Royal Papworth Hospital
NHS Foundation Trust

Papworth Integrated Performance Report (PIPR)

March 2023

Content

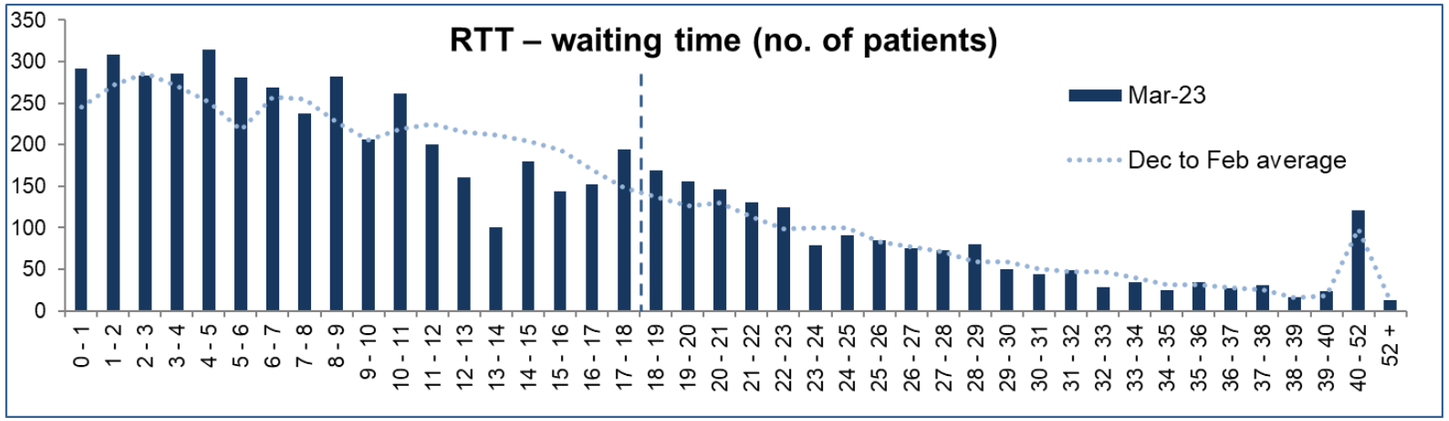
Context:

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:

Admitted Episodes	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend
Cardiac Surgery	160	141	148	127	153	158	
Cardiology	673	686	595	704	638	754	
ECMO (days)	51	80	132	110	128	144	
PTE operations	7	15	8	10	14	13	
RSSC	640	584	549	609	539	789	
Thoracic Medicine	332	318	260	316	270	338	
Thoracic surgery (exc PTE)	66	50	61	68	54	68	
Transplant/VAD	58	30	40	30	36	49	
Total Admitted Episodes	**1,987**	**1,904**	**1,793**	**1,974**	**1,832**	**2,313**	
Total Admitted episodes exc PP	1,911	1,813	1,722	1,881	1,761	2,188	
*Total Admitted episodes exc PP **plan** (Note 4)*	*2,258*	*2,343*	*2,033*	*2,249*	*2,239*	*2,476*	

Outpatient Attendances	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend
Cardiac Surgery	454	480	384	457	425	483	
Cardiology	3,724	3,978	3,266	3,942	3,616	4,010	
RSSC	1,718	2,113	1,382	1,949	1,988	1,952	
Thoracic Medicine	2,052	2,655	2,237	2,533	2,231	2,577	
Thoracic surgery (exc PTE)	110	142	86	130	100	103	
Transplant/VAD	307	345	255	310	255	305	
Total Outpatients	**8,365**	**9,713**	**7,610**	**9,321**	**8,615**	**9,430**	
Total Outpatients exc PP	8093	9360	7350	9025	8343	9076	
*Total Outpatients exc PP **plan** (Note 4)*	*8497*	*9153*	*7638*	*9053*	*8435*	*9223*	

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 - Admitted episodes include planned procedures not carried out.
Note 4 - Activity plan at March 23 was 104% 19/20 baseline for Inpatients EL/DC, 124% for NEL and 110% for Outpatients



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

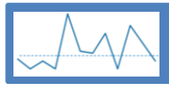
Each category within the Balanced scorecard is given an overall RAG rating based on the rating of the KPIs within the category that appear on the balance scorecard (page 4).

- **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 2021 (where data is available)

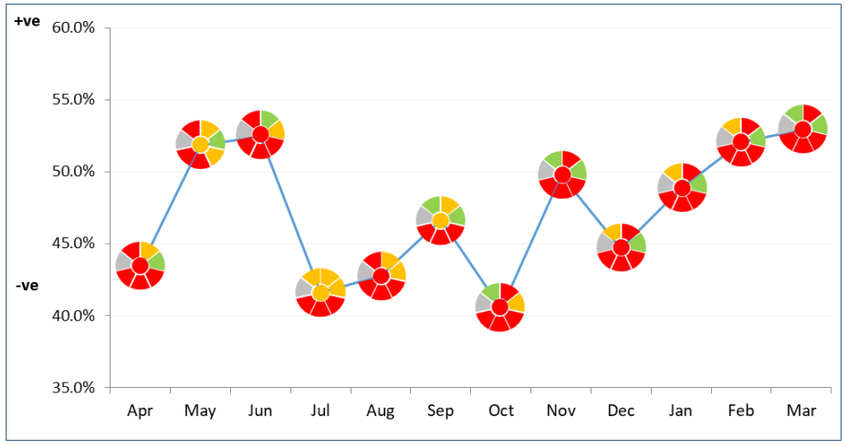
Data Quality Indicator

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: Written complaints per 1000 staff WTE remain in green at 4.6. It is a benchmark figure based on the NHS Model Health System to enable national benchmarking. The data from Model Health System continues to demonstrate we are in the lowest quartile for national comparison.

EFFECTIVE: 1) Theatre utilisation - improved again reflecting the continued impact of the theatre transformation plan. 235 procedures were delivered in month against a plan of 227, despite 3 days disruption due to industrial action. 2) Cath Lab utilisation - remained on target throughout March, although elective throughput was affected by 72 hours of industrial action. This equated to approximately 55 lost cases of elective activity. Emergency coronary pathways were maintained throughout and saw high volumes of PPCI, Rapid NSTEMI and ACS patients treated (220 cases). 3) Outpatient Capacity - was up in March by 8.78% from February (a total of 733 appointments) this is in line with an average 31-day calendar month.

PEOPLE, MANAGEMENT & CULTURE: IPR - We saw a further improvement in the IPR compliance rate to 78.8%. The clinical divisions have developed improvement plans that set out their trajectories for ensuring that at least 90% of staff have had an appraisal in the last 12 months.

FINANCE: Year to date (YTD) Surplus - the final YTD position was a surplus of £1.2m against a breakeven plan for the year.

ADVERSE PERFORMANCE

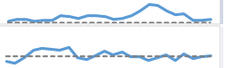
SAFE: 1) High impact interventions - Compliance with HIIs overall has decreased slightly to 95% from 97% for March. Each department of reduced compliance has an improvement plan which is monitored by the Infection Control Team and an overview is taken to the monthly Infection Control Committee. 2) Sepsis - Q4 Trust wide compliance was 81.25% of patients who meet the criteria, were screened and treated according to the full Sepsis 6 Bundle. Of the remainder (3 patients in critical care) did not have a septic screen completed, however all patients received antibiotics. Further information on Sepsis Six is on the Safe Spotlight slide. 3) Safe staffing fill rates: Nursing roster fill rates for March slightly decreased to 78% from 80% for registered staff for day shifts, however for night shifts there was a notable increase from 61% in February to 83% in March. Registered and unregistered fill rates continue to be a priority focus; Surgery, Thoracic Medicine and Cardiology are the most affected areas. Fill rates are mitigated with redeployment of staff, empty bed capacity, specialist nurses and ward sisters filling gaps in shifts. Overall CHPPD (Care Hours Per Patient Day) for March is 12.00, unchanged from February.

RESPONSIVE: ACS 3 day transfer – There were 18 patients who were unable to be transferred in the 3 day window under the ACS service in March. This was related to flow pressures throughout the Cardiology bed base linked to rising numbers of IHU patients awaiting surgery.

PEOPLE, MANAGEMENT & CULTURE: Total Trust vacancy rate - reduced to 12.2% and registered nurse vacancy rate reduced marginally to 11.7%. Level 5, Surgical Wards, continues to have the highest % vacancy rates with no improvement over the last 6 months. They have 12 recruits in the pipeline, which is an increase from the previous month. 5 of these have anticipated start dates in April and May with the remainder going through the pre-employment checking process.

At a glance – Balanced scorecard

		Month reported on	Data Quality	Plan	Current month score	YTD Actual	Forecast YE	Trend
Safe	Never Events	Mar-23	4	0	0	0		
	Moderate harm incidents and above as % of total PSIs reported	Mar-23	4	3%	1.84%	1.08%		
	Number of Papworth acquired PU (Catergory 2 and above)	Mar-23	4	35 pa	1	12		
	High impact interventions	Mar-23	3	97%	95.00%	94.67%		
	Falls per 1000 bed days	Mar-23	4	4	2.5	3.2		
	Sepsis - % patients screened and treated (Quarterly)	Mar-23	New	90%	81.25%	-		
	Trust CHPPD	Mar-23	5	9.6	12.0	12.5		
	Safer staffing: fill rate – Registered Nurses day	Mar-23	5	90%	78.0%	83.6%		
	Safer staffing: fill rate – Registered Nurses night	Mar-23	5	90%	83.0%	81.4%		
	Safer staffing: fill rate – HCSWs day	Mar-23	5	90%	61.0%	64.9%		
	Safer staffing: fill rate – HCSWs night	Mar-23	5	90%	77.00%	72.88%		
Caring	FFT score- Inpatients	Mar-23	4	95%	98.60%	99.03%		
	FFT score - Outpatients	Mar-23	4	95%	96.40%	97.15%		
	Number of written complaints per 1000 WTE (Rolling 3 mnth average)	Mar-23	4	12.6	4.6			
	Mixed sex accommodation breaches	Mar-23	4	0	0	0		
	% of complaints responded to within agreed timescales	Mar-23	4	100%	100.00%	94.75%		
Effective	Bed Occupancy (excluding CCA and sleep lab)	Mar-23	4	85% (Green 80%-90%)	82.40%	73.97%		
	CCA bed occupancy	Mar-23	4	85% (Green 80%-90%)	92.70%	86.74%		
	Admitted Patient Care (elective and non-elective) exc PP	Mar-23	4	26010	2188	21958		
	Outpatient attendances exc PP	Mar-23	4	97973	9076	99801		
	Cardiac surgery mortality (Crude)	Mar-23	3	3%	2.99%	2.99%		
	Theatre Utilisation	Mar-23	3	85%	79.4%	80.1%		
	Cath Lab Utilisation 1-6 at New Papworth (including 15 min Turn Around Times)	Mar-23	3	85%	85.0%	81.2%		

		Month reported on	Data Quality	Plan	Current month score	YTD Actual	Forecast YE	Trend
Responsive	% diagnostics waiting less than 6 weeks	Mar-23	3	99%	98.36%	97.47%		
	18 weeks RTT (combined)	Mar-23	5	92%	70.87%	70.87%		
	Number of patients on waiting list	Mar-23	5	3279	5859	5859		
	52 week RTT breaches	Mar-23	5	0	13	85		
	62 days cancer waits post re-allocation (new 38 day IPT rules from Jul18)*	Mar-23	4	85%	50.00%	49.63%		
	31 days cancer waits*	Mar-23	4	96%	100.00%	92.66%		
	104 days cancer wait breaches*	Mar-23	4	0%	4	114		
	Theatre cancellations in month	Mar-23	3	30	31	30		
	% of IHU surgery performed < 7 days of medically fit for surgery	Mar-23	4	95%	73.00%	70.42%		
	Acute Coronary Syndrome 3 day transfer %	Mar-23	4	90%	100.00%	100.00%		
People Management & Culture	Voluntary Turnover %	Mar-23	3	14.0%	13.2%	15.2%		
	Vacancy rate as % of budget	Mar-23	4	5.0%	12.2%			
	% of staff with a current IPR	Mar-23	3	90%	78.83%			
	% Medical Appraisals	Mar-23	3	90%	74.14%			
	Mandatory training %	Mar-23	3	90%	85.50%	85.59%		
	% sickness absence	Mar-23	3	3.50%	4.14%	4.79%		
Finance	Year to date surplus/(deficit) exc land sale £000s	Mar-23	5	£(532)k	£498k			
	Cash Position at month end £000s	Mar-23	5	£60,956k	£67,319k			
	Capital Expenditure YTD £000s	Mar-23	5	£4,113k	£4,026k			
	In month Clinical Income £000s	Mar-23	5	£262946k	£26,396k	£263,201k		
	CIP – actual achievement YTD - £000s	Mar-23	4	£5800k	£7,515k	£7,515k		
	CIP – Target identified YTD £000s	Mar-23	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	0	7	4		
RTT Waiting Times	% Within 18w ks - Incomplete Pathw ays	5	92%	70.87%		72.93%		Monthly measure
Cancer	31 Day Wait for 1st Treatment	4	96%	100.0%	92.7%	84.53%		Current month provisional as going through verification process.
	31 Day Wait for 2nd or Subsequent Treatment - surgery	4	94%	100.0%	91.7%	84.83%		Current month provisional as going through verification process.
	62 Day Wait for 1st Treatment	4	85%	50.0%	49.6%	52.8%		Current month provisional as going through verification process. Data is after reallocations
	104 days cancer w ait breaches	4	0	4	114	33		
VTE	Number of patients assessed for VTE on admission	5	95%	88.30%		86.2%		
Finance	Use of resources rating	5	3	n/a	n/a	n/a	n/a	No longer routinely monitored in the new financial framew ork.

