Quality & Performance Report

Author: John Adler Sponsor: Chief Executive Date: IFPIC + QAC 30th March 2017

Executive Summary from CEO

Paper H

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 have continued to achieve for 7 months consecutively. Reported **delayed transfers of care** remain within the tolerance. However there are a range of delays that do not appear in the count. **Never events** – 0 reported this month. **MRSA** – although there are 2 cases of MRSA reported for the year both were unavoidable. **C DIFF –** year to date position within trajectory. **Pressure Ulcers** – 0 **Grade 4** pressure ulcers reported this month and **Grade 3** are within the trajectory for month and year. **CAS alerts** – there have been no overdue CAS alerts throughout this financial year. Both **Stroke** indicators remain complaint for the year to date. **Ambulance Handover 60+ minutes (CAD+)** – performance 6% - the last time performance was at this level was in June 16.

Bad News: **Mortality** – the latest published SHMI (period July 2015 to June 2016) is 101 (still within the expected range)**. ED 4 hour performance** – February performance was 83.8 % with year to date performance at 79.2%. The in-month improvement was due to switching medical and surgical beds. Further detail is in the Chief Operating Officer's report. **Referral to Treatment –** was not achieved mainly due to continuing emergency pressures and the capacity switch. **52+ week waits –** current number has increased to 39. **Cancelled operations** and **patients rebooked within 28 days** – continued to be non-compliant, due emergency pressures. **Single Sex Accommodation Breaches** – 4 breaches during February. **Fractured NOF** – target not achieved during February. **Cancer Standards 62 day treatment** – although non-compliant an improving backlog number is noted. **Inpatient and Day Case Patient Satisfaction (FFT)** remains at 96% against a Quality Commitment of 97%. **Statutory & Mandatory Training** – 82% 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: 27th April 2017

Quality and Performance Executive Summary

February 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 ↑

34 ↑
Serious Incidents YTD
(No escalated each month)

114 ↑
Moderate Harm and above YTD
(PSIs with finally approved status)

0
Avoidable MRSA YTD ↔

55
CDIFF Cases YTD ↓

Headlines

- There have been 2 cases of Unavoidable MRSA's reported and zero avoidable cases
- 7 C Diff cases reported in February, with year to date within trajectory.
- Over the last five months we have consistently achieved our target of 95% of patients with an EWS of 3+ being screened for sepsis. 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

Patients with an Early Warning Score 3+ - % appropriate escalation	88% YTD ↔
Patients with EWS 3+ - % who are screened for sepsis	92% YTD ↓
ED - Patients who trigger with red flag sepsis - % that have their IV antibiotics within an hour	75% YTD ↓
Wards (including assessment units) Patients who trigger for Red Flag Sepsis - % that receive their antibiotics within an hour	52% 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 98% ↑

A&E FFT 90% ↑

Maternity FFT 94% ↓

Outpatients FFT 93% ↓

Staff FFT Quarter 3 2016 (Pulse Check)

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

Single sex accommodation breaches

59 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 94% for February, the highest it has been for seven months.
- Single Sex Accommodation Breaches – numbers have decreased to 4 in February.

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 24.3% ↑

A&E FFT 10.7% ↑

Maternity FFT 37.7% ↓

Outpatients FFT 2.8% ↔

Staff FFT Quarter 3 2016 (Pulse Check)

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%. February has been the highest month this Financial Year.
- Appraisals are 2.6% off target for February (this excludes facilities staff that were transferred over from Interserve).
- Statutory & Mandatory is 13% 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

92.4% YTD ↑

Statutory & Mandatory Training

82% YTD ↑

BME % - Leadership

26% Qtr3
8A including medical consultants

12% Qtr3
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
Jul15-Jun16 ↓

Stroke TIA clinic within 24hrs

66.9%
YTD ↓

80% of patients spending 90% stay on stoke unit

84.5%
YTD ↑

Emergency Crude Mortality Rate

2.4%
YTD ↑

30 Days Emergency Readmissions

8.5%
YTD ↔

NoFs operated on 0-35hrs

71.2%
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 which needed action that we did not already have reviews or action plans in place for.
- Fractured NoF – 67.6% of patients were operated on within 0-35hours in February, 4.4% below the 72% target. Weekly Operational meetings with the Clinical Director chairing continue.

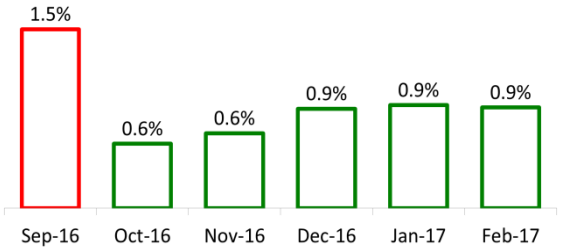
Domain – Responsive

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

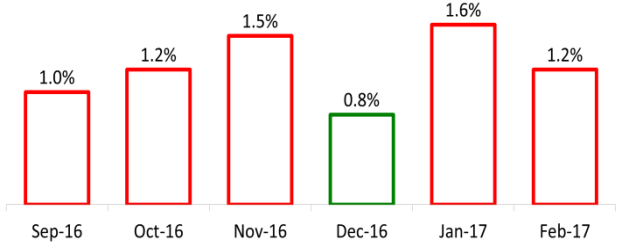
RTT - Incomplete 92% in 18 Weeks

91.2%
YTD ↑

6 week Diagnostic Wait times



Cancelled Operations



RTT 52 week wait incompletes

39
YTD ↓

ED 4Hr Wait

A&E

79.2%
YTD ↑

Ambulance Handovers

9% > 60mins ↑
14% 30-60mins ↑
YTD

Headlines

- 52+ week waiters -6 Orthodontics, 23 ENT and 10 Paediatric ENT.
- Diagnostic 6 week wait – we have now achieved five 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

93.0% YTD

93.2% Jan ↓

31 day wait

93.5% YTD

91.9% Jan ↓

62 day wait

77.4% YTD

75.5% Jan ↓

31 day backlog

4 Feb ↑

62 day backlog

44 Feb ↑

62 day adjusted backlog

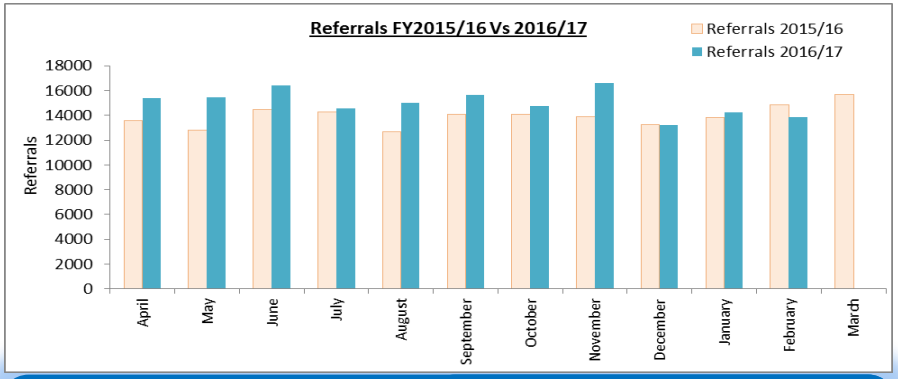
42 Feb ↑

Headlines

- Cancer Two Week Wait was achieved in January 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.

UHL Activity Trends

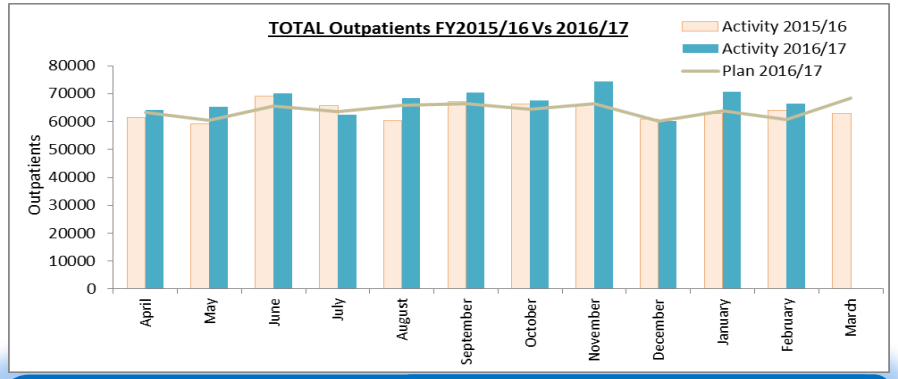
Referrals (GP)



April – February
16/17 Vs 15/16 +13,311 +9%

Planned care workstream underway to reduce referrals.

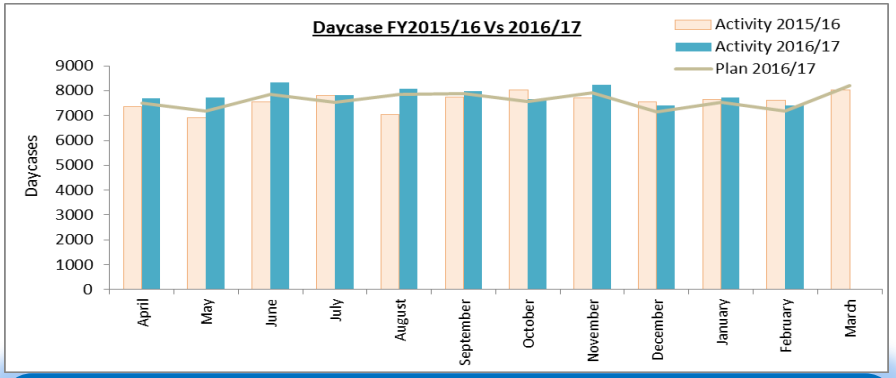
TOTAL Outpatient Appointments



April – February
16/17 Vs 15/16 +37,229 +5%
16/17 Vs Plan +39,311 +6%

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

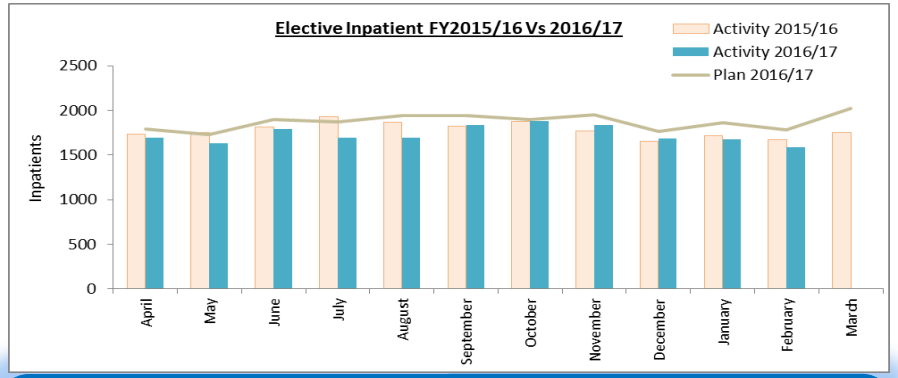
Daycases



April – February
16/17 Vs 15/16 +3,093 +4%
16/17 Vs Plan +2,945 +4%

Growth observed in Clinical Oncology and Haematology.

Elective Inpatient Admissions

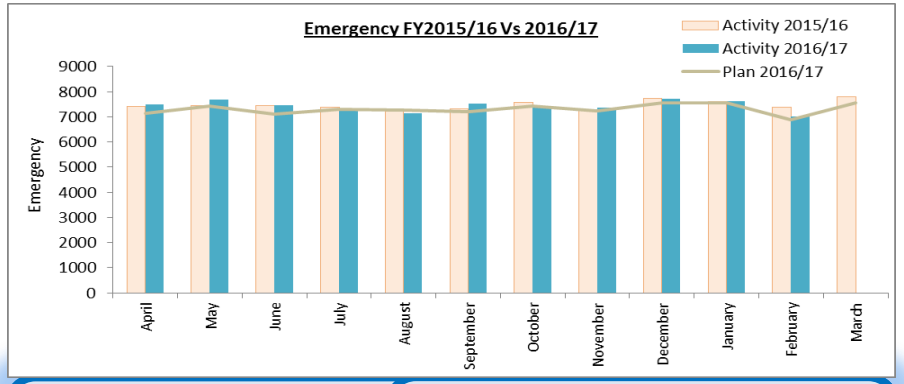


April – February
16/17 Vs 15/16 -599 -3%
16/17 Vs Plan -1,429 -7%

Pressure impacted on surgical specialties due to emergency flow. Restricted elective activity to improve flow.

