Meeting:	Board of Directors (Public)		
Meeting Date:	7 September 2021	**Agenda item:**	12
Report Title:	Integrated Performance Report (IPR) – July 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, across all Strategic Objectives. The appropriate BAF updates are received and reviewed within Finance and Activity Committee, Quality Committee, People Committee and Senior Leadership Team.	
Significant risk register	Ref to significant risks There are currently nine approved significant risks open across the Trust which align to the Strategic Objectives. These are monitored through the Trust committee structure.	
	Y/N	If Yes state impact/ implications and mitigation
Quality	Y	As monitored through Committees
Legal and regulatory	Y	As monitored through Committees
Financial	Y	As monitored through Committees

Assurance route

Previously considered by:	Senior Leadership Team / Quality Committee

Executive summary

Action required:	Approval	Information	**Discussion**	Assurance	Review
Purpose of the report:	The Trust is required to provide assurance towards performance management. Demonstrate that it is rigorous; appropriately identifying, escalating and dealing with areas of performance which are of concern. This should all be in a timely manner.				

	Focusing on the data using Statistical Process Control enables greater visibility and oversight. This, in turn, provides focus to ongoing issues in relation to performance rather than those which are delivering within the parameters of agreed statistical variation.
Summary of Key issues:	A summary of key issues highlighted in the IPR this month are detailed below: **Incidents** The number of serious incidents reduced in July (5), compared to June (9). There has been a reduction in the number of patients sustaining harm and injuries following fall incidents. **Infection Prevention and Control** In July, there have been two cases of C.Diff reported, one case (Community Onset Healthcare Associated) has been reviewed and attributed to QEHKL and the other (Hospital Onset Healthcare Associated) is pending review. There have been five cases of hospital onset E.Coli in July 2021, two have been reviewed and three reviews are ongoing. The number of MSSA cases identified in July 2021 was zero, a decrease on the two reported in June 2021. **Screening** VTE risk assessment remains stable and has been above the agreed performance threshold for over 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. **Maternity** There were 159 total births in June 2021- [96] 60.4%- normal vaginal deliveries, [11] 6.9% - assisted vaginal deliveries and [52] 32.7 % - total Ceasarean births. **Term Neonatal Unit Admissions** Total term admission rates to NICU in July 2021 were 4.5% under the current national target of 6%. **Breast Feeding Initiation Rates** Breast feeding initiation and sustained at the time of discharge from hospital rates remain generally above national targets and within common cause variation. **Smoking cessation in pregnancy** Smoking rates at the time of booking for antenatal care continue to vary between 15-25% and remain within common cause variation. **Mortality** Dr Foster have continued to experience national data reporting issues which has prevented the issue of reliable HSMR data for all trusts. We

	have now received data for the period covering April 2020 to March 2021 but ideally should be reporting for the period covering May 2020 to April 2021. SHMI remains within the "expected band" at 104.7 (12 months to March 2021). HSMR for the period April 2020 to March 2021 has fallen from 142.21 to 137.46. **Research** 167 patients were recruited into National Institute for Health Research (NIHR) trials in July, above the target and within common cause variation. **Mixed Sex Accommodation Breaches** There have been three incidents of same sex accommodation breaches affecting nine patients during July 2021. **Complaints** The timeliness of responding to complaints within 30 days has been achieved in June and July 2021. **Dementia Case Finding** For the fourth month in a row, Dementia screening rates have remained significantly above the agreed threshold indicating special cause variation improved performance since the Cognitive Impairment Assessors in the Frailty and Dementia team started in post. Their roles, which include screening of all recently admitted patients (>75 years of age admitted within 72 hours), also ensures that patients identified with cognitive impairment promptly get a specialist review and if feasible are moved to the right ward to provide ongoing care. **Emergency Care** 4-hour performance in July fell to 73.2% from 76.4% in June, below the standard of 95%. In July, admitted performance fell to 47.6% whereas non-admitted performance was significantly higher at 87.3%. Throughout July, two patients waited in the Emergency Department over 12 hours from decision to admit to admission, a reduction from nine in June. In July 45.8% of all ambulance handovers took place within 15 minutes, a reduction from 49.5% in June. The average handover time fell to 24 minutes. The percentage of handovers exceeding 60 minutes rose to 13.32% in July, an increase from 9.3% in June. **Referral to Treatment** 18-week performance fell to 66.8% in July from 67.2% in June. The Trust is not expecting to recover to the national 92% standard this financial year as services continue to work on recovery plans. In July the Trust had 1,061 patients waiting over 52 weeks. The Trust does not anticipate clearing the 52 week backlog this financial year.

	Six week diagnostic performance improved to 58.2% in July from 53.3% in June. The majority of those waiting over 6 weeks are waiting for either an Echocardiogram (1,461 patients), MRI scan (1,130 patients) or non-obstetric ultrasound (959). Actions being taken to improve this position include insourcing and outsourcing of MRI, a staffed CT van on site in August and for two weeks in September and a business case for outsourcing of echoes. Cancer 62-day performance in June 2021 was 76.6% against the standard of 85% and trajectory of 86.05%. Referral numbers have dramatically increased across all services with particular concern in Upper GI, Colorectal and Gynaecology. All 3 of these sites have seen record high numbers of referrals in the previous month. Colorectal specifically has seen a 70% increase in Pathway size in the last 2 months. This has caused a strain on clinic and diagnostic capacity. **Well Led (Finance)** As at the end of July 2021, the Trust's in month financial position is showing a deficit of £3k against the plan but is still £21k positive to plan at the end of month 4. **Well Led (Workforce)** Sickness absence has increased to 6.2% 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. A fast-track process has been implemented with closer working with Occupational Health (OH) and the attendance policy and toolkits were ratified in July 2021. A system wide review is being undertaken and a workshop planned for end of September to relook at managing absence and rewarding good attendance. There has been a decrease in bank and agency spend this month with a new VSP process for non-medical staff implemented and refined following feedback. The authorisation, visibility and sign off process for bank and agency staff is under review. On-going system wide implementation of a collaborative bank is underway with work continuing across the ICS to align bank and agency rates. 93.4 % of staff have had their first COVID-19 vaccination. 90.7% of staff have had their second COVID-19 vaccination A fast-track process is in place for breaches of confidentiality and accessing own medical records. This has seen a reduction in time to resolve employee relations cases. A number of long-term employee relations cases have now been resolved. A review of HR policies and procedures is taking place. 70% of policies are now in date with a plan for the remaining policies to be updated by 31[sst] October 2021.

	The interview panel structure has been reviewed and was implemented on 5th July including BAME and gender representation. In July 100% of panels had BAME representation and 92% of panels had full representation. Mandatory training compliance has increased to 85.2% Leadership framework being developed.
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

Integrated Performance Report

Board of Directors

July 2021 data

<u>**A note on SPC Charts**</u>

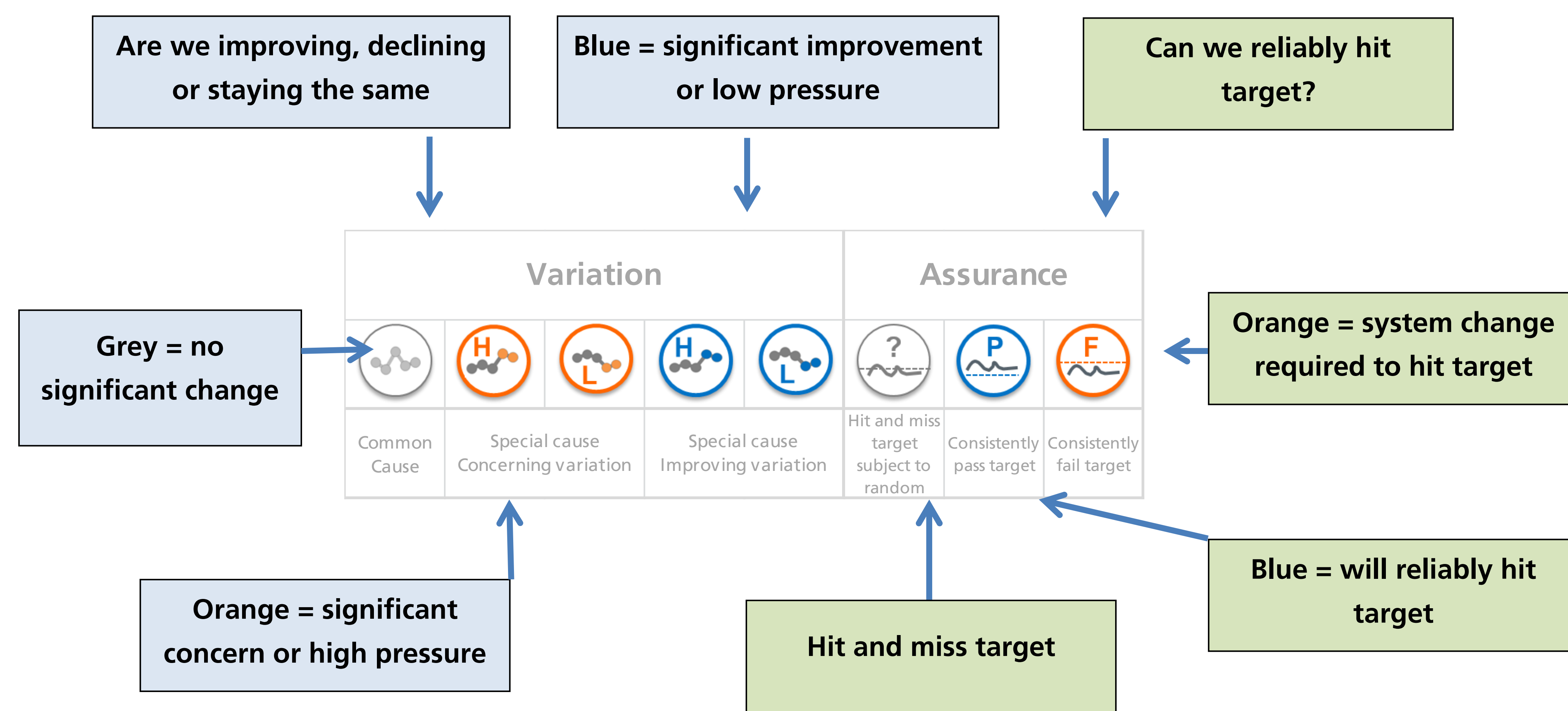
The report that follows uses the key below. A recap of using these descriptions is also included below

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

A note on SPC Charts continued

High level Key - Variation

High level Key - Assurance



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

Safe Dashboard

Data To	KPI Description	Limit	Current Value	Variance	Assurance
Jul-21	Serious Incidents (DECLARED IN MONTH)	0	5		
Jul-21	Falls (with Harm) Rate per 1000 beddays	0.98	0.07		P
Jul-21	PUs Rate per 1000 beddays	0.41	0.33		?

Data To	KPI Description	Target	Current Value	Variance	Assurance
Jul-21	Overall Fill Rate %	80.0%	87.3%		P
Jul-21	CHPPD	8.00	7.63		?
Jul-21	Cleanliness - Very High Risk	95.0%	96.6%		P
Jul-21	Cleanliness - High Risk	95.0%	95.4%		?
Jul-21	Cleanliness - Significant Risk	95.0%	92.4%		?
Jul-21	Cleanliness - Low Risk	95.0%	83.5%		
Jul-21	Cleanliness - No. of audits complete	37.00	43		?

Data To	KPI Description	Limit	Current Value	Variance	Assurance
Jul-21	CDiff (Hosp Acquired) Rate per 100k beddays	30.10	32.95		?
Jul-21	CDiff (Hosp Acquired) Actual	3	2		
Jul-21	MRSA (Hosp Acquired) Actual	0	0		
Jul-21	E Coli (Hosp Acquired) Rate per 100k beddays	16.40	19.38	H	P
Jul-21	E Coli (Hosp Acquired) Actual	2	5		
Jul-21	MSSA (Hosp Acquired) Actual		0		
Jul-21	MSSA (Hosp Acquired) Rate per 100k beddays		10.98	H	

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

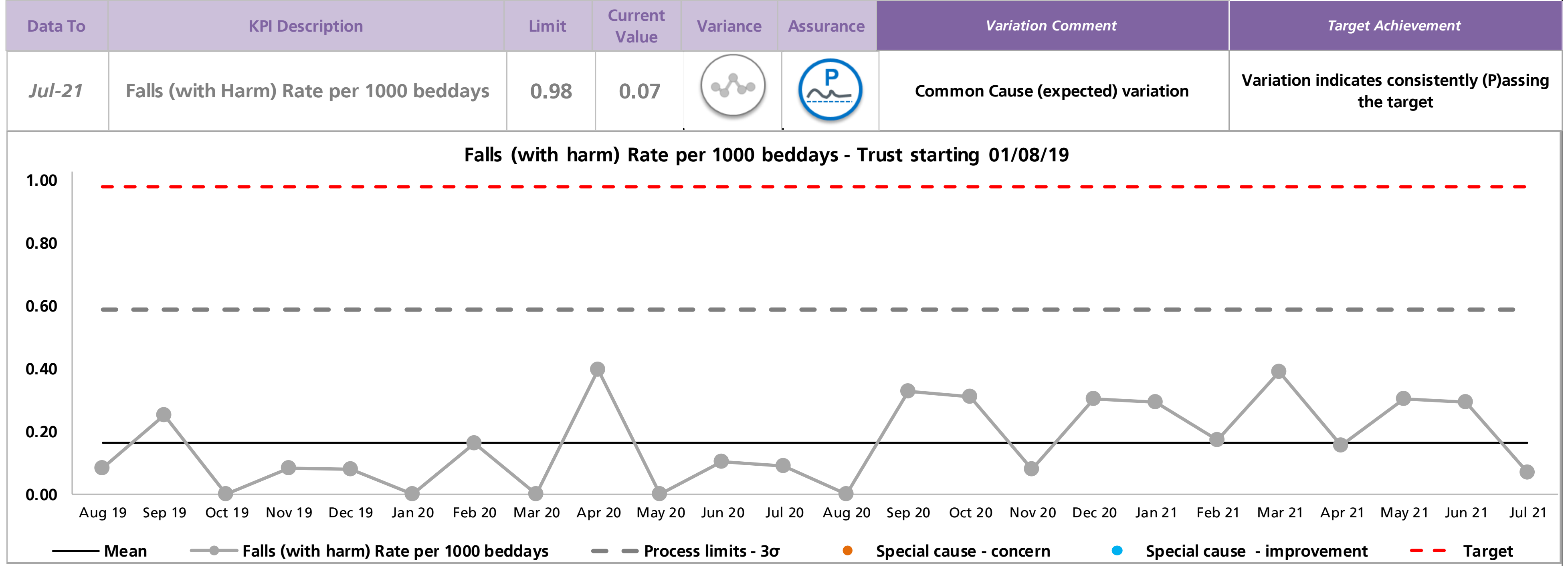
Serious Incidents

Five Serious Incidents were reported in July:

- One was an inpatient fall resulting in the patient sustaining a fractured hip
- One was the result of a patients care being delayed in Ophthalmology
- One was an intrapartum stillbirth
- One was an unexplained death of a neonate
- One was a failure to act on adverse test results

At the end of July the Trust had 14 open Serious Incidents investigations in progress. All are within the agreed submission timeframe and the backlog of outstanding Serious Incident investigation reports has been cleared.

Falls



Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jul-21	Falls (with Harm) Rate per 1000 beddays	0.98	0.07		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 is inconsistency 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 July 2021 has decreased to 0.07 from 0.30 during June 2021.
3. There are 59 inpatient falls during July 2021 which equates to a falls rate of 3.95 per 1000 bed days, a reduction from a rate of 4.47 during June 2021.
4. In order to meet the 15 % reduction in the number of falls for Quarter1, the number has been set to 162; however, there have been 180 reported incidents which only represented a reduction of 6.5%. When the current number of falls is measured against per 1000 bed days, the average for Quarter 1 is 4.37 which is a reduction of 17% from the average falls rate of 5. 28 last year.

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 was established to introduce initiatives and implement actions to reduce the number of inpatient falls and the first meeting is on 19 July 2021. The group will meet monthly initially and has multi-professional membership.
5. An audit is currently underway to review the care provided to patients who are requiring an increased level of observation (specialist/enhanced care) in order to maintain their safety. This audit will provide both qualitative and quantitative data to understand the organisations current position in relation to this element of patient care and will also inform the falls prevention/management strategy.

Recovery Forecast:

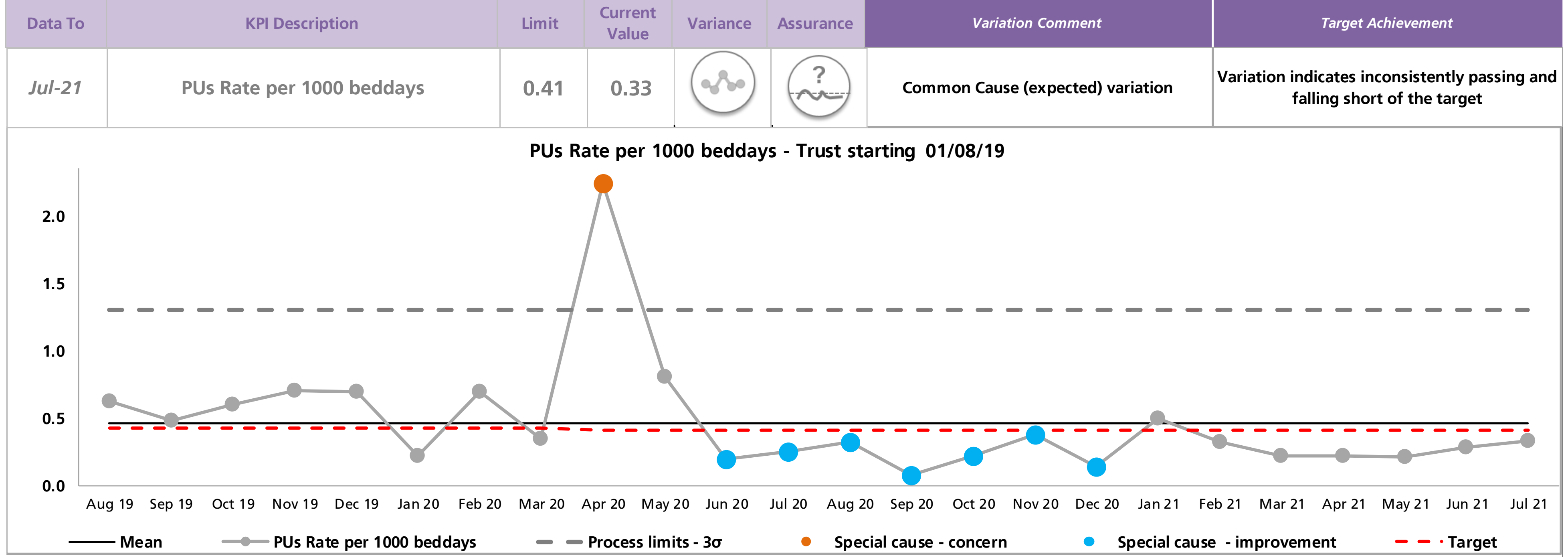
1. Although the number of patient injuries following fall incidents is still within Trust target, it has been increasing for the previous nine months.

Key Risks to Forecast Improvement:

1. Increasing number of patients admitted with high risk of falls and staff not adhering to falls policy.
2. There are a high number of patients admitted to Trust who are at high risk of falls.

Additional medical inpatient areas have been opened to support capacity with impact on overall level of falls risk.

Pressure Ulcers



Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jul-21	PUs Rate per 1000 beddays	0.41	0.33			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 the 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 has been below the tolerance level for six consecutive months 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 continue to deliver refresher training sessions with external Clinical Nurse Advisors.

3. 100 days free campaign commenced in June 2021 - the initiative sets every ward and clinical department the target of achieving 100 days free of hospital acquired pressure ulcer with lapses in care identified.

