CHIEF EXECUTIVE'S MONTHLY UPDATE REPORT – OCTOBER 2018

Authors: John Adler and Stephen Ward Sponsor: John Adler **Trust Board paper D**

Executive Summary

Context

The Chief Executive's monthly update report to the Trust Board for October 2018 is attached. It includes:-

(a) the Quality and Performance Dashboard for August 2018 attached at appendix 1 (the full month 5 quality and performance report is available on the Trust's public website and is hyperlinked within this report);

(b) key issues relating to our Strategic Objectives and Annual Priorities

Questions

1. Does the Trust Board have any questions or comments about our performance and plans on the matters set out in the report?

Conclusion

1. The Trust Board is asked to consider and comment upon the issues identified in the report.

Input Sought

We would welcome the Board's input regarding content of this month's report to the Board.

For Reference

Edit as appropriate:

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

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

2. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register [Not applicable]

If YES please give details of risk ID, risk title and current / target risk ratings.

Datix Risk ID	Operational Risk Title(s) – add new line for each operational risk	Current Rating	Target Rating	CMG
XXXX	There is a risk …			XX

If NO, why not? Eg. Current Risk Rating is LOW

b. Board Assurance Framework [Not applicable]

If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk	Principal Risk Title	Current Rating	Target Rating
No.	There is a risk …		

3. Related **Patient and Public Involvement** actions taken, or to be taken: [N/A]

4. Results of any **Equality Impact Assessment**, relating to this matter: [N/A]

5. Scheduled date for the **next paper** on this topic: [November 2018 Trust Board]

6. Executive Summaries should not exceed **2 pages**. [My paper does comply]

7. Papers should not exceed **7 pages.** [My paper does comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **4 OCTOBER 2018**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – OCTOBER 2018**

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1 Introduction

1.1 My monthly update report this month focuses on:-

(a) the Board Quality and Performance Dashboard attached at **appendix 1**;

(b) the Board Assurance Framework (BAF) and Organisational Risk Register;

(c) key issues relating to our Annual Priorities, and

(d) a range of other issues which I think it is important to highlight to the Trust Board.

1.2 I would welcome feedback on this report which will be taken into account in preparing further such reports for future meetings of the Trust Board.

2 Quality and Performance Dashboard – August 2018

2.1 The Quality and Performance Dashboard for August 2018 is appended to this report **at appendix 1**.

2.2 The Dashboard aims to ensure that Board members are able to see at a glance how we are performing against a range of key measures.

2.3 The more comprehensive monthly Quality and Performance report continues to be reviewed in depth at a joint meeting of the People, Process and Performance Committee and Quality and Outcomes Committee. The month 5 quality and performance report is published on the Trust's website.

Good News:

2.4 **52+ weeks wait –** 0 patients (compared to 18 patients same period last year). **Mortality** – the latest published SHMI (period January 2017 to December 2017) has reduced to 97 and is within the threshold. **Delayed transfers of care** - remain within the tolerance. However, there are a range of other delays that do not appear in the count. **MRSA –** 0 cases reported this month. **Pressure Ulcers** - 0 **Grade 4** reported during August. **Grade 3 and 2** are well within the trajectory for the month. **CAS alerts** – we remain compliant. **Inpatient and Day Case Patient Satisfaction (FFT)**

achieved the Quality Commitment of 97%. **Never events** – 0 reported in August. **Fractured NOF** – was 82.6% in August. **Cancelled operations –** performance was 0.9% in August a significant improvement. **Annual Appraisal** is at 91.6% (rising trend).

Bad News:

2.5 **UHL ED 4 hour performance** – was 76.3% for August, system performance (including LLR UCCs) was 83.0%. **Cancer Two Week Wait** was not achieved in July. The standard was achieved for 24 consecutive months. **Cancer 31 day** was not achieved in July. **Cancer 62 day treatment** was not achieved in July – further detail of recovery actions in is the Quality and Performance report. **Referral to Treatment –** our performance was below the NHS Improvement trajectory but the overall waiting list size (which is the key performance measure for 2018/19) is only 0.6% off plan. **Diagnostic 6 week wait –** standard not achieved however downward trend over last 5 months. **C DIFF –** 7 cases reported this month. **Patients rebooked within 28 days** – continues to be non-compliant. **Moderate harms and above** – July (reported 1 month in arrears) was above threshold. **Ambulance Handover 60+ minutes (CAD+)** – performance at 3%. **TIA (high risk patients)** – 50.4% reported in August. **Statutory and Mandatory Training** reported from HELM is at 88%.

3 <u>Board Assurance Framework (BAF) and Organisational Risk Register</u>

3.1 The Board Assurance Framework (BAF) and organisational risk register have been kept under review during August 2018 and a detailed BAF and an extract from the risk register are included in the integrated risk and assurance paper featuring elsewhere on today's Board agenda.

Board Assurance Framework

3.2 The BAF remains a dynamic document and all principal risks have been updated by their lead Directors (to report performance for July) and have been reviewed by their relevant Executive Boards during September 2018, where they have been scrutinised ahead of the final version to Board today.

3.3 The three highest rated principal risks on the BAF, all rated at 20,are in relation to staffing levels, the emergency care pathway and financial sustainability.

Organisational Risk Register

3.4 The risk register has been kept under review by the Executive Performance Board and across all CMGs during August and displays 203 risks, including 65 rated as high (i.e. with a current risk score of 15 and above), 130 rated moderate and 8 rated low.

