

# Integrated Performance Report

Trust Board paper G

## Executive Summary from CEO

### Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	X
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	X
Noting	For noting without the need for discussion	

### Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)		
Executive Board		Discussion and Assurance
Trust Board Committee		Discussion and Assurance

## Context

This report provides a high level summary of the Trust's performance against the key quality and performance metrics, together with a brief commentary where appropriate. This complements the full Integrated Performance Report and the exception reports within that which are triggered automatically when identified thresholds are met. The exception reports contain the full detail of recovery actions and trajectories where applicable. Note that the definition of "Good News" and "Performance Challenges" is for headline reporting purposes only and the full IPR should be consulted when determining any action required in response. The full IPR should also be consulted to monitor the initial impact of COVID-19 and the national restrictions on activity and social distancing.

## Question

1. What is the Trust performance against the key quality and performance metrics.

## Conclusion

### Good News:

- **Mortality** – the latest published SHMI (period May 2020 to April 2021) is 105 but remains within the expected range.

- **MRSA** – 0 cases reported.
- **C DIFF** – 8 cases reported this month.
- **VTE** – compliant at 98.6% in September.

### **Performance Challenges:**

- **Never Event** – 2 Reported in September.
- **ED 4 hour performance (including LLR UCCs)** – 68.0% reported in September.
- **12 hour trolley wait** - 148 breaches reported.
- **Ambulance Handover 60+ minutes (CAD)** – performance at 22.0%.
- **Cancer Two Week Wait** was 76.4% in August against a target of 93%.
- **Cancer 62 day backlog** was 383 patients at the end of September.
- **Cancer 62 day treatment** was 52.2% in August against a target of 85%.
- **Referral to treatment** – the number on the waiting list (now the primary performance measure) was above the target and was 103,404 patients at the end of September
- **52+ weeks wait** – 12,658 breaches reported in September.
- **Diagnostic 6 week wait** was 44.8% against a target of 1% in September.
- **Cancelled operations OTD** – 2.0% reported in September.
- **Statutory and Mandatory Training** is at 90%.
- **Annual Appraisal** is at 79.9%.

## **Input Sought**

I recommend that the Committee:

- Commends the positive achievements noted under Good News
- Note the areas of Performance Challenges and consider by reference to the IPR and topic-specific reports if the actions being taken are sufficient.

### ***For Reference:***

**This report relates to the following UHL quality and supporting priorities:**

#### **1. Quality priorities**

Safe, surgery and procedures	[Yes / <del>No</del> / <del>Not applicable</del> ]
Safely and timely discharge	[Yes / <del>No</del> / <del>Not applicable</del> ]
Improved Cancer pathways	[Yes / <del>No</del> / <del>Not applicable</del> ]
Streamlined emergency care	[Yes / <del>No</del> / <del>Not applicable</del> ]
Better care pathways	[Yes / <del>No</del> / <del>Not applicable</del> ]
Ward accreditation	[Yes / <del>No</del> / <del>Not applicable</del> ]

#### **2. Supporting priorities:**

People strategy implementation	[Yes / <del>No</del> / <del>Not applicable</del> ]
Estate investment and reconfiguration	[Yes / <del>No</del> / <del>Not applicable</del> ]
e-Hospital	[Yes / <del>No</del> / <del>Not applicable</del> ]
More embedded research	[Yes / <del>No</del> / <del>Not applicable</del> ]
Better corporate services	[Yes / <del>No</del> / <del>Not applicable</del> ]

Quality strategy development

[Yes /No /Not applicable]

**3. Equality Impact Assessment and Patient and Public Involvement considerations:**

- What was the outcome of your Equality Impact Assessment (EIA)?  
**Not applicable as purely data reporting.**
- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required  
**Not applicable as purely data reporting. What to measure is determined nationally or through priorities.**
- How did the outcome of the EIA influence your Patient and Public Involvement ?  
**N/A**
- If an EIA was not carried out, what was the rationale for this decision?  
**As above.**

**4. Risk and Assurance**

**Risk Reference:**

Does this paper reference a risk event?	Select (X)	Risk Description:
<b>Strategic:</b> Does this link to a <i>Principal Risk</i> on the BAF?	X	Failure to deliver key performance standards for emergency, planned and cancer care.
<b>Organisational:</b> Does this link to an <i>Operational/Corporate Risk</i> on Datix Register		
<b>New Risk</b> identified in paper: What <i>type</i> and <i>description</i> ?		
<b>None</b>		

5. Scheduled date for the **next paper** on this topic: 2<sup>nd</sup> December 2021

6. Executive Summaries should not exceed **5 sides** My paper does comply



# Integrated Performance Report

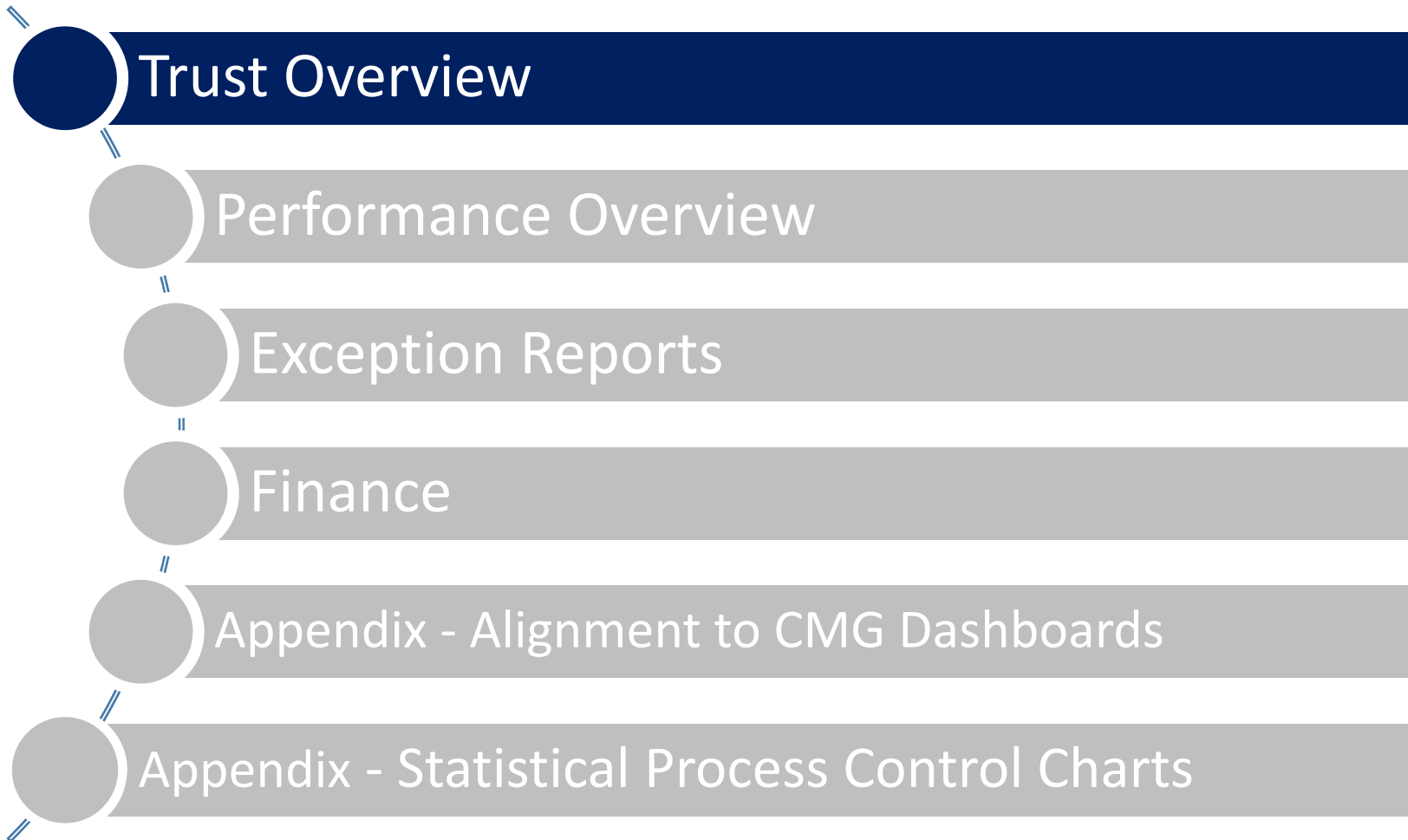
September 2021



Operational Delivery Unit

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# Trust Overview (Year to Date)

Safe	Caring	Well Led	Effective	Responsive Emergency Care	Responsive Elective Care	Responsive Cancer Care
Never Events	Inpatient and Day Case F&F Test % Positive	Staff Survey Recommend for Treatment	Mortality Published SHMI	ED 4 Hour Waits Acute Footprint	Long Stay Patients > 21 days	2WW
% of all Adults VTE Risk Assessment on Admission	A&E F&F Test % Positive	Staff Survey % Recommend as Place to Work	Mortality 12 months HSMR	Mean Time to Initial Assessment	RTT Incompletes	62 Day Backlog
No. of 3rd & 4th Degree Perineal Tears	Maternity F&F Test % Positive	Sickness Absence (Excludes E&F staff)	Crude Mortality Rate	12 Hour Trolley Waits in A&E	RTT 52+ Weeks	62 Day
Clostridium Difficile	Outpatient F&F Test % Positive	% of Staff with Annual Appraisal (Excludes E&F staff)		Time Clinically Ready to Proceed	RTT 104+ Weeks	
MRSA Total		Statutory and Mandatory Training		Ambulance Handover > 60 mins	6 Week Diagnostic	
E. Coli Bacteraemias Acute		Nursing Vacancies			% Operations Cancelled On the Day	
MSSA Acute					% Outpatient DNA Rate	
All Falls Reported per 1000 Bed Days					% Outpatient Non Face to Face	
HAPU - All categories						

Key

  Failing Target

  Achieving Target

  Target TBC

# Trust Overview (Current Month)

Safe	Caring	Well Led	Effective	Responsive Emergency Care	Responsive Elective Care	Responsive Cancer Care
Never Events	Inpatient and Day Case F&F Test % Positive	Staff Survey Recommend for Treatment	Mortality Published SHMI	ED 4 Hour Waits Acute Footprint	Long Stay Patients > 21 days	2WW
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  Failing Target

  Achieving Target

  Target TBC



# Trust Overview (Current Month)

Domain	Overview , Risks and Actions	Lead
<b>Overview</b>		CEO
<b>Safe</b> (exception reports pages 19-22)	The Trust has had 2 Never Events in September. Appropriate immediate actions have been taken but full investigations to identify further learning are taking place. A Never Event reduction plan has been discussed at the Executive Team meeting and with System colleagues – a detailed action plan will be presented to the November Quality Committee. The trust-wide Time to Train half day on 13 October focused on Safer Surgery & Interventional Procedures and Never Event learning.	Andrew Furlong / Carolyn Fox
<b>Caring</b> (exception reports page 23)	Friends and Family Test ED – The Trust has seen a decline in percentage of ‘recommend responses’ in recent months, this is in line with the national picture due to the challenges in wait times and delays within the department. The Emergency Department senior team review any comments received and action where possible. The ICS winter plans to reduce throughput through the Emergency Department should have a positive effect on the patient experience results.	Carolyn Fox
<b>Well Led</b> (exception reports pages 24-30)	Sickness levels are 2.67% over target for August (reporting is one month in arrears) and 3.03% over target over a 12 month cumulative period – largely driven by increases in COVID-19 absence and absence relating to stress and anxiety. There are risks of increased absence resulting from RSV and cold and flu and intensive work pressures with actions to support the health and well being of staff and intensive vaccination programmes. Appraisal rates are 15.1% below target and at risk because of work pressures, rates are reviewed as part of the Performance Review meetings. Statutory and Mandatory training is 5% below target with frequent automated reminders and links to pay progression in place. Nursing and midwifery vacancies are slightly above target with increased leavers in August and Sept. International and domestic recruitment and supportive education programmes are in place to reduce the gap. Paediatric nurse vacancies in the Emergency Dept are being mitigated with focused recruitment of international nurse recruitment with arrivals due in November. We have seen positive reductions in health care support worker vacancies	Hazel Wyton
<b>Effective</b> (exception reports pages 31)	The Trust continues to actively review all deaths through its Medical Examiners and Mortality Review Committee to identify potential learning. Our Summary Hospital-level Mortality Indicator (SHMI) remains within expected. The Board have previously been advised of the actions that have been taken to review our Hospital Standardised Mortality Ratios (HSMR). Our crude mortality rate remains below the national average and our in month HSMR is now below 100 but our 12 month rolling HSMR while reducing, will remain above expected for some time yet linked to the two peaks in deaths associated with the COVID pandemic.	Andrew Furlong
<b>Responsive – Emergency</b> (exception reports pages 32-38)	Emergency Department (ED) attendances during September 2021 are 9% higher than September 2019 (equates to 58 additional patients a day). September 2021 was the busiest month the ED has seen, with more patients treated than in previous winter months (traditionally the busiest months). Four of the top 10 busiest days in ED occurred in September, all were on a Monday. The UHL (Type 1 and 2) performance for September was at 56.8% and final performance for UHL and LLR was 68.0%. National ranking for the month was 97. Ambulance handovers are at 84% of September 2019 number, ranging between 119 and 173 a day. Ambulance handovers greater than 60 minutes are 22.0%.	Debra Mitchell
<b>Responsive – Elective</b> (exception reports pages 39-45)	September has been a very challenging month for elective care, in particular with the requirement to increase Intensive Care capacity to 120% which has led to a reduction in the elective theatre sessions we have been able to run. The focus has remained on the clinical urgent and cancer patients which in turn has led to an increase in long waiting (52+ and 104+) patients. There is the risk this will carry on within October and further impact of the emergency demand with the requirement to use elective bed bases to support this. A detailed Elective recovery plan is been developed supported from the achievement of the elective recovery fund which will focus on reducing the amount of patients waiting over 104+ weeks. External validation team has started within September who will be validating the elective waiting list over the coming months.	Debra Mitchell
<b>Responsive – Cancer</b> (exception reports pages 46-48)	Cancer delivery and performance has been and remains a key priority for UHL . In August UHL achieved 3 standards against the National targets, 31 Day Drugs, Faster Diagnosis Standards, Breast and 2WW. Our biggest challenges remain 2ww capacity, with a 19% increase in referrals and a reduction in capacity due to Infections Prevention Control and workforce . The 62 day waits continue to increase with a decline in performance of 52.2% and a growing 62 day backlog. This is due to the reduction in theatre and recovery capacity, pressures within emergency activity impacting on elective beds and elective theatre capacity. Updated trajectories are in place for all tumour sites with Recovery Action Plans . Monthly tumour sites meetings with the CMG and tumour site leads in place to gain assurance , identify opportunities and provide support.	Debra Mitchell
<b>Financial Improvement</b> (exception reports)	The Trust has reported a H1 surplus of £5.4m; this is a £1m favorable variance to the forecast surplus of £4.4m at Month 5. The plan for H1 was breakeven, and the positive variance to plan is in summary due to pay and non-pay underspends due to lower activity than planned and over delivery of CIP. The Trust maintained a strong cash position at the end of September (£91m).	Simon Lazarus

- Trust Overview
- Performance Overview**
- Exception Reports
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# Performance Overview (Safe)

Domain	KPI	Target	Jul-21	Aug-21	Sep-21	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Safe	Never events	0	1	1	2	6				Jan-20	MD
	% of all adults VTE Risk Assessment on Admission	95%	98.7%	98.7%	98.6%	98.7%				Oct-20	MD
	% of 3rd & 4th Degree Perineal Tears	3.5%	1.9%	3.0%	3.5%	2.9%				N/A	CN
	Clostridium Difficile	91	9	10	8	48				Jun-21	CN
	MRSA Total	0	0	0	0	0				Jun-21	CN
	E. Coli Bacteraemias Acute	198	8	15	15	81				Jun-21	CN
	MSSA Acute*	40	6	4	3	27				Jun-21	CN

\* quality improvement ambition 2.5% reduction of 19/20 numbers

Comments	Rating
<p>The Trust has had 2 Never Events in September. Appropriate immediate actions have been taken but full investigations to identify further learning are taking place. A Never Event reduction plan has been discussed at the Executive Team meeting and with System colleagues – a detailed action plan will be presented to the November Quality Committee. The trust-wide Time to Train half day on 13 October focused on Safer Surgery &amp; Interventional Procedures and Never Event learning.</p> <p>In month trajectory target has been achieved, all C difficile cases are reviewed through a root cause analysis methodology and against best practice. Higher antibiotic prescribing due to both Covid19 and other infections is monitored and reviewed. To be noted is the revised 2021/22 Trust target of 91 cases which is a reduction of 15 from the previous target.</p> <p>MSSA is an internal quality improvement reduction of 2.5% from 2019/20 year end total. MSSA predominantly relates to surgical site infections and cannula infections, monitoring and review of practice is being discussed at CMG Infection Prevention Operational groups and through the Trusts Infection Prevention and Control committee. Actions to reduce the infection rates and campaigns such as Every Action Counts formulate part of the quality improvement plan.</p>	

# Performance Overview (Safe)

Domain	KPI	Target	Jul-21	Aug-21	Sep-21	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Safe	COVID-19 Hospital-onset, probable, 8-14 days after admission		1.4%	4.2%	1.7%	2.5%				Oct-20	CN
	COVID-19 Hospital-onset, healthcare-acquired, 15 or more days after admission		2.5%	4.2%	2.0%	2.8%				Oct-20	CN
	All falls reported per 1000 bed days	5.5	3.7	4.0		4.0				Oct-20	CN
	Rate of Moderate harm and above Falls PSIs with finally approved status per 1,000 bed days	0.18	0.10	0.04		0.07				Oct-20	CN
	HAPU - All categories*	366	28	41	47	273				Jun-21	CN

\*note quality improvement ambition 50% reduction of 20/21

Comments	Rating
A reduction of 50% for Hospital Acquired Pressure Ulcers (HAPU's) is an internal quality improvement ambition, this has been translated into a monthly trajectory target. A Trust wide Quality Improvement collaborative, supported by the transformation team, commences in December this 12 month collaborative will support the reduction work that has started via the Pressure Ulcer Steering Group and will be monitored through the group chaired by the Chief Nurse.	

