Quality & Performance Report

Author: John Adler Sponsor: Chief Executive Date: IFPIC + QAC 29th September 2016

Executive Summary from CEO

Paper O

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** – the latest published SHMI (covering the period January 2015 to December 2015) is **98** – below our Quality Commitment goal of **99**. **Moderate harms and above** – the first 4 reported months continue to show a 60% reduction compared to the same period in 15/16. **Readmission rates** – at 8.3% are within the UHL's threshold of 8.5%, the lowest rate for over 18 months. **RTT** – the RTT incomplete target remains compliant. **Referral to Treatment 52+ week waits –** current number is 57 a reduction of 20 over the last month. However, there remains a risk that there might be more ENT 52+ week waits due to the high level of cancellations and long waits. The **Cancer Two Week Wait** was achieved in July and is expected to remain compliant in August and September. **Delayed transfers of care** remain within the tolerance although delays are twice as high as this time last year. **MRSA** – 0 cases reported this month and the unavoidable MRSA reported in July has been attributed to a third party. **C DIFF** – Although monthly target missed, year to date remains within trajectory. **Pressure Ulcers** – 0 **Grade 4** pressure ulcers reported this year. Although **Grade 3 and Grade 2** added together are within the year to date trajectory, there was a spike of 13 **Grade 2** during August.

Bad News: **ED 4 hour performance** – August performance was slightly improved at 80.1% % with year to date performance at 79.7%. Contributing factors are set out in the Chief Operating Officer's report. **Ambulance Handover 60+ minutes** – performance was 7% in August; this is also examined in detail in the COO's report. **Fractured NOF** – target missed for the second time this year due to the volume and complexity of the spinal surgery activity carried out this month. **Diagnostics** target was missed due to machine down time following an electrical storm. **Cancelled operations** and **patients rebooked within 28 days** – continue to be non-compliant, due to ITU/HDU and emergency pressures. **Cancer Standards 62 day treatment** - it is deeply disappointing to no longer be able to predict compliance with the 62 day standard

in September, due principally to cancellations caused by lack of ITU/HDU capacity and emergency pressures. Whilst we are making progress in reducing the backlog it is clear we still have more to do in this area. **Patient Satisfaction (FFT)** dipped to 96% for Inpatients and Day Cases. **Patient Satisfaction (FFT)** for ED remains at an all-time low of 87% during August. **ED FTT coverage** remains below the threshold of 20%. An exception report for both the ED FTT patient satisfaction and coverage is included in the Q&P report.

Input Sought

I recommend that the Committee:

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

For Reference

Edit as appropriate:

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

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

2. This matter relates to the following governance initiatives:

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

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

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

5. Scheduled date for the next paper on this topic: 27th October 2016.

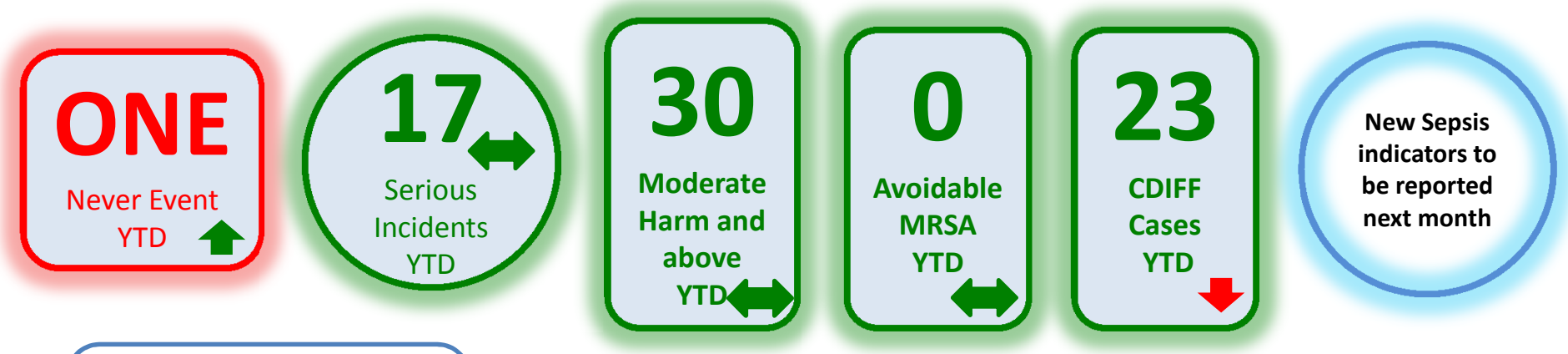
Quality and Performance Executive Summary

August 2016

Operational Delivery Unit

Domain - Safe

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



Headlines

- Serious incidents are well within the year to date trajectory and remain on a downward trend.
- This is supported by a 60% reduction in Moderate Harm and above compared to the same period last year.
- The number of C Diff cases reported in August was 7 which is above the monthly threshold, however the year to date is within the threshold.
- The 1 unavoidable MRSA case reported in July was allocated to a third party and is not attributed to UHL.
- There were no Grade 4 Pressure ulcers and combined we are within trajectory for Grade 2 and 3 within trajectory.

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 92% ↔

Maternity FFT 94% ↔

Outpatients FFT 95% ↔

Staff FFT Quarter 1 2016

↑72.3% of staff would recommend UHL as a place to receive treatment

Headlines

- Friends and family test (FFT) for Inpatient and Daycase care combined are are at 96% for August.
- A&E FFT for August remained at 87% this is 10% lower than trajectory. An exception report is included in the Q&P.
- There has been an encouraging 1.6% increase in FFT (STAFF) (Q4 to Q1) on staff who would recommend UHL as a place to receive treatment
- As previously reported we changed the way we are counting Single sex accommodation breaches in ITU in June 2016. This has resulted in an increase in breaches as anticipated.

Single sex accommodation breaches

7 YTD ↓

Domain – Well Led

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

Friends and Family FFT YTD % Coverage

Inpatients FFT 36.9% ↓

Day Case FFT 24.7% ↓

A&E FFT 10.7% ↓

Maternity FFT 36.5% ↑

Outpatients FFT 1.7% ↓

Staff FFT Quarter 1 2016

↑ 60.3% 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%. An exception report is included in the Q&P.
- There has been an encouraging 1.4% increase on staff FFT (Q4 to Q1) on staff who would recommend UHL as a place to work.
- There was a reduction of 0.5% in people appraised in August.
- Statutory & Mandatory training is 4% off target.
- Please see the HR update for more information.

% Staff with Annual Appraisals

92.4% YTD ↓

Statutory & Mandatory Training

91% YTD ↓

Domain – Effective

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

SHMI Jan15-Dec15

98
Jan15-Dec15 ↓

Stroke TIA clinic within 24hrs

59.4%
YTD ↑

80% of patients spending 90% stay on stoke unit

82.3%
YTD ↓

Emergency Crude Mortality Rate

2.2%
YTD ⟺

30 Days Emergency Readmissions

8.5%
YTD 2016 ↑

NoFs operated on 0-35hrs

73.6%
YTD ↓

Headlines

- UHL's SHMI remains lower than the England average at 98.
- After a couple of months of non compliance performance for Stroke TIA clinic was back on track at 71.7%.
- The 30 day readmissions continues to improve and at 8.3% was within the threshold of 8.5%.
- The requirement to operate on 72% of fractured neck of femurs in 0-35 hours was not achieved, due to the impact of the volume and complexity of the spinal surgery carried out this month.

