Quality & Performance Report

Author: John Adler Sponsor: Chief Executive Date: IFPIC + QAC 24th November 2016

Executive Summary from CEO

Paper F revised

Context

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

Questions

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

Conclusion

Good News: **Mortality** – although the latest published SHMI (covering the period April 2015 to March 2016) has increased to **99**, it is still within Quality Commitment goal of **99**. Further detailed analysis is under way to understand what is causing SHMI to increase. **Moderate harms and above** –there have been some increases to previous month's figures following review and CMG sign off. However, we remain well within the agreed Quality Commitment monthly thresholds. **Referral to Treatment 52+ week waits –** current number is 38 and we remain on target to be at zero by the end of January. **Cancer Two Week Wait** was achieved in September for the third consecutive month and is expected to remain compliant. Reported **delayed transfers of care** remain within the tolerance with an improved position for the past two months. However significant issues have arisen with Leicestershire social care packages. **MRSA** – 0 cases reported this month, this is for the third consecutive month. **C DIFF** – 5 cases reported in October (below trajectory) but with year to date 1 case above trajectory. **Pressure Ulcers** – 0 **Grade 4** pressure ulcers reported this year and **Grade 3** remaining within trajectory. **Diagnostic 6 week wait –** this standard has been recovered in October after two months of failure. **Sepsis indicators –** although early warning scores are down by 5%, the remaining three indicators show improvement.

Bad News: **ED 4 hour performance** – October performance was 78.3% with year to date performance at 79.5%. Contributing factors are set out in the Chief Operating Officer's report. **Ambulance Handover 60+ minutes** – performance remained poor at 9%; this is also examined in detail in the COO's report. **RTT** – the RTT incomplete target was non-compliant for October at 91.5% for the second time since December 2013. **Cancelled operations** worsened in October to 1.2% and **patients rebooked within 28 days** – continue to be non-compliant, due to ITU/HDU and emergency pressures. **Cancer Standards 62 day treatment** - remains non-compliant although on a positive note there have been continued improvements in backlog numbers

and the numbers waiting over 104 days. In discussion with NHSI and NHSE the Trust has stated that it cannot confirm recovery of the key cancer standards until there has been a sustained period of ring fenced capacity of elective beds, i.e. >2 months. **Fractured NOF** – target missed for the third consecutive month. The Medical Director Team is leading a piece of work to improve this. **Patient Satisfaction (FFT)** for ED remains low at 87% during October – ED minors and UCC come out with very poor scores. The triage system in the UCC is being reviewed, which is hoped will improve the comfort of patients. **Statutory & Mandatory Training** – performance remains at 82% against a target of 95%, as 1,500 InterServe staff have been transferred over to UHL's Estates and Facilities. **Single Sex Accommodation Breaches** – numbers have reduced since the high in September but are above average levels. **Maternal deaths** – sadly there was one in October, this unexpected maternal death was reported to the Coroner, but an inquest is not required.

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: 22nd December 2016.

Quality and Performance Executive Summary

October 2016

Operational Delivery Unit

Domain - Safe

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

ONE
Never Event YTD

24 ↓
Serious Incidents YTD

57
Moderate Harm and above YTD ↑

0
Avoidable MRSA YTD ↔

36
CDIFF Cases YTD ↑

Headlines

- Serious incidents are well within the year to date trajectory and remain on a downward trend. This is supported by a reduction in Moderate Harm and above compared to the same period last year.
- C Diff 5 unrelated cases reported in October, with year to date 1 above trajectory.
- There were no Grade 4 Pressure ulcers and combined we are within trajectory for Grade 2 and 3 within trajectory.
- Sepsis indicators - Although early warning scores are down by 5%, the remaining three indicators show improvement.

SEPSIS

Patients with an Early Warning Score 3+ - % appropriate escalation	88% ↓
Patients with EWS 3+ - % who are screened for sepsis	84% ↑
ED - Patients who trigger with red flag sepsis - % that have their IV antibiotics within an hour	71% ↑
Wards (including assessment units) Patients who trigger for Red Flag Sepsis - % that receive their antibiotics within an hour	36% ↑

Domain - Caring

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

Friends and Family Test YTD % Positive

Inpatients FFT 96% ⇔

Day Case FFT 98% ⇔

A&E FFT 90% ↓

Maternity FFT 95% ⇔

Outpatients FFT 95% ⇔

Staff FFT Quarter 2 2016

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

Single sex accommodation breaches

34

YTD ↑

Headlines

- Friends and family test (FFT) for Inpatient and Daycase care combined are at 96% for October.
- Patient Satisfaction (FFT) for ED remains low at 87% during October – ED minors and UCC come out with very poor scores. The triage system in the UCC is being reviewed, which is hoped will improve the comfort of patients.
- Single Sex Accommodation Breaches – numbers have reduced since the high in September but are above average levels

Domain – Well Led

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

Friends and Family FFT YTD % Coverage

Inpatients FFT 36.3% ↑
Day Case FFT 24.4% ↑
A&E FFT 10.7% ↓
Maternity FFT 36.9% ↑
Outpatients FFT 1.6% ↔

Staff FFT Quarter 2 2016

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

Headlines

- Inpatients and Daycase coverage remains above Trust target
- A&E coverage remains a challenge to get to Trust target of 20%.
- There was a reduction of 0.1% in people appraised in October.
- Statutory & Mandatory training is 13% off target due to the transfer of 1,500 Interserve staff to UHL
- Please see the HR update for more information.

% Staff with Annual Appraisals

91.4% YTD ↓

Statutory & Mandatory Training

82% YTD ↔

BME % - Leadership

25% Qtr2
8A including medical consultants

12% Qtr2
8A excluding medical consultants

Domain – Effective

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

SHMI Apr15-Mar16

99
Apr15-Mar16 ↓

Stroke TIA clinic within 24hrs

63.6%
YTD ↑

80% of patients spending 90% stay on stoke unit

82.7%
YTD ↓

Emergency Crude Mortality Rate

2.2%
YTD ↓

30 Days Emergency Readmissions

8.5%
YTD 2016 ↓

NoFs operated on 0-35hrs

71.4%
YTD ↓

Headlines

- UHL's SHMI remains lower than the England average at 99. Further detailed analysis is under way to understand what is causing SHMI to increase
- Fractured NOF – target missed for the third consecutive month. The Medical Director Team is leading a piece of work to improve this.

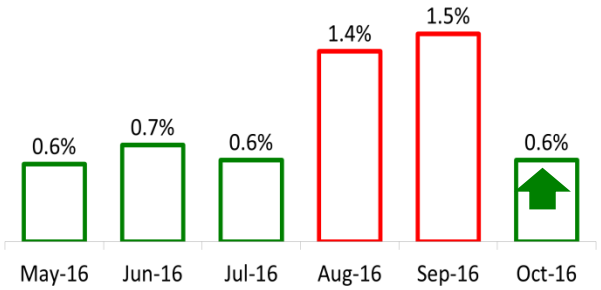
Domain – Responsive

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

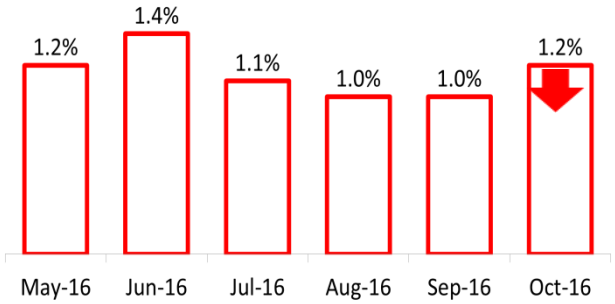
RTT - Incomplete 92% in 18 Weeks

91.5%

6 week Diagnostic Wait times



Cancelled Operations



RTT 52 week wait incompletes

38
YTD

ED 4Hr Wait

A&E

79.5%
YTD

Ambulance Handovers

7% > 60mins
14% 30-60mins
YTD

Headlines

- 52+ week waiters have reduce to 38 and we remain on target to be at zero by the end of January.
- Diagnostic 6 week wait – this standard has been recovered in October after two months of failure.
- RTT – the RTT incomplete target was non-compliant for October at 91.5% for the second time since December 2013.
- For ED 4hour wait and Ambulance Handovers please refer to Chief Operating Officers report.

Domain – Responsive Cancer

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

Cancer 2 week wait

92.4% YTD ↓ | 94.5% Sept

31 day wait

93.6% YTD ↑ | 93.8% Sept

62 day wait

77.9% YTD ↓ | 77.9% Sept

31 day backlog

10 Oct ↑

62 day backlog

66 Oct ↓

62 day adjusted backlog

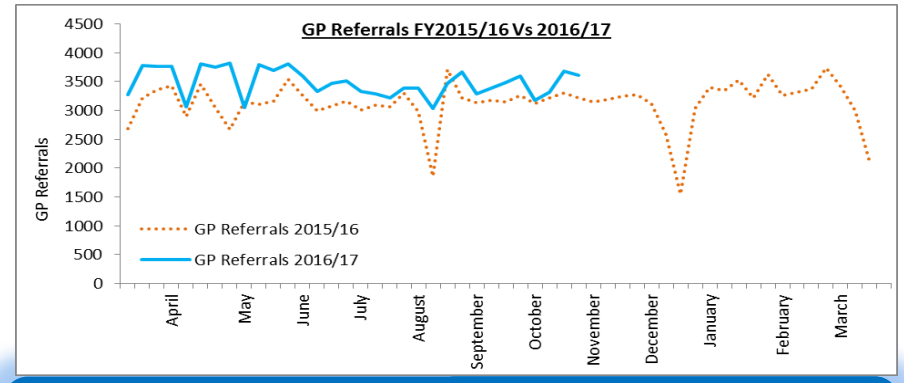
57 Oct ↓

Headlines

- Cancer Two Week Wait was achieved in September for the third consecutive month and is expected to remain compliant.
- 31 day wait non compliant due to emergency pressures and HDU capacity.
- Cancer Standards 62 day treatment - remains non-compliant although on a positive note there have been continued improvements in backlog numbers and the numbers waiting over 104 days. In discussion with NHSI and NHSE the Trust has stated that it cannot confirm recovery of the key cancer standards until there has been a sustained period of ring fenced capacity of elective beds, i.e. >2 months. .

UHL Activity Trends

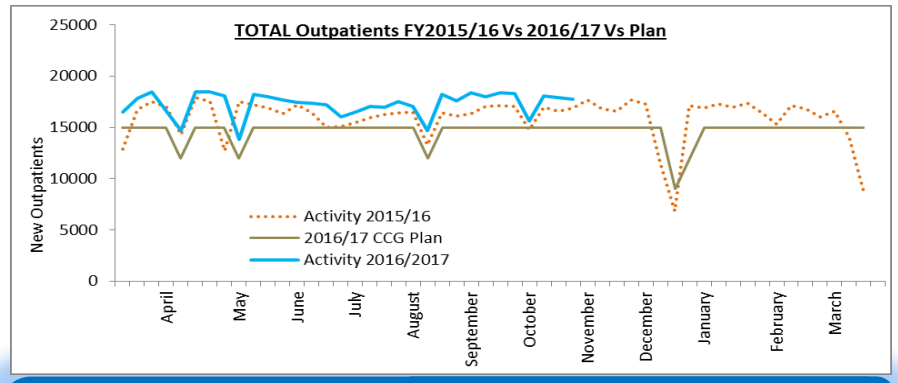
Referrals (GP)



April – October
16/17 Vs 15/16 +9,893 +10%

Increases in GP referrals seen in 8 specialties. Activity Query Notice raised with LLR in August.

