

Board of Directors

Item 5.2

Subject: CQC Insight Report Update (March 2022)
Date of Meeting: Tuesday 31st May 2022
Prepared by: Michael Filek, Head of Improvement and Transformation
Presented by: Karan Wheatcroft, Director of Risk and Improvement
Purpose of Report: To Note

BAF Ref	Impact on BAF
All	The report contributes to the assurances received by the Board in respect of continued CQC compliance.

Level of assurance (please tick one)

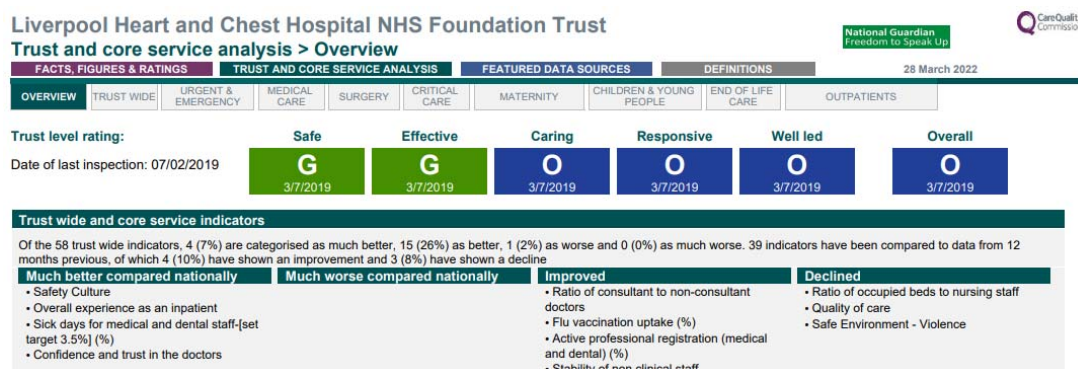
To be used when the content of the report provides evidence of assurance

<input checked="" type="checkbox"/>	Acceptable assurance Controls are suitably designed, with evidence of them being consistently applied and effective in practice	<input type="checkbox"/>	Partial assurance Controls are still maturing – evidence shows that further action is required to improve their effectiveness	<input type="checkbox"/>	Low assurance Evidence indicates poor effectiveness of controls
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1. Executive Summary

The CQC publishes its Insights report bimonthly. The Insight report draws together data from various sources and timeframes. The latest CQC Insights report (March 2022) shows continued strong performance across most measures reviewed, consistent with recent previous updates.

This is illustrated below in the overview table from the report:



Overall, 97% of the LHCH Trust level metrics are ‘much better’, ‘better’ or ‘about the same’ when compared to the national average.

Key points:

- No metrics in the category “much worse compared nationally”
- 4 metrics performing “much better compared nationally”
- 4 metrics have “improved”
- Improvement opportunities in three areas that have “declined”

This report sets out the context to these indicators, as well as any actions being taken.

In summary the paper provides strong assurance against the metrics along with ensuring regular review of the CQC Insights reports.

2. Background

The CQC publishes its Insights report bimonthly (prior to the pandemic, it was published monthly). The Insight report draws together data from various sources and timeframes. The metrics are not contemporaneous, nor are all metrics refreshed each reporting cycle. The March report was released 8th April 2022.

The CQC Insights report highlights Trust performance against a wide range of measures, at Trust level, Service / Department level, and a selection of ‘featured data sources’ (which includes incidents, mortality (although paused currently), staff survey, and Workforce Race Equality Standard). In total 114 metrics are reported across those broad areas. There are in addition a range of contextual measures included in the report.

There is typically a delay between data gathering and reporting. The level of delay depends on the metric. Some metrics are refreshed infrequently but may appear in each bi-monthly report (e.g. staff survey). The full report is set out in **Appendix 1**.

The Executive Team reviews each CQC Insights report, and for each metric identified as an outlier sets out any corrective actions required (see **Appendix 2**).




Highlights from March 2022 report are set out below in Table 1:

Table 1: Summary performance

Benchmark	Description	Performance		Highlights
1a. Trust Level metrics Current period LHCH versus National Average	Performance on core CQC KLOEs, compared to national average, latest period 58 metrics	<p>What's the current performance of trust wide indicators?</p> <p>Key</p> <ul style="list-style-type: none"> ■ Much better ■ Better ■ About the same ■ Worse ■ Much worse 	<p>How has the trust-wide indicator performance changed over time?</p> <p>Trend</p> <p>Over previous 12 months very little variation noted across Green / Dark Green / Grey above.</p> <p>Slight improvement in Amber, and no Red rated ("Much worse") metrics for several months.</p>	<p>Current performance</p> <p>Trust and Core Service Indicators (March 2022) (n=58)</p> <p>✓ "Much Better", "Better" and "About the Same" in aggregate 97% (January: 95%)</p> <p>⚠️ 1 KPIs are "Worse" than national average:</p> <ul style="list-style-type: none"> • Safe Environment – Violence – staff survey scores significantly lower than average for the 14 national specialist providers

