The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Meeting:	Board of Directors (in Public)		
Meeting Date:	1 February 2022	**Agenda item:**	14
Report Title:	Integrated Performance Report (IPR) – December 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.
Summary of Key issues:	A summary of key issues highlighted in the IPR this month are detailed below: **Incidents** The Trust declared two Serious Incidents in December 2021. **Falls** A total of 81 in-patients falls incidents reported in December 2021, 78 reported in November. **Pressure Ulcers** There were five hospital acquired pressure ulcers in November (x4 Cat 2, x1 Unstageable) and seven in December (x1 DTI, x5 Cat 2, x1 Unstageable). **C.Diff** - One case of C.Diff was identified in December 2021. (One HOHA). **E.coli** - One case of hospital onset E. coli was reported in December 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 were no still births or neonatal deaths in the month of December. **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. **Mixed Sex Accommodation** There have been **four** incidents of same sex accommodation breaches affecting **twelve** patients during December 2021. **Complaints** The timeliness of responding to complaints within 30 days has been achieved for seven consecutive months.

	Dementia Case Finding The improved screening process has been embedded in the services of Integrated Care of Older People (ICOP). Dementia Screening remains above the agreed threshold of 90% for the ninth month. **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 December (M9) 2021, the Trust's in month financial position is showing a £92k surplus and a year-to-date surplus £179k. **Well Led (People)** Overall appraisal rates have fallen slightly month on month from 72.9% to 72.2% amid ongoing Full Capacity Protocols and Omicron work pattern adjustments. Sickness absence is holding steady with a slight increase from 7.06% to 7.33% Significant improvement in Women & Children from 8% in October to 6.72% in December. Concerns remain in Facilities Management at 14.16%. New daily % sickness reporting available for the Incident Control Team to monitor absence levels through this Covid wave. Mandatory Training is at 79% against the Trust 80% target amid ongoing training cancellations due to managing the Omicron wave. Labour Turnover is at 12.4% for the rolling 12 months. In December there were 52 leavers. Of the 12-month leavers data: • 20% is due to members of staff reaching the end of their fixed term contracts or training programmes. • 18% is due to relocation within the UK or abroad. • 12% is due to retirement. • 4.5% is as a result of an HR process. Key workforce appointment to support medical job planning will see this programme of work getting back on track. Mandatory Vaccinations: • 258 QEH staff are currently recorded as unvaccinated (6.5%). • Compared to c 800 staff at James Paget (27%). • Compared to c2500 staff at NNUH (28%).

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

December 2021 Data

A note on SPC Charts

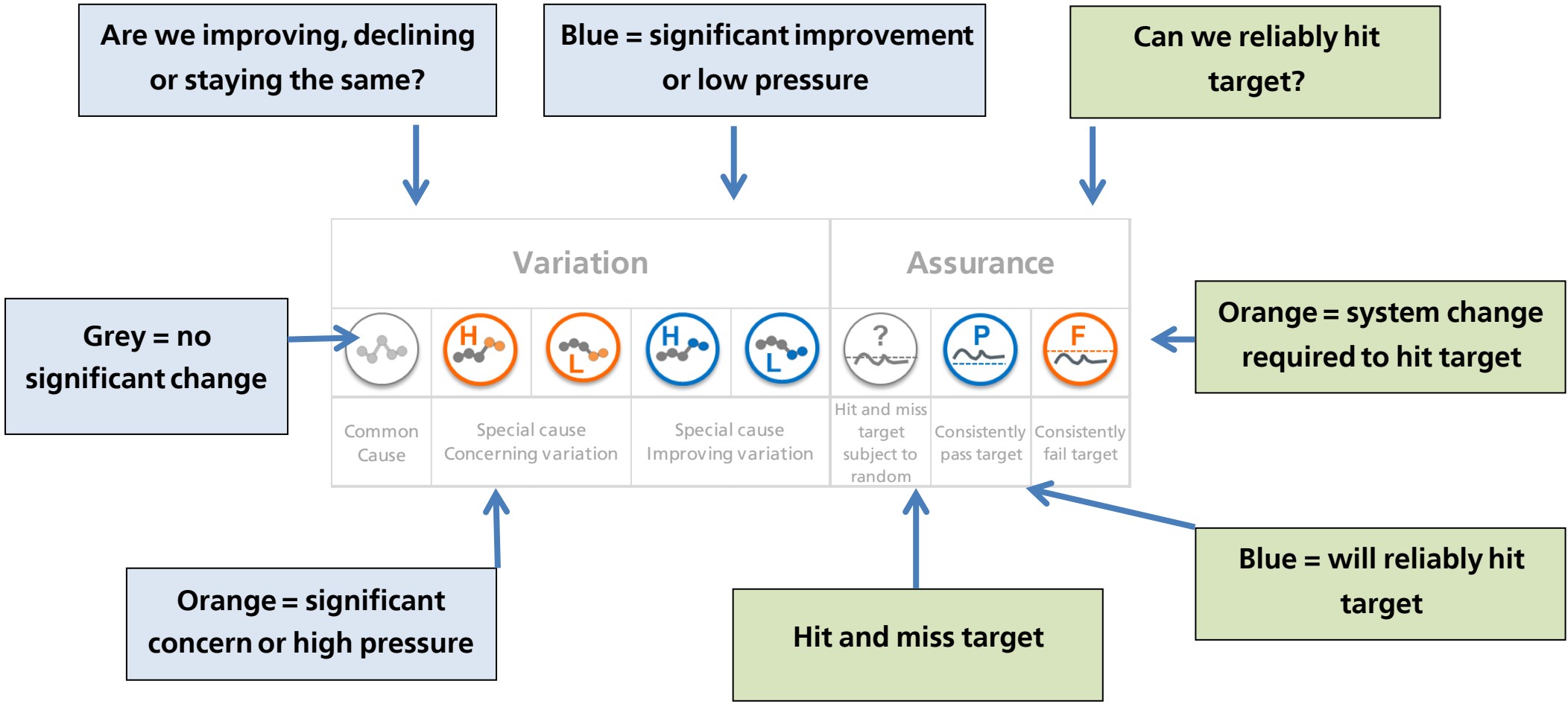
The report that follows uses the key below. A recap of using these descriptions is also included below

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



Metric 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
December 2021	A new element has been included within the Safe domain relating to a thematic review of patient safety incidents by 29 November 2021 and 2 January 2022.	Safe

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

Safe Dashboard

Data To	KPI Description	Limit	Current Value	Variance	Assurance
Dec-21	Serious Incidents (DECLARED IN MONTH)	0	2		
Dec-21	Falls (with Harm) Rate per 1000 beddays	0.98	0.22		P
Dec-21	PUs Rate per 1000 beddays	0.41	0.35		?

Data To	KPI Description	Target	Current Value	Variance	Assurance
Nov-21	Overall Fill Rate %	80.0%	85.9%	L	P
Nov-21	CHPPD	8.00	7.15	L	?
Dec-21	Cleanliness - Very High Risk	95.0%	96.6%		P
Dec-21	Cleanliness - High Risk	95.0%	96.1%		?
Dec-21	Cleanliness - Significant Risk	95.0%	94.5%		?
Dec-21	Cleanliness - Low Risk	95.0%	93.3%		
Dec-21	Cleanliness - No. of audits complete	37.00	50		?

Data To	KPI Description	Limit	Current Value	Variance	Assurance
Dec-21	CDiff (Hosp Acquired) Rate per 100k beddays	30.10	35.42	H	?
Dec-21	CDiff (Hosp Acquired) Actual	4	1		
Dec-21	MRSA (Hosp Acquired) Actual	0	0		
Dec-21	E Coli (Hosp Acquired) Rate per 100k beddays	16.40	21.75	H	?
Dec-21	E Coli (Hosp Acquired) Actual	2	1		
Dec-21	MSSA (Hosp Acquired) Actual		0		
Dec-21	MSSA (Hosp Acquired) Rate per 100k beddays		13.67	H	

Data To	KPI Description	Target	Current Value	Variance	Assurance
Nov-21	VTE Assessment Completeness	97.2%	98.1%		?
Dec-21	Patient Safety Alerts not completed by deadline	0	0		

Serious Incidents

The Trust declared **two** Serious Incidents in December 2021:

- Failure to identify a pregnant woman had previously undergone a procedure on her cervix. As a result, the woman was not offe red appropriate screening or intervention and she suffered a miscarriage.
- Failure to recognise and escalate a patient whose condition deteriorated following transfer from Critical Care. The patient s adly died.

Trust-wide Serious Incident Investigation Status October 2021 – December 2021

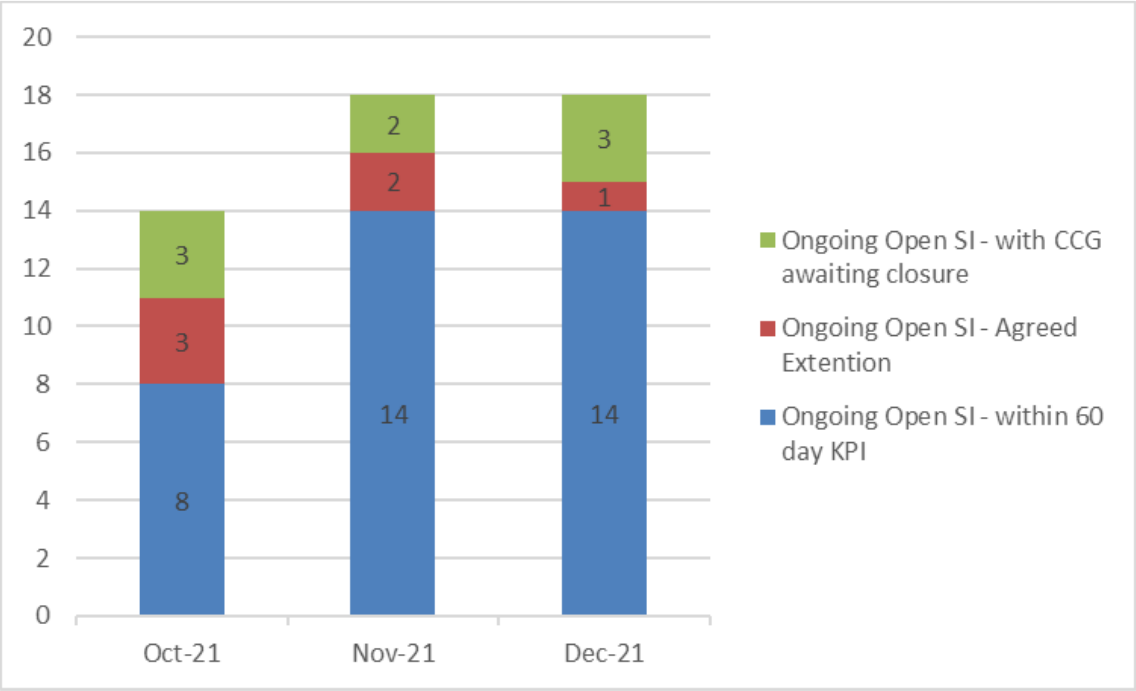
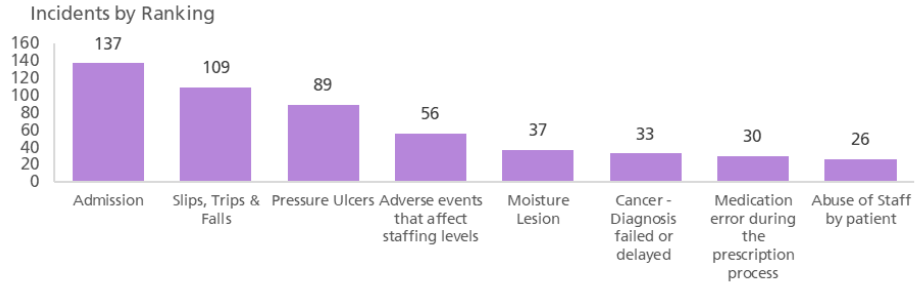


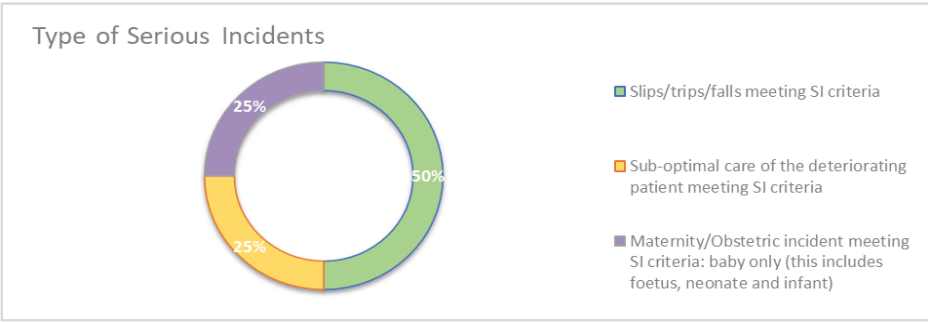
Chart 1 – Trustwide Serious Incident investigation status

Thematic review of patient safety incidents (29/11/21 – 02/01/22)

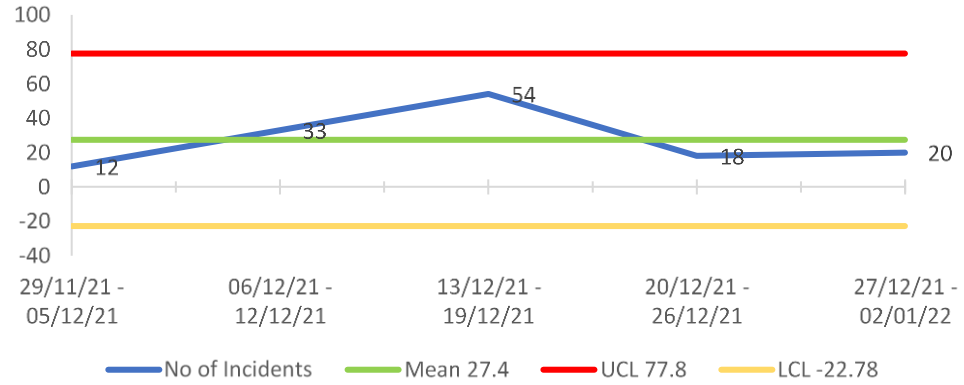


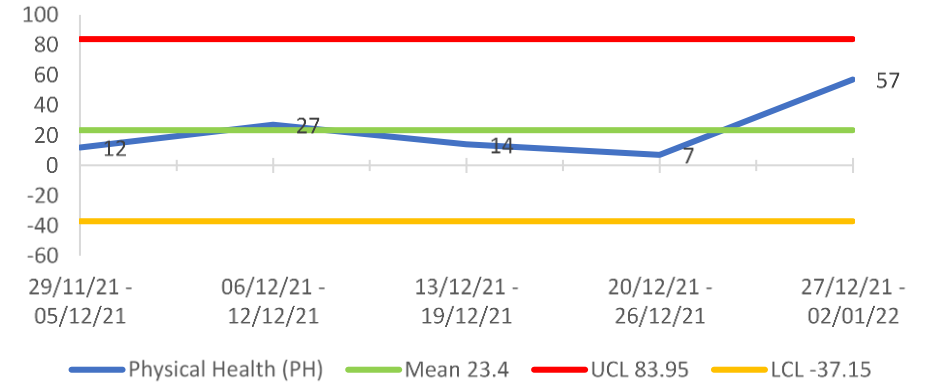
No of Incidents and Themes by highest occurring.
951 Incidents were reported.
Admission: **15%** (137/951). From the SPC chart below, by w/e 02/01/22, it was close to the expected number of reported incidents i.e. the mean (27.4).
Falls: **11.5%** (109/951); **5.5%** (6/109) were Moderate Harm attributable.
Pressure Ulcers (PU): **9.4%** (89/951); **13.5%** (12/89) were hospital acquired; no Moderate Harm attributable reported.
Adverse Staffing Levels: **5.9%** (56/951); **1.79%** (1/56) was reported as Moderate Harm due to a delay in obtaining clinical assistance in ED during that particular shift.
Moisture Lesion: **3.9%** (37/951); **13.5%** (5/37) were hospital acquired; no Moderate Harm attributable reported.

Whistleblowing (WB) 1 CQC WB enquiry received relating to Portering & Oxygen processes – no patient safety issues.
Freedom To Speak Up (FTSU)
2 FTSU received relating to ward level HR issues – not related to patient safety



12 Hour + Trolley Breaches in ED (No harm or suspected harm identified at the time of writing this report).117 Physical Health were reported. From the SPC chart below, although it was close to the UCL by w/e 02/01/22, it was 'in control'. 7 Mental Health were reported.





