The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Meeting:	Board of Directors (in Public)		
Meeting Date:	2 November 2021	**Agenda item:**	12
Report Title:	Integrated Performance Report (IPR) – September 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	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.				

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 September (5), compared to August (7). **C.Diff** - Seven cases of C.Diff were identified in September 2021. Two cases reviewed (COHA's) not attributed to QEHKL. Five cases awaiting review (HOHA's). All cases will be reviewed by 28 October. **MSSA** - Two cases of hospital onset and two cases of community onset MSSA were reported in September 2021. **E.coli** - Three cases of hospital onset E. coli were reported in September 2021. **Neonatal and Perinatal Mortality** There were no stillbirths in the month of August and all of our extended perinatal mortality rates remain within common cause variation and below the upper control limits. **Mortality** The SHMI remains within the "as expected" band for the latest reporting period 104.8 (March 2021). HSMR for the period June 2020 to May 2021 was 120.67. This remains elevated but indicates a marked fall since the peak of the second wave of the pandemic in January- February 2021. The crude number of deaths occurring per month has reduced since the peak of the second wave of the pandemic and is now similar to the number of non-COVID related deaths from previous years. **Mixed Sex Accommodation Breaches** There were six (6) incidents of same sex accommodation breaches affecting fifteen (15) patients during September 2021. The incidents occurred in the Hyperacute Stroke Unit (HASU) on West Raynham Ward. **Complaints** The timeliness of responding to complaints within 30 days has been achieved for four consecutive months. **Dementia Case Finding** Dementia Screening remains above the agreed threshold of 90% for a sixth month. The improved screening process has been embedded in the services of Integrated Care of Older People (ICOP). **Emergency Care** 4-hour performance in September fell to 64.5% from 68.6%, below the standard of 95%. Admitted performance was 30.5% and non-admitted performance was 83.9%; 1,634 patients that breached were admitted to an inpatient bed.

	There were 58 patients that waited in the Emergency Department over 12 hours from decision to admit to admission in September 2021. During September 2021, there were 1,711 conveyances by EEAST to the Emergency Department. Of those, 37.76% of handovers took place within 15 minutes against the trajectory of 51.52%. The average handover time was 42 minutes. **Referral to Treatment** At the end of September 2021, there were a total of 17,726 patients on the waiting list, of which 6,425 had waited for over 18 weeks from referral, giving performance of 63.75% (unvalidated). The top 3 specialties with the greatest number of patients waiting over 18 weeks were Orthopaedics (1,055), Ophthalmology (819) and Dermatology (794). At the end of September 2021 there were 987 patients waiting longer than 52 weeks for treatment, a reduction of 76 from August. The majority of these were in Orthopaedics (305), Gynaecology (225) and General Surgery (191). The longest waiting patient is a Gynaecology patient (P3) at 119 weeks; this patient who has a TCI date of 10th November. There were four breaches of the 28-day readmission guarantee in September 2021; three due to a single consultant led service where the consultant was unable to operate for five weeks due to injury and one breach due to consultant sickness on the day of surgery. During August 2021 the Trust implemented a new Radiology Information System (RIS) and performance reporting relating to Radiology diagnostics is temporarily suspended. Cancer 62-day performance in August 2021 was 58.8% against the standard of 85% and a trajectory of 86.2%. At the end of August 2021, 24 patients were on the pathway waiting over 104 days. The Trust has forecast this number to peak in September and reduce from October. Of the 24 patients waiting at the end of August 2021, 13 were colorectal, 4 were gynaecology, 2 were Haematology, 2 were Head & Neck, 1 was Lung, 1 was Skin and 1 was Upper GI. **Well Led (Finance)** As at the end of September (H1) 2021, the Trust's in month financial position is showing a surplus of £7k against the plan and year to date is £52k positive. This means that the Trust has achieved its breakeven target for the first half of the financial year 2021/22 **Well Led (People)** The workforce performance metrics remain challenged in a difficult operating environment:

	• Reduction in appraisal rates to 77.4%. • Increase in sickness absence to 6.89%. • Labour Turnover increase to 11%. Improvements continue to be made in: • Mandatory Training increased to 85.1%. • Time to recruit has reduced to 44.5 days. • Average time to close ER cases in month 12 days.
Recommendation:	The Board of Directors are 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 (Public)

September 2021 Data

A note on SPC Charts

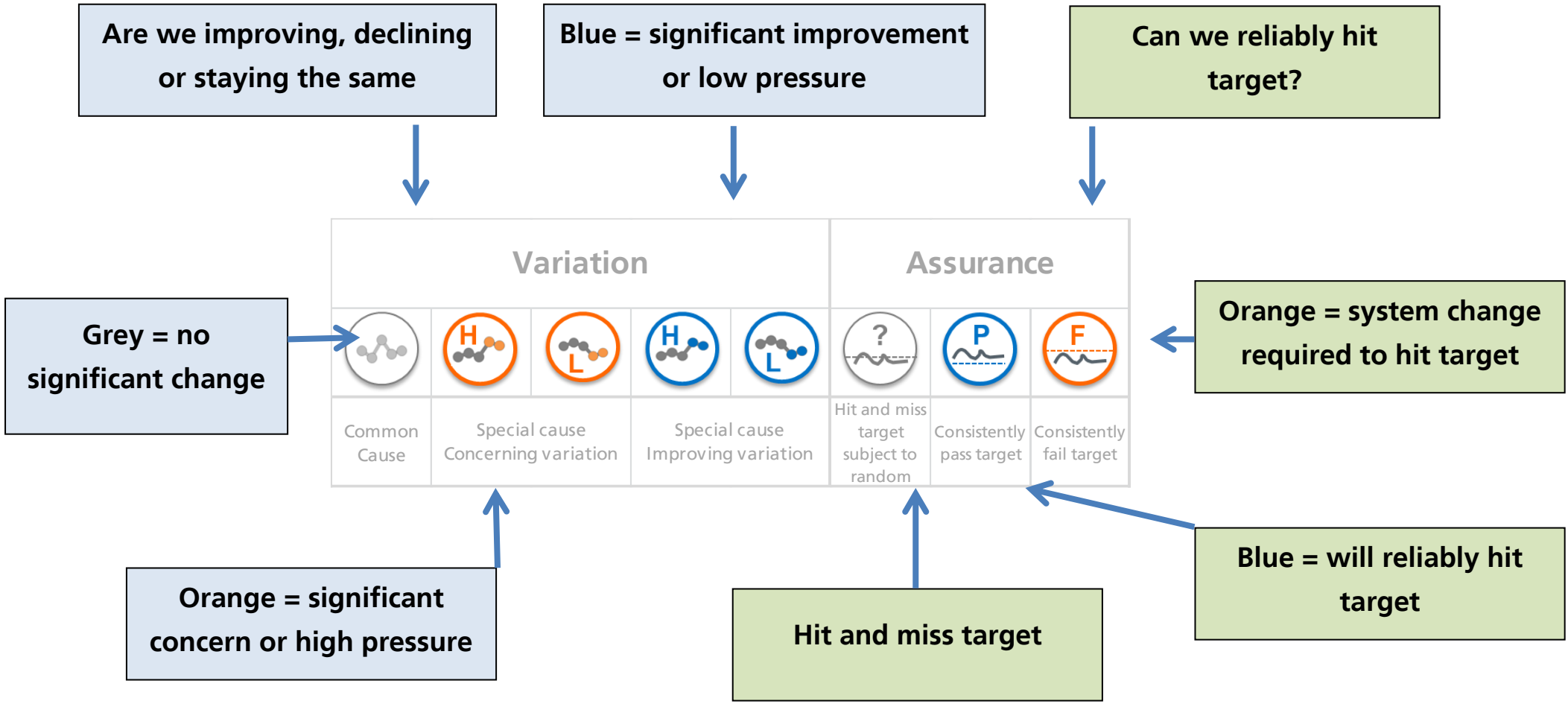
The report that follows uses the key below. A recap of using these descriptions is also included below

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



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

Safe Dashboard

Data To	KPI Description	Limit	Current Value	Variance	Assurance
Sep-21	Serious Incidents (DECLARED IN MONTH)	0	5		
Sep-21	Falls (with Harm) Rate per 1000 beddays	0.98	0.15		P
Sep-21	PUs Rate per 1000 beddays	0.41	0.58		?

Data To	KPI Description	Target	Current Value	Variance	Assurance
Aug-21	Overall Fill Rate %	80.0%	87.3%	L	P
Aug-21	CHPPD	8.00	7.52	L	?
Sep-21	Cleanliness - Very High Risk	95.0%	97.0%		P
Sep-21	Cleanliness - High Risk	95.0%	95.0%		?
Sep-21	Cleanliness - Significant Risk	95.0%	91.4%		?
Sep-21	Cleanliness - Low Risk	95.0%	88.3%		
Sep-21	Cleanliness - No. of audits complete	37.00	48		?

Data To	KPI Description	Limit	Current Value	Variance	Assurance
Sep-21	CDiff (Hosp Acquired) Rate per 100k beddays	30.10	36.64	H	?
Sep-21	CDiff (Hosp Acquired) Actual	3	7		
Sep-21	MRSA (Hosp Acquired) Actual	0	0		
Sep-21	E Coli (Hosp Acquired) Rate per 100k beddays	16.40	22.74	H	?
Sep-21	E Coli (Hosp Acquired) Actual	2	7		
Sep-21	MSSA (Hosp Acquired) Actual		4		
Sep-21	MSSA (Hosp Acquired) Rate per 100k beddays		14.53	H	

Data To	KPI Description	Target	Current Value	Variance	Assurance
Aug-21	VTE Assessment Completeness	97.2%	98.5%		?
Sep-21	Patient Safety Alerts not completed by deadline	0	0		

Serious Incidents

The Trust declared 5 Serious Incidents in September 2021:

- **Two** were 12 hour breaches within the Emergency Department following a decision to admit to mental healthcare beds.
- **Two** were due to treatment delays; one was in Cancer Services and one in Ophthalmology.
- **One** was an inpatient fall where the patient sustained a fractured neck of femur and sadly died.

The Trust has continued to demonstrate improvements in the management of its Serious Incidents against the 60 day investigation deadline, with 90% of reports due for submission in September meeting the 60 day deadline.

As of the 10 September 2021, following notification from NHSE/I, Trusts are no longer required to declare 12 hour Emergency Department breaches as Serious Incidents unless patient harm has been identified or suspected as a result of the delay. The Trust continues to report all 12 hour breaches on DATIX, with themes and learning shared routinely with the CCG, with particular focus on Mental Healthcare breaches.

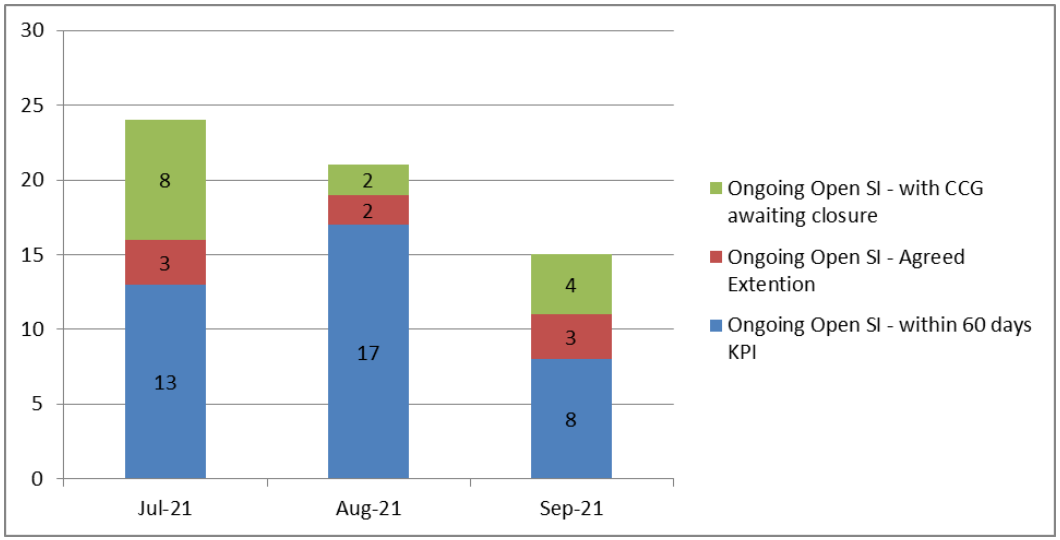


Chart 1 – Trustwide Serious Incident investigation status

Falls

Data To	KPI Description	Limit	Current Value	Variance	Assurance	*Variation Comment*	*Target Achievement*
Sep-21	Falls (with Harm) Rate per 1000 beddays	0.98	0.15		P	Common Cause (expected) variation	Variation indicates consistently (P)assing the target

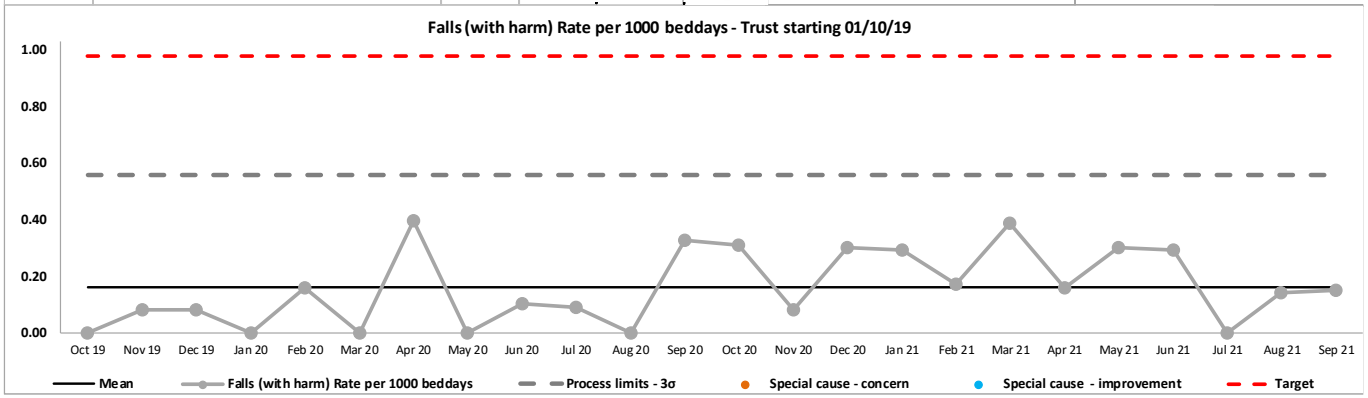


Chart 2 – Falls (with harm) Rate per 1,000 Bed Days

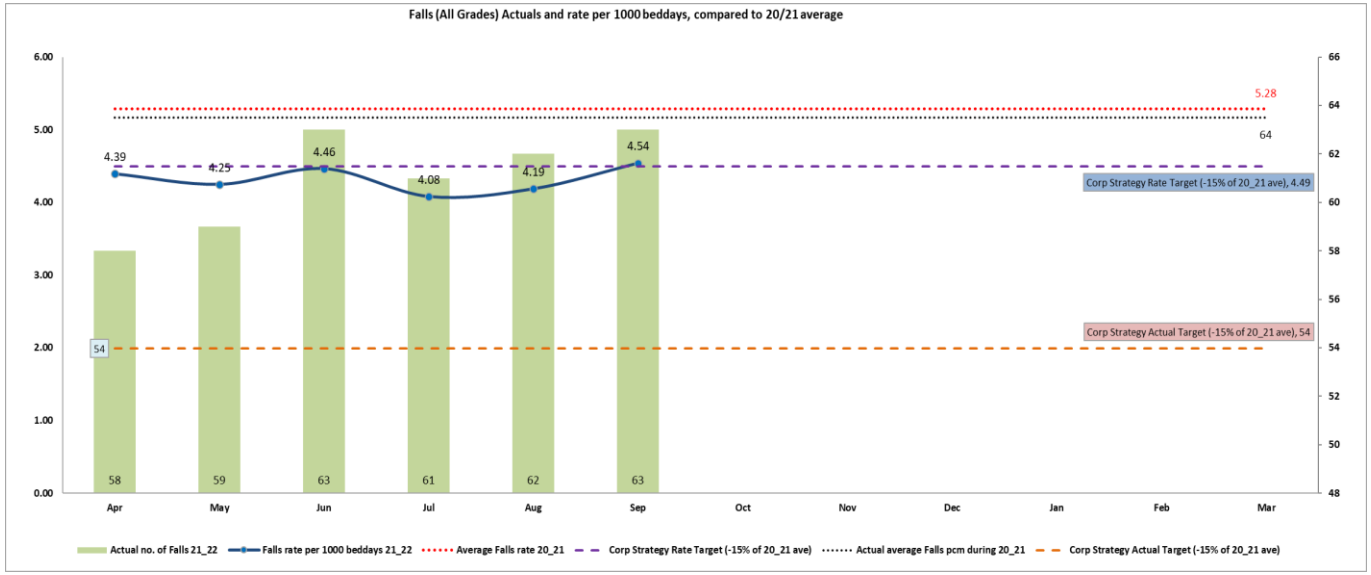


Chart 3 – Falls and rate per 1,000 bed days

Key Issues (any new issues in red):

1. The falls rate per 1000 bed days during September 2021 has remained reasonably static but continues to be statistically insignificant.
2. A total of 63 in-patients falls incidents reported in September 2021, 62 reported in August.
3. The number of falls with harm per 1000 bed days in September has decreased for the second consecutive month.
4. There is inconsistency in the number of patients sustaining harm and injuries following fall incidents.

