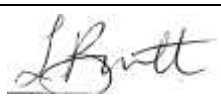
The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
5 August 2021

Agenda item	216/21			
Report	Integrated Performance Report			
Executive Lead	Louise Barnett, Chief Executive			
	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	√
	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,	
	For noting			
	For information			
	For consent			
Presented to:	SLC-O 22.7.21., and as sections relevant to the TOR of FPAC 27.7.21 and QSAC 28.7.21			
Dependent upon (if applicable)**:**	N/A			
Executive summary:	This report provides Board of Directors with an overview of the performance of the Trust to the end of June 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. Planned year-end positions have been included in the overall dashboard and planned monthly performance trajectories have been included on a number of the SPC charts. The Chief Executive Summary is included at the front of the report and function overviews are provided for each section of the report by the lead Executive Director			
Appendices	n/a			
				

Integrated Performance Report

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 Trust's functional domains and includes an overarching executive summary together with domain executive summaries for: Quality, Workforce, Operational Performance, Finance and Transformation.

Contents

1. Executive Summary
Louise Barnett, Chief Executive

- We continue to focus on the implementation of our quality strategy and the delivery of our quality improvement plans, ensuring that those plans fully respond to the key issues identified in recent reviews (including Ockenden).
- During July, the CQC have inspected a number of areas in the Trust and we are actively working to address the feedback and await the formal reports from these visits.
- We have also received positive feedback from GIRFT on our acute medicine service, particularly being commended on our length of stay and low re-admission rate.
- We are focussed on improving the response time to our patients when they raise concerns and to this end we are implementing a new process to simplify and reduce the steps in our complaints process with the aim of eliminating any delays in responding.
- During June, we have seen the return of high levels of attendances at our emergency department, exceeding the levels seen at this time of year prior to the pandemic and putting increased pressure on ambulance handover and the performance of our A&E departments. We have retained our infection control measures on both sites, linked to an increasing presence of Covid-19 in our communities, but as a result we have been unable to safely increase the occupancy in clinical areas to support increased activity.
- We have achieved an increase in the restoration of elective services during June, with the implementation of a second green pathway operating on the RSH site, and ward changes in the PRH site that have enabled elective orthopaedic surgery to recommence.
- The early indication is that our recovery across OPD, In-Patients and Day cases exceeded the 80% threshold set by NHSEI for June. We continue to use the Vanguard theatre to increase our surgical capacity and have invested in an insourcing provider to undertake additional theatre sessions throughout the week. Our staffing shortages in theatres mean we are not yet able to fully recover and we are working to recruit both immediately and to develop theatre apprentices for longer term sustainability.
- Diagnostic recovery is generally progressing well, despite the challenges of staff recruitment. We look forward to the opening of the new CT and MRI pod and the improvements being made in endoscopy to further increase our capacity in the coming months.
- We continue to recognise the hard work and dedication of our staff. During the month, 700 staff that were nominated by colleagues received Covid-19 Heroes awards. We are holding our annual awards ceremony virtually at the beginning of July. We have launched our leadership and behaviours framework to build on the work we have undertaken on our values and culture.
- Our income and expenditure and our efficiency plans are both showing a slight positive variance in the year to date period to the end of June 21.

2. Overall Dashboard

Quality - KPI	Scruitinising Committee	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	QSAC	Mar 21	81.6	100	100			No		100
RAMI	QSAC	May 21	81.1	100	100			No		100
Infection										
HCAI - MSSA	QSAC	Jun 21	1		<2.3			No	7	28
HCAI - MRSA	QSAC	Jun 21	0	0	0			No	1	0
HCAI - C.Difficile	QSAC	Jun 21	3		<2.5			Yes	5	30
HCAI - E-coli	QSAC	Jun 21	5		<3.16			Yes	15	38
HCAI - Pseudomonas Aeruginosa	QSAC	Jun 21	2		0			Yes	4	3
HCAI - Klebsiella	QSAC	Jun 21	2		<1			Yes	3	13
Patient harm										
Pressure Ulcers - Category 2 and above	QSAC	Jun 21	16		<13			Yes	40	152
Pressure Ulcers - Category 2 Per 1000 Bed Days	QSAC	Jun 21	0.78						4.9	tbc
VTE	QSAC	May 21	95.4%	95%	95%			No		95%
Falls - per 1000 Bed Days	QSAC	Jun 21	5.45	6.60	<4.5			Yes	4.92	4.50
Falls - total	QSAC	Jun 21	111		<89			Yes	310	1074
Falls - with Harm per 1000 Bed Days	QSAC	Jun 21	0.00	0.19	<0.17			No	0.07	0.17
Never Events	QSAC	Jun 21	0	0	0			No	0	0
Coroners Regulation 28s	QSAC	Jun 21	0		0			No	1	0
Serious Incidents	QSAC	Jun 21	8		<5			Yes	21	57
Mixed Sex Breaches	QSAC	Jun 21	35	0	0			Yes	87	tbc
Patient Experience										
Complaints	QSAC	Jun 21	75		<56			Yes	193	672
Complaints Responded within agreed time	QSAC	Jun 21	56%	85%	85%			Yes		85%
Friends and Family Test	QSAC	Jun 21	98%	80%	80%			No	97.5%	80%
Compliments	QSAC	Jun 21	40 letters of Thanks yous received						154	tbc
Maternity										
Smoking rate at Delivery	QSAC	Jun 21	11.8%	6.0%	6.0%			Yes	13.2%	6.0%
One to One Care In Labour	QSAC	Jun 21	99.3%	100.0%	100.0%			Yes	99.4%	100.0%
Delivery Suite Acuity	QSAC	Jun 21	68.0%	85.0%	85.0%			Yes		85.0%
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
WTE Employed**Contracted	FPAC	Jun 21	5753		6173			Yes	5753	tbc
Total temporary staff -FTE	FPAC	Jun 21	667					Yes	667	tbc
Staff turnover rate (excludes junior doctors)	FPAC	Jun 21	1.10%	0.8%	0.75%			Yes	1.14%	0.8%
Sickness absence rate Excluding Covid Related	FPAC	Jun 21	4.90%		4.00%			Yes	4.26%	4%
Appraisal Rate	FPAC	Jun 21	86%	90%	90.0%			Yes		90%
Appraisal Rate (Medical Staff)	FPAC	Jun 21	76%	90%	90.0%			Yes		90%
Vacancies	FPAC	Jun 21	7% (412)	<10%	<10%			No	412	<10%
Statutory and Mandatory Training	FPAC	Jun 21	87%	90%	90.0%			Yes		90%

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	FPAC	Jun 21	33739 (English 30502)					Yes		26209 English
18 week RTT % compliance -incomplete pathways	FPAC	Jun 21	57.48% (English Only)	92%				Yes		40% English
52 week breaches	FPAC	Jun 21	2932 (2611 English only)	0				Yes		4156 English
Cancer										
Cancer 2 week wait	FPAC	May-21	84.5%	93%	93%			Yes	84.3%	93%
Cancer 62 day compliance	FPAC	May-21	70.4%	85%	85%			Yes	74.7%	85%
Diagnostics										
Diagnostic % compliance 6 week waits	FPAC	Jun 21	80.3%	99%				Yes		tbc
DM01 Patients who have breached the standard	FPAC	Jun 21	1753	0	1254			Yes		tbc
Emergency Department										
ED - 4 Hour performance	FPAC	Jun 21	68.4%	95.0%	71%			Yes	72.2%	78%
ED - Ambulance handover > 60mins	FPAC	Jun 21	570	0				Yes	1172	tbc
ED 4 Hour Performance - Minors	FPAC	Jun 21	93.1%	95%	95%			Yes	94.9%	95%
ED 4 Hour Performance - Majors	FPAC	Jun 21	43.3%	95%				Yes	50.5%	tbc
ED time to initial assessment (mins)	FPAC	Jun 21	27	15	15			Yes	25	15mins
12 hour ED trolley waits	FPAC	Jun 21	53	0	0			Yes	13	tbc
Total Emergency Admissions from A&E	FPAC	Jun 21	2897					n/a	8807	29744
Hospital Occupancy and activity										
Bed Occupancy -G&A	FPAC	Jun 21	84.5%	92%	92%			No		92%
ED activity (total excluding planned returns)	FPAC	Jun 21	13528		12119			Yes	38891	118403
ED activity (type 1 excluding planned returns)	FPAC	Jun 21	11503		9988			Yes	32832	tbc
Total Non Elective Activity	FPAC	Jun 21	5085		5356			Yes	15115	62349
Outpatients Elective Total activity	FPAC	Jun 21	57872		52360			No	162814	558021
Total Elective IPDC activity	FPAC	Jun 21	5488		5257			No	15689	58789
Diagnostic Activity Total	FPAC	Jun 21	17712		16500			No	51098	tbc

Finance - KPI		Latest month	Latest Value	National Standard for month	Plan for year	Perfomance	Assurance	Exception	Year to Date	Year End Planned Trajectory
Cash	FPAC	Jun-21	8.603m		1.700			Yes	8.603	1.700
Efficiency	FPAC	Jun-21	0.683m		2.400(H1)			No	0.994	2.400(H1)
Income and Expenditure	FPAC	Jun-21	2.535m		3.219(H1)			No	1.714	3.219(H1)
Cumulative Capital Expenditure	FPAC	Jun-21	1.177m		34.142			Yes	1.448	34.142

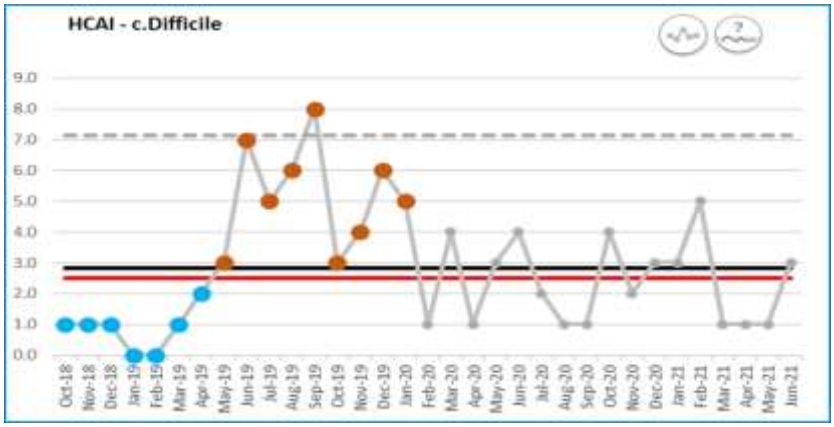
3. Quality Summary
Hayley Flavell, Director of Nursing
Richard Steyn and John Jones, Acting Co-Medical Directors

- Mortality indices remain below the reference level of 100. The Board are asked to note that HSMR will be re-based nationally in the near future and this will result in a rise in the reported level. This rise is expected to be in line with the national rebasing.
- Following the work undertaken to ensure patients are not admitted to wards without a VTE assessment completed, it is pleasing to see that the target of 95% of assessments completed was achieved this month. This will continue to be reviewed to ensure the improvement is embedded.
- No further cases of MRSA are reported this month, however the incidence of E.coli and c.Difficile are above the month standard set, with E.coli exceeding the plan for the quarter. While the number of Pseudomonas Aeruginosa are low, the performance at the end of Q1 has exceeded the internal standard set for the year.
- The improvement seen in the number and rate of pressure ulcers last month has not been sustained with 13 pressure ulcers grade 2 or above identified this month and the rate increasing to 0.78 per 1000 bed days.
- The number of falls continues to remain an area of focus, with 111 reported this month. No fall resulted in serious harm.
- There were 8 serious incidents this month
- There were 35 mixed sex breaches this month.
- The response time for concerns remains unsatisfactory, with work underway to reduce delays in the process. The poor performance is in part due to reducing the backlog of overdue complaints and in part a reflection of timing in implementing the changes proposed. An improvement trajectory aligned to the actions being taken is being developed.
- Following the recently reported Parliamentary review of maternity services, the Trust will be using Robson scores as an indicator for C.Section as opposed to the overall C.Section rates.
- The delivery suite acuity is a real-time trigger used in the unit to prompt immediate action to provide safe levels of staffing, with actions taken immediately to positively address the score by re-allocating staff to the suite.
- There are no never events or further section 28s to report this month.
- During July the CQC have undertaken unannounced visits to the Trust, at this time formal feedback is awaited, however we are actively working to address issues raised as well as recognising the positive comments made. We are expecting a Well Led visit in August 2021.

Exception Reports - Harm

Hospital Acquired Infections

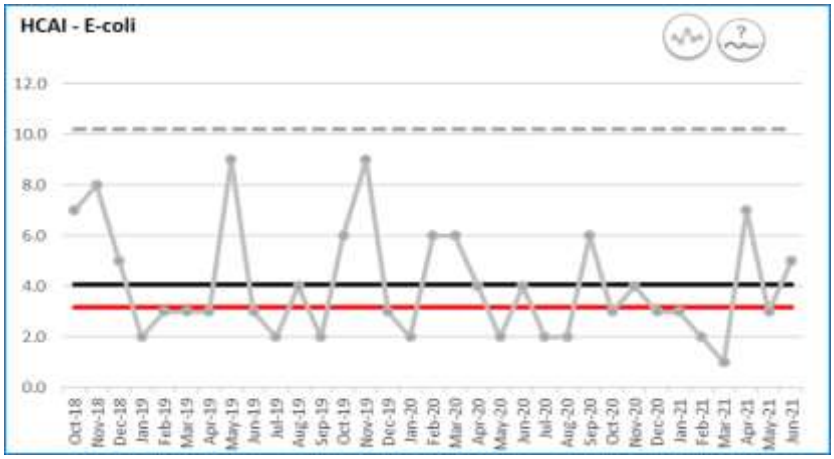
C-Difficile



June 2021 actual performance
3
Variance Type
Common cause
Local Standard
2.5
Target / Plan Achievement
Sustain or improve on 2020/21Target, is no more than 30 cases

Background	What the Chart tells us:	Issues	Actions	Mitigations
Locally agreed continuous improvement target is set at 30, compared to the target of 43 agreed with the CCG for 2019/20.	There were three cases of C difficile attributed to the Trust in June 2021. Two cases were Post 48 cases and one was a Pre 48 case that had been discharged from the Trust in the previous 28 days. There were 5 cases in Q1 (April to June 2021) against a target of no more than 7 cases. Performance is in accordance with common cause variation and on course to deliver the improvement for the year.	RCA's for the June cases are currently being undertaken to enable learning to take place.	Actions and learning from RCAs completed recently include: VIP Scores need recording more consistently. Documentation around Blood cultures needs improvement. Skin integrity assessments need completing more thoroughly.	Cases are monitored through IPC Operational Group.

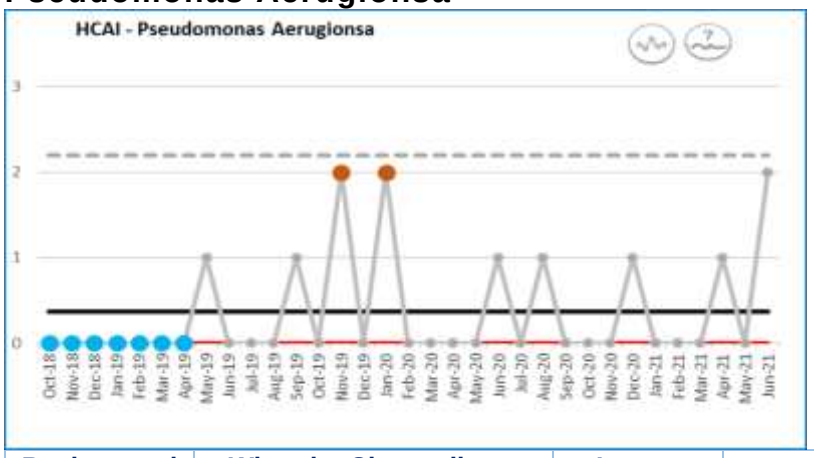
E-Coli



June 2021 actual performance
5
Variance Type
Common cause
Local Standard
3.16
Target / Plan Achievement
Target for 2021/22 is no more than 38 cases is unlikely to be delivered at the current run rate.

Background	What the Chart tells us	Issues	Actions	Mitigations
Reporting E.Coli bacteraemia has been a mandatory requirement since 2011.	There were 5 cases of E.Coli bacteraemia in June 2021. There have been 15 cases of E.Coli in Q1 (April to June 2021) against a target of 38. This run rate is suggesting the improvement set for the year is at risk.	Three of the cases were considered not to be device or intervention related. The remaining two cases are currently being reviewed to establish the cause. Documentation around insertion of devices/collection of samples needs improvement. Samples not collected in a timely manner.	Matrons to monitor documentation around insertion. Timely taking of samples to be discussed at governance meetings.	Cases where source is unknown or deemed to be device related have an RCA completed.

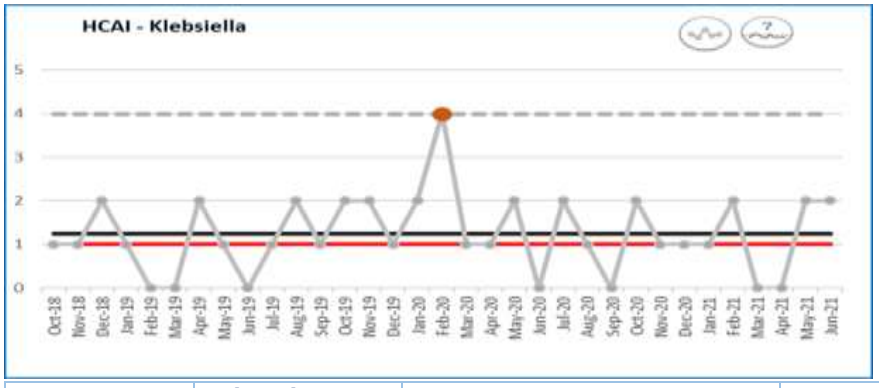
Pseudomonas Aeruglonsa



June 2021 actual performance
2
Variance Type
Common cause
Local Standard
3.16
Target / Plan Achievement
The local target for improvement has not been met with 4 cases reported in Q1

Background	What the Chart tells us	Issues	Actions	Mitigations
Reporting of pseudomonas is a mandatory requirement.	There were 2 cases of post 48 hour Pseudomonas bacteraemia in June 2021. The performance year to date is worse than 2019-20, resulting in non-achievement of the aim to sustain or improve on previous performance.	Catheter care previously highlighted as an issue.	Ongoing improvement actions included: 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.

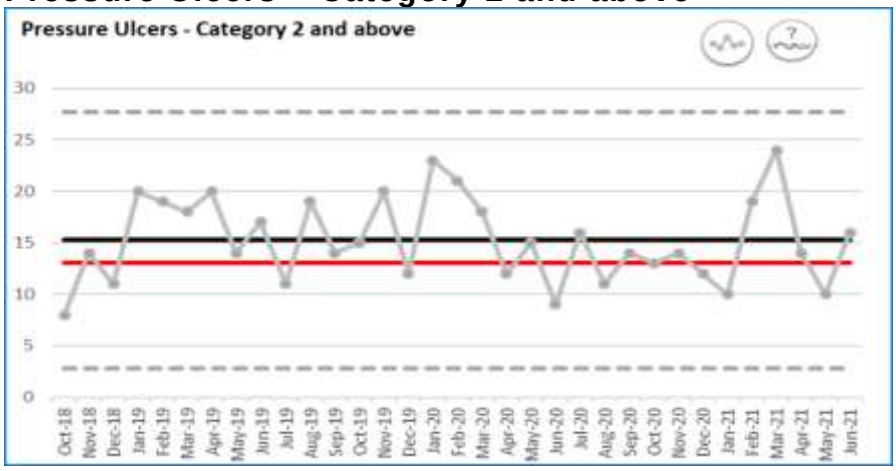
Klebsiella



June 2021 actual performance
2
Variance Type
Common Cause
Local Standard
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.	There were 2 cases of post 48 hour Klebsiella in June 2021.	One of the cases was considered to be device related and the source was a Catheter associated urinary tract infection.	Ongoing actions include: Use of catheter care plan and insertion documentation monitored through matrons quality audits.	Cases are monitored through IPC ops group.

Pressure Ulcers – Category 2 and above



June 2021 actual performance
16
Variance Type
Common Cause
Local Standard
13
Target/ Plan achievement
10% Improvement on 20/21 prorata =<12.7pm (no more than 152 cases)

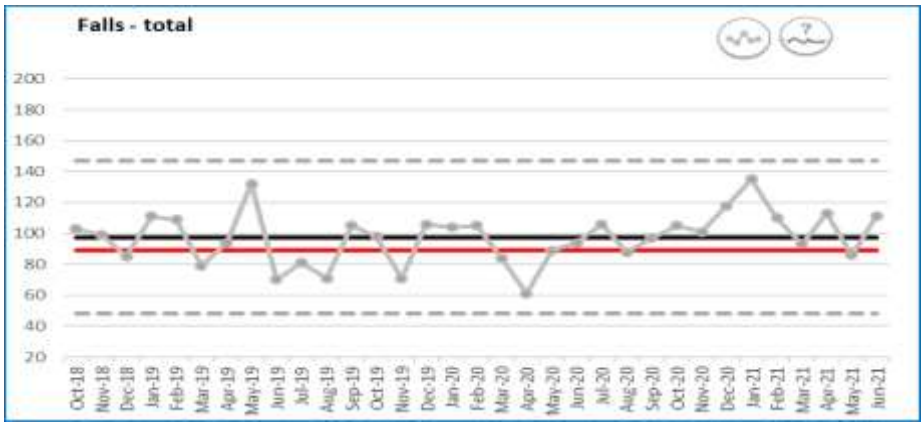
Pressure Ulcers – Total per Division	Number Reported
Medical and Emergency Care	8
Surgical, Anaesthetics and Cancer	8

Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust aims to reduce the number of hospital acquired pressure ulcers.	Acquired pressure ulcers increased in June with 16 reported across the Trust. This is part of common cause variation, however the rate is slightly higher than required at the end of Q1 to achieve the full year end improvement plan. At the present rate year end forecast is 160 v the improvement target of 152.	5 of the pressure ulcers were category 3 ulcers. 2 met the threshold for an SI, both of these were on ward 27.	Deep Dive into pressure ulcers on Ward 27 supported by Tissue Viability Team. TV training being rolled out across clinical areas. Ongoing monitoring of Pressure ulcer documentation with actions in relation to these audits taken by HONs to ensure compliance.	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 shared at the Pressure Ulcer RCA meeting Monthly Nursing Quality metrics confirm and challenge meetings.

