Quality & Performance Report

Author: John Adler Sponsor: Chief Executive Date: IFPIC + QAC 28th January 2016

Executive Summary from CEO Paper L

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: **RTT** - The RTT incomplete target remains compliant, this is particularly good in the light of rising referrals. . The NHS is failing this target as a whole which makes our compliance increasingly rare. **DTOC** - Delayed transfers of care remains well within the tolerance which reflects the continuation of the good work that takes place across the system in this area. **MRSA** - remains at zero for the year. **Falls** performance has seen a big improvement on the 7.1% of last year. **Annual Appraisals** and **Statutory and Mandatory Training** continue to show improvement. In fact, a positive from the National Staff Survey Results is that more staff feel that their appraisal is a valuable experience. **C DIFF** – over by 1 case in month but still within year to date trajectory. This continues to be closely monitored in respect of antibiotic prescribing controls and cleaning standards. **Pressure Ulcers** - there were zero avoidable **Grade 4** pressure ulcers reported for the 9th consecutive month.

Bad News:

ED 4 hour performance- was 85.1% which is a slight improvement compared to the same month last year. Year to date performance has slipped to 89.5%. Contributing factors are set out in the Chief Operating Officer's report. **Ambulance Handover** – remains a very serious issue – this s also examined in detail in the COO's report.

Referral to Treament 52+ week waits. We continue to struggle to bring down these long waits, due to an inability to recruit additional consultants or to find capacity at other providers. This is remains an issue of national significance due to the numbers involved. Supported by the NTDA, we have put a plan to commissioners to resolve the issue – their final response is awaited. We have seen continued improvement in **Diagnostics** but unfortunately progress has been slowed by the failure of 3 MRI scanners

at the same time. **Cancelled operations** and **patients rebooked within 28 days** - were both non-compliant, predominantly due to increased adult and children emergencies. **Cancer Standards -** the 62 day backlog remains too high. A Remedial Action Plan has been submitted to commissioners with a revised compliance date of June 2016. A response is awaited from the commissioners with regards to penalties. **Fractured NOF** – target not achieved in December due to high number of medically unfit patients. A review of what is included or excluded from the baseline is underway.

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: 25th February 2016

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

December 2015

One team shared values

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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

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

DATE: **28th JANUARY 2016**

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

SUBJECT: **DECEMBER 2015 QUALITY & PERFORMANCE SUMMARY REPORT**

1.0 Introduction

The following report provides an overview of TDA/UHL key quality and performance metrics and escalation reports where applicable.

2.0 Performance Summary

Domain	Page Number	Number of Indicators	Indicators with target to be confirmed	Number of Red Indicators this month
Safe	4	22	7	3
Caring	5	10	3	0
Well Led	6	18	6	4
Effective	7	16	3	2
Responsive	8	17	2	10
Responsive Cancer	9	9	0	6
Research – UHL	11	6	6	0
Total		98	38	25

3.0 New Indicators

None.

4.0 Indicators removed

None.

5.0 Indicators where reporting methodology/thresholds have changed

None.

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	KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	YTD
Safe	S1	Clostridium Difficile	JS	DJ	61	TDA	Red if >mthly threshold / ER if Red or Non compliance with cumulative target	66	73	7	7	11	7	5	7	3	1	4	4	6	6	6	4	6	40
	S2a	MRSA Bacteraemias (All)	JS	DJ	0	TDA	Red if >0 ER if >0	3	6	1	0	2	0	1	1	0	0	0	0	0	0	0	0	0	0
	S2b	MRSA Bacteraemias (Avoidable)	JS	DJ	0	UHL	Red if >0 ER if >0	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
	S3	Never Events	JS	MD	0	TDA	Red if >0 in mth ER = in mth >0	3	3	1	0	1	1	0	0	0	0	0	0	0	1	0	0	0	1
	S4	Serious Incidents	JS	MD	Not within Highest Decile	TDA	TBC	60	41	4	2	4	3	2	1	2	8	1	5	3	5	3	4	3	34
	S5a	Proportion of reported safety incidents per 1000 beddays	JS	MD	TBC	TDA	TBC	37.5	39.1	38.9	40.3	40.4	35.0	38.2	36.3	34.6	37.3	39.6	39.9	37.1	33.6	38.7	34.6	35.0	36.7
	S5b	Proportion of reported safety incidents that are harmful	JS	MD	Not within Highest Decile	TDA	TBC	2.8%	1.9%	1.4%			2.3%			2.2%			1.9%			1.8%			2.0%
	S6	Overdue CAS alerts	JS	MD	0	TDA	Red if >0 in mth ER = in mth >0	2	10	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
	S7	RIDDOR - Serious Staff Injuries	JS	MD	FYE = <40	UHL	Red / ER if non compliance with cumulative target	47	24	2	2	1	0	3	2	0	6	0	0	2	3	7	2	5	25
	S8a	Safety Thermometer % of harm free care (all)	JS	EM	Not within Lowest Decile	TDA	Red if <92% ER = in mth <92%	93.6%	94.1%	94.9%	93.3%	94.1%	95.0%	92.1%	93.6%	93.7%	94.3%	95.6%	94.6%	93.2%	94.0%	93.5%	94.4%	93.9%	94.2%
	S8b	Safety Thermometer % number of new harms	JS	EM	Not within Lowest Decile	TDA	TBC	New TDA Indicator		2.3%	3.3%	2.4%	2.5%	3.2%	2.7%	2.2%	2.6%	2.1%	1.9%	3.1%	2.4%	2.6%	2.7%	1.8%	2.4%
	S9	% of all adults who have had VTE risk assessment on adm to hosp	AF	SH	95% or above	TDA	Red if <95% ER if in mth <95%	95.3%	95.8%	95.4%	95.5%	95.0%	96.3%	96.2%	95.6%	96.0%	96.0%	96.5%	96.2%	96.5%	96.1%	95.7%	96.0%	94.6%	95.9%
	S10	All Medication errors causing serious harm	AF	CE	0	TDA	Red if >0 in mth ER if in mth >0	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	
	S11	All falls reported per 1000 bed stays for patients >65years	JS	HL	<7.1	QC	Red if >8.4 ER if 2 consecutive reds	7.1	6.9	6.4	7.5	6.9	7.1	6.7	6.3	5.7	5.8	5.0	5.7	5.7	4.1	5.2	4.3	4.7	5.1
	S12	Avoidable Pressure Ulcers - Grade 4	JS	MC	0	QS	Red / ER if Non compliance with monthly target	1	2	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0
	S13	Avoidable Pressure Ulcers - Grade 3	JS	MC	<=6 a month	QS	Red / ER if Non compliance with monthly target	71	69	4	6	7	5	9	6	3	0	4	1	4	1	1	1	5	20
	S14	Avoidable Pressure Ulcers - Grade 2	JS	MC	<=8 a month	QS	Red / ER if Non compliance with monthly target	120	91	8	13	11	7	5	9	10	8	8	8	10	11	5	4	5	69
	S15	Compliance with the SEPSIS6 Care Bundle	AF	JP	All 6 >75% by Q4	QC	Red/ER if Non compliance with Quarterly target	27.0%	<65%	<65%			<75%			AUDIT IN PROGESS									
	S16	Maternal Deaths	AF	IS	0	UHL	Red or ER if >0	3	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
	S17	Emergency C Sections (Coded as R18)	IS	EB	Not within Highest Decile	TDA	Red / ER if Non compliance with monthly target	16.1%	16.5%	18.1%	17.4%	16.2%	17.7%	15.5%	15.8%	15.3%	18.8%	15.8%	15.8%	15.2%	16.5%	20.9%	19.7%	20.9%	17.7%
	S18	Potential under reporting of patient safety indicators	JS	MD	Not within Highest Decile	TDA	Red / ER if Non compliance with monthly target	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	
	S19	Potential under reporting of patient safety indicators resulting in death or severe harm	JS	MD	Not within Highest Decile	TDA	Red / ER if Non compliance with monthly target	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	

