The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Meeting:	Board of Directors (Public)		
Meeting Date:	7 December 2021	**Agenda item:**	11
Report Title:	Integrated Performance Report (IPR) – October 2021 Data		
Author:	Nigel Hall, Chief Digital and Information Officer		
Executive Sponsor:	Laura Skaife-Knight, Deputy CEO		

Implications

Link to key strategic objectives
[highlight which KSO(s) this recommendation aims to support]

KSO1	KSO2	KSO3	KSO4	KSO5	KSO6
Safe and compassionate care	**Modernise hospital and estate**	**Staff engagement**	**Partnership working, clinical and financial sustainability**	**Healthy lives staff and patients**	**Investing in our staff**

Board assurance framework	The IPR covers all key performance indicators for the Trust, across all Strategic Objectives. The appropriate BAF updates are received and reviewed within Finance and Activity Committee, Quality Committee, People Committee and Senior Leadership Team.	
Significant risk register	Ref to significant risks There are currently eleven approved significant risks open across the Trust which align to the Strategic Objectives. These are monitored through the Trust committee structure.	
	Y/N	If Yes state impact/ implications and mitigation
Quality	Y	As monitored through Committees
Legal and regulatory	Y	As monitored through Committees
Financial	Y	As monitored through Committees

Assurance route

Previously considered by:	None previously

Executive summary

Action required:	Approval	Information	**Discussion**	Assurance	Review
Purpose of the report:	The Trust is required to provide assurance towards performance management. Demonstrate that it is rigorous; appropriately identifying, escalating, and dealing with areas of performance which are of concern. This should all be in a timely manner. Focusing on the data using Statistical Process Control enables greater visibility and oversight. This, in turn, provides focus to ongoing issues in				

	relation to performance rather than those which are delivering within the parameters of agreed statistical variation. This month, a change tracker has been introduced to monitor all changes made to metrics reported within the IPR during the year.
Summary of Key issues:	A summary of key issues highlighted in the IPR this month are detailed below: **Incidents** The number of serious incidents in October (4), compared to September (5). **Falls** A total of 80 in-patients falls incidents reported in October 2021, 63 reported in September. **Pressure Ulcers** The number of hospital acquired pressure ulcers has remained the same in October, above the tolerance level for the second consecutive month following seven months below the tolerance level. **C.Diff** - Five cases of C. Diff were identified in October 2021. (One HOHA and four COHA). **MSSA** - Three cases of hospital onset and one case of community onset MSSA were reported in October 2021. **E. coli** - Four cases of hospital onset E. coli were reported in October 2021. **VTE Assessment Completeness** VTE screening completeness remains a common cause variation above the agreed national threshold of 97.2%. This has been the case since May 2020 signifying business as usual. **Neonatal and Perinatal Mortality** There was one still birth in the month of September. This was an unexplained death awaiting post-mortem reports on the baby. There were no lapses in care identified and the patient presented with sudden decreased movements. This was reviewed at Serious Incident Review Panel (SIRP) and confirmed that appropriate care was provided. **Mortality** SHMI remains as expected and HSMR continues to fall, although challenges remain to ensure that all records are coded in time for national submission deadlines. The number of cardiac arrests remains within common cause variation well below our upper threshold. **Research** Research remains within common cause variation but continues to exceed our target.

	Dementia Case Finding The improved screening process has been embedded in the services of Integrated Care of Older People (ICOP). **Responsive** The COVID-19 pandemic had a significant detrimental impact on waiting times for elective care and this impacts upon performance against the RTT, cancer and diagnostic waiting time standards. Since the second wave of COVID-19 the Trust has seen a sustained increase in urgent and emergency care demand, and this impacts on performance against the emergency care and elective care access standards. Restoration and improvement plans are in place for urgent and emergency care and elective care. **Well Led (Finance)** As at the end of October (month 7), the Trust's in month financial position is showing a surplus of £27k with a year-to-date surplus of £79k. This is in the context of the Trust and ICS financial plan for H2 2021/22 being a breakeven financial plan with the month 7 actual financial position being used as the budget for month 7 as per NHSI&E guidance. The Trust has delivered its plan of £0.6m CIP for month 7 with a year-to-date achievement of over-performing to plan by £0.5m. The Trust is behind plan on its capital expenditure programme of in month capital expenditure incurred of £0.8m and year to date spend of £4.1m. The cash position of the Trust remains strong with the achievement of the Better Payment Practice Code standard for October of paying at least 95% of its undisputed invoices within 30 days. **Well Led (People)** Overall appraisal rates have improved from 77.4% last month to 80.27% though still behind target. Sickness Absence has increased for the 7th consecutive month and is now outside of normal variation limits at 7.22%: 1. Detailed root cause analysis discussed at People Committee and trajectory for improvement and action plan to be presented to the Board in January 2022.
Recommendation:	The Board of Directors is asked to note the contents of this report, specifically the actions which are being taken to maintain and to improve performance where appropriate.

Acronyms	AHP: Allied Health Professional BAF: Board Assurance Framework CCU: Critical Care Unit COPD: Chronic Obstructive Pulmonary Disease EEAST: East of England Ambulance Service Trust FFT: Friends and Family Test HSMR: Hospital Standardised Mortality Ratios KPI: Key Performance Indicator LMS: Local Maternity System LSCS: Lower Segment Caesarean Section RTT: Referral to Treatment SHMI: Standardised Hospital Mortality Index VTE: Venous thromboembolism

The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Integrated Performance Report

Board of Directors

October 2021 Data

A note on SPC Charts

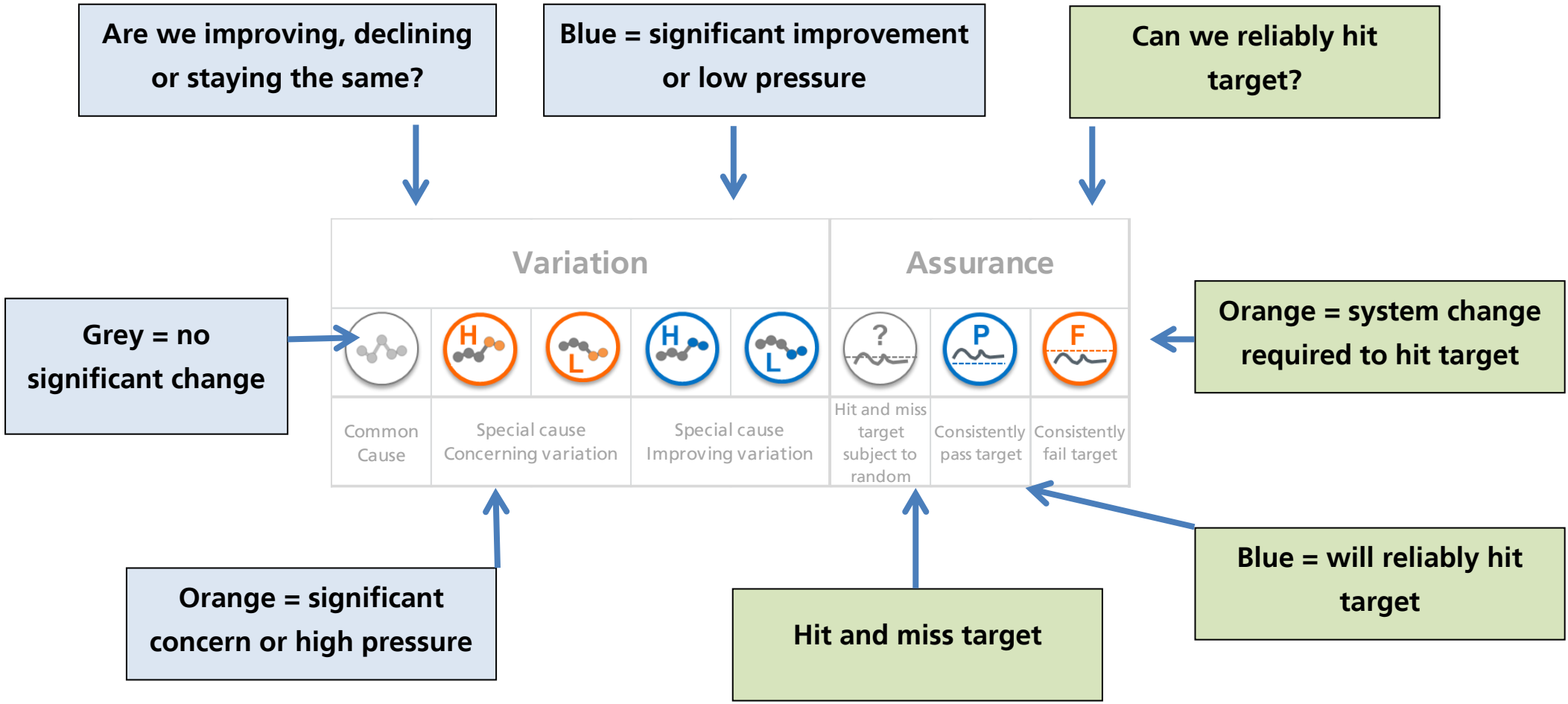
The report that follows uses the key below. A recap of using these descriptions is also included below

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

A note on SPC Charts continued

High level Key - Variation

High level Key - Assurance



Change Log:

Month	Details of Change	Domain(s)
November 2021	Still births, Neonatal deaths and perinatal deaths are rare events. In line with NHSEI best practise, these will now be recorded as time since last event. The most recent neonatal death was 16.10.2020 which was 289 days since the previous event 01.01.2020. Data is not held prior to April 2018 and no neonatal deaths were recorded in 2018 or 2019. Hence Neonatal deaths will be presented in its current format for now. However, still births and perinatal deaths are now being presented as time since last event format.	Effective

Safe - Accountable Officer - Chief Nurse/Director of Patient Safety

Data To	KPI Description	Limit	Current Value	Variance	Assurance
Oct-21	Serious Incidents (DECLARED IN MONTH)	0	4		
Oct-21	Falls (with Harm) Rate per 1000 beddays	0.98	0.36		P
Oct-21	PUs Rate per 1000 beddays	0.41	0.55		?

Data To	KPI Description	Target	Current Value	Variance	Assurance
Oct-21	Overall Fill Rate %	80.0%	84.8%	L	P
Oct-21	CHPPD	8.00	7.07	L	?
Oct-21	Cleanliness - Very High Risk	95.0%	97.0%		P
Oct-21	Cleanliness - High Risk	95.0%	95.4%		?
Oct-21	Cleanliness - Significant Risk	95.0%	92.1%		?
Oct-21	Cleanliness - Low Risk	95.0%	87.0%		
Oct-21	Cleanliness - No. of audits complete	37.00	45		?

Data To	KPI Description	Limit	Current Value	Variance	Assurance
Oct-21	CDiff (Hosp Acquired) Rate per 100k beddays	30.10	36.99	H	?
Oct-21	CDiff (Hosp Acquired) Actual	4	5		
Oct-21	MRSA (Hosp Acquired) Actual	0	0		
Oct-21	E Coli (Hosp Acquired) Rate per 100k beddays	16.40	22.57	H	?
Oct-21	E Coli (Hosp Acquired) Actual	2	4		
Oct-21	MSSA (Hosp Acquired) Actual		4		
Oct-21	MSSA (Hosp Acquired) Rate per 100k beddays		15.05	H	

Data To	KPI Description	Target	Current Value	Variance	Assurance
Sep-21	VTE Assessment Completeness	97.2%	98.4%	H	?
Oct-21	Patient Safety Alerts not completed by deadline	0	0		

Serious Incidents

The Trust declared 4 Serious Incidents in October.

- One was a patient who experienced a delay in diagnosing a pneumothorax within the urgent and emergency care setting. The patient subsequently died.
- One was a delay in the transfer of a patient with a fractured T12 to NNUH.
- One was the loss of histology samples affecting five patients under the care of Dermatology.
- One was an inpatient fall resulting in a right intertrochanteric fracture.

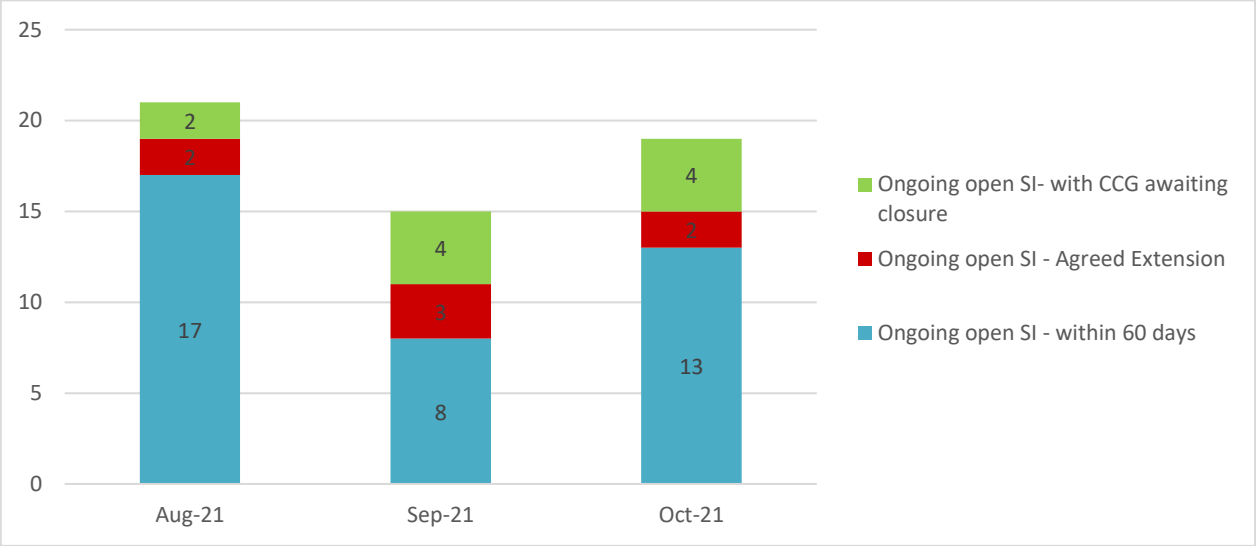


Chart 1 – Trust wide Serious Incident investigation status

Falls

Data To	KPI Description	Limit	Current Value	Variance	Assurance	*Variation Comment*	*Target Achievement*
Oct-21	Falls (with Harm) Rate per 1000 beddays	0.98	0.36			Common Cause (expected) variation	Variation indicates consistently (P)assing the target

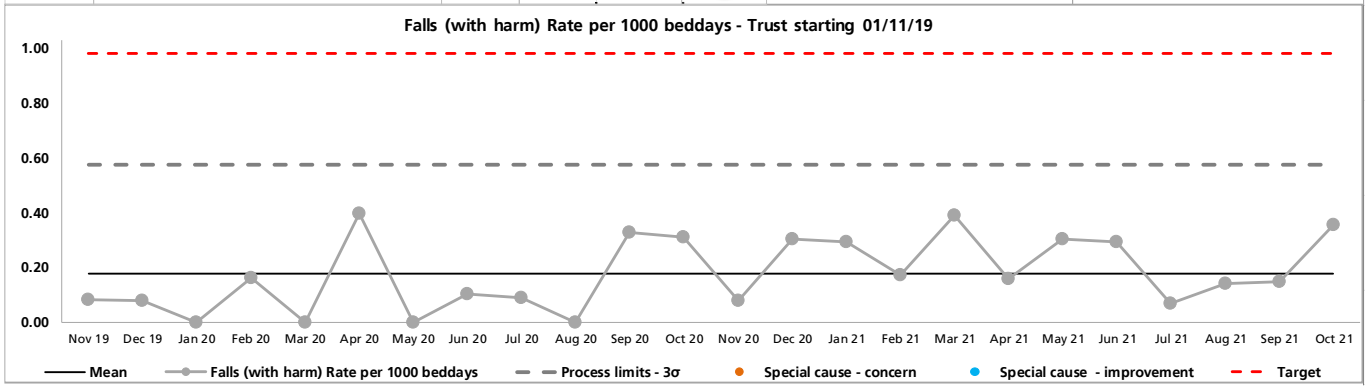


Chart 2 – Falls (with harm) Rate per 1,000 Bed Days

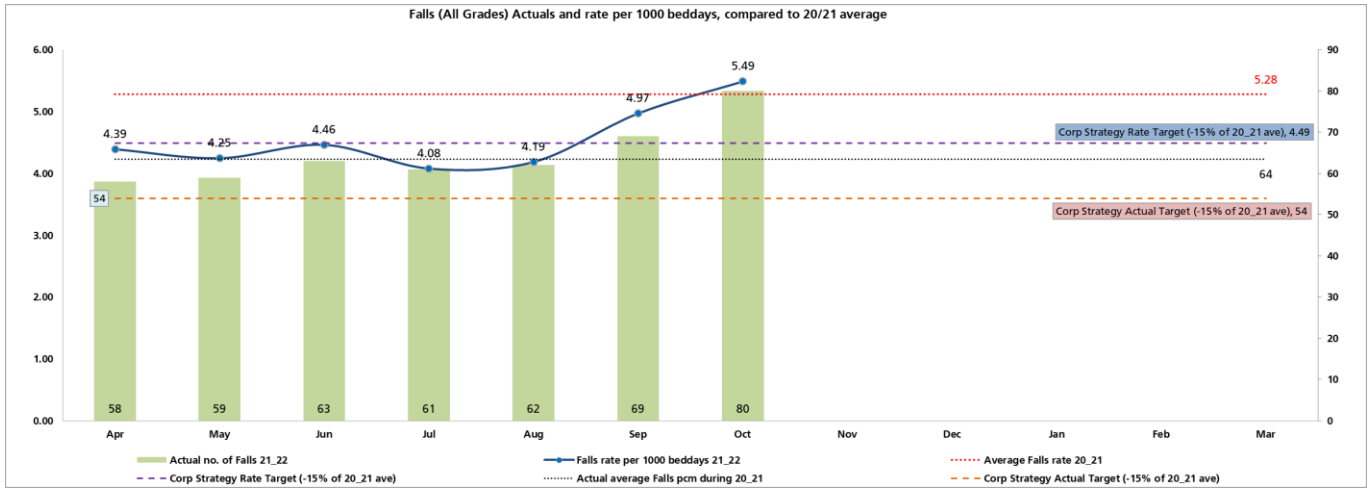


Chart 3 – Falls and rate per 1,000 bed days

Key Issues (any new issues in red):

1. A total of 80 in-patients falls incidents reported in October 2021, 63 reported in September.
2. The number of falls with harm per 1000 bed days in October has increased Since the previous months.
3. There were 5 patients sustaining harm and injuries following fall incidents categorised as X1 Major (reported as an SI - #NOF), X4 moderate.
    a. Tilney (#Shoulder)
    b. Marham (Head Injury)
    c. Stanhoe (# Pubic Rami)
    d. Windsor – fall with no bony injury but remained as near miss moderate requires validation and may be down graded

Key Actions (new actions in green):

1. The Falls Coordinator continues to deliver micro teachings on the prevention and management of falls.
2. Focused teachings are delivered to areas with high incidents of falls.
3. Train the trainer sessions on enhanced care continue.
4. The Falls Operational Group has been established to introduce initiatives and implement actions using a multidisciplinary approach.
5. Falls awareness week focussed on key areas daily highlighting falls awareness Trust wide.
6. A new dashboard was launched in September to aid visual awareness.
7. The falls operation group will be developing a workplan and an associated action plan monitored through the group.