Pressure Ulcers – Category 2 and above per 1000 Bed days

June 2021 actual performance
0.78
Variance Type
Common Cause
Local Standard
tbc

Falls

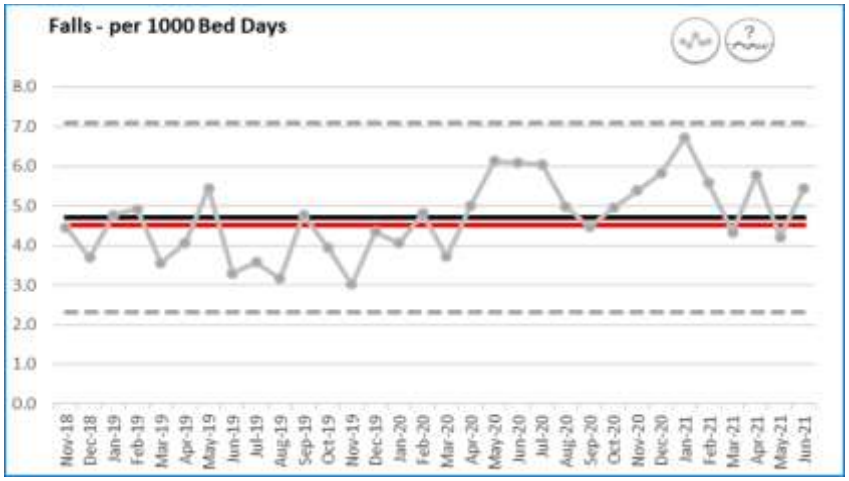


June 2021 actual performance
111
Variance Type
Common Cause
Local Target
89
Target / Plan Achievement
10% reduction on 20/21

Falls – Total per Division	Number Reported
Medical and Emergency Care	74
Surgical, Anaesthetics and Cancer	37

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.	The Number of falls in June increased to 111 compared to 86 the previous month. The run rate at the end of Q1 is higher than expected to deliver the 10% reduction by year end. The forecast based on the current run rate is 1,240 against the improvement target of 1,074.	Falls Prevention Programme continues, there are still some incidents where pre and post falls risk assessments and documentation has not been fully completed.	Ongoing daily review of every fall and feedback at time to staff and letter to staff caring for the patient at the time of the fall in relation to good practice or areas for improvement. Ongoing monthly audits of falls assessments and documentation. Quality matrons supporting improvement work in relation to lying and standing BP. Ongoing support in relation to cohorting of patients at high risk of falls. Ongoing monthly audits of falls assessments and documentation. Quality matrons supporting improvement work in relation to lying and standing BP. Ongoing support in relation to cohorting of patients at high risk of falls.	All falls resulting in significant harm are reported as SIs and have an investigation completed which is presented at NIQAM and learning shared monthly falls documentation audits monthly confirm and challenge meetings.

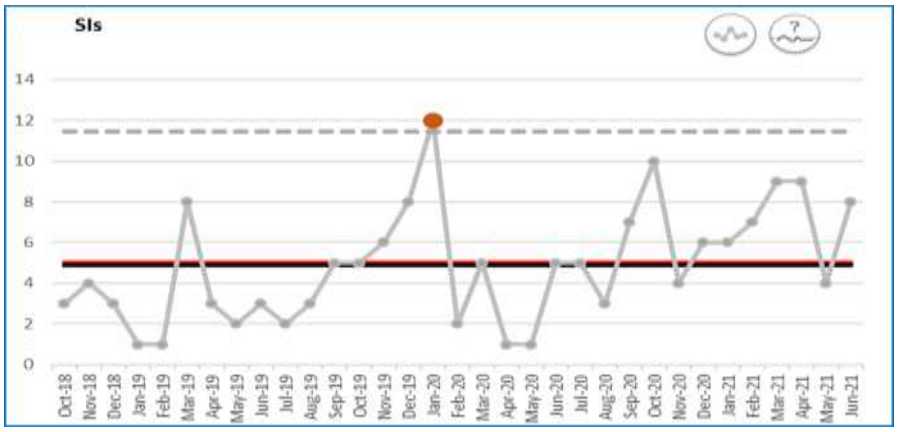
Falls – per 1000 Bed Days



June 2021 actual performance
5.45
Variance Type
Common Cause Variation
Local Plan
4.5
National Standard
6.6
Target/ Plan achievement
New local Target set for 21/22

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.	Falls per 1000 bed days increased in June compared to previous month and is currently above Trust target, although better than the national comparator. Common cause variation is exhibited and with the local standard being slightly below the mean it is likely that this standard will not be consistently delivered each month.	As per Falls Slide.	As per Falls Slide.	As per Falls Slide.

Serious Incidents



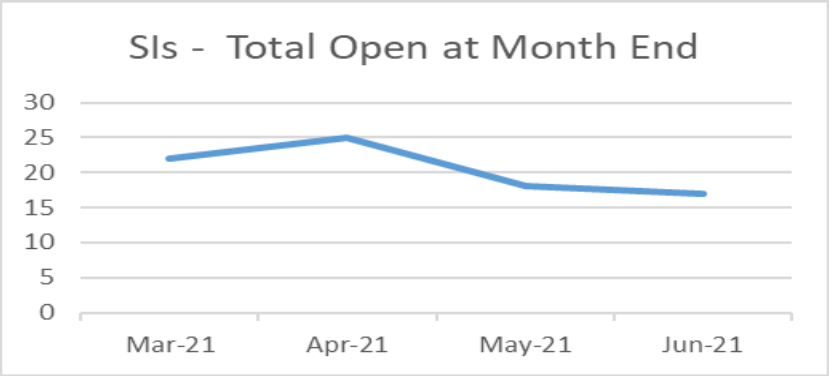
June 2021 actual performance
8
Variance Type
Common cause variation
Local Standard
5
Target/ Plan achievement
10% reduction on 20/21 (No more than 57 cases) pro-rata =<5per month

SI theme	Number Reported
Maternity Obstetric	1
Fall on 31st May resulting in fracture neck of femur – reported SI in June - Ward 22 short stay	1
Baby required cooling – HSIB referral – all HSIB cases to be reported as SI.	1
Delayed Diagnosis Bowel Obstruction – Ward 26	1
Delayed Diagnosis – CT scan clearance – PRH ED	1
Category 3 Pressure Ulcer – Ward 27	2
Complication of procedure – Gynaecology Outpatients	1
Total	8

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
Serious Incidents are adverse events with likely harm to patients that require investigation to support learning and avoid recurrence. These are reportable in line with the national framework	The number of SIs reported continues to show Common Cause Variation. Following a peak in reporting during October reporting has remained above the mean for six months with a drop in June. .	Over the coming months COVID-19 19 related incidents such as delayed diagnosis due access issues/outbreaks and COVID-19 related deaths June 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	4
Women's and Children's	6
Total	**17**

Background	What the Chart tells us	Issues	Actions	Mitigations
Current number of open Serious Incidents.	Number of open SIs.	17 open SIs all within 60 day framework.	Monitoring of progress of investigation.	Weekly review of progress.

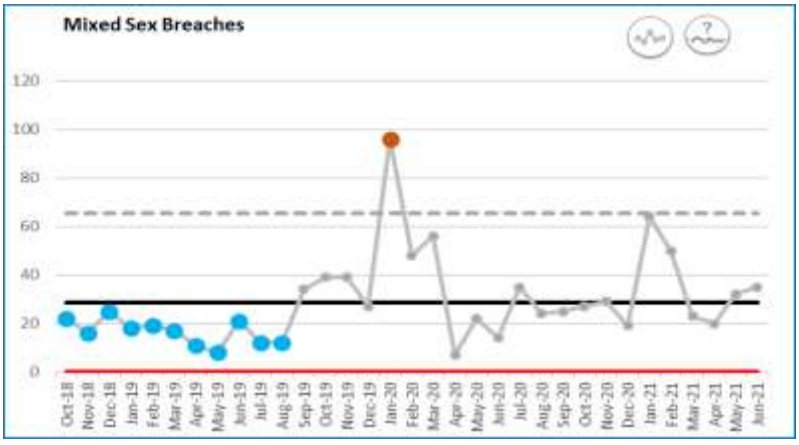
Serious Incidents – Closed in Month

June 2021 actual performance
SATH
4

Background	What the Chart tells us	Issues	Actions	Mitigations
Serious incidents have a 60 day life cycle. The number of SIs closed in month will vary dependent on the number reported.	There were 4 SIs closed in month with a 100% completion within the 60 day target.	All SIs to be completed within 60 day timeframe.	Monitor reviews. Maintain investigation reporting within national framework deadlines for timely learning. Embed learning from incidents.	Weekly review of progress of investigations.

Exception Reports – Patient Experience

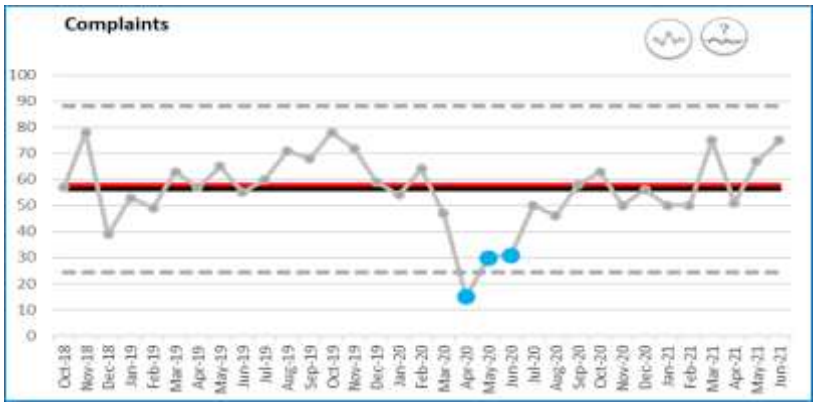
Mixed Sex Breaches Exception Report



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

Location	Number of breaches	Additional Information
ITU / HDU (PRH)	2 primary breaches	1 Medical and 1 Surgical
ITU / HDU (RSH)	25 primary breaches	4 Medical and 21 Surgical
CCU (RSH)	1 primary breaches	1 Secondary breaches
CCU (PRH)	7 Primary breaches	4 secondary breaches

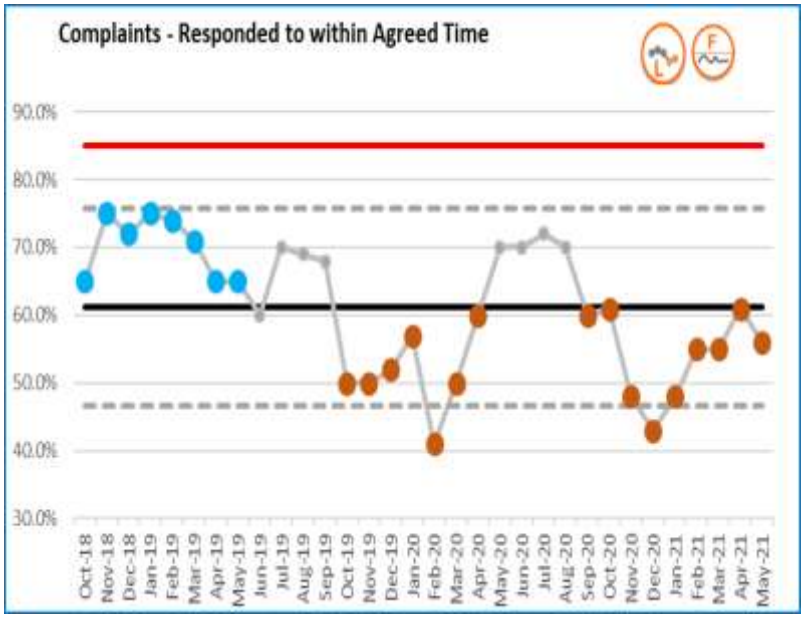
Complaints



June 2021 actual performance
75
Variance Type
Common cause
SATH internal target
<56
Target/ Plan achievement
>10% reduction on 19/20 total complaints

Background	What the Chart tells us	Issues	Actions	Mitigations
Complaints provide a valuable source of learning to the organisation.	Although higher than previous months, numbers remain within common cause variation. However the run rate at the end of Q1 suggests the end of year improvement is at risk with the forecast being 772 against a local target of 672.	Ward 26, which has previously been an area of concern, only received one complaint last month. The RSH ED saw a higher number of complaints; although this remains within expected variation, this will be monitored. There has been a slight increase in complaints relating to staff attitude, across a number of areas, with no specific trends identified.	Areas of concerns continue to be monitored.	As per actions.

Complaints – Responded within Agreed Time



May 2021 actual performance	
56%	
Variance Type	
Special cause	
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 unlikely to be achieved within current processes, process is being changed to reduce steps and delays resulting from these.	

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 remain lower than expected.	The approval process at divisional level has created some additional delays, but this is now improving. There are ongoing challenges for divisions in managing competing priorities and in accessing patient records.	Process mapping has been held within the Medicine & Emergency Division, which receives the most complaints. This has helped identify barriers and blockages. A new process, whereby specialties have greater ownership has been piloted in some areas and is being rolled out across the Divisions.	Regular updates to complainants. Regular meetings with senior managers to track open cases.

Compliments recorded

June 2021 actual performance
SATH
40
Divisions
MEC – 17
SAC - 10
W&C - 6
CSS - 4

Maternity Indicators

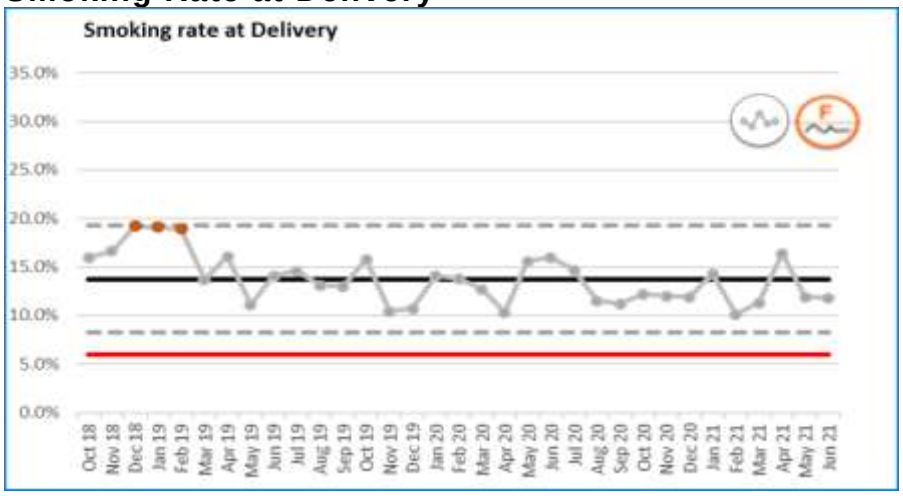
Caesarean Section

The C.Section indicator is being replaced with the Robson Score indicators to provide a more intelligent measure. The Robson classification is recognised as a global standard for assessing, monitoring and comparing Caesarean section rates both within healthcare facilities and between them. The system classifies all women into 10 mutually exclusive categorises using 5 obstetric characteristics. We are waiting confirmation as to which of the 10 categories will be used nationally. Our benchmarking data reports on 3 Robson scores up to March 2021 and demonstrates performance as follows:

At the end of March 2021 the ranking of the trust against these indicators was:

Robson group 1	51 (out of 61)
Robson group 2	10 (out of 36)
Robson group 3	20 (out of 49)

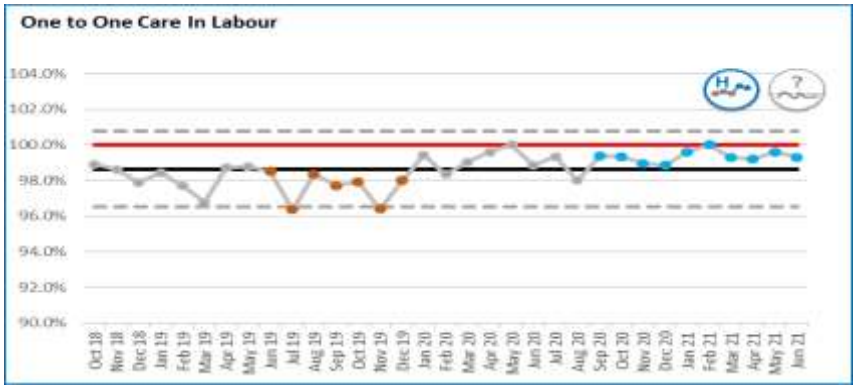
Smoking Rate at Delivery



June 2021 actual performance
11.8%
Variance Type
Common cause
National Target
6% March 2022
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

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.	There has been a decrease in SATOD rates from the previous month. Rates are lower than the same period in the previous year, but remain within common cause variation overall.	SATOD remains above national average and above government target of 6%. Transition to new integrated Public Health maternity service delayed until late 2021.	Positive change and development is in progress to encourage a family approach to lifestyle change within the county. Family approach and equitable service across Shropshire should reduce SATOD rates in the future Evaluate and review new service once started to ensure local demographic needs are being met and that the service easily accessible in deprived areas.	See actions.

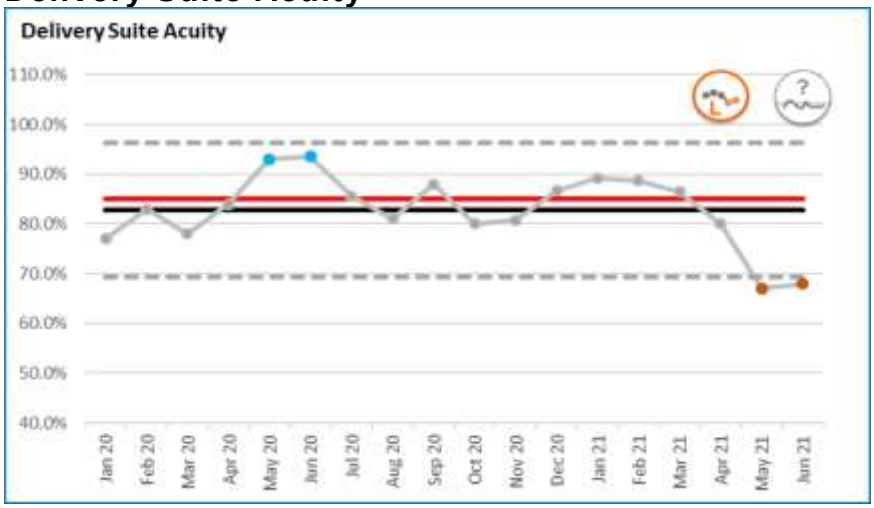
One to One Care in Labour



June 2021 actual performance
99.3%
Variance Type
Special Cause Improvement
National Standard
100% (Better Births)
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

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.	Consistently above Mean rate since summer 2020 and close to the national standard.	Staffing vacancies high currently, recruitment in progress.	Acuity is managed by Delivery Suite coordinators and SMT huddles twice daily.	Incentivised Bank shifts in place between 12th June end of July to improve staffing levels until vacancy rate improves.

Delivery Suite Acuity



June 2021 actual performance
68%
Variance Type
Special cause concern
National Standard
85% (Birth Rate Plus)
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

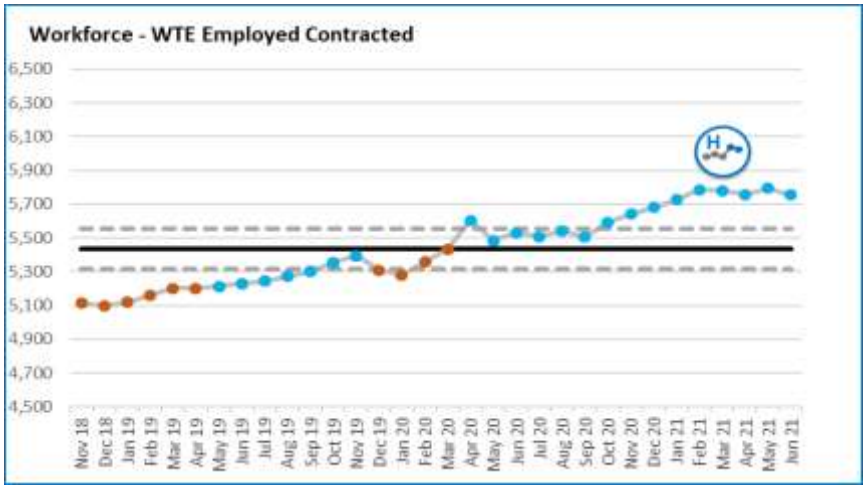
Background	What the Chart tells us	Issues	Actions	Mitigations
In 2015 NICE set out guidance for safe midwifery staffing which included the use of a tool endorsed by NICE to measure and monitor acuity. This has been in place at SaTH since 2018 and is reported monthly in line with the CNST standard safety action number 5.	Acuity has fallen in last 3 months.	High Vacancy rate currently. Imbalance in staffing due to amount of secondments in service. Some shifts unfilled in Delivery Suite area between June and July 21.	This indicator is used as a live tool and responded to at the time to rapidly adjust the staffing on the day to maintain patient safety. Escalation used appropriately when required to maintain safe acuity within CU areas. Staffing review in progress. Recruitment plan being actioned. Continue to monitor.	Incentivised bank shifts in place for CU areas from June 12th – end of July to support staffing gaps identified. Twice daily SMT huddles in place to monitor safety and staff deployment across unit.

