Report by Acting Chief Executive – monthly update: January 2021

Authors: Rebecca Brown and Stephen Ward Sponsor: Rebecca Brown **Trust Board paper E**

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	X
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)	N/A	
Executive Board	N/A	
Trust Board Committee	N/A	
Trust Board	N/A	

Executive Summary

Context

The Acting Chief Executive's monthly update report to the Trust Board for January 2021 is attached.

Questions

Does the Trust Board have any questions or comments about our performance and plans on the matters set out in the report?

Conclusion

The Trust Board is asked to consider and comment upon the issues identified in the report.

Input Sought

We would welcome the Board's input regarding the content of this month's report to the Board.

For Reference:

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	[Yes]
Improved Cancer pathways	[Yes]
Streamlined emergency care	[Yes]
Better care pathways	[Yes]
Ward accreditation	[Yes]

2. Supporting priorities:

People strategy implementation	[Yes]
Investment in sustainable Estate and reconfiguration	[Yes]
e-Hospital	[Yes]
Embedded research, training and education	[Yes]
Embed innovation in recovery and renewal	[Yes]
Sustainable finances	[Yes]

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)? N/A

- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required – None Required.

- How did the outcome of the EIA influence your Patient and Public Involvement ? N/A

- If an EIA was not carried out, what was the rationale for this decision? On the basis that this is a monthly update report.

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	Select (X)	Risk Description:
Strategic: Does this link to a ***Principal Risk*** on the BAF?	**X**	ALL
Organisational: Does this link to an ***Operational/ Corporate Risk*** on Datix Register	**X**	There are several risks which feature on the organisational risk register relating to matters covered in this paper.
New Risk identified in paper: What ***type*** and ***description***?	N/A	N/A
None		

5. Scheduled date for the **next paper** on this topic: February 2021 Trust Board
6. Executive Summaries should not exceed **5 sides** [My paper does comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **7 JANUARY 2021**

REPORT BY: **ACTING CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – JANUARY 2021**

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1. Introduction

1.1 My report this month is confined to a number of issues which I think it important to highlight to the Trust Board.

2. UHL response to COVID-19

2.1 I will report orally at the Trust Board meeting on the current position.

3. Operational Priorities for Winter and 2021/22

3.1 On 23rd December 2020, the Chief Executive, NHS Improvement and NHS Chief Financial Officer wrote to NHS leaders setting out the operational priorities for the Health Service in England for this Winter and into 2021/22.

3.2 A copy of the letter is attached at **appendix 1** to this report and, as will be seen, it details priorities for the rest of 2020/2021, planning for 2021/22 and the 2021/22 financial framework.

3.3 I will report orally at the Trust Board meeting on the Trust's response to the letter.

4. Quality and Performance Dashboard – November 2020

4.1 The Quality and Performance Dashboard for November 2020 is appended to this report at **appendix 2.**

4.2 The Dashboard aims to ensure that Board members are able to see at a glance how we are performing against a range of key measures.

4.3 The more comprehensive monthly Quality and Performance report has been reviewed as part of the deliberations of the December 2020 meetings of the People, Process and Performance Committee and the Quality and Outcomes Committee, respectively. The month 8 quality and performance report is published on the Trust's website.

4.4 ***Good News***

- **Mortality** – the latest published SHMI (period July 2019 to June 2020) is 98, and remains within the expected range.

- **CAS alerts** - compliant.
- **MRSA** – 0 cases reported.
- **C DIFF** – 7 cases reported this month.
- **90% of Stay on a Stroke Unit** – threshold achieved with 81.2% reported in October.
- **VTE** – compliant at 98.0% in October.
- **TIA (high risk patients) –** 82.5% reported in November
- **Cancer Two Week Wait (Symptomatic Breast)** was 96.9% in October against a target of 93%.