# Performance Overview (Caring)

Domain	KPI	Target	Jul-21	Aug-21	Sep-21	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead	
Caring	Single Sex Breaches	Reporting will commence once national reporting resumes									Mar-20	CN
	Inpatient and Day Case F&F Test % Positive*	95%	98%	98%	98%	98%				Mar-20	CN	
	A&E F&F Test % Positive*	84%	82%	81%	75%	83%				Mar-20	CN	
	Maternity F&F Test % Positive*	91%	95%	95%	95%	96%				Mar-20	CN	
	Outpatient F&F Test % Positive	94%	94%	94%	94%	94%				Mar-20	CN	
	% of Complaints Responded to in Agreed Timeframe	Reporting will commence 2022. This is due to ongoing work to reduce backlog as a result of COVID-19.									N/A	CN

\* Targets are based on national averages between December 2020 and August 2021

Comments	Rating
Friends and Family Test ED (FFT) – The Trust has seen a decline in percentage of ‘recommend responses’ in recent months, this is in line with the national picture due to the challenges in wait times and delays within the department. The Emergency Department (ED) senior team review any comments received and action where possible. The Integrated Care System (ICS) winter plans aim to reduce throughput through the Emergency Department should have a positive effect on the patient experience results.	

# Performance Overview (Well Led)

Domain	KPI	Target	Jul-21	Aug-21	Sep-21	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead	
Well Led	Staff Survey % Recommend as Place to Work	Reporting will commence once national reporting resumes									Data sourced externally	CPO
	Staff Survey % Recommend as Place for Treatment	Reporting will commence once national reporting resumes									Data sourced externally	CPO
	Turnover Rate	10%	8.1%	8.2%	8.3%	8.3%				Nov-19	CPO	
	Sickness Absence (Excludes E&F staff)	3%	5.8%	5.7%		5.0%				Mar-21	CPO	
	% of Staff with Annual Appraisal (Includes E&F staff from May 21)	95%	81.9%	80.8%	79.9%	79.9%				Mar-21	CPO	
	Statutory and Mandatory Training	95%	92%	91%	90%	90%				Feb-20	CPO	

Comments	Rating
<p>Sickness levels are 2.67% below target for August (reporting is one month in arrears) and 3.03% over target over a 12 month cumulative period – largely driven by increases in COVID-19 absence and absence relating to stress and anxiety. There are risks of increased absence resulting from RSV and cold and flu and intensive work pressures with actions to support the health and well being of staff and intensive vaccination programmes. Appraisal rates are 15.1% below target and at risk because of work pressures, rates are reviewed as part of Performance Review Meetings (PRMs). Statutory and Mandatory training is 5% below target with frequent automated reminders and links to pay progression in place.</p> <p>Key Actions Next Month:</p> <ul style="list-style-type: none"> <li>To intensify the health and well being support utilising the system wide health and well being hub</li> <li>To review the appropriateness of sickness targets given increased sickness and in the context of benchmarking</li> <li>To continue to performance manage appraisal completions through PRMs and continue simplified process</li> <li>To continue to performance manage statutory and mandatory training rates through PRMs</li> </ul>	





# Performance Overview (Well Led)

Domain	KPI	Target	Jul-21	Aug-21	Sep-21	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
<b>Well Led</b>	Adult Nursing Vacancies	10%	New indicators - reporting commenced in September		11.2%	11.2%				Dec-19	CPO
	Paed Nursing Vacancies	10%			15.7%	15.7%				Dec-19	CPO
	Midwives Vacancies	10%			11.0%	11.0%				Dec-19	CPO
	HCA and support workers - excluding Maternity	10%			10.1%	10.1%				Dec-19	CPO
	HCA and support workers - Maternity	5%			2.6%	2.6%				Dec-19	CPO
	Frontline Staff LFT Engagement	No Target	903	715	619	975.7				N/A	CPO

Comments	Rating
<p>Nursing vacancies are above target with increased leavers in August and Sept. Paediatric nurse vacancies particularly within the emergency department and critical care are a risk given the RSV season and intensive winter pressures. Midwifery vacancies also increased in Aug and Sept as a result of increased retirees. Despite the recruitment of 380 healthcare assistants since October 2020, there remain a number of vacancies with 5-10 HCAs leaving per month with additional Health Care Assistances (HCAs) leaving to commence nurse associate programmes.</p> <p>Actions next month:</p> <ul style="list-style-type: none"> <li>Proactive international recruitment programme with 76 adult nurse arrivals in November and 15 children's to support critical care and ED.</li> <li>Domestic recruitment of circa 60 adult nurses</li> <li>Expansion of education facilities.</li> <li>Further intervention to enable retention</li> <li>Joint international midwifery recruitment plan with Northants</li> <li>Detailed analysis of retirement data and support for retirees into clinical coaching roles.</li> </ul>	

# Performance Overview (Effective)

Domain	KPI	Target	Jul-21	Aug-21	Sep-21	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
<b>Effective</b>	Mortality Published SHMI	100	104	104	105	105 (May 20 to Apr 21)				May-21	MD
	Mortality 12 months HSMR	100	112	112	112	112 Apr 20 to Mar 21				May-21	MD
	Crude Mortality Rate	No Target	1.2%	1.4%	1.4%	1.3%				May-21	MD

Comments	Rating
<p>The Trust continues to actively review all deaths through its Medical Examiners and Mortality Review Committee to identify potential learning. Our Summary Hospital-level Mortality Indicator (SHMI) remains within expected. The Board have previously been advised of the actions that have been taken to review our Hospital Standardised Mortality Ratios (HSMR). Our crude mortality rate remains below the national average and our in month HSMR is now below 100 but our 12 month rolling HSMR while reducing, will remain above expected for some time yet linked to the two peaks in deaths associated with the COVID pandemic.</p>	



# Performance Overview (Responsive Emergency Care)

Domain	KPI	Target	Jul-21	Aug-21	Sep-21	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Responsive (Emergency Care)	ED 4 hour waits Acute Footprint	95%	72.6%	68.5%	68.0%	72.1%				Data sourced externally	COO
	Mean Time to Initial Assessment	15	26	35.8	39.5	30				TBC	COO
	12 hour trolley waits in A&E	0	84	35	148	267				Mar-20	COO
	Number of 12 hour waits in the Emergency Department	0	979	1442	1669	5529				TBC	COO
	Time Clinically Ready to Proceed	60	150.3	151.3	187.6	134				TBC	COO
	Ambulance handover >60mins	0%	18.8%	24.5%	22.0%	14.2%				Data sourced externally	COO
	Long Stay Patients (21+ days)	135	179	195	207	207				Sep-20	COO

## Comments

Emergency Department (ED) attendances during September 2021 are 9% higher than September 2019 (equates to 58 additional patients a day). September 2021 was the busiest month the ED has seen, with more patients treated than in previous winter months (traditionally the busiest months). Four of the top 10 busiest days in ED occurred in September, all were on a Monday. The UHL (Type 1 and 2) performance for September was at 56.8% and final performance for UHL and LLR was 68.0%. National ranking for the month was 97. Ambulance handovers are at 84% of September 2019 number, ranging between 119 and 173 a day. Ambulance handovers greater than 60 minutes are 22.0%.

Actions next month:

- Projects underway which support include:
- Increasing the use of alternative pathways and ED front door streaming including SDEC
- Maximise the use of the Urgent Treatment Centre at UHL
- Effective board round, reducing Long Length of Stay and increasing pre noon and pre 5pm discharges
- 8 – 10 week improvement plan with NHSE/I focusing on Red2Green and SAFER best practice across wards in medicine
- Implementation of winter efficiency schemes

## Rating

# Performance Overview (Responsive Elective Care)

Domain	KPI	Target	Jul-21	Aug-21	Sep-21	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Responsive Elective Care)	RTT Incompletes	103403	100366	103020	103404	103404				Nov-19	COO
	RTT 52+ weeks	0	11169	11697	12658	12658				Apr-21	COO
	RTT 104+ weeks	0	642	768	1040	1040				TBC	COO
	6 Week Diagnostic Test Waiting Times	1.0%	38.3%	44.1%	44.8%	44.8%				Nov-19	COO
	% Operations Cancelled On the Day	1.0%	1.4%	1.7%	2.0%	1.2%				Apr-21	COO
	% Outpatient DNA rate	5%	7.6%	7.6%	7.6%	7.1%				Feb-20	COO
	% Outpatient Non Face to Face	45%	39.6%	37.3%	37.2%	40.4%				Feb-20	COO

## Comments

## Rating

During September 2021 UHL has seen deterioration in Elective performance; main factors leading to this are the requirement to increase Intensive Care Capacity, demand growth and emergency pressures. August. As a result, UHL has reported operational OPEL 4 levels on a regular basis. This has led to reduction in elective activity against August. Urgent (P2) numbers have continued to decrease within September and both 52+ and 104+ weeks patient waits have increased. There are a number of key actions taking place to aid recovery of the long waiter performance, these include;

- Super weekend clinics to clinically review patients on the waiting list (e.g. Paediatric Ear Nose and Throat)
- Creation of new theatre capacity via the installation of a Vanguard theatre
- Extension of Waiting List Initiative payments (WLI)
- Commissioning of additional capacity via insourcing models.
- A team of 9 validators and 1 supervisor from Source Group started with the Trust on August 23rd This is in order to support elective waiting list validation to assist in waiting list size reduction. With additional 6 validators starting on October 4th.
- Rolling out rapid expansion of Patient Initiated Follow Up & switching off of Open Appointments and application of cost out efficiency modelling to all specialties.

# Performance Overview (Responsive Cancer)

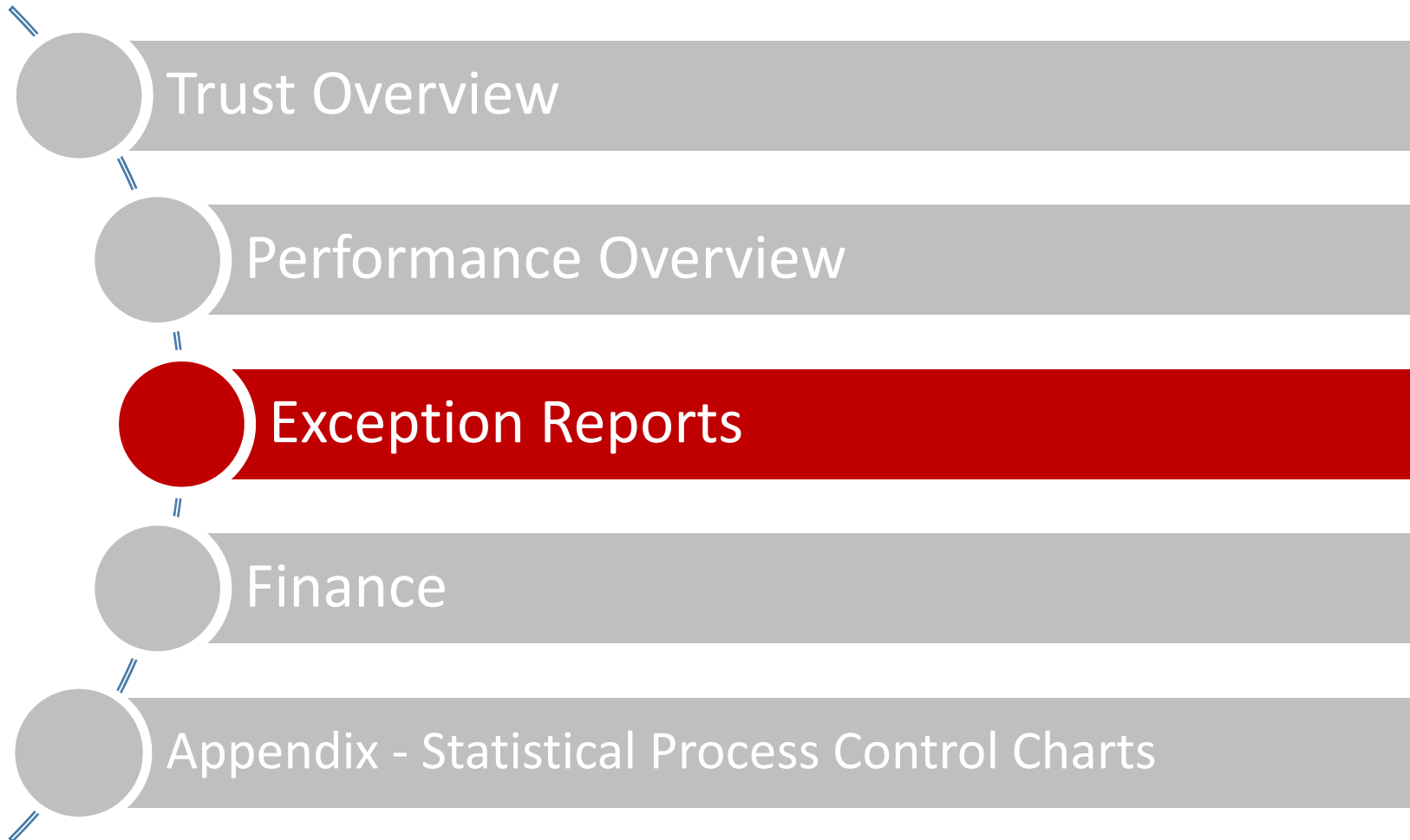
Domain	KPI	Target	Jul-21	Aug-21	Sep-21	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Responsive (Cancer)	2WW	93%	65.6%	76.4%		77.9%				Dec-19	COO
	62 Day Backlog	0	228	361	383	383				Dec-19	COO
	Cancer 62 Day	85%	57.9%	52.2%		61.6%				Dec-19	COO

Comments	Rating
<p>With the exception of 31 Day Drugs, Faster Diagnosis Standard (FDS) 2WW and FDS Breast all standards are under performing. 2WW remains challenged with a 19% increase in referrals against pre-pandemic levels at the time of reporting, significant increases seen in Breast, Haematology, Head &amp; Neck, Sarcoma, Skin and Upper GI. Combining the increased demand with capacity issues in all tumour sites affected, this puts at risk the delivery of the 2WW standard for the foreseeable future. The 62 day standard continues to see a deterioration in performance. Noting the capacity constraints for elective activity and the increase demand in emergency activity. There is a National Directive for the 62 day backlog to be back at the Trusts position in February 2020, for UHL this was 144 patients. Current forecast position will be 224 patients waiting by March 2022, a gap of 80 patients to achieve national requirement.</p> <p>Key Focus for next month:</p> <ul style="list-style-type: none"> <li>• Refreshed recovery action plans and trajectories by CMG tumour sites to improve performance and deliver standards.</li> <li>• A paper will be presented to CCG Clinical Executive Group highlighting the need for GP practices to ensure that physical face to face examinations of patients are undertaken, with some caveats, prior to all 2WW referrals to ensure that all pre-referral data is collected and transferred.</li> <li>• Work closely with elective and diagnostic leads to ensure cancer and clinically urgent patients are prioritised</li> <li>• National Recovery Funded Projects EMCA/H1/H2 identified. To ensure robust governance arrangements to deliver initiatives, project management support and commence plans for implementation including:             <ul style="list-style-type: none"> <li>- 2WW pathways - Prostate Triage</li> <li>- Skin Analytics community based diagnostic hub to reduce 2WW referrals</li> <li>- SACT transformation to expand capacity in chemotherapy, immunology and pharmacy</li> <li>- 2WW Referral Management of Lower GI Pathway and Breast pathway</li> </ul> </li> <li>• WLI, outsourcing activity, utilisation of the IS,</li> </ul>	

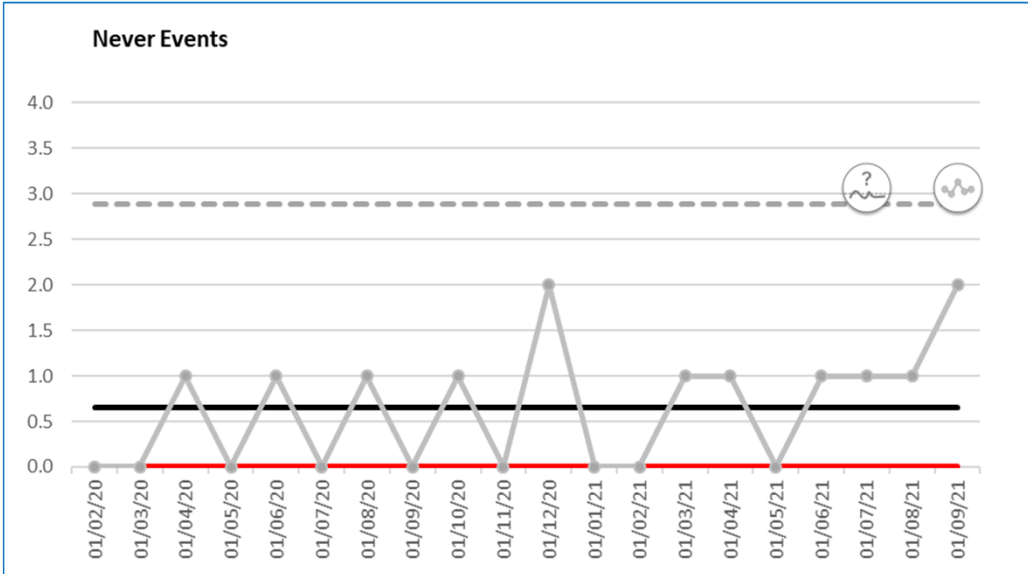
# Performance Overview (Finance)

Domain	KPI	Target	Jul-21	Aug-21	Sep-21	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Finance	Trust level performance against target	£3.3m		£2.6m	-£1.6m	£5.4m				N/A	CFO
	Capital expenditure against plan	£22.4m		£1.7m	£2.6m	£22.5m				N/A	CFO
	CIP	£4.8m		£2.9m	£1.2m	£8.4m				N/A	CFO
	Cashflow	No Target		-£0.3m	-£9.3m	£91.0m				N/A	CFO