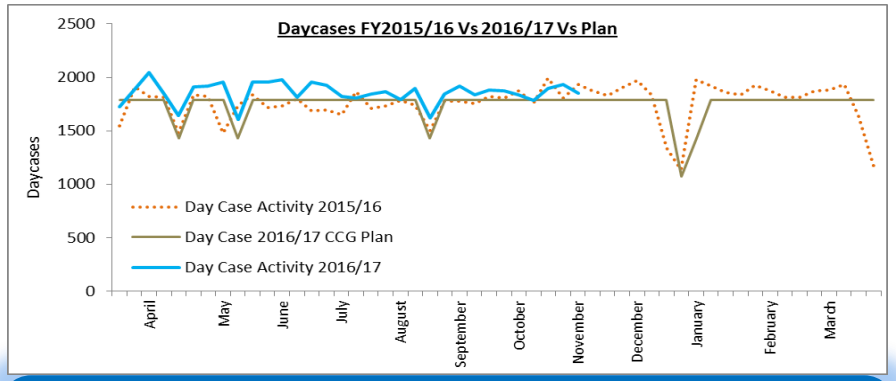
TOTAL Outpatient Appointments



April – October
16/17 Vs 15/16 +17,790 +4%
16/17 Vs Plan +17,607 +4%

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

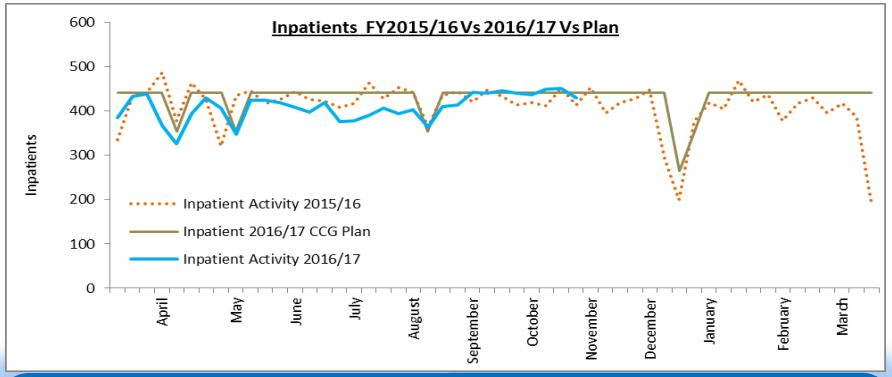
Daycases



April – October
16/17 Vs 15/16 +2,838 +5%
16/17 Vs Plan +1,930 +4%

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

Inpatient Admisisons

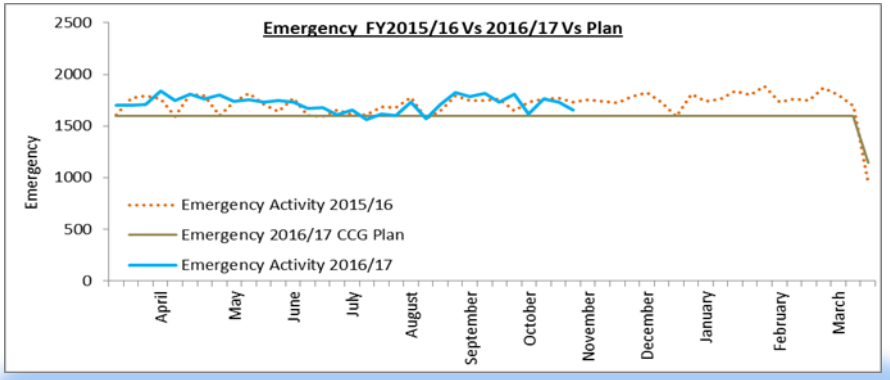


April – October
16/17 Vs 15/16 -534 -4%
16/17 Vs Plan -807 -6%

Above plan - Gynaecology
Below plan – Orthopaedics, ENT

UHL Activity Trends

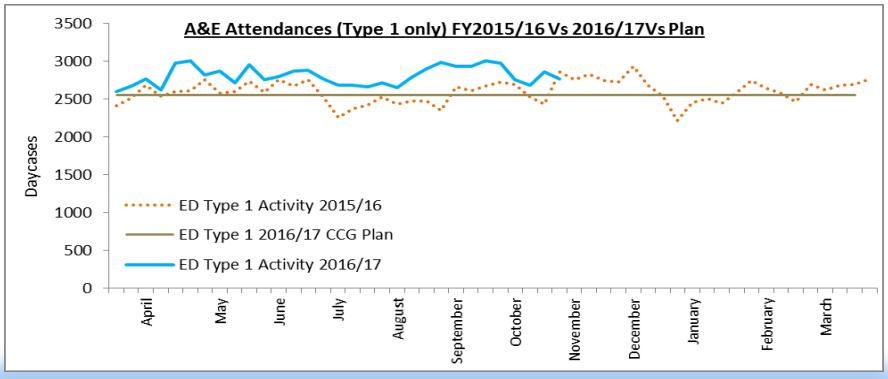
Emergency Admissions



April – October
16/17 Vs 15/16 +166 +0%
16/17 Vs Plan +1,104 +2%

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

A & E Attendances (ED Type 1 only)



April – October
16/17 Vs 15/16 +7,164 +9%
16/17 Vs Plan +7285 +9%

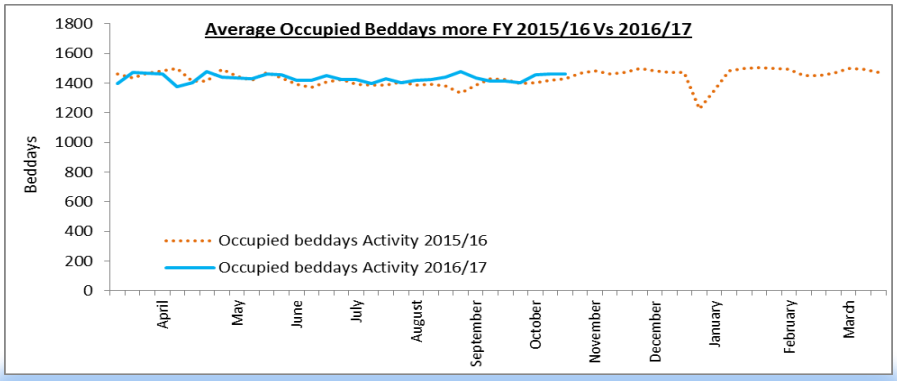
A&E attendances have been above plan and last year's outturn all year. An Activity Query Notice was raised with LLR in August.

Notes:

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

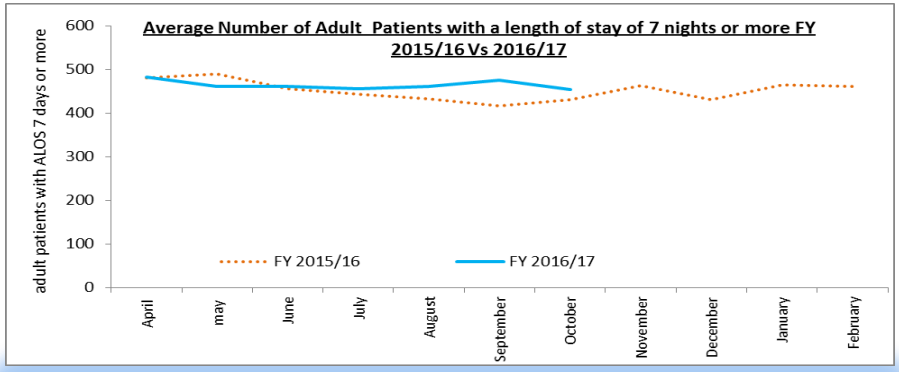
UHL Bed Occupancy

Occupied Beddays



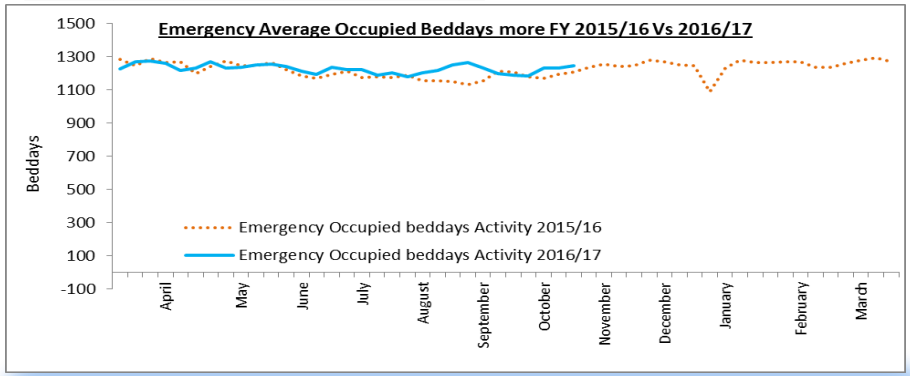
Number of inpatients beds General and Acute excluding Maternity and Obstetrics is 1634 as at September 2016. Occupied beddays are based on midnight bed census. Highest occupancy for 2016/17 was 93%.

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



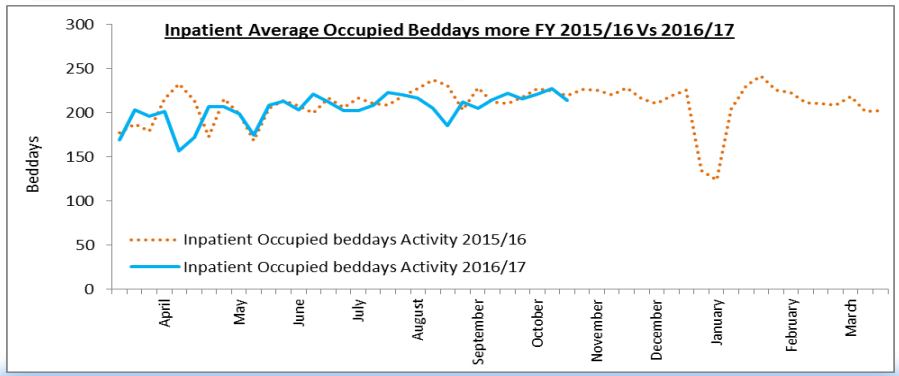
There was 58 more patients in September 2016/17 compared to September 2015/16 with a length of stay of 7 days or more, this is partially reflected in the increase of the delayed transfers of care.

Emergency Occupied beddays



Emergency occupied beddays for 2016/17 during the summer months are higher than the same period last year. During September 2016 there has been an average increase of appox 50 patients in beds overnight compared to September 2015.

Inpatient Occupied beddays



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

Sustainability and Transformation Fund – Trajectories and Performance

Cancer 62 Day

5% of STF allocation

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

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

September Performance (one month in arrears)
77.9% against a trajectory of 85.1%

Octobers Performance: Expected to be non-compliant.

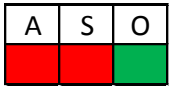
Diagnostics

0% of STF allocation

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

Timing: Required to deliver throughout the year.

October Performance
0.6% of our patients waiting more than 6 *weeks*



November Performance: Expected to be complaint

RTT 18 Week

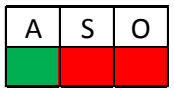
12.5% of STF allocation

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

Timing: Required to deliver throughout the year

October Performance
Not Achieved the RTT standard with 91.5% of our patients waiting less than 18 weeks

November Performance: Expected to be non-compliant



ED 4 hour

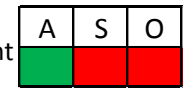
12.5% of STF allocation

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

Timing: Required to achieve 91.2% during March 2017

October Performance
78.3% against a target of 85.0%

November Performance: Expected to be non-compliant



Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

October 2016

One team shared values

CONTENTS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

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

DATE: **24th NOVEMBER 2016**

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

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

1.0 Introduction

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

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

- Executive Team Turnover – to be included from next month
- Aggressive cost reduction plans – NHSI to provide further detail
- Emergency c-section rate – included in September 2016 report
- C Diff – infection rate – C Diff numbers vs plans included
- Potential under-reporting of patient safety incidents – NHSI to provide further detail

The 4 metrics included in the Single Oversight Framework - Appendix 3 Operational performance metrics – ED 4hr wait, RTT incompletes, 6 week diagnostic and 62 day cancer metrics are all reported in the Quality and Performance report.

