Royal Papworth Hospital
NHS Foundation Trust

# Papworth Integrated Performance Report (PIPR)

## December 2022

# Content



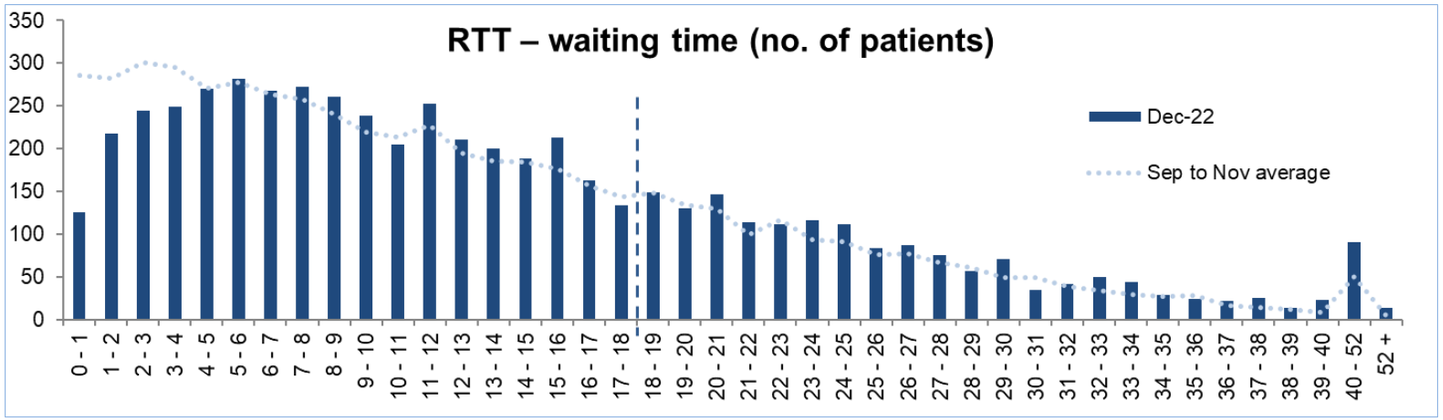
# Context:

**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 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Trend |
|---|---|---|---|---|---|---|---|
| Cardiac Surgery | 145 | 144 | 135 | 160 | 141 | 148 | |
| Cardiology | 648 | 691 | 648 | 673 | 686 | 595 | |
| ECMO (days) | 33 | 65 | 46 | 51 | 80 | 132 | |
| PTE operations | 20 | 15 | 13 | 7 | 15 | 8 | |
| RSSC | 609 | 674 | 489 | 640 | 584 | 549 | |
| Thoracic Medicine | 323 | 317 | 301 | 332 | 318 | 260 | |
| Thoracic surgery (exc PTE) | 48 | 56 | 47 | 66 | 50 | 61 | |
| Transplant/VAD | 55 | 30 | 27 | 58 | 30 | 40 | |
| **Total Inpatients** | **1,881** | **1,992** | **1,706** | **1,987** | **1,904** | **1,793** | |
| Total Inpatients exc PP | 1,811 | 1,913 | 1,609 | 1,911 | 1,813 | 1,722 | |
| *Total Inpatients exc PP* ***plan*** *(104% 19/20 baseline)* | *2,169* | *2,253* | *2,333* | *2,258* | *2,343* | *2,033* | |

| Outpatient Attendances | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Trend |
|---|---|---|---|---|---|---|---|
| Cardiac Surgery | 450 | 501 | 426 | 454 | 480 | 384 | |
| Cardiology | 3,942 | 3,620 | 3,543 | 3,724 | 3,978 | 3,266 | |
| RSSC | 1,495 | 1,401 | 1,673 | 1,718 | 2,113 | 1,382 | |
| Thoracic Medicine | 2,495 | 2,490 | 2,150 | 2,052 | 2,655 | 2,237 | |
| Thoracic surgery (exc PTE) | 62 | 93 | 96 | 110 | 142 | 86 | |
| Transplant/VAD | 265 | 315 | 266 | 307 | 345 | 255 | |
| **Total Outpatients** | **8,709** | **8,420** | **8,154** | **8,365** | **9,713** | **7,610** | |
| Total Outpatients exc PP | 8483 | 8110 | 7864 | 8093 | 9360 | 7350 | |
| *Total Outpatients exc PP* ***plan*** *(104% 19/20 baseline)* | *8229* | *8358* | *8553* | *8497* | *9153* | *7638* | |

**Note 1** - Activity figures include Private patients and exclude unbundled radiology scan activity and ALK test activity;
**Note 2** - ECMO activity shows billed days (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

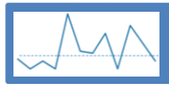
Each category within the Balanced scorecard is given an overall RAG rating based on the rating of the KPIs within the category that appear on the balance scorecard (page 4).

- **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)

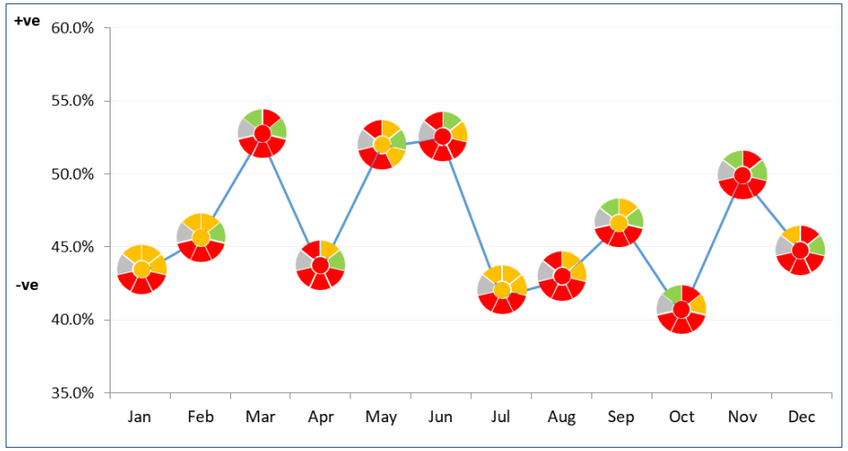
### Data Quality Indicator

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 - RED


### FAVOURABLE PERFORMANCE

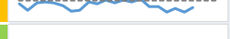
**CARING:** FFT (Friends and Family Test): For inpatients the positive experience remains high (98.3%) and well above our 95% target. Participation Rate had a slight decrease from 42.5% in November 2022 to 37.3% in December 2022. Outpatients: Positive Experience rate was 96.7% (December 2022) and above our 95% target. For benchmarking information, NHS England latest published data is for September 2022 where the Positive Experience rate was 94% for inpatients) and 93% for outpatients. The participation rate was 18.87% for inpatients and 7.56% for outpatients. See the Spotlight on FFT on page 12 for more detail.
**EFFECTIVE**: Bed occupancy and capacity utilisation: Critical care bed occupancy returned to target range with constraints in elective operating and high levels of demand for emergency surgery continuing. Ward occupancy improved despite the ongoing reduced elective programme which reflects greater acuity and demand in cardiac and respiratory pathways. Admitted patient care was impacted by the seasonal bank holidays and RCN industrial action which took place on 15 and 20 December. Despite this overall theatre utilisation was consistent with the previous month. Productivity improvements have been identified as part of the transformation plan and are being implemented, such as the three pump list trial.
**RESPONSIVE:** Diagnostic Performance: continues to be above target with 99.28% of patients waiting less than 6 weeks for their appointment.
**PEOPLE, MANAGEMENT & CULTURE:** Turnover dropped back to 10.45% in December. The year to date rate of turnover is 16.8% which is over our KPI of 14%. There were 19 leavers (17 WTE) in month. The most common reasons recorded for leaving was work life balance. Flexible working and career development are areas where we have the opportunity to improve our practices and the offer to staff.
**FINANCE:** The Trust's annual plan was agreed as part of the ICS planning submission in June 2022 and set a breakeven plan for the 2022/23 year. Year to date (YTD), the financial position is favourable to plan by c£3.6m with a reported surplus of £3.6m against a planned surplus of £0.1m.

### ADVERSE PERFORMANCE

**SAFE:** Safer staffing: Nursing roster fill rates for December were 79% for registered staff for both day and night time staffing. Unregistered fill rates in December for day and night time staffing were 64% and 71% respectively. Registered fill rates were essentially unchanged from previous month with unregistered being slightly worse. A more detailed breakdown, ward by ward, of nurse staffing fill rates including mitigations taken to maintain patient and trajectory for improvement can be seen on page 8. Overall CHPPD (care hours per patient day) for December was 12.2 which is slightly higher than November.
**EFFECTIVE:** Outpatient capacity: Outpatient attendances were behind plan. This reflects seasonal reduction and industrial action, which had a particular impact on outpatient services which were not derogated. Additional impact is expected in future months with further RCN action called in February and other professional groups balloting staff.
**RESPONSIVE**: 1) Waiting list management: The number of patients on open pathways has reduced in month but the total number on the waiting list continues to be greater than target. RTT performance has deteriorated in month, particularly in Cardiac Surgery and Respiratory. This is due to ongoing capacity issues and imbalance in the waiting list. Industrial action and targeted action to reduce the IHU backlog are contributing factors to this position. The number of 52 week breaches has increased caused by a combination of capacity restraints and patient cancellations. Route cause analysis has been undertaken for all patients and dates for treatment have been confirmed for all cases. 2) Theatre cancellations have increased in month. This reflects complex case mix with a high number of emergency cases in month and high sickness, particularly in the critical care team.
**PEOPLE, MANAGEMENT & CULTURE:** 1) Total sickness absence increased to 5.43%. The rates of absence are following a similar pattern to 2021 but are at a slightly higher level. During December we saw an increase in the prevalence of Covid in the community and an increase in cold/flu. 2) We continue to struggle to improve IPR rates with areas still experiencing constraints on releasing staff for appraisals in sufficient numbers to recover the backlog of overdue appraisals. The Appraisal Procedure has being revised to incorporate the Trusts values and behaviours and to streamline the process and paperwork. At the start of December we launched the revised policy with a communication campaign and training for appraisers.
**FINANCE:** Clinical Income/Activity: elective activity continues to track below 2019/20 levels on average, and is below the national target. Day case activity has shown a stronger recovery than inpatient activity. Surgical capacity remains a constraining factor for elective inpatient activity.

# At a glance – Balanced scorecard

| | | Month reported on | Data Quality | Plan | Current month score | YTD Actual | Forecast YE | Trend |
|---|---|---|---|---|---|---|---|---|
| Safe | Never Events | Dec-22 | 4 | 0 | 0 | 0 | |  |
| | Moderate harm incidents and above as % of total PSIs reported | Dec-22 | 4 | 3% | 0.00% | 0.92% | |  |
| | Number of Papworth acquired PU (Catergory 2 and above) | Dec-22 | 4 | 35 pa | 0 | 11 | |  |
| | High impact interventions | Dec-22 | 3 | 97% | 94.00% | 94.44% | |  |
| | Falls per 1000 bed days | Dec-22 | 4 | 4 | 2.4 | 3.2 | |  |
| | Sepsis - % patients screened and treated (Quarterly) | Dec-22 | New | 90% | 81.00% | - | | |
| | Trust CHPPD | Dec-22 | 5 | 9.6 | 12.2 | 12.7 | |  |
| | Safer staffing: fill rate – Registered Nurses day | Dec-22 | 5 | 90% | 79.0% | 85.2% | |  |
| | Safer staffing: fill rate – Registered Nurses night | Dec-22 | 5 | 90% | 79.0% | 85.7% | |  |
| | Safer staffing: fill rate – HCSWs day | Dec-22 | 5 | 90% | 64.0% | 61.5% | |  |
| | Safer staffing: fill rate – HCSWs night | Dec-22 | 5 | 90% | 71.00% | 72.72% | |  |
| Caring | FFT score- Inpatients | Dec-22 | 4 | 95% | 98.30% | 99.08% | |  |
| | FFT score - Outpatients | Dec-22 | 4 | 95% | 96.70% | 97.36% | |  |
| | Number of written complaints per 1000 WTE (Rolling 3 mnth average) | Dec-22 | 4 | 12.6 | 5.7 | | |  |
| | Mixed sex accommodation breaches | Dec-22 | 4 | 0 | 0 | 0 | | |
| | % of complaints responded to within agreed timescales | Dec-22 | 4 | 100% | 100.00% | 93.00% | |  |
| Effective | Bed Occupancy (excluding CCA and sleep lab) | Dec-22 | 4 | 85% (Green 80%-90%) | 74.20% | 72.32% | |  |
| | CCA bed occupancy | Dec-22 | 4 | 85% (Green 80%-90%) | 85.80% | 85.82% | |  |
| | Admitted Patient Care (elective and non-elective) | Dec-22 | 4 | 19046 | 1722 | 16128 | |  |
| | Outpatient attendances | Dec-22 | 4 | 71262 | 7350 | 73357 | |  |
| | Cardiac surgery mortality (Crude) | Dec-22 | 3 | 3% | 2.17% | 2.17% | |  |
| | Theatre Utilisation | Dec-22 | 3 | 85% | 82.6% | 79.5% | |  |
| | Cath Lab Utilisation 1-6 at New Papworth (including 15 min Turn Around Times) | Dec-22 | 3 | 85% | 76.0% | 80.2% | |  |

