

Integrated Performance Report

Public Trust Board 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 January 2021 to December 2022) is 104 but remains within the expected range.

- **VTE** – compliant at 97.8% in May.

Performance Challenges:

- **C DIFF** – 9 cases reported this month.
- **ED 4 hour performance (including LLR UCCs)** – 68.6% reported in May.
- **12 hour trolley wait** - 992 breaches reported.
- **Ambulance Handover 60+ minutes (CAD)** – performance at 34.0%.
- **Cancer Two Week Wait** was 83.2% in April against a target of 93%.
- **Cancer 62 day backlog** was 524 patients at the end of May.
- **Cancer 62 day treatment** was 45.3% in April 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 122,999 patients at the end of May.
- **52+ weeks wait** – 17,187 breaches reported at the end of May.
- **Diagnostic 6 week wait** was 46.9% against a target of 1% in May.
- **Cancelled operations OTD** – 1.6% reported in May.
- **Statutory and Mandatory Training** is at 91%.
- **Annual Appraisal** is at 77.5%.

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]
Safely and timely discharge	[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 <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:

4th August 2022

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

My paper does comply



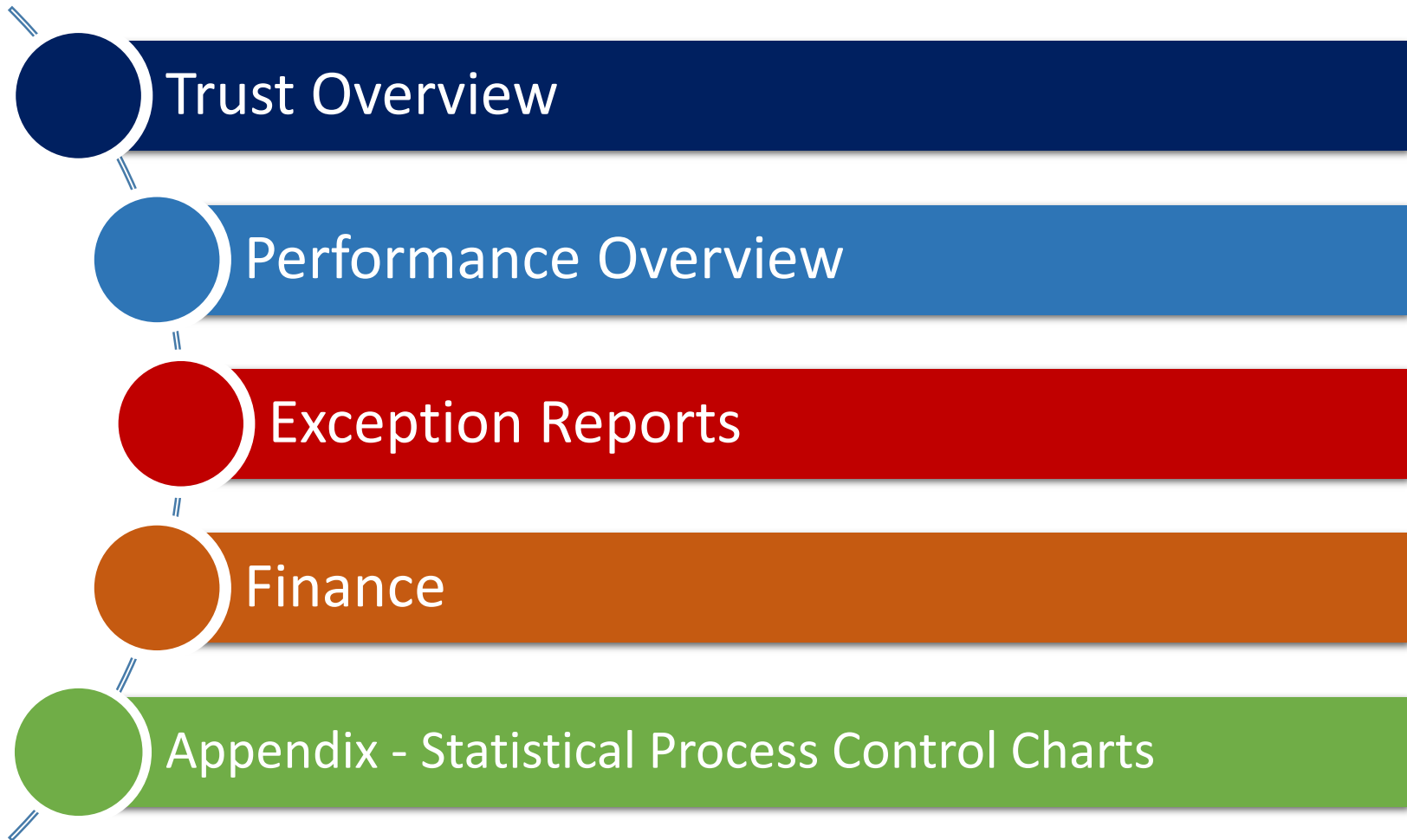
Integrated Performance Report

May 2022

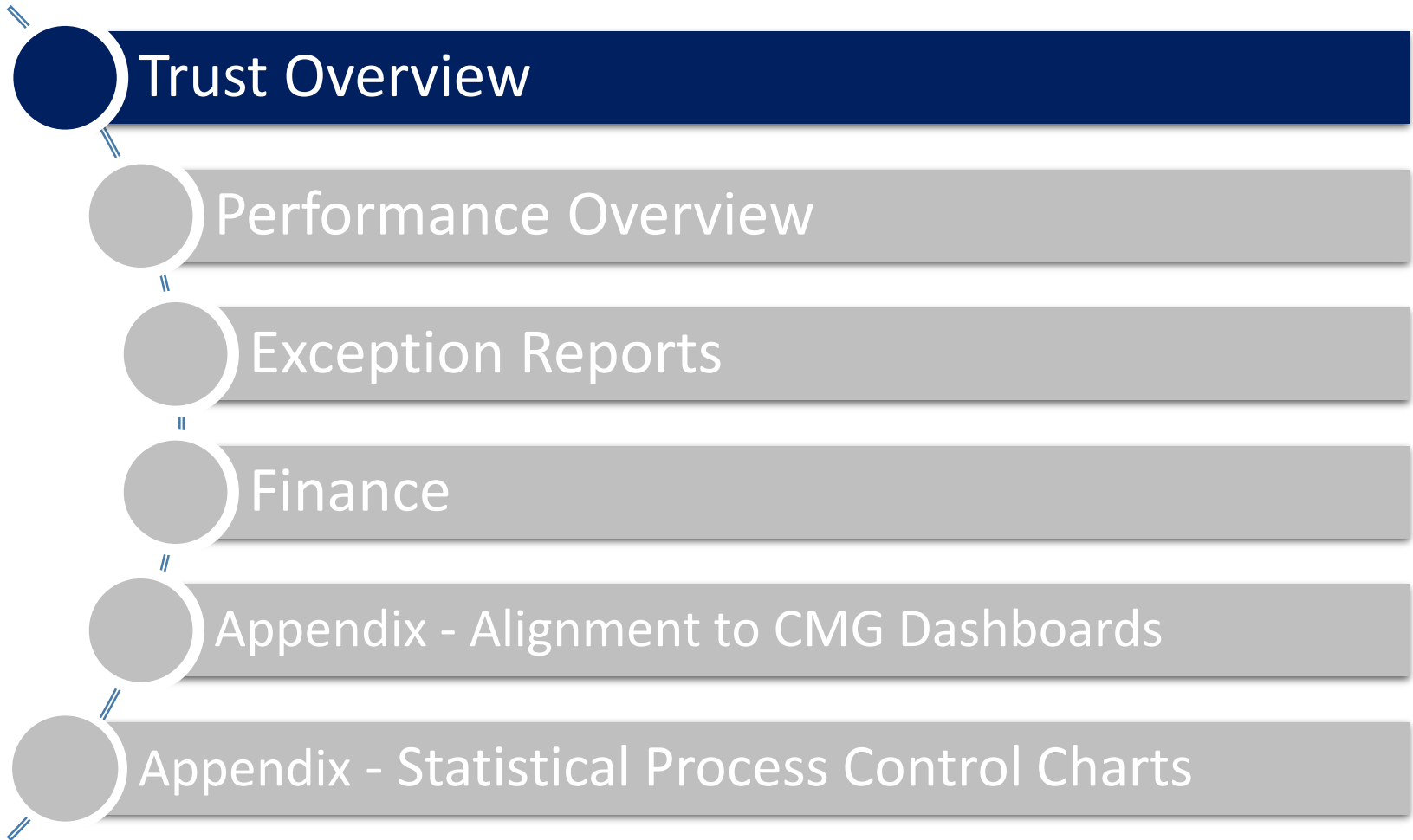


Operational Delivery Unit

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
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Key

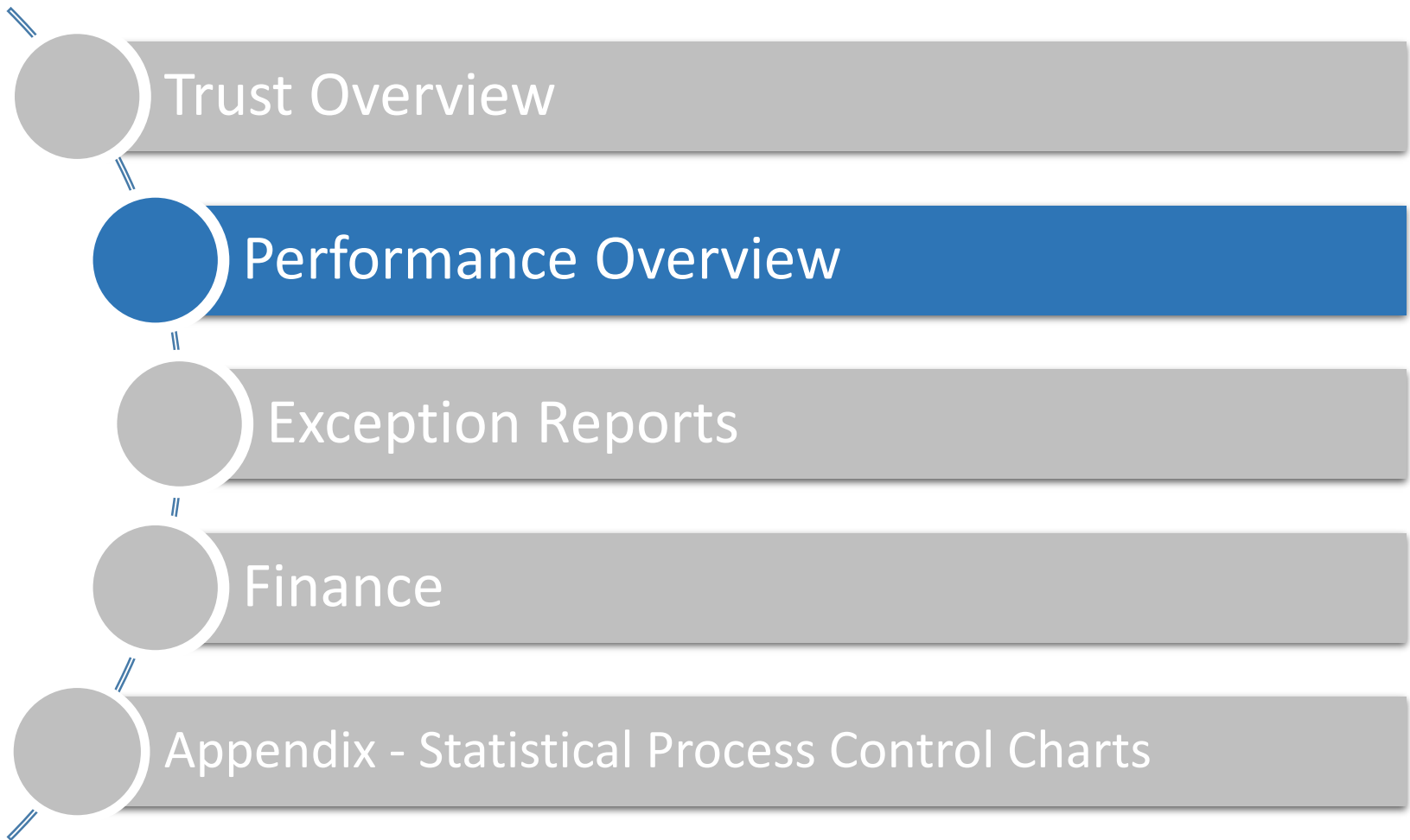
Failing Target

Achieving Target

Target TBC

Trust Overview (Current Month)

Domain	Overview , Risks and Actions	Lead
Overview		CEO
Safe (exception reports pages 19-23)	The Trust has had 3 Never Events in May – summary details are given on slide 19. All appropriate immediate actions have been undertaken. Full investigations are in train to identify further learning. The MD & CN have met with their respective patient safety leads to further review the NE reduction plan. A thematic review of NE's has been completed and the NE action plan is being updated to reflect learning from this – this will be reviewed & discussed at the Trust Board Quality Committee in August. The Safer Surgery Quality Assurance programme has commenced. Hospital Acquired Infections, focused attention on antimicrobial prescribing practice is required with one of the main focus being avoidance of broad spectrum antibiotic use except where necessary. Hospital Acquired Pressure Ulcers have risen this month, an extra ordinary meeting has been called with all CMG Heads of Nursing to understand themes and actions taking place – 3 key areas have been identified. Actions have been agreed for these 3 themes which will be monitored through the Pressure Ulcer Steering Group.	Andrew Furlong / Julie Hogg
Caring	No concerns raised in month, improvement noted in FFT for outpatients and the Emergency Department	Julie Hogg
Well Led (exception reports pages 24-31)	Sickness rates are 6.5% and have shown a slight improvement on the early cut March position. Updates given late closure of absences has meant a 1% improvement on what was reported previously. The main reasons for absence are other known reasons, stress anxiety and depression and Covid. Although there was some decrease in absence in May, early indications during the latter part of June is that sickness is increasing potentially as a result of limitations to mask wearing. Sickness is still closely monitored and staff support mechanisms are promoted and responsive to the needs of teams. Appraisal rates remain unchanged from the April 2022 position and remain below the target of 95%. The achievement of full compliance by the end of June is unlikely and CMG have been asked to outline their 3 month trajectory and associated action. Teams encouraged to have robust conversations if full appraisals are not feasible. Statutory and mandatory training compliance has shown a 2% improvement but below the performance target of 95%. Compliance is being facilitated by a new question based e learning module covering core topics. Nursing and Midwifery vacancies have deteriorated slightly across adult nursing and children's nursing. There are more nurses in post but establishments have increased slightly impacting on vacancy levels. Midwifery vacancies have remained largely static and healthcare support worker vacancies have increased as a result of increased establishments and leavers. Detailed meetings have been held with all Heads of Nursing to review vacancy positions and understand plans for recruitment and retention to mitigate risks. A number of specialty specific open days have taken place including a large event held in conjunction with Indeed. There are currently larger numbers of healthcare support workers (circa 150) in the recruitment pipeline with 53 Wte due to commence in June.	Clare Teeney
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 32-38)	May 2022 has seen an increase in ED attendances from the previous month in both total numbers and average/day. UHL 4-hour performance for May 2022 was 56.0%, combined with the rest of LLR increased to 68.6%. UHL's national ranking for May 2022 was 79th out of 110th which is a deterioration of 10 places from the previous month however is still significantly better than the May 21 position of 102nd out of 114th. Ambulance handover performance remains, challenged May 2022 saw an improvement from April 2022 (31.52% compared to 35.5%) even though the number of handovers increased (4,635 vs. 4,318 = average of 6 more/day).	Jon Melbourne
Responsive – Elective (exception reports pages 39-45)	May 2022 has seen a significant improvement in patients who have breached 104+ weeks, with the 104+ positions reducing by 841 patients. However, we have experienced significant challenges in overall waiting list growth whilst acknowledging this is less than previous months. Elective capacity remains challenging due to staff vacancies and sickness, particularly for anaesthetists and admin booking teams. We are still heavily reliant on using insourcing to bridge gaps. New agreements with IS providers have been put in place to support the 104+ positions and GIRFT have supported on successfully agreeing further mutual aid which is contributing to an end of June position of 548. Performance reported in DM01 has improved with a reduction in the overall waiting list put the performance of the percentage of patients seen within 6 weeks remains very challenged. 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 46-48)	In April improvements continued in 5 of the 12 standards, with breast 2ww and all 3 the FDS standards achieving the target. Performance in 2ww is 83.2% and 62 day 45.2 %. The 62 day backlog is 586 (17/06/22) an increase of 25 from last month. 201 patients are waiting in excess of 104 days; this is a reduction of 13 patients from last month. Referrals remain high and remain above pre pandemic levels, with significant increase in Haematology, Head and Neck & Upper / Lower GI. Capacity pressures along with workforce issues (vacancies and sickness) are presenting particular challenges. The 2WW demand and backlogs continue to directly impact on performance for 2WW and 62 day, notable improvements in April in breast, now booking within 7 days and achieving the 93% standard. Specific actions are in place; with further improvements predicted in May mainly in 2ww and FDS. These include new pathways in UHL and the community, utilisation of the independent sector and focused actions in key tumour sites. Urology backlog and 62 day position remains a significant concern; EMCA are supporting regional Urology meetings and mutual aid is in place for theatre (including robotic) capacity. Initial results from the streamlining of the Urology pathway is providing patients with an earlier diagnosis but will take some time to affect the 62 day performance given the constraints in theatre, pathology and oncology capacity.	Jon Melbourne
Financial Improvement		Lorraine Hooper



Performance Overview (Safe)

Domain	Key Performance Indicator	Target	Mar-22	Apr-22	May-22	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Safe	Never events	0	2	0	3	3				Jan-20	MD
	% of all adults Venous Thromboembolism Risk Assessment on Admission	95%	98.1%	98.0%	97.8%	97.9%				Oct-20	MD
	% of 3rd & 4th Degree Perineal Tears	3.5%	1.8%	3.7%	3.3%	3.5%				N/A	CN
	Clostridium Difficile	93	10	8	9	17				Jun-21	CN
	Methicillin Resistant Staphylococcus Aureus Total	0	0	0	2	2				Jun-21	CN
	E. Coli Bacteraemias Acute	198	14	16	15	31				Jun-21	CN
	Methicillin-susceptible Staphylococcus Aureus Acute*	40	4	8	5	13				Jun-21	CN

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

Comments

The Trust has had 3 Never Events in May – summary details are given on slide 19. All appropriate immediate actions have been undertaken. Full investigations are in train to identify further learning. The MD & CN have met with their respective patient safety leads to further review the NE reduction plan. A thematic review of NE's has been completed and the NE action plan is being updated to reflect learning from this – this will be reviewed & discussed at the Trust Board Quality Committee in August . The Safer Surgery Quality Assurance programme has commenced.

