Quality & Performance Report

Author: John Adler Sponsor: Chief Executive Date: IFPIC and QAC 29th June 2017

Executive Summary from CEO Joint Paper 1

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** – the plan to reduce numbers by a further 9% from 16/17 outturn was achieved during April. **Referral to Treatment –** was achieved for the first time since November 16 and **diagnostic 6 week wait –** remains complaint for the 8th consecutive month. **52+ week waits –** current number has reduced to 9. **Cancer Two Week Wait** – have continued to achieve the 93% threshold for 10 consecutive months. **Cancer 31 day treatment –** achieved for 2 consecutive months. Reported **delayed transfers of care** remain within the tolerance. However there are a range of other delays that do not appear in the count. **MRSA** – zero cases reported for April and May. **C DIFF** zero cases reported in May. **Pressure Ulcers** – Zero **Grade 4 and Grade 3** pressure ulcers reported this financial year and **Grade 2** are within the trajectory for month and year to date. **CAS alerts** – we remain compliant. **Inpatient and Day Case Patient Satisfaction (FFT)** achieved the Quality Commitment of 97%. **Fractured NOF** – was achieved for the first time in 6 months. **Ambulance Handover 60+ minutes (CAD+)** – performance at 7% is a slight deterioration on last few months but still significant improvement when compared to Nov 16 to Jan 17.

Bad News: **Mortality** – the latest published SHMI (period October 2015 to September 2016) is 102 (still within the expected range)**. ED 4 hour performance** – May performance was 76.3 %. Further detail is in the Chief Operating Officer's report. **Never events** – 3 reported this month – further detail included in the Q&P report. **Cancelled operations** and **patients rebooked within 28 days** – continued to be non-compliant, due emergency pressures. **Cancer 62 day treatment –** was not achieved this month, however the adjusted position, taking into account late tertiaries in line with the Inter-Provider Guidance Transfer Policy (IPGT) results in an 85% achievement of the 62 day standard. **Single Sex Accommodation Breaches** – 3 breaches during May. **Statutory & Mandatory Training** – 85% against a target of 95%.

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: 27th July 2017

Quality and Performance Executive Summary

May 2017

Operational Delivery Unit

Domain - Safe

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

3
Never Events YTD ↓

9 ↓
Serious Incidents YTD
(No escalated each month)

10 ↑
Moderate Harm and above YTD
(PSIs with finally approved status)

0
Avoidable MRSA YTD ↔

5
CDIFF Cases YTD ↑

Headlines

- Moderate harms and above - the plan to reduce numbers by a further 9% from 16/17 outturn was achieved during April.
- There have been zero cases of MRSA's reported in 17/18.
- Zero C Diff cases reported in May.
- The first two months data for 2017/18 reflects a strong performance against the EWS indicators. Our focus for 2017/18 will be to maintain this position and improve compliance with the % percentage of patients who develop Red Flag Sepsis whilst an inpatient and receive antibiotics within one hour.

SEPSIS

Patients with an Early Warning Score 3+ - % appropriate escalation	91% YTD ↓
Patients with EWS 3+ - % who are screened for sepsis	95% YTD ↓
ED - Patients who trigger with red flag sepsis - % that have their IV antibiotics within an hour	86% YTD ↓
Wards (including assessment units) Patients who trigger for Red Flag Sepsis - % that receive their antibiotics within an hour	75% 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 99% ↓

A&E FFT 94% ↓

Maternity FFT 93% ↑

Outpatients FFT 95% ↑

Staff FFT Quarter 4 2016/17 (Pulse Check)

72.7% of staff would recommend UHL as a place to receive treatment

Single sex accommodation breaches

6 YTD ⟷

Headlines

- Friends and family test (FFT) for Inpatient and Daycase care combined are at 97% for May.
- Patient Satisfaction (FFT) for ED decreased to 93% for May, YTD is 94%.
- Single Sex Accommodation Breaches – 6 YTD (April 3 and May 3).

Domain – Well Led

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

Friends and Family FFT YTD % Coverage

Inpatients FFT 37.1% ↑
Day Case FFT 26.7% ↓
A&E FFT 11.0% ↓
Maternity FFT 45.4% ↓
Outpatients FFT 5.6% ↑

Staff FFT Quarter 4 2016/17 (Pulse Check)

61.4% of staff would recommend UHL as a place to work

Headlines

- Inpatients and Daycase coverage remains above Trust target
- A&E coverage for May was 8.3% against a new Trust target of 10%.
- Appraisals are 2.5% off target for May (this excludes facilities staff that were transferred over from Interserve).
- Statutory & Mandatory is 10% 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

92.5% YTD ↑

Statutory & Mandatory Training

85% YTD ↓

BME % - Leadership

26% Qtr4
8A including medical consultants

12% Qtr4
8A excluding medical consultants

Domain – Effective

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

Mortality – Published SHMI

102
Oct15-Sep16 ↓

Stroke TIA clinic within 24hrs

57.4%
YTD ↓

80% of patients spending 90% stay on stoke unit

86.3%
YTD ↓

Emergency Crude Mortality Rate

1.9%
YTD ↑

30 Days Emergency Readmissions

9.5%
FY 2016/17 ↓

NoFs operated on 0-35hrs

61.8%
YTD ↑

Headlines

- UHL's SHMI has moved two points above the England average to 102. A recent in depth HED review of UHL mortality did not identify any additional areas of mortality by condition which needed action that we did not already have reviews or action plans in place for.
- Fractured NoF – 76.5% of patients were operated on within 0-35hours in May. However the year to date figure is 10.2% below the 72% target because of Aprils performance being 47.1%.

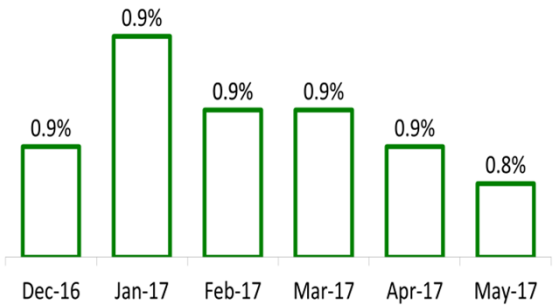
Domain – Responsive

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

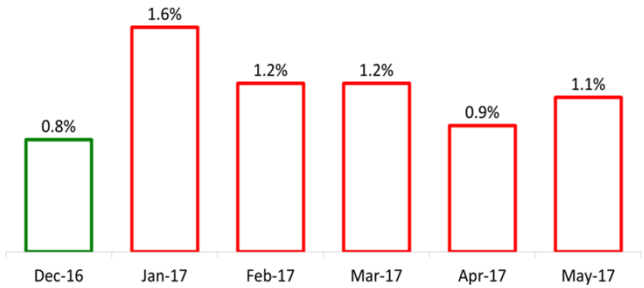
RTT - Incomplete 92% in 18 Weeks

92.3%
YTD ↑

6 week Diagnostic Wait times



Cancelled Operations UHL



RTT 52 week wait *incompletes*

9
YTD ↑

ED 4Hr Wait

A&E **78.6%**
YTD ↓

Ambulance Handovers

7% > 60mins ↓
13% 30-60mins ↔
YTD

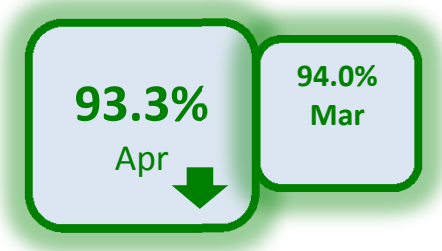
Headlines

- Nine 52+ week waiters in May compared to 17 in April – 6 ENT, 1 Paediatric ENT, 1 Orthodontics and 1 Cardiac Surgery.
- Diagnostic 6 week wait – we have now achieved eight consecutive months below the 1% national target.
- For ED 4hour wait and Ambulance Handovers please refer to Chief Operating Officers report.

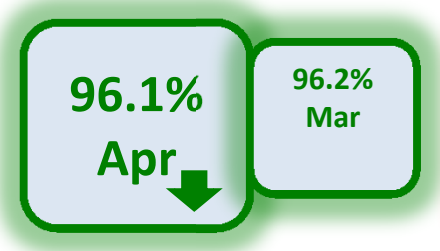
Domain – Responsive Cancer

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

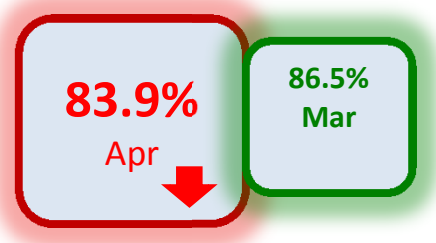
Cancer 2 week wait



31 day wait



62 day wait



31 day backlog

62 day backlog

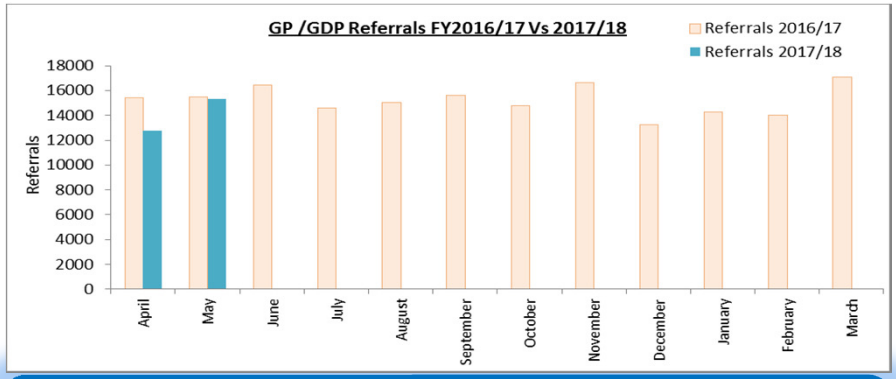
62 day adjusted backlog

Headlines

- Cancer Two Week Wait was achieved in April and has remained compliant since July 16.
- 31 day wait has now been achieved for the last two consecutive months.
- Cancer 62 day treatment – was not achieved this month, however the adjusted position, taking into account late tertiaries in line with the Inter-Provider Guidance Transfer Policy (IPGT) results in an 85% achievement of the 62 day standard.

UHL Activity Trends

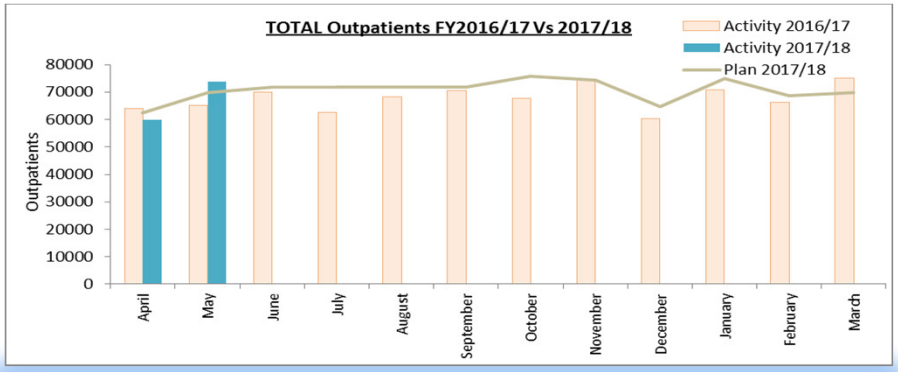
Referrals (GP)



Apr - May
17/18 Vs 16/17 -2,813 -10%

Referrals decrease due to Easter falling in April this year. May 17 referrals are similar to last May.

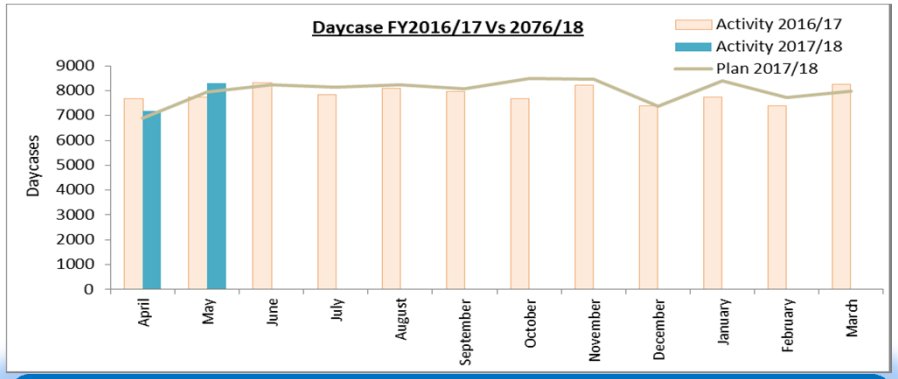
TOTAL Outpatient Appointments



Apr - May
17/18 Vs 16/17 +4,462 +3%
17/18 Vs Plan +1,571 +1%

Outpatients also effected by Easter Working days effect but activity decrease was offset by additional work in some specialties.

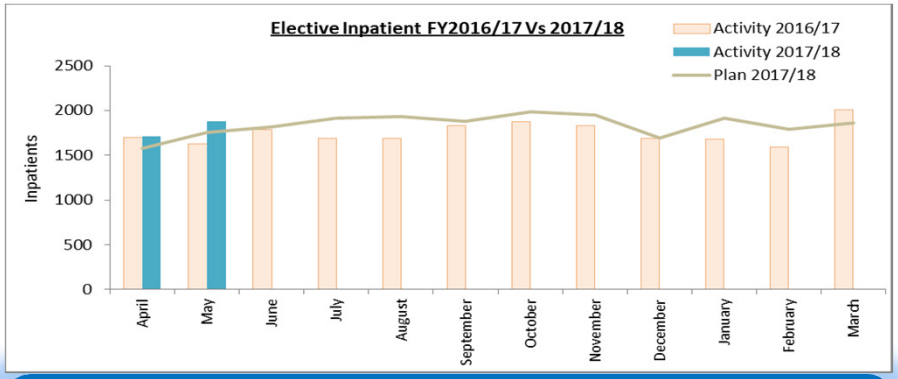
Daycases



April
17/18 Vs 16/17 +48 0%
17/18 Vs Plan +629 +4%

Growth in Gastro and Haematology against plan.