| | | Month reported on | Data Quality | Plan | Current month score | YTD Actual | Forecast YE | Trend |
|---|---|---|---|---|---|---|---|---|
| Responsive | % diagnostics waiting less than 6 weeks | Dec-22 | 3 | 99% | 99.28% | 97.16% | |  |
| | 18 weeks RTT (combined) | Dec-22 | 5 | 92% | 70.60% | 70.60% | |  |
| | Number of patients on waiting list | Dec-22 | 5 | 3279 | 5657 | 5657 | |  |
| | 52 week RTT breaches | Dec-22 | 5 | 0 | 13 | 50 | |  |
| | 62 days cancer waits post re-allocation (new 38 day IPT rules from Jul18)* | Dec-22 | 4 | 85% | 50.00% | 50.00% | |  |
| | 31 days cancer waits* | Dec-22 | 4 | 96% | 89.00% | 89.00% | |  |
| | 104 days cancer wait breaches* | Dec-22 | 4 | 0% | 10 | 104 | |  |
| | Theatre cancellations in month | Dec-22 | 3 | 30 | 37 | 30 | |  |
| | % of IHU surgery performed < 7 days of medically fit for surgery | Dec-22 | 4 | 95% | 60.00% | 66.78% | |  |
| | Acute Coronary Syndrome 3 day transfer % | Dec-22 | 4 | 90% | 100.00% | 100.00% | |  |
| People Management & Culture | Voluntary Turnover % | Dec-22 | 3 | 14.0% | 10.5% | 16.8% | |  |
| | Vacancy rate as % of budget | Dec-22 | 4 | 5.0% | 14.3% | | |  |
| | % of staff with a current IPR | Dec-22 | 3 | 90% | 74.38% | | |  |
| | % Medical Appraisals | Dec-22 | 3 | 90% | 78.07% | | |  |
| | Mandatory training % | Dec-22 | 3 | 90% | 84.92% | 85.85% | |  |
| | % sickness absence | Dec-22 | 3 | 3.50% | 5.43% | 4.89% | |  |
| Finance | Year to date surplus/(deficit) exc land sale £000s | Dec-22 | 5 | £(311)k | £3,296k | | |  |
| | Cash Position at month end £000s | Dec-22 | 5 | £61,386k | £66,873k | | |  |
| | Capital Expenditure YTD £000s | Dec-22 | 5 | £1,825k | £1,431k | | |  |
| | In month Clinical Income £000s | Dec-22 | 5 | £21914k | £21,626k | £197,048k | |  |
| | CIP – actual achievement YTD - £000s | Dec-22 | 4 | £4350k | £5,650k | £5,650k | |  |
| | CIP – Target identified YTD £000s | Dec-22 | 4 | £5,800k | £5,800k | £5,800k | |  |

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

# 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 | 2 | 7 | 3 | | |
| RTT Waiting Times | % Within 18w ks - Incomplete Pathw ays | 5 | 92% | 70.60% | | 75.96% | | Monthly measure |
| Cancer | 31 Day Wait for 1st Treatment | 4 | 96% | 89.0% | 89.0% | 84.53% | | Current month provisional as going through verification process. |
| | 31 Day Wait for 2nd or Subsequent Treatment - surgery | 4 | 94% | 100.0% | 88.9% | 96.67% | | Current month provisional as going through verification process. |
| | 62 Day Wait for 1st Treatment | 4 | 85% | 50.0% | 66.7% | 36.1% | | Current month provisional as going through verification process. Data is after reallocations |
| | 104 days cancer w ait breaches | 4 | 0 | 10 | 104 | 54 | | |
| VTE | Number of patients assessed for VTE on admission | 5 | 95% | 84.80% | | 83.1% | | |
| 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. |

* Forecast updated quarterly M01,M04, M07, M10

# Board Assurance Framework risks (where above risk appetite)

| PIPR Category | Title | Ref | Mgmt Contact | Risk Appetite | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Status since last month |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Safe | Failure to protect patient from harm from hospital aquired infections | 675 | MS | 4 | 16 | 16 | 16 | 16 | 16 | 16 | ↔ |
| Safe | Failure to meet safer staffing (NICE guidance and NQB) | 742 | MS | 6 | 12 | 12 | 12 | 12 | 12 | 12 | ↔ |
| Safe | Maintaining safe and secure environment across the organisation | 2833 | TG | 6 | 16 | 16 | 16 | 12 | 12 | 12 | ↔ |
| Safe | M.Abscessus | 3040 | MS | 10 | 15 | 15 | 15 | 15 | 15 | 15 | ↔ |
| Safe + Effective + Finance + Responsive | Continuity of supply of consumable or services failure | 3009 | TG | 6 | 12 | 12 | 12 | 12 | 12 | 12 | ↔ |
| Safe + Effective + Finance + Responsive | Activity recovery and productivity | 3223 | AB | 4 | 16 | 16 | 16 | 16 | 16 | 16 | ↔ |
| Safe + PM&C | Unable to recruit number of staff with the required skills/experience | 1854 | OM | 6 | 16 | 16 | 16 | 16 | 16 | 16 | ↔ |
| Safe + Transformation | Potential for cyber breach and data loss | 1021 | AR | 9 | 16 | 16 | 16 | 16 | 16 | 16 | ↔ |
| Effective + Finance + PM&C + Responsive + Transformation | Delivery of Trust 5 year strategy | 2901 | AB | 6 | 9 | 9 | 9 | 9 | 9 | 9 | ↔ |
| Effective + Finance + Responsive + Transformation | NHS Reforms & ICS strategic risk | 3074 | TG | 8 | 12 | 12 | 12 | 12 | 12 | 12 | ↔ |
| Effective + PM&C + Responsive | Industrial Action | 3261 | OM | 6 | - | 15 | 16 | 16 | 20 | 20 | ↔ |
| Effective + Responsive | Key Supplier Risk | 2985 | TG | 8 | 10 | 10 | 10 | 10 | 10 | 10 | ↔ |
| Responsive | Waiting list management | 678 | AB | 8 | 20 | 20 | 20 | 20 | 20 | 20 | ↔ |
| PM&C | Staff turnover in excess of our target level | 1853 | OM | 6 | 15 | 20 | 20 | 20 | 20 | 20 | ↔ |
| PM&C | Low levels of Staff Engagement | 1929 | OM | 6 | 20 | 20 | 20 | 20 | 20 | 20 | ↔ |
| Transformation | Electronic Patient Record System | 858 | AR | 6 | 16 | 16 | 16 | 16 | 16 | 16 | ↔ |

# Safe: Performance summary

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

| | | Data Quality | Target | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-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% | 1.55% | 1.65% | 0.70% | 0.80% | 0.83% | 0.00% |
| | Number of Papworth acquired PU (Catergory 2 and above) | 4 | <4 | 3 | 1 | 2 | 1 | 3 | 0 |
| | High impact interventions | 3 | 97.0% | 95.0% | 93.0% | 94.0% | 91.0% | 94.0% | 94.0% |
| | Falls per 1000 bed days | 4 | <4 | 2.6 | 1.7 | 3.0 | 1.8 | 3.2 | 2.4 |
| | Sepsis - % patients screened and treated (Quarterly) | New | 90.0% | - | - | 100.0% | - | - | 81.0% |
| | Trust CHPPD | 5 | >9.6 | 12.16 | 12.69 | 12.65 | 11.90 | 11.80 | 12.20 |
| | Safer staffing: fill rate – Registered Nurses day | 5 | 90.0% | 88.0% | 85.0% | 81.0% | 80.0% | 79.0% | 79.0% |
| | Safer staffing: fill rate – Registered Nurses night | 5 | 90.0% | 83.0% | 87.0% | 84.0% | 83.0% | 80.0% | 79.0% |
| | Safer staffing: fill rate – HCSWs day | 5 | 90.0% | 57.0% | 56.0% | 62.0% | 64.0% | 66.0% | 64.0% |
| | Safer staffing: fill rate – HCSWs night | 5 | 90.0% | 70.0% | 71.0% | 76.0% | 74.0% | 76.0% | 71.0% |
| Additional KPIs | MRSA bacteremia | 3 | 0.0% | 0 | 0 | 0 | 1 | 0 | 0 |
| | Number of serious incidents reported to commissioners in month | 4 | 0.0% | 0 | 1 | 1 | 0 | 0 | 0 |
| | E coli bacteraemia | 5 | Monitor only | 0 | 1 | 0 | 1 | 0 | 0 |
| | Klebsiella bacteraemia | 5 | Monitor only | 1 | 0 | 1 | 1 | 2 | 2 |
| | Pseudomonas bacteraemia | 5 | Monitor only | 0 | 0 | 0 | 0 | 2 | 0 |
| | Other bacteraemia | 4 | Monitor only | 0 | 1 | 1 | 0 | 0 | 0 |
| | Other nosocomial infections | 4 | Monitor only | 0 | 0 | 0 | 0 | 0 | 0 |
| | POU filters and bottled water in place | 4 | Monitor only | 100% | 100% | 100% | 100% | 100% | 100% |
| | Moderate harm and above incidents in month (including SIs) | 4 | Monitor only | 4 | 4 | 2 | 4 | 2 | 0 |
| | Monitoring C.Diff (toxin positive) | 5 | Ceiling pa of 10 | 0 | 1 | 2 | 0 | 2 | 2 |
| | Number of patients assessed for VTE on admission | 5 | 95.0% | 87.00% | 79.30% | 82.90% | 85.10% | 88.60% | 84.80% |
| | SSI CABG infections (inpatient/readmissions %) | New | <2.7% | - | - | 4.80% | - | - | 7.10% |
| | SSI CABG infections patient numbers (inpatient/readmisisons) | New | n/a | - | - | 9 | - | - | 14 |
| | SSI Valve infections (inc. inpatients/outpatients; %) | New | <2.7% | - | - | 2.60% | - | - | 4.90% |
| | SSI Valve infections patient numbers (inpatient/outpatient) | New | n/a | - | - | 4 | - | - | 6 |

**Summary of Performance and Key Messages:**

**Pressure ulcers (Category 2 and above):** There were 0 acquired PU reported in December.

**Falls:** There has been a decrease from 3.2 in November to 2.4 per 1000 bed days in December, none of the falls reported were graded as moderate harm or above.

**Sepsis**: Q1/Q2 sepsis reviews were 100% (this data was just for ward patients only). Q3 reports on ward areas and critical care and in 81% of patients, who met criteria, were screened and treated according to the sepsis 6 bundle. Of the remainder (4 patients in critical care) 1 element of the sepsis 6 was incomplete. There was no harm caused and plans are in place to improve compliance.

**Safe staffing fill rates:** Nursing roster fill rates for December were 79% for registered staff for both day and night time staffing. Unregistered fill rates in December for day and night time staffing were 64% and 71% respectively. Registered fill rates were essentially unchanged from previous month with unregistered being slightly worse. A more detailed breakdown, ward by ward, of nurse staffing fill rates including mitigations taken to maintain patient and trajectory for improvement can be seen on key performance challenges slide. Overall CHPPD (care hours per patient day) for December was 12.2 which is slightly higher than November.

**High impact interventions (HII):** Compliance with HII was 94% for December. Areas of poor compliance included were HII 5 VAP (ventilator associated pneumonia) 71%. HII8 cleaning and decontamination of clinical equipment in critical care and Cath labs 71%. HII4 surgical site infection pre- op care 79%. Each area of reduced compliance has an improvement plan which is overseen by Matron and the infection prevention and control committee.

**Alert Organisms**

- **Klebsiella bacteraemia:** There were 2 identified cases of klebsiella bacteraemia in December.
- **C Diff:** There were 2 case of C difficile in December. One of these patients was on critical care and 1 in thoracic medicine. Root cause analyses were presented to scrutiny panel, which had representation from infection control at the ICB, and concluded that there were no acts or omissions in care delivery for either case.

**Point of use filters:** Full compliance with use of POU filters and bottled water for patients.

**Serious Incidents:** There were no serious incidents reported in December.

**Moderate harm incidents and above:** There were no moderate harm or above incidents graded through the Serious Incident Executive Response Panel (SIERP) in December. All incidents are monitored via the Quality Risk Management Group (QRMG) governance process.

**VTE:** Compliance with performing VTE risk assessments was 84% in December. This continues to be an area of particular focus and actions are being monitored through QRMG and divisional performance meetings.

**Surgical Site Infections (SSI):** There was an increase in SSI's in Q3, (CABG inpatients and readmissions = 7.1%) (Valve inpatients and outpatients = 4.9%), which remains an outlying position in comparison to UKHSA benchmark. Q2 data has been updated for sept, as final data has been cleansed. All patient SSI's undergo a RCA which is presented to the surgical M and M meeting to understand any indication of harm. Improvement work in continues to be a focus and revised governance and dashboard has allowed better visibility of assurance. This is being monitored through IPCC and QRMG.