4. Workforce Summary
Rhia Boyode, Director of Workforce

- COVID-19 related sickness remains relatively low but we are seeing a spike in staff required to isolate due to growing numbers of Test and Trace Isolation alerts.
- A risk based approach has been designed to address the impact of high levels of staff needing to isolate. The expectation is that the majority of staff will isolate in accordance with instruction from NHS Test and Trace Service including advisory notification via the app. In exceptional circumstances whereby there is a significant risk to services, frontline staff may be released from isolation in order to attend work however this is only after a rigorous risk assessment process which includes Senior Level review and approval via the ICC.
- Covid-19 positive cases have continued to be low during June with majority of cases due members of household becoming symptomatic. Positive cases remain low through June. Covid-19 absence rate of 0.92% (54 FTE) throughout June.
- Overall WTE numbers have continued to increase, staffing demands continue to present challenges; high patient activity levels and staff absences continue to present challenges to staffing levels.
- High levels of absence attributed to mental health reasons along with increase in absence attributed to other known reasons and gastrointestinal. 12 month average of sickness absence 4.1%.

- The 90% Appraisal target was achieved January to April 20 then started to reduce and has remained below target, however, this month has risen to 86% this month.
- The Training compliance rate has risen to 87% this month, but still remains below target. Safeguarding training compliance continues to improve month on month.

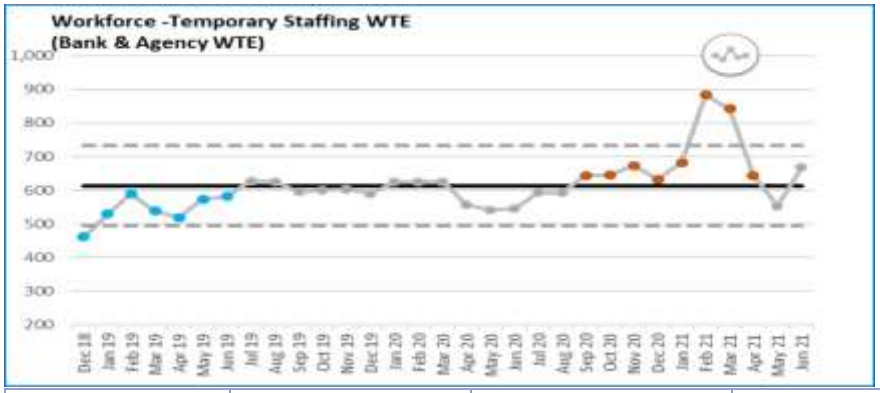
WTE employed



June 2021 actual performance
5753
Variance Type
Special cause Improvement
Local Target
6173
Target / Plan Achievement
Improvement month on month towards the target set

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., although the rate of improvement has slowed.	Overall WTE numbers have continued to increase, staffing demands continue to present challenges; high patient activity levels and staff absences continue to present challenges to staffing levels.	Recruitment activity continues to increase staffing levels.	Utilisation of bank and agency staff to support workforce gaps.

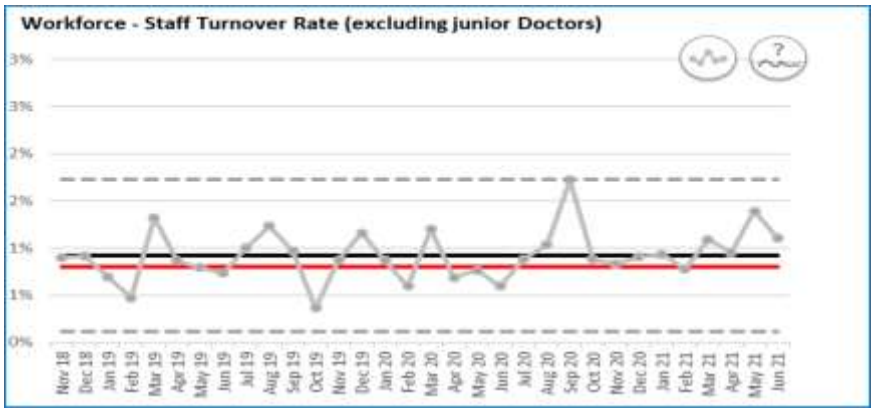
Temporary/ Agency Staffing



June 2021 actual performance
667
Variance Type
Common cause
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 WTE.	Special cause concern over Winter period between Sep20 – Apr21. Normal variation in May21 and Jun21.	Staff 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 including international nurses.

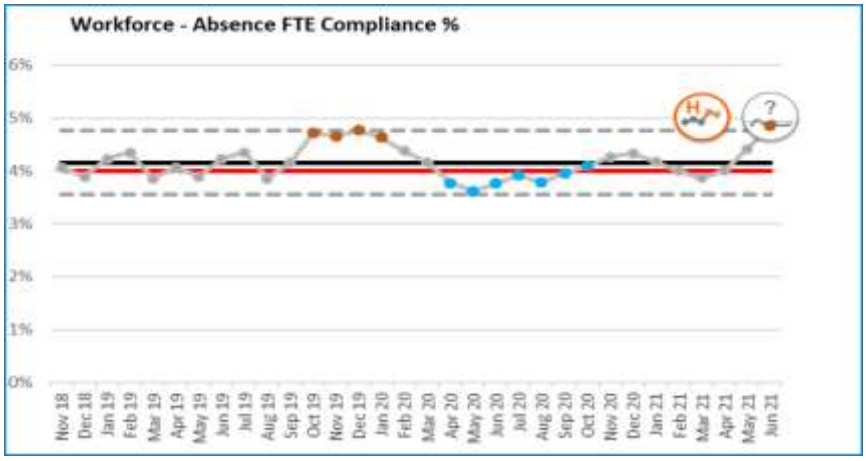
Staff Turnover Rate (excluding Junior Doctors)



June 2021 actual performance
1.1%
Variance Type
Common cause
National Target
0.8%
Target / Plan Achievement

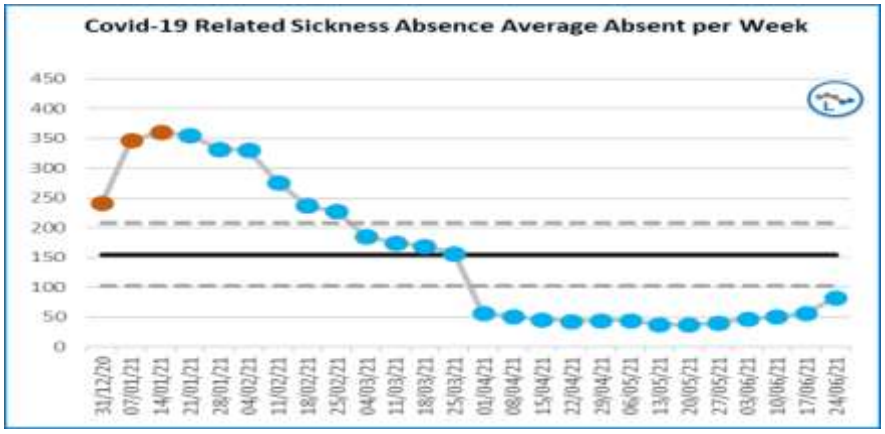
Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of the % of staff who have left the organisation.	Normal variation continues between Oct 20 and June 21.	21% (123 FTE) of staff have left due to work life balance over the last 12 months. There were 58 FTE leavers in June, which is above the average number of leavers per month of 50 FTE. In June 16% (9 FTE) of those who left gave a reason of work life balance with 10% (6 FTE) giving a reason of lack of opportunities/ further education or training. 26% (15 FTE) of staff who left in June were from the nursing and midwifery staff group; within this 27% (4 FTE) left due to work life balance.	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.

Sickness Absence



June 2021 actual performance
4.9%
Variance Type
Special cause
National Target
4%
Target / Plan Achievement
Fluctuates around the target each month

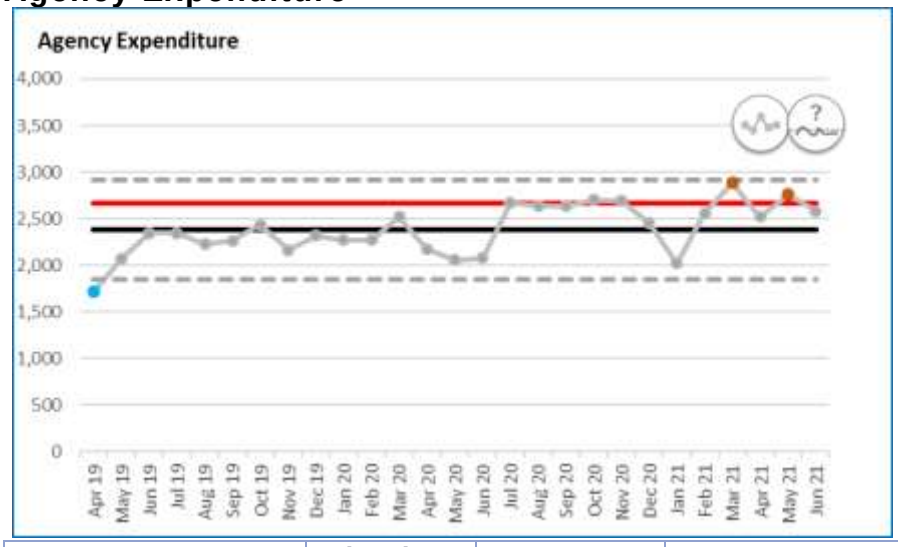
Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of staff sickness absence and is a % of FTE calendar days absent. Covid-19 related sickness and absence is not included.	Special cause improvement between Mar 20 and Nov 20 with common cause variation through Dec 20 to June 21 reflecting expected seasonal trends. June 2021 saw a special cause concern with an increase in the sickness absence reported.	High levels of absence attributed to mental health reasons along with increase in absence attributed to other known reasons and gastrointestinal. 12 month average of sickness absence 4.1%. Staff absence of 4.86% for June equates to 286 FTE of which 31% (89 FTE) is attributable to mental health reasons. Additional Clinical Services at 7.6% (86 FTE) and Nursing & Midwifery at 5.15% (88FTE) are the staff groups that have seen the most noticeable increase.	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 June 2021 actual performance
83
Variance Type
Special Cause improvement
National Target
N/A
Target / Plan Achievement

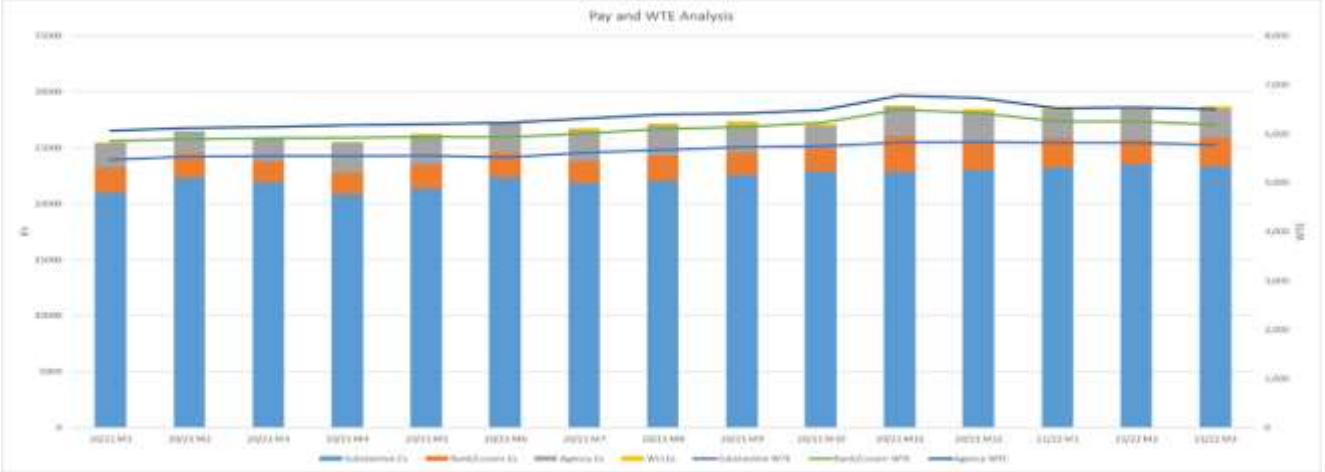
Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of staff Covid-19 sickness absence average per week and is the number of staff absent due to Covid-19 related sickness.	Covid-19 related absence shows special cause improvement through February and June, although a slight deterioration is noted this month, with 83 absences at month end.	Covid-19 positive cases have continued to be low during June with majority of cases due members of household becoming symptomatic. Positive cases remain low through June. Covid-19 absence rate of 0.92% (54 FTE) throughout June.	Continue to encourage staff to follow government guidelines on isolation periods. Ensure PPE adherence and encourage social distancing. Continue to encourage undertaking of LFT testing and Covid-19 vaccine uptake.	Maintain social distancing; regular and timely staff testing; identification of positive cases and effective contact tracing.

Agency Expenditure

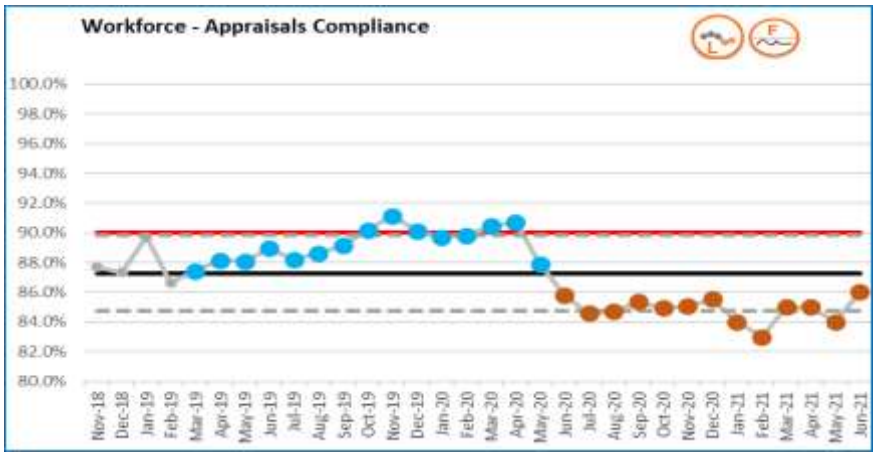


June 2021 actual performance	
Spend year to date £7.861	
Variance Type	
Underspend	
SaTH Original Forecast	**SaTH Rolling Forecast**
£2.860m	£2.860m
Target/ Plan achievement	
£0.275m favourable variance	

Background	What the Chart tells us	Issues	Actions	Mitigations
Agency is a constituent element in the Trusts £3.219m deficit plan over the H1 period. The H1 agency plan has been set equivalent to Q3 20/21 spend however; this is significantly above the Trusts agency ceiling set by NHSEI of £1.186m per month. There is a strong expectation that the Trust will ensure agency expenditure is reduced and there is a recurrent requirement to substantially reduce agency expenditure.	Agency spend is significantly above the NHSEI ceiling however, year to date agency spend was lower than the Q3 20/21 run rate.	Due to workforce fragility, the Trust is consistently overspent against its agency ceiling. There is an increased requirement for temporary staffing to support the COVID-19 vaccination programme.	Direct engagement groups now set up to focus on agency spend and approval hierarchy; including monthly dashboard review across key nursing metrics. Overseas Registered Nursing recruitment in 19/20 and 20/21. Increased nursing bank rates in specific high agency areas. HCSW, Strands A & B NHSEI agreements to fund focussed substantive nursing recruitment. Recruitment and retention strategy approved key focus on brand and reputation, retention of staff and targeted recruitment campaigns for hard to fill roles. Review of agency procurement strategy with National Procurement team (HTE).	Develop measurable metrics and action plans to understand where we can control agency spend. Build on increased medical bank fill rates since implementation of Locums Nest. Deliver year one of Recruitment and Retention strategy to increase substantive workforce and improve retention levels.



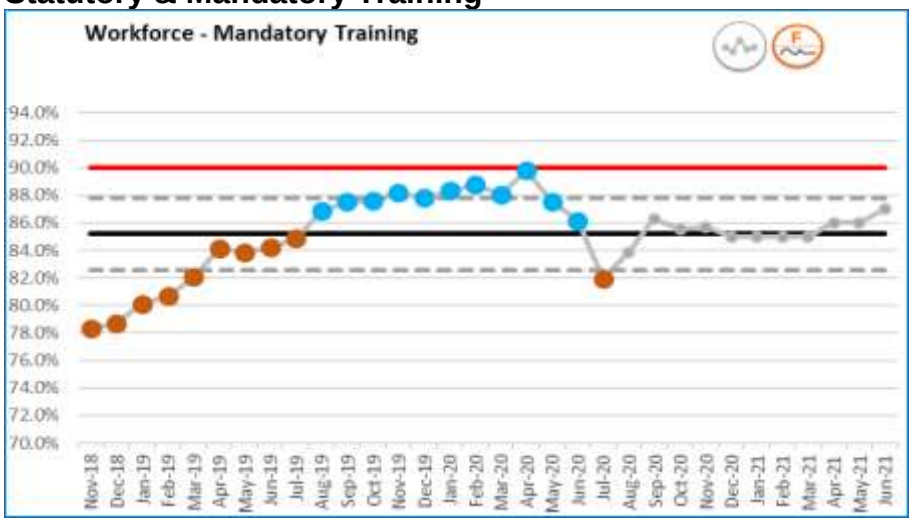
Appraisals



June 2021 actual performance
86% Medical Staff – 76%
Variance Type
Special Cause
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; however, this month has risen to 86% this month.	CV-19, staffing constraints and service improvement has reduced ability of ward staff 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. Corporate Education have sent out reminder emails to all staff who are out of date and due their appraisal.	Appraisal form has had an interim revision to include the new Trust Values and health and well-being and flexible working discussions.

Statutory & Mandatory Training

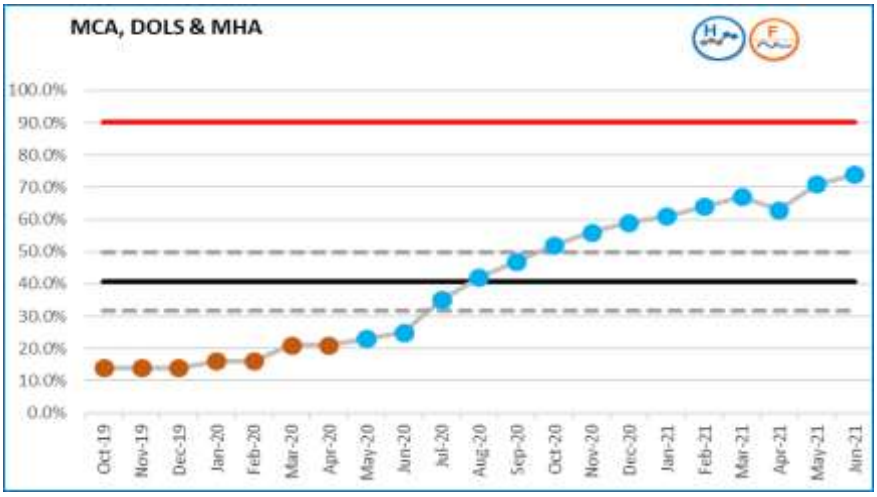


June 2021 actual performance
87%
Variance Type
Common Cause
National Target
90%
Target / Plan Achievement
The target is above the upper process limit and so unlikely to be achieved at present

Fire Safety	Load Moving & Handling	Infection Prevention & Control	Hand Hygiene Competence	Patient Moving & Handling Class	Adult Basic Life Support	Paediatric Basic Life Support	Equality & Diversity	Information Governance	Health & Safety Level 1
85%	93%	82%	96%	88%	78%	75%	91%	80%	88%

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 training needs.	Risen to 87% 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. Poor IT literacy impacting on e-learning completion. Some data validation issues.	Corporate Education is working with Care Groups to identify and reduce data conflicts. Corporate Ed is supporting Ward/Dept. managers to prioritise and schedule-training completion. Corporate Education requested proxy facility to support remote e-learners effectively. New Learning Management System purchased – implementation started. E-Learning 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 to divisional teams and staff. Libraries supporting learners to access e-learning. Phone support for e-learning.

