Board of Directors
10 June 2021

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	129/21			
Report	Integrated Performance Report			
Executive Lead	Chief Executive			
√ tick only those applicable	**Link to strategic pillar:**		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners	√	Responsive	√
	Our governance	√	Well Led	√
√ tick / input only those applicable, usually only one	**Report recommendations:**		**Link to BAF / risk:**	
	For assurance	√	BAF 1,2,3,4,5,7,8 and 9	
	For decision / approval		**Link to risk register:**	
	For review / discussion		CRR1, CRR2, CRR3, CRR4, CRR5, CRR6, CRR9, CRR10, CRR11, CRR12, CRR13, CRR15, CRR17, CRR19, CRR21, CRR22, CRR23, CRR27	
	For noting			
	For information			
	For consent			
Presented to:	SaTH Leadership Committee – Operational 27/05/21 Quality and Safety Assurance Committee – 26/05/21 Finance and Performance Assurance Committee – 01/06/21			
Dependent upon (if applicable)**:**	N/A			
Executive summary:	This report provides the committee with an overview of the performance of the Trust to the end of April 21. Key performance measures are analysed over time to understand the variation taking place and the level of assurance that can be inferred from the data. Where performance is below expected levels an exception report has been included that describes the key issues, actions and mitigations being taken to improve the performance. An annual review of the key performance indicators included in this report took place at a board seminar in May and a forward plan for the further development of the IPR will be provided to next month's Board meeting. In addition, as part of our integrated planning activities, improvement trajectories are being finalised for all relevant key indicators. The planned year-end position is included in the overall dashboard and monthly trajectories are included in a number of the SPC charts. The Board of Directors is requested to **NOTE** the content of this report.			
Appendices	n/a			

Purpose

This report provides the Board of Directors with an overview of the performance of the Trust. It reports the key performance measures determined by the board using analysis over time to demonstrate the type of variation taking place and the level of assurance that can be taken in relation to the delivery of performance targets. Where performance is below expected levels an exception report is provided. This outlines the key issues, actions and mitigations being progressed to improve the performance. The end of year targets are provisional and will be confirmed when the operational plan is formally approved.

The report is aligned to the Trusts functional domains and includes an overarching executive summary together with domain executive summaries for: Quality, Operational Performance, Workforce, Finance and Transformation.

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1. Executive Summary
Louise Barnett, Chief Executive

- We continue to make progress against our Getting to Good Plan and priorities, focusing on quality of care for patients and supporting our colleagues across the organisation. Our aim is to achieve sustainable improvements within our services for our patients and community, including maternity services, where focus continues on the implementation and embedding of the local actions for learning and immediate and essential actions outlined in the first report of the Independent Maternity Review.
- As part of our annual planning activities, we have reviewed our quality targets for 21/22 and set out ambitious but realistic targets for further improvement.
- During April and into May we have been focussing on restoring services and developing our operational recovery plans. The ongoing provision of the Vanguard theatre for the year ahead will also enable us to maintain an increased level of elective day surgery. The urgent care centres have now returned to both acute sites and the surgical same day admissions unit has re-opened to increase support to ambulatory emergency care pathways.
- A&E attendances have now increased to above 19/20 activity levels and we are continuing to implement the A&E action plan to deliver our targeted improvement trajectory.
- Our elective performance in April 2021 exceeded the 70% national threshold for recovery, however we recognise that many patients have now been waiting over a year to commence their treatment. We are continuing to prioritise patients by clinical need and schedule patients according to their priority. We are developing additional schemes to expand our capacity to support increased activity that will help to address both clinically urgent care and to manage the length of waits for our patients. However, longer waits are expected to continue throughout 21/22.
- During April 21, the number of Covid-19 patients in our general adult and critical care units remained low. We continued to work with partners to support the vaccination programme, actively encouraging the take up of first and second doses in line with national guidance. We have developed contingency plans to deal with potential further surges in the number of COVID-19 patients, and continue to maintain segregated patient pathways on both of our sites that minimise the risk of infection. The need to maintain social distancing and approved infection prevention practices restricts our ability to return to pre-covid-19 levels of elective activity.
- Our sickness absence levels have improved this month and are currently better than the national target. We recognise that our staff have worked extremely hard during the pandemic and faced many challenges to support our patients. As a consequence, we continue to provide additional health and well-being support to our staff.
- We are continuing to progress our cultural change programme and staff are engaged from across all parts of the organisation in the development of a new behavioural framework that will align more closely with our values. We have commenced additional open conversations with our staff to address issues highlighted in the recent staff survey.
- The Trust's adjusted financial position for April 21 was a deficit of £(0.353)m, which is in line with the first month of our agreed plan.

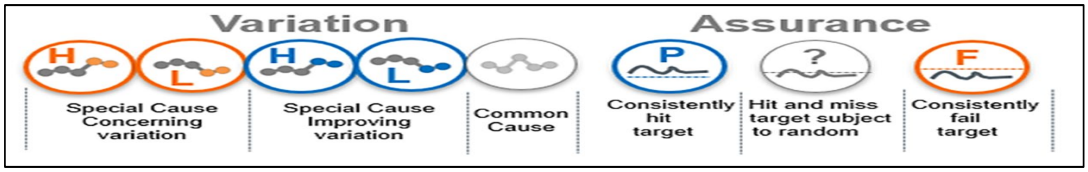
2. Overall Dashboard

Quality - KPI	Latest month	Actual Month Performance	National Standard for month	SaTH trajectory for month	Perfomance	Assurance	Exception	Year to Date	SaTH Year End Plan
Mortality									
HSMR	Feb 21	111.3	100.0	100			Yes		100
RAMI	Feb 21	86.6	100.0	100			No		100
Infection									
HCAI - MSSA	Apr 21	4		2.3			Yes	4	28
HCAI - MRSA	Apr 21	0	0	0			No	0	0
HCAI - c.Difficile	Apr 21	1		2.50			No	1	30
HCAI - E-coli	Apr 21	7		3.16			Yes	7	38
HCAI - Pseudomonas Aeruginosa	Apr 21	1		0			Yes	1	3
HCAI -Klebsiella	Apr 21	0		1			No	0	13
Patient harm									
Pressure Ulcers - Category 2 and above	Apr 21	14		13			Yes	14	152
Pressure Ulcers - Category 2 Per 1000 Bed Days	Apr 21	0.72		tbc				0.72	tbc
VTE	Apr 21	94.5%	95.0%	95.0%			Yes	94.5%	95.0%
Falls - per 1000 Bed Days	Apr 21	5.78	6.60	4.50			No	5.78	4.50
Falls - total	Apr 21	112		89			Yes	112	1074
Falls - with Harm per 1000 Bed Days	Apr 21	0.05	0.19	0.17			No	0.05	0.17
Never Events	Apr 21	0	0	0			No	0	0
Coroners Regulation 28s	Apr 21	0		0			No	0	0
SIs	Apr 21	9		5			Yes	9	57
Mixed Sex Breaches	Apr 21	20	0	0			Yes	20	tbc
Patient Experience									
Complaints	Apr 21	51		56			No	51	672
Complaints Responded within agreed time	Mar 21	55%	85%	85%			No	55%	85%
Friends and Family Test	Apr 21	98%	80%	80%			No	98%	80%
Compliments	Apr 21	80 letters of Thanks yous received						80	tbc
Maternity									
Caesarean Sections	Apr 21	25.0%	25.5%	tbc			No	25.0%	tbc
Smoking rate at Delivery	Apr 21	16.4%	6.0%	tbc			Yes	16.4%	tbc
One to One Care In Labour	Apr 21	99.1%	100.0%	tbc			Yes	99.1%	tbc
Delivery Suite Acuity	Apr 21	80.0%	85.0%	tbc			Yes	80.0%	tbc

Operational - KPI	Latest month	Actual Month Performance	National Standard for month	SaTH trajectory for month	Perfomance	Assurance	Exception	Year to Date	Year End Planned Trajectory
Elective Care									
RTT Waiting list -total size	Apr 21	33332 (English 30151)					Yes	30151 English	25338 English
18 week RTT % compliance -incomplete pathways	Apr 21	55.14% (English Only)	92%				Yes	55.14% English	39% English
52 week breaches	Apr 21	3687 (3295 English only)	0				Yes	3295 English	3757 English
Cancer									
Cancer 2 week wait	Mar-21	82.4%	93%	93%			Yes	82.4%	93%
Cancer 62 day compliance	Mar-21	60.53%	85%	85%			Yes	60.5%	85%
Diagnostics									
Diagnostic % compliance 6 week waits	Apr 21	74.8%	99%				Yes	74.8%	tbc
DM01 Patients who have breached the standard	Apr 21	1922	0	1254			Yes	1922	tbc
Emergency Department									
ED - 4 Hour performance	Apr 21	76.5%	95.0%	68.20%			Yes	76.5%	78%
ED - Ambulance handover > 60mins	Apr 21	246	0				Yes	246	tbc
ED 4 Hour Performance - Minors	Apr 21	96.5%	95%	95%			No	96.5%	95%
ED 4 Hour Performance - Majors	Apr 21	56.6%	95%	95%			Yes	56.6%	tbc
ED time to initial assessment (mins)	Apr 21	23	15				Yes	23	15mins
12 hour ED trolley waits	Apr 21	12	0				Yes	12	tbc
Total Emergency Admissions from A&E	Apr 21	2912					Yes	2912	29744
Hospital Occupancy									
Bed Occupancy -G&A	Apr 21	78.0%	92%	92%			Yes	78%	92%
Activity									
ED activity (total excluding planned returns)	Apr 21	12070		12134			Yes	12070	145608
ED activity (type 1 and 2 excluding planned returns)	Apr 21	10315		9981				10315	118403
Total Non Elective Activity	Apr 21	4924		5180			Yes	4924	62349
Outpatients Elective Total activity	Apr 21	50988		54687			No	50988	558021
Total Elective IPDC activity	Apr 21	4972		4844			No	4972	58789
Diagnostic Activity Total	Apr 21	16313		16500				16313	tbc

Workforce - KPI	Latest month	Actual Month Performance	National Standard for month	SaTH trajectory for month	Perfomance	Assurance	Exception	Year to Date	Year End Planned Trajectory
Activity									
WTE Employed**Contracted	Apr-21	5756		6173			Yes	5756	tbc
Total temporary staff -FTE	Apr-21	644					Yes	644	tbc
Agency Expenditure £	Apr-21	2.519m		2.668m			Yes	2.519m	tbc
Staff turnover rate (excludes junior doctors)	Apr-21	0.68%	0.8%	0.75%			No	0.68%	0.8%
Sickness absence rate Excluding Covid Related	Apr-21	3.96%		4.00%			No	3.96%	4%
Appraisal Rate	Apr-21	85%	90%	90.0%			Yes	85%	90%
Appraisal Rate (Medical Staff)	Apr-21	74%	90%	90.0%			Yes	74%	90%
Vacancies	Apr-21	449	<10%	<10%			No	449	<10%
Statutory and Mandatory Training	Apr-21	86%	90%	90.0%			Yes	86%	90%
Finance - KPI	Latest month	Actual Month Performance	National Standard for month	SaTH trajectory for month	Perfomanc	Assurance	Exception	Year to Date	Planned Trajectory
Cash	Apr-21	17.855m		24.268m			Yes	17.855m	tbc
Efficiency	Apr-21	115,000		0			Yes	115,000	2.4m (M6)
Income and Expenditure	Apr-21	-353000		-352000			Yes	-353000	3.998m(M6)
Cumulative Capital Expenditure	Apr-21	-52000		-248000			Yes	-52000	31,297m

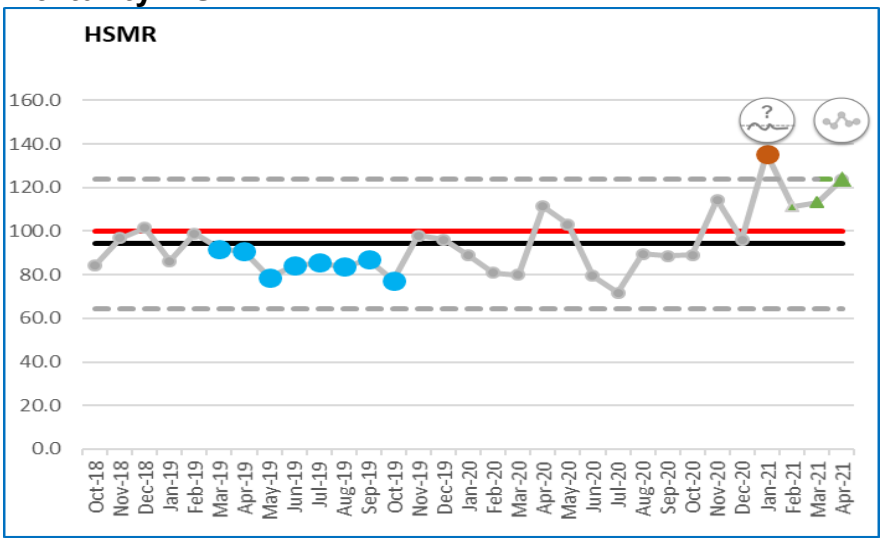
SPC Variation Icons



3. Quality Summary
Hayley Flavell, Director of Nursing and John Jones, Acting Medical Director

- There were 9 Serious Incidents reported this month and zero never events. This report also includes the 25 open SIs at the end of April split by Division.
- There were 14 pressure ulcers at grade 2 or above this month, returning to the targeted 2020/21 performance levels, but worse than the improvement trajectory set for 2021/22 by one patient.
- The infection prevention and control indicators delivered in accordance with plan for both MRSA and C. difficile, however the number of infections reported for MSSA and e.Coli exceeded the improvement plan trajectory. Two further HCAI have been included in the reporting for 2021/22 – Pseudomonas Aeruginosa and Klebsiella.
- The number of falls remains a key area of focus for improvement as this is the highest volume of safety incidents reported in the Trust. The number of falls totalled 112 in April, representing a continued increase in the volume of falls and a level that is higher than the improvement trajectory. However, both the number of falls per 1000 bed days and falls with harm were better than the national standards set. Falls per 1000 bed days is higher than the improvement trajectory set by the Trust.
- There were 20 mixed sex breaches this month, a continuing improvement on last month. This was expected as the impact of the pandemic reduces and enables the restoration of single sex accommodation.
- Acknowledgement of complaints on receipt is continuing to perform well. The response time to resolve complaints continues to be a concern, with the improvement seen last month not being sustained and performance well below the target set.
- There is a lag in mortality data and work is taking place with CHKS to seek assurance that changes are in line with peers. Performance on RAMI in February is better than the reference level of 100, however HSMR remains worse than average peer performance. More detailed mortality information is included in the quarterly update report.
- VTE performance shows sustained improvement, however is slightly below target this month. Actions to ensure patients are not transferred to inpatient wards without completed assessments are due to be delivered by 7th June 2021 to secure further improvement in patient care and risk mitigation.
- Maternity indicators are included in this report to provide an overview of the performance within the service. These indicators form a small proportion of the overall maternity dashboard that is being used to monitor service performance. The national measure for reduction in smoking in pregnancy for 2021-22 is to reduce to no more than 6% of ladies smoking at delivery.
- Patient experience in relation to FFT, cleanliness and catering scores are all showing sustained good performance.

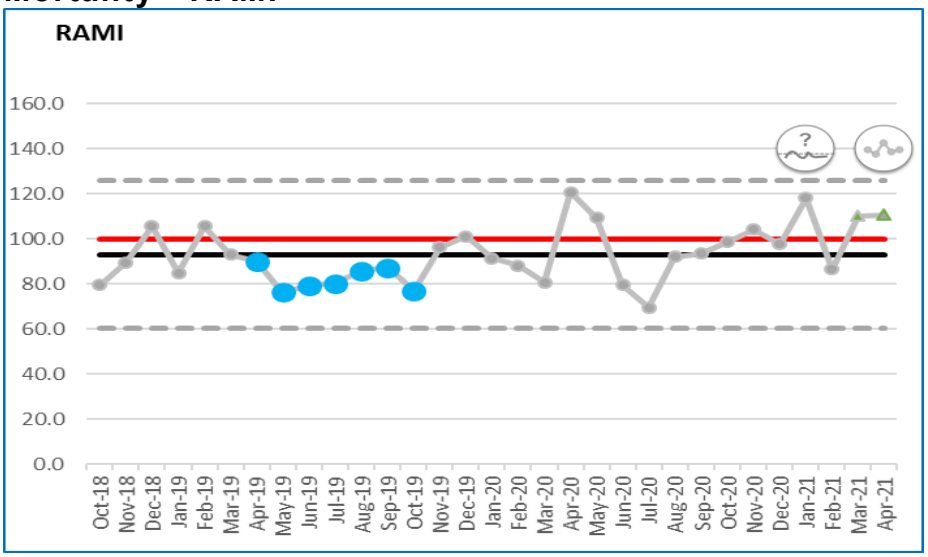
Mortality-HSMR



February 2021 actual performance
111.3 (Forecast March 113.2, April 123.7)
Variance Type
Common Cause
National Reference Value
100
Plan Achievement
Performance slightly better forecast, but below peer average

Background	What the Chart tells us	Issues	Actions	Mitigations
The Hospital Standardised Mortality Ratio (HSMR) is the quality indicator that measures whether the number of deaths across the hospital is higher or lower than expected	The Trust's HSMR position is slightly below the peer average but the index was higher than the peer in some months. There was an increase in HSMR in November, similar to the peer, but the index for SaTH fell in December. The high HSMR position in January correlates to the second wave of Covid-19 deaths.	The longer-term trend for HSMR is in line with the peer and expected range. The conditions with the highest number of 'excess' deaths are urinary tract infection, respiratory failure, acute bronchitis and other lower respiratory disease, all of which were high compared to the peer and have increased from the previous report.	Further analysis is underway to determine the accuracy of coding and recording of the primary diagnosis. For deaths where the primary diagnosis has been recorded as Covid-19 these are excluded from HSMR; however if covid-19 appears elsewhere in the spell or in a subsequent diagnosis then these deaths may be included in HSMR.	HSMR is a standing agenda item at the Trust learning from deaths group, enabling early identification of possible concerns and rapid action to be taken to better understand where the issues may lie.

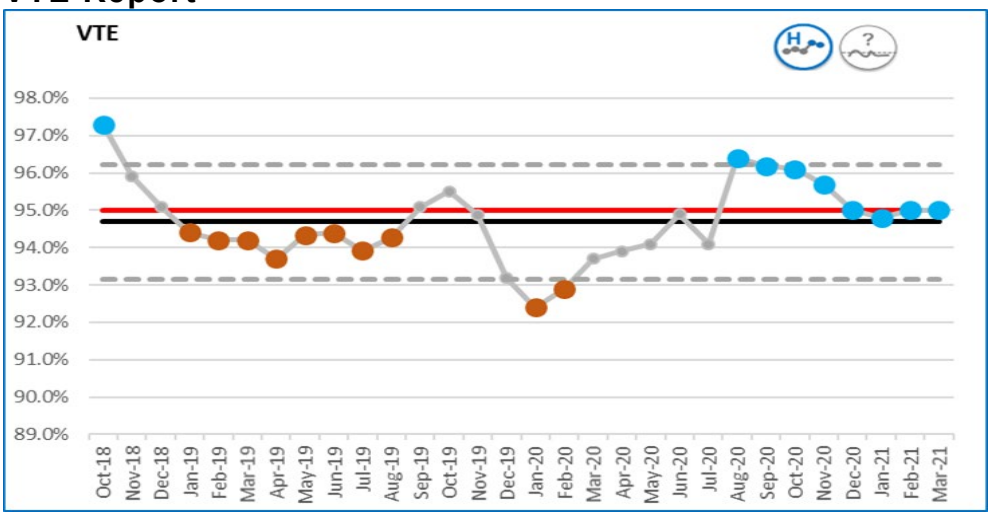
Mortality - RAMI



February 2021 actual performance
86.6 (Forecast March 109.9, April 110.7)
Variance Type
Common Cause Variance
National Reference Value
100
Plan Achievement
Reference value delivered. However monthly variation and forecast suggests this will not be sustained for March and April

Background	What the Chart tells us	Issues	Actions	Mitigations
The Risk Adjusted Mortality Index is a quality measure used to predict death within the organisation	The Trust's RAMI position is slightly below the peer average. The index for the Princess Royal Hospital was higher than the peer. The RAMI indicator excludes Covid-19 patients. Performance has been negatively impacted due to the high crude mortality rate in January 2021.	The conditions with the highest number of 'excess' deaths are pneumonia, urinary tract infection and aspiration pneumonitis, the latter two of which were high compared to the peer.	All cases with a primary diagnosis of urinary tract infection have been reviewed. Learning opportunities for both the clinical and coding teams on the recording of primary diagnosis have been identified and shared at the Trust learning from Deaths Group	Mortality performance indicators are a standing agenda item at the monthly Learning from Deaths Group where all indicators that are above the expected range are discussed and appropriate action agreed

VTE Report

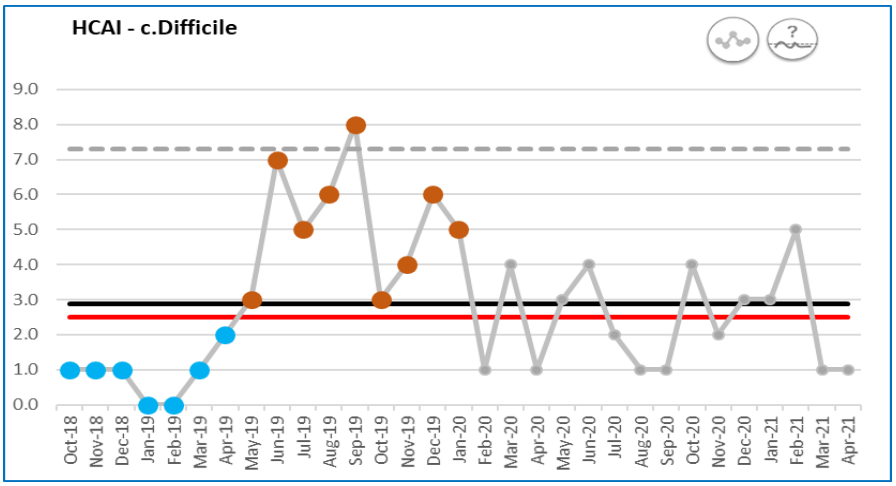


March 2021 actual performance
94.5%
Variance Type
Special cause improvement
National Target
95%
Target / Plan Achievement
Delivering continues to be close to target and planned performance

Background	What the Chart tells us	Issues	Actions	Mitigations
This is clinically important in order to protect inpatients from harm.	There has been sustained improvement in delivery of the target. However for the past 4 months performance has been close to the expected level	Not all patients are having an assessment prior to admission to the ward	Clinical leadership strengthened and requirement to have completed risk assessment prior to leaving assessment areas expected from 7.6.21. to support improved delivery	Outcome from actions scrutinised via QOC and MD team

Hospital Acquired Infections

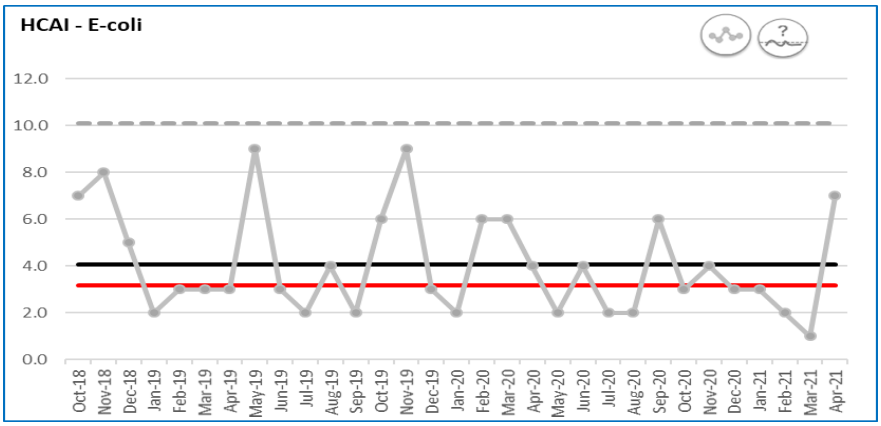
c-Difficile



April 2021 actual performance
1
Variance Type
Common Cause Variance
Local standard for improvement
2.5
Target / Plan Achievement
To sustain or improve on 2020/21Target, is no more than 30 cases reported during the year.