Benchmark	Description	Performance	Key	Highlights
1b. Trust level metrics Trend (internal)	Performance on core CQC KLOEs, compared to same period previous year (internal trend) 58 metrics	<p>Current period v Same Period Previous Year</p> <p>A pie chart titled 'Current period v Same Period Previous Year'. The chart is divided into four segments: a large grey segment for 'About the same, 32, 55%', a small green segment for 'Improving, 4, 7%', a small red segment for 'Declining, 3, 5%' with a red triangle icon, and a grey segment for 'NA, 19, 33%'.</p>	<p>Performance change</p> <ul style="list-style-type: none"> Improving About the same Declining 	<p>Trend</p> <ul style="list-style-type: none"> ✓ 62% of KPIs (36) are “Improving” (4) or are “About the same” (32) compared to the corresponding period in the previous year. ✓ 33% of KPIs (19) are “Not Applicable”* ⚠ In the March update, 5% of KPIs (3) were “declining”. These were: <ol style="list-style-type: none"> Ratio of occupied beds to nursing staff** Quality of care – LHCH still scores significantly better than average despite this statistically significant decline noted Safe Environment – Violence –statistically significant decline noted <p><i>*Indicators are classed Not Applicable when either it is inappropriate to provide trend information or because the trend methodology is still under development</i> ** See Appendix 4 for definition</p>
2a. Service level metrics Current period LHCH v National Average	20 metrics covering CQC KLOEs at specialty / department level: <ul style="list-style-type: none"> Medical Care Surgery Critical Care Outpatients 	<p>Current</p> <p>A horizontal bar chart titled 'Current'. The x-axis represents a scale from -1 to 14. The y-axis lists three categories: 'Well led', 'Effective', and 'Responsive'. For each category, there are two bars: a green bar for LHCH performance and a grey bar for National Average performance. The green bars are segmented with counts: 'Well led' has 2 (yellow), 'Effective' has 1 (green), 2 (grey), and 1 (yellow), and 'Responsive' has 1 (green), 3 (green), and 10 (grey).</p>	<ul style="list-style-type: none"> MB Much better B Better S About the same W Worse MW Much worse 	<p>Current period performance</p> <ul style="list-style-type: none"> ✓ 85% of KPIs (17) are “Much Better” (2), “Better” (3) or “About the Same” (12) as National Average ⚠ 15% of KPIs (3) are “Worse” than national average, within the ‘Well Led’ domain (no change November / January / March updates). These are: <ol style="list-style-type: none"> Participation in the ICCQIP – adult critical care Participation in the ICCQIP – paediatric critical care Is face to face palliative care available 8hours/7days?

Benchmark	Description	Performance	Key	Highlights																				
2b. Service level metrics Trend (internal)	20 metrics covering CQC KLOEs at specialty / department level: <ul style="list-style-type: none"> Medical Care Surgery Critical Care Outpatients 	<p style="text-align: center;">Trend</p> <table border="1"> <thead> <tr> <th>Category</th> <th>Improving</th> <th>About the same</th> <th>NA</th> <th>Declining</th> </tr> </thead> <tbody> <tr> <td>Well led</td> <td>0</td> <td>0</td> <td>2</td> <td>0</td> </tr> <tr> <td>Effective</td> <td>1</td> <td>2</td> <td>1</td> <td>0</td> </tr> <tr> <td>Responsive</td> <td>4</td> <td>8</td> <td>0</td> <td>2</td> </tr> </tbody> </table>	Category	Improving	About the same	NA	Declining	Well led	0	0	2	0	Effective	1	2	1	0	Responsive	4	8	0	2	<ul style="list-style-type: none"> Improving About the same NA Declining 	Trend ✓ 75% of KPIs (15) are “Improving” (5) or “About the Same” (10) compared to corresponding period previous year ✓ 15% (3) are classed as Not Applicable* ✗ 10% (2) are classed as “Declining”: 1. Referral to treatment, on completed admitted pathways in Surgery, within 18 weeks (%) . This is a comparison of the January 2021 position (LHCH score 86.9%) compared to January 2022 (LHCH score is 69.2%). The national average is 59% (Jan 22) 2. Cancelled operations not treated within 28 days of non-clinical cancellation (%) LHCH scored 5.2% in the period Oct 21 - Dec 21 <i>*Indicators are classed Not Applicable when either it is inappropriate to provide trend information or because the trend methodology is still under development</i>
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3a. Featured data sources	Incident reporting benchmarking:	<p style="text-align: center;">Comparative reporting rate for incidents in all acute trusts</p>		<ul style="list-style-type: none"> LHCH incident reporting rate per 1000 bed days is in the lower quartile (lower than expected) Data covers the 12 months ended December 2021 																				

