Royal Papworth Hospital
NHS Foundation Trust

Papworth Integrated Performance Report (PIPR)

October 2021

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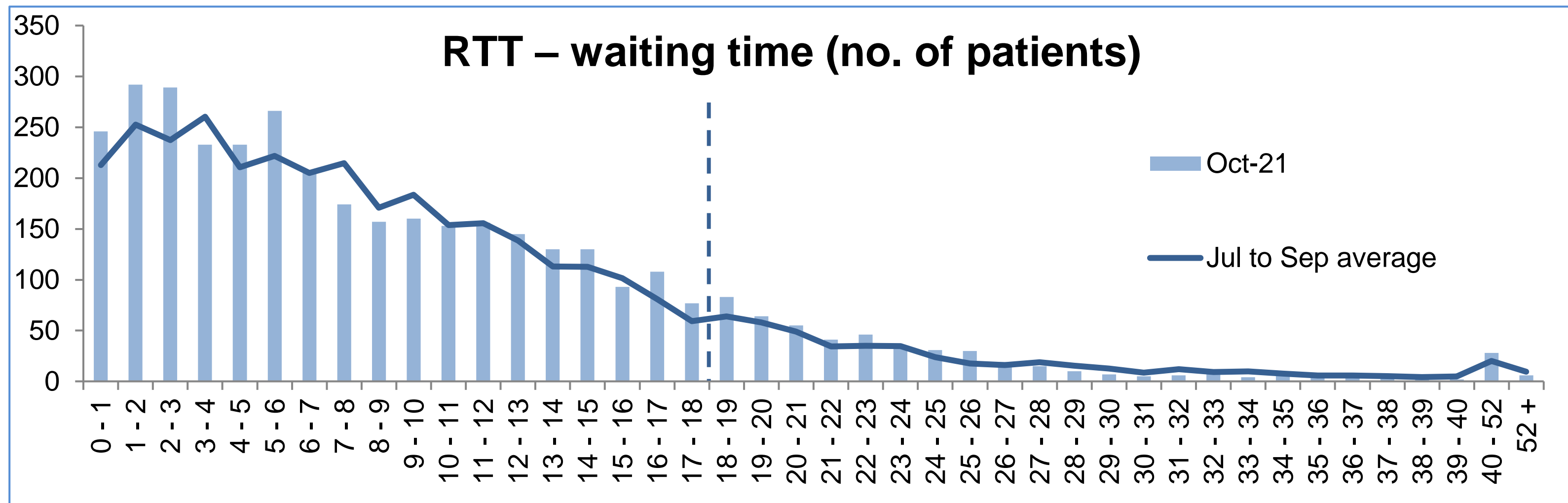
Context:

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	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Trend
Cardiac Surgery	164	174	182	154	161	165	
Cardiology	725	804	743	642	735	645	
ECMO (days)	65	83	177	294	307	234	
ITU (COVID)	1	1	0	1	0	0	
PTE operations	9	19	17	11	18	14	
RSSC	613	734	557	521	665	564	
Thoracic Medicine	262	285	306	303	311	306	
Thoracic surgery (exc PTE)	52	67	66	69	53	52	
Transplant/VAD	37	48	52	45	55	50	
Total Inpatients	**1,928**	**2,215**	**2,100**	**2,040**	**2,305**	**2,030**	

Outpatient Attendances	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Trend
Cardiac Surgery	591	592	441	416	430	381	
Cardiology	3,539	3,766	3,606	3,367	3,760	3,791	
RSSC	1,481	1,675	1,478	1,186	1,472	1,561	
Thoracic Medicine	2,160	2,472	2,360	2,066	2,340	2,120	
Thoracic surgery (exc PTE)	98	110	85	61	128	83	
Transplant/VAD	264	343	273	268	291	257	
Total Outpatients	**8,133**	**8,958**	**8,243**	**7,364**	**8,421**	**8,193**	

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

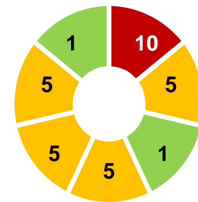
The 'RAG' ratings for each of the individual KPIs included within this report are defined as follows:

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).

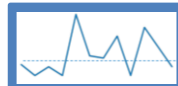
- **Red (10 points) =** 2 or more red KPIs within the category
- **Amber (5 points) =** 1 red KPI rating within the category
- **Green (1) =** No reds and 1 amber or less within the category



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)

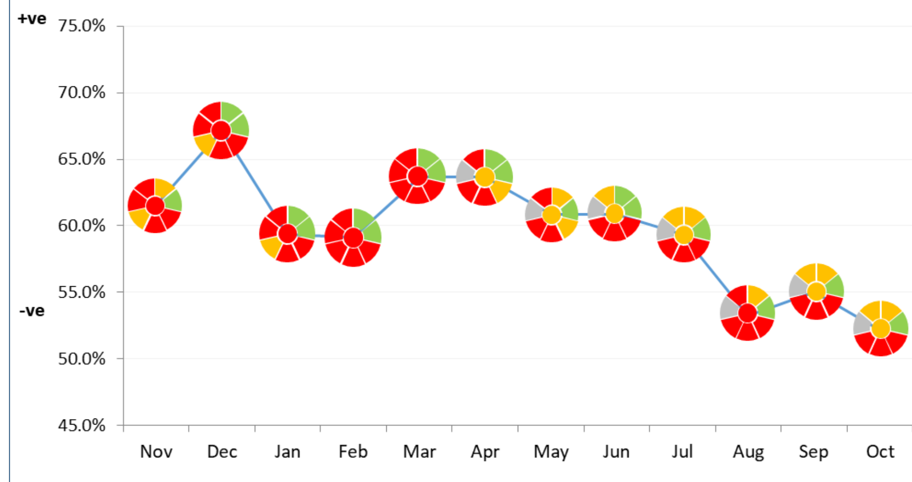
Data Quality Indicator

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: 1) Safer Staffing: RN fill rate for Oct 2021 is an improved position from the previous month for days, remaining green at 92.0% (Sep = 90.0%) and nights remaining green at 91.0% (Sep = 92.8%). 2) Sepsis: Quarter 2 shows an improved position at 97%. Of all the patients reviewed in the audit data Jul to Sep 2021 (n = 122), 44 required sepsis screening. Of those, 39 patients should have been given IV antibiotics within the hour. 38 of the 39 patients were given IV antibiotics within the hour (97%). The remaining one patient was given treatment as required, however did not have a sepsis bundle.
EFFECTIVE: Outpatient Performance - Despite staffing shortages in Outpatients, performance remains strong in this area, with the activity on plan in month. There remains a high dependence on virtual clinic which have been facilitated by the extensive rollout of remote monitoring devices during the first wave of the pandemic.
RESPONSIVE: Diagnostic Performance - Although not yet meeting the standard of 99% of diagnostic tests being undertaken within 6 weeks of request, sustained progress has been made in recovering performance against this standard. Two further mutual aid requests have been received by the Trust from system partners for support with CT imaging and Echocardiography. The Radiology team are exploring the potential of delivering some weekend CT waiting list initiatives for CUH and as Echocardiography poses a significant challenge in all three acute providers, the Trust is leading a piece of work to support productivity improvements in this area across the system.
FINANCE – 1) The YTD position is reported against the Trust's H1 and draft H2 2021/22 plan and shows a surplus of £2.6m which is marginally favourable to plan. 2) CIP is ahead of plan by £1.9m 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

CARING: FFT (Friends and Family Test): Inpatients positive Experience rate has decreased from 99.2% (Sep) to 97.8% (Oct). For Outpatients positive experience rate has decreased from 97.2% (Sep) to 95.9% (Oct). There are no indications at this stage that correlate with the drop in Positive Experience Rate score for Inpatient or Outpatients, though this will continue to be monitored.
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 October. This reduced bed occupancy against the funded number of general and acute and critical care beds. In addition ECMO demand remained high, with approximately a third of available capacity utilised to service this need, throughout the month. This has driven higher than ideal levels of occupancy in critical care. The low level of occupancy across the general and acute bed base is not consistent across all specialities. The constrained critical care capacity has limited surgical activity so the occupancy on the surgical floor has been consistently low, while the Cardiology and Respiratory bed base have been running very hot. Nursing staff from the surgical floor have been supporting critical care through a voluntary re-deployment of staff with critical care skills and experience.
RESPONSIVE: 1) 104 day Cancer breaches - Breaches have increased to 6 in October due to regional delays in referrals, turn around of PET scanning at CUH, two complex pathways and patient choice challenges. The aim from region is to reduce to nil 104 day patients by the 31st March 2022. 2) 52 week breaches - There were 6 breaches in October reported, 4 of which are awaiting surgery but have been scheduled for treatment in November. The remaining two patients are breaches of greater than 104 weeks, one each in Cardiology and Respiratory. These breaches were caused by the patients being lost during the migration to the electronic patient record system. The root cause of the errors which resulted in both pathways being closed is under investigation and a review of other pathways closed at that time is underway. Both patients have been treated and harm reviews undertaken.
PEOPLE, MANAGEMENT & CULTURE 1) Total Sickness absence further increased in October to 5.27% which is a very high level for this Trust. This includes sickness absence relating to COVID but excludes absence linked to self-isolation. The spotlight looks at sickness absence in more detail and provides information on the regional trends. 2) 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 short-notice covid absence and high levels of activity linked to emergency work and recovery of elective work. The Divisions are working together to develop actions to ensure that all staff have an annual appraisal. It is going to take some time to recover and address the backlog given the pressures on staffing utilisation.

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

Domain	Metric	Month reported on	Data Quality	Plan	Current month score	YTD Actual	Forecast YE	Trend
Safe	Never Events	Oct-21	4	0	0	1		
Safe	Moderate harm incidents and above as % of total PSIs reported	Oct-21	4	3%	0.43%	1.10%		
Safe	Number of Papworth acquired PU (grade 2 and above)	Oct-21	4	35 pa	1	11		
Safe	High impact interventions	Oct-21	3	97%	98.70%	98.54%		
Safe	Falls per 1000 bed days	Oct-21	4	4	2.8	3.2		
Safe	Sepsis - % patients screened and treated (Quarterly)	Oct-21	New	90%	-	90.50%		
Safe	Safer Staffing CHPPD – 5 North	Oct-21	5	9.6	10.4	10.0		
Safe	Safer Staffing CHPPD – 5 South	Oct-21	5	9.6	9.8	10.3		
Safe	Safer Staffing CHPPD – 4 NW (Cardiology)	Oct-21	5	9.4	8.9	9.0		
Safe	Safer Staffing CHPPD – 4 South (Respiratory)	Oct-21	5	6.7	8.8	8.7		
Safe	Safer Staffing CHPPD – 3 North	Oct-21	5	8.6	10.0	10.6		
Safe	Safer Staffing CHPPD – 3 South	Oct-21	5	8	7.5	8.2		
Safe	Safer Staffing CHPPD – Day Ward	Oct-21	5	4.5	7.0	7.0		
Safe	Safer Staffing CHPPD – Critical Care	Oct-21	5	32.9	32.5	34.5		
Effective	Bed Occupancy (excluding CCA and sleep lab)	Oct-21	4	85% (Green 80%-90%)	71.40%	71.23%		
Effective	CCA bed occupancy	Oct-21	4	85% (Green 80%-90%)	95.50%	91.64%		
Effective	Admitted Patient Care (elective and non-elective)	Oct-21	4	0 (current mnth)	2030	14629		
Effective	Outpatient attendances	Oct-21	4	0 (current mnth)	8193	57411		
Effective	Cardiac surgery mortality (Crude)	Oct-21	3	3%	2.76%	2.76%		
Effective	Theatre Utilisation	Oct-21	3	85%	77.0%	76.9%		
Effective	Cath Lab Utilisation 1-6 at New Papworth (including 15 min Turn Around Times)	Oct-21	3	85%	78.0%	81.7%		
Responsive	% diagnostics waiting less than 6 weeks	Oct-21	3	99%	97.32%	92.09%		
Responsive	18 weeks RTT (combined)	Oct-21	5	92%	85.99%	85.99%		
Responsive	Number of patients on waiting list	Oct-21	5	3279	3776	3776		
Responsive	52 week RTT breaches	Oct-21	5	0	6	68		
Responsive	62 days cancer waits post re-allocation (new 38 day IPT rules from Jul18)*	Oct-21	4	85%	62.50%	50.00%		
Responsive	31 days cancer waits*	Oct-21	4	96%	100.00%	100.00%		
Responsive	104 days cancer wait breaches*	Oct-21	4	0%	6	23		
Responsive	Theatre cancellations in month	Oct-21	3	30	45	35		
Responsive	% of IHU surgery performed < 7 days of medically fit for surgery	Oct-21	4	95%	39.00%	69.29%		
Responsive	Acute Coronary Syndrome 3 day transfer %	Oct-21	4	90%	100.00%	100.00%		

