

Quality & Performance Report

Author: John Adler Sponsor: Chief Executive Date: IFPIC + QAC 22nd December 2016

Executive Summary from CEO

Context

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

Questions

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

Conclusion

Good News: **Mortality** – although the latest published SHMI (covering the period April 2015 to March 2016) has increased to **99**, it is still within Quality Commitment goal of **99**. Further detailed analysis is under way to understand what is causing SHMI to increase. **Moderate harms and above** – we remain well within the agreed Quality Commitment monthly thresholds. **Referral to Treatment 52+ week waits** – current number is 34 (ENT and Orthodontics) and we remain on target to be at zero by the end of January. **Cancer Two Week Wait** was achieved and is expected to remain compliant. 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. **C DIFF** – 6 cases reported in November with year to date 2 cases above trajectory. **RTT** – the RTT incomplete target was compliant for November at 92.2% following two months non-compliance. **Diagnostic 6 week wait** – remains complaint after two months of failure in August and September. **Fractured NOF** – target achieved during November. The Medical Director Team is leading a piece of work to deliver this on a sustainable basis. **Single Sex Accommodation Breaches** – numbers have reduced to 1 in November. **Estates and Facilities** are reporting a suite of audit and performance KPI's in the Quality and Performance report for the first time since the service was transferred back to UHL management.

Bad News: **ED 4 hour performance** – October performance was 77.6% with year to date performance at 79.3%. Contributing factors are set out in the Chief Operating Officer's report. **Ambulance Handover 60+ minutes** – performance remained poor at 11%; this is also examined in detail in the COO's report. There was 1 **Never Event** in month; no patient harm resulted. **Pressure Ulcers** – 1 **Grade 4** pressure ulcers reported for the first time this year. **Cancelled operations** deteriorated further during November to 1.4% and **patients rebooked within 28 days** – continue to be non-compliant, due to ITU/HDU and emergency pressures. **Cancer Standards 62 day treatment** - remains non-compliant although on a positive note there

have been continued improvements in backlog numbers. **Patient Satisfaction (FFT)** for ED remains low at 84% during November – ED minors and UCC come out with very poor scores. **Statutory & Mandatory Training** – performance remains at 82% against a target of 95. Performance dipped when 1,500 staff transferred over to UHL's Estates and Facilities and work is ongoing to improve compliance in this area..

Input Sought

I recommend that the Committee:

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

For Reference

Edit as appropriate:

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

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

2. This matter relates to the following **governance** initiatives:

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

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

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

5. Scheduled date for the **next paper** on this topic: 26th January 2017

Quality and Performance Executive Summary

November 2016

Domain - Safe

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

TWO

Never Events
YTD

28

Serious
Incidents
YTD

70

Moderate
Harm and
above
YTD

0

Avoidable
MRSA YTD

42

CDIFF
Cases
YTD

Headlines

- Serious incidents are well within the year to date trajectory and remain on a downward trend. This is supported by a reduction in Moderate Harm and above compared to the same period last year.
- C Diff 6 unrelated cases reported in November, with year to date 2 above trajectory.
- There was One Grade 4 Pressure ulcer, Two Grade 3 and 10 Grade 2 for November.
- While all Sepsis indicators are not achieving the 16/17 targets they have all shown improvements for November.

SEPSIS

Patients with an Early Warning
Score 3+ - % appropriate
escalation

88%
YTD

Patients with EWS 3+ - % who are
screened for sepsis

87%
YTD

ED - Patients who trigger with
red flag sepsis - % that have their
IV antibiotics within an hour

72%
YTD

Wards (including assessment
units) Patients who trigger for
Red Flag Sepsis - % that receive
their antibiotics within an hour

43%
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 95% ↓
Outpatients FFT 95% ↔

Staff FFT Quarter 2 2016



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

Headlines

- Friends and family test (FFT) for Inpatient and Daycase care combined are at 97% for November.
- Patient Satisfaction (FFT) for ED remains low at 84% during November – ED minors and UCC come out with very poor scores. Actions have been developed to improve patient satisfaction.
- Single Sex Accommodation Breaches – numbers have reduced from 20 in September down to 1 in November.

Single sex accommodation breaches

35
YTD ↑

Domain – Well Led

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

Friends and Family FFT YTD % Coverage



Inpatients FFT 36.4% ↑

Day Case FFT 24.6% ↓

A&E FFT 10.8% ↑

Maternity FFT 37.4% ↑

Outpatients FFT 1.6% ↑

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%.
- There was an increase of 0.5% in people appraised in November (this excludes facilities staff that were transferred over from Interserve).
- Statutory & Mandatory training remains 13% off the 95% target
- Please see the HR update for more information.

% Staff with Annual Appraisals

91.9% YTD ↑

Statutory & Mandatory Training

82% YTD ↔

BME % - Leadership

25% 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



99
Apr15-Mar16 ↓

Stroke TIA clinic within 24hrs

66.1%
YTD ↓

80% of patients spending 90% stay on stoke unit

83.3%
YTD ↓

Emergency Crude Mortality Rate

2.3%
YTD ↓

30 Days Emergency Readmissions

8.5%
YTD 2016 ↔

NoFs operated on 0-35hrs

73.0%
YTD ↑

Headlines

- UHL's SHMI remains lower than the England average at 99. Further detailed analysis is under way to understand what is causing SHMI to increase.
- Fractured NOF – after missing the 72% target from August to October, 78% was achieved in November.

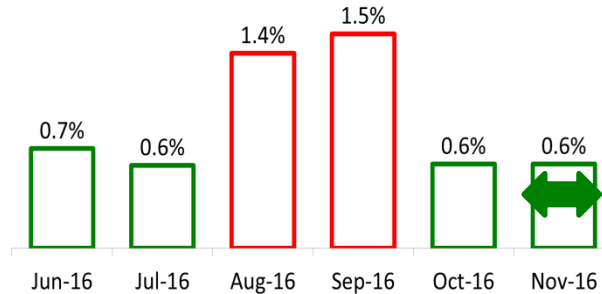
Domain – Responsive

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

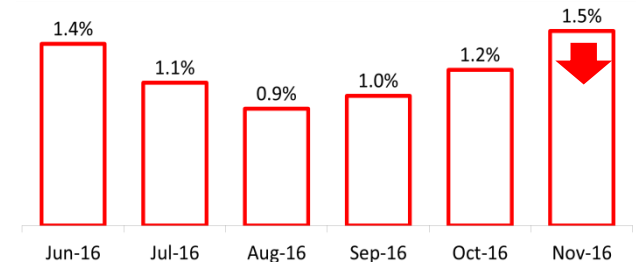
RTT - Incomplete 92% in 18 Weeks

92.2%

6 week Diagnostic Wait times



Cancelled Operations



RTT 52 week wait incompletes

34

YTD



ED 4Hr Wait

A&E

79.3%

YTD



Ambulance Handovers



8% > 60mins ↓

14% 30-60mins ↔

YTD

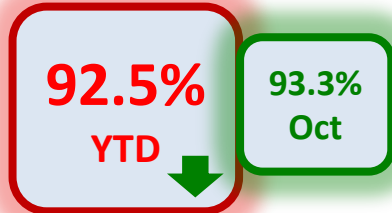
Headlines

- 52+ week waiters have reduce to 34 since the highs of April at 169.
- Diagnostic 6 week wait – we remain below the target by 0.4% for two consecutive months, achieving 0.6% in both October and November.
- RTT – the RTT incomplete target was compliant for November at 92.2% prior to two non compliant months.
- 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



31 day wait



62 day wait



31 day backlog



Headlines

- Cancer Two Week Wait was achieved in October 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 although on a positive note there have been continued improvements in backlog numbers.

62 day backlog

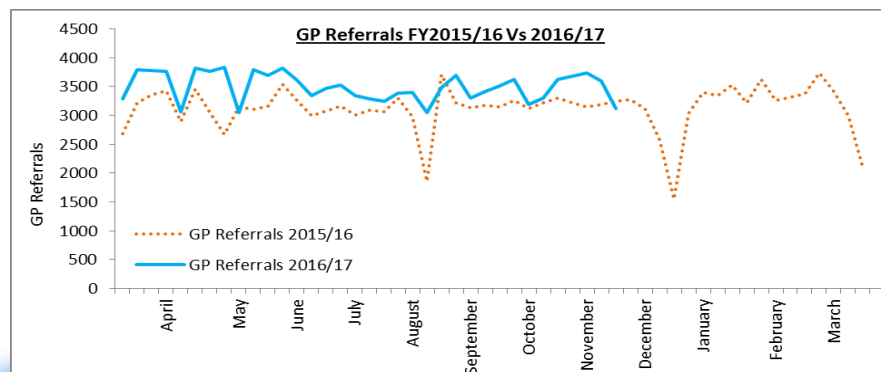


62 day adjusted backlog



UHL Activity Trends

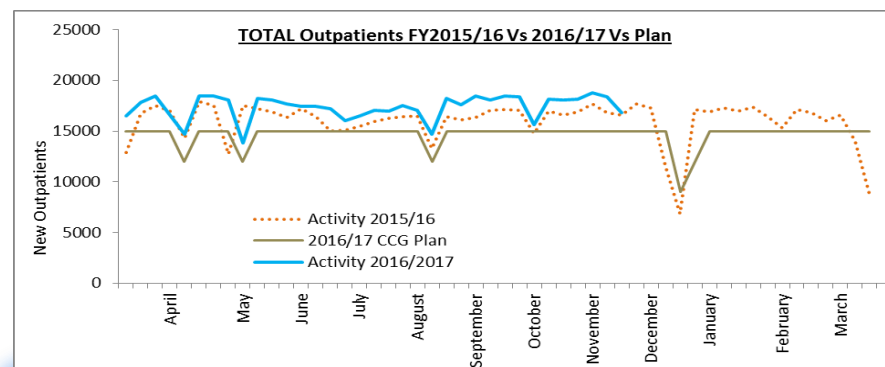
Referrals (GP)



April – November
16/17 Vs 15/16 +12,439 +11%

Activity Query Notice raised with LLR in August. Planned care workstream underway to reduce referrals.

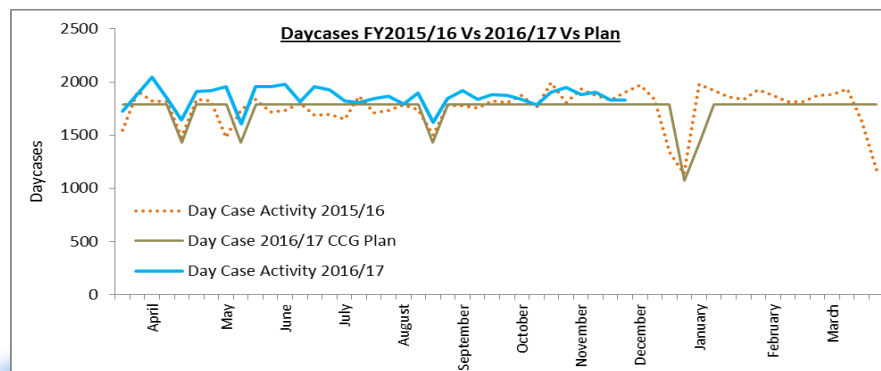
TOTAL Outpatient Appointments



April – November
16/17 Vs 15/16 +26,764 +5%
16/17 Vs Plan +26,108 +5%

Above plan – Dermatology, ENT, Paed Med, Orthopaedics/Spinal and Pain Management.
Below plan – Paed Cardiology, Haematology and Plastics.

