | 77.6% | 75.8% | 74.5% | 77.3% | 83.6% | 78.4% | 77.9% | 74.4% | 77.2% | ** | 77.4% |

**The Sustainability and Transformation Fund Trajectories and Performance**

## ED trajectory

| | Submitted on a "best endeavours" basis | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | March |
| Performance | 78% | 78% | 79% | 79% | 80% | 85% | 85% | 85% | 85% | 89% | 89% | 91.2% |
| **Actual** | **81%** | **80%** | **81%** | **77%** | **80%** | **80%** | **78%** | **78%** | **76%** | | | |

## Cancer

| | | | Submitted on a "best endeavours" basis | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | March |
| Performance | 70.2% | 74.0% | 85.1% | 85.1% | 85.1% | 85.1% | 85.1% | 85.1% | 85.1% | 85.1% | 85.1% | 85.1% |
| **Actual** | **75.8%** | **74.5%** | **77.3%** | **83.6%** | **78.4%** | **77.9%** | **73.9%** | **77.2%** | | | | |

## Diagnostics

| | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Performance | 0.98% | 0.98% | 0.98% | 0.98% | 0.98% | 0.98% | 0.98% | 0.98% | 0.98% | 0.98% | 0.98% | 0.98% |
| **Actual** | **0.7%** | **0.6%** | **0.7%** | **0.6%** | **1.4%** | **1.5%** | **0.6%** | **0.6%** | **0.9%** | | | |

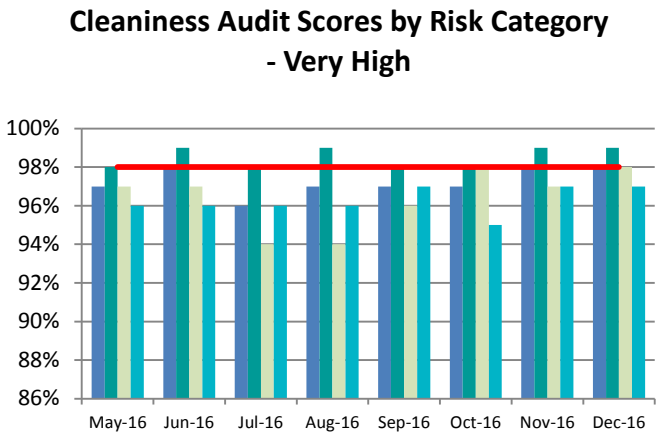
## RTT

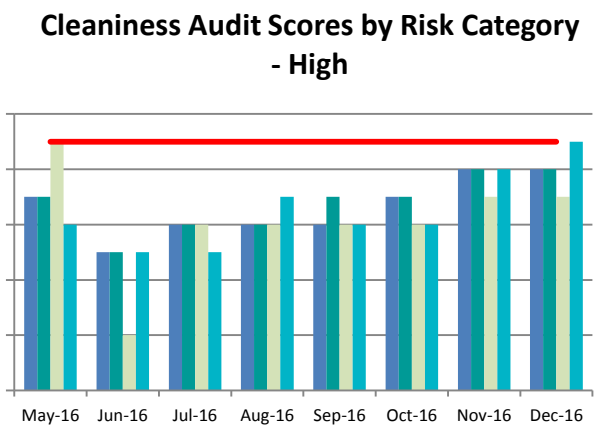
| | Submitted on a "best endeavours" basis April - June | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | March |
| Performance | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% |
| **Actual** | **92.7%** | **92.7%** | **92.4%** | **92.4%** | **92.1%** | **91.7%** | **91.5%** | **92.2%** | **91.3%** | | | |

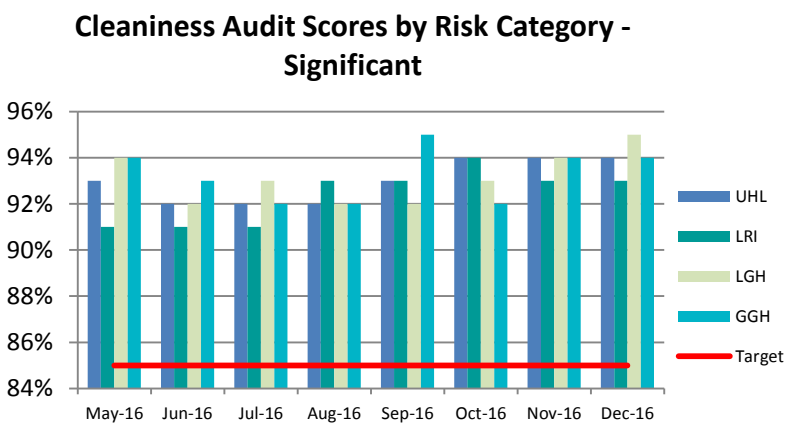
## Compliance Forecast for Key Responsive Indicators

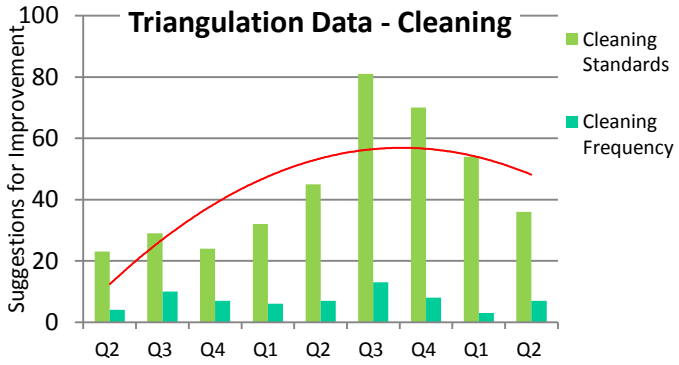
| Standard | December | January | Commentary |
|---|---|---|---|
| Emergency Care | | | |
| 4+ hr Wait (95%) - Calendar month | 75.5% | | Validated position |
| Ambulance Handover (CAD+) | | | |
| % Ambulance Handover >60 Mins (CAD+) | 17% | | EMAS monthly report |
| % Ambulance Handover >30 Mins and <60 mins (CAD+) | 18% | | |
| RTT (inc Alliance) | | | |
| Incomplete (92%) | 91.3% | 90.9% | The January target is at risk due to winter bed pressures and request from NHSI to reduce elective workload to support ED performance. |
| Diagnostic (inc Alliance) | | | |
| DM01 - diagnostics 6+ week waits (<1%) | 0.9% | 0.9% | |
| # Neck of femurs | | | |
| % operated on within 36hrs - all admissions (72%) | 60% | 72% | |
| % operated on within 36hrs - pts fit for surgery (72%) | 80% | 82% | |
| Cancelled Ops (inc Alliance) | | | |
| Cancelled Ops (0.8%) | 0.8% | 1.6% | Delivery is dependant on access to beds. |
| Not Rebooked within 28 days (0 patients) | 18 | 14 | Delivery is dependant on access to beds. |
| Cancer | | | |
| Two Week Wait (93%) | 95% | 91% | |
| 31 Day First Treatment (96%) | 94% | 84% | In discussion with NHSI compliance will be following 2 months of consistent bed access. |
| 31 Day Subsequent Surgery Treatment (94%) | 83% | 87% | |
| 62 Days (85%) | 77% | 78% | In discussion with NHSI compliance will be following 2 months of consistent bed access. |
| Cancer waiting 104 days (0 patients) | 10 | 10 | |

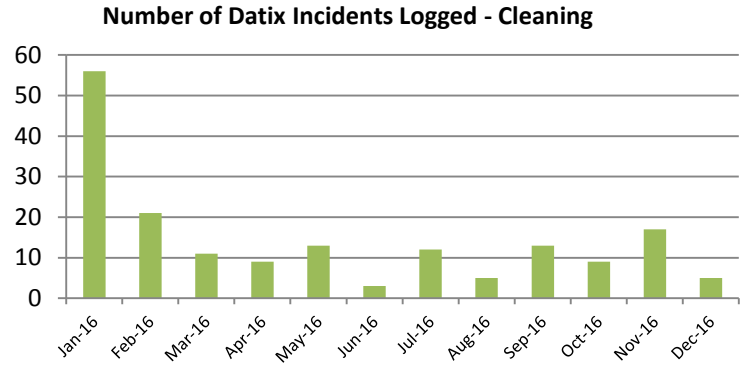
# Estates and Facilities – Cleanliness




## Cleanliness Report

The above charts show average audit scores for the whole Trust and by hospital site since May 2016 – when services were transferred back in-house. Each chart covers specific risk categories:-

- Very High – e.g. Operating Theatres, ITUs, A&E - Target Score 98%
- High – Wards e.g. Sterile supplies, Public Toilets – Target Score 95%
- Significant – e.g. Outpatient Departments, Pathology labs

Cleanliness audits are undertaken jointly involving both ward staff as well as members of the Facilities Team.

For very high risk areas the data shows that this was achieved in December 2016 overall across the Trust with a very slight improvement over last month with only GH missing this target by 1%.
For high risk areas improvement is noted in with GH now achieving to the required 95% score. Slight improvement is still required in LGH and LRI.
Significant risk areas all exceed the 85% target.
The general trend remains one of continuous but very steady improvement.

The triangulation data is collected by the Trust from numerous patient sources including Message to Matron, Friends and Family Test, Complaints, Online sources and Message to Volunteer or Carer collated collectively as 'Suggestions for Improvement'.
As this data is only collated on a quarterly basis the chart included here is as presented in last month's report and will be updated for the January report.

As a further test of service standards and issues the number of datix incidents logged for December shows a marked drop off compared to the November figure.

