

Meeting title:	Trust Board	Public Trust Board paper F			
Date of the meeting:	14 March 2024				
Title:	Integrated Performance Report and Executive Summary				
Report presented by:	Lead Executive Directors: Chief Operating Officer, Chief Nurse, Medical Director, Chief Financial Officer, Chief People Officer				
Report written by:	Sarah Taylor, Deputy COO Emergency Care and Kully Kaur, Assistant Director of BI and Information				
Action – this paper is for:	Decision/Approval		Assurance	X	Update
Where this report has been discussed previously					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
Yes, please refer to BAF

Impact assessment

Acronyms used

Purpose of the Report

This report complements the full Integrated Performance Report (IPR) 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.

The executive summary is split into 3 parts

1. Pathways updates for Urgent and Emergency Care, Elective, Cancer, and Maternity
2. Updates on Quality, Finance and Workforce
3. Update on transformation and productivity

Recommendation

The full IPR, encompassing all exception reports will be created for public access. A streamlined version of this report will be provided to the Board for the purpose of oversight after confirmation from Exec leads.

Any forthcoming changes to the IPR can be integrated using the change control process.

There have been discussions on presenting pathway analysis to Board to highlight the dependencies across metrics to deliver the pathway, this approach will be piloted with the emergency care pathway.

Summary



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.




Main report detail


Key headlines in performance are summarised below:

Summary of UHL Performance: JANUARY 2024

Arrow Indication indicates the director of performance. Colour is a subjective assessment of performance against standards and expectations

<p>Urgent & Emergency Care</p> <p>Updates on Flow in Flow through Flow out</p> 	<p>In January, UHL only ED 4-hour performance was 56.8% with an LLR performance of 73.55% this meant that UHL ranked 40th out of 124 Acute Trusts based on its acute footprint. The National average in England was 70.3%. 20 out of the 124 Acute Trusts achieved the target. UHL ranked 7th out of 17 trusts in its peer group. The best value out of the Peer Trusts was 79.4% and the worst value was 57.2%.</p> <p>12-hour performance ranks UHL 121st out of 122 Major A&E NHS Trusts. 11 out of the 122 Trusts achieved the target. The best value nationally was 0 and the worst value was 2,453. UHL ranked 17th out of 18 trusts in its peer group. This is a key measure of flow from ED and a focus area for the team.</p> <p>Ambulance performance saw a loss of 1460 hrs over 60 minutes at the LRI which means we ranked 21st out of 23 sites in the East Midlands.</p> <p>Discharge challenges remain specifically with P2 capacity, and we continue to see an increase in the number of simple discharges.</p> <p>Additional actions being taken to address the current challenges in January and February:</p> <ul style="list-style-type: none"> • Opening of additional community capacity in Loughborough and Coalville – 34 beds • Additional UTC capacity in Oadby and Merlin Vaz • Block booking of ambulances to increase capacity and prevent re-beds • Consistent allocation to one over beds in LPT
<p>Elective Care</p> <p>Referrals and Outpatient performance Elective activity Pathway Improvements</p> 	<p>The overall size of the waiting list is not reducing as planned, the main reason for this is due to the loss of activity over the Christmas period and the cumulative impact of industrial action. The validation of the waiting list remains high with over 85% of patients at 12 weeks or greater having been validated with the last 12 weeks. Therefore, we can be confident that the waiting list is as accurate as it can be. Work is being undertaken with system colleagues and will be reported through Planned Care Partnership board to understand where demand is coming from.</p> <p>Despite the above, we are seeing a reduction in waits for those waiting the longest on elective pathways with reductions on plan for both 52 and 65 week waits. However, the most recent industrial action planned for February will</p>

	<p>impact on ability to reach zero 65wws by the end of March. The trajectory is showing this will be circa 200 patients waiting 65weeks plus at the end of March 24. The Industrial Actions has also had a disproportionate impact on those waiting the longest i.e., 78 weeks plus, this is because primarily this cohort of patients are complex in nature and often the consultant in charge of care often has a large cancer backlog also and rightly cancer is prioritised first before long waits. It is still anticipated to be at zero 78 week waits by the end of March.</p> <p>Theatre utilisation has remained static, at the next theatre productivity board there will be a relook at what actions have been taken and what else must be done to get above the 80% mark.</p>
<p>Cancer</p> <p>Referrals 2 week wait Faster Diagnosis Standard 62-day referral to treatment</p> 	<p>>62 day backlog is ahead of trajectory prior to further industrial action. The 62 day backlog remains on track to deliver the Trust's fair share commitment of no more than 309 patients waiting by March 24.</p> <p>Referrals remain 7% YTD above 2022. 1st appointments offered within 7 days has increased in month to support FDS. 28 days Faster Diagnosis Standard continues to achieve and is forecast to deliver the standard by March 24.</p> <p>Recovery plans focus on time to first seen, FDS and 62 day backlog reductions. Whilst focus on backlog continues 62 day performance will be constrained. 31 day performance is constrained particularly within radiotherapy. Mitigations are in place to reduce the waits in radiotherapy and ongoing work to review opportunities in Oncology.</p>
<p>Quality</p> 	<p>We saw significant and sustained operational pressures across the emergency care pathway in January. Whilst overcrowding across the medicine and cardiorespiratory pathways will have compromised experience and timely care the performance across key metrics remains consistent.</p> <p>We continue to focus on good infection control practice and the reduction of hospital associated pressure damage. Timely response to complaints continues to improve with the introduction of the new PALS service.</p>
<p>Finance</p> 	<p>Year to date, the Trust has a deficit of £57m which is £5.9m worse than forecast mainly due to UEC pathway (£4.1mA), net expenditure pressures greater than forecast (£2.1mA) and other small variances of £0.3mF.</p> <p>CIP delivery is currently behind plan, YTD the Trust has delivered £41.2m against a plan of £44.4m. Of this delivery, £19.8m is recurrent and £21.4m non recurrent.</p> <p>The Trust committed gross expenditure of £63.9m in the year to 31st January, which nets down to £58m, after deducting charitable donations and the net book value of assets disposed/transferred, which £3.8m ahead of forecast.</p> <p>The cash position at the end of January was £23.2m, representing an increase of £3.4m on the previous month. The Trust is projecting a cash surplus of +£15.8m for 31 March 2024, based on delivery of the forecast I&E deficit.</p>

<p>Workforce</p> 	<p>Our turnover and vacancies in Adult Nursing, Midwifery and Maternity Care Assistants, continues with the improved position.</p> <p>Adult Nursing vacancies continue to reduce and are now at 2.7% which is the lowest position across 2023 / 24.</p> <p>HCSW vacancies remain stable at 14% with ongoing recruitment in place. The review of the HCSW grading is anticipated to support recruitment and retention moving forward.</p> <p>Sickness absence rates have remained static, and the current levels are not outwith the seasonal fluctuations we would expect.</p> <p>Appraisals have seen a slight decline (1.1%) this month and, as explained in the exception report, this is an area of focus for CMGs with monthly review through CMG Boards and Performance Review Meetings.</p> <p>Staff compliant with statutory and mandatory training has remained stable at 93% which is under the KPI. This is not considered to be significant and is a known consequence of recent operational pressures.</p> <p>An amber rating remains in place and KPIs continue to be monitored through Trust Performance Review meetings.</p>
<p>Transformation & Productivity</p> <p>Key Overview</p> <p>e.g Urgent and Emergency Care, Elective, digital, Estates etc</p>	<p><u>Elective Care</u></p> <ul style="list-style-type: none"> • Work continues to deliver PIFU across the Trust with a sustained improvement to now 4.3% against the national target of 5% and exceeding our local target of 3.5%. Increased uptake on digital PIFU remains the focus across all specialties. The focus for the next two months will be targeted work with specialties that could offer more PIFU to reach 5% • The rollout of Accurx for two way text messaging is nearing its completion with only three areas left to switch. Initial indications for January show this may have had a 0.9% positive impact on the DNA rate • Standardised validation process is now embedded as BAU and UHL are almost at the national target • New ways in preparing patients for appointments and diagnostic procedures is in pilot stages to avoid OTDC and DNAs • Successful award of HTAAF monies to accelerate MY Pre Op to deliver effective Pre Operative Assessment with rollout starting this month across Paediatrics, Ophthalmology and cardiology

Supporting documentation

The Integrated performance report contains further detail including exception reports of indicators which are not currently achieving targets.

The key changes to the IPR are:

- Removed executive highlight report this will be covered in the front sheet
- Removed highlight reports from metric pages
- Updated metrics to reflect changes requested

- Added in activity position (page 15)
- Highlight reports removed 3 month forecasting
- Highlight reports will only be required for those off track
- Removed explanation of SPC charts at the end

In the IPR there is a combination of national and locally agreed targets. For the locally agreed targets we will document the rationale for future reference.

The following metrics are part of the National KPIs that we do not report in the IPR. We are in the process of seeking clarification from Exec leads regarding where these metrics are reported or if there is a need to incorporate them within the IPR.

No.	NHS Oversight Framework national mandated KPIs
1	Proportion of patients discharged from hospital to their usual place of residence
2	Available virtual ward capacity per 100k head of population
3	National Patient Safety Alerts not completed by deadline
4	Potential under-reporting of patient safety incidents
5	Overall CQC rating
6	Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities
7	Proportion of acute or maternity inpatient settings offering smoking cessation services
8	Proportion of patients who have a first consultation in a post-covid service within six weeks of referral
9	Proportion of people over 65 receiving a seasonal flu vaccination
10	Acting to improve safety - safety culture theme in the NHS staff survey
11	CQC well-led rating
12	Aggregate score for NHS staff survey questions that measure perception of leadership culture
13	Staff survey engagement theme score
14	Staff survey bullying and harassment score
15	Proportion of staff in senior leadership roles who are from a) a BME background or b) are women

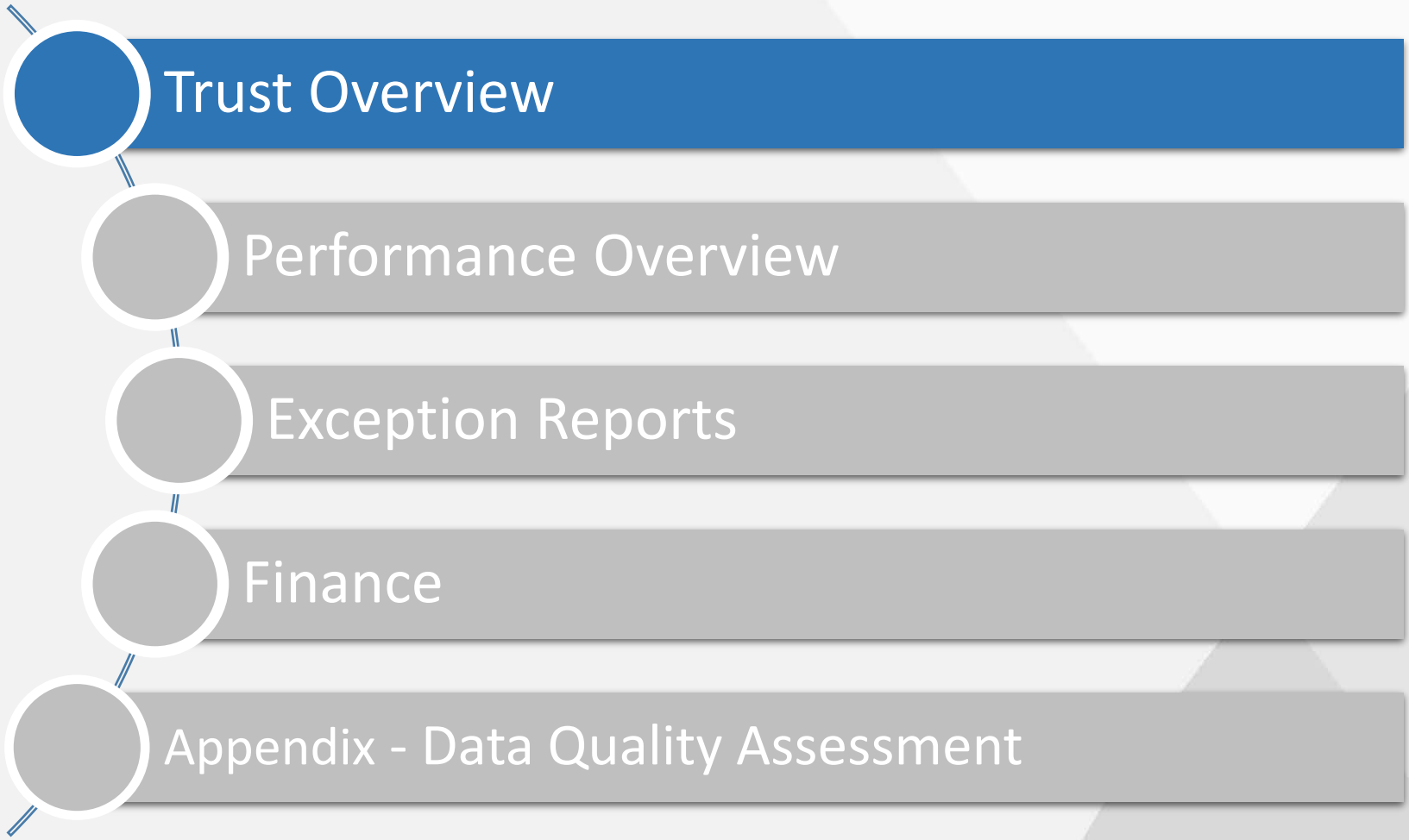
Integrated Performance Report

January 2024

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- Performance Overview
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- Finance
- Appendix - Data Quality Assessment



Trust Overview (Year to Date)

Safe	Caring	Well Led	Effective	Responsive Emergency Care	Responsive Elective Care	Responsive Cancer Care	Finance
Never Events	Single Sex Breaches	Turnover Rate	Mortality Published SHMI	ED 4 Hour Waits LLR	RTT Incompletes	28 Day FDS	Trust level control level performance
Clostridium Difficile	Inpatient and Day Case F&F Test % Positive	Sickness Absence (Excludes E&F staff)	Mortality 12 months HSMR	ED 4 Hour Waits UHL	RTT 52+ Weeks	31 Day Combined	Capital expenditure against plan
MRSA Total	A&E F&F Test % Positive	% of Staff with Annual Appraisal (Excludes E&F staff)	Crude Mortality Rate	Mean Time to Initial Assessment	RTT 65+ Weeks	62 Day Backlog	Cost Improvement (Includes Productivity)
MSSA Acute	% Complaints - 25 Days	Statutory and Mandatory Training	DNA Rate - IMD Deciles 1 and 2	12 Hour Trolley Waits in A&E	RTT 78+ Weeks	62 Day Combined	Cashflow
All Falls Reported per 1000 Bed Days	% Complaints - 60 Days	Adult Nursing Vacancies	DNA Rate - IMD Deciles 3 and 10	12 Hour Waits in Department	6 Week Diagnostic		Aged Debt
Moderate Harm and Above per 1000 Bed Days		Paed Nursing Vacancies	Gestation at Booking 71+ days, IMD Deciles 1 and 2	Ambulance Handovers	Theatre Utilisation		Invoices paid within 30 days (value)
HAPU - All categories per 1000 bed days		Midwives Vacancies	Gestation at Booking 71+ days, IMD Deciles 9 and 10	Ambulance Handover > 60 mins	PIFU		Invoices paid within 30 days (volume)
VTE Assessment		HCA Vacancies - excluding Maternity	Gestation at Booking 71+ days, White British	% Ambulance Handover > 60 mins	% Outpatient DNA Rate		
		HCA Vacancies - Maternity	Gestation at Booking 71+ days, Black African or Black Caribbean	Total Lost Ambulance Hours	% Outpatient Non Face to Face		
			Gestation at Booking 71+ days, Asian Indian, Bangladeshi or Pakistani	P1 & P2 Patients Waiting >24 Hrs for Discharge			
				Trust Bed Occupancy			
				Long Stay Patients > 21 days			

Trust Overview (Current Month)

Safe	Caring	Well Led	Effective	Responsive Emergency Care	Responsive Elective Care	Responsive Cancer Care	Finance
Never Events	Single Sex Breaches	Turnover Rate	Mortality Published SHMI	ED 4 Hour Waits LLR	RTT Incompletes	28 Day FDS	Trust level control level performance
Clostridium Difficile	Inpatient and Day Case F&F Test % Positive	Sickness Absence (Excludes E&F staff)	Mortality 12 months HSMR	ED 4 Hour Waits UHL	RTT 52+ Weeks	31 Day Combined	Capital expenditure against plan
MRSA Total	A&E F&F Test % Positive	% of Staff with Annual Appraisal (Excludes E&F staff)	Crude Mortality Rate	Mean Time to Initial Assessment	RTT 65+ Weeks	62 Day Backlog	Cost Improvement (Includes Productivity)
MSSA Acute	% Complaints - 25 Days	Statutory and Mandatory Training	DNA Rate - IMD Deciles 1 and 2	12 Hour Trolley Waits in A&E	RTT 78+ Weeks	62 Day Combined	Cashflow
All Falls Reported per 1000 Bed Days	% Complaints - 60 Days	Adult Nursing Vacancies	DNA Rate - IMD Deciles 3 and 10	12 Hour Waits in Department	6 Week Diagnostic		Aged Debt
Moderate Harm and Above per 1000 Bed Days		Paed Nursing Vacancies	Gestation at Booking 71+ days, IMD Deciles 1 and 2	Ambulance Handovers	Theatre Utilisation		Invoices paid within 30 days (value)
HAPU - All categories per 1000 bed days		Midwives Vacancies	Gestation at Booking 71+ days, IMD Deciles 9 and 10	Ambulance Handover > 60 mins	PIFU		Invoices paid within 30 days (volume)
VTE Assessment		HCA Vacancies - excluding Maternity	Gestation at Booking 71+ days, White British	% Ambulance Handover > 60 mins	% Outpatient DNA Rate		
		HCA Vacancies - Maternity	Gestation at Booking 71+ days, Black African or Black Caribbean	Total Lost Ambulance Hours	% Outpatient Non Face to Face		
			Gestation at Booking 71+ days, Asian Indian, Bangladeshi or Pakistani	P1 & P2 Patients Waiting >24 Hrs for Discharge			
				Trust Bed Occupancy			
				Long Stay Patients > 21 days			