Background	What the Chart tells us	Issues	Actions	Mitigations
There is currently no target agreed from NHSE/I for 2021/22. Locally agreed target for this year is no more than number of cases for last year, given this was a low number and the impact of covid-19 last year	There was one case of C. difficile attributed to the Trust in April 2021. This was taken post 48 hours of admission. RCA's are being undertaken for every case to enable learning to take place.	All cases of post 48 hour infection or community acquired within 28 days of discharge have an RCA completed Recurrent themes from these include: • Timeliness of obtaining stool sample • Ability to isolate immediately due to side-room availability • Antimicrobial prescribing	All cases have an RCA completed. Themes from RCAs reported via HCAI report at IPC Operational Group (IPCOG) and as part of Divisional Reporting to IPC OG. Staff reminded about importance of taking stool sample for patients who have diarrhoea Anti-microbial stewardship to be shared with Divisions for discussion in Divisional Governance meetings	Ongoing mitigating actions include: • Redirooms increases isolation capacity in the Trust • If staff unable to isolate as no side-room on ward escalate to matron and CSM for sourcing of side room • Datix if delay in isolating patient due to side room availability

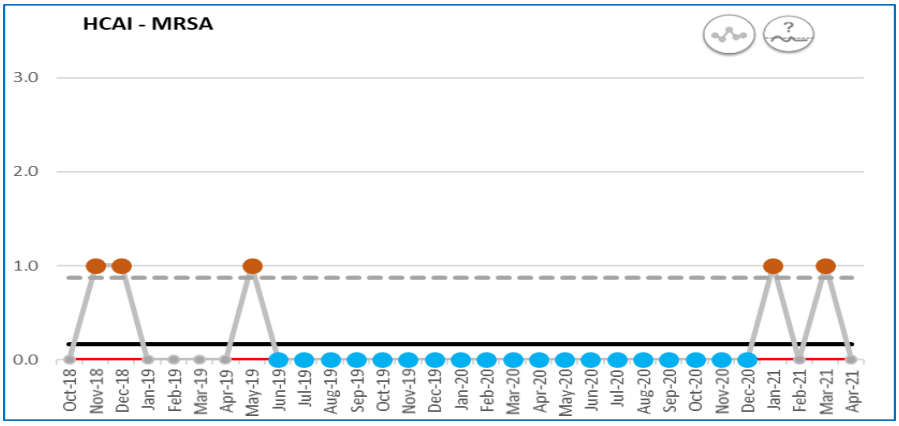
E.Coli



April 2021 actual performance
7
Variance Type
Common Cause Variance
Local Target
Mean of 3.16 per month
Target / Plan Achievement
Target for 2021/22 is no more than 38 cases reported during the year

Background	What the Chart tells us	Issues	Actions	Mitigations
Reporting E.Coli bacteraemia has been a mandatory requirement since 2011	There were 7 cases of E.coli Bacteraemia in April 2021 which were 48 hours post admission	Only one of the cases was deemed to be device related, the source was considered to be a CAUTI. The sources in the other six cases were: Upper UTI, Biliary Colic/pancreatitis, Acute Gangrenous cholecystitis with empyema, cholangitis, abdominal and neutropenic sepsis. Previous RCAs have identified concerns in relation to: • Urine sample not sent at time of blood cultures in a timely manner • Urine samples not correctly identified as MSU/CSU	RCAs are undertaken on the cases deemed to be device related, i.e. one case for April 2021. Actions in place and continue include: • Matrons and ward managers to remind staff around timely taking of samples • ensuring all patients with a catheter have a catheter care plan (audited via Matrons Quality Audits) • New catheter insertion documentation now being rolled out • Staff reminded about full documentation when samples taken	RCA's are being undertaken on all Post 48 hr cases to identify if they are device or intervention related. These are discussed at IPC Operational Group to share learning and actions. • Ongoing improvement work in relation to catheter care • Aseptic non-touch technique refresher training being implemented by the Clinical Practice Educators

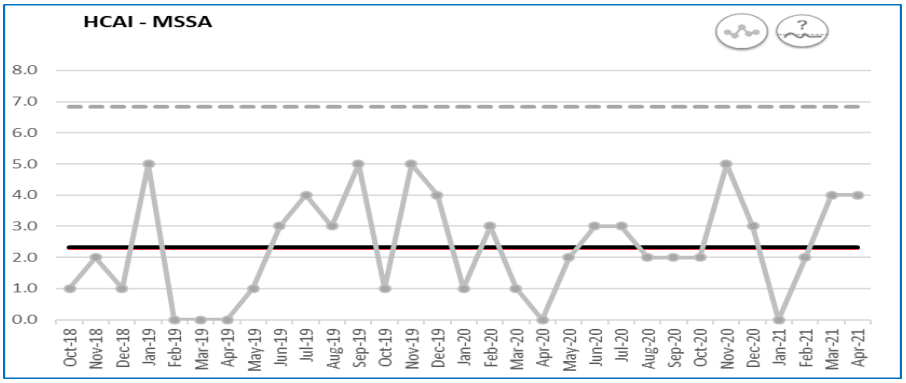
MRSA



April 2021 actual performance
0
Variance Type
Common Cause
Local Target
0
Target / Plan Achievement
0 infections for 2021-22

Background	What the Chart tells us	Issues	Actions	Mitigations
The Target for all Acute Trusts is Zero cases of MRSA bacteraemia	There were no MRSA Bacteraemia in April 2021	None to report	Ongoing daily VIPs report from Vitalpac and daily monitoring by matrons Aseptic non touch technique refresher for ward staff, training being developed by the Clinical Practice Educators	Ongoing monitoring of IPC compliance and MRSA screening at Trust and Divisional Level via the monthly IPC Operational Group and IPC Assurance Committee.

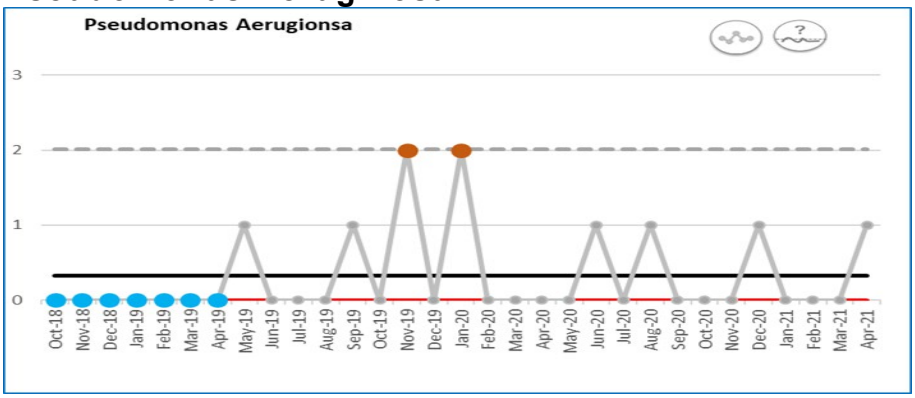
MSSA



April 2021 actual performance
4
Variance Type
Common Cause Variation
Local Target
2.3
Target/ Plan achievement
Sustain or improve on 2020/21(</=28 cases)

Background	What the Chart tells us	Issues	Actions	Mitigations
Reporting of MSSA bacteraemia is a mandatory requirement	There were four cases of MSSA Bacteraemia in April 2021 that were taken post 48 hours.	Three cases were not considered to be device or intervention related, the sources for the three non-device related cases were: Infective Endocarditis, abscess and Valve Endocarditis.	The fourth is having an RCA undertaken to determine the source. Ongoing actions from other RCAs include: • ensuring use of catheter care plan and catheter insertion documentation • Staff reminded about correct labelling of blood cultures	All MSSA Bacteraemia were the source is unknown or it is deemed device related have an RCA completed and learning is presented and discussed at the IPC Operational Group

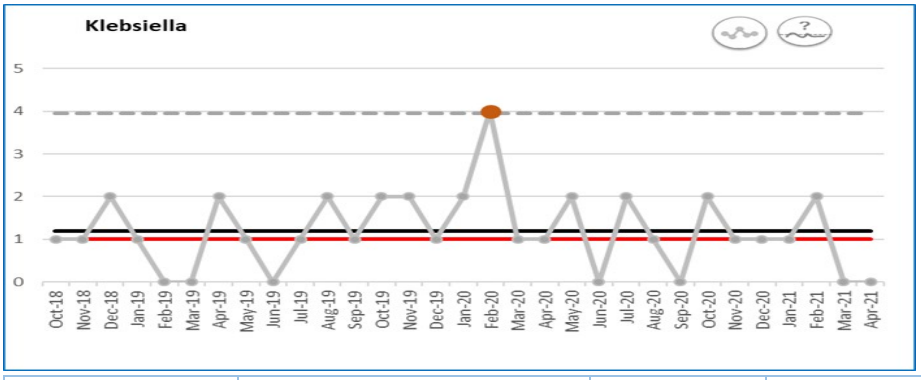
Pseudomonas Aeruginosa



April 2021 actual performance
1
Variance Type
Common Cause Variation
Local Target
0
Target/ Plan achievement
Sustain or improve on 2020/21 baseline of 3

Background	What the Chart tells us	Issues	Actions	Mitigations
Reporting of Pseudomonas Aeruginosa is a mandatory requirement	There was one case of post 48-pseudomonas aeruginosa bacteraemia in April 2021 that was taken post 48 hours of admission.	The source of this case was considered to be a CAUTI, therefore it is device related.	Ward managers reminded at Nursing metrics meeting to ensure catheter insertion documentation and care plan is used. Aseptic non-touch technique refresher training to be delivered by Clinical Practice Educators	Matrons audit catheter care as part of their monthly Quality Metrics Audits

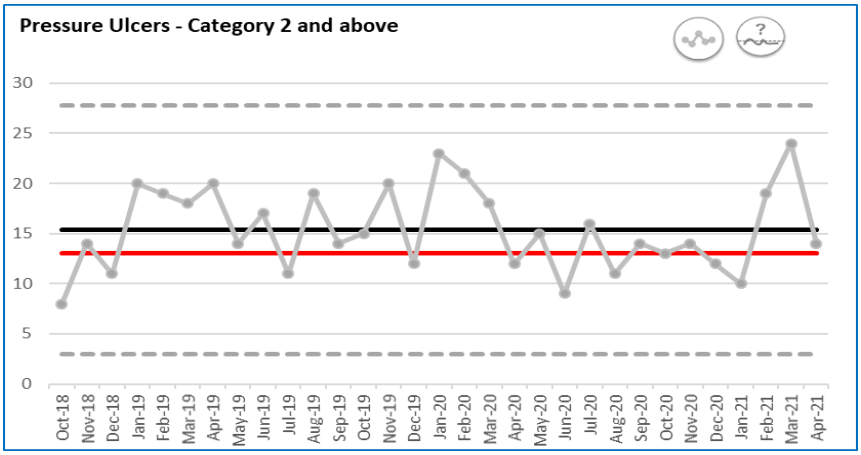
Klebsiella



April 2021 actual performance
0
Variance Type
Common Cause Variation
Local Target
1
Target/ Plan achievement
Sustain or improve on 2020/21

Background	What the Chart tells us	Issues	Actions	Mitigations
Reporting of Klebsiella is a mandatory requirement	The numbers of Klebsiella bacteraemia are small. There were no cases in April 2021	NA	As per other Health Care Associated Infections	Cases are monitored through IPC Ops Group at Trust and Divisional Level

Pressure Ulcers – Category 2+

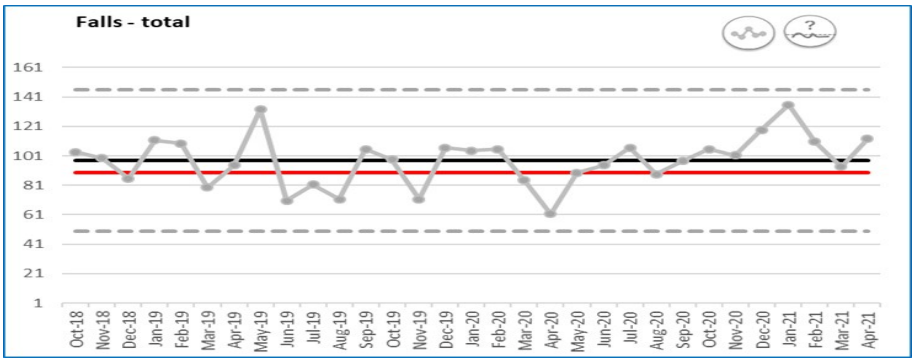


April 2021 actual performance
14
Variance Type
Common Cause
Local Target
13
Target/ Plan achievement
10% Improvement on 20/21 prorata =<12.7pm (no more than 152 cases)

Pressure Ulcers reported – Total per Division	Number Reported
Medical and Emergency Care	10
Surgical, Anaesthetics and Cancer	3
Women's and Children's	1

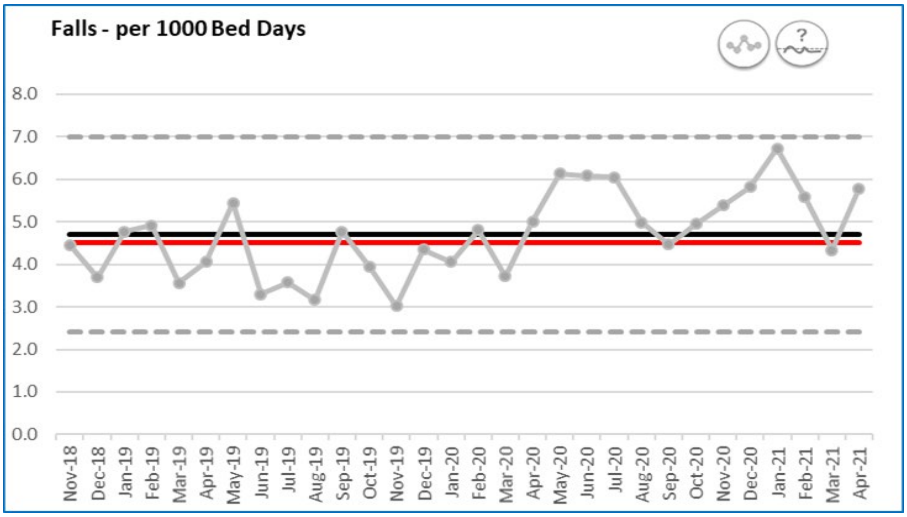
Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust aims to reduce the number of hospital acquired pressure ulcers	There was a significant increase in pressure ulcers in March with 24 cases, this has reduced in April down to 14 cases	All cases of pressure ulcers reported in April were category 2 ulcers	All pressure ulcers have an RCA completed, but a themed review of the cases in ITU, lessons learnt and actions for the ITU cases is being undertaken Additional support from Tissue Viability team to areas that have seen an increase in pressure ulcers TV training e-learning being completed in areas which have had a cat 3 PU, to be rolled out to all areas Ensure accurate completion of documentation and care delivered as per SKIN bundle with repositioning undertaken as per frequency specified Resource files with pictorial information to help guide accurate assessment of tissue and moisture damage	All pressure ulcers which meet the threshold for an SI are reported as an SI and investigated Pressure Ulcer SIs presented at NIQAM to share learning from these investigation All pressure ulcers cat 2 and above have an RCA completed and presented at the Pressure Ulcer Panel meeting Monthly matrons quality metrics include tissue viability

Falls –Total number of falls



April 2021 actual performance
112
Variance Type
Common Cause
Local Target
89
Target/ Plan achievement
1074= 20/21 total less 10 %

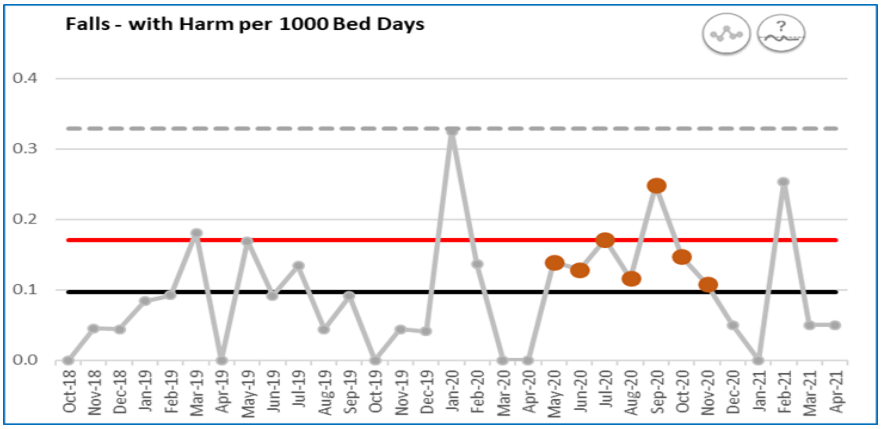
Falls – per 1000 Bed Days Exception Report



April 2021 actual performance
5.78
Variance Type
Common Cause Variation
Local Target
4.5
National Standard
6.6
Target/ Plan achievement
Variation in performance month on month. Presently better than national standard

Background	What the Chart tells us	Issues	Actions	Mitigations
Falls amongst inpatients are the most frequently reported patient safety incident in the Trust. Reducing the number of patients who fall in our care is a key quality and safety priority	There was an increase in April 2021 with 112 falls reported Falls per 1000 bed days increased to 5.78 in April 2021 Both measures are showing common cause variation	There have been improvements in the completion of falls assessments on admission but further improvements required in completion of lying and standing blood pressure. There are ongoing inconsistencies in relation to the repeat assessments and the completion of post falls neuro observations	Ongoing improvement work in relation to lying and standing BP, supported by Quality Facilitators. SQL report for lying and standing BP circulated weekly to ward managers to monitor compliance Ward managers/matrons invited to weekly falls meeting to review care of falls patients Ongoing embedding of Bay tagging (i.e. staff member in bay at all times) for patients assessed as high risk of falls Trial of falls sensory equipment on 4 wards Although quality of completion remains variable, there are improvements in some areas in relation to lying and standing BP, Prevention Care Plan being implemented.	All falls reviewed daily by Quality Facilitators and feedback give to staff at time Monthly audits of falls by matrons as part of Quality Assurance Metrics Falls SIs reviewed and discussed at NIQAM to share learning

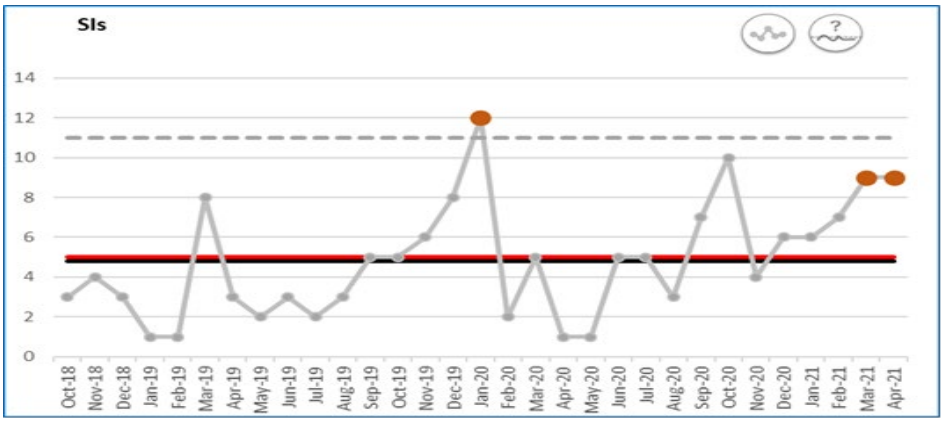
Falls – Harm per 1000 Bed Days Exception Report



April 2021 actual performance
0.05
Variance Type
Common Cause
Local Target
0.17
National Standard
0.19
Target/ Plan achievement
10% reduction on 2020-21

Background	What the Chart tells us	Issues	Actions	Mitigations
Falls amongst inpatients are the most frequently reported patient safety incident in the Trust. Reducing the number of patients who fall in our care is a key quality and safety priority	There was 1 fall with severe harm in April 2021on ward 36	Patient sustained a Fractured neck of femur as a result of the fall. The falls has been reported as an SI and is being investigated	Investigation being completed and will be presented and learning shared at Nursing Incident Quality Assurance Meeting (NIQAM)	Quality team and matron to ensure all risk assessments completed, that care plans in place and post falls care bundle in place post a fall

Serious Incidents



April 2021 actual performance
9
Variance Type
Special Cause Concern
Local Standard
5
Target/ Plan achievement
10% reduction on 2020-21 (No more than 57 cases) pro-rata =< 5 per month

SI theme	Number Reported
Delayed treatment Urology	1
MRSA Bacteraemia – ITU PRH	1
Pressure Ulcer – Category 3 Ward 11	1
Maternity Obstetric affecting baby	1
Delayed treatment – PICC Line Ward 22RE/Ward 25G	1
Pressure Ulcer – Category 3 Ward 15	1
Pressure Ulcer – Category 3 Ward 15	1
Fall Ward 36	1
Post Truss Infection	1
Total	**9**

N.B. all SIs are fully investigated to determine the cause and any necessary actions to prevent re-occurrence. The board will be updated on progress in due course.

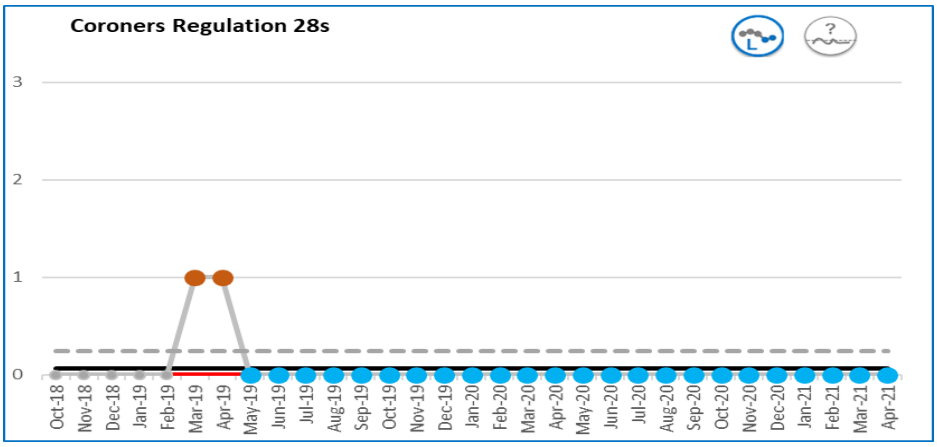
Background	What the Chart tells us	Issues	Actions	Mitigations
Since June 2020 there has been an increasing trend in SI reporting, which may reflect a more open reporting culture.	Following a peak in reporting during October, reporting has remained above the mean for the past five months. March and April have seen an increase in reporting, as detailed above.	Over the coming months COVID 19 related incidents such as delayed diagnosis due access issues/outbreaks and COVID related deaths will continue to see reporting figures increase	Monitor reviews Maintain investigation reporting within national framework deadlines for timely learning Embed learning from incidents	Weekly Rapid Review of incidents Early identification of themes Standardised investigation processes Early implementation of actions

Serious Incidents – Total Open at Month End

SI – Total Open at Month End per Division	Number Reported
Medical and Emergency Care	7
Surgical, Anaesthetics and Cancer	10
Women's and Children's	6
Clinical Support Services	1
Total	**25**

Background	What the Chart tells us	Issues	Actions	Mitigations
Current number of open Serious Incidents	Number of open SI	25 open SI all within 60 day framework	Monitoring of progress of investigation	Weekly review of progress

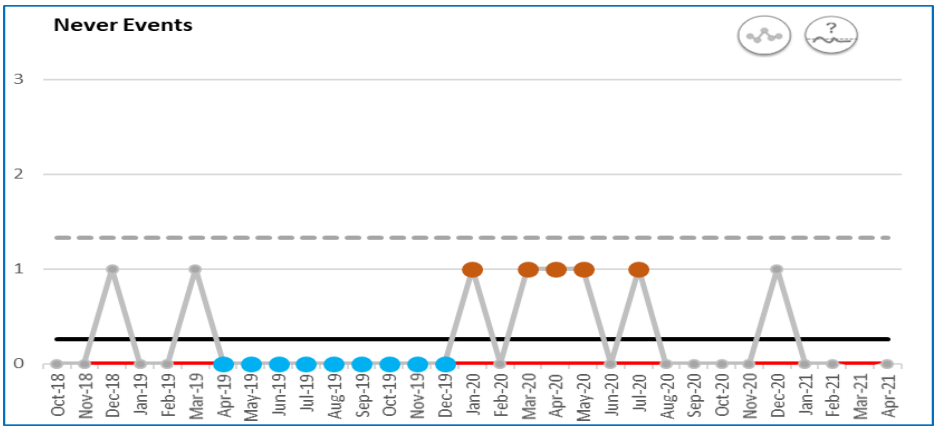
Coroner Regulation 28 Notices



April 2021 actual performance
0
Variance Type
Special Cause – None for sustained period from Mar 20 onwards
National Target
n/a
Target/ Plan achievement
Achieving target month on month.

Background	What the Chart tells us	Issues	Actions	Mitigations
Key patient safety measure	No regulation 28 notices served in 2020-21	None to report		

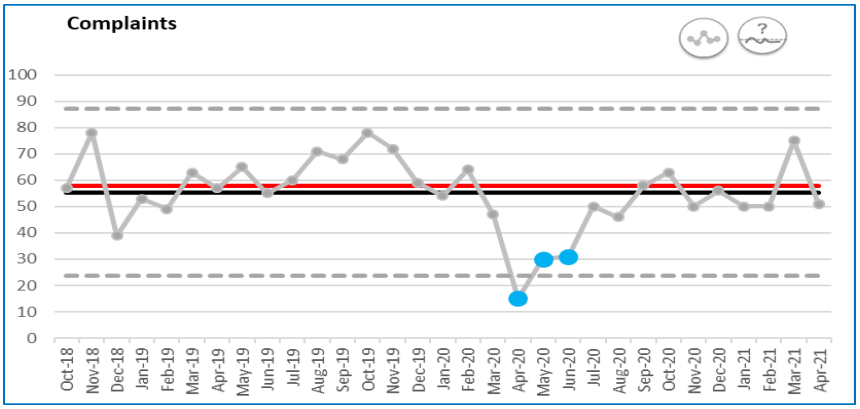
Never Events



March 2021 actual performance
0
Variance Type
Common Cause Variation
National Target
0
Target/ Plan achievement
variation exists and therefore 100% achievement cannot be relied upon

Background	What the Chart tells us	Issues	Actions	Mitigations
Key patient safety measure	No Never Events reported in April	No issues for April		No Actions

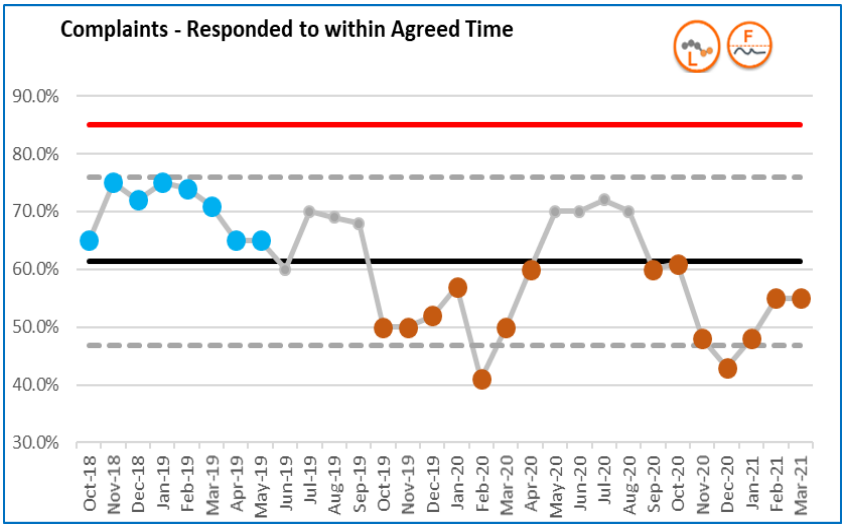
Complaints



April 2021 actual performance
51
Variance Type
Common cause variation
SaTH internal target
56
Target/ Plan achievement
>10% reduction on 2019-20 total complaints

Background	What the Chart tells us	Issues	Actions	Mitigations
Complaints provide a value source of learning to the organisation.	The number of complaints are at expected levels, with the themes similar to those of previous months	None identified this month		

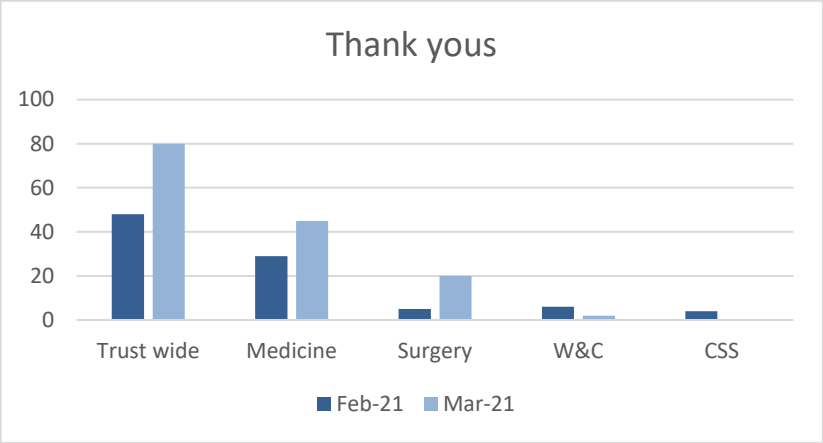
Complaints – Responded within Agreed Time



March 2021 actual performance	
55%	
Variance Type	
Special cause Concern	
National benchmark	**SaTH internal target**
85% compliant with time agreed with complainer	85% responded to within 30 days of receipt
Target/ Plan achievement	
Target is not capable of being achieved within present process	

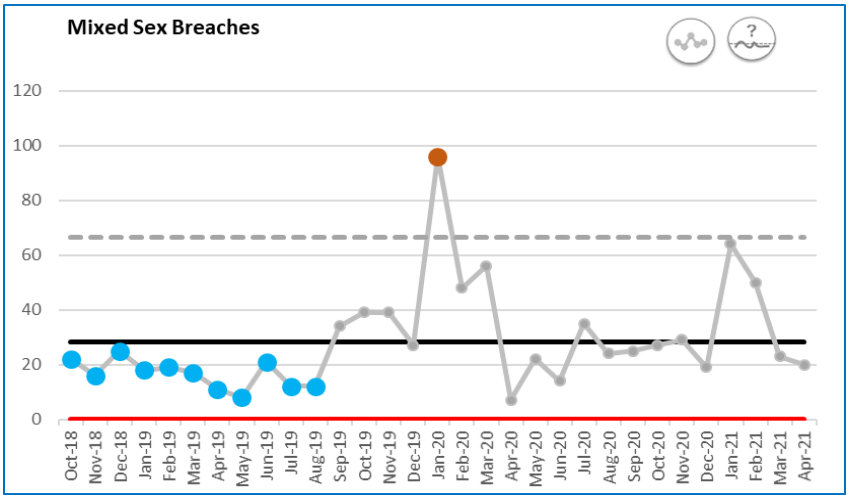
Background	What the Chart tells us	Issues	Actions	Mitigations
It is important that patients raising concerns have these investigated and the outcomes responded to in a timely manner as well as the Trust learning from these complaints	Response rates have not shown improvement expected and remain too low.	Divisions continue to struggle to manage competing priorities in responding to complaints in a timely manner.	Work is ongoing with the divisions to investigate and respond to complaints in a timelier manner.	Complainants are kept updated as to delays

Compliments



April 2021 Performance	
SaTH	**80**
Medicine, Emergency Care Division	**46**
Surgical, Anaesthetics, Cancer Division	**12**
Women and Children Division	**2**
Clinical Support Services Division	**6**
Other	**14**

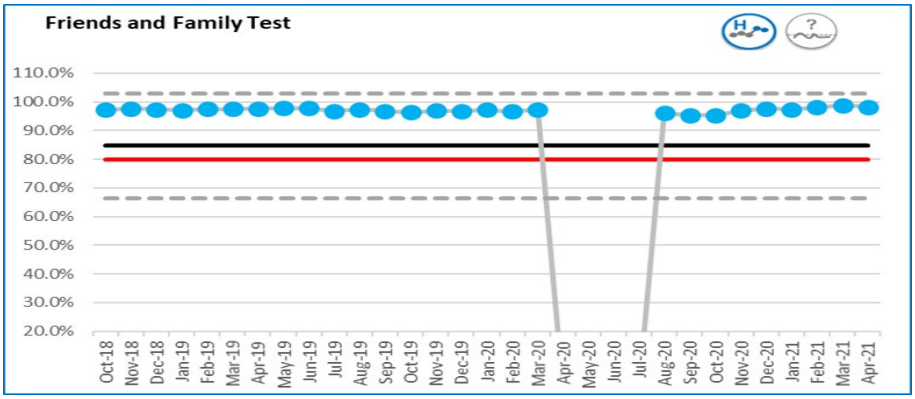
Mixed Sex Breaches Exception Report



April 2021 actual performance
20
Primary mixed sex breaches
Variance Type
Common Cause variation
National Target
0
Target/ Plan achievement
Continuing to breach this target with improvement this month. Majority of breaches relate to delays leaving ITU/HDU when fit to return to the ward.