The number of vacancies continues to be the most significant challenge to the provision of the cleaning service, however large scale recruitment is in progress and is beginning to improve the situation. The resource allocated to main entrances and corridors at the LRI is under review given the current challenges in terms of the amount of pedestrian traffic and the impact on impression and appearance.

# Estates and Facilities – Patient Catering

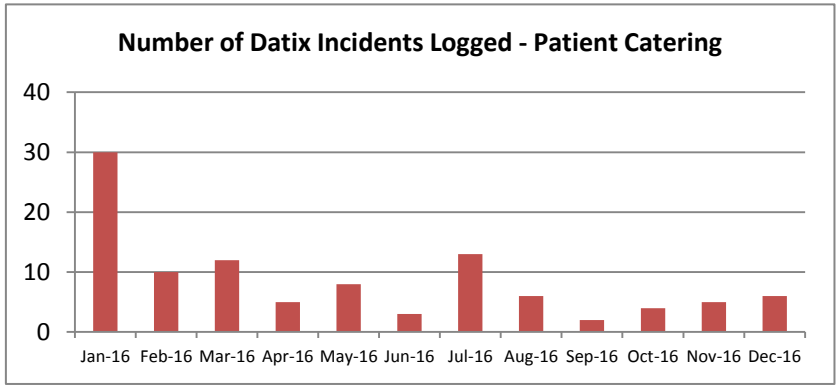
| Patient Catering Survey – November 2016 | Percentage 'OK or Good' | |
|---|---|---|
| | Nov-16 | Dec-16 |
| Did you enjoy your food? | 84% | 82% |
| Did you feel the menu has a good choice of food? | 92% | 91% |
| Did you get the meal that you ordered? | 98% | 98% |
| Were you given enough to eat? | 96% | 97% |

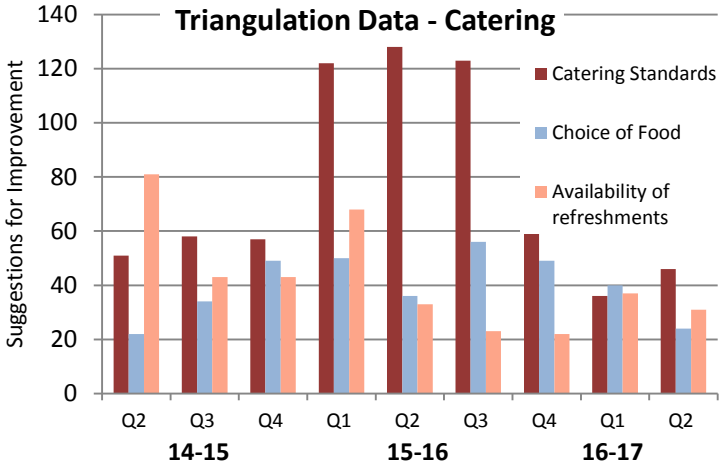
| 90 – 100% | 80 – 90% | <80% |
|---|---|---|

| Number of Patient Meals Served | | | | |
|---|---|---|---|---|
| Month | LRI | LGH | GGH | UHL |
| October | 62,008 | 26,294 | 28,030 | 116,332 |
| November | 63,828 | 22,251 | 28,460 | 114,539 |
| December | 67,893 | 22,532 | 27,945 | 118,370 |

| Patient Meals Served On Time (%) | | | | |
|---|---|---|---|---|
| Month | LRI | LGH | GGH | UHL |
| October | 100% | 100% | 100% | 100% |
| November | 100% | 100% | 100% | 100% |
| December | 100% | 100% | 100% | 100% |

| 97 – 100% | 95 – 97% | <95% |
|---|---|---|




**Patient Catering Report**

Ensuring that patients are fed was one of the key priorities at the point of hand back of services at the termination of the Estates and Facilities contract. This has continued to be achieved at 100%.

The patient catering survey results for December were based on a sample of 66 patients. Whilst the majority of patients reported that they enjoyed their meals, similar to the November picture there are a number who appear to experience some issues with the quality. Further data will be collected and analysed to shed light on this.

In terms of ensuring patients are fed this continues to perform well.

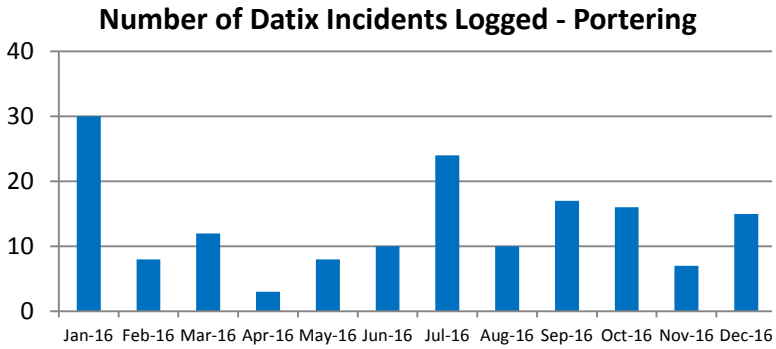
The triangulation data is refreshed on a quarterly basis and therefore the chart presented here is repeated from the November report. The updated position will be presented in next month's report.

## Estates and Facilities - Portering

| Reactive Portering Tasks in Target | | | | |
|---|---|---|---|---|
| Site | Task (Urgent 15min, Routine 30min) | Month | | |
| | | October | November | December |
| GH | Overall | 97% | 95% | 96% |
| | Routine | 96% | 95% | 96% |
| | Urgent | 98% | 97% | 97% |
| LGH | Overall | 93% | 93% | 94% |
| | Routine | 92% | 93% | 93% |
| | Urgent | 96% | 96% | 98% |
| LRI | Overall | 90% | 91% | 90% |
| | Routine | 80% | 91% | 90% |
| | Urgent | 89% | 94% | 98% |

| 95 – 100% | 90 – 95% | <90% |
|---|---|---|

| Average Portering Task Response Times | | |
|---|---|---|
| Category | Time | No of tasks |
| Urgent | 13:19 | 1,093 |
| Routine | 22:10 | 11,481 |
| | Total | 12.578 |




### Portering Report

The Reactive Task performance for Portering is based on a sample of the overall number of tasks carried out in the month as current systems do not capture the full range of duties.

December performance overall was very similar to November except that Datix incidents have shown a marked rise.

As well as continuing to struggle with the number of vacancies, December saw an increase in the level of staff sickness that impacted on our ability to fill rotas adequately.

A number of initiatives are in progress to increase efficiency in the deployment of porters – areas across the Trust where there are dedicated staff are under review with a view to operating all services from the main portering pool.

Work continues to improve reporting of performance. Future reports will include average response times by site and category.

## Estates and Facilities – Planned Maintenance

| Statutory Maintenance Tasks Against Schedule | | | | | |
|---|---|---|---|---|---|
| | Month | Fail | Pass | Total | % |
| UHL Trust Wide | October | 1 | 207 | 208 | 100% |
| | November | 2 | 172 | 174 | 99% |
| | December | 4 | 191 | 195 | 98% |

| 99 – 100% | 97 – 99% | <97% |
|---|---|---|

| Non-Statutory Maintenance Tasks Against Schedule | | | | | |
|---|---|---|---|---|---|
| | Month | Fail | Pass | Total | % |
| UHL Trust Wide | October | 334 | 2227 | 2561 | 87% |
| | November | 296 | 1823 | 2119 | 86% |
| | December | 344 | 1943 | 2287 | 85% |

| 95 – 100% | 80 – 95% | <80% |
|---|---|---|

### Estates Planned Maintenance Report

For December failure items in Statutory Maintenance relate to 4 items missed in error by our contractor – 2 emergency lights and 2 emergency gas shut off valves. These will be picked up and completed before the end of January 2017.

For the Non-Statutory tasks, completion of the monthly schedule is subject to the volume of reactive calls. Drainage issues continue to put the maintenance service under pressure. Future reports will provide reactive maintenance data alongside the planned maintenance data to provide the complete picture

Note: changes with the HRA process have changed the start point for these KPI's

| KPI Ref | Indicators | Board Director | Lead Officer | 14/15 Target | Target Set by | Red RAG/ Exception Report Threshold (ER) | 14/15 Outturn | 15/16 Outturn | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RU1 | Median Days from submission to Trust approval (Portfolio) | AF | NB | TBC | TBC | TBC | 2.8 | 1.0 | 1.0 | | | 2.0 | | | 1.0 | | | 1.0 | | | 4.5 | | | 48 | | |
| RU2 | Median Days from submission to Trust approval (Non Portfolio) | AF | NB | TBC | TBC | TBC | 2.1 | 1.0 | 1.0 | | | 1.0 | | | 1.0 | | | 1.0 | | | 41.0 | | | 90 | | |
| RU3 | Recruitment to Portfolio Studies | AF | NB | Aspirational target=10920/year (910/month) | TBC | TBC | 12564 | 13479 | 1019 | 858 | 1019 | 1516 | 1875 | 815 | 926 | 983 | 947 | 979 | 917 | 887 | 758 | 657 | 592 | 487 | 699 | 325 |
| RU4 | % Adjusted Trials Meeting 70 day Benchmark (data sunbmitted for the previous 12 month period) | AF | NB | TBC | TBC | TBC | | | (Oct14-Sep15) 92% | | | (Jan15 - Dec15) 94% | | | (Apr15 - Mar16) 94% | | | (Jul15 - Jun16) 94% | | | (Oct15 - Sep16) 90.3% | | | | | |
| RU5 | Rank No. Trials Submitted for 70 day Benchmark (data submitted for the previous 12 month period) | AF | NB | TBC | TBC | TBC | | | (Oct14-Sep15) Rank 13/215 | | | (Jan15 - Dec15) Rank 61/213 | | | (Apr15 - Mar16) Rank 16/222 | | | (Jul15 - Jun16) 12/220 | | | (Oct15 - Sep16) 10/205 | | | | | |
| RU6 | %Closed Commercial Trials Meeting Recruitment Target (data submitted for the previous 12 month period) | AF | NB | TBC | TBC | TBC | | | (Oct14-Sep15) 46.8% | | | (Jan15 - Dec 15) 43.4% | | | (Apr15 - Mar16) 65.8% | | | (Jul15 - Jun16) 40.8% | | | (Oct15 - Sep16) 52.0% | | | | | |

