Quality & Performance Report

Author: John Adler Sponsor: Chief Executive Date: IFPIC + QAC 23rd FEBRUARY 2017

Executive Summary from CEO

Paper C

Context

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

Questions

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

Conclusion

Good News: **Moderate harms and above** – we remain well within the agreed Quality Commitment monthly thresholds. **Diagnostic 6 week wait –** remains complaint. **Cancer Two Week Wait** - despite an 8% increase in activity this year we continue to achieve. Reported **delayed transfers of care** remain within the tolerance. However significant issues have arisen with Leicestershire social care packages. **MRSA** – 0 cases reported this month. **C DIFF –** 5 cases reported in January and year to date within trajectory. **Pressure Ulcers** – 0 **Grade 4** pressure ulcers reported this month and **Grade 3** are within the trajectory for month and year. The rate of **Falls per 1000 bed stays for patients >65years** reduced to 3.8 against a threshold of 5.5. Both **Stroke** indicators remain complaint, in month and for the year to date.

Bad News: **Mortality** – the latest published SHMI (period July 2015 to June 2016) is **101.** A recent in depth HED review of UHL mortality did not identify any additional areas of mortality by condition that needed action that we did not already have reviews or action plans in place for. **Never events** – 1 reported this month the patient came to no harm. **ED 4 hour performance** – January performance was 78.1 % with year to date performance at 78.8%. Contributing factors are set out in the Chief Operating Officer's report. **Ambulance Handover 60+ minutes** – performance 13% - similar to January 2016. . **Referral to Treatment –** was not achieved partly due to emergency pressures. **52+ week waits –** current number has increased to 34 all in MSS (including 15 Orthodontics). **Cancelled operations** and **patients rebooked within 28 days** – continued to be non-compliant, due emergency pressures. **Single Sex Accommodation Breaches** – 6 breaches during January. **Fractured NOF** – target not achieved during January. **Cancer Standards 62 day treatment** – although non-compliant an improving backlog number is noted. **Patient Satisfaction (FFT)** 96% against a target or 97%. **Statutory & Mandatory Training** – performance reduced to 81% against a target of 95%. Work is ongoing to improve compliance in Estates and Facilities.

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: 30th March 2017

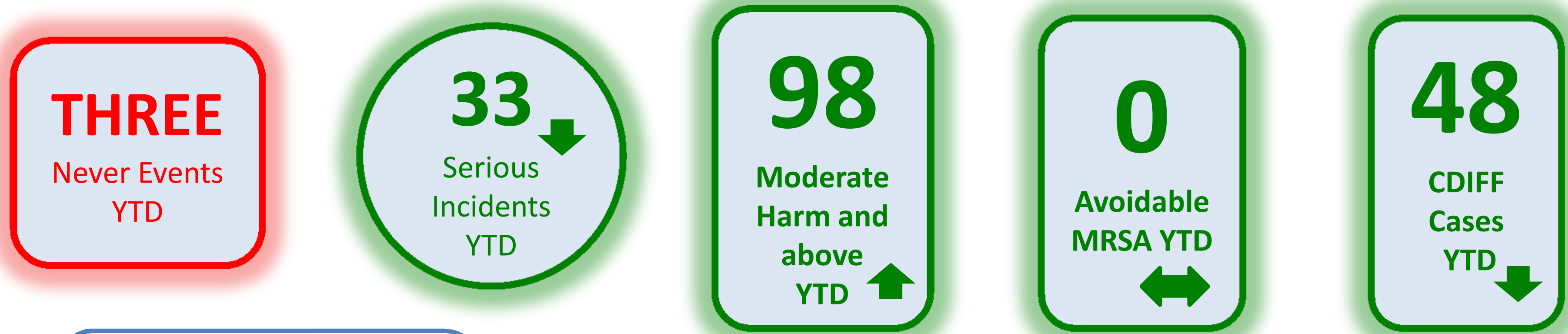
Quality and Performance Executive Summary

January 2017

Operational Delivery Unit

Domain - Safe

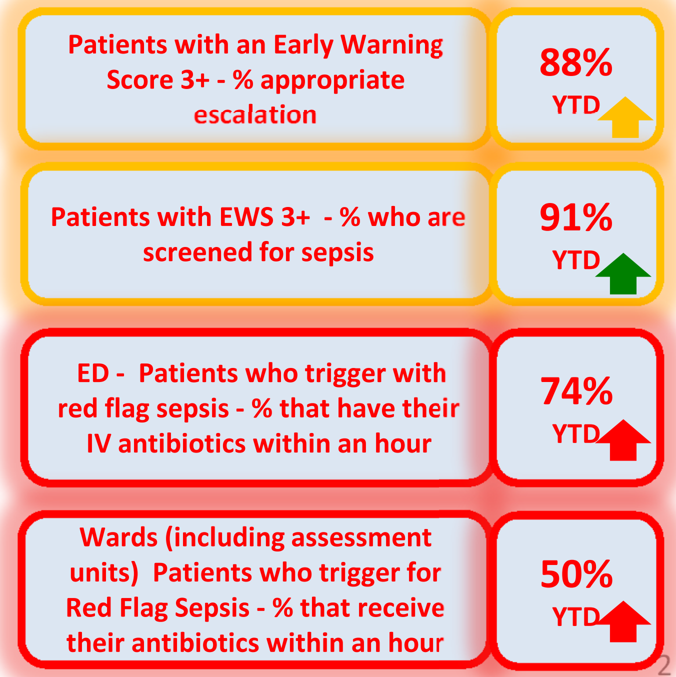
Arrows represent current month performance against previous month, upward arrow represents improvement, downward arrow represents deterioration.



Headlines

- 5 C Diff cases reported in January, with year to date within trajectory.
- Whilst there has been an increase in the number of avoidable Grade 2 pressure ulcers, overall there has been a decrease in the number of Grade 3 pressure ulcers. This suggests that less pressure ulcers are deteriorating into more serious harm.
- *Over the last six months the percentage of patients with an EWS of 3+ who are screened for sepsis has shown a steady month on month increase. Our focus continues to be ensuring an improvement in the percentage of patients that receive their antibiotics within one hour, across all areas of the Trust.*

SEPSIS



Domain - Caring

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

Friends and Family Test YTD % Positive

Inpatients FFT 96% ↓
Day Case FFT 98% ↔
A&E FFT 90% ↑
Maternity FFT 95% ↑
Outpatients FFT 94% ↔

Staff FFT Quarter 3 2016

73.3% of staff would recommend UHL as a place to receive treatment

Single sex accommodation breaches

55
YTD ↑

Headlines

- Friends and family test (FFT) for Inpatient and Daycase care combined are at 97% for the financial year.
- Patient Satisfaction (FFT) for ED increased to 93% for January, the highest it has been for six months.
- Single Sex Accommodation Breaches – numbers have decreased to 6 in January.

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 35.4% ⬇
Day Case FFT 24.1% ⬆
A&E FFT 10.4% ⬆
Maternity FFT 37.7% ⬆
Outpatients FFT 2.5% ⬆

Staff FFT Quarter 3 2016

62.9% 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%.
- Appraisals are 3.4% off target for January (this excludes facilities staff that were transferred over from Interserve).
- Statutory & Mandatory is 14% off the 95% target, predominately due to the transfer of the facilities staff.
- Please see the HR update for more information.

% Staff with Annual Appraisals

91.6% YTD ⬇

Statutory & Mandatory Training

81% YTD ⬇

BME % - Leadership

26% Qtr2
8A including medical consultants

12% Qtr2
8A excluding medical consultants

Domain – Effective

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

SHMI Apr15-Mar16

101

Jul15-Jun16 ↓

Stroke TIA clinic within 24hrs

67.9%

YTD ↑

80% of patients spending 90% stay on stoke unit

83.9%

YTD ↓

Emergency Crude Mortality Rate

2.3%

YTD ↓

30 Days Emergency Readmissions

8.5%

YTD ↓

NoFs operated on 0-35hrs

71.5%

YTD ↑

Headlines

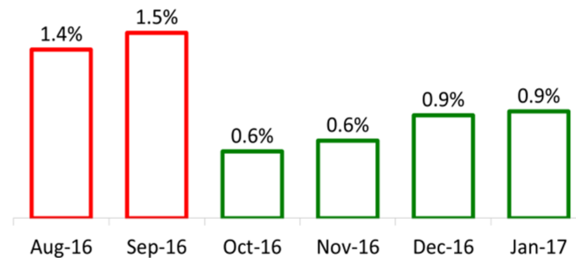
- UHL's SHMI has moved one point above the England average to 101. A recent in depth HED review of UHL mortality did not identify any additional areas of mortality by condition that needed action that we did not already have reviews or action plans in place for.
- Fractured NoF – 70.9% of patients were operated on within 0-35hours in January, 1.1% below the 72% target. Weekly Operational meetings with the Clinical Director chairing continue.

Domain – Responsive

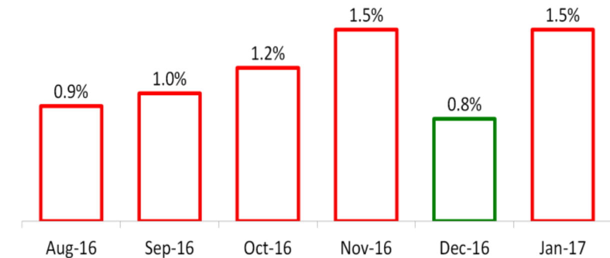
Arrows represent current month performance against previous month, upward arrow represents improvement, downward arrow represents deterioration.

RTT - Incomplete 92% in 18 Weeks

6 week Diagnostic Wait times



Cancelled Operations



RTT 52 week wait incompletes

ED 4Hr Wait

Ambulance Handovers

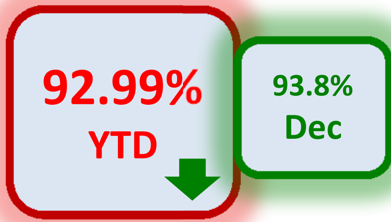
Headlines

- 52+ week waiters -15 Orthodontics, 11 ENT and 8 Paediatric ENT.
- Diagnostic 6 week wait – we have now achieved four consecutive months below the 1% national target.
- For ED 4hour wait and Ambulance Handovers please refer to Chief Operating Officers report.

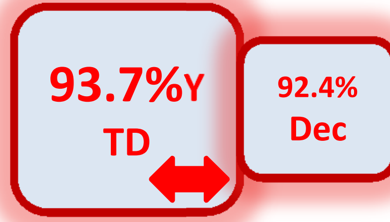
Domain – Responsive Cancer

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

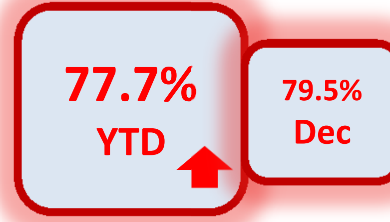
Cancer 2 week wait



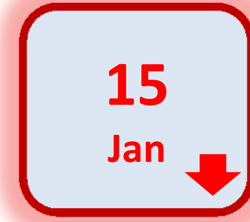
31 day wait



62 day wait



31 day backlog



Headlines

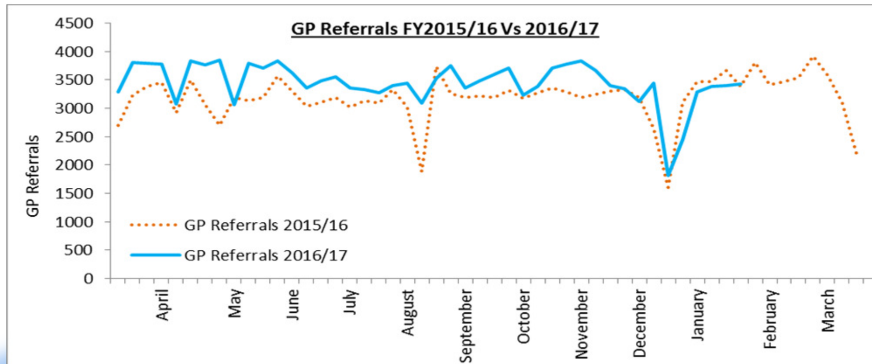
- Cancer Two Week Wait was achieved in December and is expected to remain compliant.
- 31 day wait non compliant due to emergency pressures and HDU capacity.
- Cancer Standards 62 day treatment - remains non-compliant although backlog continues to reduce.

62 day backlog

62 day adjusted backlog

UHL Activity Trends

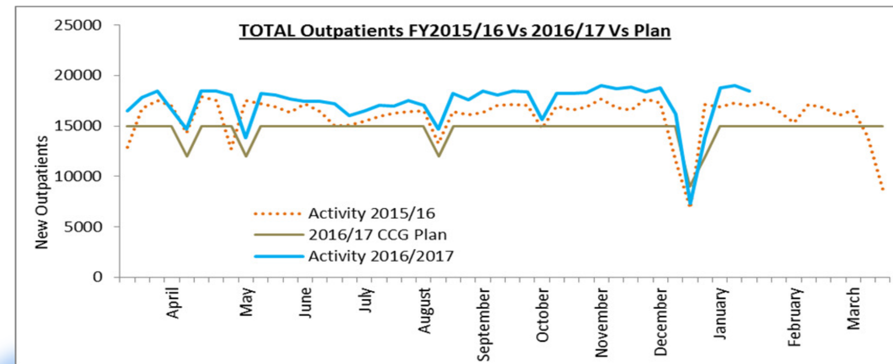
Referrals (GP)



April – January
16/17 Vs 15/16 +13,485 10%

Planned care workstream underway to reduce referrals.