* Forecast updated quarterly M01,M04, M07, M10

Board Assurance Framework risks (where above risk appetite)

PIPR Category	Title	Ref	Mgmt Contact	Risk Appetite	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	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	M.Abscessus	3040	MS	10	15	15	15	15	15	15	↔
Safe + PM&C + Responsive	Industrial Action	3261	OM	6	16	20	20	20	20	20	↔
Safe + Effective + Finance + Responsive	Continuity of supply of consumable or services failure	3009	TG	6	12	12	12	12	9	9	↔
Safe + Effective + Finance + Responsive	Activity recovery and productivity	3223	AB	4	16	16	16	16	16	16	↔
Safe + Finance + Responsive + Transformation	NHS Reforms & ICS strategic risk	3074	TG	8	12	12	12	12	12	12	↔
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	20	↑
Effective + Finance + PM&C + Responsive + Transformation	Delivery of Trust 5 year strategy	2901	AB	6	9	9	9	9	9	9	↔
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	20	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	12	↓

Safe: Performance summary

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

		Data Quality	Target	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Dashboard KPIs	Never Events	4	0	0	0	0	0	0	0
	Moderate harm incidents and above as % of total PSIs reported	4	<3%	0.80%	0.83%	0.00%	0.88%	1.98%	1.84%
	Number of Papworth acquired PU (Catergory 2 and above)	4	<35	1	3	0	0	0	1
	High impact interventions	3	97.0%	91.0%	94.0%	94.0%	94.0%	97.0%	95.0%
	Falls per 1000 bed days	4	<4	1.8	3.2	2.4	1.8	3.4	2.5
	Sepsis - % patients screened and treated (Quarterly)	New	90.0%	-	-	81.0%	-	-	81.25%
	Trust CHPPD	5	>9.6	11.90	11.80	12.20	12.20	12.00	12.00
	Safer staffing: fill rate – Registered Nurses day	5	90.0%	80.0%	79.0%	79.0%	78.0%	80.0%	78.0%
	Safer staffing: fill rate – Registered Nurses night	5	90.0%	83.0%	80.0%	79.0%	61.0%	61.0%	83.0%
	Safer staffing: fill rate – HCSWs day	5	90.0%	64.0%	66.0%	64.0%	82.0%	83.0%	61.0%
	Safer staffing: fill rate – HCSWs night	5	90.0%	74.0%	76.0%	71.0%	72.0%	71.0%	77.0%
Additional KPIs	MRSA bacteremia	3	0.0%	1	0	0	0	0	0
	Number of serious incidents reported to commissioners in month	4	0.0%	0	0	0	0	0	1
	E coli bacteraemia	5	Monitor only	1	0	0	1	2	1
	Klebsiella bacteraemia	5	Monitor only	1	2	2	3	2	1
	Pseudomonas bacteraemia	5	Monitor only	0	2	0	0	0	0
	Other bacteraemia	4	Monitor only	0	0	0	0	0	4
	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	2	0	2	5	5
	Monitoring C.Diff (toxin positive)	5	Ceiling pa of 10	0	2	2	0	0	2
	Number of patients assessed for VTE on admission	5	95.0%	85.10%	88.60%	84.80%	91.00%	91.70%	88.10%
	SSI CABG infections (inpatient/readmissions %)	New	<2.7%	-	-	7.10%	-	-	7.40%
	SSI CABG infections patient numbers (inpatient/readmisisons)	New	n/a	-	-	14	-	-	14
	SSI Valve infections (inc. inpatients/outpatients; %)	New	<2.7%	-	-	4.90%	-	-	1.60%
	SSI Valve infections patient numbers (inpatient/outpatient)	New	n/a	-	-	6	-	-	2

Summary of Performance and Key Messages:

Pressure ulcers: (Category 2 and above): There was 1 acquired PU of category 2 (WEB47195) or above reported in March, this is currently awaiting final review Scrutiny Panel to confirm grading.

Falls: There was a decrease in falls in March to 2.5 per 1000 bed days and slips/trips/falls were all graded as no harm/low harm.

Sepsis: Q4 Trust wide (Wards/CCA) compliance was 81.25% of patients who meet the criteria, were screened and treated according to the full Sepsis 6 Bundle. Of the remainder (3 patients in critical care) did not have a septic screen completed, however all patients received antibiotics. Further information on Sepsis Six is on the Safe Spotlight slide.

Safe staffing fill rates: Nursing roster fill rates for March slightly decreased to 78% from 80% for registered staff for day shifts, however for night shifts there was a notable increase from 61% in February to 83% in March. High sickness in cardiology wards and high acuity in respiratory wards were noted reasons that attributed to RN bank requests to support the mitigation of RN vacancies. Unregistered (UR) fill rates in March for daytime staffing has decreased from 83% in February to 61% in March. Important to note a higher number of UR bank requests recorded (above vacancy level) due to high number of UR staff required for specialling of patients (one-to-one care; in Surgery & Cardiology), high acuity and high level of reported staff sickness across all divisions. Night time UR was 77% in March which is higher compared to 71% in February. Registered and unregistered fill rates continue to be a priority focus; Surgery, Thoracic Medicine and Cardiology are the most affected areas. Fill rates are mitigated with redeployment of staff, empty bed capacity, specialist nurses and ward sisters filling gaps in shifts. Overall CHPPD (Care Hours Per Patient Day) for March is 12.00, unchanged from February.

High impact interventions (HII): Compliance with HIIs overall has decreased slightly to 95% from 97% for March. Areas of poor compliance show requirement for ongoing focus and targeted action. Improvement is noted for HII5 VAP (ventilator associated pneumonia) which increased to 87% from 71% in February. HII8 Cleaning and Decontamination shows a decline to 93% from 96% in February. Other HII that need review and action plans are ANTT (aseptic non-touch technique) which has reduced to 93% from 97% (*main areas of concern are Cath Labs, CCA, Theatres and Radiology). HII CVC (central venous catheter) ongoing care is 91% compared to 100% in February. Each department of reduced compliance has an improvement plan which is monitored by the Infection Control Team and an overview is taken to the monthly Infection Control Committee.

Alert Organisms: There was 1 Klebsiella bacteraemia and 1 case of E Coli bacteraemia in March. There was 4 cases of MSSA bacteraemia, 2 related to SSI, 1 related to VAD site infection and 1 related to ECMO line infection. 2 cases of C. Difficile are awaiting scrutiny panel to understand if case is attributable to RPH.

Moderate harm incidents and above: There were four moderate harm incidents and one serious incident (WEB46561, WEB46719, WEB46844, WEB46964, SUI-WEB46547) graded through the Serious Incident Executive Response Panel (SIERP) in March. All incidents are monitored via the Quality Risk Management Group (QRMG) governance process.

Serious Incidents: The serious incident (SUI-WEB46547) reported in March 2023 was in relation to a failure to escalation, categorised as suboptimal care, patient has sadly passed away, investigation is underway.

VTE: Compliance with performing VTE risk assessments was 88.10% in March. There was a slight decrease in compliance. This continues to be an area of particular focus and VTE continues to be monitored through QRMG and divisional performance.

Surgical Site Infection (SSI): The threshold ("target") for SSI infections is taken from national benchmarking data (UKHSA), set at 2.7%. For Q4 (2022/23) the RPH current result for **CABG is *7.40% (n = 14).** For **Valve Infections this was 1.60% (n=2).**

** To note these figures may change as patients are further reviewed throughout April, the overall % will be finalised and reported to UKHSA in June.*

Safe: World Health Organisation (WHO) - Surgical Safety Checklist

What is the purpose of the WHO surgical safety checklist?
The WHO checklist aims to decrease errors and adverse events, and increase teamwork and communication in surgery thereby improving patient safety. Compliance with the WHO checklist is a mandatory requirement in all NHS hospitals, England and Wales.

What is the sequence of the WHO surgical safety checklist? Checklist consists of 3 main parts at specific time points during surgery.
First part – **Sign in**, completed before administration of anaesthesia to patient; second part – **Time out** is completed before start of surgery; third part **Sign out** is completed before patient leaves Theatre.

Key performance requirements for WHO checklist – Theatres; Target is 100%

- Compliance is mandatory for all procedures carried out in operating theatres which involve general, local and regional anaesthesia e.g., elective, urgent and emergency cases **DN702 Local Safety Standards for Operating Theatres.**
- Each month all procedures carried out in Theatres 1-6 are audited using checklist forms on Lorenzo – quality of form completions not monitored only whether a form has been initiated.
- The 4 elements audited are; pre-procedure checks completed; team brief (Time Out) completed (time out +/- 2 hours of surgery start); post procedure checks completed (after Theatre admit and within 2 hours leave Theatre time); number of checklists that had all 3 criteria completed (overall compliance).

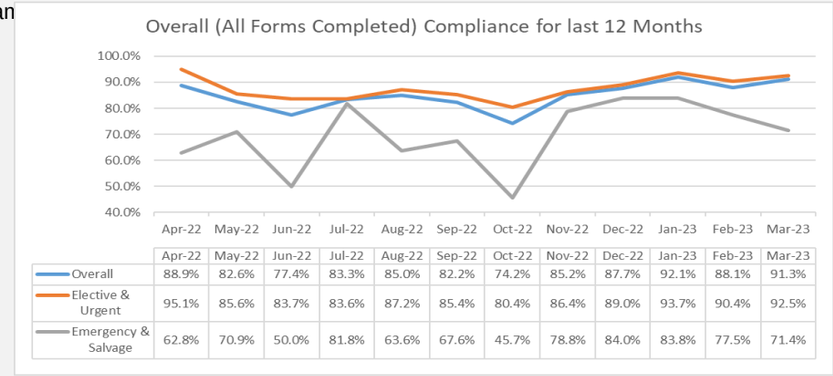
Key performance challenge

- Compliance with overall completion of the WHO checklist has seen a gradual increase in **Graph 1** for Theatres, particularly in respect to Elective and Urgent, since last PIPR Key Performance focus in Oct. 2022 (80.4%) to 92.5% in March 2023.
- Overall compliance has also increased from Oct. 2022 which was 74.2% in March 2023, to overall **compliance of 91.3%.**
- Emergency and salvage has also increased from 45.7% in Oct 2022 to 71.4% in March 2023.