3.5 Thematic analysis from the organisational risk register shows the two most common risk causation themes are workforce shortages and imbalance between service demand and capacity. Managing financial pressures, including internal control arrangements, is also recognised in various risks on the organisational risk register as an enabler to support the delivery of the Trust's objectives. These thematic

findings on the risk register are reflective of our highest rated principal risks identified on the BAF.

4 Emergency Care

4.1 Our performance against the four hour standard for August 2018 was 76.3% and 83% for Leicester, Leicestershire and Rutland as a whole. August 2018 performance was significantly impacted by the Carbapenem Resistant Organism (CRO) outbreak, upon which I reported to the Board last month.

4.2 On a more positive note, we are continuing to reduce the number of adult patients who stay in our hospital longer than 21 days ('super stranded patients') and the number of 'Delayed Transfers of Care' remains low.

4.3 We have established a new Urgent Care Board at the Trust, chaired by the Chief Operating Officer, and this Board has recently commenced its work. It meets monthly and central to its work is review of the approved action plan which is themed across the domains of governance, inflow, flow and outflow; and the key components which remain under constant review include the following:

- overall performance against the 4 hour standard,
- ambulance handover performance,
- process performance,
- reduction in 'stranded' and 'super stranded' patients (as mentioned above),
- driving down non-admitted breach performance,
- operation of the ED Front Door service by DHU,
- addressing the deterioration in ED performance during evenings and overnight.

4.4 Details of the Trust's emergency care performance continue to be the subject of report by the Chief Operating Officer monthly to the People, Process and Performance Committee.

4.5 Further details of the Winter Plan 2018/19 are to be the subject of report by the Chief Operating Officer to the September 2018 meeting of the People, Process and Performance Committee. That Committee continues to review our emergency care performance and plans for improvement at each of its meetings, and details of the Committee's most recent consideration of the position are set out in the summary of that meeting which features elsewhere on this Board agenda.

5. Consolidation of Level 3 Intensive Care and Related Service Moves

5.1 I briefed the Trust Board at its meeting held on 6th September 2018 on our discussions with the Leicester, Leicestershire and Rutland Joint Health Overview and Scrutiny Committee on these matters at the Committee's meeting held on 4th September 2018.

5.2 The Joint Committee is to continue its consideration of the issues in question at its reconvened meeting on 28th September and an oral report will be made at the Trust Board meeting on 4th October 2018 on the outcome of their deliberations.

6. Annual Priorities 2018/19

6.1 At its meeting held on 18th September 2018, the Executive Strategy Board reviewed progress for the period to August 2018 in relation to delivering our Annual Priorities 2018/19 – for the Quality Commitment, the report covered the period April – June 2018.

6.2 Full details are set out at appendix 2.

6.3 The overall status of the programme has been assessed as amber; this is largely due to the number of priorities either slightly or significantly delayed in the delivery of their key performance indicators.

6.4 The Quality Commitment confirm and challenge took place in August, with each objective assessed for actual quarter 1 performance and predicted quarter 2 performance. At this stage, performance is projected to recover against the key performance indicators by the end of quarter 2. Two objectives (outpatient transformation and 'stop the line') are at risk of being off trajectory by the end of quarter 2.

6.5 All performance objectives within the programme (e.g ED 4 hours) remain off trajectory in terms of key performance indicators with project plans delayed slightly. Plans are being reviewed with Senior Responsible Owners at this stage of the year to ensure that the actions within plans are sufficient to bring key performance indicators back in line with trajectories.

6.6 The strategic objectives have also been through a confirm and challenge process. The three which remain red with limited assurance of recovery at this stage include implementation of the commercial strategy (due to the cancellation of our plans to create a wholly-owned subsidiary, delivery of the efficiency programme and the financial position of the Trust (due principally to the financial impact of the subsidiary decision). Since the confirm and challenge, the Financial Recovery Board and Financial Recovery Operational Group have been launched with detailed recovery plans, and future progress will therefore be monitored through these groups.