Comments	Rating
<p>The Trust has reported a H1 surplus of £5.4m; this is a £1m favorable variance to the forecast surplus of £4.4m. The plan for H1 was breakeven, and the positive variance to plan is due to pay and non-pay underspends due to lower activity than planned and over delivery of CIP.</p> <p>Month 6 Year to Date (YTD) capital expenditure was £22.5m against a YTD forecast of £25.8m, representing an underspend against forecast of £3.3m. The Trust's 2021/22 capital forecast is £72.4m, funded from a combination of internally generated funding - depreciation (£43.6m); centrally funded PDC (£15.5m); the disposal of Hospital Close asset (£10.1m); and Charitable Funds (£2.4m).</p> <p>The Trust maintained a strong cash position at the end of September (£91m). Cash reserves reduced by £10.5m in September, as a consequence of making payment of the pay award arrears and settlement of Flowers holiday pay liabilities (£6.6m) and the first PDC dividend payment (£7.6m).</p>	



# Safe – Never Events



Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
2	6	0			

### National Position & Overview

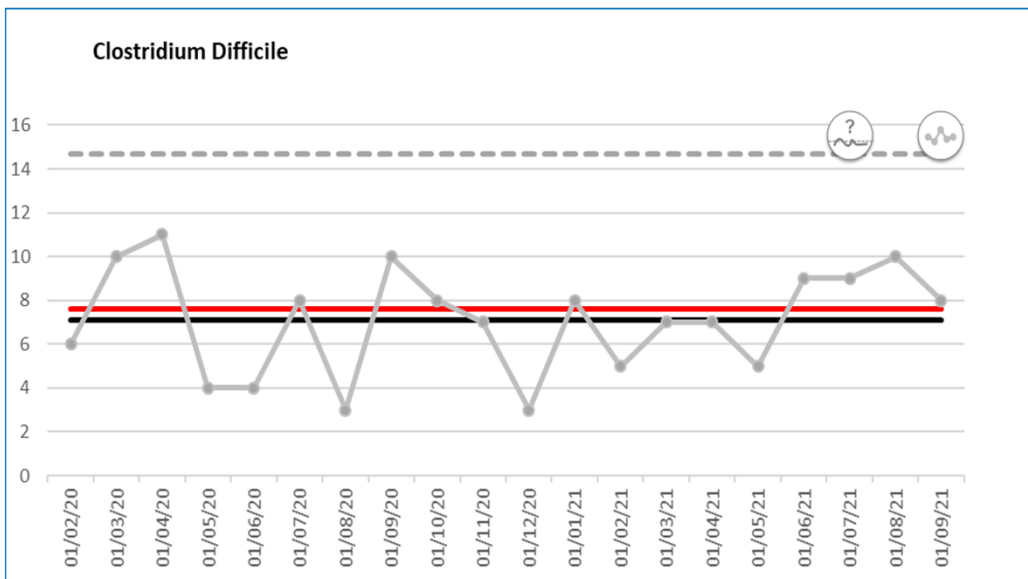
131 Never events have been reported nationally between April and July of this year although the numbers are subject to change as local investigations are completed.

UHL have reported 6 Never Events in 2021/2022 so far. In 2020/2021 UHL reported 7 Never Events in total and in 2019/2020 UHL reported 2 Never Events in total.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li><b>Never Event – Wrong Site Surgery</b> -Wrong site pan retinal photo-coagulation in Ophthalmology Outpatients Department</li> <li><b>Never Event – Retained Foreign Object Post Procedure</b> - Retained vaginal swab in LGH Delivery Suite</li> </ul>	<ul style="list-style-type: none"> <li>Internal notice circulated by Laser Lead Consultant</li> <li>Both acute sites and the low risk community settings have been informed of the event</li> <li>Item included on daily team huddles regarding this incident to increase awareness of the agreed pathway to only use LARGE swabs for perineal suturing</li> <li>Checking being carried out in all maternity sites to ensure no small/medium swabs are available in delivery rooms</li> <li>Communications to all staff regarding the importance of using large swabs and ensuring that an accurate swab count takes place before, during and after procedures.</li> </ul> <p>WIDER TRUST ACTIONS:</p> <ul style="list-style-type: none"> <li>Complete Recruitment into the Band 7 Quality Improvement roles to support the Safe Surgery programme.</li> <li>All services that undertake invasive procedures to be submitting monthly audits with universal engagement.</li> <li>Accelerate development of the QlikSense dashboard. This will be used in CMG PRMs to give assurance around engagement</li> <li>Quality Assurance visits to procedural areas to commence with improvement plans developed as necessary.</li> <li>Focused visits to areas that have had Never Events to gain assurance that actions have been embedded.</li> <li>Quality and Safety half day on 13.10. 2021 had a theme of Never Event reduction and Safe Surgery.</li> <li>Development of a revised Never Event reduction action plan to include thematic analysis of recent Never Events – due to be presented to EQB Nov 2021. This will have system involvement</li> </ul>	<ul style="list-style-type: none"> <li>No immediate harm or damage to the patient’s vision. Full RCA has been commenced with anticipated deadline of 03.12.21</li> <li>Patient was treated with antibiotics by GP and suffered minor harm. Full RCA has been commenced with anticipated deadline of 01.12.21</li> <li>Revised Never Event reduction action plan– due to be presented to EQB on 09.11.21</li> </ul>



# Safe – Clostridium Difficile



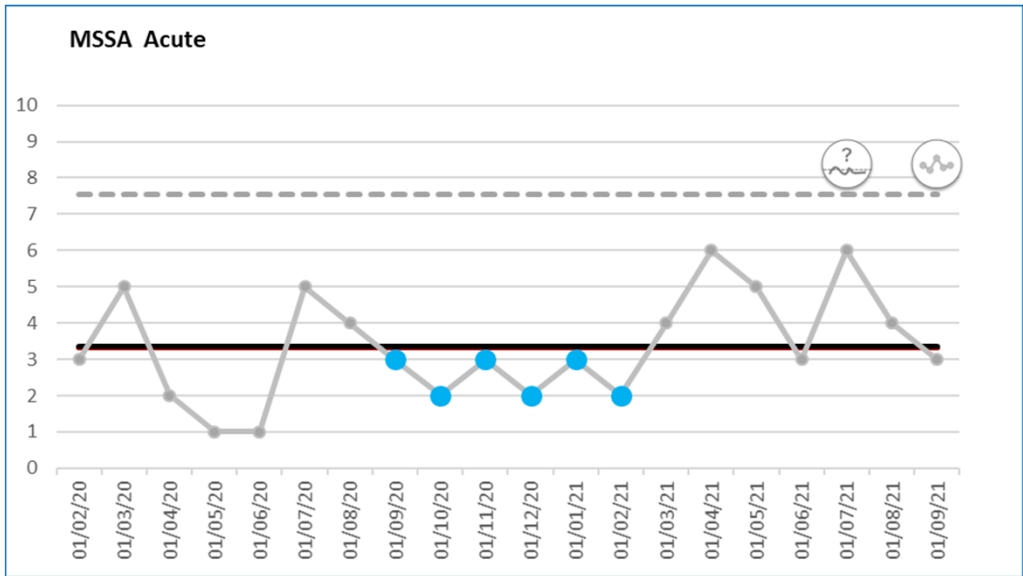
Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
8	48	91	8	8	8

### National Position & Overview

The rate of C. Difficile infection counts of hospital onset-healthcare associated cases per 100,000 bed days are, lower for UHL (10.9) compared with the national average (18.1) for last 12 months of published data (Aug 20 – Jul 21). UHL ranked 29 out of 139 trusts that submitted data and 1st out of it's 18 peers. Source fingertips.phe.org.uk UHL's low rates of C. difficile reflect the impact of robust infection prevention practice including the C. difficile Nurse role.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>The Trust remains challenged by high bed occupancy rates (a well recognised risk factor for increased risk of C. difficile infection) and high antibiotic prescribing linked to Covid 19 infections, compounded by a conflicting priority demand on single rooms for isolation of infectious patients.</li> </ul>	<ul style="list-style-type: none"> <li>Monitor and review antimicrobial prescribing is in line with UHL policy, present at TIPAC</li> <li>Design and launch of new source isolation posters for patients in single rooms</li> <li>Every C. difficile case is reviewed through root cause analysis (RCA) best practice feedback is given to each area</li> <li>Adherence to good infection prevention practice in clinical areas monitored through Infection Prevention Operational Group within CMG inclusive of shared learning from RCA's</li> </ul>	<ul style="list-style-type: none"> <li>Report progress and current trajectory against Trust target at TIPAC</li> </ul>

# Safe – MSSA



Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
3	27	40	3	4	4

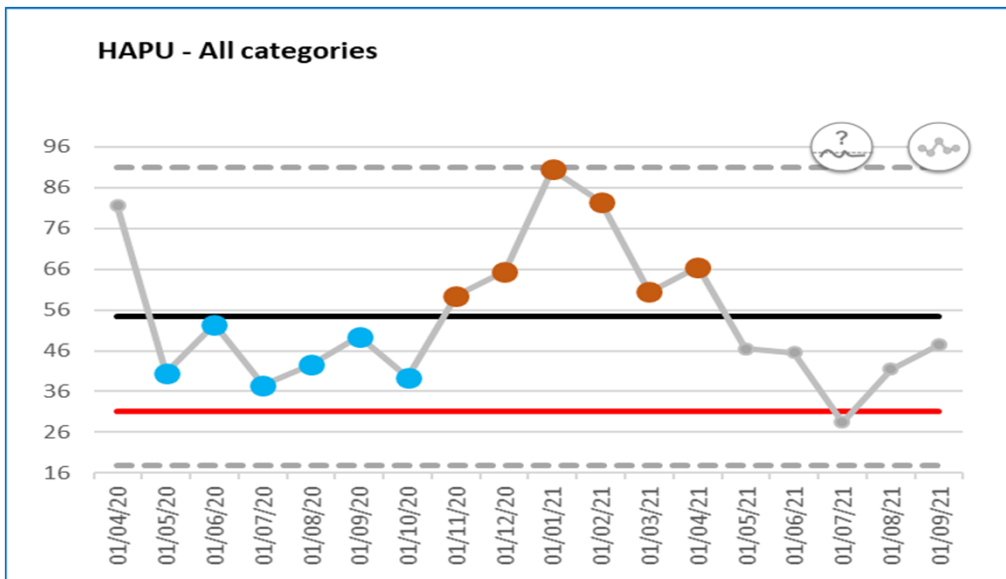
### National Position & Overview

There is no national mandated trajectory for MSSA however internally UHL will be applying a 2.5% reduction stretched reduction target to the final outturn numbers of the year ending 19/20. 2020/21 was not used due to the patient profile being vastly different to the usual elective and non-elective mix.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>Peripheral and Central line infections of the bloodstream</li> <li>Surgical Site Infections</li> </ul>	<ul style="list-style-type: none"> <li>Every Action Counts campaign including standard infection prevention precautions</li> <li>Peripheral and Central line audits to be monitored via CMG Infection Prevention Operational Groups (IPOG) and the Trust Infection Prevention Assurance Committee (TIPAC)</li> <li>Audit evidence of compliance with Infection Prevention assessment through tools such as iFive through the CMG toolkit at IPOG</li> <li>Update training and monitoring of Aseptic Non-Touch Technique (ANTT) practice via IPT and link nurses/midwives</li> </ul>	<ul style="list-style-type: none"> <li>Monitored via IPOGs which meet monthly</li> <li>Review and oversight by TIPAC which meets quarterly</li> </ul>



# Safe – HAPU All Categories



Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
47	273	366	42	37	32

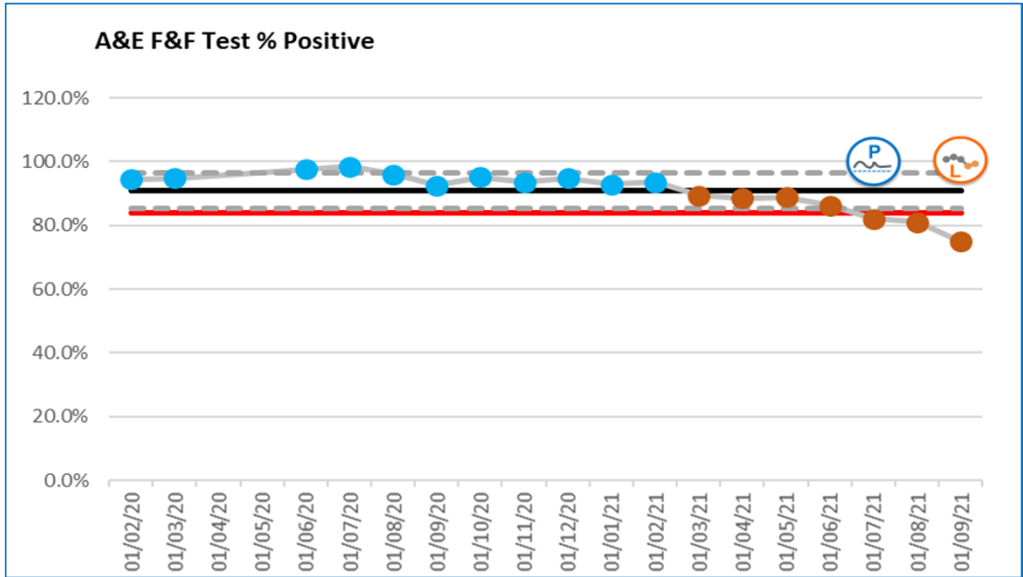
### National Position & Overview

Currently no national benchmarking or reporting.

UHL are part of a pilot with national experts and NHSEI quality team to review the national mechanism of capturing Pressure Ulcer data via the coding system.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>Increased frailty and acuity of patients throughout the pandemic and whilst in restoration/recovery phase coupled with a reduction in staffing resulting in lower than planned shift fill rate, leading to potential inability to undertake planned care and assessment review.</li> </ul>	<ul style="list-style-type: none"> <li>Monthly HAPU Care, Review and Learn meetings chaired by CMGs Heads of Nursing plus Tissue Viability Lead</li> <li>Pressure Ulcer Steering Group review of Improvement plan and sub-group work for key areas – Device related HAPUs</li> <li>Introduction of eLearning role specific module and commencement of a training needs analysis</li> <li>Commencement of a Trust wide Quality Improvement (QI) 'Break-Through Series' improvement collaborative, December 2021</li> </ul>	<ul style="list-style-type: none"> <li>Monthly improvement trajectory by each CMG</li> <li>12 month long break through series</li> </ul>

# Caring – A&E FFT



Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
75%	83%	84%	77%	80%	85%

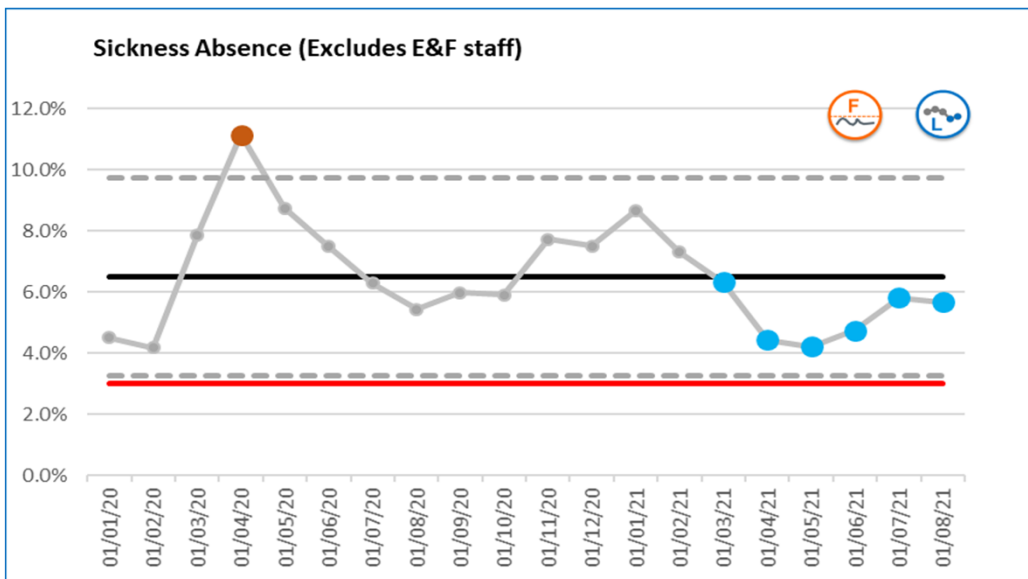
**National Position & Overview**

UHL performance has deteriorated over the past 6 months. Nationally performance has also worsened, the target has been set as 84% which was the average performance over the past 8 months (Jan 21 – Aug 21)

Despite being below the aggregated 6 month average UHL FFT compares favourably against the month on month national picture and when benchmarked against our peers UHL were 3<sup>rd</sup> best in August.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>Increased attendances and longer wait times for patients which mirrors the national figure.</li> <li>There has been a gradual reduction in respondents following the initial increase with the introduction of SMS text collection methodology</li> </ul>	<ul style="list-style-type: none"> <li>Review comments to identify themes for immediate improvement actions</li> <li>Enhance communication with patients regarding current delays in the department</li> <li>Enact the ICS winter plans which plan to reduce attendance and delays for inpatient beds through improved discharges</li> <li>Review and introduce ways to increase response rates</li> </ul>	<ul style="list-style-type: none"> <li>Improved patient satisfaction results</li> <li>FFT data reviewed and actions taken are shared through PIPEAC</li> </ul>

# Well Led – Sickness



Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
5.7%	5.0%	3%	6.2%	6.5%	7%

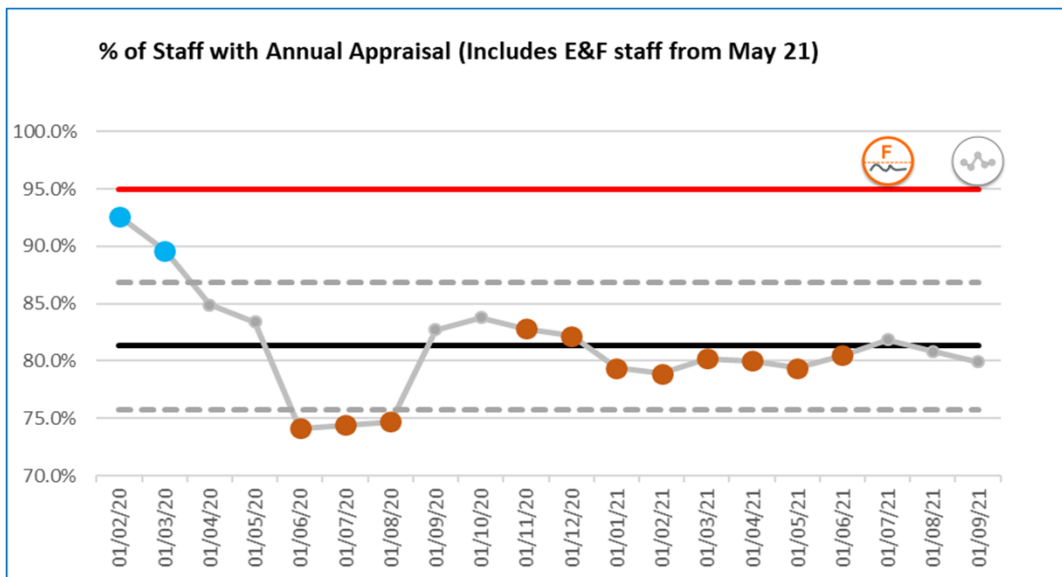
### National Position & Overview

Peer data not currently available. Benchmarking data being sourced for incorporation/ comparison.

