

Integrated Performance Report

Trust Board paper E

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 October 2020 to September 2021) is 104 but remains within the expected range.
- **VTE** – compliant at 98.0% in February.

Performance Challenges:

- **MRSA** – 1 case reported.
- **C DIFF** – 15 cases reported this month.
- **ED 4 hour performance (including LLR UCCs)** – 71.2% reported in February.
- **12 hour trolley wait** - 628 breaches reported.
- **Ambulance Handover 60+ minutes (CAD)** – performance at 28.3%.
- **Cancer Two Week Wait** was 65.6% in January against a target of 93%.
- **Cancer 62 day backlog** was 502 patients at the end of February.
- **Cancer 62 day treatment** was 37.9% in January 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 113,373 patients at the end of February.
- **52+ weeks wait** – 15,842 breaches reported at the end of February.
- **Diagnostic 6 week wait** was 44.2% against a target of 1% in February.
- **Cancelled operations OTD** – 1.9% reported in February.
- **Statutory and Mandatory Training** is at 89%.
- **Annual Appraisal** is at 77.4%.

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]
More embedded research	[Yes / No / Not applicable]
Better corporate services	[Yes / No / Not applicable]
Quality strategy development	[Yes / No / Not applicable]

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

- What was the outcome of your Equality Impact Assessment (EIA)?

Not applicable as purely data reporting.

- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required

Not applicable as purely data reporting. What to measure is determined nationally or through priorities.

- How did the outcome of the EIA influence your Patient and Public Involvement ?

N/A

- If an EIA was not carried out, what was the rationale for this decision?

As above.

4. Risk and Assurance**Risk Reference:**

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

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

5th May 2022

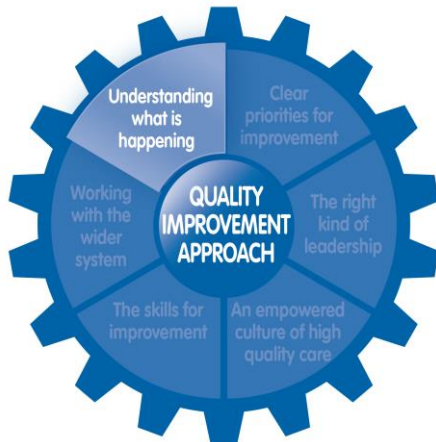
6. Executive Summaries should not exceed **5 sides**

My paper does comply



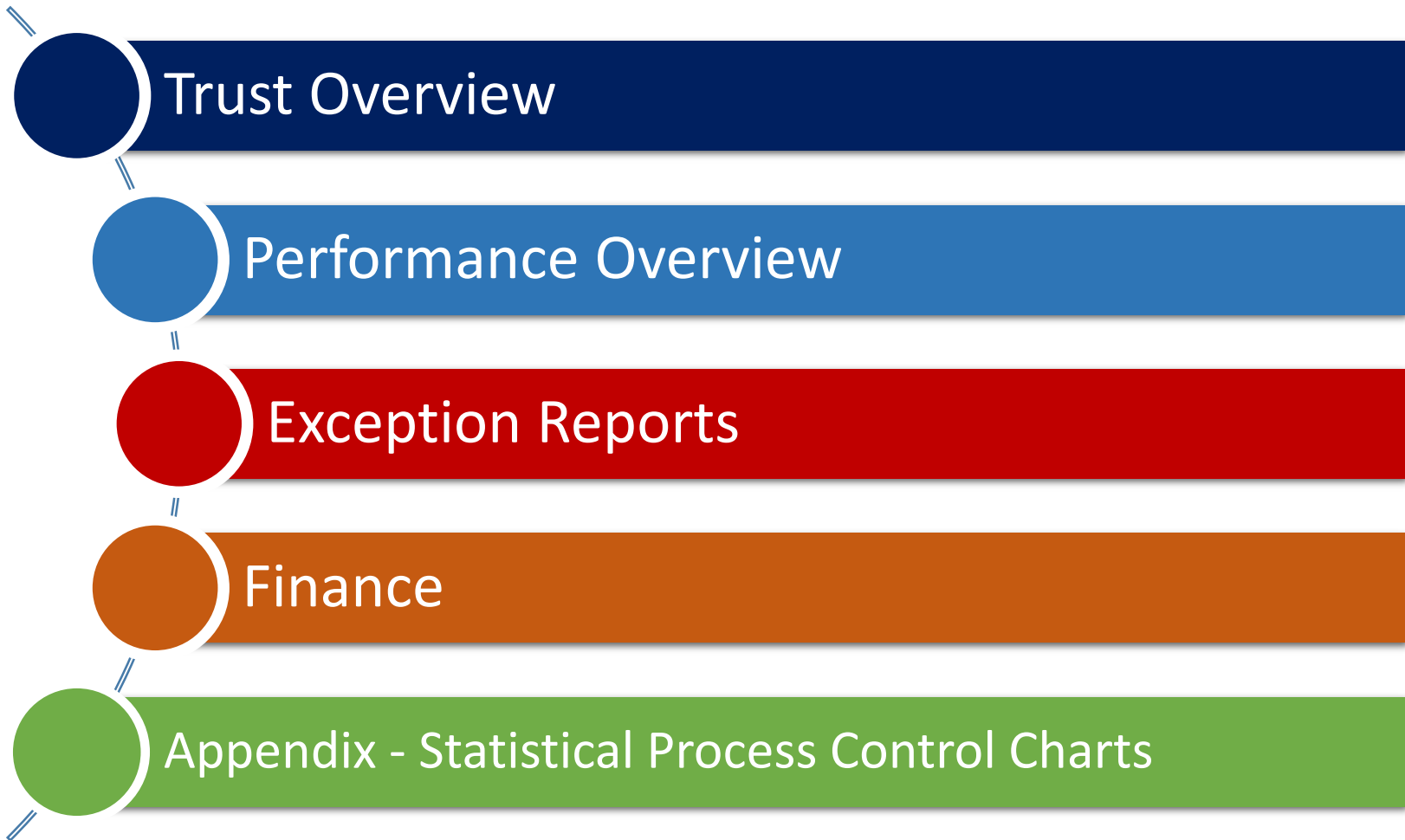
Integrated Performance Report

February 2022

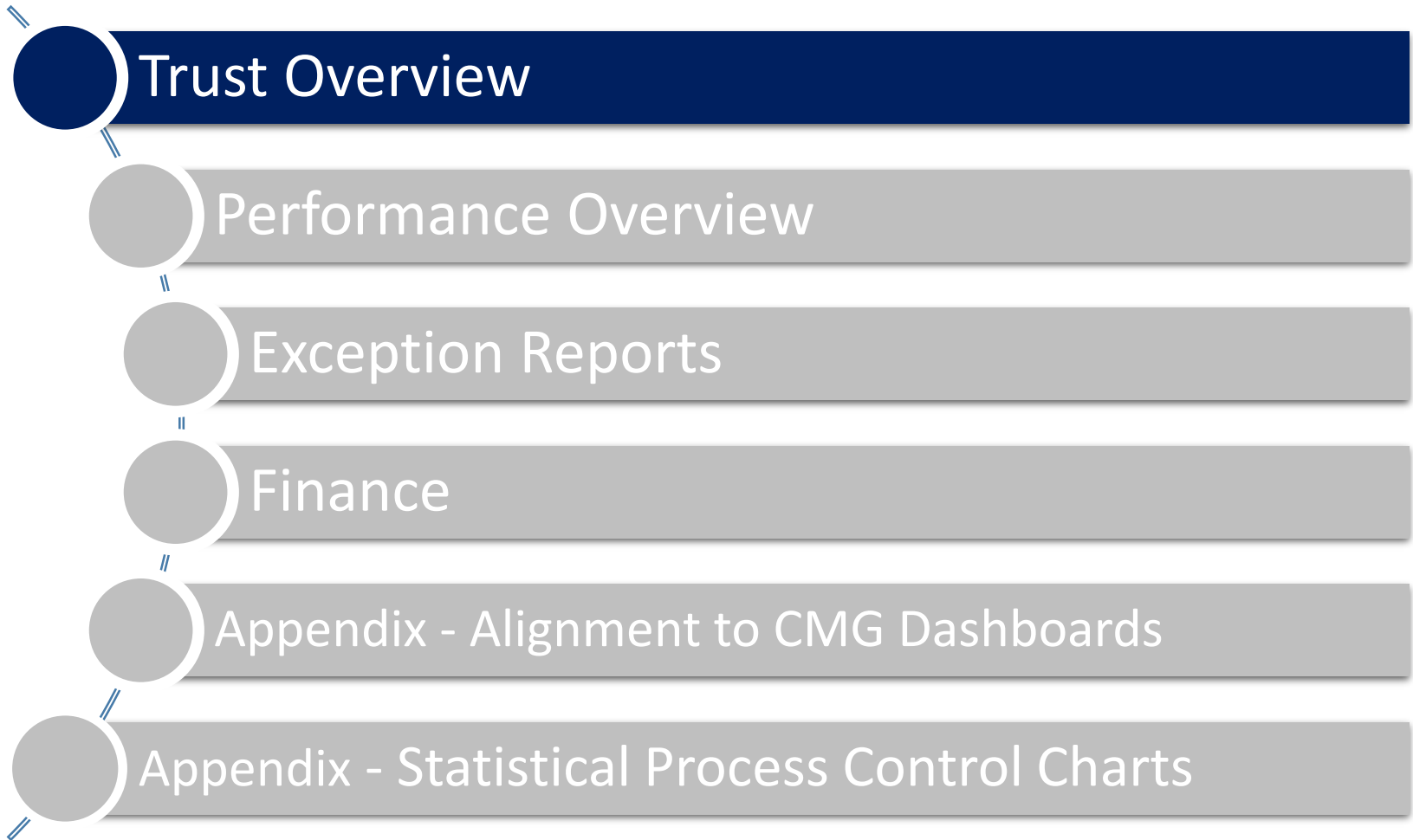


Operational Delivery Unit

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Trust Overview (Year to Date)

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

Key			
	Failing Target	Achieving Target	Target TBC

Trust Overview (Current Month)

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

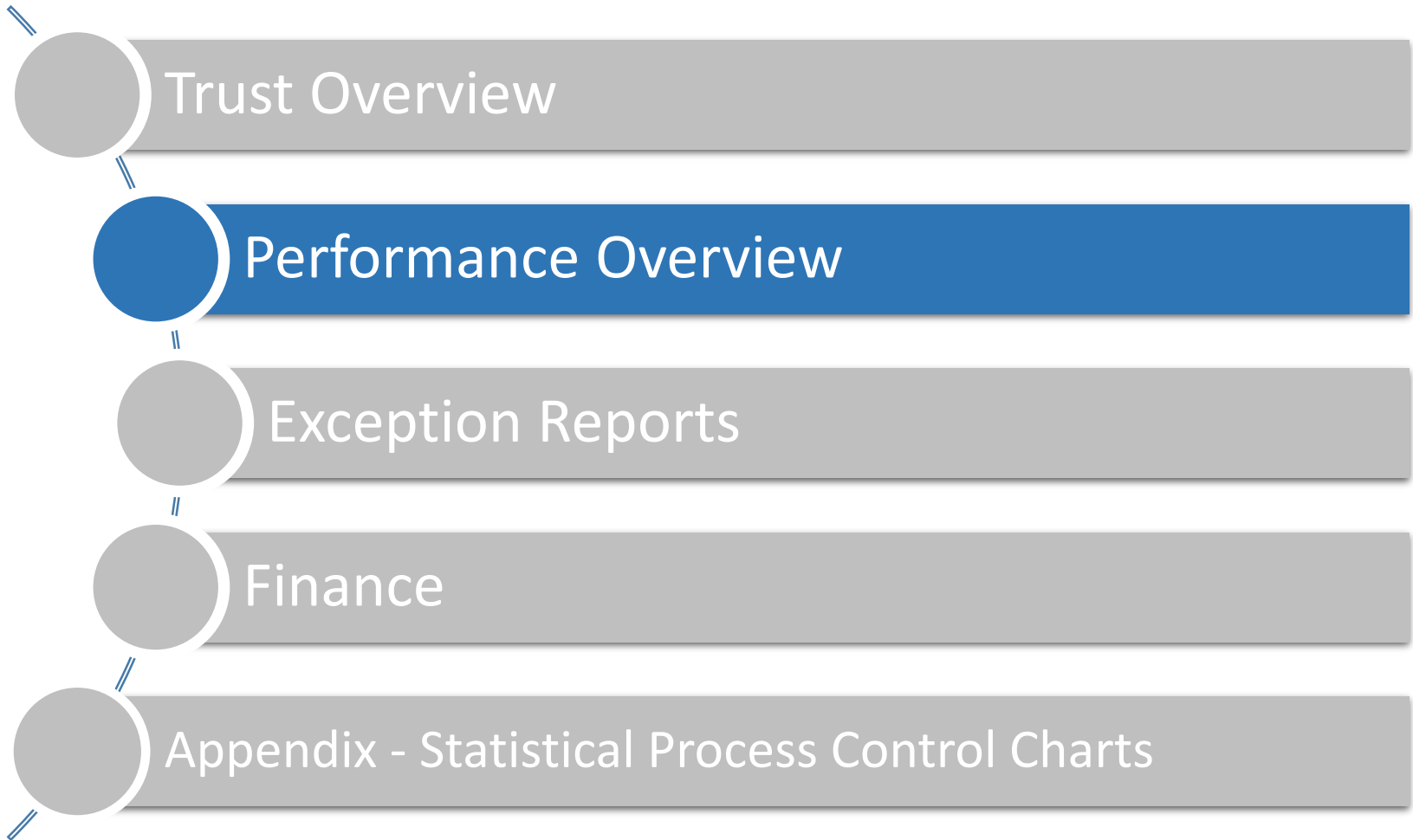
Failing Target

Achieving Target

Target TBC

Trust Overview (Current Month)