# Safe: Key performance challenges

## Escalated Performance Challenges: Roster fill rates and roster approval times.

**Table 1**

| Ward name | Day | | Night | | CHPPD |
|---|---|---|---|---|---|
| | Average fill rate - registered nurses/midwives (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses/midwives (%) | Average fill rate - care staff (%) | Overall |
| 3 NORTH | 70% | 41% | 84% | 53% | 9.2 |
| 3 SOUTH & 4 NORTH WEST | 90% | 74% | 87% | 90% | 7.8 |
| 4 N&S | 75% | 76% | 78% | 80% | 8.5 |
| 5 NORTH | 78% | 78% | 82% | 91% | 8.8 |
| 5 SOUTH | 63% | 67% | 65% | 77% | 9.4 |
| CCA | 82% | 49% | 79% | 50% | 30.8 |

**Table 2**

| | 28 Mar - 24 Apr 22 | 25 Apr - 22 May | 23 May - 19 June | 20 Jun - 17 Jul | 18 Jul - 14 Aug | 15 Aug - 11 Sep | 12 Sep - 9 Oct | 10 Oct - 6 Nov | 7 Nov - 4 Dec | 5 Dec - 1 Jan 2023 | 2 - 29 Jan 23 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Full Approval | Full Approval | Full Approval | Full Approval | Full Approval | Full Approval | Full Approval | Full Approval | Full Approval | Full Approval | Full Approval |
| 3 North | N | N | y | y | y | y | y | Y | N | Y | Y |
| Cardiology Unit (3 South, 4NW & CCU) | N | N | N | Y | N | N | y | Y | N | Y | Y |
| CCU in Cardiology | | | | | N | N | N | Y | N | Y | N |
| 4 NW (Cardiac) | N | N | N | Y | | | | | | | |
| 4 South | y | y | y | N | y | y | y | Y | Y | Y | Y |
| 5 North | y | y | y | N | N | N | N | Y | N | Y | Y |
| 5 South | y | y | N | N | N | N | y | N | Y | Y | Y |
| ALERT | N | N | y | Y | N | y | y | N | Y | Y | Y |
| Arrhythmia Specialist Nurses | y | N | y | N | N | N | y | N | N | Y | N |
| Cardiac Support Nursing | y | N | y | Y | N | y | N | N | Y | N | N |
| Catheter Lab & Bronchoscopy Nurses | N | N | y | N | N | N | y | N | N | Y | N |
| Critical Care Staff | N | N | N | N | N | y | N | N | Y | Y | Y |
| Critical Care Support Staff | N | N | N | N | N | y | y | N | Y | Y | Y |
| Critical Care Training & Admin Support | N | N | N | N | N | y | y | N | Y | Y | Y |
| Outpatients | N | N | y | N | y | y | N | N | N | N | N |
| Theatres Anaesthetics | y | N | y | N | y | N | N | N | N | N | N |
| Theatres Surgical | y | y | y | Y | N | N | y | N | N | N | N |
| Transplant Unit | N | N | N | N | y | y | N | N | N | N | N |

**RN Fill Rates:** Table 1 describe the fill rates for RN's and HCSW for day and night shifts by ward. The areas of improvement are 3S and 4NW due to reduction of vacancies. Whilst the fill rates for December remain challenging assurance can be gained from the CHPPD and mitigations described in key mitigations.

### Key risks

- Non compliance with safe staffing standards
- Patient safety and patient outcomes risk due to reduced levels of staffing
- Poor patient experience due to reduced staffing levels potential for increase in complaints
- Poor staff experience and satisfaction
- Reputational risk due to potential of poor patient experience and quality of care.

**Roster Approval Times:**
Table 2 shows roster approval times for clinical staff on 24/7 rosters. The nationally set KPI for this metric is 6 weeks in advance of the roster being worked. There are some key areas of improvement and good practise over the last number of months, ALERT, 3N, 4S and CCA. 5N and 5 s have made more recent improvements and work is ongoing to support and sustain these improvements.

### Key risks

- Potential of poor staff experience and negative effect on work life balance
- Risk to increase in staff turnover and retention
- Non compliance with National standards of attainment for e rostering
- Reputational risk

## Key mitigations for maintaining safety and update on nursing vacancies and pipeline:

**3 North:** Safety maintained by ward based ANP's, ward sister and CPD supporting staffing gaps. Reduced occupancy over Christmas period. Average nurse to patient ratios 1:3. RN vacancy rate 28% and HCSW vacancy rate 40%. 3 RN's and 5 HCSW's in pipeline.

**3S and 4 NW:** Safety maintained by staff redeployment and contribution of ward sisters and charge nurses. Average nurse to patient ratios for December were 1:2 in CCU and 1:7 on ward areas. Successful recruitment campaigns have led to pipeline to fill all vacancies.

**4 N and S:** Safety maintained by ward sister and CPD team supporting staffing gaps and reduced occupancy over Christmas period. Average nurse to patient ratio 1:4
RN vacancy rate 20% (5 RN's in pipeline currently with no future leavers known).

**5N and 5S:** Safety maintained by staff redeployment and reduced occupancy (reduced theatre activity and reduced occupancy over Christmas). Average nurse to patient ratios 1:5. RN vacancy rate 5N 28.5% and 5S 32.2%. HCSW vacancies 5N 20% and 5S 15%. Active recruitment campaigns in place with 7 RN's and 10 HCSW in pipeline.

**Critical care:** Safety maintained by reduced activity and reduced capacity. GPIC standards maintained delivering 1:1 ratios for level 3 patients and 1:2 for level 2 patients. Minimal RN vacancies reduced fill rate due to supernumerary/supervisory staff in training. HCSW vacancies 23% with 5 in pipeline.

**Roster Approval key actions:**

- Matrons supporting specialist nursing teams to improve compliance.
- Theatre and transplant nurses roster templates review has now been completed together with training for roster writers.
- Plan to finalise rosters 7 weeks in advance to allow for unexpected absence/ slippage.

# Safe: Spotlight on Digital Medicines Safety and Quality Dashboard

## Digital Medicines Safety and Quality Dashboard

The Digital Medicines Safety and Quality Dashboard is a mechanism to monitor and report medicines-related quality and safety metrics on a monthly basis (example for December 2022 is included in this slide). The dashboard includes a range of metrics intended to reflect the use of medicines by different professional groups.

This Trust wide report, alongside divisional breakdowns, is created automatically and sent for divisional review. It also is discussed at Medicines Safety Group, and reported quarterly at QRMG.

Below is a short explanation for each area displayed within the Trust wide dashboard (described from left to right, row by row, for the Trust example).

**Activity Metrics:** The first box on the dashboard (starting top left) is the inpatient/outpatient activity to give a base line of activity, alongside the area of medication focus

**Medication Incidents:** The dashboard displays the number and breakdown of medicines incidents reported and these are separately tracked in detail at the Medicine Safety Group, using an SPC chart. Fluctuations in reporting may not necessarily reflect changes in the underlying rate of incidents; other factors such as staff skill mix, a desire to highlight specific themes, and the reporting culture of different teams can result in changes to the number of incidents reported. An increase in the proportion of incidents which relate to medicines has been identified in 2022, this is thought due to a return to the good reporting culture post covid. Overall most medication related incidents are no harm incidents, in December 22, there were a total of 46 medication related incidents (trust wide). Of these there were 35 No harm, 8 low harm and 3 near misses. Further details of all incidents will be in the Q3 Quality & Risk report that will be reported through governance to Q&R next month.

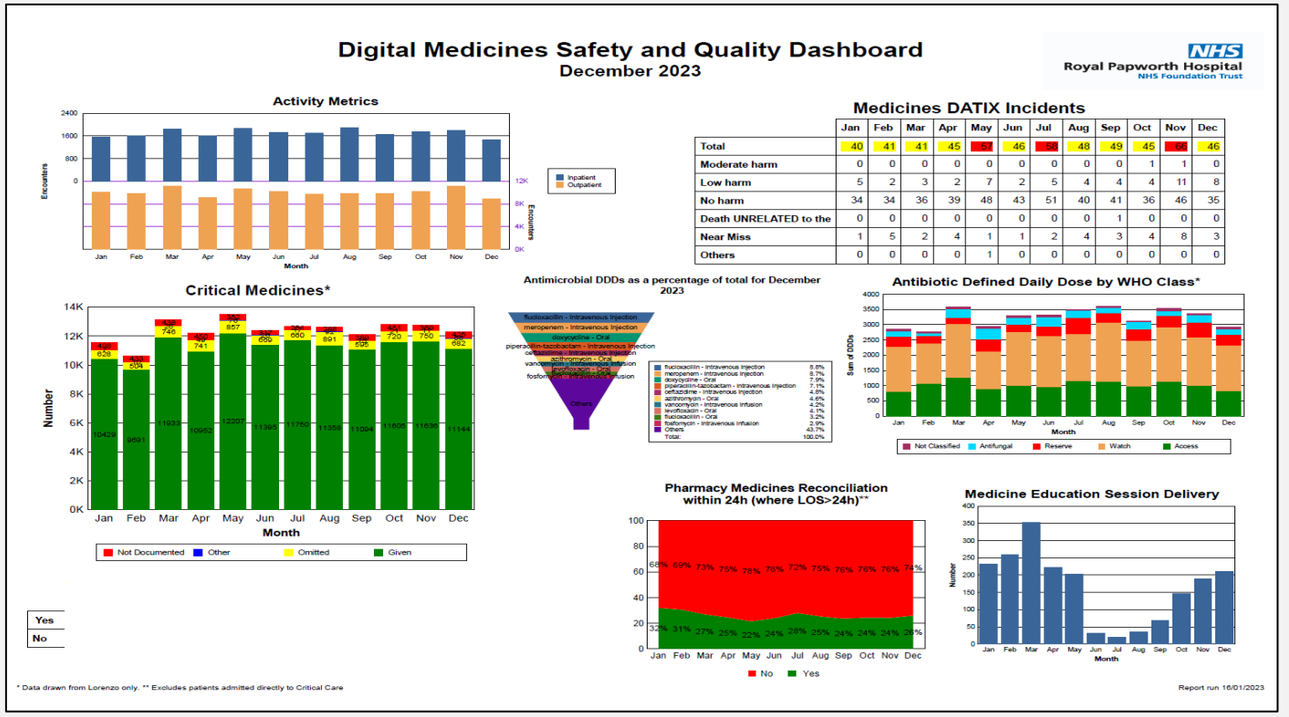
**Critical Medicines:** The visualisation displays the number of doses 'critical medicines' (those which should not be unintentionally omitted) according to the final status of the dose. Previous detailed analyses of the metric has identified that a high-proportion of Not Documented doses relate to periods where a patient may have left the ward or be in the process of being discharged.

**Antimicrobial Stewardship (AMS):** These metrics demonstrate how the Trust utilised antimicrobials in terms of Defined Daily Dose (DDD). This allows prescriptions to be standardised and compared according to a typical dose for that medicine. Wherever possible antimicrobials should be rationalised to lower-risk agents in the access group, although his is not always possible in patients who are critically unwell or who have particularly resistant or challenging pathogens. This is significant inter-division variability in these metrics, and detail analyses are frequently distributed by the AMS team.

**Medicines Reconciliation on Admission:** Medicines reconciliation on admission is the process of taking an accurate medication history, comparing this with the patients current medicines and reconciling the two. A first level reconciliation is undertaken by the admission practitioner and a second-level reconciliation is undertaken by a pharmacist or pharmacy technician. NICE guidance recommends that medicines reconciliation be completed within 24 hours of admission. Although the majority of patients do receive medicines reconciliation during their stay in Papworth only around 25% of the time does this take place within the first 24 hours of admission (this is monitored and mitigated through the risk process and is on the risk register (1841-score 9).

**Patient Medicines Education:** This metric considers the provision of structured advice on the use of medicines to patients by pharmacy staff. The number of sessions fell significantly during this summer due to workforce constraints and is now recovering. This type of service is not routinely provide in some other Trusts and it is thought to have contributed to the good response to the "information about medicines on discharge" question in the inpatient survey.

**Example of Trust wide Digital Medicine Safety and Quality dashboard –December 2022**



# Caring: Performance summary

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

| | | Data Quality | Target | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|
| Dashboard KPIs | FFT score- Inpatients | 4 | 95% | 99.2% | 99.0% | 100.0% | 98.7% | 99.4% | 98.3% |
| | FFT score - Outpatients | 4 | 95% | 97.5% | 96.9% | 98.2% | 99.0% | 96.7% | 96.7% |
| | 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 | 13.4 | 9.2 | 5.1 | 6.1 | 6.2 | 5.7 |
| | % of complaints responded to within agreed timescales | 4 | 100% | 100% | 70% | 100% | 67% | 100% | 100% |
| Additional KPIs | Number of complaints upheld / part upheld | 4 | 3pm (60% of complaints received) | 7 | 4 | 2 | 3 | 1 | 1 |
| | Number of complaints (12 month rolling average) | 4 | 5 and below | 4.8 | 4.9 | 4.9 | 4.5 | 4.7 | 5.0 |
| | Number of complaints | 4 | 5 | 3 | 3 | 4 | 5 | 3 | 3 |
| | Number of informal complaints received per month | New | Monitor only | 5 | 4 | 7 | 6 | 8 | 6 |
| | Number of recorded compliments | 4 | 500 | 1689 | 1605 | 1462 | 1638 | 1717 | 1251 |
| | Supportive and Palliative Care Team – number of referrals (quarterly) | 4 | Monitor only | - | - | 127 | - | - | 146 |
| | Supportive and Palliative Care Team – reason for referral (last days of life) (quarterly) | 4 | Monitor only | - | - | 3 | - | - | 3 |
| | Supportive and Palliative Care Team – number of contacts generated (quarterly) | 4 | Monitor only | - | - | 693 | - | - | 625 |
| | Bereavement Follow-Up Service: Number of follow-up letters sent out (quarterly) | 3 | Monitor only | - | - | 39 | - | - | 25 |
| | Bereavement Follow-Up Service: Number of follow-ups requested (quarterly) | 3 | Monitor only | - | - | 5 | - | - | 2 |

## Summary of Performance and Key Messages:

**CQC Model Health System rating for 'Caring'** is Outstanding dated June 2022 (accessed 15.11.2022).

**FFT (Friends and Family Test):** In summary; **Inpatients**: The Positive Experience remains high (98.3%) and well above our 95% target. Participation Rate had slight decrease from 42.5% in November 2022 to 37.3% in December 2022. **Outpatients**: Positive Experience rate was 96.7% (December 2022) and above our 95% target. Participation rate had slight decrease from 13.3% in November 2022 to 12.5% in December 2022.

*For information: NHS England (latest published data accessed 11.11.2022) is September 2022: Positive Experience rate: 94% (inpatients); and 93% (outpatients). Participation rate 18.97% (inpatients); and 7.56% (outpatients).*

**Number of written complaints per 1000 staff WTE** is a benchmark figure based on the NHS Model Health System to enable national benchmarking. This metric was introduced to PIPR in the 2020/21 reporting year and has this month **remained green (5.7).**

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 14.07.2022): Royal Papworth = 5.72; peer group median = 21.98; national median = 16.65.

**% of complaints responded to within agreed timescales**. We have closed 3 formal complaints in December 2022, one was partially upheld and two were not upheld. Further information is available on the next slide. All complaints were responded to within the agreed timeframes, the response time for one complaint was extended due to additional scrutiny required but this was agreed with the complainant at the time.