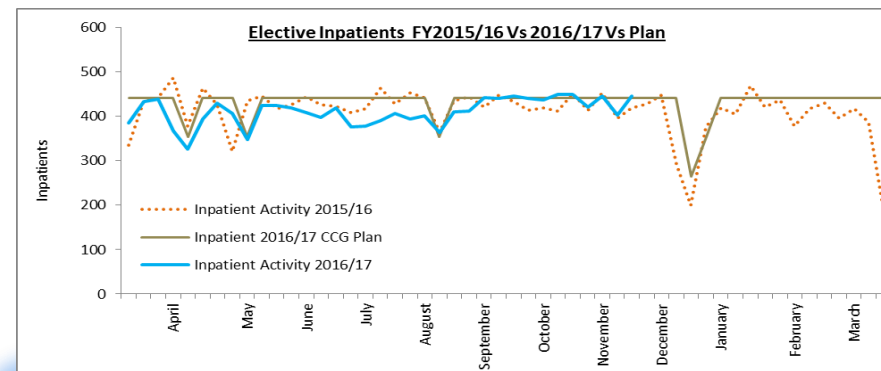
Daycases



April – November
16/17 Vs 15/16 +3,335 +6%
16/17 Vs Plan +2,210 +4%

Above plan - Clinical Onc. BMT, Gastroenterology, Haematology.
Below plan - Ophth, Gen Surg, Orthopaedics and Rheumatology.

Elective Inpatient Admissions

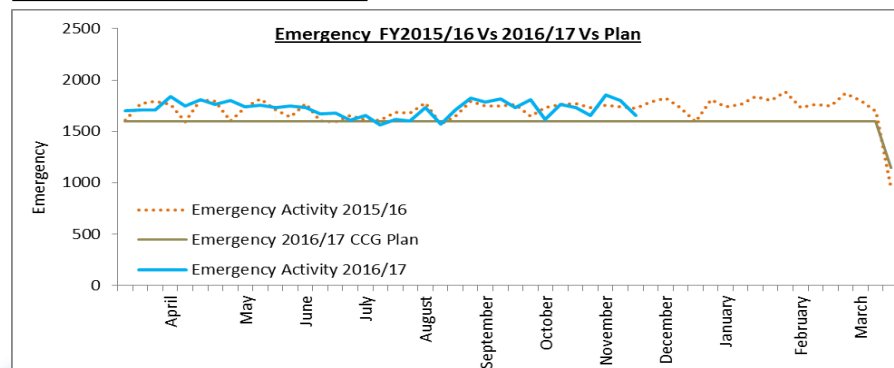


April – November
16/17 Vs 15/16 -484 -3%
16/17 Vs Plan -946 -6%

Above plan - Gynaecology
Below plan – Orthopaedics, ENT.

UHL Activity Trends

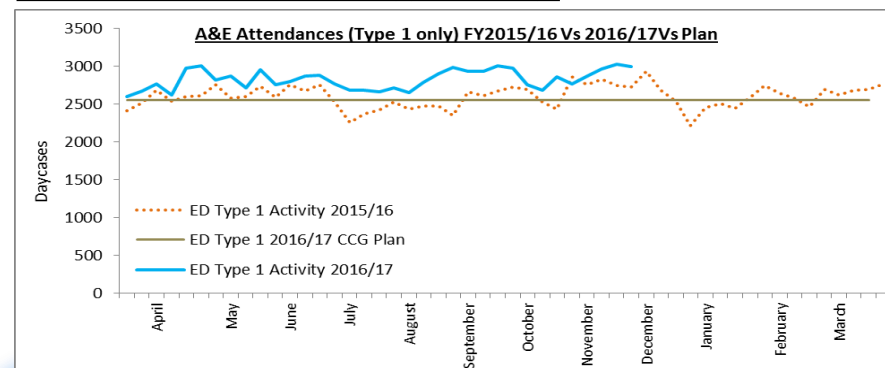
Emergency Admissions



April – November
 16/17 Vs 15/16 +197 +0%
 16/17 Vs Plan +1,169 +2%

Above plan – Cardiology and Respiratory.
Below plan – Integrated Medicine and Trauma.

A & E Attendances (ED Type 1 only)



April – November
 16/17 Vs 15/16 +7,871 +9%
 16/17 Vs Plan +8,872 +10%

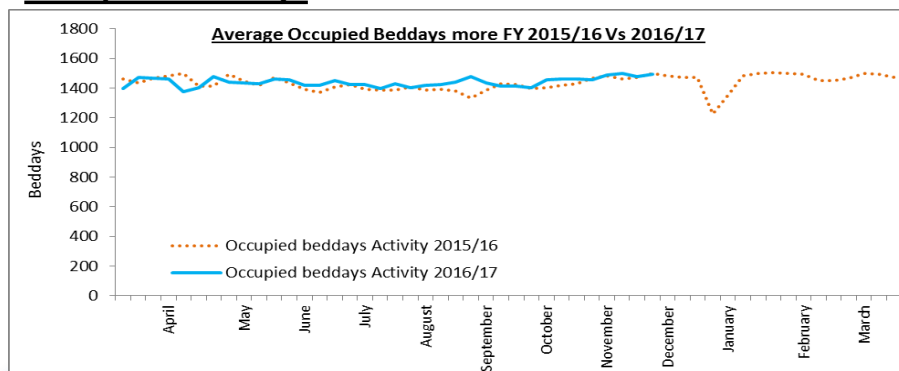
A&E attendances have been above plan and last year's outturn all year. RAP action for commissioners to get back to plan.

Notes:

- Exclusions from counts - Maternity, Obstetrics, Well Babies, Still born and Admission Unit attendances.
- ED figures within this report are based on Type 1 attendances only.
- All YTD activity figures are based on chargeable activity as reported in the monthly finance reports.

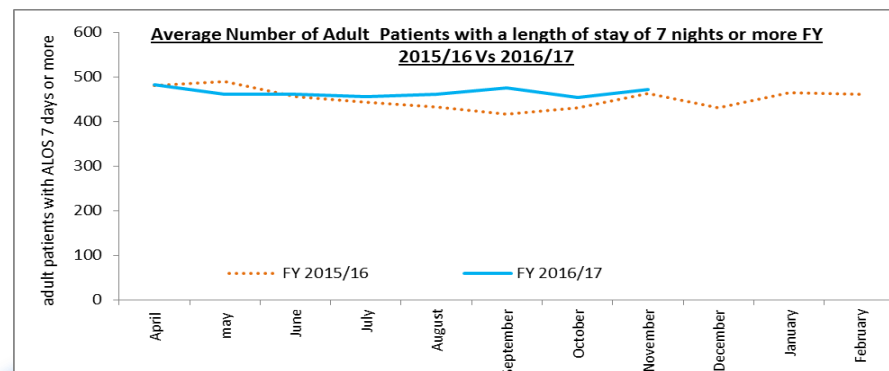
UHL Bed Occupancy

Occupied Beddays



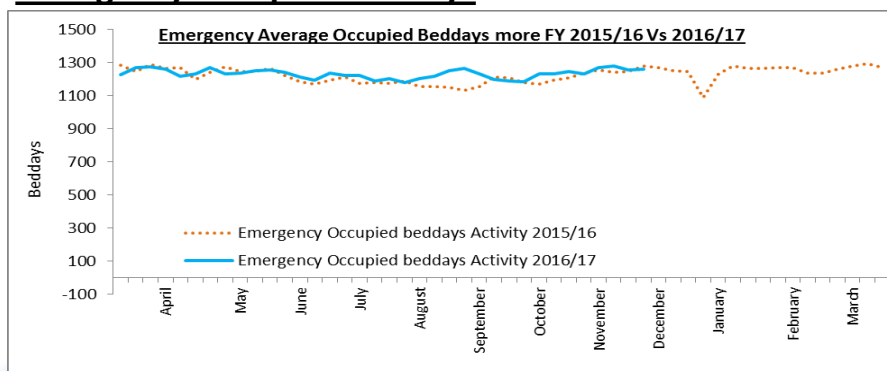
Number of inpatients beds General and Acute excluding Maternity and Obstetrics is 1656 as at November 2016. Occupied beddays are based on midnight bed census. Highest occupancy for 2016/17 was 93%.

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



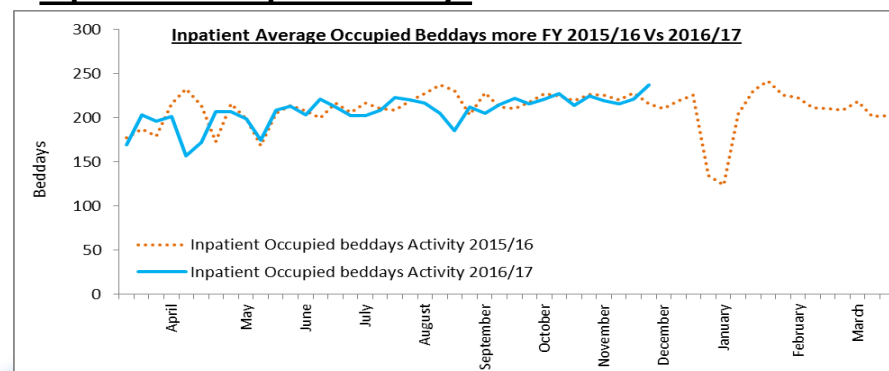
There was 23 more patients in October 2016/17 compared to October 2015/16 with a length of stay of 7 days or more, this is partially reflected in the increase of the delayed transfers of care.

Emergency Occupied beddays



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

Inpatient Occupied beddays



Bed occupancy is slightly lower for 2016 compared to 2015, 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.

October Performance (one month in arrears)

73.9% against a trajectory of 85.1%

A	S	O

November 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.

October Performance

0.6% of our patients waiting more than 6 weeks

S	O	N

December Performance: Expected to be compliant

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

Novembers Performance

Achieved the RTT standard with 92.2% of our patients waiting less than 18 weeks

S	O	N

December Performance: Expected to be compliant

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

Novembers Performance

77.6% against a target of 85.0%

S	O	N

December Performance: Expected to be non-compliant

Caring at its best

University Hospitals of Leicester



NHS Trust

Quality and Performance Report

November 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: 22nd DECEMBER 2016

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

SUBJECT: NOVEMBER 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.

Reporting of the Estates and Facilities KPI's recommences in the month's Quality & Performance Report.

2.0 Performance Summary

Domain	Page Number	Number of Indicators	Number of Red Indicators this month
Safe	4	21	7
Caring	5	11	2
Well Led	6	24	3
Effective	7	11	2
Responsive	8	15	8
Responsive Cancer	9	9	6
Research – UHL	15	6	0
Total		97	28



Safe	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	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	YTD	
	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	17	18	18	16	17	9	9	8	12	10	11	11		70	
	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	3	4	6	4	5	5	1	3	4	2	4	4	28	
	S3	Proportion of reported safety incidents per 1000 attendances (IP, OP and ED)	AF	MD	> FY 15/16	UHL	TBC		17.5	16.6	17.7	18.8	16.2	17.2	17.1	16.8	16.3	19.3	18.2	16.2	16.1	15.1	16.9	
	S4	SEPSIS - Patients with an Early Warning Score 3+ - % appropriate escalation	AF	SH	95%	UHL	TBC	New Indicator												86%	91%	86%	89%	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%	87%
	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%	72%	
	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%	43%	
	S8	Overdue CAS alerts	AF	MD	0	NHSI	Red if >0 in mth ER = in mth >0	10	1	0	0	0	0	1	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	2	5	3	2	2	5	3	3	1	0	2	4	4	22	
	S10	Never Events	AF	MD	0	NHSI	Red if >0 in mth ER = in mth >0	3	2	0	0	0	0	1	0	0	0	1	0	0	0	1	2	
	S11	Clostridium Difficile	JS	DJ	61	NHSI	Red if >mthly threshold / ER if Red or Non compliance with cumulative target	73	60	4	6	7	7	6	4	5	6	1	7	8	5	6	42	
	S12	MRSA Bacteraemias (All)	JS	DJ	0	NHSI	Red if >0 ER if >0	6	1	0	0	0	0	1	0	0	0	1	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%	97.4%	98.2%	97.7%	97.9%	98.0%	96.9%	97.2%	98.4%	97.9%	98.6%	97.9%	98.0%	97.3%	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%	96.0%	96.1%	95.5%	95.4%	95.1%	95.9%	96.1%	96.5%	96.1%	96.0%	95.7%	96.3%	96.3%	96.1%	
	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	4.8	5.7	5.4	4.9	5.2	6.5	5.8	6.0	5.6	6.4	6.0	5.3	5.6	5.9	
	S17	Avoidable Pressure Ulcers - Grade 4	JS	MC	0	QS	Red / ER if Non compliance with monthly target	2	1	0	0	0	1	0	0	0	0	0	0	0	0	1	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	1	5	6	2	5	5	3	2	2	2	2	2	2	20	
	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	4	5	5	8	7	9	6	8	3	13	6	9	10	64	
	S20	Maternal Deaths	AF	IS	0	UHL	Red or ER if >0	1	0	0	0	0	0	0	0	0	0	0	1	0	1	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%	19.7%	20.9%	17.0%	16.6%	17.3%	17.8%	16.8%	17.2%	17.0%	15.0%	18.1%	16.9%	15.3%	16.8%	



