Royal Papworth Hospital
NHS Foundation Trust

Papworth Integrated Performance Report (PIPR)

September 2021

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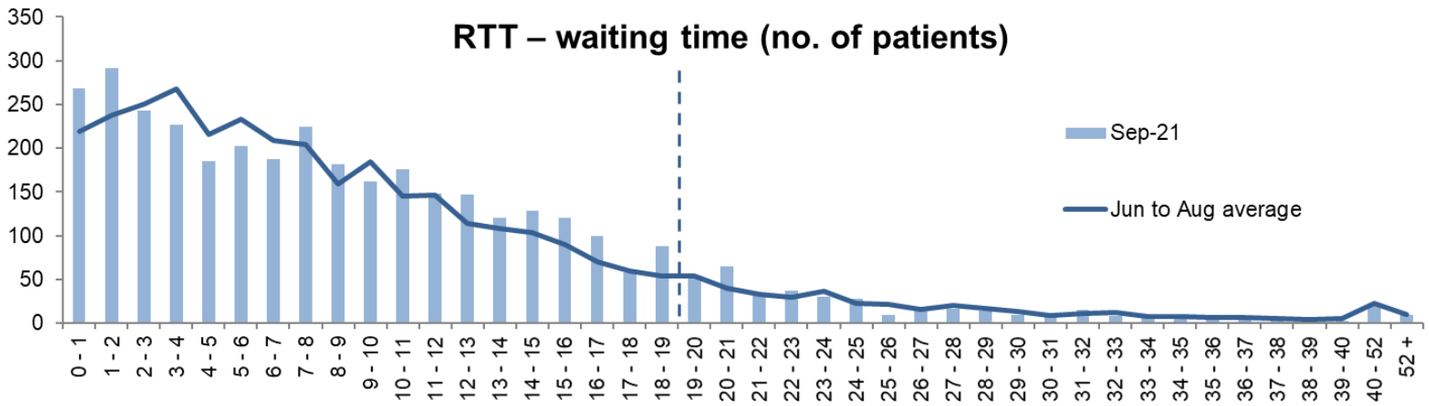
Context:

Context - The activity table and RTT waiting time curve below sets out the context for the operational performance of the Trust and should be used to support constructive challenge from the committee:

Inpatient Episodes	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Trend
Cardiac Surgery	133	164	174	182	154	161	
Cardiology	701	725	804	743	642	735	
ECMO (days)	148	65	83	177	294	307	
ITU (COVID)	5	1	1	0	1	0	
PTE operations	11	9	19	17	11	18	
RSSC	625	613	734	557	521	665	
Thoracic Medicine	284	262	285	306	303	311	
Thoracic surgery (exc PTE)	55	52	67	66	69	53	
Transplant/VAD	49	37	48	52	45	55	
Total Inpatients	**2,011**	**1,928**	**2,215**	**2,100**	**2,040**	**2,305**	

Outpatient Attendances	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Trend
Cardiac Surgery	472	591	592	441	416	430	
Cardiology	3,550	3,539	3,766	3,606	3,367	3,760	
RSSC	1,604	1,481	1,675	1,478	1,186	1,472	
Thoracic Medicine	2,098	2,160	2,472	2,360	2,066	2,340	
Thoracic surgery (exc PTE)	111	98	110	85	61	128	
Transplant/VAD	264	264	343	273	268	291	
Total Outpatients	**8,099**	**8,133**	**8,958**	**8,243**	**7,364**	**8,421**	

Note 1 - Activity figures include Private patients and exclude unbundled radiology scan activity and ALK test activity;
Note 2 - ECMO activity shows billed days in months (rather than billed episodes);
Note 3 - Inpatient episodes include planned procedures not carried out.



Reading guide

The Papworth Integrated Performance Report (PIPR) is designed to provide the Board with a balanced summary of the Trust's performance within all key areas of operation on a monthly basis. To achieve this, the Trust has identified the Board level Key Performance Indicators ("KPIs") within each category, which are considered to drive the overall performance of the Trust, which are contained within this report with performance assessed over time. The report highlights key areas of improvement or concern, enabling the Board to identify those areas that require the most consideration. As such, this report is not designed to replace the need for more detailed reporting on key areas of performance, and therefore detailed reporting will be provided to the Board to accompany the PIPR where requested by the Board or Executive Management, or where there is a significant performance challenge or concern.

- **'At a glance' section** – this includes a 'balanced scorecard' showing performance against those KPIs considered the most important measures of the Trust's performance as agreed by the Board. The second dashboard includes performance against those indicators set by the Trust's regulators and reported externally.
- **Performance Summaries** – these provides a more detailed summary of key areas of performance improvement or concern for each of the categories included within the balanced score card (Transformation; Finance; Safe; Effective; Caring; Responsive; People, Management and Culture)

Key

KPI 'RAG' Ratings

The 'RAG' ratings for each of the individual KPIs included within this report are defined as follows:

Assessment rating	Description
Green	Performance meets or exceeds the set target with little risk of missing the target in future periods
Amber	Current performance is 1) Within 1% of the set target (above or below target) unless explicitly stated otherwise or 2) Performance trend analysis indicates that the Trust is at risk of missing the target in future periods
Red	The Trust is missing the target by more than 1% unless explicitly stated otherwise

Overall Scoring within a Category

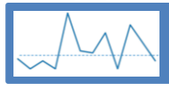
Each category within the Balanced scorecard is given an overall RAG rating based on the rating of the KPIs within the category that appear on the balance scorecard (page 4).

- **Red (10 points) =** 2 or more red KPIs within the category
- **Amber (5 points) =** 1 red KPI rating within the category
- **Green (1) =** No reds and 1 amber or less within the category

Overall Report Scoring

- **Red =** 4 or more red KPI categories
- **Amber =** Up to 3 red categories
- **Green =** No reds and 3 or less amber

Trend graphs



Within the balanced scorecard, each KPI has a trend graph which summarises performance against target from April 2020 (where data is available)

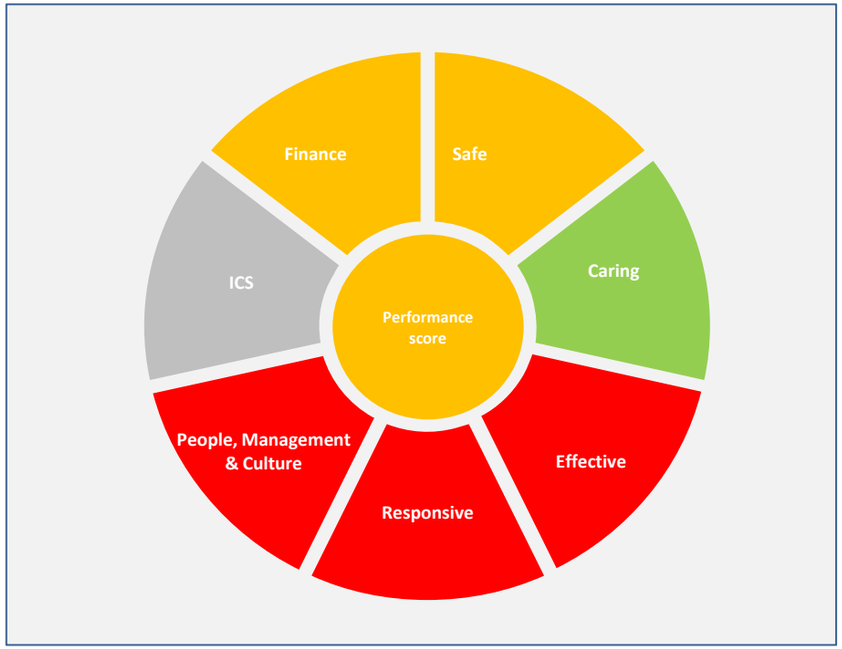
Data Quality Indicator

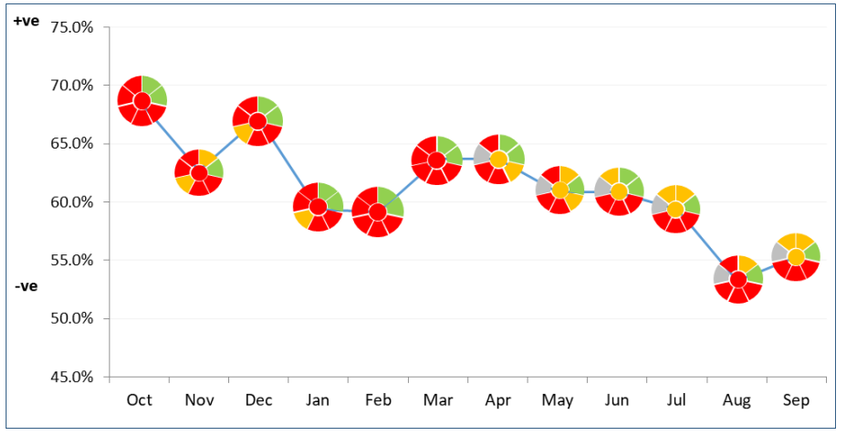
The data quality ratings for each of the KPIs included within the 'at a glance' section of this report are defined as follows. It should be noted that the assessment for each of the reported KPI's is based on the views and judgement of the business owner for that KPI, and has not been subject to formal risk assessment, testing or validation.

Rating	Description
5	High level of confidence in the quality of reported data. Data captured electronically in a reliable and auditable system and reported with limited manual manipulation with a full audit trail retained. Sufficient monitoring mechanisms in place to provide management insight over accuracy of reported data, supported by recent internal or external audits.
4	High level of confidence in the quality or reported data, but limited formal mechanisms to provide assurance of completeness and accuracy of reported information.
3	Moderate level of confidence in the quality of reported data, for example due to challenges within the processes to input or extract data such as considerable need for manual manipulation of information. These could effect the assurance of the reported figures but no significant known issues exist.
2	Lower level of confidence in the quality of reported data due to known or suspected issues, including the results of assurance activity including internal and external audits. These issues are likely to impact the completeness and accuracy of the reported data and therefore performance should be triangulated with other sources before being used to make decisions.
1	Low level of confidence in the reported data due to known issues within the input, processing or reporting of that data. The issues are likely to have resulted in significant misstatement of the reported performance and therefore should not be used to make decisions.

Trust performance summary

Overall Trust rating - AMBER





FAVOURABLE PERFORMANCE

SAFE: Safer Staffing: The RN fill rate for Sep 2021 is an improved position from the previous month with days green 90.0% and nights green 92.8%. The CHPPD thresholds ("targets column") have been updated from Sep 2021 based on the latest establishment review. All CHPPD areas are green with the exception of 4NW who are just under their green threshold, and 3 South (also just under their green threshold).
CARING: All of the dashboard KPI metrics in Caring remained green in September 2021. Number of written complaints per 1000 staff WTE is a benchmark figure based on the NHS Model Hospital to enable national benchmarking. We remain in green at 3.4. The latest data from Model Hospital demonstrates we are in the lowest quartile for national comparison (note the Model Hospital data period remains Dec 2019; accessed 18.10.2021): Royal Papworth = 9.02, peer group = 11.23, national = 21.11.
EFFECTIVE: Outpatient Performance - Outpatient throughput remains strong with the activity target exceeded again this month. This is most apparent in the level of follow-up patients seen which exceeded the 2019/2020 baseline activity both in months 5 and 6 as clinicians are working to catch-up on overdue follow-up consultations.
Virtual outpatient appointments continue where it is clinically appropriate to do so and the Trust is credited with one of the providers with the highest levels of virtual appointments in the region.
RESPONSIVE: Diagnostic Performance - In spite of Radiographer staffing challenges, a strong recovery of diagnostic performance in September has been delivered. The team continue to support referrals from outside normal referral patterns from organisations where access to diagnostics are causing delays in patient pathways.
FINANCE – 1) The YTD position is reported against the Trust's H1 2021/22 plan and shows a surplus of £2.5m which is on plan. 2) CIP is ahead of plan by £1.4m YTD. This is primarily driven by additional delivery against Pharmacy schemes where cost savings have been achieved by switching to generic brands and reducing usage, non recurrent operational pay underspends as well as savings made on the revaluation of business rates.

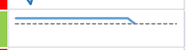
ADVERSE PERFORMANCE

SAFE: Pressure ulcers - there were three Papworth acquired pressure ulcers during Sep 2021. They have been reviewed by the Nurse Consultant for Tissue Viability. One is a deep tissue injury and two are category 2 ulcers.
EFFECTIVE: Inpatient Capacity Utilisation – High levels of staff absence, primarily due to sickness and the need to self isolate following household contact with COVID-19, persisted throughout September. This reduced bed occupancy against the funded number of general and acute and critical care beds. Critical Care capacity remained the key constraint to flow, due to high levels of COVID and ECMO demand, delayed repatriations to other providers and staff absence and as a consequence utilisation of theatre and cath lab sessions was sub-optimal. Admitted patient care levels recovered in the later part of the month despite these constraints which reflects the commitment of staff to make the best use of the capacity available. Day case activity remains strong, both in Cardiology and Respiratory Medicine, and this has supported the overall number of elective cases treated resulting the in month plan being exceeded.
RESPONSIVE: 1) Cancer Performance - Cancer performance continues to be impacted by late referrals, complexity of cases and access to PET CT. There were 3 patients that breached their 62 day pathway prior to treatment and that was due to late referrals and patient choice to delay whilst considering their treatment options. 1 of these patients also breached their 31 day target due to needing to self-isolate due to being in contact with a COVID19 positive person whilst they considered their treatment options. There were 5 patients that breached 104 days 2) Waiting list Performance- Cardiology: There has been a decline in Cardiology performance in September ,as anticipated ,following the reduction of elective activity across all cath labs throughout August. This was in response to an increase in emergency demand, number of staffing challenges across radiology and supporting overall staff wellbeing by encouraging annual leave. As activity resumes the focus has been on prioritising patients in order of clinical urgency. Surgery: Constraints on critical care capacity , due to staff absence and high levels of emergency demand, has severely impacted on the number of planned surgical cases treated. This has further reduced RTT performance . As with all specialities, all patients are being treated in order of clinical prioritisation.
PEOPLE, MANAGEMENT & CULTURE 1) Vacancy rate remained above KPI at 7.6%. The registered nurse vacancy rate remained below KPI at 2.8%. This increase in vacancy rates is primarily driven by temporary posts that have been approved as part of 20/21 staffing establishments. These relate to the increase in beds in Critical Care and Cardiology that have been approved to the end of 21/22 pending clarity on 22/23 commissioning/funding arrangements. 2) Sickness - Total Sickness absence remained over KPI at 4.3%. This includes sickness absence relating to COVID but excludes absence linked to self-isolation. There was an increased number of staff contracting COVID during the first weeks of September although this did reduce in the second half of the month. We started to see at the end of September an increase in non-covid absence as seasonal illnesses such as colds started to circulate.