Domain	Overview , Risks and Actions	Lead
Overview		CEO
Safe (exception reports pages 19-22)	<p>UHL has had 7 Never Events to date. All appropriate immediate actions were undertaken and full investigations to identify learning have been undertaken. The Trust has worked with LLR System Patient Safety Specialists and Imperial Healthcare to develop a Never Event reduction plan – this is tracked through the Trust Board Quality Committee.</p> <p>There has been 1 methicillin resistant staphylococcus aureus bacteraemia this month which is currently under investigation. There has been an increase in the number of hospital attributed clostridium difficile this month, all cases undergo a full route cause analysis and ribotyping actions are being taken to review antimicrobial prescribing and raising awareness through CMG infection prevention meetings. Hospital Acquired Pressure Ulcers have increased this month and we have exceeded the year end quality improvement 50% reduction target, the Trust are on track to have a >20% improvement.</p>	Andrew Furlong / Eleanor Meldrum
Caring (exception reports page 23)	UHL performance for ED FFT has dropped over the last 2 months matching that of performance and long delays, national average is 82% with UHL currently at 81% YTD. With the continued high attendance and delays this trend is likely to continue.	Eleanor Meldrum
Well Led (exception reports pages 24-29)	Appraisal rates have deteriorated since December 2021 as a result of the absence arising from the Omicron variant with February having a 0.8% reduction in compliance. In order to mitigate the risk of non compliance with pay step procedures, CMGs and Directorates have been requested to achieve compliance by the end of May 2022. Sickness rates have increased both in month and cumulatively. This month figures reflect some underreporting since August 2021 and resulted in a cumulative increase from 5.91% to 6.14%. There is a continuous focus on achieving timely closure of absence, supporting staff Health and Well being and reviewing vacancies and gaps. Smart reporting processes are under review and Nursing vacancies have increased slightly due to leavers exceeding starters in Feb 2022. There is a risk of high numbers of retirements in March 2022 although mitigated by retire and return, proactive recruitment campaigns in CHUGGS and ITAPS and international recruitment. Paeds nursing vacancies increased slightly although improved position on Sept 21. Newly qualified intake due April/May and international campaign to recommence. HCA vacancies showed a slight increase, risk of high leavers mitigated by retention programme and recruitment events on an 8 week cycle with 60 new recruits currently in pipeline.	Joanne Tyler-Fantom
Effective	The Trust's Summary Hospital-level Mortality Indicator (SHMI) & Hospital Standardised Mortality Ratios (HSMR) are within expected. There are no specific concerns to bring to the Board's attention at this time.	Andrew Furlong
Responsive – Emergency (exception reports pages 30-36)	Attendances were lower than February 2020 with type 1 seeing around 9 patients less per day & type 2 seeing around 3 patients less per day. The UHL performance for Feb 2022 was 57.5% and when combined with the rest of LLR was 71.2%. UHL's national ranking for the month was 65 th out of 113 which is the best ranking achieved over the last two years. February performance continues to be below the required standard. Action plans exist for all metrics, these are being reviewed in detail including delivery.	Jon Melbourne
Responsive – Elective (exception reports pages 37-43)	February 2022 has seen an improvement in the cohort of patients who will breach 104+ weeks by the end of March, with the 104+ positions reducing to 1867. There are still significant challenges in overall waiting list growth. Elective capacity remains challenging through staff vacancies and sickness but through the introduction of a number of ERF schemes we have been able to bridge some of this gap. Both vanguard units are now fully operational and there are a number of insource companies working in partnership with the organisation to ensure we can increase our elective capacity. Performance reported in DM01 has improved but still remains challenged at 44.2%. Individual modality recovery plans have been developed to ensure we are able to recover to the 95% target by March 2024.	Jon Melbourne
Responsive – Cancer (exception reports pages 44-46)	In January UHL achieved 2 standards for 31 day Drugs and 28 day FDS screening. Performance in 2WW - 65.6%, 2WW Breast 4.1% and 62 day - 37.9%. 62 day backlog is 455 (14/03/22) a reduction of 110 patients since the peak of 565 week ending the 7th January 2022. Referrals remain above pre-pandemic levels and are up by approx. 20% from pre pandemic levels, with significant increase in Skin, Breast, Upper / lower GI and Haematology. Capacity pressures along with workforce issues (vacancies and sickness) are presenting particular challenges. The 2WW demand and backlogs, particularly in Breast and ENT, continue to directly impact on performance for 2WW and 62 day. Specific actions are in place which are showing improvements across 8 standards in February and March 2022; including new pathways in the community, utilisation of the independent sector, insourcing, F2F GP appointments, recruitment to locums and waiting list initiatives. Further work is underway to ensure recovery action plans are in place for all specialties.	Jon Melbourne
Financial Improvement (exception reports)	The Trust has reported a Month 11 deficit of £0.9m. This is a £2.4m favourable variance to forecast due to additional income in month 11. The year to date surplus at Month 11 is £6.2m. Month 11 YTD capital expenditure was £47.2m against a YTD plan of £50.8m, representing an underspend against forecast of £3.6m. The total forecast is £77.8m, funded from a combination of internally generated funding (£47.3m); PDC (£17.6m); asset disposals (£10.1m); and Charitable Funds (£2.8m). The Trust maintained a strong cash position at the end of February of £126.8m.	Lorraine Hooper



Performance Overview (Safe)

Safe

Domain	Key Performance Indicator	Target	Dec-21	Jan-22	Feb-22	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Safe	Never events	0	0	0	0	7				Jan-20	MD
	% of all adults Venous Thromboembolism Risk Assessment on Admission	95%	98.1%	98.1%	98.0%	98.5%				Oct-20	MD
	% of 3rd & 4th Degree Perineal Tears	3.5%	2.6%	4.6%	4.1%	3.1%				N/A	CN
	Clostridium Difficile	91	8	13	15	105				Jun-21	CN
	Methicillin Resistant Staphylococcus Aureus Total	0	0	0	1	1				Jun-21	CN
	E. Coli Bacteraemias Acute	198	16	12	14	145				Jun-21	CN
	Methicillin-susceptible Staphylococcus Aureus Acute*	40	6	3	1	44				Jun-21	CN

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

Comments

Rating

UHL has had 7 Never Events to date. All appropriate immediate actions were undertaken and full investigations to identify learning have been undertaken. The Trust has worked with LLR System Patient Safety Specialists and Imperial Healthcare to develop a Never Event reduction plan – this is tracked through the Trust Board Quality Committee.

There has been 1 methicillin resistant staphylococcus aureus bacteraemia this month which is currently under investigation. There has been an increase in the number of hospital attributed clostridium difficile this month, all cases undergo a full route cause analysis and ribotyping actions are being taken to review antimicrobial prescribing and raising awareness through CMG infection prevention meetings. UHL remain lower (12.7%) than the national average (18.4%) per 100,000 bed days. MSSA is over the internal QI ambition for the year however has been under trajectory for 2 months.

Performance Overview (Safe)

Domain	Key Performance Indicator	Target	Dec-21	Jan-22	Feb-22	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Safe	COVID-19 Hospital-onset, probable, 8-14 days after admission		4.9%	7.8%	10.3%	5.1%				Oct-20	CN
	COVID-19 Hospital-onset, healthcare-acquired, 15 or more days after admission		3.6%	11.9%	8.2%	5.8%				Oct-20	CN
	All falls reported per 1000 bed days	5.5	4.5	4.6		4.1				Oct-20	CN
	Rate of Moderate harm and above Falls Patient Safety Incidents with finally approved status per 1,000 bed days	0.18	0.06	0.06		0.07				Oct-20	CN
	Hospital Acquired Pressure Ulcers - All categories*	366	56	46	56	509				Jun-21	CN



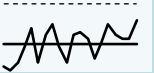









*note quality improvement ambition 50% reduction of 20/21

Comments

The last 3 months have seen an increase in the number of hospital acquired pressure ulcers following several months of reduction this has been attributed to a combination of factors, increased frailty and dependency of the patients, continual lower than planned staffing ratios 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 continues to be a reduction on the previous year.

Rating

Performance Overview (Caring)

Domain	Key Performance Indicator	Target	Dec-21	Jan-22	Feb-22	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Caring	Single Sex Breaches		0	0	0	4	National Reporting resumed from Oct 21.			Mar-20	CN
	Inpatient and Day Case Friends & Family Test % Positive*	95%	98%	98%	99%	98%				Mar-20	CN
	A&E Friends & Family Test % Positive**	82%	82%	79%	77%	81%				Mar-20	CN
	Maternity Friends & Family Test % Positive*	91%	97%	96%	95%	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

UHL performance for ED FFT has dropped over the last 2 months in line with performance results and delays, the national average is 82% with UHL currently at 81% YTD. With the continued high attendance and delays this trend is likely to continue.

Rating

Performance Overview (Well Led)

Domain	Key Performance Indicator	Target	Dec-21	Jan-22	Feb-22	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%	8.7%	8.7%	8.7%	8.7%				Nov-19	CPO
	Sickness Absence (Excludes Estates & Facilities staff)	3%	7.2%	8.9%		6.0%				Mar-21	CPO
	% of Staff with Annual Appraisal (Includes Estates & Facilities staff from May 21)	95%	80.5%	78.2%	77.4%	77.4%				Mar-21	CPO
	Statutory and Mandatory Training	95%	89%	89%	89%	89%				Feb-20	CPO







Comments

Rating

Turnover remains within target although is showing steady levels of increase, it should be noted that the figure is exclusive of staff who retain a bank only assignment. Sickness absence is 3.1% above cumulative target as a result of the Omicron variant and subsequent staffing pressures impacting on health and well being. The Trust is providing proactive and targeted health and well being support including supporting individual cases through People Services. There were signs of improvement in early March but situation is declining towards end of month.

Annual appraisal and Statutory and Mandatory training compliance have both deteriorated in February, it is recognized that performance is likely to improve as a result of movement to Covid 19 Level 2 response although operational pressures are still impacting. Trajectories for improvement will be put in place by CMGs and Corporate areas to be achieved by May 2022.

Performance Overview (Well Led)

Domain	Key Performance Indicator	Target	Dec-21	Jan-22	Feb-22	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Well Led	Adult Nursing Vacancies	10%	12.5%	11.7%	12.6%	12.6%				Dec-19	CPO
	Paed Nursing Vacancies	10%	9.0%	9.2%	11.0%	11.0%				Dec-19	CPO
	Midwives Vacancies	10%	8.5%	8.5%	9.5%	9.5%				Dec-19	CPO
	Health Care Assistants and Support Workers - excluding Maternity	10%	12.1%	12.5%	12.6%	12.6%				Dec-19	CPO
	Health Care Assistants and Support Workers - Maternity	5%	2.3%	3.7%	4.4%	4.4%				Dec-19	CPO
	Frontline Staff Lateral Flow Testing Engagement	No Target	421	387	268	710				N/A	CPO



Comments

Midwifery vacancies in ward areas are above target and adult and paediatric nursing vacancies are showing a slightly deteriorated position as leavers exceeded starters in February 2022. Intensive recruitment campaigns continue particularly international recruitment and CHUGGS and ITAPS who have held a number of successful recruitment events. Further cohorts of international nurses are planned for March May and July and newly qualified nurses commencing in April May and June. Large numbers of retirements are predicted for March 2022.

HCSW vacancies continue to remain above target partially as a result of increased establishments. Weekly reporting to NHSE/I is in place in order to show the pipeline of new recruits planned. Recruitment days take place every two months and 60 HCA are in the recruitment pipeline. A social media campaign is planned for May 2022.

Rating

Performance Overview (Effective)

Domain	Key Performance Indicator	Target	Dec-21	Jan-22	Feb-22	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Effective	Published Summary Hospital-level Mortality Indicator (SHMI)	100	104	104	104	104 (Oct 20 to Sep 21)				May-21	MD
	12 months Hospital Standardised Mortality Ratio (HSMR)	100	102	102	101	101 Dec 20 to Nov 21				May-21	MD
	Crude Mortality Rate	No Target	1.6%	1.4%	1.3%	1.3%				May-21	MD

Comments	Rating
<p>The Trust’s Summary Hospital-level Mortality Indicator (SHMI) & Hospital Standardised Mortality Ratios (HSMR) are within expected. There are no specific concerns to bring to the Board’s attention at this time.</p>	

Performance Overview (Responsive Emergency Care)

Domain	Key Performance Indicator	Target	Dec-21	Jan-22	Feb-22	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Responsive (Emergency Care)	Emergency Department 4 hour waits Acute Footprint	95%	69.5%	70.2%	71.2%	70.6%				Data sourced externally	COO
	Mean Time to Initial Assessment	15	38.6	40.6	41.3	35.9				TBC	COO
	12 hour trolley waits in Emergency Department	0	582	624	628	2930				Mar-20	COO
	Number of 12 hour waits in the Emergency Department	0	1,836	2,287	2,071	16,035				TBC	COO
	Time Clinically Ready to Proceed	60	215.4	287.1	235.2	178.7				TBC	COO
	Ambulance handover >60mins	0%	24.5%	27.8%	28.3%	20.5%				Data sourced externally	COO
	Long Stay Patients (21+ days)	135	201	247	231	231				Sep-20	COO






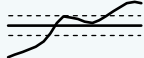











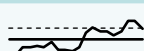



Comments

Attendances were lower than February 2020 with type 1 seeing around 9 patients less per day & type 2 seeing around 3 patients less per day.

The UHL performance for Feb 2022 was 57.5% and when combined with the rest of LLR was 71.2%. UHL's national ranking for the month was 65th out of 113 which is the best ranking achieved over the last two years. February performance continues to be below the required standard. Action plans exist for all metrics, these are being reviewed in detail including delivery.

Rating

Performance Overview (Responsive Elective Care)

Domain	Key Performance Indicator	Target	Dec-21	Jan-22	Feb-22	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Responsive (Elective Care)	Referral to Treatment Incompletes	103,403	108,373	111,017	113,373	113,373				Nov-21	COO
	Referral to Treatment 52+ weeks	0	15,877	16,276	15,842	15,842				Nov-21	COO
	Referral to Treatment 104+ weeks	0	1,630	1,948	1,867	1,867				Nov-21	COO
	6 Week Diagnostic Test Waiting Times	1.0%	49.9%	51.8%	44.2%	44.2%				Nov-19	COO
	% Operations Cancelled On the Day	1.0%	1.9%	2.5%	1.9%	1.7%				Apr-21	COO
	% Outpatient Did Not Attend rate	5%	7.9%	7.9%	7.5%	7.3%				Feb-20	COO
	% Outpatient Non Face to Face	45%	37.5%	36.5%	34.8%	39.1%				Feb-20	COO

Comments






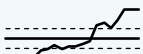


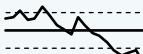
Rating

February 2022 UHL has seen an improvement in the volume of long waiting patients but has still seen a growth in overall waiting list size. The volume of patients who will breach 104+ weeks by March 31st has continued to reduce week on week with the overall cohort reducing by 60% since November (a reduction of 3157). This reduction is expected to increase with a number of schemes beginning throughout January and into February. This included both Vanguards theatres are now live and additional activity has been secured through mutual aid at Kettering/NGH and Grantham hospitals.

Technical validation for whole waiting list is on-going with 13 validators in post – plan to keep into Q1 22/23, Contacting of all admitted patients waiting above 52+ weeks has commenced and due to be completed by March 31st through the internal Booking Centre

The overall DM01 diagnostic waiting times trajectories are been developed further to ensure a full analysis of capacity against expected demand to achieve the ambition of 95% of diagnostic are delivered within 6 weeks by 2024.

Performance Overview (Responsive Cancer)

Domain	Key Performance Indicator	Target	Dec-21	Jan-22	Feb-22	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Responsive (Cancer)	2 Week Wait	93%	71.4%	65.6%		76.6%				Mar-22	COO
	62 Day Backlog	0	506	502	502	502				Mar-22	COO
	Cancer 62 Day	85%	46.1%	37.9%		52.6%				Mar-22	COO

Comments

Rating

In January UHL achieved 2 standards for 31 day Drugs and 28 day FDS screening. Performance in 2WW - 65.6%, 2WW Breast 4.1% and 62 day - 37.9%. 62 day backlog is 455 (14/03/22) a reduction of 110 patients since the peak of 565 week ending the 7th January 2022. Referrals remain above pre-pandemic levels and are up by approx. 20% from pre pandemic levels, with significant increase in Skin, Breast, Upper / lower GI and Haematology. Capacity pressures along with workforce issues (vacancies and sickness) are presenting particular challenges. The 2WW demand and backlogs, particularly in Breast and ENT, continue to directly impact on performance for 2WW and 62 day. Specific actions are in place which are showing improvements across 8 standards in February and March 2022; including new pathways in the community, utilisation of the independent sector, insourcing, F2F GP appointments, recruitment to locums and waiting list initiatives. Further work is underway to ensure recovery action plans are in place for all specialties.