7. Conclusion

7 The Trust Board is invited to consider and comment upon this report and the attached appendices.

John Adler
Chief Executive
27th September 2018

Quality & Performance

		YTD Plan	YTD Actual	Aug-18 Plan	Aug-18 Actual	Trend*	Compliant by?
Safe	S1: Reduction for moderate harm and above (1 month in arrears)	142	90	<=12	20	●	
	S2: Serious Incidents	<37	20	3	3	●	
	S10: Never events	0	4	0	0	●	
	S11: Clostridium Difficile	61	32	5	7	●	
	S12 MRSA - Unavoidable or Assigned to 3rd party	0	0	0	0	●	
	S13: MRSA (Avoidable)	0	1	0	0	●	
	S14: MRSA (All)	0	1	0	0	●	
	S23: Falls per 1,000 bed days for patients > 65 years (1 month in arrears)	<5.6	6.6	<5.6	6.1	●	
	S24: Avoidable Pressure Ulcers Grade 4	0	0	0	0	●	
	S25: Avoidable Pressure Ulcers Grade 3	<27	3	<=3	1	●	
	S26: Avoidable Pressure Ulcers Grade 2	<84	26	<=7	1	●	
Caring	C3: Inpatient and Day Case friends & family - % positive	97%	97%	97%	97%	●	
	C6: A&E friends and family - % positive	97%	96%	97%	95%	●	
	C10: Single Sex Accommodation Breaches (patients affected)	0	32	0	6	●	
Well Led	W13: % of Staff with Annual Appraisal	95%	91.6%	95%	91.6%	●	
	W14: Statutory and Mandatory Training	95%	88%	95%	88%	●	
	W16 BME % - Leadership (8A – Including Medical Consultants) - Qtr 1	28%	28%	28%	28%		
	W17: BME % - Leadership (8A – Excluding Medical Consultants) - Qtr 1	28%	14%	28%	14%		
Effective	E1: 30 day readmissions (1 month in arrears)	<8.5%	9.2%	<8.5%	9.0%	●	
	E2: Mortality Published SHMI (Jan 17 - Dec 17)	99	97	99	97	●	
	E6: # Neck Femurs operated on 0-35hrs	72%	66.4%	72%	82.6%	●	
	E7: Stroke - 90% of Stay on a Stroke Unit (1 month in arrears)	80%	85.8%	80%	86.6%	●	
Responsive	**R1: ED 4hr Waits UHL**	95%	79.9%	95%	76.3%	●	See Note 1
	R2: ED 4 Hour Waits UHL + LLR UCC (Type 3)	95%	85.6%	95%	83.0%	●	See Note 1
	R4: RTT waiting Times - Incompletes (UHL+Alliance)	92%	85.8%	92%	85.8%	●	See Note 1
	R6: 6 week – Diagnostics Test Waiting Times (UHL+Alliance)	<1%	2.0%	<1%	2.0%	●	
	R12: Operations cancelled (UHL + Alliance)	0.8%	1.2%	0.8%	0.9%	●	See Note 1
	R14: Delayed transfers of care	3.5%	1.4%	3.5%	1.6%	●	
	R15: % Ambulance Handover >60 Mins (CAD+)	TBC	2%	TBC	3%	●	
	R16: % Ambulance handover >30mins & <60mins (CAD+)	TBC	6%	TBC	8%	●	
	RC9: Cancer waiting 104+ days	0	29	0	29	●	

		YTD Plan	YTD Actual	Jul-18 Plan	Jul-18 Actual	Trend*	Compliant by?
Responsive Cancer	RC1: 2 week wait - All Suspected Cancer	93%	93.6%	93%	92.2%	●	Sep-18
	RC3: 31 day target - All Cancers	96%	95.4%	96%	95.4%	●	Aug-18
	RC7: 62 day target - All Cancers	85%	76.5%	85%	77.3%	●	Dec-18

Enablers

		YTD Plan	YTD Actual	Qtr1 18/19 Plan	Qtr1 18/19 Actual
People	W7: Staff recommend as a place to work (from Pulse Check)		60.3%		60.3%
	C10: Staff recommend as a place for treatment (from Pulse Check)		70.5%		70.5%

		YTD Plan	YTD Actual	Aug-18 Plan	Aug-18 Actual	Trend*
Finance	Surplus/(deficit) £m	(23.9)	(23.8)	(1.0)	(1.1)	●
	Cashflow balance (as a measure of liquidity) £m	1.0	7.3	1.0	7.3	●
	CIP £m	10.8	11.2	3.5	3.9	●
	Capex £m	10.0	6.9	1.9	1.2	●

		YTD Plan	YTD Actual	Aug-18 Plan	Aug-18 Actual	Trend*
Estates & facility mgt.	Average cleanliness audit score - very high risk areas	98%	96.0%	98%	95.0%	●
	Average cleanliness audit score -high risk areas	95%	94.0%	95%	93.0%	●
	Average cleanliness audit score - significant risk areas	85%	**94%**	85%	**94%**	●

* Trend is green or red depending on whether this month's actual is better or worse than the average of the prior 6 months

Please note: Quality Commitment Indicators are highlighted in bold. The above metrics represent the Trust's current priorities and the code preceding many refers to the metrics place in the Trust's Quality & Performance dashboards. Please see these Q&P dashboards for the Trust's full set of key metrics.

Note 1 - **'Compliant by?'** for these metrics a are dependent on the Trust rebalancing demand and capacity.

Progress update: Annual Priorities 18/19

Reporting period: August 2018

Introduction

We have reshaped our 5 year strategic objectives this year to provide even more focus on what matters most in terms of delivering our strategy.
In the centre is our Quality Commitment, putting safe, high quality patient-centred, efficient care at the centre of everything we do. This is our primary objective. Everything else will support the delivery of that:

Our People: We will have the right people with the right skills in the right numbers in order to deliver the most effective care

Education and Research: We will deliver high quality, relevant, education and research

Partnerships and Integration: We will develop more integrated care in partnership with others

Key Strategic Enablers: We will progress our key strategic enablers

Delivery of these priorities will enable the Trust to deliver high quality, safe and effective care for our patients as well as achieve the performance standards outlined in this document.

