The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Meeting:	Board of Directors (in Public)		
Meeting Date:	6 July 2021	**Agenda item:**	11
Report Title:	Integrated Performance Report (IPR) – May 2021 data		
Author:	Carly West-Burnham, Director of Strategy		
Executive Sponsor:	Caroline Shaw, 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, so encompasses elements of 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 9 approved significant risks open across the Trust which align to the Strategic Objectives and are monitored through the appropriate Committees.	
	Y/N	If Yes state impact/ implications and mitigation
Quality	Y	As monitored through the Committees
Legal and regulatory	Y	As monitored through the Committees
Financial	Y	As monitored through the Committees

Assurance route

Previously considered by:	Quality Committee People Committee Senior Leadership Team

Executive summary

Action required:	Approval	Information	**Discussion**	Assurance	Review

Purpose of the report:	The Trust is required to provide assurance that its approach to performance management is rigorous and appropriately identifies, escalates and deals with areas of performance which are of concern in a timely manner. Focusing on the data using Statistical Process Control enables greater visibility and oversight of areas which require clear focus due 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 doubled in May (six) compared to April (three). **Infection Prevention and Control** This month there have been six cases of C.Diff reported, up from four reported last month. All cases are currently under investigation, two cases are hospital acquired and four are community acquired. There has been one case of hospital onset E.Coli in May 2021 which is under review. The number of MSSA cases identified in May 2021 was three which was an increase on the two reported in April 2021. **Screening** VTE risk assessment remains stable and has been above the agreed performance threshold for a year. As the VTE screening process has become business as usual, the focus is now on ensuring that patients deemed to be at risk of VTE are appropriately cared for in the hospital. **Mortality** The SHMI has reduced slightly from 106 to 105.5 (latest data to December 2020) but remains within the "expected band". The HSMR has risen further to 142.21. This is above expected and rising which is a source of considerable concern. A backlog in coding has also increased meaning that that data available for Dr Foster to conduct their analyses is incomplete. Dr Foster will recalculate the HSMR baseline monthly as the backlog of coding is completed and updates submitted to them. **Mixed Sex Accommodation Breaches** There have been five incidents of same sex accommodation breaches in month affecting twenty patients. Three of these incidents were in the Hyper acute Stroke Unit affecting seven patients with the other two incidents occurring on the Surgical Assessment Unit affecting thirteen patients.

	Emergency Care 4-hour performance in May fell to 77.5% from 82.1% in April, below the standard of 95%. In May, admitted performance remained low at 56.9% whereas non-admitted performance was significantly higher at 89.9%. Although 4-hour performance fell, there were no patients waiting in the Emergency Department over 12 hours from decision to admit to admission, which was a reduction from three patients in April. In May 52.1% of all ambulance handovers took place within 15 minutes, a reduction from 58.5% in April. The average handover time was 26 minutes during May, and 9.6% of handovers exceeded 60 minutes, which is an increase from 4.5% in April. **Referral to Treatment** 18-week performance improved to 64.7% in May from 62.0% in April despite constraints caused by Day Surgery remaining closed until 14 May, the prioritisation of P2 cases in line with national guidance and increased levels of cancer referrals. The Trust is not expecting to recover to the national 92% standard this financial year and continues to work on recovery plans. As routine elective activity across the Trust continues to be restored, the number of patients waiting in excess of 52 weeks for treatment fell. In May the Trust had 1,142 patients waiting over 52 weeks, a 6% reduction from 1,257 patients breaching the maximum 52-week waiting time standard at the end of April 2021. This reduction is not expected to continue as the acceptance of routine referrals recommenced on 26 May 2020. The Trust does not anticipate clearing the 52 week backlog this financial year. Diagnostic performance remained stable at 50.6% of patients in May 2021 waiting for longer than 6 weeks for a diagnostic. The majority of those patients waiting over 6 weeks are waiting for either an Echocardiogram (1,192 patients), CT scan (990) or an MRI scan (874). Actions being taken to improve this position include sourcing some additional part-time CT resource using a mobile van and continuing efforts to return echocardiography back to pre COVID-19 levels during July. Cancer 62-day performance in April 2021 rose to 88.6% from 65.8% in March 2021. Despite this positive improvement, the service faces staff shortages within the Gynaecology team whilst at the same time experiencing rising referral demand. Long waiting times for CT & MRI scans is also causing delays in patient pathways.

	Finance The Trust's month 2 financial position is showing a surplus of £18k against the planned deficit of £721k. In addition, the Trust has achieved its CIP plan for month 2 delivering savings of £734k. **Well Led (People)** An establishment review is underway for all staff groups to align financial and workforce plans, including all staff in post, vacancies and funded establishments. At the end of May, sickness absence has increased to 5.8%. A review of all long-term sickness cases is under way with a revised plan for return to work or appropriate actions to be taken with support from Occupational Health. All shielding staff have returned to work. Appraisal rates have improved to 83.2% and the Mandatory Training rate has increased to 83.3%. Recovery plans and trajectories are in place.
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

May 2021 data

Executive Summaries

Safe

Incidents

There were six new serious incidents reported to the Strategic Executive Information System (STEIS) in May 2021, up from three reported in April 2021.

There has been an increase in the number of reported injurious inpatient falls per 1,000 beddays. The Falls Coordinator continues to deliver teaching to staff, paying particular attention to areas with high incidents of falls. A train the trainer session held on 18 May had 45 staff attend. A new Falls Operational Group will be established to monitor and make improvements.

The number of hospital acquired pressure ulcers per 1,000 beddays remains low and has been within tolerance levels for four consecutive months. The Tissue Viability team continue to work closely with ward staff to deliver and support training in pressure ulcer prevention. This aims to support the '100 days free campaign' which commenced in May 2021 – an initiative that set every ward and clinical department the target of achieving 100 days without a patient developing a pressure ulcer.

Infection Prevention and Control

There have been six cases of hospital associated C.Diff identified in May 2021, up from four reported in April 2021. All cases are currently under investigation, two cases are hospital acquired and four are community acquired. Causes are being identified, and remedial actions are planned to reduce the likelihood of reoccurrence. There have been three cases of hospital onset E.Coli in May 2021 which are under review. The number of MSSA cases identified in May 2021 was three, up from the two reported in April 2021. The Infection Prevention and Control Team continue to raise awareness of appropriate management of both E.Coli and MSSA with staff in line with Trust policy.

Screening

VTE risk assessment remains stable and has been above the agreed threshold for a year since the implementation of changes. The local reinforcement of practices along with regular audits on compliance are in place. As VTE screening process has become business as usual, the focus is now on ensuring that patients deemed to be at risk of VTE are appropriately cared for in the hospital.

Effective

Mortality

The SHMI has reduced slightly from 106 to 105.5 (latest data to December 2020) but remains within the "expected band". The HSMR has risen further to 142.21, this is above expected and rising which is a source of considerable concern. The coding backlog has also increased meaning that that data available for Dr Foster to conduct their analyses is incomplete. Dr Foster will recalculate the HSMR baseline monthly as the backlog of coding is completed and submitted.

In line with the recommendation from the Quality committee, the following cover some of the additional metrics now reported within this domain of the IPR;

Breast Feeding

Current data is within common cause variation, and the targets of 70% initiation and 60% breastfeeding on discharge from hospital are generally met. The recent fall in performance, although not yet significant raises concern and actions are being taken in this area.

Smoking Cessation in Pregnancy

The smoking cessation midwife resigned at the start of the year and efforts to recruit have not been successful, this may have contributed to the fall in cessation rates. Funding for the midwife has been converted to a Public Health Lead post to support quality improvement programmes. This new post has not been recruited to and is expected to help address smoking rates to help with smoking cessation in pregnancy.

Post-Partum Haemorrhage Rates
PPH rates have been consistent and generally below the upper threshold at QEH over the last 2 years. The Trust will contiue to monitor this for any concerns, variation and learning.

Caring

Mixed Sex Accommodation Breaches
There have been five incidents of same sex accommodation breaches affecting twenty patients. Three of these incidents were in the Hyper acute Stroke Unit affecting seven patients with the other two incidents occurring on the Surgical Assessment Unit that affected 13 patients.

Dementia Screening
The Dementia Screening rate for April 2021 was 98.2%, exceeding the agreed threshold of 90% for the second consecutive month. A step change was achieved in May 2021 after multiple changes were implemented which have led to a cultural shift around dementia screening. However, the key enabler to meeting this target has been the introduction of Cognitive Impairment Assessors (CIAs) as part of the Integrated Care of Older People team in March 2021.

Responsive

Emergency Care
4-hour performance in May fell to 77.5% from 82.1% in April, below the standard of 95%. In May, admitted performance remained low at 56.9% whereas non-admitted performance was significantly higher at 89.9%. Although 4-hour performance fell, there were no patients waiting in the Emergency Department over 12 hours from decision to admit to admission, a reduction from 3 patients in April.

In May 52.1% of all handovers took place within 15 minutes, a reduction from 58.5% in April. The average handover time was 26 minutes during May, and 9.6% of handovers exceeded 60 minutes, an increase from 4.5% in April.

The Urgent and Emergency Care Improvement programme is working to address delays within ED. The staffing model and estate are being reviewed to support more efficient decision making to address delays for patients waiting to be seen by a clinician.

Referral to Treatment
18-week performance improved to 64.7% in May from 62.0% in April despite constraints caused by Day Surgery remaining closed until 14 May, the prioritisation of P2 cases in line with national guidance and increased levels of cancer referrals. The Trust is not expecting to recover to the national 92% standard this financial year and continues to work on recovery plans.

As routine elective activity across the Trust continues to be restored, the number of patients waiting in excess of 52 weeks for treatment fell. In May the Trust had 1,142 patients waiting over 52 weeks, a 6% reduction from 1,257 patients breaching the maximum 52-week waiting time standard at the end of April 2021. This reduction is not expected to continue as the acceptance of routine referrals recommenced on 26 May 2020. The Trust does not anticipate clearing the 52 week backlog this financial year.

Diagnostic performance remained stable at 50.6% of patients in May 2021 waiting for longer than 6 weeks for a diagnostic. The majority of those waiting over 6 weeks are waiting for either an Echocardiogram (1,192 patients), CT scan (990) or an MRI scan (874). Actions being taken to improve this position include sourcing some additional part-time CT resource using a mobile van and continuing efforts to return echocardiography back to pre COVID-19 levels during July.

Cancer 62-day performance in April 2021 rose to 88.6% from 65.8% in March 2021. Despite this positive improvement, the service faces staff shortages within the Gynaecology team whilst at the same time experiencing rising referral demand. Long waiting times for CT & MRI scans are also causing delays in patient pathways.

Well Led (Finance)

The Trust's month 2 financial position is showing a surplus of £18k against the planned deficit of £721k.

Additionally, the Trust has achieved its CIP plan for month 2 delivering savings of £734k.

Well Led (People)

An establishment review is underway for all staff groups to align financial and workforce plans, including staff in post, vacancies and funded establishments. This includes a medical establishment review across the Trust for all specialities, including a review of all Junior Doctor rotas.

97% of job plans for 2020/21 have been completed.

Sickness absence has increased to 5.8% this month. A review of all long-term sickness cases is being undertaken with a revised plan for return to work or appropriate actions to be taken.

All staff who have been shielding have returned to work. 90.2 % of staff have had their 1st Vaccination and 85.7% of staff have had their 2nd vaccination.

Work continues across the ICS to align bank and agency rates. There has been a reduction in bank and agency spend this month in part due to a new VSP process for non-medical staff which has been implemented. The process for authorisation, visibility and sign off for bank and agency staff is under review.

A Head of Equality, Diversity and Inclusion has been appointed and will review the relevant data sets, recording, presentation and available information when they commence in post

A note on SPC Charts

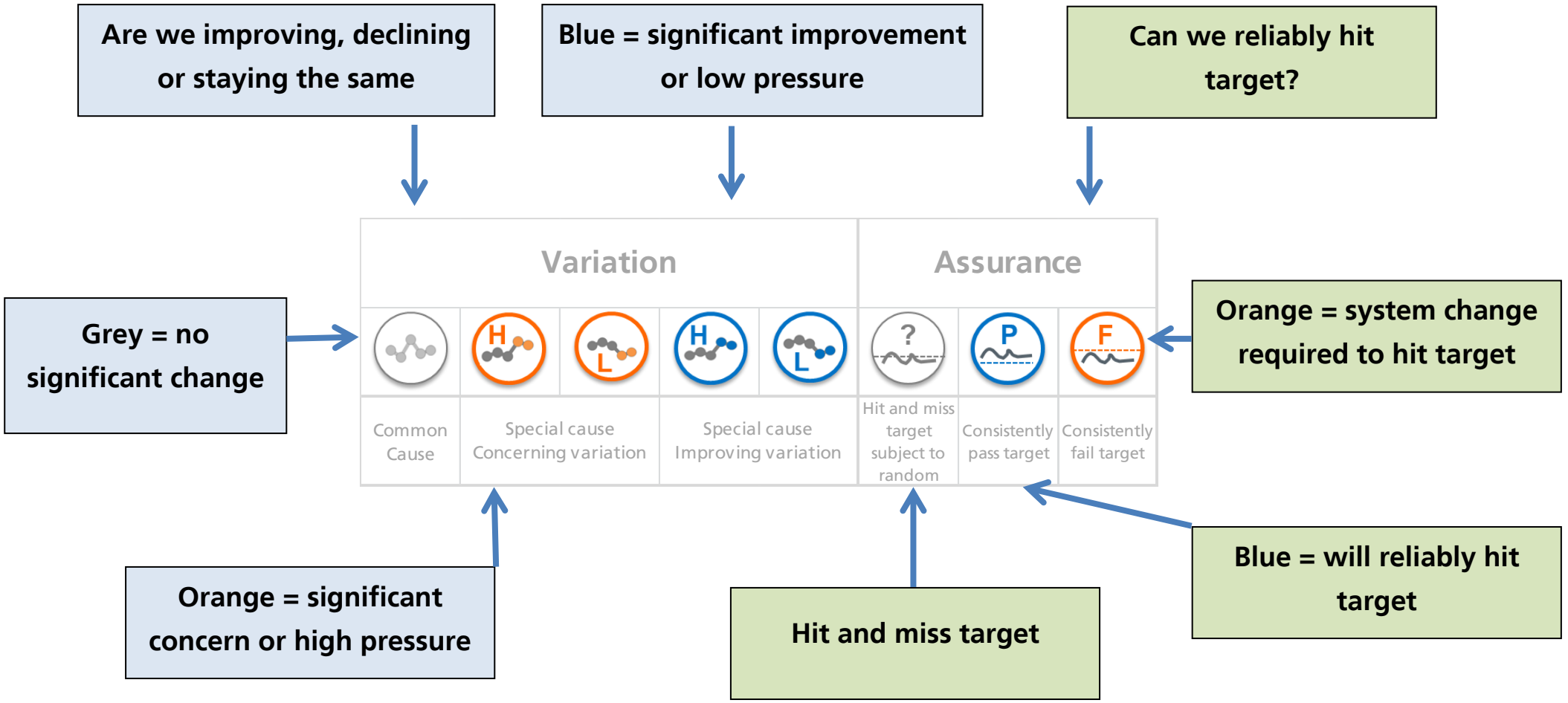
The report that follows uses the key below. A recap of using these descriptions is also included below

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

Items in blue are awaiting the latest update.

Data To	KPI Description	Limit	Current Value	Variance	Assurance
May-21	Serious Incidents (DECLARED IN MONTH)	0	6		
May-21	Falls (with Harm) Rate per 1000 beddays	0.98	0.30		P
May-21	PUs Rate per 1000 beddays	0.41	0.22		?

Data To	KPI Description	Target	Current Value	Variance	Assurance
May-21	Overall Fill Rate %	80.0%	94.0%		P
May-21	CHPPD	8.00	8.38		?
May-21	Cleanliness - Very High Risk	95.0%	97.3%		?
May-21	Cleanliness - High Risk	95.0%	96.7%		?
May-21	Cleanliness - Significant Risk	95.0%	95.5%		?
May-21	Cleanliness - Low Risk	95.0%	No Audit Req'd		
May-21	Cleanliness - No. of audits complete	37.00	36		?

Data To	KPI Description	Limit	Current Value	Variance	Assurance
May-21	CDiff (Hosp Onset) Rate per 100k beddays	30.10	35.89	H	?
May-21	CDiff (Hosp Onset) Actual	4	6		
May-21	MRSA (Hosp Onset) Actual	0	0		
May-21	E Coli (Hosp Onset) Rate per 100k beddays	16.40	18.28	H	P
May-21	E Coli (Hosp Onset) Actual	2	3		
May-21	MSSA (Hosp Onset) Actual		3		
May-21	MSSA (Hosp Onset) Rate per 100k beddays		11.51	H	

Data To	KPI Description	Target	Current Value	Variance	Assurance
Apr-21	VTE Assessment Completeness	97.2%	98.4%	H	?
May-21	Patient Safety Alerts not completed by deadline	0	1		

Serious Incidents

6 Serious Incidents were reported in May:

- Two were an where a patient fell resulting in head injury that was originally reported as a 'moderate' incident, but upgraded to an SI when the level of harm was identified in May 2021 following an investigation.

- Two were A&E admission 12 Hour Breaches with the patient requiring a mental health care bed.

- One was a patient diagnosed with PE and Clexane was not prescribed or administered.

- One was a patient who fell resulting in # right NOF

Falls

Data To	KPI Description	Limit	Current Value	Variance	Assurance	*Variation Comment*	*Target Achievement*
May-21	Falls (with Harm) Rate per 1000 beddays	0.98	0.30		P	Common Cause (expected) variation	Variation indicates consistently (P)assing the target

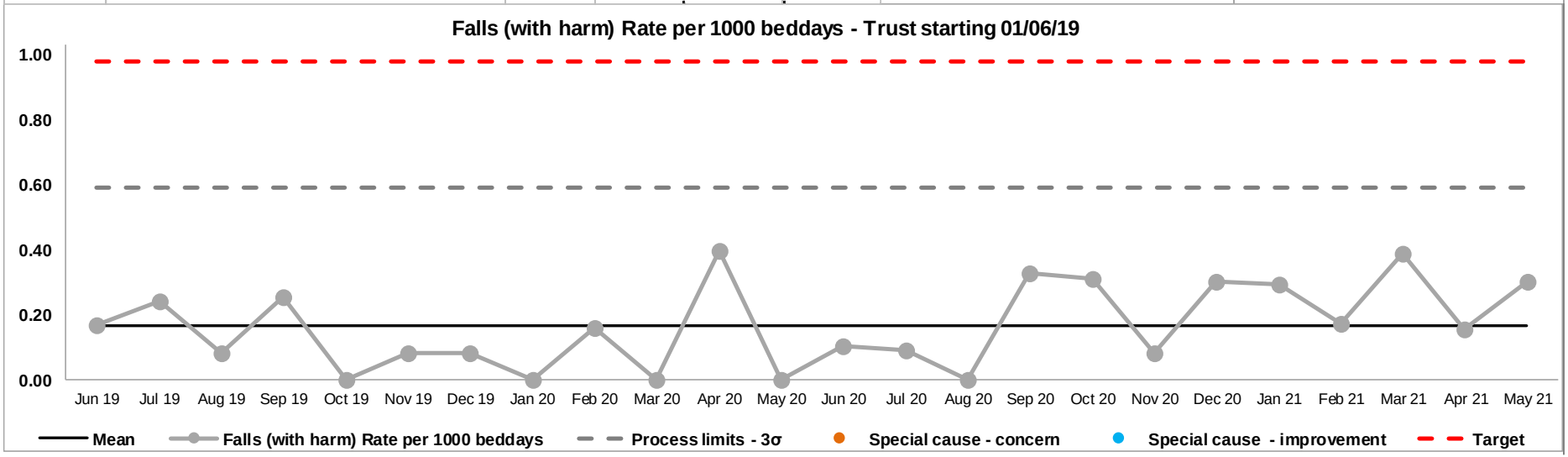


Chart 1 – Falls (with harm) rate per 1000 beddays

Key Issues (any new issues in red):

1. There has been an increase in the number of patients sustaining harm and injuries following fall incidents.
2. The falls rate per 1000 bed days for falls resulting in harm during May 2021 has increased to 0.30 from 0.16 during April 2021.

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. 45 staff attended the train the trainer session on enhanced care on 18 May 2021.

4. The Falls Operational Group will be established to introduce initiatives and implement actions to reduce the number of inpatient falls.

Recovery Forecast:

1. Although the number of patient injuries following fall incidents is still within Trust target, it has been increasingly high for the previous nine months.

Key Risks to Forecast Improvement:

1. Increasing number of patients admitted with high risk of falls and staff not adhering to falls policy.

Pressure Ulcers

Data To	KPI Description	Limit	Current Value	Variance	Assurance	*Variation Comment*	*Target Achievement*
May-21	PUs Rate per 1000 beddays	0.41	0.22			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

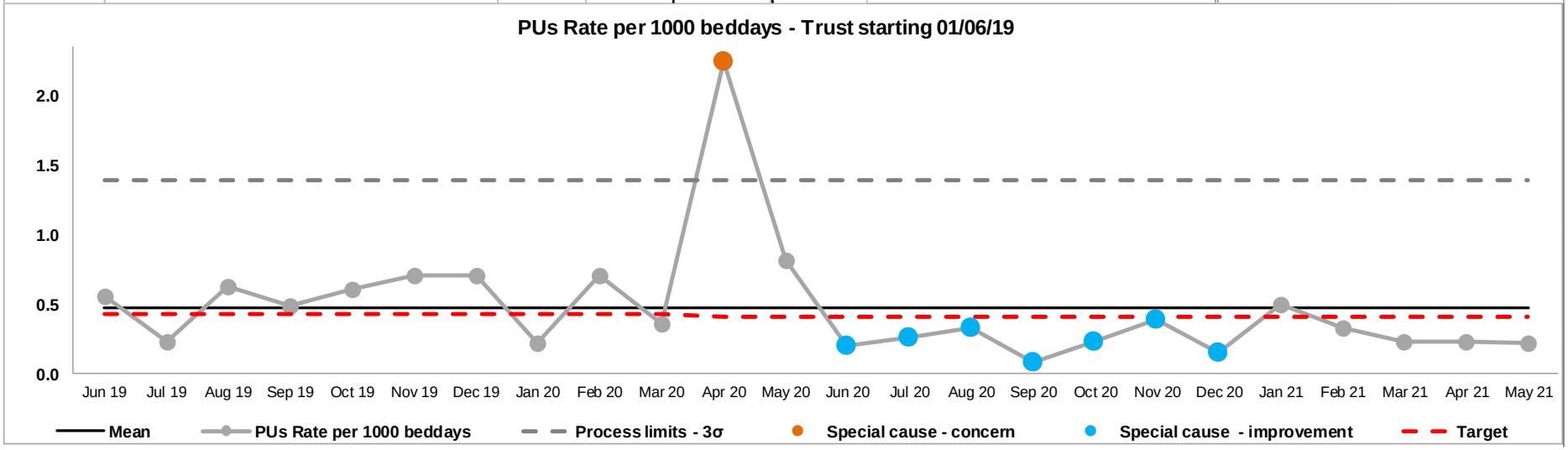


Chart 2 – Pressure Ulcer rates per 1000 beddays

Key Issues (any new issues in red):

1. Inconsistency in achieving the tolerance for hospital acquired pressure ulcer rate per 1000 bed days. The data is a 12-month rolling average.
2. The number of hospital acquired pressure ulcer is within the tolerance level for four consecutive months following a spike in January 2021.

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 delivered four joint educational refresher training sessions with external Clinical Nurse Advisors on moisture associated skin damage during May 2021.

3. 100 days free campaign commenced in May 2021 - the initiative sets every ward and clinical department the target of achieving 100 days without a pressure ulcer.

Recovery Forecast:

1. The number of hospital acquired pressure ulcers will start to reduce as we realign specialties

Key Risks to Forecast Improvement:

1. Non-compliance with the pressure ulcer prevention care bundle.
2. Increasing number of patients admitted to the Trust and who are at high risk of developing a pressure ulcer.