Domain	Metric	Month reported on	Data Quality	Plan	Current month score	YTD Actual	Forecast YE	Trend
Caring	FFT score- Inpatients	Oct-21	4	95%	97.80%	99.03%		
Caring	FFT score - Outpatients	Oct-21	4	95%	95.90%	98.26%		
Caring	Number of written complaints per 1000 WTE (Rolling 3 mnth average)	Oct-21	4	12.6	7.4			
Caring	Mixed sex accommodation breaches	Oct-21	4	0	0	0		
Caring	% of complaints responded to within agreed timescales	Oct-21	4	100%	100.00%	100.00%		
People Management & Culture	Voluntary Turnover %	Oct-21	3	12.0%	19.0%	16.9%		
People Management & Culture	Vacancy rate as % of budget	Oct-21	4	5.0%	7.6%			
People Management & Culture	% of staff with a current IPR	Oct-21	3	90%	71.26%			
People Management & Culture	% Medical Appraisals	Oct-21	3	90%	63.48%			
People Management & Culture	Mandatory training %	Oct-21	3	90%	86.31%	87.36%		
People Management & Culture	% sickness absence	Oct-21	3	3.50%	5.27%	4.07%		
Finance	Year to date surplus/(deficit) exc land sale £000s	Oct-21	5	£2,196k	£2,246k			
Finance	Cash Position at month end £000s	Oct-21	5	£0k	£59,081k			
Finance	Capital Expenditure YTD £000s	Oct-21	5	£472k	£561k			
Finance	In month Clinical Income £000s	Oct-21	5	£16873k	£16,873k	£124,004k		
Finance	CIP – actual achievement YTD - £000s	Oct-21	4	£1980k	£3,830k	£3,830k		
Finance	CIP – Target identified YTD £000s	Oct-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	0	9	4		
RTT Waiting Times	% Within 18wks - Incomplete Pathways	5	92%	85.99%		86.45%		Monthly measure
Cancer	31 Day Wait for 1st Treatment	4	96%	100.00%	100.00%	98.7%		Current month provisional as going through verification process.
	31 Day Wait for 2nd or Subsequent Treatment - surgery	4	94%	100.00%	99.46%	98.7%		Current month provisional as going through verification process.
	62 Day Wait for 1st Treatment	4	85%	62.50%	66.70%	68.40%		Current month provisional as going through verification process. Data is after reallocations
	104 days cancer wait breaches	4	0	6	23	9		
VTE	Number of patients assessed for VTE on admission	5	95%	84.10%		83.5%		
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	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Status since last month
Safe	Failure to protect patient from harm from hospital aquired infections	675	MS	5	Yes	10	10	10	15	8	8	↔
Safe	Waiting list management	678	EM	12	Yes	16	16	16	16	16	16	↔
Safe	Potential for cyber breach and data loss	1021	AR	3	Yes	16	16	16	16	16	16	↔
Safe	Risk to Trust reputation due to PFI contract performance DOWNGRADED FROM BAF TO CORPORATE RISK	2839	TG	0	In progress	12	12	16	16	16	16	↔
Safe	Key Supplier Risk	2985	TG	8	In progress	-	-	-	20	20	20	↔
Safe	Risk of maintaining safe and secure environment across the organisation	2833	TG	6	In progress	12	16	16	16	16	16	↔
Safe	Continuity of supply of consumable or services failure	3009	TG	6	In progress	-	-	-	15	15	15	↔
Safe + PM&C + Responsive	M.Abscessus	3040	MS	10	In progress	-	-	-	-	15	15	↔
Safe + Effective + Finance + PM&C.	Failure to meet safer staffing (NICE guidance and NQB)	742	MS	6	Yes	12	12	12	12	12	12	↔
Safe + Effective + Finance + PM&C + Responsive	Delivery of Trust 5 year strategy	2901	EM	4	In progress	9	9	9	9	9	9	↔
Safe + Effective + Responsive	Clinical Research Facility Core Grant Funding	3008	TG	9	In progress	-	-	-	12	12	12	↔
Safe + Finance	Staff turnover in excess of our target level	1853	OM	8	Yes	10	15	15	15	15	15	↔
Safe + Finance	Unable to recruit number of staff with the required skills/experience	1854	OM	8	Yes	10	10	10	10	10	10	↔
Safe + Finance	Low levels of Staff Engagement	1929	OM	4	In progress	12	12	12	12	12	12	↔
Effective	Achieving financial balance at ICS level	2904	TG	12	In progress	16	20	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	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Dashboard KPIs	Never Events	4	0	1	0	0	0	0	0
	Moderate harm incidents and above as % of total PSIs reported	4	<3%	1.50%	1.70%	1.18%	0.89%	0.30%	0.43%
	Number of Papworth acquired PU (grade 2 and above)	4	<4	2	0	2	2	3	1
	High impact interventions	3	97.0%	97.5%	99.1%	98.4%	98.8%	99.3%	98.7%
	Falls per 1000 bed days	4	<4	2.7	1.9	2.9	2.0	3.8	2.8
	Sepsis - % patients screened and treated (Quarterly)	New	90.0%	-	84.00%	-	-	97.00%	-
	Safer Staffing CHPPD – 5 North *	5	>9.6	10.40	9.60	9.50	10.30	10.40	10.42
	Safer Staffing CHPPD – 5 South *	5	>9.6	9.50	9.20	9.70	9.80	11.30	9.79
	Safer Staffing CHPPD – 4 NW (Cardiology) *	5	>9.4					9.00	8.91
	Safer Staffing CHPPD – 4 South (Respiratory) *	5	>6.7	9.70	7.90	7.60	9.50	8.20	8.78
	Safer Staffing CHPPD – 3 North *	5	>8.6	11.10	10.30	10.50	11.30	9.70	9.99
	Safer Staffing CHPPD – 3 South*	5	>8	9.00	8.40	8.40	7.70	7.90	7.54
	Safer Staffing CHPPD – Day Ward *	5	>4.5	10.68	9.04	5.63	5.60	6.03	7.00
	Safer Staffing CHPPD – Critical Care *	5	>32.9	34.70	32.70	33.70	36.50	34.80	32.53
Additional KPIs	Safer staffing – registered staff day	3	90-100%	83.8%	86.9%	82.2%	89.1%	90.0%	92.0%
	Safer staffing – registered staff night			90.9%	91.7%	91.8%	92.4%	92.8%	91.0%
	MRSA bacteremia	3	0	0	0	0	0	0	0
	Number of serious incidents reported to commissioners in month	4	0	2	2	1	0	0	1
	E coli bacteraemia	5	Monitor only	1	1	1	2	1	0
	Klebsiella bacteraemia	5	Monitor only	1	2	3	1	0	0
	Pseudomonas bacteraemia	5	Monitor only	1	0	1	1	0	0
	Other bacteraemia	4	Monitor only	0	1	3	0	1	1
	Other nosocomial infections	4	Monitor only	0	0	0	0	0	0
	Point of use (POU) filters (M.Abscessus)	4	Monitor only	94%	96%	91%	96%	95%	95%
	Moderate harm and above incidents reported in month (including SIs)	4	Monitor only	4	4	2	2	1	0
	Monitoring C.Diff (toxin positive)	5	Ceiling pa of 10	2	2	2	1	1	0
	Number of patients assessed for VTE on admission	5	95.0%					85.2%	84.10%

* 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 Oct 2021 (accessed 12.11.2021).

Pressure ulcers: there was one Papworth acquired pressure ulcer during Oct 2021. This is an improvement from the previous few months. There is a pressure ulcer scrutiny panel scheduled for 16.11.2021.

Sepsis: the Sepsis data for Q2 is an improved position at 97%. Of all the patients reviewed in the audit data Jul to Sep 2021 (n = 122), 44 required sepsis screening. Of those, 39 patients should have been given IV antibiotics within the hour. 38 of the 39 patients were given IV antibiotics within the hour (97%). The remaining one patient was given treatment as required, however did not have a sepsis bundle.

The recent PIPR M05 did a 'Key performance challenges' update on actions that the Sepsis Working Group are undertaking to make sustained improvements in response to the ongoing Sepsis audit. The group met on 21.10.2021. Sepsis was also the focus of the Trust Message of the Week for w/c 11.10.2021

Safe Staffing: RN fill rate for Oct 2021 is an improved position from the previous month for days, remaining green at 92.0% (Sep = 90.0%) and nights remaining green at 91.0% (Sep = 92.8%). All CHPPD areas are green with the exception of 4NW, 3 South and Critical Care – all of which are just under their respective threshold CHPPD.

Number of Serious Incidents: During Oct 2021 there was one SI reported to the CCG. The incident was initially discussed at SIERP 12.10.2021 and remains under investigation.

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

Point of Use (POU) filters (M.Abscessus): For Oct 2021, compliance was 95%. The drops in compliance were with "% IPC Admission assessment completed" and/or "% alerted on Lorenzo/CIS" 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.

For information: PIPR Safe M05 did a "Spotlight On – Point of Use filter audit" which provides further detail and background into this KPI.

C.Diff: there were zero cases of C.difficile in Oct 2021.

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 counted against our trajectory. Running total for 2021/22 = 9. 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.

VTE: from Sep 2021 data onwards, VTE has been added to PIPR as a monthly KPI; it was previously reported only on the PIPR slide "At a glance – Externally reported / regulatory standards" (PIPR, p.5). The monthly audit shows that RPH is not meeting the 95% standard and there are a number of actions that have taken place and/or are in progress with the clinical teams. Further information is provided on the next slide.

Safe: Key performance challenges

Escalated performance challenges:

VTE Assessment on Admission Compliance

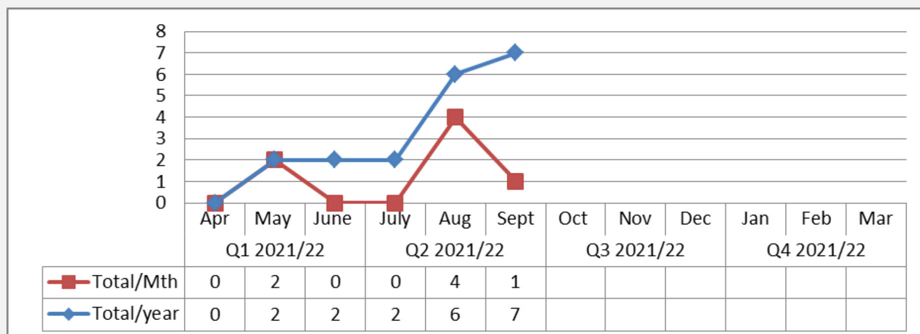
Background: Venous thromboembolism (VTE) assessment on admission is mandated by trust policy (DN 500) for most patient cohorts seen at RPH. RPH VTE trust policy utilises national guidance from NICE and the DoH as it's foundation, with some adjustments to applicable cohorts to account for the unique variety of patients we provide care for. Compliance is audited and reported monthly.

Audit criteria: The audit measures the % of admissions for which a VTE Assessment was initiated within 24 hours of admission on either Lorenzo or Metavision or within the preceding 7 days. All overnight stays are included, as well as same day admit/discharge on Day Ward.

In June 2021 the trust moved to a census style audit reviewing all applicable patients. Prior to this, the trust audited 30 randomly selected records. Due to the significant difference in methodology and results, it has been agreed not to report data using the old methodology in any future reports. This change in audit has allowed us to really look at the detail and highlight that overall, the Trust is under the 95% requirement. The extra internal scrutiny has ensured focus on a number of key areas for improvement (as shown to the right).

