Royal Papworth Hospital
NHS Foundation Trust

Papworth Integrated Performance Report (PIPR)

February 2022

Content

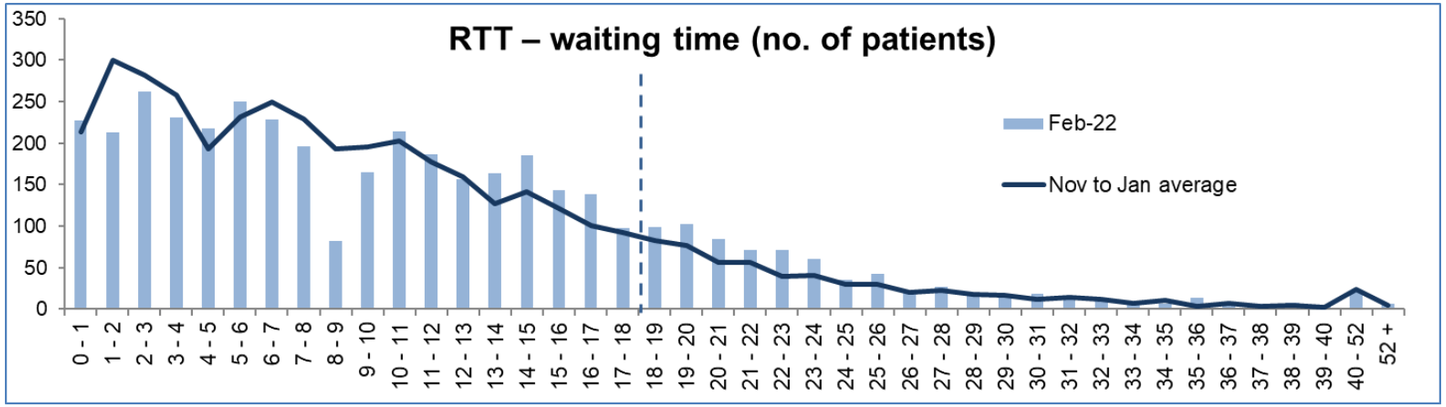
Context:

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	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Trend
Cardiac Surgery	161	165	134	156	101	146	
Cardiology	735	645	690	656	644	636	
ECMO (days)	307	234	270	212	247	165	
ITU (COVID)	0	0	0	1	0	1	
PTE operations	18	14	9	10	12	10	
RSSC	665	564	599	517	416	487	
Thoracic Medicine	311	306	318	273	284	284	
Thoracic surgery (exc PTE)	53	52	61	63	57	62	
Transplant/VAD	55	50	51	56	49	36	
Total Inpatients	**2,305**	**2,030**	**2,132**	**1,944**	**1,810**	**1,827**	

Outpatient Attendances	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Trend
Cardiac Surgery	430	381	387	393	432	415	
Cardiology	3,760	3,791	4,225	3,577	3,729	3,683	
RSSC	1,472	1,561	1,925	1,582	1,602	1,501	
Thoracic Medicine	2,340	2,120	2,511	2,201	2,265	2,225	
Thoracic surgery (exc PTE)	128	83	128	75	116	80	
Transplant/VAD	291	257	276	264	267	250	
Total Outpatients	**8,421**	**8,193**	**9,452**	**8,092**	**8,411**	**8,154**	

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

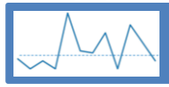
Each category within the Balanced scorecard is given an overall RAG rating based on the rating of the KPIs within the category that appear on the balance scorecard (page 4).

- **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)

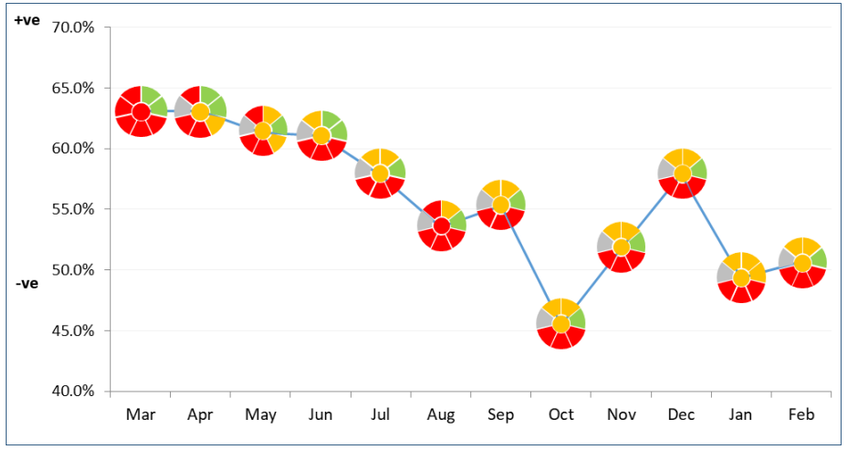
Data Quality Indicator

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

CARING: Number of written complaints per 1000 staff WTE - is a benchmark figure based on the NHS Model Health System to enable national benchmarking. We remain in green at 3.0. The data from Model Health System continues to demonstrate we are in the lowest quartile for national comparison;
EFFECTIVE: The numbers of patients seen in Outpatients remained strong despite the fewer working days in month. This was particularly true for follow-up appointments. The Outpatient productivity initiative is well established and as part of resetting expectations and processes across the Trust the monitoring of bookings with up to 6 weeks notice has been reinstated;
RESPONSIVE: This month saw an improvement in diagnostic performance in spite of further Radiographer staffing challenges. Although the national standard has not been met the achievement of 96.68% having access to diagnostic testing within 6 weeks compares favourably to 64.4% of patients across the East of England region;
PEOPLE, MANAGEMENT & CULTURE: Medical appraisal compliance continues to improve. Non medical appraisal rates have improved for the second month as managers try to refocus on appraisals and mandatory training for their staff. This does continue to be challenging as a result of high short term absence due to Covid-19;
FINANCE: 1) The YTD position is reported against the Trust's H1 and H2 2021/22 plan and shows a surplus of £5m which is £2.5m 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 partially offset by a number of non recurrent items and provisions. 2) CIP is ahead of plan by £0.9m 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

SAFE: High Impact Interventions - the result for Feb 2022 has just tipped into amber at 96.4%. IPC and Audit are reviewing the data and following up with the clinical areas as required;
EFFECTIVE: Capacity Utilisation – Although Respiratory ECMO and the numbers of COVID patients within the hospital have continued to gradually decrease in month, high levels of staff absence across the Trust due to sickness and self-isolation persisted. The adverse impact of staff absence was seen across utilisation of the commissioned bed base and treatment functions. Cardiac surgery activity increased significantly to 131 cases in February, the highest since July of last year. However, short term COVID related sickness in the Radiographer and Cardiology Consultant team meant that some elective cath lab activity had to be deferred. This reduced both the volume of patients treated on an admitted care pathway and on cath lab utilisation. A power problem on the 25th February impacted on the entire days activity in theatres and cath labs with only emergency activity being undertaken resulting in 39 cases being cancelled or deferred;
RESPONSIVE: 1) Elective Waiting Times - Although the size of the elective waiting list has stabilised, insufficient long waiting patients are being treated to prevent further deterioration in performance against the referral to treatment standards, both as an aggregate and at a speciality level. This is because treatment functions have been significantly constrained due to high levels of staff absence and because patients are selected for treatment based on their clinical priority score or P score rather than based on the length of time waiting. 2) Cancer performance continues to be challenged due to a combination of late referrals, patients needing more than one diagnostic and discussion in the MDT and timely access to PET-CT. 3) Theatre cancellations rose sharply in month, largely as a result of increasing prevalence of COVID in the community and patients presenting either with a positive COVID test or having a household contact who has tested positive;
PEOPLE, MANAGEMENT & CULTURE: 1) Turnover - at 15.97% is over the 12% KPI again this month. YTD turnover is 16.6%. There were 25 non-medical leavers of which 13 were registered nurses. We have seen turnover increasing steadily over this financial year. Anecdotally this is the trend across system partners who all report increased levels of turnover. 2) The vacancy rate remained at 8.4%. There has been a notable shift in the labour market both for permanent and temporary staff. We have seen a decline in the number of applicants for roles within the Trust particularly in Bands 2-4 as pay rates in retail and hospitality have increased. 3) Absence rates continued at a high level driven by continued high rates of Covid-19 sick leave combined with normal winter rates of absence. We saw Covid absence reduce in the latter half of February although it has increased again through March.

LOOKING AHEAD

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

At a glance – Balanced scorecard

		Month reported on	Data Quality	Plan	Current month score	YTD Actual	Forecast YE	Trend
Safe	Never Events	Feb-22	4	0	0	1		
	Moderate harm incidents and above as % of total PSIs reported	Feb-22	4	3%	0.90%	1.07%		
	Number of Papworth acquired PU (grade 2 and above)	Feb-22	4	35 pa	0	16		
	High impact interventions	Feb-22	3	97%	96.40%	98.17%		
	Falls per 1000 bed days	Feb-22	4	4	3.1	3.2		
	Sepsis - % patients screened and treated (Quarterly)	Feb-22	New	90%	-	93.67%		
	Safer Staffing CHPPD – 5 North	Feb-22	5	9.6	9.4	10.3		
	Safer Staffing CHPPD – 5 South	Feb-22	5	9.6	9.5	9.9		
	Safer Staffing CHPPD – 4 NW (Cardiology)	Feb-22	5	9.4	8.1	8.7		
	Safer Staffing CHPPD – 4 South (Respiratory)	Feb-22	5	6.7	7.8	8.4		
	Safer Staffing CHPPD – 3 North	Feb-22	5	8.6	9.7	10.6		
	Safer Staffing CHPPD – 3 South	Feb-22	5	8	7.6	8.1		
	Safer Staffing CHPPD – Day Ward	Feb-22	5	4.5	4.8	4.8		
	Safer Staffing CHPPD – Critical Care	Feb-22	5	32.9	35.8	34.1		
Effective	Bed Occupancy (excluding CCA and sleep lab)	Feb-22	4	85% (Green 80%-90%)	71.30%	69.98%		
	CCA bed occupancy	Feb-22	4	85% (Green 80%-90%)	78.70%	89.40%		
	Admitted Patient Care (elective and non-elective)	Feb-22	4	2246	1827	22342		
	Outpatient attendances	Feb-22	4	7880	8154	91520		
	Cardiac surgery mortality (Crude)	Feb-22	3	3%	1.99%	1.99%		
	Theatre Utilisation	Feb-22	3	85%	73.2%	75.5%		
	Cath Lab Utilisation 1-6 at New Papworth (including 15 min Turn Around Times)	Feb-22	3	85%	76.0%	80.0%		
Responsive	% diagnostics waiting less than 6 weeks	Feb-22	3	99%	96.68%	93.65%		
	18 weeks RTT (combined)	Feb-22	5	92%	81.32%	81.32%		
	Number of patients on waiting list	Feb-22	5	3279	4128	4128		
	52 week RTT breaches	Feb-22	5	0	6	86		
	62 days cancer waits post re-allocation (new 38 day IPT rules from Jul18)*	Feb-22	4	85%	57.10%	50.00%		
	31 days cancer waits*	Feb-22	4	96%	97.64%	97.64%		
	104 days cancer wait breaches*	Feb-22	4	0%	8	53		
	Theatre cancellations in month	Feb-22	3	30	32	34		
	% of IHU surgery performed < 7 days of medically fit for surgery	Feb-22	4	95%	97.00%	72.09%		
	Acute Coronary Syndrome 3 day transfer %	Feb-22	4	90%	100.00%	100.00%		