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Annual Priority	SRO	Delivery Lead	Q1 performance against agreed KPI's	Q1 Project Plan RAG Status & Progress to plan	Concerns & Assurance
We will embed the use of Nerve Centre for all medical handover, Board rounds and Escalation of Care in 18/19	Andrew Furlong / Eleanor Meldrum	John Jameson/Julia Ball	**1. Use of NerveCentre in Clinical Handover** **2. Use of NerveCentre in board rounds** **3.Use of NerveCentre in Clinical Escalations** **3. Use of NerveCentre in Ward Rounds**	**Overall Project status – slight delay** • The updated NerveCentre board round profile has been agreed and will be applied to the live instances of NerveCentre in August. • The Deteriorating patient strategy was presented at the July DAPB meeting. A task and Finish group will be established to develop the policy/approach. • A NerveCentre board has been established, first meeting in June. • Four exemplar wards have been identified. These will be configured (both hardware & processes) for ward rounds, board rounds and handover. • The Clinical handover policy at specialty level has been refreshed to include the use of NerveCentre and ready for P&GC approval. • Spot check audit methodology for clinical handovers, board rounds, clinical escalations and ward rounds not yet agreed • NerveCentre KPI data for board rounds and ward rounds not yet agreed.	**Concerns & PMO Assurance** Some slippage on this workstream in relation to: - Developing & agreeing spot check audit methodology (this needs to be agreed in conjunction with priority 2 (ward and board rounds) - Refreshing board round guidelines (again this needs to be agreed in conjunction with priority 2 (ward and board rounds) - Agreeing KPI data for Board rounds and ward rounds (again this needs to be agreed in conjunction with priority 2 (ward and board rounds) Joint meeting with priority 2 work stream (ward & board rounds) scheduled for In late August to agree actions needed to bring the work programme back on track.
We will ensure senior clinician led daily board or	Andrew Furlong /Eleanor Meldrum	Max Chauhan/Gill Staton	**90% of clinical areas have a senior clinician led (ST4 above) daily ward or board round** **No Q1 trajectory – baseline to be assessed in Q1**	**Overall Project status - slight delay** • **Data being pulled from a number of sources until such time as metrics can be reported from NerveCentre** • **The majority of the baseline data has been received from the CMG's however data is in different formats need to be sense checked**	**Concerns & Assurance** Some slippage on this workstream in relation to: - establishing the baseline for ward and board rounds - some CMG responses received but a full baseline has not yet been established - Developing & agreeing spot check audit

ward rounds in clinical areas & fully implement our plans to embed a standardised red2green methodology			**A standardised Red2Green methodology will be implemented by March 2019**	• **Need to meet with CMG's to refine data so in one format.** • **Excel spread sheet produced identifying CMG wards boards/ward round profile and Red2Green implementation** • **'Spot checks of usage of board round failed/carried out in a number of CMG's** • **Red2 Green Metric Packs established for all CMGs** • **KPIs/metrics will be reviewed to align with NerveCentre reporting capabilities**	methodology (this needs to be agreed in conjunction with the priority 1 workstream (embedding Nervecentre) - Agreeing KPI data for Board rounds and ward rounds (again this needs to be agreed in conjunction with the priority 1 workstream (embedding Nervecentre)
We will ensure that frail patients in our care have a Clinical Frailty Score whilst they are in our hospital	Andrew Furlong /Eleanor Meldrum	Ursula Montgomery	**95% of 65+ patients will receive a clinical frailty score on admission by December 2019** **Q1 KPI (40%) complete**	**Overall Project status – On Track** **Achieved 42% CFS in ED** • **Clinical Frailty Scale score has been built into Nerve Centre and is being tested in July across Emergency Floor in conjunction with a tailored training package for all EF staff. Expected to go live in Sept 2018.** • **Nursing leads confirmed,** • **Medical lead confirmed**	**Concerns & PMO Assurance** No concerns. Strong leadership / good governance. KPI's aligned to national requirements

Annual Priority	SRO	Delivery Lead	Q1 performance against agreed KPI's	Overall Project Plan RAG Status & Progress to plan	Progress Update/Concerns, Issues & Risks
We will embed systems to ensure abnormal results are recognised and acted upon in a clinically appropriate time	Andrew Furlong / Eleanor Meldrum	Colette Marshall / Maria McAuley	**1. Acknowledgement of in-patient test results on ICE within 24 hours - 0.01%** **On track** **2. Acknowledgment of out-patient test results on ICE within ten working days - 0.01%** **On track** **3. ICE server and software upgraded –by the end of Q1** **Q1 KPI Complete** **4. ICE optimisation and configuration** **On track** **5. Roll out of Mobile ICE - Requirements for Mobile ICE to be scoped as part of optimisation project** **On track** **6. Paperless requesting for imaging and Blood tests** **Q1 KPI Complete** **7. Reporting metrics standardised and delivered every month** **On track** **8. ICE used as a repository for all clinical letters**	**Overall Project status – On Track** • **Acting on Results (AOR) : Software upgrade completed June 29th. Work is in progress re optimisation and configuration of the system. Communications strategy in development. Planned communications at Junior Doctors Induction - August. Pilot areas identified for testing upgrade once configured are ENT and Cardiology.** • **Order Comms OPD: IT Delivery Plan incorporates schedule for work to pilot ENT and Cardiology in Q2.** • **ICE Used as Repository for all clinic letters: Communications and engagement work is in progress. Reviewed successful company Dictate 3 in UCHL - positive meeting held raised some concerns regarding voice recognition. Business Case written, and submitted to RIC on the 14th June, next step is submission to FIC.** • **Until the pilot has taken place for AoR it is not clear how much IT resource is required to deliver a roll out. A capacity review will take place at the end of the pilot and issues and risks identified. A solution for not using ilab initially for all new Junior Doctors has not been resolved to date.**	**Concerns & PMO Assurance** No Concerns