C.Diff (Hospital onset)

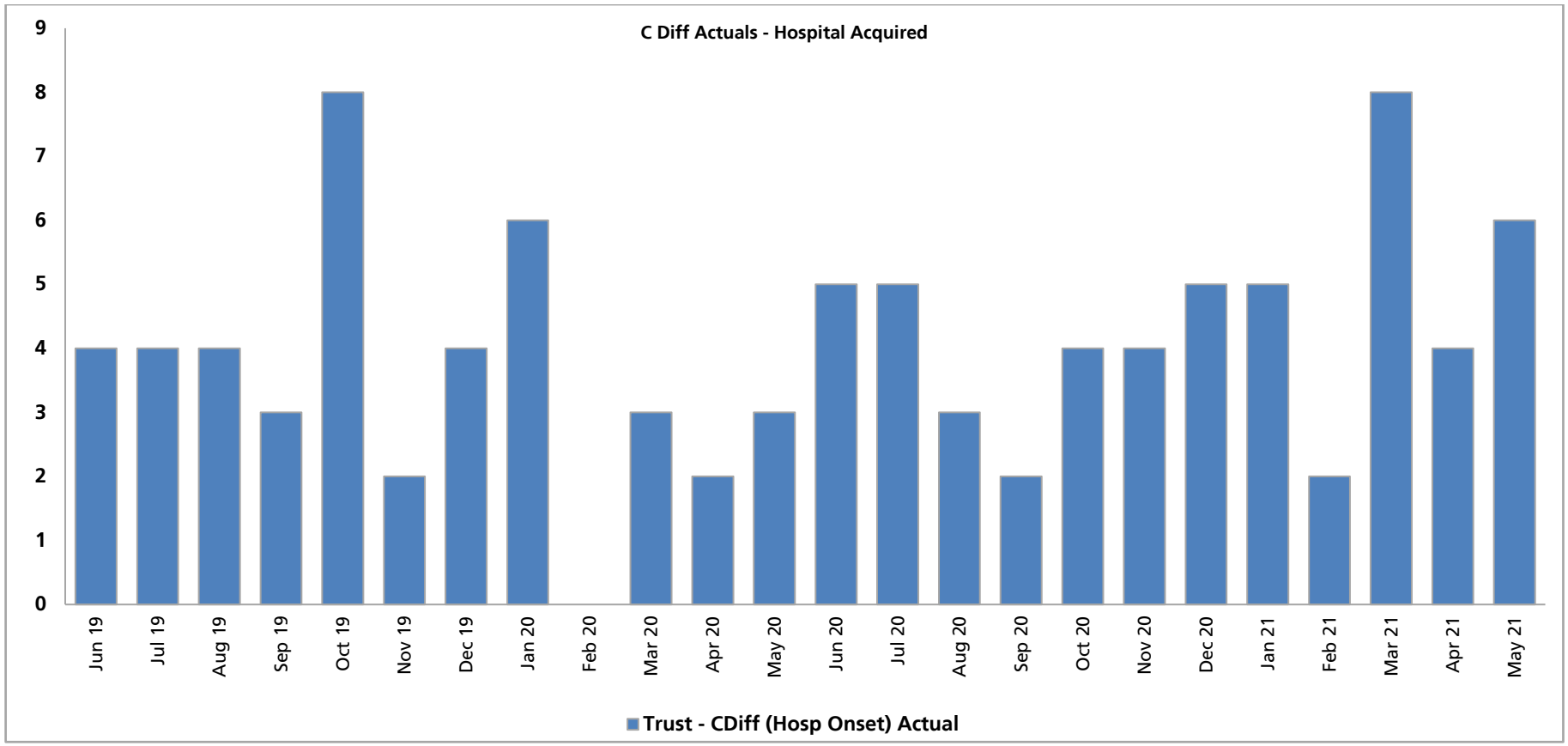


Chart 3 – C.Diff (Hospital onset) per 100k beddays

Clostridioides difficile Infection - CDI (Objective = fewer than 44)

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) .

Nationally, Acute Trusts are waiting to be advised on trajectories set for CDI for 2021/22.

Key Issues:

- Six cases identified in May 2021. All cases are presently under investigation. Two of these cases are HOHA and four are COHA.
- Period of increased incidence (PII), involving 2 cases within a 28-day period, on Marham Ward. Both cases are COHA.
- Completion of the PIR documentation, from nursing and medical staff, has been a challenge over recent months specifically with Consultant input. Without the completion of this paperwork a PIR cannot be undertaken. However, the Deputy Medical Director continues to support required improvement with this process.
- Poor compliance to Anti-biotic management
- Lack of understanding from junior medics regarding START, SMART, FOCUS
- Time delay in sampling of type 5,6,7 stools
- Time delay from loose stool to room isolation
- Embedded culture of "bay isolation" and lack of "enteric precautions" understanding
- Poor utilisation of Clinell Sporicidal wipes

Key Actions:

- Post Infection Reviews undertaken for each case, process supported by Clinical Commissioning Group (CCG) IPC colleagues, and lessons learned shared across the Trust
- Bespoke education / training provided to affected areas
- Education at Induction / Mandatory Training
- Antibiotic stewardship management and engagement (including anti-biotic ward rounds, educational sessions for junior medics, review of anti-biotic guide lines and use of broad spectrum anti-biotics)
- Addressing outbreaks and periods of increased incidence promptly undertaking measure to reduce any further transmission
- Supportive programme of audit including hand hygiene, PPE usage, isolation and environmental cleaning in place

Key Risks to Forecast Improvement:

- Ageing estate compromises bed utilisation – isolation rooms make up less than 10% of the estate
- Reconfiguration of services / pathways as part of COVID-19 exit plan
- Non-compliance to IPC Policies / procedures

- Poor IPC Mandatory training compliance – challenges to access / complete training
- Reduced resources in IPC Team (Registered Nurse establishment / Data analyst)

E.Coli Hospital (Onset)

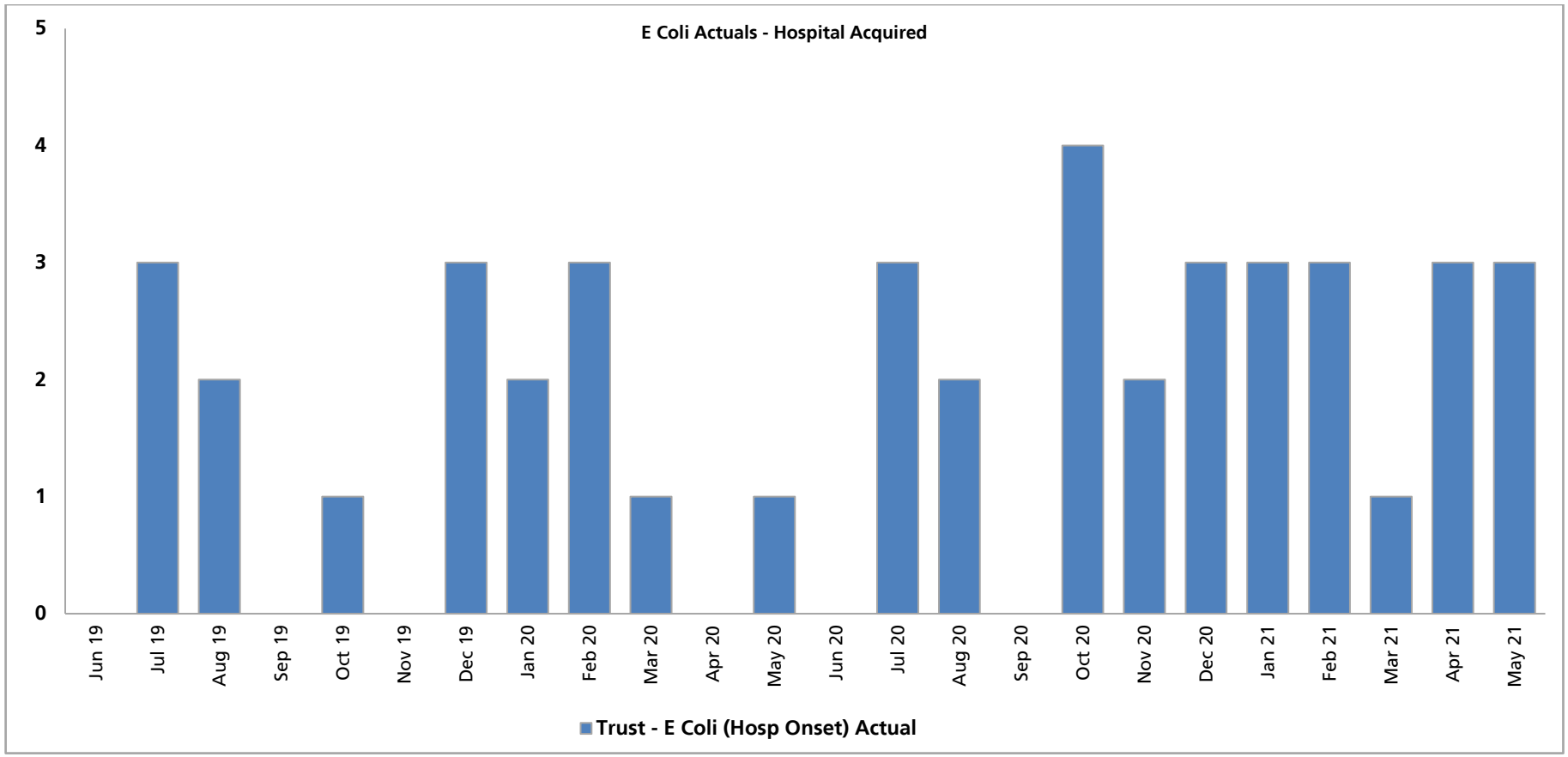


Chart 4 – E.Coli (Hospital onset) rate per 100k beddays

Key Issues

- Three cases of hospital onset E.Coli were reported in May 2021
- Cases presently under review.

Key Actions

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 e.g. ANTT
- Review of individual cases and promptly undertaking measure to reduce any further transmission
- Attendance at the daily Harm Free Care meetings to raise awareness
- Safety Thermometer in place across the Trust to monitor catheter related infections
- Reviewed standards, methods and assurance of cleaning across the Trust
- Domestic staff trained in national cleaning standards
- IPC Team support procurement colleagues to ensure effective and efficient cleaning products are purchased and in in place for use
- 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

Key Risks to Forecast Improvement:

- Compliance with Infection Prevention and Control Policies
- Compliance with IPC Mandatory training – challenges to access / complete training
- Compliance with and management of anti-microbials
- Compliance with nutrition / hydration
- Ageing estate compromises bed utilisation – isolation rooms make up less than 10% of the estate
- Reduced resources in IPC Team (Registered Nurse establishment / Data analyst)

Methicillin Sensitive Staphylococcus (MSSA)

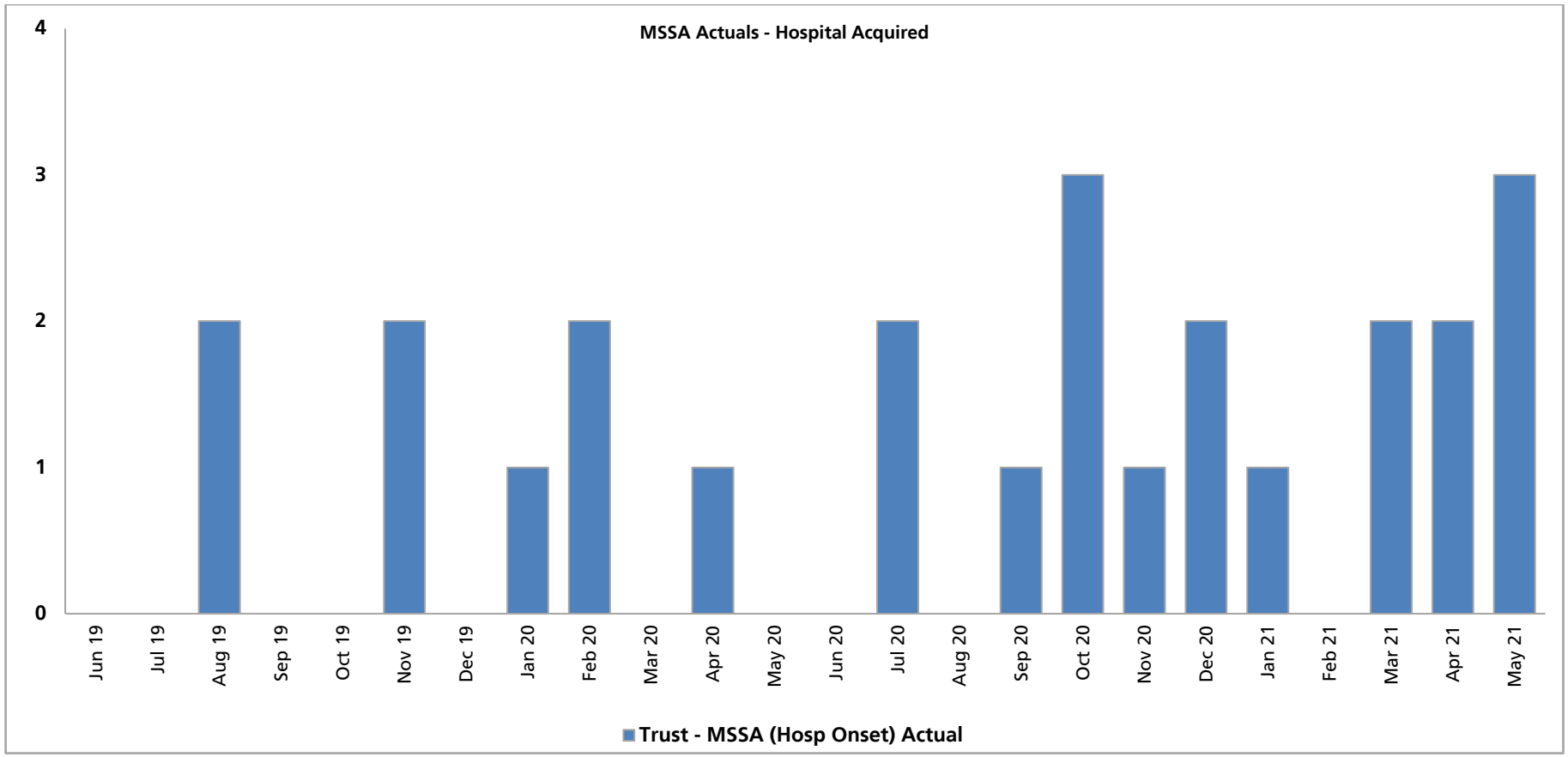


Chart 5 - MSSA (Hospital onset) rate per 100k beddays

Key Issues:

- Three cases of hospital onset MSSA were reported in May 2021.
- All cases presently under review

Key Actions:

The Infection Prevention and Control Team continue to raise awareness of appropriate management of MSSA, 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
- Review of individual cases and promptly undertaking measure to reduce any further transmission
- Attendance at the daily Harm Free Care meetings to raise awareness
- Reviewed standards, methods and assurance of cleaning across the Trust
- Domestic staff trained in national cleaning standards
- IPC Team support procurement colleagues to ensure effective and efficient cleaning products are purchased and in in place for use
- 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

Key Risks to Forecast Improvement:

- Poor compliance with Infection Prevention and Control Policies
- Poor IPC Mandatory training compliance – challenges to access / complete training
- Compliance with and management of anti-microbials
- Reduced resources in IPC Team (Registered Nurse establishment / Data analyst)

VTE Assessment completeness

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

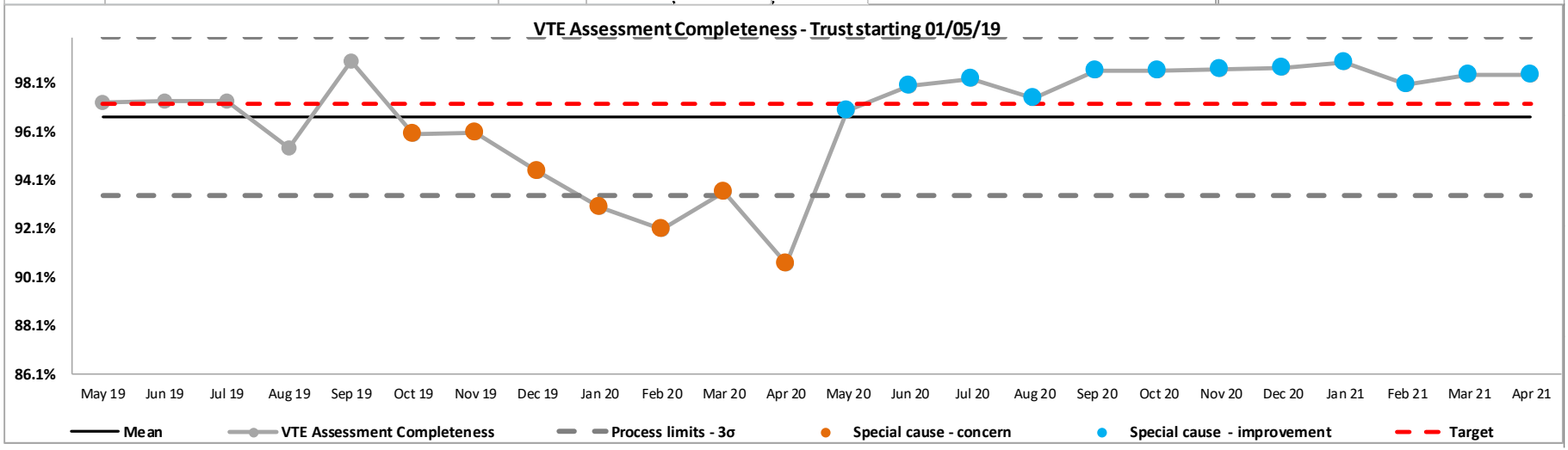


Chart 6 – VTE assessment completeness

Key Issues (any new issues in red):

1. VTE risk assessment has remained stable above the agreed threshold for a year since the implementation of changes. The local reinforcement of practices along with regular audits on compliance are in place.

Key Actions (new actions in green):

As the VTE screening process has become business as usual, the focus is now on ensuring that patients deemed to be at risk of VTE are appropriately cared for in the hospital. Towards this a range of audits looking at compliance with prescribing and administration of prophylactic anticoagulants, review of hospital acquired thrombosis, documentation of VTE care all looking at the care provision is now strengthened to ensure and monitor appropriate care provided for patients in our care. Incidences of care are also identified through the Datix incident reporting system to triangulate issues where there were lapses in care for learning and wider dissemination.

Key Risks to Forecast Improvement:

1. Electronic Prescribing and Medicines Administration (EPMA) system is currently being rolled out within the Trust and is expected to be fully implemented in all areas of the Trust in the next 3 months. Whilst there is an expectation that this will strengthen the screening process and eliminate the human factors that contribute to fluctuations in the assessment, the initial period post implementation can lead to confusion on the right place to document the screening process (whether paper based or via EPMA). It requires clear communication to the clinical staff on the need to continue paper based until full implementation. This is in place.

Effective - Accountable Officer - Medical Director

Effective Dashboard

Items in blue are awaiting the latest update

Data To	KPI Description	Limit	Current Value	Variance	Assurance
Apr-21	Total Births (inc Home, BBA's & Stillbirths)		160		
Apr-21	Stillbirth Rate	3.73	3.95		
Apr-21	Neonatal Deaths Rate	1.06	0.50		
Apr-21	Extended Perinatal Deaths Rate	4.79	4.44		
Apr-21	Total C Section Rate		31.0%		
Apr-21	EL C Section Rate		14.8%		
Apr-21	EM C Section Rate		16.1%		
Apr-21	Maternal Deaths	0	0		
May-21	% "Term" admissions to the NNU	6.00%	4.42%		
May-21	% "Avoidable Term" admissions to the NNU	0.00%	37.50%		
Apr-21	Breastfeeding initiation	70.0%	67.9%		

Data To	KPI Description	Target	Current Value	Variance	Assurance
Apr-21	Breastfeeding on discharge from hospital	60.0%	60.9%		
Apr-21	Smoking at Booking	18.6%	18.6%		
Apr-21	Stopped smoking by delivery	44.7%	35.2%		
Apr-21	Smoking at Time of Delivery		18.4%		
Apr-21	Post-Partum Haemorrhage	3.0%	3.8%		
Apr-21	3rd & 4th degree tears, exc C-Sections	3.5%	3.8%		
Feb-21	HSMR Crude Rate	3.18	5.19		
Feb-21	HSMR Relative risk	100.00	142.21		
Feb-21	HSMR Weekend Relative risk	100.00	156.57		
Dec-20	SHMI (Rolling 12 mth position)	100.00	105.50		
Apr-21	Rate per 1000 admissions of inpatient cardiac arrests	2.00	0.50		
May-21	No. of patients recruited in NIHR studies	63	76		