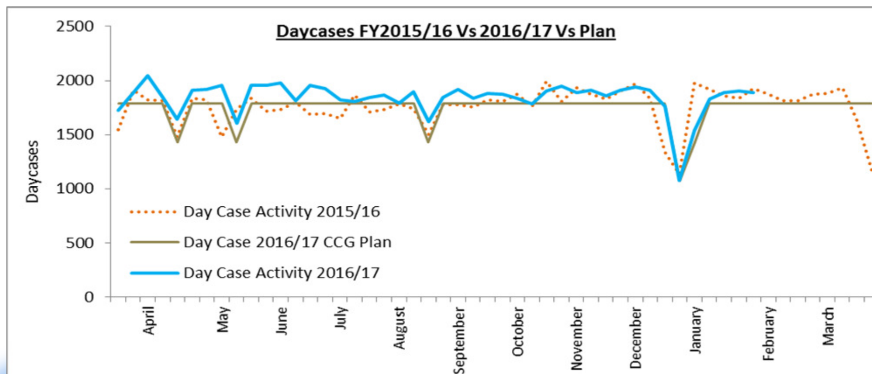
TOTAL Outpatient Appointments



April – January
16/17 Vs 15/16 +35,575 +6%
16/17 Vs Plan +32,241 +5%

Outpatients increase at a slightly lower rate than the level of GP referrals. Increase in referrals putting pressure on waiting times.

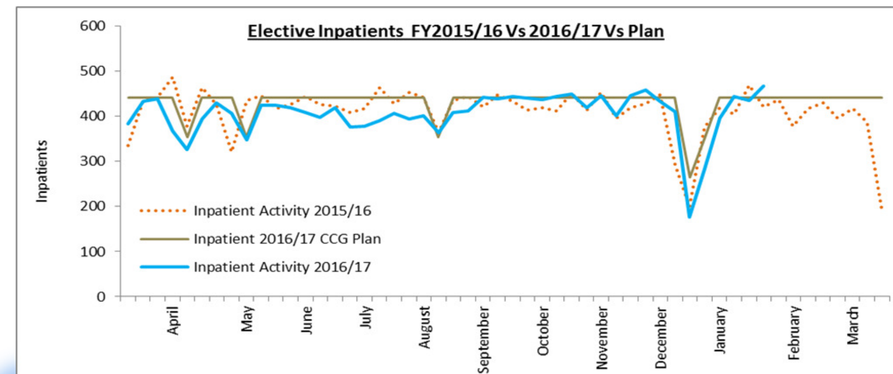
Daycases



April – January
16/17 Vs 15/16 +3,409 +5%
16/17 Vs Plan +2,664 +4%

Growth observed in Clinical Oncology and Haematology.

Elective Inpatient Admissions

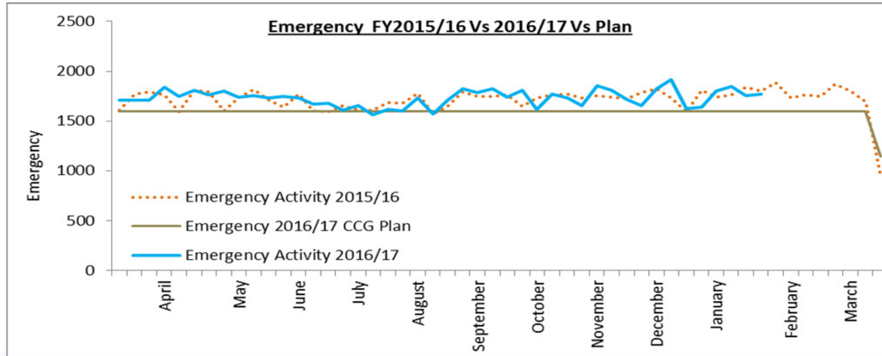


April – January
16/17 Vs 15/16 -519 -3%
16/17 Vs Plan -1,214 -7%

Pressure impacted on surgical specialties due to emergency flow.

UHL Activity Trends

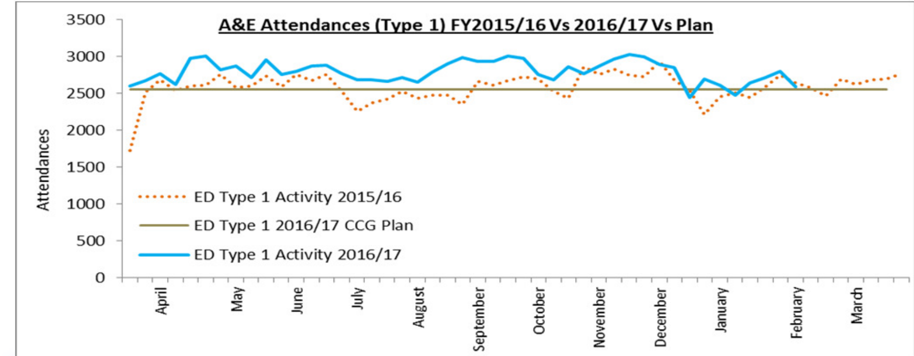
Emergency Admissions



April – January
16/17 Vs 15/16 +221 +0%
16/17 Vs Plan +1,379 +2%

Emergency admissions at GGH higher than last year offset by reduction at the LRI (Due to increase usage of GPAU)

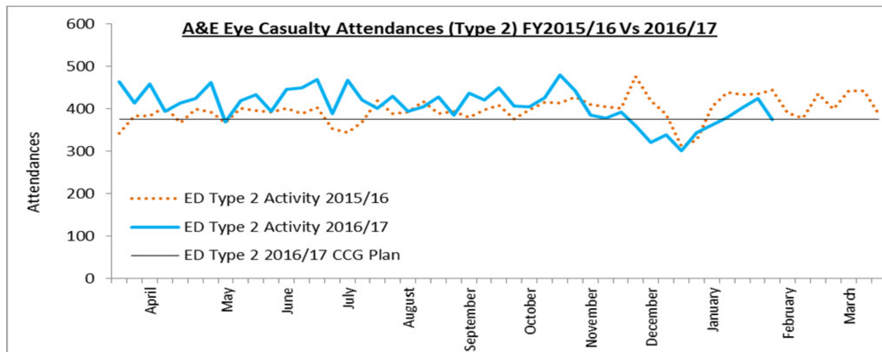
A & E Attendances (ED Type 1 only)



April – January
16/17 Vs 15/16 +9,396 +8%
16/17 Vs Plan +10,296 +9%

A&E attendances have been above plan and last year's outturn all year. RAP action for commissioners to get back to plan.

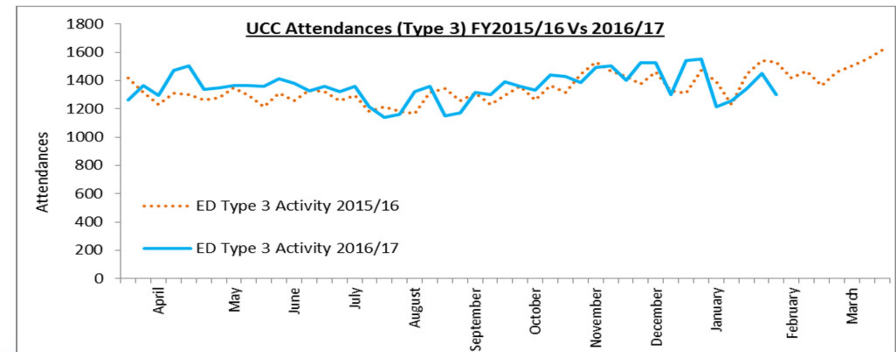
Eye Casualty Attendances (ED Type 2only)



April – January
16/17 Vs 15/16 +882 +5%
16/17 Vs Plan +770 +5%

The service have confirmed that activity levels around December was lower than expected.

UCC Attendances (Type 3, excludes referred to ED)

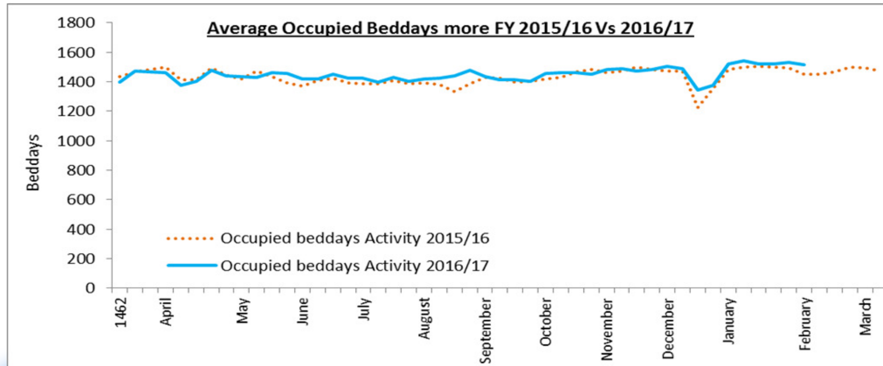


April – January
16/17 Vs 15/16 +1,180 +2%

The UCC attendance exclude patients that are referred on to ED.

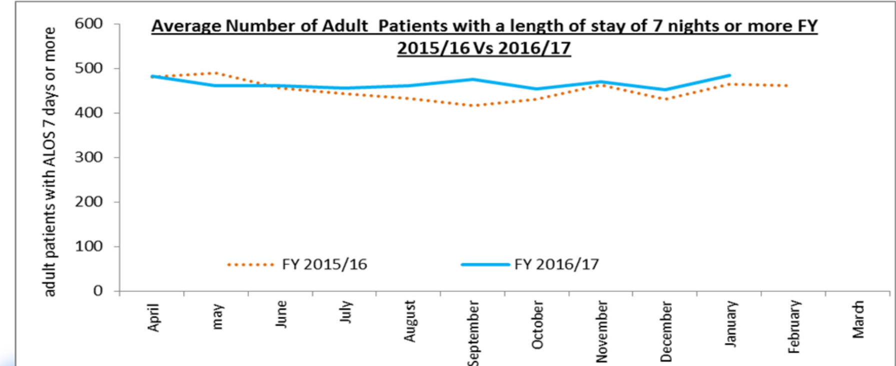
UHL Bed Occupancy

Occupied Beddays



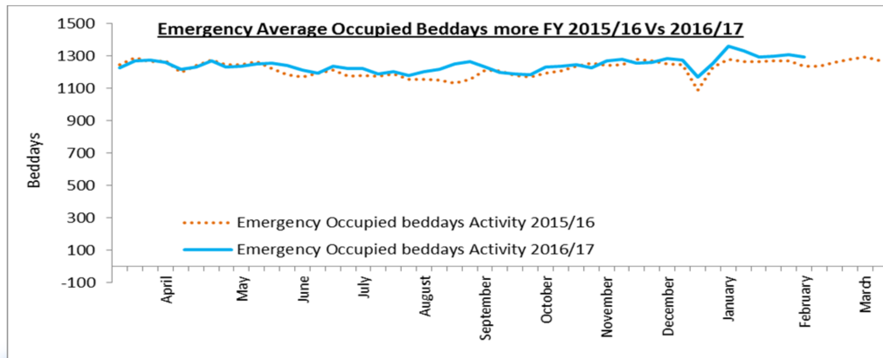
Midnight G&A bed occupancy continues to run higher this year compared to last year.

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



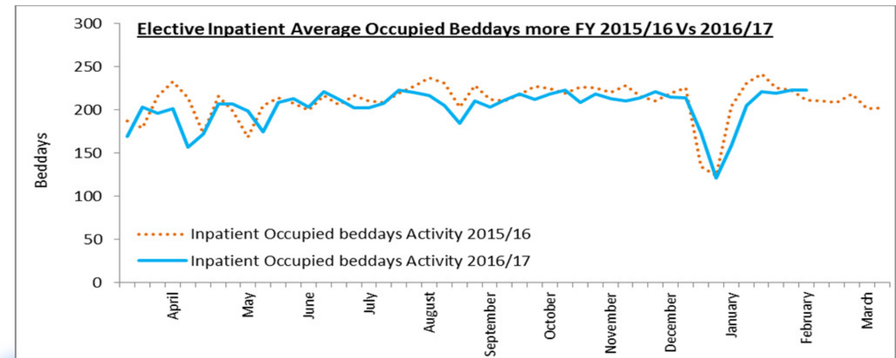
The number of patients staying in beds 7 nights or more is higher this year.

Emergency Occupied beddays



During December 2016 and January 2017 bed occupancy was higher than the same period last year.

Elective Inpatient Occupied beddays



Bed occupancy is lower for 2016/17 compared to 2015/16, most likely reflective of the emergency pressures and cancelled operations.

Sustainability and Transformation Fund – Trajectories and Performance

Cancer 62 Day | 5% of STF allocation

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

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

December Performance (one month in arrears)
79.5% against a trajectory of 85.1%

O	N	D
Red	Red	Red

January 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.