			On track		
We will empower staff to 'Stop the Line' in all clinical areas	Andrew Furlong / Eleanor Meldrum	Colette Marshall, Maria McAuley	**1. Reduction in the number of Never Events - Trajectory 0** **Actual 4** **Q1 KPI not met** **2. Percentage of clinical areas that have had Stop the Line training - Trajectory 10%** **Actual 4%** **Q1 KPI not met**	**Overall Project status – slight slippage** ➢ 4 Never Events in Q1 (trajectory 0) ➢ Previous work in theatres and dermatology have seen Stop the Line embedded in the everyday work of our staff ➢ Approach to roll-out agreed with Quality Commitment oversight group and action plan written ➢ Training resource pack for CMGs developed ➢ Delivery timetable being finalised	**Concerns/PMO Assurance** No concerns. Although the Q1 KPIs have not been met, this workstream has strong leadership / governance and is delivering against their plan
We will improve the management of diabetic patients who are treated with insulin in all areas of the Trust	Max Chauhan / Eleanor Meldrum	Eleanor Meldrum / Max Chauhan	**1. Reduction in the number of instances of severe Hypoglycaemia (3 mol/L or below)** **Q1 data to be used as baseline for Q2-4** **2. Reduction in the number of instances of severe hyperglycaemia (25.1 mmol/L or above)** **Q1 data to be used as baseline for Q2-4** **1. Reduction in the prevalence of missed doses of insulin** **Q1 data to be used as baseline for Q2-4** **2. 95% of Medical staff to complete the Foundations in Insulin Safety training module** **Q1 KPI of 50% not met - actual 44%** **3. 95% of Registered Nurses, Midwives and HCAs to complete the Foundations in Insulin Safety training module** **Q1 KPI of 50% met - actual 60%**	**Overall Project status – slight slippage** ➢ Q1 data for these two indicators (Number of instances of severe Hypoglycemia /Hyperglycemia) does not provide sufficient detail in order to apply improvement thresholds for the reminder of the year (or sufficient assurance to confirm an overall improvement in avoidable hypo / hyperglycemia). ➢ Q1 data will be used as baseline ➢ Medical and Dental staff compliance with Insulin Safety training: Face to face training has continued alongside e-learning. The Q1 trajectory has not been achieved, possibly due to issues with HELM issues, but there is no evidence to suggest that this would make a significant difference to the data	**Concerns & PMO Assurance** Baseline data required to set trajectory for specific KPI's – to be completed by the end of August Q1 data for these two indicators does not provide sufficient detail in order to apply improvement thresholds for the reminder of the year (or sufficient assurance to confirm an overall improvement in avoidable hypo / hyperglycaemia).

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Patient Experience

Annual Priority	SRO	Delivery Lead	Q1 performance against agreed KPI's	Overall Project Plan RAG Status & Progress to plan	Concerns, Issues & Risks
We will improve the patient experience in our current outpatients' service & begin work to transform the outpatient model of care in ENT & cardiology	Andrew Furlong / Eleanor Meldrum	Debra Mitchell/Jane Edyvean	**Friends and Family test score (Coverage)** **% Positive F&F Test scores** Paper Switch Off (PSO) - % GP referrals via ERS % Advice & Guidance **Electronic Referrals Appointment Slot Issue Rate** **% Clinics Waiting times Recorded (Coverage) – NO KPIs** **Reduction in number of long term FU >12 mths** **Reductions in number of FU attendances** **% Letters printed via outsourced provider** **% Reduction in hospital cancellations (ENT)** **% Room Utilisation (CSI areas)** **Room Utilisation**	**Overall Project status – Slight Slippage** **Patient experience**: Launched Customer Care Apprenticeship course. Targeted F&FT action planning by CMG commenced. Improvements to environment progressed. Plans for implementation of rebooking service for patients progressed via the Booking Centre (completion July 2018) Programme to ensure 100% recording of waiting times in OP commenced. ENT action plan under development to address waiting times in clinics. **CQC**: Progressed plans for incremental move to a centralised model for the management of outpatients in response to CQC action plan. Evidence submitted against action plan **System wide transformation**: Workshops and LiA events held to develop system wide pathways in Cardiology, Gastroenterology, ophthalmology, dermatology and elective orthopaedics. Action plans agreed for delivery in Q3. Workshops being set up for next cohort of specialities **Communication with patients and GPs**: Transcription business case approved and order placed with DictateIT. Programme plan in place for pilot and post evaluation roll out. Work to improve appointment letters and % of letters sent via CFH continued **Paperless OP/efficiency**: Preparatory work undertaken for electronic requesting of tests and investigations in ENT and cardiology via ICE, linked to acting on results. End User Compute programme (hardware refresh) awaiting funding approval. Bookwise business case approved - initiated implementation in cardiology	**Concerns & PMO Assurance** No concerns.

