Quality & Performance Report

Author: John Adler Sponsor: Chief Executive Date: IFPIC + QAC 27th July 2017
EPB 25th July 2017

Executive Summary from CEO

Joint Paper 1

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 (period January 2016 to December 2016) has reduced to 101 and remains within the expected range. **Referral to Treatment –** was achieved and **diagnostic 6 week wait –** remains complaint for the 9th consecutive month. **52+ week waits –** current number this month is 15 patients (last June the number was 130). **Cancer Two Week Wait** – have continued to achieve the 93% threshold for 11 consecutive months. D**elayed transfers of care** - remain within the tolerance. However, there are a range of other delays that do not appear in the count. **Never events** – 0 reported this month. **MRSA** – zero cases reported for first quarter. **C DIFF** although there were 10 cases reported in June, YTD remains within threshold. **Pressure Ulcers** – Zero **Grade 4** pressure ulcers reported this financial year, **Grade 3 and Grade 2** are within the trajectory year to date. **CAS alerts** – we remain compliant. **Inpatient and Day Case Patient Satisfaction (FFT)** achieved the Quality Commitment of 97%. **Fractured NOF** – was achieved May and June. **Ambulance Handover 60+ minutes (CAD+)** – performance at 2% is a significant improvement – this is by far the best performance since the introduction of CAD+ reporting in June 2015. **TIA (high risk patients)** is compliant following a couple of months of non-compliance.

Bad News: **Moderate harms and above** – 20 cases reported during May (reported 1 month in arrears). **ED 4 hour performance** – June performance was 77.6%. Further detail is in the Chief Operating Officer's report. **Cancelled operations** and **patients rebooked within 28 days** – continued to be non-compliant, predominantly due to emergency pressures. **Cancer 62 day treatment and 31 day treatment –** was not achieved in May. **Single Sex Accommodation Breaches** – 1 breach during June. **Statutory & Mandatory Training** – 82% against a target of 95%.

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: 31st August 2017

Quality and Performance Executive Summary

June 2017

Operational Delivery Unit

Domain - Safe

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

3 Never Events YTD ↑

11 ↑ Serious Incidents YTD (No escalated each month)

31 ↓ Moderate Harm and above YTD (PSIs with finally approved status)

0 Avoidable MRSA YTD ↔

15 CDIFF Cases YTD ↓

Headlines

- Moderate harms and above – 20 cases reported in May.
- There have been zero cases of MRSA's reported in 17/18.
- Although there were 10 cases reported in June, YTD remains within threshold.
- The first three months data for 2017/18 continues to demonstrate a strong performance against the EWS indicators. Our focus for 2017/18 will be to maintain this position and improve compliance with the % percentage of patients who develop Red Flag Sepsis whilst an inpatient and receive antibiotics within one hour .

SEPSIS

Patients with an Early Warning Score 3+ - % appropriate escalation	91% YTD ↑
Patients with EWS 3+ - % who are screened for sepsis	95% YTD ↓
ED - Patients who trigger with red flag sepsis - % that have their IV antibiotics within an hour	86% YTD ↑
Wards (including assessment units) Patients who trigger for Red Flag Sepsis - % that receive their antibiotics within an hour	79% YTD ↓

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 99% ↑

A&E FFT 94% ↑

Maternity FFT 93% ↑

Outpatients FFT 95% ↑

Staff FFT Quarter 1 2017/18(Pulse Check)

74.3% of staff would recommend UHL as a place to receive treatment

Single sex accommodation breaches

7 YTD ↑

Headlines

- Friends and family test (FFT) for Inpatient and Daycase care combined are at 97% for June.
- Patient Satisfaction (FFT) for ED increased to 95% for June, YTD is 94%.
- Single Sex Accommodation Breaches – 7 YTD (1 during June).

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 34.9% ↓
Day Case FFT 26.0% ↓
A&E FFT 10.5% ↑
Maternity FFT 44.3% ↓
Outpatients FFT 5.7% ↑

Staff FFT Quarter 1 2017/18 (Pulse Check)

62.5% of staff would recommend UHL as a place to work

Headlines

- Inpatients and Daycase coverage remains above Trust target
- A&E coverage for June was 9.4% against a new Trust target of 10%.
- Appraisals are 2.9% off target for June (this excludes facilities staff that were transferred over from Interserve).
- Statutory & Mandatory is 13% off the 95% target.
- Please see the HR update for more information.

% Staff with Annual Appraisals

92.1% YTD ↓

Statutory & Mandatory Training

82% YTD ↓

BME % - Leadership

26% Qtr1
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.

Mortality – Published SHMI

101
Jan16-Dec16 ↑

Stroke TIA clinic within 24hrs

61.2%
YTD ↑

80% of patients spending 90% stay on stoke unit

86.4%
YTD ↓

Emergency Crude Mortality Rate

2.0%
YTD ↓

30 Days Emergency Readmissions

9.2%
YTD ↑

NoFs operated on 0-35hrs

66.8%
YTD ↑

Headlines

- Latest UHL's SHMI is 101. A recent in depth HED review of UHL mortality did not identify any additional areas of mortality by condition which needed action that we did not already have reviews or action plans in place for.
- Fractured NoF – 76.8% of patients were operated on within 0-35hours in June. However the year to date figure is 5.2% below the 72% target because of Aprils performance being 47.1%.

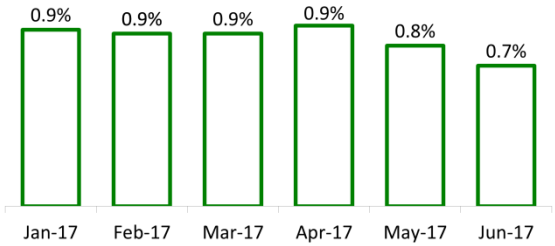
Domain – Responsive

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

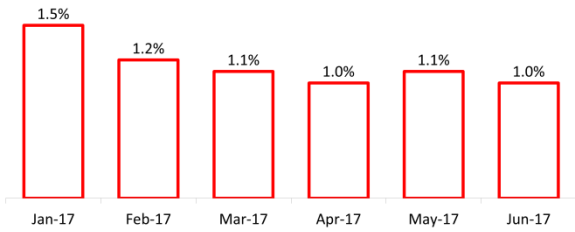
RTT - Incomplete 92% in 18 Weeks

92.3%
YTD ↑

6 week Diagnostic Wait times



Cancelled Operations UHL



RTT 52 week wait incompletes

15
YTD ↑

ED 4Hr Wait

A&E **78.3%**
YTD ↑

Ambulance Handovers

5% > 60mins ↑
11% 30-60mins ↑
YTD

Headlines

- 15 patients waiting 52+ weeks at end of June compared to 9 in May (June 16 there were 130).
- Diagnostic 6 week wait – we have now achieved nine 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

94.4% YTD

95.4% May ↑

31 day wait

95.3% YTD

94.6% May ↓

62 day wait

79.9% YTD

76.6% May ↓

31 day backlog

9 June ↑

62 day backlog

59 June ↑

62 day adjusted backlog

49 June ↑

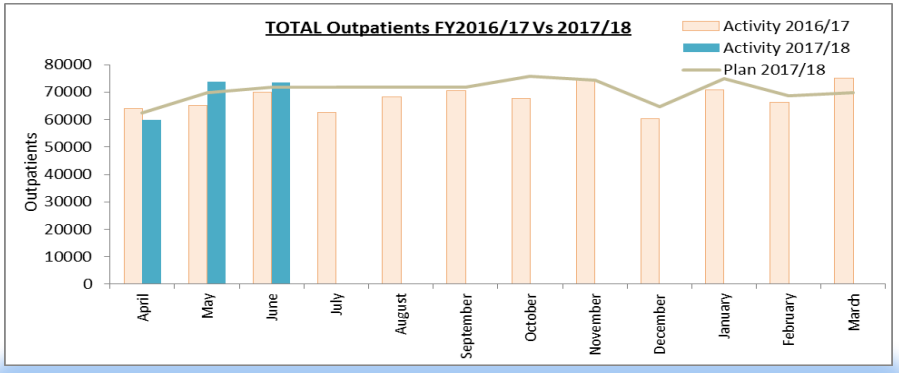
Headlines

- Cancer Two Week Wait was achieved in May and has remained compliant since July 16.
- 31 day wait was 1.4% off target for May.
- Cancer 62 day treatment – was not achieved this month.

UHL Activity Trends

Referrals (GP) – data to be reviewed and graph will be updated as soon as information is available.

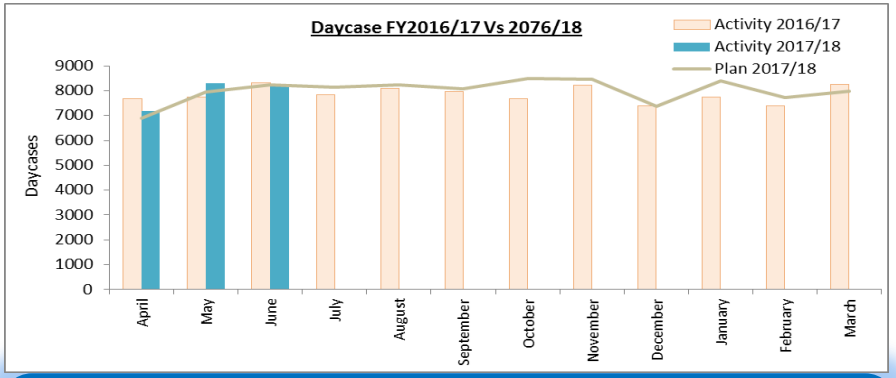
TOTAL Outpatient Appointments



April - June
17/18 Vs 16/17 +7,896 +4%
17/18 Vs Plan +3,371 +2%

Outpatients also effected by Easter Working days effect but activity decrease was offset by additional work in some specialties.

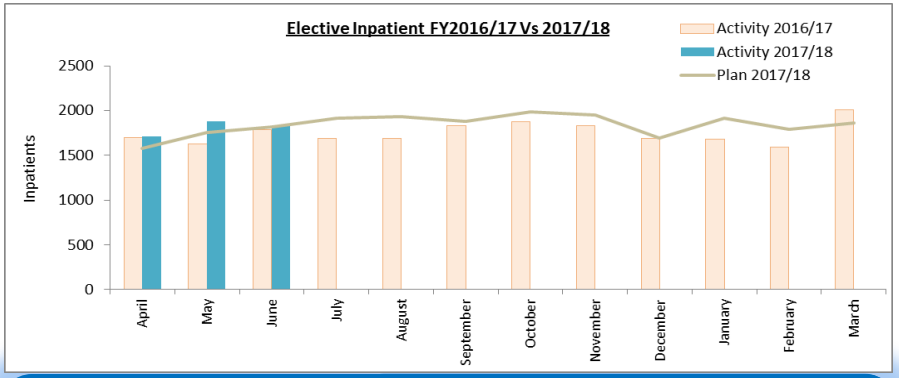
Daycases



April - June
17/18 Vs 16/17 - 95 0%
17/18 Vs Plan +557 +2%

Growth in Haematology, Medical Oncology, General Surgery and Urology against plan.

Elective Inpatient Admissions

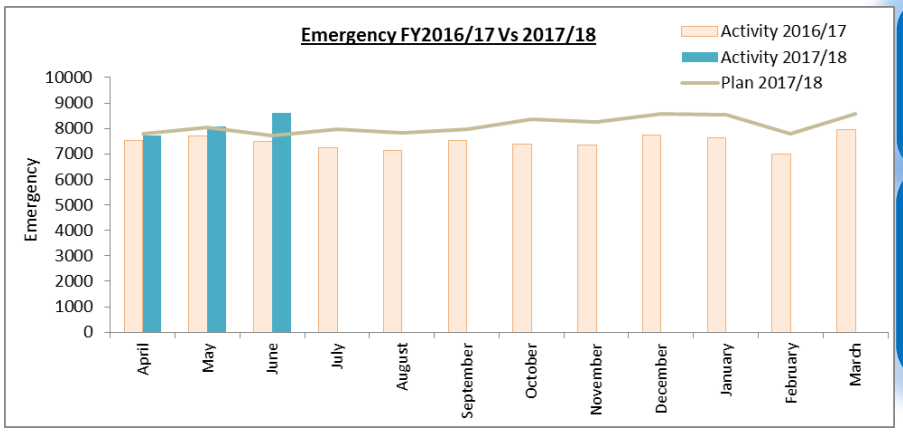


April - June
17/18 Vs 16/17 +305 +6%
17/18 Vs Plan +260 +5%

Additional work to improve RTT performance in Gen surgery, ENT and Max Fax and overall less cancellations than same period last year.

UHL Activity Trends

Emergency Admissions

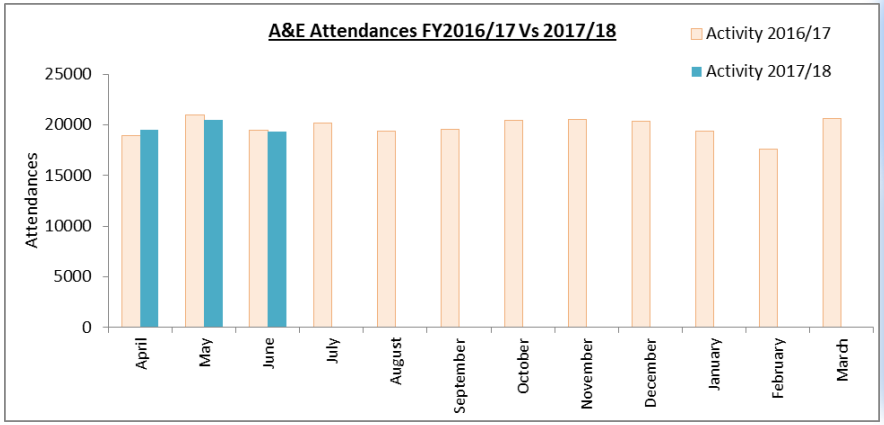


April - June
17/18 Vs 16/17 +1,754 +7%
17/18 Vs Plan 894 4%

Plan currently not fully adjusted for QIPP.

Paediatric CAU patients are reported as admissions in the 17/18 figures, last year they were reported as ward attenders.