Caring	KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	16/17 Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	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	YTD
	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							1.0	1.0	0.9	0.8	1.2	1.4	1.1	1.3	1.1
	C3	Percentage of upheld PHSO cases	AF	MD	No Target	UHL	Quarterly reporting	NEW INDICATOR							0%			0%					0%
	C4	Published Inpatients and Daycase Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <95% ER if 2 mths Red		97%	96%	97%	97%	96%	97%	97%	97%	97%	97%	96%	97%	96%	97%	97%
	C5	Inpatients only Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <95% ER if 2 mths Red	96%	97%	96%	97%	97%	96%	97%	97%	96%	97%	96%	95%	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%	98%	99%	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%	97%	95%	97%	97%	95%	96%	95%	95%	87%	87%	84%	87%	84%	90%
	C8	Outpatients Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <90% ER if 2 mths Red		94%	92%	94%	95%	95%	93%	95%	95%	95%	94%	94%	95%	95%	95%	95%
	C9	Maternity Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <94% ER if 2 mths Red	96%	95%	95%	94%	95%	95%	95%	95%	94%	94%	95%	95%	95%	95%	94%	95%
	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%	Q3 staff FFT not completed as National Survey carried out		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	0	1	0	0	0	4	1	2	20	7	1	35



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	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	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%	New Indicator reported quarterly					Achieved			Achieved					Achieved	
	W2	Published Inpatients and Daycase Friends and Family Test - Coverage (Adults and Children)	JS	HL	Not Applicable		Not Applicable		27.4%	32.4%	23.5%	31.9%	32.8%	32.9%	31.7%	32.0%	31.6%	31.9%	28.5%	27.8%	31.6%	31.6%	30.8%	
	W3	Inpatients only Friends and Family Test - Coverage (Adults and Children)	JS	HL	30%	QS	Red if <26% ER if 2mths Red		31.0%	38.2%	23.2%	29.3%	37.2%	36.1%	35.6%	36.7%	38.1%	36.9%	36.5%	33.1%	36.6%	37.0%	36.4%	
	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%	27.7%	18.7%	30.1%	26.2%	29.2%	27.3%	26.5%	24.5%	26.2%	19.8%	21.6%	25.9%	25.7%	24.6%	
	W5	A&E Friends and Family Test - Coverage	JS	HL	20%	NHSI	Red if <10% ER if 2 mths Red		10.5%	12.4%	5.4%	7.3%	5.1%	7.0%	13.0%	10.2%	12.0%	8.7%	9.9%	11.7%	9.8%	11.4%	10.8%	
	W6	Outpatients Friends and Family Test - Coverage	JS	HL	>=5%	UHL	Red/ER if <1.4%		1.4%	1.5%	1.4%	1.5%	1.6%	1.6%	1.5%	1.7%	1.8%	1.7%	1.6%	1.5%	1.5%	1.8%	1.6%	
	W7	Maternity Friends and Family Test - Coverage	JS	HL	30%	UHL	Red if <26% ER if 2 mths Red	28.0%	31.6%	38.8%	30.0%	33.3%	34.3%	31.7%	27.9%	38.3%	39.3%	38.2%	38.7%	37.8%	38.3%	41.1%	37.4%	
	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%	Q3 staff FFT not completed as National Survey carried out			58.9%			60.3%			62.8%					61.6%
	W9	Nursing Vacancies	JS	MM	TBC	UHL	Separate report submitted to QAC		8.4%	7.6%	7.6%	7.7%	6.8%	8.4%	8.2%	8.5%	8.9%	9.2%	8.2%	8.7%	10.3%	9.7%	9.7%	
	W10	Nursing Vacancies in ESM CMG	JS	MM	TBC	UHL	Separate report submitted to QAC		17.2%	14.6%	14.9%	16.4%	17.2%	18.5%	18.1%	18.9%	19.8%	20.1%	20.3%	21.4%	20.0%	20.2%	20.2%	
	W11	Turnover Rate	LT	LG	TBC	NHSI	Red = 11% or above ER = Red for 3 Consecutive Mths	11.5%	9.9%	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%	9.2%	
	W12	Sickness absence	LT	BK	3%	UHL	Red if >4% ER if 3 consecutive mths >4.0%	3.8%	3.6%	3.7%	3.9%	4.0%	4.3%	4.2%	3.9%	3.4%	3.4%	3.3%	3.1%	3.5%	3.7%		3.5%	
	W13	Temporary costs and overtime as a % of total paybill	LT	LG	TBC	NHSI	TBC	9.4%	10.7%	10.5%	10.1%	11.0%	9.7%	13.9%	10.5%	9.5%	10.9%	10.2%	10.5%	10.7%	10.9%	10.9%	10.6%	
	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%	91.1%	92.7%	91.5%	91.6%	90.7%	91.5%	92.2%	92.4%	92.9%	92.4%	91.5%	91.4%	91.9%	91.9%	
	W15	Statutory and Mandatory Training	LT	BK	95%	UHL	TBC	95%	93%	92%	93%	93%	92%	93%	92%	93%	94%	93%	91%	82%	82%	82%	82%	
	W16	% Corporate Induction attendance	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	100%	97%	97%	92%	96%	98%	98%	94%	96%	97%	100%	97%	92%	96%	95%	95%	
	W17	BME % - Leadership (8A – Including Medical Consultants)	LT	DB	28%	UHL	4% improvement on Qtr 1 baseline								24%			25%					25%	
	W18	BME % - Leadership (8A – Excluding Medical Consultants)	LT	DB	28%	UHL	4% improvement on Qtr 1 baseline								12%			12%					12%	
	W19	Executive Team Turnover - Executive Directors (rolling 12 months)	LT	DB	TBC	UHL	TBC								0%	0%	0%	0%	0%	0%	0%		0%	
	W20	Executive Team Turnover - Non Executive Directors (rolling 12 months)	LT	DB	TBC	UHL	TBC								14%	14%	28%	42%	42%	42%	42%		42%	
	W21	DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	TBC	NHSI	TBC	91.2%	90.5%	87.2%	91.0%	90.5%	89.5%	90.2%	91.6%	91.3%	91.4%	89.7%	89.4%	89.9%	90.0%	89.3%	90.3%	
	W22	DAY Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	TBC	NHSI	TBC	94.0%	92.0%	93.2%	93.9%	92.1%	86.0%	88.7%	92.5%	93.7%	93.8%	92.0%	94.7%	91.0%	91.9%	93.2%	92.9%	
	W23	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	TBC	NHSI	TBC	94.9%	95.4%	91.4%	94.8%	96.6%	95.0%	96.3%	97.6%	97.2%	96.6%	94.5%	95.0%	95.1%	96.7%	95.9%	96.1%	
	W24	NIGHT Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	TBC	NHSI	TBC	99.8%	98.9%	98.4%	98.0%	100.2%	91.6%	94.7%	98.3%	99.1%	96.7%	97.1%	98.2%	96.8%	94.2%	95.6%	97.0%	



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	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	YTD
	E1	Emergency readmissions within 30 days following an elective or emergency spell	AF	MM	Monthly <8.5% (revised)	QC	Red if >8.6% ER if >8.6%	8.5%	8.9%	8.3%	9.2%	8.8%	8.7%	8.8%	8.7%	8.7%	8.6%	8.3%	8.4%	8.5%	8.5%		8.5%
	E2	Mortality - Published SHMI	AF	RB	<=99 (revised)	QC	Red if >100 ER if >100	103	96			95 (Jul14-Jun15)		96 (Oct14-Sep15)		98 (Jan15-Dec15)		99 (Apr15-Mar16)					99
	E3	Mortality - Rolling 12 mths SHMI (as reported in HED) Rebased	AF	RB	<=99 (revised)	QC	Red if >100 ER if >100	98	97	98	99	99	99	99	100	100	101	101	Awaiting HED Update				101
	E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	AF	RB	<=99 (revised)	UHL	Red if >100 ER if >100	94	96	95	95	95	95	97	99	99	100	102	103	Awaiting HED Update			103
	E5	Crude Mortality Rate Emergency Spells	AF	RB	No Threshold	UHL	Monthly Reporting	2.4%	2.3%	2.1%	2.5%	2.4%	2.4%	2.7%	2.4%	2.2%	2.2%	2.2%	2.2%	2.0%	2.2%	2.3%	2.2%
	E6	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	AF	AC	72% or above	QS	Red if <72% ER if 2 consecutive mths <72%	61.4%	63.8%	70.9%	59.7%	66.7%	65.2%	65.1%	78.0%	78.1%	64.6%	86.0%	65.8%	69.4%	64.1%	78.0%	73.0%
	E7	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions (excluding medically unfit patients)	AF	AC	72% or above	UHL	Red if <72% ER if 2 consecutive mths <72%	NEW INDICATOR						73.2%	86.8%	87.7%	73.2%	90.0%	82.0%	87.2%	78.2%	89.0%	84.3%
	E8	Stroke - 90% of Stay on a Stroke Unit	RM	IL	80% or above	QS	Red if <80% ER if 2 consecutive mths <80%	81.3%	85.6%	84.4%	87.0%	90.6%	87.0%	86.5%	72.7%	93.5%	83.8%	80.7%	88.0%	83.7%	83.1%		83.3%
	E9	Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA)	RM	IL	60% or above	QS	Red if <60% ER if 2 consecutive mths <60%	71.2%	75.6%	67.1%	68.4%	71.3%	80.0%	67.3%	53.5%	68.2%	50.4%	54.8%	71.7%	65.3%	83.8%	75.9%	65.1%
	E10	Published Clinical Outcomes - data submission and outcome results	AF	RB	0 delayed /outside expected (revised)	UHL	ER if Red Quarterly ER if >0	Revised Indicator															
	E11	Compliance with NICE Guidance (15/16 and 16/17)	AF	RB	0 Non compliance and no actions or actions delayed (revised)	UHL	Red if in mth >0 ER if Red	Revised Indicator															