4.5 ***Bad News***

- **UHL ED 4 hour performance** – 68.5% for November, system performance (including LLR UCCs) for November is 77.6%.
- **Ambulance Handover 60+ minutes (CAD)** – performance at 9.6%.
- **12 hour trolley wait -** 5 breaches reported.
- **Cancer Two Week Wait** was 90.4% in October against a target of 93%.
- **Cancer 31 day treatment** was 93.5% in October against a target of 96%.
- **Cancer 62 day treatment** was 70.4% in October against a target of 85%.
- **Referral to treatment** – the number on the waiting list (now the primary performance measure) was above the target and 18 week performance was below the NHS Constitution standard at 58.2% at the end of October.
- **52+ weeks wait –** 5,247 breaches reported in November to be validated.
- **Diagnostic 6 week wait** was 30.6% against a target of 1% in October.
- **Patients not rebooked within 28 days following late cancellation of surgery –** 14.
- **Cancelled operations OTD** –1.2% reported in November.
- **Fractured neck of femurs operated 0-35hrs** – performance decreased below target to 64.9%.
- **Statutory and Mandatory Training** is at 88%.
- **Annual Appraisal** is at 82.8%.

5. Conclusion

5.1 The Trust Board is invited to consider and comment upon this report and the attached appendices.

Rebecca Brown
Acting Chief Executive

29th December 2020

Skipton House
80 London Road
London
SE1 6LH

23 December 2020

To:
- STP and ICS Leaders
- Chief executives of all NHS trusts and foundation trusts
- CCG Accountable Officers
- GP practices and Primary Care Networks
- Providers of community health services
- NHS 111 providers

CC:
- NHS Regional Directors
- Regional Incident Directors & Heads of EPRR
- Chairs of ICSs and STPs
- Chairs of NHS trusts, foundation trusts and CCG governing bodies
- Local authority chief executives and directors of adult social care
- Chairs of Local Resilience Forums

Dear colleague

Important – for action – Operational priorities for winter and 2021/22

As we near the end of this year, we are writing to thank you and your teams for the way you have responded to the extraordinary challenge of Covid-19 and set out the key priorities for the next phase.

An extraordinary 2020

In the past year we have cared for more than 200,000 of those most seriously ill with Covid-19 in our hospitals. At the same time NHS staff have also worked incredibly hard to keep essential services such as cancer, mental health, general practice, urgent, emergency and community healthcare running and restore non-urgent services that had to be paused. Community nurses, pharmacists, NHS 111 staff and other NHS workers have cared for countless others, and been supported by the wider NHS team, from HR and finance to admin and clerical staff. The number of cancer treatments is above the level at the same time last year. GP appointments are back to around pre-pandemic levels. Mental health services have remained open and more than 400,000 children have accessed mental health services, above the target for 2020/21. Community services are supporting 15 per cent more people than they were at the same point last year. And we have had a record number of people vaccinated against flu, including a higher percentage of NHS staff than in the last three years. It has been an incredible team effort across our health and care system.

The response to the pandemic has also demonstrated our health service's enormous capacity for innovation with rapid development and implementation of new treatments, such as dexamethasone, rolling out of pulse oximetry and at-home patient self-monitoring, and the move to virtual and telephone consultations. We are already in the third week of our world-leading vaccination programme – the largest in NHS history.

We know that this relentless pressure has taken a toll on our people. Staff have gone the extra mile again and again. But we have lost colleagues as well as family and friends to the virus; others have been seriously unwell and some continue to

experience long-term health effects. The response of the NHS to this unprecedented event has been magnificent. We thank you and your teams unreservedly for everything that you have given and achieved and the support you continue to give each other.

You have asked us for a short statement of operational priorities going forward. This letter is therefore intended to help you and your staff over the next few months by:

- ensuring we have a collective view of the critical actions for the remainder of this financial year, and
- signalling the areas that we already know will be important in 2021/22.