Benchmark	Description	Performance	Key	Highlights																																																																																																		
	LHCH Incident reporting trend	<div><p>All reported incidents</p><p>Reported incidents that resulted in moderate, severe harm or death</p><table><thead><tr><th>Year-month</th><th>2020-12</th><th>2021-01</th><th>2021-02</th><th>2021-03</th><th>2021-04</th><th>2021-05</th><th>2021-06</th><th>2021-07</th><th>2021-08</th><th>2021-09</th><th>2021-10</th><th>2021-11</th><th>2021-12</th></tr></thead><tbody><tr><td>1. Death</td><td>0</td><td>0</td><td>1</td><td>0</td><td>0</td><td>1</td><td>0</td><td>3</td><td>0</td><td>1</td><td>1</td><td>0</td><td>0</td></tr><tr><td>2. Severe</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td>1</td><td>1</td><td>0</td><td>0</td><td>1</td><td>0</td><td>0</td><td>1</td></tr><tr><td>3. Moderate</td><td>1</td><td>1</td><td>2</td><td>2</td><td>3</td><td>3</td><td>3</td><td>2</td><td>0</td><td>3</td><td>2</td><td>1</td><td>0</td></tr><tr><td>4. Low</td><td>17</td><td>15</td><td>7</td><td>22</td><td>18</td><td>18</td><td>20</td><td>9</td><td>20</td><td>15</td><td>19</td><td>22</td><td>17</td></tr><tr><td>5. No Harm</td><td>102</td><td>98</td><td>99</td><td>157</td><td>118</td><td>110</td><td>110</td><td>93</td><td>88</td><td>113</td><td>114</td><td>109</td><td>94</td></tr><tr><td>6. Total</td><td>120</td><td>115</td><td>109</td><td>161</td><td>139</td><td>133</td><td>134</td><td>107</td><td>108</td><td>133</td><td>136</td><td>132</td><td>112</td></tr></tbody></table></div>	Year-month	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12	1. Death	0	0	1	0	0	1	0	3	0	1	1	0	0	2. Severe	0	1	0	0	0	1	1	0	0	1	0	0	1	3. Moderate	1	1	2	2	3	3	3	2	0	3	2	1	0	4. Low	17	15	7	22	18	18	20	9	20	15	19	22	17	5. No Harm	102	98	99	157	118	110	110	93	88	113	114	109	94	6. Total	120	115	109	161	139	133	134	107	108	133	136	132	112		<ul style="list-style-type: none">Incident Reporting trend shows a degree of consistency month on month in the period under review, with a notable increase in March 2021 (47% higher than average for the period). However, overall the position for the year under review is significantly lower reporting rate than expected compared to national median
Year-month	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12																																																																																									
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3b.	National Clinical Audits	<div><p>Liverpool Heart and Chest Hospital, Intensive Therapy Unit</p><table><thead><tr><th>Metric</th><th>CQC Key Question</th><th>2017/18¹ Report</th><th>2018/19² Report</th><th>National Aggregate (England, Wales & Northern Ireland)</th><th>National Standard</th><th>Comparison to other Units</th></tr></thead><tbody><tr><td>Case Ascertainment</td><td>Well Led</td><td>Not reported for this audit</td><td>None</td><td>None</td><td>None</td><td>N/A</td></tr><tr><td>2531 admissions</td><td>Crude non-clinical transfers</td><td>Responsive</td><td>0.0%</td><td>0.0%</td><td>0.3%</td><td>0%*</td></tr><tr><td>2581 admissions</td><td>Crude non-delayed, out-of-hours discharge to ward proportion</td><td>Responsive</td><td>0.2%</td><td>0.1%</td><td>1.9%</td><td>0%*</td></tr><tr><td>10900 inpatient critical care bed days</td><td>Crude delayed discharge (% bed days occupied by patients with discharge delayed > 4 hours)</td><td>Responsive</td><td>0.2%</td><td>0.2%</td><td>4.4%</td><td>0%*</td></tr><tr><td>2300 admissions</td><td>Risk-adjusted hospital mortality ratio (all patients)</td><td>Effective</td><td>0.9³</td><td>0.9³</td><td>1.0</td><td>none</td></tr><tr><td>2330 admissions</td><td>Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)</td><td>Effective</td><td>0.9³</td><td>0.9³</td><td>1.0</td><td>none</td></tr></tbody></table><div><p>ICNARC is a not-for-profit organisation that provides clinical audit and research services to hospitals across the UK.</p></div><div><p>KEY: Positive outlier (above 95% expected range), Within expected range, Negative outlier (below 5% expected range)</p><p>UNIT: 95.9% (5.1%)</p></div><p>¹ Apr 17 - Mar 18 ² Apr 18 - Mar 19 ³ ICNARC₂₀₁₈ risk adjustment model ⁴ ICNARC₂₀₁₉ risk adjustment model</p></div>	Metric	CQC Key Question	2017/18 ¹ Report	2018/19 ² Report	National Aggregate (England, Wales & Northern Ireland)	National Standard	Comparison to other Units	Case Ascertainment	Well Led	Not reported for this audit	None	None	None	N/A	2531 admissions	Crude non-clinical transfers	Responsive	0.0%	0.0%	0.3%	0%*	2581 admissions	Crude non-delayed, out-of-hours discharge to ward proportion	Responsive	0.2%	0.1%	1.9%	0%*	10900 inpatient critical care bed days	Crude delayed discharge (% bed days occupied by patients with discharge delayed > 4 hours)	Responsive	0.2%	0.2%	4.4%	0%*	2300 admissions	Risk-adjusted hospital mortality ratio (all patients)	Effective	0.9 ³	0.9 ³	1.0	none	2330 admissions	Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)	Effective	0.9 ³	0.9 ³	1.0	none		<ul style="list-style-type: none">All measures reported by Intensive Care National Audit and Research Centre (ICNARC) are within range, a positive outlier, or better than expected.Latest reported information it should be noted is for 2018/19																																																	
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Benchmark	Description	Performance	Key	Highlights
3c	Staff Survey: WRES	<p>Key messages These graphs show how BME and White staff at this trust have answered the four WRES staff survey questions over time. See the WRES section of insight for additional analysis.</p> <p>Staff who experienced harassment, bullying or abuse from patients, relatives or the public</p> <p>Staff who experienced harassment, bullying or abuse from staff</p> <p>Staff believing the trust offers equal opportunities for career progression and promotion</p> <p>Staff experiencing discrimination from their manager and/or colleagues</p>		<ul style="list-style-type: none"> Workforce Race Equality Standard (WRES) questions in the staff survey highlight two areas showing statistically significant difference between BME and White staff: <ol style="list-style-type: none"> Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months Staff experiencing harassment, bullying or abuse from staff in the last 12 months