LOOKING AHEAD

ICS (New domain in 2021/22): Increasingly organisations will be regulated as part of a wider ICS context, with regulatory performance assessments actively linking to ICS performance. The ICS is developing system wide reporting to support this and the Trust is actively supportive this piece of work. In the meantime, this new section to PIPR is intended to provide an element of ICS performance context for the Trust's performance. This section is not currently RAG rated however this will be re-assessed in future months as the information develops and evolves, and as the System Oversight Framework gets finalised nationally. The metrics indicate activity recovery across the ICS is progressing favourably against national targets, with outpatient and day case activity particularly showing a faster rate of return. Despite this, system wide waiting lists remain a challenge, particularly in areas such as diagnostics.

At a glance – Balanced scorecard

		Month reported on	Data Quality	Plan	Current month score	YTD Actual	Forecast YE	Trend
Safe	Never Events	Sep-21	4	0	0	1		
	Moderate harm incidents and above as % of total PSIs reported	Sep-21	4	3%	0.30%	1.21%		
	Number of Papworth acquired PU (grade 2 and above)	Sep-21	4	35 pa	3	10		
	High impact interventions	Sep-21	3	97%	99.30%	98.52%		
	Falls per 1000 bed days	Sep-21	4	4	3.8	3.2		
	Sepsis - % patients screened and treated (Quarterly)	Sep-21	New	90%	Await data	-		
	Safer Staffing CHPPD – 5 North	Sep-21	5	9.6	10.4	9.9		
	Safer Staffing CHPPD – 5 South	Sep-21	5	9.6	11.3	10.4		
	Safer Staffing CHPPD – 4 NW (Cardiology)	Sep-21	5	9.4	9.0	9.0		
	Safer Staffing CHPPD – 4 South (Respiratory)	Sep-21	5	6.7	8.2	8.6		
	Safer Staffing CHPPD – 3 North	Sep-21	5	8.6	9.7	10.7		
	Safer Staffing CHPPD – 3 South	Sep-21	5	8	7.9	8.3		
	Safer Staffing CHPPD – Day Ward	Sep-21	5	4.5	6.0	6.0		
	Safer Staffing CHPPD – Critical Care	Sep-21	5	32.9	34.8	34.8		
Effective	Bed Occupancy (excluding CCA and sleep lab)	Sep-21	4	85% (Green 80%-90%)	70.30%	71.20%		
	CCA bed occupancy	Sep-21	4	85% (Green 80%-90%)	91.50%	91.00%		
	Admitted Patient Care (elective and non-elective)	Sep-21	4	1851 (current mnth)	2305	12599		
	Outpatient attendances	Sep-21	4	7151 (current mnth)	8421	49218		
	Cardiac surgery mortality (Crude)	Sep-21	3	3%	2.99%	2.99%		
	Theatre Utilisation	Sep-21	3	85%	62.8%	76.8%		
	Cath Lab Utilisation 1-6 at New Papworth (including 15 min Turn Around Times)	Sep-21	3	85%	80.0%	82.5%		
Responsive	% diagnostics waiting less than 6 weeks	Sep-21	3	99%	96.03%	91.22%		
	18 weeks RTT (combined)	Sep-21	5	92%	86.13%	86.13%		
	Number of patients on waiting list	Sep-21	5	3279	3683	3683		
	52 week RTT breaches	Sep-21	5	0	9	62		
	62 days cancer waits post re-allocation (new 38 day IPT rules from Jul18)*	Sep-21	4	85%	66.70%	50.00%		
	31 days cancer waits*	Sep-21	4	96%	96.20%	96.20%		
	104 days cancer wait breaches*	Sep-21	4	0%	5	19		
	Theatre cancellations in month	Sep-21	3	30	47	33		
	% of IHU surgery performed < 7 days of medically fit for surgery	Sep-21	4	95%	69.00%	74.33%		
	Acute Coronary Syndrome 3 day transfer %	Sep-21	4	90%	100.00%	100.00%		

		Month reported on	Data Quality	Plan	Current month score	YTD Actual	Forecast YE	Trend
Caring	FFT score- Inpatients	Sep-21	4	95%	99.20%	99.23%		
	FFT score - Outpatients	Sep-21	4	95%	97.20%	98.65%		
	Number of written complaints per 1000 WTE (Rolling 3 mnth average)	Sep-21	4	12.6	3.4			
	Mixed sex accommodation breaches	Sep-21	4	0	0	0		
	% of complaints responded to within agreed timescales	Sep-21	4	100%	100.00%	100.00%		
People Management & Culture	Voluntary Turnover %	Sep-21	3	12.0%	19.0%	17.0%		
	Vacancy rate as % of budget	Sep-21	4	5.0%	7.6%			
	% of staff with a current IPR	Sep-21	3	90%	73.24%			
	% Medical Appraisals	Sep-21	3	90%	53.91%			
	Mandatory training %	Sep-21	3	90%	86.83%	87.53%		
	% sickness absence	Sep-21	3	3.50%	4.28%	3.87%		
Finance	Year to date surplus/(deficit) exc land sale £000s	Sep-21	5	£2,188k	£2,238k			
	Cash Position at month end £000s	Sep-21	5	£47,613k	£60,142k			
	Capital Expenditure YTD £000s	Sep-21	5	£385k	£218k			
	In month Clinical Income £000s	Sep-21	5	£18003k	£18,543k	£107,131k		
	CIP – actual achievement YTD - £000s	Sep-21	4	£0k	£2,660k	£2,660k		
	CIP – Target identified YTD £000s	Sep-21	4	£5,390k	£5,390k	£5,390k		

* Latest month of 62 day and 31 cancer wait metric is still being validated

At a glance – Externally reported / regulatory standards

1. NHS Improvement Compliance Framework

NHSI Targets	Measure	Data Quality	NHSI Target	Month	YTD	Previous full quarter	Forecast	Comments
C. Difficile	Monitoring C.Diff (toxin positive)	5	10	1	9	5		
RTT Waiting Times	% Within 18w ks - Incomplete Pathw ays	5	92%	86.13%		83.43%		Monthly measure
Cancer	31 Day Wait for 1st Treatment	4	96%	96.20%	96.20%	100.0%		Current month provisional as going through verification process.
	31 Day Wait for 2nd or Subsequent Treatment - surgery	4	94%	96.20%	99.37%	100.0%		Current month provisional as going through verification process.
	62 Day Wait for 1st Treatment	4	85%	66.70%	66.70%	72.40%		Current month provisional as going through verification process. Data is after reallocations
	104 days cancer w ait breaches	4	0	5	19	10		
VTE	Number of patients assessed for VTE on admission	5	95%	85.20%		92.0%		
Finance	Use of resources rating	5	3	n/a	n/a	n/a	3	Unable to evaluate the UoR rating due to temporary suspension of operational planning.

2. 2021/22 CQUIN*

	Scheme	Total Available 21/22 *		Achievement						Comments	RAG status
				Q1	Q2	Q3	Q4	2021/22			
		£000s	%	£000s	£000s	£000s	£000s	£000s	%		
NHSE	Scheme 1	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc		tbc
	Scheme 2	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc		tbc
	Scheme 3	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc		tbc
	Scheme 4	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc		tbc
	NHSE	**tbc**	**tbc**	**tbc**	**tbc**	**tbc**	**tbc**	**tbc**	**tbc**		
C&P CCG (& Associates)	Scheme 1	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc		tbc
	Scheme 2	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc		tbc
	Scheme 3	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc		tbc
	Scheme 4	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc		tbc
	Scheme 5	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc		tbc
	C&P CCG (& Associates)	**tbc**	**tbc**	**tbc**	**tbc**	**tbc**	**tbc**	**tbc**	**tbc**		
Trust Total		**tbc**	**tbc**	**tbc**	**tbc**	**tbc**	**tbc**	**tbc**	**tbc**		

* CQUIN has been suspended nationally for 2021/22

Board Assurance Framework risks (above risk appetite)

PIPR Category	Title	Ref	Mgmt Contact	Risk Appetite	BAF with Datix action plan	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Status since last month
Safe	Failure to protect patient from harm from hospital aquired infections	675	MS	5	In progress	10	10	10	10	15	8	↓
Safe	Waiting list management	678	EM	12	In progress	16	16	16	16	16	16	↔
Safe	Potential for cyber breach and data loss	1021	AR	3	In progress	16	16	16	16	16	16	↔
Safe	Risk of maintaining safe and secure environment across the organisation	2833	TG	6	In progress	12	12	16	16	16	16	↔
Safe	Risk to Trust reputation due to PFI contract performance NEW	2839	TG	TBC	In progress	12	12	12	16	16	16	↔
Safe	Key Supplier Risk NEW	2985	TG	8	In progress	-	-	-	-	20	20	↔
Safe	Continuity of supply of consumable or services failure	3009	TG	6	In progress	-	-	-	-	15	15	↔
Safe + Effective + Finance + PM&C.	Failure to meet safer staffing (NICE guidance and NQB)	742	MS	6	In progress	12	12	12	12	12	12	↔
Safe + Effective + Responsive	Clinical Research Facility Core Grant Funding	3008	TG	9	In progress	-	-	-	-	12	12	↔
Safe + Effective + Responsive + People Manag. & Cult + Finance	Delivery of Trust 5 year strategy	2901	EM	4	In progress	9	9	9	9	9	9	↔
Safe + Finance	Staff turnover in excess of our target level	1853	OM	8	In progress	15	10	15	15	15	15	↔
Safe + Finance	Unable to recruit number of staff with the required skills/experience	1854	OM	8	In progress	10	10	10	10	10	10	↔
Safe + Finance	Low levels of Staff Engagement	1929	OM	4	In progress	16	12	12	12	12	12	↔
Safe + Responsive + People Manag. & Cult + Finance	M.Abscessus NEW	3040	MS	10	In progress	-	-	-	-	-	15	↑
Effective	Achieving financial balance at ICS level	2904	TG	12	In progress	16	16	20	20	20	20	↔
Transformation	Achieving financial balance	2829	TG	8	In progress	16	16	16	16	16	16	↔

Safe: Performance summary

Accountable Executive: *Chief Nurse* ***Report Author:*** *Deputy Chief Nurse / Assistant Director of Quality and Risk*

		Data Quality	Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Dashboard KPIs	Never Events	4	0	0	1	0	0	0	0
	Moderate harm incidents and above as % of total PSIs reported	4	<3%	1.69%	1.50%	1.70%	1.18%	0.89%	0.30%
	Number of Papworth acquired PU (grade 2 and above)	4	<4	1	2	0	2	2	3
	High impact interventions	3	97.0%	98.0%	97.5%	99.1%	98.4%	98.8%	99.3%
	Falls per 1000 bed days	4	<4	0.1	0.3	1.9	2.9	2.0	3.8
	Sepsis - % patients screened and treated (Quarterly)	New	90.0%	-	-	84.00%	-	-	Await data
	Safer Staffing CHPPD – 5 North *	5	>9.6	9.20	10.40	9.60	9.50	10.30	10.40
	Safer Staffing CHPPD – 5 South *	5	>9.6	12.90	9.50	9.20	9.70	9.80	11.30
	Safer Staffing CHPPD – 4 NW (Cardiology) *	5	>9.4						9.00
	Safer Staffing CHPPD – 4 South (Respiratory) *	5	>6.7	8.90	9.70	7.90	7.60	9.50	8.20
	Safer Staffing CHPPD – 3 North *	5	>8.6	11.40	11.10	10.30	10.50	11.30	9.70
	Safer Staffing CHPPD – 3 South*	5	>8	8.60	9.00	8.40	8.40	7.70	7.90
	Safer Staffing CHPPD – Day Ward *	5	>4.5	11.78	10.68	9.04	5.63	5.60	6.03
	Safer Staffing CHPPD – Critical Care *	5	>32.9	36.50	34.70	32.70	33.70	36.50	34.80
Additional KPIs	Safer staffing – registered staff day Safer staffing – registered staff night	3	90-100%	81.7% 87.2%	83.8% 90.9%	86.9% 91.7%	82.2% 91.8%	89.1% 92.4%	90.0% 92.8%
	MRSA bacteremia	3	0	0	0	0	0	0	0
	Number of serious incidents reported to commissioners in month	4	0	2	2	2	1	0	0
	E coli bacteraemia	5	Monitor only	1	1	1	1	2	1
	Klebsiella bacteraemia	5	Monitor only	3	1	2	3	1	0
	Pseudomonas bacteraemia	5	Monitor only	0	1	0	1	1	0
	Other bacteraemia	4	Monitor only	1	0	1	3	0	1
	Other nosocomial infections	4	Monitor only	0	0	0	0	0	0
	Point of use (POU) filters (M.Abscessus)	4	Monitor only	95%	94%	96%	91%	96%	95%
	Moderate harm and above incidents reported in month (including SIs)	4	Monitor only	4	4	4	2	2	1
	Monitoring C.Diff (toxin positive)	5	Ceiling pa of 10	1	2	2	2	1	1

* Note - CHPPD targets have been updated from September 21 based on the latest establishment review

Summary of Performance and Key Messages:

CQC Model Hospital rating for 'Safe' is Outstanding dated Sep 2021 (accessed 16.10.2021).

