

Integrated Performance Report

Paper F

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 August 2020 to July 2021) is 104 but remains within the expected range.
- **MRSA** – 0 cases reported.

- **VTE** – compliant at 98.1% in December.

Performance Challenges:

- **C DIFF** – 8 cases reported this month.
- **ED 4 hour performance (including LLR UCCs)** – 69.5% reported in December.
- **12 hour trolley wait** - 582 breaches reported.
- **Ambulance Handover 60+ minutes (CAD)** – performance at 24.5%.
- **Cancer Two Week Wait** was 71.0% in November against a target of 93%.
- **Cancer 62 day backlog** was 506 patients at the end of December.
- **Cancer 62 day treatment** was 45.1% in November 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 108,373 patients at the end of December.
- **52+ weeks wait** – 15,877 breaches reported at the end of December.
- **Diagnostic 6 week wait** was 49.9% against a target of 1% in December.
- **Cancelled operations OTD** – 1.9% reported in December.
- **Statutory and Mandatory Training** is at 89%.
- **Annual Appraisal** is at 80.5%.

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 / No / Not applicable]
Improved Cancer pathways	[Yes / No / Not applicable]
Streamlined emergency care	[Yes / No / Not applicable]
Better care pathways	[Yes / No / Not applicable]
Ward accreditation	[Yes / No / Not applicable]

2. Supporting priorities:

People strategy implementation	[Yes / No / Not applicable]
Estate investment and reconfiguration	[Yes / No / Not applicable]
e-Hospital	[Yes / No / Not applicable]
Embedded research, training and education	[Yes /No /Not applicable]
Embed innovation in recovery and renewal	[Yes /No /Not applicable]
Sustainable finances	[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:
Strategic: 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.
Organisational: Does this link to an <i>Operational/Corporate Risk</i> on Datix Register		
New Risk identified in paper: What <i>type</i> and <i>description</i> ?		
None		

5. Scheduled date for the **next paper** on this topic:

March 2022

6. Executive Summaries should not exceed **5 sides**

My paper does comply



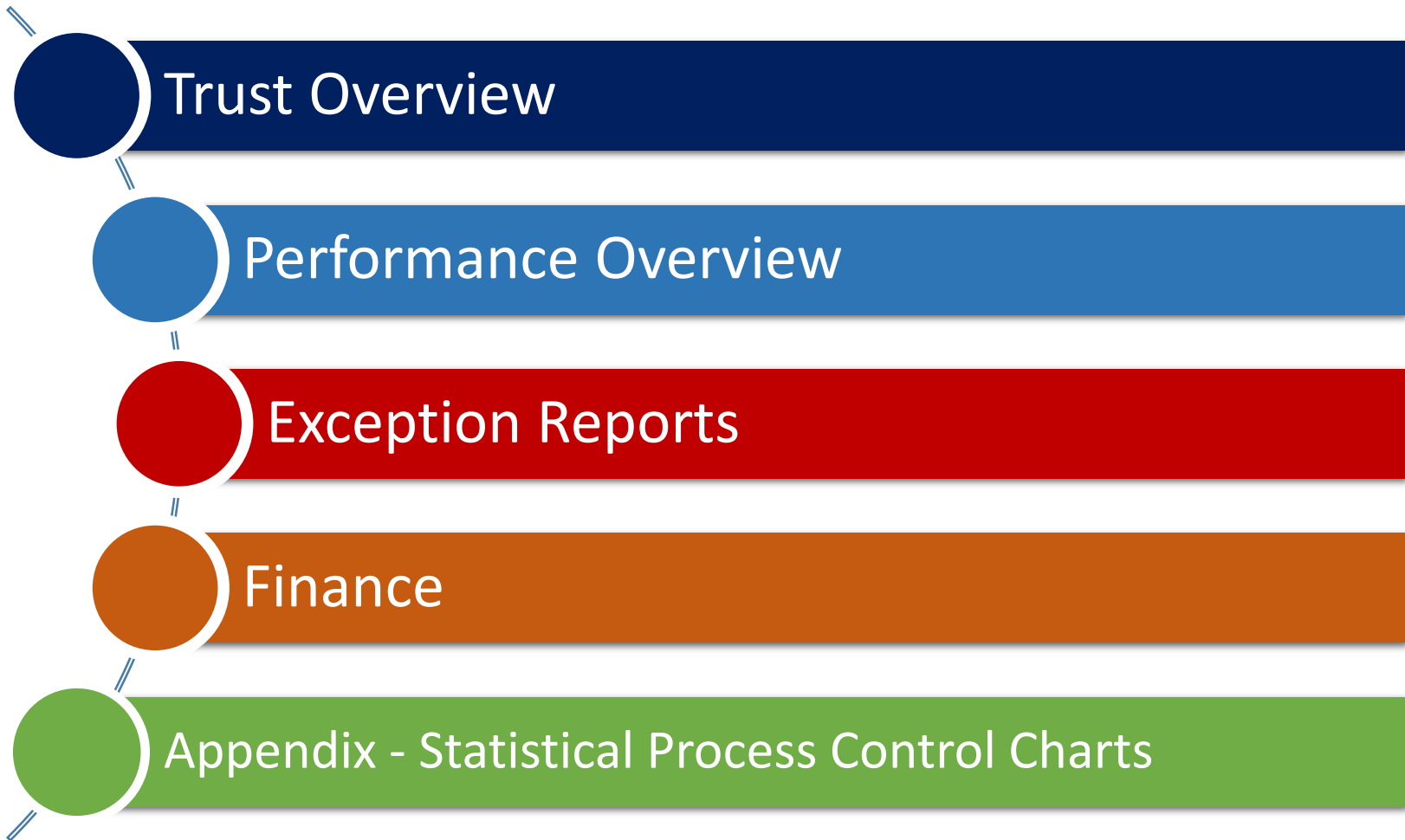
Integrated Performance Report

December 2021

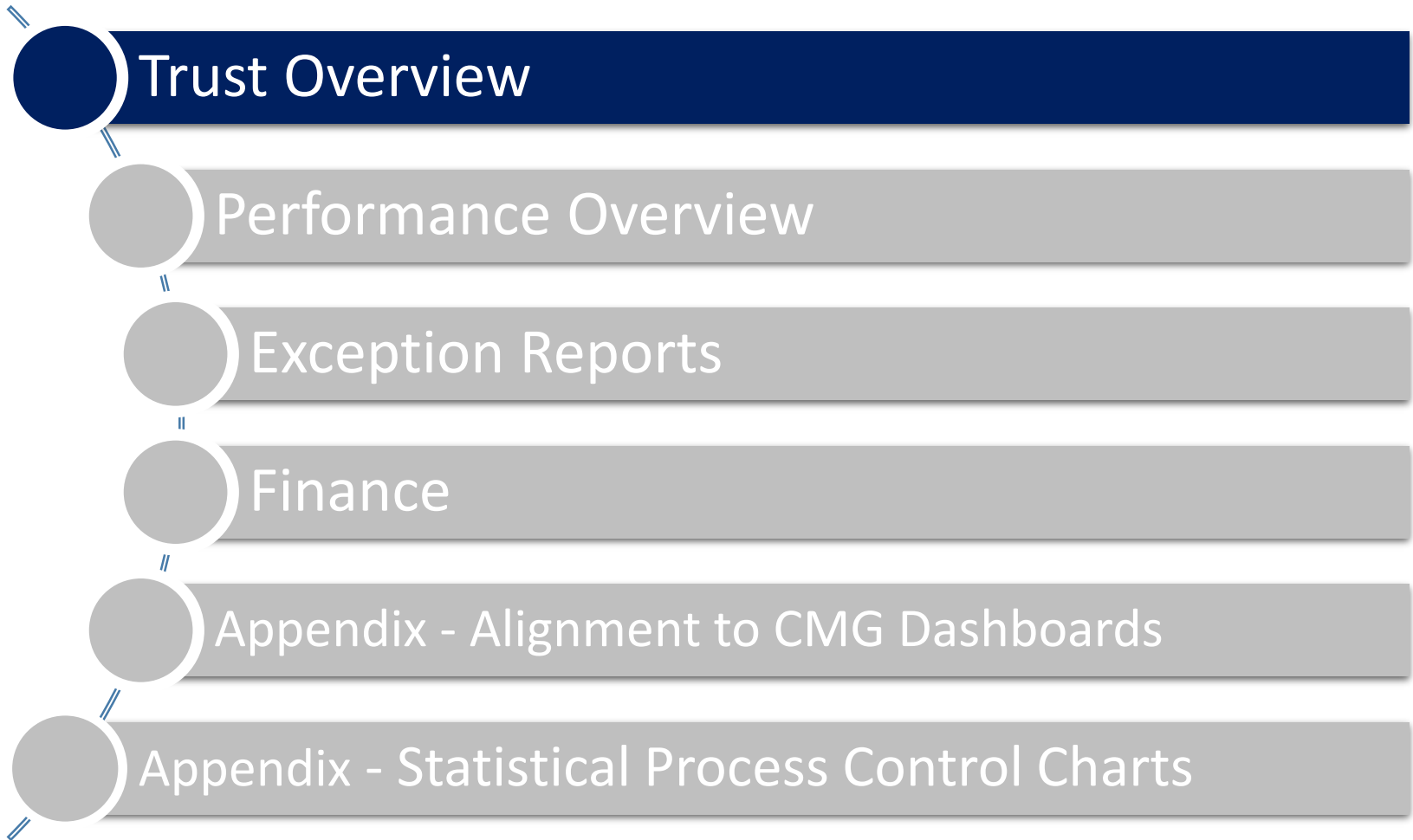


Operational Delivery Unit

Contents



- Trust Overview
- Performance Overview
- Exception Reports
- Finance
- Appendix - Statistical Process Control Charts



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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Key

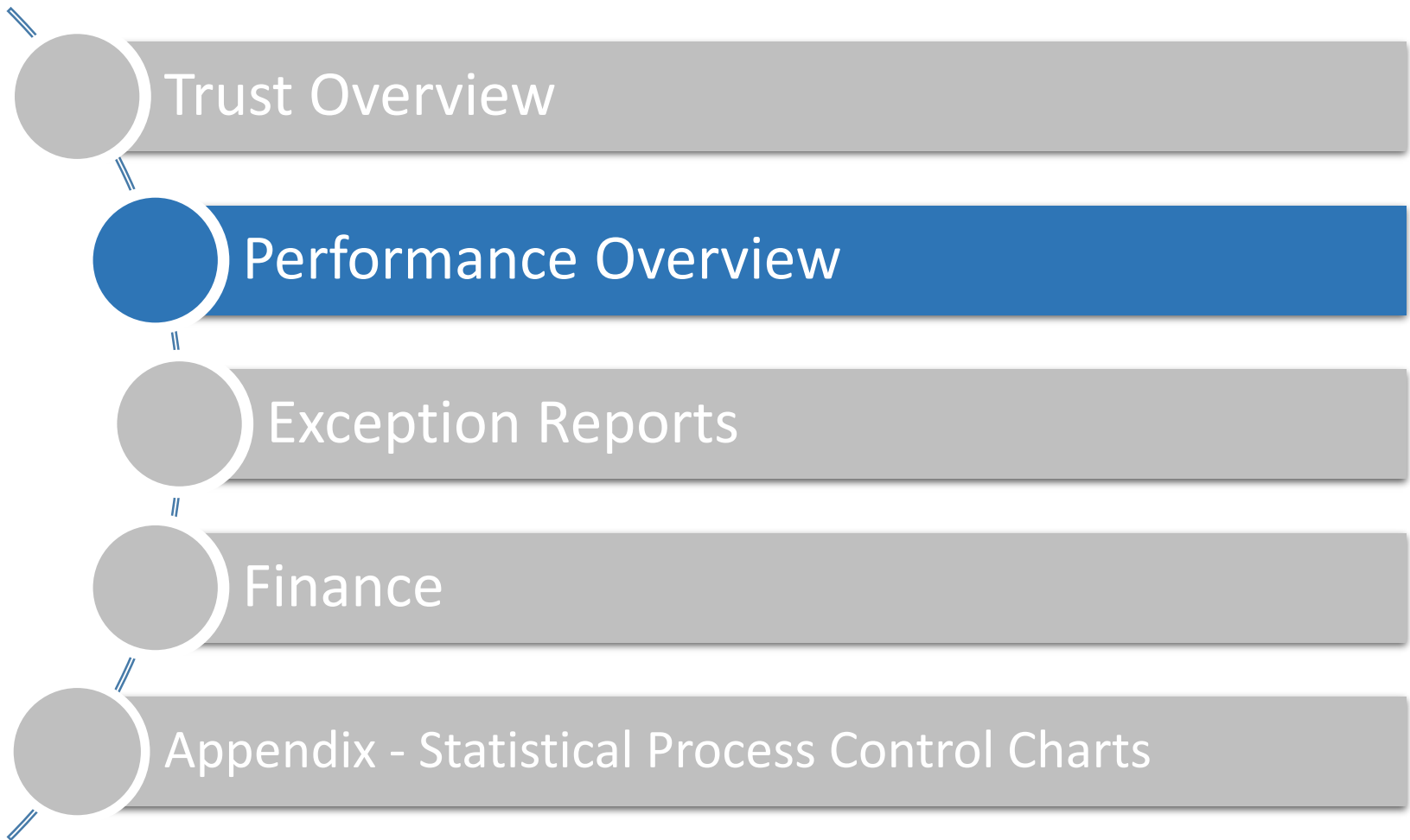
Failing Target

Achieving Target

Target TBC

Trust Overview (Current Month)