**The number of complaints (12 month rolling average):** this has remained green at 5.0 for December 2022. We will continue to monitor this in line with the other benchmarking.

**Complaints:** We have received 3 new formal complaints during December 2022 and investigations are ongoing. This number is within our expected variation of complaints received.

**Informal Complaints:** There were 6 new informal complaints received and we were able to close 7 informal complaints during December 2022

**Compliments:** the number of formally logged compliments received during December 2022 was 1251.

# **Caring:** Key performance challenges - Complaints

**Informal Complaints closed in the month:** During December 2022, we were able to close **seven informal complaints** through local resolution. Of those closed;

***Cardiology* –** 1 informal complaint was closed (15637) through the Cardiology Matron speaking directly with the family to address their concerns and provide reassurance that learning will be taken from the patient experience and feedback.

***Thoracic and Ambulatory Care*** – 2 informal complaints were closed (15633, 15628), one was closed through the Ward Sister speaking directly to the complainant via telephone to discuss their concerns and ensure correct information was provided, and the other was closed following discussion with the Estates and Facilities Team and providing the complainant with an email from the Patient Experience Manager summarising the action taken.

***Surgical, Transplant and Anaesthetics* –** 4 informal complaints were closed (15604, 15139 and 15678), one was closed through discussion with the Matron on call, these concerns were escalated and addressed by the ward sister. One was closed through email correspondence with the complainant following detailed review and response from the Catering manager, Dietitian and Matron. The other was closed via email following feedback from Matron of Outpatients, an apology was given for the patient experience and the feedback was shared with the team. Radiology **–** 1 informal complaint was closed (15602) via email with complainant, apologising for their experience and confirming the results had been sent to the referring hospital.

**Learning and Actions Agreed from Formal Complaints Closed -** This is a summary of the three formal complaints closed in December 2022

**Complaint Datix Reference: 15466 Date Closed: 01/12/2022**. **Outcome: Not Upheld** – A surgical patient raised a formal complaint regarding the ongoing pain and discomfort they are experiencing 10 months after their procedure. Patient also has concerns about the procedure itself. The outcome of the complaint investigation revealed the patient was provided with a full explanation of the risks of surgery during their pre-operative assessment and was given an accurate diagnosis, unfortunately the pain and ongoing issues are related to the known complication of their procedure. A full explanations was given to the patient with apologies for their experience and a meeting offered if further clarity is required. Whilst the complaint was not upheld the patient's feedback was shared with the Surgery, Transplant and Anaesthetic Directorate for their learning and reflection.

**Complaint Datix Reference: 15418 Date Closed: 07/12/2022. Outcome: Not Upheld** – The family of a CCA patient have raised a formal complaint in relation to the patient's clinical care and treatment following their transfer from DGH. The outcome of the investigation revealed all procedures were undertaken in accordance with clinical guidelines but due to the patient's condition the team were unable to proceed with the proposed treatment plan. Whilst this was communicated to the family, apologies were given to family for their experience and for not receiving the level of communication they needed. The family's feedback and experience will be shared anonymously with the Critical Care and Cardiology team for their learning and reflection.

**Complaint Datix Reference: 15530 Date Closed: 08/12/2022. Outcome: Partially Upheld -** A cardiology patient raised a formal complaint regarding complications they experienced following their procedure and the aftercare they received. The outcome of the complaint investigation revealed that the patient was transferred to the ward not in accordance with Trust procedure, which may have pre-empted the complication. As a result of the complaint learning and actions were identified, including ensuring the need for all post ablation patients to be transferred lying flat and information about complications on discharge. Share the patient's experience with the Cardiology, Day Ward and Cath Lab TeamS for their learning and reflection.

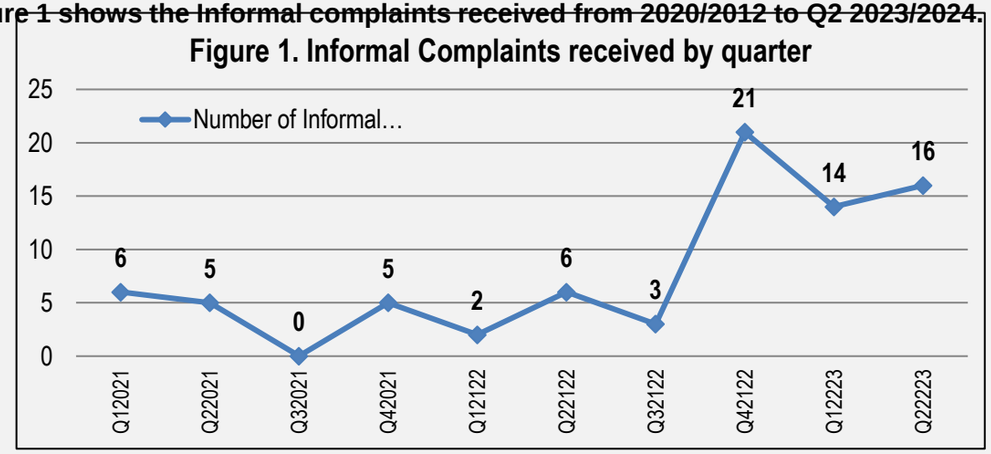
Learning and actions identified through all complaints are shared at Business Units, Clinical Division meetings and Trust wide through the Quality and Risk Management Group (QRMG reports).

# Caring: Spotlight On – Informal Complaints

**Informal Complaints** are defined as an issue that can be resolved quickly often within 15 working days. The Patient Advice and Liaison Service (PALS) team work closely with the divisions and services to manage the informal complaints process. The PALS team supports complainants if they wish to follow this route in achieving early local resolution, rather than following the formal complaints process. Complainants are given the option throughout this local resolution process (informal complaint) to pursue a formal complaints if they are not satisfied with the local resolution process. Local resolution of these informal concerns is usually verbal or written communication or through an arranged meeting.

In 2020/21 we received 16 informal complaints. Since Sept of 2022, we have focused on the recording of all patient concerns, raised through the PALS and Complaints process on to Datix. PALS enquires that were not recorded on in full in the past and where an investigation has taken place to resolve the local resolution are recorded to capture the outcome, learning, actions and themes. This ensures the recording of all concerns/complaints that are raised in one place, aiding a more robust oversight. This has meant we have seen an increase in informal in 2021/22 to 32. For 2022/23 so far we have received/recorded 30 informal complaints. This process will continue to be embedded in Q4 and from 23/24 we will be reporting on themes for both informal and formal complaints within our quality reporting to support our service improvement from our patient/carer feedback gained through the complaints process.

~~**Figure 1 shows the Informal complaints received from 2020/2012 to Q2 2023/2024.**~~

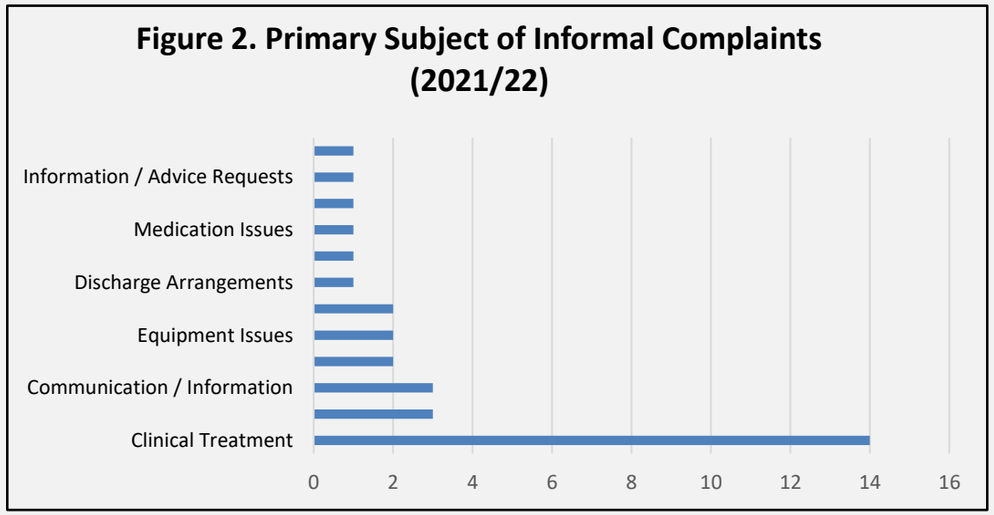




The PALS service continue to work closely with the clinical teams to ensure that both the service and complainant are informed of the outcome of concerns raised, and that these are addressed in a timely manner to provide the required resolution to the complainant.

**Figure 2 shows the primary subject of informal complaints received in 2021/22.**

Concerns related to 'Clinical Treatment', 'Delay in Diagnosis/Treatment or Referral' and 'Communication/Information' were the three highest primary subject categories for the Trust in 2021/22.




The main themes of informal complaints relate to the lack of information being provided, clarification of information and concerns regarding appointments. All learning and feedback from informal complaints is shared at Business Units, Divisional meetings and through monthly quality reports to QRMG.

# Effective: Performance summary

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

| | | Data Quality | Target | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|
| Dashboard KPIs | Bed Occupancy (excluding CCA and sleep lab) | 4 | 85% (Green 80%90%) | 70.0% | 70.9% | 71.7% | 75.5% | 70.3% | 74.2% |
| | CCA bed occupancy | 4 | 85% (Green 80%90%) | 78.2% | 87.4% | 85.2% | 88.5% | 91.4% | 85.8% |
| | Admitted Patient Care (elective and non-elective)** | 4 | 104% of 19/20 baseline | 1811 | 1913 | 1609 | 1911 | 1813 | 1722 |
| | Outpatient attendances** | 4 | 104% of 19/20 baseline | 8483 | 8110 | 7864 | 8093 | 9360 | 7350 |
| | Cardiac surgery mortality (Crude)* | 3 | <3% | 1.98% | 2.03% | 1.75% | 1.97% | 2.15% | 2.17% |
| | Theatre Utilisation | 3 | 85% | 80.4% | 79.6% | 82.2% | 75.6% | 82.2% | 82.6% |
| | Cath Lab Utilisation 1-6 at New Papworth (including 15 min Turn Around Times) | 3 | 85% | 77% | 80% | 81% | 79% | 87% | 76% |
| Additional KPIs | Length of stay – Cardiac Elective – CABG (days) | 4 | 8.20 | 8.23 | 7.43 | 8.77 | 9.03 | 10.72 | 7.43 |
| | Length of stay – Cardiac Elective – valves (days) | 4 | 9.70 | 9.02 | 9.93 | 10.43 | 9.71 | 9.72 | 8.61 |
| | CCA length of stay (LOS) (hours) - mean | 4 | Monitor only | 122 | 122 | 136 | 170 | 161 | 155 |
| | CCA LOS (hours) - median | 4 | Monitor only | 43 | 28 | 41 | 43 | 54 | 47 |
| | Length of Stay – combined (excl. Day cases) days | 4 | Monitor only | 5.63 | 5.51 | 6.45 | 6.39 | 6.27 | 6.99 |
| | % Day cases | 4 | Monitor only | 64.6% | 66.1% | 66.0% | 67.1% | 68.8% | 64.5% |
| | Same Day Admissions – Cardiac (eligible patients) | 4 | 50% | 36.1% | 31.7% | 37.9% | 42.9% | 46.8% | 43.8% |
| | Same Day Admissions - Thoracic (eligible patients) | 4 | 40% | 32.4% | 28.6% | 25.8% | 39.5% | 39.5% | 43.9% |

* Note - Provisional figure based on discharge data available at the time of reporting ** Excludes PP activity and are from SUS and represent all activity (see page 1for activity inc PP)

## Summary of Performance and Key Messages:

**Bed occupancy and capacity utilisation**
Critical care bed occupancy returned to target range with constraints in elective operating and high levels of demand for emergency surgery continuing.
Sickness absence was a factor with rates peaking at month end. The trust also declared itself in ECMO surge towards the end of the month with a number of other centres seeking support.

Ward occupancy improved despite the ongoing reduced elective programme which reflects greater acuity and demand in cardiac and respiratory pathways.

Admitted patient care was impacted by the seasonal bank holidays and RCN industrial action which took place on 15 and 20 December. Despite this overall theatre utilisation was consistent with the previous month. Productivity improvements have been identified as part of the transformation plan and are being implemented, such as the three pump list trial.

**Outpatient capacity**
Outpatient attendances were behind plan. This reflects seasonal reduction and industrial action, which had a particular impact on outpatient services which were not derogated. Additional impact is expected in future months with further RCN action called in February and other professional groups balloting staff.

**Length of stay**
Improvements in performance on cardiac elective (valves and CABG) length of stay follows ongoing work to improve patient experience with particular focus on pre-operative assessment, same day admission, effective discharge planning and collaborative working to optimise patients with our allied health professional teams.