## A&E Friends and Family Test - % Positive Performance and Coverage

| Indicators | 16/17 Target | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|
| A&E Friends and Family Test - % positive | 97% | 96% | 95% | 95% | 87% | 87% | 84% | 87% | 84% | 91% | 90% |
| A&E Friends and Family Test - Coverage | 20% | 13.0% | 10.2% | 12.0% | 8.7% | 9.9% | 11.7% | 9.8% | 11.4% | 7.1% | 10.4% |

The Friends and Family Test results for the Emergency Department includes six areas in the overall submission; Majors, Minors, Childrens ED, EDU, Eye Casualty and the Urgent Care Centre (UCC).

The has been a decline is the Friends and Family Test results, this is mostly due to the UCC, however there has been a reduction in the score received in Majors and Minors. The Minors area moved to its new location in July, since then the FFT score has decreased.

Response rate in ED has increased this month, mostly attributed to UCC, Minors and Majors gives a poor representation of the overall patients who access these areas, none of these areas has achieved the 20% minimal target.

The free text comments in the UCC indicate the reasons for the low FFT as waiting times, staff attitude and the department layout/comfort.

### Actions taken to improve performance

- The Matron Team are setting up regular meetings with the Patient Experience Team in order to review and discuss ways to improve the FFT Scores.
- A core team of staff are being selected to drive FFT within the Emergency Department.
- The Sister responsible for the UCC is reviewing ways to improve compliance and to monitor daily response rates.
- Where possible, a support worker is allocated on a daily basis to collecting FFT.
- Processes within the UCC are being reviewed by the Front Door workgroup, looking at ways to improve patient flow through the department, which is hoped, will improve the patient experience and decrease the waiting times.
- FFT Scores and patient feedback is shared with the ED team.

## Single Sex Accommodation Breaches (patients affected)

| Indicators | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|
| Single Sex Accommodation Breaches (patients affected) | 0 | 0 | 4 | 1 | 2 | 20 | 7 | 1 | 14 | 49 |

Intensive Care Unit
There were 2 same sex breaches with only these 2 patients affected; they were both due to lack of bed capacity, one in the Neurology speciality and one in the surgical speciality.

Ophthalmology Suite
There were 4 breaches with 12 patients affected. The Ophthalmology Suite is situated within a very small clinical environment which meets the needs of large numbers of patients each day. Due to activity within the Suite 4 breaches occurred for patients undergoing day case eye surgery.

**Actions taken to improve performance**

Intensive Care Unit

ICU patients are discussed at gold command as soon as they are identified for discharge from ICU and every subsequent meeting until a bed is identified.
Nurse in charge of ICU, monitors the progress of the bed allocation and ambulance availability, then escalates appropriately.
The Duty Management team make identification of a bed a priority for patients who are waiting discharge from ICU.

Ophthalmology

Regular meetings have been held with the Matron and Sister for the area, support has been offered to them and the team working in the suite. Ensuring a full understanding of the SSA Matrix. Processes have been looked at and theatre lists have been reviewed to optimise patient's privacy and dignity while in the suite.

## Mortality – Published SHMI
## Mortality - Rolling 12 months 'Unpublished SHMI' (as reported in HED) Rebased
## Mortality - Rolling 12 months HSMR (as reported in HED) Rebased

| | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Mortality - Published SHMI** | **95 (Jul14-Jun15)** | | | **96 (Oct14-Sep15)** | | | **98 (Jan15-Dec15)** | | | **99 (Apr15-Mar16)** | | | **101 (Jul15-Jun16)** | **101** |

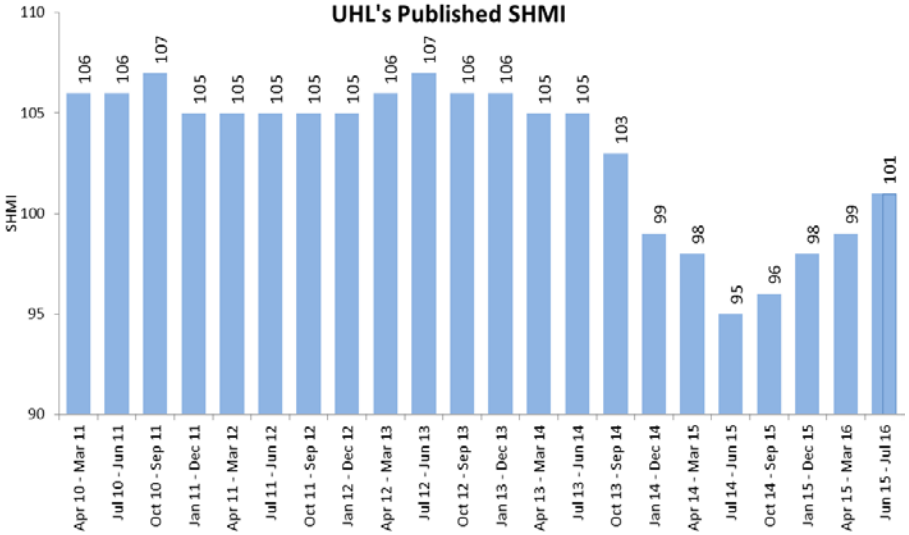
| | Jan15-Dec15 | Feb15-Jan16 | Mar15-Feb16 | Apr15 - Mar16 | May15 - Apr 16 | Jun15 - May16 | Jul15 - Jun16 | Aug15 - Jul16 | Sep15 - Aug16 | Oct15 - Sep16 | Nov15 - Oct16 | Dec15 - Nov16 | Jan16 - Dec 16 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Mortality - Rolling 12 mths SHMI (as reported in HED) Rebased** | **100** | **100** | **100** | **101** | **102** | **102** | **102** | **103** | **103** | **102** | Awaiting HED Update | | | **102** |

| | Jan15-Dec15 | Feb15-Jan16 | Mar15-Feb16 | Apr15 - Mar16 | May15 - Apr 16 | Jun15 - May16 | Jul15 - Jun16 | Aug15 - Jul16 | Sep15 - Aug16 | Oct15 - Sep16 | Nov15 - Oct16 | Dec15 - Nov16 | Jan16 - Dec 16 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)** | **95** | **95** | **95** | **97** | **99** | **99** | **100** | **102** | **103** | **102** | Awaiting HED Update | | | **102** |

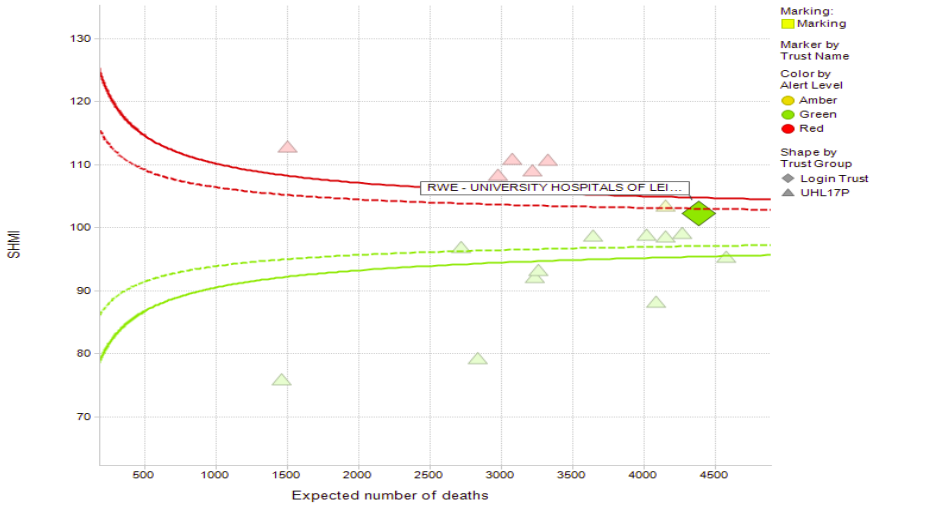
- The SHMI is the national measure for monitoring hospital mortality and includes both 'in-hospital deaths' and 'deaths occurring within 30 days of discharge from hospital'. The SHMI covers a 12 month period and is published on a quarterly basis by NHS digital.
- The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups in a specified patient group.
- UHL subscribes to both the HED mortality Benchmarking tool and is able to monitor the SHMI and HSMR. HED use the HSCIC methodology to replicate the SHMI
- A further increase in our SHMI is anticipated for the next publication at the end of March (see funnel chart below) where we are anticipating a SHMI of 102.
- Whilst this is still 'within expected' compared nationally and to similar sized trusts it is above the National average of 100 and also our Quality Commitment threshold of 99.