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Caring	C1	Inpatients (Including Daycases) Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <95% ER if 2 mths Red	New Indicator	96%	96%	96%	96%	96%	96%	97%	96%	96%	97%	96%	97%	97%	97%	96%	97%	96%
	C2	A&E Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <94% ER if 2 mths Red	New Indicator	96%	96%	96%	96%	96%	96%	97%	96%	96%	96%	96%	97%	95%	95%	97%	95%	96%
	C3	Outpatients Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <90% ER if 2 mths Red	NEW METHODOLOGY FOR CALCULATING %								94%	94%	93%	91%	93%	93%	93%	92%	94%	93%
	C4	Daycase Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <95% ER if 2 mths Red									96%	97%	97%	98%	98%	97%	98%	98%	98%	98%
	C5	Maternity Friends and Family Test - % positive	JS	HL	Q1 95% Q2/3 96% Q4 97%	QC	Red if <94% ER if 2 mths Red		96%	96%	97%	95%	97%	96%	96%	95%	96%	95%	95%	96%	95%	95%	95%	94%	95%
	C6	Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment	LT	LT	Not within Lowest Decile	TDA	TBC	New Indicator	69.2%	Q3 staff FFT not completed as National Survey carried out			71.4%			68.7%			71.9%			Q3 staff FFT not completed as National Survey carried out			70.3%
	C7a	Complaints Rate per 100 bed days	AF	MD	TBC	UHL	TBC	New Indicator	0.4	0.4	0.4	0.3	0.3	0.3	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.2	0.3
	C7b	Written Complaints Received Rate per 100 bed days	AF	MD	Not within Highest Decile	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	
	C8	Complaints Re-Opened Rate	AF	MD	<=12%	UHL	Red if >=15% ER if >=15%	New Indicator	10%	11%	11%	10%	17%	13%	11%	13%	7%	7%	7%	11%	11%	8%	9%	14%	10%
	C9	Single Sex Accommodation Breaches (patients affected)	JS	HL	0	TDA	Red / ER if >0	2	13	0	5	0	1	0	0	0	0	0	0	0	0	0	0	0	0

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W1	Inpatients Friends and Family Test - Coverage (Adults and Children)	JS	HL	30%	TDA	Red if <26% ER if 2mths Red	NEW METHODOLOGY FOR CALCULATING COVERAGE INCLUDES ADULTS AND CHILDREN								29.2%	30.5%	29.0%	27.7%	28.9%	28.9%	37.4%	38.2%	23.2%	29.5%
W2	Daycase Friends and Family Test - Coverage (Adults and Children)	JS	HL	20%	TDA	Red if <8% ER if 2 mths Red	NEW METHODOLOGY FOR CALCULATING COVERAGE INCLUDES ADULTS AND CHILDREN								12.5%	12.1%	15.5%	20.5%	23.8%	24.1%	27.2%	27.7%	18.7%	23.4%
W3	A&E Friends and Family Test - Coverage	JS	HL	20%	TDA	Red if <10% ER if 2 mths Red	NEW METHODOLOGY FOR CALCULATING COVERAGE INCLUDES ADULTS AND CHILDREN								14.7%	14.9%	13.3%	14.1%	13.3%	13.1%	16.1%	12.4%	5.4%	12.5%
W4	Outpatients Friends and Family Test - Coverage	JS	HL	Q1 3% Q2/3 4% Q4 5%	UHL	Red if <2.5% ER Qtrly	NEW METHODOLOGY FOR CALCULATING COVERAGE INCLUDES ADULTS AND CHILDREN								1.3%	1.6%	1.2%	1.2%	1.4%	1.4%	1.5%	1.5%	1.4%	1.4%
W5	Maternity Friends and Family Test - Coverage	JS	HL	30%	UHL	Red if <26% ER if 2 mths Red	25.2%	28.0%	15.8%	21.7%	22.1%	25.8%	46.5%	40.2%	32.3%	35.8%	32.6%	25.6%	30.5%	27.9%	27.2%	38.8%	30.0%	31.1%
W6	Friends & Family staff survey: % of staff who would recommend the trust as place to work	LT	BK	Not within Lowest Decile	TDA	TBC	New Indicator	54.2%	Q3 staff FFT not completed as National Survey carried out			54.9%			52.5%			55.7%			Q3 staff FFT not completed as National Survey carried out			54.0%
W7a	Nursing Vacancies	JS	MM	5% by Mar 16	UHL	Separate report submitted to QAC	NEW UHL INDICATOR		6.7%	6.4%	6.0%	6.3%	5.5%	6.5%	8.5%	8.0%	7.3%	8.7%	8.9%	8.5%	7.1%	7.6%	7.6%	7.6%
W7b	Nursing Vacancies in ESM CMG	JS	MM	5% by Mar 16	UHL	Separate report submitted to QAC	NEW UHL INDICATOR		10.8%	10.7%	9.7%	12.8%	11.4%	14.0%	19.3%	13.0%	14.4%	13.3%	13.5%	13.5%	12.9%	14.6%	14.9%	14.9%
W8	Turnover Rate	LT	LG	Not within Lowest Decile	TDA	Red = 11% or above ER = Red for 3 Consecutive Mths	10.0%	11.5%	10.8%	10.7%	10.3%	10.1%	10.1%	11.5%	10.4%	10.5%	10.5%	10.6%	10.4%	10.4%	10.2%	9.9%	10.0%	10.0%
W9	Sickness absence	LT	KK	3%	UHL	Red if >4% ER if 3 consecutive mths >4.0%	3.4%	3.8%	4.0%	4.0%	4.4%	4.2%	4.1%	4.0%	3.6%	3.4%	3.5%	3.3%	3.2%	3.3%	3.6%	4.0%		3.7%
W10	Temporary costs and overtime as a % of total paybill	LT	LG	TBC	TDA	TBC	New Indicator	9.4%	9.5%	9.0%	9.8%	10.5%	9.8%	11.5%	10.7%	10.2%	11.0%	10.8%	11.1%	9.9%	10.5%	10.5%	10.1%	10.4%
W11	% of Staff with Annual Appraisal	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	91.3%	91.4%	91.8%	92.3%	92.5%	90.9%	91.0%	91.4%	90.1%	88.7%	89.0%	89.1%	88.8%	90.0%	90.4%	91.1%	92.7%	92.7%
W12	Statutory and Mandatory Training	LT	BK	95%	UHL	TBC	76%	95%	86%	87%	89%	89%	90%	95%	93%	92%	92%	91%	91%	91%	92%	92%	93%	93%
W13	% Corporate Induction attendance	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	94.5%	100%	98%	98%	100%	99%	100%	97%	97%	97%	98%	100%	97%	98%	98%	97%	92%	92%
W14a	DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	Not within Lowest Decile	TDA	TBC	New Indicator	91.2%	92.9%	91.3%	92.7%	94.3%	91.8%	91.0%	93.6%	90.3%	91.2%	90.3%	90.2%	90.5%	91.4%	87.2%	91.0%	90.6%
W14b	DAY Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	Not within Lowest Decile	TDA	TBC		94.0%	95.4%	94.4%	95.8%	95.4%	92.8%	92.5%	94.2%	91.2%	93.5%	91.3%	92.4%	93.1%	94.2%	93.2%	93.9%	93.0%
W14c	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	Not within Lowest Decile	TDA	TBC		94.9%	97.4%	96.5%	96.4%	97.9%	96.5%	97.2%	98.9%	96.0%	96.2%	94.3%	94.3%	94.9%	96.1%	91.4%	94.8%	95.2%
W14d	NIGHT Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	Not within Lowest Decile	TDA	TBC		99.8%	100.8%	101.2%	101.4%	103.6%	100.8%	103.2%	106.3%	98.7%	99.4%	101.2%	98.0%	100.0%	99.9%	98.4%	98.0%	100.0%

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Effective

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E1	Mortality - Published SHMI	AF	PR	Within Expected	TDA	Higher than Expected	105	103	105 (Apr13-Mar14)			105 (Jul13-Jun14)			103 (Oct13-Sep14)			99 (Jan14-Dec 14)			98 (Apr14-Mar15)			98
E2	Mortality - Rolling 12 mths SHMI (as reported in HED) Rebased	AF	PR	Within Expected	QC	Red if >expected ER if >Expected or 3 consecutive mths increasing SHMI >100	105	98	101	100	99	99	98	98	98	96	95	95	96	95	Awaiting HED Update			95
E3	Mortality HSMR (DFI Quarterly)	AF	PR	Within Expected	TDA	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	88	94	93			93			89			84			Awaiting DFI Update			86
E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	AF	PR	Within Expected	QC	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	99	94	95	94	94	95	95	94	94	93	93	93	93	93	93	Awaiting HED Update		93
E5	Mortality - Monthly HSMR (Rebased Monthly as reported in HED)	AF	PR	Within Expected	QC	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	91	94	95	88	95	99	98	86	82	95	99	83	92	100	100	Awaiting HED Update		93
E6	Mortality - HSMR ALL Weekend Admissions - (DFI Quarterly)	AF	PR	Within Expected	QC	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	96	100	96			106			97			81			Awaiting DFI Update			89
E7	Crude Mortality Rate Emergency Spells	AF	PR	Within Upper Decile	TDA	TBC	2.5%	2.4%	2.1%	2.3%	3.0%	3.1%	2.7%	2.4%	2.1%	2.0%	2.3%	1.8%	2.0%	2.2%	2.4%	2.1%	2.4%	2.2%
E8	Deaths in low risk conditions (Risk Score)	AF	PR	Within Expected	TDA	Red if >expected ER if >Expected or 3 consecutive increasing mths >100	94	80	111	59	84	100	86	74	120	20	37	38	102	95	Awaiting DFI Update			68
E9	Emergency readmissions within 30 days following an elective or emergency spell	AF	JJ	Within Expected	UHL	Red if >7% ER if 3 consecutive mths >7%	7.9%	8.5%	8.6%	8.9%	9.1%	8.2%	8.5%	8.5%	9.2%	9.1%	9.0%	8.8%	8.9%	8.7%	9.0%	8.3%		8.9%
E10	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	AF	RP	72% or above	QS	Red if <72% ER if 2 consecutive mths <72%	65.2%	61.4%	69.6%	59.4%	57.3%	57.9%	67.2%	61.5%	55.7%	42.6%	70.1%	60.3%	78.1%	72.0%	60.0%	70.9%	59.7%	63.7%
E11	Stroke - 90% of Stay on a Stroke Unit	RM	IL	80% or above	QS	Red if <80% ER if 2 consecutive mths <80%	83.2%	81.3%	69.4%	72.4%	74.3%	82.5%	87.6%	81.5%	83.7%	84.5%	84.5%	85.7%	90.9%	86.9%	81.1%	83.5%		85.2%
E12	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%	64.2%	71.2%	67.8%	69.0%	83.5%	80.6%	64.0%	77.3%	86.3%	79.6%	72.0%	78.9%	80.2%	88.1%	73.3%	67.1%	68.4%	76.8%
E13	Published Consultant Level Outcomes	AF	SH	>0 outside expected	QC	Red if >0 Quarterly ER if >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
E14	Non compliance with 14/15 published NICE guidance	AF	SH	0	QC	Red if in mth >0 ER if 2 consecutive mths Red	New Indicator for 14/15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
E15	ROSC in Utstein Group	AF	PR	TBC	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	
E16	STEMI 150minutes	AF	PR	TBC	TDA	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	