VTE monitoring: ***How do we know that the remaining patients have not suffered any events?***

We are advised of confirmed VTE events by RPH staff (use of Datix), radiology alerts, patients, GPs or healthcare professionals in other hospitals. The graph below shows the number of VTE events from Q1 & Q2 2021/22. We have been informed of five VTE Datix events in Q2 2021/22 (as seen below) the investigations are ongoing and these have been reported on Datix. They will be discussed at the Nov 2021 VTE scrutiny panel. The last moderate harm reported in relation to VTE was 20/08/2019.

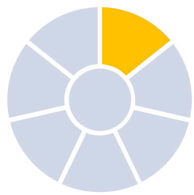


	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	Q1 2021/22			Q2 2021/22			Q3 2021/22			Q4 2021/22		
Total/Mth	0	2	0	0	4	1						
Total/year	0	2	2	2	6	7						

Key Actions:

VTE Action Plan in place (updated position as reported to QRMG 09.11.2021):

- Sisters/Charge Nurses/Team Leaders to share locally with staff the requirement to complete a VTE risk assessment on admission.
- Matrons/HoN's to raise at all three divisional governance meetings the importance of completing VTE risk assessment on admission for all patients.
- Reminder to Sisters/Charge Nurses/Team Leaders how to access the quality indicators screen in Lorenzo.
- The Lorenzo team is in negotiation with Dedalus for a digital alert on clinical care activities in Lorenzo (e.g. prescribing) to be developed if a VTE risk assessments is overdue (to try and digitally 'design the problem out').
- There was a focus on Cardiology for August to continue to drive improvement closer to the 95% target. Within cardiology this has featured as the weekly 'Buzz Word' to engage MDT learning and raise awareness of the importance of VTE.
- Within Thoracic Medicine, a pilot QIP has been initiated in Oct 2021. The Ward Sisters Administrator will check the VTE clinical indicators every morning, and give a list of non-compliance to the nurse in charge. The nurse in charge will flag non-compliance to the appropriate medical teams.
- VTE and bleeding risk assessments featured on new doctor's induction during August intake and going forward the VTE link/matrons/group members will spot check VTE risk assessments.
- CCA compliance with VTE risk assessment within 24 hours is below the 95% standard. In addition not all patients are having a risk assessment recorded within Metavision every 24 hours in line with DN500 and NG89 (NICE Guidance) best practice guidance. A new medical and nursing lead for VTE within CCA was appointed in June 2021 to lead some QI work to improve the risk assessment standards. Changes have also been made within Metavision to ensure visibility of VTE risk assessment on the daily ward round.
- An interim VTE nursing lead took over in Sep 2021.
- Two revised VTE scrutiny panels have been established: one dedicated to Critical Care which will meet on 23 Nov 2021; and the other will focus on surgery and thoracic which is meeting 30 Nov 2021. These groups will continue to progress the VTE actions and review and scrutinise the incidents.



Safe: Spotlight On – CHPPD October 2021 amber areas

Care Hours Patient Day (CHPPD) – October 2021 amber areas:
During October 2021, there were three wards/departments in amber for their CHPPD, as shown in the PIPR extract below (**top left table**). They are 4 Northwest (Cardiology), 3 South (Cardiology), and Critical Care Area .

Datix incidents: While each of these areas is just under the green threshold, we have run a report from Datix for October 2021, looking at all patient and staff incidents for these areas to look if there are any indications of impact on safety and/or quality.

- In summary, there were 133 incidents in October 2021 across the three areas, broken down as: 4NW = 10; 3S = 22; CCA = 101.
- Of the 133 incidents, there are no reported incidents graded moderate harm or above in these areas. The **bottom left table** shows a count of severity (further information is available if required).
- The **bottom right table** provides a visual overview of the top five incidents Nov 2020 to Oct 2021 (note: Nov 2020 to Feb 2021 was COVID-19 Surge phase 2). It is worth noting, that throughout this reporting period, CCA has remained in COVID surge, particularly for ECMO.

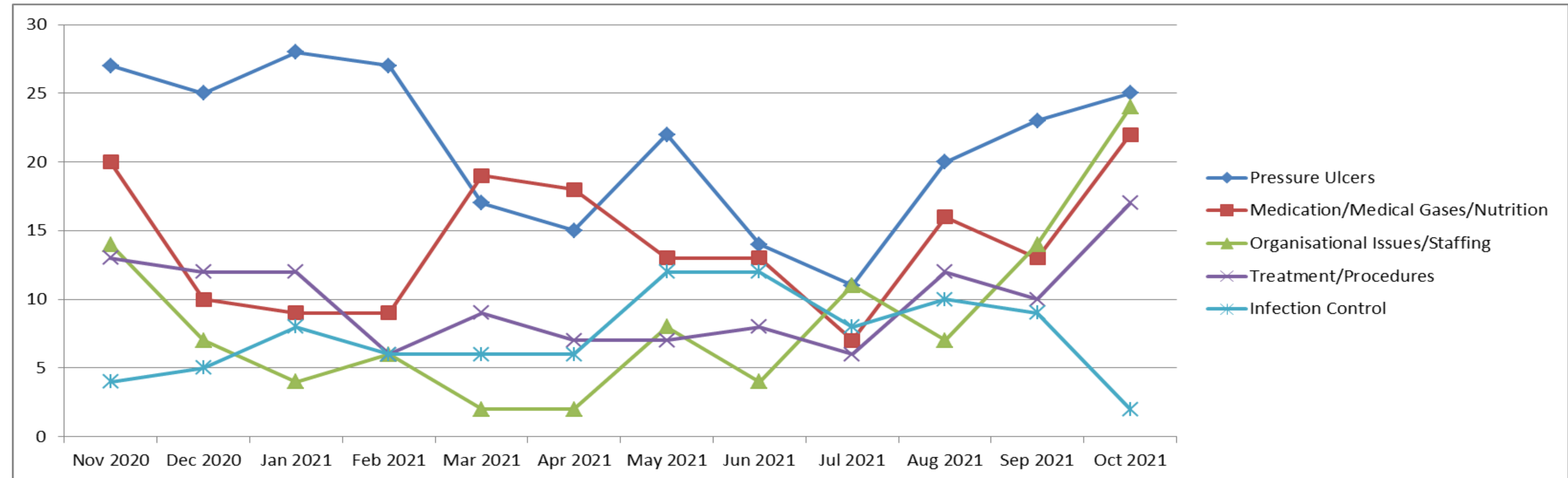
Complaints: Of the 9 complaints raised during Oct 2021 (further information is in PIPR Caring); two were located in 3 South and two were located in CCA. These remain under investigation and/or review within the Clinical Divisions. Themes and lessons learned are monitored by the Clinical Governance department in partnership with the clinical leadership teams.
Red flags: HealthRoster has been checked for red flags raised during Oct 2021. 4NW = 0; 3S = 5 (x3 missed breaks; x2 shortfall in RN time); CCA = 156 (18x bedpan/commode over 10 mins wait; 28x delay of >10mins bed hygiene ; 3x delay of >10mins pain relief; 6x shift end delay by more than 30mins; 52 x unable to deliver pressure area care; 1x Delay in providing pain relief (30mins); 2x Medication Omissions (Unplanned); 44x Missed Breaks; x1 Shortfall in RN time - 8 hours or more; x1 Vital signs not assessed or recorded).

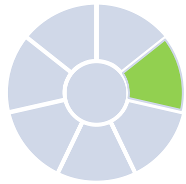
Actions being taken:

- In response to increased red flags and staff feedback, planned theatre activity has been reduced during October and November, in partnership with ops and the clinical division teams.
- Continue to promote the use of red flags – this is also reassuring for the staff who feel they have a way of escalating their concerns and this is being acknowledged (for example, the weekly Chief Nurse report to EDs also includes red flags).
- Continue to encourage and support open reporting culture and just culture.
- Ongoing monitoring of safe staffing and skill mix.
- Individual review and actions as required for each complaint and/or incident; including specialist review for example, the Tissue Viability Team review all the pressure ulcer incidents; and the medications safety group review medication incidents prevalence.

		Target	Oct-21
Dashboard KPI	Safer Staffing CHPPD – 4 NW (Cardiology) *	>9.4	8.91
	Safer Staffing CHPPD – 3 South*	>8	7.54
	Safer Staffing CHPPD – Critical Care *	>32.9	32.53

Row Labels	Count of Severity
⊟ Death UNRELATED to the incident	1
⊟ Low harm	51
⊟ Near Miss	17
⊟ No harm	64
Grand Total	133





Caring: Performance summary

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

		Data Quality	Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Dashboard KPIs	FFT score- Inpatients	4	95%	99.3%	99.4%	99.3%	99.1%	99.2%	97.8%
	FFT score - Outpatients	4	95%	99.1%	98.8%	98.5%	98.7%	97.2%	95.9%
	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	2.9	7.4	7.4	5.9	3.4	7.4
	% 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)	1	0	3	2	1	1
	Number of complaints (12 month rolling average)	4	5 and below	1.8	2.2	2.3	3.3	3.2	3.8
	Number of complaints	4	5	5	9	1	2	4	9
	Number of recorded compliments	4	500	1539	1361	1320	1251	1501	1475
	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 Oct 2021 (accessed 12.11.2021).

FFT (Friends and Family Test): In summary; **Inpatients**: Positive Experience rate has decreased from 99.2% (Sep) to 97.8% (Oct). Participation Rate has increased from 40% (Sep) to 44% (Oct). **Outpatients**: Positive Experience Rate has decreased from 97.2% (Sep) to 95.9% (Oct). Participation Rate was 13.1% (Oct) compared to 13.3% (Sep). There are no indications at this stage that correlate with the drop in Positive Experience Rate score for Inpatient or Outpatients, though this will continue to be monitored.
As a benchmark guide, NHS England FFT positive experience rate Inpatients = 94% (Sep 2021); positive experience rate Outpatients = 92% (Sep 2021). Participation rate is not reported nationally.

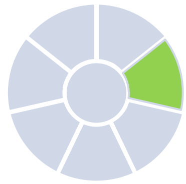
Number of written complaints per 1000 staff WTE is a benchmark figure based on the NHS Model Hospital to enable national benchmarking. We remain in green at 7.4. The latest data from Model Hospital demonstrates we are in the lowest quartile for national comparison (note the Model Hospital data period remains Dec 2019; accessed 12.11.2021): 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 October 2021 at 3.8. We will continue to monitor this in line with the other benchmarking.

Complaints: We have received nine new complaints for October 2021; 3 for Thoracic Services, 2 for Cardiology, 2 for Surgical Services, 1 for Theatres, Critical Care and Anaesthesia and 1 for Estates and Facilities. This is an increase in the number of complaints we have received in comparison to last month (4 in September 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 October 2021 was 1475, broken down as: compliments from FFT – 1413; and compliments via cards/letters etc. – 62.



Caring: Key performance challenges

Formal Complaints

- Our complaint numbers remain overall low at RPH on a annual basis 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 partially upheld. These complaints were closed within the designated timeframe within 25 working days, which had been agreed with the complainant.
- We have also received 1 informal complaint (enquiry) this month, from an MP on behalf of their constituent which has been responded to and closed within the month.
- A summary of the two recent closed complaints is in the box below.

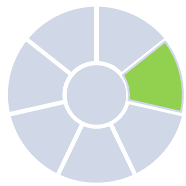
Learning from earlier Complaints

Complaint reference/Datix:14436 – Date closed 1 October 2021- Not Upheld.
This complaint related to a Cardiology patient and the care received; patient raised concerns regarding the cream given to use on a rash whilst an inpatient. The cream was issued and supplied accordingly as per manufacturer instructions. The cream was not used on the areas where latter local reactions occurred. Apology given for patient's experience and shared with the clinical team for their learning and reflection.

Complaint reference/Datix:14501 – Date closed 28 October 2021- Partially Upheld.
This complaint was from a Cardiology patient regarding the ongoing complications experienced after pacemaker insertion. The patient was unhappy with the care provided and had specific questions they wanted addressing. It was partially upheld as the patient's pain score had not been reviewed again pre-discharge once pain relief had been administered. Learning from the complaint was identified: remind the cardiology team of the importance of clearly communicating if any known complications from such a procedure occur and why and how they have happened; and remind the nursing staff about communication around pain management; and to recheck using pain scores before discharge, to check about pain and any concerns relating to ongoing pain management and what to expect. We will also implement spots checks on pain management and access to pain management in a timely way.