Performance Overview (Safe)

Domain	Key Performance Indicator	Target	Nov-23	Dec-23	Jan-24	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Safe	Never events	0	0	0	0	3				Nov-22	National	Chief Nurse and Medical Director
	Clostridium Difficile per 100,000 Bed Days	92 cases per year	13.4	10.8	19.5	20.1				Jun-21	Local	Chief Nurse and Medical Director
	Methicillin Resistant Staphylococcus Aureus Total	0	2	2	0	5				Jun-21	Local	Chief Nurse and Medical Director
	Methicillin-susceptible Staphylococcus Aureus Acute	40	1	3	6	35				Jun-21	Local	Chief Nurse and Medical Director
	All falls reported per 1000 bed days	5.5	2.3	2.8		3.0				Aug-22	Local	Chief Nurse and Medical Director
	Rate of Moderate harm and above Falls Patient Safety Incidents with finally approved status per 1,000 bed days	0.19	0.07	0.04		0.06				Aug-22	Local	Chief Nurse and Medical Director
	Hospital Acquired Pressure Ulcers - All categories per 1000 bed days	1.9	2.8	2.4	2.2	2.3				Jun-21	Local	Chief Nurse and Medical Director
	% of all adults Venous Thromboembolism Risk Assessment on Admission	95%	96.4%	96.8%	97.0%	97.1%				Oct-21	National	Chief Nurse and Medical Director

Performance Overview (Caring)

Domain	Key Performance Indicator	Target	Nov-23	Dec-23	Jan-24	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Caring	Single Sex Breaches		40	32	21	149				Jul-22	Local	Chief Nurse and Medical Director
	Inpatient and Day Case Friends & Family Test % Positive*	95%	97%	96%	97%	97%				Jul-22	Local	Chief Nurse and Medical Director
	A&E Friends & Family Test % Positive**	77%	76%	81%	83%	82%				Jul-22	Local	Chief Nurse and Medical Director
	% Complaints Responded to in Agreed Timeframe - 25 Working days	95%	63.2%	78.8%		62%				Jul-23	Local	Chief Nurse and Medical Director
	% Complaints Responded to in Agreed Timeframe - 60 Working days	95%	100%			72%				Jul-23	Local	Chief Nurse and Medical Director

Performance Overview (Well Led)

Domain	Key Performance Indicator	Target	Nov-23	Dec-23	Jan-24	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Well Led	Turnover Rate	10%	6.6%	6.6%	6.5%					Aug-22	Local	Chief People Officer
	Sickness Absence (Excludes Estates & Facilities staff)	3%	5.3%	5.3%		4.9%				Feb-24	Local	Chief People Officer
	% of Staff with Annual Appraisal	95%	82.4%	83.0%	81.9%					Feb-24	Local	Chief People Officer
	Statutory and Mandatory Training	95%	93%	93%	93%					Dec-22	Local	Chief People Officer
	Adult Nursing Vacancies	10%	4.2%	5.1%	2.7%					Dec-23	Local	Chief People Officer
	Paed Nursing Vacancies	10%	14.3%	13.9%	14.1%					Dec-23	Local	Chief People Officer
	Midwives Vacancies	10%	9.1%	9.7%	8.5%					Dec-23	Local	Chief People Officer
	Health Care Assistants and Support Workers Vacancies - excluding Maternity	10%	15.2%	15.4%	14.0%					Dec-23	Local	Chief People Officer
	Health Care Assistants and Support Workers Vacancies - Maternity	5%	4.4%	4.3%	0.7%					Dec-23	Local	Chief People Officer

Performance Overview (Effective)

Domain	Key Performance Indicator	Target	Nov-23	Dec-23	Jan-24	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Effective	Published Summary Hospital-level Mortality Indicator (SHMI)	100	103	102	102	102 Oct 22 to Sep 23)	Assurance and variance not applicable			May-21	Local	Chief Nurse and Medical Director
	12 months Hospital Standardised Mortality Ratio (HSMR)	100	99	98	98	98 Nov 22 to Oct 23	Assurance and variance not applicable			May-21	Local	Chief Nurse and Medical Director
	Crude Mortality Rate		0.9%	1.3%	1.2%	1.1%				May-21	Local	Chief Nurse and Medical Director
	DNA Rate - IMD Deciles 1 and 2	5%	11.0%	10.7%	10.4%	10.8%				TBC	Local	Director of Health Inequality and Inclusion
	DNA Rate - IMD Deciles 3 - 10	5%	6.8%	6.9%	6.0%	6.7%				TBC	Local	Director of Health Inequality and Inclusion
	Gestation at Booking 71+ days, IMD Deciles 1 and 2		34.0%	37.0%	34.0%	35.3%				TBC	Local	Director of Health Inequality and Inclusion
	Gestation at Booking 71+ days, IMD Deciles 9 and 10		32.0%	30.0%	28.0%	26.1%				TBC	Local	Director of Health Inequality and Inclusion
	Gestation at Booking 71+ days, White British		21.0%	21.0%	27.0%	23.6%				TBC	Local	Director of Health Inequality and Inclusion
	Gestation at Booking 71+ days, Black African or Black Caribbean		50.0%	56.0%	57.0%	51.1%				TBC	Local	Director of Health Inequality and Inclusion
	Gestation at Booking 71+ days, Asian Indian, Bangladeshi or Pakistani		33.0%	29.0%	39.0%	32.3%				TBC	Local	Director of Health Inequality and Inclusion

Performance Overview (Responsive Emergency Care)

Responsive (Emergency Care)

Domain	Key Performance Indicator	Target	Nov-23	Dec-23	Jan-24	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Emergency Care)	Emergency Department 4 hour waits LLR	76%	68.3%	73.3%	73.5%	72.2%				Mar-23	National	Chief Operating Officer
	Emergency Department 4 hour waits UHL	76%	51.9%	57.7%	56.8%	57.1%				Apr-23	National	Chief Operating Officer
	Mean Time to Initial Assessment	15	32.5	29.6	34.8	25.2				Nov-22	National	Chief Operating Officer
	12 hour trolley waits in Emergency Department (DTA)	0	1,387	1,167	1,625	11,112				Mar-23	National	Chief Operating Officer
	Number of 12 hour waits in the Emergency Department	0	3,269	2,734	3,316	25,550				Mar-23	National	Chief Operating Officer
	Number of Ambulance Handovers		4,943	4,836	4,889	47,183				Data sourced externally	Local	Chief Operating Officer
	Number of Ambulance Handovers >60 Mins	48	1034	899	1460	5627				Data sourced externally	Local	Chief Operating Officer
	Percentage of Ambulance Handovers >60 Mins	1%	20.9%	18.6%	29.9%	11.9%				Data sourced externally	Local	Chief Operating Officer
	Total lost Ambulance Hours	40 per day	2910	3114	4732	18756				Data sourced externally	Local	Chief Operating Officer
	Number of patients waiting greater than 24 hours for discharge P1, P2		79	79	65		Awaiting more data for assurance and variance			Data sourced externally	Local	Chief Operating Officer
	Trust Bed Occupancy	92%	95.3%	91.5%	91.5%					Dec-23	National	Chief Operating Officer
	Long Stay Patients (21+ days) as a % of G&A Bed Occupancy	12%	13.5%	14.5%	14.7%					Apr-23	Local	Chief Operating Officer

Performance Overview (Responsive Elective Care)

Responsive (Elective Care)

Domain	Key Performance Indicator	Target	Nov-23	Dec-23	Jan-24	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Elective Care)	Referral to Treatment Incompletes	103,733	108,433	109,275	108,646					Jun-23	Local	Chief Operating Officer
	Referral to Treatment 52+ weeks	0 by Mar25	4,598	4,286	3,743					Jun-23	National	Chief Operating Officer
	Referral to Treatment 65+ weeks	0 by Mar24	958	954	802					Jun-23	National	Chief Operating Officer
	Referral to Treatment 78+ weeks	0	80	65	63					Jun-23	National	Chief Operating Officer
	6 Week Diagnostic Test Waiting Times	15%	24.8%	27.8%	29.8%					Jul-23	National	Chief Operating Officer
	Theatre Utilisation	85.0%	73.6%	75.2%	75.0%	75.1%				Dec-23	National	Chief Operating Officer
	PIFU	3.5%	4.2%	4.2%	4.1%	3.0%				Oct-23	Local	Chief Operating Officer
	% Outpatient Did Not Attend rate	5%	7.8%	7.9%	7.0%	7.7%				Apr-23	Local	Chief Operating Officer
	% Outpatient Non Face to Face	25%	28.6%	30.1%	27.6%	29.6%				Apr-23	National	Chief Operating Officer

Note: RTT long waiter indicators are RAG rated based on trajectories

Performance Overview (Responsive Cancer)

Domain	Key Performance Indicator	Target	Nov-23	Dec-23	Jan-24	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Cancer)	28 Day Faster Diagnosis Standard	75%	77.4%	80.8%		74.1%				Feb-23	National	Chief Operating Officer
	Cancer 31 Day Combined	96%	80.4%	77.7%		79.0%				TBC	National	Chief Operating Officer
	62 Day Backlog	309	343	376	351					Feb-23	Local	Chief Operating Officer
	Cancer 62 Day Combined	85%	60.0%	58.6%		54.5%				Feb-23	National	Chief Operating Officer

Performance Overview (Finance)

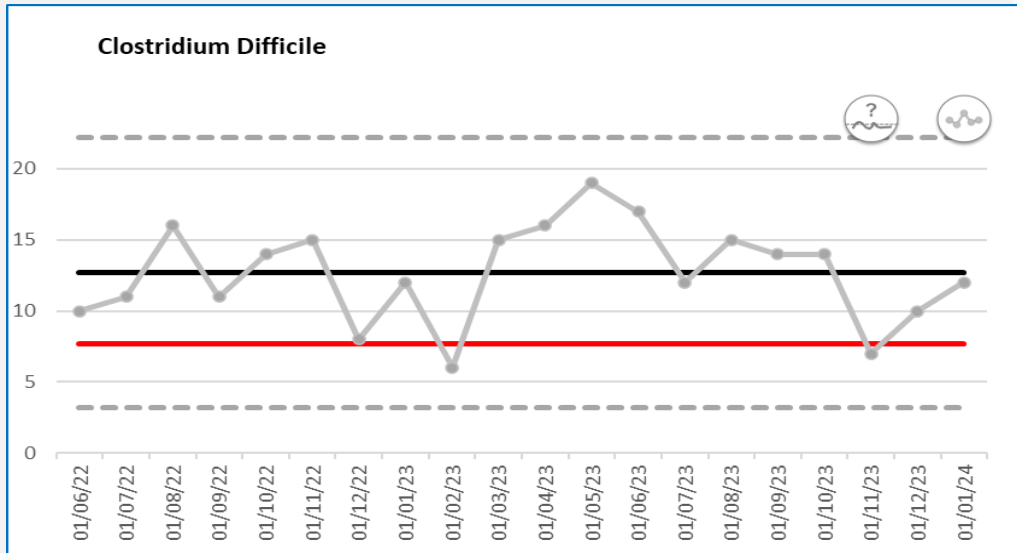
Domain	Key Performance Indicator	Target YTD	Nov-23	Dec-23	Jan-24	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Finance	Trust level control level performance	-£51.1m	£3.8m	-£6.5m	-£9.7m	-£57.0m				Jun-22	Chief Financial Officer
	Capital expenditure against plan	£75.5m	£10.7m	£9.1m	£6.9m	£58m				Jun-22	Chief Financial Officer
	Cost Improvement (Includes Productivity)	£44.4m	£6m	£5.1m	£10.7m	£41.2m				Dec-23	Chief Financial Officer
	Cashflow	No Target	-£12.1	-£4.2m	£3.4m	£23.2m				Jun-22	Chief Financial Officer
	Aged Debt	No Target	£18.7	£16.8	£16.6m	£16.6m				Feb-24	Chief Financial Officer
	Invoices paid within 30 days (value)	95%	95%	95%	94%					Feb-24	Chief Financial Officer
	Invoices paid within 30 days (volume)	95%	96%	96%	94%					Feb-24	Chief Financial Officer

Performance Overview (Activity)

Domain	Activity Type	Plan 23/24	Plan in Month (M10)	Activity In Month (M10)	Variance In Month (M10)	Plan YTD	Actual YTD	Variance YTD	YTD Variance to 19/20
Activity	New Outpatients (inc. NFTF)	365,686	20,732	21,563	831	210,062	206,509	-3,553	-20,171
	Follow Up Outpatients (inc. NFTF)	329,270	54,669	51,309	-3,360	532,534	448,709	-83,825	-57,876
	Outpatient Procedures	349,214	13,383	15,423	2,040	128,950	133,271	4,320	2,635
	Daycase	108,635	9,492	10,290	798	90,578	93,225	2,647	2,305
	Inpatient	19,625	1,739	1,673	-66	16,409	15,697	-712	-872
	Emergency	95,618	8,341	9,135	794	79,532	84,023	4,491	1,094
	Non Elective	22,578	1,919	1,896	-23	18,928	18,807	-121	248
	Emergency Department (inc. Eye Casualty)	259,693	22,059	22,453	394	216,811	221,844	5,033	4,024
	Diagnostic Imaging	161,689	14,086	15,217	1,131	135,362	144,826	9,464	6,737
	Other	11,573,486	970,310	935,273	-35,037	9,646,284	9,610,392	-35,892	2,274,312
	TOTAL	13,285,493	1,116,729	1,084,232	-32,497	11,075,450	10,977,302	-98,148	2,212,435



Safe – Clostridium Difficile



Cases			Cases per 100,000 Bed Days		
Jan 24	YTD	Target	Jan 24	YTD	Target
12	136	92	19.5	20.1	

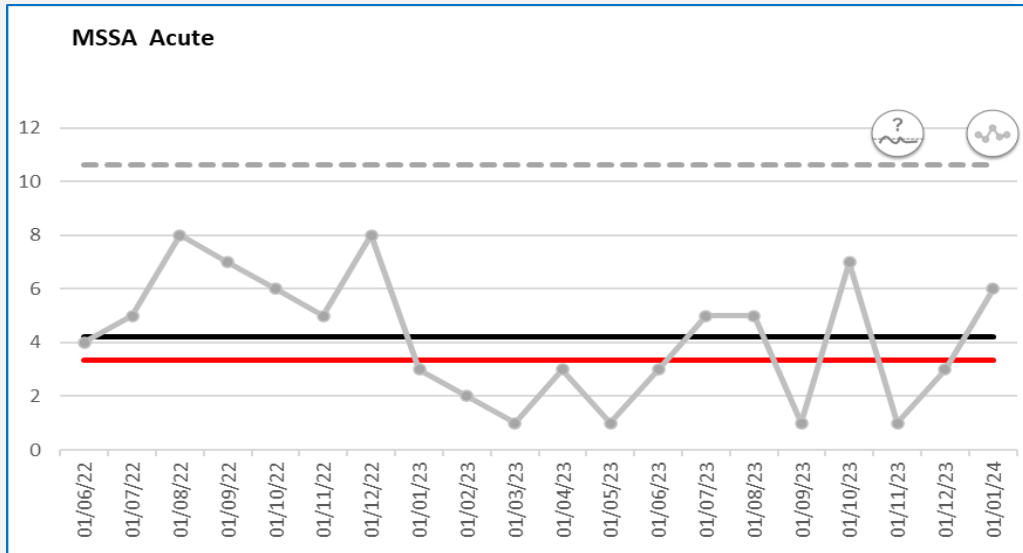
National Position & Overview

HOHA cases YTD = 88
 COHA cases YTD = 48
 (HOHA & COHA) 23/24 = 136

**Note: 100,000 bed days data source: UKHSA*

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> There are no new themes to report with regard to the Root Cause of acquisition of CDI 	<ul style="list-style-type: none"> Focused attention on antimicrobial prescribing practice is on-going 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"> On-going focus and work stream within CMG Operational Groups

Safe – Methicillin-susceptible Staphylococcus Aureus Acute



Cases (HOHA/COHA)			Cases per 100,000 Bed Days		
Jan 24	YTD	Target	Jan 24	YTD	Target
6	52	40	4.06	6.77	

National Position & Overview

Thresholds are set by NHSE and outlined in the NHS-Standard-Contract-202324-Minimising-Clostridioides-difficile-and-Gram-negative-bloodstream-infection

There are no thresholds set for MSSA by NHSE, the threshold is set by UHL to monitor the number of cases.