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

Responsive

KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	YTD
R1	ED 4 Hour Waits UHL + UCC (Calendar Month)	RM	IL	95% or above	TDA	Red if <92% ER via ED TB report	88.4%	89.1%	89.8%	89.1%	83.0%	90.7%	89.6%	91.1%	92.0%	92.2%	92.6%	92.2%	90.6%	90.3%	88.9%	81.7%	85.1%	89.5%
R2	12 hour trolley waits in A&E	RM	IL	0	TDA	Red if >0 ER via ED TB report	5	4	1	0	0	1	0	0	0	0	0	0	0	0	0	1	1	2
R3	RTT - Incomplete 92% in 18 Weeks	RM	WM	92% or above	TDA	Red /ER if <92%	92.1%	96.7%	94.8%	95.0%	95.1%	95.2%	96.2%	96.7%	96.6%	96.5%	96.2%	95.2%	94.3%	94.8%	93.6%	93.8%	93.0%	93.0%
R4	RTT 52 Weeks+ Wait (Incompletes)	RM	WM	0	TDA	Red /ER if >0	0	0	3	2	0	0	0	0	0	66	242	256	258	260	265	263	267	267
R5	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	TDA	Red /ER if >1%	1.9%	0.9%	0.7%	1.8%	2.2%	5.0%	0.8%	0.9%	0.8%	0.6%	6.1%	10.9%	13.4%	9.6%	7.7%	6.5%	7.0%	7.0%
R6	Urgent Operations Cancelled Twice	RM	PW	0	TDA	Red if >0 ER if >0	0	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	PW	0	TDA	Red if >2 ER if >0	85	33	2	0	3	4	3	1	2	0	1	1	5	1	0	3	10	23
R8	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	RM	PW	0	TDA	Red if >2 ER if >0	New Indicator for 14/15	11	0	1	1	2	1	0	0	0	1	0	0	0	0	0	0	1
R9	% Operations cancelled for non-clinical reasons on or after the day of admission UHL	RM	PW	0.8% or below	Contract	Red if >0.9% ER if >0.8%	1.6%	0.9%	0.8%	1.2%	1.1%	0.8%	0.7%	1.0%	0.7%	0.5%	0.9%	1.3%	0.7%	0.9%	0.8%	1.3%	1.1%	0.9%
R10	% Operations cancelled for non-clinical reasons on or after the day of admission ALLIANCE	RM	PW	0.8% or below	Contract	Red if >0.9% ER if >0.8%	1.6%	0.9%	1.0%	0.0%	0.8%	1.4%	0.0%	0.4%	1.2%	1.2%	1.0%	0.8%	--	1.0%	1.1%	--	1.1%	0.8%
R11	% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	0.8% or below	Contract	Red if >0.9% ER if >0.8%	New Indicator for 14/15	0.9%	0.8%	1.1%	1.1%	0.8%	0.7%	0.9%	0.8%	0.6%	0.9%	1.3%	0.7%	0.9%	0.8%	1.2%	1.1%	0.9%
R12	No of Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	N/A	UHL	TBC	1739	1071	94	108	102	85	64	98	79	56	97	138	67	104	91	131	115	878
R13	Outpatient Hospital Cancellation Rates	RM	PW	Within Upper Decile	UHL	TBC	NEW TDA INDICATOR - DEFINITION TO BE CONFIRMED																	
R14	Delayed transfers of care	RM	PW	3.5% or below	TDA	Red if >3.5% ER if Red for 3 consecutive mths	4.1%	3.9%	4.6%	5.2%	3.9%	3.2%	2.9%	1.8%	1.2%	1.0%	1.0%	0.9%	1.2%	1.3%	1.1%	1.5%	1.6%	1.2%
R15	NHS e-Referral (formally Choose and Book Slot Unavailability)	RM	WM	4% or below	Contract	Red if >4% ER if Red for 3 consecutive mths	13%	21%	20%	17%	16%	13%	19%	26%	34%	31%	Data Not Available							
R16	Ambulance Handover >60 Mins (CAD+ from June 15)	RM	PW	0	Contract	Red if >0 ER if Red for 3 consecutive mths	New Indicator for 14/15	5%	5%	6%	10%	6%	11%	9%	6%	7%	7%	8%	9%	18%	22%	27%	16%	13%
R17	Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)	RM	PW	0	Contract	Red if >0 ER if Red for 3 consecutive mths	New Indicator for 14/15	19%	25%	23%	25%	21%	21%	22%	22%	21%	17%	17%	17%	25%	26%	26%	23%	22%

Responsive Cancer

KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	14/15 Outturn	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	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	MM	93% or above	TDA	Red if <93% ER if Red for 2 consecutive mths	94.8%	92.2%	92.5%	93.0%	92.2%	93.5%	91.5%	91.2%	87.9%	91.1%	87.4%	86.8%	87.7%	89.9%	92.4%	**	89.3%
RC2	Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	RM	MM	93% or above	TDA	Red if <93% ER if Red for 2 consecutive mths	94.0%	94.1%	100.0%	93.0%	92.5%	91.5%	96.0%	99.0%	98.8%	87.2%	93.3%	98.7%	94.5%	94.6%	89.4%	**	94.2%
RC3	31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	RM	MM	96% or above	TDA	Red if <96% ER if Red for 2 consecutive mths	98.1%	94.6%	92.5%	95.2%	91.7%	95.0%	97.0%	93.9%	97.9%	93.7%	97.2%	96.5%	94.7%	95.2%	95.5%	**	95.6%
RC4	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	RM	MM	98% or above	TDA	Red if <98% ER if Red for 2 consecutive mths	100.0%	99.4%	100.0%	96.7%	100.0%	100.0%	100.0%	100.0%	100.0%	97.7%	100.0%	98.3%	100.0%	100.0%	100.0%	**	99.5%
RC5	31-Day Wait For Second Or Subsequent Treatment: Surgery	RM	MM	94% or above	TDA	Red if <94% ER if Red for 2 consecutive mths	96.0%	89.0%	82.4%	80.3%	89.2%	94.4%	87.5%	86.3%	92.2%	89.6%	92.2%	81.1%	89.7%	90.7%	76.6%	**	87.0%
RC6	31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	RM	MM	94% or above	TDA	Red if <94% ER if Red for 2 consecutive mths	98.2%	96.1%	94.7%	95.5%	87.6%	99.0%	100.0%	86.3%	98.1%	96.5%	95.9%	99.0%	92.2%	94.0%	95.0%	**	94.9%
RC7	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	RM	MM	85% or above	TDA	Red if <85% ER if Red in mth or YTD	86.7%	81.4%	77.0%	84.8%	79.3%	78.9%	83.8%	75.7%	70.1%	84.2%	73.7%	81.7%	77.2%	77.0%	82.5%	**	77.8%
RC8	62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	RM	MM	90% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	95.6%	84.5%	94.4%	93.8%	88.9%	79.4%	89.3%	91.7%	82.4%	93.3%	95.2%	97.1%	81.4%	96.2%	96.2%	**	91.7%
RC9	Cancer waiting 104 days	RM	MM	0	TDA	TBC	NEW TDA INDICATOR							12	10	12	20	12	12	17	13	23	23