# Effective: Key performance challenges

## Background and purpose

**The information in this report has been pulled together to give the executive team oversight of referral and activity numbers against the following two benchmarks;**

1. **2019/20 activity**
2. **The Trust's planned targets and the NHSE&I 104% target.** The table below shows the projected delivery rates by POD as a % of 2019/20 activity (with a working day adjustment applied).

| Targets by POD: % of 2019/20 activity | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Outpatient First | 100% | 103% | 106% | 110% | 110% | 110% | 110% | 110% | 110% | 110% | 110% | 110% |
| Outpatient Follow up | 100% | 103% | 106% | 110% | 110% | 110% | 110% | 110% | 110% | 110% | 110% | 110% |
| MRI | 100% | 103% | 106% | 110% | 110% | 110% | 110% | 110% | 110% | 110% | 110% | 110% |
| CT | 100% | 103% | 106% | 110% | 110% | 110% | 110% | 110% | 110% | 110% | 110% | 110% |
| Non-Obstetric US | 100% | 103% | 106% | 110% | 110% | 110% | 110% | 110% | 110% | 110% | 110% | 110% |
| Elective Inpatients | 80% | 83% | 85% | 90% | 95% | 100% | 100% | 102% | 104% | 104% | 104% | 104% |
| Elective Daycases | 90% | 93% | 100% | 100% | 102% | 104% | 104% | 104% | 104% | 104% | 104% | 104% |

### Dashboard headlines

**The tables to the right show how the numbers for M9 compare to working day adjusted 2019/20 numbers at a Trust level and at specialty level..**

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

***M9 activity performance in line with target***

- **Non-Admitted Activity – First activity exceeded the M9 target.**
- **Radiology – CTs met the agreed target.**

***M9 activity performance behind target***

- **Non-Admitted Activity – Follow-up activity fell slightly short of the agreed M9 target.**
- **Radiology – MRIs and Ultrasounds did not meet the M9 target.**
- **Admitted activity – Elective inpatients and daycases did not meet the agreed M9 target.**

## Summary Performance

### Table 1: Trust Level

| Category | | M9 vs 2019/20 M9 |
|---|---|---|
| Non-Admitted Activity | First | 118% |
| | Follow up | 101% |
| Radiology Activity | MRI | 87% |
| | CT | 113% |
| | US | 90% |
| Elective Admitted Activity | Inpatients | 73% |
| | Daycases | 78% |

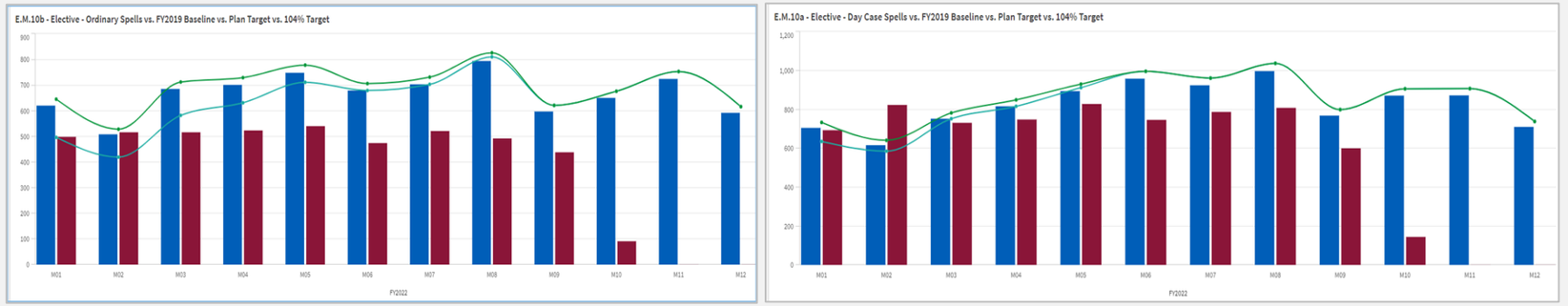
### Table 2: M9 activity compared to 2019/20 (Specialty Level)

| Category | | Cardiac Surgery | Cardiology | PTE | RSSC | Thoracic Medicine | Thoracic Surgery (exc PTE) | Transplant /VAD |
|---|---|---|---|---|---|---|---|---|
| Non-Admitted Activity | First | 96% | 83% | - | 198% | 115% | 175% | 89% |
| | Follow up | 72% | 120% | - | 70% | 110% | 87% | 90% |
| Elective Admitted Activity | Inpatients | 54% | 106% | 25% | 72% | 68% | 85% | 111% |
| | Daycases | 25% | 74% | - | 97% | 69% | 10% | - |

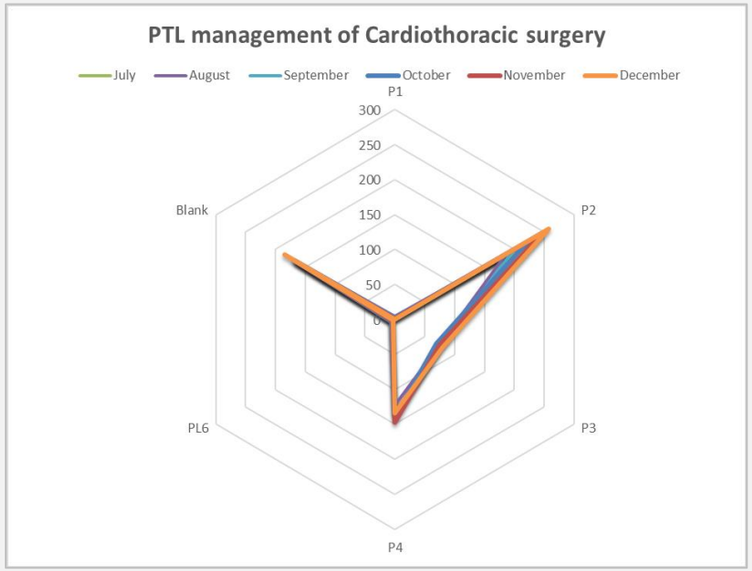
Above Planned Target
Within 5% of Planned Target
Greater than 5% below Planned Target

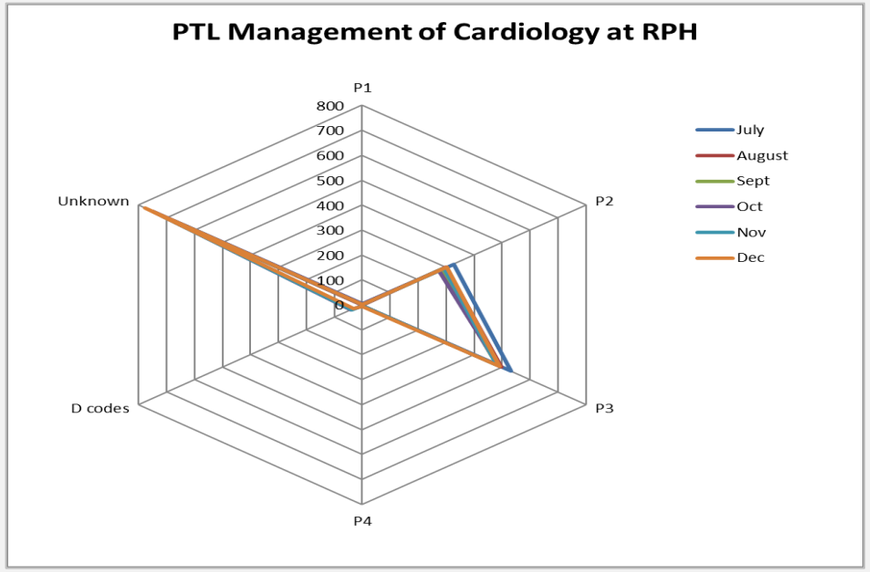
### Non-Admitted Activity

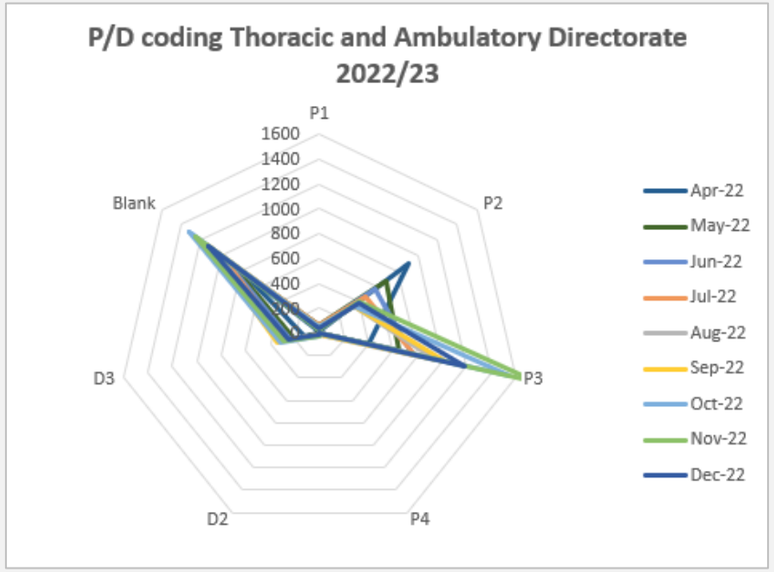

### Admitted Activity



# **Effective:** Spotlight on: Priority Status Management




**Cardiothoracic Surgery Waiting List Profile**

↑ 660 patients on the waiting list (from 638)
↑ 227 patients over 18 weeks (from 193)
↑ 10 patients over 52 weeks (from 5)
↓ RTT performance 64.92% (from 68.95 %)

**Over 18 weeks**
42 - patients with Planned or booked dates
30 – patients with planned outpatient/ MDT/ Diagnostics appointment
102 – patients awaiting surgery date (59xP2, 25xP3, 18xP4)
50 – patients awaiting Administrative update
1 – need further outpatient appointment.

**Cardiology Waiting List Profile**

↑ 1607 patients on the waiting list (from 1590)
↑ 329 patients waiting over 18 weeks (from 324)
↑ 1 over 52 weeks (-)
↑ 81.23% RTT performance (from 79.65%)

**Over 18 weeks**
70 patients with booked dates to come in for admission
58 patients with booked date for outpatient review or diagnostics
130 patients awaiting dates to come in for admission
9 patients awaiting dates for outpatient review
5 patients awaiting discussion in MDT
92 patients with data quality issues (now resolved)

**Respiratory Waiting List Profile**

↓ 3636 patients on the waiting list (from 3757)
↑ 976 patients waiting over 18 weeks (from 877)
↑ 2 over 52 weeks (from 1)
↓ 67.13% RTT performance (from 71.09%)

**Over 30 weeks:**
38 awaiting continuous positive airway pressure start
62 awaiting polysomnography tests
94 awaiting outpatient appointments
2 awaiting respiratory polygraph tests
62 awaiting a clinical decision
19 awaiting day case appointments

# **Responsive:** Performance summary

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

| | | Data Quality | Target | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|
| Dashboard KPIs | % diagnostics waiting less than 6 weeks | 3 | >99% | 97.21% | 96.90% | 98.31% | 98.79% | 99.22% | 99.28% |
| | 18 weeks RTT (combined) | 5 | 92% | 77.81% | 75.77% | 74.30% | 74.10% | 74.10% | 70.60% |
| | Number of patients on waiting list | 5 | 3,279 | 4799 | 4816 | 5300 | 5691 | 5876 | 5657 |
| | 52 week RTT breaches | 5 | 0 | 3 | 2 | 5 | 2 | 8 | 13 |
| | 62 days cancer waits post re-allocation (new 38 day IPT rules from Jul18)* | 4 | 85% | 20.0% | 53.1% | 35.3% | 40.0% | 57.0% | 50.0% |
| | 31 days cancer waits* | 4 | 96% | 88.9% | 90.9% | 82.6% | 78.0% | 90.0% | 89.0% |
| | 104 days cancer wait breaches* | 4 | 0 | 13 | 21 | 20 | 14 | 9 | 10 |
| | Theatre cancellations in month | 3 | 30 | 29 | 20 | 27 | 34 | 21 | 37 |
| | % of IHU surgery performed < 7 days of medically fit for surgery | 4 | 95% | 65.00% | 66.00% | 35.00% | 53.00% | 36.00% | 60.00% |
| | 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% | 82.17% | 84.13% | 81.53% | 80.09% | 81.68% | 81.16% |
| | 18 weeks RTT (Cardiac surgery) | 5 | 92% | 71.94% | 69.81% | 69.51% | 71.69% | 70.53% | 64.98% |
| | 18 weeks RTT (Respiratory) | 5 | 92% | 76.65% | 72.64% | 71.84% | 72.05% | 71.50% | 67.04% |
| | Non RTT open pathway total | 2 | Monitor only | 39,855 | 40,244 | 40,473 | 40,854 | 41,421 | 41,803 |
| | 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% | 80.00% | 94.12% | 71.43% | 80.00% | 84.21% | 81.82% |
| | Outpatient DNA rate | 4 | 9% | 6.70% | 6.70% | 8.17% | 6.23% | 6.32% | 8.01% |
| | Urgent operations cancelled for a second time | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | % of IHU surgery performed < 10 days of medically fit for surgery | 4 | 95% | 82.00% | 86.00% | 47.00% | 63.00% | 44.00% | 80.00% |
| | % of patients treated within the time frame of priority status | 4 | Monitor only | 41.8% | 42.0% | 40.5% | 41.5% | 45.7% | 51.0% |
| | % of patients on an open elective access plan that have gone by the suggested time frame of their priority status | 4 | Monitor only | 51.4% | 51.4% | 48.5% | 49.1% | 51.4% | 45.9% |

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

## Summary of Performance and Key Messages:

**Diagnostic Performance**
Diagnostic performance continues to be above target with 99.28% of patients waiting less than 6 weeks for their appointment.

**Waiting list management**
The number of patients on open pathways has reduced in month but the total number on the waiting list continues to be greater than target. RTT performance has deteriorated in month, particularly in Cardiac Surgery and Respiratory. This is due to ongoing capacity issues and imbalance in the waiting list. We have seen the number of patients waiting over 18 weeks increase at a greater rate than treatments for that cohort of patients. Industrial action and targeted action to reduce the IHU backlog are contributing factors to this position

The number of 52 week breaches has increased with 1 in Cardiology, 11 in Surgery and 2 in Respiratory. This has been caused by a combination of capacity restraints and patient cancellations. Route cause analysis has been undertaken for all patients and dates for treatment have been confirmed for all case.