Triangulation with other performance indicators

Ref	Metric	CQC Insights performance	Other benchmarking	Comments
1	Participation in the ICCQIP – (Infection in Critical Care Quality Improvement Programme)	LHCH is a non participant and therefore CQC scores the Trust as “worse” than national average	GIRFT identifies ICCQIP participation as best practice	Papworth participates in the ICCQIP. Benefits of ICCQIP were highlighted at GIRFT’s (virtual) site visit in December 2021, led by National Clinical Lead for Critical Care, Dr Anna Batchelor
2	Turnover rate for other clinical staff (%) Other Clinical Staff refers to 'Prof Scientific and Technic', 'Additional Clinical Services', 'Allied Health Professionals', 'Healthcare Scientists'	This metric in the previous update (Jan 22) was Worse than National Average, and declining. In the current update it has ceased to be a concern but note comments	Model Hospital	Turnover rate for additional staff groups highlighted in Model Hospital but not triggering in the CQC Insights: AHPs, Registered nurses, and Support to Nurses
3	Quality of Care – Statistically significant decline noted by CQC. However, note that despite decline LHCH is significantly better than average.	Statistically significant decline	Model Hospital / Staff Survey	According to Model Hospital, for 2020, across Staff Survey questions q7a / q7b / q7c / q18a / q18b / q18c / q18d, LHCH scored highest nationally.
4	Referral to treatment CQC Insights highlights declining performance in completed admitted pathways in Surgery	Declining	Public View	As shown in Public View benchmarking tool, LHCH RTT generally benchmarking quite well across a number of metrics.

4. Positive Outliers

The Trust delivers outstanding performance in many areas. A significant number of metrics in the report continue to demonstrate a positive trend and or perform better than national average. Acknowledging the excellent performance noted in the report, this paper does not review, or propose actions in relation to, positive variation, and instead focusses on exploring the measures that show an adverse variance and the actions required to improve LHCH performance.

5. Conclusions

LHCH demonstrates strong performance across the range of indicators in the latest CQC Insight report.

Trust Level

LHCH's performance against the 58 Trust level metrics, compared to the national average, is as follows:

- 7% are much better
- 26% are better
- 64% are about the same

The above represents 97% of the metrics reviewed, with a single metric classed as Worse than national average. One further metric is "not applicable".

LHCH did not score "Much worse" than national average, on any metric.

Service Level

LHCH's performance against the 20 service level metrics, compared to the national average, is as follows:

- 10% are much better
- 15% are better
- 60% are about the same
- 15% are worse
- No Service level metric scored "Much worse" than national average.

Featured Data sources

Key points noted in Feature Data section of the report are as follows:

- Incidents reporting rate (incidents per bed day) is lower than expected (lowest quartile), with a relatively consistent (flat) trend over a 12 month period.
- The WRES section within the Staff Survey highlights two metrics showing statistically significantly variation between White and BME staff:
 1. Staff experiencing harassment, bullying or abuse from **patients**, relatives or the public in the last 12 months
 2. Staff experiencing harassment, bullying or abuse from **staff** in the last 12 months

6. Recommendations

The Board of Directors are asked to note the content of this report and the action plan set out in Appendix 2.







Appendix 1 – CQC Insight Report 28 March 2022













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Appendix 2 - Action Plan

The table below sets out the remedial action required to improve LHCH performance in each area flagged above. For ease of reference, the area and page number of the CQC Insight report is set out below. Completed and closed actions appear at the bottom of the table.



Ref	LHCH RAG	Area/ Source	Metric and description of issue	Change over time	Better / worse than National Average?	Remedial actions	Responsible Executive	By when
1 (new)		KLOE Safe	Ratio of occupied beds to nursing staff Electronic Staff Record - ESR: Contracted FTEs - All Staff (03 Mar 2022) Performance is better than national average, but the current performance shows a decline in LHCH's performance relative to the same period the previous year (compares calendar years 2021 to 2020) The metric is defined in Appendix 4.			Assurance regarding nurse staffing is presented to the Board of Directors at each of its Board meeting demonstrating adherence to the safe staffing guidance. Proactive recruitment is in place with 80 overseas nurses recruited currently and a further 30 to be recruited by September 2022. In addition, the Trust has a full and comprehensive recruitment programme of the current student nurses overseas nurses	Director of Nursing, Quality & Safety	
2 (new)		KLOE Responsive	Cancelled operations not treated within 28 days of non-clinical cancellation (%) Previous period LHCH was showing 100% compliance with requirement to treat cancelled patients within 28 days. Period under review show LHCH had 5.2% of patients extend beyond the 28 day standard (Oct-Dec 2021). The definition is set out in Appendix 4.			All cancellations are reviewed as part of the weekly performance meeting. Q4 of 21/22 showed a return to 100% compliance for the 28 day standard. An RCA will be completed for any breach of this standard with learning taken through weekly performance.	Chief Operating Officer	

Ref	LHCH RAG	Area/ Source	Metric and description of issue	Change over time	Better / worse than National Average?	Remedial actions	Responsible Executive	By when
3		Incident reporting	Incident Reporting Rate LHCH rate is lower than expected, for the 12 months ended December 2021 (lowest quartile)	n/a	n/a	<p>Ongoing education is in place with all teams trust wide to provide examples of what an incident is and what should be reported on Datix. There are some excellent reporting areas and some areas who report very little. Incident reporting is discussed at the weekly executive meeting and at divisional governance meetings.</p> <p>The Trust has a daily safety huddle where other concerns/incident are verbally reported. Staff are consistently reminded and encouraged to report these examples on the Datix system</p>	Director of Nursing, Quality and Safety	
4		Surgery	<p>Referral to treatment, on completed admitted pathways in Surgery, within 18 weeks (%).</p> <p>Declining performance Jan21 v Jan22 but the Jan22 performance remains “about the same” as national average (which is 59%). Consistent with previous QC insights report (Jan22):</p> <p>Jan21 - 86.9% Jan22 – 69.2%</p> <p>The previous (Jan 22) CQC Insights update showed the following position: Nov20 – 75.3% Nov21 – 69.6%</p>			<p>2021 was a challenging year with the delivering of activity. This is due to the further waves of Covid that were experienced which impacted both on physical Trust capacity for ward beds along with significant pressures on the workforce. As would be expected, patients continue to be treated on clinical priority, often this cohort of patients are low waiters which don't see a significant impact on those patients waiting over 18 weeks.</p> <p>In line with national guidance the Trust is also focusing on patients waiting over 52 weeks. The Trust have a trajectory in place and have several meetings in place to</p>	Chief Operating Officer	