Recovery Forecast: Reduction monthly in the number of falls and falls with harm.

Key Risks to Forecast Improvement:

1. Increasing number of patients admitted with high risk of falls and staff not adhering to falls policy.
2. Staffing challenges may result in inconsistent facilitation of robust enhanced care on occasions.
3. There are a high number of patients admitted to Trust who are at high risk of falls.
4. Additional medical inpatient areas have been opened to support capacity with impact on overall level of falls risk.

Pressure Ulcers

Data To	KPI Description	Limit	Current Value	Variance	Assurance	*Variation Comment*	*Target Achievement*
Oct-21	PUs Rate per 1000 beddays	0.41	0.55			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

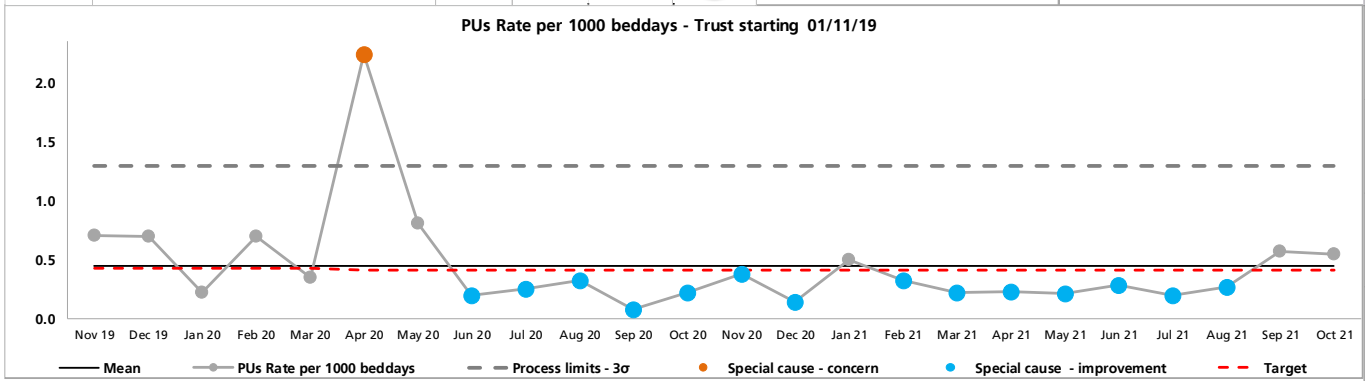


Chart 4 – Pressure Ulcer Rates per 1,000 Bed Days

Key Issues (any new issues in red):

1. The number of hospitals acquired pressure ulcer has remained the same in October above the tolerance level for the second consecutive month following six months below the tolerance level.
2. There were 8 hospital acquired pressure ulcers in October (X2 DTI, X1 Cat 3, X3 Cat 2, X2 Unstageable).
3. 3 were initially assessed as lapses in care. DOC completed. RCAs underway – action plans in place.
4. Themes identified on lapses of care was poor recording of risk and capacity assessments and reassessment's, insufficient evidence, or documentation to support to prevent further damage to the skin.

Key Actions (new actions in green):

1. The Tissue Viability team continue to work with the wards to deliver and support training in pressure ulcer prevention. Those wards with pressure ulcers also plan to share the incident and learning with their teams and will have targeted teaching sessions to support the lapses in their patient care with continued audits.
2. The Tissue Viability Nurses (TVN) continue to deliver refresher training sessions with external Clinical Nurse Advisors.

3. 100 days free campaign commenced in June 2021 - the initiative sets every ward and clinical department the target of achieving 100 days free of hospital acquired pressure ulcer with lapses in care identified.
4. The Areas with specifically identified care have an individualised plan monitored through the Divisions.
5. Trust wide point prevalence audit completed in early October (with ARJO) awaiting results.
6. The TVN team has been joined by a senior experienced nurse (started November 1st) to cover long-term sickness. This aims to ensure the team is enhanced and the addition will support on delivery of training/expertise/bedside teaching.

Recovery Forecast:

1. The number of hospital acquired pressure ulcer start to reduce as we realign specialties
2. The pressure ulcer rate per 1,000 bed days at the QEH is lower compared to similar sized organisations.

Key Risks to Forecast Improvement:

1. Non-compliance with the pressure ulcer prevention care bundle.
2. Increasing number of patients admitted to the Trust at a high risk of developing a pressure ulcer.
3. Reduced number of staff within Tissue Viability team which is partially mitigated.

Clostridioides difficile Infection - CDI

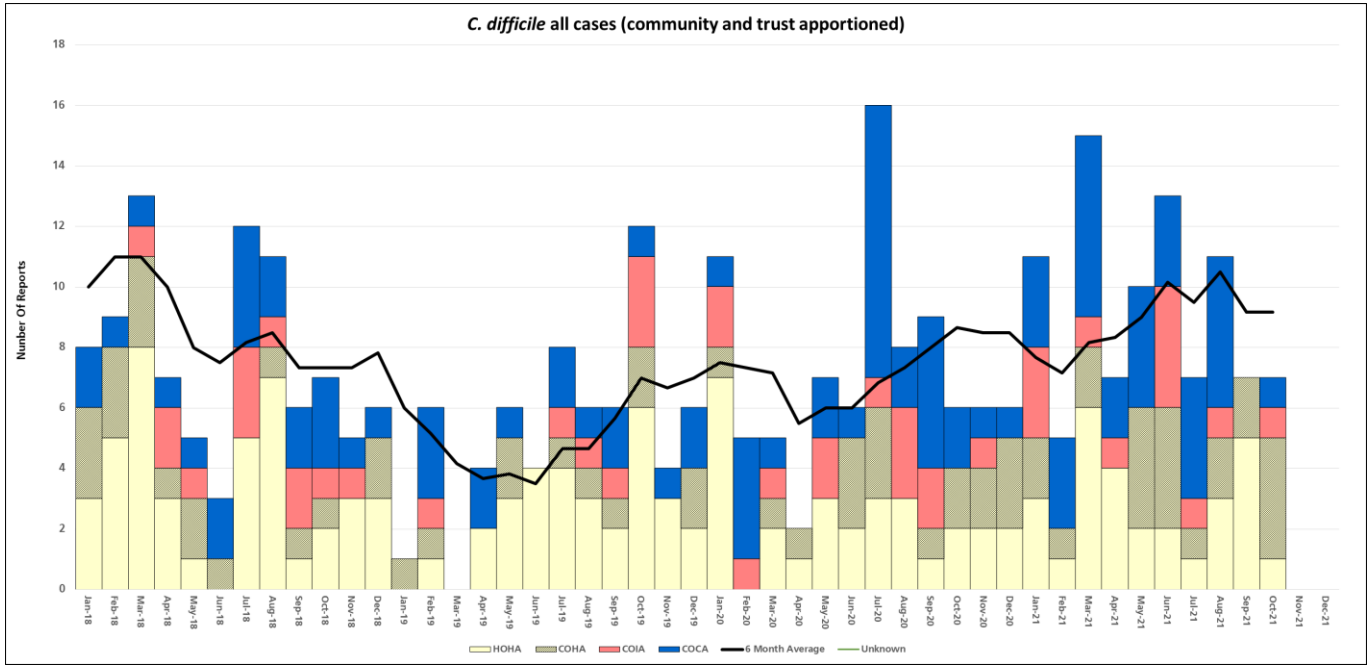


Chart 5 – C. Diff all Cases

There was a change in the reporting of C diff cases for acute providers in 2019/20 by using these two categories: Hospital onset healthcare associated (HOHA): cases that are detected in the hospital two or more days after admission. Community onset healthcare associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous four weeks prior to this, acute providers were only reporting cases relating to the first category which is (HOHA).

Threshold set for CDI for 2021/22 - 40 healthcare associated cases.

Key Issues:

1. **Five** cases identified in October 2021 (**One** HOHA and **four** COHA).
2. All cases presently under review – will be completed by 19 November 2021.

Findings:

1. Poor completion of the PIR documentation, from nursing and medical staff, continues to be a challenge specifically with Consultant input. Without the completion of this paperwork a PIR cannot be undertaken, in line with national requirements.
2. Poor AMS from community management i.e., inappropriate prescribing of antibiotics by GP.
3. Rising CDI cases within community.

Key Actions:

1. The Deputy Medical Director continues to support the PIR process required regarding timely submission of paperwork.
2. NW AMS group in place, attended by QEHKL Consultant microbiologist and Deputy DIPC to support AMS across the ICS.

Key Risks to Forecast Improvement:

1. Ageing estate compromises bed utilisation – isolation rooms make up less than 10% of the estate.
2. Timely documentation of onset of loose stools / management of ICS approach to AMS management.

Methicillin Sensitive Staphylococcus (MSSA)

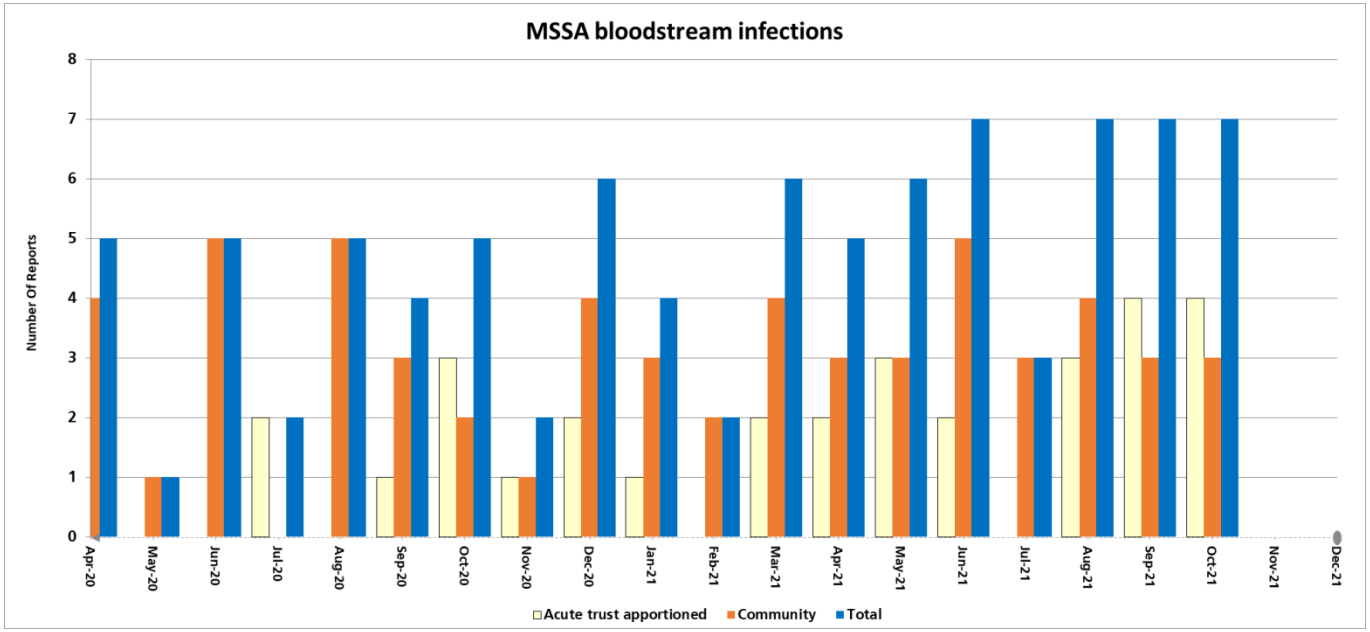


Chart 6 – MSSA Bloodstream Infections

Key Issues:

1. Three cases of hospital onset and one case community onset MSSA were reported in October 2021.
2. All cases awaiting review at PIR meeting – meetings will be completed by 25 November 2021.
3. Initial findings: non-swabbing of pre-existing skin laceration and poor with documentation of VIP score.

Key Actions:

The Infection Prevention and Control Team continue to raise awareness of appropriate management of MSSA, in line with Trust Policy, through:

1. Education at Induction / Mandatory Training.
2. Bespoke education / training on affected areas.
3. Practice Development Nurses provide training (ANTT).
4. Review of individual cases and promptly undertaking measure to reduce any further transmission.
5. Discussing individual cases with Ward Managers / Matrons and escalating concerns, in a time appropriate manner, at senior meetings and via governance reporting channels.
6. IPCT presently undertaking a point prevalence line management audit (results to be shared with HICC October 2021).

Key Risks to Forecast Improvement:

1. Poor compliance with Infection Prevention and Control Policies / practice (ANTT).
2. Poor IPC Mandatory training compliance – challenges to access / complete training.
3. Reduced resources in IPC Team (Registered Nurse establishment / Data analyst).

Escherichia coli (E. coli)

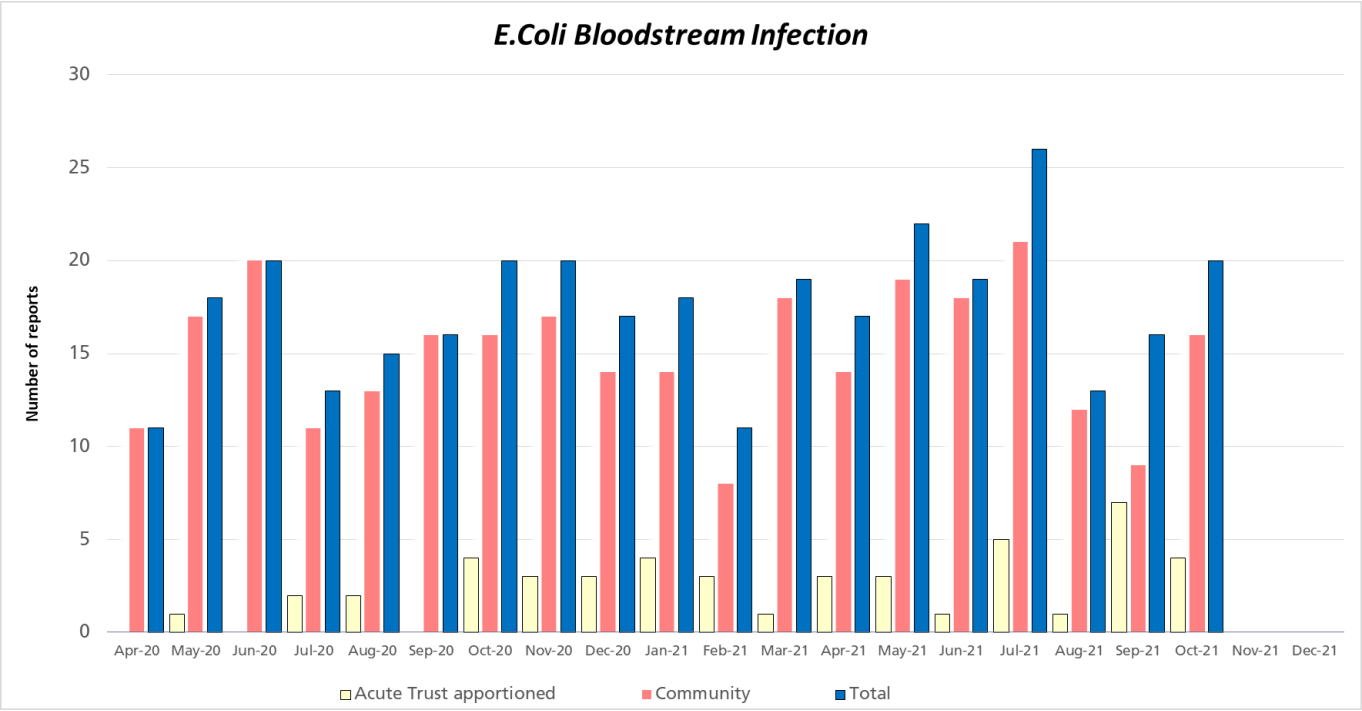


Chart 7 – E. coli Bloodstream Infections

Key Issues

Threshold set for Escherichia coli (E. coli) for 2021/22 - 68 healthcare associated cases

1. Four cases of hospital onset E. coli were reported in October 2021.
2. Cases reviewed at surveillance meeting with Infection Prevention Team, Consultant Microbiologist and Infection Control Doctor.
3. Findings: two patients catheterised one with renal history and managed with fluid intake / output, nil specific identified.