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

2.0 Performance Summary

Domain	Page Number	Number of Indicators	Number of Red Indicators this month
Safe	4	21	5
Caring	5	11	2
Well Led	6	22	4
Effective	7	11	1
Responsive	8	15	9
Responsive Cancer	9	9	6
Research – UHL	12	6	0
Total		95	27

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

	KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	16/17 Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	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	YTD
Safe	S1	Reduction for moderate harm and above PSIs with finally approved status - reported 1 month in arrears	AF	MD	10% REDUCTION FROM FY 15/16 (<20 per month)	QC	Red if >20 in mth, ER if >20 for 2 consecutive mths		262	18	17	18	18	16	17	9	9	8	12	10	9		57
	S2	Serious Incidents - actual number escalated each month	AF	MD	<=49 by end of FY 16/17 (revised)	UHL	Red / ER if >8 in mth or >5 for 3 consecutive mths	41	50	3	3	3	4	6	4	5	5	1	3	4	2	4	24
	S3	Proportion of reported safety incidents per 1000 attendances (IP, OP and ED)	AF	MD	> FY 15/16	UHL	TBC		17.5	18.3	16.6	17.7	18.8	16.2	17.2	17.1	16.8	16.3	19.3	18.2	16.0	16.3	16.9
	S4	SEPSIS - Patients with an Early Warning Score 3+ - % appropriate escalation	AF	SH	95%	UHL	TBC	New Indicator												86%	91%	86%	88%
	S5	SEPSIS - Patients with EWS 3+ - % who are screened for sepsis	AF	SH	95%	UHL	TBC	New Indicator												65%	91%	95%	84%
	S6	SEPSIS - ED - Patients who trigger with red flag sepsis - % that have their IV antibiotics within an hour	AF	SH	90%	UHL	TBC	New Indicator								63%	71%	71%	66%	69%	75%	79%	71%
	S7	SEPSIS - Wards (including assessment units) Patients who trigger for Red Flag Sepsis - % that receive their antibiotics within an hour	AF	SH	90%	UHL	TBC	New Indicator								33%	50%	21%	42%	23%	45%	61%	36%
	S8	Overdue CAS alerts	AF	MD	0	NHSI	Red if >0 in mth ER = in mth >0	10	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0
	S9	RIDDOR - Serious Staff Injuries	AF	MD	FYE <=40	UHL	Red / ER if non compliance with cumulative target	24	32	7	2	5	3	2	2	5	3	3	1	0	2	4	18
	S10	Never Events	AF	MD	0	NHSI	Red if >0 in mth ER = in mth >0	3	2	0	0	0	0	0	1	0	0	0	1	0	0	0	1
	S11	Clostridium Difficile	JS	DJ	61	NHSI	Red if >mthly threshold / ER if Red or Non compliance with cumulative target	73	60	6	4	6	7	7	6	4	5	6	1	7	8	5	36
	S12	MRSA Bacteraemias (All)	JS	DJ	0	NHSI	Red if >0 ER if >0	6	1	0	0	0	0	0	1	0	0	0	1	0	0	0	1
	S13	MRSA Bacteraemias (Avoidable)	JS	DJ	0	UHL	Red if >0 ER if >0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	S14	% of UHL Patients with No Newly Acquired Harms	JS	RB	Within expected (revised)	UHL	Red if <95% ER if in mth <95%		97.7%	97.4%	97.4%	98.2%	97.7%	97.9%	98.0%	96.9%	97.2%	98.4%	97.9%	98.6%	97.9%	98.0%	97.9%
	S15	% of all adults who have had VTE risk assessment on adm to hosp	AF	SH	>=95%	NHSI	Red if <95% ER if in mth <95%	95.8%	95.9%	95.7%	96.0%	96.1%	95.5%	95.4%	95.1%	95.9%	96.1%	96.5%	96.1%	96.0%	95.7%	96.3%	96.1%
	S16	All falls reported per 1000 bed stays for patients >65years	JS	HL	<=5.5 (revised)	UHL	Red if >=6.6 ER if 2 consecutive reds	6.9	5.4	5.2	4.8	5.7	5.4	4.9	5.2	6.4	5.8	5.9	5.5	6.3	5.9	5.3	5.9
	S17	Avoidable Pressure Ulcers - Grade 4	JS	MC	0	QS	Red / ER if Non compliance with monthly target	2	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0
	S18	Avoidable Pressure Ulcers - Grade 3	JS	MC	<=4 a month (revised) with FY End <33	QS	Red / ER if Non compliance with monthly target	69	33	1	1	5	6	2	5	5	3	2	2	2	2	2	18
	S19	Avoidable Pressure Ulcers - Grade 2	JS	MC	<=7 a month (revised) with FY End <89	QS	Red / ER if Non compliance with monthly target	91	89	5	4	5	5	8	7	9	6	8	3	13	6	9	54
	S20	Maternal Deaths	AF	IS	0	UHL	Red or ER if >0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	2
	S21	Emergency C Sections (Coded as R18)	IS	EB	Not within Highest Decile	NHSI	Red / ER if Non compliance with monthly target	16.5%	17.5%	20.9%	19.7%	20.9%	17.0%	16.6%	17.3%	17.8%	16.8%	17.2%	17.0%	15.0%	18.1%	16.9%	17.0%

	KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	16/17 Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	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	YTD
Caring	C1	Keeping Inpatients Informed (Reported quarterly from Qtr3)	JS	HL	6% increase from Qtr 1 baseline (new)	QC	Red/ER if below Quarterly Threshold	NEW INDICATOR								64%			Next survey to be done in Q3				64%
	C2	Formal complaints rate per 1000 IP,OP and ED attendances	AF	MD	No Target	UHL	Monthly reporting	NEW INDICATOR		1.3	1.2	0.9	1.0	1.4	1.2	1.0	1.0	0.9	0.8	1.2	1.4	1.2	1.1
	C3	Percentage of upheld PHSO cases	AF	MD	No Target	UHL	Quarterly reporting	NEW INDICATOR								0%			0%				0%
	C4	Published Inpatients and Daycase Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <95% ER if 2 mths Red		97%	97%	96%	97%	97%	96%	97%	97%	97%	97%	97%	96%	97%	96%	97%
	C5	Inpatients only Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <95% ER if 2 mths Red	96%	97%	97%	96%	97%	97%	96%	97%	97%	96%	97%	96%	95%	96%	96%	96%
	C6	Daycase only Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <95% ER if 2 mths Red		98%	98%	98%	98%	98%	98%	98%	98%	98%	99%	98%	98%	98%	98%	98%
	C7	A&E Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <94% ER if 2 mths Red	96%	96%	95%	97%	95%	97%	97%	95%	96%	95%	95%	87%	87%	84%	87%	90%
	C8	Outpatients Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <90% ER if 2 mths Red		94%	93%	92%	94%	95%	95%	93%	95%	95%	95%	94%	94%	95%	95%	95%
	C9	Maternity Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <94% ER if 2 mths Red	96%	95%	95%	95%	94%	95%	95%	95%	95%	94%	94%	95%	95%	95%	95%	95%
	C10	Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment	LT	LT	TBC	NHSI	TBC	69.2%	70.0%	Q3 staff FFT not completed as National Survey carried out			70.7%			72.3%			76.0%				74.2%
	C11	Single Sex Accommodation Breaches (patients affected)	JS	HL	0	NHSI	Red / ER if >0	13	1	0	0	0	0	1	0	0	0	4	1	2	20	7	34

	KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	16/17 Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	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	YTD
Well Led	W1	Outpatient Letters sent within 14 days of attendance (Reported Quarterly)	RM	WM	11% Improvement (new)	QC	Red/ER = Below 9% Improvement in Q4		40.0%	New Indicator reported quartely						Achieved			Achieved				Achieved
	W2	Published Inpatients and Daycase Friends and Family Test - Coverage (Adults and Children)	JS	HL	Not Appicable		Not Appicable		27.4%	30.9%	32.4%	23.5%	31.9%	32.8%	32.9%	31.7%	32.0%	31.6%	31.9%	28.5%	27.8%	31.6%	30.6%
	W3	Inpatients only Friends and Family Test - Coverage (Adults and Children)	JS	HL	30%	QS	Red if <26% ER if 2mths Red		31.0%	37.4%	38.2%	23.2%	29.3%	37.2%	36.1%	35.6%	36.7%	38.1%	36.9%	36.5%	33.1%	36.6%	36.3%
	W4	Daycase only Friends and Family Test - Coverage (Adults and Children)	JS	HL	20%	QS	Red if <8% ER if 2 mths Red		22.5%	27.2%	27.7%	18.7%	30.1%	26.2%	29.2%	27.3%	26.5%	24.5%	26.2%	19.8%	21.6%	25.9%	24.4%
	W5	A&E Friends and Family Test - Coverage	JS	HL	20%	NHSI	Red if <10% ER if 2 mths Red		10.5%	16.1%	12.4%	5.4%	7.3%	5.1%	7.0%	13.0%	10.2%	12.0%	8.7%	9.9%	11.7%	9.8%	10.7%
	W6	Outpatients Friends and Family Test - Coverage	JS	HL	>=5%	UHL	Red/ER if <1.4%		1.4%	1.5%	1.5%	1.4%	1.5%	1.6%	1.6%	1.5%	1.7%	1.8%	1.7%	1.6%	1.5%	1.5%	1.6%
	W7	Maternity Friends and Family Test - Coverage	JS	HL	30%	UHL	Red if <26% ER if 2 mths Red	28.0%	31.6%	27.2%	38.8%	30.0%	33.3%	34.3%	31.7%	27.9%	38.3%	39.3%	38.2%	38.7%	37.8%	38.3%	36.9%
	W8	Friends & Family staff survey: % of staff who would recommend the trust as place to work	LT	BK	Not within Lowest Decile	NHSI	TBC	54.2%	55.4%	Q3 staff FFT not completed as National Survey carried out			58.9%			60.3%			62.8%				61.6%
	W9	Nursing Vacancies	JS	MM	TBC	UHL	Separate report submitted to QAC		8.4%	7.1%	7.6%	7.6%	7.7%	6.8%	8.4%	8.2%	8.5%	8.9%	9.2%	8.2%	8.7%	10.3%	10.3%
	W10	Nursing Vacancies in ESM CMG	JS	MM	TBC	UHL	Separate report submitted to QAC		17.2%	12.9%	14.6%	14.9%	16.4%	17.2%	18.5%	18.1%	18.9%	19.8%	20.1%	20.3%	21.4%	20.0%	20.0%
	W11	Turnover Rate	LT	LG	TBC	NHSI	Red = 11% or above ER = Red for 3 Consecutive Mths	11.5%	9.9%	10.2%	9.9%	10.0%	10.1%	10.0%	9.9%	9.7%	9.6%	9.4%	9.4%	9.3%	9.2%	9.1%	9.1%
	W12	Sickness absence	LT	BK	3%	UHL	Red if >4% ER if 3 consecutive mths >4.0%	3.8%	3.6%	3.5%	3.7%	3.9%	4.0%	4.3%	4.2%	3.9%	3.4%	3.4%	3.3%	3.1%	3.5%		3.4%
	W13	Temporary costs and overtime as a % of total paybill	LT	LG	TBC	NHSI	TBC	9.4%	10.7%	10.5%	10.5%	10.1%	11.0%	9.7%	13.9%	10.5%	9.5%	10.9%	10.2%	10.5%	10.7%	10.9%	10.5%
	W14	% of Staff with Annual Appraisal	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	91.4%	90.7%	90.4%	91.1%	92.7%	91.5%	91.6%	90.7%	91.5%	92.2%	92.4%	92.9%	92.4%	91.5%	91.4%	91.4%
	W15	Statutory and Mandatory Training	LT	BK	95%	UHL	TBC	95%	93%	92%	92%	93%	93%	92%	93%	92%	93%	94%	93%	91%	82%	82%	82%
	W16	% Corporate Induction attendance	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	100%	97%	98%	97%	92%	96%	98%	98%	94%	96%	97%	100%	97%	92%	96%	96%
	W17	BME % - Leadership (8A – Including Medical Consultants)	LT	DB	28%	UHL	4% improvement on Qtr 1 baseline									24%			25%				25%
	W18	BME % - Leadership (8A – Excluding Medical Consultants)	LT	DB	28%	UHL	4% improvement on Qtr 1 baseline									12%			12%				12%
	W19	DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	TBC	NHSI	TBC	91.2%	90.5%	91.4%	87.2%	91.0%	90.5%	89.5%	90.2%	91.6%	91.3%	91.4%	89.7%	89.4%	89.9%	90.0%	90.5%
	W20	DAY Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	TBC	NHSI	TBC	94.0%	92.0%	94.2%	93.2%	93.9%	92.1%	86.0%	88.7%	92.5%	93.7%	93.8%	92.0%	94.7%	91.0%	91.9%	92.8%
	W21	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	TBC	NHSI	TBC	94.9%	95.4%	96.1%	91.4%	94.8%	96.6%	95.0%	96.3%	97.6%	97.2%	96.6%	94.5%	95.0%	95.1%	96.7%	96.1%
	W22	NIGHT Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	TBC	NHSI	TBC	99.8%	98.9%	99.9%	98.4%	98.0%	100.2%	91.6%	94.7%	98.3%	99.1%	96.7%	97.1%	98.2%	96.8%	94.2%	97.2%