**Actions taken to improve performance**

- There have been several actions undertaken to reduce mortality as part of our Quality Commitment over the past 3 years and implementation of the Pneumonia Care Bundle appears to have had a positive impact on our SHMI. Earlier recognition of both sepsis and acute kidney injury are also both key priorities for this year.
- Other areas of focus are to increase cardiology input at the LRI site and also improve the patient pathway for patients admitted with gastro-intestinal haemorrhage as both of these diagnosis groups appear to be adversely contributing to our SHMI.
- In addition to monitoring mortality rates and carrying out further analysis or investigation where applicable, we continue to embed the Medical Examiner process at the LRI, commenced in July. Over 800 cases have now been screened by the Medical Examiners (over 90% of all adult deaths at the LRI) with 20% being referred for full review by the Speciality M&M.
- Where the Medical Examiner or Specialty Screener considers there is a need for a full review, these will be referred to the M&M lead and the full review then presented and discussed at the Specialty M&M meeting and Death Classification agreed.
- A full report including detailed analysis and actions being taken has been reported at the Executive Quality Board and the Quality Assurance Committee in January 2017.




**Please note that funnel plot is only valid when SHMI score is 100 for all the organisations (shown below) as a whole. It can be verified through highlighting all data items and checking grand total in Tab 3 breakdown table.**



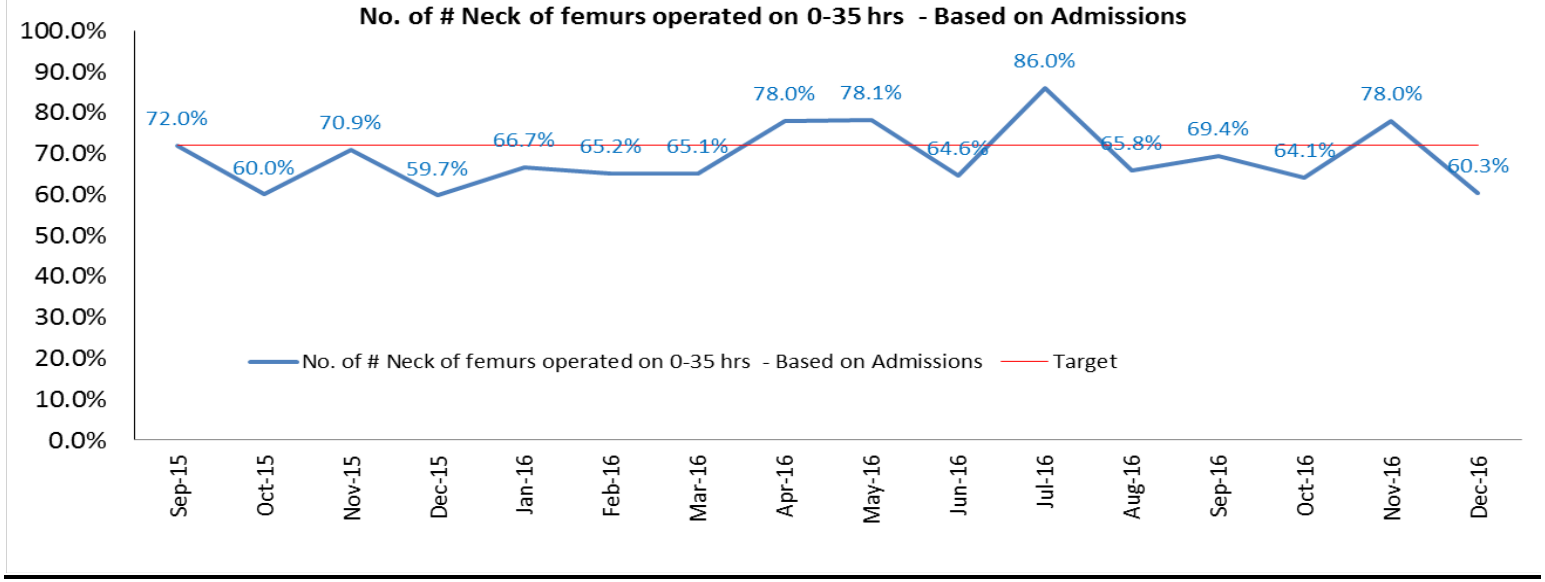
## No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions) - Performance

| | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|
| **No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions** | **78.0%** | **78.1%** | **64.6%** | **86.0%** | **65.8%** | **69.4%** | **64.1%** | **78.0%** | **60.3%** | **71.6%** |

There were 78 NOF admissions in December 2016, 30 patients breached the 36 hr target to theatre as detailed below:-
Within the service control = 15 patients. Main theme was theatre capacity ( 12 pts),
Outside service control = 15 patients. These were unfit and required stabilisation pre operatively. (14pts) and one conservative treatment.
There were 4 days when NOF admissions were 5 - 8 pts. 1st/16th / 21st/28th /30th Dec. Between 28th and 30th there were 13 NOF's admitted. There was also high admission rate of complex urgent Trauma and spinal cases mid-month which took priority clinically.

**Actions taken to improve performance**

1. Theatre team leader continues to work closely with trauma team to coordinate and manage changing priorities. Agreed at Antonymous Board 4 hips per all day session is achievable and continues to be monitored.
2. Appropriate transfers are made to LGH to help free capacity but are constrained by patients who are clinically unwell.
3. Weekly monitoring of theatre utilisation of all Trauma theatres implemented.
4. THR's have started to be undertaken at LRI. Hip surgeon availability is an issue when on-call surgeon is not of that sub speciality expertise.
5. Investigations how spinal activity can be accommodated minimising impact on other Trauma continue including moving cases if appropriate to LGH. Head of Service leading this.
6. The Medical Director has set up a steering group to look at how we can sustain NOF performance given that the service now has carried out many of the internal service 'quick' wins. Weekly NOF mtgs taking place chaired by the Clinical Director.



# RTT – Incomplete within 18 weeks and 52+ week waits

## Combined UHL and Alliance RTT Performance for December

| | <18 w | >18 w | Total Incompletes | % |
|---|---|---|---|---|
| Alliance | 7531 | 419 | 7950 | 94.73 |
| UHL | 45137 | 4589 | 49726 | 90.77 |
| Total | 52668 | 5008 | 57676 | 91.32 |

| | |
|---|---|
| Backlog Reduction required to meet 92% | **429** |

UHL and Alliance combined performance for RTT in December was 91.3%. The Trust did not achieve the standard after performing in November. Overall combined performance saw 5,008 patients in the backlog, 429 more than required amount. The total number of patients waiting more than 18 weeks for treatment increased by 502 for UHL, 108 for the Alliance with a combined backlog increase of 610 patients from the previous month.
The largest factors for not meeting performance in December were reduced planned activity due to bank holidays, reduced discretionary activity due to uptake in extra sessions over the Christmas break, patient choice reduced uptake in elective procedures outpatient appointment, requested elective pause from NSHI to support ED performance and increased referral rates in key specialities against the same period as last year.

**Forecast performance for next reporting period:**

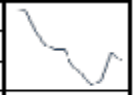
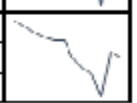
We are unlikely to meet the 92% performance standard in January, predicting close to 91.0%. Factors for the performance include,

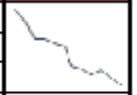
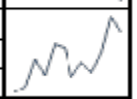
- Increasing bed pressures due to winter pressures as UHL entered a system critical incident
- Reduced number of working days due to bank holiday.
- Reduced discretionary effort post-Christmas

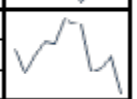
There are currently 7 specialties that due to size of number of patients in their backlog and relative size, have individual actions plans. These are monitored monthly Paediatric ENT, ENT, General Surgery, Urology, Allergy, Orthopaedics and Ophthalmology. Current plans and performance are highlighted later in the report along with the services performance and backlog trends over the past 12 months,

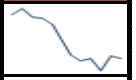
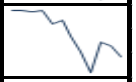
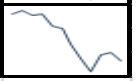
In order to achieve the 92% RTT standard performance against plan is monitored at the Weekly Access Meeting. Specialties not achieving target are escalated at the Weekly Head of Operations Meetings.

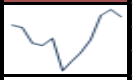
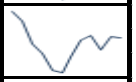
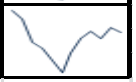
At end of December there were 32 patients who breached 52 weeks, 30 within MSS (including 15 Orthodontics), 5 patients have now had treatment, 8 patients have a treatment date and 2 for CHUGGS both treated.