Elective Inpatient Admissions

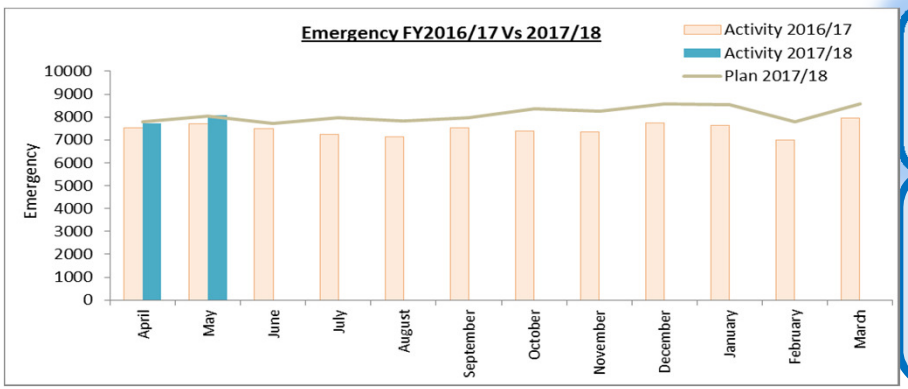


April
17/18 Vs 16/17 +260 +7%
17/18 Vs Plan +247 +7%

Additional work to improve RTT performance in Gen surgery, ENT and Maxfax and overall less cancellations than same period last year.

UHL Activity Trends

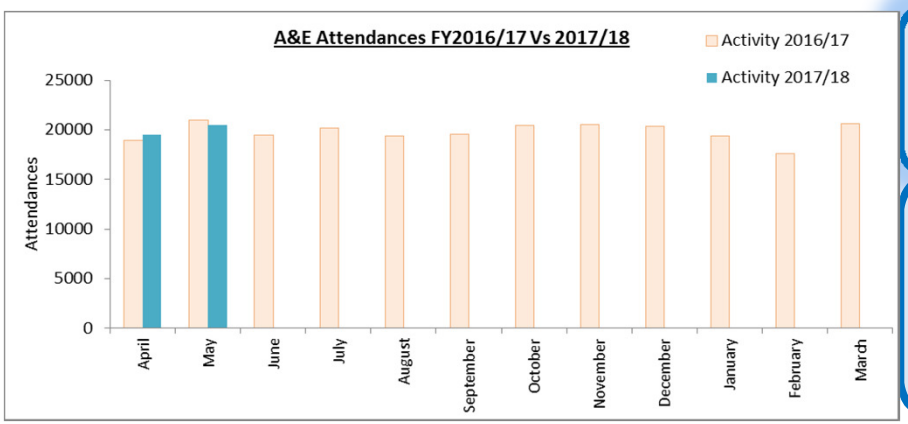
Emergency Admissions



April
17/18 Vs 16/17 +618 +4%
17/18 Vs Plan -10 0%

Emergencies as per plan. Plan currently not adjusted for QIPP. Paediatric CAU attenders are reported as admissions in the 17/18 figures.

A & E Attendances

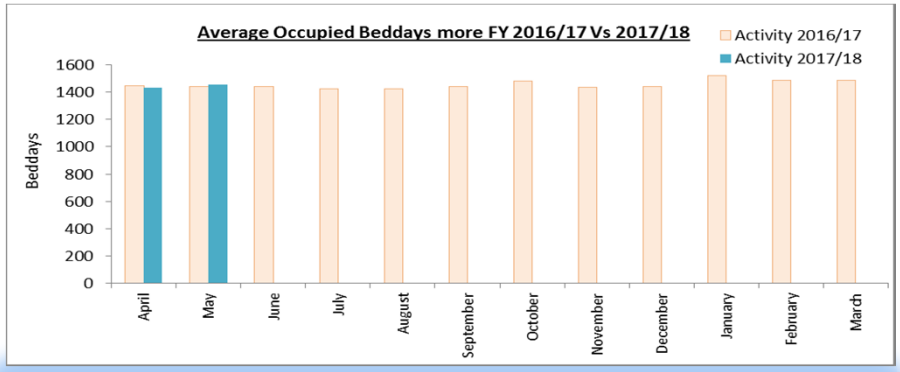


April
17/18 Vs 16/17 +72 +0%

A&E attendances includes all ED, Eye casualty and urgent care activity. Plan not included as A&E has been based on different pathways for CAU and Ophthalmology

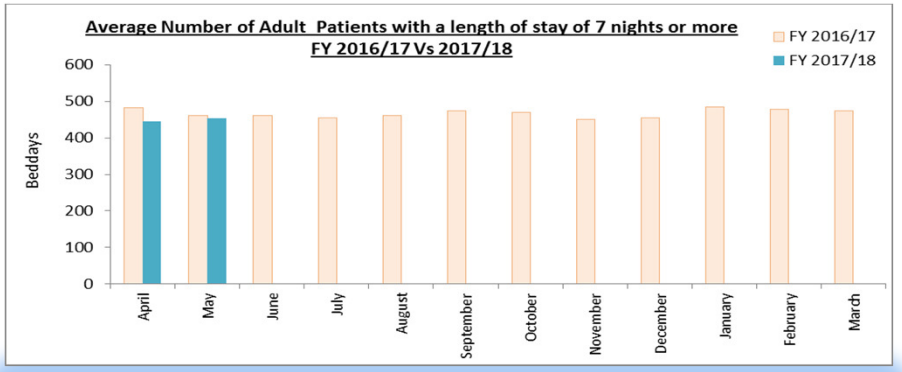
UHL Bed Occupancy

Occupied Beddays



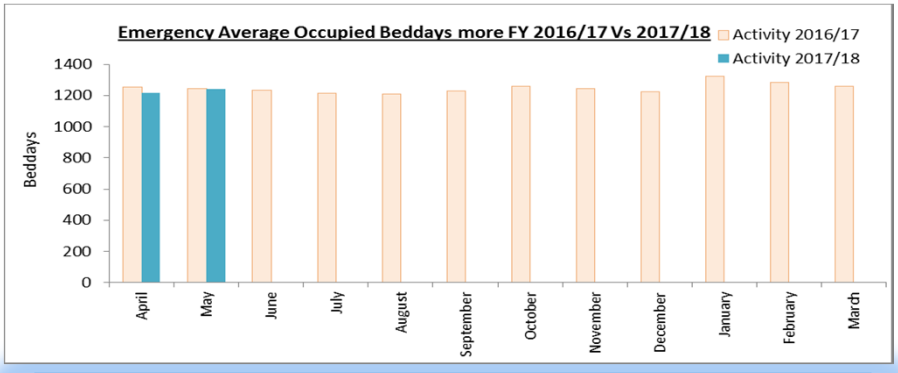
Midnight G&A bed occupancy continues to run similar to the same period last year.

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



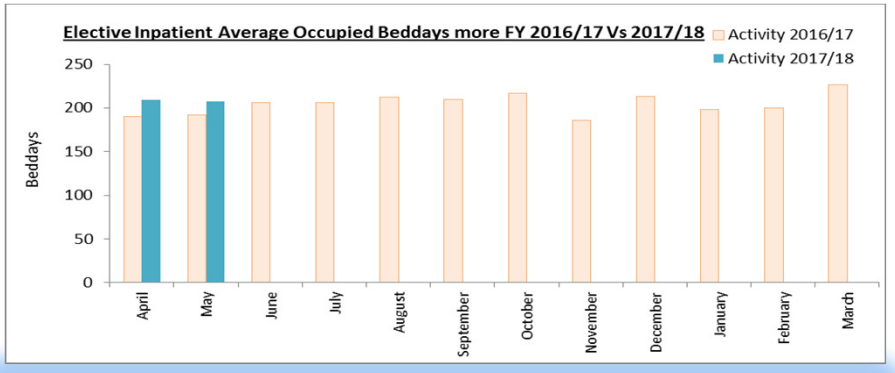
The number of patients staying in beds 7 nights or more has reduced compared to April and May 2016.

Emergency Occupied beddays



A reduction in Emergency occupied bed days, on average 32 patients less per night.

Elective Inpatient Occupied beddays



Bed occupancy is higher this year compared to the same period last year, which is reflective of the higher level of elective activity carried out.

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

May 2017

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: **29th JUNE 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: **MAY 2017 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 uses the 39 indicators listed in the 'Single Oversight Framework - Appendix 2 Quality of care (safe, effective, caring and responsive)' to identify where providers may need support under the theme of quality. All the metrics in Appendix 2 of the Oversight Framework have been reported in the Quality and Performance report with the exception of:- Aggressive cost reduction plans, C Diff – infection rate – C Diff numbers vs plans included and Potential under-reporting of patient safety incidents.

2.0 Performance Summary

Domain	Page Number	Number of Indicators	Number of Red Indicators this month
Safe	4	22	1
Caring	5	11	2
Well Led	6	23	3
Effective	7	9	5
Responsive	8	15	7
Responsive Cancer	9	9	4
Research – UHL	15	6	0
Total		95	22

3.0 Data Quality Forum (DQF) Assessment Outcome/Date

The Trust Data Quality Forum Assessment combines the Trust's old data quality forum process and the Oxford University Hospital model. The responsibility for data quality against datasets and standards under consideration are the 'data owners' rather than the forum members, with the executive lead for the data carrying the ultimate responsibility. *In this manner, the Data Quality Forum operates as an assurance function rather than holding accountability for data quality*. The process focuses on peer challenge with monthly meetings assessing where possible 4 indicators / standards at each meeting. The outputs are an agreed assessment of the data quality of the indicator under consideration with recommendations as required, a follow up date for review is also agreed. The assessment outcomes are detailed in the table below:

Rating	**Data Quality**
Green	Satisfactory
Amber	Data can be relied upon, but minor areas for improvement identified
Red	Unsatisfactory/ significant areas for improvement identified

If the indictor is not RAG rated, the date of when the indicator is due to be quality assured is included.

4.0 Changes to Indicators/Thresholds

The 16/17 Quality Commitment Keeping Inpatients Informed was achieved and has been removed from the 17/18 Quality and Performance Report.

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

	KPI Ref	Indicators	Board Director	Lead Officer	17/18 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	DQF Assessment outcome/Date	14/15 Outturn	15/16 Outturn	16/17 Outturn	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	17/18 YTD
Safe	S1	Reduction for moderate harm and above PSIs with finally approved status - reported 1 month in arrears	AF	MD	9% REDUCTION FROM FY 16/17 (<12 per month)	QC	Red if >12 in mth, ER if >12 for 2 consecutive mths	May-17	New Indicator	262	156	9	8	13	10	14	18	16	15	9	17	18	10		10
	S2	Serious Incidents - actual number escalated each month	AF	MD	<=37 by end of FY 17/18	UHL	Red / ER if >8 in mth or >5 for 3 consecutive mths	May-17	41	50	37	5	1	3	4	2	4	4	2	3	1	3	4	5	9
	S3	Proportion of reported safety incidents per 1000 attendances (IP, OP and ED)	AF	MD	> FY 16/17	UHL	Not required	May-17	New Indicator	17.5	16.5	16.8	16.4	19.3	18.3	16.5	16.2	15.3	17.1	15.8	15.8	14.2	15.8	15.8	15.8
	S4	SEPSIS - Patients with an Early Warning Score 3+ - % appropriate escalation	AF	SH	95%	UHL	TBC	Jul-17	New Indicator		88%				86%	91%	86%	89%	88%	89%	89%	90%	91%	91%	91%
	S5	SEPSIS - Patients with EWS 3+ - % who are screened for sepsis	AF	SH	95%	UHL	TBC	Jul-17	New Indicator		93%				65%	91%	95%	99%	99%	99%	97%	96%	96%	95%	95%
	S6	SEPSIS - ED - Patients who trigger with red flag sepsis - % that have their IV antibiotics within an hour	AF	SH	90%	UHL	TBC	Jul-17	New Indicator		76%	71%	71%	66%	69%	75%	79%	82%	76%	83%	88%	85%	86%	86%	86%
	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	Jul-17	New Indicator		55%	50%	21%	42%	23%	45%	61%	67%	76%	78%	77%	85%	81%	69%	75%
	S8	Overdue CAS alerts	AF	MD	0	NHSI	Red if >0 in mth ER = in mth >0	Nov-16	10	1	0	0	0	0	0	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	Nov-17	24	32	28	3	3	1	0	2	4	4	2	5	4	2	7	3	7
	S10	Never Events	AF	MD	0	NHSI	Red if >0 in mth ER = in mth >0	May-17	3	2	4	0	0	1	0	0	0	1	0	1	0	1	0	3	3
	S11	Clostridium Difficile	JS	DJ	61	NHSI	Red if >mthly threshold / ER if Red or Non compliance with cumulative target	Aug-17	73	60	60	5	6	1	7	8	5	7	0	5	7	5	5	0	5
	S12	MRSA Bacteraemias - Unavoidable or Assigned to third Party	JS	DJ	0	NHSI	Red if >0 ER Not Required	Aug-17	6	1	3	0	0	1	0	0	0	0	0	0	1	1	0	0	0
	S13	MRSA Bacteraemias (Avoidable)	JS	DJ	0	UHL	Red if >0 ER if >0	Aug-17	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	S14	MRSA Total	JS	DJ	0	UHL	Red if >0 ER if >0	Aug-17	1	0	3	0	0	1	0	0	0	0	0	0	1	1	0	0	0
	S15	% of UHL Patients with No Newly Acquired Harms	JS	NB	>=95%	UHL	Red if <95% ER if in mth <95%	Sept-16	New Indicator	97.7%	97.7%	97.2%	98.4%	97.9%	98.6%	97.9%	98.0%	97.3%	98.0%	98.0%	97.7%	96.7%	97.2%	97.8%	97.5%
	S16	% of all adults who have had VTE risk assessment on adm to hosp	AF	SR	>=95%	NHSI	Red if <95% ER if in mth <95%	Nov-16	95.8%	95.9%	95.8%	96.1%	96.5%	96.1%	96.0%	95.7%	96.3%	96.3%	95.1%	95.0%	95.1%	95.1%	95.4%	95.8%	95.6%
	S17	All falls reported per 1000 bed stays for patients >65years- reported 1 month in arrears	JS	HL	<=5.5	UHL	Red if >6.6 ER if 2 consecutive reds	Nov-17	6.9	5.4	5.9	5.9	6.1	5.7	6.4	6.1	5.4	5.7	5.7	5.4	5.7	5.7	6.1		6.1
	S18	Avoidable Pressure Ulcers - Grade 4	JS	MC	0	QS	Red / ER if Non compliance with monthly target	Jul-17	2	1	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0
	S19	Avoidable Pressure Ulcers - Grade 3	JS	MC	<=3 a month (revised) with FY End <27	QS	Red / ER if Non compliance with monthly target	Jul-17	69	33	28	3	2	2	2	2	2	2	2	2	3	1	0	0	0
	S20	Avoidable Pressure Ulcers - Grade 2	JS	MC	<=7 a month (revised) with FY End <84	QS	Red / ER if Non compliance with monthly target	Jul-17	91	89	89	6	8	3	13	6	9	10	5	8	7	5	6	5	11
	S21	Maternal Deaths (Direct within 42 days)	AF	IS	0	UHL	Red or ER if >0	Jan-17	1	0	2	0	0	0	1	0	1	0	0	0	0	0	0	0	0
	S22	Emergency C Sections (Coded as R18)	IS	EB	Not within Highest Decile	NHSI	Red / ER if Non compliance with monthly target	Jan-17	16.5%	17.5%	16.8%	16.8%	17.2%	17.0%	15.0%	18.1%	16.9%	15.3%	16.3%	17.9%	17.0%	16.7%	18.4%	19.3%	18.9%

