The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Meeting:	Board of Directors		
Meeting Date:	1 June 2021	**Agenda item:**	11
Report Title:	Integrated Performance Report (IPR) – April 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 11 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 Finance and Activity Committee Senior Leadership Team

Executive summary					
Action required: [highlight **one** only]	Approval	Information	**Discussion**	Assurance	Review
Purpose of the	The Trust is required to provide assurance that its approach to performance management is rigorous and appropriately identifies,				

report:	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:	As outlined within the report, performance for April 2021; - Three Serious Incidents - Three cases of hospital onset E.Coli - Four cases of hospital associated C.Diff - HSMR has risen further above the expected rate, recognising the impact of the COVID-19 pandemic - Four instances of same sex accommodation breaches affecting nine patients - The complaints response rate fell to 58% - A&E 4-hour performance was at 82.1% - Three patients waited >12 hours in ED for mental health inpatient beds - Ambulance handover performance within 15 minutes was 58.5% - 18-week RTT performance is at 61.1% - 1,289 patients were waiting > 52 weeks - Cancer Wait Times – 62-day referral to treatment was 65.8% - Diagnostic wait times over 6 weeks improved to 50.2% - 56.1% of patients spent 90% of their stay on the stroke unit - The Trust's month 1 financial position is showing a surplus of £12k against the planned deficit of £616k. - The Trust has achieved its CIP plan for month 1 delivering savings of £245k. - Sickness absence in April increased to 5.05% from 4.98% - Training compliance for the 11 Statutory topics is 81.66% similar to 81.63% in March - Appraisal compliance (including bank staff but excluding medical staff) decreased slightly to 82.70% from 83.47% in March
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

April 2021 data

Executive Summaries

Safe

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

There has been a decrease in the number of reported injurious inpatient falls per 1,000 beddays.

There has been an increase in hospital acquired pressure ulcers per 1,000 beddays.

There have been four cases of hospital associated CDiff reported.

There have been three cases of hospital onset E.Coli in April 2021.

VTE screening compliance remains above target, with performance maintained for eleven months.

Effective

The SHMI rate has increased QEH remains within the "as expected" band.

The HSMR has increased and is anticipated to remain elevated for at least the next 7 months due to the observed increase in the crude number of deaths and the rate of deaths per 1,000 admissions due to the pandemic in December 2020/January 2021.

Caring

There have been four incidents of same sex accommodation breaches affecting nine patients, all of whom were in the Hyper Acute Stroke Unit on West Raynham Ward.

The timeliness of responding to complaints within 30 days has deteriorated this month and remains below target. Performance is expected to improve as actions are being delivered to improve timeliness.

Responsive

4-hour performance for April was 82.1% against the standard of 95% and trajectory of 86.9%.

There were three patients waiting in the Emergency Department over 12 hours from decision to admit to admission for a Mental Health bed.

In April 58.5% of ambulance handovers were completed within 15 minutes against a trajectory of 65% and 4.5% exceeded 60 minutes.

18-week performance was 62.0% against the standard of 92%.

There are 1,257 patients breaching the maximum 52-week waiting time standard.

Diagnostic performance deteriorated to 50.9% of patients waiting for longer than 6 weeks.

Cancer 62-day performance in March 2021 was 65.8% against the standard of 85% and trajectory of 83.3%.

Well Led (Finance)

The Trust's month 1 financial position is showing a surplus of £12k against the planned deficit of £616k.

Additionally, the Trust has achieved its CIP plan for month1 delivering savings of £245k.

Well Led (People)

The new funded establishment for 2021/22 is 3631.75 FTE, with substantive FTE 3375.70.

The review of medical establishment and junior doctors' rotas has been undertaken within the Division of Medicine to ensure tighter financial control of medical posts, vacancy control and reduction in medical locum spend. This exercise is being repeated for the Divisions of Surgery and Women and Childrens.

93.3% of job plans have been completed and the new process for job planning in 2021/22 is due to commence in July 2021.

Sickness absence in April increased to 5.05% from 4.98%. 12 month cumulative sickness is at 5.99% which has decreased from 6.28%.

A review is being undertaken for long term sickness in the Divisions of Medicine and Surgery as this has increased over the last two months. 100% of shielders have returned to work in April 2021.

The Trust continues to support staff to apply for the EU settlement scheme. 239 European Economic Area (EEA) staff are yet to confirm if they have applied.

The Trust vacancy rate has increased slightly this month from 6.03% in March to 6.32%.

Turnover increased to 9.15% from 9.10% the previous month but remains below the 10% Trust target.

Bank usage increased to 347.70. FTE from 322.29 in March with 11.57 FTE charged to COVID-19 and 15.54 FTE to Vaccinators.

Agency usage decreased to 177.82 FTE from 213.30 in March with 71.86 FTE being coded directly to COVID-19 costs, 10.54 FTE to Vaccinator costs and 5.0 FTE to Special Measures Funding

Appraisal compliance (including bank staff but excluding medical staff) decreased slightly to 82.70% from 83.47% in March. Medical staff appraisal compliance is 100%.

Training compliance for the 11 Statutory topics is 81.66% similar to 81.63% in March. This includes a national 3-month extension for Data Security Training.

A note on SPC Charts

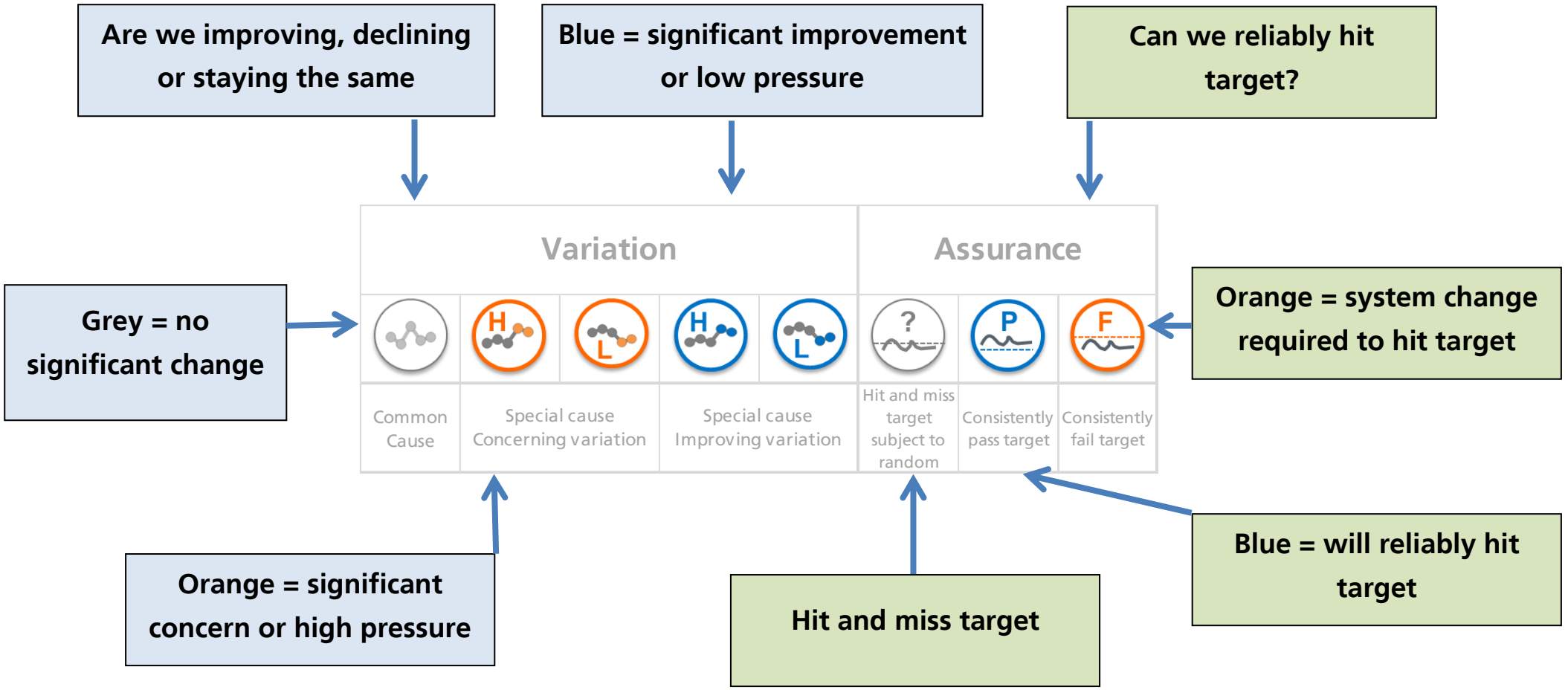
The report that follows uses the key below. A recap of using these descriptions is also included below

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	Target	Current Value	Variance	Assurance
Apr-21	Serious Incidents (DECLARED IN MONTH)	0	3		
Apr-21	Falls (with Harm) Rate per 1000 beddays	0.98	0.08		P
Apr-21	PUs Rate per 1000 beddays	0.41	0.30		?
Apr-21	Overall Fill Rate %	80.0%	93.0%		P
Apr-21	CHPPD	8.00	8.88		?
Apr-21	Cleanliness - Very High Risk	95.0%	97.1%		?
Apr-21	Cleanliness - High Risk	95.0%	96.2%		?
Apr-21	Cleanliness - Significant Risk	95.0%	92.5%		?
Apr-21	Cleanliness - Low Risk	95.0%	87.0%		
Apr-21	Cleanliness - No. of audits complete	37.00	40		?

Data To	KPI Description	Target	Current Value	Variance	Assurance
Apr-21	CDiff (Hosp Onset) Rate per 100k beddays	30.10	34.78	H	?
Apr-21	CDiff (Hosp Onset) Actual	4	4		
Apr-21	MRSA (Hosp Onset) Actual	0	0		
Apr-21	E Coli (Hosp Onset) Rate per 100k beddays	16.40	17.39	H	P
Apr-21	E Coli (Hosp Onset) Actual	2	3		
Apr-21	MSSA (Hosp Onset) Actual		2		
Apr-21	MSSA (Hosp Onset) Rate per 100k beddays		9.74	H	
Mar-21	VTE Assessment Completeness	97.2%	98.5%	H	?
Apr-21	Patient Safety Alerts not completed by deadline	0	0		

Serious Incidents

3 Serious Incidents were reported in April:

- Ventouse delivery resulting in a baby suffering an undisplaced skull fracture
- Patient fell and sustained a #NOF on Necton ward
- Failure to escalate a deteriorating patient on Denver Ward where ward based medical management had been agreed

Falls

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Falls (with Harm) Rate per 1000 beddays	0.98	0.08			Common Cause (expected) variation	Variation indicates consistently (P)assing the target

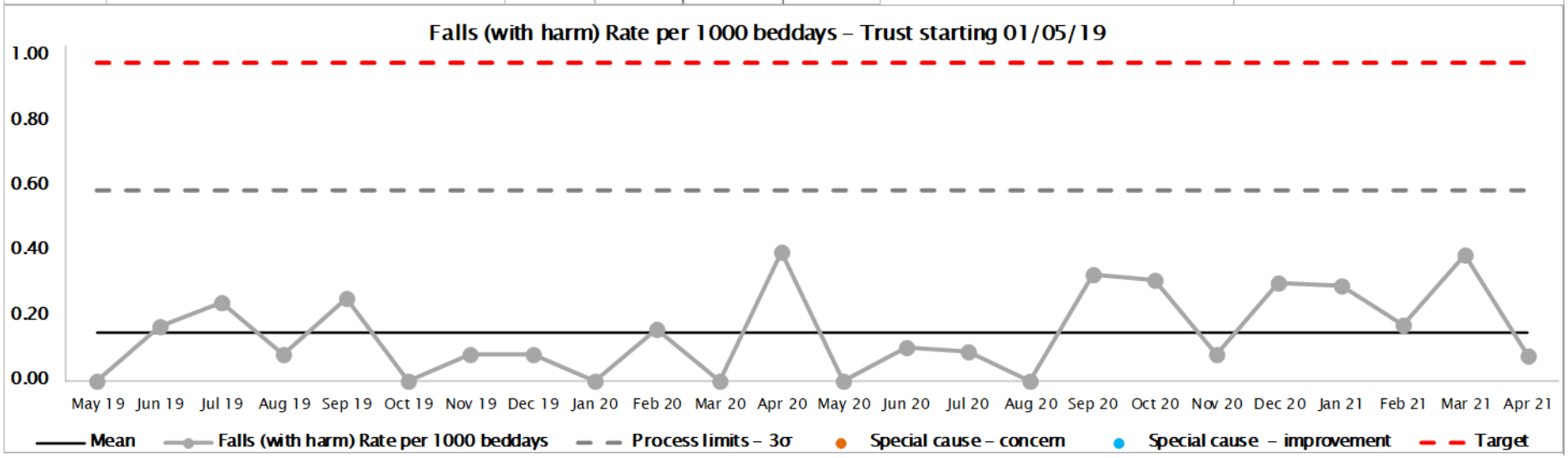


Chart 1 – Falls (with harm) rate per 1000 beddays

Key Issues (any new issues in red):

1. There has been a decrease in the number of patients sustaining harm and injuries following fall incidents.
2. The falls rate per 1,000 bed days for falls resulting in harm during April 2021 has decreased to 0.08 from 0.39 during March 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. Train the trainer session on enhanced care on 18 May 2021.

4. The multi-disciplinary falls task and finish group continue to oversee and implement actions to reduce the number of inpatient falls.

Recovery Forecast (e.g. August):

1. The number of patient injuries following fall incidents is still within Trust target

Key Risks to Forecast Improvement:

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

Pressure Ulcers

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	PUs Rate per 1000 beddays	0.41	0.30			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

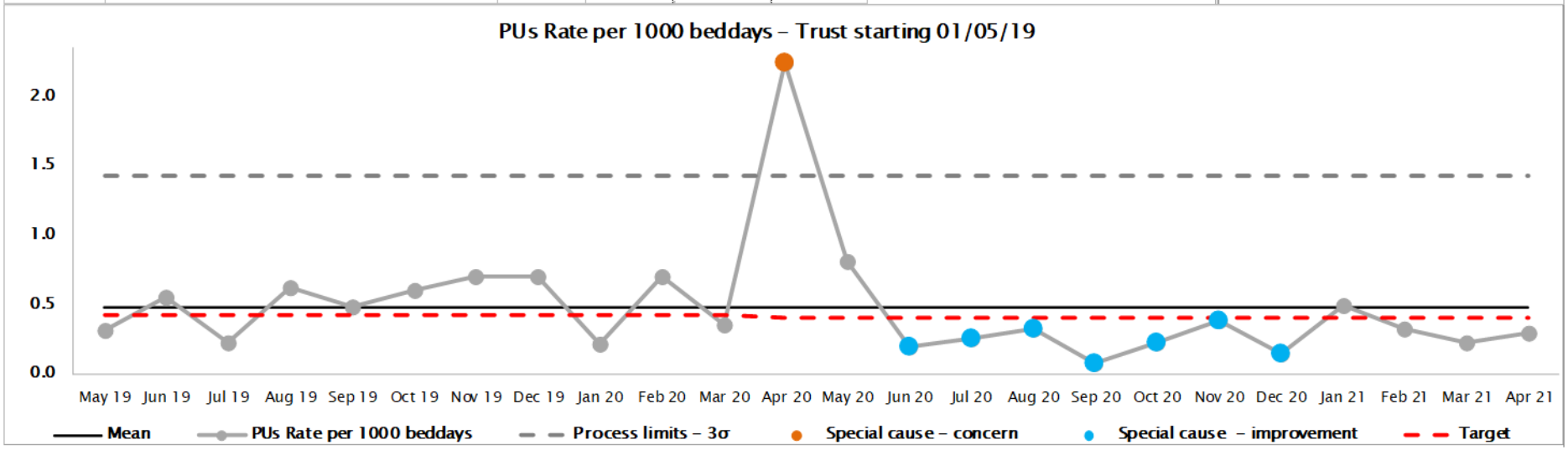


Chart 2 – Pressure Ulcer rates per 1000 beddays

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 ulcers is within the tolerance level during February, March and April 2021 following a spike in January 2021.

Key Actions (new actions in green):

1. The Tissue Viability team continue to work with the ward to deliver and support training in pressure ulcer prevention.

2. The Tissue Viability Nurses will be delivering four joint educational refresher training sessions with external Clinical Nurse Advisors on moisture associated skin damage during May 2021.
3. Reintroduction of the 100 days free campaign - it sets every ward and clinical department the target of achieving 100 days without a pressure ulcer.
4. Bespoke study day planned for the 28 May 2021 on a ward with high incidence of pressure ulcer.

Recovery Forecast:

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

Key Risks to Forecast Improvement:

Non-compliance with the pressure ulcer prevention care bundle.