		Month reported on	Data Quality	Plan	Current month score	YTD Actual	Forecast YE	Trend
Caring	FFT score- Inpatients	Feb-22	4	95%	98.10%	98.88%		
	FFT score - Outpatients	Feb-22	4	95%	97.10%	97.99%		
	Number of written complaints per 1000 WTE (Rolling 3 mnth average)	Feb-22	4	12.6	3.0			
	Mixed sex accommodation breaches	Feb-22	4	0	0	0		
	% of complaints responded to within agreed timescales	Feb-22	4	100%	100.00%	95.45%		
People Management & Culture	Voluntary Turnover %	Feb-22	3	12.0%	16.0%	16.6%		
	Vacancy rate as % of budget	Feb-22	4	5.0%	8.4%			
	% of staff with a current IPR	Feb-22	3	90%	74.96%			
	% Medical Appraisals	Feb-22	3	90%	76.07%			
	Mandatory training %	Feb-22	3	90%	84.83%	86.44%		
	% sickness absence	Feb-22	3	3.50%	5.36%	4.47%		
Finance	Year to date surplus/(deficit) exc land sale £000s	Feb-22	5	£1,933k	£4,554k			
	Cash Position at month end £000s	Feb-22	5	n/a	£65,347k			
	Capital Expenditure YTD £000s	Feb-22	5	£1,276k	£972k			
	In month Clinical Income £000s	Feb-22	5	£16992k	£17,756k	£194,223k		
	CIP – actual achievement YTD - £000s	Feb-22	4	£4713.33333333333k	£5,630k	£5,630k		
	CIP – Target identified YTD £000s	Feb-22	4	£5,390k	£5,390k	£5,390k		

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

At a glance – Externally reported / regulatory standards

1. NHS Improvement Compliance Framework

NHSI Targets	Measure	Data Quality	NHSI Target	Month	YTD	Previous full quarter	Forecast	Comments
C. Difficile	Monitoring C.Diff (toxin positive)	5	10	1	11	1		
RTT Waiting Times	% Within 18w ks - Incomplete Pathw ays	5	92%	81.32%		85.97%		Monthly measure
Cancer	31 Day Wait for 1st Treatment	4	96%	97.64%	97.64%	98.0%		Current month provisional as going through verification process.
	31 Day Wait for 2nd or Subsequent Treatment - surgery	4	94%	100.00%	100.00%	100.0%		Current month provisional as going through verification process.
	62 Day Wait for 1st Treatment	4	85%	57.10%	66.70%	55.80%		Current month provisional as going through verification process. Data is after reallocations
	104 days cancer w ait breaches	4	0	8	53	20		
VTE	Number of patients assessed for VTE on admission	5	95%	83.20%		84.3%		
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	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Status since last month
Safe	Failure to protect patient from harm from hospital aquired infections	675	MS	5	Yes	8	8	8	8	8	8	↔
Safe	M.Abscessus (linked to BAF risk ID675)	3040	MS	10	In progress	15	15	15	15	15	15	↔
Safe + Effective + PM&C + Responsive	COVID Pandemic	2532	MS	25	In progress	10	10	10	15	15	15	↔
Safe + Effective + Finance + Responsive	Continuity of supply of consumable or services failure	3009	TG	6	In progress	15	15	15	10	10	10	↔
Safe + PM&C	Unable to recruit number of staff with the required skills/experience	1854	OM	6	Yes	10	10	10	10	12	12	↔
Safe + Transformation	Potential for cyber breach and data loss	1021	AR	9	Yes	16	16	16	20	20	20	↔
Effective	Delivery of Efficiency Challenges - CIP Board approved	841	EM	8	Yes	8	8	12	12	12	12	↔
Effective + Finance + PM&C + Responsive + Transformation	Delivery of Trust 5 year strategy	2901	EM	6	In progress	9	9	9	9	9	9	↔
Effective + Finance + Responsive + Transformation	NHS Reforms & ICS strategic risk	3074	TG	8	In progress	-	12	12	12	12	12	↔
Effective + Responsive	Key Supplier Risk	2985	TG	8	In progress	20	20	20	20	20	20	↔
Responsive	Waiting list management	678	EM	8	Yes	16	16	16	16	16	16	↔
Responsive	R&D strategic direction and recognition	730	RH	8	Yes	6	6	6	6	6	9	↑
PM&C	Staff turnover in excess of our target level	1853	OM	6	Yes	15	15	15	15	15	15	↔
PM&C	Low levels of Staff Engagement	1929	OM	6	In progress	12	12	12	12	12	12	↔
Transformation	Lorenzo Optimisation Electronic Patient Record System - benefits	858	AR	12	Yes	8	8	8	8	8	8	↔
Finance	Achieving financial balance	2829	TG	8	In progress	16	16	16	16	16	16	↔
Finance	Achieving financial balance at ICS level	2904	TG	12	In progress	20	20	20	20	20	20	↔
Finance + Transformation	Clinical Research Facility Core Grant Funding	3008	TG	9	In progress	12	12	12	12	12	12	↔

Safe: Performance summary

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

		Data Quality	Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Dashboard KPIs	Never Events	4	0	0	0	0	0	0	0
	Moderate harm incidents and above as % of total PSIs reported	4	<3%	0.30%	0.43%	1.27%	0.46%	1.40%	0.90%
	Number of Papworth acquired PU (grade 2 and above)	4	<4	3	1	1	1	3	0
	High impact interventions	3	97.0%	99.3%	98.7%	96.7%	98.8%	98.2%	96.4%
	Falls per 1000 bed days	4	<4	3.8	2.8	3.1	2.0	2.4	3.1
	Sepsis - % patients screened and treated (Quarterly)	New	90.0%	97.00%	-	-	100.00%	-	-
	Safer Staffing CHPPD – 5 North *	5	>9.6	10.40	10.42	10.70	11.10	12.00	9.40
	Safer Staffing CHPPD – 5 South *	5	>9.6	11.30	9.79	10.20	9.20	7.90	9.50
	Safer Staffing CHPPD – 4 NW (Cardiology) *	5	>9.4	9.00	8.91	8.60	9.00	8.60	8.10
	Safer Staffing CHPPD – 4 South (Respiratory) *	5	>6.7	8.20	8.78	7.70	8.00	8.50	7.80
	Safer Staffing CHPPD – 3 North *	5	>8.6	9.70	9.99	9.90	11.60	10.90	9.70
	Safer Staffing CHPPD – 3 South*	5	>8	7.90	7.54	8.00	8.00	8.10	7.60
	Safer Staffing CHPPD – Day Ward *	5	>4.5	6.03	7.00	5.72	7.10	6.20	4.80
	Safer Staffing CHPPD – Critical Care *	5	>32.9	34.80	32.53	31.80	33.20	33.30	35.80
Additional KPIs	Safer staffing – registered staff day	3	90-100%	90.0%	92.0%	90.0%	86.0%	86.4%	87.2%
	Safer staffing – registered staff night			92.8%	91.0%	89.0%	87.0%	88.4%	86.2%
	MRSA bacteremia	3	0	0	0	0	0	0	0
	Number of serious incidents reported to commissioners in month	4	0	0	1	1	1	0	1
	E coli bacteraemia	5	Monitor only	1	0	1	1	0	0
	Klebsiella bacteraemia	5	Monitor only	0	0	0	0	1	1
	Pseudomonas bacteraemia	5	Monitor only	0	0	1	0	1	0
	Other bacteraemia	4	Monitor only	1	1	1	2	0	3
	Other nosocomial infections	4	Monitor only	0	0	2	0	0	0
	Point of use (POU) filters (M.Abscessus)	4	Monitor only	95%	95%	88%	91%	95%	97%
	Moderate harm and above incidents reported in month (including SIs)	4	Monitor only	1	0	3	1	3	2
	Monitoring C.Diff (toxin positive)	5	Ceiling pa of 10	1	0	1	0	0	1
	Number of patients assessed for VTE on admission	5	95.0%	85.2%	84.10%	86.00%	82.90%	83.10%	83.20%

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

Summary of Performance and Key Messages:

CQC Model Health System rating for 'Safe' is Outstanding dated Feb 2022 (accessed 11.03.2022).
High Impact Interventions: the result for Feb 2022 has just tipped into amber at 96.4%. IPC and Audit are reviewing the data and following up with the clinical areas as required.
Safe Staffing: RN fill rate for Feb 2022, shows days in amber at 87.2% and nights in amber at 86.2%. For CHPPD: 5N and 5S are just under their green threshold; 4NW is red (8.10). This reflects that although their staffing has remained safe (for example their RN to patient ratio in Feb 2022 was 1:4.6), their activity has remained high and on a number of occasions they have had more beds open on 4NW than commissioned, in order to accommodate the high cardiac activity for patients (capacity on 4NW is being reviewed as part of annual planning discussions). This also correlates with the busy 3S position, where the CHPPD has just dipped into amber at 7.60. There is no indication at the time of writing of this impacting on quality and safety metrics; which is monitored by the Matron and Head of Nursing team and reported in their monthly quality reports through Division and QRMG.
Number of Serious Incidents: During Feb 2022 there was one SI reported: SUI-WEB42015 (reported as an SI 16.02.2022); discussed at SIERP 15.02.2022.
Nosocomial COVID-19: There were no further cases of hospital acquired COVID-19 reported during February 2022 (further to the two patients reported in November 2021).
Point of Use (POU) filters (M.Abscessus): For Feb 2022, overall compliance was 97%. This is a month on month improvement, since Nov 2021. The drop in compliance were "% 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. Filters in place where required and patients being provided with bottled water where required, was 100% across all wards/departments.
C.Diff: there was one case of C.difficile in Feb 2022 (Ward 4 South, 19.02.2022).
In accordance with the NHS published Standard Contract 2021/22, the ceiling objective figures for 2021-22 at RPH has been set at 10. All C.difficile (toxin positive) cases are now counted against our trajectory. Running total for 2021/22 = 11. We are aware that we have breached the annual ceiling figure and we have liaised closely with our CCG colleagues about this. No concerns have been raised. There is no correlation with any of the C.difficile types reported at RPH. There has also been an increase in the community.
VTE: VTE risk compliance is targeted at 95% for all hospital admissions and compliance for Feb 2022 was 83.2%. It is recognised that a review of processes are required to help with the improvement necessary and this is being led by a VTE working group. Next steps: Commence review and simplify processes from 1st April 2022; Implementing a VTE alert/pop-up on Lorenzo (currently being built in the system); Instead of a suite of various procedural documents relating to VTE assessment and treatment, there will be an overarching policy; Review current cohort exceptions and opportunity to remove or include additional cohorts within the policy; Clinical indicators on Lorenzo to be addressed (review when the red flag alert comes up as a prompt for staff). This work is being led by Consultant Dr Karen Sheares and Head of Nursing Sandra Mulrennan.