Ref	LHCH RAG	Area/ Source	Metric and description of issue	Change over time	Better / worse than National Average?	Remedial actions	Responsible Executive	By when
						monitor performance in this area. The focus will also be part of the 2022/23 annual planning process and revised trajectories will be submitted.		
5		KLOE Well Led	Safe Environment – Violence Staff survey scores have declined. Previous 9.7 (Sep-Dec19) Current 9.6 (Sep-Dec20) LHCH is significantly below the average specialist provider (p 20,47), and a statistically significant decline noted (p47)			The most recent staff survey results have been released. These are being reviewed. It should be noted that the basis for measuring this has changed which will make like for like comparisons and trend analysis more difficult when reviewing the latest results. Preliminary review of the corresponding metric in the latest results shows LHCH is in line with the national average.	Chief People Officer	
6		KLOE CQC Well Led PICKER – NHS Staff Survey	Quality of care – staff survey There has not been an update in Insights since December 2020. Although score has declined, LHCH is better than national average: LHCH Sep-Dec19: 8.1 LHCH Sep-Dec20: 8.0 National Average: 7.9			The latest report has been published. and we are <ul style="list-style-type: none"> #1 in the country for 'care is our top priority' & 'staff engagement'. #1 acute specialist trust for 'care is our top priority', 'place to work' and 'staff engagement'. 'THE BEST' in 8 out of 9* of the People Promise elements & themes 	Chief People Officer	









Ref	LHCH RAG	Area/ Source	Metric and description of issue	Change over time	Better / worse than National Average?	Remedial actions	Responsible Executive	By when
						<i>*Benchmarked against 'acute specialist trusts'.</i>		
7		KLOE CQC Well Led Critical Care	<p>Participation in the ICCQIP - Adult / Paediatric critical care Services</p> <p>This is a GIRFT best practice recommendation. GIRFT highlighted at our site visit in December 2021 that we are an outlier. LHCH does not participate.</p> <p>Papworth have participated in recent years.</p> <p>C&M ICS: 5 hospital trusts representing 6 ICU units are now registered: Aintree (2), Countess (1), Mid Cheshire (1 unit), Southport and Ormskirk (1) and The Walton (1).</p>	n/a		<p>There are more units in C&M network that are considering interacting with this system; due to the extensive amount of work required and little in the way of gains there has not been widespread uptake to date. The network still feel that ICNARC data suffices and the network lead has fed back to PHE to work with ICNARC data which is routinely gathered by all units.</p> <p>Trust communicating with ICCQIP and internal stakeholders to scope in more detail the requirements of participation. The improvement team may be able to provide resource.</p>	Medical Director	
8		KLOE National Audit of Care at the End of Life (29 Jun 2021)	<p>Is face to face palliative care available 8hours/7days</p> <p>This standard was recorded as not met in the NACEL audit (June 2021)</p>	n/a		<p>We have face to face cover Monday to Friday and the weekend service is provided by Liverpool University hospital who would see patients face to face if needed. We also have a service level agreement with a local hospice.</p>	Director of Nursing, Quality & Safety	