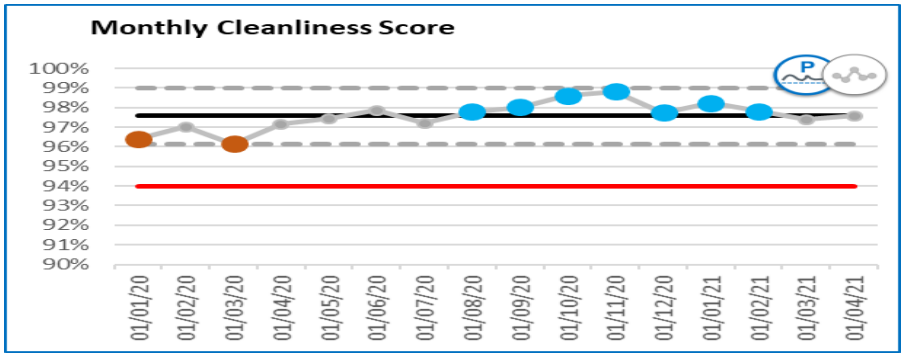
Location	Number of breaches	Additional Information
CCU (PRH)	4 primary breaches	8 secondary breaches over 4 occasions
CCU (RSH)	2 primary breaches	3 secondary breaches over 2 occasions
ITU / HDU	17 primary breaches	(7 Medical and 10 Surgical)

Friends and Family Test



April 2021 actual performance
98.3%
Variance Type
Special Cause Improvement
Target
80%
Target/ Plan achievement
Continuing to achieve better than this target each month

Monthly Cleanliness Score



April 2021 actual performance
97.6%
Variance Type
Common Cause
Local SaTH standard
94%
Target/ Plan achievement
Consistent delivery of target

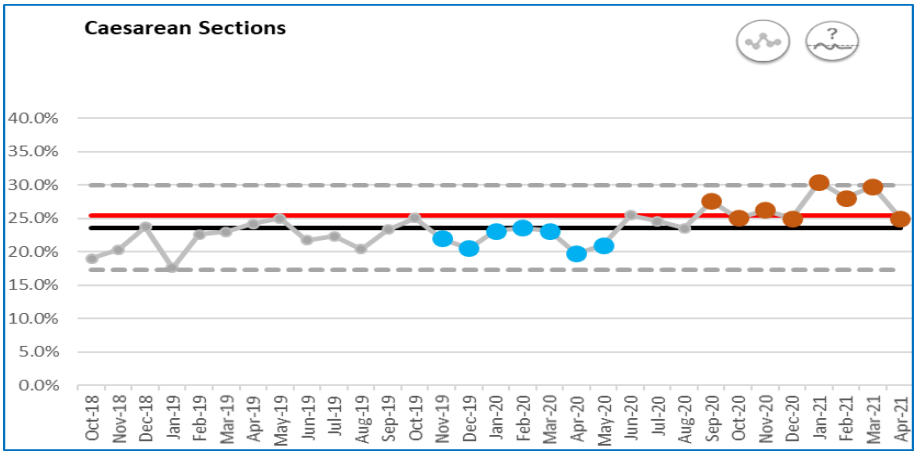
Background	What the Chart tells us	Issues	Actions	Mitigations
This is an independent monthly audit which gives assurance of the standard of cleanliness undertaken by the Cleanliness Team	Consistently performing between the mean and the upper control limit with some slight common cause variation some months	There are no concerns at present which should effect our ability to achieve the target	NA	NA

Monthly Patient Food Satisfaction Score

March 2021 actual performance
96.7% for satisfaction with food and 98.6% for satisfaction with choice%
Variance Type
Common Cause
Local SaTH standard
90%
Target/ Plan achievement
On target to achieve local standard

Background	What the Chart tells us	Issues	Actions	Mitigations
This data is taken from the monthly Matron's Audit where 10 patients per month per ward are asked whether they are happy with the hospital food and the choice they were given	The score for both measures remain above the Trust current target and remain within the upper and lower control limits with them regularly hitting the target with some common cause variation month on month. In April, the score was at or slightly above the median for both measures.	There are no concerns at present which should effect our ability to achieve the target	N/A	N/A

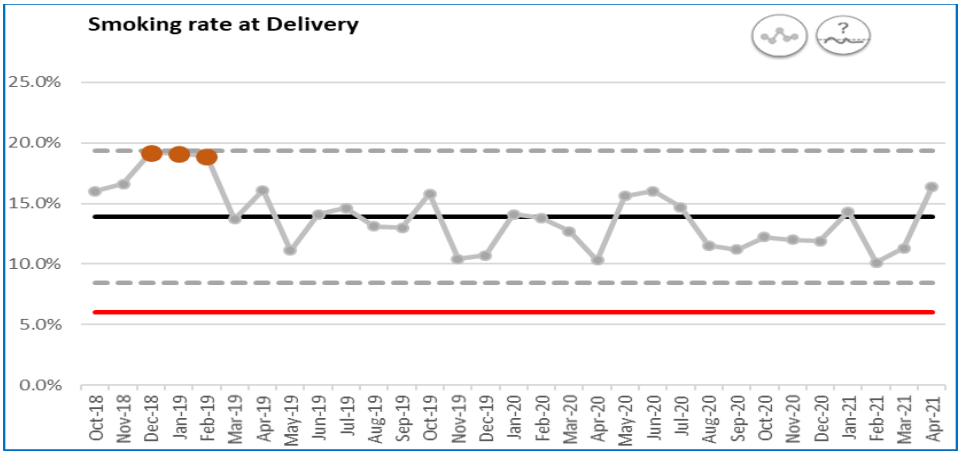
Caesarean Section



April 2021 actual performance
25%
Variance Type
Special Cause concern
National Standard
25.5% (NMPA 2019)
Plan Achievement
Consider this indicator as part of overall maternity care dashboard and benchmarking

Background	What the Chart tells us	Issues	Actions	Mitigations
Treatment and care should take into account women's needs and preferences (NICE 2019). This includes the decision as to whether to have a caesarean section or not. NICE guidance is in plan which identifies certain factors which if present, would result in the recommendation of a CS being made. In addition women are supported to choose a CS in the absence of clinical factors, both situations requiring appropriate counselling. Services monitor the rate of CS, including emergency and planned CS, and use this as an indicator of quality and safety of care. Other parameters are also used to triangulate that data to give a full picture of care	CS rate within accepted range.	This indicator alone does not tell us anything regarding indication for CS. and needs to be correlated with outcomes or measures of harm. This is aggregate data that does not differentiate between elective and emergency C.Section rates.	Await updated GIRFT data to correlate CS rates with other outcomes and to benchmark where SaTH sits Nationally. Will also help to adjust national average and process limits. Using maternity dashboard to review rates for emergency v elective sections.	Nil required

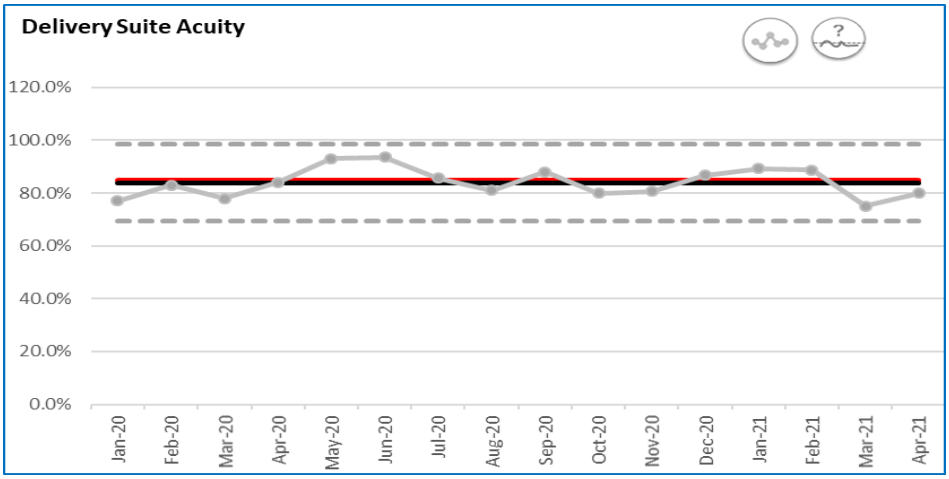
Smoking Rate at Delivery



April 2021 actual performance
16.4%
Variance Type
Normal Variation
National Target
Government Target 6% By 2022
Target / Plan Achievement

Background	What the Chart tells us	Issues	Actions	Mitigations
The National SATOD government target for smoking at time of delivery has been set to 6% by 2022. Currently there are two different smoking cessation referral pathways and services. Shropshire is a public health funded stop smoking service whereas Telford and Wrekin has been funded by the CCG /LMNS and is run by the Public health Midwife within the maternity team.	Slight increase in SATOD rates for April 2021, however not excessive and similar to previous April/May rates for 2020. No special cause for concern or need for service adjustment	Separate services remain across the county for pregnant women-plan to create integrated service this summer to improve equity for all women in the service they receive	No specific action required. Future changes to service in progress	Still aiming for government target of 6% SATOD by 2022. Integrated service can re-evaluate focus/target demographic areas to reduce smoking rates

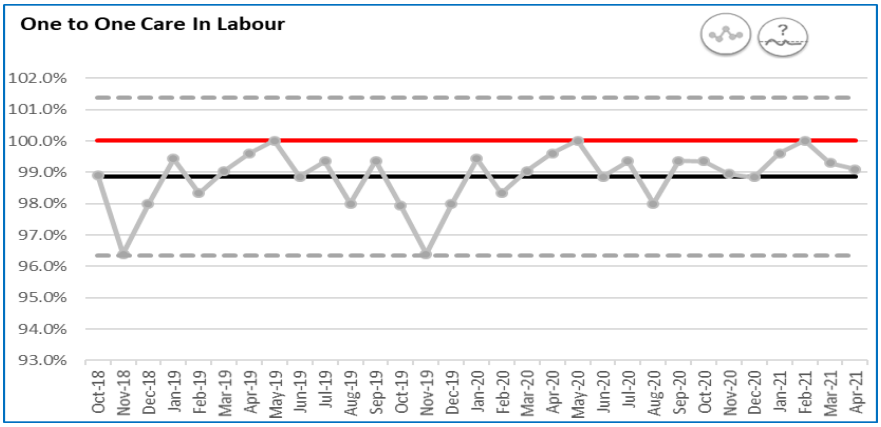
Delivery Suite Acuity



April 2021 actual performance
80%
Variance Type
Normal Variation
National Standard
85% (Birth Rate Plus)
Target / Plan Achievement

Background	What the Chart tells us	Issues	Actions	Mitigations
In 2015 NICE set out guidance for safe midwifery staffing which included the use of a tool endorsed by NICE to measure and monitor acuity. This has been in place at SaTH since 2018 and is reported monthly in line with the CNST standard safety action number 5	We are currently below the set standard set by Birth rate Plus.	Staffing currently a challenge combined with higher levels of births inQ4 Higher levels of IOL Q4 Reassured by other indicators, such as 121 care in labour, PPH rates, 3rd and 4th degree tears below expected rates, Term admissions to NNU below national rates. HIE cases 0	Recruitment in progress. Use of temp staffing and additional hours for existing staff. Use of SMT huddles to assess acuity across unit to maintain safety – good use of escalation policy used.	Twice daily SMT huddles Escalation policy when required. Further training for BR+ acuity tool planned to update Coordinators on improved input of data. Planning wider piece of work with BR+ to look at deployment of staff as a whole.

One to One Care in Labour



April 2021 actual performance
99.1%
Variance Type
Normal Variation
National Standard
100% (Better Births)
Target / Plan Achievement

Background	What the Chart tells us	Issues	Actions	Mitigations
Midwifery safe staffing should include plans to ensure women in labour are provided with 1:1 care, including a period of 2 hours after the birth of their baby. The provision of 1:1 care is part of the NCST standard safety action number 5 which requires a rate of 100% 1:1 care in labour.	121 care in labour is being achieved within the normal variation, this has been consistent over past months. It has not met 100% standard for past 2 months.	Staffing levels challenging due to vacancies, maternity leave and secondments. Birth rate up in Q4 considerably IOL rates increased considerably during Q4 also.	Recruitment in progress- with good results being seen. Use of temp staffing, process currently being reviewed for optimal cover of vacant duties. Exploring use of agency staffing if required. Workforce review and mapping in progress/reviewing secondments as priority.	Twice daily SMT huddles Use of acuity tool to advice deployment of staffing. Use of escalation policy to maintain safety when required.

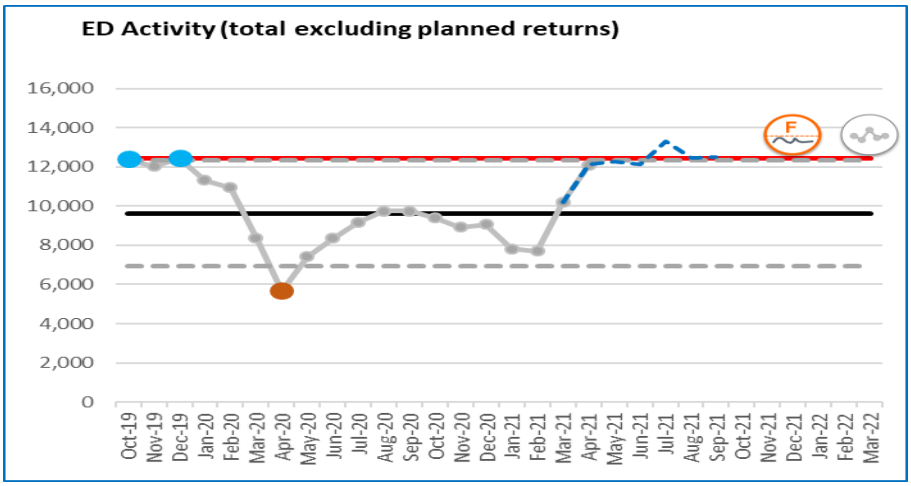
4. Operational Summary
Mr Nigel Lee, Chief Operating Officer

- April saw a continued decrease in general acute and critical care Covid activity. Covid admitted patient numbers remain in single figures, with between zero and 3 patients with Covid in critical care. Strict infection control measures for ED and assessment unit pathways remain in force, and this is mirrored for wards and theatres. Separate 'green' pathways remain for elective surgery. In addition, measures to limit risk for Outpatients remain in place to minimise any spread of infection.
- The reduction in Covid pressures allows clinical teams to work on the next steps for the critical care service. Both sites now have the 'Bioquell' isolation pods fully installed, which is already supporting more effective isolation, which also provides greater resilience for any future Covid (or other infection) surges.
- For the EDs, attendances have broadly returned to pre-Covid levels, and whilst work has commenced on the RSH ED department estate and mitigations such as the two medicine SDEC units and newly opened Surgery SDEC at RSH (open at the end of April) are in place, the flow through EDs and into the wards remains a challenge at times. During the month, RSH has been particularly affected by increases in ambulance conveyance, major presentations and conversion rates for admission. Work is ongoing with WMAS as well as Shropshire system partners to identify themes and mitigations.
- ED Performance has started to recover slowly, although the Trust had twelve 12 hour breaches in April (on 2 days at the end of April, all at RSH). Direct GP medical admissions to RSH that are not suitable for SDEC are still routed through RSH ED, and remain a factor. The project on flow continues, with pre-1200 discharge and process improvements on wards set as a priority. SATH is average for >7 day patient length of stay levels, and performing better than average for the >21 day cohort.
- We are continuing to monitor activity against the levels set in the National planning guidance thresholds. Outpatient new and follow up appointments are showing good compliance against the plan, with circa 33% of activity undertaken virtually. However, this level of activity does not yet equate to the activity levels in 2019-20, which is constrained by space within both waiting areas and clinics, as well as additional PPE requirements, especially for aerosol generating procedures. In order to drive forward on recovery for patients requiring surgery, the Trust has extended the contract for the Vanguard theatre & recovery unit for 12 months until March 2022. As availability of theatre staff remains a constraint, the benefit of this unit is that this includes theatre staff. Elective admitted activity plans still fall short of the level needed to reduce backlogs swiftly, and a set of further additional solutions is being reviewed at ICS level for financial approval in early May for rapid implementation.
- Potential risk remains in the groups of patients waiting to be seen. We are mitigating this through clinical prioritisation and scheduling our available capacity for Priority 2 patients including patients waiting on cancer pathways. During March and April, we ran additional weekend theatre sessions to re-schedule cancer activity postponed due to the loss of the green pathways during the peak of the 3rd wave of Covid-19 during January and February 2021. This is reflected in the deterioration of performance as patients over 62days are rightly receiving treatment. The RTT waiting list has also continued to rise, albeit at a lower rate than forecast, and referrals are returning once again to pre-Covid levels. To support urgent imaging activity, SATH benefitted from additional mobile CT capacity during Q3 and Q4,

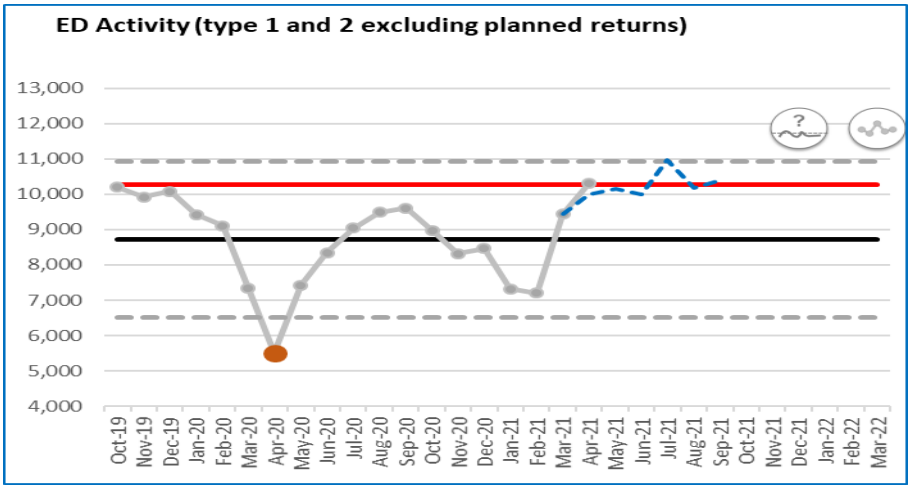
prioritised by NHSI region. The Trust has been notified that this will cease with effect from the start of June, and whilst the new CT & MRI building (with 2 new scanners) is expected to be in service from the second half of August, radiology staffing remains a constraint to fully open this immediately. The replacement of a CT scanner at PRH is due to be completed during May 2021, returning some capacity to the service.

- March represented the start of a transition for the Trust, from a period of intense clinical pressure (and pressure on staff) and impact on a range of elective services to a period of re-establishing services, albeit with appropriate safety measures in force.
- The re-opening of elective theatres has commenced, resulting in an increase in activity and enabling priority treatment to be given to our cancer patients. This is reflected in a deterioration in the reported performance for cancer 62 day pathway as patients in the backlog who had waited over 62 days prior to surgery are being treated.
- The increased capacity available during the month has enabled the improvement in 6 week wait times to continue, with the backlog of patients reducing in this area.
- However, with the priority being rightly given to clinically urgent patients, the number of long waiting patients and the length of their wait continues to increase. We are working through the plans for the first half of 2021-22 to re-establish our capacity at pre-covid levels, recognising that there will be a reduced capacity, as we need to apply appropriate safe practices.
- Unscheduled care performance has improved as the level of Covid-19 has reduced. We have seen bed occupancy reduce and have seen reduction in our long stay patients, performing extremely well on regional benchmarking in this regard. Our ED performance has also improved as patient flow improves and this is continuing into April 2021. We have presented evidence of quality improvement in ED to the CQC.

ED Activity – Type 1



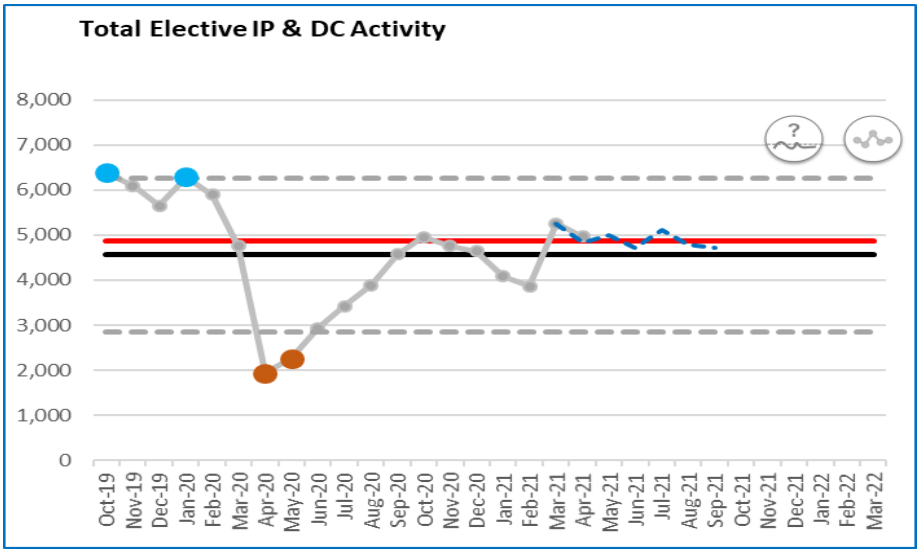
April 2021 actual performance
12070
Variance Type
Common Cause
Local Target
12134 (monthly average)
Target/ Plan achievement
Trajectory Based on H1 plan



April 2021 actual performance
10315
Variance Type
Common Cause
Local Target
9981 per month
Target/ Plan achievement
Trajectory Based on H1 plan

Background	What the Chart tells us	Issues	Actions	Mitigation
The ED activity levels reflect the demand for unscheduled care presenting at the A&E departments. Type 1 activity is the major A&E activity and excludes minor injury unit and urgent care centre activity	The level of activity is slightly higher than the planned trajectory and above the local plan for 2021-22.	Activity has returned to pre-covid-19 levels, however segmented pathways need to be retained for infection prevention and control reasons. These reduces capacity and so impacts on flow in the department. The activity that has returned to A&E tends to be patients presenting with high acuity.	A&E improvement plan developed and being implemented. SDEC being optimised. Surgical SDEC opened. UCC returned to both acute sites to support signposting of patients to these facilities.	System wide pathway work being managed by UEC group chaired by SaTH COO.