Effective

KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	16/17 Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	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	YTD
E1	Emergency readmissions within 30 days following an elective or emergency spell	AF	MM	Monthly <8.5% (revised)	QC	Red if >8.6% ER if >8.6%	8.5%	8.9%	9.0%	8.3%	9.2%	8.8%	8.7%	8.8%	8.6%	8.6%	8.5%	8.3%	8.4%	8.5%		8.5%
E2	Mortality - Published SHMI	AF	RB	<=99 (revised)	QC	Red if >100 ER if >100	103	96	98 (Apr14-Mar15)			95 (Jul14-Jun15)		96 (Oct14-Sep15)		98 (Jan15-Dec15)		99 (Apr15-Mar16)				99
E3	Mortality - Rolling 12 mths SHMI (as reported in HED) Rebased	AF	RB	<=99 (revised)	QC	Red if >100 ER if >100	98	97	97	98	99	98	97	98	100	100	100	Awaiting HED Update				100
E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	AF	RB	<=99 (revised)	UHL	Red if >100 ER if >100	94	96	94	95	95	95	95	97	100	99	100	102	Awaiting HED Update			102
E5	Crude Mortality Rate Emergency Spells	AF	RB	No Threshold	UHL	Monthly Reporting	2.4%	2.3%	2.4%	2.1%	2.5%	2.4%	2.4%	2.7%	2.4%	2.2%	2.2%	2.2%	2.2%	2.0%	2.2%	2.2%
E6	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	AF	AC	72% or above	QS	Red if <72% ER if 2 consecutive mths <72%	61.4%	63.8%	60.0%	70.9%	59.7%	66.7%	65.2%	65.1%	78.0%	78.1%	64.6%	86.0%	65.8%	69.4%	64.1%	71.4%
E7	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions (excluding medically unfit patients)	AF	AC	72% or above	UHL	Red if <72% ER if 2 consecutive mths <72%	NEW INDICATOR							73.2%	86.8%	87.7%	73.2%	90.0%	82.0%	87.2%	78.2%	83.6%
E8	Stroke - 90% of Stay on a Stroke Unit	RM	IL	80% or above	QS	Red if <80% ER if 2 consecutive mths <80%	81.3%	85.6%	81.1%	84.4%	87.0%	90.6%	87.0%	86.5%	72.7%	93.5%	83.8%	80.7%	88.0%	80.4%		82.7%
E9	Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA)	RM	IL	60% or above	QS	Red if <60% ER if 2 consecutive mths <60%	71.2%	75.6%	73.3%	67.1%	68.4%	71.3%	80.0%	67.3%	53.5%	68.2%	50.4%	54.8%	71.7%	65.3%	83.8%	63.6%
E10	Published Clinical Outcomes - data submission and outcome results	AF	RB	0 delayed /outside expected (revised)	UHL	ER if Red Quarterly ER if >0	Revised Indicator															
E11	Compliance with NICE Guidance (15/16 and 16/17)	AF	RB	0 Non compliance and no actions or actions delayed (revised)	UHL	Red if in mth >0 ER if Red	Revised Indicator															

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

	KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	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	YTD
Responsive	R1	ED 4 Hour Waits UHL + UCC (Calendar Month)	RM	IL	95% or above	NHSI	Red if <92% ER via ED TB report	89.1%	86.9%	88.9%	81.7%	85.1%	81.2%	80.2%	77.5%	81.2%	79.9%	80.6%	76.9%	80.1%	79.9%	78.3%	79.5%
	R2	12 hour trolley waits in A&E	RM	IL	0	NHSI	Red if >0 ER via ED TB report	4	2	0	1	1	0	0	0	0	0	0	0	0	0	0	0
	R3	RTT - Incomplete 92% in 18 Weeks UHL+ALLIANCE	RM	WM	92% or above	NHSI	Red /ER if <92%	96.7%	92.6%	93.6%	93.8%	93.0%	92.9%	93.2%	92.6%	92.7%	92.7%	92.4%	92.4%	92.1%	91.7%	91.5%	91.5%
	R4	RTT 52 Weeks+ Wait (Incompletes) UHL+ALLIANCE	RM	WM	0	NHSI	Red /ER if >0	0	232	265	263	267	269	261	232	169	134	130	77	57	53	38	38
	R5	6 Week - Diagnostic Test Waiting Times (UHL+ALLIANCE)	RM	WM	1% or below	NHSI	Red /ER if >1%	0.9%	1.1%	7.7%	6.5%	7.0%	4.1%	1.8%	1.1%	0.7%	0.6%	0.7%	0.6%	1.4%	1.5%	0.6%	0.6%
	R6	Urgent Operations Cancelled Twice (UHL+ALLIANCE)	RM	GH	0	NHSI	Red if >0 ER if >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	R7	Cancelled patients not offered a date within 28 days of the cancellations UHL	RM	GH	0	NHSI	Red if >2 ER if >0	33	48	0	3	6	6	9	14	24	16	18	20	19	10	9	116
	R8	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	RM	GH	0	NHSI	Red if >2 ER if >0	11	1	0	0	0	0	0	0	5	0	0	0	6	0	0	11
	R9	% Operations cancelled for non-clinical reasons on or after the day of admission UHL	RM	GH	0.8% or below	Contract	Red if >0.9% ER if >0.8%	0.9%	1.0%	0.8%	1.3%	1.1%	1.3%	1.2%	1.5%	1.5%	1.2%	1.4%	1.1%	0.9%	1.0%	1.2%	1.2%
	R10	% Operations cancelled for non-clinical reasons on or after the day of admission ALLIANCE	RM	GH	0.8% or below	Contract	Red if >0.9% ER if >0.8%	0.9%	0.9%	1.1%	0.0%	1.1%	2.2%	0.2%	1.0%	0.8%	0.3%	0.8%	1.4%	3.2%	0.9%	2.0%	1.3%
	R11	% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	GH	0.8% or below	Contract	Red if >0.9% ER if >0.8%	0.9%	1.0%	0.8%	1.2%	1.1%	1.4%	1.1%	1.4%	1.5%	1.2%	1.4%	1.1%	1.0%	1.0%	1.2%	1.2%
	R12	No of Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	GH	Not Applicable		Not Applicable	1071	1299	91	131	115	146	119	156	156	123	154	114	110	109	134	900
	R13	Delayed transfers of care	RM	SL	3.5% or below	NHSI	Red if >3.5% ER if Red for 3 consecutive mths	3.9%	1.4%	1.1%	1.5%	1.6%	1.8%	1.8%	2.0%	1.9%	1.8%	2.2%	2.9%	2.5%	2.1%	2.0%	2.2%
	R14	Ambulance Handover >60 Mins (CAD+ from June 15)	RM	SL	0	Contract	Red if >0 ER if Red for 3 consecutive mths	5%	5%	22%	27%	16%	12%	10%	11%	6%	6%	6%	9%	7%	9%	9%	7%
	R15	Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)	RM	SL	0	Contract	Red if >0 ER if Red for 3 consecutive mths	19%	19%	26%	26%	23%	13%	13%	13%	11%	12%	10%	15%	14%	15%	18%	14%

Responsive Cancer

KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	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	YTD
** Cancer statistics are reported a month in arrears.																						
RC1	Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	RM	DB	93% or above	NHSI	Red if <93% ER if Red for 2 consecutive mths	92.2%	90.5%	89.9%	92.4%	93.0%	91.4%	93.9%	93.0%	91.1%	89.5%	90.5%	94.3%	94.9%	94.5%	**	92.4%
RC2	Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	RM	DB	93% or above	NHSI	Red if <93% ER if Red for 2 consecutive mths	94.1%	95.1%	94.6%	89.4%	93.5%	96.2%	99.3%	95.7%	96.1%	88.7%	94.9%	98.7%	95.9%	95.0%	**	94.8%
RC3	31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	RM	DB	96% or above	NHSI	Red if <96% ER if Red for 2 consecutive mths	94.6%	94.8%	95.2%	95.6%	94.3%	91.5%	92.6%	94.1%	95.4%	95.5%	95.6%	90.4%	91.3%	93.8%	**	93.6%
RC4	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	RM	DB	98% or above	NHSI	Red if <98% ER if Red for 2 consecutive mths	99.4%	99.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.9%	100.0%	100.0%	100.0%	**	99.6%
RC5	31-Day Wait For Second Or Subsequent Treatment: Surgery	RM	DB	94% or above	NHSI	Red if <94% ER if Red for 2 consecutive mths	89.0%	85.3%	90.7%	76.8%	91.4%	77.5%	77.9%	80.3%	90.3%	91.6%	84.7%	74.4%	72.7%	83.5%	**	82.8%
RC6	31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	RM	DB	94% or above	NHSI	Red if <94% ER if Red for 2 consecutive mths	96.1%	94.9%	94.1%	95.1%	94.3%	96.4%	92.9%	96.4%	98.8%	93.6%	87.3%	92.5%	81.4%	90.9%	**	90.1%
RC7	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	RM	DB	85% or above	NHSI	Red if <85% ER if Red in mth or YTD	81.4%	77.5%	77.0%	82.5%	80.9%	75.1%	73.4%	77.6%	75.8%	74.5%	77.3%	83.6%	78.4%	77.9%	**	77.9%
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	84.5%	89.1%	96.0%	96.2%	95.3%	77.3%	72.5%	81.3%	94.6%	96.0%	85.0%	92.3%	78.9%	81.5%	**	88.4%
RC9	Cancer waiting 104 days	RM	DB	0	NHSI	TBC			17	13	23	23	17	21	12	7	15	12	9	7	7	7