A & E Attendances



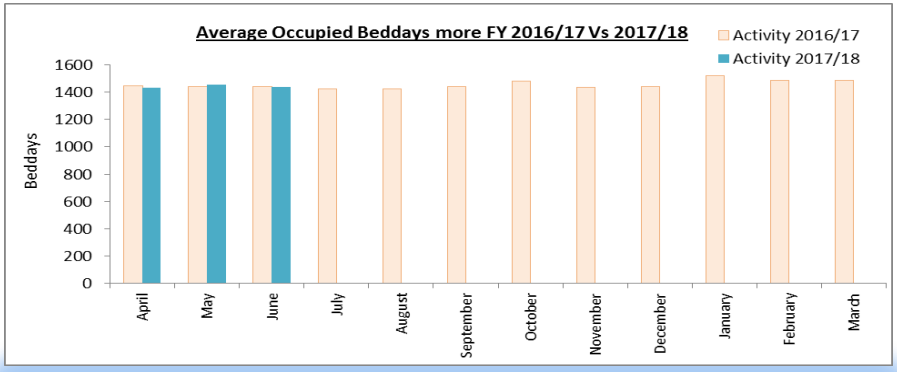
April - June
17/18 Vs 16/17 -81 +0%

A&E attendances include all ED and Eye casualty attendances.

Plan not included as A&E has been based on different pathways for CAU and Ophthalmology.

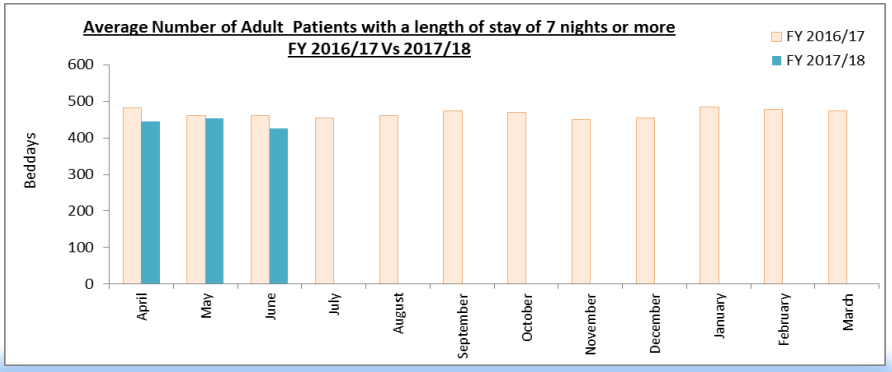
UHL Bed Occupancy

Occupied Beddays



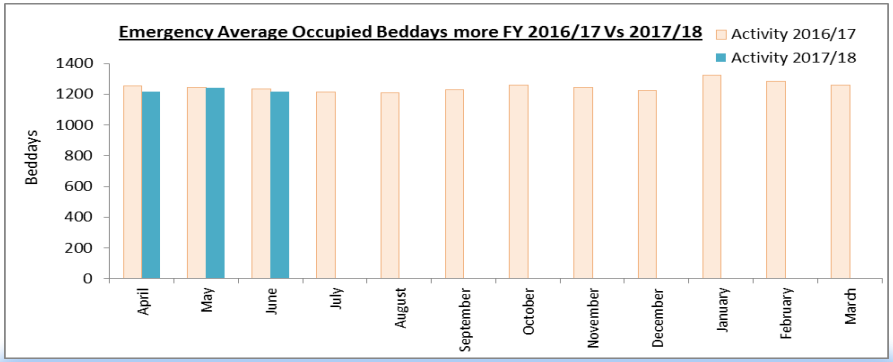
Midnight G&A bed occupancy continues to run similar to the same period last year.

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



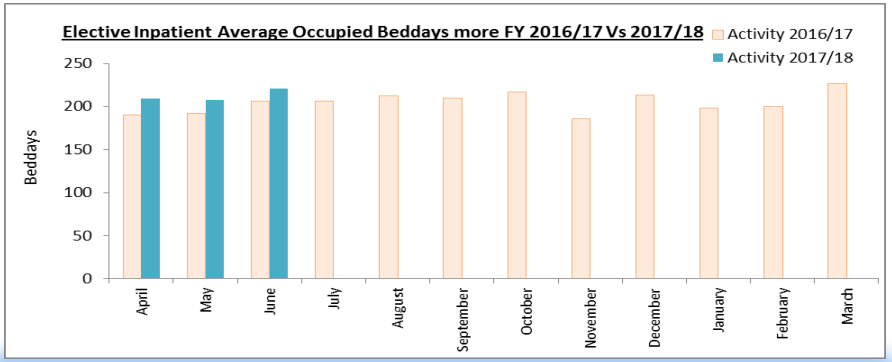
The number of patients staying in beds 7 nights or more has reduced compared to the same periods last year.

Emergency Occupied beddays



A reduction in Emergency occupied bed days, on average 32 patients less per night.

Elective Inpatient Occupied beddays



Bed occupancy is higher this year compared to the same period last year, which is reflective of the higher level of elective activity carried out.

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

June 2017

One team shared values

CONTENTS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

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

DATE: **27th JULY 2017**

REPORT BY: **ANDREW FURLONG, MEDICAL DIRECTOR**
TIM LYNCH, INTERIM CHIEF OPERATING OFFICER
JULIE SMITH, CHIEF NURSE
LOUISE TIBBERT, DIRECTOR OF WORKFORCE AND ORGANISATIONAL DEVELOPMENT
DARRYN KERR, DIRECTOR OF ESTATES AND FACILITIES

SUBJECT: **JUNE 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, C Diff – infection rate – C Diff numbers vs plans included and Potential under-reporting of patient safety incidents.

2.0 Performance Summary

Domain	Page Number	Number of Indicators	Number of Red Indicators this month
Safe	4	22	4
Caring	5	11	1
Well Led	6	23	3
Effective	7	9	4
Responsive	8	15	7
Responsive Cancer	9	9	6
Research – UHL	14	6	0
Total		95	24

3.0 Data Quality Forum (DQF) Assessment Outcome/Date

The Trust Data Quality Forum Assessment combines the Trust's old data quality forum process and the Oxford University Hospital model. The responsibility for data quality against datasets and standards under consideration are the 'data owners' rather than the forum members, with the executive lead for the data carrying the ultimate responsibility. *In this manner, the Data Quality Forum operates as an assurance function rather than holding accountability for data quality*. The process focuses on peer challenge with monthly meetings assessing where possible 4 indicators / standards at each meeting. The outputs are an agreed assessment of the data quality of the indicator under consideration with recommendations as required, a follow up date for review is also agreed. The assessment outcomes are detailed in the table below:

Rating	**Data Quality**
Green	Satisfactory
Amber	Data can be relied upon, but minor areas for improvement identified
Red	Unsatisfactory/ significant areas for improvement identified

If the indictor is not RAG rated, the date of when the indicator is due to be quality assured is included.

4.0 Changes to Indicators/Thresholds

Board Director amended from Richard Mitchell to Tim Lynch for all Responsive Indicators.

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

	KPI Ref	Indicators	Board Director	Lead Officer	17/18 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	DQF Assessment outcome/Date	14/15 Outturn	15/16 Outturn	16/17 Outturn	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	17/18 YTD
Safe	S1	Reduction for moderate harm and above PSIs with finally approved status - reported 1 month in arrears	AF	MD	9% REDUCTION FROM FY 16/17 (<12 per month)	QC	Red if >12 in mth, ER if >12 for 2 consecutive mths	May-17	New Indicator	262	156	8	13	10	14	18	16	15	9	17	18	11	20		31
	S2	Serious Incidents - actual number escalated each month	AF	MD	<=37 by end of FY 17/18	UHL	Red / ER if >8 in mth or >5 for 3 consecutive mths	May-17	41	50	37	1	3	4	2	4	4	2	3	1	3	4	5	2	11
	S3	Proportion of reported safety incidents per 1000 attendances (IP, OP and ED)	AF	MD	> FY 16/17	UHL	Not required	May-17	New Indicator	17.5	16.5	16.4	19.3	18.3	16.5	16.2	15.3	17.1	15.8	15.8	14.2	14.9	13.2	9.3	12.5
	S4	SEPSIS - Patients with an Early Warning Score 3+ - % appropriate escalation	AF	SH	95%	UHL	TBC	Jul-17	New Indicator		88%			86%	91%	86%	89%	88%	89%	89%	90%	91%	91%	92%	91%
	S5	SEPSIS - Patients with EWS 3+ - % who are screened for sepsis	AF	SH	95%	UHL	TBC	Jul-17	New Indicator		93%			65%	91%	95%	99%	99%	99%	97%	96%	96%	95%	94%	95%
	S6	SEPSIS - ED - Patients who trigger with red flag sepsis - % that have their IV antibiotics within an hour	AF	SH	90%	UHL	TBC	Jul-17	New Indicator		76%	71%	66%	69%	75%	79%	82%	76%	83%	88%	85%	86%	86%	87%	86%
	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	Jul-17	New Indicator		55%	21%	42%	23%	45%	61%	67%	76%	78%	77%	85%	81%	75%	82%	79%
	S8	Overdue CAS alerts	AF	MD	0	NHSI	Red if >0 in mth ER = in mth >0	Nov-16	10	1	0	0	0	0	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	Nov-17	24	32	28	3	1	0	2	4	4	2	5	4	2	7	3	5	15
	S10	Never Events	AF	MD	0	NHSI	Red if >0 in mth ER = in mth >0	May-17	3	2	4	0	1	0	0	0	1	0	1	0	1	0	3	0	3
	S11	Clostridium Difficile	JS	DJ	61	NHSI	Red if >mthly threshold / ER if Red or Non compliance with cumulative target	Aug-17	73	60	60	6	1	7	8	5	7	0	5	7	5	5	0	10	15
	S12	MRSA Bacteraemias - Unavoidable or Assigned to third Party	JS	DJ	0	NHSI	Red if >0 ER Not Required	Aug-17	6	1	3	0	1	0	0	0	0	0	0	1	1	0	0	0	0
	S13	MRSA Bacteraemias (Avoidable)	JS	DJ	0	UHL	Red if >0 ER if >0	Aug-17	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	S14	MRSA Total	JS	DJ	0	UHL	Red if >0 ER if >0	Aug-17	1	0	3	0	1	0	0	0	0	0	0	1	1	0	0	0	0
	S15	% of UHL Patients with No Newly Acquired Harms	JS	NB	>=95%	UHL	Red if <95% ER if in mth <95%	Sept-16	New Indicator	97.7%	97.7%	98.4%	97.9%	98.6%	97.9%	98.0%	97.3%	98.0%	98.0%	97.7%	96.7%	97.2%	97.8%	97.4%	97.5%
	S16	% of all adults who have had VTE risk assessment on adm to hosp	AF	SR	>=95%	NHSI	Red if <95% ER if in mth <95%	Nov-16	95.8%	95.9%	95.8%	96.5%	96.1%	96.0%	95.7%	96.3%	96.3%	95.1%	95.0%	95.1%	95.1%	95.4%	95.8%	96.2%	95.8%
	S17	All falls reported per 1000 bed stays for patients >65years- reported 1 month in arrears	JS	HL	<=5.5	UHL	Red if >6.6 ER if 2 consecutive reds	Nov-17	6.9	5.4	5.9	6.1	5.7	6.4	6.1	5.4	5.7	5.7	5.4	5.7	5.7	6.0	5.4		5.7
	S18	Avoidable Pressure Ulcers - Grade 4	JS	MC	0	QS	Red / ER if Non compliance with monthly target	Jul-17	2	1	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0
	S19	Avoidable Pressure Ulcers - Grade 3	JS	MC	<=3 a month (revised) with FY End <27	QS	Red / ER if Non compliance with monthly target	Jul-17	69	33	28	2	2	2	2	2	2	2	2	3	1	0	0	5	5
	S20	Avoidable Pressure Ulcers - Grade 2	JS	MC	<=7 a month (revised) with FY End <84	QS	Red / ER if Non compliance with monthly target	Jul-17	91	89	89	8	3	13	6	9	10	5	8	7	5	6	5	2	13
	S21	Maternal Deaths (Direct within 42 days)	AF	IS	0	UHL	Red or ER if >0	Jan-17	1	0	2	0	0	1	0	1	0	0	0	0	0	0	0	0	0
	S22	Emergency C Sections (Coded as R18)	IS	EB	Not within Highest Decile	NHSI	Red / ER if Non compliance with monthly target	Jan-17	16.5%	17.5%	16.8%	17.2%	17.0%	15.0%	18.1%	16.9%	15.3%	16.3%	17.9%	17.0%	16.7%	18.4%	19.3%	18.0%	18.6%

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

	KPI Ref	Indicators	Board Director	Lead Officer	17/18 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	DQF Assessment outcome/Date	14/15 Outturn	15/16 Outturn	16/17 Outturn	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	17/18 YTD
Caring	C1	>75% of patients in the last days of life have individualised End of Life Care plans	TBC	TBC	TBC	QC	TBC	NEW INDICATOR																	
	C2	Formal complaints rate per 1000 IP,OP and ED attendances	AF	MD	No Target	UHL	Monthly reporting	Aug-17	NEW INDICATOR		1.1	0.9	0.8	1.2	1.4	1.1	1.2	1.2	1.2	0.9	1.2	1.1	1.1	1.2	1.1
	C3	Percentage of upheld PHSO cases	AF	MD	No Target	UHL	Quarterly reporting	TBC	NEW INDICATOR		5%		0% (0 out of 7 cases)			0% (0 out of 3 cases)			0% (Zero cases)			0% (0 out of 2 cases)			0%
	C4	Published Inpatients and Daycase Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <95% ER if red for 3 consecutive months Revise threshold 17/18	Jun-17	New Indicator	97%	97%	97%	97%	96%	97%	96%	97%	97%	96%	96%	97%	97%	97%	97%	97%
	C5	Inpatients only Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <95% ER if red for 3 consecutive months Revise threshold 17/18	Jun-17	96%	97%	96%	97%	96%	95%	96%	96%	96%	96%	95%	95%	95%	96%	96%	96%	96%
	C6	Daycase only Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <95% ER if red for 3 consecutive months Revise threshold 17/18	Jun-17	New Indicator	98%	98%	99%	98%	98%	98%	98%	98%	98%	98%	99%	98%	99%	98%	99%	99%
	C7	A&E Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <93% ER if red for 3 consecutive months Revised threshold 17/18	Jun-17	96%	96%	91%	95%	87%	87%	84%	87%	84%	91%	93%	94%	95%	94%	93%	96%	94%
	C8	Outpatients Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <93% ER if red for 3 consecutive months Revised threshold 17/18	Jun-17	New Indicator	94%	93%	95%	94%	94%	95%	95%	95%	92%	92%	92%	92%	92%	93%	95%	94%
	C9	Maternity Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <93% ER if red for 3 consecutive months Revised threshold 17/18	Jun-17	96%	95%	95%	94%	95%	95%	95%	95%	94%	93%	96%	94%	95%	94%	95%	96%	95%
	C10	Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment (from Pulse Check)	LT	LT	TBC	NHSI	TBC	Aug-17	69.2%	70.0%	73.6%		76.0%			73.3%			72.7%			74.3%			74.3%
	C11	Single Sex Accommodation Breaches (patients affected)	JS	HL	0	NHSI	Red if >0 ER if 2 consecutive months >5	Dec-16	13	1	60	4	1	2	20	7	1	14	6	4	1	3	3	1	7