MSSA Bacteraemia 23/24 Threshold is set by UHL for HOHA is 40

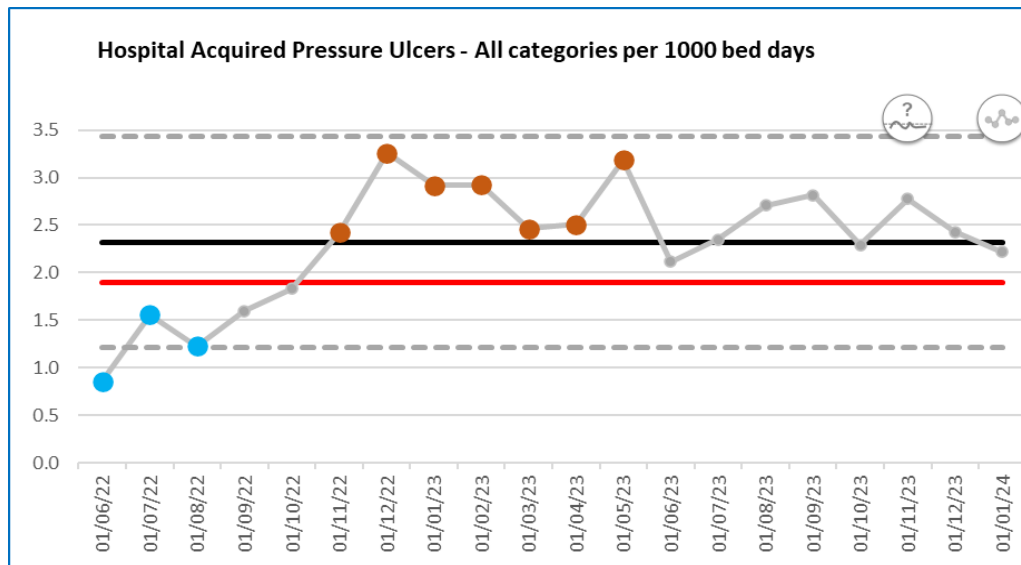
HOHA YTD = 31

COHA YTD = 21

**Note: 100,000 bed days data source: UKHSA*

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"> A PIR review of each MSSA case is undertaken Continue raising awareness, monitoring infection prevention practice Review Denominator data for blood cultures taken in comparison to MSSA positive cultures A thematic review of the years cases will be undertaken to identify any consistent themes 	<ul style="list-style-type: none"> Monitoring and review continues

Safe – Pressure Ulcers per 1,000 Bed days



Current Performance		
Jan 24	YTD	Target
2.2	2.3	1.9

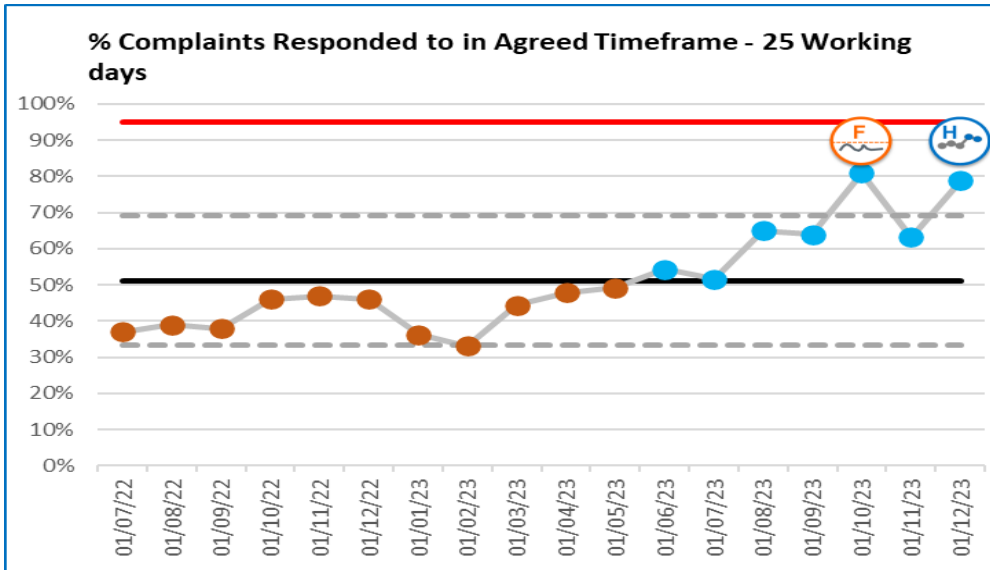
National Position & Overview

Benchmarking across different organisations suggest a similar picture in numbers and trend lines. This has been confirmed with an external report by Professor Mike Clarke from Birmingham City University.

Total HAPUs slightly down in January and moderate level harm remains low with 2 Cat 3 wounds in January and 0 cat 4 wounds since November.

Root Cause	Actions	Impact/Timescale
<p>Ongoing scrutiny continues with weekly validations chaired by the Deputy Chief Nurse, and monthly care review and learning meetings chaired by the CMG Heads of Nursing and teams.</p> <p>Contributing factors include:</p> <ul style="list-style-type: none"> - Incorrect categorisation - Initial recognition of risk and therefore escalation to appropriate interventions - Timely provision of care such as repositioning 	<p>Pioneer Phase 3 to be launched including Unstageable wound review and management</p> <p>Ongoing training including TV team training for debridement and ward level training for categorisation</p> <p>Continued work with QI team</p> <p>Quality meetings with HoNs continue to look at hot spot areas</p> <p>Ongoing national discussions regarding the National Wound Care Strategy Programme</p>	<p>New sessions launched</p> <p>TV team to be all trained by early Summer</p> <p>Fed back to PU steering group in February – further work being undertaken to widen this engagement</p> <p>Continue monthly</p> <p>For further discussions at the national wound care conference in March with UHL speakers and representation</p>

Caring – % Complaints Responded to in Agreed Timeframes

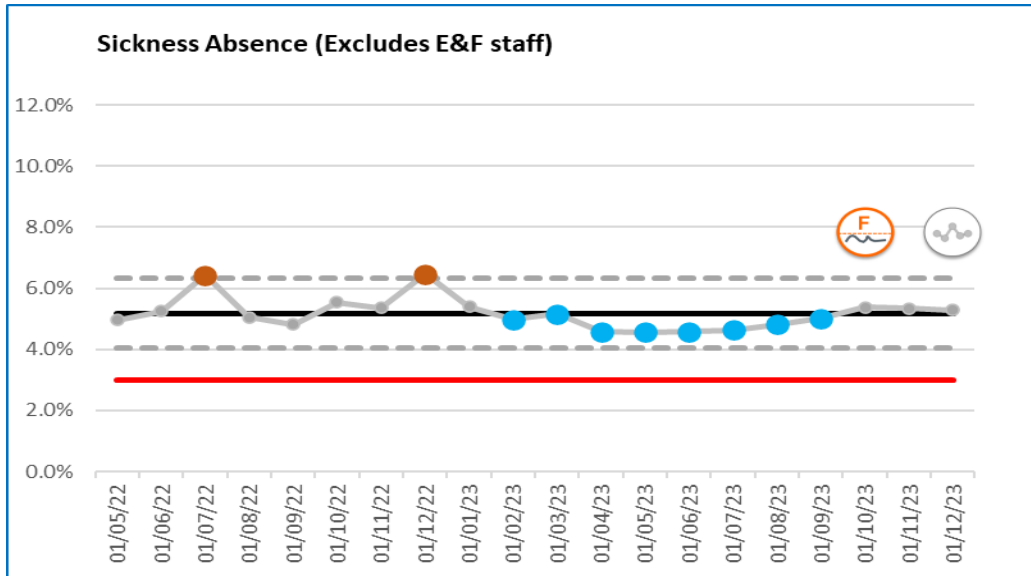


25 Working Days			60 Working Days		
Dec 23	YTD	Target	Nov 23	YTD	Target
79%	62%	95%	100%	74%	95%

National Position & Overview

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> A 10 working day response is now part of the PALS concerns process – new formal complaint responses will not be allocated this timescale going forwards 100% 60 working days for formal complaint responses was achieved in November 23 	<ul style="list-style-type: none"> Formal complaint responses will not be allocated 10 working days The PALS team will support with local resolution 	<ul style="list-style-type: none"> It is anticipated that the PALS concerns process will meet the 10 working day timescale The Complaints team will have greater capacity to achieve an improved KPI for 25 working day responses

Well Led – Sickness Absence (Excludes Estates & Facilities staff)



Current Performance		
Dec 23	YTD	Target
5.3%	4.9%	3%

National Position & Overview

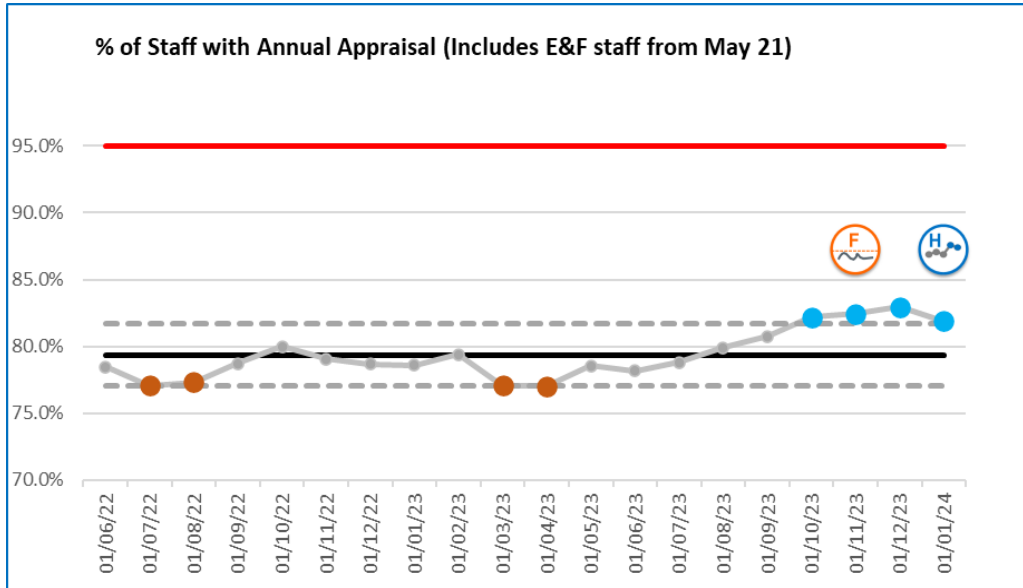
Peer data not available.

Sickness absence levels have been maintained at 5.3% in November and December 2023.

Estates and Facilities absence will be captured through ESR in the coming months.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> The top 3 reasons for sickness absence are anxiety/stress/depression, cold/cough/flu or other known reasons – not elsewhere classified. We expect to see increased seasonal cold, flu, COVID-19 and measles impacts during the January. Strike action is continuing to have an impact on staff absence and fatigue levels, with 6 days in January 2024 and a further 4 in February 2024. 	<ul style="list-style-type: none"> The person-centred approach to attendance and wellbeing was implemented in December 2022, and remains in place whilst the updated policy is finalized. Wellbeing conversations are encouraged to support colleagues alongside a number other wellbeing initiatives e.g. inner wellness webinars, menopause support, Steps4Health, financial wellbeing, Drinkaware. SMART absence reports are reviewed regularly in People Services to ensure robust action plans are in place, with particular focus on absences over 3, 6 and 10 months. The COVID-19 and Flu vaccinations have been promoted during December and January 2024. Advice and guidance has been provided on the management of measles. 	<ul style="list-style-type: none"> The new policy should be in place early in 2024. This will be supported with training, template letters and toolkit/guidance. The Trust is working alongside other Trusts regarding benchmarking and sharing best practice. The staff survey will be an indicator of the effectiveness of the 'winter wellbeing' approach implemented in 2023.

Well Led – % of Staff with Annual Appraisal



Current Performance		
Jan 24	YTD	Target
81.9%	-	95%

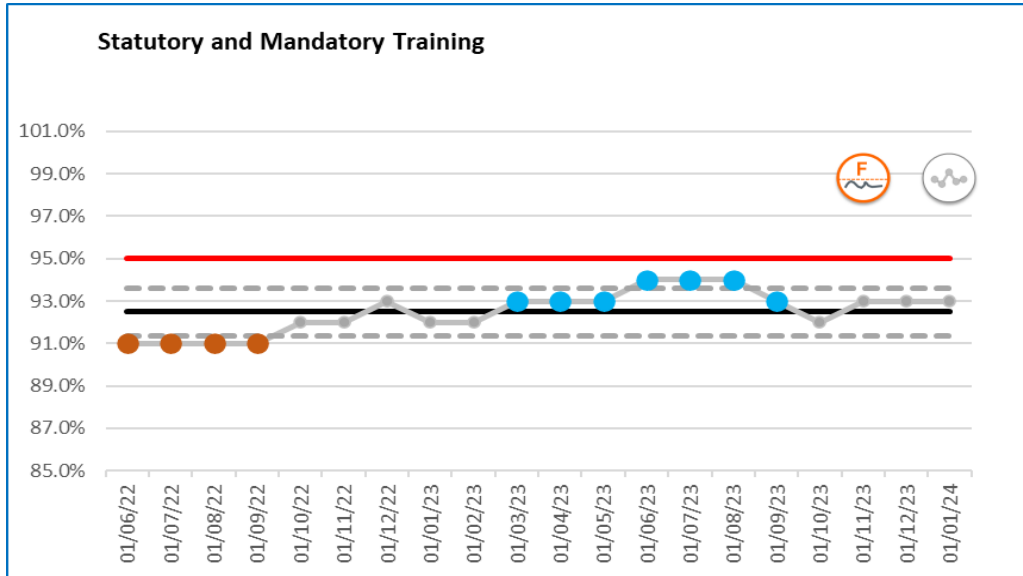
National Position & Overview

Peer data not available.

There has been a 1.05% deterioration in the Trust wide Appraisal performance. We are 13.1% away from the Trust target of 95%.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> A number of colleagues have had appraisals within the last 12 months, outside the reporting/incremental date and therefore show as non-compliant. Over the last year strike action will have impacted management time and the ability to undertake appraisals. There were 6 days of industrial action in January 2024 and to date the national pay dispute has not been resolved. 	<ul style="list-style-type: none"> It was acknowledged in recent exception reports that we would be unlikely to reach full compliance of 95% in the short term. From 2023, CMG reports are provided, highlighting performance and areas of focus, to enable targeted support and action. In month, the appraisal average for CMGs is 84.95%, a reduction of 1.42% and for Corporate Directorates, 69.8%, with an improvement of 0.52%. ITAPS is exceeding the Trust target and is currently at 95%; closely followed by RRCV at 93.4% There are two Corporate areas above 95%, being Finance and Procurement and the Transformation Team. Regular meetings with line managers are taking place at CMG level to review appraisal performance and any additional support required. 	<ul style="list-style-type: none"> Appraisals are reviewed through regular line management and Board oversight meetings. Appraisals are also monitored through the PRM monthly meetings.

Well Led – Statutory and Mandatory Training



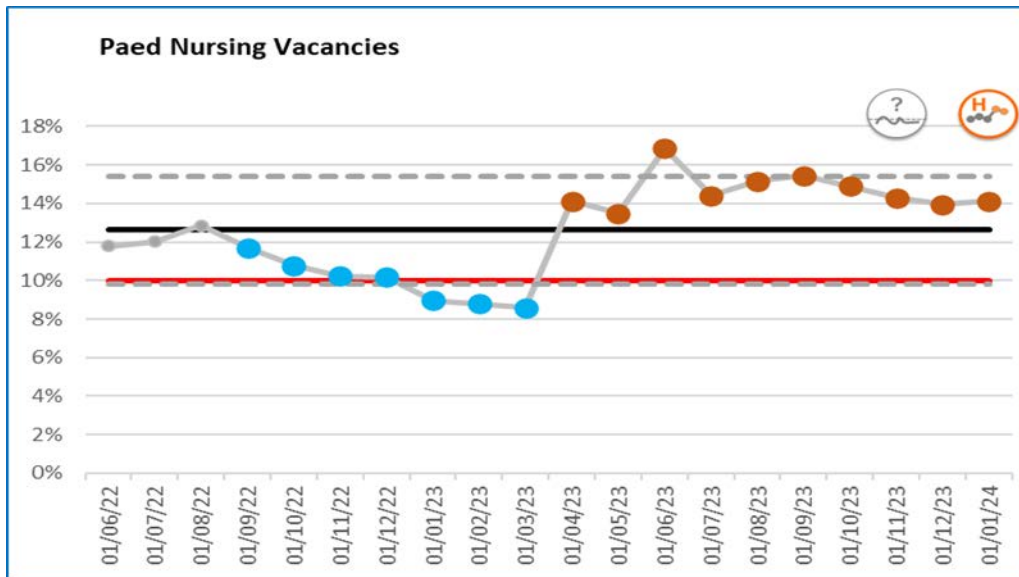
Current Performance		
Jan 24	YTD	Target
93%	-	95%

National Position & Overview

Peer data not available.