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

	KPI Ref	Indicators	Board Director	Lead Officer	17/18 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	DQF Assessment outcome/Date	14/15 Outturn	15/16 Outturn	16/17 Outturn	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	17/18 YTD
Caring	C1	>75% of [patients in the last days of life have individualised End of Life Care plans	TBC	TBC	TBC	QC	TBC	NEW INDICATOR																	
	C2	Formal complaints rate per 1000 IP,OP and ED attendances	AF	MD	No Target	UHL	Monthly reporting	Aug-17	NEW INDICATOR		1.1	1.0	0.9	0.8	1.2	1.4	1.1	1.2	1.2	1.2	0.9	1.2	1.1	1.2	1.1
	C3	Percentage of upheld PHSO cases	AF	MD	No Target	UHL	Quarterly reporting	TBC	NEW INDICATOR		5%			0% (0 out of 7 cases)			0% (0 out of 3 cases)			0% (Zero cases)					
	C4	Published Inpatients and Daycase Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <95% ER if red for 3 consecutive months	Jun-17	New Indicator	97%	97%	97%	97%	97%	96%	97%	96%	97%	97%	96%	96%	97%	97%	97%	97%
	C5	Inpatients only Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <95% ER if red for 3 consecutive months	Jun-17	96%	97%	96%	96%	97%	96%	95%	96%	96%	96%	96%	95%	95%	95%	96%	96%	96%
	C6	Daycase only Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <95% ER if red for 3 consecutive months	Jun-17	New Indicator	98%	98%	98%	99%	98%	98%	98%	98%	98%	98%	98%	99%	98%	99%	98%	99%
	C7	A&E Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <93% ER if red for 3 consecutive months	Jun-17	96%	96%	91%	95%	95%	87%	87%	84%	87%	84%	91%	93%	94%	95%	94%	93%	94%
	C8	Outpatients Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <93% ER if red for 3 consecutive months	Jun-17	New Indicator	94%	93%	95%	95%	94%	94%	95%	95%	95%	92%	92%	92%	92%	92%	93%	93%
	C9	Maternity Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <93% ER if red for 3 consecutive months	Jun-17	96%	95%	95%	94%	94%	95%	95%	95%	95%	94%	93%	96%	94%	95%	94%	95%	95%
	C10	Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment (from Pulse Check)	LT	LT	TBC	NHSI	TBC	Aug-17	69.2%	70.0%	73.6%			76.0%			73.3%			72.7%					
	C11	Single Sex Accommodation Breaches (patients affected)	JS	HL	0	NHSI	Red if >0 ER if 2 consecutive months >5	Dec-16	13	1	60	0	4	1	2	20	7	1	14	6	4	1	3	3	6

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	KPI Ref	Indicators	Board Director	Lead Officer	17/18 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	DQF Assessment outcome/Date	14/15 Outturn	15/16 Outturn	16/17 Outturn	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	17/18 YTD
Well Led	W1	Published Inpatients and Daycase Friends and Family Test - Coverage (Adults and Children)	JS	HL	Not Appicable	N/A	Not Appicable	Jun-17	New Indicator	27.4%	30.2%	32.0%	31.6%	31.9%	28.5%	27.8%	31.6%	31.6%	27.5%	27.2%	30.7%	30.4%	32.4%	31.9%	32.1%
	W2	Inpatients only Friends and Family Test - Coverage (Adults and Children)	JS	HL	30%	QS	Red if <26% ER if 2mths Red	Jun-17	New Indicator	31.0%	35.3%	36.7%	38.1%	36.9%	36.5%	33.1%	36.6%	37.0%	31.9%	31.3%	35.4%	33.8%	37.1%	37.2%	37.1%
	W3	Daycase only Friends and Family Test - Coverage (Adults and Children)	JS	HL	20%	QS	Red if <10% ER if 2 mths Red	Jun-17	New Indicator	22.5%	24.4%	26.5%	24.5%	26.2%	19.8%	21.6%	25.9%	25.7%	22.3%	22.5%	25.5%	26.4%	27.1%	26.4%	26.7%
	W4	A&E Friends and Family Test - Coverage	JS	HL	10%	QS	Red if <7.1% ER if 2 mths Red	Jun-17	New Indicator	10.5%	10.8%	10.2%	12.0%	8.7%	9.9%	11.7%	9.8%	11.4%	7.1%	10.4%	13.8%	12.1%	13.8%	8.3%	11.0%
	W5	Outpatients Friends and Family Test - Coverage	JS	HL	5%	QS	Red if <1.5% ER if 2 mths Red	Jun-17	New Indicator	1.4%	3.0%	1.7%	1.8%	1.7%	1.6%	1.5%	1.5%	1.8%	5.7%	5.9%	5.9%	6.5%	5.4%	5.6%	5.6%
	W6	Maternity Friends and Family Test - Coverage	JS	HL	30%	UHL	Red if <26% ER if 2 mths Red	Jun-17	28.0%	31.6%	38.0%	38.3%	39.3%	38.2%	38.7%	37.8%	38.3%	41.1%	37.1%	40.9%	38.0%	41.1%	46.8%	44.1%	45.4%
	W7	Friends & Family staff survey: % of staff who would recommend the trust as place to work (from Pulse Check)	LT	BK	Not within Lowest Decile	NHSI	TBC	Sep-17	54.2%	55.4%	61.9%	60.3%		62.9%			62.9%			61.4%					
	W8	Nursing Vacancies	JS	MM	TBC	UHL	Separate report submitted to QAC	Sep-17	New Indicator	8.4%	9.2%	8.5%	8.9%	9.2%	8.2%	8.7%	10.3%	9.7%	7.1%	7.6%	7.4%	9.2%	10.9%	9.9%	10.9%
	W9	Nursing Vacancies in ESM CMG	JS	MM	TBC	UHL	Separate report submitted to QAC	Sep-17	New Indicator	17.2%	15.4%	18.9%	19.8%	20.1%	20.3%	21.4%	20.0%	20.2%	14.5%	11.9%	13.7%	15.4%	19.7%	16.9%	19.7%
	W10	Turnover Rate	LT	LG	TBC	NHSI	Red = 11% or above ER = Red for 3 Consecutive Mths	Sep-17	11.5%	9.9%	9.3%	9.6%	9.4%	9.4%	9.3%	9.2%	9.1%	9.2%	9.3%	9.3%	9.3%	9.3%	8.7%	8.8%	8.8%
	W11	Sickness absence	LT	BK	3%	UHL	Red if >4% ER if 3 consecutive mths >4.0%	Oct-16	3.8%	3.6%	3.3%	3.4%	3.4%	3.3%	3.1%	3.4%	3.5%	3.6%	3.6%	3.7%	3.5%	3.3%	3.1%		3.1%
	W12	Temporary costs and overtime as a % of total paybill	LT	LG	TBC	NHSI	TBC	Oct-17	9.4%	10.7%	10.6%	9.5%	10.9%	10.2%	10.5%	10.7%	10.9%	10.9%	10.1%	10.8%	10.5%	11.4%	11.6%	11.0%	11.1%
	W13	% of Staff with Annual Appraisal (excluding facilities Services)	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	Dec-16	91.4%	90.7%	91.7%	92.2%	92.4%	92.9%	92.4%	91.5%	91.4%	91.9%	91.7%	91.6%	92.4%	91.7%	92.1%	92.5%	92.5%
	W14	Statutory and Mandatory Training	LT	BK	95%	UHL	TBC	Dec-16	95%	93%	87%	93%	94%	93%	91%	82%	82%	82%	83%	81%	82%	87%	86%	85%	85%
	W15	% Corporate Induction attendance	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	Dec-16	100%	97%	96%	96%	97%	100%	97%	92%	96%	95%	99%	98%	97%	96%	100%	98%	98%
	W16	BME % - Leadership (8A – Including Medical Consultants)	LT	DB	28%	UHL	4% improvement on Qtr 1 baseline	TBC	New Indicator		26%	24%		25%			26%			26%					
	W17	BME % - Leadership (8A – Excluding Medical Consultants)	LT	DB	28%	UHL	4% improvement on Qtr 1 baseline	TBC			12%	12%		12%			12%			12%					
	W18	Executive Team Turnover Rate - Executive Directors (rolling 12 months)	LT	DB	TBC	UHL	TBC	TBC	New Indicator		0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	W19	Executive Team Turnover Rate - Non Executive Directors (rolling 12 months)	LT	DB	TBC	UHL	TBC	TBC			25%	14%	29%	43%	43%	43%	43%	43%	25%	25%	25%	25%	25%	25%	25%
	W20	DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	TBC	NHSI	TBC	Apr-17	91.2%	90.5%	90.5%	91.3%	91.4%	89.7%	89.4%	89.9%	90.0%	89.3%	90.4%	91.6%	91.6%	89.8%	90.3%	90.3%	90.3%
	W21	DAY Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	TBC	NHSI	TBC	Apr-17	94.0%	92.0%	92.3%	93.7%	93.8%	92.0%	94.7%	91.0%	91.9%	93.2%	91.9%	89.7%	91.1%	87.4%	96.7%	91.6%	94.2%
	W22	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	TBC	NHSI	TBC	Apr-17	94.9%	95.4%	96.4%	97.2%	96.6%	94.5%	95.0%	95.1%	96.7%	95.9%	96.9%	97.6%	97.2%	96.2%	96.6%	96.5%	96.6%
	W23	NIGHT Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	TBC	NHSI	TBC	Apr-17	99.8%	98.9%	97.1%	99.1%	96.7%	97.1%	98.2%	96.8%	94.2%	95.6%	98.5%	95.8%	97.8%	94.7%	100.2%	99.1%	99.7%

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	KPI Ref	Indicators	Board Director	Lead Officer	17/18 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	DQF Assessment outcome/Date	14/15 Outturn	15/16 Outturn	16/17 Outturn	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	17/18 YTD
Effective	E1	Emergency readmissions within 30 days following an elective or emergency spell	AF	CM	Monthly <8.5% (revised)	QC	Red if >8.6% ER if >8.6%	Jun-17	8.51% Target 7%	8.9%	8.5%	8.7%	8.6%	8.3%	8.4%	8.5%	8.5%	8.1%	8.7%	8.7%	8.4%	8.8%	9.5%		9.5%
	E2	Mortality - Published SHMI	AF	RB	<=99 (revised)	QC	Red if >100 ER if >100	Sep-16	103	96	102 (Oct15-Sep16)		98 (Jan15-Dec15)			99 (Apr15-Mar16)			101 (Jul15-Jun16)			102 (Oct15-Sep16)			102 (Oct15-Sep16)
	E3	Mortality - Rolling 12 mths SHMI (as reported in HED) Rebased	AF	RB	<=99 (revised)	QC	Red if >100 ER if not within national expected range	Sep-16	98	97	101	100	101	102	101	102	102	101	101	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 not within national expected range	Sep-16	94	96	102	99	100	102	103	102	102	103	103	102	103	101	Awaiting HED Update		101
	E5	Crude Mortality Rate Emergency Spells	AF	RB	<=2.4%	UHL	Monthly Reporting	Apr-17	2.4%	2.3%	2.4%	2.2%	2.2%	2.2%	2.2%	2.0%	2.2%	2.4%	2.7%	2.9%	2.6%	2.4%	2.1%	1.9%	2.0%
	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%	Jun-17	61.4%	63.8%	71.2%	78.1%	64.6%	86.0%	65.8%	69.4%	64.1%	78.0%	60.3%	70.9%	67.6%	71.2%	47.1%	76.5%	61.8%
	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%	Jun-17	New Indicator		83.6%	87.7%	73.2%	90.0%	82.0%	87.2%	78.2%	89.0%	79.5%	89.5%	80.0%	80.0%	64.0%	89.0%	76.5%
	E8	Stroke - 90% of Stay on a Stroke Unit	RM	IL	80% or above	QS	Red if <80% ER if 2 consecutive mths <80%	Dec-17	81.3%	85.6%	85.0%	93.5%	83.8%	80.7%	88.0%	84.5%	86.5%	88.0%	83.8%	87.4%	86.6%	85.1%	86.3%		86.3%
	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%	Dec-17	71.2%	75.6%	66.9%	68.2%	50.4%	54.8%	71.7%	65.3%	83.8%	75.9%	69.2%	87.7%	57.3%	66.3%	57.8%	57.0%	57.4%