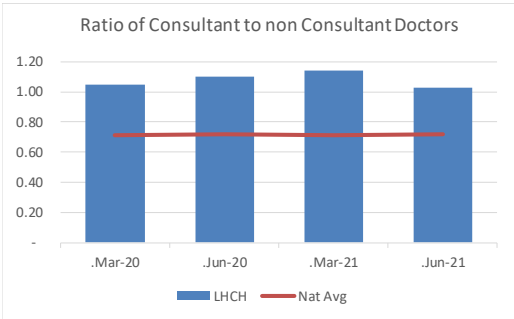


9		<div>WRES</div> <div>Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</div> <div>Statistically significant difference between the experiences of BME and White staff. There is not a significant difference between LHCH and our peer group.</div> <table><thead><tr><th colspan="2">WRES Indicators from the NHS staff survey (")</th><th colspan="3">Are there significant differences between...</th></tr><tr><th></th><th></th><th>BME and white staff?</th><th>This trust and its peer group?</th><th>Last year and year? (BME)</th></tr></thead><tbody><tr><td>5. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</td><td>Trust</td><td><div></div></td><td><div></div></td><td>-5.6%</td></tr><tr><td></td><td>Peer group</td><td></td><td></td><td></td></tr><tr><td>6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months</td><td>Trust</td><td><div></div></td><td><div></div></td><td>-5.5%</td></tr><tr><td></td><td>Peer group</td><td></td><td></td><td></td></tr></tbody></table>	WRES Indicators from the NHS staff survey (")		Are there significant differences between...					BME and white staff?	This trust and its peer group?	Last year and year? (BME)	5. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Trust	<div></div>	<div></div>	-5.6%		Peer group				6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months	Trust	<div></div>	<div></div>	-5.5%		Peer group					n/a	<div>Staff are encouraged to report any form of harassment and bullying, localised measures are put in place and wellbeing support offered</div> <div>The WRES results in the CQC Insights for the under review, shown opposite, are from the Staff Survey 2020.</div> <div>The more recent WRES results (Aug21) show improvement in:</div> <ul style="list-style-type: none">• % of staff experiencing harassment, bullying or abuse from patients – improved result for BAME workforce from 20.4% in 2020 to 15.7% in 2021. This is lower than the national average which is reporting at 17.7%• % of staff experiencing harassment, bullying and abuse from staff - improved result for BAME workforce from 28.2% 2020 to 25.9% 2021. This is lower than the national average which is 27.8%• % of staff believing that the organisation provides equal opportunity for career progression and promotion – reduction in results for BAME staff from 64.2% to 59.1%. The is higher than the national average which is 44.5% (please note pause on non-mandatory training during covid which could influence this score).	Chief People Officer
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Ref	LHCH RAG	Area/ Source	Metric and description of issue	Change over time	Better / worse than National Average?	Remedial actions	Responsible Executive	By when																														
						A decline has been noted however for the % of staff experiencing discrimination at work from manager / team leader or colleague in last 12 months – declined results for BAME workforce from <u>6.7% in 2020 to 11.8% in 2021</u> . This is lower than the national average which is reporting at 16.7%																																
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Closed Actions


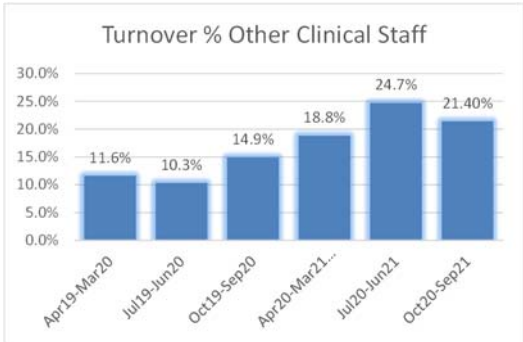


The following actions have been closed for the reasons stated:

Ref	LHCH RAG	Metric and description of issue	Change over time	Better / worse than National	Previously reported remedial actions	Responsible Executive	Closure reasons
1		Whistleblowing Alerts Number of alerts open, pending, in progress, or on hold. As per the July 2021 update, there is one whistleblowing enquiry raised with the CQC that remains open in the period under review*	NA		The Trust continues to promote its open and transparent culture encouraging its people to speak out where they are concerned about any issues pertaining to themselves or others. Despite all the mechanisms to report there have been a number of whistle blows outside of the trust which are not from staff who work in the Trust currently – Be kind be civil campaign launched trust wide 8 th November 2021	Director of Nursing, Quality & Safety	See actions opposite, and CQC Insights no longer highlighting concern.
2		Active professional registration (medical and dental) (%) LHCH has declined from 100% in Mar20, to 91.7% in Mar21, and is showing 94.2% in June 21. This is worse than national average Jun21 of 99.1%. Following the release of the Insights July 2021 report, a data quality issue was identified			There has been a problem recording this on ESR. This has been reviewed and corrected. There are no doctors who do not have active professional registration. Done	Medical Director / Chief People Officer	Jan22 update: 99.2% registration rate. Data flows appear to have been resolved.
3		Ratio of consultant to non-consultant doctors The Insights Report shows LHCH to be “about the same” as national average.			Nothing required	Medical Director	No concern identified in Jan22 CQC Insights. See narrative opposite

Ref	LHCH RAG	Metric and description of issue	Change over time	Better / worse than National	Previously reported remedial actions	Responsible Executive	Closure reasons															
		<p>It appears though that LHCH is in fact consistently better than national average, and this despite the marginal decline observed in Jun21 as reported in</p> <p>November 2021 Insights report:</p> <div><p>Ratio of Consultant to non Consultant Doctors</p><table border="1"><thead><tr><th>Period</th><th>LHCH</th><th>Nat Avg</th></tr></thead><tbody><tr><td>.Mar-20</td><td>1.05</td><td>0.75</td></tr><tr><td>.Jun-20</td><td>1.10</td><td>0.75</td></tr><tr><td>.Mar-21</td><td>1.15</td><td>0.75</td></tr><tr><td>.Jun-21</td><td>1.05</td><td>0.75</td></tr></tbody></table></div>	Period	LHCH	Nat Avg	.Mar-20	1.05	0.75	.Jun-20	1.10	0.75	.Mar-21	1.15	0.75	.Jun-21	1.05	0.75					
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4		<p>Mortality outlier alert: CABG (other)</p> <p>Worse than national average. Action plans being followed up by CQC Dec20</p>	n/a		<p>Now outliers discussed at monthly Mortality Improvement Group.</p> <p>The meetings between LHCH and Dr Foster (Telstra health) have been formalised into the Mortality Improvement Group; meeting monthly. TORs have been agreed, there is an agreed agenda and admin support from Exec PA.</p> <p>The first formal meeting was on 3rd</p>	Medical Director	Process described opposite. Note that Mortality has been suspended from the CQC Insights reporting until further notice															

Ref	LHCH RAG	Metric and description of issue	Change over time	Better / worse than National	Previously reported remedial actions	Responsible Executive	Closure reasons
					<p>November and included most of the expanded membership with representation from coding, informatics and audit and the divisions. Representation from the MRG and digital systems has been agreed.</p> <p>The standard agenda includes a deep dive into outliers and follow up of previous deep dives. Initial scrutiny of factors driving outlier status have shown difficulties presented to coding by note keeping and also the difficulties in assessing Charlson and Carstairs scores. Actions are in place to improve this.</p> <p>The head of coding has joined the MRG and will facilitate accuracy of coding in discussion at the committee.</p> <p>The follow ups with CQC have been discussed at relationship meeting and actions agreed</p>		