We will improve patient involvement in care and decision making, focusing on cancer and emergency medicine	Andrew Furlong / Eleanor Meldrum	Carole Ribbins /John Jameson	**1. Reduction in formal complaints relating to EoLC in ED** **2. Number of relatives rating EoLC care as "good" or "very good" in ED** **3. A reduction in the instances of EoLC communication as a theme identified through the Medical Examiner case record review process.** **4. An increase in the number of rapid discharges from ED**	**Overall Project status – On Track** ➢ Specialist Palliative Care Team recently recruited and appointed to band six and seven positions to fill the vacant nursing posts ➢ Business Case under development to increase the specialist palliative care resource ➢ Improved data collection and draft dashboard under development ➢ External and internal EOLC websites updated with links to information inside and outside UHL ➢ Last Days of Life Policy and paperwork updated along with the prescribing guidance (in line with NICE guidance) and now available on InSite	**Concerns & PMO Assurance** Awaiting the EoLC dashboard in order to set the baseline / trajectory for the KPIs, therefore we are unable to RAG rate the trajectories.

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Annual Priority	SRO	Delivery Lead	August performance against agreed KPI's	August Project Plan RAG Status & Progress to plan	Concerns, Issues & Risks
We will eliminate all but clinical 4 hour breaches for non-admitted patients in ED	Rebecca Brown	Debra Mitchell	**Increase 4 hour performance for non-admitted patients to 98% in 18/19** **KPI not met YTD – YTD 87.25%**	**Overall Project status – slight slippage** ➢ The percentage of patients discharged or admitted via Emergency Department within 4 hours in July was 80.7% (LLR 83.1%)	**Concerns & PMO Assurance** Plan in place; significant gaps in staffing impacting on progress of plan
We will resolve the problem of evening & overnight deterioration in ED performance	Rebecca Brown	Debra Mitchell	**Decrease the difference between 4 hour performance at 5pm and 4am to under 5%** **KPI not met YTD – not available**	**Overall Project status – slight slippage** We have seen a decrease in the number of breaches between 8pm and 4am; however the percentage of breaches overnight continues to rise.	**Concerns & PMO Assurance** Plan in place: Additional staff are being recruited; once these staff are in place we expect to see an improvement in this metric.
We will ensure timely 7 days a week availability of medical beds for emergency admissions	Rebecca Brown	Debra Mitchell	**95% of patients will be allocated a bed within 60 mins from DTA** **KPI not met YTD 61%**	**Overall Project status – slight slippage** ➢ Work on Red2Green continues, particularly around stranded patients and we now have weekly meetings to challenge delays. ➢ We have now completed the Integrated Discharge Hub moves (Level 2, Windsor, LRI) and we are moving to NerveCentre in medicine to run Red2Green meetings to improve completion of fields and ensure the bed state is accurate.	**Concerns & PMO Assurance** Plan in place: Being reinforced at Consultants conference

We will deliver the 62 day standard for cancer during 18/19	Rebecca Brown	Sam Leak	**We will achieve the 62 day standard for cancer during 18/19** **KPI not met**	**Overall Project status – slight slippage** ➢ **Q1 performance was 76.2%** **Targets achieved** **31 day second or subsequent treatment – drugs** **31 day second or subsequent radiotherapy**	**Concerns & PMO Assurance** The Rap is being updated in August with UHL and LLR actions to reflect the system wide focus and increased challenge to deliver the trajectory A change in Director leadership for Cancer COO to chair monthly cancer taskforce to drive CMG ownership A robust governance process to ensure accountability and ownership for all tumour sites A change in the theatre timetable to prioritise capacity for challenged tumour sites – delivered in September New monthly joint steering group between CCG and UHL to ensure delivery Agreement to fund LLR transformational bids submitted to Cancer Alliance 2018/19 circa £900k – release of funding TBC IST started working with Urology 03/08/18

People - We will have the right people with the right skills in the right numbers in order to deliver the most effective care

NHS University Hospitals of Leicester NHS Trust

Caring at its best

Our Supporting Objectives

Annual Priority	SRO	Delivery Lead	August performance against agreed KPI's	August Project Plan RAG Status & Progress to plan	Concerns, Issues & Risks
We will develop a sustainable 5 year workforce plan by the end of Q1 18/19, with a delivery plan to reduce our nursing and medical vacancy rates and reduce time to hire	Hazel Wyton	Louise Gallagher	**Develop a 2018 - 2023 strategic workforce plan by June 2018** **KPI complete** **Workforce plan for 18/19 by April 2018** **KPI complete** **Reduce Trust vacancy rate from 8.9% to 7.5% in 18/19 with bespoke target to be agreed for staff groups exceeding 10% by 31st July 2018** **Manage agency expenditure within NHSI ceiling £18.8m** **KPI on track** **Reduce time to hire from an average 80 days to 60 days** **KPI not met – actual 73 days**	**Overall Project status – on track**	**Concerns & PMO Assurance** No concerns, Strong leadership and Governance

Annual Priority	SRO	Delivery Lead	August performance against agreed KPI's	August Project Plan RAG Status & Progress to plan	Concerns, Issues & Risks
We will launch our People Strategy in April 2018 to attract, recruit & retain a workforce that reflects our local communities across all levels of the Trust, with a specific focus on meeting the Workforce Race Equality Standards	Hazel Wyton	Louise Gallagher	**1.Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by:** **Q1 KPI met (target – 14%/actual 14.2%)** **2. Relative likelihood of staff being appointed from shortlisting across all posts** **Q1KPI met (target – 1.5%/actual 2.2%)** **3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation** **Q1 target – 32% - Actual Unknown** **4. Relative likelihood of BAME staff accessing non-mandatory training and CPD as compared to White staff** **Q1 target - increase access to internal training to 25% - Actual Unknown**	**Overall Project status – on track**	**Concerns & PMO Assurance** Equality and Diversity Board was established in June. It was therefore challenging to agree Trust wide targets and interventions prior to Equality and Diversity board set up. Strong leadership and governance in place