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	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	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%	81.7%	85.1%	81.2%	80.2%	77.5%	81.2%	79.9%	80.6%	76.9%	80.1%	79.9%	78.3%	77.6%	79.3%
	R2	12 hour trolley waits in A&E	RM	IL	0	NHSI	Red if >0 ER via ED TB report	4	2	1	1	0	0	0	0	0	0	0	0	0	0	0	0
	R3	RTT - Incomplete 92% in 18 Weeks UHL+ALLIANCE	RM	WM	92% or above	NHSI	Red /ER if <92%	96.7%	92.6%	93.8%	93.0%	92.9%	93.2%	92.6%	92.7%	92.7%	92.4%	92.4%	92.1%	91.7%	91.5%	92.2%	92.2%
	R4	RTT 52 Weeks+ Wait (Incompletes) UHL+ALLIANCE	RM	WM	0	NHSI	Red /ER if >0	0	232	263	267	269	261	232	169	134	130	77	57	53	38	34	34
	R5	6 Week - Diagnostic Test Waiting Times (UHL+ALLIANCE)	RM	WM	1% or below	NHSI	Red /ER if >1%	0.9%	1.1%	6.5%	7.0%	4.1%	1.8%	1.1%	0.7%	0.6%	0.7%	0.6%	1.4%	1.5%	0.6%	0.6%	0.6%
	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	0	3	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	3	6	6	9	14	24	16	18	20	19	10	9	13	129
	R8	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	RM	GH	0	NHSI	Red if >2 ER if >0	11	1	0	0	0	0	0	5	0	0	0	6	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%	1.3%	1.1%	1.3%	1.2%	1.5%	1.5%	1.2%	1.4%	1.1%	0.9%	1.0%	1.2%	1.5%	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%	0.0%	1.1%	2.2%	0.2%	1.0%	0.8%	0.3%	0.8%	1.4%	3.2%	0.9%	2.0%	0.5%	1.3%
	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%	1.2%	1.1%	1.4%	1.1%	1.4%	1.5%	1.2%	1.4%	1.1%	1.0%	1.0%	1.2%	1.4%	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	131	115	146	119	156	156	123	154	114	110	109	134	164	1064
	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%	1.5%	1.6%	1.8%	1.8%	2.0%	1.9%	1.8%	2.2%	2.9%	2.5%	2.1%	2.0%	2.7%	2.3%
	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%	27%	16%	12%	10%	11%	6%	6%	6%	9%	7%	9%	9%	11%	8%
	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%	26%	23%	13%	13%	13%	11%	12%	10%	15%	14%	15%	18%	18%	14%



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	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	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%	92.4%	93.0%	91.4%	93.9%	93.0%	91.1%	89.5%	90.5%	94.3%	94.9%	94.5%	93.3%	**	92.5%
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%	89.4%	93.5%	96.2%	99.3%	95.7%	96.1%	88.7%	94.9%	98.7%	95.9%	95.0%	90.7%	**	94.2%
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%	95.6%	94.3%	91.5%	92.6%	94.1%	95.4%	95.5%	95.6%	90.4%	91.3%	93.8%	94.8%	**	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%	100.0%	97.9%	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%	76.8%	91.4%	77.5%	77.9%	80.3%	90.3%	91.6%	84.7%	74.4%	72.7%	83.5%	90.4%	**	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%	95.1%	94.3%	96.4%	92.9%	96.4%	98.8%	93.6%	87.3%	92.5%	81.4%	90.9%	97.8%	**	91.0%
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%	82.5%	80.9%	75.1%	73.4%	77.6%	75.8%	74.5%	77.3%	83.6%	78.4%	77.9%	73.9%	**	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%	96.2%	95.3%	77.3%	72.5%	81.3%	94.6%	96.0%	85.0%	92.3%	78.9%	81.5%	84.2%	**	87.9%
RC9	Cancer waiting 104 days	RM	DB	0	NHSI	TBC			13	23	23	17	21	12	7	15	12	9	7	7	9	9
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	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	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%	100.0%	93.1%	94.6%	100.0%	94.1%	93.3%	95.3%	97.1%	100.0%	100.0%	95.8%	100.0%	**	97.5%
RC12	Gynaecological	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	77.5%	73.4%	80.0%	85.7%	50.0%	70.0%	78.6%	72.7%	78.6%	75.0%	62.5%	66.7%	66.7%	78.6%	**	71.0%
RC13	Haematological	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	66.5%	63.0%	50.0%	58.3%	100.0%	60.0%	60.0%	14.3%	61.5%	72.7%	100.0%	85.7%	28.6%	58.3%	**	63.6%
RC14	Head and Neck	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	69.9%	50.7%	42.9%	37.5%	62.5%	37.5%	35.7%	35.7%	45.5%	100.0%	42.9%	44.4%	0.0%	38.5%	**	39.3%
RC15	Lower Gastrointestinal Cancer	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	63.7%	59.8%	68.2%	77.8%	52.4%	31.3%	57.1%	62.5%	45.0%	64.5%	58.8%	64.4%	47.1%	36.4%	**	53.5%
RC16	Lung	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	69.9%	71.0%	88.6%	81.6%	73.7%	53.8%	71.1%	66.7%	46.7%	64.2%	60.9%	64.2%	68.0%	78.8%	**	64.1%
RC17	Other	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	95.0%	71.4%	80.0%	--	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%	**	42.1%
RC19	Skin	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	96.7%	94.1%	95.6%	94.9%	100.0%	92.5%	94.6%	95.2%	100.0%	96.8%	97.4%	95.9%	97.7%	100.0%	**	97.5%
RC20	Upper Gastrointestinal Cancer	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	73.9%	63.9%	84.6%	90.0%	42.9%	57.1%	76.5%	74.3%	70.0%	46.9%	66.7%	82.0%	70.3%	43.8%	**	66.4%
RC21	Urological (excluding testicular)	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	82.6%	74.4%	76.7%	75.0%	67.4%	78.7%	83.6%	83.7%	73.1%	77.8%	96.3%	74.5%	83.5%	88.2%	**	82.6%
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%	82.5%	80.9%	75.1%	73.4%	77.6%	75.8%	74.5%	77.3%	83.6%	78.4%	77.9%	73.9%	**	77.4%

Responsive Cancer

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%				

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%					

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%				

RTT

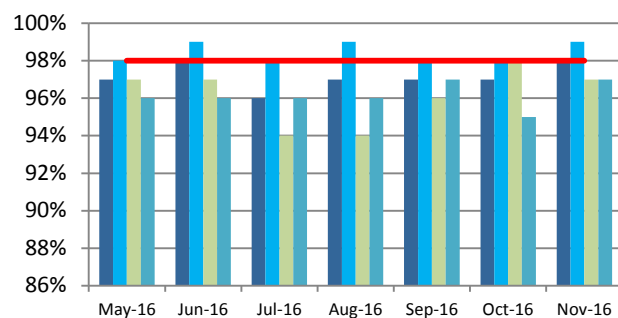
	Submitted on a "best endeavours" basis April - June											
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Performance	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Actual	92.7%	92.7%	92.4%	92.4%	92.1%	91.7%	91.5%	92.2%				

Compliance Forecast for Key Responsive Indicators

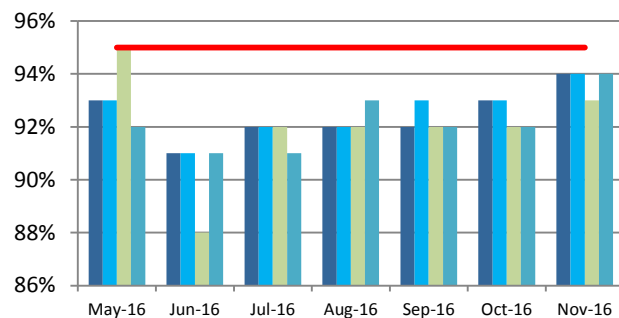
Standard	November	December	Commentary
Emergency Care			
4+ hr Wait (95%) - Calendar month	77.6%		Validated position
Ambulance Handover (CAD+)			
% Ambulance Handover >60 Mins (CAD+)	11%		EMAS monthly report
% Ambulance Handover >30 Mins and <60 mins (CAD+)	18%		
RTT (inc Alliance)			
Incomplete (92%)	92.2%	92.0%	The December 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%)	0.6%	0.9%	
# Neck of femurs			
% operated on within 36hrs - all admissions (72%)	78%	72%	
% operated on within 36hrs - pts fit for surgery (72%)	89%	80%	
Cancelled Ops (inc Alliance)			
Cancelled Ops (0.8%)	1.4%	1.0%	Delivery is dependant on access to beds.
Not Rebooked within 28 days (0 patients)	13	10	Delivery is dependant on access to beds.
Cancer			
Two Week Wait (93%)	94%	94%	
31 Day First Treatment (96%)	92%	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%)	80%	80%	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

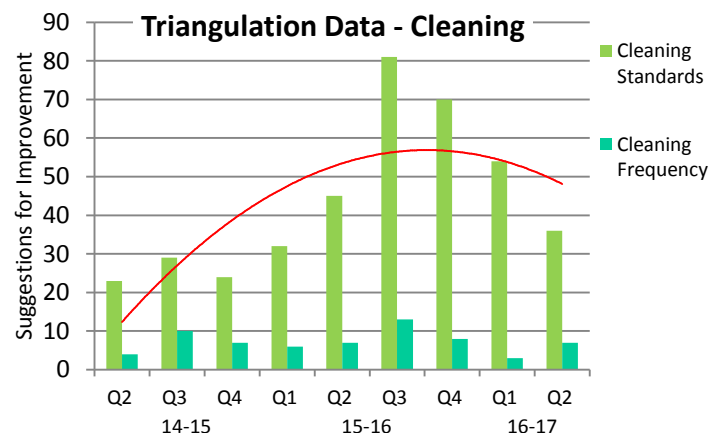
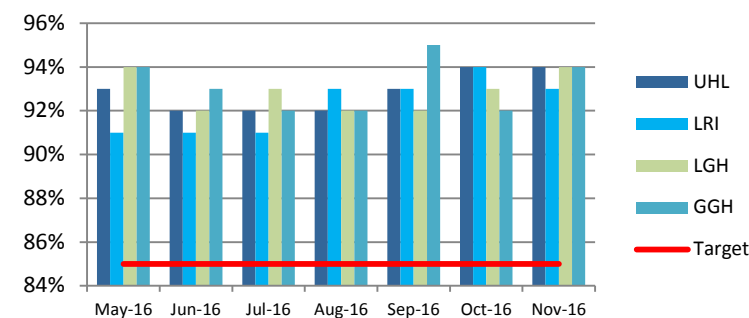
Average Cleanliness Audit Scores by Risk Category - Very High



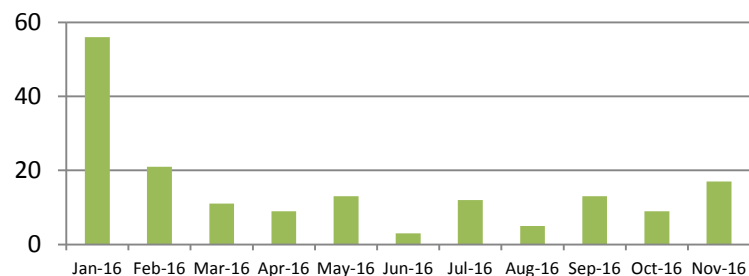
Average Cleanliness Audit Scores by Risk Category - High



Average Cleanliness Audit Scores by Risk Category - Significant



Number of Datix Incidents Logged - Cleaning



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. Data immediately prior to this date was not considered to be reliable. Each chart covers specific risk categories:-

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

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

Very high risk areas should achieve a score of 98%. The data shows that this was achieved in November 2016 overall across the Trust with LGH and GH missing this target by 1%.

For high risk areas improvement is needed to achieve the required 95% score with an overall score of 94% achieved in November 2016 with the LGH scoring 93%.

Significant risk areas all exceed the 85% target.

In terms of trend for all risk categories the picture in general is one of a drop off in scores from the service hand over in May 2016 followed by a steady improvement. Some of the early difference in scores was attributable to a 're-calibration' of the audit scoring process.

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'. It shows a historical picture covering the period where our previous service provider undertook an exercise to change the cleaning methodology and drastically reduce the number of cleaning hours across the Trust. The (paranomial) trend line illustrates the change over time.

The data shows marked improvement since this time and improvement continuing post hand over into Q2.

As a baseline for the transferred service, this is a more reliable source (as it has always been under the Trusts control) for comparing future performance. The number of vacancies continues to be the most significant challenge, however large scale recruitment is in progress and is expected to improve the situation over the coming months.