CDiff (Hospital onset)

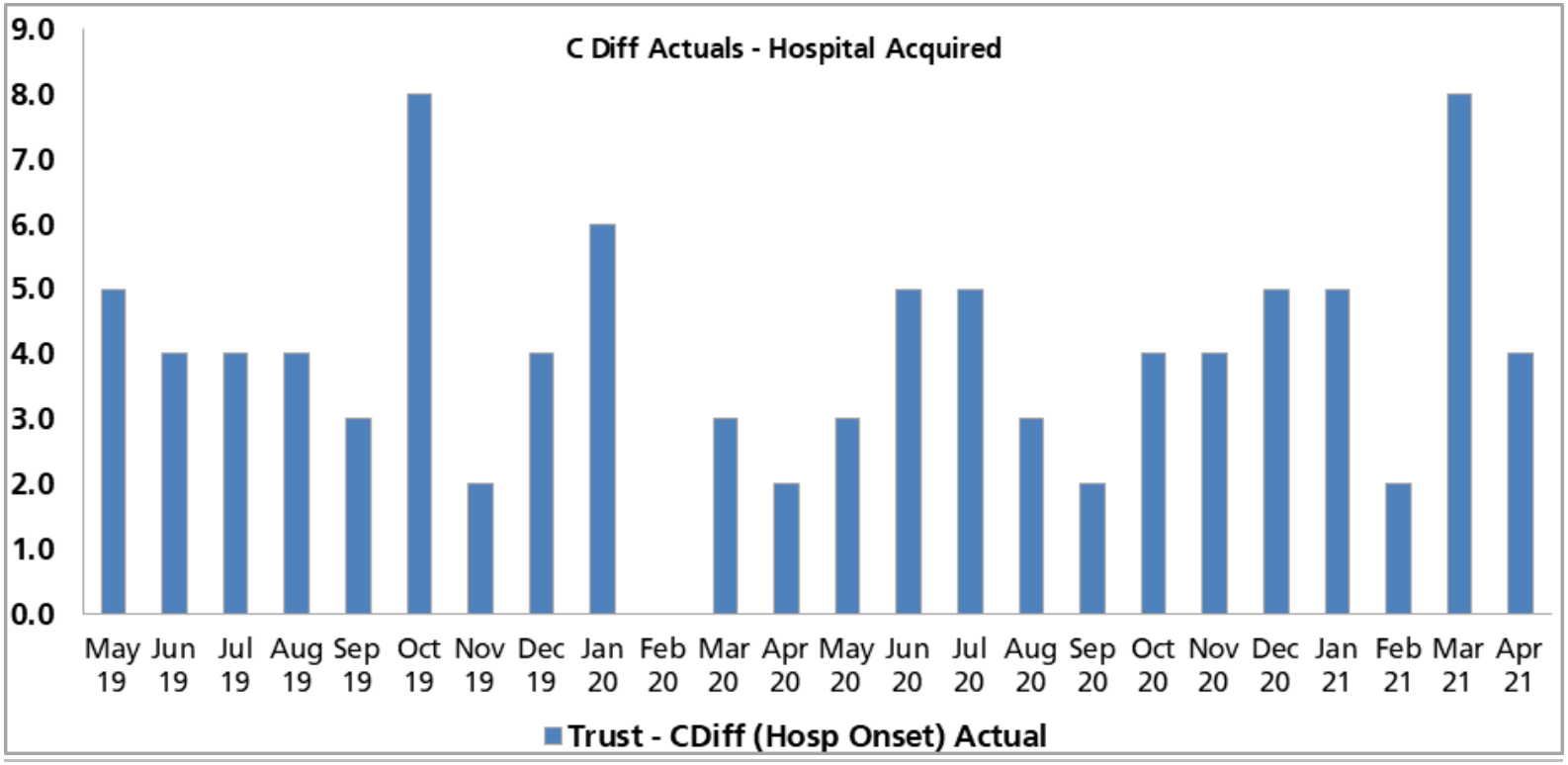


Chart 3 – CDiff (Hospital onset) per 100k beddays

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:

- Four cases identified in April 2021. All cases are presently under investigation.
- 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 paper work a PIR cannot be undertaken. However, recent support from the Deputy Medical Director has seen an improvement in 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"
- Increased use of hand gel (in response to COVID-19) – requirement for hand washing when spores involved
- 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
- Trust C Diff Policy re-launched at ward huddles
- Site Team educated in isolation room prioritization
- 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
- 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

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)

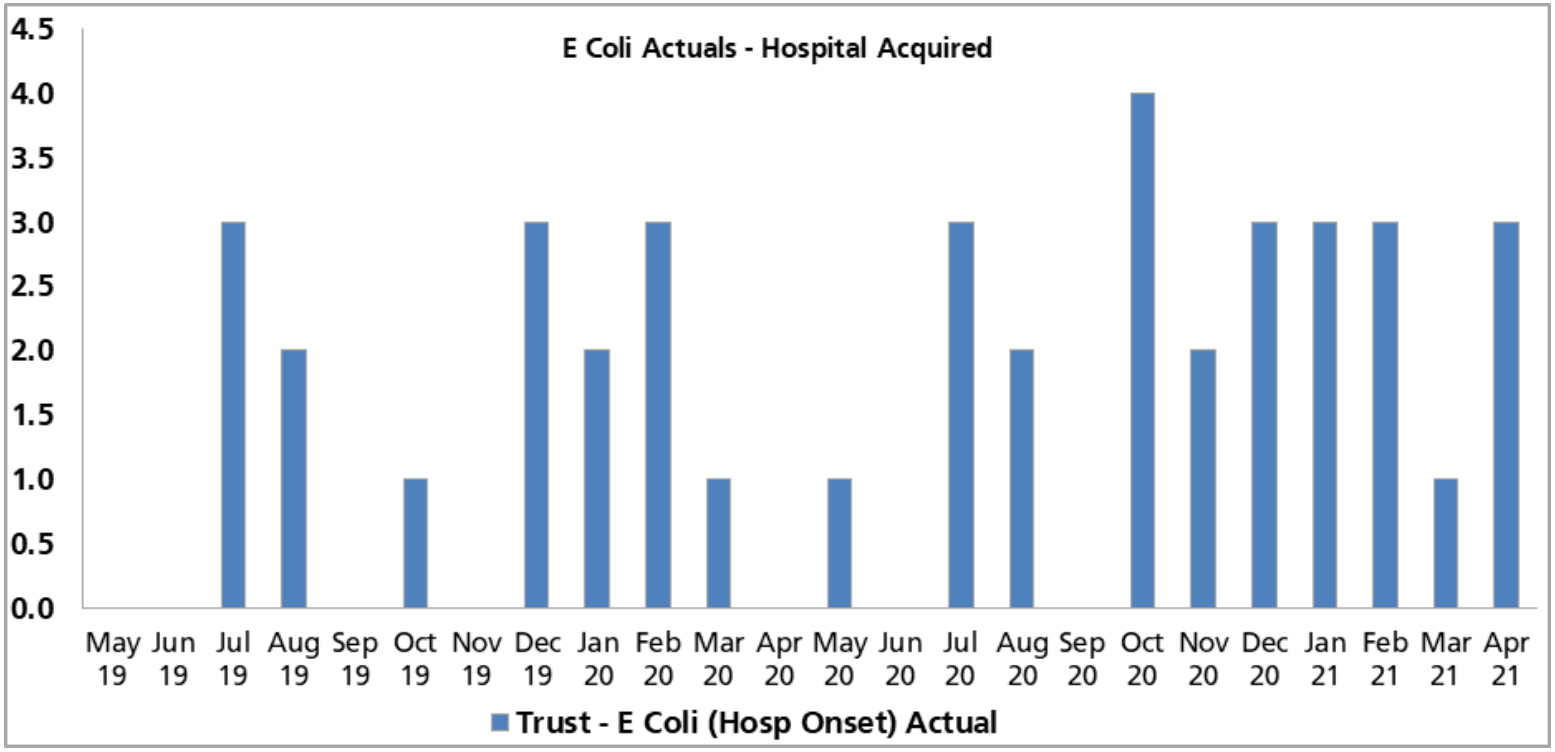


Chart 4 – E.coli (Hospital onset) rate per 100k beddays

Key Issues

- Three cases of hospital onset E. coli were reported in April 2021
- All cases are 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)

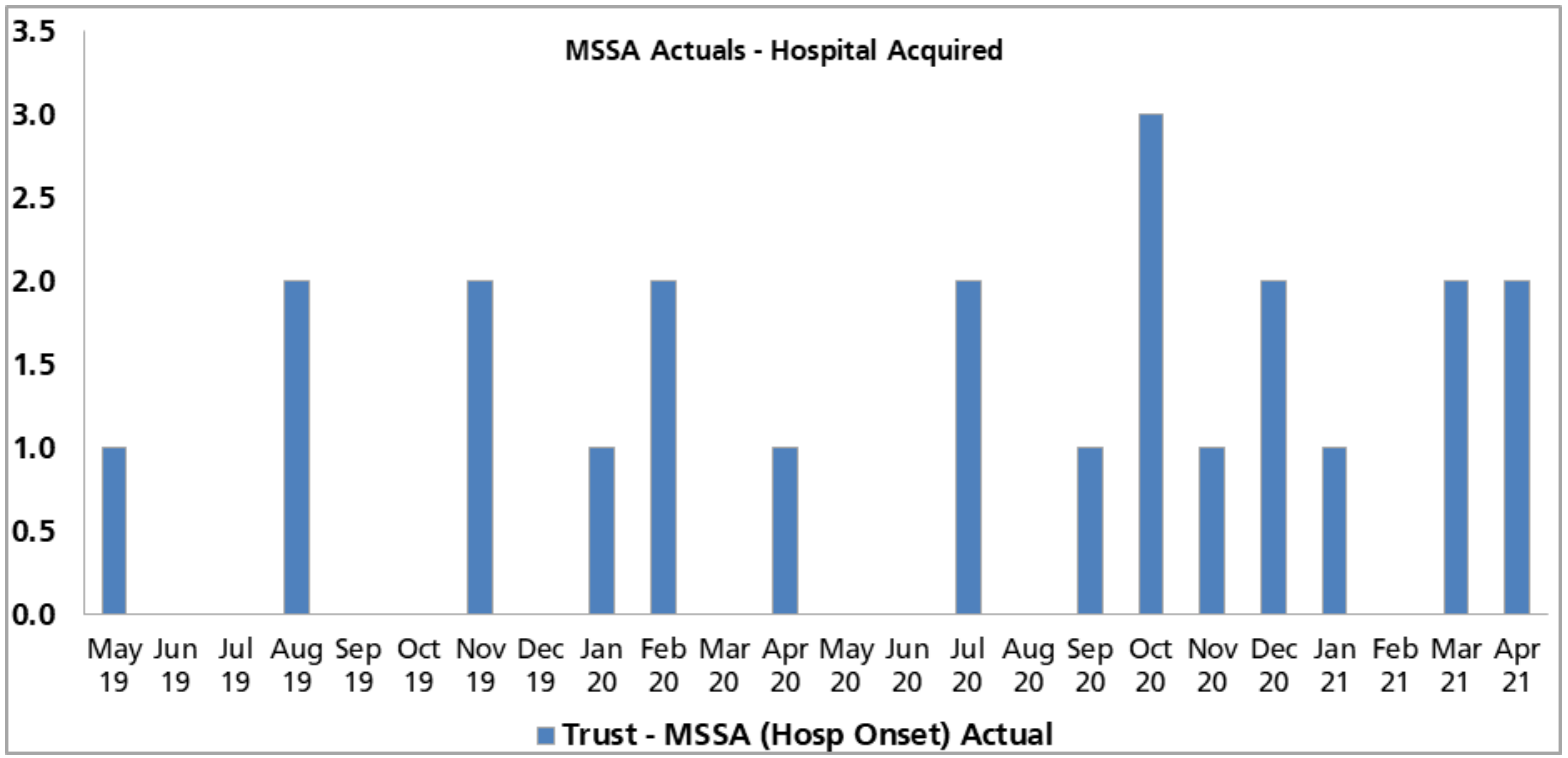


Chart 5 - MSSA (Hospital onset) rate per 100k beddays

Meticillin Sensitive Staphylococcus (MSSA)

Key Issues:

- Two cases of hospital onset MSSA were reported in April 2021.
- Both 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*
Mar-21	VTE Assessment Completeness	97.2%	98.5%	H	?	Special cause (unexpected) variation - Improvement (H)	Variation indicates inconsistently passing and falling short of the target

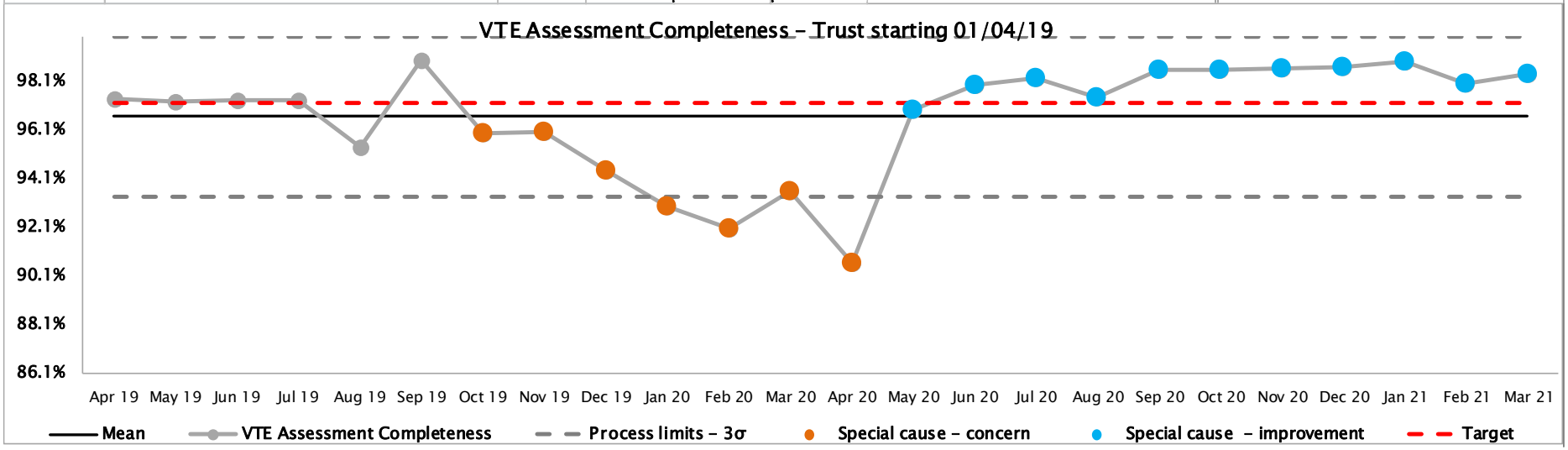


Chart 6 – VTE assessment completeness

Key Issues (any new issues in red):

1. VTE screening continues to remain stable and changes introduced in April have now become business as usual.

Key Actions (new actions in green):

1. Improved awareness at induction, junior doctors forum, Medical directors introductory meeting at junior doctors induction, grand round case studies, have all improved the levels of compliance of this indicator consistently.
2. This was also a theme in the Patient Safety Learning Event conducted on 29th April 2021, where the hazards of not screening, administering or monitoring patients at risk were discussed in detail to a Trust wide audience. This was very well received with excellent feedback from the audience.

3. Electronic Patient Medicines Administration (EPMA) system was rolled out successfully on the 29th of April to one of the medical wards. This will be gradually expanded to all the clinical areas in the hospital by June 2021. Forcing function of this system will enable compliance eliminating the human factors associated with fluctuating compliances in the past.

Key Risks to Forecast Improvement:

1. With roll out of EPMA planned to be completed by June 2021, there may be a period of fluctuation where compliance may be altered in the transition period. With EPMA fully in place, compliance in the screening will be measured through EPMA. However, in the transition period there will be 2 systems (EPMA and paper based) both measuring compliance in the transition periods with a potential to miss assessments. Coding teams have been notified of this and hence mitigations are in place.

Effective - Accountable Officer - Medical Director

Items in blue are awaitIng the latest update

Data To	KPI Description	Limit	Current Value	Variance	Assurance
Mar-21	Stillbirth Rate	3.73	3.45		?
Mar-21	Neonatal Deaths Rate	1.06	0.49	H	P
Mar-21	Extended Perinatal Deaths Rate	4.79	3.94		?
Mar-21	Total C Section Rate	25.0%	27.0%		?
Mar-21	EL C Section Rate	10.0%	12.2%		?
Mar-21	EM C Section Rate	15.0%	14.9%		?
Mar-21	Maternal Deaths	0	0		
Apr-21	% "Term" admissions to the NNU	6.00%	6.00%		?
Apr-21	% "Avoidable Term" admissions to the NNU	0.00%	22.22%		?

Data To	KPI Description	Target	Current Value	Variance	Assurance
Jan-21	HSMR Crude Rate	3.18	4.86	H	?
Jan-21	HSMR Relative risk	100.00	140.52	H	F
Jan-21	HSMR Weekend Relative risk	100.00	155.07	H	F
Nov-20	SHMI (Rolling 12 mth position)	100.00	104.91	H	?
Mar-21	Rate per 1000 admissions of inpatient cardiac arrests	2.00	0.48		?
Apr-21	No. of patients recruited in NIHR studies	63	15		?