Pressure ulcers: there were three Papworth acquired pressure ulcers during Sep 2021. They have been reviewed by the Nurse Consultant for Tissue Viability. One is a deep tissue injury (WEB40793); and two are category 2 ulcers (WEB40764, WEB40694).

Sepsis: the Sepsis data for Q2 is being validated at the time of writing this report (18.10.2021).

Safe Staffing: RN fill rate for Sep 2021 is an improved position from the previous month with days green 90.0% and nights green 92.8%. The CHPPD thresholds ("targets column") have been updated from Sep 2021 based on the latest establishment review. All CHPPD areas are green with the exception of 4NW who are just under their green threshold, and 3 South (also just under their green threshold). 4NW has been added to PIPR to reflect the substantive position following the establishment reviews. Also, further to the recent establishment reviews, progress is being made with updating the roster templates and to date, updates have been made to 5N, 5S and Critical Care.

Number of Serious Incidents: During Sep 2021 there were 0 SI's reported to the CCG.

Nosocomial COVID-19: There have been no hospital acquired COVID-19 infections since 17.04.2020.

Point of Use (POU) filters (M.Abscessus): For Sep 2021, compliance was 95%. The drops in compliance this month have been with "% IPC Admission assessment completed" across some of the wards. Where there are gaps in compliance, each occasion is followed up by the IPC Team to help with education and sustaining compliance.

C.Diff: there was one case of C.difficile in Sep 2021 (10.09.2021, Critical Care). The scrutiny panel was held on 12.10.2021 and there were no themes or specific lessons from the panel to report. The clinical team were praised for a good RCA and care of a very sick patient.
The NHS published Standard Contract 2021/22 "Minimising Clostridioides difficile and Gram-negative Bloodstream Infections" in June 2021 and further to this, the ceiling objective figures for 2021-22 at RPH have been set at 10 (this is an update to earlier PIPR reports). This was confirmed at the RPH IPC Committee 07.10.2021. All C.difficile cases are now be counted against our trajectory. Running total for 2021/22 = 9. There is no correlation with any of the C.difficile types reported at RPH. There is further information on the next slide. RCAs and internal scrutiny panels are held for every case of C.difficile, so that the Trust is assured that lessons will be learnt and patient safety maintained.

Safe: Key performance challenges

Escalated performance challenges:

Pressure Ulcers

While there are no concerns about an increase in prevalence, because Royal Papworth Hospital (RPH) acquired pressure ulcers is amber for September, there is further detail included in this section.

During September, there have been three RPH acquired sacral area pressure ulcers at grade 2: 12.09.2021 (WEB40694, CCA); 19.09.2021 (WEB40764, 3 South); and 20.09.2021 (WEB40793, 5 South). The Nurse Consultant for Tissue Viability is reviewing each patient event. There will also be follow up as required through the Pressure Ulcer Scrutiny Panel which is Chaired by the Nurse Consultant for Tissue Viability and attended by the clinical teams from the respective areas.

Clostridioides / Clostridium difficile (C.difficile)

As noted on the first slide of PIPR Safe, the C.difficile ceiling objective figures for 2021-22 at RPH have been set at 10 (this is an update to earlier PIPR reports). The running total for 2021/22 = 9. This PIPR therefore provides a summary position of numbers and locations so far this reporting year, as indicated in the below table.

C.difficile numbers by month and location					
Apr 2021	May	Jun	Jul	Aug	Sep
1	2	2	2	1	1
5NW	CCA, 5NE	4SW, CCA	4SW, CCA	3NE	CCA

There is no correlation with any of the C.difficile types reported at RPH. RCAs and internal scrutiny panels are held for every case of C.difficile, so that the Trust is assured that lessons will be learnt and patient safety maintained. As also reported in PIPR M04, it is noted by the Infection Prevention and Control Team and community partners that there is increased prevalence in the community, which may correlate to increased prevalence in hospitals. This will continue to be closely monitored.

Key Actions and ongoing learning:

- Trust wide prevalence audits occur twice per year (led by the Nurse Consultant for Tissue Viability/Wound Care).
- Ongoing education and training, including outreaching to the clinical areas, by the Trust Tissue Viability/Wound Care team.
- Ongoing investment in pressure offloading equipment for patients (new dynamic mattress systems and heel pressure offloading devices), has been very effective.
- Maintaining pressure ulcer scrutiny panels and sharing lessons learned from these panels.
- During Sep 2021, a new pressure ulcer care bundle has also been introduced onto Lorenzo, which has been updated after lessons learned and feedback from staff.

- All cases are investigated by the ward team using an RCA template and supported by the Infection Prevention and Control (IPC) Team;
- Scrutiny panels are held for every case of C.Diff, chaired by the Chief Nurse or Deputy Chief Nurse and attended by a member of the CCG Infection Prevention and Control Team;
- Prevalence is monitored by the IPC Team;
- Assurance and ongoing monitoring is led by the IPC Committee ;
- There is a Clostridioides Difficile Procedure in place (DN226);
- Enhanced cleaning.

Safe: Spotlight On – Care Hours Per Patient Day (CHPPD)

The recent establishment reviews for nurse staffing, have led to appropriate updates in Care Hours Per Patient Day (CHPPD) thresholds for each of the wards and departments. This months PIPR therefore provides a Spotlight On this particular measure. Recording CHPPD provides a single consistent way of recording and reporting deployment of staff working on inpatient wards/units. It is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by number of in-patients per 24 hours (Carter, 2016). In accordance with the national NHS guidelines, the 'in patient admissions' are taken from the 23:59 ('midnight') bed occupancy. Method of calculation of CHPPD (Carter, 2016, p.21):

$$\text{Care Hours Per Patient Day} = \frac{\text{Hours of registered nurses} + \text{Hours of healthcare support workers}}{\text{Total number of inpatients}}$$

We monitor CHPPD in two different ways: 1. operationally through three x daily census periods (early, late, night) using the NICE endorsed HealthRoster SafeCare-Live system; and 2. the mandated daily 23:59 bed count position which is reported monthly via NHS Digital. As a guide, Carter (2016) observed significant variation in CHPPD from 6.3 to 15.48 although Lord Carter cautioned that we should be mindful of comparing different types of wards and trusts. Also, there is no national standard at this stage to indicate what CHPPD is expected or seen as 'best practice'; however Model Hospital (in their People, Working Differently module) now provides Organisation Level CHPPD data for benchmarking.
The latest position (accessed 18.10.2021) shows:

Care Hours Per Patient Day	Data period	Trust value	Peer median	National median
Care Hours per Patient Day - Total Nursing, Midwifery and AHP staff	Jul 2021	13.5	13.1	8.7
Care Hours per Patient Day - Total Nursing and Midwifery staff	Jul 2021	13.5	13.1	13.1
Care Hours per Patient Day - Registered Nurses and Midwives	Jul 2021	9.9	8.7	5.1

We will continue to monitor this closely as an organisation and SafeCare (HealthRoster) helps us with this. The National Quality Board and CQC advise using a triangulated approach, so that decisions about staffing and skill mix are not made on just one measure (such as just ratios or just CHPPD); therefore it is best practice that a group of measures are used.

At RPH, other measures in place are:

- HealthRoster template fill rate (shown as "safer staffing" measure on PIPR)
- Registered / unregistered nurse to patient ratios
- % Utilisation (an effectiveness measure which is part of the SafeCare-Live module)
- Use of professional judgement
- Monitoring of nurse sensitive indicators (prevalence of pressure ulcers, falls, other patient safety incidents, complaints, PALS concerns)

RPH ongoing monitoring of CHPPD: From Jan 2020 onwards, the Matrons have undertaken a monthly peer audit of each others areas, in partnership with the ward team, to look at the acuity and dependency score allocated for each patient; then check to see if the assessment would be the same in their professional opinion. This is undertaken for every patient. This is to help validate the acuity and dependency scoring; help benchmarking and learning with peers; and assure that there is no under or over assessment as this has an impact on the SafeCare-Live rating and % Utilisation. This is reported via the Safe Staffing eRoster Effectiveness Report, which is reported monthly at CPAC. This report also includes the Data Range table (which has been shared through PIPR before) which looks at "% Utilisation", "required and actual CHPPD" and "staff to patient ratios", thus supporting the triangulated approach.

The table below shows ward areas with the new CHPPD post establishment review and their previous PIPR threshold. It is best practice (as in this case) that this data evolves with staffing establishment reviews and as such, this will be closely monitored.

Clinical Area	CHPPD Post establishment review	PIPR (up to Aug 2021)
5N and 5S	9.6	>7.8
4NW (Cardiology)	9.4	n/a. Added from Sep 2021 data onwards
4S (Respiratory) (Formerly 4North/South on PIPR)	6.7	>7.8
3N	8.6	>7.8
3S	8.0	>7.8
Critical Care	No change (see note 1)	>32.9
Day Ward	4.5	>6

Note 1: The Critical Care CHPPD has been left unadjusted in PIPR. Their CHPPD shows as 41 in the establishment review template because it includes the Duty Sister and Transfer Team, however these are not included in operational monitoring of CHPPD as they are supernumerary. Looking at the SafeCare data ranges from June data to Sep data (with the new CCA template), the average required for CCA was 31.65; and the average actual was 32.41; the average from the NHS Digital upload is 34.3 CHPPD. It has therefore been decided to leave CCA as >32.9 on PIPR and continue to monitor for the rest of the reporting year.

Caring: Performance summary

Accountable Executive: *Chief Nurse* ***Report Author:*** *Deputy Chief Nurse / Assistant Director of Quality and Risk*

		Data Quality	Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Dashboard KPIs	FFT score- Inpatients	4	95%	99.1%	99.3%	99.4%	99.3%	99.1%	99.2%
	FFT score - Outpatients	4	95%	99.6%	99.1%	98.8%	98.5%	98.7%	97.2%
	Mixed sex accommodation breaches	4	0	0	0	0	0	0	0
	Number of written complaints per 1000 WTE (Rolling 3 mnth average)	4	12.6	2.4	2.9	7.4	7.4	5.9	3.4
	% of complaints responded to within agreed timescales	4	100%	100%	100%	100%	100%	100%	100%
Additional KPIs	Number of complaints upheld / part upheld	4	3 (60% of complaints received)	2	1	0	3	2	1
	Number of complaints (12 month rolling average)	4	5 and below	2.8	1.8	2.2	2.3	3.3	3.2
	Number of complaints	4	5	1	5	9	1	2	4
	Number of recorded compliments	4	500	2337	1539	1361	1320	1251	1501
	Supportive and Palliative Care Team – number of referrals (quarterly)	4	0	-	-	81	-	-	95
	Supportive and Palliative Care Team – reason for referral (last days of life) (quarterly)	4	0	-	-	4	-	-	7
	Supportive and Palliative Care Team – number of contacts generated (quarterly)	4	Monitor only	-	-	952	-	-	997
	Bereavement Follow-Up Service: Number of follow-up letters sent out (quarterly)	3	Monitor only	-	-	35	-	-	39
	Bereavement Follow-Up Service: Number of follow-ups requested (quarterly)	3	Monitor only	-	-	10	-	-	9

Summary of Performance and Key Messages:

CQC Model Hospital rating for 'Caring' is Outstanding dated Sep 2021 (accessed 16.10.2021).

FFT (Friends and Family Test): In summary; **Inpatients**: Positive Experience rate was 99.2% (Sep). Participation Rate has increased from 39.5% (Aug) to 40% (Sep). **Outpatients**: Positive Experience rate was 97.2% (Sep). Outpatient Participation rate has increased from 12.7% (Aug) to 13.3% (Sep).
As a benchmark guide, NHS England FFT positive experience rate Inpatients = 94% (August 2021); positive experience rate Outpatients = 93% (August 2021). Participation rate is not reported nationally.

Number of written complaints per 1000 staff WTE is a benchmark figure based on the NHS Model Hospital to enable national benchmarking. We remain in green at 3.4. The latest data from Model Hospital demonstrates we are in the lowest quartile for national comparison (note the Model Hospital data period remains Dec 2019; accessed 18.10.2021): Royal Papworth = 9.02, peer group = 11.23, national = 21.11.

% of complaints responded to: The Trust continues to respond to 100% of complaints within the agreed timescales.

The number of complaints (12 month rolling average): this has remained in green for September 2021 at 3.2. We will continue to monitor this in line with the other benchmarking.

Complaints: We have received four new complaints for Sep 2021; 1 for Thoracic Services, 1 for Cardiology, 1 for Surgical Services and 1 for Supportive and Palliative Care. This is an increase in the number of complaints we have received in comparison to last month (2 in Aug 2021) but comparable to our yearly figures for the number of the complaints received. The investigations for these complaints are in progress. We have closed two complaints during Sep 2021, details of which are on the next slide.