Education & Research - To deliver high quality, relevant education and research:

NHS University Hospitals of Leicester NHS Trust

Caring at its best

Our Supporting Objectives

Annual Priority	SRO	Delivery Lead	August performance against agreed KPI's	August Project Plan RAG Status & Progress to plan	Concerns, Issues & Risks
We will improve the experience of medical students at UHL and address specialty-specific shortcomings in postgraduate medical education, improving our local retention rate and the UHL medical student satisfaction score	Andrew Furlong/Eleanor Meldrum	Sue Carr	**Improve the number of good/satisfactory 'overall satisfaction' score in the GMC NTS from 76% to >80%**	**Overall Project status – on track** UHL survey outcomes for Mar 18- 80% would recommend their post to a colleague. Cardiology and Respiratory Medicine have been removed from enhanced monitoring (still awaiting formal confirmation from HEE)	**Concerns** At organisational level, UHL has no negative outliers (red flags) in the 2018 GMC survey. HEE require action plans for all individual programme negative outliers . There are 75 negative outliers and CMGs have been asked to respond to theirs by 14/09/18. Medical specialties in CHUGGS (Clinical Oncology and Gastroenterology) have a number of red flags- see risk below reappointment of CHUGGS CMG Education Lead
			Maintain the number of good/satisfactory 'overall satisfaction' score in the GMC NTS from 76% to >80%	On Track - 82% of programmes within UHL had satisfactory or good scores in the 2018 GMC survey (includes all programmes with >3 trainees) The UHL survey will be repeated in Sept/Oct so KPI will be updated again	
			Increase the retention rate of Leicester's medical students from 24% to 28% in 18/19	➢ Retention rates for Leicester Medical School have been confirmed as 33% in 2018	
			Work with Leicester University to improve the NSS student overall satisfaction score from 28/33 into the 3rd quartile by March 2020	➢ NSS data is held by UoL and not yet available	

We will explore the model for an Academic Health Sciences Partnership as part of our 5 Year Research Strategy and align priorities with our local universities	Andrew Furlong	Nigel Brunskill/ Stephen Ward	**Academic Health Sciences Partnership assessed by the end of Q2** **On track**	**Overall Project status – on track** ➢ **Draft business case in advanced stage after a series of meetings of senior colleagues from potential partner organisations**	**Concerns & PMO Assurance** No concerns, plan in place and strong leadership.

Caring at its best

Partnerships & Integration - To develop more integrated care in partnership with others

Our Supporting Objectives

We will integrate the new model of care for frail people with partners in other parts of health and social care in order to deliver an end to end pathway by the end of 18/19	Mark Wightman	Rachna Vyas	1. Pathway created across LLR by Sept 2018 **On track** 2. Pathway implemented by Dec 2018 **On track**	**Overall Project status – on track** ➢ LLR Frailty Checklist agreed by health and social care. This is a single page reminding professionals to check that vaccinations, falls assessments, medication reviews etc. have been completed ➢ Task ahead is to ensure that those at risk of emergency admission have access to these interventions in a standardised manner across the system ➢ Hampton Suite live; model of care being developed further through Integrated Discharge Team. ➢ Plans in place through July to enable testing of CFS on the Hampton Suite from mid-august, inc. training and development. ➢ PDSA underway with City ICRS to trial on-site support at weekends to increase discharge rate in medicine. Initial pilot showed an increase in discharges but the data needs qualitative assessment	**Concerns & PMO Assurance** No concerns. Strong leadership / good governance.
We will increase the support, education and specialist advice we offer to our patients and our	**partners to help them receive/ deliver**	**care in**	Mark Wightman	John Curringto n	Primary Care Education and Engagement Strategy

- A Delivery Lead has been identified for this Supporting Objective.
- A considerable amount of work around support, education and specialist advice we offer to GPs is both in place and being developed.

Concerns & PMO Assurance

No concerns

the community in order to reduce demand on our hospitals				- Primary Care Education and Engagement Strategy supported by PCOB and being implemented. - Process in place for managing and reporting GP Concerns. • - Exceeding the national CQUIN standards of 80% turnaround time of two working days for the ERS Advice and Guidance (A&G) services -148 services providing A&G across 31 specialties.	
			Establish a Primary Care Oversight (PCOB) and Integration Board Complete		
			Monthly reporting, and reduction, of GP Concern On track		
			Advice and Guidance Service for Primary Care On track		
We will lead the development of a 5 year regional Specialist Services Strategy which will place UHL at the heart of a regional network and supporting local DGH services	Mark Wightman	Jon Curringto n	**1. Five-Year Regional Specialised Services Strategy complete by Q1** **KPI COMPLETE**	**Overall Project status – on track**	**Concerns & PMO Assurance** No Concerns, good leadership and governance
	Mark Wightman	Jon Curringto n	2. Year 1 action plan implemented by 30th March 2019		

	Mark Wightman	Jon Curringto n	3. Monitor tertiary flows into UHL on a monthly basis Delay in data collection		