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)	13/14 Outturn	14/15 Outturn	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	YTD
RC10	Brain/Central Nervous System	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	100.0%	--	--	--	--	--	--	--	100.0%	--	--	--	--	--	--	**	100.0%
RC11	Breast	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	96.1%	92.6%	81.8%	100.0%	93.3%	97.4%	98.1%	92.3%	96.8%	97.8%	91.4%	96.3%	97.5%	92.0%	100.0%	**	95.6%
RC12	Gynaecological	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	88.2%	77.5%	75.0%	66.7%	54.5%	91.7%	75.0%	64.3%	55.6%	66.7%	100.0%	72.2%	80.0%	84.6%	80.0%	**	74.7%
RC13	Haematological	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	65.9%	66.5%	73.3%	75.0%	66.7%	50.0%	80.0%	50.0%	55.0%	83.3%	37.5%	82.6%	66.7%	70.0%	50.0%	**	62.3%
RC14	Head and Neck	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	65.4%	69.9%	33.3%	77.8%	70.0%	87.5%	62.5%	75.0%	54.5%	66.7%	36.4%	60.9%	50.0%	75.0%	42.9%	**	55.3%
RC15	Lower Gastrointestinal Cancer	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	71.3%	63.7%	62.5%	92.9%	65.0%	46.7%	63.2%	63.6%	55.6%	93.3%	63.6%	60.0%	38.9%	70.6%	68.2%	**	63.8%
RC16	Lung	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	89.7%	69.9%	64.1%	74.4%	67.7%	74.2%	88.6%	84.6%	50.9%	74.6%	81.8%	70.4%	73.5%	65.2%	88.6%	**	72.0%
RC17	Other	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	78.7%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100%	100%	100%	100%	50.0%	60.0%	80.0%	**	71.9%
RC18	Sarcoma	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	82.9%	46.2%	0.0%	0.0%	100.0%	--	0.0%	66.7%	--	100%	--	--	80.0%	50.0%	--	**	75.0%
RC19	Skin	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	96.8%	96.7%	98.4%	94.1%	100.0%	94.3%	95.6%	91.7%	94.0%	91.3%	93.8%	94.1%	96.7%	91.1%	95.6%	**	93.5%
RC20	Upper Gastrointestinal Cancer	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	72.2%	73.9%	64.7%	68.0%	85.7%	77.8%	81.8%	66.7%	55.0%	84.6%	51.4%	81.8%	45.7%	48.6%	84.6%	**	62.9%
RC21	Urological (excluding testicular)	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	89.3%	82.6%	81.5%	85.7%	83.3%	66.7%	71.0%	62.1%	62.1%	74.7%	61.5%	86.1%	80.4%	80.0%	76.7%	**	73.7%
RC22	Rare Cancers	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	92.3%	84.6%	100.0%	100.0%	100.0%	66.7%	100.0%	--	100%	100%	100%	100.0%	100.0%	100.0%	100.0%	**	100%
RC23	Grand Total	RM	MM	85% or above	TDA	Red if <90% ER if Red for 2 consecutive mths	86.7%	81.4%	77.0%	84.8%	79.3%	78.9%	83.7%	75.7%	70.1%	84.2%	73.7%	81.7%	77.2%	77.0%	82.5%	**	77.8%

Compliance Forecast for Key Responsive Indicators

Standard	December/actual predicted	January predicted	Month by which to be compliant	RAG rating of required month delivery	Commentary
Emergency Care					
4+ hr Wait (95%) - Calendar month	85.1%		Mar-16		Final figure.
Ambulance Handover (CAD+)					
% Ambulance Handover >60 Mins (CAD+)	16%		Not Confirmed		A protocol has been agreed between UHL and EMAS which includes what happens when patients are held on ambulances and arrangements for a pre-handover cohorting arrangement when there are serious delays.
% Ambulance Handover >30 Mins and <60 mins (CAD+)	23%		Not Confirmed		
RTT (inc Alliance)					
Incomplete (92%)	93.0%	92.0%			
Diagnostic (predicted)					
DM01 - diagnostics 6+ week waits (<1%)	7.0%	4.0%	Mar-16		Gastro backlog and 3 MRI machines unexpected downtime during December. Plans are in place to increase MRI during January.
# Neck of femurs					
% operated on within 36hrs - admissions (72%)	60%	65%			Missing target due to high number of frailty patients. A review of what is included or excluded from the baseline is underway.
Cancelled Ops (inc Alliance)					
Cancelled Ops (0.8%)	1.1%	1.0%	Feb-16		December target missed due to increased emergency pressures.
Not Rebooked within 28 days (0 patients)	10	8	Feb-16		Result of high level of cancellations in November
Cancer (predicted)					
Two Week Wait (93%)	93%	93%	Dec-15		
31 Day First Treatment (96%)	85%	90%	Mar-16		Delivery rephased.
31 Day Subsequent Surgery Treatment (94%)	90%	78%	Mar-16		Delivery rephased.
62 Days (85%)	85%	80%	Jun-16		The rephasing of delivery has been revised to June 2016, given the challenge we and other centres are experiencing and the backlog not being where we need it to be. Nationally this target hasn't been achieved since April 2014.
Cancer waiting 104 days (0 patients)	23	15			

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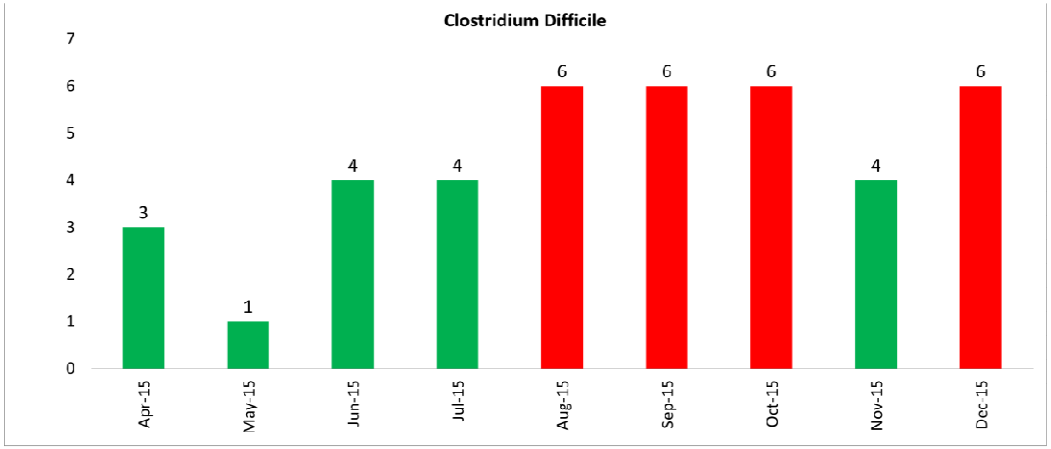
Research UHL

KPI Ref	Indicators	Board Director	Lead Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	YTD
RU1	Median Days from submission to Trust approval (Portfolio)	AF	NB	TBC	TBC	TBC	3.0		2.0			3.0			3.0			2.8	2.0			1.0			2.0			1.0
RU2	Median Days from submission to Trust approval (Non Portfolio)	AF	NB	TBC	TBC	TBC	2.0		3.5			2.0			1.0			2.1	4.0			1.0			1.0			1.0
RU3	Recruitment to Portfolio Studies	AF	NB	Aspirational target=10920/year (910/month)	TBC	TBC	1092	963	1075	1235	900	1039	1048	604	1030	1043	1298	12564	1078	869	1165	999	862	1004	1368	1306		8651
RU4	% Adjusted Trials Meeting 70 day Benchmark (data sunbmitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC	(Jul13-Jun14) 43.4%		(Oct13-Sep14) 70.5%			(Nov13-Dec14) 70.5%			(Apr14-Mar15) 86%				(Jul14-Jun15) 76%			(Oct14-Sep15) 92%						92%
RU5	Rank No. Trials Submitted for 70 day Benchmark (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC	(Jul13-Jun14) Rank 17/61		(Oct13-Sep14) Rank 18/60			(Nov13-Dec14) Rank 18/59			(Apr14-Mar15) Rank 60/198				(Jul14-Jun15) Rank 108/210			(Oct14-Sep15) Rank 13/215						Rank 13/215
RU6	%Closed Commercial Trials Meeting Recruitment Target (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC	(Jul13-Jun14) 50%		(Oct13-Sep14) 52%			(Nov13-Dec14) 48%			(Apr14-Mar15) 38.6%				(Jul14-Jun15) 15.3%			(Oct14-Sep15) 46.8%						46.8%

Clostridium Difficile

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
The cases of CDT are currently subject to Post Infection Reviews.	Any learning following the outcome of the PIRs should be presented to the CMG Infection Prevention Groups and should follow the PIR process flow chart as described in the Infection Prevention Toolkit. Action plans with named local leads will be produced if the PIR feels action is required to reduce further cases.	**5**	**6**	**40**	**5**