January Performance
0.9% of our patients waiting more than 6 *weeks*

N	D	J
Green	Green	Green

February 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

January Performance
90.9% of our patients waiting less than 18 weeks

February Performance: Expected to be non-compliant

N	D	J
Green	Red	Red

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

January Performance
78.1% against a target of 85.0%

February Performance: Expected to be non-compliant

N	D	J
Red	Red	Red

Caring at its best

University Hospitals of Leicester NHS Trust

Quality and Performance Report

January 2017

One team shared values

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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO:	**INTEGRATED FINANCE, PERFORMANCE AND INVESTMENT COMMITTEE** **QUALITY ASSURANCE COMMITTEE**
DATE:	**23rd FEBRUARY 2017**
REPORT BY:	**ANDREW FURLONG, MEDICAL DIRECTOR** **RICHARD MITCHELL, DEPUTY CHIEF EXECUTIVE/CHIEF OPERATING OFFICER** **JULIE SMITH, CHIEF NURSE** **LOUISE TIBBERT, DIRECTOR OF WORKFORCE AND ORGANISATIONAL DEVELOPMENT** **DARRYN KERR, DIRECTOR OF ESTATES AND FACILITIES**
SUBJECT:	**JANUARY 2017 QUALITY & PERFORMANCE SUMMARY REPORT**

1.0 Introduction

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

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

- Aggressive cost reduction plans – NHSI to provide further detail
- C Diff – infection rate – C Diff numbers vs plans included
- Potential under-reporting of patient safety incidents – NHSI to provide further detail

The following indicators have been removed from the report this month:-

- Published Clinical Outcomes - data submission and outcome results
- Compliance with NICE Guidance (15/16 and 16/17)

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

2.0 Performance Summary

Domain	Page Number	Number of Indicators	Number of Red Indicators this month
Safe	4	21	5
Caring	5	11	3
Well Led	6	24	2
Effective	7	9	5
Responsive	8	15	9
Responsive Cancer	9	9	6
Research – UHL	15	6	0
Total		95	30

Safe

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	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	YTD
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	18	16	17	9	10	8	12	11	14	13	11	10		98
S2	Serious Incidents - actual number escalated each month	AF	MD	<=49 by end of FY 16/17 (revised)	UHL	Red / ER if >8 in mth or >5 for 3 consecutive mths	41	50	3	4	6	4	5	5	1	3	4	2	4	4	2	3	33
S3	Proportion of reported safety incidents per 1000 attendances (IP, OP and ED)	AF	MD	> FY 15/16	UHL	TBC		17.5	17.7	18.8	16.2	17.2	17.1	16.8	16.3	19.3	18.2	16.4	16.2	15.2	16.7	15.2	16.7
S4	SEPSIS - Patients with an Early Warning Score 3+ - % appropriate escalation	AF	SH	95%	UHL	TBC	New Indicator										86%	91%	86%	89%	88%	89%	88%
S5	SEPSIS - Patients with EWS 3+ - % who are screened for sepsis	AF	SH	95%	UHL	TBC	New Indicator										65%	91%	95.0%	98.9%	98.9%	99.3%	91%
S6	SEPSIS - ED - Patients who trigger with red flag sepsis - % that have their IV antibiotics within an hour	AF	SH	90%	UHL	TBC	New Indicator						63%	71%	71%	66%	69%	75%	79%	82%	76%	83%	74%
S7	SEPSIS - Wards (including assessment units) Patients who trigger for Red Flag Sepsis - % that receive their antibiotics within an hour	AF	SH	90%	UHL	TBC	New Indicator						33%	50%	21%	42%	23%	45%	61%	67%	76%	78%	50%
S8	Overdue CAS alerts	AF	MD	0	NHSI	Red if >0 in mth ER = in mth >0	10	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
S9	RIDDOR - Serious Staff Injuries	AF	MD	FYE <=40	UHL	Red / ER if non compliance with cumulative target	24	32	5	3	2	2	5	3	3	1	0	2	4	4	2	5	29
S10	Never Events	AF	MD	0	NHSI	Red if >0 in mth ER = in mth >0	3	2	0	0	0	1	0	0	0	1	0	0	0	1	0	1	3
S11	Clostridium Difficile	JS	DJ	61	NHSI	Red if >mthly threshold / ER if Red or Non compliance with cumulative target	73	60	6	7	7	6	4	5	6	1	7	8	5	7	0	5	48
S12	MRSA Bacteraemias (All)	JS	DJ	0	NHSI	Red if >0 ER if >0	6	1	0	0	0	1	0	0	0	1	0	0	0	0	0	0	1
S13	MRSA Bacteraemias (Avoidable)	JS	DJ	0	UHL	Red if >0 ER if >0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
S14	% of UHL Patients with No Newly Acquired Harms	JS	RB	Within expected (revised)	UHL	Red if <95% ER if in mth <95%		97.7%	98.2%	97.7%	97.9%	98.0%	96.9%	97.2%	98.4%	97.9%	98.6%	97.9%	98.0%	97.3%	98.0%	98.0%	97.8%
S15	% of all adults who have had VTE risk assessment on adm to hosp	AF	SH	>=95%	NHSI	Red if <95% ER if in mth <95%	95.8%	95.9%	96.1%	95.5%	95.4%	95.1%	95.9%	96.1%	96.5%	96.1%	96.0%	95.7%	96.3%	96.3%	95.1%	95.0%	95.9%
S16	All falls reported per 1000 bed stays for patients >65years	JS	HL	<=5.5 (revised)	UHL	Red if >=6.6 ER if 2 consecutive reds	6.9	5.4	5.7	5.4	4.9	5.2	6.5	5.8	6.0	5.6	6.4	6.0	5.4	5.5	5.6	3.8	5.6
S17	Avoidable Pressure Ulcers - Grade 4	JS	MC	0	QS	Red / ER if Non compliance with monthly target	2	1	0	0	1	0	0	0	0	0	0	0	0	1	0	0	1
S18	Avoidable Pressure Ulcers - Grade 3	JS	MC	<=4 a month (revised) with FY End <33	QS	Red / ER if Non compliance with monthly target	69	33	5	6	2	5	5	3	2	2	2	2	2	2	2	2	24
S19	Avoidable Pressure Ulcers - Grade 2	JS	MC	<=7 a month (revised) with FY End <89	QS	Red / ER if Non compliance with monthly target	91	89	5	5	8	7	9	6	8	3	13	6	9	10	5	8	77
S20	Maternal Deaths	AF	IS	0	UHL	Red or ER if >0	1	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	2
S21	Emergency C Sections (Coded as R18)	IS	EB	Not within Highest Decile	NHSI	Red / ER if Non compliance with monthly target	16.5%	17.5%	20.9%	17.0%	16.6%	17.3%	17.8%	16.8%	17.2%	17.0%	15.0%	18.1%	16.9%	15.3%	16.3%	17.9%	16.8%

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	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	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%			Next survey to be done in Q3			69%				69%
C2	Formal complaints rate per 1000 IP,OP and ED attendances	AF	MD	No Target	UHL	Monthly reporting	NEW INDICATOR		0.9	1.0	1.4	1.2	1.0	1.0	0.9	0.8	1.2	1.4	1.1	1.2	1.2	1.3	1.1
C3	Percentage of upheld PHSO cases	AF	MD	No Target	UHL	Quarterly reporting	NEW INDICATOR						10% (1 out of 10 cases)			0% (0 out of 7 cases)			0% (0 out of 3 cases)				5%
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%	96%	97%	97%	97%	97%	97%	96%	97%	96%	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%	96%	97%	97%	96%	97%	96%	95%	96%	96%	96%	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%	98%	98%	98%	98%	98%	99%	98%	98%	98%	98%	98%	98%	98%	98%
C7	A&E Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <94% ER if 2 mths Red	96%	96%	95%	97%	97%	95%	96%	95%	95%	87%	87%	84%	87%	84%	91%	93%	90%
C8	Outpatients Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <90% ER if 2 mths Red		94%	94%	95%	95%	93%	95%	95%	95%	94%	94%	95%	95%	95%	92%	92%	94%
C9	Maternity Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <94% ER if 2 mths Red	96%	95%	94%	95%	95%	95%	95%	94%	94%	95%	95%	95%	95%	94%	93%	96%	95%
C10	Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment	LT	LT	TBC	NHSI	TBC	69.2%	70.0%		70.7%			72.3%			76.0%			73.3%				73.9%
C11	Single Sex Accommodation Breaches (patients affected)	JS	HL	0	NHSI	Red / ER if >0	13	1	0	0	1	0	0	0	4	1	2	20	7	1	14	6	55

Well Led

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	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	YTD
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%						Achieved			Achieved			Achieved			Achieved
W2	Published Inpatients and Daycase Friends and Family Test - Coverage (Adults and Children)	JS	HL	Not Appicable		Not Appicable		27.4%	23.5%	31.9%	32.8%	32.9%	31.7%	32.0%	31.6%	31.9%	28.5%	27.8%	31.6%	31.6%	27.5%	27.2%	30.1%
W3	Inpatients only Friends and Family Test - Coverage (Adults and Children)	JS	HL	30%	QS	Red if <26% ER if 2mths Red		31.0%	23.2%	29.3%	37.2%	36.1%	35.6%	36.7%	38.1%	36.9%	36.5%	33.1%	36.6%	37.0%	31.9%	31.3%	35.4%
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%	18.7%	30.1%	26.2%	29.2%	27.3%	26.5%	24.5%	26.2%	19.8%	21.6%	25.9%	25.7%	22.3%	22.5%	24.1%
W5	A&E Friends and Family Test - Coverage	JS	HL	20%	NHSI	Red if <10% ER if 2 mths Red		10.5%	5.4%	7.3%	5.1%	7.0%	13.0%	10.2%	12.0%	8.7%	9.9%	11.7%	9.8%	11.4%	7.1%	10.4%	10.4%
W6	Outpatients Friends and Family Test - Coverage	JS	HL	>=5%	UHL	Red/ER if <1.4%		1.4%	1.4%	1.5%	1.6%	1.6%	1.5%	1.7%	1.8%	1.7%	1.6%	1.5%	1.5%	1.8%	5.7%	5.9%	2.5%
W7	Maternity Friends and Family Test - Coverage	JS	HL	30%	UHL	Red if <26% ER if 2 mths Red	28.0%	31.6%	30.0%	33.3%	34.3%	31.7%	27.9%	38.3%	39.3%	38.2%	38.7%	37.8%	38.3%	41.1%	37.1%	40.9%	37.7%
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%			58.9%			60.3%			62.9%			62.9%			62.0%
W9	Nursing Vacancies	JS	MM	TBC	UHL	Separate report submitted to QAC		8.4%	7.6%	7.7%	6.8%	8.4%	8.2%	8.5%	8.9%	9.2%	8.2%	8.7%	10.3%	9.7%	7.1%	7.6%	7.6%
W10	Nursing Vacancies in ESM CMG	JS	MM	TBC	UHL	Separate report submitted to QAC		17.2%	14.9%	16.4%	17.2%	18.5%	18.1%	18.9%	19.8%	20.1%	20.3%	21.4%	20.0%	20.2%	14.5%	11.9%	11.9%
W11	Turnover Rate	LT	LG	TBC	NHSI	Red = 11% or above ER = Red for 3 Consecutive Mths	11.5%	9.9%	10.0%	10.1%	10.0%	9.9%	9.7%	9.6%	9.4%	9.4%	9.3%	9.2%	9.1%	9.2%	9.3%	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%	3.9%	4.0%	4.3%	4.2%	4.0%	3.4%	3.4%	3.3%	3.1%	3.4%	3.5%	3.7%	3.7%		3.5%
W13	Temporary costs and overtime as a % of total paybill	LT	LG	TBC	NHSI	TBC	9.4%	10.7%	10.1%	11.0%	9.7%	13.9%	10.5%	9.5%	10.9%	10.2%	10.5%	10.7%	10.9%	10.9%	10.1%	10.8%	10.6%
W14	% of Staff with Annual Appraisal (excluding facilities Services)	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	91.4%	90.7%	92.7%	91.5%	91.6%	90.7%	91.5%	92.2%	92.4%	92.9%	92.4%	91.5%	91.4%	91.9%	91.7%	91.6%	91.6%
W15	Statutory and Mandatory Training	LT	BK	95%	UHL	TBC	95%	93%	93%	93%	92%	93%	92%	93%	94%	93%	91%	82%	82%	82%	83%	81%	81%
W16	% Corporate Induction attendance	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	100%	97%	92%	96%	98%	98%	94%	96%	97%	100%	97%	92%	96%	95%	99%	98%	98%
W17	BME % - Leadership (8A – Including Medical Consultants)	LT	DB	28%	UHL	4% improvement on Qtr 1 baseline								24%			25%			26%			26%
W18	BME % - Leadership (8A – Excluding Medical Consultants)	LT	DB	28%	UHL	4% improvement on Qtr 1 baseline								12%			12%			12%			12%
W19	Executive Team Turnover Rate - Executive Directors (rolling 12 months)	LT	DB	TBC	UHL	TBC							0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
W20	Executive Team Turnover Rate - Non Executive Directors (rolling 12 months)	LT	DB	TBC	UHL	TBC							14%	14%	29%	43%	43%	43%	43%	43%	25%	25%	25%
W21	DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	TBC	NHSI	TBC	91.2%	90.5%	91.0%	90.5%	89.5%	90.2%	91.6%	91.3%	91.4%	89.7%	89.4%	89.9%	90.0%	89.3%	90.4%	91.6%	90.4%
W22	DAY Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	TBC	NHSI	TBC	94.0%	92.0%	93.9%	92.1%	86.0%	88.7%	92.5%	93.7%	93.8%	92.0%	94.7%	91.0%	91.9%	93.2%	91.9%	89.7%	92.4%
W23	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	TBC	NHSI	TBC	94.9%	95.4%	94.8%	96.6%	95.0%	96.3%	97.6%	97.2%	96.6%	94.5%	95.0%	95.1%	96.7%	95.9%	96.9%	97.6%	96.3%
W24	NIGHT Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	TBC	NHSI	TBC	99.8%	98.9%	98.0%	100.2%	91.6%	94.7%	98.3%	99.1%	96.7%	97.1%	98.2%	96.8%	94.2%	95.6%	98.5%	95.8%	97.0%

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	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	YTD
E1	Emergency readmissions within 30 days following an elective or emergency spell	AF	MM	Monthly <8.5% (revised)	QC	Red if >8.6% ER if >8.6%	8.5%	8.9%	9.2%	8.8%	8.7%	8.8%	8.7%	8.7%	8.6%	8.3%	8.4%	8.5%	8.5%	8.1%	8.7%		8.5%
E2	Mortality - Published SHMI	AF	RB	<=99 (revised)	QC	Red if >100 ER if >100	103	96	95 (Jul14-Jun15)			96 (Oct14-Sep15)			98 (Jan15-Dec15)			99 (Apr15-Mar16)			101 (Jul15-Jun16)		101
E3	Mortality - Rolling 12 mths SHMI (as reported in HED) Rebased	AF	RB	<=99 (revised)	QC	Red if >100 ER if >100	98	97	99	98	98	99	100	100	101	102	101	101	101	Awaiting HED Update			101
E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	AF	RB	<=99 (revised)	UHL	Red if >100 ER if >100	94	96	95	95	95	97	99	99	100	102	103	102	102	102	Awaiting HED Update		102
E5	Crude Mortality Rate Emergency Spells	AF	RB	No Threshold	UHL	Monthly Reporting	2.4%	2.3%	2.5%	2.4%	2.4%	2.7%	2.4%	2.2%	2.2%	2.2%	2.2%	2.0%	2.2%	2.3%	2.7%	2.9%	2.3%
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%	59.7%	66.7%	65.2%	65.1%	78.0%	78.1%	64.6%	86.0%	65.8%	69.4%	64.1%	78.0%	60.3%	70.9%	71.5%
E7	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions (excluding medically unfit patients)	AF	AC	72% or above	UHL	Red if <72% ER if 2 consecutive mths <72%	NEW INDICATOR					73.2%	86.8%	87.7%	73.2%	90.0%	82.0%	87.2%	78.2%	89.0%	79.5%	89.5%	84.3%
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%	87.0%	90.6%	87.0%	86.5%	72.7%	93.5%	83.8%	80.7%	88.0%	84.5%	86.5%	88.0%	80.7%		83.9%
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%	68.4%	71.3%	80.0%	67.3%	53.5%	68.2%	50.4%	54.8%	71.7%	65.3%	83.8%	75.9%	69.2%	87.7%	67.9%