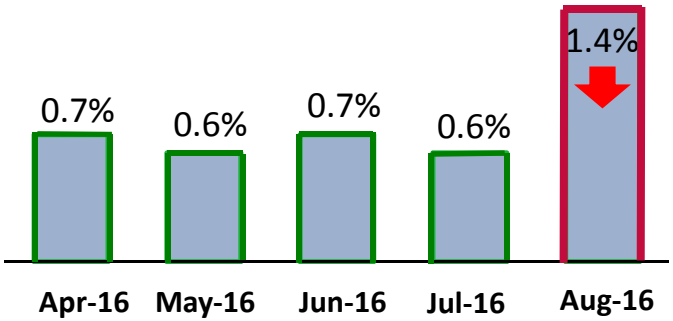
Domain – Responsive

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

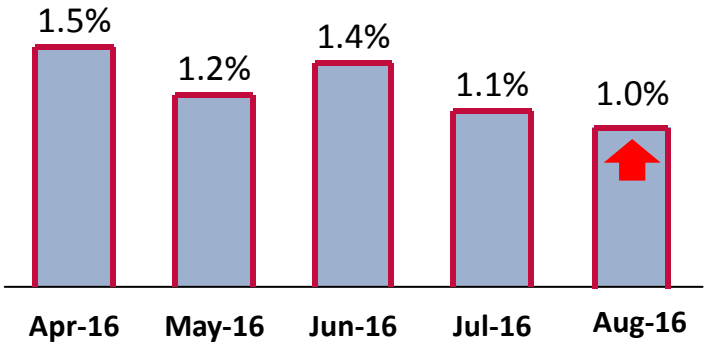
RTT - Incomplete 92% in 18 Weeks

92.1%

6 week Diagnostic Wait times



Cancelled Operations



RTT 52 week wait *incompletes*

57

ED 4Hr Wait

A&E **79.7%** YTD

Ambulance Handovers

6% > 60mins
12% 30-60mins
YTD

Headlines

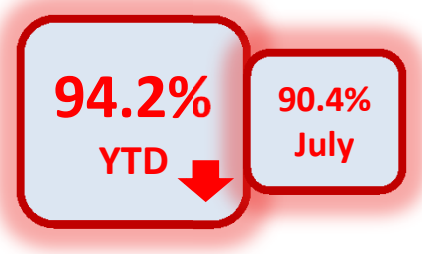
- The number of 52+ week waiters reduced by another 20 patients and is ahead of the trajectory.
- The diagnostic standard was not compliant during August due to machine downtime following an electrical storm.
- RTT remains compliant despite the pressures in theatre capacity.
- For ED 4hour wait and Ambulance Handovers please refer to Chief Operating Officers report.

Domain – Responsive Cancer

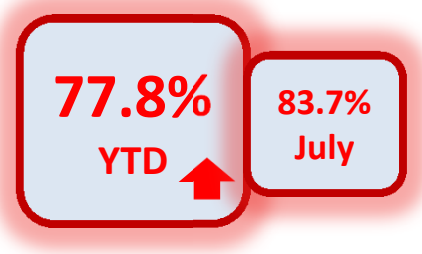
Arrows represent current month performance against previous month, upward arrow represents improvement, downward arrow represents deterioration.

Cancer 2 week wait

31 day wait



62 day wait



31 day backlog

62 day backlog

62 day adjusted backlog

Headlines

- Cancer 2 week wait was compliant in July, the first time for 6 months. Compliance is expected to continue in August and September.
- 31 day wait non compliant due to emergency pressures and HDU capacity, monthly compliance expected from November 2016.
- It is deeply disappointing to no longer be able to predict compliance with the 62 day standard in September. Whilst we are making progress in reducing the backlog it is clear we still have more to do in this area. Lower GI, Lung and Urology remain the most pressure tumour sites.

Sustainability and Transformation Fund – Trajectories and Performance

Cancer 62 Day — 5% of STF allocation

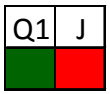
Standard: 85% of patients are treated within 62 days from urgent referrals

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

July Performance (one month in arrears)
83.7% against a trajectory of 85.1%

Quarter 1 STF compliant: Trajectory agreed

August 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.

August Performance
1.4% of our patients waiting more than 6 *weeks*

Quarter 1 STF compliant: Trajectory agreed

August STF: Non Compliant

September 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

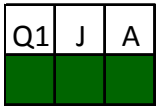
Timing: Required to deliver throughout the year

August Performance
Achieved the RTT standard with 92.1% of our patients waiting less than 18 weeks

Quarter 1 STF compliant: Trajectory agreed

August STF: Compliant

September Performance: Expected to be compliant



ED 4 hour — 12.5% of STF allocation

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

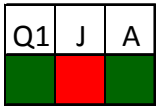
Timing: Required to achieve 91.2% during March 2017

August Performance
80.1 % against a target of 80.0%

Quarter 1 STF compliant: Trajectory agreed

August STF: Compliant

September Performance: Expected to be non-complaint



Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

August 2016

One team shared values

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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

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

DATE: **29th SEPTEMBER 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: **AUGUST 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 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	3	17	3
Caring	4	11	2
Well Led	5	23	3
Effective	6	11	1
Responsive	7	15	10
Responsive Cancer	8	9	6
Research – UHL	11	6	0
Total		92	25

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	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	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	16	18	17	18	18	16	17	6	8	8	8		30
	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	4	6	3	3	3	4	6	4	5	5	1	3	3	17
	S3	Proportion of reported safety incidents per 1000 attendances (IP, OP and ED)	AF	MD	> FY 15/16	UHL	TBC		17.5	18.4	15.5	18.3	16.6	17.7	18.8	16.2	17.2	17.1	16.8	16.3	19.2	18.0	16.9
	S4	SEPSIS Metrics						Sepsis Metrics to be agreed and popualated in the September Q&P															
	S5	Overdue CAS alerts	AF	MD	0	NHSI	Red if >0 in mth ER = in mth >0	10	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0
	S6	RIDDOR - Serious Staff Injuries	AF	MD	FYE <=40	UHL	Red / ER if non compliance with cumulative target	24	32	2	3	7	2	5	3	2	2	5	3	3	1	1	13
	S7	Never Events	AF	MD	0	NHSI	Red if >0 in mth ER = in mth >0	3	2	0	1	0	0	0	0	0	1	0	0	0	1	0	1
	S8	Clostridium Difficile	JS	DJ	61	NHSI	Red if >mthly threshold / ER if Red or Non compliance with cumulative target	73	60	6	6	6	4	6	7	7	6	4	5	6	1	7	23
	S9	MRSA Bacteraemias (All)	JS	DJ	0	NHSI	Red if >0 ER if >0	6	1	0	0	0	0	0	0	0	1	0	0	0	1	0	1
	S10	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
	S11	% of UHL Patients with No Newly Acquired Harms	JS	RB	Within expected (revised)	UHL	Red if <95% ER if in mth <95%		97.7%	97.0%	97.7%	97.4%	97.4%	98.2%	97.7%	97.9%	98.0%	96.9%	97.2%	98.4%	97.9%	98.6%	97.8%
	S12	% of all adults who have had VTE risk assessment on adm to hosp	AF	SH	>=95%	NHSI	Red if <95% ER if in mth <95%	95.8%	95.9%	96.5%	96.1%	95.7%	96.0%	96.1%	95.5%	95.4%	95.1%	95.9%	96.1%	96.5%	96.1%	95.9%	96.1%
	S13	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	5.9	5.0	5.2	4.8	5.7	5.4	4.9	5.2	6.3	5.7	5.6	5.4	5.8	5.7
	S14	Avoidable Pressure Ulcers - Grade 4	JS	MC	0	QS	Red / ER if Non compliance with monthly target	2	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0
	S15	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	4	1	1	1	5	6	2	5	5	3	2	2	2	14
	S16	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	10	11	5	4	5	5	8	7	9	6	8	3	13	39
	S17	Maternal Deaths	AF	IS	0	UHL	Red or ER if >0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1

Caring

KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	16/17 Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	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	YTD
C1	Keeping Inpatients Informed (Reported quarterly from Qtr3)	JS	HL	6% increase from Qtr 1 baseline (new)	QC	Red/ER if below Quarterly Threshold	NEW INDICATOR										64%					64%
C2	Formal complaints rate per 1000 IP,OP and ED attendances	AF	MD	No Target	UHL	Monthly reporting	NEW INDICATOR		1.5	1.3	1.3	1.2	0.9	1.0	1.4	1.2	1.0	1.0	0.9	0.8	1.4	1.0
C3	Percentage of upheld PHSO cases	AF	MD	No Target	UHL	Quarterly reporting	NEW INDICATOR										10%					10%
C4	Published Inpatients and Daycase Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <95% ER if 2 mths Red		97%	97%	97%	97%	96%	97%	97%	96%	97%	97%	97%	97%	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%	97%	97%	96%	97%	97%	96%	97%	97%	96%	97%	96%	95%	96%
C6	Daycase only Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <95% ER if 2 mths Red		98%	98%	97%	98%	98%	98%	98%	98%	98%	98%	98%	99%	98%	98%	98%
C7	A&E Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <94% ER if 2 mths Red	96%	96%	97%	95%	95%	97%	95%	97%	97%	95%	96%	95%	95%	87%	87%	92%
C8	Outpatients Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <90% ER if 2 mths Red		94%	93%	93%	93%	92%	94%	95%	95%	93%	95%	95%	95%	94%	94%	95%
C9	Maternity Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <94% ER if 2 mths Red	96%	95%	96%	95%	95%	95%	94%	95%	95%	95%	95%	94%	94%	95%	95%	94%
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%					72.3%
C11	Single Sex Accommodation Breaches (patients affected)	JS	HL	0	NHSI	Red / ER if >0	13	1	0	0	0	0	0	0	1	0	0	0	4	1	2	7