Root Cause	Actions	Impact/Timescale
<p>It is recognised that performance has been, and is being, affected by:</p> <ul style="list-style-type: none"> • Covid-19, Flu & related Staff Absence Levels • Operational pressures • Operational demand • Staffing Levels • Seasonal absences and demands 	<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 2400 relevant staff & more than 9,000 direct emails per month.</p> <p>Question based eLearning modules now on HELM for Fire Safety and Cyber Security.</p> <p>Booklets being updated and developed for certain staff, including Estates and Facilities Colleagues.</p> <p>Educational Review has started looking into the amount and quality of Mandatory and Essential 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 the financial year has been implemented with renewed chasing on non-compliant with organisational support.</p> <p>Review of ESR and HELM data alignment is ongoing. Challenges to this data alignment are under consistent scrutiny.</p>

Well Led – Paed Nursing Vacancies



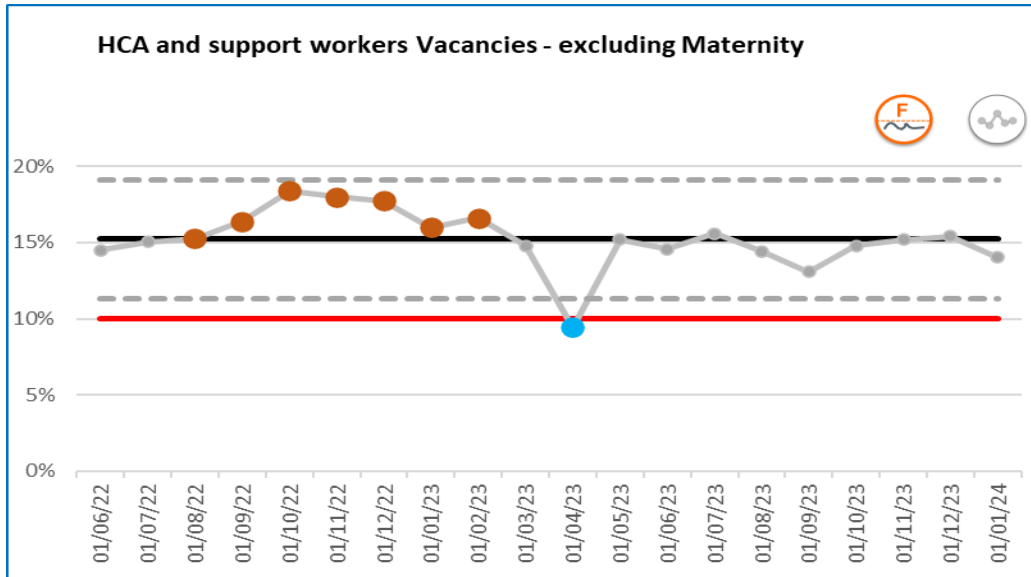
Current Performance		
Jan 24	YTD	Target
14.1%	-	10%

National Position & Overview

In June 2023 NHS Digital reported a national vacancy rate of 10.6% within the Registered Nursing staff group (Next data update Feb 2024)

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Underlying RN vacancies in Paediatric Emergency Department (PED) of 23.68wte. Slight decrease from Dec '23 (33% vacancy rate). PED have a higher proportion of Band 6 vacancies as opposed to Band 5 nurses. Retention of experienced nurses continues to be an area of focus in the children's hospital No significant areas of concern in terms of the number of leavers increasing Acuity continues to rise in the children's hospital and establishment modelling requires ongoing review in response to capacity and demand 	<ul style="list-style-type: none"> Ongoing & innovative recruitment advertisement across social media platforms to increase 'reach' and attendance at national recruitment fairs Nine-month rotation placements offered across the Childrens' Hospital, PED & NNU Enhanced focus on flexible working offer Childrens ED is supported by band 5/6 experienced nurses on rotation from Adult ED, looking to increase this initiative as the vacancies reduce in Adult ED Regular agency staff also are working in PED to support safe staffing levels. Continued utilisation of temporary workforce to support winter surge in Childrens Hospital 	<p>Paed ED</p> <ul style="list-style-type: none"> Children's ED had 1 Newly Qualified Nurse starting in January on a 9-month rotational post with the Childrens Hospital. All of our international nurses (IEN) have their pin numbers and in the final stages of completing their supernumerary periods. Two IENs band 6 nurses due to start in February. <p>Children's Hospital</p> <ul style="list-style-type: none"> Reduction in RN overall vacancies to 20.wte Recruitment to 3 new starters with 2 in pipeline due to commence in Q4 Rotational posts continue to be supported

Well Led – HCA and Support Workers Vacancies – excluding Maternity



Current Performance		
Jan 24	YTD	Target
14.0%	-	10%

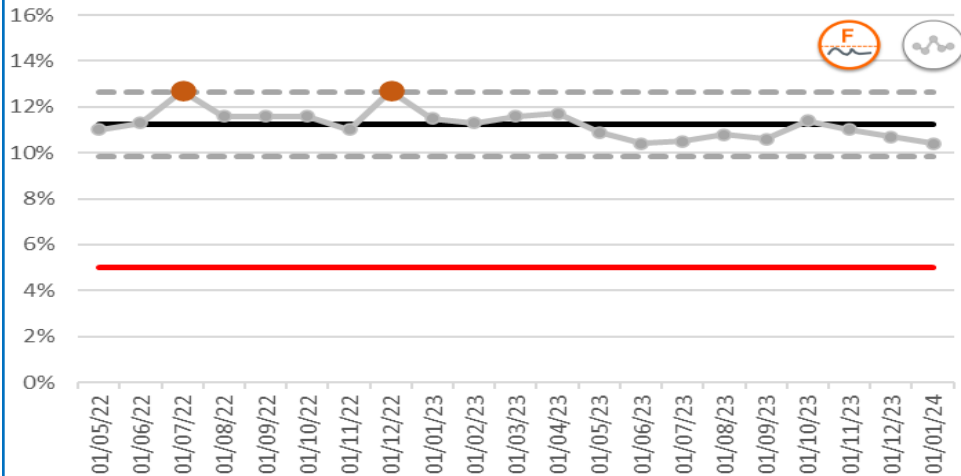
National Position & Overview

There is a reduction in vacancies this month and UHL continues to work towards a zero percent vacancy in line with the continued national direction.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Vacancies remain stable with minimal variance in leavers We continue to see staff leave substantive posts to bank roles, evidence suggests this is due to increase in pay rates and flexible working Some increase in vacancies due to existing HCAs moving into Trainee Nursing Associate (tNA) roles HCSW vacancies circa.240 WTE in month 	<ul style="list-style-type: none"> Bi-monthly HCSW recruitment continues Encouraging flexible working as business as usual to promote retention and reduce attrition to the nurse bank. Local system event planned to support recruitment of HCSW 	<ul style="list-style-type: none"> 103 new starters now in post 86 Waiting to start in the next month Programme of masterclasses continues to roll out throughout 2024 to support HCSW professional development Re - banding of HCSW from band 2 to 3 in progress which will support retention and career progression

Effective – DNA Rate (IMD Deciles 1-2 & IMD Deciles 3-10)

DNA Rate - IMD Deciles 1 and 2



DNA Rate – IMD Deciles 1-2			DNA Rate – IMD Deciles 3-10		
Jan 24	YTD	Target	Jan 24	YTD	Target
10.4%	10.8%	5%	6.0%	6.7%	5%

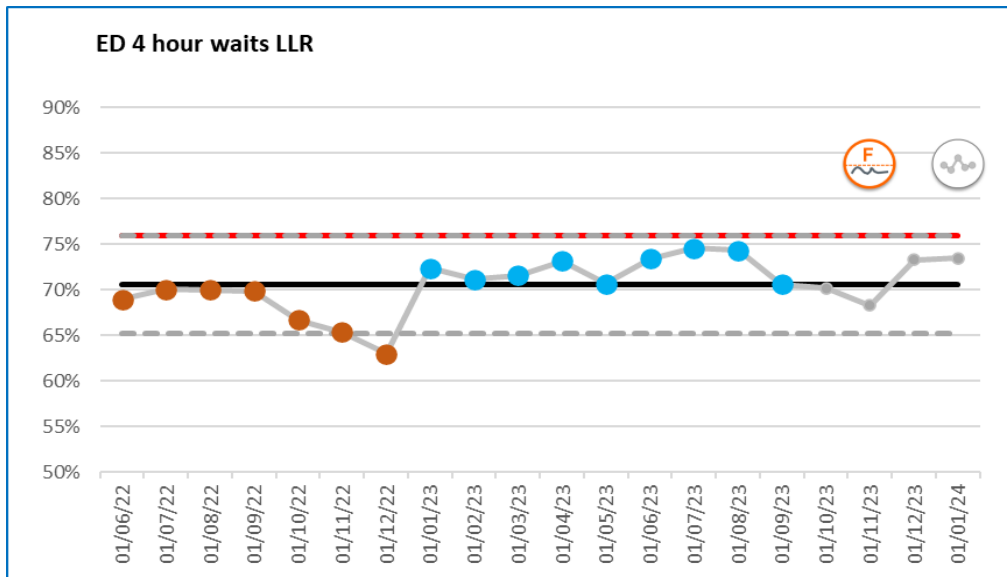
National Position & Overview

There is no national target for DNA rates, but understanding the role inequity plays in rates of non-attendance is a key foundational pillar of UHLs attempts to improve Theatre and Outpatients utilisation. This understanding also plays a broader, role in supporting the achievement of targets on productivity and the Trust’s aim of embedding health equality & inclusion in all we do.

The Organisational Outpatient strategy set a DNA target rate for UHL of 4.9% by March 2024.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> The latest DNA survey was successfully delivered via SMS to 4305 patients and received 1800 responses. Patients in the most deprived IMD quartile account for 27% of DNAs compared with 21% from the least deprived quartile. No significant difference across the quartiles in terms of having a mobile device capable of receiving/responding via Accurx SMS. However, a higher percentage of those in the most deprived v. least deprived quartile are textable (96% v. 92%) but the response rate is lower in the most deprived quartile (36% v. 48%). Response rates from the 2 most deprived IMD quartiles was 39%, compared to 45% in the 2 least deprived IMD quartiles. When asked why they were unable to attend the appointment, some of the following reasons were given: <ul style="list-style-type: none"> 21% didn’t know that they had an appointment. 40% of those who DNA because they were “anxious or worried about the appointment” were from the most deprived quartile, compared to 15% from the least deprived quartile. 14% of the 2 most deprived quartiles stated that they had forgotten the date/time of the appointment, compared to 8% of the 2 least deprived quartiles. 	<ul style="list-style-type: none"> All patients from IMD1 and IMD2 are called two weeks prior to their appointment. Accurx is used to send appointment reminders. Accurx have also conducted a deep dive with 5 specialties to review DNA rates and identify potential actions to improve rates. Patients from Inclusion Healthcare are contacted and a further contact is made with Inclusion Healthcare to enable enhanced support to attend where needed. DNA rates will be included in PRM packs and WAM discussions moving forwards. Focus group work with communities to explore barriers to access and sharing insights across the system. 	<p>The UHL DNA rate is improving and progress is being monitored by the Outpatient Board. Evidence to date shows that:</p> <p>IMD1 January: Patients called DNA rate – 6.81% (646) Patients not contacted DNA rate – 13.59% (552)</p> <p>IMD2 January: Patients called DNA rate – 4.5% (467) Patients not contacted DNA rate – 13.82% (398)</p> <p>Inclusion Healthcare: DNA rate for those called – 50% (4) DNA rate for those not called – 46.67% (15)</p>

Responsive (Emergency Care) – ED 4 Hour Waits



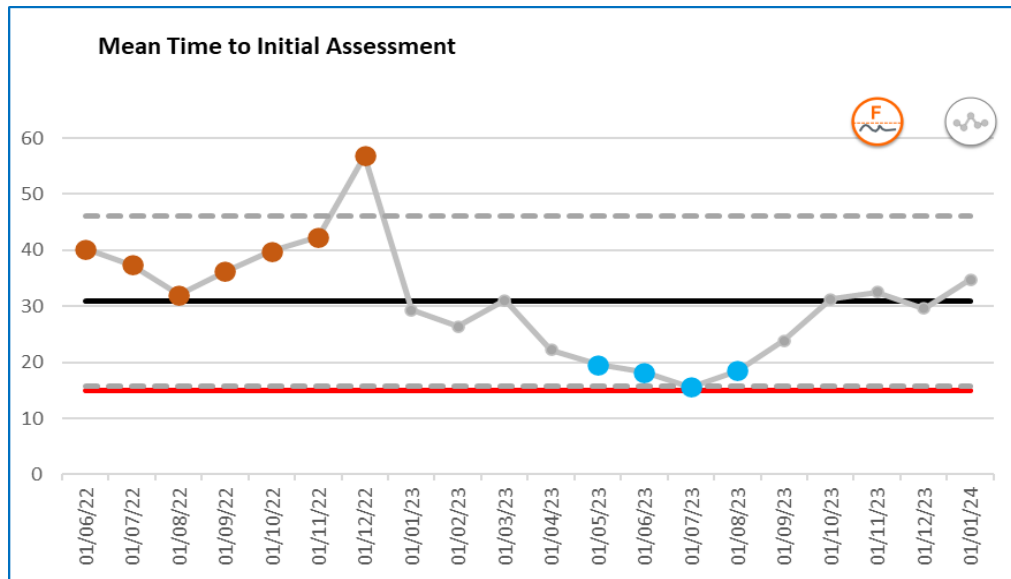
LLR Performance			UHL Performance		
Jan 24	YTD	Target	Jan 24	YTD	Target
73.5%	72.2%	76%	56.8%	57.1%	76%

National Position & Overview

In January, UHL ranked 40th out of 124 Acute Trusts based on its acute footprint. The National average in England was 70.3%. 20 out of the 124 Acute Trusts achieved the target. UHL ranked 7th out of 17 trusts in its peer group. The best value out of the Peer Trusts was 79.4% and the worst value was 57.2%.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> High attendances to ED resulting in overcrowding in ED High periods of inflow particularly in walk-in impacting on ambulance arrivals UHL bed occupancy >92% resulting in an inability for patients to move out of ED 	<ul style="list-style-type: none"> Reiterate 30-minute rule for speciality review Increase in SDEC (GPAU) activity Deflection of Injuries patients to reduce numbers waiting in ED Daily breach validation Additional UTC capacity 	<ul style="list-style-type: none"> Completed – will be monitored through Performance Review Meetings In place - currently impacted by bed waits January 2023 October 2023 – in place Oadby and Merlin Vaz from January 2024

Responsive (Emergency Care) – Mean Time to Initial Assessment



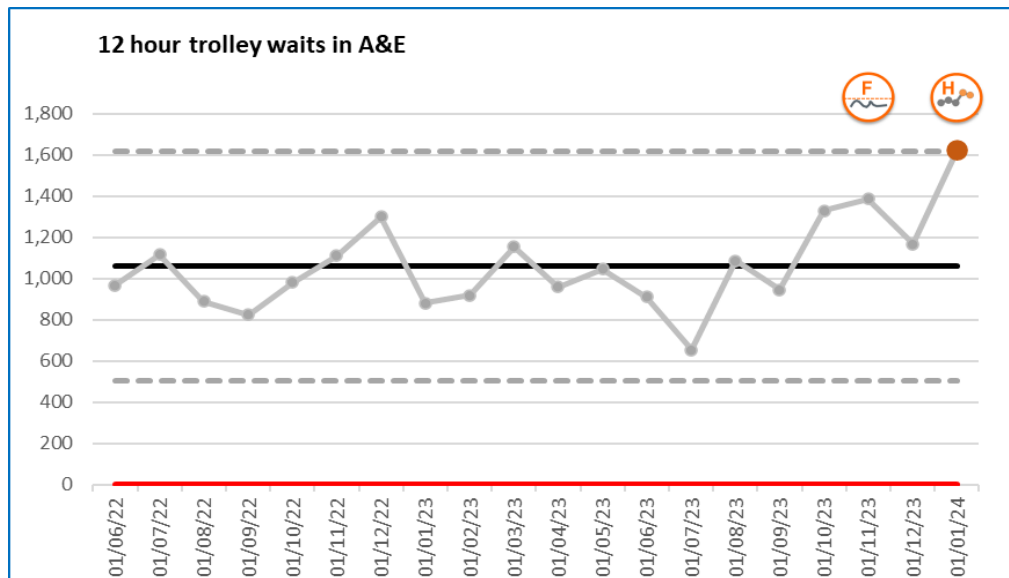
Current Performance		
Jan 24	YTD	Target
34.8	25.2	15

National Position & Overview

National data not currently available for reporting.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Demand higher than capacity 	<ul style="list-style-type: none"> Redirect patients to UTC and SDEC's Redirect patients to Walk in Centres ED consultant deployed to front desk STAT clinician allocated to front door for each shift Stream patients to injuries Extended MIaMI opening Development of UTC slots at Oadby, Merlin Vaz and Westcotes 	<ul style="list-style-type: none"> In place In place In place In place In place In place In place and under review in terms of utilisation and plans for Winter 23/24

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



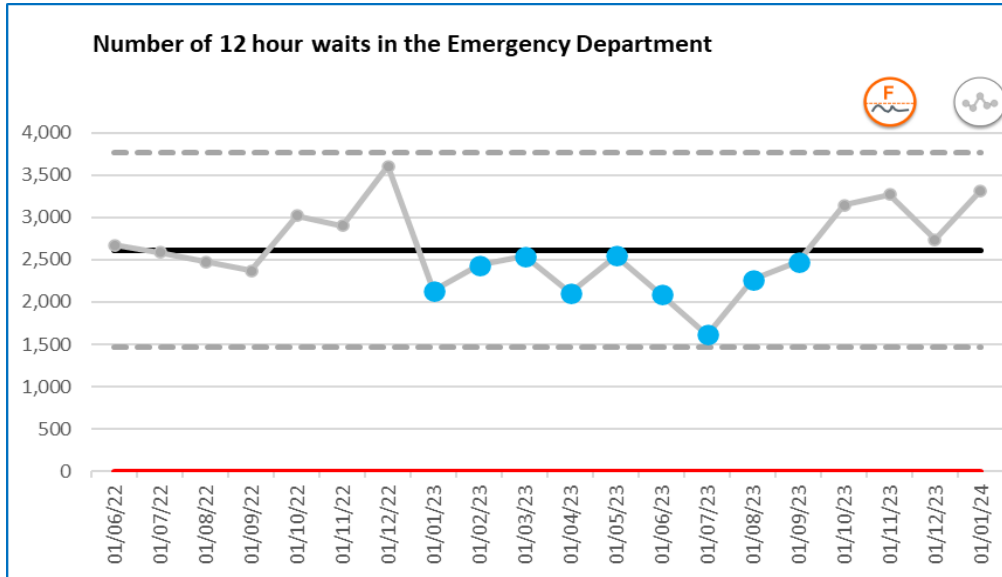
Current Performance		
Jan 24	YTD	Target
1,625	11,112	0