Recovery Forecast:

1. The number of hospital acquired pressure ulcers is starting to reduce as we realign specialties.

2. The pressure ulcer rate per 1000 bed days at the QEH is lower when compared to similar sized organisations.

Key Risks to Forecast Improvement:

1. Non-compliance with the pressure ulcer prevention care bundle.

2. Increasing number of patients admitted to the Trust who are at high risk of developing a pressure ulcer.

3. Reduced number of staff within Tissue Viability team which is partially mitigated.

C.Diff (Hospital onset)

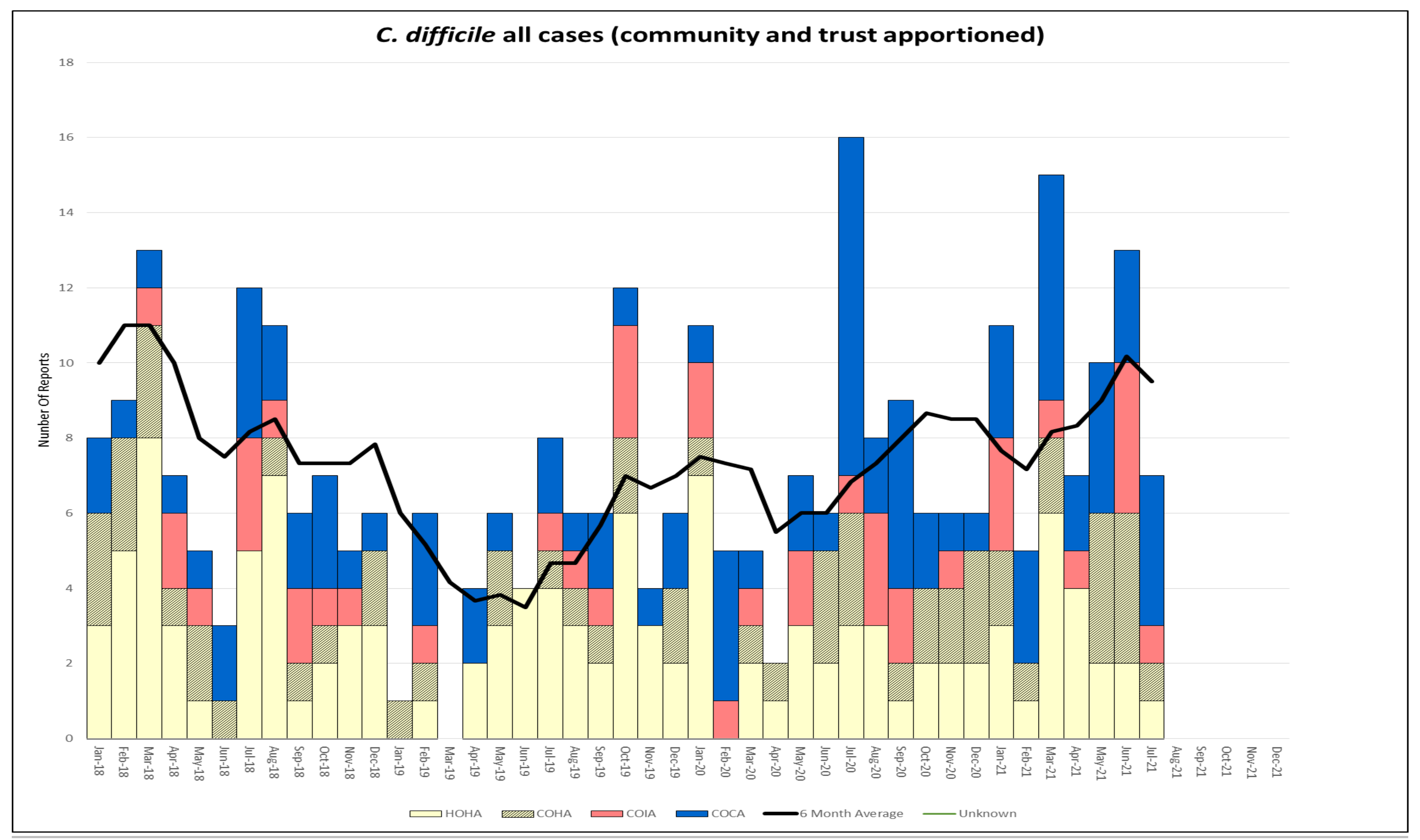


Chart 3 – C.Diff - all cases (community and trust apportioned)

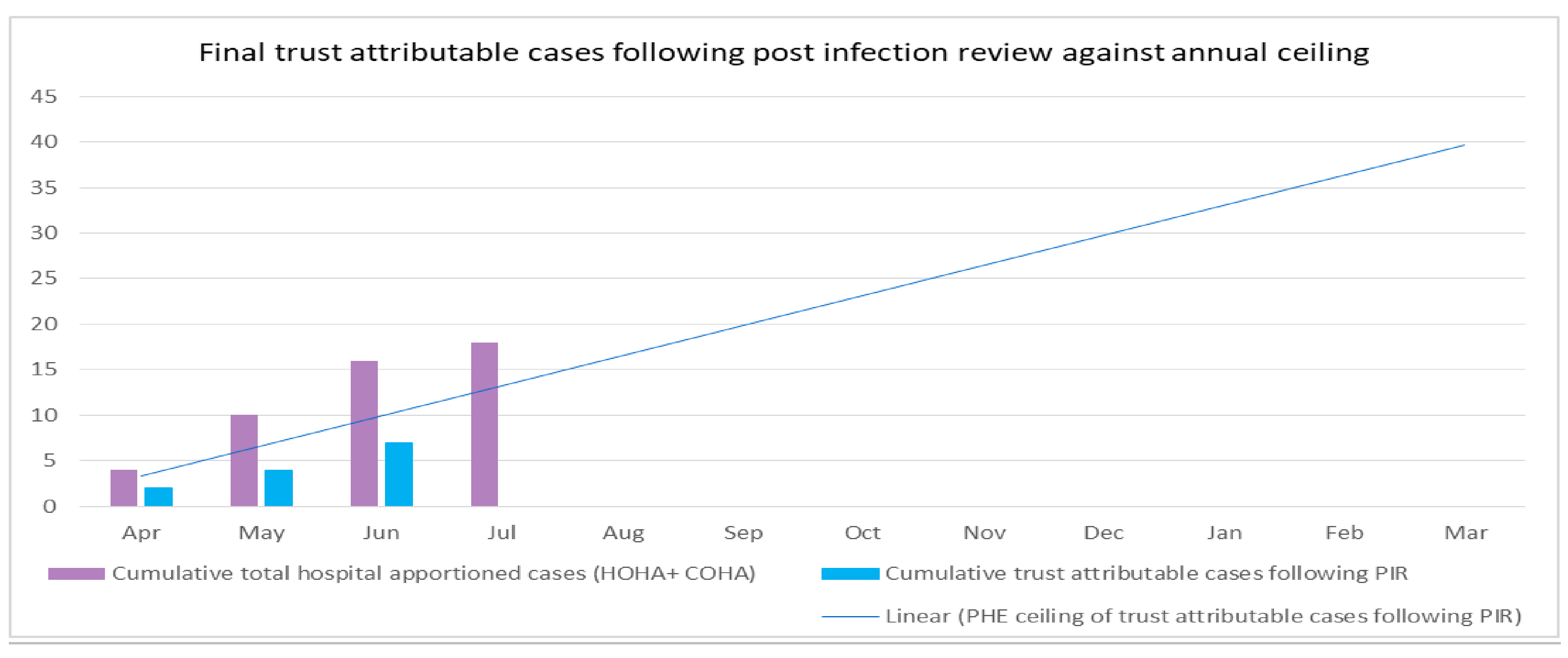


Chart 4 – C.Diff - Final trust attributable cases following post infection review against annual ceiling

Clostridioides difficile Infection - CDI (Ceiling = 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:

- Two cases identified in July 2021 (1 HOHA and 1 COHA)
- One case (COHA) reviewed and attributed to QEHKL and the other (HOHA) pending review

Findings:

- Timely completion of the PIR documentation, from nursing and medical staff, continues to be a challenge specifically with Consultant input. Without the completion of this paperwork a PIR cannot be undertaken, in line with national requirements. The Deputy Medical Director continues to support required improvement with this process
- Poor documentation regarding onset of loose stools and management in line with Trust Policy
- Prophylactic antibiotics, prescribed by surgeon

Key Actions:

- Antibiotic stewardship management and engagement (including anti-biotic ward rounds, educational sessions for junior medics, review of anti-biotic guidelines and use of broad-spectrum anti-biotics)
- Discussion between surgeon and Consultant Microbiologist regarding prescribing
- Documentation concerns discussed with Ward Manager / Matron a spart of the PIR process

Key Risks to Forecast Improvement:

- Ageing estate compromises bed utilisation – isolation rooms make up less than 10% of the estate
- Non-compliance to IPC Policies / procedures (anti-biotic prescribing)
- Timely documentation of onset of loose stools / management

E.coli Hospital (Onset)

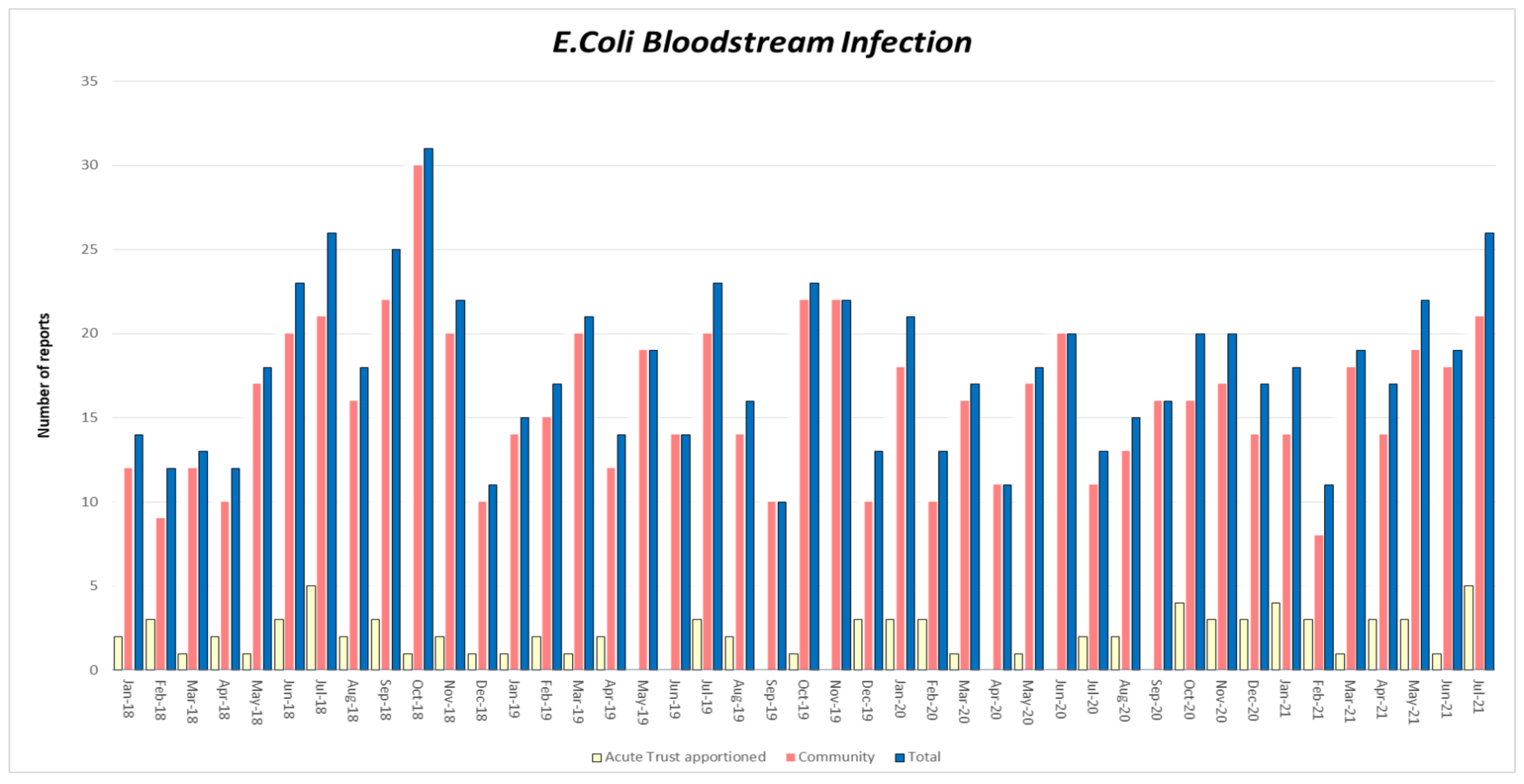


Chart 5 – E.coli Bloodstream Infection

Key Issues

- Five cases of hospital onset E. coli were reported in July 2021
- Two cases reviewed under Post Infection Review (PIR)
- Findings: both cases attributed to underlying deep seated infections as cause
- Three cases awaiting review

Key Actions

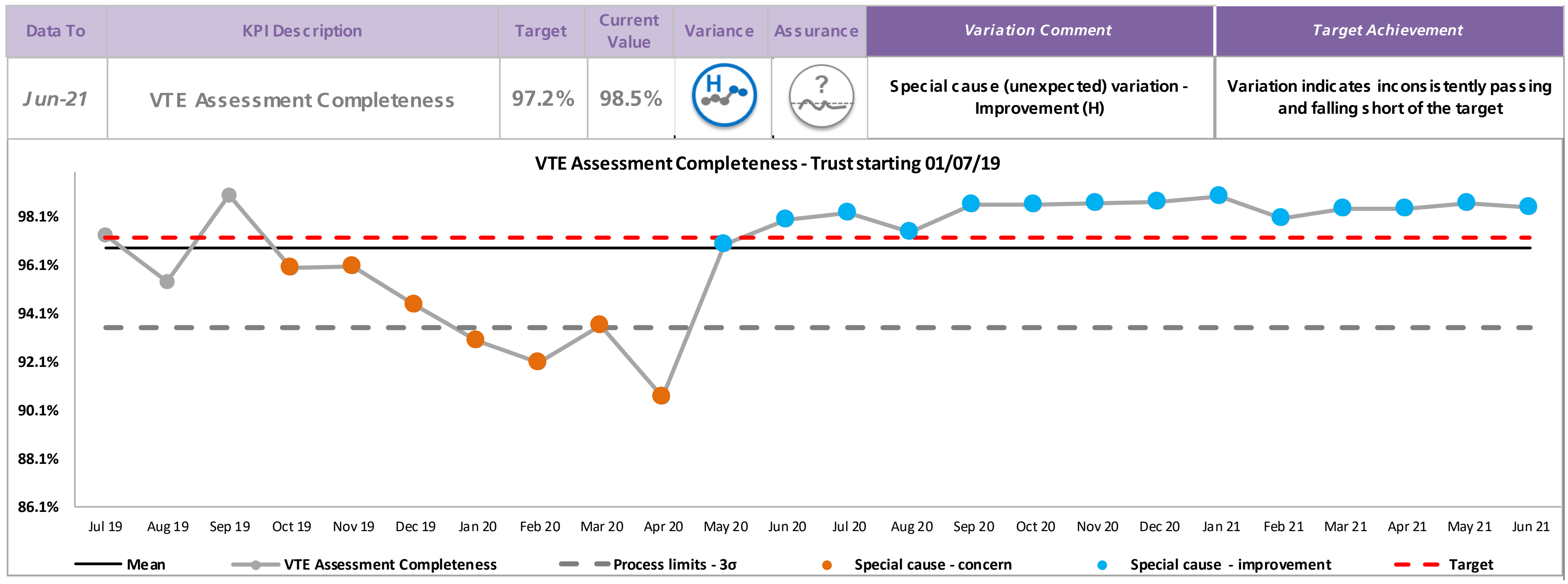
The Infection Prevention and Control Team continue to raise awareness of appropriate management of E. coli, in line with Trust Policy, through;

- 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 (ANTT)
- Review of individual cases and promptly undertaking measure to reduce any further transmission
- Supportive programme of audit including hand hygiene, PPE usage, isolation and environmental cleaning in place
- Discussing individual cases with Ward Managers / Matrons and escalating concerns , in a time appropriate manner, at senior meetings and via governance reporting channels

Key Risks to Forecast Improvement:

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

VTE Assessment completeness



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jun-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 rates have been above the national thresholds for 13 months and this has now become business as usual. The reasons for improved performance are well understood and embedded, and so the process limits will now be recalculated to show common cause variation, consistently attaining the target.

Key Actions (new actions in green):

1. With screening for VTE embedded in the clinical front, the hospital thrombosis committee is now focussing on reducing harms relating to prescribing and administration errors related to anticoagulant use. A task and finish group has been set up to address this area and this will be reporting to Hospital Thrombosis committee.

Recovery Forecast: Not Applicable

Key Risks to Forecast Improvement:

1. Electronic prescribing and medicines administration (EPMA) is being rolled out to all in patient areas within the Trust. Once implemented fully (October 2021), the process of capturing the VTE screening will move from paper based (from admission booklets) to electronic data capture on EPMA. Whilst in transition, there is a risk that capture of the screening may drop and so the target continues to require close monitoring. The relevant teams have been notified to monitor this.

Effective - Accountable Officer - Medical Director

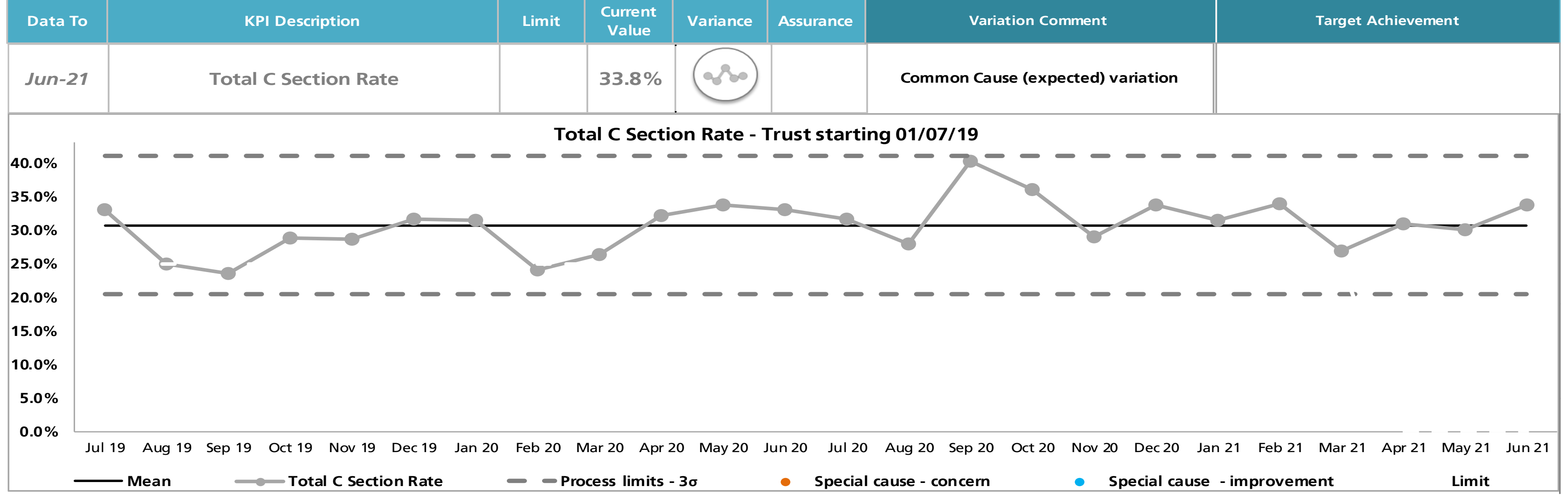
Effective Dashboard

Items in blue are awaitIng the latest update

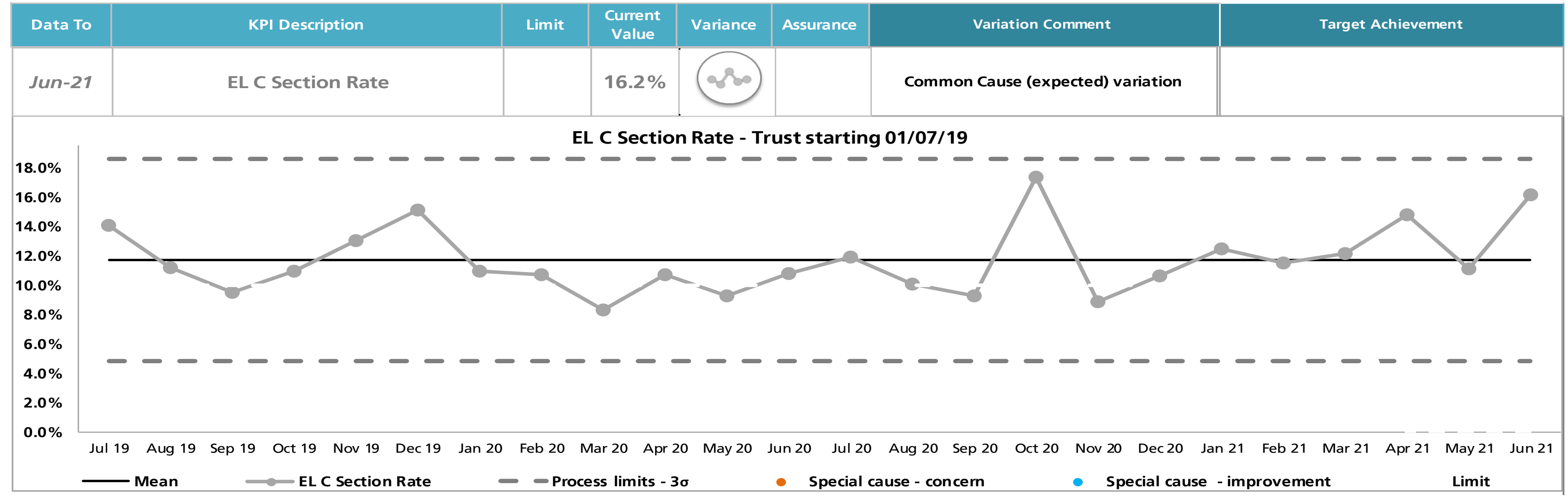
Data To	KPI Description	Limit	Current Value	Variance	Assurance
Jun-21	Total Births (inc Home, BBA's & Stillbirths)		159		
Jun-21	Stillbirth Rate	3.73	2.97		
Jun-21	Neonatal Deaths Rate	1.06	0.50		
Jun-21	Extended Perinatal Deaths Rate	4.79	3.47		
Jun-21	Total C Section Rate		33.8%		
Jun-21	EL C Section Rate		16.2%		
Jun-21	EM C Section Rate		17.5%		
Jun-21	Maternal Deaths	0	0		
Jul-21	% "Term" admissions to the NNU	6.00%	4.55%		?
Jul-21	% "Avoidable Term" admissions to the NNU	0.00%	12.50%		?
Jun-21	Breastfeeding initiation	70.0%	81.8%		?

Data To	KPI Description	Target	Current Value	Variance	Assurance
Jun-21	Breastfeeding on discharge from hospital	60.0%	58.7%		?
Jun-21	Smoking at Booking	18.6%	20.5%		?
Jun-21	Stopped smoking by delivery	44.7%	58.7%		?
May-21	Smoking at Time of Delivery		20.4%		
Jun-21	Post-Partum Haemorrhage	3.0%	0.0%		?
Jun-21	3rd & 4th degree tears, exc C-Sections	3.5%	2.3%		?
Mar-21	HSMR Crude Rate	3.18	5.29		
Mar-21	HSMR Relative risk	100.00	137.46		
Mar-21	HSMR Weekend Relative risk	100.00	148.87		
Dec-20	SHMI (Rolling 12 mth position)	100.00	105.50		
Jun-21	Rate per 1000 admissions of inpatient cardiac arrests	2.00	0.42		?
Jul-21	No. of patients recruited in NIHR studies	63	167		?