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	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	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%	85.1%	81.2%	80.2%	77.5%	81.2%	79.9%	80.6%	76.9%	80.1%	79.9%	78.3%	77.6%	75.5%	78.1%	78.8%
R2	12 hour trolley waits in A&E	RM	IL	0	NHSI	Red if >0 ER via ED TB report	4	2	1	0	0	0	0	0	0	0	0	0	0	0	1	9	10
R3	RTT - Incomplete 92% in 18 Weeks UHL+ALLIANCE	RM	WM	92% or above	NHSI	Red /ER if <92%	96.7%	92.6%	93.0%	92.9%	93.2%	92.6%	92.7%	92.7%	92.4%	92.4%	92.1%	91.7%	91.5%	92.2%	91.3%	90.9%	90.9%
R4	RTT 52 Weeks+ Wait (Incompletes) UHL+ALLIANCE	RM	WM	0	NHSI	Red /ER if >0	0	232	267	269	261	232	169	134	130	77	57	53	38	34	32	34	34
R5	6 Week - Diagnostic Test Waiting Times (UHL+ALLIANCE)	RM	WM	1% or below	NHSI	Red /ER if >1%	0.9%	1.1%	7.0%	4.1%	1.8%	1.1%	0.7%	0.6%	0.7%	0.6%	1.4%	1.5%	0.6%	0.6%	0.9%	0.9%	0.9%
R6	Urgent Operations Cancelled Twice (UHL+ALLIANCE)	RM	GH	0	NHSI	Red if >0 ER if >0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	3
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	6	6	9	14	24	16	18	20	19	10	9	13	18	22	169
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	5	0	0	0	6	0	0	0	0	0	11
R9	% Operations cancelled for non-clinical reasons on or after the day of admission UHL	RM	GH	0.8% or below	Contract	Red if >0.9% ER if >0.8%	0.9%	1.0%	1.1%	1.3%	1.2%	1.5%	1.5%	1.2%	1.4%	1.1%	0.9%	1.0%	1.2%	1.5%	0.8%	1.6%	1.2%
R10	% Operations cancelled for non-clinical reasons on or after the day of admission ALLIANCE	RM	GH	0.8% or below	Contract	Red if >0.9% ER if >0.8%	0.9%	0.9%	1.1%	2.2%	0.2%	1.0%	0.8%	0.3%	0.8%	1.4%	3.2%	0.9%	2.0%	0.5%	0.1%	0.4%	1.0%
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%	1.1%	1.4%	1.1%	1.4%	1.5%	1.2%	1.4%	1.1%	1.0%	1.0%	1.2%	1.4%	0.8%	1.5%	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	115	146	119	156	156	123	154	114	110	109	134	164	82	167	1313
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%	1.6%	1.8%	1.8%	2.0%	1.9%	1.8%	2.2%	2.9%	2.5%	2.1%	2.0%	2.7%	2.8%	2.7%	2.4%
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%	16%	12%	10%	11%	6%	6%	6%	9%	7%	9%	9%	11%	17%	13%	9%
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%	23%	13%	13%	13%	11%	12%	10%	15%	14%	15%	18%	18%	18%	15%	15%

Responsive Cancer

** Cancer statistics are reported a month in arrears.

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	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	YTD
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%	93.0%	91.4%	93.9%	93.0%	91.1%	89.5%	90.5%	94.3%	94.9%	94.5%	93.3%	95.2%	93.8%	**	92.99%
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%	93.5%	96.2%	99.3%	95.7%	96.1%	88.7%	94.9%	98.7%	95.9%	95.0%	90.7%	96.0%	91.1%	**	94.1%
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%	94.3%	91.5%	92.6%	94.1%	95.4%	95.5%	95.6%	90.4%	91.3%	93.8%	94.8%	94.2%	92.4%	**	93.7%
RC4	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	RM	DB	98% or above	NHSI	Red if <98% ER if Red for 2 consecutive mths	99.4%	99.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	**	99.7%
RC5	31-Day Wait For Second Or Subsequent Treatment: Surgery	RM	DB	94% or above	NHSI	Red if <94% ER if Red for 2 consecutive mths	89.0%	85.3%	91.4%	77.5%	77.9%	80.3%	90.3%	91.6%	84.7%	74.4%	72.7%	83.5%	90.4%	83.3%	87.2%	**	84.1%
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%	94.3%	96.4%	92.9%	96.4%	98.8%	93.6%	87.3%	92.5%	81.4%	90.9%	97.8%	94.8%	98.1%	**	92.2%
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%	80.9%	75.1%	73.4%	77.6%	75.8%	74.5%	77.3%	83.6%	78.4%	77.9%	74.5%	77.2%	79.5%	**	77.7%
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%	95.3%	77.3%	72.5%	81.3%	94.6%	96.0%	85.0%	92.3%	78.9%	81.5%	84.2%	88.0%	90.9%	**	88.3%
RC9	Cancer waiting 104 days	RM	DB	0	NHSI	TBC			23	23	17	21	12	7	15	12	9	7	7	9	10	8	8

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	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Dec-16	YTD
RC10	Brain/Central Nervous System	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	--	100.0%	--	--	100.0%	--	--	--	--	--	--	100.0%	--	--	--	**	100.0%
RC11	Breast	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	92.6%	95.6%	93.1%	94.6%	100.0%	94.1%	93.3%	95.3%	97.1%	100.0%	100.0%	95.8%	100.0%	95.8%	94.6%	**	97.0%
RC12	Gynaecological	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	77.5%	73.4%	85.7%	50.0%	70.0%	78.6%	72.7%	78.6%	75.0%	62.5%	66.7%	66.7%	80.0%	66.7%	44.4%	**	67.2%
RC13	Haematological	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	66.5%	63.0%	58.3%	100.0%	60.0%	60.0%	14.3%	61.5%	72.7%	100.0%	85.7%	28.6%	58.3%	77.8%	66.7%	**	65.5%
RC14	Head and Neck	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	69.9%	50.7%	37.5%	62.5%	37.5%	35.7%	35.7%	45.5%	100.0%	42.9%	44.4%	0.0%	38.5%	66.7%	33.3%	**	43.0%
RC15	Lower Gastrointestinal Cancer	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	63.7%	59.8%	77.8%	52.4%	31.3%	57.1%	62.5%	45.0%	64.5%	58.8%	64.4%	47.1%	38.1%	61.5%	75.0%	**	56.1%
RC16	Lung	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	69.9%	71.0%	81.6%	73.7%	53.8%	71.1%	66.7%	46.7%	64.2%	60.9%	64.2%	68.0%	79.4%	67.5%	79.5%	**	66.1%
RC17	Other	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	95.0%	71.4%	--	66.7%	--	--	0.0%	50.0%	100.0%	100.0%	33.3%	0.0%	66.7%	--	100.0%	**	53.8%
RC18	Sarcoma	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	46.2%	81.3%	--	--	100.0%	100.0%	0.0%	50.0%	16.7%	--	--	100.0%	50.0%	100.0%	66.7%	**	47.8%
RC19	Skin	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	96.7%	94.1%	94.9%	100.0%	92.5%	94.6%	95.2%	100.0%	96.8%	97.4%	95.9%	97.7%	100.0%	92.3%	97.0%	**	97.1%
RC20	Upper Gastrointestinal Cancer	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	73.9%	63.9%	90.0%	42.9%	57.1%	76.5%	74.3%	70.0%	46.9%	66.7%	82.0%	70.3%	43.8%	100.0%	72.0%	**	68.3%
RC21	Urological (excluding testicular)	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	82.6%	74.4%	75.0%	67.4%	78.7%	83.6%	83.7%	73.1%	77.8%	96.3%	74.5%	83.5%	88.2%	75.0%	79.3%	**	81.3%
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%	80.9%	75.1%	73.4%	77.6%	75.8%	74.5%	77.3%	83.6%	78.4%	77.9%	74.5%	77.2%	79.5%	**	77.7%

The Sustainability and Transformation Fund Trajectories and Performance

ED trajectory

	Submitted on a "best endeavours" basis											
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Performance	78%	78%	79%	79%	80%	85%	85%	85%	85%	89%	89%	91.2%
Actual	**81%**	**80%**	**81%**	**77%**	**80%**	**80%**	**78%**	**78%**	**76%**	**78%**		

Cancer

			Submitted on a "best endeavours" basis									
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Performance	70.2%	74.0%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%
Actual	**75.8%**	**74.5%**	**77.3%**	**83.6%**	**78.4%**	**77.9%**	**73.9%**	**77.2%**	**79.5%**			

Diagnostics

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Performance	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%
Actual	**0.7%**	**0.6%**	**0.7%**	**0.6%**	**1.4%**	**1.5%**	**0.6%**	**0.6%**	**0.9%**	**0.9%**		

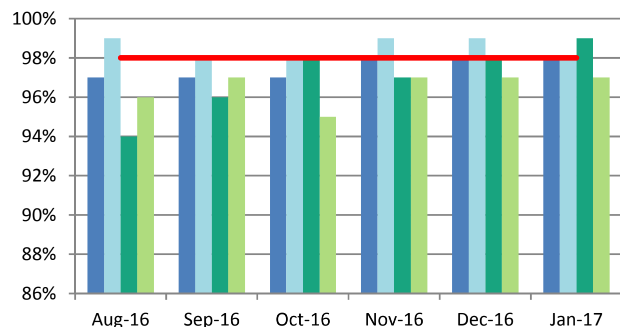
RTT

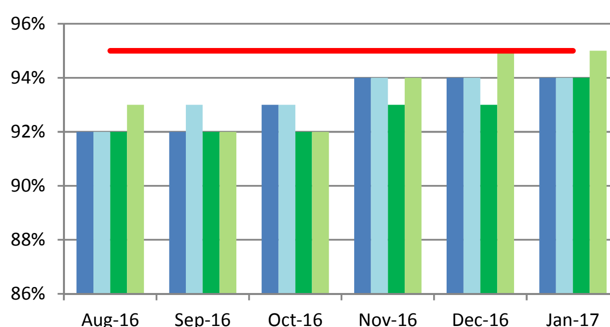
	Submitted on a "best endeavours" basis April - June											
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Performance	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Actual	**92.7%**	**92.7%**	**92.4%**	**92.4%**	**92.1%**	**91.7%**	**91.5%**	**92.2%**	**91.3%**	**90.9%**		

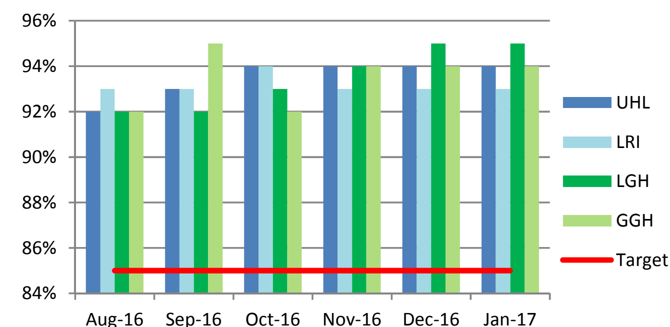
Compliance Forecast for Key Responsive Indicators

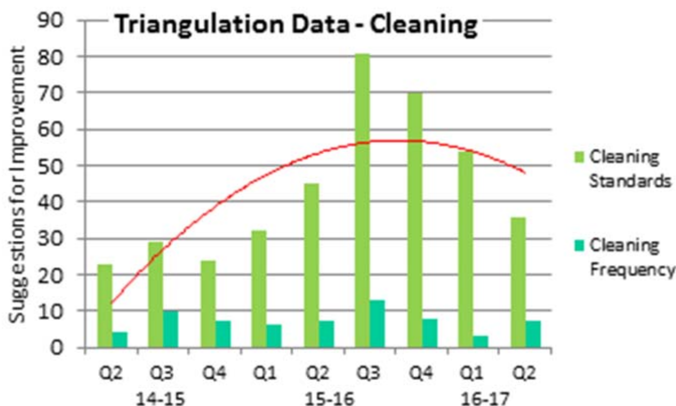
Standard	January	February	Commentary
Emergency Care			
4+ hr Wait (95%) - Calendar month	78.1%		Validated position
Ambulance Handover (CAD+)			
% Ambulance Handover >60 Mins (CAD+)	13%		EMAS monthly report
% Ambulance Handover >30 Mins and <60 mins (CAD+)	15%		
RTT (inc Alliance)			
Incomplete (92%)	90.9%	89.7%	Elective operations cancelled for 10 days in February to protect emergency and cancer capacity.
Diagnostic (inc Alliance)			
DM01 - diagnostics 6+ week waits (<1%)	0.9%	0.9%	
# Neck of femurs			
% operated on within 36hrs - all admissions (72%)	71%	72%	
% operated on within 36hrs - pts fit for surgery (72%)	90%	85%	
Cancelled Ops (inc Alliance)			
Cancelled Ops (0.8%)	1.5%	1.4%	Delivery is dependant on access to beds.
Not Rebooked within 28 days (0 patients)	22	15	Delivery is dependant on access to beds.
Cancer			
Two Week Wait (93%)	93%	93%	
31 Day First Treatment (96%)	89%	90%	In discussion with NHSI compliance will be following 2 months of consistent bed access.
31 Day Subsequent Surgery Treatment (94%)	90%	90%	
62 Days (85%)	80%	80%	In discussion with NHSI compliance will be following 2 months of consistent bed access.
Cancer waiting 104 days (0 patients)	8	8	

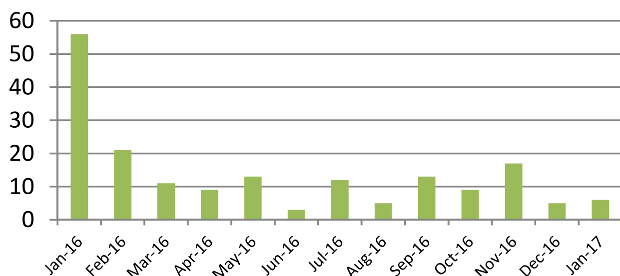
Estates and Facilities – Cleanliness











Cleanliness Report

The above charts show average audit scores for the whole Trust and by hospital site since August 2016 – when services were transferred back in-house. Each chart covers specific risk categories:-

- Very High – e.g. Operating Theatres, ITUs, A&E - Target Score 98%
- High – Wards e.g. Sterile supplies, Public Toilets – Target Score 95%
- Significant – e.g. Outpatient Departments, Pathology labs

Cleanliness audits are undertaken jointly involving both ward staff as well as members of the Facilities Team.