SHMI

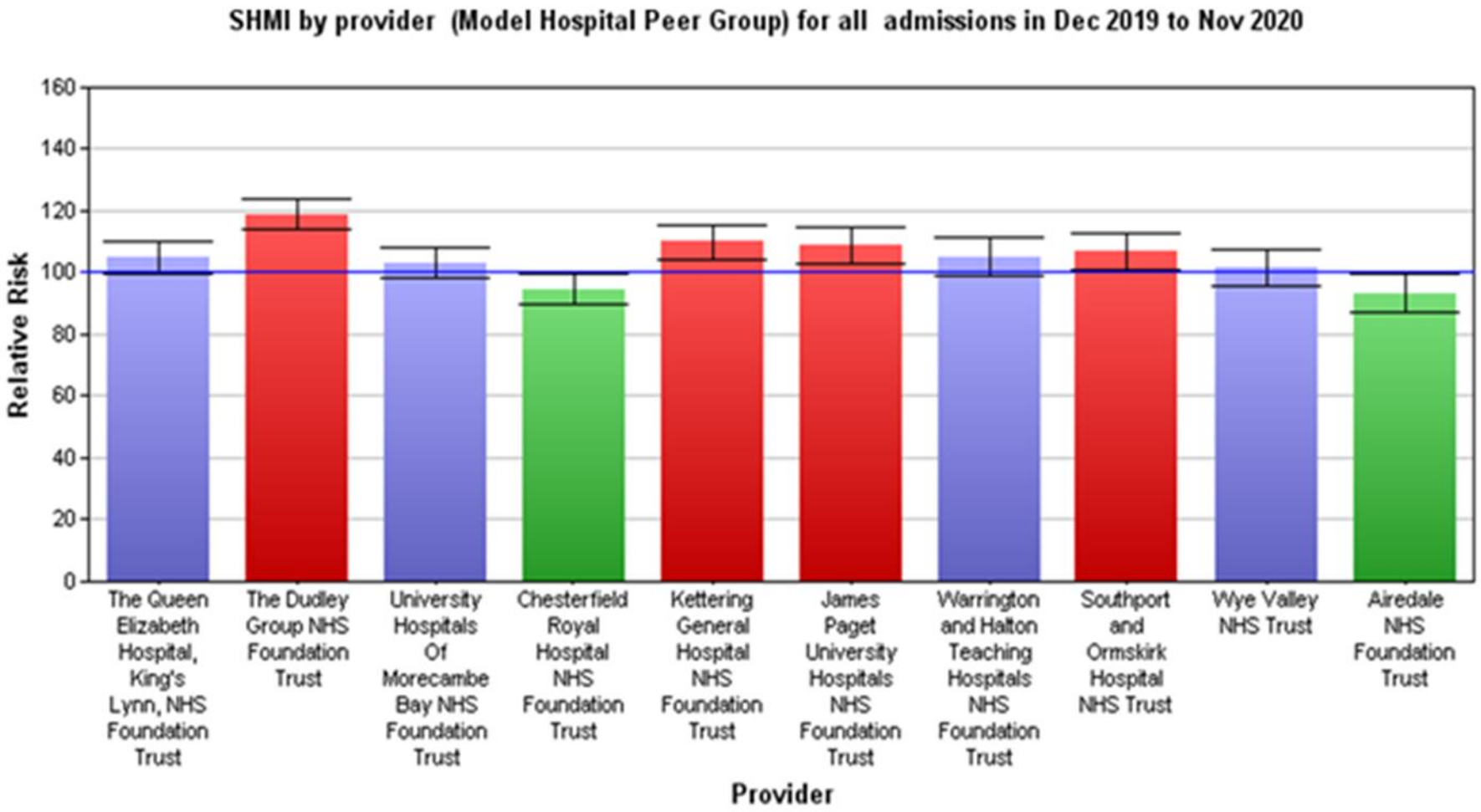


Chart 7 – SHMI by Provider

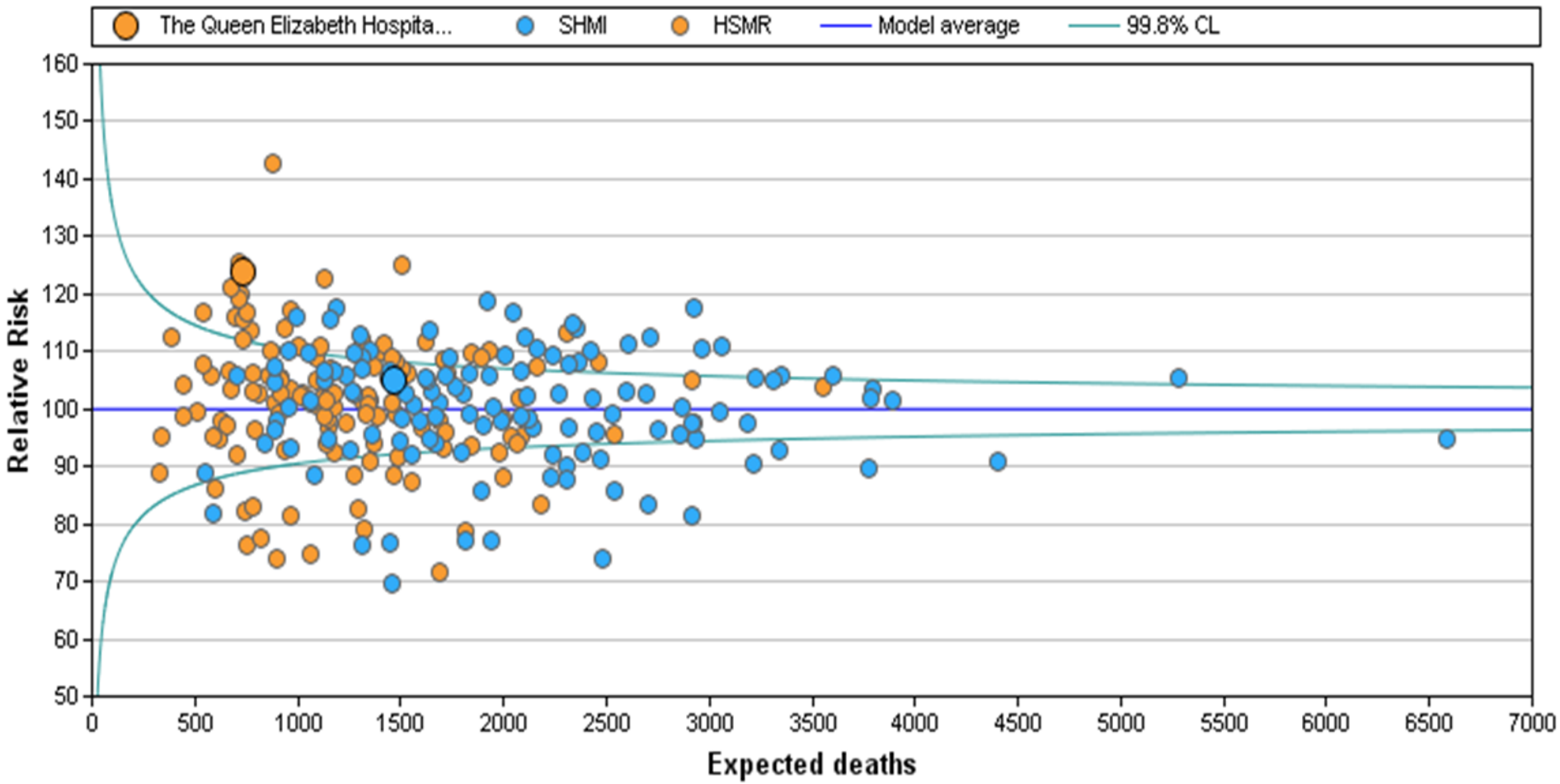


Chart 8 – SHMI and HSMR by provider

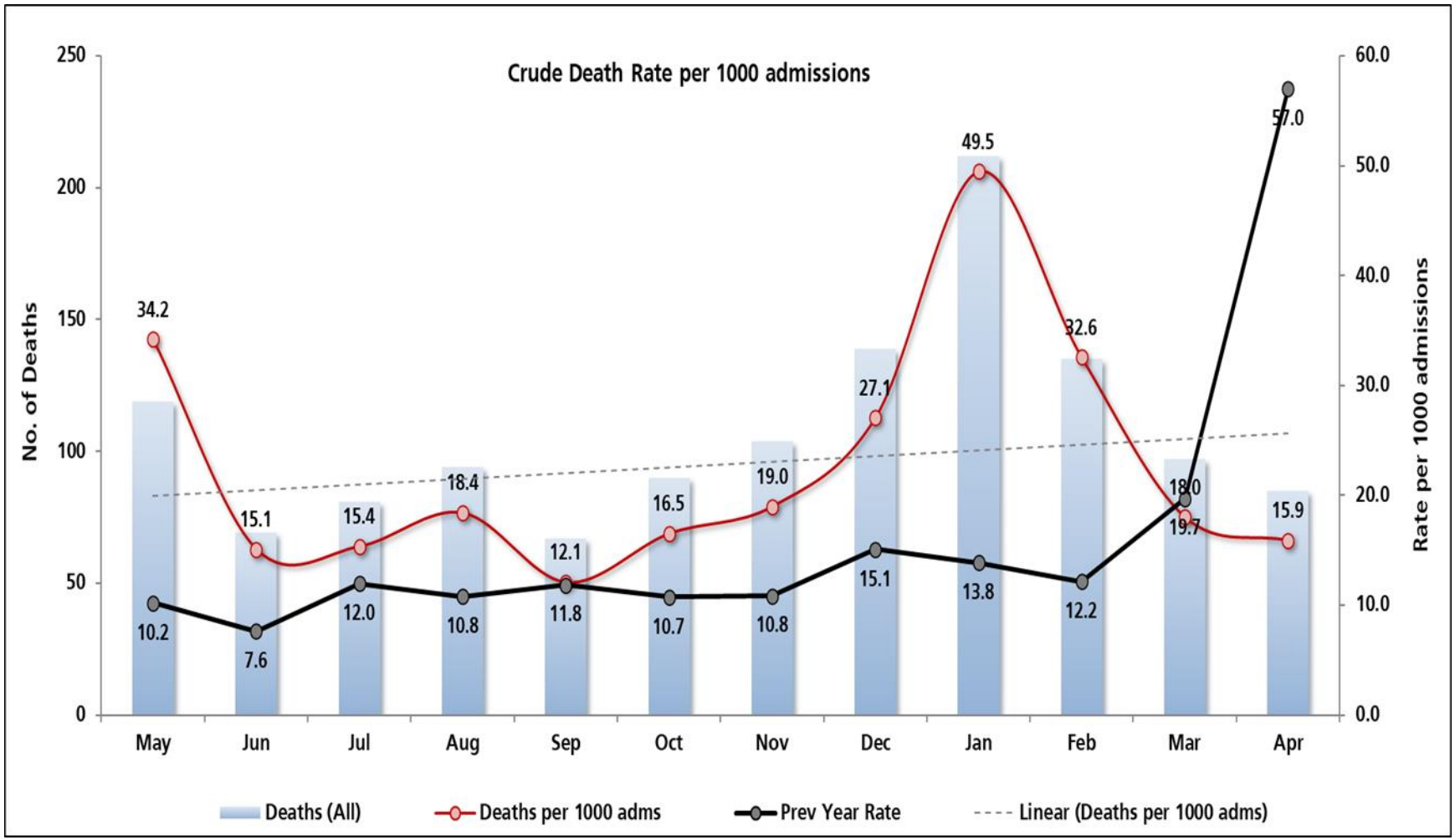


Chart 9 – Crude death rate per 1,000 admissions

Factors Driving the Performance

- The SHMI has risen slightly to 106 (latest data to December 2020) but remains within the "expected band". 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.

- The HSMR has risen further to 140.52 (latest data to January 2021). This is above expected and rising which is a source of considerable concern. An action plan to address this has been agreed, led and monitored through the learning from deaths forum.
- The coding backlog has also increased meaning that that data available for Dr Foster to conduct these analyses are incomplete. There had been 654 uncoded records for December at the time of the last report, there are 2483 uncoded records for January 2021. We have therefore requested Dr Foster recalculate our HSMR based on the full data sets and so we are expecting to submit revised data on a monthly basis until this backlog has been cleared. This is expected to change our HSMR by at least 3 points.
- Repeated reviews confirm that very low rate of palliative care coding for end of life patients (6% v peer and national averages of 33.2% and 33.6%) is the largest reason behind our raised HSMR.
- However, an increased number of deaths combined with a reduced number of admissions due to the pandemic are the largest contributors to the ongoing rise. This is expected to continue for February data, before declining as the number of patients admitted with Covid-19 started to fall combined with the impact of the palliative care transformation during March. However, due to the way in which HSMR is calculated, for a 12-month rolling period, this will remain elevated for 12 months following any change in observed mortality rates.
- Aside from the alert for Viral infection (COVID) the four alerts with the highest number of patients are Acute Renal Failure, COPD, Congestive Heart Failure and Pneumonia. Although CQC has suspended using the CUSUM (Cumulative Summary) alert during the pandemic, it is important that we do not lose sight of these key diagnosis groups. Work regarding the validation of the primary diagnosis is underway as part of the learning from deaths action plan.
- In April 2021 there were 83 deaths, 7 of which were COVID deaths. In comparison there were 165 deaths in April 2020 and 90 in April 2019. 48 (out of 83) of the deaths occurred in patients aged 80 and over, with a high proportion (9) aged 90 and over.

Key Actions Taken:

- The Palliative Care team have been established, working in an integrated way with the integrated care of older people (ICOP) team, from March 2021. This impact should be seen within our HSMR reporting from June 2021.
- March mortality analysis revealed 70% of deaths were 'expected' deaths (ie. reference made that the patient was either palliative or EoL prior to death.) 62% had an IPOC in place and 41% had a documented review by the palliative care team in the medical records.
- This means that over half of the 'expected' deaths had a palliative care review compared to our baseline is 8%. The national average is 36%.
- A mortality review group has been established to verify the primary diagnosis of all deaths to ensure the HSMR is reflective of the acuity of the patients presenting.
- Structured review of ME requested COVID 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 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 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

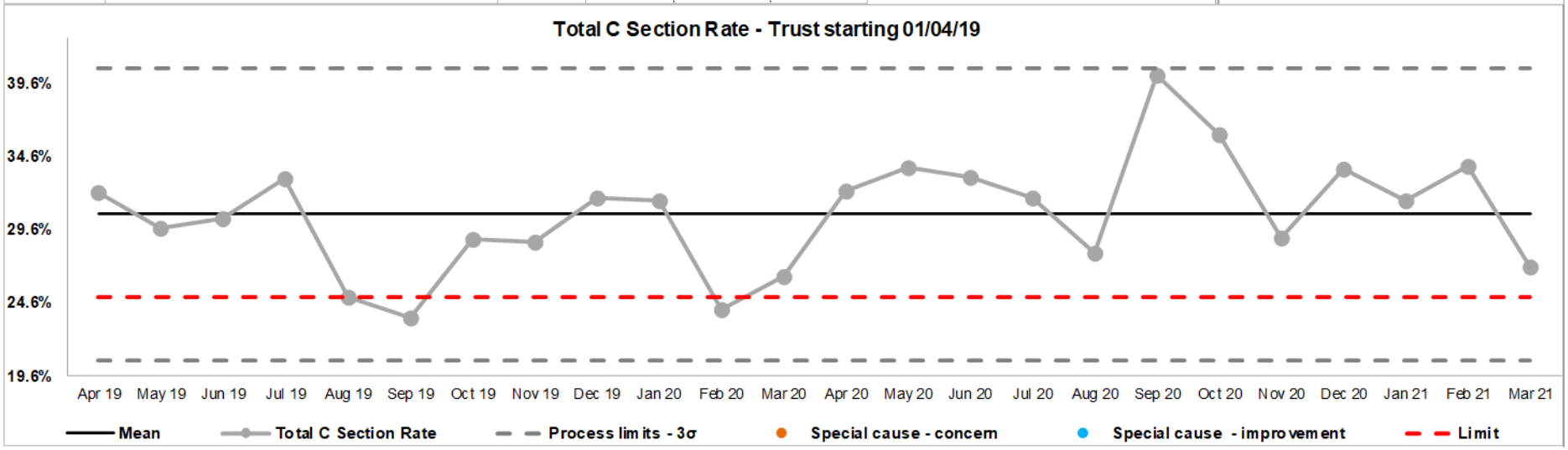


Chart 10 – Total C-Section rate

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Mar-21	EL C Section Rate	10.0%	12.2%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

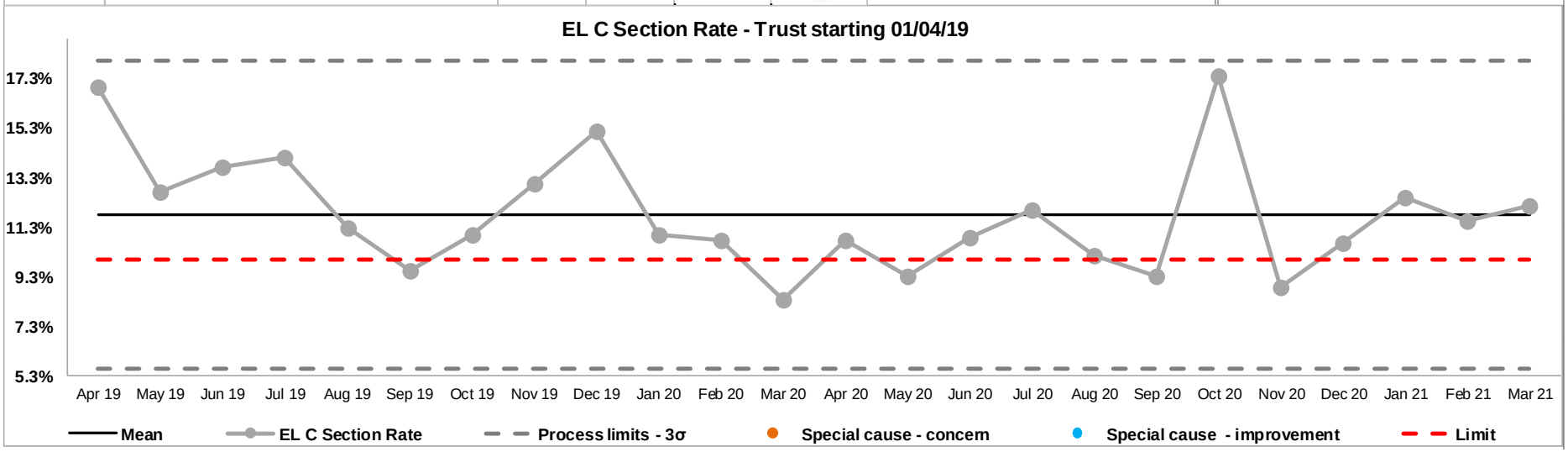


Chart 11 – Elective C-Section rate

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Mar-21	EMC Section Rate	15.0%	14.9%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

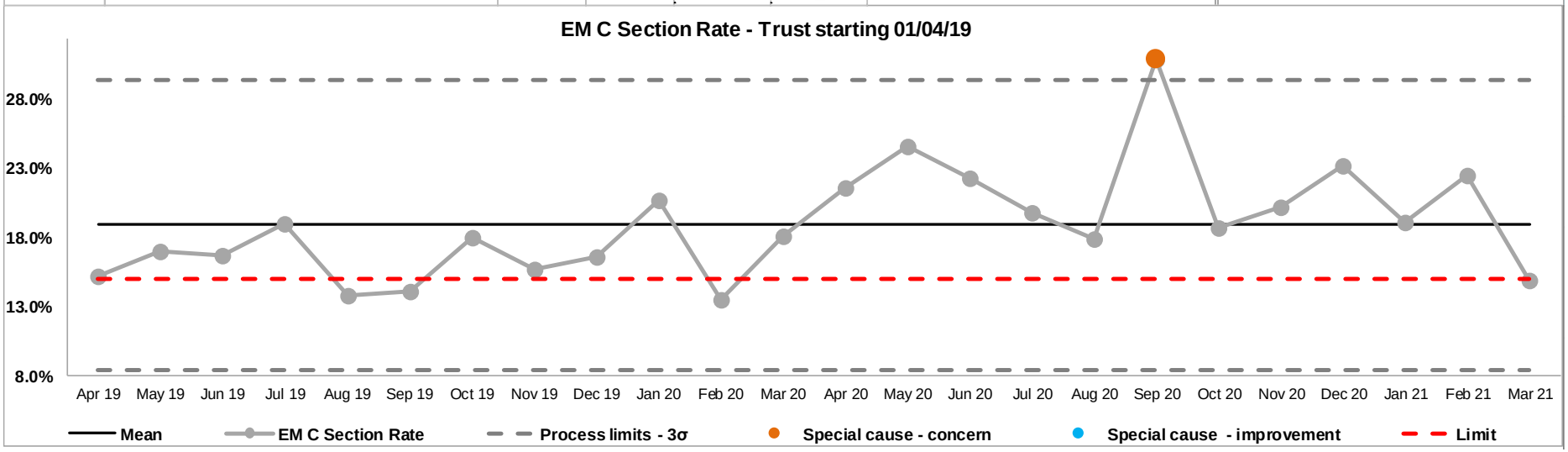


Chart 12 – Emergency C-Section rate

Key Issues (any new issues in red):

- Caesarean section rates at QEH continue to average above the previously agreed threshold of 25% but still remains the lowest in the region. Emergency caesarean section rates are below the lower control limits for the first time since March 2020. However, following the Ockendon report, caesarean section rates are no longer recommended as a quality indicator and so the "target" will be removed from next month. The measure will continue to be reported through the IPR and maternity dashboard, and the indications and appropriateness of both emergency and elective caesarean sections will remain under multidisciplinary scrutiny.

Key Actions (new actions in green):

- The retropsective, weekly, multidisciplinary LSCS reviews are now embedded with good attendance from midwivery, consultants and junior doctors to ensure that all decisions were clinically appropriate and in line with maternal choice. From March case reviews, commendable good practice among the MDT team and documentation improvement have been noticed. There have been some learning needs identified and training update organised to improve electronic documentation in badgernet for doctors.

- Timing of induction of labour is being currently audited to help with maximising the benefits of decision making during the day time hours where senior decision makers are available. This audit will advise the timings of induction for the indicated patients.

Recovery Forecast: Not Applicable as this threshold is no longer a requirement. However, reported for information only.

Key Risks to Forecast Improvement:

- Staffing levels and skill mix issues will continue to cause variations in performance. This is addressed through regular training sessions with prospective discussion for elective cases, and individual retrospective feedback for learning where alternative decisions might have been suitable for emergency cases.