Key Actions

The Infection Prevention and Control Team continue to raise awareness of appropriate management of E. coli, in line with Trust Policy, through;

1. Antibiotic stewardship and engagement - IPCT presently working with Consultant Microbiologists (Infection Control Dr and Anti-microbial lead) and anti-microbial Lead for pharmacy to review the anti-microbial strategy and working group to influence and support future work.
2. Education at Induction / Mandatory Training.
3. Bespoke education / training on affected areas.
4. Practice Development Nurses provide training (ANTT).
5. Review of individual cases and promptly undertaking measure to reduce any further transmission.
6. Supportive programme of audit including hand hygiene, PPE usage, isolation and environmental cleaning in place.
7. Discussing individual cases with Ward Managers / Matrons and escalating concerns, in a time appropriate manner, at senior meetings and via governance reporting channels.
8. Deputy DIPC attends NW QI Group that will be focussing on catheter management.

Key Risks to Forecast Improvement:

1. Compliance with Infection Prevention and Control Policies.
2. Compliance with nutrition / hydration.

VTE Assessment Completeness

Data To	KPI Description	Target	Current Value	Variance	Assurance	*Variation Comment*	*Target Achievement*
Sep-21	VTE Assessment Completeness	97.2%	98.4%	H	?	Special cause (unexpected) variation - Improvement (H)	Variation indicates inconsistently passing and falling short of the target

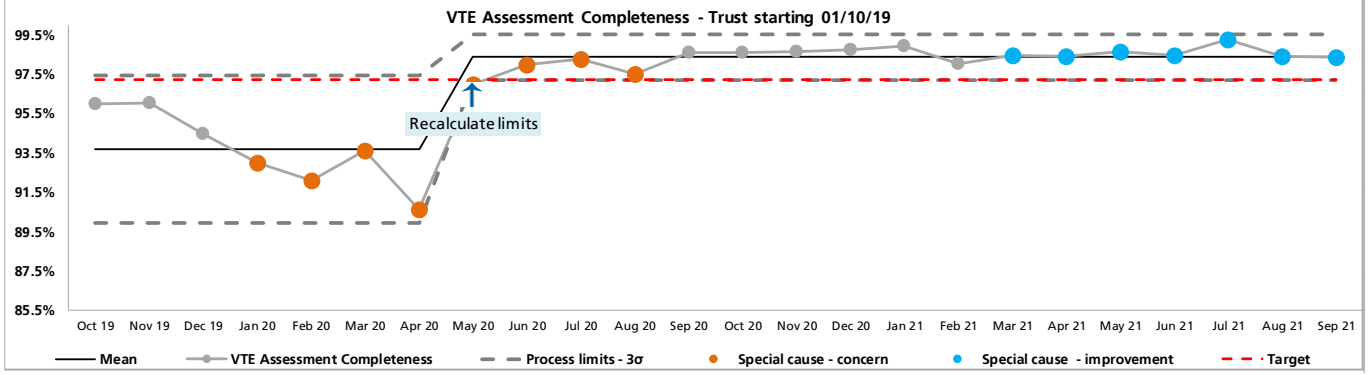


Chart 8 – VTE Assessment Completeness

Key Issues (any new issues in red):

1. VTE screening process remains a common cause variation but higher than the agreed national threshold of 97.2% signifying business as usual. This has been the case since May 2020.

Key Actions (new actions in green):

1. Currently the screening rates are being monitored closely during the installation of EPMA across the trust. Once rolled out and with the implementation of the forcing function, human factors related variations will be minimised and reporting source will be transitioned from admission booklets to EPMA.

Recovery Forecast (e.g. August): Not applicable

Key Risks to Forecast Improvement:

1. The key risk is losing compliance with the screening process whilst EPMA is being implemented. This transition period can result in reduction in compliance as staff may stop recording screening in the admission booklets (which is the primary source of data capture). This is being monitored closely.

Effective - Accountable Officer - Medical Director

Data To	KPI Description	Limit	Current Value	Variance	Assurance
Sep-21	Total Births (inc Home, BBA's & Stillbirths)		175		
Sep-21	Stillbirth Rate	3.73	3.92		
Sep-21	Neonatal Deaths Rate	1.06	0.49		
Sep-21	Extended Perinatal Deaths Rate	4.79	4.41		
Sep-21	Total C Section Rate		34.5%		
Sep-21	EL C Section Rate		16.4%		
Sep-21	EM C Section Rate		18.1%		
Sep-21	Maternal Deaths	0	0		
Sep-21	% "Term" admissions to the NNU	6.00%	4.17%		
Sep-21	% "Avoidable Term" admissions to the NNU	0.00%	0.00%		
Sep-21	Breastfeeding initiation	70.0%	83.3%		

Data To	KPI Description	Target	Current Value	Variance	Assurance
Sep-21	Breastfeeding on discharge from hospital	60.0%	66.3%		
Sep-21	Smoking at Booking	18.6%	16.7%		
Sep-21	Stopped smoking by delivery	44.7%	44.3%		
Aug-21	Smoking at Time of Delivery		14.3%		
Sep-21	Post-Partum Haemorrhage	3.0%	0.6%		
Sep-21	3rd & 4th degree tears, exc C-Sections	3.5%	1.4%		
Jun-21	HSMR Crude Rate	3.18	4.71		
Jun-21	HSMR Relative risk	100.00	121.41		
Jun-21	HSMR Weekend Relative risk	100.00	129.55		
Mar-21	SHMI (Rolling 12 mth position)	100.00	103.75		
Sep-21	Rate per 1000 admissions of inpatient cardiac arrests	2.00	0.29		
Oct-21	No. of patients recruited in NIHR studies	63	98		

Neonatal and Perinatal Mortality

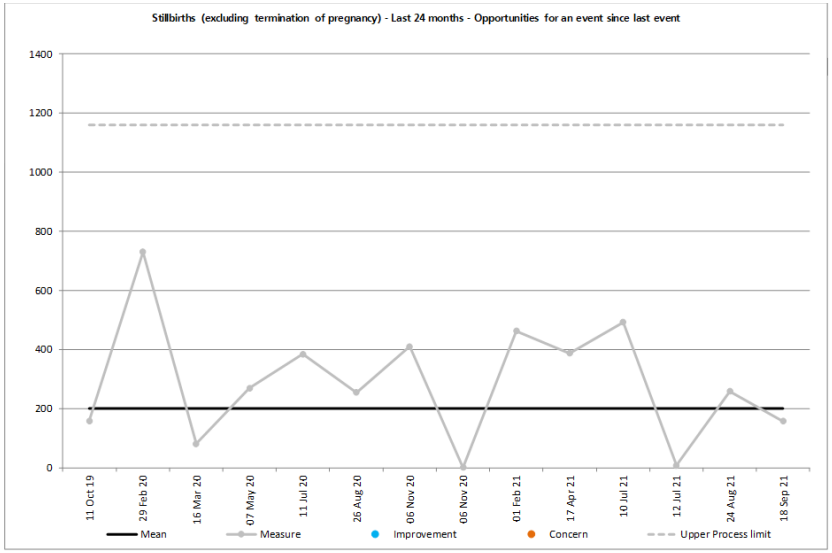


Chart 9 - Stillbirths (recorded as duration in days between events)

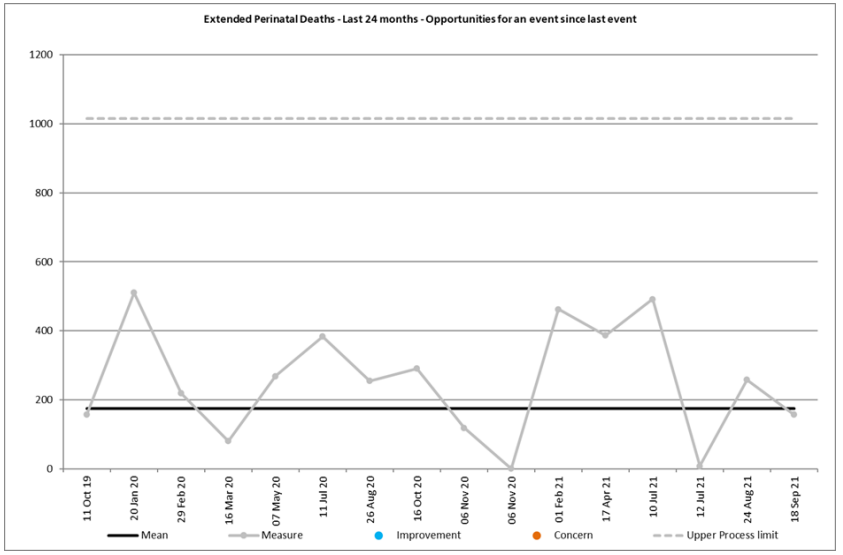


Chart 10 - Extended Perinatal Deaths Rate (recorded as duration in days between events)

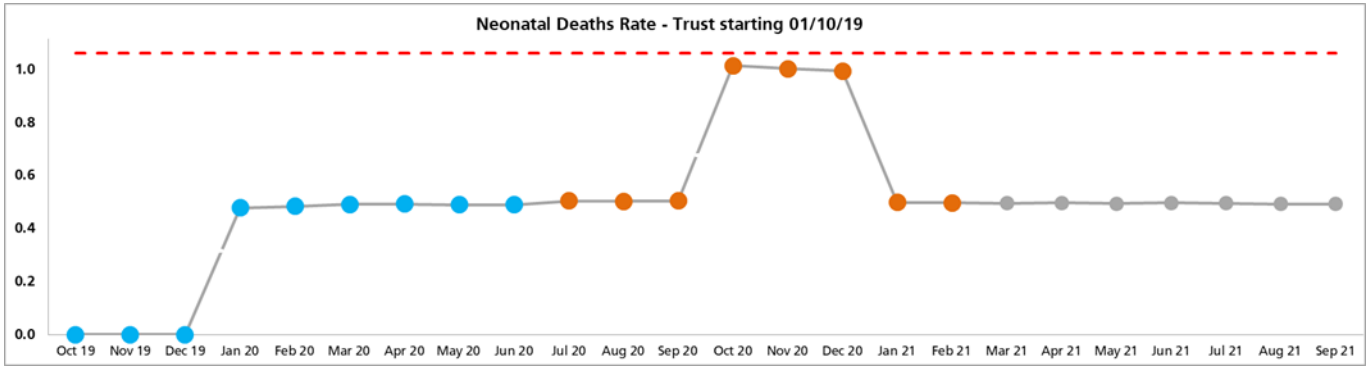


Chart 11 - Neonatal Death Rate

Still births, Neonatal deaths and perinatal deaths are rare events. In line with NHSEI best practise, these should be recorded as number of days since last event but as there are only two events for neonatal deaths recorded since 2019/20 an SPC will be used for this metric.

Key Issues

1. There was one still birth in the month of September. This was an unexplained death awaiting post-mortem reports on the baby. There were no lapses in care identified and the patient presented with sudden decreased movements. This was reviewed at Serious Incident Review Panel (SIRP) and confirmed that appropriate care was provided.

Actions being taken:

1. The division is committed to fully embedding the Saving Babies Lives Care Bundle (SBLCB) Version 2, which is specifically aimed at reducing perinatal mortality in line with the national ambition to half the number of stillbirths, neonatal deaths, brain injuries and maternal deaths by 2025.
2. The Maternity department is working to ensure compliance with the 10 safety actions for the Maternity Incentive Scheme, year 4
3. Work on the Maternity Improvement Plan (MIP) continues with actively engaged workstream leads (safety being one of these workstreams) overseen by the Transforming Maternity Safety and Strategy Forum within the division.

Risk to delivery:

Staffing vacancies continue to pose risks to safe service delivery, but mitigations and daily oversight are in place to manage this risk.

Term Neonatal unit admissions

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	% "Term" admissions to the NNU	6.00%	4.17%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

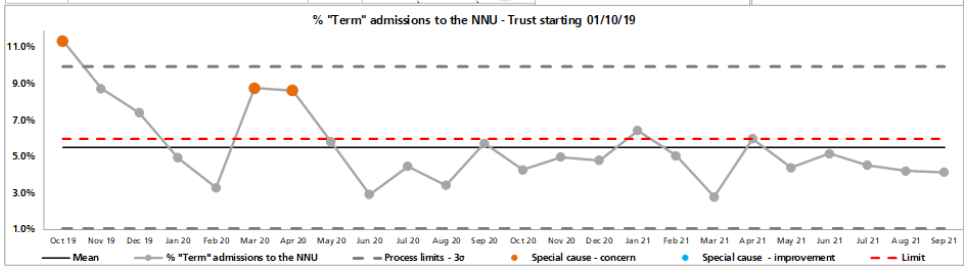


Chart 12 - % 'Term' admissions to NNU

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	% "Avoidable Term" admissions to the NNU	0.00%	0.00%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

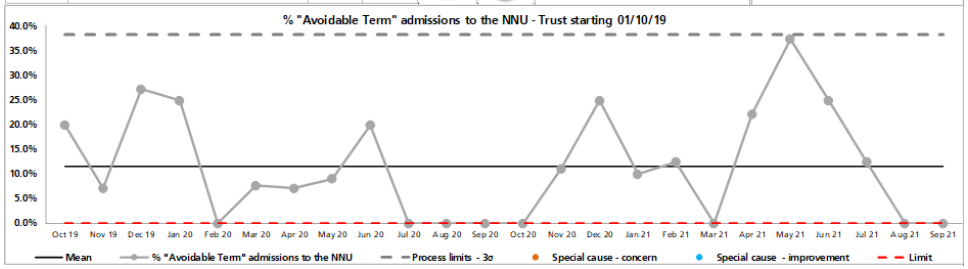


Chart 13 - % 'Avoidable Term' admissions to NNU

Key Issues:

1. Term admissions into the Neonatal Unit remain below the 6% target. In October We had five term babies admitted to the unit.

Key Actions

1. Any term admissions to the NICU are reported via Datix and monitored through maternity safety board. Reviews of all admissions are undertaken for appropriateness and indications and reported.

Avoidable Term admissions

1. There were no admissions to the NICU that were deemed avoidable through the ATAIN MDT review process.

LSCS rates

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	Total C Section Rate		34.5%			Common Cause (expected) variation	

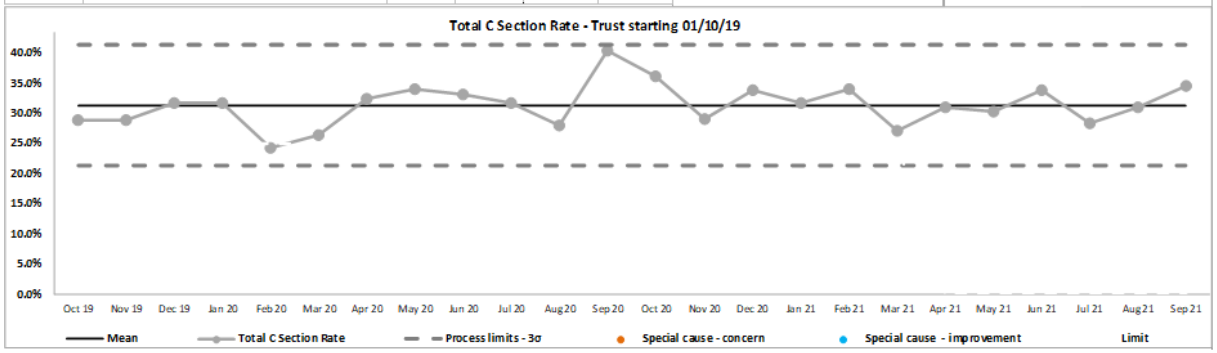


Chart 14 – Total Caesarean Section Rate

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	EL C Section Rate		16.4%			Common Cause (expected) variation	

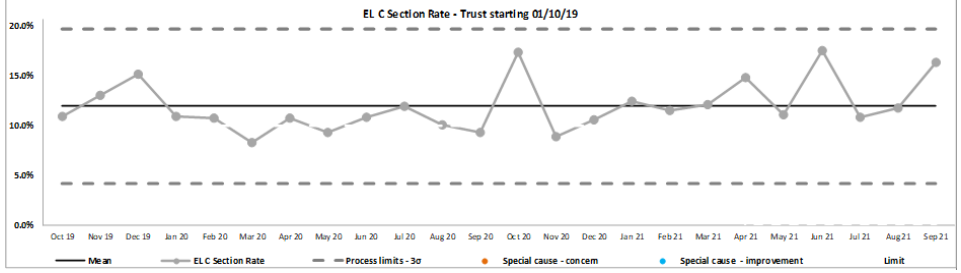


Chart 15 – Elective Caesarean Section Rate

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	EM C Section Rate		18.1%	L		Special cause (unexpected) variation - Improvement (L)	

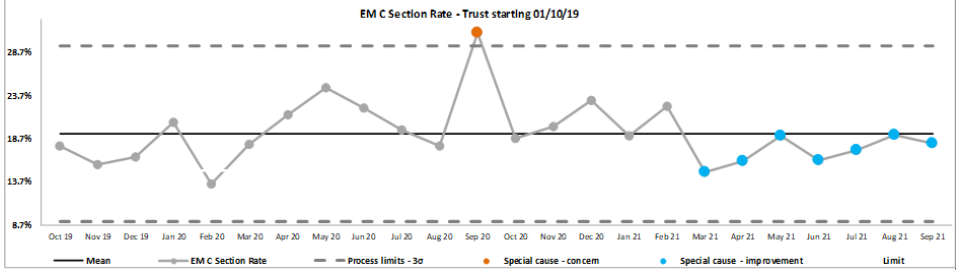


Chart 16 – Emergency Caesarean Section Rate

Factors driving performance:

1. There were 177 births in Septmber 2021 of which 101 [57.05%] were spontaneous vaginal deliveries 17 [9.60%] assisted deliveries and 59 [33.33%] were LSCS.