Staff Sickness absences have decreased significantly this financial year compared to the previous year. The current percentage of absences is approximately 1% higher than the year before the COVID-19 pandemic.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>Covid-related absences are continuing as well as a number of absences due to other causes.</li> <li>We have been focusing on non-Covid related absences and have seen a reduction in overall sickness rates since the previous month.</li> <li>Reporting identifies a 2 month time lag for accurate capture and change of approx. 2% retrospectively on data figures.</li> </ul>	<ul style="list-style-type: none"> <li>Flu vaccine and Covid booster vaccines are being promoted.</li> <li>Staff absent due to Long Covid are being supported in line with the Sickness Policy.</li> <li>Focus this month updating and closing absences in a timely way to ensure accurate reporting and timely support for staff.</li> <li>Making it Happen meetings are continuing to support and advise managers.</li> <li>We will be reviewing the reasons for absence via our "Looking After Our People" Group</li> <li>The People Services team continue to review Smart reports and support managers.</li> <li>The current sickness target (3%) is being reviewed in line with other Trusts to ensure it is achievable and realistic.</li> </ul>	<ul style="list-style-type: none"> <li>Sickness is having a significant impact particularly maintaining safe staffing and keeping staff morale up in our clinical areas.</li> <li>We anticipate a seasonal increase in sickness absence over the coming months</li> <li>The indicative trajectory will be kept under review, to take account of RSV and flu cases</li> <li>Over the next few months, actions to be reviewed to minimise absences, ensure oversight and provide targeted management.</li> </ul>

# Well Led – Appraisals



Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
79.9%	79.9%	95%	80%	83%	85%

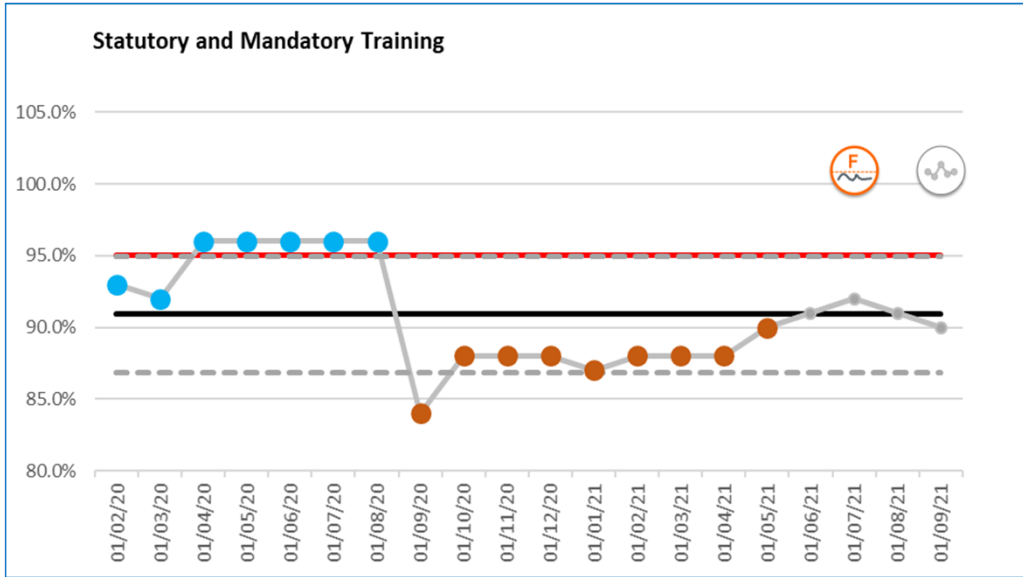
### National Position & Overview

National data not available for reporting.

Appraisals performance has been stable this financial year following a significant decline in performance last year due to COVID-19 related pressures.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>It is recognised that performance has been impacted on by Covid-19 and operational pressures/ demand.</li> <li>Furthermore this is compounded by increased staff absence levels.</li> </ul>	<ul style="list-style-type: none"> <li>An alternative approach has been agreed in response to Covid-19 for pressurized areas. People Services Colleagues continue to communicate performance and support managers with implementing improvements.</li> <li>People Services colleagues continue to send out details of outstanding appraisal to all areas for urgent line by line review/update.</li> <li>CMGs and Corporate areas have agreed trajectories on recovery and timeframes. Performance against trajectories is being monitored via Executive Corporate and CMG Performance Reviews</li> </ul>	<ul style="list-style-type: none"> <li>Reviewed through the Making it All Happen reviews chaired by CMG / Directorate leadership teams with support from HR. This is a meeting with each line manager to review sickness, appraisals and S&amp;MT compliance.</li> <li>CMGs and Corporate directorates have been asked to submit their trajectory to achieve 95% .</li> </ul>

# Well Led – Statutory and Mandatory Training



Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
90%	90%	95%			

**National Position & Overview**

National data not available for reporting.

Performance has declined over the past two months following an improvement this summer.

Root Cause	Actions	Impact/Timescale
It is recognised that performance has been impacted on by Covid-19 and operational pressures/ demand. Furthermore this is compounded by increased staff absence levels and peaks in recruitment with 2 intakes of doctors in training.	<p>People Services Colleagues continue to communicate performance and support managers with implementing improvements to their compliance.</p> <p>Performance against trajectories is being monitored via Executive Corporate and CMG Performance Reviews. This is complimented by access for 2000 managers to the compliance reports for local level prioritising of release for training completions.</p> <p>Subject Matter Experts whose training is lower than the target have been contacted to support raising compliance and manage their risks.</p>	Reviewed through the Making it All Happen reviews chaired by CMG / Directorate leadership teams with support from HR. This is a meeting with each line manager to review sickness, appraisals and S&MT compliance.

# Well Led – Adult Nursing Vacancies

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>During 2020/21, the UHL vacancy rate for Nursing &amp; Midwifery registrants has remained fairly static in line with the national position, possibly as a result of the pandemic interrupting recruitment and individuals delaying leaving / retirement plans in order to support colleagues &amp; the NHS. Over the last couple of months (Aug/Sept) we have seen an increase in leavers, mainly retirees.</li> <li>Three month forecast (Oct-Dec) remains static as we need more analysis into retirees. Also, international nurses arriving in Nov'21 and newly qualified UK nurses will not be working as registrants until Jan'22</li> </ul>	<ul style="list-style-type: none"> <li>System support (3.1 million pounds) for International Nurse Recruitment. Our target was 245 nurses by March 31st 2021, but we are slightly above trajectory but this will support possible attrition later in the year (but still working within financial envelope).</li> <li>Domestic recruitment active with local employment of newly qualified nurses Oct to Jan'22 (circa 60 headcount)</li> <li>New marketing campaign commenced, focusing on UHL providing a positive practice environment for all nurses and midwives who come to work for our organisation</li> <li>Expansion of teaching facilities in the UHL School of Nursing and Midwifery Practice to accommodate growth in recruitment</li> <li>Specific data analysis to confirm the numbers of retirees over the next 4 months</li> </ul>	<ul style="list-style-type: none"> <li>International Nurse Recruitment arrival dates below. It should be noted that UHL has a 100% OSCE pass rate</li> <li>Aug - 32 nurses arrived. OSCE Test centre postponed some exams due to illness but all nurses should complete OSCE by 28th Oct</li> <li>Sept - 66 nurses arrived (OSCES due 10th to 22nd Nov)</li> <li>Nov - 76 arrivals (OSCES due Dec / Jan)</li> <li>Jan - 40 arrivals (OSCES due March'22)</li> <li>March - 40 arrivals (OSCES due April'22)</li> <li>N.B. UHL is also training 30 overseas nurses in November '21 for Leicestershire Partnership Trust</li> <li>12 adult nurses start in October</li> <li>Revenue to capital funding has been agreed by CMIC to support a two storey modular build adjacent to the School that will provide more classrooms. Build should be complete by Dec 2021.</li> </ul>

Current Performance		
Sep 21	YTD	Target
11.2%	11.2%	10%

Three Month Forecast		
Oct 21	Nov 21	Dec 21
11%	10.5%	10.5%

National Position & Overview
Data from NHS England and NHS Improvement show a vacancy rate for Nursing & Midwifery registrants of 10.3% as at 30 June 2021 (Midlands is 11.2%). This rate is the same as last year (June 2020) acknowledging that recruitment in the NHS has been severely disrupted due to the COVID Pandemic. NHS Digital will publish the next vacancy data set on <b>November 25<sup>th</sup> 2021</b>

# Well Led – Paed Nursing Vacancies

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>The vacancy data includes all paediatric registered nurses (Paeds ED / neonates / EMCHC and Children’s Hospital).</li> <li>There are currently 90wtes paediatric vacancies (15.7%) at end of M6 across several cost centres relative to where the majority of paediatric nurses are coded in respect of NHS occupational codes.</li> <li>Childrens Hospital vacancies reported as 33.9wte. Other cost centres mapping to paediatric nursing amount to 56.2wte vacancies with ED Paed nursing at 27wte vacancies.</li> <li>Vacancy position overall is due to general leavers (not retirees).</li> </ul>	<ul style="list-style-type: none"> <li>Proactive international nurse recruitment of nurses who possess extensive paediatric critical care and ED experience is underway .</li> <li>Additional support for paediatric ED is being sourced in the form of medical students who have the Care Certificate</li> <li>Continuous senior nurse oversight with nursing staff moves to mitigate gaps.</li> <li>Domestic supply of paediatric nurses continues with graduates from DMU being proactively recruited</li> <li>Robust training and preceptorship packages in place to support UK and international paediatric nurses settle into their roles in a safe and supportive way.</li> </ul>	<ul style="list-style-type: none"> <li>In November, 15 nurses for paediatric critical care areas and nine for ED will arrive in UHL and they will complete their OSCE in Dec/Jan</li> <li>Locally trained graduate paediatric nurses will commence employment throughout Nov to Jan ‘22</li> </ul>

Current Performance		
Sep 21	YTD	Target
15.7%	15.7%	10%

Three Month Forecast		
Oct 21	Nov 21	Dec 21
15%	14%	12%

**National Position & Overview**

Data from NHS England and NHS Improvement show a vacancy rate for Nursing & Midwifery registrants of 10.3% as at 30 June 2021 (Midlands is 11.2%). This rate is the same as last year (June 2020) acknowledging that recruitment in the NHS has been severely disrupted due to the COVID Pandemic. NHS Digital will publish the next vacancy data set on **November 25<sup>th</sup> 2021**

# Well Led –Midwives Vacancies

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>In August and September '21 there was an increase in midwifery leavers mainly due to retirements (circa 15wte)</li> <li>Business case for additional midwives incorporating Ockenden / Birthrate plus recommendations supported by LMNS but these posts not yet in establishments but we will be proactively recruiting into these positions</li> </ul>	<ul style="list-style-type: none"> <li>UHL bid submitted to NHSI to support the international recruitment of midwives.</li> <li>UHL working collaboratively with three other Trusts in the Midlands to recruit international midwives (15 for UHL).</li> <li>The midwives will take a midwifery OSCE exam and UHL will be the lead education / OSCE training provider for other Trusts</li> <li>Analysis of data for prospective retirements over the next four months</li> <li>Retaining retirees into clinical coaching roles to support new midwives coming into UHL</li> </ul>	<ul style="list-style-type: none"> <li>Not yet known when international midwifery recruits could land in the UK but anticipate from Spring 2022 – this will be confirmed once outcome of NHSI bid is known. We anticipate this number may grow subject to initial success</li> <li>Domestic supply of newly qualified midwives from DMU is good with graduates commencing in Nov-Jan'22 and another output in the spring of 2022.</li> <li>University of Leicester will have their first output of newly qualified midwives in Sept 2022, so will be encouraging their transition into UHL midwives in their final year at university</li> </ul>

Current Performance		
Sep 21	YTD	Target
11.0%	11.0%	10%

Three Month Forecast		
Oct 21	Nov 21	Dec 21
11%	11%	11%

**National Position & Overview**

Data from NHS England and NHS Improvement show a vacancy rate for Nursing & Midwifery registrants of 10.3% as at 30 June 2021 (Midlands is 11.2%). This rate is the same as last year (June 2020) acknowledging that recruitment in the NHS has been severely disrupted due to the COVID Pandemic. NHS Digital will publish the next vacancy data set on **November 25<sup>th</sup> 2021**



# Well Led – HCA and support workers - excluding Maternity

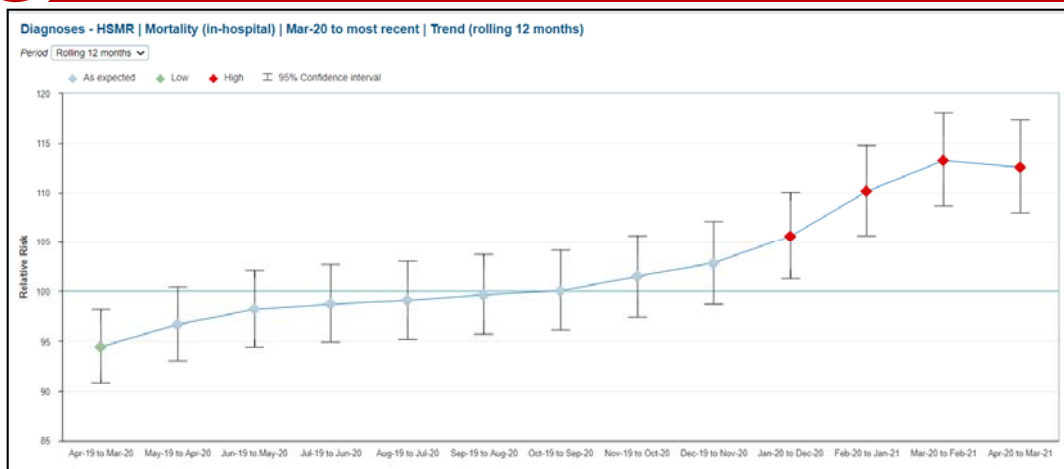
Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>Across England the number of vacant healthcare support worker posts have remained high. In November 2020, a national focus on achieving 'close to zero vacancies as possible' commenced.</li> <li>From October 2020 to Sept 2021, 380 HCAs recruited in UHL who have completed the Care Certificate.</li> <li>Approximately 5-10 HCAs (headcount) leave UHL every month (non-retirees) we have one of the lowest HCA turnover rates in the East Midlands</li> <li>Approximately 50-100 HCAs leave their posts in UHL every year to become apprentice Nursing Associates (through the LLR School of Nursing Associates)</li> </ul>	<ul style="list-style-type: none"> <li>There are pending interviews for circa 130 additional candidates including Theatre Support Assistants and Midwifery Care Assistants.</li> <li>Ongoing recruitment events scheduled for the remainder of the year and into 2022 with more frequent Open Days will be held in order for recruitment teams to manage the flow and pipeline of applicants</li> <li>UHL will be participating in an NHSI Direct Support Programme with a focus on recruitment practices / processes to reduce attrition specifically from the point of job offer to commencement in post.</li> <li>Expansion of teaching facilities in the UHL School of Nursing and Midwifery Practice to accommodate ongoing increase in recruitment</li> </ul>	<ul style="list-style-type: none"> <li>It is anticipated that we should be reporting 50-70wte vacancies by December 2021 noting that there are new posts to be recruited into as a result of winter investment plans (circa 50wte +)</li> <li>Capital funding (from revenue) has been agreed by CMIC to support a two storey modular build adjacent to the School that will provide more classrooms. Should be complete by Dec 2021.</li> <li>First NHSI Direct Support meeting in November '21</li> </ul>

Current Performance		
Sep 21	YTD	Target
10.1%	10.1%	10%

Three Month Forecast		
Oct 21	Nov 21	Dec 21
10%	10%	10%

National Position & Overview
At the present time there is no national vacancy data (%) for healthcare support workers but the NHS ambition is to achieve as 'close to zero vacancies as possible' for healthcare support roles that support registered nurses by the bedside i.e. Healthcare Assistants (HCAs)