Neonatal and Perinatal Mortality

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Mar-21	Stillbirth Rate	3.73	3.45			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

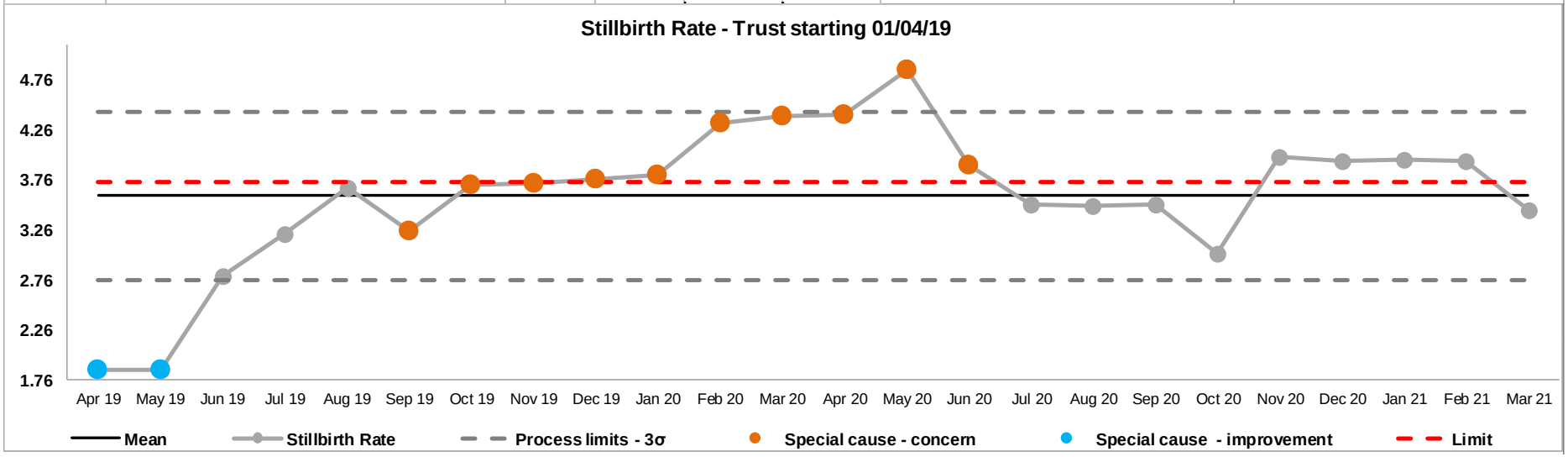


Chart 13 – Stillbirth rate

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Mar-21	Neonatal Deaths Rate	1.06	0.49	H	P	Special cause (unexpected) variation - Concern (H)	Variation indicates consistently (P)assing the target

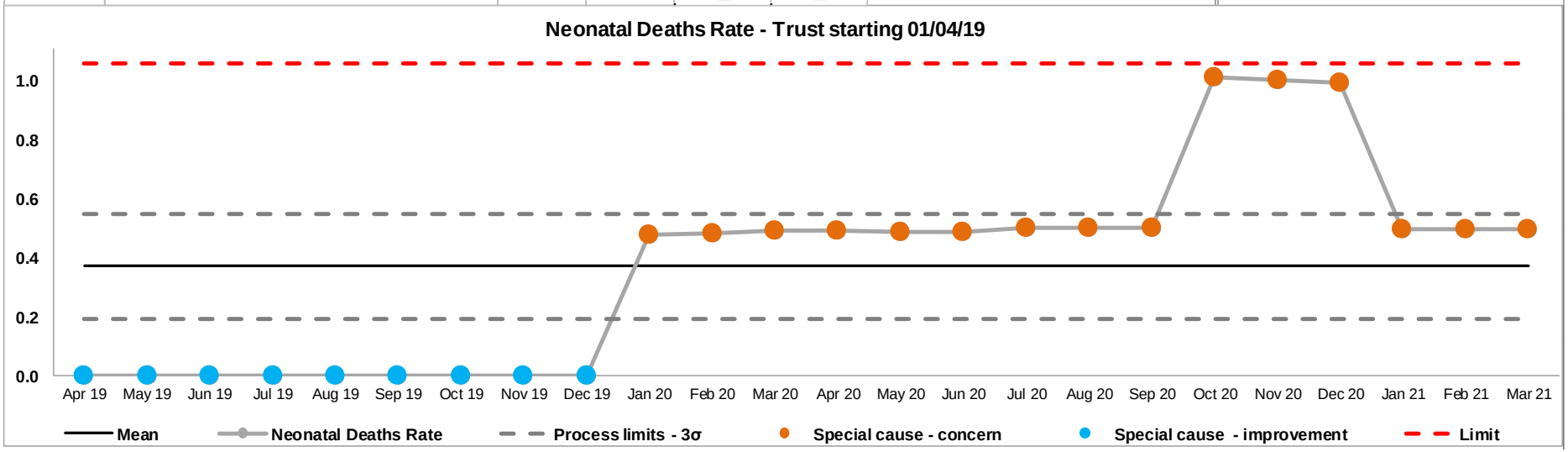


Chart 14 – Neonatal Deaths rate

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Mar-21	Extended Perinatal Deaths Rate	4.79	3.94			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

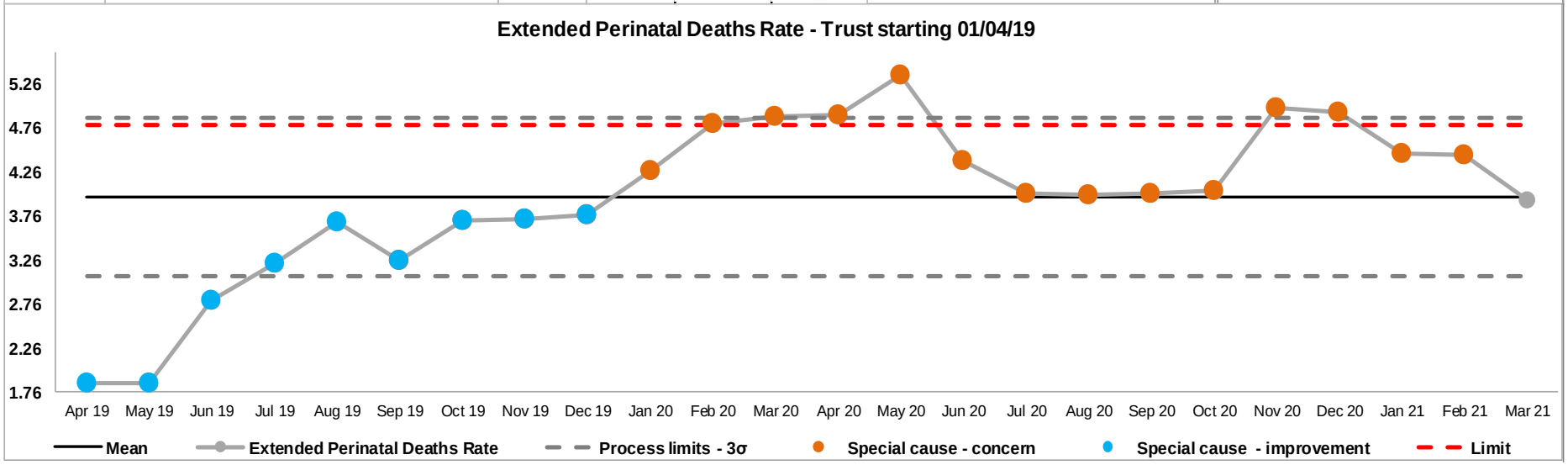


Chart 15 – Extended perinatal deaths rate

Factors Driving Performance:

The still birth rate remains within common cause variation.

The neonatal death rate also remains low at 0.5 below the upper threshold of 1.0. Together these comprise the extended perinatal death rate: 4.44 (well below the national upper threshold 4.79).

Actions being taken:

- We are continuing to work towards full compliance with the immediate and essential actions that have come out of the Ockenden report. We are engaging with our LMNS partners in the implementation of the Perinatal Quality Surveillance model.

- We are working on our Maternity Improvement plan, with evidence submitted through the Trust wide Evidence Assurance Group, to close down actions as they are completed. There is a significant amount of Culture Improvement work ongoing within the service to support the safety agenda.

Risk to delivery:

- **Midwifery Staffing:** Recruitment is underway to expand our midwifery team to support and we are working closely with the Comms team to develop a recruitment plan to support this ambition. Our midwifery vacancy rate is currently 3.78%, although the additional uplift in midwives agreed at Board in February, this will increase the rate to just over 8% until we are able to fill these posts.
- **Medical staffing:** Service redesign has supported vastly improved 7 day working patterns for consultants. This requires further revision in the light of the Ockendon Report and a bid hase been made through the Local Maternity and Neonatl System (LMNS) to expand our consultant and midwifery teams and to support additional multiprofessional training to meet these additional requirements.

Term Neonatal unit admissions

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

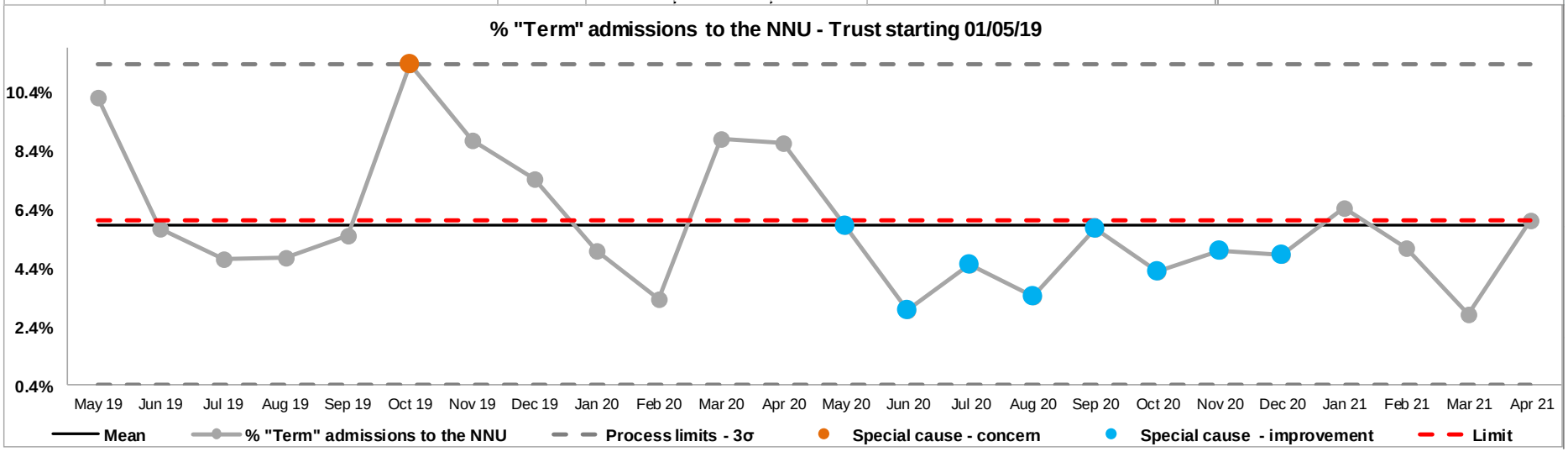


Chart 16 - % term admissions to the NNU

Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	% "Avoidable Term" admissions to the NNU	0.00%	22.22%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

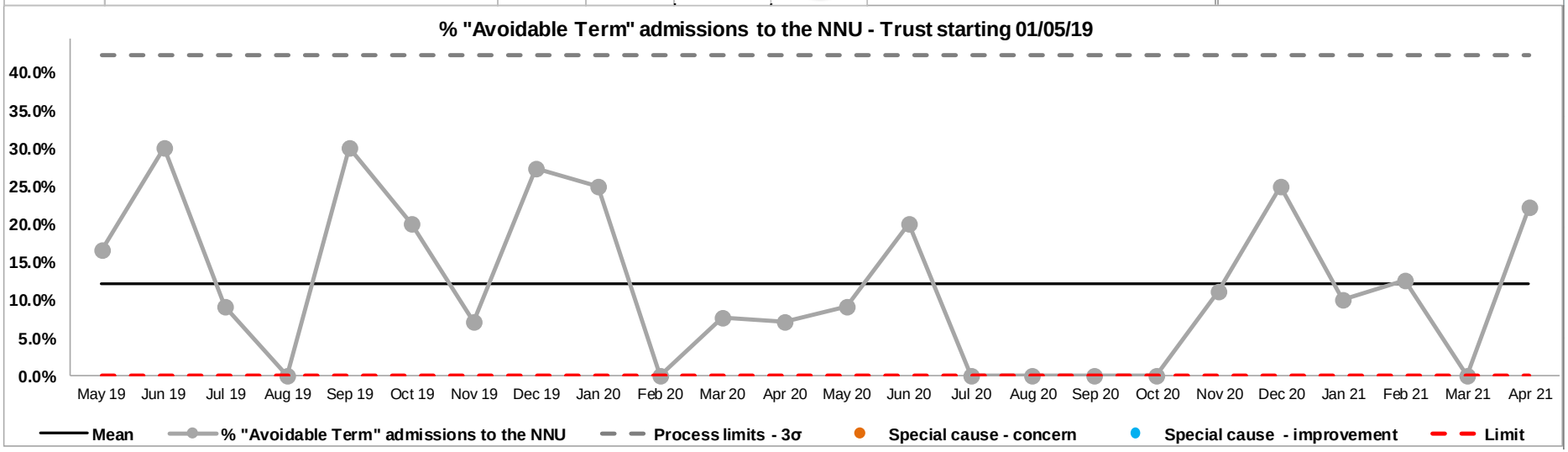


Chart 17 - % avoidable term admissions to the NNU

Factors Driving Performance:

- We continue to have very low numbers of term babies admitted to the neonatal unit. There were a total of 10 term admissions to NICU in April 2021. ATAIN reviews of all cases continue, with additional administrative support to ensure accurate documentation.
- Two of the ten cases were deemed potentially avoidable admissions to NICU in April 2021. One was an instrumental delivery with significant subgaleal haemorrhage needing neuro observation- this will be investigated under the serious incident framework and support and additional supervision is in place for the staff involved.
- The second baby was observed for hypoglycaemia. The reviewers considered that this baby could have been discharged home, if the review had been undertaken earlier.

Actions taken:

- The ATAIN review also highlighted that the guidelines for instrumental delivery need further consultation and clarification to provide additional support for assisted deliveries.
- Prompt neonatal review of the babies to avoid separation of baby from mum has been stressed and learning has been disseminated to all staff via NICU newsletter, Riscovery

Risks to Recovery:

Human factors continue to contribute to potentially avoidable admissions. This requires a continuous improvement approach through training and feedback of incidents to relevant staff.

Rate per 1000 admissions of inpatient cardiac arrests

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Mar-21	Rate per 1000 admissions of inpatient cardiac arrests	2.00	0.48			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

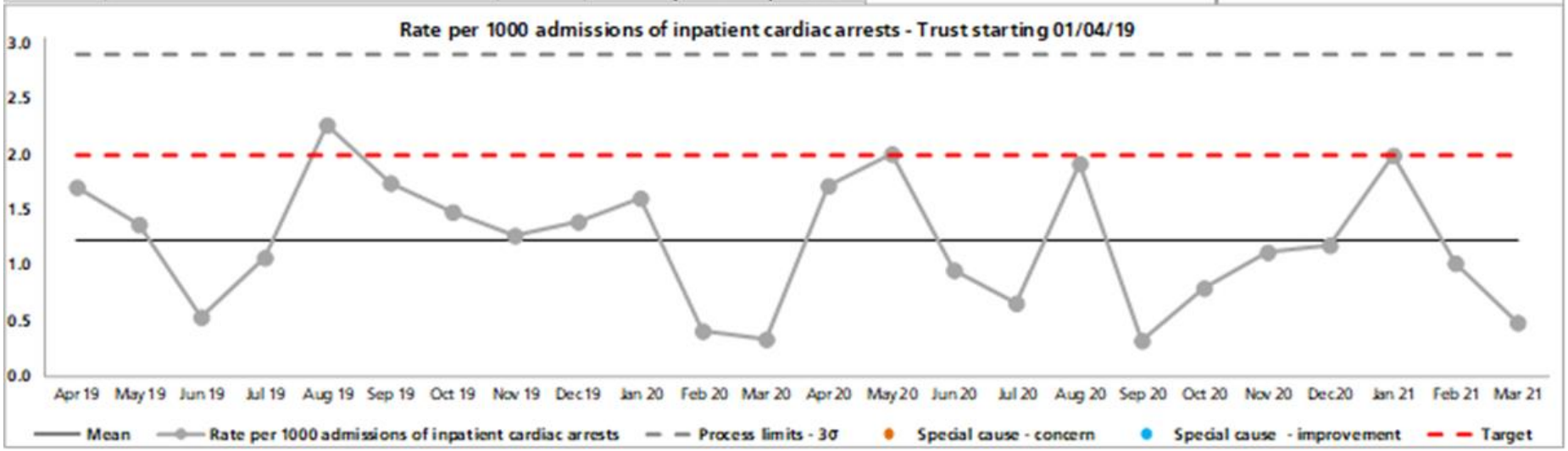


Chart 18 – rates per 1000 admissions of inpatient cardiac arrests

Key Issues (any new issues in red):

1. Cardiac arrest rates currently are within the expected limits.
2. There were 5 reportable cardiac arrests in March 2021. These numbers have broadly been stable. One of these calls was an out of hospital arrest who re-arrested in Emergency Department, one was a patient for whom ReSPECT should have been considered. This may indicate a generally continued early consideration of ReSPECT and CPR decisions.

Key Actions (new actions in green):

- Currently all monitoring and assurance are provided through the Recognise and Respond Forum. All cardiac arrests are reviewed for learning to identify avoidability and sharing forwards. Deaths are scrutinised through Structured Judgement Reviews and any learning reported to Learning from Deaths Forum.
- ReSPECT actions are moving forwards with a planned relaunch of training, strategy and version 3 of ReSPECT.

Recovery Forecast:

The process currently remains stable and hence recovery forecast is not required. However, measures to seek reduction in this target are ongoing, especially through work in the Deteriorating Patient (DP) and ReSPECT agendas.

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. Failures to recognise patients for whom a cardiac arrest would represent a natural death in a timely fashion, make and document an appropriate resuscitation decision will lead to predictable and avoidable cardiac arrests. Little training outside of resuscitation courses is currently on offer for this decision-making to assist clinicians in making sound and lawful clinical decisions, which may, in turn, affect decisions being made.

Research

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	No. of patients recruited in NIHR studies	63	15			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

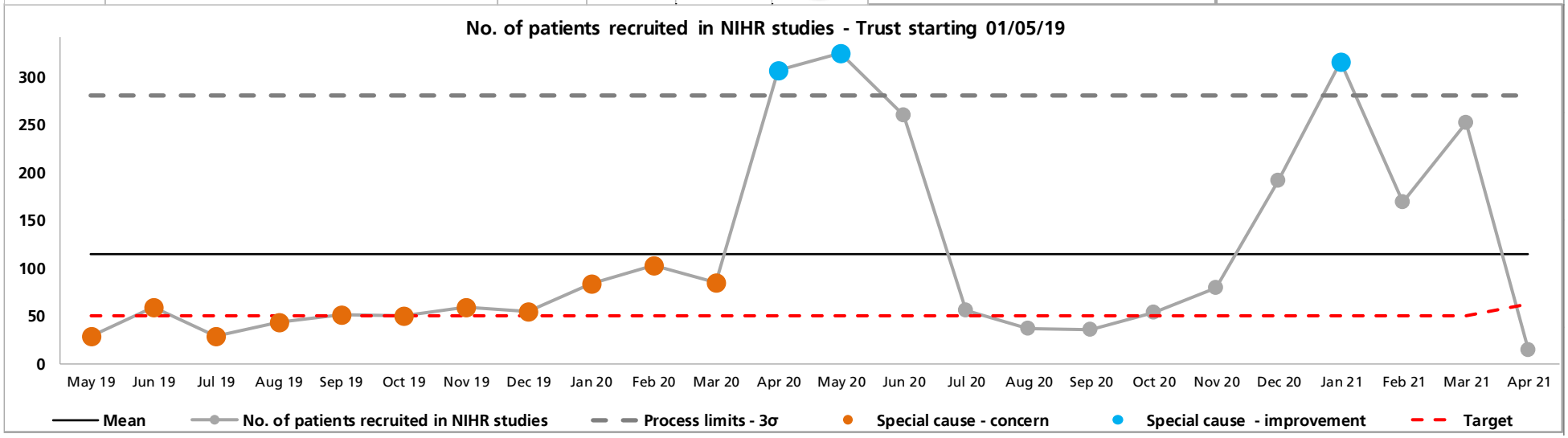


Chart 19 – number of patients recruited in NIHR studies

Introduction

There is a noticeable reduction in recruitment figures for the month of April at 15 participants which falls below the set target of 65 participants /month. As expected, this figure is less than previous financial year (Apr 2020 = 307), due to the reduction in the number of COVID admissions. In the previous year (2020-21), >94% of overall recruitment was to COVID studies. The new financial year will focus on the managed recovery of 30+ non-COVID studies and the increased diversification of our portfolio to include under-represented specialities.