National Position & Overview

In January, UHL ranked 121st out of 122 Major A&E NHS Trusts. 7 out of the 122 Trusts achieved the target. The best value nationally was 0 and the worst value was 2,453. UHL ranked 17th out of 18 trusts in its peer group.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Poor outflow across the emergency care pathway 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"> Create additional bedded capacity to increase flow out of department Additional capacity in discharge lounge Weekly reporting of performance to increase awareness and focus Frailty patients to be reviewed by FES Strengthen specialty in-reach Daily breach validation 	<ul style="list-style-type: none"> Grace Dieu – January 2024 Coalville Ward 4 – January 2023 Opened In place In place In place In place

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



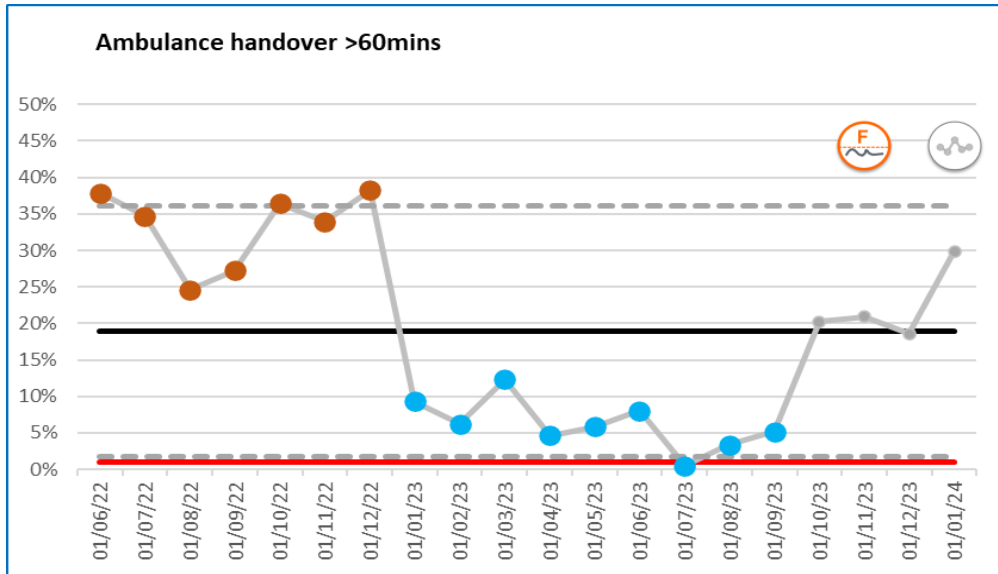
Current Performance		
Jan 24	YTD	Target
3,316	25,550	0

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 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"> Create additional bedded capacity to increase flow out of department Additional capacity in discharge lounge Weekly reporting of performance to increase awareness and focus Frailty patients to be reviewed by FES Strengthen specialty in-reach Daily breach validation 	<ul style="list-style-type: none"> January 2024 Opened October 2023 In place In place In place In place

Responsive (Emergency Care) – Ambulance Handovers > 60 Minutes



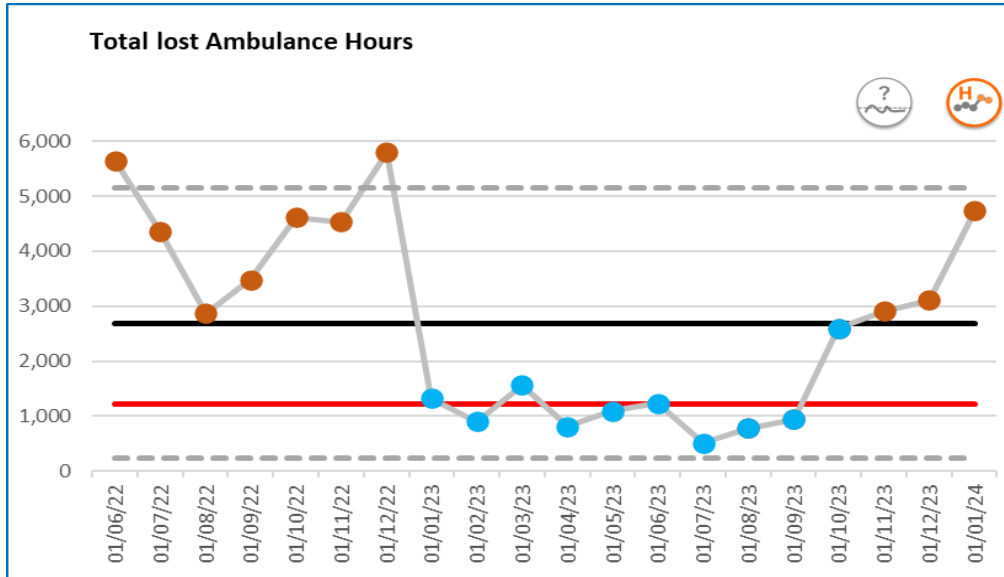
Number of Handovers >60 Mins			% of Handovers >60 Mins		
Jan 24	YTD	Target	Jan 24	YTD	Target
1,460	5,627	48	29.9%	11.9%	1%

National Position & Overview

LRI ranked 21st out of 23 sites in the East Midlands and reported the second highest number of handovers in January (source EMAS monthly handover report).

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"> Utilisation of pre-transfer unit at LRI Embed PTCDA and Urgent Care Co-ordination hub Ensure utilisation of UHL beds in Care Home Open permanent cohorting facility at LRI Open permanent cohorting facility at GH Open new wards at GH Development of winter plan / actions to support surges in activity during winter 	<ul style="list-style-type: none"> In place In place Ongoing – daily / weekly monitoring Opened Opened – extending capacity in line with phasing plan February 2024 / Summary 2024 Completed

Responsive (Emergency Care) – Total Lost Ambulance Hours



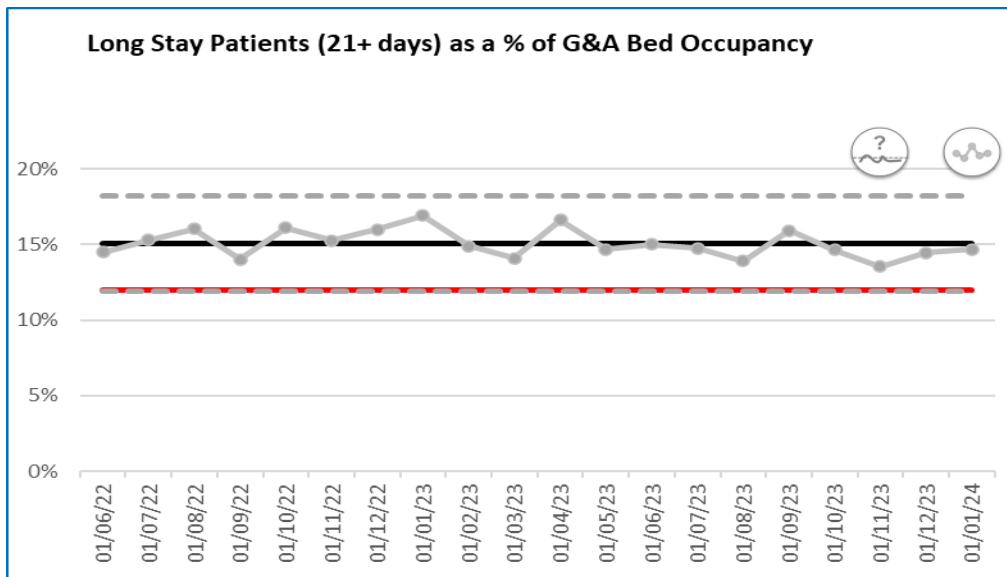
Current Performance		
Jan 24	YTD	Target
4,732	18,756	40 per day

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. 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"> Utilisation of pre-transfer unit at LRI Embed PTCDA and Urgent Care Co-ordination hub Ensure utilisation of UHL beds in Care Home Open permanent cohorting facility at LRI Open permanent cohorting facility at GH Open new wards at GH Development of winter plan / actions to support surges in activity during winter 	<ul style="list-style-type: none"> In place In place Ongoing – daily / weekly monitoring Opened Opened – extending capacity in line with phasing plan February 2024 / Summary 2024 Completed

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



Current Performance		
Jan 24	YTD	Target
14.7%	-	12%

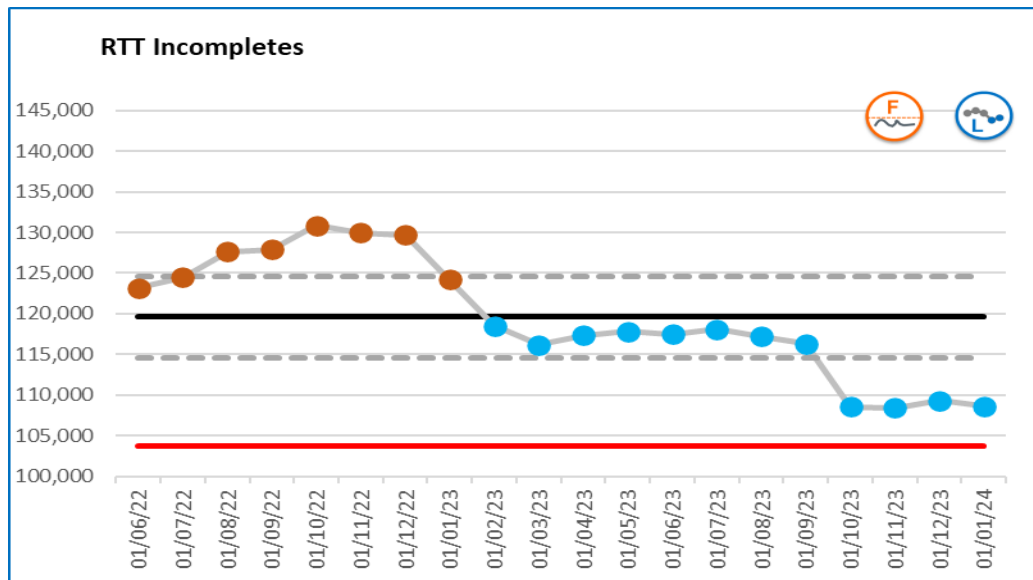
National Position & Overview

UHL is ranked 13th out of 20 trusts in the Midlands for the % beds occupied by Long Stay (21+ Day) patients (for the w/c 29/01/24).

- 45 (240) Patients (19%) are receiving appropriate care/treatment on a neuro rehabilitation or brain injury pathway or on an Intensive care Unit or Infectious Diseases Unit.
- 41 Patients (17%) are medically optimised for discharge with no acute medical reason to stay .

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Circa 180 Complex Medically optimised for discharge patients of which 41 have a LLOS and are awaiting a discharge outcome from the LLR discharge coordination hub. Suboptimal /inconsistent Discharge Coordination: Over investigation, family /carer involvement, board rounds , red2green principles, preparing the patient in advance of discharge. In addition to impacts of long stays in ED, extra capacity wards, outlying and boarding of patients. 	<p>Continue to work with health and social care system partners during February to:</p> <ul style="list-style-type: none"> Review the Temporary Health Conditions Pathway. Embed the new P2 nursing and residential beds in LPT and understand delays to flow. <p>Work with CMG's to:</p> <ul style="list-style-type: none"> Promote opportunities for earlier discharge /decision making in the patients journey (early bird concept/correct transport booking). Continue to promote the eligibility criteria for non emergency transport Promote Criteria led discharge pathways at the LGH site. 	<ul style="list-style-type: none"> Aim to reduce number of MOFD patients waiting for discharge in UHL beds. Increase numbers of patients discharged on a Pathway 1. Reduce daily 'Incomplete discharges' Reduce time to discharge from MOFD identification Reduce transport delays Increase number of patients on a criteria led discharge pathway

Responsive (Elective Care) – RTT Incompletes



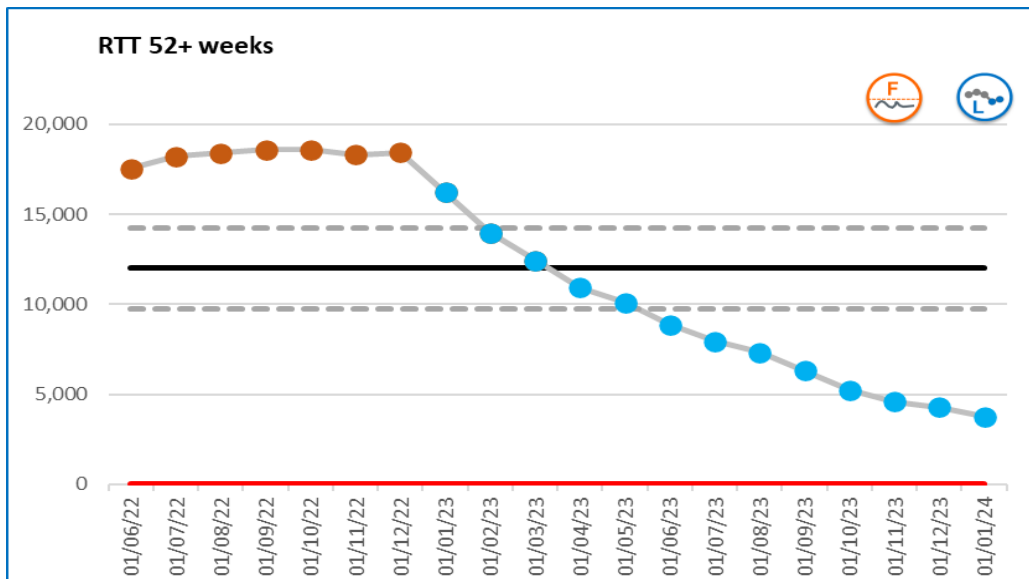
Current Performance		
Jan 24	YTD	Target
108,646	-	103,733

National Position & Overview

At the end of December, UHL ranked 14th out of 18 trusts in its peer group with a total waiting list size of 109,256 patients. The best value out of the 18 Peer Trusts was 71,797 the worst value was 183,927 and the median value was 92,458. (Source: NHSE published monthly report)

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. Continued growth in demand against significant number of specialities Continued workforce challenges within ITAPS reducing theatre capacity Estate- lack of theatre capacity and outpatient capacity to increase sessions Significant productivity challenges across elective care Cumulative impact of regular industrial action leading to loss of activity Emergency/winter pressures are resulting in elective cancellations, with paediatric specialities particularly challenged. 	<ul style="list-style-type: none"> Validation action plan created to respond to national ambition of 90% of patients who have been waiting over 12 weeks to be validated within the last 12 weeks by the end of March 24. Planned additional data quality validation each month to support overall reduction of WL and achieving March 24 103,733 target Demand and Capacity modelling commissioned to support future planning. Plan to assess demand for elective treatment to understand why the total wait list is currently not reducing as required. Refresh of the elective Access policy in line with national guidance New training strategy and comms to support understanding and application of revised policy. Elective Care Access Policy Masterclasses 	<ul style="list-style-type: none"> Fortnightly texting cycle commenced Monday 25th September. Improved 12ww validation performance from c25% to over 84% in mid February. Increased frequency of Accurx cycle and continued DQ validation work resulted in a significant reduction in overall WL (c.6,000 patients removed) at end October, risen as expected throughout December and new year due to reduced activity (validation and clinical) over holiday period and December/January strike action. Clean waiting list- ensuring those on the waiting list do want to be seen/have treatment Rightsizing capacity to meet demand Training strategy continues to be developed – systematic rollout from Autumn 2023 onwards. Access Policy masterclasses through Jan and Feb 24 have been a success with excellent attendance numbers and attendees reporting an improved understanding of the topic after their session.