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Responsive

KPI Ref	Indicators	Board Director	Lead Officer	17/18 Target	Target Set by	17/18 Red RAG/ Exception Report Threshold (ER)	DQF Assessment outcome/Date	14/15 Outturn	15/16 Outturn	16/17 Outturn	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	17/18 YTD
R1	ED 4 Hour Waits UHL + UCC (Calendar Month)	RM	IL	95% or above	NHSI	Red if <92% ER via ED TB report	Jun-17	89.1%	86.9%	79.6%	79.9%	80.6%	76.9%	80.1%	79.9%	78.3%	77.6%	75.5%	78.1%	83.8%	83.9%	81.0%	76.3%	78.6%
R2	12 hour trolley waits in A&E	RM	IL	0	NHSI	Red if >0 ER via ED TB report	Jun-17	4	2	11	0	0	0	0	0	0	0	1	10	0	0	0	0	0
R3	RTT - Incomplete 92% in 18 Weeks UHL+ALLIANCE	RM	WM	92% or above	NHSI	Red /ER if <92%	Nov-16	96.7%	92.6%	91.8%	92.7%	92.4%	92.4%	92.1%	91.7%	91.5%	92.2%	91.3%	90.9%	91.2%	91.8%	91.3%	92.3%	92.3%
R4	RTT 52 Weeks+ Wait (Incompletes) UHL+ALLIANCE	RM	WM	0	NHSI	Red /ER if >0	Nov-16	0	232	24	134	130	77	57	53	38	34	32	34	39	24	17	9	9
R5	6 Week - Diagnostic Test Waiting Times (UHL+ALLIANCE)	RM	WM	1% or below	NHSI	Red /ER if >1%	Dec-16	0.9%	1.1%	0.9%	0.6%	0.7%	0.6%	1.4%	1.5%	0.6%	0.6%	0.9%	0.9%	0.9%	0.9%	0.9%	0.8%	0.8%
R6	Urgent Operations Cancelled Twice (UHL+ALLIANCE)	RM	WM	0	NHSI	Red if >0 ER if >0	Jan-17	0	0	3	0	0	0	0	0	0	3	0	0	0	0	0	0	0
R7	Cancelled patients not offered a date within 28 days of the cancellations UHL	RM	WM	0	NHSI	Red if >2 ER if >0	Jan-17	33	48	212	16	18	20	19	10	9	13	18	22	26	17	13	13	26
R8	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	RM	WM	0	NHSI	Red if >2 ER if >0	Jan-17	11	1	11	0	0	0	6	0	0	0	0	0	0	0	0	0	0
R9	% Operations cancelled for non-clinical reasons on or after the day of admission UHL	RM	WM	0.8% or below	Contract	Red if >0.8% ER if >0.8%	Jan-17	0.9%	1.0%	1.2%	1.2%	1.4%	1.1%	0.9%	1.0%	1.2%	1.5%	0.8%	1.6%	1.2%	1.2%	0.9%	1.1%	1.0%
R10	% Operations cancelled for non-clinical reasons on or after the day of admission ALLIANCE	RM	WM	0.8% or below	Contract	Red if >0.8% ER if >0.8%	Jan-17	0.9%	0.9%	0.9%	0.3%	0.8%	1.4%	3.2%	0.9%	2.0%	0.5%	0.1%	0.4%	1.3%	0.5%	2.5%	0.1%	1.3%
R11	% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	WM	0.8% or below	Contract	Red if >0.8% ER if >0.8%	Jan-17	0.9%	1.0%	1.2%	1.2%	1.4%	1.1%	1.0%	1.0%	1.2%	1.4%	0.8%	1.5%	1.2%	1.1%	1.0%	1.1%	1.0%
R12	No of Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	WM	Not Applicable	UHL	Not Applicable	Jan-17	1071	1299	1566	123	154	114	110	109	134	164	82	167	122	131	99	123	222
R13	Delayed transfers of care	RM	JD	3.5% or below	NHSI	Red if >3.5% ER if Red for 3 consecutive mths	Jan-18	3.9%	1.4%	2.4%	1.8%	2.2%	2.9%	2.5%	2.1%	2.0%	2.7%	2.8%	2.7%	2.3%	2.5%	2.1%	2.0%	2.0%
R14	Ambulance Handover >60 Mins (CAD+ from June 15)	RM	LG	0	Contract	Red if >0 ER if Red for 3 consecutive mths	TBC	5%	5%	9%	6%	6%	9%	7%	9%	9%	11%	17%	13%	6%	6%	6%	7%	6%
R15	Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)	RM	LG	0	Contract	Red if >0 ER if Red for 3 consecutive mths	TBC	19%	19%	14%	12%	10%	15%	14%	15%	18%	18%	18%	15%	12%	13%	13%	13%	13%

Responsive Cancer

KPI Ref	Indicators	Board Director	Lead Officer	17/18 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	DQF Assessment outcome/Date	14/15 Outturn	15/16 Outturn	16/17 Outturn	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	17/18 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	Jul-16	92.2%	90.5%	93.2%	89.5%	90.5%	94.3%	94.9%	94.5%	93.3%	95.2%	93.8%	93.2%	94.3%	94.0%	93.3%	**	93.3%
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	Jul-16	94.1%	95.1%	93.9%	88.7%	94.9%	98.7%	95.9%	95.0%	90.7%	96.0%	91.1%	93.4%	97.0%	90.8%	89.6%	**	89.6%
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	Jul-16	94.6%	94.8%	93.9%	95.5%	95.6%	90.4%	91.3%	93.8%	94.8%	94.2%	92.4%	91.9%	95.3%	96.2%	96.1%	**	96.1%
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	Jul-16	99.4%	99.7%	99.7%	100.0%	97.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	98.7%	**	98.7%
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	Jul-16	89.0%	85.3%	86.4%	91.6%	84.7%	74.4%	72.7%	83.5%	90.4%	83.3%	87.2%	90.9%	88.5%	95.4%	85.5%	**	85.5%
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	Jul-16	96.1%	94.9%	93.5%	93.6%	87.3%	92.5%	81.4%	90.9%	97.8%	94.8%	98.1%	95.3%	99.1%	96.7%	95.0%	**	95.0%
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	Jul-16	81.4%	77.5%	78.1%	74.5%	77.3%	83.6%	78.4%	77.9%	74.5%	77.2%	79.5%	75.4%	76.1%	86.5%	83.9%	**	83.9%
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	Jul-16	84.5%	89.1%	88.6%	96.0%	85.0%	92.3%	78.9%	81.5%	84.2%	88.0%	90.9%	93.1%	78.1%	95.1%	95.0%	**	95.0%
RC9	Cancer waiting 104 days	RM	DB	0	NHSI	TBC	Jul-16	New Indicator		10	7	15	12	9	7	7	9	10	8	3	10	6	6	6

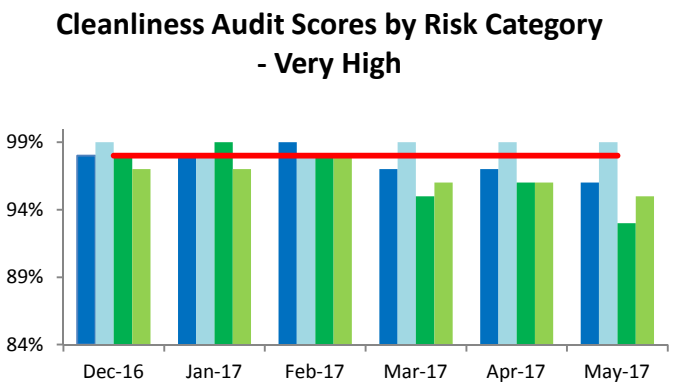
62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers Inc Rare Cancers

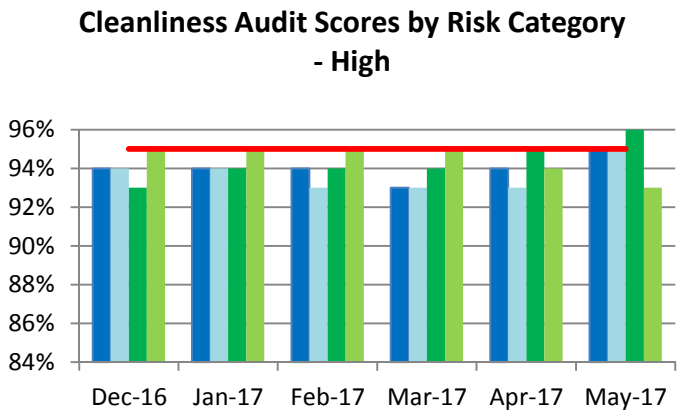
KPI Ref	Indicators	Board Director	Lead Officer	17/18 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	DQF Assessment outcome	14/15 Outturn	15/16 Outturn	16/17 Outturn	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	17/18 YTD
RC10	Brain/Central Nervous System	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	--	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	Jul-16	92.6%	95.6%	96.3%	95.3%	97.1%	100.0%	100.0%	95.8%	100.0%	95.8%	94.6%	96.6%	92.6%	93.48%	97.4%	**	97.4%
RC12	Gynaecological	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	77.5%	73.4%	69.5%	78.6%	75.0%	62.5%	66.7%	66.7%	80.0%	66.7%	44.4%	71.4%	81.8%	78.6%	64.3%	**	64.3%
RC13	Haematological	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	66.5%	63.0%	70.6%	61.5%	72.7%	100.0%	85.7%	28.6%	58.3%	77.8%	66.7%	87.5%	81.8%	88.9%	100.0%	**	100.0%
RC14	Head and Neck	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	69.9%	50.7%	44.5%	45.5%	100.0%	42.9%	44.4%	0.0%	38.5%	66.7%	33.3%	41.7%	33.3%	66.7%	85.7%	**	85.7%
RC15	Lower Gastrointestinal Cancer	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	63.7%	59.8%	56.8%	45.0%	64.5%	58.8%	64.4%	47.1%	38.1%	61.5%	75.0%	48.3%	54.5%	75.0%	40.0%	**	40.0%
RC16	Lung	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	69.9%	71.0%	65.1%	46.7%	64.2%	60.9%	64.2%	68.0%	79.4%	67.5%	79.5%	74.0%	33.3%	67.5%	80.6%	**	80.6%
RC17	Other	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	95.0%	71.4%	60.0%	50.0%	100.0%	100.0%	33.3%	0.0%	66.7%	--	100.0%	--	--	100.0%	50.0%	**	50.0%
RC18	Sarcoma	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	46.2%	81.3%	45.2%	50.0%	16.7%	--	--	100.0%	50.0%	100.0%	66.7%	40.0%	0%	100.0%	--	**	--
RC19	Skin	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	96.7%	94.1%	96.9%	100.0%	96.8%	97.4%	95.9%	97.7%	100.0%	92.3%	97.0%	96.9%	96.6%	96.2%	96.8%	**	96.8%
RC20	Upper Gastrointestinal Cancer	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	73.9%	63.9%	68.0%	70.0%	46.9%	66.7%	82.0%	70.3%	43.8%	100.0%	72.0%	61.4%	63.6%	85.7%	92.3%	**	92.3%
RC21	Urological (excluding testicular)	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	82.6%	74.4%	80.8%	73.1%	77.8%	96.3%	74.5%	83.5%	88.2%	75.0%	79.3%	71.4%	76.2%	89.9%	82.1%	**	82.1%
RC22	Rare Cancers	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	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%	**	100.0%
RC23	Grand Total	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	81.4%	77.5%	78.1%	74.5%	77.3%	83.6%	78.4%	77.9%	74.5%	77.2%	79.5%	75.4%	76.1%	86.5%	83.9%	**	83.9%

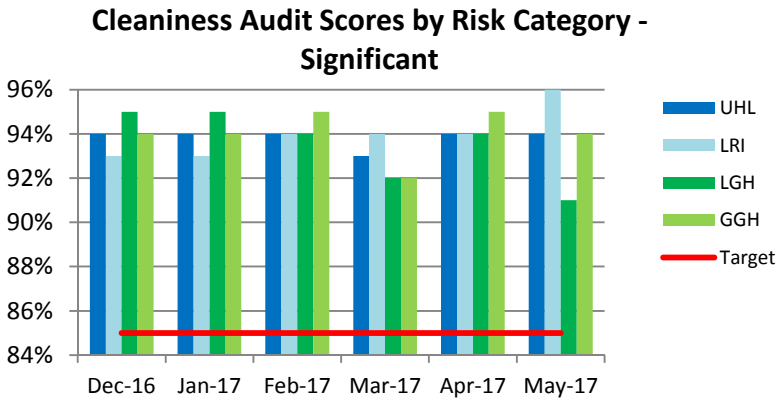
Compliance Forecast for Key Responsive Indicators