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.

Recovery Forecast: The falls operation group will be completing a focussed review to ensure resource is effectively targeted to maximise impact.

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.

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*
Sep-21	PUs Rate per 1000 beddays	0.41	0.58			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

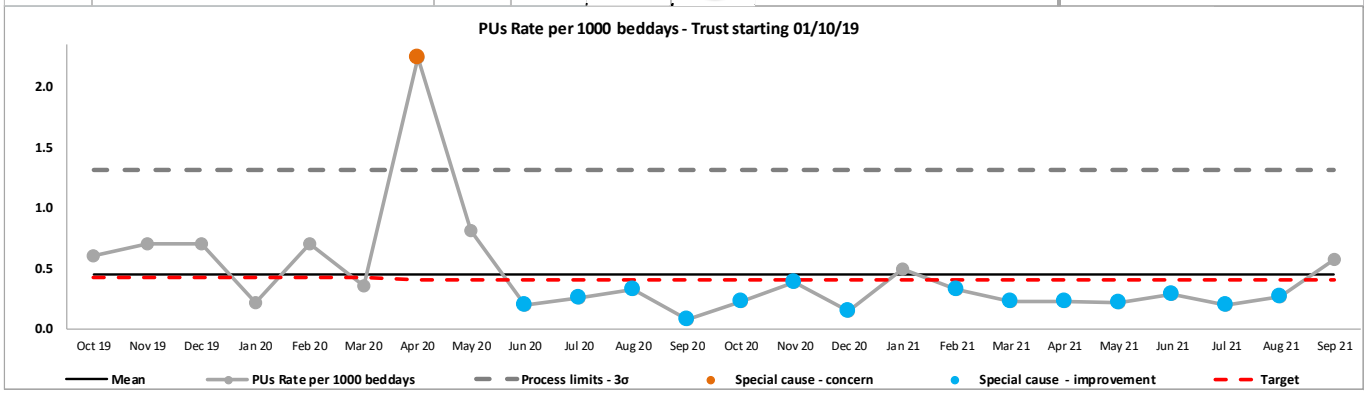


Chart 4 – Pressure Ulcer Rates per 1,000 Bed Days

Key Issues (any new issues in red):

1. The number of hospital acquired pressure ulcer has increased in September above the tolerance level for the first time in seven consecutive months.
2. There were 8 hospital acquired pressure ulcers in September (X4 Cat 2 X3 Unstageable, X1 DTI).
3. 5 were initially assessed as lapses in care. DOC completed. RCAs underway – action plans in place.
4. The lapses in care were inaccurate/incomplete documentation or delay/no pressure relieving equipment.

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.
2. The Tissue Viability Nurses 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.

Recovery Forecast (e.g. August):

1. The number of hospital acquired pressure ulcer start to reduce as we realign specialties.
2. The pressure ulcer rate per 1000 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

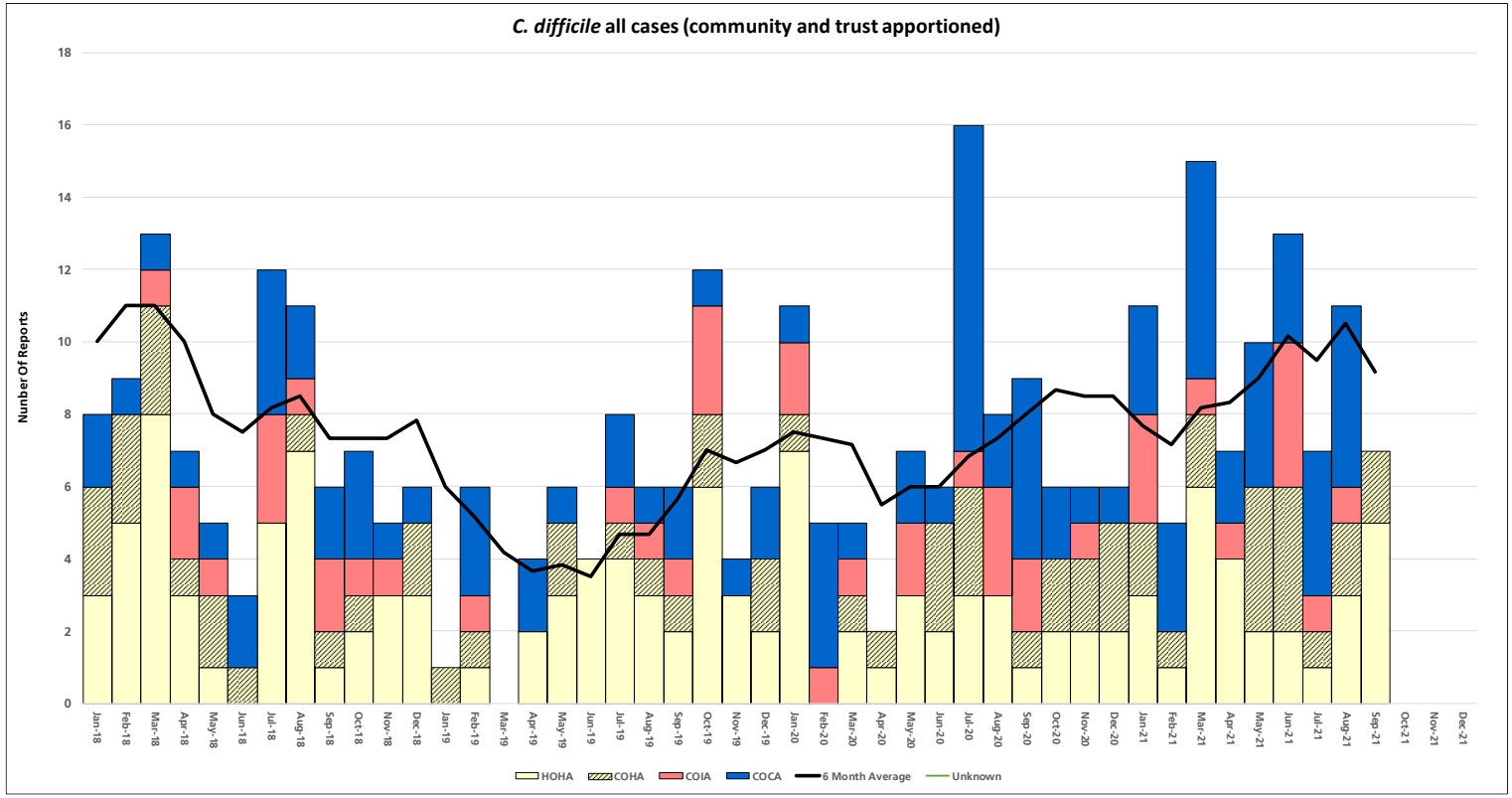


Chart 5 – C.Diff all Cases

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. Seven cases identified in September 2021 (5 HOHA and 2 COHA).
2. Two cases reviewed (COHA's) not attributed to QEHKL.
3. Five cases awaiting review (HOHA's). All cases will be reviewed by 28 October.

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 paper work 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 paper work.
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)

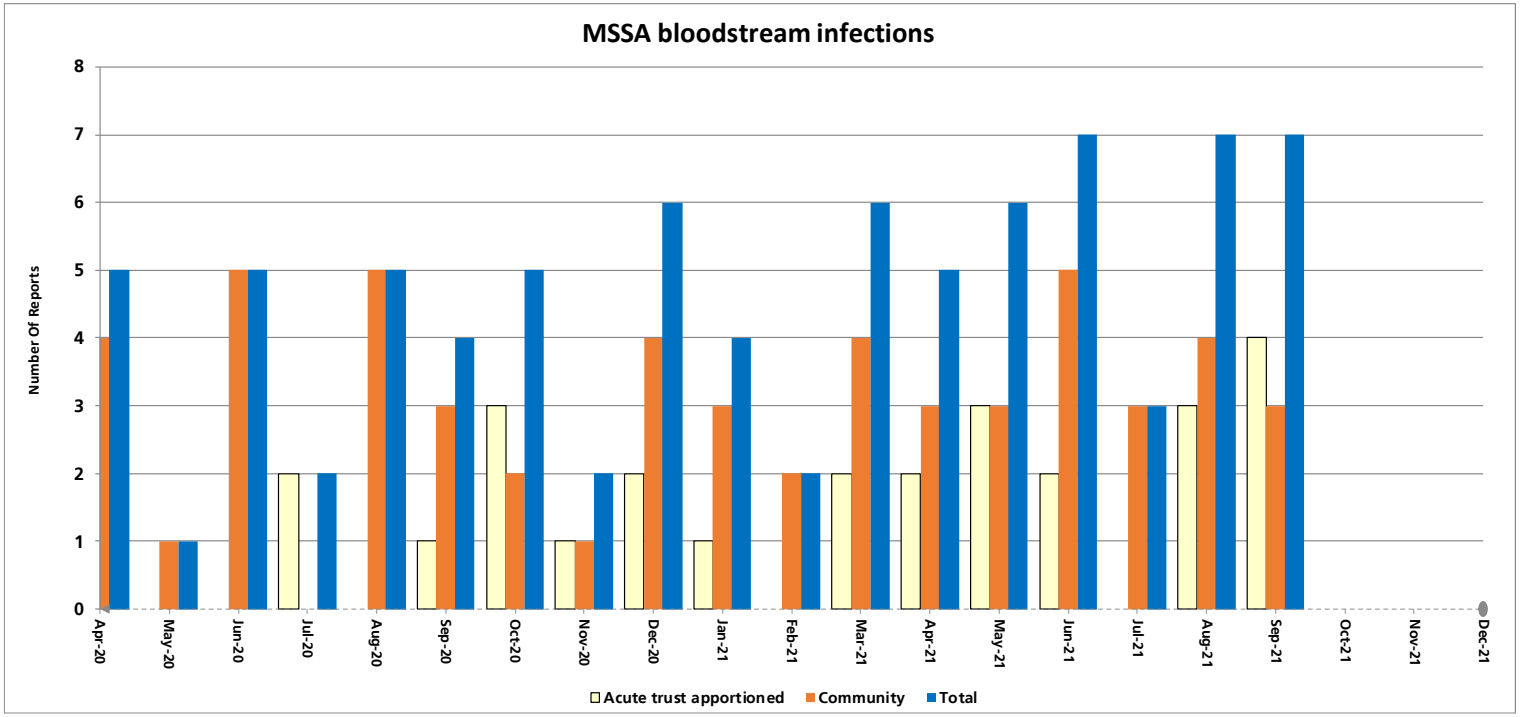


Chart 6 – MSSA Bloodstream Infections

Key Issues:

1. Two cases of hospital onset and two cases community onset MSSA were reported in September 2021.
2. All cases awaiting review at PIR meeting – meetings will be completed by 26 October 2021.
3. Initial findings: Discrepancy in Octenisan use, poor with documentation of VIP score and low compliance with ANTT training.

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)

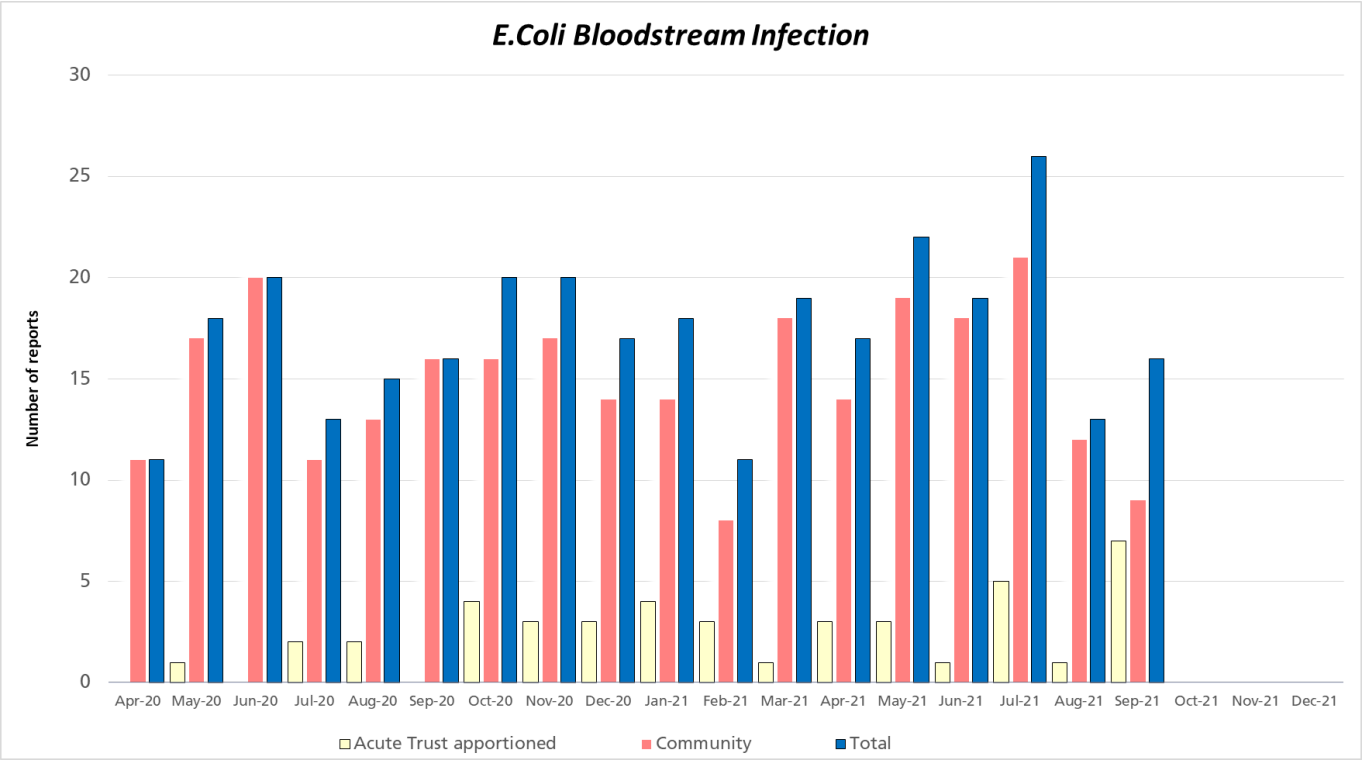


Chart 7 – E.coli Bloodstream Infections

Key Issues

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

1. Three cases of hospital onset E. coli were reported in September 2021.
2. Cases reviewed at surveillance meeting with Infection Prevention Team, Consultant Microbiologist and Infection Control Doctor.
3. Findings: 1 patient catheterised, 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 in order 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
Aug-21	VTE Assessment Completeness	97.2%	98.5%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

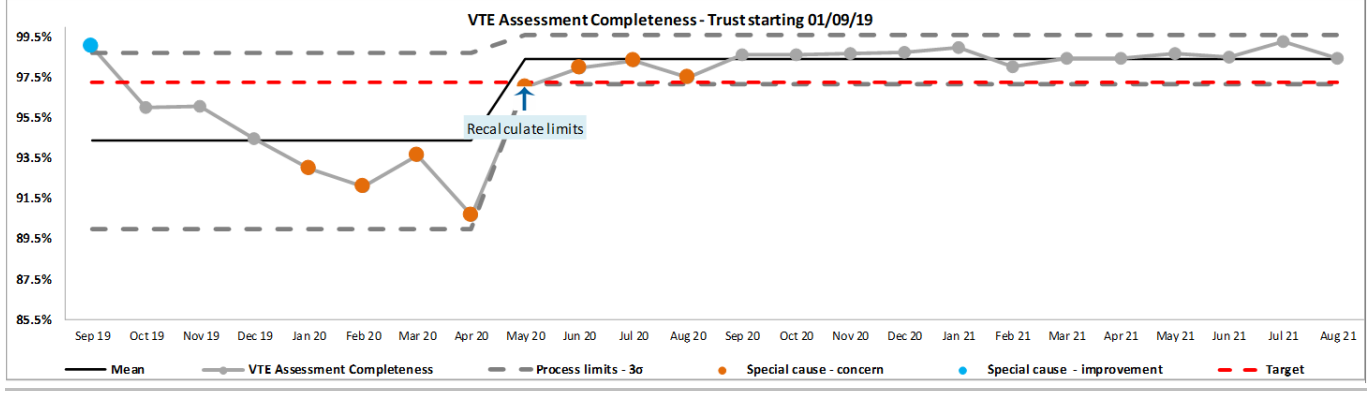


Chart 8 – VTE Assessment Completeness

Key Issues (any new issues in red):

1. Compliance with VTE assessments remains excellent, within common cause variation and above the target of 97.2% for over 12 months.