	KPI Ref	Indicators	Board Director	Lead Officer	17/18 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	DQF Assessment outcome/Date	14/15 Outturn	15/16 Outturn	16/17 Outturn	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	17/18 YTD
Well Led	W1	Published Inpatients and Daycase Friends and Family Test - Coverage (Adults and Children)	JS	HL	Not Appicable	N/A	Not Appicable	Jun-17	New Indicator	27.4%	30.2%	31.6%	31.9%	28.5%	27.8%	31.6%	31.6%	27.5%	27.2%	30.7%	30.4%	32.4%	31.9%	27.7%	30.6%
	W2	Inpatients only Friends and Family Test - Coverage (Adults and Children)	JS	HL	30%	QS	Red if <26% ER if 2mths Red	Jun-17	New Indicator	31.0%	35.3%	38.1%	36.9%	36.5%	33.1%	36.6%	37.0%	31.9%	31.3%	35.4%	33.8%	37.1%	37.2%	30.6%	34.9%
	W3	Daycase only Friends and Family Test - Coverage (Adults and Children)	JS	HL	20%	QS	Red if <10% ER if 2 mths Red	Jun-17	New Indicator	22.5%	24.4%	24.5%	26.2%	19.8%	21.6%	25.9%	25.7%	22.3%	22.5%	25.5%	26.4%	27.1%	26.4%	24.7%	26.0%
	W4	A&E Friends and Family Test - Coverage	JS	HL	10%	QS	Red if <7.1% ER if 2 mths Red	Jun-17	New Indicator	10.5%	10.8%	12.0%	8.7%	9.9%	11.7%	9.8%	11.4%	7.1%	10.4%	13.8%	12.1%	13.8%	8.3%	9.4%	10.5%
	W5	Outpatients Friends and Family Test - Coverage	JS	HL	5%	QS	Red if <1.5% ER if 2 mths Red	Jun-17	New Indicator	1.4%	3.0%	1.8%	1.7%	1.6%	1.5%	1.5%	1.8%	5.7%	5.9%	5.9%	6.5%	5.4%	5.6%	5.9%	5.7%
	W6	Maternity Friends and Family Test - Coverage	JS	HL	30%	UHL	Red if <26% ER if 2 mths Red	Jun-17	28.0%	31.6%	38.0%	39.3%	38.2%	38.7%	37.8%	38.3%	41.1%	37.1%	40.9%	38.0%	41.1%	46.8%	44.1%	42.2%	44.3%
	W7	Friends & Family staff survey: % of staff who would recommend the trust as place to work (from Pulse Check)	LT	BK	Not within Lowest Decile	NHSI	TBC	Sep-17	54.2%	55.4%	61.9%		62.9%			62.9%			61.4%			62.5%			62.5%
	W8	Nursing Vacancies	JS	MM	TBC	UHL	Separate report submitted to QAC	Sep-17	New Indicator	8.4%	9.2%	8.9%	9.2%	8.2%	8.7%	10.3%	9.7%	7.1%	7.6%	7.4%	9.2%	10.9%	9.9%	11.1%	11.1%
	W9	Nursing Vacancies in ESM CMG	JS	MM	TBC	UHL	Separate report submitted to QAC	Sep-17	New Indicator	17.2%	15.4%	19.8%	20.1%	20.3%	21.4%	20.0%	20.2%	14.5%	11.9%	13.7%	15.4%	19.7%	16.9%	21.3%	21.3%
	W10	Turnover Rate	LT	LG	TBC	NHSI	Red = 11% or above ER = Red for 3 Consecutive Mths	Sep-17	11.5%	9.9%	9.3%	9.4%	9.4%	9.3%	9.2%	9.1%	9.2%	9.3%	9.3%	9.3%	9.3%	8.7%	8.8%	8.8%	8.8%
	W11	Sickness absence (reported 1 month in arrears)	LT	BK	3%	UHL	Red if >4% ER if 3 consecutive mths >4.0%	Oct-16	3.8%	3.6%	3.3%	3.4%	3.3%	3.1%	3.4%	3.5%	3.6%	3.6%	3.7%	3.5%	3.3%	3.0%	3.2%		3.2%
	W12	Temporary costs and overtime as a % of total paybill	LT	LG	TBC	NHSI	TBC	Oct-17	9.4%	10.7%	10.6%	10.9%	10.2%	10.5%	10.7%	10.9%	10.9%	10.1%	10.8%	10.5%	11.4%	11.1%	11.0%	11.1%	11.1%
	W13	% of Staff with Annual Appraisal (excluding facilities Services)	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	Dec-16	91.4%	90.7%	91.7%	92.4%	92.9%	92.4%	91.5%	91.4%	91.9%	91.7%	91.6%	92.4%	91.7%	92.1%	92.5%	92.1%	92.1%
	W14	Statutory and Mandatory Training	LT	BK	95%	UHL	TBC	Dec-16	95%	93%	87%	94%	93%	91%	82%	82%	82%	83%	81%	82%	87%	86%	85%	82%	82%
	W15	% Corporate Induction attendance	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	Dec-16	100%	97%	96%	97%	100%	97%	92%	96%	95%	99%	98%	97%	96%	100%	98%	96%	98%
	W16	BME % - Leadership (8A – Including Medical Consultants)	LT	DB	28%	UHL	4% improvement on Qtr 1 baseline	TBC	New Indicator		26%		25%			26%			26%			26%			26%
	W17	BME % - Leadership (8A – Excluding Medical Consultants)	LT	DB	28%	UHL	4% improvement on Qtr 1 baseline	TBC			12%		12%			12%			12%			12%			12%
	W18	Executive Team Turnover Rate - Executive Directors (rolling 12 months)	LT	DB	TBC	UHL	TBC	TBC	New Indicator		0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	20%	20%
	W19	Executive Team Turnover Rate - Non Executive Directors (rolling 12 months)	LT	DB	TBC	UHL	TBC	TBC			25%	29%	43%	43%	43%	43%	43%	25%	25%	25%	25%	25%	25%	13%	13%
	W20	DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	TBC	NHSI	TBC	Apr-17	91.2%	90.5%	90.5%	91.4%	89.7%	89.4%	89.9%	90.0%	89.3%	90.4%	91.6%	91.6%	89.8%	90.3%	90.3%	89.9%	90.2%
	W21	DAY Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	TBC	NHSI	TBC	Apr-17	94.0%	92.0%	92.3%	93.8%	92.0%	94.7%	91.0%	91.9%	93.2%	91.9%	89.7%	91.1%	87.4%	96.7%	91.6%	87.9%	92.1%
	W22	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	TBC	NHSI	TBC	Apr-17	94.9%	95.4%	96.4%	96.6%	94.5%	95.0%	95.1%	96.7%	95.9%	96.9%	97.6%	97.2%	96.2%	96.6%	96.5%	95.9%	96.3%
	W23	NIGHT Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	TBC	NHSI	TBC	Apr-17	99.8%	98.9%	97.1%	96.7%	97.1%	98.2%	96.8%	94.2%	95.6%	98.5%	95.8%	97.8%	94.7%	100.2%	99.1%	93.1%	97.5%

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

	KPI Ref	Indicators	Board Director	Lead Officer	17/18 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	DQF Assessment outcome/Date	14/15 Outturn	15/16 Outturn	16/17 Outturn	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	17/18 YTD
Effective	E1	Emergency readmissions within 30 days following an elective or emergency spell	AF	CM	Monthly <8.5% (revised)	QC	Red if >8.6% ER if >8.6%	Jun-17	8.51% Target 7%	8.9%	8.5%	8.6%	8.3%	8.4%	8.5%	8.5%	8.1%	8.7%	8.7%	8.4%	8.8%	9.5%	8.9%		9.2%
	E2	Mortality - Published SHMI	AF	RB	<=99 (revised)	QC	Red if >100 ER if >100	Sep-16	103	96	102 (Oct15-Sep16)	98 (Jan15-Dec15)			99 (Apr15-Mar16)			101 (Jul15-Jun16)			102 (Oct15-Sep16)			101 Jan16-Dec 16	101 Jan16-Dec 16
	E3	Mortality - Rolling 12 mths SHMI (as reported in HED) Rebased	AF	RB	<=99 (revised)	QC	Red if >100 ER if not within national expected range	Sep-16	98	97	101	101	102	101	102	102	101	101	101	101	Awaiting HED Update	Awaiting HED Update			
	E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	AF	RB	<=99 (revised)	UHL	Red if >100 ER if not within national expected range	Sep-16	94	96	102	100	102	103	102	102	103	103	102	103	101	Awaiting HED Update			
	E5	Crude Mortality Rate Emergency Spells	AF	RB	<=2.4%	UHL	Monthly Reporting	Apr-17	2.4%	2.3%	2.4%	2.2%	2.2%	2.2%	2.0%	2.2%	2.4%	2.7%	2.9%	2.6%	2.4%	2.1%	1.9%	2.0%	2.0%
	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%	Jun-17	61.4%	63.8%	71.2%	64.6%	86.0%	65.8%	69.4%	64.1%	78.0%	60.3%	70.9%	67.6%	71.2%	47.1%	76.5%	76.8%	66.8%
	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%	Jun-17	New Indicator		83.6%	73.2%	90.0%	82.0%	87.2%	78.2%	89.0%	79.5%	89.5%	80.0%	80.0%	64.0%	89.0%	89.3%	80.8%
	E8	Stroke - 90% of Stay on a Stroke Unit	TL	IL	80% or above	QS	Red if <80% ER if 2 consecutive mths <80%	Dec-17	81.3%	85.6%	85.0%	83.8%	80.7%	88.0%	84.5%	86.5%	88.0%	83.8%	87.4%	86.6%	85.1%	87.3%	85.7%		86.4%
	E9	Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA)	TL	IL	60% or above	QS	Red if <60% ER if 2 consecutive mths <60%	Dec-17	71.2%	75.6%	66.9%	50.4%	54.8%	71.7%	65.3%	83.8%	75.9%	69.2%	87.7%	57.3%	66.3%	57.8%	57.0%	68.6%	61.2%

Responsive

KPI Ref	Indicators	Board Director	Lead Officer	17/18 Target	Target Set by	17/18 Red RAG/ Exception Report Threshold (ER)	DQF Assessment outcome/Date	14/15 Outturn	15/16 Outturn	16/17 Outturn	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	17/18 YTD
R1	ED 4 Hour Waits UHL + UCC (Calendar Month)	TL	IL	95% or above	NHSI	Red if <92% ER via ED TB report	Aug-17	89.1%	86.9%	79.6%	80.6%	76.9%	80.1%	79.9%	78.3%	77.6%	75.5%	78.1%	83.8%	83.9%	81.0%	76.3%	77.6%	78.3%
R2	12 hour trolley waits in A&E	TL	IL	0	NHSI	Red if >0 ER via ED TB report	Aug-17	4	2	11	0	0	0	0	0	0	1	10	0	0	0	0	0	0
R3	RTT - Incomplete 92% in 18 Weeks UHL+ALLIANCE	TL	WM	92% or above	NHSI	Red /ER if <92%	Nov-16	96.7%	92.6%	91.8%	92.4%	92.4%	92.1%	91.7%	91.5%	92.2%	91.3%	90.9%	91.2%	91.8%	91.3%	92.3%	92.3%	92.3%
R4	RTT 52 Weeks+ Wait (Incompletes) UHL+ALLIANCE	TL	WM	0	NHSI	Red /ER if >0	Nov-16	0	232	24	130	77	57	53	38	34	32	34	39	24	17	9	15	15
R5	6 Week - Diagnostic Test Waiting Times (UHL+ALLIANCE)	TL	WM	1% or below	NHSI	Red /ER if >1%	Dec-16	0.9%	1.1%	0.9%	0.7%	0.6%	1.4%	1.5%	0.6%	0.6%	0.9%	0.9%	0.9%	0.9%	0.9%	0.8%	0.7%	0.7%
R6	Urgent Operations Cancelled Twice (UHL+ALLIANCE)	TL	WM	0	NHSI	Red if >0 ER if >0	Jan-17	0	0	3	0	0	0	0	0	3	0	0	0	0	0	0	0	0
R7	Cancelled patients not offered a date within 28 days of the cancellations UHL	TL	WM	0	NHSI	Red if >2 ER if >0	Jan-17	33	48	212	18	20	19	10	9	13	18	22	26	17	13	14	10	37
R8	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	TL	WM	0	NHSI	Red if >2 ER if >0	Jan-17	11	1	11	0	0	6	0	0	0	0	0	0	0	0	0	0	0
R9	% Operations cancelled for non-clinical reasons on or after the day of admission UHL	TL	WM	0.8% or below	Contract	Red if >0.8% ER if >0.8%	Jan-17	0.9%	1.0%	1.2%	1.4%	1.1%	0.9%	1.0%	1.2%	1.5%	0.8%	1.6%	1.2%	1.2%	0.9%	1.1%	1.0%	1.0%
R10	% Operations cancelled for non-clinical reasons on or after the day of admission ALLIANCE	TL	WM	0.8% or below	Contract	Red if >0.8% ER if >0.8%	Jan-17	0.9%	0.9%	0.9%	0.8%	1.4%	3.2%	0.9%	2.0%	0.5%	0.1%	0.4%	1.3%	0.5%	2.5%	0.1%	0.4%	1.0%
R11	% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	TL	WM	0.8% or below	Contract	Red if >0.8% ER if >0.8%	Jan-17	0.9%	1.0%	1.2%	1.4%	1.1%	1.0%	1.0%	1.2%	1.4%	0.8%	1.5%	1.2%	1.1%	1.0%	1.1%	1.0%	1.0%
R12	No of Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	TL	WM	Not Applicable	UHL	Not Applicable	Jan-17	1071	1299	1566	154	114	110	109	134	164	82	167	122	131	99	123	114	336
R13	Delayed transfers of care	TL	JD	3.5% or below	NHSI	Red if >3.5% ER if Red for 3 consecutive mths	Jan-18	3.9%	1.4%	2.4%	2.2%	2.9%	2.5%	2.1%	2.0%	2.7%	2.8%	2.7%	2.3%	2.5%	2.1%	2.0%	1.4%	1.8%
R14	Ambulance Handover >60 Mins (CAD+ from June 15)	TL	LG	0	Contract	Red if >0 ER if Red for 3 consecutive mths	TBC	5%	5%	9%	6%	9%	7%	9%	9%	11%	17%	13%	6%	6%	6%	7%	2%	5%
R15	Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)	TL	LG	0	Contract	Red if >0 ER if Red for 3 consecutive mths	TBC	19%	19%	14%	10%	15%	14%	15%	18%	18%	18%	15%	12%	13%	13%	13%	8%	11%