Domain	Overview , Risks and Actions	Lead
Overview		CEO
Safe (exception reports pages 19-22)	<p>Clostridium difficile hit the monthly trajectory however it is unlikely that UHL will meet the external target of 91 for the year, UHL are not an outlier nationally being benchmarked as 27 out of 139 trusts that submitted data and 2nd out of it's 18 peers.</p> <p>Methicillin susceptible staphylococcus aureus was 6 attributable UHL infections which bring the total YTD to the internal stretch target of 40, these infections are currently not published nationally therefore we are unable to benchmark against other organisations</p> <p>Hospital Acquired Pressure Ulcers have increased this month which has resulted in the total YTD exceeded the quality improvement 50% reduction target. The Trust continues to be in line for at least a 20% reduction. The 12 month breakthrough QI collaborative started in December with 46 clinical areas involved.</p> <p>The Trust remains under considerable pressure caused by COVID, urgent & emergency care demands, ambulance handover delays, and backlogs in elective care . Whilst we have robust processes to detect actual harm and mitigate risk, the Board will need to remain vigilant to the risks that we carry over the Winter period.</p>	Andrew Furlong / Eleanor Meldrum
Caring (exception reports page 23)	No in month concerns	Eleanor Meldrum
Well Led (exception reports pages 24-30)	Currently, sickness rates have increased as a result of COVID – November 21 reporting reflects rates at 5.8% which is a 2.8% variance to the target of 3%. There are large number of support packages in place for both managers and staff to provide appropriate support for both mental and physical health. Appraisal rates are below the target of 95% and remain at the same level as December (80.5%). The trajectory has been revised following the Omicron outbreak and rates are in line with this trajectory. Statutory and Mandatory training compliance is below target of 95% but on the predicted trajectory of 89% for 21/22. Adult nursing vacancies have increased in December due to an uplift of 97 WTE in establishment. HCSW vacancies have increased again because of an increase in establishment and further scrutiny is being undertaken on leavers data to fully understand the position.	Hazel Wyton
Effective (exception reports pages 31)	The Trust's Summary Hospital-level Mortality Indicator (SHMI) remains within expected. The Board have previously been advised of the actions that were taken to review our Hospital Standardised Mortality Ratios (HSMR) . Our in month HSMR has been below 100 since March 2021 and the HSMR has now returned to within expected. There are no specific concerns to bring to the Board's attention.	Andrew Furlong
Responsive – Emergency (exception reports pages 32-38)	ED attendances during December 2021 were 12.2% lower than December 2019. Emergency admissions have remained fairly consistent and are still lower than the same period in 2019, which has led to the conversion rate reducing. December performance continues to be below the required standards. Action plans are in place for all the metrics and are detailed in the exception reports.	Debra Mitchell
Responsive – Elective (exception reports pages 39-45)	January baseline elective capacity is recovering compared with pre-Christmas, however is still being impacted on by theatre and recovery staff sickness. This also includes anaesthetic and insourcing staff . ACPL has recovered from an recovery availability perspective, but is being negatively impacted by the acuity and complexity of long waiter patients. Emergency bed pressures also impacting on ability to deliver activity, particularly inpatient activity. MSK ward 14 at the LGH remains medical until 24.1.22. Emergency bed pressures/outliners also resulting in more cancellations on the day due to lack of elective bed capacity. Increased referrals to diagnostic services has counteracted the additional capacity created via ERF schemes. 104+ cohort is growing as roll-ons are greater than number treated, however, roll-on numbers are decreasing weekly as ERF schemes are delivering treatment for a wider cohort of long waiter patients. The Step 3/104+ combine cohort has reduced by over 800 patients in the last month.	Debra Mitchell
Responsive – Cancer (exception reports pages 46-48)	2WW demand and backlogs particularly in Breast and ENT continue to directly impact on performance for 2WW and 62 day. Capacity issues, workforce challenges, IP due to COVID, increased waiting list volumes, diagnostic capacity issues in Endoscopy and bed reductions due to overall system pressures continue to put at risk improvements in performance. Specific actions in place to reduce the risk with Breast taking action this month and expect to have a positive impact in February. Asymptomatic COVID positive patients on PCR test pre-treatment impacting on treatment activity. CMGs continue to clinically prioritise patients waiting for treatment and focus on recovery in monthly RAP meetings.	Debra Mitchell
Financial Improvement (exception reports)	<p>The Trust has reported a month 9 deficit of £1.9m. This is a £12k adverse variance to forecast. The year to date surplus at month 9 is £9.2m. This positive variance is due to pay and non-pay underspends due to lower activity than planned, vacancies across the Trust and over delivery of CIP.</p> <p>Month 9 YTD capital expenditure was £32.9m against a YTD plan of £33.1m, representing an underspend against forecast of £0.2m. The Trust's 2021/22 capital forecast is £73.3m, funded from a combination of internally generated funding (£43.6m); centrally funded PDC (£16.0m); the disposal of Hospital Close asset (£10.1m); Charitable Funds (£2.8m) and ICS funding/cash (£0.9m). The Trust's maintained a strong cash position at the end of December of £95m, representing an decrease of £4.5m compared with November.</p>	Rob Cooper



Performance Overview (Safe)

Safe

Domain	Key Performance Indicator	Target	Oct-21	Nov-21	Dec-21	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Safe	Never events	0	1	0	0	7				Jan-20	MD
	% of all adults Venous Thromboembolism Risk Assessment on Admission	95%	98.3%	98.4%	98.1%	98.5%				Oct-20	MD
	% of 3rd & 4th Degree Perineal Tears	3.5%	3.2%	2.8%	2.6%	2.9%				N/A	CN
	Clostridium Difficile	91	13	9	8	78				Jun-21	CN
	Methicillin Resistant Staphylococcus Aureus Total	0	0	0	0	0				Jun-21	CN
	E. Coli Bacteraemias Acute	198	11	11	16	119				Jun-21	CN
	Methicillin-susceptible Staphylococcus Aureus Acute*	40	1	6	6	40				Jun-21	CN

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

Comments

Rating

Winter increase in infections particularly Clostridium difficile and Methicillin susceptible staphylococcus aureus is expected due to increased antibiotic use for respiratory infections, exacerbated by COVID admissions, extreme bed occupancy rates, reduced staffing and increased sample taking. One symptom of the Omnicom variant is diarrhoea and therefore increased sampling has been noted. UHL are not an outlier nationally nor with our peers for Cdiff rates MSSA is not nationally reported.

UHL has had 7 Never Events to date. All appropriate immediate actions were undertaken and full investigations to identify learning are in train or have been completed. The Trust has worked with LLR System Patient Safety Specialists and Imperial Healthcare to develop a Never Event reduction plan – this was presented to the December Trust Board Quality Committee and progress against this will be tracked by the Executive Quality Board and Trust Board Quality Committee.

Performance Overview (Safe)

Domain	Key Performance Indicator	Target	Oct-21	Nov-21	Dec-21	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Safe	COVID-19 Hospital-onset, probable, 8-14 days after admission		2.8%	2.9%	4.9%	3.1%				Oct-20	CN
	COVID-19 Hospital-onset, healthcare-acquired, 15 or more days after admission		2.8%	3.5%	3.6%	3.1%				Oct-20	CN
	All falls reported per 1000 bed days	5.5	3.9	4.1		4.0				Oct-20	CN
	Rate of Moderate harm and above Falls Patient Safety Incidents with finally approved status per 1,000 bed days	0.18	0.04	0.06		0.07				Oct-20	CN
	Hospital Acquired Pressure Ulcers - All categories*	366	27	51	56	407				Jun-21	CN



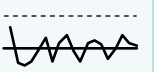








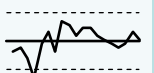
*note quality improvement ambition 50% reduction of 20/21

Comments

November and December have seen an increase in the number of hospital acquired pressure ulcers resulting from a combination of factors, increased frailty and dependency of the patients, continual reduced staffing levels which results in the potential for patients not being assisted to change position as frequently as needed. Despite not meeting the quality improvement target of 50% reduction there is a reduction on the previous year, an increased focus on prevention has commenced with the 12 month QI breakthrough collaborative.

Rating

Performance Overview (Caring)

Domain	Key Performance Indicator	Target	Oct-21	Nov-21	Dec-21	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Caring	Single Sex Breaches		4	0	0	4	National Reporting resumed from Oct 21.			Mar-20	CN
	Inpatient and Day Case Friends & Family Test % Positive*	95%	99%	98%	98%	98%				Mar-20	CN
	A&E Friends & Family Test % Positive**	82%	75%	72%	82%	81%				Mar-20	CN
	Maternity Friends & Family Test % Positive*	91%	95%	96%	97%	96%				Mar-20	CN
	Outpatient Friends & Family Test % Positive	94%	94%	95%	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 ** Targets are based on national averages between December 2020 and November 2021

Comments

Rating

No in month concerns

Performance Overview (Well Led)

Domain	Key Performance Indicator	Target	Oct-21	Nov-21	Dec-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%	8.6%	8.6%	8.7%	8.7%				Nov-19	CPO
	Sickness Absence (Excludes Estates & Facilities staff)	3%	5.7%	5.8%		5.3%				Mar-21	CPO
	% of Staff with Annual Appraisal (Includes Estates & Facilities staff from May 21)	95%	79.6%	80.2%	80.5%	80.5%				Mar-21	CPO
	Statutory and Mandatory Training	95%	89%	90%	89%	89%				Feb-20	CPO

Comments

Rating

Sickness rates are increasing above the Trust target as a result of increased COVID and other respiratory illness. 29.1% of calendar days lost is a result of COVID, 19.3% of calendar days lost is as a result of stress and anxiety. This is being supported by the mental health hub and a range of occupational health and well being interventions.

Appraisal rates on below target but in line with the revised compliance trajectory given the impact of COVID.


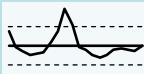
Statutory and Mandatory Training compliance remains below target but in line with trajectory.

Performance Overview (Well Led)

Domain	Key Performance Indicator	Target	Oct-21	Nov-21	Dec-21	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Well Led	Adult Nursing Vacancies	10%	11.5%	10.0%	12.5%	12.5%				Dec-19	CPO
	Paed Nursing Vacancies	10%	15.0%	9.6%	9.0%	9.0%				Dec-19	CPO
	Midwives Vacancies	10%	10.5%	8.5%	8.5%	8.5%				Dec-19	CPO
	Health Care Assistants and Support Workers - excluding Maternity	10%	10.0%	10.6%	12.1%	12.1%				Dec-19	CPO
	Health Care Assistants and Support Workers - Maternity	5%	1.3%	4.4%	2.3%	2.3%				Dec-19	CPO
	Frontline Staff Lateral Flow Testing Engagement	No Target	467	413	421	794.7				N/A	CPO

Comments	Rating
<p>Nursing vacancies have increased during December driven by an increase of 97WTE in establishment. There are robust international and domestic recruitment plans in place to offset these increases.</p> <p>In line with regional trends there is an increase in HCSW vacancies. There are slightly more in post in UHL compared to November 2021 but an increase in establishment has impacted the vacancies and turnover rates including those switching to bank only has increased.</p>	

Performance Overview (Effective)

Domain	Key Performance Indicator	Target	Oct-21	Nov-21	Dec-21	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Effective	Published Summary Hospital-level Mortality Indicator (SHMI)	100	105	105	104	104 (Aug 20 to Jul 21)				May-21	MD
	12 months Hospital Standardised Mortality Ratio (HSMR)	100	106	106	102	102 Oct 20 to Sep 21				May-21	MD
	Crude Mortality Rate	No Target	1.4%	1.3%	1.6%	1.3%				May-21	MD

Comments

Rating

The Trust's Summary Hospital-level Mortality Indicator (SHMI) remains within expected. The Board have previously been advised of the actions that were taken to review our Hospital Standardised Mortality Ratios (HSMR) . Our in month HSMR has been below 100 since March 2021 and the HSMR has now returned to within expected. There are no specific concerns to bring to the Board's attention.

Performance Overview (Responsive Emergency Care)



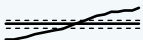








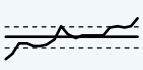





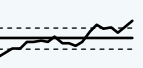



Domain	Key Performance Indicator	Target	Oct-21	Nov-21	Dec-21	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Responsive (Emergency Care)	Emergency Department 4 hour waits Acute Footprint	95%	67.3%	66.4%	69.5%	70.6%				Data sourced externally	COO
	Mean Time to Initial Assessment	15	41.1	46.7	38.6	35.8				TBC	COO
	12 hour trolley waits in Emergency Department	0	224	605	582	1678				Mar-20	COO
	Number of 12 hour waits in the Emergency Department	0	1,989	2,323	1,836	11,677				TBC	COO
	Time Clinically Ready to Proceed	60	206.2	241.5	215.4	160.4				TBC	COO
	Ambulance handover >60mins	0%	28.0%	35.0%	24.5%	19.0%				Data sourced externally	COO
	Long Stay Patients (21+ days)	135	207	218	203	203				Sep-20	COO

Comments

ED attendances during December 2021 were 12.2% lower than December 2019. Emergency admissions have remained fairly consistent and are still lower than the same period in 2019, which has led to the conversion rate reducing. December performance continues to be below the required standards. Action plans are in place for all the metrics and are detailed in the exception reports.

Rating

Performance Overview (Responsive Elective Care)

Domain	Key Performance Indicator	Target	Oct-21	Nov-21	Dec-21	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Responsive (Elective Care)	Referral to Treatment Incompletes	103,403	105,575	106,127	108,373	108,373				Nov-21	COO
	Referral to Treatment 52+ weeks	0	14,020	14,946	15,877	15,877				Nov-21	COO
	Referral to Treatment 104+ weeks	0	1,376	1,648	1,783	1,783				Nov-21	COO
	6 Week Diagnostic Test Waiting Times	1.0%	43.9%	44.7%	49.9%	49.9%				Nov-19	COO
	% Operations Cancelled On the Day	1.0%	2.3%	2.1%	1.9%	1.5%				Apr-21	COO
	% Outpatient Did Not Attend rate	5%	7.2%	7.5%	7.9%	7.2%				Feb-20	COO
	% Outpatient Non Face to Face	45%	37.9%	35.1%	36.4%	39.5%				Feb-20	COO

Comments

Rating

January baseline elective capacity is recovering compared with pre-Christmas, however is still being impacted on by theatre and recovery staff sickness. This also includes anaesthetic and insourcing staff.

ACPL has recovered from an recovery availability perspective, but is being negatively impacted by the acuity and complexity of long waiter patients.









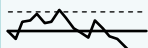
Emergency bed pressures also impacting on ability to deliver activity, particularly inpatient activity. MSK ward 14 at the LGH remains medical until 24.1.22.

Emergency bed pressures/outliners also resulting in more cancellations on the day due to lack of elective bed capacity.

Increased referrals to diagnostic services has counteracted the additional capacity created via ERF schemes.

104+ cohort is growing as roll-ons are greater than number treated, however, roll-on numbers are decreasing weekly as ERF schemes are delivering treatment for a wider cohort of long waiter patients. The Step 3/104+ combine cohort has reduced by over 800 patients in the last month.

Performance Overview (Responsive Cancer)

Domain	Key Performance Indicator	Target	Oct-21	Nov-21	Dec-21	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Responsive (Cancer)	2 Week Wait	93%	80.0%	71.0%		78.4%				Dec-19	COO
	62 Day Backlog	0	345	411	506	506				Dec-19	COO
	Cancer 62 Day	85%	43.3%	45.1%		55.4%				Dec-19	COO

Comments

2WW demand and backlogs particularly in Breast and ENT continue to directly impact on performance for 2WW and 62 day. Capacity issues, workforce challenges, IP due to COVID, increased waiting list volumes, diagnostic capacity issues in Endoscopy and bed reductions due to overall system pressures continue to put at risk improvements in performance. Specific actions in place to reduce the risk with Breast taking action this month and expect to have a positive impact in February. Asymptomatic COVID positive patients on PCR test pre-treatment impacting on treatment activity. CMGs continue to clinically prioritise patients waiting for treatment and focus on recovery in monthly RAP meetings.