Performance Overview (Finance)

Domain	Key Performance Indicator	Target YTD	Dec-21	Jan-22	Feb-22	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Finance	Trust level control level performance	£3.8m Forecast	-£1.9m	-£2.1m	-£0.9m	£6.2m				N/A	CFO
	Capital expenditure against plan	£50.8m	£4.7m	£4.7m	£9.7m	£47.2m				N/A	CFO
	Cost Improvement	£11.6m Plan	£1.3m	£1.2m	£1.3m	£15.3m				N/A	CFO
	Cashflow	No Target	-£5.6m	£13.6m	£17m	£127m				N/A	CFO

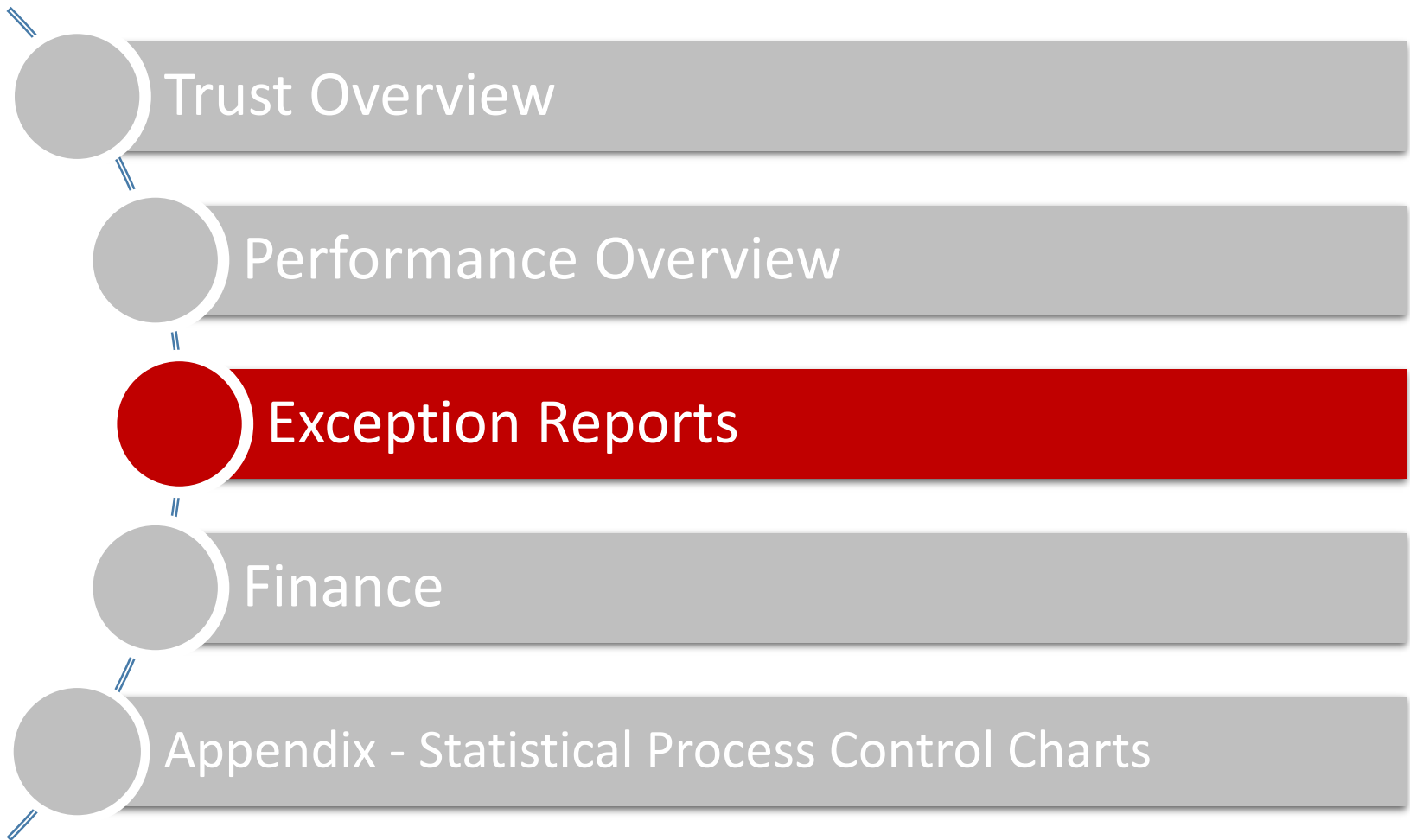
Comments

Rating

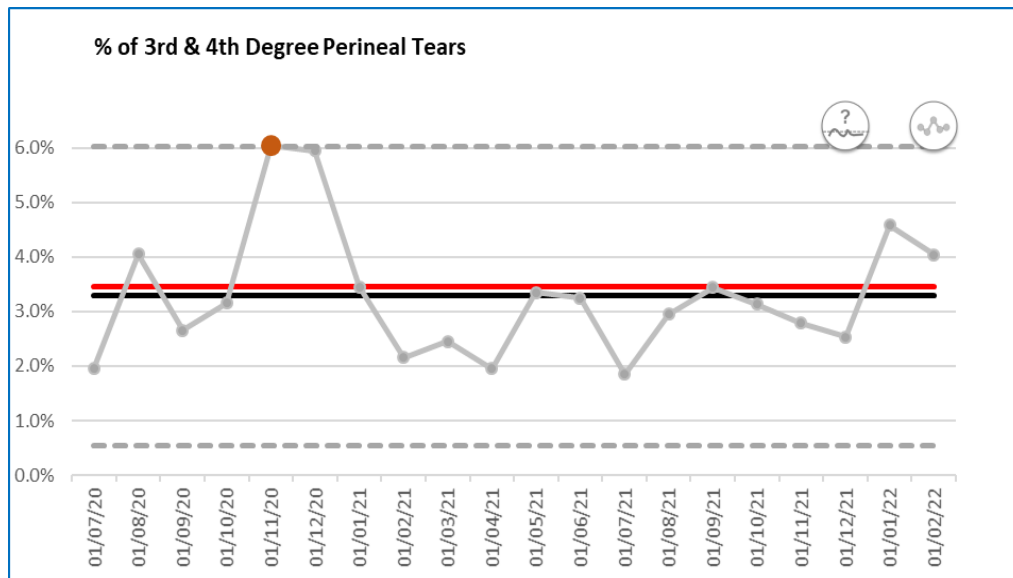
The Trust has reported a Month 11 deficit of £0.9m. This is a £2.4m favourable variance to forecast due to additional income in month 11. The year to date surplus at Month 11 is £6.2m.

Month 11 YTD capital expenditure was £47.2m against a YTD plan of £50.8m, representing an underspend against forecast of £3.6m. The total forecast is £77.8m, funded from a combination of internally generated funding (£47.3m); PDC (£17.6m); asset disposals (£10.1m); and Charitable Funds (£2.8m).

The Trust maintained a strong cash position at the end of February of £126.8m.



Safe – % of 3rd & 4th Degree Perineal Tears

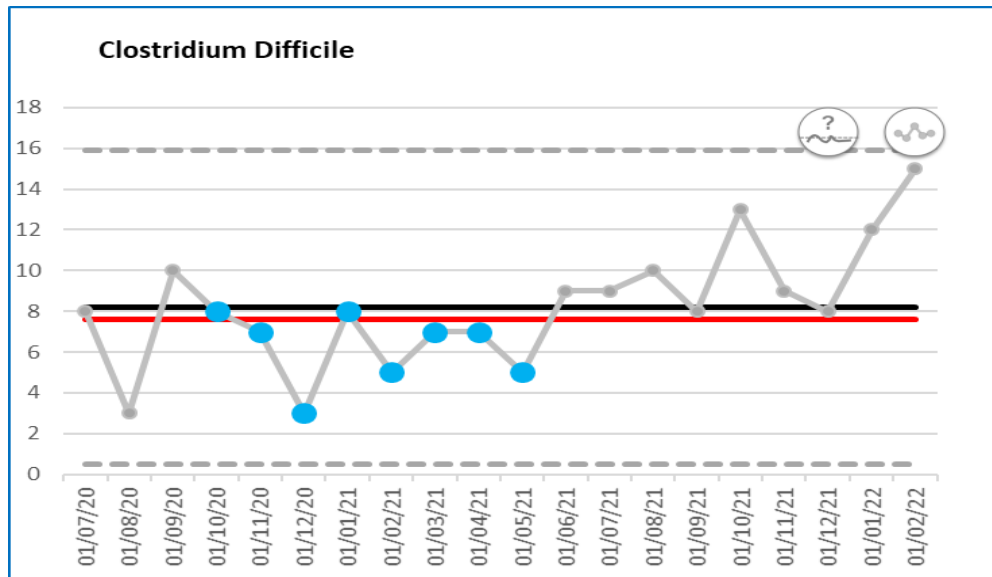


Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
4.1%	3.1%	3.5%			

National Position & Overview
National data not currently available for reporting.
However UHL introduced the OASI bundle 3-4 years, training staff in perineal protection and position at delivery, this initially had an impact in reducing Tears but the they have gradually increased and appear to be more prevalent on one site which has a larger mix of ethnic minority groups

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Normal vaginal delivery or Assisted Delivery with ventouse or forceps Any delivery of a baby vaginally carries a small risk of this extent of perineal tear 	<ul style="list-style-type: none"> Review and monitor the data and numbers per site on a monthly basis Review the care provided for each case and complete the proforma in relation to capturing this data Depending on the data consider interventions Continue to teach and provide perineal protection with new Junior doctors and newly qualified midwives 	<ul style="list-style-type: none"> The percentage of tears are monitored monthly and a sustained increased will trigger and evidence based intervention

Safe – Clostridium Difficile



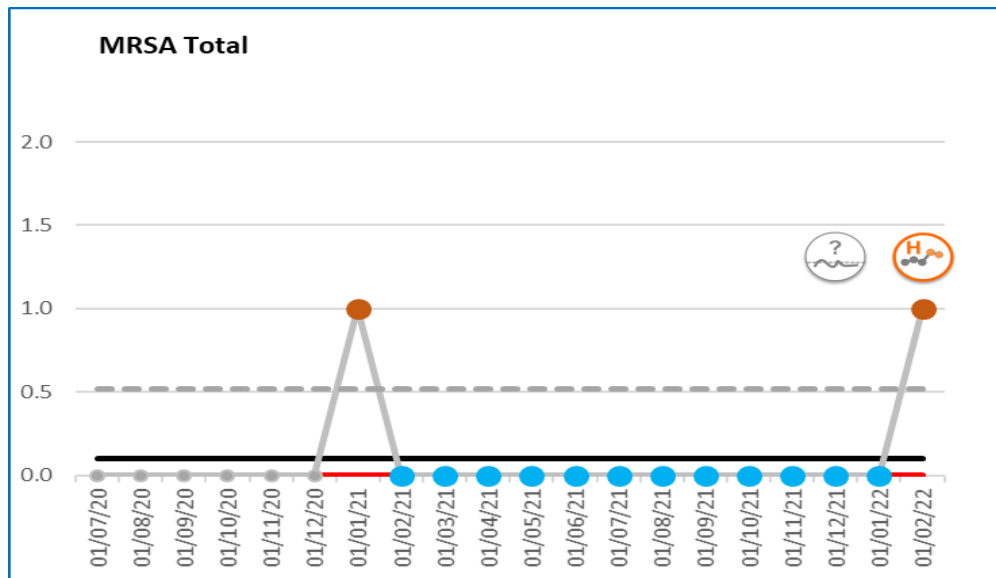
Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
15	105	91	8	8 tbc	7 tbc

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 (12.7) compared with the national average (18.4) for last 12 months of published data (Jan 21 – Dec 21). UHL ranked 45 out of 135 trusts that submitted data and 1st out of it's 18 peers. Source fingertips.phe.org.uk

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> High bed occupancy is a significant risk factor for increased <i>C.difficile</i> infections. Antibiotic prescribing is high and whilst the reasons are multifactorial the COVID-19 Pandemic has undoubtedly contributed to this. Of note: These cases are ascribed as 8 = Hospital onset healthcare associated 7 = Community onset healthcare associated UHL is required to report all cases using these criteria noting that the COHA have been in-patients within 28 days of a positive faecal sample. 	<ul style="list-style-type: none"> Focused attention on antimicrobial prescribing practice is required with one of the main foci being avoidance of broad spectrum antibiotic use except where necessary. Review of where the current CMG Antibiotic Consumption reports are disseminated and whether action plans have been developed to address any exceptions identified Focused action by CMG Operational Infection Prevention Groups to review and monitor monthly CDT data. Where required develop a CDT reduction action plan 	<ul style="list-style-type: none"> 7 has been allocated for the April forecast based on the trajectory from last year. The official trajectories for 2022/23 have not been released yet. Once the official trajectories have been released we will be able to come up with a more accurate trajectory Whilst a report will be submitted monthly it should be noted these actions will be undertaken up to end of March. End of Q4

Safe – Methicillin Resistant Staphylococcus Aureus (MRSA)



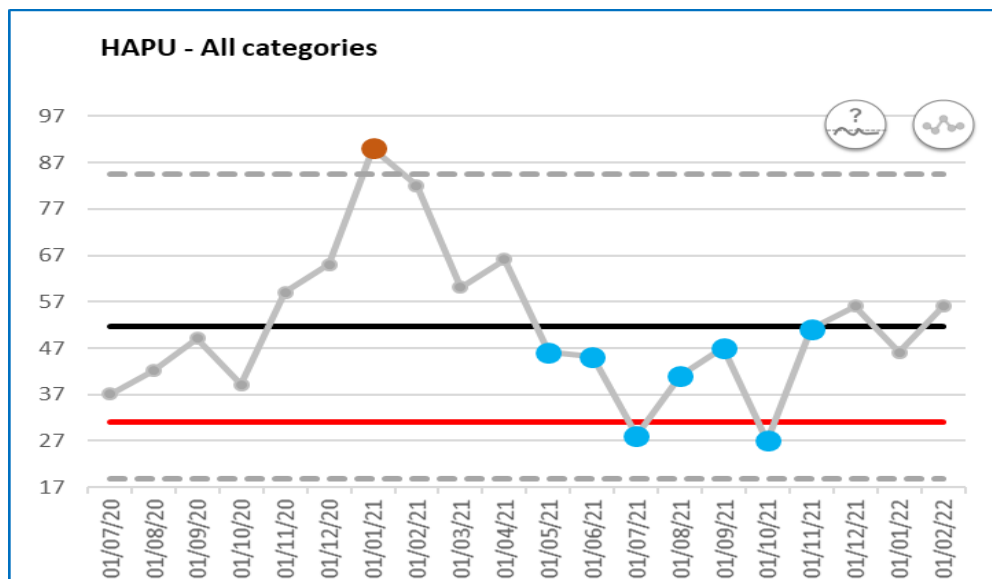
Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
1	1	0			

National Position & Overview

UHL is one of the best performing trusts for MRSA bacteraemia rates in England however a thorough investigation is being undertaken to ensure that any identified lessons/actions are implemented if appropriate

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Currently under investigation 	<ul style="list-style-type: none"> UHL follows The Department of Health guidance as set out in the planning guidance <i>Everyone counts: Planning for Patients 2013/14</i> when investigating the identification of the an MRSA bacteraemia Appropriate CMG colleagues have held the Post Infection Review /RCA meeting. Further meetings are planned 	<ul style="list-style-type: none"> A full RCA will be presented to the April Trust Infection Prevention Committee

Safe – Hospital Acquired Pressure Ulcers All Categories



Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
56	509	366	50	45	40

National Position & Overview

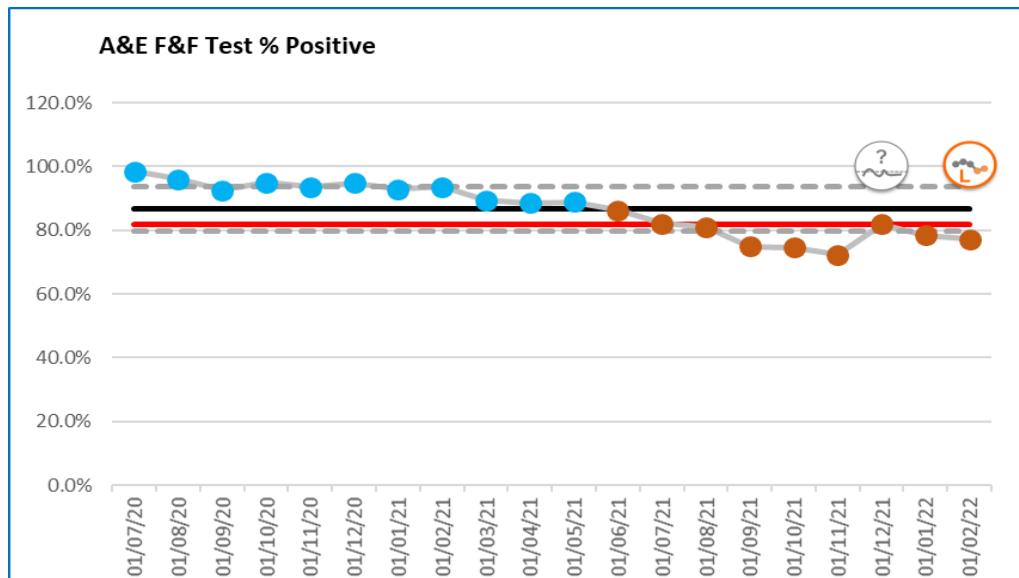
Currently no national benchmarking or reporting is available to provide comparative data.