Actions taken:

1. Multidisciplinary Team meeting to review all emergency and elective indications for caesarean sections is now well attended. A 6 monthy report demonstrates the most common themes: prolonged labour following induction in primiparous women and maternal choice in patients who have had previous LSCS.
2. Improving trust and rapport with the patients through facilitating continuity of care (throughout pregnancy) is currently the recommended approach to address this problem. An audit on Induction of Labour (IOL) is also underway to understand and improve the induction of labour pathway and timings.
3. Encouraging suitable women who had previous one LSCS for trial of labour is our next project to focus as a team involving obstetricians along with Consultant midwife and Clinical Psychology team.
4. A VBAC clinic pathway has been drafted to ensure these women get individualised care plan for delivery.

Risk to delivery:

This domain remains out of purview of thresholds but is continuously monitored for appropriateness.

Breast Feeding Initiation rates

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	Breastfeeding initiation	70.0%	83.3%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

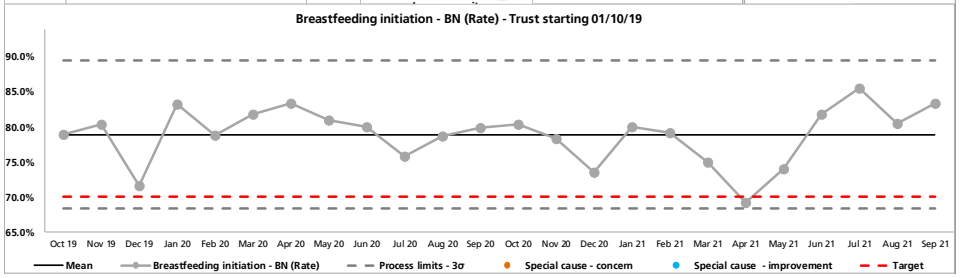


Chart 17 – Breastfeeding Initiation – BN (rate)

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	Breastfeeding on discharge from hospital	60.0%	66.3%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

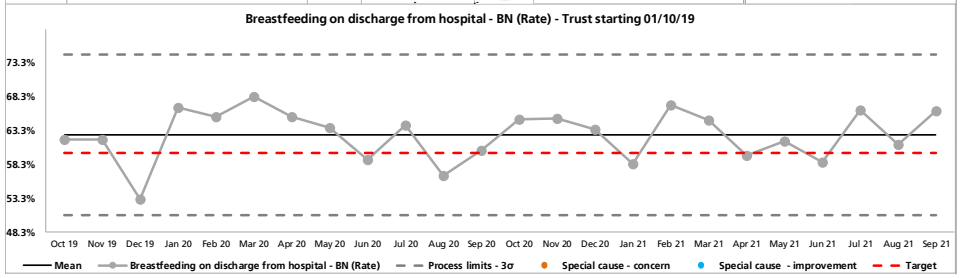


Chart 18 – Breastfeeding on discharge from hospital – BN (rate)

Factors driving performance:

1. Breastfeeding initiation rate remains within common cause variaiont but above the agreed threshold of 70%.
2. The AN hand expressing pack initiative and new infant feeding specialist are thought to be the reason for these steady improvements.
3. Plan in place for community hubs to host infant feeding classes and cafes to improve access to professional and peer breastfeeding to support maintenance of breastfeeding post discharge.
4. Recruitment to the Baby Friendly Initiative Guardian post has been completed.

Risk to delivery:

1. Midwifery staffing remains a challenge at this time with less dedicated time for specialist roles as midwives support acute activity.
2. Frenulotomy service is dependednt on one trained individual. The division is currently reviewing options to ensure this service is more robust or alternatively is delivered through a systemwide resourcing process.

Smoking Cessation in Pregnancy

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	Stopped smoking by delivery	44.7%	44.3%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

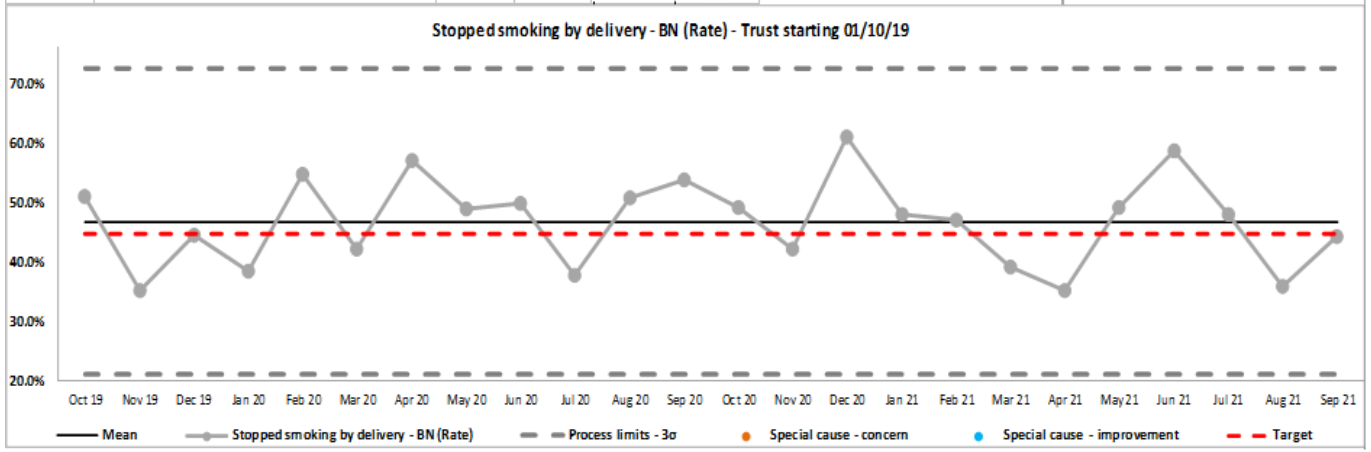


Chart 19 – Stopped smoking by delivery – BN (rate)

Factors driving performance:

1. % of Smoking cessation (average) by delivery remains in common cause variation above agreed levels.
2. Smoking prevelance amongst pregnant women remains higher than national avarages: in Norfolk this was 14.1% compared to national average of 11.4% in 2014, reducing to 13.4% and 10.6% in 2018.

Key Actions:

1. CO screening rates rates ceased during the peaks of the pandemic and continue to rise. Direct electronic referals to smoking cessation services are planned to support increased referal rates.
2. The system are considering the introduction of health coaches.

Risks to delivery:

1. Appitite for engagement with smoking cessation services has been impacted by the rising levels of smokers in the general population during the pandemic with multiple contributory factors. 1:1 smoking cessation support by health coaches aims to address this.

Post-patum Haemorrhage (PPH)

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	Post-Partum Haemorrhage	3.0%	0.6%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

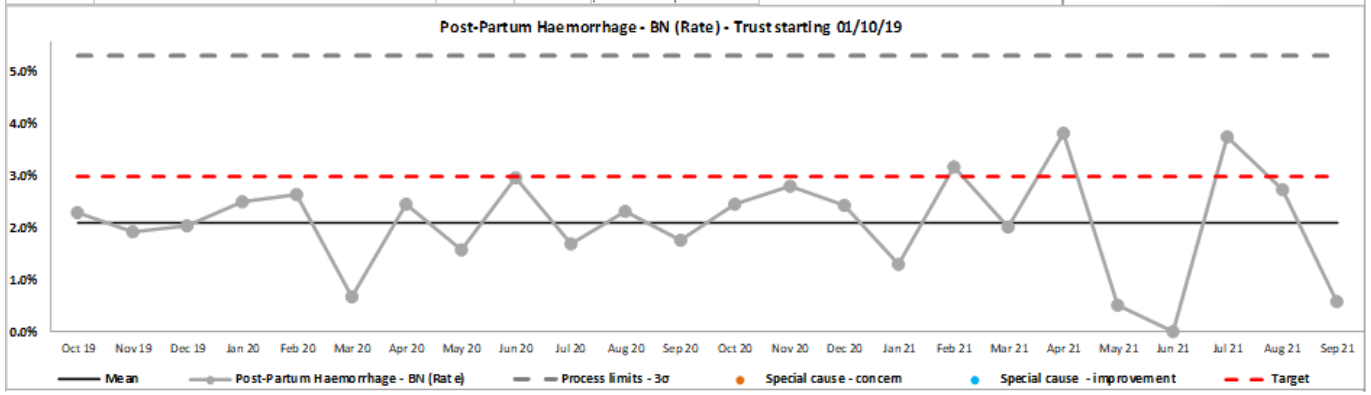


Chart 20 – Post-Partum Haemorrhage – BN (rate)

Factors driving performance:

1. Post Partum haemorrhage remains within common cause variation inconsistently below the agreed threshold of 3 %.

Key Actions:

1. All incidents are reported and reviewed at the Serious Incident Review Panel (SIRP) to identify if the management of the case was appropriate, where indeicated a more detailed investigation is requested and to ensure learning is captured and shared.

Risks to Delivery:

1. Appropriate decision making and timely interventions to prevent or minimise PPH depends on the skills and experience of clinical staff. Reviews of cases, feedback and ongoing Prompt Training are in place to support this.

3rd & 4th degree perineal trauma

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	3rd & 4th degree tears, exc C-Sections	3.5%	1.4%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

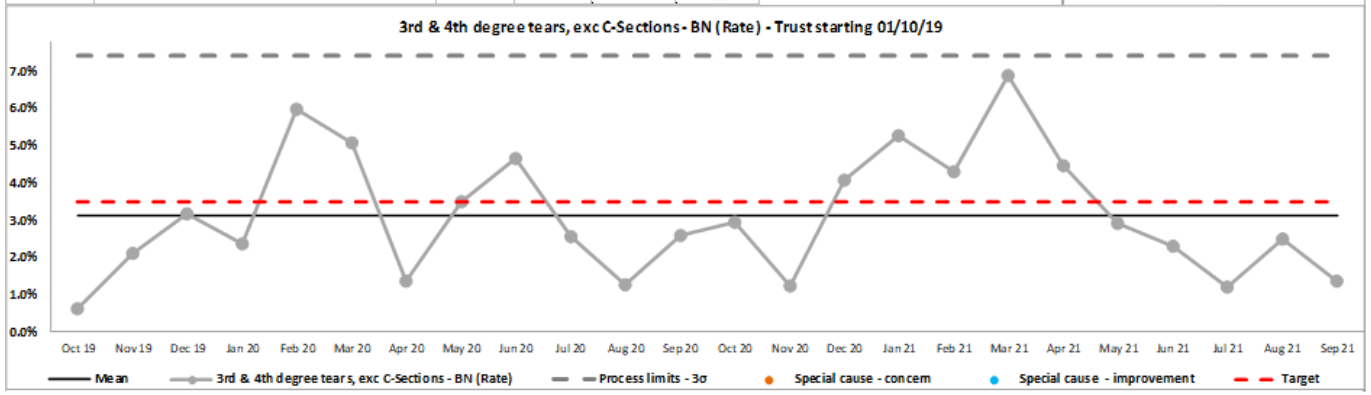


Chart 21 – 3rd and 4th degree tears

Factors driving performance:

1. % of cases with perineal trauma remains wihtin common cause variaion, inconsistently below agreed threshold of 3.5%.

Key Actions:

1. All cases are reviewed monthly by the multi disciplinary team, including an Obstetrician, Midwife and Specialist physiotherapist. Documentation of application of perineal pressures at delivery has been identified as a key issue which is being addressed through these review and feedback processes.
2. Training staff on OASI bundle of care that enables safe delivery with minimal trauma is in place for midwives.

Key Risks to Delivery:

1. Continuous training and updates remain a key mitigating factor.

Mortality (HSMR and SHMI)

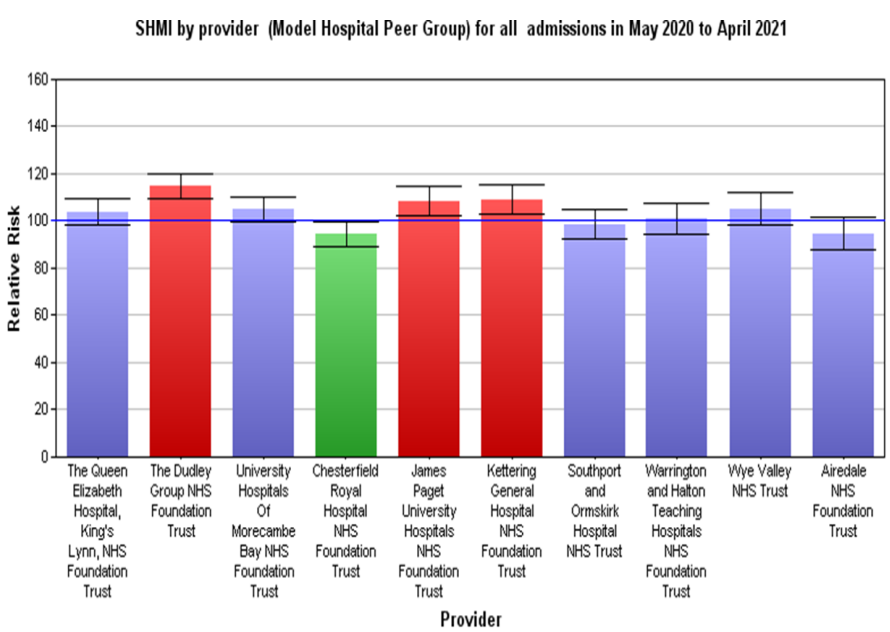


Chart 22 – SHMI by provider

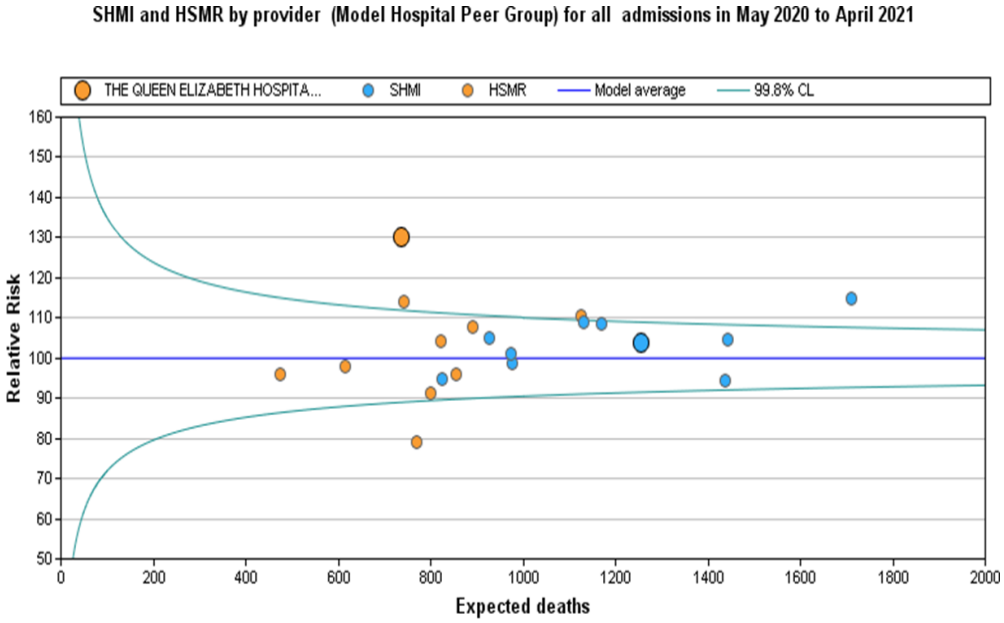


Chart 23 - HSMR Relative Risk

Chart 23 - HSMR Relative Risk

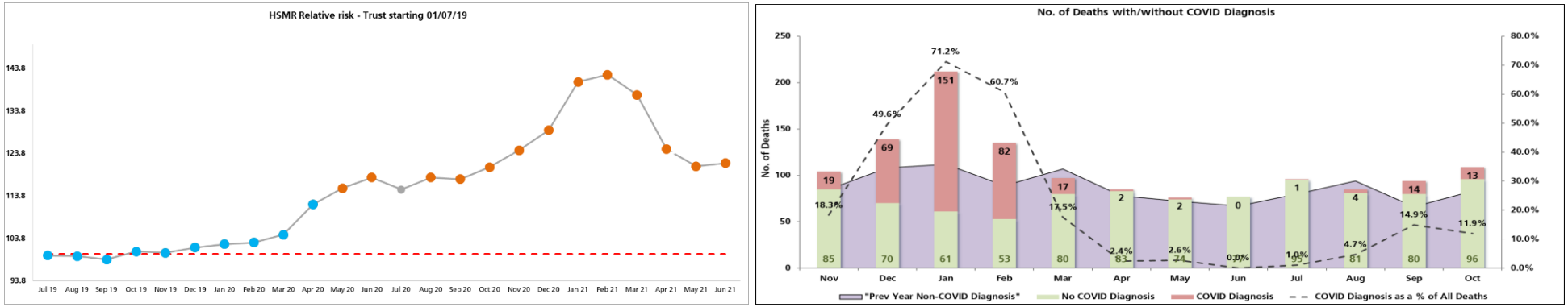


Chart 24 – HSMR Relative Risk and Number of deaths with/without COVID diagnosis

Factors Driving the Performance:

1. The SHMI remains within the "expected band." This has fallen from 106 for the period to December 2020, to 103.75 to March 2021. NHS Digital Clinical Indicator Previewer shows a further fall to 102 for the period July 2020 to June 2021 and we await this publication.
2. The Funnel plot has only been updated to April 2021 and so both metrics are included in figure 22b.
3. More recent data have now been published and demonstrate a reduction in HSMR since the peak in deaths associated with Covid was reported in January 2021. Chart 24 also indicates the stabilisation in numbers of deaths since this time, indicating that the HSMR is likely to continue to stabilise and fall. However, the June HSMR calculation (reported as 121.41), is based on an incomplete dataset. When this coding backlog is complete, submitted and the data recalculated, the June HSMR is likely to fall further. The previously published HSMR for the 12 months to February 2021 fell from 142 to 131 when our complete dataset was re-analysed. The March HSMR has similarly now been reissued and reduced from 137.5 to 130. April and May HSMR publication was delayed due to technical problems in the national team and so these were both calculated against a complete dataset and so are not expected to change; however, the June calculation is likely to change as more data are uploaded.
4. Aside from the alert for viral infection (COVID) the four alerts with the highest number of patients are Stroke, COPD, Congestive Heart Failure and Pneumonia. Although CQC has suspended using the CUSUM (Cumulative Summary) alert during the pandemic, it is important that we do not lose sight of these key diagnosis groups.
5. In October 2021 there were 110 deaths. In comparison there were 90 deaths in October 2020 and 87 in October 2019. 63 (out of 110) of the deaths occurred in patients aged 80 and over, of this number 28 were aged 90 and over. There were 14 COVID deaths in September and 13 in October.
6. The activity on which the HSMR and SHMI is based is still below pre-pandemic levels but overall activity continues to gradually increase.