LSCS rates



Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jun-21	Total C Section Rate		33.8%			Common Cause (expected) variation	



Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jun-21	EL C Section Rate		16.2%			Common Cause (expected) variation	

Chart 7 – C-Section rates

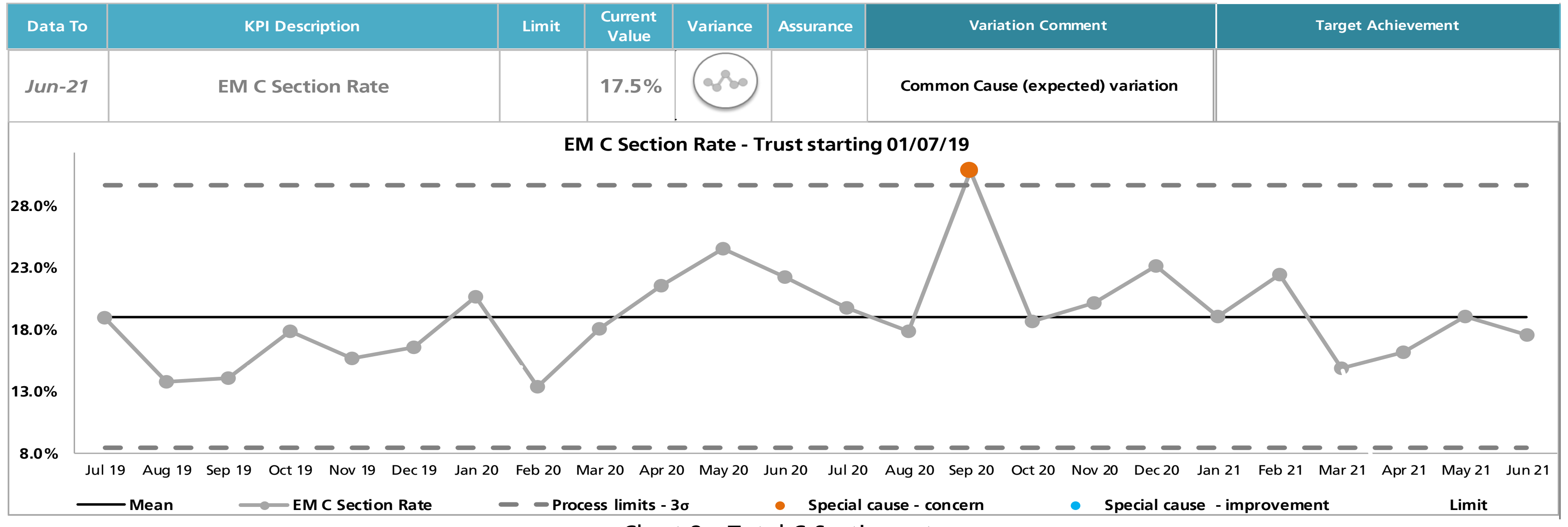


Chart 8 – Total C-Section rate

There were 159 total births in June 2021- [96]60.4%- normal vaginal deliveries, [11]6.9% - assisted vaginal deliveries, [52]32.7 % - total Ceasarean births. The majority of elective Lower Segment Caesarean Sections (LSCS) in June 2021 were women with previous LSCS requesting planned LSCS.

Factors driving performance

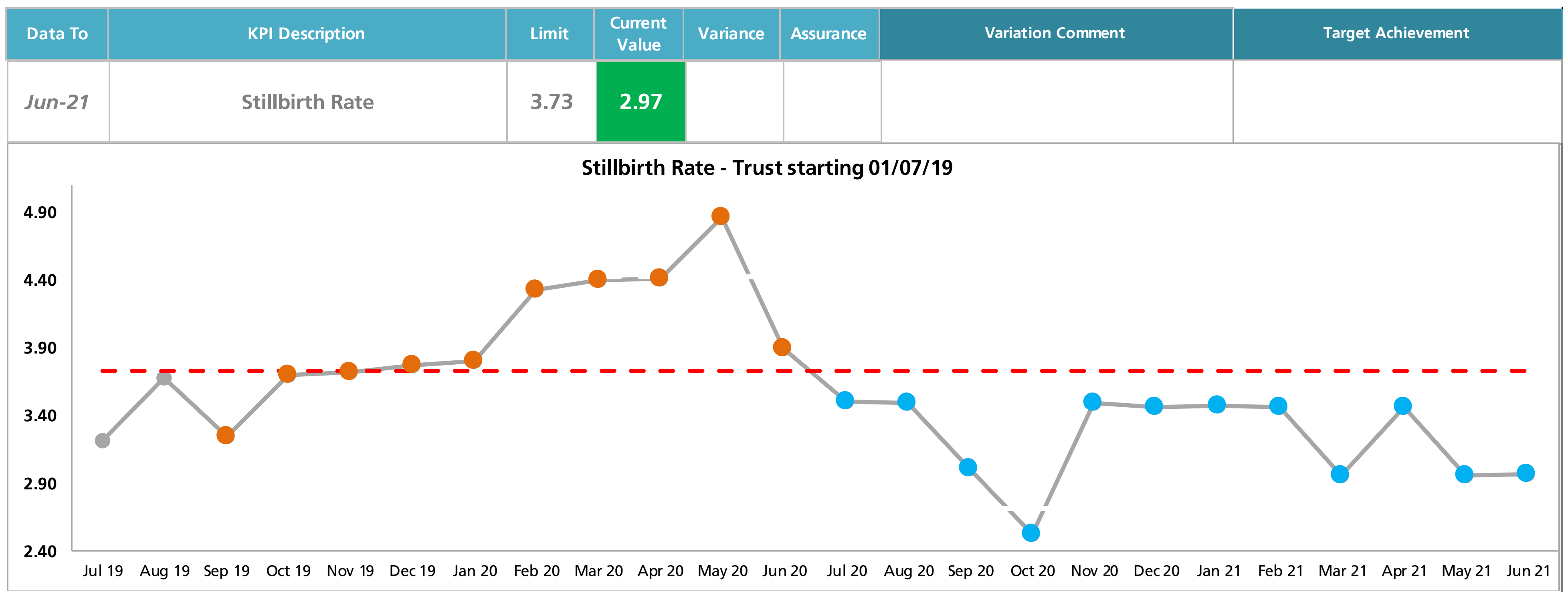
The use of Robsons criteria has helped to monitor trends in the indications for Caesarean sections performed in our unit. The Robson system classifies all deliveries into one of ten groups on the basis of five parameters: obstetric history, onset of labour, fetal lie, number of neonates, and gestational age. These are used to inform MDT review, focusing on recurring themes to identify and share learning. This has identified that additional training is required on the management of the second stage of labour for some medical staff. This has also identified an ongoing improvement in medical documentation.

Actions taken:

We have successfully recruited a consultant midwife to our team. This role will improve continuity of care for high risk patients, support the VBAC pathway and help address the needs of women with previous traumatic experiences requesting LSCS.

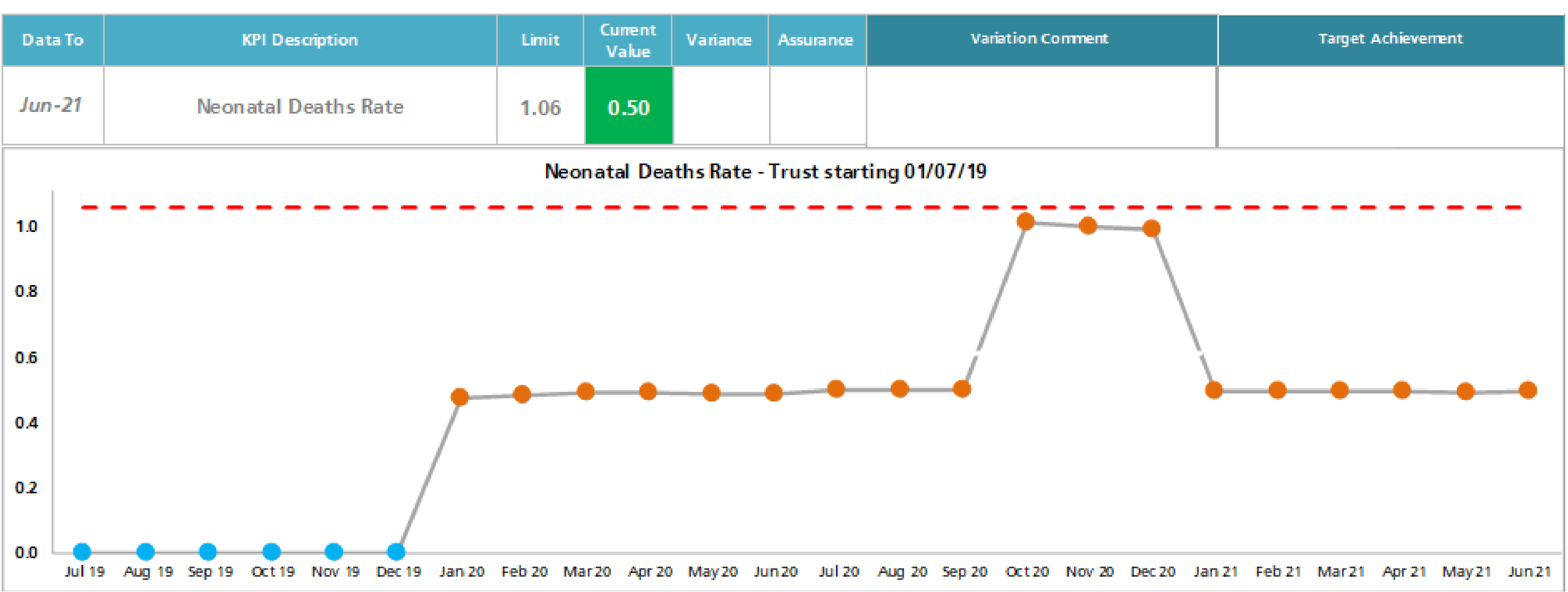
The educational lead and Clinical lead have arranged specific teaching sessions focussing on the learning from the MDT to improve competence and confidence in managing second stage deliveries for our middle grade team.

Neonatal and Perinatal Mortality



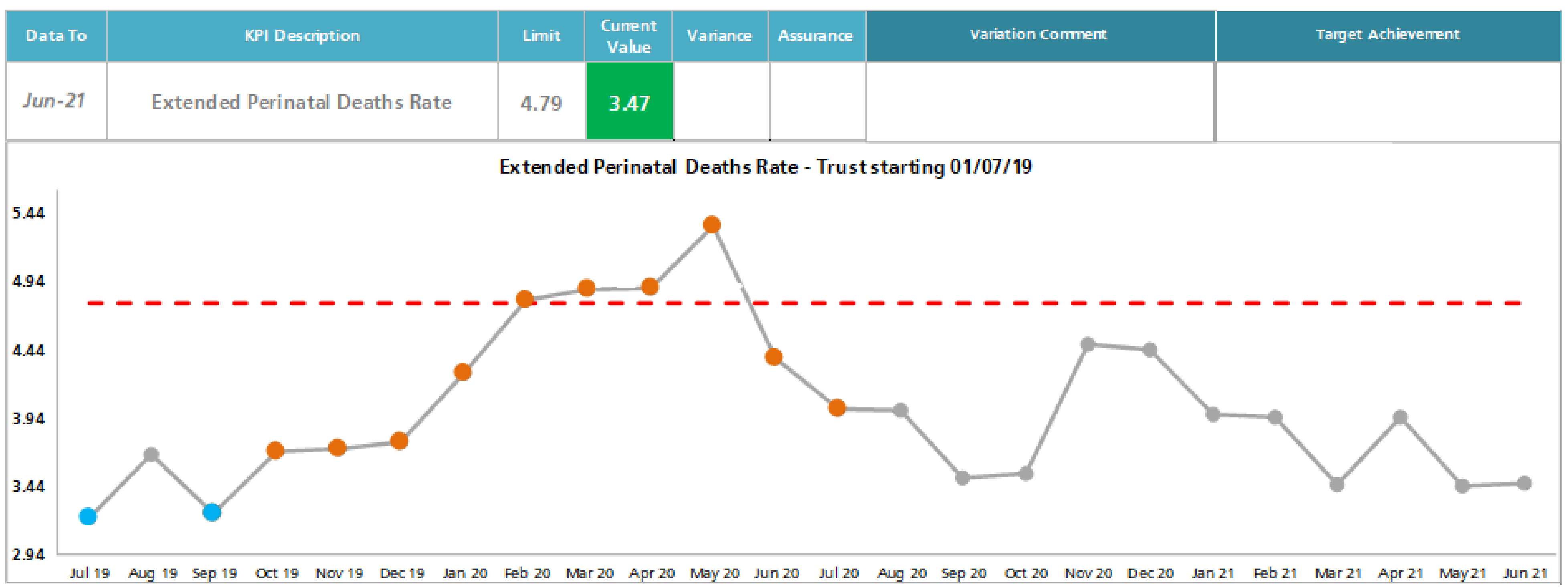
Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jun-21	Stillbirth Rate	3.73	2.97				

Chart 9 – Stillbirth rate



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

Chart 10 – Neonatal Deaths rate



Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jun-21	Extended Perinatal Deaths Rate	4.79	3.47				

Chart 11 – Extended perinatal deaths rate

Factors Driving Performance:

The Perinatal and neonatal mortality rates remain stable and well below the upper control limits. There have been no stillbirths in the month of June. As these metrics measure against very rare events, we propose that their presentation is changed from next month to indicate the time since last event, although the rates will continue to be included in the score card.

Actions being taken:

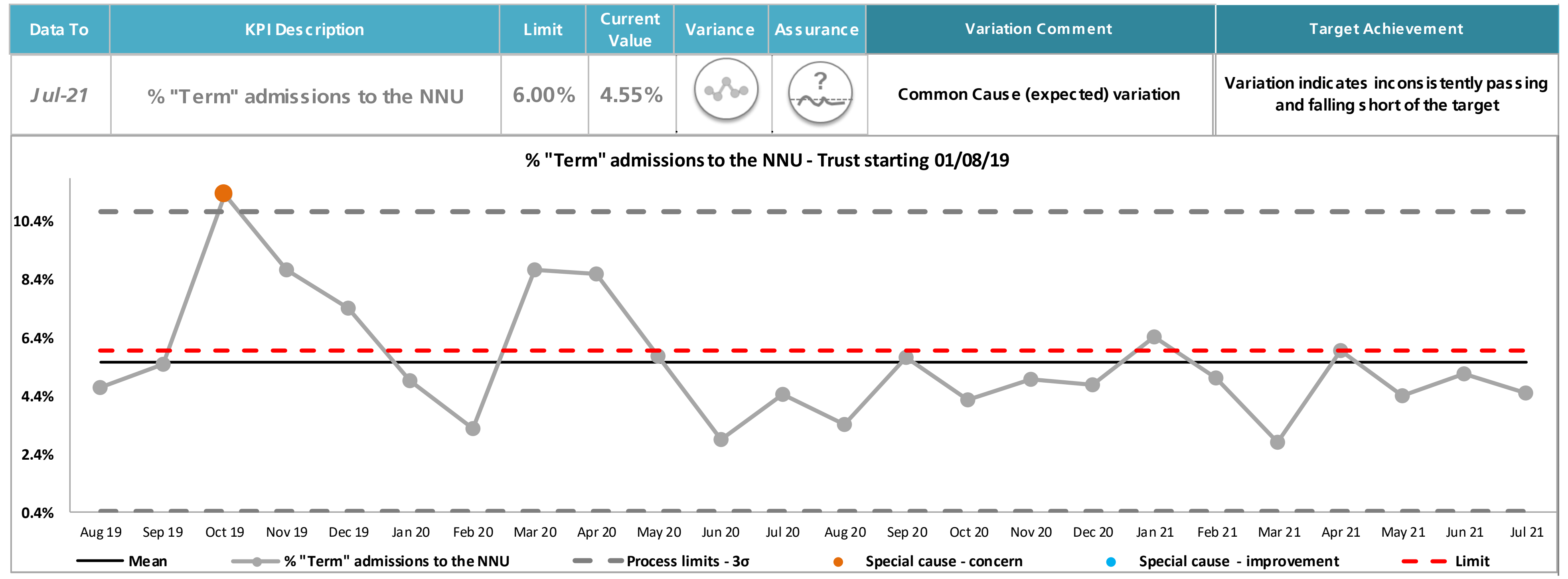
- We are working through the Local Maternity and Neonatal System (LMNS) to share best practise and learning from untoward events. We have successfully submitted our evidence to NHS Resolution to demonstrate our compliance against the 10 steps to Maternity Safety as part of CNST (Clinical Negligence Scheme for Trusts)
- We are on track to deliver the Saving Babies Lives Care bundle which is reviewed monthly at MSSF

- We are continuing to work on our Maternity Improvement plan, with a major focus on the culture within the maternity department as culture significantly impacts team working and patient safety

Risk to delivery:

- **Midwifery Staffing:** Following a system wide bid, QEH have been allocated funding for a further 8 WTE midwives to support the implementation of our safety plans, including the role out of Continuity of Carer. We are now working with Regional partners and have submitted a bid for support with international recruitment of midwives to support the deficit we have within the region. We are also working with the communications team to develop a recruitment plan
- **Medical staffing:** Two substantive middle grade doctors are due to start from August 2021. The Consultant team is currently being consulted on moving to a Consultant of the Week to improve availability of consultant level support

Term Neonatal unit admissions



Data To	KPI Description	Limit	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jul-21	% "Term" admissions to the NNU	6.00%	4.55%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

Chart 12 - % term admissions to the NNU

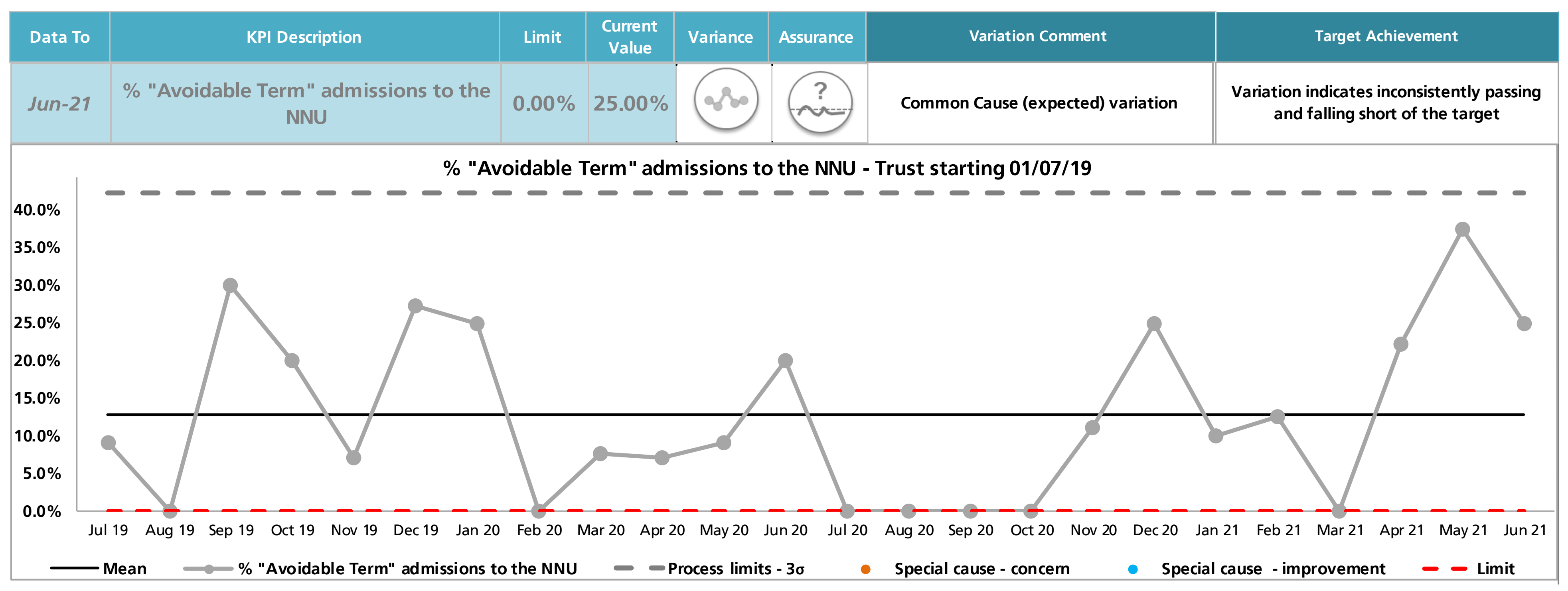
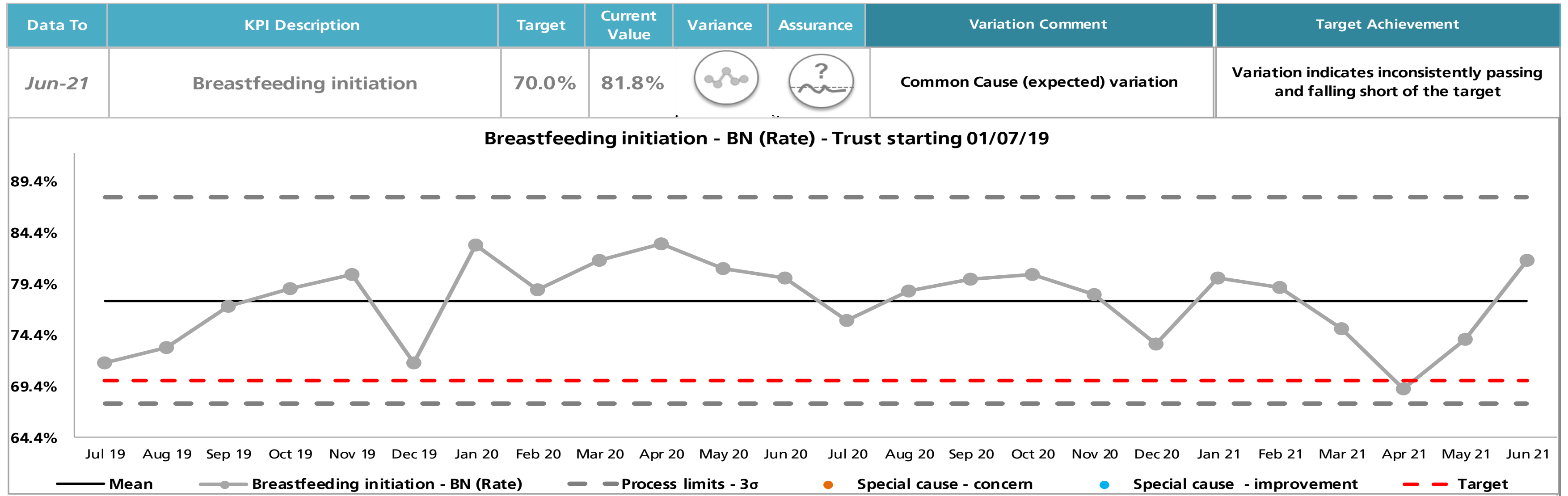