Rating

Performance Overview (Safe)

Safe

Domain	Key Performance Indicator	Target	Mar-22	Apr-22	May-22	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Safe	COVID-19 Hospital-onset, probable, 8-14 days after admission		11.6%	11.8%	7.0%	10.5%				Oct-20	CN
	COVID-19 Hospital-onset, healthcare-acquired, 15 or more days after admission		9.5%	11.2%	13.4%	11.8%				Oct-20	CN
	All falls reported per 1000 bed days	5.5	4.1	4.7		4.7				Oct-20	CN
	Rate of Moderate harm and above Falls Patient Safety Incidents with finally approved status per 1,000 bed days	0.18	0.08	0.06		0.06				Oct-20	CN
	Hospital Acquired Pressure Ulcers - All categories	366	49	39	54	93				Jun-21	CN













Comments

Rating

Hospital Acquired Infections, focused attention on antimicrobial prescribing practice is required with one of the main focus being avoidance of broad spectrum antibiotic use except where necessary.

Hospital Acquired Pressure Ulcers have risen this month, an extra ordinary meeting has been called with all CMG Heads of Nursing to understand themes and actions taking place – 3 key areas have been identified Actions have been agreed for these 3 themes which will be monitored through the Pressure Ulcer Steering Group.

Performance Overview (Caring)

Domain	Key Performance Indicator	Target	Mar-22	Apr-22	May-22	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Caring	Single Sex Breaches		3	8	0	8	National Reporting resumed from Oct 21.			Mar-20	CN
	Inpatient and Day Case Friends & Family Test % Positive*	95%	98%	98%	98%	98%				Mar-20	CN
	A&E Friends & Family Test % Positive**	77%	74%	78%	79%	78%				Mar-20	CN
	Maternity Friends & Family Test % Positive*	91%	96%	97%	97%	97%				Mar-20	CN
	Outpatient Friends & Family Test % Positive	94%	94%	93%	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 October 2021 and March 2022

Comments

Rating

No concerns raised in month, improvement noted in FFT for outpatients and the Emergency Department.

Performance Overview (Well Led)

Well Led

Domain	Key Performance Indicator	Target	Mar-22	Apr-22	May-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%	9.1%	9.2%	9.3%	9.3%				Nov-19	CPO
	Sickness Absence (Excludes Estates & Facilities staff)	3%	6.6%	6.5%		6.5%				Mar-21	CPO
	% of Staff with Annual Appraisal (Includes Estates & Facilities staff from May 21)	95%	77.2%	77.9%	77.5%	77.5%				Mar-21	CPO
	Statutory and Mandatory Training	95%	89%	89%	91%	91%				Feb-20	CPO

Comments






Rating

Turnover rates are stable but there is an expectation there will be an increase this year partially due to a technical change in the capturing leavers who retain a bank assignment. We are seeing higher levels of turnover for nursing and midwifery and additional clinical services which includes healthcare assistants. New People Promise Manager will review retention strategies to improve turnover rates. Revised figures for March show a further 1% decrease in sickness due to late closure of absences. This is being monitored through continued daily reporting to track the impact. The improvement trajectory reflects falling sickness rates in May although there are early indications of an increase in June. There continues to be a strong focus on supporting staff well being and close monitoring of attendance levels. Work is ongoing to improve the Smart sickness reporting system and data quality.

Appraisal performance is static compared to April 2022 although the Trust is unlikely to meet its June trajectory. Work continues to encourage timely completion of appraisals. Automatic Pay Progression has now ceased. Full appraisals are encouraged but where this is not possible, robust conversations need to take place.

Statutory and mandatory training compliance has improved by 2% to 91% but below the performance target of 95%. There is a renewed focus on achieving compliance in Q1 with regular reminders from the HELM system and via teams in Making it Happen meetings. There is also a new question based module available to facilitate completion of training

Performance Overview (Well Led)



Domain	Key Performance Indicator	Target	Mar-22	Apr-22	May-22	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Well Led	Adult Nursing Vacancies	10%	11.5%	12.5%	12.7%	12.7%				Dec-19	CPO
	Paed Nursing Vacancies	10%	10.4%	10.6%	12.4%	12.4%				Dec-19	CPO
	Midwives Vacancies	10%	9.9%	14.9%	14.7%	14.7%				Dec-19	CPO
	Health Care Assistants and Support Workers - excluding Maternity	10%	13.0%	13.1%	14.4%	14.4%				Dec-19	CPO
	Health Care Assistants and Support Workers - Maternity	5%	5.2%	9.2%	8.7%	8.7%				Dec-19	CPO

Comments

Nursing and Midwifery vacancies have increased across Adult Nursing, Children's, Midwifery and Healthcare Assistants. There are more adult and children's nursing in post but vacancies have increased as a result of increased establishments. The increase in vacancies has also largely been driven by high numbers of healthcare support worker leavers. For HCAs both locally and nationally there is a decreased future supply of workforce driven by a buoyant labour market. During the first quarter of 22/23 41 newly qualified adult nurses are scheduled to join the organisation and 13 children's nurses. International nursing is continuing and 57 nurses arrived in May 2022 and further cohorts of 64 and 60 nurses are expected in July and September respectively. A large RN open day is planned for May 21st and locally CMGs are holding recruitment events including one for Children's and Paediatric ED on June 18th. There are circa 150 Healthcare Assistants in the recruitment pipeline as a result of the large recruitment open day for Health Care Assistants which took place on May 21st. In June and July intakes of 60 HCAs are planned assuming there is sufficient supply.



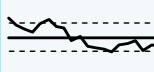


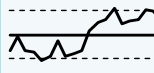





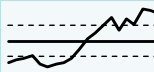













Rating

Performance Overview (Effective)

Domain	Key Performance Indicator	Target	Mar-22	Apr-22	May-22	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Effective	Published Summary Hospital-level Mortality Indicator (SHMI)	100	103	104	104	104 (Jan 21 to Dec 22)				May-21	MD
	12 months Hospital Standardised Mortality Ratio (HSMR)	100	99	96	95	95 Mar 21 to Feb 22				May-21	MD
	Crude Mortality Rate	No Target	1.3%	1.3%	1.1%	1.2%				May-21	MD

Comments	Rating
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.	

Performance Overview (Responsive Emergency Care)















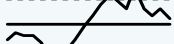






Domain	Key Performance Indicator	Target	Mar-22	Apr-22	May-22	YTD	Assurance	Variation	Trend
Responsive (Emergency Care)	Emergency Department 4 hour waits Acute Footprint	95%	67.2%	69.6%	68.6%	69.0%			
	Mean Time to Initial Assessment	15	46	45.0	39.8	42.2			
	12 hour trolley waits in Emergency Department	0	906	781	992	1773			
	Number of 12 hour waits in the Emergency Department	0	2,707	2,634	2,541	5,175			
	Time Clinically Ready to Proceed	60	265.9	269.5	258.3	264.0			
	Number of Ambulance Handovers		4,916	4,318	4,635	8,953			
	Number of Ambulance Handovers >60 Mins		1,759	1,535	1,575	3,110			
	Ambulance handover >60mins	0%	35.8%	35.5%	34.0%	34.7%			
	Long Stay Patients (21+ days) as a % of G&A Bed Occupancy	12%	13.8%	18.1%	16.2%	16.2%			

Comments

May 2022 has seen an increase in ED attendances from the previous month in both total numbers and average/day. UHL 4-hour performance for May 2022 was 56.0%, combined with the rest of LLR increased to 68.6%. UHL's national ranking for May 2022 was 79th out of 110th which is a deterioration of 10 places from the previous month however is still significantly better than the May 21 position of 102nd out of 114th. Ambulance handover performance remains, challenged May 2022 saw an improvement from April 2022 (31.52% compared to 35.5%) even though the number of handovers increased (4,635 vs. 4,318 = average of 6 more/day).

Rating

Performance Overview (Responsive Elective Care)

Domain	Key Performance Indicator	Target	Mar-22	Apr-22	May-22	YTD	Assurance	Variation	Trend
Responsive (Elective Care)	Referral to Treatment Incomplete	103,403	117,857	122,516	122,999	122,999			
	Referral to Treatment 52+ weeks	0	15,994	16,936	17,187	17,187			
	Referral to Treatment 104+ weeks	0	1,485	1,138	841	841			
	6 Week Diagnostic Test Waiting Times	1.0%	43.6%	47.5%	46.9%	46.9%			
	% Operations Cancelled On the Day	1.0%	1.7%	1.9%	1.6%	1.8%			
	% Outpatient Did Not Attend rate	5%	8.0%	7.7%	7.9%	7.8%			
	% Outpatient Non Face to Face	45%	35.9%	36.2%	32.9%	34.4%			

Comments

Rating

May 2022 has seen a significant improvement in patients who have breached 104+ weeks, with the 104+ position reducing to 841 patients. However, we continue to experience significant challenges in terms of overall waiting list growth, whilst acknowledging this has reduced compared to previous months.



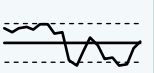






System colleagues are to support to contact 220 patients where we have not had any response/contact since patient choice letters were sent in April. This will help to ensure that those on the waiting list do still wish to have surgery, establish if patients require further advice/guidance and if they are willing to travel outside of Leicester to have their surgery earlier. For those patients who are not contactable, patients will have a clinical review and potentially be referred back to their referrer.

Technical validation for the whole waiting list is ongoing.

Planning for a day case unit at the LGH has started with the aim to support the long-term ambitions for elective performance by increasing overall elective capacity.

The overall DM01 diagnostic waiting times trajectories are been developed further to ensure a full analysis of capacity against expected demand with the aim of achieving the ambition of 95% of diagnostics delivered within 6 weeks by 2025.

Performance Overview (Responsive Cancer)

Domain	Key Performance Indicator	Target	Mar-22	Apr-22	May-22	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Responsive (Cancer)	2 Week Wait	93%	79.0%	83.2%		83.2%				Mar-22	COO
	62 Day Backlog	0	515	514	524	524				Mar-22	COO
	Cancer 62 Day	85%	44.8%	45.3%		45.3%				Mar-22	COO

Comments

Rating

In April improvements continued in 5 of the 12 standards, with breast 2ww and all 3 the FDS standards achieving the target. Performance in 2ww is 83.2% and 62 day 45.2 %. The 62 day backlog is 586 (17/06/22) an increase of 25 from last month. 201 patients are waiting in excess of 104 days; this is a reduction of 13 patients from last month.

Referrals remain high and remain above pre pandemic levels, with significant increase in Haematology, Head and Neck & Upper / Lower GI. Capacity pressures along with workforce issues (vacancies and sickness) are presenting particular challenges. The 2WW demand and backlogs continue to directly impact on performance for 2WW and 62 day, notable improvements in April in breast, now booking within 7 days and achieving the 93% standard.

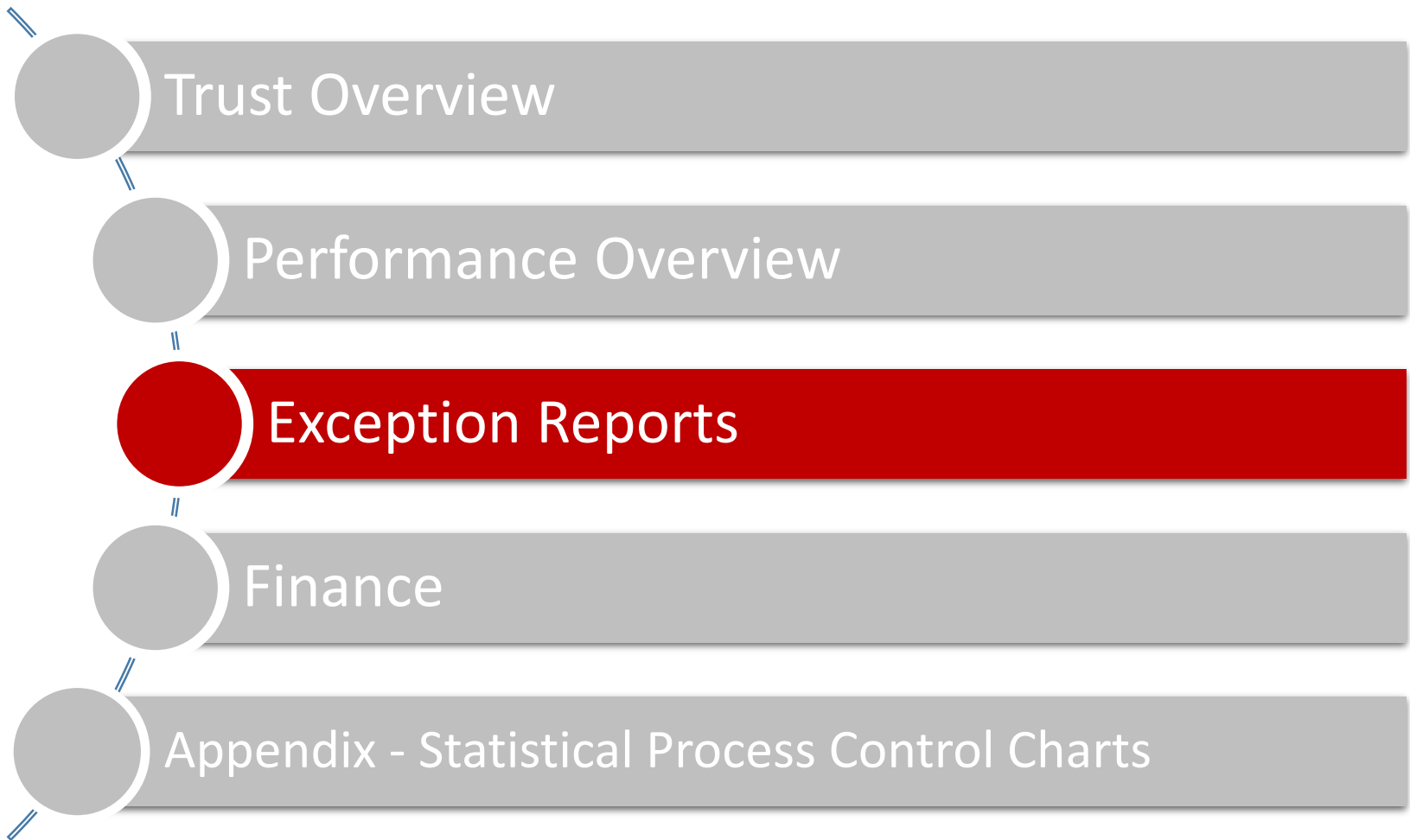
Specific actions are in place; with further improvements predicted in May mainly in 2ww and FDS. These include new pathways in UHL and the community, utilisation of the independent sector and focused actions in key tumour sites.

Urology backlog and 62 day position remains a significant concern; EMCA are supporting regional Urology meetings and mutual aid is in place for theatre (including robotic) capacity. Initial results from the streamlining of the Urology pathway is providing patients with an earlier diagnosis but will take some time to affect the 62 day performance given the constraints in theatre, pathology and oncology capacity.

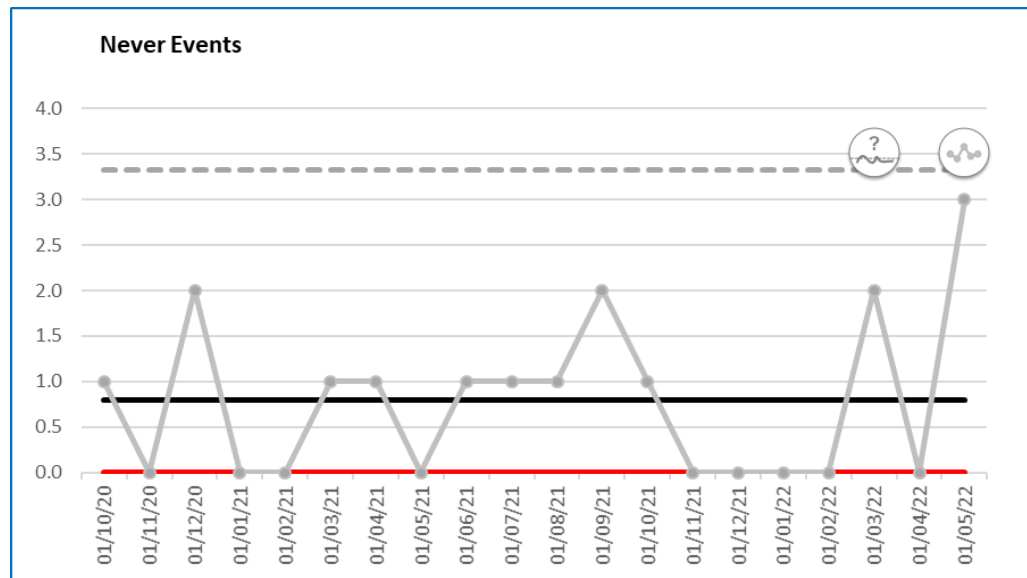
Performance Overview (Finance)

Domain	Key Performance Indicator	Target YTD	Mar-22	Apr-22	May-22	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Finance	Trust level control level performance	-£7.8m Plan	£4.5m	-£3.8m	-£3.4m	-£7.2m				Jun-22	CFO
	Capital expenditure against plan	£7.9m	£30.3m	£3.9m	£1.9m	£5.9m				Jun-22	CFO
	Cost Improvement	£2.1m	£1.7m	£1m	£1.2m	£2.2m				N/A	CFO
	Cashflow	No Target	-£17m	-£10.3m	-£21.5m	£78.2m				Jun-22	CFO

Comments	Rating



Safe – Never Events



Current Performance			Three Month Forecast		
May 22	YTD	Target	Jun 22	Jul 22	Aug 22
3	3	0	0	0	0

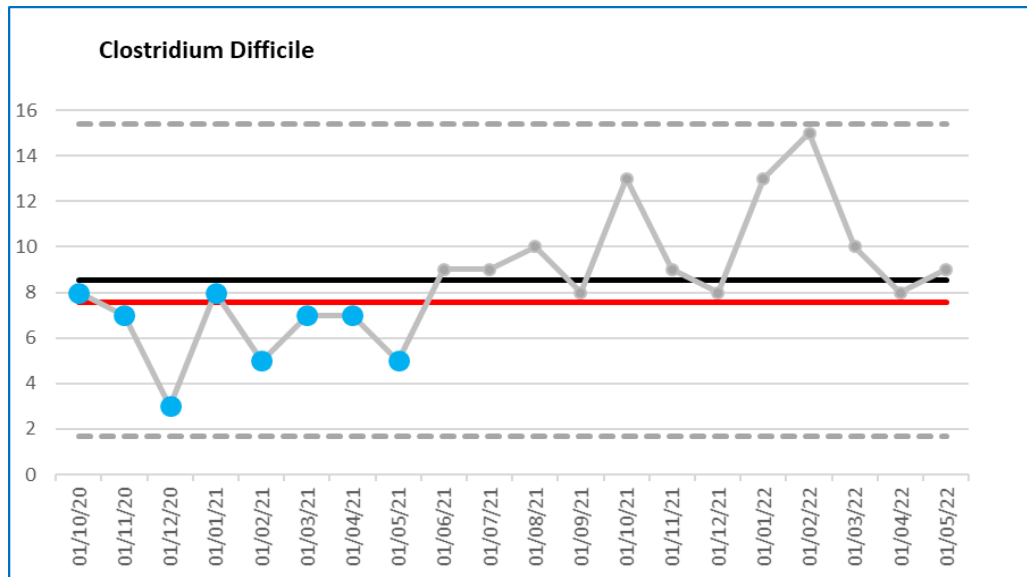
National Position & Overview

407 Never events have been reported nationally for the 2021/22 financial year although the numbers are subject to change as local investigations are completed.