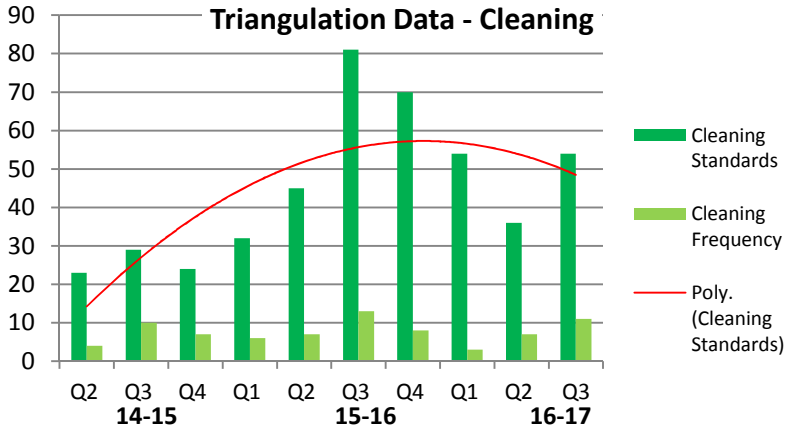
Standard	May	June	Commentary
Emergency Care			
4+ hr Wait (95%) - Calendar month	76.3%		Validated position.
Ambulance Handover (CAD+)			
% Ambulance Handover >60 Mins (CAD+)	7%		EMAS monthly report
% Ambulance Handover >30 Mins and <60 mins (CAD+)	13%		
RTT (inc Alliance)			
Incomplete (92%)	92.3%	92.0%	
Diagnostic (inc Alliance)			
DM01 - diagnostics 6+ week waits (<1%)	0.8%	0.9%	
# Neck of femurs			
% operated on within 36hrs - all admissions (72%)	79%	72%	
% operated on within 36hrs - pts fit for surgery (72%)	88%	85%	
Cancelled Ops (inc Alliance)			
Cancelled Ops (0.8%)	1.1%	1.0%	Delivery is dependant on access to beds.
Not Rebooked within 28 days (0 patients)	13	13	Delivery is dependant on access to beds.
Cancer			
Two Week Wait (93%)	95%	94%	
31 Day First Treatment (96%)	94%	94%	In discussion with NHSI compliance will be following 2 months of consistent bed access.
31 Day Subsequent Surgery Treatment (94%)	85%	80%	
62 Days (85%)	79%	80%	In discussion with NHSI compliance will be following 2 months of consistent bed access.
Cancer waiting 104 days (0 patients)	8	6	

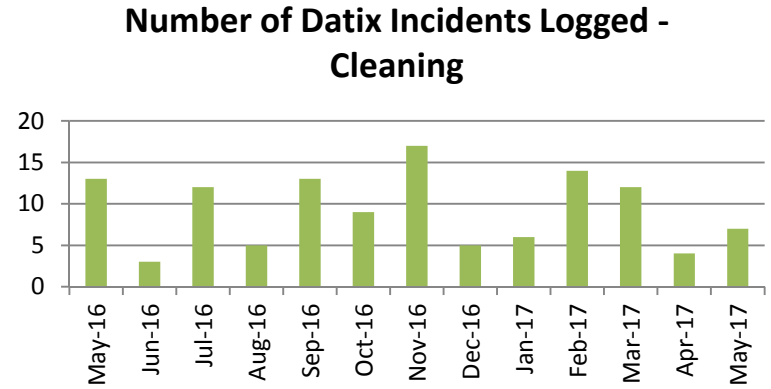
Estates and Facilities - Cleanliness











Cleanliness Report

The above charts show average audit scores for the whole Trust and by hospital site since October 2016. 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.

The target scores are based on the National Specification for Cleanliness – these are higher than those within the Cleaning Specification which is 90%. Facilities are working hard to achieve the NSC targets, and very good progress is being made despite no additional resource.

For very high-risk areas the data shows that the target of 99% was achieved in May 2017 by the LRI. GGH requires a slight improvement as it only managed to achieve 95%; whereas the LGH has dropped it's performance by 3% since April 2017. High-risk areas require improvement at the GGH, where they achieved a score of 93%. Both the LRI and the LGH reached the target score of 95%. The UHL has an overall score of 95%.
Significant risk areas all exceed the 85% target.

For very high-risk areas the data shows that the target of 99% was achieved in May 2017 by the LRI. GGH requires a slight improvement as it only managed to achieve 95%; whereas the LGH has dropped it's performance by 3% since April 2017. This is due to a mixture of sickness levels, vacancies and annual leave.
High-risk areas require improvement at the GGH, where they achieved a score of 93%. Both the LRI and the LGH reached the target score of 95%. The UHL has an overall score of 95%.
Significant risk areas all exceed the 85% target.

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'. This data is only collated on a quarterly basis and the chart shown here is inclusive of Q1 to Q3.

As a further test of service standards and issues, the number of Datix incidents logged for May has increased since April 2017 which is reflected in the audit score.

The number of vacancies continues to be the most significant challenge to the provision of the cleaning service, however large scale recruitment is starting to reduce vacancy levels. Main entrances and corridors at the LRI remain a challenge with the amount of pedestrian traffic and the frequency of cleaning required to maintain appearance. Additional resources are deployed when available but this is difficult to sustain without risking the service to clinical areas.

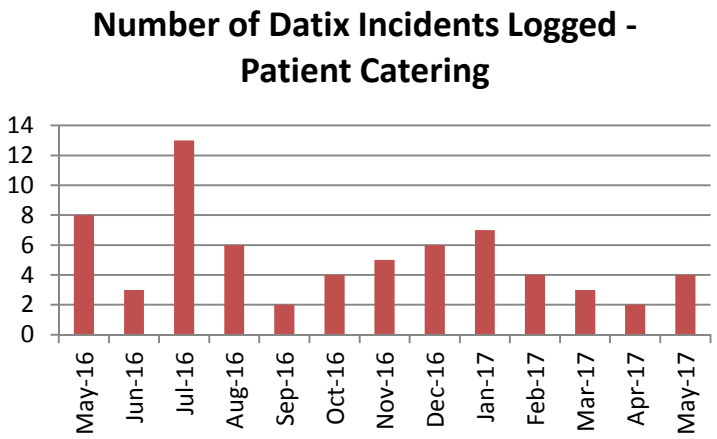
Estates and Facilities – Patient Catering

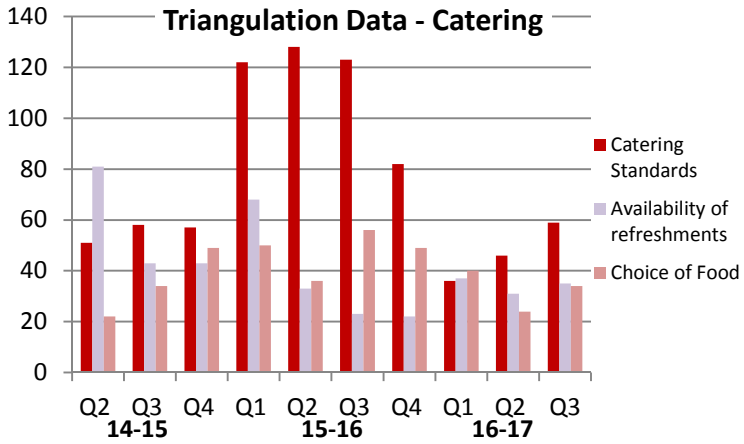
Patient Catering Survey – May 2017	Percentage 'OK or Good'	
	Apr-17	May-17
Did you enjoy your food?	100%	88%
Did you feel the menu has a good choice of food?	97%	84%
Did you get the meal that you ordered?	100%	86%
Were you given enough to eat?	97%	87%

90 – 100%	80 – 90%	<80%

Number of Patient Meals Served				
Month	LRI	LGH	GGH	UHL
March	72,003	24,062	28,578	124,643
April	69,270	22,262	25,362	116,894
May	69,420	22,432	29,399	121,251

Patient Meals Served On Time (%)				
Month	LRI	LGH	GGH	UHL
March	100%	100%	100%	100%
April	100%	100%	100%	100%
May	100%	100%	100%	100%





Patient Catering Report

This month we received a return of 101 surveys.

We continue to appraise the comment data collected alongside survey scores this month 10% of patients stated the food was not enjoyable as it was too cold, sloppy, soggy, some meals were too dry and the veg was hard.

Whereas 11% of patients claimed the food was lovely and we had a good selection on food on the menu.

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

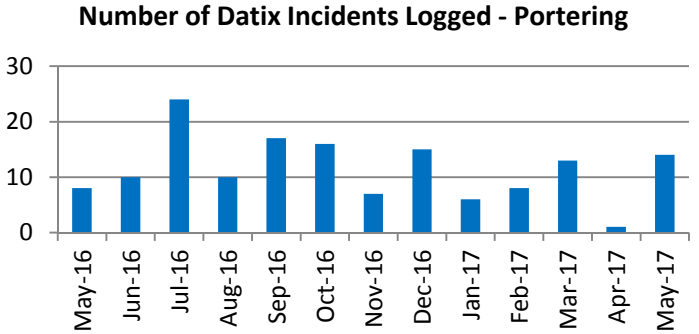
The triangulation data is a repeat of that reported last month as this is refreshed on a quarterly basis.

Estates and Facilities - Portering

Reactive Portering Tasks in Target				
Site	Task (Urgent 15min, Routine 30min)	Month		
		March	April	May
GH	Overall	95%	96%	92%
	Routine	95%	95%	94%
	Urgent	100%	98%	100%
LGH	Overall	94%	93%	92%
	Routine	93%	92%	92%
	Urgent	99%	96%	95%
LRI	Overall	92%	94%	89%
	Routine	91%	94%	89%
	Urgent	99%	98%	92%

95 – 100%	90 – 94%	<90%

Average Portering Task Response Times		
Category	Time	No of tasks
Urgent	16:01	1,876
Routine	26:23	11,597
	Total	12,980



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. May's performance overall has dropped across the board at the LRI and this is attributed to a number of changes that were in progress during this time including the relocation of some Imaging services to the new ED floor and the increase in distance from a number of base wards, introduction of new systems of working and spikes in service demand. Datix incidents have risen quite sharply and this is attributed to teething problems with the introduction of the iPorter system. It is anticipated from more recent experience these with significantly decrease in next month's report

Electronic Portering Service Request System ('iPorter')

As a means of improving the portering service, for reactive requests, rather than phoning the Facilities Helpdesk, an electronic system has been developed which is effectively an interface for a service user to communicate their request directly to the Planet system. The was particularly developed to help where dedicated porters in imaging and ED were to be linked in to the main pool of porters enabling the full portering resource to be utilised and managed more efficiently and effectively. Instead of them having to potentially wait in a phone queue, the intention is that requests are logged electronically through an easy and quick to use web based portal from any IT device (commonly referred to as iPorter).

The system was introduced in Imaging to coincide with the removal of dedicated staff and despite a number of teething problems that have been resolved. This has worked without issue for several weeks.

As far as ED was concerned, although a number of staff were trained ahead of the opening of the new area and support was on hand, discussions with Senior Nursing staff at the time raised issues relating to difficulties with the use of iPorter. At a time when some many more new systems and processes were introduced, whilst it was acknowledged to be good in concept, it was felt that this is another 'new system too many' and it was agreed to revert to the old method using radio contact with porters on a temporary basis.

Whilst this has relieved staff of the need to 'think about' using the electronic system, the use of radios is sub optimal for a number of reasons. There is no robust way to manage the resource efficiently. At any one time nobody is tracking which porters are where making management extremely difficult. Activity levels overall cannot be tracked which makes for inefficient rostering, and an inability to respond to peaks and troughs in demand. Recent ad-hoc observations point to the ED porters only being fully utilised for around 25% of the time and on occasions insufficient resources in the dedicated team at peak times.

At present, the iPorter application is being tweaked to streamline the process of making a request (although data from Imaging use of the system has demonstrated that once embedded the existing format takes less than 20 seconds to 'book a porter').

Once the development work is complete, the plan is to re-introduce this system in ED with a greater level of preparation to better integrate its usage with ED processes. As we are experiencing with Imaging, we will be able to generate very powerful **live** data that shows what jobs are in progress, who is doing them, how long they have been on a particular job, what jobs are coming in, what resource is available to allocate. It allows anticipation of increasing or falling demand on the spot and based on larger scale trend analysis.

Estates and Facilities – Planned Maintenance

Statutory Maintenance Tasks Against Schedule					
UHL Trust Wide	Month	Fail	Pass	Total	%
	March	3	146	151	98%
	April	0	168	168	100%
	May	1	112	113	99%
99 – 100%		97 – 99%		<97%	

Non-Statutory Maintenance Tasks Against Schedule					
UHL Trust Wide	Month	Fail	Pass	Total	%
	March	369	2324	2693	86%
	April	350	2157	2514	86%
	May	356	1963	2319	85%
95 – 100%		80 – 95%		<80%	

Estates Planned Maintenance Report

For May we incurred 1 failure in the delivery of Statutory Maintenance tasks in the month. This was for maintenance to a fire door at Glenfield hospital. It was not completed on time due to staffing levels. The work has now been completed, so we are currently fully compliant , however as it was completed 2 weeks later than the scheduled date this is counted as a 'fail' from the point of view of the measure.

For the Non-Statutory tasks, completion of the monthly schedule is subject to the volume of reactive calls. Drainage issues appear have reduced at the LRI and GGH with only 19% of the calls pertaining to blockages and floods.