	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Trajectory 15/16	*5*	*5*	*5*	*5*	*5*	*5*	*5*	*5*	*5*	*6*	*5*	*5*	*61*
Actual Infections 15/16	3	1	4	4	6	6	6	4	6				**40**

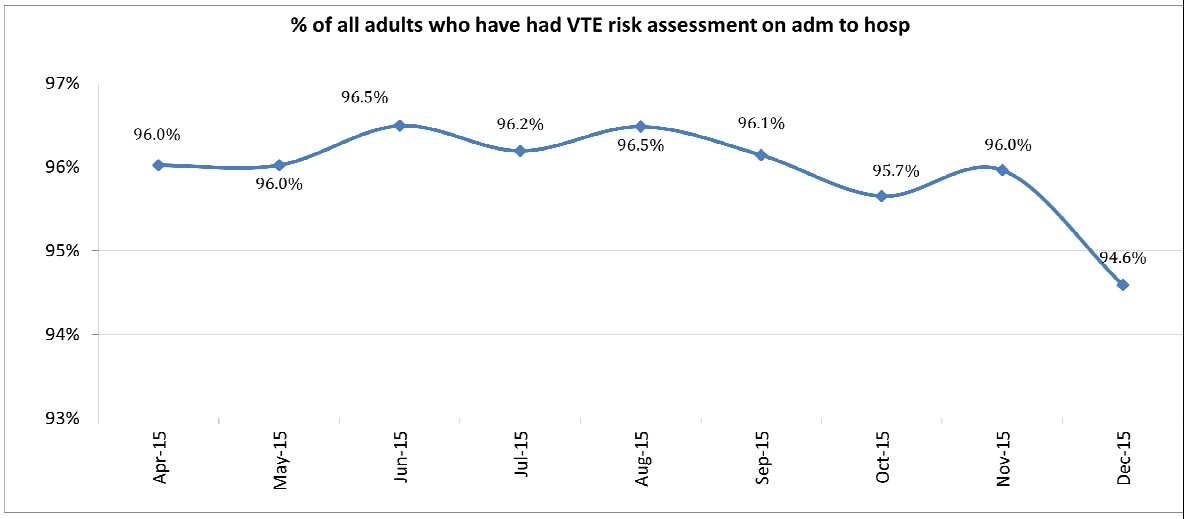


Expected date to meet monthly target	January 2016
Lead Director / Lead Officer	Julie Smith, Chief Nurse Liz Collins, Lead Nurse Infection Prevention

% of all adults who have had VTE risk assessment on admission to hospital

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly)	Latest month performance	YTD performance	Forecast performance for next reporting period
VTE risk assessment document completion is under reported on PatientCentre by Wards. The assessment document may or may not have been completed but where no data is entered onto PatientCentre it is automatically reported that the document was not completed. Ward Clerks enter the data. CMGs receive performance information monthly, identifying their most underperforming area(s).	VTE nurse (Simon Rudge) is working with the area facing the greatest challenge in respect of VTE risk assessment completion and data entry (GH CDU). A method has been devised which will act as a prompt to both clinicians (to complete the assessment) and Ward Clerks (to enter the data). SR awaiting agreement of relevant parties to implement the process. It may be possible that remedial work by SR in conjunction with medical records will regain achievement of the performance target for December 2015, however the time scale in which to achieve this is short therefore success is not certain.	95%	94.6%	95.9%	≥95%

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	YTD
% of all adults who have had VTE risk assessment on adm to hosp	96.0%	96.0%	96.5%	96.2%	96.5%	96.1%	95.7%	96.0%	94.6%	95.9%



Expected date to meet standard / target	January 2016
Revised date to meet standard	
Lead Director / Lead Officer	Andrew Furlong, Interim Medical Director Simon Rudge, Nurse Specialist

Outpatients Friends and Family Test – Coverage

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	December 2015 performance	YTD performance	Forecast performance for next reporting period
A clear system for the collection of Friends and Family test results has been established within the three main outpatients' departments as well as the majority of all stand-alone clinic facilities. Staff within these departments have been cited to the coverage requirements, to ensure success: Underperformance is due to: • CMGs current focus on achieving FFT in inpatient, day case and Emergency facilities to achieve Quality Schedule and external reporting • Gaining engagement and ownership across all staff groups in department • Review of Clinic Clerk activity and resource to ensure staff have time to direct patients to the touch screens to complete the Friends and Family Test	Senior Management Teams have been highlighted to results and asked to increase coverage respond directly to patient feedback at clinic level. Main clinic visited weekly to identify areas of concern and requiring action. Feedback highlighted to Clinical Management Groups through Nursing Executive Team and Executive Quality Board. Presently exploring the feasibility of alternative methods of feedback collection	**Q1 – 3%** **Q2/3 – 4%** **Q4 – 5%**	**1.4%**	**1.4%**	**2.0%**

CMG	% coverage		
	Oct-15	Nov-15	Dec-15
CHUGGS	0.4%	0.9%	1.3%
CSI	1.0%	0.7%	0.6%
ESM	0.6%	0.2%	0.4%
ITAPS	4.6%	5.2%	4.6%
MSKSS	2.9%	3.6%	2.8%
RRCV	2.1%	2.1%	2.2%
WC	0.7%	0.3%	0.4%
The Alliance	1.3%	1.0%	1.4%

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	YTD
Outpatients Friends and Family Test - Coverage	1.3%	1.6%	1.2%	1.2%	1.4%	1.4%	1.5%	1.5%	1.4%	1.4%

Expected date to meet standard / target	Quarter 1 2016/17
Lead Director / Lead Officer	Heather Leatham, Assistant Chief Nurse

Emergency Readmissions within 30 days

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Novembers performance	YTD performance	Forecast performance for next reporting period
UHL's readmission rate has increased during 15/16 and when compared with other Trusts (using the Dr Foster tool) our 'risk adjusted readmission rate' has been higher than expected for the past 3 years.	On 11 January we will start a 3-month pilot of the Readmissions Risk Tool (PARR30). The pilot will run in all adult in-patient areas (excluding maternity) and there will be a daily report of patients with more than a 50% risk of readmission. There will be a preliminary review by Specialist Discharge/ Primary Care co-ordinator Teams with Re-ablement Teams in the City (ICRS) and hopefully County and Rutland (REACH/HART) providing 'post discharge check' telephone calls and visits. All Clinical Teams need to ensure effective discharge planning/ communication/ letters.	**Within Expected**	**8.3%**	**8.9%**	**9.0%**

UHL'S READMISSION RATE 12/13 to 14/15 (as measured by Dr Foster Intelligence)

F/Y	Super Spells	Observed	Rate (%)	Relative Risk
2012/13	220024	17414	7.91	103.15
2013/14	220346	17294	7.85	102.45
2014/15	242563	20418	8.42	106.39

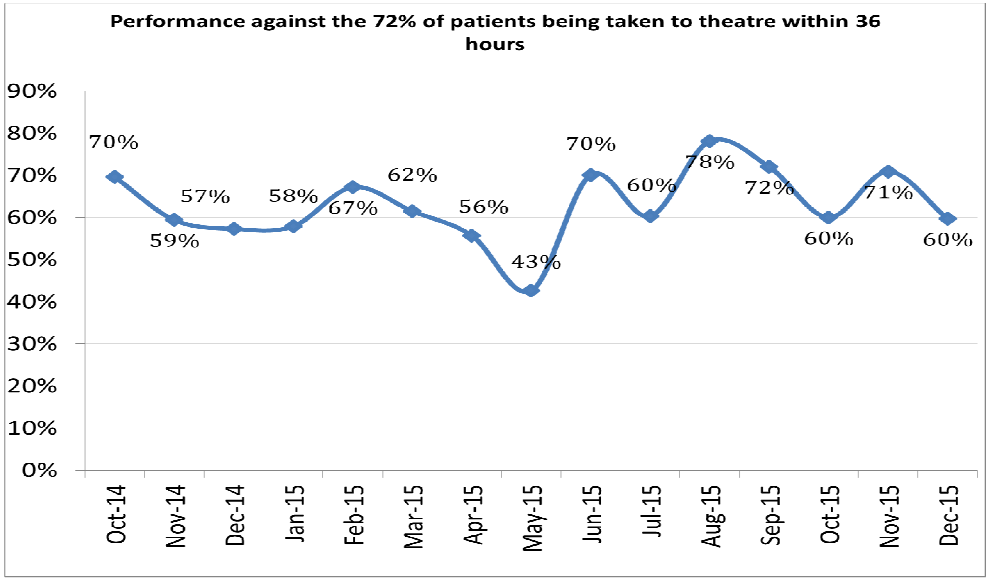
UHL'S READMISSION RATE FOR 14/15 COMPARED WITH OTHER TRUSTS