UHL reported 9 Never Events in 2021/2022. In 2020/2021 UHL reported 7 Never Events and in 2019/2020 UHL reported 2 Never Events.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> 1. NEVER EVENT – Wrong site surgery Wrong patient lumbar puncture 	<ul style="list-style-type: none"> Immediate Actions <ul style="list-style-type: none"> Information sent to staff via QUAIL Newsletter to highlight importance of safety checks Ensured the patient who needed the Lumbar Puncture has received one 	<p>The Registrar immediately highlighted the incident to the Consultant and the family were contacted to explain the incident. Patient Y who was supposed to have the LP has received the correct appropriate care.</p>
<ul style="list-style-type: none"> 2. NEVER EVENT – Wrong site surgery Wrong site Botox treatment 	<ul style="list-style-type: none"> Immediate Actions <ul style="list-style-type: none"> The patient has been offered an earlier review appointment in 2 months' time in case the dystonia goals were not achieved, in addition to the ability of contacting the consultant by telephone with any concerns before that time 	<p>The consultant administering the injections realised the error and ceased administration. The patient was immediately verbally informed and an apology given, and the incident documented in the patient's notes.</p>
<ul style="list-style-type: none"> 3. NEVER EVENT – Transfusion of ABO-incompatible blood components or organs Transfusion of one unit of ABO-incompatible blood 	<ul style="list-style-type: none"> Immediate Actions <ul style="list-style-type: none"> Trust wide Communication safety briefing regarding the importance of using the Blood Track system went out on the UHL weekly all staff communication SHOT reporting process being adhered to by the Transfusion Team <p>Wider Trust actions are included in the updated Safe Surgery and Procedures work programme and Never Event action plan update, presented to EQB on 12.04.22</p>	<p>Following an emergency deterioration fifteen units of blood product were transfused prior to transferring Patient X back to theatre. After filling in the prescriptions for blood transfusions, and analysing the blood packets that were used, the team identified that one blood packet meant for a different patient had been transfused to Patient X which was ABO-incompatible blood.</p>

Safe – Clostridium Difficile

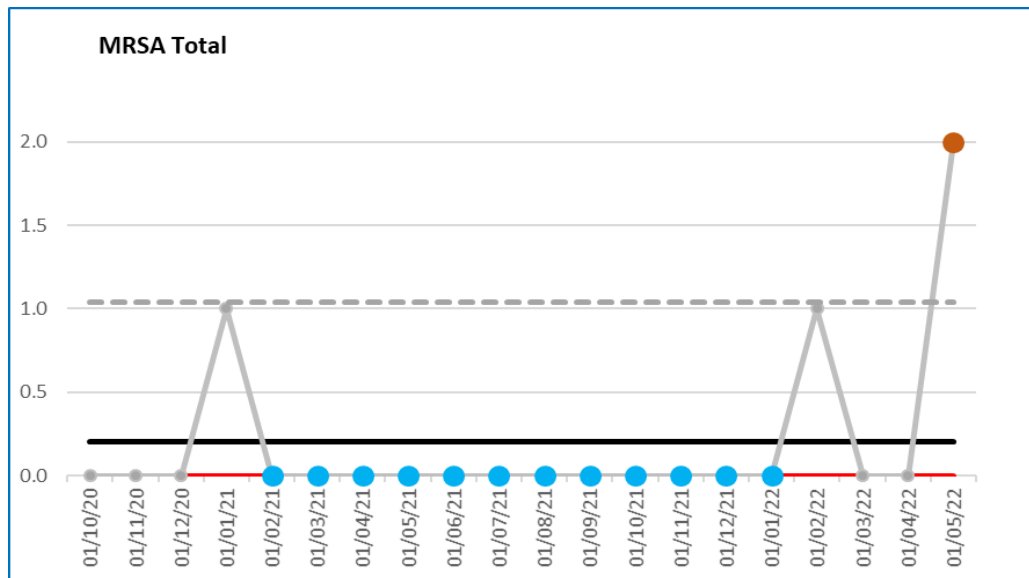


Current Performance			Three Month Forecast		
May 22	YTD	Target	Jun 22	Jul 22	Aug 22
9	17	91	7	8	8

National Position & Overview
<p>The rate of C. Difficile infection counts of hospital onset-healthcare associated cases per 100,000 bed days are significantly lower for UHL (14.0) compared with the national average (18.3) for last 12 months of published data (Apr 21 – Mar 22). UHL ranked 48 out of 138 trusts that submitted data and 4th out of it's 18 peers. Source fingertips.phe.org.uk</p>

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 4= Hospital onset healthcare associated (HOHA) 5 = Community onset healthcare associated (COHA) 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 focus 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"> The official trajectory for 2022/23 for <i>C.difficile</i> infections is 93 .

Safe – Methicillin Resistant Staphylococcus Aureus (MRSA)



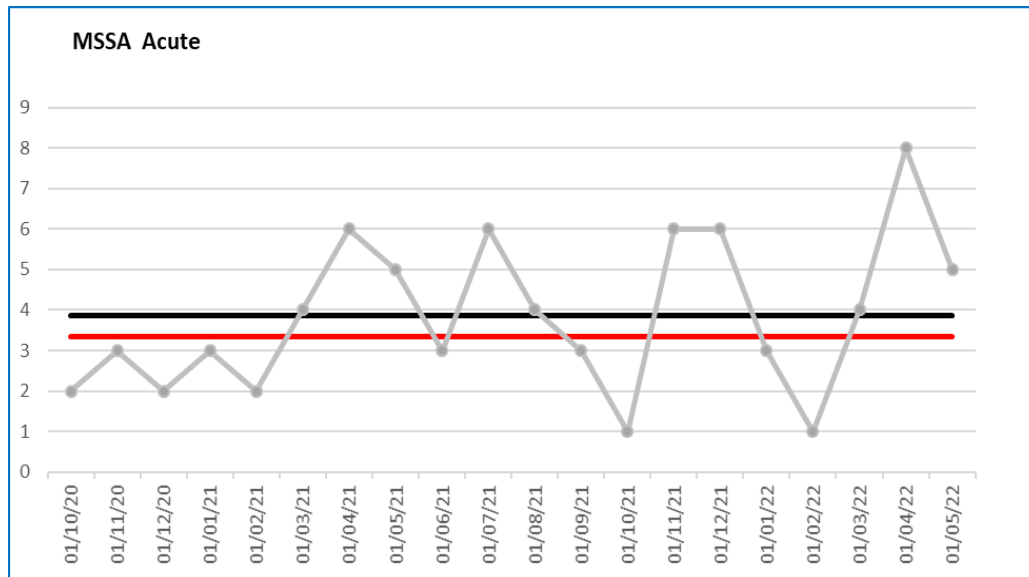
Current Performance			Three Month Forecast		
May 22	YTD	Target	Jun 22	Jul 22	Aug 22
2	2	0	0	0	0

National Position & Overview

The national trajectory for MRSA is zero cases.

2 Hospital Onset Hospital attributed MRSA have been reported in May 2022. These cases were identified on F27 and RSCB.

Root Cause	Actions	Impact/Timescale
<p>The Department of Health guidance to support commissioners and providers of care to deliver zero tolerance on MRSA bloodstream infections, is set out in the planning guidance <i>Everyone counts: Planning for Patients 2013/14</i>.</p> <p>UHL uses this guidance in order to comply with the formal DH investigation process and a Post Infection Review (PIR) meeting is held for any identified cases.</p>	<ul style="list-style-type: none"> Post Infection Review meetings have either been held or are arranged and subsequent action plans have/will be developed and these will be overseen by the Clinical Management Groups Infection Prevention Operational Groups and the reports presented to the CMG Quality and Safety Boards and the Trust Infection Prevention Assurance Committee. 	<ul style="list-style-type: none"> The reporting timeframe is 60 days from identification of positive blood culture

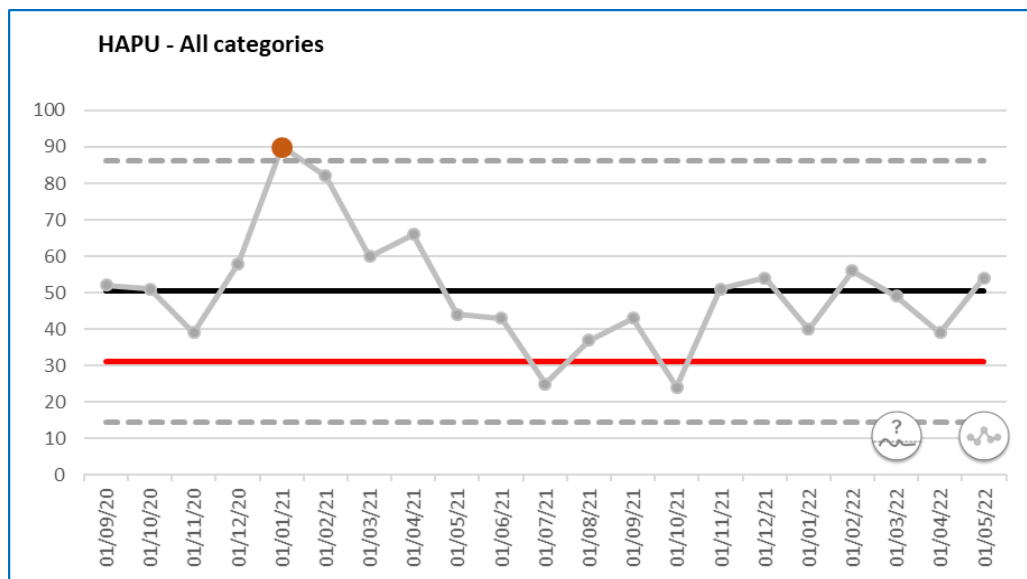


Current Performance			Three Month Forecast		
May 22	YTD	Target	Jun 22	Jul 22	Aug 22
5	13	40	3	3	3

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. This was 41 cases. The trajectory therefore will be 40 cases.

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

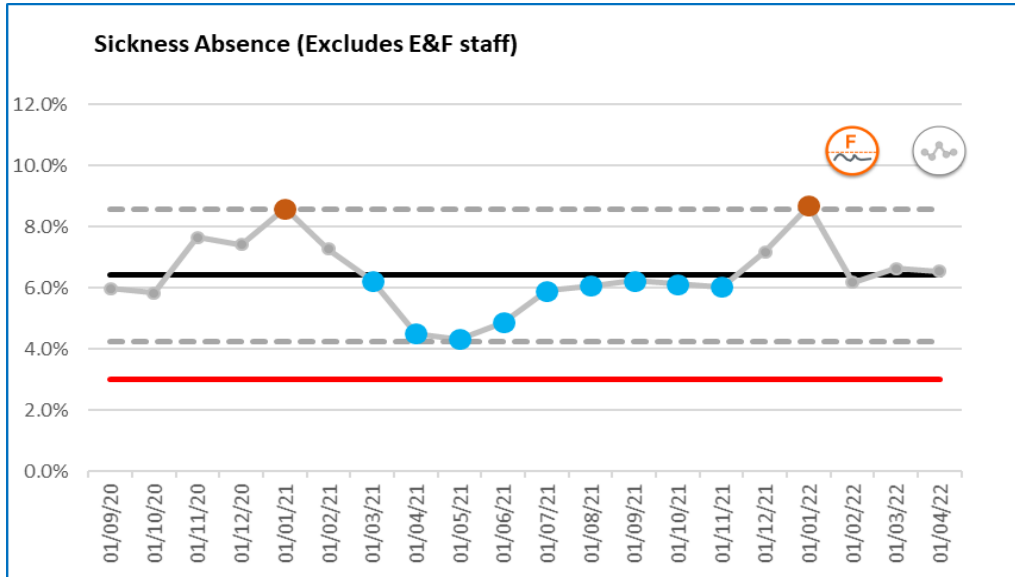


Current Performance			Three Month Forecast		
May 22	YTD	Target	Jun 22	Jul 22	Aug 22
54	93	372	31	31	31

National Position & Overview
<p>Currently no national benchmarking or reporting is available to provide comparative data.</p> <p>UHL are one of six organisations working with national experts and NHSEI quality team to review the national mechanisms of capturing Pressure Ulcer data via the coding systems.</p> <p>The Trust Target of 372 HAPUSs (30% reduction) for 2022-23 is an internal quality improvement stretch target.</p>

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Four main themes from the root cause review meetings – gaps in documentation for independent patients; equipment delays or inappropriate use; device related and staff prevention knowledge gaps Contributing factor relating to reduced staffing and decreased care hours per patient day Inconsistent evidence from clinical areas to support provision of pressure area care and management of identified patients risks factors 	<ul style="list-style-type: none"> Extraordinary meeting chaired by Deputy Chief Nurse – all CMGs Review training of link staff and add extra sessions for CMGs Harms relating to staffing shortages, including HAPUs, via the safer staffing monthly report Non clinical faculty members providing QI support via a series of teaching event Annual improvement trajectory for each CMG shared with HON External review 	<ul style="list-style-type: none"> Monthly review of actions with ACN and DCN plus CMGs We aim to continue to reduce hospital acquired pressure ulcers during 2022/2023 by 30% Raising awareness through a data driven collaborative with area specific quality Improvement projects over the next 6 months

Well Led – Sickness

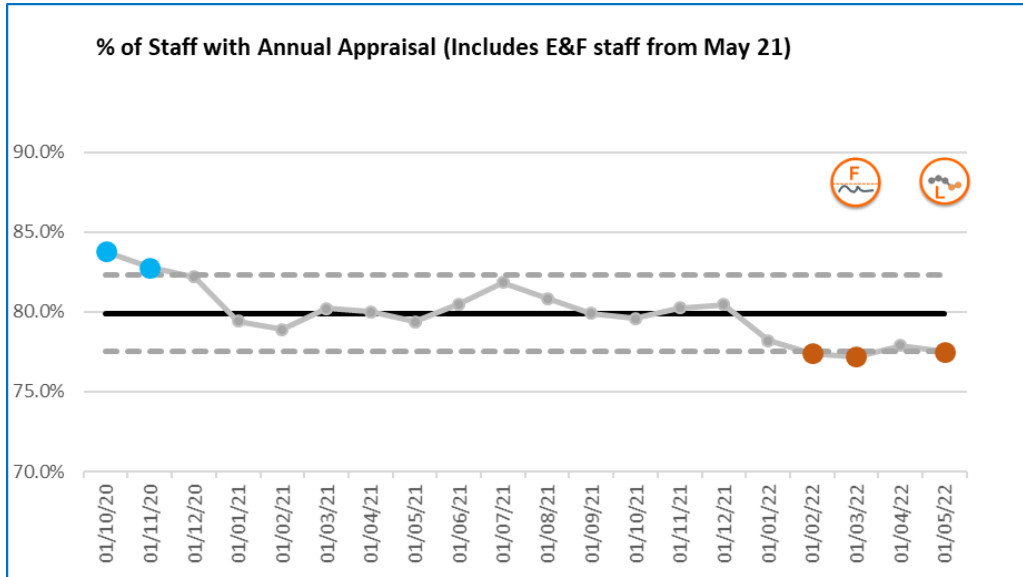


Current Performance			Three Month Forecast		
Apr 22	YTD	Target	May 22	Jun 22	Jul 22
6.5%	6.5%	3%	5.8%	5.5%	5.0%

National Position & Overview
Data Excludes Estates and Facilities staff. Peer data not currently available.
Staff Sickness absences has started to reduce in May 2022, and daily information indicates up to 2% over-reporting due to late reporting.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> We have seen a 1% reduction in sickness absence from what was reported the previous month (6.8%) Reporting identifies a 2 month time lag for accurate capture and change of up to 4% at the peak. The top three reasons for sickness absence are 'other known causes', 'stress anxiety depression' and 'covid'. In June 2022 we have seen a relaxing of face mask requirements in hospitals, which runs the risk of increased infections / absences. 	<ul style="list-style-type: none"> CMG's have been more closely reviewing sickness absences to ensure robust support and management. The People Services team review Smart reports and support managers, and are reviewing CMG alignment to ensure consistent support for all areas. 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, with case management discussions with Occupational Health and EDI where appropriate. Continuing to promote staff wellbeing and support. 	<ul style="list-style-type: none"> We saw a significant increase in sickness absence in the first quarter due to the omicron variant and seasonal fluctuation, and saw this continue in April 2022. In May 2022 we are starting to see a reduction in sickness absence through daily reporting. The indicative trajectory has been revised, and will be kept under review to take account of further national guidance.