At this stage, the Planet system has been upgraded and the devices for the engineers have been delivered and are now with IT to be configured, so that the Estates department can commence using the real-time element of the system.

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

Research UHL

KPI Ref	Indicators	Board Director	Lead Officer	17/18 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	16/17 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	Jan-17	Feb-17	Mar-17
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			45		
RU2	Median Days from submission to Trust approval (Non Portfolio)	AF	NB	TBC	TBC	TBC	2.1	1.0	Q2-Q4 158	1.0			1.0			1.0			1.0			41			90			27		
RU3	Recruitment to Portfolio Studies	AF	NB	Aspirational target=10920/year (910/month)	TBC	TBC	12564	13479	8603	1019	858	1019	1516	1875	815	926	983	947	979	917	887	758	657	592	487	699	325	636	531	1135
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%			(Jan16 - Dec16) 100%			(Apr16 - Mar17) 50% (metric change due to HRA process change)		
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			(Jan16 - Dec16) 31/186			(Apr16 - Mar17) 14/187		
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%			(Jan16 - Dec16) 49.2%			(Apr16 - Mar17) 44.9%		

Never Events

	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	YTD
Never Event	0	0	1	0	0	0	1	0	1	0	1	0	3	3

Actions taken to improve performance

Never Event 1 – Intravenous administration of a medicine intended to be administered via the epidural route

During the management of a patient in labour, Bupivacaine was being administered via the epidural catheter to provide adequate anaesthesia. In this incident bupivacaine that should have been administered via the epidural line was administered peripherally. The patient was not harmed.

Immediate Actions Taken
Staff advised not to have multiple syringes in trays
Review of the use of 'octopus' lines in delivery suite

Never Event 2 - Retention of a Foreign Object Post-Procedure

Following a cardiac arrest the patient had a routine insertion of a venous catheter and a flexible catheter. There were no reported complications post-procedure. A chest X-ray taken post-procedure identified that one of the guide wires only had been left in situ. Documentation in the patient's records report that the patient was immediately attended and the guide wire removed. The patient was not harmed.

Immediate Actions Taken
Safety notice sent out in CMG

Never event 3 – Misplaced nasogastric tube

A patient was brought into Coronary Care Unit (CCU) following an out of hospital arrest. The patient continued to be in arrest and required stabilisation prior to being taken to the cardiac catheterisation lab (cath lab) for a Percutaneous Coronary Intervention (PCI) angiogram +/- stent. A nasogastric tube was inserted during the resuscitation. Aspirin and Ticagrelor were administered via the NGT by a nurse as prescribed The patient was then taken into the cath lab for a PCI where imaging identified that the inserted NGT was in the right bronchus of the lung. The patient was not harmed.

Immediate Actions Taken
Agreement at that CCU practice will immediately change from administering pre PCI DAPT via NGT in post arrest situation on the unit to administering after confirmation of line placement can occur in the cath lab. Further discussions to be held with Cardiology team about giving IV aspirin and then later dose of second antiplatelet as an alternative approach. This practice is specific to the Cardiac Specialty and therefore no immediate actions required across the Trust.

Emergency Readmissions within 30 days

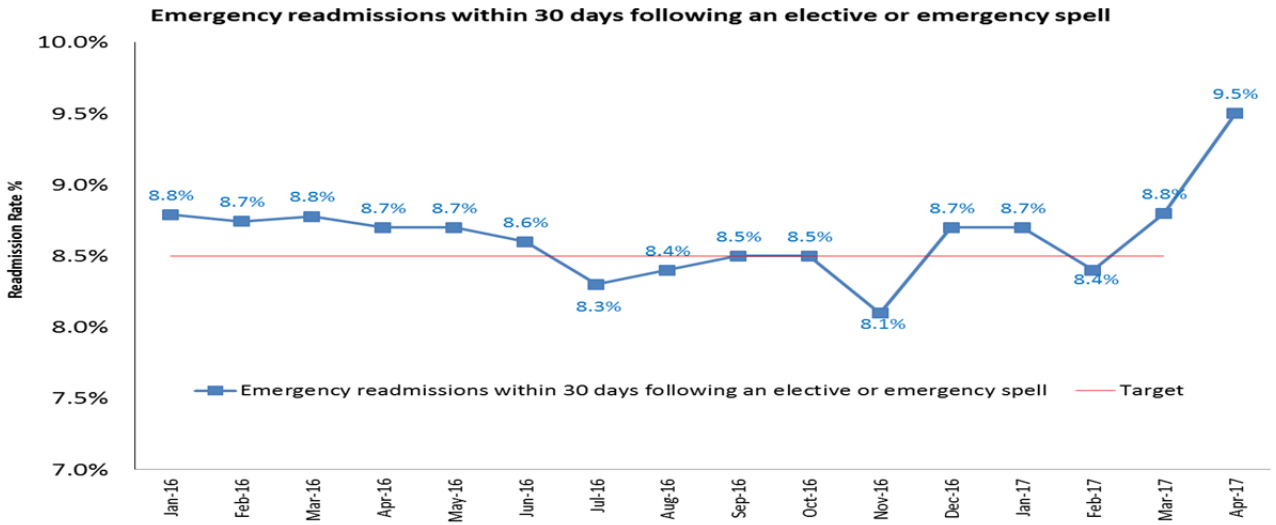
	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Emergency readmissions within 30 days following an elective or emergency spell	9.2%	8.8%	8.7%	8.8%	8.7%	8.7%	8.6%	8.3%	8.4%	8.5%	8.5%	8.1%	8.7%	8.7%	8.4%	8.8%	9.5%

What actions have been taken to improve performance?

The readmissions group has met to address this. The rise in readmissions is thought to be due to the dedicated resource that was targeted at patients at high risk of readmission no longer being available, combined with the demise of the daily conference call.

The following actions have been agreed to address this:

- Pilot in CDU of Integrated Clinical Response Team following up all discharged patients by telephone.
- New Integrated Discharge Team (IDT- commencing July 2017) to build into their Standard Operating Procedures how to deal with patients at high risk of readmission using the PARR30 score. Members of this team will attend all board rounds so have a unique opportunity to interact with clinical teams to remind them of the actions that need to be undertaken according to the UHL guideline.
- Publicity planned for raising awareness of the readmission guideline is that it will be included in a piece about the new IDT in the CEO's briefing; and written material will be provided to all new junior doctors starting in the trust in August at the trust-wide induction.



RTT Performance

Combined UHL and Alliance RTT Performance for May

	<18 w	>18 w	Total Incompletes	%
Alliance	8422	466	8888	94.76%
UHL	47922	4205	52127	91.93%
Total	56344	4671	61015	92.34%

Backlog Reduction required to meet 92%	-228

UHL and Alliance combined performance for RTT in May was 92.34%. The Trust achieved the standard for the first time since November 2016. Overall combined performance saw 4,671 patients in the backlog, a reduction of 637 since the last reporting period (UHL reduction of 554, Alliance reduction of 81). There were 228 fewer patients waiting over 18 weeks in order to achieve the standard.

The overall RTT performance has increased by 1.0% from the previous month; an increase was forecasted in April's EPB report. Performance in May was supported by a reduced number of roll-ons 18 weeks post-Christmas and increased number of total patients on the waiting list. Performance was achieved despite 2 bank holidays in month.

In order to ensure to accuracy of our waiting lists, regular audits are completed for each specialty to ensure compliance with the Trusts access policy.

Forecast performance for next reporting period: It is forecasted the trust will achieve the 92% standard for June. This is ahead of the planned RTT trajectory if 91.89%

Risks to performance include:

- Suspension of WLI's that are not positive margin making to support the Trusts financial position
- Competing demands with Emergency and Cancer performance

There are currently 6 specialties that, due to size of number of patients in their backlog and relative size, have individual action plans. They are Paediatric ENT, ENT, General Surgery, Urology, Allergy and Orthopaedics. They are monitored monthly. Current plans and performance are highlighted later in the report.

The table below details the average case per list against speciality targets.

Specialty	ACPL Target	M2 ACPL Actual
Breast	1.9	1.8
ENT	2.6	2.7
General Surgery	1.9	2.1
Gynae	2.9	2.6
MaxFax	2.2	2.2
Ophthalmology	3.6	3.5
Ortho	1.9	1.9
Paediatrics	2.4	2.8
Pain	5.2	5.3
Plastics	2.9	2.7
Renal	1.6	2.1
Urology	2.6	2.5
Vascular	1.3	1.1
Total	2.4	2.4

At the end May there was 9 patients with an incomplete pathway at more than 52 weeks. The 9 patients are broken down into 6 ENT, 1 Paediatric ENT and 1 Orthodontics, Cardiac Surgery 1. This has reduced from 39 at the end February. The forecasted number of 52 week breaches is 9 at the end of June and 3 at the end of July. This is dependent on no patients being cancelled.

The total number of patients waiting over 40 weeks yet to receive treatment has reduced from 252 on 05/03/2017 to 165 as of 28/05/2017.

The tables opposite outline the overall 10 largest backlog increases, 10 largest backlog reductions and 10 overall largest backlogs by specialty from last month. The largest overall backlog increases were within Paediatric ENT, Anaesthetics for patients who have had a high risk assessment and vascular surgery.

The overall largest reductions in backlog size was achieved ENT 98, Allergy 75 and Interventional Radiology 49.

Although there are 2 bank holidays in May, this month benefited from being 18 weeks since Christmas and a reduced number of roll-ons. Of the 62 specialties with a backlog, 17 saw their backlog increase, 9 specialties backlog stayed the same and 36 specialties reduced their backlog size.

10 highest backlog increases	Admitted			Non Admitted			Total			
	Apr 17	May 17	Change	Apr 17	May 17	Change	Apr 17	May 17	Change	RTT %
Paediatric ENT	405	407	2	12	24	12	417	431	14	61.3%
Anaesthetics	0	0	0	7	18	11	7	18	11	84.7%
Vascular Surgery	14	21	7	6	9	3	20	30	10	95.2%
Thoracic Medicine	0	0	0	36	43	7	36	43	7	96.0%
Gynaecology Oncology	1	3	2	1	3	2	2	6	4	98.1%
Chemical Pathology	0	0	0	3	6	3	3	6	3	97.1%
Paediatric Ophthalmology	1	1	0	3	6	3	4	7	3	98.9%
Diabetology	0	0	0	0	2	2	0	2	2	99.5%
Paed Immun & Allergy	0	0	0	1	3	2	1	3	2	99.1%
Paediatric Plastic Surgery	0	0	0	2	3	1	2	3	1	50.0%

10 highest backlog decreases	Admitted			Non Admitted			Total			
	Apr 17	May 17	Change	Apr 17	May 17	Change	Apr 17	May 17	Change	RTT %
ENT	446	391	-55	275	232	-43	721	623	-98	83.5%
Allergy	1	1	0	154	79	-75	155	80	-75	80.1%
Interventional Radiology	36	18	-18	54	23	-31	90	41	-49	88.5%
Gynaecology	163	182	19	122	57	-65	285	239	-46	92.9%
Ophthalmology	172	132	-40	64	59	-5	236	191	-45	97.1%
Urology	401	381	-20	128	110	-18	529	491	-38	84.9%
Orthopaedic Surgery	240	238	-2	252	218	-34	492	456	-36	89.1%
Paediatric Urology	65	59	-6	35	12	-23	100	71	-29	79.7%
Spinal Surgery	76	79	3	311	281	-30	387	360	-27	80.4%
Maxillofacial Surgery	122	94	-28	35	37	2	157	131	-26	92.8%

10 highest overall backlogs	Admitted			Non Admitted			Total			
	Apr 17	May 17	Change	Apr 17	May 17	Change	Apr 17	May 17	Change	RTT %
ENT	446	391	-55	275	232	-43	721	623	-98	83.5%
Urology	401	381	-20	128	110	-18	529	491	-38	84.9%
Orthopaedic Surgery	240	238	-2	252	218	-34	492	456	-36	89.1%
Paediatric ENT	405	407	2	12	24	12	417	431	14	61.3%
Spinal Surgery	76	79	3	311	281	-30	387	360	-27	80.4%
General Surgery	249	234	-15	106	121	15	355	355	0	89.1%
Gynaecology	163	182	19	122	57	-65	285	239	-46	92.9%
Ophthalmology	172	132	-40	64	59	-5	236	191	-45	97.1%
Maxillofacial Surgery	122	94	-28	35	37	2	157	131	-26	92.8%
Cardiology	74	65	-9	49	34	-15	123	99	-24	95.8%

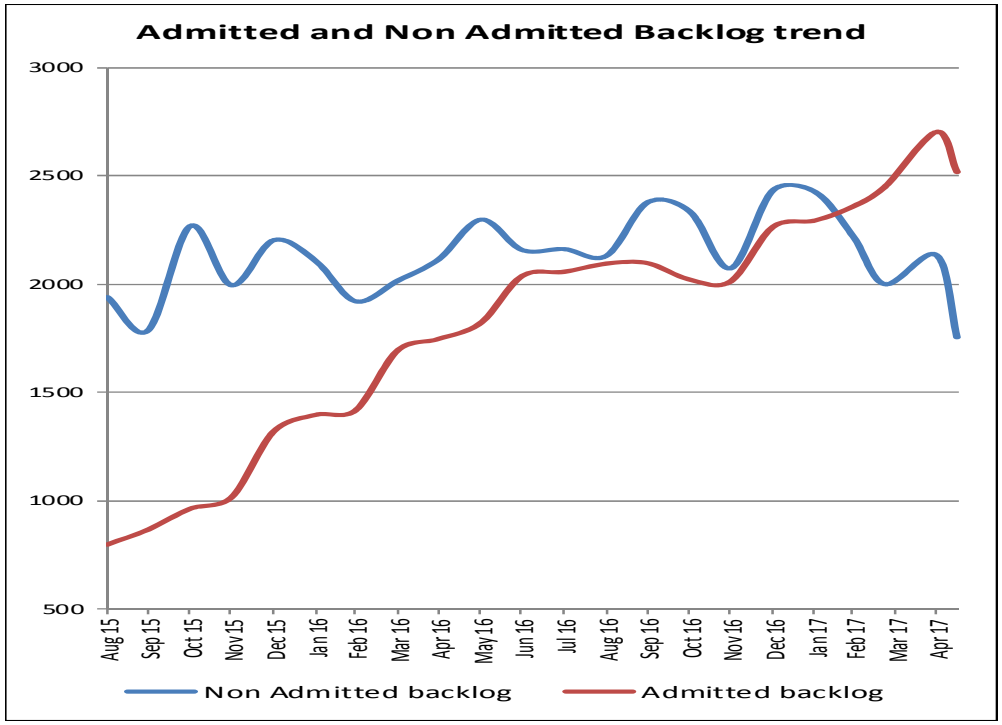
The table below illustrates changes in the non-admitted and admitted backlog size. The non-admitted backlog has remained relatively consistent over the past 18 months and at the end of May was at its lowest point since September 2015. During the same period the admitted backlog has increased by over 300%.