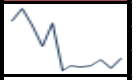
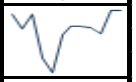
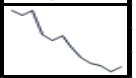
| GENERAL SURGERY | | Jan 16 | Feb 16 | Mar 16 | Apr 16 | May 16 | Jun 16 | Jul 16 | Aug 16 | Sep 16 | Oct 16 | Nov 16 | Dec 16 | % Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Admitted | < 18 | 611 | 695 | 648 | 627 | 598 | 675 | 654 | 646 | 593 | 578 | 651 | 628 |  |
| | 18+ | 157 | 173 | 209 | 238 | 238 | 268 | 303 | 328 | 334 | 312 | 268 | 278 | |
| | % | 79.6% | 80.1% | 75.6% | 72.5% | 71.5% | 71.6% | 68.3% | 66.3% | 64.0% | 64.9% | 70.8% | 69.3% | |
| Non Admitted | < 18 | 1917 | 1902 | 2088 | 2367 | 2306 | 2419 | 2228 | 2167 | 2346 | 1915 | 2177 | 2154 |  |
| | 18+ | 70 | 81 | 73 | 89 | 87 | 80 | 76 | 75 | 109 | 138 | 88 | 90 | |
| | % | 96.5% | 95.9% | 96.6% | 96.4% | 96.4% | 96.8% | 96.7% | 96.7% | 95.6% | 93.3% | 96.1% | 96.0% | |
| Total | < 18 | 2528 | 2597 | 2736 | 2994 | 2904 | 3094 | 2882 | 2813 | 2939 | 2493 | 2828 | 2782 |  |
| | 18+ | 227 | 254 | 282 | 327 | 325 | 348 | 379 | 403 | 443 | 450 | 356 | 368 | |
| | % | 91.8% | 91.1% | 90.7% | 90.2% | 89.9% | 89.9% | 88.4% | 87.5% | 86.9% | 84.7% | 88.8% | 88.3% | |

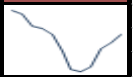
| UROLOGY | | Jan 16 | Feb 16 | Mar 16 | Apr 16 | May 16 | Jun 16 | Jul 16 | Aug 16 | Sep 16 | Oct 16 | Nov 16 | Dec 16 | % Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Admitted | < 18 | 466 | 488 | 453 | 478 | 500 | 531 | 490 | 486 | 496 | 504 | 483 | 518 |  |
| | 18+ | 103 | 132 | 157 | 165 | 184 | 204 | 236 | 241 | 265 | 255 | 265 | 310 | |
| | % | 81.9% | 78.7% | 74.3% | 74.3% | 73.1% | 72.2% | 67.5% | 66.9% | 65.2% | 66.4% | 64.6% | 62.6% | |
| Non Admitted | < 18 | 1451 | 1406 | 1634 | 1606 | 1626 | 1604 | 1548 | 1522 | 1601 | 1676 | 1908 | 2029 |  |
| | 18+ | 121 | 112 | 98 | 115 | 80 | 82 | 113 | 94 | 111 | 93 | 57 | 83 | |
| | % | 92.3% | 92.6% | 94.3% | 93.3% | 95.3% | 95.1% | 93.2% | 94.2% | 93.5% | 94.7% | 97.1% | 96.1% | |
| Total | < 18 | 1917 | 1894 | 2087 | 2084 | 2126 | 2135 | 2038 | 2008 | 2097 | 2180 | 2391 | 2547 |  |
| | 18+ | 224 | 244 | 255 | 280 | 264 | 286 | 349 | 335 | 376 | 348 | 322 | 393 | |
| | % | 89.5% | 88.6% | 89.1% | 88.2% | 89.0% | 88.2% | 85.4% | 85.7% | 84.8% | 86.2% | 88.1% | 86.6% | |

| ORTHOPAEDICS | | Jan 16 | Feb 16 | Mar 16 | Apr 16 | May 16 | Jun 16 | Jul 16 | Aug 16 | Sep 16 | Oct 16 | Nov 16 | Dec 16 | % Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Admitted | < 18 | 1124 | 1178 | 1051 | 1167 | 1211 | 1244 | 1160 | 1054 | 1141 | 1065 | 1212 | 1174 |  |
| | 18+ | 128 | 131 | 163 | 157 | 177 | 209 | 187 | 197 | 196 | 193 | 175 | 196 | |
| | % | 89.8% | 90.0% | 86.6% | 88.1% | 87.2% | 85.6% | 86.1% | 84.3% | 85.3% | 84.7% | 87.4% | 85.7% | |
| Non Admitted | < 18 | 2616 | 2117 | 2176 | 2298 | 2480 | 2517 | 2572 | 2650 | 2518 | 2578 | 2483 | 2520 |  |
| | 18+ | 242 | 232 | 210 | 201 | 219 | 176 | 190 | 197 | 274 | 273 | 242 | 315 | |
| | % | 91.5% | 90.1% | 91.2% | 92.0% | 91.9% | 93.5% | 93.1% | 93.1% | 90.2% | 90.4% | 91.1% | 88.9% | |
| Total | < 18 | 3740 | 3295 | 3227 | 3465 | 3691 | 3761 | 3732 | 3704 | 3659 | 3643 | 3695 | 3694 |  |
| | 18+ | 370 | 363 | 373 | 358 | 396 | 385 | 377 | 394 | 470 | 466 | 417 | 511 | |
| | % | 91.0% | 90.1% | 89.6% | 90.6% | 90.3% | 90.7% | 90.8% | 90.4% | 88.6% | 88.7% | 89.9% | 87.8% | |

| OPHTHALMOLOGY | | Jan 16 | Feb 16 | Mar 16 | Apr 16 | May 16 | Jun 16 | Jul 16 | Aug 16 | Sep 16 | Oct 16 | Nov 16 | Dec 16 | % Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Admitted | < 18 | 1198 | 1192 | 1212 | 1154 | 1113 | 995 | 1027 | 995 | 1026 | 1013 | 1109 | 1085 |  |
| | 18+ | 36 | 17 | 42 | 43 | 58 | 92 | 129 | 142 | 142 | 173 | 143 | 148 | |
| | % | 97.1% | 98.6% | 96.7% | 96.4% | 95.0% | 91.5% | 88.8% | 87.5% | 87.8% | 85.4% | 88.6% | 88.0% | |
| Non Admitted | < 18 | 3453 | 3586 | 3835 | 4003 | 4291 | 4633 | 4648 | 4585 | 4583 | 4464 | 4580 | 4720 |  |
| | 18+ | 10 | 8 | 17 | 11 | 73 | 58 | 139 | 217 | 321 | 162 | 186 | 245 | |
| | % | 99.7% | 99.8% | 99.6% | 99.7% | 98.3% | 98.8% | 97.1% | 95.5% | 93.5% | 96.5% | 96.1% | 95.1% | |
| Total | < 18 | 4651 | 4778 | 5047 | 5157 | 5404 | 5628 | 5675 | 5580 | 5609 | 5477 | 5689 | 5805 |  |
| | 18+ | 46 | 25 | 59 | 54 | 131 | 150 | 268 | 359 | 463 | 335 | 329 | 393 | |
| | % | 99.0% | 99.5% | 98.8% | 99.0% | 97.6% | 97.4% | 95.5% | 94.0% | 92.4% | 94.2% | 94.5% | 93.7% | |

| ENT | | Jan 16 | Feb 16 | Mar 16 | Apr 16 | May 16 | Jun 16 | Jul 16 | Aug 16 | Sep 16 | Oct 16 | Nov 16 | Dec 16 | % Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Admitted | < 18 | 395 | 402 | 381 | 380 | 429 | 311 | 286 | 305 | 339 | 398 | 462 | 439 |  |
| | 18+ | 343 | 359 | 415 | 427 | 436 | 483 | 395 | 373 | 352 | 305 | 323 | 341 | |
| | % | 53.5% | 52.8% | 47.9% | 47.1% | 49.6% | 39.2% | 42.0% | 45.0% | 49.1% | 56.6% | 58.9% | 56.3% | |
| Non Admitted | < 18 | 2365 | 2359 | 2422 | 2609 | 2513 | 2422 | 2450 | 2359 | 2343 | 1999 | 2077 | 1991 |  |
| | 18+ | 291 | 349 | 507 | 616 | 725 | 718 | 609 | 469 | 437 | 454 | 391 | 385 | |
| | % | 89.0% | 87.1% | 82.7% | 80.9% | 77.6% | 77.1% | 80.1% | 83.4% | 84.3% | 81.5% | 84.2% | 83.8% | |
| Total | < 18 | 2760 | 2761 | 2803 | 2989 | 2942 | 2733 | 2736 | 2664 | 2682 | 2397 | 2539 | 2430 |  |
| | 18+ | 634 | 708 | 922 | 1043 | 1161 | 1201 | 1004 | 842 | 789 | 759 | 714 | 726 | |
| | % | 81.3% | 79.6% | 75.2% | 74.1% | 71.7% | 69.5% | 73.2% | 76.0% | 77.3% | 76.0% | 78.1% | 77.0% | |

| PAEDIATRIC ENT | | Jan 16 | Feb 16 | Mar 16 | Apr 16 | May 16 | Jun 16 | Jul 16 | Aug 16 | Sep 16 | Oct 16 | Nov 16 | Dec 16 | % Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Admitted | < 18 | 238 | 255 | 241 | 216 | 279 | 229 | 237 | 246 | 241 | 251 | 252 | 279 |  |
| | 18+ | 229 | 220 | 241 | 256 | 274 | 333 | 332 | 348 | 335 | 333 | 360 | 367 | |
| | % | 51.0% | 53.7% | 50.0% | 45.8% | 50.5% | 40.7% | 41.7% | 41.4% | 41.8% | 43.0% | 41.2% | 43.2% | |
| Non Admitted | < 18 | 558 | 478 | 599 | 503 | 435 | 593 | 398 | 321 | 252 | 230 | 206 | 215 |  |
| | 18+ | 46 | 58 | 49 | 107 | 115 | 83 | 45 | 37 | 30 | 31 | 15 | 15 | |
| | % | 92.4% | 89.2% | 92.4% | 82.5% | 79.1% | 87.7% | 89.8% | 89.7% | 89.4% | 88.1% | 93.2% | 93.5% | |
| Total | < 18 | 796 | 733 | 840 | 719 | 714 | 822 | 635 | 567 | 493 | 481 | 458 | 494 |  |
| | 18+ | 275 | 278 | 290 | 363 | 389 | 416 | 377 | 385 | 365 | 364 | 375 | 382 | |
| | % | 74.3% | 72.5% | 74.3% | 66.5% | 64.7% | 66.4% | 62.7% | 59.6% | 57.5% | 56.9% | 55.0% | 56.4% | |