Estates and Facilities – Patient Catering

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

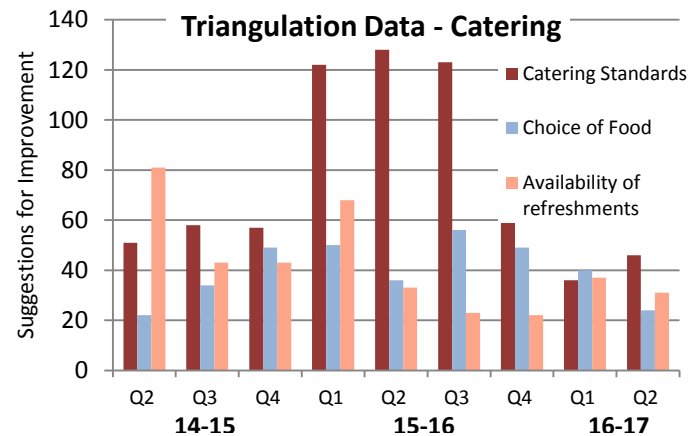
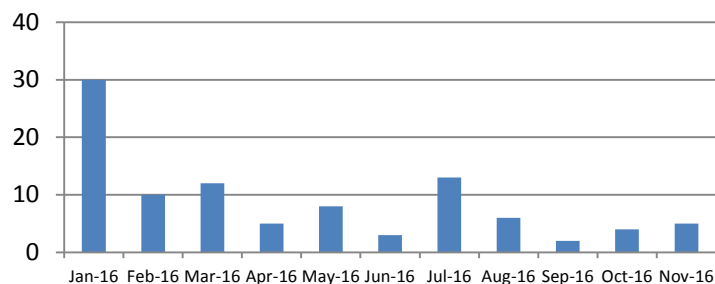
90 – 100%	80 – 90%	<80%
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Number of Patient Meals Served				
Month	LRI	LGH	GGH	UHL
October	62,008	26,294	28,030	116,332
November	63,828	22,251	28,460	114,539

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

97 – 100%	95 – 97%	<95%
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Number of Datix Incidents Logged - Patient Catering



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%.

In terms of the quality of food, November saw the reintroduction of the catering survey undertaken by the Facilities team. At this stage the results presented here are based on a limited sample (49 patients) across the Trust. As the number of surveys increases in future months, closer analysis will be undertaken to ascertain the particular issues experienced by patients who give negative feedback.

The triangulation data (see above report on cleaning for explanatory context) gives a similar picture in terms of the volume of negative feedback experienced peaking at the time of service transition undertaken by the previous service provider. This is followed by a period of significant improvement with the post-handover measure in Q2 showing a slight increase. At the time of handover, the food offering remained the same, however stock holding levels have been increased compared to the pre-handover levels and this has improved the likelihood of patients getting the meal they ordered.

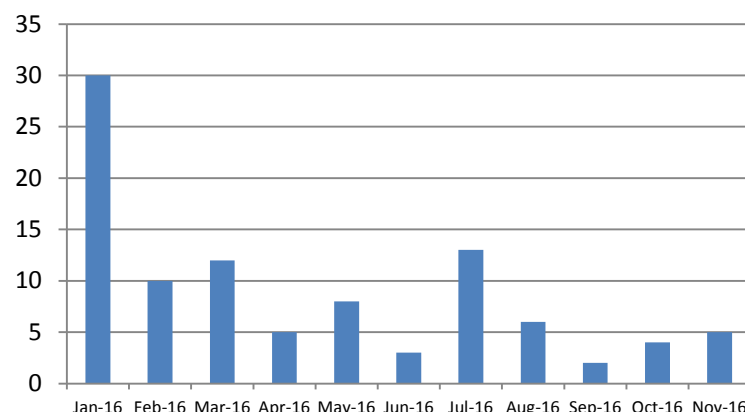
The datix data shows a slightly fluctuating picture that is in general below pre-handover levels with a blip in the middle of the summer.

Estates and Facilities - Portering

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

95 – 100%	90 – 95%	<90%
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Number of Datix Incidents Logged - Portering



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. Data is not available for the period prior to October 2016, however the Datix Incidents show an overall marked reduction in negative feedback over the course of the year. The key issue putting pressure on performance (especially at LRI) is the current number of vacancies and the need to cover from the staff bank and agency workers. A number of initiatives are in progress to increase efficiency in the deployment of porters. Work is on-going to improve reporting of performance. Future reports will include average response times by site and category. Across the Trust as a whole at present this is running at 12:52 minutes to attend an urgent request 21:51 minutes to attend a routine request.

Estates and Facilities – Planned Maintenance

Statutory Maintenance Tasks Against Schedule					
UHL Trust Wide	Month	Fail	Pass	Total	%
	October	1	207	208	100%
	November	2	172	174	99%

99 – 100%	97 – 99%	<97%
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Non-Statutory Maintenance Tasks Against Schedule					
UHL Trust Wide	Month	Fail	Pass	Total	%
	October	334	2227	2561	87%
	November	296	1823	2119	86%

95 – 100%	80 – 95%	<80%
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Estates Planned Maintenance Report

Failures in Statutory Maintenance relates to 2 fire extinguishers not completed. This is as a result of switching to a new contractor and alignment of schedules. A global exercise to ensure alignment with contractors is currently being undertaken and will be completed by mid-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

Research UHL	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
	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			
	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			
	RU3	Recruitment to Portfolio Studies	AF	NB	Aspirational target=10920/year (910/month)	TBC	TBC	12564	13479	1019	858	1019	1516	1875	815	926	983	947	788	797	803	708	672	610	462
	RU4	% Adjusted Trials Meeting 70 day Benchmark (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC			(Oct14-Sep15) 92%			(Jan15 - Dec15) 94%			(Apr15 - Mar16) 94%			(Jul15 - Jun16) 94%						
	RU5	Rank No. Trials Submitted for 70 day Benchmark (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC			(Oct14-Sep15) Rank 13/215			(Jan15 - Dec15) 61/213			(Apr15 - Mar16) 16/222			(Jul15 - Jun16) 12/220						
	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%						

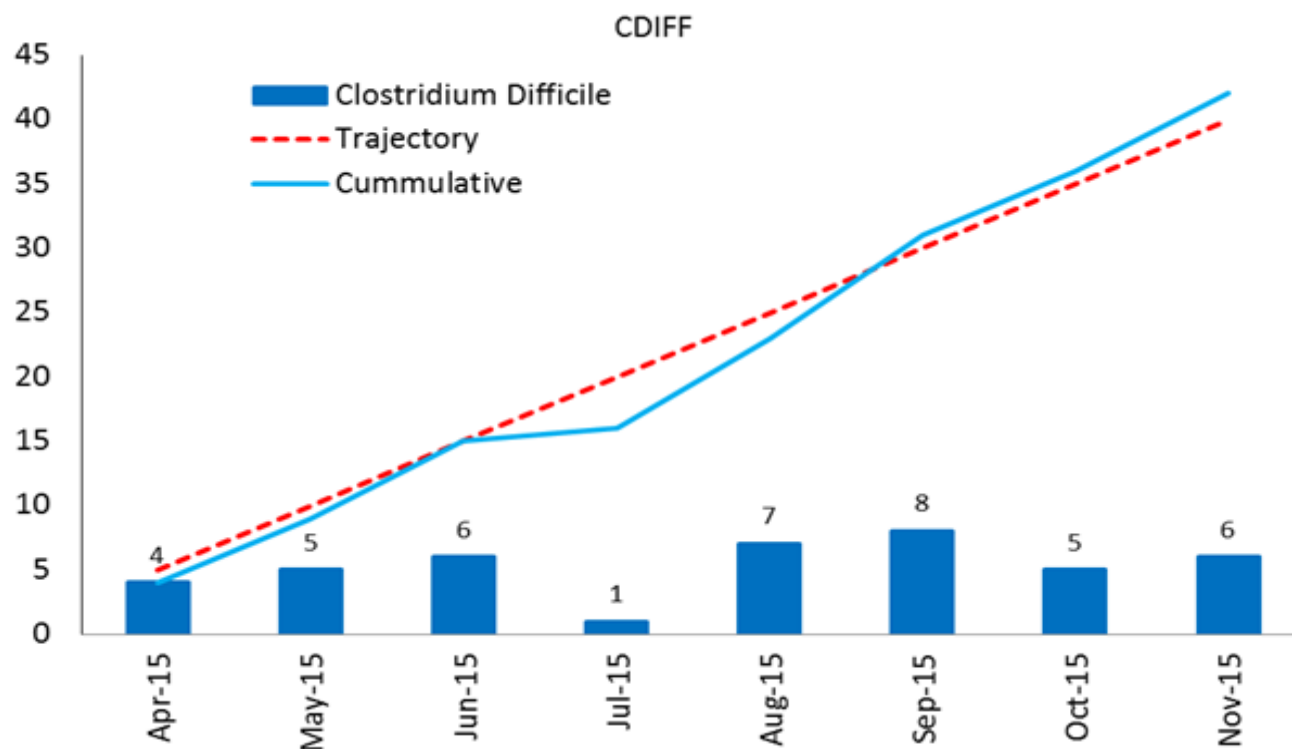
Clostridium Difficile

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	YTD
Clostridium Difficile	4	5	6	1	7	8	5	6	42

The CDT figures have risen steadily in line with the trajectory but there are no 'stand out' months which are cause for concern. The YTD position is 2 cases above the cumulative trajectory of 40.

Actions taken to improve performance

Continue to monitor cases. All patients with CDI nursed in UHL are reviewed weekly by the specialist multi-disciplinary team to ensure appropriate management and treatment. The CDT specialist nurse reviews individual patients' at least twice weekly sometimes daily dependent upon condition and circumstances. The IP nurses also review patients and isolation precautions and treatment during ward reviews. The IP and MD teams have not identified any care failures which can be directly linked to these cases.



Never Events

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	YTD
Never Event	0	0	0	1	0	0	0	1	2

Tampon left insitu following instrumental delivery and suturing of perineum. Expelled within 48 hours. No adverse outcome to patient

Actions taken to improve performance

- Tampons removed immediately from stores within the Maternity Hospital.
- Communication out to all midwives and medical staff informing them of the removal of tampons for use in clinical practice
- Individual feedback
- Other Trusts in region contacted to confirm their practice

Pressure Ulcers

Indicators	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	YTD
Avoidable Pressure Ulcers - Grade 4	0	0	0	0	0	0	0	1	1
Avoidable Pressure Ulcers - Grade 3	5	3	2	2	2	2	2	2	20
Avoidable Pressure Ulcers - Grade 2	9	6	8	3	13	6	9	10	64

What actions have been taken to improve performance?

The revised trajectory for Hospital Acquired Pressure Ulcers (HAPUs) was introduced in April 2016 based on the previous years out turn with an added improvement target.

There was 1 Grade 4 HAPU reported in November. This is being investigated via the RCA process and further details will be provided in next month's report.

The Trust has continued to make improvements and sustained good results in the number of avoidable Grade 3 pressure ulcers that have developed in our care, but continues to struggle to maintain a similar position for Grade 2 pressure ulcers. A big percentage of these are Medical Device Related Pressure Injuries. Lately, an international and national trend has emerged, recognising that Medical Device Related Pressure injuries should be addressed and monitored differently to general pressure ulcers. Furthermore the Grade 2 pressure ulcers that are being investigated and validated as avoidable in many cases are very small in size and are healed by the time of the validation meeting indicating minimal harm to the patients.

The Tissue Viability (TV) team continues to support every ward / clinical area through the RCA process so that effective learning is achieved from each incident. All HAPUs are reviewed on a monthly basis through a rigorous validation process. All clinical staff has access to Pressure Ulcer Prevention update sessions that they can book onto via e-uhl and bespoke training sessions are offered to the areas with identified high incidence of avoidable HAPUs.

The other common theme continues to be gaps in repositioning however other issues were raised this month such as delays or lack of heel protection, inconsistent or lack of documentation of pressure areas inspection (BEST SHOT not undertaken as per UHL policy) by night staff and agency staff resulting in incipient (pre-admission) skin damage possibly being missed on admission.