Safe: Key performance challenges: Prescribing in ‘Fractured Pathways’

Report Author: *Deputy Chief Pharmacist & Chief Pharmaceutical Information Officer*

Escalated performance challenge: Prescribing in ‘Fractured Pathways’

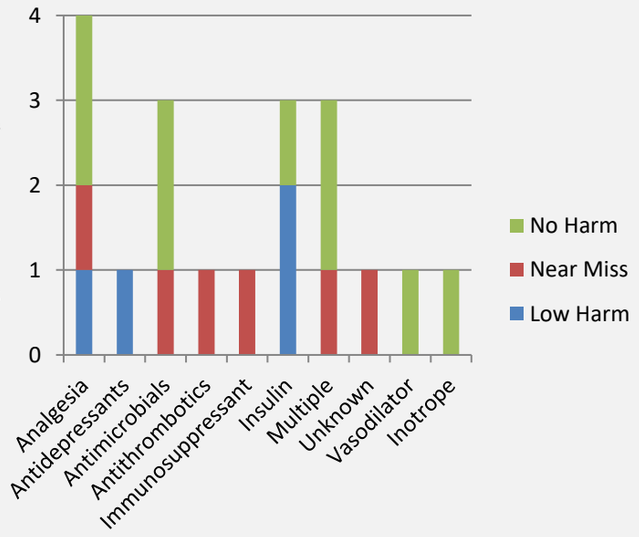
The prescribing of medicines for patients who move between different patient records (*‘fractured pathways’*) has been a longstanding challenge within the organisation. Issues are reported around the accuracy of the transcription of medicines between systems and clinical review of prescriptions at the point that patients have a change in level of care.

A “free text” search of DATIX identified 19 records in a 12 month period which reported a medicines incident at the point of transfer between critical care and a ward area (Figure 1). The vast majority of reported incidents relate to high risk medicines, suggesting that reporting of incidents is biased toward those with higher potential severity. Taken alongside the challenging search methodology and reporting fatigue of a longstanding issue, it is likely that the true number of incidents is significantly higher. The majority of incidents are reported as “no harm” or “near miss”, but some low harm incidents are reported, including:

WEB41743 - Patient suffered from hypertension, agitation, and anxiety in the post-op period. This was managed with anti-hypertensives and 1:1 nursing care. This may be associated with abrupt discontinuation of [high dose] antidepressants … These were not prescribed in the post-op period on critical care, nor on transfer to the ward

Incidents have also been reported where it has not been clear as to what medicines have been administered in the catheter laboratory. In these cases two different systems were used concurrently to record medicines administration such that neither system held a complete record.

Figure 1 - Reported Incidents 03/2021 - 02/2022



Key risks:

Medicines reconciliation on transfer between systems (2106)
If…Medicines are not appropriately reviewed and accurately prescribed on transfer
Then… Critical medicines may be omitted or medicines prescribed inappropriately

This risk is challenging to mitigate as it is often necessary for junior doctors on critical care to write prescriptions for use on the ward, whilst in the busy critical care environment, and using a system which with which they are less familiar. It is not possible to electronically integrate the two e-prescribing systems within the current architecture. Mitigation includes:

- Provision of dual-screen workstations in critical care for transcription
- Training in the use of the Trust’s main e-prescribing system for critical care staff
- Comprehensive nurse-to-nurse handover of prescriptions on transfer to ward
- Increase in establishment of critical care pharmacists will allow a proportion of patients to have a thorough prescription chart review at the time of transfer once this post has been filled

Mitigated risk score: Likelihood **2** x Consequence **4** = **8 – High Risk**

Use of multiple e-prescribing systems concurrently in catheter laboratories (new)
If…Staff only have a view of one system and do not know that record is incomplete
Then… Medicines may be prescribed/administered with are duplicates or interact with those documented in the other system. Alternatively medicines may be unintentionally omitted if it is assumed that they were administered and documented in the other system

This risk comes about in procedures undertaken under general anaesthetic, where the medicines administered by the anaesthetist are documented in the critical care / theatres system, whilst those administered by the cardiologist and catheter laboratory nurse are documented in the main electronic patient record. This risk has a small number of inherent mitigations:

- A relatively small proportion of patients require general anaesthesia
- Medicines administered by the anaesthetist are unlikely to be duplicated by or interact with medicines administered by the cardiologist in the lab or medicines prescribed on the ward.

Mitigated risk score: Likelihood **2** x Consequence **3** = **6 – Moderate Risk**

Safe: Spotlight On – Considering 'Message of the Week' effectiveness

- Message of the Week (formerly Nursing Message of the Week) was introduced at the end of 2020, with the first report distributed 07.12.2020. During PIPR Safe M04 21/22 there was a Spotlight On the Message of the Week in order to provide an overview of the initiative and list the messages that had been shared up to the date of that PIPR report. This PIPR Safe now considers some examples of where Message of the Week is believed to have helped make a difference in practice.
- Message of the Week was designed to help improve communications amongst all staff and remains a popular way amongst staff of receiving information (staff report liking the one page format that can be easily displayed and communicated, and a message that is updated weekly).
- Because of the content and nature of Message of the Week, it is not always possible to provide evidence to quantify the impact, however this slide considers some examples where it is seems likely that Message of the Week has made a difference.

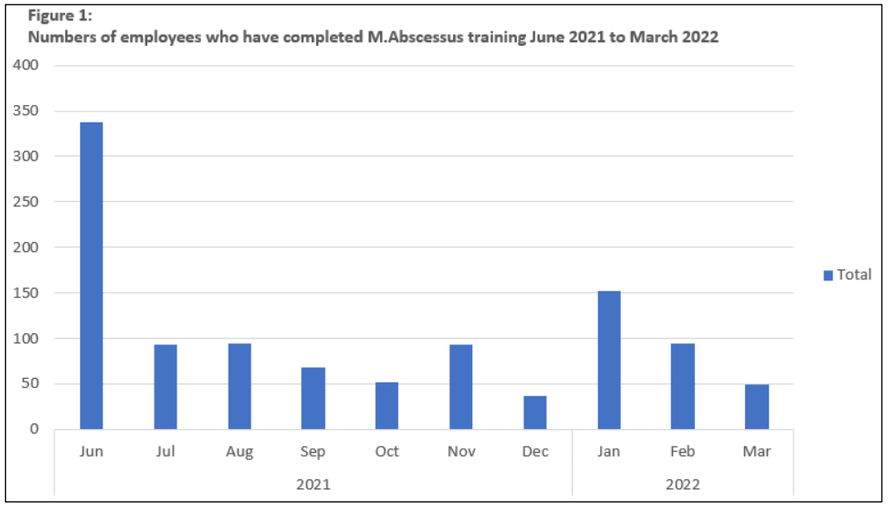
M.Abscessus

M.Abscessus has been the focus of Message of the Week (MoW) on several occasions during 2021 and 2022 (Table 1 below). M.Abscessus training was introduced via eLearning (LearnZone) in June 2021 and Figure 1 below shows results of staff who have completed training since June 2021. We can see that in the months where M.Abscessus training was a focus of MoW (Jun 2021; Nov 2021; Jan 2022) there was an increase in training numbers. In Aug 2021 and Feb 2022, where MoW has been linked to M.Abscessus but not specifically training, these training figures do also seem favourable when compared to Sep, Oct and Dec 2021 (Mar 2022 is part month) which are the lowest reporting months; where there has been no MoW focus on M.Abscessus. It is recognised that this is not a validated quantitative study, however the correlation is interesting and does perhaps indicate that use of MoW is helping to sustain a spotlight on this important issue for staff, keeping it at the forefront of messaging and communications.

Table 1: M.Abscessus Message of the Week – dates and message

w/c 28.02.2022	Vulnerable Patients, M.Abs
w/c 17.01.2022	M.Abs training
w/c 01.11.2021	M.Abs training
w/c 09.08.2021	Point of Use (POU) filters
w/c 07.06.2021	M.Abs training
w/c 15.03.2021	About M.Abs inc. POU filters

Figure 1:
Numbers of employees who have completed M.Abscessus training June 2021 to March 2022



Mask fit testing

Mask fit testing was Message of the Week w/c 18.10.2021.
For this PIPR, the Fit Testing Support Worker was asked:
"Did including fit testing as Message of the Week increase uptake at that time?"
The Fit Testing Support Worker answered:
"We saw an increase in the requests, both from managers and general staff".

Purple Trees

Purple Trees was Message of the Week w/c 24.01.2022.
For this PIPR, the Supportive and Palliative Care Team were asked:
"Did including Purple Trees as Message of the Week increase uptake at that time?"
The Supportive and Palliative Care Team answered:
It is difficult to notice a significant increase in use, however "we have had more people asking for a supply of them since we have been promoting them more" in addition to also promoting them in the champions [link staff] meeting.

pH Strips

"pH Strips Are Changing" was Message of the Week w/c 07.03.2022.
For this PIPR, the Specialist Dietitian who was the lead for introducing the new pH strips was asked: *"Did Message of the Week help raise the awareness?"*
The Specialist Dietitian answered:
"When I went round the wards to do the change over on Wednesday 9th March most of the staff I spoke to were aware the pH strips were changing and on several wards they had printed out the message of the week and it was on display on the ward. So yes the message of the week did raise the profile- thank you."

Caring: Performance summary

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

		Data Quality	Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Dashboard KPIs	FFT score- Inpatients	4	95%	99.2%	97.8%	98.3%	98.6%	99.5%	98.1%
	FFT score - Outpatients	4	95%	97.2%	95.9%	96.8%	97.7%	98.5%	97.1%
	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	3.4	7.4	6.9	6.0	2.5	3.0
	% of complaints responded to within agreed timescales	4	100%	100%	100%	100%	100%	50%	100%
Additional KPIs	Number of complaints upheld / part upheld	4	3 (60% of complaints received)	1	1	2	2	2	0
	Number of complaints (12 month rolling average)	4	5 and below	3.2	3.8	3.7	3.7	3.3	3.2
	Number of complaints	4	5	4	9	1	2	2	2
	Number of recorded compliments	4	500	1501	1475	1357	1221	1159	1159
	Supportive and Palliative Care Team – number of referrals (quarterly)	4	0	95	-	-	84	-	-
	Supportive and Palliative Care Team – reason for referral (last days of life) (quarterly)	4	0	7	-	-	5	-	-
	Supportive and Palliative Care Team – number of contacts generated (quarterly)	4	Monitor only	997	-	-	787	-	-
	Bereavement Follow-Up Service: Number of follow-up letters sent out (quarterly)	3	Monitor only	39	-	-	46	-	-
	Bereavement Follow-Up Service: Number of follow-ups requested (quarterly)	3	Monitor only	9	-	-	8	-	-

Summary of Performance and Key Messages:

CQC Model Health System rating for 'Caring' is Outstanding dated Feb 2022 (accessed 11.03.2022).

FFT (Friends and Family Test): In summary; **Inpatients**: Positive Experience rate has decreased from 99.5% (Jan) to 98.1% (Feb). Participation Rate has decreased from 28.5% (Jan) to 25.2% (Feb). **Outpatients**: Positive Experience rate has decreased from 98.5% (Jan) to 97.1% (Feb). Participation rate has increased from 12.2% (Jan) to 13.5% (Feb).
The NHS England (latest published data accessed 11.03.2022) is Jan 2022:
Positive Experience rate: 94% (inpatients); and 93% (outpatients). Participation rate 16.8% (inpatients); and 7.1% (outpatients).

Number of written complaints per 1000 staff WTE is a benchmark figure based on the NHS Model Health System to enable national benchmarking. We remain in green at 3.0.
The data from Model Health System continues to demonstrate we are in the lowest quartile for national comparison. The Model Health System data period is Mar 2021; accessed 11.03.2022): Royal Papworth = 5.72; peer group median = 11.39; national median = 16.65.

% of complaints responded to: This has returned back to 100% for Feb 2022.

The number of complaints (12 month rolling average): this has remained green for February 2022 at 3.2. We will continue to monitor this in line with the other benchmarking.

Complaints: We have received two new formal complaints during February 2022. The investigations are ongoing and this is within our expected variation of complaints received within the month. We have closed one formal complaint in February 2022. Further information is available on the next slide.

Compliments: the number of formally logged compliments received during February 2022 was 1159 (which is the same as the previous month). This is broken down as: compliments from FFT – 1121; and compliments via cards/letters/PALS –38.