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.

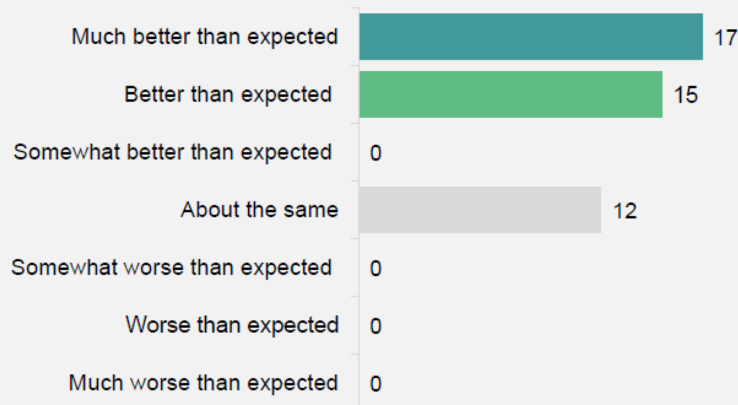


Caring: Spotlight On – CQC Inpatient Survey results

NHS Adult Inpatients Survey 2020 Benchmark Report
The Adult Inpatient Survey 2020 Benchmark Report was published on the CQC website on 19th October 2021 and highlights a very positive adult inpatient experience at RPH.
Results have been presented to the Trust Board and Q&R Committee. This report will provide an overview for PIPR.

Executive Summary
Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital during November 2020 and were not admitted to maternity or psychiatric units. Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between January and May 2021.

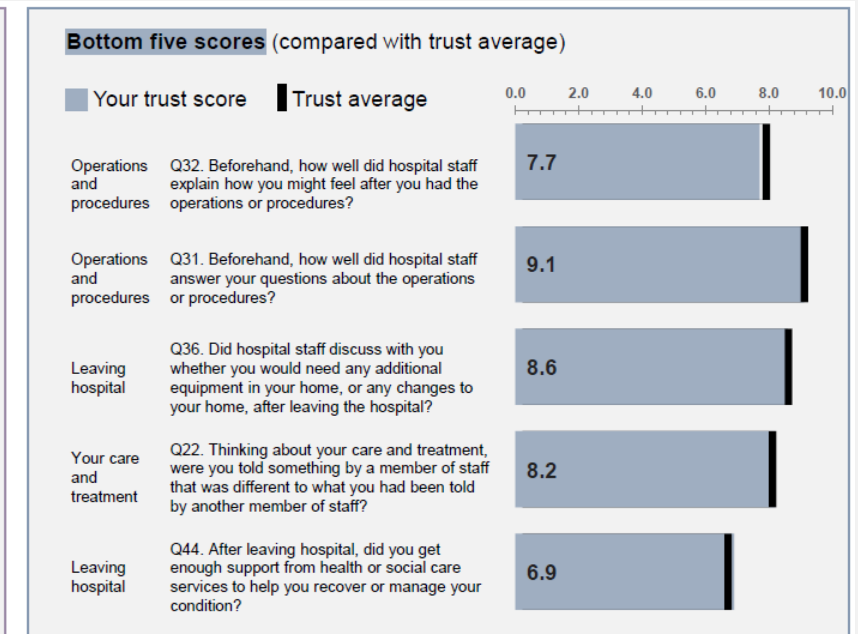
Respondents and response rate
825 RPH patients responded to the survey (response rate 67.85% (last year it was a 60% response rate); average response rate for all trusts = 46%)



The CQC note that "results for the Adult Inpatient 2020 survey are not comparable with results from previous years. This is because of a change in survey methodology, extensive redevelopment of the questionnaire, and a different sampling month."
The 'trust average' mentioned in this report is the arithmetic mean of all trusts' scores after weighting is applied.

Respect and Dignity: RPH = 9.7; Trust average = 9.2 **Overall experience:** RPH = 9.2; Trust average = 8.4

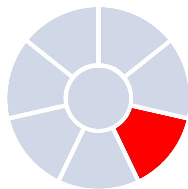
Top 5 and Bottom 5



Of the Bottom five scores, we were defined as "about the same" when compared with the Trust average position. For information (in the same order as the graph above right): Q32 Trust average = 7.8 (RPH = 7.7); Q31 Trust average = 9.0 (RPH = 9.1); Q36 Trust average = 8.5 (RPH = 8.6); Q22 Trust average = 8.0 (RPH = 8.2); and Q44 Trust average = 6.6 (RPH = 6.9).

Following the survey results, the Trust will:

- Celebrate the adult inpatient survey results with staff, patients and public.
- Working with the Trust Quality Compliance Officer and staff, review the areas for improvement, for example the "Bottom five scores", such as leaving hospital.
- Continue to proactively seek feedback from patients, their families and from staff to make improvements.



Effective: Performance summary

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

		Data Quality	Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Dashboard KPIs	Bed Occupancy (excluding CCA and sleep lab)	4	85% (Green 80%90%)	70.2%	73.7%	71.2%	69.2%	70.3%	71.4%
	CCA bed occupancy	4	85% (Green 80%90%)	89.7%	96.1%	93.3%	86.8%	91.5%	95.5%
	Admitted Patient Care (elective and non-elective)	4	0 (current mnth)	1928	2215	2100	2040	2305	2030
	Outpatient attendances	4	0 (current mnth)	8133	8958	8243	7364	8421	8193
	Cardiac surgery mortality (Crude)*	3	<3%	2.80%	2.90%	2.76%	2.84%	2.99%	2.76%
	Theatre Utilisation	3	85%	95.2%	74.4%	75.7%	63.7%	62.8%	77.0%
	Cath Lab Utilisation 1-6 at New Papworth (including 15 min Turn Around Times)	3	85%	85%	88%	81%	73%	79%	78%
Additional KPIs	Length of stay – Cardiac Elective – CABG (days)	4	8.20	8.32	8.24	9.33	7.20	8.27	8.28
	Length of stay – Cardiac Elective – valves (days)	4	9.70	8.04	9.59	10.40	11.42	9.79	9.07
	CCA length of stay (LOS) (hours) - mean	4	Monitor only	84	96	94	100	120	102
	CCA LOS (hours) - median	4	Monitor only	30	37	42	33	25	45
	Length of Stay – combined (excl. Day cases) days	4	Monitor only	5.55	5.81	5.44	6.11	5.59	5.54
	% Day cases	4	Monitor only	64.4%	65.5%	61.6%	65.2%	63.7%	64.0%
	Same Day Admissions – Cardiac (eligible patients)	4	50%	44.2%	39.5%	33.3%	38.0%	17.9%	30.2%
	Same Day Admissions - Thoracic (eligible patients)	4	40%	13.5%	7.7%	20.5%	14.6%	16.7%	6.7%

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

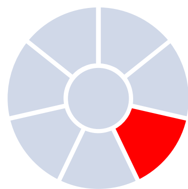
Summary of Performance and Key Messages:

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 October. This reduced bed occupancy against the funded number of general and acute and critical care beds. In addition ECMO demand remained high, with approximately a third of available capacity utilised to service this need, throughout the month. This has driven higher than ideal levels of occupancy in critical care.
The low level of occupancy across the general and acute bed base is not consistent across all specialities. The constrained critical care capacity has limited surgical activity so the occupancy on the surgical floor has been consistently low, while the Cardiology and Respiratory bed base have been running very hot. Nursing staff from the surgical floor have been supporting critical care through a voluntary re-deployment of staff with critical care skills and experience.

Utilisation of Treatment functions
Critical Care capacity remained the key constraint to flow and as a consequence utilisation of theatre was reduced. Daily review of electivity activity has taken place with clinical input and evaluation, to ensure the most appropriate use of capacity. This has been done in collaboration across the surgical division. However, in spite of planned reductions in elective surgical cases, cancellations have remained high due to on the day staffing shortages in critical care due to short term sickness.
Cath lab utilisation has been constrained by Radiographer shortages and gaps in staffing within the Booking team, also due to staff sickness. The Cardiology divisional team have been supporting the Booking team to optimise the booking of cath lab schedules in the later part of October and November.

Outpatient Activity
Despite staffing shortages in Outpatients, performance remains strong in this area, with the activity on plan in month. There remains a high dependence on virtual clinic which have been facilitated by the extensive rollout of remote monitoring devices during the first wave of the pandemic.

CPAP Recall and Repair Programme
The planned rollout of the Philips CPAP repair and replacement programme has been delayed from it's scheduled start in October due to delays in replacement CPAP devices arriving in the UK. The team continuing to work closely with the Philips team in preparation for commencement of the programme.



Effective: Activity Restoration

Background and purpose

It is intended to provide a summary of referral and activity numbers 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 later changed to 95%.
- Guidance on finance and contracting arrangements relating to the second half of the financial year was received on 30 Sep. This is currently being assessed. Further details will be included in future reports.

Dashboard headlines

The tables to the right show how the provisional numbers for M7 compare to 2019/20 numbers at a Trust level and at specialty level. At the time of publication the billing data is still being processed so these numbers are subject to change.

Green represents where the NHSI/E target has been met, Amber is where performance is within +/-5% of the target.

M7 provisional activity performance in line with target

- **Radiology –** CTs met the M7 expected target.

M7 provisional activity performance behind target

- **Referrals** – GP referrals fell short of the expected target by 27%. Cons-to-Cons referrals fell short of the expected target by just 0.3%
- **Admitted activity** – Elective inpatients and daycases did not meet the expected M7 NHSI/E target.
- **Non-Admitted Activity** – First and Follow-up activity did not meet the expected M7 target.
- **Radiology –** MRIs and Other Radiology exams did not meet the expected M7 target.

Summary of Performance

Table 1: Trust Level

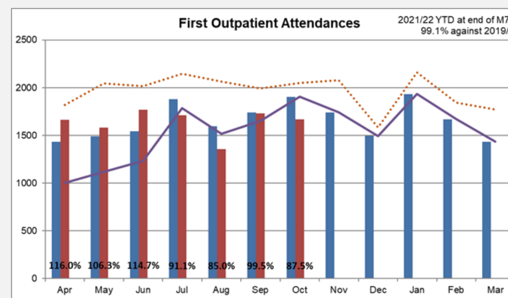
Category		M7 against 2019/20 M7 *
Referrals	GP	73.0%
	Cons-to-Cons	99.7%
Non-Admitted	First	87.5%
	Follow up	94.8%
Radiology	MRI	81.1%
	CT	103.9%
	Other	85.1%
Admitted Activity	Elective Inpatients	65.0%
	Daycases	73.8%
	Non-Elective Inpatients	91.5%

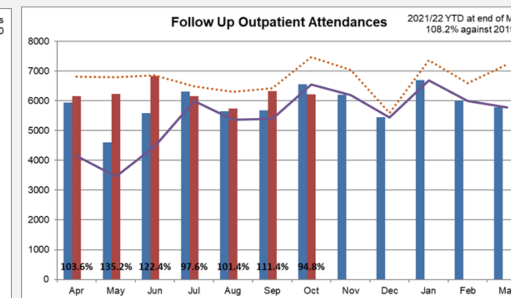
Table 2: M7 activity compared to 2019/20 (Specialty Level)

Specialty	EL	DC	NEL	OPFA	OPFU
Cardiac Surgery	62.6%	100.0%	104.8%	58.2%	57.9%
Cardiology	77.6%	78.3%	89.8%	74.5%	112.4%
RSSC	52.5%	86.7%	160.0%	155.2%	64.5%
Thoracic Medicine	77.6%	58.0%	88.9%	69.8%	112.4%
Thoracic Surgery	66.7%	37.5%	91.7%	62.3%	69.2%
Transplant/VAD	127.8%	#DIV/0!	60.0%	60.0%	78.1%
PTE	50.0%	#DIV/0!	#DIV/0!	100.0%	76.7%
Trust	65.0%	73.8%	91.5%	87.5%	94.8%