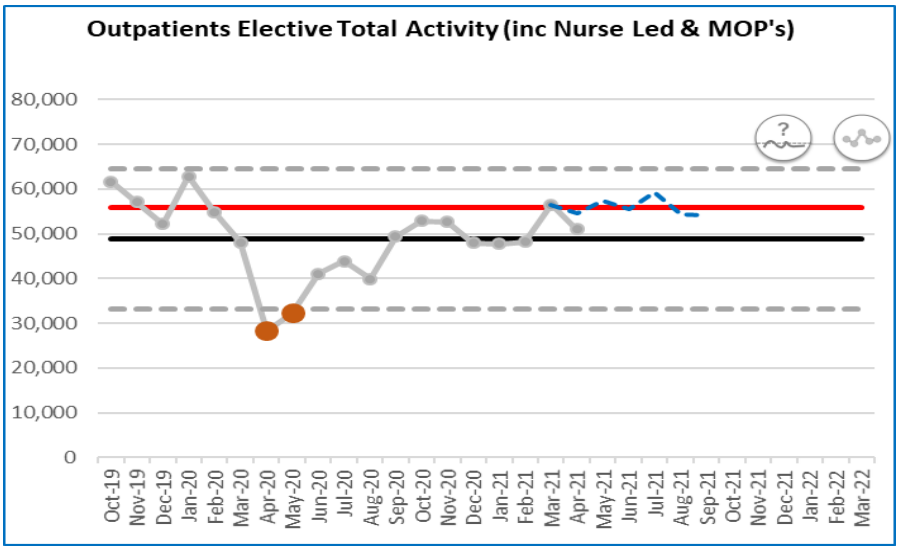
Elective IP & DC Activity v Phase 3 recovery plan



April 2021 actual performance
Total 4972 **DC** 4695 **IP** 277
Variance Type
Common Cause
National Target
National DC & IP 70% **Local** 4844 (monthly average of H1 plan
Target/ Plan achievement
H1 plan achieved

Background	What the Chart tells us	Issues	Actions	Mitigation
The Trust monitors delivery of its elective inpatient and day case activity against the H1 plan thresholds. The level of activity delivered impacts on waiting times and waiting list size as well as potential for H1 funding through the Elective Recovery Fund/	Activity remains below the pre-covid levels but has recovered to deliver the H1 target of >70% of 2019-20 baseline in April.	Limited green elective bed base Shortage of theatre nursing staff	Plans in place to expand elective bed base at RSH from 24.5.2021 and PRH Orthopaedics from 10.6.2021 Theatre nurse recruitment continuing Additional interventions are proposed to further increase capacity including insourcing provider for weekend working	Patients dated in order of clinical priority subject to specialties

Outpatients Elective Total Activity



April 2021 actual performance
50988
Variance Type
Common cause
Local Target
54687 (Monthly Average of H1 plan)
Target/ Plan achievement
Below target with pre-covid delivery unachievable at the present time

Background	What the Chart tells us	Issues	Actions	Mitigation
The availability of outpatient capacity remains constrained as a result of 2 metre social distancing, and the availability of man power in some specialities where staff have been redeployed to support emergency and Covid-19 related pressures.	The teams are trying to micromanage all element of RTT in line with clinical urgency and long waits	Limited outpatient rooms and visibility	Implementation of Bookwise for outpatient room visualisation QIA to reduce social distancing to 1m sent to Director of Nursing to consider Non-face to face consultations continuing to deliver 33% of activity	

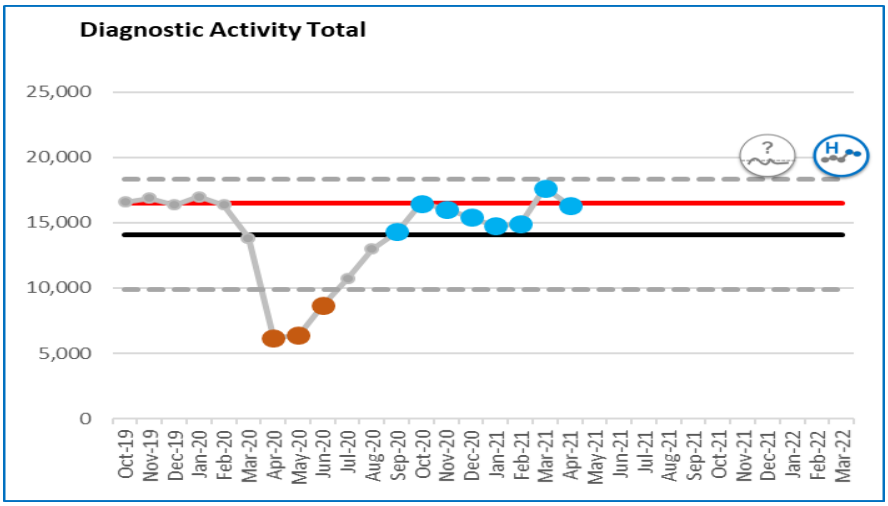
From April 21 to September 21, the elective recovery scheme for England will be in operation. The activity levels for Outpatients, IPDC are monitored against the % of 19/20 baseline activity to assess the extent of service recovery. The Elective Recovery Funding (ERF) scheme sets out thresholds for expected levels of performance increasing from 70% of the 19/20 baseline in April 21 to reach 85% of the July 19 activity by July 21, and then to sustain this level in August and September. Achievements above these thresholds are incentivised via the ERF scheme providing the other criteria for transformation, improvement and management health inequalities are met. It is noted that the activity plan is applied to all patients, however the ERF is based on English patients and the financial value of activity

delivered as opposed to the number of patients treated. The table below sets out a baseline forecast position for the remainder of 21/22, which is expected to improve with the additional activity proposed through additional interventions.

		Target Description		Actual v PIs vs Target Mar-21	Actual v PIs vs Target Apr-21	Forecast vs Target Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Outpatient Activity	Total Outpatients (inc Op Proc)	vs 19/20 - 70% April, increasing to 85% by July	19/20 Actual	37,480	41,555	41,555	43,205	41,093	46,017	40,275	42,217	46,634	45,541	40,149	48,297	42,716	37,480
			20/21 Actual	**47,202**	**43,222**	**45,047**	**47,185**	**46,158**	**48,719**	**45,351**	**45,592**	**47,896**	**47,100**	**45,077**	**49,822**	**45,152**	**44,920**
			YOY %	126%	104%	108%	109%	112%	106%	113%	108%	103%	103%	112%	103%	106%	120%
			Variance to plan		- 1,825												
			Variance to ERF threshold		34%												

		Target Description		Actual v PIs vs Target Mar-21	Actual v PIs vs Target Apr-21	Forecast vs Target Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Elective Activity	Elective Day Case	vs 19/20 - 70% April, increasing to 85% by July	19/20 Actual	5,474	5,495	5,495	5,974	5,476	5,911	5,419	5,419	5,906	5,628	5,249	5,972	5,492	4,457
			20/21 Actual/Plan	**4,976**	**4,695**	**4,633**	**4,769**	**4,484**	**4,875**	**4,548**	**4,493**	**4,867**	**4,709**	**4,636**	**5,027**	**4,562**	**4,538**
			YOY %	**112%**	**85%**	**84%**	**80%**	**82%**	**82%**	**84%**	**83%**	**82%**	**84%**	**88%**	**84%**	**83%**	**102%**
			Variance to plan		62												
			Variance to ERF threshold		15%												
	Elective Inpatient	vs 19/20 - 70% April, increasing to 85% by July	19/20 Actual	306	362	362	431	474	516	447	421	471	460	401	319	408	306
			20/21 Actual/Plan	274	277	**211**	**226**	**229**	**230**	**230**	**219**	**223**	**219**	**211**	**224**	**206**	**220**
			YOY %	90%	77%	58%	52%	48%	45%	52%	52%	47%	48%	53%	70%	50%	72%
			Variance to plan		66												
			Variance to ERF threshold		7%												

Diagnostics phase 3 recovery plan

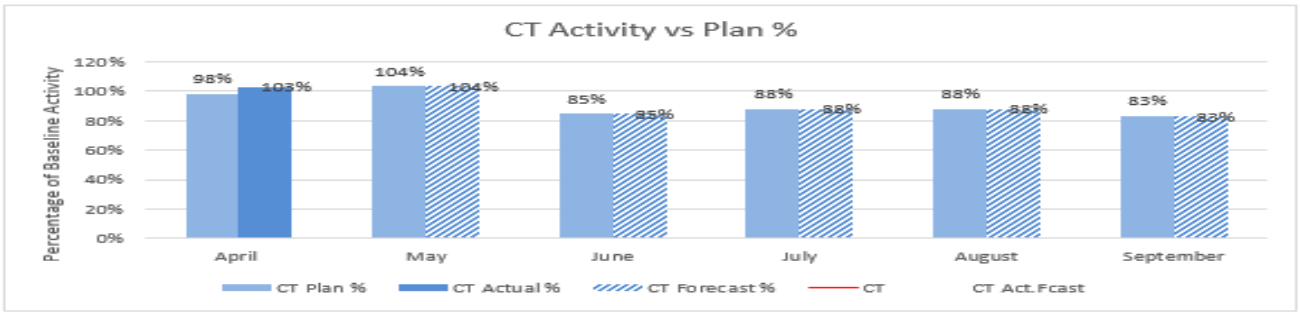


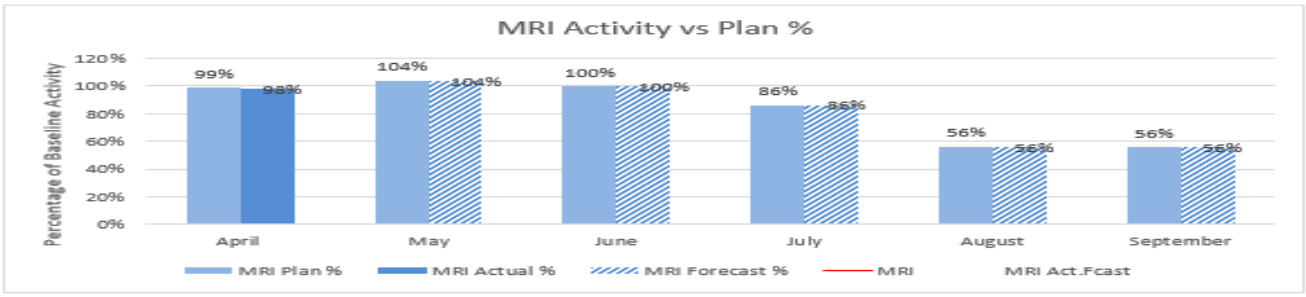
April 2021 actual performance
16313 (provisional)
Variance Type
Recovering to pre-covid Special Cause Improvement
Local Target
16500 (based on Apr-19-Feb-20 average)
Target/ Plan achievement
Recovered close to target.

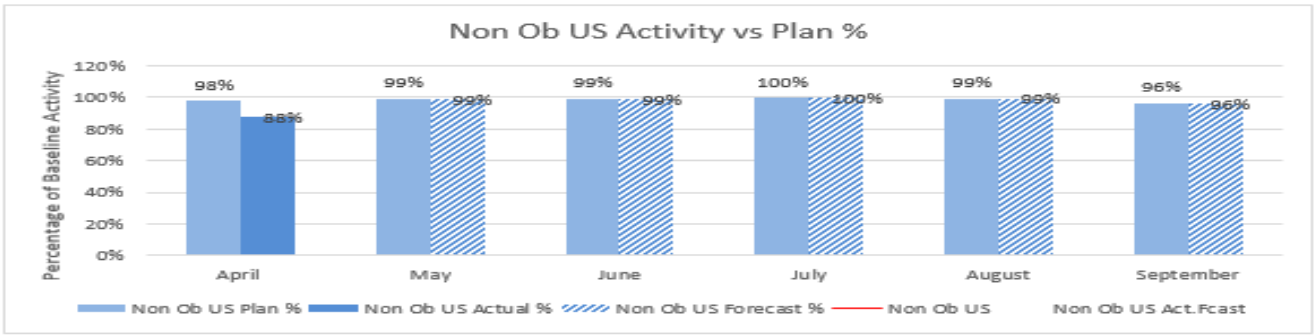
Background	What the Chart tells us	Issues	Actions	Mitigations
Diagnostic Activity is made up of the number of tests/procedures carried out during the month; it contains Imaging, Physiological Measurement and Endoscopy Tests.	There has been a continuous improvement in the level of activity since the 1st wave of COVID in March 2020. Following a peak in performance above target in March, there has been a slight drop in April with activity just below target.	Activity fluctuates with staff availability. Inability to attract bank and agency staff means that we cannot always cover staff absence and sessions have to be reduced or cancelled. Patient flow through imaging is restricted by social distancing requirements and enhanced cleaning	Additional voluntary overtime to provide additional capacity. Continued use of agency and bank where possible. Use of final year students to support depleted Radiographer teams.	Weekly monitoring of activity vs plan data

	April activity is in line with pre-COVID levels	regimes for all equipment. Potential loss of one mobile CT scanner to another Trust at the end of May 2021	Continued use of additional mobile CT&MRI capacity. Expansion of endoscopy suite will facilitate Trans-nasal endoscopy, subject to staffing Replacement CT scanner opens at PRH end of May 2021	

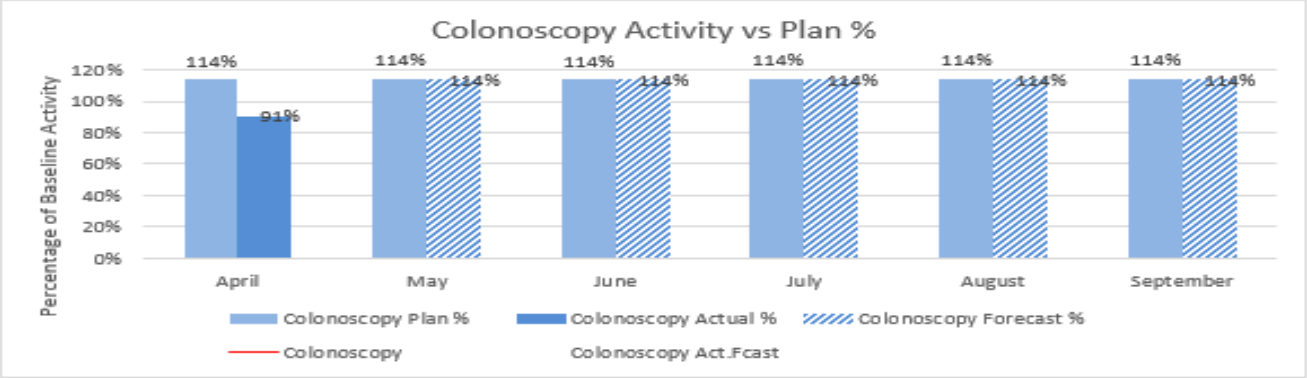
Imaging Recovery v plan (national target is 70% April, 75% May, 80% June, 85% July onwards of 2019-20 baseline). All three imaging modalities delivered better than the national recovery thresholds for April, although Ultrasound delivered below the intended plan.

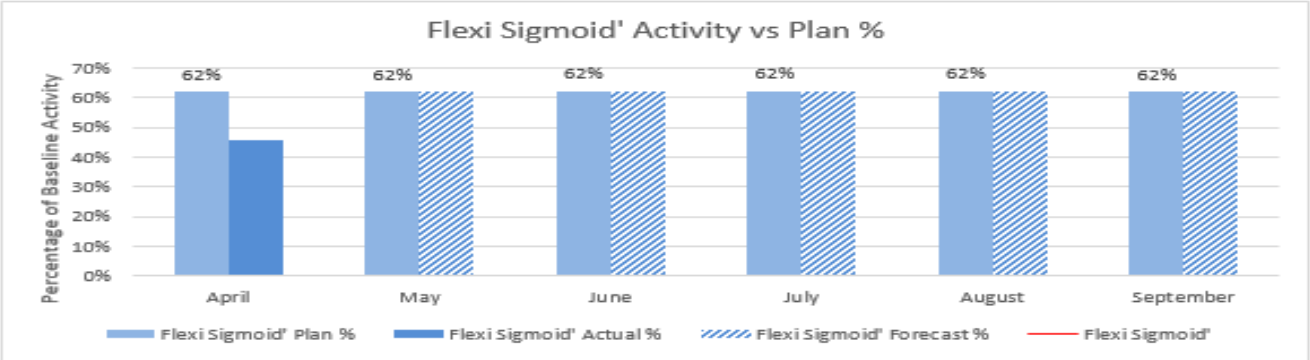


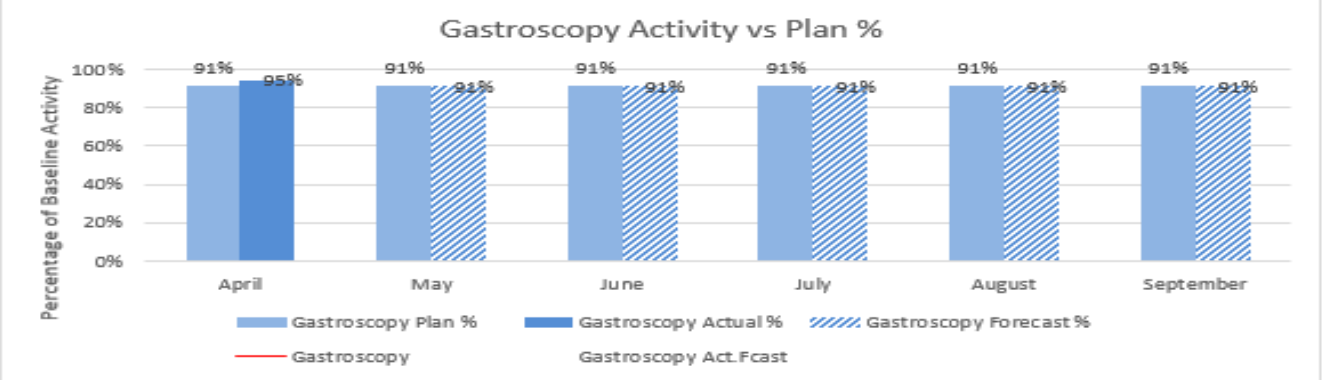




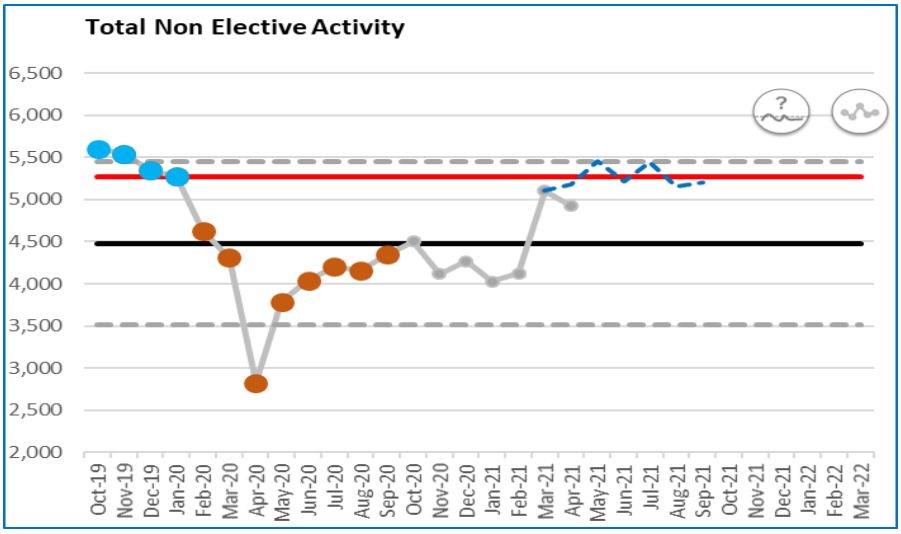
Endoscopy recovery v plan (national target is 70% April, 75% May, 80% June, 85% July onwards of 2019-20 baseline). While above the April 2021 threshold for colonoscopy and gastroscopy, the threshold was not achieved for flexi-sigmoidoscopy.







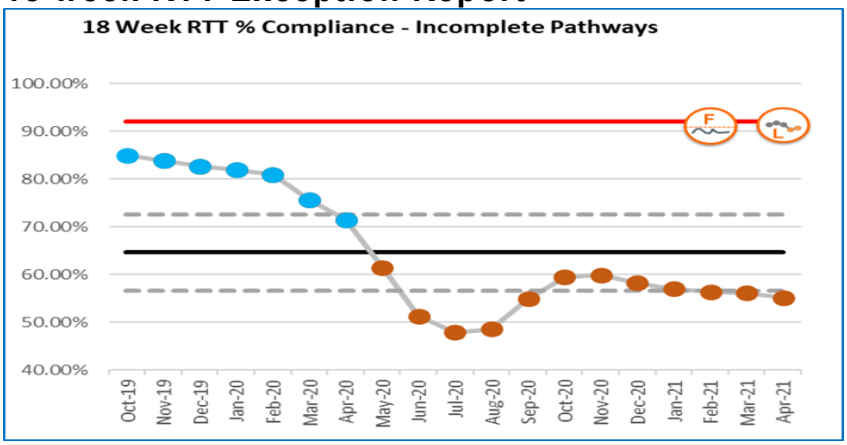
Non-Elective Activity



April 2021 actual performance
4924
Variance Type
Common Cause
Local Target
5180 (Monthly Average of H1 plan)
Target/ Plan achievement
The forecast is for demand to return to 2019-20 baseline

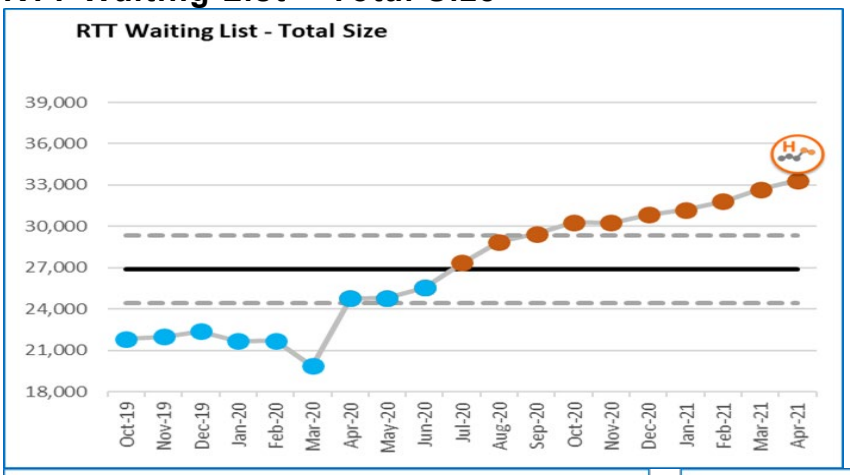
Background	What the Chart tells us	Issues	Actions	Mitigations
Ability to respond to emergency demand in a timely fashion is important to meet the needs of patients unexpectedly taken seriously ill or involved in an accident requiring hospitalisation. The non-elective activity is demand led activity.	Demand has increased and is returning towards 2019-20 baseline. It is forecast to continue to do so, although reduced slightly in April 2021.	Increased demand while we need to maintain separate covid-19 and non covic-19 pathways	Responding to demand Supporting additional CEPOD and Trauma lists as needed	Revised General Surgeon rota to support CEPOD surgeon Additional trauma sessions at PRH

18 week RTT Exception Report

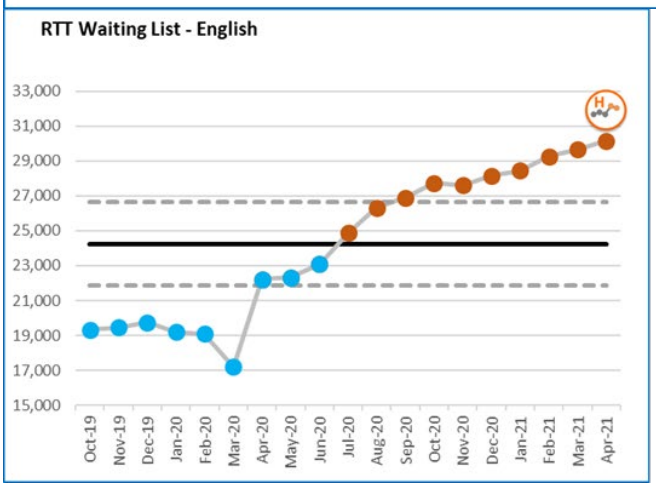


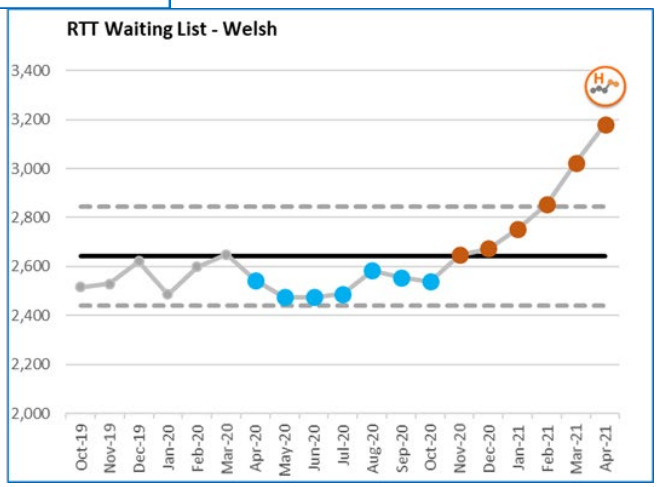
April 2021 actual performance
55.14%
Variance Type
Special Cause
National Target
92%
Target / Plan Achievement
Due to the size of the backlog developed the target will not be achieved. Local plan focuses on clinical prioritised patients.