Key actions

- A targeted focus on Emergency & Salvage procedures will continue to increase compliance
- Action plans for WHO Checklist compliance now included in monthly Quality Report; monitored at Business Unit Meetings
- Education and a team approach on WHO compliance has been a constant at Team Briefings
- Timepoints have been identified for each stage of the process and allocated to the MDT, where omissions have occurred, tean

Graph 1 shows RPH Theatre performance April 2022 – March 2023



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Overall	88.9%	82.6%	77.4%	83.3%	85.0%	82.2%	74.2%	85.2%	87.7%	92.1%	88.1%	91.3%
Elective & Urgent	95.1%	85.6%	83.7%	83.6%	87.2%	85.4%	80.4%	86.4%	89.0%	93.7%	90.4%	92.5%
Emergency & Salvage	62.8%	70.9%	50.0%	81.8%	63.6%	67.6%	45.7%	78.8%	84.0%	83.8%	77.5%	71.4%

Key performance requirements for WHO checklist – Cath Labs; Target is 100%

- All procedures are audited against the Pre and Post procedure form (Lorenzo)
- Checks recorded on pre-procedure checklist; final clinical and identity checks carried out before intervention
- **DN705 The Local Safety Standard for Catheter Labs**

Four elements are audited:

- Pre-procedure checks completed (Sign in)
- Post procedure checks completed (Sign out)
- Checklist present in the notes
- Number of checklists that had all 3 criteria completed (Overall Compliance)

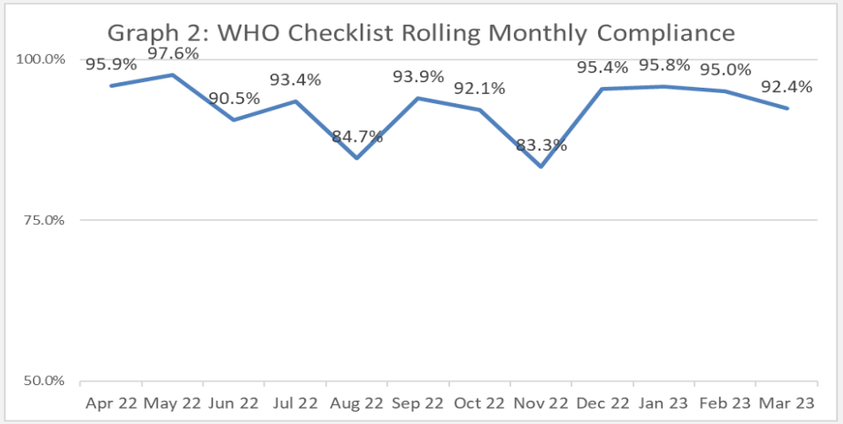
Key performance challenge

- Compliance with completion of the WHO checklist has been steady since last reported in October 2022, which was 92.1%, and in March 2023, the WHO checklist compliance is 92.4%, as shown in **Graph 2**.

Key actions

- Cath Lab Sister working with Digital Team to change the document format on Lorenzo so the WHO checklist cannot be missed (*current different documents to access during the procedure makes it a challenge) – Digital update will make biggest impact – nearly finalised, awaiting date
- Cath Lab Daily Staff Briefings; highlighted to one specific speciality group and to nurses in same Lab to improve compliance

Graph 2 shows RPH Catheter Labs performance April 2022 – March 2023



Safe: Spotlight – The Management of Sepsis

What is sepsis?

Sepsis is a potentially life-threatening condition and without prompt recognition and management can prove fatal. Simple, timely interventions can be lifesaving. The Trust DN598 Guidelines on the Management of Sepsis, provides the relevant information to enable prompt recognition and management, of potential sepsis and to reduce the incidence of severe sepsis.

Once the diagnosis of sepsis is made we advise our clinical teams to START the Sepsis Care Bundle. This is an important step that ensures all patients receive the most appropriate and optimal care to manage their sepsis. The Sepsis Resuscitation Bundle describes six elements that should begin immediately and must be accomplished within the first hour of presentation. This bundle may be achieved in full within the ward area with specialist assistance from the medical team and / or the ALERT / Advance Nurse Practitioner teams.

What are the Sepsis Six ?

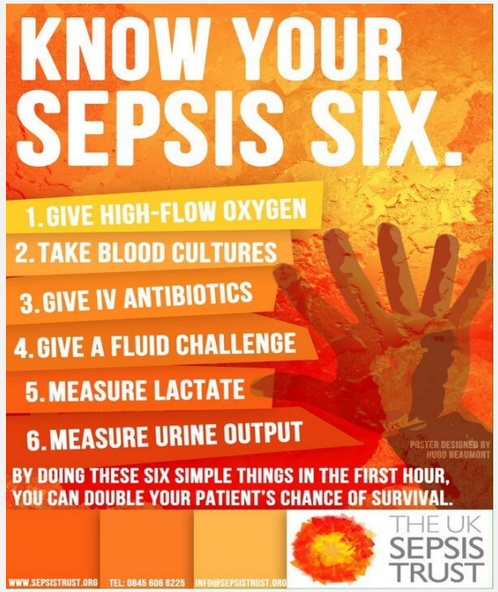
Within the Trust, we breakdown 6 areas of focus into 3 investigations and 3 treatments.

Investigations:

1. Blood cultures
2. Measure Lactate
3. Measure urine output

Treatments:

4. Give a fluid challenge
5. Give IV antibiotics
6. Give high-flow oxygen



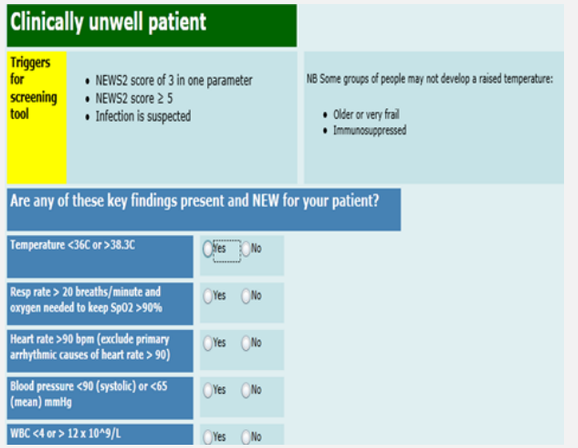
Prior to February 2023

We had a high volume of patients that had the Sepsis 6 Bundle started. On review of the bundles, it was found that a high number of patients who had had a bundle completed had not met the criteria for screening. This led to too many bundles being started, completed and antibiotics prescribed when not required e.g., in the immediate post operative phase in patients with Systemic Inflammatory Response Syndrome (SIRS).

Current Practice February 2023

Through a quality improvement review, these processes have been reviewed and changes were made within the Electronic Medical Record (EMR) which means the Sepsis Six Pathway Bundle can now only be accessed when patients meet two or more of the key findings present as per the Sepsis UK Trust NICE recommendations.

The screen shot on the right is an example of the first part of the Sepsis Bundle Pathway in EMR (Lorenzo).



Following these changes staff awareness included, training using 'the tea trolley' concept, updates within the DN598 Guidelines and a Message of the Week published in March 2023. We have also worked with our clinical staff around commentary/ language used in relation to sepsis.

The Trust Sepsis Bundles (pathway templates) within the Electronic Medical Record have been developed and adapted from the revised 2018, Surviving Sepsis Campaign (SSC) Guidelines for the Management of Sepsis, Severe Sepsis and Septic Shock. The Sepsis Care Bundle is a an early sepsis recognition and treatment pathway. It focuses on the first six hours of care after Systemic Inflammatory Response Syndrome (SIRS) or clinical signs of sepsis or septic shock have been recognised. This is an important step that ensures all patients receive the most appropriate and optimal care to manage sepsis.

Current Compliance Monitoring

The SAFE Performance slide on page 7, discusses data collected to review the appropriate use and completion of Sepsis Bundle. During 22/23 Q1/Q2 we were only able to review the use of the bundle in ward areas using data from Lorenzo. Following the addition of the bundle to Metavison, CCA has now been able to provide their data for Q3/Q4.

Caring: Performance summary

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

		Data Quality	Target	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Dashboard KPIs	FFT score- Inpatients	4	95%	98.7%	99.4%	98.3%	99.4%	98.7%	98.6%
	FFT score - Outpatients	4	95%	99.0%	96.7%	96.7%	97.6%	95.6%	96.4%
	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	6.1	6.2	5.7	5.2	5.1	4.6
	% of complaints responded to within agreed timescales	4	100%	67%	100%	100%	100%	100%	100%
Additional KPIs	Number of complaints upheld / part upheld	4	3pm (60% of complaints received)	3	1	1	4	1	0
	Number of complaints (12 month rolling average)	4	5 and below	4.5	4.7	5.0	5.0	5.2	4.8
	Number of complaints	4	5	5	3	3	4	3	2
	Number of informal complaints received per month	New	Monitor only	6	8	6	4	5	9
	Number of recorded compliments	4	500	1638	1717	1251	1705	1508	1797
	Supportive and Palliative Care Team – number of referrals (quarterly)	4	Monitor only	-	-	146	-	-	149
	Supportive and Palliative Care Team – reason for referral (last days of life) (quarterly)	4	Monitor only	-	-	3	-	-	5
	Supportive and Palliative Care Team – number of contacts generated (quarterly)	4	Monitor only	-	-	625	-	-	715
	Bereavement Follow-Up Service: Number of follow-up letters sent out (quarterly)	3	Monitor only	-	-	25	-	-	25
	Bereavement Follow-Up Service: Number of follow-ups requested (quarterly)	3	Monitor only	-	-	2	-	-	4

Summary of Performance and Key Messages:

CQC Model Health System rating for 'Caring' is Outstanding dated Dec 2021 (accessed 07.02.2022).

FFT (Friends and Family Test): In summary; **Inpatients**: Positive Experience rate was 98.6% in March 2023 for our recommendation score. Participation Rate has increased from 37.5% (February) to 43.9% in March 2023. **Outpatients**: Positive Experience rate was 96.4% for our recommendation score. Participation rate has increased from 14.0% (February) to 14.4% in March 2023.

For information: NHS England (latest published data accessed 06.04.2023) is February 2023: Positive Experience rate: 95% (inpatients); and 94% (outpatients). Since September 2021 NHS England does not calculate a response rate for services.

Number of written complaints per 1000 staff WTE: is a benchmark figure based on the NHS Model Health System to enable national benchmarking. **We remain in green at 4.6.**
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 07.02.2022): Royal Papworth = 5.72; peer group median = 11.39; national median = 16.65.

% of complaints responded to: is 100% for March 2023.

The number of complaints (12 month rolling average): is green at 4.8 for March 2023. We will continue to monitor this in line with the other benchmarking.

Complaints: We have received two new formal complaints during March 2023. The investigations are ongoing and this is within our expected variation of complaints received within the month. We have closed three formal complaints in March 2023. Further information is available on the next slide.

Compliments: the number of formally logged compliments received during March 2023 was 1797, broken down as: compliments from FFT- 1754; and compliments via cards/letters/PALS- 43.

Caring: Key performance challenges

Informal Complaints closed in the month:
During March 2023, we were able to close **six informal complaints** through local resolution and verbal feedback. Staff, Ward Sisters/Charge Nurses and Matrons proactively respond to and address concerns when raised. This helps to ensure that concerns are heard and where possible handled in a positive way, often avoiding the need for a formal complaint.

Cardiology: 3 were closed. The three issues were one in relation to poor communication regarding discharge arrangements, one for the waiting time for a procedure and one was related to a delay in obtaining a follow up appointment and communication regarding ECGs.

Thoracic and Ambulatory Care: 2 were closed, one was in relation to lack of information and poor communication regarding test results and one was regarding dissatisfaction with the treatment provided.

Surgical, Transplant and Anaesthetics: 1 was closed. This concern was related to staff attitude during an outpatient appointment and was resolved to the patient's satisfaction with the input from the Deputy Lead Nurse.

Learning and Actions Agreed from Formal; Complaints Closed: During March 2023, we have closed **three formal complaints**. All complaints were responded to on time. Of those closed, all three were not upheld:

Complaint 1: The family of a Thoracic patient had raised concerns regarding the patient's treatment with RPH prior to their sad death. The outcome of the investigation revealed that the clinical care received and the management plan for the patient was appropriate. The clinical team were able to provide the family with an overview of the care and treatment provided and appropriate reassurance. Furthermore a copy of the statement provided to the Coroner for inquest was shared with the family with the Coroner's permission which provided a detailed response to the questions raised**.**

Complaint 2: The family of a Cardiology patient had raised concerns regarding the ongoing chronic pain the patient is experiencing following a pericardial effusion. The outcome of the investigation revealed the treatment provided was routine, and no difficulties were experienced during the procedure. The patient suffered no immediate complications and no errors occurred during the procedure which indicates another pathology is the cause of the patient's pain. A full explanation was given to the family with apologies for their experience. A further CT was offered and accepted by the patient to assist in the identification of the cause of the chronic pain.