Well Led – Appraisals

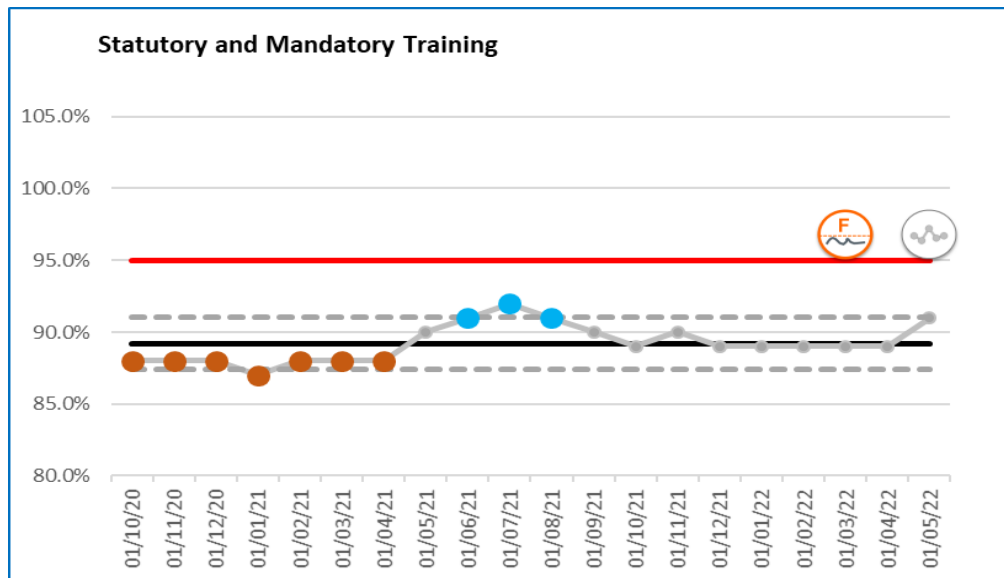


Current Performance			Three Month Forecast		
May 22	YTD	Target	Jun 22	Jul 22	Aug 22
77.5%	77.5%	95%	80%	82%	85%

National Position & Overview
<p>Peer data not currently available.</p> <ul style="list-style-type: none"> In the second month of quarter one we have seen a marginal decrease, to date, this has been hindered by staffing and operational demand

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> It is recognised that performance continues to be impacted by Covid-19 resulting in staff absences Additionally operational demand while in Covid -19 Escalation Level 2 have hindered appraisal performance. 	<ul style="list-style-type: none"> As we remain in Covid 19 Escalation Level 2 the need to remind services of the importance of appraisal discussions continues to be made however services are unlikely to reach full compliance by 30 June 2022. Automatic pay progression ceased on 31 May 2022. Full appraisals should 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. Each CMG has been asked to outline their 3 month trajectory and associated actions. 	<ul style="list-style-type: none"> 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. CMGs will be asked to refresh their trajectory

Well Led – Statutory and Mandatory Training

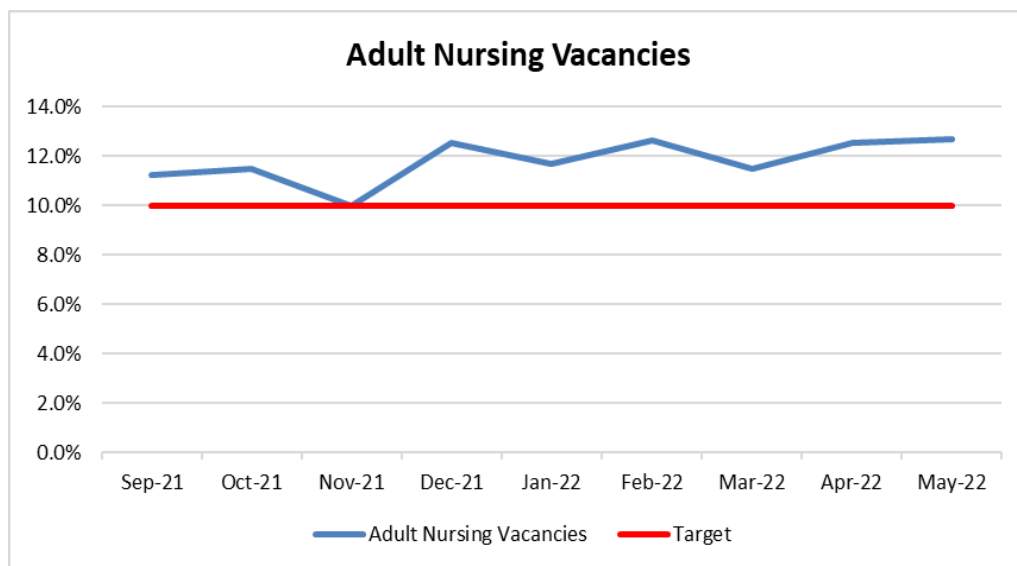


Current Performance			Three Month Forecast		
May 22	YTD	Target	Jun 22	Jul 22	Aug 22
91%	91%	95%			

National Position & Overview
Peer data not available.

Root Cause	Actions	Impact/Timescale
<p>It is recognised that performance has been affected by:</p> <ul style="list-style-type: none"> • Covid-19 and related Staff Absence Levels • Operational pressures • Operational 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>New question based eLearning modules are live on HELM for Fire Safety, Infection Prevention and Cyber Security training.</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 during Q1 of the financial year has been implemented with renewed chasing on non-compliance and organisational support.</p>

Well Led – Adult Nursing Vacancies



Current Performance			Three Month Forecast		
May 22	YTD	Target	Jun 22	Jul 22	Aug 22
12.7%	12.7%	10%	12.4%	10.9%	11.5%

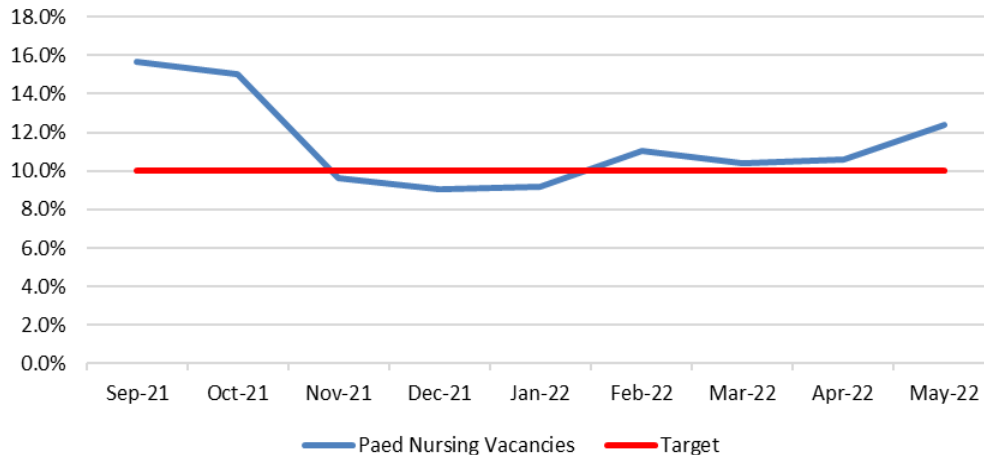
National Position & Overview

NHS Digital data published in May 2022 for NHS England and NHS Improvement shows a vacancy rate for Nursing & Midwifery registrants of 10.0% at 31 March 2022 (Midlands is 10.8%). Next data is expected Sept 2022.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> The UHL 2020/21 vacancy rate for Nursing registrants has deteriorated in month by 0.2 from April '22. The increased leavers trend including retirees continues at 19 WTE in May. Delayed landing of internationally educated nurses due to unexpected visa delays in May. However, nurses on arrival commenced the programme virtually after arriving late in May so no longer term implications of delays should be noticed. 	<ul style="list-style-type: none"> CMG workforce bridging and respective recruitment and retention plans submitted to build a Trust workforce action plan. Recruitment agencies interviews continue fortnightly to maintain a pipeline of international nurses to arrive bi-monthly; 320 planned within financial year. Targeted interviews of international nurses for areas with high vacancies theatres, renal dialysis units in progress. Bi Monthly trust wide/CMG & specialty adverts for all RN posts. 	<ul style="list-style-type: none"> Continue to work to the arrival dates below for International Nurse Recruitment - no anticipated delays Late May -June arrivals capture circa 20 July – 64 arrivals Sept – 60 arrivals Nov – 60 arrivals Circa 12WTE Newly qualified graduates for adult nursing to commence into post throughout June '22.

Well Led – Paed Nursing Vacancies

Paed Nursing Vacancies



Current Performance

Three Month Forecast

May 22	YTD	Target	Jun 22	Jul 22	Aug 22
12.4%	12.4%	10%	12.4%	12.2%	12.6%

National Position & Overview

Root Cause

- Small supply of registered children's nurses
- There is a deterioration in vacancy position by 1.8% in month, wte compared to April '22 (this equates to 11WTE).
- Increased establishment in month 6.0 WTE

Actions

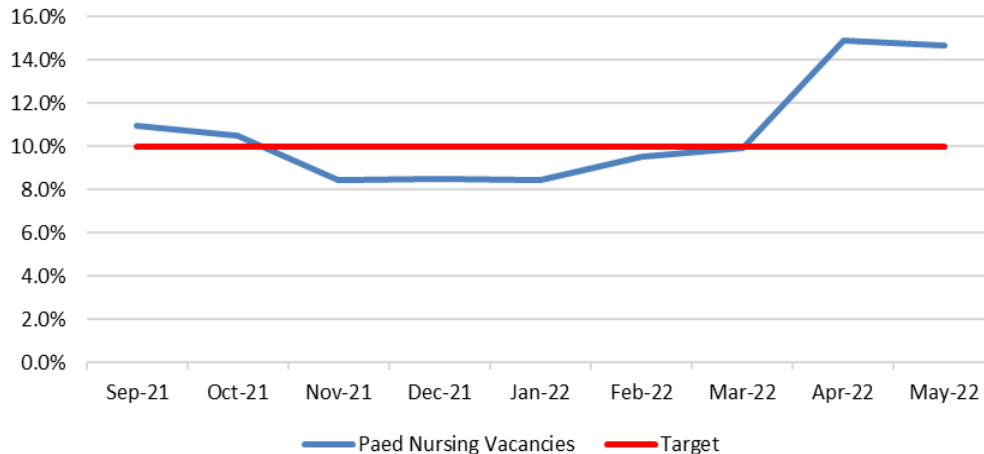
- Daily senior nurse oversight with nursing staff moves to mitigate gaps and maintain safety and achieve nurse to child ratio's.
- The Head of Nursing for Childrens developing a workforce / recruitment & retention plan for 2022.
- Childrens and Paed ED recruitment event / open day June 18th 2022
- Support for the international nurses who are undergoing their OSCE training and ensuring smooth transition into their clinical role.
- Supporting adult pathway international nurses to children's services as supply where they can be safely deployed.

Impact/Timescale

- Continue to seek international nurses who possess paediatric ward, ICU and ED experience and who have applied on the children's NMC pathway to interview and offer positions at UHL .
- July – 2 arrivals

Well Led – Midwives Vacancies

Midwives Vacancies



Current Performance

Three Month Forecast

May 22	YTD	Target	Jun 22	Jul 22	Aug 22
14.7%	14.7%	10%			

National Position & Overview

Root Cause

- There is a slight improvement in vacancy position by 0.2% in month, compared to April which was 14.9%, this equates to 1.7WTE new starters, plus an international midwife who was employed as a Band 3 until she has a registration with the NMC
- Vacancy position overall continues to be due to the limited supply of newly qualified midwives

Actions

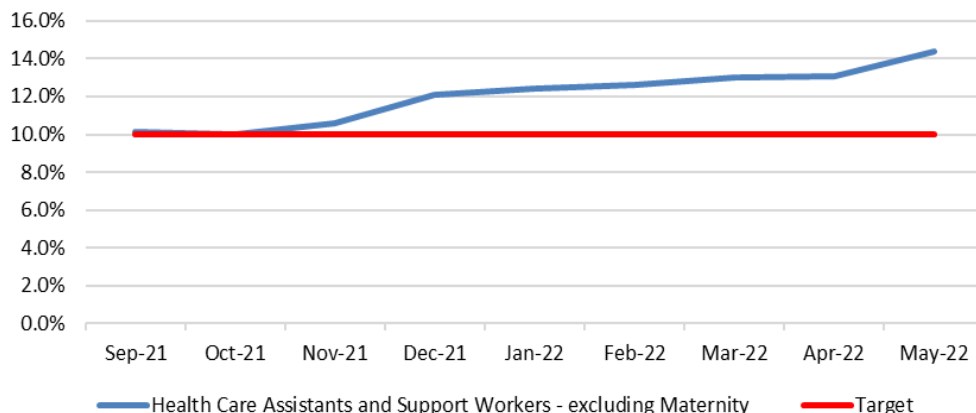
- A Midwifery open day was held 11th June, there was limited attendance
- Rolling advert now increased to 2 weeks open advert 2 weeks closed for shortlisting with good response from international midwives
- Appointment of education midwife to support international recruitment
- Proactive marketing of a shortened course midwifery (for nurses) with financial support from NHSI to support employers with study costs.
- Both recruitment retention and pastoral care midwives in post

Impact/Timescale

- One international midwife has commenced two more in Jul'22, an OSCE place has been secured by the end of June
- 7 Nurses put forward for shortened course midwifery and more are still expressing interest
- First out turn of newly qualified midwives from University of Leicester in September, there is interest from 3 midwives to secure jobs out of the initial cohort of 5 (two lost to attrition).

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

Health Care Assistants and Support Workers - excluding Maternity



Current Performance

Three Month Forecast

May 22	YTD	Target	Jun 22	Jul 22	Aug 22
14.4%	14.4%	10%	12.4%	13.4%	11.4%

National Position & Overview

Nationally the number of vacant healthcare support worker posts remains high acknowledging UHL is an outlier. The national drive from Nov 2020 is ongoing in 2022 and remains 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

- The position has deteriorated from April '22 demonstrating 1.3% increase in vacancies month equating to 29WTE.
- There continues to be HCA leavers (19WTE) and staff moving from substantive posts bank posts (6WTE) impacting on substantive headcount.
- Planned service developments increasing establishment and leavers negates the positive recruitment of 29WTE HCAs
- The supply of HCSW's is decreasing, noted with the regional and national team as a similar picture across England.

Actions

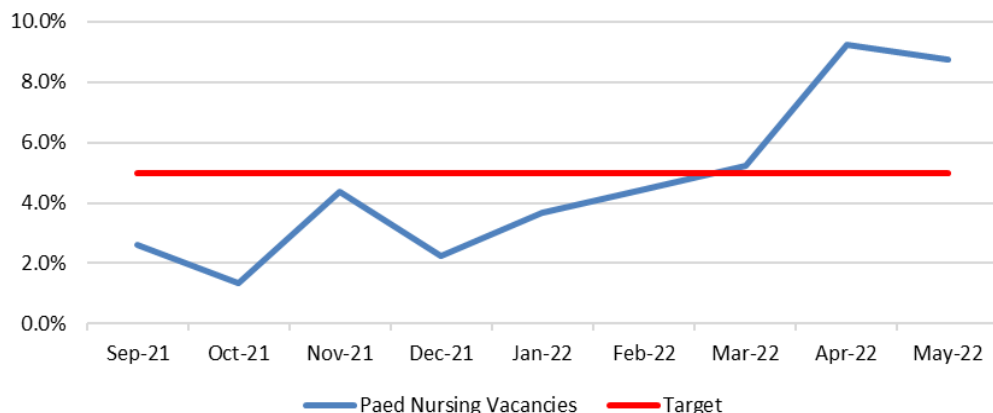
- Recruitment events / interviews every 8 weeks in 2022 .
- Interview day streamlined to increase efficiency and improve time to hire.
- Removal of social distancing will allow larger cohorts
- Blended Face to face / virtual induction and training plan ready in preparation for June July if supply increases.
- Additional financial resources from NHSI to increase administrative support in Recruitment Services and nurse education team to increase capacity of cohorts.

Impact/Timescale

- 60 applicants with Jun'22 start dates (53WTE)
- 10 applicants with August '22 start date
- 156 job offers in pipeline for June/ August / Sept Start.
- Open day supported by indeed in May increased pipeline to commence June , August and September.
- July 1st open day.at LRI for Sept, October pipeline
- Continued intakes doubled to 60 to ensure that we see UHL achieve target of 10% by Sept '22

Well Led – Health Care Assistants and Support Workers - Maternity

Health Care Assistants and Support Workers - Maternity



Current Performance

Three Month Forecast

May 22	YTD	Target	Jun 22	Jul 22	Aug 22
8.7%	8.7%	10%			

National Position & Overview

Root Cause

- Difficult to attract new applicants despite previous track record.
- Perceived lack of development pathway

Actions

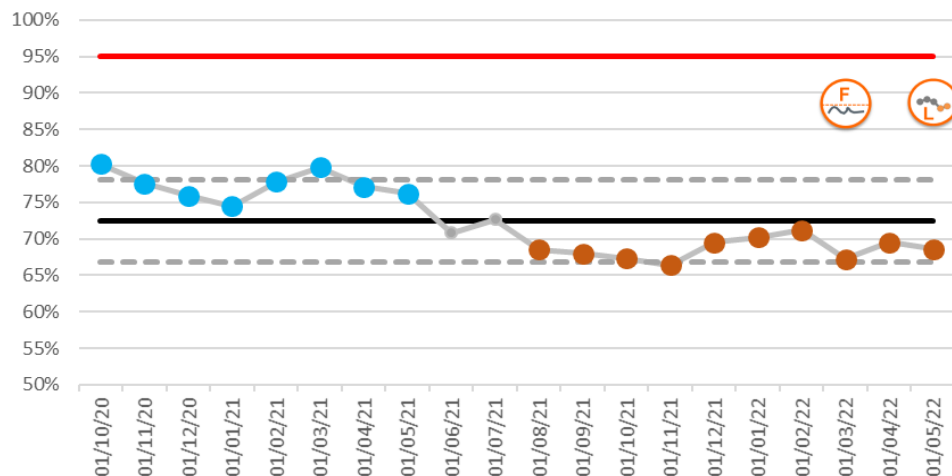
- Review marketing materials to ensure the role is clear and applicants are clear about the different aspects of the role
- Review of support staff workforce to ensure roles / numbers are correct
- Review apprenticeship pathways for Band 2 to 3 development to enable a 'grow your own' model
- Empowering voices programme commencing in maternity to understand lived experience of this cohort of colleagues

Impact/Timescale

Anticipated that the review and development pathway are established later in the year

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

ED 4 hour waits Acute Footprint



Current Performance

May 22	YTD	Target
68.6%	69.0%	95%

Three Month Forecast

Jun 22	Jul 22	Aug 22
69.8%	67.8%	67%

National Position & Overview

In May, UHL ranked 79 out of 110 Acute Trusts. The National average in England was 73.0%. Only 1 out of the 110 Acute Trusts achieved the target. UHL ranked 9th out of 15 trusts in its peer group. The best value out of the Peer Trusts was 82.5% and the worst value was 62.5%.