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	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	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 quarterly								Achieved					
	W2	Published Inpatients and Daycase Friends and Family Test - Coverage (Adults and Children)	JS	HL	Not Appicable		Not Appicable		27.4%	25.9%	26.5%	30.9%	32.4%	23.5%	31.9%	32.8%	32.9%	31.7%	32.0%	31.6%	31.9%	28.5%	31.1%
	W3	Inpatients only Friends and Family Test - Coverage (Adults and Children)	JS	HL	30%	QS	Red if <26% ER if 2mths Red		31.0%	28.9%	28.9%	37.4%	38.2%	23.2%	29.3%	37.2%	36.1%	35.6%	36.7%	38.1%	36.9%	36.5%	36.9%
	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%	23.8%	24.1%	27.2%	27.7%	18.7%	30.1%	26.2%	29.2%	27.3%	26.5%	24.5%	26.2%	19.8%	24.7%
	W5	A&E Friends and Family Test - Coverage	JS	HL	20%	NHSI	Red if <10% ER if 2 mths Red		10.5%	13.3%	13.1%	16.1%	12.4%	5.4%	7.3%	5.1%	7.0%	13.0%	10.2%	12.0%	8.7%	9.9%	10.7%
	W6	Outpatients Friends and Family Test - Coverage	JS	HL	>=5%	UHL	Red/ER if <1.4%		1.4%	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%	1.7%
	W7	Maternity Friends and Family Test - Coverage	JS	HL	30%	UHL	Red if <26% ER if 2 mths Red	28.0%	31.6%	30.5%	27.9%	27.2%	38.8%	30.0%	33.3%	34.3%	31.7%	27.9%	38.3%	39.3%	38.2%	38.7%	36.5%
	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%					60.3%
	W9	Nursing Vacancies	JS	MM	TBC	UHL	Separate report submitted to QAC		8.4%	8.9%	8.5%	7.1%	7.6%	7.6%	7.7%	6.8%	8.4%	8.2%	8.5%	8.9%	9.2%	8.2%	8.2%
	W10	Nursing Vacancies in ESM CMG	JS	MM	TBC	UHL	Separate report submitted to QAC		17.2%	13.5%	13.5%	12.9%	14.6%	14.9%	16.4%	17.2%	18.5%	18.1%	18.9%	19.8%	20.1%	20.3%	20.3%
	W11	Turnover Rate	LT	LG	TBC	NHSI	Red = 11% or above ER = Red for 3 Consecutive Mths	11.5%	9.9%	10.4%	10.4%	10.2%	9.9%	10.0%	10.1%	10.0%	9.9%	9.7%	9.6%	9.4%	9.4%	9.3%	9.3%
	W12	Sickness absence	LT	BK	3%	UHL	Red if >4% ER if 3 consecutive mths >4.0%	3.8%	3.6%	3.2%	3.3%	3.5%	3.7%	3.9%	4.0%	4.3%	4.2%	4.0%	3.5%	3.7%	3.5%		3.7%
	W13	Temporary costs and overtime as a % of total paybill	LT	LG	TBC	NHSI	TBC	9.4%	10.7%	11.1%	9.9%	10.5%	10.5%	10.1%	11.0%	9.7%	13.9%	10.5%	9.5%	10.9%	10.2%	10.5%	10.4%
	W14	% of Staff with Annual Appraisal	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	91.4%	90.7%	88.8%	90.0%	90.4%	91.1%	92.7%	91.5%	91.6%	90.7%	91.5%	92.2%	92.4%	92.9%	92.4%	92.4%
	W15	Statutory and Mandatory Training	LT	BK	95%	UHL	TBC	95%	93%	91%	91%	92%	92%	93%	93%	92%	93%	92%	93%	94%	93%	91%	91%
	W16	% Corporate Induction attendance	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	100%	97%	97%	98%	98%	97%	92%	96%	98%	98%	94%	96%	97%	100%	97%	97%
	W17	BME % - All Staff	LT	DB	28%	UHL	TBC			New Indicator reported quarterly								28%					28%
	W18	BME % - Leadership (8A – Including Medical Consultants)	LT	DB	28%	UHL	TBC											24%					24%
	W19	BME % - Leadership (8A – Excluding Medical Consultants)	LT	DB	28%	UHL	TBC											12.0%					12%
	W20	DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	TBC	NHSI	TBC	91.2%	90.5%	90.2%	90.5%	91.4%	87.2%	91.0%	90.5%	89.5%	90.2%	91.6%	91.3%	91.4%	89.7%	89.4%	90.7%
	W21	DAY Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	TBC	NHSI	TBC	94.0%	92.0%	92.4%	93.1%	94.2%	93.2%	93.9%	92.1%	86.0%	88.7%	92.5%	93.7%	93.8%	92.0%	94.7%	93.3%
	W22	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	TBC	NHSI	TBC	94.9%	95.4%	94.3%	94.9%	96.1%	91.4%	94.8%	96.6%	95.0%	96.3%	97.6%	97.2%	96.6%	94.5%	95.0%	96.2%
	W23	NIGHT Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	TBC	NHSI	TBC	99.8%	98.9%	98.0%	100.0%	99.9%	98.4%	98.0%	100.2%	91.6%	94.7%	98.3%	99.1%	96.7%	97.1%	98.2%	97.9%

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

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	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	YTD
E1	Emergency readmissions within 30 days following an elective or emergency spell	AF	MM	Monthly <8.5% (revised)	QC	Red if >8.6% ER if >8.6%	8.5%	8.9%	8.9%	8.7%	9.0%	8.3%	9.2%	8.8%	8.7%	8.8%	8.6%	8.6%	8.5%	8.3%		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)				98
E3	Mortality - Rolling 12 mths SHMI (as reported in HED) Rebased	AF	RB	<=99 (revised)	QC	Red if >100 ER if >100	98	97	96	95	97	98	99	98	97	98	98	98	Awaiting HED Update			98
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	93	93	94	95	95	95	95	97	99	99	100	Awaiting HED Update		100
E5	Crude Mortality Rate Emergency Spells	AF	RB	No Threshold	UHL	Monthly Reporting	2.4%	2.3%	2.0%	2.2%	2.4%	2.1%	2.5%	2.4%	2.4%	2.7%	2.4%	2.2%	2.2%	2.2%	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%	78.1%	72.0%	60.0%	70.9%	59.7%	66.7%	65.2%	65.1%	78.0%	78.1%	64.6%	86.0%	65.8%	73.6%
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%	83.9%
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%	90.9%	86.9%	81.1%	84.4%	87.0%	90.6%	87.0%	86.5%	72.7%	93.5%	83.8%	80.7%		82.3%
E9	Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA)	RM	IL	60% or above	QS	Red if <60% ER if 2 consecutive mths <60%	71.2%	75.6%	80.2%	88.1%	73.3%	67.1%	68.4%	71.3%	80.0%	67.3%	53.5%	68.2%	50.4%	54.8%	71.7%	59.4%
E10	Published Clinical Outcomes - data submission and outcome results	AF	RB	0 delayed /outside expected (revised)	UHL	ER if Red Quarterly ER if >0	Revised Indicator															
E11	Compliance with NICE Guidance (15/16 and 16/17)	AF	RB	0 Non compliance and no actions or actions delayed (revised)	UHL	Red if in mth >0 ER if Red	Revised Indicator															