SHMI

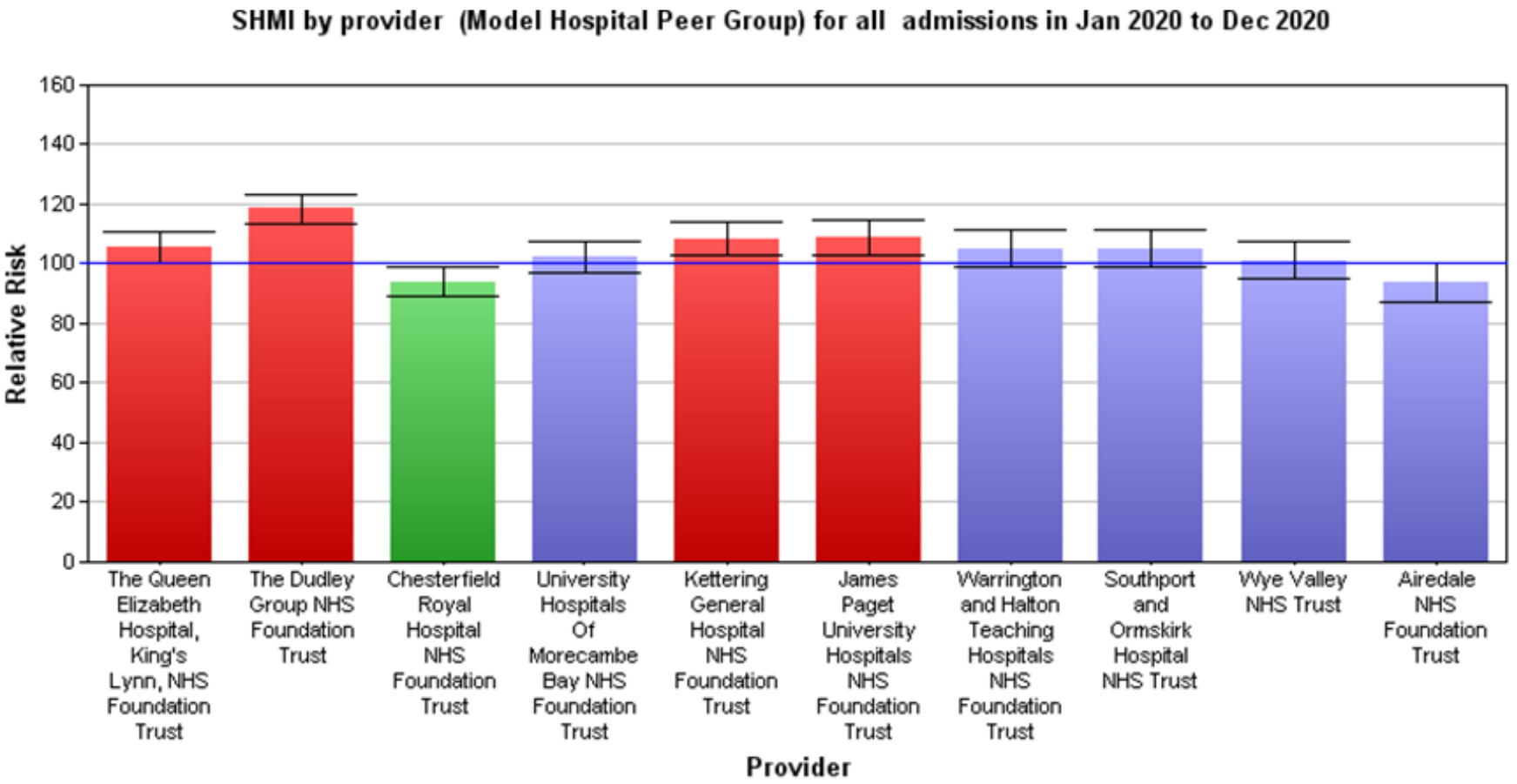


Chart 7 – SHMI by Provider

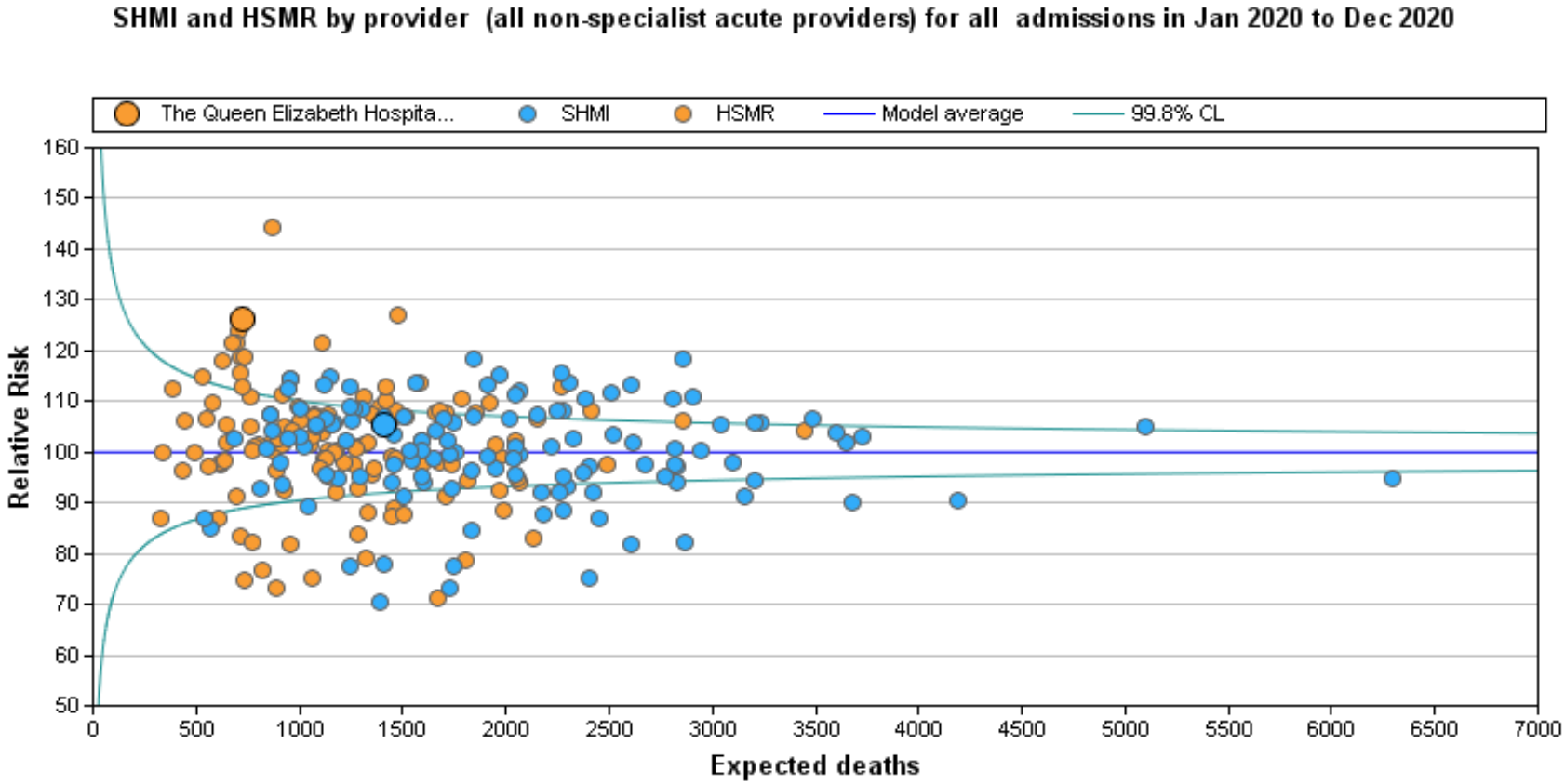


Chart 8 – SHMI and HSMR by provider

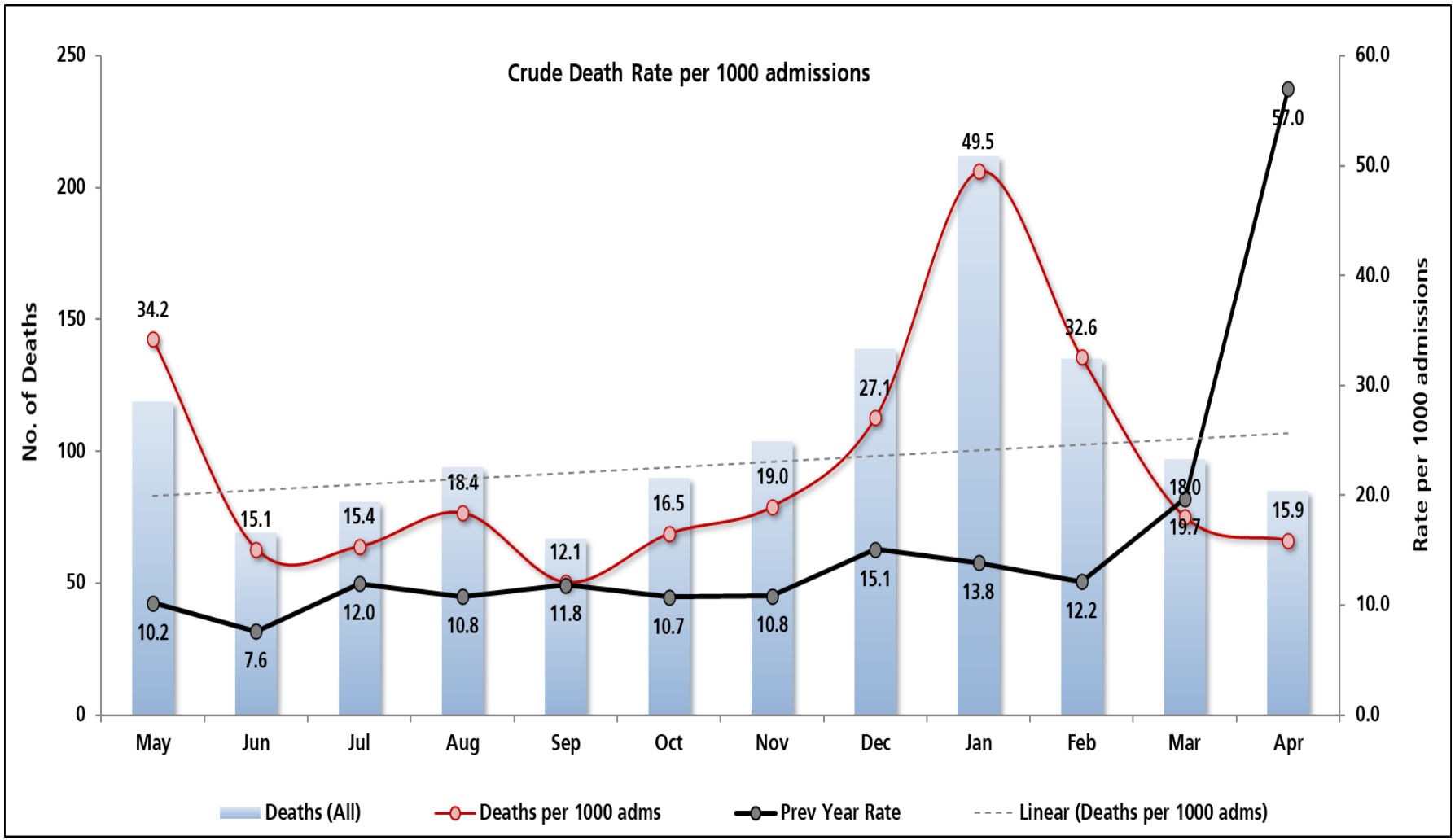


Chart 9 – Crude death rate per 1,000 admissions

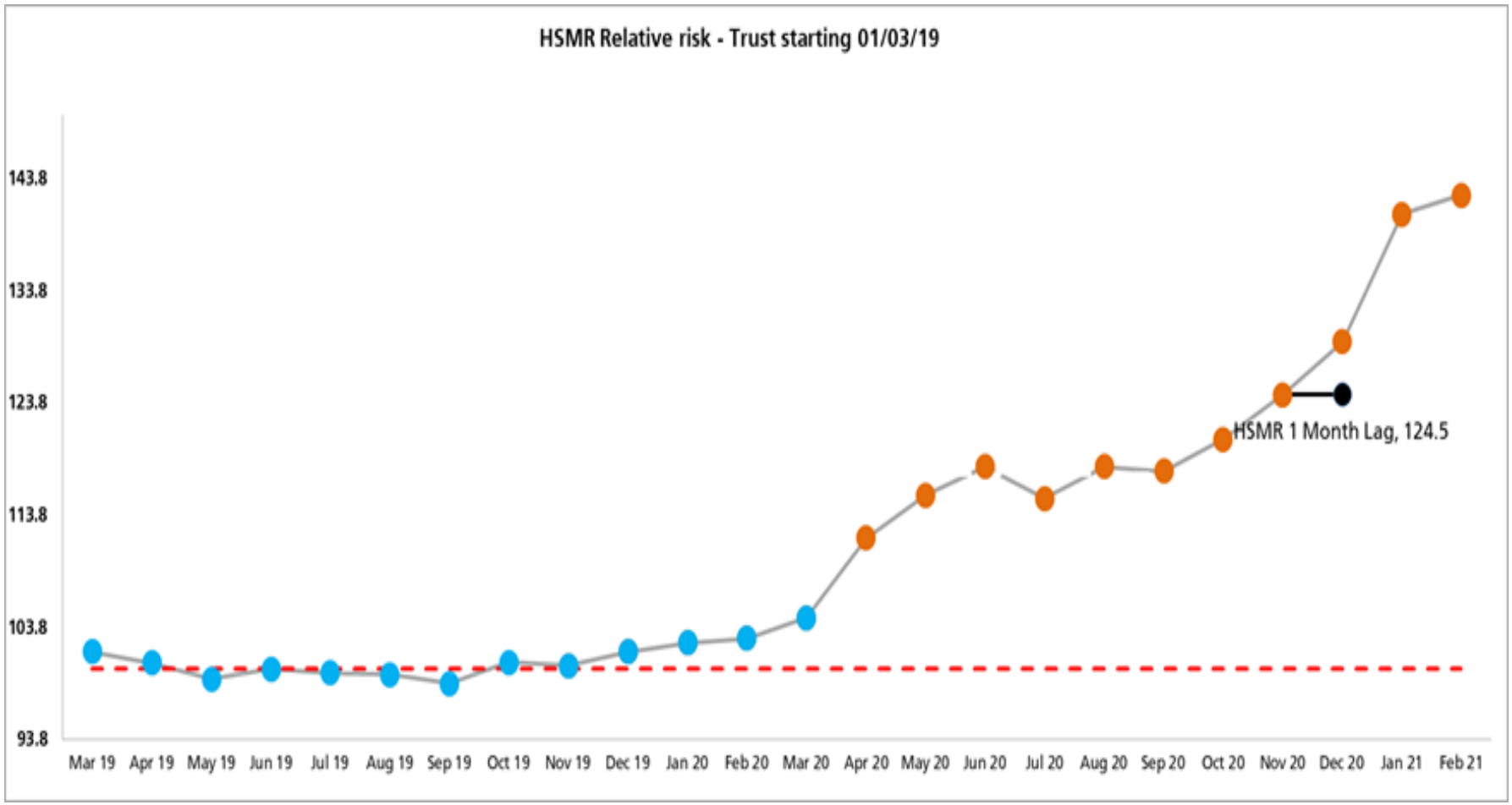


Chart 10 – HSMR Relative risk

Coding Completion Status

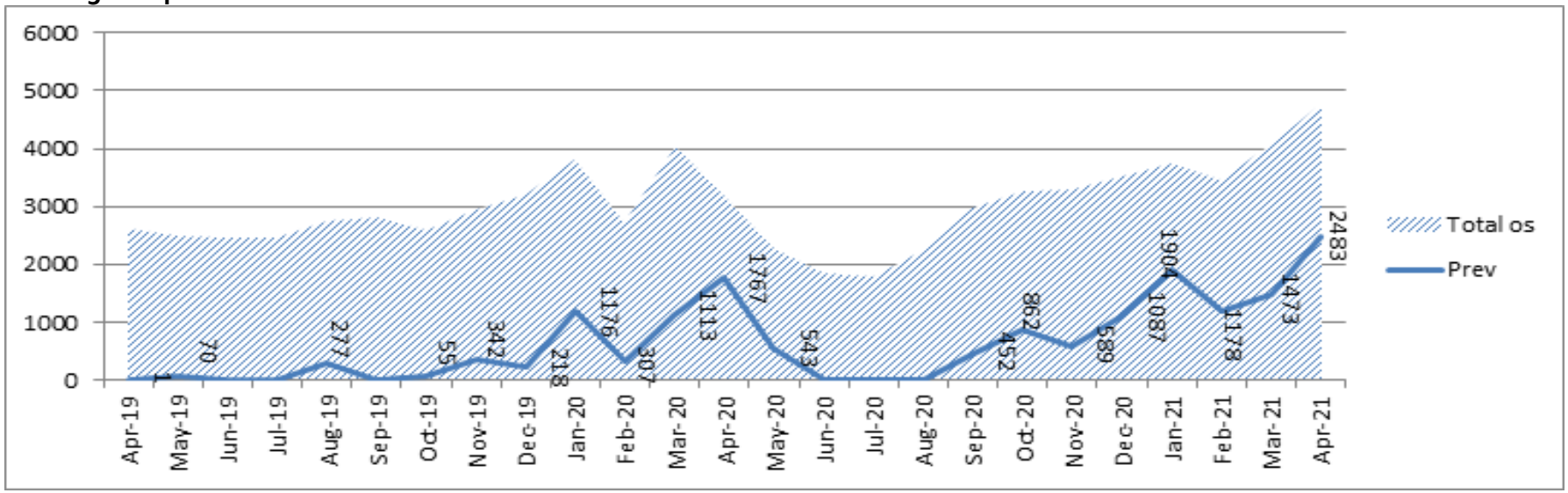


Chart 11 – Coding Completion Status

Factors Driving the Performance

- The SHMI has reduced slightly from 106 to 105.5 (latest data to December 2020) and remains within the "expected band" (within the confidence intervals of the funnel plot). COVID-19 related deaths have been excluded from SHMI calculations as this is not designed for this type of pandemic activity. Our regional position also remains unchanged (3rd lowest SHMI in the region).
- The total number of deaths and the crude death rate has fallen since the second wave of the pandemic. In May 2021 there were 77 deaths, 1 of which was due to COVID-19. In comparison there were 117 deaths in May 2020 and 82 in May 2019. 48 (out of 77) of the deaths occurred in patients aged 80 and over, with a high proportion (16) aged 90 and over.
- However, the HSMR has risen further to 142.21 (latest data to February 2021).
- Chart 11 indicates that the proportion of spells which were uncoded at the time of data submission (dark blue line, v shaded area indicating the total number of spells) has dramatically increased since the start of the pandemic. This is causing a significant delay in the ability for Dr Foster to issue accurate mortality data.
- The HSMR for the 12 months to December has now been recalculated by Dr Foster as we have uploaded the outstanding coding data for that period. Dr Foster has agreed to issue revised data on a monthly basis until this backlog has been cleared. After resubmitting the complete data for December, the recalculated HSMR fell from 129.2 to 124.5, as indicated by the black line on chart 10.
- The backlog of coding from January to March has also now been addressed and submitted, and we are awaiting recalculation of the HSMR for these months. There were 3291 un-coded records for May 2021 at the time of data upload.

- Aside from the alert for viral infection (COVID-19) the four alerts with the highest number of patients are Acute Renal Failure, Congestive Heart Failure, Stroke 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. The LFDF will focus on the increase in Strokes during January and February.

Key Actions Taken:

- The coding team has recruited 5 new staff members, and all staff are being offered additional weekend and out of hours shifts to address the backlog. The use of additional agency coding staff is being explored and medical students are due to start a quality improvement project to support the team from the end of June.
- Expansion and changes in the way in which the palliative care team are working has led to an increase in the proportion of patients who have died, having appropriate palliative care input since March 2021. This will lead to an increase in the proportion of patients with a Z code and so increase our expected mortality and reduce our HSMR in due course.
- The mortality review group continues to verify the primary diagnosis of deaths to ensure the HSMR is reflective of the acuity of the patients presenting.
- Structured review of ME requested COVID-19 deaths to understand and disseminate learning is underway. The findings will be shared upon completion July 2021. The delays in review of these deaths have been due to redeployment of all clinical staff in the front line to manage the staffing challenges.

Risks to recovery

- The impact of COVID-19 deaths on our HSMR and SHMI will continue for the duration of the time this metric is shown in the rolling 12-month report.
- The second wave of COVID-19 deaths will further impede our ability to predict and benchmark our deaths against others. However, restoration of activities along with improving EOL care provision will help recover the position.
- Coding backlogs continue to pose a risk in the way the data is displayed nationally as the residual codes add to worsening position of HSMR Mitigations through additional work to clear the backlog is being undertaken at the weekends to improve this.

LSCS rates

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Mar-21	Total C Section Rate	25.0%	27.0%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

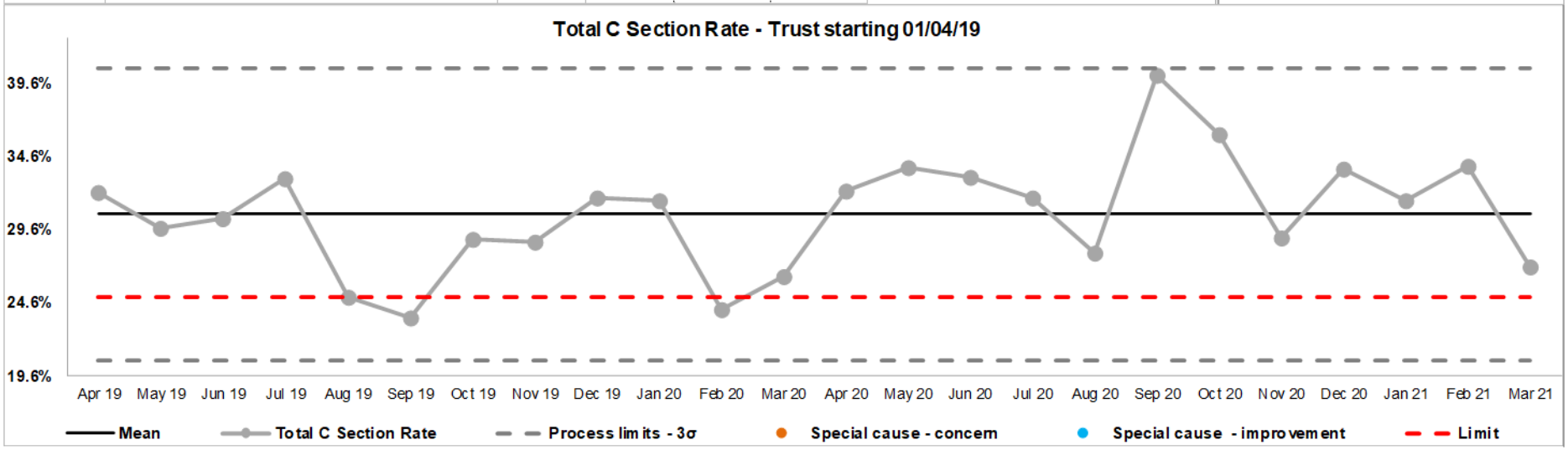


Chart 12 – Total C-Section rate

In line with the recommendations of the Shrewsbury and Telford review and as agreed through the Quality Committee, The Trust no longer has a target for Caesarean section rates, but these continue to be monitored with appropriate multidisciplinary oversight on all elective decisions, and with retrospective analysis and feedback on all emergency decisions by the MDT.