RTT Waiting List – Total Size



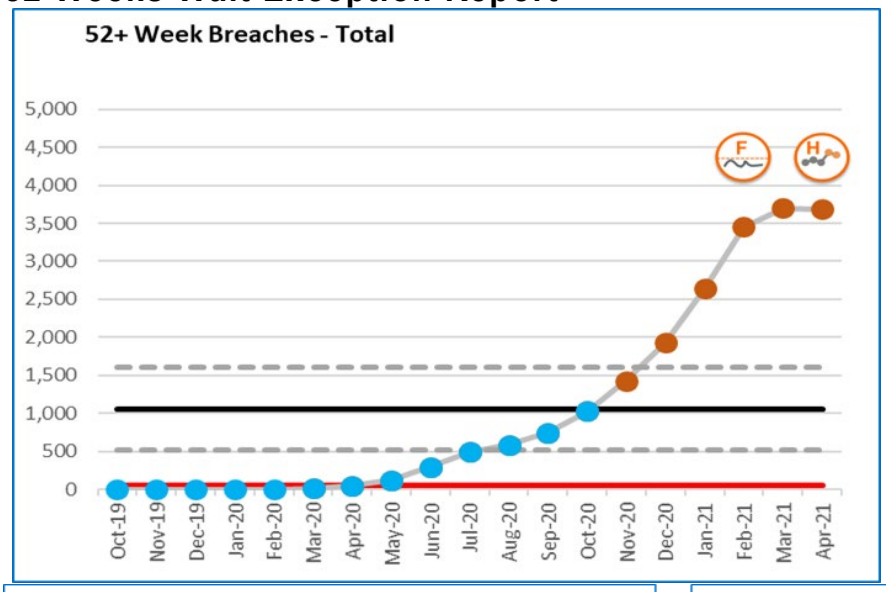
April 2021 actual performance
33332 30151 (English) 3181 (Welsh)
Variance Type
Special Cause
Local Plan
25338 (English) by Mar 2022
Target / Plan Achievement
The interventions are currently being finalised to support local planned reduction shown



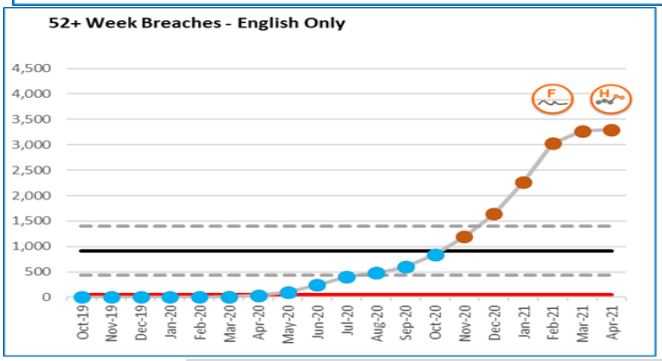


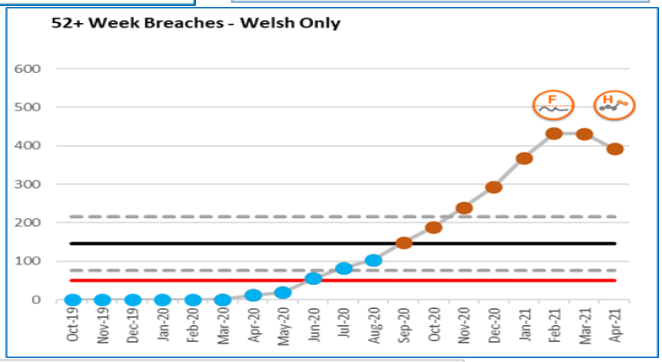
Background	What the Chart tells us	Issues	Actions	Mitigations
The total waiting list size impacts on patient access times for consultation, diagnosis and treatment	The total waiting list is continuing to increase at present	Capacity has not been fully recovered. Referrals are returning towards pre-covid-19 levels	Recovery is proposed in line with the H1 plan. Additional interventions are proposed, subject to investment, which will result in the waiting list starting to reduce, providing the referrals remain at 2019-20 baseline levels	The IP and DC waiting lists have been clinically prioritised.

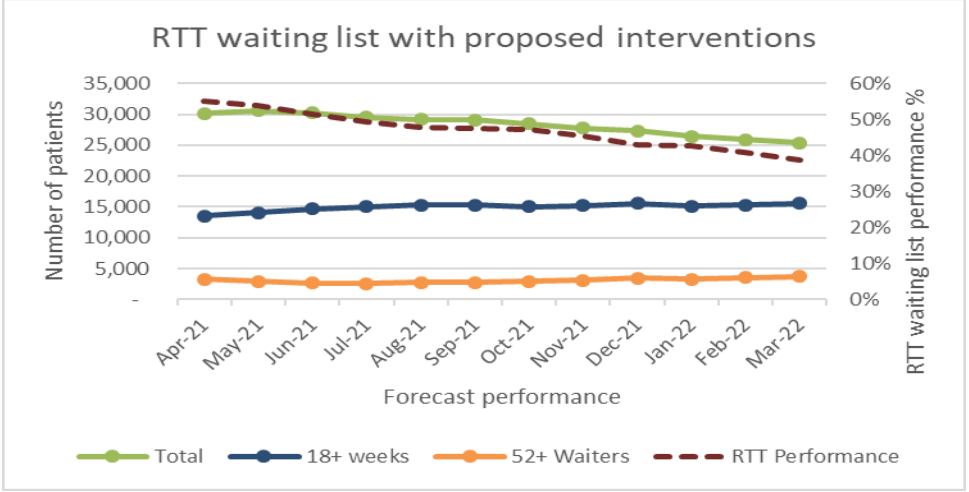
52 Weeks Wait Exception Report



April 2021 actual performance
3687 3295 (English only) 392 (Welsh patients)
Variance Type
Special Cause Concern
National Target
0
Target / Plan Achievement
The target will not be delivered in 2020-21. Local profile developed aligned to the H1 plan.

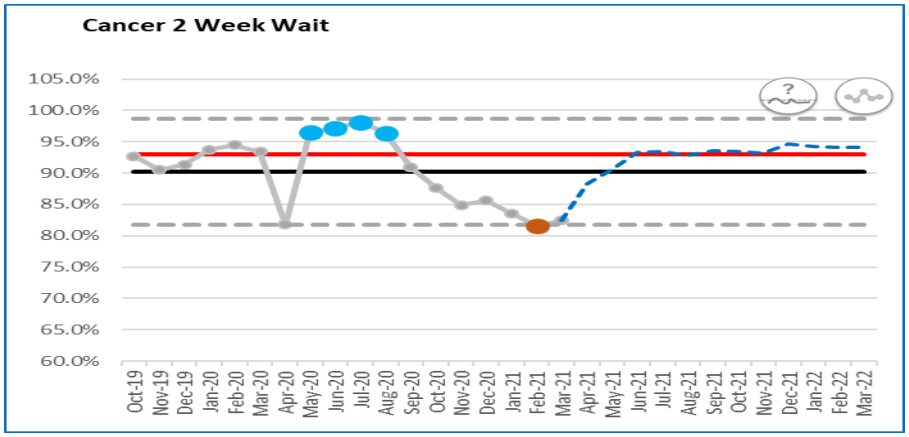






Background	What the Chart tells us	Issues	Actions	Mitigations
From a baseline position of zero pre-Pandemic, the volume of patients waiting in excess of 52 weeks on an open RTT pathway has increased significantly. It continues to increase because routine patients are not currently being prioritised for treatment.	The teams are trying to micromanage all element of RTT in line with clinical urgency and long waits	Limited theatre capacity, staffing, elective "green " pathway bed capacity and outpatient rooms Given the priority will be for clinically urgent cases , containing the waiting list size could result in adverse performance on long waiters and RTT performance	QIA developed to reduce social distancing to 1m to support additional rooms. Implementation of book wise to support room utilisation. Plans developed to support delivery of additional elective activity. Subject to funding.	Local delivery plan and trajectory in place to monitor waiting times against.

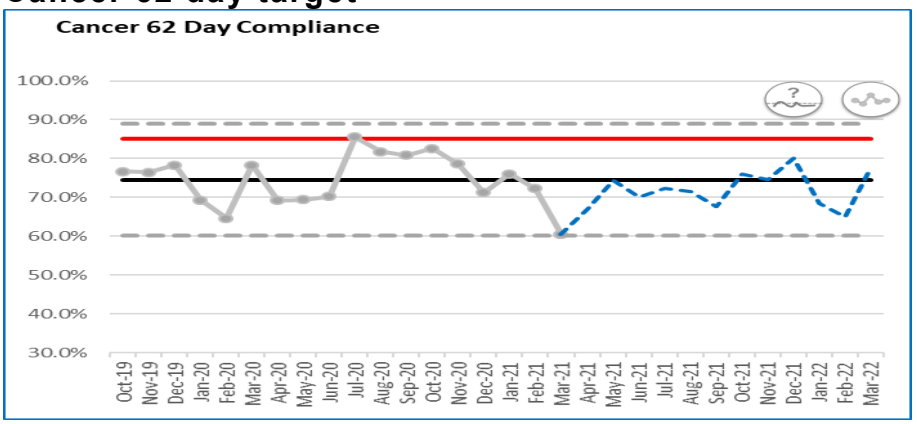
Cancer 2 week waits



March 2021 actual performance
82.43%
Variance Type
Special Cause Concern
National Target
93%
Target / Plan Achievement
Measure unlikely to meet the target

Background	What the Chart tells us	Issues	Actions	Mitigation
This measure is a key indicator for the organisation's performance against the national Cancer Waiting Times guidance ensuring wherever possible that any patient referred by their GP with suspected cancer has a first appointment within 14 days	Compliance with this target has fluctuated since April 2019 – attributed to poor performance (capacity) within the breast service With the recovery plan in place performance is forecast to improve month on month	Capacity issues in the Breast specialty has impacted negatively on SaTH's overall 2WW performance	Extra capacity being added to the Breast 2WW clinics + improvement trajectory in place	Implementation of revised 2WW Breast Referral Proformas

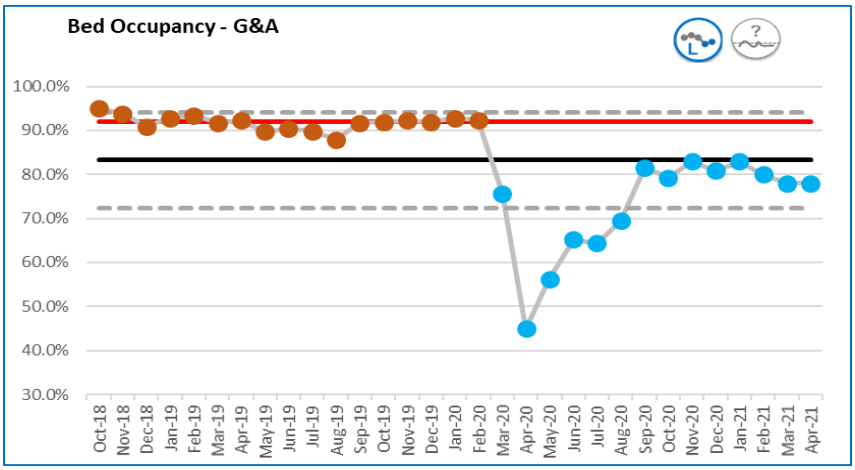
Cancer 62 day target



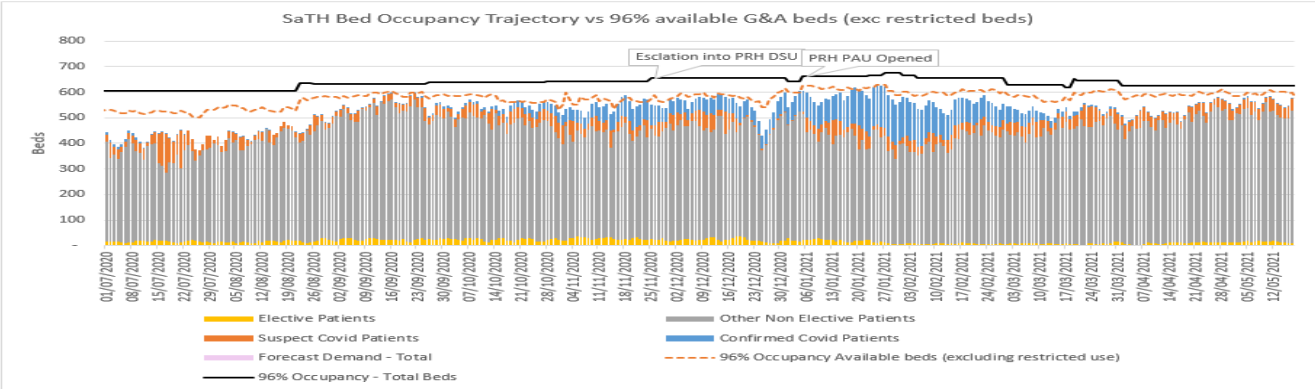
March 2021 actual performance
60.53%
Variance Type
Common Cause
National Target
85%
Target / Plan Achievement
Unlikely to meet target consistently

Background	What the Chart tells us	Issues	Actions	Mitigations
This measure is a key indicator for the organisation's performance against the national Cancer Waiting Times guidance ensuring wherever possible that any patient referred by their GP with suspected cancer is treated within 62 days of referral.	The present system is unlikely to deliver the target. Compliance with this target has been achieved once since April 2019.	Capacity does not meet demand (diagnostics a significant issue even prior to COVID). Surgical capacity not back to pre covid levels. Losing mobile CT scanner at the end of May. Rise in 2WW referrals.	Weekly review of PTL lists using Somerset Cancer Register – escalations made as per Cancer Escalation Procedure. New pod to house a CT/MRI scanner to be in place in Aug 2021, with a view to have capacity ready in Oct 2021	Pathway Project Managers introduced to review pathways and implement efficiencies to assist compliance with targets Cancer Performance and Assurance Meetings on-going chaired by Deputy COO

Bed Occupancy

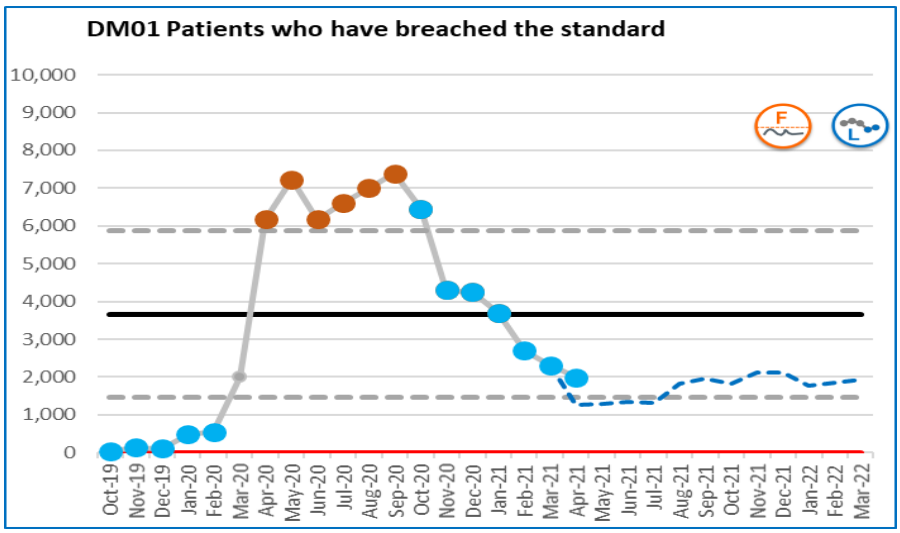


April 2021 actual performance
78%
Variance Type
Special Cause improvement
National Target
92%
Target / Plan Achievement
Occupancy continuing to be lower than pre-covid-19



Background	What the Chart tells us	Issues	Actions	Mitigations
Bed occupancy is an important measure indicating the flow and capacity within the system	Bed occupancy has increased overall, however the majority of the increase represents an increase in emergency non-covid-19 admissions Occupancy levels remain below the pre-covid-19 levels	Segmentation of beds has created smaller bed pools and reduced flexibility. The increase in NEL occupancy has reduced capacity to restore elective activity	Bed base assessment to be conducted to ensure bed establishment and changes to bed allocation are accurately reported Winter planning commenced and schemes under-development to continue admission avoidance	Bed base to be re-allocated to increase green elective capacity

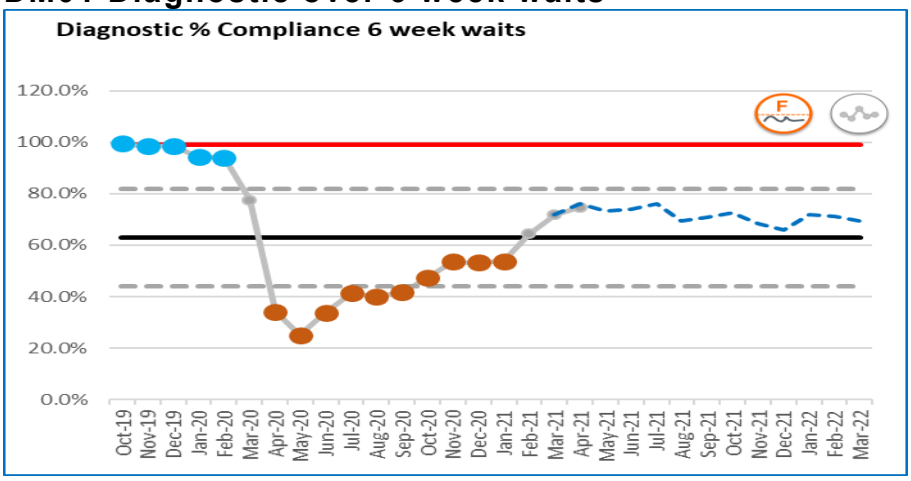
DM01 Patients who have breached the Standard



April 2021 actual performance
1992
Variance Type
Special Cause improvement
National Target
0 - < 6weeks
Target / Plan Achievement
Target will not be delivered with present capacity constraints in some diagnostic services

Background	What the Chart tells us	Issues	Actions	Mitigations
DM01 is the national standard for non-urgent diagnostics completed within 6w of the referral. There must be no more than 1% of patients waiting longer than 6w	Performance is showing signs of continuing improvement with a reduction in the backlog of patients waiting over 6 weeks. However performance has not improved to the forecast position for April 2021.	Balancing the capacity to deliver urgent access for new referrals while delivering backlog reduction at a time of constrained capacity. Lack of additional imaging capacity to support increasing requests for service restoration and recovery. Endoscopy - Patient choice of appointment and compliance with swabbing and self-isolation 3 days before admission.	Extended / Additional sessional working through voluntary overtime Use of mobile capacity Use of Nuffield MRI Use of CT and MRI at RJAH Continuing to utilise 2 endoscopy suites Continued use of staffed mobile CT and MRI scanners Seek approval to cease swabbing for colonoscopy.	Weekly tracking of activity v plan Prioritising urgent requests and cancer pathway referrals Weekly performance review against trajectory Daily PTL tracking Prioritising urgent requests and cancer pathway referrals

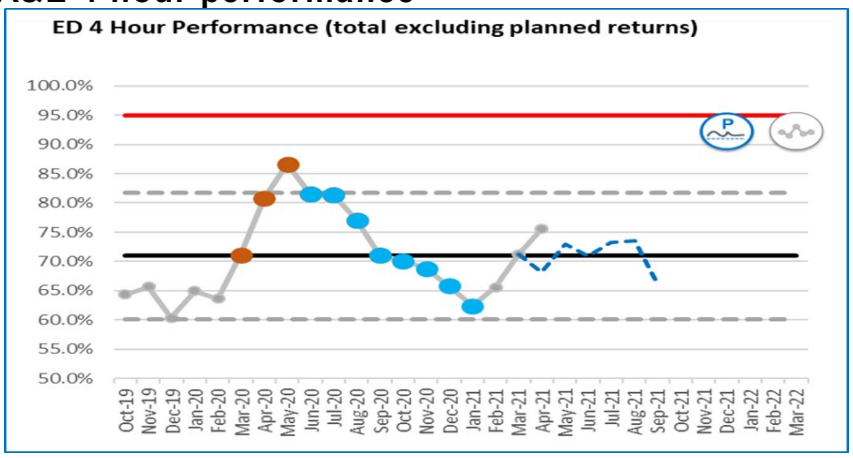
DM01 Diagnostic over 6 week waits



April 2021 actual performance
74.76%
Variance Type
Special Cause
National Target
99%
Target / Plan Achievement
Target will not be delivered with present capacity constraints in some diagnostic services

Background	What the Chart tells us	Issues	Actions	Mitigations
M01 is the national standard for non-urgent diagnostics completed within 6w of the referral	Performance is gradually improving, however remains below 99% target and pre-covid-19 levels of performance	Opportunities to recover further are limited due to capacity constraints and low staffing levels Unable to reduce cleaning regime in order to maintain good practice and reduce risk of cross-infection. IPC requirement to maintain enhanced cleaning regimes and social distancing reduces patient flow through the department and reduces imaging capacity. Mobile CT due to leave site at the end of May. January – March 2021 elective capacity lost as a result of staffing redeployment to critical care. Patient choice of appointment and compliance with swabbing and self-isolation 3 days before admission. Patients wanting to 'wait' until they have had their second vaccine. Gastroscopy throughput still not at pre-covid-19 levels due to IPC measures and turnaround times following aerosol-generating procedures.	Additional mobile capacity in use. Mobile CT scanner remains on-site until the end of May During March used some capacity at Nuffield and at RJAH Re-establishing fully the endoscopy capacity. Continued support of 2 mobile MRI scanners Staff working voluntary overtime to maintain existing capacity and provide additional sessions capacity Elective sessions restored to full template capacity and increase in individual list sizes. Seek approval to cease swabbing for colonoscopy.	Urgent and cancer referrals prioritised. Split site by procedures performed to maximise throughput and better forecast recovery.

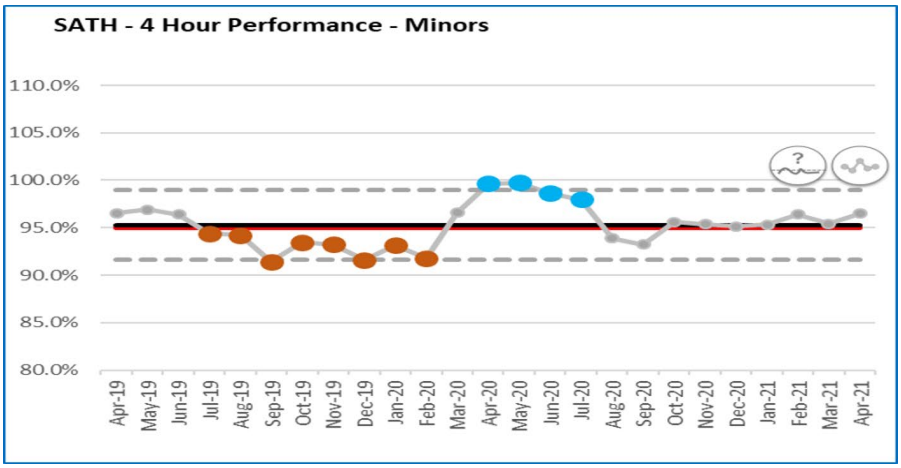
A&E 4 hour performance



April performance
76.5%
Variance Type
Common cause
National Target
95%
Target / Plan Achievement
Trajectory Based on A&E improvement plan will be applied to this baseline forecast as a recovery trajectory.

Background	What the Chart tells us	Issues	Actions	Mitigations
The national target is for all patients to be seen treated, admitted, transferred or discharged within 4 hours of arrival at the emergency department	ED performance is forecast to continue to be below national target. The A&E improvement plan has been developed which will now be applied to this forecast to demonstrate likely year end improvement. However. this will not alone deliver the national target.	ED attendances are increasing returning to close to the pre-covid-19 levels New UEC measures being introduced during 2021-22	Urgent Care Centre has returned to PRH site to support with the increase in minor activity Ensuring whole system approach adopted to deliver improvement ED performance improvement plan with associated trajectory developed and in process of implementation. Key actions include mapping of workforce against demand, increasing physical capacity for RSH ED via capital build programme, maximising capacity created by SDEC models and supporting flow through from the departments by improving ward management processes. Timescales in line with detailed action plan.	Daily 'safe today' huddles in place across both departments. Demonstrable improvement in the quality of care for patients within ED submitted to CQC

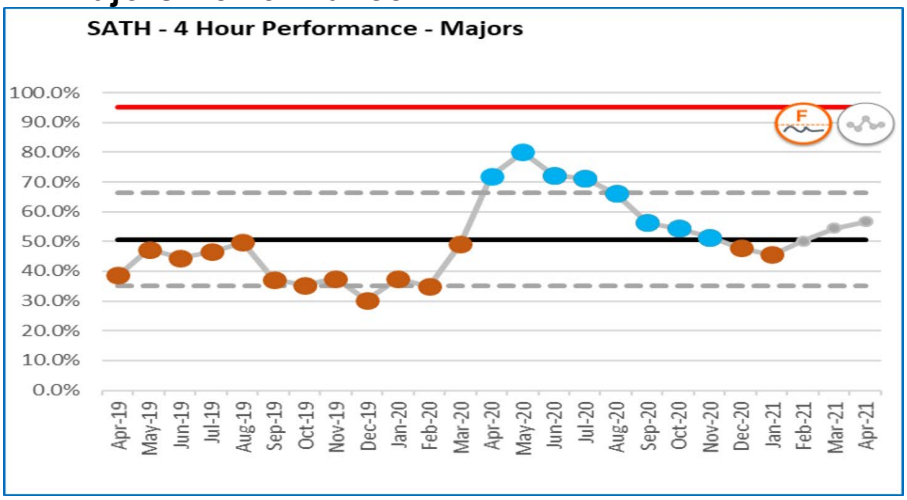
ED Minors Performance



April 2021 actual performance
96.5%
Variance Type
Common Cause Variation
National Target
95%
Target / Plan Achievement
Delivered for last 7 mths.