Root Cause

- Crowding in ED due to chronic and sustained lack of flow
- High Inflow of both walk-in and ambulance arrivals
- UHL bed occupancy >85%

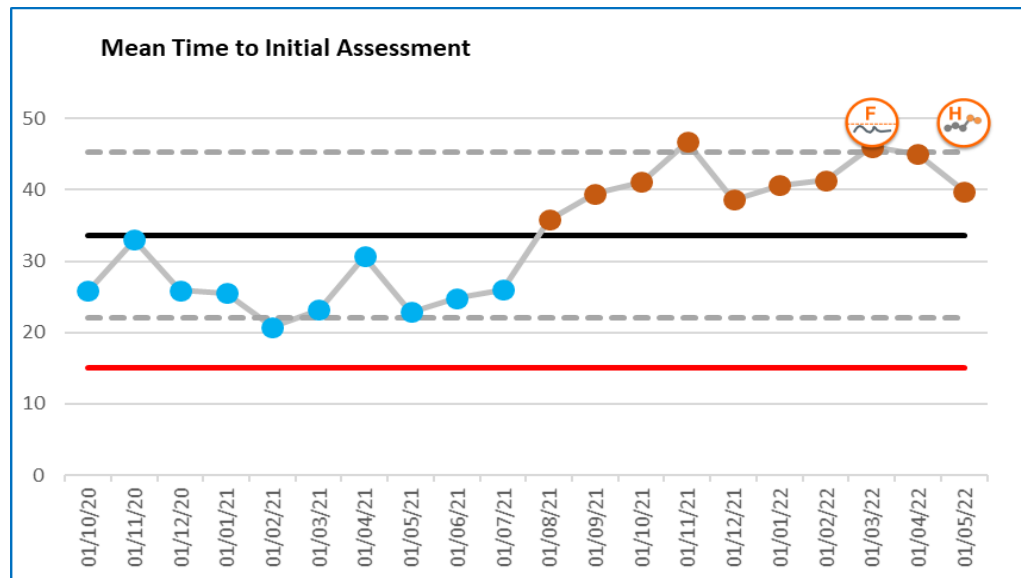
Actions

- Recruitment plans following investment in additional funding for overnight consultant in ED
- Prepare to relocate mobile UTC to MiaMI due to open on the 7th June.
- Emergency flow action plan focus on reduction in non-admitted breaches and adherence to new UEC standards

Impact/Timescale

- Improve time to senior decision making – from August.
- June 2022
- June 2022

Responsive (Emergency Care) – Mean Time to Initial Assessment

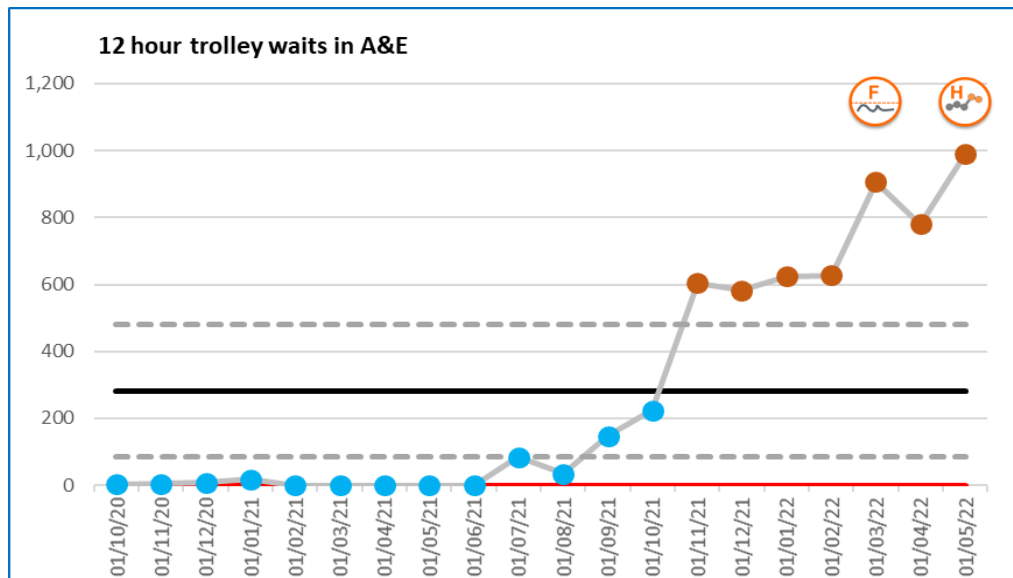


Current Performance			Three Month Forecast		
May 22	YTD	Target	Jun 22	Jul 22	Aug 22
38.8	42.2	15	32	28	26

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"> Redirect patients to UTC and SDEC;s ED consultant deployed to front desk STAT clinician allocated to front door for each shift Stream patients to injuries Plan for Urgent Care Co-ordination hub test pilot in July 	<ul style="list-style-type: none"> In place In place In place In place July 2022

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



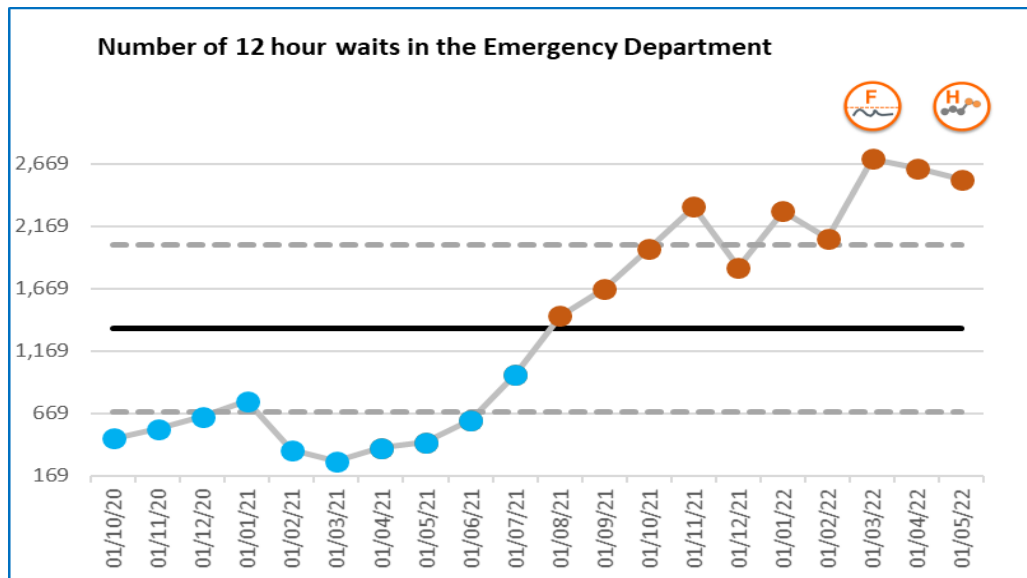
Current Performance			Three Month Forecast		
May 22	YTD	Target	Jun 22	Jul 22	Aug 22
992	1,773	0	780	750	730

National Position & Overview

In May, UHL ranked 122 out of 122 Major A&E NHS Trusts. 24 out of the 122 Trusts achieved the target. The best value nationally was 0 and the worst value was 992. UHL ranked 17th out of 17 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 / using the discharge lounge overnight 	<ul style="list-style-type: none"> Medical in reach in place 24/7 Cardiology in reach in place 9 – 5 Mon to Friday and 9 – 12 Sat – Sun Ensure full utilisation of LGH beds Focused work on flow through the hospital to include board rounds, criteria led discharge, TTO's Avoid using discharge lounge overnight for additional capacity 	<ul style="list-style-type: none"> June 2022 June 2022 June 2022 August 2022 June 2022

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

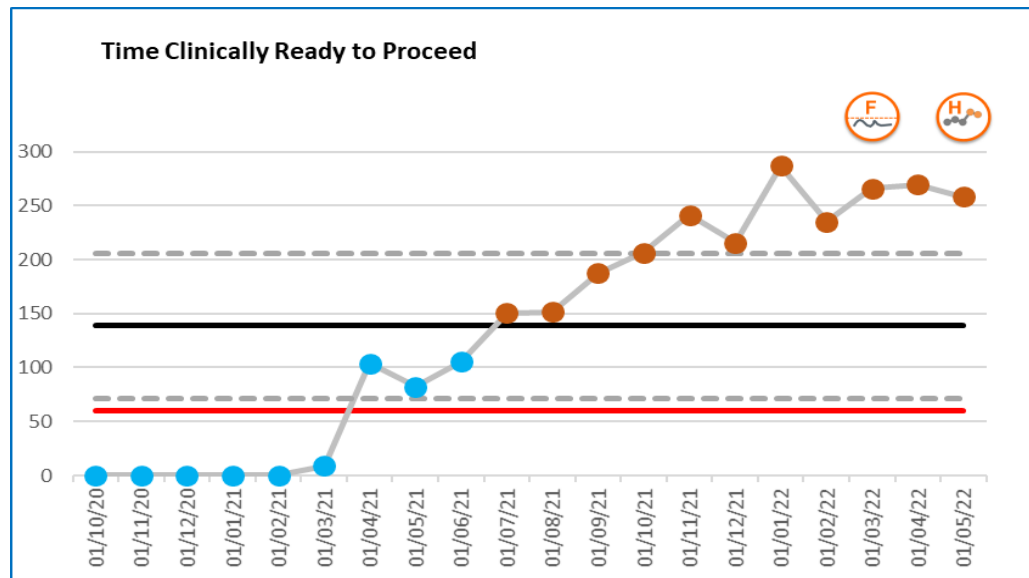


Current Performance			Three Month Forecast		
May 22	YTD	Target	Jun 22	Jul 22	Aug 22
2,541	5,175	0			

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 Overcrowding in ED result in long waits to see a doctor 	<ul style="list-style-type: none"> Relocate UTC to MIaMI Medical in reach in place 24/7 Cardiology in reach in place 9 – 5 Mon to Friday and 9 – 12 Sat – Sun 	<ul style="list-style-type: none"> 7th June 2022 June 2022

Responsive (Emergency Care) – Time Clinically Ready to Proceed

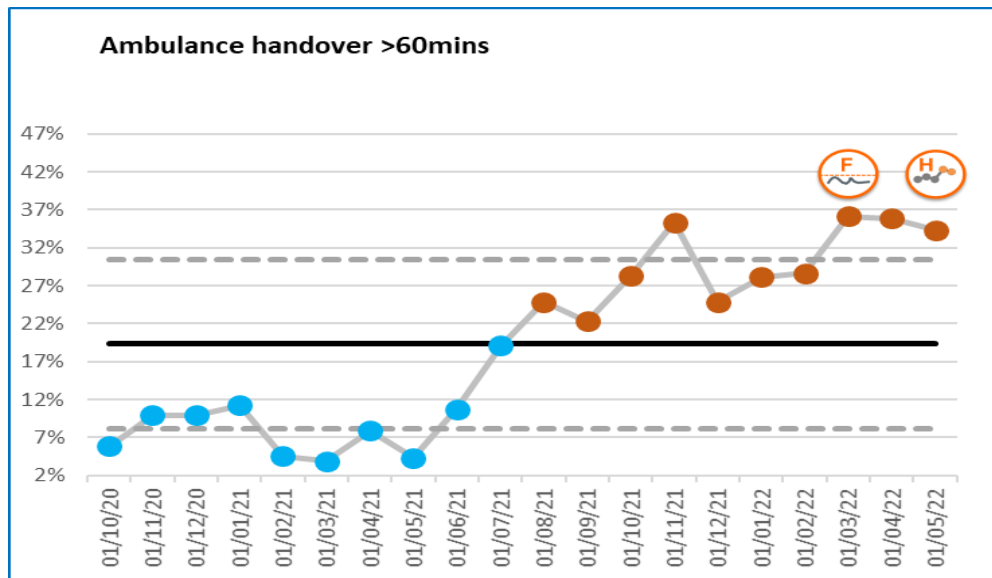


Current Performance			Three Month Forecast		
May 22	YTD	Target	Jun 22	Jul 22	Aug 22
258.3	264.0	60	265	265	255

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"> Embed E-Referrals Embed Interprofessional standards 	<ul style="list-style-type: none"> Full action plan in place commencing June to September 2022

Responsive (Emergency Care) – Ambulance Handovers >60 Mins



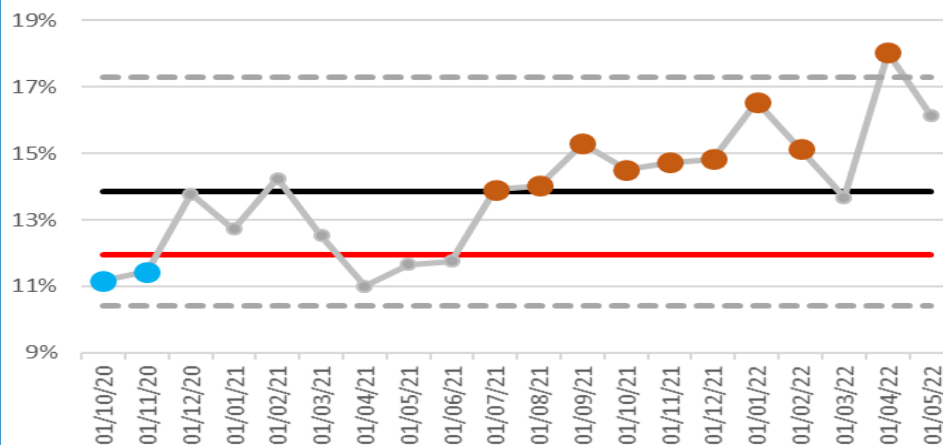
Current Performance			Three Month Forecast		
May 22	YTD	Target	Jun 22	Jul 22	Aug 22
34.0%	34.7%	0%	37%	36%	35%

National Position & Overview
<p>LRI ranked 22nd out of 23 sites last month (source EMAS monthly report) and had the second highest number of arrivals (4,635).</p> <p>UHL is an outlier in Ambulance handover performance and recorded the highest number of handovers over 60 minutes last month, 1,575 (source EMAS monthly report).</p>

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 Sick patients walking in due to inability to get an ambulance 	<ul style="list-style-type: none"> Medical in reach in place 24/7 Cardiology in reach in place 9 – 5 Mon to Friday and 9 – 12 Sat – Sun Ensure full utilisation of LGH beds Focused work on flow through the hospital to include board rounds, criteria led discharge, TTO's Avoid using discharge lounge overnight for additional capacity Plan for Urgent Care Co-ordination hub test pilot in July 	<ul style="list-style-type: none"> June 2022 June 2022 June 2022 August 2022 June 2022 July 2022

Responsive (Emergency Care) – Long Stay Patients as a % of G&A Bed Occupancy

Long Stay Patients (21+ days) as a % of G&A Bed Occupancy



Current Performance

May 22	YTD	Target
16.2%	16.2%	12%

Three Month Forecast

Jun 22	Jul 22	Aug 22
15%	14%	13%

National Position & Overview

UHL is ranked 12th out of 20 trusts in the Midlands for the % beds occupied by Long Stay (21+ Day) patients (for the w/c 30/05/22).

- 36 Patients (14%) are receiving appropriate care/ treatment on a neuro rehabilitation or brain injury pathway or on an Intensive care Unit or Infectious Diseases Unit.
- 85 Patients (33%) are medically optimised for discharge with no acute medical reason to stay .

Root Cause

- Circa 150 Complex Medically optimised for discharge patients of which 85 (57 %) have a LLOS 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.

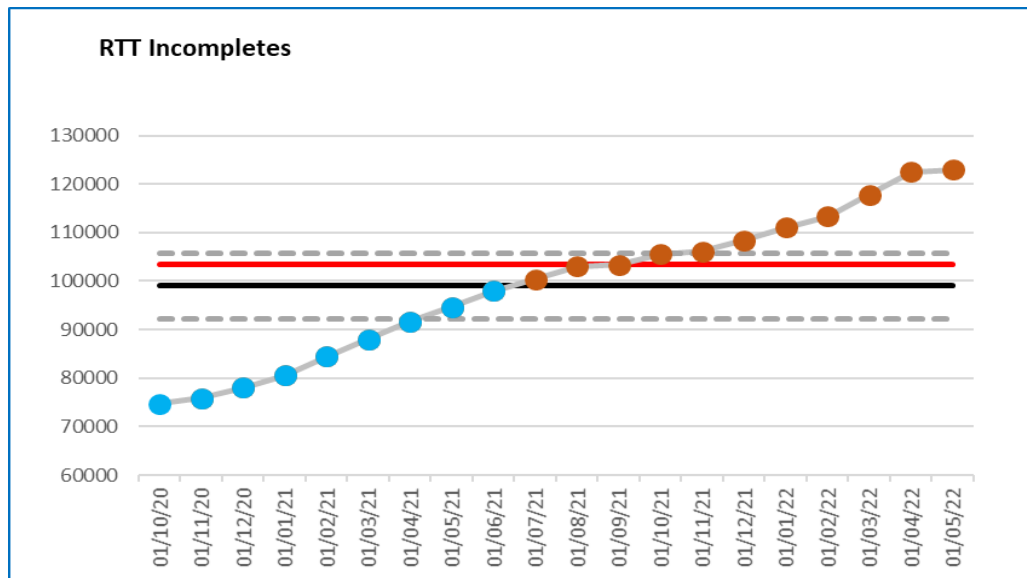
Actions

- Continue to work Collaboratively with health and social care system partners during June to:
- Further develop pathways for High dependency Residential Home placements.
 - Continue to review patients awaiting discharge destinations daily to see if alternative solutions exist: RVS, Bridging etc.
- Work with CMG's to:
- Embed Long length of stay patient reviews
 - Redesign how the discharge specialist team work and embed roles within the CMG's
 - Establish TTO working group to understand the end to end process and where improvements can be made.