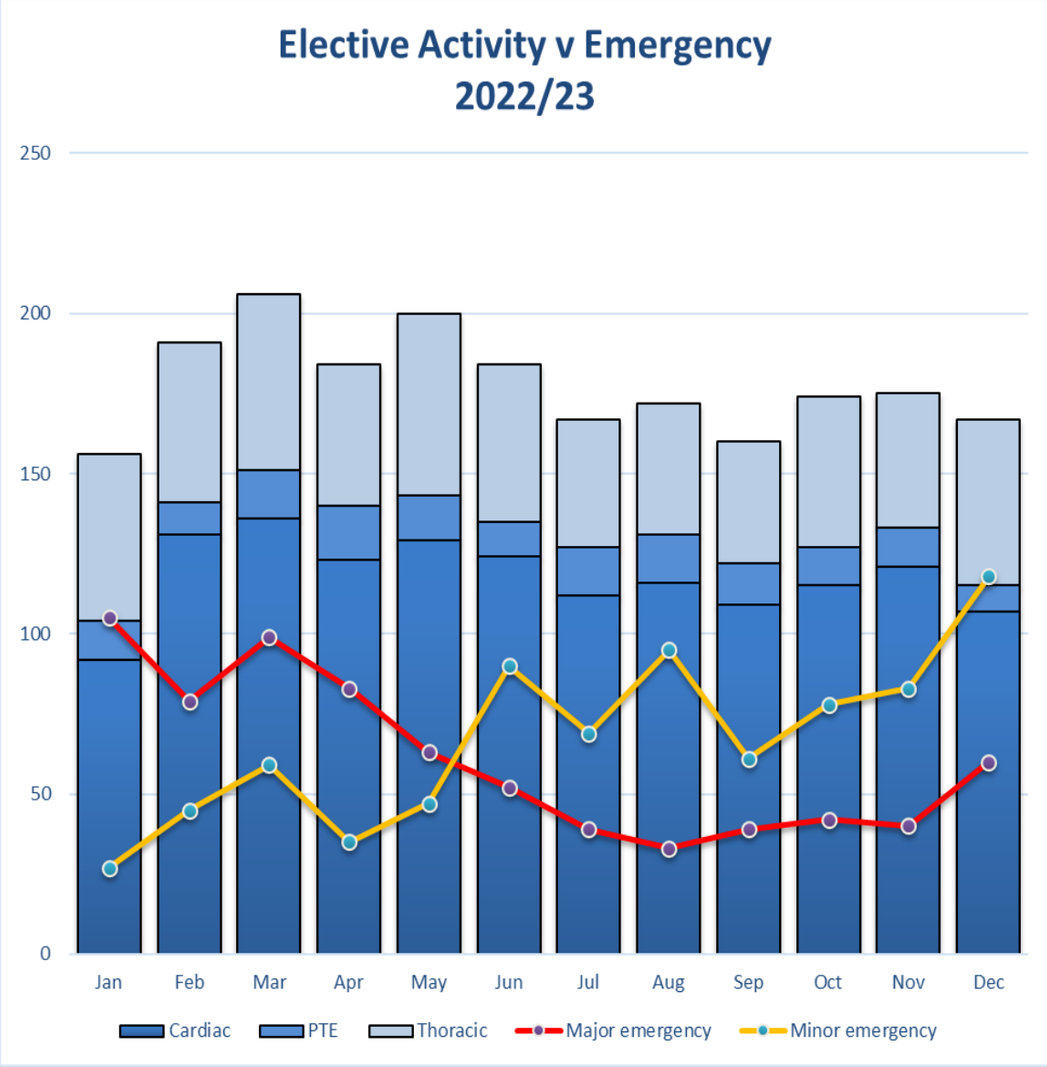
Theatre cancellations increased in month. This reflects complex case mix with a high number of emergency cases in month and high sickness, particularly in the critical care team.

**Cancer Performance**
62 day – There have been 14 patients treated on the 62-day pathway of which 8 breached. 3 were due to late referrals. 1 patient required additional CT scan and first surgical date was cancelled. 1 patient required DGH opinion and delays to receiving clinic appointments, 1 was patient choice wanting to be seen at local centre, 1 patients diagnostics delayed due to COVID, 1 patient had surgery cancelled. Current compliance is 50%

31 days – 27 first treatments with 3 breaches. All were first treatments. The expected compliance is currently 89%.

**IHU & ACS Performance**
Targeted action taken in November to reduce the IHU backlog was successful with an overall reduction in patient waiting for surgical dates. The percentage for patients having surgery withing 10 days of being medically fit has increased accordingly.

# **Responsive:** Key performance challenges



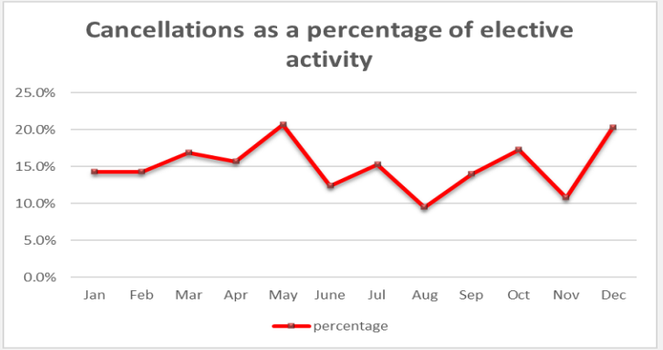

**107 Cardiac (33 IHU) 52 Thoracic / 8 PTE / 8 TX activity**

60 emergency/urgent procedures went through theatres – combination of transplants, returns to theatre and emergency explorations.

118 additional emergency minor procedures also went through theatre and critical care, utilising the theatre team.

| Cancellation reason | Dec-22 | Total |
|---|---|---|
| 1b Patient refused surgery | 1 | 11 |
| 1c Patient unfit | 2 | 98 |
| 3a Critical Care | 9 | 156 |
| 3b Theatre Staff | 4 | 22 |
| 3c Consultant Surgeon | 2 | 17 |
| 4a Emergency took time | 7 | 79 |
| 4b Transplant took time | 3 | 34 |
| 4d Additional urgent case added and took slot | 4 | 61 |
| 5a Planned case overran | 4 | 94 |
| 5b Additional urgent case added and took slot | 1 | 3 |
| **Total** | 37 | 575 |

Planned activity reduced overall, which is a trend for December and reflects the industrial activity impact. There was a focus on IHU cases in the month, with a means to get flow going. Emergency activity spiked, with 60 major cases going through Theatres, and 118 minor/minimal interventions. Cancellations also rose, with CCA staffing the main reason, though emergency activity also replaced 7 planned cases in the month.



# **Responsive:** Spotlight on – 31 day Cancer Performance

## Performance

Over the previous 3 months Cancer performance was as follows:

| | 62 day | | | 31 day | | | 104 day |
|---|---|---|---|---|---|---|---|
| | Patients Treated | Shared pathways | Performance (%) | First treatments | Breaches | Performance (%) | |
| October | 6 | 1 | 33.33 | 18 | 4 | 78.0 | 14 |
| November | 7 | 3 | 57.0 | 16 | 2 | 87.5 | 9 |
| December | 18 | 8 | 50 | 27 | 3 | 89.0 | 10 |

## Current issues delaying patient pathways

### Late referrals from referring trusts

Of the 61 breaches (YTD) 56 patients were on a 62 day pathway. The average referral date from DGH was on day 42. The range of referral being received by RPH is Day 1-128. DGHs are asked to refer by Day 14-21 at latest.

### Diagnostic capacity

Due to increasing complexity of patients, it is often only possible to schedule 3 CT biopsies per list when previously there were 4 slots.

### Availability of clinics

Of the 61 breaches (YTD) the average wait for clinic appointments is 10.45 days. The range of clinic wait is 2-26 days Analysis of the data shows that the largest delay is for surgical appointments.

### Theatre capacity and cancellations

Due to scrub nurse staffing skill mix issues, there has been reduced capacity for surgical procedures under all specialities, including thoracic oncology. This has resulted in the loss of 2 sessions per week since August.

There have been fifteen 31 day breaches since April 2022. 6 due to cancellation of surgery on the day, 3 were due to patient choice, 3 were for clinical reasons, 3 were scheduled outside of the 31 day timeframe.

## Actions

- All patients who breach the pathways have a Datix completed and Route Cause Analysis to establish whether the delays have caused harm to the patient. These are done in collaboration with the referring trusts and are submitted to the Executives for review.
- Late referrals from DGHs on risk register. Dialogue with referring partners to identify and resolve issues.
- Operations teams from Thoracics and Surgery collaborating closely to identify, resolve or mitigate bottlenecks within RPH.
- Surgical operations team attend weekly oncology PTL.
- Increased clinics in October and November; December affected by industrial action and seasonal bank holidays. Work underway within Surgery to review demand and capacity, in terms of clinic availability.
- Theatre capacity model increases to 4.5 theatres from January. As the number of trained staff increases; plan to increase to 5 theatre model from June. Plan to increase thoracic activity relative to overall theatre capacity.
- During January cardiac capacity will be flexed to give thoracic surgery additional capacity during the week in addition to some extended and weekend lists.
- A detailed action plan has been developed to monitor actions and delivery. This will be reviewed at Trust Access on a weekly basis.

# People, Management & Culture: Performance summary

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

| | | Data Quality | Target | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|
| Dashboard KPIs | Voluntary Turnover % | 3 | 14.0% | 22.60% | 15.28% | 28.16% | 19.70% | 11.35% | 10.45% |
| | Vacancy rate as % of budget | 4 | 5.00% | 13.81% | 14.08% | 14.10% | 14.29% | 14.08% | 14.33% |
| | % of staff with a current IPR | 3 | 90% | 75.88% | 75.28% | 74.31% | 73.06% | 73.12% | 74.38% |
| | % Medical Appraisals | 3 | 90% | 72.57% | 68.47% | 68.47% | 75.22% | 72.81% | 78.07% |
| | Mandatory training % | 3 | 90.00% | 86.21% | 86.92% | 86.60% | 86.35% | 85.37% | 84.92% |
| | % sickness absence | 3 | 3.5% | 5.34% | 4.48% | 4.34% | 5.35% | 4.86% | 5.43% |
| Additional KPIs | FFT – recommend as place to work | 3 | 70.0% | n/a | n/a | n/a | n/a | n/a | n/a |
| | FFT – recommend as place for treatment | 3 | 90% | n/a | n/a | n/a | n/a | n/a | n/a |
| | Registered nursing vacancy rate (including pre-registered nurses) | 3 | 5.00% | 11.11% | 11.76% | 12.91% | 13.62% | 13.79% | 13.38% |
| | Unregistered nursing vacancies excluding pre-registered nurses (% total establishment) | 3 | 10.00% | 26.82% | 26.28% | 22.90% | 21.06% | 18.84% | 19.77% |
| | Long term sickness absence % | 3 | 0.80% | 1.86% | 1.81% | 1.81% | 1.77% | 2.07% | 1.91% |
| | Short term sickness absence | 3 | 2.70% | 3.48% | 2.67% | 2.53% | 3.58% | 2.78% | 3.52% |
| | Agency Usage (wte) Monitor only | 3 | Monitor only | 28.6 | 28.9 | 31.6 | 28.9 | 28.6 | 24.0 |
| | Bank Usage (wte) monitor only | 3 | Monitor only | 62.2 | 67.1 | 57.5 | 57.4 | 59.4 | 62.1 |
| | Overtime usage (wte) monitor only | 3 | Monitor only | 41.9 | 44.3 | 38.6 | 48.6 | 47.8 | 41.0 |
| | Agency spend as % of salary bill | 5 | 1.41% | 1.66% | 2.34% | 1.66% | 1.57% | 1.98% | 1.77% |
| | Bank spend as % of salary bill | 5 | 1.95% | 1.99% | 1.90% | 2.06% | 2.32% | 1.88% | 2.10% |
| | % of rosters published 6 weeks in advance | 3 | Monitor only | 26.50% | 24.20% | 24.20% | 51.50% | 23.50% | 41.20% |
| | Compliance with headroom for rosters | 3 | Monitor only | 31.10% | 31.70% | 35.30% | 31.80% | 30.70% | 34.50% |
| | Band 5 % White background: % BAME background | 3 | Monitor only | n/a | n/a | 55.83% : 42.99% | n/a | n/a | 53.62% : 45.06% |
| | Band 6 % White background: % BAME background | 3 | Monitor only | n/a | n/a | 71.40% : 27.71% | n/a | n/a | 70.72% : 28.57% |
| | Band 7 % White background % BAME background | 3 | Monitor only | n/a | n/a | 84.01% : 14.11% | n/a | n/a | 82.13% : 15.36% |
| | Band 8a % White background % BAME background | 3 | Monitor only | n/a | n/a | 86.14% : 11.88% | n/a | n/a | 84.91% : 13.21% |
| | Band 8b % White background % BAME background | 3 | Monitor only | n/a | n/a | 93.75% : 3.13% | n/a | n/a | 92.31% : 3.85% |
| | Band 8c % White background % BAME background | 3 | Monitor only | n/a | n/a | 92.86% : 7.14% | n/a | n/a | 100% : 0% |
| | Band 8d % White background % BAME background | 3 | Monitor only | n/a | n/a | 100% : 0.00% | n/a | n/a | 100% : 0% |

## Summary of Performance and Key Messages:

- Turnover dropped back to 10.45% in December. The year to date rate of turnover is 16.8% which is over our KPI of 14%. There were 19 leavers (17 WTE) in month. The most common reasons recorded for leaving was work life balance. 6 staff gave this as the reason for leaving; they all worked in clinical areas requiring 24 hr/7 day rotas. The other theme was Band 6, 7 and 8 staff who leave for promotion or lack of opportunities. Flexible working and career development are areas where we have the opportunity to improve our practices and the offer to staff.
- Total Trust vacancy rate and registered nurse vacancy rate both remained broadly static at 14.3% and 13.4% respectively. Level 5, Surgical Wards, having the highest % vacancy rates and are also high in Day Ward. The Unregistered Nurse vacancy rate increased to 19.8% and remains significantly above the KPI. At the end of December there were 39 Registered Nurses in the pipeline and 46 Unregistered Nurses.
- Total sickness absence increased to 5.43%. The rates of absence are following a similar pattern to 2021 but are at a slightly higher level. During December we saw an increase in the prevalence of Covid in the community and an increase in cold/flu.
- We continue to struggle to improve IPR rates with areas still experiencing constraints on releasing staff for appraisals in sufficient numbers to recover the backlog of overdue appraisals. The Appraisal Procedure has being revised to incorporate the Trusts values and behaviours and to streamline the process and paperwork. At the start of December we launched the revised policy with a communication campaign and training for appraisers. The Spotlight provides information on the compliance recovery plans for the Divisions.
- Temporary staffing usage and spend remained at a similar level to the previous month as departments sought to mitigate the impact of increasing vacancy and sickness absence rates. Agency availability was lower in December which is normal for this month.
- Compliance with the roster approval improved to 41.2%. The bimonthly roster review meetings continue and we are now on the second cycle of these, tracking completion of actions and further areas for improvement. There is also a monthly rostering review meeting led by the Heads of Nursing to support areas with rostering practice and compliance with KPIs. The factors affecting areas finalising rosters at least 6 weeks in advance are high vacancy levels and the capacity of senior nursing staff to complete roster sign off in line within the required timetable.