Responsive (Elective Care) – RTT Long Waiters



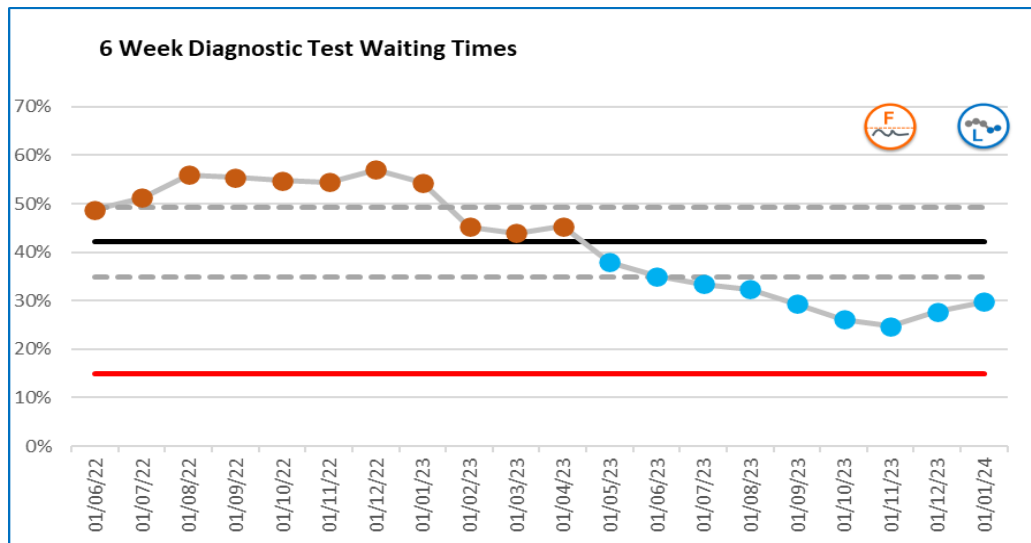
Current Performance – January 24		
52+ Weeks	65+ Weeks	78+ Weeks
3,743 (Target 0 by March 25)	802 (Target 0 by March 24)	63 (Target 0 by March 23)

National Position & Overview

At the end of December, UHL ranked 7th out of 18 trusts in its peer group with 3.9% of patients on the waiting list waiting over 52+ weeks. The best value out of the 18 Peer Trusts was 2.7%, the worst value was 8.7% and the median value was 4.3%. (Source: NHSE published monthly report)

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Impact of COVID-19 on planned activity capacity led to a growing backlog Significant operational pressures due to the emergency demand impacting upon elective activity Challenged Cancer position and urgent priority patients requiring treatment Workforce challenges in anaesthetics leading to cancellations of theatre lists Admin workforce challenges across a range of posts, particularly band 2/3 impacting on ability to book patients Cumulative impact of regular industrial action leading to loss of activity Emergency/winter pressures are resulting in elective cancellations, with paediatric specialties particularly challenged. 	<ul style="list-style-type: none"> Focus on all patients from 65-week cohort to have first OPA as soon as possible to support overall zero 65 ww by March 24 ambition. Using ERF to fund insourcing in particularly challenged specialities to increase predominately outpatient capacity e.g. ENT, Gastro, Maxfac, Ophthalmology Super-clinics planned to increase capacity to see new outpatients Continued roll-out and focus on PIFU to increase capacity for new patients 65 and 52 week cohort forecasts produced weekly/fortnightly, shared with CMGs. Standard Operating Procedures developed linked to the access policy, improving data quality 	<ul style="list-style-type: none"> 104 week waits – 0 reported at end January. 78 week waits – January performance was 63 78ww v. forecast 71. Emergency pressures combined with strike action in December, January and February are impacting but we remain confident in a zero position by end March 24, NHSE red line. 65 week waits - Continued positive downward trend on 65 weeks. Specialties with an identified risk of breach according to weekly forecasts have plans to mitigate. Current forecasts are showing 114 breaches at end March 24 (includes impact of Dec/Jan IA but not February). 52 week waits - Continued positive downward trend on 52 weeks. Currently no identified risk to achievement of zero 52 ww by end March 25.

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



Current Performance		
Jan 24	YTD	Target
29.8%	-	15.0%

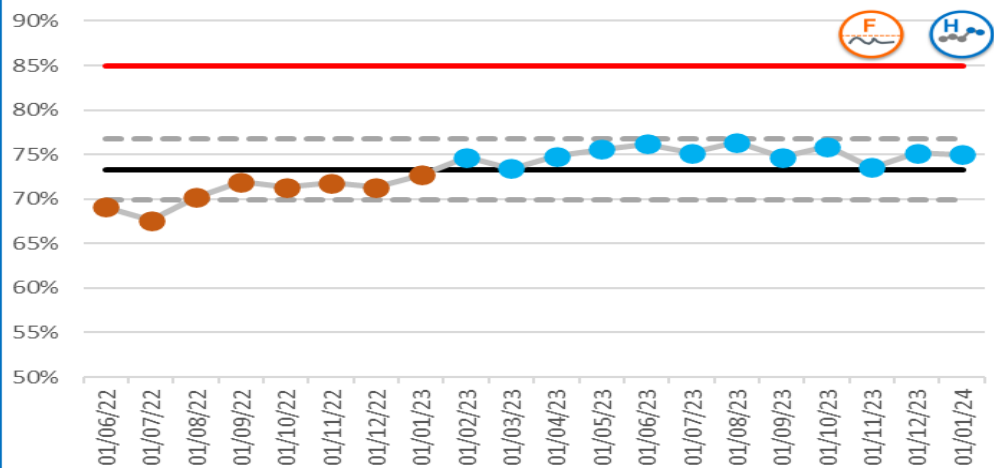
National Position & Overview

Published National data at the end of December 23 shows 1.55m patients on the diagnostic waiting list with 27% waiting over 6 weeks. For January 24, UHL with 24,705 would comparatively rank as the 7th highest waiting list. Performance has improved from a peak in December 22 of 57% of patients waiting over 6 weeks to 29.8%. Whilst this is adverse to last month it is within expected within normal variation. Improvement has been delivered by insourcing, increasing productivity and validation.

Root Cause	Actions	Impact/Timescale
<p>Diagnostics pressure areas are in the main:</p> <ul style="list-style-type: none"> Endoscopy (incl Cystoscopy) CT / MRI <p>Root cause</p> <ul style="list-style-type: none"> Clinical workforce – national shortage Admin recruitment Pressures from cancer pathways Emergency demand impacting on elective capacity 	<p>Insourcing:</p> <ul style="list-style-type: none"> Modular Endoscopy unit. In place <p>Productivity:</p> <ul style="list-style-type: none"> Productivity lead appointed – started Jan 24. A deep dive in Endoscopy will be led by this post and is expected to conclude by Mid March on D&C and actions to recover. <p>Validation:</p> <ul style="list-style-type: none"> All – weekly validation report circulated to review and update waiting list entry. 	<ul style="list-style-type: none"> Significant reduction in long waits evidenced in NOUS, Echo and DEXA. Mid-March for Endoscopy Deep Dive. For the 23/24 operational plan - expect c.75-80% for all DM01 activity against an interim standard of 85% by end of March 24. CT / MRI / Colonoscopy. Endoscopy recovery is key.

Responsive (Elective Care) – Theatre Utilisation

Theatre Utilisation



Current Performance

Jan 24	YTD	Target
75.0%	75.1%	85%

National Position & Overview

GIRFT has set a target for Integrated Care Systems and providers to achieve 85% theatre touch time (capped) utilisation by 2024/25. This supports the aims of NHS England's 2022/ 23 priorities and operational planning guidance to secure sustainable elective recovery.

Root Cause

Overall theatre utilisation excluding the LRI was **77.96%** for Jan 24 a drop of 2% from the previous month. Jan 24 also saw 144hrs of continuous strikes after the New Year resulting in a reduction of activity delivered.

- OTDC = 8.72% (420 patients) Top 3 reasons : Patient Unfit (65), Out of theatre time (58) and Patient Unwell (42)
- Late Starts >15 minutes = 36.63%

Site	% Utilisation	% late starts over 15-mins	OTDC %
LRI	69.49%	50.51%	9.75%
GGH	82.86%	27.32%	8.74%
LGH	74.83%	25.28%	7.06%
EMPCC	87.50%	6.25%	9.93%
Community	76.72%	59.02%	9.57%

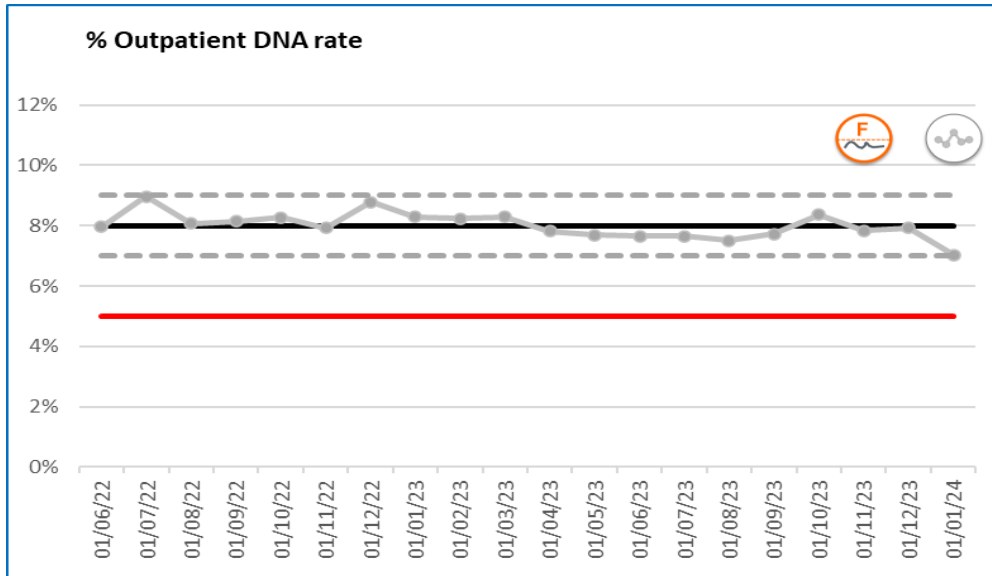
Actions

1. Focused work to started at the LGH and Community sites to drive utilisation to the 85% target by the end of Q4 23/24, improving the overall Trust Utilisation
2. GS Planning the 'Perfect 2 weeks' with support from ITAPS and POA for March 24 at the LGH.
3. Phased roll out of adding patients onto my pre-op (digital system) without a TCI date (up to 4 months out) by Q4 23/24 to tackle clinical cancellations.
4. Challenging under booked lists and reviewing ACPL targets for 24/25
5. Drive down OTDC to below the 5% target by initiatives such as rolling out pre-surgery questionnaires across all suitable services.
6. Further reduction in late starts by reinstate Auto-send, current bed pressures have halted process during significant UCE pressures in Nov/Dec 23.

Impact/Timescale

1. ITAPS & Clinical TP lead attending scheduling sessions and challenging under-booked list within LGH and Community. 2% improvement seen in Jan for the community hospitals (74.2% Dec 23).
2. 'Perfect 2 weeks' support building a booking/scheduling best practice time-line – assumed this could be developed into a blue print and replicated across other surgical services.
3. Patients unfit was the highest reason for OTDC in Jan 24. UHL early screen rollout plan started in the community 30th Jan. Analysis needed throughout Feb to review impact.
4. Annual ACPL target review completed, challenged and triangulated targets against 2nd activity planning alongside current theatre performance. Further work is needed throughout Feb to review impact (CIP/Activity).
5. Pre-surgery questionnaire SOP to be finalised once response analysis completed , roll out across all services by Q4 23/24 and explore further reminders– automated text reminders.
6. Out of session time was the 2nd highest reason for cancellation, reinstate Auto-send at the LRI site and focus work looking at start times within the Community by Feb 24.

Responsive (Elective Care) – Outpatient DNA Rate

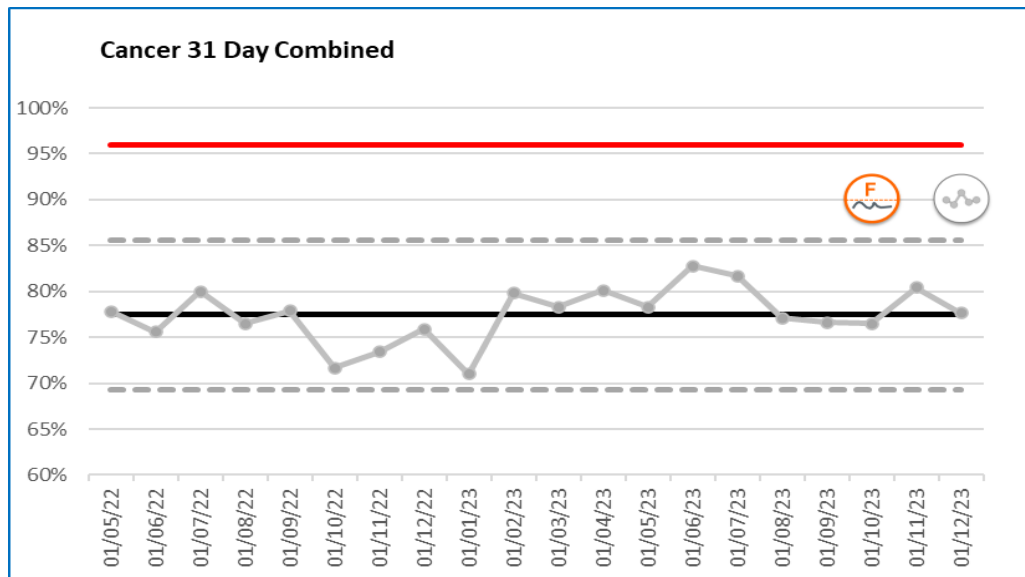


Current Performance		
Jan 24	YTD	Target
7.0%	7.7%	5.0%

National Position & Overview

Root Cause	Actions	Impact/Timescale
<ol style="list-style-type: none"> For virtual consultations, demographic information often isn't being checked with the patient then updated on HISS so some patients aren't receiving appointment letters Late cancellations/rebooks often mean patients do not receive their appointment letters on time so unaware of appointment Due to lack of admin staff, patients unable to get through to department to let them know they're unable to attend Some services are using the DNA outcome for VIR clinics as well as for the diagnostic (therefore double counting) 	<ol style="list-style-type: none"> Remind services of the need to check the patients details are correct and up to date at every contact Booking Centre are making additional calls to 'Health Inequalities' cohort DNA florey is being sent to patients who DNA and further analysis is being done around the reasons for DNA. Accurx automated clinic appointment reminders have gone live in the majority of services. Clinic lists are also available in Accurx for most services. Ask services to offer choice of video or telephone consultation, and stop recording DNAs on VIR clinics 	<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 Cancer – Cancer 31 Day Combined



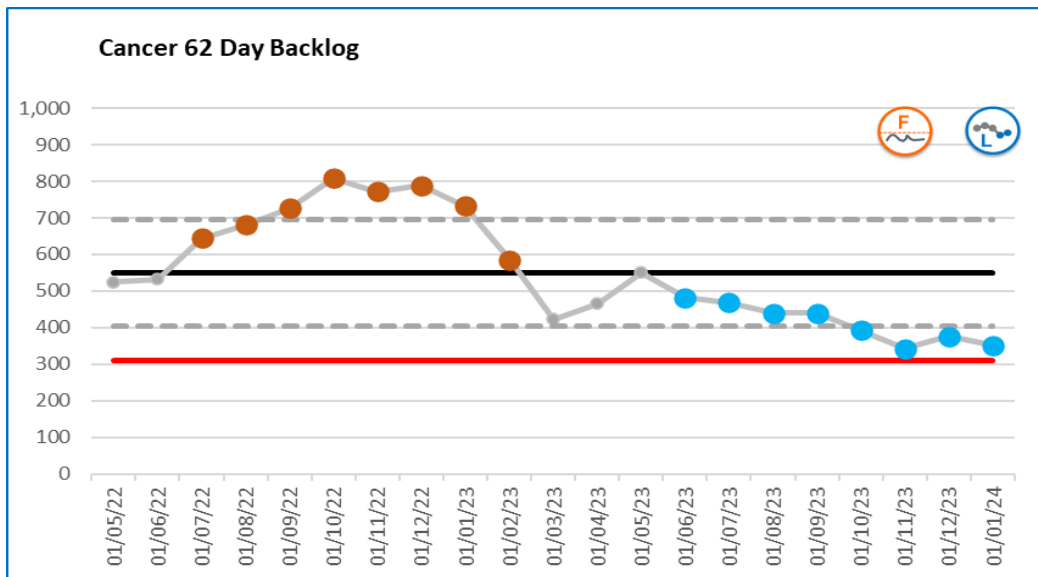
Current Performance		
Dec 23	YTD	Target
77.7%	79.0%	93%

National Position & Overview

In December, UHL ranked 133rd out of 136 Acute Trusts. The National average was 91.1%. 54 out of the 136 Acute Trusts achieved the target. UHL ranked 17th out of the 18 UHL Peer Trusts. The best value within our peer group was 96.3%, the worst value was 75.9% and the median value was 88.9%.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Insufficient capacity within surgery, chemotherapy and radiotherapy to meet current demand Surgical capacity remains a constraint (physical and workforce including case mix) Radiotherapy demand has exceeded capacity – affecting prostate and breast patients 31 day anti-cancer drug regimes capacity is constrained on the SACT delivery suite due to cyclical treatments 	<ul style="list-style-type: none"> Radiotherapy D&C review undertaken Business case for a 5th Linac Mitigations to reduce wait times for prostate and breast include temporary weekend working, mutual aid and change to prostate fractions Surgical D&C review required (particular focus in LOGI/Urology) Oncology SACT D&C review Oncology efficiency review programme 	<ul style="list-style-type: none"> Business case for 5th linac submitted to capital programme – 25/26 Weekend working commenced in Radiotherapy. NGH to offer capacity (2patients per week) from March Prostate fraction changes – due March Surgical D&C review to commence in Feb Oncology SACT D&C review commenced Oncology efficiency programme to release capacity includes virtual/digital solutions in progress Mobile Treatment Centre for chemotherapy in place, extension to capacity delayed due to staff within the company. Saturday SACT working commenced

Responsive Cancer – Cancer 62 Day Backlog



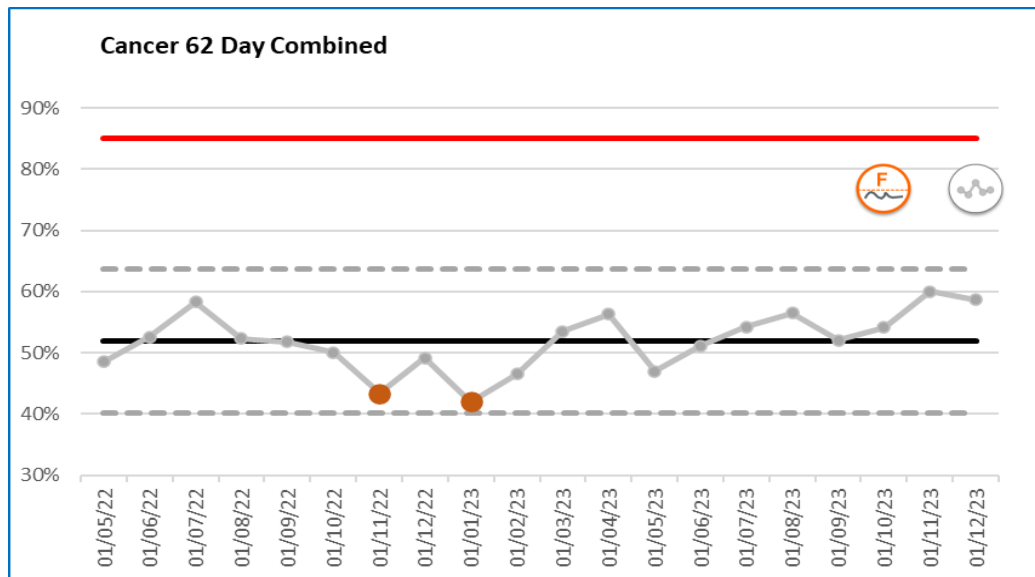
Current Performance		
Jan 24	YTD	Target
351	-	309

National Position & Overview

January Plan 391 (40 patients better than Plan)
 Nationally 50th against fair shares out of 120 trusts (04/02/23).