Rating

Performance Overview (Finance)

Domain	Key Performance Indicator	Target YTD	Oct-21	Nov-21	Dec-21	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Finance	Trust level control level performance	£9m Forecast	£3.5m	£2.1m	-£1.9m	£9.2m				N/A	CFO
	Capital expenditure against plan	£29.4m	£2.7m	£3.6m	£4.7m	£32.9m				N/A	CFO
	Cost Improvement	£9m Plan	£1.7m	£1.2m	£1.3m	£12.8m				N/A	CFO
	Cashflow	No Target	£2.2m	£6.2m	-£4.5m	£95.0m				N/A	CFO

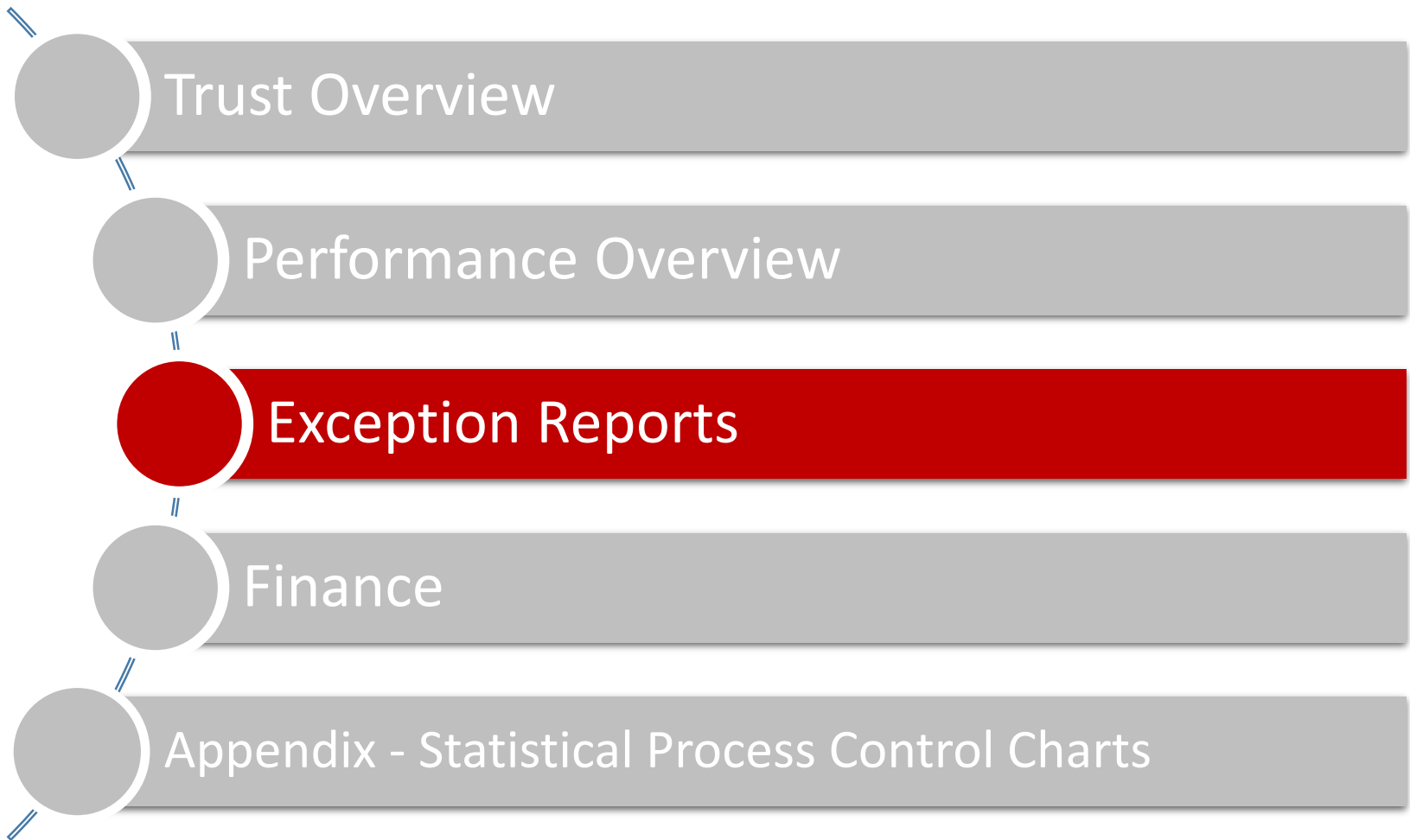
Comments

Rating

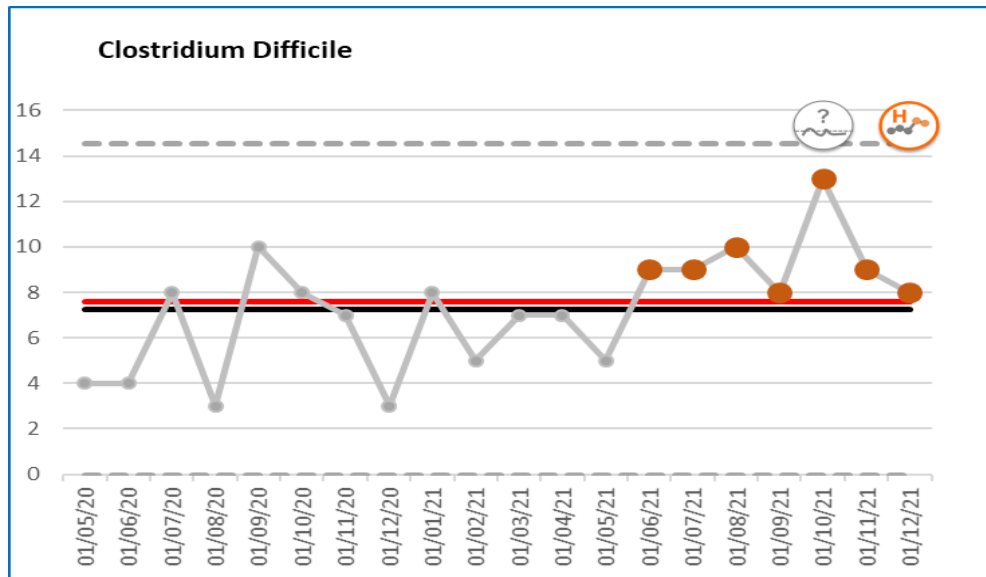
The Trust has reported a month 9 deficit of £1.9m. This is a £12k adverse variance to forecast. The year to date surplus at month 9 is £9.2m. This positive variance is due to pay and non-pay underspends due to lower activity than planned, vacancies across the Trust and over delivery of CIP.

Month 9 YTD capital expenditure was £32.9m against a YTD plan of £33.1m, representing an underspend against forecast of £0.2m. The Trust's 2021/22 capital forecast is £73.3m, funded from a combination of internally generated funding (£43.6m); centrally funded PDC (£16.0m); the disposal of Hospital Close asset (£10.1m); Charitable Funds (£2.8m) and ICS funding/cash (£0.9m).

The Trust's maintained a strong cash position at the end of December of £95m, representing an decrease of £4.5m compared with November.



Safe – Clostridium Difficile



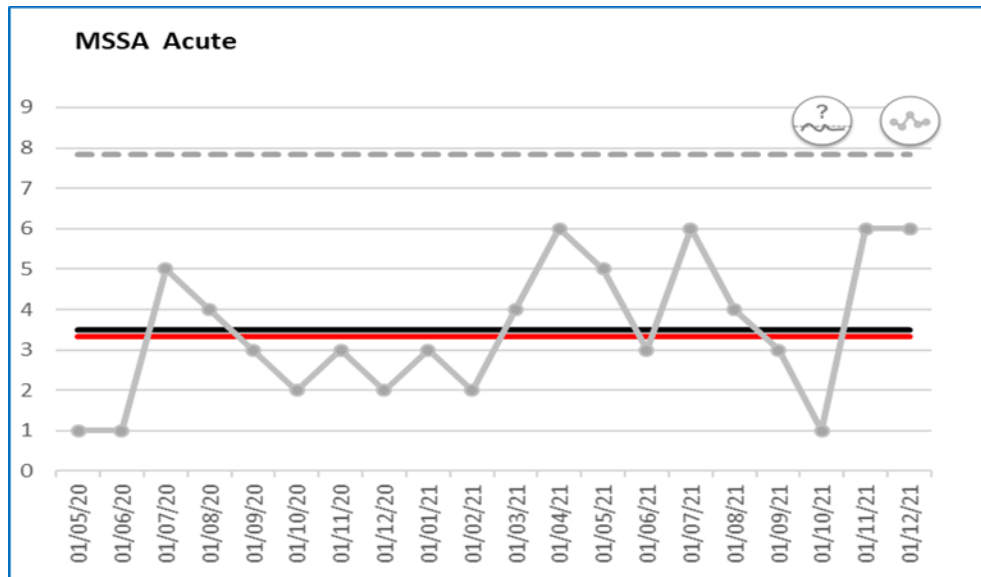
Current Performance			Three Month Forecast		
Dec 21	YTD	Target	Jan 22	Feb 22	Mar 22
8	78	91	8	8	8

National Position & Overview

The rate of *C. Difficile* infection counts of hospital onset-healthcare associated cases per 100,000 bed days are significantly lower for UHL (11.4) compared with the national average (18.9) for last 12 months of published data (Nov 20 – Oct 21). UHL ranked 27 out of 139 trusts that submitted data and 2nd out of it's 18 peers. Latest data available via fingertips.phe.org.uk to date

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Winter increase is expected due to antibiotic use for respiratory infections, exacerbated by COVID admissions, extreme bed occupancy rates, reduced staffing and consequent negative impact on environmental hygiene, all contribute adversely to infection and transmission. Due to the small numbers of positive reportable cases over trajectory at this point in the year a Root Cause cannot be identified 	<ul style="list-style-type: none"> Ribotype all available samples Every <i>C. difficile</i> case is reviewed through root cause analysis (RCA) best practice feedback is given to each area by the Specialist CD nurse 	<ul style="list-style-type: none"> Report progress and current trajectory against Trust target at TIPAC and through CMG PRMs

Safe – Methicillin Sensitive Staphylococcus Aureus



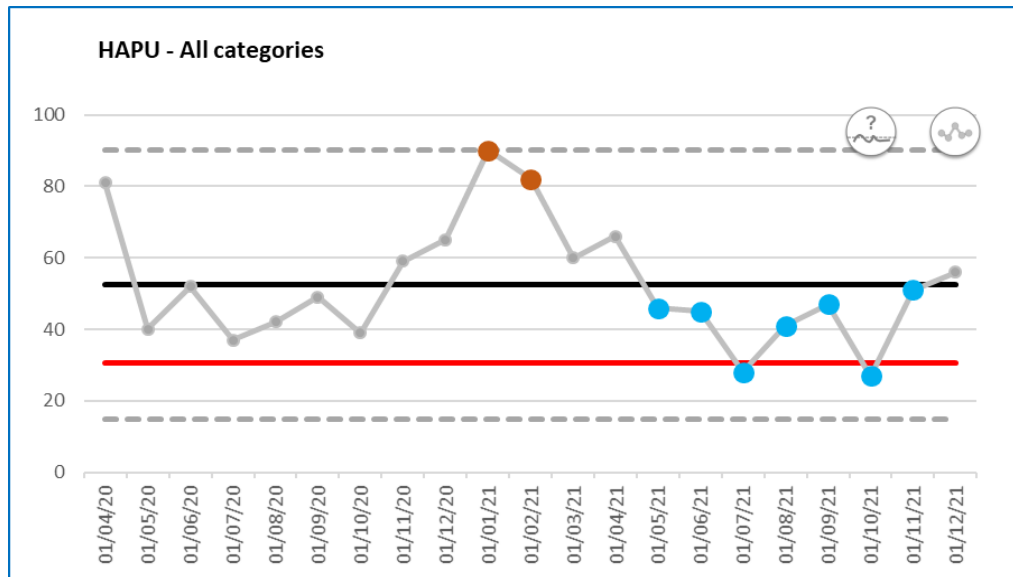
Current Performance			Three Month Forecast		
Dec 21	YTD	Target	Jan 22	Feb 22	Mar 22
6	40	40	4	4	4

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.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Peripheral and Central line infections of the bloodstream Surgical Site Infections Increased attendance of high acuity patients through the Emergency and Specialist medicine departments 	<ul style="list-style-type: none"> Thematic review of MSSA cases Continue raising awareness, monitoring infection prevention practice Review Denominator data for blood cultures taken in comparison to MSSA positive cultures 	<ul style="list-style-type: none"> The chart demonstrates occasional spikes of a similar level, this will be monitored and reviewed

Safe – Hospital Acquired Pressure Ulcers All Categories

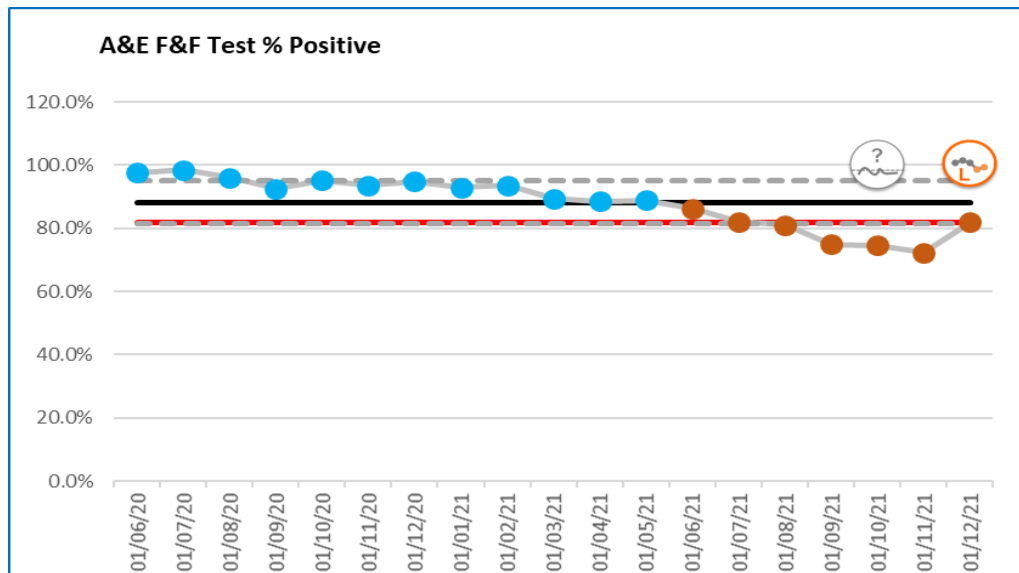


Current Performance			Three Month Forecast		
Dec 21	YTD	Target	Jan 22	Feb 22	Mar 22
56	407	366	50	45	40

National Position & Overview
Currently no national benchmarking or reporting is available to provide comparative data.
UHL are one of six organizations working with national experts and NHSEI quality team to review the national mechanism of capturing Pressure Ulcer data via the coding system.
The Trust target of 366 HAPUs is an internal quality improvement stretch target

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> 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. Delays in undertaking reviews has added to increased monthly numbers in last 2 months 	<ul style="list-style-type: none"> Monthly HAPU Care, Review and Learn meetings chaired by CMGs HON plus Tissue Viability Lead, monitor delays due to Trust pressures Pressure Ulcer 12 month breakthrough series collaborative clinical faculty providing individual ward level support with PDSA projects Non clinical faculty members providing QI support via a series of teaching events Harms relating to staffing shortages, including HAPUs, via the safer staffing monthly report 	<ul style="list-style-type: none"> Monthly improvement trajectory for each CMG Raising awareness through a data driven collaborative with area specific quality Improvement projects over the next 12 months

Caring – A&E Friends & Family Test



Current Performance			Three Month Forecast		
Dec 21	YTD	Target	Jan 22	Feb 22	Mar 22
82%	81%	82%	83%	84%	85%

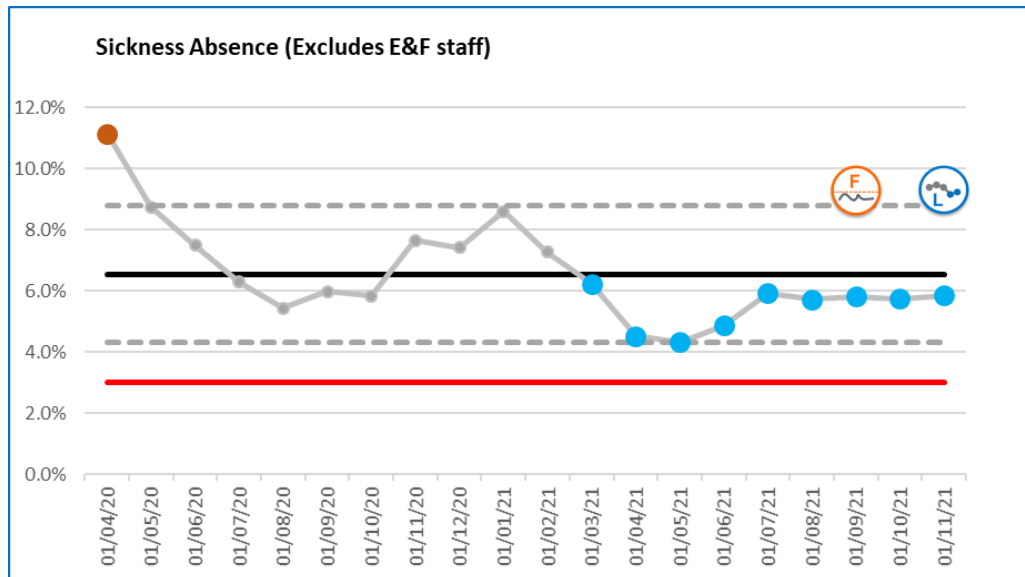
National Position & Overview

UHL performance has improved this month from 72% in November to 82% in December following a significant deterioration over the past 7 months. The target has been set as 82% which was the average performance between Jan 21 and Nov 21.