# Effective– Mortality HSMR



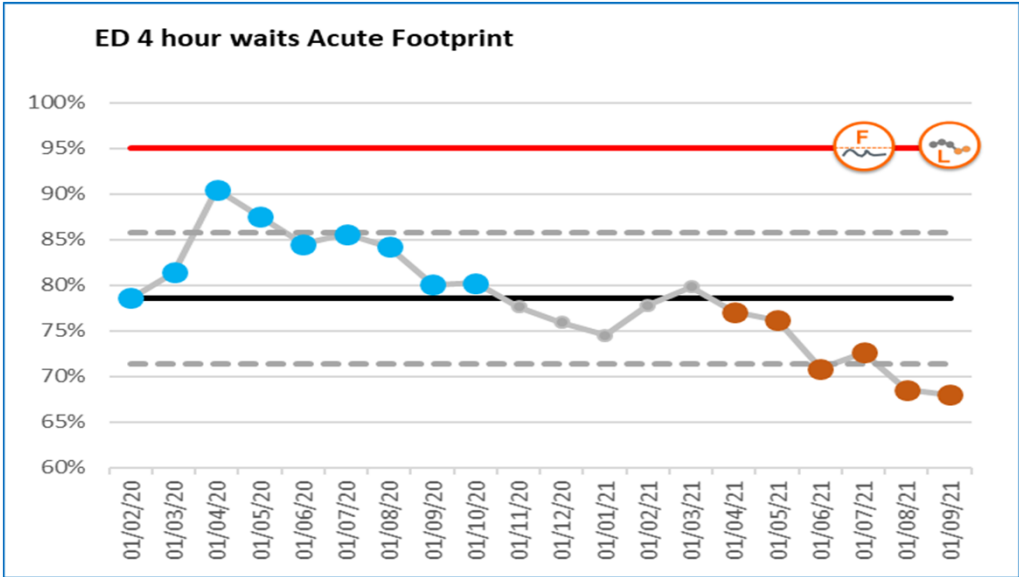
Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
NA	112	100	NK	NK	NK

**National Position & Overview**

HSMR is a risk adjusted mortality indicator (based on patient’s demographics and diagnosis on admission) where patients die in hospital (either in UHL or if transferred directly to another NHS hospital trust) over a 12 month period in one of 56 ‘diagnostic groups’ which contribute to 80% of in-hospital deaths

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>UHL’s latest monthly HSMR (Mar 21) is below 100</li> <li>Our Rolling 12 month HSMR is still above expected for the latest period(Apr 20 to Mar 21) and the increased monthly HSMR correlates with the two peaks of the COVID pandemic (April 20 and Nov 20 to Jan 21)</li> <li>Whilst UHL’s HSMR does not compare favourably against the England Average, those Trusts who saw similar numbers of COVID patients appear to have seen a similar rise in their HSMR (HSMR includes activity/deaths where COVID is a secondary code)</li> <li>UHL’s crude mortality rate continues to be below the national average</li> <li>Reviews of diagnosis groups with a higher HSMR identified a small number of cases with the wrong primary diagnosis code on admission and some areas of learning for the clinical teams; but no issues found with clinical pathways and no deaths were considered to be due to problems in care</li> </ul>	<p><b>Actions Agreed at MRC</b></p> <ul style="list-style-type: none"> <li>To review our latest Monthly HSMR once available in the DFI tool (Delayed due to DFI’s changes to process of downloading data from HES -identified issues with the data feed from NHS Digital)</li> <li>DFI to benchmark our HSMR with Trusts with higher numbers of COVID activity</li> <li>To continue to monitor our HSMR against our crude mortality data</li> <li>To continue undertaking reviews of diagnosis groups with a higher than expected HSMR</li> </ul>	<ul style="list-style-type: none"> <li>There has been an overall reduction in the HSMR now that the Benchmarking period has been updated to Dec 20</li> <li>UHL’s latest Rolling 12 month HSMR for April 20 to March 21 remains ‘above expected’ at 112 but has reduced from the previously reported ‘rolling 12 month; HSMR for the first time since Apr 19 to Mar 20 (ie pre Pandemic)</li> <li>It is anticipated that our HSMR for the 12 months May 20 to April 20 will be lower than 112 but how much is not known</li> <li>It is also not known when our HSMR will return to 100</li> </ul>

# Responsive (Emergency Care) – ED 4 Hour Waits Acute Footprint



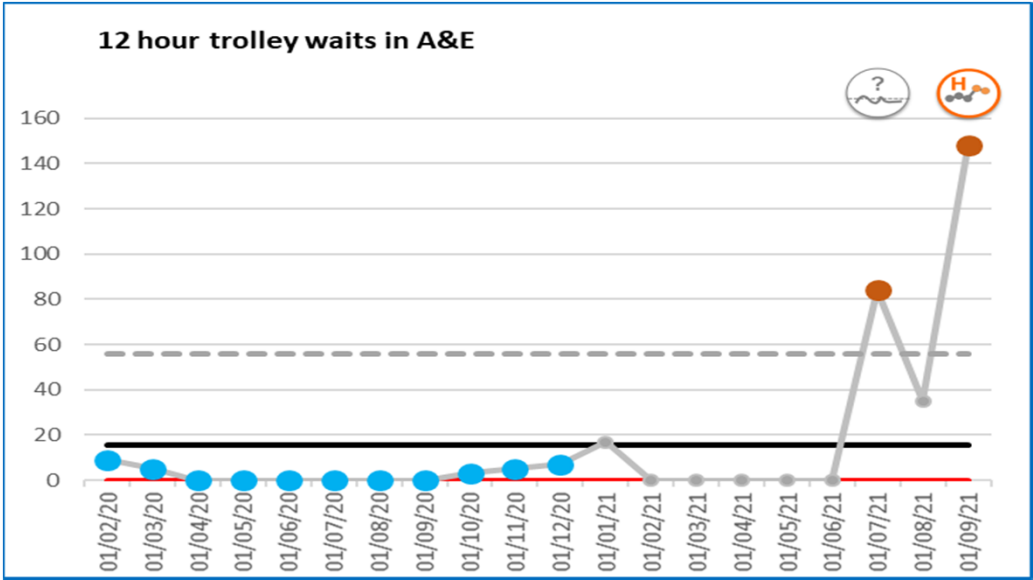
Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
68.0%	72.1%	95%	68%	69%	69.5%

### National Position & Overview

In September, UHL ranked 97 out of 114 Acute Trusts. The National average in England was 75.2%, the best value nationally was 100% and the lowest value was 56.7%. Only 2 out of the 114 Acute Trusts achieved the target.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>• Crowding in ED due to poor outflow</li> <li>• High inflow of both walk-in and ambulance arrivals</li> <li>• UHL bed occupancy &gt;85%</li> </ul>	<ul style="list-style-type: none"> <li>• Overnight ED consultant locum shift available (via winter monies)</li> <li>• Additional funding provided via winter monies for registrars (adults and paed)</li> <li>• Number of redirection and pre hospital actions in place to reduce occupancy and overall attendances</li> <li>• Maximise the use of the on-site UTC</li> </ul>	<ul style="list-style-type: none"> <li>• Improve time to senior decision making from November 2021</li> <li>• Improve time to senior decision making from November 2021</li> <li>• Reduce conveyances and occupancy to improve wait to be seen and time to decision/in place</li> <li>• Treat patients in a timely manner and reduce patient numbers in ED</li> </ul>

# Responsive (Emergency Care) – 12 Hour Trolley Waits in A&E



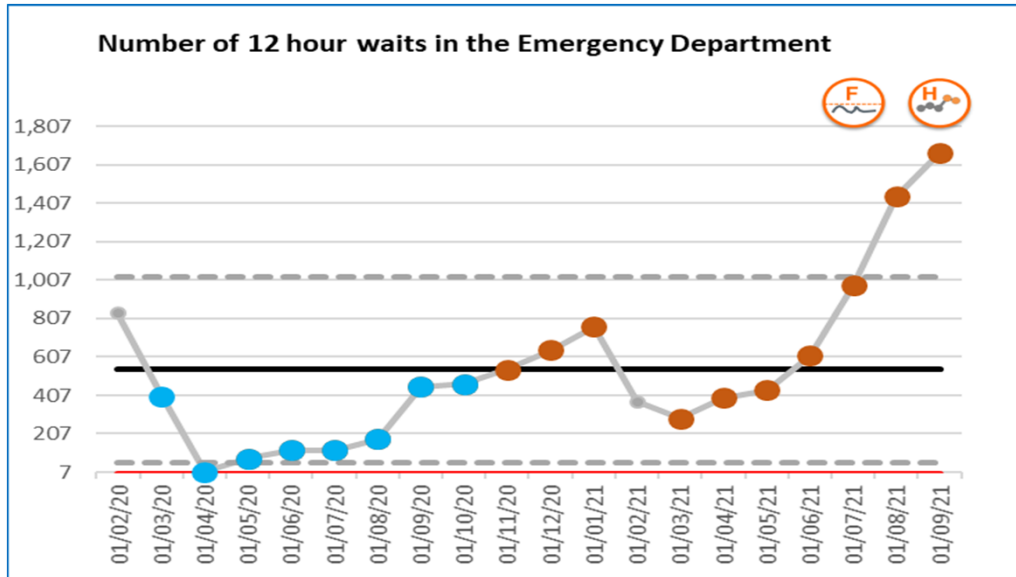
Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
148	267	0	140	135	130

### National Position & Overview

In September, UHL ranked 150 out of 156 NHS Trusts. The best value nationally was 0 and the worst value was 456. 73 out of the 156 NHS Trusts achieved the target.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>Poor outflow across the emergency care pathway</li> <li>Insufficient discharges from the base wards to meet demand</li> <li>Inability to create early capacity across the emergency care pathway due to lack of early discharges.</li> </ul>	<ul style="list-style-type: none"> <li>Review of patients on bed list by medical in-reach to ensure appropriate admission</li> <li>Increased consultant cover to ED frailty team to review frail patients</li> <li>Implement the actions in the winter plan including additional capacity and optimising patient flow</li> <li>8-10 week improvement led by NHSi for medical wards focusing on Board Rounds and principles of Red2green and SAFER patient flow best practices.</li> </ul>	<ul style="list-style-type: none"> <li>Only those patients that need a medical bed are admitted/Ongoing</li> <li>Reduce patient admission numbers from November 2021</li> <li>Reduce trolley waits and increase pre-noon/5pm discharges from November 2021</li> <li>Aim to improve /embed SAFER patient flow best practice principles within key wards in medicine by December 2021</li> </ul>

# Responsive (Emergency Care) – 12 Hour Waits in the Emergency Department



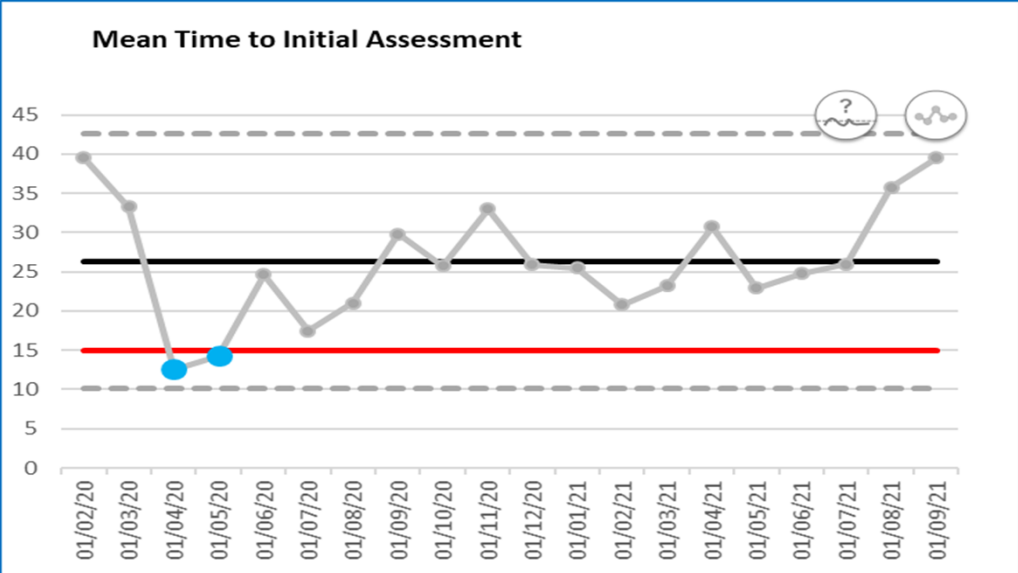
Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
1669	5529	0	1657	1740	1827

**National Position & Overview**

National data not available for reporting.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>Poor outflow across the emergency care pathway</li> <li>Crowding in ED resulting in long waits to be seen by a doctor</li> </ul>	<ul style="list-style-type: none"> <li>Plan in place to expand UTC service (workforce dependent) and locate off emergency floor footprint, to enable increased numbers of patients to utilise service</li> <li>ED consultant overnight and additional registrar locum shifts funded as part of winter plan</li> <li>Winter funding for medical in-reach consultant</li> <li>Expansion of GPAU/ambulatory service</li> </ul>	<ul style="list-style-type: none"> <li>Decant ED to reduce crowding/end of November</li> <li>Increase senior decision maker presence/in place (dependent on fill)</li> <li>Appropriate senior clinical review facilitating discharge directly from ED/in place</li> <li>Redirect those patients that can be seen by acute medic team/in place</li> </ul>

# Responsive (Emergency Care) – Mean Time to Initial Assessment



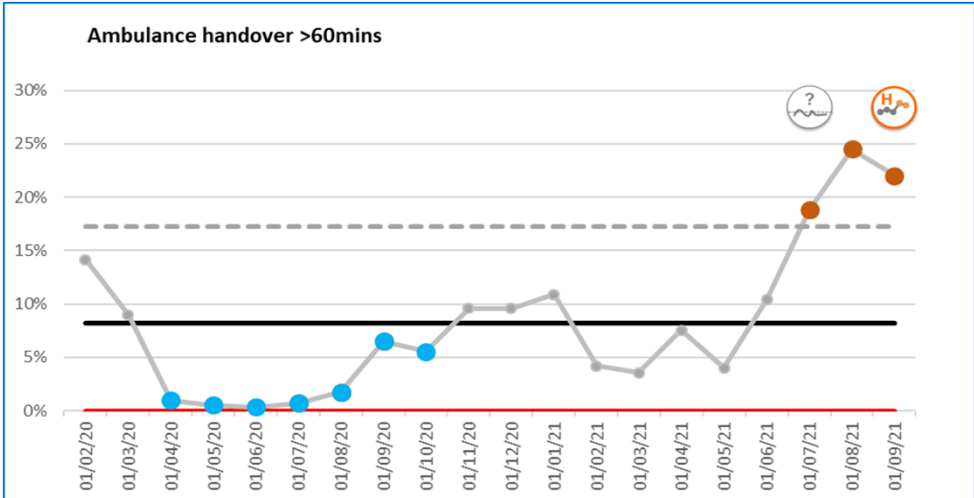
Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
39.5	30	15	40	42	45

### National Position & Overview

National data not available for reporting.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>Insufficient workforce to manage sustained walk in demand of in excess of 40 patients per hour</li> </ul>	<ul style="list-style-type: none"> <li>Redirecting appropriate patients to Westcotes/hub appointments, Urgent Treatment Centre (UTC), Gynaecology Assessment Unit (GAU) and GP Assessment Unit (GPAU)</li> <li>ED consultant deployed to sit on front desk to redirect patients to alternative settings (when workforce allows)</li> <li>Front door working group in place focused on improvement actions for achieving 15 minute target, including STAT clinician at front door; use of DPS 4 to ensure sickest patients are identified; guide to rapid assessments for triage team</li> <li>Working with system colleagues to implement national Streaming Tool</li> <li>Continued support from Urgent and Emergency Care (UEC) regional team on managing inflow demand.</li> </ul>	<ul style="list-style-type: none"> <li>In place and ongoing</li> <li>Senior decision maker able to deflect pre-triage/in place when staffing allows</li> <li>Improve time to assessment/group established and meet weekly</li> <li>Reduce inflow by streaming away pre-entry to ED/November 2021</li> <li>Ensure best practice and learning from other sites/ongoing</li> </ul>

# Responsive (Emergency Care) – Ambulance Handovers >60 Mins



Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
22.0%	14.2%	0%	21%	20%	20%

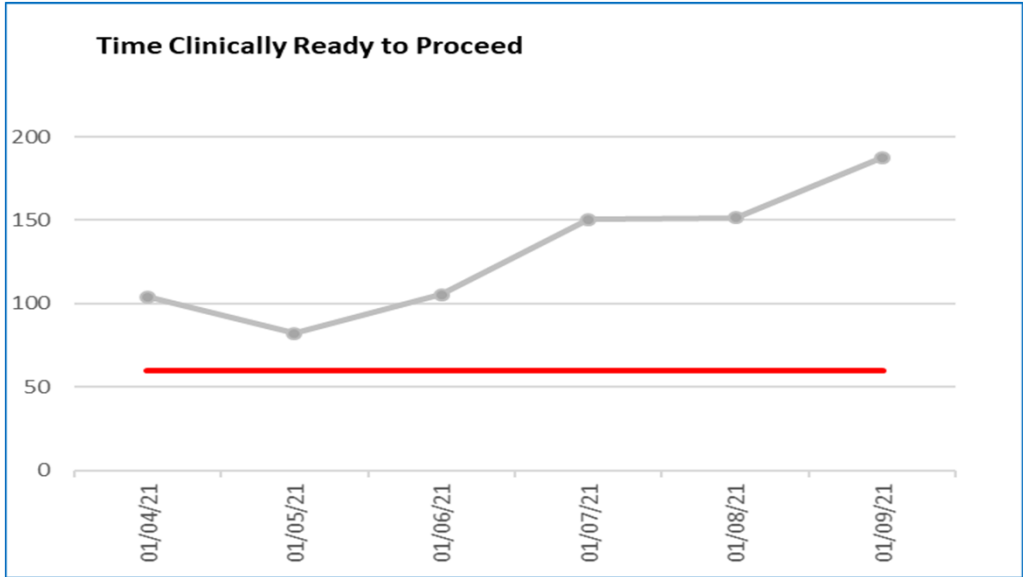
**National Position & Overview**

LRI ranked 20 out of 23 sites last month (source EMAS monthly report) and had the second highest number of arrivals (4,892).