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

KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	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	YTD
RC10	Brain/Central Nervous System	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	--	100.0%	--	--	--	--	100.0%	--	--	--	--	--	--	100.0%	**	100.0%
RC11	Breast	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	92.6%	95.6%	92.0%	100.0%	93.1%	94.6%	100.0%	94.1%	93.3%	95.3%	97.1%	100.0%	100.0%	95.8%	**	97.2%
RC12	Gynaecological	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	77.5%	73.4%	84.6%	80.0%	85.7%	50.0%	70.0%	78.6%	72.7%	78.6%	75.0%	62.5%	66.7%	66.7%	**	69.8%
RC13	Haematological	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	66.5%	63.0%	70.0%	50.0%	58.3%	100.0%	60.0%	60.0%	14.3%	61.5%	72.7%	100.0%	85.7%	28.6%	**	64.8%
RC14	Head and Neck	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	69.9%	50.7%	75.0%	42.9%	37.5%	62.5%	37.5%	35.7%	35.7%	45.5%	100.0%	42.9%	44.4%	0.0%	**	39.6%
RC15	Lower Gastrointestinal Cancer	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	63.7%	59.8%	70.6%	68.2%	77.8%	52.4%	31.3%	57.1%	62.5%	45.0%	64.5%	58.8%	64.4%	47.1%	**	56.9%
RC16	Lung	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	69.9%	71.0%	65.2%	88.6%	81.6%	73.7%	53.8%	71.1%	66.7%	46.7%	64.2%	60.9%	64.2%	68.0%	**	62.4%
RC17	Other	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	95.0%	71.4%	60.0%	80.0%	--	66.7%	--	--	0.0%	50.0%	100.0%	100.0%	33.3%	0.0%	**	44.4%
RC18	Sarcoma	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	46.2%	81.3%	50.0%	--	--	--	100.0%	100.0%	0.0%	50.0%	16.7%	--	--	100.0%	**	38.5%
RC19	Skin	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	96.7%	94.1%	91.1%	95.6%	94.9%	100.0%	92.5%	94.6%	95.2%	100.0%	96.8%	97.4%	95.9%	97.7%	**	97.1%
RC20	Upper Gastrointestinal Cancer	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	73.9%	63.9%	48.6%	84.6%	90.0%	42.9%	57.1%	76.5%	74.3%	70.0%	46.9%	66.7%	82.0%	70.3%	**	69.6%
RC21	Urological (excluding testicular)	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	82.6%	74.4%	80.0%	76.7%	75.0%	67.4%	78.7%	83.6%	83.7%	73.1%	77.8%	96.3%	74.5%	83.5%	**	81.9%
RC22	Rare Cancers	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	84.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	**	100.0%
RC23	Grand Total	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	81.4%	77.5%	77.0%	82.5%	80.9%	75.1%	73.4%	77.6%	75.8%	74.5%	77.3%	83.6%	78.4%	77.9%	**	77.9%

The Sustainability and Transformation Fund Trajectories and Performance

ED trajectory

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

Cancer

			Submitted on a "best endeavours" basis									
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Performance	70.2%	74.0%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%
Actual	**75.8%**	**74.5%**	**77.3%**	**83.7%**	**78.4%**	**77.9%**						

Diagnostics

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

RTT

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

Compliance Forecast for Key Responsive Indicators

Standard	October Actual/Predicted	November predicted	Month by which to be compliant	RAG rating of required month delivery	Commentary
Emergency Care					
4+ hr Wait (95%) - Calendar month	78.3%		Not Confirmed		Validated position
Ambulance Handover (CAD+)					
% Ambulance Handover >60 Mins (CAD+)	9%		Not Confirmed		EMAS monthly report
% Ambulance Handover >30 Mins and <60 mins (CAD+)	18%		Not Confirmed		
RTT (inc Alliance)					
Incomplete (92%)	91.5%	91.5%	Not Confirmed		
Diagnostic (inc Alliance)					
DM01 - diagnostics 6+ week waits (<1%)	0.6%	0.9%			
# Neck of femurs					
% operated on within 36hrs - all admissions (72%)	64%	72%			
% operated on within 36hrs - pts fit for surgery (72%)	78%	80%			
Cancelled Ops (inc Alliance)					
Cancelled Ops (0.8%)	1.2%	1.2%	Not Confirmed		Delivery is dependant on access to beds.
Not Rebooked within 28 days (0 patients)	9	8	Not Confirmed		Delivery is dependant on access to beds.
Cancer					
Two Week Wait (93%)	94.5%	94%			
31 Day First Treatment (96%)	93.8%	80%	See commentary		In discussion with NHSI compliance will be following 2 months of consistent bed access.
31 Day Subsequent Surgery Treatment (94%)	83.5%	85%	See commentary		
62 Days (85%)	77.9%	80%	See commentary		In discussion with NHSI compliance will be following 2 months of consistent bed access.
Cancer waiting 104 days (0 patients)	7	8			

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

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

	KPI Ref	Indicators	Board Director	Lead Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Research UHL	RU1	Median Days from submission to Trust approval (Portfolio)	AF	NB	TBC	TBC	TBC	2.8	1.0	1.0			2.0			1.0			1.0			4.5			
	RU2	Median Days from submission to Trust approval (Non Portfolio)	AF	NB	TBC	TBC	TBC	2.1	1.0	1.0			1.0			1.0			1.0			41.0			
	RU3	Recruitment to Portfolio Studies	AF	NB	Aspirational target=10920/year (910/month)	TBC	TBC	12564	13479	1019	858	1019	1516	1875	815	926	983	947	788	797	803	708	672	610	462
	RU4	% Adjusted Trials Meeting 70 day Benchmark (data sunbmitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC			(Oct14-Sep15) 92%			(Jan15 - Dec15) 94%			(Apr15 - Mar16) 94%			(Jul15 - Jun16) 94%						
	RU5	Rank No. Trials Submitted for 70 day Benchmark (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC			(Oct14-Sep15) Rank 13/215			(Jan15 - Dec15) Rank 61/213			(Apr15 - Mar16) Rank 16/222			(Jul15 - Jun16) 12/220						
	RU6	%Closed Commercial Trials Meeting Recruitment Target (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC			(Oct14-Sep15) 46.8%			(Jan15 - Dec 15) 43.4%			(Apr15 - Mar16) 65.8%			(Jul15 - Jun16) 40.8%						

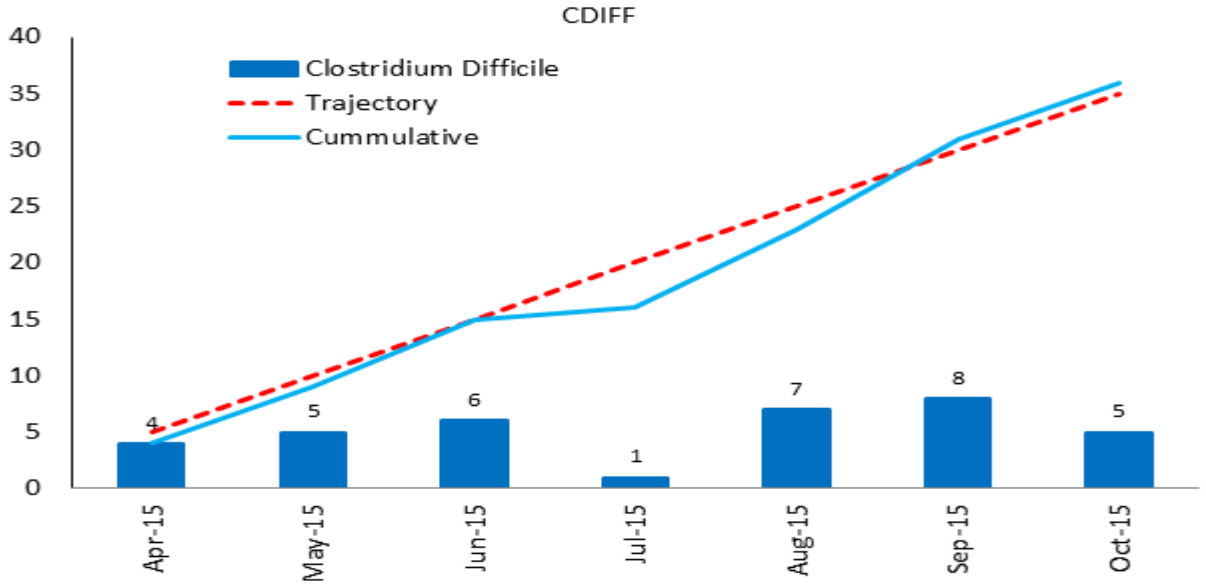
Clostridium Difficile

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	YTD
Clostridium Difficile	4	5	6	1	7	8	5	36

The CDT figures have risen steadily in line with the trajectory but there are no 'stand out' months which are cause for concern. The YTD position is 1 case above the cumulative trajectory of 35.

Actions taken to improve performance

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



Pressure Ulcers

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	YTD
Avoidable Pressure Ulcers - Grade 4	0	0	0	0	0	0	0	0
Avoidable Pressure Ulcers - Grade 3	5	3	2	2	2	2	2	18
Avoidable Pressure Ulcers - Grade 2	9	6	8	3	13	6	9	54

What actions have been taken to improve performance?

The revised trajectory for hospital pressure ulcers was introduced in April 2016, this was based on the previous years out turn together with an added improvement target.

The Trust has continued to make significant improvements in the number of avoidable Grade 3 pressure ulcers developed in our care, but have struggled to maintain a similar position for Grade 2 pressure ulcers.
All hospital acquired pressure ulcers are reviewed on a monthly basis through a rigorous validation process, and additional support is offered to Wards where performance has not improved. We know that hospital admissions remain high and that more patients are being seem within the Trust compared to last year.
Throughout this year we have raised awareness of the principles of pressure ulcer prevention through Heads of Nursing and shared with senior nurses the common themes are attributed to avoidable pressure ulcers. We continue to do this, In addition in the month of November the Trust will support the national STOP THE PRESSURE CAMPAIGN. We also incorporate pressure ulcer data into ward performance reviews, to ensure individual ward performance is monitored. One area of concern for this month was the lack of recorded interventions that Ward teams took and further work will be undertaken to remind staff about the importance of making accurate records of care interventions.

Maternal Deaths

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	YTD
Maternal Deaths	0	0	0	0	1	0	1	2

What actions have been taken to improve performance?

A woman pregnant with twins under the care of the maternity services in Leicester passed away during October.

This unexpected maternal death was reported to the Coroner, but an inquest is not required.

The CCG and NHS England were informed and as per CCG guidance this had to be escalated as a Serious Untoward Incident. There do not appear to be any omissions or mismanagement in care that led to the maternal death.

A Rote Cause Analysis date has been arranged.

A&E Friends and Family Test - % Positive Performance

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

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

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

The low submission levels of surveys in UCC, Minors and Majors gives a poor representation of the overall patients who access these areas, none of these areas has achieved the 20% minimal target

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

Actions taken to improve performance

The senior management team are aware of the Friends and Family Test scores in the Emergency Department and are looking at ways to improve them. They have mechanisms in place to increase the submission levels in each area, to get a better overview of patient opinion

The triage system in the UCC is being reviewed, looking at improving patient flow through the department, which is hoped will improve the comfort of patients in the waiting areas and improve the waiting times

Staff members are being advised of the patient's feedback regarding staff attitude

Single Sex Accommodation Breaches (patients affected)

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	YTD
Single Sex Accommodation Breaches (patients affected)	**0**	**0**	**4**	**1**	**2**	**20**	**7**	**34**

Discharge Lounge – 6 breaches

A decision was made by the on call director on three separate critical incidents during October to care for patients in the Discharge Lounge in their night clothes. These breaches occurred to mitigate risk in the Emergency Department; six patients were admitted in their night clothes during these incidents.