Compliments: the number of formally logged compliments received during August 2021 was 1501 in total (135 via post/ email/ thank you cards; 1366 from FFT surveys).

Supportive and Palliative Care Team (SPCT): During Q2 2021/22 there were 95 referrals to the SPCT. This generated 997 contacts. Of the 95 referrals, seven were for last days of life. The Spotlight On slide (p.12) provides more detail.

Bereavement Follow Up Service: During Q2 2021/22 (Jul to Sep) the service sent out 39 letters and they had nine follow up enquiries.

Caring: Key performance challenges

Formal Complaints

- Our complaint numbers remain low at RPH as indicated on the first slide of PIPR Caring.
- We continue to learn from complaints raised. This slide looks at a summary of the most recently closed complaints. We have closed two complaints in September 2021.
- Of these, 1 was not upheld and 1 was upheld. These complaints were closed within the designated timeframe which had been agreed with the complainant, one had been extended beyond 60 working days due to extenuating circumstances which had been discussed with the patient and one within 25 working days.
- A summary of the two recent closed complaints is in the box below.
- Progress with these actions will be monitored through QRMG on a monthly basis.

Learning from earlier Complaints

Complaint reference/Datix Q22122-21F/ 14415 – Date closed 23 Sep 2021 – Not Upheld
The complaint was from a Cardiology patient regarding an injury sustained during intubation for her procedure. The complaint was investigated by the Anaesthetic Department and it was not upheld because the injury was a result of a known complication, the potential of which was discussed with the patient during pre-assessment appointment. However, learning from the complaint was identified: highlight and reiterate to the Anaesthetic Department the importance of good communication regarding potential complications following the induction of anaesthesia; any potential complications needing to be discussed with the patient at pre- admission; and reminders given on the procedure day.

Complaint reference/Datix Q42021-53F/ 14397 – Date closed 29 Sep 2021 – Upheld
The complaint related to a patient experience with a member of staff during an overnight sleep study. The complaint was investigated by the Thoracic Matron with support from the workforce team. The complaint was upheld and a number of actions were identified to improve patient information regarding the unit including a patient information leaflet, posters and a video, the use of Chaperones and improving nursing documentation.

Complaints:
Key actions and how we share our learning:

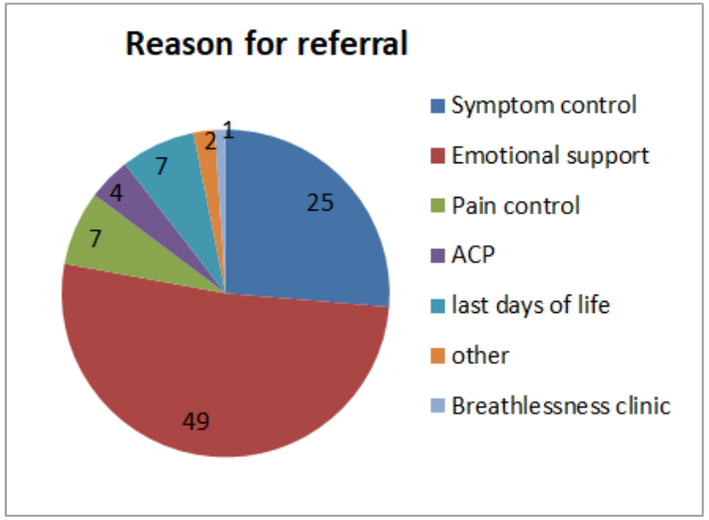
- All complaints are subject to a full investigation. Individual investigations and responses are prepared. Actions are identified.
- Complaints and lessons learned shared at Business Unit and Clinical Division meetings and Trust wide through the Quality and Risk Management Group (QRMG reports and/or patient stories.
- Continued monitoring of further complaints and patient and public feedback.
- Staff, Sisters/Charge Nurses and Matrons proactively respond to and address concerns when raised. This helps to ensure that concerns are heard and where possible handled in a positive way, often avoiding the need for a formal complaint. An apology is given where necessary.
- From live feedback, feedback from complaints and/or lessons learned, changes are made to improve the experience for patients going forward.
- Where applicable, You Said We Did feedback is displayed in boards in each ward / department for patients and other staff and visitors to see.

Caring: Spotlight On – Supportive and Palliative Care Team

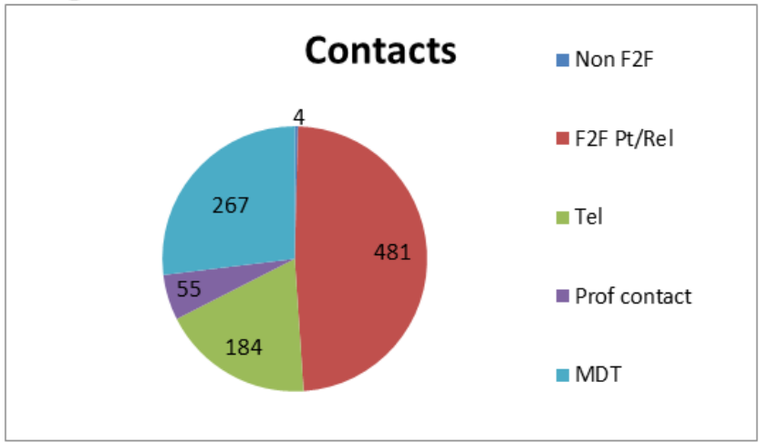
Supportive and Palliative Care Team (SPCT) Dashboard
Every quarter, the SPCT produce a Dashboard. An extract is always included in PIPR (p.10) and it is discussed in the End of Life Steering Group. This PIPR, in line with the quarterly reporting will share some more information from the Q2 2021/22 (July to September) Dashboard.

This pie chart shows that during Q2, the number one reason for referral was emotional support (n=49), followed by symptom control (n=25), then pain control (n=7) and last days of life (n=7).

No. referrals Jul to Sep = 95
30 urgent referrals received, 100% seen within 24 hours
95% of all referrals seen within 24 hours *(N = 80/84) (NA=11)*



This generated 997 contacts: *(N=952 Apr-Jun)*



This pie chart shows a breakdown by type of the 997 contacts, which is an increase of the previous month (952). The highest contact type was face to face (F2F).

Outcomes

Discharged N = 45	Deceased N = 22	Ongoing (as at 4.10.21) N = 28

The small table below the pie chart shows the outcomes for Q2.

It is helpful to see some of the compliments sent into the SPCT from this Q2 Dashboard (which helps to visualise some of the work the team undertake):

- A patient and his family shared how “grateful and how appreciative of all that care and support that they have received whilst he has been on the ward”.
- Patient comment from a clinical note: “[the patient says he] has recently really valued the support from the Supportive and Palliative Care Team”.
- Email from a RPH Consultant: [SPCT staff] were amazing over the weekend, along with [SPCT staff] today. [Doctor] has been readily available for advice and guidance throughout which has helped. Delighted to have such amazing support from the SPC team for our patients, makes a massive difference.
- A thank you card from a patient and his wife: “You have been such a big part of the recovery process sand helping with all our worries”.

Effective: Performance summary

Accountable Executive: *Chief Operating Officer* ***Report Author:*** *Chief Operating Officer*

		Data Quality	Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Dashboard KPIs	Bed Occupancy (excluding CCA and sleep lab)	4	85% (Green 80%90%)	72.6%	70.2%	73.7%	71.2%	69.2%	70.3%
	CCA bed occupancy	4	85% (Green 80%90%)	88.6%	89.7%	96.1%	93.3%	86.8%	91.5%
	Admitted Patient Care (elective and non-elective)	4	1851 (current mnth)	2011	1928	2215	2100	2040	2305
	Outpatient attendances	4	7151 (current mnth)	8099	8133	8958	8243	7364	8421
	Cardiac surgery mortality (Crude)*	3	<3%	2.83%	2.80%	2.90%	2.76%	2.84%	2.99%
	Theatre Utilisation	3	85%	89.3%	95.2%	74.4%	75.7%	63.7%	62.8%
	Cath Lab Utilisation 1-6 at New Papworth (including 15 min Turn Around Times)	3	85%	88%	85%	88%	81%	73%	80%
Additional KPIs	Length of stay – Cardiac Elective – CABG (days)	4	8.20	9.43	8.32	8.24	9.33	7.20	8.33
	Length of stay – Cardiac Elective – valves (days)	4	9.70	8.09	8.04	10.14	11.24	11.64	9.65
	CCA length of stay (LOS) (hours) - mean	4	Monitor only	131	84	96	94	100	120
	CCA LOS (hours) - median	4	Monitor only	42	30	37	42	33	25
	Length of Stay – combined (excl. Day cases) days	4	Monitor only	5.86	5.55	5.81	5.44	6.11	5.59
	% Day cases	4	Monitor only	63.8%	64.4%	65.5%	61.6%	65.1%	63.5%
	Same Day Admissions – Cardiac (eligible patients)	4	50%	36.8%	44.2%	39.5%	33.3%	38.0%	17.9%
	Same Day Admissions - Thoracic (eligible patients)	4	40%	12.4%	13.5%	7.7%	20.5%	14.6%	16.7%

* Note - Cardiac Surgery Mortality latest month is a provisional figure based on discharge data available at the time of reporting

Summary of Performance and Key Messages:

Inpatient Capacity Utilisation
High levels of staff absence, primarily due to sickness and the need to self isolate following household contact with COVID-19, persisted throughout September. This reduced bed occupancy against the funded number of general and acute and critical care beds.

Critical Care capacity remained the key constraint to flow, due to high levels of COVID and ECMO demand, delayed repatriations to other providers and staff absence and as a consequence utilisation of theatre and cath lab sessions was sub-optimal. Admitted patient care levels recovered in the later part of the month despite these constraints which reflects the commitment of staff to make the best use of the capacity available. Day case activity remains strong, both in Cardiology and Respiratory Medicine, and this has supported the overall number of elective cases treated resulting the in month plan being exceeded.

Length of Stay
Length of stay for elective valve surgery has returned to normal levels. No specific action has been taken achieve this and it is considered that this movement is a feature of case mix.

Same Day Admission
Same day admissions, for both cardiac and thoracic patients, remains low due to the case selection of more acutely unwell patients who need more complex assessment and pre-surgery workup. This will also have contributed to a longer length of stay for these patients. The return of full pre-operative assessment clinics in the later part of August are expected to positively impact over the coming months.

Outpatient Performance
Outpatient throughput remains strong with the activity target exceeded again this month. This is most apparent in the level of follow-up patients seen which exceeded the 2019/2020 baseline activity both in months 5 and 6 as clinicians are working to catch-up on overdue follow-up consultations.
Virtual outpatient appointments continue where it is clinically appropriate to do so and the Trust is credited with one of the providers with the highest levels of virtual appointments in the region. The teams are working on mechanisms to capture Friends and Family feedback from virtual appointments as they have been well received by patients.

Effective: Key performance challenges: Activity Recovery

Background and Purpose:

The information in this report is intended to provide an over view of referral and activity numbers up to September 2021, against the following benchmarks;

- 2019/20 activity
- The NHSI/E targets as set out in the 2021/22 Planning Guidance released in March 2021 along with further guidance released in July 2021. A reminder of the targets by POD is set out below;

Targets by POD: % of 2019/20 activity	Apr	May	Jun	Jul-Sep
Inpatient elective and day case	70%	75%	80%	95%
Diagnostics	70%	75%	80%	95%
Outpatient	70%	75%	80%	95%

- Thresholds have been set nationally, measured against the value of total activity delivered in 2019/20. This report uses activity as a proxy for value.
- In early July 2021 NHSI/E released a change to the targets. The guidance release in March 20201 stated the target for the period Jul-Sep was 85% of 2019/20 value. This was changed to 95% in the latest guidance.
- Guidance on finance and contracting arrangements relating to the second half of the financial year was received on 30 Sep. This is being worked through but early indications are that the targets are likely to change to focus on RTT clock stops rather than total activity. Further details will be included in future reports.

Dashboard headlines

M6 activity performance in line with target

- **Referrals –** M6 GP referrals exceeded 2019/20 by 12%. C2C referrals exceeded the baseline year referrals for M6 by 7%.
- **Non-admitted activity –** both first and follow-up activity met the NHSI/E target for M6.
- **Radiology –** MRIs, CTs and Other Radiology exams met the M6 target.

M6 activity performance behind target

- **Admitted activity – E**lective inpatients and daycases did not meet the M6 NHSI/E target.

As the latest data only goes up to 3rd Oct it is too early in the month to show a projection for M7 activity.