UHL is an outlier in Ambulance handover performance

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>Poor outflow across the emergency care pathway</li> <li>High inflow of walk-in patients competing with ambulance patients for trolley space</li> </ul>	<ul style="list-style-type: none"> <li>Member of regional Ambulance Collaborative with system colleagues focusing on pre-hospital attendance avoidance</li> <li>Ambulance assessment task and finish group established to look at processes when patients arrive.</li> <li>Winter funding being used to: open GPAU overnight where staffing allows; increase medical cover to meet ambulance professional standards of care.</li> <li>Rapid cycle test of medical admissions direct to AMU complete; further test scheduled for w/c25/10 for one week.</li> <li>Meeting held with EMAS to further implement direct referrals to GPAU.</li> <li>Priority Admissions Unit (5 spaces) created next to GPAU footprint</li> </ul>	<ul style="list-style-type: none"> <li>In place</li> <li>Review of efficiencies in overall handover process/in place</li> <li>Increase senior decision makers and ability to create capacity in ED/locum and bank shifts out to fill</li> <li>Anticipated reduced ambulance arrivals to ED w/c 25 October 2021</li> <li>Reduce ambulance arrivals to ED from Nov</li> <li>Create capacity for offloading ambulances in ED from 31.11.21</li> </ul>

# Responsive (Emergency Care) – Time Clinically Ready to Proceed



Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
187.6	134	60	185	183	180

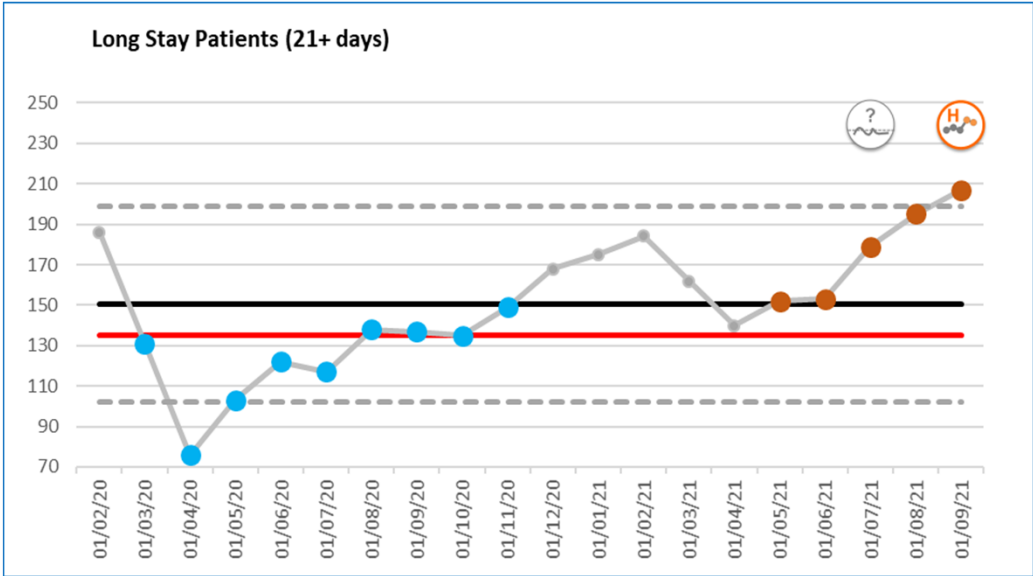
**National Position & Overview**

National data not available for reporting.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>Bed occupancy &gt; 85%</li> </ul>	<ul style="list-style-type: none"> <li>Further embed e-referrals on Nervecentre</li> <li>Embed further response to Inter-Professional Standards</li> <li>Work with System partners to increase the number of patients discharged within 24 hours of being Medically Optimized for Discharge (MOFD)</li> <li>8-10 week improvement led by NHSi for medical wards focusing on Board Rounds and principles of Red2green and SAFER patient flow best practices.</li> </ul>	<ul style="list-style-type: none"> <li>Increase response time to senior clinical review and decision making to improve time to ready to proceed time by all specialities</li> <li>Change of culture to improve timeliness of response to emergency patients/ongoing</li> <li>Aim to reduce number of MOFD patients waiting for discharge in UHL beds. By October 2021</li> <li>Aim to improve /embed SAFER patient flow best practice principles within key wards in medicine by December 2021</li> </ul>



# Responsive Emergency Care– Long Stay Patients



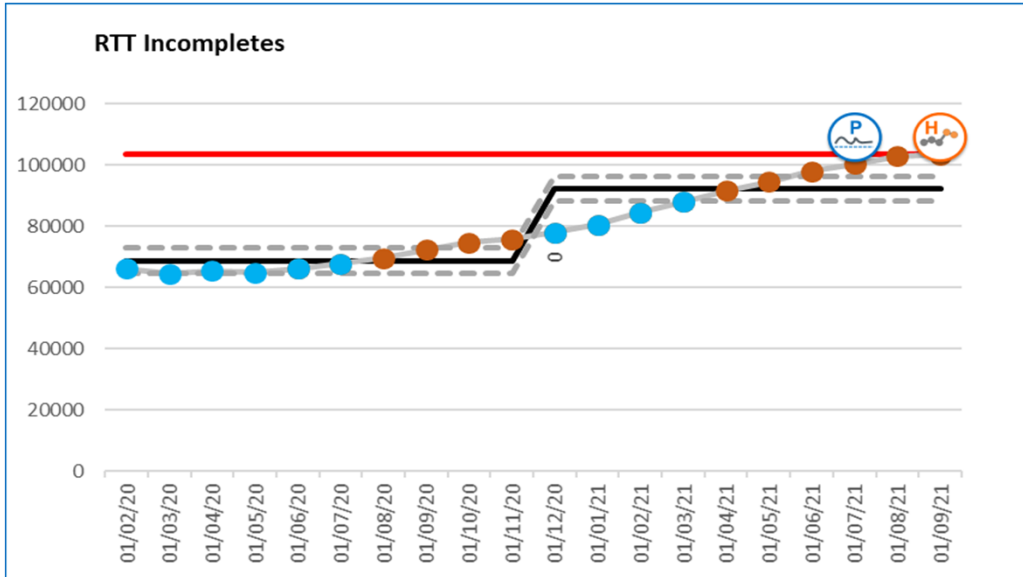
Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
207	207	135	190	185	180

**National Position & Overview**

- UHL is ranked 13 out of 20 trusts in the Midlands for the % beds occupied by Long Stay (21+ Day) patients (for the w/c 04/10/21).
- 39 Patients (18%) are receiving appropriate care/ treatment on a neuro rehabilitation or brain injury pathway.
- 8 Patients ( 4%) are receiving appropriate care/treatment on an Intensive care Unit or Infectious Diseases Unit.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>• 59 patients (29%) are Medically Optimised for Discharge (MOFD) awaiting a Discharge Destination form Health and Social care partners .</li> <li>• Suboptimal Discharge Coordination:(Over investigation, family /carer involvement, board rounds , red2green principles, preparing the patient in advance of discharge)</li> </ul>	<ul style="list-style-type: none"> <li>• Work with System partners to increase the number of patients discharged within 24 hours of being MOFD:                             <ul style="list-style-type: none"> <li>• Increased numbers of spot purchased, interim care home and commissioned D2A/ D2A therapy beds being made available</li> <li>• Undertake MADE event of patients waiting longer than 10 days</li> </ul> </li> <li>• 8-10 week improvement led by NHSi for medical wards focusing on Board Rounds and principles of Red2green and SAFER patient flow best practices.</li> </ul>	<ul style="list-style-type: none"> <li>• Aim to reduce number of MOFD patients waiting for discharge in UHL beds. By October 2021</li> <li>• Aim to improve /embed SAFER patient flow best practice principles within key wards in medicine by December 2021</li> </ul>

# Responsive (Elective Care) – RTT Incompletes



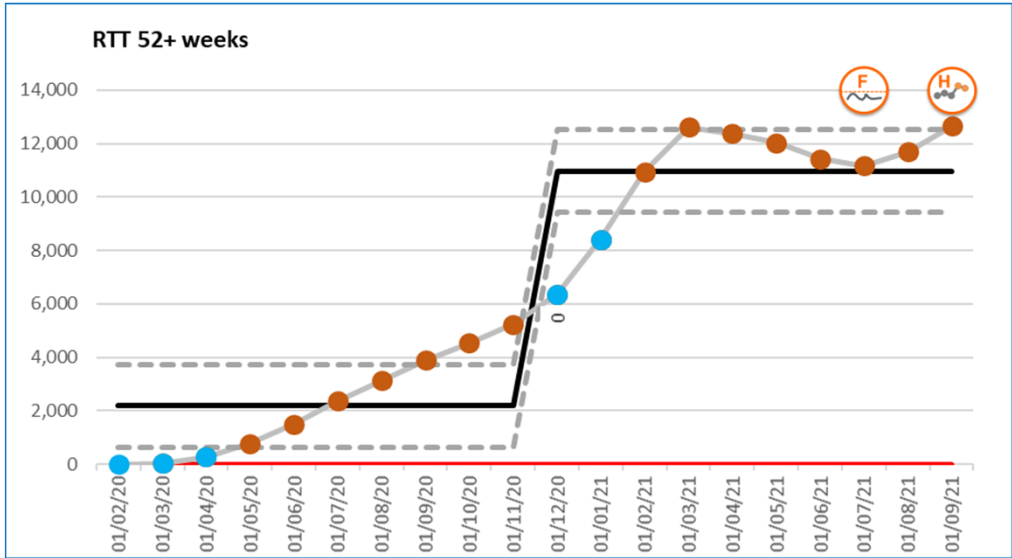
Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
103404	103404	103403	103579	105977	105140

**National Position & Overview**

UHL ranked 156 and of 170 Trusts based on published data for the end of August. Average performance for August was 61.7%. 21 out of 170 Trusts achieved the target. UHL ranked 16 out of 18 trusts in it's peer group.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>Impact of reduced outpatients and Inpatient activity. Due to COVID-19 and introduction of social distance and infection prevention measures.</li> <li>Reduction in theatre capacity to support ITU resulting in significant growth of the Admitted waiting list.</li> <li>Referrals increasing but still below 19/20 levels</li> </ul>	<ul style="list-style-type: none"> <li>A team of 9 validators and 1 supervisor from Source Group started with the Trust on August 23<sup>rd</sup> This is in order to support elective waiting list validation to assist in waiting list size reduction.</li> <li>An additional 6 validators will be starting on October 4th with the intention of the 15 validators working until December 8th and 5 to be extended until the end of March 2022.</li> <li>Changes to IP measures within outpatients departments</li> <li>Additional weekend sessions to support outpatients procedures and activities.</li> </ul>	<ul style="list-style-type: none"> <li>Ensuring all waiting list data is correct and remove any DQ issues by December 21 with continued review until March 22 (3400 patients validated per week)</li> <li>To support the waiting list to remain at Sept 2021 levels. Increase of activity across outpatients and inpatient activity resulting in an increase in clock stops.</li> <li>Super weekends to take place monthly until March 2022 (96 cases per month)</li> <li>Glaucoma and Alliance backlog, planning to start Oct 2021 - 2 weekends per month (212 patients per month)</li> </ul>

# Responsive (Elective Care) – RTT 52+ Weeks



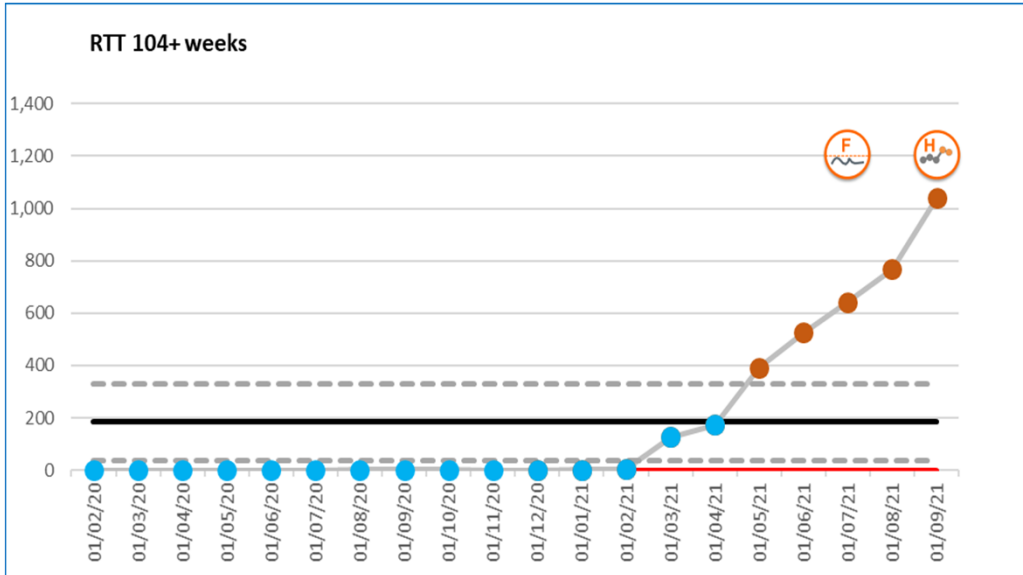
Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
12658	12658	0	13755	14770	15617

### National Position & Overview

UHL ranked 168 and of 171 Trusts based on published data for the end of August. 21 out of 170 Trusts achieved the target. UHL ranked 16 out of 18 trusts in it's peer group.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>Impact COVID-19 waves</li> <li>Significant operational pressures due the emergency demand and COVID-19 current inpatients, UHL has reported operational OPEL 4 levels on a regular basis.</li> <li>The requirement to increase Intensive Care Capacity, leading to a reduction in theatre capacity</li> </ul>	<ul style="list-style-type: none"> <li>Super weekend clinics to clinically review patients on the waiting list (e.g. Paediatric ENT)</li> <li>Creation of new theatre capacity via the installation of a Vanguard theatre</li> <li>Extension of WLI payments</li> <li>Commissioning of additional capacity via insourcing models</li> <li>Increase of theatre capacity within October following a reduction in demand for ITU</li> </ul>	<ul style="list-style-type: none"> <li>Increase in elective activity within October 2021 within ENT, Orthopaedics and Max fax</li> <li>Vanguard to come online on the 13<sup>th</sup> December, (Activity plan to be developed by 27.10.21)</li> <li>WLI rates continuing until 31.11.21 to be taken over by the ERF rate card from 1.12.21. (Specialities to submit plans for additional activity by 27.10.21)</li> <li>Theatre activity to increase week beginning 25<sup>th</sup> October</li> <li>Impact/timelines to target will be amended next month to reflect national guidance.</li> </ul>

# Responsive (Elective Care) – RTT 104+ Weeks



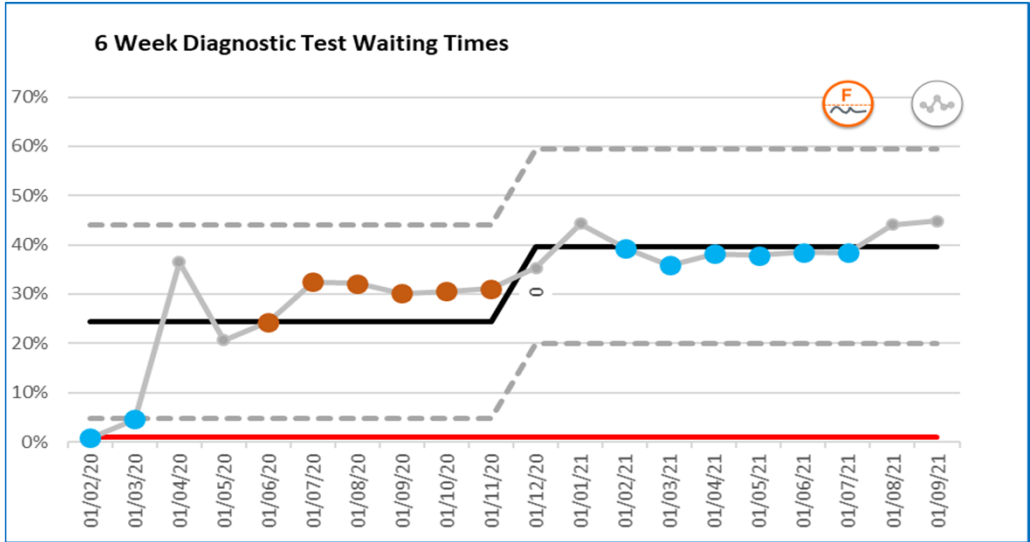
Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
1040	1040	0	1016	787	466

### National Position & Overview

UHL ranked 169 and of 170 Trusts based on published data for the end of August. 58 out of 170 Trusts achieved the target. UHL ranked 17 out of 18 trusts in it's peer group

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>Impact COVID-19 waves</li> <li>Significant operational pressures due the emergency demand and wave 3, UHL has reported operational OPEL 4 levels on a regular basis</li> <li>The requirement to increase ITU Capacity, leading to a reduction in theatre capacity</li> <li>Theatre capacity which has been available been used for clinical priority, cancer patients and P2's</li> </ul>	<ul style="list-style-type: none"> <li>Waiting list initiatives</li> <li>Use of existing but "dormant" or under-utilised capacity</li> <li>Commissioning of additional capacity via insourcing models and working with Vanguard theatre capacity</li> <li>Further use of the I.S</li> <li>Use of Community hospital capacity (UHL Alliance pillar)</li> <li>Transfer of work to neighbouring units (mutual aid)</li> <li>Increase of theatre capacity within October following a reduction in demand for ITU</li> </ul>	<ul style="list-style-type: none"> <li>To deliver 0 104+ week waits by March 31<sup>st</sup> 2021</li> <li>Vanguard to come online on the 13<sup>th</sup> December, (Activity plan to be developed by 27.10.21)</li> <li>WLI rates continuing until 31.11.21 to be taken over by the ERF rate card from 1.12.21. (Specialities to submit plans for additional activity by 27.10.21)</li> <li>Theatre activity to increase week beginning 25<sup>th</sup> October</li> <li>Impact/timelines to target will be amended next month to reflect national guidance.</li> </ul>