Neonatal and Perinatal Mortality

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Stillbirth Rate	3.73	3.95				

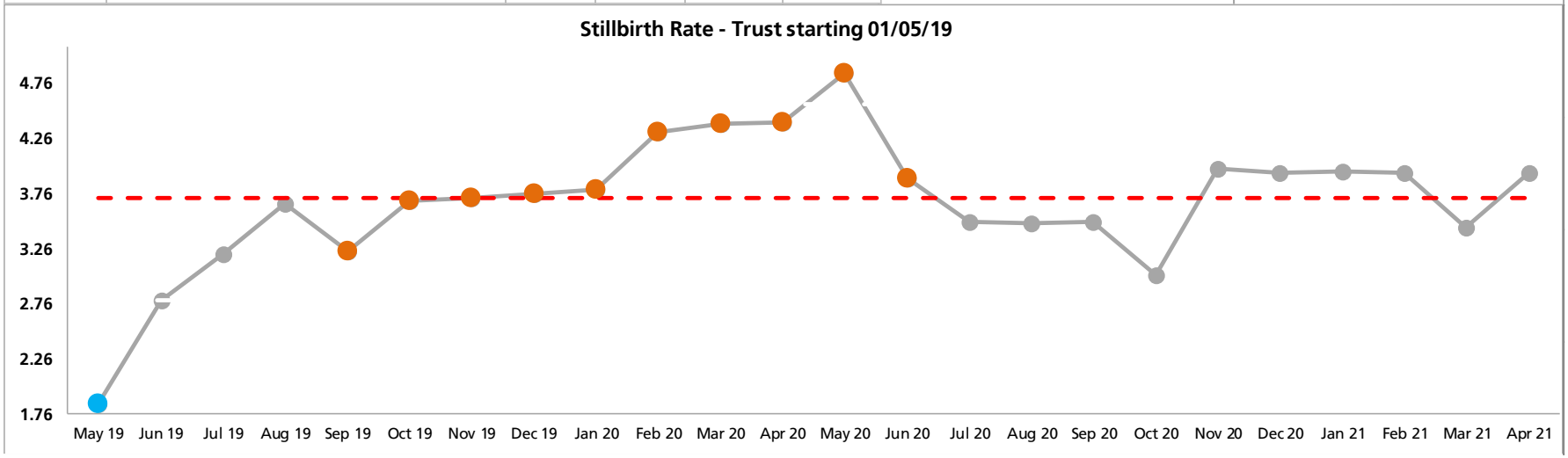


Chart 13 – Stillbirth rate

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Neonatal Deaths Rate	1.06	0.50				

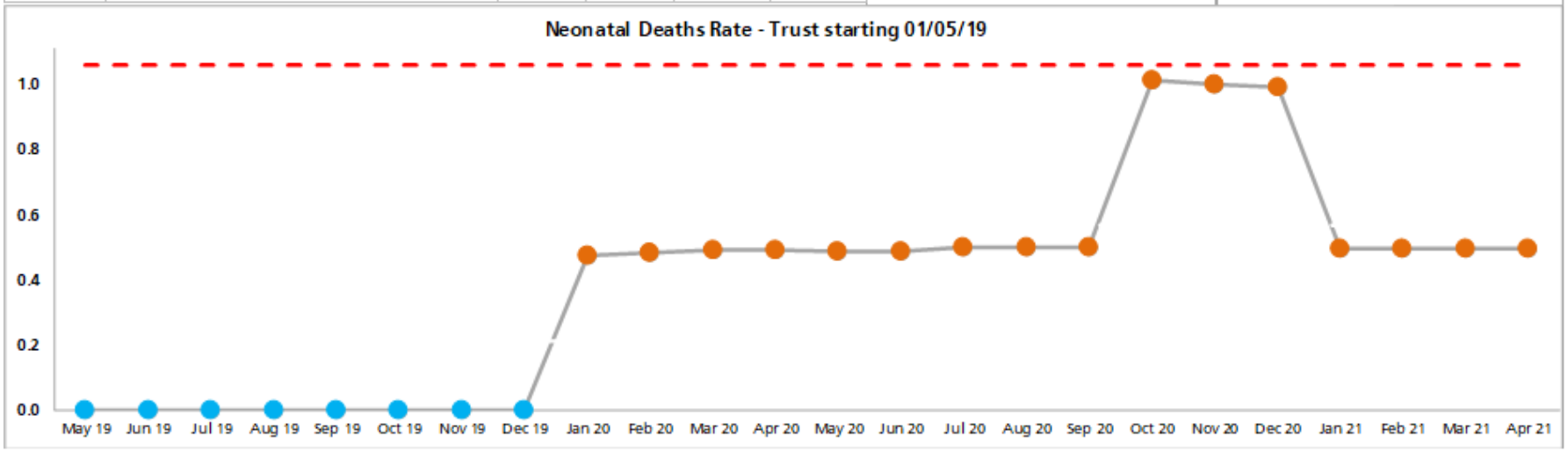


Chart 14 – Neonatal Deaths rate

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Extended Perinatal Deaths Rate	4.79	4.44				

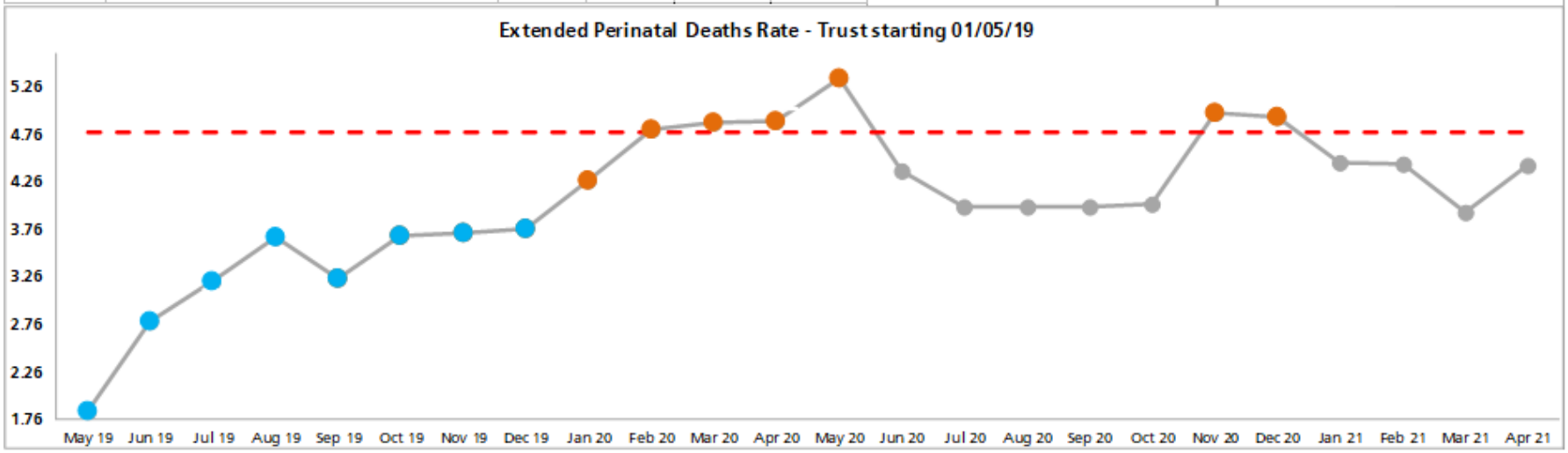


Chart 15 – Extended perinatal deaths rate

Factors Driving Performance:

The rolling rate remains stable, within control limits and with no concerns. Sadly the Trust reported a stillbirth in the month of April, which has been investigated with no care issues identified at the time. The case will be discussed with external scrutiny using the perinatal mortality review tool later this month.

Actions being taken:

- By the end of June the Trust will have fully implemented the Saving Babies Lives Care Bundle (v2) and is working with system partners within the ICS through the Local Maternity and Neonatal System (LMNS) to share best practise and learning from untoward events.
- There is also a significant amount of Culture Improvement work ongoing within the service to support the safety agenda – this is reported up through the division and to the Quality Committee

Risk to delivery:

- **Midwifery Staffing:** There is a shortfall of midwifery prior to the new cohort of midwives completing their training and registration. The summer staffing plan is being reviewed in advance to ensure contingency plans are in place to mitigate the risk.
- **Medical staffing:** Service redesign has supported vastly improved 7 day working patterns for Consultants. However, workforce planning requires a further revision in wake of the Ockendon Report. The additional resource requirements to meet these new recommendations have been submitted for national funding.

Term Neonatal unit admissions

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
May-21	% "Term" admissions to the NNU	6.00%	4.42%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

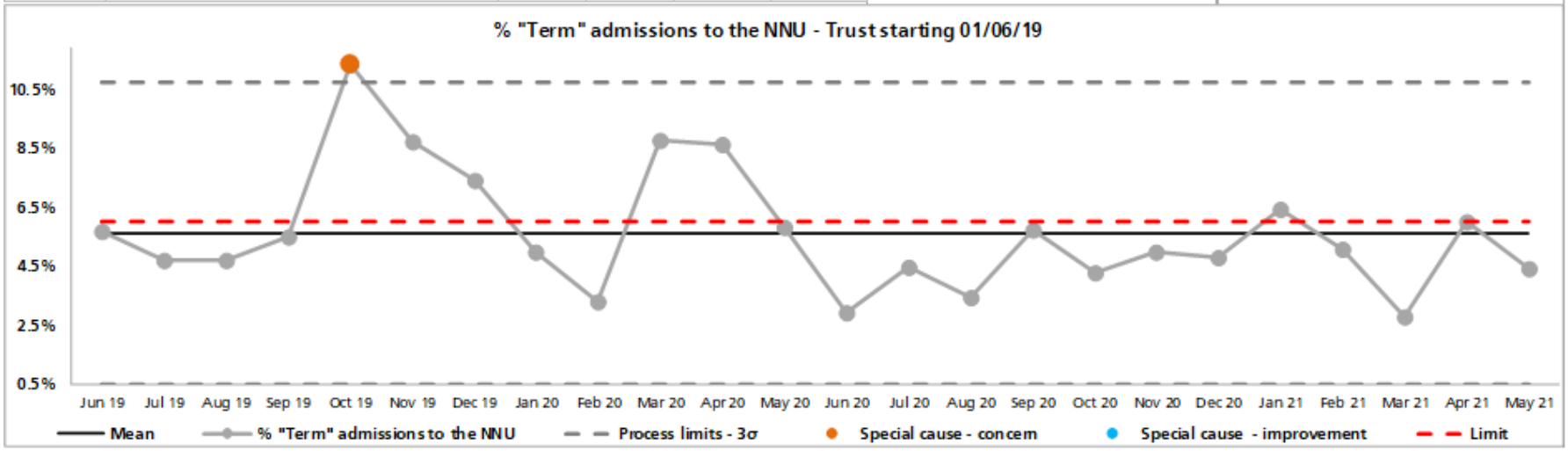


Chart 16 - % term admissions to the NNU

Term admission rates to NICU remain low at 4.42% and under the current national upper limit of 6%.

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
May-21	% "Avoidable Term" admissions to the NNU	0.00%	37.50%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

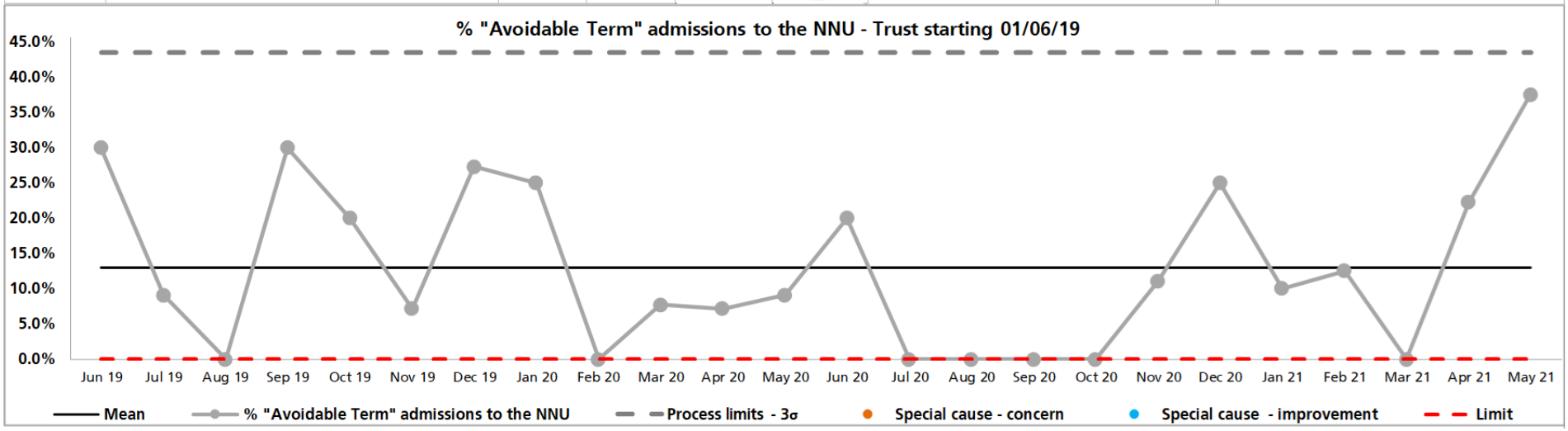


Chart 17 - % avoidable term admissions to the NNU

Breast Feeding Initialtion rates

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Breastfeeding initiation	70.0%	67.9%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

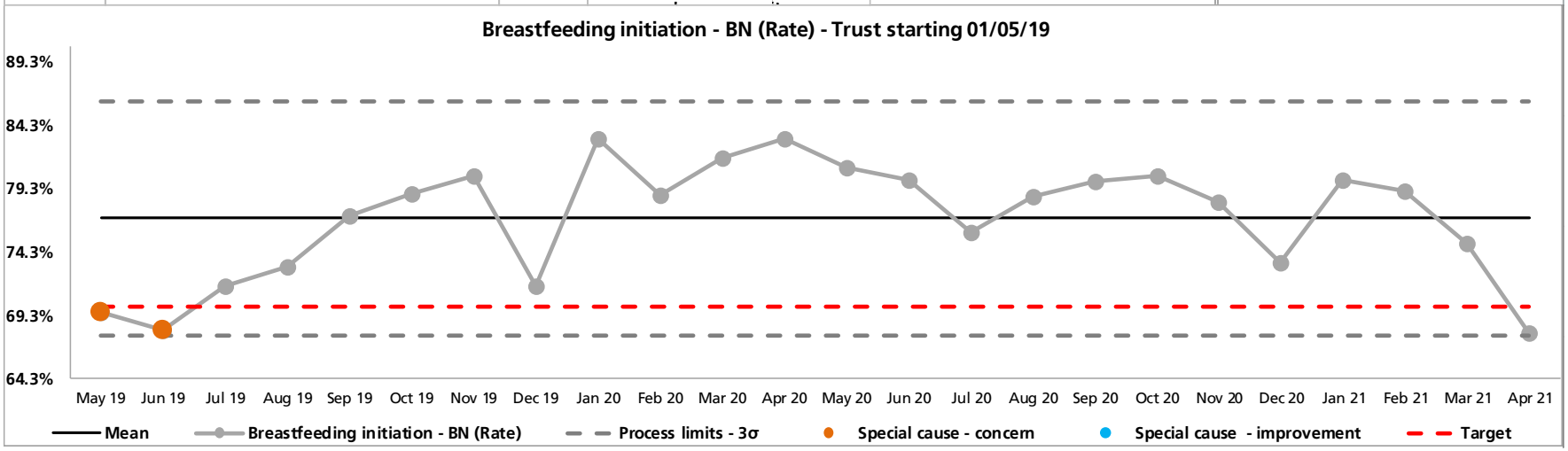


Chart 18 – Breastfeeding initiation – BN (rate)

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Breastfeeding on discharge from hospital	60.0%	60.9%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

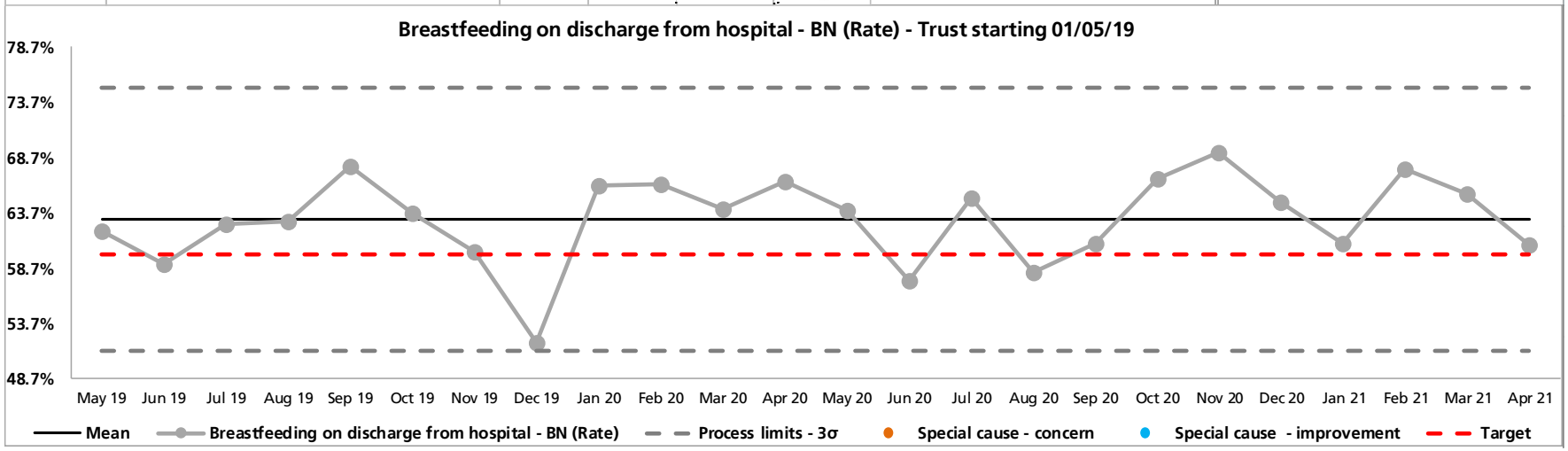


Chart 19 – Breastfeeding on discharge from hospital – BN (rate)

In line with the recommendation from the Quality Committee, the Trust are now reporting this KPI within the IPR. Current data is within common cause variation, and the targets of 70% initiation and 60% of appropriate patients breastfeeding on discharge from hospital are generally met.

Factors driving performance:

The recent fall in performance, although not yet significant does raise concern. This could potentially be due to the breastfeeding update for staff being removed from the staff schedule as the Trust limited the amount of training staff had to complete during the pandemic. This is now being reintroduced but it may take some months to see improvements in the data.

Risk to delivery:

- Staffing concerns over the summer might mean it takes longer for all staff to recive their training updates
- The Trust are currently recruiting to fill the vacancy we have in the Infant Feeding team

Smoking Cessation in Pregnancy

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Smoking at Booking	18.6%	18.6%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

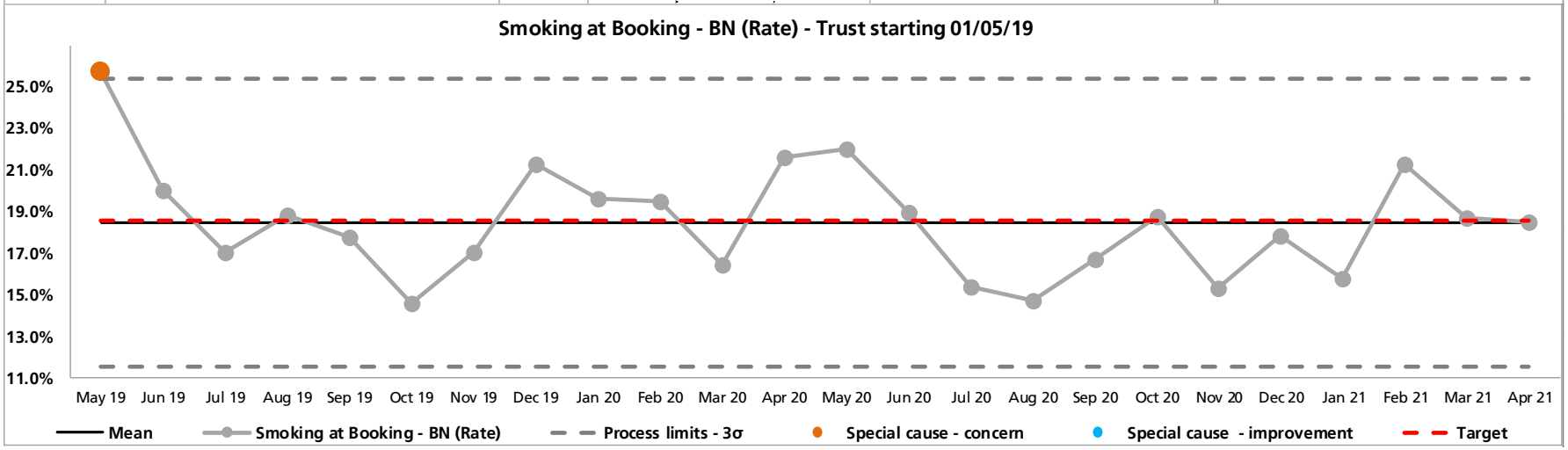


Chart 20 – Smoking at Booking – BN (rate)

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Stopped smoking by delivery	44.7%	35.2%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

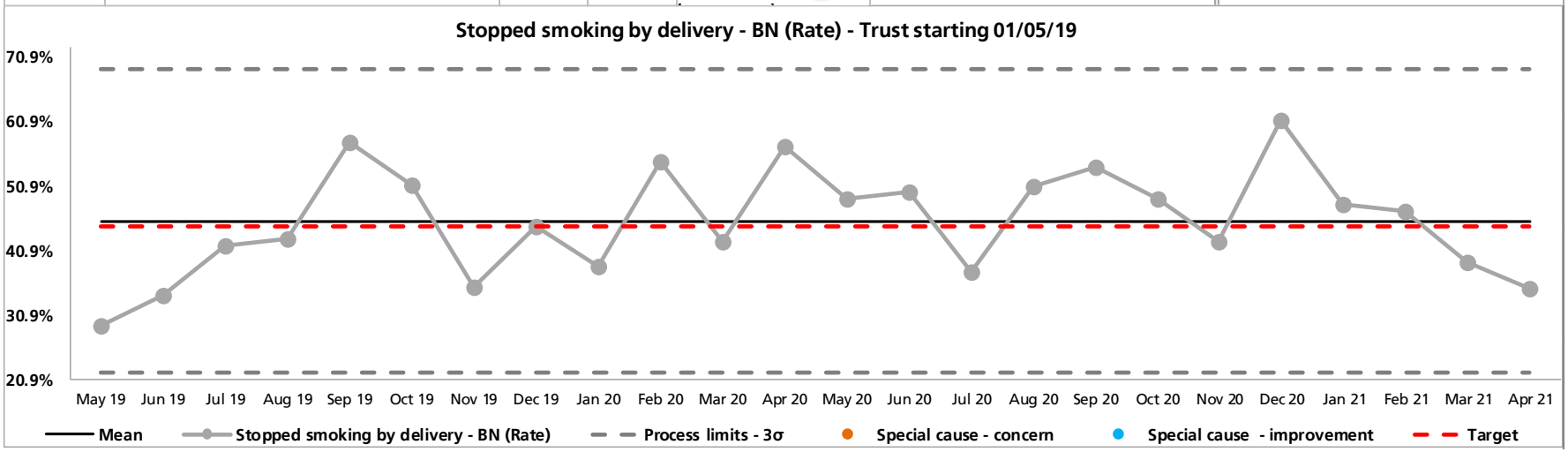


Chart 21 – Stopped smoking by delivery – BN (rate)

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Smoking at Time of Delivery		18.4%			Common Cause (expected) variation	Variation indicates consistently (F)alling short of the target

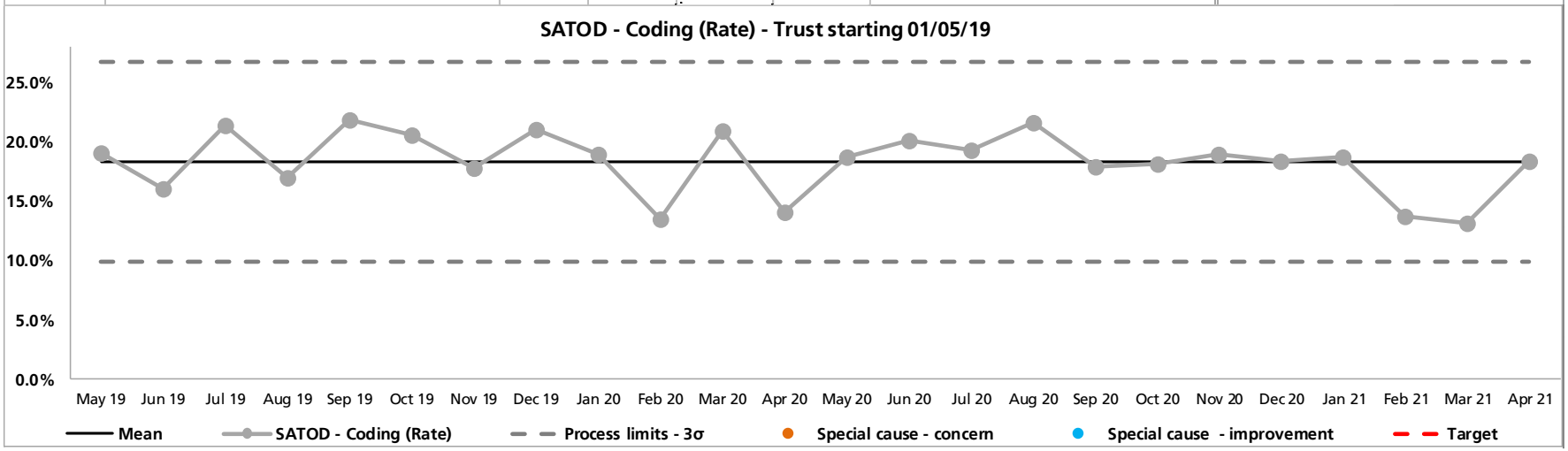


Chart 22 – Smoking at Time of Delivery – Coding (rate)

In line with the recommendation from the Quality committee, the Trust is now reporting smoking cessation KPIs within the IPR. Smoking is the largest modifiable risk factor to any pregnancy and in line with the NHS Long Term Plan, should be a focus for the service.

The demographic area that QEH serves has a higher than average deprivation rate though the smoking rate for the population as reflected in the first graph for smoking at booking is in line with the national average.

Factors driving performance:

The Smoking Cessation Midwives for both the QEH and JPUH are funded by LMNS transformation funds. Both resigned at the start of this year, and efforts to recruit have not been successul. This may have contributed to the (insignificant) fall in cessation rates in the second graph above against a target that at least 44.7% women who smoke, will have stopped by the time of delivery.

Carbon Monoxide (CO) testing was also paused during the pandemic as this creates an Aerosol-Generating Procedure so was not permitted for IP&C purpsose. This is now being reintroduced and we can see CO screening rates rising within our maternity dashboard.