Key Actions (new actions in green):

1. With roll out of EPMA, we are currently collecting parallel information from EPMA and admission notes for capture of VTE screening. Eventually the mode of capture will be through EPMA only once this is in place for all patients across all inpatient areas which should remove reliance on human factor errors in the screening process.

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

Key Risks to Forecast Improvement:

1. With EPMA not fully rolled out, there are risks identified in the data collection process that relying solely on patient clerking notes for capture of screening will result in under reporting of the VTE assessment rates. This is being monitored and parallel validation of data is in place in the transition period.

Effective - Accountable Officer - Medical Director

Data To	KPI Description	Limit	Current Value	Variance	Assurance
Aug-21	Total Births (inc Home, BBA's & Stillbirths)		185		
Aug-21	Stillbirth Rate	3.73	3.43		
Aug-21	Neonatal Deaths Rate	1.06	0.49		
Aug-21	Extended Perinatal Deaths Rate	4.79	3.92		
Aug-21	Total C Section Rate		30.9%		
Aug-21	EL C Section Rate		11.8%		
Aug-21	EM C Section Rate		19.1%		
Aug-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%		
Aug-21	Breastfeeding initiation	70.0%	80.4%		

Data To	KPI Description	Target	Current Value	Variance	Assurance
Aug-21	Breastfeeding on discharge from hospital	60.0%	61.3%		
Aug-21	Smoking at Booking	18.6%	20.9%		
Aug-21	Stopped smoking by delivery	44.7%	36.0%		
Jul-21	Smoking at Time of Delivery		13.2%		
Aug-21	Post-Partum Haemorrhage	3.0%	2.7%		
Aug-21	3rd & 4th degree tears, exc C-Sections	3.5%	2.5%		
May-21	HSMR Crude Rate	3.18	4.79		
May-21	HSMR Relative risk	100.00	120.67		
May-21	HSMR Weekend Relative risk	100.00	129.25		
Feb-21	SHMI (Rolling 12 mth position)	100.00	104.84		
Aug-21	Rate per 1000 admissions of inpatient cardiac arrests	2.00	0.30		
Sep-21	No. of patients recruited in NIHR studies	63	78		

Neonatal and Perinatal Mortality

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Aug-21	Stillbirth Rate	3.73	3.43				

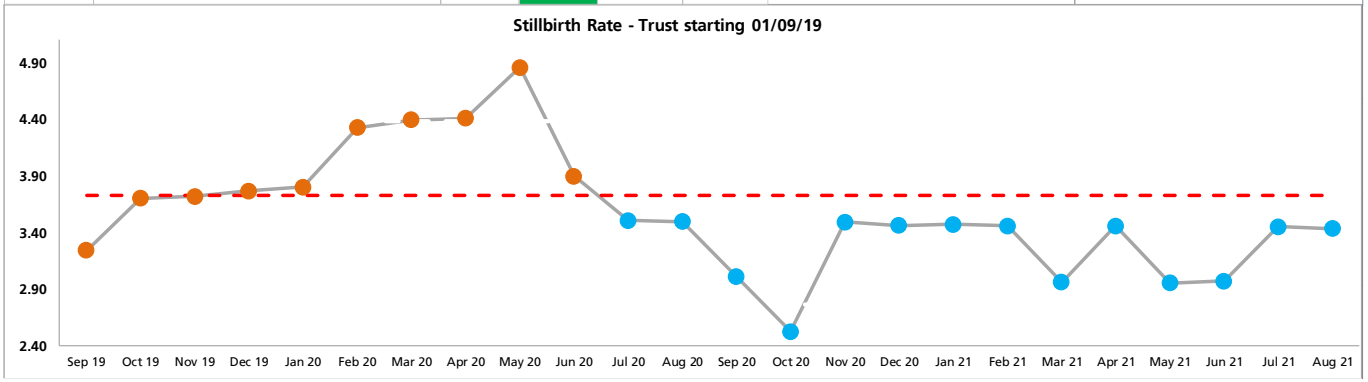


Chart 9 – Stillbirth rate

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Aug-21	Neonatal Deaths Rate	1.06	0.49				

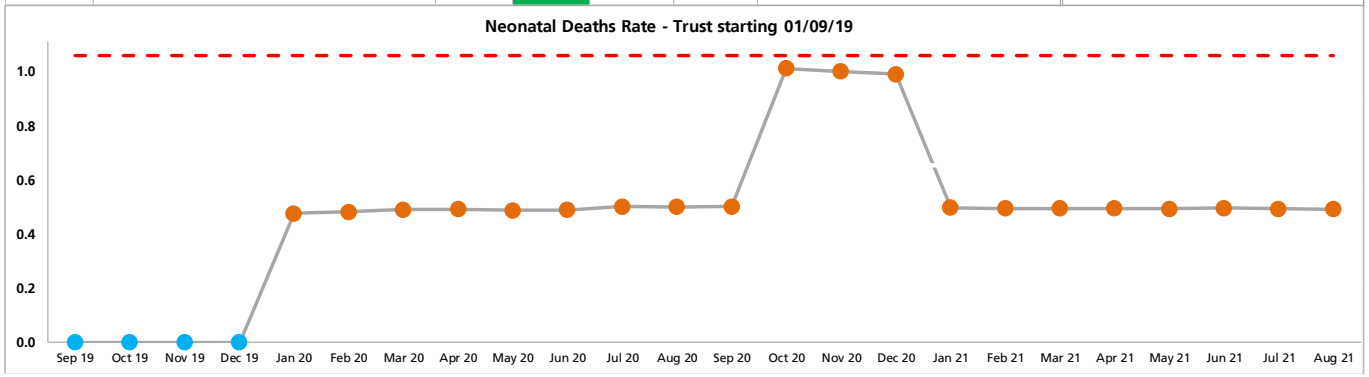


Chart 10 – Neonatal Death Rate

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Aug-21	Extended Perinatal Deaths Rate	4.79	3.92				

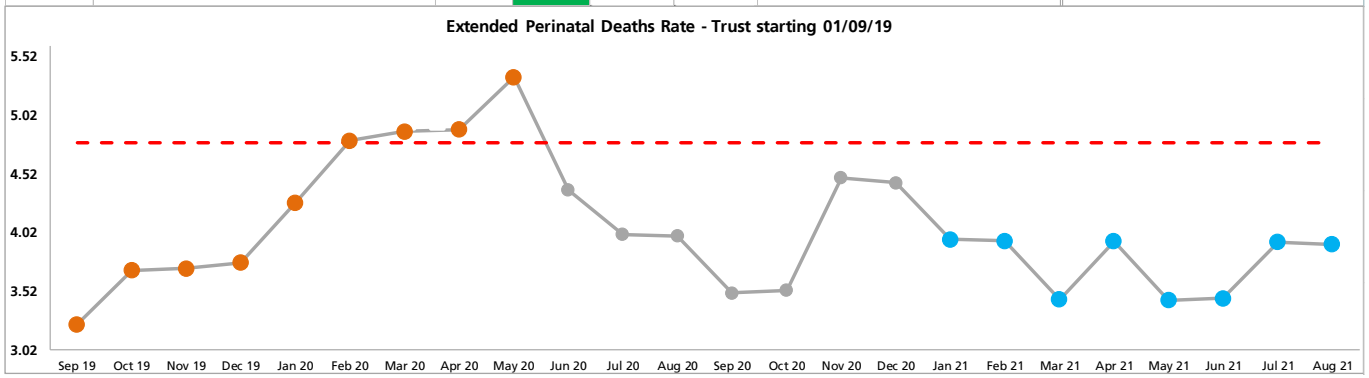


Chart 11 – Extended Perinatal Deaths Rate

Factors Driving Performance:

1. There were no stillbirths in the month of August and all of our extended perinatal mortality rates remain within common cause variation and below the upper control limits.

Actions being taken:

1. The Maternity Incentive Scheme Year 4 was launched 9 August to support the delivery of safer maternity care.
2. The safety and culture work streams of the Maternity Improvement Plan (MIP) continue to actively address issues identified from investigation into previous deaths, with check and challenge through our Transforming Maternity Safety and Strategy Forum.

Risk to delivery: Staffing shortages across the maternity team continues to remain a risk to delivering highest quality antenatal care.

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

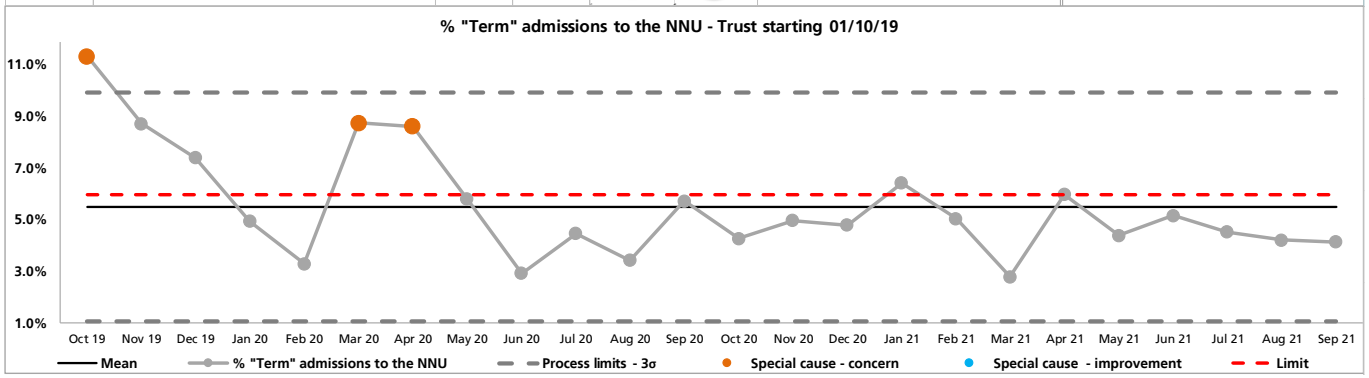


Chart 12 - % 'Term' admissions to NNU

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

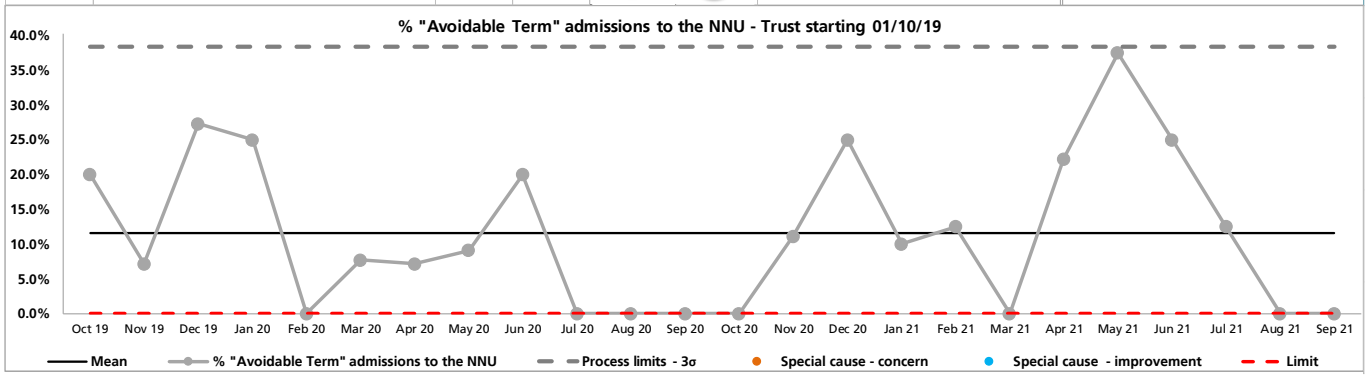


Chart 13 - % 'Avoidable Term' admissions to NNU

Factors Driving Performance:

1. Term admissions into the Neonatal Unit remain within common cause variation, below the 6% target.

Avoidable Term admissions

1. There were no admissions to the NICU in August or September 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
Aug-21	Total C Section Rate		30.9%			Common Cause (expected) variation	

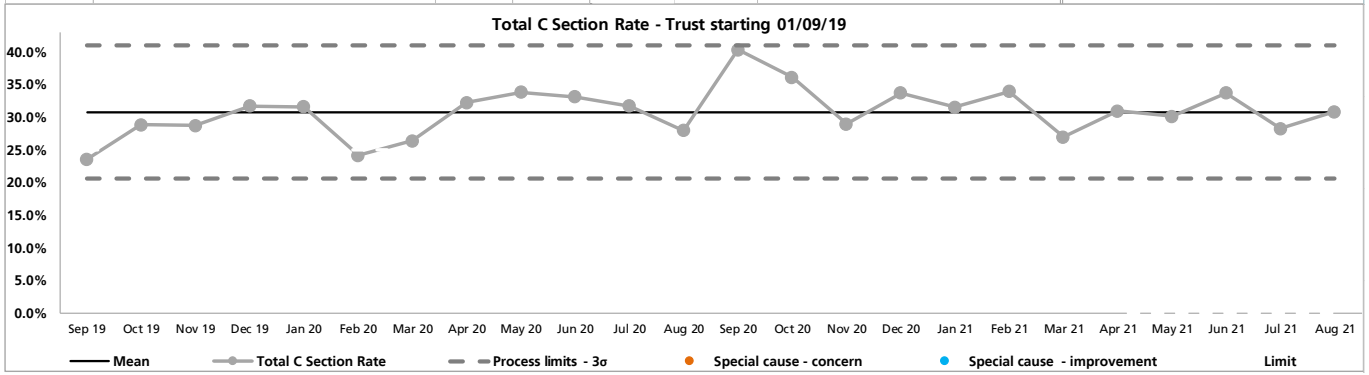


Chart 14 – Total Caesarean Section Rate

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Aug-21	EL C Section Rate		11.8%			Common Cause (expected) variation	

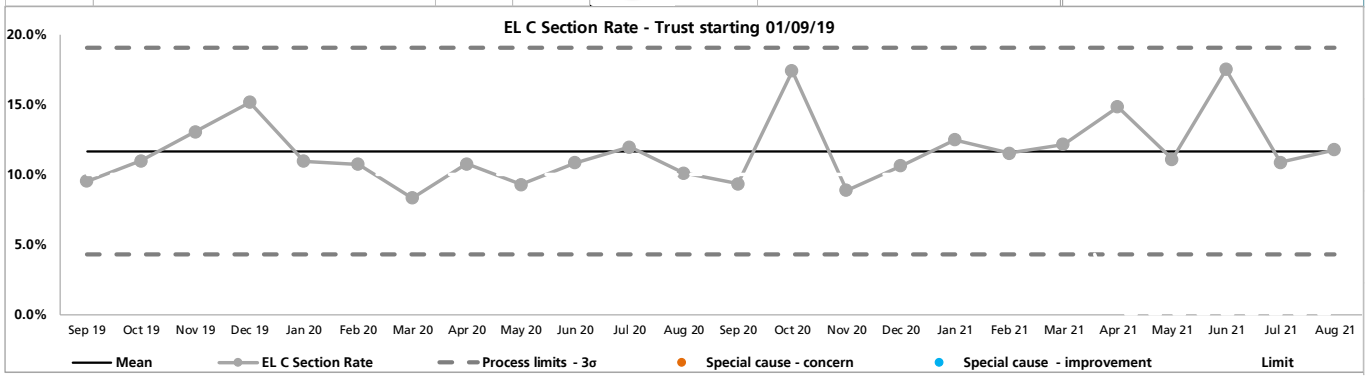


Chart 15 – Elective Caesarean Section Rate

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Aug-21	EM C Section Rate		19.1%			Common Cause (expected) variation	

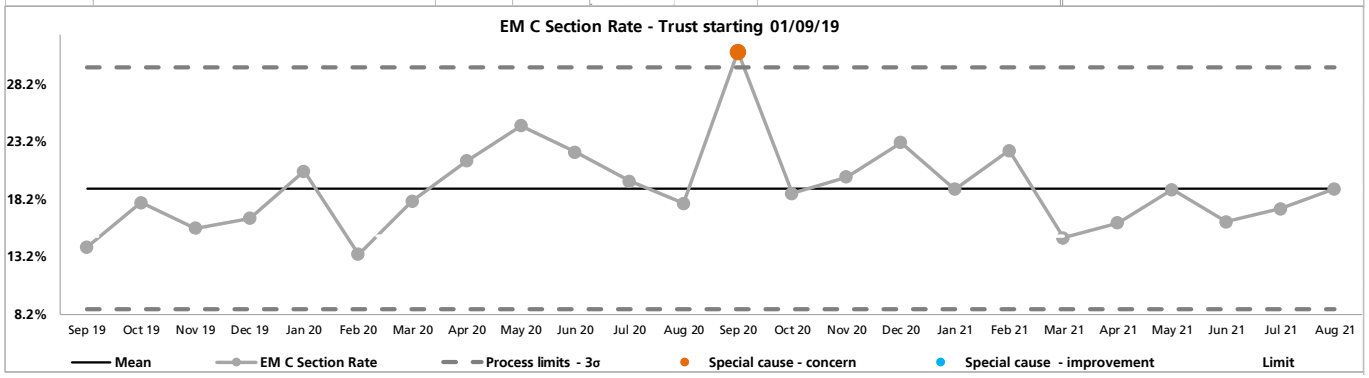


Chart 16 – Emergency Caesarean Section Rate

Factors driving performance

1. There were 185 births in July 2021 of which 114 [61.62%], were spontaneous vaginal deliveries 16[8.65%] assisted deliveries and 55 [29.73%] were LSCS.
2. From the regular MDT reviews of the emergency LSCS cases, the most common indications for Caesarean section were identified to be primigravida women with delayed progress following induced labour and women with a previous LSCS choosing to go for repeat LSCS.