Chart 13 - % avoidable term admissions to the NNU

Factors Driving Performance:

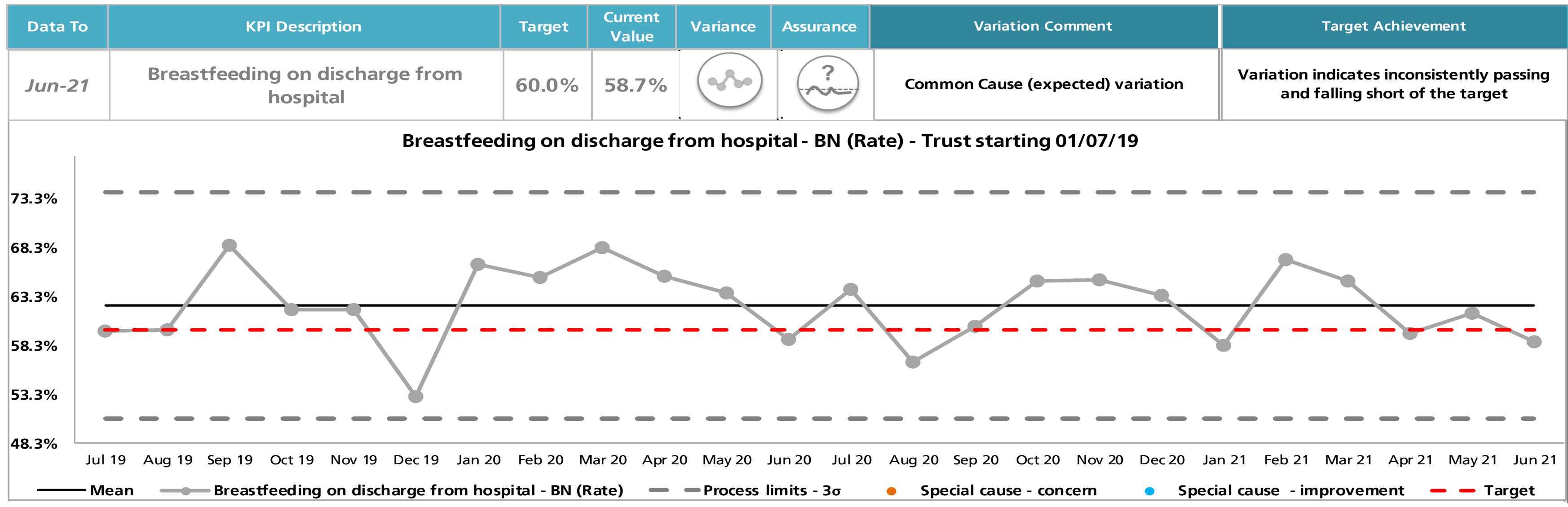
Total term admission rates to NICU in July 2021 were 4.5% under the current national target of 6%. Performance has been reliably below or close to the target for 13 months. The process limits will therefore be recalculated from next month. Two of eight admissions were identified as potentially avoidable after ATAIN review in June as reported in the July IPR. However, the reviews have not yet been completed to determine whether any of the July admissions may have been avoidable.

Breast Feeding Initialtion rates



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jun-21	Breastfeeding initiation	70.0%	81.8%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

Chart 14 – Breastfeeding initiation – BN (rate)



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jun-21	Breastfeeding on discharge from hospital	60.0%	58.7%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

Chart 15 – Breastfeeding on discharge from hospital – BN (rate)

Factors driving performance:

Breast feeding initiation and sustained at the time of discharge from hospital rates remain generally above national targets and within common cause variation.

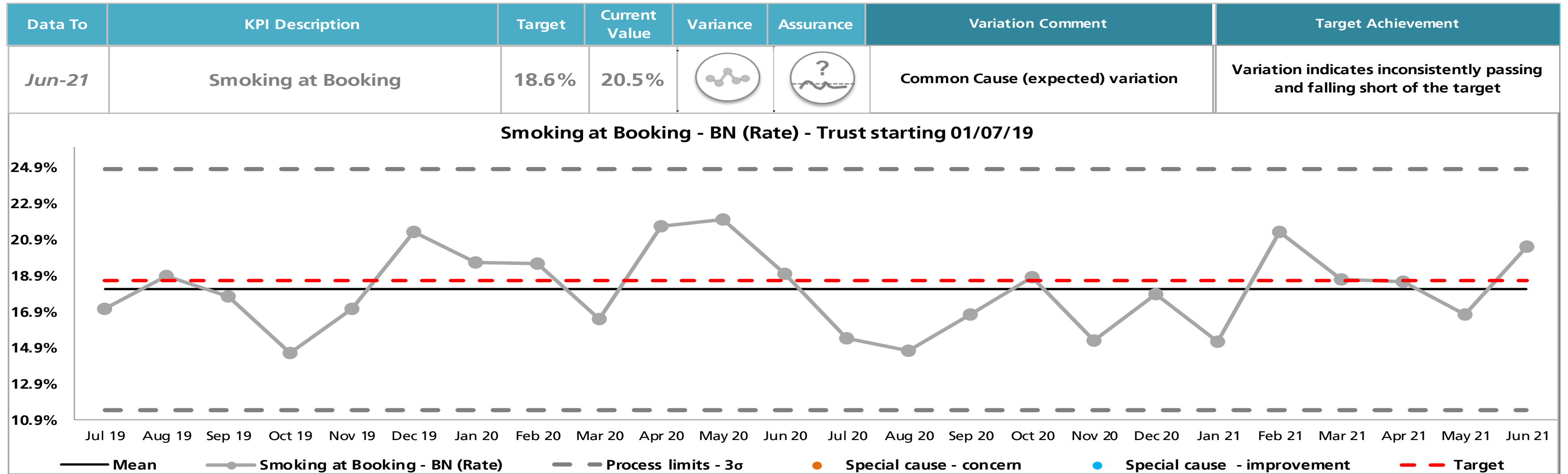
Actions Taken:

The infant feeding team has recruited a new member of staff who is due to start in August 21 and face to face training has been reinstated both of which aim to improve these rates.

Risk to delivery:

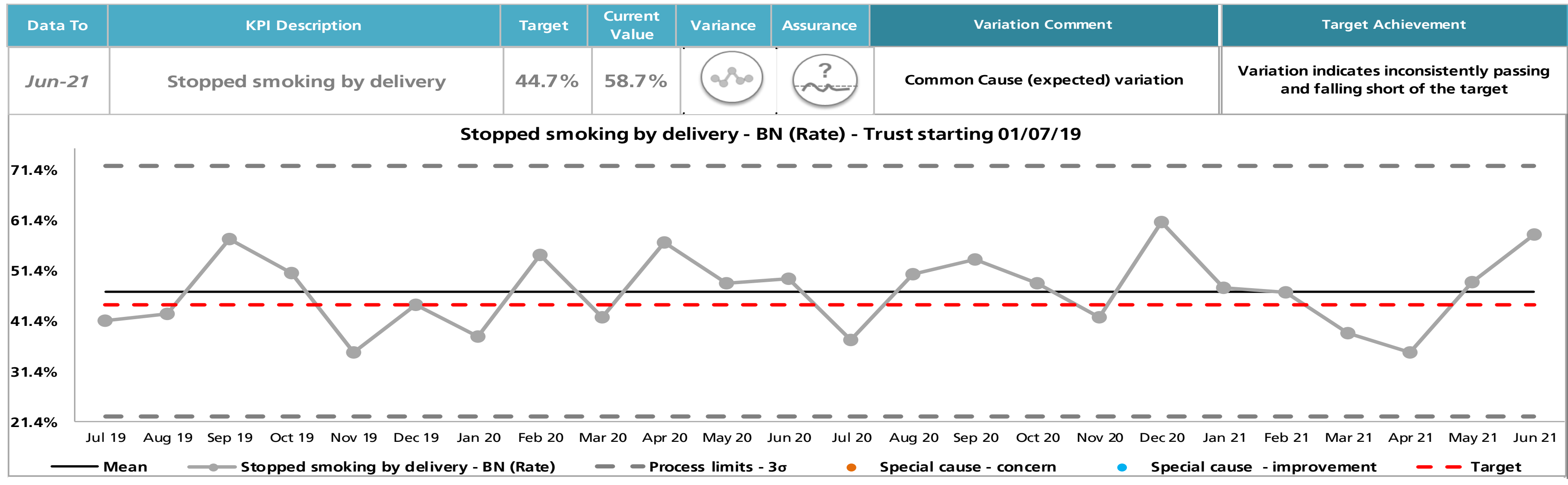
Clinical demands often conflict with staff training and ability to provide one to one support for mothers. Recruitment plans to expand the team are in place to mitigate this.

Smoking Cessation in Pregnancy



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jun-21	Smoking at Booking	18.6%	20.5%		?	Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

Chart 16 – Smoking at Booking – BN (rate)



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jun-21	Stopped smoking by delivery	44.7%	58.7%		?	Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

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

Factors driving performance:

Smoking rates at the time of booking for antenatal care continues to vary between 15-25% and remains within common cause variation. However, this metric is largely affected by the demographic and deprivation index of the population we serve and so will be removed from the IPR from next month.

The rate of women who successfully stop smoking during pregnancy is however a key metric for our team. This remains within common cause variation.

Recent changes to the pathway of antenatal care have been made, but will take several months to be reflected in smoking rates of women at the time of delivery.

Actions Taken:

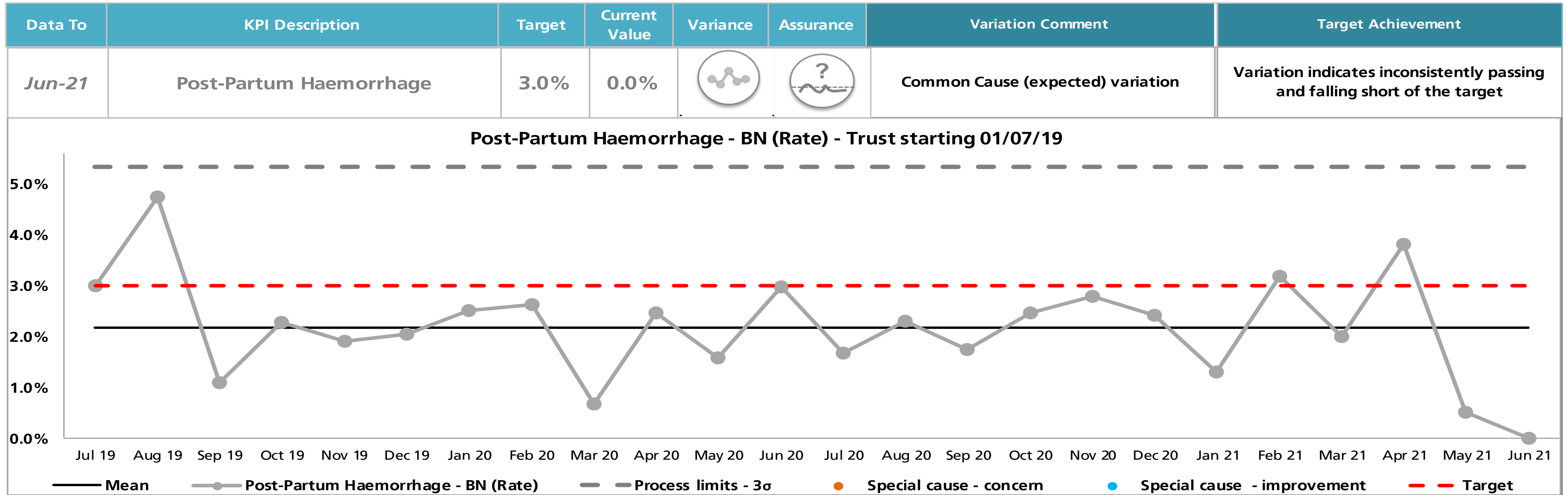
Carbon Monoxide (CO) testing has been reintroduced as a routine part of antenatal care after being temporarily discontinued during the pandemic. CO screening rates are rising, they are monitored through the maternity dashboard and this is also part of the Saving babies lives care bundle (SBLCB), performance of which is monitored by the maternity safety and strategy forum. We are also working with our system parterns to implement a one stop shop approach within our midwifery hubs to ensure women have access to these vital support services at the time when they are receiving their antenatal care.

Risks to delivery:

Any changes to the pathway of antenatal care will take several months to reach women at the time of delivery.

CO monitoring during preChanges in the planned model of maternity delivery including the implementation of Continuity of Carer will support this work, but may cause a period of instability as ways of working change.

Post-patum Haemorrhage (PPH)



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jun-21	Post-Partum Haemorrhage	3.0%	0.0%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

Chart 18 – Post-Partum Haemorrhage - BN (rate)

Factors Driving Performance:

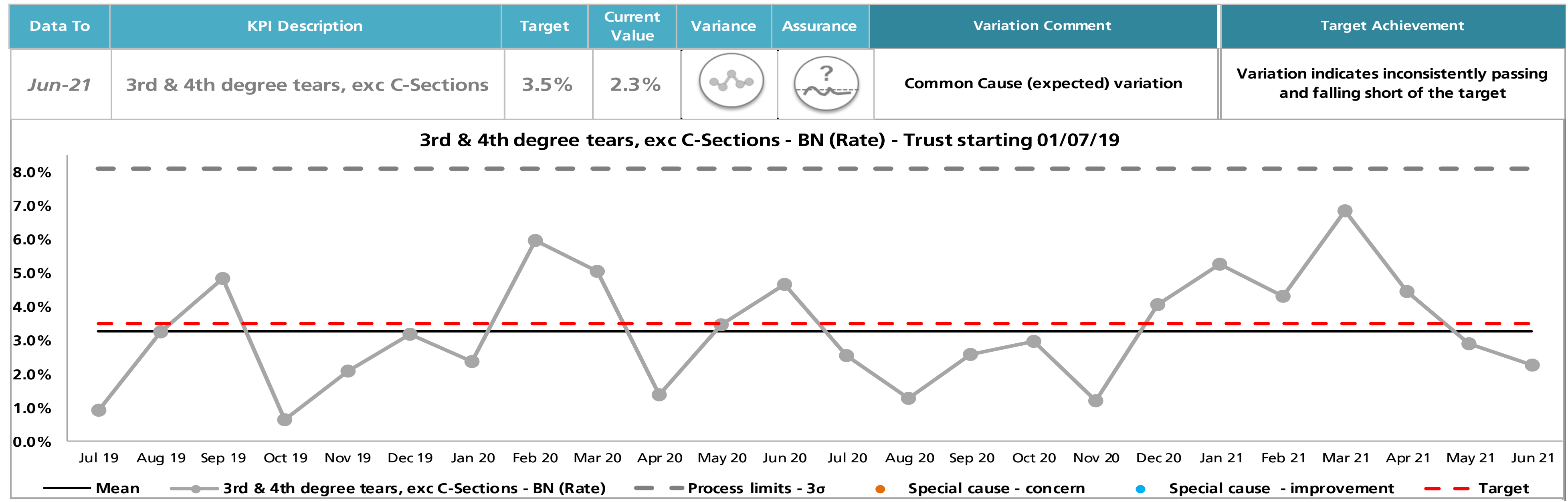
Post Partum Haemorrhage (PPH) is defined as blood loss of 500ml or more within 24 hours of delivery. The current rate of PPH remains within common cause variation, presently below the agreed threshold of 3%.

Actions Taken:

All PPH over 1500ml are reported and investigated as moderate incidents to ensure learning is captured and shared. Themes of recent PPH include uterine atony (flaccid or non contracting uterus), perineal and uterine trauma at child birth. These are reviewed promptly to look for avoidability and learning disseminated to clinical staff.

Risks to Delivery: No risks currently identified.

3rd & 4th degree perineal trauma



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jun-21	3rd & 4th degree tears, exc C-Sections	3.5%	2.3%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

Chart 19 – 3rd and 4th degree tears, exc C-Sections - BN (rate)

Factors Driving Performance:

3rd and 4th degree perineal trauma remains within common cause variation, currently below the agreed target level.

Actions Taken

An evidence based Perineal Care Bundle was launched at the end of January this year, as care bundles are nationally recognised to reduce perineal trauma. This includes antenatal education, optimal positioning during labour and perineal massage which may take some time to embed.

All cases of Obstetric Anal Sphincter Injury (OASI) are also reviewed and discussed at the monthly OASI MDT (launched February 2021) to monitor compliance with all elements of the care bundle.

Risks to Delivery:

Skill levels and competency issues remain a risk which is addressed by training and assessment processes.