Risks to delivery:

The LMNS has converted the funding for smoking cessation midwives to a senior Public Health Lead to support Quality Improvement programmes of work across the system. However, this post has not yet been recruited to. Once in post, this may help address smoking rates and support QI projects to help with smoking cessation in pregnancy.

Changes in the model of maternity delivery (implementing Continuity of Carer) will support performance but there may be a period of instability as we move across to this new way of working over the coming months.

Post-patum Haemorrhage (PPH)

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Post-Partum Haemorrhage	3.0%	3.8%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

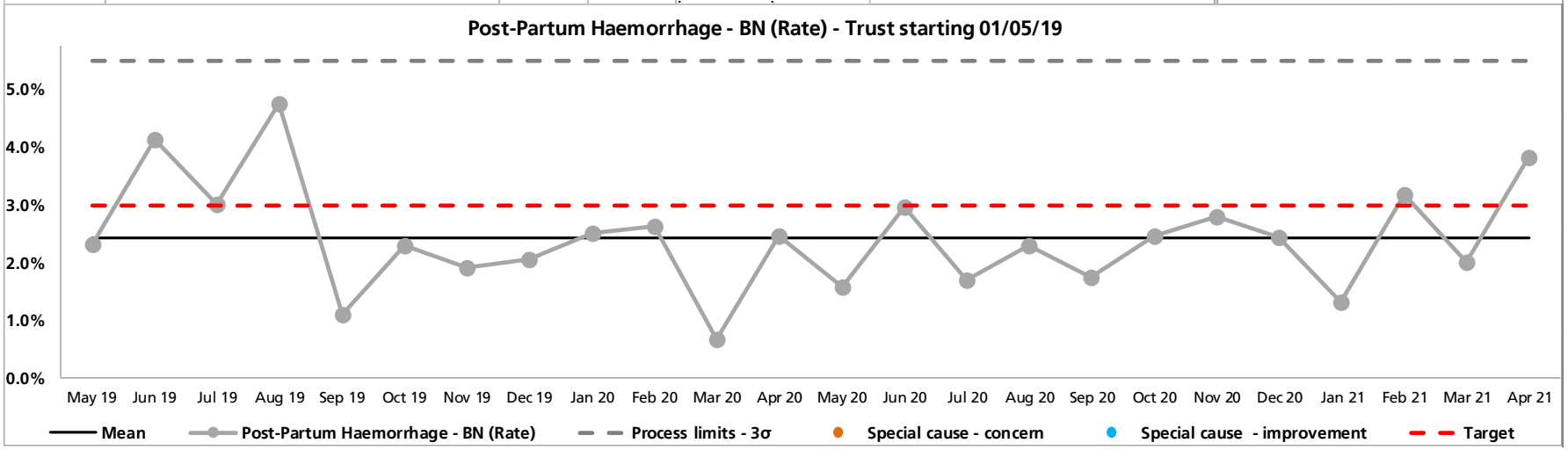


Chart 23 – Post-Partum Haemorrhage - BN (rate)

In line with the recommendation from the Quality Committee, the Trust are now reporting post partum haemorrhage (PPH) KPIs within the IPR. PPH is a known complication of birth and one of the leading causes of maternal mortality and morbidity in the UK. There are many risk factors incluing maternal age, multiple pregnancy, raised BMI and increased medical interventions; all of which are increasing in our pregnant population, and there is also a rising trend nationally.

However, PPH rates have been consistent and generally below the upper threshold at QEH over the last 2 years. The Trust will contiue to monitor this for any concerns, variation and learning.

3rd & 4th degree perineal trauma

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	3rd & 4th degree tears, exc C-Sections	3.5%	3.8%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

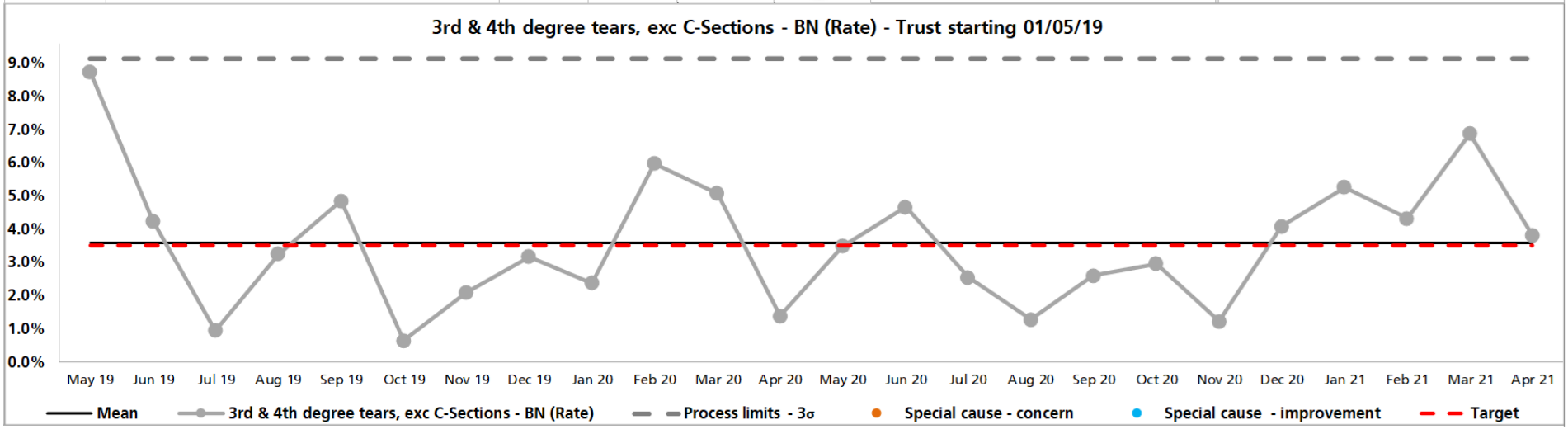


Chart 24 – 3rd and 4th degree tears, exc C-Sections - BN (rate)

The Trust launched the Obstetric Anal Sphincter Injury (OASI) Care Bundle at the end of January this year (a nationally recognised bundle of care aimed to redcue perineal trauma) and is monitoring the impact this will have on the rates. One aspect of the bundle is around antenal education and perineal massage which may take some time to embed and see the demonstrable results.

The Trust has also commenced the OASI MDT review meetings that are held monthly (commenced in February) and has so far only identified 2 potentially preventable cases. The Trust will continue to monitor and report progress.

Rate per 1000 admissions of inpatient cardiac arrests

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Rate per 1000 admissions of inpatient cardiac arrests	2.00	0.50			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

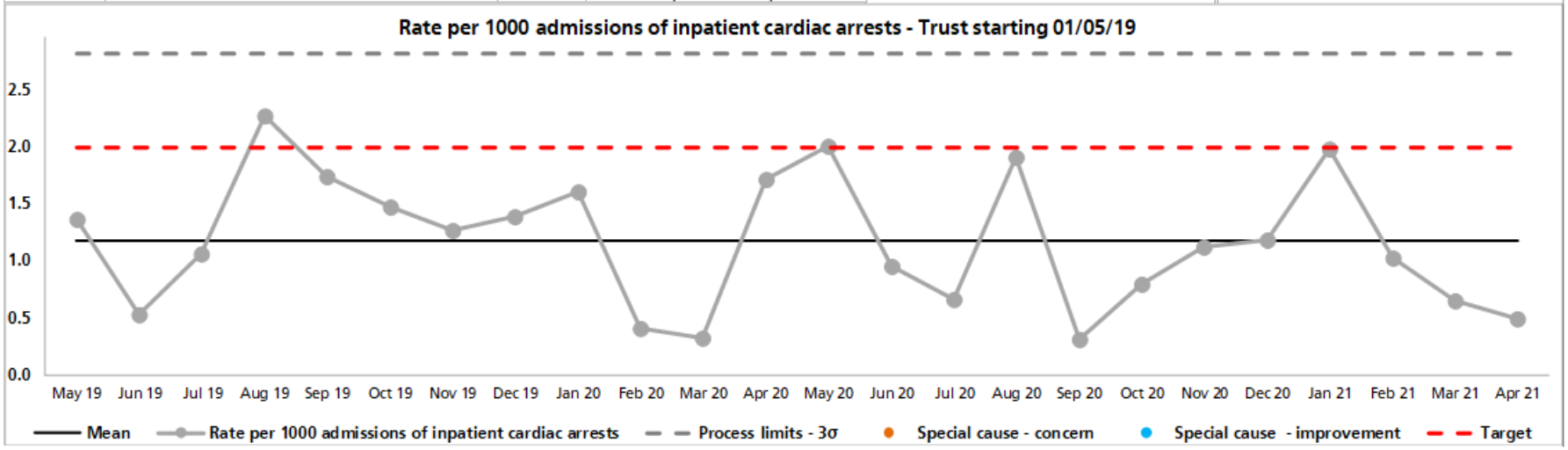


Chart 25 – rates per 1000 admissions of inpatient cardiac arrests

Key Issues (any new issues in red):

1. Cardiac arrest rates remain low which is a positive indicator suggesting good recognition of the deteriorating and dying patient.
2. There was 1 definite reportable cardiac arrest in ICU and 1 possible cardiac arrest in April 2021. Most calls have been for the support of the arrest team for a deteriorating or peri-arrest patient, or to attend ED when a patient with an out-of-hospital cardiac arrest attends.

Key Actions (new actions in green):

The ReSPECT relaunch is now scheduled for 19 July. A training plan is in place and support for launching the new documentation is ready for deployment. This will be supported by a wider communication plan to improve the uptake of this training. ReSPECT Writer Training which focuses on essential aspects of documentation by medical staff will be part of academic assessments of Junior Doctors from August 2021.

Finally, ReSPECT familiarisation training is also now included into level 2 BLS e-learning for launch July 2021. All these measures will improve awareness and aim to improve decision making and documentation around end of life care planning.

Recovery Forecast:

Measures to maintain and further reduce cardiac arrests are ongoing, through work in the Deteriorating Patient and ReSPECT agendas, overseen by the Recognise and Respond forum.

Key Risks to Forecast Improvement:

1. Monitoring of deteriorating patients via the early warning scoring system remains paper based and audits on these are done on a monthly basis (snapshot and not continuous). This significantly restricts the ability to provide a birds' eye view of the hot spots and dynamic trouble shooting abilities that could be facilitated through Electronic e-observation system. This hence is a key risk to initiating improvements.
2. Ongoing education is required to help staff to recognise patients for whom a cardiac arrest would represent a natural death in a timely fashion, initiate difficult conversations with those patients and their families, and to make and document appropriate resuscitation decisions and advanced care planning.

Research

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
May-21	No. of patients recruited in NIHR studies	63	76			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

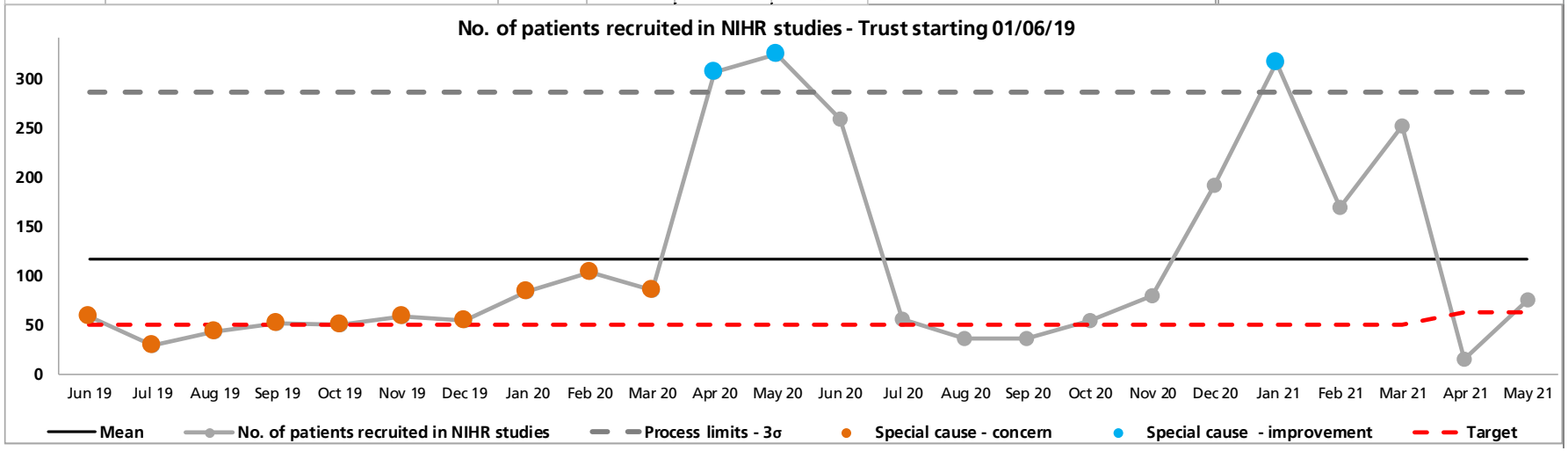


Chart 26 – number of patients recruited in NIHR studies

Total recruitment figures increased to 91 for the new financial year and 76 for the month of May which exceeds the monthly target of 63 participants/month. The Trust currently has 40 active studies, from which 16 were recruited in the month of April. The focus in the new year is on the NIHR-managed recovery approach to restarting suspended multi-site intervention studies. Currently, 7 studies on portfolio have been identified by the NIHR and are on the approved 'managed recovery' list. The month of May has been especially busy with positive and successful activities as follows:

1. The QEH is the first site in the UK to set up an all-important trial investigating the treatment of Long-COVID (HEAL-COVID).
2. The QEH successfully hosted internal and external distinguished speakers on our International Clinical Trials Day event (20/5/2021)
3. The Trust has Successfully recruited to the vacancies within the team and start dates are imminent.
4. The Trust has successfully adopted the EDIS/Patient Administration System (PAS) for patients enrolled onto drug trials

Key Drivers

Despite constraints experienced by clinical teams due to the recovery phase of clinical services in the hospital, the team continues to work hard to engage clinical teams in the hospital by ensuring their presence at MDTs, ward rounds and offering them the opportunity to participate in new research. Working with lead clinicians/principal investigators, the Trust have expressed interest in several new studies to help improve diversity. In line with developing research capacity among health staff, the Trust have been inundated by medical and nursing staff willing to play their part in research. The team continues to use NHS Improvement Quality Improvement methods to maintain high performance in teams and plans for delivery in 2021. Other key drivers of high performance include excellent motivation among the team and the abundance of diverse and complementary skills, ideas, and experience.

Key Actions

The following have been implemented to improve and sustain high performance within the team:

- Ongoing discussions with radiology, and paediatric leads to adopt identified NIHR study
- Continuous presence of research staff at MDTs and ward rounds
- Weekly review of studies (board rounds)
- Bi-monthly 1:1 supervision to continue

Risks

1. Our main challenges are our ability to restarting Non COVDI-19 Studies which will be influenced by recovery and restoration activities within the Trust. With a huge backlog that has built up following the pandemic, sustaining focus on research can be difficult. However with staffing levels back to baseline, we will try and persist with recruitments to Non COVID-19 Trials.

Caring - Accountable Officer - Chief Nurse

Items in blue are awaiting the latest update

Data To	KPI Description	Target	Current Value	Variance	Assurance
May-21	MSA Incidents	0	5		?
May-21	MSA Breaches	0	20		?
May-21	Total Clinical & Non_Clinical Complaints	20	17	L	?
May-21	Complaints Rate per AE Atts, IP Adms & OP Activity	0.00%	0.05%		?
May-21	Complaints receiving a response within 30 working days %	90.0%	41.0%		?
May-21	Complaints - Reopened (% of Total)	15.0%	0.0%		?
Apr-21	Dementia Case Finding	90.0%	98.2%	H	F

Data To	KPI Description	Target	Current Value	Variance	Assurance
May-21	FFT % "Very Good" or "Good" (IP & DC)	95.00%	97.25%	H	?
May-21	FFT % "Very Good" or "Good" (AE)	95.00%	88.48%		?
May-21	FFT % "Very Good" or "Good" (OP)	95.00%	93.61%	L	?
May-21	FFT % "Very Good" or "Good" Mat Question 1 (Antenatal)	95.00%	60.0%	L	?
May-21	FFT % "Very Good" or "Good" Mat Question 2 (Labour)	95.00%	95.8%		?
May-21	FFT % "Very Good" or "Good" Mat Question 3 (Postnatal)	95.00%	88.2%	L	P
May-21	FFT % "Very Good" or "Good" Mat Question 4 (Comm Postnatal)	95.00%	100.0%	H	?

MSA breaches

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
May-21	MSA Breaches	0	20			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

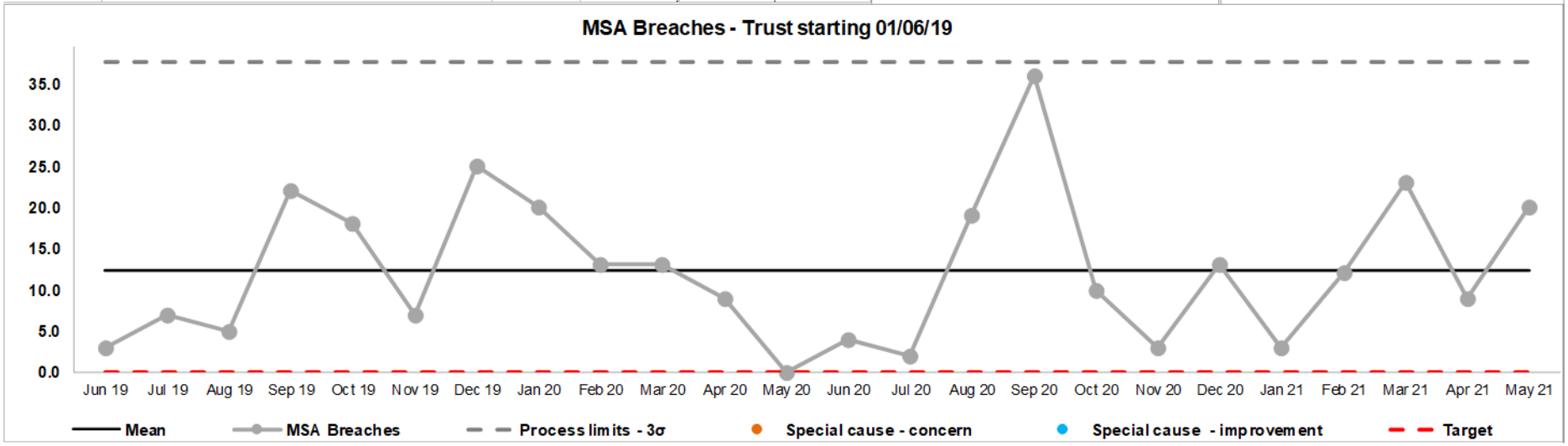


Chart 27 – MSA breaches

Key Issues (any new issues in red):

1. There have been five incidents of same sex accommodation breaches affecting 20 patients. Three incidents were in the Hyper acute Stroke Unit (HASU) on West Raynham Ward affecting seven patients and two incidents were in the Surgical Assessment Unit affecting 13 patients. The breaches in SAU were related to capacity and appropriate escalation was in place.

2. The Trust breaches are reported in line with the national guidance.

Key Actions (new actions in green):

1. The Nurse in charge has active conversation with patients with regard to their experiences whilst being cared for in a mixed sex bay and there have been no concerns raised by patients.

2. Same sex accommodation breaches are discussed and possible mitigations are considered during the Board rounds.
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:

1. Unable to forecast recovery due to capacity challenges.

Complaints

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
May-21	Complaints receiving a response within 30 working days %	90.0%	41.0%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

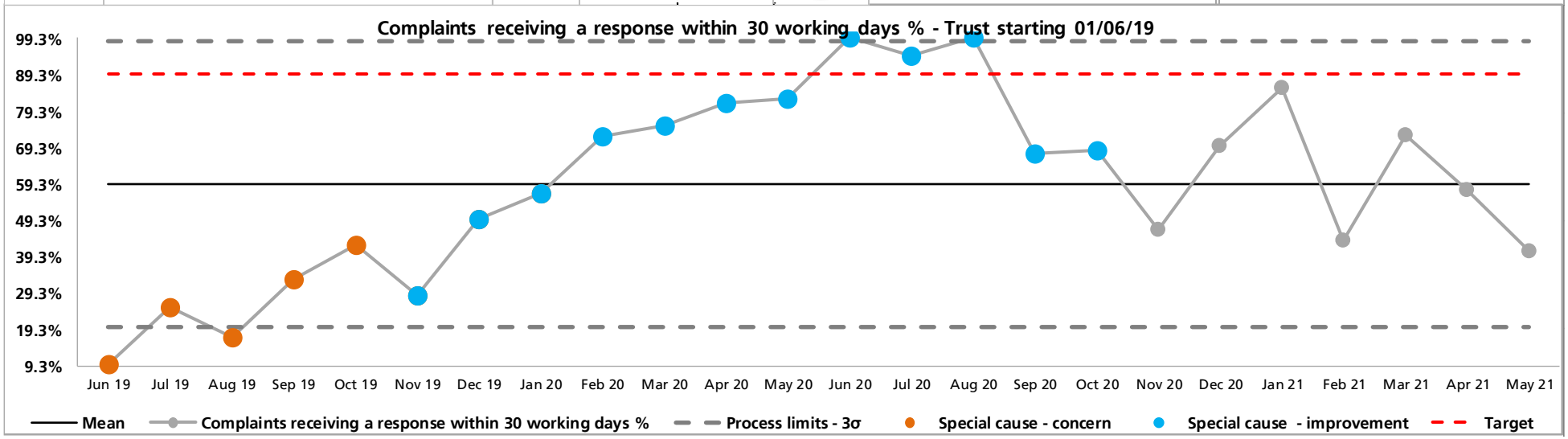


Chart 28 – complaints receiving a response within 30 working days

Key Issues (any new issues in red):

- The timeliness of responding to complaints within 30 days is not achieved with a deterioration from last month.
- Complete review and refocus undertaken backlog of all overdue complaints cleared (W/E 4.6.21)
- Poorly understood/complicated process
- Inconsistent adherence to ensuring delivery of the complaint process including response times
- Inconsistent letter response quality
- Data inconsistent and via multiple sources (resulting in inaccuracy and frustrations)
- Inconsistent engagement and ownership
- Poor evidence of learning/actions
- Patients "voice" lost

- Capacity and capability issues

Key Actions (new actions in green):

- The Chief Nurse and Deputy Chief nurse have had a series of meetings with the Divisional Leadership Teams to define the process, responsibilities, accountability and that complaints is a top priority
- Improvement trajectory plan in place
- Commenced initial Triage by a senior member of staff
- Divisional senior to ring complainant (define options, agree timescales, offer LRM)
- Increase in Local Resolution Meetings (LRMs)
- Simplify the process
- Data information simplified to one process
- Share point for all to access with PTL information
- Twice weekly tracking meetings DCN with DLT with escalation as required
- Review each response with coaching to improve quality

Recovery Forecast:

- The response compliance has deteriorated during May 2021 but there is already an improvement resulting from the key actions in place. The recovery plan includes sustained improvement in the coming months.
- The actions include a continued scrutiny on quality, LRMs being offered and timeliness which are 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

Dementia Case Finding

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Dementia Case Finding	90.0%	98.2%	H	F	Special cause (unexpected) variation - Improvement (H)	Variation indicates consistently (F)alling short of the target

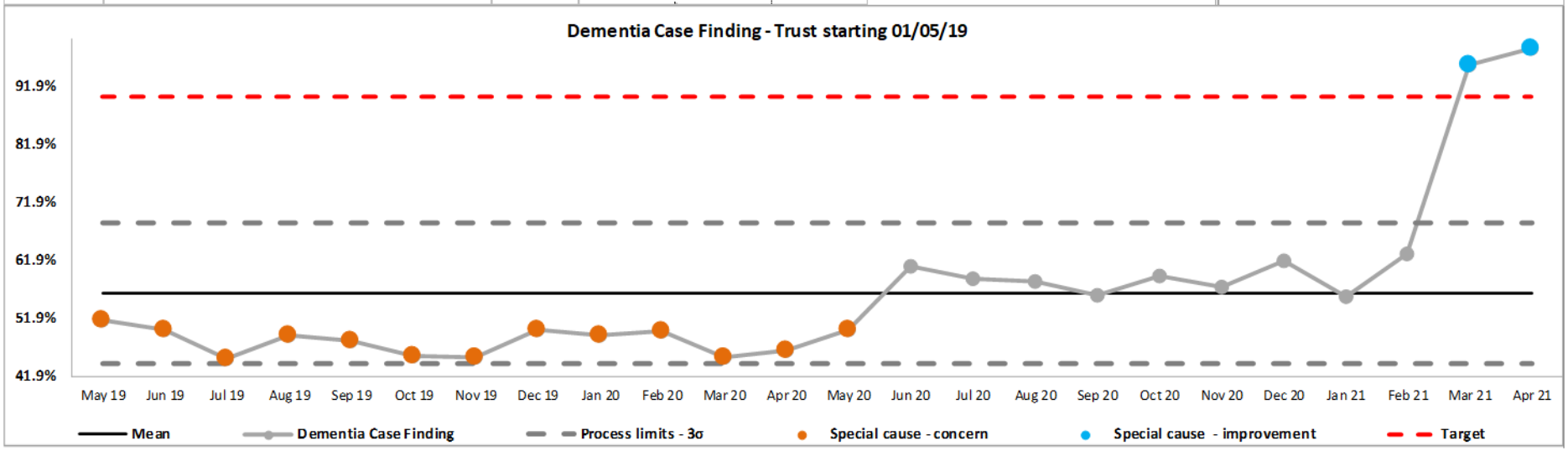


Chart 29 – Dementia Case finding

Key Issues (any new issues in red):

The Dementia screening rate for April 2021 was 98.2%, exceeding the agreed threshold of 90% for two consecutive months. A step change was achieved in May 2020 after multiple changes were implemented which have led to a cultural shift around dementia screening. However, the key enabler to meeting this target has been the introduction of Cognitive Impairment Assessors (CIAs) as part of the Integrated Care of Older People team in March 2021. They have been instrumental in highlighting all patients requiring a dementia screen to their clinical team and supporting these screens where necessary within 72 hours of admission.