For very high risk areas the data shows that this was achieved in January 2017 overall across the Trust with a very slight improvement over last month with GH continuing to perform at 1% below target.
High risk areas are consistent with December 2016 scores, with GH now achieving to the required 95%. Slight improvement is still required in LGH and LRI.
Significant risk areas all exceed the 85% target.
The general trend remains one of continuous but very steady improvement.

The triangulation data is collected by the Trust from numerous patient sources including Message to Matron, Friends and Family Test, Complaints, Online sources and Message to Volunteer or Carer collated collectively as 'Suggestions for Improvement'.
As this data is only collated on a quarterly basis the chart included here is as presented in December's report and will be updated for the February report.

As a further test of service standards and issues the number of datix incidents logged for January remains low.

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

Estates and Facilities – Patient Catering

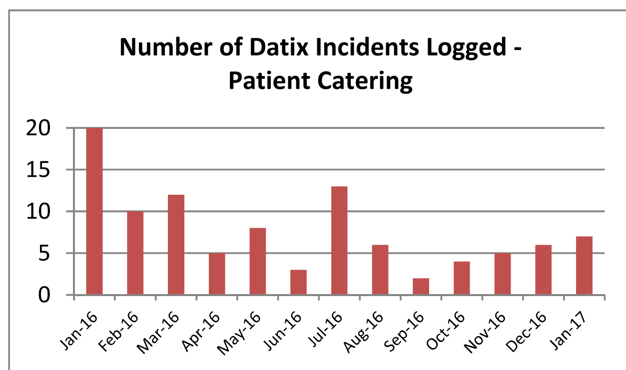
Patient Catering Survey – November 2016	Percentage 'OK or Good'	
	Dec-16	Jan-17
Did you enjoy your food?	82%	74%
Did you feel the menu has a good choice of food?	91%	94%
Did you get the meal that you ordered?	98%	100%
Were you given enough to eat?	97%	100%

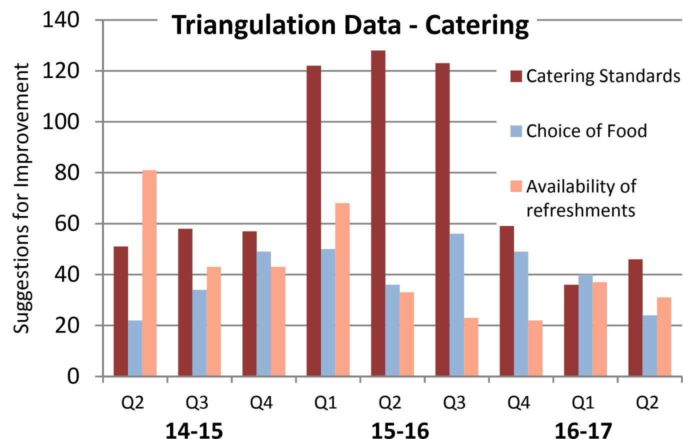
90 – 100%	80 – 90%	<80%

Number of Patient Meals Served				
Month	LRI	LGH	GGH	UHL
November	63,828	22,251	28,460	114,539
December	67,893	22,532	27,945	118,370
January	64,921	24,276	28,546	117,743

Patient Meals Served On Time (%)				
Month	LRI	LGH	GGH	UHL
November	100%	100%	100%	100%
December	100%	100%	100%	100%
January	100%	100%	100%	100%

97 – 100%	95 – 97%	<95%





Patient Catering Report

Due to a poor rate of return the patient catering survey results for January were based on a sample of only 31 patients. As a result the methodology for collecting the data is under review. Whilst the majority of patients continue to report that they enjoyed their meals, the January figure shows a clear dip. Datix incidents reported are also slowly increasing.

From the comments made to date in the survey the recurrent issues are around :-

- 'soggy batter' on fish
- vegetables 'too hard' or 'undercooked'
- lack of cooked breakfast
- insufficient choice (tending to come from longer stay patients)

Despite the comments about fish this still remains a popular choice. The Steamplicity regeneration system will not produce a crispy texture with batter and previous attempts to remove this from the menu have met with even more complaints.
Cooking of vegetables tends to be a personal taste issue and on balance, in order to preserve nutritional content and taste they are served 'firm' rather than soft and overcooked.

Further comment data will be collected to identify trends.

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

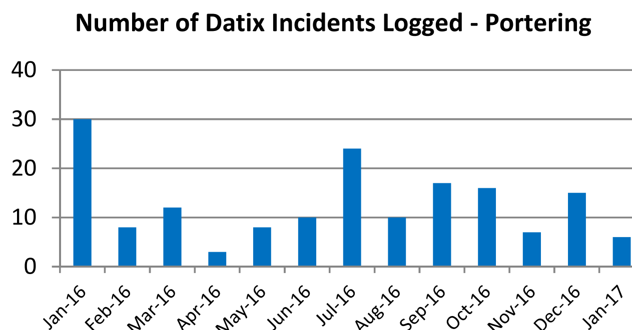
The triangulation data is refreshed on a quarterly basis and therefore the chart presented here is repeated from the December report. The updated position will be presented in next month's report.

Estates and Facilities - Portering

Reactive Portering Tasks in Target				
Site	Task (Urgent 15min, Routine 30min)	Month		
		November	December	January
GH	Overall	95%	96%	96%
	Routine	95%	96%	96%
	Urgent	97%	97%	99%
LGH	Overall	93%	94%	93%
	Routine	93%	93%	92%
	Urgent	96%	98%	93%
LRI	Overall	91%	90%	93%
	Routine	91%	91%	92%
	Urgent	94%	98%	97%

95 – 100%	90 – 95%	<90%

Average Portering Task Response Times		
Category	Time	No of tasks
Urgent	12:00	1,128
Routine	24:00	12,221
	Total	13,349



Portering Report

The Reactive Task performance for Portering is based on a sample of the overall number of tasks carried out in the month as current systems do not capture the full range of duties.

January performance overall was very similar to December except for a slight drop in urgent tasks at the LGH. Datix incidents returned to a low number following the December increase.

The number of vacancies has improved with currently only one position unfilled. The use of agency staff is kept to an absolute minimum and has only recently been utilised to support ED/patient flow initiatives. Progress is being made in the efforts to improve efficiency in the deployment of porters. New electronic systems are under development to improve both the requesting process and recording of performance for a wider range of activity.

Estates and Facilities – Planned Maintenance

Statutory Maintenance Tasks Against Schedule					
	Month	Fail	Pass	Total	%
UHL Trust Wide	November	2	172	174	99%
	December	4	191	195	98%
	January	3	148	151	100%

99 – 100%	97 – 99%	<97%

Non-Statutory Maintenance Tasks Against Schedule					
	Month	Fail	Pass	Total	%
UHL Trust Wide	November	296	1823	2119	86%
	December	344	1943	2287	85%
	January	277	2098	2375	88%

95 – 100%	80 – 95%	<80%

Estates Planned Maintenance Report

For January there no failures in the delivery of Statutory Maintenance tasks in month.

For the Non-Statutory tasks, completion of the monthly schedule is subject to the volume of reactive calls. Drainage issues continue to put the maintenance service under pressure. Up to two thirds of reactive calls for the LRI (where the issue is most marked) relate to drainage.

At this stage work is still on-going with the reactive call data to enable reliable reporting to take place.

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

KPI Ref	Indicators	Board Director	Lead Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
RU1	Median Days from submission to Trust approval (Portfolio)	AF	NB	TBC	TBC	TBC	2.8	1.0	1.0			2.0			1.0			1.0			4.5			48		
RU2	Median Days from submission to Trust approval (Non Portfolio)	AF	NB	TBC	TBC	TBC	2.1	1.0	1.0			1.0			1.0			1.0			41.0			90		
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	979	917	887	758	657	592	487	699	325
RU4	% Adjusted Trials Meeting 70 day Benchmark (data sunbmitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC			(Oct14-Sep15) 92%			(Jan15 - Dec15) 94%			(Apr15 - Mar16) 94%			(Jul15 - Jun16) 94%			(Oct15 - Sep16) 90.3%					
RU5	Rank No. Trials Submitted for 70 day Benchmark (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC			(Oct14-Sep15) Rank 13/215			(Jan15 - Dec15) Rank 61/213			(Apr15 - Mar16) Rank 16/222			(Jul15 - Jun16) 12/220			(Oct15 - Sep16) 10/205					
RU6	%Closed Commercial Trials Meeting Recruitment Target (data submitted for the previous 12 month period)	AF	NB	TBC	TBC	TBC			(Oct14-Sep15) 46.8%			(Jan15 - Dec 15) 43.4%			(Apr15 - Mar16) 65.8%			(Jul15 - Jun16) 40.8%			(Oct15 - Sep16) 52.0%					

Never Events

	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17		YTD
Never Events	0	0	0	1	0	0	0	1	0	1		3

Patient was booked for surgical removal of lower right 6th tooth (LR6) and upper left 6th (UL6) tooth on 29 December 2016. The patient was appropriately consented for this procedure with relevant theatre time outs and checking processes taking place.

Once the patient was anaesthetised, the procedure began with the Senior House Officer attempting extraction of the UL6 tooth, under the supervision and guidance of the locum staff grade Oral Maxillofacial Surgeon (Dr B) On extraction, Dr B noted the tooth only had one root. It was at this point he realised the upper left 5th tooth had been removed (UL5) rather than the intended UL6.

Once the error was realised the registrar took over the procedure and appropriate measures were taken to preserve and re-insert the UL5 tooth. This was completed successfully and will require follow up by the patient's dental practitioner.

The patient subsequently had the UL6 and LR6 teeth removed as intended.

Actions taken to improve performance

The tooth was preserved appropriately and re-inserted.

The registrar and SHO ensured contact was made with the Head of Service and another senior specialist registrar.

Theatre staff alerted their team leader and general manager to the incident.

A full RCA investigation is in progress, which will include the development of any required actions to prevent recurrence.

Pressure Ulcers

Indicators	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	YTD
Avoidable Pressure Ulcers - Grade 4	0	0	0	0	0	0	0	1	0	0	1
Avoidable Pressure Ulcers - Grade 3	5	3	2	2	2	2	2	2	2	2	24
Avoidable Pressure Ulcers - Grade 2	9	6	8	3	13	6	9	10	5	8	77

What actions have been taken to improve performance?

Whilst there has been an increase in the number of avoidable Grade 2 pressure ulcers, overall there has been a decrease in the number of Grade 3 pressure ulcers. This suggests that less pressure ulcers are deteriorating into more serious harm.

All incidents are reviews every month and Pressure Ulcer Team raise awareness of findings through the Trust Nursing Executive. We in addition have negotiated with our specialist mattress provider to make available more pressure relieving mattresses without additional cost

Single Sex Accommodation Breaches (patients affected)

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	YTD
Single Sex Accommodation Breaches (patients affected)	0	0	4	1	2	20	7	1	14	6	55

Intensive Care Units

In January 2017 - 3 same sex breaches with 3 patients affected. 2 breaches were due to lack of bed capacity in surgical speciality and 1 breach due to a delay in obtaining an appropriate ambulance to transfer the patient to a speciality vascular bed.

Ward 17 GH

There were 3 breaches with 3 patients affected. All 3 patients were in HDU receiving level 2 care. When they were seen by the medical team and declared to no longer require level 2 care there was not a speciality respiratory bed available.

Actions taken to improve performance

ICU

The Nurse in charge of ICU ensures that all patients as soon as they are identified for potential discharge from ICU, are discussed at gold command and the progress of bed allocation is monitored. These patients are discussed at every gold command until a bed is allocated. Ambulance availability is escalated appropriately during this time. The Duty Management team are notified and priorities patients being discharged from ICU.

Ward 17 GH

Meetings have been held with the Matron for the area and support offered to the CMG. Staff understanding of the SSA Matrix and early escalation when there is not an available bed has been reiterated. Heighted levels of privacy and dignity with screening provided for all patients no longer requiring level 2 care.

A&E Friends and Family Test - % Positive Performance

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	YTD
A&E Friends and Family Test - % positive	96%	95%	95%	87%	87%	84%	87%	84%	91%	93%	90%

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

Although December and January performance shows improvement, there has been a decline is the Friends and Family Test results from July. This is mostly due to the UCC, however there has been a reduction in the scores received in Majors and Minors. The Minors area moved to its new location in July, since then the FFT score has decreased.

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

Actions taken to improve performance

- The Matron Team are setting up regular meetings with the Patient Experience Team in order to review and discuss ways to improve the FFT Scores.
- A core team of staff are being selected to drive FFT within the Emergency Department.
- The Sister responsible for the UCC is reviewing ways to improve compliance and to monitor daily response rates.
- Where possible, a support worker is allocated on a daily basis to collecting FFT.
- Processes within the UCC are being reviewed by the Front Door workgroup, looking at ways to improve patient flow through the department, which is hoped, will improve the patient experience and decrease the waiting times.
- FFT Scores and patient feedback is shared with the ED team.