Falls

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Dec-21	Falls (with Harm) Rate per 1000 beddays	0.98	0.22			Common Cause (expected) variation	Variation indicates consistently (P)assing the target

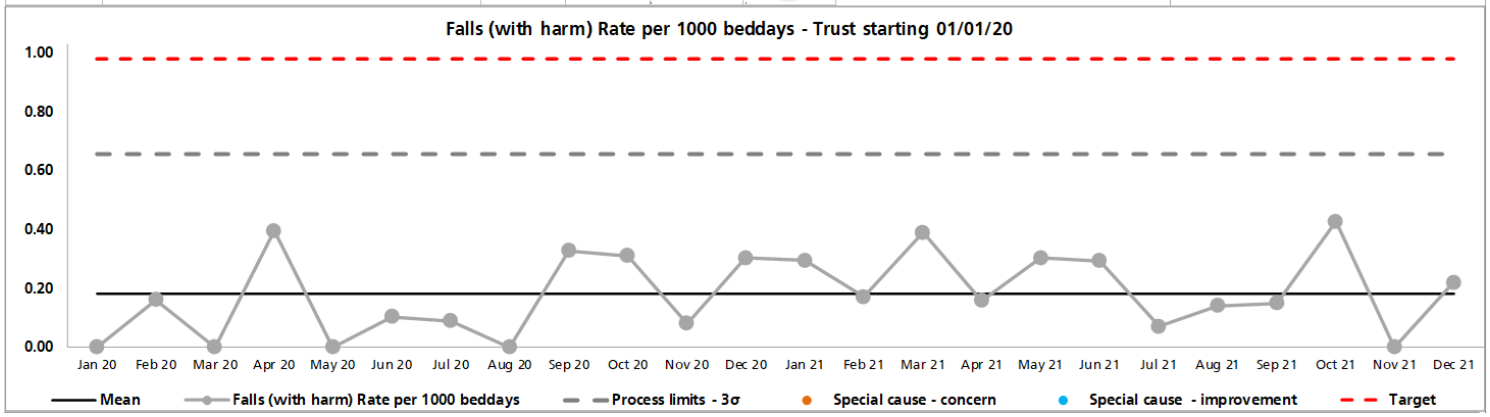


Chart 2 – Falls (with harm) Rate per 1,000 Bed Days

Key Issues (any new issues in red):

- Whilst there has been a small decrease in the number of patients sustaining harm and injuries following a fall incident; with no significant harm falls observed in November 2021, decreasing the per 1000 bed day rate from 0.40 (Oct 2021) to 0.00 (Nov 2021) this increases again in December to 0.22.
- There were 78 inpatient falls during November 2021 which equates to a falls rate of 5.50 per 1000 bed days (78 falls), and 81 falls in December which breaches the aspired 15% target reduction rate of 4.49 (54 falls per month). This is the 9th consecutive month above trajectory falls rate, with the months of September, October, November and December indicating a significant increase, following a more static period between April and August 2021, with a range of 58-63 falls per month.

Key Actions (new actions in green):

- Falls Operational Group continues to meeting monthly with multi-disciplinary membership/attendance.
- KPI lead work plan developed and currently being ratified for falls prevention and management. The work plan crosses boundaries and pathways of care to provide a more holistic response to falls prevention and management.

- Trust wide Falls Annual Audit to be undertaken in January 2022.
- Two 'train the trainer' for enhanced care booked for January 2022 along with Trust wide audit of policy concordance.
- Recruiting to 'Falls Prevention Support Worker' Posts (x2).
- Monthly falls 'Confirm and Support' meetings introduced to explore with all clinical areas learning from incidents and implementation of supportive change.

Recovery Forecast:

- Although the number of patient injuries following fall incidents is higher than expected, overall harm incident levels remain below the national benchmark of 0.98.

Key Risks to Forecast Improvement:

- Increased organisational activity/demand often requires the use of additional beds; increasing overall bed base increasing the potential level of risk.
- Non Concordance with delivery of high impact interventions and adherence to fall's policy.

Pressure Ulcers

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Dec-21	PUs Rate per 1000 beddays	0.41	0.35			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

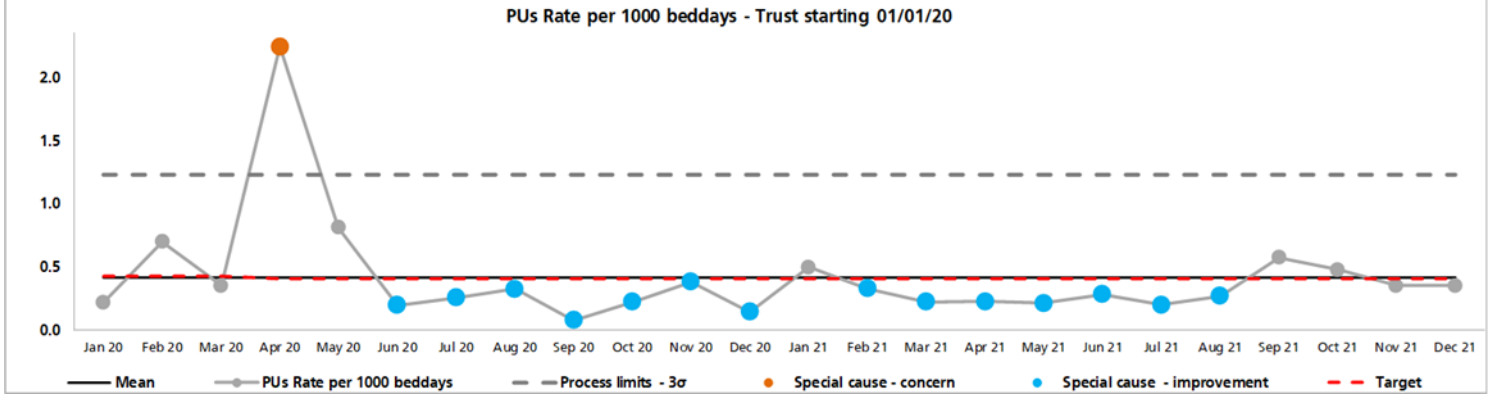


Chart 3 – Pressure Ulcer Rates per 1,000 Bed Days

Key Issues (any new issues in red):

- The number of hospitals acquired pressure ulcer has reduced in November and December to just below the tolerance level which is a positive improvement however there will need to be further improvement that is sustained.
- There were five hospital acquired pressure ulcers in November (x4 Cat 2, x1 Unstageable) and seven in December (x1 DTI, x5 Cat 2, x1 Unstageable).
- Two were initially assessed as lapses in care in November and four in December. DOC was completed. RCAs are underway – action plans in place.
- Themes identified on lapses of care was poor recording of risk and capacity assessments and reassessment's, insufficient evidence, or documentation of plans to support to prevent further damage to the skin.

Key Actions (new actions in green):

- 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.
- The Tissue Viability Nurses continue to deliver refresher training sessions with external Clinical Nurse Advisors.
- 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.
- The Areas with specifically identified care have an individualised plan monitored through the Divisions.
- The Trust wide point prevalence pressure ulcer clinical prevalence audit completed in early October (with ARJO) results, will be fed back to the Trust on 19 January. The reported areas of concern will form an action plan.
- The Tissue Viability Mandatory Training video is now live with staff now more able to completing this aspect of their mandatory training.
- The TVN team has been joined by a senior experienced nurse (started November 1st) to cover a vacancy. This aims to ensure the team is enhanced and the addition will support on delivery of training/expertise/bedside teaching – Delivery plans in place Jan/Feb 2022.

Recovery Forecast (e.g., August):

- The number of hospital acquired pressure ulcer start to reduce as we realign specialties.
- The pressure ulcer rate per 1000 bed days at the QEH is lower compared to similar sized organisations.

Key Risks to Forecast Improvement:

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

Clostridioides difficile Infection - CDI

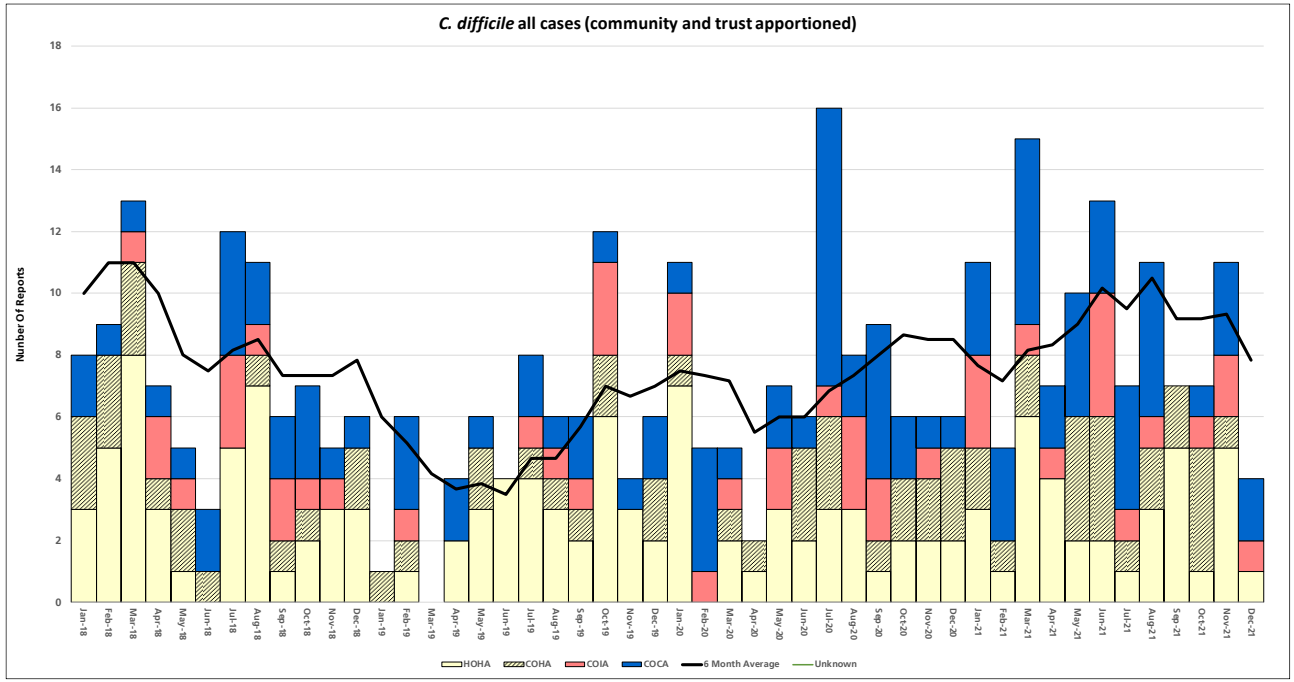


Chart 4 – C.Diff all Cases

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 (any new issues in red):

- One case identified in December 2021 (1 HOHA).
- Case reviewed - presently under appeal review by NW CCG.
- Findings: No lapses in care identified.

Escherichia coli (E.coli)

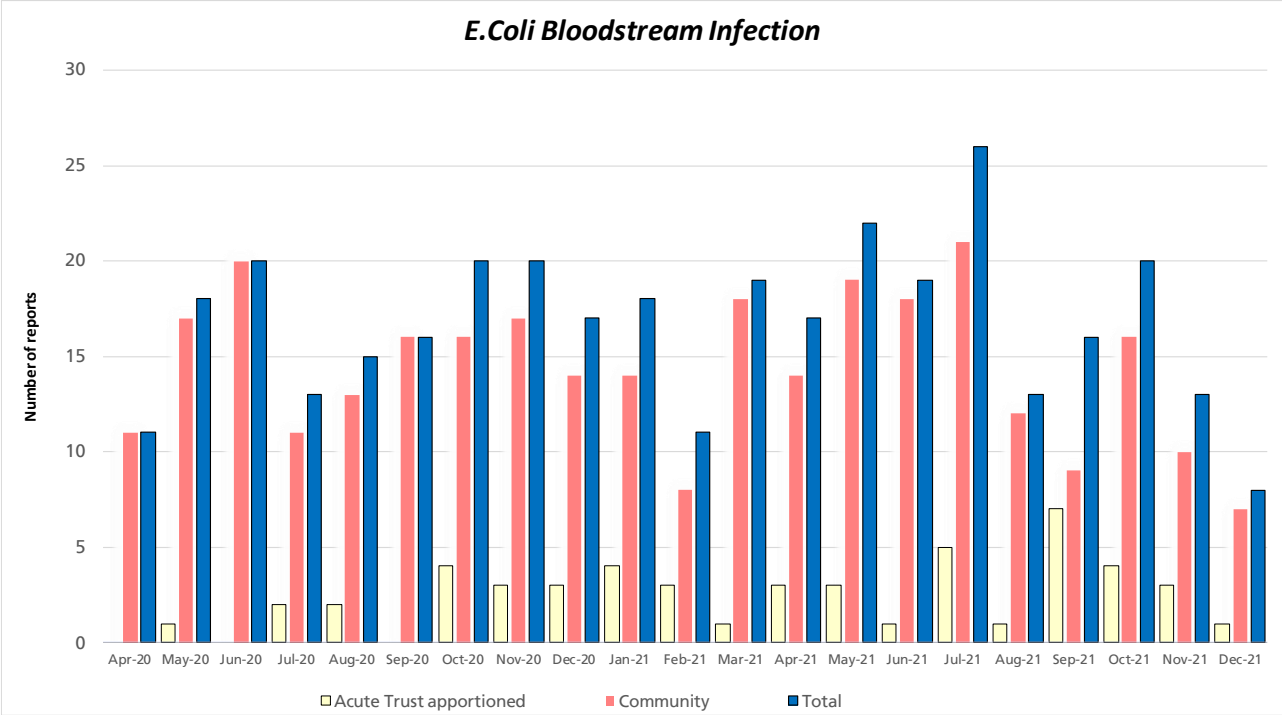


Chart 5 – E.coli Bloodstream Infections

Key Issues (any new issues in red):

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

- One case of hospital onset E. coli was reported in December 2021.
- Case waiting to be reviewed at surveillance meeting with Infection Prevention Team, Consultant Microbiologist and Infection Control Doctor (will be reviewed by 21 January 2022).

Key Actions (new actions in green):

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

- 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.
- Education at Induction / Mandatory Training.
- Bespoke education / training on affected areas.
- Practice Development Nurses provide training (ANTT).
- Review of individual cases and promptly undertaking measure to reduce any further transmission.
- Supportive programme of audit including hand hygiene, PPE usage, isolation and environmental cleaning in place.
- Discussing individual cases with Ward Managers / Matrons and escalating concerns, in a time appropriate manner, at senior meetings and via governance reporting channels.
- Deputy DIPC attends NW QI Group that will be focussing on catheter management.

Key Risks to Forecast Improvement:

- Compliance with Infection Prevention and Control Policies.
- Compliance with nutrition / hydration.

VTE Assessment Completeness

Data To	KPI Description	Target	Current Value	Variance	Assurance	*Variation Comment*	*Target Achievement*
Nov-21	VTE Assessment Completeness	97.2%	98.1%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

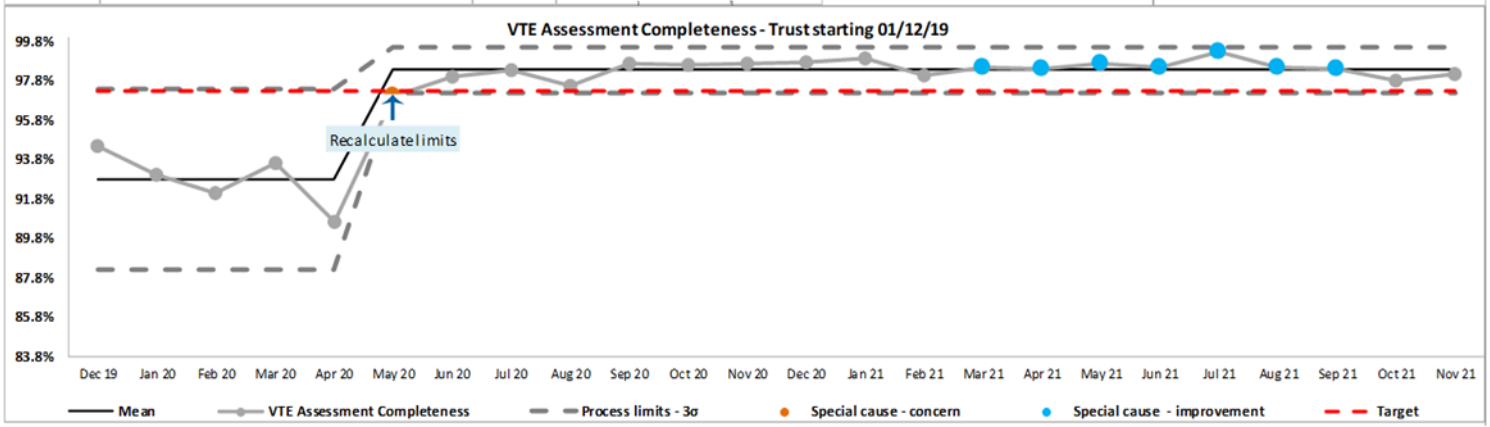


Chart 6 – VTE Assessment Completeness

Key Issues (any new issues in red):

- 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):

- Trustwide roll out of EPMA is expected to be completed in March 2022. Following this data capture for reporting will be switched over to EPMA. This is expected to improve compliance further.

Key Risks to Forecast Improvement: Currently none.