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

Outpatient Performance

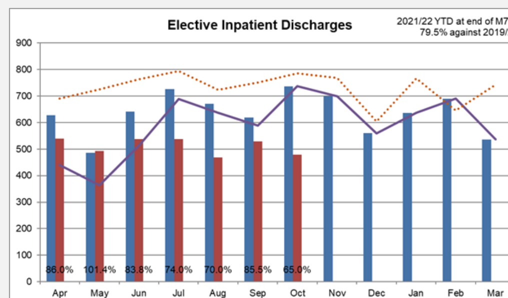


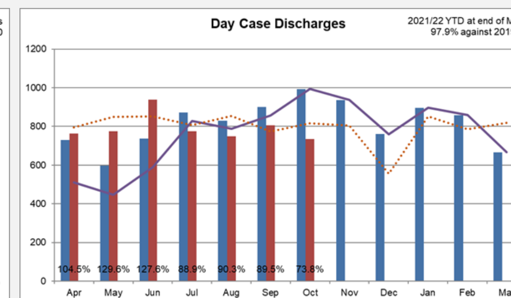


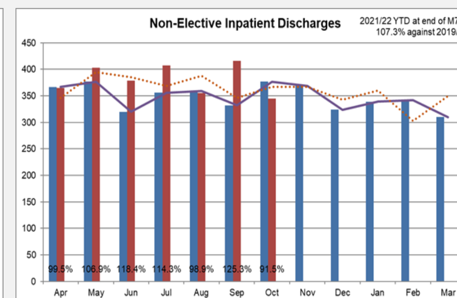
Key:
- Activity 19/20
- Activity 21/22
- Projection of monthly performance
- NHSI/E Target
- Activity 18/19

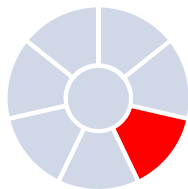
NB: % denotes 2020/21 vs same month in prior year

Admitted Performance



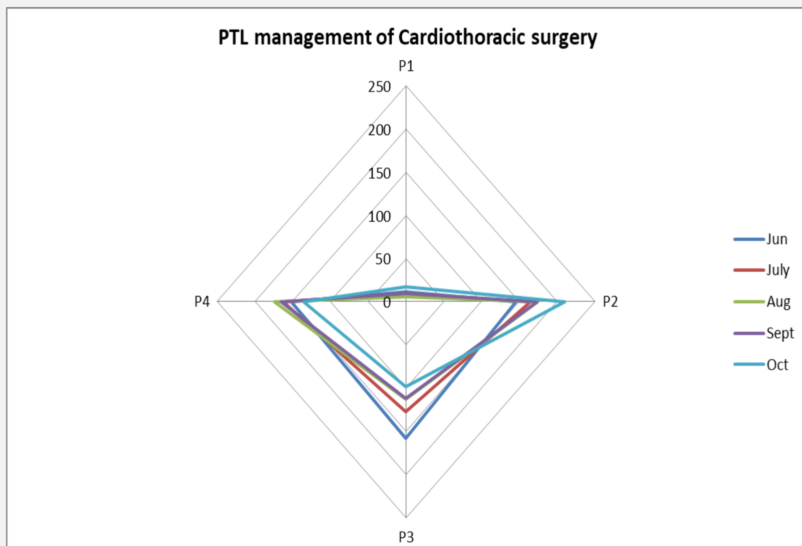


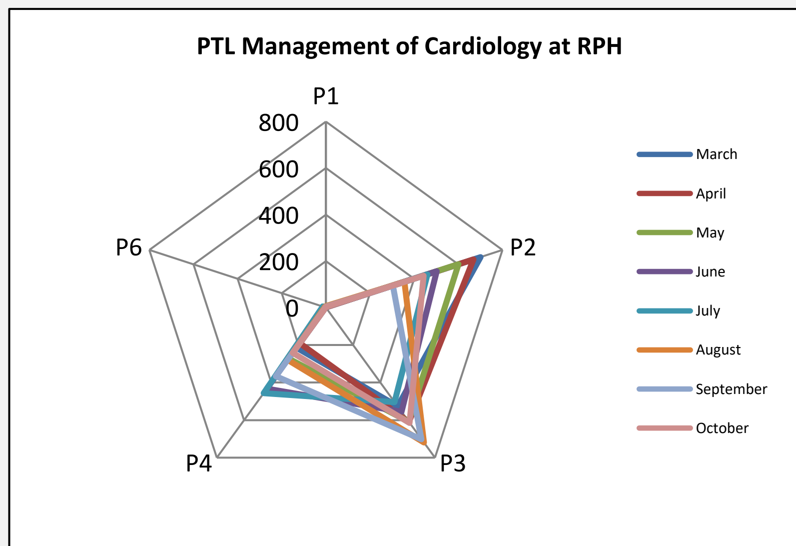


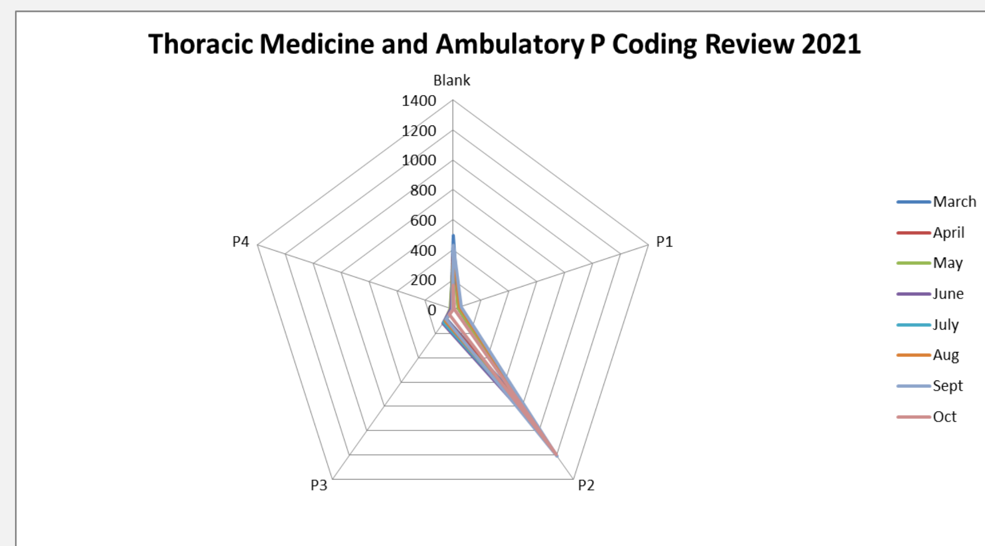


Effective: Spotlight on: Priority Status Management

>24 hours for treatment	PL1a
> 72 hours for treatment	PL1b
<1 month	PL2
<3 months	PL3
>3 months (Delay 3 months possible)	PL4
Patient wishes to postpone surgery because of COVID-19 concerns**	PL5
Patient wishes to postpone surgery due to non-COVID-19 concerns**	PL6







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 537 patients on the PTL as of end October in total and the current live actions are as follows:

- 145 - Planned or booked
- 196 - Awaiting action to book varying priority statuses
- 73 - Planned OPD / Diagnostic appointment
- 75 - Awaiting Admin action to progress (chasing up imaging etc)

- There are currently 1 P6 patient on the PTL, which is the code used for patients that have chosen to delay their care due to non-COVID concerns.

Cardiology

The total PTL size for Cardiology in October was 1303, which was a reduction of 6% on the previous month. The number of P2 patients increased in October as patients progress through the time stratification of the P levels.

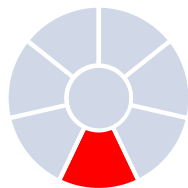
Booking remains focused on clinical urgency of patients but, in accordance with case mix availability, best use of resources and the high throughput of patients via the day ward, P3 patients are being routinely offered dates to come in.

Thoracic and Ambulatory

Total number on the PTL for Oct is 1416, a decrease of 21% on last month. We are still maintaining a high volume of P2 patients until they have been through their diagnostics and reviewed.

- 718 – planned and dated
- 164 – awaiting triage and P coded [44 under 4 weeks]
- 532 – awaiting booking of which [436 under 4 weeks]

D coding has now commenced and consultants will clinically prioritise the diagnostic wait and put on the diagnostic action plan, this is now evidenced on the PTL.



Responsive: Performance summary

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

		Data Quality	Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Dashboard KPIs	% diagnostics waiting less than 6 weeks	3	>99%	87.09%	94.29%	92.21%	90.78%	96.03%	97.32%
	18 weeks RTT (combined)	5	92%	83.55%	86.73%	86.26%	86.95%	86.13%	85.99%
	Number of patients on waiting list	5	3,279	3422	3458	3429	3595	3683	3776
	52 week RTT breaches	5	0	11	10	11	9	9	6
	62 days cancer waits post re-allocation (new 38 day IPT rules from Jul18)*	4	85%	66.7%	78.6%	100.0%	38.5%	50.0%	62.5%
	31 days cancer waits*	4	96%	100.0%	100.0%	100.0%	100.0%	96.2%	100.0%
	104 days cancer wait breaches*	4	0	4	4	1	3	3	6
	Theatre cancellations in month	3	30	13	26	46	50	47	45
	% of IHU surgery performed < 7 days of medically fit for surgery	4	95%	47.00%	84.00%	86.00%	82.00%	69.00%	39.00%
	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%	81.10%	85.83%	87.20%	88.40%	85.79%	86.35%
	18 weeks RTT (Cardiac surgery)	5	92%	64.38%	70.70%	71.88%	72.56%	70.91%	68.23%
	18 weeks RTT (Respiratory)	5	92%	93.85%	93.51%	90.45%	90.31%	90.53%	91.03%
	Non RTT open pathway total	2	Monitor only	33,408	34,060	35,086	38,414	36,423	37,020
	Other urgent Cardiology transfer within 5 days %	4	90%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	% patients rebooked within 28 days of last minute cancellation	4	100%	100.00%	100.00%	100.00%	92.59%	85.00%	66.67%
	Outpatient DNA rate	4	9%	5.72%	6.38%	7.34%	6.72%	8.20%	7.76%
	Urgent operations cancelled for a second time	4	0	0	0	0	0	0	1
	% of IHU surgery performed < 10 days of medically fit for surgery	4	95%	66.00%	89.00%	95.00%	87.00%	86.00%	52.00%
	% of patients treated within the time frame of priority status	4	Monitor only	55.0%	45.7%	46.5%	49.4%	48.8%	47.1%
	% of patients on an open elective access plan that have gone by the suggested time frame of their priority status	4	Monitor only	43.1%	38.9%	38.4%	41.5%	39.3%	43.5%

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

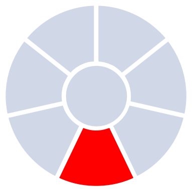
Summary of Performance and Key Messages:

Diagnostic Performance
Although not yet meeting the standard of 99% of diagnostic tests being undertaken within 6 weeks of request, sustained progress has been made in recovering performance against this standard. Two further mutual aid requests have been received by the Trust from system partners for support with CT imaging and Echocardiography. The Radiology team are exploring the potential of delivering some weekend CT waiting list initiatives for CUH and as Echocardiography poses a significant challenge in all three acute providers, the Trust is leading a piece of work to support productivity improvements in this area across the system.