However, it is important to acknowledge that hospital admissions / ED pressures remain high and that there has been a considerable increase in the Trust activity compared to last year.

Throughout this year we continued to raise awareness of the principles of pressure ulcer prevention through the Heads of Nursing and shared with senior nurses the common themes attributed to avoidable pressure ulcers. The TV team undertook an additional initiative this month as 17th November marked the the International STOP Pressure Ulcers Day. This was celebrated with some promotional stands at all three hospital sites during the 3rd week of November and some ad hoc training sessions (trolley dash approach) on some of the LRI medical and surgical wards. The TV team is also exploring new technologies that may be able to support the ED / EMU staff with better pressure area skin inspection and early recognition of incipient / pre-admission pressure damage and if feasible will be organising clinical evaluation early next year.

A&E Friends and Family Test - % Positive Performance

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	YTD
A&E Friends and Family Test - % positive	96%	95%	95%	87%	87%	84%	87%	84%	90%

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).

There has been a decline in 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 senior management team are aware of the Friends and Family Test scores in the Emergency Department and are looking at ways to improve them. They have mechanisms in place to increase the submission levels in each area, to get a better overview of patient opinion
- The triage system in the UCC has been reviewed, looking at improving patient flow through the department, which is hoped will improve the comfort of patients in the waiting areas and improve the waiting times. There is now a Doctor in Charge & Nurse in Charge on a daily basis.
- Staff members are being advised of the patient's feedback regarding staff attitude
- A support worker is allocated on a daily basis to collecting FFT.

Single Sex Accommodation Breaches (patients affected)

Indicators	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	YTD
Single Sex Accommodation Breaches (patients affected)	0	0	4	1	2	20	7	1	35

Intensive Care Unit

All patients who step down from level 3/2 care must be in a single sex facility.

This breach was due to lack of bed capacity in the cardiology speciality and then an ambulance to transfer the patient to the Glenfield Site.

Actions taken to improve performance

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.

Mortality - Rolling 12 mths SHMI (as reported in HED) Rebased

Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)

	May-15 Apr-16	Jun-15 May-16	Jul-15 Jun-16	Aug-15 Jul-16	Sep-15 Aug-16	Oct-15 Sep-16	Nov-15 Oct-16	Dec-15 Nov-16	YTD
Mortality - Rolling 12 mths SHMI (as reported in HED) Rebased	100	100	101	101	Awaiting HED Update				101
Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	99	99	100	102	103	Awaiting HED Update			103

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 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

Actions taken to improve performance

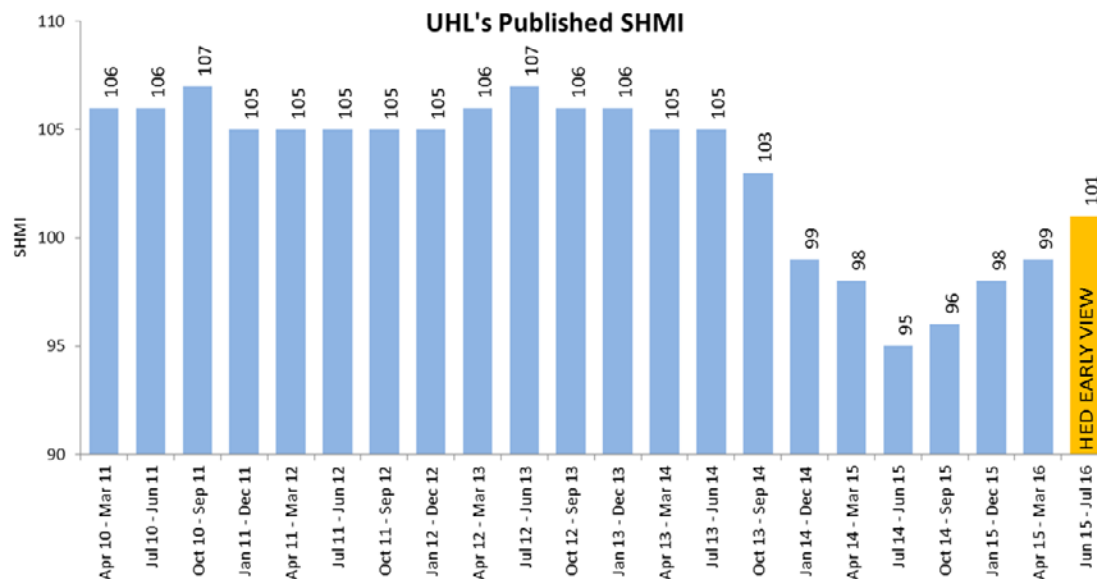
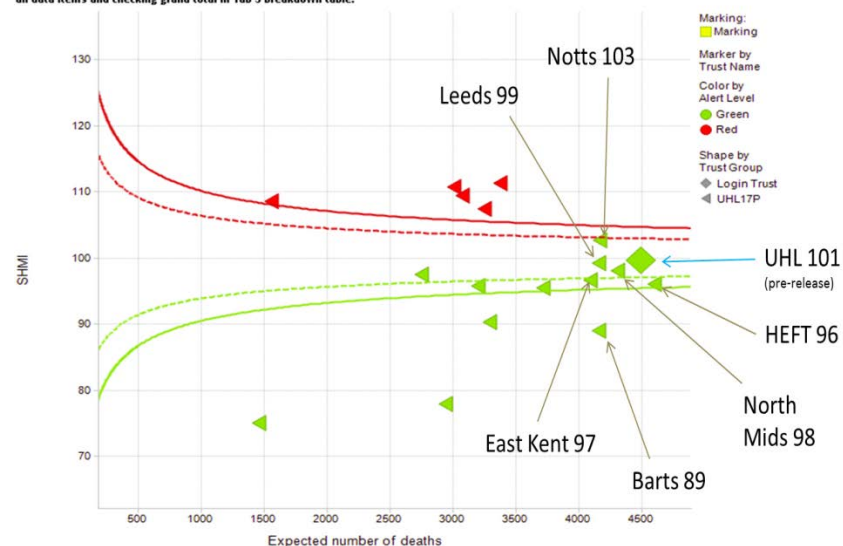
UHL subscribes to both the HED and Dr Foster Clinical Benchmarking tools and is able to monitor the SHMI and HSMR. HED use the HSCIC methodology to replicate the SHMI and Dr Foster is used by the CQC. We are therefore able to predict what our published SHMI will look like ahead of time and this suggests our next published SMHI is likely to be at 101 for the Jun15-Jul16 period. Whilst this is still 'within expected' compared nationally and to similar sized trusts (as displayed in the funnel chart below) it is above the National average of 100 and also our Quality Commitment threshold of 99. This increase is also seen in the HSMR indicator. A full report including detailed analysis and actions being taken will be reported at the Executive Quality Board and the Quality Assurance Committee in January 2017.

In addition to the in depth analysis, case note reviews have been undertaken for AMI, GI Haemorrhage and Intestinal infection. Other reviews are in progress for Cerebral Vascular Accident and Fluid & Electrolyte Disorders.

Improvement projects underway include increased Cardiology input to the LRI and the development of an AMI educational tool plus review of the GI Haemorrhage pathway.

The Mortality Review Committee continues to review UHLs crude mortality on a monthly basis.

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.



RTT – Incomplete within 18 weeks and 52+ week waits

November	<18 w	>18 w	Total Incompletes	%
Alliance	7,613	311	7924	96.08%
UHL	44,357	4,087	48,444	91.56%
Total	51970	4398	56368	92.20%

Backlog Reduction required to meet 92%	-122
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UHL and Alliance combined achieved the 92% standard for Referral to Treatment for November after failing to achieve in September and October. Overall combined performance saw 4,398 patients in the backlog, 122 less than required amount. The total number of patients waiting more than 18 weeks for treatment reduced by 275 for UHL, 85 for the Alliance with a combined backlog reduction of 360 patients from the previous month. Within UHL the reduction was mainly within the non-admitted pathway reducing by 11.3% whereas admitted backlog reduced by 0.4%.

Forecast performance for next reporting period: Meeting the 92% standard is at risk due to

- Increasing bed pressures due to winter pressures.
- Requested elective pause from NSHI to support ED performance
- Reduced number of working days due to bank holiday.

Top 5 Specialties with the largest backlog improvement

Admitted Backlog					Non Admitted Backlog				
Specialty	October	November	Change	% Change	Specialty	October	November	Change	% Change
General Surgery	312	268	-44	-14.1%	ENT	454	391	-63	-14%
Ophthalmology	173	143	-30	-17.3%	Thoracic Medicine	99	47	-52	-53%
Orthopaedic Surgery	193	175	-18	-9.3%	General Surgery	139	89	-50	-36%
Gynaecology	88	79	-9	-10.2%	Urology	93	57	-36	-39%
Paediatric Trauma & Orthopaedics	19	11	-8	-42.1%	Orthopaedic Surgery	273	242	-31	-11%

Top 5 Specialties with the largest backlog change

Admitted Backlog					Non Admitted Backlog				
Specialty	October	November	Change	% Change	Specialty	October	November	Change	% Change
Paediatric ENT	333	360	27	8.1%	Spinal Surgery	229	252	23	10%
ENT	305	323	18	5.9%	Ophthalmology	164	186	22	13%
Maxillofacial Surgery	71	82	11	15.5%	Paediatric Cardiology	50	69	19	38%
Urology	255	265	10	3.9%	Maxillofacial Surgery	15	24	9	60%
Paediatric Urology	16	26	10	62.5%	Paediatric Surgery	1	9	8	800%

Of the 90 listed specialties 32 specialties saw a backlog increase month on month compared with 58 that improved or did not increase.

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.

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.

Forecast performance for next reporting period: Meeting the 92% standard is at risk due to

- Increasing bed pressures due to winter pressures.
- Requested elective pause from NSHI to support ED performance
- Reduced number of working days due to bank holiday.

Specialty	October 2016				November 2016				Backlog Change	% Change +/-
	< 18	18+	Total	%	< 18	18+	Total	%		
ENT	2397	759	3156	76.0%	2539	714	3253	78.1%	-45	2.1%
Orthopaedics	3644	466	4110	88.7%	3695	417	4112	89.9%	-49	1.2%
Paediatric ENT	482	364	846	57.0%	460	375	835	55.1%	11	-1.9%
Ophthalmology	5486	337	5823	94.2%	5693	329	6022	94.5%	-8	0.3%
General Surgery	2248	414	2662	84.4%	2612	323	2935	89.0%	-91	4.5%
Total	14257	2340	16597	85.9%	14999	2158	17157	87.4%	-182	1.5%

The specialties with the 5 largest backlogs saw a reduction in their overall number of patients waiting more than 18 weeks with the exception of Paediatric ENT. This service was significantly impacted upon due to paediatric bed capacity.

Two of the 5 specialties with the lowest overall performance % achieved improvements from the previous month.

Month on month change for specialties with the lowest performance										
Specialty	October 2016				November 2016				Backlog Change	% change +/-
	< 18	18+	Total	%	< 18	18+	Total	%		
Paediatric ENT	482	364	846	57.0%	460	375	835	55.1%	11	-1.9%
Allergy	304	132	436	69.7%	357	133	490	72.9%	1	3.1%
Paed Max - Fax	158	45	203	77.8%	160	47	207	77.3%	2	-0.5%
ENT	2397	759	3156	76.0%	2539	714	3253	78.1%	-45	2.1%
Spinal Surgery	1448	272	1720	84.2%	1472	298	1770	83.2%	26	-1.0%
Total	4789	1572	6361	75.3%	4988	1567	6555	76.1%	-5	0.8%

52 week breaches for Orthodontics are currently 22 (with a trajectory of 1 by February 2017) with 9 adult ENT and 3 Paediatric ENT breaches.