Mortality – Published SHMI
Mortality - Rolling 12 months ‘Unpublished SHMI’ (as reported in HED) Rebased
Mortality - Rolling 12 months HSMR (as reported in HED) Rebased

	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	YTD
Mortality - Published SHMI	95 (Jul14-Jun15)			96 (Oct14-Sep15)			98 (Jan15-Dec15)			99 (Apr15-Mar16)			101 (Jul15-Jun16)	101

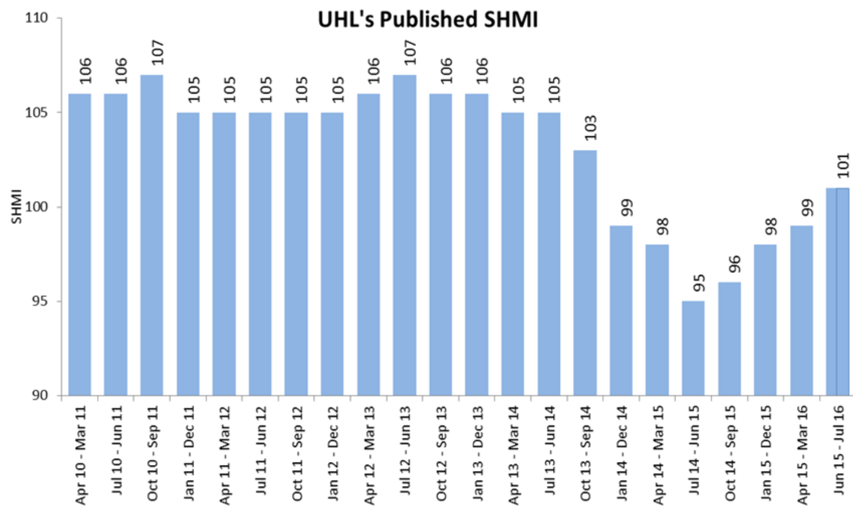
	Jan15-Dec15	Feb15-Jan16	Mar15-Feb16	Apr15 - Mar16	May15 - Apr 16	Jun15 - May16	Jul15 - Jun16	Aug15 - Jul16	Sep15 - Aug16	Oct15 - Sep16	Nov15 - Oct16	Dec15 - Nov16	Jan16 - Dec 16	Feb16 - Jan 17	YTD
Mortality - Rolling 12 mths SHMI (as reported in HED) Rebased	99	98	98	99	100	100	101	102	101	101	101	Awaiting HED Update			101

	Jan15-Dec15	Feb15-Jan16	Mar15-Feb16	Apr15 - Mar16	May15 - Apr 16	Jun15 - May16	Jul15 - Jun16	Aug15 - Jul16	Sep15 - Aug16	Oct15 - Sep16	Nov15 - Oct16	Dec15 - Nov16	Jan16 - Dec 16	Feb16 - Jan 17	YTD
Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	95	95	95	97	99	99	100	102	103	102	102	102	Awaiting HED Update		102

- The SHMI is the national measure for monitoring hospital mortality and includes both ‘in-hospital deaths’ and ‘deaths occurring within 30 days of discharge from hospital’. The SHMI covers a 12 month period and is published on a quarterly basis by NHS digital.
- The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups in a specified patient group.
- UHL subscribes to both the HED mortality Benchmarking tool and is able to monitor the SHMI and HSMR. HED use the HSCIC methodology to replicate the SHMI
- A further increase in our SHMI is anticipated for the next publication at the end of March (see funnel chart below) where we are anticipating a SHMI of 102.
- Whilst this is still ‘within expected’ compared nationally and to similar sized trusts it is above the National average of 100 and also our Quality Commitment threshold of 99.

Actions taken to improve performance

- There have been several actions undertaken to reduce mortality as part of our Quality Commitment over the past 3 years and implementation of the Pneumonia Care Bundle appears to have had a positive impact on our SHMI. Earlier recognition of both sepsis and acute kidney injury are also both key priorities for this year.
- Other areas of focus are to increase cardiology input at the LRI site and also improve the patient pathway for patients admitted with gastro-intestinal haemorrhage as both of these diagnosis groups appear to be adversely contributing to our SHMI.
- In addition to monitoring mortality rates and carrying out further analysis or investigation where applicable, we continue to embed the Medical Examiner process at the LRI, commenced in July. Over 800 cases have now been screened by the Medical Examiners (over 90% of all adult deaths at the LRI) with 20% being referred for full review by the Speciality M&M.
- Where the Medical Examiner or Specialty Screener considers there is a need for a full review, these will be referred to the M&M lead and the full review then presented and discussed at the Specialty M&M meeting and Death Classification agreed.
- Recent in depth HED review of UHL mortality did not identify any additional areas of mortality by condition that needed action that we did not already have reviews or action plans in place for but has highlighted that there appears to be a change in UHL risk profile suggesting that there have been changes in coding practice – a further review of coding practice will be undertaken.


UHL's Published SHMI
SHMI
110
105
100
95
90
106
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107
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103
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99
101
Apr 10 - Mar 11
Jul 10 - Jun 11
Oct 10 - Sep 11
Jan 11 - Dec 11
Apr 11 - Mar 12
Jul 11 - Jun 12
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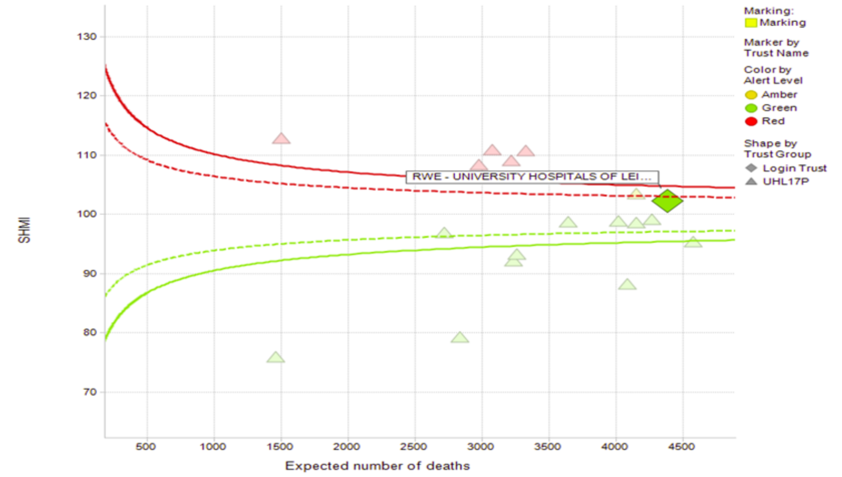
Apr 15 - Mar 16
Jun 15 - Jul 16


Please note that funnel plot is only valid when SHMI score is 100 for all the organisations (shown below) as a whole. It can be verified through highlighting all data items and checking grand total in Tab 3 breakdown table.
SHMI
130
120
110
100
90
80
70
RWE - UNIVERSITY HOSPITALS OF LEI...
500
1000
1500
2000
2500
3000
3500
4000
4500
Expected number of deaths
Marking:
Marking
Marker by
Trust Name
Color by
Alert Level
Amber
Green
Red
Shape by
Trust Group
Login Trust
UHL17P

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

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17		YTD
No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	78.0%	78.1%	64.6%	86.0%	65.8%	69.4%	64.1%	78.0%	60.3%	70.9%		71.5%

There were 86 NOF admissions in January 2017, 21 patients breached the 36 hr target to theatre as detailed below:-

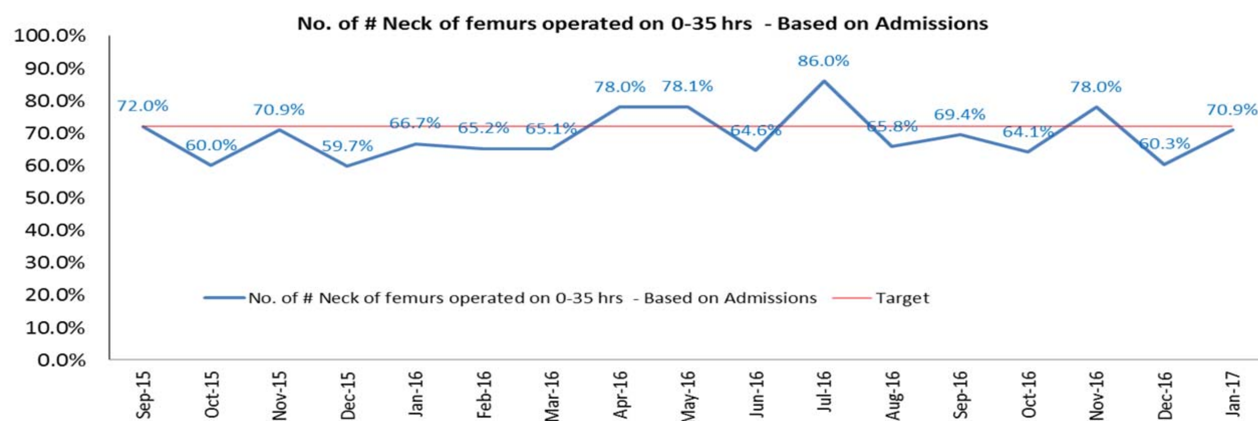
- Within the service control = 9 patients. Main theme was capacity once fit, aligned to other Trauma demand.
- Outside service control = 16 patients. These were unfit and required stabilisation pre operatively. (12pts) EOL pts, RIP, and conservative treatment.

4 patients did not have surgery.

There were 5 days when NOF admissions were 5 - 6 pts. 10th/11th/13th/16th/18th Jan. Between 10th and 18th Jan there was 27 NOF's admitted.
There was once again this month a degree of complex urgent Trauma and spinal cases which took priority clinically.

Actions taken to improve performance

- Theatre team leader continues to work closely with trauma team to coordinate and manage changing priorities. Agreed at Antonymous Board 4 hips per all day session is achievable and continues to be monitored.
- 21 transfers are made to LGH to help free capacity. These were pre-operative cases.
- Weekly monitoring of theatre utilisation of all Trauma theatres implemented.
- THR's have started to be undertaken at LRI. Hip surgeon availability is an issue when on-call surgeon is not of that sub speciality expertise.Investigations how spinal activity can be accommodated minimising impact on other Trauma continue including moving cases if appropriate to LGH. Head of Service leading this and Business case has been written to go to EQB.
- Weekly Operational meetings with the Clinical Director chairing continue.



RTT – Incomplete within 18 weeks and 52+ week waits

Combined UHL and Alliance RTT Performance for January

	<18 w	**>18 w**	**Total Incompletes**	**%**
Alliance	7,355	360	7,715	95.33%
UHL	43,376	4,734	48,110	90.16%
Total	50,731	5,094	55,825	90.88%

Backlog Reduction required to meet 92%	**683**

UHL and Alliance combined performance for RTT in December was 90.9%. The trust did not achieve the standard. Overall combined performance saw 5,094 patients in the backlog an increase of 86 since the last reporting period. There were 429 more patients waiting over 18 weeks then the required amount.

The largest factors for not meeting performance in January were reduced planned activity due to a bank holiday, reduced discretionary activity due to uptake in extra sessions over the Christmas Period Holiday, patient choice reducing uptake in elective procedures out patient appointment, increased cancellations to support emergency care.

Forecast performance for next reporting period: We are unlikely to meet the 92% performance standard in February, predicting close to 90.0%. Factors for the performance include:

- Increasing bed pressures due to winter pressures as UHL entered a system critical incident
- Suspension of WLI's for admitted and non-admitted activity to support the Trusts financial position.
- Ceasing of insourced capacity

There are currently 7 specialties that due to size of number of patients in their backlog and relative size, have individual actions plans. These are monitored monthly Paediatric ENT, ENT, General Surgery, Urology, Allergy, Orthopaedics and Ophthalmology. Current plans and performance are highlighted later in the report along with the services performance and backlog trends over the past 12 months.

In order to achieve the 92% RTT standard performance against plan is monitored at the Weekly Access Meeting. Specialties not achieving target are escalated at the Weekly Head of Operations Meetings. Performance against average cases per list is highlighted in the table. Capacity via wait list initiatives and insourced capacity from Medinet are intrinsically linked to the services actions plans. The longer term impact on RTT performance is likely to be a reduction between 2-5% at the end of the financial year.

At end of January there were 34 patients who breached 52 weeks. 15 Orthodontics, 11 ENT and 8 Paediatric ENT patients. Available bed capacity has impacted on the ability to treat 52 week breach patients.

The table below outlines the overall 10 largest backlog increase and 10 largest backlog reductions by specialty. The largest overall increase was for ophthalmology. This has been linked to reduced available outpatient in January as well as booking practices. The services backlog has subsequently reduced by 110 as of the 14th February to 423.

Elective activity remains a key risk whilst resources are directed towards the supporting the emergency pathway. During this period there additional focus on transferring clinicians to support non admitted performance through out patient and virtual clinics where available.