UHL Activity Trends

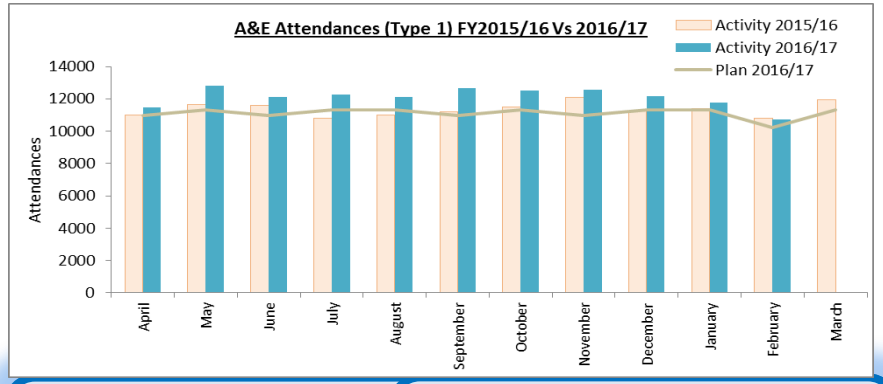
Emergency Admissions



April – February
16/17 Vs 15/16 -214 +0%
16/17 Vs Plan +1,491 +2%

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

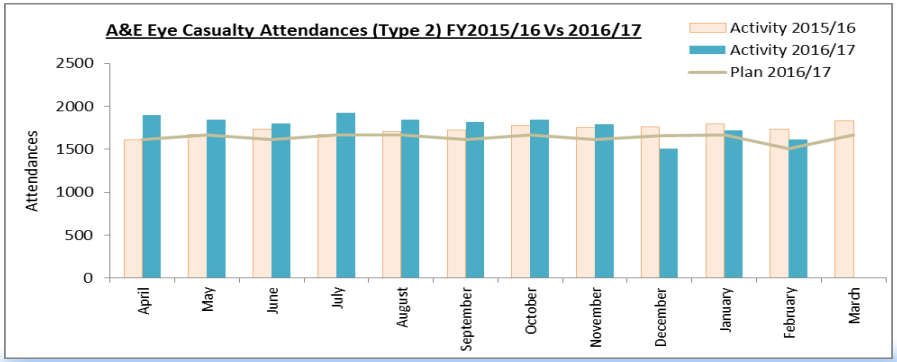
A & E Attendances (ED Type 1 only)



April – February
16/17 Vs 15/16 +8,912 +7%
16/17 Vs Plan +11,137 +9%

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

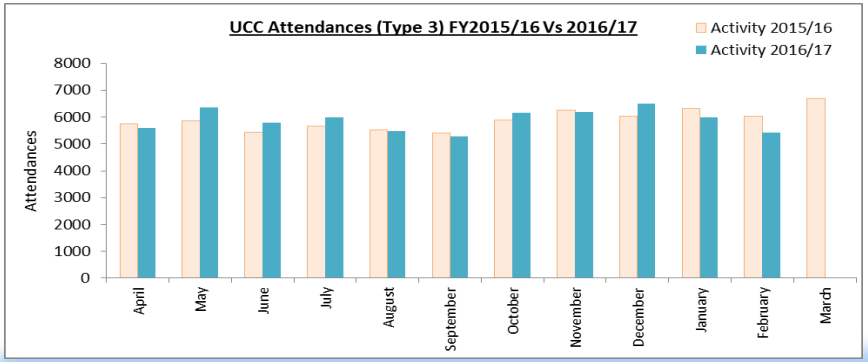
Eye Casualty Attendances (ED Type 2 only)



April – February
16/17 Vs 15/16 +662 +3%
16/17 Vs Plan +1,646 +9%

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

UCC Attendances (Type 3, excludes referred to ED)

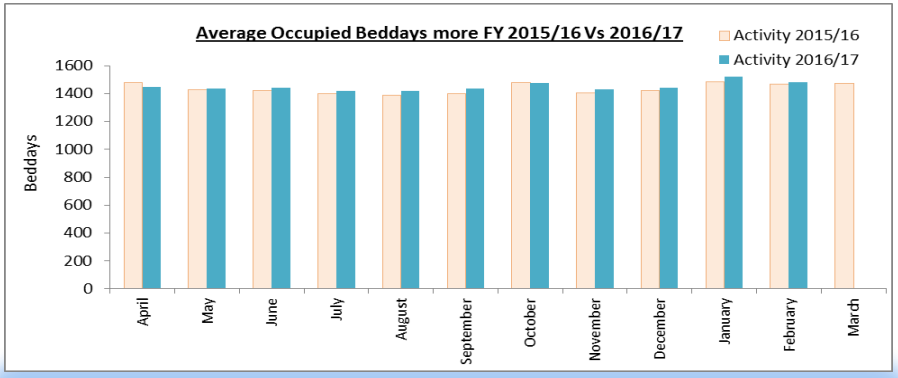


April – February
16/17 Vs 15/16 +564 +1%

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

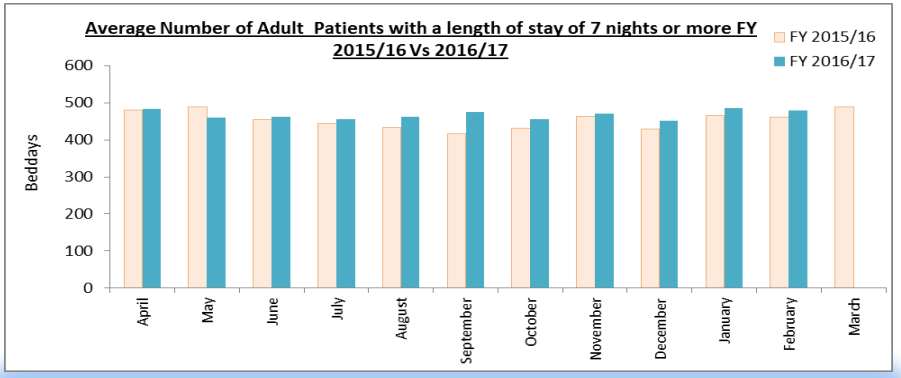
UHL Bed Occupancy

Occupied Beddays



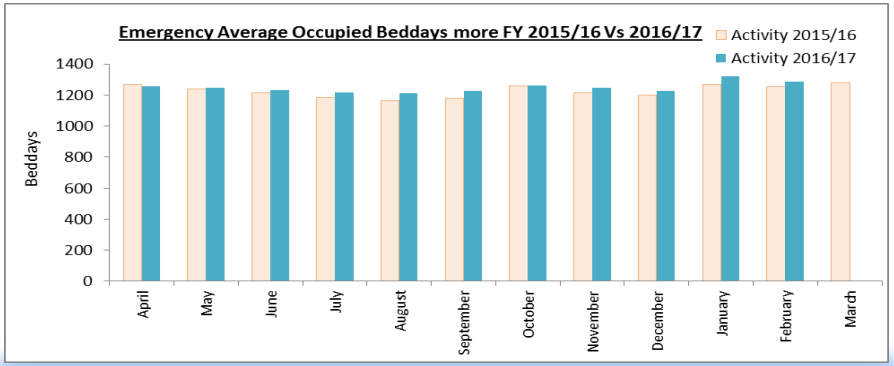
Midnight G&A bed occupancy continues to run higher this year compared to last year.

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



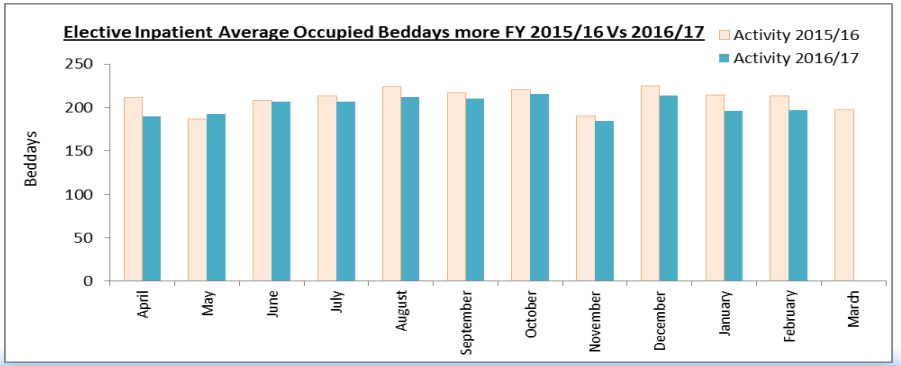
The number of patients staying in beds 7 nights or more is higher this year.

Emergency Occupied beddays



For eight of the months during this year 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.

January Performance (one month in arrears)
75.5% against a trajectory of 85.1%

February Performance: Expected to be non-compliant.

N	D	J

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.

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

March Performance: Expected to be complaint

D	J	F

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

February Performance
91.2% of our patients waiting less than 18 weeks

March Performance: Expected to be non-compliant

D	J	F

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

February Performance
83.8% against a target of 89.0%

March Performance: Expected to be non-compliant

D	J	F

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

February 2017

One team shared values

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Dashboards

Exception Reports

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

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

DATE: **30th MARCH 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: **FEBRUARY 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
- Potential under-reporting of patient safety incidents

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	4
Caring	5	11	3
Well Led	6	24	2
Effective	7	9	5
Responsive	8	15	9
Responsive Cancer	9	9	4
Research – UHL	15	6	0
Total		95	27

3.0 Data Quality Forum (DQF) Assessment Outcome/Date – new in this month's Q&P

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.

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

	KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	16/17 Red RAG/ Exception Report Threshold (ER)	DQF Assessment outcome/Date	14/15 Outturn	15/16 Outturn	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	YTD
Safe	S1	Reduction for moderate harm and above PSIs with finally approved status - reported 1 month in arrears	AF	MD	10% REDUCTION FROM FY 15/16 (<20 per month)	QC	Red if >20 in mth, ER if >20 for 2 consecutive mths	Apr-17		262	18	16	17	9	10	8	12	11	14	14	14	14	8		114
	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	Apr-17	41	50	4	6	4	5	5	1	3	4	2	4	4	2	3	1	34
	S3	Proportion of reported safety incidents per 1000 attendances (IP, OP and ED)	AF	MD	> FY 15/16	UHL	TBC	Apr-17		17.5	18.8	16.2	17.2	17.1	16.8	16.4	19.3	18.2	16.5	16.2	15.3	17.0	15.7	15.9	16.7
	S4	SEPSIS - Patients with an Early Warning Score 3+ - % appropriate escalation	AF	SH	95%	UHL	TBC	Jun-17	New Indicator									86%	91%	86%	89%	88%	89%	89%	88%
	S5	SEPSIS - Patients with EWS 3+ - % who are screened for sepsis	AF	SH	95%	UHL	TBC	Jun-17	New Indicator									65%	91%	95%	99%	99%	99%	97%	92%
	S6	SEPSIS - ED - Patients who trigger with red flag sepsis - % that have their IV antibiotics within an hour	AF	SH	90%	UHL	TBC	Jun-17	New Indicator					63%	71%	71%	66%	69%	75%	79%	82%	76%	83%	88%	75%
	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	Jun-17	New Indicator					33%	50%	21%	42%	23%	45%	61%	67%	76%	78%	77%	52%
	S8	Overdue CAS alerts	AF	MD	0	NHSI	Red if >0 in mth ER = in mth >0	Nov-16	10	1	0	0	1	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	3	2	2	5	3	3	1	0	2	4	4	2	5	4	26
	S10	Never Events	AF	MD	0	NHSI	Red if >0 in mth ER = in mth >0	Apr-17	3	2	0	0	1	0	0	0	1	0	0	0	1	0	1	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	7	7	6	4	5	6	1	7	8	5	7	0	5	7	55
	S12	MRSA Bacteraemias (All)	JS	DJ	0	NHSI	Red if >0 ER if >0	Aug-17	6	1	0	0	1	0	0	0	1	0	0	0	0	0	0	1	2
	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	% of UHL Patients with No Newly Acquired Harms	JS	RB	Within expected (revised)	UHL	Red if <95% ER if in mth <95%	Sept-16		97.7%	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%	97.7%	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%	Nov-16	95.8%	95.9%	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%	95.1%	95.8%
	S16	All falls reported per 1000 bed stays for patients >65years- reported 1 month in arrears	JS	HL	<=5.5 (revised)	UHL	Red if >=6.6 ER if 2 consecutive reds	Nov-17	6.9	5.4	5.4	4.9	5.2	6.5	5.9	6.1	5.7	6.4	6.1	5.4	5.7	5.7	5.4		5.6
	S17	Avoidable Pressure Ulcers - Grade 4	JS	MC	0	QS	Red / ER if Non compliance with monthly target	Apr-17	2	1	0	1	0	0	0	0	0	0	0	0	1	0	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	Apr-17	69	33	6	2	5	5	3	2	2	2	2	2	2	2	2	3	27
	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	Apr-17	91	89	5	8	7	9	6	8	3	13	6	9	10	5	8	7	84
	S20	Maternal Deaths (Direct within 42 days)	AF	IS	0	UHL	Red or ER if >0	Jan-17	1	0	0	0	0	0	0	0	0	1	0	1	0	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	Jan-17	16.5%	17.5%	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%	17.0%	16.8%