Patients on an admitted incomplete pathway make up only 21% of the UHL incomplete waiting list whilst making up 60% of the backlog.

The largest challenge to sustaining 92% RTT Performance remains capacity constraints for patients requiring surgery.

Overall capacity remains a constraint. Long term actions include:

- Right sizing bed capacity to increase the number of admitted patients able to received treatment.
- Demand reduction with primary care as a key priority to achieving on-going performance for our patients to receive treatment in a timely manner.



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 continues to reduce. Actions: Trust grade has been appointed with a start date in May, passed ILETS exam and awaiting GMC registration end of June/July. Anticipate from June significant backlog reductions. SLA with Nottingham consultant for weekend WLI's continues. Reminder calls to reduce DNA's in place. Project to start advice and guidance initiated. Use of agency to support in increased capacity.
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. Cancellations for both adult and Paediatric ENT have remained high over the winter period into 2017 due to limited bed capacity. This has also resulted in prior to the day cancellations or reduced booking of lists. The combined adult and Paediatric ENT service has seen a referral increase of over 12% year to date to the previous financial year. Actions: Continued use of Medinet and wait list initiatives for admitted and non-admitted patients continue. Assess ability to increase WLI for Balance patients, linked to consultant discretionary effort dates agreed on going. Bed capacity modeling for Paediatric day case beds aims to improve throughput.
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. Further risk going into winter months of increased cancellations due to further bed pressure demands. The service has seen a 16% increase in referrals year on year. Actions: Continued WLI's for admitted and non-admitted pathways. Left shift minor work to the Alliance, business case for 2 additional consultants
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. Impacted on elective cancellations to support emergency care. 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, increase in referrals resulting in higher demand. Increase in patients cancelled before the day due to bed capacity. Alliance capacity decrease from Coventry and Warwick clinicians, impacts on ability to left shift activity as planned. 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. Left shifting of low complex patients to the Alliance started on 25th January.

Diagnostic Performance

May diagnostic performance for UHL and the Alliance combined is 0.82% achieving the standard performing below the 1% threshold. UHL alone achieved 0.79% for the month of May with 128 patients out of 16,252 not receiving their diagnostic within 6 weeks. Performance remains ahead of trajectory.

Of the 15 modalities measured against, 9 achieved the performance standard with 6 areas having waits of 6 weeks or more greater than 1%. Strong performance in non-obstetric ultrasound with 14 breaches from 7,479 patients (0.2%) and CT, 3 breaches (0.1%) from 2,353 supported the overall Trust performance. The 5 modalities with the highest number of breaches are listed below:

Modality	Waiting list	Breaches	Performance
Cystoscopy	172	41	23.8%
Magnetic Resonance Imaging	2,729	36	1.3%
Non-obstetric ultrasound	7,479	14	0.2%
Cardiology - echocardiography	930	13	1.4%
Flexi sigmoidoscopy	585	7	1.2%

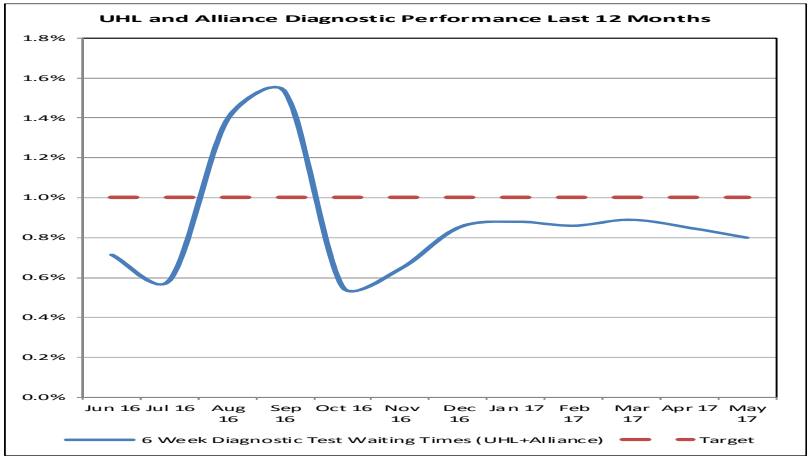
A non-recurrent breach issue for patients requiring an outpatient flexible cystoscopy occurred in May. Increased visibility of patients allowed for demand and capacity to match for future reporting months.

Risks to future months performance

It is anticipated the overall diagnostic performance for June will remain less than 1%.

- •Cardiac MRI capacity remains a constraint.
- •Patients requiring sedation under continues to be managed through ad hoc theatre sessions.
- •Clinical capacity within the Alliance has reduced for flexible cystoscopies.

Capacity for echocardiography for planned patients limited in June/July. Impact assessment for patients converting to active diagnostic requested from service and managed via WAM



% 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%	1.0%	1.0%	0.9%
	2	0	14	27	11

What is causing underperformance?

For May there were 123 non clinical hospital cancellations for UHL and Alliance combined. This resulted in a failure of the 0.8% standard as 1.06% of elective FCE's were cancelled on the day for non-clinical reasons (122 UHL 1.1% and 1 Alliance 0.1%).
UHL alone saw 122 patients cancelled on the day for a performance of 1.1%. 66 patients (54%) were cancelled due to capacity related issues of which 10 were Paediatrics and 56 cancelled for other reasons. The 5 most common reasons for cancellation are listed below.

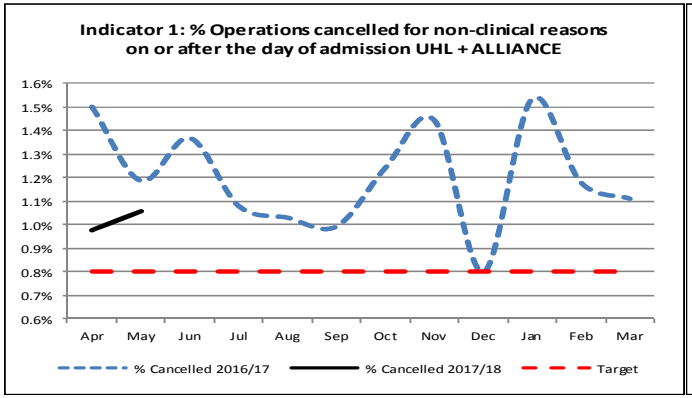
Type	Reason	Pts Cancelled
Capacity Pressures	Hospital cancel - ward bed unavailable	29
Other	Hospital cancel - lack theatre time / list overrun	26
Capacity Pressures	Hospital cancel - pt delayed to adm high priority patient	25
Other	Hospital cancel - lack theatre equipment	11
Capacity Pressures	Hospital cancel – ITU bed unavailable	7

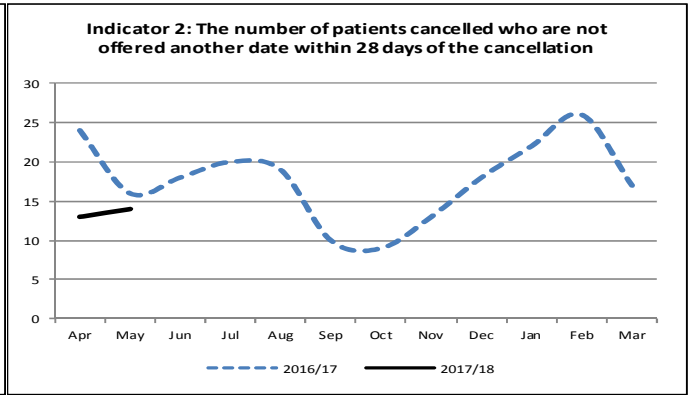
The specialties with the highest number of cancellations were General Surgery 21, Ophthalmology 19, Gynaecology 12, Maxillofacial Surgery 11 and Paed Cardiothoracic Surg 9. Cancellations for UHL in the first 2 months of 2017/18 are 203 (1.0% of FCE's) compared with performance 272 (1.4% of FCEs') in from 2016/17.

There were 14 patients who did not receive their operation within 28 days of a non-clinical cancellation. These comprised of CHUGGS 3, MSS 6 and RRCV 3, W&C 2.

Risk for next reporting period

Achieving the 0.8% standard in June remains a risk as Emergency pressures remain high. As of the 13 June the performance was 0.6%.



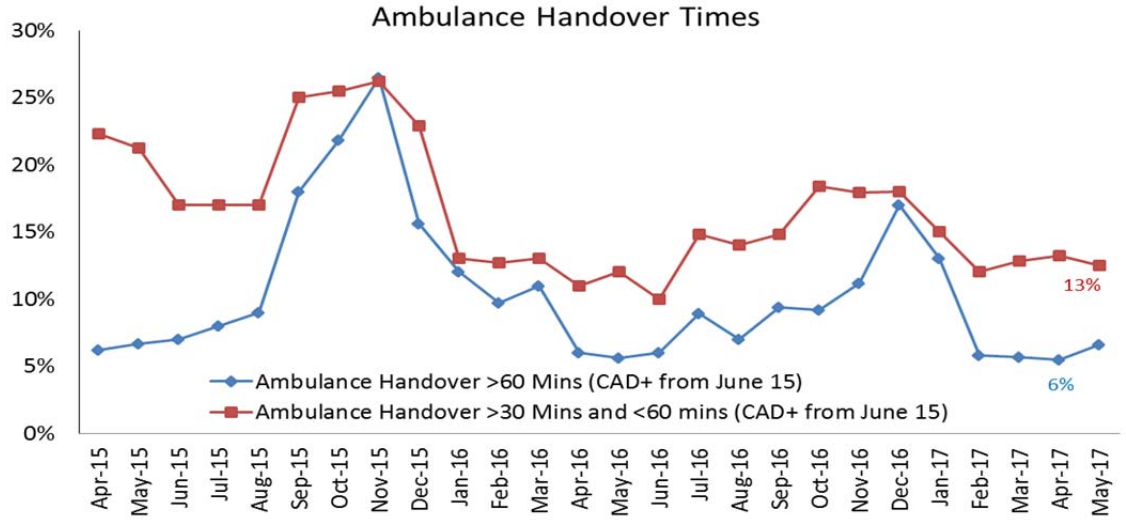


Ambulance handover > 30 minutes and >60 minutes - Performance

	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	YTD
Ambulance Handover >60 Mins (CAD+ from June 15)	6%	6%	9%	7%	9%	9%	11%	17%	13%	6%	6%	6%	7%	6%
Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)	12%	10%	15%	14%	15%	18%	18%	18%	15%	12%	13%	13%	13%	13%

What actions have been taken to improve performance?

- Focussed work with staff embedding the new Standard Operation Procedures.
- Senior leadership on the shop floor both clinically and managerially to support ambulance offload.
- Daily SITREP meetings with the senior leadership team to review previous day before identifying key actions to improve processes.
- Frequent monitoring in Gold meetings to ensure traction.
- Real time escalation by duty team to Director on call of all patients that have waited longer than 60 minutes on an ambulance.
- GPAU opened longer to improve flow and appropriate patients moved from assessment bay into GPAU scheme.