# People, Management & Culture : Key performance challenges

**Escalated performance challenges:**

- Staff health and wellbeing continuing to be impacted by the after effect of pandemic and high levels of vacancies 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 competitive and the gap between private and public sector pay increases.
- Staff engagement and wellbeing negatively impacted by the high vacancy rates, increased cost of living, high levels of dissatisfaction with the 22/23 pay award and impending industrial action.
- 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 line manager capacity and difficulties releasing staff from clinical duties.
- 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.
- Industrial action by a number of Trade Unions on the national pay award impacting on the provision of services and negatively impacting staff engagement
- Staff experiencing 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 in 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 appraisals and mandatory training.
- 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.
- Inconsistent talent management practices and poorly articulated and communicated career pathway leading to staff leaving the Trust in order to develop their careers.

**Key Actions:**

**Recruitment Update**

Pipeline as at end of December :
39 Band 5 Nurses remain in the pipeline – 21 of these are overseas nurses
46 Healthcare support workers remain in the pipeline
130 other candidates remain in the pipeline (includes 34 internal candidates and 12 for temporary staffing

We are hosting an STA recruitment event on Saturday 21st January in the hospital for RNs, ODPs and HCSWs. There will be a programme of events in 2023/24 including participation at events in universities and other external recruitment events.

We continue to have a 100% pass rate (by second attempt) for overseas nurses in completing their OSCE exams..

Overseas Campaigns:
Critical Care – 20 have arrived to date.
Theatres - Recruited 6, 1 arrived to date and a further 2 in January
Thoracic - Recruiting for 6 respiratory nurses, interviews ongoing, 3 appointed to date
Surgery - Recruiting for 10 surgical nurses, interviews ongoing, 4 appointed to date
Cath lab - Recruited 5, anticipated arrivals from January
Cardiology - Recruiting for 5 nurses, interviews ongoing, 3 appointed to date

Recruitment and selection training dates for 2023 have been released. Two new training offerings for staff are being publicised. Completing an application form – a new training for 2023 aimed at staff wanting support completing application forms. This is for staff who require support completing application forms and want to know how best to do it. Having a successful interview – another new training for 2023. A training for staff on what it takes to have a successful interview and how best to prepare.

We are progressing the procurement of a new electronic recruitment system. Time to hire was 57 days in December, above our KPI of 48 days

**Hardship Fund**

We have had a hardship fund in place since 2020 supported by the RPH Charity. This fund gives grants of up to £500 to staff experiencing unexpected financial difficulties. In December, in recognition of the financial pressures experienced by some staff, we extended the scheme to provide staff with a £30 voucher for Tesco and a £30 fuel voucher. We will review the uptake in Jan in order to understand the demand for this, the cost and how long it is feasible to maintain it.

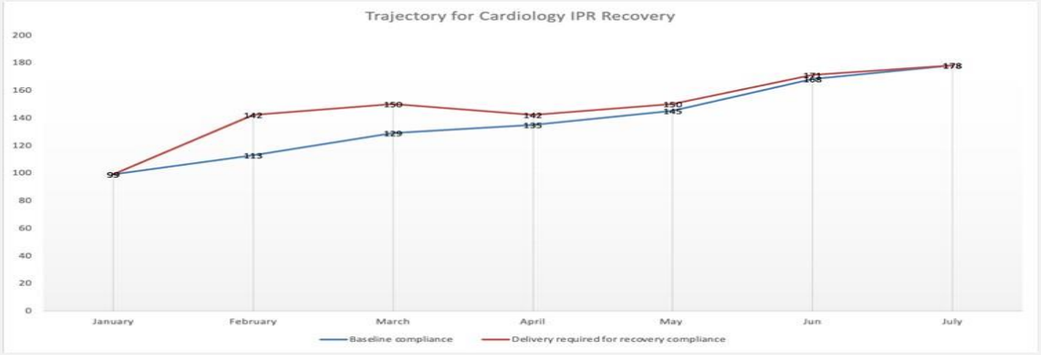
# People, Management & Culture : Spotlight on – Appraisal compliance recovery plans.

During 2020 and 2021 we had periods when we suspended appraisals in response to the Covid-19 surges. Since then we have struggled to regain compliance with the KPI of 90% of staff having an annual appraisal. There is a solid evidence base that good quality appraisals are important for staff engagement and morale and career progression/talent management.

As part of the work through the Compassionate and Leadership Programme to embed the Trust's values and behaviours framework, reflect best practice set out in the Fair Recruitment – No More Tick Boxes and to comply with changes to terms and conditions relating to pay progression we revised our Appraisal Policy.(previously called the Individual Performance Review Policy) The revised policy, documentation and training was launched in December 2023. In March 2023 we will also be offering skills training for line managers on how to undertake high quality appraisals, set objectives and support staff career progression/development.

The clinical Divisions were asked to develop recovery trajectories and improvement plans to achieve compliance with the KPI of at least 90% of staff having an annual appraisal.

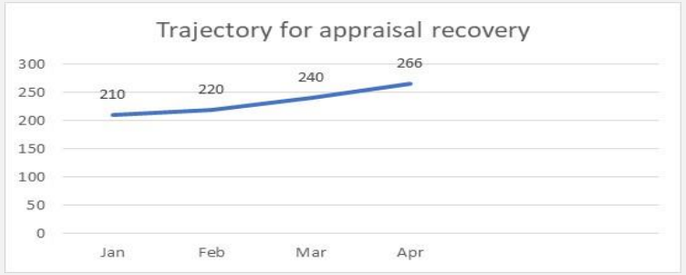
Cardiology Division




The department recognises the importance of appraisals and the need to improve appraisal compliance performance. Their approach is a targeted approach to supporting those departments with the greatest challenge. All departments have been given trajectories for recovery based on the number of staff they still have to appraise, the numbers of staff who are most overdue for review, and the numbers of staff who are available on shift to carry out IPR's. The longest trajectory has been issued to the Cardiology wards collectively who have 56 appraisals to deliver before the end of June inclusive of those that are already overdue. This equates to 2 appraisals per week.

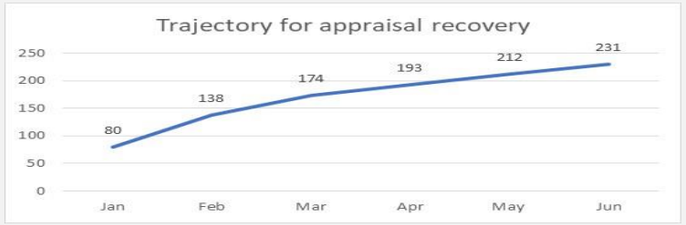
The greatest risk revolves around the wards and the ongoing requirement for office days to be stood down at short notice. However, the trajectory allocates a front loading of appraisals to be booked and creates a tolerance within itself for slippage which will then be monitored through fortnightly performance reporting. All departments have been provided with the new appraisal paperwork and links to the advice and guidance given. The importance of appraisals will be promoted through staff briefings and newsletters.

Thoracic Division




They have developed a targeted approach to supporting those departments with the greatest challenge. Those departments RAG rated as red have been given trajectories for recovery based on the number of staff non-compliant. These departments will be monitored on their performance against this trajectory on a fortnightly basis. Those departments categorised as amber have been provided with a list of their staff and asked to ensure that all remaining staff have been appraised by end of March 2023. These departments will be monitored monthly to ensure they are achieving the trajectory. The importance of appraisals will be promoted through staff briefings and newsletters and offer support for anyone unsure of how to proceed. The risks associated with achieving the planned trajectory are staffing levels where time out of clinical duties to complete the IPR is unable to be supported. To mitigate this we ask that each area identifies strategies to reduce this risk for example, a planned approach where additional staff are available on specific days to cover clinical duties and allow staff and managers time to complete appraisal.

STA Division




Those departments categorised as red have been given trajectories for recovery based on the number of staff they still have to achieve. The longest trajectory has been given to critical care who have the largest number of staff to appraise to recover. They have been given a 6 month trajectory which equates to 5 appraisals per week. These departments will be monitored on their performance against this trajectory on a fortnightly basis. Those departments categorised as amber have been provided with a list of their staff and asked to ensure that all remaining staff have been appraised by end of February 2023. These departments will be monitored on a monthly basis to ensure achieving the trajectory. All red and amber departments have been provided with the new appraisal paperwork and links to the advice and guidance given. We will also promote the importance of appraisals through staff briefings and newsletters and offer support for anyone unsure of how to proceed.

# Finance: Performance summary

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

| | | Data Quality | Target | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|
| Dashboard KPIs | Year to date surplus/(deficit) exc land sale £000s | 5 | £(311)k | £1,404k | £1,415k | £2,551k | £2,821k | £2,876k | £3,296k |
| | Cash Position at month end £000s | 5 | £61,386k | £63,594k | £63,232k | £64,395k | £67,645k | £67,720k | £66,873k |
| | Capital Expenditure YTD £000s | 5 | £1825 YTD | £920k | £933k | £967k | £1,083k | £1,220k | £1,431k |
| | In month Clinical Income £000s* | 5 | £21914k (current month) | £22,126k | £22,145k | £22,700k | £21,808k | £21,814k | £21,626k |
| | CIP – actual achievement YTD - £000s | 4 | £4,350k | £2,010k | £2,470k | £3,090k | £3,710k | £4,760k | £5,650k |
| | CIP – Target identified YTD £000s | 4 | £5800k | £5,810k | £5,440k | £5,800k | £5,800k | £5,800k | £5,800k |
| Additional KPIs | NHS Debtors > 90 days overdue | 5 | 15% | 91.1% | 88.8% | 92.8% | 55.9% | 4.4% | 3.9% |
| | Non NHS Debtors > 90 days overdue | 5 | 15% | 27.0% | 23.2% | 21.8% | 23.9% | 35.5% | 34.6% |
| | 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 | £7,225k | £8,660k | £11,189k | £12,838k | £14,242k | £15,941k |
| | Use of Resources rating | 5 | Monitor only | n/a | n/a | n/a | n/a | n/a | n/a |
| | Total debt £000s | 5 | Monitor only | £3,572k | £4,253k | £3,740k | £4,768k | £7,091k | £7,395k |
| | Better payment practice code compliance - NHS (YTD) | 5 | Monitor only | 87% | 83% | 86% | 87% | 89% | 89% |
| | Better payment practice code compliance - Non NHS (YTD) | 5 | Monitor only | 93% | 94% | 94% | 94% | 94% | 94% |

**Summary of Performance and Key Messages:**

- **The Trust's annual plan was agreed as part of the ICS planning submission in June 2022 and set a breakeven plan for 2022/23. Year to date (YTD), the position is favourable to plan by c£3.6m with a reported surplus of c£3.6m against a planned surplus of £0.1m. The key factors contributing to this position are:**
  - **Activity:** elective activity continues to track below 2019/20 levels on average, and is below the national target. Day case activity has shown a stronger recovery than inpatient activity. Surgical capacity remains a constraining factor for elective inpatient activity.
  - **ERF:** the approach to ERF has been agreed for the first half of 2022/23 and is expected to continue for the second half of 2022/23. This has resulted in the Trust securing its original ERF plan for NHSE and Cambridgeshire & Peterborough ICB (C&P), amounting to c£3.8m YTD. Contracts with other commissioners do not allow ERF to be earned, however this adverse variance is being offset by changes in the NHSE and C&P ERF values, including updates to reflect national uplifts for the pay award and inflation. Nationally, ERF monies are being awarded despite activity falling short of the national targets.
  - **System support:** the income position includes a provision of c£1.2m YTD for expected future funding changes to support the achievement of a breakeven position by organisation across the ICS. There is a risk that this increases as risks crystallise in partner positions. Discussion continues at ICS level to understand the real picture of risk and any funding flow adjustments required.
  - **Pay spend:** there was an overspend against plan in month due to backdated payment to overseas nurses (£0.2m) and other backdated pay adjustments (£0.1m). The YTD underspend against budget is £1.0m as the Trust continues to carry a number of vacancies. Included in the YTD position is the top-up to the band 2 to band 3 provision for back pay of 6 years (c£1.5m); thank you payments to staff employed by the Trust (£0.4m) and the costs of the Compassionate and Collective Leadership programme (c£0.2m). Excluding non-recurrent items, the underlying pay run rate remains broadly stable.
  - **Non-pay spend** on an underlying basis remains in line with the YTD average. The in month reported position includes aged provision releases / adjustments offset by catch up adjustment on Cardiology stock (£0.3m) and other stock adjustments in Theatres (£0.1m). The YTD position remains adverse to plan, driven by a number of one-off items including the recognition of provisions/accruals for the expected research and development grant to University of Cambridge (£2.5m); the staff support scheme (c£1.0m); VAD stock obsoletion write offs (£0.4m); dilapidations (£0.2m); HLRI Expenditure (£0.4m) offset by same value of income recharged to University of Cambridge and other adjustments.
- **The cash position closed at c£66.9m.** This represents a decrease of £0.8m from the previous month due to increase in supplier payments
- **The Trust has a business as usual (BAU) capital allocation of £2.7m** as part of the overall ICS budget. In addition, the Trust has been allocated £0.2m PDC for the purchase of IT equipment. The BAU actual capital expenditure YTD of c£1.4m was £0.3m below plan. The majority of expenditure YTD is related to the implementation of PACS, new laptops and servers and capital projects delayed from 2021/22.