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 (50% reduction) 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 Contributing factor relating to reduced staffing and decreased care hours per patient day Delays in validation process and double counting in some anatomical areas 	<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 ongoing with clinical faculty providing individual ward level support with PDSA projects Harms relating to staffing shortages, including HAPUs, via the safer staffing monthly report Development of additional teaching package using 60 sec 'talking heads' training/updates accessible at ward level by individual staff Planned review of validation process and look back at 12 months for double counting 	<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

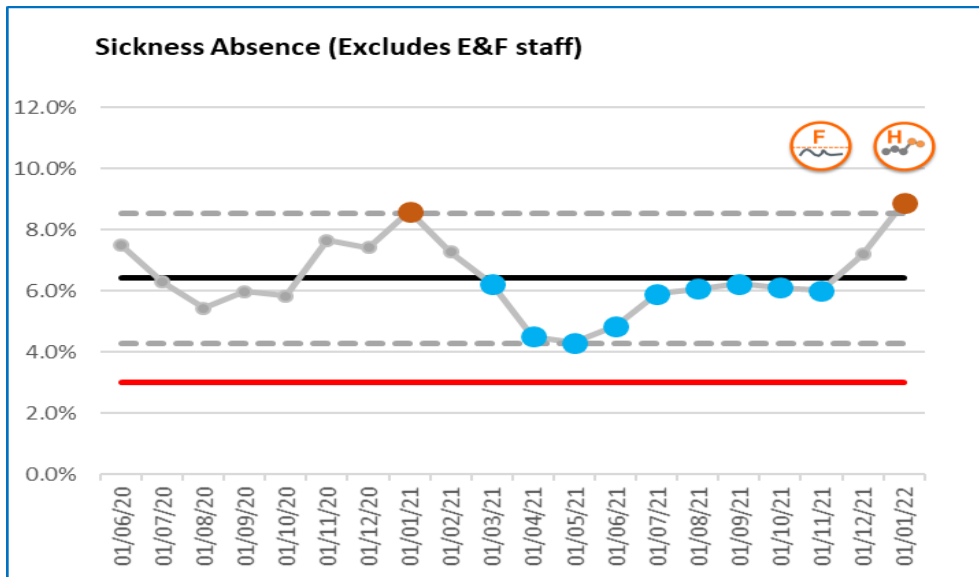


Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
77%	81%	82%	79%	82%	83%

National Position & Overview
<p>UHL performance has deteriorated significantly over the past 9 months. The target has been set as 82% which was the average performance between Jan 21 and Nov 21.</p> <p>National performance in January was 81%, UHL ranked 86 out of 118 acute trusts and 12 out of 16 in its peer group. The highest performing trust in UHL's peer group achieved 96% and the lowest performing trust achieved 68%.</p>

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 	<ul style="list-style-type: none"> FFT comment themes regarding long waits analysed to inform local targeted improvements Enhance focus on communication with patients regarding current delays in the department UEC system plan to reduce attendance and delayed discharges of those that are medically fit Use of on site urgent treatment centre to reduce the number of attendances in the emergency department 	<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		
Jan 22	YTD	Target	Feb 22	Mar 22	Apr 22
8.9%	6.1%	3%	5.0%	5.0%	5.0%

National Position & Overview

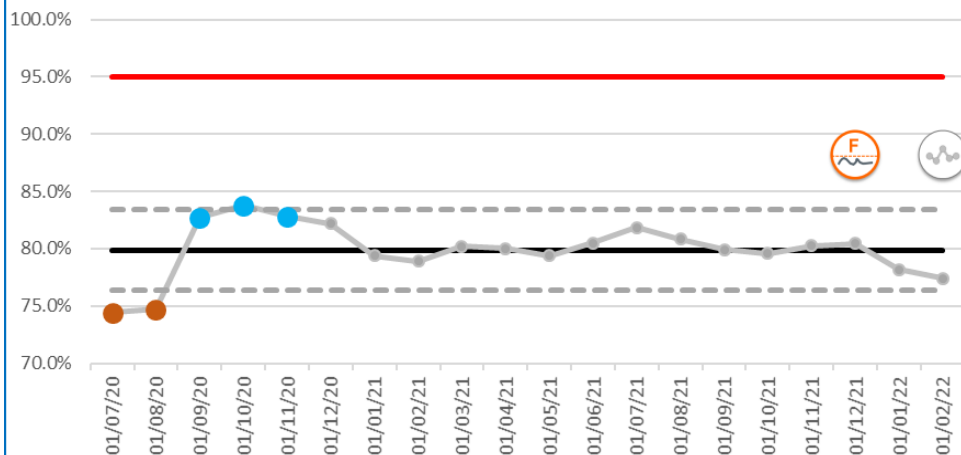
Data Excludes Estates and Facilities staff. Peer data not currently available.

Staff Sickness absences have increased significantly over the last two months. The current percentage of absences is at a similar level to the same period last year.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> We have seen an increase in sickness absence during December and January. In addition an issue has been identified, resulting in the under reporting of sickness absence since August 2021. The most significant increase in January 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 up to 4% retrospectively on data figures. 	<ul style="list-style-type: none"> Covid vaccinations are being actively promoted despite the VCOD regulations to be revoked on 15 March 2022. CMG's have been more closely reviewing sickness absences to ensure robust support and management. 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. Review of current Smart reporting processes and data. A digital staff health and wellbeing booklet has been developed to support staff. 	<ul style="list-style-type: none"> The reporting issues have resulting in a cumulative increase from 5.91% to 6.14% Sickness is having a significant impact particularly on maintaining safe staffing and keeping staff morale up. We have seen a significant increase in sickness absence in January 2022 due to the omicron variant and seasonal fluctuation , and in February are starting to see a reduction in sickness absence through daily reporting. The indicative trajectory has been reviewed and will be kept under review, 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

Feb 22	YTD	Target
77.4%	77.4%	95%

Three Month Forecast

Mar 22	Apr 22	May 22
80%	87%	95%

National Position & Overview

Peer data not currently available.

- This last quarter of the financial year to date, appraisal performance has seen a steady drop following a period of stable compliance; this is due to COVID-19 related pressures.
- February has seen a 0.8% reduction in compliance
- The appraisal and pay progression paper, outlining the approach from 1st November 2021 was approved by Strategic on 8th November 2021; see additional changes in 'Actions'
- Due to the impact of Omicron on staffing it is necessary to again review the trajectory as above. Please also see 'Actions' below

Root Cause

- It is recognised that performance has been impacted by Covid-19 and the Omicron variant and resulting in operational pressures/ demand while in Covid -19 Escalation Level 4.
- Though now at Level 2 these impacts are still felt (staff absence levels and resulting isolation guidelines for healthcare workers); this impact is reflected in the compliance figures which sees a further drop in the month of February

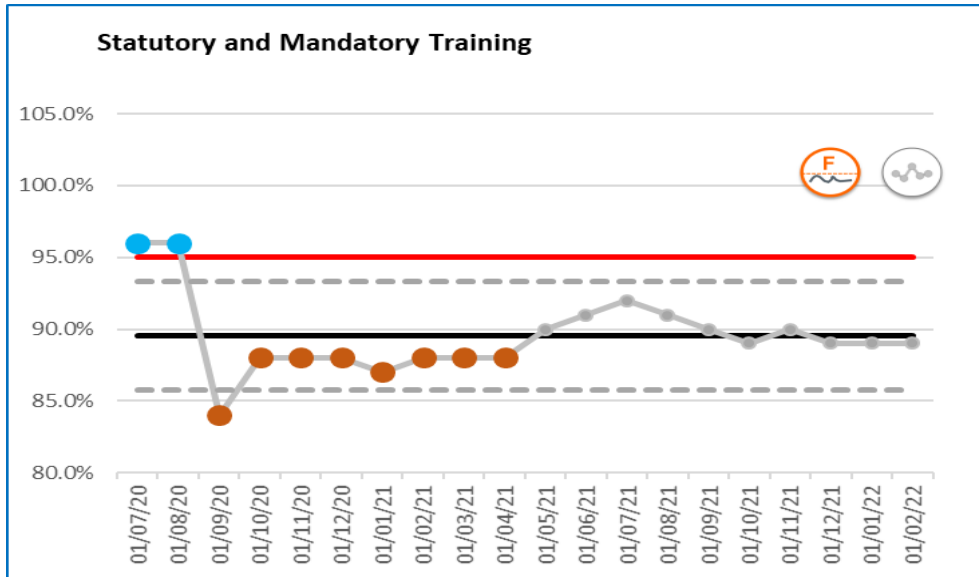
Actions

- As we have now moved to Covid 19 Escalation Level 2 the need to remind services of the importance of appraisal discussions and capturing this has resulted in a request from Services to extend the period to meet appraisal compliance to 31 May 2022
- Automatic pay progression has therefore been extended from 31 March to 31 May 2022 as requested by Services to meet compliance
- The trajectory has been reviewed to reflect the time requested by Services to meet compliance due to the impacts on staffing pressures and subsequently on appraisal compliance.
- 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 system approach to be taken for the re-earnable process for staff on the top of Bands 8c, 8d and 9, in consultation with System organisations

Impact/Timescale

- CMG's / Directorates to provide a trajectory to achieve and sustain 95% appraisal performance;
- 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.
- Also to be monitored via PRM monthly.

Well Led – Statutory and Mandatory Training

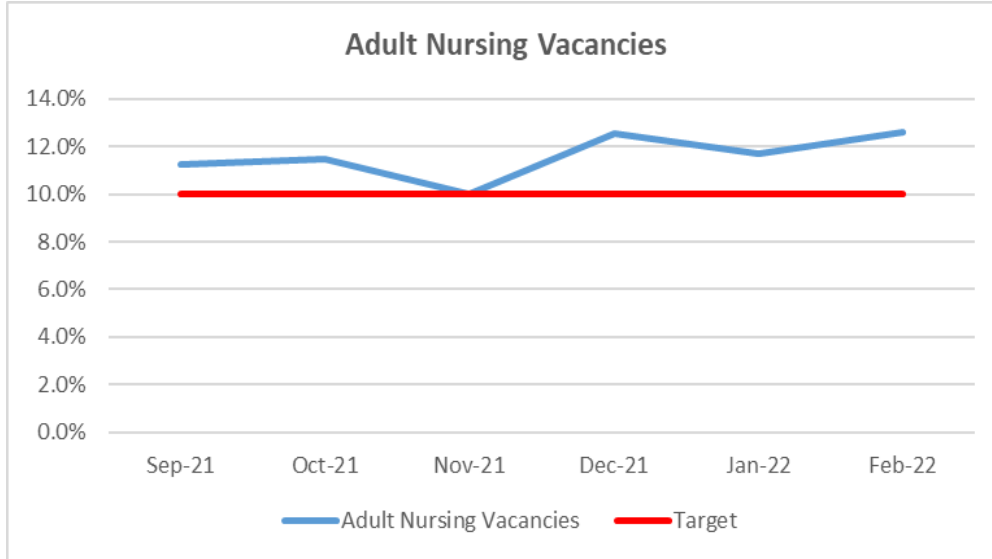


Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
89%	89%	95%	90%	91%	91%

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 improving their compliance.</p> <p>Performance against trajectories is being monitored via Executive Corporate and CMG Performance Reviews. This is complimented by access to compliance reports, direct emailed snapshot reports to over 2000 relevant staff & more than 10,000 direct emails per month to non-compliant staff.</p> <p>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. This is a meeting with each line manager to review sickness, appraisals and S&MT compliance.</p> <p>Drive towards improving the overall percentage of UHL before the start of the financial year has been implemented during March 2022.</p>

Well Led – Adult Nursing Vacancies

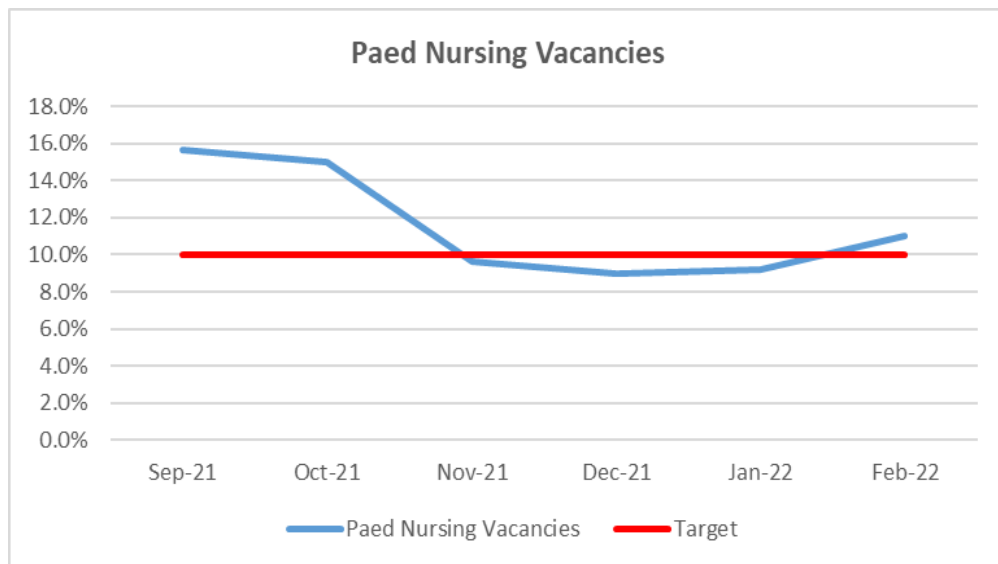


Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
12.6%	12.6%	10%	11.6%	12.0%	10.0%
National Position & Overview					

NHS Digital data published in March 2022 for NHS England and NHS Improvement and show a vacancy rate for Nursing & Midwifery registrants of 10.3% at 31 December 2021 (Midlands is 11.0%). This rate is nationally and regionally highlights a deterioration from the same time last year (Dec 2020).