TRUST	Discharges	ReAdm	%	RELATIVE RISK
University Hospitals Bristol NHS Foundation Trust	130778	8446	6.46	88.51
Leeds Teaching Hospitals NHS Trust	191790	14650	7.64	95.14
Central Manchester University Hospitals	178044	12541	7.04	97.02
Coventry and Warwickshire NHS Trust	147190	11849	8.05	98.92
South Tees Hospitals NHS Foundation Trust	153427	12636	8.24	100.65
Oxford University Hospitals NHS Trust	198372	14779	7.45	102.77
Nottingham University Hospitals NHS Trust	204619	18603	9.09	103.06
University Hospitals Birmingham NHS Foundation	108166	10330	9.55	105.23
University Hospitals Of Leicester NHS Trust	**242268**	**20375**	**8.41**	**106.4**
University Hospital Of North Staffordshire NHS	176781	16220	9.18	106.77
Sheffield Teaching Hospitals NHS Foundation	221048	18764	8.49	111.66
University Hospital Southampton NHS Foundation	134319	12991	9.67	112.74

Expected date to meet standard / target	TBC - following implementation of actions.
Lead Director / Lead Officer	Andrew Furlong, Interim Medical Director John Jameson, Interim Deputy Medical Director

No. of # Neck of femurs operated on < 36 hrs

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance FY 15/16	Forecast performance for next reporting period
There were 72 NOF admissions in December 2015, 22 patients breached the 36 hr target to theatre as detailed below:- Medically Unfit – 16pts List over ran therefore pt cancelled Weekend – 1pt Required specific Hip surgeon to perform op – 1 pt Xmas / NY Consultants decision -3 pts Higher priority pt – 1 pt There was also an increased number of patients who are included in the denominator who did not have surgery in their pathway / RIP'd Dec saw 2 occasions where high numbers of NOF patients were admitted on one day 18th Dec = 6 NOF's 24th Dec = 6 NOF's Increased number of patients admitted who were not clinically fit for surgery despite ortho geri intervention. These patients were frail and vulnerable on admission and required extensive stabilisation. OG services stretched to capacity and no backfill when pulled to medicine.	It has been agreed that #NOF will be supported corporately by Director of Performance and Information. The Chief Resident / Trauma schedulers/Clinical aides are now all in post. Additional anaesthetic PA's have been scheduled to provide pre op assessment. New prioritisation pathways and check lists have been implemented. Breach dates of patients now included on theatre lists and on ORMIS by schedulers. Theatre utilisation is being tracked monthly to optimise usage and reduce downtime between cases. Raised via CMG board OG cover and gaps in service. Definitions are under review.	**72.0%**	**59.7%**	**63.7%**	**65% due to pts frailty**



Performance by Month for 15/16

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	YTD
No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	55.7%	42.6%	70.1%	60.3%	78.1%	72.0%	60.0%	70.9%	59.7%	63.7%

Revised date to meet standard	Quarter 4 2015/16
Lead Director / Lead Officer	Richard Power, MSS CD Sarah Taylor, Head of Operations

52 week breaches (incompletes)

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>December performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="4">The Trust had 267 patients on an incomplete pathway that breached 52 weeks at the end of December 2015. All patients were from the Orthodontics Department.

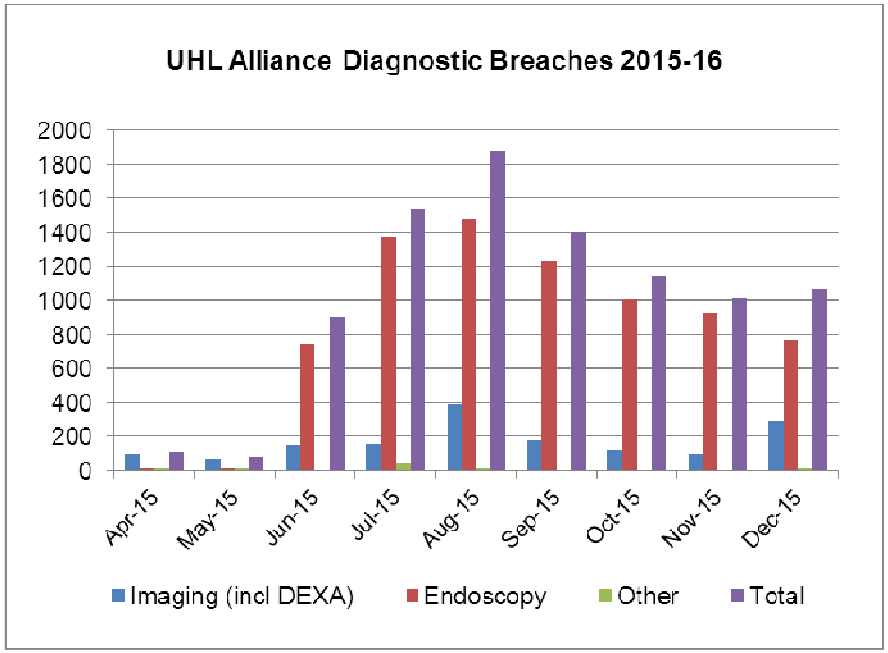
The reasons for underperformance in Orthodontics are as follows:
Incorrect use and management of a planned waiting list for outpatients.
Inadequate capacity within the service to see patients when they are ready for treatment.
An additional 3 patients will become 52 week breaches by the end of January 2016.</td><td rowspan="4">The service is now closed to new referrals with some clinical exceptions. Adherence to this is being monitored by the Director of Performance and Information.
Funding has been secured from NHS England for 2 WTE locums to clear the backlog. So far, recruitment attempts have been unsuccessful.
The Serious Untoward Incident (SUI) report was recently published. Recommendations included a clearly defined SOP to be put in place for the administration of planned waiting lists and that all administrative and clinical staff running outpatient clinics should have RTT e-learning training.
UHL are exploring capacity for Orthodontics patients within both local community and acute providers. Around 24 patients will transfer to Northampton General Hospital, approximately 20 are expected to be treated at Oakham Dental Studio. There have been some complications with the transfer of patients to Clearly Orthodontics due to consultant sickness. Additional capacity is being explored with Hallcross Dental, No. 1 Practice Stoneygate, United Lincolnshire Hospitals NHS Trust and Ramsay Healthcare
Resolution to this ongoing problem is being led by the Chief Executive, NHSE and the TDA</td><td>0</td><td>267</td><td>267</td><td>270</td></tr>
<tr><td colspan="4">The problem which surfaced in Orthodontics has prompted a deliberate, Trust-wide review of planned waiting lists at specialty level. Therefore the following actions have been taken Trust-wide:
Communication around planned waiting list management to all relevant staff;
System review of all waiting list codes;
All General Managers and Heads of Service have signed a letter confirming review and assurance of all waiting lists, to be returned to Richard Mitchell;
Weekly review at Heads of Ops meeting for assurance;
Performance team to review all waiting list code returns and identify areas of risk.</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">TBC</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Richard Mitchell, Chief Operating Officer
Will Monaghan, Director of Performance and Information</td></tr>
</table>

6 Week Diagnostic Test Waiting Times

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>Latest month performance (UHL Alliance)</th><th>YTD performance (UHL Alliance)</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="3">Imaging
3 of the MRI scanners were down for a significant number of days in December. Astral, who service the machines, were unable to provide an MRI van to cover the gap in service, meaning 243 MRI patients breached six weeks at the end of the month. As a result of the impact of this down time, there is likely to be 100-150 MRI breaches at the end of January as the Imaging department recovers its position. There were also 17 CT breaches and 28 non-obstetric ultrasound breaches at the end of December.

Endoscopy
An issue with planned waiting lists in Endoscopy surfaced in May 2015. There were 764 breaches for December 2015 across flexible sigmoidoscopy, gastroscopy and colonoscopy, an improvement of 154 from the November position. Capacity and demand review in Endoscopy has identified that the Trust is short of approximately 8-10 lists per week.</td><td rowspan="3">Imaging
Machine stability remains an issue; all extra capacity is being utilised in MRI to minimise the number of breaches. An MRI van will be on site for eight days in January, extra sessions have been arranged and some outpatient sessions up to midnight may be reinstated. Approximately 100 MRIs are being sent to Nuffield each month.