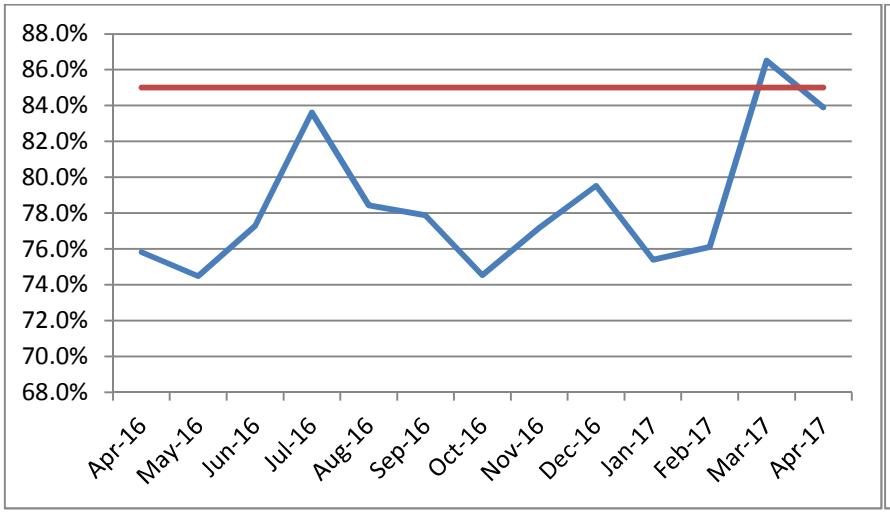


Cancer Waiting Time Performance

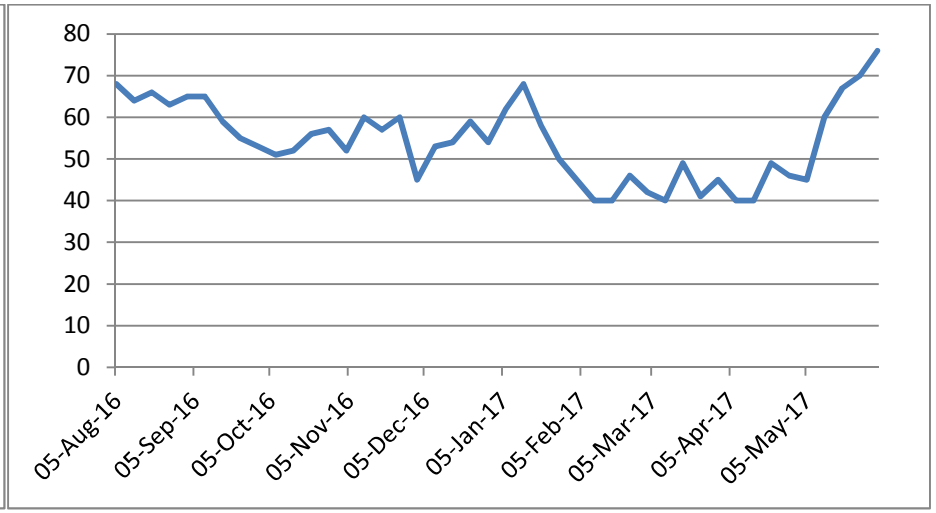
Current Performance:-

- Out of the 9 standards, UHL achieved 5 in April – 62 Day Screening, 31 Day Radiotherapy and Drugs, 31 day first treatments and 2WW.
- 2ww performance remained strong in April achieving 93.3% against a national performance of 92.8%. May is also expected to deliver the standard.
- 62 day performance achieved 83.9% in April being above national performance (82.7%). The adjusted position, taking into account late tertiaries in line with the Inter-Provider Guidance Transfer Policy (IPGT) results in an 85% achievement of the 62 day standard.
- The adjusted backlog has seen a deterioration over the past 5 weeks, now sitting in the 70s, with particular pressure seen in Lower GI, Upper GI, Head & Neck, Lung and Gynae. Mitigating action includes daily PTL reviews with the Director of Performance for all 5 tumour sites for a 2 week initial period commencing w/c 12/6/17. The outcomes of this, combined with feedback from NHSE/NHSI on a timed pathway audit in June and a quarterly thematic breach review will form the basis of a full RAP review during July 2017.

62 Day Performance



62 Day Adjusted Backlog



62 Day Backlog by Tumour Site

The following details the backlog numbers by Tumour Site for week ending 9th June 2017. The Trend reflects performance against target on the previous week. The forecast position is the early prediction for week ending 16th June 2017 which shows an improving position.

Note:- these numbers are subject to validation and review throughout the week via the clinical PTL reviews and Cancer Action Board.

Tumour Site	Target	Backlog	Trend	Forecast
Haematology	0	0		1
HPB	0	3		3
Lower GI	6	10		8
Testicular	0	0		0
Upper GI	2	4		5
Urology	10	15		18
Skin	1	2		0
Breast	2	4		3
Head & Neck	5	11		8
Sarcoma	0	1		1
Lung	6	7		5
Gynaecology	7	14		12
Brain	0	1		0

Key themes identified in backlog

Summary of delays	Numbers of patients	Summary
Complex Patients/Complex Diagnostic Pathways	12	Across 4 tumour sites, – these are patients undergoing multiple tests, MDTs, complex pathology reporting and diagnostics. This includes patients referred between multiple tumour sites with unknown primaries and patients with complex pathology to inform diagnosis.
Capacity Delays – OPD & Surgical	16	Across 5 tumour site – Gynae, Lung, Urology, Lower & Upper GI. Oncology outpatient waits in Lung and Upper GI having a noticeable impact as a primary delay reason – note RAP action 2.3. For Urology, this relates to patients awaiting robotic surgery following delayed pathways pending patient thinking time and all options review – note RAP action 3.1 for Urology around theatre capacity for the service.
UHL Pathway Delays (Next Steps compliance)	15	Across 7 tumour sites – where more than 1 delay has occurred within the pathway and lack of compliance with Next Steps is evident. The delays range across Imaging, Anaesthetics, Cardiology, Endoscopy and Pathology. This includes where diagnostic tests have been incorrectly requested as non 2WW and subsequently escalated. Primary delays seen in Lower GI relating to lack of compliance with turnaround times for CT Colon test and reporting.
Patient Delays	16	Across 4 tumour sites – a significant proportion of the backlog where patients have DNA'd on multiple occasions , required patient thinking time re decision making for treatment planning , and general lack of engagement and patient holidays.
Patients Unfit	13	Across 6 tumour sites, patients who are unavailable for treatment due to other ongoing health issues of a higher clinical priority mainly affecting Skin and Gynae at the time of reporting. Including a delayed Sarcoma patient due to the patient requiring fertility sparing prior to commencing chemotherapy.
Late Tertiary Referrals	7	For HPB, Upper GI, Urology, Sarcoma and Lung, patients referred at Day 39 and over from PBH, NGH, KGH, Burton and Nottingham.

Backlog Review for patients waiting >104 days

The following details all patients declared in the 104 Day Backlog for week ending 9/6/17. Note the patient reference number has been added to track patients each month as requested by the CCG. Last month's report showed 5 patients in the 104 Day backlog, all of which have now been treated. There are currently 8 patients in the backlog at the time of reporting.

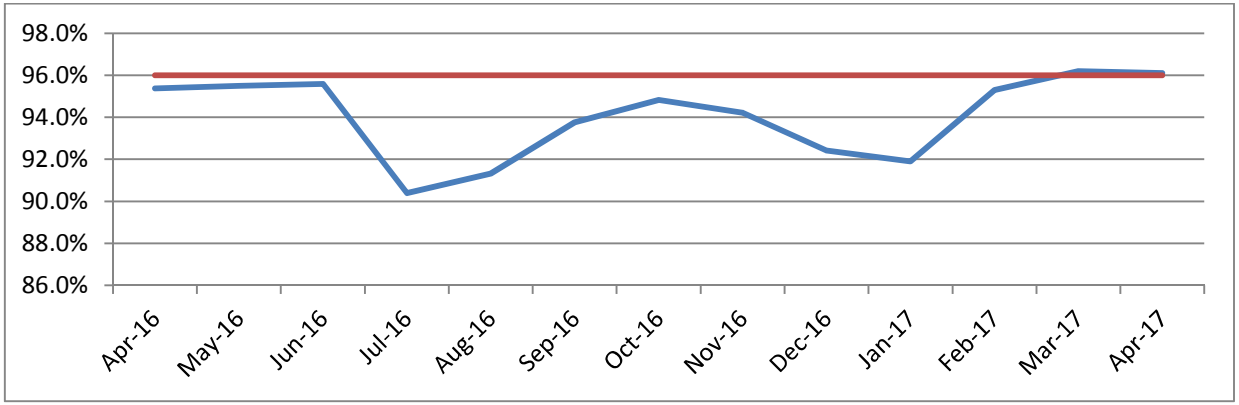
NOTE: where patients who have a treatment date confirmed but with no diagnosis of Cancer confirmed, on review of histology, should that confirm a cancer diagnosis then this would class as treatment in those cases.

Tumour Site	Total Number of patients	Pt No	Current Wait (Days)	Confirmed Cancer Y/N	Treatment Date Y/N	Summary Delay Reasons
Lower GI	1	19	138	N	N	Patient had delayed EMR procedure due to complexity of removing polyps which required 3 attempts, the 3rd of which the patient DNA'd. Due to anti-coagulation therapy for an irregular heartbeat, the GP advised it wasn't safe to proceed therefore diagnostic plan changed. Further delays in pathway due to patient having an infected leg and inpatient episode, currently awaiting discharge before planning next step in pathway.
UROLOGY	3	20	137	Y	Y	Due to difficulties in engaging with the patient to attend, the template biopsy was delayed until Day 75. Subsequent additional pathology required, bone scan and Oncology opinion further delayed pathway. From decision to treat and consent from the patient for surgical option, the patient has waited 13 days for admission date.
		21	123	N	N	Complex diagnostic pathway with incidental finding requiring treatment prior to primary. Patient was high risk for surgery, required ECHO and cardiac investigations - delays to high risk anaesthetic review and bone scan results experienced in pathway, escalated and resolved. Awaiting HRA outcome
		22	104	N	Y	Complex diagnostic pathway with 2 potential primaries and 3rd opinions required before patient could make a decision on options. Renal neoplasm confirmed with likely renal cell carcinoma - surgical resection specimen required for tumour diagnosis. The patient required multiple multi-disciplinary consultations prior to agreeing to surgery. Patient choice for robotic partical nephrectomy made 15th May 2017, delay to admission due to surgical capacity within Urology for robotic procedures.

Tumour Site	Total Number of patients	Pt No	Current Wait (Days)	Confirmed Cancer Y/N	Treatment Date Y/N	Summary Delay Reasons
LUNG	1	26	111	Y	N	Patient referred from Burton on day 98. Discussed at Peritoneal Mesothelioma MESO MDT 09/06/17 - outcome for consideration of trial options
Gynae	3	23	117	N	N	Patient had a TCI prior to breach date which was cancelled following pre-assessment due to severe acid reflux, undergoing GI investigations and treatment over a 3 month period. Patient not fit for Gynae procedure until completion.
		24	105	N	N	Patient had a TCI (7.4.17) prior to breach date, following pre-assessment this was cancelled due to multiple co-morbidities. Delay to patient's high risk anaesthetic review due to non-related inpatient admission. Currently awaiting discharge and review of patient fitness before re-dating.
		25	104	Y	N	Patient had a TCI (18.4.17) prior to breach date, subsequently cancelled following high risk anaesthetic review which recommended further diagnostics. Patient underwent PET and additional discussion with anaesthetists about fitness. Patient requested thinking time to decide on whether to go ahead with surgery, delaying the pathway until the 24.5.17. Patient declined surgery, requesting referral for Radiotherapy. 21 day wait for Oncology consultation due to capacity issues within Oncology. Awaiting outcome from Oncology.

31 Day First Treatment – Performance

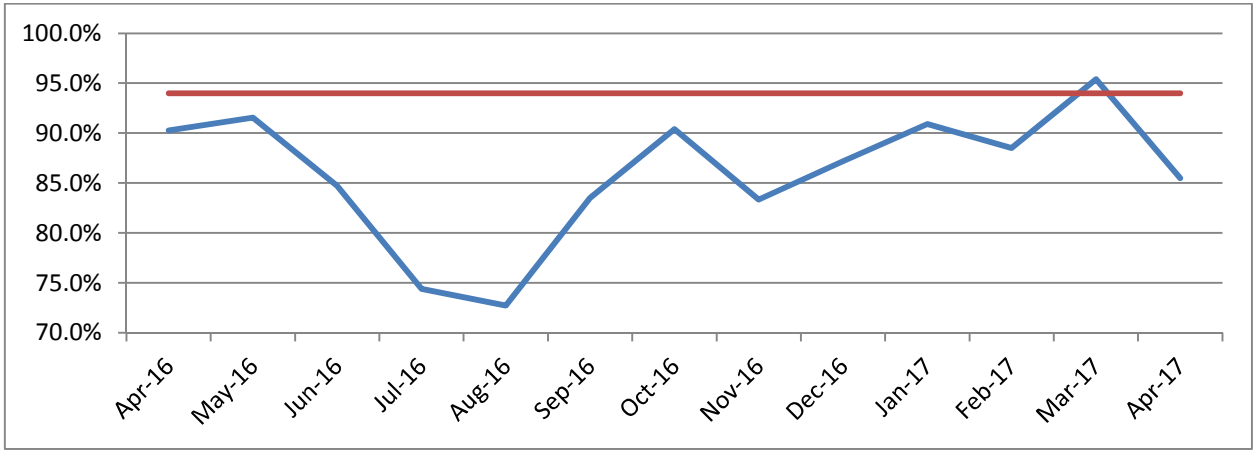
31 day 1st treatment performance was above the national target at 96.1% for April 2017. May is expected to remain in the early 90's at the time of reporting due to a reduction in the backlog by approximately 50% since the last reporting period.
At the time of reporting, there are 6 patients in the backlog: access to beds and timely theatre capacity remains the key issue with particular issue for robotic capacity affecting the delivery of performance for Urology *(See RAP action 3.1).* Patient fitness is a primary delay factor in the remaining backlog patients across Skin & Gynae.



31 Day Subsequent Surgery Performance

31 day Subsequent performance for Surgery in April under performed at 92% with a reduced backlog throughout the month resulting.

The backlog at the time of reporting sits at 3, in Urology (primarily robotic surgical delays).



Summary of the plan

The recovery action plan (RAP) is the central repository detailing measureable actions agreed between the Cancer Centre, Tumour Sites and CCGs aimed to address recovery in performance delivery and quality of patient care. It is recognised that a number of tumour sites have successfully achieved and closed down their actions over the past 12 months. However, it is acknowledged that a full review of the RAP will be required over the next reporting period. A number of data sources will be used to support the Tumour Sites in developing new actions where required and refining existing actions remaining relevant to improved performance against the 62 day standard.

Summary of high risks

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	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