Managing the remainder of 2020/21

Given the second wave and the new more transmissible variant of the virus, it is clear that this winter will be another challenging time for the NHS. Our task is five-fold:

A. Responding to Covid-19 demand
B. Pulling out all the stops to implement the Covid-19 vaccination programme
C. Maximising capacity in all settings to treat non-Covid-19 patients
D. Responding to other emergency demand and managing winter pressures
E. Supporting the health and wellbeing of our workforce

In addition, as the UK approaches the end of the transition period with the European Union on 31 December 2020, we will provide updates as soon as the consequences for the NHS become known. We are following a single operational response model for winter pressures, including Covid-19 and the end of the EU transition period. All CCGs and NHS trusts should have an SRO to lead the EU/UK transition work and issues should be escalated to the regional incident centre established for Covid-19, EU transition and winter.

A. Responding to ongoing Covid-19 demand

With Covid-19 inpatient numbers rising in almost all parts of the country, and the new risk presented by the variant strain of the virus, you should continue to plan on the basis that we will remain in a level 4 incident for at least the rest of this financial year and NHS trusts should continue to safely mobilise all of their available surge capacity over the coming weeks. This should include maximising use of the independent sector, providing mutual aid, making use of specialist hospitals and hubs to protect urgent cancer and elective activity and planning for use of funded additional facilities such as the Nightingale hospitals, Seacole services and other community capacity. Timely and safe discharge should be prioritised, including making full use of hospices. Support for staff over this period will need to remain at the heart of our response, particularly as flexible redeployment may again be required.

Maintaining rigorous infection prevention and control procedures continues to be essential. This includes separation of blue/green patient pathways, asymptomatic testing for all patient-facing NHS staff and implementing the ten key actions on infection prevention and control, which includes testing inpatients on day three of their admission.

All systems are now expected to provide timely and equitable access to post-Covid assessment services, in line with the commissioning guidance.

B. Implementing the Covid-19 vaccination programme

On 8 December, after the MHRA confirmed the Pfizer BioNTech vaccine was safe and effective, the biggest and most ambitious vaccine campaign in NHS history began.

The Joint Committee for Vaccination and Immunisation (JCVI) priorities for roll out of the vaccine have been accepted by Government, which is why the priority for the first phase of the vaccination is for individuals 80 years of age and over, and care home workers, with roll out to care home residents now underway. It is critical that vaccinations take place in line with JCVI guidance to ensure those with the highest mortality risk receive the vaccine first. To minimise wastage, vaccination sites have been ensuring unfilled appointments are used to vaccinate healthcare workers who have been identified at highest risk of serious illness from Covid-19. Healthcare providers have been undertaking staff risk assessments throughout the pandemic to identify these individuals and it remains important that this is organised across the local healthcare system to ensure equitable access.

If further vaccines are approved by the independent regulator, the NHS needs to be prepared and ready to mobilise additional vaccination sites as quickly as possible. In particular, Covid-19 vaccination is the highest priority task for primary care networks including offering the vaccination to all care home residents and workers. All NHS trusts should be ready to vaccinate their local health and social care workforce very early in the new year, as soon as we get authorisation and delivery of further vaccine.

C. Maximising capacity in all settings to treat non-Covid-19 patients

Systems should continue to maximise their capacity in all settings. This includes making full use of the £150m funding for general practice capacity expansion and supporting PCNs to make maximum use of the Additional Roles Reimbursement Scheme, in order to help GP practices maintain pre-pandemic appointment levels. NHS trusts should continue to treat as many elective patients as possible, restoring services to as close to previous levels as possible and prioritising those who have been waiting the longest, whilst maintaining cancer and urgent treatments.

To support you to maximise acute capacity, as set out in Julian Kelly and Pauline Phillip's letter of 17 December, we have also extended the national arrangement with the independent sector through to the end of March, to guarantee significant access to 14 of the major IS providers. NHS trusts have already been notified of the need for a Q4 activity plan for their local IS site by Christmas; this should be coordinated at system level. If you need it, we can also access further IS capacity within those providers subject to the agreement of the national team. However, we will need to return to local commissioning from the beginning of April and local systems, in partnership with their regional colleagues, will need to prepare for that.