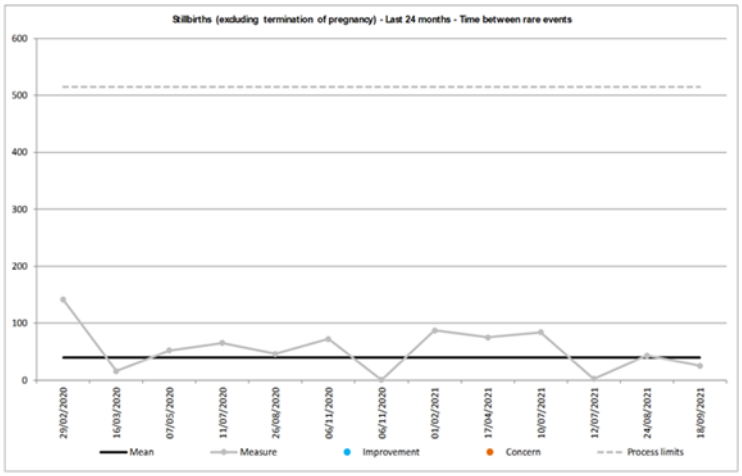
Effective - Accountable Officer - Medical Director

Effective Dashboard

Data To	KPI Description	Limit	Current Value	Variance	Assurance
Nov-21	Total Births (inc Home, BBA's & Stillbirths)		167		
Nov-21	Stillbirth Rate	3.73	2.95		
Nov-21	Neonatal Deaths Rate	1.06	0.00		
Nov-21	Extended Perinatal Deaths Rate	4.79	2.95		
Nov-21	Total C Section Rate		29.0%		
Nov-21	EL C Section Rate		8.6%		
Nov-21	EM C Section Rate		20.4%		
Nov-21	Maternal Deaths	0	0		
Nov-21	% "Term" admissions to the NNU	6.00%	1.90%		
Nov-21	% "Avoidable Term" admissions to the NNU	0.00%	0.00%		
Nov-21	Breastfeeding initiation	70.0%	81.4%		

Data To	KPI Description	Target	Current Value	Variance	Assurance
Nov-21	Breastfeeding on discharge from hospital	60.0%	62.1%		
Nov-21	Smoking at Booking	18.6%	17.2%		
Nov-21	Stopped smoking by delivery	44.7%	42.6%		
Nov-21	Smoking at Time of Delivery		11.7%		
Nov-21	Post-Partum Haemorrhage	3.0%	1.8%		
Nov-21	3rd & 4th degree tears, exc C-Sections	3.5%	0.7%		
Sep-21	HSMR Crude Rate	3.18	4.35		
Sep-21	HSMR Relative risk	100.00	126.69		
Sep-21	HSMR Weekend Relative risk	100.00	142.99		
Jul-21	SHMI (Rolling 12 mth position)	100.00	101.37		
Nov-21	Rate per 1000 admissions of inpatient cardiac arrests	2.00	0.14		
Dec-21	No. of patients recruited in NIHR studies	63	106		

Neonatal and Perinatal Mortality



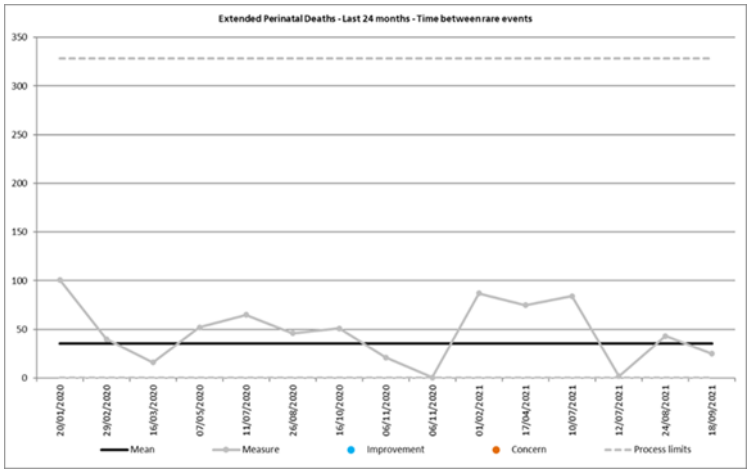


Chart 7 – Stillbirths and Chart 8 Extended Perinatal Deaths Rate (recorded as duration in days between events)

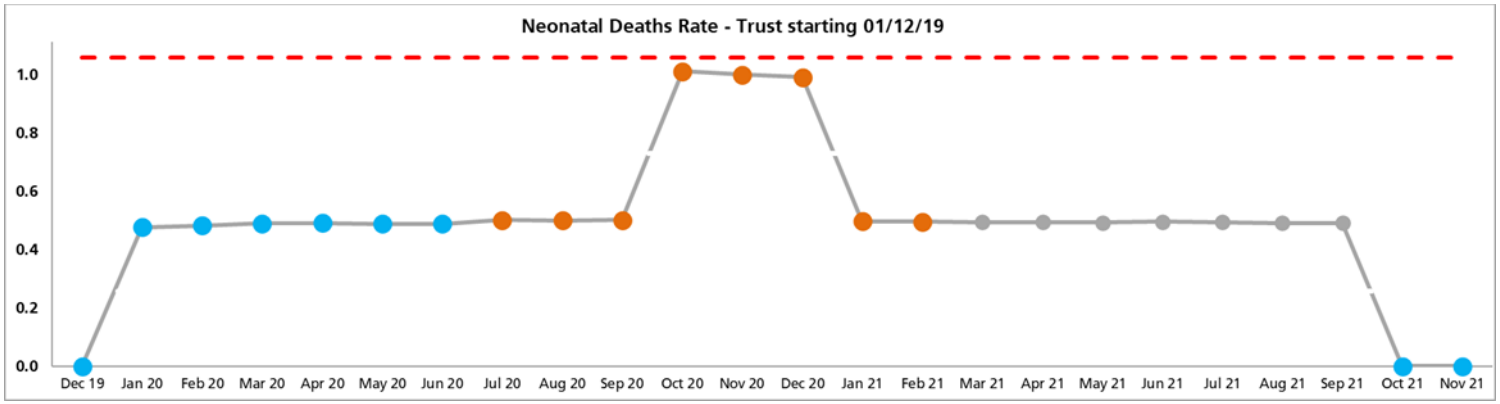


Chart 9 Neonatal Death rate

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

Key Issues

- There were no still births or neonatal deaths in the month of November.

Actions being taken

- The division is committed to fully embedding the Saving Babies Lives Care Bundle (SBLCB) Version 2, 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.
- Despite the pause for reporting that has been announced by NHSR, the Maternity department continue to work towards full compliance with the 10 safety actions for the Maternity Incentive Scheme, year 4 (there are differences to the year three scheme which was achieved in full.
- Work on the Maternity Improvement Plan (MIP) continues overseen by the Transforming Maternity Safety and Strategy Forum. A further 18 actions have been generated from the Ockenden feedback which are being reviewed by the workstreams at this time.

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
Nov-21	% "Term" admissions to the NNU	6.00%	1.90%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

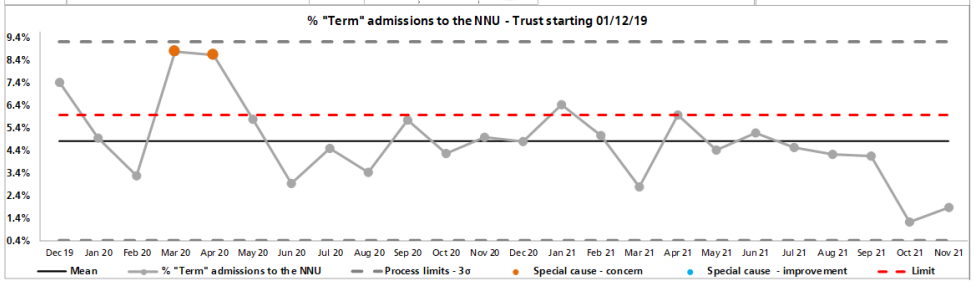


Chart 10 - % 'Term' admissions to NNU

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Nov-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

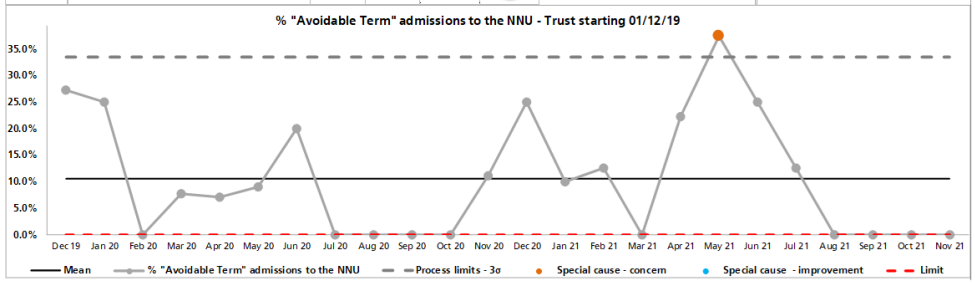


Chart 11 - % 'Avoidable Term' admissions to NNU

Key Issues:

- Term admissions into the Neonatal Unit remain within common cause variation and below the 6% target. No admissions to NICU were deemed avoidable through the ATAIN review process in November.

Key Actions

- All term admissions to the NICU are subject to ATAIN reviews and monthly MDT discussion.

Caesarean Section Rates

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Nov-21	Total C Section Rate		29.0%			Common Cause (expected) variation	

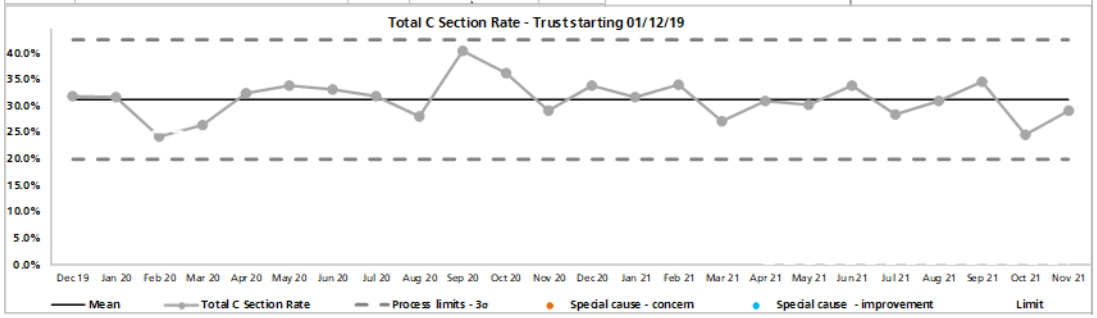


Chart 12 – Total Caesarean Section Rate

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Nov-21	EL C Section Rate		8.6%			Common Cause (expected) variation	

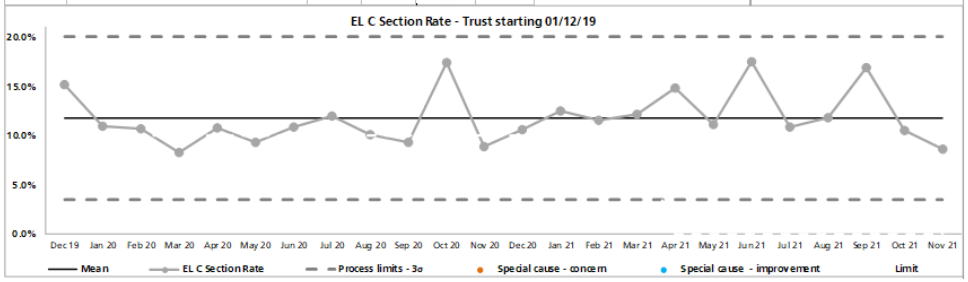


Chart 13 – Elective Caesarean Section Rate

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Nov-21	EM C Section Rate		20.4%			Common Cause (expected) variation	

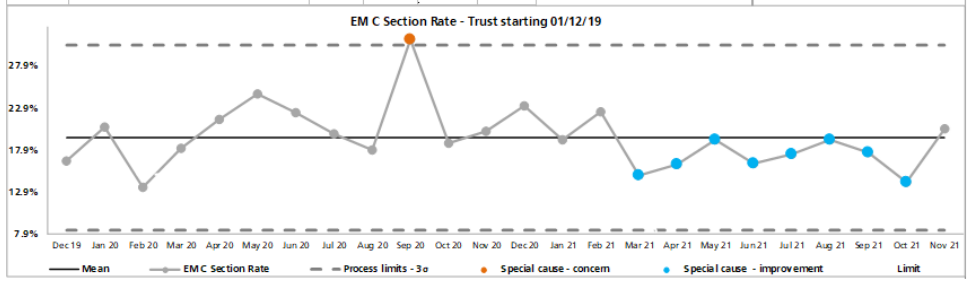


Chart 14 – Emergency Caesarean Section Rate

Key Issues

- There were 167 births in November 2021 of which; 67% were spontaneous vaginal deliveries, 5% assisted instrmental deliveries and 28% were LSCS.

Key Actions

- Multidisciplinary Team meeting to review all caesarean sections is embedded as Business as usual and is well attended.
- A multidisciplinary task and finish group including input from the clinical psychology team has been established to review pathways to encourage suitable women with one previous LSCS for trial of labour.
- A VBAC clinic pathway has been drafted to ensure women get individualised care plan for delivery.

Risk to delivery

- Current staffing challenges due to both vacancy and absence might delay both VBAC and IOL reviews as priority of time resource is redirected to acute care 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
Nov-21	Breastfeeding initiation	70.0%	81.4%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

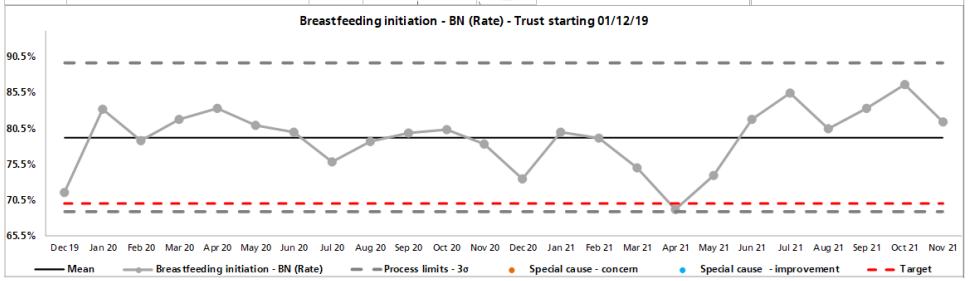


Chart 15 – Breastfeeding Initiation – BN (rate)

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Nov-21	Breastfeeding on discharge from hospital	60.0%	62.1%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

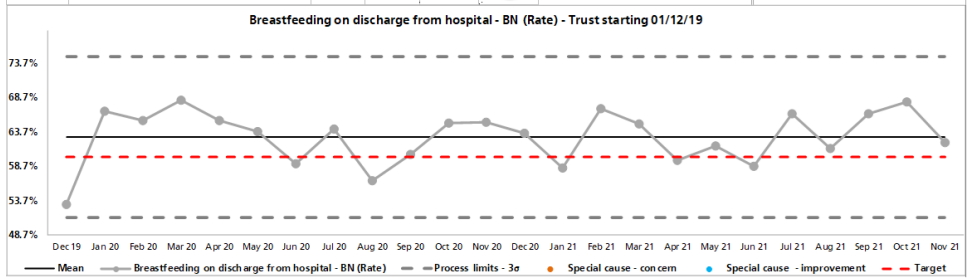


Chart 16 – Breastfeeding on discharge from hospital – BN (rate)

Key Issues

- Breastfeeding initiation rate remains within common cause variation but above the current target threshold of 70%
- The AN hand expressing pack initiative and new infant feeding specialist, along with the reintroduction of the infant feeding annual training are thought to be the reason for the recent improvements although statistical significance has not yet been reached .
- 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.

Risk to delivery

- The cancelation of mandatory training due to the current pandemic situation has the potential to reduce these numbers, as we saw with the first wave of Covid.
- A full service review is underway to ensure sustainability of the infant feeding support during these challenging times.

Smoking Cessation in Pregnancy

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Nov-21	Stopped smoking by delivery	44.7%	42.6%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

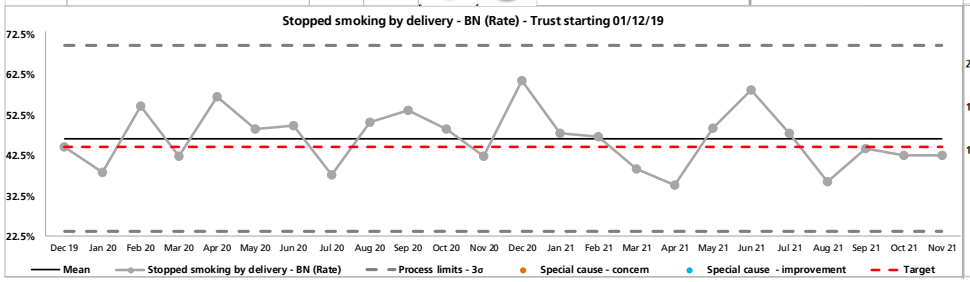


Chart 17 – Stopped smoking by delivery – BN (rate)

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Nov-21	Smoking at Time of Delivery		11.7%			Special cause (unexpected) variation - Improvement (L)	

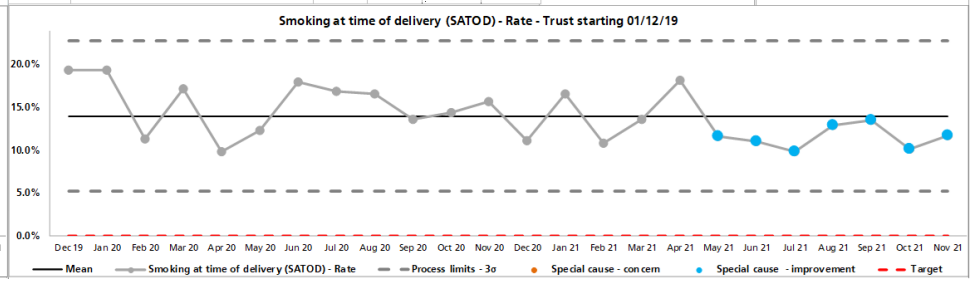


Chart 18 – Smoking at time of delivery (SATOD)

Key Issues

- 42.6% of Smoking cessation by delivery remains in common cause variation. Smoking prevelance amongst pregnant women in our catchment population remains higher than national avarages and well above the national ambition to achieve a SATOD rate of 6% or less by 2022. However, the re-establishment of CO screening during pregnancy is thought to be the reason for the special cause variation reduction in smoking at the time of delivery since May 2021. CO screening rates have doubled from from 30% to 60% at booking in October and improved further to 86% in November on track to achieve our target for our yr 4 CNST ambitions of >95% by December 2021. This is expected to translate to improvements in smoking at time of delivery in due course.

Key Actions

- Further action is required to improve CO screening rates at 36 weeks gestation.
- Direct electronic referals to smoking cessation services are planned to support increased referal rates but we do not have a roll out date at this time.