Responsive

KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	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	YTD
R1	ED 4 Hour Waits UHL + UCC (Calendar Month)	RM	IL	95% or above	NHSI	Red if <92% ER via ED TB report	89.1%	86.9%	90.6%	90.3%	88.9%	81.7%	85.1%	81.2%	80.2%	77.5%	81.2%	79.9%	80.6%	76.9%	80.1%	79.7%
R2	12 hour trolley waits in A&E	RM	IL	0	NHSI	Red if >0 ER via ED TB report	4	2	0	0	0	1	1	0	0	0	0	0	0	0	0	0
R3	RTT - Incomplete 92% in 18 Weeks	RM	WM	92% or above	NHSI	Red /ER if <92%	96.7%	92.6%	94.3%	94.8%	93.6%	93.8%	93.0%	92.9%	93.2%	92.6%	92.7%	92.7%	92.4%	92.4%	92.1%	92.1%
R4	RTT 52 Weeks+ Wait (Incompletes)	RM	WM	0	NHSI	Red /ER if >0	0	232	258	260	265	263	267	269	261	232	169	134	130	77	57	57
R5	6 Week - Diagnostic Test Waiting Times	RM	WM	1% or below	NHSI	Red /ER if >1%	0.9%	1.1%	13.4%	9.6%	7.7%	6.5%	7.0%	4.1%	1.8%	1.1%	0.7%	0.6%	0.7%	0.6%	1.4%	1.4%
R6	Urgent Operations Cancelled Twice	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	5	1	0	3	6	6	9	14	24	16	18	20	19	97
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	0	0	5	0	0	0	6	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%	0.7%	0.9%	0.8%	1.3%	1.1%	1.3%	1.2%	1.5%	1.5%	1.2%	1.4%	1.1%	0.9%	1.2%
R10	% Operations cancelled for non-clinical reasons on or after the day of admission ALLIANCE	RM	GH	0.8% or below	Contract	Red if >0.9% ER if >0.8%	0.9%	0.9%	0.0%	1.0%	1.1%	0.0%	1.1%	2.2%	0.2%	1.0%	0.8%	0.3%	0.8%	1.4%	3.2%	1.2%
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%	0.7%	0.9%	0.8%	1.2%	1.1%	1.4%	1.1%	1.4%	1.5%	1.2%	1.4%	1.1%	1.0%	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	67	104	91	131	115	146	119	156	156	123	154	114	110	657
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%	1.2%	1.3%	1.1%	1.5%	1.6%	1.8%	1.8%	2.0%	1.9%	1.8%	2.2%	2.9%	2.5%	2.3%
R14	Ambulance Handover >60 Mins (CAD+ from June 15)	RM	SL	0	Contract	Red if >0 ER if Red for 3 consecutive mths	5%	5%	9%	18%	22%	27%	16%	12%	10%	11%	6%	6%	6%	9%	7%	6%
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%	17%	25%	26%	26%	23%	13%	13%	13%	11%	12%	10%	15%	12%	12%

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	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jul-16	Jul-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%	86.8%	87.7%	89.9%	92.4%	93.0%	91.4%	93.9%	93.0%	90.5%	91.1%	89.5%	90.5%	94.3%	**	91.3%
RC2	Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	RM	DB	93% or above	NHSI	Red if <93% ER if Red for 2 consecutive mths	94.1%	95.1%	98.7%	94.5%	94.6%	89.4%	93.5%	96.2%	99.3%	95.7%	95.1%	96.1%	88.7%	94.9%	98.7%	**	94.4%
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%	96.5%	94.7%	95.2%	95.6%	94.3%	91.5%	92.6%	94.1%	94.8%	95.4%	95.5%	95.6%	90.4%	**	94.2%
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%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.7%	100.0%	100.0%	97.9%	100.0%	**	99.4%
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%	81.1%	89.7%	90.7%	76.8%	91.4%	77.5%	77.9%	80.3%	85.3%	90.3%	91.6%	84.7%	74.4%	**	85.1%
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%	99.0%	92.2%	94.1%	95.1%	94.3%	96.4%	92.9%	96.4%	94.9%	98.8%	93.6%	87.3%	92.5%	**	92.5%
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%	81.7%	77.2%	77.0%	82.5%	80.9%	75.1%	73.4%	77.6%	77.5%	75.8%	74.5%	77.3%	83.7%	**	77.8%
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%	97.1%	81.4%	96.0%	96.2%	95.3%	77.3%	72.5%	81.3%	89.1%	94.6%	96.0%	85.0%	92.3%	**	91.4%
RC9	Cancer waiting 104 days	RM	DB	0	NHSI	TBC			12	12	17	13	23	23	17	21	21	12	7	15	12	9	9

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

KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-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%	--	--	--	--	**	--
RC11	Breast	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	92.6%	95.6%	96.3%	97.5%	92.0%	100.0%	93.1%	94.6%	100.0%	94.1%	95.6%	93.3%	95.3%	97.1%	100.0%	**	96.8%
RC12	Gynaecological	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	77.5%	73.4%	72.2%	80.0%	84.6%	80.0%	85.7%	50.0%	70.0%	78.6%	73.4%	72.7%	78.6%	75.0%	62.5%	**	71.7%
RC13	Haematological	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	66.5%	63.0%	82.6%	66.7%	70.0%	50.0%	58.3%	100.0%	60.0%	60.0%	63.0%	14.3%	61.5%	72.7%	100.0%	**	60.0%
RC14	Head and Neck	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	69.9%	50.7%	60.9%	50.0%	75.0%	42.9%	37.5%	62.5%	37.5%	35.7%	50.7%	35.7%	45.5%	100.0%	42.9%	**	44.1%
RC15	Lower Gastrointestinal Cancer	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	63.7%	59.8%	60.0%	38.9%	70.6%	68.2%	77.8%	52.4%	31.3%	57.1%	59.8%	62.5%	45.0%	64.5%	58.8%	**	56.9%
RC16	Lung	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	69.9%	71.0%	70.4%	73.5%	65.2%	88.6%	81.6%	73.7%	53.8%	71.1%	71.0%	66.7%	46.7%	64.2%	61.7%	**	61.1%
RC17	Other	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	95.0%	71.4%	100%	50.0%	60.0%	80.0%	--	66.7%	--	--	71.4%	0.0%	50.0%	100.0%	100.0%	**	60.0%
RC18	Sarcoma	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	46.2%	81.3%	--	80.0%	50.0%	--	--	--	100.0%	100.0%	81.3%	0.0%	50.0%	16.7%	--	**	27.3%
RC19	Skin	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	96.7%	94.1%	94.1%	96.7%	91.1%	95.6%	94.9%	100.0%	92.5%	94.6%	94.1%	95.2%	100.0%	96.8%	97.4%	**	97.3%
RC20	Upper Gastrointestinal Cancer	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	73.9%	63.9%	81.8%	45.7%	48.6%	84.6%	90.0%	42.9%	57.1%	76.5%	63.9%	74.3%	70.0%	46.9%	66.7%	**	65.0%
RC21	Urological (excluding testicular)	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	82.6%	74.4%	86.1%	80.4%	80.0%	76.7%	75.0%	67.4%	78.7%	83.6%	74.4%	83.7%	73.1%	77.8%	96.3%	**	83.5%
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%	**	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%	81.7%	77.2%	77.0%	82.5%	80.9%	75.1%	73.4%	77.6%	77.5%	75.8%	74.5%	77.3%	83.7%	**	77.8%

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	**81.2%**	**79.9%**	**80.6%**	**76.9%**	**80.1%**							

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	**75.9%**	**74.9%**	**77.3%**	**83.7%**								

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%**							

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%**							

Compliance Forecast for Key Responsive Indicators

Standard	August	September (predicted)	Month by which to be compliant	RAG rating of required month delivery	Commentary
Emergency Care					
4+ hr Wait (95%) - Calendar month	80.1%		Not Confirmed		August position may change due to validation
Ambulance Handover (CAD+)					
% Ambulance Handover >60 Mins (CAD+)	7%		Not Confirmed		EMAS monthly report
% Ambulance Handover >30 Mins and <60 mins (CAD+)	14%		Not Confirmed		
RTT (inc Alliance)					
Incomplete (92%)	92.1%	92.1%			
Diagnostic (inc Alliance)					
DM01 - diagnostics 6+ week waits (<1%)	1.4%	0.9%			August target missed due to machine downtime following electrical storm.
# Neck of femurs					
% operated on within 36hrs - all admissions (72%)	66%	72%			
% operated on within 36hrs - pts fit for surgery (72%)	82%	78%			
Cancelled Ops (inc Alliance)					
Cancelled Ops (0.8%)	1.0%	1.0%	Oct-16		
Not Rebooked within 28 days (0 patients)	19	10	Oct-16		
Cancer (predicted)					
Two Week Wait (93%)	94%	94%			
31 Day First Treatment (96%)	88%	88%	Nov-16		
31 Day Subsequent Surgery Treatment (94%)	74%	74%	Dec-16		Revised compliance date.
62 Days (85%)	78%	79.0%	Sep-16		Current unadjusted backlog 65 and adjusted backlog 59.
Cancer waiting 104 days (0 patients)	9	9			