Highest 10 specialties with backlog increases	Admitted Backlog			Non Admitted Backlog			Total Backlog		
	Dec-16	Jan-17	Admitted Change	Dec-16	Jan-17	Non Admitted Change	Total Dec	Total Feb	Total Change
Ophthalmology	148	132	16	249	401	-152	397	533	136
Interventional Radiology	18	28	-10	40	67	-27	58	95	37
Maxillofacial Surgery	108	133	-25	21	29	-8	129	162	33
Allergy	1	4	-3	110	131	-21	111	135	24
Paediatric Surgery	18	30	-12	6	8	-2	24	38	14
Paediatric ENT	367	379	-12	15	15	0	382	394	12
Paediatric Neurology	0	0	0	17	29	-12	17	29	12
Paediatric Medicine	0	1	-1	44	53	-9	44	54	10
Gastroenterology	5	5	0	101	108	-7	106	113	7
Pain Management	0	3	-3	1	5	-4	1	8	7

Highest 10 specialties with backlog reduction	Admitted Backlog			Non Admitted Backlog			Total Backlog		
	Dec-16	Jan-17	Admitted Change	Dec-16	Jan-17	Non Admitted Change	Total Dec	Total Feb	Total Change
Orthopaedic Surgery	196	221	-25	315	247	68	511	468	-43
Dermatology	0	0	0	79	39	40	79	39	-40
Spinal Surgery	49	51	-2	299	263	36	348	314	-34
Paediatric Dermatology	3	0	3	39	16	23	42	16	-26
Urology	310	282	28	83	87	-4	393	369	-24
General Surgery	252	220	32	82	93	-11	334	313	-21
Plastic Surgery	50	28	22	4	6	-2	54	34	-20
Cardiology	56	51	5	48	34	14	104	85	-19
Paediatric Cardiology	6	4	2	37	23	14	43	27	-16
Thoracic Medicine	0	0	0	62	52	10	62	52	-10

Allergy	Background: Underperformance on admitted RTT is related to Consultant vacancies since June 2015 (2 clinics per week) with additional vacancy since May 2016 (3 clinics per week). Service has now appointed to 1 consultant post. RTT remains continues to reduce. Actions: September interview appointed trust grade to start in April. SLA with Nottingham consultant will continue ongoing. Demand and Capacity work to be finalised. Reminder calls to reduce DNA's in place. Project to start advice and guidance initiated.
ENT / Paediatric ENT	Background: Current backlog driven by a high level of cancellations from 2015/16 winter bed pressures that has carried over into 2016/17. Cancellation on the day and limited paediatric bed capacity resulting in prior to the day cancellations or reduced booking of lists. Medinet activity suspended, increased risk for 52 week breaches. Actions: Convert elective activity to outpatient clinics where available. Convert adult ENT to Paediatric ENT where paediatric team is available for paediatric long waiters. Departmental away day to address key actions including advice and guidance, single point of access. Service working up plans, delayed due to daily operational pressures.
General Surgery	Background: Current performance driven by lack of capacity to meet SLA demands. Circa 3 sessions per week. Service highly affected by winter bed pressures on inpatient and critical care beds resulting in patient cancelations. On the day cancellations due to clinical reasons are 154 year to date with further cancellations before the day (data pending). Further risk going into winter months of increased cancellations due to further bed pressure demands. Actions: Business case for consultant workforce. Reduce first appointment wait time to reduce pathway lengths. Aim to reduce non admitted waits, convert elective activity to outpatient.
Ophthalmology	Background: A demand and capacity analysis has identified a 51 WTE workforce gap across the whole service at all workforce levels in order to meet the demands. A business case will be presented to the Revenue and Investment Committee in January. Actions: Long term action on approval of business case for expansion of service workforce. Consultant element of business case to advertised. Other interim actions include the Single Point of Access. Focused PTL work on longest waiter.
Orthopaedic Surgery	Background: Delays within with urgent diagnostic reporting adding to the outpatient pathway. Capacity gap between clinicians for sub specialties. Including Hand and Foot and Ankle patients. High levels to support the emergency ward base. Actions: Increased clinical capacity from February 2017. Reminder phone calls, re-balancing backlog between clinicians.
Urology	Background: Lack of in week outpatient and theatre capacity. Increased cancellations. Increased activity over and above SLA predicted 297 admitted patient's full year. Increase in patients cancelled before the day due to bed capacity. Actions: Left shifting of low complex patients to the Alliance, circa 25 per month. Improve waits for first appointment through PTL management.

Diagnostic Performance

January diagnostic performance for UHL and the Alliance is 0.88% achieving the standard performing below the 1% threshold. This is the 4th month of continuous diagnostic performance post EMRAD installation. This is the first time the trust has achieved the 1% standard in January since the current reporting documentation available began in 2013. Historically the best January performance had been 4.1%

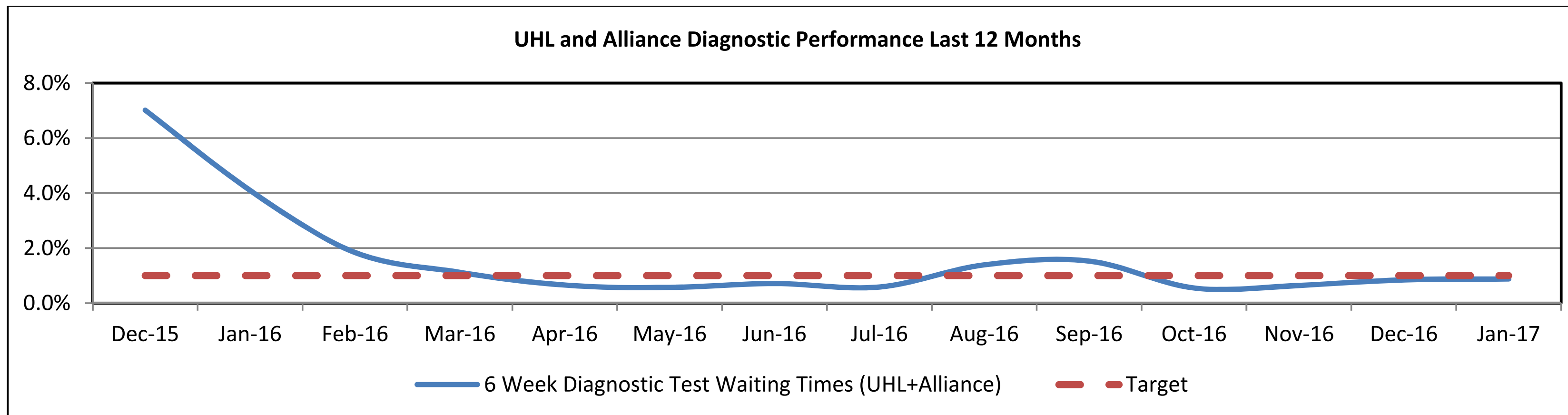
Of the 15 modalities measured against, 8 achieved the performance standard with 7 areas having waits of 6 weeks or more greater than 1%. Strong performance in Non-obstetric ultrasound with only 1 breach / 0.02% greatly supported the overall performance. The 5 lowest performing modalities are listed below:

Modality	Breaches	Performance
Cardiology - electrophysiology	2	40.00%
Cystoscopy	7	6.09%
Gastroscopy	14	3.14%
Flexi sigmoidoscopy	10	1.83%
Magnetic Resonance Imaging	38	1.58%

Risks to future months performance

CT remains a capacity risk, however overall capacity within imaging and early indications from the other modalities indicate a low risk within February. The endoscopy service have reduced the number of breaches to 10 or less in the past 2 reporting periods. There is still a risk for patients requiring sedation under propofol as there is still no scheduled sessions for this activity, with ad hoc sessions sought.

It is anticipated the overall diagnostic performance for February will be less than 1%.



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

INDICATORS: The cancelled operations target comprises of two components 1.The % of cancelled operations for non-clinical reasons On The Day (OTD) of admission 2.The number of patients cancelled who are not offered another date within 28 days of the cancellation	Indicator	Target (monthly)	Latest month	YTD performance (inc Alliance)	Forecast performance for next reporting period
	1	0.8%	1.5%	1.2%	**1.4%**
	2	0	22	169	**15**

What is causing underperformance?

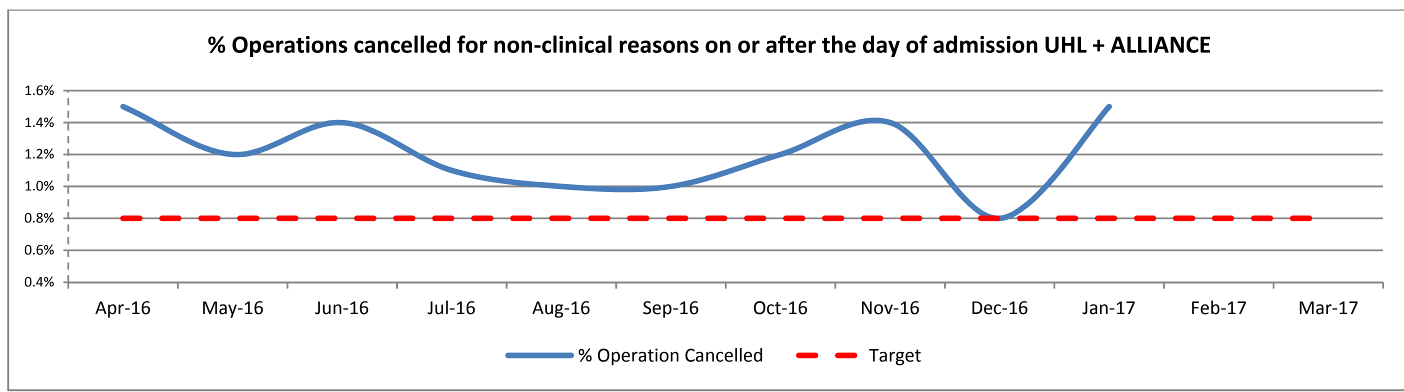
For January there are 169 non clinical hospital cancellations for UHL and Alliance combined. This resulted in a failure of the 0.8% standard as 1.5% of elective FCE's were cancelled on the day for non clinical reasons. 163 of the cancellations were at UHL with 114 due to capacity related issues and 49 for other reasons. 97 cancellations were related to lack of beds either Ward beds or ITU/HDU.

The 5 largest cancellations on the day were for:
Hospital Cancel - Ward Bed Unavailable : 79
Hospital Cancel - Lack Theatre Time / List Overrun: 33
Hospital Cancel -Pt Delayed To Adm High Priority Patient: 17
Hospital Cancel - ITU Bed Unavailable: 12
Hospital Cancel - HDU Bed Unavailable: 6

There were 22 patients who were not offered there operation within 28 days of a non clinical cancellation. These comprised of CHUGGS 4, CSI 1, Musculoskeletal and Specialist Surgery 10, RRCV 3, Women's and Children's 3

What actions have been taken to improve performance?

Due to emergency bed pressures cancellations on the day as of 12th February there were 60 non clinical cancellations in month, currently at 1.5%
An executive decision to cancel non urgent non cancer elective operations was taken on 8th February to run until the 19th February. This should reduce the number of cancellations on the day for the remainder of the month. Due to the current level of cancellations it is unlikely 0.8% standard will be met in February.



Ambulance handover > 30 minutes and >60 minutes - Performance

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

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

What actions have been taken to improve performance?

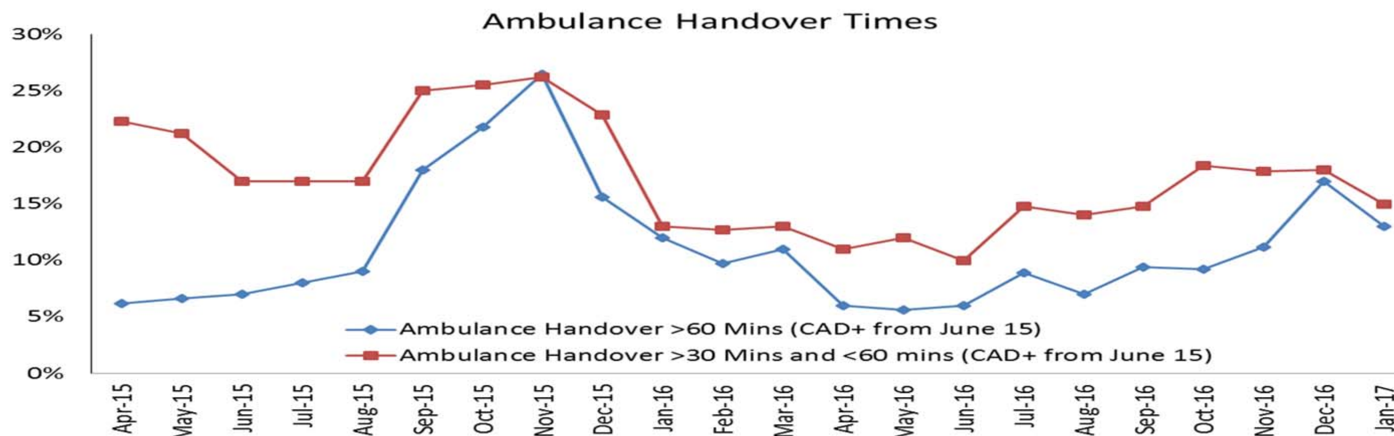
11 cohort spaces used in hours, 17 spaces out of hours to increase flow out of assessment bay.

Traction in gold meetings to ensure spaces are filled.

Real time escalation by duty team to Director on call of all patients that have waited longer than 60 minutes on an ambulance.

GPAU opened longer to improve flow and appropriate patients moved from assessment bay into GPAU scheme.

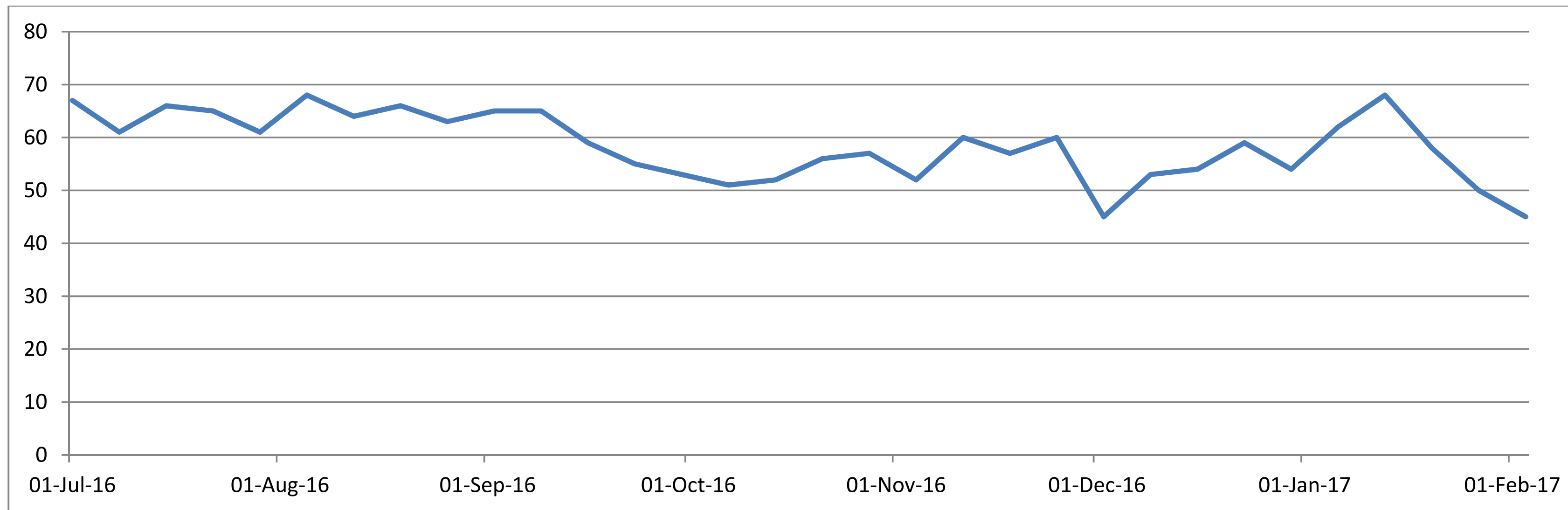
ASU has been temporarily converted to medical ward to increase flow out of ED.