Risk to delivery

- Appetite 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-partum Haemorrhage (PPH)

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Nov-21	Post-Partum Haemorrhage	3.0%	1.8%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

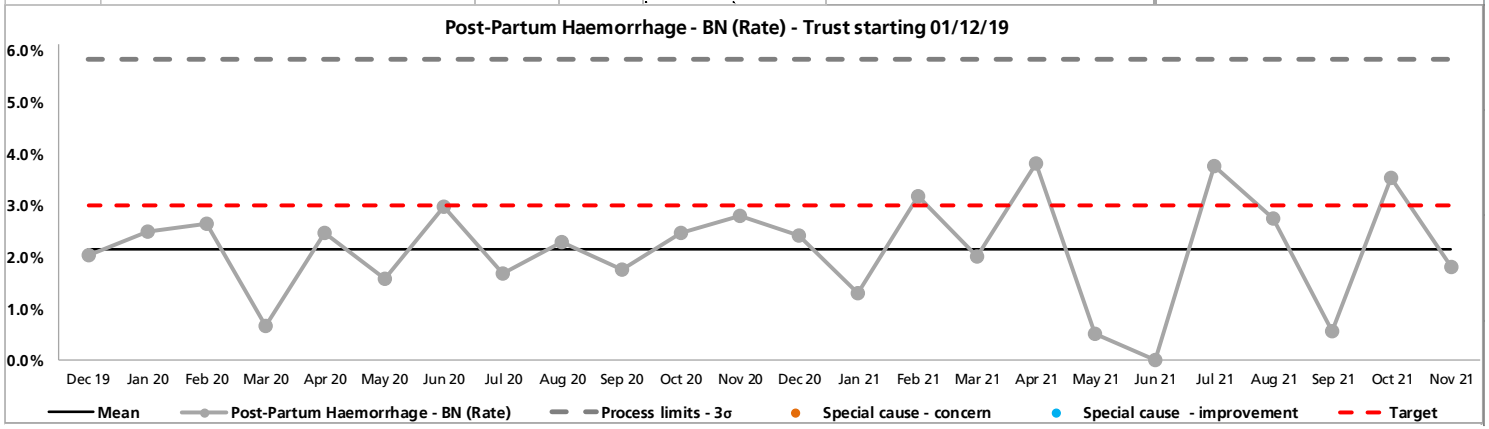


Chart 19 – Post-Partum Haemorrhage – BN (rate)

Factors driving performance:

- Rates remain within common cause variation inconsistently below the target.

Key Actions:

- All PPHs are reported and reviewed at the Serious Incident Review Panel (SIRP) to identify if the management of the case was appropriate, and whether a full investigation is required.
- PPH audit is ongoing will be presented in the new year.

Risks to Delivery:

- 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
Nov-21	3rd & 4th degree tears, exc C-Sections	3.5%	0.7%	L	?	Special cause (unexpected) variation - Improvement (L)	Variation indicates inconsistently passing and falling short of the target

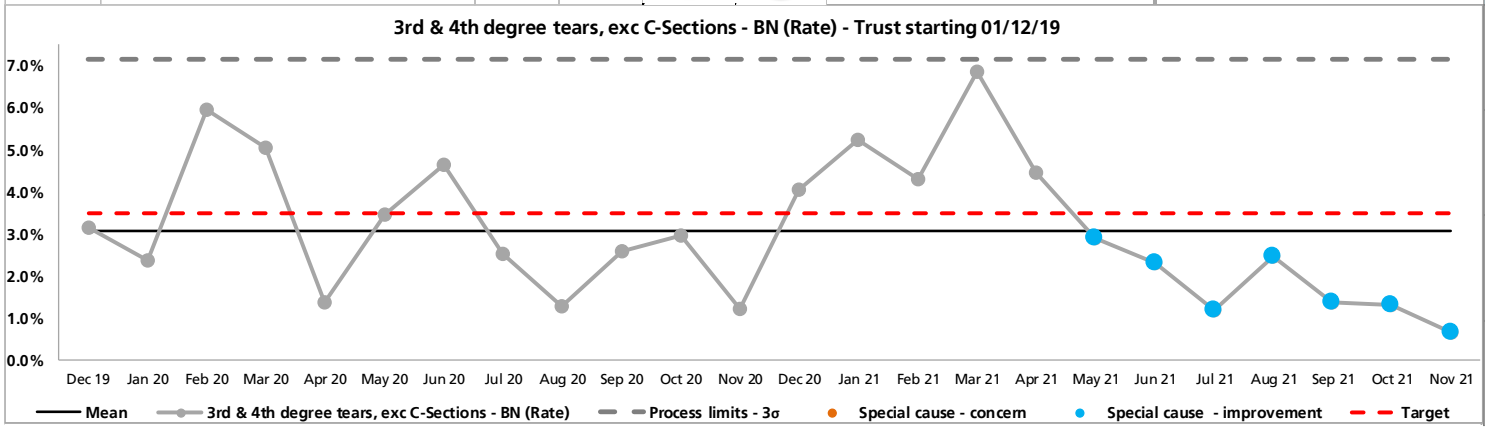


Chart 20 – 3rd and 4th degree tears

Factors driving performance:

- Implementation of the OASI bundle is now embedded as confirmed in a recent audit, which is thought to underlie the special ca use variation improvement in this indicator, with a current rate of perineal trauma 0.66% of caseswell below agreed threshold of 3.5%.

Key Actions:

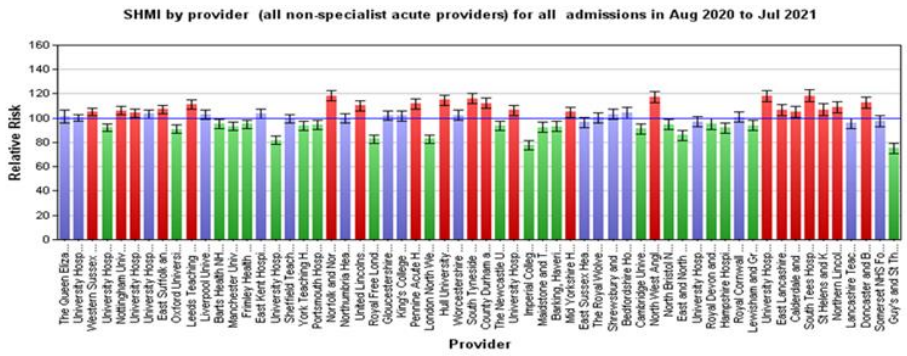
- All cases are reviewed monthly by the multi disciplinary team. Documentation of application of perineal pressure at delivery has been identified as a key issue addressed through these review and feedback processes and included in the annual training programme

Key Risks to Delivery:

- The cessation of training during this time of significant staffing challenges might impact on care.

Mortality

SHMI and HSMR



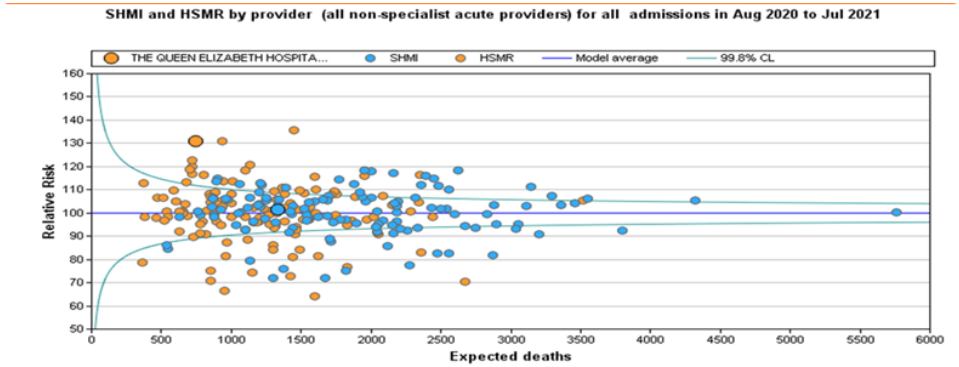


Chart 21 and 22 – SHMI and HSMR data for the period May 2020 to July 2021 only.

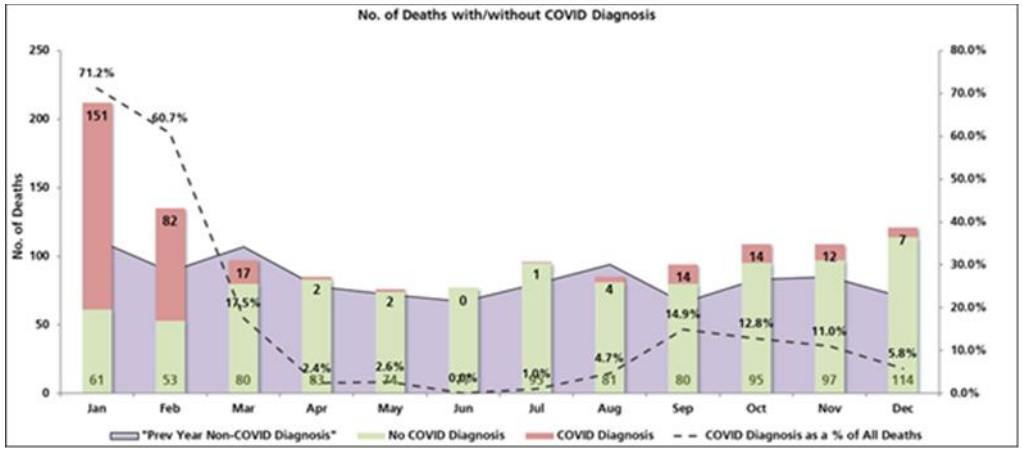


Chart 23 – No of deaths with/without COVID diagnosis

Key Issues

- The SHMI remains within the "expected band." This has fallen from 106 for the period to December 2020, to 102 to June 2021.
- The Funnel plot has only been updated to July 2021.
- HSMR data has changed dramatically for many providers since the start of the pandemic, as COVID deaths have been included in this calculation unlike SHMI. Dr Foster have therefore rebased their HSMR early (this is usually undertaken annually in April). We are yet to understand the full impact of this change, but using the Dr Foster HSMR tool to calculate our HSMR from April 2021 to September 2021 (which excludes the pandemic related peak in deaths), our HSMR reverts to pre pandemic levels: 101.1.
- Aside from the alert for viral infection (COVID) the five alerts with the highest number of patients are Pneumonia, Stroke, COPD, Aspiration Pneumonia and Residual Codes (uncoded). 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.
- In December 2021 there were 119 deaths. In comparison there were 138 deaths in December 2020 and 108 in December 2019. 75 (out of 119) of the deaths occurred in patients aged 80 and over, of this number 24 were aged 90 and over. There were 7 COVID deaths in December.
- The activity on which the HSMR and SHMI is based is still below pre-pandemic levels but overall activity to December continues to gradually increase.

Key Actions

- 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.
- The recording of SJR's within the SJR+ tool will provide us more opportunity to extract learning from the death review process.

Risk to delivery

- 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
Nov-21	Rate per 1000 admissions of inpatient cardiac arrests	2.00	0.14			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

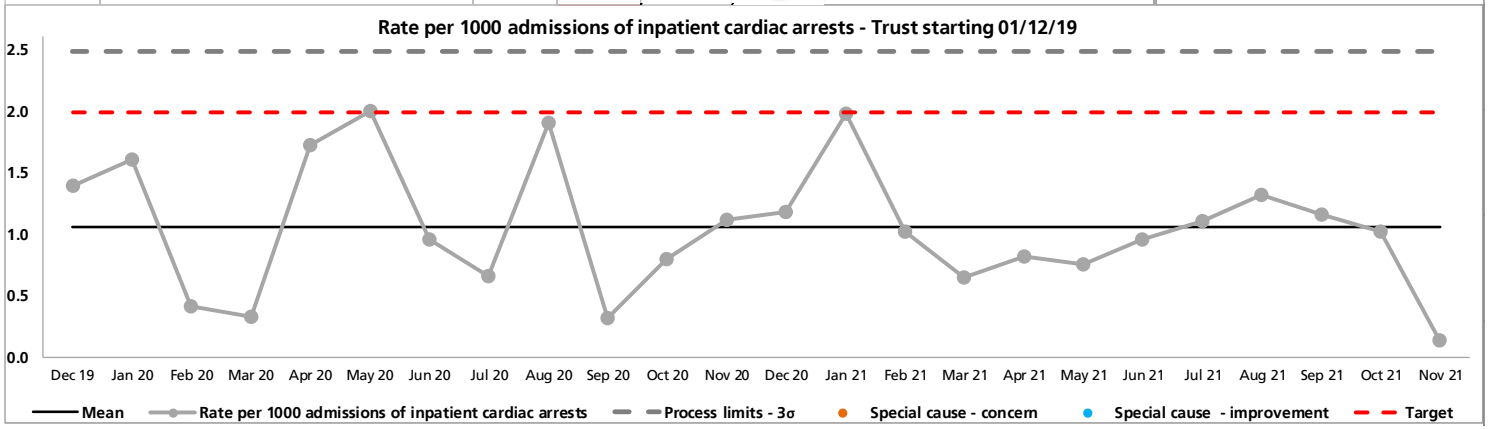


Chart 24 – Inpatient Cardiac Arrests per 1,000 admissions

Key Issues (any new issues in red):

- Cardiac arrest rates remain below maximum expected numbers and within common cause variation.
- There were 2 reportable cardiac arrests on our wards in November 2021. One incident has incomplete data. The other was an unexpected MI.

Key Actions (new actions in green):

- 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
Dec-21	No. of patients recruited in NIHR studies	63	106			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

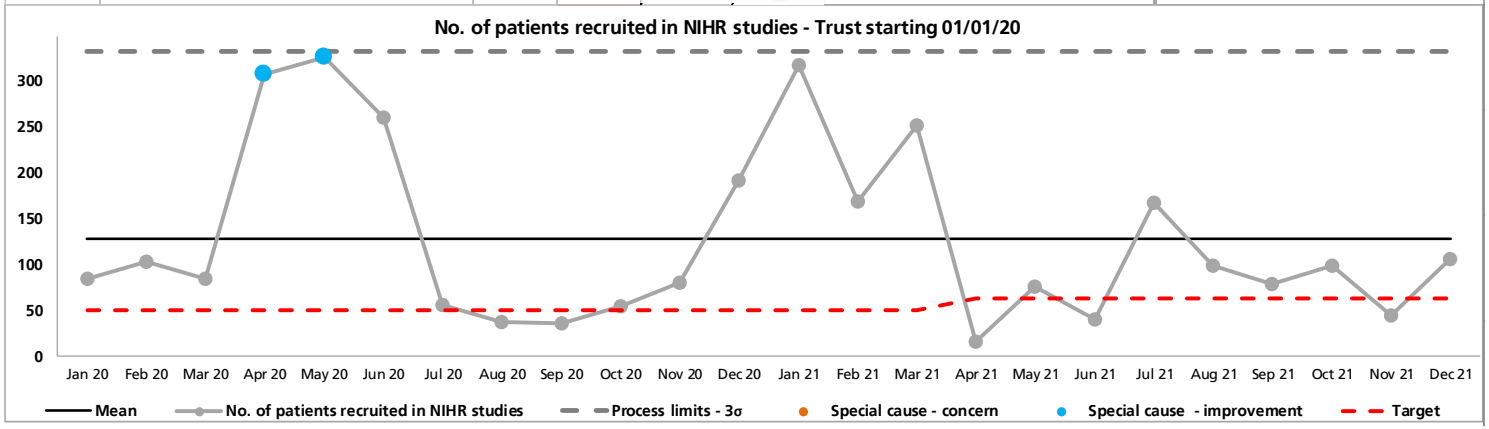


Chart 25 – No. of patients recruited in NIHR studies

Key Issues

- Recruitment remains within common cause variation on track to exceed the annual target. Despite increase in clinical demand (winter pressure) and clinical study offices closing earlier in December, 106 NIHR study accruals were made in December, against the target of 63 participants/month.

Key Actions

- Recruitment of 5 bank research nurses and 1 bank admin (15 hours/ week) to mitigate for staff unavailability due to sickness/ planned leave.
- Positive results of staff engagement in research survey, action plan in development.
- Discussion about designated clinic space for research started at ICPEG to address issues with room availability for trial patients.

Risk to delivery

- Inefficient research admin functions (e.g. site file management, set-up, archiving delays) may affect ability to meet research governance.
- Risk of protocol deviation from delays in securing clinic room for trial appointments.
- Reduced clinician capacity to support studies due to pandemic related and winter pressures.

Caring - Accountable Officer - Chief Nurse

Caring Dashboard - Trust Level

Data To	KPI Description	Target	Current Value	Variance	Assurance
Dec-21	MSA Incidents	0	4		?
Dec-21	MSA Breaches	0	12		?
Dec-21	Total Clinical & Non_Clinical Complaints	0	3	L	F
Dec-21	Complaints Rate per AE Atts, IP Adms & OP Activity	0.00%	0.01%	L	?
Dec-21	Complaints receiving a response within 30 working days %	90.0%	100.0%	H	?
Dec-21	Complaints - Reopened (% of Total)	15.0%	0.0%		?
Nov-21	Dementia Case Finding	90.0%	94.6%	H	?