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> The UHL 2020/21 vacancy rate for Nursing & Midwifery registrants has seen a 0.9% deteriorated position from Jan '22 (equating to a increase of 30 wte vacancies reported). In the H2 budgeted establishments across UHL There was an increase of 97wte (due to investment) which directly impacted on the previously improved 2021 position. The leavers trend remains at circa 15 leavers per month including retirees, however the forecast data indicates a risk with increased retirees in March 2022. 	<ul style="list-style-type: none"> Marketing Campaign live adverts to promote UHL as an employer of choice. RCN conferences recommence with an event in March '22, and Virtual RCNi conference for students nurses March '22 CMG recruitment events held in March '22 specifically aligned to ITAPS and CHUGGS as part of reconfiguration and to support restoration. Recruitment agencies interviews will continue with pipeline for UHL cohorts for international nurses to arrive bi-monthly in 2022: 320 planned within financial year. Bi Monthly trust wide/CMG & specialty adverts for all RN posts. 	<p>Continue to work to the arrival dates below for International Nurse Recruitment - no anticipated delays</p> <ul style="list-style-type: none"> March - 62 arrivals (OSCES due April'22) May -60 arrivals July – 60 arrivals <ul style="list-style-type: none"> 41 wte Newly qualified graduates for adult nursing to commence into post April/May/June '22

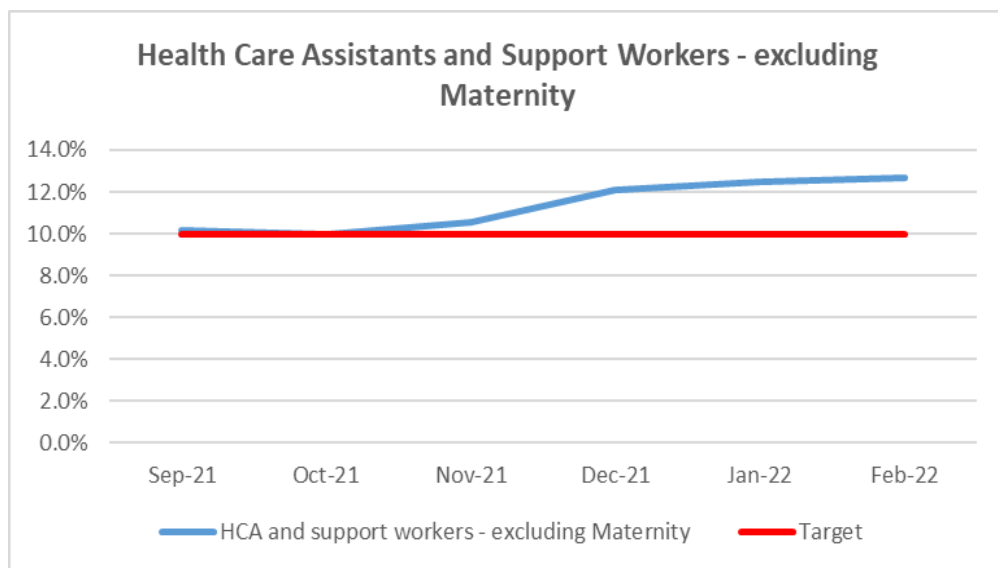
Well Led – Paed Nursing Vacancies



Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
11.0%	11.0%	10%	11.0%	10.3%	9.7%
National Position & Overview					

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> The vacancy position has deteriorated in month by 1.8 % , 9wte compared to Jan '22. However this demonstrates a continued improved position from 90wte paediatric vacancies across several cost centres from Sept '21. ED Paediatrics have reduced their vacancies from 27wte in Sept '21 to 19.2wte vacancies. Vacancy position overall continues to be due to the limited supply of NQN and leavers who are not retirees. 	<ul style="list-style-type: none"> Daily senior nurse oversight with nursing staff moves to mitigate gaps and maintain safety and achieve nurse to child ratio's Recruitment leads are actively attending conferences, RN and NQN virtual event to interview and recruit local and candidates from the midlands and nationally. Ongoing support of the international nurses who have landed ensuring OSCE completion and a smooth transition into their clinical role. 	<ul style="list-style-type: none"> Plan to do further interviews for international nurses who possess paediatric critical care and ED experience following successful recruitment in Nov '21 and Jan '22. 13 wte Newly qualified graduate children's nurses will be commencing into post in April/ May '22.

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

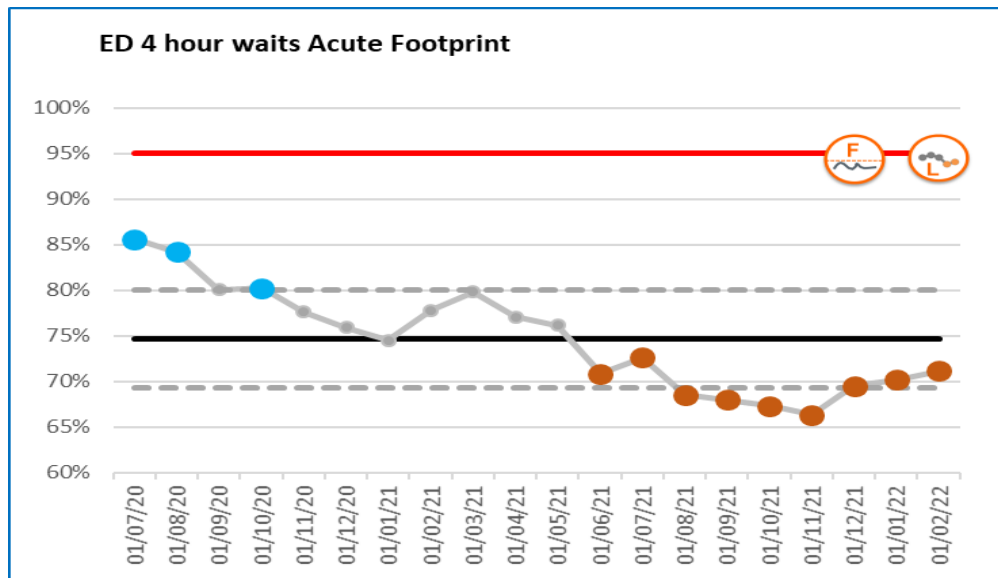


Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
12.6%	12.6%	10%	10.6%	11.0%	10.0%
National Position & Overview					

Across England the number of vacant healthcare support worker posts remains high. The drive from Nov 2020 has not been realised nationally and remains in February 2022, a national focus on achieving 'close to zero vacancies as possible' 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 0.1 % deterioration in month compared to Jan '22, this equates to 4wte. The H2 budgeted establishments across UHL increased by 47 wte due to investment which remains reflected in Dec '21 growth. There continues, in month, to have HCA leavers and staff moving from substantive posts to bank posts impacting on the substantive headcount. The supply of HCSW's is decreasing , noted with the regional and national team as a similar picture across England. 	<ul style="list-style-type: none"> Recruitment events booked every 8 weeks throughout 2022, 170 individuals booked into an interview day in March, all assessments incorporated. ID checks and allocation all completed on the interview day to reduce onboarding delays and improve candidate recruitment experience. UHL working with NHSI Direct Support / 'Indeed' to review the processes and increase supply. Marketing and social media campaign planned for launch in May 2022. Recruitment huddle held weekly to monitor and ensure pipeline progression to start dates. 	<ul style="list-style-type: none"> It is anticipated that UHL will be reporting to an improved position of vacancy by May '22, to meet the target of 10.0% Additional meetings held with NHSI Direct as support and specifically working with Indeed in Feb , Mar & planned for April '22. In March '22 recruitment circa 60 HCA candidates in pipeline undergoing recruitment checks - start dates agreed. May '22 intake planned of 35 , mapping an alternative induction pathway for the supply from the March interviews, if candidates able to commence an April induction date. Recruitment and Open day planned for April & May '22 with planned start for 60 in June / July .

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

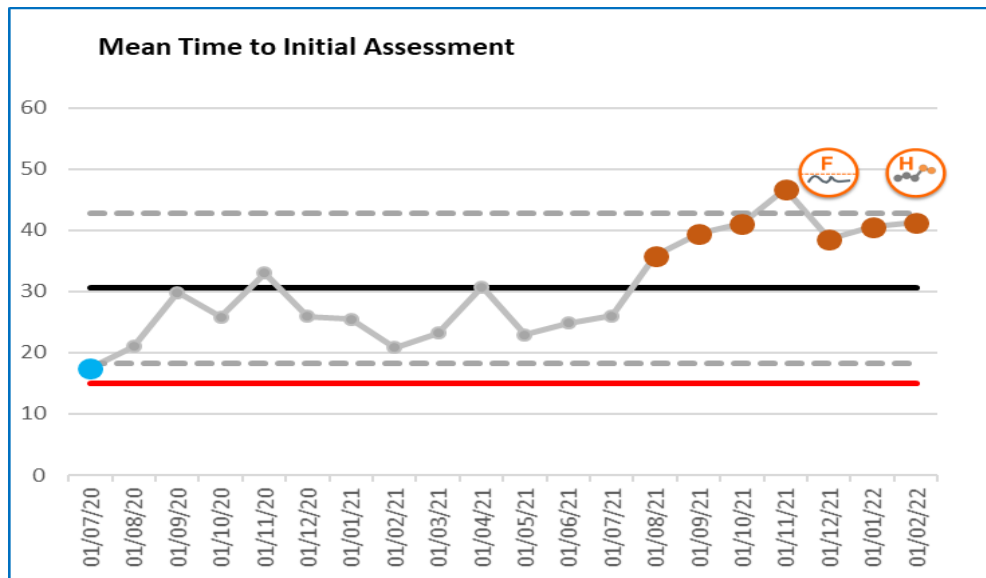


Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
71.2%	70.6%	95%	67%	71.5%	71%

National Position & Overview
<p>In February, UHL ranked 65 out of 113 Acute Trusts. The National average in England was 73.3%. Only 1 out of the 113 Acute Trusts achieved the target. UHL ranked 7 out of 16 trusts in its peer group. The best value out of the 18 Peer Trusts was 85.6% and the worst value was 62.3%.</p>

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Crowding in ED due to chronic and sustained lack of outflow High inflow of both walk-in and ambulance arrivals UHL bed occupancy >85% 	<ul style="list-style-type: none"> Overnight ED consultant locum shift continues to be available (via winter monies until end of March). 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 working well to support deflection of patients away from ED front door. Emergency medicine flow action plan being developed to focus on reduction in non-admitted breaches and adherence to new UEC standards. 	<ul style="list-style-type: none"> Improve time to senior decision making from November 2021 Improve time to senior decision making from November 2021 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 Reduce non-admitted breaches/April 2022

Responsive (Emergency Care) – Mean Time to Initial Assessment

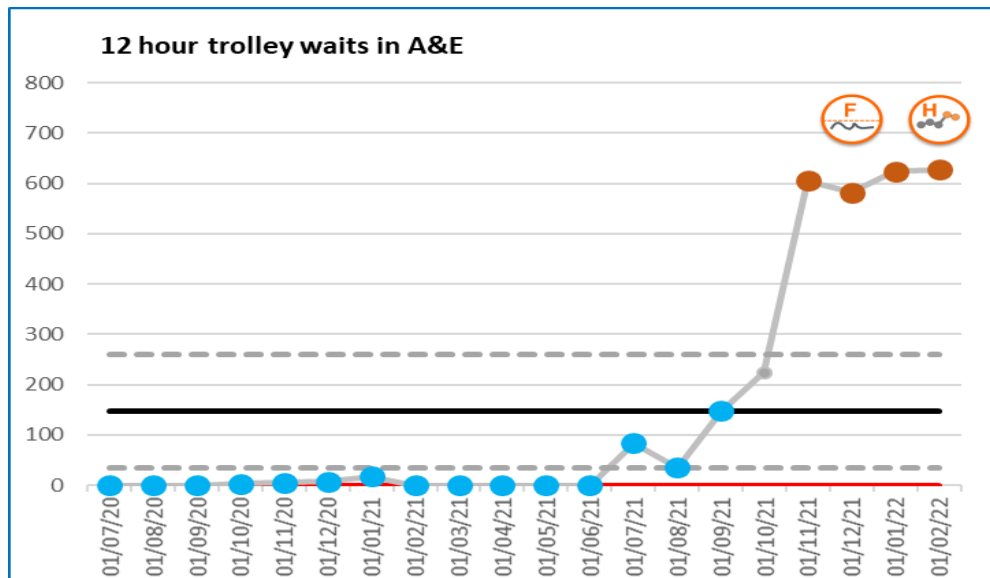


Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
41.3	35.9	15	41	40	40

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 -50 patients per hour 	<ul style="list-style-type: none"> Redirecting appropriate patients to Westcotes/hub appointments, UTC, GAU and GPAU 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 Continued support from UEC regional team on managing inflow demand. PDSA of clinical bed bureau project, seeking to direct more patients to specialties rather than default to ED. 15min Time To Assessment working group being established to focus on delivery of key actions for both ambulance and walk-in arrivals. 	<ul style="list-style-type: none"> In place and ongoing Senior decision maker able to deflect pre-triage/in place when staffing allows Ensure best practice and learning from other sites/ongoing Reduce attendances to ED/PDSA w/c 14 March 2022 Patient assessment within 15minutes of arrival in the department/April 2022

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



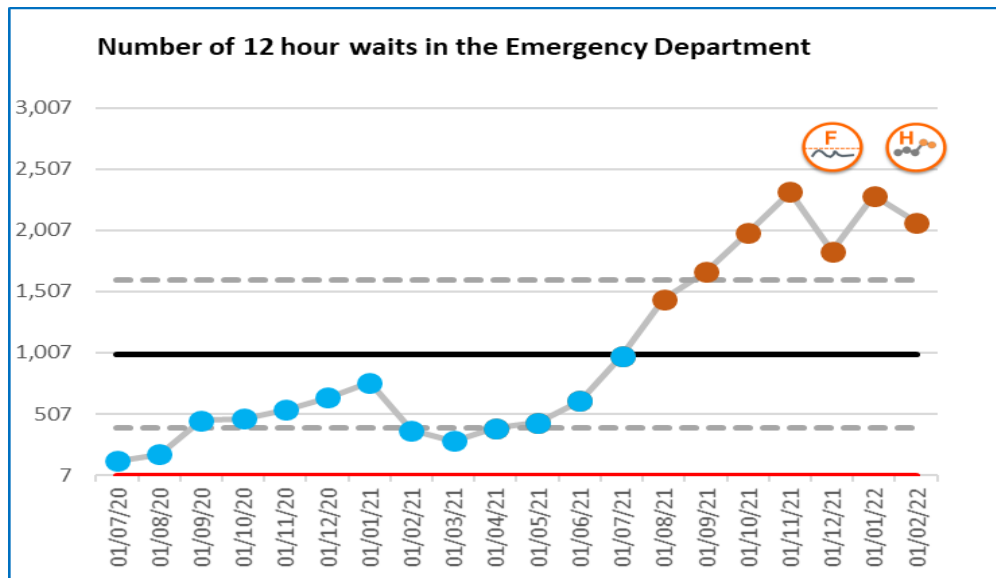
Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
628	2,930	0	620	590	570

National Position & Overview

In February, UHL ranked 120 out of 125 Major A&E NHS Trusts. 28 out of the 125 Trusts achieved the target. The best value nationally was 0 and the worst value was 844. UHL ranked 16 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 to review overnight bed list and clerk/discharge patients. Additional medical ward open at LGH. Development of action plan to review discharge processes across the emergency floor, including review of discharge support roles and timely input from pharmacy and therapy teams. 8-10 week improvement led by NHSi for medical wards focusing on Board Rounds and principles of Red2green and SAFER patient flow best practices. 	<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 from May 2022 Improve morning discharge rate/May 2022 Aim to improve /embed SAFER patient flow best practice principles within key wards in medicine by April 2022

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

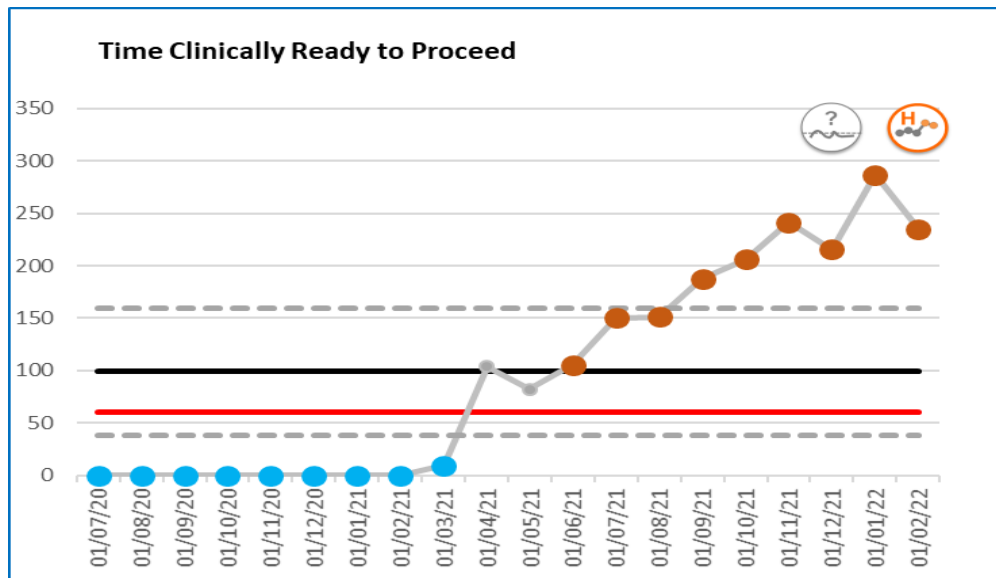


Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
2,071	16,035	0	2,528	2,506	2,558

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"> System-wide clinical and operational group set up to implement mobile UTC service off the emergency floor footprint from 1 April, to enable increased numbers of patients to utilise service via deflection from ED front door. Elite provided UTC extended for 1 month until end of April. 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.