General Surgery: Admitted	Jul	Aug	Sep	Oct	Nov	Trajectory ↓	ACPL Target	1.9
	263	278	289	285	244		ACPL Actual	1.9
	Background: Current performance driven by lack of capacity to meet SLA demands. Circa 3 sessions per week. In addition short notice cancellations of theatre sessions by the service: 4.4 sessions per week financial year to date. Business case currently being written with aim to address this. Winter bed pressures on inpatient and critical care beds resulting in patient cancelations 9.9% Sep15 - Aug16 data. Further risk going into winter months of increased cancellations due to further bed pressure demands. The service was able to meet there average cases per list target of 1.9 for Month 8 Actions: Insource capacity – Medinet. Start October into November. Business case for consultant workforce. Reduce first appointment wait time to reduce pathway lengths.							
Urology: Admitted	Jul	Aug	Sep	Oct	Nov	Trajectory →	ACPL Target	2.8
	236	241	265	255	265		ACPL Actual	2.5
	Background: Lack of in week outpatient and theatre capacity. Processes within outpatients increasing pathway length, such as a lack of pre-operative assessment slots. Unable to bring patients on short notice fill cancelled gaps. Increased activity over and above SLA predicted 297 admitted patient's full year. The service was 0.3 under there ACPL target for the month. Actions: To insource capacity - Medinet 8 sessions per weekend. Additional POA slots. Look to Alliance for additional outpatient capacity. Left shift low acuity day case work to the community with a January target for this to occur.							

Allergy: Admitted	Non	Jul	Aug	Sep	Oct	Nov	Trajectory →		
		209	197	166	129	133			
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 in steady state with use of wait list initiatives.									
Actions: Recruit to vacant consultant post. September interview not successful, 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.									
ENT: Admitted ENT: Non Admitted		Jul	Aug	Sep	Oct	Nov	Trajectory →	ACPL Target	2.4
		395	373	352	305	323		Trajectory →	ACPL Actual
		609	469	437	333	360			
Background: Current backlog driven by a high level of cancellations from 2015/16 winter bed pressures carried over to 2015/16. Internal service pressures due to clinician Long Term Sickness, average 3.5 sessions per week (91 YTD) cancelled due to no surgeon. Lack of pre-operative assessment slots has inhibited the services ability to utilise all sessions/slots that have become available. The service was 0.3 under there ACPL target									
Actions: Insource outpatient and inpatient capacity (Medinet). Use of Alliance for low risk patients. Appointment of additional consultants to reduce cancelled sessions. Assess ability to increase WLI for Balance patients, linked to consultant discretionary effort.									
Ophthalmology: Non Admitted		Jul	Aug	Sep	Oct	Nov	Trajectory ↑	ACPL Target	3.8
		143	222	325	164	186		ACPL Actual	3.8
Background: There has been a significant reduction in outpatient capacity due to reduced staffing of middle grade doctors and lack of replacements. Reduced capacity in outpatient clinic slots increasing wait for first appointment. Reduced take up of wait list initiatives both for both outpatient and theatre sessions. Lack of follow up capacity resulted in patients not being listed for surgery as unable to have a clinically required follow up within 4 weeks of surgery. The service met there ACPL target for November									
Actions: Assess all patients in backlog. Move general ophthalmology to clinical fellow lists. Additional Capacity at London Road Clinic. Insource outpatient capacity – Newmedica. Outpatient Wait list initiatives.									

Orthopaedic Surgery: Non Admitted	Jul	Aug	Sep	Oct	Nov	Trajectory ↓	ACPL Target	2.1
	190	197	274	273	242		ACPL Actual	1.9

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. The service was 0.2 under there ACPL target.

Actions: Additional clinics to reduce out patient backlog. Clinical engagement for patients on foot and ankle pathway for waiting list management. Increased clinical capacity from February 2017

Diagnostic Performance

November diagnostic performance for UHL and the Alliance is 0.64% We have achieved the standard performing below the 1% threshold for the second consecutive month after non delivery in August and September. Factors for September's non-performance were the installation of EMRAD resulted in a system failure within the Imaging Service due to the high level of management time required and a lack of reporting for the first several weeks post go live. The key actions taken to support in the delivery of the performance listed below appear embedded practice and provide confidence of these factors will not impact on diagnostic performance going forward.

- Bi weekly escalation meetings between the Performance and Radiology teams to ensure full visibility of current performance.
- Sufficient capacity for Endoscopy patients requiring sedation under propofol

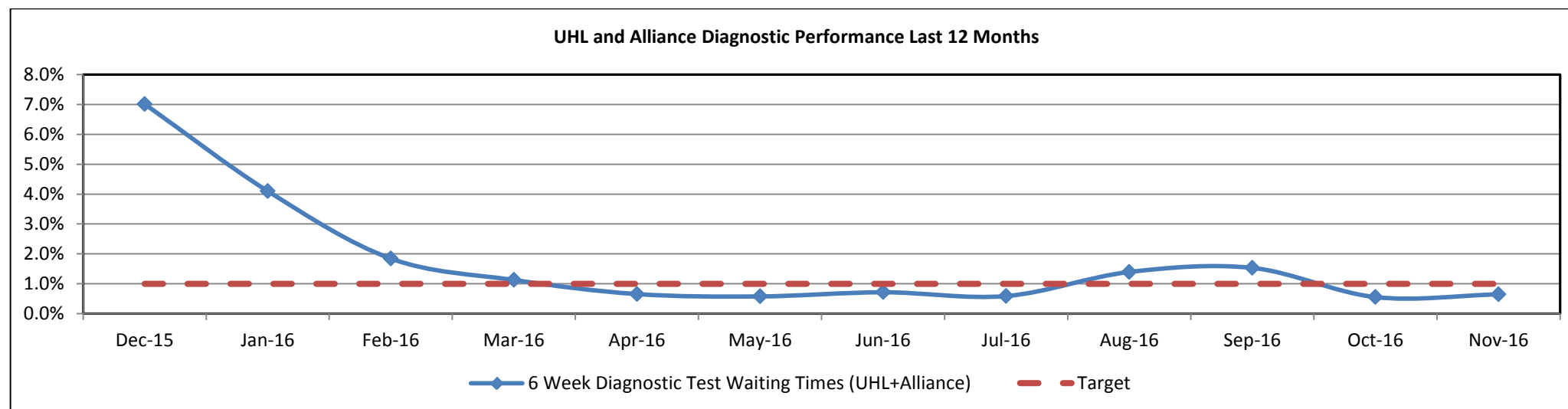
Actions taken to improve performance

An escalation meeting between with CSI and Operations now occurs twice weekly to give assurance on the end of month position and to be sighted early when there are any significant capacity gaps that can be supported with extra capacity to hit the 1% standard. This includes a bespoke Imaging Diagnostic scorecard to ensure greater visibility of waits.

Clinicians timely vetting / protocoling of referrals earlier to increase the pool of patients available to book at any one time
Imaging booking 4-6 weeks ahead to give greater accuracy to capacity gaps.

CHUGGS and ITAPS have worked collaboratively to source regular capacity at LRI for patients requiring sedation under propofol. This has started Mid October and has seen endoscopy diagnostic breaches reduce to less then 10.

Predicted diagnostic performance for December = < 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

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

Indicator	Target (monthly)	Latest month	YTD performance (inc Alliance)	Forecast performance for next reporting period
1	0.8%	1.4%	1.2%	1.0%
2	0	13	129	8

What is causing underperformance?

Across UHL in October 159 patients were cancelled on the day, This equates to 1.5% cancellations on the day for UHL excluding the Alliance of all elective FCEs against a target of 0.8%. This is an increase of 40 since October. Of the 159 cancellations 96 were due to capacity pressures and the other 63 due to hospital related causes. Of the 96 patients cancelled for capacity pressures, 84 of the cancellations related to availability of beds (either HDU, ITU or ward). The five key reasons for cancellations were:

1. Hospital cancel - ward bed unavailable (47)
2. Hospital cancel - lack theatre time / list overrun (34)
3. Hospital cancel – HDU bed unavailable (28)
4. Hospital cancel -pt delayed to adm high priority patient (12)
5. Hospital cancel – ITU bed unavailable (9)

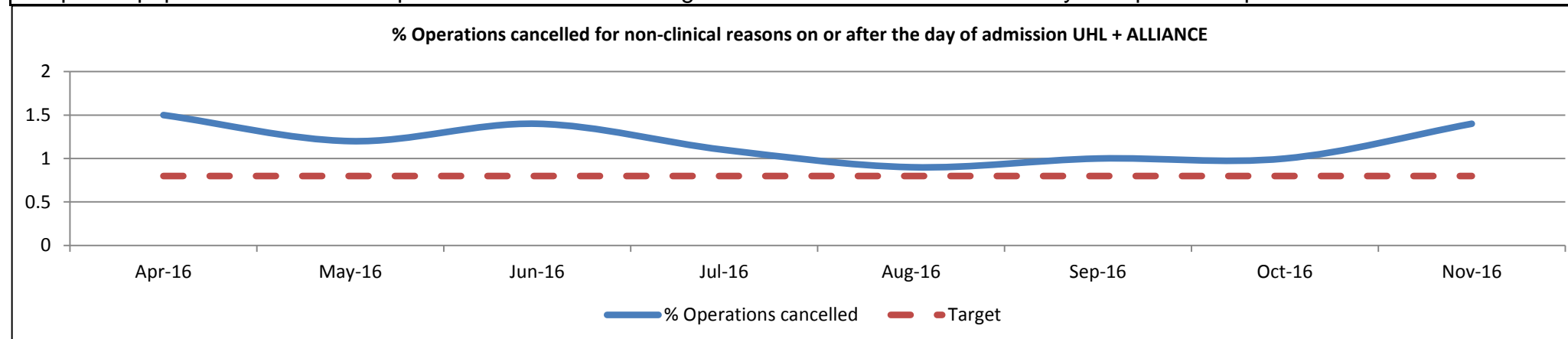
Although cancellations have increased overall by 40 from last month non capacity related cancellations fell by 2 indicating winter bed pressure as the increasing factor in current cancellation performance.

13 patients breached 28 days. These comprised of CHUGGS 6, CSI 1, Musculoskeletal and Specialist Surgery 4, Renal, Respiratory and Cardiac 1, Women's and Children's 1

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

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

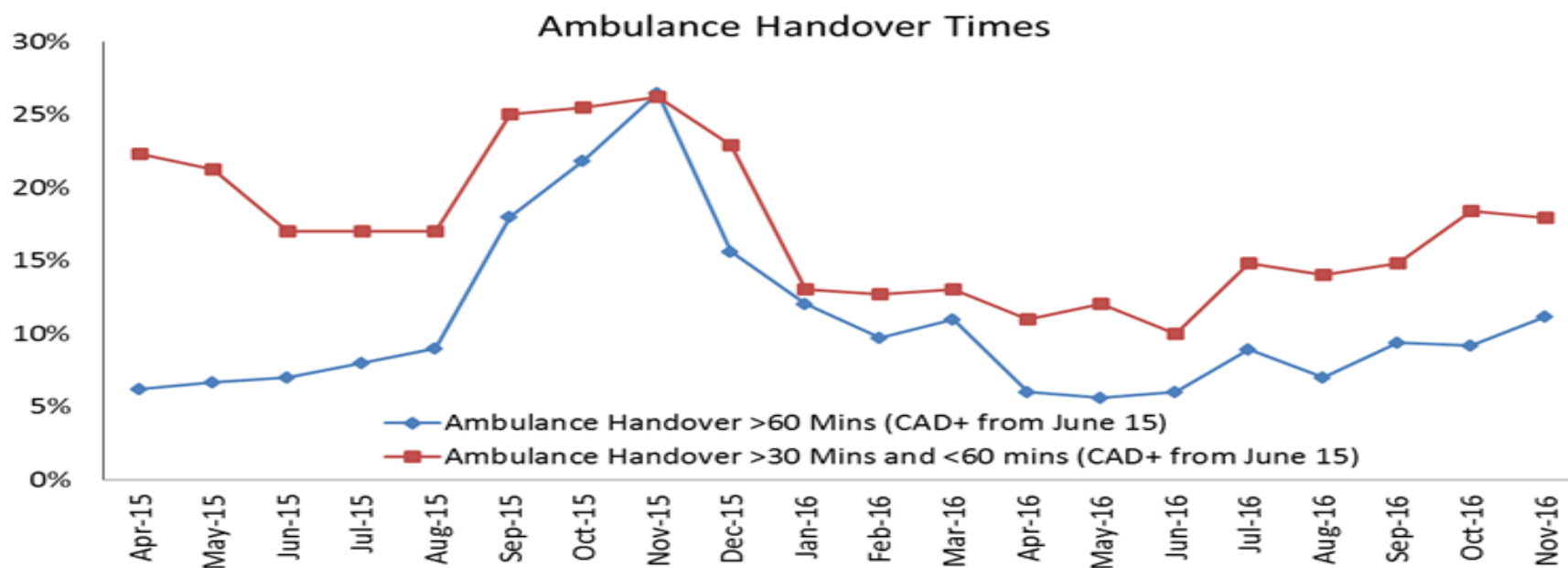
What actions have been taken to improve performance?