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.
- We have closed one formal complaint in February 2022, this was not upheld.
- The one complaint responded to was closed on day 39 (current standard is 35 working days), this was extended in agreement with the patient as we required a second opinion for an independent review of our finding. The patient agreed to the extended timescale.
- Overall, the primary subject of complaints received at RPH remains clinical care and communication, although we have noticed an increase in the number of concerns relating to discharge and concerns whether the patient was fit for discharge.

Learning from earlier Complaints

This is a summary of the one complaint closed in month.

Complaint Datix Reference: 14770, Date closed: 11 February 2022, Outcome: Complaint not upheld. This complaint related to a Thoracic patient who raised concerns regarding the outcome of a cardiology scan and the report provided which resulted in further follow up CT scans and tests. The patient's CT images and radiology report were re-reviewed by two Consultant Radiologists and also at the Trust's Radiology discrepancy meeting. It was concluded that the findings and report were correct. Learning and actions from the complaint were identified: the themes and findings from the patient's feedback was shared with the Radiology Team for their learning and reflection and will be discussed at the Radiology Business Unit meeting in March 2022.

Progress in implementing actions identified through formal and informal complaints is monitored through the Quality and Risk Management Group on a monthly basis.

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.
- From M05 21/22 PIPR Caring has also included "Learning from earlier complaints" feedback as part of sharing learning.

Caring: Spotlight On – Informal complaints and local resolutions

Informal Complaints and Local Resolution:

In line with the Trust's complaint policy, all complaints should be resolved at the earliest opportunity without necessarily escalating to the formal complaint process.

We have introduced a focus on 'Informal complaints' that have been resolved through local resolution, which are intended to provide complainants with a quick, amicable and satisfactory resolution to their concerns. We are now aiming to resolve all informal complaints within 15 working days.

As a Trust we should always respond positively and appropriately to anyone who provides feedback, comments or concerns and:

- acknowledge the feedback, comment or concern in an open and honest way demonstrating sensitivity and understanding
- clarify the nature of the feedback, comment or concern whilst demonstrating that the information has been listened to and understood
- establish the expected outcome of the person providing the feedback comment or concern
- discuss the matter of concern with the patient, encouraging them to speak freely; and
- provide an honest and objective response.

Patients may offer their feedback and comments and often raise issues of concern without wishing to make a complaint. In some instances individuals may need reassurance, additional information, advice and support or they may wish to talk to someone to share their experiences.

Feedback, comments and concerns may identify shortcomings, areas for improvement, good practice and also reflect the level of satisfaction with the service provided and not all will require a response.

In February 2022, we **received seven informal complaints**, three in relation to outpatients, two for surgical services, one for Critical Care and one for Day Ward. The themes of these concerns were clinical care (4), staff attitude (1), delay in appointments (1) and equipment issues (1). Two of these informal complaints were closed within the new 15 working days following the involvement of the relevant clinical teams to provide the complainant with a satisfactory resolution to the concerns raised. The other 5 continue to be under review at the time of reporting.

Example one of concerns closed through local resolution:
Thoracic patient emailed Viewpoint to raise concerns regarding the ongoing problems they were experiencing with their CPAP machine and the difficulties they were experiencing with contacting the CPAP team. Acknowledgement sent to patient and concerns forwarded to CPAP team for investigating. On receipt, the CPAP team contacted the patient to discuss the difficulties they were experiencing with their equipment and discuss their concerns. Immediate action was taken by the team to provide the patient with a replacement device and advice given on who to contact should they experience any further problems. Patient confirmed they were satisfied with the actions taken to resolve their concerns and were happy for the informal complaint to be closed.

Example two of concerns closed through local resolution:
RSSC patient contacted the Chief Executive to raise concerns regarding their recent appointment and the documentation received. Acknowledgement sent to patient and concerns forwarded to RSSC team for investigating. On review, the RSSC team identified areas for improvement including communication with patients and accurate documentation. On completion of the local investigation, the Thoracic Matron contacted the patient to feedback the action taken locally to address their concerns and a revised discharge summary with the correct information was sent to the patient. The patient confirmed they were satisfied with the actions taken and were happy for the informal complaint to be closed.

All feedback is shared with the wider clinical team at Business Unit and Clinical Division meetings for their learning and reflection.

Effective: Performance summary

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

		Data Quality	Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Dashboard KPIs	Bed Occupancy (excluding CCA and sleep lab)	4	85% (Green 80%90%)	70.3%	71.4%	69.9%	64.2%	65.8%	71.3%
	CCA bed occupancy	4	85% (Green 80%90%)	91.5%	95.5%	92.0%	85.6%	85.6%	78.7%
	Admitted Patient Care (elective and non-elective)	4	2246 (in Current Mnth)	2305	2030	2132	1944	1810	1827
	Outpatient attendances	4	7880 (in Current Mnth)	8421	8193	9452	8092	8411	8154
	Cardiac surgery mortality (Crude)*	3	<3%	2.99%	2.76%	2.50%	2.34%	2.17%	1.99%
	Theatre Utilisation	3	85%	62.8%	77.0%	67.0%	75.6%	76.6%	73.2%
	Cath Lab Utilisation 1-6 at New Papworth (including 15 min Turn Around Times)	3	85%	79%	78%	81%	72%	79%	76%
Additional KPIs	Length of stay – Cardiac Elective – CABG (days)	4	8.20	8.27	8.28	7.00	9.01	13.16	7.09
	Length of stay – Cardiac Elective – valves (days)	4	9.70	9.79	9.07	9.84	11.19	8.81	9.18
	CCA length of stay (LOS) (hours) - mean	4	Monitor only	120	102	108	147	188	135
	CCA LOS (hours) - median	4	Monitor only	25	45	41	42	44	29
	Length of Stay – combined (excl. Day cases) days	4	Monitor only	5.82	5.61	5.88	6.00	5.71	3.50
	% Day cases	4	Monitor only	63.7%	64.1%	65.7%	63.3%	66.4%	63.8%
	Same Day Admissions – Cardiac (eligible patients)	4	50%	17.9%	30.2%	31.0%	34.9%	24.0%	32.0%
	Same Day Admissions - Thoracic (eligible patients)	4	40%	16.7%	6.7%	15.2%	9.5%	2.1%	7.1%

* 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:

Capacity Utilisation

Although Respiratory ECMO and the numbers of COVID patients within the hospital have continued to gradually decrease in month, high levels of staff absence across the Trust due to sickness and self-isolation persisted. The adverse impact of staff absence was seen across utilisation of the commissioned bed base and treatment functions.

Cardiac surgery activity increased significantly to 131 cases in February, the highest since July of last year. However, short term COVID related sickness in the Radiographer and Cardiology Consultant team meant that some elective cath lab activity had to be deferred. This reduced both the volume of patients treated on an admitted care pathway and on cath lab utilisation.

A power problem on the 25th February impacted on the entire days activity in theatres and cath labs with only emergency activity being undertaken. A total of 39 cases were cancelled or deferred and one primary PCI was diverted to another provider.

Outpatient

The numbers of patients seen in Outpatients remained strong despite the fewer working days in month. This was particularly true for follow-up appointments. The Outpatient productivity initiative is well established and as part of resetting expectations and processes across the Trust the monitoring of bookings with up to 6 weeks notice has been reinstated.

Length of Stay

Although length of stay has returned to within target level this month both for CABG and valve surgery, this is a consequence of case selection rather than any active intervention or action. The discharge team continue to review in-patients daily to identify “red” days, where patients are within the hospital but no action is underway to progress their care. Action is taken to expedite next steps when red days are identified.

Effective: Activity Restoration

Background and purpose

The purpose of this report is to provide oversight of referral and activity numbers against the following two benchmarks;

1. 2019/20 activity
2. The NHSI/E Elective Recovery Fund (ERF) targets relating to the first half of the financial year 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 for H1 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.
- Guidance on the ERF targets for the second half of the financial year was received on 30 Sep. H2 focuses on reported RTT completed pathways, using 2019/20 as the baseline year rather than total activity. This will be monitored through a separate report.
- For the purposes of this report, the target for each month after Sep 2021 has been set at 100% of 2019/20 activity to continue to show current year performance against the baseline year.

Dashboard headlines

The tables to the right show how the numbers for M10 compare to 2019/20 numbers at a Trust level and at specialty level and a forward look based on provisional M11 data.

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

M11 activity performance in line with target

- **Non-Admitted activity** – Follow-up non-admitted activity met the expected target.
- **Radiology –** CT activity met the expected M11 target.

M11 activity performance behind target

- **Non-Admitted activity** – First non-admitted activity did not meet the expected target.
- **Radiology –** MRIs and Other Radiology exams did not meet the expected M11 target.
- **Admitted activity** – Elective inpatients and daycases fell short of the expected target.

Activity Summary

Table 1: Trust Level

Category		M11 against 2019/20 M11 *	M12 projection against 2019/20 M12
Referrals	GP	75.5%	57.8%
	Cons-to-Cons	96.0%	116.6%
Non-Admitted	First	97.1%	96.6%
	Follow up	104.1%	103.3%
Radiology	MRI	79.4%	100.7%
	CT	113.7%	151.8%
	Other	88.2%	110.9%
Admitted Activity	Elective Inpatients	61.9%	68.0%
	Daycases	81.6%	75.8%
	Non-Elective Inpatients	93.9%	97.7%

Table 2: M11 activity compared to 2019/20 (Specialty Level)

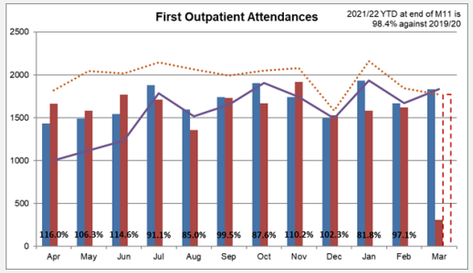
Specialty	EL	DC	NEL	OPFA	OPFU
Cardiac Surgery	77.0%	#DIV/0!	91.4%	88.0%	97.7%
Cardiology	73.7%	92.3%	96.5%	78.3%	125.4%
RSSC	41.9%	96.0%	155.6%	135.9%	70.8%
Thoracic Medicine	64.3%	59.7%	85.7%	93.3%	105.8%
Thoracic Surgery	128.9%	20.0%	42.1%	100.0%	81.1%
Transplant/VAD	71.4%	100.0%	93.3%	131.3%	85.8%
PTE	100.0%	#DIV/0!	0.0%	62.5%	113.8%
Trust	61.9%	81.6%	93.9%	97.1%	104.1%

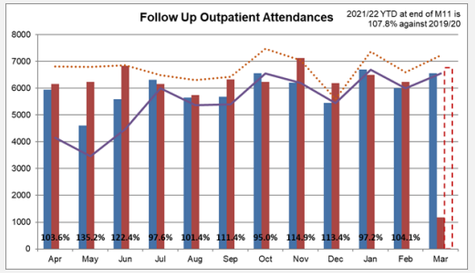
Key:

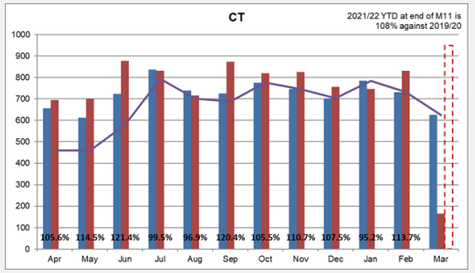
- Activity 19/20
- Activity 21/22
- Projection of monthly performance
- NHSI/E Target
- Activity 18/19