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	KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	16/17 Red RAG/ Exception Report Threshold (ER)	DQF Assessment outcome/Date	14/15 Outturn	15/16 Outturn	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	YTD
Caring	C1	Keeping Inpatients Informed (Reported quarterly from Qtr3)	JS	HL	6% increase from Qtr 1 baseline (new)	QC	Red/ER if below Quarterly Threshold	TBC	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	Aug-17	NEW INDICATOR		1.0	1.4	1.2	1.0	1.0	0.9	0.8	1.2	1.4	1.1	1.2	1.2	1.2	1.0	1.1
	C3	Percentage of upheld PHSO cases	AF	MD	No Target	UHL	Quarterly reporting	TBC	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	Jun-17		97%	97%	96%	97%	97%	97%	97%	97%	96%	97%	96%	97%	97%	96%	96%	97%
	C5	Inpatients only Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <95% ER if 2 mths Red	Jun-17	96%	97%	97%	96%	97%	97%	96%	97%	96%	95%	96%	96%	96%	96%	95%	95%	96%
	C6	Daycase only Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <95% ER if 2 mths Red	Jun-17		98%	98%	98%	98%	98%	98%	99%	98%	98%	98%	98%	98%	98%	98%	99%	98%
	C7	A&E Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <94% ER if 2 mths Red	Jun-17	96%	96%	97%	97%	95%	96%	95%	95%	87%	87%	84%	87%	84%	91%	93%	94%	90%
	C8	Outpatients Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <90% ER if 2 mths Red	Jun-17		94%	95%	95%	93%	95%	95%	95%	94%	94%	95%	95%	95%	92%	92%	92%	93%
	C9	Maternity Friends and Family Test - % positive	JS	HL	97%	UHL	Red if <94% ER if 2 mths Red	Jun-17	96%	95%	95%	95%	95%	95%	94%	94%	95%	95%	95%	95%	94%	93%	96%	94%	94%
	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%	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	Dec-16	13	1	0	1	0	0	0	4	1	2	20	7	1	14	6	4	59

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	KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	16/17 Red RAG/ Exception Report Threshold (ER)	DQF Assessment outcome/Date	14/15 Outturn	15/16 Outturn	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	YTD
Well Led	W1	Outpatient Letters sent within 14 days of attendance (Reported Quarterly)	RM	WM	11% Improvement (new)	QC	Red/ER = Below 9% Improvement in Q4	TBC		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	Jul-17		27.4%	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%	30.7%	30.2%
	W3	Inpatients only Friends and Family Test - Coverage (Adults and Children)	JS	HL	30%	QS	Red if <26% ER if 2mths Red	Jul-17		31.0%	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%	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	Jul-17		22.5%	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%	25.5%	24.3%
	W5	A&E Friends and Family Test - Coverage	JS	HL	20%	NHSI	Red if <10% ER if 2 mths Red	Jul-17		10.5%	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%	13.8%	10.7%
	W6	Outpatients Friends and Family Test - Coverage	JS	HL	>=5%	UHL	Red/ER if <1.4%	Jul-17		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%	5.9%	2.8%
	W7	Maternity Friends and Family Test - Coverage	JS	HL	30%	UHL	Red if <26% ER if 2 mths Red	Jul-17	28.0%	31.6%	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%	38.0%	37.7%
	W8	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%		58.9%			60.3%			62.9%			62.9%				62.0%
	W9	Nursing Vacancies	JS	MM	TBC	UHL	Separate report submitted to QAC	Sep-17		8.4%	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%	7.4%	7.4%
	W10	Nursing Vacancies in ESM CMG	JS	MM	TBC	UHL	Separate report submitted to QAC	Sep-17		17.2%	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%	13.7%	13.7%
	W11	Turnover Rate	LT	LG	TBC	NHSI	Red = 11% or above ER = Red for 3 Consecutive Mths	Sep-17	11.5%	9.9%	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%	9.3%
	W12	Sickness absence	LT	BK	3%	UHL	Red if >4% ER if 3 consecutive mths >4.0%	Oct-16	3.8%	3.6%	4.0%	4.3%	4.2%	3.9%	3.4%	3.4%	3.3%	3.1%	3.4%	3.5%	3.6%	3.6%	3.8%		3.5%
	W13	Temporary costs and overtime as a % of total paybill	LT	LG	TBC	NHSI	TBC	Oct-17	9.4%	10.7%	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%	10.5%	10.6%
	W14	% 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%	91.5%	91.6%	90.7%	91.5%	92.2%	92.4%	92.9%	92.4%	91.5%	91.4%	91.9%	91.7%	91.6%	92.4%	92.4%
	W15	Statutory and Mandatory Training	LT	BK	95%	UHL	TBC	Dec-16	95%	93%	93%	92%	93%	92%	93%	94%	93%	91%	82%	82%	82%	83%	81%	82%	82%
	W16	% Corporate Induction attendance	LT	BK	95%	UHL	Red if <90% ER if 3 consecutive mths <90%	Dec-16	100%	97%	96%	98%	98%	94%	96%	97%	100%	97%	92%	96%	95%	99%	98%	97%	98%
	W17	BME % - Leadership (8A – Including Medical Consultants)	LT	DB	28%	UHL	4% improvement on Qtr 1 baseline	TBC							24%			25%			26%				26%
	W18	BME % - Leadership (8A – Excluding Medical Consultants)	LT	DB	28%	UHL	4% improvement on Qtr 1 baseline	TBC							12%			12%			12%				12%
	W19	Executive Team Turnover Rate - Executive Directors (rolling 12 months)	LT	DB	TBC	UHL	TBC	TBC						0%	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	TBC						14%	14%	29%	43%	43%	43%	43%	43%	25%	25%	25%	25%
	W21	DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	TBC	NHSI	TBC	Apr-17	91.2%	90.5%	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%	91.6%	90.5%
	W22	DAY Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	TBC	NHSI	TBC	Apr-17	94.0%	92.0%	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%	91.1%	92.3%
	W23	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	JS	MM	TBC	NHSI	TBC	Apr-17	94.9%	95.4%	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%	97.2%	96.4%
	W24	NIGHT Safety staffing fill rate - Average fill rate - care staff (%)	JS	MM	TBC	NHSI	TBC	Apr-17	99.8%	98.9%	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%	97.8%	97.1%

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Effective

KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	16/17 Red RAG/ Exception Report Threshold (ER)	DQF Assessment outcome/Date	14/15 Outturn	15/16 Outturn	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	YTD
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%	8.8%	8.7%	8.8%	8.7%	8.7%	8.6%	8.3%	8.4%	8.5%	8.5%	8.1%	8.7%	8.7%		8.5%
E2	Mortality - Published SHMI	AF	RB	<=99 (revised)	QC	Red if >100 ER if >100	Sept-16	103	96			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	Sept-16	98	97	98	98	99	100	100	101	102	101	101	101	100	Awaiting HED Update			100
E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	AF	RB	<=99 (revised)	UHL	Red if >100 ER if >100	Sept-16	94	96	95	95	97	99	99	100	102	103	102	102	102	102	Awaiting HED Update		102
E5	Crude Mortality Rate Emergency Spells	AF	RB	No Threshold	UHL	Monthly Reporting	Oct-17	2.4%	2.3%	2.4%	2.4%	2.7%	2.4%	2.2%	2.2%	2.2%	2.2%	2.0%	2.2%	2.4%	2.7%	2.9%	2.6%	2.4%
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%	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%	67.6%	71.2%
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				73.2%	86.8%	87.7%	73.2%	90.0%	82.0%	87.2%	78.2%	89.0%	79.5%	89.5%	80.0%	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%	Dec-17	81.3%	85.6%	90.6%	87.0%	86.5%	72.7%	93.5%	83.8%	80.7%	88.0%	84.5%	86.5%	88.0%	83.8%	87.4%		84.5%
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%	Dec-17	71.2%	75.6%	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%	57.3%	66.9%

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Responsive

KPI Ref	Indicators	Board Director	Lead Officer	16/17 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	DQF Assessment outcome/Date	14/15 Outturn	15/16 Outturn	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	YTD
R1	ED 4 Hour Waits UHL + UCC (Calendar Month)	RM	IL	95% or above	NHSI	Red if <92% ER via ED TB report	Jun-17	89.1%	86.9%	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%	83.8%	79.2%
R2	12 hour trolley waits in A&E	RM	IL	0	NHSI	Red if >0 ER via ED TB report	Jun-17	4	2	0	0	0	0	0	0	0	0	0	0	0	1	9	0	10
R3	RTT - Incomplete 92% in 18 Weeks UHL+ALLIANCE	RM	WM	92% or above	NHSI	Red /ER if <92%	Nov-16	96.7%	92.6%	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%	91.2%	91.2%
R4	RTT 52 Weeks+ Wait (Incompletes) UHL+ALLIANCE	RM	WM	0	NHSI	Red /ER if >0	Nov-16	0	232	269	261	232	169	134	130	77	57	53	38	34	32	34	39	39
R5	6 Week - Diagnostic Test Waiting Times (UHL+ALLIANCE)	RM	WM	1% or below	NHSI	Red /ER if >1%	Dec-16	0.9%	1.1%	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%	0.9%
R6	Urgent Operations Cancelled Twice (UHL+ALLIANCE)	RM	GH	0	NHSI	Red if >0 ER if >0	Jan-17	0	0	0	0	0	0	0	0	0	0	0	0	3	0	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	Jan-17	33	48	6	9	14	24	16	18	20	19	10	9	13	18	22	26	195
R8	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	RM	GH	0	NHSI	Red if >2 ER if >0	Jan-17	11	1	0	0	0	5	0	0	0	6	0	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%	Jan-17	0.9%	1.0%	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%	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%	Jan-17	0.9%	0.9%	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%	1.3%	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%	Jan-17	0.9%	1.0%	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%	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	Jan-17	1071	1299	146	119	156	156	123	154	114	110	109	134	164	82	167	122	1435
R13	Delayed transfers of care	RM	SL	3.5% or below	NHSI	Red if >3.5% ER if Red for 3 consecutive mths	Jan-18	3.9%	1.4%	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%	2.3%	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	TBC	5%	5%	12%	10%	11%	6%	6%	6%	9%	7%	9%	9%	11%	17%	13%	6%	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	TBC	19%	19%	13%	13%	13%	11%	12%	10%	15%	14%	15%	18%	18%	18%	15%	12%	14%

Responsive Cancer

KPI Ref	Indicators	Board Director	Lead Officer	15/16 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	DQF Assessment outcome/Date	14/15 Outturn	15/16 Outturn	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	YTD
** Cancer statistics are reported a month in arrears.																								
RC1	Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	RM	DB	93% or above	NHSI	Red if <93% ER if Red for 2 consecutive mths	Jul-16	92.2%	90.5%	91.4%	93.9%	93.0%	91.1%	89.5%	90.5%	94.3%	94.9%	94.5%	93.3%	95.2%	93.8%	93.2%	**	93.0%
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	Jul-16	94.1%	95.1%	96.2%	99.3%	95.7%	96.1%	88.7%	94.9%	98.7%	95.9%	95.0%	90.7%	96.0%	91.1%	93.4%	**	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	Jul-16	94.6%	94.8%	91.5%	92.6%	94.1%	95.4%	95.5%	95.6%	90.4%	91.3%	93.8%	94.8%	94.2%	92.4%	91.9%	**	93.5%
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	Jul-16	99.4%	99.7%	100.0%	100.0%	100.0%	100.0%	100.0%	97.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%	**	99.6%
RC5	31-Day Wait For Second Or Subsequent Treatment: Surgery	RM	DB	94% or above	NHSI	Red if <94% ER if Red for 2 consecutive mths	Jul-16	89.0%	85.3%	77.5%	77.9%	80.3%	90.3%	91.6%	84.7%	74.4%	72.7%	83.5%	90.4%	83.3%	87.2%	90.9%	**	84.9%
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	Jul-16	96.1%	94.9%	96.4%	92.9%	96.4%	98.8%	93.6%	87.3%	92.5%	81.4%	90.9%	97.8%	94.8%	98.1%	95.3%	**	92.5%
RC7	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	RM	DB	85% or above	NHSI	Red if <85% ER if Red in mth or YTD	Jul-16	81.4%	77.5%	75.1%	73.4%	77.6%	75.8%	74.5%	77.3%	83.6%	78.4%	77.9%	74.5%	77.2%	79.5%	75.5%	**	77.4%
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	Jul-16	84.5%	89.1%	77.3%	72.5%	81.3%	94.6%	96.0%	85.0%	92.3%	78.9%	81.5%	84.2%	88.0%	90.9%	93.1%	**	88.8%
RC9	Cancer waiting 104 days	RM	DB	0	NHSI	TBC	Jul-16			23	17	21	12	7	15	12	9	7	7	9	10	8	3	3