Intensive Care Unit (ICU) – 1 breach

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

This breach was due to lack of bed capacity in the respiratory speciality at Glenfield Hospital.

Actions taken to improve performance

Discharge Lounge staff are aware of the Same-Sex Accommodation Matrix and are receiving support from their Clinical Management Group senior management team.

CU patients are discussed at gold command as soon as they are identified for discharge from ICU and every subsequent meeting until a bed is identified.

Nurse in Charge of ICU, monitors the progress of the bed allocation and escalates appropriately.

The Duty Management Team makes identification of a bed a priority for patients who are waiting discharge from ICU.

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

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	YTD
No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	78.0%	78.1%	64.6%	86.0%	65.8%	69.4%	64.1%	71.4%

There were 78 NOF admissions in October 2016, 27 patients breached the 36 hr target to theatre. Within the service control = 13 variety of reasons. Main themes are theatre weekend capacity / THR surgeon availability / Pre op prep and communication. Outside service control = 14 These were unfit and required stabilisation pre operatively.

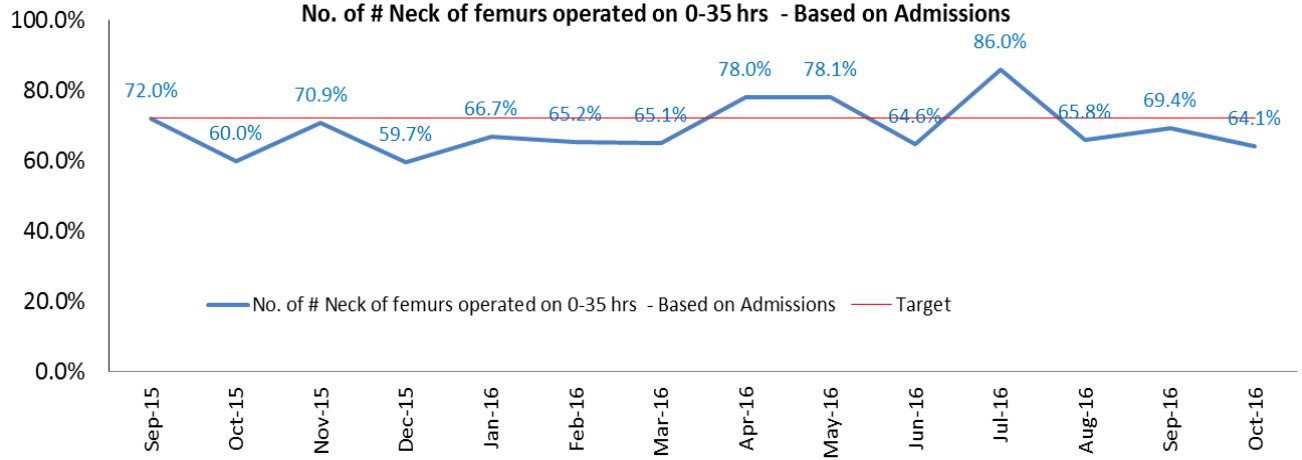
There were 3 days when NOF admissions were 5 pts or more. 18th / 22nd/26th Oct. This resulted in capacity problems once patients became fit.

Actions taken to improve performance

The theatre team leader is working closely with the trauma team to inform of changing priorities and move patients across to LGH site to create capacity – both bed and theatres in times of pressure Training given to LGH theatre team and is on-going. Agreed at Antonymous Board 4 hips per all day session is achievable - monitoring in progress.

THR's have started to be undertaken at LRI. Hip surgeon availability is an issue when on-call surgeon is not of that sub speciality expertise. Investigations how spinal activity can be accommodated minimising impact on other Trauma continue including moving cases if appropriate to LGH. Head of Service leading this.

The Medical Director has set up a steering group to look at how we can sustain NOF performance given that the service now has carried out many of the internal service 'quick' wins. Weekly #NOF meetings are taking place chaired by the Clinical Director.



RTT – Incomplete within 18 weeks and 52+ week waits

Combined UHL and Alliance RTT Performance for October

September	<18 w	>18 w	Total Incompletes	%
Alliance	8,070	396	8,466	95.3%
UHL	42,971	4,362	47,333	90.8%
Total	51,041	4,758	55,799	91.5%

Backlog Reduction required to meet 92%	319

UHL and Alliance combined did not achieve the 92% standard for Referral to Treatment for October. Overall combined performance saw 4,758 patients in the backlog, 319 more than the required amount. All specialties agreed to a backlog reduction target. Of the 95 specialties reported on the daily backlog tracker 48 specialties achieved their target with a further 27 having a variance of 10 or less. The combined variance for the 5 specialties which were furthest away from their target was 653, which pushed the combined performance below the required standard for RTT.

For UHL overall number of patients in the backlog reduced by 95 in October compared to September. The reduced number of patients in the UHL backlog is not reflected improved performance % as due to the large decrease in the number of patients waiting less than 18 weeks.

The Alliance's backlog position also worsened in October, seeing a backlog increase of 51 compared to the previous month. This is compounded by the backlog increase the previous month due discovering over 100 patients not added to the waiting list.

There are 3 factors which have contributed to the failure of this standard: Increase in GP/GDP referral rates 10.9% for UHL as a whole against 15/16 YTD. Although there is an overall increase in activity versus plan Trust wide, 12.1% overall (5.9% admitted and 14.8% non admitted) within the key specialities there is underperformance against plan. At trust level the average there an average of 120 cancellations on the day per month, 841 YTD. These form a large portion of the backlog taking us under the 92% standard.

Forecast performance for next reporting period: Meeting the 92% is at risk due increasing bed pressures due to winter pressures.

Specialties with the 5 largest variance against October backlog target	October Target - 18+ weeks			Backlog Size October			**Variance to agreed position**
	Admitted	**Non-admitted**	**Total**	**Admitted**	**Non-admitted**	**Total**	
Urology	135	80	215	273	95	368	153
Orthopaedic Surgery	190	155	345	195	289	484	139
Ophthalmology	101	159	260	178	197	375	115
General Surgery	288	72	360	322	145	467	147
Spinal Surgery	55	100	155	53	201	254	99
Total	**769**	**566**	**1335**	**1021**	**927**	**1948**	**653**

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

Ophthalmology although overall achieving the 92% standard has seen a sharp backlog rise since June. From October daily calls have been initiated with the General Manager for Ophthalmology with theDeputy Head of Performance and Director of Performance and Information in order to ensure service delivery. This has seen a positive impact with their total backlog subsequently reducing by 92. Similar actions are now in place for Orthopaedics and Spinal services.

4 of the 5 specialties with the largest backlog variance (Urology, Orthopaedic Surgery, Ophthalmology and General Surgery) to the backlog target also make up the 5 specialties with the highest overall backlog. These specialties have action plans in place to achieve performance along with ENT, Paediatric ENT, Allergy and Spines. These are managed by the Deputy Head of Performance alongside the General Managers for each service.

Specialties with the 5 largest overall backlogs	Total Backlog	Variance to agreed position	%
ENT	766	64	**75.94%**
Orthopaedic Surgery	484	139	**89.15%**
General Surgery	467	147	**88.24%**
Ophthalmology	375	115	**94.31%**
Urology	368	153	**86.49%**
Total	**2,460**	**618**	

Specialties with the 5 worst RTT %	Total Backlog	Variance to agreed position	%
Paediatric ENT	361	28	**55.5%**
Allergy	125	-14	**71.6%**
ENT	769	64	**76.2%**
Paediatric Maxillo-Facial	44	12	**77.9%**
Adult Congenital Cardiology	16	4	**78.7%**
Total	**1,315**	**94**	

Had the 5 specialties with the worst variance to backlog plan achieved their target along with the Alliance achieving their backlog number prior to the found patients not on a waiting list the UHL combined would have achieved 92.8%

The context for the performance for the specialties with action plans are included shown below.

General Surgery: Admitted	Jun	Jul	Aug	Sep	Oct	Trajectory →
	224	**263**	**278**	**289**	**293**	

Background: Current performance driven by lack of capacity to meet SLA demands. Circa 3 sessions per week. In addition short notice cancellations of theatre sessions by the service: 4.4 sessions per week financial year to date. Business case currently being written with aim to address this. Winter bed pressures on inpatient and critical care beds resulting in patient cancelations 9.9% Sep15 - Aug16 data. Further risk going into winter months of increased cancellations due to further bed pressure demands.
Actions: Insource capacity – Medinet. Start October into November. Business case for consultant workforce. Reduce first appointment wait time to reduce pathway lengths. Additional lists for outpatient to reduce non admitted backlog

Urology: Admitted	Jun	Jul	Aug	Sep	Oct	Trajectory →
	204	**236**	**241**	**265**	**269**	

Background: Lack of in week outpatient and theatre capacity. Processes within outpatients increasing pathway length, such as a lack of pre-operative assessment slots. Unable to bring patients on short notice fill cancelled gaps. Increased activity over and above SLA predicted 297 admitted patient's full year.
Actions: To insource capacity - Medinet 8 sessions per weekend. Additional POA slots. Look to Alliance for additional outpatient capacity. Left shift low acuity day case work to the community. Left shift low risk patients.

Allergy: Non Admitted	Jun	Jul	Aug	Sep	Oct	Trajectory ↓
	179	**209**	**197**	**166**	**129**	

Background: Underperformance on admitted RTT is related to Consultant vacancies since June 2015 (2 clinics per week) with additional vacancy since May 2016 (3 clinics per week). Service has now appointed to 1 consultant post. RTT remains in steady state with use of wait list initiatives.
Actions: Recruit to vacant consultant post. September interview not successful, appointed trainee to start in January. SLA with Nottingham consultant for weekend WLI's with the aim to continue to January. Consultant appointed to joint post has indicated intention to leave, Clinical Director to complete as service review.

	Jun	Jul	Aug	Sep	Oct	Trajectory →
ENT: Admitted	**483**	**395**	**373**	**352**	**305**	
ENT: Non Admitted	**718**	**609**	**469**	**437**	**454**	

Background: Current backlog driven by a high level of cancellations from 2015/16 winter bed pressures carried over to 2015/16. Internal service pressures due to clinician Long Term Sickness, average 3.5 sessions per week (112 YTD) cancelled due to no surgeon. Lack of pre-operative assessment slots has inhibited the services ability to utilise all sessions/slots that have become available.
Actions: Insource outpatient and inpatient capacity (Medinet). Use of Alliance for low risk patients. Appointment of additional consultants to reduce cancelled sessions. Outsource Balance patients to Melton Road clinic and full Balance service review.

Ophthalmology: Non Admitted	Jun	Jul	Aug	Sep	Oct	Trajectory ↓
	58	**143**	**222**	**325**	**164**	

Background: There has been a significant reduction in outpatient capacity due to reduced staffing of middle grade doctors and lack of replacements. Reduced capacity in outpatient clinic slots increasing wait for first appointment. Reduced take up of wait list initiatives both for both outpatient and theatre sessions. Lack of follow up capacity resulted in patients not being listed for surgery as unable to have a clinically required follow up within 4 weeks of surgery.
Actions: Additional Capacity at London Road Clinic. Outpatient Wait list initiatives including 2 Super Saturday clinics in October. Macular unit to increase capacity circa 300 patient per week to be in place for December.

Orthopaedics Non Admitted	Jun	Jul	Aug	Sep	Oct	Trajectory →
	178	**190**	**197**	**274**	**273**	
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. Gap within the clinical workforce for fellow post. **Actions:** Super Saturday outpatient clinics to reduce backlog. Clinical engagement for patients on foot and ankle pathway for waiting list management. Agreed pathway change with radiology for hip and knee patients reduce pathway length by 4 weeks. Increased use of ESP and CNS to increase non admitted capacity.						