Responsive Cancer

KPI Ref	Indicators	Board Director	Lead Officer	17/18 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	DQF Assessment outcome/Date	14/15 Outturn	15/16 Outturn	16/17 Outturn	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	17/18 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	TL	DB	93% or above	NHSI	Red if <93% ER if Red for 2 consecutive mths	Jul-16	92.2%	90.5%	93.2%	90.5%	94.3%	94.9%	94.5%	93.3%	95.2%	93.8%	93.2%	94.3%	94.0%	93.3%	95.4%	**	94.4%
RC2	Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	TL	DB	93% or above	NHSI	Red if <93% ER if Red for 2 consecutive mths	Jul-16	94.1%	95.1%	93.9%	94.9%	98.7%	95.9%	95.0%	90.7%	96.0%	91.1%	93.4%	97.0%	90.8%	89.6%	94.2%	**	92.2%
RC3	31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	TL	DB	96% or above	NHSI	Red if <96% ER if Red for 2 consecutive mths	Jul-16	94.6%	94.8%	93.9%	95.6%	90.4%	91.3%	93.8%	94.8%	94.2%	92.4%	91.9%	95.3%	96.2%	96.1%	94.6%	**	95.3%
RC4	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	TL	DB	98% or above	NHSI	Red if <98% ER if Red for 2 consecutive mths	Jul-16	99.4%	99.7%	99.7%	97.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	98.7%	97.7%	**	98.2%
RC5	31-Day Wait For Second Or Subsequent Treatment: Surgery	TL	DB	94% or above	NHSI	Red if <94% ER if Red for 2 consecutive mths	Jul-16	89.0%	85.3%	86.4%	84.7%	74.4%	72.7%	83.5%	90.4%	83.3%	87.2%	90.9%	88.5%	95.4%	85.5%	85.7%	**	85.6%
RC6	31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	TL	DB	94% or above	NHSI	Red if <94% ER if Red for 2 consecutive mths	Jul-16	96.1%	94.9%	93.5%	87.3%	92.5%	81.4%	90.9%	97.8%	94.8%	98.1%	95.3%	99.1%	96.7%	95.0%	93.0%	**	94.0%
RC7	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	TL	DB	85% or above	NHSI	Red if <85% ER if Red in mth or YTD	Jul-16	81.4%	77.5%	78.1%	77.3%	83.6%	78.4%	77.9%	74.5%	77.2%	79.5%	75.4%	76.1%	86.5%	83.9%	76.6%	**	79.9%
RC8	62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	TL	DB	90% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	84.5%	89.1%	88.6%	85.0%	92.3%	78.9%	81.5%	84.2%	88.0%	90.9%	93.1%	78.1%	95.1%	95.0%	92.3%	**	93.7%
RC9	Cancer waiting 104 days	TL	DB	0	NHSI	TBC	Jul-16	New Indicator		10	15	12	9	7	7	9	10	8	3	10	6	6	12	12

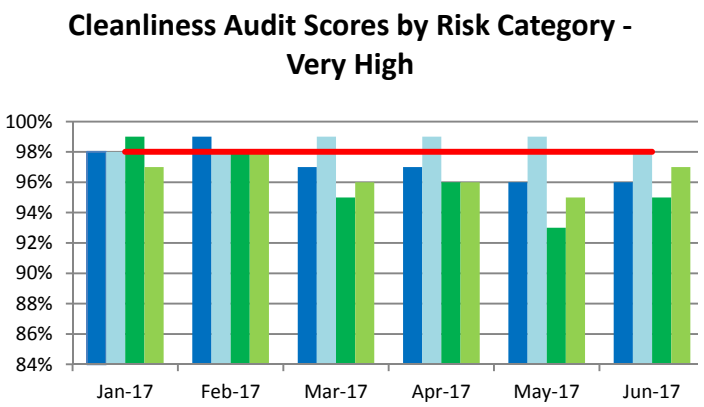
62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers Inc Rare Cancers

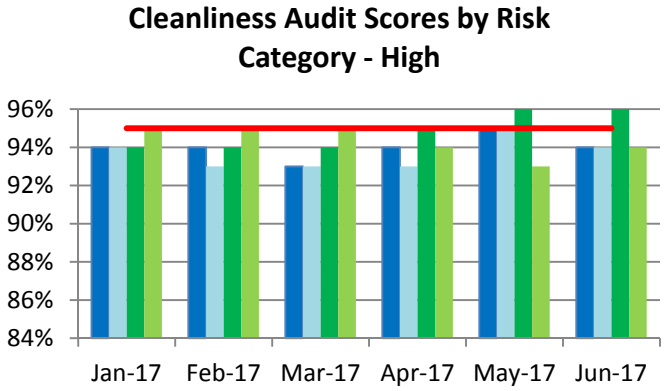
KPI Ref	Indicators	Board Director	Lead Officer	17/18 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	DQF Assessment outcome	14/15 Outturn	15/16 Outturn	16/17 Outturn	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	17/18 YTD
RC10	Brain/Central Nervous System	TL	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	--	100.0%	100.0%	--	--	--	100.0%	--	--	--	100.0%	--	--	--	--	**	--
RC11	Breast	TL	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	92.6%	95.6%	96.3%	97.1%	100.0%	100.0%	95.8%	100.0%	95.8%	94.6%	96.6%	92.6%	93.48%	97.4%	97.4%	**	97.4%
RC12	Gynaecological	TL	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	77.5%	73.4%	69.5%	75.0%	62.5%	66.7%	66.7%	80.0%	66.7%	44.4%	71.4%	81.8%	78.6%	64.3%	89.5%	**	78.8%
RC13	Haematological	TL	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	66.5%	63.0%	70.6%	72.7%	100.0%	85.7%	28.6%	58.3%	77.8%	66.7%	87.5%	81.8%	88.9%	100%	64.3%	**	76.2%
RC14	Head and Neck	TL	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	69.9%	50.7%	44.5%	100.0%	42.9%	44.4%	0.0%	38.5%	66.7%	33.3%	41.7%	33.3%	66.7%	85.7%	48.3%	**	55.6%
RC15	Lower Gastrointestinal Cancer	TL	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	63.7%	59.8%	56.8%	64.5%	58.8%	64.4%	47.1%	38.1%	61.5%	75.0%	48.3%	54.5%	75.0%	40.0%	63.8%	**	54.5%
RC16	Lung	TL	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	69.9%	71.0%	65.1%	64.2%	60.9%	64.2%	68.0%	79.4%	67.5%	79.5%	74.0%	33.3%	67.5%	81.1%	63.0%	**	70.3%
RC17	Other	TL	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	95.0%	71.4%	60.0%	100.0%	100.0%	33.3%	0.0%	66.7%	--	100.0%	--	--	100.0%	50.0%	100.0%	**	66.7%
RC18	Sarcoma	TL	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	46.2%	81.3%	45.2%	16.7%	--	--	100.0%	50.0%	100.0%	66.7%	40.0%	0%	100.0%	--	40.0%	**	40.0%
RC19	Skin	TL	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	96.7%	94.1%	96.9%	96.8%	97.4%	95.9%	97.7%	100.0%	92.3%	97.0%	96.9%	96.6%	96.2%	96.8%	95.5%	**	96.2%
RC20	Upper Gastrointestinal Cancer	TL	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	73.9%	63.9%	68.0%	46.9%	66.7%	82.0%	70.3%	43.8%	100.0%	72.0%	61.4%	63.6%	85.7%	92.3%	66.7%	**	75.0%
RC21	Urological (excluding testicular)	TL	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	82.6%	74.4%	80.8%	77.8%	96.3%	74.5%	83.5%	88.2%	75.0%	79.3%	71.4%	76.2%	89.9%	82.1%	79.4%	**	80.9%
RC22	Rare Cancers	TL	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	84.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	--	**	100.0%
RC23	Grand Total	TL	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	81.4%	77.5%	78.1%	77.3%	83.6%	78.4%	77.9%	74.5%	77.2%	79.5%	75.4%	76.1%	86.5%	83.9%	76.6%	**	79.9%

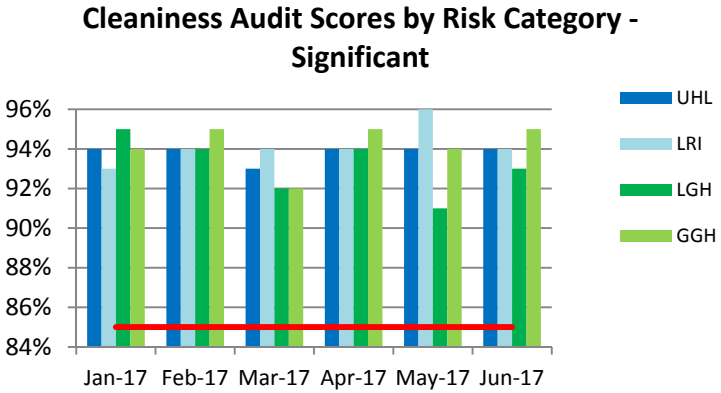
Compliance Forecast for Key Responsive Indicators

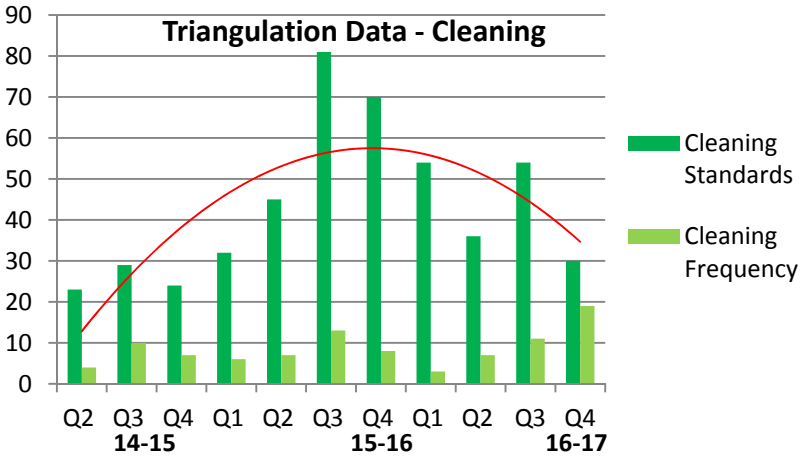
Standard	June	July	Commentary
Emergency Care			
4+ hr Wait (95%) - Calendar month	77.6%		Validated position.
Ambulance Handover (CAD+)			
% Ambulance Handover >60 Mins (CAD+)	2%		EMAS monthly report
% Ambulance Handover >30 Mins and <60 mins (CAD+)	8%		
RTT (inc Alliance)			
Incomplete (92%)	92.3%	92.0%	
Diagnostic (inc Alliance)			
DM01 - diagnostics 6+ week waits (<1%)	0.7%	0.9%	
# Neck of femurs			
% operated on within 36hrs - all admissions (72%)	77%	72%	
% operated on within 36hrs - pts fit for surgery (72%)	89%	85%	
Cancelled Ops (inc Alliance)			
Cancelled Ops (0.8%)	1.0%	1.0%	Delivery is dependant on access to beds.
Not Rebooked within 28 days (0 patients)	10	10	Delivery is dependant on access to beds.
Cancer			
Two Week Wait (93%)	94%	94%	
31 Day First Treatment (96%)	96%	96%	In discussion with NHSI compliance will be following 2 months of consistent bed access.
31 Day Subsequent Surgery Treatment (94%)	87%	94%	
62 Days (85%)	82%	85%	In discussion with NHSI compliance will be following 2 months of consistent bed access.
Cancer waiting 104 days (0 patients)	12	6	

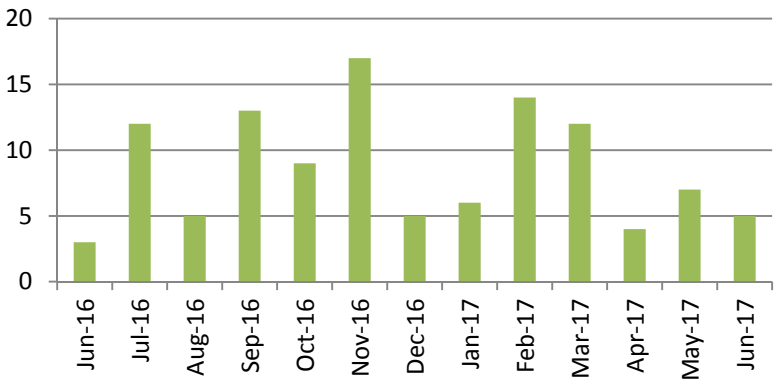
Estates and Facilities - Cleanliness











Cleanliness Report

The above charts show average audit scores for the whole Trust and by hospital site since October 2016. 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 the target of 98% was not achieved in June 2017 by GGH and LGH. GGH improved on last month's score moving from 95% to 97%; LGH also improved over last month moving from 93% to 95%. Overall the target was not achieved across the Trust.
High-risk areas require improvement across both the LRI and GGH who both achieved 94%. Whereas, the LGH has achieved above the 95% required to achieve its target. The UHL has an overall score of 94% which is 1% lower than May's score.

Significant risk areas all exceed the 85% target.

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'. This data is only collated on a quarterly basis and the chart shown here is inclusive of Q1 to Q4.