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

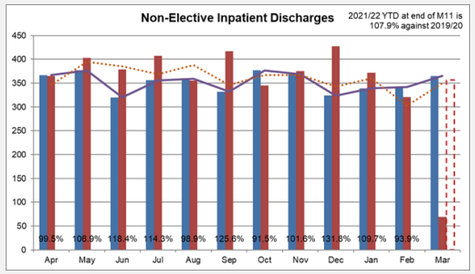
Non-Admitted Activity

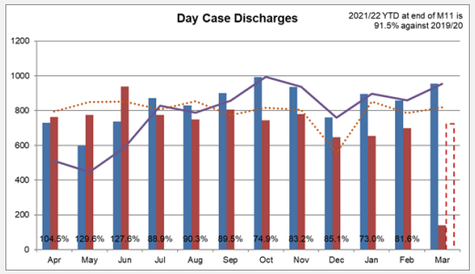


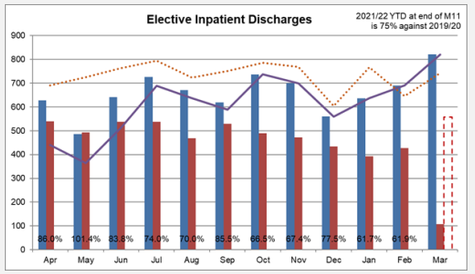




Admitted Activity

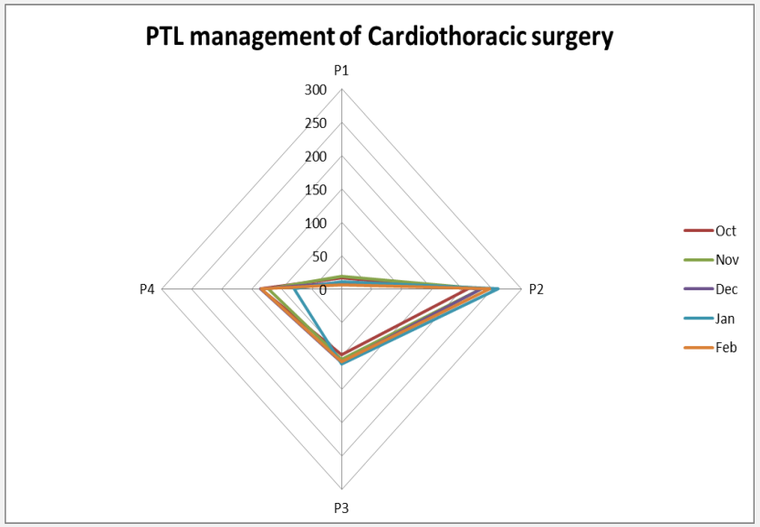


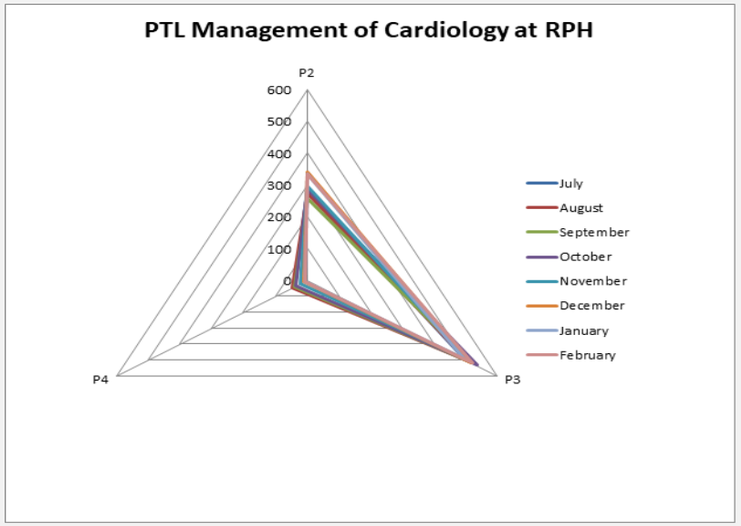


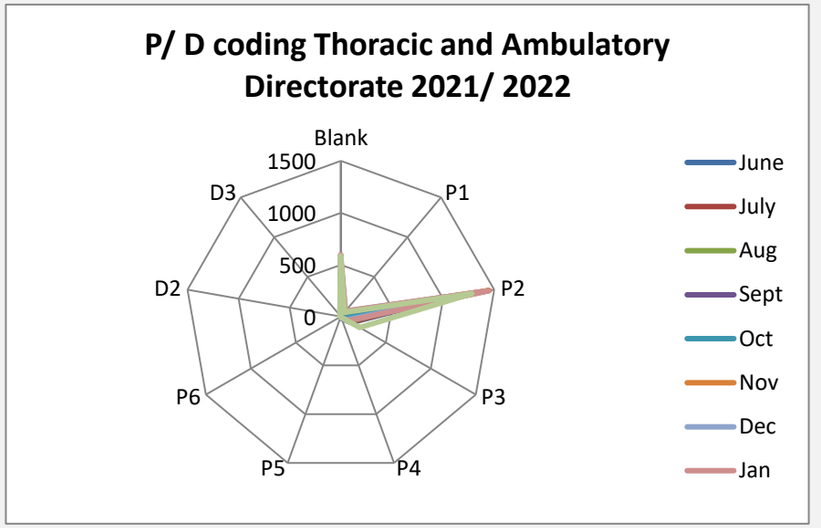


Effective: Spotlight on: Priority Status Management

>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 Waiting List Profile

↑ 579 patients on the waiting list
↑ 201 patients over 18 weeks
↑ 5 patients over 52 weeks, 4 of which were treated in March.
↔ 0 patients over 104 weeks
↓ 65.36% RTT performance

- 125 patients planned or booked for admission
- 70 Planned OPD / Diagnostic appointment
- 254 Awaiting action to book varying priority statuses

! Key Concern
This is the waiting list area of highest risk and concern as capacity is limiting the volume of surgery undertaken.

Cardiology Waiting List Profile

↓ 1399 patients on the waiting list
↑ 198 patients over 18 weeks
↔ 0 patients over 52 weeks
↔ 0 patients over 104 weeks
↑ RTT performance 87.30%

- 135 – Booked for admission
- 16 - Planned OPD / Diagnostic appointment
- 39 – requiring general anaesthetic support
- 15 – TOE cases
- 37 - Awaiting ablation capacity (6 with booked dates)

Respiratory Waiting List Profile

↓ 2155 patients on the waiting list
↓ 327 patients over 18 weeks
↔ 1 patients over 52 weeks, treated in March
↔ 0 patients over 104 weeks
↓ RTT performance 81.92%

- 327 – Booked for admission
- 804- Boked OPD / Diagnostic appointment
- 119 – Patients on Oncology pathways
- 83 – Remote diagnostic devices awaiting return, booked or at reporting stage
- 24 - Awaiting to start CPAP when devices available
- 29 CPAP new starters booked

Responsive: Performance summary

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

		Data Quality	Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Dashboard KPIs	% diagnostics waiting less than 6 weeks	3	>99%	96.03%	97.32%	97.86%	97.93%	93.04%	96.68%
	18 weeks RTT (combined)	5	92%	86.13%	85.99%	86.54%	85.38%	84.25%	81.32%
	Number of patients on waiting list	5	3,279	3683	3776	3914	4110	4172	4128
	52 week RTT breaches	5	0	9	6	3	5	4	6
	62 days cancer waits post re-allocation (new 38 day IPT rules from Jul18)*	4	85%	50.0%	66.7%	46.2%	54.5%	42.9%	57.1%
	31 days cancer waits*	4	96%	96.2%	100.0%	94.1%	100.0%	100.0%	97.6%
	104 days cancer wait breaches*	4	0	3	8	7	5	8	8
	Theatre cancellations in month	3	30	47	45	53	27	22	32
	% of IHU surgery performed < 7 days of medically fit for surgery	4	95%	69.00%	39.00%	47.00%	85.00%	79.00%	97.00%
	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%	85.79%	86.35%	88.33%	88.43%	89.59%	87.30%
	18 weeks RTT (Cardiac surgery)	5	92%	70.91%	68.23%	67.19%	67.00%	66.01%	65.36%
	18 weeks RTT (Respiratory)	5	92%	90.53%	91.03%	90.85%	88.61%	85.91%	81.92%
	Non RTT open pathway total	2	Monitor only	36,423	37,020	37,506	37,467	37,681	38,137
	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%	85.00%	66.67%	73.33%	69.23%	100.00%	88.89%
	Outpatient DNA rate	4	9%	8.20%	7.76%	8.00%	8.10%	7.21%	7.05%
	Urgent operations cancelled for a second time	4	0	0	1	0	0	0	0
	% of IHU surgery performed < 10 days of medically fit for surgery	4	95%	86.00%	52.00%	61.00%	97.00%	91.00%	100.00%
	% of patients treated within the time frame of priority status	4	Monitor only	48.8%	47.1%	43.5%	43.1%	36.4%	41.2%
	% of patients on an open elective access plan that have gone by the suggested time frame of their priority status	4	Monitor only	39.3%	43.5%	44.6%	45.5%	49.9%	47.8%

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

Summary of Performance and Key Messages:

Diagnostic Performance

This month saw an improvement in diagnostic performance in spite of further Radiographer staffing challenges. Although the national standard has not been met the achievement of 96.68% having access to diagnostic testing within 6 weeks compares favourably to 64.4% of patients across the East of England region.

Elective Waiting Times

Although the size of the elective waiting list has stabilised, insufficient long waiting patients are being treated to prevent further deterioration in performance against the referral to treatment standards, both as an aggregate and at a speciality level. This is because treatment functions have been significantly constrained due to high levels of staff absence and because patients are selected for treatment based on their clinical priority score or P score rather than based on the length of time waiting.

There were 6 patients waiting for treatment more than 52 weeks at the end of February, 5 awaiting surgical procedures and one on a respiratory pathway. All bar one of the surgical patients have been treated in March. This remaining patient is a priority 4 patient (treatment within 3 months) who has now transferred to a surgeon with a shorter waiting list and is currently being worked up for surgery.