Key Actions Taken:

1. Significant improvements have already been made to documentation, to coding and to palliative care provision, all of which will contribute to a reduction in our expected deaths and so a reduction in HSMR.
2. The learning from deaths action plan has now been agreed with NHSE/I aiming to build on this and to further improve the quality of care for our inpatients.

Risks to recovery:

1. The impact of COVID deaths on our HSMR and SHMI will continue for the duration of the time this metric is shown in the rolling 12-month report. Any further peaks of COVID deaths and reductions in overall activity will further impede our ability to predict and benchmark our deaths against others.

Cardiac Arrests

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	Rate per 1000 admissions of inpatient cardiac arrests	2.00	0.29			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

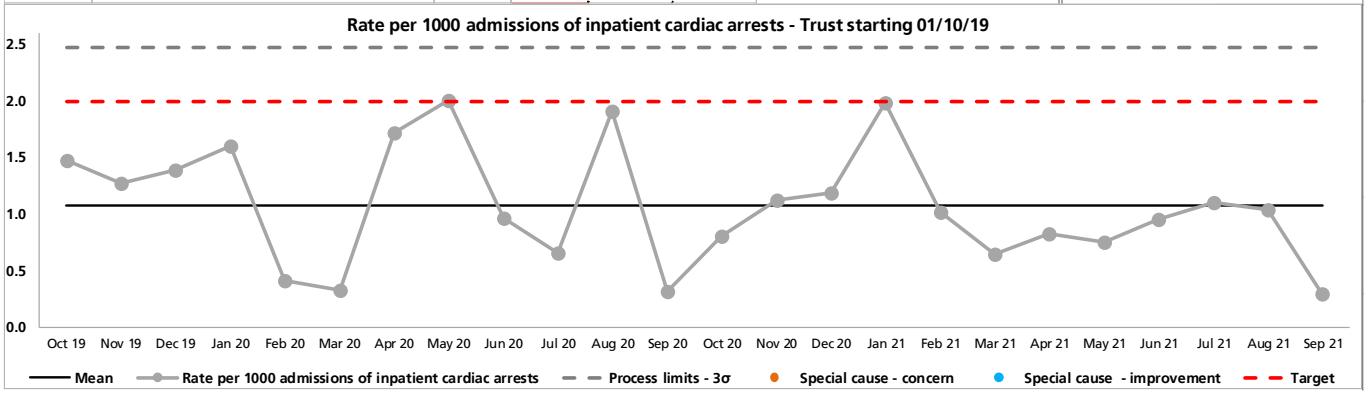


Chart 25 – Inpatient Cardiac Arrests per 1,000 admissions

Key Issues (any new issues in red):

1. Cardiac arrest rates remain below maximum expected numbers and within common cause variation.
2. There were 10 reportable cardiac arrests on our wards in September 2021. All have been reviewed and it is possible that 5 of these might have benefited from an earlier decision regarding resuscitation. These have been fed back to the clinical teams.

Key Actions (new actions in green):

1. NEWS 2 Training, NEWS 2 audits and Structured Judgement Reviews of all avoidable cardiac arrests are ongoing to improve the early identification of deteriorating patients and proactive discussions on escalating, limiting or withdrawal of treatment where appropriate which is overseen through the Recognise and Respond Forum.
2. A regional working group to address the ReSPECT policy and writer training has been initialised by QEH, involving CCG, JPUH and NNUH, with a plan to develop a combined Policy and training package.

Recovery Forecast (e.g. August): Not applicable.

Key Risks to Forecast Improvement: None identified.

Research

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Oct-21	No. of patients recruited in NIHR studies	63	98			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

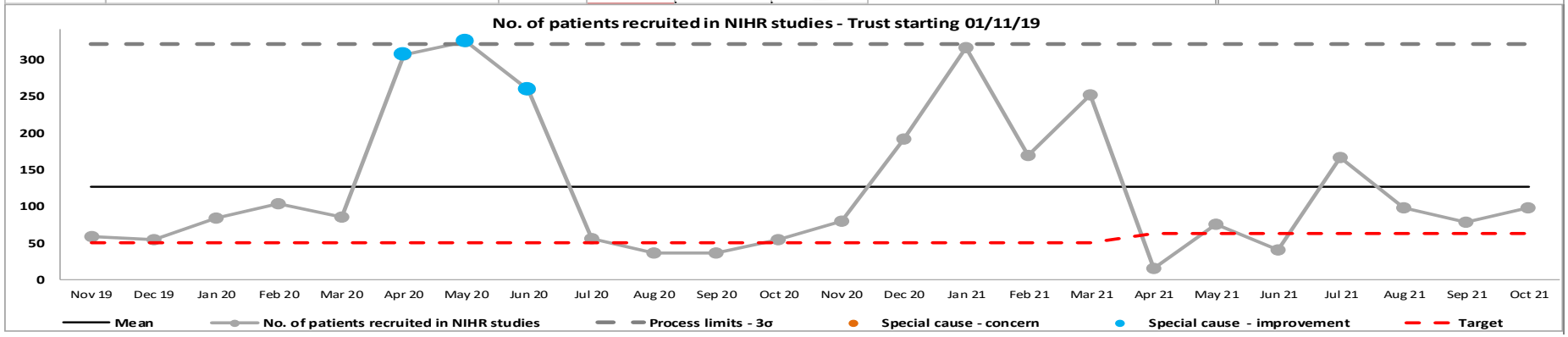


Chart 26 – No. of patients recruited in NIHR studies

Key Issues

1. 98 NIHR study accruals were made in October. This remains within common cause variation and above the agreed target.

Key Actions

1. Successful team building away day has been held and the team has been shortlisted for QEH Awards: clinical team of the year and 'We Listen' categories.
2. Staff survey on research engagement is planned.
3. Tissue viability specialist nurse has commenced to assist with recruitment to the SWSHI study.

Risks

1. Experienced Head of Innovation, Research and Education leaves the Trust this month, but the previous gaps in the team have now all been filled, and we have an experienced Research Manager and Research Director, so this is not anticipated to directly affect performance.

Caring - Accountable Officer - Chief Nurse

Data To	KPI Description	Target	Current Value	Variance	Assurance
Oct-21	MSA Incidents	0	7		?
Oct-21	MSA Breaches	0	17		?
Oct-21	Total Clinical & Non_Clinical Complaints	0	4	L	F
Oct-21	Complaints Rate per AE Atts, IP Adms & OP Activity	0.00%	0.01%	L	?
Oct-21	Complaints receiving a response within 30 working days %	90.0%	100.0%		?
Oct-21	Complaints - Reopened (% of Total)	15.0%	0.0%		?
Sep-21	Dementia Case Finding	90.0%	96.0%	H	?

Data To	KPI Description	Target	Current Value	Variance	Assurance
Oct-21	FFT % "Very Good" or "Good" (IP & DC)	95.00%	94.78%		?
Oct-21	FFT % "Very Good" or "Good" (AE)	95.00%	80.38%		?
Oct-21	FFT % "Very Good" or "Good" (OP)	95.00%	94.30%	L	?
Oct-21	FFT % "Very Good" or "Good" Mat Question 1 (Antenatal)	95.00%	87.5%		?
Oct-21	FFT % "Very Good" or "Good" Mat Question 2 (Labour)	95.00%	100.0%		?
Oct-21	FFT % "Very Good" or "Good" Mat Question 3 (Postnatal)	95.00%	100.0%		?
Oct-21	FFT % "Very Good" or "Good" Mat Question 4 (Comm Postnatal)	95.00%	100.0%		?

Mixed Sex Accommodation breaches

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Oct-21	MSA Incidents	0	7			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

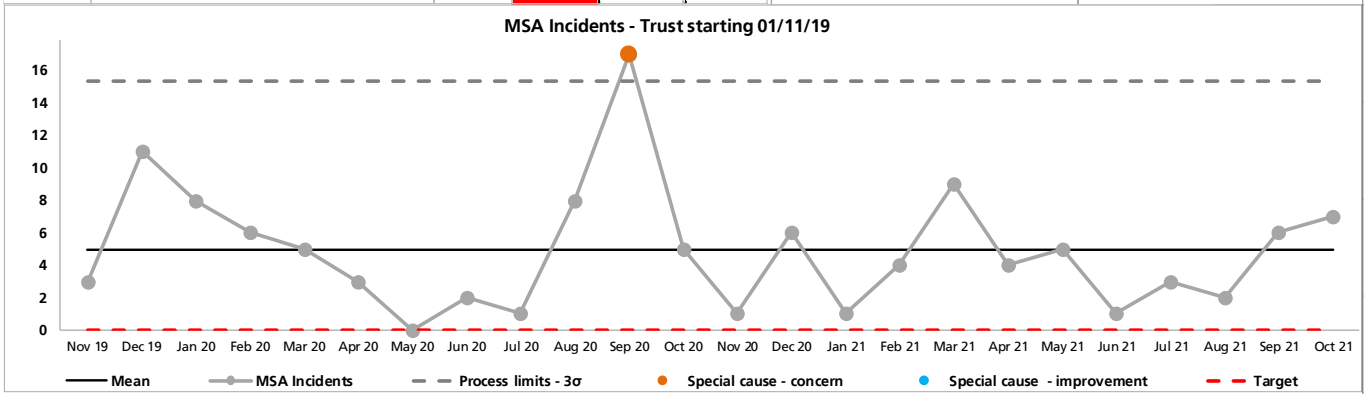


Chart 27 – MSA Breaches

Key Issues (any new issues in red):

1. There have been seven (7) incidents of same sex accommodation breaches affecting fifteen (17) patients during October 2021. The incident occurred in the Hyperacute Stroke Unit (HASU) on West Raynham Ward. This is an increase since September.
2. During October the Trust has been under significant capacity and demand pressures which have contributed to the EMSA breeches.
3. The Trust breaches are reported in line with the national guidance.

Key Actions (new actions in green):

1. Nurse in charge has active conversation with patients about their experiences whilst being cared for in a mixed sex bay and there have been no concerns raised by patients.
2. Same sex accommodation breaches are discussed, and possible mitigations are considered during the Board round.
3. Same sex accommodation breaches are escalated to the clinical site team and are reflected on the bed template in the operations centre.
4. The Trust has an ongoing UEC programme with workstreams reviewing access and discharges (in addition to other capacity/demand) aimed at improving the Organisations capacity challenges.

Recovery Forecast (e.g. August): Unable to forecast recovery due to capacity challenges.

Key Risks to Forecast Improvement:

1. Beds for patients who need to be stepped down are not always available and are dependent on demand.
2. Bed capacity will be a factor for future breaches.

Complaints

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Oct-21	Total Clinical & Non_Clinical Complaints	0	4	L	F	Special cause (unexpected) variation - Improvement (L)	Variation indicates consistently (F)alling short of the target

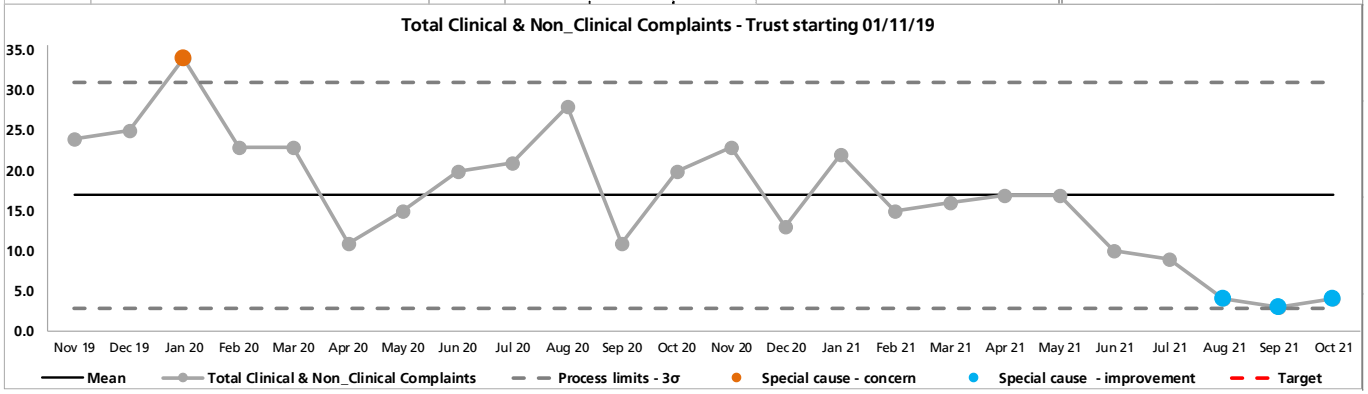


Chart 28 – Total Complaints

Issues (any new issues in red):

1. The timeliness of responding to complaints within 30 days has been achieved for 5 consecutive months.
2. The actions put into place in April/May continue to assist the improvement and will remain in place to ensure sustained performance and delivery.

Key Actions (new actions in green):

1. The reviewed and revised process remains in place with senior leadership and Governance.
2. Initial Triage by a senior member of staff continues with Divisional senior to ring complainant (define options, agree timescales, offer LRM or descalation of the complaint in some cases).
3. Continue to sustain an increase in Local Resolution Meetings (LRMs).
4. Share point for all to access with PTL information.
5. Review each response with coaching to improve quality.

Recovery Forecast:

1. The recovery plan includes sustained improvement in the coming months.
2. The actions include a continued scrutiny on quality, LRMs being offered and timeliness. These are expected to positively impact on the reduction in re-opened complaints.

Key Risks to Forecast Improvement:

1. The ability of the teams to prioritise complaint responses in the expected time frames and provide patient focussed responses.
2. Maintenance of the streamlined processes.
3. Planned dates for complaints and customer services training for the Medical Consultants.

Dementia Case Finding

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	Dementia Case Finding	90.0%	96.0%	H	?	Special cause (unexpected) variation - Improvement (H)	Variation indicates inconsistently passing and falling short of the target

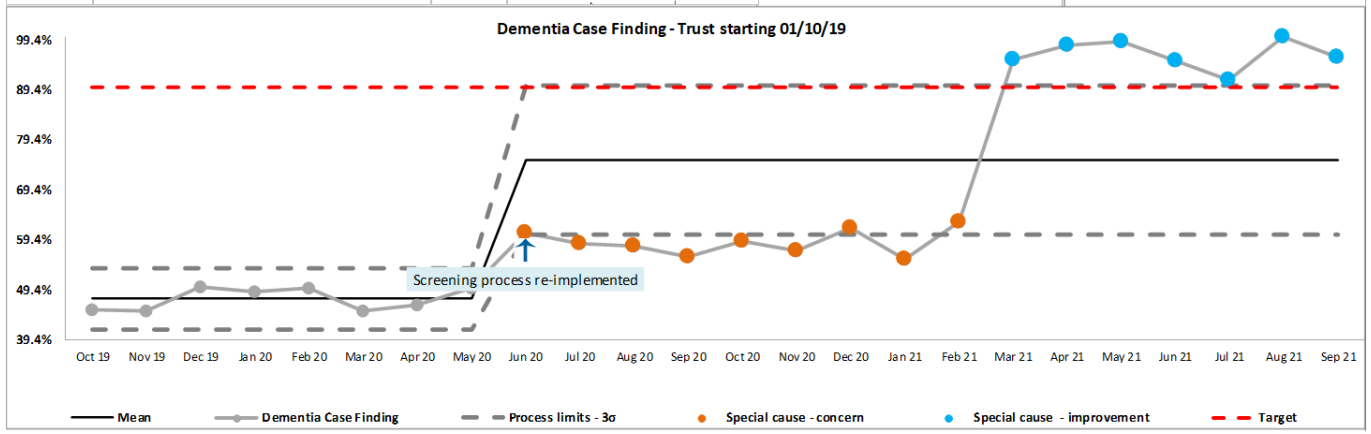


Chart 29 – Dementia Case Finding

Key Issues (any new issues in red):

1. Dementia screening rates have remained above the agreed threshold of 90% since February 2021. This improvement is attributable to the introduction of dedicated Cognitive Impairment Assessors (CIAs) who have improved screening rates and embedded the aftercare necessary when cognitive impairment is detected.