As a further reflection of service standards and issues, the number of Datix incidents logged for June has dropped since last month. None of the Datix reports are related to any very high risk areas.

The overall picture continues to be one of plateaued performance with month on month small variations still remaining just behind target. In practice this means that there are a small number of areas that will be noticeably below standard. Progress against reducing the number of vacancies continues to be made but this is slow given the on-going levels of staff turnover.

Estates and Facilities – Patient Catering

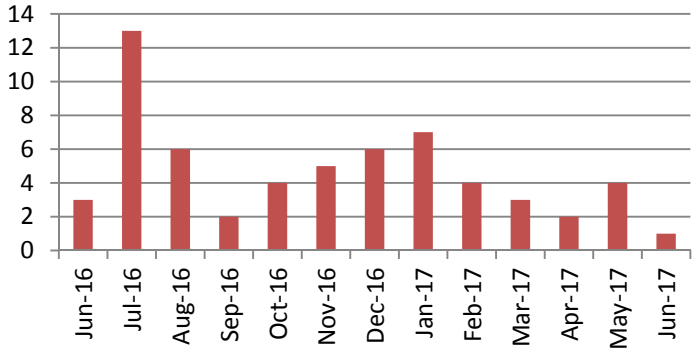
Patient Catering Survey – May 2017	Percentage 'OK or Good'	
	May-17	Jun-17
Did you enjoy your food?	88%	93%
Did you feel the menu has a good choice of food?	84%	100%
Did you get the meal that you ordered?	86%	98%
Were you given enough to eat?	87%	98%

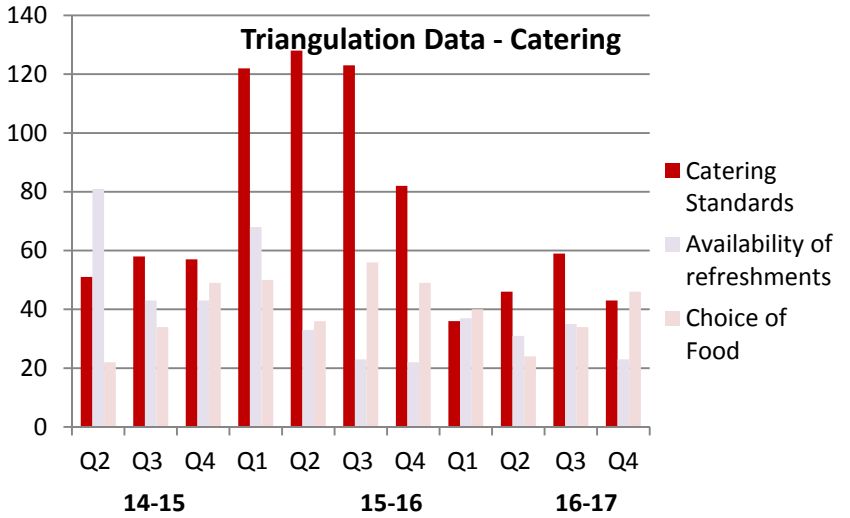
90 – 100%	80 – 90%	<80%

Number of Patient Meals Served				
Month	LRI	LGH	GGH	UHL
April	69,270	22,262	25,362	116,894
May	69,420	22,432	29,399	121,251
June	67,630	21,858	29,331	118,819

Patient Meals Served On Time (%)				
Month	LRI	LGH	GGH	UHL
April	100%	100%	100%	100%
May	100%	100%	100%	100%
June	100%	100%	100%	100%

Number of Datix Incidents Loogged - Patient Catering





Patient Catering Report

This month we received a very low return of 45 surveys.

We continue to appraise the comment data collected alongside survey scores this month showing no discernible trend with comments tending to reflecting individual tastes rather than genuine quality issues.

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

The triangulation data is refreshed on a quarterly basis.

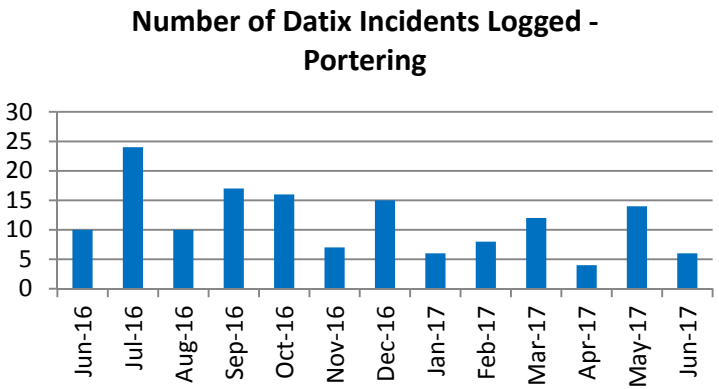
Datix's for the month of June have dropped to only one, showing continued improvement of the service.

Estates and Facilities – Portering

Reactive Portering Tasks in Target				
Site	Task (Urgent 15min, Routine 30min)	Month		
		April	May	June
GH	Overall	96%	92%	93%
	Routine	95%	94%	93%
	Urgent	98%	100%	96%
LGH	Overall	93%	92%	94%
	Routine	92%	92%	93%
	Urgent	96%	95%	98%
LRI	Overall	94%	89%	93%
	Routine	94%	89%	92%
	Urgent	98%	92%	98%

95 – 100%	90 – 94%	<90%

Average Portering Task Response Times		
Category	Time	No of tasks
Urgent	14:22	2,174
Routine	26:10	13,306
	Total	12,980



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.
June's performance overall was similar to May except for a slight rise in tasks, but this can be attributed to the length of the month. Datix incidents have fallen by over 50% since last month. These will continue to be monitored.
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	April	0	168	168	100%
	May	1	112	168	99%
	June	0	130	130	100%

99 – 100%	97 – 99%	<97%

Non-Statutory Maintenance Tasks Against Schedule					
	Month	Fail	Pass	Total	%
UHL Trust Wide	April	350	2157	2514	88%
	May	356	1963	2319	86%
	June	449	1778	2227	80%

95 – 100%	80 – 95%	<80%

Estates Planned Maintenance Report

For June we incurred no failures in the delivery of Statutory Maintenance tasks in the 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.

At this stage, the Planet system has been upgraded and the devices for the engineers have been delivered and are being upgraded by IT to allow testing on the live system to begin within the next two months.

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

Research UHL

KPI Ref	Indicators	Board Director	Lead Officer	17/18 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	16/17 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	Jan-17	Feb-17	Mar-17
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			45		
RU2	Median Days from submission to Trust approval (Non Portfolio)	AF	NB	TBC	TBC	TBC	2.1	1.0	Q2-Q4 158	1.0			1.0			1.0			1.0			41			90			27		
RU3	Recruitment to Portfolio Studies	AF	NB	Aspirational target=10920/year (910/month)	TBC	TBC	12564	13479	8603	1019	858	1019	1516	1875	815	926	983	947	979	917	887	758	657	592	487	699	325	636	531	1135
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%			(Jan16 - Dec16) 100%			(Apr16 - Mar17) 50% (metric change due to HRA process change)		
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			(Jan16 - Dec16) 31/186			(Apr16 - Mar17) 14/187		
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%			(Jan16 - Dec16) 49.2%			(Apr16 - Mar17) 44.9%		

RIDDOR - Serious Staff Injuries

	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	17/18 YTD
RIDDOR - Serious Staff Injuries	3	1	0	2	4	4	2	5	4	2	7	3	5	15

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What actions have been taken to improve performance?

First quarter figures indicate 6 incidents beyond target. A review of the 15 incidents has shown a wide disparity in cause location, site and affected staff. There are no particular themes observed. First quarter figures for 16/17 did show a similar picture and this was recovered by the year end. We are also taking into account we are now reporting incidents for Estates and Facilities through our mechanisms that have not been reported previously under IFM. With the upsurge in total staffing this may have an effect on our original year end targets but this will be closely monitored by the Health and Safety Services team.

Pressure Ulcers

Indicators	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	17/18 YTD
Avoidable Pressure Ulcers - Grade 4	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Avoidable Pressure Ulcers - Grade 3	2	2	2	2	2	2	2	2	3	1	0	0	5	5
Avoidable Pressure Ulcers - Grade 2	8	3	13	6	9	10	5	8	7	5	6	5	2	13

What actions have been taken to improve performance?

There have been 5 avoidable Grade 3 pressure ulcers. An analysis of the reasons behind these has been completed which has identified the following themes.

- Inconsistent evidence of assessment
- Inconsistent evidence of nursing interventions
- Inconsistent use of pressure relieving aids.

These issues have been discussed at the validation events with the Ward sister, matron and Head of Nursing. In addition the key issues will be discussed through the Nursing Executive Meetings.

Clostridium Difficile

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD	Apr-15	May-15	Jun-15	YTD
Clostridium Difficile	4	5	6	1	7	8	5	7	0	5	7	5	60	5	0	10	15

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What actions have been taken to improve performance?

There is no obvious reason for the increase in positive reportable CDT results in June. The patients were not linked between by time and place, so there is no suggestion of cross infection.

It should be noted that there were a total of 36 CDT positives samples in June and 37 in May. A higher than average percentage of the June samples fit the criteria for reporting, but this does not affect the clinical management of patients in UHL. All patients with a CDT positive result are assessed by a multi-disciplinary team and treated according to clinical history and symptoms. Therefore, there is no indication that remedial action is required at this point.

Emergency Readmissions within 30 days

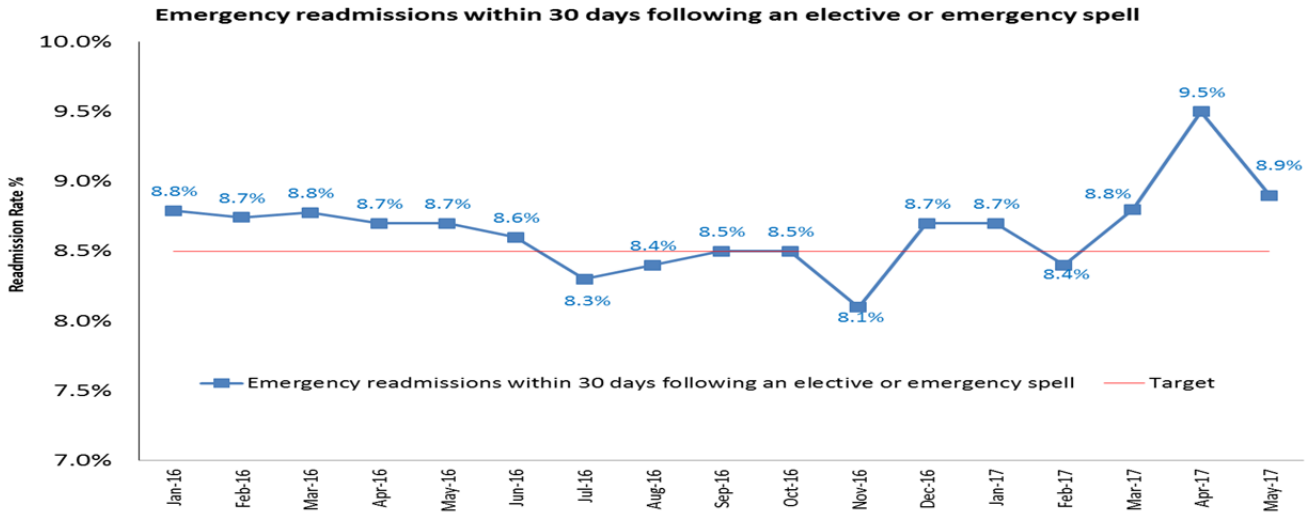
	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Emergency readmissions within 30 days following an elective or emergency spell	9.2%	8.8%	8.7%	8.8%	8.7%	8.7%	8.6%	8.3%	8.4%	8.5%	8.5%	8.1%	8.7%	8.7%	8.4%	8.8%	9.5%	8.9%

What actions have been taken to improve performance?

The readmissions group has met to address the recent rise in readmissions. This is thought to be due to the dedicated resource that was targeted at patients at high risk of readmission no longer being available, combined with the demise of the daily conference call. The following actions have been agreed to address this:

1. Pilot in CDU of Integrated Clinical Response Team following up all discharged patients by telephone.
2. New Integrated Discharge Team (IDT- commencing July 2017) to build into their Standard Operating Procedures how to deal with patients at high risk of readmission using the PARR30 score. Members of this team will attend all board rounds so have a unique opportunity to interact with clinical teams to remind them of the actions that need to be undertaken according to the UHL guideline.

Publicity planned for raising awareness of the readmission guideline is that it will be included in a piece about the new IDT in the CEO's briefing; and written material will be provided to all new junior doctors starting in the trust in August at the trust-wide induction.



RTT Performance

Combined UHL and Alliance RTT Performance for June

	<18 w	>18 w	Total Incompletes	%
Alliance	8359	531	8890	94.03%
UHL	48014	4186	52200	91.98%
Total	56373	4717	61090	92.28%

Backlog Reduction required to meet 92%	-185

UHL and Alliance combined performance for RTT in June was 92.28%. The Trust achieved the standard for the second consecutive month. Overall combined performance saw 4,717 patients in the backlog, a increase of 46 since the last reporting period (UHL reduction of 19, Alliance increase of 65). There were 185 fewer patients waiting over 18 weeks in order to achieve the standard.

The overall RTT performance has reduced slightly by 0.05% from the previous month. Achieving the RTT standard was forecasted in May's EPB report and remains ahead of performance trajectory. In order to ensure to accuracy of our waiting lists, regular audits are completed for each specialty to ensure compliance with the Trusts access policy.