Ref	LHCH RAG	Metric and description of issue	Change over time	Better / worse than National	Previously reported remedial actions	Responsible Executive	Closure reasons
5		Mortality outlier alert: Coronary atherosclerosis and other heart disease Worse than national average. Report indicates action plans being followed up by CQC Dec20	n/a		As above outliers discussed at Mortality Improvement Group and actions agreed The follow ups with CQC have been discussed at relationship meeting and actions agreed	Medical Director	Process described opposite. Note that Mortality has been suspended from the CQC Insights reporting until further notice
6		Mortality outlier alert: Acute myocardial Infarction Worse than national average. Report indicates action plans being followed up by CQC Dec20	n/a		As above The follow ups with CQC have been discussed at relationship meeting and actions agreed	Medical Director	Process opposite. Note that Mortality has been suspended from the CQC Insights reporting until further notice
7		Able to take own medication when needed Significantly lower score in Patient Survey 2019 compared to 2018, but within expected range		n/a	This was addressed from the outcome of the national inpatient survey results from 2019. The Trust has seen an improvement in this question in 2020 survey results.	Director of Nursing, Quality & Safety	See narrative opposite. Jan22 CQC Insights report no longer raises concern
8		Discussed taking part in a research study Significantly lower score in Patient Survey 2019 compared to 2018, but within expected range		n/a	This was addressed from the outcome of the national inpatient survey results from 2019	Director of Nursing, Quality & Safety	See narrative opposite. Jan22 CQC Insights report no longer raises concern

Ref	LHCH RAG	Metric and description of issue	Change over time	Better / worse than National	Previously reported remedial actions	Responsible Executive	Closure reasons
					Work is ongoing to involve patients in research. This question has been removed from that national inpatient survey.		
9		<p>Turnover rate for other clinical staff (%)</p> <p>Declining trend, that is worse than national average.</p> <p>Note in the table below the 12 month periods and how they overlap (which reflects the periods reviewed in the bimonthly CQC Insight reports).</p>  <p>Definition: (Number of leavers in the last 12 months) divided by (Average headcount over the last 12 months)</p>			Meeting with clinical staff groups to understand what can be improved and how to improve retention and engagement. This is ongoing	Chief People Officer	No longer an outlier in latest (Mar22) CQC Insights update

Appendix 4 – Definitions

The definitions provided by the CQC for areas where LHCH is identified as an outlier are copied here from the CQC guidance

Core Service: Trust Wide Indicators Key Question: Safe			
Indicator ID	ESRRAT02	KLOE	S2
Indicator name	Ratio of occupied beds to nursing staff		
Data stream	ESR		
Rationale	CQC guidance about compliance - providers can demonstrate that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of people who use the services at all times.		
Indicator construction	Ratio Count 1: Estimated patient contact hours in one week Calculation: Number of occupied overnight beds (KH03) * 24 (hours in a day) * 7 (days in a week) + Number of occupied day beds (KH03) * 8 (hours in a day) * 7 (days in a week) Ratio Count 2: Estimated staff contract hours available in one week Calculation (for Nursing and Midwifery Registered): FTE of staff * 37.5 (weekly contract hours) Refer to page 13 of the statistical methodology guidance to view more details of the parameters used.		
Indicator type	z-scored	Sentinel distribution	High values are worse
Change over time category	Change in national comparison	Data source	ESR

Core Service: Trust Wide Indicators Key Question: Well-led			
Indicator ID	NHSSTFSVY06	KLOE	W3
Indicator name	Quality of care		
Data stream	NHS Staff Survey		
Rationale	<p>The staff pledges, part of the NHS Constitution, define what the NHS expects from staff and what staff can expect from NHS employers. The constitution also includes staff responsibilities. Staff pledge 2: The NHS commits to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.</p>		
Indicator construction	<p>Staff survey questions relating to Quality of care are aggregated into a single score out of 10 by Picker, the staff survey contractor.</p> <p>At CQC the indicator values are z-scored and assessed using these rules:</p> <ul style="list-style-type: none"> • Trusts with z-score ≤ -2 are shown as "much better" than expected • Otherwise, the best-scoring 25% of trusts are "better" than expected. • Trusts with z-score ≥ 2 are shown as "much worse" than expected. • Otherwise, the worst-scoring 25% of trusts are "worse" than expected. • Trusts in the middle 50% of trusts are "about the same" as expected. 		
Indicator type	Rule-based and z-scored	Sentinel distribution	Low values are worse
Change over time category	T-test	Data source	NHS England

Core Service: Trust Wide Indicators Key Question: Well-led			
Indicator ID	NHSSTFSVY08	KLOE	W3
Indicator name	Safe Environment – Violence		
Data stream	NHS Staff Survey		
Rationale	<p>The staff pledges, part of the NHS Constitution, define what the NHS expects from staff and what staff can expect from NHS employers. The constitution also includes staff responsibilities. Staff pledge 4: The NHS commits to provide support and opportunities for staff to maintain their health, well-being and safety.</p>		
Indicator construction	<p>Staff survey questions relating to Safe Environment – Violence are aggregated into a single score out of 10 by Picker, the staff survey contractor.</p> <p>At CQC the indicator values are z-scored and assessed using these rules:</p> <ul style="list-style-type: none"> • Trusts with z-score ≤ -2 are shown as “much better” than expected • Otherwise, the best-scoring 25% of trusts are “better” than expected. • Trusts with z-score ≥ 2 are shown as “much worse” than expected. • Otherwise, the worst-scoring 25% of trusts are “worse” than expected. • Trusts in the middle 50% of trusts are “about the same” as expected. 		
Indicator type	Rule-based and z-scored	Sentinel distribution	Low values are worse
Change over time category	T-test	Data source	NHS England

7.5. Critical Care – Well-led

The critical care well-led indicators based on participation in the ICCQIP surveillance programme use a data source, critical care bed occupancy, suspended during the COVID-19 pandemic. The indicators' specifications are on the following pages.