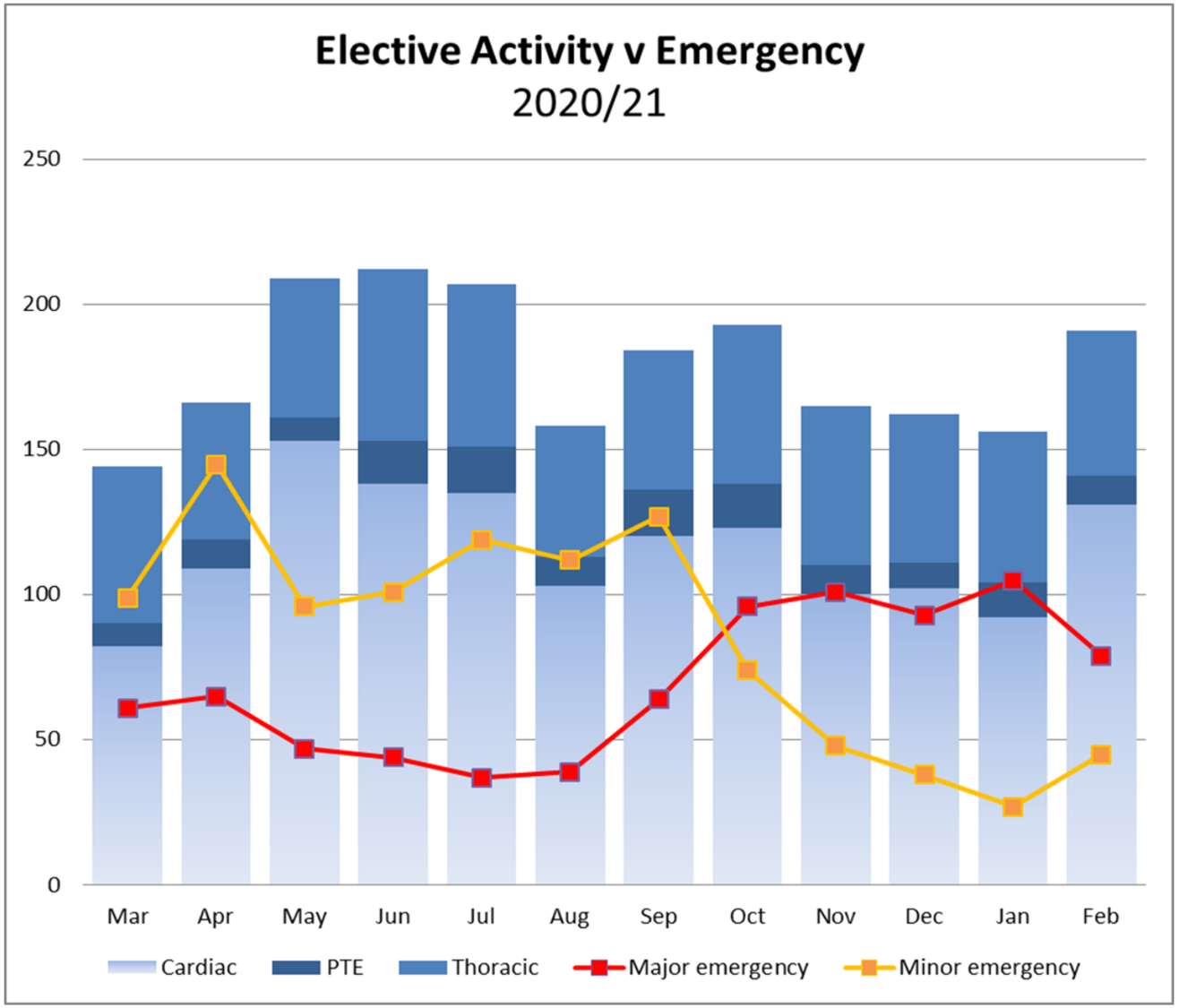
Cancer Waiting Times

Cancer performance continues to be challenged due to a combination of late referrals, patients needing more than one diagnostic and discussion in the MDT and timely access to PET-CT. Meetings with the CUH delivered PET-CT service and the Cancer Alliance have continued weekly due to the reduced capacity on site with the swap out of the static scanner which began on 24th January. Patients are also being offered appointments at other CA sites with static scanners – namely Northampton and Colchester. Swap out due for completion on 1st April 2022 has been moved out to 12th April due to some early challenges in the building works which have since been resolved. All patient pathways with delays have been subject to review to tease out common themes which will become areas for focused improvement work.

Theatre Cancellations

Theatre cancellations rose sharply in month, largely as a result of increasing prevalence of COVID in the community and patients presenting either with a positive COVID test or having a household contact who has tested positive. In light of evidence which indicates that cardiac surgery patients have poorer outcomes if treated while they have the infection decisions were taken in the best interest of the patients to postpone surgery if safe to do so. This also impacted on our ability to bring patient back for surgery within 28 days of cancellation.
Cancellations due to equipment / estate failure related to the power problems experienced on site on 25th February 2022.

Responsive: Elective versus Emergency demand on Theatres



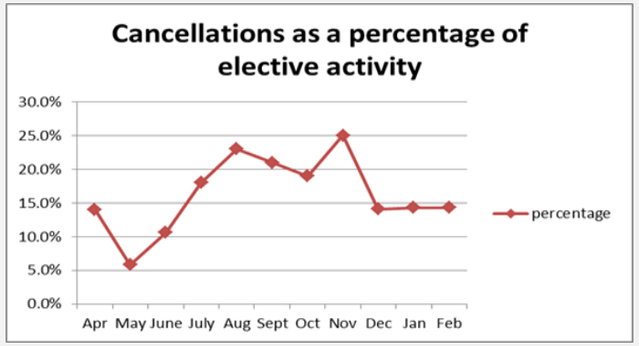
131 Cardiac / 50 Thoracic / 10 PTE / 42 IHU / 5 TX activity

79 emergency/urgent procedures went through theatres – combination of transplants, returns to theatre and emergency explorations.
45 additional emergency minor procedures also went through theatre and critical

Cancellation reason	Feb-22	Total
1b Patient refused surgery	1	6
1c Patient unfit	10	53
1d Sub optimal work up	5	11
4a Emergency took time	3	32
4b Transplant took time	1	11
4e Equipment/estate unavailable	9	13
5a Planned case overran	3	43
Total	32	388

Cardiac activity increased significantly to 131 cases in February, the highest since July of last year. This was as a result of the increase in planned elective cases, as well as better staffing on critical care.
Though the amount of cancellations increased marginally, the percentage remained the same at just over 14%

Main reason for cancellations was patient unfit, which is worrying but there were also 9 patients cancelled in one day due to a power outage at the trust.



Responsive : Cancer Performance

Cancer Waiting Times

CWT 2021/22										
62 day waits										
	1. 62 day patients (Urgent GP Referral) IPT = 50/50			2. 62 day patients after re-allocations) IPT = v6			3. 62 day patients Consultant Upgrade IPT = 50/50			
	Target = 85%			Target = 85%			Target = 85%			
	Total treated	Breaches	%	Total treated	Breaches	%	Total treated	Breaches	%	Status
Q1	11.0	3.5	68.2%	16.5	4.5	72.7%	5.5	2.0	63.6%	
Q2	7.5	2.3	70.0%	11.0	5.0	54.5%	4.0	1.0	75.0%	
Q3	10.0	7.0	30.0%	15.5	7.5	51.6%	2.5	0.5	80.0%	
Jan-22	1.5	1.0	33.3%	3.5	2.0	42.9%	2.5	2.0	20.0%	
Feb-22	2.0	1.5	25.0%	3.5	1.5	57.1%	3.5	2.5	28.6%	

62 day – Feb performance (provisional):

4 patients were treated on the 62 day pathway with 3 breaches. 2 are shared breaches and 1 is wholly attributed to RPH. There were 7 upgrades of which 5 breached. Expected compliance post re-allocation is 57.1%

CWT 2021/22										
31 day waits										
	4. 31 day patients first treatment only			5. Subsequent (all treatments)			6. Subsequent (surgery only)			
	Target = 96%			Target = 96%			Target = 96%			
	Total treated	Breaches	%	Total treated	Breaches	%	Total treated	Breaches	%	Comments
Q1	69	0	100.0%	10	0	100.0%	10	0	100.0%	
Q2	52	1	98.1%	7	0	100.0%	7	0	100.0%	
Q3	70	1	98.6%	2	0	100.0%	2	0	100.0%	
Jan-22	24	1	95.8%	0	0	100.0%	0	0	100.0%	
Feb-22	22	1	95.5%	1	0	100.0%	1	0	100.0%	

31 day – Feb performance (provisional):

22 patients were treated on the 31 day pathway of which 22 were first treatment only and 1 was a subsequent surgical treatment. There was one breach due to the patient having to household isolate due to COVID and compliance is at 95.5% for the month and 97.6% for the year up to the end of February

Oncology GIRFT Report

A virtual GIRFT review meeting, chaired by Dr Paul Beckett and Dr Liz Toy (GIRFT programme Clinical Leads for lung cancer), was undertaken on the 8th October 2021 with attendance from key stakeholders both at CUH and RPH. Whilst this was a joint visit the team collated separate reports for the two sites.

Areas of good practice for RPH were identified as follows:

- A high functioning team whose attention to detail and pursuit of excellence benefits patients across the whole region
- Combined clinics allow patients to move rapidly from MDT discussion into receiving assessment by respiratory physicians, oncologists and surgeons in the one clinic environment
- There is an exemplary combined EBUS/EUS service
- Surgical resection rates are high with excellent rates of minimally-invasive access approaches and low mortality
- A number of the clinicians serve on national groups and have been instrumental in the development of the National Lung Optimal Pathway and the accompanying guidance for its introduction. Many exemplar practices were evident during the team's visits demonstrating the changes possible in an appropriately resourced service
- The clinicians are very committed to supporting the major lung cancer charitable organisations who provide patient support across England
- Clinical research is integral to the team's approach to patient care. The team have an excellent portfolio of studies resulting in high recruitment rates, offering many patients the option of novel therapies

The visit also provided some actions to help build on the areas of good practice and improve patient care and experience and the team are now working through an action plan looking at the following 6 areas:

Diagnostic PET

- To carry out an assessment of capacity and demand and make plans to align these
- To work with Alliance Medical to enable electronic requests for patients in line with the national contract
- Alliance Medical to consider prioritising lung cancer scans given how critical they are in the early part of the pathway
- In discussion with CUH and Alliance Medical, to establish other providers to support with the provision of PET within the region based on the patient's location

Data Extraction

- To embed the Somerset Care Record System to ensure accurate and complete submission of data for COSD compliance

Development of KPIs

- To consider developing their own set of benchmarks to be used as a future measure of improvement

Diagnostic Histopathology

- To review current resources and processes to ensure that turnaround time meet the NOLCP and to audit and process map this part of the pathway to see if improvements can be made

Pathways

- To develop patient and tumour-stratified follow up which could be shared nationally to standardise practice

Treatment

- To explore the readmission rates from the most recent lung cancer audits which are above the national average and to understand the detail and reasons behind these figures
- To look at introducing end of treatment summaries as routine practice and to expand the use of eHNAs

People, Management & Culture: Performance summary

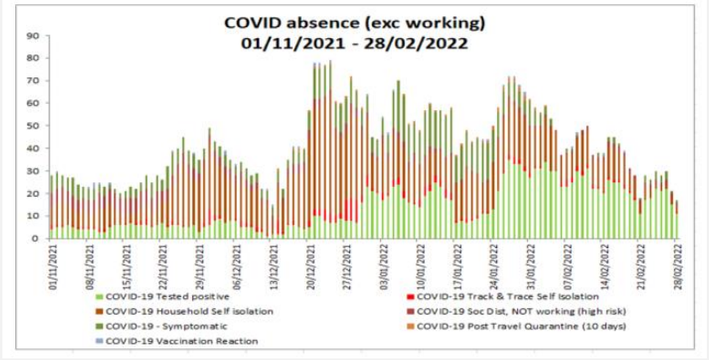
Accountable Executive: *Director of Workforce and Organisational Development* ***Report Author:*** *HR Manager Workforce*