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Post pandemic demand increased significantly above capacity, causing high backlogs for both 62 and 104 day pathways post pandemic Urology and LOGI hold the majority of the backlog with skin being the third. Constraints include capacity, specifically outpatient, diagnostic and clinical administrative time, in addition to workforce to deliver additional capacity. Further risk to recovery due to winter pressures and anticipated further IA 	<ul style="list-style-type: none"> Clinical prioritisation of all cancer patients. Clinical review of patients over 104 days. Daily backlog report, including next steps, to support focused actions for recovery. Escalation of next steps process to be embedded. Independent sector in place to assist with skin backlog and urology outpatients. 	<ul style="list-style-type: none"> RAPs in place. Weekly review for Skin and Oncology. Bi-weekly for Urology and GI and Endoscopy. Additional clinic capacity in skin and urology (ongoing until March 24). Escalation next steps process re-launched for all patients, weekly escalations of 104+day patients without next steps by ADO. Urology and Endoscopy reviewing dating process. Focus from services on utilisation of capacity, next steps for patients and review of patients rolling onto the backlog.

Responsive Cancer – Cancer 62 Day Combined



Current Performance		
Dec 23	YTD	Target
58.6%	54.5%	85%

National Position & Overview

In December, UHL ranked 110th out of 139 Acute Trusts. The National average was 65.8%. 11 out of the 139 Acute Trusts achieved the target. UHL ranked 11th out of the 18 UHL Peer Trusts. The best value within our peer group was 75.8%, the worst value was 48.0% and the median value was 60.5%.

Root Cause	Actions	Impact/Timescale
<ul style="list-style-type: none"> Capacity constraints across all points of the pathways Focus on treating patients in order of clinical priority and longest waits impact performance Oncology and radiotherapy capacity with high wait times contribute Workforce challenges including reduction of WLI activity have impacted ability to deliver increased activity 	<ul style="list-style-type: none"> Clinical prioritisation of patients. Weekly PTL reviews and clinical review of >104day patients. Next step review in place for all 104day patients and escalated to services. Recovery & Performance (RAP) in place. Review of pathways in line with Best Practice Timed Pathways (BPTP) to identify areas for improvement Pathway analyser to review opportunities Independent sector support for dermatology and urology 	<ul style="list-style-type: none"> BPTP completed for Prostate, UPGI, Lung and H&N in progress. Referral to decision to treat times have been reviewed and opportunities to streamline are being looked at in LOGI, Urology and Skin. Pathway analyser re-audit Urology – due Feb 24. Review of skin to plastics administrative process due March 24. Additional capacity in skin and urology. Urology and Endoscopy weekly escalations in place for timely dating. Patient engagement supported by NSS/Pre-diagnosis CNS



Executive Summary

- For December (M10), the Trust is reporting an in month deficit of £9.7m, which is £2.4m worse than the NHSE trajectory adjusted for industrial action. This variance is driven primarily by UEC pressures of £1.4m, additional pressures not included in the M7 trajectory of £0.6m and a write-off of £0.4m. Year to date, the Trust has a deficit of £57m which is £5.9m worse than forecast which is mainly due to UEC pathway (£4.1mA), net expenditure pressures greater than forecast (£2.1mA) and other small variances of £0.3mF. The Trust is in discussions with NHSE and the ICB regarding the impact of industrial action on the Trust's cash balances, especially in light of the additional action at the end of February.
- CIP delivery is currently behind plan, YTD the Trust has delivered £41.2m against a plan of £44.4m. Of this delivery, £19.8m is recurrent and £21.4m non recurrent.
- The Trust committed gross expenditure of £63.9m in the year to 31st January, which nets down to £58m, after deducting charitable donations and the net book value of assets disposed/transferred, which £3.8m ahead of forecast. The Trust remains on target to deliver its year end capital plan. Schemes have been identified and are being progressed to fully utilise the ACTIF UEC and national PDC funding for the EMPCC and Endoscopy schemes in year.
- The cash position at the end of January was £23.2m, representing an increase of £3.4m on the previous month. The Trust is projecting a cash surplus of +£15.8m for 31 March 2024, based on delivery of the forecast I&E deficit. The forecast cash position at the end of the first quarter of 24/25 is a cash deficit position of -£15.8m, which will necessitate draw down of PDC revenue support in Quarter 1, equivalent to the forecast deficit at Q1 (£23.7m) The Trust continues to monitor its cash position and will be required to make an application for additional PDC revenue support (signed off by the Trust Board on 8 February) by 13th March.

Summary Financial Position – YTD M10

	I&E YTD		
	Forecast	Actual	Variance to Forecast
	£'000	£'000	£'000
NHS Patient-Rel Income	1,129,835	1,143,832	13,997
Other Operating Income	132,043	129,002	(3,041)
Total Income	1,261,878	1,272,834	10,956
Pay	(780,316)	(785,883)	(5,567)
Agency Pay	(25,916)	(28,230)	(2,314)
Non Pay	(443,583)	(451,796)	(8,213)
Total Costs	(1,249,816)	(1,265,909)	(16,094)
EBITDA	12,063	6,925	(5,138)
Non Operating Costs	(61,676)	(65,219)	(3,543)
Retained Surplus/(Deficit)	(49,613)	(58,294)	(8,681)
Donated Assets	(1,488)	(2,392)	(904)
Net Total Surplus/(Deficit)	(51,101)	(60,686)	(9,585)
Less Capital Impairment		3,690	3,690
Reported Control Total Surplus/(Deficit)	(51,101)	(56,996)	(5,895)

The Trust agreed a forecast outturn deficit with NHSE of £51.9m including IA.

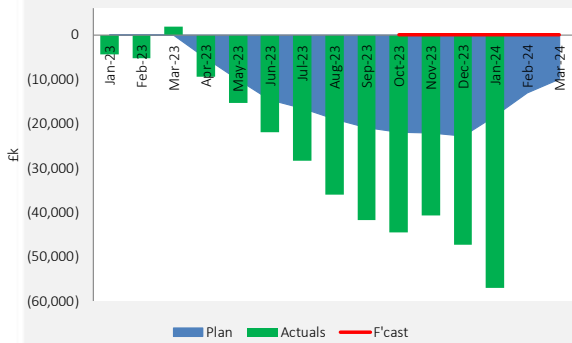
Income over-recovery is mainly driven by more income for EDD pass through and this is offset by the negative variance against non-pay.

The pay variance reflects UEC costs greater than forecast and other pay pressures due to acuity of patients and filling of vacancies. The agency variance results from costs being recoded from non-pay to agency in M10.

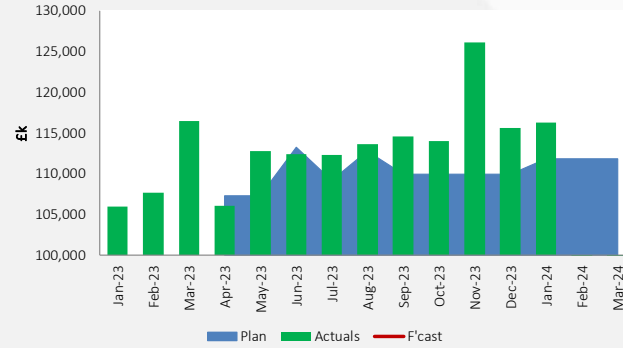
Variance to Forecast	
	£m
UEC pressures	-4.1
Net expenditure pressures not included in M7 trajectory	-2.1
Other	0.3
Total variance against YTD trajectory	-5.9

Month 10 I&E Dashboards

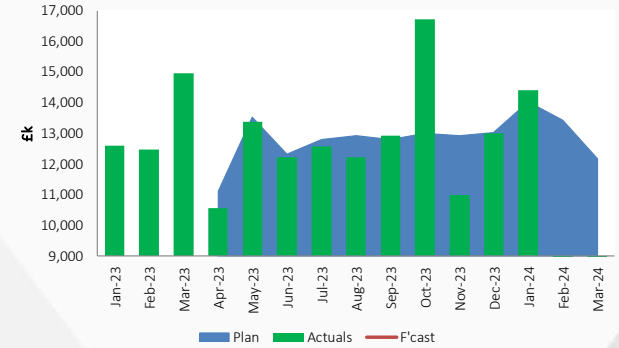
Cumulative Surplus/(Deficit)



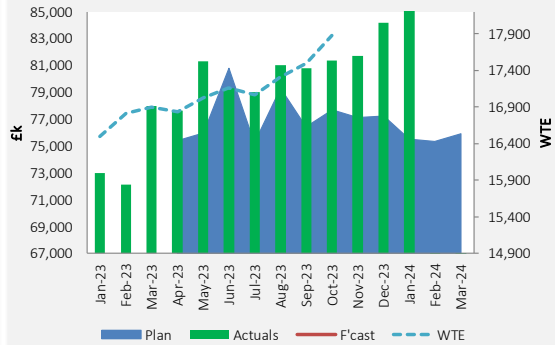
Monthly PCI Income



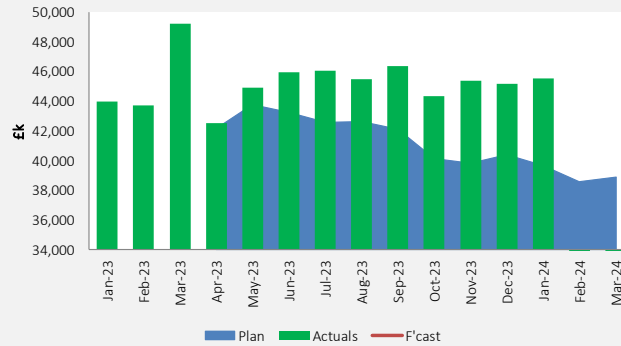
Monthly Other Income



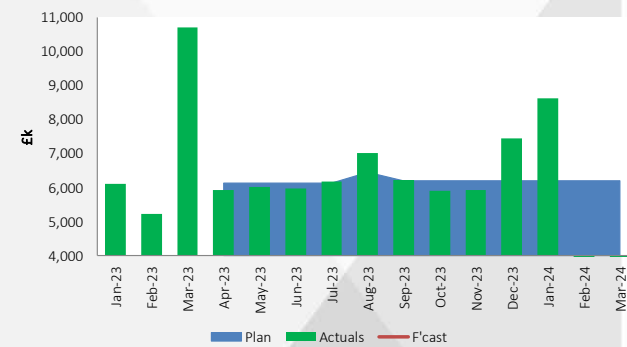
Monthly Substantive/Bank/Agency Pay



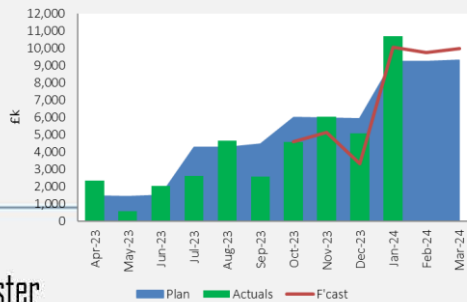
Monthly Non Pay



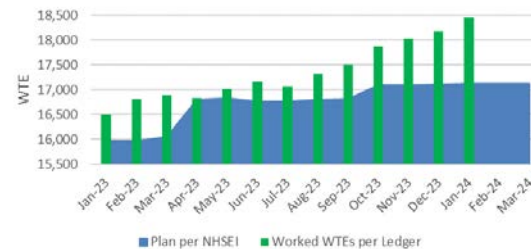
Monthly Non Ops



CIP Performance Excl Productivity

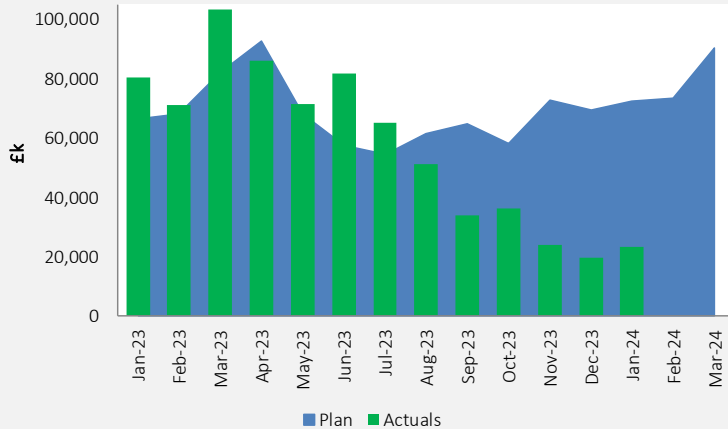


Worked WTEs vs NHSEI Workforce Plan

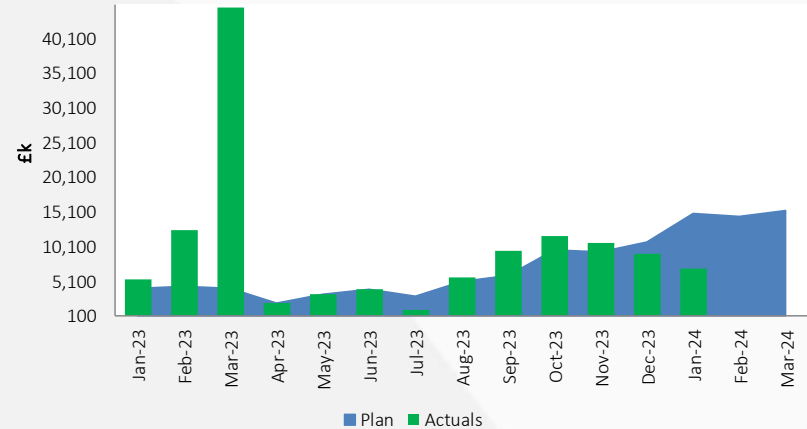


Month 10 Balance Sheet Dashboards

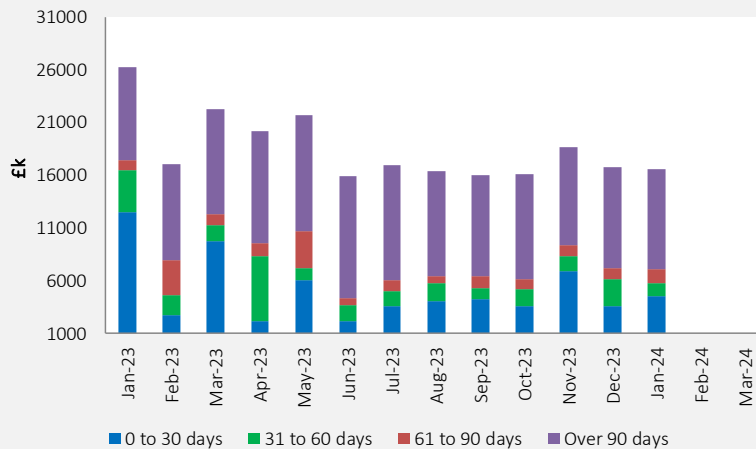
Cash



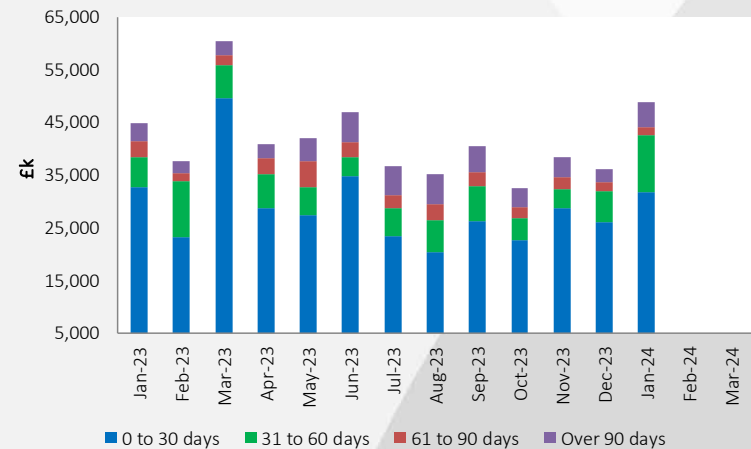
Capital



Debtors



Creditors



Statement of Financial Position

Statement of Financial Position	2023/24 M7 YTD				
	31-Mar-23	31-Dec-23	31-Jan-24	In Month Movement	YTD Movement
Non current assets	£000s	£000s	£000s	£000s	£000s
Intangible assets	15,506	11,776	10,841	(935)	(4,665)
Property, plant and equipment	719,387	731,402	736,150	4,748	16,763
Other non-current assets	3,099	3,277	3,284	7	185
Total non-current assets	737,992	746,454	750,274	3,820	12,283
Current assets					
Inventories	22,663	24,263	25,296	1,033	2,634
Trade and other receivables	62,691	73,775	72,140	(1,634)	9,449
Cash and cash equivalents	103,344	19,763	23,165	3,402	(80,180)
Total current assets	188,698	117,801	120,602	2,801	(68,097)
Current liabilities					
Trade and other payables	(163,436)	(122,223)	(128,121)	(5,898)	35,315
Borrowings / leases	(7,895)	(11,990)	(11,703)	286	(3,808)
Accruals	(23,066)	(32,801)	(33,168)	(366)	(10,101)
Deferred income	(4,167)	(16,148)	(10,999)	5,148	(6,832)
Dividend payable	(609)	(4,409)	(6,121)	(1,712)	(5,512)
Provisions < 1 year	(13,014)	(6,847)	(6,732)	115	6,282
Total current liabilities	(212,188)	(194,417)	(196,844)	(2,427)	15,343
Net current assets / (liabilities)	(23,489)	(76,617)	(76,243)	374	(52,754)
Total Assets less Current Liabilities	714,502	669,838	674,032	4,194	(40,471)
Borrowings / leases	(33,847)	(32,034)	(32,361)	(327)	1,487
Provisions for liabilities & charges	(4,033)	(4,033)	(4,033)	0	0
Total non-current liabilities	(37,881)	(36,067)	(36,394)	(327)	1,487
Total assets employed	676,622	633,770	637,638	3,867	(38,984)
Public dividend capital	(797,141)	(801,223)	(816,451)	(15,228)	(19,310)
Revaluation reserve	(202,796)	(202,796)	(202,796)	0	0
Income and expenditure reserve	323,316	370,253	381,609	11,357	58,294
Total taxpayers equity	(676,622)	(633,766)	(637,638)	(3,871)	38,984