Background	What the Chart tells us	Issues	Actions	Mitigations
Maintaining streaming between minor and major conditions will support delivery of the 4 hour standard for patients with more minor presentations	This target has been achieved for the past 7 months.	Ensuring delivery is sustained during the present capital works.	Return of urgent treatment centre activity to both sites from April 2021 will further support delivery of this metric as activity increases	

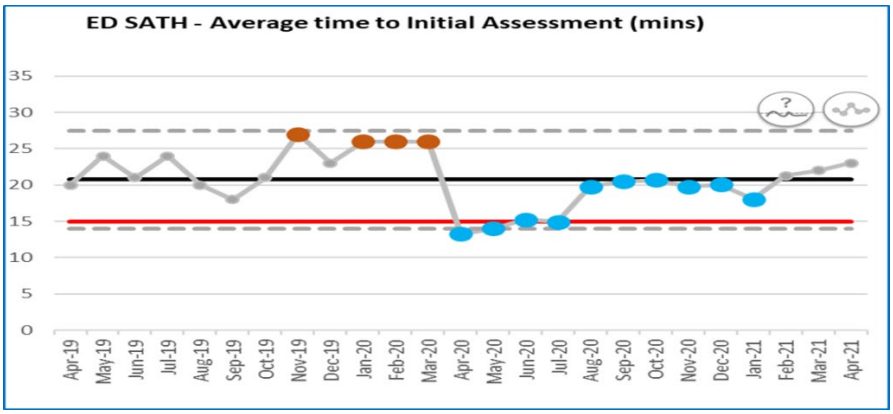
ED Majors Performance



April 2021 actual performance
56.6%
Variance Type
Common Cause
National Target
95%
Target / Plan Achievement
The target is above the upper process control limit and so will not be achieved without service re-design

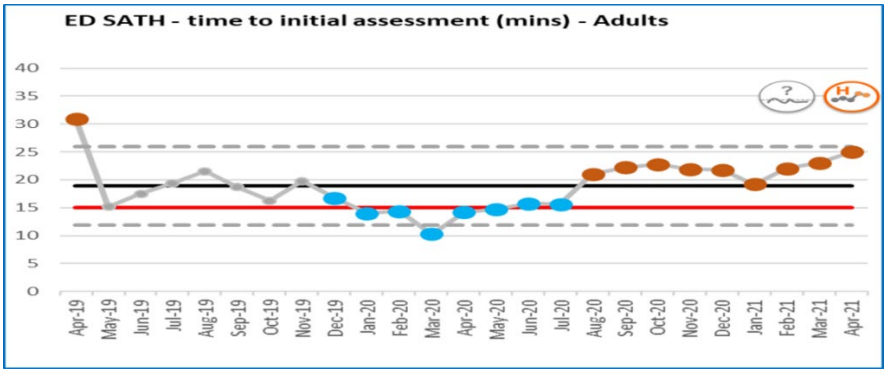
Background	What the Chart tells us	Issues	Actions	Mitigations
4 hour performance for major presentations is dependent on having good flow into and out of ED	Performance is improving however the target is well above the upper control limit and so will need the redesign proposed	Increased in proportion of attendees who are classified as majors Maintaining red and green IPC pathways	As per the 4hour A&E improvement plan and estate redesign as described above	Improved quality of care within ED

ED –Time of Initial assessment (mins)



April 2021 actual performance
23 Minutes
Variance Type
Common Cause
National Target
15 Minutes
Target / Plan Achievement
Performance remains above target

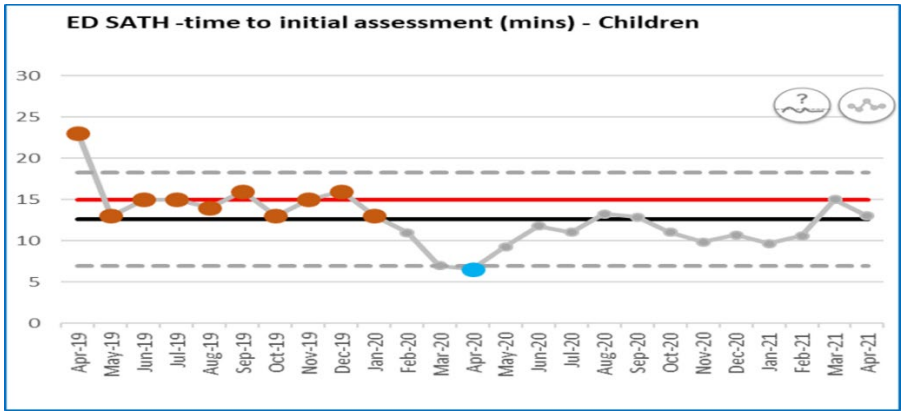
ED Time to Initial Assessment - Adult



April 2021 actual performance
25 Minutes
Variance Type
Special Cause Concern
National Target
15 Minutes
Target / Plan Achievement
Performance remains worse than target

Background	What the Chart tells us	Issues	Actions	Mitigations
Time to initial assessment is a patient safety indicator.	Overall time to initial assessment is worse than the target. The performance for adult initial assessment is the key contributor to this, with paediatric assessments being within target.	Capacity constraints within the departments especially when patients arrive in close proximity	Continued recruitment into vacant ED posts will allow resilience in planning rota's to support expected peak arrival times and further improve initial assessment times. Think 111 implemented on a phased approach to drive patients to pre booking walk in appointments where appropriate which can be staggered Increased senior nurse focus in Q1 2021-22-improvement plan to address this.	Internal escalation processes

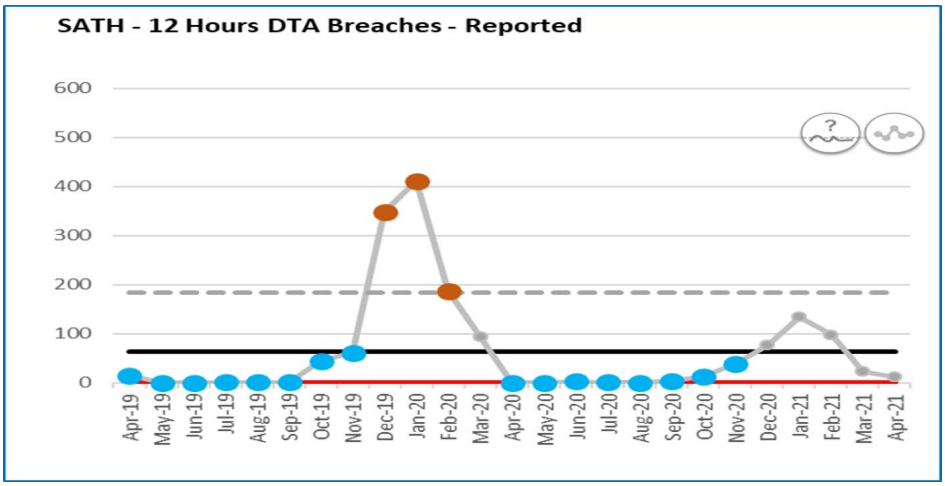
ED Time to Initial Assessment - Children



April 2021 actual performance
13 Minutes
Variance Type
Common Cause
National Target
15 Minutes
Target / Plan Achievement
The target has been achieved consistently.

Background	What the Chart tells us	Issues	Actions	Mitigations
Time to initial assessment is a patient safety indicator.	This target is continuing to be delivered and has been delivered for the last 15 months	Delivery sustained however risk to delivery identified due to change in management practice associated with paediatric referral management may have a negative impact going forward	Increased focus from senior nursing on the consistency of achievement for all children and continuing to audit and address reasons for non-achievement.	Escalated to Director of Nursing re process management issue

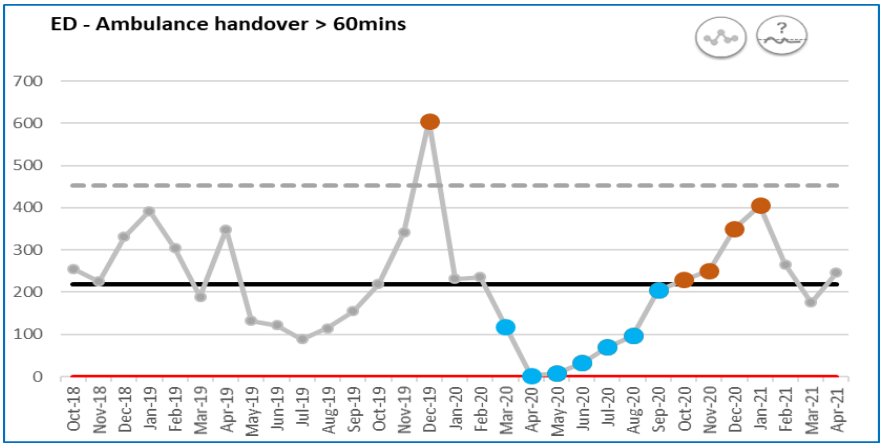
12 Hour ED Trolley waits



April 2021 actual performance
12
Variance Type
Common Cause
National Target
0
Target / Plan Achievement
The target was breached this month

Background	What the Chart tells us	Issues	Actions	Mitigations
This is a patient experience and outcome measure	Performance has improved and is returning towards delivery of the target	Flow out of ED into available ward beds Performance from the end of May, may be affected by closure of discharge lounge and reduction in number of medical beds to facilitate surgical recovery plan	Continue delivery of ward process improvement plan to facilitate earlier discharge and allow flow from ED's. Ensure SDEC clinical model is fully optimised	Patient safety SOP and navigator role in ED for ambulance offload delays

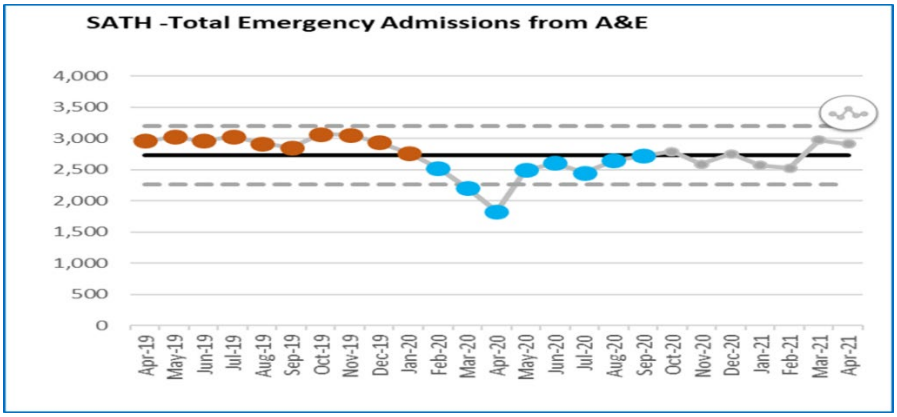
Ambulance handover> 60 Mins



April 2021 actual performance
246
Variance Type
Common Cause
National Target
0
Target / Plan Achievement
The system is not capable of delivering this target consistently

Background	What the Chart tells us	Issues	Actions	Mitigations
Ambulance handover times are an important indicator for patient safety and to support the community response to 999 calls by release of ambulances to respond.	Improvement is demonstrated in the number of delays, however this is still well above target	Ambulance offload delays due to lack of capacity HALO role no longer in place. Insufficient physical capacity for offload.	Ambulance navigator role in place with plan to increase initial assessment to SDEC & UTC where appropriate. Senior clinical doctor supports with assessing patients delayed on ambulance where appropriate	Ambulance arrival sop in place Harm review process established

Total Emergency Admissions from A&E



April 2021 actual performance
2912
Variance Type
Common Cause
National Target
N/A
Target / Plan Achievement
N/A

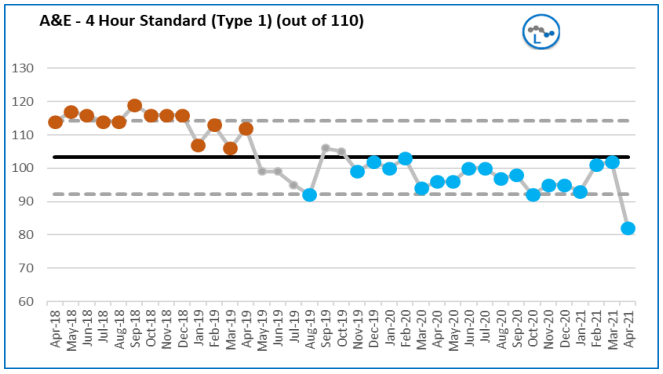
Background	What the Chart tells us	Issues	Actions	Mitigations
The number of emergency admissions is an indicator of system performance and a reflection of the prevalence of serious illness and injuries in the community	The level of emergency admissions has returned to close to pre-covid-19 levels	Green and red pathways need to be maintained Lack of flow into beds results in patients being held in ED and impacts on ED performance and ambulance hand-over times.	Bed allocations being reset Additional bed requirements for winter 2021-22 identified and bid for modular beds submitted Professional standards and direct access to assessment areas proposed	

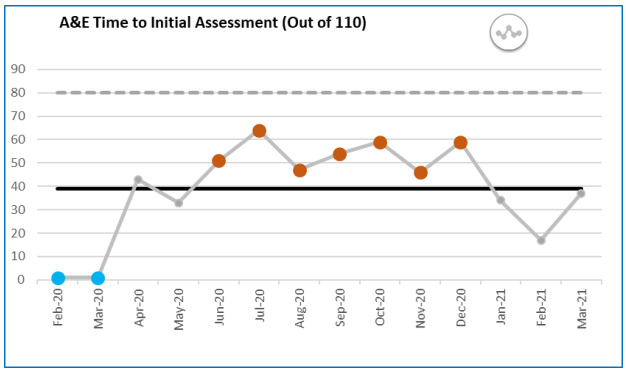
Operational Performance Comparison

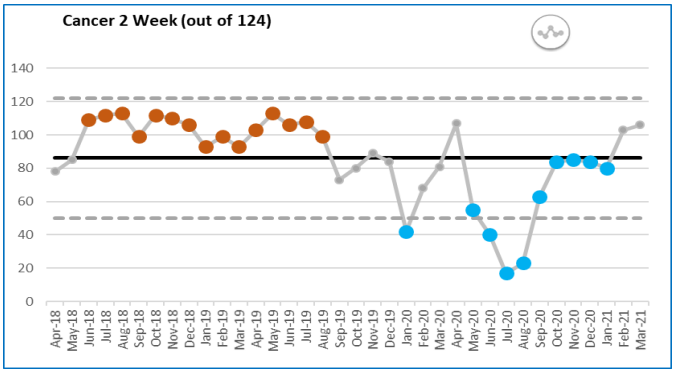
This table demonstrates the relative position of the trust at a point in time compared to other English trusts reporting the same indicator. The icon shows the trend of ranking over time of the trust in relation to other trusts. Work is underway to adapt this icon so as to distinguish it from the icon used in other charts, ensuring it is clear this icon refers to relative ranking of the trust rather than performance over time.

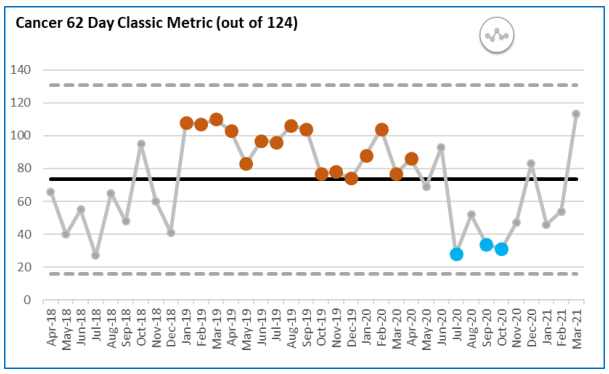
KPI	Latest month	Actual Performance Ranking	Perfomance
A&E - 4 Hour Standard (Type 1) (out of 110)	Apr 21	82	
A&E - Time to Initial Assessment (OUT OF 110)	Mar 21	37	
Cancer 2 Week (out of 124)	Mar 21	106	
Cancer 62 Day Metric (out of 124)	Mar 21	113	
Diagnostic 6 Week Standard (out of 124)	Mar 21	80	
Diagnostic 6 Week Standard - Cardiology : echocardiography (out of 123)	Mar 21	18	
Diagnostic 6 Week Standard - Audiology Assessments (out of 112)	Mar 21	67	
Diagnostic 6 Week Standard - Urodynamics: pressures & flows (out of 99)	Mar 21	87	
Diagnostic 6 Week Standard - Respiratory physiology : sleep studies (out of 93)	Mar 21	1	
Diagnostic 6 Week Standard - Magnetic Resonance Imaging (out of 124)	Mar 21	99	
Diagnostic 6 Week Standard - Computed Tomography (out of 124)	Mar 21	51	
Diagnostic 6 Week Standard - Non-obstetric ultrasound (out of 124)	Mar 21	109	
Diagnostic 6 Week Standard - Colonoscopy (out of 124)	Mar 21	44	
Diagnostic 6 Week Standard - Flexi sigmoidoscopy (out of 123)	Mar 21	71	
Diagnostic 6 Week Standard - Cystoscopy (out of 121)	Mar 21	68	
Diagnostic 6 Week Standard - Gastroscopy (out of 124)	Mar 21	52	
RTT 52 Week Breach (out of 123)	Mar 21	84	
RTT Incomplete 18 Week Standard – (out of 123)	Mar 21	104	
Emergency C-Section (out of 122)	Jan 21	42	
Elective C-Section (out of 122)	Jan 21	103	
RTT Incomplete 18 Week Standard Metric - Gynaecology (out of 122)	Jan 21	91	

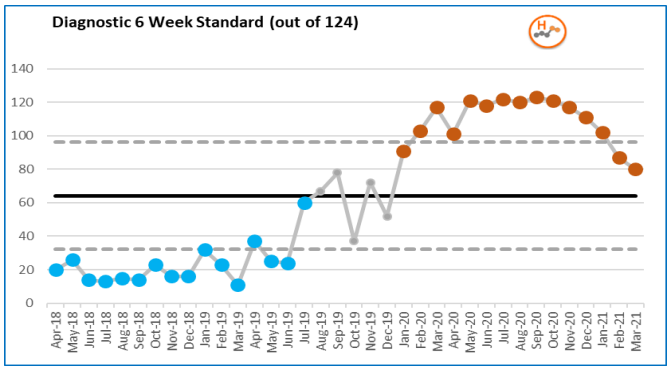
The SPC charts show the relative ranking of the Trust compared to other English trusts reporting the indicator over time and so demonstrates the change in relative position compared to previous periods and the variation in the Trust ranking. The Trust has consistently improved its ranked position in relation to A&E 4 hour performance, echocardiography, respiratory sleep studies, but is deteriorating in terms of RTT performance.

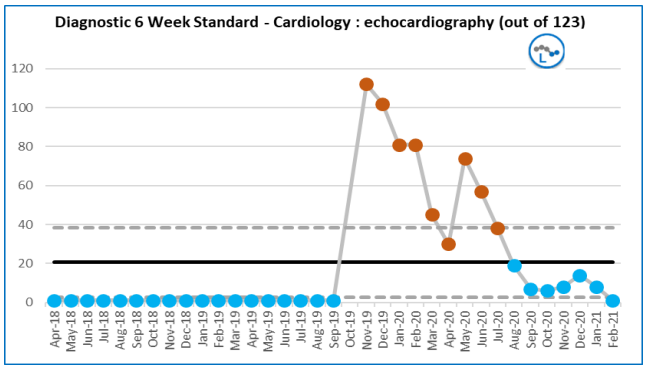

A&E - 4 Hour Standard (Type 1) (out of 110)

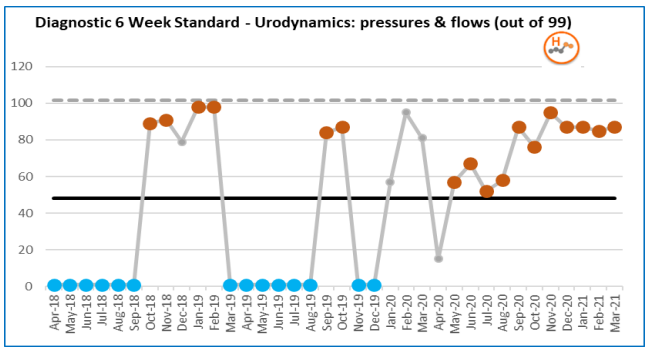

A&E Time to Initial Assessment (Out of 110)

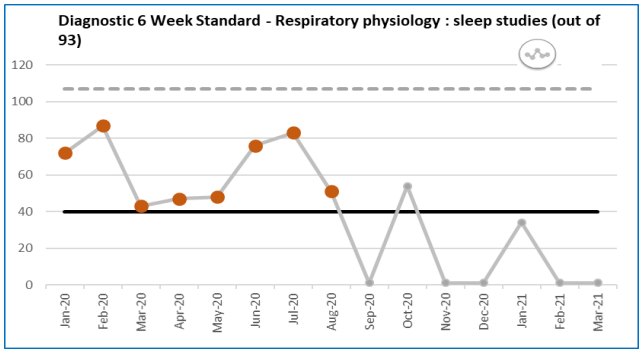

Cancer 2 Week (out of 124)

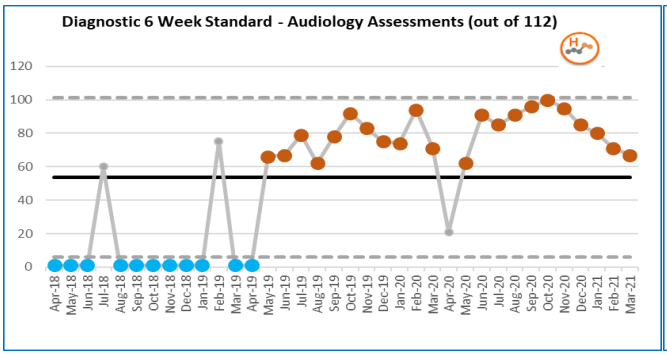

Cancer 62 Day Classic Metric (out of 124)

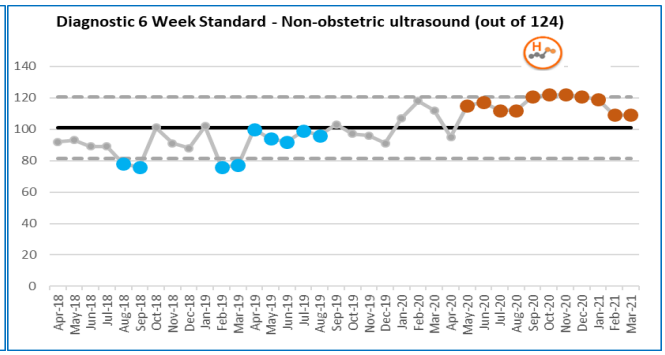

Diagnostic 6 Week Standard (out of 124)

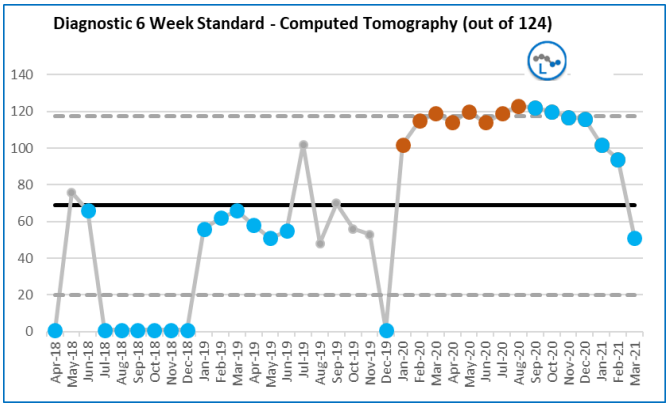

Diagnostic 6 Week Standard - Cardiology : echocardiography (out of 123)


Diagnostic 6 Week Standard - Urodynamics: pressures & flows (out of 99)


Diagnostic 6 Week Standard - Respiratory physiology : sleep studies (out of 93)


Diagnostic 6 Week Standard - Audiology Assessments (out of 112)


Diagnostic 6 Week Standard - Non-obstetric ultrasound (out of 124)


Diagnostic 6 Week Standard - Computed Tomography (out of 124)
L
0
20
40
60
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100
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140
Apr-18
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Jun-18
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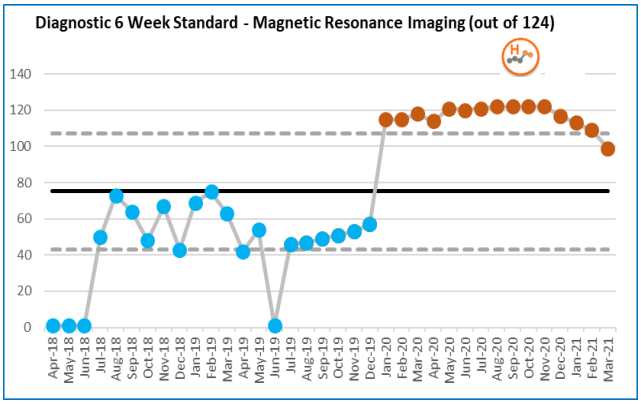
Mar-21


Diagnostic 6 Week Standard - Magnetic Resonance Imaging (out of 124)
H
0
20
40
60
80
100
120
140
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Jul-18
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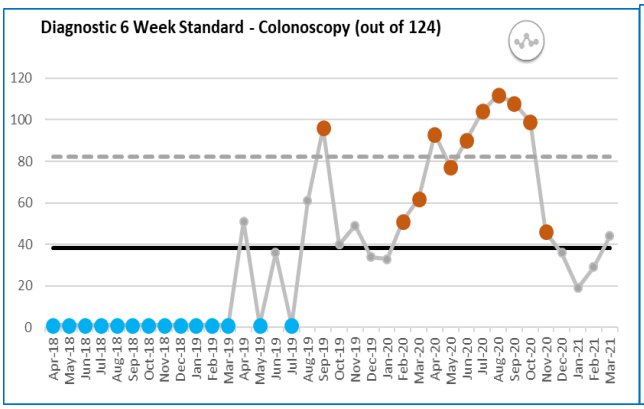
Diagnostic 6 Week Standard - Colonoscopy (out of 124)
0
20
40
60
80
100
120
Apr-18
May-18
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Aug-18
Sep-18
Oct-18
Nov-18
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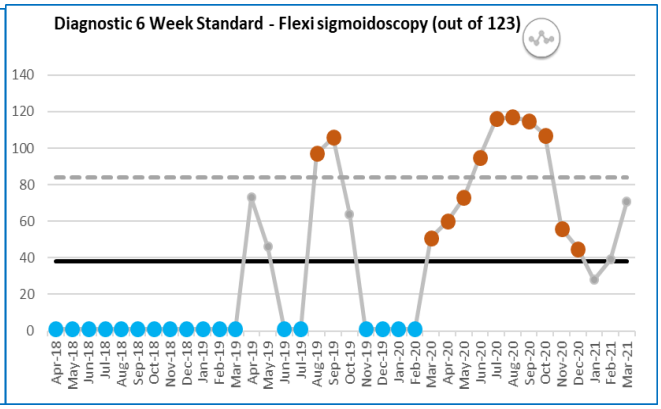
Feb-21
Mar-21


Diagnostic 6 Week Standard - Flexi sigmoidoscopy (out of 123)
0
20
40
60
80
100
120
140
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
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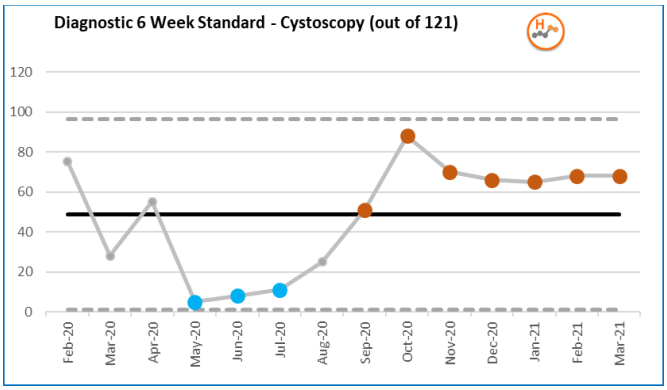
Diagnostic 6 Week Standard - Cystoscopy (out of 121)
H
0
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100
120
Feb-20
Mar-20
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Jun-20
Jul-20
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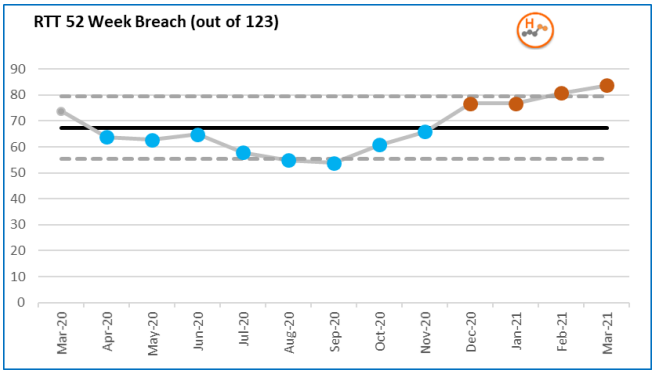
Nov-20
Dec-20
Jan-21
Feb-21
Mar-21


RTT 52 Week Breach (out of 123)
H
0
10
20
30
40
50
60
70
80
90
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
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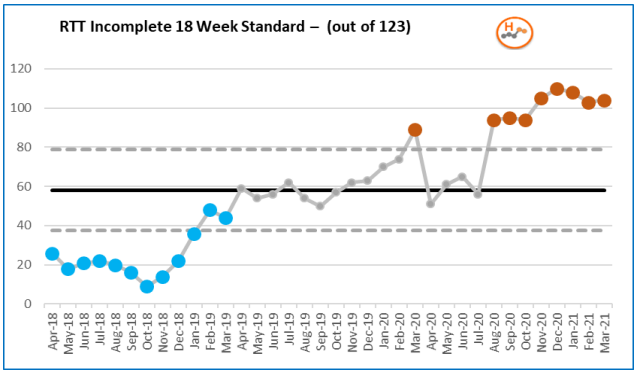
Feb-21
Mar-21