Performance Summary:

Table 1: Trust Level summary

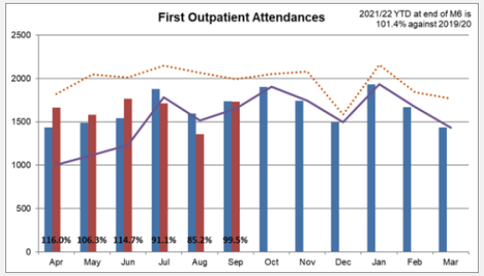
Category		M6 against 2019/20 M6 *
Referrals	GP	111.8%
	Cons-to-Cons	107.3%
Non-Admitted	First	99.5%
	Follow up	111.0%
Radiology	MRI	111.3%
	CT	120.6%
	Other	97.1%
Admitted Activity	Elective Inpatients	85.3%
	Daycases	87.8%
	Non-Elective Inpatients	125.0%

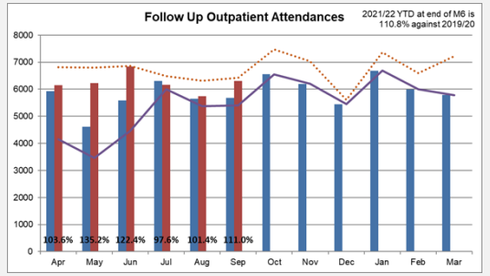
Table 2: M6 activity compared to 2019/20 (Specialty Level)

Specialty	EL	DC	NEL	OPFA	OPFU
Cardiac Surgery	64.9%	0.0%	100.0%	70.9%	87.4%
Cardiology	88.7%	97.4%	125.8%	85.7%	127.6%
RSSC	80.5%	112.5%	350.0%	153.5%	72.3%
Thoracic Medicine	88.5%	59.7%	177.8%	91.1%	138.9%
Thoracic Surgery	115.6%	33.3%	43.8%	116.7%	124.2%
Transplant/VAD	186.7%	#DIV/0!	176.9%	50.0%	87.8%
PTE	80.0%	#DIV/0!	#DIV/0!	145.5%	93.0%
Trust	85.3%	87.8%	125.0%	99.5%	111.0%

Key: Above NHSI/E Target; Within 5% of NHSI/E Target; Greater than 5% below NHSI/E Target

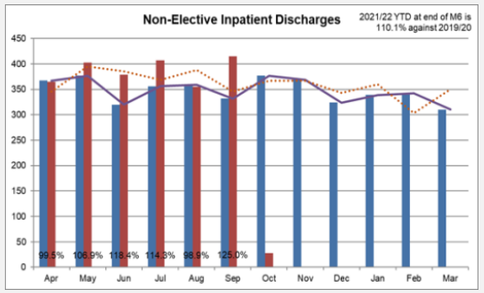
Non-admitted Activity

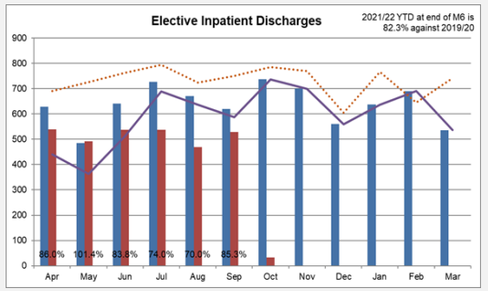


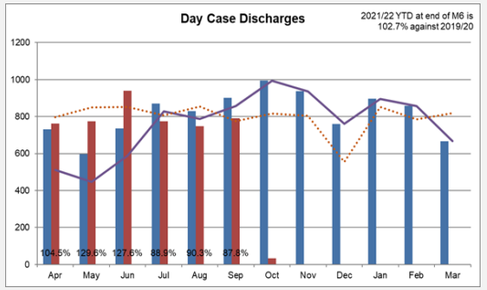


Key:

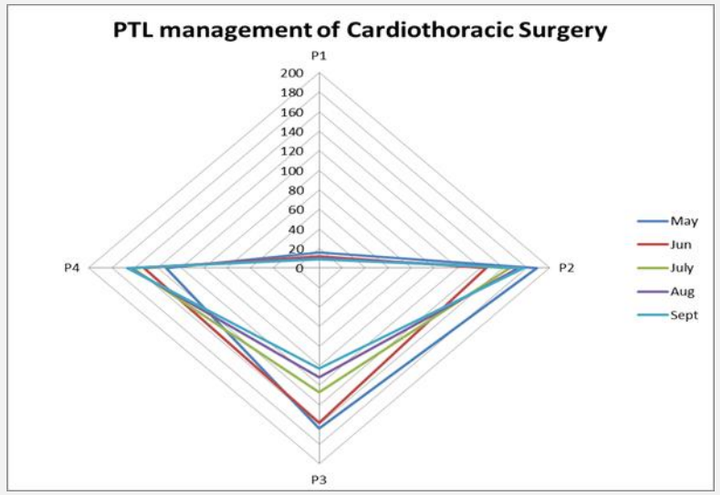
Admitted Activity

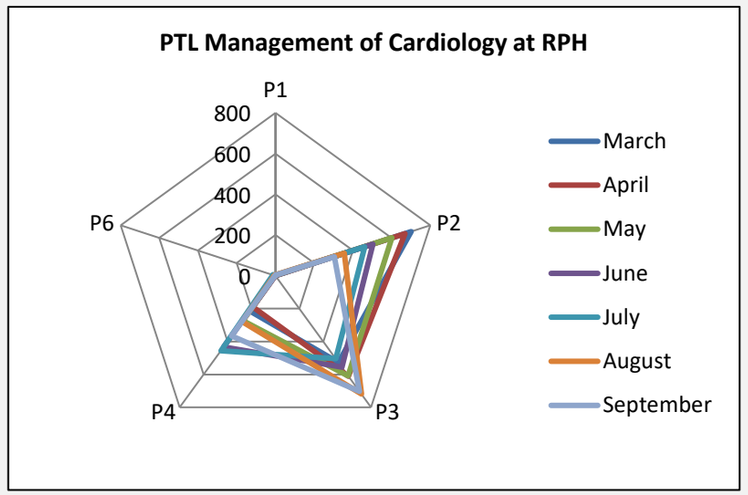


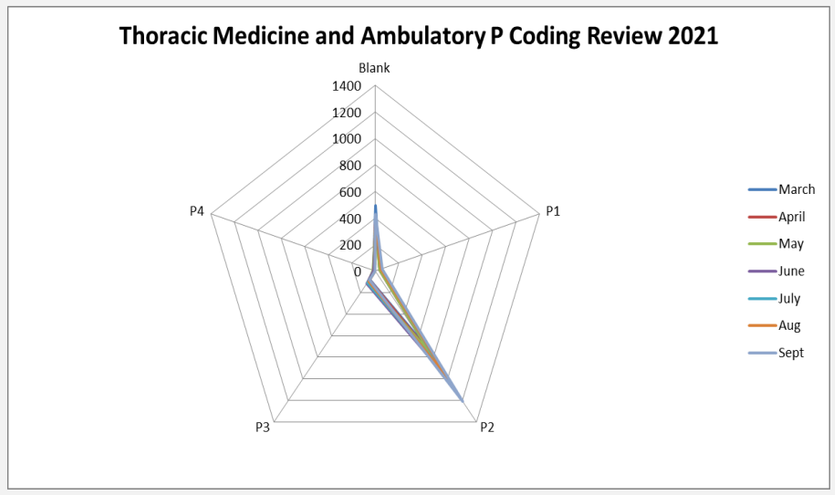




Effective: Spotlight on: Priority Status Management







Cardiothoracic Surgery

As part of the Patient Tracking List (PTL) process, each surgeon undertakes a harm review for each patient who is 35 weeks and over. There are 539 patients on the PTL in total and the current live actions are as follows:

- 109 patients - Planned or booked
- 200 patients – Awaiting action to book varying priority statuses
- 84 patients – Planned OPD / Diagnostic appointment
- 20 patients – Awaiting an OPD appointment
- 9 patients – Awaiting Transplant assessment

- There are currently 3 P6 patients on the PTL, which is the code used for patients that have chosen to delay their care due to COVID concerns.

Cardiology

The Cardiology PTL continues to be well maintained and the total PTL size remains consistent with a total of 1377 patients on open pathways.

Following the reduction of cath lab in activity in August (equivalent to 200hrs) the booking focus remains to be on treating patients in clinical priority, and there has been a slight decrease P2 patients which supports this. Additionally there has been a growth in P4 patients, whilst P3 patients remain in a steady state which is reflective of the booking priority.

The are only 2 patients who have opted to delay their treatment for COVID related reasons.

Respiratory Medicine

Thoracic and Ambulatory PTL activity has increased Av 12% month on Month. PTL for September totals 1353 patients with an open pathway.

We continue to triage a high volume at P2 due to the wait for diagnostics. Total waiting at P2 was 1209. We continue to provide a more accurate P code at point of first review.

We continue to see an increase in blank P codes due to the timing out of the codes between awaiting clinical decision and the ACD appointment being made. These patients will be reviewed again at their first appointment.

Responsive: Performance summary

Accountable Executive: *Chief Operating Officer* ***Report Author:*** *Chief Operating Officer*

		Data Quality	Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Dashboard KPIs	% diagnostics waiting less than 6 weeks	3	>99%	86.91%	87.09%	94.29%	92.21%	90.78%	96.03%
	18 weeks RTT (combined)	5	92%	80.00%	83.55%	86.73%	86.26%	86.95%	86.13%
	Number of patients on waiting list	5	3,279	3340	3422	3458	3429	3595	3683
	52 week RTT breaches	5	0	12	11	10	11	9	9
	62 days cancer waits post re-allocation (new 38 day IPT rules from Jul18)*	3	85%	75.0%	66.7%	78.6%	100.0%	38.5%	66.7%
	31 days cancer waits*	3	96%	100.0%	100.0%	100.0%	100.0%	100.0%	96.2%
	104 days cancer wait breaches*	3	0	2	4	4	1	3	5
	Theatre cancellations in month	3	30	18	13	26	46	50	47
	% of IHU surgery performed < 7 days of medically fit for surgery	4	95%	78.00%	47.00%	84.00%	86.00%	82.00%	69.00%
	Acute Coronary Syndrome 3 day transfer %	4	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Additional KPIs	18 weeks RTT (cardiology)	5	92%	76.45%	81.10%	85.83%	87.20%	88.40%	85.79%
	18 weeks RTT (Cardiac surgery)	5	92%	65.14%	64.38%	70.70%	71.88%	72.56%	70.91%
	18 weeks RTT (Respiratory)	5	92%	90.88%	93.85%	93.51%	90.45%	90.31%	90.53%
	Non RTT open pathway total	2	Monitor only	32,988	33,408	34,060	35,086	38,414	36,423
	Other urgent Cardiology transfer within 5 days %	4	90%	97.67%	100.00%	100.00%	100.00%	100.00%	100.00%
	% patients rebooked within 28 days of last minute cancellation	4	100%	85.71%	100.00%	100.00%	100.00%	92.59%	85.00%
	Outpatient DNA rate	4	9%	5.69%	5.72%	6.38%	7.34%	6.72%	8.20%
	Urgent operations cancelled for a second time	4	0	0	0	0	0	0	0
	% of IHU surgery performed < 10 days of medically fit for surgery	4	95%	93.00%	66.00%	89.00%	95.00%	87.00%	86.00%
	% of patients treated within the time frame of priority status	4	Monitor only	52.5%	55.0%	45.7%	46.5%	49.4%	48.8%
	% of patients on an open elective access plan that have gone by the suggested time frame of their priority status	4	Monitor only	37.9%	43.1%	38.9%	38.4%	41.5%	39.3%

* Note - latest month of 62 day and 31 cancer wait metric is still being validated

Summary of Performance and Key Messages:

Waiting list Performance

Respiratory: Steady progress is being made on the recovery for thoracic and Ambulatory, with some reduction over the summer months to allow for staff annual leave, with a view to reset during the month of September. The Division is focusing on scheduling follow up patients for face to face clinics where necessary and continue to provide virtual support to agreed criteria of patients.

Cardiology: There has been a decline in Cardiology performance in September ,as anticipated ,following the reduction of elective activity across all cath labs throughout August. This was in response to an increase in emergency demand, number of staffing challenges across radiology and supporting overall staff wellbeing by encouraging annual leave. As activity resumes the focus has been on prioritising patients in order of clinical urgency.

Surgery: Constraints on critical care capacity , due to staff absence and high levels of emergency demand, has severely impacted on the number of planned surgical cases treated. This has further reduced RTT performance . As with all specialities, all patients are being treated in order of clinical prioritisation.

52 week breaches

There has been one 52 week breach declared in Cardiology and one 52 week breach in Respiratory who have waited 244 weeks and 282 weeks respectively. Harm reviews and RCA reports have been undertaken and on investigation it has been found that these referrals became lost in the migration from the old IT system to Lorenzo.