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

	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
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			
	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			
	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	607
	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%						
	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						
	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%						

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 monthly trajectory for CDT infections is the annual trajectory divided by 12. This will be subject to seasonal variation and is a point of reference to check progress against the annual trajectory. The figures per month in themselves are not significant unless the cases are linked in time and place. This was not the case in June	No action required, currently we are below trajectory for this point of year	**5/61**	**7**	**23**	**On/below trajectory**

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	YTD
Clostridium Difficile	4	5	6	1	7	23

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

Pressure Ulcers – Grade 2

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
From April 2016, a revised trajectory was agreed as part of the Trusts continuous aim to reduce the number of avoidable pressure ulcers. The new targets are based on the out turn for the previous year, together with a percentage reduction The revised targets are challenging , and for April the Trust has not achieved the revised target for Grade 2 and 3 pressure ulcers The main causation of avoidable pressure ulcers grade 2 is associated with device related harm. Particularly in hot weather which it was in August moisture caused by sweating can rapidly cause skin damage and more frequent observation is required.	Through the nursing executive meeting, awareness and information will be shared to ensure all clinical areas are aware of the importance of heal protection and the use of repose boots. We will monitor areas , in next month's validation to ensure that the themes are not recurring, and take action to put in target support from the Pressure ulcer team if required We will raise awareness across nursing teams of the importance of checking skin more frequently in hot weather.	**Grade 3 target <=4 with FY end <33** **Grade 2 target <=7 with FY end <89**	**G3 = 2** **G2 = 13**	**G3 = 14** **G2 = 39**	Work is focussed to achieve the ambitious new targets, as part of a continuous improvement plan, and actions have been instigated to reverse trend.

Indicators	Apr-16	May-16	Jun-16	Jul-16	Aug-16	YTD
Avoidable Pressure Ulcers - Grade 4	0	0	0	0	0	0
Avoidable Pressure Ulcers - Grade 3	5	3	2	2	2	14
Avoidable Pressure Ulcers - Grade 2	9	6	8	3	13	39

Expected date to meet standard / target	December 2016
Revised date to meet standard	
Lead Director / Lead Officer	Julie Smith, Chief Nurse Carole Ribbins, Deputy Chief Nurse Michael Clayton, Head of Nursing

Maternal Deaths

<table>
<tr><th colspan="2"></th><th>Target</th><th>Latest Month</th><th>YTD</th><th>Forecast</th></tr>
<tr><td>What is causing underperformance?</td><td>What actions have been taken to improve performance?</td><td>0</td><td>1</td><td>1</td><td>0</td></tr>
<tr><td>A woman was under the care of the maternity services in Leicester. She arrived from Malawi at 35+ weeks gestation to give birth in this country. She had a congenital abnormality of Turners syndrome.

She was transferred to delivery suite for induction of labour at 38 weeks due to pre-eclampsia. Proceeded to delivery on 10/08/16 by C/S. Then monitored on delivery suite in HDU. Transferred to the ward after 24hrs. Reviewed on ward 13/08/16 for severe back pain by consultant anaesthetist who reviewed at 21.30.

14/08/16 MCA went to help with feeding, the woman cried out in pain, midwife summoned then the woman screamed and collapsed in cardiac arrest, from which the team were unable to revive her</td><td>This unexpected maternal death was reported to the Coroner, but an inquest is not required.

The CCG and NHS England were informed.

As per CCG guidance this had to be escalated as a maternal death. A decision was made by the CCG that despite this woman paying privately for care an RCA investigation was required. There were no omissions or mismanagement in care that led to the maternal death. However there is a need to raise awareness of women with Turner’s syndrome need monitoring of the heart and aorta. This was thought to be due to ruptured aortic aneurysm, still awaiting post mortem results.

RCA date has been arranged.</td><td colspan="4">Performance:

<table>
<tr><th>Financial Year</th><th>Deliveries</th><th>Maternal Deaths</th></tr>
<tr><td>2015/16</td><td>10521</td><td>0</td></tr>
<tr><td>2016/17 (YTD 15/09/16)</td><td>3572(April-July16)</td><td>1</td></tr>
<tr><td></td><td></td><td></td></tr>
</table>
<table>
<tr><td>Expected date to meet standard</td><td>September 2016</td></tr>
<tr><td>Revised date to meet standard</td><td>September 2016</td></tr>
<tr><td>Lead Director</td><td>Elaine Broughton, Head of Midwifery
Ian Scudamore, Clinical Director Women and Children’s</td></tr>
</table>
</td></tr>
</table>

A&E Friends and Family Test - % Positive

<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>August 2016</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="4">The FFT for ED has 6 areas that are included in the overall submission:
• Majors
• Minors
• Childrens ED
• EDU
• Eye Casualty
• Urgent Care Centre (UCC)

For the last 4 months there has been a slow decline in the overall FFT score for the Emergency Department.

This is attributable to a reduction in satisfaction levels for patients attending the Urgent Care Centre. Main reason stated in the free text comments is waiting times and conditions in the waiting area when the department gets busy (crowded and hot). Comments about staff very positive despite environment.</td><td rowspan="4">The Senior Management Team are aware of the reduced FFT score. There have structures in place to increase the overall submission levels and in turn get a better view of patient opinion.

Until this service has access to the new ED build there are immediate actions being taken:

When ED becomes busy the footprint of the department is now used differently to reduce overcrowding.

All free text comments are reviewed in real time and action taken to improve the experience for patients.

The Team are looking at the waiting area and exploring possible short term solutions before the move to the new build to improve this environment.</td><td>97%</td><td>87%</td><td>92%</td><td>94%</td></tr>
<tr><td colspan="4"><table>
<tr><th></th><th>Apr-16</th><th>May-16</th><th>Jun-16</th><th>Jul-16</th><th>Aug-16</th></tr>
<tr><td>ED - Majors</td><td>90.9%</td><td>92.7%</td><td>90.7%</td><td>90.5%</td><td>91.3%</td></tr>
<tr><td>ED - Minors</td><td>96.7%</td><td>94.1%</td><td>96.0%</td><td>81.3%</td><td>78.0%</td></tr>
<tr><td>Childrens ED</td><td>96.9%</td><td>96.8%</td><td>96.7%</td><td>97.9%</td><td>96.8%</td></tr>
<tr><td>EDU</td><td>95.8%</td><td>95.5%</td><td>94.6%</td><td>94.3%</td><td>93.6%</td></tr>
<tr><td>UCC</td><td>94.6%</td><td>90.1%</td><td>88.6%</td><td>71.1%</td><td>65.4%</td></tr>
<tr><td>Eye Casualty</td><td>97.6%</td><td>97.0%</td><td>99.1%</td><td>98.6%</td><td>99.0%</td></tr>
<tr><td>ED total</td><td>96.1%</td><td>94.9%</td><td>94.7%</td><td>87.3%</td><td>86.9%</td></tr>
</table></td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">September 2016</td></tr>
<tr><td colspan="2">Revised date to meet standard</td><td colspan="2">October 2016</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Julie Smith, Chief Nurse
Heather Leatham, Assistant Chief Nurse
Julie Taylor, Head of Nursing ED</td></tr>
</table>

Single Sex Accommodation Breaches (patients affected)

<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>August 2016</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="4">In line with the Same-Sex Accommodation Matrix it is not acceptable for patients to be undressed with members of the opposite sex in any clinical area, except in specific circumstances.

<u>Osborne Day Case</u>
A patient was transferred from an inpatient ward for treatment in the Osborne Day case Unit. The Day Case Unit is a mixed facility as all patients are dressed and the inpatient was in nightwear.