Trust MCA – DOLS & MHA



June 2021 actual performance
74%
Variance Type
Special Cause Improvement
National Target
90%
Target / Plan Achievement
Improvement trajectory in place to deliver at end of Q3

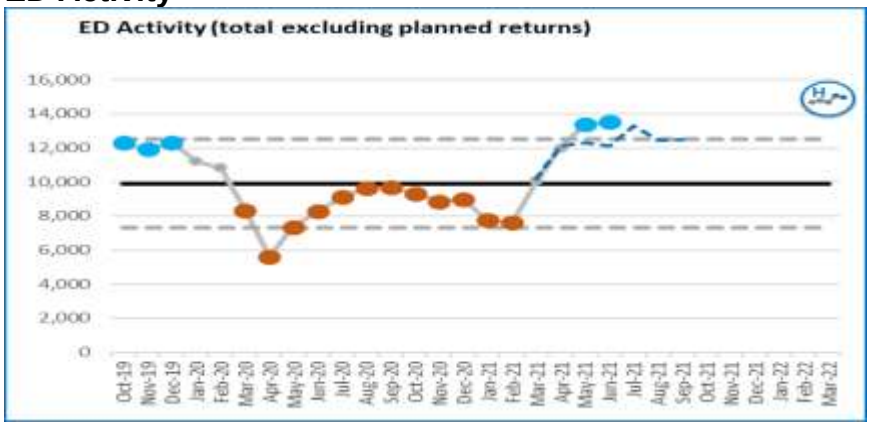
Training trajectory 2021-22
Note – the base figure of staff requiring training alters each month with staffing movements and intakes

Training & Level	Total Staff requiring training as at 31.03.2021	Total Staff having completed training as at 31.03.2021	Total Staff having completed training as at 31.05.2021	% increase over 2 months	Anticipated compliance based on current training data (90%)
Adult Level 1	5905	Not available	5713	N/A	Compliant
Adult Level 2	3652	3134	3314	4%	Compliant
Adult Level 3	2165	657	927	13%	End Q4 2021-22
MCA & DoLS	3214	2031	2276	8%	End Q3 2021-22
BPAT	5905	4534	4836	5%	End Q3 2021-22
WRAP	3781	2954	3130	5%	End Q2 2021-22

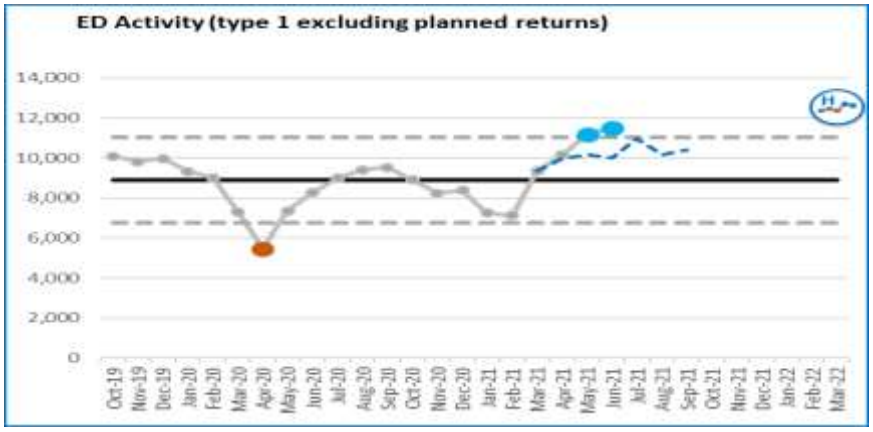
5. Operational Summary
Mr Nigel Lee Chief Operating Officer

- June 2021 has seen a parallel focus on managing the increasing Urgent and Emergency care demand whilst looking to expand the recovery in elective and diagnostics given our high waiting lists. Covid-19 inpatient numbers remain low (single figures and primarily between 1 and 4 inpatients throughout the month) albeit we have cared for Covid-19 patients on critical care. However, in accordance with national Infection Prevention and Control (IPC) guidance, we have retained separate high and medium risk pathways in A&E, assessment areas and wards. And separate low risk (Green) pathways have been maintained for elective surgery together with strict protocols for cleaning and separation between patients in all clinical areas.
- Urgent care demand has risen to pre-Covid-19 levels and beyond, with total activity up to circa 10% vs 19/20 levels; ambulance activity has similarly increased vs June 2019 (up by 9%), but with an increase in the Category 1 and 2 conveyances (usually greater clinical urgency). For A&E activity overall, the level of 'majors' has also risen, especially at the Royal Shrewsbury site. Volumes of patient arrivals at peak periods continue to cause challenges (especially later afternoon and early evening), and the Trust has seen pressure on ambulance handover delays. The peaks in activity also put pressure on certain metrics such as initial assessment within 15 minutes. Joint work continues with West Midlands Ambulance service and our local system partners to promote alternatives to A&E and alternate admission routes. Of note, the activity at the urgent treatment centres alongside both A&Es has risen, with the centre at PRH up 26% above June 19 levels.
- Elective recovery delivery also remains a key priority. The Trust, and local system as a whole, delivered against the national delivery threshold in June (75% vs 19/20 levels), and we expect to deliver against the increasing threshold for June and July 21 (80 and 85% respectively). Plans to expand the elective inpatient capacity have been implemented at the end of June on both sites; this will put additional pressure on emergency care capacity but is vital to reduce waiting lists. Additional internal capacity also began in late June, with insource and outsource activity starting in June; both schemes are funded through the national Elective Recovery Fund and will be vital to begin to see reductions in the waiting lists.
- Diagnostics presents a vital enabler but a key risk; the regional mobile CT scanner left SATH at the start of June, and the service is prioritising the urgent and cancer activity (and any routine activity where possible) until new capacity comes on line at start of September 2021. Radiology staffing is also pressured, and is limiting some restoration of services.
- Cancer activity has also returned to above pre-Covid-19 levels, and a number of specialty areas are challenged. The Breast service is steadily returning to a two week wait time below 14 days (albeit is currently at 16 days at start of June). Pressure remains in Urology, Colorectal and Lung services. The Skin service continues to perform well.

ED Activity



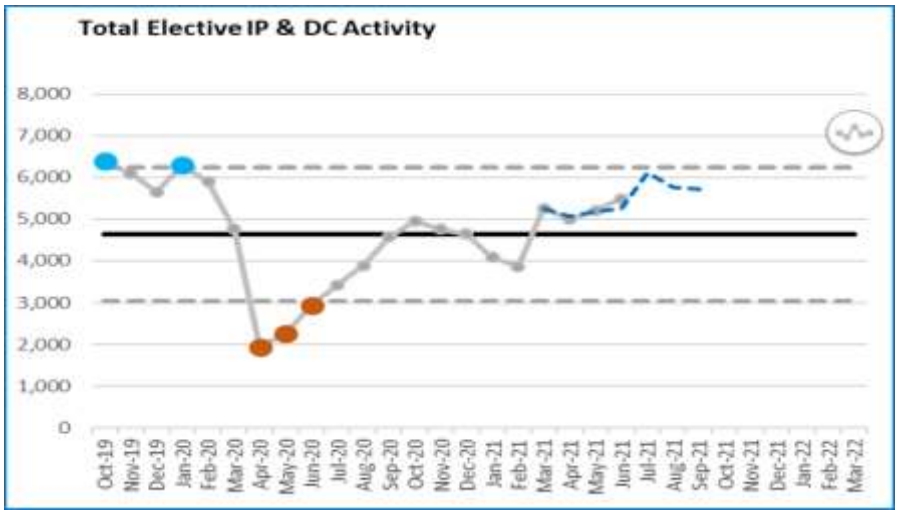
June 2021 actual performance
13528
Variance Type
Special Cause
Local Target
12119 (H1 Plan)
Target/ Plan achievement
Trajectory Based on H1 plan



June 2021 actual performance
11503
Variance Type
Special Cause
Local Target
9988 (H1 Plan)
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.	Activity has significantly increased in the first quarter of 2021-22 with demand now above forecast levels and higher than seen in the winter of 2019 (pre-Covid-19) and at any time during the pandemic.	The increased demand is exceeding expected demand and occurring at a time where we need to continue to segment patients for good infection and prevention control. This is impacting on ambulance handover delays and 4 hour performance.	The SDEC is continuing to actively pull suitable patients through and achieving over 30% of admitted patients going through SDEC. Working with WMAS to improve conveyance times and ambulance handover. ED improvement plan being implemented.	System UEC meeting and reviewing performance dashboard. Additional 32 bedded ward expected by end of Feb 2021. Winter schemes being reviewed. Admission avoidance scheme supported through .system investment committee.

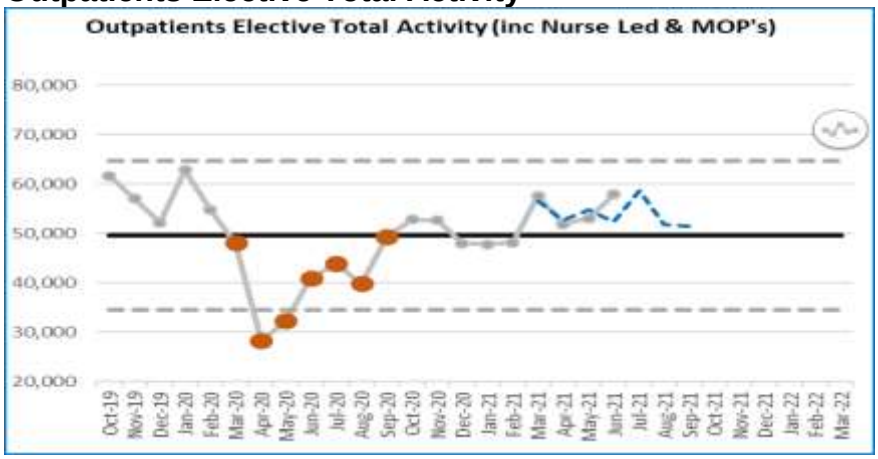
Elective IP & DC Activity v H1 recovery plan



June 2021 actual performance
Total 5488 **DC** 5154 **IP** 334
Variance Type
Common Cause
National Target
National DC & IP 80% **5257** (H1 plan)
Target/ Plan achievement
H1 80% achieved and activity higher than plan.

Background	What the Chart tells us	Issues	Actions	Mitigation
The Trust is working to recover services in line with the level of activity delivered in 2019-20 which is being used as a baseline. The NHSEI threshold for recovery in June 2021 is 80% of the June 2019 activity. The trust has developed a recovery plan for the first half of 2020-21 (H1 plan) and is tracking performance against this and against the NHSEI threshold which links to the Elective Recovery Fund (ERF).	Performance is tracking broadly in line with the H1 plan trajectory, however remains lower than 19/20. Delivered H1 activity combined plan for inpatient and daycase June and 80% threshold. Elective IP plan delivered but this plan is below the threshold set and remains an area of challenge.	Social distancing and IPC requirements have reduced our capacity. Staff shortages in key areas are impacting on the speed of recovery. Staff absences due to self-isolation have some impact on lists running. Significant number of patients breaching waiting times due to the volume on the waiting list.	2nd green pathway opened at RSH. Wards re-allocated enabling elective orthopaedics to re-start at PRH. Insourcing company providing staff to support additional theatre lists on site. IS providing support for certain specialties and procedures. Continuing to work with RJAH on elective orthopaedic and diagnostic capacity. Vanguard theatre in use on site. Clinical prioritisation of patients in terms of PL scores and monitoring patients over 52 and 76 weeks date where possible.	Clinical prioritisation of patients in terms of PL scores and monitoring patients over 52 and 76 weeks date where possible avoidance of over 104 week breaches except where patients are choosing to wait to return to services.

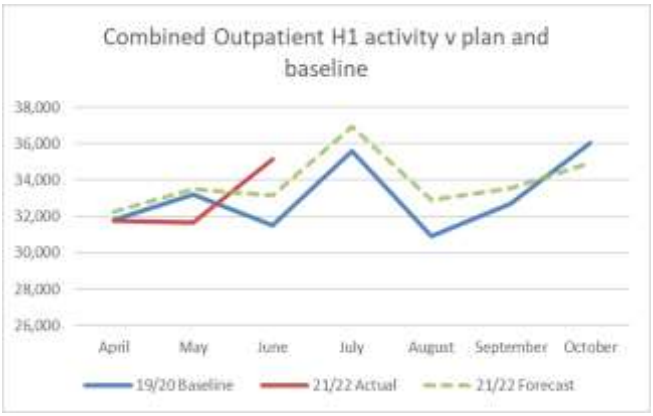
Outpatients Elective Total Activity

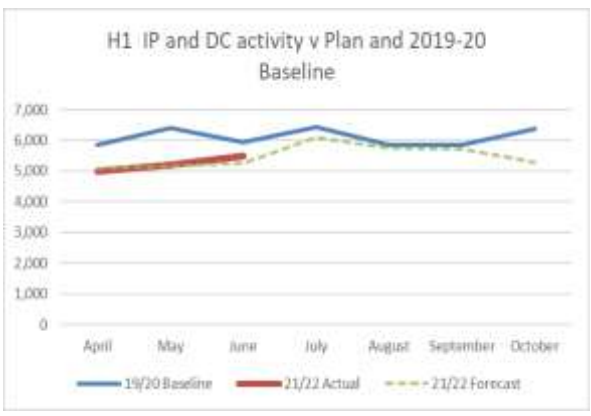


June 2021 actual performance
57872
Variance Type
Common cause
Local Target
52360 (H1 plan)
Target/ Plan achievement
Better than H1 plan

Background	What the Chart tells us	Issues	Actions	Mitigation
The H1 activity plan aims to recover activity during Q1 and Q2 of 2021-22, using 2019-20 activity as a baseline. In addition transformation is expected to support new ways of working such as virtual activity, patient initiated follow up (PIFU) and increased use of advice and guidance.	The chart shows that overall the outpatient activity is above the H1 plan and recovering towards the 2019-20 baseline. In June both new and follow up outpatients delivered to plan and above the 80% H1 threshold. Virtual OPD activity was better than the 25% target set.	The availability of outpatient capacity remains constrained as a result of 2 metre social distancing, and the availability of manpower in some specialities where staff have been redeployed to support emergency and Covid-19 related pressures. While recovery is in line with plan the backlog of patients waiting is considerable with a large number waiting over 52 weeks on the RTT pathway.	Book wise now operationally giving the trust the ability to use rooms and see available rooms. Review the use of virtual appointments where appropriate. Linked to outpatient transformation meeting work streams.	See actions.

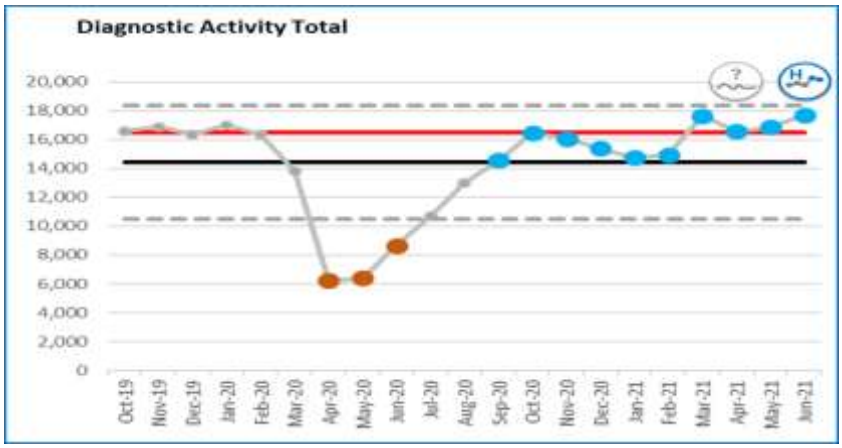
From April 21 – September 21 the elective recovery scheme for England is in operation. The activity levels for Outpatients, IPDC are monitored against the % of 19/20 baseline activity to assess the extent of service recovery. The ERF sets out thresholds for expected levels of performance increasing from 70% of the 19/20 baseline in April 21 to reach 85% of the July 19 activity by July 21 and sustain this level in August and September. The threshold for June 21 is 80% of the June 2019 activity. 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 tables and charts below show the actual positions for April and June 2021 and the forecast for June – October 21. The diagnostic recovery plan is shown in the next section of the report. It is noted that there have been changes made to the ERF scheme during July which will change the threshold to 95% from July and refocus some of the gateway priorities. The scheme funding at 120% will not be available until 100% of 2019-20 baseline activity has been achieved. The impact of this change is presently being assessed.





Outpatient consultant-led activity above 2019-20 baseline and plan, IPDC activity above plan, below baseline but above the H1 threshold. These activity levels need to be converted into values to assess whether ERF resource will be provided.

Diagnostics phase 3 recovery plan

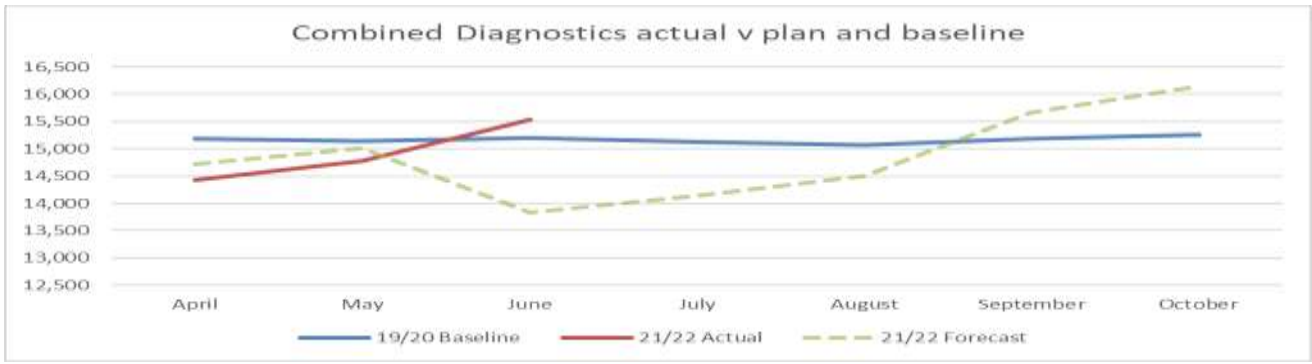


June 2021 actual performance
17712 (Provisional)
Variance Type
Special Cause Improvement
Local Target
16500 (based on Apr-19-Feb-20 average)
Target/ Plan achievement
Recovered to target and slightly better than H1 plan

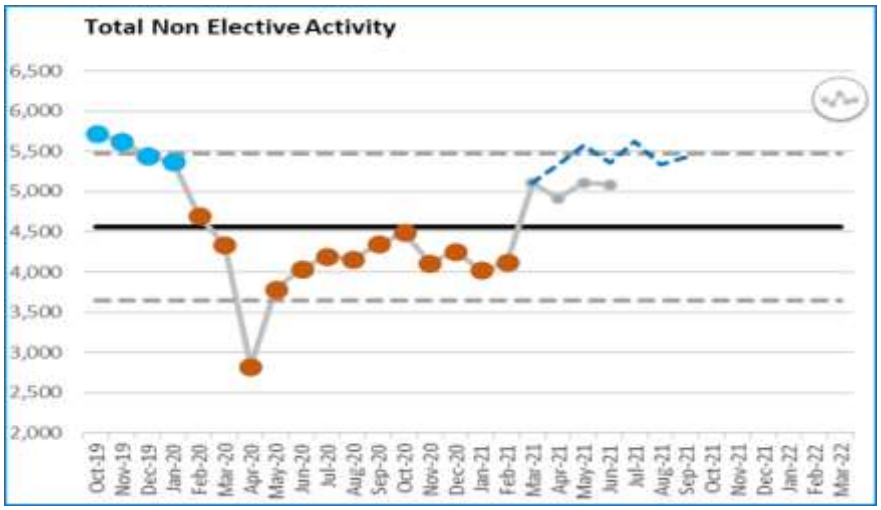
Background	What the Chart tells us	Issues	Actions	Mitigations
Diagnostic activity is made up of the number of tests/procedures carried out during the month; it contains Imaging, Physiological Measurement and Endoscopy Tests.	Continued special cause improvement in overall monthly activity through June.	Staffing challenges continue to affect activity. Radiology situation has led to a decrease in CT capacity and, to a smaller extent, in MRI. Requirement to prioritise resources to address the continuous increase in acute workload (ED & I-Ps), particularly in CT, is reducing capacity for other Urgent referrals and leading to cancellation of lists, including cancer patients. Increases in cancer referral demand and the balance of capacity against DM01 recovery. Surveillance backlog.	Review of templates in line with staff availability to fully utilise capacity. Ongoing recruitment across all modalities activity, including HEE international recruitment. Weekly performance review against trajectory. Daily PTL tracking. Combine overdue surveillances with D4 category. Complete D category prioritisation, reporting classifications by the end of July 2021.	Additional voluntary overtime providing additional capacity. 2 newly qualified Radiographers expected to join RSH team in July; 1 at PRH. Continue to work with temporary staffing to source bank/agency Radiographers. Clinical priority as opposed to chronological order. Maximise capacity for overdue surveillance cases and push out R wait times.

Imaging Recovery v H1 plan (national target is 70% April, 75% June, 80% June, 85% July onwards of 2019-20 baseline). All three imaging modalities delivered better than the national recovery thresholds for June.

Endoscopy recovery v H1 plan (national target is 70% April, 75% June, 80% June, 85% July onwards of 2019-20 baseline). While above the threshold for colonoscopy and gastroscopy, the threshold was not achieved for flexi-sigmoidoscopy.



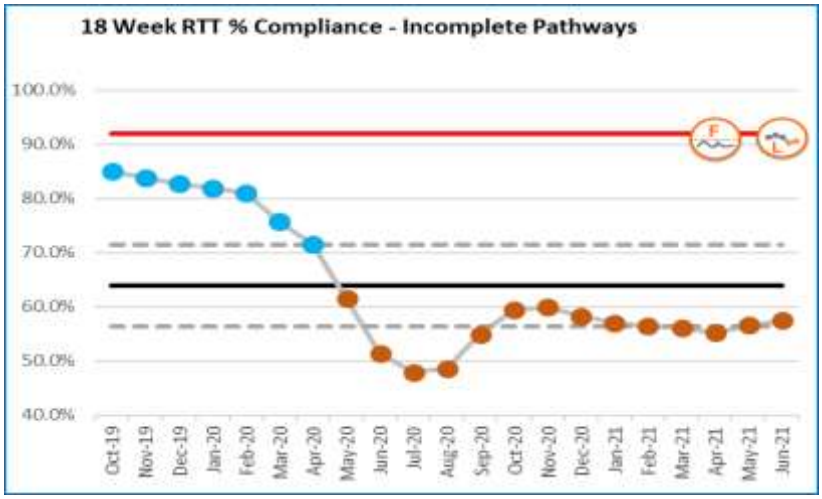
Non-Elective Activity



June 2021 actual performance
5085
Variance Type
Common Cause
Local Target
5356 (H1 plan)
Target/ Plan achievement
The forecast is for demand to return to 19/20 baseline

Background	What the Chart tells us	Issues	Actions	Mitigations
Non-elective activity reflects the demand from unscheduled care for admissions to hospital. It represents the greatest demand on beds and increases can result in constraints on elective activity, while reductions impacts negatively on contract income.	The level of activity has not yet returned to the pre-Covid-19 levels, despite the rise in A&E attendances and acuity.	Primary care admissions remain lower than in 19/20. Covid-19 inpatients are presently low, however segmentation of beds remains important for infection control.	Increase capacity for elective activity while unscheduled bed occupancy remains low. Monitor impact on H1 plan.	See actions.