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 and ward rounds and offering them the opportunity to

participate in new research. Working with lead clinicians/principal investigators, we have expressed interest in new studies to help improve diversity. One of these studies, HEAL-COVID, is the first platform trial in the UK aimed at investigating treatment for long COVID symptoms and will open in QEH in May 2021. In line with developing research capacity among health staff, the HEAL-COVID study will be led by a new Principle Investigator, a QEH fellow with an interest in infectious diseases. The team continues to use NHS Improvement Quality Improvement methods to maintain high performance in terms and plan for delivery in 2021. Other key drivers of high performance include excellent motivation among 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:

- HEAL-COVID, a UPH study to commence shortly
- Ongoing discussions with radiology, cardiology and paediatric leads to adopt identified NIHR study
- International Clinical Trials Day (including 1-hour event with distinguished speakers (internal and external)
- Existing non-COVID studies restarted
- Continuous presence of research staff at MDTs and ward rounds
- Weekly review of studies (board rounds)
- Complete interviews to vacant posts on 07/05/2021, with a view to successful recruitment
- Bi-monthly 1:1 supervision to continue

Risks

For sustainability, the recruitment figures for 2021/22 has been revised down to 750. Still, research is expected to experience challenges in restarting non-COVID studies, which will be influenced by the timeline for recovery of clinical services (e.g. elective surgery and cancer) in QEH. Other key challenges include:

1. Reduction in COVID admissions (paradoxically detrimental to recruitment to UPH studies)
2. Engaging health staff in research in face of pressures to reduce long waitlist
3. Recruiting to existing vacancies in research (3.6 WTE).

Caring - Accountable Officer - Chief Nurse

Items in blue are awaiting the latest update

Data To	KPI Description	Target	Current Value	Variance	Assurance
Apr-21	MSA Incidents	0	4		?
Apr-21	MSA Breaches	0	9		?
Apr-21	Total Clinical & Non_Clinical Complaints	20	17	L	?
Apr-21	Complaints Rate per AE Atts, IP Adms & OP Activity	0.00%	0.06%		?
Apr-21	Complaints receiving a response within 30 working days %	90.0%	58.0%		?
Apr-21	Complaints - Reopened (% of Total)	15.0%	41.2%	H	?
Mar-21	Dementia Case Finding	90.0%	95.4%	H	F

Data To	KPI Description	Target	Current Value	Variance	Assurance
Apr-21	FFT % "Very Good" or "Good" (IP & DC)	95.00%	95.89%	H	?
Apr-21	FFT % "Very Good" or "Good" (AE)	95.00%	87.09%		?
Apr-21	FFT % "Very Good" or "Good" (OP)	95.00%	95.29%		?
Apr-21	FFT % "Very Good" or "Good" Mat Question 1 (Antenatal)	95.00%	100.0%		?
Apr-21	FFT % "Very Good" or "Good" Mat Question 2 (Labour)	95.00%	94.4%		?
Apr-21	FFT % "Very Good" or "Good" Mat Question 3 (Postnatal)	95.00%	96.7%		P
Apr-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
Apr-21	MSA Incidents	0	4			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

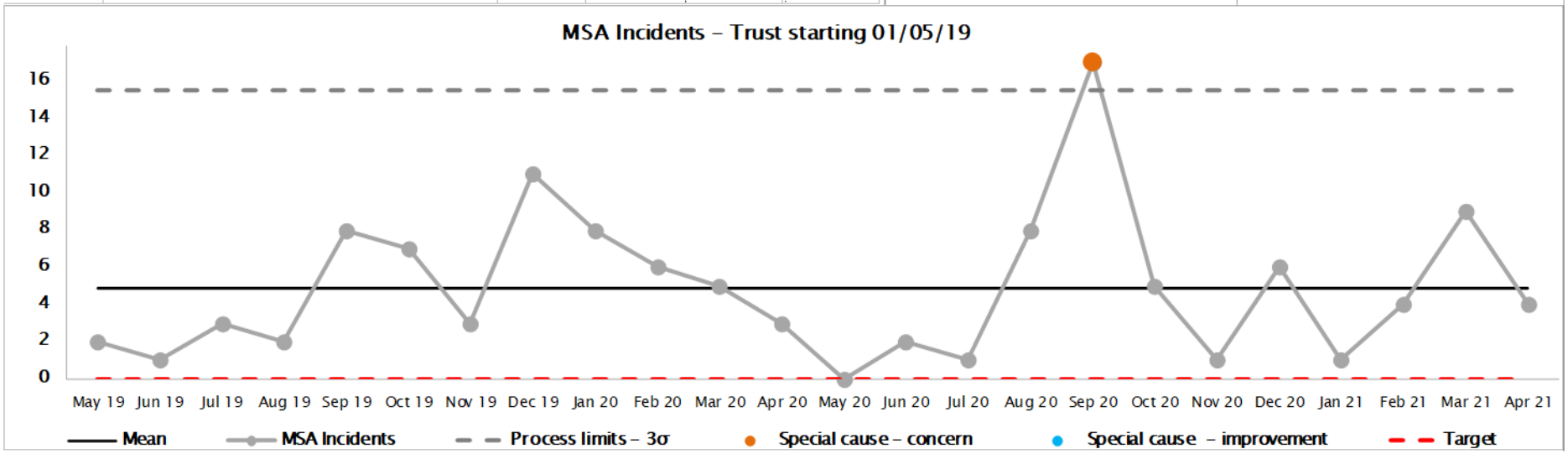


Chart 20 – MSA breaches

Key Issues (any new issues in red):

1. There have been four incidents of same sex accommodation breach affecting nine patients and all of them were in the Hyperacute Stroke Unit (HASU) on West Raynham Ward. This is a reduction from the nine incidents and 23 breaches recorded during March 2021.
2. The Trust breaches are reported in line with the national guidance.
3. There have been no concerns raised by patients or relatives with regard to same sex accommodation breaches.

Key Actions (new actions in green):

1. Nurse in charge has active conversation with patients with regard to their experiences whilst being cared for in a mix sex bay.
2. Same sex accommodation breaches are discussed and possible mitigations are considered at the ward Board round.
3. Same sex accommodation breaches are escalated to the clinical site team and are reflected on the bed template in the operations centre.

Recovery Forecast:

1. Unable to forecast recovery due to capacity challenges.

Key Risks to Forecast Improvement:

1. Beds for patients who need to be stepped down are not always available and are dependent on demand.

Complaints

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Complaints receiving a response within 30 working days %	90.0%	58.0%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

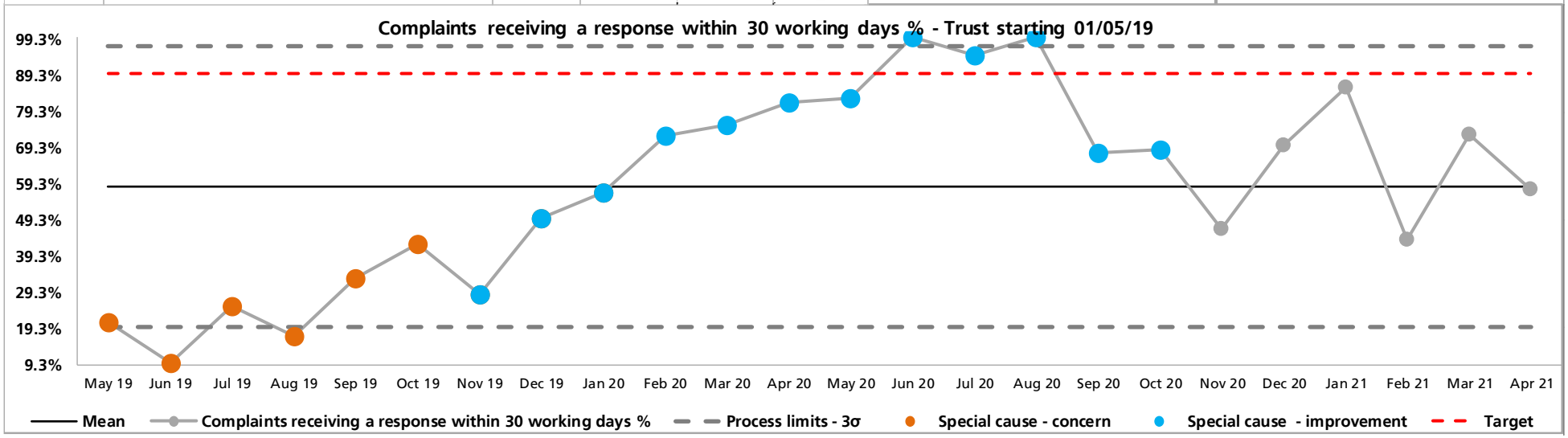


Chart 21 – complaints receiving a response within 30 working days

Key Issues (any new issues in red):

- The increase noted on the data is accounted to the changes in previous data collection and recording departmentally. All complaints received from complainants' discontent with the original response are recorded as re-opened; this had not previously been recorded in this way.
- The increase noted demonstrates these changes to data recording and historical complaints

Key Actions (new actions in green):

- The department is currently under review in terms of team structure and the complaints process
- Accurate recording and data collection with clear ownership is being actioned

- Corporate and Divisional processes to improve cohesion/clarity is being addressed
- Emphasis on quality improvements in the responses is being addressed through education and mentoring
- Focus on addressing key areas of concern through verbal contact and/or LRM meetings

Recovery Forecast:

- There is an expected reduction in re-opened complaints incrementally by 10% per month from June 2021

Key Risks to Forecast Improvement:

Possible capability issues which would need to be addressed

Dementia Case Finding

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Mar-21	Dementia Case Finding	90.0%	95.4%	H	F	Special cause (unexpected) variation - Improvement (H)	Variation indicates consistently (F)alling short of the target

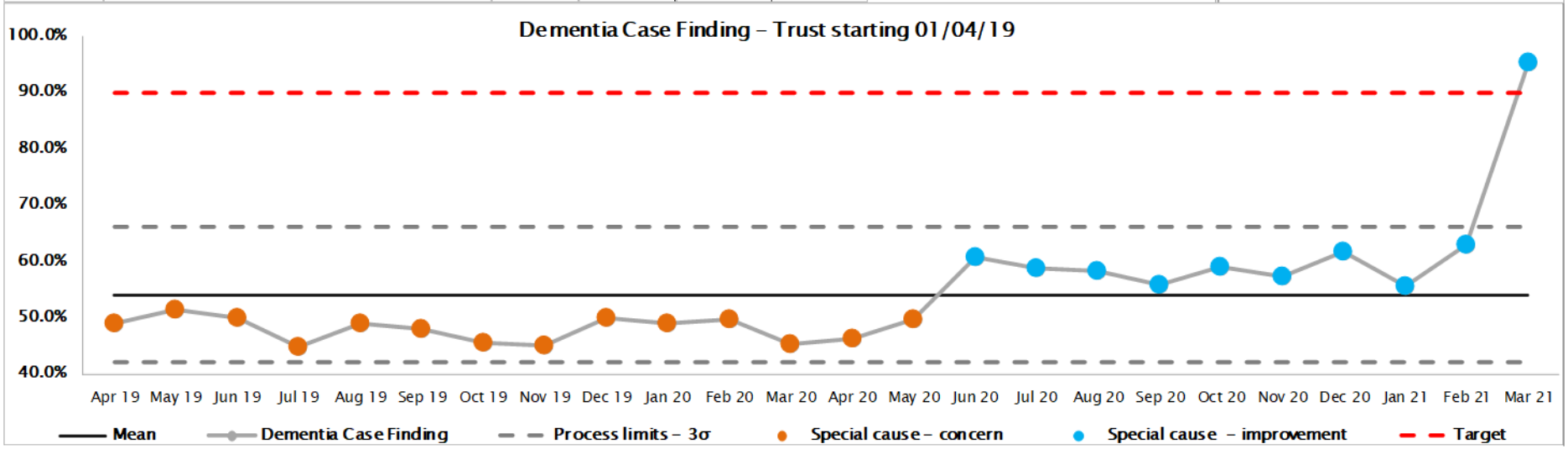


Chart 22 – Dementia Case finding

Key Issues (any new issues in red):

1. Dementia case finding compliance in the Trust has exceeded the accepted threshold for the first time ever since this target was introduced.
2. Cognitive Impairment Assessors are now in place to ensure screening compliance on all patients admitted to the hospital. These personnel started in March 2021 and current performance is attributable to their diligence with the screening process.

Key Actions (new actions in green):

1. Multiple actions have already taken place to improve compliance with the screening process. These have aimed to make the screening more relevant, easier to perform, with newsletters, education sessions, monthly dementia hub meetings and dementia champions all

now in place. This work has had a significant impact on raising dementia awareness with a culture shift in attitudes toward cognitive screening ongoing.

2. However, the introduction of dedicated resource in the form of assessors to actively identify and screen patients has made the most significant impact and enabled us to comply with this screening target.

Recovery Forecast: Not applicable

Key Risks to Forecast Improvement:

1. Compliance still relies on human factors and if these dedicated staff are unavailable at any time, performance is likely to fall again.

Long term an electronic forcing function would eliminate this risk. That had been planned to be incorporated into EPMA but unlike VTE assessment, this was not deemed possible by the implementation team. However, it is still hoped that this will be incorporated into our E-observation or electronic patient record systems.

Friends and Family Test

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	FFT % "Very Good" or "Good" (IP & DC)	95.00%	95.89%	H	?	Special cause (unexpected) variation - Improvement (H)	Variation indicates inconsistently passing and falling short of the target

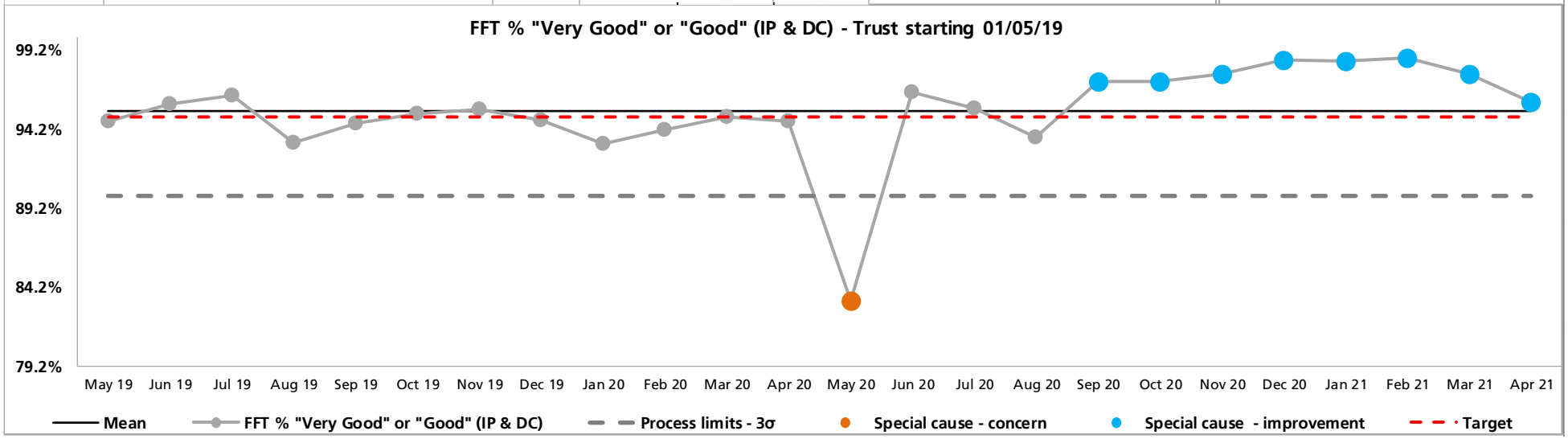


Chart 23 – FFT "Very Good" or "Good" (IP and DC)

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	FFT % "Very Good" or "Good" (AE)	95.00%	87.09%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

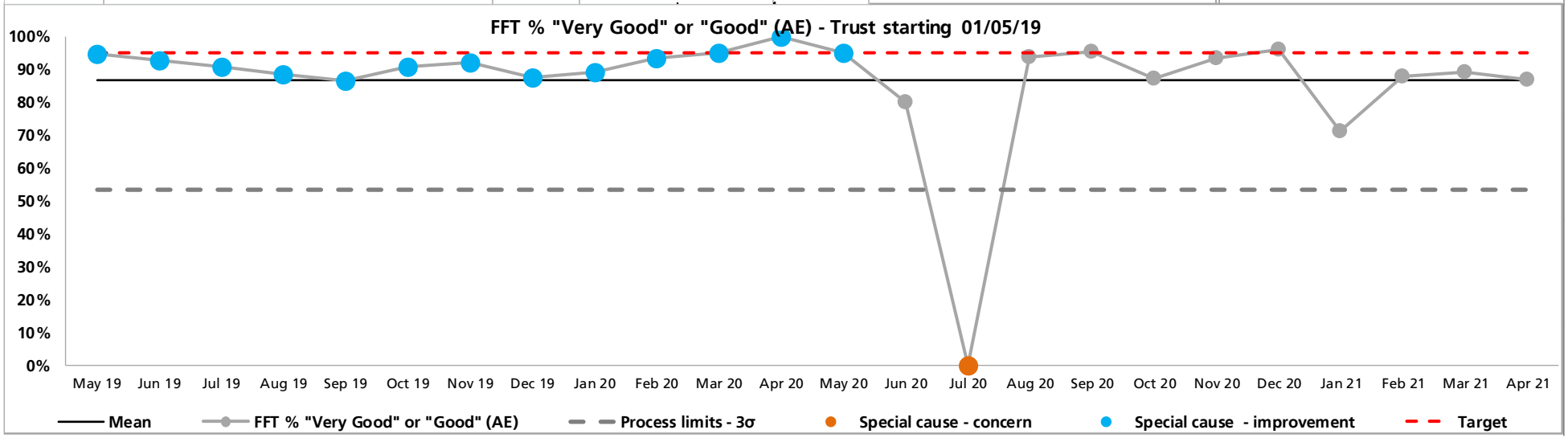


Chart 24 – "Very Good" or "Good" (A&E)

Key Issues (any new issues in red):

Reviewing the overall satisfaction rate the level of satisfaction appears to be decreasing, However it should be noted that the previous months reporting was only on the recommended score not satisfaction therefore this month's data is not comparable to previous months as they are different questions.

Key Actions (new actions in green):

1. QR (Quick Response) Code posters have been created for areas across the Trust to offer an alternative method of providing feedback which has no infection control implications as patients use their own smart phones to scan the link. As the Trust returns to pre-COVID-19 activity, the FFT will be made available in Arthur Levin DSU as individual QR code posters on patient bed tables (as well as cards). Collection of feedback also commenced in the COVID-19 vaccination centre in Downham Market. QR code flyers are also provided to

patients attending the physiotherapy women and men's health clinics to allow patients to respond to feedback from home as well as the SMS text service.

2. All logons have been set up, initial training provided and online learning promoted with all users of the new Envoy system.

Key Risks to Forecast Improvement:

Compliance still relies on human factors and it will be hard to identify any trends of FFT feedback before the end of quarter 1 due to the change in questions.