Data To	KPI Description	Target	Current Value	Variance	Assurance
Dec-21	FFT % "Very Good" or "Good" (IP & DC)	95.00%	96.42%		?
Dec-21	FFT % "Very Good" or "Good" (AE)	95.00%	81.60%		?
Dec-21	FFT % "Very Good" or "Good" (OP)	95.00%	95.07%	L	?
Dec-21	FFT % "Very Good" or "Good" Mat Question 1 (Antenatal)	95.00%	92.3%		?
Dec-21	FFT % "Very Good" or "Good" Mat Question 2 (Labour)	95.00%	100.0%		?
Dec-21	FFT % "Very Good" or "Good" Mat Question 3 (Postnatal)	95.00%	100.0%		?
Dec-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
Dec-21	MSA Incidents	0	4			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

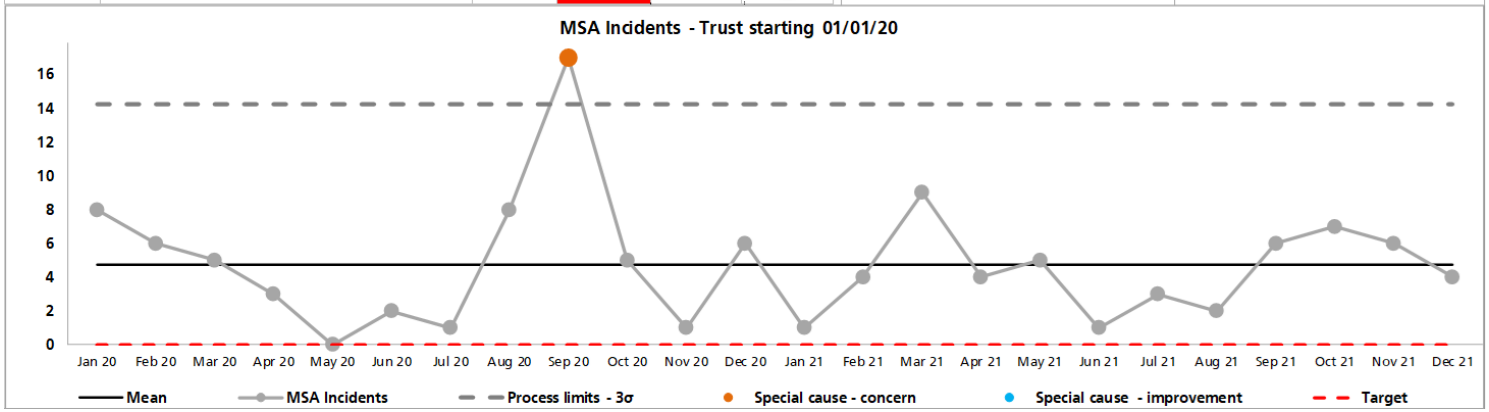


Chart 26 – MSA Breaches

Key Issues (any new issues in red):

- There were four (4) incidents of same sex accommodation breaches affecting twelve (12) patients during December 2021. The incidents occurred in the Hyperacute Stroke Unit (HASU) on West Raynham Ward. This is a decrease since November.
- During December the Trust has been under significant capacity and demand pressures, in line with National profiling, which has contributed to the EMSA breeches.
- The Trust breaches are reported in line with the national guidance.
- All patient's involved privacy and dignity was maintained throughout and all patients (and where applicable their NOK) were clearly communicated with explaining the rationale. There were no reported complaints, concerns, or incidents. Appropriate senior decision makers were involved.

Key Actions (new actions in green):

- Nurse in charge has active conversation with patients regarding their experiences whilst being cared for in a mixed sex bay and there have been no concerns raised by patients.
- Same sex accommodation breaches are discussed, and possible mitigations are considered during the Board round.
- Same sex accommodation breaches are escalated to the clinical site team and are reflected on the bed template in the operations centre.

- 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.
- The Trust has realigned its case mix bed base in line with IPC demands, National expectations/alignment and to support the N&W system pressures.

Key Risks to Forecast Improvement:

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

Complaints

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Dec-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

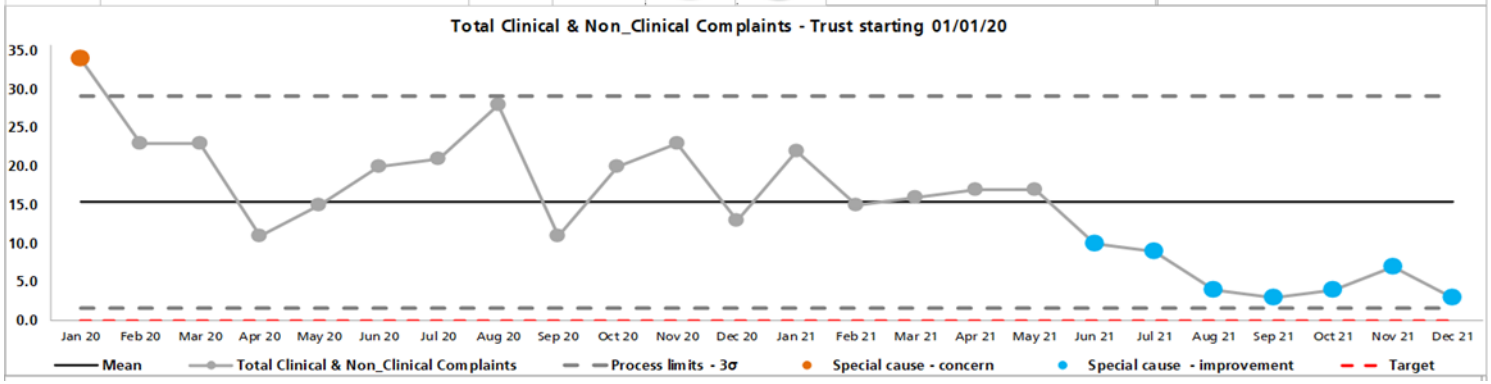


Chart 27 – Total Complaints

Key Issues (any new issues in red):

- The timeliness of responding to complaints within 30 days has been achieved for 7 consecutive months at 100%.
- There has been an almost continuous reduction in formal complaints since May 2021.
- The actions put into place in April/May 2021 continue to assist the improvement and will remain in place.

Key Actions (new actions in green):

- Initial Triage by a senior member of staff continues with Divisional senior to ring complainant.
- Continue to sustain an increase in Local Resolution Meetings (LRMs)
- Review each response with coaching to improve quality
- Planned patient experience workshop with a leading external industry facilitator to continue the pathway development for pati ents.
- Completion of the departmental audit and review of PALS informal concern process to strengthen timeliness/quality of response
- Development of a departmental dashboard and Share point to access PTL information regarding rolling statistics, KPI's and outcomes.

Recovery Forecast:

- The recovery plan includes sustained improvement in the coming months.
- The actions include a continued scrutiny on quality expected to positively impact on reduction in re-opened complaints.

Key Risks to Forecast Improvement:

- The ability of the teams to prioritise complaint responses in the expected time frames and provide patient focussed responses.
- Maintenance of the streamlined processes.
- 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
Nov-21	Dementia Case Finding	90.0%	94.6%	H	?	Special cause (unexpected) variation - Improvement (H)	Variation indicates inconsistently passing and falling short of the target

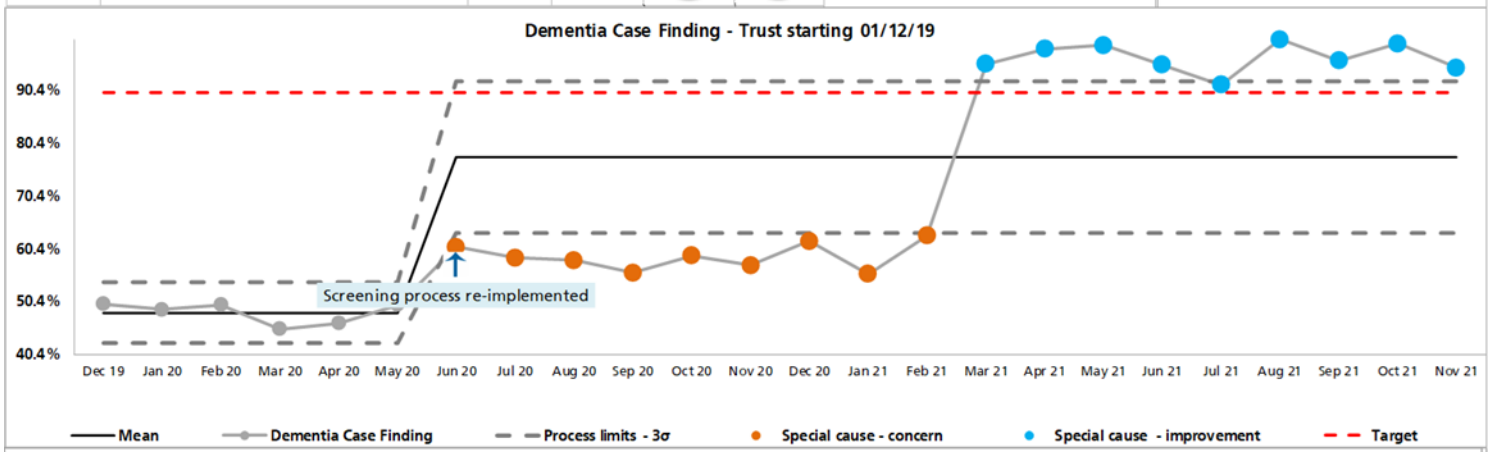


Chart 28 – Dementia Case Finding

Key Issues (any new issues in red):

- Dementia Screening remains above the agreed threshold of 90% for the ninth month.
- The improved screening process has been embedded in the services of Integrated Care of Older People (ICOP).

Key Actions (new actions in green):

- Plans to bring comprehensive a geriatric assessment process into the Front door (assessment areas) is progressing well with the appointment of a Nurse Consultant and service redesign. This will not only strengthen the screening process, but also enable place-based care through admission avoidance plans such as telephone advice and guidance. All such advanced care planning will improve care for patients identified with dementia.
- Increased access to memory clinics will be provided in January 22 through an additional neurologist joining us at QEH.
- The recruitment process is underway via Medicine Division to substantively recruit to the Dementia Screening team – Cognitive Impairment Assessors (CIA).

Key Risks to Forecast Improvement:

- Currently all risks have been mitigated.

NURSING METRICS

Ward Level Indicators for the month of Dec-21

Dec-21	Indicator Description	Data Source	Den	Elm	SAU	Gayt	SAND	C Care	Nec	Oxb	A&E	Stan	Sho	Til	West New	West Ray
Incidents & IPACS	Total Incidents (SI's, Falls, PU's & Drug Errors)	DATIX via Risk Mng't	8	2	0	7	2	4	5	3	13	1	3	5	5	3
	Serious Incidents		1	0	0	0	0	0	0	0	0	0	0	0	0	0
	Drug Administration Errors		2	0	0	2	0	2	0	1	8	0	0	0	0	1
	All Drug Errors (inc Admin)		2	2	0	4	0	3	0	4	10	0	0	1	3	3
	Falls Total		5	2	0	5	1	0	4	2	5	1	2	5	5	2
	Pressure Ulcers - Deep Tissue Injury (DTI)		0	0	0	0	0	0	0	0	0	0	1	0	0	0
	Pressure Ulcers - Unstageable		0	0	0	0	0	1	0	0	0	0	0	0	0	0
	H/A Pressure Ulcers Grade 2		0	0	0	0	1	1	1	0	0	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
	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	0	0	0	0	1	0	0	0	0	0	0	0	0
	MRSA		0	0	0	0	0	0	0	0	0	0	0	0	0	0
	MSSA		0	0	0	0	0	0	0	0	0	0	0	0	0	0
	E.Coli		0	0	0	0	0	0	0	0	0	0	0	0	0	0
	ESBL		0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Psuedomonas		0	0	0	0	0	1	0	0	0	0	0	0	0	0
	Klebsiella		1	0	0	1	1	0	0	0	0	0	1	0	0	0
Patient Experience	Complaints	Complaints Dept	1	0	0	0	0	1	0	0	0	0	0	0	0	0
	Compliments		2	3	1	6	1	5	19	14	8	24	11	8	11	9
	Family And Friends Response Rate	Meridian	23.2%	14.1%	13.2%	67.8%	14.1%	166.7%	12.7%	17.2%	1.8%	29.0%	2.4%	25.7%	29.5%	56.6%
	Family And Friends (% Recommended)		89.7%	100.0%	86.2%	92.5%	94.0%	100.0%	87.5%	84.0%	96.2%	100.0%	100.0%	100.0%	100.0%	96.7%
Safer Staffing	Fill Rate Registered	Info Serv via M Ojelade	84.6%	102.7%	87.8%	86.1%	71.0%	93.9%	85.6%	83.8%		81.1%	89.6%	93.4%	86.8%	85.8%
	Fill Rate Unregistered		74.4%	73.7%	75.4%	83.5%	64.3%	60.7%	77.2%	79.6%		79.6%	85.5%	86.2%	85.7%	78.6%
	CHPPD		6.2	4.9	14.3	5.2	7.8	28.6	5.3	5.5		8.5	7.4	6.9	7.9	6.3
Staff Experience	Appraisals	WIS Team	58.1%	90.6%	86.4%	84.8%	64.3%	94.1%	90.5%	58.3%	75.0%	75.0%	86.4%	71.1%	82.8%	100.0%
	Sickness		12.4%	11.2%	6.9%	6.8%	10.9%	5.8%	7.8%	13.9%	10.4%	8.8%	3.0%	10.0%	10.0%	14.5%
	Vacancies		15.2%	6.2%	19.6%	13.9%	21.5%	-3.0%	26.5%	16.6%	0.1%	19.5%	21.1%	6.5%	8.8%	12.5%
	Mandatory Training		74.5%	82.1%	90.9%	87.8%	85.8%	90.3%	83.3%	73.1%	87.4%	86.4%	86.2%	73.1%	78.3%	94.9%
Perfect Ward	Documentation	Perfect Ward	94.4%	90%		85%	84%		92%	96%		91%	93%	95%	86%	91%
	IPC		95%	100%	97%	98%	100%		100%	95%	97%	96%	97%	96%	96%	95%
	Observations		94%	97%	98%	98%	100%		100%	97%	99%	98%	95%	99%	97%	92%
	Staff			97%	98%	93%	98%		98%	100%	86%	97%	93%	97%	97%	94%
	Patient Experience			93%	96%	100%	100%		94%	98%	100%	99%	98%	96%		90%

"Total Incidents (SI's, Falls, PU's & Drug Errors only)" figure includes Serious Incidents, Falls, Pressure Ulcers and Drug "Administration Errors" only, not all Drug Errors.

FFT - The "Response Rate" and "% Recommended" figures attributed to AE include the sub areas of "A&E Adult", "A&E Children" & "A&E Primary Streaming".

FFT - The "% Recommended" attributed to Castle Acre includes both sub areas of "Castle Acre Antenatal" and "Castle Acre Postnatal", although the "Response Rate %" figure attributed to "Castle Acre Postnatal" only.

Ward Level Indicators for the month of Dec-21

Dec-21	Indicator Description	Data Source	Wind	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	9	6	8	6	0	1	2	0	0	4	13	2	0	1	111
	Serious Incidents		0	0	0	0	0	0	1	0	0	0	0	0	0	0	2
	Drug Administration Errors		0	1	3	1	0	1	1	0	0	1	0	0	0	1	25
	All Drug Errors (inc Admin)		1	4	4	2	0	1	1	0	2	3	1	0	0	5	56
	Falls Total		9	5	5	5	0	0	0	0	0	3	13	2	0	0	79
	Pressure Ulcers - Deep Tissue Injury (DTI)		0	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	0	1
	H/A Pressure Ulcers Grade 2		0	0	0	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	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	0	0	0	0	0	0	0	1
	MRSA		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	MSSA		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	E.Coli		1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	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	0	0	0	0	1
	Klebsiella		0	0	0	1	0	0	0	0	0	0	0	0	0	0	5
Patient Experience	Complaints	Complaints Dept	0	0	0	0	0	0	0	0	0	0	0	0	0	1	3
	Compliments		20	7	8	19	0	1	7	0	1	8	4	1	1	65	262
	Family And Friends Response Rate	Meridian	43.7%	11.6%	10.9%	40.8%	200.0%	25.5%	0.0%	0.0%	17.3%	7.7%	13.2%	9.7%	7.1%		
	Family And Friends (% Recommended)		90.3%	100.0%	100.0%	92.9%	100.0%	100.0%	100.0%	0.0%	94.9%	100.0%	100.0%	99.0%	95.0%		
Safer Staffing	Fill Rate Registered	Info Serv via M Ojelade	87.2%	86.3%	93.0%	94.4%	99.1%	67.0%	81.1%		83.8%	82.3%	78.3%				86.5%
	Fill Rate Unregistered		74.0%	59.5%	73.5%	68.0%	84.5%	92.0%	75.3%		109.7%	82.8%	77.4%				77.4%
	CHPPD		5.0	7.2	5.9	5.3	25.6	5.7	28.1		12.4	5.2	5.8				7.2
Staff Experience	Appraisals	WIS Team	63.0%	77.5%	90.2%	92.9%	68.8%	65.0%		85.7%	91.8%			70.0%	40.0%		0.0%
	Sickness		8.9%	8.9%	4.4%	6.8%	10.5%	9.0%		0.7%	4.6%			2.2%	3.2%		
	Vacancies		17.1%	31.1%	11.2%	17.1%	12.6%	31.3%		7.9%	12.2%			11.6%	-6.9%		
	Mandatory Training		87.2%	84.2%	82.5%	93.0%	90.1%	74.2%		73.3%	82.0%		71.5%	83.8%	72.7%		
Perfect Ward	Documentation	Perfect Ward	96%	99%	93%	91%	95%				97%		95%	100%	91%		93.0%
	IPC			95%	95%	87%	96%				100%	93%	79%	100%	88%		95.2%
	Observations		94%	99%	97%	92%	100%				100%	97%	77%	100%	91%		96.3%
	Staff		99%	94%	96%	97%	98%				94%	97%	92%	97%	98%		95.4%
	Patient Experience		96%	96%	97%	90%	100%				100%	93%	93%	100%	100%		96.7%

"Total Incidents (SI's, Falls, PU's & Drug Errors only)" figure includes Serious Incidents, Falls, Pressure Ulcers and Drug "Administration Errors" only, not all Drug Errors.

FFT - The "Response Rate" and "% Recommended" figures attributed to AE include the sub areas of "A&E Adult", "A&E Children" & "A&E Primary Streaming".

FFT - The "% Recommended" attributed to Castle Acre includes both sub areas of "Castle Acre Antenatal" and "Castle Acre Postnatal", although the "Response Rate %" figure attributed to "Castle Acre Postnatal" only.