Diagnostic Performance

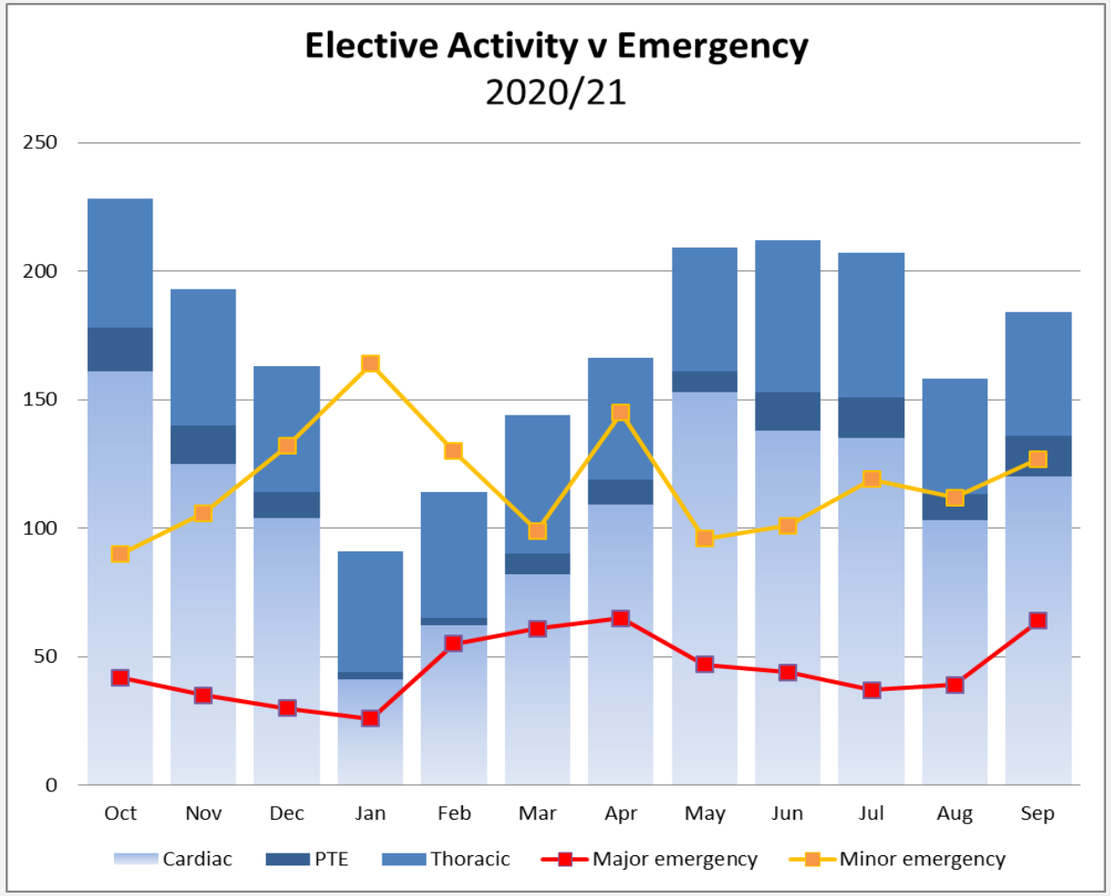
In spite of Radiographer staffing challenges, a strong recovery of diagnostic performance in September has been delivered. The team continue to support referrals from outside normal referral patterns from organisations where access to diagnostics are causing delays in patient pathways.

Cancer Performance

Cancer performance continues to be impacted by late referrals, complexity of cases and access to PET CT. There were 3 patients that breached their 62 day pathway prior to treatment and that was due to late referrals and patient choice to delay whilst considering their treatment options. 1 of these patients also breached their 31 day target due to needing to self-isolate due to being in contact with a COVID19 positive person whilst they considered their treatment options. There were 5 patients that breached 104 days: 1 was re-referred on 9th August (day 88) and was treated on 08/09 (day 119), 1 was referred on 24th Sept (day 99), 1 was referred on 30th Sept (day 107) and 2 were complex pathways on the non-62 day pathways one who as referred in May and the other in June. Harm reviews are being completed for all patients.

Responsive: Key Challenges: Theatre cancellations

Activity Profile:

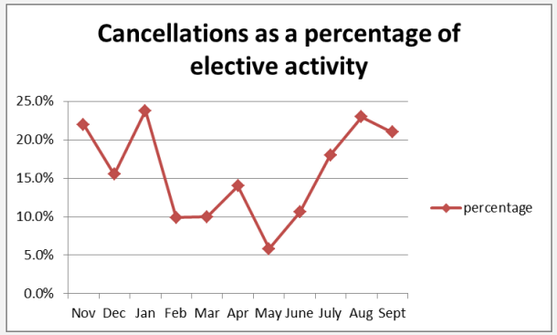


Activity Monthly Snapshot:

120 Cardiac / **48** Thoracic / **16** PTE / **42** IHU / **11** TX
64 emergency/urgent procedures went through theatres – combination of transplants, returns to theatre and emergency explorations.
127 additional emergency minor procedures also went through theatre and critical care, utilising the theatre team.

Cancellation reason	Sep-21	Total
1b Patient refused surgery	1	1
1c Patient unfit	1	24
2a All CCA beds full with CCA patients	6	17
2b No ward bed available to accept transfer from CCA	1	7
3a Critical Care	17	62
3b Theatre Staff	3	3
3c Consultant Surgeon	1	4
4a Emergency took time	6	23
4b Transplant took time	2	8
4d Additional urgent case added and took slot	2	12
5a Planned case overran	6	31
7e – Additional case – Thoracic	1	1
Total	**47**	**205**

Increase in Cardiac Activity in M6 to 120 elective cases, along with continued emergency activity, both major (64) and minor (127) cases. A marginal decrease in Elective cancellations in September with Critical Care staffing the main reason. This equated to 21% of elective activity that was cancelled.



Responsive: Spotlight on: Delays to Cancer Pathways

Spotlight on 62 day waits

CWT 2021/22 62 day waits	1. 62 day patients (Urgent GP Referral) IPT = 50/50			2. 62 day patients after re-allocations) IPT = v6			3. 62 day patients Consultant Upgrade IPT = 50/50			
	Target = 85%			Target = 85%			Target = 85%			
	Total treated	Breaches	%	Total treated	Breaches	%	Total treated	Breaches	%	Status
Apr-21	2.5	0.5	80.0%	4.0	1.0	75.0%	1.0	0.5	50.0%	
May-21	4.5	1.5	66.7%	5.5	2.0	63.6%	1.5	0.5	66.7%	
Jun-21	4.0	1.5	62.5%	7.0	1.5	78.6%	3.0	1.0	66.7%	
Q1	11.0	3.5	68.2%	16.5	4.5	72.7%	5.5	2.0	63.6%	
Jul-21	2.5	0.0	100.0%	2.5	0.0	100.0%	0.0	0.0	100.0%	
Aug-21	4.5	2.0	55.6%	6.5	4.0	38.5%	1.5	0.0	100.0%	
Sep-21	3.0	1.5	50.0%	3.0	1.0	66.7%	0.0	0.0	100.0%	
Q2	10.0	3.5	65.0%	12.0	5.0	58.3%	1.5	0.0	100.0%	

Sept performance (provisional):

- 62 day – 6 patients treated at RPH on the 62 day pathway with 3 breaches. 1 of these breaches will be attributed to the referring Trust and 2 will be a shared breaches. Expected compliance post re-allocation = 66.7%. There were no consultant upgrades

CWT 2021/22 31 day waits	4. 31 day patients first treatment only			5. Subsequent (all treatments)			6. Subsequent (surgery only)			
	Target = 96%			Target = 96%			Target = 96%			
	Total treated	Breaches	%	Total treated	Breaches	%	Total treated	Breaches	%	Comments
Apr-21	20	0	100.0%	3	0	100.0%	3	0	100.0%	
May-21	24	0	100.0%	5	0	100.0%	5	0	100.0%	
Jun-21	25	0	100.0%	2	0	100.0%	2	0	100.0%	
Q1	69	0	100.0%	10	0	100.0%	10	0	100.0%	
Jul-21	15	0	100.0%	4	0	100.0%	4	0	100.0%	
Aug-21	23	0	100.0%	3	0	100.0%	3	0	100.0%	
Sep-21	15	1	96.7%	0	0	100.0%	0	0	100.0%	
Q2	53	0.5	99.1%	7	0	100.0%	7	0	100.0%	

Sept performance (provisional):

- 31 day – 15 patients treated at RPH on the 31 day pathway with 1 breach which is shared breach with the referring Trust. 15 patients were all 1st treatments. Expected compliance = 96.7%.

Summary of timelines for breached patients

Patient 1 – shared breach

Day 29 – referral received
Day 31 – patient discussed in MDT as *Mesothelioma*
Day 36 – clinic appointment and patient requested one month to consider treatment options
Day 73 – clinic appointment and patient decided to go for Best Supportive Care as their treatment option and referred back to referring Trust

Patient 2 – breach attributed to referring Trust

Day 88 – referral back on upgrade pathway
Day 89 – patient discussed in MDT and planned for repeat EBUS due to inconclusive results from previous EBUS
Day 91 – clinic appointment with chest physician and due to patient's high levels of anxiety around having repeat EBUS it was agreed that this would be done under a general anaesthetic. Due to complexity of this case and procedure it was discussed at further planning meetings and scheduled when there was capacity to complete
Day 105 – EBUS performed under general anaesthetic
Day 112 – results discussed at MDT and in clinic appointment
Day 118 – patient underwent surgery as 1st treatment

Patient 3 – shared breach

Day 30 – referral received
Day 35 – patient discussed at MDT. Patient required MRI liver/adrenal and head at referring Trust
Day 36 – clinic appointment with chest physician and surgeon. Patient also needing to be seen by cardiology team
Day 42 – clinic appointment and patient agreed to surgery. Patient happy to switch surgeons due to availability within the team due to annual leave.
Day 58 – clinic appointment with new surgeon. Patient now self-isolating due to being in contact with a COVID + person
Day 64 – patient requested a further clinic appointment with surgeon to discuss treatment
Day 77 – clinic appointment with surgeon
Day 86 – patient underwent surgery as 1st treatment and was the 31 day breach as well

Learning on shortening pathways

Our cancer performance continues to be impacted by:

- late referrals from other Trusts
- complex pathways that may have added to the reason they are referred later in their pathway
- increasingly patients choosing to take additional time to consider their options for treatment
- PET CT delays at CUH

Once we have accepted the patients we work hard to expedite any further diagnostics required to ensure that they receive the diagnosis as soon as possible and have access to appropriate treatment quickly

We work hard to shorten these pathway by:

- liaising with referring Trusts to understand why the patients are delayed coming to us and if there is anything that we can do to assist them with this
- working with CUH to support them in the provision of PET CT scans and helping to identify patients that can be sent to other Cancer Alliance PET CT sites
- meeting regularly with the surgical team to book/expedite surgery dates for patients
- collaborative working through joint MDTs with other Trusts to ensure those being referred onwards from us to them for treatment are referred on quickly
- ensuring that the MDT have access to pathway training and support to be able to effectively track and manage all oncology patients

People, Management & Culture: Performance summary

Accountable Executive: *Director of Workforce and Organisational Development* ***Report Author:*** *HR Manager Workforce*

		Data Quality	Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Dashboard KPIs	Voluntary Turnover %	3	12.0%	17.98%	14.67%	14.08%	11.20%	24.13%	19.01%
	Vacancy rate as % of budget	4	5.00%	4.27%	4.99%	4.93%	6.80%	7.27%	7.57%
	% of staff with a current IPR	3	90%	71.24%	73.97%	75.86%	76.72%	75.15%	73.24%
	% Medical Appraisals	3	90%	26.79%	32.73%	36.61%	38.39%	48.70%	53.91%
	Mandatory training %	3	90.00%	86.66%	87.41%	88.81%	88.18%	87.30%	86.83%
	% sickness absence	3	3.5%	3.34%	3.52%	3.79%	4.41%	3.89%	4.28%
Additional KPIs	FFT – recommend as place to work	3	67.0%	n/a	n/a	n/a	n/a	n/a	n/a
	FFT – recommend as place for treatment	3	80%	n/a	n/a	n/a	n/a	n/a	n/a
	Registered nursing vacancy rate (including pre-registered nurses)	3	5.00%	0.00%	0.00%	0.00%	2.30%	2.24%	2.82%
	Unregistered nursing vacancies excluding pre-registered nurses (% total establishment)	3	5.00%	15.19%	17.36%	17.11%	14.90%	19.36%	22.43%
	Long term sickness absence %	3	0.80%	1.51%	1.58%	1.67%	1.88%	1.48%	1.55%
	Short term sickness absence	3	2.70%	1.83%	1.93%	2.12%	2.53%	2.41%	2.74%
	Agency Usage (wte) Monitor only	3	Monitor only	21.7	23.2	24.7	26.2	24.1	28.9
	Bank Usage (wte) monitor only	3	Monitor only	62.5	59.0	58.3	67.7	67.1	61.5
	Overtime usage (wte) monitor only	3	Monitor only	33.1	33.8	42.3	61.1	50.4	58.5
	Agency spend as % of salary bill	4	3.35%	0.77%	1.23%	2.14%	1.83%	1.63%	1.27%
	Bank spend as % of salary bill	4	1.72%	2.25%	2.45%	1.86%	2.03%	2.56%	1.83%
	% of rosters published 6 weeks in advance	New	Monitor only	2.50%	10.10%	6.50%	65.70%	26.50%	20.60%
	Compliance with headroom for rosters	New	Monitor only	28.20%	24.30%	30.60%	30.60%	34.00%	33.70%
	Band 5 % White background: % BAME background*	New	Monitor only	n/a	n/a	58.16% : 41.00%	n/a	n/a	57.93% : 39.22%
	Band 6 % White background: % BAME background*	New	Monitor only	n/a	n/a	72.34% : 26.14%	n/a	n/a	73.44% : 24.88%
	Band 7 % White background % BAME background*	New	Monitor only	n/a	n/a	87.35% : 11.43%	n/a	n/a	85.32% : 13.49%
	Band 8a % White background % BAME background*	New	Monitor only	n/a	n/a	89.53% : 10.47%	n/a	n/a	88.89% : 10.00%
	Band 8b % White background % BAME background*	New	Monitor only	n/a	n/a	86.67% : 10.00%	n/a	n/a	88.48% : 7.69%
	Band 8c % White background % BAME background*	New	Monitor only	n/a	n/a	92.31% : 7.69%	n/a	n/a	93.33% : 6.67%
	Band 8d % White background % BAME background*	New	Monitor only	n/a	n/a	100% : 0.00%	n/a	n/a	100.00% : 0.00%

* - Data available quarterly from June 21

Summary of Performance and Key Messages:

Key highlights in September are:

- Total turnover reduced in September but remained over KPI at 19%. There were 36 leavers spread across all departments of the Trust including corporate and clinical areas. The most common reason for leaving in September was to return to education/training. The number of staff leaving to return overseas was lower than in the previous 4 months.
- The total Trust vacancy rate remained above KPI at 7.6%. The registered nurse vacancy rate remained below KPI at 2.8%. This increase in vacancy rates is primarily driven by temporary posts that have been approved as part of 20/21 staffing establishments. These relate to the increase in beds in Critical Care and Cardiology that have been approved to the end of 21/22 pending clarity on 22/23 commissioning/funding arrangements. There have also been temporary posts approved in some Corporate areas such as Workforce to support the Compassionate and Collective Leadership Programme and the activity linked to Covid-19 and flu vaccination programmes. These temporary posts will be filled by a mix of fixed term contracts but for nursing posts and some other clinical roles we will be using temporary staffing options as it is not possible to recruit to fixed term contracts. This will mean that the established posts will remain vacant however the temporary staffing usage/spend will increase.
- Mandatory Training compliance reduced to 86.8%. The majority of mandatory training is now delivered through e-learning platforms. Divisions have been encouraging and supporting staff to resume training and development as part of recovery.
- Total Sickness absence remained over KPI at 4.3%. This includes sickness absence relating to COVID but excludes absence linked to self-isolation. There was an increased number of staff contracting COVID during the first weeks of September although this did reduce in the second half of the month. We started to see at the end of September an increase in non-covid absence as seasonal illnesses such as colds started to circulate.
- IPR compliance was suspended during both surge periods. Managers were asked to have wellbeing conversations with staff in place of formal IPRs. We resumed the formal IPR process in June 2021 but compliance is not recovering which is due to a combination of the higher rates of annual leave, short-notice covid absence and high levels of activity linked to emergency work and recovery of elective work. The Spotlight section this months focuses on IPRs.
- Total temporary staffing usage increased in September and remains at a high level in response to higher than normal staff sickness absence, short notice Covid-19 absence and the increase in staffing establishments referenced above.
- Rosters are for a 4 week period and managers are required to approve them (“lock down”) 6 weeks in advance of the date they commence. We have now excluded from the calculation rotas where there is no requirement for shift working as there is no negligible impact of late sign off for these rosters. However for areas where shift working is required late approval of rosters means uncertainty for staff on their working patterns and inhibits effective planning of temporary staffing resources. Compliance remains very poor with this important aspect of rostering practice. Rostering Check and Support six monthly support meetings are being resumed with clinical areas. These will focus on compliance with rostering policy and identify opportunities for improvement particularly with signing off in a timely way. The Roster Support team provide support and training to managers on good rostering practice.
- Compliance with the headroom for rosters is a measure of how closely the rosters worked have complied with effective utilisation rules relating to leave, study time, administration time, sick leave and parenting leave. Clinical teams that provide 7 day services have 28% headroom built in to their budgets and rosters for 21/22 to recognise the additional annual leave that staff have carried over from last year and the need for staff to take leave as part of wellbeing measures. The metric now being reported is an aggregate metric of the headroom for the relevant roster period. The aggregate metric for the September roster period was 34% which reflects the higher levels of leave both planned and unplanned.
- This is the second quarter reporting on the % of staff from a BAME background and the % of staff from a white background in Band 5 and above roles. At a Trust level 73.5% of staff are from a White background and 25.3% are from a BAME background. This purpose of this metric is to track the impact of action the Trust is taking to improve equality of opportunity and career progression for staff from a BAME background. The data and the reported experience of staff is that we are not providing equality of opportunity and career progression . There are a range of actions within the Compassionate and Collective Leadership Programme and the Trust’s WRES action plan to address this. It is a multi-faceted issue and it is going to be a longer-term goal to achieve.

People, Management & Culture: Key Performance challenges

Escalated performance challenges:

- Staff health and wellbeing negatively impacted by the demands of the pandemic and the recovery of services leading to fatigue, higher levels of sickness absence, turnover and lower levels of staff engagement.
- Ensuring that staff are supported and encouraged to take annual leave to rest and recuperate
- Impact of heightened risks for certain staff as a result of COVID-19 risk factors requiring reasonable adjustments which can impact on staff utilisation.
- High levels of short notice staff absence as a result of staff infection with Covid-19, self-isolation following Covid-19 contact and increases in illnesses more prevalent during the winter.
- Poor rostering practice leading to ineffective workforce utilisation causing activity through services to be constrained, high temporary staffing costs and a poor experience for staff.
- Ensuring compliance with mandatory as a result of the backlog created during the surge periods and competing demands for training space and staff time.
- Achieving the KPI of 90% of staff having an annual performance review meeting because of the backlog in appraisals and competing demands on line manager and staff time.
- WRES and WDES data and feedback in staff surveys indicates that staff from a BAME background and/or with a disability have a significantly less positive working experience.

Key risks:

- Staff engagement and morale reduces and this in turn drives high turnover, sickness absence, poor working relationships and damages the patient experience.
- Staff feelings of burnout and negatively impacted mental health as a result of their experiences during the emergency response lead to higher absence and turnover rates.
- Reduction in capacity to maintain safe staffing levels leading additional pressure on staff and increased temporary staffing costs.
- The Trust is not able to recruit the numbers of clinical and non-clinical staff to match turnover and meet increases in establishments as a result of new operating models required for recovery.
- Pay costs in excess of budget as a result of the cost of temporary staffing used to increase capacity ahead of substantive recruitment and to mitigate vacancies.
- Managers are unable to release staff to participate with mandatory training
- Line managers are unable to release sufficient time to catch up on IPRs.
- Inequalities and discrimination in our processes and practices results in poor talent management and low staff engagement particularly for staff from a BAME background and staff with a disability.

Key Actions:

Vaccination Programme
We launched our Covid-19 booster and flu vaccination programme on the 27 September 2021. We are vaccinating our staff and those of our partner organisations on site. This is an extremely important staff wellbeing programme. There is a very pro-active communication campaign and we will continue until we have achieved over 90% of staff being vaccinated. The uptake of flu vaccination is in line with last year at this point in the programme and we have one of the highest uptake rates in the EoE. Covid-19 booster vaccination uptake is somewhat slower. The reasons indicated for this are a combination of factors including that there needs to be a 4 week gap between staff who have had Covid-19 being able to have the vaccine, staff who have colds etc being reluctant to get vaccinated until they feel well again and we believe staff who have had the vaccine elsewhere are not informing us. Managers will be supporting staff to be released to have the vaccine and we are writing to staff who are recorded as not have had the vaccine to encourage them to get vaccinated or tell us if they have had it elsewhere.

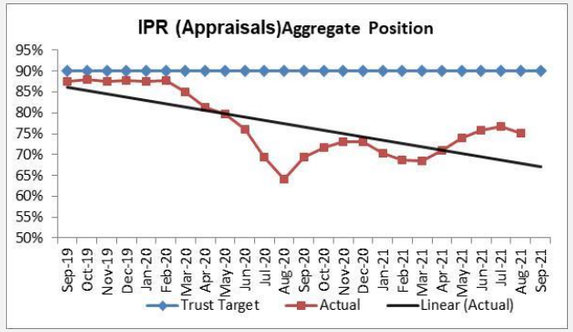
Network Meeting Updates
During September we celebrated Pride and national Inclusion Week by a variety of events including bake offs, online events and picnics. All of the Networks had meetings during the month and the key areas of discussion in each was as follows:
BAME Network:
- Reciprocal Mentoring Programme, Black History Month planning, CCA Development Sessions, Appreciation (Thank you) to different faith Communities who helped during the pandemic.

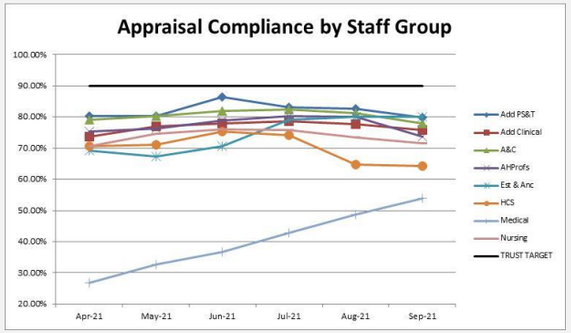
Disability and Difference Network:
- Reciprocal Mentoring Programme, WDES action plan, working carers, Agile Working Policy, promotion of the network, Exec Sponsor

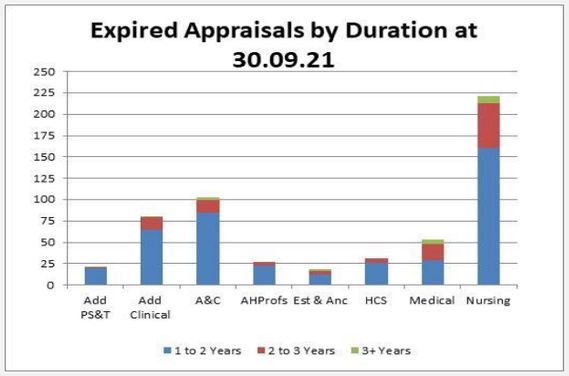
LGBT+ Network:
- Gender neutral facilities, Trans Awareness Training, promotion of the Network, Exec Sponsor

Womens Network:
- Planning for the launch, menopause awareness and support, agreeing ToR and the focus of the Network,

People, Management & Culture: Individual Performance Reviews (IPRS)







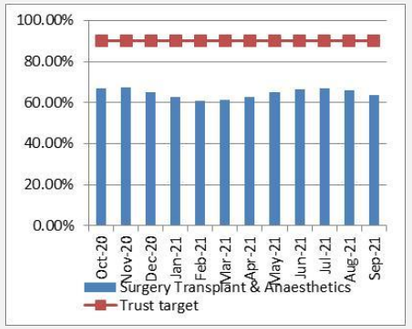
Regular IPRs are an essential element of supporting staff and building positive staff engagement. The Trust policy is that all staff have at least an annual IPR which provides the opportunity for staff to discuss with their line manager not only their performance and achievements over the previous 12 months but also their development needs and career aspirations, their health and wellbeing and their working arrangements.

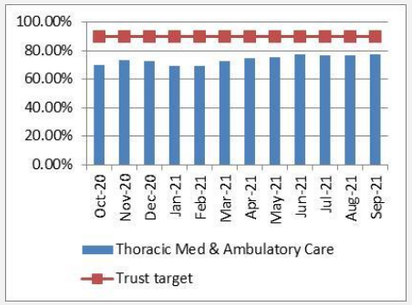
The IPR policy and process are being reviewed to embed the Trust values and behaviours framework and ensure that they are fundamental to the discussion about performance. We will also be strengthening the structure around career and development planning.

During the first and second surge in Covid-19 patients we paused IPRs and managers were asked to undertaken Wellbeing Conversations in their place. We resumed the requirement for annual IPRs in June 2021 however departments are struggling to catch up.

The only staff group making steady progress in catching up is medical staff although their compliance is still significantly below the KPI of 90%. The focus during the summer months has been on giving staff the opportunity to take a break and on addressing our activity backlog. These factors have been compounded by high levels of short-notice sick leave and self isolation; making it very difficult for line managers to release staff to prepare and participate in IPR meetings. We have a growing number of staff who have not had a formal IPR discussion for more than 2 years.

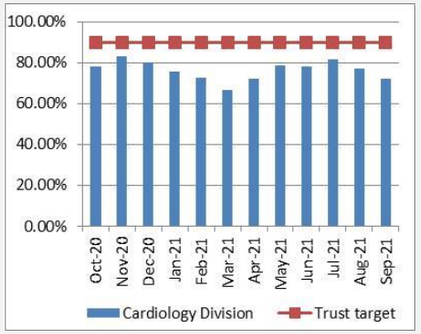
Division	Yes	Total Compliant (%)
175 Cardiology Division Total	184	72.16%
175 Clinical Administration Total	120	82.19%
175 Digital Total	41	89.13%
175 Finance Directorate Total	107	84.92%
175 Nursing Clinical Total	169	79.34%
175 Nursing Corporate Total	27	79.41%
175 R&D Funds Total	51	80.95%
175 Research & Development Total	17	89.47%
175 Surgery Transplant & Anaesthetics Total	463	63.51%
175 Thoracic Med & Ambulatory Care Total	221	77.54%
175 Workforce Directorate Total	41	82.00%
Grand Total	1453	73.24%

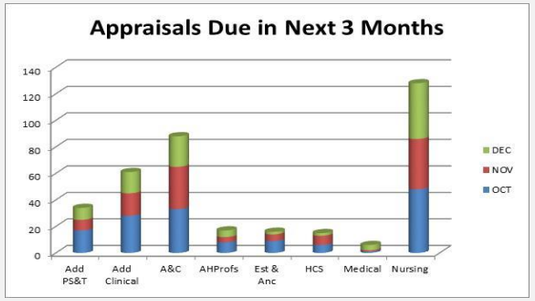




Not surprisingly the clinical divisions are particularly struggling to recover with Surgery, Transplant and Anaesthetics having the lowest and deteriorating level of compliance. This problem is compounded each month with more staff becoming due an appraisal.

We need to be realistic about what is achievable over the winter months with the continuing pressures on workforce utilisation and availability whilst continuing the focus on this important staff support measure. Divisions will be requested to develop realistic recovery plans and trajectories.