52 week breaches for Orthodontics are currently 33 and remain on target to be zero by the end of January.

Proposed Principles for LLR Planned Care Clinical Pathways

UHL and CCGs have jointly commissioned public health colleagues to conduct a series of reviews across a range of clinical interventions (in dialogue with specialties and primary care) with a view to discussing alternatives and/or decommissioning services where they are not supported by an evidence base. The work (and resulting policy recommendations) is overseen by the Clinical Priorities Implementation Group (CPIG), which is chaired by a GP and attended by all CCGs, UHL and patient representatives. The CPIG reports into the LLR Planned Care Board and updates will be represented to ESB / EQB going forward.

The CPIG is also supporting the wider planned care agenda by ensuring mechanisms are in place to improve referral processes from primary care, freeing up consultant / specialist time within the Trust.

Some overarching principles have been developed, below, which are being considered by CCG boards in late November. These may well be adopted more widely across planned care too.

1. Referrals to secondary care should be based on a principle of health care need i.e. determining through shared decision making whether attending secondary care will offer significant additional clinical benefit which the patient may wish to receive.
2. When a clinical presentation or condition has been developed into a LLR clinical pathway, there will be a single point of access from GPs to UHL investigations, services and interventions using PRISM to create the referral letter.
3. There will be no alternative routes to make a referral from primary care nor can secondary care consultants create, or retain, other access routes to their care.
4. Gatekeeping is the responsibility of the primary referrer. Unless referral threshold criteria are met at the time of referral, the referral will not be accepted. Referral may require a triage tool, such as completing a shared decision aid or template, to determine whether a referral should be sent, and to whom.

5. The clinical pathways will be closely linked to Consultant Advice and Guidance. When the criteria/thresholds are not met, or there is clinical uncertainty about diagnosis or management, GPs will have access to timely specialist advice and support which then may result in a referral being accepted.
6. Patients cannot be referred to secondary care without evidence of significant clinical benefit as opposed to agreeing to patient demand.
7. The gatekeeper role generates additional pressures to manage demand in primary care. This will need strong, consistent support from both primary and secondary care to facilitate shared evidence based decision making with patients.
8. PRISM will provide GPs with the necessary tools to discuss whether further tests or referral would benefit the patient as a part of day to day primary care consultations.
9. Consultant to consultant referrals will follow the same LLR clinical pathways and thresholds to access additional specialist care (but without using PRISM)
10. Evidence based thresholds/pathways will apply equally in all NHS primary and secondary care providers (including community clinics).
11. The same pathways/policy criteria will apply irrespective of the source of referral so will include all commissioners from outside LLR.

Diagnostic Performance

October diagnostic performance for UHL and the Alliance is 0.58%. We have achieved the standard performing below the 1% threshold this is after non delivery in August and September. Factors for September's non-performance were the installation of EMRAD resulted in a system failure within the Imaging Service due to the high level of management time required and a lack of reporting for the first several weeks post go live. Key actions taken to support in the delivery of the performance were:

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

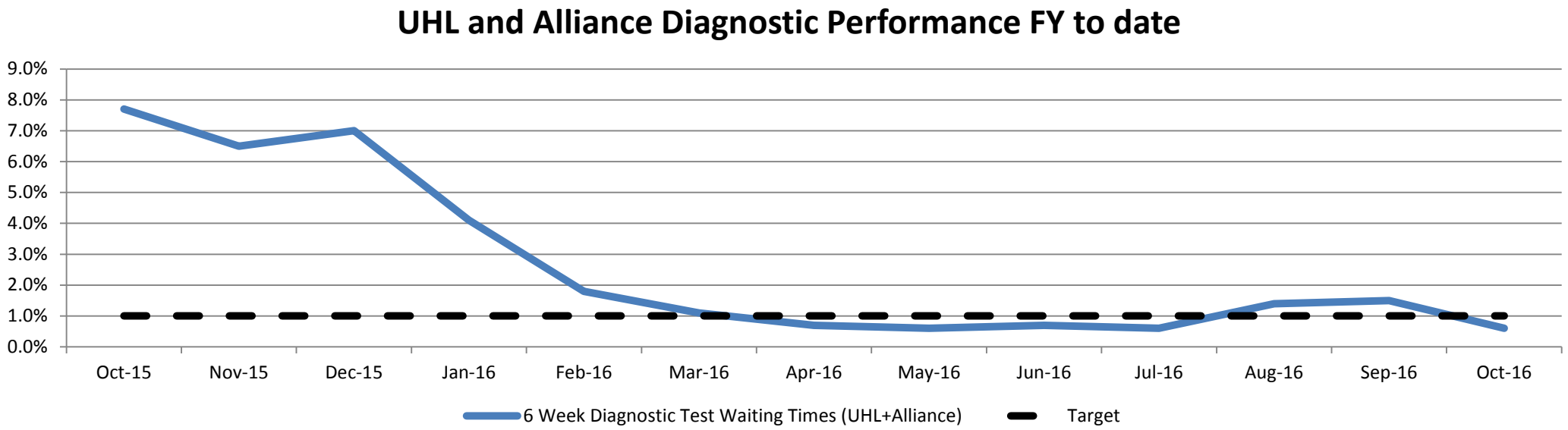
Actions taken to improve performance

An escalation meeting between with CSI and Operations now occurs twice weekly to give assurance on the end of month position and to be sighted early when there are any significant capacity gaps that can be supported with extra capacity to hit the 1% standard.

- This includes a bespoke Imaging Diagnostic scorecard to ensure greater visibility of waits
- Clinicians timely vetting / protocoling of referrals earlier to increase the pool of patients available to book at any one time
- Imaging booking 4-6 weeks ahead to give greater accuracy to capacity gaps

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

Predicted diagnostic performance for November = < 1%



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

INDICATORS: The cancelled operations target comprises of two components 1.The % of cancelled operations for non-clinical reasons On The Day (OTD) of admission 2.The number of patients cancelled who are not offered another date within 28 days of the cancellation	Indicator	Target (monthly)	Latest month	YTD performance (inc Alliance)	Forecast performance for next reporting period
	1	0.8%	1.2%	1.2%	1.0%
	2	0	9	116	8

Across UHL in October 119 patients were cancelled on the day, This equates to 1.2% of all elective FCEs against a target of 0.8%. This is increase since September with 12 patients being cancelled because of infrastructure problems related to a power failure in theatres. Of the 119 cancellations 54 were due to capacity pressures and the other 65 due to hospital related causes. Of the 54 patients cancelled for capacity pressures, 37 of the cancellations related to availability of beds (either HDU, ITU or ward).

The five key reasons for cancellations were:

1. Hospital Cancel - Lack Theatre Time / List Overrun (29)
2. Hospital Cancel - Ward Bed Unavailable (25)
3. Hospital Cancel -Pt Delayed To Adm High Priority Patient (17)
4. Hospital Cancel - Infrastructure Problems (12)
5. Hospital Cancel - Lack Surgeon (11)

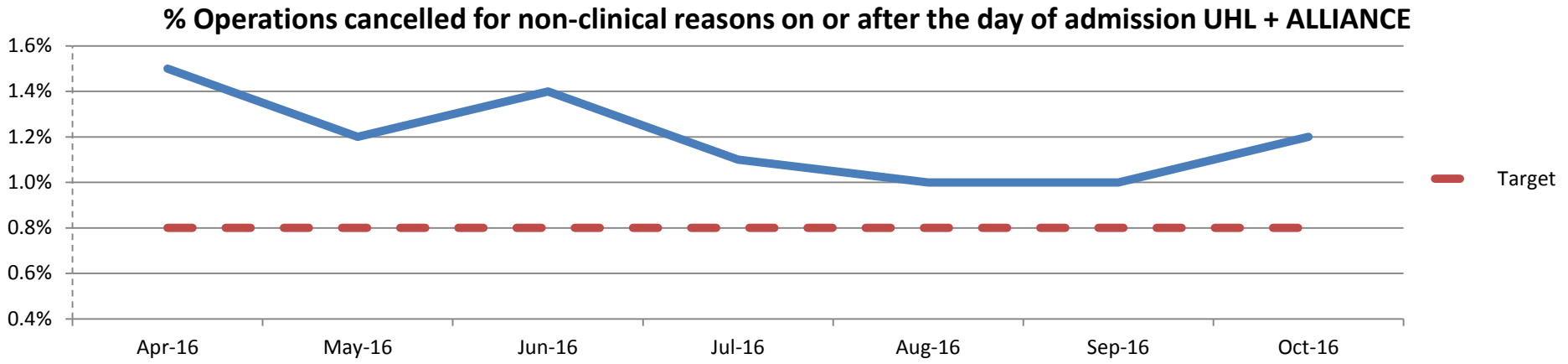
9 patients breached 28 days. These comprised: 5 CHUGGS, 2 MSS, 2 W&C.

What actions have been taken to improve performance?

List over runs: the process of exception reporting is now better able to identify any over booked operation lists by the theatre managers working with theatre staff.

The number of cancellations due to ward bed availability has deteriorated during August, a reflection of emergency pressures across the Trust. The ring fencing of ASU/Ward 7 for surgical patients continues. Weekly bed meetings and early escalation through GOLD command prior to the day where capacity is seen to likely result in a cancellation on the day.

HDU/ITU bed cancellation continues to reduce from 13 in August down to 9 has seen a slight increase to 12 cancellations on the day in October up from 9 in August. Capacity remains a key risk to meeting performance in November.



Ambulance handover > 30 minutes and >60 minutes – Performance

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

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

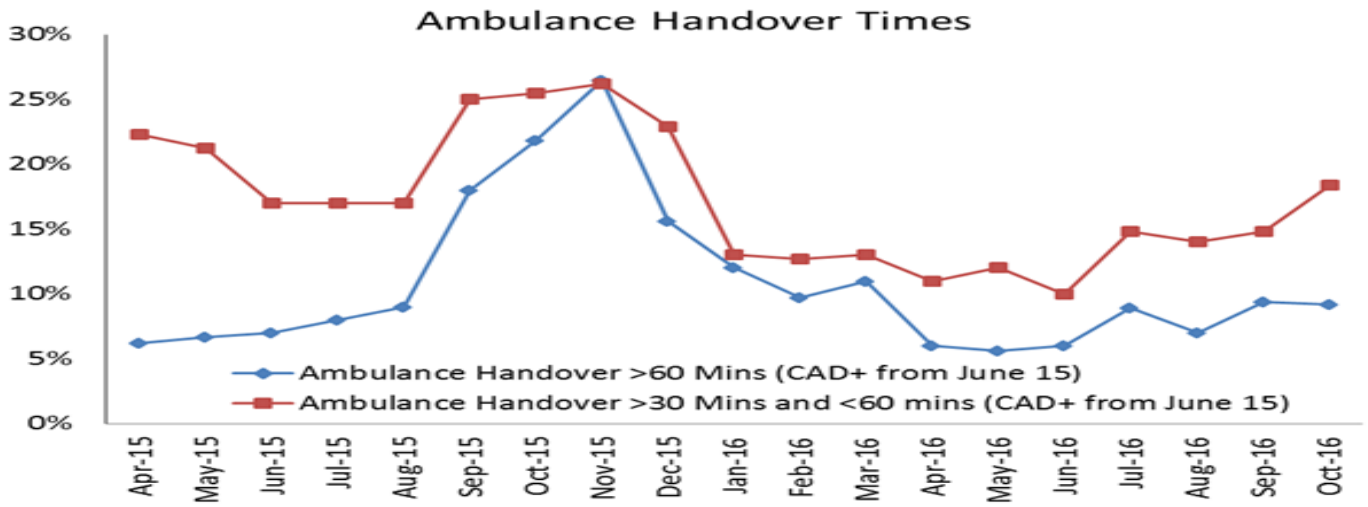
What actions have been taken to improve performance?