The publication of the Ockenden Review of maternity services is a critical reminder of the importance of safeguarding clinical quality and safety. As set out in our letter of 14 December there are twelve urgent clinical priorities that need to be implemented. All Trust Boards must consider the review at their next public meeting along with an assessment of their maternity services against all the review's immediate and essential actions. The assessment needs to be reported to and assured by local systems, who should refresh their local programmes to make maternity care safer, more personalised and more equitable.

D. Responding to emergency demand and managing winter pressures

Alongside providing £80m in new funding to support winter workforce pressures, we are asking systems to take the following steps to support the management of urgent care:

- Ensure those who do not meet the 'reasons to reside' criteria are discharged promptly. We know that maximising capacity over the coming weeks and months is essential to respond to seasonal pressures. We are asking all systems to improve performance on timely and safe discharge, as set out in today's letter, as well as taking further steps that will improve the position on 14+ and 21+ day length of stay, aided by 100% completion of discharge and reasons to reside data.

- Complete the flu vaccination programme, including vaccinating our staff against flu and submitting vaccination uptake data to the National Immunisation and Vaccination system (NIVS).

- To minimise the effects of emergency department crowding, continue to develop NHS 111 as the first point of triage for urgent care services in your locality, with the ability to book patients into the full range of local urgent care services, including urgent treatment centres, same day emergency care and speciality clinics as well as urgent community and mental health services.

- Maximise community pathways of care for ambulance services referral, as a safe alternative to conveyance to emergency departments. Systems should also ensure sufficient arrangements are in place to avoid unnecessary conveyance to hospital, such as the provision of specialist advice, including from emergency departments, to paramedics as they are on scene.

E. Supporting the health and wellbeing of our workforce

Our NHS people continue to be of the utmost importance, and systems should continue to deliver the actions in their local People Plans. Please remind all staff that wellbeing hubs have been funded and will mobilise in the new year in each system.

Planning for 2021/22

The Spending Review announced further funding for the NHS for 2021/22 but in the new year, once we know more about the progress of the pandemic and the impact of the vaccination programme, the Government will consider what additional funding will be required to reflect Covid-19 cost pressures.

In the meantime, systems should continue to:

- **Recover non-covid services**, in a way that reduces variation in access and outcomes between different parts of the country. To maximise this recovery, we will set an aspiration that all systems aim for top quartile performance in productivity on those high-volume clinical pathways systems tell us have the greatest opportunity for improvements: ophthalmology, cardiac services and MSK/orthopaedics. The Government has provided an additional £1bn of funding for elective recovery in 2021/22. In the new year we will set out more details of

how we will target this funding, through the development of system-based recovery plans that focus on addressing treatment backlogs and long waits and delivering goals for productivity and outpatient transformation. In the meantime we are asking you to begin preparatory work for this important task now, through the appointment of a board-level executive lead per trust and per system for elective recovery.

- Strengthen delivery of local **People Plans**, and make ongoing improvements on: equality, diversity and inclusion of the workforce; growing the workforce; designing new ways of working and delivering care; and ensuring staff are safe and can access support for their health and wellbeing.

- Address the **health inequalities** that covid has exposed. This will continue to be a priority into 2021/22, and systems will be expected to make and audit progress against the eight urgent actions set out on 31 July as well as reduce variation in outcomes across the major clinical specialties and make progress on reducing inequalities for people with learning disabilities or serious mental illness, including ensuring access to high-quality health checks.

- Accelerate the planned expansion in **mental health** services through delivery of the Mental Health Investment Standard together with the additional funding provided in the SR for tackling the surge in mental health cases. This should include enhanced crisis response and continuing work to minimise out of area placements.