Responsive - Accountable Officer - Chief Operating Officer

Responsive Dashboard - Trust Level

Data To	KPI Description	Target	Current Value	Variance	Assurance
Dec-21	18 Weeks RTT - Incomplete Perf	92.0%	61.6%		F
Dec-21	18 Weeks RTT - No. of Specialties failing the target of 92%	0	26		
Dec-21	18 Weeks RTT - Over 52 Wk waiters	0	818		
Dec-21	A&E 4 Hour Performance	95.0%	56.6%	L	F
Dec-21	A&E 4 Hour Performance (Majors only)	95.0%	35.7%	L	F
Dec-21	A&E 4 Hour Performance (Minors only)	100.0%	80.7%	L	F
Dec-21	A&E 12 Hour Trolley Waits	0	107		
Dec-21	Ambulance Handovers	100.0%	31.2%	L	F
Dec-21	Last minute non-clinical cancelled elective operations	0.8%	0.62%	L	?
Dec-21	Breaches of the 28 day readmission guarantee	0	1		
Dec-21	Total non-clinical cancelled elective operations	3.2%	5.08%	L	?
Dec-21	Urgent operations cancelled more than once	0	0		
Oct-21	% of beds occupied by Delayed Transfers of Care	3.5%	3.8%	H	?
Dec-21	Medically Fit For Discharge - Patients		248		
Dec-21	Medically Fit For Discharge - Days		866	L	
Dec-21	No. of beds occ by inpatients >=21 days - (Mthly average over rolling 3 mths)	46	55		?

Data To	KPI Description	Target	Current Value	Variance	Assurance
Nov-21	Cancer Wait Times - Two Week Wait Performance	93.0%	77.3%	L	?
Nov-21	Cancer Wait Times - 31 Day Diag to Treatment Performance	96.0%	94.9%		?
Nov-21	Cancer Wait Times - 62 Day Ref to Treatmemt Performance	85.0%	76.2%		?
Nov-21	Cancer Wait Times - 104 Day waiters	0	9.0		
Nov-21	Cancer Wait Times - Two Week Wait (Breast Symptomatic) Performance	93.0%	4.0%	L	?
Nov-21	Cancer Wait Times - 31 Day Subsequent Treatment - (Surgery) Performance	94.0%	84.6%		?
Nov-21	Cancer Wait Times - 31 Day Subsequent Treatment - (Drug) Performance	98.0%	96.6%	L	?
Nov-21	Cancer Wait Times - 62 Day Screening Performance	90.0%	75.7%		?
Nov-21	Cancer Wait Times - Consultant Upgrade (62 day)	90.0%	83.3%		?
Nov-21	Cancer Wait Times - 28 Day FDS - Two week wait	75.0%	60.9%		?
Dec-21	Diagnostic Wait Times - % of over 6 Week Waiters	1.0%	67.7%	H	F
Sep-21	Stroke - 90% of time on a Stroke Unit	90.0%	63.8%		?
Sep-21	Stroke - Direct to Stroke Unit within 4 hours	90.0%	34.0%	L	F
Sep-21	Stroke - Patient scanned within 1 hour of clock start	48.0%	33.3%		?
Sep-21	Stroke - Patient scanned within 12 hours of clock start	95.0%	93.8%		?
Click here to view other National Stroke (SSNAP Domain) Results					
Nov-21	Trust - Seen <24 hrs (1st contact to investigations complete)	60.0%	50.0%		?

Emergency Care

Emergency access within 4 hours

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Dec-21	A&E 4 Hour Performance	95.0%	56.6%	L	F	Special cause (unexpected) variation - Concern (L)	Variation indicates consistently (F)alling short of the target

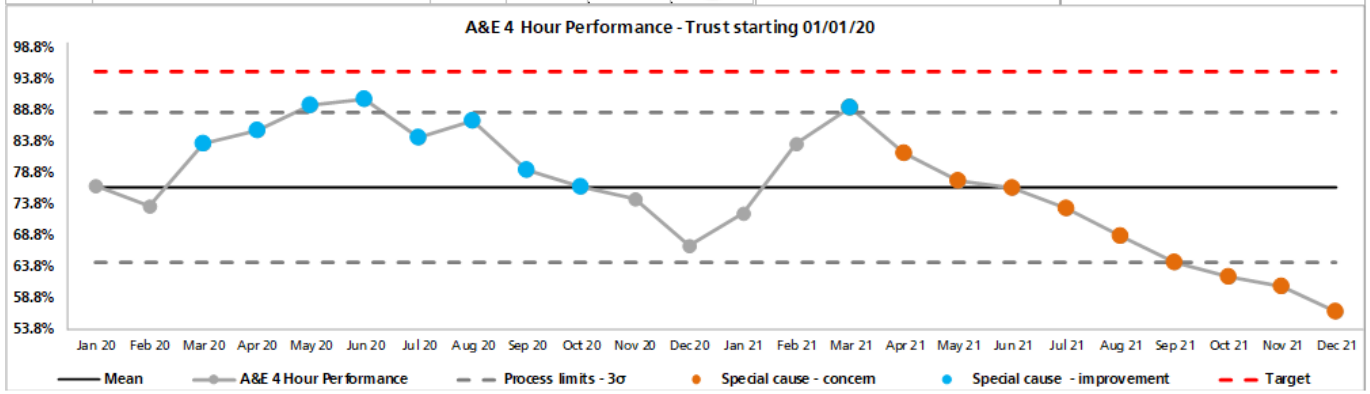


Chart 29 – A&E 4-hour performance

- During December 6,140 patients attended the Emergency Department (ED), of these 2,663 patients were in the department over fo ur (4) hours before admission, discharge, or transfer. Performance was 56.63% against the standard of 95%.
- Admitted performance was 33.39% and non-admitted performance was 76.41%.
- 1,774 patients that breached were admitted to an inpatient bed.
- 89.82% of all attendances presented to Amber ED, 10.18% to Red ED.
- As of 10 January 2022, there were 82 patients on discharge pathways 1 – 3 referred for transfer of care, the breakdown of these by CCG is shown in the table below:

CCG	Pathway 1	Pathway 2	Pathway 3	Total	Number ≥7 days	Longest delay (days)
N&W	32	25	3	60	30	75
Cambs	6	5	3	14	5	30
Lincs	8	0	0	8	6	31
	46	30	6	82	41	

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 107 patients that waited in the Emergency Department over 12 hours from decision to admission.

Ambulance Handovers

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Dec-21	Ambulance Handovers	100.0%	31.2%	L	F	Special cause (unexpected) variation - Concern (L)	Variation indicates consistently (F)alling short of the target

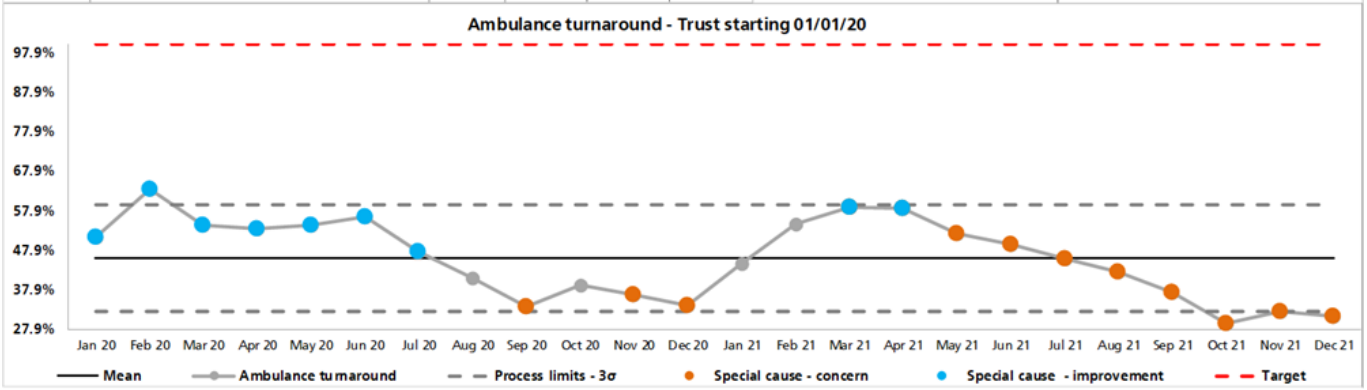


Chart 30 – Ambulance Handovers

Performance Summary

- During December there were 1,822 conveyances by EEAST to the Emergency Department. 31.04% of all handovers took place within ≤15 minutes and the average handover time was 54 minutes.
- The Trust ranked 4th out of 17 hospitals within the region for the percentage of handovers completed within 15 minutes. 27.87% of handovers exceeded 60 minutes, with 449 patients waiting over 60 minutes on an ambulance.

Key Issues:

- Sustained increase in urgent and emergency care demand.
- Bed occupancy levels routinely above 92%, limiting flow out of the Emergency Department for admitted patients.
- 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:

- Co-located Primary Care Service due to commence early January 2022. This service is expected to see, treat and discharge c. 30% of walk-in patients attending the Emergency Department.

- Expansion plans in place to increase the Emergency Department footprint. This is due for completion by the end of March 2022.
- Divisional review of internal escalation processes and triggers to improve timely flow through the Emergency Department.

Recovery Forecast:
The recovery forecast for the remainder of 2021/22 and for 2022/23 is under review. The 2022/23 priorities and operational planning guidance sets out the following expected performance levels in 2022/23:

- reduce 12-hour waits in EDs towards zero and no more than 2%.
- minimise ambulance handover delays;
    - eliminating handover delays of over 60 minutes.
    - ensuring 95% of handovers take place within 30 minutes.
    - ensuring 65% of handovers take place within 15 minutes.

Key Risks:

- Sustained increase in Emergency Department attendances.
- Increased incidence of suspected COVID-19 presentations.
- 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
Dec-21	18 Weeks RTT - Incomplete Perf	92.0%	61.6%		F	Common Cause (expected) variation	Variation indicates consistently (F)alling short of the target

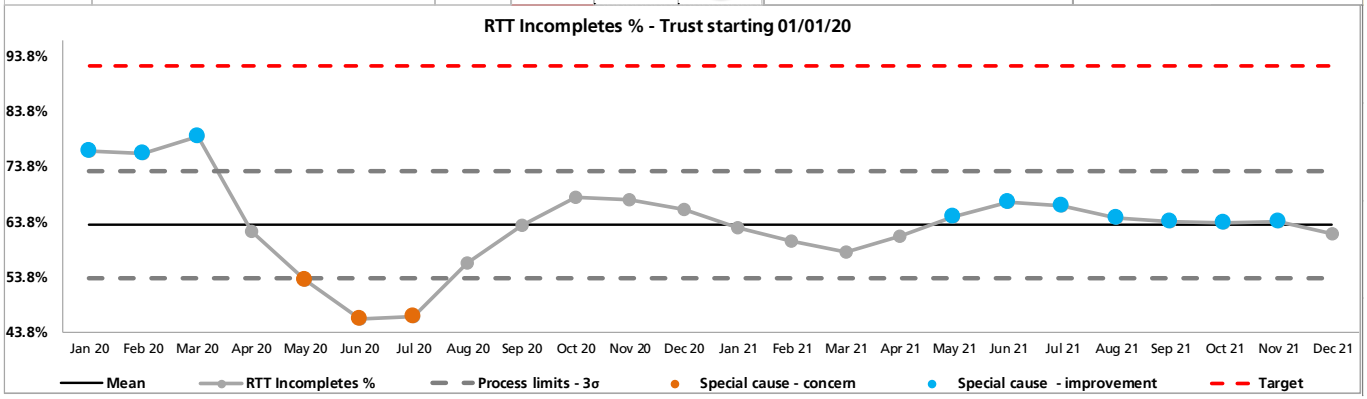


Chart 31 - RTT Incomplete Pathways

Performance Summary

- At the end of December 2021, there were a total of 19,108 patients on the waiting list, of which 7,343 had waited for over 18 weeks from referral, giving performance of 61.6%. The three specialties with the greatest number of patients waiting over 18 weeks were Orthopaedics (1,122), Cardiology (962) and Dermatology (919).

Key Issues:

- Increasing number of postponements due patient choice, sickness and isolation.
- Reduction in Cardiology activity due to a consultant vacancy.
- Fluctuating levels of demand for Trauma demand impacted on Elective Orthopaedic Theatre availability as elective capacity was used for trauma cases on occasion.
- Sustained increases in cancer referrals across all tumour sites, leading to increase in the number of P2 patients on the waiting list.

Key Actions:

- Locum Cardiology Consultant appointed and due to start in post January 2022.
- Improved theatre productivity and efficiency to maximise the use of theatre capacity.

Recovery Forecast:

- The waiting list is growing as there are more Referral to Treatment (RTT) clock starts occurring than RTT clock stops. Recovery back to 92% is likely in some specialities within 2021/2022; however, the Trusts RTT Incomplete aggregate performance is not expected to recover to 92% during the 2021/2022 financial year.

Key Risks:

- Increasing emergency care pressures resulting in the use of the Day Surgery and Sandringham ward for non-elective patients from early January 2022.
- Unforeseen disruption to theatre capacity due RAAC plank issues.
- 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 December 2021 there were 818 patients waiting longer than 52 weeks for treatment. This is a decreasing trend over the last six months. The top 3 specialties with the greatest number of patients waiting over 52 weeks are Orthopaedics (252), Gynaecology (220) and General Surgery (115). The longest waiting patient is a Gynaecology patient (P6) at 120 weeks; this patient has chosen to delay treatment until the new year.
- The number of patients waiting over 52 weeks continues to reduce, and the 92nd percentile waiting time in weeks is reducing in most specialities.

Speciality Description	>=52 weeks	Non-Admitted WL	Admitted WL	Total WL Size	Performance %	92nd Percentile In Weeks
Breast Surgery	3	109	40	149	87.25%	35.2
Cardiology	7	1791	48	1839	47.69%	38.0
Colorectal	17	134	224	358	80.45%	33.0
Dermatology	1	1670	291	1961	53.14%	38.0
Ear, Nose And Throat	62	1757	280	2037	62.20%	34.0
General Surgery	115	504	486	990	67.98%	63.9
Gynaecology	220	859	576	1435	63.34%	67.0
Ophthalmology	35	2061	336	2397	63.91%	37.0
Oral Surgery	57	95	290	385	55.32%	80.3
Paediatric Dermatology	1	3	0	3	66.67%	45.3
Paediatric Surgery	1	2	0	2	0.00%	51.2
Pain	35	730	0	730	37.81%	48.0
Trauma & Orthopaedics	252	1410	893	2303	51.28%	59.0
Upper Gi	2	63	46	109	84.40%	26.0
Vascular	10	191	39	230	80.87%	35.4
	818	15371	3737	19108	61.57%	
Urology	37	962	342	1304	59.05%	35.0

Key Issues:

- A number of cases require Gynaecology and Colorectal surgeons to undertake the list together.
- 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.

Key Actions:

- Confirm de-escalation plans to revert Sandringham ward and the Day Surgery Unit to Green, elective capacity.
- Open Sandringham theatres 7 days per week, supported by Targeted Investment Funding (TIF) until end of March 2022.
- Additional sessions in Main Theatres by specialties with the most P2 and longest waiting patients (General Surgery, Gynaecology and Orthopaedics) following the relocation of the Breast lists (Monday and Tuesday) to the Sandringham Theatre 8.

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:

- Increasing emergency care pressures resulting in the use of the Day Surgery and Sandringham wards for non-elective patients from early January 2022.
- Unforeseen disruption to theatre capacity due to RAAC plank issues.
- Sustained increase in number of P2 cases extends the waiting time for less clinically urgent patients.

Last minute non-clinical cancelled elective operations

There were 15 last minute cancelled operations in the month of December, as detailed below:

- 6 General Surgery patients,
- 3 ENT patients,
- 3 General Medicine patients,
- 2 Ophthalmology patients, and
- 1 Dermatology patient who did not attend for their surgery.

Breaches of the 28-day guarantee (unvalidated)

There was one breach of the 28-day readmission guarantee in December 2021.

Urgent Operations cancelled more than once

There were no urgent operations cancelled more than once in the month of December.

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
Nov-21	Cancer Wait Times - Two Week Wait Performance	93.0%	77.3%			Special cause (unexpected) variation - Concern (L)	Variation indicates inconsistently passing and falling short of the target

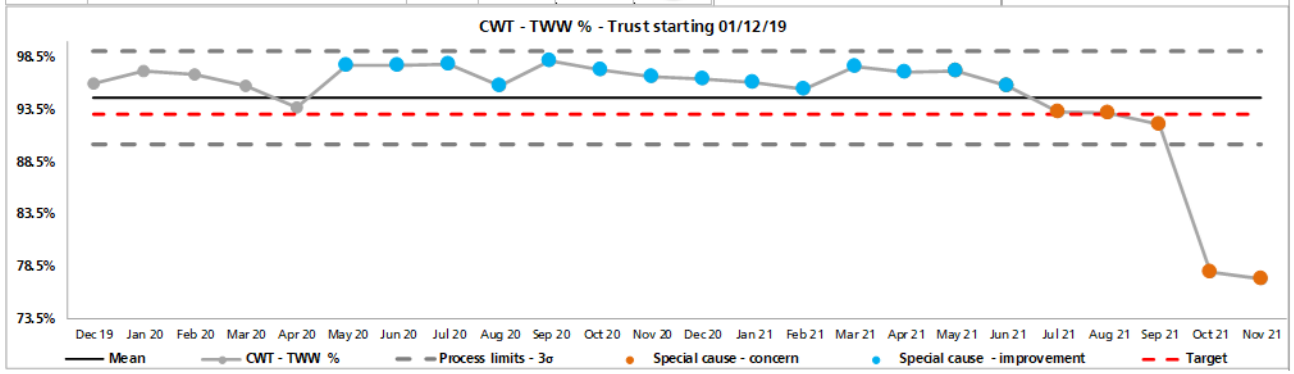


Chart 32 – Cancer Wait Times: Two Week Wait Performance

Two week wait performance in November 2021 was **77.35%** against the standard of **93%**, Staffing shortages and an increase in referrals have caused delays. Concerns for meeting the target remain in place for the next two months; however, additional capacity is being secured to enable the continued achievement of the standard moving forward.