| ALLERGY | | Jan 16 | Feb 16 | Mar 16 | Apr 16 | May 16 | Jun 16 | Jul 16 | Aug 16 | Sep 16 | Oct 16 | Nov 16 | Dec 16 | % Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Non Admitted | < 18 | 460 | 517 | 485 | 501 | 468 | 389 | 305 | 274 | 258 | 300 | 352 | 369 |  |
| | 18+ | 54 | 73 | 110 | 124 | 142 | 179 | 209 | 197 | 166 | 129 | 133 | 110 | |
| | % | 89.5% | 87.6% | 81.5% | 80.2% | 76.7% | 68.5% | 59.3% | 58.2% | 60.8% | 69.9% | 72.6% | 77.0% | |

| | |
|---|---|
| Allergy | Background: Underperformance on admitted RTT is related to Consultant vacancies since June 2015 (2 clinics per week) with additional vacancy since May 2016 (3 clinics per week). Service has now appointed to 1 consultant post. RTT remains continues to reduce.<br><br>Actions: September interview appointed trust grade to start in February/March pending HR update. SLA with Nottingham consultant for weekend WLI's with the aim to continue to January. Demand and Capacity work to be finalised. Reminder calls to reduce DNA's in place. Project to start advice and guidance initiated. |

| | |
|---|---|
| ENT / Paediatric ENT | Background: Current backlog driven by a high level of cancellations from 2015/16 winter bed pressures that have carried over into 2016/17. Cancellation on the day and limited Paediatric bed capacity resulting in prior to the day cancellations or reduced booking of lists.<br><br>Actions: Continued use of Medinet and wait list initiatives for admitted and non-admitted patients. Use of Alliance for low risk patients. Assess ability to increase WLI for Balance patients, linked to consultant discretionary effort. Dates agreed in January / February. Departmental away day to address key actions including advice and guidance, single point of access. Backlog split by sub specialty to tackle bespoke cohorts of patients with longest waits. |
| General Surgery | Background: Current performance driven by lack of capacity to meet SLA demands. Circa 3 sessions per week. Service highly affected by winter bed pressures on inpatient and critical care beds resulting in patient cancelations. On the day cancellations due to clinical reasons are 154 year to date with further cancellations before the day (data pending). Further risk going into winter months of increased cancellations due to further bed pressure demands.<br><br>Actions: Aim for 42 additional weekend sessions out of 56 requested in January. Business case for consultant workforce. Reduce first appointment wait time to reduce pathway lengths. |
| Ophthalmology | Background: A demand and capacity analysis has identified a 51 WTE workforce gap across the whole service at all workforce levels in order to meet the demands. A business case will be presented to the Revenue and Investment Committee in January.<br><br>Actions: The service currently relies on discretionary effort for additional capacity, with weekly inpatient and outpatient sessions. Long term impact will be if approval of business case for expansion of service workforce. Other interim actions include the Single Point of Access. Insource outpatient capacity – Newmedica and the addition of the Macular Unit. |
| Orthopaedic Surgery | Background: Delays within with urgent diagnostic reporting adding to the outpatient pathway. Capacity gap between clinicians for sub specialties. Including Hand and Foot and Ankle patients.<br><br>Actions: Additional clinics to reduce outpatient backlog. Clinical engagement for patients on foot and ankle pathway for waiting list management. Increased clinical capacity from February 2017 |
| Urology | Background: Lack of in week outpatient and theatre capacity. Increased cancellations. Increased activity over and above SLA predicted 297 admitted patient's full year. Increase in patients cancelled before the day due to bed capacity.<br><br>Actions: Wait list initiatives. Increase in uptake of UHL staffed lists allowing for more patients from the backlog to be treated. Medinet used to fill gap in sessions, currently in January 7 all day UHL staffed lists and 5 Medinet lists (24 sessions). Continuing WLI and process change in outpatients to reduce non admitted backlog.<br>Left shifting of low complex patients to the Alliance on track for 25th January |

## Diagnostic Performance

December diagnostic performance for UHL and the Alliance is 0.85% achieving the standard performing below the 1% threshold.

This is the 3rd month of continuous diagnostic performance post EMRAD installation. This is the first time the trust has achieved the 1% standard in December since the current reporting documentation available began in 2013.

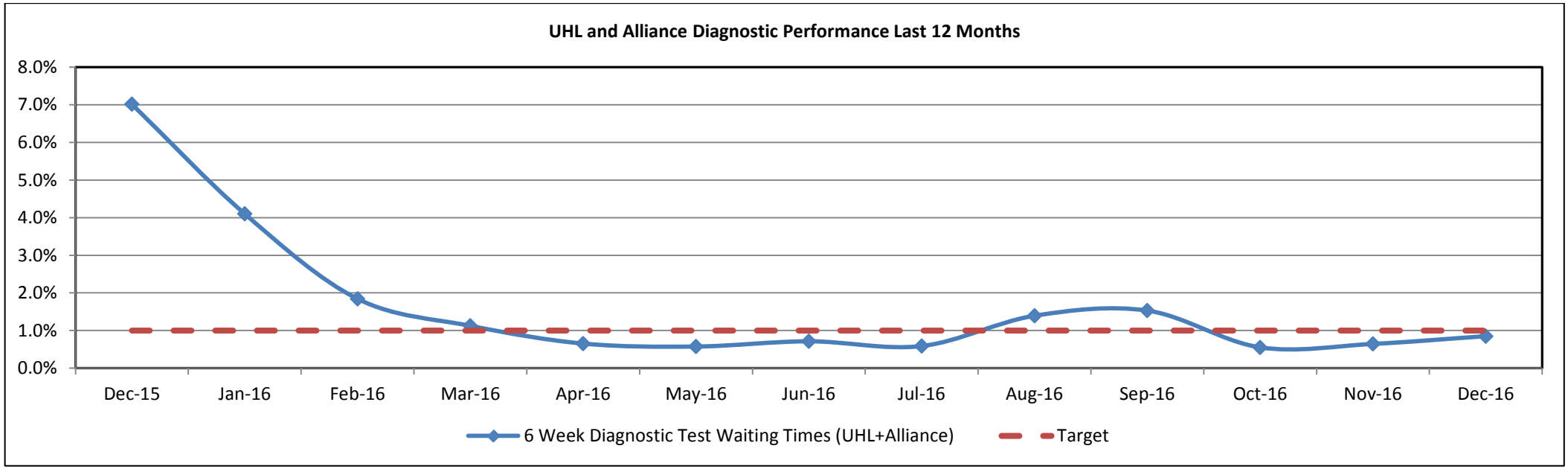
Of the 15 modalities measured against, 10 achieved the performance standard with 5 areas having waits of 6 weeks or more greater than 1%.
The largest wait was patients requiring a CT scan, accounting for 86 of 124 breaches.

## Risks to future months performance

CT remains a capacity risk. The service is looking to increase capacity and is awaiting the return of clinicians from long term sickness at the end of the January.

The endoscopy service has reduced the number of breaches to 10 or less in the past 2 reporting periods. There is still a risk for patients requiring sedation under propofol as there is still no scheduled sessions for this activity, with ad hoc sessions sought.

It is anticipated the overall diagnostic performance for January will be less than 1%.



## % Cancelled on the day operations and patients not offered a date within 28 days - Performance

| INDICATORS: The cancelled operations target comprises of two components | Indicator | Target (monthly) | Latest month | YTD performance (inc Alliance) | Forecast performance for next reporting period |
|---|---|---|---|---|---|
| 1.The % of cancelled operations for non-clinical reasons On The Day (OTD) of admission | 1 | 0.8% | 0.8 | 1.2% | **1.5%** |
| 2.The number of patients cancelled who are not offered another date within 28 days of the cancellation | 2 | 0 | 15 | 155 | **10** |

**What is causing underperformance?**

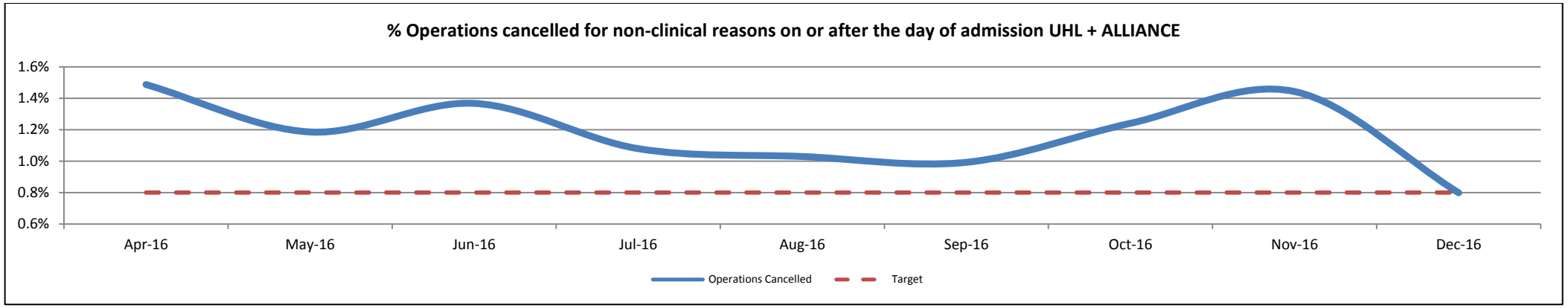
The combined number of UHL + Alliance Non clinical cancellations on the day for December was 82 patients, 0.8% resulting in an achievement of the standard.
81 of the cancellations were in UHL, 32 for bed capacity reasons (either either HDU, ITU or ward) with 49 for other hospital reasons.
84 of the cancellations related to availability of beds (HDU, ITU or ward). The five key reasons for cancellations were:

- HOSPITAL CANCEL - LACK THEATRE TIME / LIST OVERRUN 25
- HOSPITAL CANCEL -PT DELAYED TO ADM HIGH PRIORITY PATIENT 13
- HOSPITAL CANCEL - WARD BED UNAVAILABLE 10
- HOSPITAL CANCEL - HDU BED UNAVAILABLE 6
- HOSPITAL CANCEL - INFRASTRUCTURE PROBLEMS 6

15 patients breached 28 days. These comprised of CHUGGS 4, CSI 1, Musculoskeletal and Specialist Surgery 8, Renal, Women's and Children's 2
The system critical incident in January has resulted in performance up to 08/01/2016 of 1.6%. It is predicted cancellations on the day will be circa 1.5%

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

Weekly Winter bed meetings occur to forward plan elective capacity to match predicted bed availability. At LRI the Trust is initiating the Red 2 Green process to reduce patient LOS and improve flow, reducing the risk of patient cancellations due to bed pressures.
A separate paper to EPB has been produced to look at the larger context of cancellations and way to improve the performance



## Ambulance handover > 30 minutes and >60 minutes - Performance

| Indicators | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|
| Ambulance Handover >60 Mins (CAD+ from June 15) | 6% | 6% | 6% | 9% | 7% | 9% | 9% | 11% | 17% | 8% |
| Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15) | 11% | 12% | 10% | 15% | 14% | 15% | 18% | 18% | 18% | 14% |

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

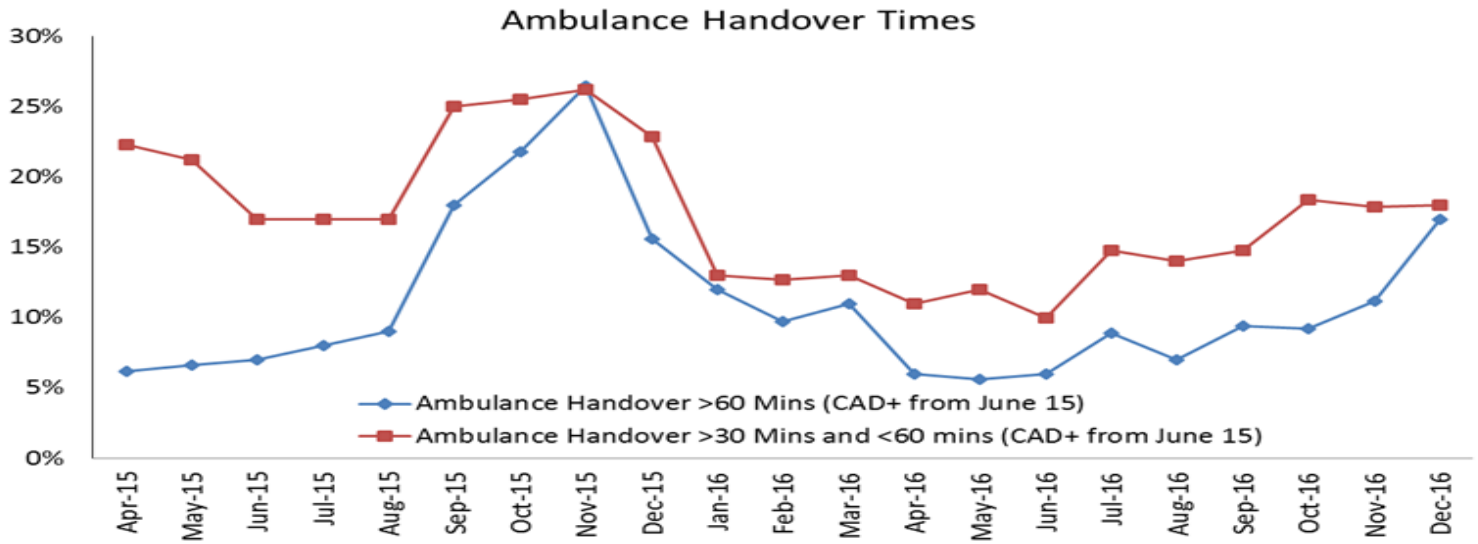
**What actions have been taken to improve performance?**

Frailty training by Jay Banerjee to EMAS staff to reduce conveyance

GP in Fast Response Vehicle to reduce Conveyance

Cohorting policy in place for patients awaiting beds up to 17 spaces

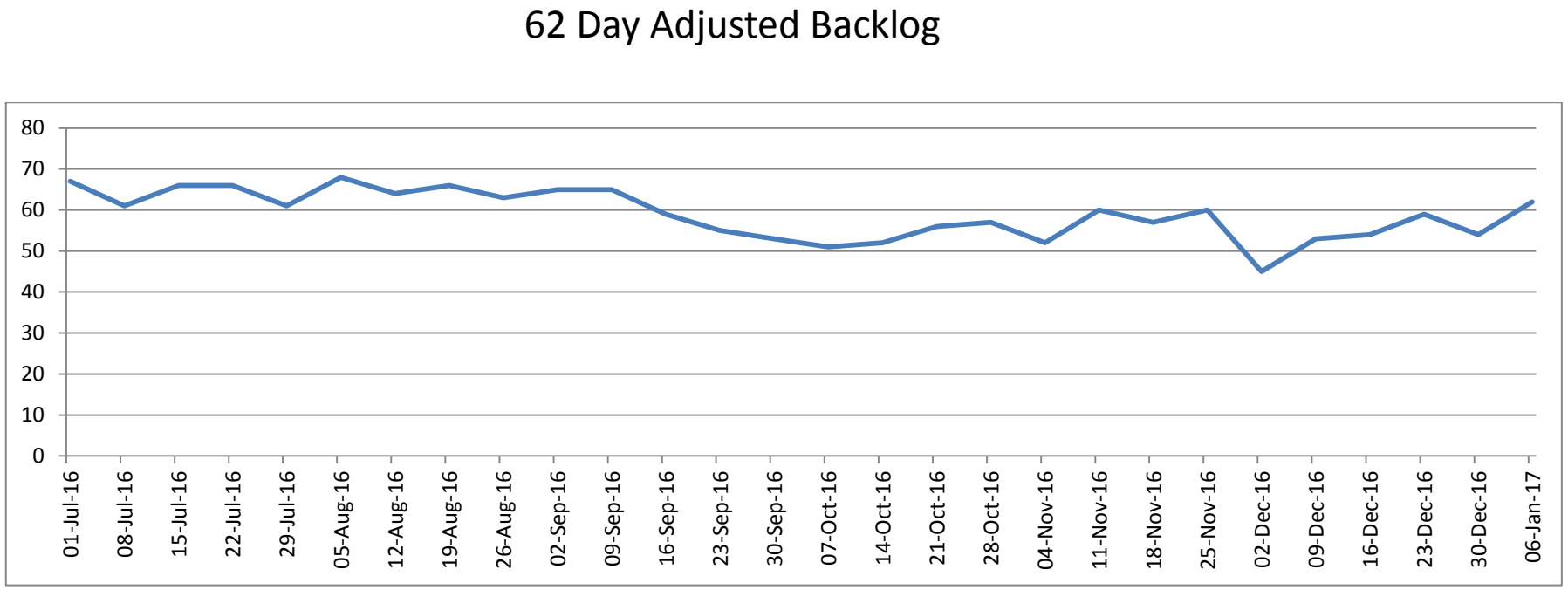
GPAU review of patients POA to see who can be seen as ambulatory.



## Cancer waiting time performance

**Current Performance**

- Current Performance
- 2ww performance remained strong in December with an expectation of delivery of the standard, January is under performing at the time of reporting (91.4%) with access to CT Colon and patient choice being the primary factors.
- 62 day performance as anticipated remains below the required standard, December (pre-upload) at 82.1% and January expected at circa 80%. In discussion with NHSI and NHSE the Trust has stated that it cannot confirm recovery of the key cancer standards until there has been a sustained period of ring fenced capacity of elective beds, i.e. >2 months. The Trust is clear that all efforts to deliver good patient care and improve cancer performance is a priority.
- The adjusted backlog (excluding tertiary referrals received after day 39) has averaged in the 50's for over 8 weeks, however at the time of reporting currently sits at 62.