# Finance: Key Performance – Year to date SOCI position

**The YTD position is c£3.6m favourable to plan, driven by the net effect of: surplus income funding for the pay award YTD (c£1.2m), the continued underlying underspend on pay due to vacancies and the continued underlying underspends on variable activity costs (mitigated by income blocks). These items are partly offset by the recognition of a provision for the band 2 to band 3 risk (£1.5m), a provision for the staff benefit scheme (£1.0m) and a provision for an expected grant payment to the University of Cambridge (£2.5m), other staff support schemes (£0.2m), stock obsoletion (£0.4m) dilapidation provisions and various other adjustments.**

| | 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 | £120,110 | £103,852 | £0 | £1,500 | £105,352 | (£14,758) | |
| Balance to block payment -activity only | £0 | £17,270 | £0 | £0 | £17,270 | £17,270 | |
| Homecare Pharmacy Income | £37,378 | £34,831 | £0 | £0 | £34,831 | (£2,547) | |
| Drugs and Devices - cost and volume | £11,262 | £12,953 | £0 | £0 | £12,953 | £1,690 | |
| Balance to block payment - drugs and devices | £0 | (£737) | £0 | £0 | (£737) | (£737) | |
| **Sub-total** | **£168,750** | **£168,169** | **£0** | **£1,500** | **£169,669** | **£919** 1 | |
| Clinical income - Outside of national block framework | | | | | | | |
| Drugs & Devices | £902 | £1,665 | £0 | £0 | £1,665 | £762 | |
| Other clinical income | £2,156 | £1,898 | £0 | £0 | £1,898 | (£258) | |
| Private patients | £6,858 | £6,298 | £0 | £0 | £6,298 | (£560) | |
| **Sub-total** | **£9,916** | **£9,860** | **£0** | **£0** | **£9,860** | **(£56)** | |
| **Total clinical income** | **£178,666** | **£178,029** | **£0** | **£1,500** | **£179,529** | **£863** | |
| Other operating income | | | | | | | |
| Covid-19 funding and ERF | £4,847 | £0 | £990 | £3,785 | £4,774 | (£73) | |
| Top-up funding | £13,696 | £13,912 | £0 | (£1,172) | £12,740 | (£956) | |
| Other operating income | £10,080 | £11,933 | £0 | £444 | £12,377 | £2,297 | |
| ERF provision * | £0 | £0 | £0 | £0 | £0 | £0 | |
| **Total operating income** | **£28,623** | **£25,845** | **£990** | **£3,057** | **£29,891** | **£1,268** 2 | |
| **Total income** | **£207,289** | **£203,874** | **£990** | **£4,557** | **£209,420** | **£2,131** | |
| Pay expenditure | | | | | | | |
| Substantive * | (£88,776) | (£84,858) | £15 | (£2,586) | (£87,429) | £1,347 | |
| Bank | (£1,811) | (£1,754) | (£25) | £0 | (£1,779) | £31 | |
| Agency | (£1,310) | (£1,713) | £0 | £0 | (£1,713) | (£403) | |
| **Sub-total** | **(£91,897)** | **(£88,326)** | **(£10)** | **(£2,586)** | **(£90,922)** | **£975** 3 | |
| Non-pay expenditure | | | | | | | |
| Clinical supplies * | (£33,407) | (£32,631) | (£32) | (£168) | (£32,830) | £577 4 | |
| Drugs | (£5,440) | (£4,061) | (£0) | £0 | (£4,062) | £1,378 5 | |
| Homecare Pharmacy Drugs | (£37,500) | (£33,705) | £0 | £0 | (£33,705) | £3,795 | |
| Non-clinical supplies * | (£25,947) | (£26,940) | (£473) | (£4,544) | (£31,956) | (£6,010) 6 | |
| Depreciation (excluding Donated Assets) | (£7,730) | (£7,712) | £0 | £0 | (£7,712) | £18 | |
| Depreciation (Donated Assets) | (£399) | (£408) | £0 | £0 | (£408) | (£9) | |
| **Sub-total** | **(£110,422)** | **(£105,457)** | **(£505)** | **(£4,712)** | **(£110,674)** | **(£251)** | |
| **Total operating expenditure** | **(£202,319)** | **(£193,783)** | **(£514)** | **(£7,298)** | **(£201,595)** | **£724** | |
| Finance costs | | | | | | | |
| Finance income | £1 | £888 | £0 | £0 | £888 | £887 | |
| Finance costs | (£3,920) | (£4,093) | £0 | £0 | (£4,093) | (£174) | |
| PDC dividend | (£1,362) | (£1,362) | £0 | £0 | (£1,362) | (£0) | |
| Revaluations/(Impairments) | £0 | £0 | £0 | £0 | £0 | £0 | |
| Gains/(losses) on disposals | £0 | £12 | £0 | £0 | £12 | £12 | |
| **Sub-total** | **(£5,281)** | **(£4,555)** | **£0** | **£0** | **(£4,555)** | **£726** | |
| **Surplus/(Deficit) including central funding** | **(£311)** | **£5,536** | **£475** | **(£2,741)** | **£3,270** | **£3,581** | |
| **Surplus/(Deficit) Control Total basis** | **£88** | **£5,902** | **£475** | **(£2,741)** | **£3,636** | **£3,560** | |

**RAG:** ● = adverse to Plan, ● = favourable / in line with Plan

* Adjusted for CIP plan alignment

1 **Clinical income is c£1m favourable to plan**

- Income from contract activity on a PbR basis is below block funding levels by c£14.8m; this is mainly due to surgical activity. This activity risk is being mitigated by the block arrangements, which are providing security to the income position. The block was uplifted to provide funding for pay inflation and this has resulted in additional income being received vs plan. The Trust had provided for the costs of the pay award from April to August and therefore £1.2m of the funding is contributing to the variance at bottom line. YTD Homecare includes a net benefit of £1.1m due to income received on block offset by reduced expenditure linked to activity.
- Private Patient income is c£0.6m below plan YTD.

2 **Other operating income is favourable to plan by c£1.3m** due to increased accommodation occupancy, R&D additional funding from NIHR, training income, charitable recharges and HLRI income £0.4m (offset in expenditure). ERF includes 100% achievement for NHSE and C&P only. The adverse variance on ERF is driven by the inability to achieve ERF on associate contracts but is mitigated by additional ERF funding from NHSE and C&P, linked to the pay award and inflation. Top-up remains below plan due to the recognition of a provision to reflect the re-allocation of system funding to achieve breakeven positions across the ICS.

3 **Pay expenditure is favourable to plan by c£0.9m.** This is driven by the underlying vacancies. Cost also includes provision for the potential band 2 to band 3 risk (c£1.5m); thank you payments to staff (£0.4m) and the Trust funding a year of the compassionate and collective leadership programme (£0.2m), backdated pay costs of (£0.3m) for overseas nurses, radiographers and junior doctors.

4 **Clinical Supplies is favourable to plan by £0.6m.** This is due to underspend linked to activity levels being below plan. These variances are partly offset by higher than planned DCD activity and other high value device usage (offset in income).

5 **Total drugs spend is favourable to plan by c£5.1m.** c£1.4m of this is non-Homecare drugs and reflects the activity levels being behind baseline levels. The remaining element relates to Homecare drugs spend and is partly offset by the income variance.

6 **Non-clinical supplies is adverse to plan by £6.0m.** This is driven by the recognition for grant to University of Cambridge (£2.5m); the staff benefit provision (£1.0m); aged stock write off due to COVID-19 (£0.4m); dilapidation provisions for the House (£0.2m); HLRI cost (£0.4m); general provisions (£0.5m); COVID costs in relation to ongoing spend on estates and facilities schemes (£0.4m), additional non-recurrent costs incurred in response to M Abscessus and other adjustments to provisions.

# Integrated Care Board (ICB): Performance summary

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

| | | Data Quality | Target | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Comments |
|---|---|---|---|---|---|---|---|---|---|---|
| Additional KPIs | **Elective activity as % 19/20 (ICB)** | 3 | Monitor only | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | Latest data to w/e 03/07/22. Awaiting data from ICB for Jul to Nov 22 |
| | Papworth - Elective NHS activity as % 19/20 baseline plan* | 4 | Monitor only | 84.8% | 71.6% | 70.3% | 83.4% | 66.4% | 87.4% | |
| | **Non Elective activity as % 19/20 (ICB)** | 3 | Monitor only | **89.7%** | **96.9%** | **93.1%** | **99.6%** | **104.1%** | **94.4%** | Latest data to w/e 08/01/23 |
| | Papworth - Non NHS Elective activity as % 19/20 baseline plan* | 4 | Monitor only | 68.2% | 85.6% | 52.3% | 85.5% | 89.9% | 76.9% | |
| | **Day Case activity as % 19/20 (ICB)** | 3 | Monitor only | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | Latest data to w/e 03/07/22. Awaiting data from ICB for Jul to Dec 22 |
| | Papworth - Day NHS Case activity as % 19/20 baseline plan* | 4 | Monitor only | 96.8% | 100.0% | 79.8% | 92.0% | 89.3% | 114.5% | |
| | **Outpatient - First activity as % 19/20 (ICB)** | 3 | Monitor only | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | Latest data to w/e 03/07/22. Awaiting data from ICB for Jul to Dec 22 |
| | Papworth - Outpatient - First activity NHS as % 19/20 baseline plan* | 4 | Monitor only | 113.3% | 90.8% | 88.1% | 96.9% | 109.5% | 133.8% | |
| | **Outpatient - Follow Up activity as % 19/20 (ICB)** | 3 | Monitor only | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | Latest data to w/e 03/07/22. Awaiting data from ICB for Jul to Dec 22 |
| | Papworth - Outpatient - Follow Up & Non face to face NHS activity as % 19/20 baseline plan* | 4 | Monitor only | 105.6% | 103.1% | 97.3% | 100.5% | 105.0% | 125.2% | |
| | **Virtual clinics – % of all outpatient attendances that are virtual (ICB)** | 3 | Monitor only | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | Latest data to w/e 03/07/22. Awaiting data from ICB for Jul to Dec 22 |
| | Papworth - Virtual clinics – % of all outpatient attendances that are virtual | 4 | Monitor only | 15.6% | 12.2% | 13.6% | 15.3% | 16.2% | 15.8% | |
| | **Diagnostics < 6 weeks % (ICB)** | 3 | Monitor only | **n/a** | **57.2%** | **57.6%** | **58.3%** | **59.3%** | **52.4%** | Latest data to w/e 08/01/23 |
| | Papworth - % diagnostics waiting less than 6 weeks | 3 | 99% | 97.2% | 96.9% | 98.3% | 98.8% | 99.2% | 99.3% | |
| | **18 week wait % (ICB)** | 3 | Monitor only | **59.5%** | **59.1%** | **58.6%** | **57.9%** | **58.1%** | **56.2%** | RTT Metrics comprise CUHFT & NWAFT & RPH to w/e 01/01/23 |
| | Papworth - 18 weeks RTT (combined) | 5 | 92% | 77.8% | 75.8% | 74.3% | 74.1% | 74.1% | 70.6% | |
| | **No of waiters > 52 weeks (ICB)** | 3 | Monitor only | **8,215** | **8,575** | **8,760** | **8,935** | **8,597** | **8,310** | RTT Metrics comprise CUHFT & NWAFT & RPH to w/e 01/01/23 |
| | Papworth - 52 week RTT breaches | 5 | 0% | 3 | 2 | 5 | 2 | 8 | 13 | |
| | **Cancer - 2 weeks % (ICB)** | 3 | Monitor only | **71.1%** | **67.7%** | **63.8%** | **58.3%** | **64.9%** | **59.1%** | Latest Cancer Performance Metrics available are November 2022 |
| | | | | | | | | | | |
| | **Cancer - 62 days wait % (ICB)** | 3 | Monitor only | **56.9%** | **59.2%** | **59.4%** | **52.3%** | **48.4%** | **61.2%** | Latest Cancer Performance Metrics available are November 2022 |
| | Papworth - 62 Day Wait for 1st Treatment including re-allocations | 4 | 85% | 20.0% | 53.1% | 35.3% | 33.3% | 75.0% | 50.0% | |
| | **Finance – bottom line position (ICB)** | 3 | Monitor only | **n/a** | **£1.2m** | **n/a** | **n/a** | **n/a** | **n/a** | Latest ICB financial position to August 22 YTD (M05) |
| | Papworth - Year to date surplus/(deficit) exc land sale £000s | 5 | £(311)k | £1,404k | £1,415k | £2,551k | £2,821k | £2,876k | £3,296k | |
| | **Staff absences % C&P (ICB)** | 3 | Monitor only | **3.6%** | **3.3%** | **4.1%** | **3.9%** | **4.3%** | **4.4%** | Latest data to w/e 08/01/23 |
| | Papworth - % sickness absence | 3 | 3.5% | 5.3% | 4.5% | 4.3% | 5.4% | 4.9% | 5.4% | |

## 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 ICB is becoming more important. Increasingly organisations will be regulated as part of a wider ICB context, with regulatory performance assessments actively linking to ICB performance.

There is a national expectation that individual organisations are leaning in to support recovery post COVID-19 across the ICB and or local region and the Trust is not exempt from this. The ICB 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 ICB 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.

Comparative metric data for Royal Papworth was requested at the March 2022 Performance Committee. This has now been included (where available) as additional rows in the table opposite.