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.
- Reduce the number of patients awaiting 'next steps'/LLOS

Responsive (Elective Care) – RTT Incompletes

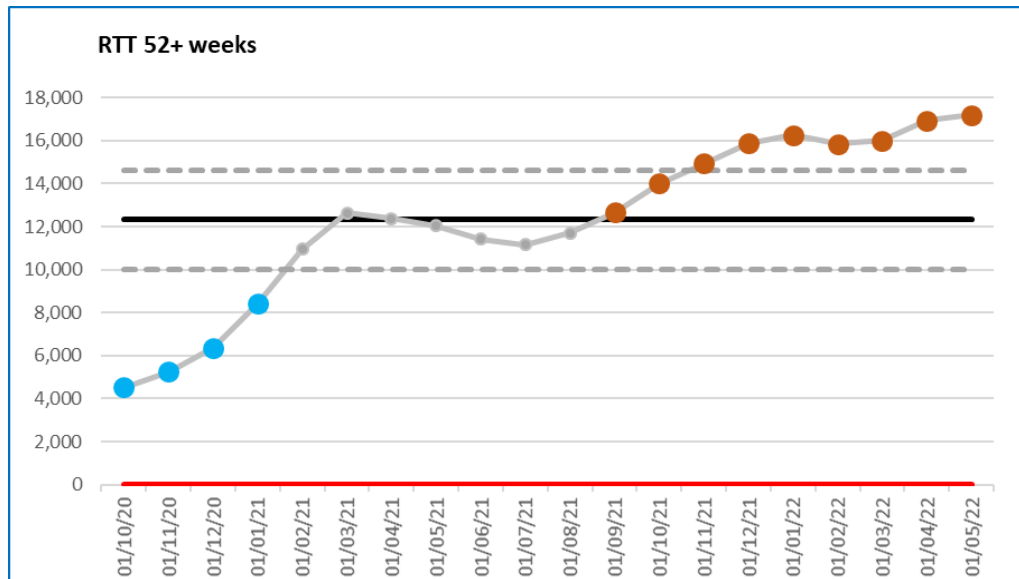


Current Performance			Three Month Forecast		
May 22	YTD	Target	Jun 22	Jul 22	Aug 22
122,999	122,999	103,403			

National Position & Overview
At the end of April, UHL ranked 15th out of 18 trusts in its peer group with a total waiting list size of 122,500 patients. The best value out of the 18 Peer Trusts was 59,033, the worst value was 159,942 and the median value was 78,100.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Impact of reduced outpatients and Inpatient activity. Due to COVID-19 and the introduction of social distancing 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 Robot Automation of ASIs 	<ul style="list-style-type: none"> Submit final trajectory for system planning External validation contract and ensure robust validation plan from internal UHL is in place Ufonia to start contacting all patients on the waiting list for administrative validation Advertise RRT improvement office 	<ul style="list-style-type: none"> 20/06/22 – outline the delivery against national ambitions 30/06/22 Exit strategy for delivering a more cost-effective validation solution 30/06/22 remove patients who no longer want to be on the waiting list 08/07/22 to lead on improving the volume of patients who are IPT'd resulting in lower waiting list numbers within UHL

Responsive (Elective Care) – RTT 52+ Weeks

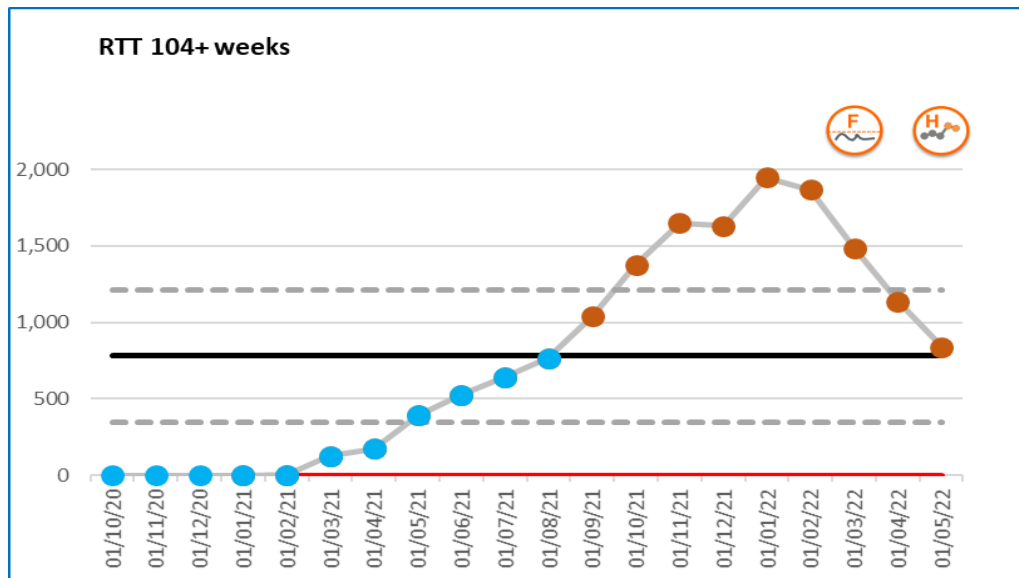


Current Performance			Three Month Forecast		
May 22	YTD	Target	Jun 22	Jul 22	Aug 22
17,187	17,187	0	17,005	16,483	16,103

National Position & Overview
<p>At the end of April, UHL ranked 17th out of 18 trusts in its peer group with 16,935 patients waiting over 52+ weeks. The best value out of the 18 Peer Trusts was 970, the worst value was 30,810 and the median value was 4,136.</p>

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Impact of COVID-19 on planned activity capacity Significant operational pressures due to the emergency demand and COVID-19, UHL has reported operational OPEL 4 levels regularly. The requirement to increase ITU Capacity, leading to a reduction in theatre capacity Increase demand for Urgent and Cancer Patients 	<ul style="list-style-type: none"> Submit final trajectory for system planning Identify a suitable cohort of patients awaiting above 52+ weeks for mutual aid, this is to be shared with the GIRFT team to contact patients Focused validation of all non-admitted patients above 52+ Ufonia to contact all Gynaecology patients 	<ul style="list-style-type: none"> 20/06/22 – outline the delivery against national ambitions 30/06/22 Paed ENT and Pain patients first of all to be offered alternative organisation to be treated sooner 30/06/22 Reduce volumes requiring outpatients appointments 30/06/22 high volume of patients waiting for new appointments to understand if all these patients still require treatment

Responsive (Elective Care) – RTT 104+ Weeks

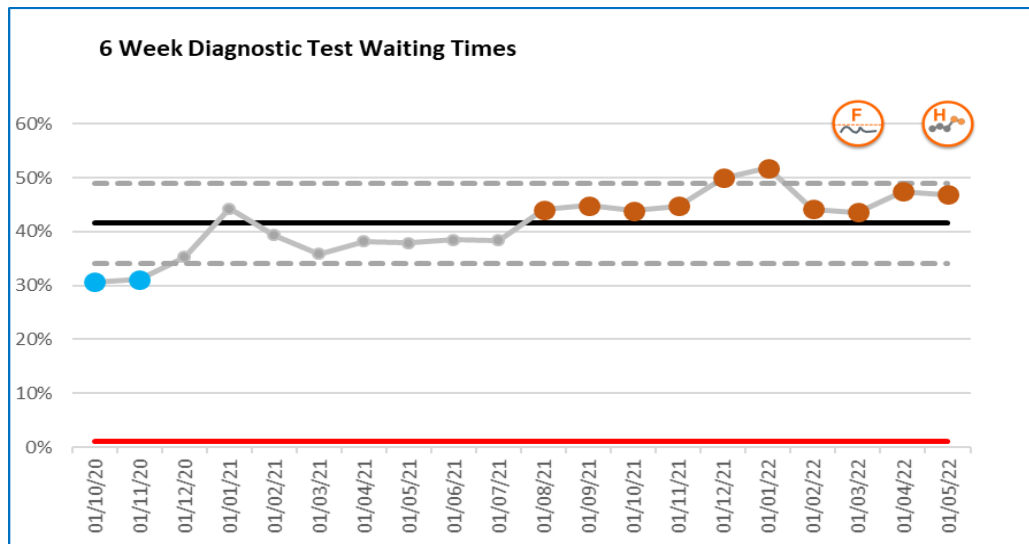


Current Performance			Three Month Forecast		
May 22	YTD	Target	Jun 22	Jul 22	Aug 22
841	841	0	548	351	203

National Position & Overview
At the end of April, UHL ranked 18th out of 18 trusts in its peer group with 1,138 patients waiting 104+ weeks. The best value out of the 18 Peer Trusts was 1 and the median value was 211.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Impact of COVID-19 on planned activity capacity Significant operational pressures due to the emergency demand and wave 3, UHL has reported operational OPEL 4 levels regularly The requirement to increase ITU Capacity, leading to a reduction in theatre capacity Theatre capacity which has been available has been used for clinical priority, cancer patients, and P2's 	<ul style="list-style-type: none"> Submit final trajectory for system planning To contact all patients who will breach 104+ weeks 30/09/22 to ask if they're willing to travel to an alternative provider outside of the county. Continue to review the June cohort of patients for mutual aid with support from the GIRFT team. 220 patients to be contacted by system colleagues where we have not had a previous response from them 	<ul style="list-style-type: none"> 20/06/22 – outline the delivery against national ambitions 24/06/22 – To have a cohort of the patient that are ready and willing to travel 30/06/22 – Reduction in 104+ patients on UHL waiting list with patients being treated quicker elsewhere 17/06/22 Identify more patients for mutual aid and arrange clinical review and potentially refer back to the referrer where clinically suitable.

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

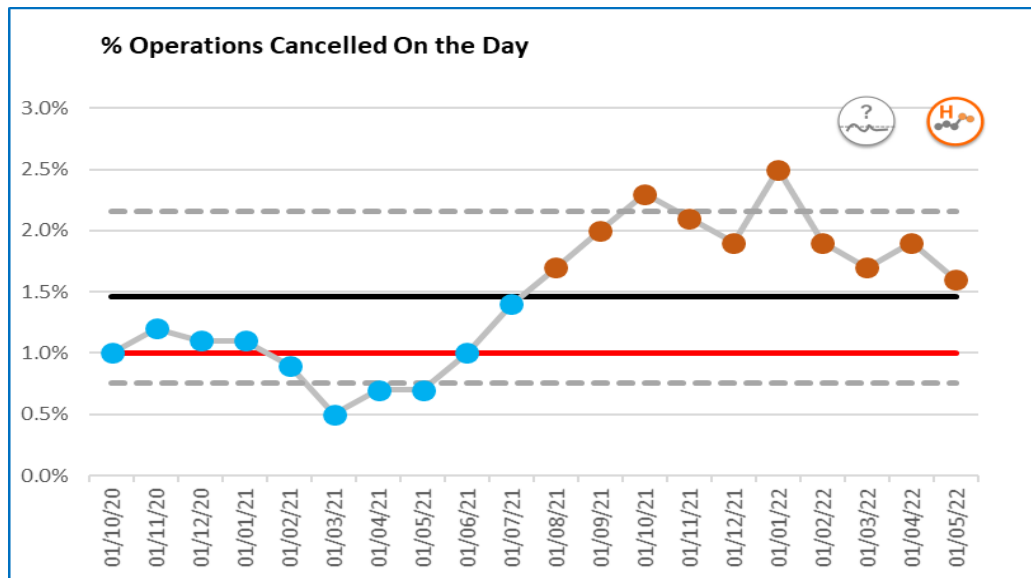


Current Performance			Three Month Forecast		
May 22	YTD	Target	Jun 22	Jul 22	Aug 22
46.9%	46.9%	1.0%	43.6%	42.1%	38.7%

National Position & Overview
<p>National average performance for April was 28.4%. UHL ranked 17th out of 18 trusts in its peer group with a performance of 47.4% in April. The best value out of the 18 Peer Trusts was 5.0%, the worst value was 50.9% and the median value was 31.8%.</p>

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Impact of COVID-19 on planned activity capacity Increased demand for MRI, Non-Obstetric Ultrasound, and Endoscopy. Reduced capacity due to the 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"> Submit final trajectory for system planning RTT team to support endoscopy for validation Development and submission of community Diagnostic hub 	<ul style="list-style-type: none"> 20/06/22 – outline the delivery against national ambitions 30/06/22- Reduction in overall waiting list 31/07/22 - Increase in diagnostic capacity for LLR

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



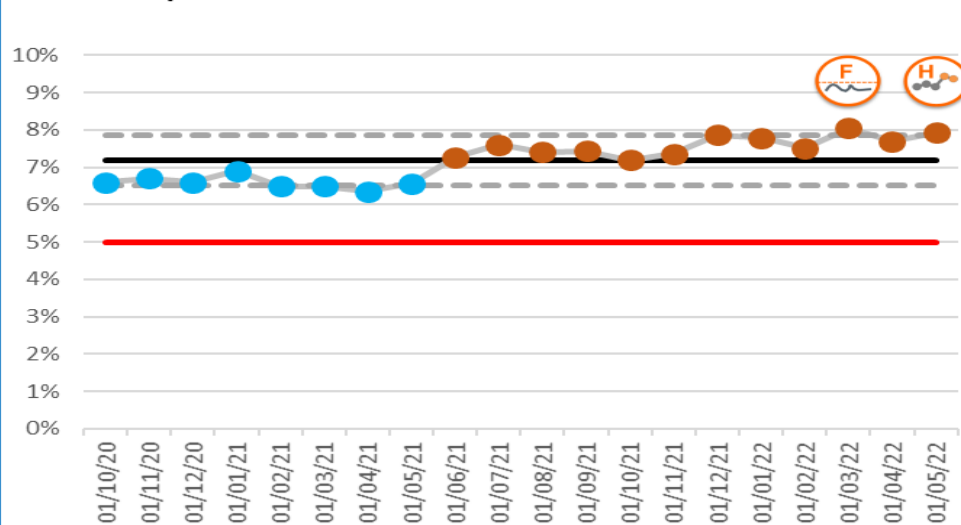
Current Performance			Three Month Forecast		
May 22	YTD	Target	Jun 22	Jul 22	Aug 22
1.6%	1.8%	1%	1.6%	1.4%	1.3%

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 regularly. Volume of medical outliers increased reducing the volume of available beds to support elective care. 	<ul style="list-style-type: none"> Sign off Audit carried out by PWC and assign actions leads and timescales. Business care for Centralisation and standardisation of pre-operative assessment to be signed off 8 elective ring-fenced beds to come online implementing spot checks to ensure that cancellations are going through the appropriate escalation process and take action to remind staff of the required process where issues are noted. 	<ul style="list-style-type: none"> 31/06/22 – Increase governance process for cancellations on the day and improvement in data quality. 30/06/22- To support the pre-op process and will result in fewer cancellations on the day due to patient being unfit. 08/06/22 – To support elective capacity resulting in fewer cancellations on the day due to no ward bed available 15/07/22 – improve data quality and ensure all OTDC are correctly escalated

Responsive (Elective Care) – Outpatient DNA Rate

% Outpatient DNA rate



Current Performance

May 22	YTD	Target	Three Month Forecast		
May 22	YTD	Target	Jun 22	Jul 22	Aug 22
7.9%	7.8%	5.0%	7.6%	7.3%	7.0%

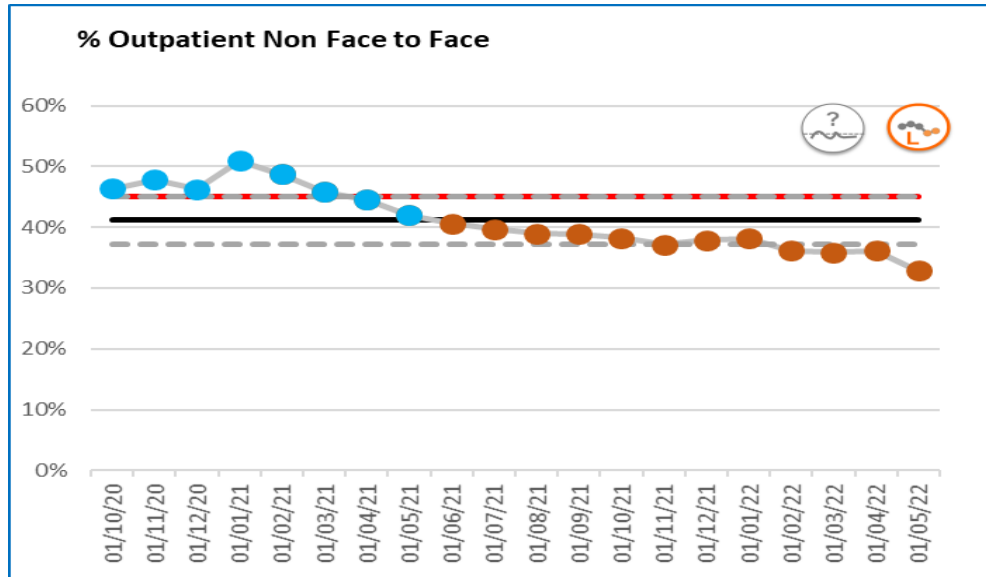
National Position & Overview

UHL compares better than its peers for the previous financial year, 7.2% compared to 8.5% (data up to the end of February, 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"> 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 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 3. Late cancellations/rebooks often mean patients do not receive their appointment letters on time so unaware of appointment 4. Due to lack of admin staff, patients unable to get through to department to let them know they're unable to attend 5. Some patients are still afraid to come in to hospital 	<ol style="list-style-type: none"> 1. On the Risk register. IT are looking into. Continue to promote the use of Attend Anywhere as an alternative. 2. Remind services of the need to check the patients details are correct and up to date at every contact 3. Services are being encouraged to use the OP QlikSense dashboard, plus ENVOY or AccuRx to send reminders to patients 4. Working on increasing numbers on the admin bank and getting them upskilled 5. 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



Current Performance			Three Month Forecast		
May 22	YTD	Target	Jun 22	Jul 22	Aug 22
32.9%	34.4%	45.0%	33.9%	34.9%	35.9%