# Key themes identified in backlog (13th January)

| Summary of delays | Numbers of patients | Summary |
|---|---|---|
| **Clinical Decision Making/Change of Treatment Plan** | **2** | Patient in Gynae who have had a change of treatment plan and patient choice delays waiting for treatment post New Year |
| **Complex Patients** | **15** | Across 5 tumour sites, Lung, Lower GI, Urology, Sarcoma and Head & Neck – these are patients undergoing multiple tests, MDTs and diagnostics. This includes patients requiring further pathology due to insufficient samples for diagnosis, molecular markers and those requiring second opinions from other tumour sites. |
| **Long Term Follow Up/Surveillance** | **5** | 2 patients within Lung, one of which was also a tertiary referral that have converted from Long Term Follow Up and are undergoing diagnostic tests. 3 in Testicular awaiting repeat scans on a surveillance pathway. |
| **Diagnostic Delays/Capacity** | **5** | Across 2 tumour sites, this cohort represents patients delayed due to diagnostic delays, predominantly due to capacity within Endoscopy. |
| **Late Referrals Other Tumour Sites** | **2** | In Haematology (late referral from ENT) and Lung (complex patient referred late from HPB). |
| **OPD Delays/Capacity including UHL Pathway Delays** | **10** | Predominantly in services where Next Steps has only recently been implemented (Gynae, Head & Neck) and for Lower GI where Next Steps is experiencing some issues which are being worked through with the support of the Cancer Centre. Delays including anaesthetic review specific to Lower GI which is in hand with the ITAPS team. |
| **Patient Delays & Patients Unfit** | **26** | Spread across 6 tumour sites, a combination of patients unavailable due to holidays or requiring additional thinking time to make pathway decisions on treatment, DNA's and being inpatients or requiring Cardiac intervention prior to treatment. |
| **Trial Patients** | **1** | Specific to Lung, patient going through assessment for MORAB trial, however, patient unavailability has also played a key factor in the delayed pathway. |
| **Tertiary Referrals** | **3** | In Lung (x2) and Urology, late referrals from Burton and NGH. Once received within UHL, all 3 patients have received their TCI date within 28 days. |

# Backlog Review for patients waiting >104 days

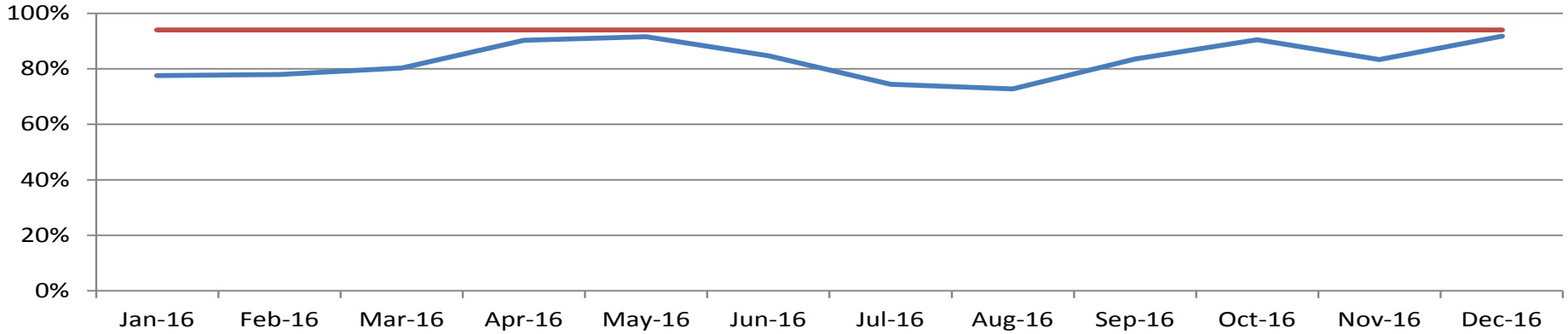
The following details all patients declared in the 104 Day Backlog for week ending 6/1/17.

Of the 11 patients in the current 104 Day Backlog, 7 patients have treatment dates confirmed, 4 of which were treated at the time of reporting.

NOTE: where patients who have a treatment date confirmed but with no diagnosis of Cancer confirmed, on review of histology, should that confirm a cancer diagnosis then this would class as treatment in those cases.

| Tumour Site | Total Number of patients | Pt No | Current Wait (Days) | Confirmed Cancer Y/N | Treatment Date Y/N | Summary Delay Reasons |
|---|---|---|---|---|---|---|
| LOGI | 2 | 1 | 133 | N | N | Multiple diagnostics required, HDU Bed cancellation x1 and subsequent TCI cancellation due to patient being unfit – await Cardiology review 17/1/17 |
| | | 2 | 112 | N | N | Diagnostic delays (hospital and patient) awaiting EMR in Endoscopy 16/1/17 |
| BREAST | 1 | 1 | 105 | N | N | Clinical decision – watchful wait – for repeat diagnostics 24/1/17 |
| GYNAE | 1 | 1 | 123 | N | Y | UHL Pathway delays, patient choice delays, ? Non ca. TCI 25/1/17 |
| HEAD & NECK | 1 | 1 | 125 | N | Y | Diagnostic delays in PET requests from ENT, patient choice delays and multiple diagnostics – TCI 10/1/17 |
| LUNG | 4 | 1 | 165 | N | Y | Long Term Follow Up patient, patient then unfit, TCI 5/1/17 for palliative care |
| | | 2 | 142 | Y | Y | Complex diagnostic – repeat biopsies delayed due to patient's medication, patient further delayed due to entering a Trial for Chemo. TCI 5/1/17 |
| | | 3 | 137 | Y | Y | Diagnostic delays due to patient's reaction to anaesthetic, complex patient pathway, not suitable for surgery or trial. TCI 6/1/17 for chemotherapy. |
| | | 4 | 128 | N | N | Long Term Follow Up Patient, further diagnostics requested 4/1/17, MDT 13/1/17 |
| UROLOGY | 2 | 1 | 128 | Y | Y | Patient delays – both holiday and DNA's. TCI 6/1/17 |
| | | 2 | 108 | Y | Y | Patient unfit, not a surgical candidate. Symptomatic treatment TCI 15/1/17 |

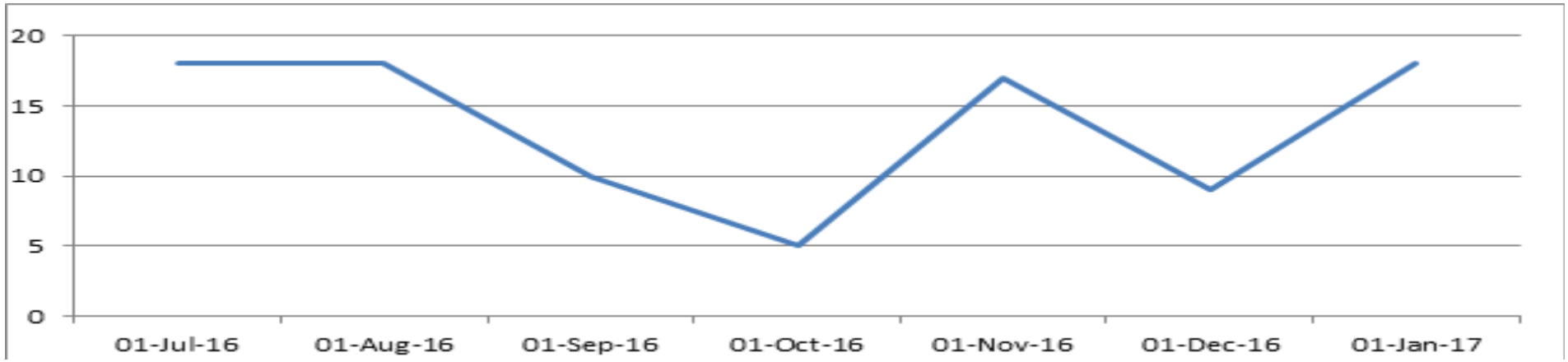
## 31 Day Subsequent Surgery Performance




31 day subsequent surgery performance was below the standard at 87.2% in November, December (pre-upload) expected at 91.7% with January currently at 88.3%.

Although backlogs have reduced, access to beds and timely theatre capacity remains the key issue. This is small numbers across a number of tumour sites.

## 31 Day First Treatment - Backlog



31 day 1st treatment performance in November was below the standard at 94.2%, with December (pre-upload) at 91.7%, expected position for January to be circa 86%. On-going backlog reduction is not being sustained, again access to beds and timely theatre capacity remains the key issue. This primarily impacts on Urology and Gynaecology.

## Summary of the plan

The recovery plan (RAP) consists of 29 actions following detailed work initially with the CMG's and also with the joint UHL and CCG working group. The issues detailed in the plan have been identified by a consistent review of tumour site breach maps (rolling 3 month themes) and the current tumour site backlog reasons.

A recent spike in the backlog numbers and review within Gynae will result in RAP additions and this will be done in conjunction with the tumour site.

The actions are targeted at tumour site specific issues taking into account 'linked' services that impact on delivery. Metrics have been devised for each action to ensure that they are measurable and that they are on track. Each action has been risk rated (high, medium or low).

The following remain the high risk issues affecting the delivery of the cancer standards and have been categorised as agreed by the joint working group

| | Issue | Action being taken | Category |
|---|---|---|---|
| **1** | Underlying theatre capacity shortfall for all electives , specifically affecting, Urology , Gynaecology , GI and ENT | Additional weekend work / use of external providers | Unavoidable factors impacting on delivery |
| **2** | Underlying HDU / ITU bed capacity | Daily bed / patient management. | Unavoidable factors impacting on delivery |
| **3** | Underlying access to ward beds associated with increased emergency admissions above plan. | ASU (day case) at LRI remains ring fenced, ward 7 ring fenced against medical patients | External factors impacting on delivery |
| **4** | Workforce on Oncology | Business case to expand Consultant workforce | Internal factors impacting on delivery / Unavoidable factors impacting on delivery |
| **5** | Workforce in Head and Neck surgeon (national shortage) | Recruitment process underway | External factors impacting on delivery |
| **6** | Workforce Head and neck imaging (national shortage) | Recruitment process underway | External factors impacting on delivery |
| **7** | Late tertiary referrals | Meeting with tertiary providers. Support from NHSE | External factors impacting on delivery |
| **8** | Delayed impact of Next Steps rollout resulting in delayed pathways specifically affecting Gynae, ENT and Lower GI | Full PTL review and micro management from the Cancer Centre and Tumour Sites and additional on the ground resources to support in clinic where appropriate. | Internal factors impacting on delivery |