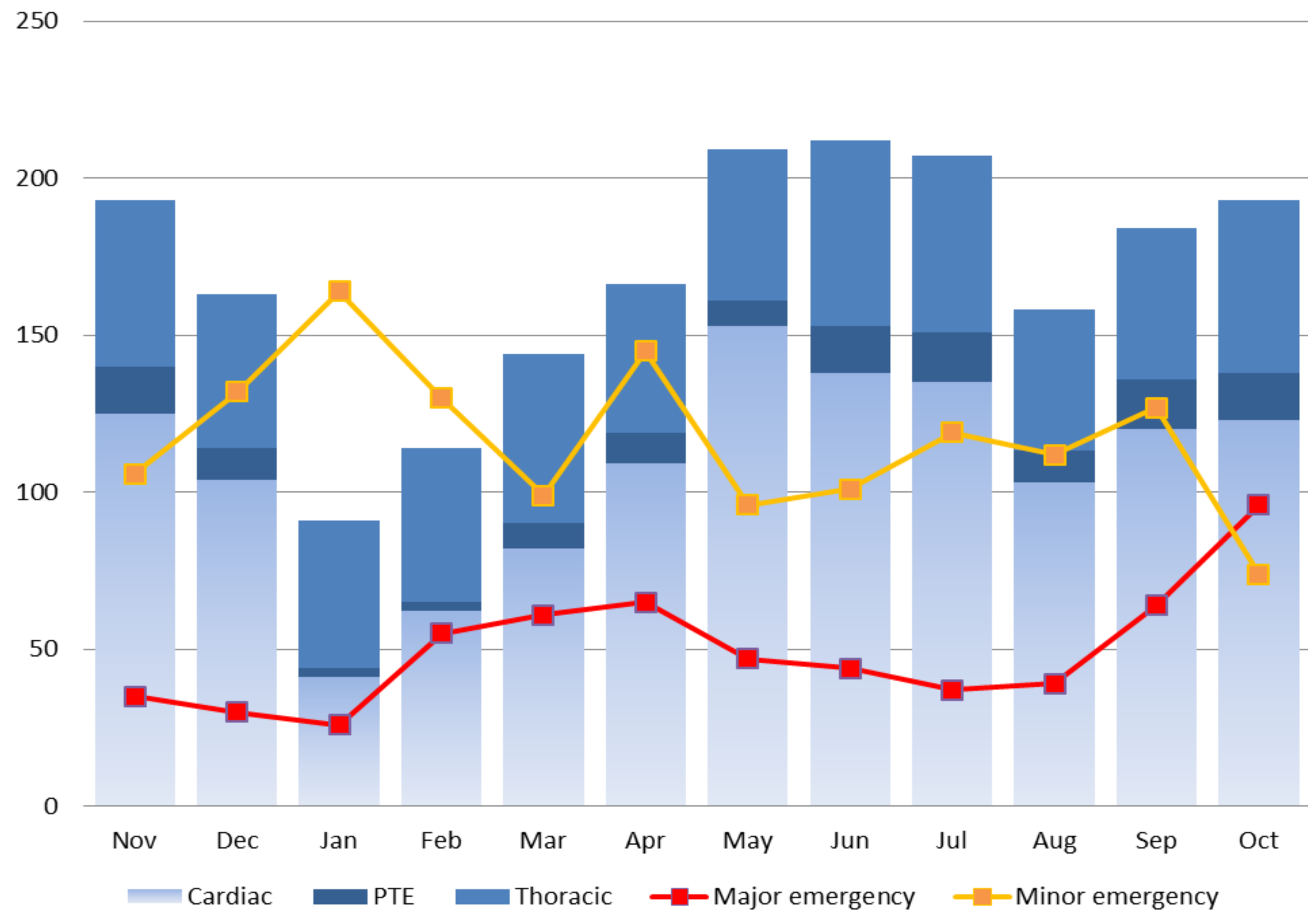
Waiting list Performance
Cardiology: Cardiology have made marginal progress in October in terms of recovering the RTT position with an achievement of 86%. The division offered support to the clinical admin team with a focused piece of work to support bookings for a period in October during staff shortages to enable an increase in cath lab and day ward utilisation.
Respiratory: This month the specialities main focus has been on the Philips CPAP device repair and replace programme. Efforts have been directed to review patients who have been affected by this program of work, which has limited work to support RTT performance recovery. Some data quality errors have been identified by the division and the team are working collaboratively with the BI team to rectify and mitigate.
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 were 6 breaches in October reported, 4 of which are awaiting surgery but have been scheduled for treatment in November. The remaining two patients are breaches of greater than 104 weeks, one each in Cardiology and Respiratory. These breaches were caused by the patients being lost during the migration to the electronic patient record system. The root cause of the errors which resulted in both pathways being closed is under investigation and a review of other pathways closed at that time is underway. Both patients have been treated and harm reviews undertaken.

Cancer Performance
104 day Cancer breaches: Breaches have increased to 6 in October due to regional delays in referrals, turn around of PET scanning at CUH, two complex pathways and patient choice challenges. The aim from region is to reduce to nil 104 day patients by the 31st March 2022.
62 day Cancer waits: Progress made post reallocations and shared success with patients being referred onto CUH for treatment. PET turnaround and late referrals continue to impact on overall compliance.

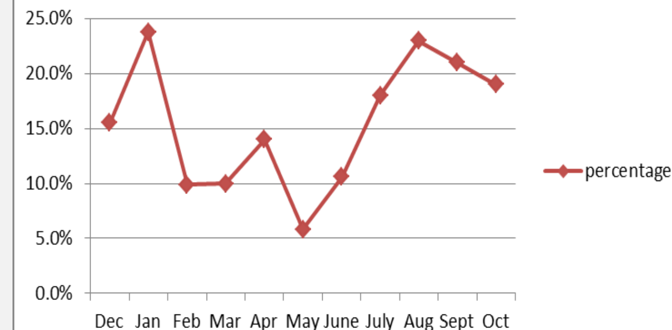


Responsive: Elective versus Emergency demand on Theatres

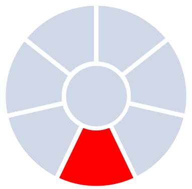


123 Cardiac / 55 Thoracic / 15 PTE / 52 IHU / 12 TX
96 emergency/urgent procedures went through theatres – combination of transplants, returns to theatre and emergency explorations.
74 additional emergency minor procedures also went through theatre and critical care, utilising the theatre team.

Cancellation reason	Oct-21	Total
1b Patient refused surgery	2	3
1c Patient unfit	4	28
2a All CCA beds full with CCA patients	9	26
2b No ward bed available to accept transfer from CCA	2	9
3a Critical Care	13	75
4a Emergency took time	5	28
4b Transplant took time	1	9
4d Additional urgent case added and took slot	6	18
4e Equipment/estate unavailable	1	4
5a Planned case overran	2	33
Total	**45**	**250**



Both Cardiac and Thoracic activity increased marginally in M07, with a number of days of full activity. However, cancellations remained high at 45, which was 19% of all planned activity.
Major emergencies is now classed as an unscheduled procedure that utilised all, or part of the Theatre team which therefore impacted elective work, of which there was 96 in October.



Responsive: Spotlight on Sources of Referral

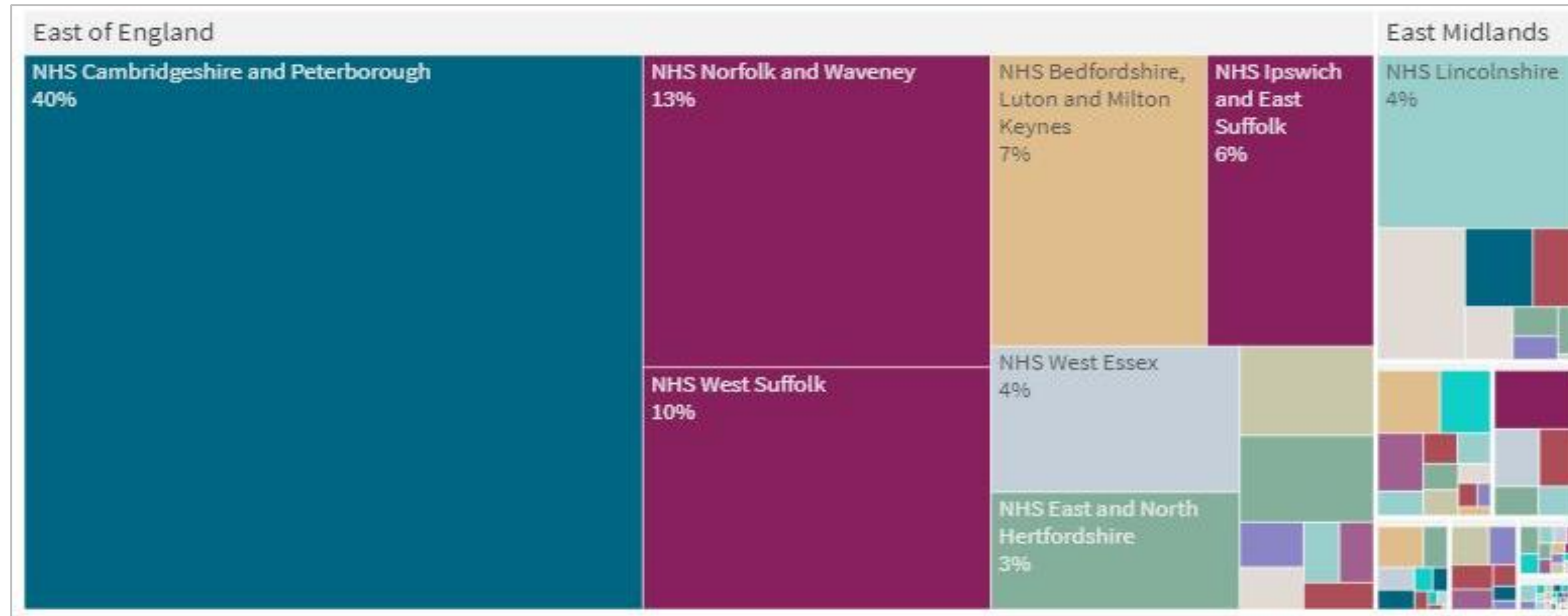
Background

Following a question from the October Performance Committee, this spotlight is intended to describe the relative contributions to both activity and income of referrers at local STP / ICS, regional and national level.

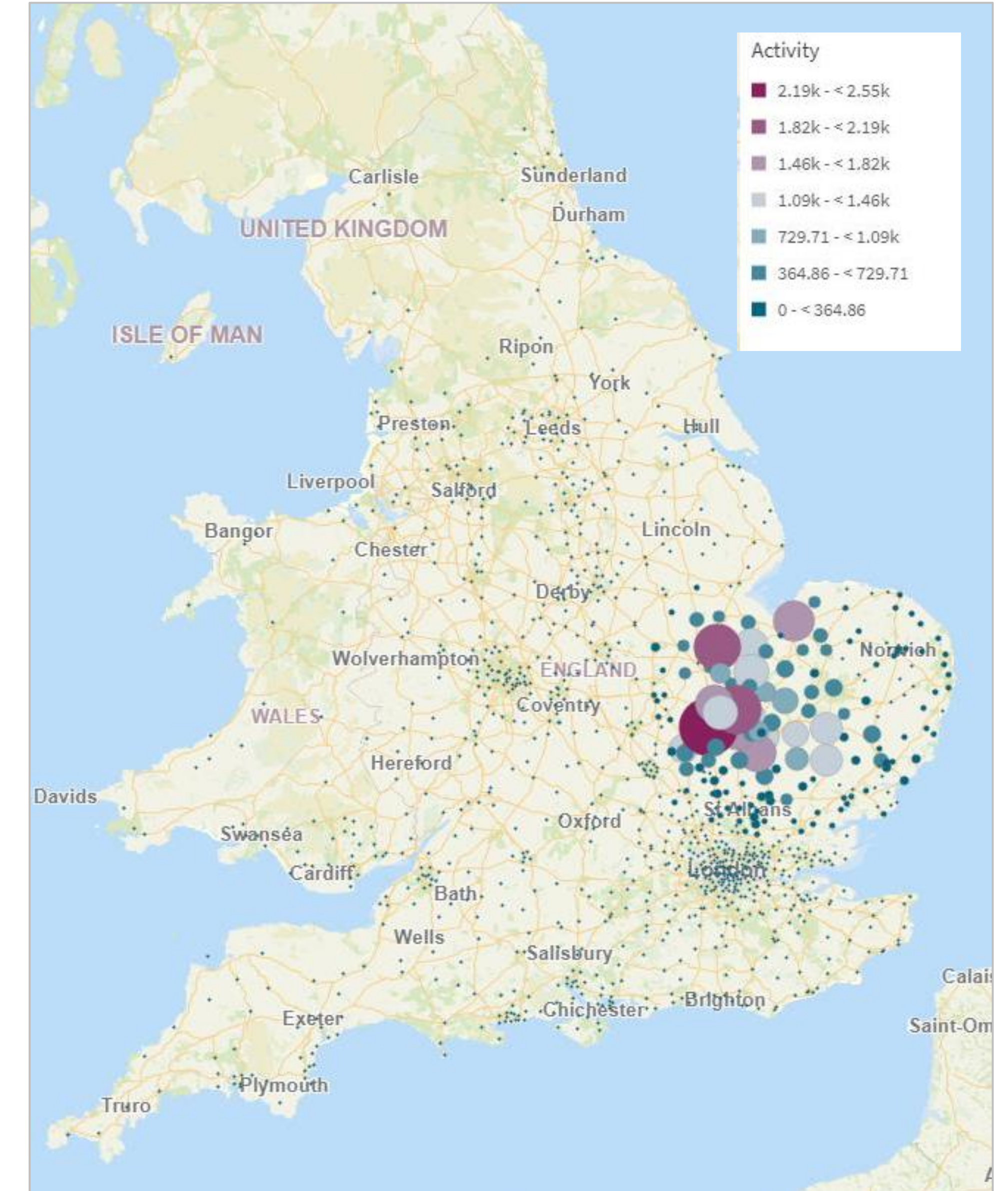
The table below demonstrates that there is good correlation between at activity and income contributions for nationally or specialist commissioned services but it should be noted that the activity, in terms of patients encounters, is significantly higher for our local system than that income contribution would suggest. The reverse is true referrals from outside our region that are not nationally commissioned.