Key Issues:

- Capacity pressures due to staffing and a sustained increase in referrals.

Key Actions:

- Additional capacity to be secured to address the backlog in breast 2ww referrals.
- A new radiologist is due to start in February 2022 and will support additional clinics.
- A cross divisional remedial action plan and trajectory is in development to support sustained delivery of the standard.

Recovery Forecast:

- Two week wait performance is forecast to improve from January 2021.

Key Risks:

- A further increase in the number of 2 weeks wait referral levels received.
- Lack of radiological staffing cover due to sickness.
- Increasing emergency care pressures resulting in the re-deployment of staff from outpatient clinics to support Surge pressures for Covid-19.

Two week wait (Breast Symptomatic)

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Nov-21	Cancer Wait Times - Two Week Wait (Breast Symptomatic) Performance	93.0%	4.0%	L	?	Special cause (unexpected) variation - Concern (L)	Variation indicates inconsistently passing and falling short of the target

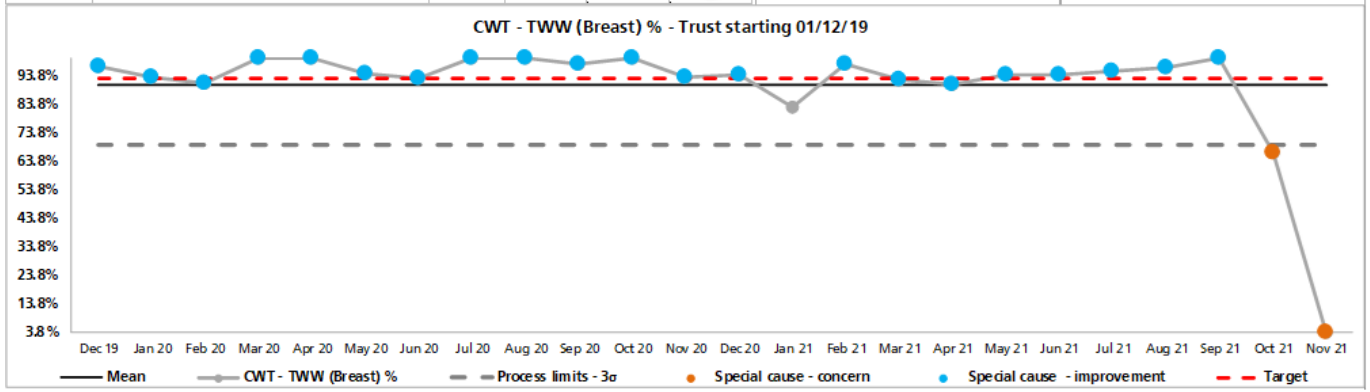


Chart 33 – Cancer Wait Times: Two Week Wait Performance (Breast Symptomatic)

Performance Summary

- Performance in November 2021 significantly deteriorated from 66.67% to 4.0% against the standard of 93%. Staffing shortages in Breast Radiology and an increase of referrals in month have caused delays. However, it is noted that 91.5% of these patients met the faster diagnostic standard for Breast Symptomatic.
- The standard forecast to recover from March 2022, a remedial action plan and recovery trajectory are in place.

31 day diagnosis to treatment

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Nov-21	Cancer Wait Times - 31 Day Diag to Treatment Performance	96.0%	94.9%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

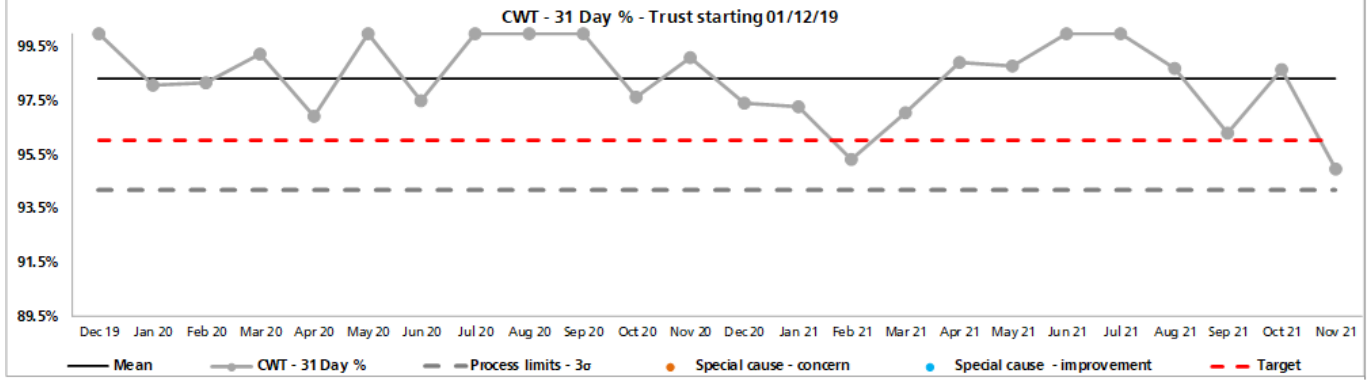


Chart 34 – Cancer Wait Times: 31 day diagnosis to treatment

Performance Summary

- Performance in November was 94.95% against the national standard of 96%. The drop in performance was due to a number of patients who cancelled their scheduled treatment in the month. Due to the low numbers of patients on this pathway, the tolerance of 4% was exceeded by the number of cancellations. The standard will be achieved in December 2021.

31 day diagnosis to subsequent treatment

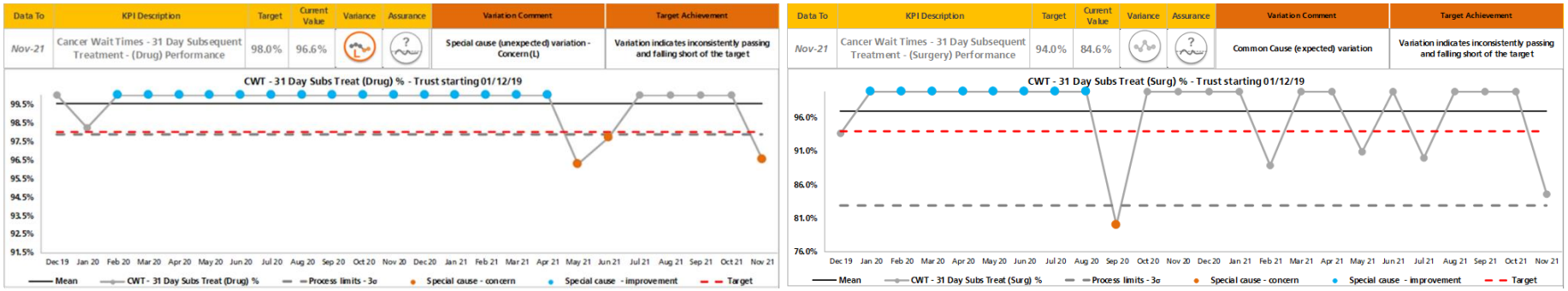


Chart 35 and 36 – 31 day diagnosis to subsequent treatments for drug an Surgery

Performance Summary (Drug)

- Performance in November was 96.55% against the national standard of 98%. One patient breached the target in November due to a cancellation, due to the very low numbers this affected performance. The standard will be achieved in December 2021.

Performance Summary (Surgery)

- Performance in November was 84.62% against the national standard of 94%. 2 of 13 patients cancelled their scheduled treatment in the month which impacted significantly on performance. The performance will recover in December 2021.

62-day referral to treatment

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Nov-21	Cancer Wait Times - 62 Day Ref to Treatmemt Performance	85.0%	76.2%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

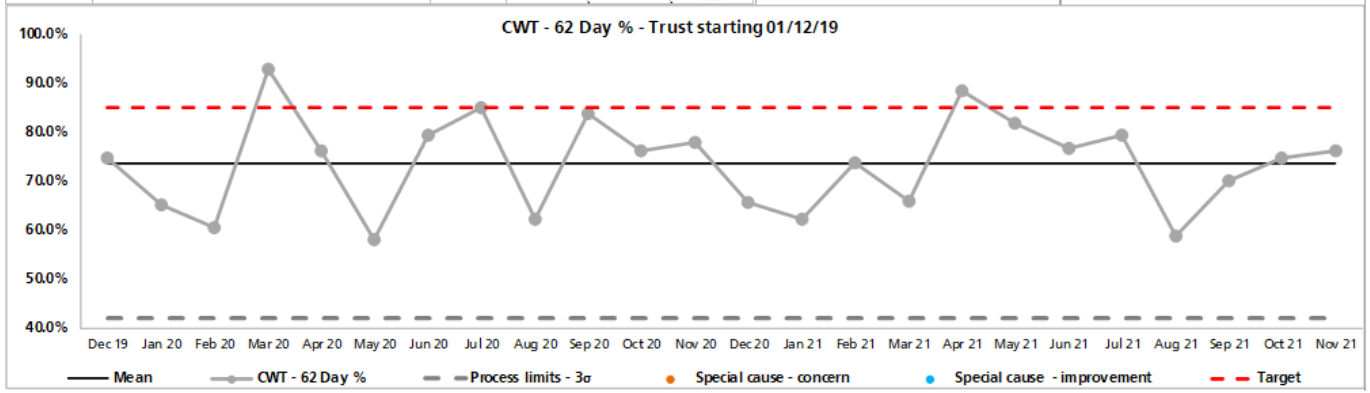


Chart 37 – Cancer Wait Time – 62 Day RTT performance

Performance Summary

- Performance in November 2021 was 76.23% against the standard of 85%. There were 61 treatments of which 14.5 breached the 62-day standard, (0.5 Head and Neck, 8.5 Gynaecology, 2 Colorectal, 1 Lung, 0.5 Other and 2 Upper GI).

Key Issues:

- There has been a sustained increase in two week wait referrals, with consistent conversion rates of patients confirmed as having cancer.
- Waiting Times for CT & MRI scans and reporting are continuing to cause delays in patient pathways.
- Delays in histology reporting from CUH.

Key Actions:

- Cancer funding has been agreed to support the backlog on the Colorectal and Gynaecology pathway. A new clinical fellow is due to be appointed in January 2022 to support Colorectal patients and additional clinics will be undertaken.
- A mobile CT unit is now on site to support the backlog. Additional support will also be in place in the next two months to provide extra capacity for Virtual Colonoscopies
- Ongoing discussions are continuing with CUH regarding histology delays and a formal recovery plan is being completed by the CUH Pathology management team.

62-day referral to treatment screening

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Nov-21	Cancer Wait Times - 62 Day Screening Performance	90.0%	75.7%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

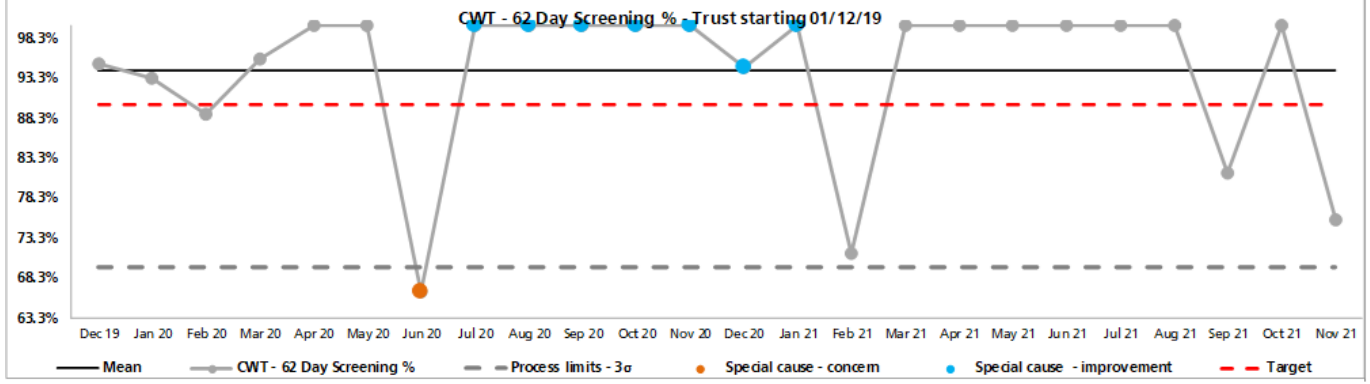


Chart 38 – Cancer Wait Time – 62 Day referral to treatment screening

Performance Summary

- Performance in October was 75.66% against the national standard of 90%. There were 4.5 breaches from a total of 18.5 patients. It is forecast that performance will recover in December 2021.

Patients waiting for 104+ days

The significant increase in referrals in the first 6 months of the year has resulted in an increase in the number of patients on a cancer pathway ≥104 days, with a continued increase through Quarter 3. Additional funding from the Cancer Alliance has been secured to provide support to the most challenged areas in the service to help reduce the backlog of patients waiting over 104 days on the pathway. Additional clinical and administrative posts are due to be appointed in January 2022.

At the end of November 2021, 42 patients were on a cancer pathway waiting over 104 days.

Of the 42 patients waiting, 25 were colorectal, 15 were gynaecology, 1 was skin and 1 was Upper GI.

31 of which have now been treated or removed from the pathway, 1 is booked for treatment, 3 are awaiting a treatment date, 2 are awaiting a diagnostic test or Histology results.

Diagnostic Waiting Times

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Dec-21	Diagnostic Wait Times - % of over 6 Week Waiters	1.0%	67.7%	H	F	Special cause (unexpected) variation - Concern (H)	Variation indicates consistently (F)alling short of the target

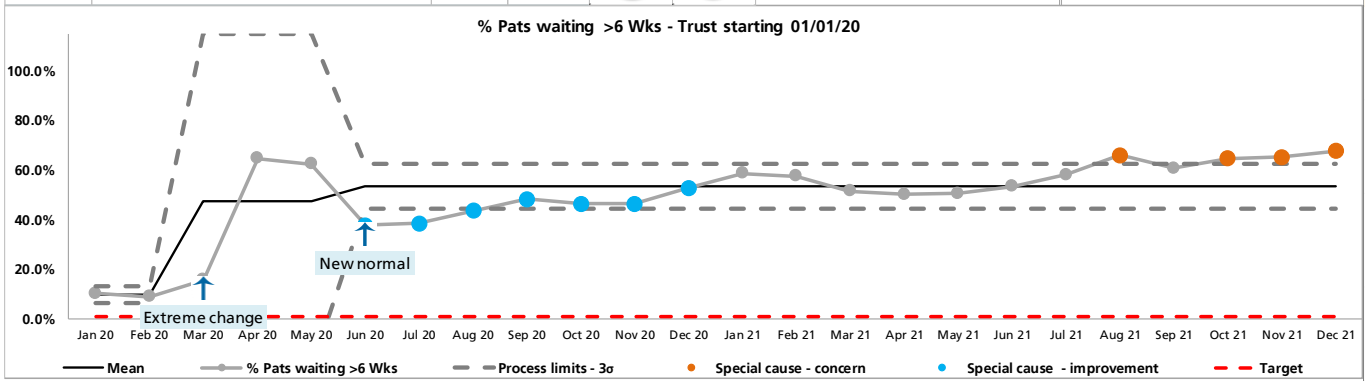


Chart 39 – Percentage of diagnostic waiting times over 6 weeks

In December 2021 performance was 67.7% against a standard of 1%. There were 6,752 patients waiting over 6 weeks for diagnostic tests captured by the DM01 metrics. The majority of patients waiting over 6 weeks are in Non-Obstetric Ultrasound (2,101), MRI (1,589) and CT (1,965). This position is detailed in the table below:

Modality	Total WL Size	>6 weeks	Total Activity	Performance against 1% standard
Magnetic Resonance Imaging	2141	1589	550	74.20%
Computed Tomography	1965	1382	2008	70.30%
Non-obstetric ultrasound	3013	2101	1445	69.70%
Barium Enema	0	0	0	N/A
DEXA Scan	167	81	96	48.50%
Audiology - Audiology Assessments	193	0	242	0%
Cardiology - echocardiography	1411	1099	389	77.90%
Cardiology - electrophysiology	0	0	0	N/A
Neurophysiology - peripheral neurophysiology	532	346	124	65.00%
Respiratory physiology - sleep studies	0	0	0	N/A
Urodynamics - pressures & flows	79	60	35	76.00%
Colonoscopy	160	8	225	5%
Flexi sigmoidoscopy	40	4	61	10%
Cystoscopy	143	67	147	46.80%
Gastroscopy	130	15	192	11.50%
Total	**9974**	**6752**	**5514**	**67.70%**

Key Issues:

- Impact of unplanned staff absence, sickness, and isolation (Covid-19) in CT, MRI and Non-obstetric Ultrasound and Endoscopy.
- Reliance on locum staff in CT, MRI, Neurophysiology, non-obstetric ultrasound, and Echocardiogram with a perceptible impact due to leave over the bank holiday periods.
- Single substantive neurophysiology technician retired with effect from 31 December 2021.

Key Actions:

- Outsourcing confirmed for CT commencing 7th January 2022, and planned for non-obstetric ultrasound, MRI, and Echocardiogram.
- Optimised utilisation of Endoscopy sessions at QEH and NCH through funding.
- Outsourcing and mutual aid being explored for Neurophysiology.

Recovery Forecast:

- The DM01 standard is not expected to be achieved during 2021/22; trajectories for improvement are in place. The business planning underway for 2022/23 will encompass DM01 recovery and development of associated remedial action plans.

Key Risks to Forecast Improvement:

- Vacancy factor across all diagnostic services and reliance on locum staff.
- Scale and pace of patient uptake for outsourced diagnostic services provided externally to QEH.
- Lack of availability of skilled workforce for recruitment, locum, or outsourcing.
- Increased demand due to surge or cancer.