Key Actions (new actions in green):

1. Funding and permanent appointments for CIAs are in place with interviews being held on 15th November 2021. Scheduling with consistency will improve with these permanent appointments.
2. Onward care of patients identified through screening is highlighted to primary care through discharge summaries. Direct notification to the Care of Older People team is planned as the next step. The new frailty in-reach service into the assessment areas, has further improved the care for older patients and those with delirium enabling admission avoidance where suitable, and direct admissions to appropriate geriatric wards for inpatient care in most cases.
3. Scoping with the CCG on a single point of access referral system has been initiated with aim to provide an in-house memory clinic run locally by ICOP clinicians with support from regional multidisciplinary team to enable place-based care for this group of patients.

Recovery Forecast (e.g. August): Not applicable

Key Risks to Forecast Improvement: Currently all risks have been mitigated.

NURSING METRICS

Ward Level Indicators for the month of Oct-21

Oct-21	Indicator Description	Data Source	Den	Elm	SAU	Gayt	SAND	C Care	Nec	Oxb	A&E	Stan	Sho	Til	West New	West Ray	Wind
Incidents & IPACS	Total Incidents (SI's, Falls, PU's & Drug Errors)	DATIX via Risk Mng't	5	0	1	4	3	1	8	9	11	8	1	3	5	9	9
	Serious Incidents		0	0	0	0	0	0	0	0	2	0	0	0	0	0	0
	Drug Administration Errors		1	0	0	1	2	0	1	0	5	1	0	0	1	2	2
	All Drug Errors (inc Admin)		1	1	0	1	4	0	5	3	6	1	1	0	1	7	3
	Falls Total		4	0	1	3	1	0	7	9	4	5	1	3	3	7	7
	Pressure Ulcers - Deep Tissue Injury (DTI)		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Pressure Ulcers - Unstageable		0	0	0	0	0	1	0	0	0	1	0	0	0	0	0
	H/A Pressure Ulcers Grade 2		0	0	0	0	0	0	0	0	0	1	0	0	1	0	0
	H/A Pressure Ulcers Grade 3		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	H/A Pressure Ulcers Grade 4		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	C.Diff > 2 Days	IPACS	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0
	MRSA		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	MSSA		0	0	0	0	0	1	1	0	0	0	0	0	1	0	0
	E.Coli		1	0	0	0	0	0	1	1	0	0	0	0	0	1	0
	ESBL		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Psuedomonas		0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
	Klebsiella		0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Patient Experience	Complaints	Complaints Dept	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0
	Compliments		2	8	0	3	11	1	8	2	7	8	6	3	0	2	2
	Family And Friends Response Rate	Meridian	37.2%	24.5%	6.0%	13.1%	21.2%	192.3%	27.5%	18.4%	1.2%	50.0%	59.5%	47.8%	10.5%	63.2%	18.9%
	Family And Friends (% Recommended)		92.2%	91.2%	100.0%	76.9%	97.5%	100.0%	96.4%	78.9%	87.2%	90.9%	92.0%	97.7%	100.0%	95.8%	87.5%
Safer Staffing	Fill Rate Registered	Info Serv via M Ojelade	95.6%	90.4%	86.6%	89.4%	71.6%	93.9%	90.1%	85.8%		105.7%	91.4%	93.7%	92.5%	92.2%	93.2%
	Fill Rate Unregistered		77.5%	68.4%	81.9%	85.4%	78.5%	59.1%	79.7%	84.0%		78.2%	88.3%	74.7%	91.4%	82.5%	73.1%
	CHPPD		5.7	5.5	10.6	5.4	10.4	25.5	5.7	5.2		7.4	7.4	6.7	8.0	6.9	5.5
Staff Experience	Appraisals	WIS Team	87.0%	93.5%	95.2%	75.0%	85.7%	87.5%	90.5%	73.0%	86.4%	90.0%	95.7%	74.4%	91.7%	100.0%	88.6%
	Sickness		6.9%	5.8%	4.0%	9.2%	9.5%	4.5%	10.9%	13.6%	10.4%	12.6%	8.6%	9.1%	9.7%	7.0%	9.5%
	Vacancies		11.3%	6.2%	19.6%	18.1%	23.8%	-1.2%	25.1%	27.5%	3.6%	14.6%	10.4%	16.2%	6.6%	16.9%	15.4%
	Mandatory Training		78.4%	83.7%	95.1%	88.4%	91.1%	94.3%	86.3%	80.7%	93.1%	88.3%	90.2%	83.1%	88.0%	98.5%	92.5%

Ward Level Indicators for the month of Oct-21

Oct-21	Indicator Description	Data Source	AMU	TSS	Mar	NICU	C Acre	CDS	MLBU	Rud	Lev	Felt	AEC	TIU	Non IP Wards/Area	Trust
Incidents & IPACS	Total Incidents (SI's, Falls, PU's & Drug Errors)	DATIX via Risk Mng't	4	8	8	3	1	3	1	2	6	8	0	1	12	133
	Serious Incidents		0	0	1	0	0	0	0	0	0	0	0	0	2	5
	Drug Administration Errors		1	2	1	3	1	3	1	2	1	4	0	1	5	40
	All Drug Errors (inc Admin)		8	6	4	4	1	3	1	4	2	5	1	5	19	91
	Falls Total		3	5	5	0	0	0	0	0	4	4	0	0	4	80
	Pressure Ulcers - Deep Tissue Injury (DTI)		0	0	1	0	0	0	0	0	0	0	0	0	1	2
	Pressure Ulcers - Unstageable		0	0	0	0	0	0	0	0	0	0	0	0	0	2
	H/A Pressure Ulcers Grade 2		0	1	0	0	0	0	0	0	0	0	0	0	0	3
	H/A Pressure Ulcers Grade 3		0	0	0	0	0	0	0	0	1	0	0	0	0	1
	H/A Pressure Ulcers Grade 4		0	0	0	0	0	0	0	0	0	0	0	0	0	0
	C.Diff > 2 Days	IPACS	0	1	0	0	0	0	0	1	0	1	0	0	0	5
	MRSA		0	0	0	0	0	0	0	0	0	0	0	0	0	0
	MSSA		0	0	1	0	0	0	0	0	0	0	0	0	0	4
	E.Coli		0	0	0	0	0	0	0	0	0	0	0	0	0	4
	ESBL		0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Psuedomonas		0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Klebsiella		0	0	0	0	0	0	0	0	0	2	0	0	0	4
Patient Experience	Complaints	Complaints Dept	0	0	0	0	0	0	0	0	0	0	0	0	2	4
	Compliments		1	2	4	5	5	0	4	2	1	3	2	0	32	122
	Family And Friends Response Rate	Meridian	19.6%	12.4%	31.5%	400.0%	30.8%	0.0%	0.0%	8.8%	24.6%	46.7%	8.6%	4.5%		
	Family And Friends (% Recommended)		93.9%	95.5%	92.9%	91.7%	100.0%	100.0%	100.0%	95.2%	82.4%	87.8%	89.7%	100.0%		
Safer Staffing	Fill Rate Registered	Info Serv via M Ojelade	88.2%	85.6%	93.5%	100.2%	64.4%	78.4%		84.3%	89.2%	92.8%				89.2%
	Fill Rate Unregistered		73.2%	77.9%	69.5%	78.6%	87.1%	79.3%		107.6%	68.5%	76.0%				78.7%
	CHPPD		7.9	5.6	5.1	26.5	4.0	30.1		10.3	4.7	5.8				7.1
Staff Experience	Appraisals	WIS Team	90.9%	96.2%	93.5%	88.2%	89.2%		62.5%	86.0%	85.0%	100.0%	80.6%	66.7%		80.3%
	Sickness		6.3%	8.6%	11.8%	8.8%	8.1%		9.0%	3.7%	3.6%	7.9%	3.9%	25.6%		7.2%
	Vacancies		26.7%	12.7%	18.6%	10.6%	20.0%		16.1%	12.4%	56.4%	75.3%	9.8%	-3.1%		10.6%
	Mandatory Training		92.5%	90.7%	97.6%	94.4%	82.8%		77.0%	87.8%	91.3%	87.4%	82.6%	92.7%		82.5%

Responsive - Accountable Officer - Chief Operating Officer

Data To	KPI Description	Target	Current Value	Variance	Assurance
Oct-21	18 Weeks RTT - Incomplete Perf	92.0%	63.7%		F
Oct-21	18 Weeks RTT - No. of Specialties failing the target of 92%	0	25		
Oct-21	18 Weeks RTT - Over 52 Wk waiters	0	928		
Oct-21	A&E 4 Hour Performance	95.0%	62.3%	L	F
Oct-21	A&E 4 Hour Performance (Majors only)	95.0%	46.0%	L	F
Oct-21	A&E 4 Hour Performance (Minors only)	100.0%	85.5%		F
Oct-21	A&E 12 Hour Trolley Waits	0	25		
Oct-21	Ambulance Handovers	100.0%	29.3%	L	F
Oct-21	Last minute non-clinical cancelled elective operations	0.8%	0.55%		?
Oct-21	Breaches of the 28 day readmission guarantee	0	0		
Oct-21	Total non-clinical cancelled elective operations	3.2%	4.02%	L	?
Oct-21	Urgent operations cancelled more than once	0	0		
Oct-21	% of beds occupied by Delayed Transfers of Care	3.5%	3.8%	H	?
Oct-21	Medically Fit For Discharge - Patients		359	H	
Oct-21	Medically Fit For Discharge - Days		2406		
Oct-21	No. of beds occ by inpatients >=21 days - (Mthly average over rolling 3 mths)	46	67		?

Data To	KPI Description	Target	Current Value	Variance	Assurance
Sep-21	Cancer Wait Times - Two Week Wait Performance	93.0%	92.1%	L	P
Sep-21	Cancer Wait Times - 31 Day Diag to Treatment Performance	96.0%	96.3%		?
Sep-21	Cancer Wait Times - 62 Day Ref to Treatmemt Performance	85.0%	70.1%		?
Sep-21	Cancer Wait Times - 104 Day waiters	0	5.0		
Sep-21	Cancer Wait Times - Two Week Wait (Breast Symptomatic) Performance	93.0%	100.0%		?
Sep-21	Cancer Wait Times - 31 Day Subsequent Treatment - (Surgery) Performance	94.0%	100.0%		?
Sep-21	Cancer Wait Times - 31 Day Subsequent Treatment - (Drug) Performance	98.0%	100.0%		P
Sep-21	Cancer Wait Times - 62 Day Screening Performance	90.0%	81.5%		?
Sep-21	Cancer Wait Times - Consultant Upgrade (62 day)	90.0%	100.0%		?
Sep-21	Cancer Wait Times - 28 Day FDS - Two week wait	75.0%	61.5%		?
Oct-21	Diagnostic Wait Times - % of over 6 Week Waiters	1.0%	64.7%	H	F
Aug-21	Stroke - 90% of time on a Stroke Unit	90.0%	74.4%		F
Aug-21	Stroke - Direct to Stroke Unit within 4 hours	90.0%	44.2%	L	F
Aug-21	Stroke - Patient scanned within 1 hour of clock start	48.0%	41.9%		?
Aug-21	Stroke - Patient scanned within 12 hours of clock start	95.0%	86.0%		?
Click here to view other National Stroke (SSNAP Domain) Results					
Sep-21	Trust - Seen <24 hrs (1st contact to investigations complete)	60.0%	54.2%		F

Emergency Care

Emergency access within 4 hours

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Oct-21	A&E 4 Hour Performance	95.0%	62.3%	L	F	Special cause (unexpected) variation - Concern (L)	Variation indicates consistently (F)alling short of the target

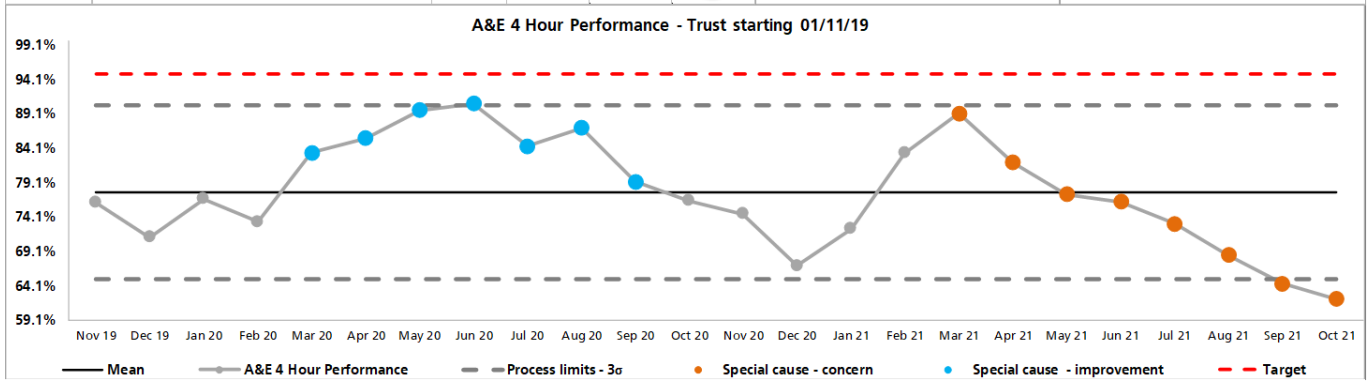


Chart 30 – A&E 4-hour performance

During October 7,097 patients attended the Emergency Department (ED), of these 2,678 patients were in the department over four (4) hours before admission, discharge, or transfer. Performance was 62.27% against a standard of 95%. Admitted performance was 29.29% and non-admitted was 80.02%. The Trust ranked 99th out of 112 Trusts on all Type performance and 52nd out of 109 Trusts on Type 1 only performance.

General and Acute Bed occupancy, which includes Sandringham, Castleacre and Rudham wards, ranged from 92% - 96% during October 2021. It is noted that a bed occupancy above 92% limits patient flow, causing delays in ED for patients awaiting a bed.

As of 22 October 2021, there were 61 patients on discharge pathways 1 – 3 referred for transfer of care, the breakdown of these by CCG is shown below:

CCG	Pathway 1	Pathway 2	Pathway 3	Total	≥ 7 days	Longest delay (days)
N&W	14	23	2	**39**	17	84
Camb	4	7	4	**15**	5	42
Linc	3	2	1	**6**	2	28
Suffolk	1	0	0	**1**	0	1
				61		

Pathway definitions:

Pathway 0 *no new or additional support is required to get the person home, or such support constitutes only informal input from support agencies, a continuation of an existing health or social care support package that remained active while the person was in hospital*

Pathway 1 *able to return home with new, additional or a restarted package of support from health and/or social care*

Pathway 2 *recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, ideally before returning home*

Pathway 3 *people who require bed-based 24-hour care: includes people discharged to a care home for the first time. Those discharged to a care home for the first time will have such complex needs that they are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs.*

There were 25 12-hour breaches reported in October 2021. The breach reasons are summarised below:

- 16 patients awaiting admission to an amber medical bed
- 3 patients awaiting admission to a red bed
- 3 patients awaiting admission to a mental health bed
- 3 patients awaiting admission to a surgical bed

Ambulance Handovers

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Oct-21	Ambulance Handovers	100.0%	29.3%	L	F	Special cause (unexpected) variation - Concern (L)	Variation indicates consistently (F)alling short of the target

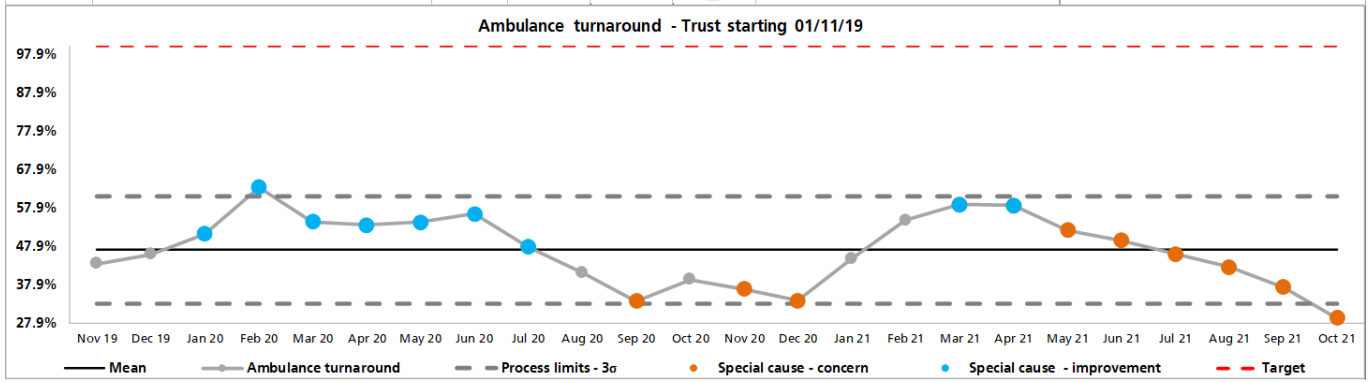


Chart 31 – Ambulance Handovers

During October 2021, there were 1,896 conveyances by EEAST to the Emergency Department. Of these 29.28% of all handovers took place within ≤15 minutes, against the trajectory of 54.7%. The average handover time was 49 minutes. 26.85% of handovers exceeded 60 minutes.