The AE Delivery Board chaired by UHL CEO commenced in September.

A new RAP has been agreed by LLR, NHSE and NHSI and has a focus on decreasing conveyance and increasing 'hear and treat' and 'see and treat' to divert patients away from the ED. It is essential that the focus remains on decreasing EMAS attendance by increasing / improving the primary care offer which will be managed through the new RAP.

From the 14th of November we have implemented the following to help improve the position.

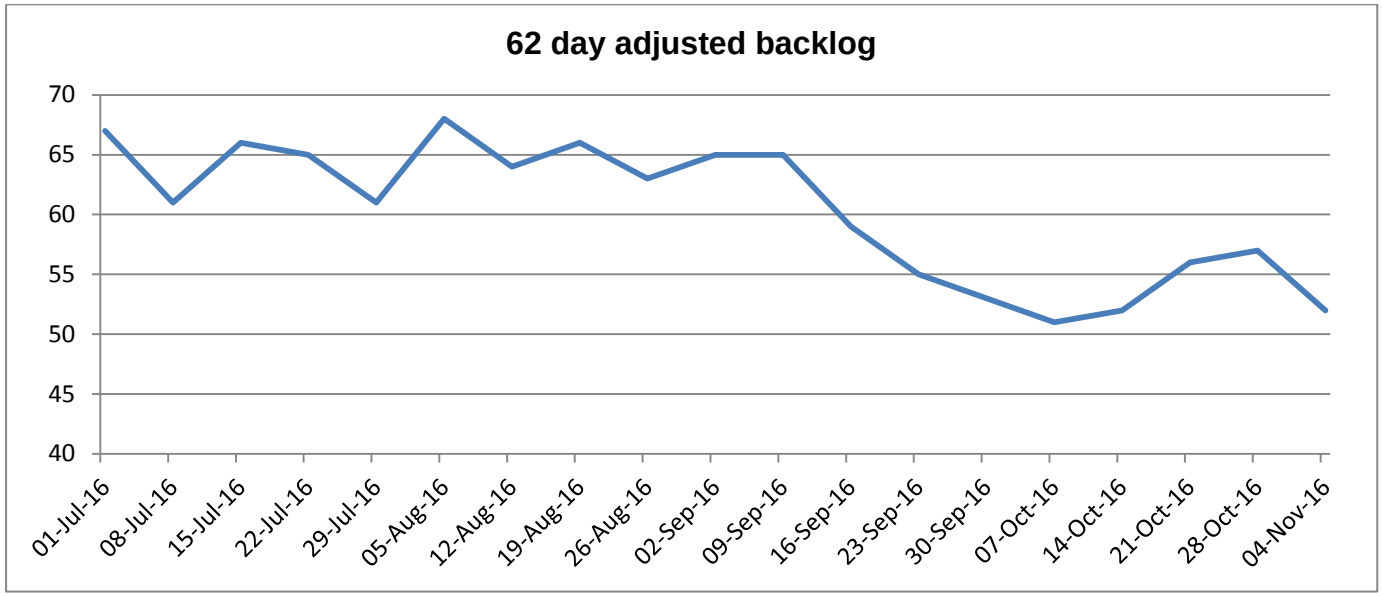
- Service managers have moved back to support this function to ensuring it is as efficient as possible.
- The majority of delays fall out of normal working hours therefore the team have implemented a month of 16.00-12.00 shifts Monday to Friday which started November 14th. The outcome of this trial will be reviewed to decide next steps.



Cancer waiting time performance

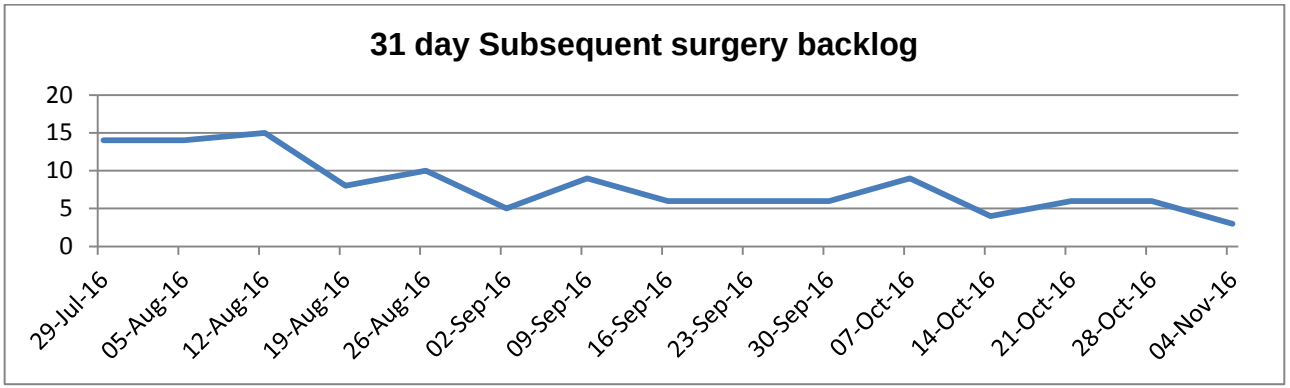
Current performance

2ww performance remains strong with September at 94.6% October and November performance will be above the standard.
62 day performance as anticipated remains below the required standard, September being at 77.9% and October and November expected at circa 80%. In discussion with NHSI and NHSE the Trust has stated that it cannot confirm recovery of the key cancer standards until there has been a sustained period of ring fenced capacity of elective beds, ie >2 months. But the Trust is clear that all efforts to deliver good patient care and improve cancer performance is priority. The positive news is that the adjusted backlog (excluding tertiary referrals received after day 39) has remained in the 50 ‘s for 8 weeks. This sustained reduction is a lead indicator of future performance.

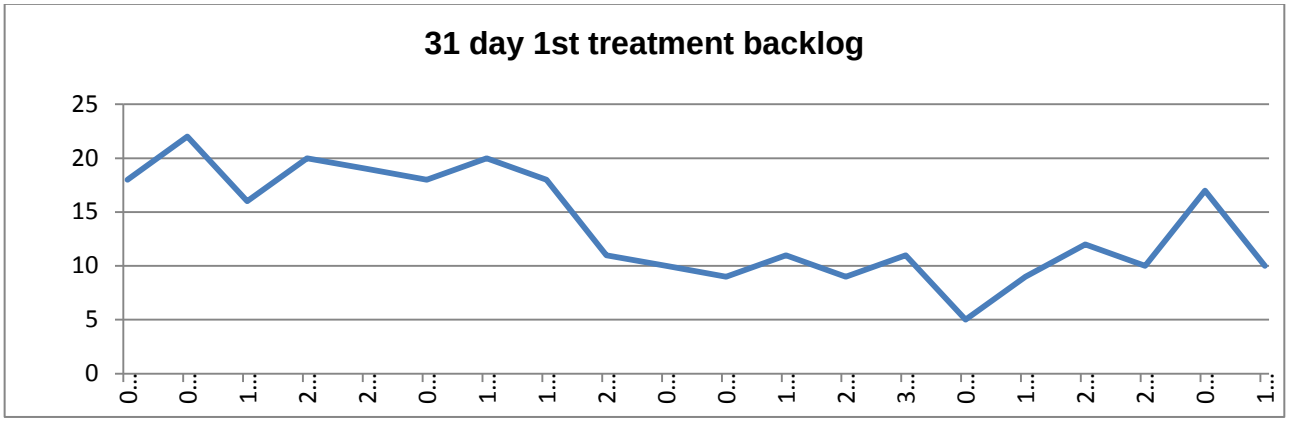


Key themes identified in backlog (4th November)

Summary of delays	Numbers of patients	Summary
Capacity – Surgical	2	Predominantly inpatient surgical capacity for Lung and Urology, Urology specific to Robotic Prostatectomy.
Complex Patients	10	Across 6 tumour sites a combination of patients requiring multiple diagnostics, cardiac investigations and complex histology/cytology requiring immuno reporting, all options patients (Urology specific) and patients going through multiple MDTs to determine primary diagnosis.
Diagnostic Delays/Capacity	6	A combination of capacity and reporting issues including cancellations for diagnostics due to lack of theatre staff delays, to US Guided Biopsy (Urology) and cancellations due to surgical bed availability and PET delays for patient related reasons.
Late Referrals Other Tumour Sites	3	Patients going through multiple MDTs to determine primary, 2 of these are for Haem, 1 for Gynae.
OPD Delays/Capacity including UHL Pathway Delays	11	Predominantly in services where Next Steps has only recently been implemented (Gynae, Head & Neck) and for Lower GI where Next Steps is experiencing some issues which are being worked through with the support of the Project Manager.
Patient Delays & Patients Unfit	13	A combination of patients unavailable due to holidays or requiring additional thinking time to make pathway decisions on treatment, DNA's and being inpatients or requiring Cardiac intervention prior to treatment.
Trial Patients	2	Specific to Lung and the CheckMate trial where specimens are sent to the US for testing.
Tertiary Referrals	7	Referrals from Boston, Derby, NGH, Lincoln and Burton ranging from Day 39 to Day 62



31 day subsequent surgery performance is below the standard at 83.5% in September. Although backlogs have reduced, access to beds and timely theatre capacity remains the key issue. The main but not exclusive tumour site of concern remains urology.



31 day 1st treatment performance is below the standard at 93.8% in September. On going backlog reduction is not being sustained, again access to beds and timely theatre capacity remains the key issue

Summary of the plan

The recovery plan (RAP) consists of 50 actions following detailed work initially with the CMG's and also with the joint UHL and CCG working group.

The issues detailed in the plan have been identified by a consistent review of tumour site breach maps (rolling 3 month themes) and the current (4th November) tumour site backlog reasons. The actions are targeted at tumour site specific issues taking into account 'linked' services that impact on delivery. Metrics have been devised for each action to ensure that they are measurable and that they are on track. Each action has been risk rated (high, medium or low).

Key actions that are off track are:

- Recruitment to head and neck surgeon post, start date now December 2016
- Recruitment to imaging head and neck post, this has been unsuccessful a number of times
- The remaining big ticket items are the 'wicked issues' elective bed capacity / HDU / ITU capacity / Theatres

Summary of high risks

	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	Linac Replacement (radiotherapy, capital availability)	Business case	External factors impacting on delivery

Tumour sites that are off their 62 day adjusted trajectory

	Adjusted Backlog as at 4th Nov 2016	Adjusted trajectory	Key mitigating recovery action plan (RAP) actions
Lower GI	10	6	- Action 1: consolidating MDTs on one site , on track for January 2016 - Actions 3+4 and full embedding of Next steps which has slipped. Additional actions taken to support next steps process - Other Key issues are the Trusts ' Wicked issues', theatre capacity / elective beds including HDU / ITU
Urology	12	10	- Action 1: additional theatre lists , remains high risk due to lack of availability of additional theatres. Medinet in place - Action 3 : PSA follow up will be in place from 1st December - Action 4: shortening the wait for renal biopsy, process and capacity now in place - Key issues in urology remain the Trust 'wicked issues'
Head and Neck	8	5	- Action 1: ENT recruit head and neck surgeon, due to start in December - Action 5: Max fax posts recruited to , to start January 2017 - Action 6: max fax anaesthetic cover process being reviewed - Embedded next steps process
Lung	9	6	- Action : Agreement with tertiary provider , Burton to adopt UHL pathway. Head of service meeting and cancer lead meeting with Burton - Action 3 , full embedding on Next steps
Gynaecology	8	7	- Action 3: key action is embedding of next steps process, initiated in November