- Prioritise investment in **primary and community care**, to deal with the backlog and likely increase in care required for people with ongoing health conditions, as well as support prevention through vaccinations and immunisations. Systems should continue to focus on improving patient experience of access to general practice, increasing use of online consultations, and supporting the expansion of capacity that will enable GP appointments to increase by 50 million by 2023/24.

- Build on the development of effective **partnership working at place and system level**. Plans are set out in our Integrating Care document.

These priorities should be supported through the use of data and digital technologies, including the introduction of a minimum shared care record in all systems by September 2021 to which we will target some national funding, and improved use of remote monitoring for long term conditions.

The 2021/22 financial framework

For the reasons set out above, we won't know the full financial settlement for the NHS until much closer to the beginning of the new financial year, reflecting, in particular, uncertainty over direct Covid-19 costs. We will, however, need to start work early in the new year to lay the foundation for recovery. The underlying financial framework for 2021/22 will therefore have the following key features:

- Revenue funding will be distributed at system level, continuing the approach introduced this year. These **system revenue envelopes will be consistent with the LTP financial settlement**. They will be based on the published CCG allocation and the organisational Financial Recovery Fund each system would

have been allocated in 2021/22. There will be additional funding to offset some of the efficiency and financial improvements that systems were unable to make in 2020/21.

- Systems will **need to calculate baseline contract values to align with these financial envelopes** so there is a clear view of baseline financial flows. Our planning guidance will suggest that these should be based on 2019/20 outturn contract values adjusted for non-recurrent items, 2020/21 funding growth and service changes, not on the nationally-set 2020/21 block contracts.
- Systems and organisations should start to develop plans for **how Covid-19 costs can be reduced and eliminated** once we start to exit the pandemic.
- **System capital envelopes** will also be allocated based on a similar national quantum and using a similar distributional methodology to that introduced for 2020/21 capital planning.

We will aim to circulate underlying financial numbers early in the new year. We will then provide fuller planning guidance once we have resolved any further funding to reflect the ongoing costs of managing Covid-19. Further detail of non-recurrent funding announced in the recent Spending Review for elective and mental health recovery will also be provided at that point.

Conclusion

This year has arguably been the most challenging in the NHS's 72-year history. But even in these most testing times, people across the service have responded with passion, resilience and flexibility to deal with not only the virus but also the needs of patients without Covid-19. The rollout of the vaccine will bring hope to 2021 and we will need to maintain the energy and effort to meet the needs of all we serve throughout the year. Thank you for all that you have done and continue to do to achieve this.

With best wishes,

Amanda Pritchard
Chief Executive, NHS Improvement and NHS Chief Operating Officer

Julian Kelly
NHS Chief Financial Officer

Quality and Performance Report Board Summary November 2020

This dashboard uses icons to indicate if a process is showing special cause or common cause variation. It also indicates whether the process is able to meet any stated target. Here is a key to the icons

Icon	Description
	Special cause variation - cause for concern (indicator where high is a concern)
	Special cause variation - cause for concern (indicator where low is a concern)
	Common cause variation
	Special cause variation - improvement (indicator where high is good)
	Special cause variation - improvement (indicator where low is good)

These icons are used to indicate statistical variation. We have identified special cause variation based on three rules which are shown below. If none of the rules are present then the metric is showing common cause variation.

- An upwards or downwards trend in performance for seven or more consecutive months.
- Seven or more months above or below the average.
- One month or more outside the control limits .

Icon	Description
	The system is expected to consistently fail the target
	The system is expected to consistently pass the target
	The system may achieve or fail the target subject to random variation

These icons are used to indicate if a target is likely to be achieved next month, has the potential to be achieved or is expected to fail.

Green indicates that the metric has passed the monthly or YTD target while **Red** indicates a failure to do so.

The trend shows performance for the most recent 13 months.