Actions taken:

1. Robson criteria for classification of Caesareans sections are now used, ensuring consistent language and understanding for all staff (see appendix, page 30).
2. All medical staff and middle grade doctors are encouarged to attend the MDTs the week after their on call to ensure they are involved in the discussion and learning from their own cases.
3. A monthly deep dive by the MDT is planned to explore the most common reasons for emergencey LSCS. The first is planned to explore LSCS following induction of labour, the second will focus on trial of labour following previous LSCS which will also have input from the Clinical Psychology team

Breast Feeding Initiation rates

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Aug-21	Breastfeeding initiation	70.0%	80.4%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

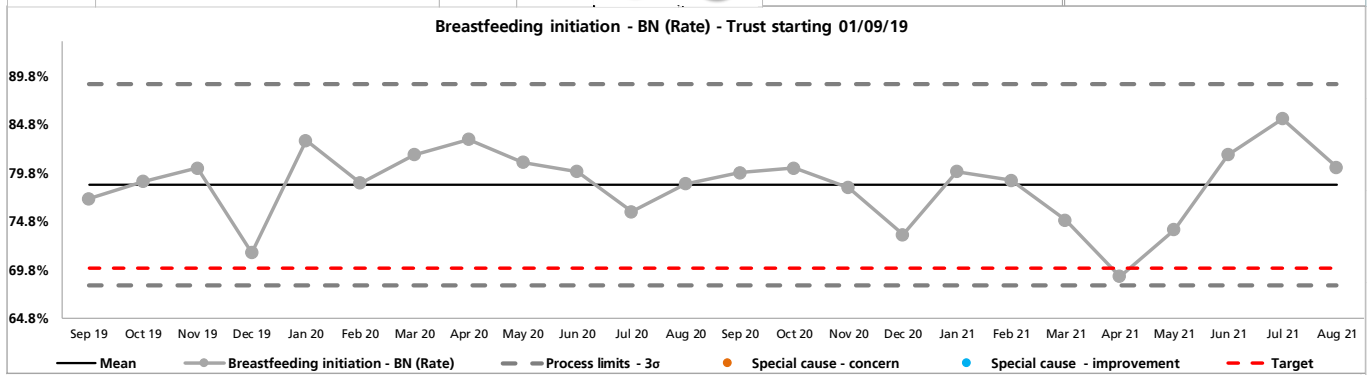


Chart 17 – Breastfeeding Initiation – BN (rate)

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Aug-21	Breastfeeding on discharge from hospital	60.0%	61.3%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

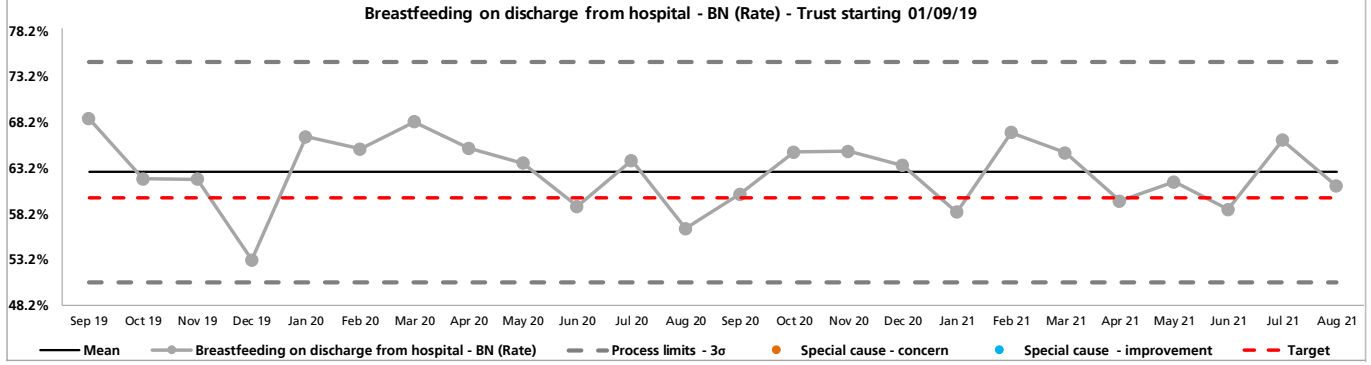


Chart 18 – Breastfeeding on discharge from hospital – BN (rate)

Factors driving performance:

1. Breastfeeding initiation rate remains in common cause variation, and has been above our target of 70% for the last 4 months since the hand expressing pack initiative was introduced.

Key Actions

1. The new infant feeding specialist has now started in role, intended to impove awareness, support training and embed changes leading to improvements.
2. Plans are in place for community hubs to host infant feeding classes and cafes will improve access to professional and peer breastfeeding support in community, an evidenced model to to support our women and babies
3. Recruitment to the Baby Friendly Initiative Guardian post has been completed

Risk to delivery:

1. Specialist midwives are needed to suport acute activity at times of high demand, where staffing shortages occur.
2. The frenulotomy service, which also supports continuation of breastfeeding, relies on one trained indivudal. The division is currently reviewing options to make this service more robust.

Smoking Cessation in Pregnancy

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Aug-21	Stopped smoking by delivery	44.7%	36.0%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

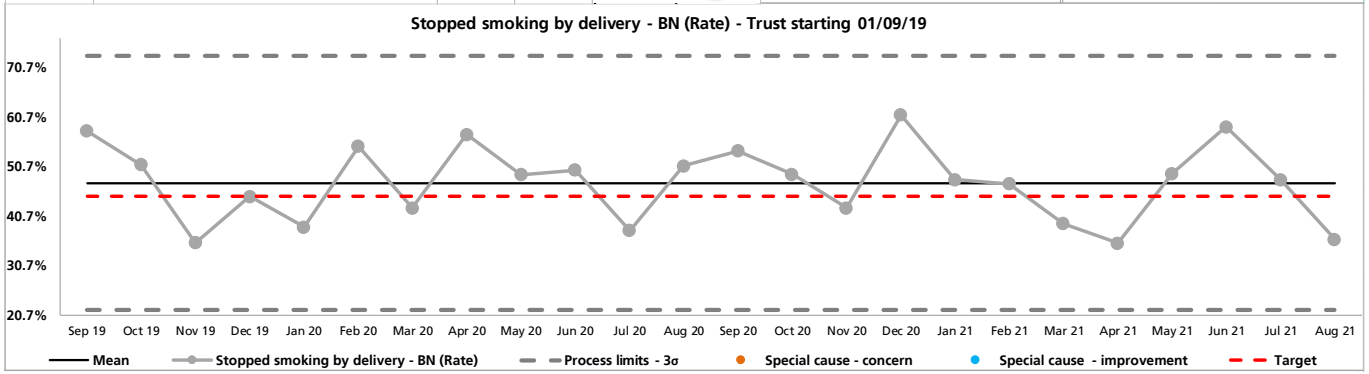


Chart 19 – Stopped smoking by delivery – BN (rate)

Factors driving performance:

1. Smoking cessation rates remain within common cause variation.
2. CO screening rates rates continue to rise slowly and are monitored through the maternity dashboard.

Key Actions

1. Direct electronic referals to smoking cessation services are due to be implemented in the coming weeks to improve referal rates.
2. The system are also reviewing the opportunity to introduce health coaches to provide additional support to women who want to stop smoking during their pregnancy.

Risks to delivery:

1. Appitite for engagement with smoking cessation services from service users has been impacted by a rising levels of smokers in the general population during the pandemic.

Post-patum Haemorrhage (PPH)

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Aug-21	Post-Partum Haemorrhage	3.0%	2.7%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

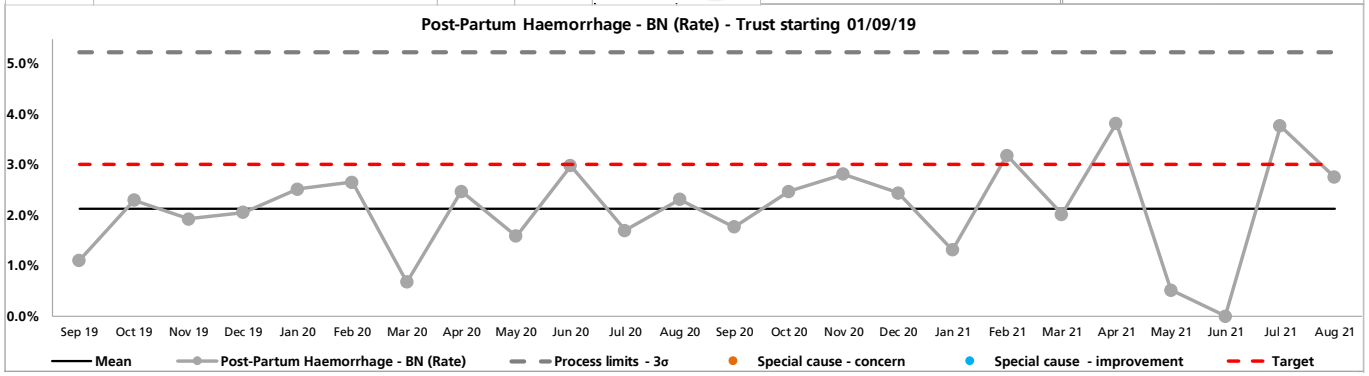


Chart 20 – Post-Partum Haemorrhage – BN (rate)

Factors driving performance:

1. Post partum haemorrhage rates remain within common cause variation.

Key Actions:

1. All incidents are discussed at Serious Incidents Review Panel to identify and share learning.

3rd & 4th degree perineal trauma

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Aug-21	3rd & 4th degree tears, exc C-Sections	3.5%	2.5%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

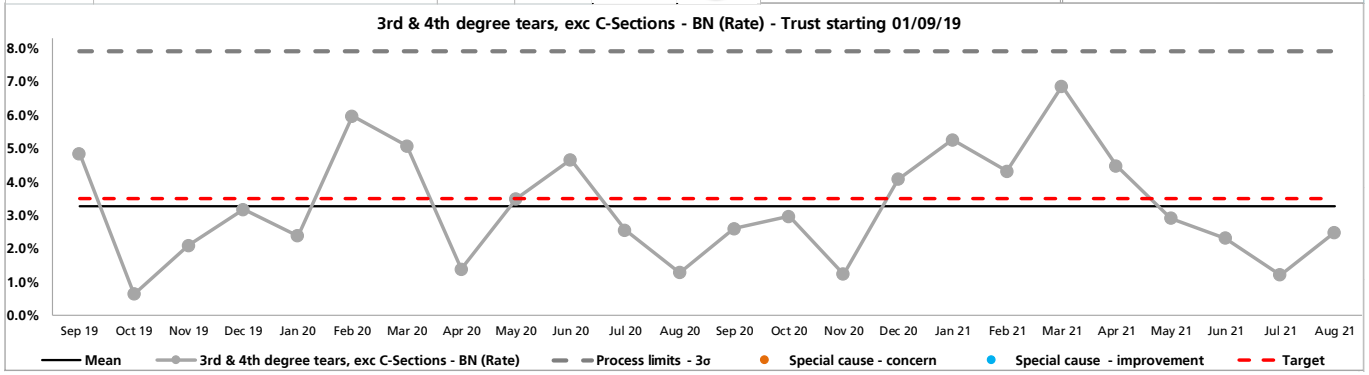


Chart 21 – 3rd and 4th degree tears

Factors driving performance:

1. Perineal trauma rates remain within common cause variation. The perineal care bundle was introduced in January 2021 and all cases continue to be reviewed monthly by a multi disciplinary team, and it is hoped that these interventions underlie the fall in injuries noted since March which will be sustainable long term.

Appendix: Robson-classification-system-Reproduced-with-permission-from-World-Health-Organisation

Mortality (HSMR and SHMI)

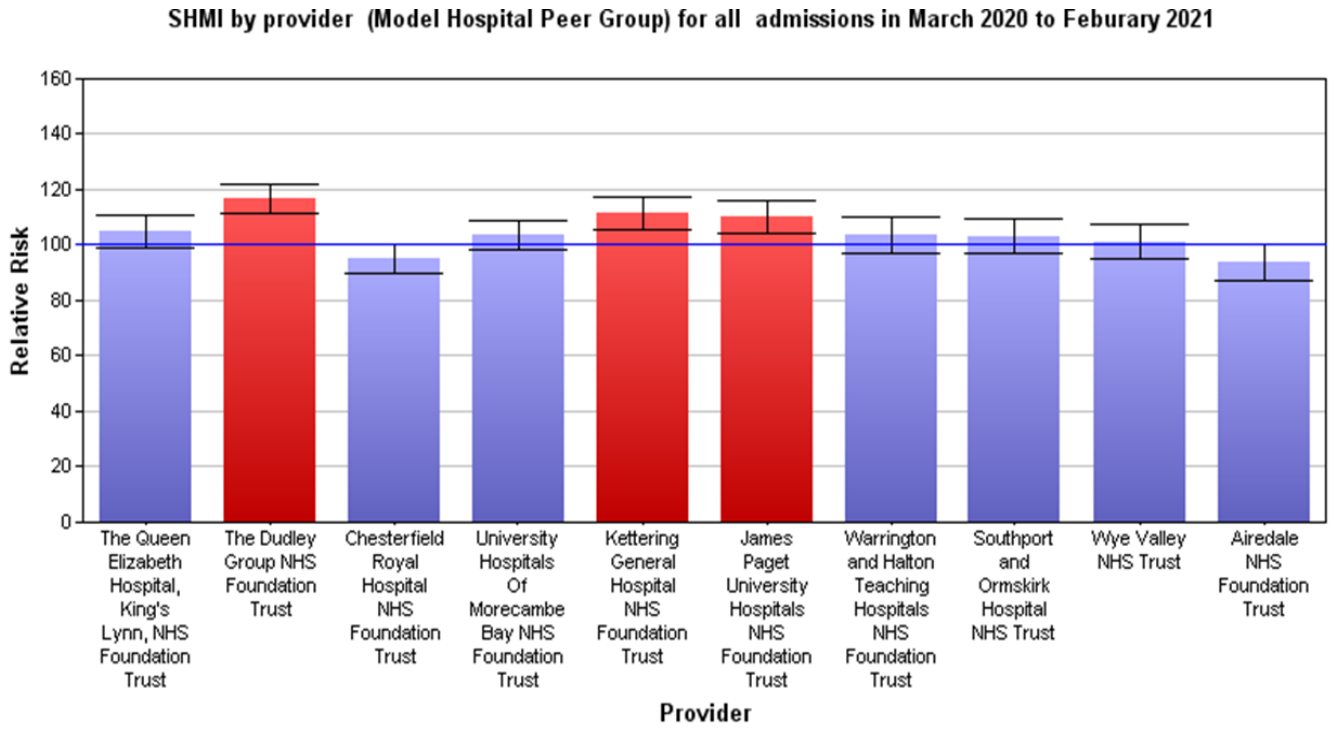


Chart 22 – SHMI by provider

Data To	KPI Description	Target	Current Value	Variance	Assurar	Variation Comment	Target Achievement
May-21	HSMR Relative risk	100.00	120.67				