		Data Quality	Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Dashboard KPIs	Voluntary Turnover %	3	12.0%	19.01%	16.34%	13.55%	19.44%	15.14%	15.97%
	Vacancy rate as % of budget	4	5.00%	7.57%	7.57%	7.19%	7.87%	8.42%	8.40%
	% of staff with a current IPR	3	90%	73.24%	71.26%	71.38%	71.37%	72.94%	74.96%
	% Medical Appraisals	3	90%	53.91%	63.48%	68.64%	71.55%	75.00%	76.07%
	Mandatory training %	3	90.00%	86.83%	86.31%	85.14%	85.02%	84.32%	84.83%
	% sickness absence	3	3.5%	4.28%	5.27%	4.79%	4.95%	5.59%	5.36%
Additional KPIs	FFT – recommend as place to work	3	67.0%	67.00%	n/a	n/a	74.00%	n/a	n/a
	FFT – recommend as place for treatment	3	80%	89.00%	n/a	n/a	90.00%	n/a	n/a
	Registered nursing vacancy rate (including pre-registered nurses)	3	5.00%	2.82%	3.05%	3.22%	4.30%	4.87%	5.50%
	Unregistered nursing vacancies excluding pre-registered nurses (% total establishment)	3	5.00%	22.43%	24.03%	23.56%	23.49%	24.52%	24.27%
	Long term sickness absence %	3	0.80%	1.55%	1.75%	1.94%	2.18%	1.56%	1.61%
	Short term sickness absence	3	2.70%	2.74%	3.52%	2.85%	2.78%	4.04%	3.76%
	Agency Usage (wte) Monitor only	3	Monitor only	28.9	30.6	29.0	23.7	20.8	22.8
	Bank Usage (wte) monitor only	3	Monitor only	61.5	63.4	60.9	55.9	59.4	56.3
	Overtime usage (wte) monitor only	3	Monitor only	58.5	59.1	59.1	51.2	45.0	49.0
	Agency spend as % of salary bill	5	3.35%	1.27%	1.53%	1.50%	2.42%	1.63%	0.94%
	Bank spend as % of salary bill	5	2.21%	1.83%	1.86%	2.06%	1.66%	2.46%	2.57%
	% of rosters published 6 weeks in advance	3	Monitor only	20.60%	18.20%	32.40%	38.20%	32.40%	55.90%
	Compliance with headroom for rosters	3	Monitor only	33.70%	30.70%	31.50%	28.50%	34.10%	33.80%
	Band 5 % White background: % BAME background*	3	Monitor only	57.93% : 39.22%	n/a	n/a	57.17% : 39.93%	n/a	n/a
	Band 6 % White background: % BAME background*	3	Monitor only	73.44% : 24.88%	n/a	n/a	73.13% : 25.23%	n/a	n/a
	Band 7 % White background % BAME background*	3	Monitor only	85.32% : 13.49%	n/a	n/a	85.83% : 12.99%	n/a	n/a
	Band 8a % White background % BAME background*	3	Monitor only	88.89% : 10.00%	n/a	n/a	87.50% : 11.36%	n/a	n/a
	Band 8b % White background % BAME background*	3	Monitor only	88.48% : 7.69%	n/a	n/a	90.32% : 6.45%	n/a	n/a
	Band 8c % White background % BAME background*	3	Monitor only	93.33% : 6.67%	n/a	n/a	92.86% : 7.14%	n/a	n/a
	Band 8d % White background % BAME background*	3	Monitor only	100.00% : 0.00%	n/a	n/a	100.00% : 0.00%	n/a	n/a

* - Data available quarterly from June 21

Summary of Performance and Key Messages:

- Turnover at 15.97% is over the 12% KPI again this month. YTD turnover is 16.6%. There were 25 non-medical leavers of which 13 were registered nurses. There were leavers across all areas. We have seen turnover increasing steadily over this financial year. Anecdotally this is the trend across system partners who all report increased levels of turnover.
- The Trust vacancy rate remained at 8.4%. There has been a notable shift in the labour market both for permanent and temporary staff. We have seen a decline in the number of applicants for roles within the Trust particularly in Bands 2-4 as pay rates in retail and hospitality have increased. Registered nurse vacancy rates have increased to 5.5%, the first time this financial year that we our over our KPI. We have seen an increase in recruitment to Band 5 posts in February and recruited 15 UK nurses. The overseas nurses campaign for Critical Care has also progressed well. At the end of February we had 47 Band 5 nurses in the pipeline. HCSW vacancy rates remain very high at 24.3% across Bands 2-4. We have increased capacity in the Nurse Recruitment Team to focus on HSCW recruitment and retention.
- Medical appraisal compliance continues to improve. Non medical appraisal rates have improved for the second month as managers try to refocus on appraisals and mandatory training for their staff. This does continue to be challenging as a result of high short term absence due to Covid-19.
- Absence rates continued at a high level driven by continued high rates of Covid-19 sick leave combined with normal winter rates of absence. We saw Covid absence reduce in the latter half of February although it has increased again through March.



- Rosters are for a 4 week period and managers are required to approve them 6 weeks in advance of the date they commence. For areas where shift working is required late approval of rosters causes uncertainty for staff on their working pattern and adversely impacts on wider resource planning. Compliance improved in February and support and training continues to be given to managers to ensure compliance and improved practice. More detail on this is provided in the spotlight section.
- Temporary staffing usage continues at a high level with supply being challenging as demand outstrips supply.
- The recommender as a place to work score improved to 74% in the Q4 Pulse Survey and the recommender as a place for treatment was maintained at a high level of 90%.

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.

Increasing turnover and vacancy rates as the labour market both locally and nationally becomes more competitve.

High levels of short notice staff absence as a result of self-isolation and/or IPC requirements following Covid-19 contact and high infection rates.

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 induction and mandatory training as a result of the backlog created during the surge periods and competing demands for training space and line manager/staff time.

Achieving the KPI of 90% of staff having an annual performance review meeting because of the backlog of appraisals created by appraisals being put on hold through the pandemic.

WRES and WDES data and feedback in staff surveys indicates that staff from a BAME background or with a disability have a significantly less positive working experience.

Key risks:

- Staff engagement and morale reduces, leading in turn to higher turnover, absence, reduced efficiency and quality and poor relationships all of which could adversely impact on patience experience.
- Staff experiencing extreme fatigue and burnout as well as negative impact on their mental health. This has a significant detrimental impact on the individual with the potential to result in long term absence as well as all the repercussions set out in the point above.
- Reduction in workforce capacity to maintain safe staffing levels, additional pressures on staff and increased temporary staffing costs.
- The Trust is not able to recruit clinical and non clinical staff in sufficient numbers to meet demand due to labour market shortages through both permanent and temporary staff pipelines.
- Pay costs in excess of budget as a result of the rising cost of temporary staffing used to cover new work and vacancies.
- 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.

Registered and Unregistered Nurse Recruitment

The Nurse Recruitment Team have been expanded using temporary funding from Health Education England . This increased capacity has enabled a more proactive approach to attracting and recruiting HCSWs. This has included attending career events at sixth form colleges and running a Saturday recruitment event in the hospital, the first since the start of the pandemic. This event was extremely well run and 17 offers of employment were made on the day . We have also been trialling recruitment through Indeed online agency although we do not see this being a signficant source of high calibre candidates.

Level 5 wards are piloting a Refer a HCSW Friend to test whether this would increase the number of suitable applicants. All staff on 5th floor have been invited to participate. Any “friend” interviewed/offered March-May will lead to the 5th floor staff member receiving £250 upon their friends commencement.

Critical Care and Theatres are participating in a trial to appoint HCSW on Temporary Staffing without a Care Certificate to see if we can safely increase the recruitment pool for the bank.

We have seen an increase in interest in Band 5 nurses. This may be partly due to the resumption of engagement with universities with the Recruitment Team once again able to attend face to face events. Critical Care continues to be attractive to candidates. There are 47 Band 5 nurses in the pipeline including 17 overseas staff for Critical Care. The first cohort of overseas staff are planned to arrive at the end of April .

Cultural Ambassadors

The Cultural Ambassador Programme was established by the Royal College of Nursing with the aim of ensuring fairness and improving the experience of staff from a Black and Minority Ethnic staff and other staff with protected characteristic involved in employee relations processes. It has also now expanded to include recruitment processes. Having a cohort of trained Cultural Ambassadors is one of the key actions in our WRES plan. The first two members of staff completed the programme in February and we are recruiting a further cohort to start training in May 2022.

People, Management & Culture : Roster Approval Compliance

E-rostering has a pivotal function in healthcare delivery because it ensures staffing resources are appropriately allocated to provide a high quality, safe and efficient health service.

Best practice recommendations are that rosters are approved 6-8 week in advance with the aim of extending to 12 weeks. Our current KPI is that all rosters should be approved 6 weeks in advance. Apart from the benefits of staff knowing their future working pattern in order to enable them to balance work and personal commitments/wishes, there is evidence showing that the sooner vacant shifts are sent out to bank, the higher the success in bookings and a subsequent reduction in agency/overtime usage. It also enables advance warning of periods when safe staffing levels may be compromised and mitigating actions considered and planned.

NHSi have set out five 'levels of attainment' (0-4) for Trusts in using e-rostering systems. These enable a trust to benchmark its progress as it adopts e-rostering software. Each level of attainment is underpinned by 'meaningful use standards'. These describe the processes and systems that Trusts need to meet each level of attainment. Currently we are on level 1. In order to reach level 2, part of the requirement is that the rosters must be finalised (i.e. published to staff) at least 6 weeks before the roster start date. Therefore in order to attain the next level of attainment we need to be consistently achieving our KPI for roster sign off.

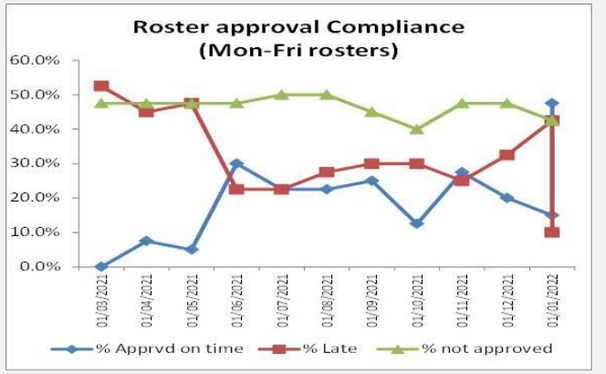
The roster approval is a two part process – it is partially approved and then fully approved. In most clinical areas the first stages of developing a roster is delegated to the ward sister administrator or a Band 6 Deputy Sister. The partial approval of the rota is then undertaken by the ward/unit manager and full approval by matron/senior manager. Once a roster is partially approved, an email goes to the named full approver on the roster template advising that the roster is ready for review and full approval. The roster approval dates are not only shown on the eRostering intranet page, but also on HealthRoster itself for the current and next 2 roster periods.The e-rostering system has a Roster Analyser function which breaks down the roster effectiveness and enables managers to drill down on any areas of concern under the headers of Unavailability, Safety, Effectiveness, Annual Leave and Fairness. In relation to effectiveness – there is a further tab with a more details breakdown for managers to review.

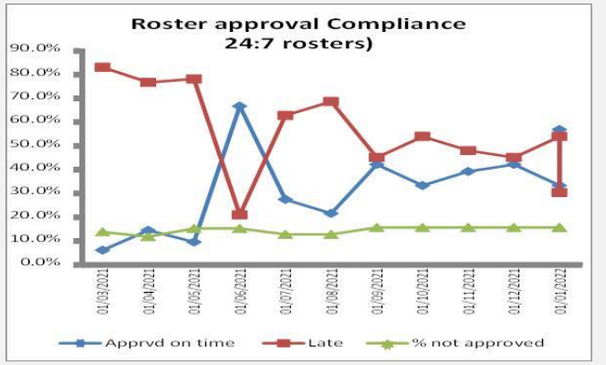
We currently have 40 rosters which are 24:7 and 34 that are for Mon-Fri services. The metrics in PIPR KPIs relates only to 24:7 rosters as these are where the late approval of rotas has the most impact on individuals, staff utilisation and temporary staffing usage.