Core Service: Critical Care Key Question: Well-Led			
Indicator ID	ICCQIPA_01	KLOE	W6
Indicator name	Participation in the ICCQIP - Adult critical care services		
Data stream	Critical Care Bed Occupancy; and ICCQIP Register		
Rationale	<p>There has been an increasing threat posed by antimicrobial resistance. Hospitals are routinely reporting multi-resistant infections, particularly those caused by multi-resistant Gram-negative bacteria. Some of these strains are now resistant to all antibiotics and are therefore untreatable. This is of particular concern for critically ill patients of all ages.</p> <p>A collaboration of professional organisations representing adult, paediatric and neonatal intensive care, microbiology, and infection control, have partnered with Public Health England to establish a surveillance programme for critical care units – ICCQIP (Infection in Critical Care Quality Improvement Programme) to support local efforts to control infections through standardised reporting and benchmarking. The system can link data from individual patients and units to other sources of data across the NHS, helping to identify national trends and reduce infection rates in some of the most vulnerable patient groups.</p>		
Indicator construction	<p>The value shown describes the status of the provider registration with the ICCQIP on the day of the ICCQIP register extract:</p> <ul style="list-style-type: none"> • No units registered: assessed as Much worse than expected • No units [registered] have authorised local administrator: assessed as Worse than expected • Some units [registered] have authorised local administrator: assessed as About the same • All units [registered] have authorised local administrator: assessed as Better than expected <p>This is an assessment of the provider's capability to report data to the ICCQIP for its adult critical care services, and so use information available from the ICCQIP surveillance programme locally to control and avoid infections in critically ill patients.</p> <p>Critical care services are registered at unit level. A unit requires an authorised local administrator to report data to the ICCQIP.</p>		
Indicator type	Rules based	Sentinel distribution	N/A (nominal value)
Change over time category	Categorical	Data source	NHS England ICCQIP

Core Service: Critical Care Key Question: Well-Led			
Indicator ID	ICCQIPA_02	KLOE	W6
Indicator name	Participation in the ICCQIP – Paediatric critical care services		
Data stream	Critical Care Bed Occupancy; and ICCQIP Register		
Rationale	<p>There has been an increasing threat posed by antimicrobial resistance. Hospitals are routinely reporting multi-resistant infections, particularly those caused by multi-resistant Gram-negative bacteria. Some of these strains are now resistant to all antibiotics and are therefore untreatable. This is of particular concern for critically ill patients of all ages.</p> <p>A collaboration of professional organisations representing adult, paediatric and neonatal intensive care, microbiology, and infection control, have formed a partnership with Public Health England to establish a novel surveillance programme for all critical care units – ICCQIP (Infection in Critical Care Quality Improvement Programme) to support local efforts to control infections through standardised web-based reporting and benchmarking. The system can link data from individual patients and units to other sources of data across the NHS, thereby helping to identify national trends and reduce infection rates in some of the most vulnerable patient groups.</p>		
Indicator construction	<p>The value shown describes the status of the provider registration with the ICCQIP on the day of the ICCQIP register extract:</p> <ul style="list-style-type: none"> • No units registered: assessed as Much worse than expected • No units [registered] have authorised local administrator: assessed as Worse than expected • Some units [registered] have authorised local administrator: assessed as About the same • All units [registered] have authorised local administrator: assessed as Better than expected <p>This is an assessment of the provider's capability to report data to the ICCQIP for its paediatric critical care services, and so use information available from the ICCQIP surveillance programme locally to control and avoid infections in critically ill patients.</p> <p>Critical care services are registered at unit level. A unit requires an authorised local administrator to report data to the ICCQIP.</p>		
Indicator type	Rules based	Sentinel distribution	N/A (nominal value)
Change over time category	Categorical	Data source	NHS England ICCQIP

Core Service: Surgery Key Question: Responsive			
Indicator ID	CND_OP01	KLOE	R3
Indicator name	Cancelled operations not treated within 28 days of non-clinical cancellation (%)		
Data stream	Cancelled Operations (QMCO)		
Rationale	<p>The NHS Plan (published in July 2000) states that patients will have the right to redress when things go wrong. When a patient's operation is cancelled by the hospital on the day of admission, or later, for non-clinical reasons, the hospital will have to offer another binding date to treat the patient within a maximum of 28 days or fund the patient's treatment at the time and hospital of the patient's choice. This continues to be a standard that the NHS should maintain, as set out in the 2009/10 NHS Operating Framework. Cancelled operations are defined as those that have been cancelled by the trust for non-clinical reasons on the day of admission or later</p>		
Indicator construction	<p>Numerator: Number of patients not treated within 28 days of last minute cancellation. Denominator: Number of last minute cancellations for non-clinical reasons in the time period.</p>		
Indicator type	z-scored	Sentinel distribution	High values are worse
Change over time category	Percentage	Data source	NHS England

This indicator uses a data source suspended during the COVID-19 pandemic, and currently results are not available for time periods after Q3 2019-20.