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)	DQF Assessment outcome	14/15 Outturn	15/16 Outturn	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	YTD
RC10	Brain/Central Nervous System	RM	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%	**	100.0%
RC11	Breast	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	92.6%	95.6%	94.6%	100.0%	94.1%	93.3%	95.3%	97.1%	100.0%	100.0%	95.8%	100.0%	95.8%	94.6%	96.6%	**	97.0%
RC12	Gynaecological	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	77.5%	73.4%	50.0%	70.0%	78.6%	72.7%	78.6%	75.0%	62.5%	66.7%	66.7%	80.0%	66.7%	44.4%	71.4%	**	67.8%
RC13	Haematological	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	66.5%	63.0%	100.0%	60.0%	60.0%	14.3%	61.5%	72.7%	100.0%	85.7%	28.6%	58.3%	77.8%	66.7%	87.5%	**	67.4%
RC14	Head and Neck	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	69.9%	50.7%	62.5%	37.5%	35.7%	35.7%	45.5%	100.0%	42.9%	44.4%	0.0%	38.5%	66.7%	33.3%	41.7%	**	42.9%
RC15	Lower Gastrointestinal Cancer	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	63.7%	59.8%	52.4%	31.3%	57.1%	62.5%	45.0%	64.5%	58.8%	64.4%	47.1%	38.1%	61.5%	75.0%	48.3%	**	55.5%
RC16	Lung	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	69.9%	71.0%	73.7%	53.8%	71.1%	66.7%	46.7%	64.2%	60.9%	64.2%	68.0%	79.4%	67.5%	79.5%	74.0%	**	67.1%
RC17	Other	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	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	Jul-16	46.2%	81.3%	--	100.0%	100.0%	0.0%	50.0%	16.7%	--	--	100.0%	50.0%	100.0%	66.7%	40.0%	**	46.4%
RC19	Skin	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	96.7%	94.1%	100.0%	92.5%	94.6%	95.2%	100.0%	96.8%	97.4%	95.9%	97.7%	100.0%	92.3%	97.0%	96.9%	**	97.0%
RC20	Upper Gastrointestinal Cancer	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	73.9%	63.9%	42.9%	57.1%	76.5%	74.3%	70.0%	46.9%	66.7%	82.0%	70.3%	43.8%	100.0%	72.0%	61.9%	**	67.5%
RC21	Urological (excluding testicular)	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	82.6%	74.4%	67.4%	78.7%	83.6%	83.7%	73.1%	77.8%	96.3%	74.5%	83.5%	88.2%	75.0%	79.3%	71.4%	**	80.4%
RC22	Rare Cancers	RM	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%	**	100.0%
RC23	Grand Total	RM	DB	85% or above	NHSI	Red if <90% ER if Red for 2 consecutive mths	Jul-16	81.4%	77.5%	75.1%	73.4%	77.6%	75.8%	74.5%	77.3%	83.6%	78.4%	77.9%	74.5%	77.2%	79.5%	75.5%	**	77.4%

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%**	**84%**	

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%**	**75.5%**		

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%**	**0.9%**	

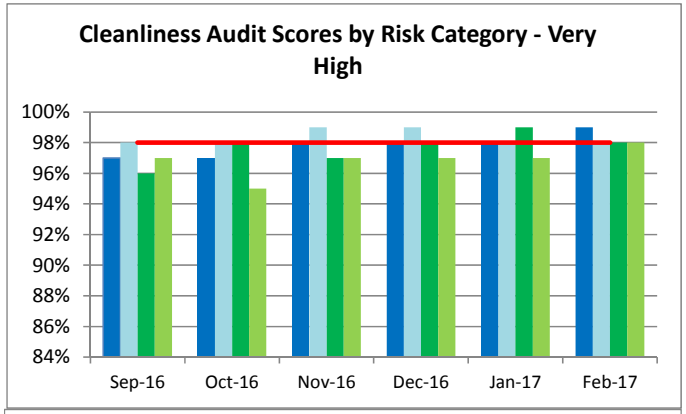
RTT

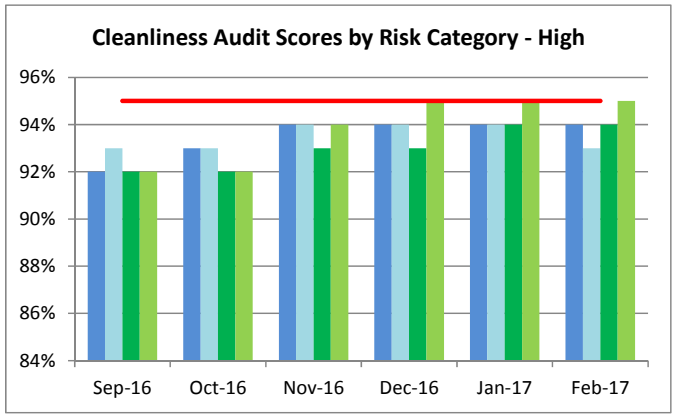
	Submitted on a "best endeavours" basis April - June											
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Performance	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Actual	**92.7%**	**92.7%**	**92.4%**	**92.4%**	**92.1%**	**91.7%**	**91.5%**	**92.2%**	**91.3%**	**90.9%**	**91.2%**	

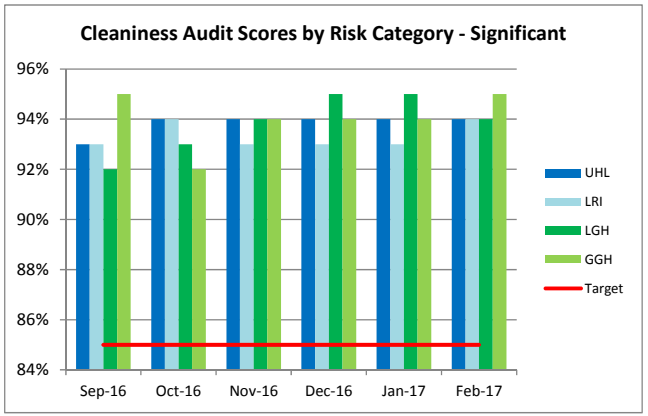
Compliance Forecast for Key Responsive Indicators

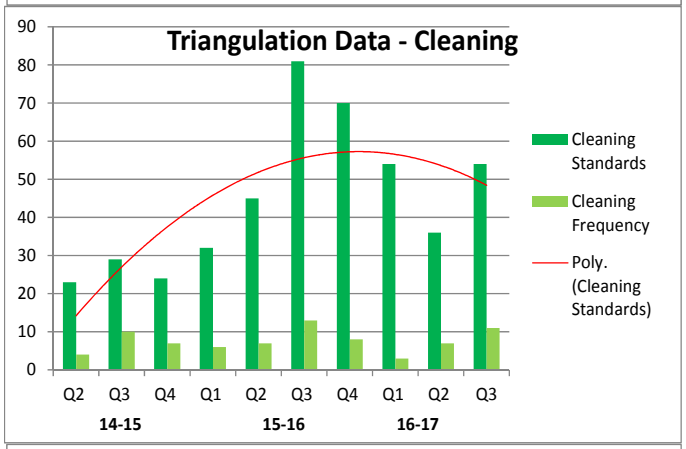
Standard	February	March	Commentary
Emergency Care			
4+ hr Wait (95%) - Calendar month	83.8%		Validated position
Ambulance Handover (CAD+)			
% Ambulance Handover >60 Mins (CAD+)	6%		EMAS monthly report
% Ambulance Handover >30 Mins and <60 mins (CAD+)	12%		
RTT (inc Alliance)			
Incomplete (92%)	91.2%	91.4%	Delivery is partially dependant on access to beds.
Diagnostic (inc Alliance)			
DM01 - diagnostics 6+ week waits (<1%)	0.9%	0.9%	
# Neck of femurs			
% operated on within 36hrs - all admissions (72%)	68%	72%	
% operated on within 36hrs - pts fit for surgery (72%)	80%	85%	
Cancelled Ops (inc Alliance)			
Cancelled Ops (0.8%)	1.2%	1.2%	Delivery is dependant on access to beds.
Not Rebooked within 28 days (0 patients)	26	15	Delivery is dependant on access to beds.
Cancer			
Two Week Wait (93%)	94%	94%	
31 Day First Treatment (96%)	94%	94%	In discussion with NHSI compliance will be following 2 months of consistent bed access.
31 Day Subsequent Surgery Treatment (94%)	89%	94%	
62 Days (85%)	78%	84%	In discussion with NHSI compliance will be following 2 months of consistent bed access.
Cancer waiting 104 days (0 patients)	3	10	

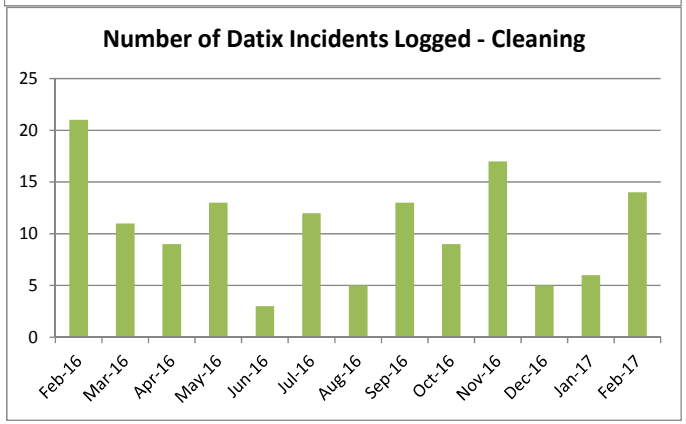
Estates and Facilities – Cleanliness











Cleanliness Report

The above charts show average audit scores for the whole Trust and by hospital site since September 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 achieved in February 2017 overall across the Trust. High risk areas show similar results to January 2017 scores, with GGH achieving the required 95% for the second month running. Improvement is still required in LGH and LRI to meet the target.

Significant risk areas all exceed the 85% target.

The general trend remains one of continuous but very steady improvement. For illustration the charts also show where the IFM contracted target would have been (although at 90% this was their overall average target consolidated across all risk areas). This level of performance – effectively the standard that currently funded- is being exceeded. In other words although we still need to improve and sustain performance we are delivering a better service than IFM for a given level of resources.

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'. The latest available data for Q3 shows an increase in the number of issues raised by patients/visitors on cleaning standards. For the corresponding period the Datix incidents recorded don't bear out this observation, however there is an increase for the February scores. This will continue to be monitored closely. The Datix issues raised are responded to and rectified on an incident by incident basis.

The on-going challenge of recruitment maintaining pace with vacancies continues to slowly improve but be the most significant issue in the provision of the cleaning service. The condition of main entrances and corridors at the LRI remain a challenge. Additional resource has resulted in periodic improvement but appearance can deteriorate very quickly with the volume of traffic experienced. Responding to this has been more difficult especially where demands on the service have increased to deal with the impact of infections on particular ward areas.

Estates and Facilities – Patient Catering

Patient Catering Survey – February 2017	Percentage 'OK or Good'	
	Jan-17	Feb-17
Did you enjoy your food?	74%	91%
Did you feel the menu has a good choice of food?	94%	100%
Did you get the meal that you ordered?	100%	91%
Were you given enough to eat?	100%	100%

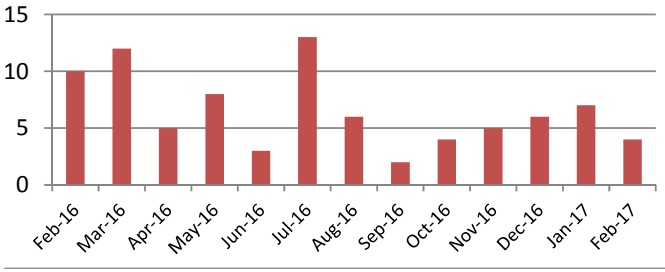
90 – 100%	80 – 90%	<80%

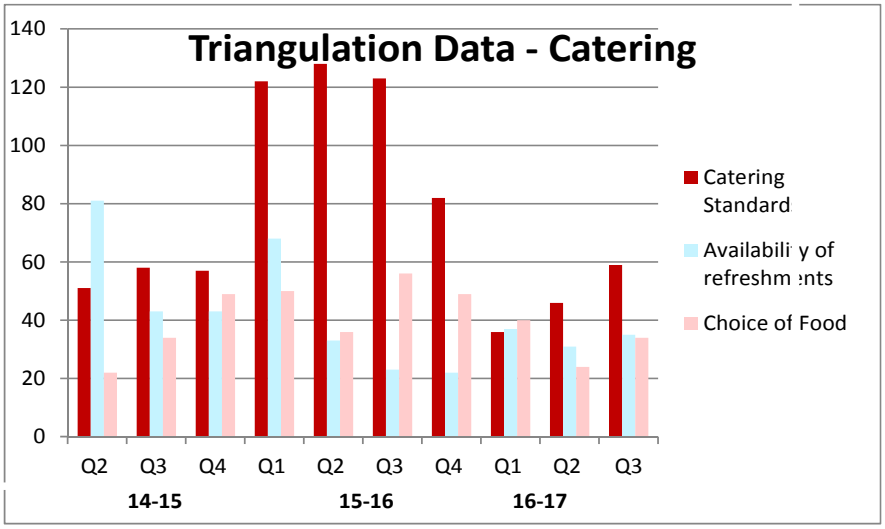
Number of Patient Meals Served				
Month	LRI	LGH	GGH	UHL
December	67,893	22,532	27,945	118,370
January	64,921	24,276	28,546	117,743
February	66,197	21,509	26,853	114,559

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

97 – 100%	95 – 97%	<95%

Number of Datix Incidents Logged -Patient Catering





Patient Catering Report

Due to a poor rate of return the patient catering survey results for January were based on a small sample of patients. As a result the methodology for collecting the data has been reviewed with a minimum of 100 food patient surveys required going forward. With the caveat of the small sample size the February survey result shows an improvement in the number of patients reporting positively on food quality despite a slight fall in those that got the mean they ordered.