Complaint 3: A Thoracic patient raised a formal complaint regarding the cancellation of their overnight sleep study on arrival for their admission. The outcome of the investigation revealed that due to staff sickness there was not the appropriate skill mix of staff on the unit required for the patient to be admitted and therefore the appointment had to be cancelled. The decision was communicated to the booking team who contacted the patient on the morning of their admission and left a voicemail message informing the patient of the appointment cancellation. Unfortunately, this message was not picked up by the patient. A full explanation was given to the patient with apologies for their experience. Whilst the complaint was not upheld the patient's feedback was shared with the Clinical Administration and RSSC team along with a reminder to staff to reattempt contacting a patient if they are unable to speak with them directly. The patient has now received a further appointment for next month.

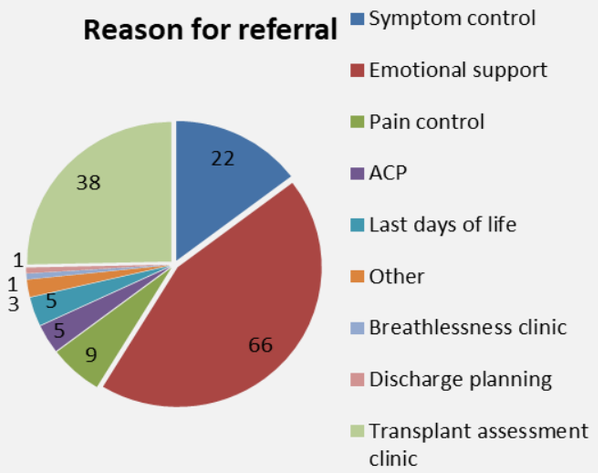
Lessons learned and actions identified through complaints are monitored monthly through the Quality and Risk Management Group.

Caring: Spotlight On – Supportive and Palliative Care Team

Supportive and Palliative Care Team (SPCT) Dashboard

Every quarter, the SPCT produce a Dashboard. An extract is always included in PIPR (p.10) and it is discussed in the End of Life Steering Group. This PIPR, in line with the quarterly reporting will share some more information from the Q4 2022/23 (Jan to March 2023) Dashboard.

No. referrals Oct - Dec 22 = 146



This pie chart shows that during Q4, out of 150 referrals, the number one reason for referral remains emotional support (n=66), followed by transplant assessment clinic (n=38), then symptom control (n=22).

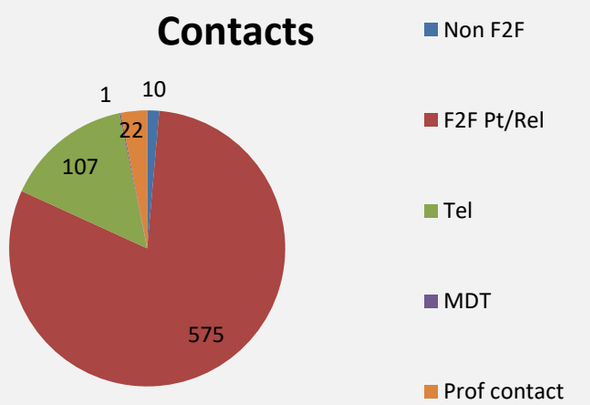
Reason for referral 'last days of life' n = 5.
[ACP (in the chart below) = advanced care planning]

As with earlier reports, this is an extract of some of the compliments from the SPCT Dashboard for Q4 2022/23 which helps to visualise some of the work the team undertake:

• Thank you card from bereaved relative: "for the time she was under your care she was treated with the upmost dignity and respect and this was a comfort for us all knowing she was cared for to such a high standard".

• Email feedback from a CCA Consultant: "Rachel, thanks for your input with ……. - I think your role has been invaluable in this case".

This generated 715 contacts: (N = 625 Oct – Dec 2022)



This pie chart shows a breakdown by type of the 715 contacts for Q4 (Jan to March 2023). The previous quarter (Q3) was 625 contacts.

The highest contact type remains face to face (F2F) at 575 (previous quarter n = 488). The second highest remains telephone at 107 (previous quarter n = 85).

The table below shows the outcomes for Q4. Previous quarter (Q3, 2022/23) discharged n = 110; Deceased n = 13; Ongoing n = 23.

Discharged N = 114	Deceased N = 24	Ongoing (as at 14.4.23) N = 12

Further examples of compliments from the SPCT Dashboard for Q4 2022/23:

- Laudit for Rachel Fernandes - For working a really challenging weekend by herself, staying late both days, and doing some amazing, meaningful work with a number of patients, under very difficult circumstances. And supporting staff whilst she was at it. I hope she is as proud of herself as I am of her, and so very proud to call her a colleague.

- Laudit for Stephen Parish - Stephen is an exemplary member of the SPC team and Royal Papworth Hospital. He works so hard each day, with compassion and humour, providing outstanding supportive and palliative care to our patients. He makes a positive difference in the lives of so many patients and their families, with positive experiences that will stay with them forever.

There have been no complaints this quarter.

Effective: Performance summary

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

		Data Quality	Target	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Dashboard KPIs	Bed Occupancy (excluding CCA and sleep lab)	4	85% (Green 80%90%)	75.5%	70.3%	74.2%	76.4%	77.9%	82.4%
	CCA bed occupancy	4	85% (Green 80%90%)	88.5%	91.4%	85.8%	84.9%	90.9%	92.7%
	Admitted Patient Care (elective and non-elective) exc PP**	4	104% of 19/20 baseline	1911	1813	1722	1881	1761	2188
	Outpatient attendances exc PP**	4	104% of 19/20 baseline	8093	9360	7350	9025	8343	9076
	Cardiac surgery mortality (Crude)*	3	<3%	1.97%	2.15%	2.17%	2.48%	2.85%	2.99%
	Theatre Utilisation	3	85%	75.6%	82.2%	82.6%	82.1%	83.7%	79.4%
	Cath Lab Utilisation 1-6 at New Papworth (including 15 min Turn Around Times)	3	85%	79%	87%	76%	81%	86%	85%
Additional KPIs	Length of stay – Cardiac Elective – CABG (days)	4	8.20	8.71	10.73	7.44	9.45	9.27	8.56
	Length of stay – Cardiac Elective – valves (days)	4	9.70	9.71	8.46	8.30	10.78	11.45	12.11
	CCA length of stay (LOS) (hours) - mean	4	Monitor only	170	161	155	135	240	123
	CCA LOS (hours) - median	4	Monitor only	43	54	47	48	40	43
	Length of Stay – combined (excl. Day cases) days	4	Monitor only	6.39	6.41	7.06	6.06	6.86	5.72
	% Day cases	4	Monitor only	67.14%	68.66%	64.47%	71.4%	68.3%	69.5%
	Same Day Admissions – Cardiac (eligible patients)	4	50%	42.9%	46.8%	43.8%	46.6%	38.4%	32.8%
	Same Day Admissions - Thoracic (eligible patients)	4	40%	39.5%	39.5%	43.9%	40.4%	35.0%	48.9%

Summary of Performance and Key Messages:

Bed occupancy and capacity utilisation:
Critical care bed occupancy increased again in month as a result of high demand for emergency surgery. Ward occupancy has also increased driven by demand and increased length of stay, which reflects increase in acuity

Theatre Activity:
Theatre utilisation improved again reflecting the continued impact of the theatre transformation plan. 235 procedures were delivered in month against a plan of 227, despite 3 days disruption due to industrial action.

Cath Labs:
Cath Lab utilisation remained on target throughout March, although elective throughput was affected by 72 hours of industrial action. This equated to approximately 55 lost cases of elective activity.
Emergency coronary pathways were maintained throughout and saw high volumes of PPCI, Rapid NSTEMI and ACS patients treated (220 cases).

Outpatient Capacity:
Outpatient capacity was up in March by 8.78% from February (a total of 733 appointments) this is in line with an average 31-day calendar month.
Nurses strikes on the 1-3rd March were cancelled so minimal impact – as cancellations had not been processed by bookings prior to strike being cancelled.
Junior Doctors strikes on the 13-16th March only resulted in 47 outpatient appointments being cancelled by Clinical Admin – again very low impact.

Effective: Harm Reviews

Overview

The trusts' Harm Review Policy (DN807) has been subject to review and is currently awaiting final comments before final ratification at Quality and Risk Management Group (QRMG). The amendment proposed is the following:

'For outpatients, those who have waited over 35 and 52 weeks for OP treatment, the responsible consultant will conduct a Harm Review following the appointment at which the patient was treated. This should take place within 4 weeks of the clock stop.

If a patient has come to harm, the responsible consultant will liaise with the operations team for a datix incident to be completed.'

The current plan is for the amended policy to be presented to QRMG in May 2023.

The number of harm reviews to be completed, number completed and number of patients coming to harm will be reported through divisional meetings and upwards through performance reviews to the executive team.

Divisional Updates

Thoracic and Ambulatory

Within 2022/23, 86 harm reviews were carried out within oncology. Three of these were reported as possible harm and a datix incident was completed. On further investigation, it has been established that the patients did not come to harm.

Harm reviews within the remainder of the division have not routinely been carried out and will be carried out and monitored as of 1 May 2023.

One harm review has been completed recently within RSSC which shows the patient has come to harm and needs to be completed through the datix incident reporting process.

Cardiology

Within 2022/23, 6 RCA and 4 harm reviews were carried out on patients who breached the 52 week threshold. On investigation, it was established that none of these patients came to harm through delays to treatment.

The majority of patient pathways within Cardiology are held by referring District General Hospitals and are inherited by RPH for purposes of treatment only. These patients tend to be reviewed only at the point of treatment and are discharged directly to the care of their local unit for follow-up.

The division has experienced a growing number of patients being referred later in their pathway and would be reliant on the referring hospital to highlight harm caused by delays to care at the point of referral. Ongoing concerns of harm would be escalated from the referring centre through requests to expedite treatment or conversion to acute treatment at which point this would trigger a secondary harm review by the RPH team.

Surgery, Transplant and Anaesthetics

Within surgery the completion of harm reviews has not been routinely performed. Within the 2022/23 period 217 patients met the criteria for a harm review. There is disparity with the data this is being reviewed by BI.

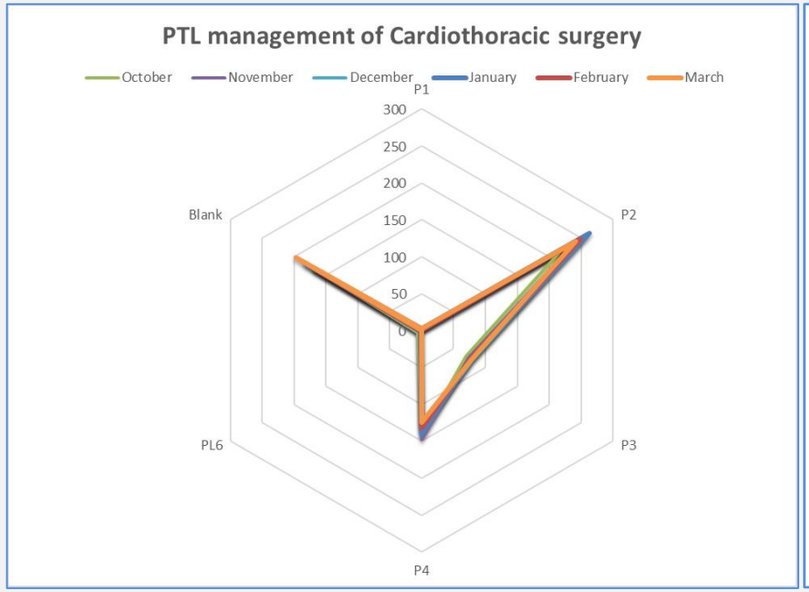
Currently there are 59 patients on the PTL that require a harm review; 50 over 35 weeks (of which 2 completed) and 9 over 52 weeks. Of which none completed.