The Trust ranked 7th out of 17 hospitals within the region for the percentage of handovers completed within 15 minutes.

Key Issues (any new issues in red):

1. Sustained increase in urgent and emergency care demand (Emergency Department attendances and emergency admissions to medicine and surgery).
2. Bed occupancy levels routinely above 92%, limiting flow out of the Emergency Department for admitted patients.
3. Emergency Department footprint does not meet the needs of the service and this is further exacerbated by the requirement to segregate patients on Red and Amber pathways.

Key Actions (new actions in green):

1. Urgent and Emergency Care Improvement Programme in place, this includes the implementation and embedding of the SAFER care bundle across all wards.
2. Implementation of a co-located primary care service planned for December 2021.
3. Maximisation of same day emergency care to reduce inpatient bed demand.

Recovery Forecast:

1. The improvement trajectories for emergency care access and ambulance handovers are under review and will be re-set for Q4.

Key Risks to Forecast Improvement:

1. Sustained increase in Emergency Department attendances.
2. Increased incidence of suspected COVID-19 presentations.
3. The capacity of health and social care partners to facilitate timely discharges for patients on discharge to assess pathways 1, 2 and 3.

Elective Care

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Oct-21	18 Weeks RTT - Incomplete Perf	92.0%	63.7%		F	Common Cause (expected) variation	Variation indicates consistently (F)alling short of the target

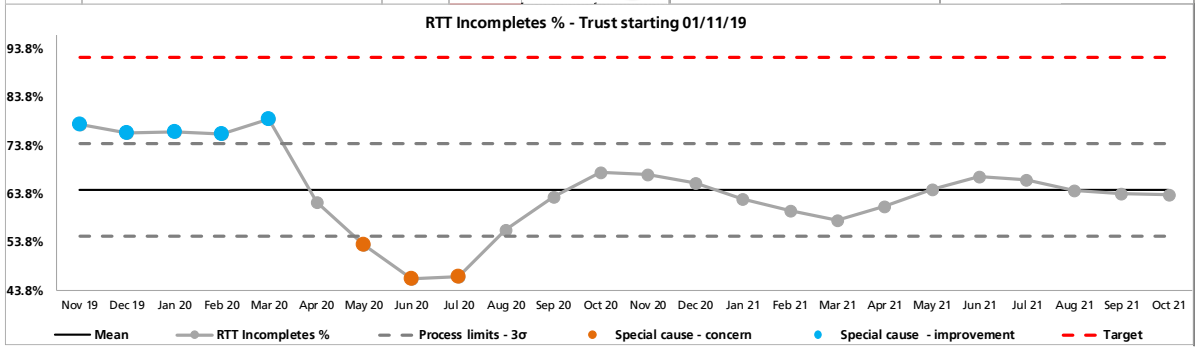


Chart 32 - RTT Incomplete Pathways

At the end of October 2021, there were a total of 18,269 patients on the waiting list, of which 6,638 had waited for over 18 weeks from referral, giving performance of 63.7%. The top 3 specialties with the greatest number of patients waiting over 18 weeks were Orthopaedics (1,041), Dermatology (863) and Ophthalmology (793).

Key Issues (new issues in red):

1. Prioritisation of P2 (clinically urgent) cases in line with national guidance
2. Sustained increases in cancer referrals across all tumour sites, leading to increase in the number of P2 patients on the waiting list.

Key Actions (new actions in green):

1. Ophthalmology locum consultant commenced in post mid-October and a further locum consultant due to start early November.
2. Increased capacity through additional sessions in outpatients and theatres.
3. Improved theatre productivity and efficiency to maximise the use of theatre capacity.

Recovery Forecast:

1. The number of 52-week breaches is reducing; however, the Trust is not forecast to achieve the standard 92% incomplete RTT standard during 2021/2022.

Key Risks to Forecast Improvement:

1. Unforeseen disruption to theatre capacity due RAAC plank issues.
2. A further wave of COVID-19 necessitating the return of Day Surgery to a Red ED.
3. Sustained Increase in number of P2 cases extends the waiting time for less clinically urgent patients.

52-week breaches

Waiting times significantly increased during 2020/21 because of the cessation of routine elective activity in March to May 2020 in response to the COVID-19 pandemic.

At the end of October 2021 there were 928 patients waiting longer than 52 weeks for treatment. This is a decreasing trend over the last two months. The top 3 specialties with the greatest number of patients waiting over 52 weeks are Orthopaedics (284), Gynaecology (223) and General Surgery (165). The longest waiting patient is a joint Gynaecology and Colorectal patient (P3) at 123 weeks; this patient who has a TCI date of 17th November.

The number of patients waiting over 52 weeks continues to reduce, and the 92nd percentile waiting time in weeks is reducing in most specialities.

Specialty Description	>=52 weeks	Non-Admitted WL	Admitted WL	Total WL Size	Performance %	92nd Percentile in weeks
Cardiology	9	1689	48	1737	54.98%	35
Colorectal	20	170	188	358	81.28%	42
Ear, Nose and Throat	80	1610	296	1906	64.06%	34
General Surgery	165	457	574	1031	59.55%	65
Gynaecology	223	731	611	1342	62.15%	66
Ophthalmology	32	1810	330	2140	62.85%	35
Oral Surgery	84	73	349	422	47.39%	90
Paediatric Dermatology	2	11	0	11	36.36%	55
Paediatric Urology	1	52	29	81	65.43%	30
Pain	12	268	0	268	44.80%	49
Plastic Surgery	1	39	6	45	86.67%	24
Respiratory Medicine	1	430	0	430	73.26%	27
Trauma & Orthopaedics	284	1378	899	2277	54.24%	62
Upper Gi	1	54	47	101	85.15%	25
Vascular	13	152	30	182	79.12%	43
Total	928					
Urology	48	831	321	1152	66.32%	31

Key Issues (new issues in red):

1. Prioritisation of urgent P2 cases in line with national guidance; however, the sustained increase in cancer referrals has subsequently increased the number of P2 patients requiring priority treatment.
2. Increased number of P2 patients who have been expedited for due to a change in clinical risk.

Actions (new actions in green):

1. Utilisation of Sandringham theatre (8).
2. Development of a business case to staff both Sandringham theatres, Monday to Friday.
3. Flexible allocation of theatre lists to prioritise theatre capacity for clinically urgent and longest waiting patients.

Recovery Forecast:

1. The numbers of patients waiting longer than 52 weeks is expected to reduce during the remainder of 2021/22 financial year; however, the backlog of patients waiting for over 52 weeks will not be cleared.

Key Risks to Forecast Improvement:

1. Unforeseen disruptions to theatre capacity due to RAAC plank issues.
2. Sustained increase in number of P2 cases extends the waiting time for less clinically urgent patients.
3. Effective utilisation and prioritisation of all available theatre capacity.

Breaches of the 28-day readmission guarantee

There were no breaches of the 28-day readmission guarantee in October 2021.

Diagnostic Waiting Times

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Oct-21	Diagnostic Wait Times - % of over 6 Week Waiters	1.0%	64.7%	H	F	Special cause (unexpected) variation - Concern (H)	Variation indicates consistently (F)alling short of the target

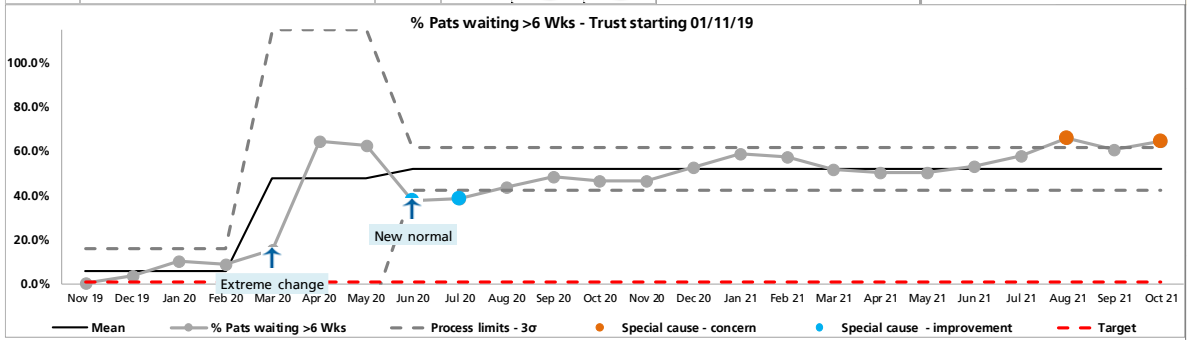


Chart 33 – Diagnostic Waiting Times

At the end of October 2021, the total waiting list size was 9,404 and there were 6,087 patients waiting over 6 weeks, giving performance of 64.73% against the standard of 1%. Performance at diagnostic test level is as follows:

Diagnostic Test	Total waiting list	Number of patients waiting > 6 weeks	Performance
Magnetic Resonance Imaging	2075	1411	68.00%
Computed Tomography	1846	1056	57.20%
Non-obstetric ultrasound	2336	1803	77.18%
Barium Enema	0	0	
DEXA Scan	213	78	36.62%
Audiology - Audiology Assessments	305	8	2.62%
Cardiology - echocardiography	1491	1251	83.90%
Cardiology - electrophysiology	0	0	
Neurophysiology - peripheral neurophysiology	537	266	49.53%
Respiratory physiology - sleep studies	0	0	
Urodynamics - pressures & flows	149	105	70.47%
Colonoscopy	135	12	8.89%
Flexi sigmoidoscopy	45	2	4.44%
Cystoscopy	132	83	62.88%
Gastroscopy	140	12	8.57%
Total	**9404**	**6087**	**64.73%**

Key Issues (any new issues in red):

1. Delay in commencing MRI outsourcing.
2. There are staffing gaps within the Neurophysiology department which has impacted on the delivery of the DM01 standard in this modality.
3. Capacity gaps in echocardiography and non-obstetric ultrasound.

Key Actions (new actions in green):

1. MRI outsourcing of non-contrast requests began early October 2021.
2. Implementing weekend MRI lists with current staffing base and creation of specialist MRI lists to maximise capacity.
3. Additional non-obstetric ultrasound lists commenced in October 2021.

Recovery Forecast:

1. The Trust is not forecast to achieve the standard during 2021/22 however an internal trajectory for improvement will be in place for Q4.

Key Risks to Forecast Improvement:

1. High levels of demand for patients referred on a suspected cancer pathway.
2. Continued mechanical failure of the existing MRI, whilst replacement programme is underway.

Cancer waiting times

Two week wait from urgent referral for suspected cancer referral to first outpatient appointment

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	Cancer Wait Times - Two Week Wait Performance	93.0%	92.1%			Special cause (unexpected) variation - Concern (L)	Variation indicates consistently (P)assing the target

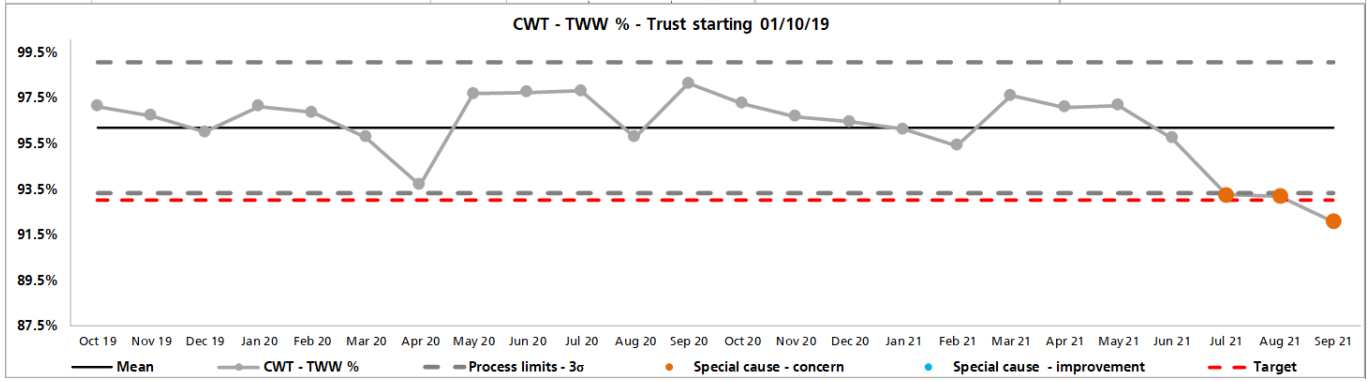


Chart 34 – Cancer Wait Times: Two Week Wait Performance

Two week wait performance in September 2021 was **92.1**% against the standard of **93**%. There are capacity constraints and an increase of referrals which have caused delays in two week wait turnaround, which is impacting on the delivery of the two week wait standard for September and October 2021.

Key Issues (any new issues in red):

1. Capacity constraints in Dermatology and Upper GI due to gaps in medical staffing.
2. Increase in the number of Upper GI two week wait referral forms which are not completed fully, leading to delays whilst further information is sought from the referring GP.
3. Increase in the number of Breast two week wait referrals.

Key Actions (new actions in green):

1. Dermatology consultant to commence in post at the beginning of October 21.
2. Additional two week wait clinics to be implemented in Dermatology in October and November.
3. Collaboration with CCG, Cancer Alliance, and primary care to encourage the use of the straight to test pathway in Colorectal and to ensure completeness of referral forms.

Recovery Forecast:

1. Two week wait performance is forecast to recover in November 2021.

Key Risks to Forecast Improvement:

1. A further increase in the number of two weeks wait referral levels received.
2. Lack of radiological staffing cover due to sickness.

62-day referral to treatment

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	Cancer Wait Times - 62 Day Ref to Treatmemt Performance	85.0%	70.1%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

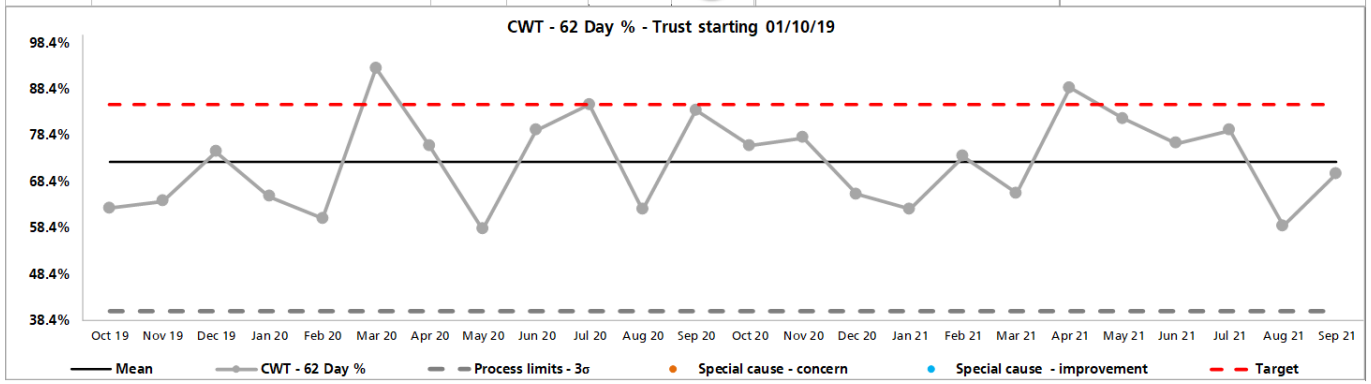


Chart 35 – Cancer Wait Time – 62 Day RTT performance

Performance in September 2021 increased to **70.1**% against the standard of **85%.**

There were 73.5 treatments, of which **22** breached the 62-day standard, (2 Breast, 1 Haematology, 4 Gynaecology, 10 Colorectal, 1.5 Skin, 2 Upper GI, 1.5 Other).

Key Issues (any new issues in red):

1. There has been a sustained increase in two week wait referrals, with consistent conversion rates of patients confirmed as having cancer.
2. Waiting times for CT & MRI scans and reporting are continuing to cause delays in patient pathways.
3. Capacity constraints in Dermatology, Upper GI and Breast.

Key Actions (new actions in green):

1. Ongoing pathway improvement work with the Cancer Intensive Support Team focussed on streamlining Gynaecology and Colorectal pathways.
2. New Consultant commences in Dermatology early October 21, with weekend, evening and one stop clinics planned.
3. Additional capacity has been added to support the backlog in breast two week wait referrals.

Patients waiting for 104+ days

The significant increase in referrals coming into the system in the first 6 months of the year has resulted in an increase in the number of patients on a cancer pathway ≥104 days.

At the end of September 2021, 32 patients were on a cancer pathway waiting over 104 days. This is in line with the Trusts forecast that numbers will peak in September and reduce from October 2021.

Of the 32 patients waiting at the end of September 2021, 20 were colorectal, 8 were gynaecology, 1 was Haematology, 1 was Head & Neck, 1 was Skin and 1 was Upper GI.

21 of which have now been treated or removed from the pathway, 2 are booked for treatment, 3 are awaiting a treatment date, 2 are awaiting a diagnostic test, 1 patient is awaiting an appointment at a tertiary centre and 3 patients are awaiting a consultant decision.