Stroke

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	Stroke - 90% of time on a Stroke Unit	90.0%	63.8%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

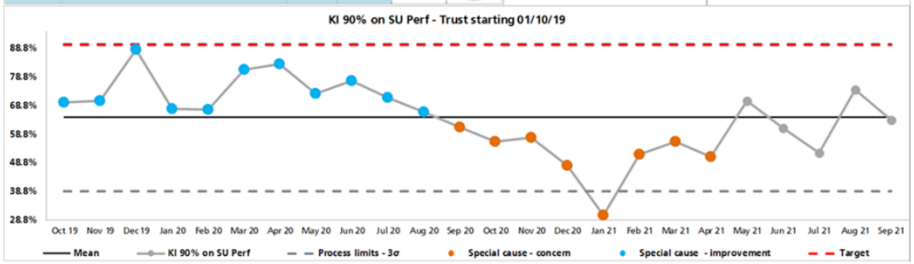


Chart 39 – Stroke: 90% of time on a stroke unit

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	Stroke - Direct to Stroke Unit within 4 hours	90.0%	34.0%	L	F	Special cause (unexpected) variation - Concern (L)	Variation indicates consistently (F)alling short of the target

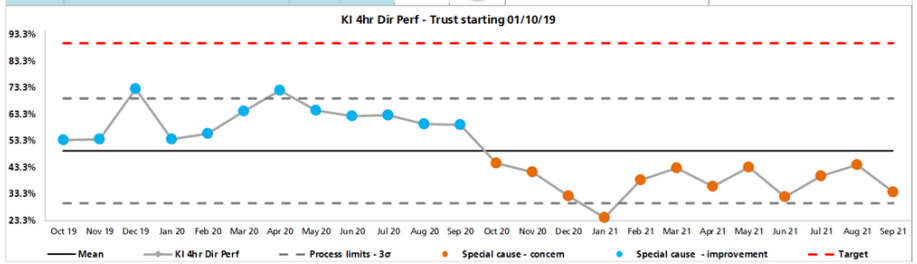


Chart 40 – Stroke: Direct to stroke unit within 4 hours of admission

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	Stroke - Patient scanned within 1 hour of clock start	48.0%	33.3%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

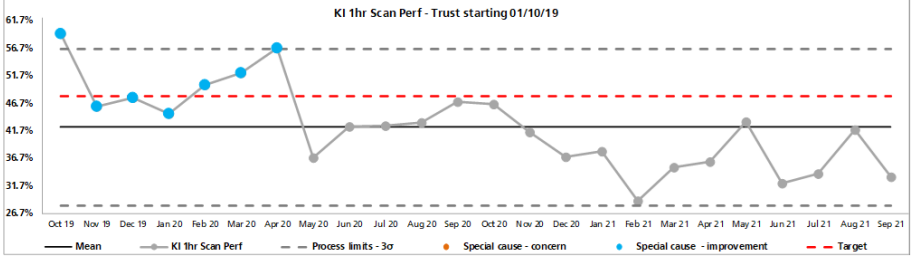


Chart 41 – Stroke: Patient scanned within 1 hour

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Sep-21	Stroke - Patient scanned within 12 hours of clock start	95.0%	93.8%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

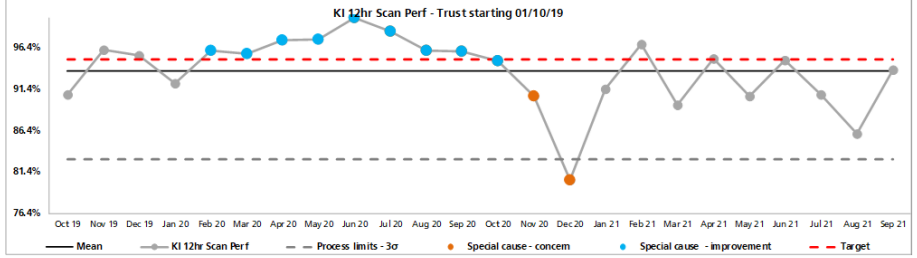


Chart 42 – Stroke: Patient scanned within 12 hours

Recovery Forecast:

- Pre-Covid performance typically indicated performance of a "D" for this metric, indicating a structural gap in capacity versus demand. Proposals for increased capacity will be captured in the business planning round for 2022-23.
- With the current level of admission demand, ongoing challenges in discharging patients to P1, P2 and P3 destinations and bed pressures across the Trust limiting timely transfer out of the ward to create stroke capacity, there remains a significant risk that Stroke performance across the two main domains will remain at an "E".

Key Risks to Forecast Improvement:

- Adherence to the new Stroke Admissions SOP.
- Stroke admission activity continues to be over plan
- The capacity of health and social care partners to facilitate timely discharges for patients on discharge to assess pathways 1, 2 and 3.
- COVID impact resulting in stroke patients not being admitted or staying on the ward.
- Unable to transfer patients out of the Stroke Unit to another ward to facilitate new discharge.

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	19,014	18,120	(894)	(5%)	172,378	172,589	211	0%
Elective Recovery Fund Plus (ERF Plus)	622	(1,621)	(2,243)	100%	1,867	1,799	(68)	100%
Other Income	1,245	1,414	169	14%	12,186	12,088	(98)	(1%)
Notional Income	0	4,967	4,967	100%	0	5,294	5,294	100%
COVID-19 Additional Income	1,302	1,441	139	11%	11,598	12,836	1,238	11%
Total Income	**22,183**	**24,321**	**2,138**	**10%**	**198,029**	**204,606**	**6,577**	**3%**
Pay Costs - Substantive	(13,382)	(12,559)	823	6%	(111,935)	(114,085)	(2,150)	(2%)
Pay Costs - (ERF Plus)	0	2,566	2,566	(100%)	0	(1,242)	(1,242)	(100%)
Pay Costs - Bank	(541)	(1,053)	(512)	(95%)	(9,029)	(9,509)	(480)	(5%)
Pay Costs - Agency	(1,036)	(970)	66	6%	(11,285)	(8,748)	2,537	22%
Pay Costs - Additional COVID-19	(595)	(432)	163	27%	(5,862)	(5,648)	214	4%
Pay Costs - Vaccination Centres	0	(176)	(176)	(100%)	0	(1,163)	(1,163)	
Total Pay	(15,554)	(12,624)	2,930	19%	(138,111)	(140,395)	(2,284)	(2%)
Non Pay - Additional COVID-19	(40)	(29)	11	28%	(741)	(392)	349	47%
Non Pay	(5,500)	(5,783)	(283)	(5%)	(48,326)	(51,251)	(2,925)	(6%)
Notional Expenditure	0	(4,967)	(4,967)	(100%)	0	(5,294)	(5,294)	(100%)
Total Operating Costs	**(21,094)**	**(23,403)**	**(2,309)**	**(11%)**	**(187,178)**	**(197,332)**	**(10,154)**	**(5%)**
EBITDA	**1,089**	**918**	**(171)**	**(16%)**	**10,851**	**7,274**	**(3,577)**	**(33%)**
Non-Operating Costs	(1,033)	(859)	174	17%	(8,747)	(7,366)	1,381	16%
Adjust Donated Assets	34	33	(1)	(3%)	274	271	(3)	(1%)
TOTAL (Deficit) / Surplus	**90**	**92**	**2**	**2%**	**2,378**	**179**	**(2,199)**	**(92%)**
Agency : Total Pay	6.9%	8.1%			8.5%	6.5%		
EBITDA : Income	4.9%	3.8%			5.5%	3.6%		
Net Deficit : Income	0.4%	0.4%			1.2%	0.1%		

I&E

Ratios

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

- As at the end of December (M9) 2021, the Trust's in month financial position is showing a surplus of £92k, year to date the surplus is £179k.

- Key points of note in month / Material variances:
  - The Trust was responding within the NHS national Level 4 incident during December 2021. As a direct result of the urgent and emergency care pressures the Trust, alongside the ICS, has not recognised any ERF within the month.
  - In accordance with Audit recommendations, notional income and expenditure has been included for the cost of pensions.
  - A review of existing provisions has been under-taken and a total of £255k has been released into the month 9 position. These are all in non-pay.
  - 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.
  - Year to date the adverse variance is £2,199k. The plan submitted includes a deficit expectation of £2.4m in Q4. As the forecast is to break even, the adverse variance will reduce as we move through Q4.

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

	31-Mar-21 £m	30-Nov-21 £m	31-Dec-21 £m	Month on Month Movement £m	YTD Movement £m
Non current assets	101	104	109	5	8
Current Assets					
Inventories	2	2	2	-	-
Trade & Other Receivables	13	15	10	(5)	(3)
Cash	27	35	33	(2)	6
Current liabilities					
Trade & Other Payables	(19)	(19)	(19)	0	1
Accruals	(18)	(13)	(11)	2	7
PDC dividend	-	-	(1)	(1)	(1)
Other current liabilities	(2)	(3)	(2)	1	-
Non current liabilities	(1)	(1)	(1)	-	-
Borrowings	-	-		-	-
Total assets employed	**103**	**120**	**120**	**0**	**17**
Tax payers' equity					
Public Dividend Capital	198	212	212	-	14
Revaluation Reserve	9	9	9	-	-
Income & Expenditure Reserve	(104)	(101)	(101)	-	3
Tax payers' equity	**103**	**120**	**120**	**-**	**17**

Executive Summary – Balance Sheet Position

Key points of note in month / Material variances:

- Non-current assets have increased by £5m during December 2021, principally due to capital expenditure on various key projects during the month.
- Trade and other receivable have decreased due to significant cash collections from other NHS bodies during December and a reduction in anticipated ERF income against last month.
- Cash balances have decreased by £2m due to scheduled payments for on-going capital projects.

Well Led (People) Dashboard

Data To	KPI Description	Target	Current Value	Variance	Assurance
Dec-21	Appraisal Rate	90.0%	72.2%		
Dec-21	Appraisal Rate (Med Staff exc Jnr Drs)	90.0%	93.0%		
Dec-21	Sickness Absence Rate	4.50%	7.33%		
Dec-21	Long Term Sick	2.7%	3.8%		
Dec-21	Short Term Sick	1.8%	3.6%		
Dec-21	Mandatory Training Rate	80.0%	79.0%		
Dec-21	Turnover Rate	10.0%	12.4%		

Appraisal Rate

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Dec-21	Appraisal Rate	90.0%	72.2%	L	F	Special cause (unexpected) variation - Concern (L)	Variation indicates consistently (F)alling short of the target

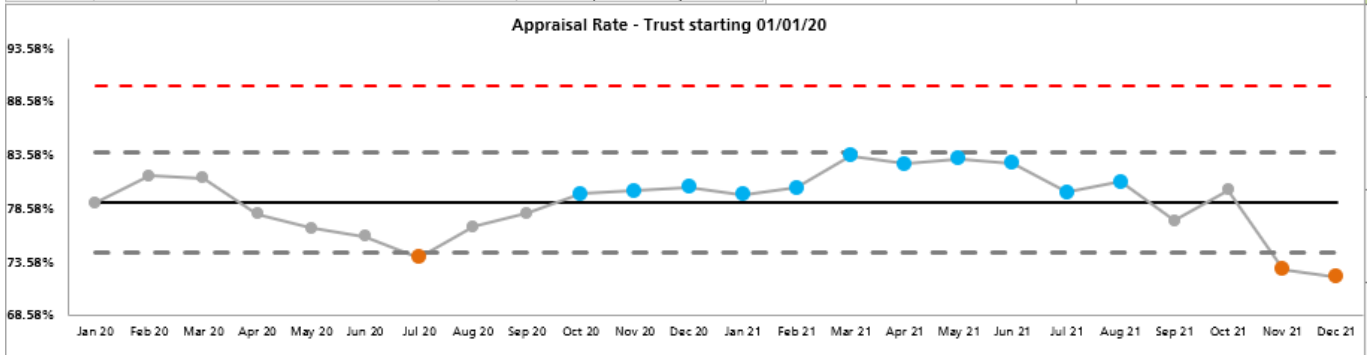


Chart 43 – Appraisal Rate

- Full capacity protocols continue to delay appraisals, relatively steady performance over the Christmas Period .
- A summary of outstanding appraisals is being circulated to all Divisional and Executive leads.

Sickness Absence rate

Data To	KPI Description	Target	Current Value	Variance	Assurance
Dec-21	Sickness Absence Rate	4.50%	7.33%		

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

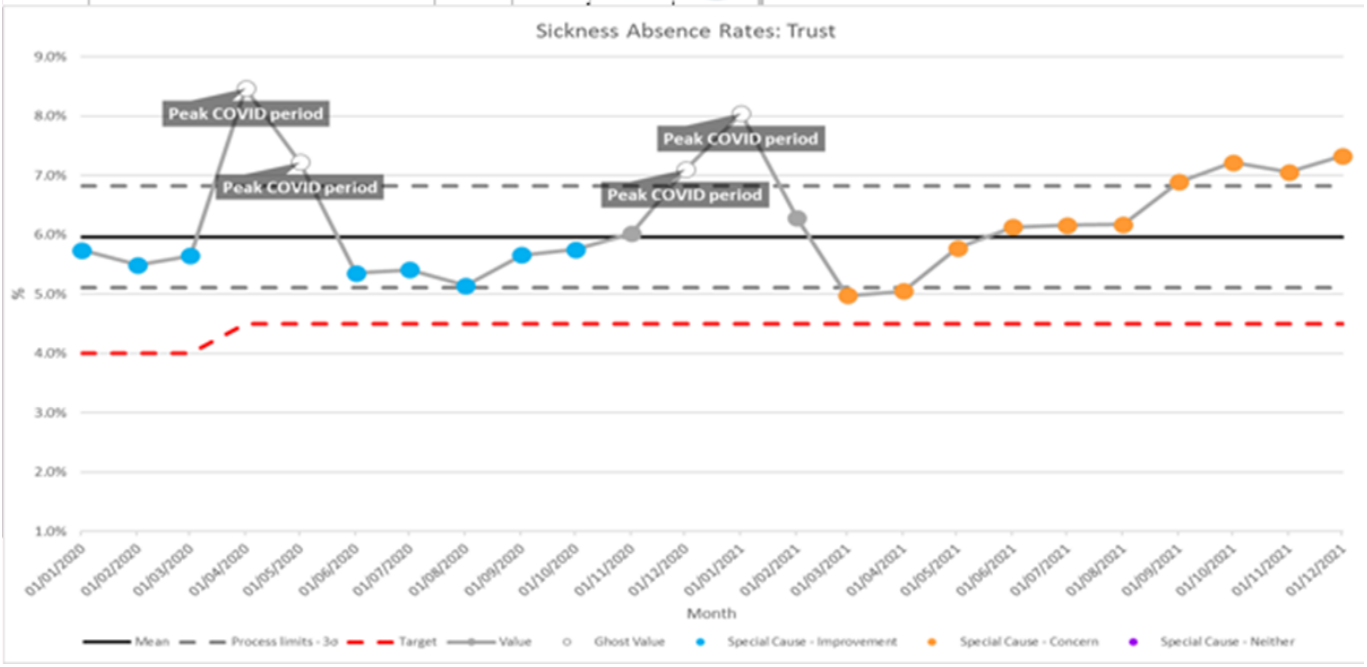


Chart 44 – Sickness Absence Rate

- There has been a significant improvement in Women & Children.
- Facilities Management remains an area of concern.
- New short term Cavell & Lind solution 24th Jan.
- Additional Matron support for Covid sickness line.
- Call to Action Incentive.
- New Staff Welfare Calls day 3 and 21.
- ER Specialist commenced 17 Jan and will focus on outstanding long term sickness cases.
- New daily sickness tracking (headcount + bank + maternity) used as an indicator in daily ICT.

Labour Turnover

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Dec-21	Turnover Rate	10.0%	12.4%	H	?	Special cause (unexpected) variation - Concern (H)	Variation indicates inconsistently passing and falling short of the target

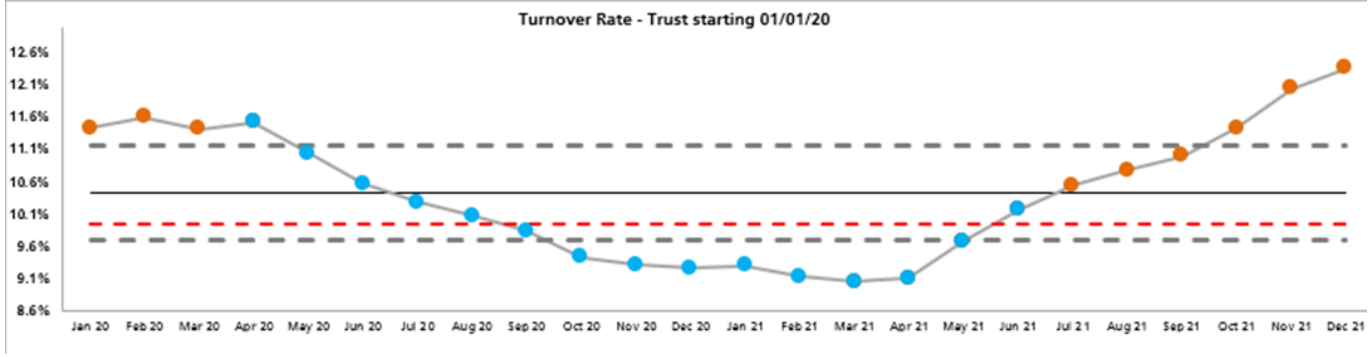


Chart 45 – Turnover Rate

- Continues to increase month on month – In December there were 52 leavers
- Over the past 12 months (594 leavers):
    - 111 (18.7%) relocation to partner/family members/UK & abroad.
    - 119 (20%) end of contract.
        - 50% of which were completion of training scheme.
        - 46% of which were end of FTC.
    - 72 (12%) retirement.
    - 27 (4.5%) HR exit.