<u>Intensive Care Unit</u>
All patients who step down from level3/2 care must be in a single sex facility.

Due to lack of appropriate specialist Hepatobiliary bed capacity in the Trust, a patient's discharge from ICU was delayed; they had stepped down from level 3/2 care and were mixed with the opposite sex.</td><td rowspan="4">Base ward staff asked to ensure patients are dressed when attending day case areas.

Day case Staff to contact wards that are sending patients for treatment to ensure they are aware of the need for day clothes. Senior staff leading this process.

When ICU patients are identified for discharge, if delays anticipated this to be discussed at Gold Command.

Further meetings with ICU matron and sisters, escalation process re-confirmed and matron is going to ensure all staff are aware of the escalation process.

Duty Managers Team to make every effort to ensure that a bed is made available when a patient is identified for discharge from the ICU.</td><td>0</td><td>2</td><td>7</td><td>0</td></tr>
<tr><td colspan="4"><table>
<tr><th>Indicator</th><th>Apr-16</th><th>May-16</th><th>Jun-16</th><th>Jul-16</th><th>Aug-16</th><th>YTD</th></tr>
<tr><td>Single Sex Accommodation Breaches (patients affected)</td><td>0</td><td>0</td><td>4</td><td>1</td><td>2</td><td>7</td></tr>
</table></td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">September 2016</td></tr>
<tr><td colspan="2">Revised date to meet standard</td><td colspan="2"></td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Julie Smith, Chief Nurse
Heather Leatham, Assistant Chief Nurse</td></tr>
</table>

A&E Friends and Family Test - % Coverage

<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>August 2016</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="4">The FFT for ED has 6 areas that are included in the overall submission levels:
• Majors
• Minors
• Childrens ED
• EDU
• Eye Casualty
• Urgent Care Centre (UCC)

The UCC has been included in the ED footfall since Dec 2015, this area in August had 5542 patients who attended and were discharged.

This has increased the overall FFT target a week by nearly 300 surveys.

There has been a reduction in the submission levels of surveys from ED as a whole.

This department including the UCC has been under considerable pressure over the last few months and staff have focused on the safety and care of attending patients, which has resulted in the reduction of the surveys submitted.</td><td rowspan="4">The Senior Management Team have plans in place to improve the collection of surveys:
• Meetings have been held with the Matrons, Sisters and the Head of service to address the submission levels.

• Key staff on each shift has been tasked with ensuring they offer a minimum number of surveys to patients.

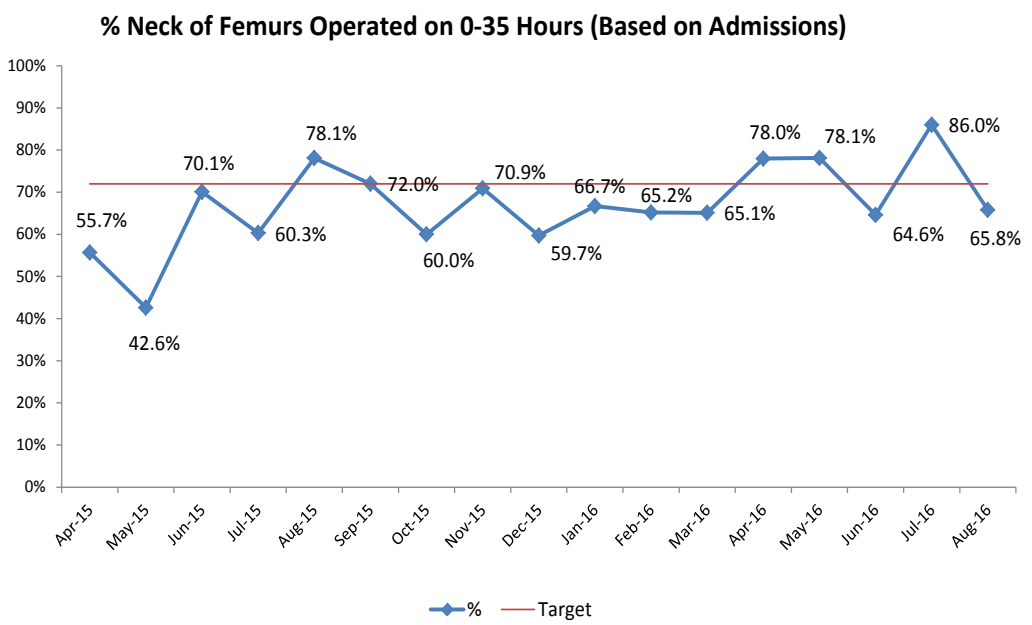
• Information has been shared at multidisciplinary team meetings regarding the reduced levels of submission.

• The requirement to collect patient feedback has been discussed with General Practitioners in UCC.

• Senior Management Team have reviewed the mechanisms for FFT collection and established processes to share results with all staff.</td><td>20%</td><td>9.9%</td><td>10.7%</td><td>20%</td></tr>
<tr><td colspan="4"><table>
<tr><th></th><th>Apr-16</th><th>May-16</th><th>Jun-16</th><th>Jul-16</th><th>Aug-16</th></tr>
<tr><td>ED - Majors</td><td>7.9%</td><td>7.4%</td><td>10.7%</td><td>11.6%</td><td>8.2%</td></tr>
<tr><td>ED - Minors</td><td>14.4%</td><td>10.5%</td><td>17.7%</td><td>7.6%</td><td>6.0%</td></tr>
<tr><td>Childrens ED</td><td>21.0%</td><td>17.3%</td><td>20.4%</td><td>6.7%</td><td>14.4%</td></tr>
<tr><td>EDU</td><td>28.5%</td><td>22.8%</td><td>22.6%</td><td>23.6%</td><td>23.2%</td></tr>
<tr><td>UCC</td><td>4.9%</td><td>2.0%</td><td>2.1%</td><td>3.9%</td><td>5.2%</td></tr>
<tr><td>Eye Casualty</td><td>14.2%</td><td>15.5%</td><td>6.7%</td><td>12.1%</td><td>16.7%</td></tr>
<tr><td>ED total</td><td>13.0%</td><td>10.2%</td><td>12.0%</td><td>8.7%</td><td>9.9%</td></tr>
</table></td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">September 2016</td></tr>
<tr><td colspan="2">Revised date to meet standard</td><td colspan="2"></td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Julie Smith, Chief Nurse
Heather Leatham, Assistant Chief Nurse
Julie Taylor – Head of Nursing, Emergency Department</td></tr>
</table>

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

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	August 2016	YTD performance	Forecast performance for next reporting period
There were 76 NOF admissions in August 2016, 25 patients breached the 36 hr target to theatre as detailed below:- Medically Unfit – 13pts List capacity – 5pts LGH transfer for THR – 1pt Needed Consultant surgeon– 1pt List over run – 3pts Pt Cardiac arrest in theatre– 1pt Change of clinical plan -1pt Therefore 14 pts are outside our control and 11 we were within it. The main causal factor, once again, of the breaches this month was the impact of the volume and complexity of the spinal surgery carried out this month. This activity goes through Theatre 4 which displaced general trauma into Theatre 3 (NOF theatre) when clinically urgent. Thus all cases become backlogged and the 36 hr target is compromised. There were 7 occasions when NOF admissions exceeded or was 5 in a day this too contributed to the breach total as patients once 'fit' then struggled to be accommodated. on lists.	Theatre schedulers working more closely with theatre team to inform of changing priorities and predict when 'pinch' points occur. 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. THR's have started to be undertaken at LRI Non urgent Trauma move to LGH lists – this is very much work in progress. Investigations how spinal activity can be accommodated minimising impact on other Trauma. Head of Service leading this. 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.	**72%**	**64.8%**	**73.6%**	**72%**



Expected date to meet standard / target	November 2016
Revised date to meet standard	Quarter 3 2016/17
Lead Director / Lead Officer	Dr Andy Currie MSS Clinical Director Catherine Chadwick, 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>August performance</th><th>YTD performance</th><th>Forecast performance for next period</th></tr>
<tr><td rowspan="4">UHL had 57 patients breaching 52 weeks at the end of August, consisting of 54 Orthodontics patients,

Orthodontics – The 54 Orthodontics patients have breached 52 weeks as a result of incorrect use and management of a planned waiting list, as well as inadequate capacity within the service. (NB; this is a significant reduction from the original 270, March 2016).