National performance in November was 77%, UHL ranked 92 out of 119 acute trusts and 15 out of 18 in its peer group. The highest performing trust in UHL's peer group achieved 84.2 and the lowest performing trust achieved 63.8%.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Increased attendances and longer wait times for patients continue which mirrors the national figure and within the performance reports There has been in recent months a gradual reduction in respondents following the initial increase with the introduction of SMS text collection methodology 	<ul style="list-style-type: none"> Enhance communication with patients regarding current delays in the department Enact the ICS winter plans to reduce attendance and delayed discharges of those that are medically fit Use of on site urgent treatment centre to debulk the emergency department Increase SMS texting to include the Urgent Treatment Centre NHSI/E MADE event planned for January to support the safe discharge of patients with ongoing Health and Social Care needs and reduce LOS 	<ul style="list-style-type: none"> With reduction in wait times, improvement in satisfaction scores will be demonstrated

Well Led – Sickness



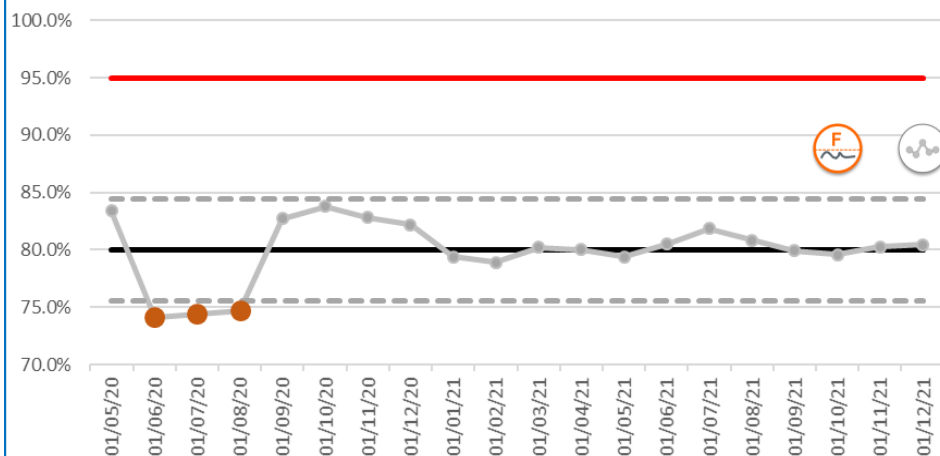
Current Performance			Three Month Forecast		
Nov 21	YTD	Target	Dec 21	Jan 21	Feb 22
5.8%	5.3%	3%	7%	7%	6.5%

National Position & Overview	
<ul style="list-style-type: none"> Data Excludes Estates and Facilities staff. Peer data not currently available. 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. Data has a two month time lag due to retrospective reporting. Current position is significantly higher reflection 3rd wave omicron variant. 	

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Whilst sickness absence remained fairly static in recent months, we have seen an increase in since November. The most significant increase is in Covid-related absences. Many areas are seeing increasing sickness rates as winter viruses and other causes increase. Reporting identifies a 2 month time lag for accurate capture and change of approx. 3.7% retrospectively on data figures. 	<ul style="list-style-type: none"> Covid vaccinations are being actively promoted, recognising these become mandatory for many staff from 1st April. CMG's are reviewing their business continuity plans to take account of increased absences due to the Omicron variant The People Services team continue to review Smart reports and support managers. Continued focus on updating and closing absences to ensure accurate reporting and timely support for staff. Making it Happen meetings are continuing to support and advise managers. 	<ul style="list-style-type: none"> Sickness is having a significant impact particularly on maintaining safe staffing and keeping staff morale up. We anticipate an increase in absence levels due to the omicron variant and seasonal fluctuation over the coming months, as seen in the daily reporting in December. The indicative trajectory will be kept under review, to take account of the Omicron variant, RSV, flu cases and change to isolation guidance. Over the next few months, actions to be reviewed to minimise absences, ensure oversight and provide targeted management.

Well Led – Appraisals

% of Staff with Annual Appraisal (Includes E&F staff from May 21)



Current Performance

Dec 21	YTD	Target	Three Month Forecast		
80.5%	80.5%	95%	Jan 21	Feb 22	Mar 22
			80%	82%	82%

National Position & Overview

Peer data not currently available.

- This financial year to date, appraisal performance has been stable following a significant decline last year due to COVID-19 related pressures.
- December has seen the figure remain somewhat static with a 0.5 % increase in performance despite the winter and capacity challenges
- The appraisal and pay progression paper, outlining the approach from 1st November 2021 was approved by Strategic on 8th November 2021
- Due to the impact of Omicron on Staffing it is reasonable to maintain the current trajectory in January 2022, which has been revised as above (please see the update in 'Actions' below)

Root Cause

- It is recognised that performance has been impacted on by Covid-19 and operational pressures/ demand.
- This is further compounded by increased staff absence levels.
- We may see further impact in the coming months due to the new strain based on both matters as above

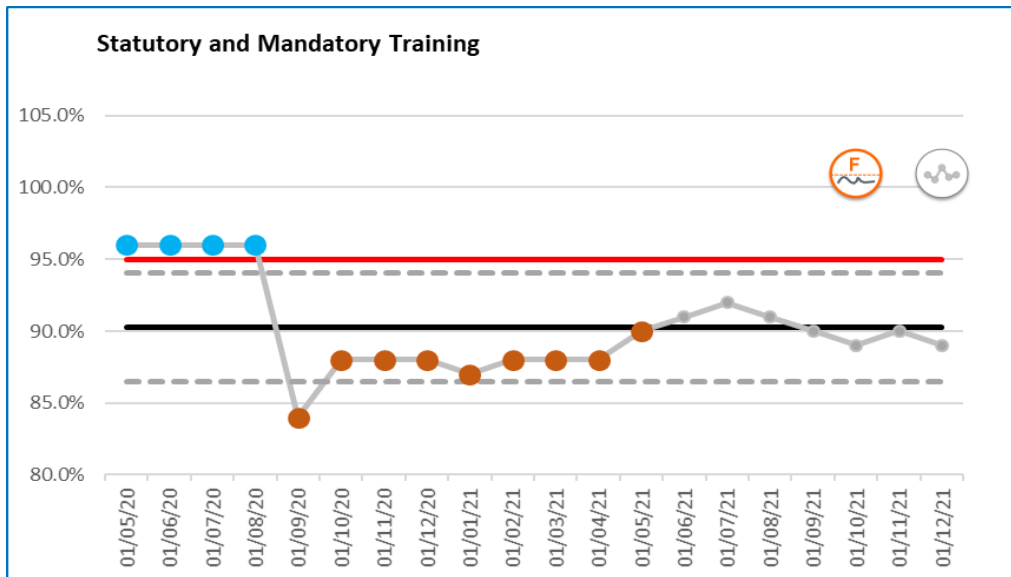
Actions

- From 1st November 21
- Automatic pay progression will continue to 31 March 2022
 - Full appraisals to be undertaken wherever possible. As a minimum, a robust discussion must take place. Both to be recorded through the normal data capture processes.
 - We will continue with aligned appraisal and pay step reporting processes.
 - The current increment / pay step arrangements continue for bank workers.
 - A separate proposal will be developed for the re-earnable process for staff on the top of Bands 8c, 8d and 9, in consultation with partner organisations after 1 April 2022
 - The trajectory has been reviewed to reflect the impact of Omicron on staffing pressures and subsequently on appraisal compliance.

Impact/Timescale

- CMG's / Directorates have robust plans to achieve and sustain 95% appraisal performance by 1 April 2022;
- Appraisals are 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.
- Potential impact of Omicron on absences and in turn on operational pressures has resulted in the need to review targets.

Well Led – Statutory and Mandatory Training



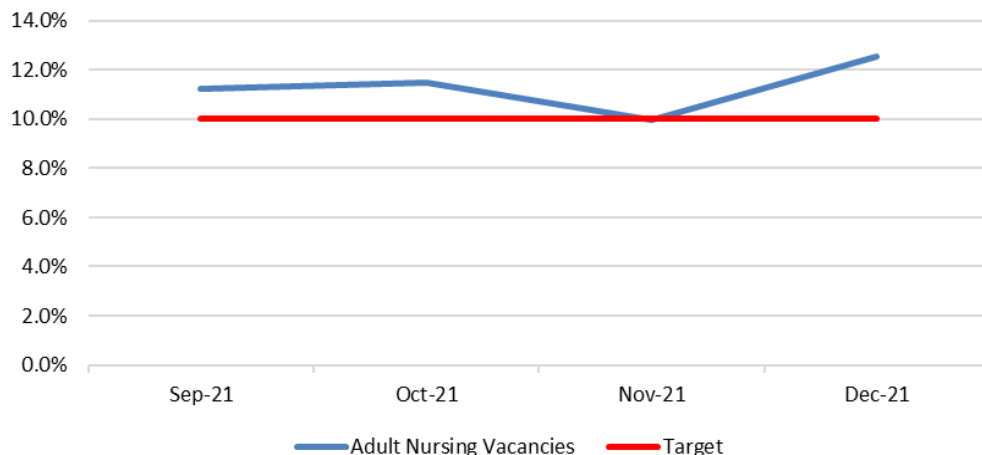
Current Performance			Three Month Forecast		
Dec 21	YTD	Target	Jan 22	Feb 22	Mar 22
89%	89%	95%	89%	89%	89%

National Position & Overview
Peer data not available.

Root Cause	Actions	Impact/Timescale
<p>It is recognised that performance has been impacted on by:</p> <ul style="list-style-type: none"> • Covid-19 • Operational pressures • Operational demand • Seasonal pressures • Seasonal demand 	<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 to the compliance reports, and direct emailed snapshot reports to over 2000 managers and relevant staff. This supports local level prioritising of release for training completions.</p>	<p>Reviewed through the Making it All Happen reviews chaired by CMG / Directorate leadership teams with support from HR.</p> <p>This is a meeting with each line manager to review sickness, appraisals and S&MT compliance.</p>

Well Led – Adult Nursing Vacancies

Adult Nursing Vacancies



Current Performance

Three Month Forecast

Dec 21	YTD	Target	Jan 22	Feb 22	Mar 22
12.5%	12.5%	10%	11.5%	11.5%	10.5%

National Position & Overview

Root Cause

- The UHL 2020/21 vacancy rate for Nursing & Midwifery registrants has seen an increase of 2.5% from Nov'21. This is due to increasing establishments across CMG budgets.
- The H2 budgeted establishments across UHL have increased by 97wte which equates to 3.2%.
- The leavers trend has not deteriorated and remains at circa 15 leavers per month including retirees.

Actions

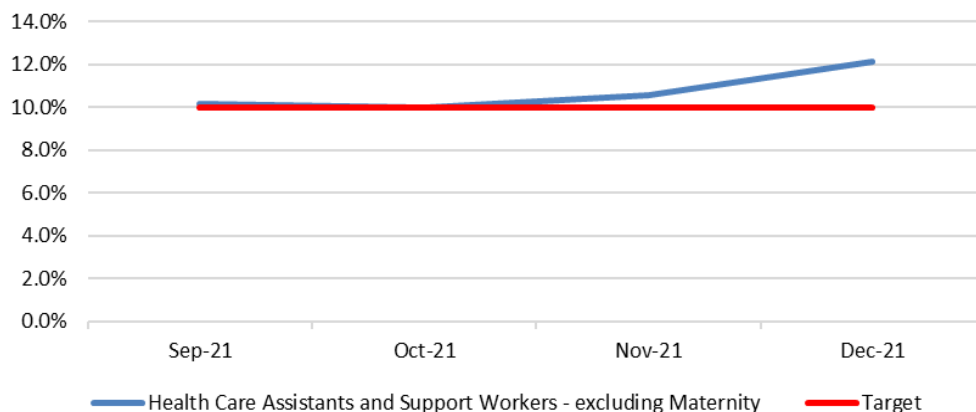
- Marketing Campaign and digital resources development underway to promote UHL as an employer of choice .
- Recruitment agencies to provide assurance that all is on track for our ongoing cohorts of international nurses to arrive bi monthly in 2022: 320 planned within financial year.
- Education support for all RN staff joining the trust during the winter /Covid-19 pandemic staffing challenges to support their competence, confidence and retain individuals at UHL.

Impact/Timescale

- Continue to work with arrival dates below for International Nurse Recruitment arrival dates no anticipated delays
- Jan - 52 arrivals (OSCES due March'22)
 - March - 50 arrivals (OSCES due April'22)
 - May -60 arrivals
 - July – 60 arrivals

Well Led – Health Care Assistants and Support Workers - excluding Maternity

Health Care Assistants and Support Workers - excluding Maternity



Current Performance

Three Month Forecast

Dec 21	YTD	Target	Jan 22	Feb 22	Mar 22
12.1%	12.1%	10%	12.5%	12%	11.0%

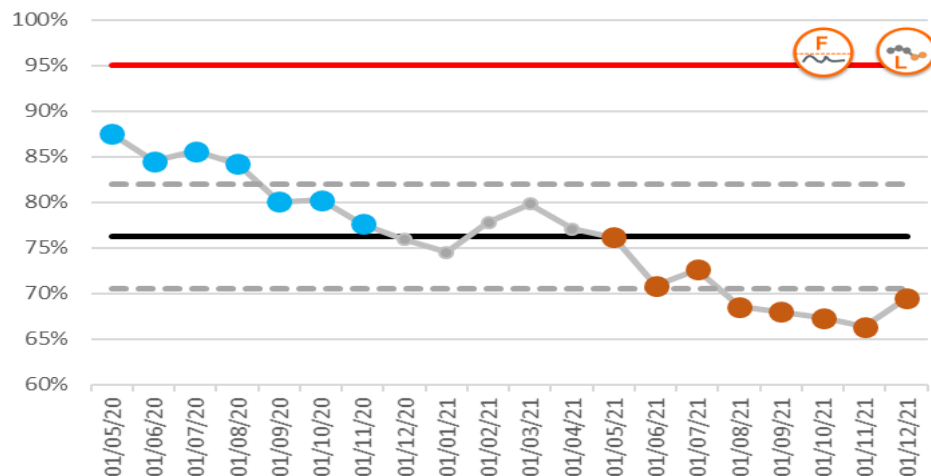
National Position & Overview

Across England the number of vacant healthcare support worker posts remained high. In November 2020, a national focus on achieving 'close to zero vacancies as possible' commenced for healthcare support roles that support registered nurses by the bedside i.e. Healthcare Assistants (HCAs)

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> The position demonstrates 1.5 % deterioration in month compared to Nov'21. The H2 budgeted establishments across UHL have increased by 47 wte equating to a 2.7% increase in vacancies. There are approximately 15 leavers per month. There are 10 HCA (headcount) that move from substantive to bank posts every month for flexible working patterns impacting on the substantive headcount. Noted that a similar picture of increasing HCA vacancies emerging across region 	<ul style="list-style-type: none"> Recruitment events every 6 weeks for 2022. UHL working with NHSI Direct Support and Indeed now expanding portability to capture greater supply and applicants. Increased digital format and pre screening plans. Data analysis further work on the leavers, reporting in 2022 for accuracy and workforce planning. Marketing and social media posters are funded and ready for next adverts. 	<ul style="list-style-type: none"> It is anticipated that UHL will be reporting target 11.0% improved position of vacancy by March '22. Next NHSI Direct Support meeting in Jan 2022, weekly support. From Jan to March 2022 circa 100 HCA candidates in pipeline to commence in post so ensuring regular contact with all candidates pre start dates

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

ED 4 hour waits Acute Footprint



Current Performance

Dec 21	YTD	Target
69.5%	70.6%	95%

Three Month Forecast

Jan 22	Feb 22	Mar 22
70%	72%	70%

National Position & Overview

In December, UHL ranked 78 out of 113 Acute Trusts. The National average in England was 73.3%. Only 2 out of the 113 Acute Trusts achieved the target. The best value out of the 18 Peer Trusts was 85.3% and the worst value was 60.0%.