Key Actions (new actions in green):

1. With the CIAs now in place, the key next steps are to ensure that all patients with newly detected cognitive impairment, at risk of dementia are referred to appropriate community services. This is currently being audited by the team.

Recovery Forecast: Not Applicable

Key Risks to Forecast Improvement:

1. The process of regular reviews supported by the CIA team needs to become business as usual through training of all relevant personnel in the department.
2. With improved screening rates, the Trust are identifying many more patients requiring onward referral to the community memory clinics. This may lead to delays in access to the appropriate services for these patients and reveal the need for enhanced provision for these vulnerable patients. The Trust are auditing this currently and are keen to work collaboratively with commissioning colleagues if this becomes an issue.

Friends and Family Test

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
May-21	FFT Resp Rate (IP & DC)	30.00%	16.06%	L	F	Special cause (unexpected) variation - Concern (L)	Variation indicates consistently (F)alling short of the target

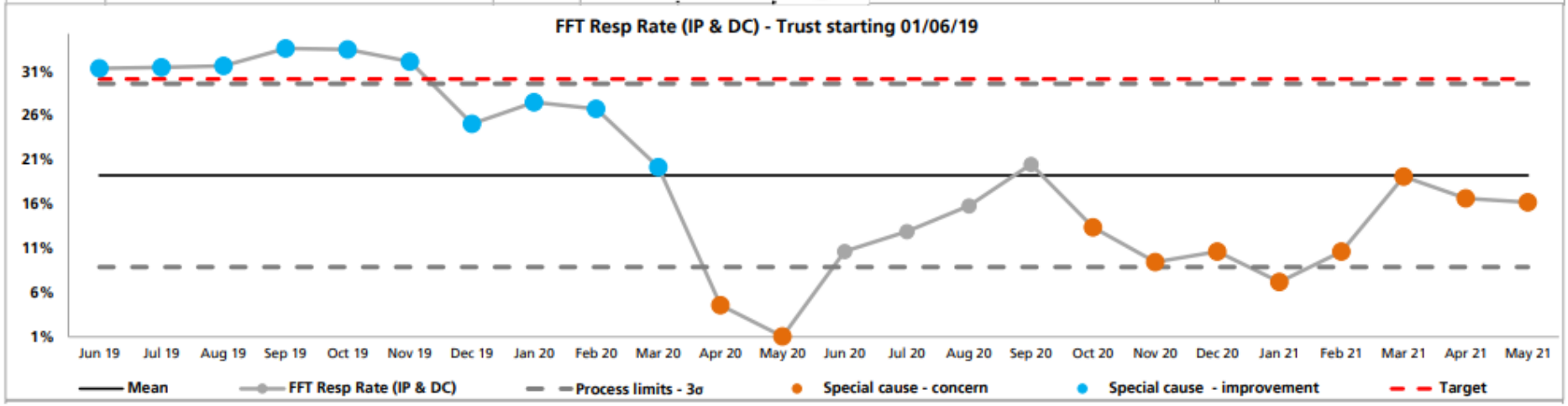


Chart 30 – FFT Response Rate (IP and DC)

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
May-21	FFT Resp Rate (AE)	20.00%	10.35%		F	Common Cause (expected) variation	Variation indicates consistently (F)alling short of the target

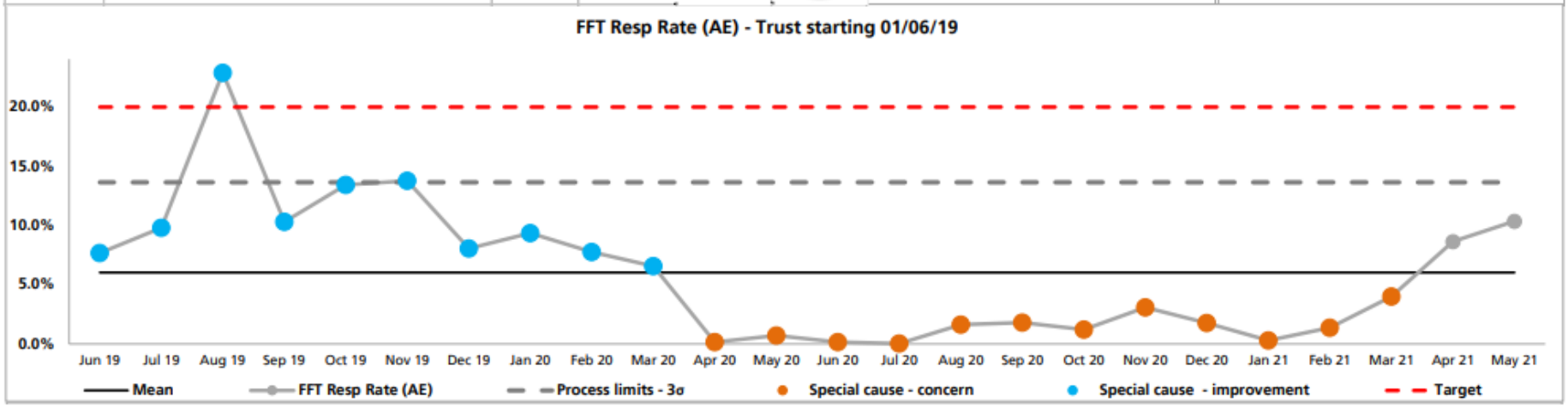


Chart 31 – Response Rate (A&E)

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
May-21	FFT % "Very Good" or "Good" (OP)	95.00%	93.61%			Special cause (unexpected) variation - Concern (L)	Variation indicates inconsistently passing and falling short of the target

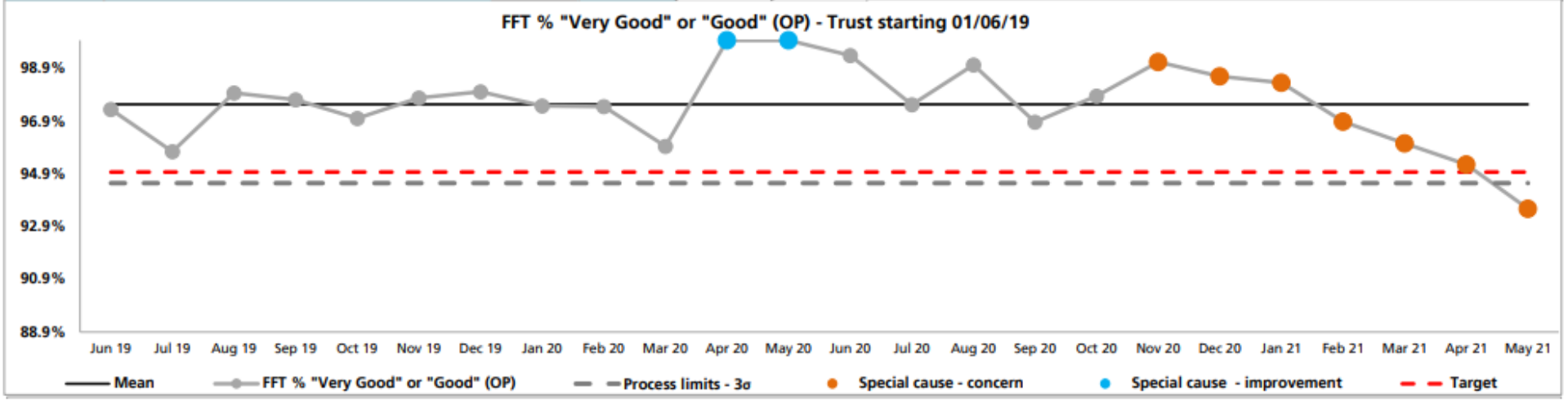


Chart 32 – "Very Good" or "Good" (OP)

Key Issues (any new issues in red):

- FFT feedback collection reduced slightly from 2855 in April 2021 to 2629 in May 2021. This was accounted for by a drop in responses in outpatients and general feedback (this includes the discharge lounge, COVID-19 vaccination centres, bereavement and mortuary).
- The response rate in the Emergency Department remains low but has been steadily increasing and has exceeded 10% in May for the first time since November 2019.
- Trust wide, the number of electronic responses (combined web submissions and tablet) remains steady between 1274 -1174.

Key Actions (new actions in green):

- The introduction of SMS texts has been implemented to support the Emergency Department and outpatients to collect feedback. In April 6,535 SMS texts were sent to eligible patients, in May this fell to 6,166. All patients have the option of opting out of the survey – to date only 3 patients have made this choice.

- QR (Quick Response) Code posters continue to be created for areas across the Trust to offer an alternative method of providing feedback. These have now been introduced to the community midwives to encourage feedback responses. All new areas when set up on the system are offered QR code posters automatically.
- ED has introduced a new system to collect hard copy feedback via staff, with each collecting two pieces of feedback per shift. This has shown an improvement in responses from 30 in April to 105 in May. If sustained this could be replicated across ward areas.
- Support continues from patient experience promoting the FFT to staff and patients via different methods to provide feedback.
- New areas for FFT data collection have been established in the Children's Community Nursing Team (acute and long-term care), Paediatric Oncology Clinic, Paediatric Respiratory Clinic, Rheumatology Day Procedures (NCH)
- An exclusion from SMS texting list is in place for all patients attending a cancer clinic in which bad news is likely to be broken, to avoid contact at a potentially insensitive time. This does not prevent these patients providing feedback via QR code, website, or card.
- New logons continue to be regularly created. Online learning provided to all colleagues receiving a new logon.
- System glitches continue to be identified and resolved.
- Automated monthly reporting commenced. The automated email alerts to advise of negative feedback facilitating a timely review and address any actions requiring improvements to the patient's experience – this will drive improvement in the chart shown below.

Recovery Forecast:

The increase in methods for data collection and included areas ae intended to improve the Trust wide response rate.

Key Risks to Forecast Improvement:

- As the number of responses increases via SMS text it is possible that the level of satisfaction may reduce as the human factor of 'handing out cards' does not have the same impact.
- Online responses may reduce due to survey fatigue

Responsive - Accountable Officer - Chief Operating Officer

Responsive Dashboard - Trust Level

Items in blue are awaiting the latest update

Data To	KPI Description	Target	Current Value	Variance	Assurance
May-21	18 Weeks RTT - Incomplete Perf	92.0%	64.7%		F
May-21	18 Weeks RTT - No. of Specialties failing the target of 92%	0	25		
May-21	18 Weeks RTT - Over 52 Wk waiters	0	1142		
May-21	A&E 4 Hour Performance	95.0%	77.5%		F
May-21	A&E 4 Hour Performance (Majors only)	95.0%	64.4%		F
May-21	A&E 4 Hour Performance (Minors only)	100.0%	92.0%		F
May-21	A&E 12 Hour Trolley Waits	0	0		
May-21	Ambulance Handovers	100.0%	52.1%		F
May-21	Last minute non-clinical cancelled elective operations	0.8%	1.05%		?
May-21	Breaches of the 28 day readmission guarantee	0	0		
May-21	Total non-clinical cancelled elective operations	3.2%	3.82%		?
May-21	Urgent operations cancelled more than once	0	0		
May-21	% of beds occupied by Delayed Transfers of Care	3.5%	3.8%	H	P
May-21	Medically Fit For Discharge - Patients		369	H	
May-21	Medically Fit For Discharge - Days		2261	H	
May-21	No. of beds occ by inpatients >=21 days - (Mthly average over rolling 3 mths)	46	48		?

Cancelled Ops figures are provisional- awaiting agreed confirmation/sign off for May's numbers

Data To	KPI Description	Target	Current Value	Variance	Assurance
Apr-21	Cancer Wait Times - Two Week Wait Performance	93.0%	97.1%		P
Apr-21	Cancer Wait Times - 31 Day Diag to Treatment Performance	96.0%	98.9%		?
Apr-21	Cancer Wait Times - 62 Day Ref to Treatmemt Performance	85.0%	88.6%		?
Apr-21	Cancer Wait Times - 104 Day waiters	0	2		
Apr-21	Cancer Wait Times - Two Week Wait (Breast Symptomatic) Performance	93.0%	90.6%		?
Apr-21	Cancer Wait Times - 31 Day Subsequent Treatment - (Surgery) Performance	94.0%	100.0%		?
Apr-21	Cancer Wait Times - 31 Day Subsequent Treatment - (Drug) Performance	98.0%	100.0%	H	P
Apr-21	Cancer Wait Times - 62 Day Screening Performance	90.0%	100.0%		?
Apr-21	Cancer Wait Times - Consultant Upgrade (62 day)	90.0%	100.0%	H	?
May-21	Diagnostic Wait Times - % of over 6 Week Waiters	1.0%	50.6%	H	F
Apr-21	Stroke - 90% of time on a Stroke Unit	90.0%	50.8%	L	F
Apr-21	Stroke - Direct to Stroke Unit within 4 hours	90.0%	36.1%	L	F
Apr-21	Stroke - Patient scanned within 1 hour of clock start	48.0%	36.1%		?
Apr-21	Stroke - Patient scanned within 12 hours of clock start	95.0%	95.1%		?
	Click here to view other National Stroke (SSNAP Domain) Results				?
Apr-21	Trust - Seen <24 hrs (1st contact to investigations complete)	60.0%	39.3%		?

Emergency Care

Emergency access within 4 hours

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
May-21	A&E 4 Hour Performance	95.0%	77.5%		F	Common Cause (expected) variation	Variation indicates consistently (F)alling short of the target

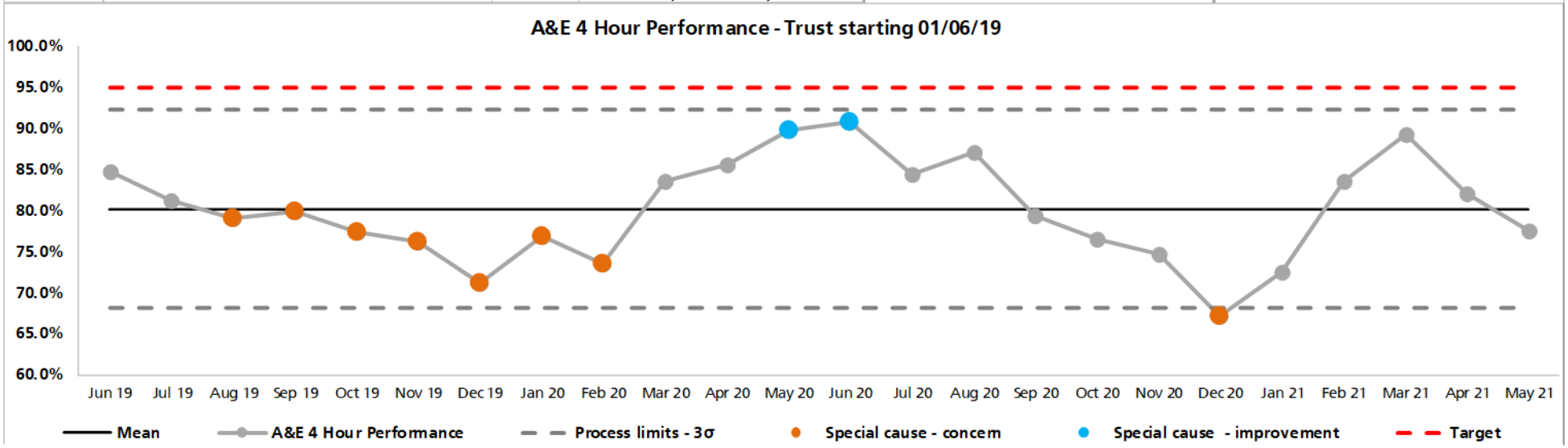


Chart 33 – A&E 4-hour performance

In May 2021, 6,715 patients attended the Emergency Department (ED) and of these, 1,511 patients were in department over 4 hours before admission, discharge or transfer. Performance was **77.5%** against the standard of **95%**.

Admitted performance was 56.9% and non-admitted performance was 89.9%; 77.9% of all breaches were admitted patients. 93.7% of all attendances presented to Amber ED, 6.3% to Red ED. 10.3% of all breaches were from Red ED.

Minor performance was 82.1% in month, however of the 253 breaches recorded as 'minor', 134 (53.0%) were admitted.

The main breach reasons were as follows:

- 596 patients waiting for a bed (39.5%). Of these the top three were;
  - 427 patients were awaiting a bed on an Amber Medical ward
  - 101 patients were awaiting a bed on a Surgical ward
  - 63 patients were awaiting a bed on a Red ward

- 225 patients due to delays to be seen by ED doctors (14.9%), 74 of which were due to a lack of physical capacity within the department.

- 118 patients awaiting specialty review or decision (7.8%). Of these the top three were;
  - 33 patients were Surgical patients (General Surgery, ENT, Urology & Orthopaedics)
  - 25 patients were Amber Medical patient requiring review in ED i.e. clinically unstable for transfer or direct transfers to ward beds
  - 24 patients were awaiting decision making by the Stroke team

There were no patients that waited in the Emergency Department over 12 hours from decision to admit to admission in May 2021.

Ambulance Handovers completed within 15 minutes

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
May-21	Ambulance Handovers	100.0%	52.1%		F	Common Cause (expected) variation	Variation indicates consistently (F)alling short of the target

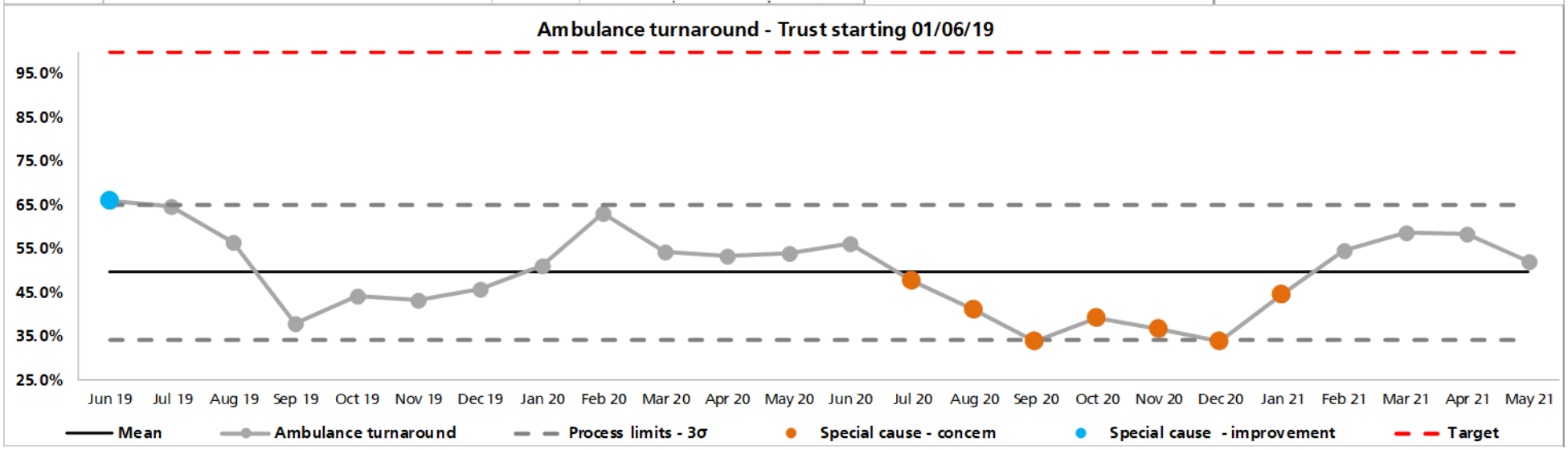


Chart 34 – Ambulance handover performance

In May 2021 there were 2,125 conveyances by EEAST to the Emergency Department (ED). 52.1% of all handovers took place within 15 minutes against the trajectory of 65.0%. 79.8% of handovers were completed within 30 minutes against a trajectory of 85.0%.

The average handover time was 26 minutes and 9.6% of handovers exceeded 60 minutes. In month, the Trust ranked 4th out of 17 hospitals within the region for the percentage of handovers completed within 15 minutes.

Key Issues (any new issues in red):

1. ED attendances increasing above pre COVID-19 levels (approximately 20% higher) with insufficient Amber capacity to meet the demand for new admissions.
2. Current ED medical staffing model and physical space within the ED is insufficient for managing the increased demand.

3. Poor compliance with the Trust Internal Professional Standards resulting in delays for specialty reviews and decision making within the ED.

Key Actions (new actions in green):

1. Review of the current ED staffing model to support more efficient decision making for patients presenting with a minor injury or illness to address delays for patients to be seen by a clinician.
2. Development of pathway redesign work being undertaken through the Urgent & Emergency Care Improvement programme to address specialty delays within ED.
3. Development of a long-term space solution for ED to increase capacity for majors and ambulance offload. A weekly working group has been established to monitor actions and progress.

Recovery Forecast:

Emergency Access within 4 hours and Ambulance Handovers completed within 15 minutes is forecast to deliver to trajectory from July 2021.

Key Risks to Forecast Improvement:

Continued attendances above expected activity levels and forecast increase in seasonal demand.