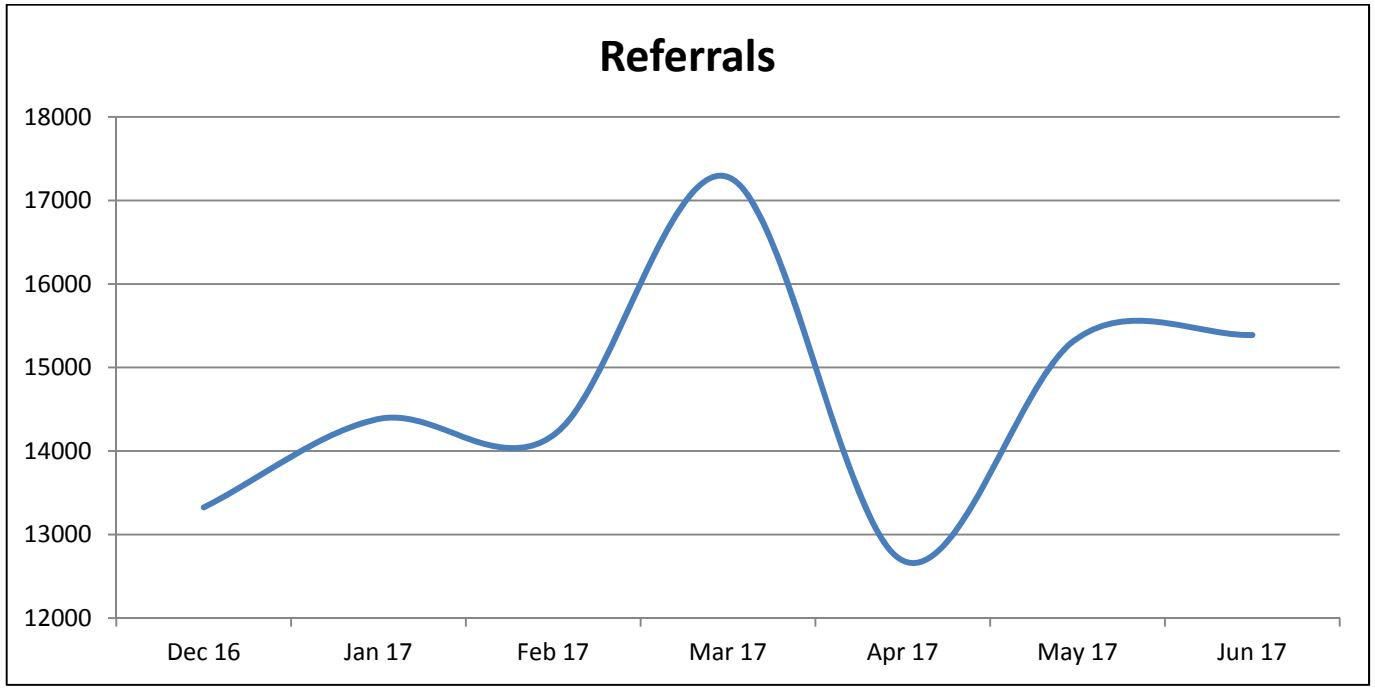
Forecast performance for next reporting period: It is forecasted there is a risk to achieving the 92% standard in July.

Risks to performance include:

- Significantly higher number of roll-ons. July's reporting period is 18 weeks after March 2017 which had 2,000 more referrals then average and the highest ever recorded number of referrals received at UHL. Average referrals per month for 2016/17 = 15,276. March referrals = 17,282
- Significant backlog increase in the Alliance
- Reduced clinical capacity due to increased annual leave take up
- Competing demands with Emergency and Cancer performance

UHL is currently 18 weeks after the spike of referrals seen in March 2017 which saw the largest number of referrals in a single month. March saw a 2,006 more referrals (13%) than the average for 2016/17. This will impact on the ability to achieve July's performance with a higher number of patients reaching there 18 week period then normal. In subsequent months the number of referrals received has significantly reduced.

If the referral trend continues to track lower than the previous financial year this will support the delivery of RTT in future months.



There are currently 6 specialties that, due to size of number of patients in their backlog and relative size, have individual action plans. They are Paediatric ENT, ENT, General Surgery, Urology, Allergy and Orthopaedics. They are monitored monthly. Current plans and performance are highlighted later in the report.

At the end June there were 15 patients with an incomplete pathway at more than 52 weeks. The 15 patients are broken down into 10 ENT, 4 Paediatric ENT and 1 Orthodontics. This has reduced from 39 at the end February. The forecasted number of 52 week breaches is 13 at the end of July. This is dependent on no patients being cancelled.

The total number of patients waiting over 40 weeks yet to receive treatment has reduced from 252 on 05/03/2017 to 123 as of at the end of June.

The table below details the average case per list against speciality targets.

Speciality	ACPL Target	M3 ACPL Actual	Variance
Breast Care	1.9	1.8	-0.1
ENT	2.6	2.5	-0.1
General Surgery	1.9	2.3	0.4
Gynaecology	2.9	2.5	-0.4
Maxillofacial Surgery	2.2	2.3	0.1
Ophthalmology	3.6	3.4	-0.2
Orthopaedics	1.9	1.8	-0.1
Paediatric Surgery	2.4	2.7	0.3
Pain Management	5.2	5.5	0.3
Plastic Surgery	2.9	2.4	-0.5
Renal Surgery	1.6	1.6	0
Urology	2.6	2.6	0
Vascular Surgery	1.3	1.3	0
Total	2.4	2.38	-0.02

The tables below outline the overall 10 largest backlog increases, 10 largest backlog reductions and 10 overall largest backlogs by specialty from last month. The largest overall backlog increases were within Cardiology, Ophthalmology and Thoracic Medicine.

The overall largest reductions in backlog size was achieved in ENT 66, Gynaecology 35 and Allergy 33.

Of the 62 specialties with a backlog, 26 saw their backlog increase, 8 specialties backlog stayed the same and 29 specialties reduced their backlog size.

Overall the non admitted backlog reduced by 1.6%. And the admitted backlog increased by 0.7%

10 highest backlog decreases	Admitted			Non Admitted			Total			
	May 17	Jun 17	Change	May 17	Jun 17	Change	May 17	Jun 17	Change	RTT %
ENT	391	345	-46	232	212	-20	623	557	-66	84.9%
Gynaecology	182	174	-8	57	30	-27	239	204	-35	93.8%
Allergy	1	-	0	79	47	-32	80	47	-33	86.1%
Orthopaedic Surgery	238	234	-4	218	194	-24	456	428	-28	89.8%
Spinal Surgery	79	87	8	281	249	-32	360	336	-24	81.6%
Paediatric Urology	59	45	-14	12	15	3	71	60	-11	84.1%
Paediatric Surgery	44	29	-15	3	7	4	47	36	-11	91.0%
General Surgery	234	211	-23	121	134	13	355	345	-10	89.3%
Plastic Surgery	28	24	-4	15	10	-5	43	34	-9	94.9%
Pain Management	16	7	-9	2	2	0	18	9	-9	98.9%

10 highest backlog increases	Admitted			Non Admitted			Total			
	May 17	Jun 17	Change	May 17	Jun 17	Change	May 17	Jun 17	Change	RTT %
Cardiology	65	88	23	34	59	25	99	147	48	93.7%
Ophthalmology	132	197	65	59	38	-21	191	235	44	96.4%
Thoracic Medicine	-	-	0	43	79	36	43	79	36	93.3%
Gastroenterology	3	3	0	45	73	28	48	76	28	97.3%
Urology	381	385	4	110	130	20	491	515	24	83.8%
IR	18	27	9	23	29	6	41	56	15	86.2%
Vascular Surgery	21	29	8	9	15	6	30	44	14	93.9%
Paed Max-Fax	48	58	10	1	4	3	49	62	13	71.2%
Paediatric Cardiology	10	8	-2	34	49	15	44	57	13	88.0%
Maxillofacial Surgery	94	102	8	37	35	-2	131	137	6	92.8%

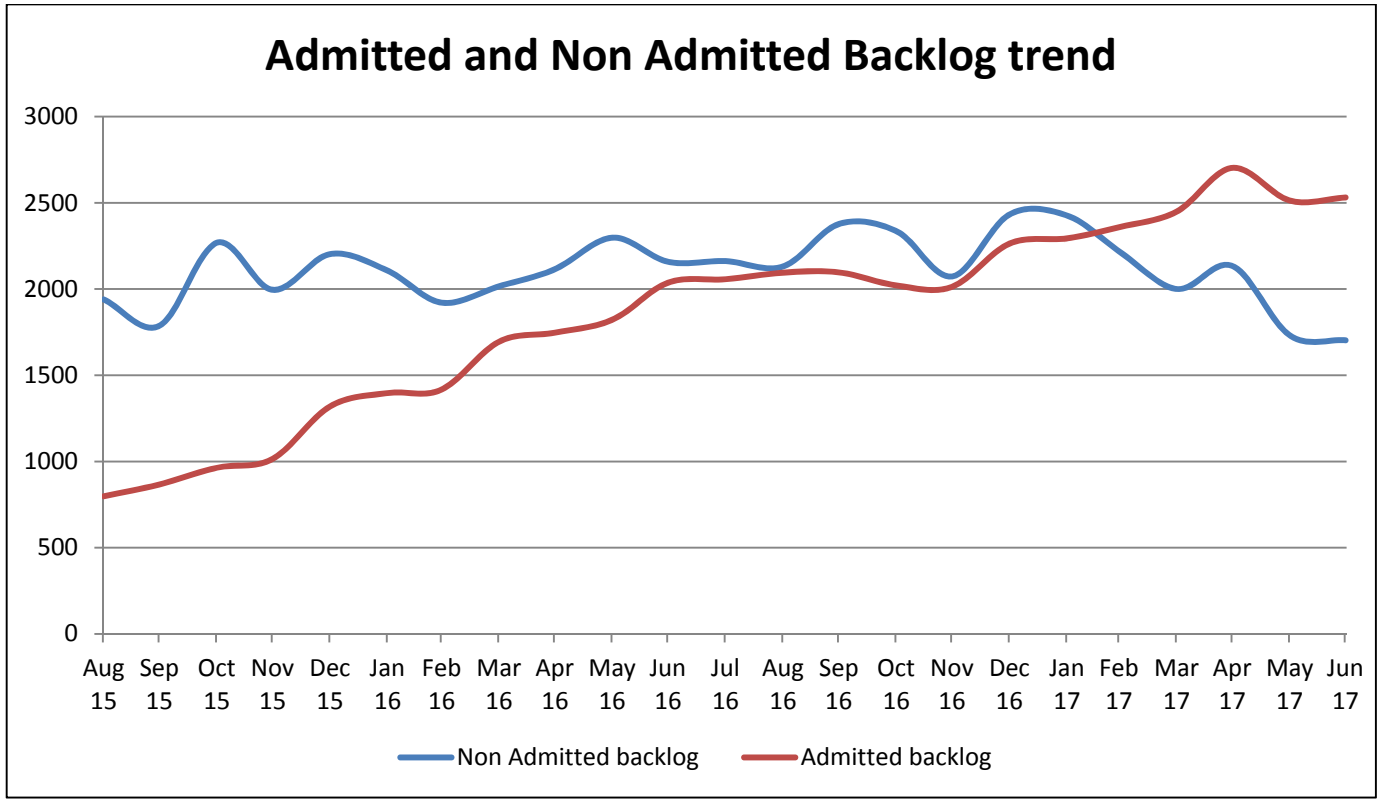
10 highest overall backlogs	Admitted			Non Admitted			Total			
	May 17	Jun 17	Change	May 17	Jun 17	Change	May 17	Jun 17	Change	RTT %
ENT	391	345	-46	232	212	-20	623	557	-66	84.9%
Urology	381	385	4	110	130	20	491	515	24	83.8%
Paediatric ENT	407	407	0	24	24	0	431	431	0	62.2%
Orthopaedic Surgery	238	234	-4	218	194	-24	456	428	-28	89.8%
General Surgery	234	211	-23	121	134	13	355	345	-10	89.3%
Spinal Surgery	79	87	8	281	249	-32	360	336	-24	81.6%
Ophthalmology	132	197	65	59	38	-21	191	235	44	96.4%
Gynaecology	182	174	-8	57	30	-27	239	204	-35	93.8%
Cardiology	65	88	23	34	59	25	99	147	48	93.7%
Maxillofacial Surgery	94	102	8	37	35	-2	131	137	6	92.8%

This table illustrates changes in the non-admitted and admitted backlog size. The non-admitted backlog has remained relatively consistent over the past 18 months. At the end of June continues to decrease. UHLs current end of June non admitted RTT performance of 95.95% is the highest its been in 2 years since June 2015. During the same period the admitted backlog has increased by over 300%. RTT performance for Admitted is still below 76%

Sustaining an overall 92% will only be achievable by improving the admitted performance, with a step change in capacity required through:

- Right sizing bed capacity to increase the number of admitted patients able to received treatment.
- Improving ACPL through reduction in cancellation and increased theatre throughput.
- Demand reduction with primary care as a key priority to achieving on-going performance for our patients to receive treatment in a timely manner.

Patients on an admitted incomplete pathway make up only 20% of the UHL incomplete waiting list whilst making up 60% of the backlog.



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 trust grade post and awaiting GMC registration. RTT remains continues to reduce. Actions: Trust grade has been appointed with a start date in June. Anticipate from June significant backlog reductions. SLA with Nottingham consultant for weekend WLI's continues. Reminder calls to reduce DNA's in place. Project to start advice and guidance initiated. Use of agency to support in increased capacity.
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. Cancellations for both adult and Paediatric ENT have remained high over the winter period into 2017 due to limited bed capacity. This has also resulted in prior to the day cancellations or reduced booking of lists. The combined adult and paediatric ENT service has seen a referral increase of over 12% year to date to the previous financial year. Actions: Continued use of Medinet and wait list initiatives for admitted and non admitted patients continue to end of April 2017. On-going use after this point is pending further discussion. Change to balance pathway including new DOS and PRISM forms to direct patients at point of referral to most appropriate clinic. Additional 60 hours of theatre capacity for paediatric ENT agreed. Circa 42 patients. Agreement of Nuffield tariff for adult and paediatric patients circa 50 patients.
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. Further risk going into winter months of increased cancellations due to further bed pressure demands. The service has seen a 16% increase in referrals year on year. Actions: Continued WLI's for admitted and non-admitted pathways. Left shift minor work to the Alliance, business case for 2 additional consultants
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. Impacted on elective cancellations to support emergency care. Actions: Additional clinics to reduce outpatient backlog. ESP utilised across Orthopaedics and spines, double running of clinical fellows to increase clinical capacity.
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 and 10 increase in referrals from the previous year. Increase in patients cancelled before the day due to bed capacity. Alliance capacity decrease from Coventry and Warwick clinicians, impacts on ability to left shift activity. Actions: Wait list initiatives. Increase in uptake of UHL staffed lists allowing for more patients from the backlog to be treated. Continued use of weekend sessions including Medinet to utilise theatre space where insufficient theatre uptake. Left shifting of low complex patients to the Alliance.