Root Cause

- Crowding in ED due to poor outflow
- High inflow of both walk-in and ambulance arrivals
- UHL bed occupancy >85%

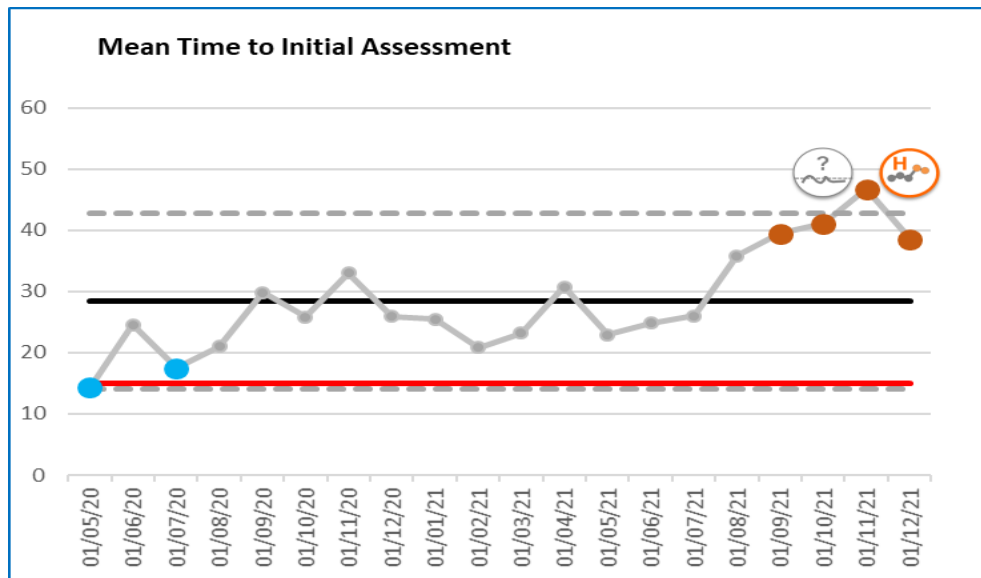
Actions

- Overnight ED consultant locum shift continues to be available (via winter monies).
- Additional funding provided via winter monies for registrars (adults and paed) continues to be available.
- Number of redirection and pre hospital actions in place to reduce occupancy and overall attendances.
- Mobile UTC on LRI site from 4 January supporting deflection of patients away from ED front door.

Impact/Timescale

- Improve time to senior decision making/ in place
- Improve time to senior decision making/ in place
- Reduce conveyances and occupancy to improve wait to be seen and time to decision/in place
- Treat patients in a timely manner and reduce patient numbers in ED
- Urgent care provision away from ED thereby reducing crowding/January 2022

Responsive (Emergency Care) – Mean Time to Initial Assessment



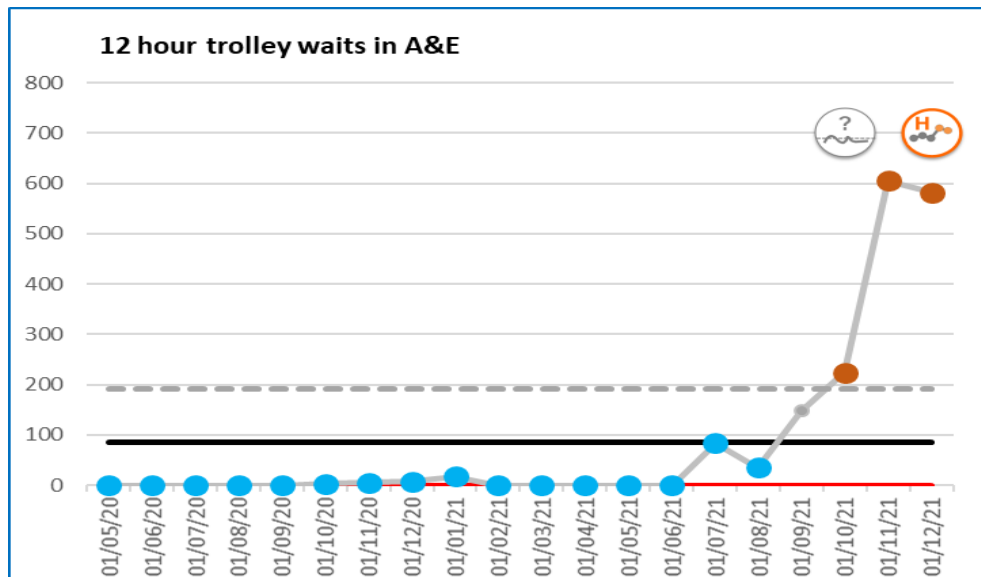
Current Performance			Three Month Forecast		
Dec 21	YTD	Target	Jan 22	Feb 22	Mar 22
38.6	35.8	15	38	38	38

National Position & Overview

National data not currently available for reporting.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Insufficient workforce to manage sustained walk in demand of in excess of 40 patients per hour 	<ul style="list-style-type: none"> Mobile UTC in place for streaming of primary care and ambulatory patients from front door Redirecting appropriate patients to Westcotes/hub appointments, UTC, GAU and GPAU continues ED consultant deployed to sit on front desk to redirect patients to alternative settings (when workforce allows) STAT clinician allocated to front door for each shift Work to operationally commission national Streaming Tool at ED front door continues 	<ul style="list-style-type: none"> Reduction in numbers at front door/January 2022 In place and ongoing Senior decision maker able to deflect pre-triage/in place when staffing allows Reduce inflow by streaming away pre-entry to ED/March 2022

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



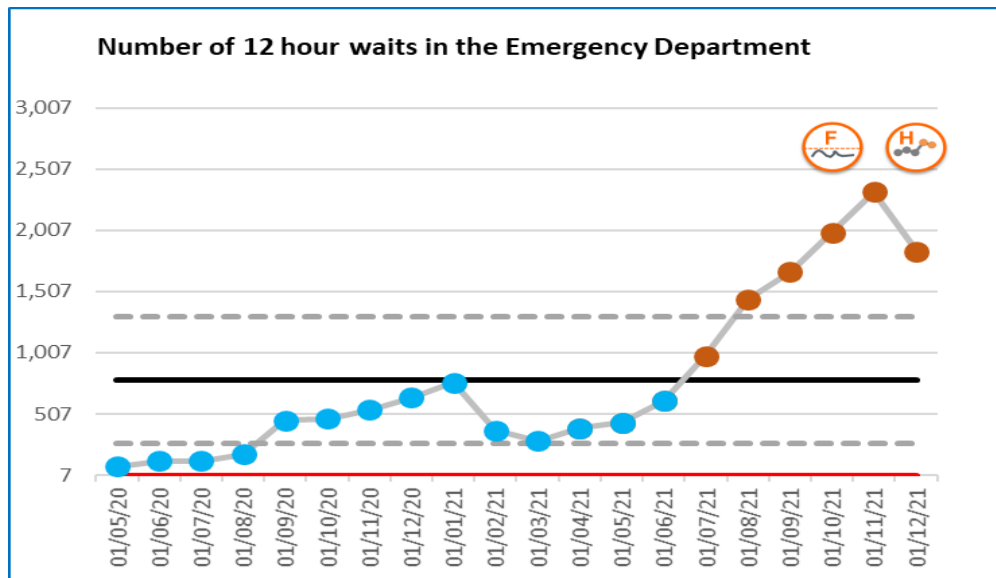
Current Performance			Three Month Forecast		
Dec 21	YTD	Target	Jan 22	Feb 22	Mar 22
582	1678	0	650	575	570

National Position & Overview

In December, UHL ranked 120 out of 125 Major A&E NHS Trusts. 30 out of the 125 Trusts achieved the target. The best value nationally was 0 and the worst value was 786. UHL ranked 17 out of 18 trusts in its peer group.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Poor outflow across the emergency care pathway Insufficient discharges from the base wards to meet demand Inability to create early capacity across the emergency care pathway due to lack of early discharges. 	<ul style="list-style-type: none"> Medical in-reach to ED in place every morning to review overnight bed list and clerk/discharge patients. Medical registrar and junior doctor cover in place in afternoons/evenings in ED. Implement the actions in the winter plan including additional capacity and optimising patient flow. Direct admissions to AMU trial starts 17 January to take ambulance arrivals directly into the assessment area. NHSI/E supported MADE event to focus on delays and discharge processes across base wards. 	<ul style="list-style-type: none"> Only those patients that need a medical bed are admitted/Ongoing Support national standard of all medical patients being seen by a medical doctor within 14 hours of arrival/Ongoing Reduce patient admission numbers /ongoing Reduce ambulance numbers to ED/January 2022 Reduce number of MFFD patients and release capacity in bed base/January 2022

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

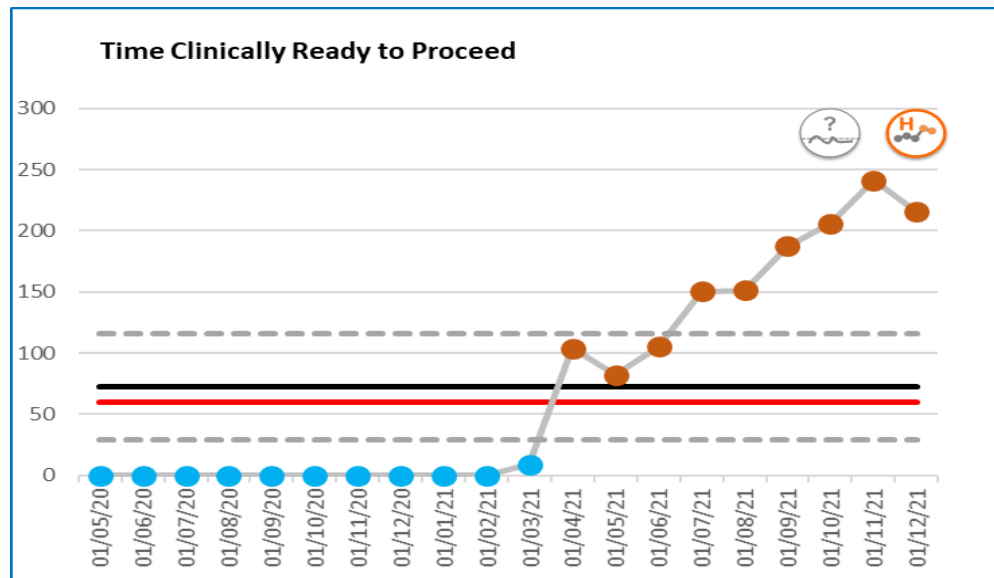


Current Performance			Three Month Forecast		
Dec 21	YTD	Target	Jan 22	Feb 22	Mar 22
1,836	11,677	0	1300	1150	1100

National Position & Overview
National data not currently available for reporting.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Poor outflow across the emergency care pathway Crowding in ED resulting in long waits to be seen by a doctor 	<ul style="list-style-type: none"> Mobile UTC service established off the emergency floor footprint, enabling increased numbers of patients to be streamed from the ED front door. ED consultant overnight and additional registrar locum shifts funded as part of winter plan. Rota for medical in-reach consultant to ED in place. 	<ul style="list-style-type: none"> Decant ED to reduce crowding/January 2022 Increase senior decision maker presence/in place (dependent on fill) Appropriate senior clinical review facilitating discharge directly from ED/in place Redirect those patients that can be seen by acute medic team/in place Earlier discharge for patients and debulking of ED cubicles/January 2022.

Responsive (Emergency Care) – Time Clinically Ready to Proceed



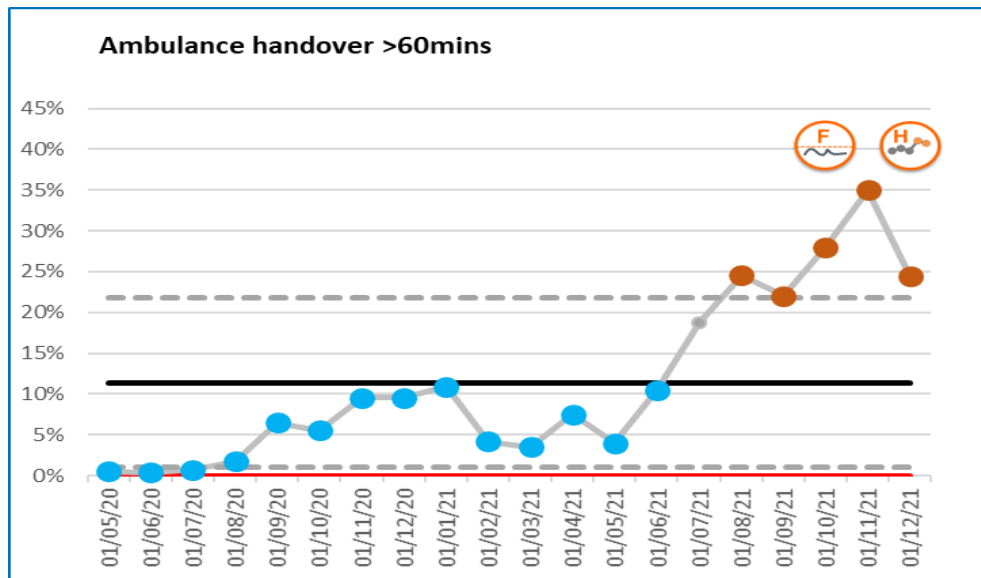
Current Performance			Three Month Forecast		
Dec 21	YTD	Target	Jan 22	Feb 22	Mar 22
215.4	160.4	60	200	180	180

National Position & Overview

National data not currently available for reporting.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Bed occupancy > 85% 	<ul style="list-style-type: none"> Nervecentre e-referral SOP developed following presentation to CMGs about process of ensuring timeliness of speciality response. Embed further response to Inter-Professional Standards, focusing on speciality in-reach Focussed discharge days in January supported by NHSI Multi-agency discharge event late January 	<ul style="list-style-type: none"> Increase response time to senior clinical review and decision making to improve time to ready to proceed time by all specialities/February 2022 Reduced pathway 0 and 1 patients, reducing bed occupancy Reduced pathway 2 and 3 patients, reducing bed occupancy

Responsive (Emergency Care) – Ambulance Handovers >60 Mins



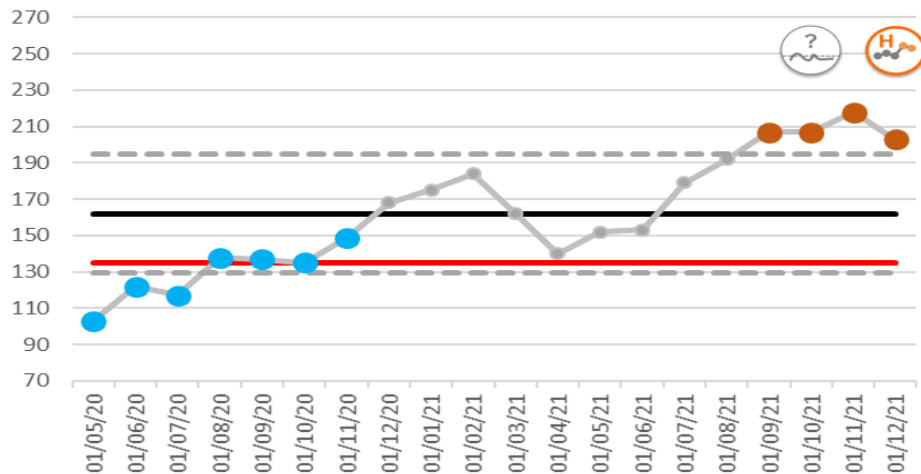
Current Performance			Three Month Forecast		
Dec 21	YTD	Target	Jan 22	Feb 22	Mar 22
24.5%	19.0%	0%	25%	23%	24%

National Position & Overview
LRI ranked 22 out of 23 sites last month (source EMAS monthly report) and had the second highest number of arrivals (4,932).
UHL is an outlier in Ambulance handover performance

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Poor outflow across the emergency care pathway High inflow of walk-in patients competing with ambulance patients for trolley space 	<ul style="list-style-type: none"> GPAU cubicles opened overnight, where staffing allows, for up to 10 patients. Further rapid cycle test of medical admissions direct to AMU planned for 18/01. Further push with EMAS to implement direct referrals to GPAU. Senior discussions with EMAS continue about mandating calls to pre-admission clinical assessment service before conveyance to acute site. From 17/01, ED consultant remote advise and support on EMAS CAD to maximise attendance avoidance 	<ul style="list-style-type: none"> In place Anticipated reduced ambulance arrivals to ED/January 2022 Reduce ambulance arrivals to ED/ongoing Create capacity for offloading ambulances in ED/in place Admission avoidance/January 2022

Responsive (Emergency Care) – Long Stay Patients

Long Stay Patients (21+ days)



Current Performance

Three Month Forecast

Dec 21	YTD	Target	Jan 22	Feb 22	Mar 22
203	203	135	250	225	200

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 27/12/21).