SHMI and HSMR Mortality

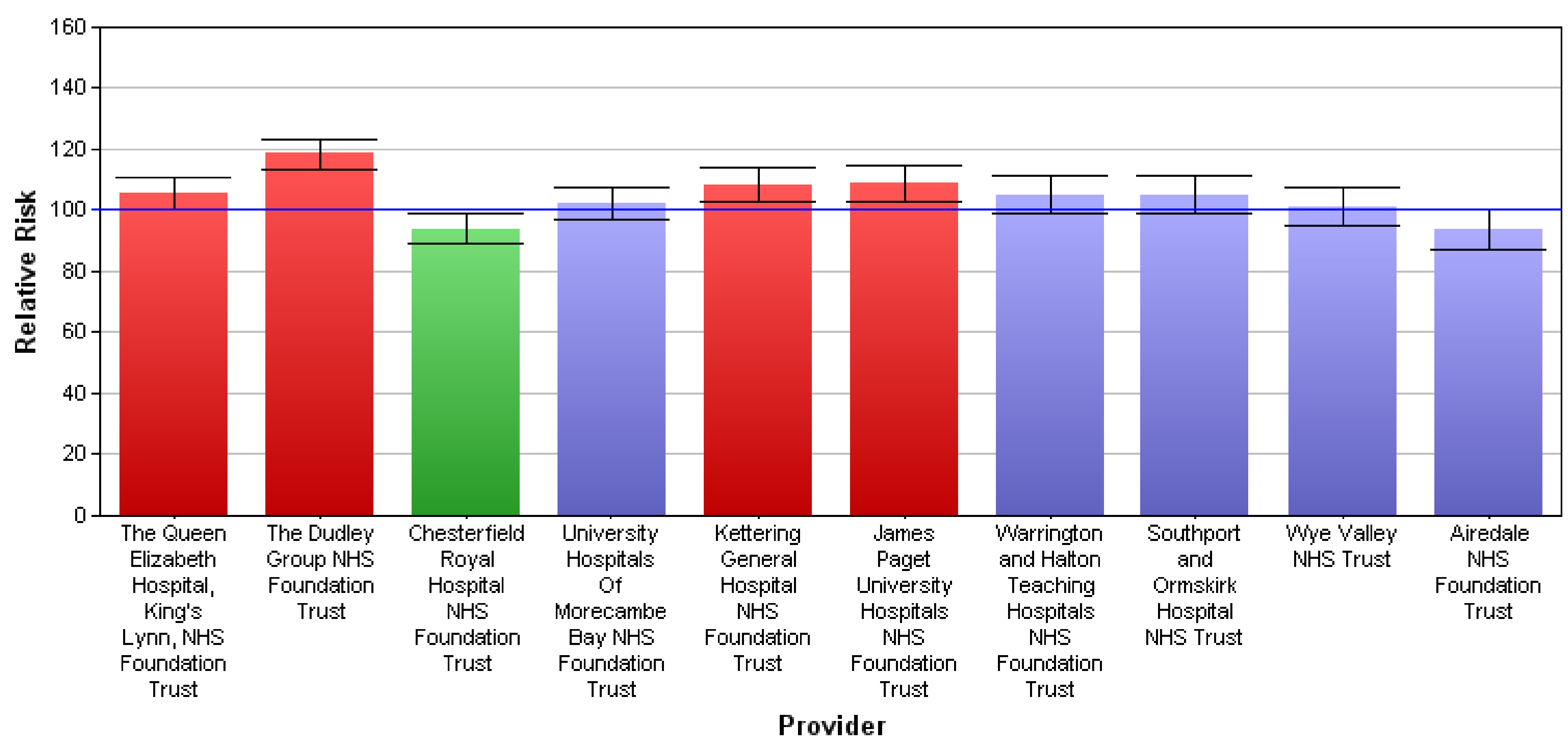


Chart 20 - SHMI

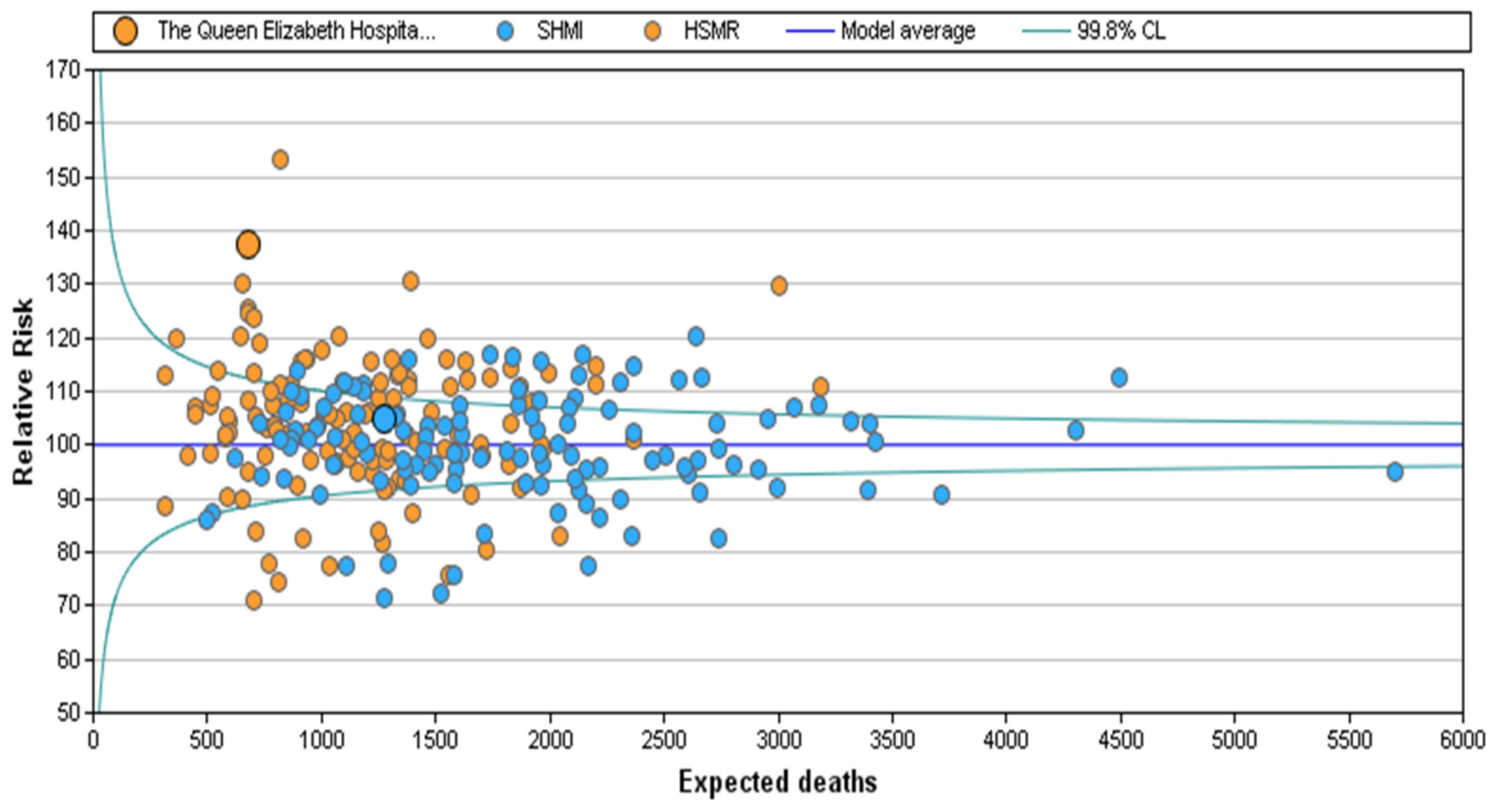


Chart 21 – SHMI and HSMR by Provider

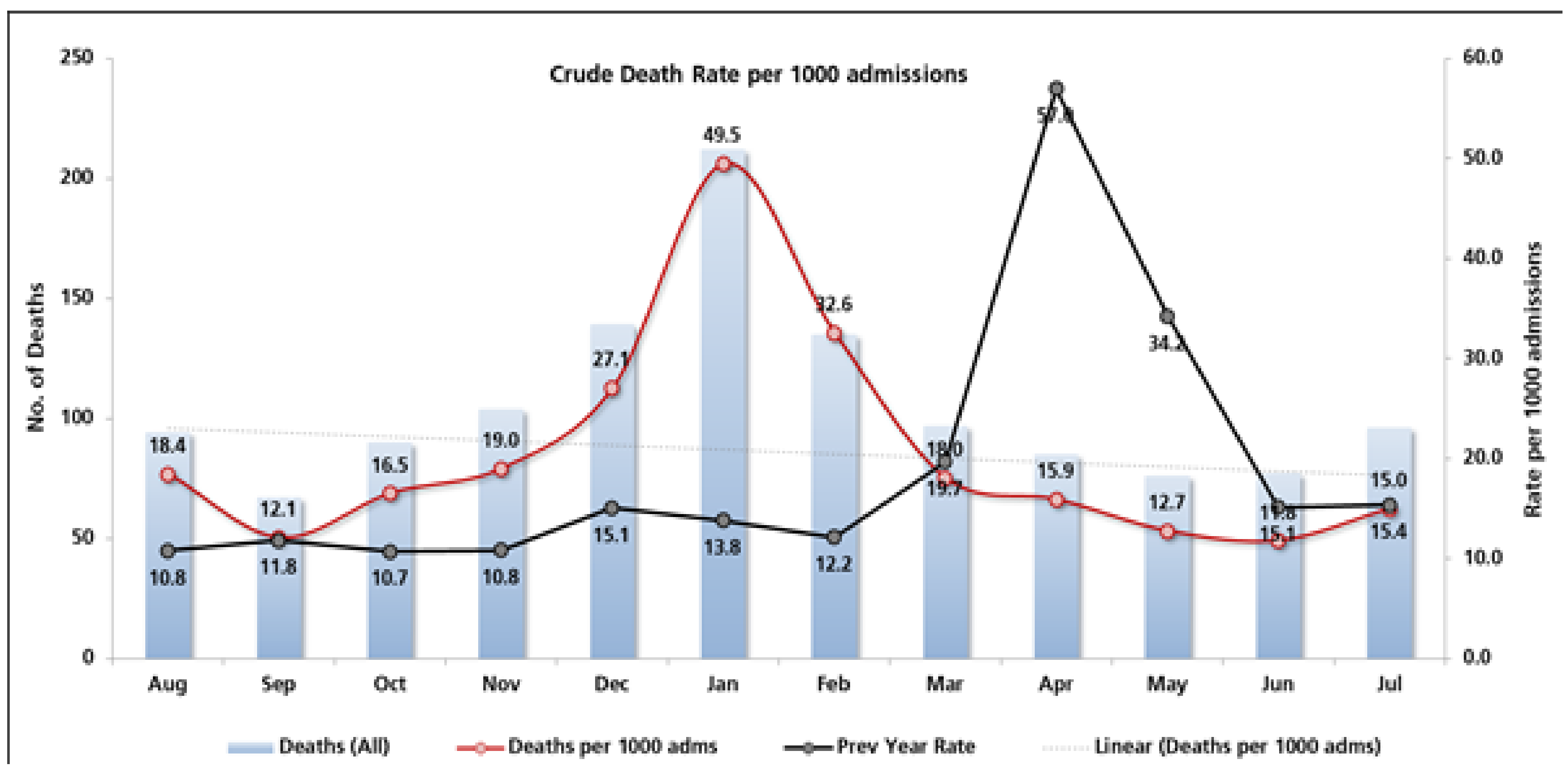


Chart 22 – Crude Death rate per 1000 admissions

Factors Driving the Performance

- National reporting issues continue but Dr Foster has now issued SHMI data to March 2021
- SHMI remains within the “expected band” at 104.7 (12 months to March 2021). The national funnel plot has been updated to include data to February, but no plot has been published yet by Dr Foster for the latest period.

- The Trust is 1 of 7 with a SHMI banded as statistically ‘within expected’ in the NHS Midlands and East region. Three trusts are within the region are banded as statistically ‘higher than expected’.
- Dr Foster have continued to experience national data reporting issues which has prevented the issue of reliable HSMR data for all trusts. We have now received data for the period covering April 2020 to March 2021 but ideally should be reporting for the period covering May 2020 to April 2021.
- HSMR for the period April 2020 to March 2021 has fallen from 142.21 to 137.46, and weekend HSMR for the same period has fallen from 156.57 to 148.87.
- The current improvement is largely thought to relate to a fall in crude death rates per 1000 admissions and the drop in the number of deaths due to Covid in March 2021. Both of these factors are predicted to lead to further marked falls in the 12 month rolling HSMR in future months.
- Extensive service changes resulted in double the number of patients who received palliative care input in March 2021 compared to March 2020 (12.7 % vs 6.5%). This will also lead to a change in our expected mortality and a slow fall in HSMR over time.
- There was also a significant coding backlog for February and March at the time that HSMR was first calculated and issued. This has now been addressed and the complete dataset has now been uploaded to the national portal. However, due to the unrelated technical issues with data capture and analysis by the national team, Dr Foster has not yet recalculated the HSMR to include these data. This is expected to lead to a further improvement in this metric.
- Aside from the alert for viral infection (COVID) the four alerts with the highest number of patients are Stroke, COPD, Congestive Heart Failure and Pneumonia. Although CQC has suspended using the CUSUM (Cumulative Summary) alert during the pandemic, it is important that we do not lose sight of these key diagnosis groups and a detailed analysis of all heart failure deaths is awaited.
- In July 2021 there were 96 deaths, with just one related to Covid infection. In comparison there were 80 deaths in July 2020 and 101 in July 2019. 50 (out of 96) of the deaths occurred in patients aged 80 and over, of this number 12 were aged 90 and over.

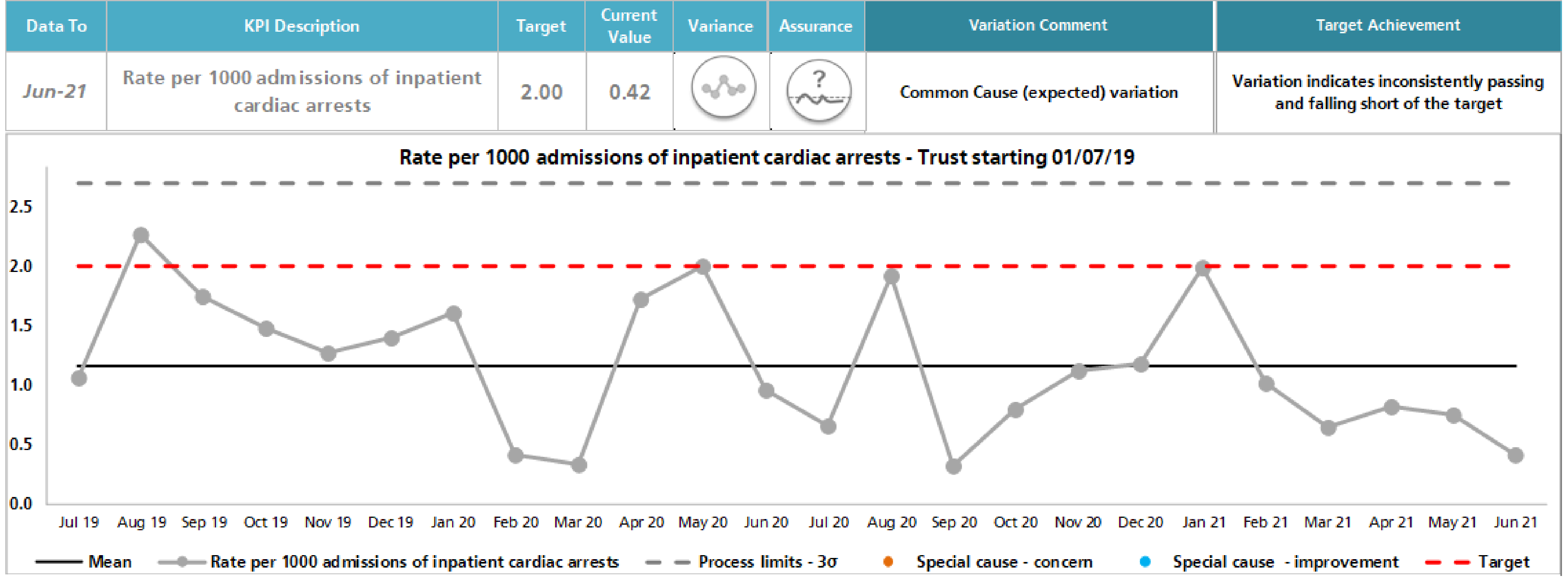
Key Actions Taken:

- An NHSE/I action plan is being finalized to improve quality of care in wards. Key themes include improving quality through senior decision makers at the earliest point in the patient journey and at every chain of intervention. Continuity and accountability of care, improved communication, improved documentation, appropriate and timely End of Life care are other key deliverables within the plan.
- The Palliative Care team have been established and commenced interventions from March 2021 which is expected to further improve patient experience and care, as well as to impact on HSMR but not SHMI.

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. A third wave or any further peaks of COVID deaths will further impede our ability to predict and benchmark our deaths against others.

Rate per 1000 admissions of inpatient cardiac arrests



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jun-21	Rate per 1000 admissions of inpatient cardiac arrests	2.00	0.42		?	Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

Chart 23 – rates per 1000 admissions of inpatient cardiac arrests

Key Issues (any new issues in red):

1. Cardiac arrest rates continue to be below expected numbers.
2. There were 2 reportable cardiac arrests in June 2021. 2 further incidents on wards have incomplete data, meaning it is uncertain if these were cardiac arrest or peri-arrest. Most calls have been for peri-arrest or out-of-hospital cardiac arrests to ED. This may again indicate a generally continued early consideration of ReSPECT and CPR decisions.

Key Actions (new actions in green):

- The key focus areas are identifying deteriorating patients and making proactive decisions on escalating, limiting or withdrawal of treatment to reduce avoidable cardiac arrests in patients. Several initiatives are ongoing to facilitate this; NEWS 2 Training, audits on compliance with NEWS 2 scoring and escalation processes and Structured Judgement Reviews of all avoidable cardiac arrests in order to identify and share learning along with other initiatives that report currently to the Recognise and Respond Forum
- One key initiative is the relaunch of ReSPECT on 19th of July 2021. A training plan is in place to support the launch and new documentation has been deployed. The communications strategy to announce the relaunch will commence shortly. Writer training (contents that are required to be filled in in the ReSPECT document) is included in Doctors' induction training and the Resuscitation Service will ensure that this training covers all specialties at least twice in a year in order to ensure continued familiarity and to improve the quality of documentation. Discussions with the Director of Medical Education are ongoing surrounding incorporating this as part of the Grand Round and F1 and F2 training. ReSPECT familiarisation training is included as part of all Level 2 Basic Life Support (BLS) E-learning delivered from 1st July 2021

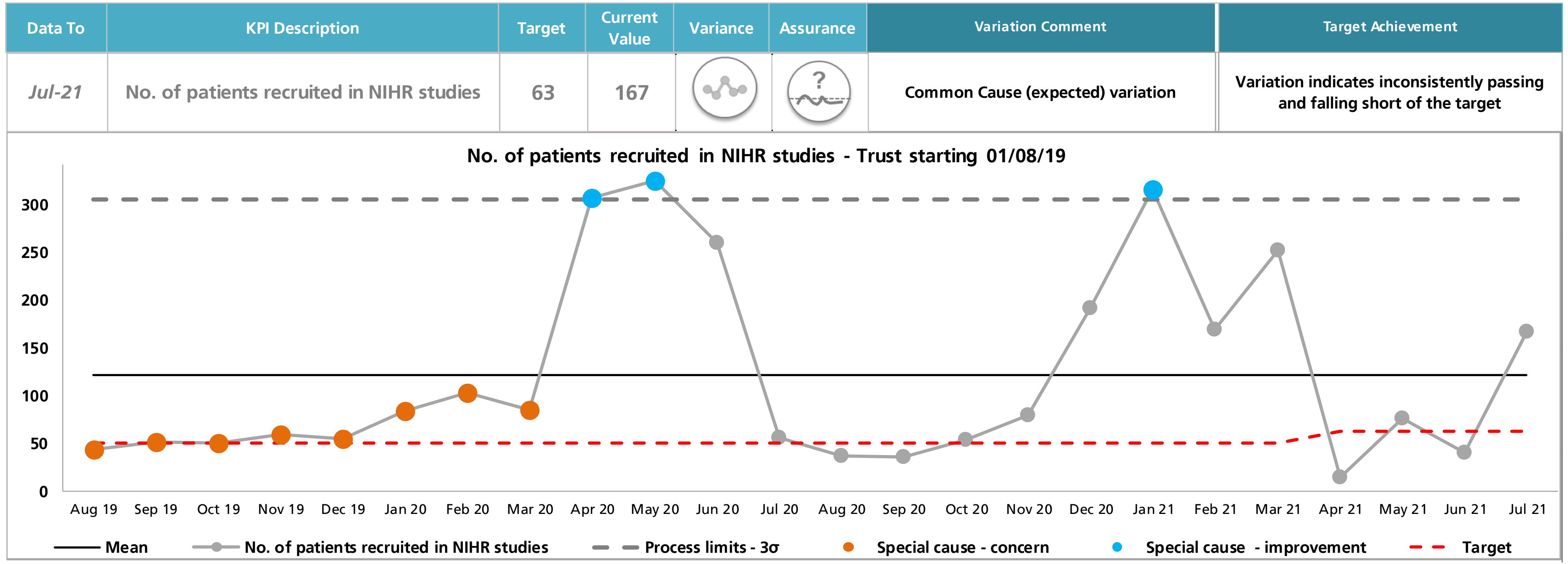
Recovery Forecast:

The process currently remains stable and hence a recovery forecast is not required. However, measures to seek a reduction in this target are ongoing, especially through work in the 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 real time reporting of the hot spots and deliver targeted 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 and resulting failures to 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, although a robust plan is now in existence for August onwards.

Number of patients recruited in NIHR studies



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jul-21	No. of patients recruited in NIHR studies	63	167			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

Chart 24 – number of patients recruited in NIHR studies

167 patients were recruited into National Institute for Health Research (NIHR) trials in July, above the target and within common cause variation.

We currently have 39 open and actively recruiting studies. 9 of these are on the ‘NIHR-managed recovery’ list, which is the key area of focus for the NIHR this year. Nationally, 4 out of the 9 identified managed recovery studies are designated as ‘red,’ and one out of 9 is designated ‘green.’ However, QE have exceeded performance target (and so are designated green) in 4 out of these 9 (4/9) studies.

The department have recently adopted the use of EDIS and PatientCentre. This alerts the research team to all admissions of patients who are involved in drug trials. Similarly, ED clinicians will also be able to more easily identify patients involved in drug trials, with access to a brief summary of relevant information regarding the study, and with an easier means of contacting the study team for further information and or emergency treatment changes.

Key Drivers

The recent increase in our recruitment figures was down to the exceptional effort by a member of the team (Band 2 HCA research post). This is a new developing role to broaden research capacity at QE.

The team continues to work with lead clinicians/principal investigators, expressing interest in several new studies to help improve trial diversity. The team continues to use NHS Improvement Quality Improvement methods to maintain high performance in terms and plan for delivery in 2021.

Key Actions

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

- Continuous presence of research staff at MDTs and ward rounds
- Weekly review of studies (board rounds)
- Vacancy authorisation to replace pharmacy support role being sought

Risks

1. Recovery of clinical services and increased clinical demand is a risk to QEH staff being able to actively recruit to non COVID studies.
2. Lack of a full and experienced research team remains a risk to research delivery. 5 of 6 vacancies have been filled.
3. Burn-out experienced by existing team during period of transition.

Caring - Accountable Officer - Chief Nurse

Caring Dashboard - Trust Level

Items in blue are awaiting the latest update

Data To	KPI Description	Target	Current Value	Variance	Assurance
Jul-21	MSA Incidents	0	3		?
Jul-21	MSA Breaches	0	9		?
Jul-21	Total Clinical & Non_Clinical Complaints	20	9		?
Jul-21	Complaints Rate per AE Atts, IP Adms & OP Activity	0.00%	0.03%	L	?
Jul-21	Complaints receiving a response within 30 working days %	90.0%	100.0%	H	?
Jul-21	Complaints - Reopened (% of Total)	15.0%	11.1%		?
Jun-21	Dementia Case Finding	90.0%	95.2%	H	F

Data To	KPI Description	Target	Current Value	Variance	Assurance
Jul-21	FFT % "Very Good" or "Good" (IP & DC)	95.00%	98.13%	H	?
Jul-21	FFT % "Very Good" or "Good" (AE)	95.00%	85.93%		?
Jul-21	FFT % "Very Good" or "Good" (OP)	95.00%	95.30%	L	?
Jul-21	FFT % "Very Good" or "Good" Mat Question 1 (Antenatal)	95.00%	100.0%		?
Jul-21	FFT % "Very Good" or "Good" Mat Question 2 (Labour)	95.00%	100.0%		?
Jul-21	FFT % "Very Good" or "Good" Mat Question 3 (Postnatal)	95.00%	100.0%		?
Jul-21	FFT % "Very Good" or "Good" Mat Question 4 (Comm Postnatal)	95.00%	100.0%	H	?