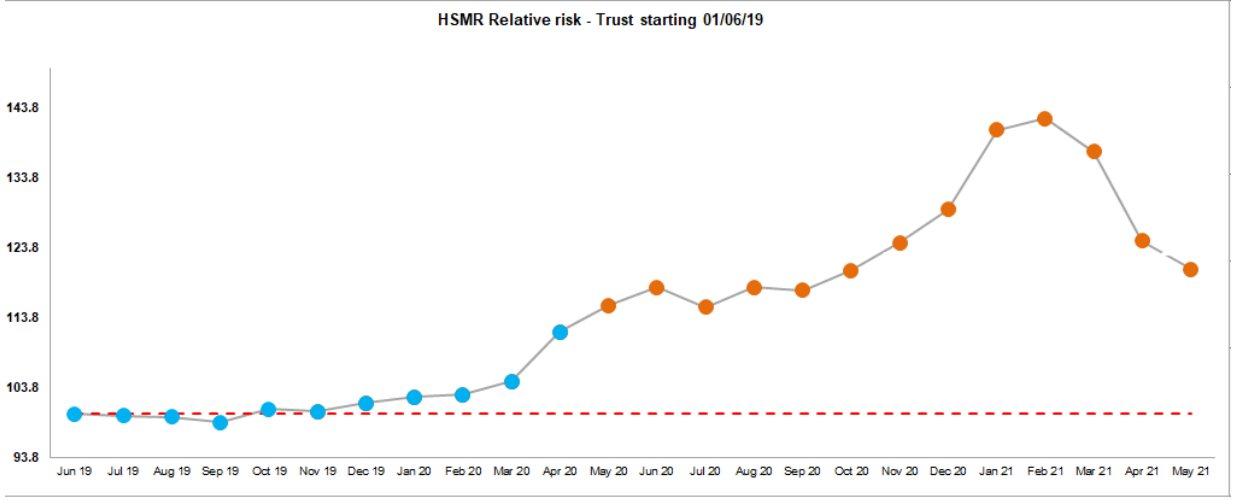


Chart 23 - HSMR Relative Risk

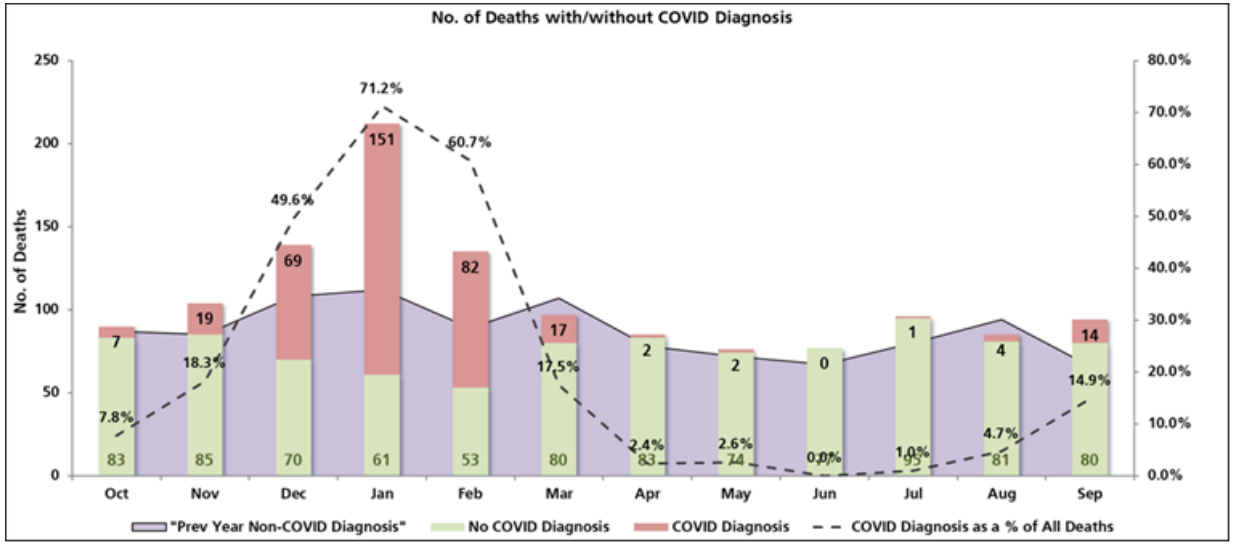


Chart 24 – Number of deaths with/without COVID diagnosis

Factors Driving the Performance

1. The SHMI remains within the "as expected" band for the latest reporting period 104.8 (March 2021).
2. National reporting by Dr Foster HES remains delayed and the funnel plot to demonstrate SHMI and HSMR together has not been updated since the data for March 2020 to February 2021 (as presented in the August IPR). For this reason the plot the dots format has been used to demonstrate the most up to date national data, though we will return to the funnel plot as soon as this becomes available again.
3. Dr Foster has now issued national HSMR data up to June 2021. QEH had a significant backlog of coding earlier in the year meaning that data used by Dr Foster when making an analysis of our HSMR has been incomplete. We are continuing to submit revised data as historic admissions are coded, and so the data for June are likely to change once these data have been incorporated. For this reason, this report includes data to May 2021 only.
4. HSMR for the period June 2020 to May 2021 was 120.67. This remains elevated but indicates a marked fall since the peak of the second wave of the pandemic in January- February 2021. Continued actions in line with our learning from deaths action plan as well as the reduction in COVID related deaths and increasing volumes of non-elective spells underlie this observed reduction which is predicted to continue for the remainder of the year - until the peak in rates occurring in January-February 21 is no longer included in the 12 month rolling data collection period.
5. The crude number of deaths occurring per month has reduced since the peak of the second wave of the pandemic and is now similar to the number of non-COVID related deaths from previous years. In September 2021 there were 93 deaths, with 14 deaths relating to COVID. In comparison there were 66 deaths in September 2020 and 88 in September 2019. 57 (out of 93) of the deaths occurred in patients aged 80 and over, of this number 20 were aged 90 and over. This provides reassurance that the HSMR is likely to continue falling when these episodes are fully coded, uploaded and the HSMR calculated.
6. 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.

Key Actions Taken:

1. An NHSE/I action plan has been finalised to improve quality of care in wards. Key themes include improving quality of care during our admissions - through senior decision makers present far ahead of patient journey and at every chain of intervention, improved continuity and accountability of care, improved communication and improved documentation. Other areas focus on our coding, transforming our end of life and palliative care, and on continuous learning from our deaths by undertaking and sharing structured judgement reviews where indicated.

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. A third wave or any further peaks of COVID deaths 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
Aug-21	Rate per 1000 admissions of inpatient cardiac arrests	2.00	0.30			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

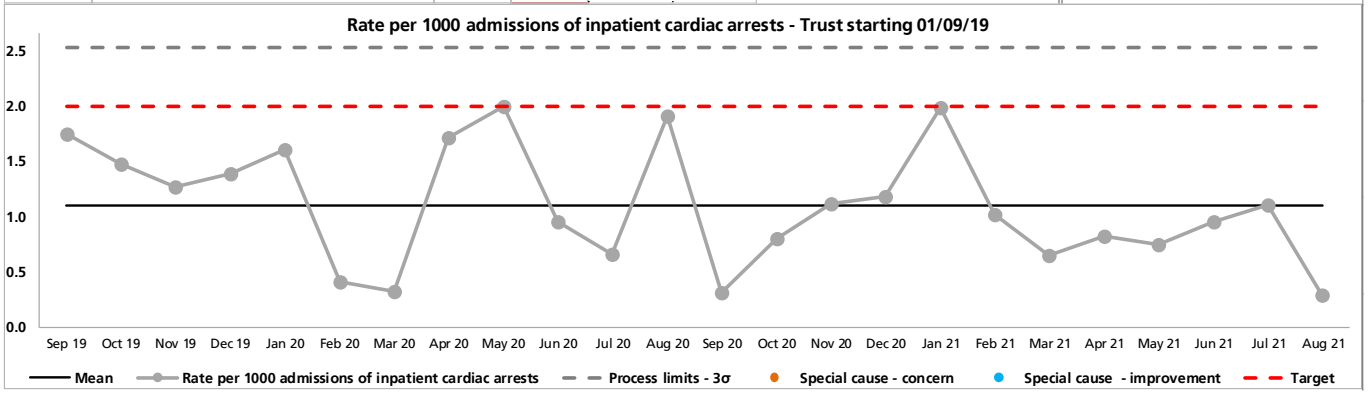


Chart 25 – Inpatient Cardiac Arrests per 1,000 admissions

Key Issues (any new issues in red):

1. Cardiac arrest rates continue to be within common cause variation below expected numbers.
2. The July figure has increased now that coding is complete, and so it is proposed that this metric will be reported 2 months in arrears from now on to ensure accuracy of published information.
3. There was 1 reportable cardiac arrest in August 2021. It is not obvious that the patient would have been suitable for an advance resuscitation decision to have been made, as this was an unexpected event.

Key Actions (new actions in green):

1. The key focus areas continue to be on identification, prevention and rescue of deteriorating patients and in making proactive decisions on treatment escalation plans in advance for patients recognised to be nearing end of life to reduce futile cardiac arrest calls in patients at end of life. This work is led by the Recognise and Respond forum and the end of life forum.
2. A further engagement campaign to build on the recent ReSPECT relaunch and education programme is planned as part of the Guidelines 2021 launch in November. ReSPECT writer training is included in Doctors' induction.
3. The Resuscitation Service has committed to provide additional ReSPECT training for all specialties at least twice in a year in order to ensure continued familiarity and to improve quality of documentation.

4. A regional working group to address the ReSPECT policy and writer training has been initiates by QEH, involving CCG, JPH 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: Currently the process remains stable and there are no ongoing risks.

Note:

The data in the graph is only ~53% complete for August (compared to75% complete for July) indicating a worsening backlog in coding entries. The clinical coding team advise caution is applied when interpreting this data as this is likely to change when the remaining 47% of data is processed. Data will be presented 2 months in arrears from next month to mitigate this.

Caring - Accountable Officer - Chief Nurse

Caring Dashboard - Trust Level

Data To	KPI Description	Target	Current Value	Variance	Assurance
Sep-21	MSA Incidents	0	6		?
Sep-21	MSA Breaches	0	15		?
Sep-21	Total Clinical & Non_Clinical Complaints	0	3	L	F
Sep-21	Complaints Rate per AE Atts, IP Adms & OP Activity	0.00%	0.01%	L	?
Sep-21	Complaints receiving a response within 30 working days %	90.0%	100.0%	H	?
Sep-21	Complaints - Reopened (% of Total)	15.0%	33.3%		?
Aug-21	Dementia Case Finding	90.0%	100.0%	H	F

Data To	KPI Description	Target	Current Value	Variance	Assurance
Sep-21	FFT % "Very Good" or "Good" (IP & DC)	95.00%	94.77%		?
Sep-21	FFT % "Very Good" or "Good" (AE)	95.00%	86.16%		?
Sep-21	FFT % "Very Good" or "Good" (OP)	95.00%	94.69%	L	?
Sep-21	FFT % "Very Good" or "Good" Mat Question 1 (Antenatal)	95.00%	100.0%		?
Sep-21	FFT % "Very Good" or "Good" Mat Question 2 (Labour)	95.00%	100.0%		?
Sep-21	FFT % "Very Good" or "Good" Mat Question 3 (Postnatal)	95.00%	96.8%		?
Sep-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
Sep-21	MSA Breaches	0	15			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

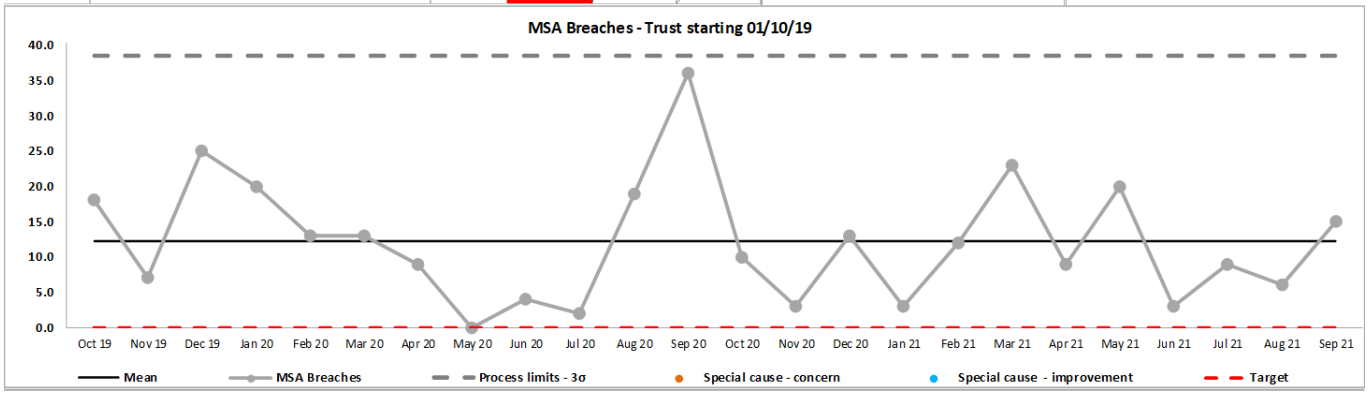


Chart 1 – MSA Breaches

Key Issues (any new issues in red):

1. There were six (6) incidents of same sex accommodation breaches affecting fifteen (15) patients during September 2021. The incident occurred in the Hyperacute Stroke Unit (HASU) on West Raynham Ward.
2. 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 with regard to their experiences whilst being cared for in a mixed sex bay and there has 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.

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
Sep-21	Total Clinical & Non_Clinical Complaints	0	3	L	F	Special cause (unexpected) variation - Improvement (L)	Variation indicates consistently (F)alling short of the target

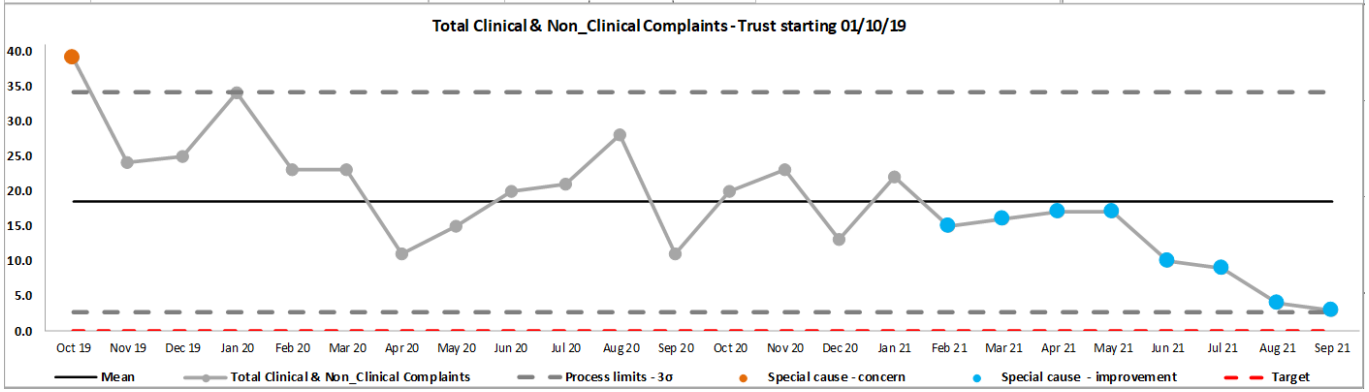


Chart 2 – Total Complaints

Issues (any new issues in red):

1. The timeliness of responding to complaints within 30 days has been achieved for 4 consecutive months.
2. There has been a continuous reduction in formal complaints since May.
3. 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
Aug-21	Dementia Case Finding	90.0%	100.0%	H	F	Special cause (unexpected) variation - Improvement (H)	Variation indicates consistently (F)alling short of the target

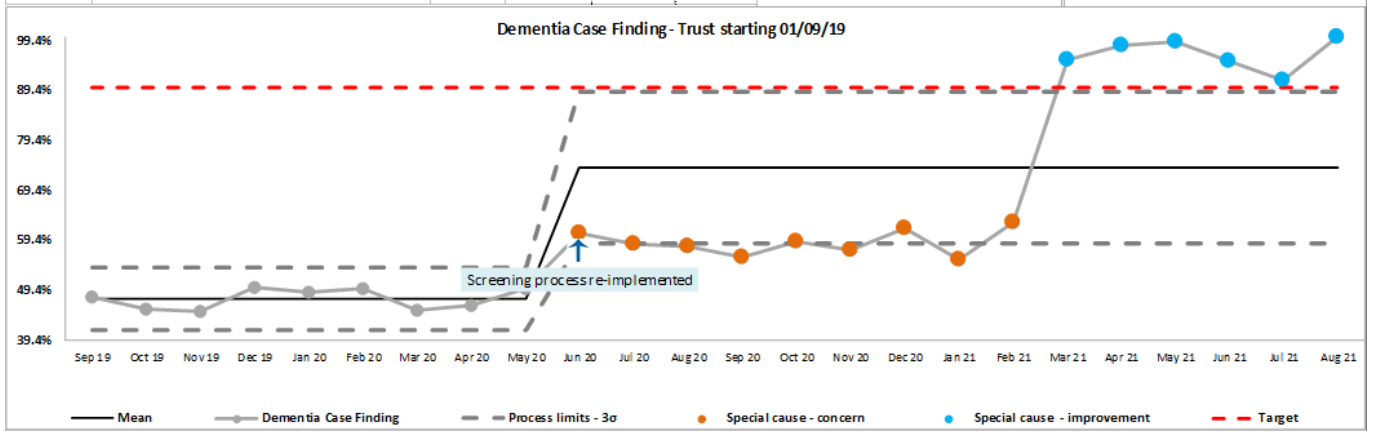


Chart 3 – Dementia Case Finding

Key Issues (any new issues in red):

1. Dementia screening in August achieved 100% for the first time, and has remained above the agreed threshold of 90% since March 2021. This improvement is attributable to the Cognitive Impairment Assessor (CIA) pilot, and this role has now been approved for substantive recruitment.