Responsive (Emergency Care) – Time Clinically Ready to Proceed



Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
235.2	178.7	60	230	225	230

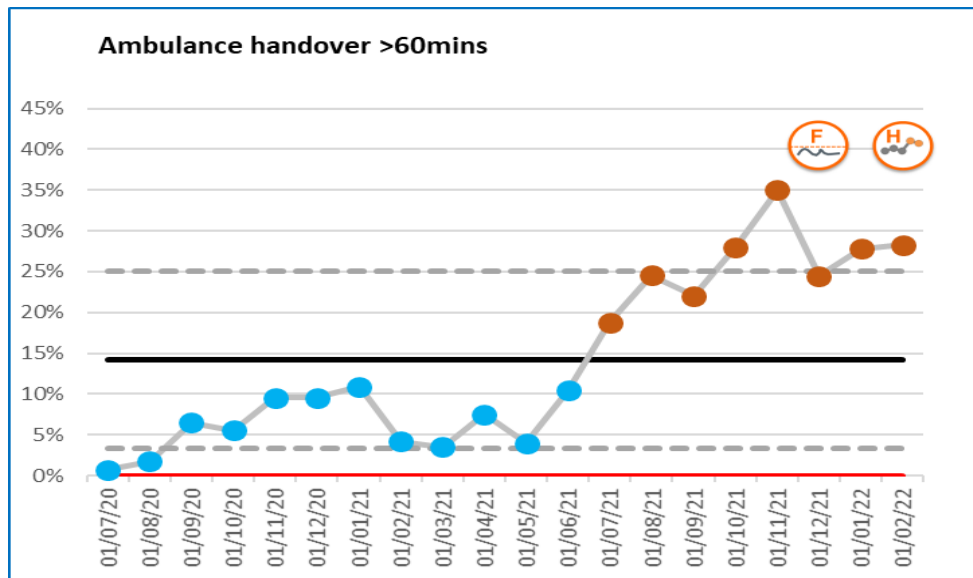
National Position & Overview

National data not currently available for reporting.

Note: The metric isn't correct, the standard should be % of patients that leave the department within 1 hour following CRTP

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Bed occupancy > 85% 	<ul style="list-style-type: none"> Further work with CMGs on timeliness of response for Nervecentre e-referral to specialities. Embed further response to Inter-Professional Standards, focusing on specialty in-reach Work with System partners to increase the number of patients discharged within 24 hours of being MOFD. Implementation of discharge action plan focusing on Board Rounds and principles of Red2green and SAFER patient flow best practices. 	<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/May 2022 Change of culture to improve timeliness of response to emergency patients/ongoing. 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 April 2022

Responsive (Emergency Care) – Ambulance Handovers >60 Mins



Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
28.3%	20.5%	0%	35%	33%	30%

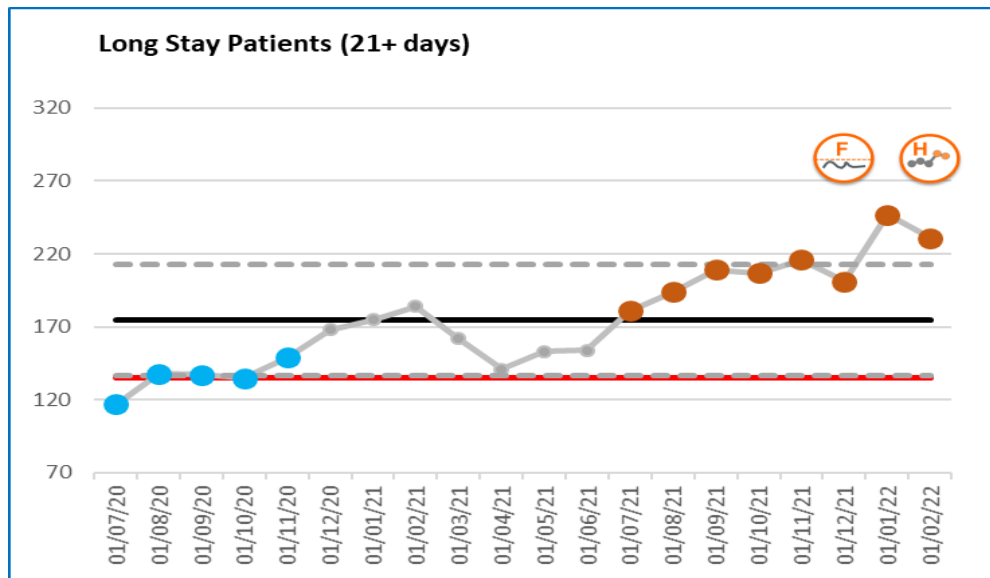
National Position & Overview

LRI ranked 21 out of 23 sites last month (source EMAS monthly report) and had the second highest number of arrivals (4,462).

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"> Winter funding being used to: open GPAU overnight where staffing allows; increase medical cover to meet ambulance professional standards of care. Further push with EMAS to implement direct referrals to GPAU. Senior discussions with EMAS about mandating calls to pre-admission clinical assessment service before conveyance to acute site. Plans in place to re-establish medical wards at LGH as part of Trust reconfiguration 	<ul style="list-style-type: none"> In place Reduce ambulance arrivals to ED/ongoing Create capacity for offloading ambulances in ED/in place Admission avoidance/February 2022 Loss/reduction of medical capacity/April 2022

Responsive (Emergency Care) – Long Stay Patients



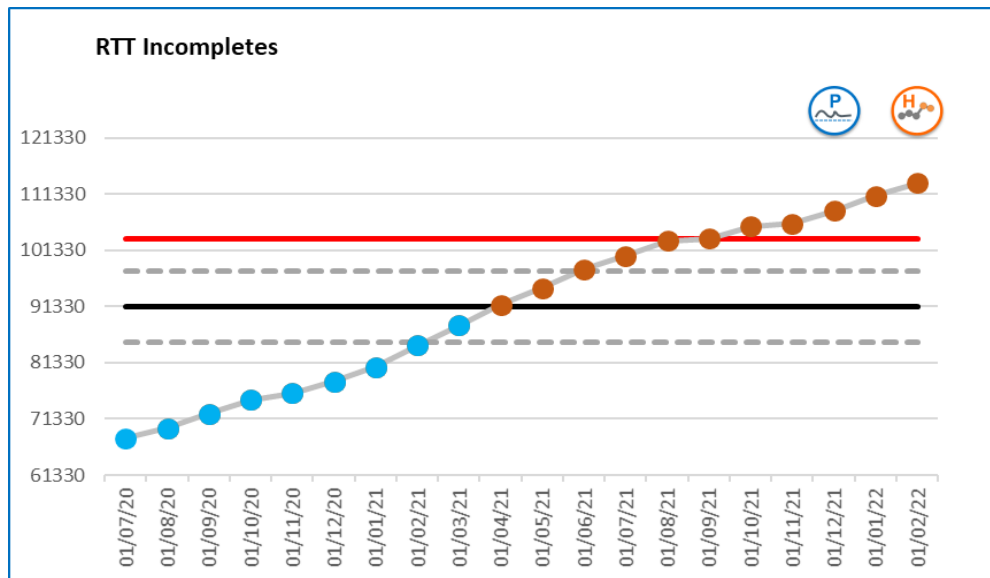
Current Performance			Three Month Forecast		
Feb 21	YTD	Target	Mar 22	Apr 22	May 22
231	231	135	220	200	150
National Position & Overview					

UHL is ranked 11 out of 20 trusts in the Midlands for the % beds occupied by Long Stay (21+ Day) patients (for the w/c 28/02/22).

- 28 Patients (12%) are receiving appropriate care/ treatment on a neuro rehabilitation or brain injury pathway.
- 7 Patients (3%) are receiving appropriate care/treatment on an Intensive care Unit or Infectious Diseases Unit.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> • Circa 170 Complex Medically optimised for discharge patients of which 50 have a LLOS (29%) 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. In addition to impacts of extra capacity wards , outlying and COVID. 	<p>Continue to work Collaboratively with health and social care system partners during March to:</p> <ul style="list-style-type: none"> • Ensure timely use of COVID designated care Home, therapy led D2A and interim beds. • Review patients awaiting discharge destinations see if alternative solutions exist. • Develop pathway for High dependency Residential Home placements. <p>Work with CMG's to:</p> <ul style="list-style-type: none"> • embed Long length of stay patient reviews in CHUGGs and ESM • Use 'future discharge's notifications' to prepare patients in advance of discharge date. • support additional capacity areas and patients outlied to prevent delays to discharge. 	<ul style="list-style-type: none"> • Aim to reduce number of MOFD patients waiting for discharge in UHL beds. • Aim to improve /embed SAFER patient flow best practice principles. • Reduce the number of patients awaiting 'next steps'/LLOS

Responsive (Elective Care) – RTT Incompletes



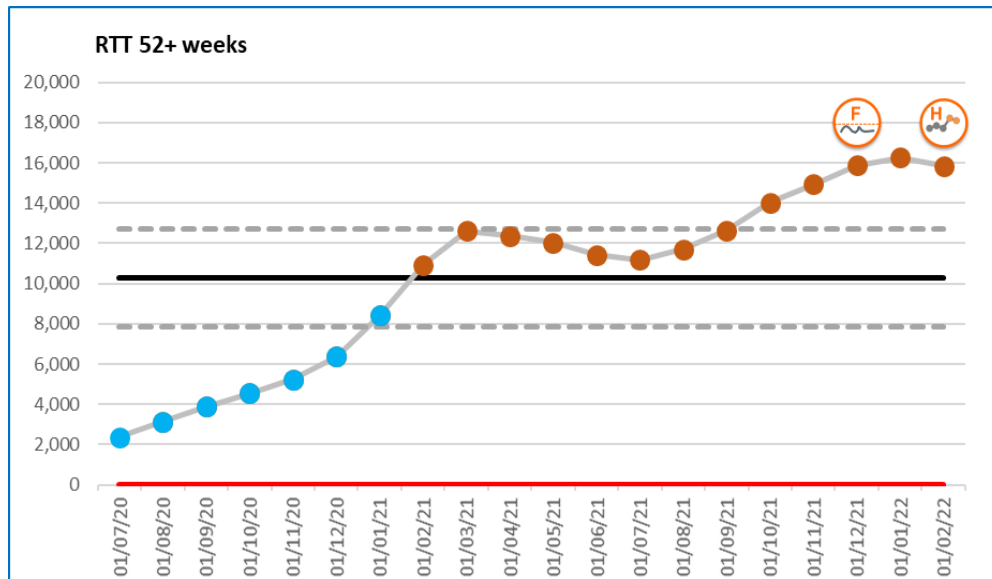
Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
113,373	113,373	103,403	115,921	114,089	116,184

National Position & Overview

At the end of January, UHL ranked 15 out of 18 trusts in its peer group with a total waiting list size of 111,008 patients. The best value out of the 18 Peer Trusts was 54,997, the worst value was 171,233 and the median value was 73,761.

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"> Appointment of 7 RTT validators to start in April Contact all patients waiting above 52+ weeks to assess if they still want treatment or have had treatment at an alternative provider Extend external validation contract for Q1 Robotic automation work to be rolled out across other specialties 22/23 trajectory to be submitted for national planning return 	<ul style="list-style-type: none"> 20/03/2022 – Internal capacity to support CMGs to validate waiting list 31/03/2022 – Contact 5800 admitted patients, around 3% removal rate of patients contacted so far. 15/03/22 – continued support to ensure all patients on the waiting list are validated 17/03/22 – trajectory submitted

Responsive (Elective Care) – RTT 52+ Weeks



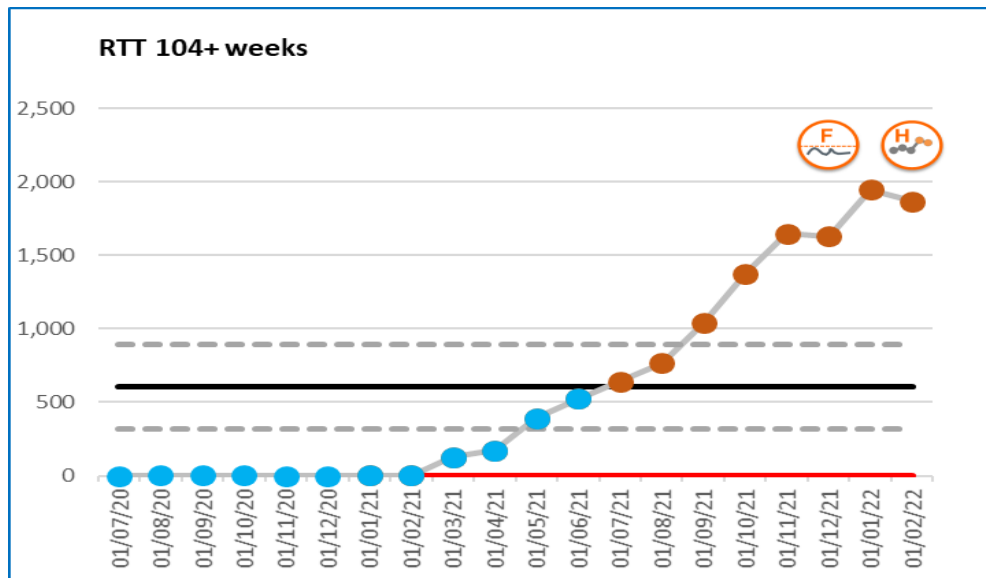
Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
15,842	15,842	0	15,394	14,817	14,305

National Position & Overview

At the end of January, UHL ranked 17 out of 18 trusts in its peer group with 16,274 patients waiting over 52+ weeks. The best value out of the 18 Peer Trusts was 830, the worst value was 29,993 and the median value was 4,067.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Impact of COVID-19 on planned activity capacity 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"> Identify patients who are suitable transfer to IS providers for 22/23 contract Levels Orthopaedics transfers to Grantham through Mutual aid (60 patients) Booking centre to call all admitted 52+ patients to check if they still require treatment 22/23 trajectory to be submitted for national planning return 	<ul style="list-style-type: none"> 31/03/2022 – reduction in 52+ patients waiting at UHL 30 patients to be seen in clinic at the LGH on the 26/03 for suitability 31/03/22 – Contact 5800 patients, removal rate at 3% so far 17/03/22 - trajectory submitted