18 week RTT Exception Report

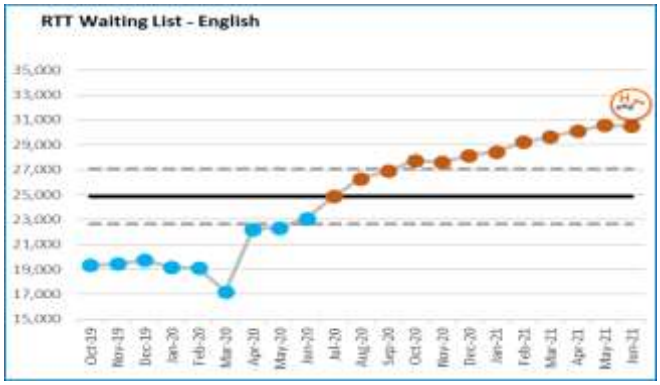


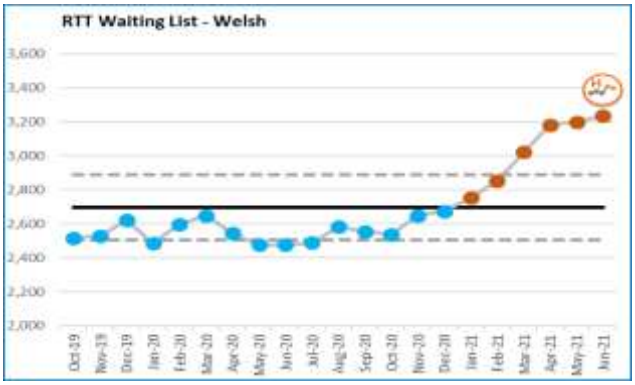
June 2021 actual performance
57.48%
Variance Type
Special Cause
National Target
92%
Target / Plan Achievement
Due to the size of the backlog developed the target will not be achieved. Local plan focuses on clinically prioritised patients.

Background	What the Chart tells us	Issues	Actions	Mitigation
Headline performance against this measure has now stabilised (57.48% at end June compared to 56.6% at end May 2021) but this compares to a much better performance with 18 week compliant pathways before the Pandemic commenced.	Incomplete pathway appear to have stabilised at a level significantly below the national target.	Limited outpatient capacity. 1m social distancing restrictions. Theatre capacity and staffing. Referrals rates returning to pre Covid-19 rates. Increases in cancer referrals impacting on routine capacity. Total list size increased because of the inability to treat clinically routine patients and close RTT pathways.	Optimising theatre capacity via 6-4-2 process. RTT meeting to monitor RTT and ERF delivery. Long waiter scenario modelling to be completed July.	System elective and cancer meeting established. Modelling to inform system actions.

RTT Waiting List – Total Size

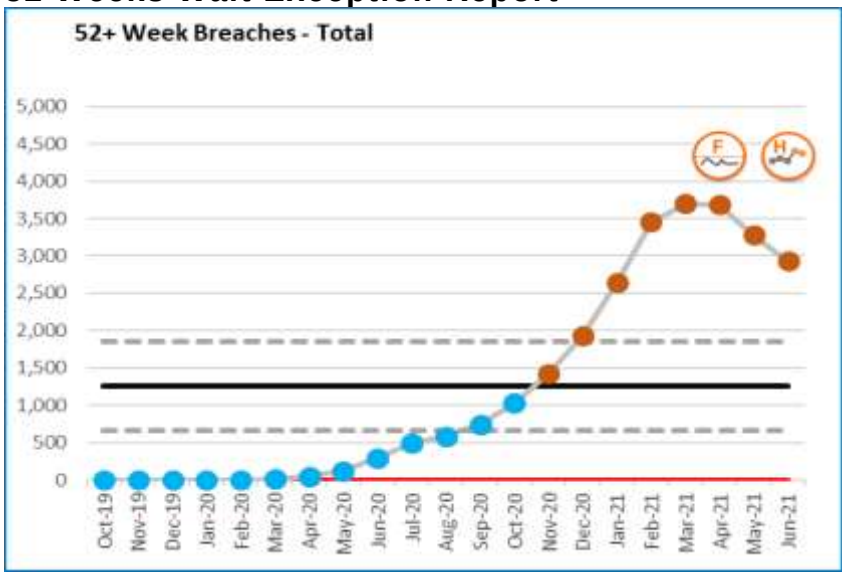
June 2021 actual performance
33739
30502 (English) 3237 (Welsh)
Variance Type
Special Cause
Local Plan
26209 (English) by Mar 2022
Target / Plan Achievement
Overall plan dependant on Welsh ERF scheme confirmation



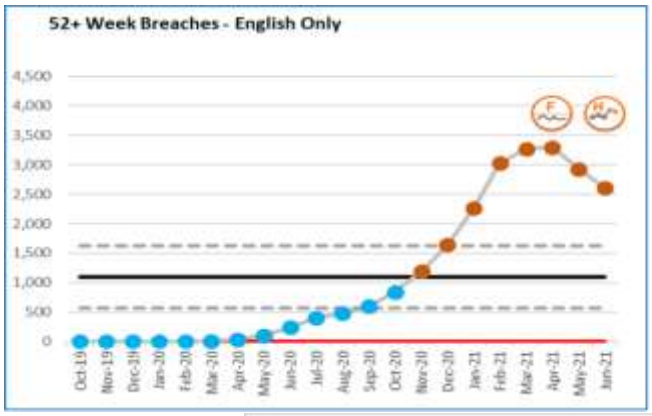


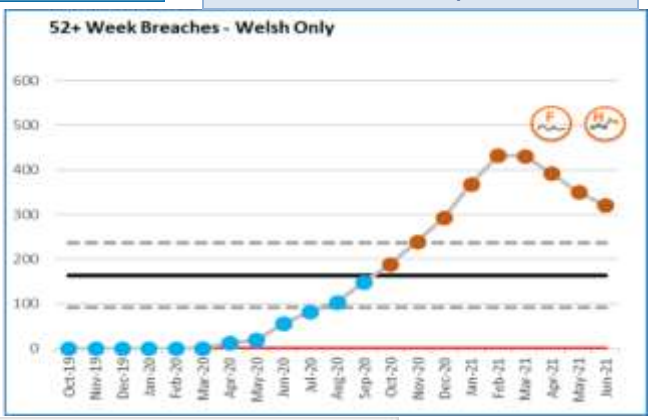
Background	What the Chart tells us	Issues	Actions	Mitigations
Total list size continues to increase because of the inability to treat clinically routine patients and close RTT pathways.	Continuation of the increase in the total waiting list size albeit at a slower rate than previously.	A high proportion of the waiting list being over 18 weeks due to the backlog of elective activity and need to address clinically urgent cases. Limited OPD capacity (social distancing). Limited operating capacity (theatre staffing & beds to enable segregation). The prioritisation of urgent patients due to the limited available capacity means that high volume procedures are not being cleared. Referrals returning to prior Covid-19 levels. Increase in cancer demands impacting on RTT capacity.	Clinical prioritisation of patients in terms of PL scores and monitoring patients over 52 and 76 weeks date to avoid over 104 week waits where possible. Restoration of further OPD face-to-face capacity. ERF plan and use of Nuffield for suitable patients where possible and outsourcing to Rowley Hall for urology. Elective orthopaedics commenced mid-June. RSH elective inpatient bed base expanded from end June. Book wise operationally to aid room visibility and scheduling. Insourcing by 18weeks planned from end of June to increase surgical weekend working and additional outpatient activity.	System review of actions needed to address demand, outpatient transformation and midlands elective care improvement programme. Additional 32 beds to be available from mid Feb 2022 to mitigate some of the bed shortages may alleviate risk of loss of elective activity due to winter pressures.

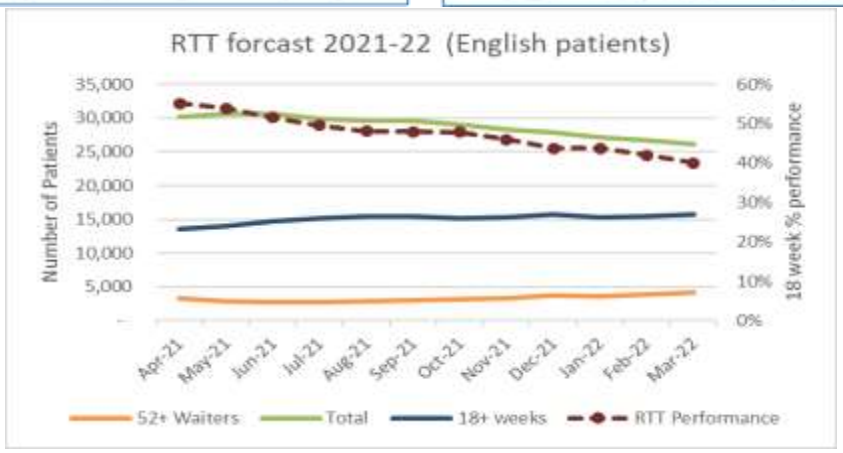
52 Weeks Wait Exception Report



June 2021 actual performance	
2932 2611 (English only) 321 (Welsh patients)	
Variance Type	
Special Cause	
National Target	**Local Forecast**
0	**4156**
Target / Plan Achievement	
The target will not be delivered in 21/22. Local forecast developed aligned to the H1 plan.	

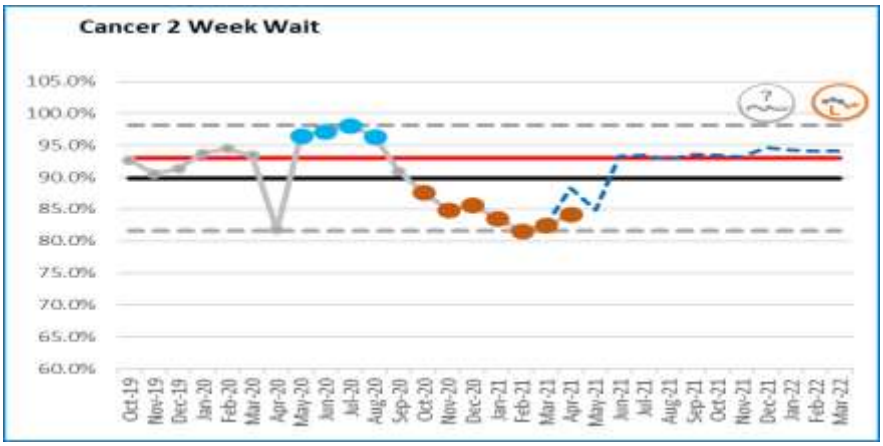






Background	What the Chart tells us	Issues	Actions	Mitigations
From a baseline position of zero pre-pandemic, the volume of patients waiting in excess of 52 weeks on an open RTT pathway has increased significantly. It continues to increase because routine patients are not currently being prioritised for treatment.	The reduction seen in over 52 weeks at present is not forecast to be sustained. Total waiting list is forecast to reduce as the most urgent patients are treated. This means that the 18 week performance will continue to decline as the most urgent patients tend to wait in shorter time bands.	Significant number of patients breaching due to the volume on the waiting list and the priority given to the most urgent patients in shorter time bands.	Clinical prioritisation of patients in terms of PL scores and monitoring patients over 52 and 76 weeks date where possible. Avoidance of over 104 week breaches. ERF plan and use of Nuffield for suitable patients where possible and outsourcing to Rowley Hall for urology.	Clinical prioritisation of patients in terms of PL scores and monitoring patients over 52 and 76 weeks date where possible.

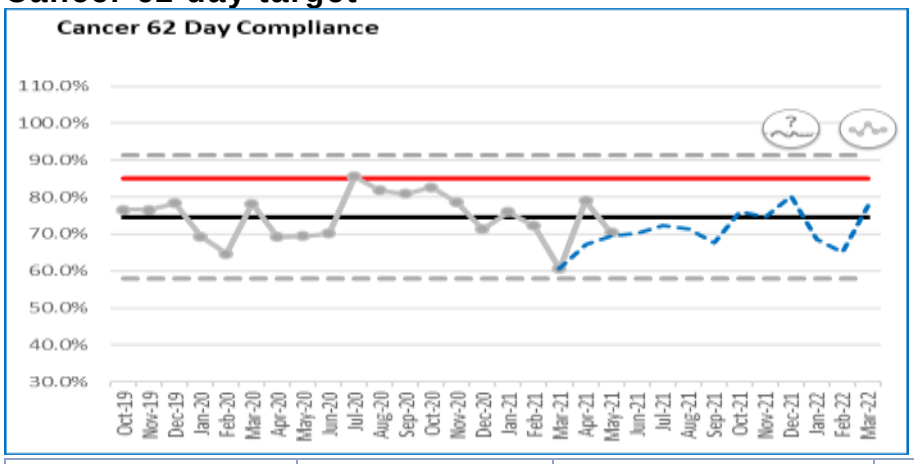
Cancer 2 week waits



May 2021 actual performance
84.5% (June forecast 93.4%)
Variance Type
Special Cause
National Target
93%
Target / Plan Achievement
Improvement trajectory being monitored weekly

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.	The present system is unlikely to deliver the target. Compliance with this target has fluctuated since April 2019 – attributed to poor performance (capacity) within the breast service. Performance reported is slightly worse than the improvement trajectory.	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. Current forecast is that Breast will be back in target in August.	Implementation of revised 2WW Breast Referral Proformas.

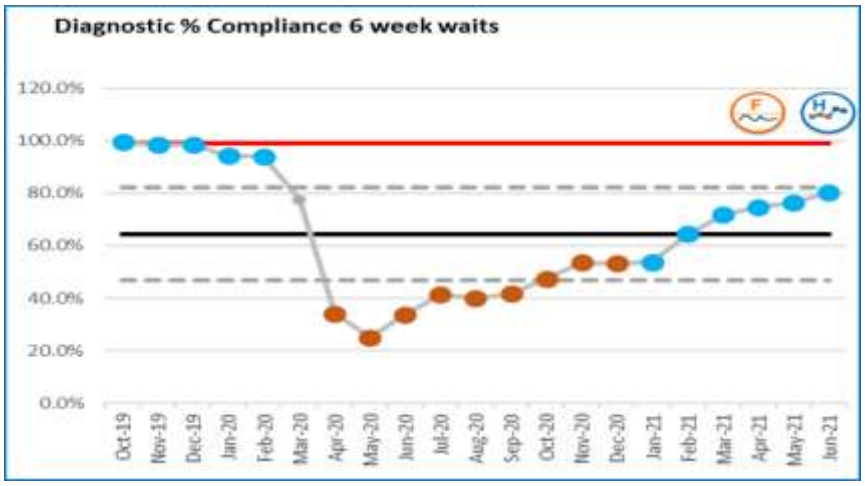
Cancer 62 day target



May 2021 actual performance
70.41% (June forecast 70.1%)
Variance Type
Common Cause
National Target
85%
Target / Plan Achievement
Performance aligned to improvement plan

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. Performance is currently in line with plan.	Capacity does not meet demand (diagnostics a significant issues even prior to COVID-19). Surgical capacity not back to pre Covid-19 levels. Losing mobile CT scanner at the end of June. 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. .	Cancer Performance and Assurance Meetings on-going chaired by Deputy COO.

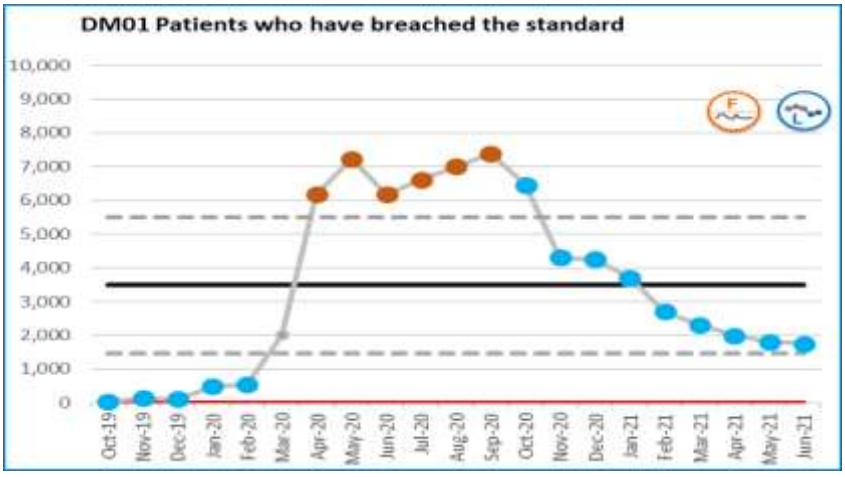
DM01 Diagnostic over 6 week waits



June 2021 actual performance
80.32%
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
DM01 is the national standard for non-urgent diagnostics completed within 6 weeks of the referral.	While there is a continued failure to reach the 99% target, overall monthly performance continues to improve.	The Radiology staffing situation has escalated through June. With the loss of the CT mobile there has been a 5% drop in CT DM01 performance. Cancellation of urgent CT lists, including cancer patients, in line with staff availability. Execs aware. Potential for ongoing issues to negatively impact performance. IPC requirement to maintain enhanced cleaning regimes and social distancing reduces patient flow through the department and reduces capacity for recovery. Overdue surveillance to be migrated into D4 category will push out current reporting of R wait times.	Continued voluntary overtime, however staff now showing signs of stress and fatigue. Recruitment is ongoing, including international candidates. Mobile CT business case to be updated for resubmission when national contract ends. Seek QIA to reduce to 1 m distancing in recovery. Elective list for AGP not at full capacity. Detail action plan and brief on the management of overdue surveillances and the impact to DM01 6 week compliance.	Prioritisation of appointments with regard to available capacity. Split site by procedures performed to maximise throughput and better forecast recovery. Urgent and cancer referrals prioritised.

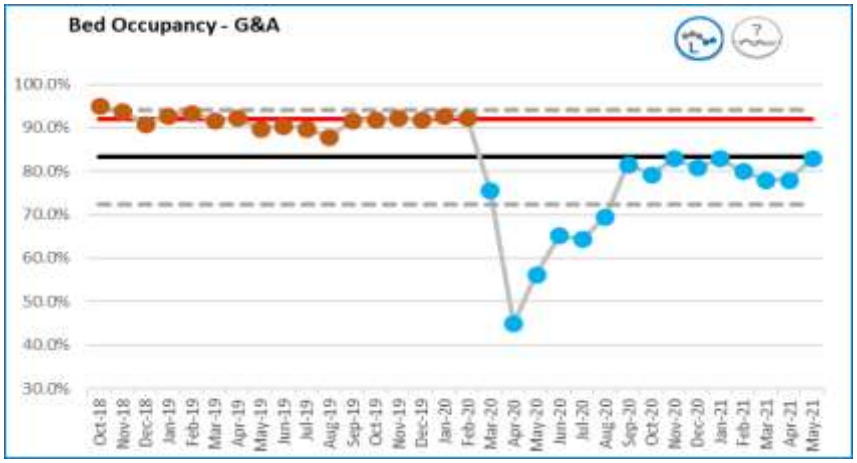
DM01 Patients who have breached the Standard



June 2021 actual performance
1753
Variance Type
Special Cause improvement
National Target
0 - < 6weeks
Target / Plan Achievement
Continuing improvement towards the target

Background	What the Chart tells us	Issues	Actions	Mitigations
DM01 is the national standard for non-urgent diagnostics completed within 6 weeks of the referral. There must be no more than 1% of patients waiting longer than 6w.	While we are still in breach of the DM01, numbers of patients breaching continues to reduce through June.	Deterioration of staffing situation, particularly at RSH. Loss of mobile CT has impacted on DM01 as predicted. Issues could negatively impact performance over coming months. Patient choice - patients wanting to wait until their second vaccine.	Ongoing recruitment, including HEE international programme. Clinical prioritisation of all referrals in line with available capacity. Request to NHSI for mobile CT support. Mandatory Swabbing and self-isolation prior to admission for lower GI diagnostics is not required. This is to improve on maximising capacity and availability to our patients. Non-restrictive.	Review of appointment templates with utilisation of all available capacity. Weekly review of activity plan against trajectory performance. Daily tracking of PTL and validation in pathway. Prioritising urgent and cancer referral pathways.

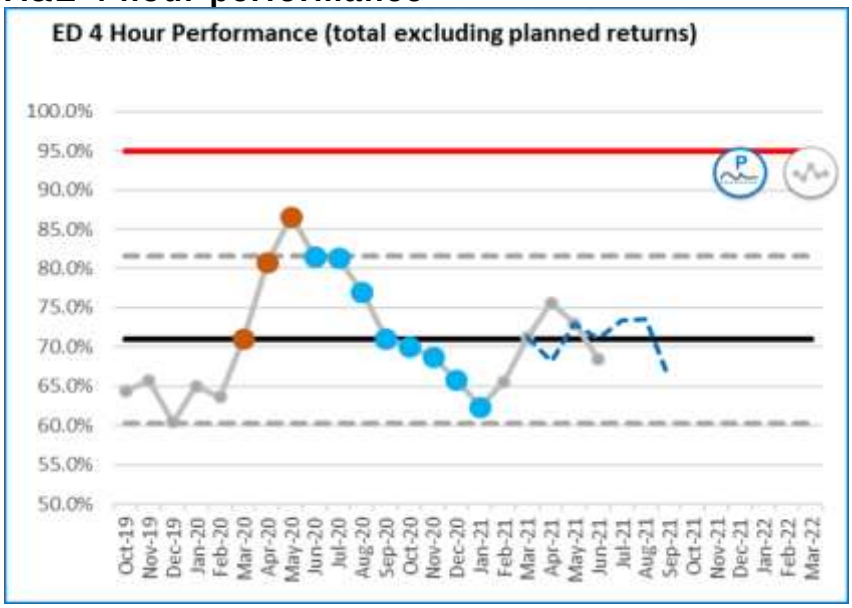
Bed Occupancy



June 2021 actual performance
83%
Variance Type
Special Cause improvement
Local Target
92%
Target / Plan Achievement
Occupancy continuing to be lower than pre-Covid-19

Background	What the Chart tells us	Issues	Actions	Mitigation
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. Re-allocation of beds to specialties means that some wards will have lower occupancy levels however their beds may not be clinically suitable to other specialty patients. Further work needed to mitigate against the forecast winter bed shortfall.	Bed base re-allocated to increase green elective capacity. Bed base assessment to be conducted to ensure bed establishment and changes to bed allocation are accurately reported. Bed modelling completed demonstrating underlying bed shortfall for winter 2021-22. Winter planning commenced and schemes under-development to continue admission avoidance.	Additional 32 beds subject to approval from Feb 2022 to reduce a portion of the forecast bed gap.