Key Actions (new actions in green):

1. Sustain current pace of compliance through ongoing dementia awareness campaigns within the Trust (monthly dementia hub education sessions (Trustwide), new digital platform for dementia care resources, maintenance of CIA role)
2. Cognitive Screening and Management QIP focuses on transition from acute to primary care and ensuring that patients identified with cognitive impairment have that information communicated to their GP. A new function on the discharge letter has been created and educational work is ongoing to ensure compliance (results will be available in one month from round one)

3. Establish scale of demand for memory clinic referrals to identify with NSFT whether existing capacity is sufficient to meet this need or whether service development may be required to establish an in-house memory service or to expand the existing service provided by NSFT.

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

Key Risks to Forecast Improvement:

1. The cognitive impairment assessors have been redeployed to health care assistant roles at times of extreme operational pressure which reduces their capacity to maintain screening compliance. These roles have now been funded within the establishment of the medical division to ring fence this function as far as possible to mitigate this risk.

Research

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	No. of patients recruited in NIHR studies	63	78			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

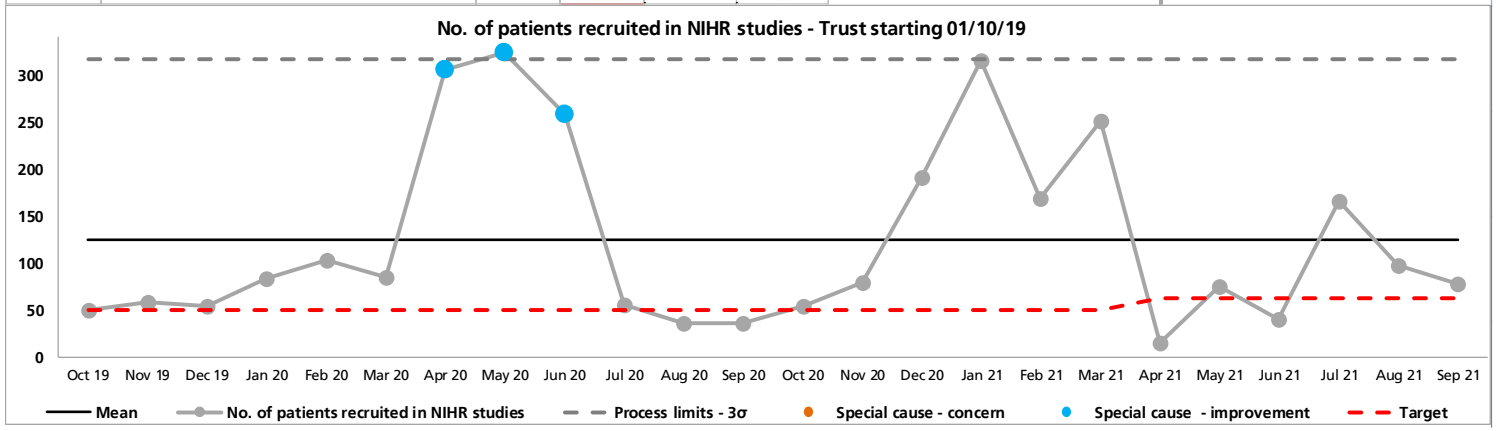


Chart 4 – Number of patients recruited in NIHR studies

78 NIHR study accruals were made in September; this remains within common cause variation and above the target of 63 participants/month. We currently have 43 active studies out of which 15 studies were recruited to in September. There are currently 9 active studies designated as priority by the NIHR and on the 'Managed Recovery' list. 5 out of those 9 studies have either met or towards meeting our site performance targets.

Key Drivers

1. Vacancies have all been filled so the research team is now fully staffed (11.92 WTE).
2. Team success: Finalists in QEH Awards: clinical team of the year and 'We Listen' categories and winners of HSJ patient safety innovation award for SAFIRA device.
3. Increased interest and participation in research by junior doctors.

Key Actions

1. Outsource Tissue Viability Nurse specialist (TVN) to recover the SWSHI 2 trial (Surgical Wounds Healing by Secondary Intention).
2. Planned team development day on 18 October 2021.

3. Active absence management, flexi-working and promoting annual leave uptake to support team resilience.

Risks

1. 1/3 of team appointed in past 3 months and still embedding.
2. No capacity available for TVN to deliver 'Managed Recovery' study- SWSHI, which is currently underperforming.

NURSING METRICS

Ward Level Indicators for the month of Sep-21

Sep-21	Indicator Description	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)	4	5	0	5	2	3	6	8	4	8	0	1	3	7	5
	Serious Incidents	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
	Drug Administration Errors	2	2	0	0	2	0	2	1	2	1	0	0	0	1	0
	All Drug Errors (inc Admin)	5	2	0	0	2	1	2	1	4	1	0	0	0	2	1
	Falls Total	2	3	0	5	0	0	3	6	2	5	0	1	3	6	5
	Pressure Ulcers - Deep Tissue Injury (DTI)	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
	Pressure Ulcers - Unstageable	0	0	0	0	0	2	0	0	0	1	0	0	0	0	0
	H/A Pressure Ulcers Grade 2	0	0	0	0	0	0	1	0	0	1	0	0	0	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	0	0	0	2	0	0	0	0	0	0	1	0	0	1	1
	MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	MSSA	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0
	E.Coli	0	0	0	0	1	0	1	2	0	0	0	1	0	0	0
	ESBL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Psuedomonas	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
	Klebsiella	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0
Patient Experience	Complaints	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Compliments	18	2	1	6	2	3	6	7	3	6	5	1	5	9	4
	Family And Friends Response Rate	19.6%	36.5%	15.5%	20.9%	13.3%	360.0%	26.2%	13.2%	1.8%	1.5%	61.3%	55.3%	23.4%	61.5%	18.6%
	Family And Friends (% Recommended)	92.9%	83.3%	100.0%	89.5%	92.5%	100.0%	88.9%	75.0%	95.5%	100.0%	100.0%	93.6%	100.0%	100.0%	89.5%
Safer Staffing	Fill Rate Registered	92.0%	91.5%	79.9%	88.3%	73.2%	91.4%	82.2%	83.9%		96.9%	88.4%	95.9%	91.7%	89.7%	87.6%
	Fill Rate Unregistered	76.1%	75.3%	81.4%	80.9%	75.8%	69.0%	77.2%	80.6%		76.0%	82.3%	70.8%	87.6%	79.7%	62.7%
	CHPPD	5.5	5.8	10.5	5.6	8.6	29.6	5.7	5.9		9.0	7.5	7.0	7.6	6.7	5.5
Staff Experience	Appraisals	78.3%	90.0%	90.5%	63.9%	82.5%	86.3%	90.7%	73.7%	86.1%	90.5%	95.5%	76.9%	87.3%	100.0%	85.1%
	Sickness	10.0%	2.9%	3.4%	5.5%	12.0%	3.2%	10.3%	15.2%	11.1%	7.4%	6.7%	14.2%	8.4%	4.0%	10.5%
	Vacancies	9.3%	6.2%	20.8%	23.9%	26.9%	-4.1%	25.1%	27.2%	1.3%	17.8%	9.9%	19.3%	3.0%	15.5%	15.4%
	Mandatory Training	76.1%	80.9%	93.2%	84.0%	89.6%	91.4%	85.4%	80.0%	91.7%	89.1%	88.4%	82.5%	86.0%	97.1%	91.1%

Ward Level Indicators for the month of Sep-21

Sep-21	Indicator Description	AMU	TSS	Mar	NICU	C Acre	CDS	MLBU	Rud	Lev	Felt	AEC	TIU	Non IP Wards/Area	Trust
Incidents & IPACS	Total Incidents (SFs, Falls, PU's & Drug Errors)	10	4	7	2	0	1	0	1	8	3	0	0	5	102
	Serious Incidents	0	0	0	0	0	0	0	0	0	0	0	0	1	2
	Drug Administration Errors	3	3	1	2	0	1	0	1	2	0	0	0	4	30
	All Drug Errors (inc Admin)	4	4	1	7	2	1	0	4	4	1	1	0	11	60
	Falls Total	5	1	6	0	0	0	0	0	6	3	0	0	0	62
	Pressure Ulcers - Deep Tissue Injury (DTI)	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Pressure Ulcers - Unstageable	0	0	0	0	0	0	0	0	0	0	0	0	0	3
	H/A Pressure Ulcers Grade 2	2	0	0	0	0	0	0	0	0	0	0	0	0	4
	H/A Pressure Ulcers Grade 3	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
	C.Diff > 2 Days	0	1	0	0	1	0	0	0	0	0	0	0	0	7
	MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	MSSA	0	1	1	0	0	0	0	0	0	0	0	0	0	4
	E.Coli	2	0	0	0	0	0	0	0	0	0	0	0	0	7
	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	2
	Klebsiella	0	0	0	0	0	0	0	0	0	1	0	0	0	3
Patient Experience	Complaints	0	0	0	0	0	0	0	0	1	0	0	0	2	3
	Compliments	1	2	9	0	3	1	0	5	0	3	0	0	32	134
	Family And Friends Response Rate	15.6%	17.8%	65.7%	350.0%	40.2%	0.0%	0.0%	12.5%	18.4%	51.9%	6.8%	13.6%		
	Family And Friends (% Recommended)	90.0%	87.5%	96.9%	85.7%	98.3%	100.0%	100.0%	100.0%	83.3%	82.5%	93.0%	100.0%		
Safer Staffing	Fill Rate Registered	79.0%	83.2%	92.6%	105.6%	73.5%	79.1%		73.3%	81.4%	79.2%				85.9%
	Fill Rate Unregistered	79.8%	81.6%	74.4%	89.3%	87.9%	73.7%		101.5%	73.9%	69.3%				77.8%
	CHPPD	8.4	6.5	5.6	23.8	5.0	24.3		10.9	5.0	6.0				7.4
Staff Experience	Appraisals	81.6%	96.0%	87.9%	86.8%	89.9%		61.3%	74.5%	80.0%	100.0%	80.0%	71.4%		77.4%
	Sickness	11.1%	7.5%	10.2%	5.0%	9.4%		6.8%	9.0%	4.3%	13.5%	5.7%	9.7%		6.9%
	Vacancies	21.2%	12.7%	0.8%	10.6%	17.9%		19.5%	9.6%			11.4%	-3.1%		7.3%
	Mandatory Training	91.9%	90.2%	95.9%	94.0%	82.1%		72.9%	87.6%	88.8%	87.4%	83.8%	92.4%		85.1%

Responsive - Accountable Officer - Chief Operating Officer

Data To	KPI Description	Target	Current Value	Variance	Assurance
Sep-21	18 Weeks RTT - Incomplete Perf	92.0%	63.8%		F
Sep-21	18 Weeks RTT - No. of Specialties failing the target of 92%	0	26		
Sep-21	18 Weeks RTT - Over 52 Wk waiters	0	976		
Sep-21	A&E 4 Hour Performance	95.0%	64.5%	L	F
Sep-21	A&E 4 Hour Performance (Majors only)	95.0%	46.4%	L	F
Sep-21	A&E 4 Hour Performance (Minors only)	100.0%	87.3%		F
Sep-21	A&E 12 Hour Trolley Waits	0	58		
Sep-21	Ambulance Handovers	100.0%	37.3%	L	F
Sep-21	Last minute non-clinical cancelled elective operations	0.8%	0.42%		?
Sep-21	Breaches of the 28 day readmission guarantee	0	4		
Sep-21	Total non-clinical cancelled elective operations	3.2%	3.50%	L	?
Sep-21	Urgent operations cancelled more than once	0	0		
Sep-21	% of beds occupied by Delayed Transfers of Care	3.5%	5.8%	H	?
Sep-21	Medically Fit For Discharge - Patients		419	H	
Sep-21	Medically Fit For Discharge - Days		2959		
Sep-21	No. of beds occ by inpatients >=21 days - (Mthly average over rolling 3 mths)	46	63		?

Data To	KPI Description	Target	Current Value	Variance	Assurance
Aug-21	Cancer Wait Times - Two Week Wait Performance	93.0%	93.2%	L	P
Aug-21	Cancer Wait Times - 31 Day Diag to Treatment Performance	96.0%	98.7%		?
Aug-21	Cancer Wait Times - 62 Day Ref to Treatmemt Performance	85.0%	58.8%		?
Aug-21	Cancer Wait Times - 104 Day waiters	0	4.0		
Aug-21	Cancer Wait Times - Two Week Wait (Breast Symptomatic) Performance	93.0%	96.8%		?
Aug-21	Cancer Wait Times - 31 Day Subsequent Treatment - (Surgery) Performance	94.0%	100.0%		?
Aug-21	Cancer Wait Times - 31 Day Subsequent Treatment - (Drug) Performance	98.0%	100.0%		P
Aug-21	Cancer Wait Times - 62 Day Screening Performance	90.0%	100.0%		?
Aug-21	Cancer Wait Times - Consultant Upgrade (62 day)	90.0%	33.3%		?
Aug-21	Cancer Wait Times - 28 Day FDS - Two week wait	75.0%	61.3%		?
Sep-21	Diagnostic Wait Times - % of over 6 Week Waiters	1.0%	60.7%	H	F
Jul-21	Stroke - 90% of time on a Stroke Unit	90.0%	52.3%		F
Jul-21	Stroke - Direct to Stroke Unit within 4 hours	90.0%	40.0%	L	F
Jul-21	Stroke - Patient scanned within 1 hour of clock start	48.0%	33.8%		?
Jul-21	Stroke - Patient scanned within 12 hours of clock start	95.0%	90.8%		?
Click here to view other National Stroke (SSNAP Domain) Results					
Aug-21	Trust - Seen <24 hrs (1st contact to investigations complete)	60.0%	47.1%		?

Emergency Care

Emergency access within 4 hours

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	A&E 4 Hour Performance	95.0%	64.5%	L	F	Special cause (unexpected) variation - Concern (L)	Variation indicates consistently (F)alling short of the target

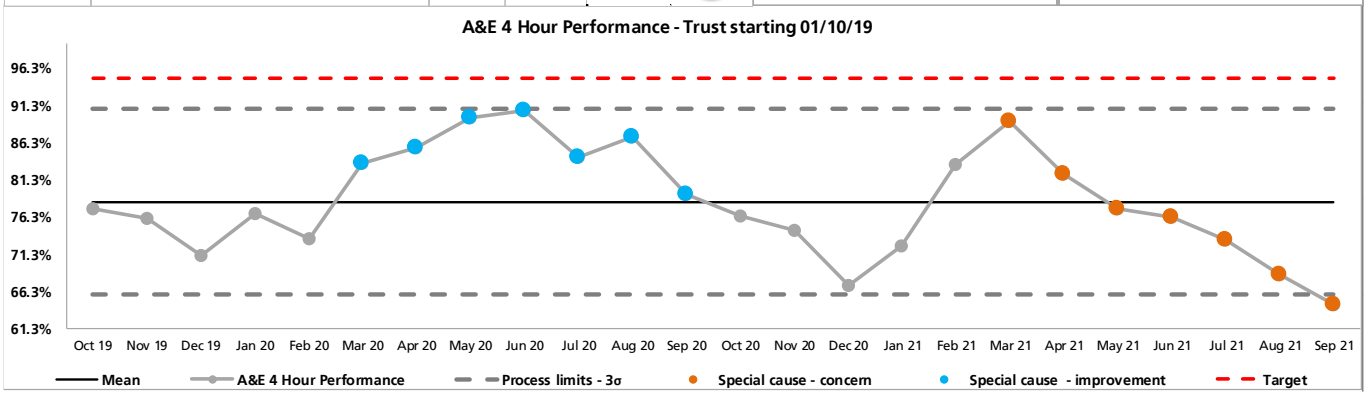


Chart 30 – A&E 4 hour performance

During September 2021, 6,488 patients attended the Emergency Department (ED), of these 2,301 patients were in the department over four (4) hours before admission, discharge, or transfer. Performance was 64.53% against a standard of 95% and a trajectory of 81.29%. Admitted performance was 30.53% and non-admitted was 83.90%. 1,634 patients that breached were admitted to an inpatient bed. Minor performance was 87.34%; 363 minor patients breached: an improvement from the 560 minor breaches in August.

There were 58 patients that waited in the Emergency Department over 12 hours from decision to admit to admission in September 2021.