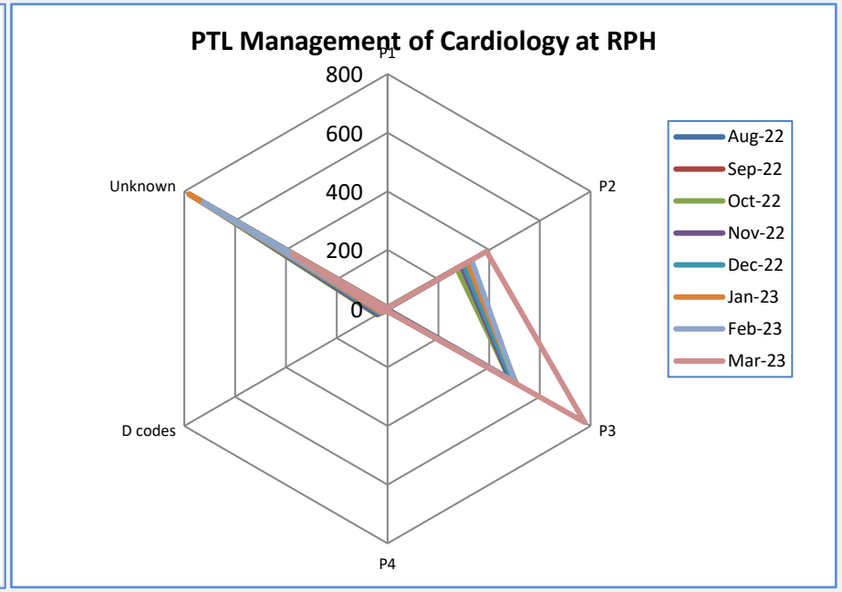
Patients escalated to surgery via their GP or cardiology will have their treatment expedited if appropriate, a growing number transfer to the IHU pathway.

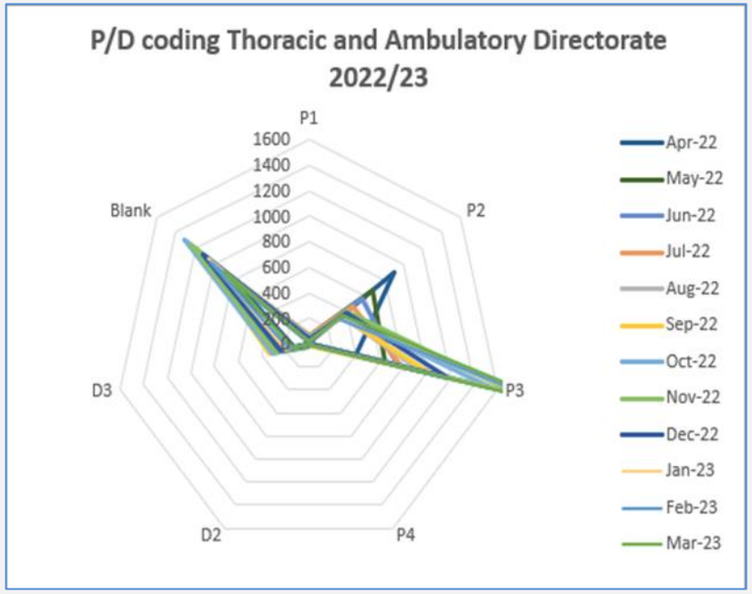
Immediate actions will be:

- Recirculate harm review procedure to surgeons with a list of patients that require this documentation
- Weekly monitoring at the directorate pre-PTL meeting
- Report to the business unit meeting monthly

Effective: Spotlight on: Priority Status Management







Cardiothoracic Surgery Waiting List Profile

↑ 643 patients on the waiting list (from 627)
↑ 232 patients over 18 weeks (from 212)
↑ 9 patients over 52 weeks (from 7)
↓ RTT performance 64.69% (from 65.89%)

Over 18 weeks
92 - patients with Planned or booked dates
16 – patients with outpatient/Diagnostics appointment
72 – patients awaiting surgery date (42xP2, 24xP3, 6xP4)
53 – patients awaiting Administrative update

Cardiology Waiting List Profile

↓ 1571 patients on the waiting list (from 1586)
↑ 346 patients over 18 weeks (from 327)
↑ 1 patients over 52 weeks (from 0)
↓ RTT performance 74.76% (from 79.43%)

Over 18 weeks
85 - patients with Planned or booked dates
45 – patients with outpatient/Diagnostics appointment
137 – patients awaiting surgery date
30 – patients awaiting outpatient review
15 – patients awaiting Administrative update
34 – patients with data quality issue now resolved

Respiratory Waiting List Profile March

↓ 3541 patients on the waiting list
↓ 849 patients waiting over18 weeks
↑ 5 over 52 weeks
↑ 69.91% RTT performance

Over 30 weeks:
45 Continuous Positive Airway Pressure Starters
51 Polysomnograpy
80 Outpatients
2 Respiratory polygraphy
80 Awaiting Clinical Decision
12 Day case
42 Community Sleep Service

Responsive: Performance summary

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

		Data Quality	Target	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Dashboard KPIs	% diagnostics w aiting less than 6 w eeks	3	>99%	98.79%	99.22%	99.28%	98.22%	98.66%	98.36%
	18 w eeks RTT (combined)	5	92%	74.10%	74.10%	70.60%	72.07%	72.72%	70.87%
	Number of patients on w aiting list	5	3,279	5691	5876	5657	5690	5674	5859
	52 w eek RTT breaches	5	0	2	8	13	14	8	13
	62 days cancer w aits post re-allocation (new 38 day IPT rules from Jul18)*	4	85%	40.0%	57.0%	50.0%	40.0%	57.0%	50.0%
	31 days cancer w aits*	4	96%	78.0%	90.0%	89.0%	95.0%	100.0%	100.0%
	104 days cancer w ait breaches*	4	0	14	9	10	3	3	4
	Theatre cancellations in month	3	30	34	21	37	25	28	31
	% of IHU surgery performed < 7 days of medically fit for surgery	4	95%	53.00%	36.00%	60.00%	83.00%	88.00%	73.00%
	Acute Coronary Syndrome 3 day transfer %	4	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Additional KPIs	18 w eeks RTT (cardiology)	5	92%	80.09%	81.68%	81.16%	80.71%	79.43%	74.98%
	18 w eeks RTT (Cardiac surgery)	5	92%	71.69%	70.53%	64.98%	66.62%	66.26%	67.86%
	18 w eeks RTT (Respiratory)	5	92%	72.05%	71.50%	67.04%	69.30%	70.95%	69.51%
	Non RTT open pathw ay total	2	Monitor only	40,854	41,421	41,803	42,248	42,785	43,331
	Other urgent Cardiology transfer w ithin 5 days %	4	90%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	% patients rebooked w ithin 28 days of last minute cancellation	4	100%	80.00%	84.21%	81.82%	80.00%	66.67%	80.00%
	Outpatient DNA rate	4	9%	6.23%	6.32%	8.01%	7.64%	7.25%	7.47%
	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%	63.00%	44.00%	80.00%	89.00%	94.00%	90.00%
	% of patients treated w ithin the time frame of priority status	4	Monitor only	41.5%	45.7%	51.0%	47.2%	45.9%	46.1%
	% of patients on an open elective access plan that have gone by the suggested time frame of their priority status	4	Monitor only	49.1%	51.4%	45.9%	50.9%	50.3%	49.9%

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

Summary of Performance and Key Messages:

62 day patients - 11 patients treated of who 10 breached. 5 patients breached due to late referrals. One patient was treated on day 72 but waited 15 days for clinic and 21 days for surgery, another patient breached as they refused the first surgical date, another patient treated on day 76 as first surgical date was cancelled and another patient treated on day 75 who had an 11 day delay to clinic and 16 day delay to surgery.

Upgraded patients -7 patients have been treated on the upgraded pathway with one breach -the patient was treated on day 69, the delays were referral on day 36 day and a further 20 day delay for surgery.

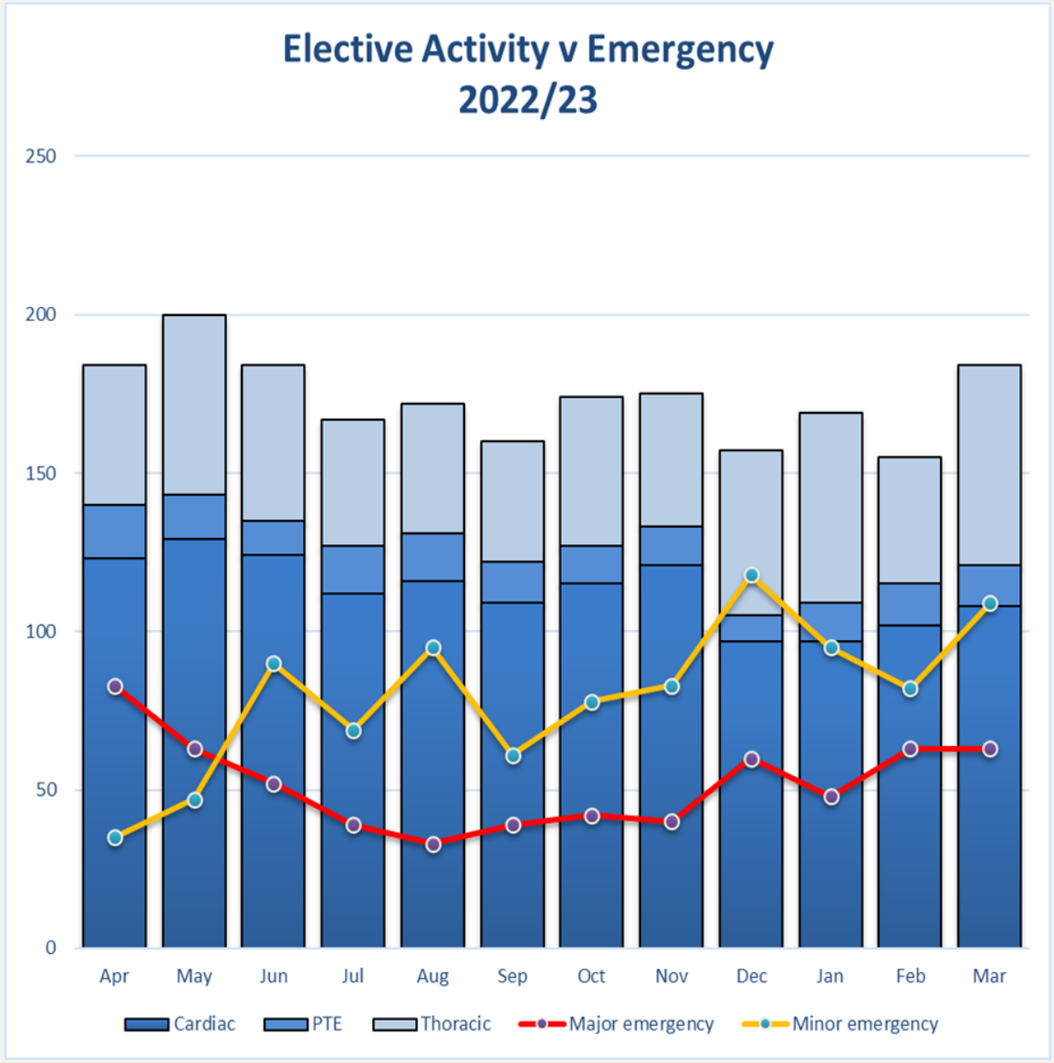
104 days- There were 4 patients over 3 were due to late referrals the other 63 days in diagnostic phase of pathway. 20 day delay for clinic availability. 22 day delay for surgery.

ACS 3 day transfer – There were 18 patients who were unable to be transferred in the 3 day window under the ACS service in March. This was related to flow pressures throughout the Cardiology bed base linked to rising numbers of IHU patients awaiting surgery.