Finance: Performance summary

Accountable Executive: *Chief Finance Officer* ***Report Author:*** *Deputy Chief Finance Officer*

		Data Quality	Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Dashboard KPIs	Year to date surplus/(deficit) exc land sale £000s	5	£2,188k	£221k	£827k	£5,771k	£5,802k	£4,042k	£2,238k
	Cash Position at month end £000s	5	£47,613k	£55,042k	£61,532k	£62,939k	£66,388k	£57,425k	£60,142k
	Capital Expenditure YTD £000s	5	£385 YTD	£118k	£26k	£139k	£139k	£206k	£218k
	In month Clinical Income £000s*	5	£18003k (current month)	£17,445k	£17,197k	£20,333k	£18,179k	£15,434k	£18,543k
	CIP – actual achievement YTD - £000s	4	£0k	£20k	£550k	£880k	£1,260k	£1,960k	£0k
	CIP – Target identified YTD £000s	4	£5390k	£3,550k	£4,250k	£5,390k	£5,390k	£5,390k	£5,390k
Additional KPIs	NHS Debtors > 90 days overdue	4	15%	41.3%	40.6%	41.3%	72.5%	51.5%	61.1%
	Non NHS Debtors > 90 days overdue	4	15%	20.7%	11.5%	11.1%	14.6%	16.8%	22.6%
	Capital Service Rating	5	4	2	2	1	1	2	3
	Liquidity rating	5	2	1	1	1	1	1	1
	I&E Margin rating	5	1	1	1	1	1	1	1
	Year to date EBITDA surplus/(deficit) £000s	5	Monitor only	£1,621k	£3,609k	£9,971k	£11,363k	£10,991k	£10,575k
	Use of Resources rating	5	Monitor only	n/a	n/a	n/a	n/a	n/a	n/a
	Total debt £000s	5	Monitor only	£4,014k	£3,761k	£3,744k	£3,699k	£2,700k	£2,291k
	Better payment practice code compliance - NHS	5	Monitor only	95%	85%	83%	83%	77%	86%
	Better payment practice code compliance - Non NHS	5	Monitor only	94%	94%	92%	96%	93%	94%

Summary of Performance and Key Messages:

- **The YTD position is reported against the Trust's H1 2021/22 plan and shows a surplus of £2.5m which is on plan.** Recognition of YTD income earned through the Elective Recovery Fund (ERF), private patient income over-performance, favourable delivery against the Trust's CIP plan is offset by a number of non recurrent items and provisions.
- **The position includes the continuation of the national funding arrangements** comprising of block payments for NHS clinical activity, top-up payments and COVID-19 funding. The plan and actuals include the originally agreed system allocation distribution and YTD income under the ERF mechanism. The ERF is designed to support systems to work collaboratively to restore elective services against the backdrop of unprecedented demands on the service driven by COVID-19. At M6, the additional funding against system baseline which has been included in the Trust's YTD position is c.£4.8m.
- **CIP is ahead of plan by £1.4m YTD.** This is primarily driven by additional delivery against Pharmacy schemes where cost savings have been achieved by switching to generic brands and reducing usage, non recurrent operational pay underspends as well as savings made on the revaluation of business rates. The Trust has £5.4m of pipeline schemes identified against its annual target of £5.4m (see CIP report).
- **The Trust fell short of the national activity targets in September: this was in the context of growing COVID-19 numbers and lower levels of backfill than expected for staff leave.** This has given rise to a lower than plan underlying spend position in month. This continues to be partly offset by a number of non-recurrent items of spend which are considered one-off.
- **The cash position closed at £60.1m.** This represents an increase of c£2.7m from last month and is mainly driven by receipt of April & May ERF payments offset by 2021 closing dividend payment. The Trust's capital spend is behind plan due to delay in the start of projects. Plans are being worked up in order to bring forward as many projects as possible.
- **Better Payments Practice Code** performance at M6 across all suppliers is 87% by value and 94% by volume vs the 95% standard. This is a significant improvement over M5 and the Trust will continue to follow its action plan to ensure that the Trust meets the 95% stand by Q3.

Finance: Key Performance – year to date SOCI

On a YTD basis the Trust delivered £2.5m surplus against a surplus plan of £2.5m. Income performance reflects the better than planned performance on private patient activity and the pay inflation income for H1. This is offset by the adverse variance on non-clinical supplies due to COVID-19 costs, provisions for clinical perfusion service, DCD, M Abscessus and the H1 pay inflation costs.

	YTD £000's Plan	YTD £000's Underlying Actual	YTD £000's COVID: spend	YTD £000's Other Non Recurrent Actual	YTD £000's Actual Total	YTD £000's Variance	RAG
Clinical income - in national block framework							
Clinical income on PbR basis - activity only	£66,830	£71,958	£0	£0	£71,958	£5,128	
Balance to block payment -activity only	£0	(£5,128)	£0	£0	(£5,128)	(£5,128)	
Homecare Pharmacy Income	£24,101	£21,495	£0	£0	£21,495	(£2,606)	
Drugs and Devices - cost and volume	£5,977	£5,687	£0	£0	£5,687	(£289)	
Balance to block payment - drugs and devices	£0	£685	£0	£0	£685	£685	
Sub-total	**£96,908**	**£94,697**	**£0**	**£0**	**£94,697**	**(£2,211)**	
Clinical income - Outside of national block framework							
Drugs & Devices	£307	£811	£0	£0	£811	£504	
Other clinical income	£1,120	£1,498	£0	£0	£1,498	£379	
Private patients	£3,000	£4,089	£0	£0	£4,089	£1,089	
Sub-total	**£4,427**	**£6,398**	**£0**	**£0**	**£6,398**	**£1,971**	
Total clinical income	**£101,335**	**£101,095**	**£0**	**£0**	**£101,095**	**(£240)**	
Other operating income							
Covid-19 funding and ERF	£7,307	£0	£2,308	£4,791	£7,099	(£208)	
Top-up funding	£14,832	£14,848	£0	£0	£14,848	£16	
Other operating income	£10,753	£12,043	£0	£0	£12,043	£1,290	
Total operating income	**£32,891**	**£26,891**	**£2,308**	**£4,791**	**£33,990**	**£1,099**	
Total income	**£134,225**	**£127,986**	**£2,308**	**£4,791**	**£135,084**	**£859**	
Pay expenditure							
Substantive	(£55,709)	(£54,317)	(£222)	(£2,432)	(£56,971)	(£1,262)	
Bank	(£1,090)	(£1,173)	(£87)	£0	(£1,260)	(£170)	
Agency	(£1,972)	(£849)	(£16)	£0	(£865)	£1,107	
Sub-total	**(£58,771)**	**(£56,338)**	**(£325)**	**(£2,432)**	**(£59,095)**	**(£324)**	
Non-pay expenditure							
Clinical supplies	(£20,922)	(£19,734)	(£19)	(£1,197)	(£20,951)	(£29)	
Drugs	(£3,415)	(£2,538)	(£358)	£0	(£2,895)	£520	
Homecare Pharmacy Drugs	(£24,161)	(£21,079)	£0	£0	(£21,079)	£3,082	
Non-clinical supplies	(£16,304)	(£16,012)	(£1,028)	(£3,449)	(£20,489)	(£4,185)	
Depreciation (excluding Donated Assets)	(£4,590)	(£4,543)	£0	£0	(£4,543)	£47	
Depreciation (Donated Assets)	(£306)	(£262)	£0	£0	(£262)	£44	
Sub-total	**(£69,698)**	**(£64,168)**	**(£1,406)**	**(£4,646)**	**(£70,219)**	**(£521)**	
Total operating expenditure	**(£128,469)**	**(£120,506)**	**(£1,731)**	**(£7,078)**	**(£129,315)**	**(£846)**	
Finance costs							
Finance income	£0	£0	£0	£0	£0	(£0)	
Finance costs	(£2,564)	(£2,529)	£0	£0	(£2,529)	£34	
PDC dividend	(£1,000)	(£1,002)	£0	£0	(£1,002)	(£2)	
Revaluations/(Impairments)	£0	£0	£0	£0	£0	£0	
Gains/(losses) on disposals	£0	£0	£0	£0	£0	£0	
Sub-total	**(£3,564)**	**(£3,531)**	**£0**	**£0**	**(£3,531)**	**£32**	
Surplus/(Deficit) including central funding	**£2,193**	**£3,948**	**£577**	**(£2,286)**	**£2,238**	**£46**	
Surplus/(Deficit) Control Total basis	**£2,499**	**£4,210**	**£577**	**(£2,286)**	**£2,500**	**£2**	
ERF					£4,791		
Surplus/(Deficit) less ERF					**(£2,291)**		

In month headlines:

- **Clinical income** is £0.9m favourable to plan.
  - Income from activity on PbR basis was above block levels by £5.1m. This is the net effect of an increase in ECMO, cardiology and RSSC, offset by lower PTE, Thoracic surgery and Transplant operations.
  - Private patient income delivery is £1.1m higher than plan. This is driven by increased activity within Cardiology, Thoracic Medicine, RSSC services

  Other operating income is favorable to plan by £1.1m, mainly due to the H1 pay inflation income, which is offset by the equivalent cost in pay expenditure.
- **Pay expenditure** is adverse to plan by £0.3m. Substantive spend run rates have held consistent throughout the year, with the increase this month explained by the pay inflation cost. Incremental COVID-19 pay costs recorded to date are attributed to additional hours of staff time worked in vaccination clinic and ongoing spend on the transfer service. Non-recurrent pay cost include additional provisions for untaken annual leave and for an outstanding employment case.
- **Clinical Supplies** is on plan. Included in this spend is the incremental costs in respect of the CPAP recall and provision for long term VADs that are within the expiry threshold.
- **The Homecare backlog has continued to be monitored.** YTD Homecare spend was £3.1m favourable to plan. This is different to the income variance due to underspends on items covered in block payment mechanisms and the release of a historic income provision where the debt has now been paid.
- **Non-clinical supplies** is adverse to plan by £4.1m. £1m of this is COVID-19 spend on schemes that have continued longer than expected. The remaining variance is driven by non-recurrent items including M Abscessus costs (purchase of additional water filters and provision for legal cost), a DCD devices provision, clinical perfusion costs and a provision for dilapidations at the House.

Integrated Care System (ICS): Performance summary

Accountable Executive: *Chief Operating Officer / Chief Finance Officer* ***Report Author:*** *Chief Operating Officer / Chief Finance Officer*

		Data Quality	Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Comments
Additional KPIs	Elective activity as % 19/20 (ICS)	New	Monitor only	69.8%	66.6%	77.8%	77.30%	82.10%	76.00%	Latest data to w/e 10/10/21
	Non Elective activity as % 19/20 (ICS)	New	Monitor only	96.8%	96.2%	95.8%	92.90%	86.40%	92.60%	Latest data to w/e 10/10/21
	Day Case activity as % 19/20 (ICS)	New	Monitor only	86.5%	86.8%	99.3%	73.20%	91.90%	98.40%	Latest data to w/e 10/10/21
	Outpatient - First activity as % 19/20 (ICS)	New	Monitor only	77.1%	69.3%	95.7%	86.50%	91.00%	112.10%	Latest data to w/e 10/10/21
	Outpatient - Follow Up activity as % 19/20 (ICS)	New	Monitor only	91.9%	76.5%	106.6%	98.70%	104.70%	105.60%	Latest data to w/e 10/10/21
	Virtual clinics – ICS wide % of all outpatient attendances that are virtual	New	Monitor only	33.5%	34.7%	29.0%	26.60%	27.30%	26.80%	Latest data to w/e 10/10/21
	Diagnostics < 6 weeks %	New	Monitor only	53.3%	54.9%	57.4%	56.20%	50.80%	54.10%	Latest data to w/e 10/10/21
	18 week wait %	New	Monitor only	60.9%	63.7%	66.7%	67.20%	64.60%	63.70%	RTT Metrics comprise CUHFT & NWAFT & RPH to w/e 05/10/21
	No of waiters > 52 weeks	New	Monitor only	7,720	6,644	6,103	6,385	7,149	7,672	RTT Metrics comprise CUHFT & NWAFT & RPH to w/e 05/10/21
	Cancer - 2 weeks % (ICS)	New	Monitor only	81.70%	n/a	n/a	77.50%	n/a	n/a	Latest Cancer Performance Metrics available are July 2021
	Cancer - 62 days wait % (ICS)	New	Monitor only	77.00%	n/a	n/a	75.70%	n/a	n/a	Latest Cancer Performance Metrics available are July 2021
	Finance – ICS bottom line position	New	Monitor only	n/a	n/a	£0.9m	n/a	n/a	n/a	Latest financial update is for June 21
	Staff absences % (C&P)	New	Monitor only	3.2%	3.2%	4.0%	4.00%	4.00%	4.20%	Latest data to w/e 10/10/21

Summary of Performance and Key Messages:

The sector is entering a new national landscape post COVID-19 and the Trust's role as a partner in the Cambridgeshire and Peterborough ICS is becoming more important. Increasingly organisations will be regulated as part of a wider ICS context, with regulatory performance assessments actively linking to ICS performance.

There is a national expectation that individual organisations are leaning in to support recovery post COVID-19 across the ICS and or local region and the Trust is not exempt from this. The ICS is developing system wide reporting to support this and the Trust is actively supportive this piece of work. In the meantime, this new section to PIPR is intended to provide an element of ICS performance context for the Trust's performance. This section is not currently RAG rated however this will be re-assessed in future months as the information develops and evolves, and as the System Oversight Framework gets finalised nationally.

The metrics indicate activity recovery across the ICS is gradually progressing against national targets, with outpatient activity particularly showing a faster rate of return offset in part by additional COVID activity in July compared to the start of the financial year. System wide waiting lists remain a challenge, particularly in areas such as diagnostics.