Mixed Sex Accommodation breaches

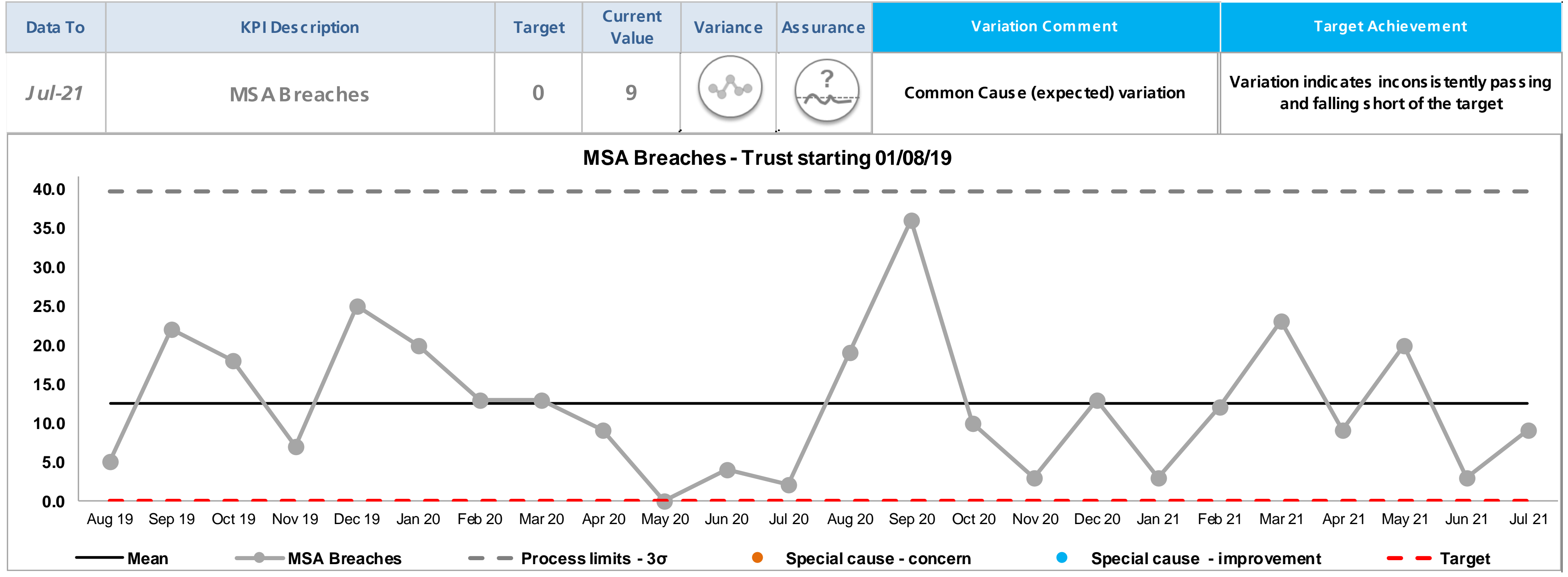


Chart 25 – MSA breaches

Key Issues (any new issues in red):

1. There have been three incidents of same sex accommodation breaches affecting nine patients during July 2021. The incident occurred in the Hyperacute Stroke Unit (HASU) on West Raynham Ward.
2. The Trust breaches are reported in line with the national guidance.

Key Actions (new actions in green):

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

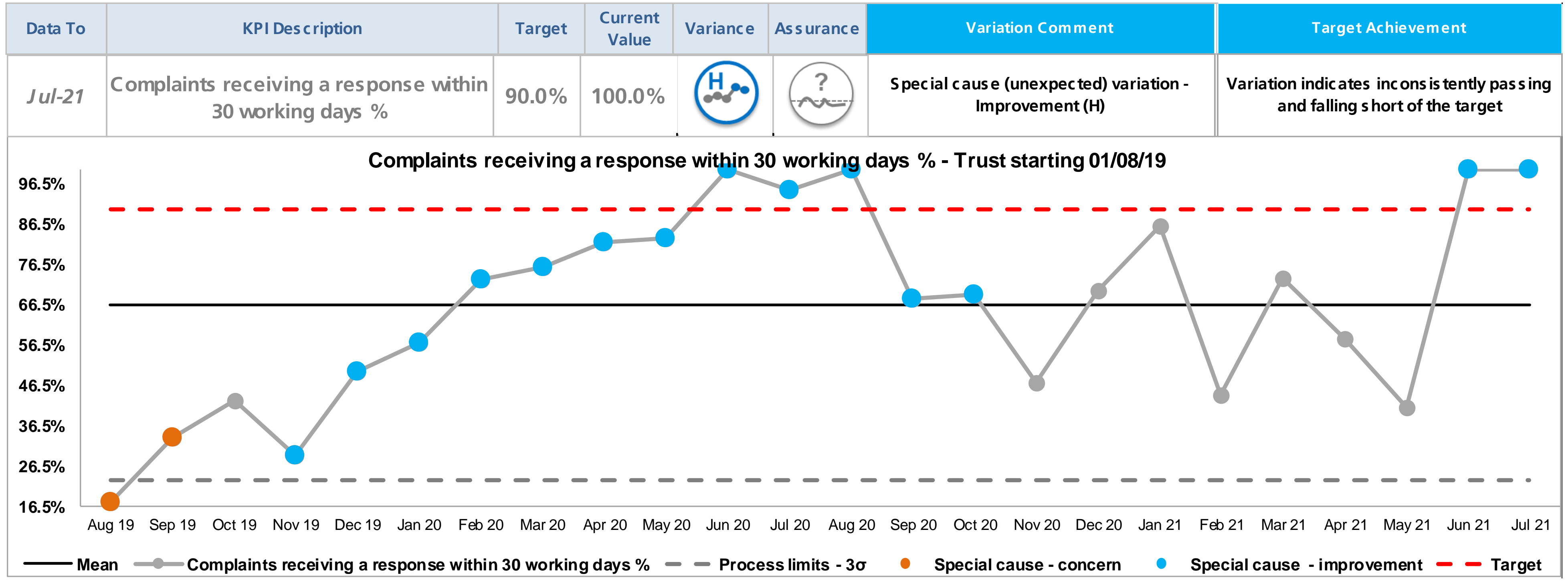
Recovery Forecast:

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.
2. Bed capacity will be a factor for future breaches.

Complaints



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jul-21	Complaints receiving a response within 30 working days %	90.0%	100.0%			Special cause (unexpected) variation - Improvement (H)	Variation indicates inconsistently passing and falling short of the target

Chart 26 – Complaints receiving a response within 30 working days

Key Issues (any new issues in red):

1. The timeliness of responding to complaints within 30 days has been achieved in June and July 2021.
2. The actions put into place in April/May continue to assist the improvement and will remain in place to ensure sustained performance and delivery.

Key Actions (new actions in green):

1. The Deputy Chief Nurse continues to meet with the Heads of Nursing and Governance leads to track the progress of the complaints within each Division.

2. Initial Triage by a senior member of staff continues.
3. Divisional senior to ring complainant (define options, agree timescales, offer LRM or de-escalation of the complaint in some cases).
4. Continue to sustain an increase in Local Resolution Meetings (LRMs).
5. Share point for all to access with PTL information.
6. Review each response with coaching to improve quality.

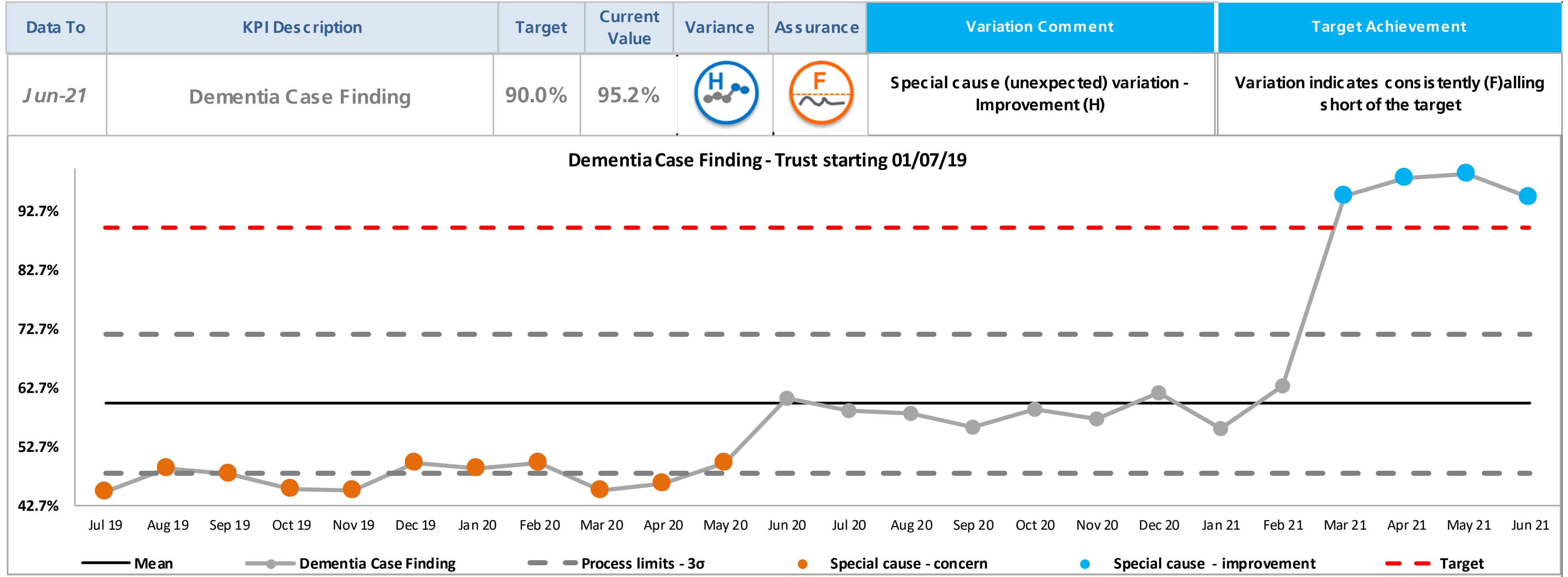
Recovery Forecast:

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

Key Risks to Forecast Improvement:

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

Dementia Case Finding



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jun-21	Dementia Case Finding	90.0%	95.2%	H	F	Special cause (unexpected) variation - Improvement (H)	Variation indicates consistently (F)alling short of the target

Chart 27 – Dementia Case finding

Key Issues (any new issues in red):

1. For the 4th month in a row, Dementia screening rates have remained significantly above the agreed threshold indicating special cause variation improved performance since the Cognitive Impairment Assessors in the Frailty and Dementia team have started in post. Their roles which include screening of all recently admitted patients (>75 years of age admitted within 72 hours) also ensures that patients identified with cognitive impairment promptly get a specialist review and if feasible, moved to the right ward to provide ongoing care.

Key Actions (new actions in green):

1. The next key action is to ensure that the patients identified with cognitive impairment are promptly referred to General Practitioners to ensure timely and safe onward care in the community. Recent audit of the screening process showed the 7.5% (30 out of 400) patients were identified with cognitive impairment.
2. Onward notification of dementia through the discharge process require further tightening to ensure all identified patients are referred promptly at discharge. In this recent audit, 7 (24%) out of 30 patients were not notified. This is being addressed by the Frailty team urgently.
3. Increased onward referral to the community team is likely to increase demand and to outstrip the current capacity of this service in the community. This has been raised with the commissioners to expand both community and hospital commissioned dementia services.

Recovery Forecast: Not applicable

Key Risks to Forecast Improvement:

1. The HCAs undertaking this role are currently employed through the bank on a pilot basis. A business case has been prepared to make the Cognitive Impairment Assessment (CIA) roles substantive and to build this role into our establishment and on e-roster to maintain performance long term.
2. Shortages of Healthcare assistants and increased emergency pressures across the trust has meant that CIAs are often delegated other clinical roles and responsibilities. This will impact on the timely screening of admitted patients.

Responsive - Accountable Officer - Chief Operating Officer

Responsive Dashboard - Trust Level

Items in blue are awaiting the latest update

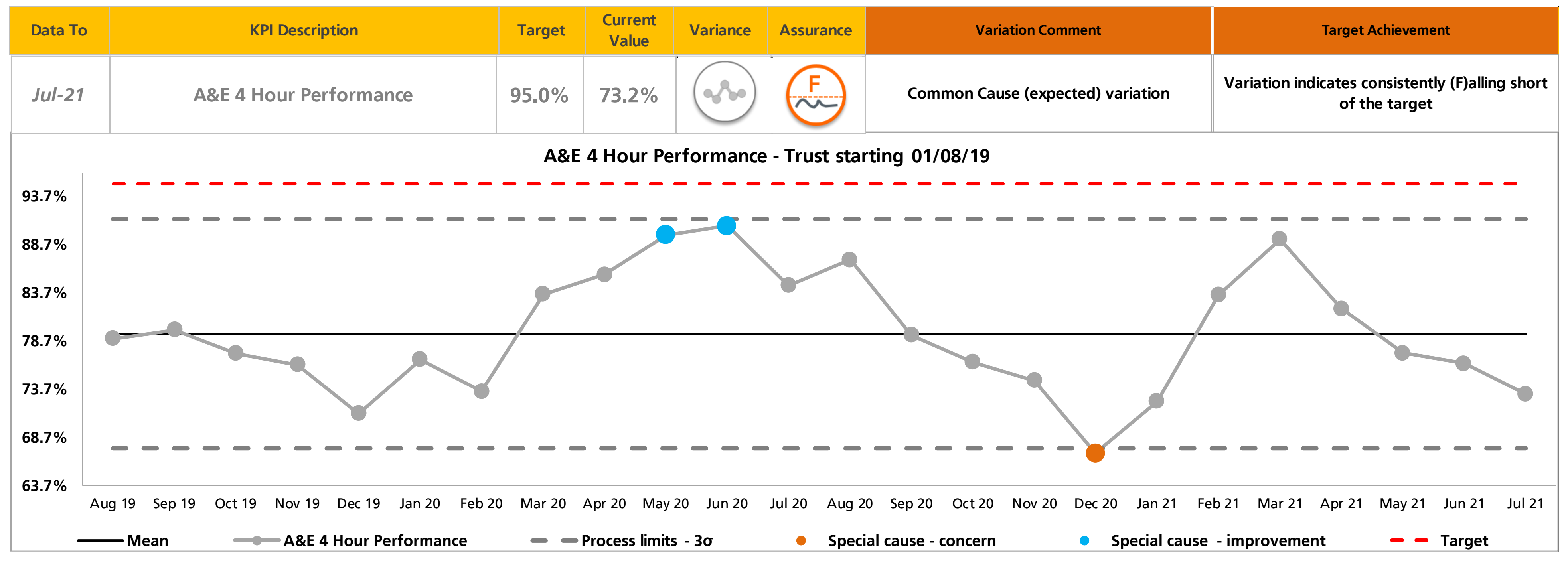
Data To	KPI Description	Target	Current Value	Variance	Assurance
Jul-21	18 Weeks RTT - Incomplete Perf	92.0%	66.8%		F
Jul-21	18 Weeks RTT - No. of Specialties failing the target of 92%	0	28		
Jul-21	18 Weeks RTT - Over 52 Wk waiters	0	1061		
Jul-21	A&E 4 Hour Performance	95.0%	73.2%		F
Jul-21	A&E 4 Hour Performance (Majors only)	95.0%	57.0%		F
Jul-21	A&E 4 Hour Performance (Minors only)	100.0%	88.4%		F
Jul-21	A&E 12 Hour Trolley Waits	0	2		
Jul-21	Ambulance Handovers	100.0%	45.8%		F
Jul-21	Last minute non-clinical cancelled elective operations	0.8%	0.63%		?
Jul-21	Breaches of the 28 day readmission guarantee	0	0		
Jul-21	Total non-clinical cancelled elective operations	3.2%	3.46%		?
Jul-21	Urgent operations cancelled more than once	0	0		
Jul-21	% of beds occupied by Delayed Transfers of Care	3.5%	6.7%	H	P
Jul-21	Medically Fit For Discharge - Patients		411	H	
Jul-21	Medically Fit For Discharge - Days		2910		
Jul-21	No. of beds occ by inpatients >=21 days - (Mthly average over rolling 3 mths)	46	54		?

Data To	KPI Description	Target	Current Value	Variance	Assurance
Jun-21	Cancer Wait Times - Two Week Wait Performance	93.0%	95.7%		P
Jun-21	Cancer Wait Times - 31 Day Diag to Treatment Performance	96.0%	100.0%		?
Jun-21	Cancer Wait Times - 62 Day Ref to Treatmemt Performance	85.0%	76.6%		?
Jun-21	Cancer Wait Times - 104 Day waiters	0	3.5		
Jun-21	Cancer Wait Times - Two Week Wait (Breast Symptomatic) Performance	93.0%	94.0%		?
Jun-21	Cancer Wait Times - 31 Day Subsequent Treatment - (Surgery) Performance	94.0%	100.0%		?
Jun-21	Cancer Wait Times - 31 Day Subsequent Treatment - (Drug) Performance	98.0%	97.7%	L	P
Jun-21	Cancer Wait Times - 62 Day Screening Performance	90.0%	100.0%		?
Jun-21	Cancer Wait Times - Consultant Upgrade (62 day)	90.0%	66.7%		?
Jun-21	Cancer Wait Times - 28 Day FDS - Two week wait	75.0%	62.9%		?
Jul-21	Diagnostic Wait Times - % of over 6 Week Waiters	1.0%	58.2%	H	F
May-21	Stroke - 90% of time on a Stroke Unit	90.0%	70.4%		?
May-21	Stroke - Direct to Stroke Unit within 4 hours	90.0%	43.4%	L	F
May-21	Stroke - Patient scanned within 1 hour of clock start	48.0%	43.4%	L	?
May-21	Stroke - Patient scanned within 12 hours of clock start	95.0%	90.6%		?

Click here to view other ***National Stroke (SSNAP Domain)*** *Results*

Emergency Care

Emergency access within 4 hours



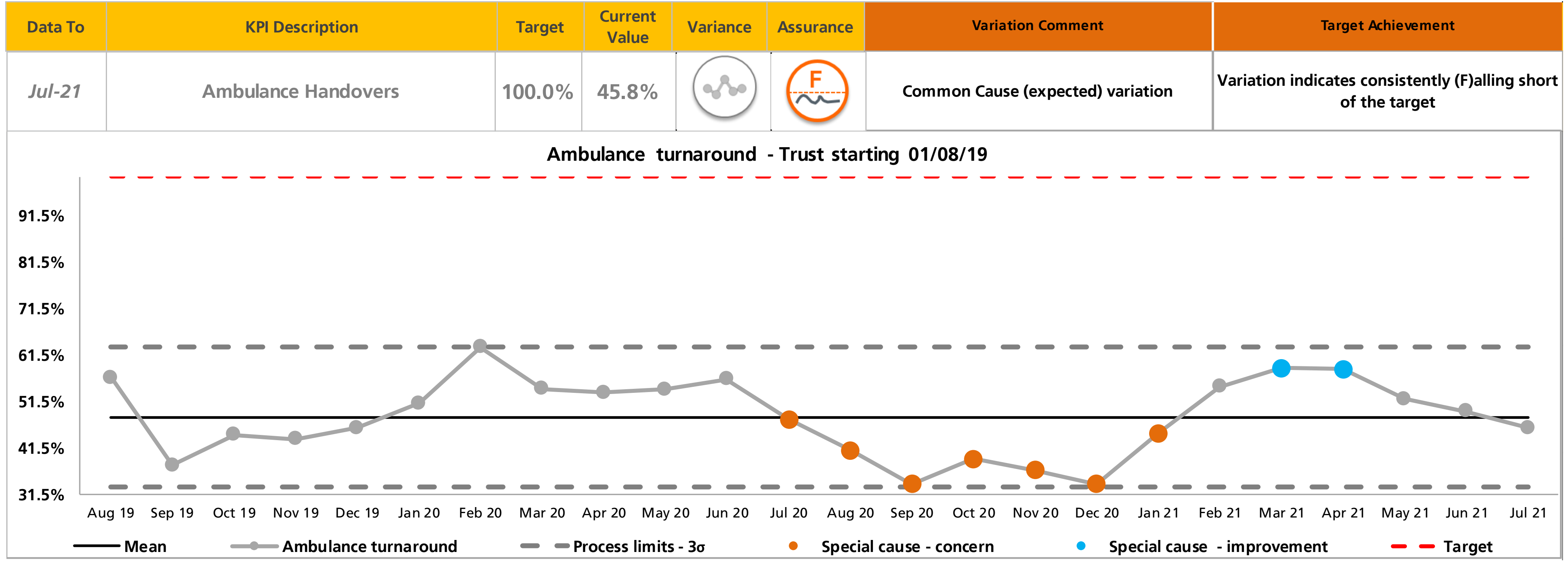
Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jul-21	A&E 4 Hour Performance	95.0%	73.2%		F	Common Cause (expected) variation	Variation indicates consistently (F)alling short of the target

Chart 28 – A&E 4-hour performance

In July 2021 7,241 patients attended the Emergency Department (ED) and of these, 1,938 patients were in department over 4 hours before admission, discharge or transfer. Performance was **73.22%** against the standard of **95%** and trajectory of **81.42%**. Admitted performance was 47.62% and non-admitted performance was 87.34%; 1,340 (69.14%) patients that breached were admitted. Minor performance was 88.4% in month, however of the 430 breaches recorded as minor, 213 (49.53% were admitted).

There were two patients that waited in the Emergency Department over 12 hours from decision to admit to admission in July 2021; both patients were awaiting a mental health bed.