STROKE

90% of time on a Stroke Unit

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jul-21	Stroke - 90% of time on a Stroke Unit	90.0%	52.3%		F	Common Cause (expected) variation	Variation indicates consistently (F)alling short of the target

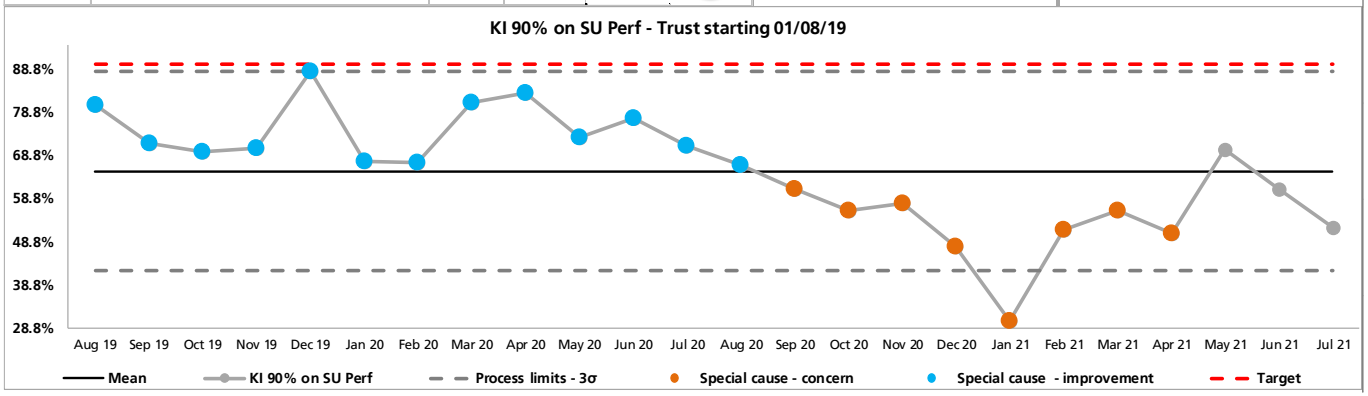


Chart 36 – Stroke: 90% of time on a stroke unit

During July, 52.31% of patients spent less than 90% of their stay on a Stroke Unit. This was based on 65 confirmed stroke cases with 31 breaches (SSNAP audit score 'E').

The key breach themes were:

1. Patients not transferred directly to Stroke Unit initially.
2. Patients not referred to the Stroke team on admission.
3. Patients with a challenging diagnosis where Stroke was not initially indicated.

Key Issues:

1. 15 of the 31 breaches (48%) did not stay on the Stroke Unit during their inpatient admission.
2. The Coronary Care Unit (CCU) remained on the Stroke Unit during this period reducing the Stroke bed base from 29 to 24 beds.
3. Not all new stroke patients were admitted to the HASU (Hyper Acute Stroke Unit) bay during the period. This was due to at least one (1) HASU bed being ring fenced for thrombolysis.

Key Actions:

1. The Stroke SOP has been ratified by Divisional Board and OMEG. This has clarified the pathway with key stakeholders and has been implemented.
2. The Stroke SOP principally ensures that all new stroke patients who are admitted go to HASU. This ensures the whole bay is routinely used more often with clear step-down plans in place to return a vacant HASU bed within one (1) hour.
3. Coronary Care Unit has been relocated to Tilney ward and therefore returning five (5) back to the Stroke Unit, reducing the number of stroke outliers on other wards.

Recovery Forecast:

1. The implementation of the new Stroke Admissions SOP, clarity around the HASU pathway, and the return of five (5) beds is forecasted to improve the metric performance from an "E" to a "D" from September 2021 onwards, barring any unforeseen changes and further impact of COVID, which will result in fewer patients able to be admitted to the Stroke Unit and spending more time on a non-Stroke ward.

Key Risks to Forecast Improvement:

1. Adherence to the new Stroke Admissions SOP.
2. Stroke admission activity continues to be over plan and/or to increase at a rate faster than anticipated.
3. The capacity of health and social care partners to facilitate timely discharges for patients on discharge to assess pathways 1, 2 and 3.
4. COVID impact resulting in stroke patients not being admitted or staying on the ward.

Well Led (Finance) - Accountable Officer - Director of Finance

	In Month				Year to Date			
	Plan £'000s	Actual £'000s	Fav / (Adv) £'000s	%	Plan £'000s	Actual £'000s	Fav / (Adv) £'000s	%
Clinical Income	19,192	19,192	0	0%	132,508	134,982	2,474	2%
Other Income	1,424	1,424	0	0%	9,506	9,299	(207)	(2%)
COVID-19 Additional Income	1,414	1,414	0	0%	9,106	9,998	892	10%
Total Income	**22,030**	**22,030**	**0**	**0%**	**151,120**	**154,279**	**3,159**	**2%**
Pay Costs - Substantive	(12,763)	(12,763)	0	0%	(85,809)	(89,952)	(4,143)	(5%)
Pay Costs - Bank	(999)	(999)	0	0%	(7,775)	(7,132)	643	8%
Pay Costs - Agency	(965)	(965)	0	0%	(8,902)	(6,371)	2,531	28%
Pay Costs - Additional COVID-19	(583)	(583)	0	0%	(4,619)	(4,586)	33	1%
Pay Costs - Vaccination Centres	(84)	(84)	0	0%	(84)	(903)	(819)	
Total Pay	(15,394)	(15,394)	0	0%	(107,189)	(108,944)	(1,755)	(2%)
Non Pay - Additional COVID-19	(61)	(61)	0	0%	(661)	(309)	352	53%
Non Pay	(5,788)	(5,788)	0	0%	(36,998)	(39,489)	(2,491)	(7%)
Total Operating Costs	**(21,243)**	**(21,243)**	**0**	**0%**	**(144,848)**	**(148,742)**	**(3,894)**	**(3%)**
EBITDA	**787**	**787**	**0**	**0%**	**6,272**	**5,537**	**(735)**	**(12%)**
Non-Operating Costs	(793)	(793)	0	0%	(6,450)	(5,663)	787	12%
Adjust Donated Assets	33	33	0	0%	205	205	0	0%
TOTAL (Deficit) / Surplus	**27**	**27**	**0**	**0%**	**27**	**79**	**52**	**193%**
Ratios: Agency : Total Pay	6.6%	6.6%			8.7%	6.2%		
Ratios: EBITDA : Income	3.6%	3.6%			4.2%	3.6%		
Ratios: Net Deficit : Income	0.1%	0.1%			0.0%	0.1%		

I&E

Key
- EBITDA refers to Earnings Before Interest, Taxes, Depreciation and Amortisation
- Fav refers to a favourable variance to plan
- (Adv) refers to an adverse variance to plan

Executive Summary – Income and Expenditure Position

The system financial plan for H2 2021/22 has been submitted on 18 November 2021. It has been developed in the context of being a breakeven position for 2021/22.

October (Month 7) actuals will be used as the budget for month 7 as per NHSI&E guidance.

As at the end of Month 7, the Trust's in month financial position is showing a surplus of £27k with a year to date surplus of £79k.

Key points of note in month / Material variances:

- Leverington and Feltwell wards remain open to provide additional bed capacity. These wards have now been built into the base budget for the second half of the year and form part of the H2 plan.
- Covid-19 vaccination costs incurred and reimbursed in month are £0.1m.
- Agency expenditure has decreased by £0.1m in month 7 against the 2021/22 run-rate average.
- Non-pay expenditure has increased by £0.5m in month 7 against the 2021/22 run-rate average. This is mainly due to increases in supplies, drugs and premises expenditure.
- The CIP/waste reduction programme has achieved £0.6m of efficiencies in month, YTD the achievement of CIP is favourable to plan by £0.5m.

Well Led (Finance) - Accountable Officer - Director of Finance

	31-Mar-21 £m	30-Sep-21 £m	31-Oct-21 £m	Month on Month Movement £m	YTD Movement £m
Non current assets	101	100	100	-	(1)
Current Assets					
Inventories	2	2	2	-	-
Trade & Other Receivables	13	11	11	-	(2)
Cash	27	24	27	3	-
Current liabilities					
Trade & Other Payables	(19)	(18)	(15)	3	4
Accruals	(18)	(11)	(9)	2	9
PDC dividend	-	-	-	-	-
Other current liabilities	(2)	(1)	(2)	(1)	-
Non current liabilities	(1)	(1)	(1)	-	-
Borrowings	-	-	-	-	-
Total assets employed	**103**	**106**	**113**	**7**	**10**
Tax payers' equity					
Public Dividend Capital	198	198	205	7	7
Revaluation Reserve	9	9	9	-	-
Income & Expenditure Reserve	(104)	(101)	(101)	-	3
Tax payers' equity	**103**	**106**	**113**	**7**	**10**

Executive Summary – Balance Sheet Position

Key points of note in month / Material variances:

- In month capital expenditure incurred is £0.8m. YTD this is at £4.1m.
- Cash balances have increased by £3m, principally as a result of PDC advance funding for the RAAC project.
- Trade and other payables have decreased primarily due to the faster payment of suppliers in line with BPPC requirements.
- Public Dividend capital has increased by £7m during M7 due to an initial cash drawdown from the £22.4m approved funding for the RAAC project in the current financial year.
- Better Payment Practice Code (BPPC). The Trust has achieved the BPPC standard for October of paying at least 95% of its undisputed invoices within 30 days.

Well Led (People) - Accountable Officer – Director of People

Data To	KPI Description	Target	Current Value	Variance	Assurance
Oct-21	Appraisal Rate	90.0%	80.3%		F
Oct-21	Appraisal Rate (Med Staff exc Jnr Drs)	90.0%	90.0%	L	?
Oct-21	Sickness Absence Rate	4.50%	7.22%	L	F
Oct-21	Long Term Sick	2.7%	3.5%		F
Oct-21	Short Term Sick	1.8%	3.7%	L	?
Oct-21	Mandatory Training Rate	80.0%	82.5%	H	?
Oct-21	Turnover Rate	10.0%	11.5%	H	?

Appraisal Rate

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Oct-21	Appraisal Rate	90.0%	80.3%		F	Common Cause (expected) variation	Variation indicates consistently (F)alling short of the target

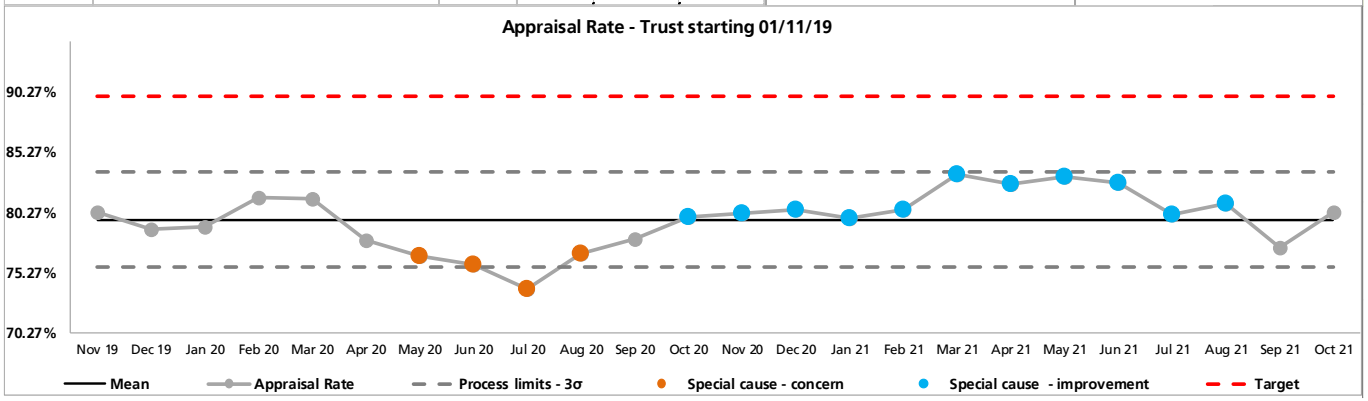


Chart 37 – Appraisal Rate

- Overall appraisal rates have improved from 77.4% last month to 80.27% though still behind target.
- Continues to be hampered by full capacity protocols.

Sickness Absence rate

Data To	KPI Description	Target	Current Value	Variance	Assurance
Oct-21	Sickness Absence Rate	4.50%	7.22%	L	F

The chart shown below excludes the peak COVID periods (annotated) from the mean and control limit calculations

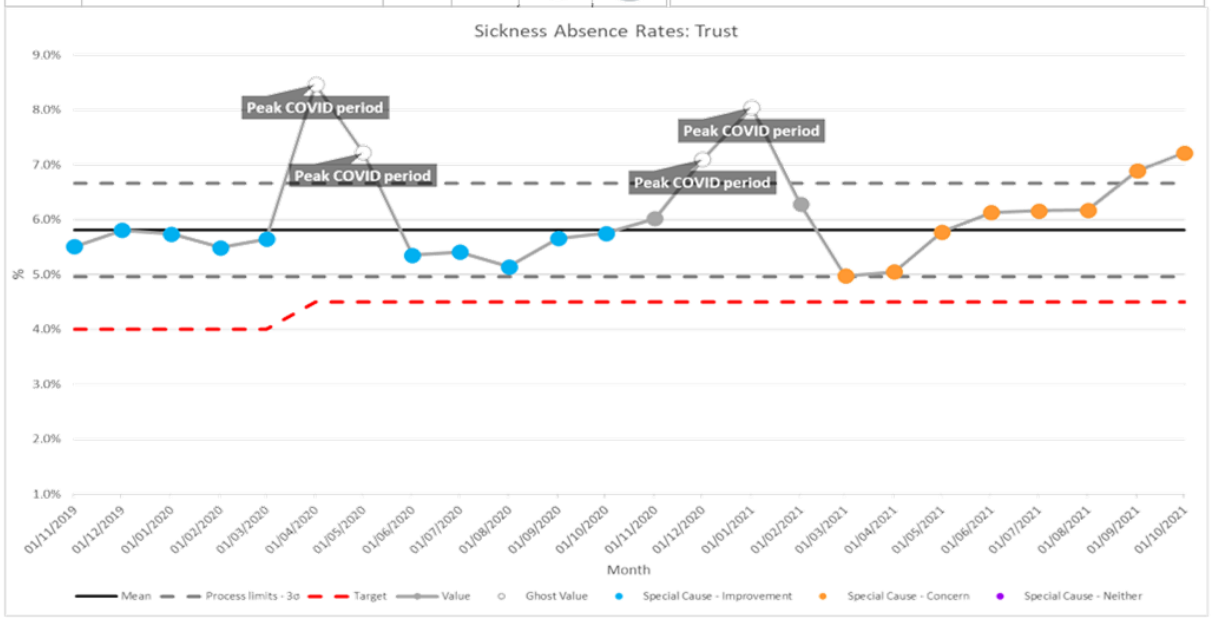


Chart 38 – Sickness Absence Rate

Sickness Absence has increased for the 7th consecutive month and is now outside of normal variation limits at 7.22%:

1. Short term sickness 3.72% and long-term sickness 3.50%.
2. Clinical Services (9.78%/295 occurrences), Nursing/Midwifery (6.54%/361 occurrences), Estates/ Ancillary (13.08%/156 occurrences).
3. 20.4% anxiety, stress, depression, other psychiatric illness (vs 22% last month).
4. 12.4% cough, cold, flu.
5. 8.8% other musculoskeletal problems (not back).
6. 5.6% absences recorded as unknown (vs 7% last month.

Benchmarking sickness absence in Norfolk Acute trusts:

NNUH currently 4.9% vs 3.9% target.
JPUH currently 4.6% vs 3.5% target.

Labour Turnover

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Oct-21	Turnover Rate	10.0%	11.5%	H	?	Special cause (unexpected) variation - Concern (H)	Variation indicates inconsistently passing and falling short of the target

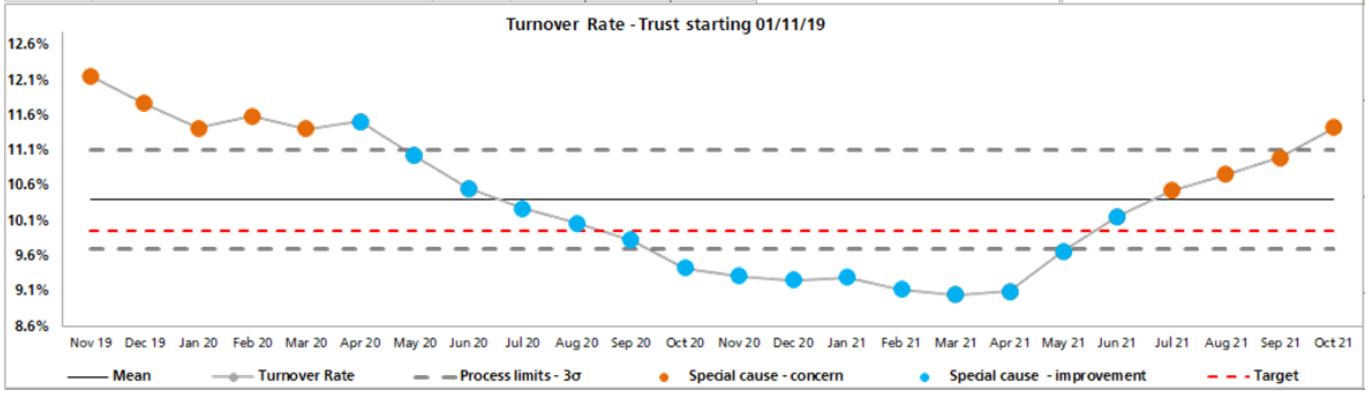


Chart 39 – Turnover Rate

Benchmarking: JPUH currently at 9.6% and NNUH currently at 10.6%.