Previous Actions:

- Service managers have moved back to support this function to ensuring it is as efficient as possible.

New Actions:

- Open up offload area (7 spaces) from Tuesday 13 December with support of additional Amvale crew
- Additional paramedic crew (central medical services) to support with inter-hospital transfers

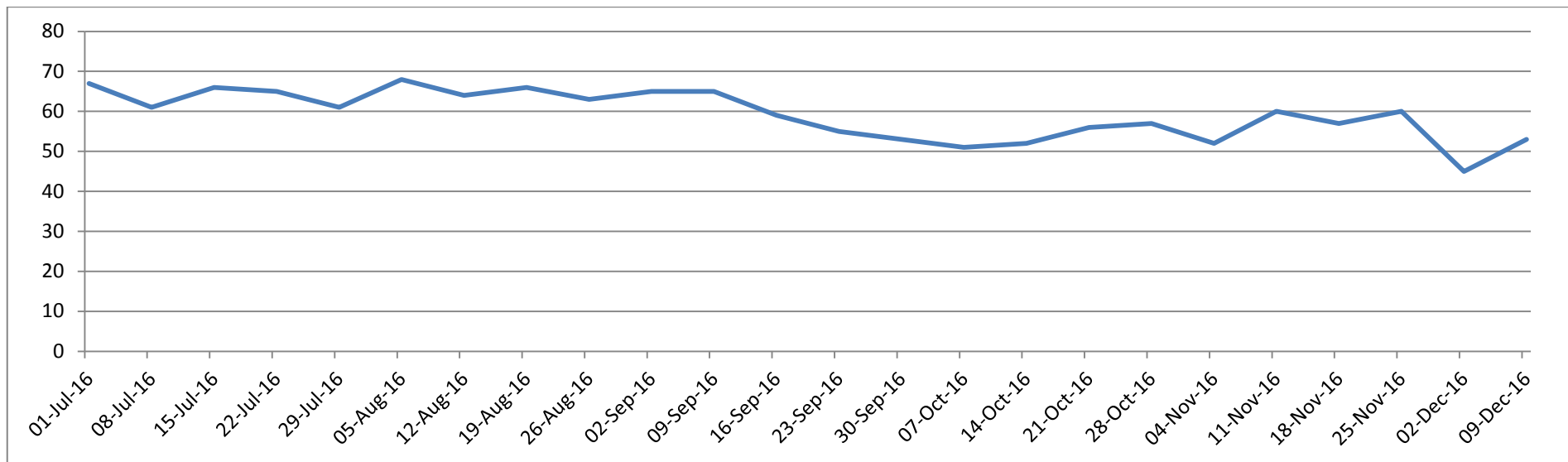


Cancer waiting time performance

Current Performance

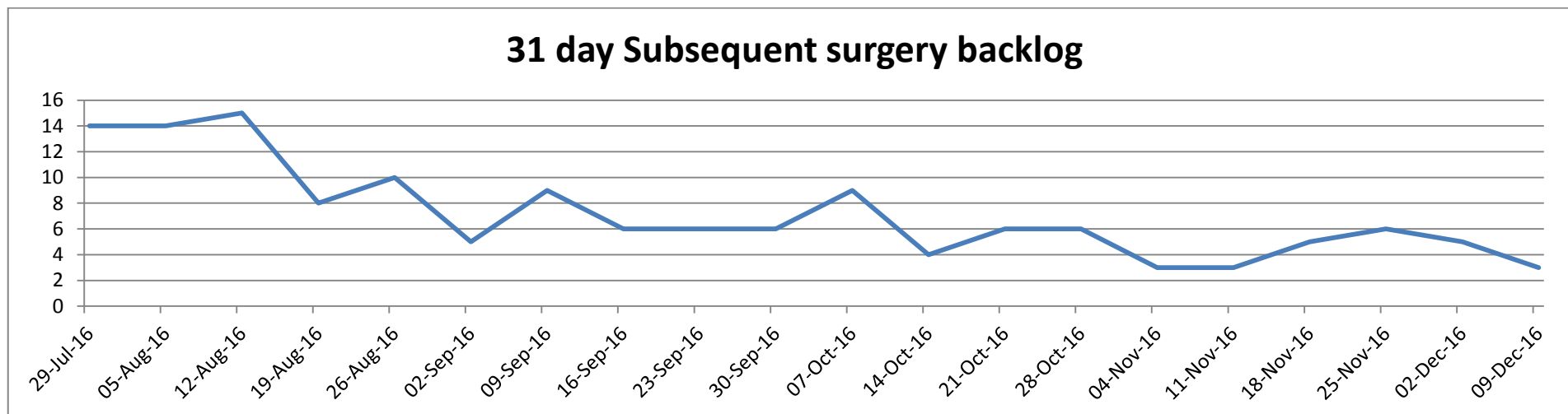
- 2ww performance remains strong with November and December performance expected to be above the standard.
- 62 day performance as anticipated remains below the required standard, November (pre-upload) at 80% and December expected at circa 85%. *In discussion with NHSI and NHSE the Trust has stated that 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. The Trust is clear that all efforts to deliver good patient care and improve cancer performance is priority.*
- The positive news is that the adjusted backlog (excluding tertiary referrals received after day 39) has averaged in the 50's for over 8 weeks, currently sitting at 53. This sustained reduction is a lead indicator of future performance.

62 Day Adjusted Backlog



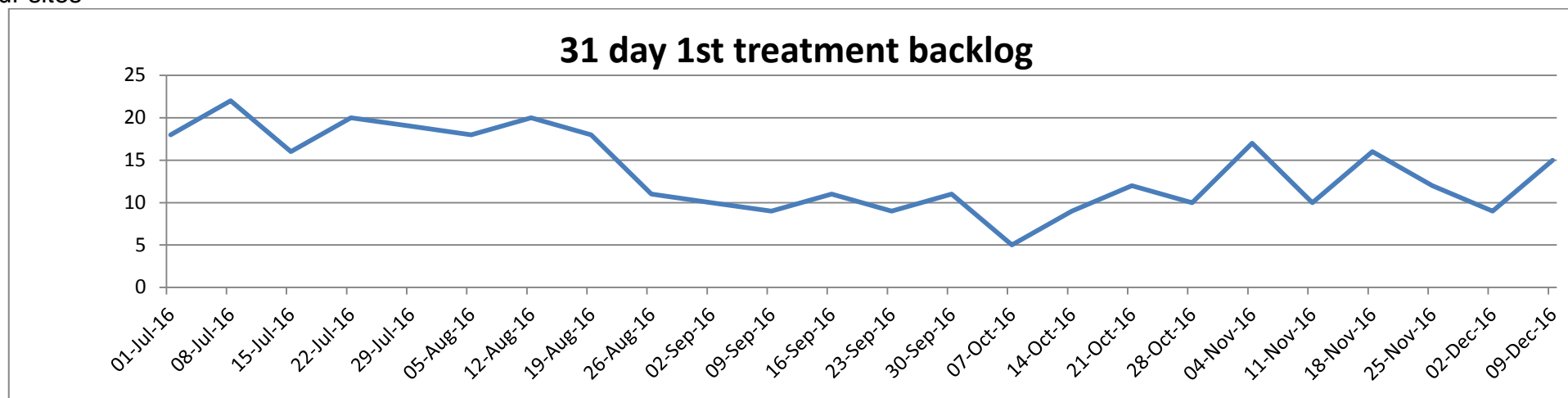
Key themes identified in backlog (9th December)

Summary of delays	Numbers of patients	Summary
Clinical Decision Making	2	Patients in Breast and Gynae who have had changes in clinical treatment plans following multiple investigations.
Complex Patients	4	Across 4 tumour sites, Lung, Lower GI, Urology and Head & Neck – these are patients undergoing multiple tests, MDTs and diagnostics. 3 out of the 4 patients have decision to treat dates, 1 is awaiting pathology for diagnostic purposes.
Long Term Follow Up/Surveillance	2	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.
Diagnostic Delays/Capacity	12	Across 5 tumour sites, this cohort represents patients delayed due to diagnostic delays, covering delays due to capacity within surgery (3), delays due to capacity within Endoscopy (3), Pathology/Imaging reporting delays (3), patients undergoing multiple diagnostics (1).
Late Referrals Other Tumour Sites	1	Specifically a patient transferred from Haematology on Day 45 to Gynae.
OPD Delays/Capacity including UHL Pathway Delays	15	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 Project Manager. 10 of the 15 patients are within Gynae – see further paper to be tabled at Board.
Patient Delays & Patients Unfit	13	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	3	Specific to Lung (2) and Gynae (1) patients, process in place for accurate and timely update on patients awaiting consent and randomisation with Trials unit.
Tertiary Referrals	1	Referral from Derby on Day 60 to Lung.



31 day subsequent surgery performance is below the standard at 90.4% in October, November (pre-upload) expected at 83.7% with December currently at 88.6%.

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 1st treatment performance is below the standard at 91.8% (pre-upload) in November, with December expected position to be circa 86%. Ongoing backlog reduction is not being sustained, again access to beds and timely theatre capacity remains the key issue. This primarily impacts on Urology and Gynae.

Summary of the plan

The recovery action plan (RAP) consists of 32 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 require RAP additions and this will be done in conjunction with the tumour site. A verbal update will be provided at the next CA/RTT Board in December.

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).

Tumour sites that are off their 62 day adjusted trajectory

Over the past 2 weeks, a number of tumour sites have reduced their backlogs below or at their trajectory set with those remaining being 1 or 2 away from meeting their target with the exception of Gynae.

Tumour site	Adjusted Backlog as at 9 th Dec 2016	Adjusted trajectory	Key mitigating recovery action plan (RAP) actions
Lower GI	7	6	Action 1: consolidating MDTs on one site , on track for January 2017 Actions 3+4 and full embedding of Next steps which has slipped. Additional actions taken to support next steps process Other Key issues are the Trusts ' Wicked issues', theatre capacity / elective beds including HDU / ITU
Skin	2	1	Although Skin have a RAP Action (Action no 12/3 – Next Steps), the patients in the current Skin backlog would not have been prevented by the rollout of Next Steps. Both patients have had holidays during their pathway and are now awaiting pathology for diagnosis.
Lung	7	4	Action 5/1 & 2: meetings have been held with Burton with clear actions agreed to support improved pathways between the two Trusts, a further meeting is planned for January 2017 to work through admin processes and improved communication Action 5/3: Thematic review ongoing, Next Steps co-ordinator appointed – awaiting HR processes for start date, LTFU policy – awaiting final sign off from MDT Lead.
Urology	8	7	Action 1: additional theatre lists , remains high risk due to lack of availability of additional theatres. Medinet in place
Gynaecology	17	7	Paper to be tabled at CA/RTT Board