Ambulance Handovers



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jul-21	Ambulance Handovers	100.0%	45.8%		F	Common Cause (expected) variation	Variation indicates consistently (F)alling short of the target

Chart 29 – Ambulance Turnaround

In July 2021 there were 1,612 conveyances by EEAST to the Emergency Department. Of those, **45.8%** of handovers took place within 15 minutes against a trajectory of **45.4%**. 1,426 handovers, which equates to **72.8%** of handovers, were completed within 30 minutes, with the **average handover time being 24:02 minutes**. **13.32%** of handovers exceeded 60 minutes. In month, the Trust **ranked 8th out of 32** hospitals within the region for the percentage of handovers completed within 15 minutes.

Key Issues (any new issues in red):

1. There was a further 0.8% increase in attendances to the ED compared to the previous month. Since April 2021, this amounts to an 18.3% increase in attendances. Compared to 2019-20, this is a 23.6% increase in activity with the majority self-presenting between 10:00-23:00. Seasonal modelling shows that this increase in demand is likely to be sustained.
2. ED continues to experience delays for patients requiring admission. 69.14% of patients that breached were admitted with 49.53% of the 430 breaches recorded as minor being admitted.

3. Delays in assessment and decision making from specialties.

Key Actions (new actions in green):

1. Implementation of an alternative staffing model utilising Advanced Care Practitioners (ACPs) during peak hours to support the increased demand of patients presenting with minor injury and minor illness – the first shift was undertaken on 07 August. Recruitment remains a challenge and therefore coverage remains inconsistent. This will support the existing ED establishment to manage the increased demand for minor injury & illness currently being seen within the department.
2. Implementation of the SAFER discharge principles across all wards to support more timely discharge. To date, SAFER has been rolled out across four wards within the Division of Medicine with a plan for further roll-out in place from late August. Initial data shows improvements in discharge rates from the wards where SAFER has been implemented and embraced by the MDTs.
3. The UEC Models of Care pathway redesign is underway. The ambition is to ensure that 30% of UEC patients are managed via SDEC in line with national requirements. Moreover, it seeks to standardise the SDEC pathway to improve emergency access for patients.

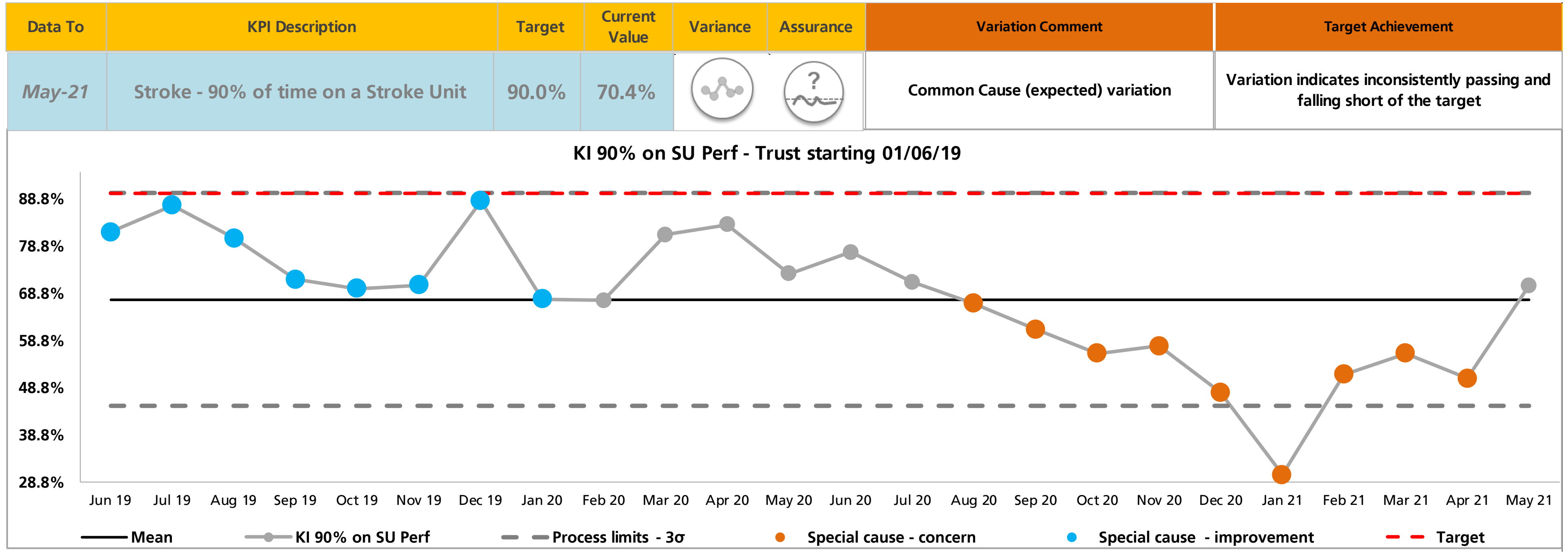
Recovery Forecast:

1. The trajectory Emergency Care Access within 4 hours is to achieve performance of 85% by October 2021 and 90% by March 2022.
2. The trajectory for Ambulance Handovers completed within 15 minutes is to achieve performance of 70% by March 2022.

Key Risks to Forecast Improvement:

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

Stroke – 90% of time on a Stroke Unit



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
May-21	Stroke - 90% of time on a Stroke Unit	90.0%	70.4%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

Chart 30 – 90% of time on the Stroke Unit

Performance in May was 70.37% based on 54 confirmed stroke cases with 16 breaches (SSNAP audit score 'E').

The key breach themes were:

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

Key Issues (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. 5 of the 16 breaches (31%) did not stay on the Stroke Unit during their inpatient admission.

2. The Coronary Care Unit (CCU) remained on the Stroke Unit during this period reducing the Stroke bed base from 29 to 24 beds.

Key Actions (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 hyper acute or acute Stroke care. Two workshops were conducted in June with involvement from the Stroke Unit, ED and the Operational Site Team. A Stroke Admission SOP has been drafted and is pending Divisional Board approval.
2. The relocation of the Coronary Care Unit in line with the finalised ward reconfiguration took place during the first week of August.

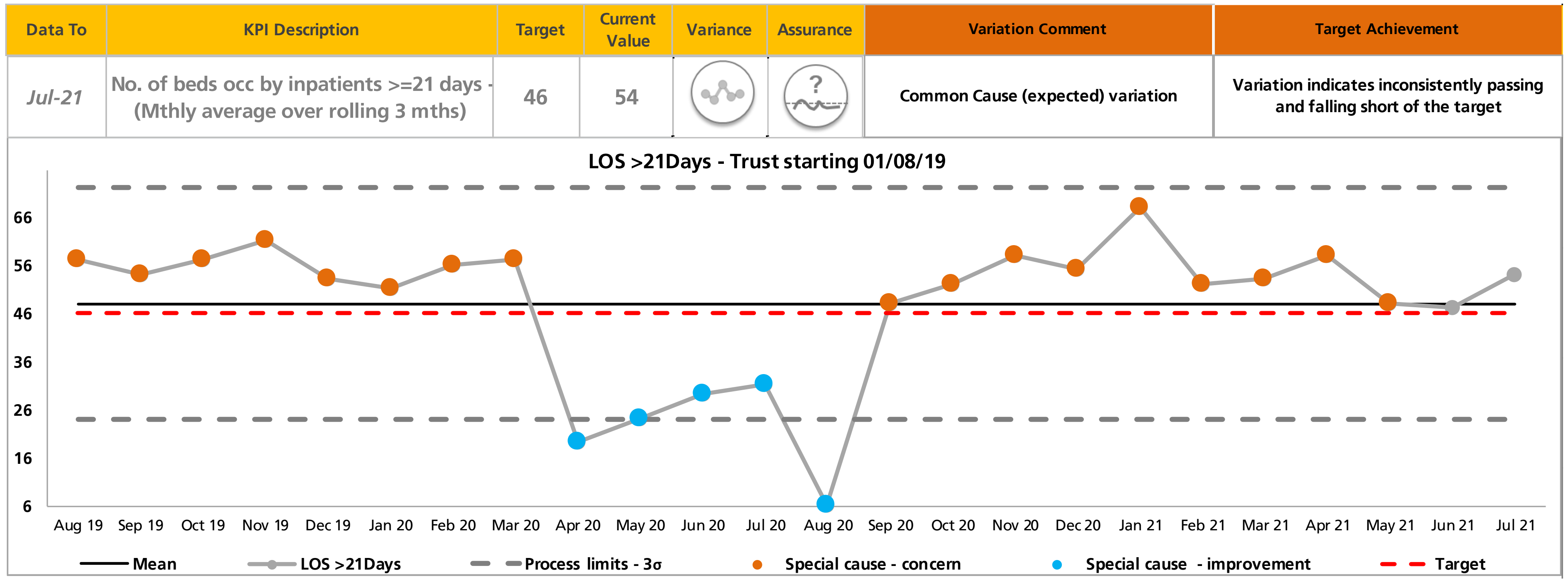
Recovery Forecast:

1. A recovery trajectory will be in place once the Stroke flow principles have been approved in agreement with the new Stroke Clinical Director and the Divisional Leadership Team.

Key Risks to Forecast Improvement:

1. Once implemented, the Stroke flow principles being adopted by all key stakeholders.
2. Stroke admission activity over plan.
3. The capacity of health and social care partners to facilitate timely discharges for patients on discharge to assess pathways 1, 2 and 3.

Beds occupied by adult inpatients >=21 days



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jul-21	No. of beds occ by inpatients >=21 days - (Mthly average over rolling 3 mths)	46	54		?	Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

Chart 31 – LoS > 21 days

At the end of July 12% (54) patients had a length of stay >21 days against the trajectory of 11% for July. Through the discharge work streams within the UEC Restoration and Improvement Programme the target is 5% of patients with a LOS >21 days by March 2022.

The Primary reasons for patients meeting the criteria to reside were:

1. Requiring clinical treatment that can only be provided in an acute setting.
2. Active ongoing clinical treatment.
3. Waiting for diagnostic test, specialist opinion or similar.

The Primary reasons for patients **not** meeting the criteria to reside were:

1. Waiting for continuing health care package (POC).
2. Waiting for a residential or nursing home.
3. Waiting for community bedded care – intermediate or reablement.

Key issues (new issues in red):

1. Homecare provider removed from marketplace with no notice, causing a significant short-term reduction in capacity for Packages of Care.

Key actions (new actions in green)

1. Senior escalation to partner organisations. Replacement for the homecare provider is with procurement, it is not clear when this capacity will be replaced.
2. Agreed flexing of community Intermediate Care Beds to allow patients awaiting a package of care to be placed in this capacity rather than remain in acute beds.
3. Additional Social Services capacity (not replacing the above) is expected by the end of August.
4. Weekly LLOS reviews undertaken with excellent engagement from the ward staff.

Recovery Forecast:

Performance is ahead of trajectory in June.

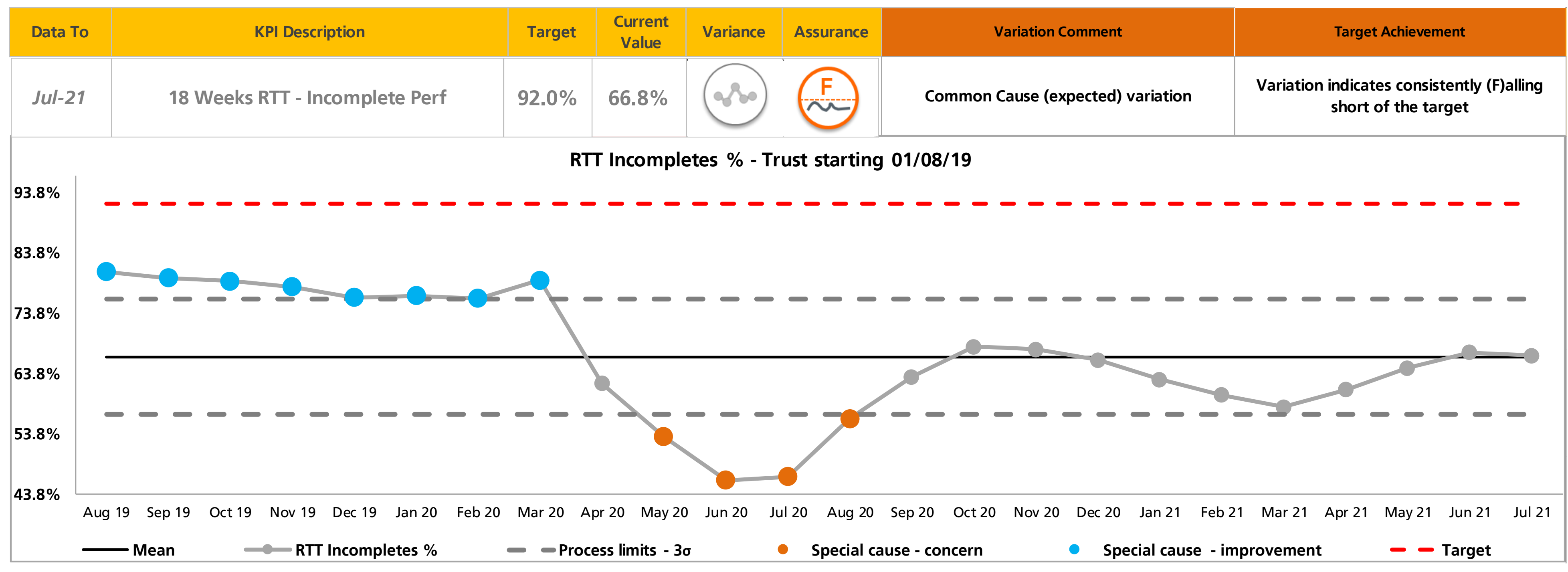
Forecast to achieve end of year target however dependent on resolution of capacity gap within the community services.

Key risk to maintaining target:

1 Ongoing high numbers of admissions requiring supported discharges.
2 No resolution to insufficient POC provision in the community.

Elective Care

18 weeks referral to treatment



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jul-21	18 Weeks RTT - Incomplete Perf	92.0%	66.8%		F	Common Cause (expected) variation	Variation indicates consistently (F)alling short of the target

Chart 32 – RTT incompletes

At the end of July 2021, there were a total of 17,504 patients on the waiting list, of which 5,817 had waited for over 18 weeks from referral, giving performance of 66.8%. The top 3 specialties with the greatest number of patients waiting over 18 weeks were Orthopaedics (1,042), Ophthalmology (714) and ENT (645).

Key Issues (new issues in red):

1. Prioritisation of urgent P2 cases in line with national guidance.
2. Cancer referrals remain at an increased level.

Key Actions (new actions in green):

1. All theatres within the main theatre suite and Day Surgery are utilised Monday – Friday.
2. Prioritisation of P2 patients and long waiters in the allocation of treatment
3. Provision of weekend WLI sessions for additional outpatient and theatre capacity

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 July 2021 there were 1,061 patients waiting longer than 52 weeks for treatment. The majority of these were in Orthopaedics (348), Gynaecology (221) and General Surgery (198). The longest waiting patient is a Gynaecology patient (P5) at 115 weeks; this patient has an agreed treatment date on the 8 September 2021.

Key Issues (new issues in red):

1. 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.
2. There has been an increased number of P2 patients who have been expedited due to a change in clinical risk.
3. Acute staff shortage in admission team has affected advanced booking to theatre list.

Actions (new actions in green):

1. Flexible allocation of surgeon to theatre list to ensure specialty with greater need are prioritise with theatre capacity.
2. Additional support provided to admission team and review of booking team structure to be complete by the end of August 2021.
3. 6-4-2 theatre booking process to be fully implemented by the end of September 2021.

Recovery Forecast:

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

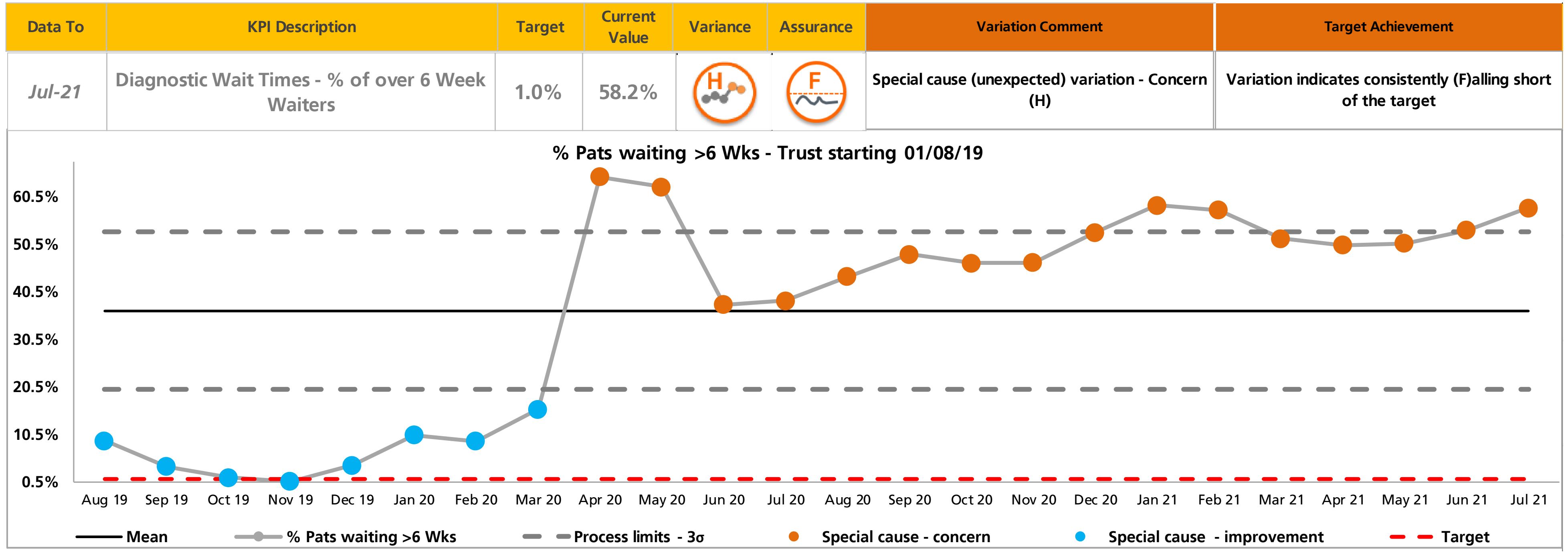
Key Risks to Forecast Improvement:

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 July 2021.

Diagnostic Waiting Times



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jul-21	Diagnostic Wait Times - % of over 6 Week Waiters	1.0%	58.2%	H	F	Special cause (unexpected) variation - Concern (H)	Variation indicates consistently (F)alling short of the target

Chart 33 - % patients waiting > 6 weeks

In July 2021 performance was 58.2% against the standard of 1%. There were 5,159 patients waiting over 6 weeks at the end of the month from a total waiting list of 8,871. The majority of patients waiting over 6 weeks are in Echocardiogram (1,461), MRI (1,130) and Non-Obstetric Ultrasound (959).

Key Issues (any new issues in red):

1. Increase in the number of non-obstetric ultrasounds awaiting – action plan to address includes extra clinics at North Cambs.
2. Increase in echocardiograms – new vetting procedure introduced, and backlog reviewed and D scored for priority.

Key Actions (new actions in green):

1. Business case for insourcing and outsourcing of MRI has been approved.

2. A staffed mobile CT van is on site for August and for two weeks in September.
3. Clinical validation of echo's completed and business case for outsourcing is being prepared.

Recovery Forecast:

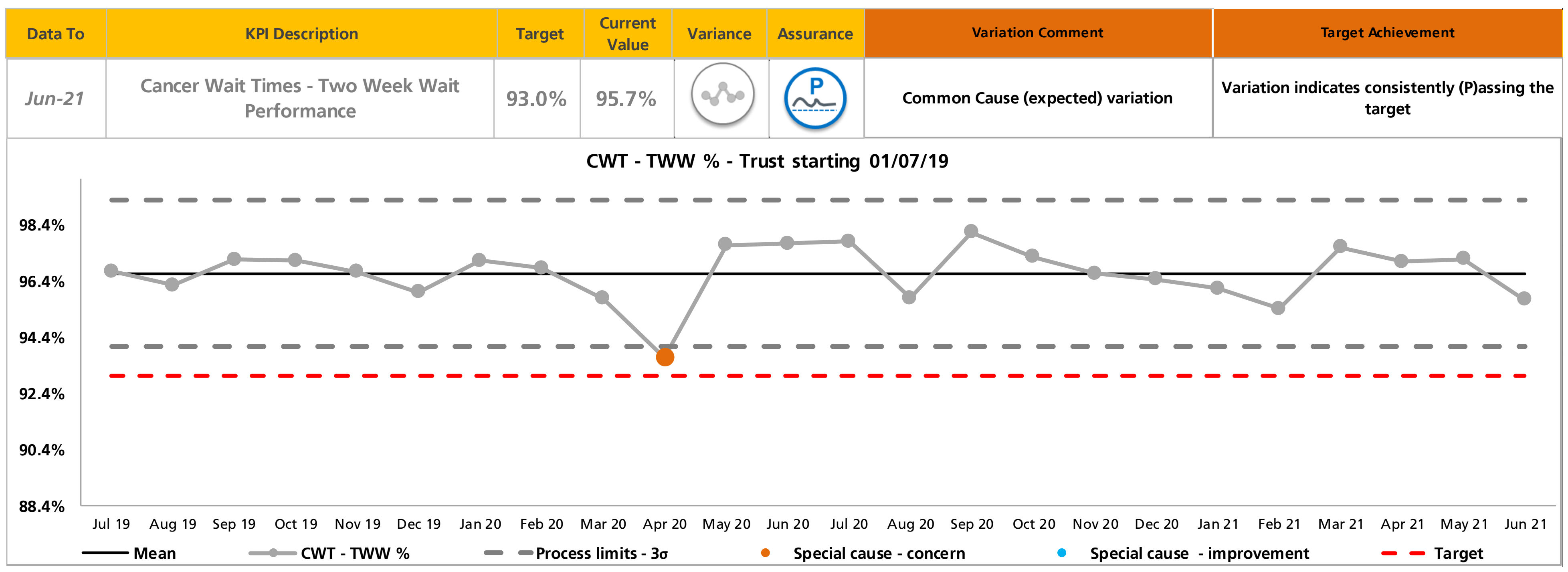
Services are planned against a recovery trajectory 2021/22.