Ambulance Handovers

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	Ambulance Handovers	100.0%	37.3%	L	F	Special cause (unexpected) variation - Concern (L)	Variation indicates consistently (F)alling short of the target

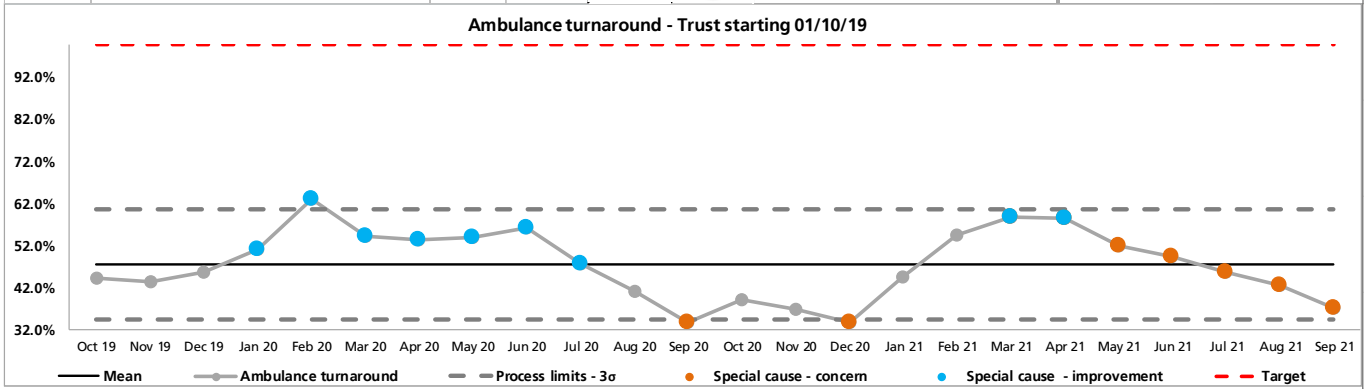


Chart 31 – Ambulance Handovers

During September 2021, there were 1,711 conveyances by EEAST to the Emergency Department. Of those, 37.76% of all handovers took place within ≤15 minutes against the trajectory of 51.52%. The average handover time was 42 minutes.

The Trust ranked 5th out of 17 hospitals within the region for the percentage of handovers completed within 15 minutes. 19.16% of handovers exceeded 60 minutes.

Key Issues (any new issues in red):

1. Poor compliance with the Trust Internal Professional Standards resulting in delays for specialty reviews and decision making.
2. Limited capacity with Red and Amber ED combined into one footprint.
3. Sustained increase (circa 23%) in ED demand compared to 2019/20.
4. Minor performance has been impacted by inaccuracies in Triage codes.

Key Actions (new actions in green):

1. Urgent and Emergency Care Improvement Programme in place.
2. Development of long-term expansion plans for the Emergency Department is underway to address physical capacity issues.
3. Implementation of a revised staffing model for walk in patients presenting with minor illnesses/injury during peak hours.
4. Implementation of the SAFER discharge principles across all wards to support more timely discharge.

5. Review of internal escalation processes and triggers in managing all ED delays.

Recovery Forecast:

1. The trajectory for the 4-hour standard is to achieve performance of 85% by October 2021 and 90% by March 2022.
2. The trajectory for ambulance handovers completed within 15 minutes is to achieve performance of 70% by March 2022.

Key Risks to Forecast Improvement:

1. Continued increases in Emergency Department attendances above expected activity levels and forecast increase in seasonal demand.
2. The capacity of health and social care partners to facilitate timely discharges for patients on discharge to assess pathways 1, 2 and 3.
3. The completion of the ward bed reconfiguration and decant process that could negatively impact flow.

Elective Care

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	18 Weeks RTT - Incomplete Perf	92.0%	63.8%		F	Common Cause (expected) variation	Variation indicates consistently (F)alling short of the target

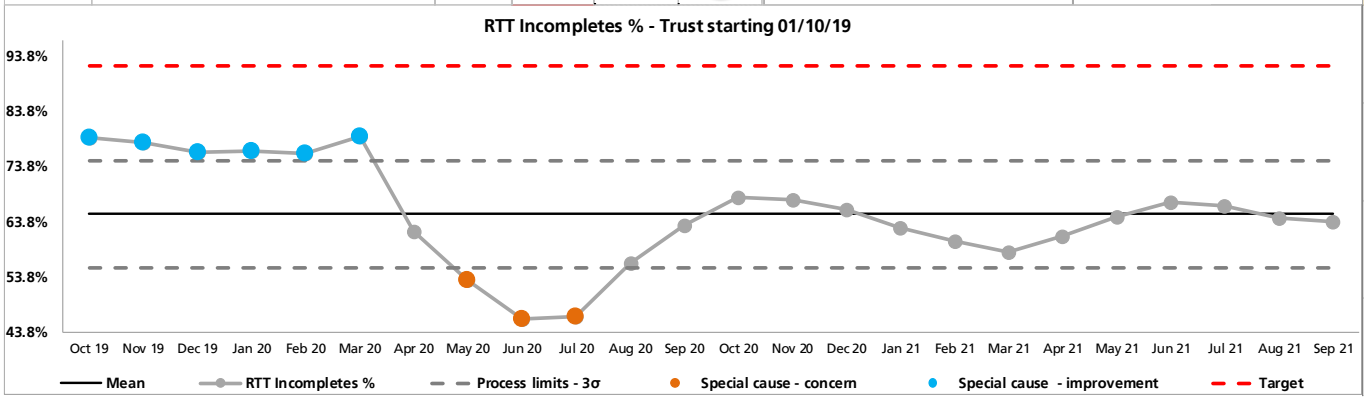


Chart 32 - RTT Incomplete Pathways

18 weeks referral to treatment

At the end of September 2021, there were a total of 17,711 patients on the waiting list, of which 6,420 had waited for over 18 weeks from referral, giving performance of 63.8%. The top 3 specialties with the greatest number of patients waiting over 18 weeks were Orthopaedics (1,027), Ophthalmology (790) and Dermatology (786).

Key Issues (new issues in red):

1. Prioritisation of urgent P2 cases in line with national guidance.
2. Sustained increases in Cancer referrals across all tumour sites.
3. Staffing challenges in Dermatology, resulting in increased waiting times for urgent and routine referrals.

Key Actions (new actions in green):

1. Prioritisation of P2 patients and long waiters in the allocation of treatment.
2. Review of booking processes to identify areas for improvement.
3. Provision of weekend WLI sessions for additional outpatient and theatre capacity.
4. Implementation of Dermatology WLI 'super' clinics, weekend, and one-stop clinics.

Recovery Forecast:

1. The waiting list has remained static, with the number of patients waiting longer than 52-week breaches. Recovery back to 92% is likely in some specialities within 2021/22; however, the trusts Referral to Treatment (RTT) Incomplete Pathway aggregate performance is not expected to recover to 92% during the 2021/22 financial year.

Key Risks to Forecast Improvement:

1. Unforeseen disruption to theatre capacity due to planned RAAC works due to commence in January 2022.
2. A further wave of COVID-19 necessitating the return of Day Surgery to a Red ED.
3. The potential for unknown demand in the community for both suspected cancer and routine referrals.
4. Increase in number of P2 Cancer cases extends timeframe for clearance of longer waits.

52-week breaches

At the end of September 2021 there were 987 patients waiting longer than 52 weeks for treatment, a reduction of 76 from August. The majority of these were in Orthopaedics (305), Gynaecology (225) and General Surgery (191). The longest waiting patient is a Gynaecology patient (P3) at 119 weeks; this patient who has a TCI date of 10th November.

Key Issues (new issues in red):

1. High numbers of joint cases for Gynaecology and Colorectal with limited theatre capacity for the single Colorectal surgeon who undertakes these.
2. Prioritisation of urgent P2 cases in line with national guidance; however, the sustained increased in cancer referrals has subsequently increased the number of P2 patients requiring priority of treatment.
3. Increase in the number of P2 patients following a review of clinical prioritisation.

Actions (new actions in green):

1. Flexible allocation of surgeons to theatre lists to ensure specialities with greater need are prioritised.
2. Review current criteria and surgeon availability for joint Gynaecology cases to support joint lists.
3. Review theatre workforce and develop business case for substantive staffing to run both Sandringham theatres.

Recovery Forecast:

The numbers 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. Disruption to theatre capacity due to planned RAAC works due to commence in January 2022.
2. Theatre capacity to meet waiting list backlog.
3. Effective utilisation of all available theatre capacity.
4. Increase in number of P2 Cancer cases extends timeframe for clearance of longer, lower clinical priority waits.

Breaches of the 28-day readmission guarantee

There were four breaches of the 28-day readmission guarantee in September 2021; three due to a single consultant led service where the consultant was unable to operate for five weeks due to injury and one breach due to consultant sickness on the day of surgery.

Diagnostic Waiting Times

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	Diagnostic Wait Times - % of over 6 Week Waiters	1.0%	60.7%	H	F	Special cause (unexpected) variation - Concern (H)	Variation indicates consistently (F)alling short of the target

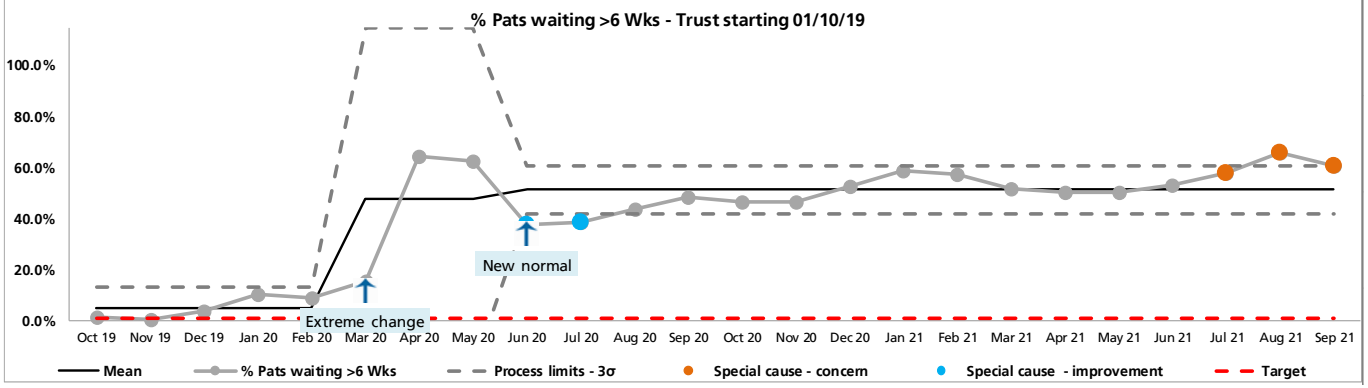


Chart 33 – Diagnostic Waiting Times

During August 2021 the Trust implemented a new Radiology Information System (RIS), and performance reporting relating to Radiology Diagnostics is suspended temporarily.

In September 2021, performance was 39.3% against the standard of 1% (Radiology figures are not included in this total).
Improvements in waiting list numbers >6 weeks reported in Urology, Gynaecology, 'other scopes and Echocardiograms which has seen a reduction of patients waiting over 6 weeks.

Key Issues (any new issues in red):

1. The continuing inability to extract data from the RIS system is unexpected this month. Due to be resolved by end October 2021.
2. Insourcing of MRIs is yet to commence, and the contract team are pursuing.

Key Actions (new actions in green):

1. MRI outsourcing contract signed off for 400 patients, to begin imminently.
2. Scoping for MRI and CT staffed mobile options is currently underway.
3. Trust Board approval for 1 x MRI scanner replacement.

4. 0.2wte additional substantive consultant Neurophysiologist activity from 16th September and a locum consultant Neurophysiologist (0.6wte) will be holding clinics from beginning October 2021.

Recovery Forecast:

1. Services are planned against a recovery trajectory within 2021/22.

Key Risks to Forecast Improvement:

1. Delays in confirmation of funding (previously identified as Early Adopter Funding, now identified as a revenue bid) to support diagnostic recovery in MRI, CT, Echocardiogram and Endoscopy.
2. Backlog of radiology reporting and data quality problems with the new RIS system.
3. Continued mechanical failure of the existing MRI, whilst replacement programme is underway.
4. High levels of demand for patients referred on a suspected cancer pathway.

Cancer waiting times

2 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
Aug-21	Cancer Wait Times - Two Week Wait Performance	93.0%	93.2%	L	P	Special cause (unexpected) variation - Concern (L)	Variation indicates consistently (P)assing the target

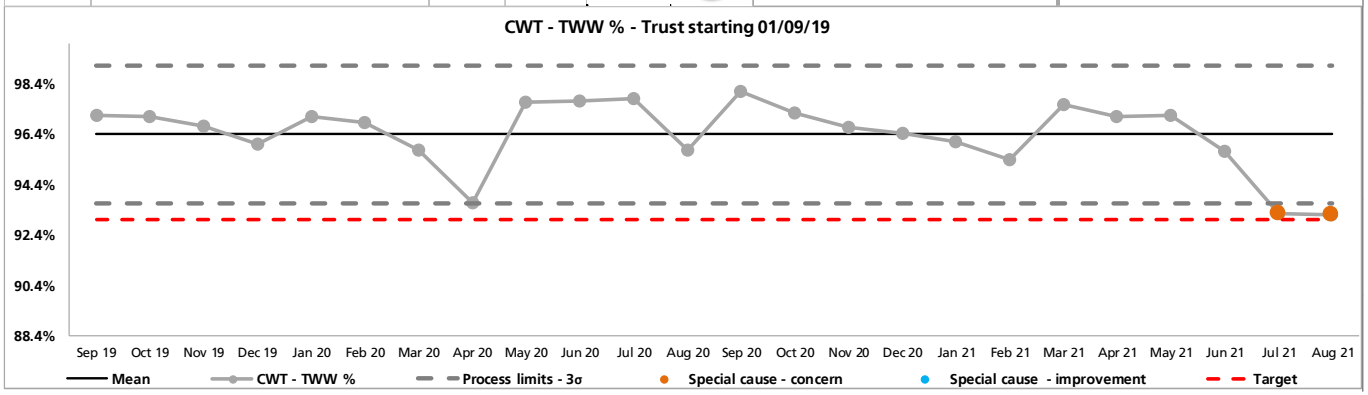


Chart 34 – Cancer Wait Times: 2 Week Wait Performance

Performance in August 2021 was **93.2%** against the standard of **93%**. Capacity constraints are likely to impact on 2ww turnaround times over the next two months.

Key Issues (any new issues in red):

1. Dermatology consultant vacancy and annual leave taken within remaining team, with high levels of referrals.
2. There have been an increased number of Upper GI 2ww referral forms which are not completed fully, leading to delays whilst confirmation of details is sought.

Key Actions (new actions in green):

1. Dermatology consultant to commence in post at the beginning of October 21.
2. Additional 2 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.
4. Collaboration with primary care colleagues to ensure completeness of referral forms.

Recovery Forecast:

1. 2 week wait performance is forecast to recover in November 2021.

Key Risks to Forecast Improvement:

1. A further increase in the number of 2 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
Aug-21	Cancer Wait Times - 62 Day Ref to Treatmemt Performance	85.0%	58.8%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

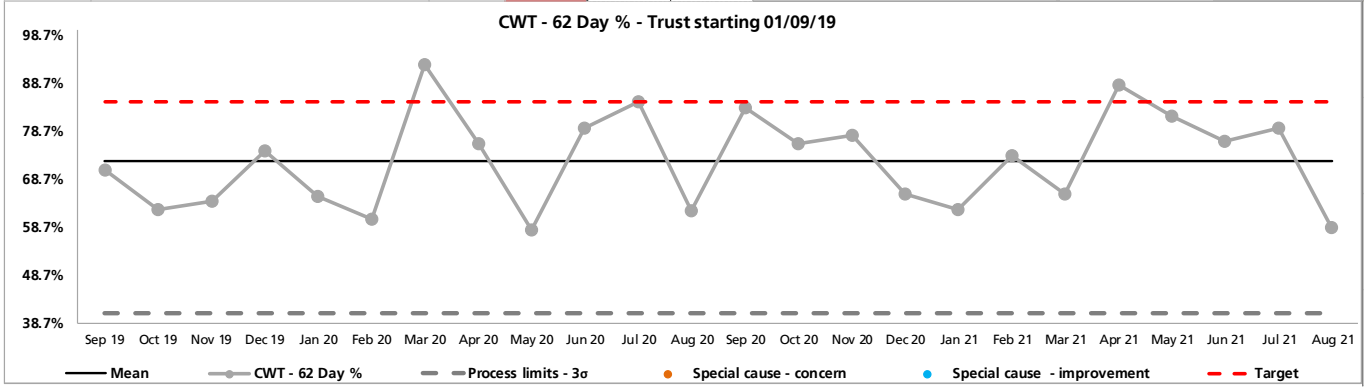


Chart 35 – Cancer Wait Time – 62 Day RTT performance

Performance in August 2021 was **58.8%** against the standard of **85%** and a trajectory of **86.2%**.

There were 51 treatments, of which **21** breached the 62-day standard, (4 Haematology, 1 Head & Neck, 9 Colorectal, 1 Lung, 2 Skin, 3 Upper GI, 1 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 are continuing to cause delays in patient pathways.
3. There are significant capacity issues within Lower GI and Dermatology, as a result of increased referral numbers and staffing shortfalls.