Responsive - Accountable Officer - Chief Operating Officer

Items in blue are awaiting the latest update

Data To	KPI Description	Target	Current Value	Variance	Assurance
Apr-21	18 Weeks RTT - Incomplete Perf	92.0%	61.1%	L	F
Apr-21	18 Weeks RTT - No. of Specialties failing the target of 92%	0	26		
Apr-21	18 Weeks RTT - Over 52 Wk waiters	0	1289		
Apr-21	A&E 4 Hour Performance	95.0%	82.1%		F
Apr-21	A&E 4 Hour Performance (Majors only)	95.0%	71.4%		F
Apr-21	A&E 4 Hour Performance (Minors only)	100.0%	94.7%		F
Apr-21	A&E 12 Hour Trolley Waits	0	3		
Apr-21	Ambulance Handovers	100.0%	58.5%		F
Apr-21	Last minute non-clinical cancelled elective operations	0.8%	0.31%		?
Apr-21	Breaches of the 28 day readmission guarantee	0	1		
Apr-21	Total non-clinical cancelled elective operations	3.2%	2.10%		?
Apr-21	Urgent operations cancelled more than once	0	0		
Apr-21	% of beds occupied by Delayed Transfers of Care	3.5%	4.2%	H	P
Apr-21	Medically Fit For Discharge - Patients		368	H	
Apr-21	Medically Fit For Discharge - Days		2533	H	
Apr-21	No. of beds occ by inpatients >=21 days - (Mthly average over rolling 3 mths)	46	58	H	?

Data To	KPI Description	Target	Current Value	Variance	Assurance
Mar-21	Cancer Wait Times - Two Week Wait Performance	93.0%	97.6%		?
Mar-21	Cancer Wait Times - 31 Day Diag to Treatment Performance	96.0%	97.1%		?
Mar-21	Cancer Wait Times - 62 Day Ref to Treatmemt Performance	85.0%	65.8%		?
Mar-21	Cancer Wait Times - 104 Day waiters	0	4		
Mar-21	Cancer Wait Times - Two Week Wait (Breast Symptomatic) Performance	93.0%	92.2%		?
Mar-21	Cancer Wait Times - 31 Day Subsequent Treatment - (Surgery) Performance	94.0%	100.0%		?
Mar-21	Cancer Wait Times - 31 Day Subsequent Treatment - (Drug) Performance	98.0%	100.0%	H	P
Mar-21	Cancer Wait Times - 62 Day Screening Performance	90.0%	100.0%		?
Mar-21	Cancer Wait Times - Consultant Upgrade (62 day)	90.0%	100.0%	H	?
Apr-21	Diagnostic Wait Times - % of over 6 Week Waiters	1.0%	50.2%	H	F
Mar-21	Stroke - 90% of time on a Stroke Unit	90.0%	56.1%	L	F
Mar-21	Stroke - Direct to Stroke Unit within 4 hours	90.0%	43.1%		F
Mar-21	Stroke - Patient scanned within 1 hour of clock start	48.0%	35.1%		?
Mar-21	Stroke - Patient scanned within 12 hours of clock start	95.0%	89.5%		?
Click here to view other National Stroke (SSNAP Dom					?
Mar-21	Trust - Seen <24 hrs (1st contact to investigations complete)	60.0%	52.8%		?

Emergency Care

Emergency access within 4 hours

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	A&E 4 Hour Performance	95.0%	82.1%		F	Common Cause (expected) variation	Variation indicates consistently (F)alling short of the target

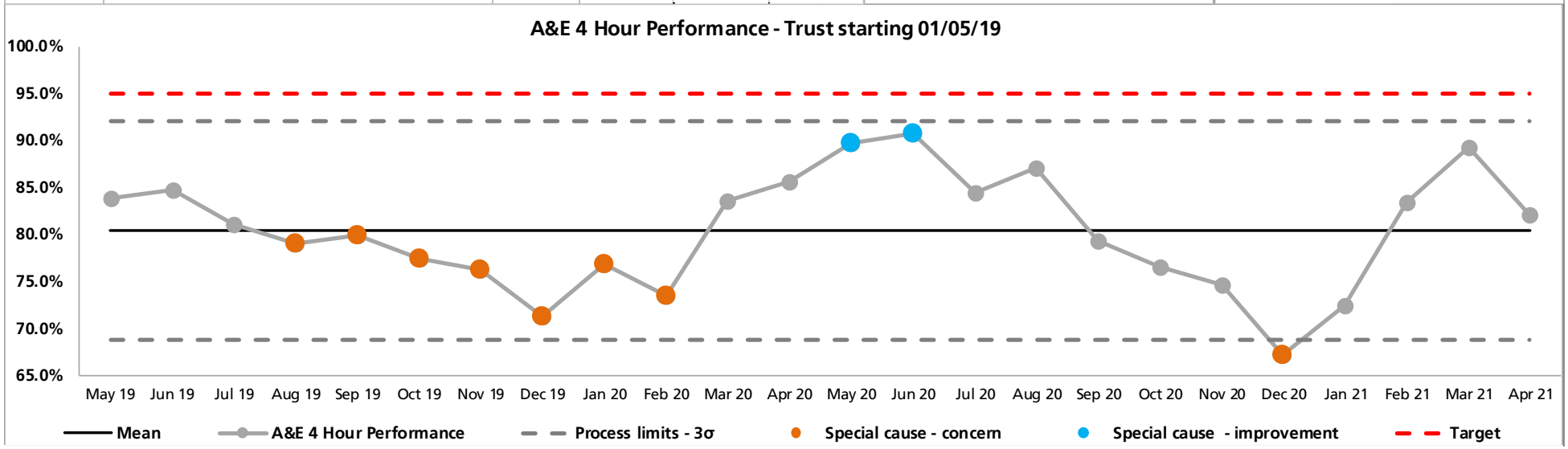


Chart 25 – A&E 4-hour performance

In April 2021, 6,121 patients attended the Emergency Department (ED) and of these, 1,097 patients were in department over 4 hours before admission, discharge or transfer. Performance was 82.1% against the standard of 95% and trajectory of 86.9%.

Admitted performance was 67.5% and non-admitted performance was 90.5%; 66.4% of all breaches were admitted patients. 94.5% of all attendances presented to Amber ED, 5.5% to Red ED. 11.2% of all breaches were from Red ED.

The main breach reasons were as follows:

- 366 patients waiting for a bed (33.7%). Of these the top three were;

- 228 patients were awaiting a bed on an Amber Medical ward
- 87 patients were awaiting a bed on a Red ward
- 47 patients were awaiting a bed on a Surgical ward

- 100 patients awaiting specialty review or decision (9.1%). Of these the top three were;
  - 24 patients were awaiting decision making by the Stroke team
  - 22 patients were Amber Medical patient requiring review in ED i.e. clinically unstable or direct transfers to ward beds
  - 12 patients were Surgical patients

Three patients waited in the Emergency Department over 12 hours from decision to admit to admission. All patients were awaiting transfer to a mental health inpatient bed.

Ambulance Handovers completed within 15 minutes

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Ambulance Handovers	100.0%	58.5%		F	Common Cause (expected) variation	Variation indicates consistently (F)alling short of the target

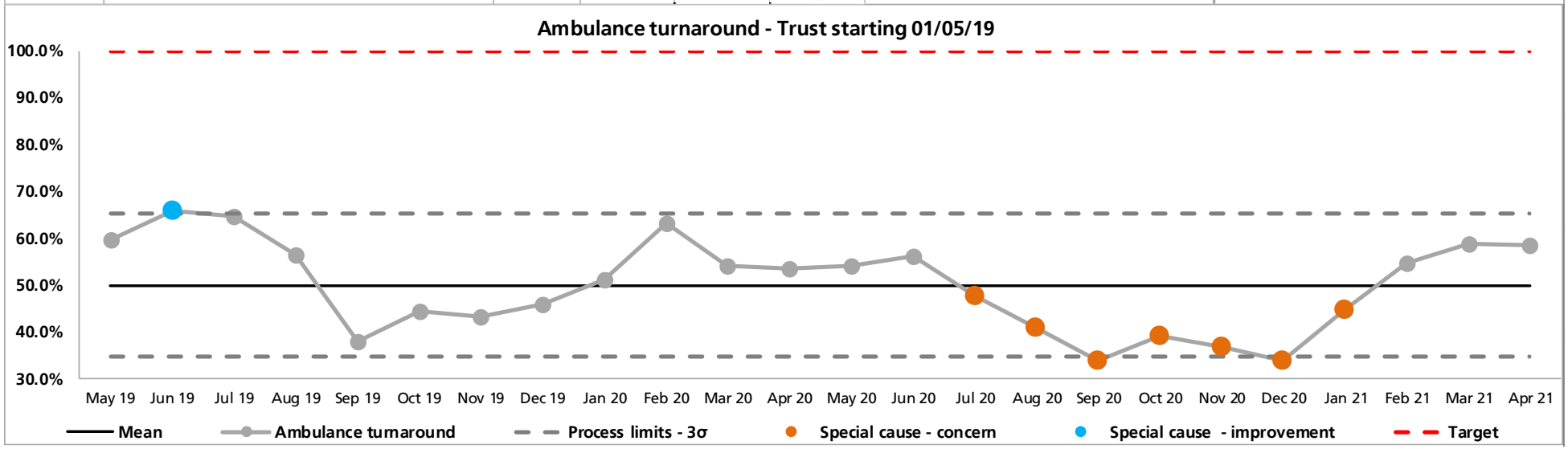


Chart 26 – Ambulance handover performance

In April 2021 there were 1,986 conveyances by EEAST to the Emergency Department (ED). 58.5% of all handovers took place within 15 minutes against the trajectory of 65.0%. 88.0% of handovers were completed within 30 minutes against a trajectory of 85.0%.

The average handover time was 22 minutes and 4.5% of handovers exceeded 60 minutes. In month, the Trust ranked 3rd 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 levels with insufficient Amber capacity to meet the demand for new admissions and patients being stepped down from the Red pathway.

2. 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. Implementation of the approved ward configuration to ensure sufficient Red and Amber inpatient capacity is available to meet demand.
2. 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.
3. Reinforce the internal professional standards and ensure appropriate escalation and action is taken to address non-compliance.

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.

Beds occupied by adult inpatients >=21 days

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	No. of beds occ by inpatients >=21 days - (Mthly average over rolling 3 mths)	46	58	H	?	Special cause (unexpected) variation - Concern (H)	Variation indicates inconsistently passing and falling short of the target

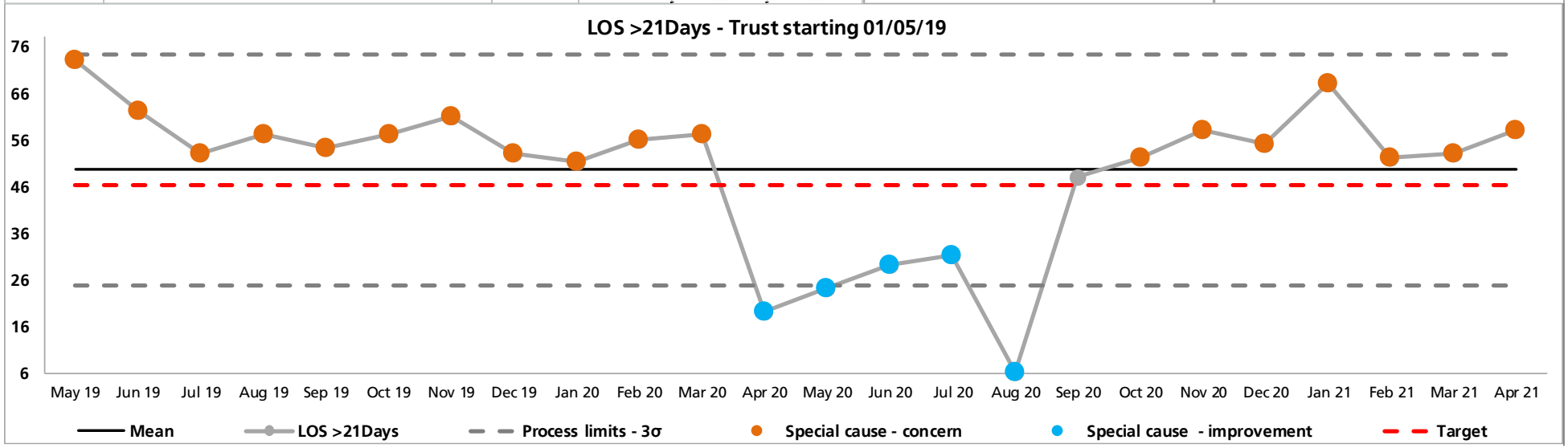


Chart 27 – LoS <21 days

At the end of April, 58 patients had a length of stay over 21 days, against a target of 46.

Primary reasons for patients in hospital where the criteria to reside were met:

- Patients requiring on-going clinical treatment or treatment that can only be provided in an acute setting
- Patients requiring intravenous therapy that cannot be delivered in the community
- Waiting for diagnostic or internal test or specialist opinion

Primary reasons for patients in hospital where the criteria to reside was not met

- Waiting for social care reablement or home-based intermediate care
- Waiting for residential or nursing home
- Waiting for transfer of care to specialist unit

Key Issues (new actions in red):

1. Lack of community IV antibiotics therapy service for patients needing treatment more than twice a day
2. Lack of community capacity for patients requiring health and social care input after discharge, particularly one to one care

Key Actions (new actions in green):

1. Increased dialogue with system partners and prompt escalation of patient delays is being provided through and agreed escalation pathway.
2. An Accelerated Discharge and Multi-Agency Discharge Event (MADE) is planned for week commencing 24 May. This will bring together colleagues across the system to recognise and unblock delays to discharge.

Recovery Forecast:

Recovery forecast to trajectory 46 (10%) >21 days LOS in May 2021

Key Risks to Forecast Improvement:

- Community and social care capacity to support patient discharge, particularly for one to one care.

Elective Care

18 weeks referral to treatment

At the end of April 2021, there were a total of 16,783 patients on the waiting list, 6,531 of these patients had waited for over 18 weeks from referral, giving performance of 61.09%.

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	18 Weeks RTT - Incomplete Perf	92.0%	61.1%	L	F	Special cause (unexpected) variation - Concern (L)	Variation indicates consistently (F)alling short of the target

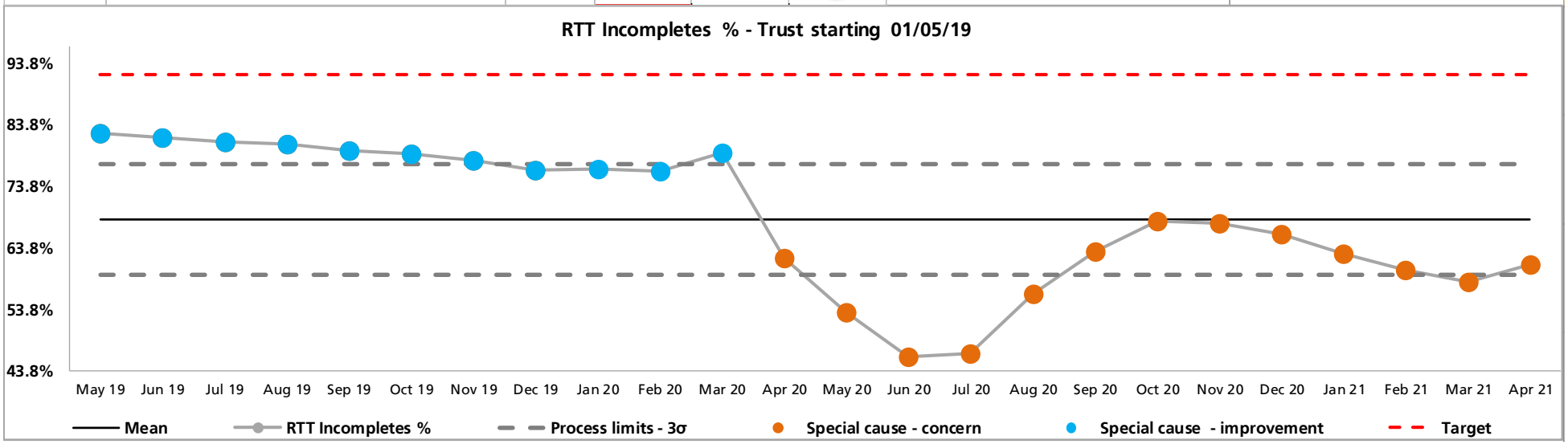


Chart 28 – RTT Incompletes

Key Issues (new issues in red):

1. Day Surgery remained as Red ED throughout April.
2. Prioritisation of urgent P2 cases in line with national guidance.

Key Actions (new actions in green):

1. All six elective theatres within the main theatre suite are fully utilised Monday – Friday.
2. Day Surgery Unit to re-open as a surgical unit on the 17th May 2021.
3. A trajectory has been produced which shows the backlog of P2 patients will be cleared by July, after which point P2 patients will be booked within 4 weeks and capacity will be available for routine long-waiting patients.

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 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.

52-week breaches (unvalidated)

Waiting times significantly increased during 2020/21 as a result of the cessation of routine elective activity in response to the COVID-19 pandemic. At the end of April 2021 there were 1,289 patients waiting longer than 52 weeks for treatment; the majority of these were in Orthopaedics (426), Gynaecology (220) and General Surgery (206). The longest waiting patient is an orthopaedic patient at 103 weeks.

Key Issues (new issues in red):

1. Day Surgery remained as red ED throughout April.
2. Prioritisation of urgent P2 cases in line with national guidance. A trajectory has been created which shows the backlog of P2 patients will be cleared by July, after which point P2 patients will be booked within 4 weeks and capacity will be available for routine long-waiting patients.
3. The impact of the relocation of ITU in March to main theatres was an increase in the number of patients waiting over 52 weeks for treatment.

Actions (new actions in green):

1. All 6 elective theatres within the main theatre suite are now fully utilised Monday – Friday.
2. 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.

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

In April there was 1 breach of the 28 day readmission guarantee. This related to a gynaecology patient who was cancelled on 3 March 2021 due to the absence of a pacemaker technician in theatre. The patient's procedure was undertaken on 29 April 2021.

Diagnostic Waiting Times

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Diagnostic Wait Times - % of over 6 Week Waiters	1.0%	50.2%	H	F	Special cause (unexpected) variation - Concern (H)	Variation indicates consistently (F)alling short of the target

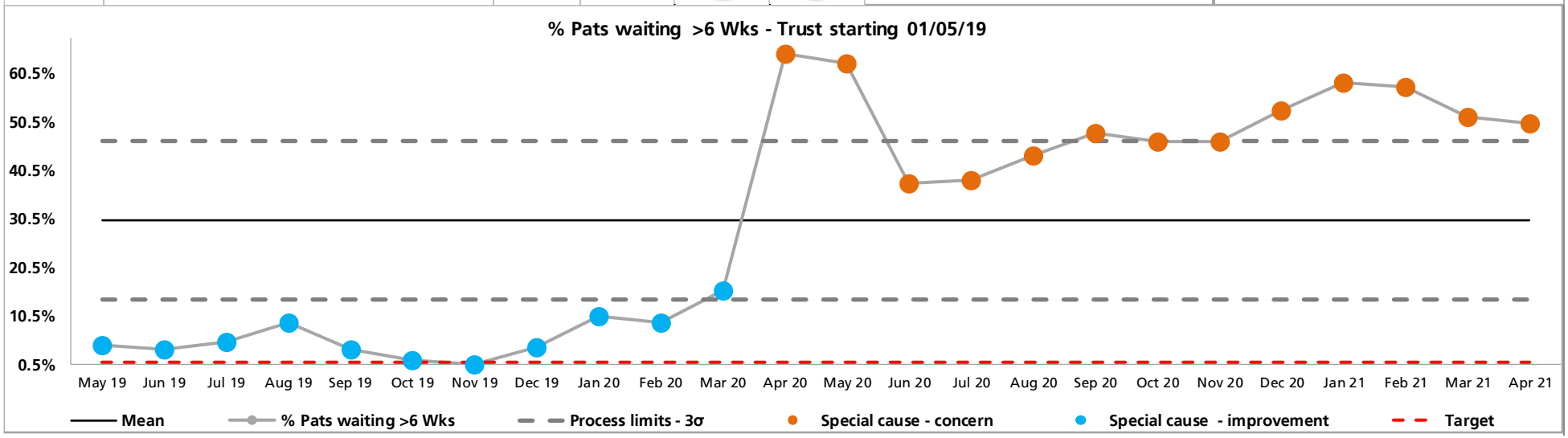


Chart 29 - % waiting > 6 weeks

In April 2021 performance was 50.2% against the standard of 1%. There were 3,516 patients waiting over 6 weeks at the end of the month from a total waiting list of 6,905. The majority of patients waiting over 6 weeks are in MRI (866), Echocardiogram (1,070) and CT (887).