# Responsive (Elective Care) – 6 Week Diagnostic Test Waiting Times



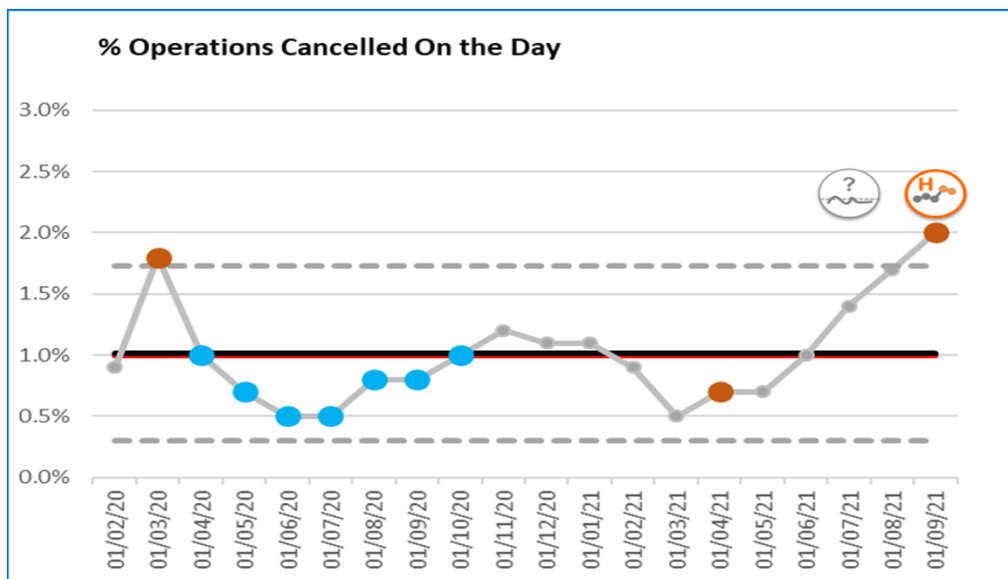
Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
44.8%	44.8%	1.0%	41%	34%	30%

### National Position & Overview

UHL ranked 143 out of 161 Trusts based on published data for the end of August. Average performance for August was 21.6%. 21 out of 170 Trusts achieved the target. UHL ranked 16 out of 18 trusts in it's peer group.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>Impact of COVID-19 waves 1 and 2.</li> <li>Increased demand in MRI, Non-Obstetric Ultrasound and Endoscopy.</li> <li>Reduced capacity due to introduction of social distancing and infection prevention measures.</li> <li>Staff vacancies and high levels of staff sickness.</li> <li>Availability of locums to backfill gaps in staffing.</li> </ul>	<ul style="list-style-type: none"> <li>Recent approvals for temporary solutions agreed through CDH and ERF funding to be used for:                             <ul style="list-style-type: none"> <li>- Additional Mobile MRI and CT units</li> <li>- Agency staff for US and Imaging</li> <li>- Additional staff for DEXA</li> </ul> </li> <li>Additional scanners loaned by NHSI/E.</li> <li>Continuous review of outsourcing solutions and use of WLI's to increase capacity.</li> <li>Recruitment to vacant funded posts.</li> <li>Assessing the risks to delivery of the Endoscopy trajectory by March 22 and will look at additional options to increase activity.</li> <li>Community Diagnostic Hub at LGH approved by NHSI/E.</li> </ul>	<ul style="list-style-type: none"> <li>Increased capacity across all diagnostic tests targeted at long waits. Timescale will vary.</li> <li>MRI/CT/US expected to be 10% above 19/20 levels from November/December.</li> <li>Audiology will be back on trajectory if staffing levels in their funded plan can be maintained.</li> <li>Community Diagnostic Hub delayed as funding from NHSI/E not announced until late September. Expected to commence November and will treat additional patients from the UHL diagnostic waiting list.</li> </ul>

# Responsive (Elective Care) – % Operations Cancelled On the Day



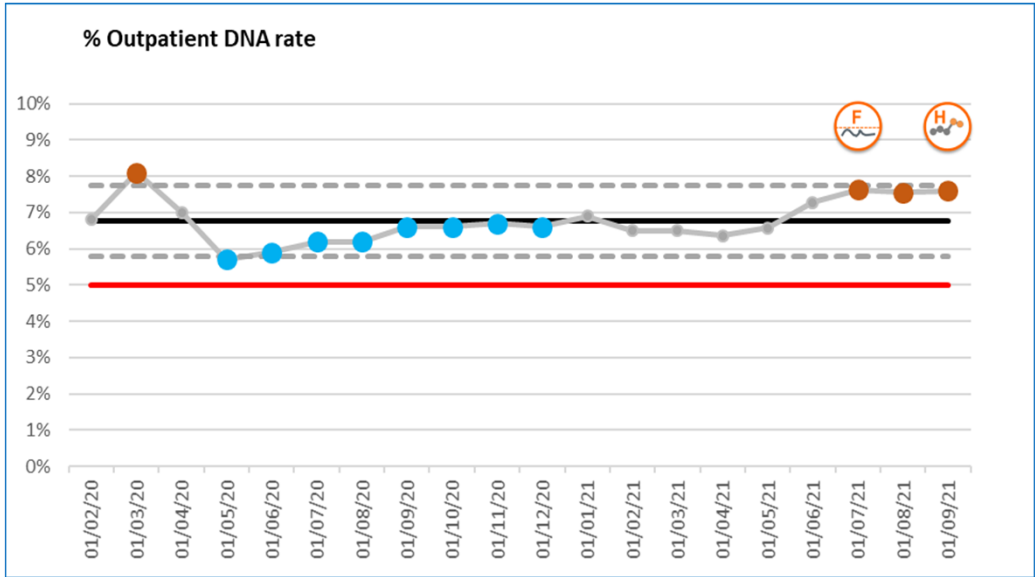
Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
2.0%	1.2%	1%	1.7%	1.4%	1%

## National Position & Overview

Published Cancelled Operations data for all trusts is not currently available on the NHS England website. Q3 2021/22 data should be published in February 2022.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>Significant operational pressures due to the emergency demand and wave 3, UHL has reported operational OPEL 4 levels on a regular basis.</li> <li>Volume of medical outliers increased within September reducing the volume of available beds to support elective care.</li> </ul>	<ul style="list-style-type: none"> <li>Develop plan to increase theatre capacity following reduction in ITU requirements</li> <li>Winter plan developed to support emergency flow and reduce impact on elective capacity.</li> <li>Reintroduce 6,4,2 process</li> <li>IP guidance changing</li> </ul>	<ul style="list-style-type: none"> <li>Theatre activity to increase week beginning 25<sup>th</sup> October with the reintroduction of 6,4,2</li> <li>Changes of IP measures in October 2021</li> <li>Performance will only be achieved if elective beds can be protected</li> </ul>

# Responsive Elective Care – Outpatient DNA Rate



Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
7.6%	7.1%	5.0%	7.5%	7.4%	7.3%

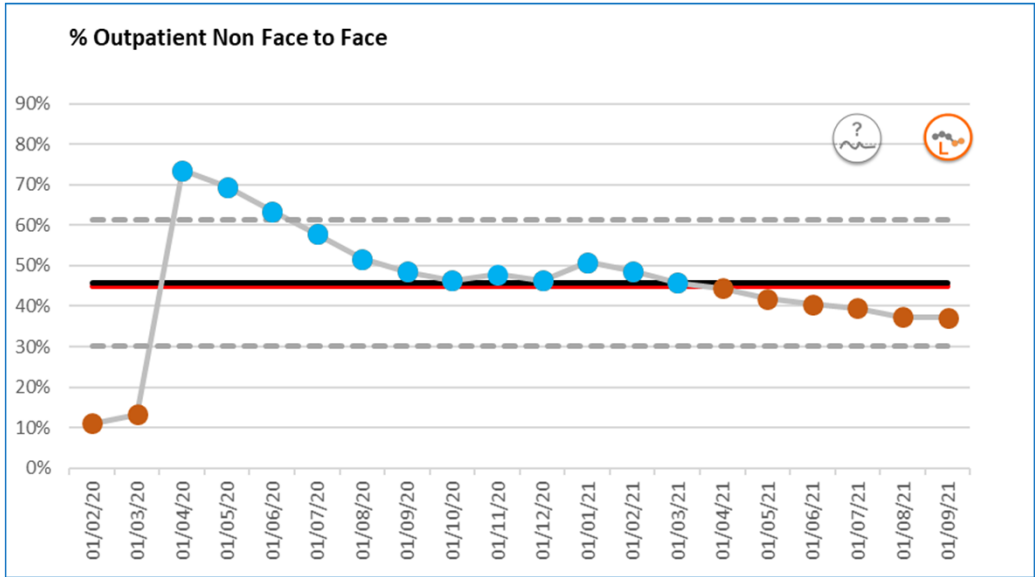
### National Position & Overview

UHL compares better than it's peers for this financial year so far, 6.6% compared to 7.9% (data up to the end of June, source CHKS).

The DNA rate has increased significantly in recent months and is currently worse than performance before the COVID-19 pandemic, performance in 19/20 was 7.0%.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>The limited number of external phone lines continues to be an issue – the clinician thinks the patient is not answering the call therefore DNAs the patient</li> <li>For virtual consultations, demographic information often isn't being checked with the patient then updated on HISS so some patients aren't receiving appointment letters</li> <li>Late cancellations/rebooks often mean patients do not receive their appointment letters on time so unaware of appointment</li> <li>Due to lack of admin staff, patients unable to get through to department to let them know they're unable to attend</li> <li>Some patients are still afraid to come in to hospital</li> </ul>	<ul style="list-style-type: none"> <li>On the Risk register. IT are looking into. Continue to promote the use of Attend Anywhere as an alternative.</li> <li>Remind services of the need to check the patients details are correct and up to date at every contact</li> <li>Services are being encouraged to use the OP QlikSense dashboard and call patients</li> <li>Working on increasing numbers on the admin bank and getting them upskilled</li> <li>Ask services to offer choice of video consultation</li> </ul>	<ul style="list-style-type: none"> <li>All actions, plus many others, are happening imminently to help reduce the number of DNAs.</li> <li>An improvement in the DNA rate should be visible within the next 3 months.</li> </ul>

# Responsive Elective Care – Outpatient Non Face to Face



Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Oct 21	Nov 21	Dec 21
37.2%	40.4%	45.0%	39.2%	41.2%	43.2%

### National Position & Overview

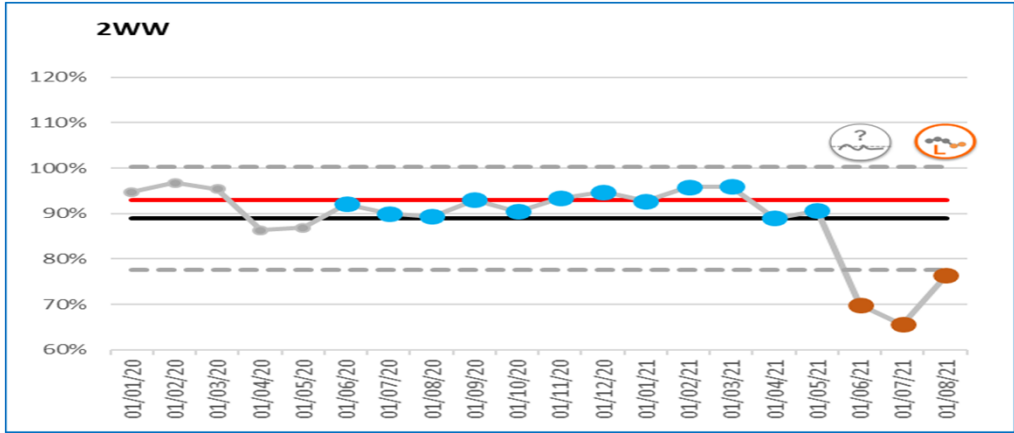
National data not available for reporting.

The proportion of non face to face appointments is still significantly higher than before the COVID-19 pandemic, performance in 19/20 was 9.9%. However it would appear that the number of non F2F is reducing which would suggest that the number of F2F is increasing

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>Not all Outpatient rooms are set up for video consultation eg no webcam or 2<sup>nd</sup> screen, and not all rooms have phones in them</li> <li>There is a fear of losing consulting rooms amongst clinicians therefore they are bringing patients in Face to Face (F2F)</li> <li>Some clinicians and patients do prefer F2F over non F2F</li> </ul>	<ul style="list-style-type: none"> <li>All of central outpatient rooms have now been provided with webcams, 2<sup>nd</sup> screens and headsets. Other OP areas have been asked what they need.</li> <li>Services are being encouraged to run blended clinics (part F2F/part non F2F) so the room will still be needed. Transformation Leads are working with services offering more F2F then non F2F.</li> <li>Attend Anywhere demos are being carried it and kit is being supplied to encourage video consultation as an alternative. Improve comms around the benefits of video consultation.</li> </ul>	<ul style="list-style-type: none"> <li>All actions, plus others, are happening imminently to help increase the number of non F2F appointments.</li> <li>An improvement in the non F2F rate should be visible within the next 3 months.</li> </ul>



# Responsive Cancer – 2 Week Wait



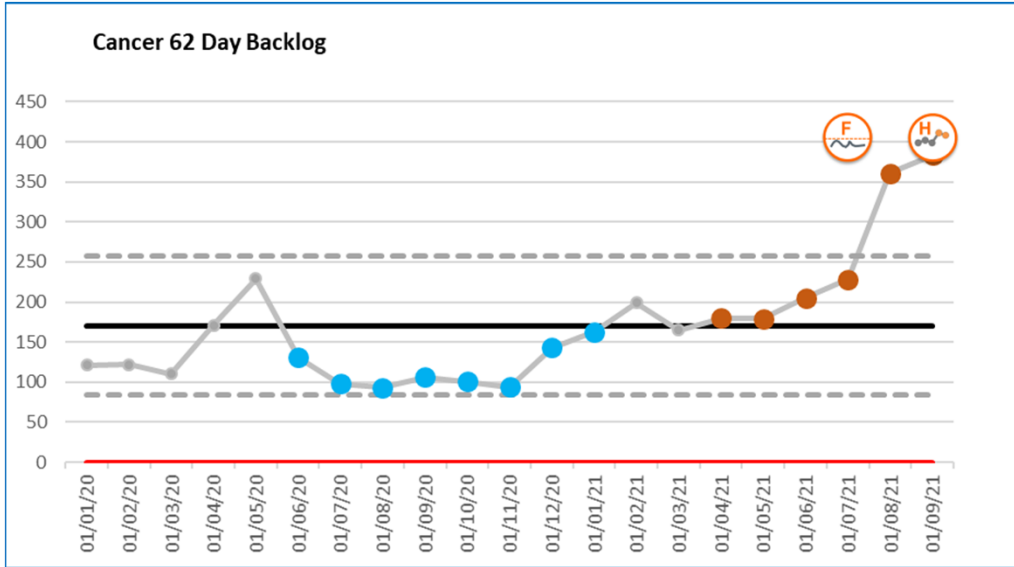
Current Performance			Three Month Forecast		
Aug 21	YTD	Target	Sep 21	Oct 21	Nov 21
76.4%	77.9%	93%	85.9%	77.2%	77.6%

### National Position & Overview

In August, UHL ranked 109 out of 127 Acute Trusts. The National average was 84.7% and the best value nationally was 100% (multiple Trusts). 52 out of the 127 Acute Trusts achieved the target. UHL ranked 15th out of the 18 UHL Peer Trusts. The best value within our peer group was 97.9% (East Kent Hospitals University NHS Foundation Trust).