Key Actions (new actions in green):

1. Ongoing work to improve diagnostic pathways.
2. New Consultant commences in Dermatology early October 21, with weekend, evening and one stop clinics planned.
3. Gynaecology and Colorectal workshops to review and streamline cancer pathways.

Patients waiting for 104+ days
The large increase in patients coming into the system in Q1 and Q2 has impacted on the number of patients waiting on a Cancer pathway over 104 days, as clinical time is diluted by the numbers of patients needed to be seen.

At the end of August 2021, 24 patients were on the pathway waiting over 104 days. The Trust has forecast this number to peak in September and reduce from October.

Of the 24 patients waiting at the end of August 2021, 13 were colorectal, 4 were gynaecology, 2 were Haematology, 2 were Head & Neck, 1 was Lung, 1 was Skin and 1 was Upper GI.

17 of these patients are now treated, 1 is booked for treatment, 1 is awaiting a treatment date, 2 are awaiting a diagnostic test and 3 patients are awaiting histology results.

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

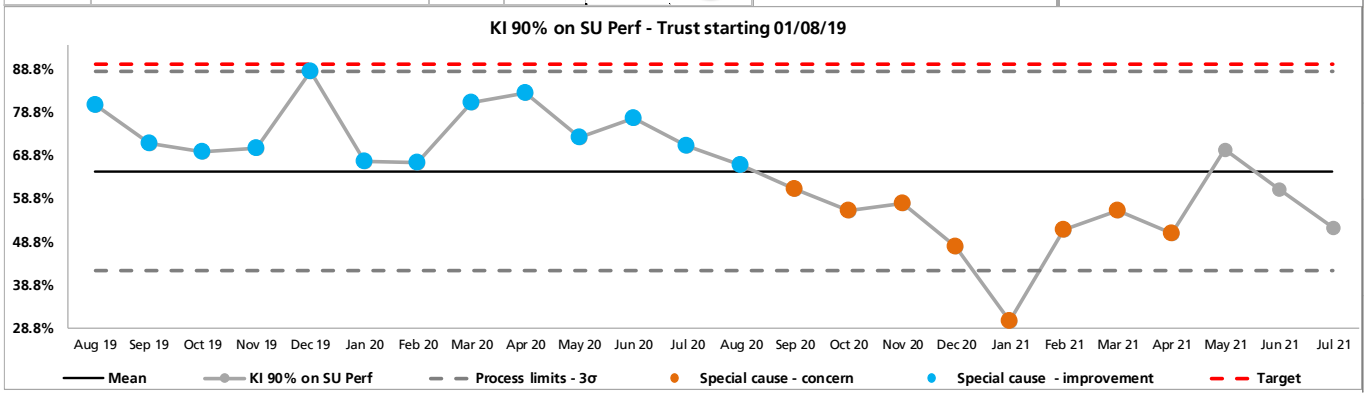


Chart 36 – Stroke: 90% of time on a stroke unit

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.

Key Actions:

1. The Stroke SOP has been ratified by Divisional Board and OMEG; this has clarified the pathway with key stakeholders.
2. 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

Statement of comprehensive income: Month 6 – 2021/22

	In Month				Year to Date			
	Plan £'000s	Actual £'000s	Fav / (Adv) £'000s	%	Plan £'000s	Actual £'000s	Fav / (Adv) £'000s	%
Clinical Income	18,886	21,293	2,407	13%	113,316	115,790	2,474	2%
Other Income	1,347	1,215	(132)	(10%)	8,082	7,875	(207)	(3%)
COVID-19 Additional Income	1,282	1,386	104	8%	7,692	8,584	892	12%
Total Income	**21,515**	**23,894**	**2,379**	**11%**	**129,090**	**132,249**	**3,159**	**2%**
Pay Costs - Substantive	(12,174)	(14,679)	(2,505)	(21%)	(73,046)	(77,189)	(4,143)	(6%)
Pay Costs - Bank	(1,130)	(1,246)	(116)	(10%)	(6,776)	(6,133)	643	9%
Pay Costs - Agency	(1,322)	(1,020)	302	23%	(7,937)	(5,406)	2,531	32%
Pay Costs - Additional COVID-19	(549)	(390)	159	29%	(4,036)	(4,003)	33	1%
Pay Costs - Vaccination Centres	0	(78)	(78)		0	(819)	(819)	
Total Pay	(15,175)	(17,413)	(2,238)	(15%)	(91,795)	(93,550)	(1,755)	(2%)
Non Pay - Additional COVID-19	(75)	(10)	65	87%	(600)	(248)	352	59%
Non Pay	(5,130)	(5,412)	(282)	(5%)	(31,210)	(33,701)	(2,491)	(8%)
Total Operating Costs	**(20,380)**	**(22,835)**	**(2,455)**	**(12%)**	**(123,605)**	**(127,499)**	**(3,894)**	**(3%)**
EBITDA	**1,135**	**1,059**	**(76)**	**(7%)**	**5,485**	**4,750**	**(735)**	**(13%)**
Non-Operating Costs	(942)	(839)	103	11%	(5,657)	(4,870)	787	14%
Adjust Donated Assets	28	8	(20)	(71%)	172	172	0	0%
TOTAL (Deficit) / Surplus	**221**	**228**	**7**	**3%**	**0**	**52**	**52**	

I&E

Ratios				
Agency : Total Pay	9.0%	6.0%	9.0%	6.1%
EBITDA : Income	5.3%	4.4%	4.2%	3.6%
Net Deficit : Income	1.0%	1.0%	(0.0%)	0.0%

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

During M6 September the 2021/22 backdated pay award of 3% was applied. Adjustments applied to income and expenditure of £2.1m, in accordance with national guidance.

Key points of note in month / Material variances:

- Leverington and Feltwell wards remain open to provide additional bed capacity. This is creating a c. £0.5m to £0.6m cost pressure per month. These wards will be included within the H2 financial plan.
- Covid-19 vaccination costs incurred and reimbursed in month are £0.1m.
- After taking into account the £2.1m back pay, total pay expenditure is negative to plan by £0.1m.
- Agency expenditure is favourable to plan by £0.3m
- Non-pay is adverse to plan by £0.3m but includes the release of provisions totalling £0.5m.
- The CIP/ waste reduction programme has achieved £0.3m of efficiencies in month, which is still favourable to plan YTD.
- In month capital expenditure incurred is £1.1m. YTD this is at £3.3m.

Statement of Financial Position (SOFP) Update

	31-Mar-21 £m	31-Jul-21 £m	31-Aug-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	14	8	(6)	(5)
Cash	27	22	26	4	(1)
Current liabilities					
Trade & Other Payables	(19)	(16)	(15)	1	4
Accruals	(18)	(12)	(12)	-	6
PDC dividend	-	(1)	(1)	-	(1)
Other current liabilities	(2)	(2)	(2)	-	-
Non current liabilities	(1)	(1)	(1)	-	-
Borrowings	-	-	-	-	-
Total assets employed	**103**	**106**	**106**	**(1)**	**2**
Tax payers' equity					
Public Dividend Capital	198	198	198	-	-
Revaluation Reserve	9	9	9	-	-
Income & Expenditure Reserve	(104)	(101)	(101)	-	3
Tax payers' equity	**103**	**106**	**106**	**-**	**3**

Month-on-Month Key movements / variances

- There has been a significant reduction in debtors due to increased collections from both NHS and Non NHS.
- Cash balances have increased by £4m as a result of increased collections from debtors.

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

Data To	KPI Description	Target	Current Value	Variance	Assurance
Sep-21	Appraisal Rate	90.0%	77.4%		
Sep-21	Appraisal Rate (Med Staff exc Jnr Drs)	90.0%	87.0%		
Sep-21	Sickness Absence Rate	4.50%	6.89%		
Sep-21	Long Term Sick	2.7%	3.9%		
Sep-21	Short Term Sick	1.8%	3.0%		
Sep-21	Mandatory Training Rate	80.0%	85.1%		
Sep-21	Turnover Rate	10.0%	11.0%		

Appraisal Rate

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	Appraisal Rate	90.0%	77.4%		F	Common Cause (expected) variation	Variation indicates consistently (F)alling short of the target

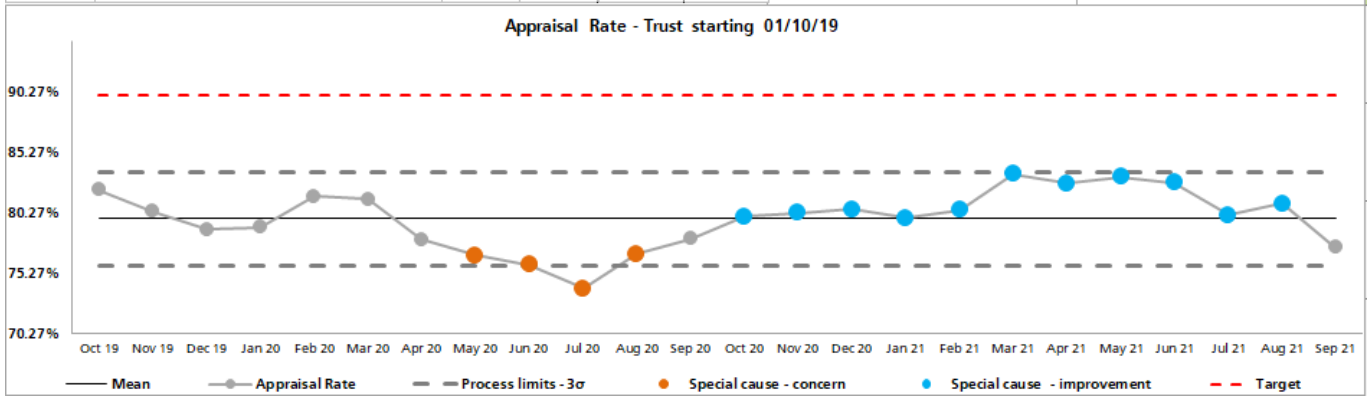


Chart 37 – Appraisal Rate

- Challenged by Full Capacity Protocols
- Continued focus through Divisional and Directorate performance Reviews

Sickness Absence rate

Data To	KPI Description	Target	Current Value	Variance	Assurance
Sep-21	Sickness Absence Rate	4.50%	6.89%	L	F

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

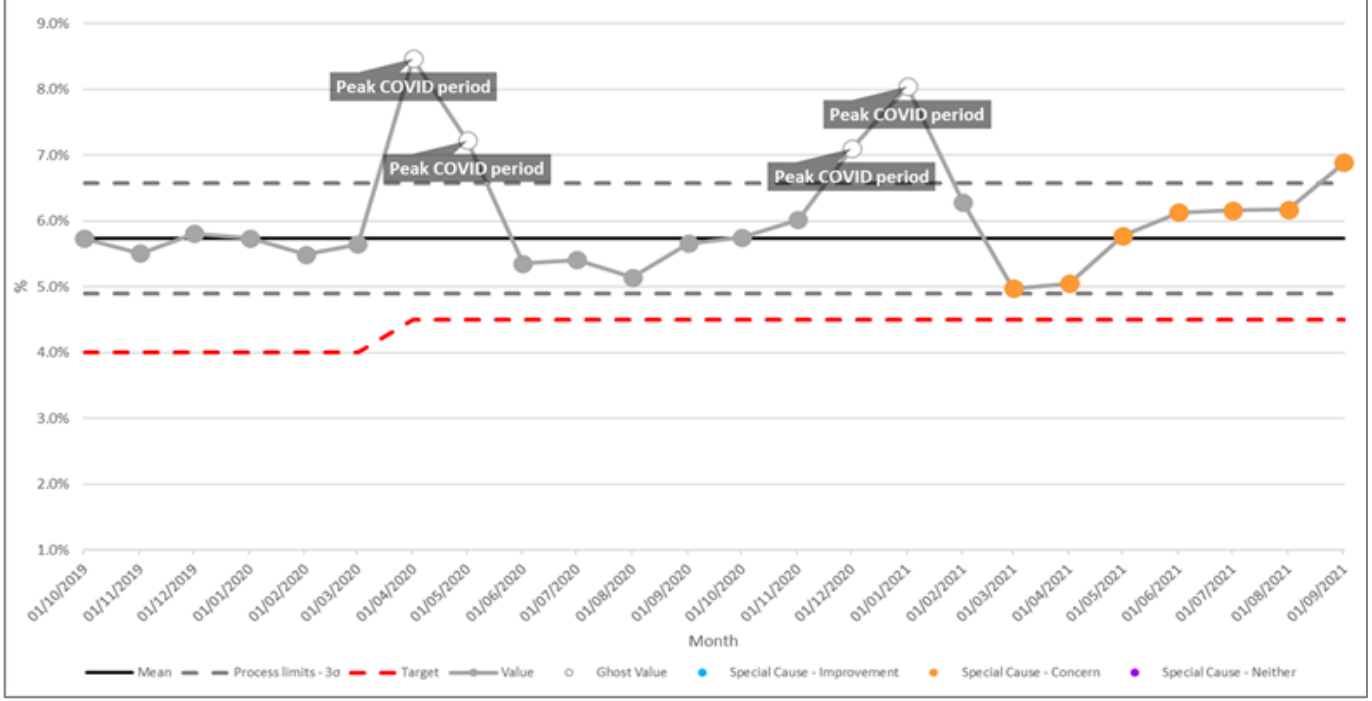


Chart 38 – Sickness Absence Rate

Benchmarking sickness absence in Norfolk Acute trusts:

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

Key Themes emerging from Attendance Improvement workshops:

1. Prevention is better than cure:
    a. Stop people becoming unwell at work and if they do, make sure it stays as a short term not a long term sickness episode (the longer people are off the harder it is to return).
    b. Increase health education and wellbeing through staff informed/led interventions – what do staff need, not what do we think they need to stay well at work.
    c. Culture: tackle team/department issues head on before individuals withdraw from the situation through sickness absence.
    d. Active annual leave management to support wellbeing.
2. Introduce Health Passports:
    a. Designed in such a way as to have great facilitated team or 1:1 conversations about staying well at work.
    b. Used to drive active health management and monitoring.
    c. Build into return to work discussions for ongoing maintenance of wellbeing after sickness episodes.
    d. Use as a means to recognise long-term conditions and enable discussions regarding job role accommodation to better manage symptoms and stay well at work.
3. Policy Change:
    a. Put People Before Process.
    b. To promote and advocate for wellness.
    c. Manage conditions not frequency triggers.
    d. Prevent gaming of processes through effective people:people interactions.
    e. Flexibility of options to facilitate staying in work.

Labour Turnover

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	Turnover Rate	10.0%	11.0%	H	?	Special cause (unexpected) variation - Concern (H)	Variation indicates inconsistently passing and falling short of the target

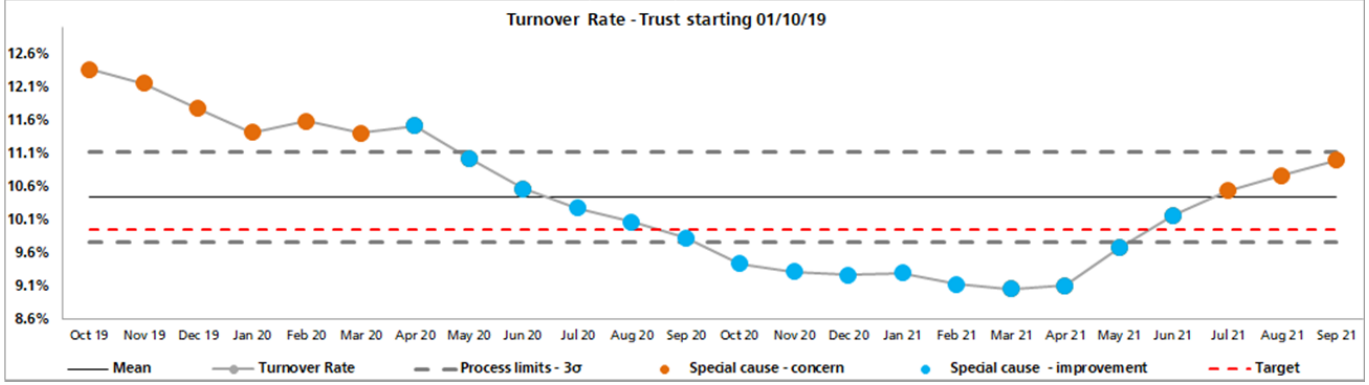


Chart 39 – Turnover Rate

- Between July-Sept there were 111 leavers, 42 (38%) left for other NHS employment and 31 (28%) unknown cause.
- Further analysis has confirmed this relates to substantive staff positions only.
- Since survey monkey exit survey created 7 years ago, 263 responses have been received indicating a new process is required.
- Benchmarking: JPUH currently at 9.6% and NNUH currently at 10.6%.