RTT Incomplete 18 Week Standard – (out of 123)
H
0
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60
80
100
120
Apr-18
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Aug-18
Sep-18
Oct-18
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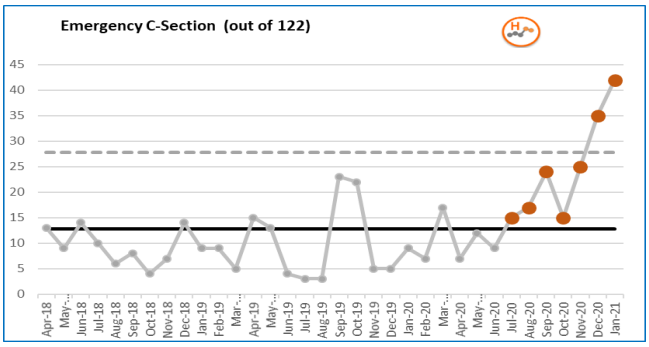
Emergency C-Section (out of 122)
45
40
35
30
25
20
15
10
5
0
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May-...
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
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Mar-...
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May-...
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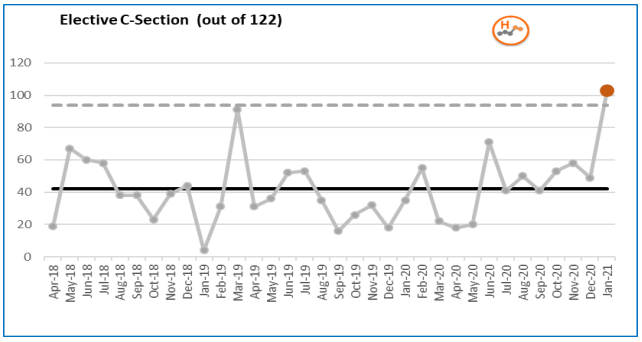
Elective C-Section (out of 122)
120
100
80
60
40
20
0
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
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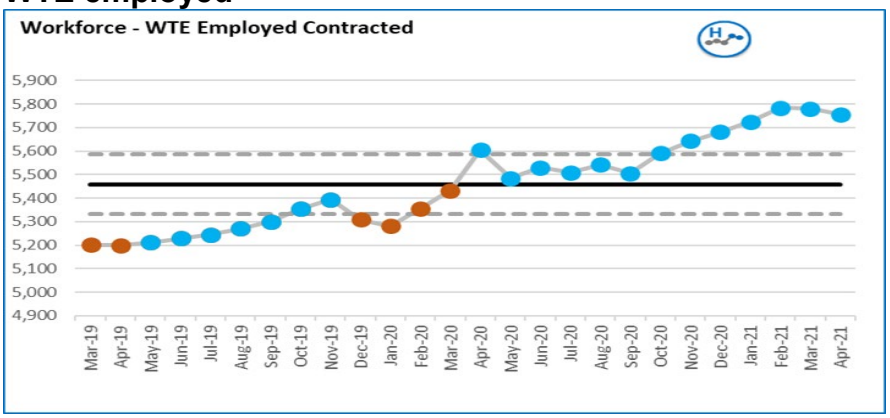
5. Workforce Summary
Rhia Boyode, Acting Director of Workforce

- Covid-19 sickness levels have reduced by 1.21% from February and now stand at 2.86% across the Trust. Non Covid-19 sickness is below target at 3.96%, which has continued to reduce since December 2020.
- The Mandatory Training compliance rate remains below the 90% target at 85, this performance has been maintained during the third wave.
- Corporate Induction is being restarted in April 2021 as part of our post-Covid-19 restoration programme. It will run virtually and will include an introduction to the Trust and its Values as well as covering some critical topics, such as improving patient experience and improving our performance on Equality, Diversity and Inclusion.
- We have launched further staff and stakeholder 'conversations' to develop our Behavioural Framework further and agree our behavioural standards as a collective using the platform. This closes at the beginning of April. Development of Courageous Conversations and Giving and Receiving feedback workshops is nearly complete, with roll out planned for April 2021.
- To support our staff as the third wave of pandemic is passing, we have collaborated to set out our Pathway from Pandemic, taking a Restore, Recover and Renew approach, bringing all WF disciplines together to support our staff. Examples of activity this month include preparing to support staff return from redeployment or shielding, recognition and thank you for mutual aid and redeployed staff, supporting staff to take annual leave.
- We have also developed a briefing session for managers "Supporting staff in distress" which will inform and develop understanding of Mental Health & Psychological First Aid, Non-judgemental Listening Skills, REACT Mental Health Conversation Model, Trim Assessment, Debriefing, Suicide Prevention and Self-Care, Health & wellbeing resources and Appraisal & Attendance Management. The first of these sessions will run in April 2021.
- The Trust has launched our Covid-19 Hero Awards, where we will recognise our people and achievements. The nominations are open to all to nominate a team or individual for recognition for their efforts over the last 12 months.

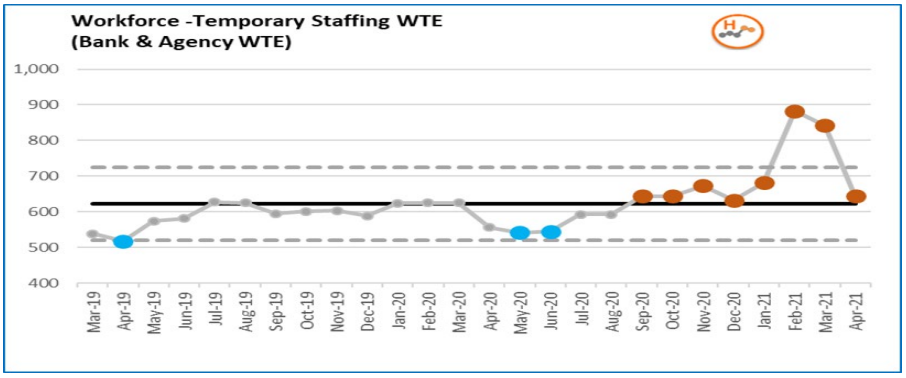
WTE employed



April 2021 actual performance
5756
Variance Type
Special cause Improvement
Local Target
6173
Target / Plan Achievement

Background	What the Chart tells us	Issues	Actions	Mitigations
This is a measure of the WTE contracted staff in post.	WTE numbers show special cause improvement since Apr-20.	Overall WTE numbers have continued to increase, staffing demands continue to present challenges; high patient activity levels and staff absences attributed to covid continues to present challenges to staffing levels.	Recruitment activity continues to increase staffing levels	Staff redeployed as required to support in key areas. Utilisation of bank and agency staff to support workforce gaps.

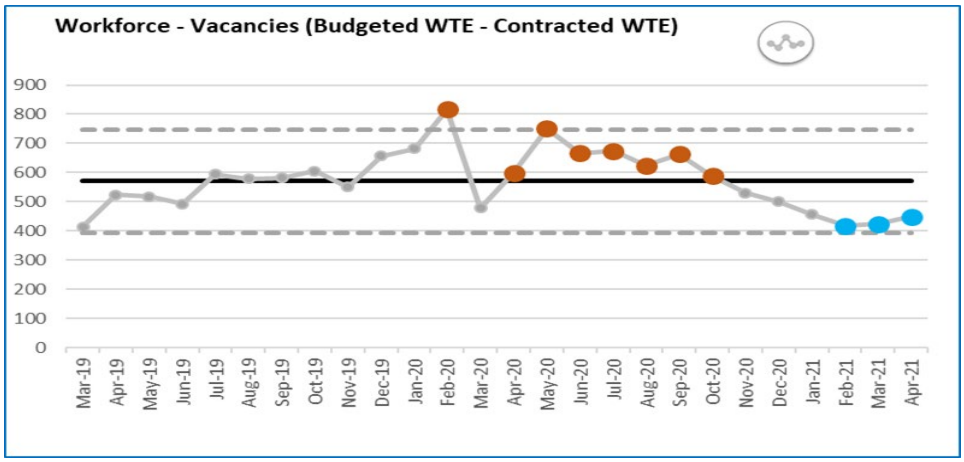
Temporary/ Agency Staffing



April 2021 actual performance
644
Variance Type
Special Cause Concern
National Target
N/A
Target / Plan Achievement
TBC

Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of agency and bank usage expressed as an WTE	Special cause concern over Winter period between Sep20 – Apr21.	Covid-related absences continue to present staffing challenges along with high patient acuity levels and escalation.	Continue to monitor staff absence levels. Monitor roster approvals to help ensure unfilled duties are sent to temporary staffing in timely manner.	Escalated bank rates in ITU Progress with recruitment activities to increase substantive workforce

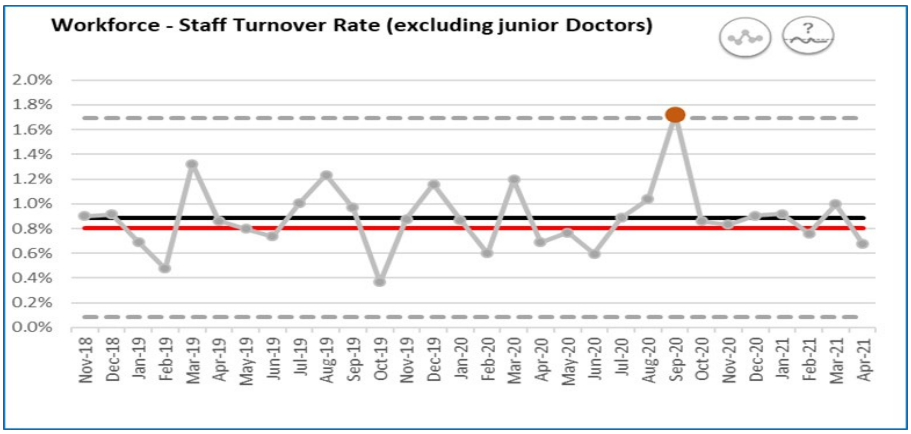
Vacancies



April 2021 actual performance
449
Variance Type
Special Cause Improvement
National Target
<10%
Target / Plan Achievement
Better than target level of performance

Background	What the Chart tells us	Issues	Actions	Mitigations
This is a measure of the gap between budgeted WTE and contracted WTE.	Special cause improvement between Feb21 – Apr21.	Shortfall in gap between contracted WTE and budgeted WTE continues to put pressure on bank and agency usage.	Continue recruitment activities to increase contracted WTE staffing levels and reduce vacancy gap.	Recruitment activity continues to reduce workforce gaps. Use of temporary staff to cover vacant posts.

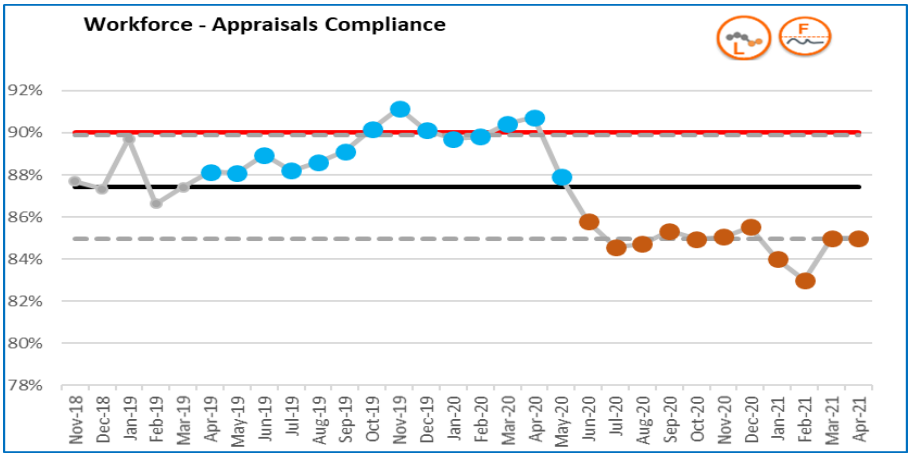
Staff Turnover Rate (excluding Junior Doctors)



April 2021 actual performance
0.68%
Variance Type
Normal Variation
National Target
0.8%
Target / Plan Achievement
Better than target level of performance

Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of the % of staff who have left the organisation	Normal variation continues between Oct 20 and Apr 21.	The number of staff who leave within the first 12 months of starting remains high; this remains particularly prominent within the nursing and midwifery staff group. Across all staff groups over the last 12 months, the reason for leaving with the highest rate was work life balance with 16% (108 FTE) of staff leaving for this reason. Within the nursing and midwifery staff group 22% (39 FTE) of those who have left over the last 12 months was due to a reason of work life balance. 24% (37 FTE) of staff who have left with less than 12 months service have been from nursing and midwifery staff group with 23% (35 FTE) from additional clinical services.	Interventions in place to try to identify potential leavers prior to leaving. Opportunity to complete exit questionnaires to help learn lessons from why people are leaving. Review recommendations within the NHS People Plan regarding supporting staff to adopt flexible working practices. Improvement initiatives to improve culture and work-life balance.	Recruitment activity to help ensure minimal workforce gaps Utilisation of temporary workforce to maintain suitable staffing levels

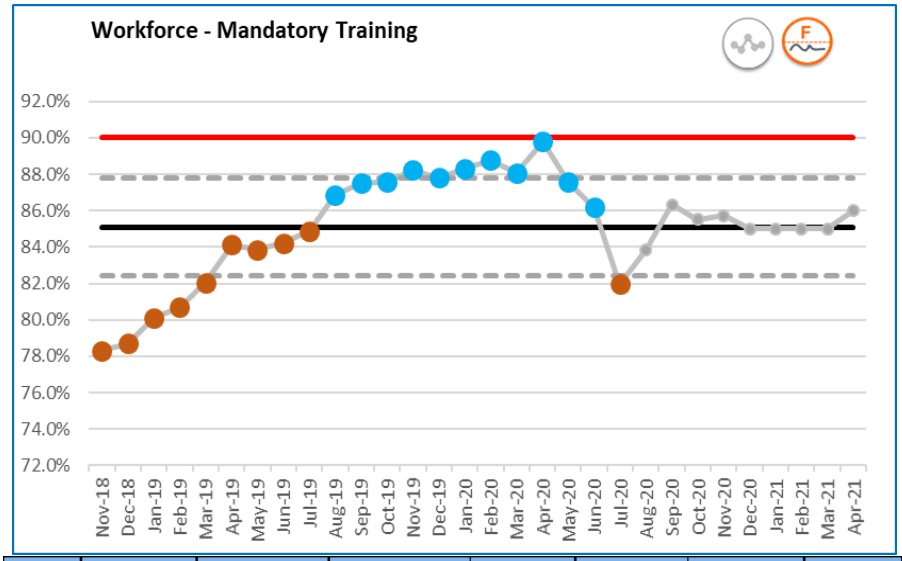
Appraisals



April 2021 actual performance
85%
Variance Type
Special Cause Concern
National Target
90%
Target / Plan Achievement
Below target level of performance

Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is a key indicator for patient safety in ensuring staff are compliant in having completed their annual appraisal.	The 90% target was achieved January to April 20 then started to drop and has remained below target, it has maintained this month.	CV-19, staffing constraints and service improvement have reduced ability of Wards to have time to complete.	Focused support is being provided to the managers of any Ward that is below target. A substantial review of appraisal will be undertaken once the behaviours and values work is complete to ensure alignment with overall Trust objectives.	Appraisal form has had an interim revision to include the new Trust Values and health and well-being and flexible working discussions

Mandatory Training

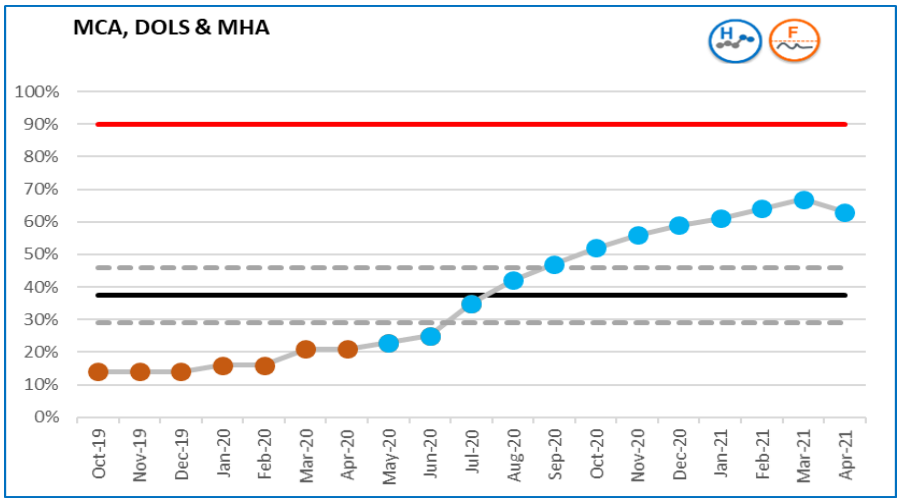


April 2021 actual performance
86%
Variance Type
Common Cause Variation
National Target
90%
Target / Plan Achievement
The target is above the upper process limit and so unlikely to be achieved at present

Fire Safety	Load Moving & Handling	Infection Prevention & Control	Hand Hygiene Competence	Patient Moving & Handling Class	Adult Basic Life Support	Paediatric Basic Life Support	Food Safety & Hygiene	Conflict Resolution Training	Equality & Diversity	Information Governance	Health & Safety Level 1
87%	94%	82%	89%	88%	73%	72%	85%	92%	91%	81%	86%

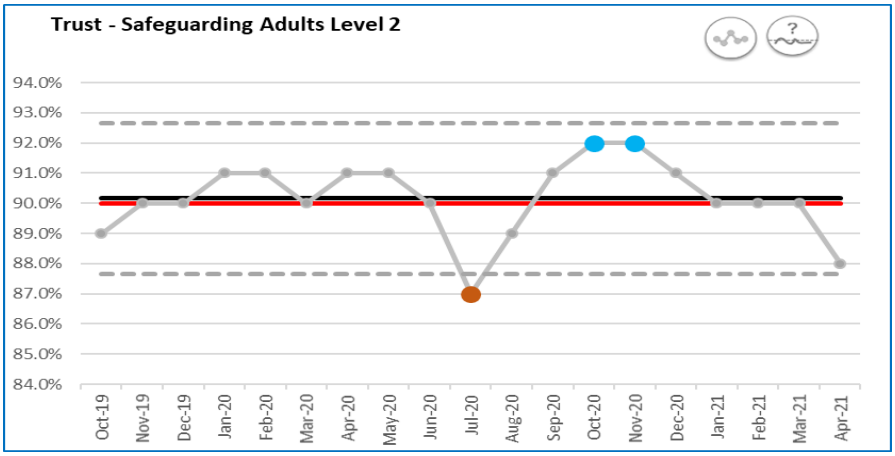
Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is a key indicator for patient safety in ensuring staff are compliant in having completed their annual appraisal.	There has been a 1% increase this month, but still remains below target. Safeguarding training compliance continues to improve month on month.	CV-19 & the Vaccination Programme, staffing constraints and service improvement have reduced ability of Wards to release staff for training Increased Stat/Mand training requirements e.g. Hand Hygiene moving from triennial to annual Poor IT literacy impacting on e-learning completion Some data validation issues	Corp Ed is working with Care Groups to identify and reduce data conflicts Corp Ed is supporting Ward/Dep managers to prioritise and schedule training completion Corp Ed requested proxy facility to support remote e-learners effectively New Learning Management System purchased – implementation started. ELearning reminder email sent to all staff who are non-compliant.	E-learning and workbooks offered as alternatives to face to face training Requirements made more transparent and newsletters to staff are signposting more clearly Libraries supporting learners to access e-learning Phone support for e-learning

Trust MCA – DOLS & MHA

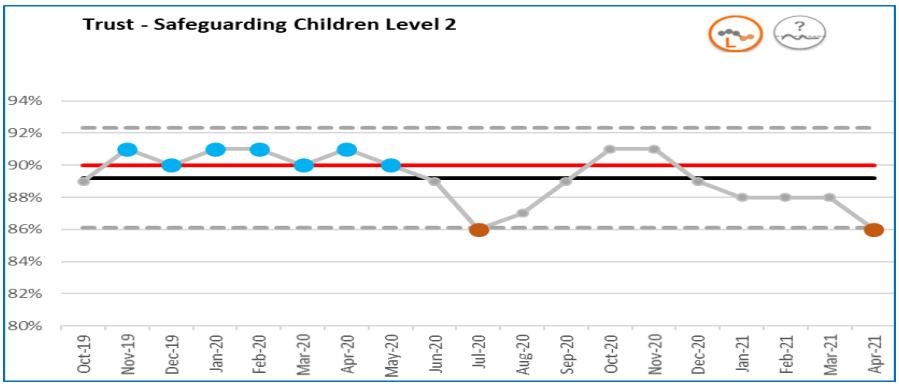


April 2021 actual performance
63%
Variance Type
Special Cause Improvement
National Target
90%
Target / Plan Achievement
Remains significantly below target, with target above upper control limits

Safeguarding

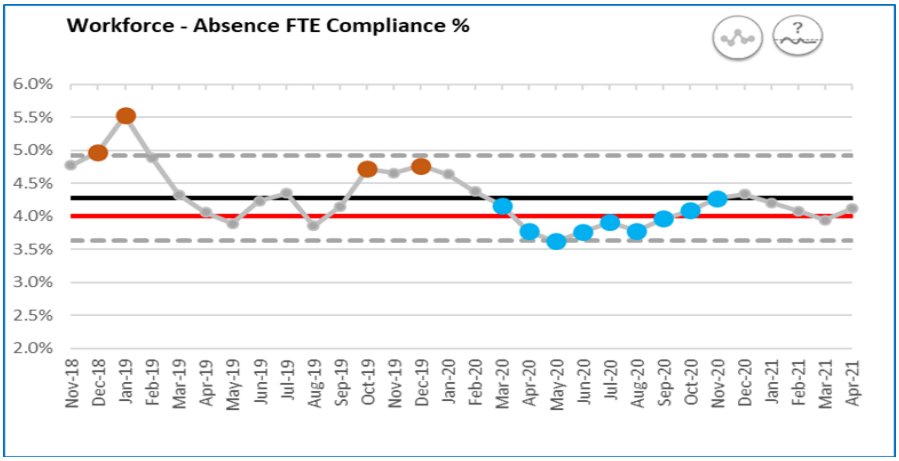


April 2021 actual performance
88%
Variance Type
Common Cause
National Target
90%
Target / Plan Achievement
Performance has declined & is worse than target



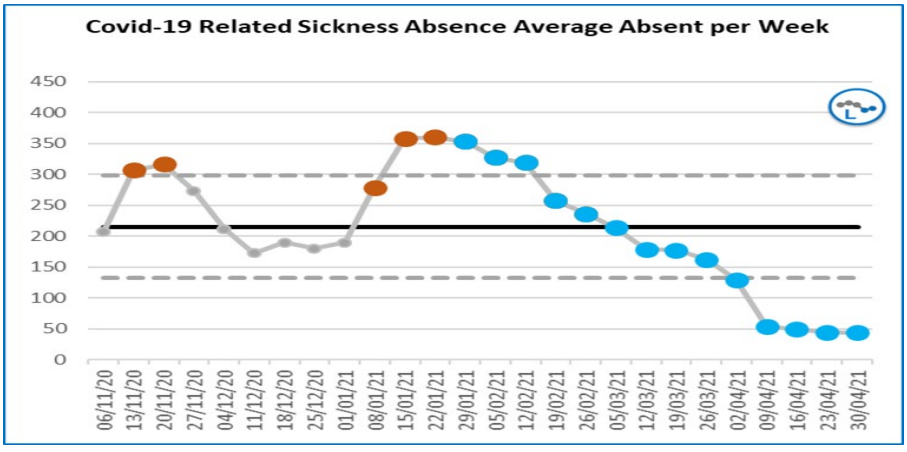
April 2021 actual performance
86%
Variance Type
Special cause concern
National Target
90%
Target / Plan Achievement
Worse than target

Sickness Absence



April 2021 actual performance
3.96%
Variance Type
Common Cause Variation
National Target
4%
Target / Plan Achievement
Better than target, although variable month on month

Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of staff sickness absence and is a % of FTE calendar days absent Covid-19 related sickness and absence is not included.	Special cause improvement between Mar20 – Nov20 with common cause variation through Dec20 – Apr21 reflecting expected seasonal trends.	High levels of absence attributed to mental health reasons. 12 month average of sickness absence 4%. Staff absence of 3.96% for April equates to 243 FTE of which 34% (83 FTE) is attributable to mental health reasons. Staff group of additional clinical services has the highest sickness rate at 5.8% (67 FTE).	Continue to promote health and wellbeing initiatives HR team supporting with welfare conversations Introduction of new employee wellbeing and attendance management policy	Work with temporary staffing departments to ensure gaps can be filled with temporary workforce where necessary



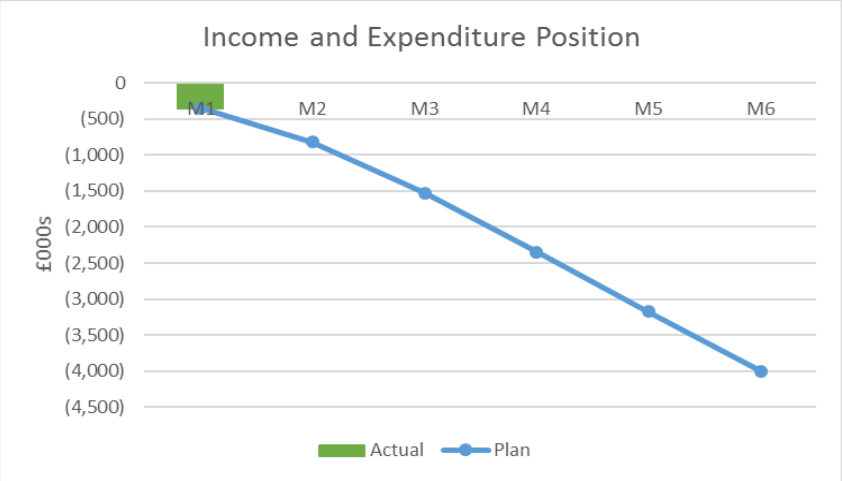
30th April 2021 actual performance
44
Variance Type
Special Cause improvement
National Target
N/A
Target / Plan Achievement

Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of staff Covid sickness absence average per week and is the number of staff absent Covid-19 related sickness	Covid-19 related absence shows special cause improvement through February and April.	Covid-19 positive cases have continued reduce through April. Covid absence rate of 0.73% (43 FTE) throughout April	Continue to encourage staff to follow government guidelines on isolation periods. Ensure PPE adherence and encourage social distancing. Continue to monitor numbers of staff undertaking LFT testing and Covid vaccine uptake.	Maintain social distancing; regular and timely staff testing; identification of positive cases and effective contact tracing.