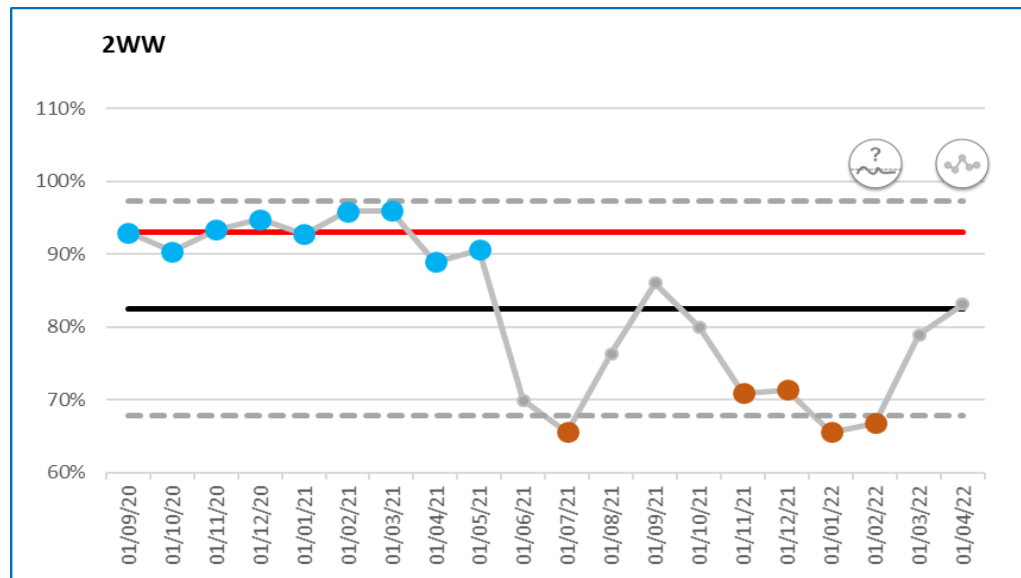
National Position & Overview

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	Actions	Impact/Timescale
<ol style="list-style-type: none"> Not all Outpatient rooms and consultant offices are set up for video consultation e.g. 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 Poor experience with One Consultation has made rollout of Attend Anywhere more challenging 	<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 than non F2F. 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. 	<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



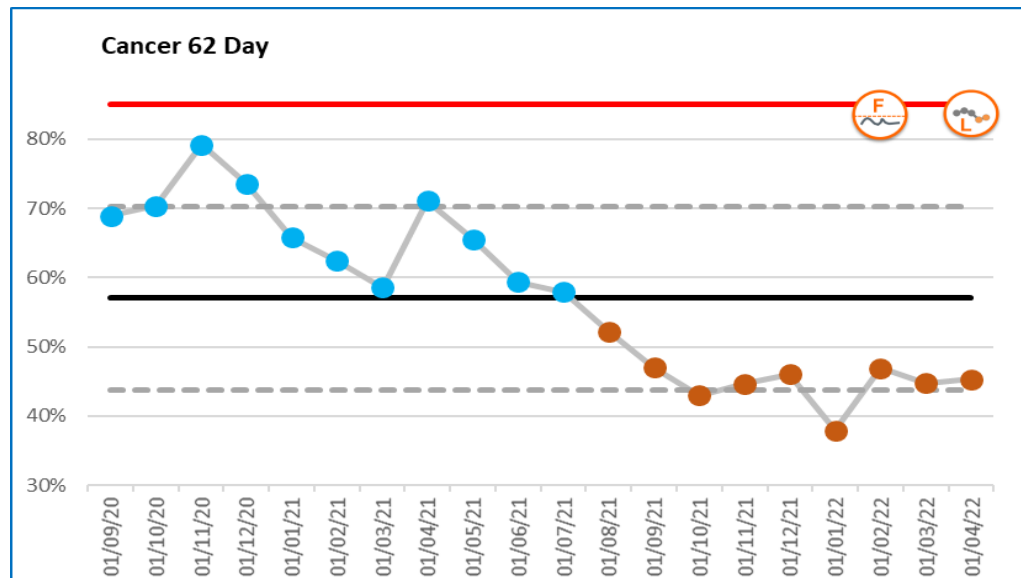
Current Performance			Three Month Forecast		
Apr 22	YTD	Target	May 22	Jun 22	Jul 22
83.2%	83.2%	93%	85%	87%	89%

National Position & Overview

In April, UHL ranked 70 out of 121 Acute Trusts. The National average was 79.1%. 27 out of the 121 Acute Trusts achieved the target. UHL ranked 7th out of the 18 UHL Peer Trusts. The best value within our peer group was 100%, the worst value was 46.6% and the median value was 76.3%.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> 2WW demand overall remains above 20–25% above pre-COVID levels with H&N, Upper & Lower GI and Haematology showing the largest increases in April Improvements in Breast and Skin 2WW are supporting the overall improvement with breast achieving > 93% in April Despite the pathway improvements the 2WW standard remains at risk due to the sustained increase in demand, out-patient and diagnostic capacity issues and workforce challenges in both admin and clinical areas. 	<p>Monthly CMG/tumour site recovery action plan meetings held with all tumour sites with clear actions on 2WW recovery identified :-</p> <p>Breast</p> <ul style="list-style-type: none"> Breast pain & Outsourcing under 35s Additional WLI and USS rooms at GGH Insourcing for weekend activity <p>ENT</p> <ul style="list-style-type: none"> Mandatory F2F assessment prior to referral Task & Finish group for national timed pathway implementation setup Increase clinic capacity following removal of social distancing <p>Haematology</p> <ul style="list-style-type: none"> Demand and capacity gap – service clinically triaging each referral and appropriately booking 2ww triage pilot planned with PCL for August 	<ul style="list-style-type: none"> Breast U35 backlog cleared in February, delivery of 2WW performance in April and forecast to continue from May 2022 ENT backlog is improving due to the increase in clinic capacity; waiting times have improved for >10 weeks to 5 weeks. Trajectories for 22/23 show improving performance but remain below the 2WW standard due to the backlog of referrals 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 forecast to continue due to capacity gap. The pilot in August aims to support a reduction in inappropriate referrals. Overall UHL position for 22/23 reflective of key areas of concern and forecast for under delivery of the standard in these areas.

Responsive Cancer – Cancer 62 Day



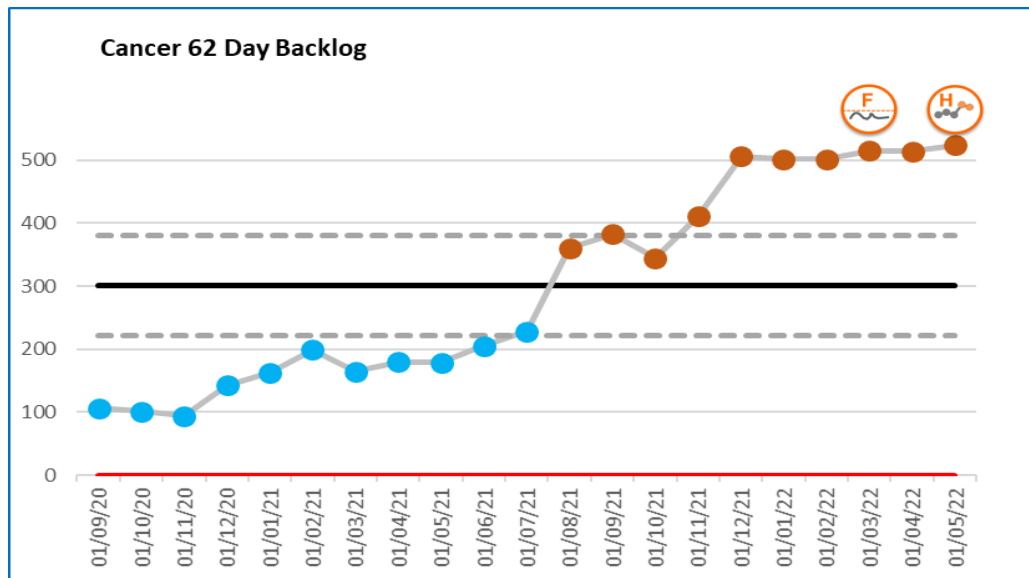
Current Performance			Three Month Forecast		
Apr 22	YTD	Target	May 22	Jun 22	Jul 22
45.3%	45.3%	85%			

National Position & Overview

In April, UHL ranked 128 out of 136 Acute Trusts. The National average was 65.2%. 18 out of the 136 Acute Trusts achieved the target. UHL ranked 16th out of the 18 UHL Peer Trusts. The best value within our peer group was 75.5%, the worst value was 20.5% and the median value was 57.0%.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Capacity constraints across all points of the pathways High backlog levels being treated and prioritised having a direct impact on performance Theatre capacity remains challenged due to staffing and capacity where HDU beds are required Emergency operational pressures impacting on elective bed base 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/CAB 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/FDS 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 	<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

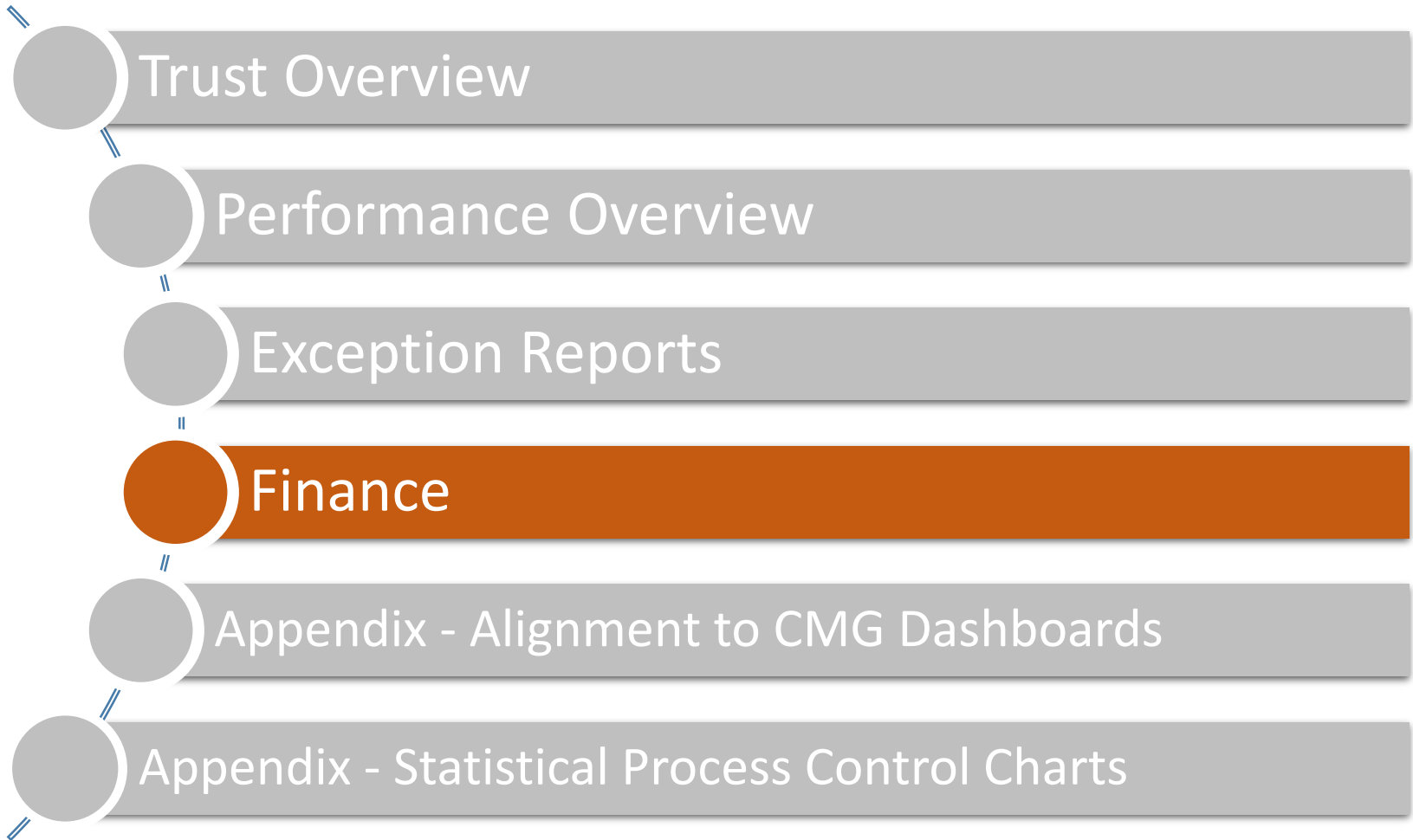
Responsive Cancer – Cancer 62 Day Backlog



Current Performance			Three Month Forecast		
May 22	YTD	Target	Jun 22	Jul 22	Aug 22
524	524	0			

National Position & Overview
National data not currently available for reporting.
Of the 62 day backlog 40% of the backlog was over 104 days (210 patients) with 69% of the 104d backlog in Urology, 7.6% in LOGI and 6.6% in H&N.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Waiting list volumes for 62 day remain high as a result of ongoing demand. Urology remains the key area of concern. Some improvements are being seen in H&N and Breast Constraints include Diagnostic capacity, particularly Endoscopy and theatre sessions. Reduced theatre sessions (due to staffing) Patient choice remains of concern across several pathways as does fitness to proceed Emergency bed pressures continued to put pressure on elective capacity including HDU/ICU in May 	<ul style="list-style-type: none"> Continue to clinically prioritise all patients on a cancer pathway with ongoing focus on ensuring cancer 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 & FDS 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 Develop action plans around RDC with a view to expediting pathways at the front end and prevent pathway delays where possible Skin AI programme (pilot in progress at Loughborough, Melton and Hinckley) to release capacity and improve pathway delays 	<ul style="list-style-type: none"> Regional support for Urology; including mutual aid at Derby, Coventry and Lincoln Roll out of Skin AI to further sites– 3 sites 'live', City Hub (at LGH) to commence following recruitment (date TBC) RDC/Faster Diagnosis Framework paper submitted and work to commence on national timed pathways by end of Q4 2022 Weekly PTL/CAB meetings continue to be prioritised to ensure pathway delays are expedited and accurate CWT rules are applied – New Head of Cancer Performance commenced in June. HDU/ICU and elective on the day cancellations are anticipated to reduce in June following reconfiguration of ICU and surgical services to support LOGI, UPGI and Urology pathways.



Single Oversight Framework – Month 2 Overview

Single Oversight Framework – Month 2

At a Glance		Indicator	Plan / Standard	Period	YTD Actuals	RAG Rating	Executive Director
Best Value Care	Finance	Trust level control total performance against target	M2 YTD Plan of -£7.8m	M2	-£7.2m		CFO
		Capital expenditure against plan	M2 YTD Plan of £7.9m	M2	£5.9m		CFO

Summary Financial Position & CIP Performance

		May-22			YTD			Full Year Plan	YTD		
		Plan	Actual	Variance to Plan	Plan	Actual	Variance to Plan		CIP Target	CIP Actual	Variance to Plan
		£'000	£'000	£'000	£'000	£'000	£'000		£'000	£'000	£'000
I&E	NHS Patient-Rel Income	98,622	98,170	(452)	197,244	196,801	(443)	1,183,463	0	0	0
	Other Operating Income	11,762	12,305	543	23,511	23,932	421	135,340	38	173	135
	Total Income	110,384	110,475	91	220,755	220,733	(23)	1,318,803	38	173	135
	Pay	(66,399)	(65,759)	640	(132,859)	(131,743)	1,116	(802,245)	1,020	1,232	212
	Agency Pay	(1,692)	(1,867)	(175)	(3,351)	(3,826)	(475)	(20,263)	0	0	0
	Non Pay	(41,621)	(41,010)	611	(81,927)	(82,122)	(195)	(480,226)	999	791	(208)
	Total Costs	(109,712)	(108,636)	1,076	(218,137)	(217,691)	446	(1,302,733)	2,019	2,023	4
	EBITDA	672	1,839	1,167	2,618	3,042	424	16,070	2,057	2,196	139
	Non Operating Costs	(5,225)	(5,132)	92	(10,448)	(10,301)	147	(62,669)	0	0	0
	Retained Surplus/(Deficit)	(4,553)	(3,293)	1,260	(7,830)	(7,259)	571	(46,599)	2,057	2,196	139
	Donated Assets	39	(94)	(133)	77	31	(46)	464	0	-	0
	Net Total Surplus/(Deficit)	(4,514)	(3,387)	1,127	(7,753)	(7,228)	524	(46,135)	2,057	2,196	139
	Less Capital Impairment	0	0	0	0	0	0	0	0	0	0
	Control Total Surplus/(Deficit)	(4,514)	(3,387)	1,127	(7,753)	(7,228)	524	(46,135)	2,057	2,196	139

Comments – YTD Variance to Plan

Total Income: £23kA, £443kA in the main relating to Community Diagnostic Centre £355kF offset by reduced Nightingale Income £558kA (matched by non pay) and ITU Business Case £352kA. Other income relates to R&I £248kF from grant and commercial income, E&F £315kF from car parking £93k, LPT £122k, catering £72k and £171kA relating to lower Covid-19 income offset by reduced expenditure. The balance of £29kF is linked mainly to private and overseas income.

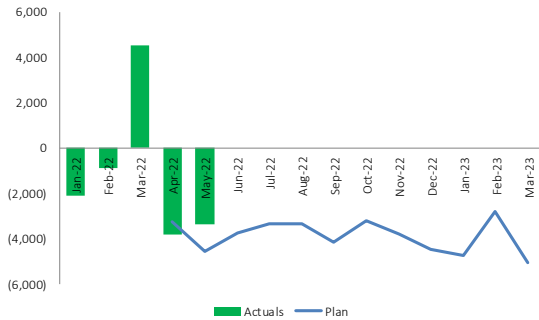
Pay and Agency £641kF, predominantly relating to vacancies across CMGS, mainly in Healthcare Assistants £642kF, Healthcare Scientists £600kF, and Maintenance & Works staff £321kF. Agency in the main relate to catering and porters £271kA and Nursing both qualified and unqualified £336kA.

Non Pay £195kA, mainly relates to £558kF reduced Nightingale expenditure offset by income, £580kF marginal cost linked to activity, £751kA relating to activity cost and volume drugs, £208kA CIP.