Elective Care

18 weeks referral to treatment

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
May-21	18 Weeks RTT - Incomplete Perf	92.0%	64.7%		F	Common Cause (expected) variation	Variation indicates consistently (F)alling short of the target

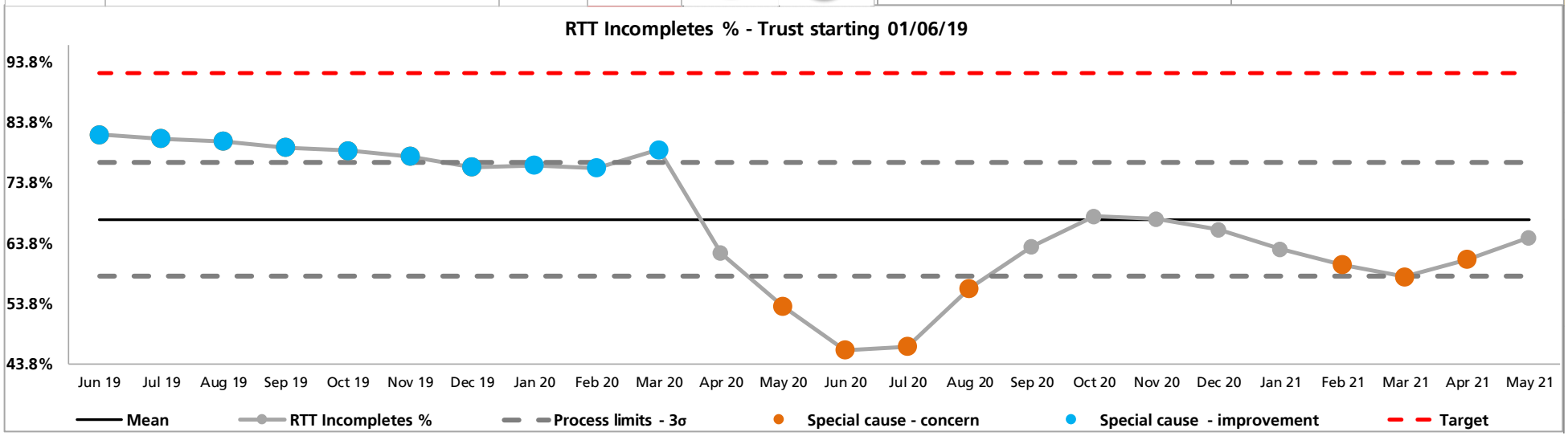


Chart 35 – RTT incompletes

At the end of May 2021, there were a total of 17,173 patients on the waiting list, 6,067 of these patients had waited for over 18 weeks from referral, giving performance of 64.7%. The top 3 specialties with the greatest number of patients waiting over 18 weeks were Orthopaedics (1261), Ophthalmology (735) and ENT (717).

Key Issues (new issues in red):

1. Day Surgery remained closed for Red ED until 14th May 2021.
2. Prioritisation of urgent P2 cases in line with national guidance.
3. Cancer referrals have remained at and increased level

Key Actions (new actions in green):

1. All 6 elective theatres within the main theatre suite are fully utilised Monday – Friday.
2. All 4 theatres in the Day Surgery Unit reopened for surgical procedures on 17th May 2021
3. Prioritisation of Cancer P2 patients in the allocation of treatment trajectory

Recovery Forecast:

The 18-week performance is not expected to recover to 92% during the 2021/22 financial year.

Key Risks to Forecast Improvement:

1. A further wave of COVID-19 necessitating the return of Day Surgery to a Red ED.
2. Unforeseen disruption to theatre capacity due to RAAC issues.
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

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 May 2021 there were 1,142 patients waiting longer than 52 weeks for treatment. The majority of these were in Orthopaedics (379), Gynaecology (219) and General Surgery (198). The longest waiting patient is an orthopaedic patient at 108 weeks and has a treatment date on the 17 June 2021.

A further increase in the number of 52-week breaches is forecast as the acceptance of routine referrals recommenced on 26/05/2020.

Key Issues (new issues in red):

1. Day Surgery remained closed for surgical procedure until 14 May 2021
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. There has been an increased number of P2 patients who have been expedited due to a change in clinical risk.

Actions (new actions in green):

1. All 6 elective theatres within the main theatre suite are now fully utilised Monday – Friday.
2. All 4 theatres within Day Surgery Unit reopened for surgical procedures on the 17th May 2021
3. Continue to allocate theatre capacity in line with P2 demand, to ensure the backlog of P2 patients can be cleared as quickly as possible and therefore release capacity to treat long-waiting patients.
4. Long waiters over 98 weeks + included in the priority group for theatre allocations

Recovery Forecast:
The backlog of patients waiting for over 52 weeks will not be cleared in this financial year.

Key Risks to Forecast Improvement:

1. Theatre capacity to meet waiting list backlog
2. Effective utilisation of all available theatre capacity.

Breaches of the 28-day readmission guarantee

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

Diagnostic Waiting Times

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
May-21	Diagnostic Wait Times - % of over 6 Week Waiters	1.0%	50.6%	H	F	Special cause (unexpected) variation - Concern (H)	Variation indicates consistently (F)alling short of the target

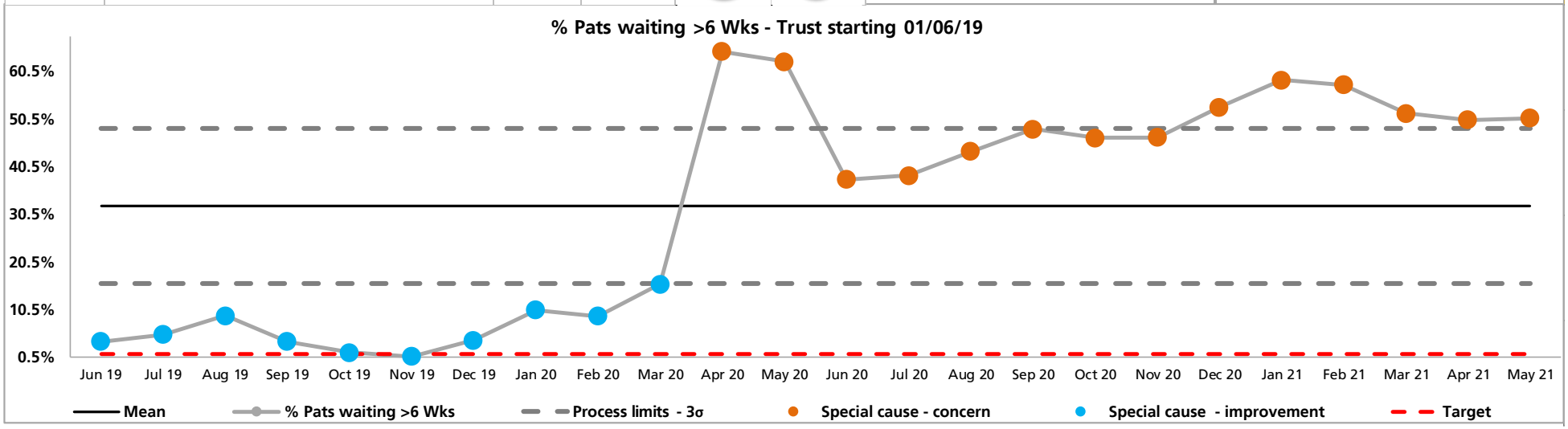


Chart 36 - % patients waiting > 6 weeks

In May 2021 the unvalidated performance was 50.6% against the standard of 1%. There were 3,937 patients waiting over 6 weeks at the end of the month from a total waiting list of 7,715. The majority of these are in MRI (874), Echocardiogram (1,192) and CT (990); the total waiting list size has increased by 630 which is a combination of Non-Obstetric Ultrasound (+326) and CT (+237)

Key Issues (any new issues in red):

1. Activity levels have not yet returned to pre COVID-19 levels in Echocardiography, but this is planned for July.
2. The number patients waiting for non-obstetric Ultrasound has increased this month.
3. Insufficient capacity within MRI and CT.

Key Actions (new actions in green):

1. A staffed mobile CT van has been secured for 7 days in June, 239 patients have been booked. A further staffed van is being supplied for 2 weeks in July and confirmation is waited for all of August.

2. Echocardiography staffing will improve in June and further in July when activity levels will revert to pre COVID-19 levels.
3. A review of Non-Obstetric Ultrasound service delivery is in progress.
4. The National Clinical Prioritisation Programme for Diagnostics is underway and will ensure the most clinically appropriate patients are booked first; ensuring resources are used to best effect.

Recovery Forecast:
A recovery trajectory has been created but is heavily dependent on Imaging and Echo capacity.

Key Risks to Forecast Improvement:
1. Continued mechanical failure of the MRI
2. Availability of MRI, CT, and Echo outsourced capacity
3. High levels of demand for patients referred on a suspected cancer pathway

Stroke – 90% of time on a Stroke Unit

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Stroke - 90% of time on a Stroke Unit	90.0%	50.8%	L	F	Special cause (unexpected) variation - Concern (L)	Variation indicates consistently (F)alling short of the target

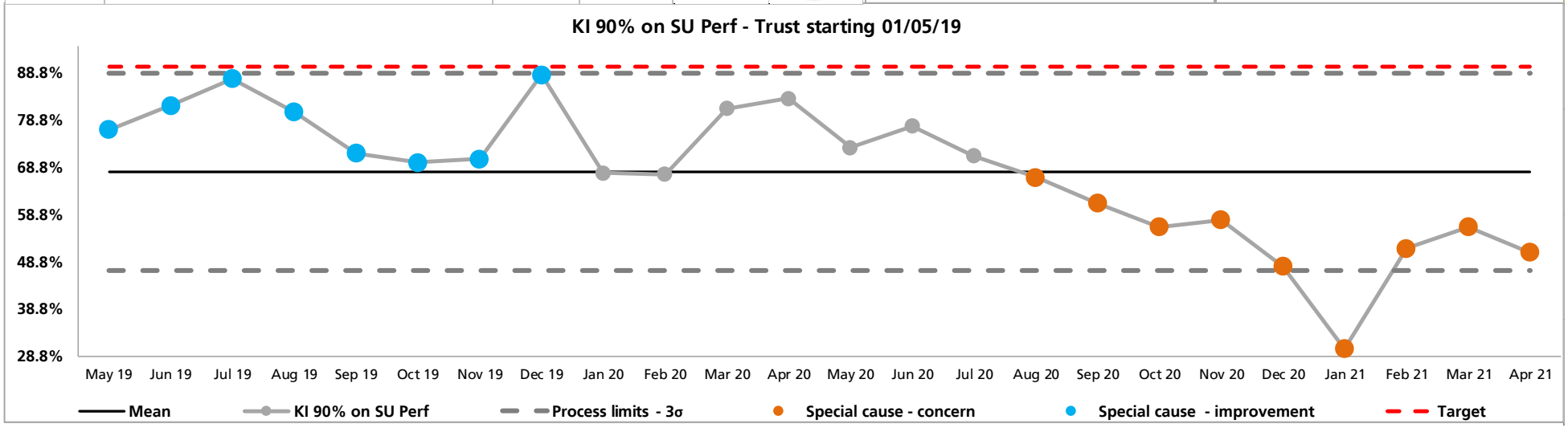


Chart 37 – Stroke – 90% of time on a Stroke Unit

In April, 50.8% of patients spent less than 90% of their stay on the Stroke Unit (SSNAP audit score 'E').

The key breach themes are:

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

Key Issues (any new issues in red):

1. The number of Stroke patients based on a non-stroke ward ranged from 6 to 10 on a daily basis. 47% of breaches (7 patients) did not stay on the Stroke Unit during their inpatient admission.
2. The Coronary Care Unit (CCU) remains Stroke Unit reducing the Stroke bed base from 29 to 24 beds.

Key Actions (new actions in green):

1. Agreement of Stroke flow principles to ensure timely admission of acute Stroke patients and step down of patients not requiring acute Stroke care. Principles agreed with a provisional 'go-live' date of 14th June.
2. Relocation of the Coronary Care Unit in line with the finalised ward reconfiguration.
3. To continue to work with the Integrated Stroke Delivery Network (ISDN) and Emergency Care Improvement Support Team (ECIST) to improve stroke outcomes and pathway efficiencies.

Recovery Forecast:

A recovery trajectory will be in place once the timescales for the relocation of the coronary care unit are confirmed.

Key Risks to Forecast Improvement:

Coronary Care remaining on the Stroke Unit.

Cancer waiting times

2 week wait from referral to first outpatient appointment

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Cancer Wait Times - Two Week Wait Performance	93.0%	97.1%			Common Cause (expected) variation	Variation indicates consistently (P)assing the target

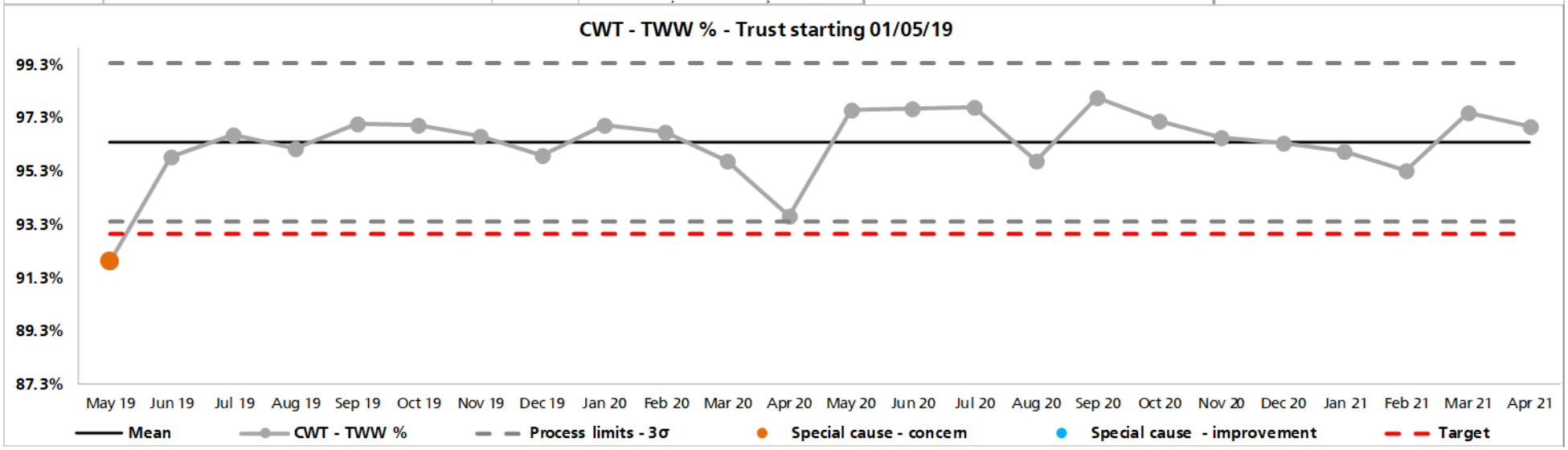


Chart 38 – CWT 2 week wait performance

Performance in April 2021 was 97.1% against the standard of 93%, there are no current concerns regarding the ongoing delivery of this standard.

62-day referral to treatment

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Cancer Wait Times - 62 Day Ref to Treatmemt Performance	85.0%	88.6%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

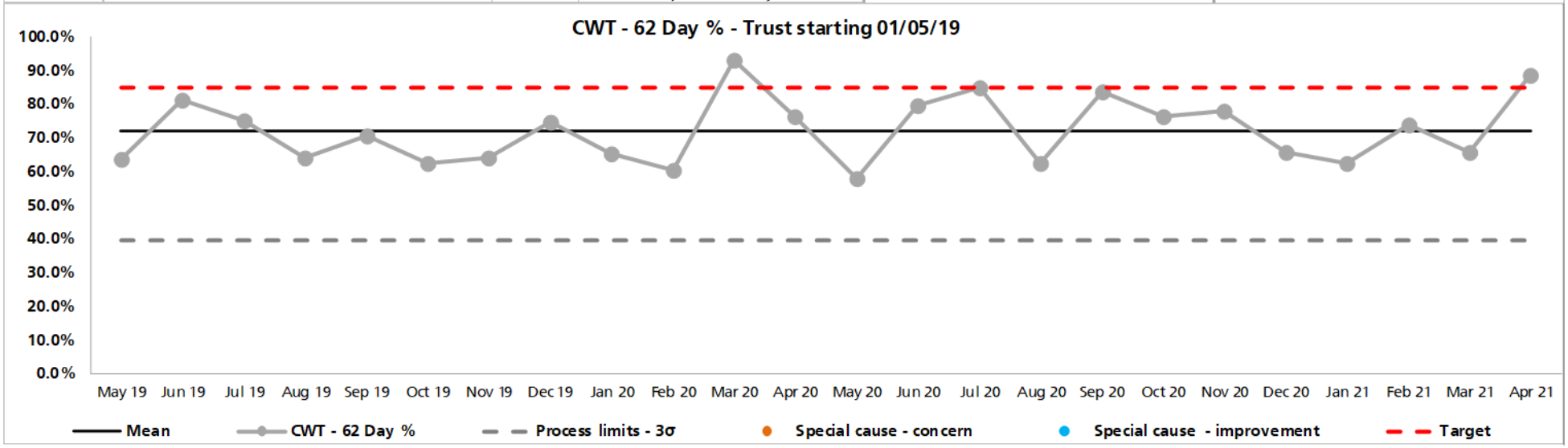


Chart 39 – CWT 62-day referral to treatment

Performance in April 2021 was **88.6%** against the standard of **85%** and trajectory of **77.23%**.

There were **52.5** treatments of which **6** breached the 62-day standard (1 Gynaecology, 2 Haematology, 2 Colorectal, 0.5 Lung and 0.5 Head and Neck)

Key Issues (any new issues in red):

1. Staff Shortages within the Gynaecology team combined with rising referral numbers (Feb 79, March 111, April 107) has caused significant pressures within the service

2. Waiting Times for CT & MRI scans have risen again causing delays in patient pathways. Current waits are 15-16 days and 18-19 days respectively

Key Actions (new actions in green):

1. A Gynaecology locum consultant has been requested and is currently with the VSP panel. A full departmental review of job plans is currently being undertaken
2. A mobile CT unit has now been secured and will be on site 7 days in June, 2 weeks in July and for all of August. Outsourcing of MRI capacity is being explored and a paper will be submitted to OMG by the end of June 21.

Patients waiting for 104+ days

The Trust has been able to reduce the number of 104+ day waiters significantly in recent months. At the peak last year **38** patients were waiting over 104 days for treatment. There are now currently **11** patients waiting for over 104 days, of which **4** are colorectal, **4** are gynaecology, **2** are Head and Neck and **1** Upper GI.

6 of these patients are now treated and are either awaiting histology results or a consultant review, **1** is awaiting confirmation to be removed from the pathway, and **1** patient has a treatment booked.

Of the 3 remaining patients, 1 has a primary diagnosis and is awaiting a surgery date at NNUH. 1 has been referred to NNUH and is currently undergoing diagnostic procedures. 1 patient is currently on a Colorectal pathway but is due to move to the Lung pathway due to suspected Lung metastases.

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

Statement of comprehensive income: Month 2 – 2021/22

I&E

	In Month				Year to Date			
	Plan £'000s	Actual £'000s	Fav / (Adv) £'000s	%	Plan £'000s	Actual £'000s	Fav / (Adv) £'000s	%
Clinical Income	18,886	18,820	(66)	(0%)	37,772	37,695	(77)	(0%)
Other Income	1,347	1,312	(35)	(3%)	2,694	2,641	(53)	(2%)
COVID-19 Additional Income	1,282	1,448	166	13%	2,564	3,007	443	17%
Total Income	**21,515**	**21,580**	**65**	**0%**	**43,030**	**43,343**	**313**	**1%**
Pay Costs - Substantive	(12,175)	(12,641)	(466)	(4%)	(24,349)	(25,135)	(786)	(3%)
Pay Costs - Bank	(1,129)	(910)	219	19%	(2,258)	(1,931)	327	14%
Pay Costs - Agency	(1,320)	(665)	655	50%	(2,640)	(1,652)	988	37%
Pay Costs - Additional COVID-19	(691)	(986)	(295)	(43%)	(1,782)	(2,222)	(440)	(25%)
Pay Costs - Vaccination Centres	0	(143)	(143)		0	(355)	(355)	
Total Pay	(15,315)	(15,345)	(30)	(0%)	(31,029)	(31,295)	89	0%
Non Pay - Additional COVID-19	(125)	(47)	78	62%	(275)	(151)	124	45%
Non Pay	(5,266)	(5,504)	(238)	(5%)	(10,622)	(11,034)	(412)	(4%)
Total Operating Costs	**(20,706)**	**(20,896)**	**(190)**	**(1%)**	**(41,926)**	**(42,480)**	**(554)**	**(1%)**
EBITDA	**809**	**684**	**(125)**	**(15%)**	**1,104**	**863**	**(241)**	**(22%)**
Non-Operating Costs	(944)	(816)	128	14%	(1,883)	(1,632)	251	13%
Adjust Donated Assets	29	33	4	14%	58	66	8	14%
TOTAL (Deficit) / Surplus	**(106)**	**(99)**	**7**	**7%**	**(721)**	**(703)**	**18**	**2%**

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

Key points of note in month:

- Red ED in Day Surgery and the escalation ward on Windsor ward have both been closed during M2.
- COVID-19 Income is positive to plan due to the recovery of vaccination costs and additional COVID-19 testing costs.
- Excluding COVID-19, the pay bill is £0.4m positive to plan (i.e. net variance of substantive, bank and agency).
- COVID-19 pay expenditure is adverse to plan mainly due timing differences in stepping down the escalation wards.
- Excluding COVID-19 expenditure, agency spend is positive to plan by £0.7m
- Non-pay includes an additional provision of £0.2m.
- The CIP programme has achieved £0.7m of efficiencies in month, which is positive to plan.
- In month capital expenditure incurred is £0.6m.

Statement of Financial Position (SOFP) Update

	31-Mar-21 £m	30-Apr-21 £m	31-May-21 £m	Month on Month Movement £m	YTD Movement £m
Noncurrent assets	101	99	100	1	(1)
Current Assets					-
Inventories	2	2	2	-	-
Trade & Other Receivables	13	15	12	(3)	(1)
Cash	27	25	26	1	(1)
Current liabilities					-
Trade & Other Payables	(19)	(20)	(18)	2	1
Accruals	(18)	(13)	(14)	(1)	4
PDC dividend	-			-	-
Other current liabilities	(2)	(2)	(1)	1	1
Noncurrent liabilities	(1)		(1)		-
Borrowings	-		-	-	-
Total assets employed	**103**	**106**	**106**	**3**	**3**
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**	**3**

Month-on-Month Key movements

There have been no significant movements in the Balance Sheet during May 2021.

Trade and other receivables have reduced by £3m as a result of the collection of Covid-19 expenditure funding outstanding from the CCG.