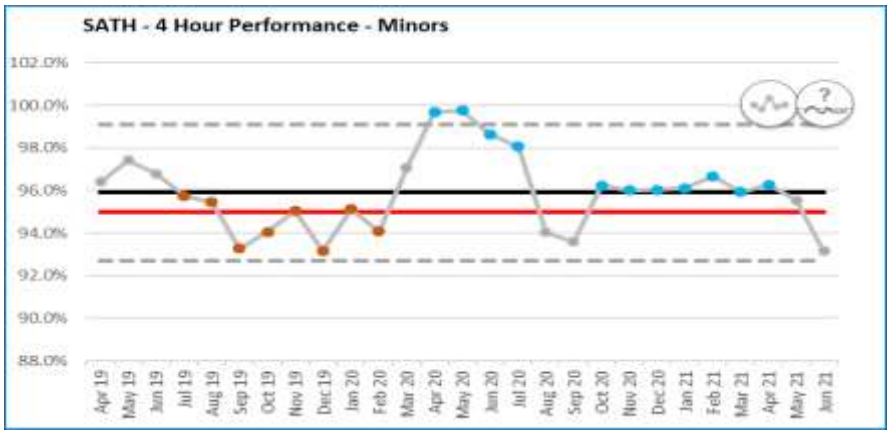
A&E 4 hour performance



June performance
68.4%
Variance Type
Common cause
National Target
95%
SaTH Local Plan
71%
Target / Plan Achievement
Performance is worse than the improvement trajectory set. The 95% target cannot be achieved and the Trust is working with system partners towards delivery of 85%

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.	Increased demand from attenders. Ambulance arrivals groups to certain times of the day adding to the in-day peaks in demand. Flow out of ED restricted due to number of MFFD patients and late in the day discharges.	Implementation of the A&E improvement plan has been developed. Continued full use of SDEC for suitable patients. Focus on morning discharge and reduction in MFFD patients occupying beds. Working with WMAS on conveyance improvements. Introducing new UEC measures in ED to focus on clinical pathways and mean waits in A&E with reporting from August 2021. MD leading professional standards group for transfer of patients from A&E to ward beds.	System UEC group. Support from NHSEI on flow.

ED Minors Performance

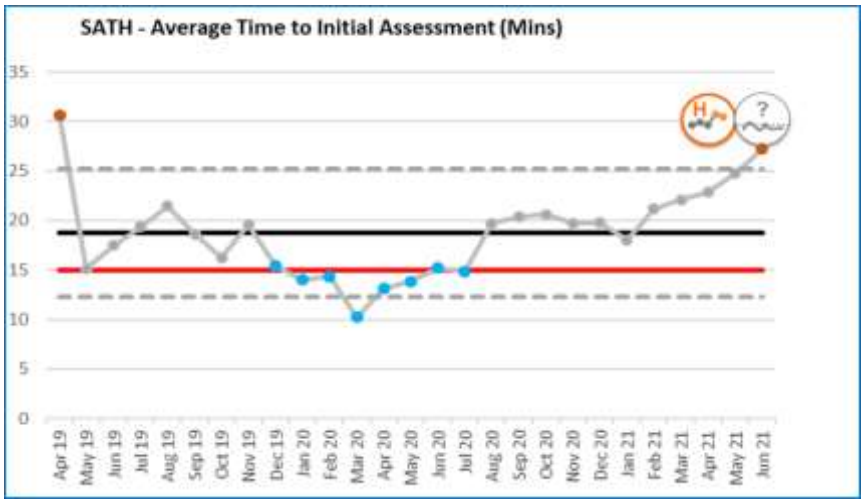


June 2021 actual performance
93.1%
Variance Type
Common Cause
National Target
95%
Target / Plan Achievement
The target being between the process limits will not be delivered reliably each month

ED Majors Performance

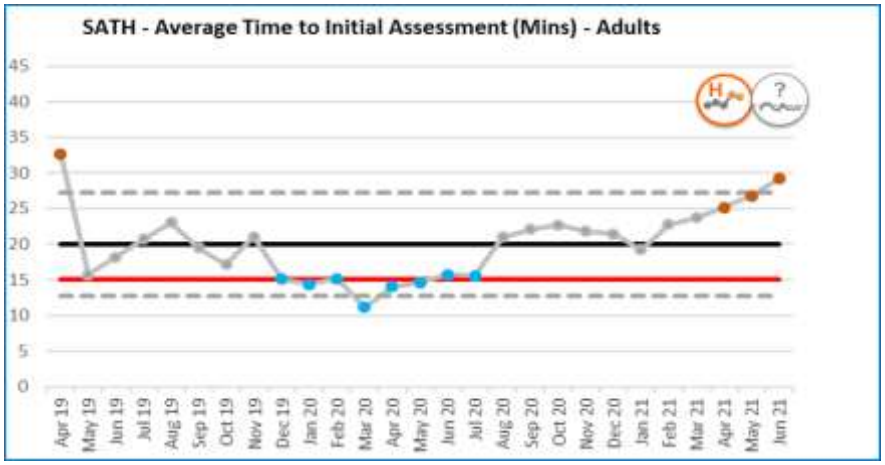
June 2021 actual performance
43.3%
Variance Type
Common Cause
National Target
95%
Target / Plan Achievement
The target is well above the upper process control limit and so will not be achieved without process re-design

ED –Time of Initial assessment (mins)



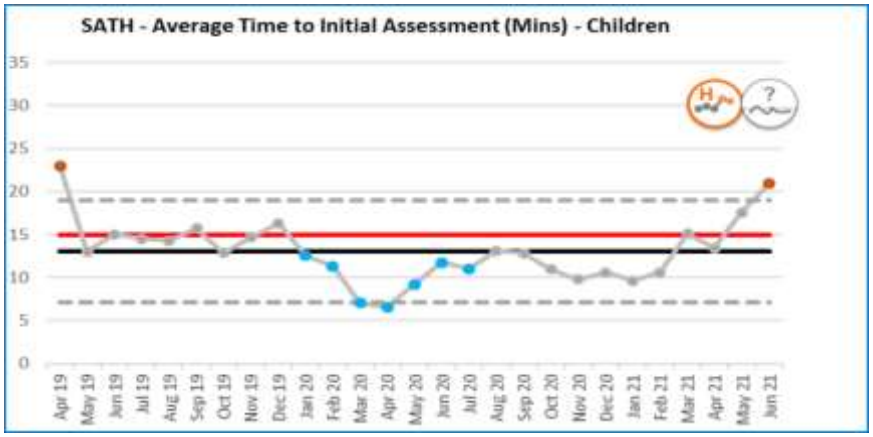
June 2021 actual performance
27 Minutes
Variance Type
Special Cause Concern
National Target
15 Minutes
Target / Plan Achievement
Performance has further deteriorated this month and is now above the upper process limit

ED Time to Initial Assessment - Adult



June 2021 actual performance
29 Minutes
Variance Type
Special Cause Concern
National Target
15 Minutes
Target / Plan Achievement
Performance worse than target and above upper process limit

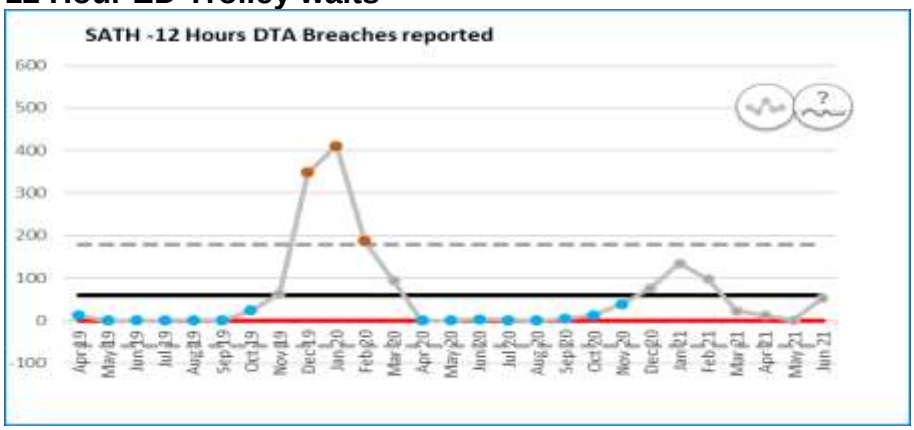
ED Time to Initial Assessment - Children



June 2021 actual performance
21 Minutes
Variance Type
Special cause concern
National Target
15 Minutes
Target / Plan Achievement
Performance deteriorated and now above upper process limit

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 although in recent months deterioration has been seen in the paediatric time to initial assessment.	Increase in both adult and paediatric attendance. Conditions placed on the Trust for Paediatrics with MH conditions mean these patients cannot be admitted to wards, requiring assessment in ED and so reducing clinical capacity and space.	Matrons focussing on restoration of initial assessment times. Working with MPFT to increase support to Children attending ED and transfer to CAMHs facilities where appropriate in a timely manner.	ED assurance meeting chaired by COO.

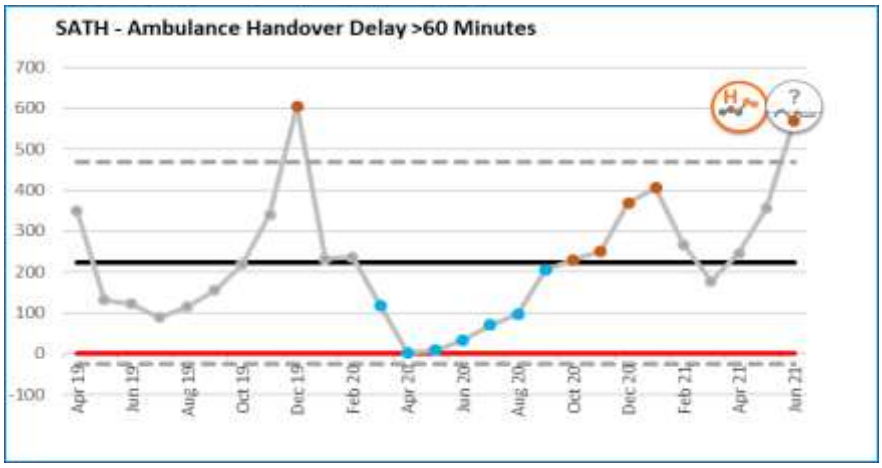
12 Hour ED Trolley waits



June 2021 actual performance
53
Variance Type
Common Cause
National Target
0
Target / Plan Achievement
The target was nearly missed this month

Background	What the Chart tells us	Issues	Actions	Mitigations
This is a patient experience and outcome measure.	Following a period of improvement from January 2021 the June performance has deteriorated.	Increased volume of ED attenders. Flow of patients from ED to wards. Balance of provision of beds for elective recovery and urgent care admissions.	Bed modelling completed to inform winter planning. Improvement focus on morning discharges to release beds for admissions earlier in the day.	Subject to final approval 32 beds additional beds are expected to be available from mid Feb.2022.

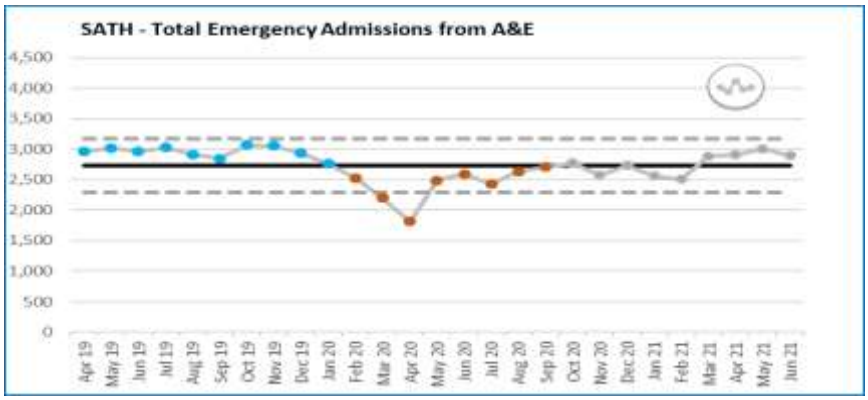
Ambulance handover> 60 Mins



June 2021 actual performance
570
Variance Type
Special cause concern
National Target
0
Target / Plan Achievement
Performance deteriorated to above upper control limit

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.	Handover delays have increased in volume this month and performance further deteriorated to be a special cause concern.	High volume of ambulance presentations with a large number presenting around the same time of day.	Working with WMAS to improve timing of arrivals and seek joint solutions to release ambulances from sites. Analysis of time to initial assessment for ambulance patients. Matrons and clinical staff working to escalate handover based on clinical need.	System UEC group.

Total Emergency Admissions from A&E

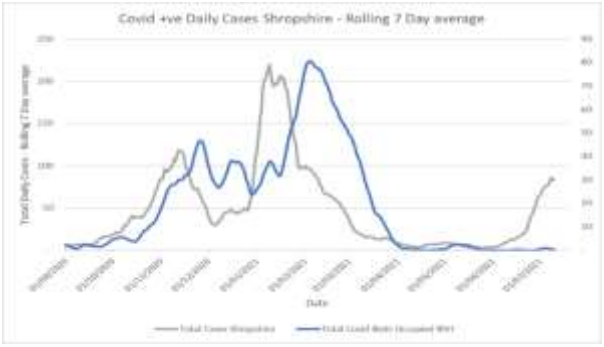


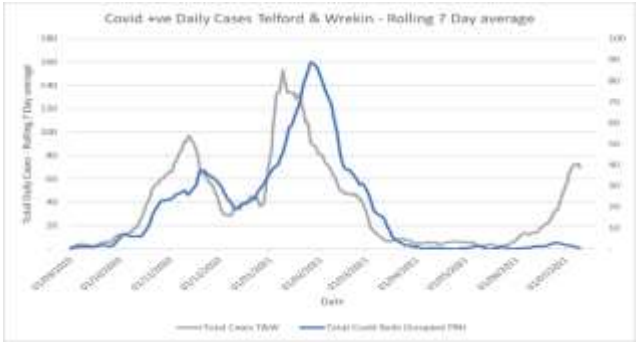
June 2021 actual performance
2897
Variance Type
Common Cause
National Target
N/A
Target / Plan Achievement
N/A

Background	What the Chart tells us	Issues	Actions	Mitigation
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.	Emergency admissions from ED have returned to pre-Covid-19 levels.	Segmentation of patients continues to be necessary to ensure good IPC is maintained. Beds are required across elective and emergency care.	Beds have been re-allocated to specialties to support recovery. Trigger tool being developed to determine points are which capacity will need to switch from elective to emergency care and actions to be taken at this point. System wide working to address capacity requirements and potential solutions to bed shortfall.	

Covid-19

While we work through the recovery of elective services and manage the demand for urgent and emergency care we are mindful of the increasing prevalence of Covid-19 in the community and the work needed to maximise the vaccination uptake so as to mitigate against further increases in hospitalisation in the coming weeks.
The graph below shows the rising prevalence of the virus in our communities during June.



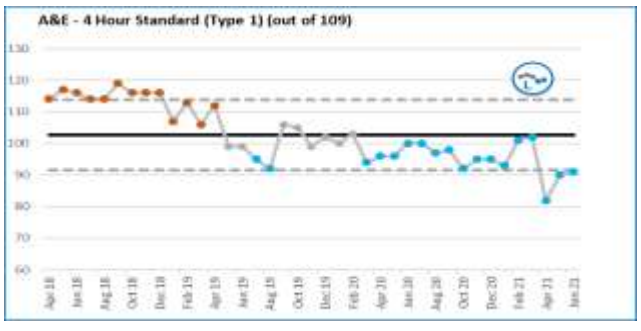


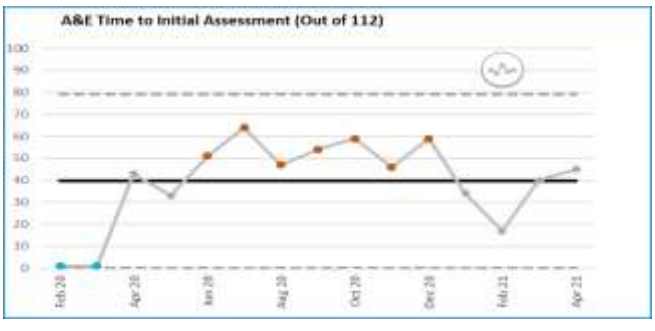
Operational Performance Benchmarking

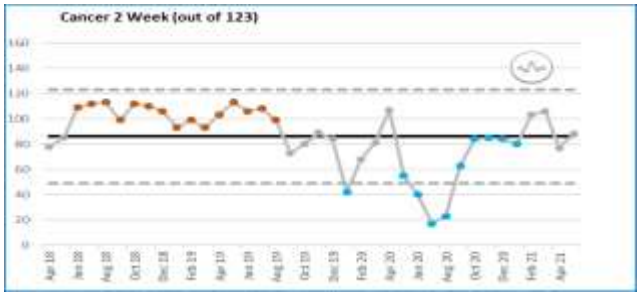
This table below demonstrates the benchmarked position of the trust at a point in time compared to other English trusts reporting the same indicator. The icon shows the trend of ranking over time of the trust in relation to other trusts. Work is underway to adapt this icon so as to distinguish it from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

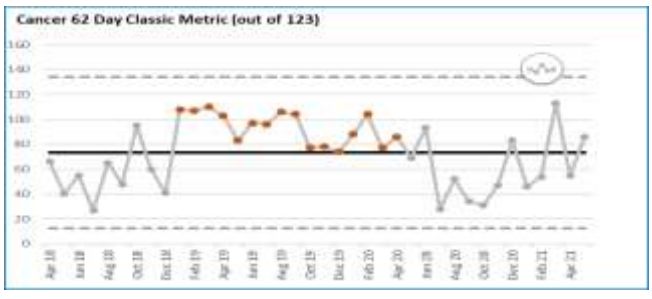
KPI	Latest month	Actual Performance Ranking	Performance	Assurance	Lower process limit	Upper process limit
Group 1 metrics						
A&E - 4 Hour Standard (Type 1) (out of 109)	Jun 21	91			91	114
A&E Time to Initial Assessment (Out of 112)	Apr 21	45			0	79
Cancer 2 Week (out of 123)	Apr 21	45			0	79
Cancer 2 Week Breast Symptomatic (out of 112)	May 21	88			49	123
Diagnostic 6 Week Standard (out of 123)	May 21	80			14	138
Diagnostic 6 Week Standard - Cardiology : echocardiography (out of 123)	May 21	76			34	96
Diagnostic 6 Week Standard - Audiology Assessments (out of 108)	May 21	2			-7	45
Diagnostic 6 Week Standard - Urodynamics: pressures & flows (out of 101)	May 21	62			7	101
Diagnostic 6 Week Standard - Respiratory physiology : sleep studies (out of 91)	May 21	92			-2	103
Diagnostic 6 Week Standard - Magnetic Resonance Imaging (out of 123)	May 21	30			-25	102
Diagnostic 6 Week Standard - Computed Tomography (out of 123)	May 21	88			45	107
Diagnostic 6 Week Standard - Non-obstetric ultrasound (out of 123)	May 21	67			21	116
Diagnostic 6 Week Standard - Colonoscopy (out of 123)	May 21	111			83	120
Diagnostic 6 Week Standard - Flexi sigmoidoscopy (out of 123)	May 21	45			-4	81
Diagnostic 6 Week Standard - Cystoscopy (out of 117)	May 21	55			-5	84
Diagnostic 6 Week Standard - Gastroscopy (out of 123)	May 21	87			9	98
RTT 52 Week Breach (out of 123)	May 21	44			4	76
RTT Incomplete 18 Week Standard – (out of 123)	May 21	92			59	83
Emergency C-Section (out of 122)	May 21	111			41	81
Elective C-Section (out of 122)	Mar 21	34			22	62

The SPC charts show the relative ranking of the Trust compared to other English trusts over time and so demonstrates the change in relative position compared to previous periods and the variation in the Trust ranking. The lower the ranking the higher is the relative position of the Trust compared to others. It is noted that 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.