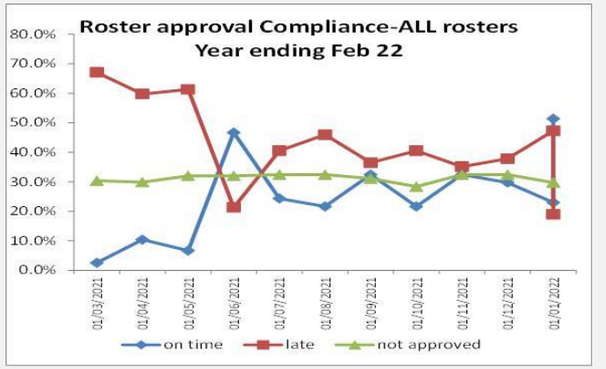
Compliance with the KPI for roster approval has been on an improving trend over the last 12 months. There is no doubt that the demands of the Covid pandemic in particular the need to move staff between areas to respond to spikes in activity levels in particular areas severely disrupted normal rostering practice. The Rostering Check and Support process instigated by the Chief Nursing Officer and Director of Workforce and OD have provided the opportunity for in-depth exploration of the rostering processes in each clinical areas and the reasons why an area may not be consistently achieving the KPI for approval. There is good understanding of the importance of rosters being approved at least 6 weeks in advance and a commitment from the line managers to achieve this. The themes emerging from these sessions relating to late approval are:

- Poor utilisation of auto-rostering and a reliance on manual rostering
- Lack of capacity with the administrative support for rostering
- Poor level of skills/expertise in rostering
- Insufficient management time for sisters/charge nurses as they are pulled into working clinical because of staffing levels
- Area rostering "rules" (eg optimal shift patterns, competencies required, flexible working arrangements) not being kept up to date in the roster

An action log is developed for each area following the 6 monthly Check and Support sessions and progress with the actions and improving roster sign off and effectiveness will be tracked. The Rostering Support provide support and training for managers and administrators. Monthly Staffing Action meetings have been set up on a Divisional basis to provide further support and share learning.







Finance: Performance summary

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

		Data Quality	Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Dashboard KPIs	Year to date surplus/(deficit) exc land sale £000s	5	£1,933k	£2,238k	£2,246k	£2,205k	£2,580k	£3,610k	£4,554k
	Cash Position at month end £000s	5	n/a	£60,142k	£59,081k	£60,027k	£61,840k	£62,174k	£65,347k
	Capital Expenditure YTD £000s	5	£1276 YTD	£218k	£561k	£606k	£716k	£733k	£972k
	In month Clinical Income £000s*	5	£16992k (current month)	£18,543k	£16,873k	£17,198k	£17,605k	£17,660k	£17,756k
	CIP – actual achievement YTD - £000s	4	£4,713k	£2,660k	£3,830k	£4,450k	£4,920k	£5,290k	£5,630k
	CIP – Target identified YTD £000s	4	£5390k	£5,390k	£5,390k	£5,390k	£5,390k	£5,390k	£5,390k
Additional KPIs	NHS Debtors > 90 days overdue	5	15%	61.1%	46.7%	68.3%	26.9%	7.8%	24.4%
	Non NHS Debtors > 90 days overdue	5	15%	22.6%	25.6%	23.6%	20.6%	27.4%	23.0%
	Capital Service Rating	5	4	3	3	3	3	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	£10,575k	£11,974k	£13,370k	£15,085k	£17,495k	£19,801k
	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	£2,291k	£2,708k	£2,643k	£3,827k	£6,885k	£3,743k
	Better payment practice code compliance - NHS	5	Monitor only	86%	80%	91%	94%	87%	80%
	Better payment practice code compliance - Non NHS	5	Monitor only	94%	95%	95%	97%	94%	96%

Summary of Performance and Key Messages:

- **The YTD position is reported against the Trust's H1 and H2 2021/22 plan and shows a surplus of £5m which is £2.5m 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 partially 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 M11, 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 £0.9m 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 February: this was in the context of sustained ECMO 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 £65m.** This represents an increase of c£3m from last month and is mainly driven by a reduction in trade receivables. The Trust's capital spend is behind plan due to the delayed start of IT and estates projects which are still forecast to be completed in year. £0.18m of Digital Aspirant funding has been deferred in 22/23.
- **Better Payments Practice Code** performance for M11 across all suppliers is 95% by value and 86% by volume vs the 95% standard. This remains a significant improvement over earlier months. The Trust will continue to follow its action plan with the aim to ensure that the 95% standard is met consistently in future months.

Finance: Key Performance – year to date SOCI

On a YTD basis the Trust delivered £5m surplus against a surplus plan of £2.5m. YTD position reflects the better than planned performance on private patient activity, reduced pay spend due to continued vacancies and other movements on non-clinical supplies due to COVID-19 costs, provisions for clinical perfusion service, DCD and M Abscessus. This improved financial performance in year over plan has led to the Trust adjusting the FOT position to a £6.9m surplus.

	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	£125,759	£131,319	£0	£0	£131,319	£5,560	
Balance to block payment -activity only	£0	(£4,825)	£0	£0	(£4,825)	(£4,825)	
Homecare Pharmacy Income	£45,127	£39,088	£0	£0	£39,088	(£6,039)	
Drugs and Devices - cost and volume	£11,019	£10,947	£0	£0	£10,947	(£72)	
Balance to block payment - drugs and devices	£0	£860	£0	£1,853	£2,713	£2,713	
Sub-total	**£181,906**	**£177,389**	**£0**	**£1,853**	**£179,242**	**(£2,664)**	
Clinical income - Outside of national block framework							
Drugs & Devices	£563	£1,466	£0	£0	£1,466	£902	
Other clinical income	£2,048	£2,524	£0	£0	£2,524	£476	
Private patients	£5,500	£7,411	£0	£0	£7,411	£1,911	
Sub-total	**£8,111**	**£11,400**	**£0**	**£0**	**£11,400**	**£3,290**	
Total clinical income	**£190,017**	**£188,790**	**£0**	**£1,853**	**£190,643**	**£626**	
Other operating income							
Covid-19 funding and ERF	£8,841	£0	£3,842	£4,791	£8,634	(£208)	
Top-up funding	£31,425	£31,441	£0	(£2,400)	£29,041	(£2,384)	
Other operating income	£13,576	£14,059	£0	£0	£14,059	£484	
Total operating income	**£53,842**	**£45,500**	**£3,842**	**£2,391**	**£51,734**	**(£2,108)**	
Total income	**£243,858**	**£234,290**	**£3,842**	**£4,244**	**£242,376**	**(£1,482)**	
Pay expenditure							
Substantive	(£103,893)	(£101,501)	(£412)	(£1,275)	(£103,187)	£706	
Bank	(£2,200)	(£2,136)	(£126)	£0	(£2,262)	(£61)	
Agency	(£3,612)	(£1,616)	(£16)	£0	(£1,633)	£1,980	
Sub-total	**(£109,706)**	**(£105,252)**	**(£554)**	**(£1,275)**	**(£107,081)**	**£2,625**	
Non-pay expenditure							
Clinical supplies	(£37,676)	(£35,739)	(£106)	(£1,704)	(£37,550)	£126	
Drugs	(£5,191)	(£4,577)	(£683)	£0	(£5,261)	(£70)	
Homecare Pharmacy Drugs	(£45,063)	(£38,105)	£0	£0	(£38,105)	£6,958	
Non-clinical supplies	(£28,777)	(£29,719)	(£2,031)	(£2,830)	(£34,579)	(£5,803)	
Depreciation (excluding Donated Assets)	(£8,413)	(£8,326)	£0	£0	(£8,326)	£88	
Depreciation (Donated Assets)	(£566)	(£479)	£0	£0	(£479)	£87	
Sub-total	**(£125,686)**	**(£116,945)**	**(£2,820)**	**(£4,533)**	**(£124,299)**	**£1,387**	
Total operating expenditure	**(£235,392)**	**(£222,198)**	**(£3,375)**	**(£5,808)**	**(£231,380)**	**£4,012**	
Finance costs							
Finance income	£0	£31	£0	£0	£31	£31	
Finance costs	(£4,700)	(£4,637)	£0	£0	(£4,637)	£64	
PDC dividend	(£1,833)	(£1,837)	£0	£0	(£1,837)	(£4)	
Revaluations/(Impairments)	£0	£0	£0	£0	£0	£0	
Gains/(losses) on disposals	£0	£0	£0	£0	£0	£0	
Sub-total	**(£6,534)**	**(£6,442)**	**£0**	**£0**	**(£6,442)**	**£91**	
Surplus/(Deficit) including central funding	**£1,932**	**£5,650**	**£468**	**(£1,563)**	**£4,554**	**£2,621**	
Surplus/(Deficit) Control Total basis	**£2,498**	**£6,129**	**£468**	**(£1,563)**	**£5,033**	**£2,534**	

- **Clinical income** is £0.63m 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, Cardiac Surgery, Thoracic Surgery and Transplant Operations.
  - Private patient income delivery is £1.9m higher than plan. This is driven by increased activity within Cardiology, Cardiac Surgery and Thoracic Medicine
- **Other operating income** is adverse to plan by £2.1m, mainly due to the net movement in top-up funding recognised, Digital aspirant funding and SIFT funding. Better than planned accommodation income also contributed towards the position.
- **Pay expenditure** is favourable to plan by £2.6m. 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 costs include additional provisions for untaken annual leave, the staff bonus and for an outstanding employment case.
- **Clinical Supplies** is favourable to plan by £0.1m. 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 £7.0m 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 £5.8m. £2.0m 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), DCD devices provision, clinical perfusion costs and 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	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Comments
Additional KPIs	Elective activity as % 19/20 (ICS)	3	Monitor only	76.00%	70.80%	81.00%	54.50%	73.40%	77.20%	Latest data to w/e 06/03/22
	Non Elective activity as % 19/20 (ICS)	3	Monitor only	92.60%	84.20%	91.10%	89.80%	92.50%	n/a	Latest data to w/e 06/03/22
	Day Case activity as % 19/20 (ICS)	3	Monitor only	98.40%	99.00%	96.10%	81.10%	96.70%	100.60%	Latest data to w/e 06/03/22
	Outpatient - First activity as % 19/20 (ICS)	3	Monitor only	112.10%	127.00%	111.30%	84.60%	113.30%	132.80%	Latest data to w/e 06/03/22
	Outpatient - Follow Up activity as % 19/20 (ICS)	3	Monitor only	105.60%	116.50%	102.50%	80.70%	101.60%	119.70%	Latest data to w/e 06/03/22
	Virtual clinics – ICS wide % of all outpatient attendances that are virtual	3	Monitor only	26.80%	25.70%	26.20%	28.30%	21.90%	25.90%	Latest data to w/e 06/03/22
	Diagnostics < 6 weeks %	3	Monitor only	54.10%	55.20%	56.60%	52.90%	60.70%	60.40%	Latest data to w/e 06/03/22
	18 week wait %	3	Monitor only	63.70%	62.70%	62.50%	60.30%	59.20%	59.50%	RTT Metrics comprise CUHFT & NWAFT & RPH to w/e 06/03/22
	No of waiters > 52 weeks	3	Monitor only	7,672	8,045	8,049	7,852	7,560	6,695	RTT Metrics comprise CUHFT & NWAFT & RPH to w/e 06/03/22
	Cancer - 2 weeks % (ICS)	3	Monitor only	n/a	79.70%	n/a	67.90%	n/a	67.00%	Latest Cancer Performance Metrics available are Feb 2022
	Cancer - 62 days wait % (ICS)	3	Monitor only	n/a	66.20%	n/a	60.50%	n/a	54.60%	Latest Cancer Performance Metrics available are Feb 2022
	Finance – ICS bottom line position	3	Monitor only	n/a	n/a	n/a	n/a	n/a	n/a	Latest financial update is for June 21
	Staff absences % (C&P)	3	Monitor only	4.20%	4.50%	4.40%	4.80%	4.90%	4.60%	Latest data to w/e 06/03/22

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.