Data Quality Assessment – The Data Quality Forum panel is presented with an overview of data collection and processing for each performance indicator in order to gain assurance by best endeavours that it is of suitably high quality. The forum provides scrutiny and challenge on the quality of data presented, via the attributes of (i) Sign off and Validation (ii) Timeliness and Completeness (iii) Audit and Accuracy and (iv) Systems and Data Capture to calculate an assurance rating.

Quality and Performance Report Board Summary November 2020

Domain	KPI	Target	Sep-20	Oct-20	Nov-20	YTD	Assurance	Variation	Trend	Data Quality Assessment
Safe	Never events	0	0	1	0	4	?			Jan-20
	Overdue CAS alerts	0	0	0	0	0	?	L		Nov-19
	% of all adults VTE Risk Assessment on Admission	95%	98.7%	98.0%	98.2%	98.5%	P			Dec-19
	Emergency C-section rate	No Target	18.5%	21.1%	24.1%	20.6%				Feb-20
	Clostridium Difficile	108	10	8	7	54	?			Nov-17
	MRSA Total	0	0	0	0	0	?	L		Nov-17
	E. Coli Bacteraemias Acute	No Target	6	11	12	65				Jun-18
	MSSA Acute	No Target	3	4	3	22				Nov-17
	COVID-19 Community Acquired <= 2 days after admission	No Target	79.7%	75.5%	76.6%	78.6%				Oct-20
	COVID-19 Hospital-onset, indeterminate, 3-7 days after admission	No Target	6.8%	12.1%	9.6%	8.9%				Oct-20
	COVID-19 Hospital-onset, probable, 8-14 days after admission	No Target	5.9%	6.7%	6.4%	7.1%				Oct-20
	COVID-19 Hospital-onset, healthcare-acquired, 15 or more days after admission	No Target	7.6%	5.7%	7.4%	5.4%				Oct-20
	All falls reported per 1000 bed days	5.5	4.5	4.6		4.5	?			Oct-20
	Rate of Moderate harm and above Falls PSIs with finally approved status per 1,000 bed days	No Target	0.02	0.16		0.08				Oct-20

Domain	KPI	Target	Sep-20	Oct-20	Nov-20	YTD	Assurance	Variation	Trend	Data Quality Assessment
Caring	Staff Survey Recommend for treatment	No Target	Reporting will commence once national reporting resumes							Aug-17
	Single Sex Breaches	0	National reporting commences in April 2021				?			Mar-20
	Inpatient and Day Case F&F Test % Positive	TBC	98%	98%		98%		H		Mar-20
	A&E F&F Test % Positive	TBC	93%	95%		95%				Mar-20
	Maternity F&F Test % Positive	TBC	97%	98%		96%				Mar-20
	Outpatient F&F Test % Positive	TBC	93%	94%		94%				Mar-20
	Complaints per 1,000 staff (WTE)	No Target	National reporting expected to resume from November onwards							Jan-20

Domain	KPI	Target	Sep-20	Oct-20	Nov-20	YTD	Assurance	Variation	Trend	Data Quality Assessment
Well Led	Staff Survey % Recommend as Place to Work	No Target	Reporting will commence once national reporting resumes							Sep-17
	Turnover Rate	10%	9.2%	9.3%	9.5%	9.5%	P	H		Nov-19
	Sickness Absence	3%	6.1%	6.0%		6.8%	F	H		Oct-16
	% of Staff with Annual Appraisal	95%	82.7%	83.8%	82.8%	82.8%	F	L		Dec-16
	Statutory and Mandatory Training	95%	84%	88%	88%	88%	?			Feb-20
	Nursing Vacancies	No Target	11.8%	12.6%		12.6%		H		Dec-19