The block diagram maps patient postcode to system and the geographical heat map, maps patient activity to GP locations. Both of these illustrations are based on post code only and will be a mixture of locally, regionally and nationally commissioned services.

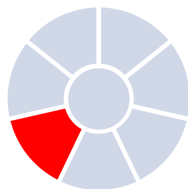
Region	Year	Activity	Income
East of England	2021/21 YTD	47%	49%
NHS Cambridgeshire and Peterborough	2021/21 YTD	40%	29%
Outside our region	2021/21 YTD	13%	22%



2021/22 YTD patient activity by GP location



*NHS elective, non elective, outpatient discharged activity excluding GP practice not known.



People, Management & Culture: Performance summary

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

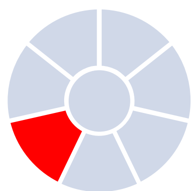
		Data Quality	Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Dashboard KPIs	Voluntary Turnover %	3	12.0%	14.67%	14.08%	11.20%	24.13%	19.01%	19.00%
	Vacancy rate as % of budget	4	5.00%	4.99%	4.93%	6.80%	7.27%	7.57%	7.57%
	% of staff with a current IPR	3	90%	73.97%	75.86%	76.72%	75.15%	73.24%	71.26%
	% Medical Appraisals	3	90%	32.73%	36.61%	38.39%	48.70%	53.91%	63.48%
	Mandatory training %	3	90.00%	87.41%	88.81%	88.18%	87.30%	86.83%	86.31%
	% sickness absence	3	3.5%	3.52%	3.79%	4.41%	3.89%	4.28%	5.27%
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%	2.30%	2.24%	2.82%	3.05%
	Unregistered nursing vacancies excluding pre-registered nurses (% total establishment)	3	5.00%	17.36%	17.11%	14.90%	19.36%	22.43%	24.03%
	Long term sickness absence %	3	0.80%	1.58%	1.67%	1.88%	1.48%	1.55%	1.75%
	Short term sickness absence	3	2.70%	1.93%	2.12%	2.53%	2.41%	2.74%	3.52%
	Agency Usage (wte) Monitor only	3	Monitor only	23.2	24.7	26.2	24.1	28.9	30.6
	Bank Usage (wte) monitor only	3	Monitor only	59.0	58.3	67.7	67.1	61.5	63.4
	Overtime usage (wte) monitor only	3	Monitor only	33.8	42.3	61.1	50.4	58.5	59.1
	Agency spend as % of salary bill	5	1.53%	1.23%	2.14%	1.83%	1.63%	1.27%	1.53%
	Bank spend as % of salary bill	5	1.86%	2.45%	1.86%	2.03%	2.56%	1.83%	1.86%
	% of rosters published 6 weeks in advance	3	Monitor only	10.10%	6.50%	65.70%	26.50%	20.60%	18.20%
	Compliance with headroom for rosters	3	Monitor only	24.30%	30.60%	30.60%	34.00%	33.70%	30.70%
	Band 5 % White background: % BAME background*	3	Monitor only	n/a	58.16% : 41.00%	n/a	n/a	57.93% : 39.22%	n/a
	Band 6 % White background: % BAME background*	3	Monitor only	n/a	72.34% : 26.14%	n/a	n/a	73.44% : 24.88%	n/a
	Band 7 % White background % BAME background*	3	Monitor only	n/a	87.35% : 11.43%	n/a	n/a	85.32% : 13.49%	n/a
	Band 8a % White background % BAME background*	3	Monitor only	n/a	89.53% : 10.47%	n/a	n/a	88.89% : 10.00%	n/a
	Band 8b % White background % BAME background*	3	Monitor only	n/a	86.67% : 10.00%	n/a	n/a	88.48% : 7.69%	n/a
	Band 8c % White background % BAME background*	3	Monitor only	n/a	92.31% : 7.69%	n/a	n/a	93.33% : 6.67%	n/a
	Band 8d % White background % BAME background*	3	Monitor only	n/a	100% : 0.00%	n/a	n/a	100.00% : 0.00%	n/a

* - Data available quarterly from June 21

Summary of Performance and Key Messages:

The headlines for October are as follows:

- Total turnover reduced in October but remained over KPI at 19%. There was not a particular theme in the reasons for leaving but the most common reason for leaving, for those where we have a reason, was lack of opportunity. Staff giving this reason were spread across departments and staff groups and were in primarily Band 5 and Band 2 roles.
- The total Trust vacancy rate remained above KPI at 7.6%. The registered nurse vacancy rate remained below KPI at 3.05%. 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 remained broadly static at 86.3%. 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 further increased in October to 5.27% which is a very high level for this Trust. This includes sickness absence relating to COVID but excludes absence linked to self-isolation. The spotlight looks at sickness absence in more detail and provides information on the regional trends.
- 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 short-notice covid absence and high levels of activity linked to emergency work and recovery of elective work. The Divisions are working together to develop actions to ensure that all staff have an annual appraisal. It is going to take some time to recover and address the backlog given the pressures on staffing utilisation.
- Total temporary staffing usage increased in October 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 have resumed with clinical areas. Theses 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 October roster period was 30.7% which reflects the higher levels of leave both planned and unplanned.



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.
- Mandatory vaccination of staff could result in increased turnover and reduction in workforce utilisation/flexibility as a consequence of needing to redeploy from patient facing roles staff who are not vaccinated either on personal or health grounds.

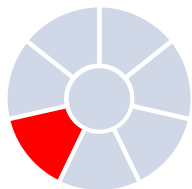
Key Actions:

Flu and Covid-19 Vaccination

The vaccination programme has made good progress and remains a key priority. The Trust Covid-19 hub closed on 9 November 2021 as the numbers remaining requiring vaccination were too small to make it efficient. Staff who still need a booster can receive it at the CUH hub or the mass vaccination hubs. We continue to run a central flu hub and roving flu vaccination service. Communication of the importance of getting vaccinated is a key message in the weekly briefings. At the time of writing this report 83% of staff have had their Covid-19 booster and 72% have had their flu vaccination. This is the highest rate for flu vaccination in the EoE and the second highest for Covid-19. We are awaiting further information from the DH on the requirements for mandatory Covid-19 vaccination. The information we have so far is that the requirement will be for staff in patient facing roles to have received two doses of the vaccine by 1 April 2022. Whilst we await final clarification from the DH on the details of the requirement line managers will start the discussion with staff who have not been double vaccinated to understand their reasons and provide them with support and information.

Rostering Check and Support Sessions

These sessions have resumed co-chaired by the Chief Nursing Officer and the Director of Workforce and OD. At the sessions there is an in-depth review of the roster build looking at the staffing demand template, rostering performance against KPIs, Safer Staffing data and then budgets and staffing establishments. The session brings together the nursing teams responsible for rostering in the clinical area with the rostering, finance and workforce information leads. The sessions will take place on a rolling 6 month basis to enable actions to be checked and progress monitored.

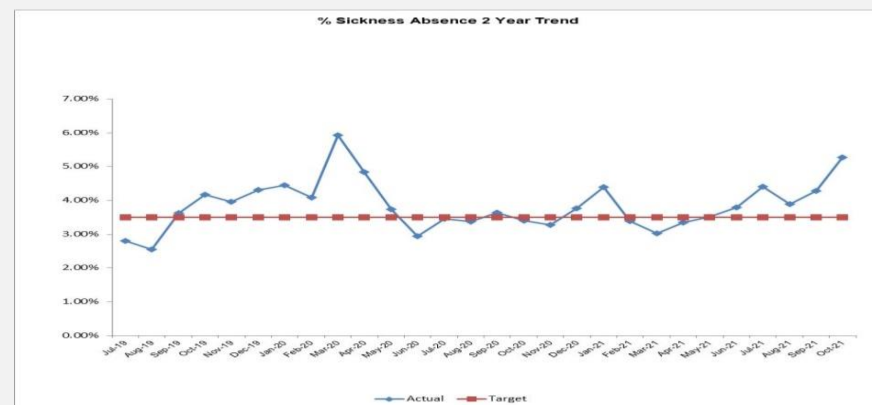


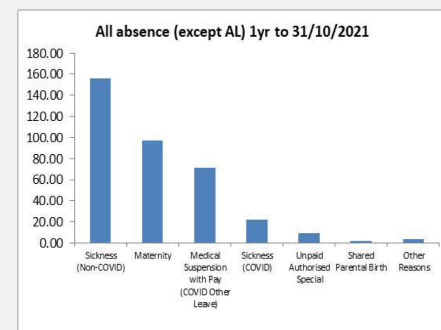
People, Management & Culture: Spotlight On Sickness Absence

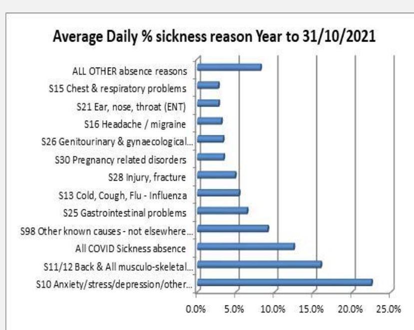
Trust sickness absence trends:

In October the average sickness absence was 5.3% which is the highest rate since the height of the first surge in March 2020. At that time the key driver was Covid-19 sickness absence rates. At this point in the pandemic Covid-19 is not the key driver. Currently the high rates of short-term absence are being driven by coughs/colds/respiratory illnesses, this accounts for a third of the absence in October. Stress, anxiety and depression accounts for a sixth of the absence.

Over the last year the most common reason for absence was stress, anxiety and depression, followed by MSK illnesses and then Covid-19 sickness absence.





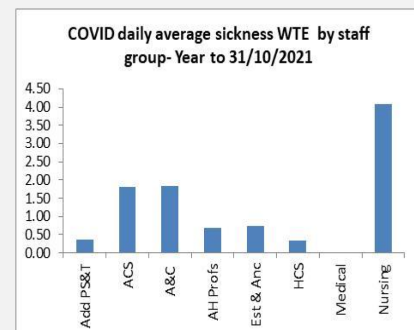


Absence by staff group

Looking at the rates of absence over the last 12 months by staff group, unsurprisingly healthcare support workers (Additional Clinical Services staff group) and estates and facilities had the highest rates of absence. These staff groups traditionally have higher rates of absence than other staff groups. The rate for Medical staff is not accurate as we have identified low levels of reporting with this staff group. Action is being taken to rectify this with medical absence now being reported and recorded centrally by Medical Staffing.

Sickness absence for stress/anxiety/depression accounted for a third of the absence for administrative and clerical staff. This warrants further exploration and consideration of what is driving this.