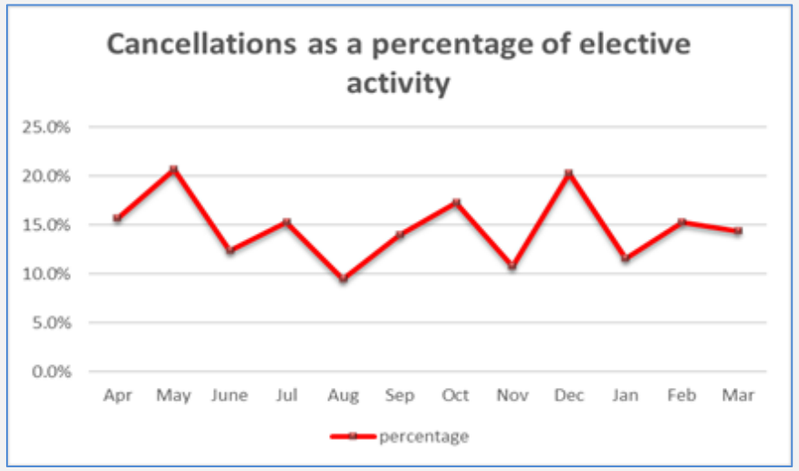
Diagnostic performance

Diagnostic performance was slightly lower in month and is marginally below the national standard.

Responsive: Performance summary



Cancellation reason	Mar-23	Total
1c Patient unfit	4	104
1d Sub optimal work up	1	25
2a All CCA beds full with CCA patients	3	42
2b No ward bed available to accept transfer from CCA	2	17
2d No ward bed available	3	4
3a Critical Care	2	149
3b Theatre Staff	2	20
3e Other	1	1
4a Emergency took time	4	90
4b Transplant took time	3	37
4d Additional urgent case added and took slot	1	64
5a Planned case overran	4	108
5c Overruns delayed start	1	1
Total	31	750



108 Cardiac (51 IHU) 63 Thoracic /13 PTE / 9 TX activity

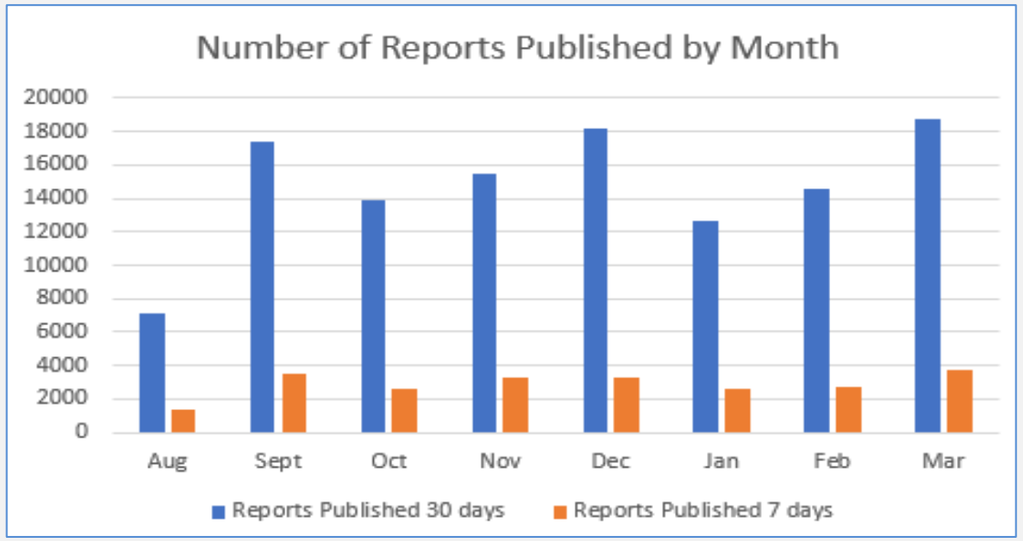
63 emergency/urgent procedures went through theatres – combination of transplants, returns to theatre and emergency explorations.

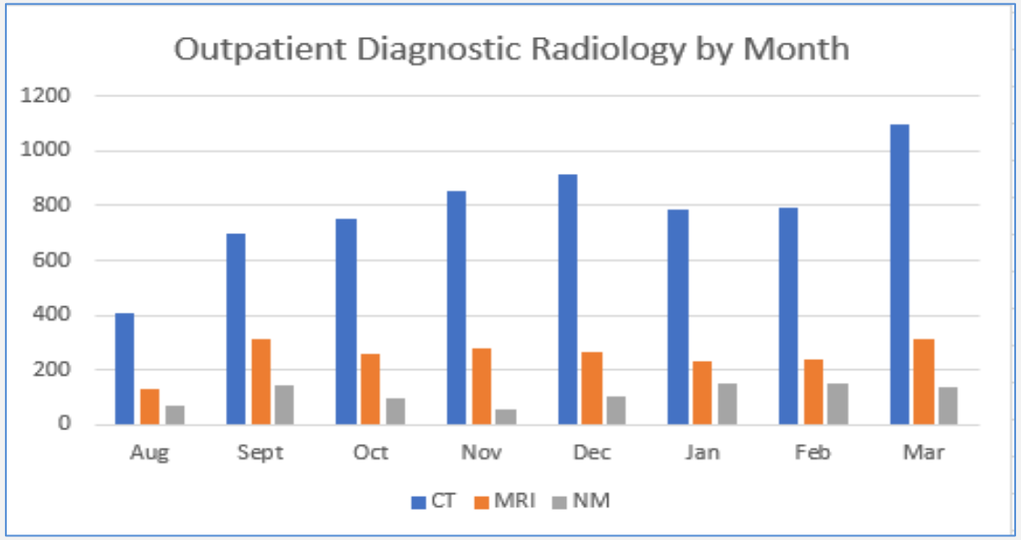
109 additional emergency minor procedures also went through theatre and critical care, utilising the theatre team.

Both Cardiac and Thoracic activity increased in March, which was promising – with cardiac supporting 51 IHU cases as part of that number.

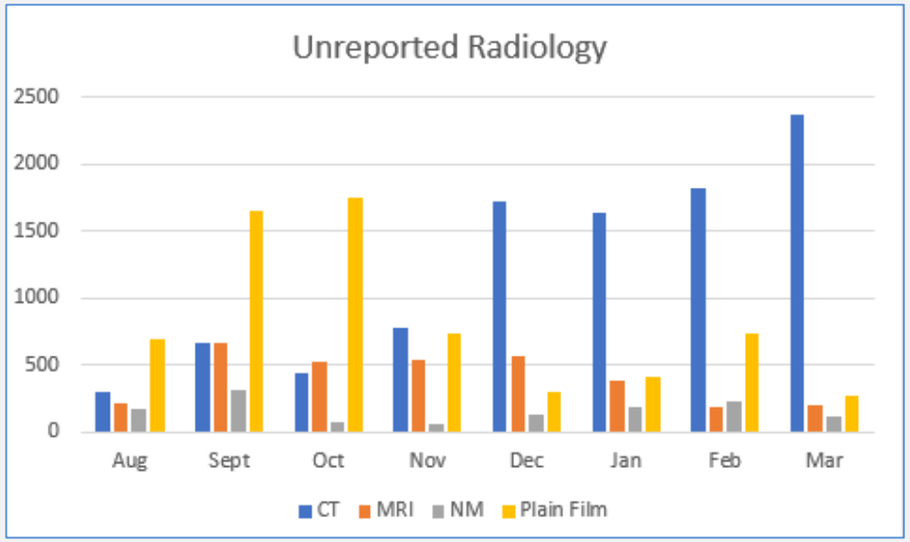
Cancellations increased marginally with Emergencies and Overruns once again being the main cause, along with patient unfit. There was a total of 63 major emergencies that went through Theatre with an additional 109 minor emergencies.

Responsive: Spotlight on: Radiology Reporting 2022/23





- PACS Implementation July 2022, data gathering commenced Aug 2022
- Digital connections have continued to be problematic due to reduced speed for image access and VPN issues for home reporting
- Significantly positive reduction in plain film unreported scans (now routinely within 24-48 hours)
- Significant increase in CT unreported scans, but corresponding increase in CT scans undertaken
- Numbers of reports published by month also continues to increase
- Consultant job plans under review during this time to ascertain shortfall in reporting time
- Priority for reporting continues to be given to inpatients clinically unwell, patients for MDT and those on quick pathways such as oncology & transplant



People, Management & Culture: Performance summary

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

		Data Quality	Target	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Dashboard KPIs	Voluntary Turnover %	3	14.0%	19.70%	11.35%	10.45%	13.90%	7.07%	13.16%
	Vacancy rate as % of budget	4	5.00%	14.29%	14.08%	14.33%	13.85%	12.72%	12.16%
	% of staff with a current IPR	3	90%	73.06%	73.12%	74.38%	75.63%	77.67%	78.83%
	% Medical Appraisals	3	90%	75.22%	72.81%	78.07%	75.65%	72.41%	74.14%
	Mandatory training %	3	90.00%	86.35%	85.37%	84.92%	84.65%	84.32%	85.50%
	% sickness absence	3	3.5%	5.35%	4.86%	5.43%	5.32%	4.05%	4.14%
Additional KPIs	FFT – recommend as place to work	3	70.0%	n/a	n/a	n/a	n/a	58.90%	n/a
	FFT – recommend as place for treatment	3	90%	n/a	n/a	n/a	n/a	85.00%	n/a
	Registered nursing vacancy rate (including pre-registered nurses)	3	5.00%	13.62%	13.79%	13.38%	12.04%	11.91%	11.69%
	Unregistered nursing vacancies excluding pre-registered nurses (% total establishment)	3	10.00%	21.06%	18.84%	19.77%	16.11%	13.02%	12.76%
	Long term sickness absence %	3	0.80%	1.77%	2.07%	1.91%	2.23%	1.54%	1.44%
	Short term sickness absence	3	2.70%	3.58%	2.78%	3.52%	3.08%	2.51%	2.69%
	Agency Usage (wte) Monitor only	3	Monitor only	28.9	28.6	24.0	24.8	25.5	34.6
	Bank Usage (wte) monitor only	3	Monitor only	57.4	59.4	62.1	70.2	63.2	70.4
	Overtime usage (wte) monitor only	3	Monitor only	48.6	47.8	41.0	55.4	65.6	75.0
	Agency spend as % of salary bill	5	1.37%	1.57%	1.98%	1.77%	1.81%	2.57%	1.29%
	Bank spend as % of salary bill	5	1.97%	2.32%	1.88%	2.10%	2.07%	2.06%	1.28%
	% of rosters published 6 weeks in advance	3	Monitor only	51.50%	23.50%	41.20%	35.30%	30.30%	63.60%
	Compliance with headroom for rosters	3	Monitor only	31.80%	30.70%	34.50%	31.20%	35.00%	35.40%
	Band 5 % White background: % BAME background	3	Monitor only	n/a	n/a	53.62% : 45.06%	n/a	n/a	55.65% : 42.92%
	Band 6 % White background: % BAME background	3	Monitor only	n/a	n/a	70.72% : 28.57%	n/a	n/a	68.87% : 30.46%
	Band 7 % White background % BAME background	3	Monitor only	n/a	n/a	82.13% : 15.36%	n/a	n/a	81.98% : 15.90%
	Band 8a % White background % BAME background	3	Monitor only	n/a	n/a	84.91% : 13.21%	n/a	n/a	85.42% : 13.54%
	Band 8b % White background % BAME background	3	Monitor only	n/a	n/a	92.31% : 3.85%	n/a	n/a	88.46% : 7.69%
	Band 8c % White background % BAME background	3	Monitor only	n/a	n/a	100% : 0%	n/a	n/a	93.75% : 6.25%
	Band 8d % White background % BAME background	3	Monitor only	n/a	n/a	100% : 0%	n/a	n/a	100% : 0%

Summary of Performance and Key Messages:

- Turnover remained below KPI at 13.2%. The 22/23 average turnover was 15.2% against our target of 14%. There were 21.56 wte non-medical leavers in month. The nursing staff group had the most leavers in month (11.04 wte) and HCSW's were the next most prevalent group of leavers (5.65wte). The most common reasons given for leaving were health, retirement, promotion and relocation.

- Total Trust vacancy rate reduced to 12.2% and registered nurse vacancy rate reduced marginally to 11.7%. Level 5, Surgical Wards, continues to have the highest % vacancy rates with no improvement over the last 6 months. They have 12 recruits in the pipeline, which is an increase from the previous month. 5 of these have anticipated start dates in April and May with the remainder going through the pre-employment checking process.