ENT – the 3 ENT patients breaching 52 weeks, delays can be attributed to administrative errors; however this has been exacerbated by the mismatch between capacity and demand in ENT.</td><td rowspan="4">Orthodontics – The Orthodontics service is now closed to referrals with some clinical exceptions. With NHS Improvement and NHS England, UHL have identified treatment opportunities from across the regional health economy for the majority of the patients on the Orthodontics waiting list. The service team are in the process of transferring patients to these providers. The numbers over 52 weeks have reduced significantly.

ENT – The RTT Team delivered a bespoke education and training course for the ENT administrative team and continues to provide support. This training is reiterated regularly to the waiting list team by the service management. Extra capacity has been identified for both outpatients and inpatients via Medinet weekend clinics and theatre lists.</td><td>0</td><td>57</td><td>57</td><td>49</td></tr>
<tr><td colspan="4">The problem which surfaced in Orthodontics 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 Chief Operating Officer;
Weekly review at Heads of Operations meeting for assurance.
Looking forward
UHL is forecasting ongoing achievement of RTT, however achievement of the standard remains at risk. This is the culmination of the significant impact of cancellations on the admitted position as well as the deterioration of performance in ENT and other key specialties such as Allergy. RTT was failed nationally in April 2016 for the first time since 2012, reflecting the pressures felt across the acute sector. ENT remains very high risk due to the high number of cancellations the service has experienced and the number of patients with long waits. There are likely to be more 52 week breaches.</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">January 2017</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>

Diagnostics

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (monthly / 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="5">The Trust has maintained 4 consistent months of good performance against the diagnostic standard , this was anticipated to continue however due to an unforeseen power surge from an electrical storm imaging lost a significant amount scanning capacity. This was the major contributing factor to failure of this standard in August.

Imaging
Five machines were disrupted by electrical storm on 25th August. This resulted in a loss of power across 5 (3 x MR, 2 x CT) out of 8 machines working that day. Two machines were rebooted at the time with <5 hours down time, two machines for three days being repaired on the Tuesday morning, with a final MR only coming back on 6th September. This resulted in the cancellation of patients many of whom were rebooked; however 61 patients were not able to be rebooked in month.

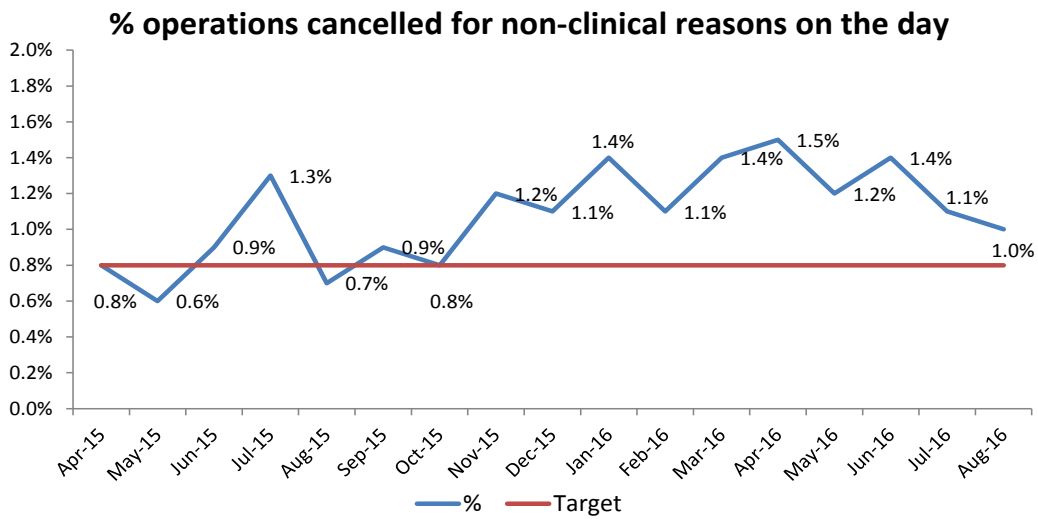
Endoscopy
33 breaches , the majority of patients requiring propofol.</td><td rowspan="5">Imaging
Machine stability remains an issue; all extra capacity is being utilised in MRI to minimise the number of breaches. MR vans are booked for the year, to capacity, with additional activity being sent to private providers. Waiting lists are validated by the senior team alongside the CMG Head of Operations. A review of out of area referrals is underway and GPs are being actively engaged to reduce inappropriate breaches.
Radiographer led protocolling and scanning is being further developed in order to shore up clinical capabilities.

Endoscopy
Additional capacity for propofol patients is being sourced, this requires anaesthetics support</td><td><1%</td><td>1.4%</td><td>1.4%</td><td><1%</td></tr>
<tr><td colspan="4">The Trust is confident that the overall diagnostic position will be recovered in September</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">September 2016</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>

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

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

What is causing underperformance?	What actions have been taken to improve performance?	Target (monthly)	Latest month	YTD performance (inc Alliance)	Forecast performance for next reporting period
Across UHL, 57% of all cancellations (55/95) were due to capacity pressures. The five key reasons for cancellations were: 1. Ward bed availability (26 patients) 2. Lack of theatre time / lists overrunning (25 patients) 3. Patient delayed to admit a higher priority patient (16 patients) 4. ITU bed unavailability (8 patients) 5. HDU bed availability (5 patients) Of the 55 patients cancelled for capacity pressures, 39 of the cancellations related to availability of beds (either HDU, ITU or ward).	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. HDU bed cancellation is significantly down on last month (19 in July) Dedicated member of staff now in place to ensure data quality of cancellations, to replace function of previous OTD project manager.	1) 0.8% 2) 0	1) 1.0% 2) 25 (12 CHUGGS, 1 MSS, 6 RRCV) and 6 Alliance	1) 1.2% 2) 108	1) 1.0% 2) 15



Expected date to meet standard / target	On the day – October 2016 28 day – TBC
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer G Harris, Head of Ops ITAPS

Ambulance handover > 30 minutes and >60 minutes

<table>
<tr><th colspan="2"></th><th>Target</th><th>Latest Month</th><th>YTD</th><th>Forecast</th></tr>
<tr><td>What is causing underperformance?</td><td>What actions have been taken to improve performance?</td><td>0 delays over 15 minutes</td><td>>60 min – 7%

30-60 min –14%</td><td>>60 min - 6%

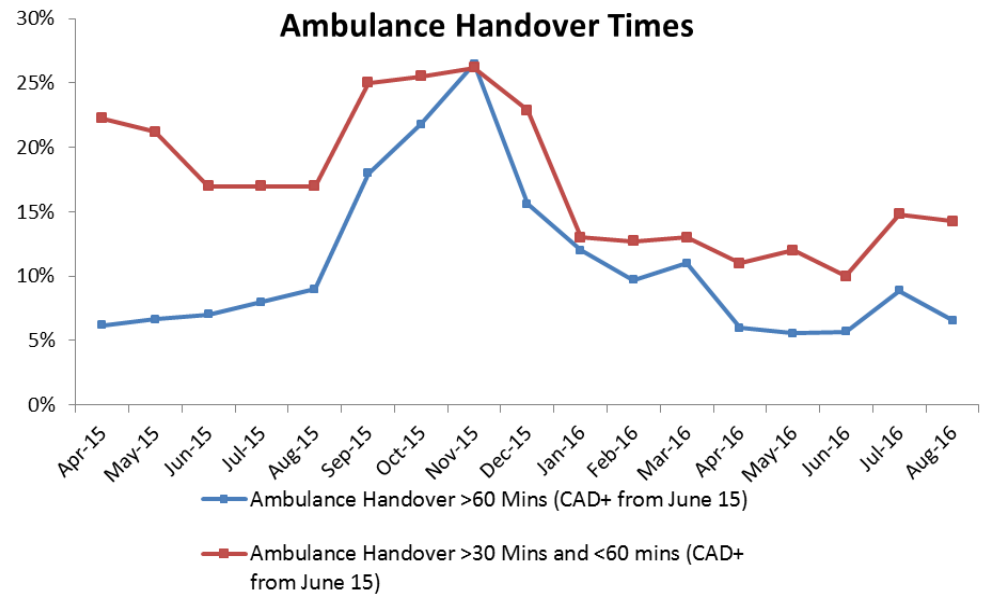
30-60 min –12%</td><td>> 60 min – 7%

30-60 min – 15%</td></tr>
<tr><td rowspan="4">Difficulties continue in accessing beds and high occupancy in ED leading to congestion in the assessment area and delays to ambulance handover.</td><td rowspan="4">A new structure for the LLR Emergency Care Programme is being rolled out in September. The focus (identified by NHSI, NHSE and ECIP) will be to deliver five interventions this winter:

1. Streaming at the front door – to ambulatory and primary care.
2. NHS 111 – Increasing the number of calls transferred for clinical advice
3. Ambulances – aim is for a decrease in conveyance and an increase in ‘hear and treat’ and ‘see and treat’ to divert patients away from the ED.
4. Improved flow – must do’s that each Trust should implement to enhance patient flow.
5. Discharge – mandating ‘Discharge to Assess’ and ‘trusted assessor’ type models.