The Statement of Financial Position (SOFP) as of 31st January 2024 is presented in the table opposite. The key movements are explained as follows:

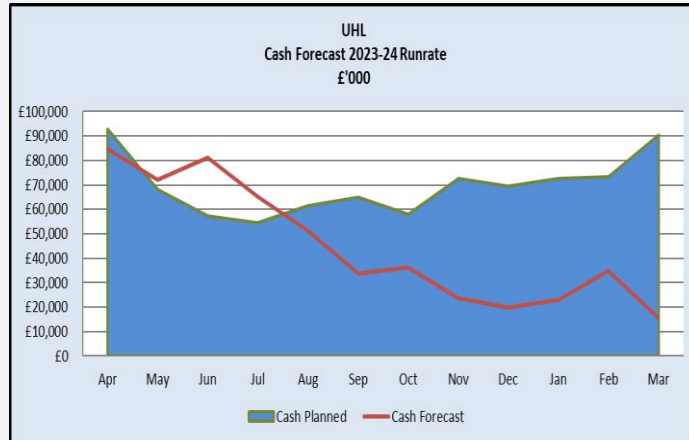
- **Non-Current Assets** - PPE and intangibles increased by £3.8m. Capex of £10.6m was offset by depreciation of £4.7m and impairments and asset disposals of £2.1m.
- **Trade and other receivables** – reduced by £1.6m mainly due to a reduction in patient care activity income of £3.7m, offset by increased HEE income accrual
- **Cash Balances** – Cash balances increased by £3.4m
- **Trade and other payables and accruals** – Trade payables and accruals increased by £6.1m, essentially relating to timing, with significant drivers being an increase in GRNIs (£4.7m), increased capital creditors (0.6m), increased Tax and Ni creditor (0.8m), all of which will be transacted in cash terms before year end.
- **PDC Dividend** –the increase of £1.7m reflected the PDC accrued liability for the month of January.
- **Deferred Income** – reduced by £5.1m as the Trust invoiced for its contract payment from HEE income in advance of £4.7m, supplemented by additional deferral of patient care activity income of £0.7m.
- **Income and Expenditure Reserve** – The I&E reserve deteriorated by £11.4m in line with the in year reported income and expenditure position (including the impact of impairment arising from the asset verification exercise. which does not form part of the Trust's adjusted in year performance).

Cash

The Trust cash balance at the end of January was £23.2m, representing an in month increase of £3.4m. This was in line with forecast.

The current cash forecast for the Trust for 31 March 24 is £15.8m consistent the Trust's forecast I&E deficit. This compares with a planned year end cash surplus of £90.3m based on an I&E deficit plan of £10m. The table opposite sets out the reasons for the reduction in cash of £80.1m since the start of the year. The contraction of the cash position is largely driven by the delivery of the in-year deficit and the capital expenditure incurred at the start of 2023/24 but relating to 22/23 commitments.

The Trust will apply for additional revenue cash support in March for Quarter 1 24/25 to ensure the Trust is able to meeting ongoing liabilities as they fall due. This application has been signed off by the Board.



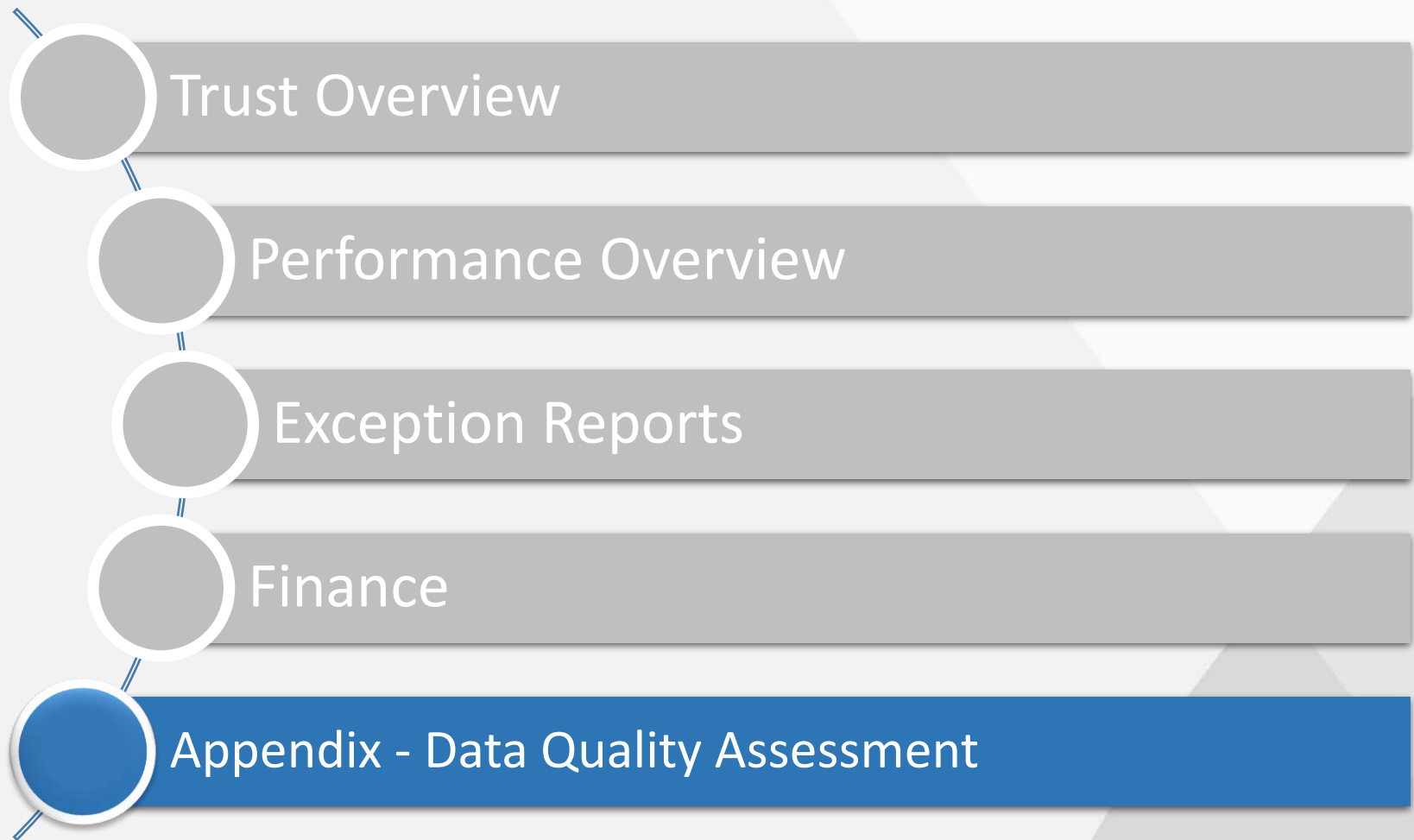
STATEMENT OF CASH FLOWS	YTD Actual
	2324 YTD
	£'000's
CASH FLOWS FROM OPERATING ACTIVITIES	
Operating surplus/(-deficit) before i	(41,927)
Depreciation and Amortisation	45,087
Impairment losses	0
Charitable Donations djustments	(6)
Tax (paid)/received	0
Increase/(Decrease) in Working Cap	0
Inventory	(2,634)
Receivables	(9,634)
Payables	(26,789)
Other Liabilities	6,832
Provisions	(6,282)
Cashflows from operating activities	(35,351)
CASH FLOWS FROM INVESTING ACT	
Interest Received	3,534
(-Payments) for Property , Plant and	(55,607)
+ Receipt of cash donations to purc	0
(-Payments) for Other Investments	0
(-Payments) for Intangible Assets	0
Proceeds from Disposal of Plant , Pr	(455)
Proceeds from Disposal of Intangibl	0
Net Cash Inflow/(-Outflow) from Inv	(52,528)
Net Cash Inflow/(-Outflow) before f	
	(87,880)
CASH FLOWS FROM FINANCING ACT	
Borrowings	0
Finance Lease	2,321
Interest Paid	(2,328)
Public Dividend Capital Received	19,310
Public Dividend Capital Repaid	(11,607)
Other Capital Receipts	0
Dividend Paid	0
Net Cash Inflow/(-Outflow) from Fir	7,696
Net Increase/(-Decrease) in Cash an	
	(80,183)
Cash and Cash Equivalents at the b	103,350
Cash and Cash Equivalents at the er	23,167

Capital Programme

Area	Year to Date					Forecast			
	M10 Plan £'000	M10 Forecast £'000	M10 Actual £'000	Variance to M10 YTD Plan	Variance to YTD M10 Forecast	Original Annual Plan £'000	Revised Plan £'000	Forecast £'000	Variance to Forecast £'000
System Funded									
East Midlands Planned Care Centre inc ICS Reserve	0	188	139	0	(49)	3,724	6,481	6,193	288
Reconfiguration	1,042	781	1,614	454	833	1,250	1,250	1,250	0
MEE	1,200	1,173	1,528	307	355	1,500	1,173	1,935	(762)
MES	3,729	2,865	3,078	(651)	213	3,729	3,729	3,729	0
MES Enabling	1,908	2,777	3,262	1,149	485	3,425	3,425	3,425	(0)
IMT - BAU/ Rep'ment /Obsolescence	210	1,213	694	(210)	(520)	3,292	3,490	3,490	(0)
IMT - Strategic EPR	5,788	4,750	5,721	(1,781)	971	4,850	5,500	5,500	0
IMT - Strategic Digitisation - workplace & data	0	550	654	536	104	0	860	860	0
IM&T - eEquip - Purchase	0	499	2,726	2,461	2,227	2,640	4,403	3,592	811
IM&T - eEquip - Lease	2,200	377	481	(1,824)	104	0	377	377	(0)
IM&T - Addition Kit	0	0	0	0	0	0	0	1,000	(1,000)
Estates and Facilities Backlog	3,667	3,966	4,810	930	844	5,000	5,000	5,000	0
Estates Projects	6,581	5,174	6,502	(310)	1,328	8,249	7,740	7,740	0
Linear Accelerator	4,078	3,212	4,751	507	1,539	5,074	3,699	3,699	0
Research and Education	830	854	503	(327)	(351)	1,000	1,000	1,000	(0)
Surgery Robot - Equipment & Estates	0	205	43	43	(162)	0	601	601	0
Contingency	756	0	0	(756)	0	1,015	0	0	0
Other Schemes	0	971	282	255	(689)	0	2,606	1,943	663
VAT Credit	0	(4,528)	(4,528)	0	0	0	(4,528)	(4,528)	0
Endoscopy	0	0	0	0	0	0	0	0	0
Total Schemes funded from System envelope	31,988	25,028	32,260	783	7,232	44,748	46,806	46,806	(0)
PDC Funded Schemes									
Reconfiguration	880	1,060	1,060	180	(0)	1,060	1,060	1,060	0
East Midlands Planned Care Centre	15,278	12,319	11,282	(3,996)	(1,038)	16,151	13,975	13,975	(0)
UEC - Wards	19,902	7,755	6,997	(13,075)	(758)	24,500	23,997	9,218	14,779
UEC - Modular	6,000	0	0	(6,000)	0	6,000	0	0	0
CDC Hinckley	0	0	1,426	1,426	1,426	900	1,778	1,778	0
Endoscopy	0	241	248	248	7	0	248	248	0
Total Cost Model Fees	0	73	0	0	(73)	0	219	219	0
Enabling Fees	0	0	0	0	0	0	1,701	1,701	0
New Endoscopy unit - LGH	0	2,263	1,998	1,998	(265)	0	5,275	5,275	(0)
Digital Diagnostics Capability - Additional funding for iRefer	0	0	0	0	0	0	243	243	0
Cyber Improvement Programme - Cyber risk reduction	0	0	0	0	0	0	127	127	0
Blopsy Diagnostic System (Breast)	0	0	0	0	0	0	78	78	0
Cepheid/Fibroscan/ Phrobes	0	0	0	0	0	0	187	187	0
Red Blood Cell Exchange Machines	0	0	0	0	0	0	60	60	0
Video Conferencing/SMOTS	0	0	0	0	0	0	42	42	0
Elective Care Coordination (IECCP)	0	0	0	0	0	0	750	750	0
Frontline Digitisation (EPR)	0	0	0	0	0	0	1,400	1,400	0
Slippage schemes b/f	0	393	0	0	(393)	0	0	13,179	(13,179)
Slippage schemes (not b/f)	0	0	0	0	0	0	0	1,600	(1,600)
Other Schemes Unallocated	0	0	0	0	0	0	0	0	0
Total PDC Funded Schemes	42,060	24,105	23,010	(19,219)	(1,094)	48,611	51,140	51,139	0
Charitable Funds	420	256	394	(26)	138	480	393	393	0
NHR1 Grant	0	0	144	144	144	0	754	754	0
NHR2 Grant	0	0	0	0	0	0	219	219	(0)
Surgery Robot - Charity	0	1,849	1,849	1,849	0	0	1,849	1,849	0
Total Charitable Funds/Grant	420	2,105	2,387	1,967	282	480	3,215	3,215	(0)
Total Capital Programme	74,468	51,238	57,658	(16,469)	6,420	93,839	101,161	101,161	1
Leases:IFRS16	6,853	5,850	6,192	(1,003)	342	10,060	9,052	9,052	(0)
Total Capital Programme inc Leases	81,321	57,088	63,850	(17,472)	6,762	103,899	110,213	110,213	1
Linacc transfer To MES provider	0	2,918	0	0	(2,918)	0	2,918	2,918	0
Total	81,321	60,006	63,850	(17,472)	3,844	103,899	113,131	113,131	1
Donated Income/Grant rec'd	(2,882)	(2,882)	(2,882)	0	0	(500)	(3,216)	(3,216)	(0)
Less: Book value of asset disposals	(2,918)	(2,918)	(2,918)	0	0	0	(2,918)	(2,918)	0
Net CDEL	75,521	54,206	58,049	(17,472)	3,844	103,399	106,997	106,996	1

The Trust has agreed a revised gross capital plan of £113.1m for 2023/24 (CDEL of £106.0m). At Month 10, expenditure committed was £58.1m (Net CDEL) against a year-to-date forecast of £54.2m (£3.8m above forecast).

The Trust remains on target to deliver its year end capital plan. Schemes have been identified and are being progressed to fully utilise the ACTIF UEC and national PDC funding for the EMPCC and Endoscopy schemes in year, to mitigate any residual risk of underspend and loss of funding on these schemes into 24/25.



Data Quality Assessment

The Data Quality Assurance Group (DQAG) panel is presented with an overview of data collection and processing for each performance indicator in order to gain assurance that it is of suitably high quality. DQAG provides scrutiny and challenge on the quality of data presented, via the attributes of:

- i. Sign off and Validation
- ii. Timeliness and Completeness
- iii. Audit and Accuracy and
- iv. Systems and Data Capture to calculate an assurance rating.

Assurance rates key Green = Reasonable/Substantial Assurance, Amber = Limited Assurance and Red = No Assurance.