From the comments made to date in the survey there were no recurrent issues this month, with only one patient stating they felt their chips were undercooked.

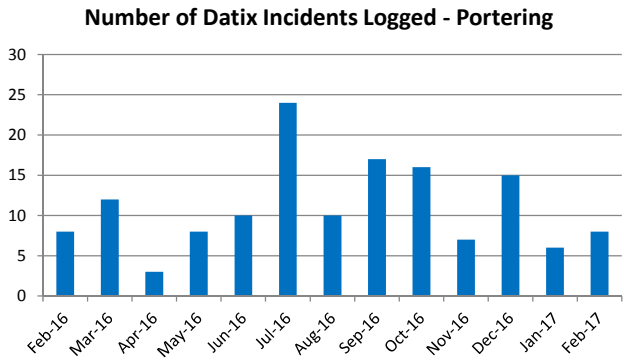
The latest triangulation data for Q3 corresponds to a slight rise in Datix incidents across the quarter, however the February position suggests that the potential negative trend is not persisting.

Estates and Facilities - Portering

Reactive Portering Tasks in Target				
Site	Task (Urgent 15min, Routine 30min)	Month		
		November	December	January
GH	Overall	96%	96%	95%
	Routine	96%	96%	95%
	Urgent	97%	99%	100%
LGH	Overall	94%	93%	93%
	Routine	93%	92%	93%
	Urgent	98%	93%	100%
LRI	Overall	90%	93%	91%
	Routine	91%	92%	90%
	Urgent	98%	97%	94%

95 – 100%	90 – 95%	<90%

Average Portering Task Response Times		
Category	Time	No of tasks
Urgent	08:53	712
Routine	27:30	11,278
	Total	11,990



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.

February performance overall continues to reflect the picture of 'steady' performance save for a slight drop in urgent tasks at the LRI. Datix incidents have risen slightly following the January reduction; however they remain comparatively low overall.

The number of vacancies has increased with 6 positions progressing through the recruitment process. The gaps are being filled through the use of bank and overtime with one supervisory role being covered by an agency staff member. This is essential to maintaining a responsive service in respect of supporting patient flow relating to ED and Red to Green activity across the Trust.

Progress is being made in the efforts to improve efficiency in the deployment of porters. New electronic systems are to be trialled in ED process and work on the effective deployment of porters in specific service areas is anticipated to be concluded prior to the next reporting period.

Estates and Facilities – Planned Maintenance

Statutory Maintenance Tasks Against Schedule					
	Month	Fail	Pass	Total	%
UHL Trust Wide	December	4	191	195	98%
	January	3	148	151	100%
	February	19	139	158	88%

99 – 100%	97 – 99%	<97%

Non-Statutory Maintenance Tasks Against Schedule					
	Month	Fail	Pass	Total	%
UHL Trust Wide	December	344	1943	2287	85%
	January	277	2098	2375	88%
	February	260	1866	2126	88%

95 – 100%	80 – 95%	<80%

Estates Planned Maintenance Report

For February we incurred 19 failures in the delivery of Statutory Maintenance tasks in month. This was due to an omission of Dry Risers from our fire contract. This issue has now been picked up and resolved.

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. As in January, up to two thirds of reactive calls for the LRI (where the issue is most marked) relate to drainage.

At this stage the Planet system has been upgraded to allow the first stage of commencement of a switch over from a paper based system to an electronic system to take place.

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

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

	KPI Ref	Indicators	Board Director	Lead Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	14/15 Outturn	15/16 Outturn	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Research UHL	RU1	Median Days from submission to Trust approval (Portfolio)	AF	NB	TBC	TBC	TBC	2.8	1.0	1.0			2.0			1.0			1.0			4.5			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%							

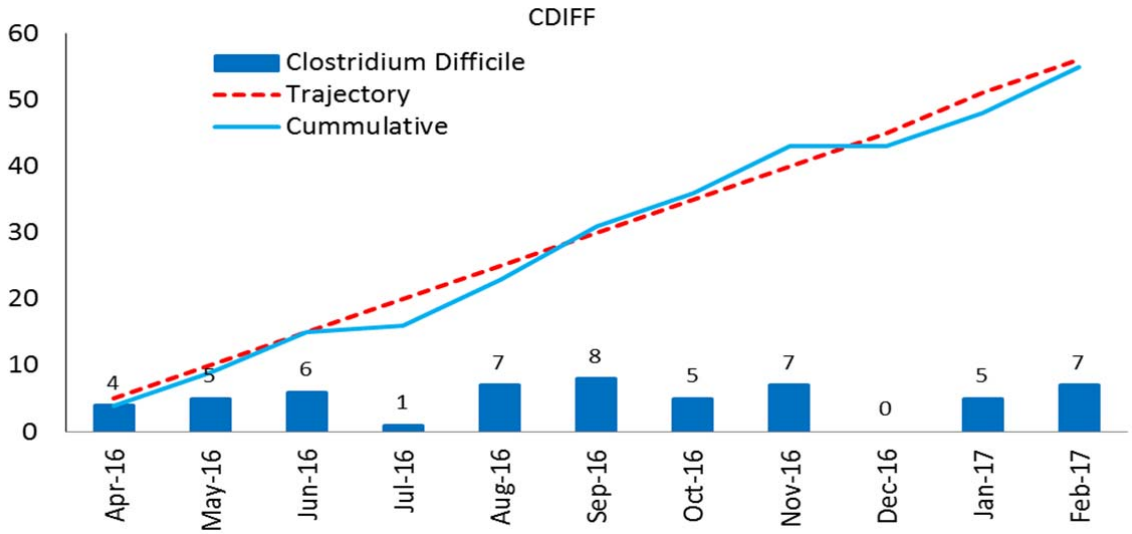
C DIFF

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	YTD
Clostridium Difficile	4	5	6	1	7	8	5	7	0	5	7	55

The CDT figures have risen steadily in line with the trajectory but there are no 'stand out' months which are cause for concern. The YTD position is 1 case below the cumulative trajectory of 56.

Actions taken to improve performance

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



Single Sex Accommodation Breaches (patients affected)

Indicators	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	YTD
Single Sex Accommodation Breaches (patients affected)	0	0	4	1	2	20	7	1	14	6	4	59

Intensive Care Unit, Leicester Royal Infirmary

In February there were three same sex accommodation breaches with three patients affected. Two breaches were due to lack of bed capacity in the Surgical and Diabetology specialities. The other breach was due to a delay in obtaining an appropriate ambulance to transfer the patient to a speciality Hepatobiliary bed at the Leicester General Hospital.

Ward 25, Leicester Royal Infirmary

In February there was one breach with one patient affected on ward 25, Leicester Royal Infirmary. A male patient was admitted to the Stroke Unit into a bay where a female patient was being cared for as this was the only available bed.

Actions taken to improve performance

Intensive Care Unit, Leicester Royal Infirmary

All patients who are identified for potential discharge from the Intensive Care Unit are discussed by the Nurse in Charge at Gold Command and this is monitored until a bed is identified. At every Gold Command any patients who have not got a bed identified are discussed again and ambulance availability is escalated. Intensive Care Unit patients discharge is prioritised by the Duty Management Team.

Ward 25, Leicester Royal Infirmary

Meetings have been held with the Ward Sister and support has been offered to the team. The Same Sex Accommodation Matrix has been reiterated and the escalation process reviewed.

Inpatients only 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	Feb-17	YTD
Inpatients only Friends and Family Test - % positive	**97%**	**96%**	**97%**	**96%**	**95%**	**96%**	**96%**	**96%**	**96%**	**95%**	**95%**	**96%**

There has been a reduction in the Friends and Family Test (FFT) recommend score within the inpatient wards in January and February 2017, this is due to a decline in the overall FFT recommend score in the RRCV Clinical Management Group (CMG). However four other CMGs did not achieve the Trust target of 97% and this is a recurrent trend.

Patients appear to be shifting and rather than providing a positive response about theTrust there is an increase in the number of paients identifying 'neither likely nor unlikely/don't know' responses in February. This shift appears to be Trust wide as opposed to a particular CMG.

From the free text comments the main negative themes for 'neither likely nor unlikely/don't know' responses were due to patients' perceived waiting too long, poor staff attitude, poor communication and inadequate information.

Actions taken to improve performance

- The senior management team are aware of the FFT scores in the inpatient areas and are looking at ways to improve and respond to feedback
- Free text comments will be closely monitored by CMG's particularly in the neither likely nor unlikely/don't know responses to identify themes that need to be addressed.

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	Feb-17	YTD
A&E Friends and Family Test - % positive	96%	95%	95%	87%	87%	84%	87%	84%	91%	93%	94%	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).

February's performance is the highest since June 16. The main reason for decrease in score is due to the UCC. The free text comments in the UCC indicate the reasons for the low FFT as waiting times, staff attitude and the department layout/comfort. Also, since the Minors area moved to its new location in July, since then the FFT score has decreased.

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.

Emergency Readmissions within 30 days

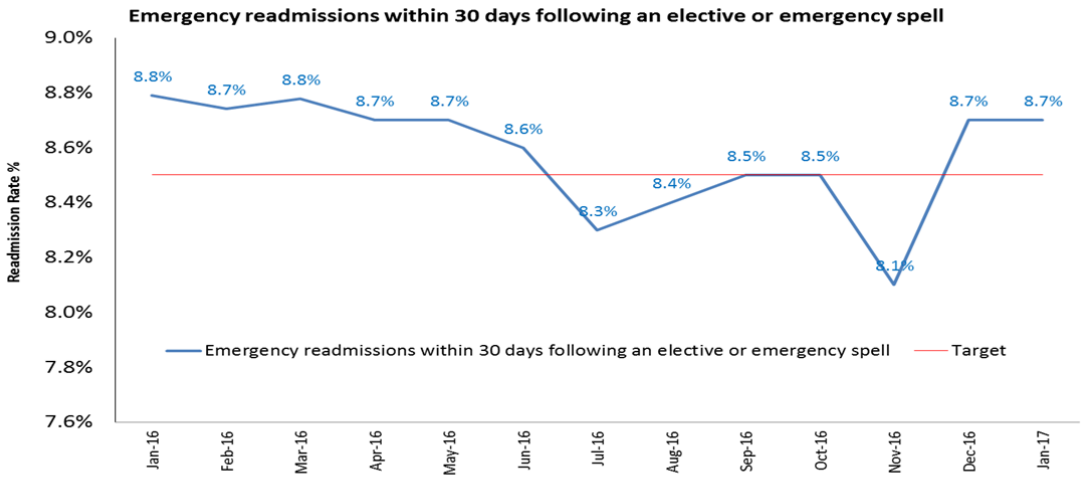
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	YTD
Emergency readmissions within 30 days following an elective or emergency spell	8.7%	8.7%	8.6%	8.3%	8.4%	8.5%	8.5%	8.1%	8.7%	8.7%	8.5%

What actions have been taken to improve performance?

On-going work to improve readmission rates includes merging this work-stream with the Red to Green work-stream with the following actions:

- Introduction of a "stranded patient" Dragons' Den – this weekly meeting will invite wards to present their three patients with the longest length of stay to the Red 2 Green leads in order to gain support and help in getting these patient out of hospital. The PARR30 score will feed into this meeting and be a focus of discussion.
- NerveCentre developments – the PARR30 score will become visible on the patient discharge view in NerveCentre – this is the view used to perform board rounds. The icon for PARR30 will be able to be used to record actions taken to reduce readmissions, and will turn from red to green when the actions have been taken.
- Use of the PARR30 score as a focus of discussion in the daily conference call held with community partners.