Responsive (Elective Care) – RTT 104+ Weeks

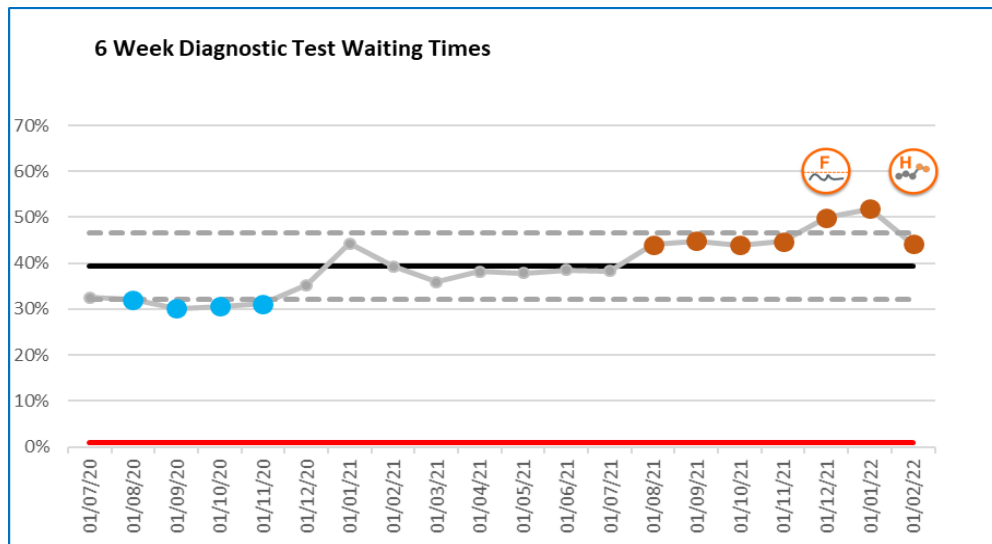


Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
1,867	1,867	0	1468	956	655

National Position & Overview
At the end of January, UHL ranked 16 out of 18 trusts in its peer group with 1,947 patients waiting 104+ weeks.
The best value out of the 18 Peer Trusts was 26, the worst value was 2,158 and the median value was 354.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Impact of COVID-19 on planned activity capacity 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"> Speciality level meetings to be set up to be chaired by Jon Melbourne (COO) Identify 300 suitable patients to be transferred to Kettering/NGH through mutual aid Re- validate 104+ cohort Identify 50 General Surgery patients to transfer to Park BMI 22/23 trajectory to be submitted for national planning return Clinically review all septoplasty on UHL waiting list to move to Nuffield through new agreement for 22/23 financial year 	<ul style="list-style-type: none"> 15/03/2022 – to develop key action plans for 4 specialties with the highest 104+ waits 31/03/2022- Transfer of long waiters 1830 patients to be validated by RTT team to ensure all patients pathways are correct 31/03/2022 – Increase capacity for 104+ patients 25/03/2022 Reduction in ENT Long waits

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

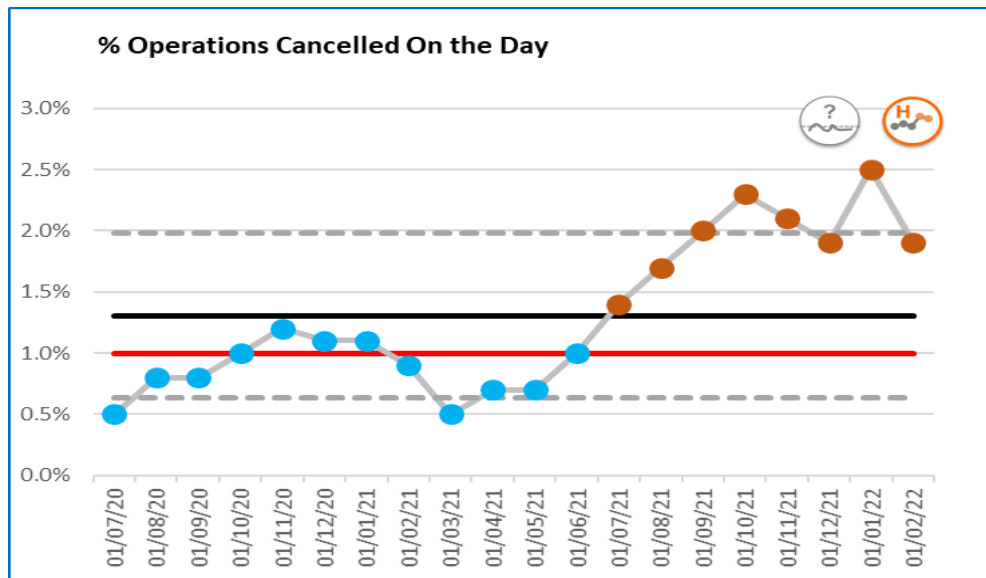


Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
44.2%	44.2%	1.0%	44.1%	41.5%	39.8%

National Position & Overview
<p>National average performance for January was 30.0%. UHL ranked 18 out of 18 trusts in its peer group with a performance of 50.6% in January. The best value out of the 18 Peer Trusts was 6.8% and the median value was 35.1%.</p>

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Impact of COVID-19 on planned activity capacity 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"> 22/23 trajectory to be submitted for national planning return Increase in additional capacity for CT and MR via the 22/23 ERF programme Address rising demand via communicate to primary care Extension to Endoscopy Vanguard contract Community Diagnostic Centres phase two business cases to be developed. Supporting diagnostics at Hinckley hospital 	<ul style="list-style-type: none"> 01/04/22 - Will continue to drive recovery (if demand plateaus) or will mitigate demand growth should it continue 01/04/22 - Ensure demand is entirely clinically driven 20/04/22 -Endoscopy recovery capacity delivery April, to apply for funding outlined in the Community Diagnostic Centres for system diagnostics schemes

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



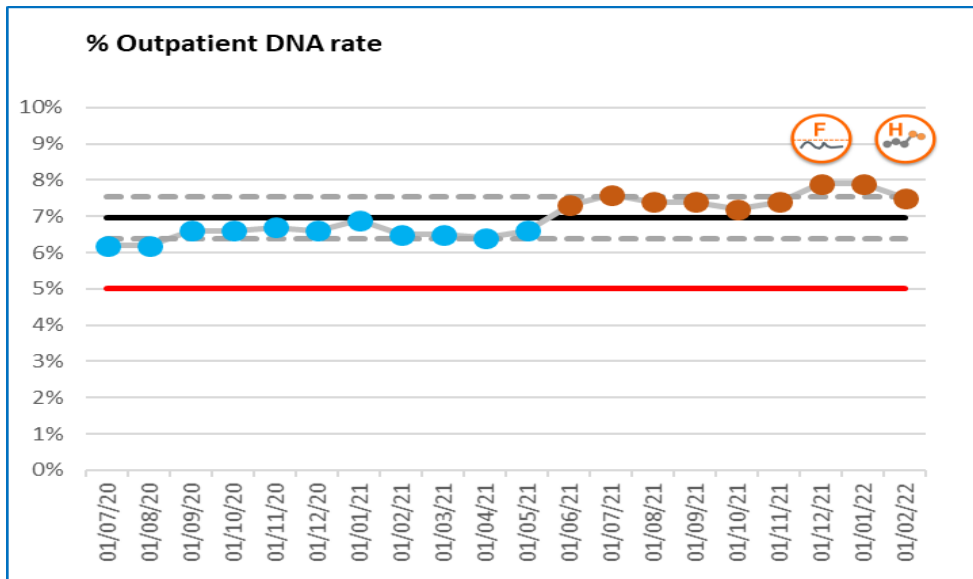
Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
1.9%	1.7%	1%	1.8%	1.3%	1.1%

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 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 supports elective care. 	<ul style="list-style-type: none"> Implementation of digital pre-operative assessment (ePOA) Through 104+ long wait speciality support meetings identify areas where we can potentially ring-fence elective beds Develop further comms for patients to ensure they fully understand what to expect on the day of surgery. A Number of patients choosing to not have surgery on the day Reviewing cancellation fields to ensure accurate recording of reasons 	<ul style="list-style-type: none"> On-going – reduce on the day cancellations through earlier identification of additional requirements of patients 31/03/22 – reduction in cancelled ops due to no bed availability 14/04/22 – Decrease cancelations due to patients choice 31/03/22 – ensure that there is increased data quality to ensure we are focussing efforts in the correct area

Responsive (Elective Care) – Outpatient DNA Rate



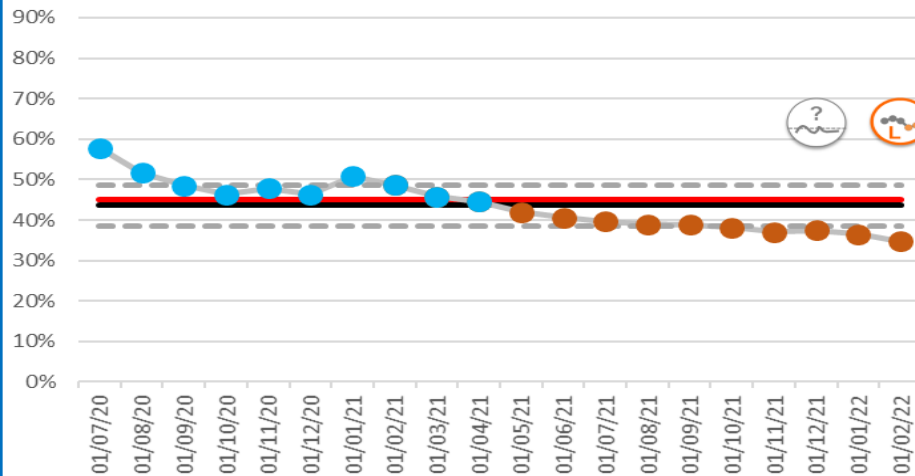
Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
7.5%	7.3%	5.0%	7.2%	6.9%	6.6%

National Position & Overview
UHL compares better than its peers for this financial year so far, 7.0% compared to 8.4% (data up to the end of November, 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
<ol style="list-style-type: none"> 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 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 Late cancellations/rebooks often mean patients do not receive their appointment letters on time so unaware of appointment Due to lack of admin staff, patients unable to get through to department to let them know they're unable to attend Some patients are still afraid to come in to hospital 	<ol style="list-style-type: none"> On the Risk register. IT are looking into. Continue to promote the use of Attend Anywhere as an alternative. Remind services of the need to check the patients details are correct and up to date at every contact Services are being encouraged to use the OP QlikSense dashboard and call patients Working on increasing numbers on the admin bank and getting them upskilled Ask services to offer choice of video consultation 	<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.

Responsive (Elective Care) – Outpatient Non Face to Face

% Outpatient Non Face to Face



Current Performance

Feb 22	YTD	Target	Three Month Forecast		
Mar 22	Apr 22	May 22			
34.8%	39.1%	45.0%	36%	38%	40%

Three Month Forecast

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%.

Root Cause

1. Not all Outpatient rooms and consultant offices are set up for video consultation eg no webcam or 2nd screen, and not all rooms have phones in them
2. There is a fear of losing consulting rooms amongst clinicians therefore they are bringing patients in F2F
3. Some clinicians and patients do prefer F2F over non F2F
4. Poor experience with One Consultation has made rollout of Attend Anywhere more challenging

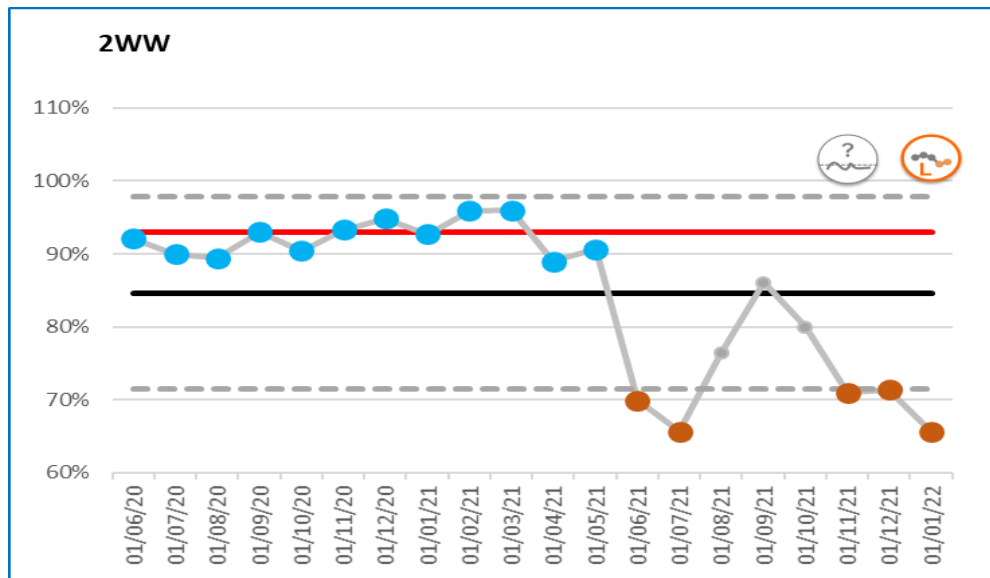
Actions

1. All of central outpatient rooms have now been provided with webcams, 2nd screens and headsets. Other OP areas have been asked what they need.
2. 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.
3. Attend Anywhere demos are being carried out and kit is being supplied to encourage video consultation as an alternative. Improve comms around the benefits of video consultation.

Impact/Timescale

- 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



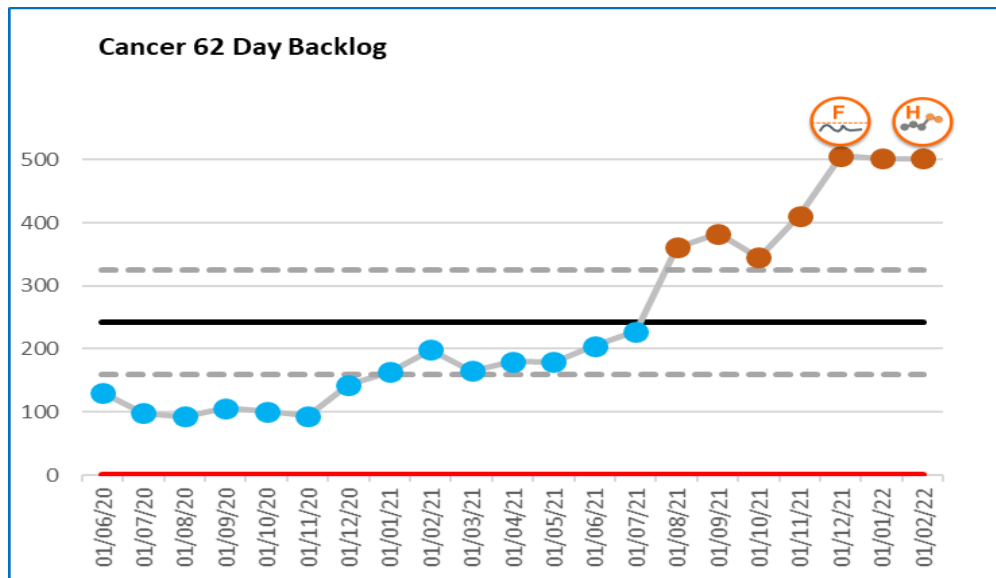
Current Performance			Three Month Forecast		
Jan 22	YTD	Target	Feb 22	Mar 22	Apr 22
65.6%	76.6%	93%	66.6%	77.5%	84.7%

National Position & Overview

In January, UHL ranked 101 out of 125 Acute Trusts. The National average was 75.0%. 25 out of the 125 Acute Trusts achieved the target. UHL ranked 12th out of the 18 UHL Peer Trusts. The best value within our peer group was 96.6% and the median value was 71.4%.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> 2WW demand overall remained higher than pre-COVID levels in January (2.8%) with Breast (8.7%) & Colorectal (13.6%), Haematology (88.9%). Although overall numbers seen in January were lower than the previous month, an increase of 464 patients were seen compared to January 2021. Breast, Haematology, H&N, Skin, Upper GI and Urology failed to meet the standard The continued increase in 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 & Outsourcing U35s (Jan 2022) Additional WLI and USS rooms at GGH Insourcing for weekend activity (Feb 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) WLI activity and review of I/P for clinic capacity <p>Haematology</p> <ul style="list-style-type: none"> Demand and capacity gap – service clinically triaging each referral and appropriately booking Service to consider clinical triage telephone consultations 	<ul style="list-style-type: none"> Breast U35 backlog clearance by Feb 2022, expected delivery of 2WW performance from April 2022 ENT backlog remains a concern, system approach to reviewing 2WW referral appropriateness in planning for April 2022 onwards. Trajectories for 22/23 show improving performance but under achievement forecasted to continue due to capacity gap Haematology continue to manage increased demand by clinically triaging referrals whilst managing non 2WW clinically urgent patients. Trajectories for 22/23 show improving performance but under achievement forecasted to continue due to capacity gap. Overall UHL position for 22/23 reflective of key areas of concern and forecast for under delivery of the standard.