- 30 Patients (14%) are receiving appropriate care/treatment on a neuro rehabilitation or brain injury pathway.
- 15 Patients (7%) are receiving appropriate care/treatment on an Intensive care Unit or Infectious Diseases Unit.

Root Cause

- Circa 150 Complex Medically optimised for discharge patients of which 53 have a LLOS (26%) and are awaiting a discharge outcome from the LLR discharge coordination Hub.
- Suboptimal Discharge Coordination: Over investigation, family /carer involvement, board rounds , red2green principles, preparing the patient in advance of discharge.

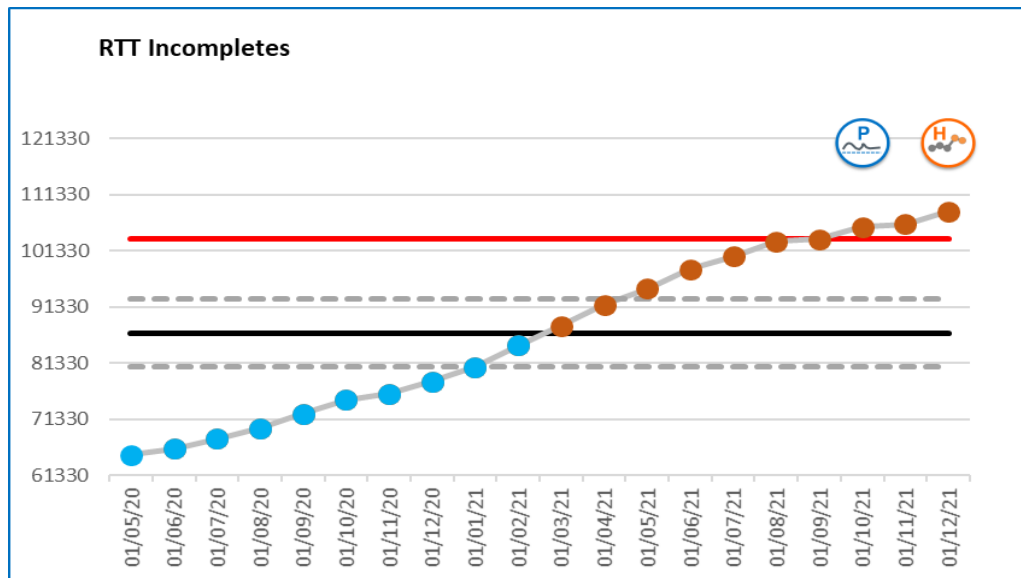
Actions

- Work Collaboratively with health and social care system partners during January to:
- Embed the New Home First Referral Form and MDT triage
 - Continue the PDSA on LPT bed allocation once TTO's have been commenced.
 - Undertake system wide MADE event with system partners.
- Work with CMG wards to:
- promote early discharge. 'golden ticket lottery campaign' running up until January 2022
 - Undertake 'Where Best next? Focussed discharge events in January

Impact/Timescale

- Aim to reduce number of MOFD patients waiting for discharge in UHL beds.
- Aim to improve /embed SAFER patient flow best practice principles within key wards in medicine by January 2022
- Increase the number of patients discharged before Noon (30%) and before 17.00 hours (70%)

Responsive (Elective Care) – RTT Incompletes

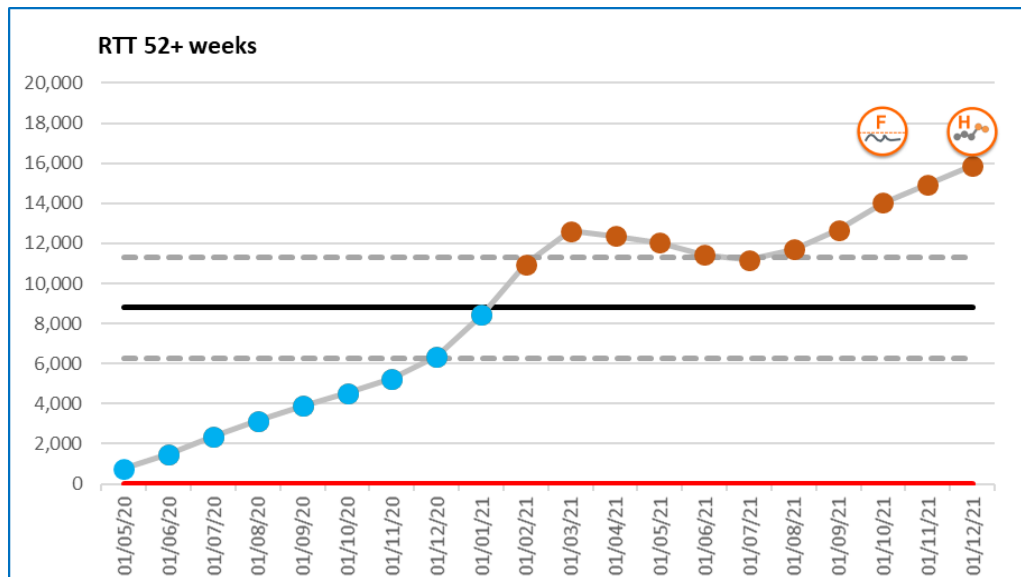


Current Performance			Three Month Forecast		
Dec 21	YTD	Target	Jan 22	Feb 22	Mar 22
108,373	108,373	103,403	110,321	109,754	108,224

National Position & Overview
At the end of November, UHL ranked 15 out of 18 trusts in its peer group with a total waiting list size of 106,117 patients. The best value out of the 18 Peer Trusts was 52,851 and the worst value was 184,956.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Impact of reduced outpatients and Inpatient activity. Due to COVID-19 and introduction of social distance and infection prevention measures. Reduction in theatre capacity to support ITU resulting in significant growth of the Admitted waiting list. Referrals increasing but still below 19/20 levels 	<ul style="list-style-type: none"> Continue validation process (3844 records validated this week with a 30.8% removal rate. Only 1% removed are long waiters) Investigating outsourcing new non-admitted patients to support specialties using Vanguard Insourcing for Max Fax outpatients Investigate solution for Gynaecology additional outpatient activity through WLI payments or insourcing 	<ul style="list-style-type: none"> External team here till March 31st, aim to have 91% of waiting list validated. Reduce to 0 104+ week waits and over waiting list numbers. Seeing 60 patients per week. Discussion set up with clinical team for 14th January – improve wait time for first appointment

Responsive (Elective Care) – RTT 52+ Weeks

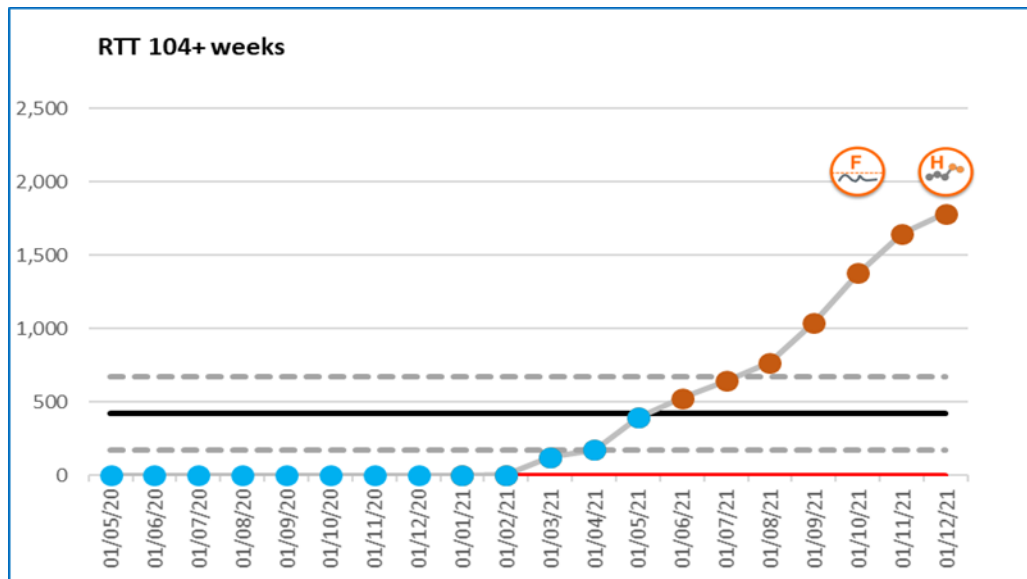


Current Performance			Three Month Forecast		
Dec 21	YTD	Target	Jan 22	Feb 22	Mar 22
15,877	15,877	0	16,823	16,301	15,987

National Position & Overview
<p>At the end of November, UHL ranked 17 out of 18 trusts in its peer group with 14,943 patients waiting over 52+ weeks. The best value out of the 18 Peer Trusts was 744 and the worst value was 31,770.</p>

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Impact COVID-19 waves Significant operational pressures due the emergency demand and COVID-19 current inpatients, UHL has reported operational OPEL 4 levels on a regular basis. The requirement to increase ITU Capacity, leading to a reduction in theatre capacity 	<ul style="list-style-type: none"> Creation of new theatre capacity via the installation of a Vanguard theatre Extension of WLI payments to encourage weekend activity Commissioning of additional capacity via insourcing models Continued utilisation of the independent sector 	<ul style="list-style-type: none"> Vanguard to come online on the 31st January ERF rate card from 1.12.21 Impact/timelines to target will be amended next month to reflect national guidance.

Responsive (Elective Care) – RTT 104+ Weeks



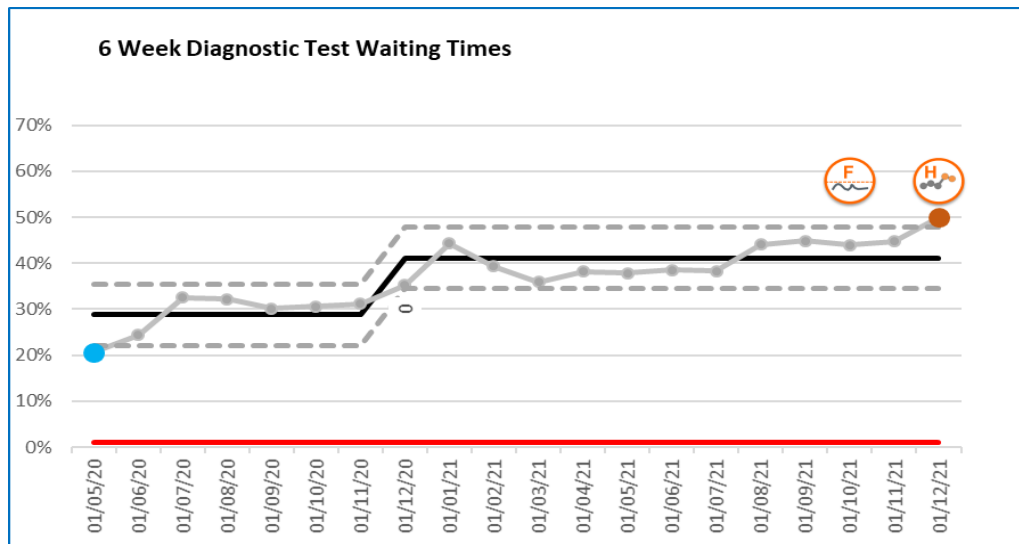
Current Performance			Three Month Forecast		
Dec 21	YTD	Target	Jan 22	Feb 22	Mar 22
1,783	1,783	0	1,920	1,576	962

National Position & Overview

At the end of November, UHL ranked 16 out of 18 trusts in its peer group with 1,648 patients waiting 104+ weeks. The best value out of the 18 Peer Trusts was 9 and the worst value was 2,008.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Impact COVID-19 waves Significant operational pressures due the emergency demand and wave 3, UHL has reported operational OPEL 4 levels on a regular basis The requirement to increase ITU Capacity, leading to a reduction in theatre capacity Theatre capacity which has been available been used for clinical priority, cancer patients and P2's 	<ul style="list-style-type: none"> Vanguard team induction – starts 17.1.22 Operational weekly booking group in partnership with Kettering in place and has achieved a growing number of IPT patients 22/23 protected elective capacity (cohorting) plan in development – aligned to Ward 14 at the LGH to return to orthopedics to support elective recovery 	<ul style="list-style-type: none"> 17.1.22 – Patients to be booked to start 31st Jan Start IPT 18.1.22 – aiming to move 130 patients across 24.01.22 increase in orthopaedic patients