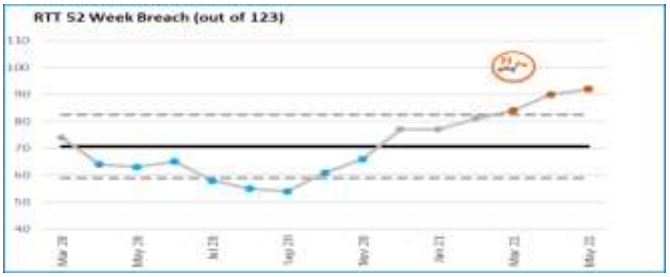




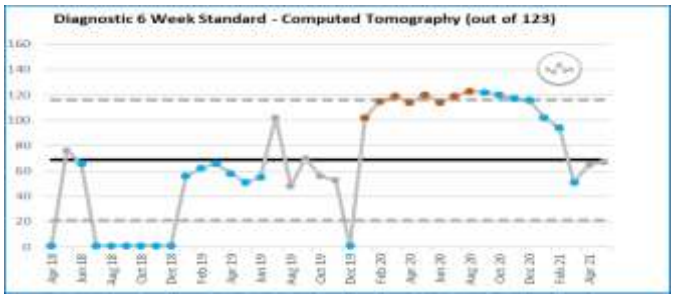


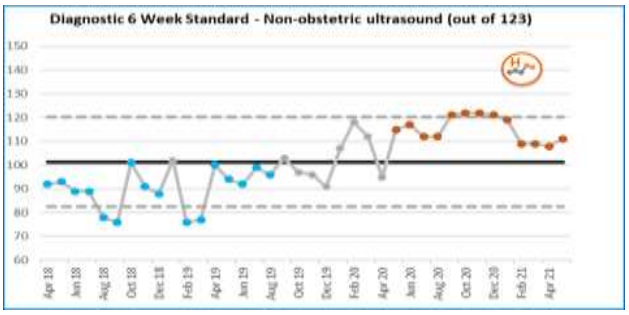


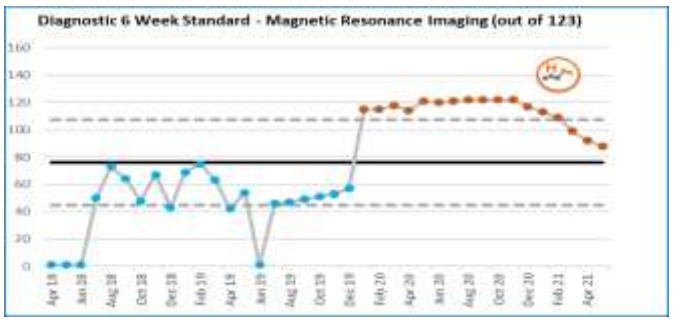

RTT Incomplete 18 Week Standard – (out of 123)

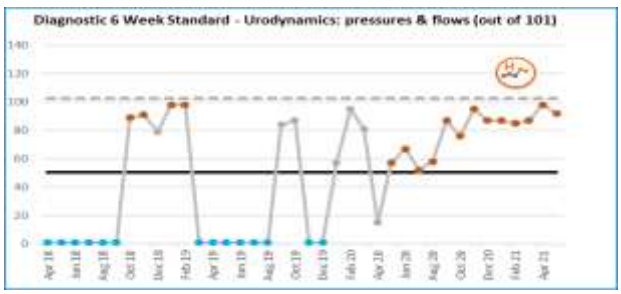

RTT 52 Week Breach (out of 123)

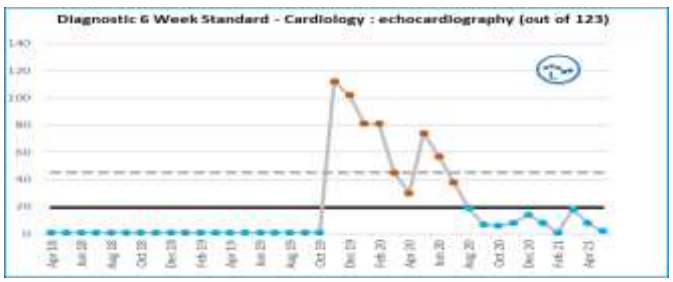

Diagnostic 6 Week Standard (out of 123)

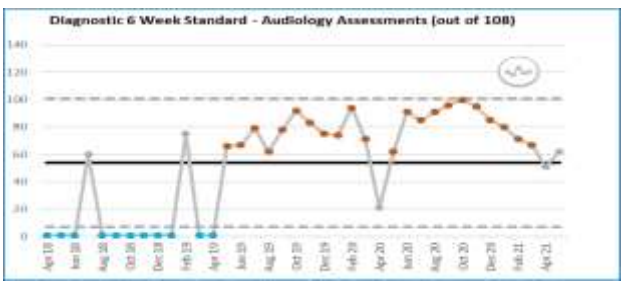

Diagnostic 6 Week Standard - Computed Tomography (out of 123)

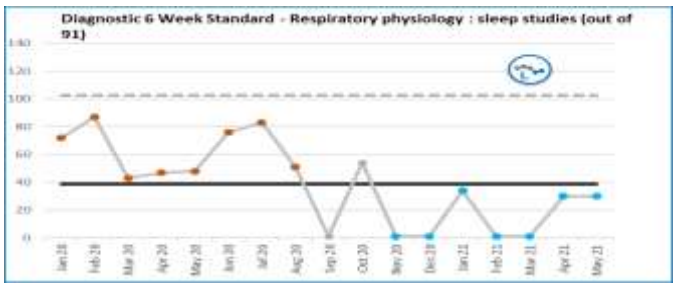

Diagnostic 6 Week Standard - Non-obstetric ultrasound (out of 123)

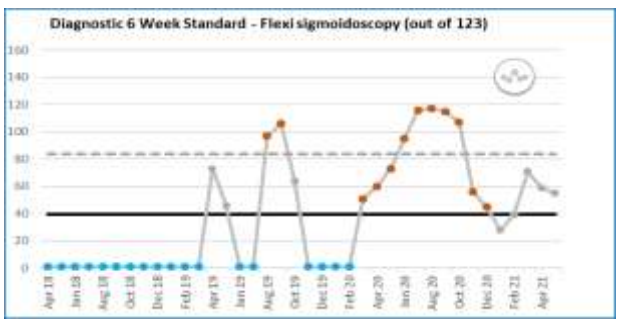

Diagnostic 6 Week Standard - Magnetic Resonance Imaging (out of 123)

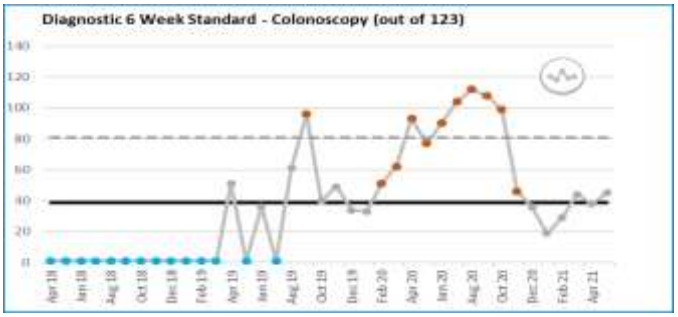

Diagnostic 6 Week Standard - Urodynamics: pressures & flows (out of 101)


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


Diagnostic 6 Week Standard - Audiology Assessments (out of 108)


Diagnostic 6 Week Standard - Respiratory physiology : sleep studies (out of 91)

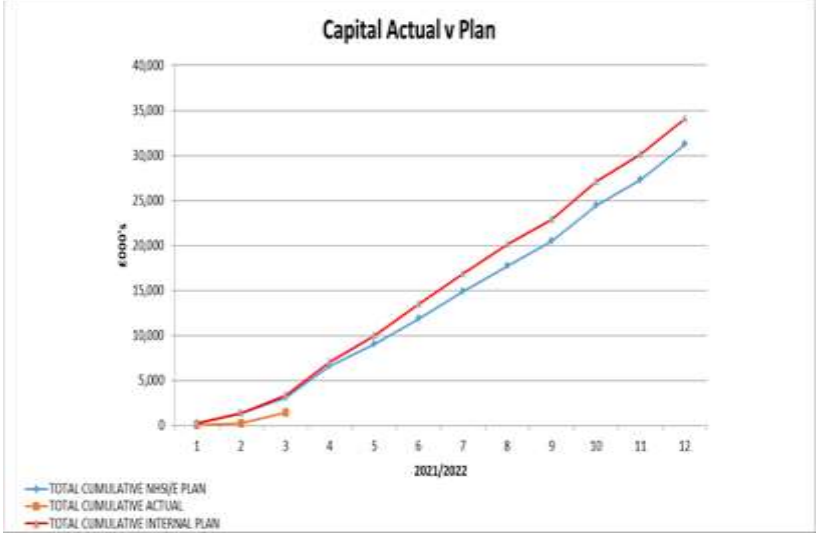

Diagnostic 6 Week Standard - Flexi sigmoidoscopy (out of 123)


Diagnostic 6 Week Standard - Colonoscopy (out of 123)

6. Finance Summary
Helen Troalen, Director of Finance

- The Trust continues to operate within a temporary finance regime for the first 6 months (H1) of the 2021/22 financial year. Negotiations continue between the NHS and HMT to agree a settlement for H2 which is delaying the publication of the framework for that period. However, NHSE/I have indicated that the H2 period is likely to be similar to H1 but with a greater level of efficiency requirement imposed.
- The Trust is working to a revised deficit plan of £3.219m for H1. The system submitted a plan for the period which was compliant with the funding envelope but includes £6m of unmitigated risk.
- The Trust recorded a net surplus of £1.714m, £2.851m favourable to plan at the end of Q1. However, this position is underpinned by the timing of £3.866m of estimated income linked to delivery of the Elective Recovery Fund (ERF) with only £1.015m of costs incurred to date. The forecast expenditure for ERF over the H1 period is expected to be in line with plan and therefore this favourable YTD variance is purely a timing difference.
- Excluding the £2.851m YTD variance associated with ERF the Trust recorded a deficit of £0.316m in month, £1.137m YTD which remains in line with plan. A lower level of COVID-19 spend offsets an increase in costs linked to non-COVID-19 related activity which is not unexpected.
- £8.474m of funding to support the ongoing Covid-19 response has been received for H1. The Trust's Covid-19 related spend in the month was £0.818m which is slightly lower than previous month. The YTD Covid-19 spend is £3.294m, £1.706m lower than the plan. This position is offsetting overspends against non-Covid-19 related spend.
- Trust expenditure (excluding Covid-19) is £2.327m over plan which is primarily a timing/phasing issue due mainly to activity related expenditure and one-off set-up costs linked to the recently implemented endoscopy maintenance contract (£0.450m). A further £0.400m of this variance is linked to the Trust hosting the ICS and is covered in full by additional income.

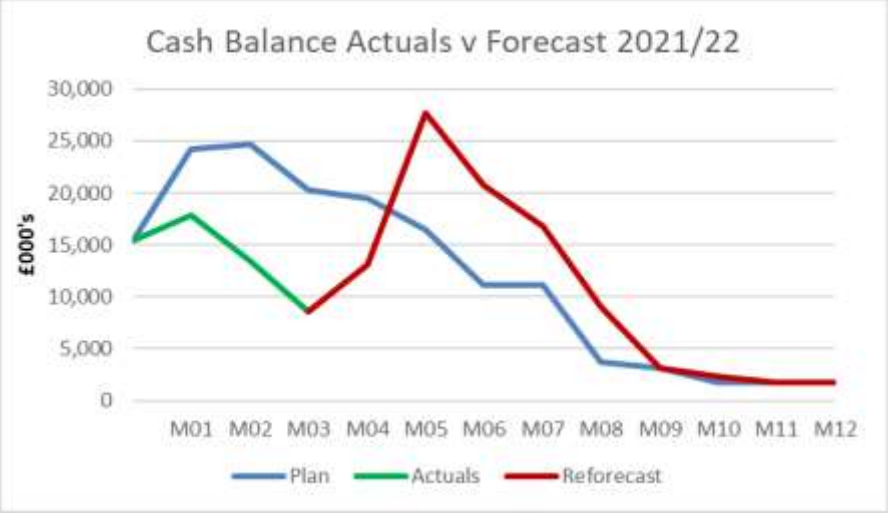
Capital Expenditure



June 2021 actual performance	
Spend year to date is £1.448m	
Variance Type Underspend	
Underspend to date £1.671m	
National Target	**SaTH Plan 2021/22**
N/A	£34.142m
Target/ Plan achievement	
To meet the Trust's Capital Resource Limit (CRL) at year end.	

Background	What the Chart tells us	Issues	Actions	Mitigation
The Trust's total Capital Programme for 2021/22 as at Month 03 remains £34.142m, following inclusion of the Endoscopy Project.	Within the Capital Plan submitted to NHSEI, the Trust forecast spend at Month 3 of £3.119m. Only £1.448m has been expended giving an underspend of £1.671m to Plan. The Internal Plan includes the Endoscopy Reconfiguration in addition to the original NHSEI Plan.	No issues of concern.	The detailed Capital Programme was discussed at June Capital Planning Group and it is expected that expenditure will shortly be incurred on the agreed Projects.	No mitigations required.

Cash



June 2021 actual performance	
£8.603m cash in Bank	
Variance Type	
Lower Cash Balance	
SaTH Original Forecast	**SaTH Rolling Forecast**
£20.248m	£15.566
Target/ Plan achievement	
£6.963m lower Cash Balance than Rolling Forecast	

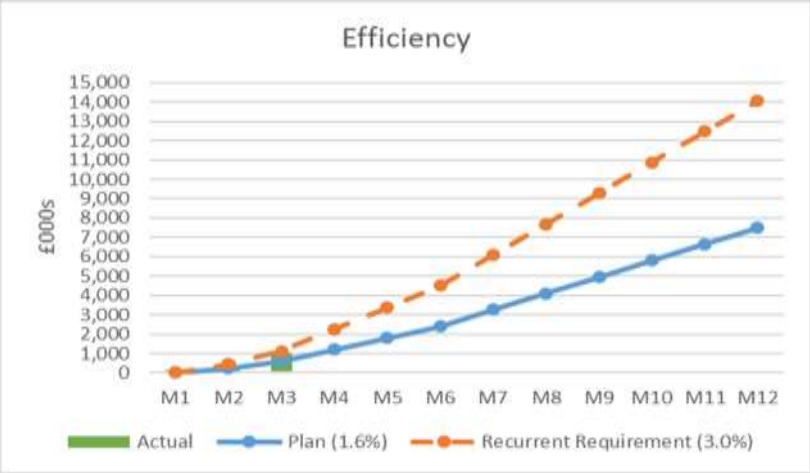
Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust developed a Cashflow forecast as part of Going Concern requirement for the Annual Accounts on which the plan is based. The Trust's reforecasts on a monthly basis taking account of actuals to date.	Within the Trust's reforecast, the cash balance was £6.963m higher than the actual balance held at month 03.	The Trust received less income than forecast mainly due to timing of receipt of cash from ICS, this income should now be received in August.	The difference between forecast and actual is a difference in timing. A rolling monthly forecast is produced to take this timing difference into account. The year-end forecast remains the same.	No mitigations required.

Income and Expenditure Position

April 2021 actual performance	
Income & Expenditure Position year to date £1.714m)	
Variance Type	
Underspend to date	
National Target	**SaTH Plan 2021/22**
£1.137m	£1.137m
Target/ Plan achievement	
£2.851m favourable variance	

Background	What the Chart tells us	Issues	Actions	Mitigation
The Trust continues to operate within a temporary finance regime for the first 6 months of 21/22 (H1). The STW system has submitted a plan which is compliant with the H1 system funding received but with £6m of unmitigated risk. As part of this the Trust is plan is to deliver a deficit over the H1 period of £ (3.219) m. This plan is compliant with the recurrent system sustainability plan.	The Trust recorded a net surplus of £1.714m in month, £2.851m favourable to plan at the end of Q1. However, this position is underpinned by the timing of £3.866m of estimated income linked to delivery of the Elective Recovery Fund (ERF) with only £1.015m of costs incurred to date. The forecast expenditure for ERF over the H1 period is expected to be in line with plan and therefore this favourable YTD variance is purely a timing difference.	No issues of concern.	Further work will be done ahead of Q2 to report the underlying financial position going forward.	No further mitigations required.

Efficiency



June 2021 actual performance	
Income & Expenditure Position year to date £0.994m	
Variance Type	
Over performance to date	
National Target	**SaTH Plan 2021/22**
£0.000m	£0.600m
Target/ Plan achievement	
£0.394m favourable variance	

Background	What the Chart tells us	Issues	Actions	Mitigations
In order to achieve the £(3.219) m deficit plan over the H1 period the Trust is required to deliver £2.400m of efficiency savings. A minimum of 1.6% in year savings are required to deliver the recurrent system sustainability plan, 3% FYE. This would allow the Trust to make new investments in year.	The efficiency delivery is phased to commence from month 02 with £2.400m required to deliver H1 plan, 3% FYE to allow investments and deliver underlying sustainability position.	Whist the Trust has delivered an efficiency saving year to date equivalent to £0.994m, there is an accelerated need to identify efficiency savings and to deliver 3% savings recurrently.	Head of Efficiency commenced with the Trust. Efficiency group established in May. Finalise governance arrangements (SROs, PIDs etc.). Agree project priorities and milestones.	Non-recurrent opportunities .

7. Transformation Summary
Helen Troalen, Director of Finance

- Across the 25 programmes, fifteen have remained consistent in period and six have improved. Four projects have seen a worsening performance in month, which are: 2 – Reducing Mortality and Excess Deaths; 8 – Clinical Standards, Skills and Capability; 23 – Performance Data and Analytics; and 24 – Risk Management. Details of individual project performance are shown in the table below showing 'RAG status by project'.

- At this stage of the programme as we close phase 1 and transition to phase 2, we can report that of those milestones due in phase 1, 81% have been delivered with the remaining 19% being recorded as either reasonable, at risk or paused due to Covid-19. At the end of June 21, the RAG status for overall delivery of the 25 'Getting to Good' work plans is as follows:

OVERALL PROJECT STATUS	MAY	JUNE	TREND BETWEEN PERIODS		
GOOD	15	8	IMPROVING	CONSISTENT	WORSENING
REASONABLE	7	9	6	15	4
BELOW REQUIRED	2	2			
COMPLETE	1	6			
TOTAL	**25**	**25**			

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

- In the month of June, 23 milestones were delivered and 15 milestones were not delivered. Programme and project performance is reviewed at the Getting to Good Committee, along with change requests to make minor adjustments to project plans and milestones.
- Phase 2 of the Getting to Good (G2G) programme commenced 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

Detailed plans have now been finalised for Phase 2 of the G2G programme and will form a core part of the Trust's Integrated Plan for 21/22. Performance monitoring against the new plans and deliverables will commence next month.

RAG STATUS AT PROJECT LEVEL

	G2G Project (and executive sponsor)	RAG Status		Status Reason	Link to Improvement Alliance priority
		Previous Overall	Current Overall		
1.	**Quality Strategy and Plan (Director of Nursing)**			**1a Quality Strategy** June has seen the continued of engagement all teams involved in patient care, including medical, nursing and allied healthcare professionals. Work has been undertaken with the Performance team to develop the underpinning metrics to support the KPIs that will form the framework for the Quality Strategy. Ongoing work to develop a Quality Strategy Dashboard has taken place as this will provide a baseline and forecast for the delivery of the strategy across the Trust. **1b Quality Governance** The governance for the Ward to Board arrangements has been completed and is now in place. A Trust Wide Communication of the Quality Strategy has been completed at a high level, having been discussed at various senior meetings and leads for many of the work stream priorities. Grass roots level communications plans are being developed and will form part of the year 2 milestones. The Review of QOC and underpinning steering groups is also complete and a standard divisional template for QOC with a review of the agenda and reporting cycle was also finalised in month. Existing Steering Groups will be used to monitor delivery of the priorities within the Strategy, and a new Discharge Improvement Group, chaired by the Deputy COO, is now in place to drive the improvements. Delivery plans are to be progressed and agreed in July for priorities and agreed trajectories for improvement.	Developing the leadership capacity of SaTH to deliver the necessary improvements in patient safety and service quality; c. Developing clinical improvement plans with the purpose of SaTH delivering rapid and sustainable quality improvement;

2.	**Reducing Mortality and Excess Deaths (Medical Director)**			The Wave 1 backlog mortality review sampling is currently 48% complete against the target of 50% and will be completed by the end of June 21. The Service Improvement team have completed the process mapping of the Mortality review process and further work is required to define the requirements and re-establish the process. Until an informatics solution can be supported by the Trust to support screening, the SJR Tool can't be further progressed and this will impact the opportunity to widen the training programme and to embed this methodology.	Determining standards for clinical services and developing working practices and culture to achieve them effectively; Developing a communications and engagement strategy for quality improvement
3.	**Quality/ Regulatory Compliance (Director of Nursing)**			Work has continued towards the application for removal of conditions against our licence and has resulted in the lifting of two regulatory conditions around environment and environmental risk assessment. Work has continued to embed the assurance process for evidence based improvement and aligning this to the Quality Strategy. The plan to implement the Governance Structure is in progress to ensure an existing committee or group holds responsibility for one of the key improvement themes and for divisional leads to attend these meetings to provide updates on relevant divisional actions, underpinned by an action plan. In June, work continued to amend the TOR for these groups to reflect the improvement plan. Focussed work in core service areas of UEC, Medicine, End of Life and the Care of Older people continues to progress. Responses to quality self-assessments by core services are behind schedule with mitigation in place for this to be delivered by October 2021 as part of Phase 2 for accelerated delivery. From September onwards regular confirm and challenge sessions will be in place to give assurance on submissions.	Developing clinical improvement plans with the purpose of SaTH delivering rapid and sustainable quality improvement.
4.	**Maternity Transformation (Director of**			Progress towards the delivery of the Ockenden actions has continued, with 8 LAFL and 2 IEA expected to move to 'Delivered, Not Yet Evidenced' subject to approval by	