Key Issues (any new issues in red):

1. Continued mechanical issues with MRI, helium escape causing one week down time for one machine.
2. Activity levels have not yet returned to pre-COVID-19 levels in Echocardiography but this is planned for July.

Key Actions (new actions in green):

1. A service review of capacity and demand in CT and MRI is in progress.

2. A staffed mobile CT van has been secured for 7 days In June.
3. Echocardiography staffing will improve in June and further in July when activity levels will revert back to pre-COVID-19 levels.

Recovery Forecast:

A recovery trajectory will be in place by the end of quarter 1 2021/22.

Key Risks to Forecast Improvement:

1. Continued mechanical failure of the MRI
2. Availability of MRI and CT outsourced capacity
3. High levels of demand for patients referred on a suspected cancer pathway

Stroke – 90% of time on a Stroke Unit (unvalidated)

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Mar-21	Stroke - 90% of time on a Stroke Unit	90.0%	56.1%	L	F	Special cause (unexpected) variation - Concern (L)	Variation indicates consistently (F)alling short of the target

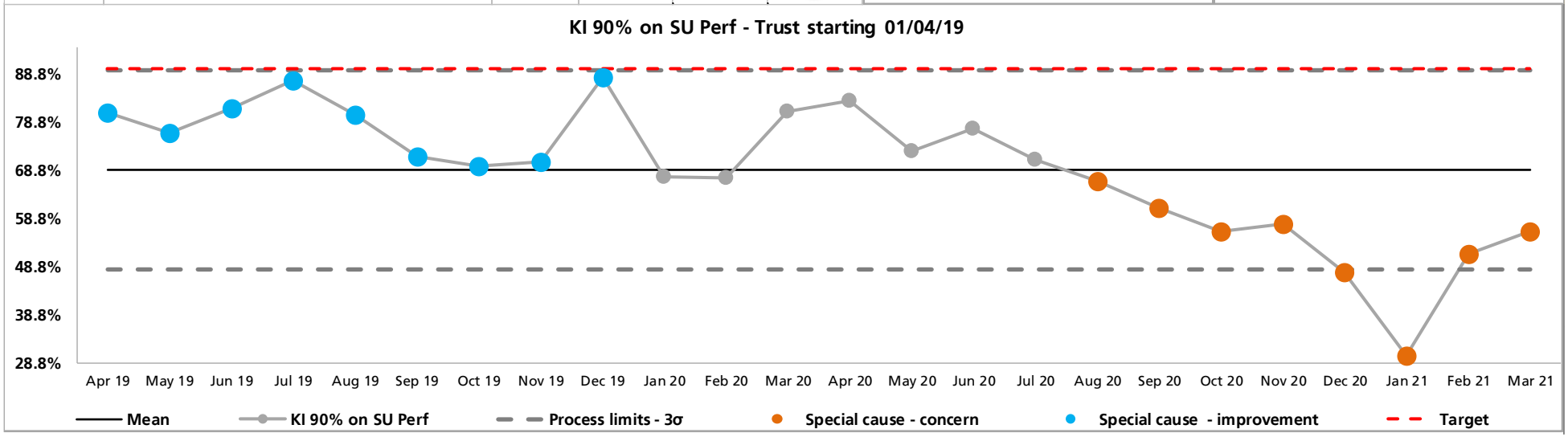


Chart 30 – 90% of time on Stroke Unit

In April 2021 performance was 56.1% of patients who spent 90% of their stay on the stroke unit (SSNAP audit score 'E') against the standard of 90%. The main breach reasons are as follows:

- Patients not directly transferred to the Stroke unit
- Patients admitted or transferred via the COVID-19 pathway
- Patients with a challenging diagnosis

Key Issues (any new issues in red):

1. The Coronary Care Unit (CCU) remains Stroke Unit reducing the Stroke bed base from 29 to 24 beds

2. Stroke patients presenting with suspected COVID-19 and requiring admission to a COVID-19 ward

Key Actions (new actions in green):

1. Relocation of the Coronary Care Unit in line with the finalised seasonal bed modelling
2. To continue to work with the Integrated Stroke Delivery Network (ISDN) 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 unit remaining on the Stroke Unit
- Continued impact of COVID-19 – Stroke patients with suspected COVID-19 cannot be admitted directly to 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
Mar-21	Cancer Wait Times - Two Week Wait Performance	93.0%	97.6%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

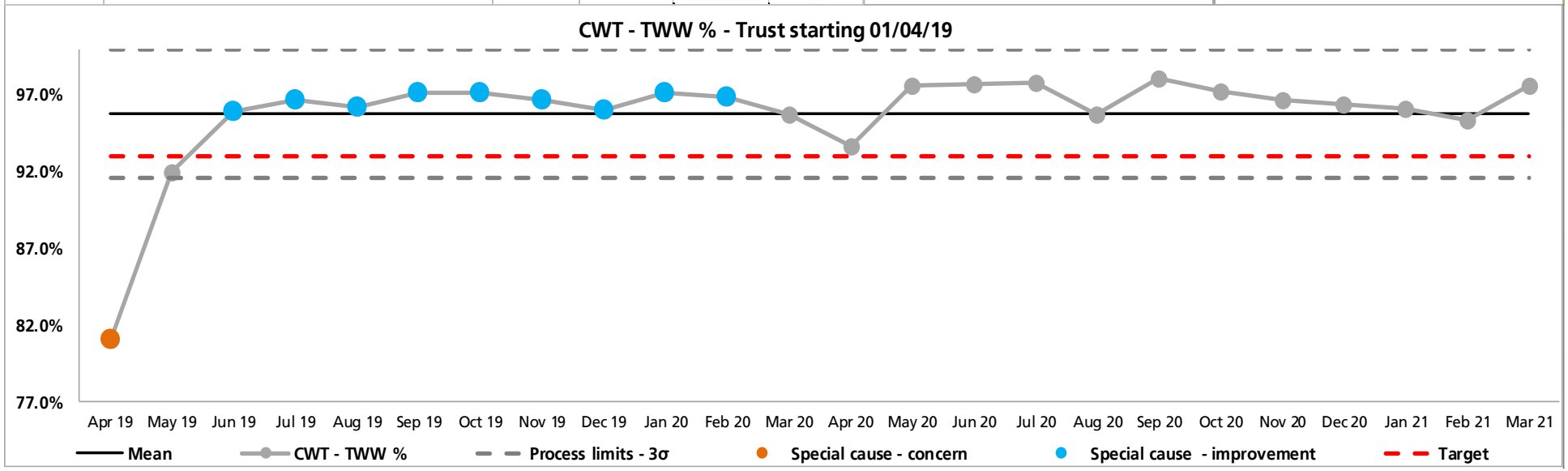


Chart 31 – CWT 2 week wait performance

Performance in March 2021 was 97.6% 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
Mar-21	Cancer Wait Times - 62 Day Ref to Treatmemt Performance	85.0%	65.8%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

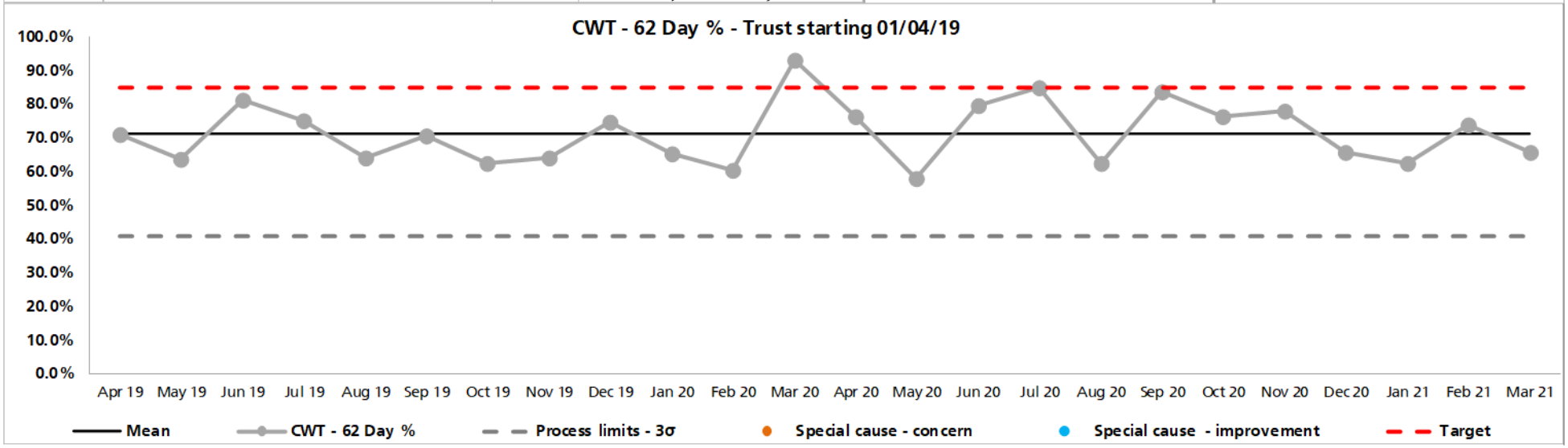


Chart 32 – CWT 62-day referral to treatment

Performance in March 2021 was **65.8%** against the standard of **85%** and trajectory of **83.33%**.

There were **58.5** treatments in month, of which **20** breached the 62-day standard:

- 1 breast
- 6 gynaecology
- 1 haematology
- 8 colorectal
- 2 lung
- 2 upper GI

Key Issues (any new issues in red):

1. Continued delays in surgery at Tertiary centres across multiple cancer sites

2. Further increases in GP referrals across multiple body sites. Colorectal and breast are again seeing week on week increases in their referral numbers

Key Actions (new actions in green):

1. Tertiary centres have developed plans to increase surgical capacity in the coming weeks and months. Twice weekly catch up calls are now in place to run tertiary PTL meetings to update on a patient by patient basis. Steady improvement has already been made with majority of surgeries now dated and all within 31 days of Decision to Treat.
2. Operational teams have developed robust plans to maximise outpatient capacity over the coming weeks to meet the increasing demand for 2ww slots. Further capacity has been added where required and clinic utilisation is being maximised to deliver maximum throughput.

Patients waiting for 104+ days

The Trust has reduced 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 **7** patients waiting for over 104 days, of which **1** is colorectal, **4** are gynaecology, **1** is Haematology and **1** Head and Neck. None of these patients have a decision to treat.

Recovery Forecast:

The Trust is forecasting delivery of the 62 day referral to treatment standard by June 2021.

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

Statement of comprehensive income: Month 1 – 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	18,866	18,855	(11)	(0%)	18,866	18,855	(11)	(0%)
Other Income	1,347	1,329	(18)	(1%)	1,347	1,329	(18)	(1%)
COVID-19 Additional Income	1,302	1,579	277	21%	1,302	1,579	277	21%
Total Income	**21,515**	**21,763**	**248**	**1%**	**21,515**	**21,763**	**248**	**1%**
Pay Costs - Substantive	(12,660)	(12,494)	166	1%	(12,660)	(12,494)	166	1%
Pay Costs - Bank	(988)	(1,021)	(33)	(3%)	(988)	(1,021)	(33)	(3%)
Pay Costs - Agency	(976)	(987)	(11)	(1%)	(976)	(987)	(11)	(1%)
Pay Costs - Additional COVID-19	(1,091)	(1,236)	(145)	(13%)	(1,091)	(1,236)	(145)	(13%)
Pay Costs - Vaccination Centres	0	(212)	(212)		0	(212)	(212)	
Total Pay	(15,715)	(15,950)	(235)	(1%)	(15,715)	(15,950)	(23)	(0%)
Non Pay - Additional COVID-19	(150)	(104)	46	31%	(150)	(104)	46	31%
Non Pay	(5,479)	(5,530)	(51)	(1%)	(5,479)	(5,530)	(51)	(1%)
Total Operating Costs	**(21,344)**	**(21,584)**	**(240)**	**(1%)**	**(21,344)**	**(21,584)**	**(240)**	**(1%)**
EBITDA	**171**	**179**	**8**	**5%**	**171**	**179**	**8**	**5%**
Non-Operating Costs	(816)	(816)	0	0%	(816)	(816)	0	0%
Adjust Donated Assets	29	33	4	14%	29	33	4	14%
TOTAL (Deficit) / Surplus	**(616)**	**(604)**	**12**	**2%**	**(616)**	**(604)**	**12**	**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:

- The Trust continues to operate RED ED in the Day Surgery Unit and an escalation ward based on Windsor ward. The Day Surgery is planned to re-open on 17 May following the relocation of RED ED to the main ED with a phased closure of Windsor ward is planned.
- COVID Income is positive to plan due to the recovery of vaccination costs.
- Excluding Covid-19, the pay bill is £0.1m positive to plan (i.e. net variance of substantive, bank and agency).
- Excluding Covid-19 agency spend is adverse to plan by £11k in month.
- The CIP programme has achieved £0.2m of efficiencies in month in line with plan.
- In month capital expenditure incurred/committed is £0.3m.

Statement of Financial Position (SOFP) Update

	31-Mar-21 £m	30-Apr-21 £m	Month on Month Movement £m
Non current assets	104	102	(2)
Current Assets			
Inventories	2	2	(0)
Trade & Other Receivables	13	15	2
Cash	27	25	(2)
Current liabilities			
Trade & Other Payables	(19)	(20)	(1)
Accruals	(18)	(13)	5
PDC dividend	-		-
Other current liabilities	(2)	(2)	(0)
Non current liabilities	(1)		1
Borrowings	-	-	0
Total assets employed	**106**	**109**	**3**
Tax payers' equity			
Public Dividend Capital	198	198	(0)
Revaluation Reserve	12	12	(0)
Income & Expenditure Reserve	(104)	(101)	3
Tax payers' equity	**106**	**109**	**3**

Month-on-Month Key movements

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

Cash balances have decreased from £26.9m at 31 March 2021 to £24.6m at the end of April, this is due to increased payments made to suppliers and other key stakeholders during the month.

Decreases in accrued expenses for the month are mainly offset by a similar increase in prepayment balances.

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
Apr-21	Appraisal Rate	90.0%	82.7%		
Apr-21	Appraisal Rate (Med Staff exc Jnr Drs)	95.0%	89.0%		
Apr-21	Sickness Absence Rate	4.0%	5.1%		
Apr-21	Mandatory Training Rate	80.0%	81.7%		
Apr-21	Turnover Rate	10.0%	9.1%		

Well-Led (People)

The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	Establishment	Baseline	Actual	Plan			
	2020/2021	Staff in post outturn	As at 30th April 2021	30/06/21	30/09/21	31/12/21	31/03/22
	Year End (31st March 2021)	Year End (31st March 2021)	Month 1	Q1	Q2	Q3	Q4
Workforce (WTE)	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Substantive	**3588.93**	**3372.81**	**3375.7**	3387.81	3386.81	3386.81	3386.81
Bank	375.01	375.01	347.70	385.01	385.01	403.31	403.31
Agency	208.13	208.13	177.82	198.13	198.13	179.83	179.83
Total Provider Workforce (WTE)	**4172.07**	**3955.95**	**3901.22**	**3970.95**	**3969.95**	**3969.95**	**3969.95**

Table 1: Staff in post

Vacancy Levels and Turnover

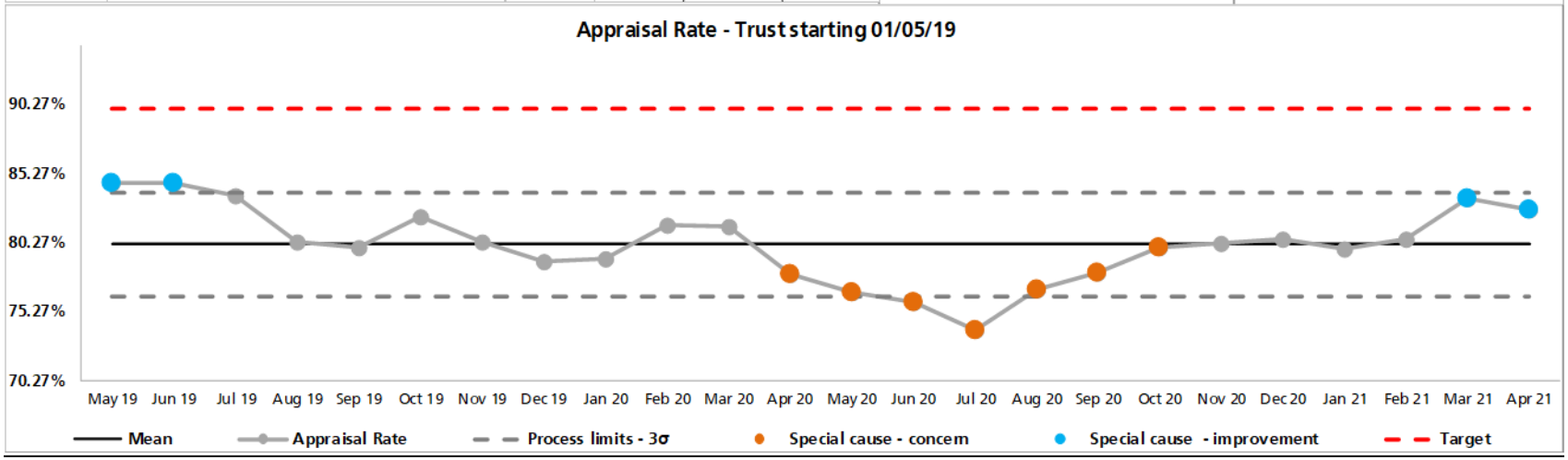
Division	March 2021	April 2021
Trust	6.03%	6.32%
Nursing and Midwifery	5.6%	5.43%
Medical and Dental	5.13%	4.97%
AHP	14.57%	15.79%