Diagnostic Performance

June diagnostic performance for UHL and the Alliance combined is 0.69% achieving the standard by performing below the 1% threshold. UHL alone achieved 0.7% for the month of May with 107 patients out of 15,178 not receiving their diagnostic within 6 weeks. Performance remains ahead of trajectory. Of the 15 modalities measured against, 9 achieved the performance standard with 6 areas having waits of 6 weeks or more greater than 1%.

Strong performance in non-obstetric ultrasound with 0 breaches from 5,907 patients (0%) and CT, 11 breaches from 2,197 patient (0.1%) and audiology 0 breaches from 846 patients (0%) supported the overall Trust performance. The 5 modalities with the highest number of breaches are listed below:

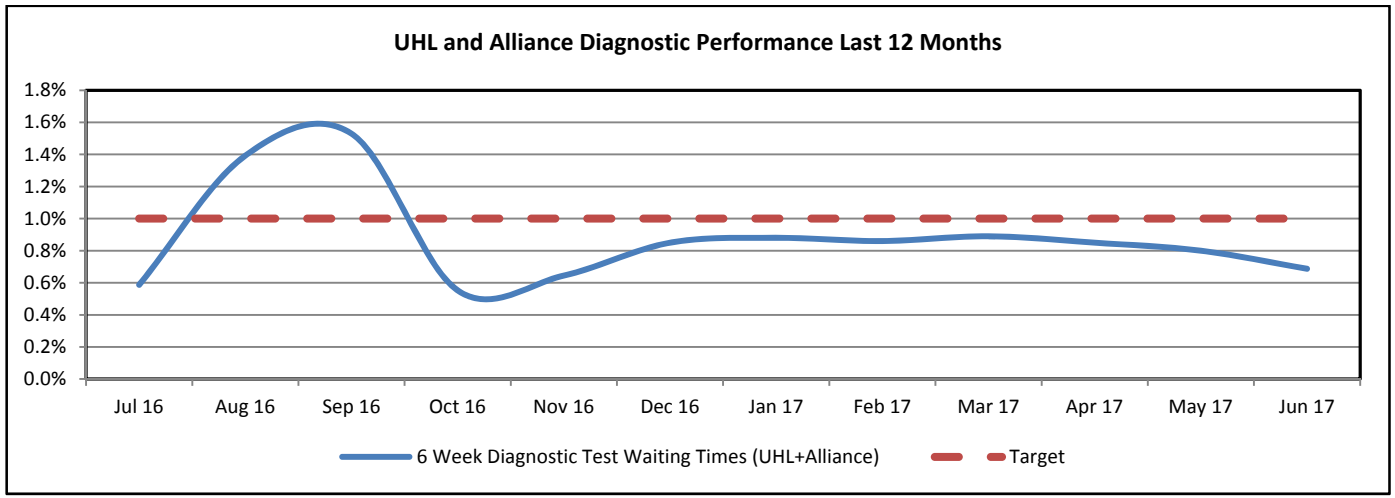
Modality	Waiting list	Breaches	Performance
Cystoscopy	172	32	18.60%
Magnetic Resonance Imaging	2900	31	1.07%
Computed Tomography	2197	11	0.50%
Flexi sigmoidoscopy	639	9	1.41%
Colonoscopy	318	8	2.52%

Performance for cystoscopy remains an outlier after a rectified reporting issue for outpatient flexible cystoscopies occurred in May.

Risks to future months performance

It is anticipated the overall diagnostic performance for June will remain less than 1%.

- Cardiac MRI capacity remains a constraint.
- Patients requiring sedation under propofol continues to be managed through ad hoc theatre sessions.
- Clinical capacity within the Alliance has reduced for flexible cystoscopies.
- Capacity for inpatient cystoscopy will be a constraint in July with competing urgent day case priorities.



% Cancelled on the day operations and patients not offered a date within 28 days – Performance (inc Alliance)

INDICATORS: The cancelled operations target comprises of two components	Indicator	Target (monthly)	Latest month	YTD performance	Forecast for next reporting period
1.The % of cancelled operations for non-clinical reasons On The Day (OTD) of admission	1	0.8%	0.99%	1.01%	0.9%
2.The number of patients cancelled who are not offered another date within 28 days of the cancellation	2	0	10	37	11

What is causing underperformance?

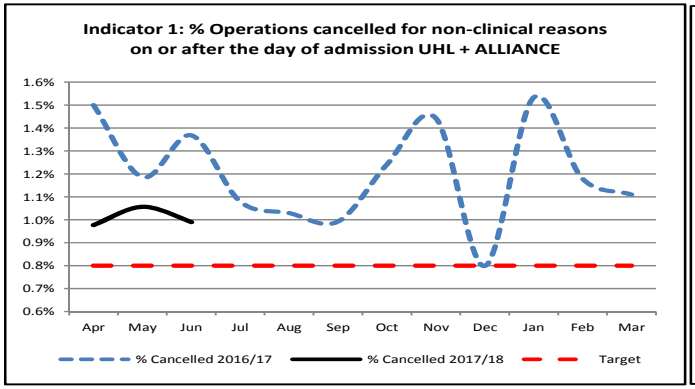
For June there were 114 non clinical hospital cancellations for UHL and Alliance combined. This resulted in a failure of the 0.8% standard as 0.99% of elective FCE's were cancelled on the day for non-clinical reasons (111 UHL 1.01% and 3 Alliance 0.44%).

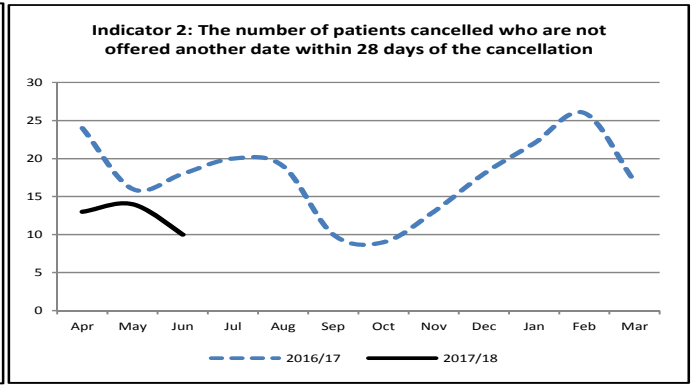
UHL alone saw 111 patients cancelled on the day for a performance of 1.01%. 44 patients (40%) were cancelled due to capacity related issues of which 13 were Paediatrics. 67 patients were cancelled for other reasons. The 5 most common reasons for cancellation are listed below.

Type	Reason	Pts Cancelled
Other	Hospital cancel - lack theatre time / list overrun	44
Capacity Pressures	Hospital cancel -pt delayed to adm high priority patient	24
Capacity Pressures	Hospital cancel - ward bed unavailable	10
Capacity Pressures	Hospital cancel - ITU bed unavailable	6
Capacity Pressures	Hospital cancel – HDU bed unavailable	4

Cancellations related to list over runs are monitored via the Weekly Access Meeting and Theatre Program Board. Cancellations for UHL in the first 3 months of 2017/18 are 314 (1.0% of FCE's) compared with performance 420 (1.4% of FCEs') in from 2016/17. There have been 106 fewer non clinical on the day cancellations.
There were 10 patients who did not receive their operation within 28 days of a non-clinical cancellation. These comprised of CHUGGS 1, MSS 6 and RRCV 5, W&C 2. Year to date there have been 26 fewer 28 day breaches compared to last financial year.

Achieving the 0.8% standard in July remains a risk as Emergency pressures remain high.



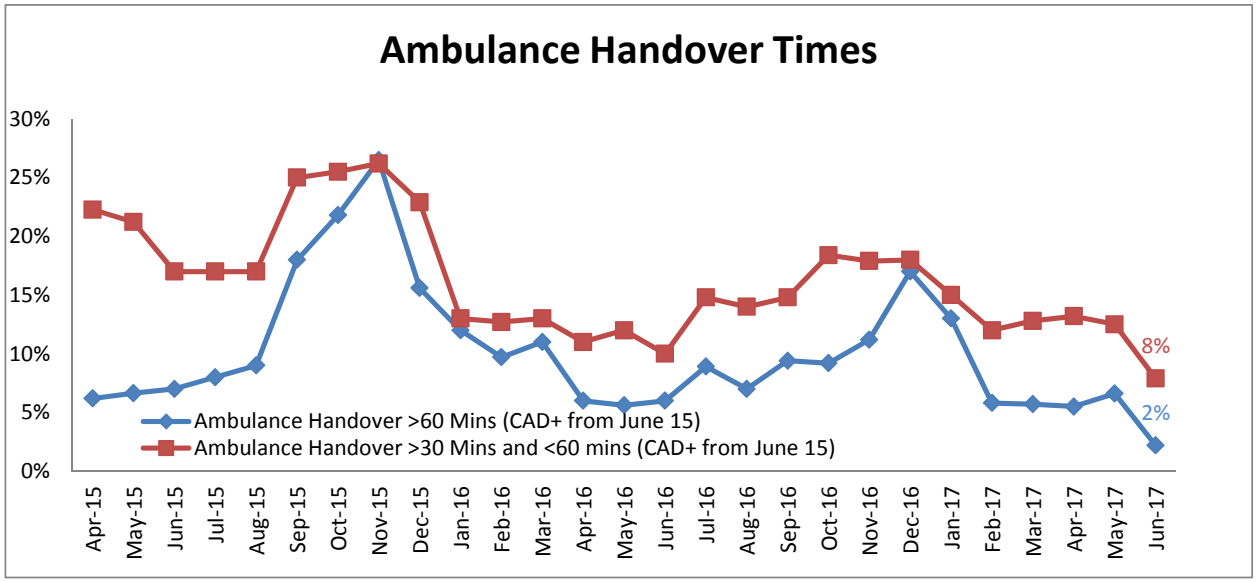


Ambulance handover > 30 minutes and >60 minutes - Performance

Indicators	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	17/18 YTD
Ambulance Handover >60 Mins (CAD+ from June 15)	6%	9%	7%	9%	9%	11%	17%	13%	6%	6%	6%	7%	2%	5%
Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)	10%	15%	14%	15%	18%	18%	18%	15%	12%	13%	13%	13%	8%	11%

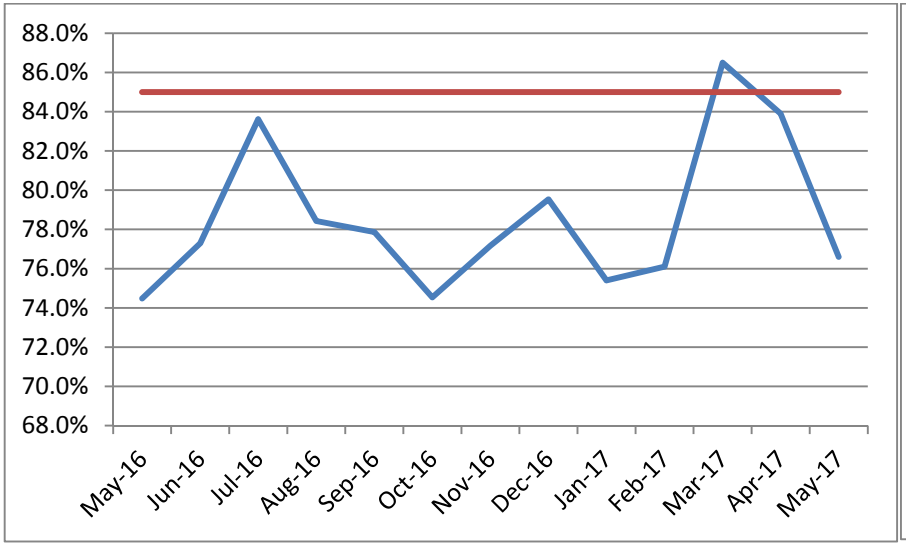
What actions have been taken to improve performance?

- Focussed work with staff embedding the new Standard Operation Procedures.
- Senior leadership on the shop floor both clinically and managerially to support ambulance offload.
- Daily SITREP meetings with the senior leadership team to review previous day before identifying key actions to improve processes.
- Frequent monitoring in Gold meetings to ensure traction.
- 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.

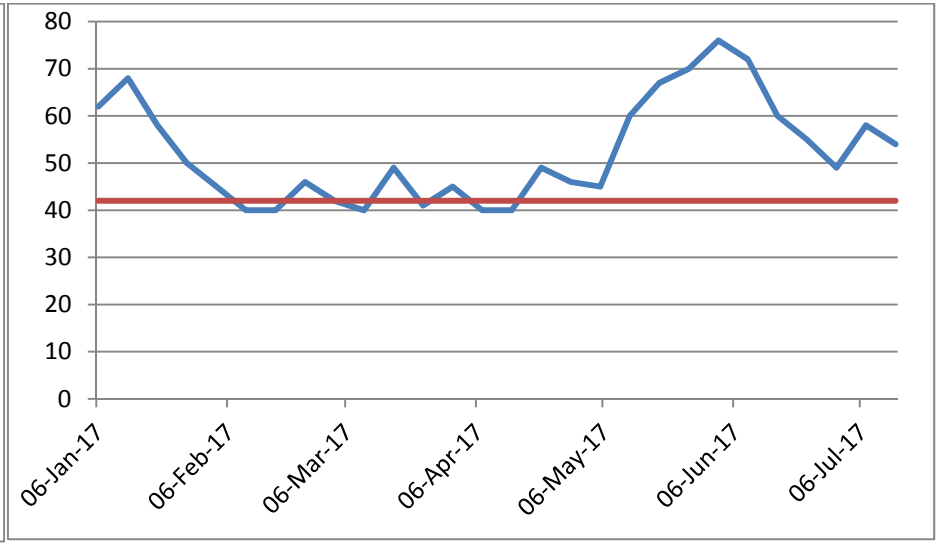


Cancer Waiting Time Performance
Out of the 9 standards, UHL achieved 3 in May – 62 Day Screening, 2WW Breast and 2WW. • 2WW performance remained strong in May achieving 94.5% against a national performance of 94%. June is also expected to deliver the standard. • 62 day performance failed at 76.6% in May with highest number of breaches treated since May 2016 which is as a result of services working through treating patients in their backlogs. • The adjusted backlog has seen a steady reduction through June and into July following mitigating action including daily PTL reviews with the Director of Performance for all tumour sites above trajectory. At the time of reporting, the key tumour sites remain:- Gynae, Lower GI and Urology – representing over 60% of the total backlog. • Review of the Cancer RAP will be completed during July to encompass timed pathway audit findings, thematic breach analysis and Next Steps audit results combined with local knowledge by all tumour sites and support services.