In addition a case management approach to patients with a high PARR30 score has been adopted. This has approach has already gained valuable insights into individual patients by visiting them in their home environment to look at factors that might be impacting on their high readmission rate. This is currently in a pilot stage and success will be evaluated at the year end.



Mortality - Rolling 12 months HSMR (as reported in HED) Rebased

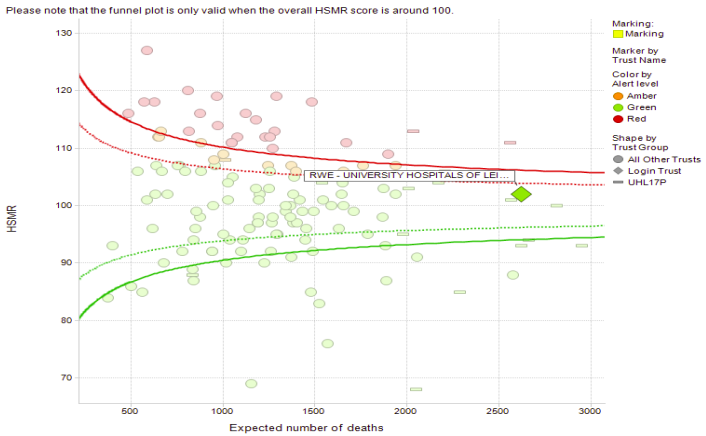
	Jan15-Dec15	Feb15-Jan16	Mar15-Feb16	Apr15 - Mar16	May15 - Apr 16	Jun15 - May16	Jul15 - Jun16	Aug15 - Jul16	Sep15 - Aug16	Oct15 - Sep16	Nov15 - Oct16	Dec15 - Nov16	Jan16 - Dec 16	Feb16 - Jan 17	Mar16 - Feb17	YTD
Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	**95**	**95**	**95**	**97**	**99**	**99**	**100**	**102**	**103**	**102**	**102**	**102**	**102**	Awaiting HED Update		**102**

- 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 HSMR.

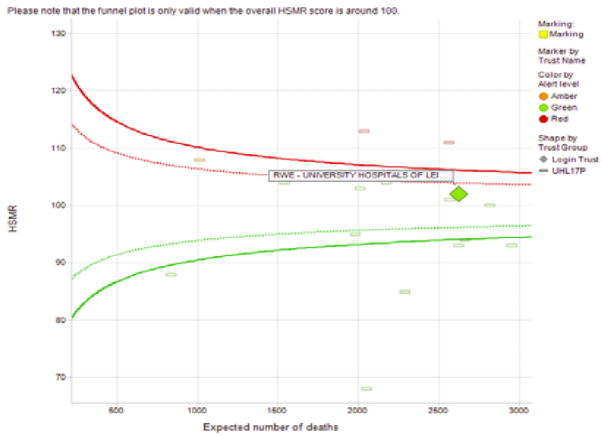
Actions taken to improve performance

- 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. Earlier recognition of both sepsis and acute kidney injury are also both key priorities for this year.
- 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.
- Whilst our HSMR score is slightly above the 100 average, comparing ourselves both nationally and to our peer group we are not an outlier and our HSMR score remains within the nationally expected range.

HSMR Jan16-Dec16 UHL Vs All Trusts



HSMR Jan16-Dec16 UHL Vs Peer Trusts



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	Feb-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%	67.6%	71.2%

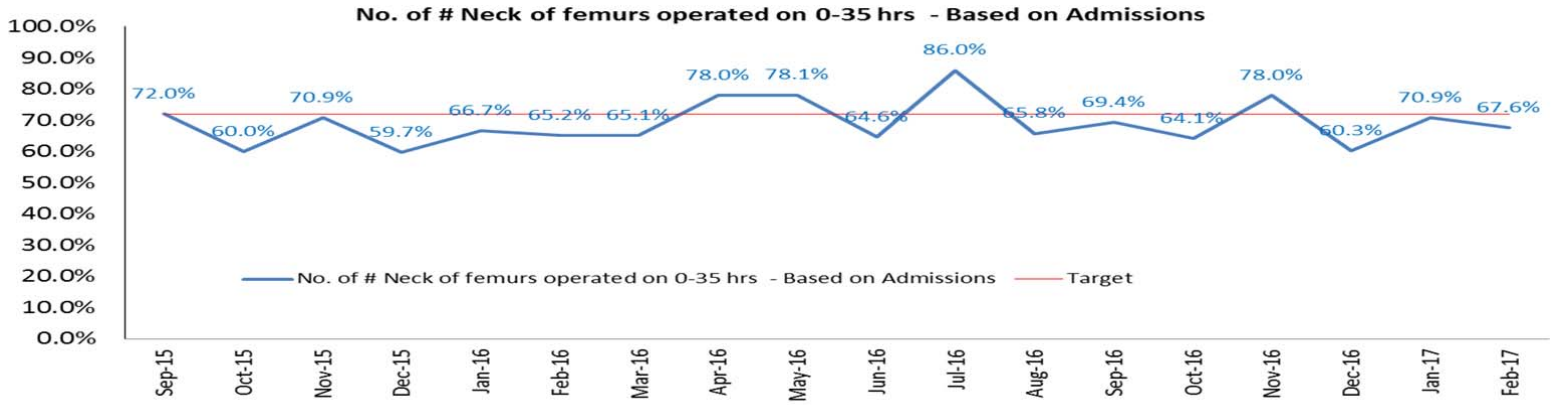
There were 71 NOF admissions in February 2017, 23 patients breached the 36 hr target to theatre as detailed below:-

- Within the service control = 12 patients. Main theme was capacity once fit, aligned to other Trauma demand.
- Outside service control = 9 patients. These were unfit and required stabilisation pre operatively. (8 patients)

There were 2 days when NOF admissions were 5 - 6 pts (2nd and 23rd Feb). There was once again this month a degree of complex urgent Trauma and spinal cases which took priority clinically particularly over the weekend.

Actions taken to improve performance

- Theatre team leader continues to work closely with trauma team to coordinate and manage changing priorities.
- Implementation consistently regarding the application of the DOAC reversal protocol being taken forward.
- 6 transfers are made to LGH to help free capacity. These were pre-operative cases.
- Weekly monitoring of theatre utilisation of all Trauma theatres continues.
- 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.
- Operational meetings with the Clinical Director chairing continue.



RTT Performance

Combined UHL and Alliance RTT Performance for February

	<18 w	>18 w	Total Incompletes	%
Alliance	7,464	463	7927	94.2%
UHL	44,581	4,582	49,63	90.7%
Total	52,045	5,045	57,090	91.2%

Backlog Reduction required to meet 92%	**520**

UHL and Alliance combined performance for RTT in January was 91.2%. The trust did not achieve the standard. Overall combined performance saw 5,045 patients in the backlog a reduction of 49 since the last reporting period (UHL reduction of 152, Alliance increase of 103). There were 520 too many patients waiting over 18 weeks in order to achieve the standard.

The starting position in February made it unlikely the standard would be achieved. This was forecasted in January's EPB report with a position of circa 90.0% projected. This initial figure was based on the executive decision to cancel elective activity at the LRI between 8th February and 19th February that was not cancer or clinically urgent. This included the suspension of all WLI's as well as insourced activity. WLIs that do not result in a negative margin have now been authorised to continue. This has lessened the impact that was previously modeled.

Forecast performance for next reporting period: We are unlikely to meet the 92% performance standard in February, projecting closer to 91.4%. 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.
- Increased number of patients rolling onto the backlog from previous months cancellations.
- Increase of referrals of 13.4% year on year for patients that turn 18 weeks on the month of March.

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.

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

Specialty	ACPL Target	M11 ACPL Actual	YTD ACPL
MaxFax	2.2	3	2.1
Vascular	1.2	1.6	1.3
Paediatrics	2.6	3	2.4
General Surgery	1.9	1.9	1.8
Gynae	3.2	3.2	2.8
Ophthalmology	3.8	3.7	3.6
Plastics	2.8	2.7	2.9
ENT	2.4	2.3	2.3
Breast	1.8	1.7	1.9
Urology	2.8	2.5	2.6
Renal	1.6	1.4	1.6
Ortho	2.1	1.8	1.9
Pain	5.7	4.5	5.2
Total	2.8	2.4	2.4

A top down plan is being worked through to identify the improvements required within key specialties to achieve 92% performance. This is currently being worked through with the each specialty to assess the operational and financial viability. The model currently projects performance to be achieved by the end of June.

At end of February there were 39 patients who breached 52 weeks. 23 ENT, 10 Paediatric ENT and 6 Orthodontics. Excluding the Orthodontics patients, 11 have now been treated, 22 have there treatment date with 1 patient awaiting MRI results before. Daily emails to HoOPS highlighting patients at 48 weeks or more for the following day has been operationalised to minimise the risk of cancellation of this cohort of patients.

The tables below outline the 10 largest overall backlogs, 10 largest backlog increases and 10 largest backlog reductions by specialty from last month. The largest overall backlog increases were within ENT and Orthopaedic Surgery. These services were significantly impacted by the elective cancellations to support ED. Actions plans to address these backlogs are in place.

10 largest backlog overall backlogs	Admitted Backlog			Non Admitted Backlog			Total		
Local UHL Specialty	Jan-17	Feb-17	Change	Jan-17	Feb-17	Change	Jan-17	Feb-17	Change
ENT	374	417	43	343	345	2	717	762	45
Orthopaedic Surgery	221	238	17	247	260	13	468	498	30
Paediatric ENT	379	380	1	15	21	6	394	401	7
Urology	282	291	9	87	98	11	369	389	20
Spinal Surgery	51	38	-13	263	268	5	314	306	-8
General Surgery	220	215	-5	93	85	-8	313	300	-13
Ophthalmology	132	137	5	401	128	-273	533	265	-268
Gynaecology	144	164	20	72	75	3	216	239	23
Maxillofacial Surgery	133	144	11	29	29	0	162	173	11

10 largest backlog increases	Admitted Backlog			Non Admitted Backlog			Total		
Local UHL Specialty	Jan-17	Feb-17	Change	Jan-17	Feb-17	Change	Jan-17	Feb-17	Change
ENT	374	417	43	343	345	2	717	762	45
Orthopaedic Surgery	221	238	17	247	260	13	468	498	30
Allergy	4	3	-1	131	159	28	135	162	27
Gynaecology	144	164	20	72	75	3	216	239	23
Urology	282	291	9	87	98	11	369	389	20
Interventional Radiology	28	30	2	67	80	13	95	110	15
Maxillofacial Surgery	133	144	11	29	29	0	162	173	11
Paediatric Cardiology	4	7	3	23	29	6	27	36	9
Pain Management	3	8	5	5	7	2	8	15	7
Paediatric ENT	379	380	1	15	21	6	394	401	7