Table 2: Vacancies

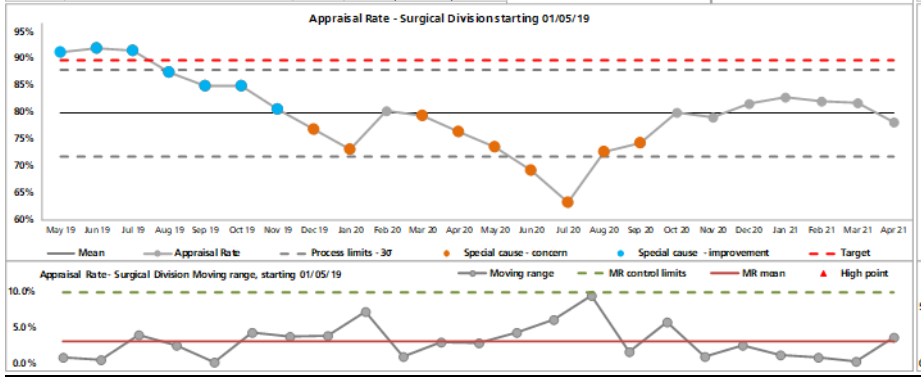
An additional 6 International Nurses are due to start in July 2021

Appraisals

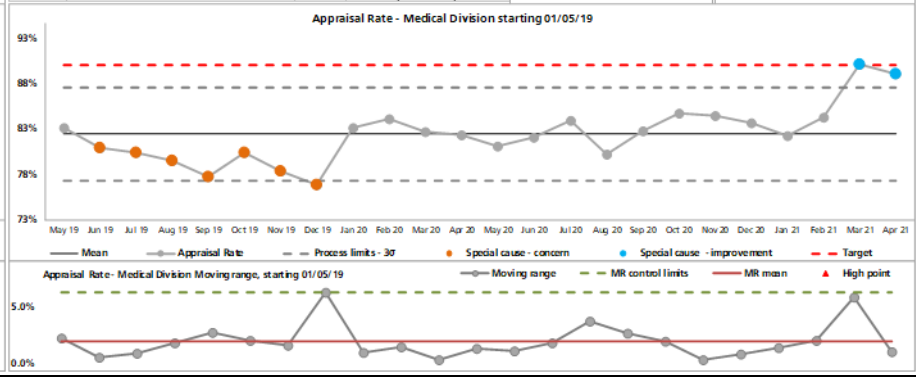
Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Appraisal Rate	90.0%	82.7%	H	F	Special cause (unexpected) variation - Improvement (H)	Variation indicates consistently (F)alling short of the target



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Appraisal Rate	90.0%	78.4%		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
Apr-21	Appraisal Rate	90.0%	89.1%	H	F	Special cause (unexpected) variation - Improvement (H)	Variation indicates consistently (F)alling short of the target



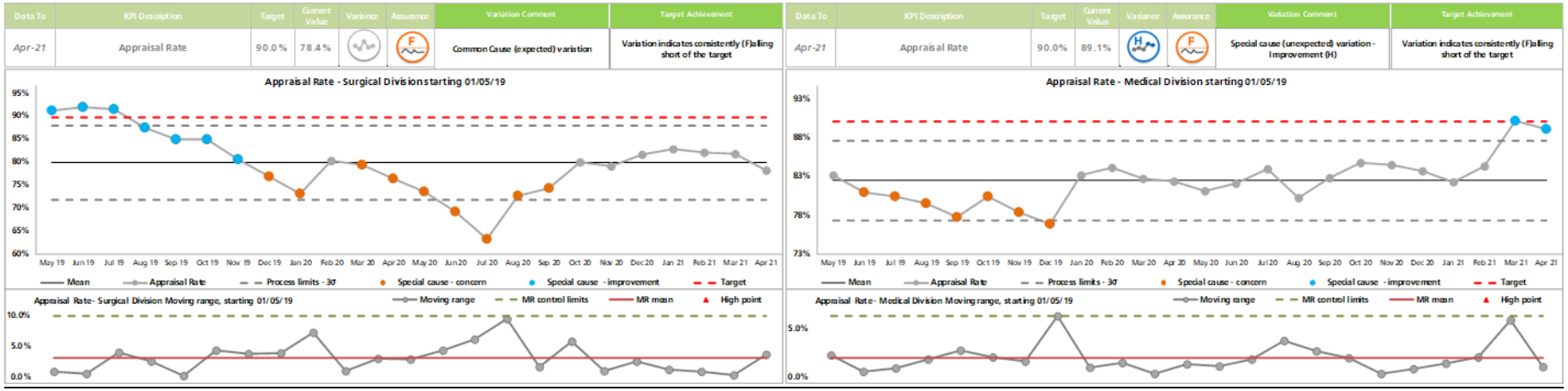


Chart 33 – Appraisal rate

Key Issues

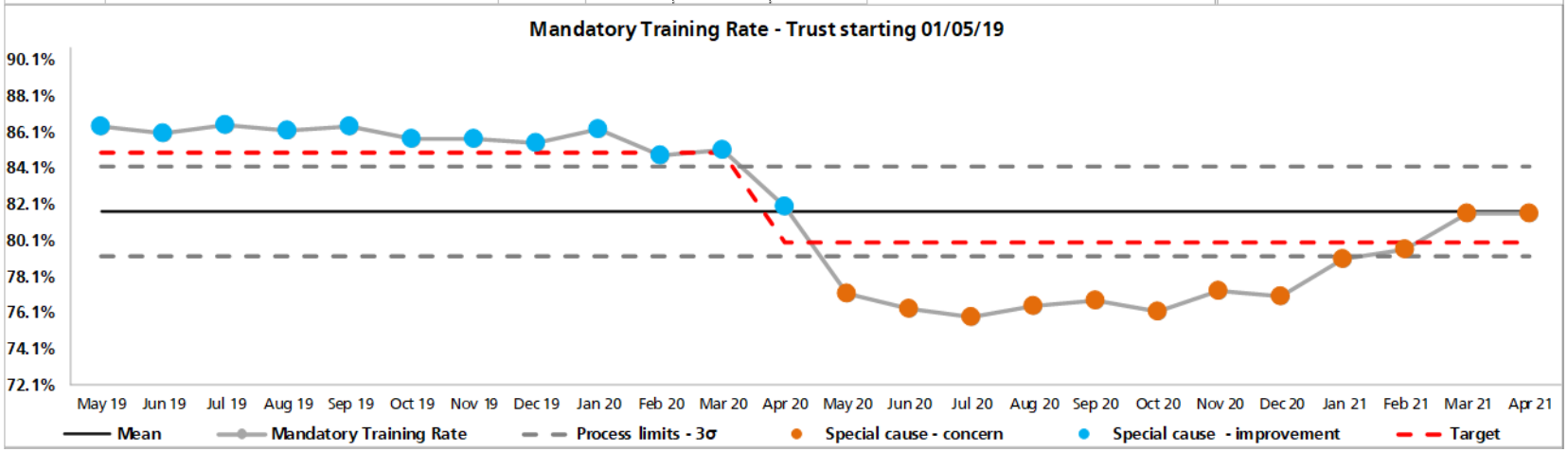
- Seriously Overdue appraisals (in excess of 18 months overdue) - 55 decrease of 9 on the previous month,
- 20 overdue by 18 – 24 months
- 35 appraisals overdue by 24 months.
- 30/55 substantive employees
- 25/55 bank workers unable to complete a shift without having an appraisal in place.

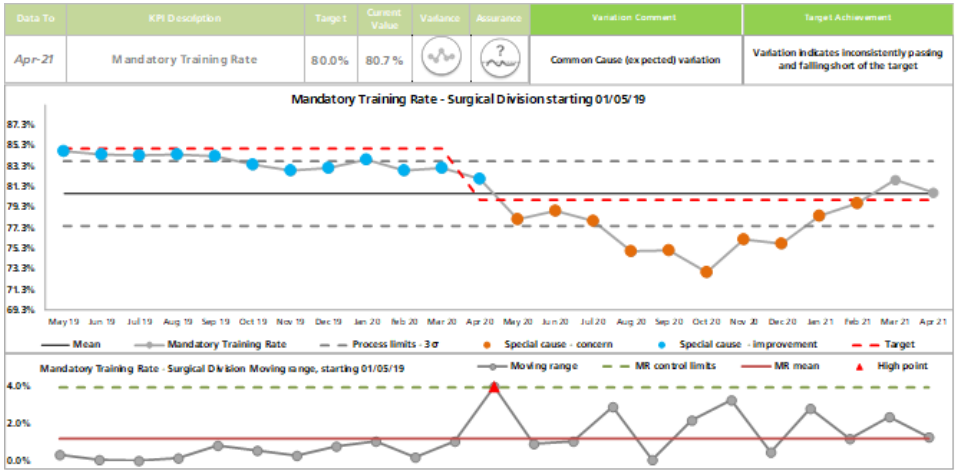
Key Actions

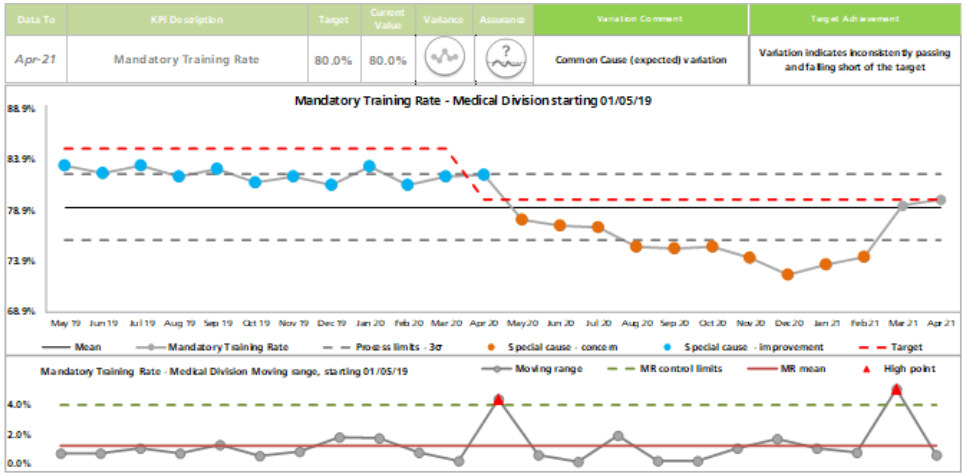
- A pay progression policy is under development and will automatically apply to new starters from April 2021.
- Appraisal documentation amended to incorporate the Trust's values
- Additional training provided
- Recovery plans and trajectories in place

Mandatory Training

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Mandatory Training Rate	80.0%	81.7%			Special cause (unexpected) variation - Concern (L)	Variation indicates inconsistently passing and falling short of the target







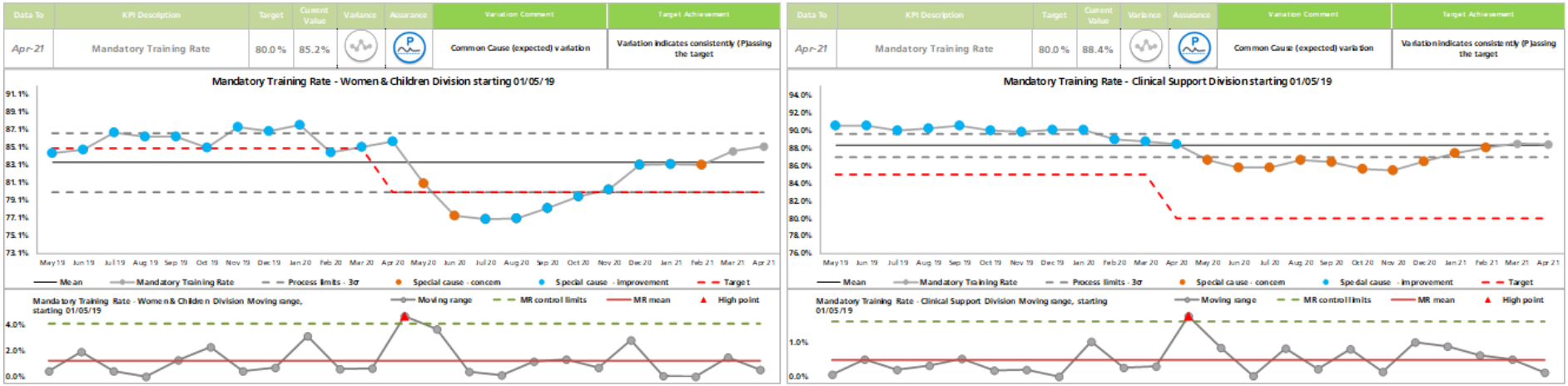


Chart 34 – Mandatory Training rate

Key Issues:

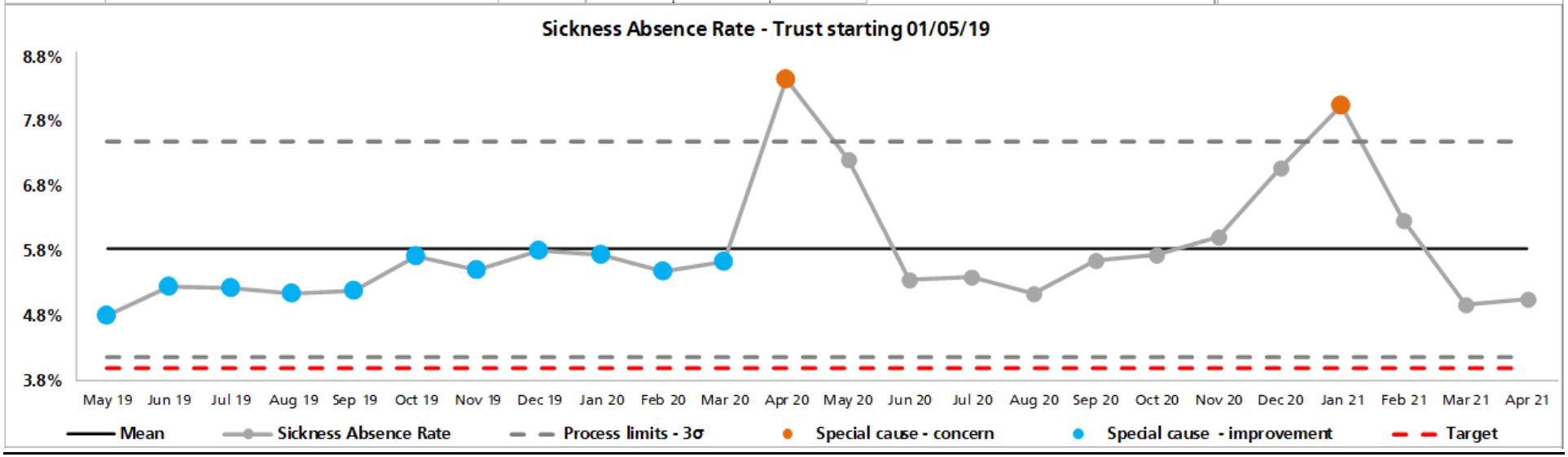
- COVID-19 social distancing restricts the number of attendees on each face-to-face course

Key Actions:

- Targeted communications and training for all staff and managers regarding ESR Self-serve
- FAQs and 'How to' guide developed and shared
- A three-month expiry extension for face to face Resus and Manual Handling Level 2
- A national extension of 3 months for Date Security Training
- Focus on building and improving an E-Learning portal
- Digital staff passport implemented from 1st April 2021
- A pay progression policy is under development
- Policy Convergence and Alignment across the three acute trusts
- A task and finish group in place recommending improvements to the Trust Mandatory training including comprehensive role-specific training requirements for medical, clinical and non-clinical roles across the trust.

Sickness Absence Rate

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Apr-21	Sickness Absence Rate	4.0%	5.1%		F	Common Cause (expected) variation	Variation indicates consistently (F)alling short of the target



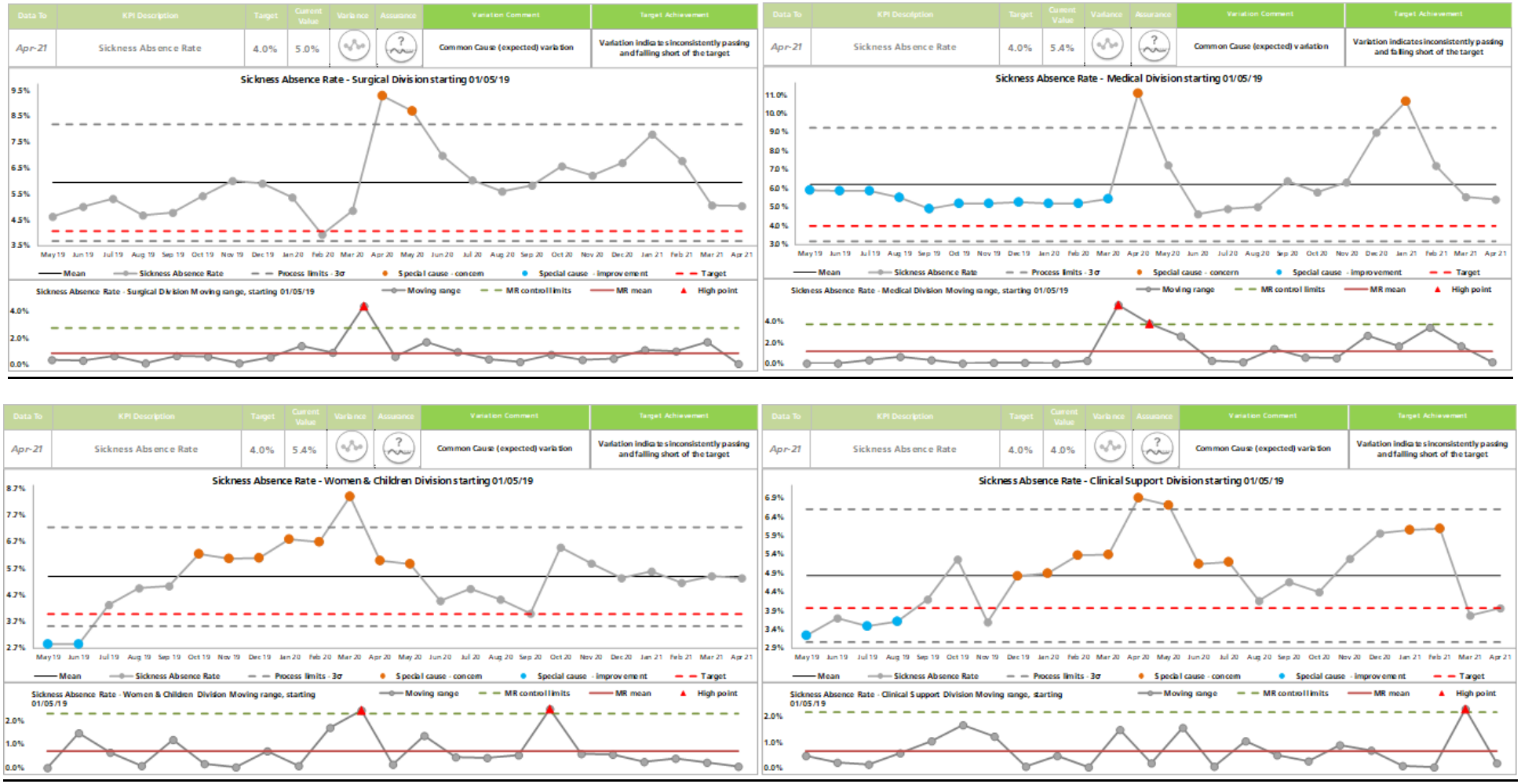


Chart 35 – Sickness Absence rate

Sickness absence in April increased to 5.05% from 4.98%. 12 month cumulative sickness is at 5.99% which has decreased from 6.28%.

A review is being undertaken for long term sickness in the Divisions of Medicine and Surgery as this has increased over the last two months. 100% shielders have returned to work in April 2021.