A new RAP is being developed against the above key interventions and will be delivered through UHL governance and reporting to the AE delivery board.

Key interventions being implemented
1. Ward 7 to open for additional medial capacity in November
2. Additional cohorting space and staff at times of escalation
3. EMAS educator at the front door to assess if patients could be redirected

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.</td><td colspan="4">Performance:
 
</td></tr>
<tr><td>Expected date to meet standard</td><td colspan="3">May 2017</td></tr>
<tr><td>Revised date to meet standard</td><td colspan="3"></td></tr>
<tr><td>Lead Director</td><td colspan="3">Sam Leak, Director of Emergency Care and ESM CMG</td></tr>
</table>

Cancer Waiting Times Performance

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance July	Performance 2016/17 YTD	Forecast performance for August
2ww – The Trust achieved the standard in July, exceeding this by 1.3%. 4 services failed to achieve the standard, those being Skin, Head & Neck, Sarcoma and Gynae.	**2ww –** additional activity continues to be arranged to support delivery within Head & Neck (ENT) and Skin. Patient choice is a key factor in underperformance for Gynae.	**2WW (Target: 93%)**	**94.3%**	**91.3%**	**94.3%**
		31 day 1st (Target: 96%)	**90.4%**	**94.2%**	**89.2%**
31 day first treatment – UHL's performance against this standard was 90.4%. 34 patients were treated after the 31 day target compared to 16 in June 2016. Haem, Testicular, Skin and Breast were the only tumour sites to achieve the standard within July. Continuing elective capacity and patient choice are the main factors contributing to under performance	**31 day first treatment –** Reduced emergency pressures and recovery in Urology/Lower GI/Gynae are key to the achievement of this standard. Urology has a known shortage of theatre capacity; additional long term capacity is in the process of being identified with extra sessions/ weekend working. Additional HDU capacity opened in July 2016 which enabled the services to treat previously cancelled waiting patients.	**31 day sub – Surgery (Target: 94%)**	**74.4%**	**85.1%**	**74.1%**
31 day subsequent (surgery) – Performance against this standard in July was 74.4% - a 10% deterioration from June, the issues remain with inadequate theatre capacity in key tumour sites (Urology, Gynae) and the impact of cancellations due to HDU/ITU bed availability (LRI specific).	**31 day subsequent (surgery) –** Across all tumour sites cancer patients are being prioritised over RTT patients, however cancellations due to emergency pressures are having an impact. The key issue in Urology is inadequate elective capacity; as mentioned above plans to increase their theatre capacity are ongoing. The Theatre Programme board are reviewing demand and capacity analysis across the 3 sites.	**62 day RTT (Target: 85%)**	**83.7%**	**77.8%**	**78.4%**
62 day – 62 day performance remains below target at 83.7% in July, a significant improvement from June; 35 patients from the backlog were treated. The main pressures remain robust patient pathways and supporting processes, inadequate theatre capacity and shortages in consultant staff. The only tumour sites to achieve the standard were Haem, Breast, Urology and Skin.	**62 day RTT –** Lower GI, Lung and Urology remain the most pressured tumour sites. Three band 7 service managers with responsibility for managing cancer pathways in our worst performing tumour sites are providing the key focus required. Although 62 day backlog reduction has steadily been taking place, there are increasing pressures in Urology and Gynae. 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. Monthly performance meetings and ad-hoc weekly meetings are taking place to support tumour sites as appropriate with the Cancer Management Team.	**62 day screening (Target: 90%)**	**92.3%**	**91.4%**	**86.7%**
		Current cancer performance is an area of significant concern across UHL and focus on recovery is of the highest priority within the organisation. The weekly cancer action board chaired by the Director Of Performance and Information with mandatory attendance by all tumour site leads ensures that corrective actions are taken. **62 Day July** performance has been nationally reported as 82.6%, post upload adjustments have been made which increases performance to 83.7% and this will be reflected in the quarterly position. The Trust has initiated a programme 'Next Steps' for cancer patients in 3 key tumour sites. The pilot started in the Prostate pathway in early April and has since rolled out to Lower GI and Lung. Further roll out to other tumour sites will happen in June.			
		Expected date to meet standard / target	62 day – Surgery: September 16 (at risk)		
		Revised date to meet standard	31 day 1st treatment: November 16 31 day sub – Surgery: December 16		
		Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Dan Barnes, Clinical Lead for Cancer		

Cancer Patients Breaching 104 days

What is causing underperformance?

9 cancer patients on a 62 day pathway breached 104 days at the end of July across 4 tumour sites, all of which are confirmed cancer. Three of these patients had been waiting over 6 months from initial referral.

Tumour site	Number of patients breaching 104 days
Lung	5
Gynae	1
Head & Neck	1
Urology	2

The following factors have significantly contributed to delays:

Reason	No. patients
Complex diagnostic pathway	1
Patient fitness	2
LTFU/PSA Surveillance	4
Patient initiated delays (compliance or choice)	1
Late Tertiary Referrals	1

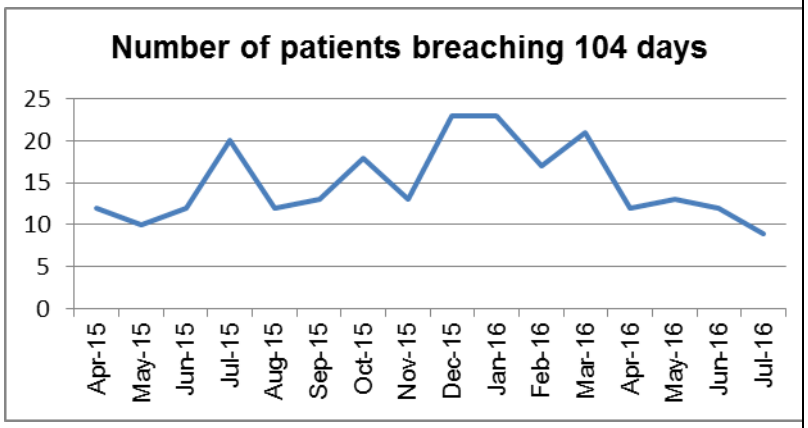
What actions have been taken to improve performance?

Current cancer performance is an area of significant concern across UHL and is given the highest priority by the executive and operational teams. The weekly cancer action board chaired by the Director Of Performance and Information with mandatory attendance by all tumour site leads ensures that corrective actions are taken.

The number of patients breaching 104 days on a 62 day pathway reduced by 3 from the end of June. The split of the numbers demonstrates patient fitness and surveillance patients account for more than 50% of the total. Ongoing monthly backlog summary reports and delay reasons are produced in conjunction with the services for thematic review and root cause resolution where appropriate. Long term follow up (Lung) and PSA Surveillance (Urology) patients where active monitoring without cancer exclusion retains these patients on a 62 day pathway are significant contributory factors for the number of patients waiting over 104 days. Lung are seeking to implement a local policy for improved pathway management to enable appropriate patients to be removed from active cancer monitoring.

Month by month breakdown of patients breaching 104 days

The graph below outlines the number of cancer patients breaching 104 days by month going back to April 2015:



NB: Not all patients have confirmed cancer. However 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 Dan Barnes, Clinical Lead for Cancer