Cancer waiting time performance

Current Performance

- 2ww performance remained strong in December delivering at, January is also expected to deliver the standard sitting at 93.1% (pre-upload).
- 62 day performance as anticipated remains below the required standard, December at 79.5% which was a slight increase in performance on November by 2.3% and January (pre-upload) expected at circa 80%. In discussion with NHSI and NHSE the Trust has stated that it cannot confirm recovery of the key cancer standards until there has been a sustained period of ring fenced capacity of elective beds, ie >2 months. The Trust is clear that all efforts to deliver good patient care and improve cancer performance is priority.
- The adjusted backlog (excluding tertiary referrals received after day 39) has averaged in the 50's for over 8 weeks and at the time of reporting currently sits at 45 – the key outliers being Gynae and HPB.



Key themes identified in backlog (3rd February)

Summary of delays	Numbers of patients	Summary
Clinical Decision Making/Change of Treatment Plan	1	Patient in Lung, complex pathway with multiple diagnostics and MDTs, on the day of surgery cancelled by the anaesthetist – high risk for surgery for Radiotherapy. Previously dated prior to breach date.
Complex Patients	6	Across 3 tumour sites, Lung, Lower GI and HPB – these are patients undergoing multiple tests, MDTs and diagnostics. This includes patients being reviewed in 3 separate tumour site MDTS prior to diagnosis and patients awaiting complex molecular markers with Pathology,
Long Term Follow Up/Surveillance	1	1 patient in Testicular who on interval surveillance scan, a mass was identified for further ultrasound.
Diagnostic Delays – Pathology & Imaging	2	2 patients, 1 in HPB, the other in Lower GI. Patients where delayed pathology reporting and Imaging reporting were the main contributors to the pathway delays.
Diagnostic Delays – Surgical Capacity & Endoscopy	7	Across 4 tumour sites – Lower GI, Gynae, Upper GI and HPB – 2 patients delayed due to process and capacity issues in Endoscopy, 5 patients by delays to diagnostics due to surgical capacity (Gynae and HPB specifically).
UHL Pathway Delays (Next Steps compliance)	11	Across 4 tumour sites – Lower GI, Skin, Lung and Head & Neck, where more than 1 delay has occurred within the pathway and lack of compliance with Next Steps is evident including where diagnostic tests have been incorrectly prioritised by the requesting clinician. This also includes 1 patient with a delayed Oncology Outpatient of 19 days.
Patient Delays & Patients Unfit	17	Across 4 tumour sites (Breast x1, Gynae x9, H&N x3, Urology x4) – a significant proportion of the backlog (34%) where they are or have been unfit during their pathway – ranging from Cardiac issues requiring treatment prior to surgery, Patients unfit due to chest infections, multiple DNAs and general lack of engagement and patient holidays.
Tertiary Referrals	5	In Lung (x2) and Urology (x2) and HPB (x1), late referrals from Burton, KGH and NGH all received over Day 38.

Backlog Review for patients waiting >104 days

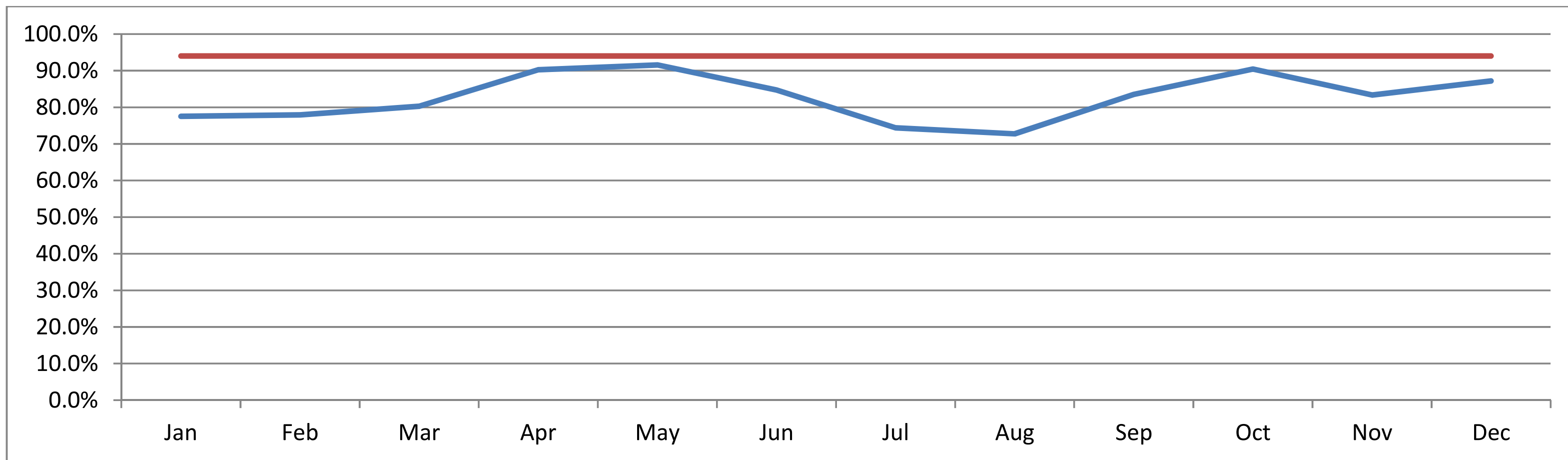
The following details all patients declared in the 104 Day Backlog for week ending 3/2/17.

Of the 8 patients in the current 104 Day Backlog, 4 patients have since commenced treatment.

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

Tumour Site	Total Number of patients	Pt No	Current Wait (Days)	Confirmed Cancer Y/N	Treatment Date Y/N	Summary Delay Reasons
LOGI	2	1	140	N	N	Diagnostic delays (hospital and patient) awaiting EMR in Endoscopy - now booked for 9/2/17
		2	112	N	N	Delays in requesting diagnostics as 2WW urgency which also led to a delay in CT reporting in addition to Endoscopy delays in organising a repeat Flexi
HPB	1	1	119	N	N	Late tertiary referral from Peterborough Hospital at Day 103.
GYNAE	1	1	113	N	Y	Diagnostic TCI was provided within 14 days of decision, however, this was cancelled due to the patient being unfit and pending Cardiology review – patient choice decision to wait for Gynae further consultation until after Cardiology. Patient has since been treated.
HEAD & NECK	1	1	116	Y	Y	Multiple delays due to patient choice and DNA's during diagnostic stage of pathway despite significant CNS, clinician and service attempts to engage with the patient. Patient has since been treated.
LUNG	1	1	113	Y	N	Complex patient pathway, referred through 3 separate MDTS – Breast, H&N and Lung. Late referral to Lung, now awaiting chemotherapy start date, first seen in Oncology 1/2/17
UROLOGY	2	1	140	Y	Y	Patient underwent multiple diagnostics which due to fitness, some were re-booked which incurred delays to the pathway. Patient not fit for surgery. Has since commenced treatment.
		2	119	Y	Y	Late referral from KGH at Day 66, has now been treated.

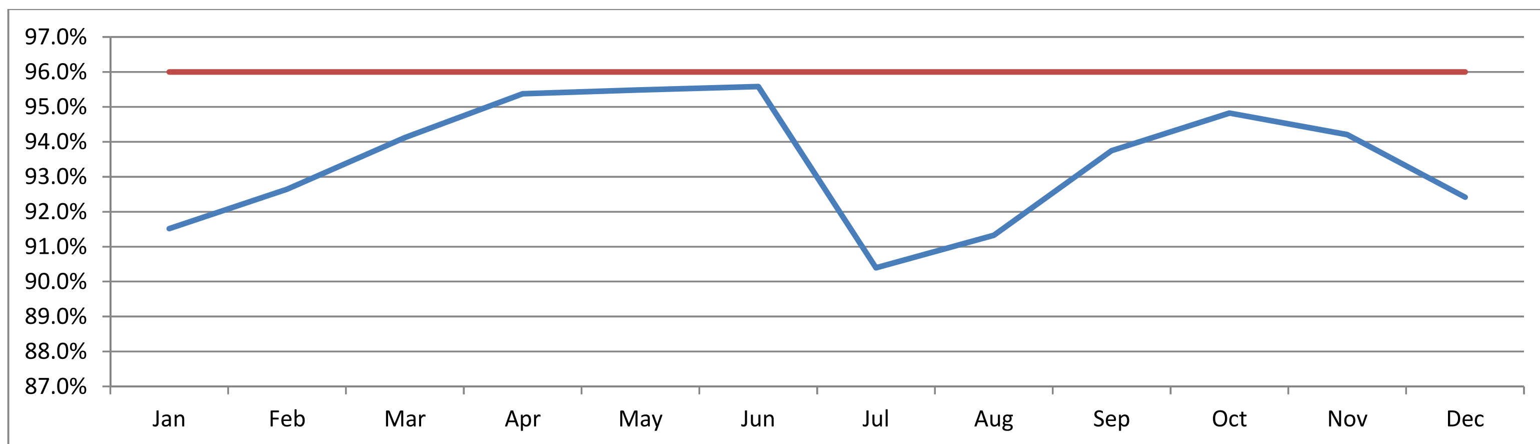
31 Day Subsequent Surgery Performance



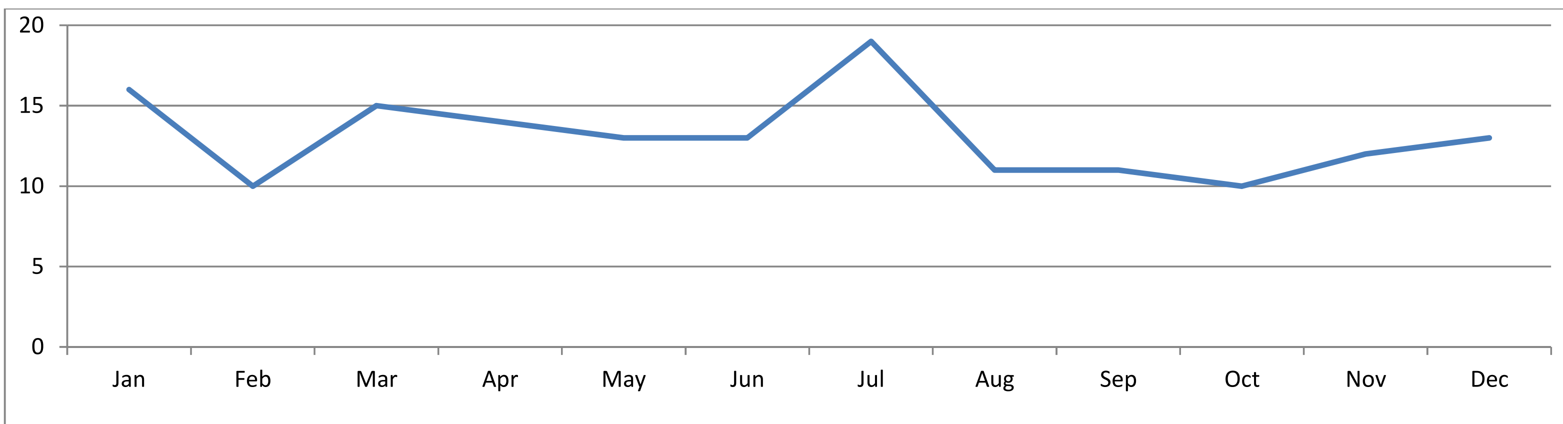
31 day subsequent surgery performance was below the standard at 86.7% in December, with January (pre-upload) currently at 90.9%.

Although backlogs have reduced, access to beds and timely theatre capacity remains the key issue. This is small numbers across a number of tumour sites

31 Day First Treatment - Performance



31 day 1st treatment performance in December was below the standard at 92.4%,, expected position for January to be circa 89% (Pre-Upload). On going backlog reduction is not being sustained, again access to beds and timely theatre capacity remains the key issue. This primarily impacts on Urology and Gynae



Summary of the plan

The recovery plan (RAP) consists of 33 actions following detailed work initially with the CMG's and also with the joint UHL and CCG working group. The issues detailed in the plan have been identified by a consistent review of tumour site breach maps (rolling 3 month themes) and the current tumour site backlog reasons.

A recent spike in the backlog numbers and review within Gynae has resulted in an additional 4 RAP actions this month in line with their localised action plan for recovery.

The actions are targeted at tumour site specific issues taking into account 'linked' services that impact on delivery. Metrics have been devised for each action to ensure that they are measurable and that they are on track. Each action has been risk rated (high, medium or low).

Summary of high risks

The following remain the high risk issues affecting the delivery of the cancer standards and have been categorised as agreed by the joint working group

	Issue	Action being taken	Category
1	Underlying theatre capacity shortfall for all electives , specifically affecting, Urology , Gynaecology , GI and ENT	Additional weekend work / use of external providers	Unavoidable factors impacting on delivery
2	Underlying HDU / ITU bed capacity	Daily bed / patient management.	Unavoidable factors impacting on delivery
3	Underlying access to ward beds associated with increased emergency admissions above plan.	ASU (day case) at LRI remains ring fenced, ward 7 ring fenced against medical patients	External factors impacting on delivery
4	Workforce on Oncology	Business case to expand Consultant workforce	Internal factors impacting on delivery / Unavoidable factors impacting on delivery
5	Workforce in Head and Neck surgeon (national shortage)	Recruitment process underway	External factors impacting on delivery
6	Workforce Head and neck imaging (national shortage)	Recruitment process underway	External factors impacting on delivery
7	Late tertiary referrals	Meeting with tertiary providers. Support from NHSE	External factors impacting on delivery
8	Delayed impact of Next Steps rollout resulting in delayed pathways specifically affecting Gynae, ENT and Lower GI	Full PTL review and micro management from the Cancer Centre and Tumour Sites and additional on the ground resources to support in clinic where appropriate.	Internal factors impacting on delivery