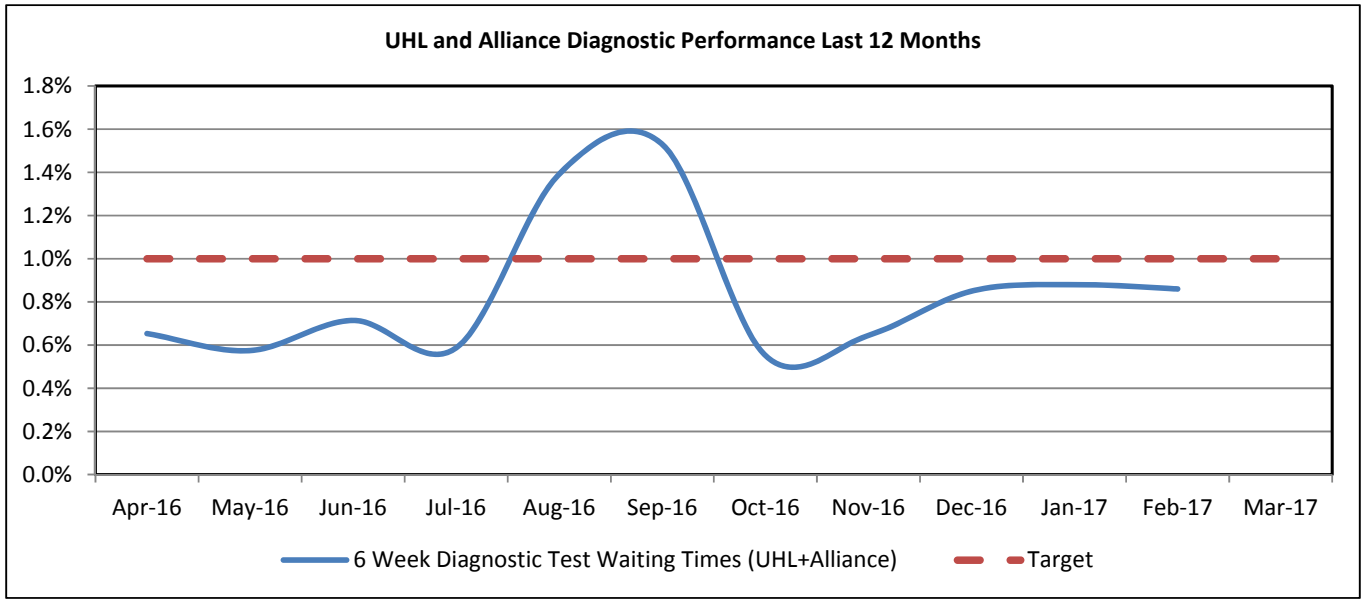
10 largest backlog reductions	Admitted Backlog			Non Admitted Backlog			Total		
Local UHL Specialty	Jan-17	Feb-17	Change	Jan-17	Feb-17	Change	Jan-17	Feb-17	Change
Ophthalmology	132	137	5	401	128	-273	533	265	-268
Paediatric Medicine	1	1	0	53	32	-21	54	33	-21
General Surgery	220	215	-5	93	85	-8	313	300	-13
Cardiology	51	40	-11	34	32	-2	85	72	-13
Hepatobiliary & Pancreatic Surgery	28	18	-10	2	2	0	30	20	-10
Cardiac Surgery	21	18	-3	19	12	-7	40	30	-10
Gastroenterology	5	4	-1	108	100	-8	113	104	-9
Spinal Surgery	51	38	-13	263	268	5	314	306	-8
Paediatric Neurology	0	0	0	29	21	-8	29	21	-8
Orthodontics	0	0	0	14	7	-7	14	7	-7

The overall largest reduction in backlog size was achieved in ophthalmology, reducing their non admitted backlog by 273. This was achieved via focused attention in booking practices, service changes within specialty and introducing additional capacity. It is anticipated there non admitted backlog will continue to reduce and be below 100 at the end of March.

Overall capacity remains a constraint. Long term actions include targeting demand reduction with primary care as a key priority to achieving on-going performance for our patients to receive treatment in a timely manner.

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:** Trust grade has been appointed with a start date in April pending completion of language test. 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 have 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. Assess ability to increase WLI for Balance patients, linked to consultant discretionary effort dates agreed on going. Bed capacity modeling for Paediatric daycase beds aims to improve throughput.
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
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. Consultants authorised to appoint outside of business case signoff at RIC. **Actions:** The service currently relies on discretionary effort for additional capacity, with weekly inpatient and outpatient sessions. Long term impact will be if approval of business case for expansion of service workforce. Other interim actions include the Single Point of Access. Insource outpatient capacity – YourWorldDoctors. Started 24th February.
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. **Actions:** Additional clinics to reduce outpatient backlog. Clinical engagement for patients on foot and ankle pathway for waiting list management. Increased clinical capacity from February 2017
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. **Actions:** Wait list initiatives. Increase in uptake of UHL staffed lists allowing for more patients from the backlog to be treated. Medinet used to fill gap in sessions, currently in January 7 all day UHL staffed lists and 5 Medinet lists (24 sessions). Continuing WLI and process change in outpatients to reduce non admitted backlog. Left shifting of low complex patients to the Alliance started on 25th January.

Diagnostic Performance
February diagnostic performance for UHL and the Alliance combined is 0.86% achieving the standard performing below the 1% threshold. UHL alone achieved 0.91% for the month of February with 116 patients out of 12,699 not receiving their diagnostic within 6 weeks. Of the 15 modalities measured against, 6 achieved the performance standard with 9 areas having waits of 6 weeks or more greater than 1%. Strong performance in Non-obstetric ultrasound with only 1 breach / 0.02% and CT 3 breaches / 0.1% supported the overall performance. The 5 lowest performing modalities are listed below
Risks to future months performance
Overall there are 1,326 fewer patients now waiting for a diagnostic compared to November 2016. This reduction is largely within Ultrasound as the service has reduced the number of patients by over 1,200 during this period. This will positively impact on patients overall wait times and reduce total pathway length. It is important to be mindful that this overall reduction in patient on the waiting list has a significant reduction in the breach tolerance allowed. Patients requiring sedation under propofol remains a risk with capacity available through ad hoc lists. MRI capacity for March remain a risk. It is anticipated the overall diagnostic performance for March 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	Indicator	Target (monthly)	Latest month	YTD performance (inc Alliance)	Forecast performance for next reporting period
1.The % of cancelled operations for non-clinical reasons On The Day (OTD) of admission	1	0.8%	1.2%	1.2%	1.0%
2.The number of patients cancelled who are not offered another date within 28 days of the cancellation	2	0	26	195	25

What is causing underperformance?

For February there were 122 non clinical hospital cancellations for UHL and Alliance combined. UHL alone saw 110 patients cancelled on the day for a performance of 1.2%. Of the 111 cancellations, 67 patients were due to capacity related issues and 44 for other reasons. 52 cancellations were related to lack of beds either Ward beds or ITU/HDU.

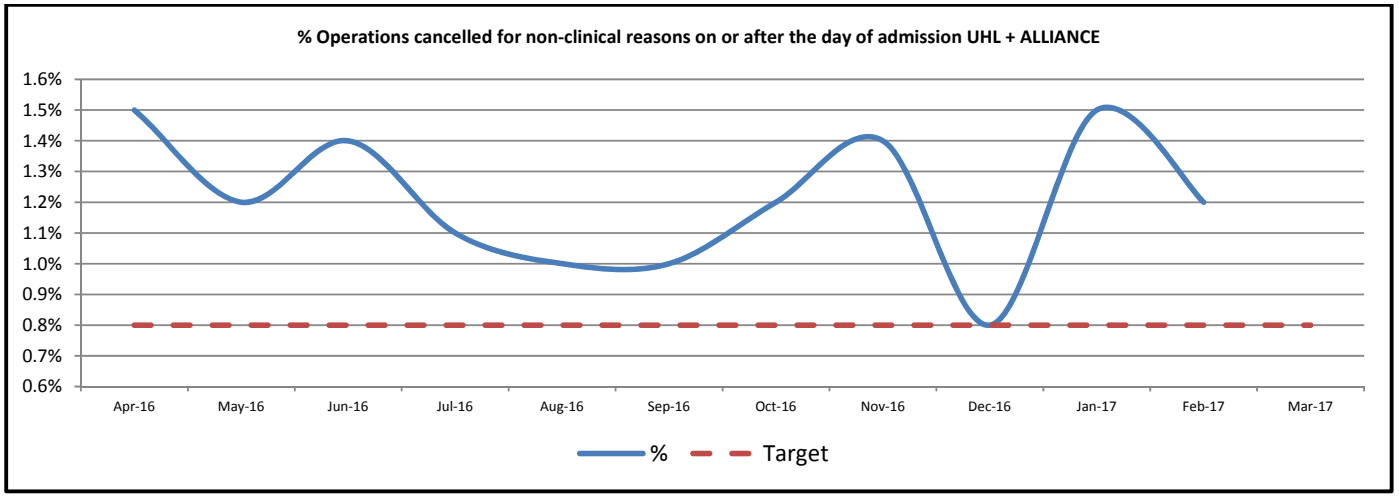
The 5 largest cancellations on the day were for: Hospital cancel - ward bed unavailable (37), Hospital cancel - lack theatre time / list overrun (30), Hospital cancel -pt delayed to adm high priority patient (15), Hospital cancel – HDU bed unavailable (12), Hospital cancel - lack surgeon (7)

There were 26 patients who did not received there operation within 28 days of a non clinical cancellation. These comprised of CHUGGS 16, CSI, Musculoskeletal and Specialist Surgery 7 and RRCV 3

An executive decision to cancel non urgent non cancer elective operations was taken on 8th February to run until the 19th February, the number of on the day cancellations, prior to the day cancellations and patients not booked to avoid a cancellation were circa 500 during this period.

Risk for next reporting period

Achieving the 0.8% standard in March remains a risk as Emergency pressures remain high. A new cancellation policy is in the process of being shadow monitored.



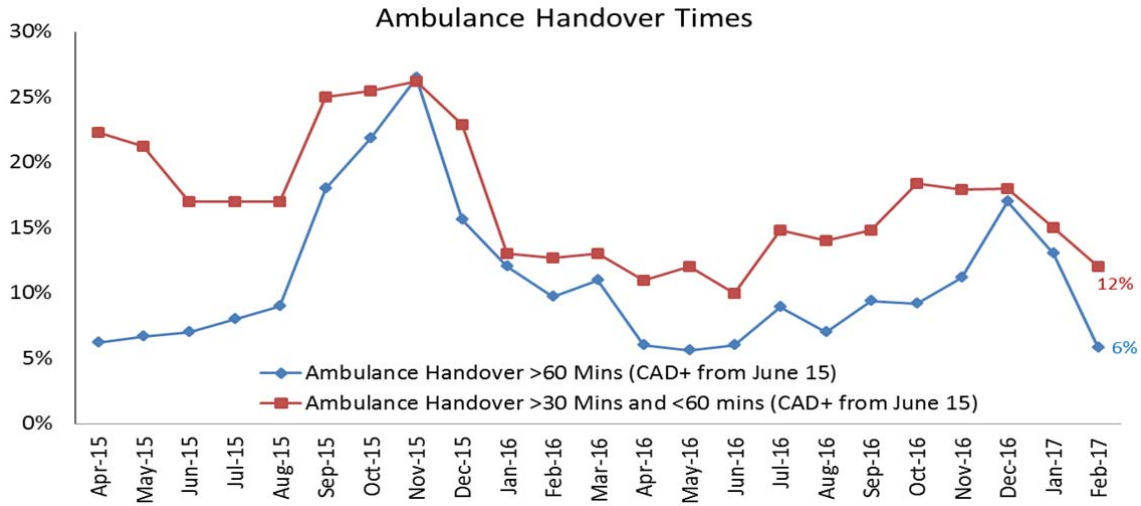
Ambulance handover > 30 minutes and >60 minutes - Performance

	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	YTD
Ambulance Handover >60 Mins (CAD+ from June 15)	12%	10%	11%	6%	6%	6%	9%	7%	9%	9%	11%	17%	13%	6%	9%
Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)	13%	13%	13%	11%	12%	10%	15%	14%	15%	18%	18%	18%	15%	12%	15%

Although ambulance handover time improved during February, 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?

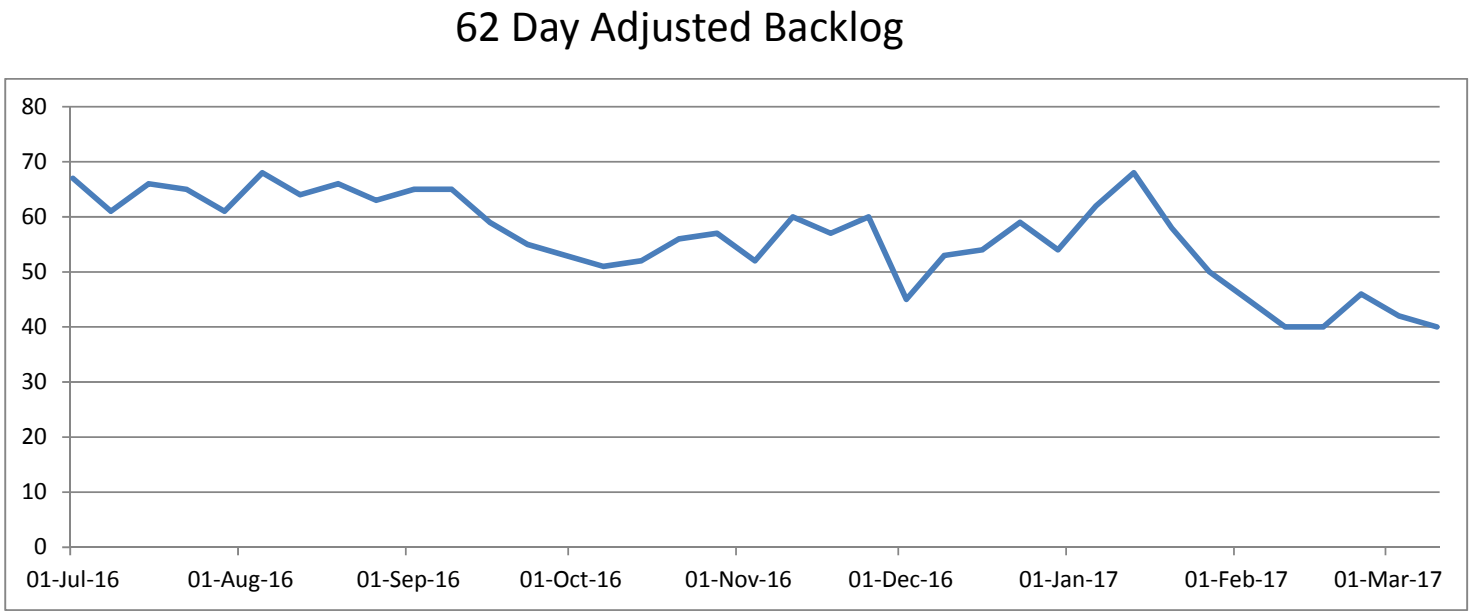
- 11 cohort spaces used in hours, 17 spaces out of hours to increase flow out of assessment bay.
- Traction in gold meetings to ensure spaces are filled.
- Real time escalation by duty team to Director on call of all patients that have waited longer than 60 minutes on an ambulance.
- GPAU opened longer to improve flow and appropriate patients moved from assessment bay into GPAU scheme.
- Long waits are escalated to the Chief Executive.