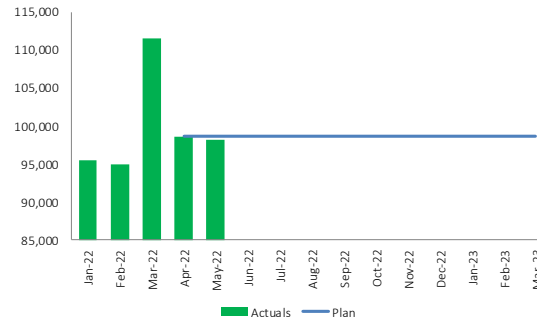
****Please note an updated plan was resubmitted on the 20th June 2022. This will realign Trust and CMG budgets.**

Finance – Best Value Care

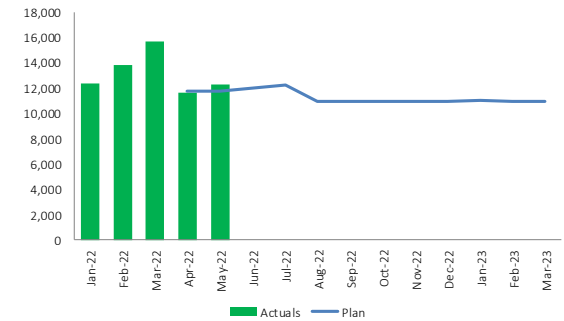
Monthly Surplus/(Deficit) £k



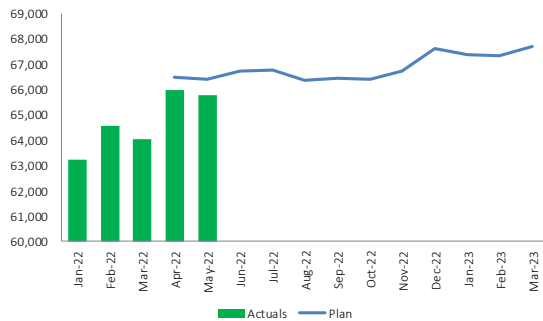
Monthly PCI Income £k



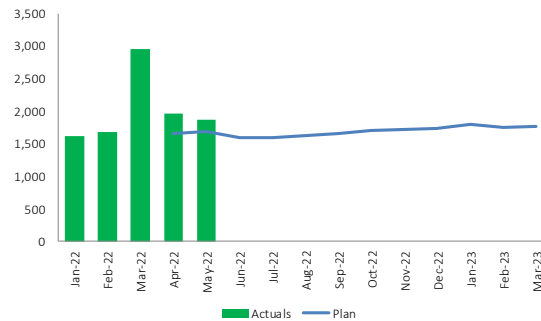
Monthly Other Income £k



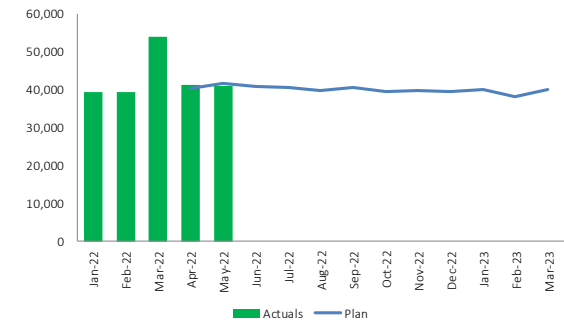
Monthly Pay £k



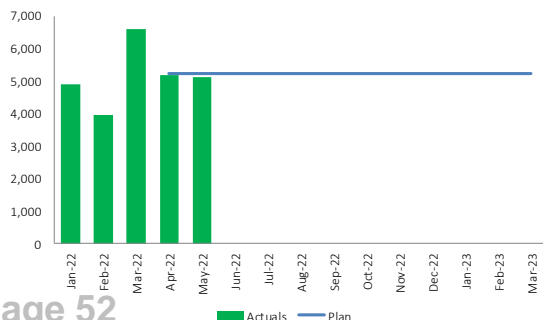
Monthly Agency £k



Monthly Non Pay £k



Monthly Non Ops £k



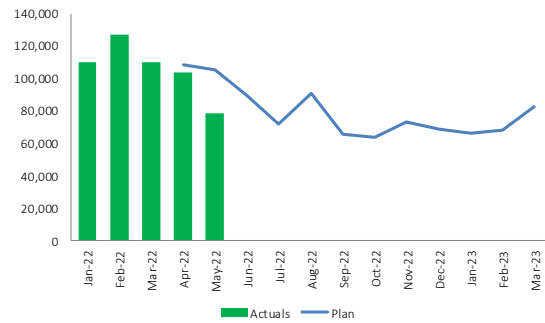
CMG – Worked WTE - Workforce Actuals

	Actual	Actual	Actual	Actual	Actual
	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Substantive	14,193	14,338	14,428	14,440	14,358
Bank	931	995	1,136	952	911
Agency	345	323	333	317	317
Total	15,470	15,656	15,897	15,709	15,585
Budgeted Posts	16,665	16,708	16,727	16,767	16,858

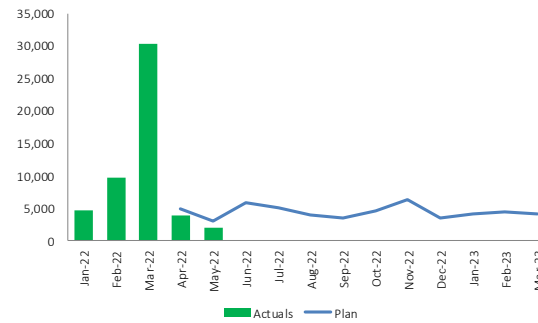
In month		
Actual M1	Actual M2	Variance
14,440	14,358	(82)
952	911	(41)
317	317	(1)
15,709	15,585	(124)

Finance – Best Value Care

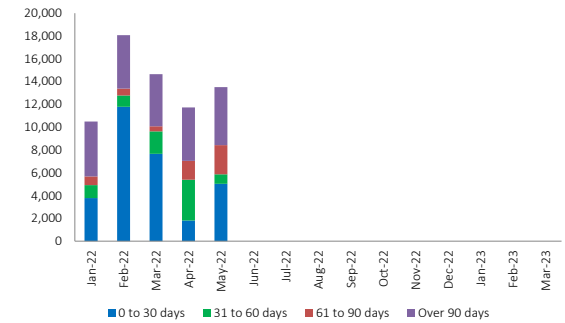
Cash £k



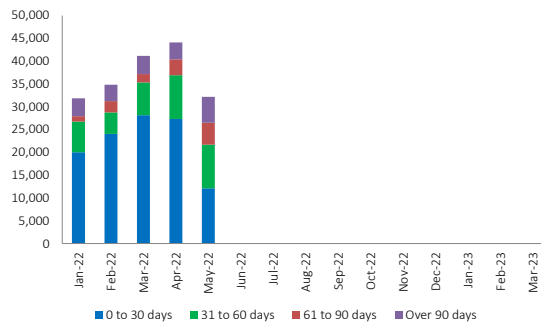
Capital £k



Debtor Days £k



Creditor Days £k



Statement of Financial Position

	M2 YTD		
	30-Apr-22	31-May-22	In month Movement
Non current assets	£000	£000	£000
Intangible assets	6,370	6,148	(222)
Property, plant and equipment	668,761	667,384	(1,377)
Other non-current assets	3,483	3,483	0
Total non-current assets	678,614	677,015	(1,599)
Current assets			
Inventories	21,042	22,014	972
Trade and other receivables	38,122	53,950	15,828
Cash and cash equivalents	103,570	78,171	(25,399)
Total current assets	162,734	154,135	(8,600)
Current liabilities			
Trade and other payables	(123,041)	(115,570)	7,471
Borrowings / leases	(18,125)	(8,845)	9,280
Accruals	(20,491)	(24,397)	(3,906)
Deferred income	(11,634)	(8,145)	3,489
Dividend payable	(0)	0	0
Provisions < 1 year	(15,520)	(16,085)	(566)
Total current liabilities	(188,811)	(173,043)	15,768
Net current assets / (liabilities)	(26,077)	(18,908)	7,168
Non-current liabilities			
Borrowings / leases	(13,494)	(22,357)	(8,862)
Provisions for liabilities & charges	(4,903)	(4,903)	0
Total non-current liabilities	(18,397)	(27,259)	(8,862)
Total assets employed	634,140	630,847	(3,293)
Public dividend capital	(760,831)	(760,831)	0
Revaluation reserve	(184,878)	(184,878)	0
Income and expenditure reserve	311,569	314,862	3,293
Total taxpayers equity	(634,140)	(630,847)	3,293

The Statement of Financial Position (SOFP) at 31st May 2022 is presented in the table opposite. The balance sheet fully reflects the impact of 2020/21 draft Accounts adjustments currently being audited. The key movements in the balance sheet at M2 were as follows:

- Current Assets**

Trade and other receivables increased by £15.8m. This is primarily made up of an additional £4.2m of non-nhs receivables and timing of VAT claims to HMRC (£2.3m) and prepayments, mainly associated with payment of clinical negligence premiums and maintenance contracts. There was also an additional £1.4m due from Leicester Partnership NHS Trust for intra-unit services provided.

- Cash Balances** – Cash and cash equivalents reduced by £21.4m compared to M1, which is explained in the cash flow slide.
- Trade and other payables and accruals** – reduced by £3.6m.
- Borrowings/Leases** – £8.9m of the movement in current lease liabilities is due to a reclassification to non-current lease liabilities, as a consequence of the implementation of IFRS 16.

- Reserves**

I&E reserve - The cumulative deficit on the I&E reserve increased by £3.3m, reflecting the reported May I&E deficit .

Cash Flow

M2 Actual YTD			
Monthly cash flow(£000)	Mar	Apr	May
	"£000"	"£000"	"£000"
Block payments-Other CCG	1,931	1,965	1,987
Block payments-Leic City CCG	18,429	29,621	29,895
Block payments-Leic West CCG	14,441	14,441	17,868
Block payments-Leic East CCG	15,317	14,752	15,880
Block payments-NHS England	29,263	31,637	32,821
System Top Up	10,800	0	0
COVID-19 top up	0	0	0
Health education payments	7,060	11,448	0
Other NHS income	4,511	5,854	567
Research	2,411	0	2,191
Capital Receipts	0	0	0
TMP	2,551	4,288	3,337
PDC Drawdown	8,853	0	0
Other non-NHS income	5,253	4,863	3,271
Total receipts	120,820	118,869	107,817
Salaries and wages	(63,981)	(62,446)	(63,691)
Creditor payments	(59,552)	(63,608)	(62,941)
PDC dividend	(9,441)	0	0
NHSE/I	0	0	0
TMP	(3,045)	(3,575)	(2,703)
Total payments	(136,019)	(129,629)	(129,335)
Month end balance	(15,199)	(10,760)	(21,518)
Cash in transit and cash in hand adjustment	(1,681)	455	35
Balance brought forward	126,840	109,959	99,655
Balance carried forward	109,959	99,655	78,171

The Trust achieved a cash balance at the end of May of £78.2m.

Cash reserves reduced by £21.4m in the month, this being the net impact cash receipts of £107.8m less £129.3m of outgoing payments.

Outgoings in May were comparable with April. However, receipts were lower as no Health Education income was received in May (£11.4m), this income is received quarterly. Also, other NHS income was £5.3m lower than the previous month.

Although the Trust currently maintains a 'healthy' cash position, if our financial position deteriorates, this would result in reduction in cash, which year on year would ultimately compromise the Trust's ability to pay liabilities as they fall due leading to interruption of supplies to the Trust, impacting on operational performance and resulting in reputational damage. It is therefore essential that good cash management disciplines are embedded to meet these challenges ahead.

A following actions are in place:

- Daily and monthly cash monitoring and forecasting of cash balances, including explanation of the key drivers of the reported and underlying cash position and sign off of cash forecast prior to submission to EFPB and FIC.
- Active daily cash management and forecasting on a rolling 12 month basis and submission of daily cash flow reports to Chief Financial Officer.
- Actively chasing debtors and optimising working capital management to facilitate timely payments.
- Bi-weekly reporting of capital position to Cash Committee.
- Escalation through Cash Committee to EFPB, Financial Investment Committee and Trust Board.
- Implementation of the Trust's Financial Improvement Plan in relation to cash management
- Working capital management and reporting, including review of key performance target indicators, metrics and dashboard.

The cash position is forecast to reduce in 2022/23 to £82.3m at 31 March 2023, as a consequence primarily of the impact of 2021/22 capex cash spend in 22/23.

Working Capital

	Total	0 to 30 days	31 to 60 days	61 to 90 days	Over 90 days	Percentage over 90 days
May 2022	£000	£000	£000	£000	£000	%
Non-NHS receivables	9,760	2,874	904	1,410	4,572	47%
NHS receivables	3,755	2,159	68	1,154	510	14%
Total receivables	13,515	5,033	836	2,564	5,082	38%
Non-NHS payables	27,576	10,128	8,916	4,348	4,184	15%
NHS payables	4,607	1,996	643	461	1,507	33%
Total payables	32,183	12,124	9,559	4,809	5,691	18%

April 2022	£000	£000	£000	£000	£000	%
Non-NHS receivables	9,611	1,472	2,365	1,433	4,341	45%
NHS receivables	2,118	340	1,221	215	342	16%
Total receivables	11,729	1,812	3,586	1,648	4,683	40%
Bad debt provision	13,847					
Non-NHS payables	39,149	24,386	9,089	2,862	2,812	7%
NHS payables	4,941	2,921	508	627	885	18%
Total payables	44,090	27,307	9,597	3,489	3,697	8%

Target	Feb-22	Mar-22	Apr-22	May-22
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BPPC (cumulative)

Value %	95%	94%	94%	95%	94%
Volume %	95%	93%	93%	94%	94%

BPPC (SMEs) paid within 30 days

Value %	100%	60%	72%	59%	58%
Volume %	100%	69%	63%	59%	54%

Aged Debt (Sales Ledger) Sales Ledger Receivables

Sales Ledger Receivables

Overall sales ledger debt Increased by £1.8m. This was predominantly due to a an additional £1.4m due from Leicester Partnership NHS Trust. Over 90 day debt has increased by £0.4m in May.

Purchase Ledger Payables

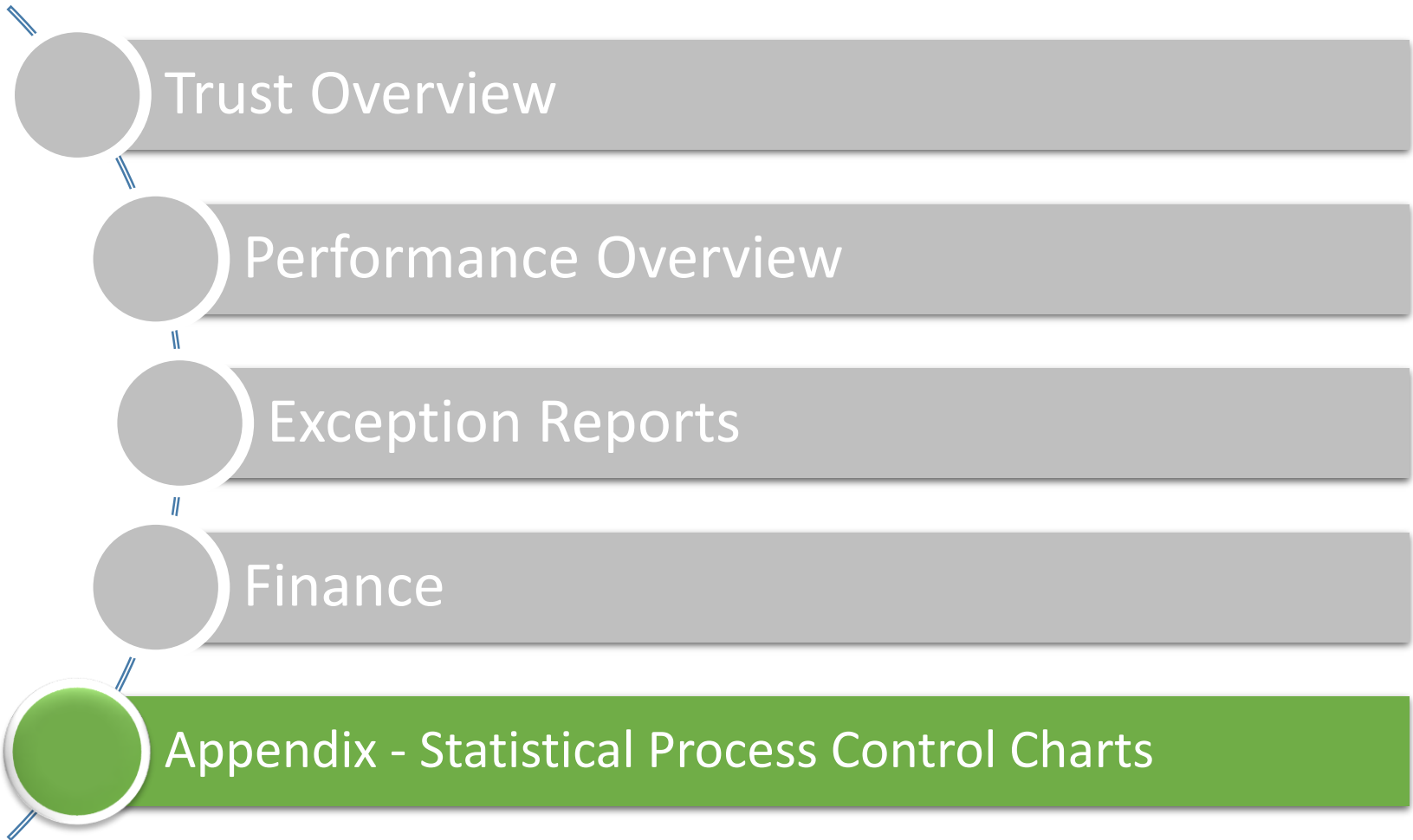
In month trade payables reduced by £11.9m.

BPPC

The month 2 performance was 94% for value and 94% for volume of invoices processed, against the target of 95%.

In line with other NHS trusts, all suppliers are being moved onto standard payment terms of 30 days (unless agreed as an exception) as we move into “business as usual.” As a consequence we will no longer be reporting on SMEs paid within 5 days, as this measure was specifically to ease the pressures of Covid-19 for smaller suppliers.

The Trust has implemented a ‘No PO, No Pay Policy’ from 1st April 2022, one of the aims of which is to strengthen financial controls and improve the efficiency of the purchase to pay process, supported by the use of a more automated 3 way matching process. The objectives of the improvement plan reflect the current challenges of the whole purchase to pay process, especially in the invoice processing stages.



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.

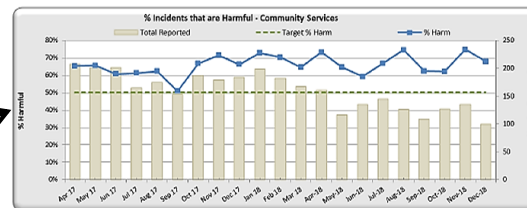
- Two horizontal lines either side of the Mean-(called the upper and lower control limits).

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

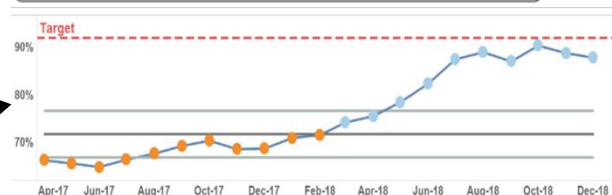
- A horizontal line showing the Target.

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