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>2WW remains challenged with a 19.3% increase in referrals against pre-pandemic levels at the time of reporting,</li> <li>significant increases seen in:                             <ul style="list-style-type: none"> <li>Breast, 26.7%</li> <li>Head &amp; Neck 24.7%</li> <li>Sarcoma 27.3%</li> <li>Skin 26.3%</li> <li>Upper GI 24.4%</li> </ul> </li> <li>Combining the increased demand with capacity issues, workforce challenges, IP distancing all tumour sites are affected, this puts at risk the delivery of the 2WW standard for the coming months</li> </ul>	<p>Strong governance arrangements for Cancer Recovery with key stakeholders (ICS). Updated RAPs and Trajectories</p> <p><b>Breast</b></p> <ul style="list-style-type: none"> <li>Implementation of breast pain pathway</li> <li>Outsourcing for U35 2WW referrals, procurement process to be confirmed</li> <li>F2F assessment prior to referral in Primary Care</li> <li>2 Additional ultrasound rooms UHL GGH</li> <li>IPC review and WLI</li> <li>YourWorld to provide Breast WLI on Saturdays for 2WW</li> </ul> <p><b>ENT</b></p> <ul style="list-style-type: none"> <li>Task and Finish group specific for 2WW</li> <li>Agreement 2WW seen F2F in Primary Care.</li> <li>Additional equipment to shorten diagnostic pathway with H2 funding.</li> <li>IPC review.</li> </ul> <p><b>Skin</b> - Analytics Programme - H2 funding £300k Additional clinics in Coolville and MKT Harb, Loughborough require upskilling. Support from PCL BBC Vanguard coming online H2, Paging system to increase outpatient capacity</p>	<p>RAP- October 2021 for all tumour sites Focus at the forums to support improvement and delivery for H2</p> <p><b>Breast:</b> Pathway (Likely 5% reduction) 01/12/21</p> <ul style="list-style-type: none"> <li>Outsourcing January 2022 capacity to be confirmed by company</li> <li>Ultra sound rooms 1)25 slots per week 15/11/21 2)25 slots 01/04/22</li> <li>IPC 18 additional slots 01/11/21</li> <li>WLI 15 slots per week ongoing</li> <li>Yourworld additional 20 slots per week commence 01/12/21</li> </ul> <p><b>ENT:</b> 2WW Task and finish group established with clinical involvement. F2F – Commenced October in PC, IPC pages 01/11/21</p> <p><b>Skin:</b> Analytics potential opportunity 25% discharge immediately requires H2 funding. Additional capacity in community opportunity 16 slots per week per site staged approach commence 01/11/21</p>

# Responsive Cancer – Cancer 62 Day Backlog



Current Performance			Three Month Forecast		
Sep 21	YTD	Target	Sep 21	Oct 21	Nov 21
370	383	224	370	338	317

**National Position & Overview**

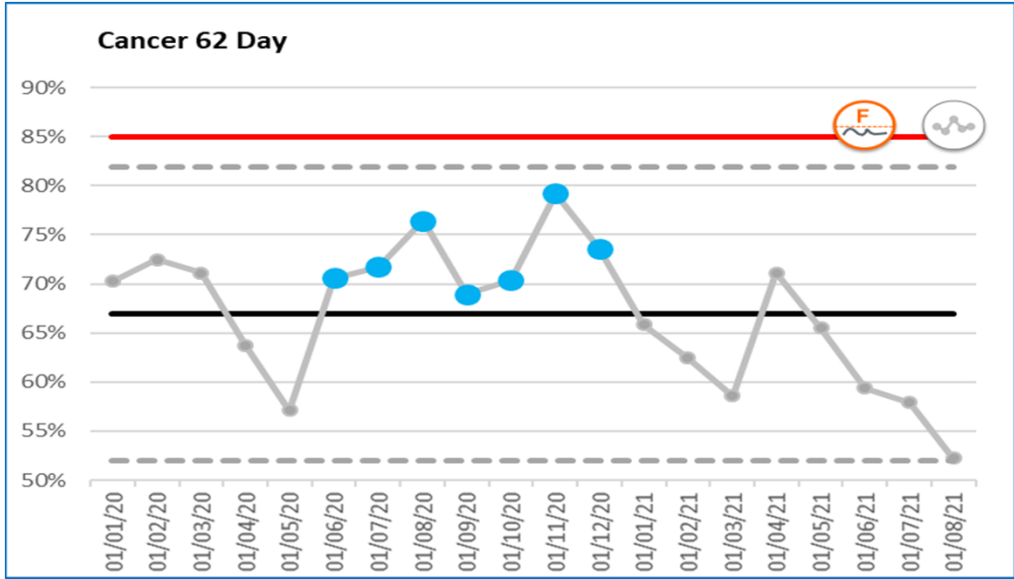
Nationally the 62 day backlog remains challenged with circa 25,000 patients over 62 days

Regionally, the East Midlands has a total backlog position of 1,713 (includes Derby, Lincs, Notts and LLR)

For LLR the backlog makes up 9.4% of the overall PTL size compared to the Midlands overall being 11.4%

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>Due to COVID -19 waves and significant pressures due to emergency demand there has been an increase in patients waiting 62 days and over</li> <li>Reduction in theatre capacity delaying both diagnostic and treatment procedures</li> <li>There is a National Directive for the 62 day backlog to be back at Trusts position in February 2020. For UHL this was 144</li> <li>Current forecast position will be 224 patients waiting by March 2022.</li> <li>A gap of 80 patients to achieve national requirement</li> </ul>	<ul style="list-style-type: none"> <li>First draft backlog trajectories to be reviewed as slippage against plan identified in October</li> <li>To work closely with the Elective and Diagnostic leads to ensure cancer patients prioritised.</li> <li>Recovery Funding utilised to create additional capacity for specialties:</li> <li>Utilising the Alliance /ENT and Urology additional equipment purchase .</li> <li>Recruitment of specialty Doctors Urology</li> <li>WLI and utilisation of Vanguards as per elective recovery IPR slides</li> <li>Theatre capacity to be returned to 100% for all tumour sites</li> </ul>	<ul style="list-style-type: none"> <li>11 October 2022 Robust and detailed plans with ownership at CMG level to support national returns and improve performance</li> <li>Funding confirmed £300k Oncology /Haematology plan in place to be implemented</li> <li>October 2021 plan developed</li> <li>October 2021 Additional slots for Urology</li> <li>October Urology Speciality Doctors x2 at offer stage - to increase capacity</li> <li>November 2021- return to normal pre COVID theatre capacity</li> </ul>

# Responsive Cancer – Cancer 62 Day



Current Performance			Three Month Forecast		
Aug 21	YTD	Target	Sep 21	Oct 21	Nov 21
52.2%	61.6%	85%	41.1%	52.7%	56.9%

**National Position & Overview**

In August, UHL ranked 130 out of 137 Acute Trusts. The National average was 70.7% and the best value nationally was 100% (multiple Trusts). 19 out of the 137 Acute Trusts achieved the target. UHL ranked 16th out of the 18 UHL Peer Trusts. The best value within our peer group was 81.0% (Imperial College Healthcare NHS Trust).

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>Waiting list volumes for 62 day now at the highest peak as a result of the previous spike in 2WW referrals, and continued increased referrals which has impacted on delayed pathways.</li> <li>Diagnostic capacity constraints.</li> <li>Reduced theatre sessions, theatre recovery capacity, ICU constraints .</li> <li>Bed reductions due to challenges with ED volumes .</li> <li>Workforce challenges including recruitment, reduced number of staff willing to support additional activity including WLI.</li> </ul>	<ul style="list-style-type: none"> <li>Refreshed cancer recovery trajectories with all CMGs and system partners. Robust action plans at tumour site level</li> <li>Prioritise Cancer patients for theatre sessions</li> <li>Focus on tumour sites with significant challenges including:</li> <li><b>ENT:</b> Time out for all clinical team and stakeholders to support cancer and RTT.</li> <li>ITAPS to reinstate theatre capacity 100% to support cancer surgery</li> <li>Locum ENT extension agreed</li> <li><b>Breast:</b> IS Breast Surgery Nuffield</li> </ul>	<ul style="list-style-type: none"> <li>Monthly cancer CMG forum and updated RAPs to gain assurance, oversight and identify opportunities.</li> <li>100% theatre capacity back online 01/11/21</li> <li>ENT Workshop external facilitator Thursday 11 November – output to produce several workstreams with key action plans to improve ENT capacity and performance</li> <li>Increase capacity for breast with additional 2 theatre sessions per week at Nuffield</li> </ul>

- Trust Overview
- Performance Overview
- Exception Reports
- Finance**
- Appendix - Alignment to CMG Dashboards
- Appendix - Statistical Process Control Charts

## Single Oversight Framework – Month 6 Overview

Single Oversight Framework – Month 6

At a Glance	Indicator	Plan / Standard	Period	YTD Actuals	Monthly Actuals	Trend	RAG Rating	Executive Director	
Best Value Care	Finance	Trust level control total performance against target	Break-even/ Surplus	21/22	£5.4m	(£1.63)m			CFO
		Capital expenditure against plan	YTD Forecast of £25.8m	21/22	£22.5m	£2.6m			CFO

# Finance – Best Value Care

The Trust has reported a H1 (M6 YTD) surplus of £5.4m. This is a £1m favourable variance to the forecast surplus of £4.4m.

The H1 actuals include the following items:

- £8.5m income and expenditure relating to the 2021/22 pay awards.
- £2.3m expenditure relating to the H1 19/20 recurrent element of the accounts restatement.
- The Trust recognised £0.6m into the month 6 position relating to prior year Salary Sacrifice taxable benefits as per Audit committee recommendation
- Elective Recovery Funds (ERF) expenditure of £0.4m YTD was incurred in H1 based on current CMG expenditure
- Zero headroom funding was received from the System based on a surplus H1 position

## Single Oversight Framework – Month 6

	Sept - In Month			Sept - YTD			H1 Plan £000	H1 Forecast £000	Forecast Variance £000	H1 Month 6 Forecast £000	H1 Outturn Month 6 £000	Forecast Variance £000
	Forecast £000	Actual £000	Variance £000	Forecast £000	Actual £000	Variance £000						
<b>Income:</b>												
Patient Care Income	91,569	100,450	8,881	546,523	555,405	8,881	556,560	555,405	(1,155)	546,523	555,405	8,881
Other Income	12,122	12,349	227	69,952	70,179	227	69,827	70,179	353	69,952	70,179	227
<b>Total Income</b>	<b>103,691</b>	<b>112,799</b>	<b>9,108</b>	<b>616,476</b>	<b>625,584</b>	<b>9,108</b>	<b>626,387</b>	<b>625,584</b>	<b>(803)</b>	<b>616,476</b>	<b>625,584</b>	<b>9,108</b>
<b>Expenditure:</b>												
Pay - Substantive/Bank	(60,493)	(69,903)	(9,410)	(358,877)	(368,287)	(9,410)	(365,015)	(368,287)	(3,272)	(358,877)	(368,287)	(9,410)
Pay - Agency	(1,765)	(1,736)	29	(9,700)	(9,671)	29	(9,312)	(9,671)	(359)	(9,700)	(9,671)	29
<b>Total Pay</b>	<b>(62,258)</b>	<b>(71,639)</b>	<b>(9,381)</b>	<b>(368,577)</b>	<b>(377,958)</b>	<b>(9,381)</b>	<b>(374,327)</b>	<b>(377,958)</b>	<b>(3,631)</b>	<b>(368,577)</b>	<b>(377,958)</b>	<b>(9,381)</b>
Non-Pay	(39,217)	(37,234)	1,983	(215,094)	(213,112)	1,983	(224,841)	(213,112)	11,730	(215,094)	(213,112)	1,983
Non-Operating Costs	(4,690)	(5,624)	(934)	(27,482)	(28,416)	(934)	(26,506)	(28,416)	(1,910)	(27,482)	(28,416)	(934)
<b>Total Non-Pay</b>	<b>(43,907)</b>	<b>(42,858)</b>	<b>1,049</b>	<b>(242,577)</b>	<b>(241,528)</b>	<b>1,049</b>	<b>(251,347)</b>	<b>(241,528)</b>	<b>9,819</b>	<b>(242,577)</b>	<b>(241,528)</b>	<b>1,049</b>
<b>Total Expenditure</b>	<b>(106,165)</b>	<b>(114,497)</b>	<b>(8,332)</b>	<b>(611,153)</b>	<b>(619,486)</b>	<b>(8,332)</b>	<b>(625,674)</b>	<b>(619,486)</b>	<b>6,188</b>	<b>(611,153)</b>	<b>(619,486)</b>	<b>(8,332)</b>
Donated Assets	(158)	65	223	(442)	(219)	223	(712)	(219)	494	(442)	(219)	223
Less Profit On Disposal	0	0	0	(450)	(450)	0	0	(450)	(450)	(450)	(450)	0
<b>Control Total Surplus/(Deficit)</b>	<b>(2,632)</b>	<b>(1,633)</b>	<b>999</b>	<b>4,430</b>	<b>5,429</b>	<b>999</b>	<b>0</b>	<b>5,429</b>	<b>5,429</b>	<b>4,430</b>	<b>5,429</b>	<b>999</b>

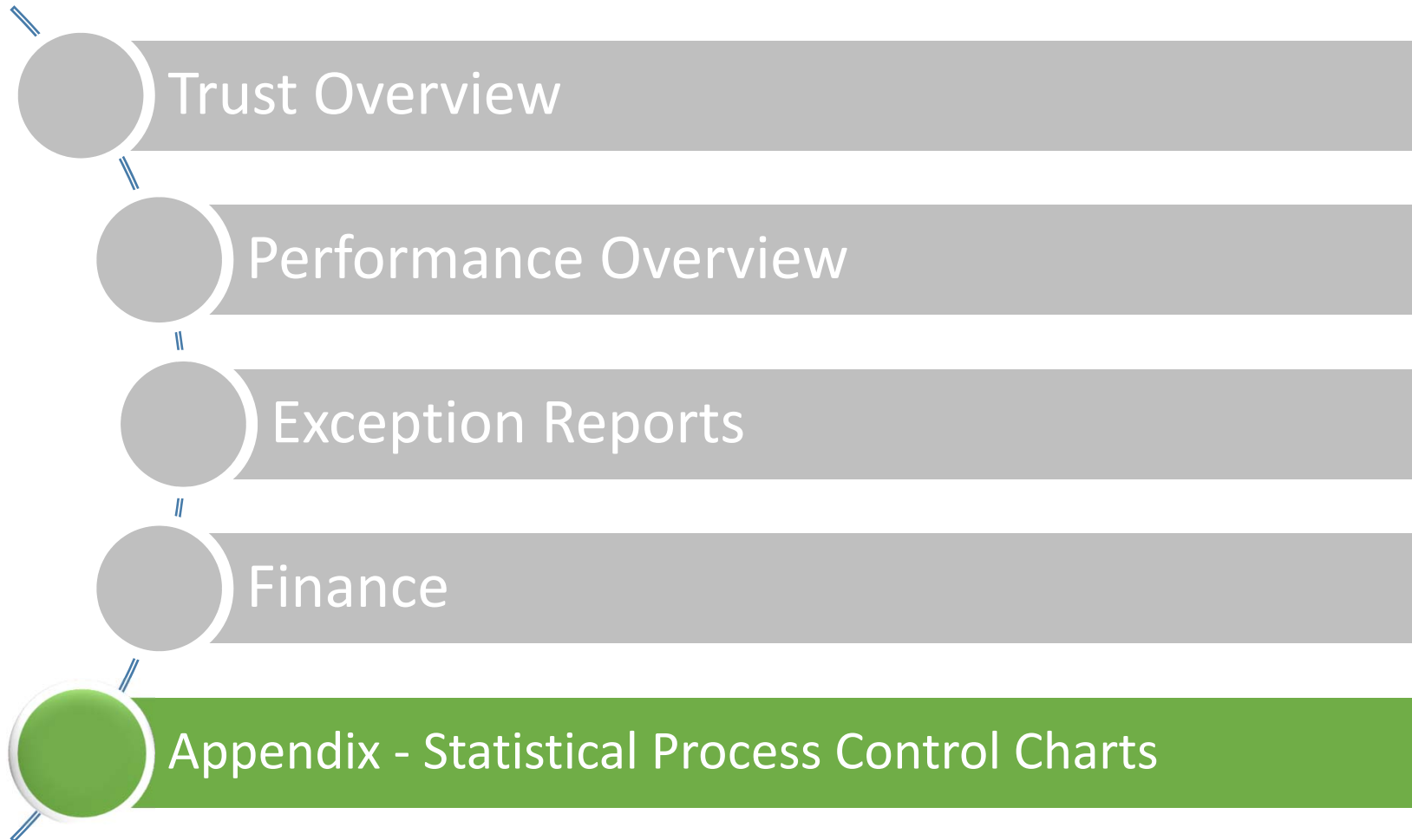
# Finance – Best Value Care

## Single Oversight Framework – Month 6

	Sept - In Month			Sept - YTD			H1 Plan £000	H1 Forecast £000	Forecast Variance £000	H1 Month 6 Forecast £000	H1 Outturn Month 6 £000	Forecast Variance £000
	Forecast £000	Actual £000	Variance £000	Forecast £000	Actual £000	Variance £000						
Income	103,691	112,799	9,108	616,476	625,584	9,108	626,387	625,584	(803)	616,476	625,584	9,108
Expenditure	(106,323)	(114,432)	(8,109)	(612,045)	(620,154)	(8,109)	(626,386)	(620,154)	6,232	(612,045)	(620,154)	(8,109)
<b>Surplus/(Deficit) - Control Total Basis excl. Impairments</b>	<b>(2,632)</b>	<b>(1,633)</b>	<b>999</b>	<b>4,430</b>	<b>5,429</b>	<b>999</b>	<b>0</b>	<b>5,429</b>	<b>5,429</b>	<b>4,430</b>	<b>5,429</b>	<b>999</b>
Capex (including donated)				(25,804)	(22,463)	3,341						
Closing Cash					90,997							

### Comments – H1 Forecast vs Outturn – Variance

- Income position of £9.1mF is driven by £8.5m income relating to 2021/22 pay awards
- The adverse expenditure variance of £8.1m is due to the payment of the pay awards in month 6





# Statistical Process Control Charts (SPC)

SPC charts look like a traditional run chart but consist of:

- A line graph showing the data across a time series.

*The data can be in months, weeks, or days- but it is always best to ensure there are at least 15 data points in order to ensure the accurate identification of patterns, trends, anomalies and random variations.*

- A horizontal line showing the Mean.

*This is used in determining if there is a statistically significant trend or pattern.*

- Two horizontal lines either side of the Mean-(called the upper and lower control limits).

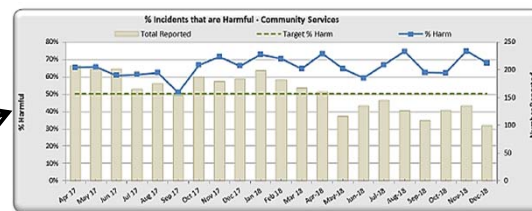
*Any data points on the line graph outside these limits, are 'extreme values' and is not within the expected 'normal variation'.*

- A horizontal line showing the Target.

*In order for this target to be achievable, it should sit within the control limits. Any target set that is not within the control limits will not be reached without dramatic changes to the process involved in reaching the outcomes.*

Appreciation of variance over time

Highlighting special cause and its nature



# Statistical Process Control Charts (SPC)

Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

## Within an SPC chart there are three different patterns to identify:

- **Normal variation** – (common cause) fluctuations in data points that sit between the upper and lower control limits
- **Extreme values** – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful of reasons outside the control of the process behind the extreme value
- **A trend** – may be identified where there are 7 consecutive points in either a pattern that could be; a downward trend, an upward trend, or a string of data points that are all above, or all below the mean. A trend would indicate that there has been a change in process resulting in a change in outcome

Narrative support that supports SPC theory

Summary icons and a top level summary view

	Jun-18	Target	Variation	Target Capability	Comment
Staff Sickness absence	4.4%	3.5%			Shift change in August 2017 showing increase in sickness - staff survey review indicated.....