This has given rise to a £1m increase in cash balances, with the remaining £2m used to reduce trade creditors through additional payments to suppliers

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

Items in blue are awaiting the latest update

Data To	KPI Description	Target	Current Value	Variance	Assurance
May-21	Appraisal Rate	90.0%	83.2%	H	F
May-21	Appraisal Rate (Med Staff exc Jnr Drs)	95.0%	90.0%		?
May-21	Sickness Absence Rate	4.0%	5.8%		F
May-21	Long Term Sick		3.0%		
May-21	Short Term Sick		2.8%		
May-21	Mandatory Training Rate	80.0%	83.3%		?
May-21	Turnover Rate	10.0%	9.7%	L	F

Well-Led (People)

Vacancy Levels and Turnover

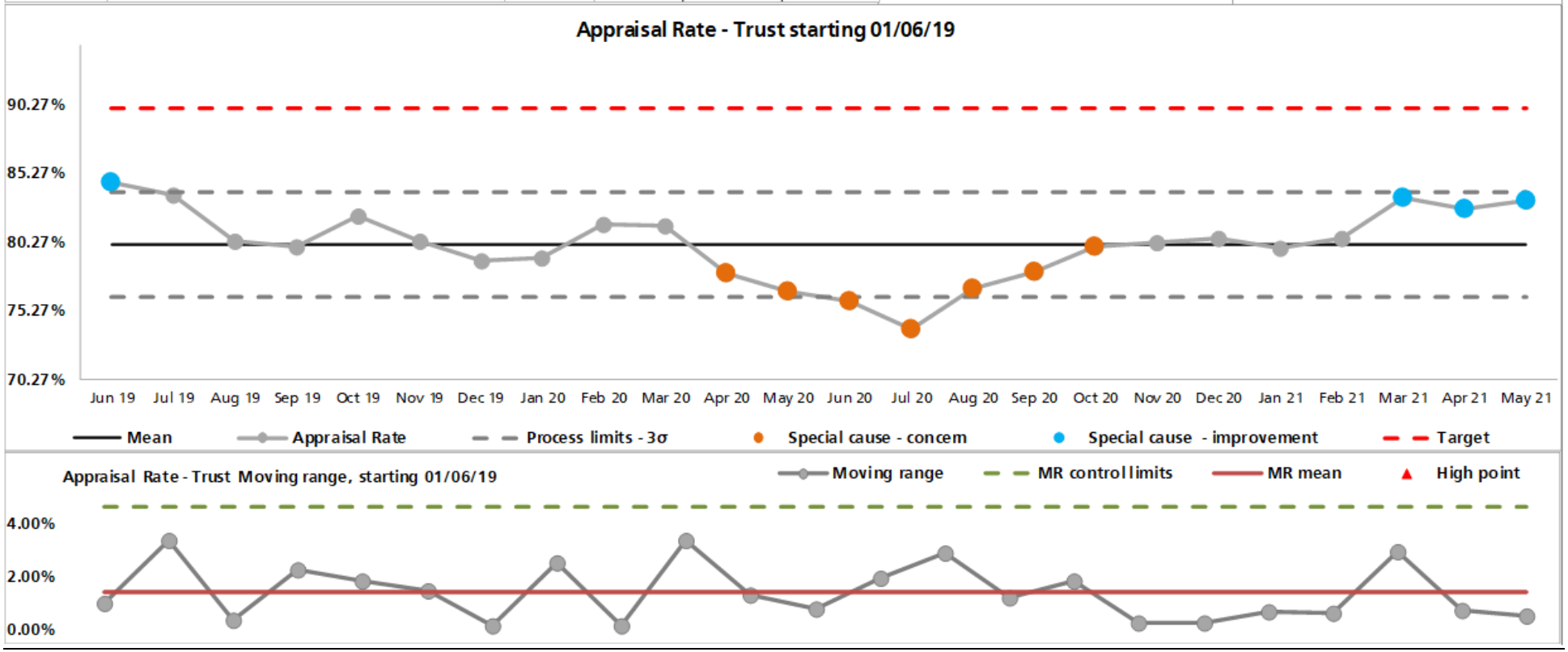
Division	March 2021	April 2021	May 2021
Trust	6.03%	6.32%	6.31%
Nursing and Midwifery	5.6%	5.43%	6.3%
Medical and Dental	5.13%	4.97%	4.7%
AHP	14.57%	15.79%	15.79%

Table 1: Vacancies

An additional six International Nurses are due to start in July 2021

Appraisals

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
May-21	Appraisal Rate	90.0%	83.2%	H	F	Special cause (unexpected) variation - Improvement (H)	Variation indicates consistently (F)alling short of the target



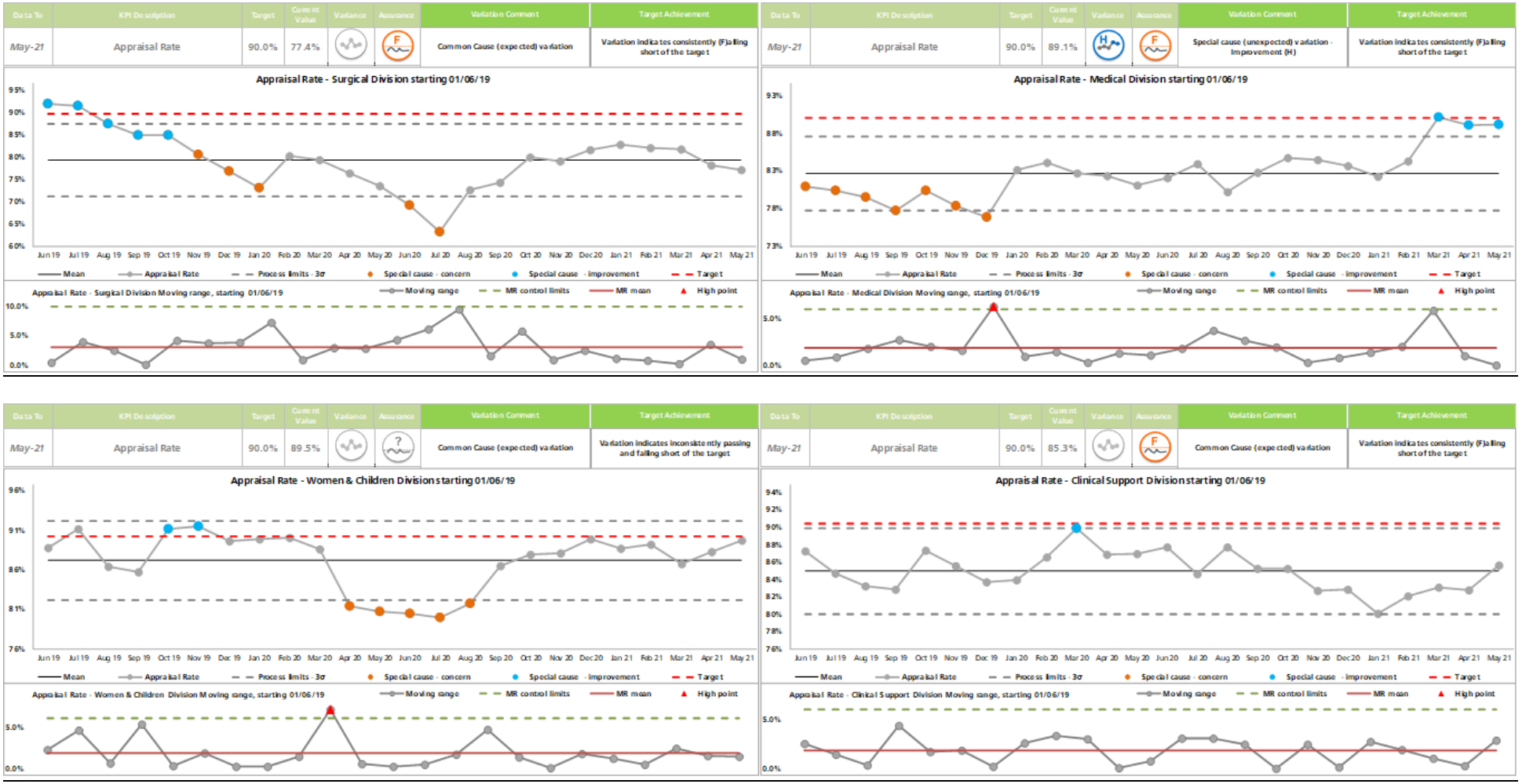


Chart 40 – Appraisal rate

Key Issues

- Seriously Overdue appraisals (in excess of 18 months overdue) – 88 increase of 33 on the previous month,
- 47 overdue by 18 – 24 months
- 41 appraisals overdue by 24 months.

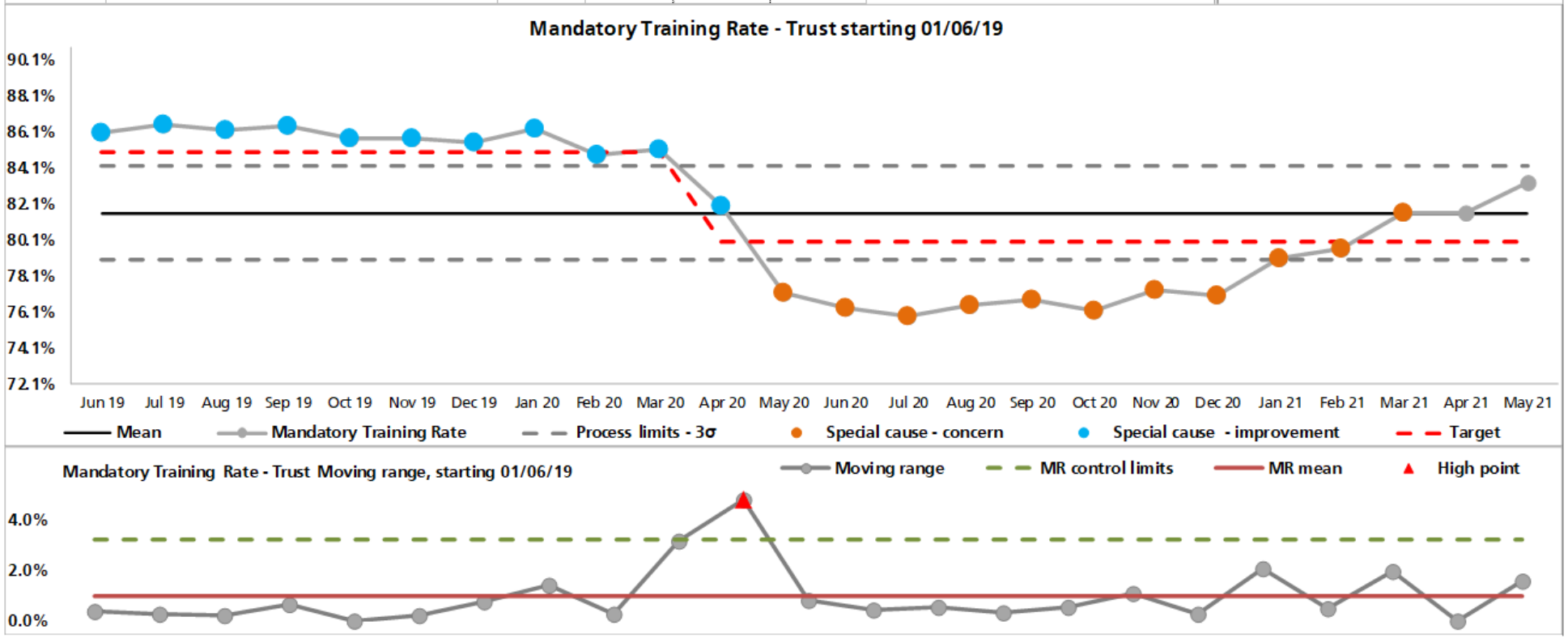
- 64/88 substantive employees
- 24/88 bank workers unable to complete a shift without having an appraisal in place.

Key Actions:

- A pay progression policy is under development and will automatically apply to new starters from April 2021.
- Appraisal documentation amended to incorporate the Trust's values
- Additional training provided
- Recovery plans and trajectories in place

Mandatory Training

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
May-21	Mandatory Training Rate	80.0%	83.3%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target



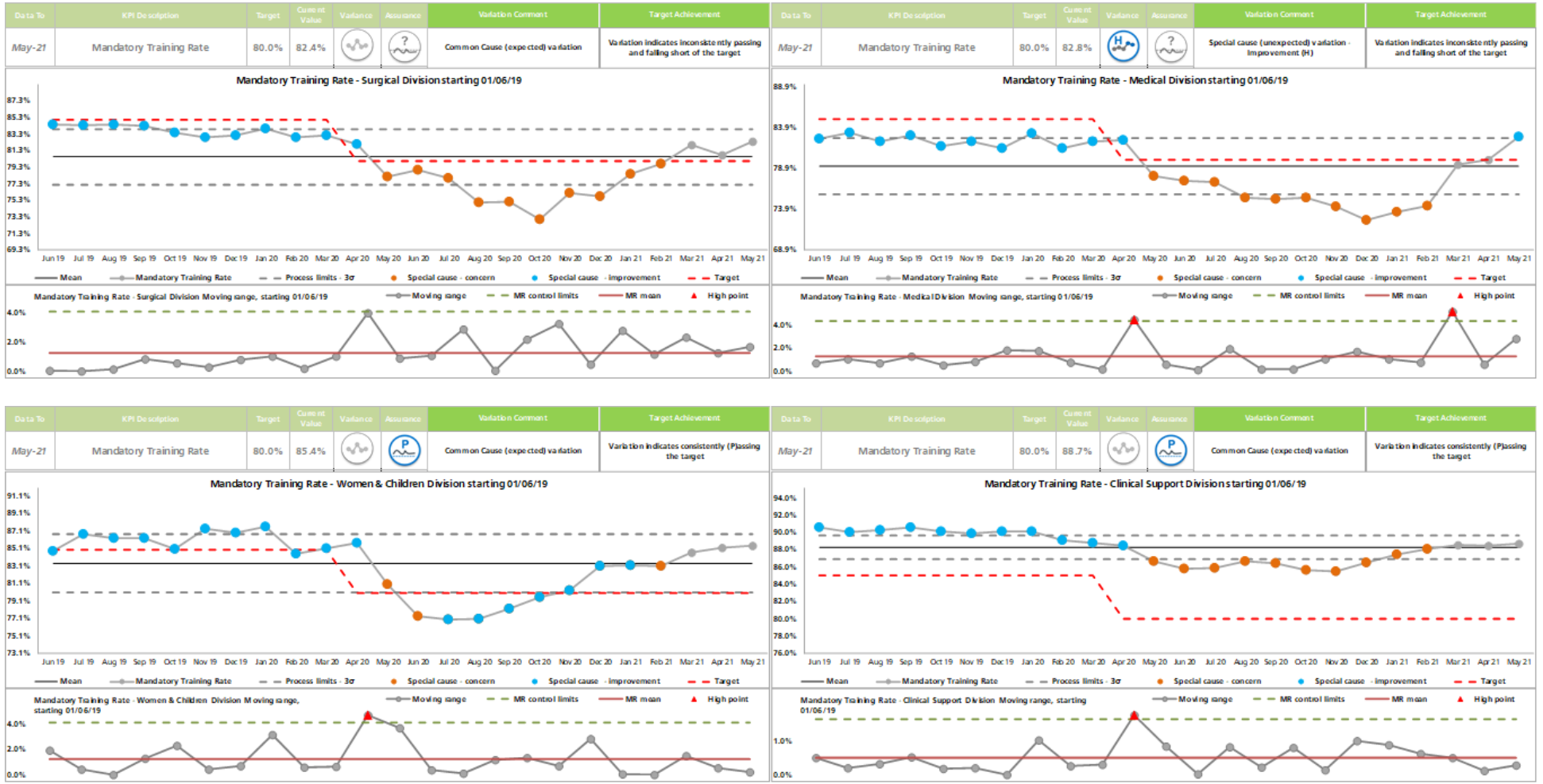


Chart 41 – Mandatory Training rate

Key Issues:

- COVID-19 social distancing restricts the number of attendees on each face-to-face course

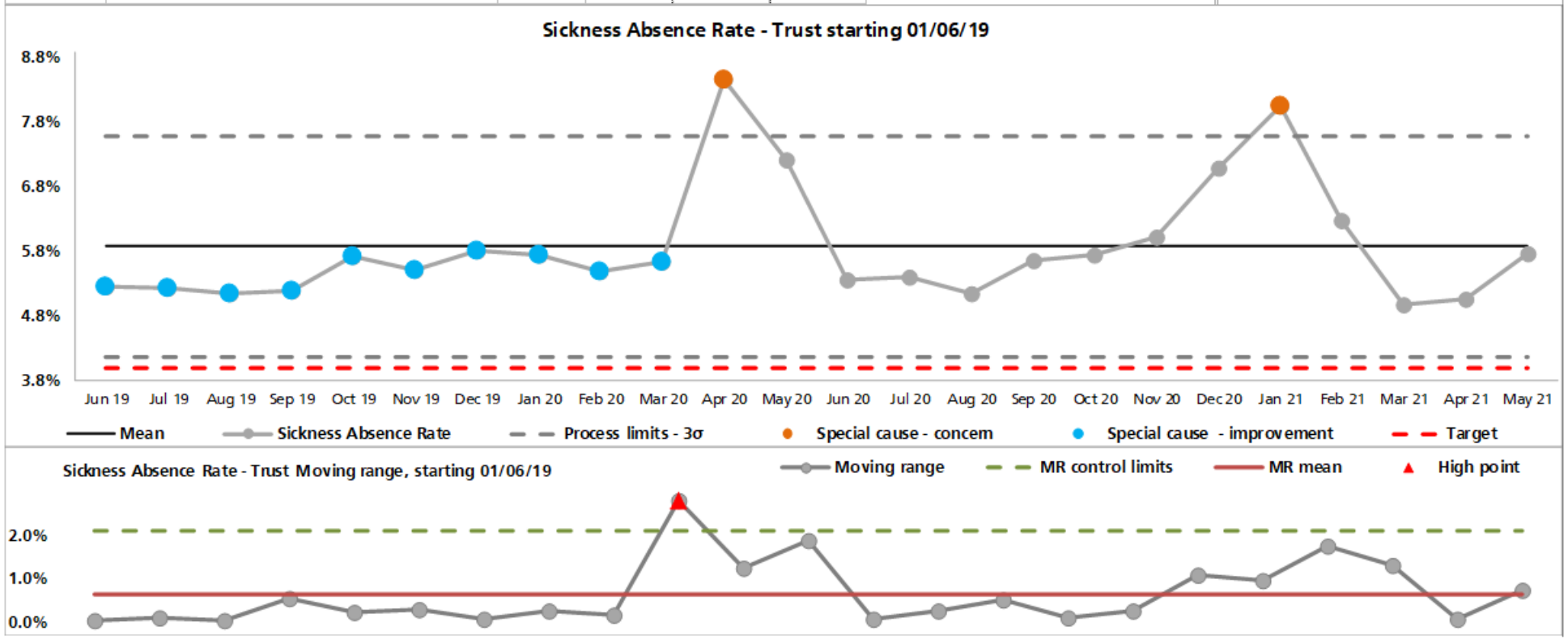
Key Actions:

- Electronic FAQs and 'How to' guides being developed including video guides

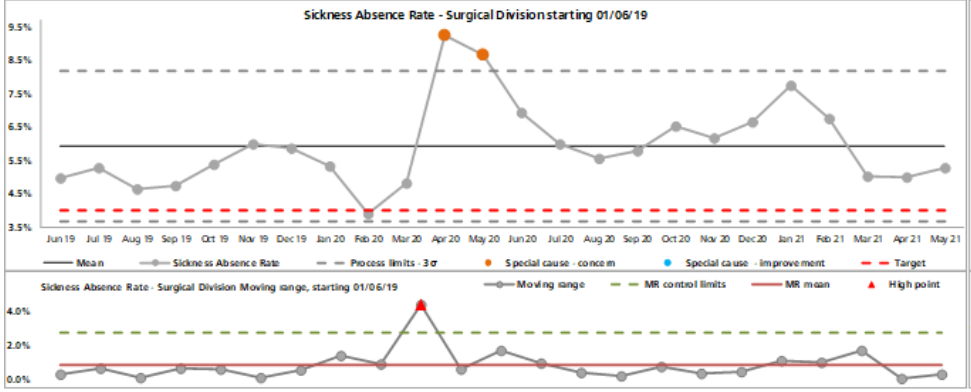
- A three-month expiry extension for face to face Resus and Manual Handling Level 2 Has now passed
- Electronic Assessment of workbooks is reducing submission in hardcopy
- A potential pay progression deferral if Statutory and Mandatory Training is not 100% is to be included in a new Mandatory Training Policy
- Policy Convergence and Alignment across the three acute trusts is progressing
- A task and finish group in place recommending improvements to the Statutory and Trust Mandatory Training. This has been approved by CELM and DLTs is now entering the implementation phase
- Barriers to not achieving compliance in Face to Face Subjects identified and solution presented to CELM.

Sickness Absence Rate

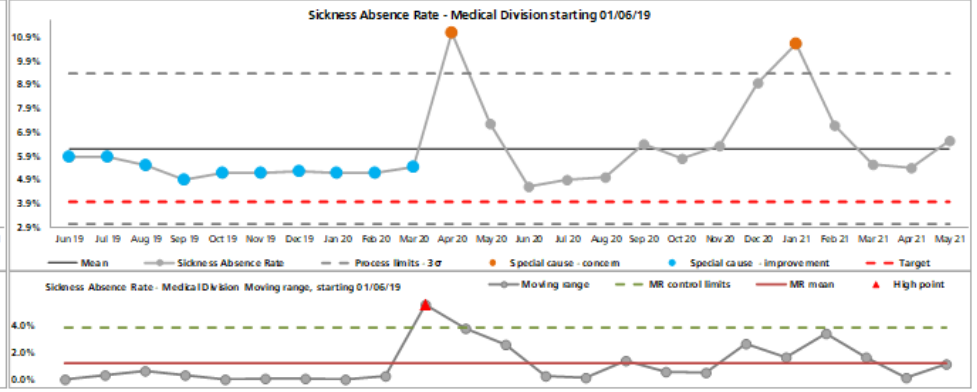
Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
May-21	Sickness Absence Rate	4.0%	5.8%		F	Common Cause (expected) variation	Variation indicates consistently (F)alling short of the target



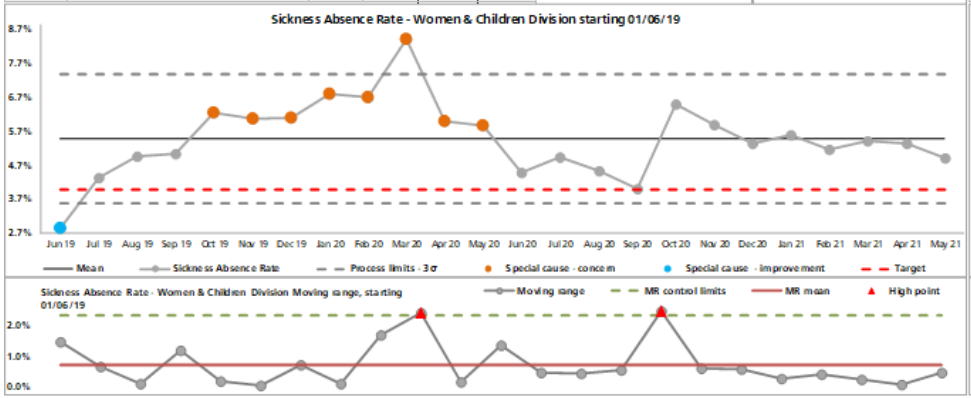
Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
May-21	Sickness Absence Rate	4.0%	5.3%			Common Cause (expected) variation	Variation indicates inconsistently passing and failing short of the target



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
May-21	Sickness Absence Rate	4.0%	6.6%			Common Cause (expected) variation	Variation indicates inconsistently passing and failing short of the target



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
May-21	Sickness Absence Rate	4.0%	4.9%			Common Cause (expected) variation	Variation indicates inconsistently passing and failing short of the target



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
May-21	Sickness Absence Rate	4.0%	5.2%			Common Cause (expected) variation	Variation indicates inconsistently passing and failing short of the target

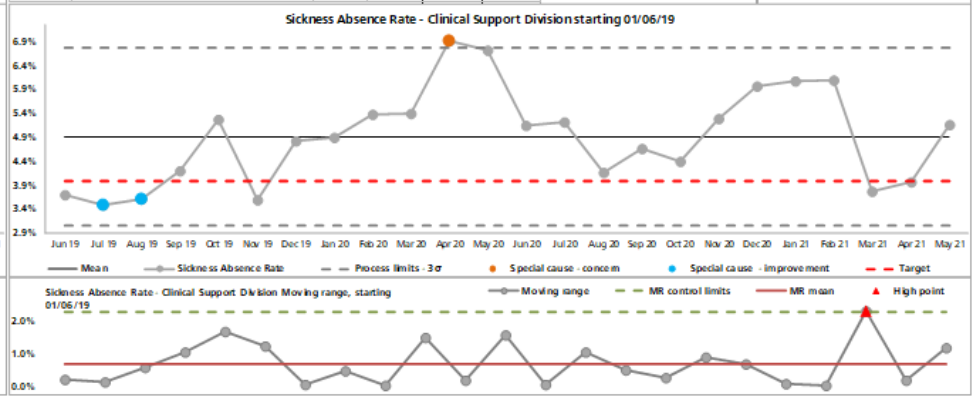


Chart 42 – Sickness Absence rate

Sickness absence in May increased to 5.8% from 5.1%.

A detailed review of long-term Sickness in all areas is under way. Specific individual plans being established for return to work or options meetings. Additional OH support and case conferences being arranged to manage Long-Term Sick cases.