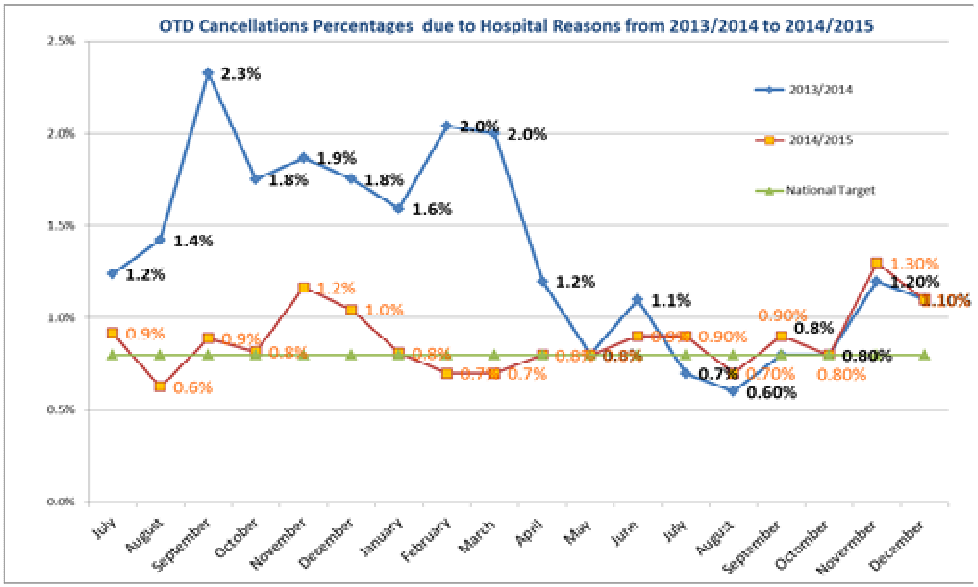
Endoscopy
The Trust is working with a number of Independent Sector providers to obtain extra capacity, including Medinet, Your World Doctors and Nuffield. Your World Doctors are also backfilling lists during the week, which would otherwise be cancelled.

The extra capacity is complemented by a robust action plan addressing general performance issues in the service, with particular focus on ensuring that all lists are fully booked and efforts to improve cancer performance via access to Endoscopy tests. There has also been a management review in the department and a General Manager has been appointed to focus solely on the service, in post since early September. The Trust invited the IST to assist with capacity analysis; this has confirmed the shortfall that exists. In addition NHSIQ have been working in the endoscopy units alongside our teams on process improvements.</td><td><1%</td><td>7.0%</td><td>7.0%</td><td>4%</td></tr>
<tr><td colspan="4">The following graph outlines the total number of diagnostic breaches per month for 15-16:
 
</td></tr>
<tr><td colspan="4"><table>
<tr><td>Expected date to meet standard / target</td><td>March 2016</td></tr>
<tr><td>Lead Director / Lead Officer</td><td>Richard Mitchell, Chief Operating Officer
Suzanne Khalid, Clinical Director CSI</td></tr>
</table></td></tr>
</table>

Cancelled patients not offered a date within 28 days of the cancellations

INDICATORS: The cancelled operations target comprises of three components: 1. The % of cancelled operations for non-clinical reasons On The Day (OTD) of admission **2**.The number of patients cancelled who are offered another date within 28 days of the cancellation

What is causing underperformance?	What actions have been taken to improve performance?	Target (monthly)	Latest month December 15	YTD performance (inc Alliance)	Forecast performance for next reporting period
The OTD cancellation in December was 1.1% (105). The Alliance recorded 10 cancellations for this month (1.1%). The five main reasons for cancellations were: • Lack of theatre time due to list over runs (31) • Adult Critical care bed Unavailability (22) • Patient delayed to admission of a higher priority patient(18) • Ward bed unavailability (8) • Theatre and Anaesthetic staff unavailability (11). During this month, 50 operations were cancelled due to capacity pressures in UHL. This is a significantly higher number of OTDO cancellation compared to October. This month capacity pressures mainly impact on adult critical care services. This was caused mainly by increase in emergency admissions. Due to the adult critical pressures capacity pressures it is likely that we will see around eight 28 day breaches next month.	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 high numbers of emergency admissions are a significant risk to OTD cancellations and 28 day rebooking of patients. The availability of beds, particularly those in ITU is monitored daily and interventions will be made where necessary. A request to open an additional 6 ITU beds asap is currently being processed. Theatre managers have increased theatre capacity for the increased cancer demand by making additional lists available to reduce 28 breaches. The ITAPS and CHUGGS Senior Managers are working together to improve theatre capacity in the long term.	1) 0.8% 2) 0	1)1.1 (1.1% UHL & 1.1% Alliance) 2) 10 (4 -Gen Sur, 2 - paed Sur, 1- paed ENT, 1- paed Plastics, 2 - ENT)	1) 0.9% (0.9% - UHL & 0.8% Alliance) 2) 24	1) 1.0 % 2) 8



Expected date to meet standard / target	On the day – February 2016 28 day – February 2016
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Phil Walmsley. Head of Operations, ITAPS

NHS e-Referral System (formerly known as Choose and Book)

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>Latest month performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="5">The Trust is measured on the % of Appointment Slot Unavailability (ASI) per month.

UHL has not met the required standard of <4% for approximately two years. When it has been able to reach this standard, it has not been sustainable.

The two most significant factors causing underperformance are:
• Shortage of outpatient capacity;
• Inadequate training and education of administrative staff in the set up and use of the NHS e-Referral System (ERS).

The specialties with the highest number of ASIs are:
• General Surgery;
• Orthopaedics;
• Paediatric and Adult ENT;
• Gastroenterology;
• Gynaecology.</td><td rowspan="5">Action plan
• An action plan has been written outlining steps for recovering performance. This has been shared with commissioners.

Capacity
• Additional capacity in key specialties is part of RTT recovery and sustainability plans.

Training and Education
• Training and education of staff in key specialties continues, to ensure that the system is adequately set up and administrative processes are fit for purpose;
• Meetings are taking place with the specialties experiencing the highest rate of ASIs, focusing on awareness raising and seeking named accountability.
• Current focus is on working with specialties with no known capacity problems, but high ASI rates to raise awareness and promote accountability.

Additional resource to support the e-Referral System
• An ERS administrator has been in post since May;
• She will be working with key specialties to help reduce their ASIs and promote administrative housekeeping.</td><td><4%</td><td>Unable to report</td><td>Unable to report</td><td>No forecast as unable to measure</td></tr>
<tr><td colspan="4">As a result of the significant challenges experienced post-cut over from Choose and Book, the HSCIC have indicated that they will not be releasing weekly ASI data until further notice. A date for publication of these reports has not been confirmed. This means that the Trust is currently unable to track and report on progress in the usual manner.

New Appointment Slot Issue (ASI) Process
In light of the difficulties experienced by services in managing their ASIs on ERS, a new process is being rolled out across all specialties, following a pilot. This process aims to simplify the UHL administrative processes related to ERS as well as promote standardised practice.

Advice and Guidance (A&G)
The Advice and Guidance service within ERS allows a GP to seek clinical advice from a service rather than directly referring into the hospital. Analysis of the last year's A&G requests has found that in 84% of these cases, a referral into UHL is then avoided. This means that of the 460 requests made via A&G, only 68 patients required an outpatient appointment in that specialty. The ERS team is working with specialties including Orthopaedics, Rheumatology, Urology and Respiratory Medicine to expand the number of A&G services available, a local tariff has been agreed for this. A new A&G service for Renal, requested by GPs, went live on 14th January.</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">To be confirmed</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Richard Mitchell, Chief Operating Officer
Will Monaghan, Director of Performance and Information</td></tr>
</table>

Ambulance handover > 30 minutes and>60 minutes

		Target	Dec 15	YTD	Forecast
What is causing underperformance?	What actions have been taken to improve performance?	0 delays over 15 minutes	>60 min - 16% 30-60 min – 23%	>60 min - 13% 30-60 min – 22%	> 60 min - 15% 30-60 min – 20%

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

CCG's, EMAS and UHL have come together to define a valid data set and have arranged a number of audits. They have agreed that patient numbers will be reported and not resources with regard to fines. UHL continue to validate reports.

EMAS have provided further training on CAD+ for crews and this will continue.

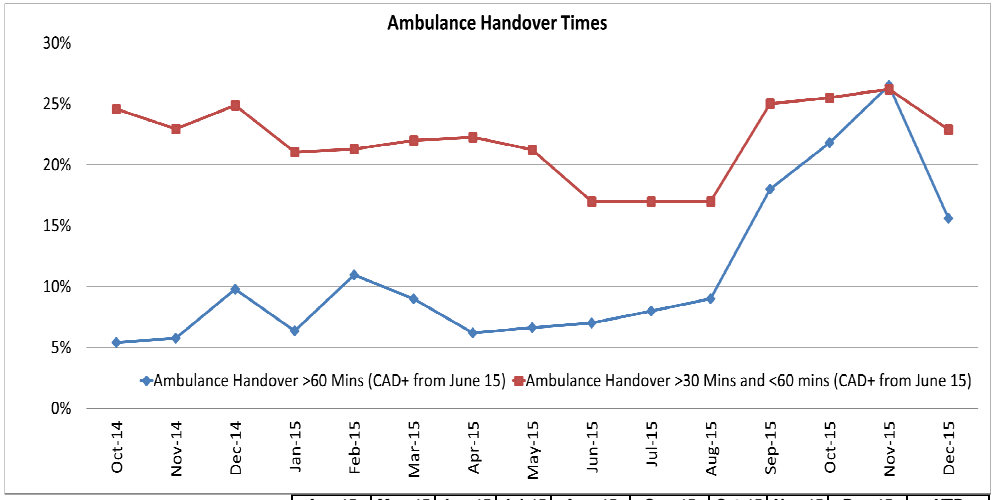
UHL and EMAS are looking for staffing resource to care for patients in the red zones in ED to enable crews to be released earlier to improve handover times. This is in conjunction with other recommendations from the Unipart report.