Responsive Cancer – Cancer 62 Day Backlog



Current Performance			Three Month Forecast		
Feb 22	YTD	Target	Mar 22	Apr 22	May 22
502	502	0	462	370	348

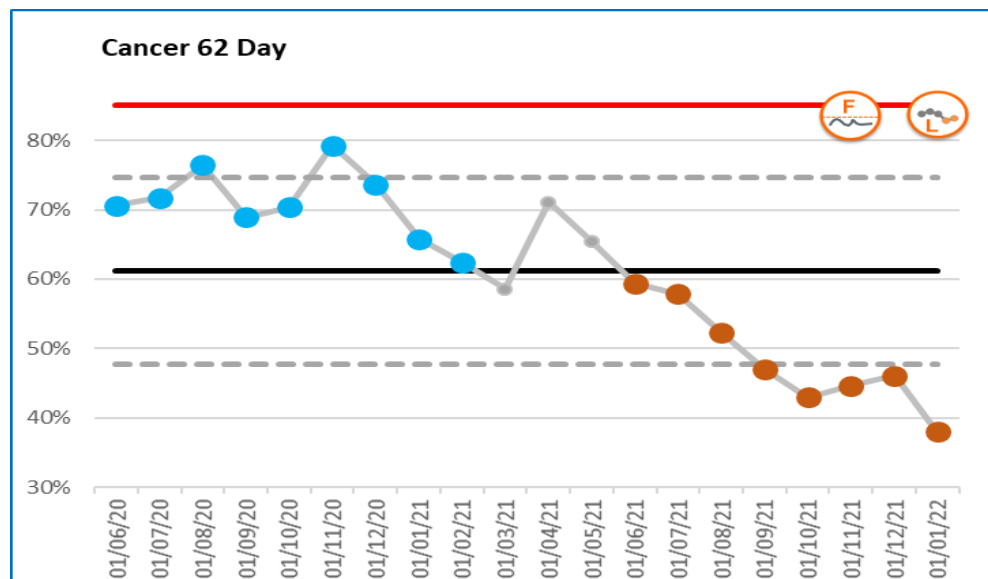
National Position & Overview

National data not currently available for reporting.

3 month forecast based on March actuals and forecasted recovery position for UHL following CMG submissions

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> 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. Diagnostic capacity constraints, particularly Endoscopy. Reduced theatre sessions, theatre recovery capacity, ICU constraints . COVID positive patient delays on diagnostic and treatment pathways are evident across the 62 day backlog in addition to patient choice Bed reductions due to challenges with ED volumes, ICU and COVID patients on Wards particularly LGH. Staffing issues in ITAPS having an impact on theatre sessions with the CMGs 	<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, progress Skin AI programme to release capacity and improve pathway delays 	<ul style="list-style-type: none"> Mutual aid for MaxFax treatments with Derby commencing February 2022 Recovery action plans submission in March 2022 Skin AI to go live March 2022 – pilot site initially with full go live by end May 2022 RDC/Faster Diagnosis Framework paper submitted February 2022 and work to commence on national timed pathways by end of Q4 2022 Weekly PTL meetings continue to be prioritised to ensure pathway delays are expedited and accurate CWT rules are applied

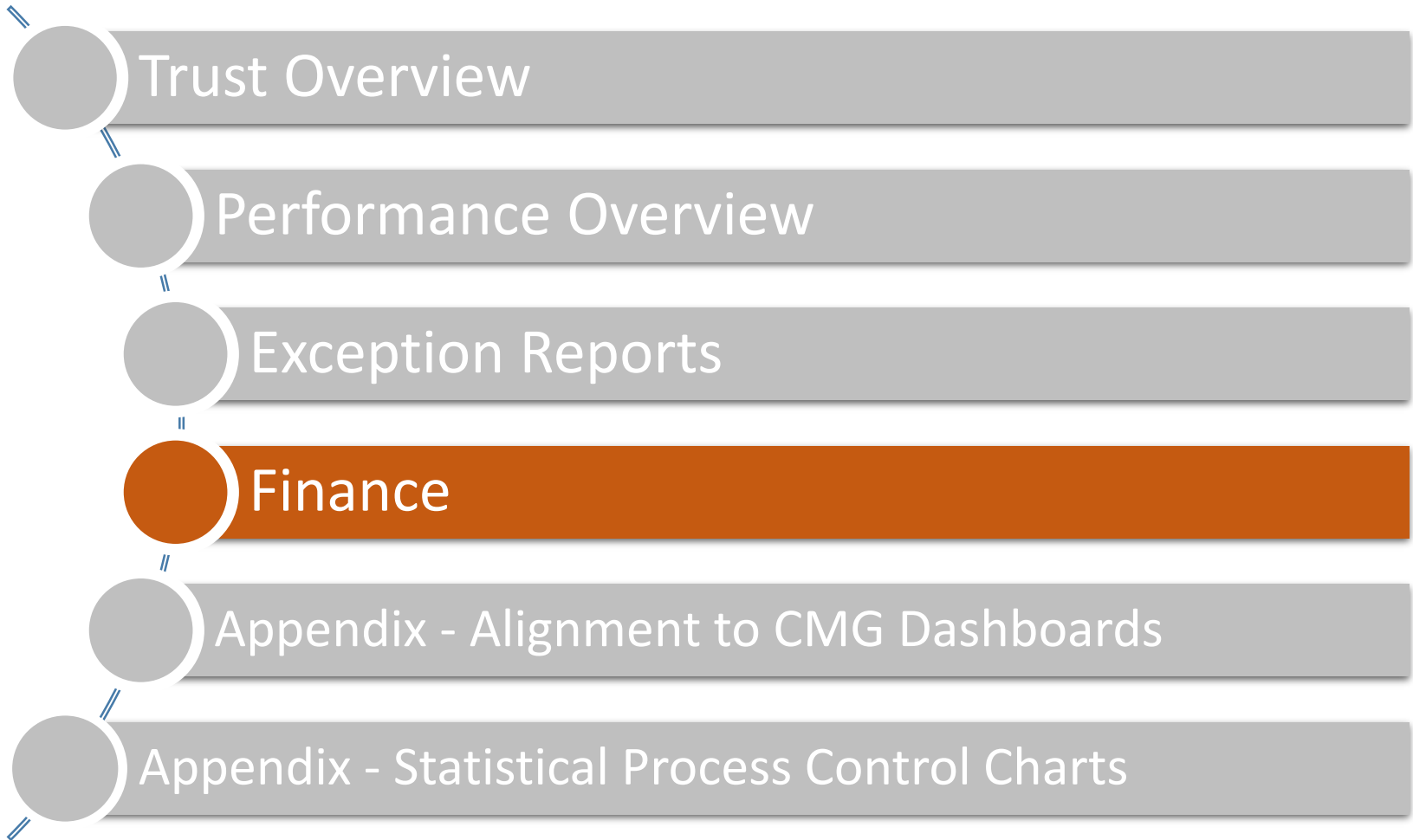
Responsive Cancer – Cancer 62 Day



Current Performance			Three Month Forecast		
Jan 22	YTD	Target	Feb 22	Mar 22	Apr 22
37.4%	52.6%	85%	45.7%	58.1%	60.3%

National Position & Overview
<p>In January, UHL ranked 128 out of 137 Acute Trusts. The National average was 61.8%. 11 out of the 137 Acute Trusts achieved the target. UHL ranked 15th out of the 18 UHL Peer Trusts. The best value within our peer group was 76.0% and the median value was 53.7%.</p> <p>Forecasted position based on actuals for February 2022 and CMG recovery trajectories submitted March 2022</p>

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 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 	<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 Transfer of diagnostics to IS for Urology to commence February 2022 – expected numbers to be confirmed depending on capacity



Single Oversight Framework – Month 11 Overview

At a Glance		Indicator	Plan / Standard	Period	YTD Actuals	Monthly Actuals	RAG Rating	Executive Director
Best Value Care	Finance	Trust level control total performance against target	Break-even/ Surplus	21/22	£6.2m	£(0.9)m		CFO
		Capital expenditure against plan	YTD Plan of £50.8m	21/22	£47.2m	£9.7m		CFO

Finance – Best Value Care

The Trust has reported a month 11 deficit of £0.9m. The year to date surplus at month 11 is £6.2m, which generates a favourable variance against forecast of £2.4m. This variance is driven by additional income of £2.6m consisting of Clinical Excellence Awards income of £0.8m, international nurse recruitment income £0.6m, £0.4m relating to increased commercial and grant R&I income and LDA income of £0.2m.

The Trust maintained a strong cash position at the end of February (£126.8m), showing an improvement of £16.9m from the previous month.

	Feb - In Month			Feb - YTD			M1-M12 FOT £000
	Forecast £000	Actual £000	Variance £000	Forecast £000	Actual £000	Variance £000	
Income:							
Patient Care Income	94,744	94,937	193	1,027,458	1,027,651	193	1,136,914
Other Income	11,398	13,792	2,394	131,847	134,241	2,394	144,186
Total Income	106,142	108,729	2,587	1,159,305	1,161,892	2,587	1,281,101
Expenditure:							
Pay - Substantive/Bank	(63,813)	(64,549)	(737)	(679,340)	(680,077)	(737)	(744,434)
Pay - Agency	(1,779)	(1,684)	94	(18,551)	(18,457)	94	(20,378)
Total Pay	(65,591)	(66,234)	(642)	(697,891)	(698,534)	(642)	(764,812)
Non-Pay	(39,628)	(39,247)	381	(401,815)	(401,435)	381	(451,264)
Non-Operating Costs	(4,099)	(3,941)	159	(53,421)	(53,262)	159	(57,354)
Total Non-Pay	(43,727)	(43,188)	539	(455,236)	(454,697)	539	(508,617)
Total Expenditure	(109,319)	(109,422)	(103)	(1,153,128)	(1,153,231)	(103)	(1,273,429)
Donated Assets	(76)	(186)	(110)	(1,932)	(2,042)	(110)	(2,118)
Less Profit On Disposal	0	0	0	(450)	(450)	0	(450)
Control Total Surplus/(Deficit)	(3,254)	(879)	2,375	3,795	6,170	2,375	5,103

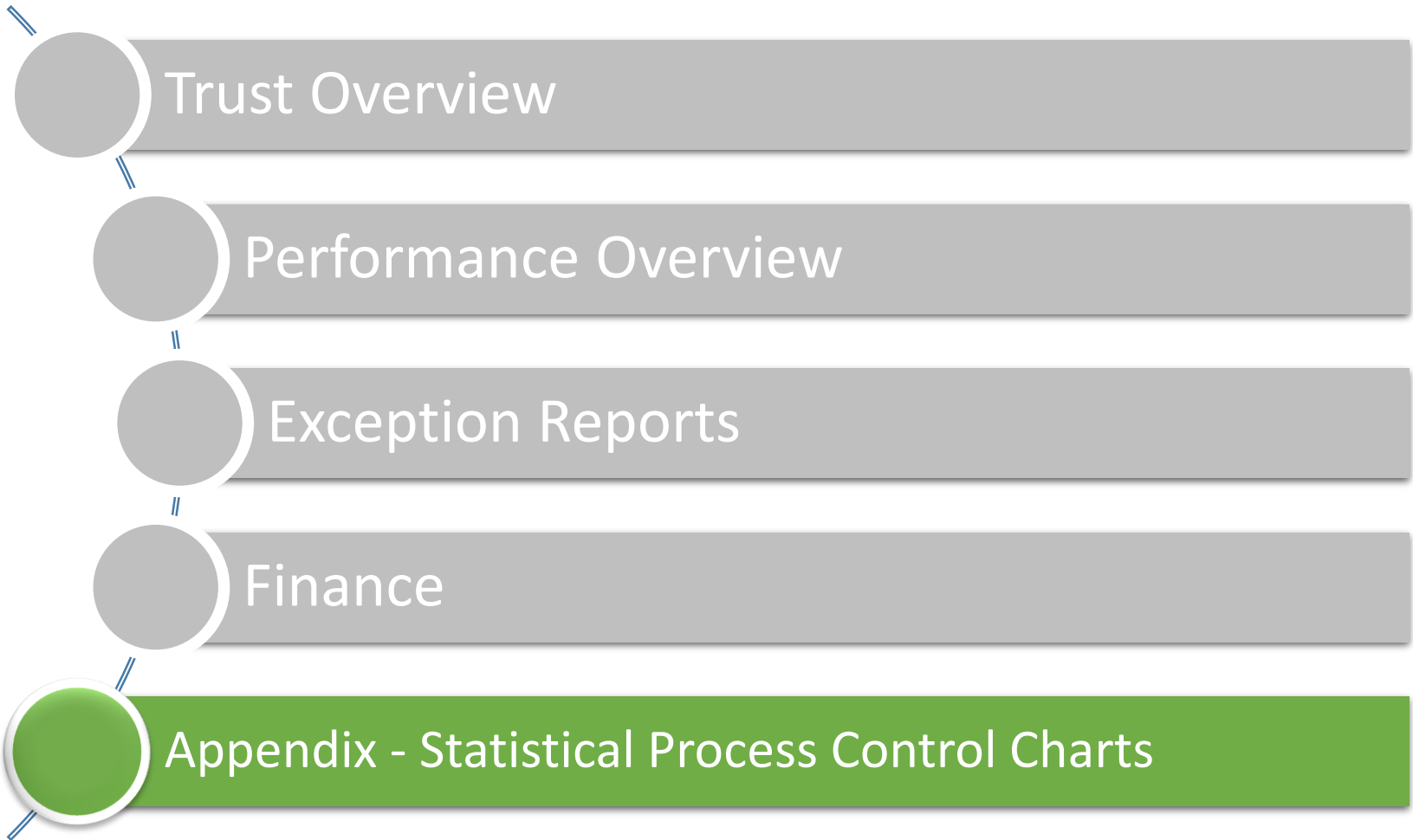
Finance – Best Value Care

	Feb - In Month			Feb - YTD			M1-M12 FOT £000
	Forecast £000	Actual £000	Variance £000	Forecast £000	Actual £000	Variance £000	
Total Income (Excluding Donated Assets)	106,065	108,543	2,478	1,157,373	1,159,850	2,478	1,278,982
Total Expenditure (Excluding Donated Assets)	(109,319)	(109,422)	(103)	(1,153,578)	(1,153,681)	(103)	(1,273,879)
Surplus/(Deficit) - Control Total Basis excl. Impairments	(3,254)	(879)	2,375	3,795	6,170	2,375	5,103
Capex (including donated)	(11,200)	(9,738)	1,462	(50,831)	(47,273)	3,558	(77,872)
Closing Cash	115,620	126,840	11,220	115,620	126,840	11,220	115,068

The Trust has reported a Month 11 deficit of £0.9m. This is a £2.4m favourable variance to forecast due to additional income in month 11. The year to date surplus at Month 11 is £6.2m.

Month 11 YTD capital expenditure was £47.2m against a YTD plan of £50.8m, representing an underspend against forecast of £3.6m. The total forecast is £77.8m, funded from a combination of internally generated funding (£47.3m); PDC (£17.6m); asset disposals (£10.1m); and Charitable Funds (£2.8m).

The Trust maintained a strong cash position at the end of February of £126.8m.



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).

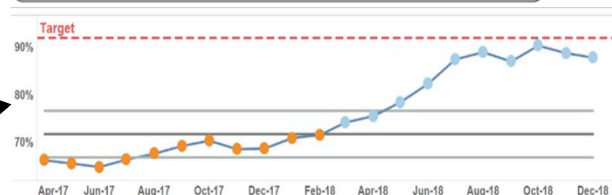
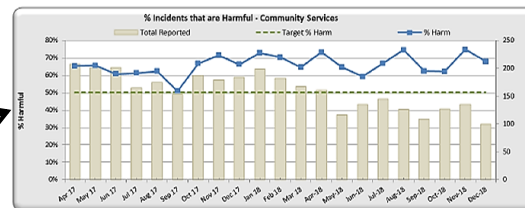
Any data points on the line graph outside these limits, are 'extreme values' and is not within the expected 'normal variation'.

- 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