Cancer waiting time performance

Current Performance:-

- 2ww performance remained strong in January achieving 93.2% supporting an improved YTD position now at 93.01%. February is also expected to deliver the standard sitting at 94% (pre-upload).
- 62 day performance as anticipated remains below the required standard, January at 75.5% against a national average of 79.5%. February (pre-upload) expected at circa 80%.
- The adjusted backlog (excluding tertiary referrals received after day 39) has averaged in the 40's for over 6 weeks and at the time of reporting currently sits at 40 – the key outliers remain Gynae and HPB.



Key themes identified in backlog (10th March)

Summary of delays	Numbers of patients	Summary
Complex Patients/Complex Diagnostic Pathways	11	Across 6 tumour sites, – these are patients undergoing multiple tests, MDTs and diagnostics. This includes patients referred between multiple tumour sites with unknown primaries.
All Options Patients *(Urology specific)*	2	Complex pathways where patients are offered a range of options for consideration regarding treatment, involving consultation with Oncology and complex Urology clinics.
Capacity Delays – OPD & Endoscopy	2	In Lower GI and Lung. For LOGI, this includes a patient at 179 days who has had 3 failed EMRs and requires a specific clinician to carry out with limited capacity – this patient has a TCI for the 16/3/17. In Lung, the primary delay is as a result of limited capacity in Oncology.
UHL Pathway Delays (Next Steps compliance)	7	Across 3 tumour sites – Gynae, Urology and Lower GI, where more than 1 delay has occurred within the pathway and lack of compliance with Next Steps is evident . The delays range across Imaging, Cardiology, Endoscopy . This includes outpatient delays and surgical delays due to capacity within Gynae.
Patient Delays & Patients Unfit	17	Across 8 tumour sites – a significant proportion of the backlog where they are or have been unfit during their pathway – ranging from Cardiac issues requiring treatment prior to surgery, Patients unfit for pathway progression/treatment, multiple DNAs, patient thinking time re decision making for treatment planning and general lack of engagement and patient holidays.
Tertiary Referrals	4	In Urology (x2) and HPB (x2), late referrals from KGH , ULH and NGH all received over Day 82.

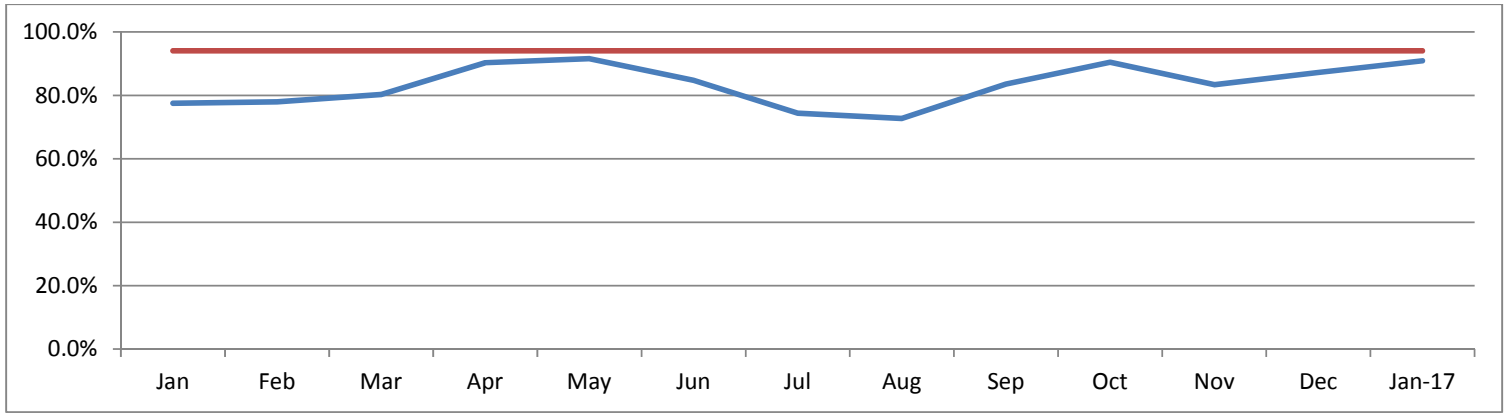
Backlog Review for patients waiting >104 days

The following details all patients declared in the 104 Day Backlog for week ending 10/3/17.

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	175	N	N	Diagnostic delays (hospital and patient), 3 failed EMRs. Now booked for 16/3/17.
		2	116	N	N	Patient holiday led to a 3 week delay at the beginning of the pathway, on return patient required ECHO and lung function tests prior to treatment planning in addition to a high risk anaesthetic review. HPB input also required in addition to blood transfusion. Patient still awaiting a TCI date, joint case and HDU bed required.
GYNAE	2	1	105	N	N	Patient declined x3 TCI dates for diagnostics due to requiring a carer to attend alongside – resulting in a 4 week delay, the patient then DNA'd this TCI. A TCI date was provided which was subsequently cancelled due to high BMI, required INR review and bridging plan. Subsequent TCI provided which the patient cancelled on the day. Awaiting outpatient review 20/3/17.
		2	104	N	Y	Patient DNA'd multiple outpatient appointments due to being an inpatient in Cardiology – Cardiology advice to date patient in late March 2017 with fitness review beforehand. TCI now 25/3/17.
UROLOGY	2	1	161	N	N	Late tertiary referral at Day 102 from ULH, patient subsequently cancelled UHL OPD as they weren't aware of being referred over. Seen in UHL 3/3/17 and added to the waiting list – awaiting a TCI date at time of reporting.
		2	116	N	N	Patient delayed due to Cardiology assessments and confirmation patient is optimised for surgery. TCI date provided, subsequently cancelled as patient was admitted via A&E for jaundice. Patient currently an inpatient with sepsis.

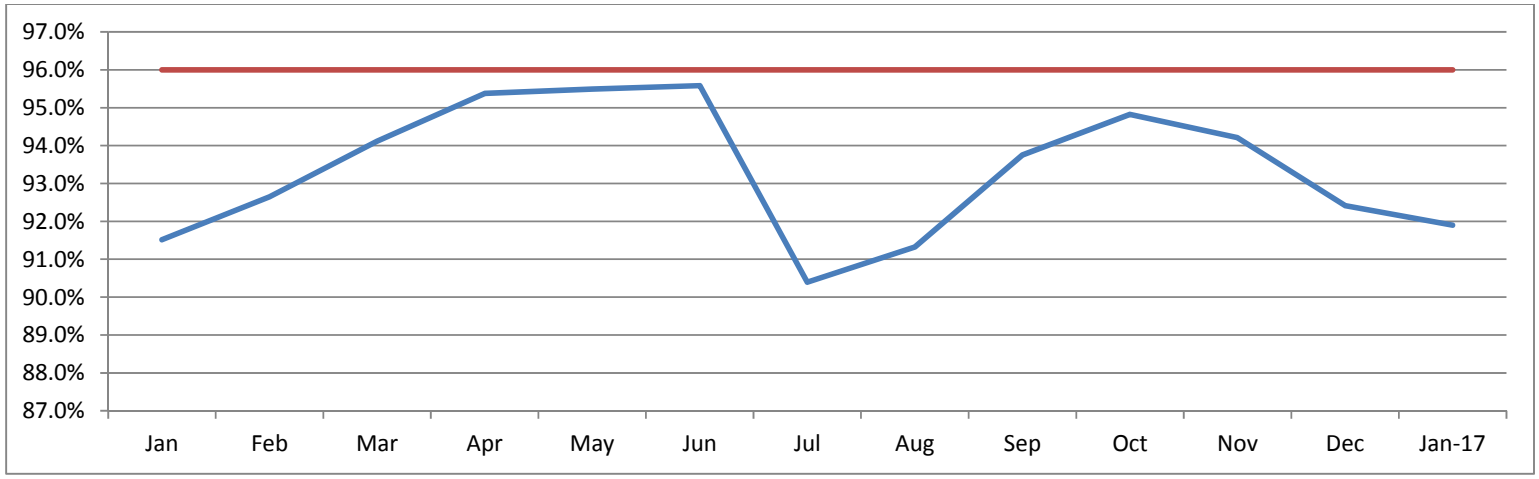
31 Day Subsequent Surgery Performance



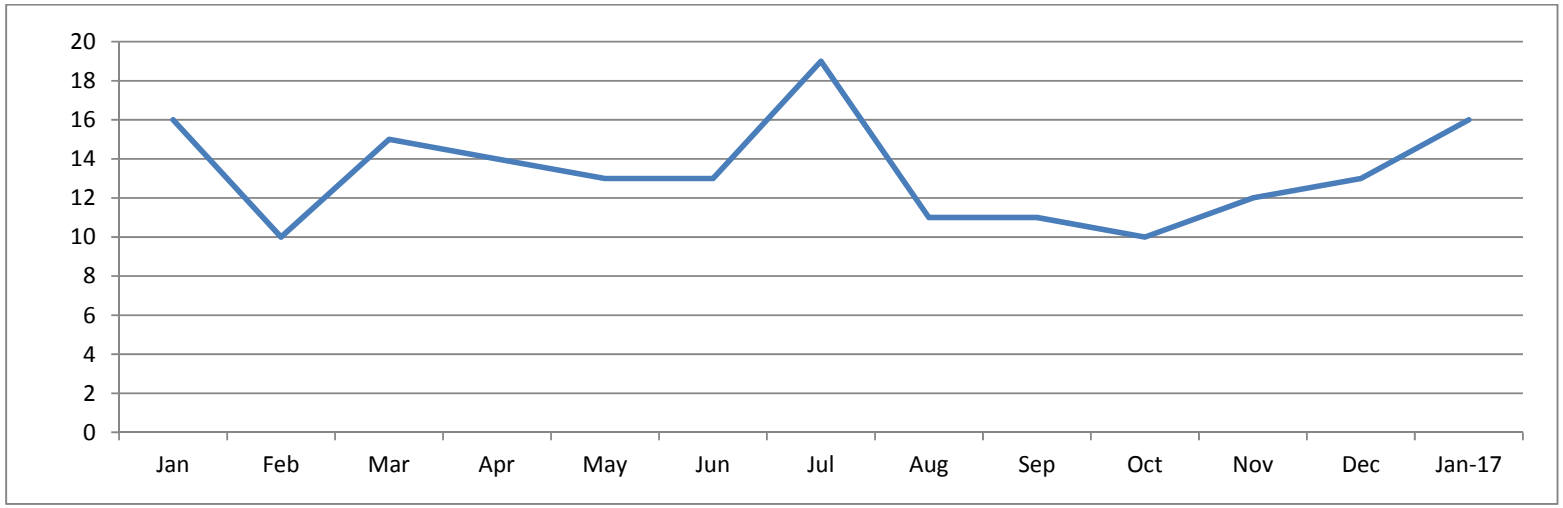
31 day subsequent surgery performance was below the standard at 90.9% in January showing a 3.3% improvement on the previous month, with February (pre-upload) currently at 88.8%. Although at the time of reporting, there are zero patients in the backlog, access to beds and timely theatre capacity remains the key issue.

31 Day First Treatment - Performance

31 day 1st treatment performance in January was below the standard at 91.9%, expected position for February to be circa 93% *(Pre-Upload).* At the time of reporting, the backlog has significantly reduced to 4 from 16 (end Jan).



31 Day First Treatment - Backlog



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.

Key milestones and delivery dates on the RAP are updated on a weekly basis in within UHL via the Cancer Action Board and Tumour site performance meetings, further reviewed monthly at the CA/RTT Working Group to provide appropriate assurances around improved sustainable delivery of the National Cancer Standards.

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	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