UHL have implemented a full capacity protocol for the use of areas outside ED when ED is full to enable crews to offload patients and handover.

UHL have put into place a member of staff to triage patients should they be waiting on the back of ambulances to identify the acuity of patients along with EMAS stating their DPS of the patient on booking into ED.

A new escalation protocol which is designed to eliminate 2 hour plus delays as a starting point was put in place in January 2016.

Performance:



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	YTD
Ambulance Handover >60 Mins (CAD+ from June 15)	6%	7%	7%	8%	9%	18%	22%	27%	16%	13%
Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)	22%	21%	17%	17%	17%	25%	26%	26%	23%	22%

Expected date to meet standard	TBC
Revised date to meet standard	TBC
Lead Director	Richard Mitchell, Chief Operating Officer

Cancer Waiting Times Performance

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance November	Performance to date 2015/16	Forecast performance for December
2 week wait 2WW performance remains under target, however is much improved. This standard was failed mainly due to Lower GI; however the Trust expects to achieve in December as the new CT colon pathway embeds. The biggest improvement was seen in Head and Neck, who had 41 fewer patients breaching 2 weeks in November (10). **31 day first treatment** The Trust missed the 31 day first treatment standard due to performance in Gynae, Head and Neck, Lung and Urology. Both Gynae and particularly Urology have a shortage of theatre capacity, which has combined with a higher incidence of cancer in Gynae in recent months. Additionally Head and Neck are short of medical staffing capacity. Despite a number of advertisements for an additional Head and Neck consultant, so far recruitment has been unsuccessful. Lung, which usually achieves this standard, had an increase in breaches due to delays in Oncology and one delay in pathology. **31 day subsequent (surgery)** 31 day subsequent (surgery) was failed predominantly as a result of Urology performance. The main factor is inadequate elective capacity. **62 day RTT** 62 day performance remains below target and has not been achieved nationally since April 2014. Lower/ Upper GI, Lung, Head and Neck, Gynae and Urology remain the most pressured tumour sites. The main pressures on achievement are robust patient pathways and supporting processes, inadequate theatre capacity and shortages in consultant staff.	Current Cancer performance is an area of significant concern across UHL and focus on recovery is of the highest priority within the organisation. Since September, there have been weekly meetings chaired by the COO, attended by the CMG Heads of Ops, where they are required to account for their tumour site performance. **2 week wait** The CT Colon pathway for Lower and Upper GI Cancer patients began in November and the positive impact of this is already being felt, but will continue to embed in December when compliance is expected. More broadly, the Trust is working with CCGs to improve the quality of 2WW referrals, specifically in relation to correct process, use of appropriate clinical criteria, and preparation of patients for the urgency of appointments. Performance in January is expected to take a dip whilst a backlog of 2ww referrals from the Christmas period is resolved, recovery is anticipated in February. **31 day first treatment** Recovery in Gynae, Head and Neck and Urology are key to the achievement of this standard. Head and Neck are currently recruiting a Head and Neck fellow, which will help to support Cancer performance, and continue to advertise for a consultant. Gynae and Urology both have a shortage of theatre capacity; additional long term capacity is in the process of being identified and current arrangements are being complemented by extra sessions/ weekend working. **31 day subsequent (surgery)** Cancer patients are being prioritised over RTT patients. Significant investment in more clinical staff has also been planned, including a nurse specialist in Urology and consultants in Head and Neck and Dermatology. An additional Urology Consultant starts in late January. **62 day RTT** Lower/ Upper GI, Lung, Head and Neck, Gynaecology and Urology remain the most pressured tumour sites. Improvements in Endoscopy and CT colon implementation have started to improve performance in Lower/ Upper GI. Three band 7 service managers with responsibility for managing cancer pathways in our worst performing tumour sites are all in post and are providing the key focus required. Weekly executive scrutiny of 62 day backlog reduction plans was initiated in September, led by the COO. A Remedial Action Plan has been submitted to commissioners; this is updated weekly via the Trust's Cancer action Board and monitored monthly via the joint Cancer and RTT Board. Although predicted performance for this standard for December is much improved, the lead indicator of whether the Trust is resolving the underlying issue is the size of the backlog (patients untreated over 62 days). Unfortunately the backlog has increased over the Christmas period. Clear and revised actions to address the underlying causes are being rapidly developed and implemented.	**2WW (Target: 93%)**	**92.4%**	**89.3%**	**93%**
		31 day 1st (Target: 96%)	**95.5%**	**95.6%**	**85%**
		31 day sub – Surgery (Target: 94%)	**76.6%**	**87.0%**	**90%**
		62 day RTT (Target: 85%)	**82.5%**	**77.8%**	**85%**
		62 day screening (Target: 90%)	**96.2%**	**91.7%**	**95%**
		Taking a straight line extrapolation of cancer activity for the remainder of this year potentially UHL could see increases of: • Two week waits potentially growth of 12.4% i.e., an additional 2,862 with significant growth in Breast, Gynae, Head and Neck, Upper and Lower GI and Skin • 31-Day (Diagnosis To Treatment) Wait For First Treatment potentially growth of 13.2% i.e., 516 more of which 234 of this relates to Urology alone, 107 potentially in Lung and potentially 94 in Skin • 62-Day (Urgent GP Referral To Treatment) Wait For First Treatment potentially growth of 16.9% 335 more of which potentially a further 80 in Urology, 71 Skin and 70 in Lung • Early discussion with commissioners about how to address future growth is being undertaken as part of the capacity planning process			
		Expected date to meet standard / target	2WW: December 2015 31 day sub – Surgery: March 2016 62 day pathway: June 2016		
		Revised date to meet standard			
		Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Matt Metcalfe, Clinical Lead for Cancer		

Cancer Patients Breaching 104 days

What is causing underperformance?

23 Cancer patients on the 62 day pathway breached 104 days at the end of December across seven tumour sites.

Tumour site	Number of patients breaching 104 days
Lung	2
Lower GI	6
Upper GI	3
HPB	1
Urology	7
Breast	1
Gynaecology	3

The following factors have significantly contributed to delays:

Reason	No. patients
Diagnostic delays	4
Patient initiated delays	3
Patient fitness	6
Complex diagnostic pathway	5
Tertiary referral	1
Appointment delays	1
Admin/ process delays	1
Clinical reasons/ complexity	2

What actions have been taken to improve performance?

Current cancer performance is an area of significant concern across UHL and is given the highest priority by the executive and operational teams. Since September, there have been weekly meetings chaired by the Chief Operating Officer, attended by the CMG Heads of Ops, where they are required to account for their tumour site performance.

The number of patients breaching 104 days on a 62 day pathway has risen by 10 from the end of November. This is due to significant numbers of the longest waiters being unfit for surgery, a number of complex diagnostic pathways, as well as patients choosing to wait for treatment after Christmas.

Given the poor 62 day performance specifically in Lung, Lower GI and Urology, three band 7 Cancer Delivery Managers are in post to support them. All three are now in post. This dedicated full-time service management will improve Cancer performance over the medium term.

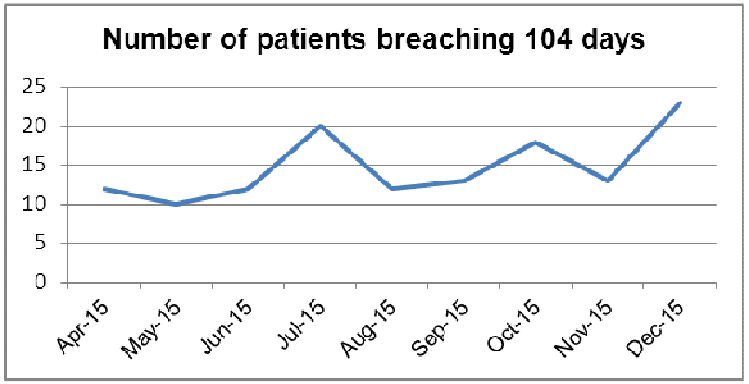
In light of poor performance against the 62 day pathway, the Trust has a remedial action plan for cancer, which is monitored through the Cancer / RTT Board chaired by the City CCG. The plan is based around emerging themes from the first four months' of 62 day breach analysis.

Month by month breakdown of patients breaching 104 days

The table and graph below outline the number of Cancer patients breaching 104 days by month for 15-16:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Pts br. 104d	12	10	12	20	12	12	17	13	23

NB: not all patients confirmed Cancer



NB: all patients breaching 104 days undergo a formal 'harm review' process and these are reviewed by commissioners

Expected date to meet standard / target	N/A
Revised date to meet standard	N/A
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Matt Metcalfe, Clinical Lead for Cancer