62 Day Performance



62 Day Adjusted Backlog



62 Day Backlog by Tumour Site

The following details the backlog numbers by Tumour Site for week ending 14th July 2017. The Trend reflects performance against target on the previous week.

The forecast position is the early prediction for week ending 21st July 2017.

Note:- these numbers are subject to validation and review throughout the week via the clinical PTL reviews and Cancer Action Board

Tumour Site	Target	Backlog	Trend	Forecast
Haematology	0	0		1
HPB	0	3		3
Lower GI	6	9		13
Testicular	0	0		0
Upper GI	2	2		2
Urology	10	17		20
Skin	1	1		1
Breast	2	3		3
Head & Neck	5	5		5
Sarcoma	0	0		0
Lung	6	7		5
Gynaecology	7	9		9
Brain	0	0		0

Key themes identified in backlog (14th July)

Summary of delays	Numbers of patients	Summary
Complex Patients/Complex Diagnostic Pathways	10	Across 3 tumour sites, – these are patients undergoing multiple tests, MDTs, complex pathology reporting and diagnostics. This includes patients referred between multiple tumour sites with unknown primaries and patients with complex pathology to inform diagnosis. This also includes patients previously on a long term follow up pathway in Lung.
Capacity Delays – OPD & Surgical	9	Across 5 tumour site – Gynae, Lung, Urology, Lower & Upper GI. Oncology outpatient waits in Lung and Upper GI having a noticeable impact as a primary delay reason – note RAP action 2.3.
UHL Pathway Delays (Next Steps compliance)	13	Across 7 tumour sites – where more than 1 delay has occurred within the pathway and lack of compliance with Next Steps is evident. The delays range across Imaging, Anaesthetics, Cardiology, Endoscopy and Pathology. This includes where diagnostic tests have been incorrectly requested as non 2WW and subsequently escalated. Primary delays seen in Lower GI relating to lack of compliance with turnaround times for CT Colon test and reporting.
Patient Delays	12	Across 5 tumour sites – a significant proportion of the backlog where patients have DNA'd on multiple occasions , required patient thinking time re decision making for treatment planning , and general lack of engagement and patient holidays.
Patients Unfit	10	Across 6 tumour sites, patients who are unavailable for treatment due to other ongoing health issues of a higher clinical priority mainly affecting Skin and Gynae at the time of reporting. Including a delayed Sarcoma patient due to the patient requiring fertility sparing prior to commencing chemotherapy.
Late Tertiary Referrals	5	For Skin, Lung, Lower GI and Urology, patients referred at Day 39 and over from PBH, NGH, KGH, Burton and Nottingham.

Backlog Review for patients waiting >104 days @ 13/7/17

The following details all patients declared in the 104 Day Backlog for week ending 14/7/17. Note the patient reference number has been added to track patients each month as requested by the CCG. Last month's report showed 8 patients in the 104 Day backlog, 7 of which have now been treated. There are currently 13 patients in the backlog at the time of reporting, 5 of which have treatment TCI dates agreed/planned.

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
Lower GI	3	28	115	Y	N	Multiple diagnostics (x6) early in the pathway combined with the need for high risk anaesthetic assessment, ECHO and CPEX testing. Patient has multiple comorbidities, awaiting Oncology outpatients 18/7/17 to assess options for palliative radiotherapy – complex due to recent prior prostate radiotherapy.
		29	125	N	N	Patient discussed across 2 tumour sites within 11 separate MDT discussions following multiple diagnostic tests, some of which were delayed due to the patient declining dates. Patient not suitable for surgery, required further diagnostics – PET & CTGBx with a recommendation to treat a Lower GI primary with Oncology review for Lung in addition post operatively. Awaiting further Lung MDT discussion re radiotherapy following outpatient consultation 11/7/17.
		30	128	Y	Y	Patient initially referred through 2WW Lung pathway with COPD and x2 lung nodules, multiple diagnostics including EBUS, CT and PET required investigations into ?mets from a Lower GI primary. 5 separate MDT discussions and additional diagnostics were required in Lower GI prior to planning appropriate treatment with the patient. TCI now agreed for treatment 24/7/17

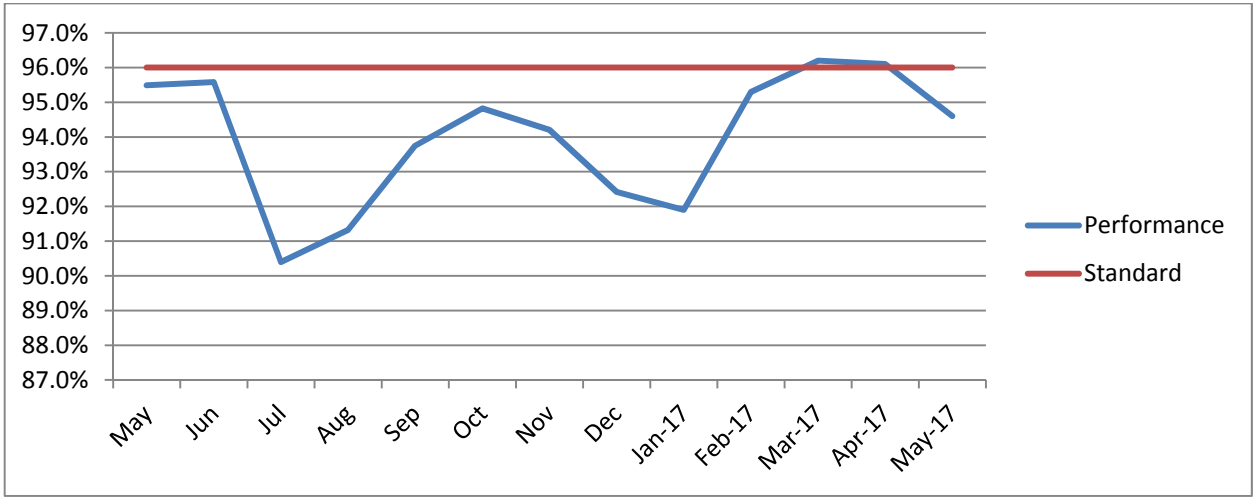
Tumour Site	Total Number of patients	Pt No	Current Wait (Days)	Confirmed Cancer Y/N	Treatment Date Y/N	Summary Delay Reasons
Urology	4	21	105	Y	N	Complex diagnostic pathway with incidental finding requirement treatment prior to primary. Patient was high risk for surgery requiring ECHO and cardiac investigations, delays to high anaesthetic review and bone scan results experienced in pathway – escalated and resolved. Patient delay on treatment options re thinking time. Decision made 9/6/17 for PACE trial following return from holiday end July 2017. Await return and confirmation of treatment start date.
		27	114	N	N	Delay to diagnostic cystoscopy due to patient relying on family members to attend hospital with him. Following high risk anaesthetic review, patient not fit for surgery requiring cardiology input which was delayed due to patient admission to hospital for non-related issue. On discharge, the patient felt too unwell to travel for ECHO and pacemaker fitting. Pacemaker to be fitted 18/7/17 – Urology to assess patient fitness for surgery post recovery from pacemaker fitting.
		31	132	Y	Y	Patient had treatment date planned prior to 62 day breach date which was subsequently cancelled due to spinal appearances in diagnostic imaging. Surgery placed on hold until spinal team assessment. Patient required radiotherapy to spine prior to Urology surgical treatment plus recovery time. Provisional TCI arranged pending recovery from radiotherapy treatment.
		32	209	Y	Y	Tertiary referral on Day 181 from Lincoln. 15/6/17. Seen in Urology outpatients 29/6/17, delay to outpatients due to patient not being informed by Lincoln of transfer to Leicester. Patient for robotic partial nephrectomy. TCI date 26/7/17.
ENT	1	23	105	Y	Y	Delay to inpatient diagnostic due to both capacity and cross MDT discussions with Lower GI. Pathology from TCI 1/6/17 took 14 days to report to due supplementary reporting. Further biopsy 16/6/17. Added to waiting list for surgery 21/6/17. Surgical capacity delays resulting in treatment TCI of 19/7/17
Breast	1	25	108	Y	N	Patient had treatment TCI within breach which was cancelled due to ECG results and need for an ECHO. High risk anaesthetic assessment recommended 24 hour tape, not medically fit for surgery until review 19/6/17. Further TCI date arranged for 11/7/17, cancelled on the day as patient had taken medication against instructions. Await further TCI date

Tumour Site	Total Number of patients	Pt No	Current Wait (Days)	Confirmed Cancer Y/N	Treatment Date Y/N	Summary Delay Reasons
LUNG	2	26	111	Y	N	Patient referred from Burton on day 98. Discussed at Peritoneal Mesothelioma MESO MDT 09/06/17 – for Breast assessment due to incidental finding with Meso confirmed via immuno pathology. Clinical delays due to need for repeat CT at 3 week intervals to assess progression of disease. 7/7/17 CT showed stable disease, await further MDT discussion and treatment plan 14/7/17.
		33	302	N	N	Patient was a Lung Long Term follow up until recent review 4/7/17, persistent change to lobe requires further review and evaluation. Patient for PET scan 12/7/17 and follow up in outpatients 18/7/17
Gynae	13	24	107	N	N	Patient couldn't tolerate outpatient hysteroscopy, required GA under named consultant. Delay to TCI date of 26 days. Following pre-assessment 22.5.17, the TCI date was cancelled as the patient was unfit with a water infection. CNS input supported patient engagement to attend, date agreed for 11.6.17 which was cancelled due to the patient unable to arrive due to ambulance transport in addition to sodium levels requiring further GP input prior to surgery. Discussions with the clinicians and GP recommended an MRI prior to re-dating, the patient's carer declined dates offered as the patient was bed bound and required ambulance transport with a stretcher. Patient requested delay to further discussion until GP review 4/7/17. MRI arranged for 6/7/17 - cancelled by the patient's carer as patient unwell. Service actively chasing GP for management of patient's sodium levels. MRI rebooked for 12/7/17 - review report at clinical review 14/7/17
HPB	1	22	105	Y	Y	Patient originally referred under Upper GI pathway, went for CT and OGD within 14 days. MDT 20/4/17 referred to HPB due to cystic lesion in liver. MDT 28/4/17 - patient for MRI with tumour markers and re-discussion. Delay to MRI request of 20 days. MRI 30/5/17 showed reduction in size of liver - ? over whether a bleed or a cyst with resolving haematoma. MDT discussion 5/6/17 - outcome for laparascopy. Laparascopy 23/6/17, outpatient discussion 29/6/17 - primary malignancy within lever, not ?bleed or scarring from previous liver cyst. For treatment TCI 14/7/17

31 Day First Treatment – Performance

31 day 1st treatment performance was below the national target at 94.6% for May 2017. With a reduced backlog, June is expected to deliver the standard at the time of reporting.

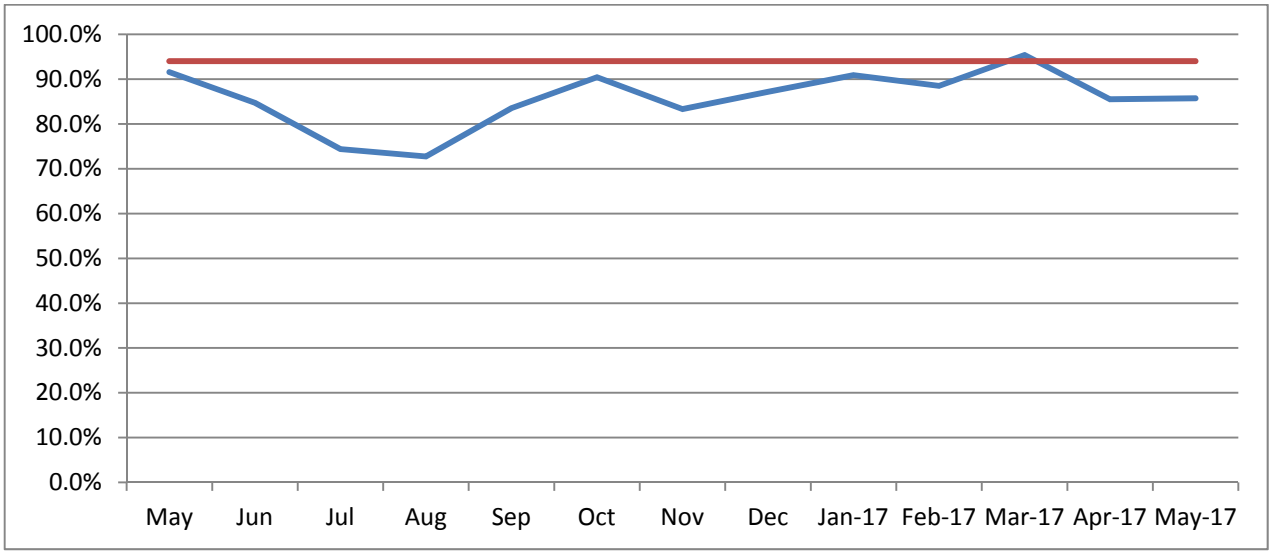
At the time of reporting, there are 5 patients in the backlog: access to beds and timely theatre capacity remains the key issue with particular issue for robotic capacity affecting the delivery of performance for Urology with 3 out of the 5 being in the Urology backlog *(See RAP action 3.1).*



31 Day Subsequent Surgery Performance

31 day Subsequent performance for Surgery in June under performed at 85.7% with a reduced backlog throughout the month resulting.

The backlog at the time of reporting sits at 6, 4 of which are in Urology (primarily robotic surgical delays) and 2 in Lower GI (1 patient choice and 1 complex joint surgical procedure)



Summary of the plan

The recovery action plan (RAP) is the central repository detailing measureable actions agreed between the Cancer Centre, Tumour Sites and CCGs aimed to address recovery in performance delivery and quality of patient care.

It is recognised that a number of tumour sites have successfully achieved and closed down their actions over the past 12 months.

However, it is acknowledged that a full review of the RAP will be required over the next reporting period. A number of data sources will be used to support the Tumour Sites in developing new actions where required and refining existing actions remaining relevant to improved performance against the 62 day standard.

This review is ongoing, expected to be completed by end July 2017.

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	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