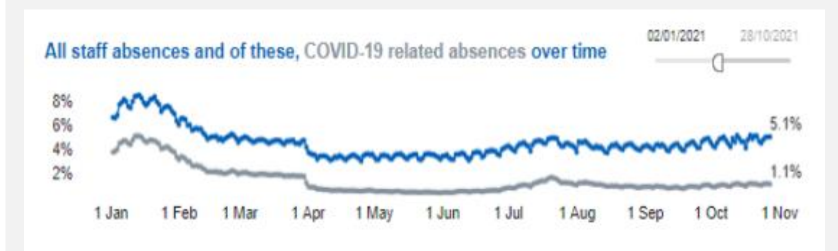
staff group	Absence FTE	Available FTE	Abs %	WTE Average daily Sickness Absence	Ave workforce available
Add Prof Scientific and Technic	571.65	30875.68	1.85%	**1.57**	**84.59**
Additional Clinical Services	7177.99	118452.44	6.06%	**19.67**	**324.53**
Administrative and Clerical	5288.68	153587.77	3.44%	**14.49**	**420.79**
Allied Health Professionals	1288.56	32760.85	3.93%	**3.53**	**89.76**
Estates and Ancillary	1975.53	30132.99	6.56%	**5.41**	**82.56**
Healthcare Scientists	777.95	28245.13	2.75%	**2.13**	**77.38**
Medical and Dental	327.53	84509.63	0.39%	**0.90**	**231.53**
Nursing and Midwifery Registered	11584.32	256575.21	4.51%	**31.74**	**702.95**
Grand Total	**28992.21**	**735308.71**	**3.94%**	**79.43**	**2014.54**



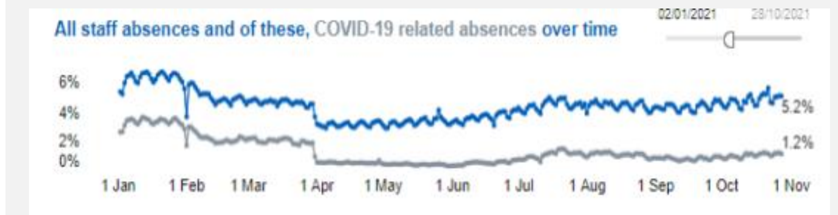
Anxiety/stress/depression/other psychiatric illnesses (SAD)			
Staff Group	**SAD ABS (average wte per day)**	**ALL ABSENCE (average wte per day)**	**% OF ALL due to SAD**
Add PS&T	**0.15**	1.57	**10%**
ACS	**4.45**	19.67	**23%**
A&C	**5.23**	14.49	**36%**
AH Profs	**0.38**	3.53	**11%**
Est & Anc	**1.32**	5.41	**24%**
HCS	**0.18**	2.13	**8%**
Nursing	**5.54**	31.74	**17%**
Grand Total	**17.85**	79.43	**22%**

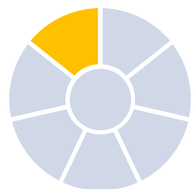
Regional and System Position

In October the EoE average rate of sickness absence was 5.1% of which 1.1% was Covid-19 related sickness absence. The table below shows the 2021 trend which indicates an increasing rate of absence from May onwards for all sickness absence but a relatively flat rate of Covid-19 related absence.



The chart below is the trend for Cambridge and Peterborough ICS. The average absence rate for our system was 5.2% in October. Our absence rate in October was 5.27%. The outlier in our system in October was CCS who had very high rates of non-covid related sickness abence. The rates in the acutes were running at pretty similar levels.





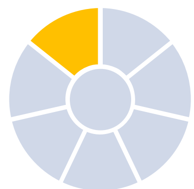
Finance: Performance summary

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

		Data Quality	Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Dashboard KPIs	Year to date surplus/(deficit) exc land sale £000s	5	£2,196k	£827k	£5,771k	£5,802k	£4,042k	£2,238k	£2,246k
	Cash Position at month end £000s	5	£0k	£61,532k	£62,939k	£66,388k	£57,425k	£60,142k	£59,081k
	Capital Expenditure YTD £000s	5	£472 YTD	£26k	£139k	£139k	£206k	£218k	£561k
	In month Clinical Income £000s*	5	£16873k (current month)	£17,197k	£20,333k	£18,179k	£15,434k	£18,543k	£16,873k
	CIP – actual achievement YTD - £000s	4	£1,980k	£550k	£880k	£1,260k	£1,960k	£2,660k	£3,830k
	CIP – Target identified YTD £000s	4	£5390k	£4,250k	£5,390k	£5,390k	£5,390k	£5,390k	£5,390k
Additional KPIs	NHS Debtors > 90 days overdue	5	15%	40.6%	41.3%	72.5%	51.5%	61.1%	46.7%
	Non NHS Debtors > 90 days overdue	5	15%	11.5%	11.1%	14.6%	16.8%	22.6%	25.6%
	Capital Service Rating	5	4	2	1	1	2	3	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	£3,609k	£9,971k	£11,363k	£10,991k	£10,575k	£11,974k
	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	£3,761k	£3,744k	£3,699k	£2,700k	£2,291k	£2,708k
	Better payment practice code compliance - NHS	5	Monitor only	85%	83%	83%	77%	86%	80%
	Better payment practice code compliance - Non NHS	5	Monitor only	94%	92%	96%	93%	94%	95%

Summary of Performance and Key Messages:

- **The YTD position is reported against the Trust's H1 and draft H2 2021/22 plan and shows a surplus of £2.6m which is marginally favourable to 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 M7, 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 £1.9m 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 October: 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 £59.1m.** This represents an decrease of c£1m from last month and is mainly driven by a reduction in trade and other payables. 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 79% by value and 95% by volume vs the 95% standard. This is a reduction over M6 and below expectations. The reduction is due to one off issue and actions have been put in place to mitigate reoccurrence of the issue in future months. The Trust will continue to follow its action plan to ensure that the 95% standard is met consistently by Q3.



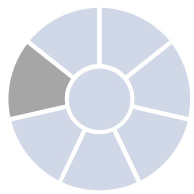
Finance: Key Performance – year to date SOCI

On a YTD basis the Trust delivered £2.6m surplus against a surplus plan of £2.5m. Income performance reflects the better than planned performance on private patient activity. This is offset by the adverse variance on non-clinical supplies due to COVID-19 costs, provisions for clinical perfusion service, DCD, M Abscessus.

	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	£79,563	£84,386	£0	£0	£84,386	£4,823	
Balance to block payment -activity only	£0	(£4,823)	£0	£0	(£4,823)	(£4,823)	
Homecare Pharmacy Income	£28,275	£24,848	£0	£0	£24,848	(£3,428)	
Drugs and Devices - cost and volume	£7,017	£6,841	£0	£0	£6,841	(£176)	
Balance to block payment - drugs and devices	£0	£655	£0	£0	£655	£655	
Sub-total	**£114,856**	**£111,906**	**£0**	**£0**	**£111,906**	**(£2,950)**	
Clinical income - Outside of national block framework							
Drugs & Devices	£358	£913	£0	£0	£913	£554	
Other clinical income	£1,306	£1,693	£0	£0	£1,693	£387	
Private patients	£3,500	£4,684	£0	£0	£4,684	£1,184	
Sub-total	**£5,165**	**£7,290**	**£0**	**£0**	**£7,290**	**£2,125**	
Total clinical income	**£120,020**	**£119,196**	**£0**	**£0**	**£119,196**	**(£824)**	
Other operating income							
Covid-19 funding and ERF	£8,739	£0	£3,739	£4,791	£8,531	(£209)	
Top-up funding	£20,736	£20,752	£0	£0	£20,752	£16	
Other operating income	£8,581	£8,804	£0	£0	£8,804	£223	
Total operating income	**£38,056**	**£29,556**	**£3,739**	**£4,791**	**£38,087**	**£31**	
Total income	**£158,076**	**£148,752**	**£3,739**	**£4,791**	**£157,283**	**(£793)**	
Pay expenditure							
Substantive	(£66,649)	(£63,769)	(£257)	(£3,682)	(£67,708)	(£1,059)	
Bank	(£1,338)	(£1,366)	(£98)	£0	(£1,465)	(£127)	
Agency	(£2,300)	(£1,017)	(£17)	£0	(£1,033)	£1,266	
Sub-total	**(£70,287)**	**(£66,153)**	**(£372)**	**(£3,682)**	**(£70,207)**	**£80**	
Non-pay expenditure							
Clinical supplies	(£24,485)	(£23,261)	(£21)	(£667)	(£23,949)	£536	
Drugs	(£3,984)	(£2,954)	(£472)	£0	(£3,425)	£559	
Homecare Pharmacy Drugs	(£28,288)	(£24,338)	£0	£0	(£24,338)	£3,950	
Non-clinical supplies	(£19,021)	(£17,832)	(£1,138)	(£4,421)	(£23,392)	(£4,371)	
Depreciation (excluding Donated Assets)	(£5,355)	(£5,301)	£0	£0	(£5,301)	£54	
Depreciation (Donated Assets)	(£358)	(£305)	£0	£0	(£305)	£53	
Sub-total	**(£81,491)**	**(£73,991)**	**(£1,631)**	**(£5,088)**	**(£80,710)**	**£781**	
Total operating expenditure	**(£151,778)**	**(£140,143)**	**(£2,003)**	**(£8,770)**	**(£150,917)**	**£861**	
Finance costs							
Finance income	£0	£0	£0	£0	£0	(£0)	
Finance costs	(£2,991)	(£2,951)	£0	£0	(£2,951)	£40	
PDC dividend	(£1,167)	(£1,169)	£0	£0	(£1,169)	(£2)	
Revaluations/(Impairments)	£0	£0	£0	£0	£0	£0	
Gains/(losses) on disposals	£0	£0	£0	£0	£0	£0	
Sub-total	**(£4,158)**	**(£4,120)**	**£0**	**£0**	**(£4,120)**	**£38**	
Surplus/(Deficit) including central funding	**£2,141**	**£4,489**	**£1,736**	**(£3,979)**	**£2,246**	**£105**	
Surplus/(Deficit) Control Total basis	**£2,499**	**£4,794**	**£1,736**	**(£3,979)**	**£2,551**	**£53**	

- Clinical income is £0.8m favourable to plan.
    - Income from activity on PbR basis is above block levels by £4.8m. 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 £1.2m higher than plan. This is driven by increased activity within Cardiology, Cardiac Surgery and Thoracic Medicine and RSSC services.

  Other operating income is favorable to plan by £0.2m, mainly due to Digital aspirant funding which is offset by non-clinical supplies and pay spend.
- Pay expenditure is favourable to plan by £0.1m. Substantive spend run rates have held consistent throughout the year. 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 favourable to plan by £0.5m. 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 £4m 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 £4.4m. £1.1m 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	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Comments
Additional KPIs	Elective activity as % 19/20 (ICS)	3	Monitor only	66.6%	77.8%	77.30%	82.10%	76.00%	70.80%	Latest data to w/e 07/11/21
	Non Elective activity as % 19/20 (ICS)	3	Monitor only	96.2%	95.8%	92.90%	86.40%	92.60%	84.20%	Latest data to w/e 07/11/21
	Day Case activity as % 19/20 (ICS)	3	Monitor only	86.8%	99.3%	73.20%	91.90%	98.40%	99.00%	Latest data to w/e 07/11/21
	Outpatient - First activity as % 19/20 (ICS)	3	Monitor only	69.3%	95.7%	86.50%	91.00%	112.10%	127.00%	Latest data to w/e 07/11/21
	Outpatient - Follow Up activity as % 19/20 (ICS)	3	Monitor only	76.5%	106.6%	98.70%	104.70%	105.60%	116.50%	Latest data to w/e 07/11/21
	Virtual clinics – ICS wide % of all outpatient attendances that are virtual	3	Monitor only	34.7%	29.0%	26.60%	27.30%	26.80%	25.70%	Latest data to w/e 07/11/21
	Diagnostics < 6 weeks %	3	Monitor only	54.9%	57.4%	56.20%	50.80%	54.10%	55.20%	Latest data to w/e 07/11/21
	18 week wait %	3	Monitor only	63.7%	66.7%	67.20%	64.60%	63.70%	62.70%	RTT Metrics comprise CUHFT & NWAFT & RPH to w/e 02/11/21
	No of waiters > 52 weeks	3	Monitor only	6,644	6,103	6,385	7,149	7,672	8,045	RTT Metrics comprise CUHFT & NWAFT & RPH to w/e 02/11/21
	Cancer - 2 weeks % (ICS)	3	Monitor only	n/a	n/a	77.50%	n/a	n/a	79.70%	Latest Cancer Performance Metrics available are September 2021
	Cancer - 62 days wait % (ICS)	3	Monitor only	n/a	n/a	75.70%	n/a	n/a	66.20%	Latest Cancer Performance Metrics available are September 2021
	Finance – ICS bottom line position	3	Monitor only	n/a	£0.9m	n/a	n/a	n/a	n/a	Latest financial update is for June 21
	Staff absences % (C&P)	3	Monitor only	3.2%	4.0%	4.00%	4.00%	4.20%	4.50%	Latest data to w/e 07/11/21

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.