Quality and Performance Report Board Summary November 2020

Domain	KPI	Target	Sep-20	Oct-20	Nov-20	YTD	Assurance	Variation	Trend	Data Quality Assessment
Effective	Mortality Published SHMI	99	97	98	98	98 (Jul 19 to Jun 20)				Sep-16
	Mortality 12 months HSMR	99	103	102	103	102.5 (Sep 19 to Aug 20)				Sep-16
	Crude Mortality Rate	No Target	1.2%	1.2%	1.8%	1.7%				Sep-16
	Emergency Readmissions within 30 Days	8.5%	9.1%	8.9%		9.6%	?			Sep-20
	Emergency Readmissions within 48 hours	No Target	1.1%	1.2%		1.2%				Sep-20
	No of #neck of femurs operated on 0-35hrs	72%	74.2%	72.5%	64.9%	64.0%	?			Sep-20
	Stroke - 90% Stay on a Stroke Unit	80%	82.9%	81.2%		86.6%	?			Mar-20
	Stroke TIA Clinic Within 24hrs	60%	51.3%	66.8%	82.5%	68.9%	?			Mar-20

Domain	KPI	Target	Sep-20	Oct-20	Nov-20	YTD	Assurance	Variation	Trend	Data Quality Assessment
Responsive	ED 4 hour waits UHL	95%	70.2%	71.3%	68.5%	75.8%	F			Mar-20
	ED 4 hour waits Acute Footprint	95%	80.1%	80.2%	77.6%	83.2%	F			Aug-17
	12 hour trolley waits in A&E	0	0	3	5	8	?			Mar-20
	Ambulance handover >60mins	0.0%	6.5%	5.5%	9.6%	3.4%	F			TBC
	RTT Incompletes	92%	54.3%	58.2%	59.6%	59.6%	F	L		Nov-19
	RTT Waiting 52+ Weeks	0	3886	4538	5248	5248	F	H		Nov-19
	Total Number of Incompletes	66,397 (by year end)	72,292	74,717	75,886	75,886	?	H		Nov-19
	6 Week Diagnostic Test Waiting Times	1.0%	30.2%	30.6%	31.1%	31.1%	F	H		Nov-19
	Cancelled Patients not offered <28 Days	0	10	22	14	155	?	L		Nov-19
	% Operations Cancelled OTD	1.0%	0.8%	1.0%	1.2%	0.8%	?			Jul-18
	Long Stay Patients (21+ days)	70	137	139	154	154	F			Sep-20
	Inpatient Average LOS	No Target	3.3	3.3	3.6	3.5				Sep-20
	Emergency Average LOS	No Target	4.9	4.8	5.1	4.8				Sep-20

Domain	KPI	Target	Aug-20	Sep-20	Oct-20	YTD	Assurance	Variation	Trend	Data Quality Assessment
Responsive - Cancer	2WW	93%	89.4%	93.0%	90.4%	90.0%	?			Dec-19
	2WW Breast	93%	95.5%	94.2%	96.9%	95.9%	?			Dec-19
	31 Day	96%	91.9%	89.2%	93.5%	91.4%	?			Dec-19
	31 Day Drugs	98%	100%	98.8%	100%	99.7%	?			Dec-19
	31 Day Sub Surgery	94%	73.0%	68.0%	77.4%	72.9%	?			Dec-19
	31 Day Radiotherapy	94%	99%	96.4%	95.5%	91.2%	?			Dec-19
	Cancer 62 Day	85%	76.4%	68.9%	70.4%	69.0%	F			Dec-19
	Cancer 62 Day Consultant Screening	90%	25.0%	92.9%	78.9%	52.9%	?			Dec-19

Domain	KPI	Target	Sep-20	Oct-20	Nov-20	YTD	Assurance	Variation	Trend	Data Quality Assessment
Outpatient Transformation	% DNA rate	No Target	6.6%	6.7%	6.8%	6.4%				Feb-20
	% Non Face to Face Appointments	No Target	48.4%	45.3%	46.4%	56.1%		H		Feb-20
	% 7 day turnaround of OP clinic letters	90%	83.0%	86.5%	84.8%	88.2%	?	H		Feb-20