- The Unregistered Nurse vacancy rate continued to improve to 12.8% but remains above the KPI of 10%. There has been a steady reduction in Unregistered Nurse vacancy rates over the last year which is as a result of proactive attraction and recruitment with the support of the Nurse Recruitment team.

- Total sickness absence remained over the KPI at 4.1%. Workforce Business Partners are working with line managers to review sickness absence management processes.

- We saw a further improvement in the IPR compliance rate to 78.8%. The clinical divisions have developed improvement plans that set out their trajectories for ensuring that at least 90% of staff have had an appraisal in the last 12 months. Cardiology and Respiratory Divisions are making good progress against their improvement plans. STA Division are not seeing significant improvement and have been asked to review their plans and consider that further actions need to be taken to support an improvement. The Appraisal Procedure has being revised to incorporate the Trusts values and behaviours and to streamline the process and paperwork. Training in the revised process is being delivered and we are encouraging all appraisers to undertake this training. We commenced face to face skills training in February and have been promoting this in the communications with managers.

- Temporary staffing usage increased in March. This usage is linked to high vacancy rates and sickness rates in some departments. Critical Care had high usage of overtime linked to annual leave management.

- Compliance with the roster approval improved to 63.6%. 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. Headroom remains high and over KPI. This is linked to higher than KPI sickness and parental absence rates and specialling requirements.

People, Management & Culture : Key performance challenges

Escalated performance challenges:

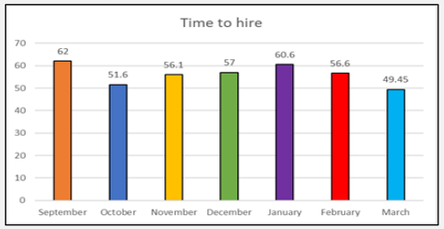
- Staff health and wellbeing continuing to be impacted by the after effect of the pandemic and high levels of vacancies leading to fatigue, higher levels of sickness absence, turnover and lower levels of staff engagement.
- Increasing turnover and vacancy rates as the labour market both locally and nationally 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:

Time to Hire:



There has been an improvement in time to hire in March as a result of the continuing focus on streamlining processes. The KPI is 48 days.

Recruitment Update:

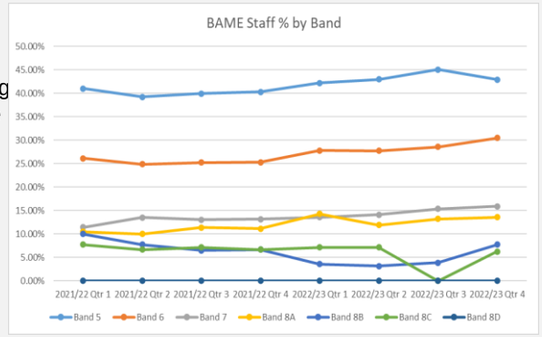
Band 5 Nurses:52 Nurses remain in the pipeline – 25 of these are overseas nurses
11 nurses are booked for the 24th April induction to date
Band 2 Healthcare support workers: 23 Healthcare support workers remain in the pipeline
5 HCSW is booked for 24th April induction to date
All other: 54 candidates remain in the pipeline plus 32 internal candidates and a further 7 for temporary staffing. 15 are booked for 24th April induction to date

Our next recruitment event is the 22nd April. We are celebrating respiratory areas and will use this as the focal point to advertise the Trust and what we do. We will be interviewing for registered nurses and ODPs for all areas.

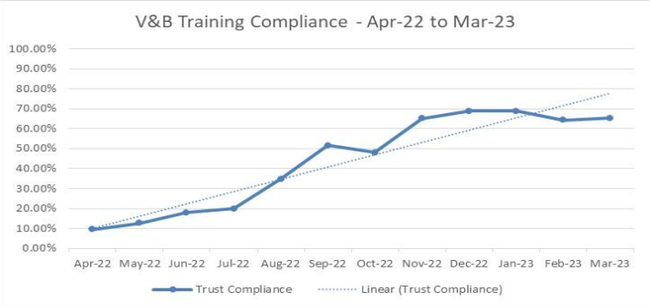
We have a goal of recruiting 35 overseas nurses in 23/24. We will be starting these recruits in small cohorts so not to overwhelm clinical areas and training capacity. We continue to have a 100% pass rate (by second attempt) for overseas nurses in completing their OSCE exams.

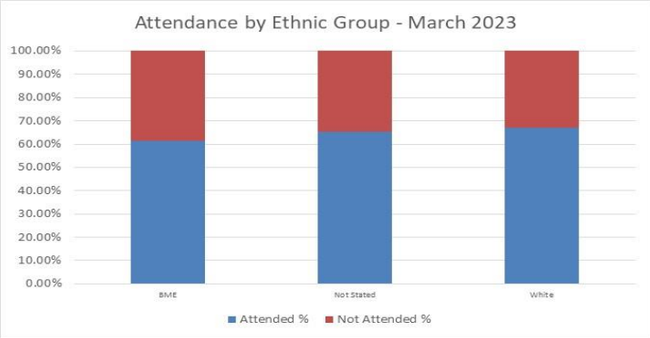
Profile of Workforce by Ethnicity:

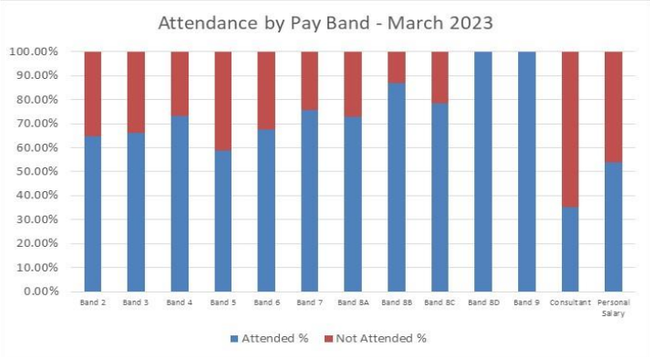
Looking at the quarterly data on the % of staff from a BAME background by band we are seeing small improvements in representation at a more senior level although representation at the most senior level is still lacking and the rate of improvement is slow.



People, Management & Culture : Values and Behaviour Workshops



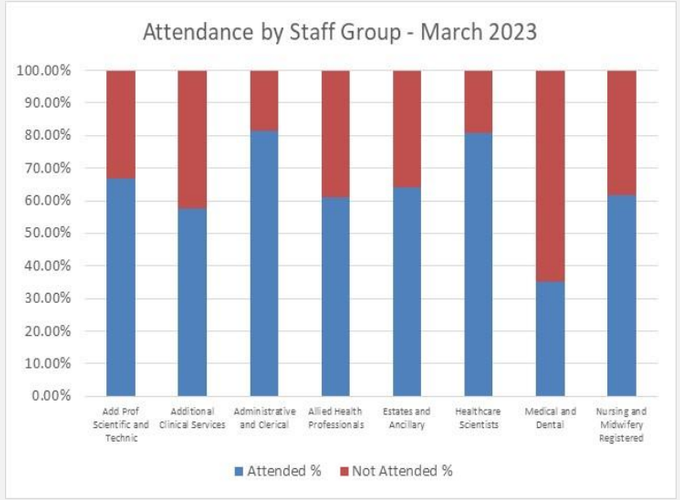


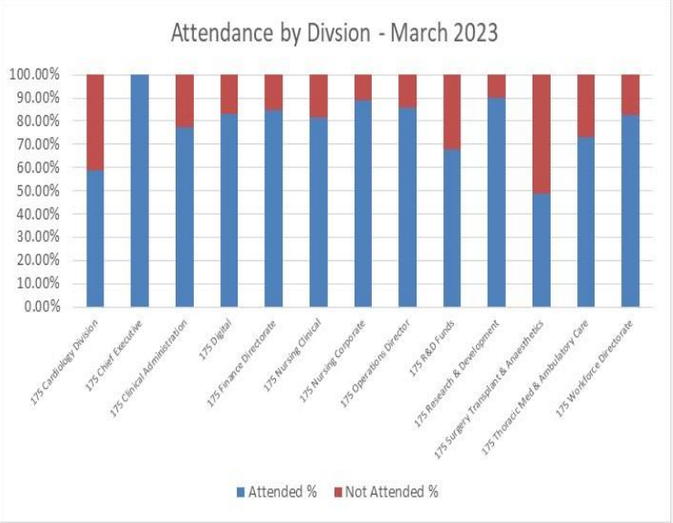


As part of the work to embed our revised values and behaviours we developed a 2.5 hour workshop for all staff. This workshop focused on what the values meant, the behaviours that underpinned these values and how to give and receive feedback. We launched the workshops in April 22 and set an aspiration that 90% of staff attend a workshop by December 2022. We developed a session that is now delivered as part of the corporate induction. Promoting the workshops has been a focus of corporate communication over the last year.

The chart to the right provides an overview of attendance as a proportion of the workforce. Junior doctors and temporary staff are excluded from the denominator. We reduced the number of sessions being run every month from January 2023 in order to make best use of training capacity. The workshops have experienced high levels of DNAs as over the last year we have experienced higher than usual sickness absence and a number of areas have experienced high vacancy rates both of have lead to difficulties releasing staff.

A lower % of staff from a BAME background have attended that white colleagues. This may be because a lower % of Band 5 have attended that other bands. This lower attendance of Band 5s will be as a result of the impact of sickness and vacancy rates in releasing staff as Registered Nurses make up a significant proportion of the Band 5 workforce.





Despite lots of effort we have struggled to engage senior medical colleagues with the workshops and this is reflected in the low % of consultant staff who have attended a workshop. We have offered options such as a trainer attending team meetings and this has been taken up by a few teams.

The Division with lowest attendance is STA. This is the Division with the least positive staff survey feedback. A number of the departments have high vacancy and sickness rates which would make it difficult for staff to be released to attend.

As we move forward with this programme into 2023/24 we will continue to encourage attendance on courses in Q1 to ensure that all existing employees have undertaken the training and we will take a targeted approach to those staff groups and teams that are finding it difficult to release staff to train to find a way to provide this training to them in a way that works for them.

As we move forward beyond Q1 this training will move into our business as usual programme and will be available on demand throughout the year.

Finance: Performance summary

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

		Data Quality	Target	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Dashboard KPIs	Year to date surplus/(deficit) exc land sale £000s	5	£(532)k	£2,821k	£2,876k	£3,269k	£2,660k	£1,643k	£498k
	Cash Position at month end £000s	5	£60,956k	£67,645k	£67,720k	£66,873k	£67,756k	£74,620k	£67,319k
	Capital Expenditure YTD £000s	5	£4113 YTD	£1,083k	£1,220k	£1,431k	£2,254k	£2,627k	£4,026k
	In month Clinical Income £000s*	5	£21913k (current month)	£21,808k	£21,814k	£21,626k	£20,564k	£19,193k	£26,396k
	CIP – actual achievement YTD - £000s	4	£5,800k	£3,710k	£4,760k	£5,650k	£6,200k	£6,900k	£7,515k
	CIP – Target identified YTD £000s	4	£5800k	£5,800k	£5,800k	£5,800k	£5,800k	£5,800k	£5,800k
Additional KPIs	NHS Debtors > 90 days overdue	5	15%	55.9%	4.4%	3.9%	4.1%	29.2%	10.3%
	Non NHS Debtors > 90 days overdue	5	15%	23.9%	35.5%	34.6%	36.3%	31.0%	22.9%
	Capital Service Rating	5	4	3	3	3	2	4	4
	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	£12,838k	£14,242k	£15,915k	£16,611k	£16,890k	£17,270k
	Use of Resources rating	5	Monitor only	n/a	n/a	n/a	n/a	n/a	n/a
	Total debt £000s	5	Monitor only	£4,768k	£7,091k	£7,395k	£7,053k	£3,151k	£4,257k
	Better payment practice code compliance - NHS (YTD)	5	Monitor only	87%	89%	89%	90%	91%	92%
	Better payment practice code compliance - Non NHS (YTD)	5	Monitor only	94%	94%	94%	95%	95%	95%

Summary of Performance and Key Messages:

- **In month 12, The Trust reported a deficit of £1.1m taking the final YTD position to a surplus of £1.2m against a breakeven plan for the year.**
- **The YTD position includes the continuation of the national funding arrangements including** ERF income for NHSE and Cambridgeshire & Peterborough ICB (C&P) of c£5.1m. Contracts with other commissioners do not allow ERF to be earned, however this adverse variance is offset by changes in the NHSE and C&P ERF values, including updates to reflect national uplifts for the pay award and inflation.
- **The Trust did not achieve the national activity targets**. Elective activity was below 2019/20 levels on average, and is below the national target. Day case activity has shown a stronger recovery and despite improvements in recent movements, surgical capacity remains a constraining factor for elective inpatient activity.
- **System support:** the YTD income position includes a re-allocation £3.8m to support delivery of an ICS wide breakeven and £2.3m to support health inequalities work programmes in the system.
- **The in month position includes national non-recurrent adjustments** for 6.3% centrally funded additional pension contribution, AfC non consolidated pay offer (per national guidance), CUHP invoices and DHSC donated PPE. The impact of the donated assets is removed in the adjusted financial performance bottom line, in line with national guidance.
- **The underlying pay run rate remains broadly stable as the Trust continues to carry a number of vacancies.** Included in the YTD position is the band 2 to band 3 provision including anticipated back pay (c£1.5m); thank you payments to staff employed by the Trust (£0.4m), the costs of the CCL programme (c£0.2m) and the nationally required accrual for AfC pay award (£3.9m) and the additional 6.3% pension contribution (c£4.6m).
- **Non-pay spend in month includes** Cambridge university Health Partner (CUHP) contributions (£0.8m), DHSC PPE stock (0.4m), reduction in the fair value of assets resulting in impairment (£0.2m), utilities accrual (£0.3m) and other movements. The YTD position includes R&D grant to University of Cambridge (c£2.5m); staff support scheme (c£1.0m); VAD stock obsoletion write offs (£0.4m); dilapidation provisions (£0.2m); DCD (£0.6m), and HLRI expenditure (£0.4m) offset by same value of income recharged to UoC.
- **The cash position closed at £67.3m.** This represents a reduction of £7.3m from the previous month due to a number of larger one off payments (UoC grant - £2.5m, System contribution clawback - £2m) coupled with higher supplier payments.
- **The final YTD spend was £0.1m below plan excluding IFRS 16 impacts.** March total includes the purchase of the surgical robot for £1.0m.

Finance: Key Performance – Year to date SOCI position

The YTD position is c£1.2m 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); a grant payment to the UoC (£2.5m); system support (£3.8m), Health Inequalities contribution (£2.3m), CUHP contribution (£0.8m), unfunded pay award (£0.3m). The position also includes the national 6.3% pension contribution £4.6m and Pay award £3.6m (pay and income) which has no impact on the Trust's bottom line.

	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	£160,147	£141,274	£0	£2,000	£143,274	(£16,874)	
Balance to block payment -activity only	£0	£20,050	£0	£0	£20,050	£20,050	
Homecare Pharmacy Income	£49,837	£47,361	£0	£0	£47,361	(£2,476)	
Drugs and Devices - cost and volume	£15,016	£17,675	£0	£0	£17,675	£2,658	
Balance to block payment - drugs and devices	£0	(£1,082)	£0	£0	(£1,082)	(£1,082)	
Sub-total	**£225,000**	**£225,277**	**£0**	**£2,000**	**£227,277**	**£2,277**	
Clinical income - Outside of national block framework							
Drugs & Devices	£1,203	£2,126	£0	£0	£2,126	£923	
Other clinical income	£2,874	£2,586	£0	£3,969	£6,555	£3,681	
Private patients	£9,144	£8,341	£0	£0	£8,341	(£803)	
Sub-total	**£13,221**	**£13,053**	**£0**	**£3,969**	**£17,022**	**£3,801**	
Total clinical income	**£238,222**	**£238,330**	**£0**	**£5,969**	**£244,299**	**£6,078**	
Other operating income							
Covid-19 funding and ERF	£5,925	£0	£1,319	£5,048	£6,367	£442	
Top-up funding	£16,739	£18,536	£0	(£6,001)	£12,535	(£4,204)	
Other operating income	£15,497	£17,381	£0	£5,320	£22,701	£7,203	
ERF provision *	£0	£0	£0	£0	£0	£0	
Total operating income	**£38,161**	**£35,917**	**£1,319**	**£4,367**	**£41,603**	**£3,441**	
Total income	**£276,383**	**£274,247**	**£1,319**	**£10,336**	**£285,902**	**£9,519**	
Pay expenditure							
Substantive *	(£118,883)	(£113,838)	£15	(£10,155)	(£123,862)	(£4,979)	
Bank	(£2,414)	(£2,390)	(£28)	£0	(£2,418)	(£3)	
Agency	(£1,747)	(£2,380)	£0	£0	(£2,380)	(£633)	
Sub-total	**(£123,045)**	**(£118,609)**	**(£12)**	**(£10,155)**	**(£128,660)**	**(£5,615)**	
Non-pay expenditure							
Clinical supplies *	(£44,543)	(£45,591)	(£37)	£584	(£45,044)	(£501)	
Drugs	(£7,253)	(£5,537)	(£0)	£0	(£5,537)	£1,716	
Homecare Pharmacy Drugs	(£50,000)	(£45,855)	£0	£0	(£45,855)	£4,145	
Non-clinical supplies *	(£34,208)	(£37,188)	(£625)	(£5,670)	(£43,483)	(£9,275)	
Depreciation (excluding Donated Assets)	(£10,295)	(£10,291)	£0	£0	(£10,291)	£3	
Depreciation (Donated Assets)	(£532)	(£547)	£0	£0	(£547)	(£15)	
Sub-total	**(£146,831)**	**(£145,009)**	**(£662)**	**(£5,086)**	**(£150,757)**	**(£3,927)**	
Total operating expenditure	**(£269,875)**	**(£263,618)**	**(£674)**	**(£15,241)**	**(£279,417)**	**(£9,542)**	
Finance costs							
Finance income	£1	£1,577	£0	£0	£1,577	£1,577	
Finance costs	(£5,225)	(£5,459)	£0	£0	(£5,459)	(£234)	
PDC dividend	(£1,816)	(£1,947)	£0	£0	(£1,947)	(£131)	
Revaluations/(Impairments)	£0	(£156)	£0	£0	(£156)	(£156)	
Gains/(losses) on disposals	£0	(£2)	£0	£0	(£2)	(£2)	
Sub-total	**(£7,040)**	**(£5,987)**	**£0**	**£0**	**(£5,987)**	**£1,053**	
Surplus/(Deficit) including central funding	**(£532)**	**£4,643**	**£644**	**(£4,905)**	**£498**	**£1,030**	
Adjusted financial performance surplus/(deficit)	**£0**	**£5,354**	**£644**	**(£4,905)**	**£1,205**	**£1,210**	

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

* Adjusted for CIP plan alignment

YTD month headlines:

1 Clinical income is c£6.1m favourable to plan

- Income from contract activity on a PbR basis is below block funding levels by £16.9m; this is mainly due to surgical activity underperformance. 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. YTD Homecare includes a net benefit of c£1.7m due to income received on block offset by reduced expenditure linked to activity. YTD also includes national uplifts for the pay award £3.6m and IFRS 16 revenue support £0.2m

2 Other operating income is favourable to plan by £3.4m. ERF includes 100% achievement for NHSE and C&P only. The inability to achieve ERF on associate contracts is mitigated by additional ERF funding from NHSE and C&P, linked to the pay award and inflation. The YTD income includes 6.3% pension contribution £4.6m, DHSC PPE income £0.3m, higher accommodation income due to occupancy, charitable recharges, training income due to invoice based on up to date schedule from HEE and HLRI income £0.4m (offset in expenditure) offset by Health Inequalities payment (£2.3m) and system contribution (3.8m)

3 Pay expenditure is unfavourable to plan by £5.6m. This includes pay award and additional 6.3% pension contribution, 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 (£0.4m) for overseas nurses and junior doctors. These are offset by underlying vacancies.

4 Clinical Supplies is unfavourable to plan by £0.5m. This includes DHSC PPE stock, higher than planned DCD activity and other high value device usage (offset in income).

5 Total drugs spend is favourable to plan by £5.8m. £1.7m 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 £9.3m driven by the recognition for grant to UoC (£2.5m); contribution to CUHP (£0.8m), 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); DCD provisions (£0.6m); COVID costs in relation to ongoing spend on estates and facilities schemes (£0.7m),impairment (£0.2m), utility accruals, 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	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Comments
Additional KPIs	**Elective activity as % 19/20 (ICB)**	3	Monitor only	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**0.0%**	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	85.7%	70.6%	83.9%	77.8%	24.9%	0.0%	
	Non Elective activity as % 19/20 (ICB)	3	Monitor only	**99.6%**	**104.1%**	**94.4%**	**100.2%**	**96.3%**	**0.0%**	Latest data to w/e 12/03/23
	Papworth - Non NHS Elective activity as % 19/20 baseline plan*	4	Monitor only	86.0%	91.8%	98.8%	84.8%	133.0%	0.0%	
	Day Case activity as % 19/20 (ICB)	3	Monitor only	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**0.0%**	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	92.8%	86.1%	85.6%	99.3%	92.8%	0.0%	
	Outpatient - First activity as % 19/20 (ICB)	3	Monitor only	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**0.0%**	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	102.5%	115.9%	109.7%	108.3%	110.5%	0.0%	
	Outpatient - Follow Up activity as % 19/20 (ICB)	3	Monitor only	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**0.0%**	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	105.3%	111.7%	105.0%	110.0%	108.4%	0.0%	
	Virtual clinics – % of all outpatient attendances that are virtual (ICB)	3	Monitor only	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**0.0%**	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	15.2%	16.2%	15.7%	17.0%	15.6%	0.0%	
	Diagnostics < 6 weeks % (ICB)	3	Monitor only	**58.3%**	**59.3%**	**52.4%**	**56.7%**	**57.6%**	**0.0%**	Latest data to Jan 23
	Papworth - % diagnostics waiting less than 6 weeks	3	99%	98.8%	99.2%	99.3%	98.2%	98.7%	0.0%	
	18 week wait % (ICB)	3	Monitor only	**57.9%**	**58.1%**	**56.2%**	**56.2%**	**56.6%**	**0.0%**	RTT Metrics comprise CUHFT & NWAFT & RPH to w/e 05/03/23
	Papworth - 18 weeks RTT (combined)	5	92%	74.1%	74.1%	70.6%	72.1%	72.7%	69.8%	
	No of waiters > 52 weeks (ICB)	3	Monitor only	**8,935**	**8,597**	**8,310**	**8,003**	**7,786**	**0**	RTT Metrics comprise CUHFT & NWAFT & RPH to w/e 05/03/23
	Papworth - 52 week RTT breaches	5	0%	2	8	13	14	8	17	
	Cancer - 2 weeks % (ICB)	3	Monitor only	**58.3%**	**64.9%**	**59.1%**	**62.2%**	**68.8%**	**0.0%**	Latest Cancer Performance Metrics available are Jan 2023
	Cancer - 62 days wait % (ICB)	3	Monitor only	**52.3%**	**48.4%**	**61.2%**	**61.2%**	**48.9%**	**0.0%**	Latest Cancer Performance Metrics available are Jan 2023
	Papworth - 62 Day Wait for 1st Treatment including re-allocations	4	85%	33.3%	75.0%	50.0%	40.0%	57.0%	0.0%	
	Finance – bottom line position (ICB)	3	Monitor only	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**£m**	Latest ICB financial position to August 22 YTD (M05)
	Papworth - Year to date surplus/(deficit) exc land sale £000s	5	£(532)k	£2,821k	£2,876k	£3,269k	£2,660k	£1,643k	£0k	
	Staff absences % C&P (ICB)	3	Monitor only	**3.9%**	**4.3%**	**4.4%**	**3.1%**	**n/a**	**0.0%**	Latest data to w/e 12/02/23. Due to discrepancy issue ICS caanot cannot supply this data for Feb-23
	Papworth - % sickness absence	3	3.5%	5.4%	4.9%	5.4%	5.3%	4.1%	0.0%	

* - figures above are from SUS and represent all activity

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.