Key Strategic Enablers - We will progress our key strategic enablers

Our Supporting Objectives

Annual Priority	SRO	Delivery Lead	August performance against agreed KPI's	August Project Plan RAG Status & Progress to plan	Concerns, Issues & Risks
We will progress our hospital reconfiguration plans by developing our plans for PACH & the maternity hospital and finalising plans to relocate Level 3 ICU and dependent services at the LRI/Glenfield	Paul Traynor	Nicky Topham	**ICU OBC and FBC successfully agreed through assurance process; slight delay as a result of HOSC** **PCBC successfully agreed through CCG assurance process** **KPI met - Slight delay in completion**	**Overall Project status – on track** ➢ ICU OBC signed off by SCDH / Treasury department. FBC submitted to regional NHSE Specialist Commissioning for approval before onward dissemination. ➢ East Midlands Clinical Senate supported reconfiguration plans described in the PCBC. ➢ PCBC full draft completed and submitted in August	**Concerns & PMO Assurance** No concerns, good leadership and governance
We will make progress towards a paperless hospital with user-friendly systems by replacing all computers over 5 years old, computerising services to outpatient clinics, using technology to support Quality Commitment objectives and implementing an in-house digital imaging solution in	John Clarke	Elizabeth Simons/ Andy Carruthers	**EUC -5500 desktops to be replaced** **Computerising Services to OPD** **KPI slipped** **Computerising Services to OPD Implementation ICE Order**	**Overall Project status – on track** ➢ Commenced Aug18 - 10% delayed to Nov 18 ➢ Replaced broken PCs remainder for EUC delayed to Q3 Some Slippage - In analysis roll-out delayed to Q3	**Concerns** 1. Fluid Balance has been deferred to Q4 as now dependent on release 5 from Nerve Centre. Changed to Frailty in Q2 now instead 2. Delays to bring in additional resources added significant delay to whole programme for remainder of this year - particularly roll-out capacity and PMO function 3. Network delays, network operational issues and GE readiness impacted on go live date now deferred 22/09/18

18/19			**Comms**	**On Track** - Fluid Balance, Risk Assessment, Purple Booklet **Some Slippage** - SOPs, Mobile Devices, IT resources approved, BI reporting in place **Some Slippage - ePMA v10 and H/W deferred to 2019** **Data Migration on track - go live deferred to 22/09/18**	4. e-PMA upgrade to v10 deferred due to show stopper issues now with the supplier to resolve. The e-PMA rollout will commence on current version without AD enabled Caring at its best
			Quality Commitment: Nerve Centre		
			Quality Commitment: ICE Acknowledging Results		
			eHospital - e-PMA roll-out KPI on track		
			GE – PACS No local solution		
We will deliver the year 3 implementation plan for the 'UHL Way' to support & develop staff, (medical and non-medical) and offer tailored education programmes focusing on key areas	Joanne Tyler-Fantom	Bina Kotecha	**Sign off of PCF in Q1**	**Overall Project status – on track** ➢ PCF developed and shared with 5 CMG's, UHL Way Sponsorship Group and EWB. PCF shared with a small number of local teams requiring support when working with people/team challenges. EWB has approved approach.	**Concerns & PMO Assurance** ➢ Medical colleagues not able to adopt the Talent approach at this time. ➢ Staff side engagement and links to AFC New Deal pay progression implications ➢ Implementation teams capacity to deliver within defined timelines
			Strategy agreed by UHL Way Sponsorship group/EWB **KPI met**	**On Track** ➢ Talent strategy shared with UHL Way Sponsorship Group and EWB and agreed in broad principle. ➢ Talent conversation development programmes have been designed and are being delivered. 03.07.18 - PCF structure and language has been completed subject to UHL Way Sponsorship Group signoff.	
			Final agreement to agree with on line portal and supplier selected	➢ On line portal specification - initial draft has been created subject to comment and signoff.	
			Continued roll out of talent conversations training **KPI on track**	**On Track** ➢ Nursing Engagement has been positive and PCF amendments made accordingly. 03.07.18 - Feedback received around programme content which is being revised to better meet the Health care context.	
			Develop and roll out Lean Capability Programme across the Trust **KPI met**	**On Track** ➢ Next cohort due to commence in August 18.	
We will implement Y2 of our Commercial Strategy in order to exploit commercial opportunities available to the	Paul Traynor	TBC		**Overall Project status – significant delay**	No Update

Trust					
We will improve the efficiency & effectiveness of our key services and our operating theatres and implement our Carter-based LLR corporate consolidation programme	Paul Traynor	Ben Shaw	**1. Deliver a theatre productivity programme of £2.3m in 18/19** **2. Achieve 6.5% spend of turnover on back office by March 2019** **3. Benchmarked Trust productivity will improve to the next quartile by the end of 18/19** **4. Deliver a CIP programme of £51m in 18/19**	**Overall Project status – significant delay**	**Concerns & PMO Assurance** Red due to level of unidentified CIP and the significant risk to Programme with a high number of 'red' schemes How to improve progress with 18/19 CIP – agreed target for full CIP plans now end of June in preparation for Q1 reporting. How to bridge the additional £8.7m CIP gap if revised control total is agreed. Good leadership and governance in place.
We will continue on our journey towards financial stability as a consequence of the priorities described here, aiming to deliver our financial target in 18/19	Paul Traynor	Chris Benham	0% variance to financial control total and plan	**Overall Project status – significant delay**	

RAG KEY:	Trajectory achieved	Trajectory on track	Trajectory off track	Trajectory not met