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

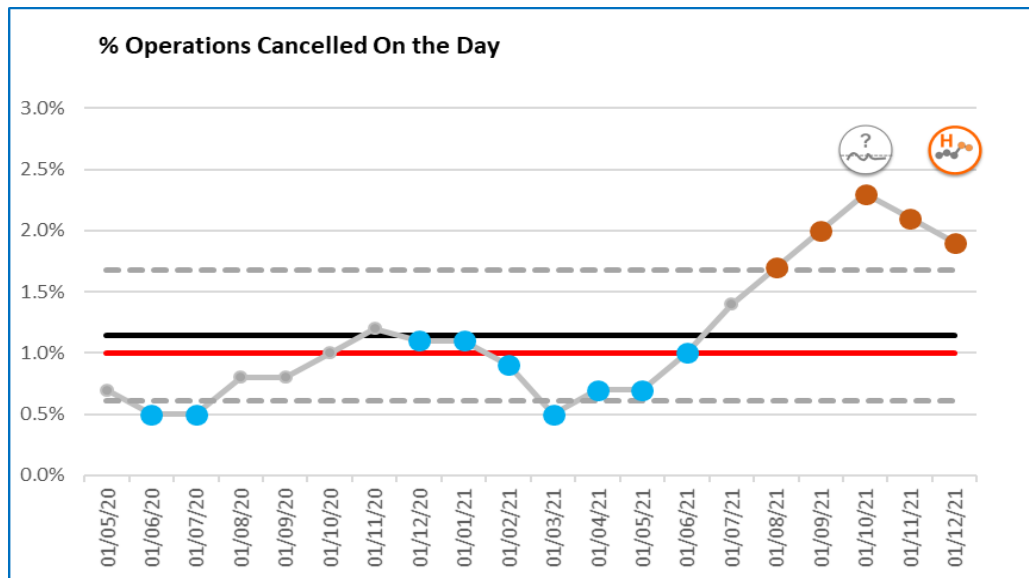


Current Performance			Three Month Forecast		
Dec 21	YTD	Target	Jan 22	Feb 22	Mar 22
49.9%	49.9%	1.0%	47.1%	45.4%	40.4%

National Position & Overview
<p>National average performance for November was 25.0%. UHL ranked 18 out of 18 trusts in its peer group with a performance of 44.7% in November. The best value out of the 18 Peer Trusts was 7.3%</p>

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Impact of COVID-19 waves 1 and 2 and 3 Increased demand in MRI, Non-Obstetric Ultrasound and Endoscopy. Reduced capacity due to introduction of social distancing and infection prevention measures. Staff vacancies and high levels of staff sickness. Availability of locums to backfill gaps in staffing. Increase in patient demand 	<ul style="list-style-type: none"> Assessing the risks to delivery of the Endoscopy trajectory by March 22. Looking at further options to increase capacity. Community Diagnostic Hub at LGH approved by NHSI/E. Full analysis of demand by diagnostic test compared to expected demand, Complete required CDC business case for April Increase validation support for CSI 	<ul style="list-style-type: none"> January – increase volume of patient sent to Ramsey System partners developing plan Jan – 21 increase capacity April, to apply for funding outlined in the CDC for system diagnostics schemes Support validation of 21000 patients – 31st January

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

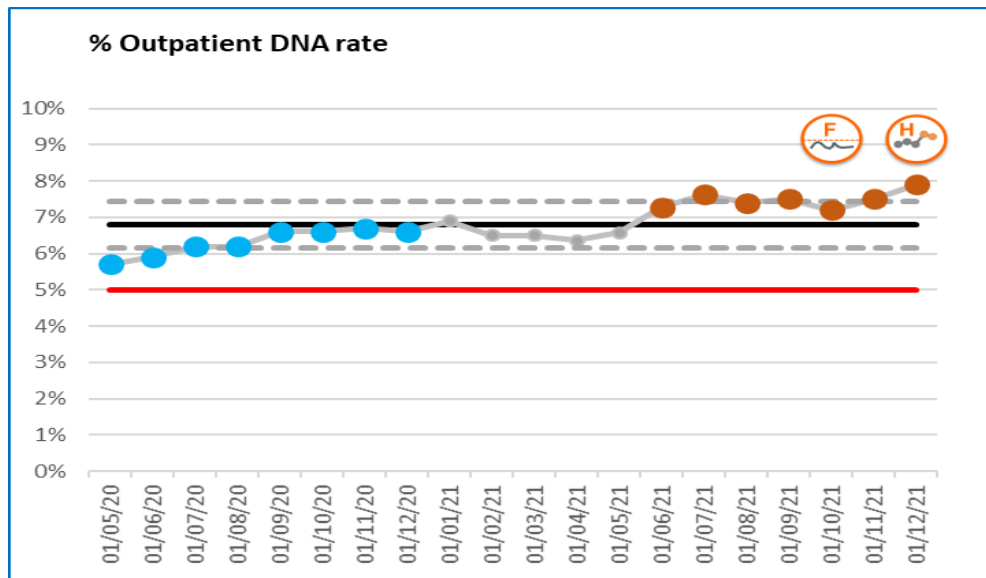


Current Performance			Three Month Forecast		
Dec 21	YTD	Target	Jan 22	Feb 22	Mar 22
1.9%	1.5%	1%	2.3%	1.9%	1.6%

National Position & Overview
National data not currently available for reporting.

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

Responsive (Elective Care) – Outpatient DNA Rate



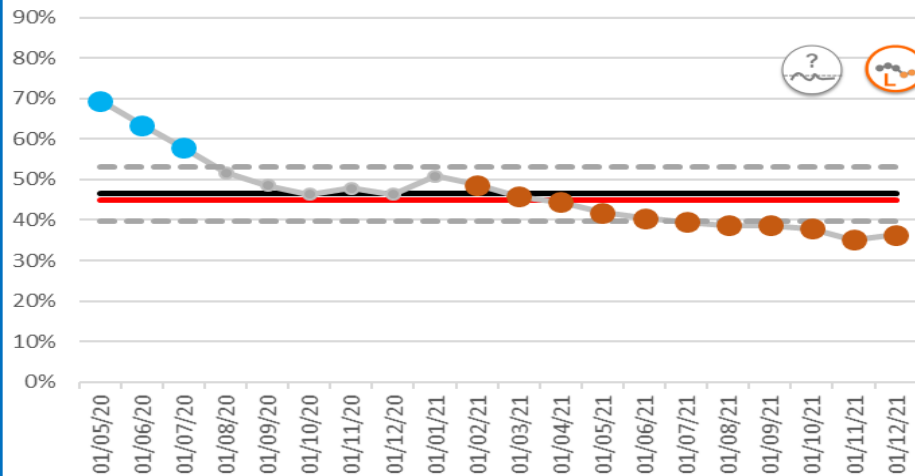
Current Performance			Three Month Forecast		
Dec 21	YTD	Target	Jan 22	Feb 22	Mar 22
7.9%	7.2%	5.0%	7.5%	7.1%	6.7%

National Position & Overview
UHL compares better than its peers for this financial year so far, 7.0% compared to 8.3% (data up to the end of September, 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
1. 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	1. On the Risk register. IT are looking into. Continue to promote the use of Attend Anywhere as an alternative.	<ul style="list-style-type: none"> All actions, plus many others, are happening imminently to help reduce the number of DNAs. An improvement in the DNA rate should be visible within the next 3 months.
2. 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	2. Remind services of the need to check the patients details are correct and up to date at every contact	
3. Late cancellations/rebooks often mean patients do not receive their appointment letters on time so unaware of appointment	3. Services are being encouraged to use the OP QlikSense dashboard and call patients	
4. Due to lack of admin staff, patients unable to get through to department to let them know they're unable to attend	4. Working on increasing numbers on the admin bank and getting them upskilled	
5. Some patients are still afraid to come in to hospital	5. Ask services to offer choice of video consultation	

Responsive (Elective Care) – Outpatient Non Face to Face

% Outpatient Non Face to Face



Current Performance

Dec 21	YTD	Target	Three Month Forecast		
Dec 21	YTD	Target	Jan 22	Feb 22	Mar 22
36.4%	39.5%	45.0%	38.4%	40.4%	42.4%

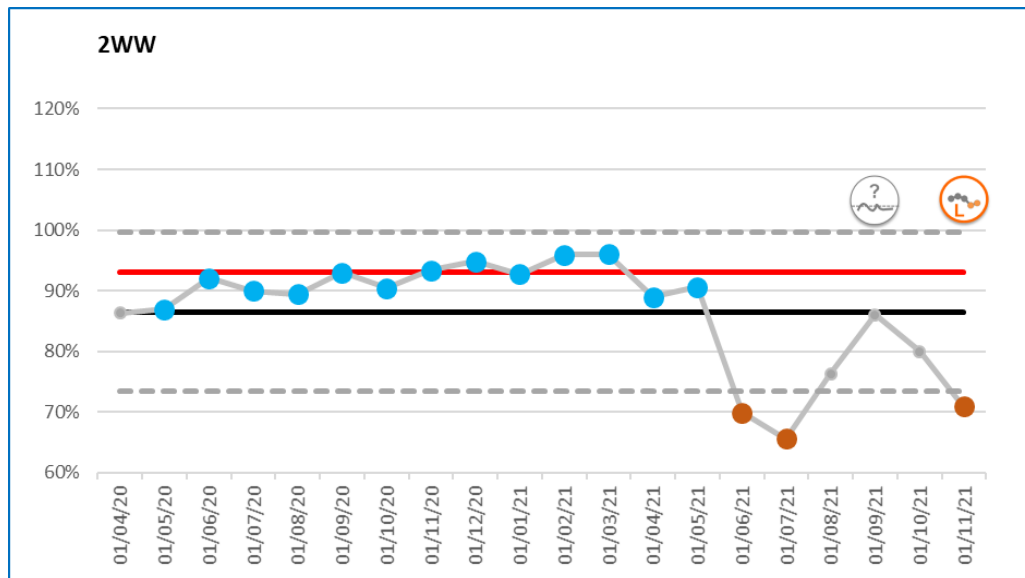
National Position & Overview

Peer data not currently available.

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
<ol style="list-style-type: none"> Not all Outpatient rooms are set up for video consultation eg no webcam or 2nd screen, and not all rooms have phones in them There is a fear of losing consulting rooms amongst clinicians therefore they are bringing patients in F2F Some clinicians and patients do prefer F2F over non F2F 	<ol style="list-style-type: none"> All of central outpatient rooms have now been provided with webcams, 2nd screens and headsets. Other OP areas have been asked what they need. 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. 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. 	<ul style="list-style-type: none"> All actions, plus others, are happening imminently to help increase the number of non F2F appointments. An improvement in the non F2F rate should be visible within the next 3 months.

Responsive Cancer – 2 Week Wait

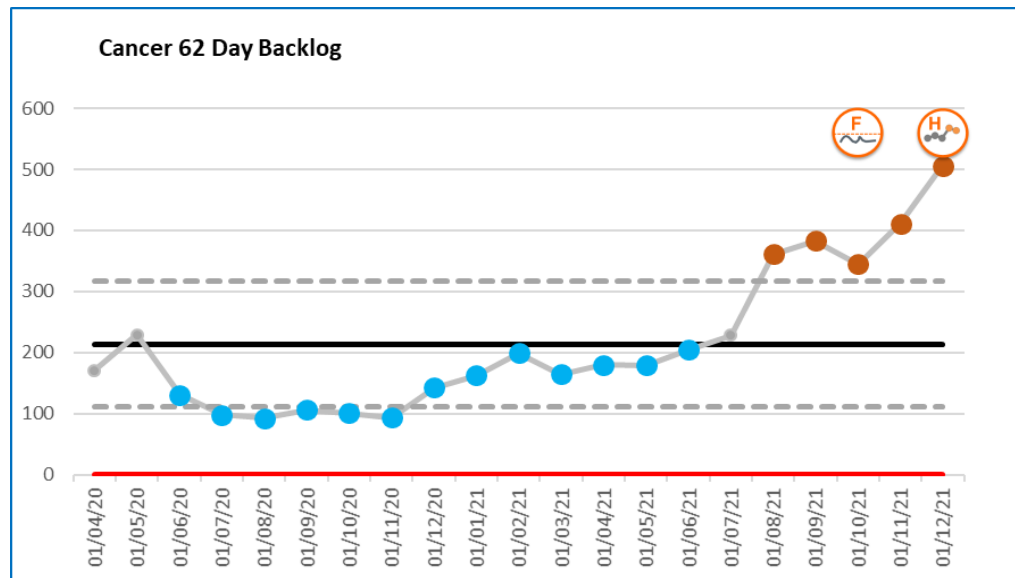


Current Performance			Three Month Forecast		
Nov 21	YTD	Target	Dec 21	Jan 22	Feb 22
71.0%	78.4%	93%	71.4%	53.4%	74.0%

National Position & Overview
<p>In November, UHL ranked 95 out of 125 Acute Trusts. The National average was 77.4%. 37 out of the 125 Acute Trusts achieved the target. UHL ranked 10th out of the 18 UHL Peer Trusts. The best value within our peer group was 98.0% (East Kent Hospitals University NHS Foundation Trust).</p>

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> 2WW demand sustained higher than pre-COVID levels in November (10.3%) /December (8.7%) with Breast & ENT primarily contributing to the under performance for 2WW 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 	<p>Monthly stakeholder recovery action plan meetings held with all tumour sites with clear actions on 2WW recovery identified where possible:-</p> <p>Breast</p> <ul style="list-style-type: none"> Breast pain pathway (Jan 2022) Outsourcing U35s (Jan 2022) Mandatory F2F assessment prior to referral live Nov 2021 Additional WLI and USS rooms at GGH Insourcing for weekend activity (Jan 2022) – delayed action due to lack of mammographers available <p>ENT</p> <ul style="list-style-type: none"> Mandatory F2F assessment prior to referral Task & Finish group for national timed pathway implementation setup (Jan 2022) <p>Skin</p> <ul style="list-style-type: none"> Task & Finish group setup for implementation of Skin AI working collaboratively with the Alliance (date tbc) 	<ul style="list-style-type: none"> Pain pathway expected to reduce referrals by up to 5% with the current backlog being assessed to divert patients back to primary care – January 2022 implementation Insourcing to go live with a minimum of 24 slots/week by February 2022. Expected clearance of under 35 year olds backlog by end Jan 2022 (breast). Skin AI to support ongoing demand, FDS compliance and have significant impact on the 31 day backlog/target for Skin.

Responsive Cancer – Cancer 62 Day Backlog

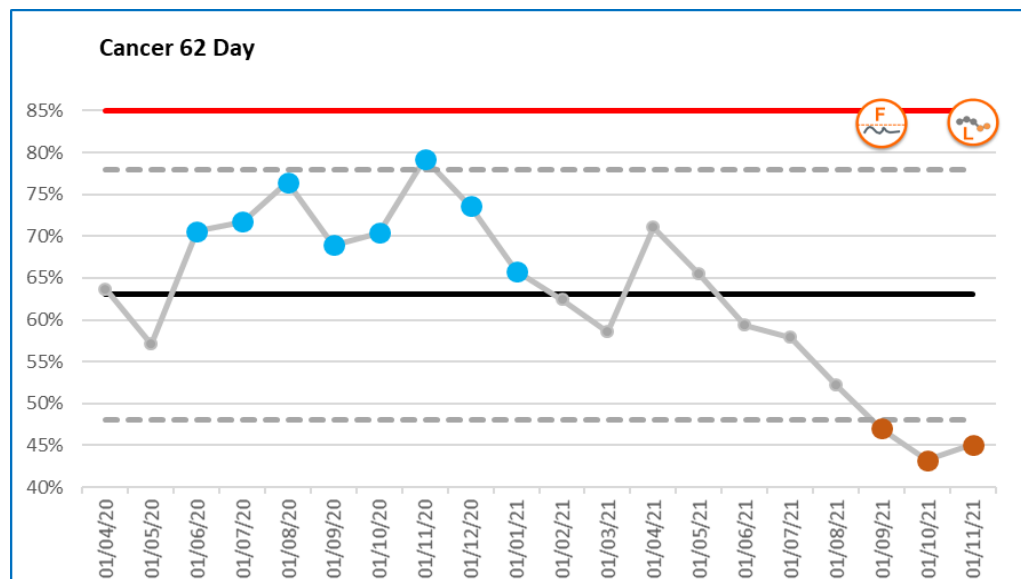


Current Performance			Three Month Forecast		
Dec 21	YTD	Target	Jan 22	Feb 22	Mar 22
506	506	144	558		

National Position & Overview
National data not currently available for reporting.