6. Finance Summary
Helen Troalen, Director of Finance

- The Trust is operating within a temporary financial regime for the first six months of the 2021/22 financial year (H1). A H1 deficit plan for the Trust of £(3.998)m has been agreed with system partners and NHSE/I.
- The Trust recorded a deficit of £(0.353)m in April, which is in line with the first month of the agreed H1 plan. It should be noted that the plan is phased in line with the forecast delivery of efficiency savings.
- The Trust must, as a minimum, deliver £2.4m of efficiency savings during H1. These savings have been planned to deliver incrementally from month two and will be a mixture of recurrent and non-recurrent items. Savings of £0.115m were delivered during April.
- Excluding costs relating to the vaccination and testing programmes, the Trust has a COVID allocation for the H1 period of £8.474m. Spend in April was £1.590m which is a reduction of £0.7m relative to previous month.
- Total capital spend in April was £0.052m against a planned spend of £0.248m. The total capital allocation for 2021/22 is £31.297m, including £21.934m of capital allocation agreed within the ICS Capital Programme and £9.363m of external funding for Phase 2 of RSH A&E Capital Scheme.
- The Trust held a cash balance at the end of April of £17.855m compared to a planned level of £24.268m, which is a £(6.413)m adverse variance. However, this is a timing difference only, linked to the phasing of capital payments and additional payments expected from STW CCG, which will be paid in May. The year-end forecast position remains the same.
- At the end of April, the Trust incurred agency costs of £2.519m inclusive of COVID. This monthly spend was £0.149m favourable to plan.

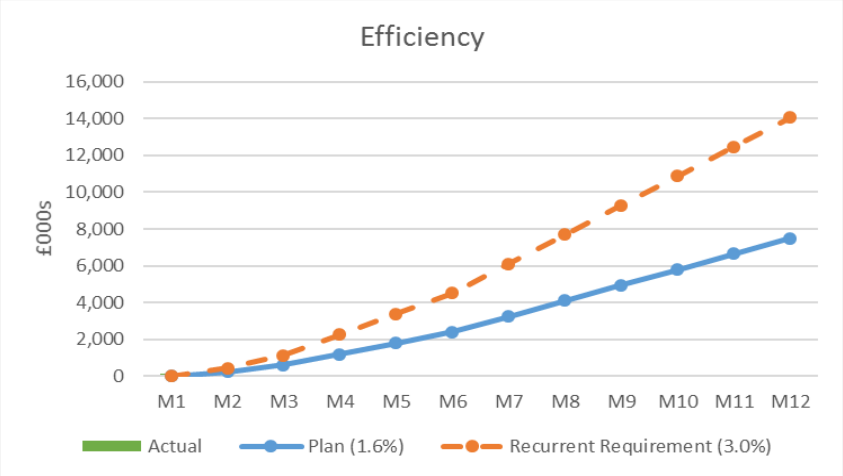
Income and Expenditure Position



April 2021 actual performance	
Income & Expenditure Position year to date (£0.353m)	
Variance Type	
Overspend to date	
National Target	SaTH Plan 2021/22
(£0.352m)	(£0.352m)
Target/ Plan achievement	
Balanced position	

Background	What the Chart tells us	Issues	Actions	Mitigation
All NHS organisations agree a financial plan each year which is phased monthly. Due to only having six months of income data the plan currently covers six months.	The chart shows the monthly phasing of the plan building to a planned deficit of £4m at the end of H1. The Trusts financial position is line with plan in month.	None to report	None required	None required

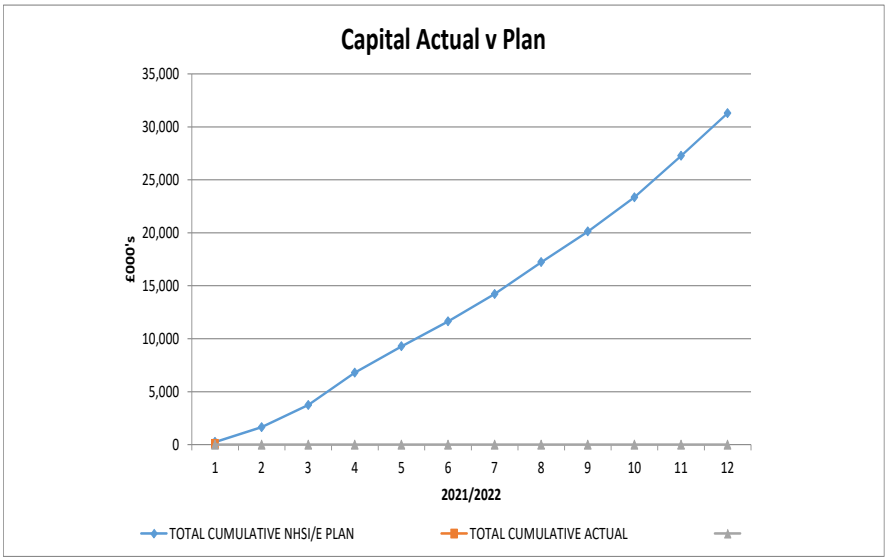
Efficiency improvement



April 2021 actual performance	
Savings year to date is £0.115m	
Variance Type	
Over performance to date	
National Target	SaTH Plan 2021/22
	£2.4 m to M6
Target/ Plan achievement	
£0.115m favourable variance	

Background	What the Chart tells us	Issues	Actions	Mitigations
In common with all NHS organisations the Trust has limited resources. The Trust must therefore ensure that services are delivered efficiently and effectively and generate savings in order to manage cost pressures and required investments.	The efficiency delivery is phased to commence from month two with £2.400m required to deliver H1 plan. The Trust must aim for 3% recurrent savings in order to deliver the sustainability plan. This is also show in the orange line on the chart.	Whist the Trust has delivered an efficiency saving in month there is an accelerated need to identify efficiency savings and to deliver 3% savings recurrently.	• Appoint Head of Efficiency • Efficiency group established in May. • Finalise governance arrangements (SROs, PIDs etc) • Agree project priorities and milestones	• Non-recurrent opportunities

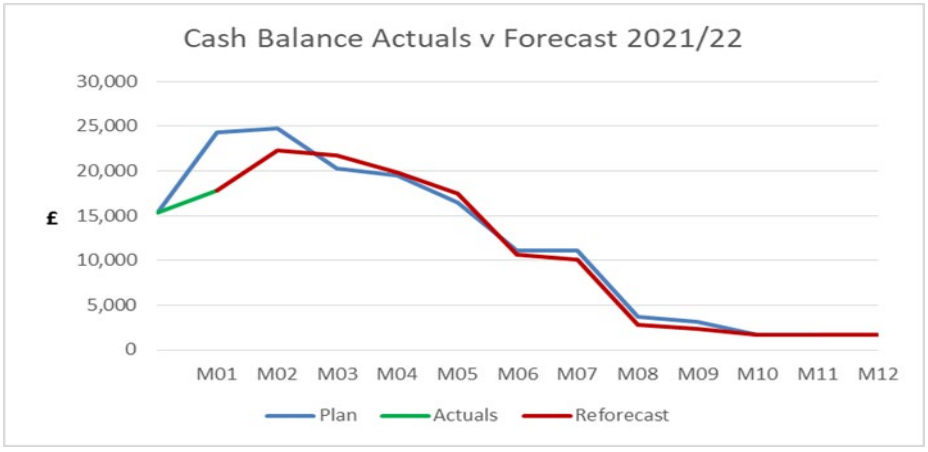
Capital Expenditure



April 2021 actual performance	
Spend year to date is £0.052m	
Variance Type	
Underspend to date £0.196m	
National Target	SaTH Plan 2021/22
N/A	£31.297m
Target/ Plan achievement	
To meet the Trust's Capital Resource Limit (CRL) at year end.	

Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust has a capital allocation and a plan to spend that allocation over the year. The plan is phased across each month.	The Trust's total Capital Allocation for 2021/22 is £31.297m. The planned spend at month one was £0.248m. Only £0.052m has been spent giving an underspend of £0.196m to plan.	The underspend in the month one position is a concern as delays in committing the capital programme should be avoided.	The detailed Capital Programme is to be discussed at May Capital Planning Group. Project allocations will be agreed and expenditure will then start to be incurred.	No mitigations required.

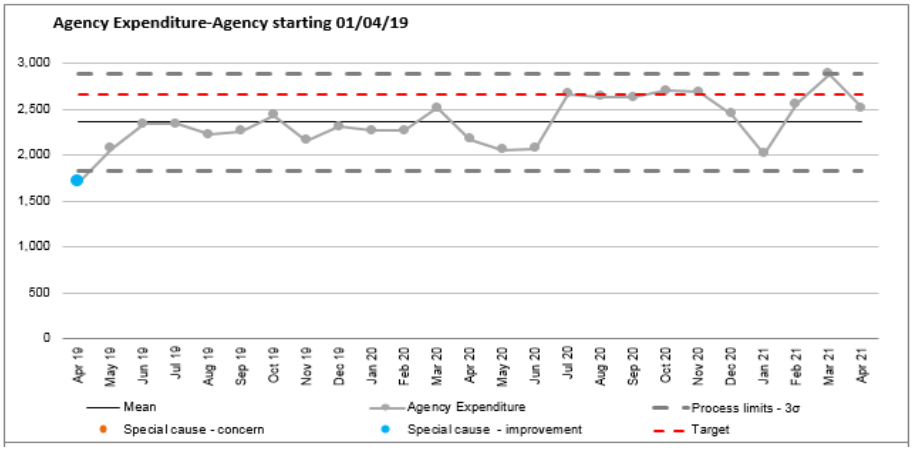
Cash



April 2021 actual performance	
£17.855m cash in Bank	
Variance Type	
Lower Cash Balance	
National Target	SaTH Plan
N/A	£24.268m
Target/ Plan achievement	
£6.413m lower Cash Balance	

Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust developed a Cashflow forecast as part of Going Concern requirement for the Annual Accounts on which the plan is based.	The Trust forecast a cash balance which was £6.413m higher than the actual balance held at month 1.	The Trust received £2.320m less income than forecast mainly due to timing of expected system discretionary funding which we expect to receive in month 2 and outflowed £4.093m more than forecast, mainly due to higher payments of Capital Creditors.	The difference between forecast and actual is a difference in timing and a reforecast has been undertaken to take this timing difference into account. The year end forecast remains the same.	

Agency Expenditure



April 2021 actual performance	
£2.519m	
Variance Type	
Underspend	
National Target	SaTH Plan
	£2.668m
Target/ Plan achievement	
£0.149m favourable variance	

7. Transformation Summary
Chris Preston, Interim Director of Strategy and Planning

- Across the 25 programmes, nineteen of the ratings have remained consistent in period, three have improved and three have deteriorated. The three programmes that have worsened are; 11 Recruitment and Retention; 16 Improving Service Sustainability and 20 System Long Term Plan. Detailed explanations for the deterioration in ratings are contained in the project summaries below. Key highlights:
  - the recent announcement from Central Government to pause all nurse international travel from India taking up employment in the NHS until further notice has impacted the timelines in the Recruitment and Retention plan
  - the project to Improve Service Sustainability was paused in April while the approach was reviewed and is scheduled to recommence in May 21.
  - there is an increasing risk that there may be insufficient staff capacity and capability available (given other competing priorities) to deliver the System Long Term Plan to the planned timescales
- Phase 2 of the Getting to Good (G2G) programme will commence in July 2021, building upon the foundations of the work completed in 20/21, and key aims include:
  - Reviewing and streamlining the plans to ensure that the core focus remains on delivering sustainable quality improvements within our services for our patients and community, including maternity services
  - Increasing the pace of delivery and aligning plans with CQC domains and other strategic priorities
  - Embedding learnings from 20/21 and taking on board feedback from reviews, NHSE/I and the Alliance
- G2G Phase 2 will form a core part of the Trust's Integrated Plan for 21/22, with plans covering the period of July 2021 through to March 2022 scheduled for review and sign off at the June 2021 SLC meeting.

BRAG ratings are based on an overall assessment of delivery progress:

BRAG RATINGS	PROJECT / MILESTONE:
BLUE	Complete
GREEN	No material performance concerns
AMBER	Material risk(s) of non-delivery of objectives or targets, robust plans in place to mitigate and/or recover
RED	Material risk(s) of non-delivery of objectives or targets, without clear plans to mitigate and/or recover
PURPLE	Paused as a result of COVID pandemic

At the end of April 21, the RAG status for overall delivery of the 25 'Getting to Good' work plans is as follows:

FULL PROJECT STATUS	MARCH	APRIL	TREND BETWEEN PERIODS		
GOOD	13	12	IMPROVING	CONSISTENT	WORSENING
REASONABLE	12	11	3	19	3
BELOW REQUIRED	0	1			
PAUSED	0	0			
COMPLETE	0	1			
TOTAL	25	25			

In line with the change requests discussed and approved by the executive at the relevant control sessions, as at the end of April 2021 the RAG status for the delivery of relevant milestones for the next period is as follows:

MILESTONE STATUS	MAY
GOOD	21
REASONABLE	10
BELOW REQUIRED	1
PAUSED	0
COMPLETE	1
TOTAL	**33**

RAG STATUS BY PROJECT

G2G Programme		UHB QIP Priority	RAG Status		Status Update
			Previous Overall	Current Overall	
1.	**Quality Strategy and Plan**	*b. Develop the leadership capacity of SaTH* *c. Clinical improvement plans*			Work continues to develop the KPI metrics that will form the framework for the Quality Strategy, a Quality Strategy Dashboard will be developed to provide a baseline and forecast for the delivery of the strategy across the Trust. Further work is required to establish some elements of qualitative data and there is ongoing work with the Patient Engagement Team to support this via the development of mechanisms for patient feedback around care quality as part of the qualitative measures to be included. Clinical engagement to develop implementation plans to support delivery of the Quality Strategy is ongoing, initial high level communication of the strategy has been completed but this now needs to be widened out to colleagues from across the Trust at all levels. A review of QOC and its TOR has been completed and will support the wider Trust structures and hold to account the ongoing delivery of the Quality Strategy.
2.	**Reducing Mortality and Excess Deaths**	*d. Determine standards for clinical services* *i. Developing a communications and engagement strategy*			Three training sessions for the SJR Plus Mortality Review Tool have now been held with in excess of 50 consultants trained. A number of these individuals have now received their log in details although we are yet to see the outcome of Mortality Review using this methodology. Further work has been undertaken with a number of specialty mortality leads to support local processes. The final report of the NICHE1 project has been received and will be presented with the recommendations to the Trust Learning from Deaths Group on 13th May. All recommendations have already been addressed. The NICHE2 report was received on 21st April and will be shared with appropriate clinical teams for initial comment.
3.	**Quality / Regulatory Compliance**	*c. Clinical improvement plans*			The evidence to support the application to CQC for the possible lifting of 11 section 31 conditions against our registration (9 ED and 2 Reporting requirements) was submitted on 9th April 2021. Work is now underway to develop the underpinning improvement plans for the 6 key themes, these improvement plans will include section 31, section 29, must and should do actions. Once developed the action plans will be monitored at the relevant overarching group as identified in the governance structure. Divisional leads will be responsible for the delivery of relevant actions and reporting back to the committee/group each month with progress updates. Once finalised, these improvement plans will be included in our performance dashboard to provide an overview on progress against our Improvement plans.
4.	**Maternity Transformation**				This has been a productive month, which has included delivery of phase 2 of the Ockenden Report action plan. The second meeting of the ORAC took place, and the first meeting of MTAC. This has improved the level of scrutiny and assurance over all MTP deliverables, particularly those set out in the Ockenden report. The Maternity Improvement Plan is being integrated into the MTP, as Workstream 6. CNST evidence is being refreshed in the light of changes announced by NHS Resolutions.

5.	**Increasing Community Engagement**				Our online conversation 'Get Involved' through the Clever Together Platform was launched on the 21st April for 4 weeks. The aim of this online conversation is to engage with our local communities about how we can keep them informed and engaged in SaTH developments and progress and will support the development of our Public Participation Plan. Members of the HOSC, CHC, Healthwatch and patient groups were involved in the development of this platform. Our monthly community update meeting was well attended in April with over 40 members of the public in attendance (including members of HOSC, Healthwatch CHC and patient groups). Following feedback from our community members we have introduced an evening community update meeting this month. The Trust's Response Volunteer Scheme has over 91 volunteers and in March over 1216 hours of time was given by volunteers involved in this scheme.
6.	**Quality Improvement Approach and Methodology**				The KPO team is now undergoing the implementation phase as it moves towards repositioning the team into a consultancy and coaching model. Recruitment into the Head of Service Improvement has taken place and the process remains on track to fill the remaining posts. The team is planning to move to a more central position within RSH (former TCI Innovation suite, Mytton Oak Restaurant) and preparing for a re-launch. Despite current staff vacancies, the team is applying itself to provide a wraparound service following the MADE activity on hospital flow, as it supports 4 PDSA activities. Future training plans are being reviewed and re-phased. The three year plan, which brings together the work completed so far and describes the future vision is nearing completion.
7.	**Leadership, Development and Education**	*b. Develop the leadership capacity of SaTH* *d. Clinical leadership model and managerial development;*			7a. Leadership - The first triumvirate programme cohort took place during March, we have commissioned the design of our management/leadership development programmes and the executive development programme is due to commence in June. 7b. Organisational Structure – consultations on revised job descriptions for the new clinically led divisional structure continue 7c. Education – The Integrated Education strategy engagement continues ready to be presented to Board for agreement in May. Funding was secured for the LMS system which will enable improved oversight and management of skills and professional development.
8.	**Clinical Standards, Skills and Capability**	*c. Clinical improvement plans;* *e. Standards for clinical services;* *f. Benchmarking clinical outcomes* *and productivity*			Programme progressing well with further engagement and consultation with medical workforce, focusing particularly on the development of speciality clinical standards in this period. Challenges identified around the specific outcomes identified and a proposal to revise the wording to reflect more realistic and achievable outcomes for year 1 has been agreed.
9.	**Culture and Behaviours**				The second conversation for 'Making a Difference Together, was launched on 22nd March and has now closed , there were over 850 participants, casting 4263 votes and sharing 515 ideas and comments. The final iterations of the Behavioural Framework are to be shared and a communications strategy to support the roll out will be developed; this will link with the cultural steering group. The development of the cultural dashboard is underway through a working collaboration with the People Directorate from NHSE/I.

10.	**Communication and Engagement**	*i. Comms and engagement strategy*			The review of existing internal communication channels and a survey to gather feedback on wider communications has been completed and actions embedded. In March, we undertook a review of the current communications team capacity and skills, resulting in a proposal for the future team structure and vision. The procurement of an external firm to support strategic communications (other than Ockenden) is being progressed, which will support the delivery of key proposals and advise on future team structure. Procurement will take place in May, together with additional recruitment to cover vacancies and planned absence. An interim Head of Communications has been appointed and started in May. The substantive HoC role will be externally advertised to recruit an 'on site' manager who can provide leadership to the new team and develop the Communications Strategy.
11.	**Recruitment & Retention**				Our focus over the last month has been on recruiting international nurses as part of the 21/22 business case. However, there are a number of risks associated with the current prevalence of COVID in India as many of our international nurses are recruited from this country (20 out of the planned 27). The main risk is that new recruits will either not be able to join us as planned (due to restrictions) or that they delay travel to stay longer to support pandemic (some already not able to provide notice). We are exploring all other options to ensure the business case remains on track such as looking at other agencies to help recruit from other countries. We will also be exploring other ways to ensure delivery of numbers outlined in our overseas work programme. The recent announcement from Central Government to pause all nurse international travel from India taking up employment in the NHS until further notice will impact on the delivery of milestone 2 and 3.
12.	**Urgent and Emergency Care**				Delivery on the three key UEC work streams continues with progress being made in all areas and the initial draft of the UEC dashboard has been shared internally and with the System. Ward flow work progresses with the PDSA's expanding to include 2 further Wards, and the SDEC project continues to deliver with the completion of capital work to the fracture clinic and SAU and the Surgical SDEC coming online. The Workforce development for both Medical and Surgical SDEC is underway.
13.	**Restoration & Recovery**				Demand and capacity modelling and detailed analysis of the backlog is underway to develop proposals for recovery and to share with the CCG and establish financial implications. The Restoration and Recovery Steering Group has been re-established to guide the recovery of elective and diagnostic services, and the operational sub groups covering diagnostics, outpatients and elective (including theatres, cancer and critical care). A review of the independent sector options is underway and will feed into the planning round, linking to the CCG for system wide coordination of service recovery and capacity. A Business Case has been developed to increase bed capacity later in 2021/22.
14.	**Digital transformation and Infrastructure**	*h. Developing new models to support the development of integrated health and care;* *k. Implementing joint*			Digital Team deployed in Women's and Children's and progressing engagement with clinicians - flexible training approach developed to ensure that staff can access training externally as well as internally and time to complete training reduced. Competence test developed instead of 12 hour face to face training sessions. Revised Digital Roadmap priorities and timescales agreed. Divisional Digital Roadmap discussions in progress.

		working with partner organisations			
15.	**Physical capacity and estates development**				This overall Year 1 G2G programme for Physical Capacity and Estates Development is now complete. All projects have been delivered ahead of time, to budget and handed over to clinical teams to operationalise. The focus will now be on the delivery of the Year 2 plan which centers on A&E redevelopment and forms part of the Estates Strategy.
16.	**Service Sustainability**				Changes at Executive level resulted in a pause in this programme in April to re-evaluate the approach and procurement route for this programme. An option to incorporate this specific G2G programme into HTP, as part of the Strategic Outline Case development (G2G 19) was considered. However, it was felt that whilst there was an interdependency, it should continue as a discrete piece of work and the findings will contribute to the wider objectives of the Trust (relevant findings will also be incorporated into HTP).
17.	**Using Technology to optimise Outpatient efficiency and experience**				The first steering group for this programme has taken place and the Terms of Reference are in development. The questions and format of the baseline information gathering exercise from specialties have been agreed. The KPIs for the programme have been agreed. PIFU user acceptance testing has commenced, however, issues with the SEMA patch are delaying the go live while we undertake another round of user acceptance testing.
18.	**System Improvement and integration plan**				System H1 Plan 21/22: During April all System partners have been working on their H1 plan in line with the National Planning Guidelines. SaTH has developed its draft activity, workforce and financial plan which has been submitted into the System. SaTH have also provided input into the System narrative where required, the system is currently on track to submit H1 draft plan by the 6th May. Work is still ongoing within SaTH to look at further options to improve our elective recovery trajectory such as outsourcing, insourcing which will continue into May so that this can be built into the final plan which is required to be submitted in June. Partnerships: In the last month, the MSK Alliance programme has been reviewed and this is now one of the System 'big ticket' items. The MSK Alliance Shadow Board Terms of reference have been updated to reflect the latest position. A draft Project Initiation Document was discussed at the MSK Programme Board in April and feedback provided. Final versions will be going to the May Programme Board for approval along with updated objectives and outcomes.
19.	**Revise SOC for Hospitals Transformation Programme**				Revised drawdown template completed and submitted to NHSE/I. Completion of procurement exercise for professional advisors in support of SOC and associated business case for NHSE/I approval. High level modelling for HTP acceleration completed. Work needs to be undertaken to ensure there is alignment of HTP with the local health economy system plan. There is a risk that this will significantly impact upon the scale of the HTP design solution. The scheme assumes significant bed benefit arising from system Local Care schemes. These and their associated impact are still to be concluded upon. If the assumed benefit is deemed to be lower than levels assumed within the bed modelling - then there will be an increase in capital cost and associated revenue consequences.

20.	**System Long Term Plan**				SaTH have escalated the need for a delivery group to be established to progress the development of the System Long Term Plan. The System Lead has written to Senior Leaders within the system to identify individuals to sit on the delivery group but this group is yet to be established.
21.	**Oversight, assurance, roles and accountabilities**	*g. Developing new working models;* *j. Clinical quality and risks*			The review and optimisation of the Executive portfolios remains RAG green rather than blue as the CEO has provided the opportunity for executives to provide further details of updates with regard to their portfolios. Board seminars are in place; these are well embedded and continue on a monthly basis. The mapping of the board assurance framework was also completed and fully embedded. The board development programme is still to be procured, team sickness and lack of capacity have delayed this and it is expected that this can be revisited and quickly put into place during May.
22.	**Strong Financial Foundations**				Following F&P approval of the 21-22 M1 budget in March the Trust is finalising its H1 high level forecast as part of the ICS system plan, which is due to be approved by CEOs on 6 May. It is expected to deliver a breakeven but with some significant risks and outstanding issues including potential adjustment for SaTH baseline for the impact of material asset revaluation at year end. The Trust is also preparing a full year forecast and the system capital plan has been agreed for 21-22. The Trust's annual accounting returns have been made on time to NHSE/I and the 20/21 out-turn, for performance purposes, of a £3,752k deficit, as agreed with the ICS and NHSE/I, subject to audit. The Department's Level 1 FFF accreditation submission has been made and validated, and the FFF panel is due to consider this mid-May.
23.	**Performance data and analytics**	*f. Benchmarking clinical outcomes and productivity*			The team have had a number of successes throughout April, we have successfully procured and commenced the implementation of the Inphase product and the hierarchy design to support this first step has been submitted. Further lines of work have seen the completion and confirmation of the key indicators and metrics as well as the development of divisional PRM's were used in April. Forecasting tools have been circulated and are currently being populated by Divisions, an NHSE/I progress report has been drafted and the annual report performance section is prepared. We have been invited to present to the National Data Analysts team on our process of IPR construction and we have also been invited by NHSE/I to support another NHS provider in developing their IPR. In addition to this we have been invited to test the development of a national maternity dashboard that is based on our internal work. The IPR continues to be developed with benchmarking data now included for F&P QSAG, CIC and Board.
24.	**Risk Management**	*g. Developing new working models;* *j. Clinical quality and risks*			Team capacity has continued to be an issue throughout most of April, which has had a knock-on effect on achievement of milestones. Interim support has been assigned to working on the production of the annual report, rather than risk management issues. However, some progress has nevertheless been made in month: a risk management session with internal auditors resulted in the board updating the Trust's risk appetite for 2021/22, which will now be incorporated into the Risk Management Policy. End of year 2020/21 BAF and high level risk register have been prepared for sign off at board in early May, with work commenced on 2021/22 BAF (which will more align with Trust objectives,

					rather than the generic version drawn up in 2020/21)
25.	**Programme and Project Management**	*i. Providing assurance*			In the last month, a first draft of the Project Management training package has been produced but requires further refinement during May. To support development, discussions have been had with other Trusts to learn from best practice elsewhere. The business case for the PMO team has been finalised and added to the Trust Investment log however this will need to go through the priorisation process. The team are focusing on ensuring the current resource and structure is fully utilized to support the Trust's key priorities. Meetings have been held to undertake an initial review of the different Project Management software systems being used in the system and in the Trust.