Key Risks to Forecast Improvement:

1. Change over to RIS on w/e of 7th August 2021.
2. Availability of MRI and Echo outsourced capacity and CT when the national contract ends in September.
3. High levels of demand for patients referred on a suspected cancer pathway.

Cancer waiting times

2 week wait from referral to first outpatient appointment

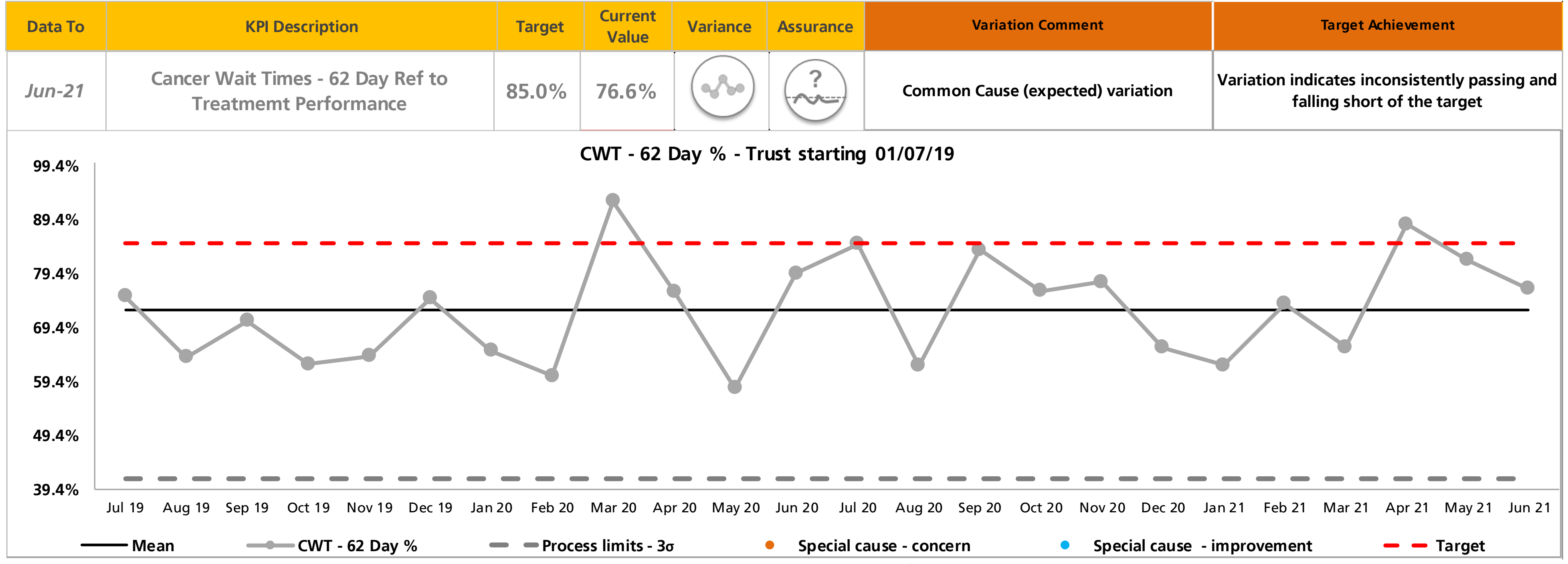


Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jun-21	Cancer Wait Times - Two Week Wait Performance	93.0%	95.7%		P	Common Cause (expected) variation	Variation indicates consistently (P)assing the target

Chart 34 – Cancer two week wait performance

Performance in June 2021 was **95.7%** 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
Jun-21	Cancer Wait Times - 62 Day Ref to Treatmemt Performance	85.0%	76.6%		?	Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

Chart 35 – Cancer 62 day wait performance

Performance in June 2021 was **76.6%** against the standard of **85%** and trajectory of **86.05%**.

There were **70.5** treatments of which **16.5** breached the 62-day standard, (1.5 Gynaecology, 3 Haematology, 1.5 Head & Neck, 4 Colorectal, 1.5 Lung, 1 Skin, 4 Upper GI)

Key Issues (any new issues in red):

1. Referral numbers have dramatically increased across all services with particular concern in Upper GI, Colorectal and Gynaecology. All 3 of these sites have seen record high numbers of referrals in the previous month. Colorectal specifically has seen a 70% increase in Pathway size in the last 2 months. This has caused a strain on clinic and diagnostic capacity.
2. Waiting Times for CT & MRI scans have raised again causing delays in patient pathways. Current waits are 15-16 days and 16-17 days respectively.

3. Delay in Gynaecology Histology reporting, with waits of up to 21 days.

Key Actions (new actions in green):

1. All cancer sites are closely monitoring the referral numbers coming into the system. Additional clinics are being run on an adhoc basis to keep waiting times below 14 days.
2. A mobile CT unit is now on site for all of August.
3. Additional gynaecology histology reporting resource will be in place by September to meet the increased demand.

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. By the end of June **10** patients were waiting for over 104 days, of which **2** were colorectal, **6** were gynaecology, **1** was Haematology and **1** was Head & Neck.

3 of these patients are now treated, **1** is awaiting treatment and **6** patients had no cancer diagnosed.

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

Statement of comprehensive income: Month 4 – 2021/22

		In Month				Year to Date			
		Plan £'000s	Actual £'000s	Fav / (Adv) £'000s	%	Plan £'000s	Actual £'000s	Fav / (Adv) £'000s	%
I&E	Clinical Income	18,886	18,841	(45)	(0%)	75,544	75,781	237	0%
	Other Income	1,347	1,603	256	19%	5,388	5,351	(37)	(1%)
	COVID-19 Additional Income	1,282	1,448	166	13%	5,128	5,910	782	15%
	Total Income	**21,515**	**21,892**	**377**	**2%**	**86,060**	**87,042**	**982**	**1%**
	Pay Costs - Substantive	(12,174)	(12,509)	(335)	(3%)	(48,698)	(50,186)	(1,488)	(3%)
	Pay Costs - Bank	(1,130)	(1,096)	34	3%	(4,517)	(3,972)	545	12%
	Pay Costs - Agency	(1,327)	(894)	433	33%	(5,287)	(3,576)	1,711	32%
	Pay Costs - Additional COVID-19	(557)	(380)	177	32%	(2,938)	(3,218)	(280)	(10%)
	Pay Costs - Vaccination Centres	0	(148)	(148)		0	(646)	(646)	
	Total Pay	(15,188)	(15,027)	161	1%	(61,440)	(61,598)	488	1%
	Non Pay - Additional COVID-19	(75)	5	80	107%	(450)	(209)	241	54%
	Non Pay	(5,144)	(5,828)	(684)	(13%)	(20,983)	(22,504)	(1,521)	(7%)
	Total Operating Costs	**(20,407)**	**(20,850)**	**(443)**	**(2%)**	**(82,873)**	**(84,311)**	**(1,438)**	**(2%)**
	EBITDA	**1,108**	**1,042**	**(66)**	**(6%)**	**3,187**	**2,731**	**(456)**	**(14%)**
	Non-Operating Costs	(944)	(885)	59	6%	(3,771)	(3,310)	461	12%
	Adjust Donated Assets	29	33	4	14%	116	132	16	14%
	TOTAL (Deficit) / Surplus	**193**	**190**	**(3)**	**(2%)**	**(468)**	**(447)**	**21**	**4%**
Ratios	Agency : Total Pay	9.1%	6.2%			9.0%	6.2%		
	EBITDA : Income	5.2%	4.8%			3.7%	3.1%		
	Net Deficit : Income	0.9%	0.9%			(0.5%)	(0.5%)		

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

Executive Summary

As at the end of July 2021, the Trust's in month financial position is showing a deficit of £3k against the plan but is still £21k positive to plan at the end of month 4 (July).

The financial plan was developed in the context of the first six months (H1) being a breakeven position. It is based on the 'roll-over' of the block income arrangements from 2020/21.

Key points of note in month / Material variances:

Leverington and Feltwell wards remain open to provide additional bed capacity. This is creating a c. £0.5m to £0.6m cost pressure per month.

Covid-19 vaccination costs incurred and reimbursed in month are £0.2m.

Total pay expenditure is positive to plan by £0.2m.

Agency expenditure is favourable to plan by £0.4m.

Non-pay is adverse to plan by £0.7m (mainly in drugs and clinical supplies).

The CIP/ waste reduction programme has achieved £0.4m of efficiencies in month, which is adverse to plan by £0.1m. YTD delivery of the CIP/ waste reduction programme is £0.6m positive to plan.

In month capital expenditure incurred is £0.7m. YTD this is at £1.8m.

Statement of Financial Position (SOFP) Update

	31-Mar-21 £m	30-Jun-21 £m	30-Jul-21 £m	Month on Month Movement £m	YTD Movement £m
Non current assets	101	100	100	-	(1)
Current Assets					
Inventories	2	2	2	-	-
Trade & Other Receivables	13	12	14	2	1
Cash	27	26	22	(4)	(5)
Current liabilities					
Trade & Other Payables	(19)	(17)	(16)	1	3
Accruals	(18)	(14)	(12)	2	6
PDC dividend	-	(1)	(1)	-	(1)
Other current liabilities	(2)	(1)	(2)	(1)	-
Non current liabilities	(1)	(1)	(1)	-	-
Borrowings	-	-	-	-	-
Total assets employed	**103**	**106**	**106**	**-**	**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**

Month-on-Month Key movements

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

Trade and other receivables have increased by £2m as a result of a significant charge to Health Education England in support of the Trust's ongoing efforts to come out of special measures.

Cash balances have reduced during the month by £4m as a result of significant payments made to clear previously queried NHS balances and payments in support of capital commitments.

Trade and other payables have decreased by £1m as a result of catch-up payments and additionally billing from NNUH for the urology contract.

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

Well Led (People) Dashboard

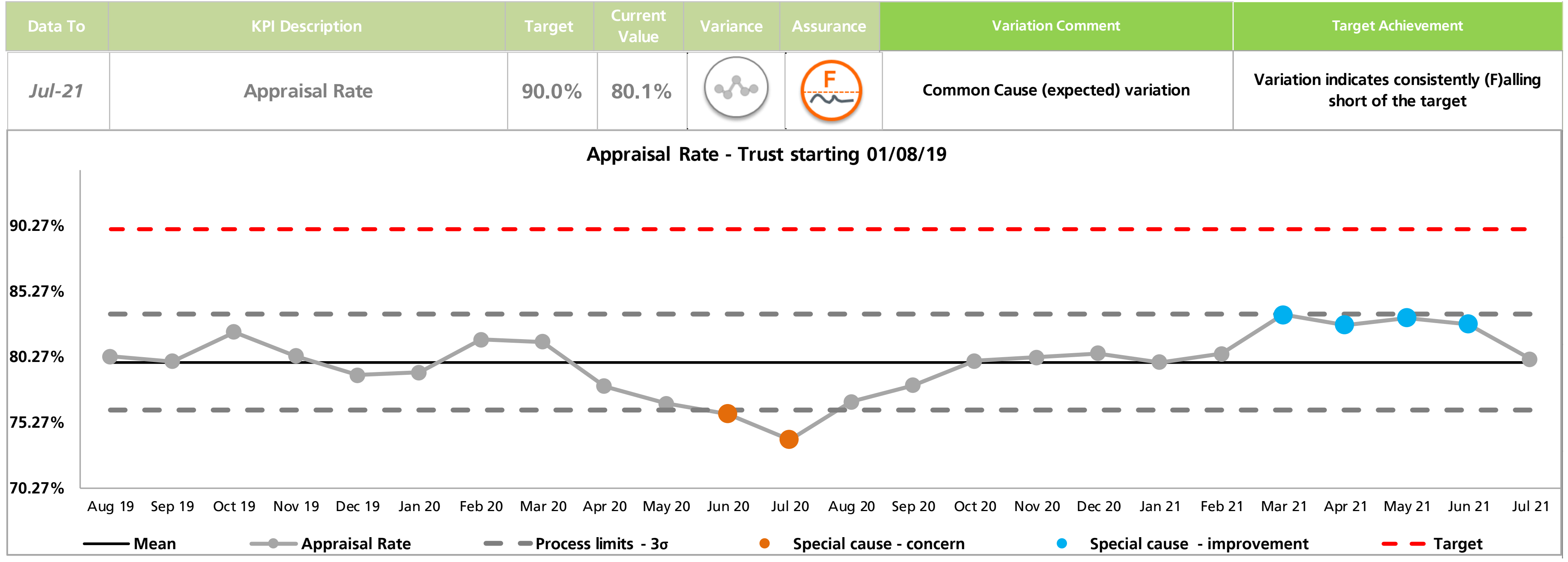
Items in blue are awaiting the latest update

Data To	KPI Description	Target	Current Value	Variance	Assurance
Jul-21	Appraisal Rate	90.0%	80.1%		F
Jul-21	Appraisal Rate (Med Staff exc Jnr Drs)	90.0%	87.0%		?
Jul-21	Sickness Absence Rate	4.5%	6.2%		?
Jul-21	Long Term Sick		3.2%		
Jul-21	Short Term Sick		2.9%		
Jul-21	Mandatory Training Rate	80.0%	85.2%	H	?
Jul-21	Turnover Rate	10.0%	10.6%		?

Vacancy Levels

- Additional 5 International Nurses started July 2021
- Additional funding has been provided for Healthcare Support Workers (HSW) recruitment from ICS
- Further international recruitment being planned for midwifery and nurses
- Change to student midwifery process being implemented
- Allied Health Professional (AHP) recruitment campaign being planned
- Below planned establishment in substantive, bank and agency categories
- Bank and agency collaboration programme in place across the ICS – new system to start in September 2021
- Vacancy Scrutiny Panel to review and recommend action plan by end August 2021 for specific staff groups

Appraisal rate



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jul-21	Appraisal Rate	90.0%	80.1%		F	Common Cause (expected) variation	Variation indicates consistently (F)alling short of the target

Chart 36 – Appraisal Rate

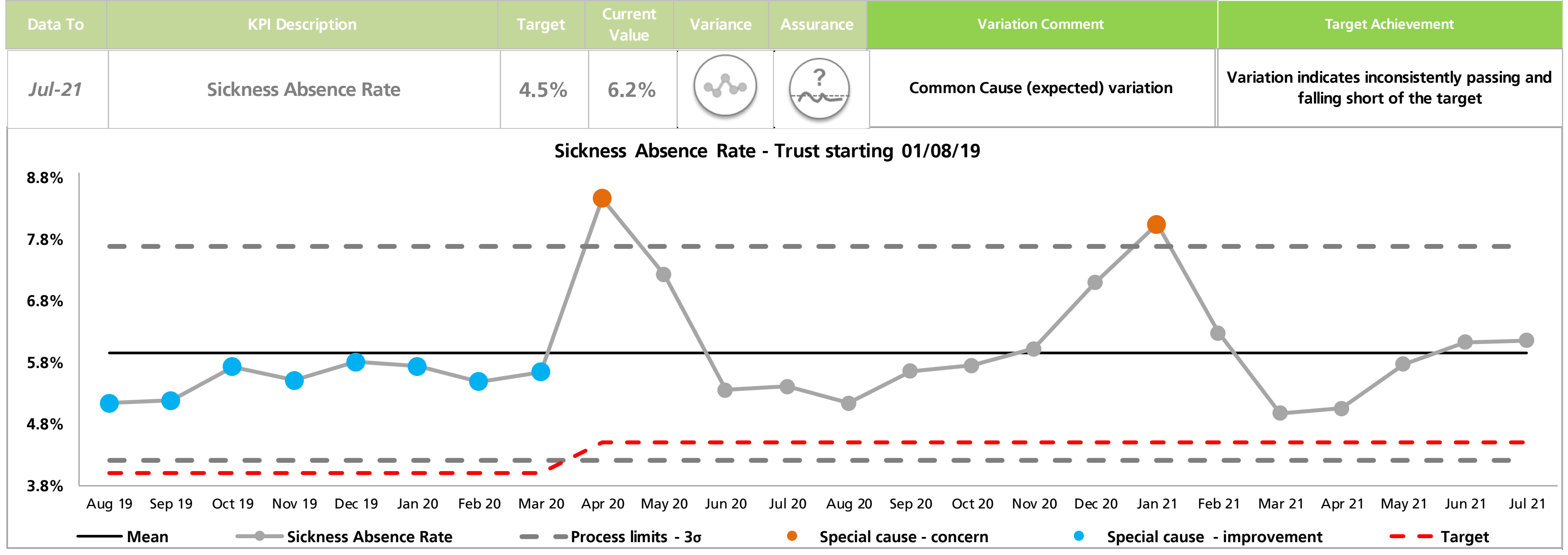
Key Issues

- Current performance below trajectory at 80.1%

Key Actions:

- A pay progression policy is in place applies to new starters
- Appraisal documentation amended to incorporate the Trust's values
- Additional training provided
- Recovery plans and trajectories in place

Sickness Absence rate



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jul-21	Sickness Absence Rate	4.5%	6.2%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target

Chart 37 – Sickness absence rate

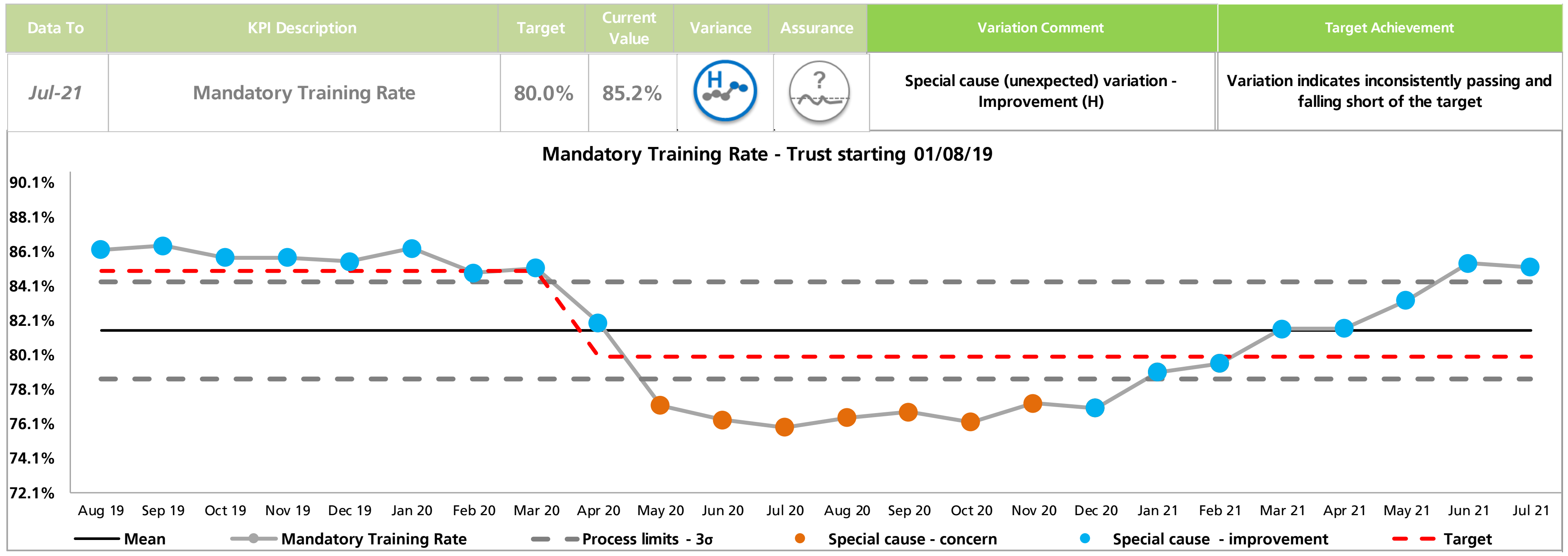
Key Issues:

- Continued increase in long term sickness, all cases over 28 days have been reviewed and are being monitored through monthly check and challenge meetings
- Stress and anxiety sickness increased with a Fast-track referral process available as needed
- Long covid remains a cause for absence
- A slight increase in sickness related to COVID
- Additional Occupational Health (OH) support and case conferences being arranged to manage very long term LTS cases
- OH capacity under review

Key actions

- No identifiable trends in Short Term Sickness around holiday periods
- Staff signed off sick are now unable to work bank shifts, three strike rule for bank staff implemented
- Absence toolkits ratified in June 2021; new attendance policy ratified at PEG in July 2021
- System wide review to be undertaken on managing absence
- Workshop to be held at the end of September to complete a new way of managing absence and rewarding good attendance, with staff side colleagues, senior leaders, Occupational Health and HR colleagues

Mandatory Training



Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jul-21	Mandatory Training Rate	80.0%	85.2%	H	?	Special cause (unexpected) variation - Improvement (H)	Variation indicates inconsistently passing and falling short of the target

Chart 38 – Mandatory Training

Key Issues:

- Current performance has increased to 85.2% for the core subjects

Key Actions:

- Electronic FAQs and 'How to' guides being developed including video guides
- Electronic Assessment of workbooks is reducing submission in hardcopy
- 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 now entering the implementation phase
- Barriers to not achieving compliance in Face-to-Face Subjects identified and solution presented to CELM.

- Adjustments have been made to the reporting of training so lower levels recorded if attending a higher-level course ie safeguarding
- Digital passports being rolled out on a system wide level