Root Cause	Actions	Impact/Timescale
<p>Waiting list volumes for 62 day remain high peak as a result of ongoing demand for 2WW with delayed appointments in Breast and ENT resulting in patients entering the 62 day backlog.</p> <p>Diagnostic capacity constraints, particularly Endoscopy.</p> <p>Reduced theatre sessions, theatre recovery capacity, ICU constraints .</p> <p>COVID positive patient delays on diagnostic and treatment pathways are evident across the 62 day backlog in addition to patient choice</p> <p>Bed reductions due to challenges with ED volumes, ICU and COVID.</p> <p>Staffing issues in ITAPS having an impact on theatre sessions with the CMGs</p> <p>Staffing issues in outpatients to support Skin outpatient procedures</p>	<ul style="list-style-type: none"> Continue to clinically prioritise all patients on a cancer pathway with ongoing focus on ensuring theatre sessions are protected where possible Weekly tumour site PTL review meetings with the Cancer Centre as well as deep dive into all backlog patients Work with EMCA and regional providers to seek mutual aid where possible to support equitable access for all patients Ensure the 2WW actions identified are progressed to support a reduction in the overall PTL and backlog Work with tumour sites to review national timed pathways and identify possible areas for improvement through the RAP meetings Explore opportunities in the IS Develop action plans around RDC with a view to expediting pathways at the front end and prevent pathway delays where possible For Skin, explore capacity opportunity for Plastics to transfer treatment pathways in UHL and at Alliance sites. 	<p>All tumour sites continue to prioritise the RAP meetings to work through recovery action plans in order to reduce the backlog and transform pathways where identified.</p> <p>Weekly PTL meetings continue to be prioritised to ensure pathway delays are expedited and accurate CWT rules are applied.</p> <p>Mutual aid continues for MaxFax in order to treat patients in a timely manner</p> <p>Actions for 2WW will impact a reduction on the backlog for Breast specifically – expected realisation Feb 2022.</p> <p>RDC plans to be submitted by end of Feb 2022</p> <p>Patient transfers to Plastics to commenced Dec 2021</p>

Responsive Cancer – Cancer 62 Day

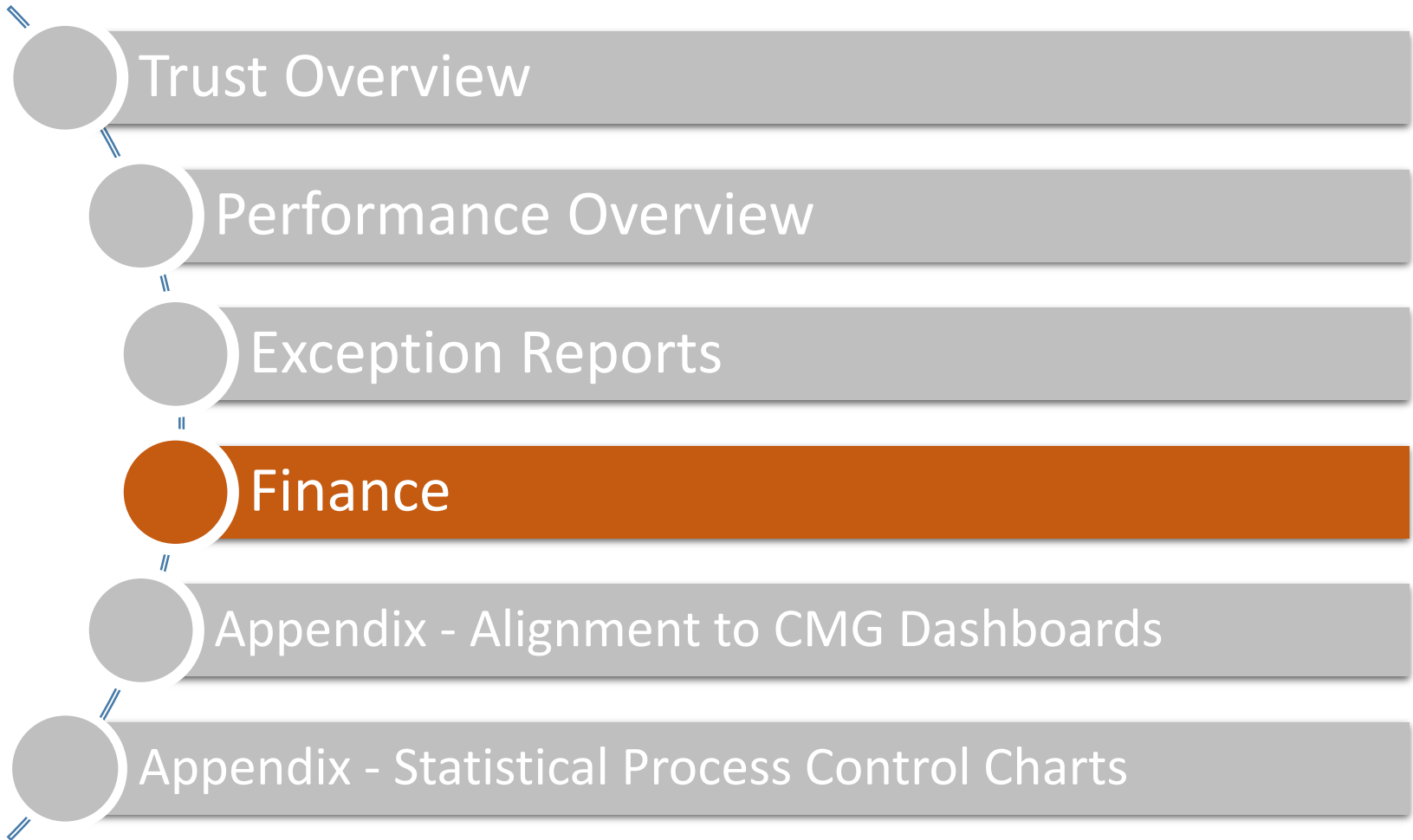


Current Performance			Three Month Forecast		
Nov 21	YTD	Target	Dec 21	Jan 22	Feb 22
45.1%	55.4%	85%	44.3%	40%	40%

National Position & Overview

In November, UHL ranked 129 out of 136 Acute Trusts. The National average was 67.5%. 17 out of the 136 Acute Trusts achieved the target. UHL ranked 15th out of the 18 UHL Peer Trusts. The best value within our peer group was 84.7% (East Kent Hospitals University NHS Foundation Trust).

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> High backlog levels being treated and prioritised having a direct impact on performance Theatre capacity remains challenged, particularly where HDU beds are required COVID & ED bed occupancy having an impact COVID positive status for asymptomatic patients on pre treatment PCR having an impact Staffing issues having an impact on theatre sessions, pre-assessment slots and outpatient capacity delaying pathways Workforce challenges including recruitment and lack of WLI activity 	<ul style="list-style-type: none"> Continue to clinically prioritise all patients on a cancer pathway where ready for treatment Weekly tumour site PTL review meetings with the Cancer Centre Work with EMCA and regional providers to seek mutual aid where possible to support equitable access for all patients Ensure the 2WW actions identified are progressed to support a reduction in the overall PTL and backlog Work with tumour sites to review national timed pathways and identify possible areas for improvement through the RAP meetings Explore opportunities in the IS For Skin, explore capacity opportunity for Plastics to transfer treatment pathways in UHL and at Alliance sites. 	<ul style="list-style-type: none"> Monthly cancer CMG forum and updated RAPs to gain assurance, oversight and identify opportunities. Continue to explore mutual aid and raise specific tumour site concerns via EMCA weekly regional call Patient transfers to Plastics to commenced Dec 2021



Single Oversight Framework – Month 9 Overview

Single Oversight Framework – Month 9

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	£9.2m	£(1.9)m			CFO
		Capital expenditure against plan	YTD Plan of £33.1m	21/22	£32.9m	£4.7m			CFO

Finance – Best Value Care

The Trust has reported a month 9 deficit of £1.9m. This was inline with forecast. The year to date surplus at month 9 is £9.2m. This surplus is due to pay and non-pay underspends due to lower activity than planned, vacancies across the Trust and over delivery of CIP. The Trust maintained a strong cash position at the end of December of £95m, representing an decrease of £4.5m compared with November

	Dec - In Month			Dec - YTD			M1-M12 FOT £000
	Forecast £000	Actual £000	Variance £000	Forecast £000	Actual £000	Variance £000	
Income:							
Patient Care Income	93,864	93,481	(383)	837,641	837,258	(383)	1,139,679
Other Income	11,706	12,953	1,247	106,885	108,133	1,247	143,195
Total Income	105,569	106,434	865	944,527	945,391	865	1,282,874
Expenditure:							
Pay - Substantive/Bank	(62,744)	(62,950)	(206)	(552,110)	(552,316)	(206)	(744,604)
Pay - Agency	(2,058)	(1,828)	230	(15,387)	(15,158)	230	(21,551)
Total Pay	(64,802)	(64,778)	24	(567,497)	(567,474)	24	(766,155)
Non-Pay	(37,406)	(36,519)	886	(323,706)	(322,820)	886	(454,987)
Non-Operating Costs	(5,130)	(5,729)	(599)	(43,827)	(44,426)	(599)	(60,008)
Total Non-Pay	(42,535)	(42,248)	287	(367,533)	(367,246)	287	(514,995)
Total Expenditure	(107,337)	(107,026)	311	(935,031)	(934,720)	311	(1,281,149)
Donated Assets	(73)	(1,261)	(1,188)	133	(1,056)	(1,188)	(1,275)
Less Profit On Disposal	0	0	0	(450)	(450)	0	(450)
Control Total Surplus/(Deficit)	(1,841)	(1,853)	(12)	9,178	9,166	(12)	(0)

Finance – Best Value Care

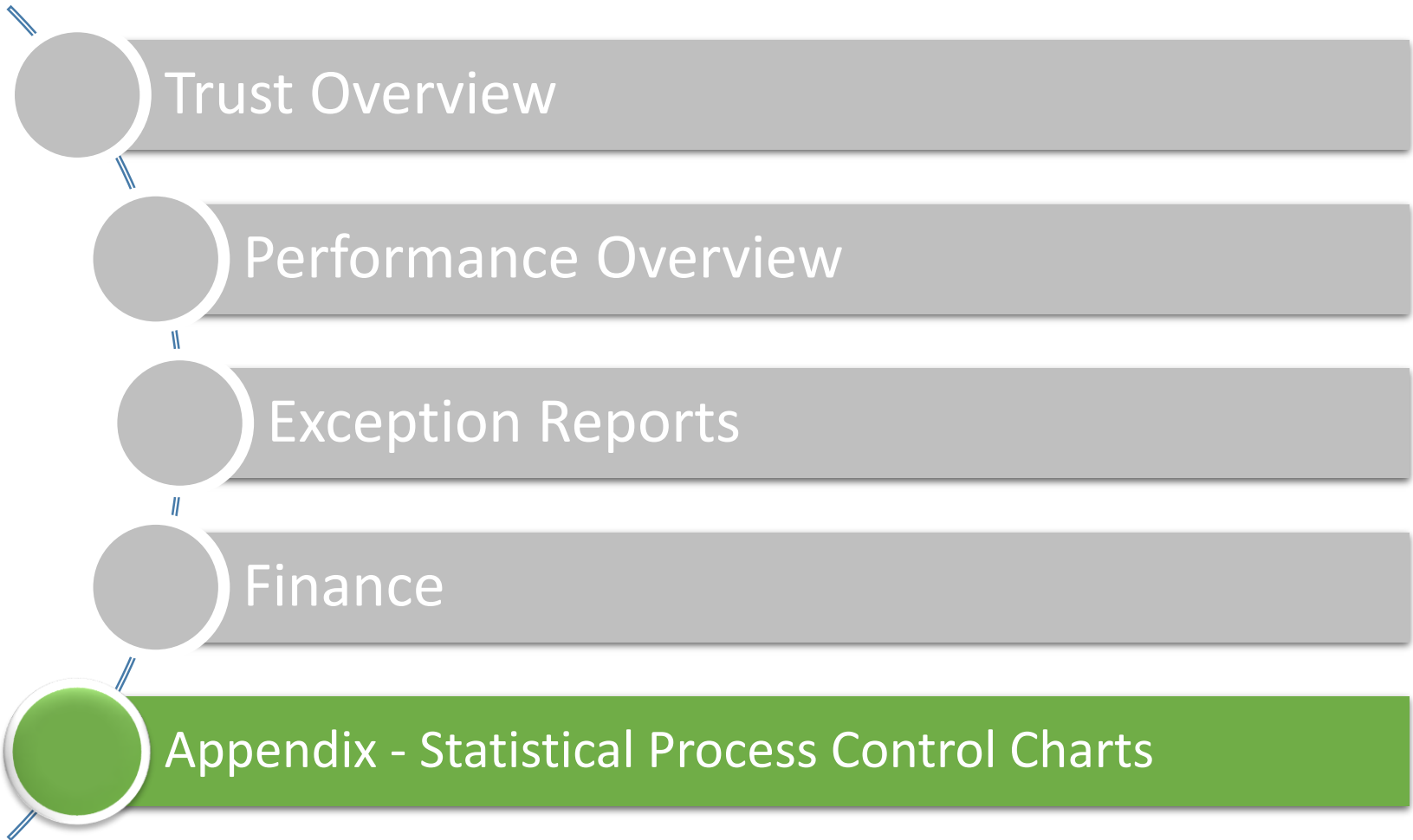
Single Oversight Framework – Month 9

	Dec - In Month			Dec - YTD			M1-M12 FOT £000
	Forecast £000	Actual £000	Variance £000	Forecast £000	Actual £000	Variance £000	
Income	105,496	105,172	(324)	944,659	944,335	(324)	1,281,599
Expenditure	(107,337)	(107,026)	311	(935,481)	(935,170)	311	(1,281,599)
Surplus/(Deficit) - Control Total Basis excl. Impairments	(1,841)	(1,853)	(12)	9,178	9,166	(12)	(0)
Capex (including donated)				(33,100)	(32,900)	200	
Closing Cash					95,000		

The Trust has reported a month 9 deficit of £1.9m. This is a £12k adverse variance to forecast. The year to date surplus at month 9 is £9.2m. This positive variance is due to pay and non-pay underspends due to lower activity than planned, vacancies across the Trust and over delivery of CIP.

Month 9 YTD capital expenditure was £32.9m against a YTD plan of £33.1m, representing an underspend against forecast of £0.2m. The Trust's 2021/22 capital forecast is £73.3m, funded from a combination of internally generated funding (£43.6m); centrally funded PDC (£16.0m); the disposal of Hospital Close asset (£10.1m); Charitable Funds (£2.8m) and ICS funding/cash (£0.9m).

The Trust's maintained a strong cash position at the end of December of £95m, representing an decrease of £4.5m compared with November.



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.

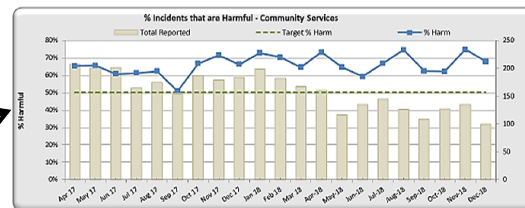
- Two horizontal lines either side of the Mean-(called the upper and lower control limits).

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

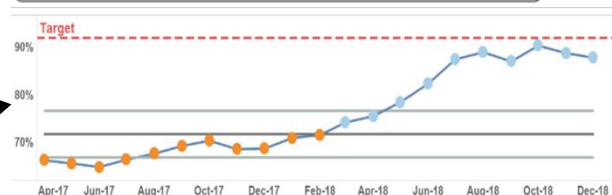
- A horizontal line showing the Target.

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