	Nursing)			MTAC. However, there are 5 deliverables that were due for June that missed their target dates. Exception reports have been prepared and will be shared with MTAC along with proposed rescheduled dates. Milestones 7 and 8 have been fully delivered: the training matrix is undergoing peer-review by SFH and course booking is underway. The engagement strategy (known as the UX system' has been co-produced with MVP and rolled out to service users with considerable success. CNST actions are largely complete, however there are some outstanding issues in Safety Actions 2, 5, 8 and 10 and a number of board-level actions and attestations also remaining, therefore it is unlikely the Trust will be able to declare full compliance. Gap analysis action plans per the NHS-R templates will be produced with associated funding bids.	
5.	**Increasing Community Engagement (Director of Public Participation)**			During June, a report was received following an online conversation called "Get Involved" through the Clever Together Platform. A focus group is being planned with patient groups and statutory bodies e.g. Healthwatches and CHC to discuss next steps. Nearly 1000 people and voluntary organisations have contributed with feedback or given ideas to support the development of the Public Participation Plan, these will form the basis of the draft Plan. Throughout June the public participation team have been going out to local community groups and venues to promote getting involved with our organisation. Our monthly community update meetings were well attended in June and this month we hosted a Health Lecture delivered by Dr Kevin Eardley and Paul Twitchell on Veteran Awareness at SaTH – this lecture was well received with over 40 members of the public in attendance. Further engagement was undertaken with the public and patients	

				around the possible service relocation of PRH renal dialysis unit off site to Hadley Park, and over 20 patients attended the meeting organised in this month. The pre-engagement over this potential service change has been completed and further plans will be developed once a decision has been made. The Trust is working in partnership with St Johns Ambulance to provide an NHS Cadets programme at SaTH. The programme is for young people aged 14-18 years old and we will be providing the Foundation and Advanced programme at the Trust, with the first cohort beginning in September 2021. Phase 1 has seen the appointment of a Social Inclusion Engagement Facilitator who will work with colleagues in the community to work with isolated communities and undertake a mapping and gap analysis of community groups to identify areas for increasing engagement. All community meetings are recorded and are available for the public to view for the subsequent month. The Public Participation Team identify themes from questions asked at Trust Board, Freedom of Information requests and public questions from Community meeting.	
6.	**Quality improvement approach and methodology (Director of People and Organisational Development)**			Following successful appointments into the newly branded Improvement Hub and having moved location into new premises at RSH, a launch is planned to take place w/c 19 July. The team continues to apply itself as it promotes a consultancy approach in support of the hospital flow improvement programme. Additionally, the team is supporting the Medicine & Emergency Care Division to improve the complaints process and has plans to support improvements to the booking process for outpatient	

				appointments. To enrich the repository and prepare for the launch event, many case studies have been written from a range of areas. This month, eight members of staff completed their Lean for Leaders course which demonstrated how they continue to embed the daily management processes and improvement tools in their respective areas. A draft three year plan, which brings together all the work so far, has been drafted and is in the process of being finalised.	
7.	**Leadership, Development and Education (Director of People and Organisational Development)**			Phase 1 of the Leadership and Development programme is now complete with all milestones delivered. The Leadership Masterclasses, Executive Development and Senior Leader Triumvirate Programme commenced in June. The leadership prospectus has been published and letters sent out to the '100 under board'. Collaborative working with other partners has taken place throughout the programme, underpinned by Culture and Behaviours. A Leadership development framework has been created to develop a more compassionate and inclusive leadership approach to create an environment where people can flourish and have a sense of belonging. This framework caters for the needs of aspiring leaders to senior and executive level leaders. This includes mandated programmes for supervisors, first line managers, middle managers and senior leaders. In June, the Integrated Education Proposal was submitted to Committee with a preferred option recommended by key stakeholders, following discussions the Committee have suggested that further options should be explored which will be carried forward into Phase 2. The Learning Management System project team and plan are in place and the medical and clinical support education reviews	d. Developing the model and capability for clinical leadership and managerial development;

				have been completed. A review of nurse education will be included in Phase 2.	
8.	**Clinical Standards, Skills and Capability (Medical Director)**			A new SRO has now been assigned to this programme, Dr Ian Tanswell. The PMO lead has met with Dr Tanswell and agreed that as further information is required on the delivery status for this plan, that each milestone moves to amber until further assurance and a progress update is completed.	c. Developing clinical improvement plans with the purpose of SaTH delivering rapid and sustainable quality improvement; e. Determining standards for clinical services and developing working practices and culture to achieve them effectively; f. Overseeing processes which benchmark clinical outcomes and productivity supporting the implementation of best practice solutions
9.	**Culture and Behaviours (Director of People and Organisational Development)**			June saw the final sign off for our Behavioural Framework and the start of the Leadership Masterclasses. Cultural reviews and feedback sessions continue to take place with teams, promoting the values and behaviours work. The Executive Board Development programme is being delivered. June has seen the finalising of actions to celebrate the behaviours and values, with a range of communications to engage staff and patients - this includes	

				posters, intranet communications, workshops, drop in sessions, lanyards, cupcakes and pin badges. All milestones have been completed from Phase 1 of the Getting to Good Programme with some great outcomes being achieved. The plan to undertake a Trust-wide cultural assessment has moved to later in the year and develop staff engagement plan for all aspects of the getting to good programme. We have commenced implementation of the cultural improvement plan. Ambitions for Phase 2 - • Embed Vision, Values and Behavioural framework. Communication to re-energise values and behavioural framework to ensure awareness along with the Trust Values awards on 9th July to celebrate achievements and COVID-19 heroes. • Develop and implement Team Working programme including coaching, cultural change, SDI/DISC supported by Culture Change Team. Commence use of Affina Cultural Assessment Tool. • Develop the Cultural Dashboard (reporting tool) • Develop and implement a cultural improvement programme from staff survey and "Making A Difference Together" (MADT) • Compassion: Embed Just and Learning culture through our supportive approach to people management and patient care	
10.	**Communication and Engagement (Director of Governance and Communications)**			The new Head of Communications has undertaken a review of the current team capacity and skills, and a new structure has been agreed with adverts going out for vacant positions. The Communications Team is supporting the SaTH staff awards on the 9th July.	i. Developing a communications and engagement strategy for quality improvement;

11.	**Recruitment & Retention (Director of People and Organisational Development)**			Overall the international recruitment programme has been successfully delivered particularly in terms of the numbers of new recruits who have arrived, been trained, passed their OSCE and have been retained so far. The vacancy level has reduced by 10% in the last 12 months and we have been able to retain 100% of all the nurses recruited overseas. This has been as a result of the combined efforts of our established on boarding (new team introduced specifically to support international recruits) and the investment in practice development nursing teams supported by divisional nursing teams. There has been a number of challenges this year as a result of COVID-19 which has resulted in travel restrictions and delays. The programme has increased our substantive workforce and reduced vacancies although we are yet to see the reduction in agency as outlined in the business case. The pass rate of OSCE examinations continues to be above the National Average and to date no one has failed on their second attempt. To date we have not had any resignations from the nurses who have arrived. There have been delays associated with 21/22 international recruitment but progress is now being made following the easing of travel restrictions. Since the India travel ban has been lifted we have made 167 offers and have 22 arriving in June, 25 arriving in July, 9 arriving in August and 4 arriving in September.	
12.	**Urgent and Emergency Care (Chief Operating Officer)**			Delivery on the three key UEC work streams continues with progress being made in all areas. Further work continues in preparation for the new UEC measures, and this has been linked for the Trust with the development of a System wide UEC dashboard to provide greater oversight to the Systems UEC delivery group and Board, as well	

				enabling tracking of outcomes and benefits for the UEC Getting to Good programme as a whole. Medical and Surgical SDEC continues to develop and embed processes 'pull' from ED and direct admission from ambulances. Surgical SDEC have appointed into the two UGI surgeon posts, one started in June and the other due to start in October 2021. The FFA electronic process is being rolled out to Ward 22 T&O and 35 and the revised pathway zero process has been agreed with the system and is being launched on Ward 35 on 1st July 21. The PDSA Ward/Board round changes now include Ward 22 T&O and Ward 35 Renal at RSH. The revised POD and bed meeting changes are now embedded across both sites.	
13.	**Restoration & Recovery (Chief Operating Officer)**			All actions are on track and delivering the programme outputs. Successful commencement of the insourcing programme with '18 weeks'. Governance structure has been reviewed and changes made to the monthly steering group function.	
14.	**Digital Transformation and Infrastructure (Deputy Chief Executive)**			BadgerNet Maternity training in progress, super users trained. Additional changes made to training location to support attendance of midwives at training. Delivery of the system is dependent on midwives being able to attend training sessions. Divisional Digital Roadmap resource requirements review is in progress. Vitals Sepsis process design underway with Sepsis leads, and roll out of Vitals needs to be completed before CareFlow can be rolled out within ED in November 2021.	k. Proposing and implementing joint working with partner organisations where collaborative approaches will yield tangible improvements and/ or efficiencies
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	

	(Director of Finance)			be on the delivery of the Year 2 plan which centres on A&E redevelopment and finalisation of the Estates Strategy.	
16.	**Improving Service Sustainability (Medical Director)**			Changes at Executive level resulted in a pause in this programme in April to revaluate the approach and procurement route for this programme. Discussions around Phase 2 of G2G have commenced and this programme has been put on hold pending finalisation of the scope of this work	h. Developing new models to support the development of integrated health and care; k. Proposing and implementing joint working with partner organisations where collaborative approaches will yield tangible improvements and/ or efficiencies
17.	**Using Technology to optimise Outpatient efficiency and experience (Medical Director)**			PIFU is now live in Gynae, ENT and MSK. Therapies and Ophthalmology have been identified as likely specialties for the next batch. Ongoing difficulties with clinical engagement and resource time required to get meaningful qualitative data from suitably informed members of the specialities. Non-face-to-face proportion dropping - investigating whether this is reduced engagement post Covid-19, or catching-up with a post-Covid-19 face-to-face cohort.	
18.	**System Improvement and Integration Plan (Director of Finance)**			The System Operational plan and the Trust annual integrated plan 21/22 have now been produced. The system operational plan has yet to be formally approved by NHSI/E, no formal issues have been raised during two checkpoint meetings.	
19.	**Revise SOC for Hospitals Transformation**			Progress with HTP acceleration work - Clinical Advisory Panel held 14 June and second workshop with operational colleagues held 21 June. First weekly Acute Delivery	

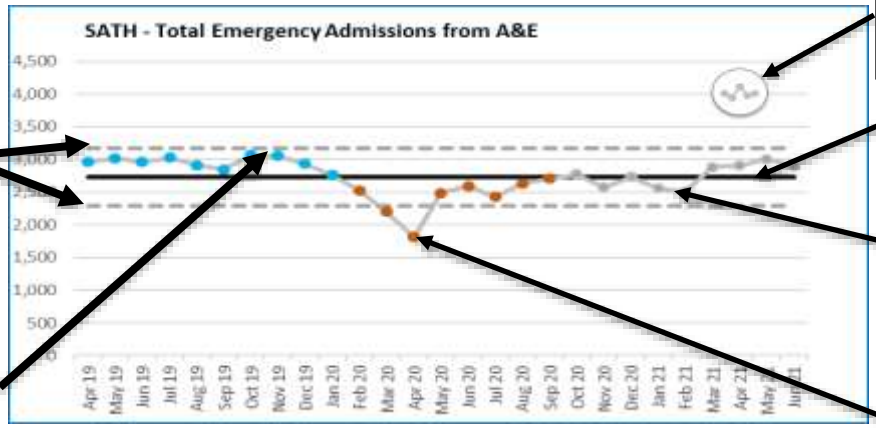
	Programme (Deputy Chief Executive)			Group held (replaces monthly Steering Group) A draft SOC plan has been developed with PA Consulting colleagues	
20.	**System Long Term Plan (Deputy Chief Executive)**			An ICS Sustainability Committee has been established to develop the system assumptions and baseline position. ICS Sustainability Committee is reviewing revised milestones and base line assumptions in July 2021. 6 big ticket items currently developing programmes with assumptions and timelines. An outline plan (5+5 years) is expected to be approved by the Integrated Care System by the end of September 21.	
21.	**Oversight, Assurance, Roles and Accountabilities (Director of Governance and Communications)**			June has seen successful completion of the review and optimisation of Executive portfolios, and these changes will be implemented from 1st July 2021. A major milestone for the organisation has been met in June with the completion and sign off of the Annual Report. However a consequence of timely delivery of this key report has meant that the recruitment of Compliance and Assurance Manager was delayed and the recruitment will now complete in July. Review of the sub-committees is still ongoing and delivery timescales have been pushed back by one month.	g. Developing new working models for: Clinical governance; and Clinical Quality Risk Management j. SaTH identifying reviewing and mitigating clinical quality and risks;
22.	**Strong Financial Foundations (Director of Finance)**			The Trust's H1 budget has been approved by F&PC and is going to the Board on 8th July. Budgets will be issued to budget holders in line with this approval. Work is ongoing with colleagues at NHSEI to agree the underlying expenditure plan for 2021/22 and that will allow the Trust to set expenditure budgets for that period as well. Development of a revised business case tracker has progressed to ensure all cases, and their governance status, are tracked and visible to finance staff and divisional managers. Finalising this will be a focus in July. The new Head of Efficiency joined the Trust at the	

				beginning of the month and the pipeline of efficiency schemes is now being developed. The Trust's accounts for 2020/21 were finalised and approved in June with the Trust receiving a clean audit opinion.	
23.	**Performance Data and Analytics (Director of Finance)**			During June 21, we have completed the population of the IPR measures into the InPhase tables and tested presentation within InPhase. Work is also underway to enable the data to be presented in Making Data Counts SPC format. We are future proofing the build to enable the data to be cut in multiple directions for the creation of multiple dashboards. The next phase of the build includes the quality metrics and this is being linked to the indicators in the Quality Improvement Strategy. The IPR end of year review with Board members has been completed and some initial changes were included in this month's report. Recruitment to the UEC band 7 post (funded for 12 months from NHSEI) has been completed and the post holder has taken up this role. A secondment is being advertised to backfill the vacancy created. The draft weekly UEC dashboard has been produced together with the monthly UEC dashboard. The maternity dashboard has been developed and presented to QSAC. STAR self-assessment is underway for the IPR metrics with the expectation this will be complete by end of September.	
24.	**Risk Management (Director of Governance and Communications)**			Within the current reporting period, the Risk Management Strategy has been updated and communicated to Partners. Recruitment of a Risk Manager remains off track, however recruitment of a new manager has started. One of the key roles of the new Risk Manager will be to drive forward a Hearts and Minds culture for how Risk Management is perceived within SaTH	

25.	**Programme and Project Management (Director of Finance)**			Throughout June work has commenced to assess various Programme/Project Management systems used by system partners. To date we have viewed Monday.com, Smartsheet and In-phase, though additional demos of the latter two are being rearranged to provide a more in-depth analysis. If we can succeed in procuring one PM solution for implementation across the system this will provide us will the ability to share key project information, link dependencies and outcomes in a much wider context and will reduce duplication whilst accelerating delivery. The team have been working with executive leads and SROs to develop phase 2 of the Getting to Good Programme and will be completing final highlight reports to wrap up year 1 of this programme. We have composed and agreed our team vision and provision statements which will be incorporated into a structured and measured approach to internal and external programme communications.	Providing assurance to the Committees, and respective Boards, by monitoring delivery of the overall quality improvement plan against a comprehensive framework.

Appendix 1: Understanding Statistical control process charts in this report

The charts included in this paper are generally moving range charts (XmR) that plot the performance over time and calculate the mean of the difference between consecutive points. The process limits are calculated based on the calculated mean.



Icon showing most recent point type of variation

Process limits – upper and lower

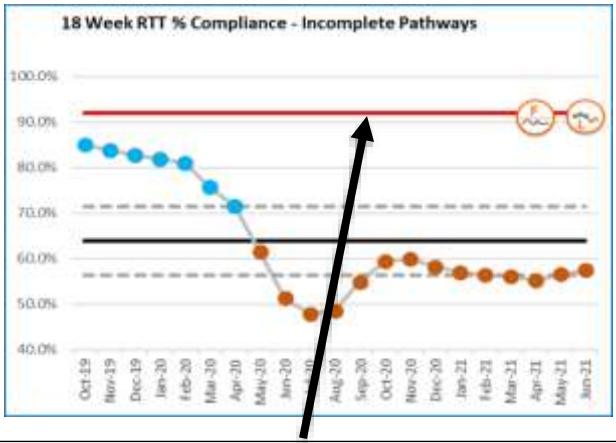
Mean or median line

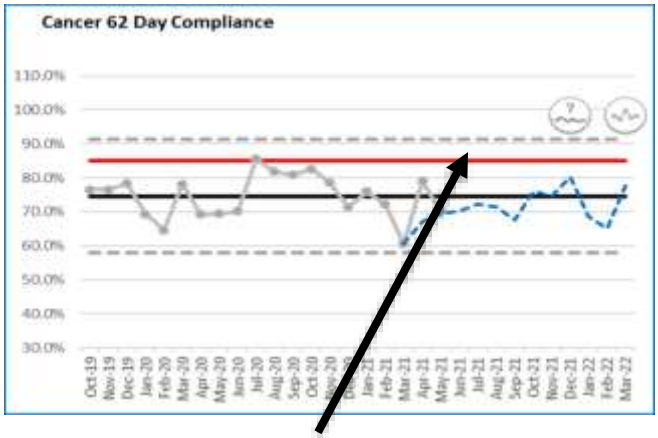
Common cause variation

Special cause variation -7 consecutive points above (or below) the mean

Special cause variation – data point outside of the process limit

Where a target has been set the target line is superimposed on the SPC chart. It is not a function of the process.





Target line –outside the process limits. In this case process is performing worse than the target and target will only be achieved when special cause is present or process is re-designed

Target line – between the process limits and so will be hit and miss whether or not the target will be achieved

Glossary

Term	Definition
Centre reference line	The average line (often represented by the mean, sometimes the median)
Common cause variation	Periodic changes in the data that are predictable and expected
Control limits	Two lines, one above and one below the average line, which define the variation of the dataset. Also known as process limits
Linear trend line	A best fit straight line drawn onto charts to indicate something that is increasing or decreasing at a steady rate
Lower process limit	The line below the average line (mean), which defines the lower boundary of expected variation
Mean line	Represents the arithmetic average data plotted on the chart
Median line	Represents the middle number in the data plotted on the chart
Natural variation	See common cause variation
Process limits	See control limits
Process mapping	Enables you to create a visual picture of how the system currently works
RAG approach	Categorising data using 'red, amber, green' based on targets
Random variation	See common cause variation
Rebasing	Redrawing the reference lines on the chart to reflect a change in the system
Reference lines	Represent the upper and lower process limits and mean or median line. Overlaid on the recorded data line
Special cause variation	Changes in the data that are unpredictable and unexpected
Statistical process control	A method to support the robust statistical interpretation of measures presented over time and to understand if your process has special cause and/or common cause variation
Times series	Values of a quantity obtained at successive times, often with equal intervals between them
Upper and lower reference lines	Process limits, see control limits
Upper process limit	The line above the average line (mean), which defines the upper boundary of expected variation
Variation	A change or slight difference in the data, typically within certain limits
XmR chart	The XmR chart has two parts. The X-chart displays the data points over time together with a calculated average. The calculated average is then used to calculate the upper and lower process limits The moving range (mR) chart shows the difference between consecutive observations and is recorded as a positive number. The average is displayed and then used to calculate the upper process limit

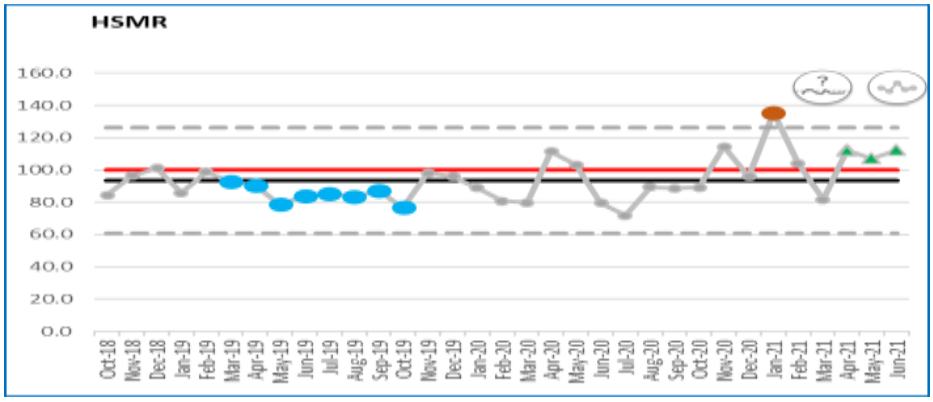
Appendix 2: Abbreviations used in this report

Term	Definition
CRR	Corporate Risk Register
CQC	Care Quality Commission
BAF	Board Assurance Framework
HSMR	Hospital Standardised Mortality Rate
RAMI	Risk Adjusted Mortality Rate
HCAI	Health Care Associated Infections
MSSA	Methicillin- Sensitive Staphylococcus Aureus
MRSA	Methicillin- Sensitive Staphylococcus Aureus
C.Difficile	Clostridium Difficile
E.Coli	Escherichia Coli
VTE	Venous Thromboembolism
SI	Serious Incidents
IPC	Infection Prevention Control
RCA	Route Cause Analysis
ANTT	Antiseptic Non-Touch Training
ITU/HDU	Intensive Therapy Unit / High Dependency Unit
FTE	Full Time Equivalent
WTE	Whole Time Equivalent
RTT	Referral To Treatment
DMO1	Diagnostics Waiting Times and Activity
ED	Emergency Department
SRO's	Senior Responsible Officer
PMO	Programme Management Office
QSAC	Quality and Safety Assurance Committee
UEC	Urgent and Emergency Care service
ERF	Elective Recovery Fund
OPD	Out Patient Department
WEB	Weekly Executive Briefing
OPOG	Organisational performance operational group
CCG	Clinical Commissioning Groups
IPR	Integrated Performance Review
F&P	Finance and Performance
NHSEI	NHS England and NHS Improvement
ICS	Integrated Care System
SOC	Strategic Outline Case
PIFU	Patient Initiated follow up
HTP	Hospital Transformation Programme
G2G	Getting to Good
POD	Point of Delivery
T&O	Trauma and Orthopaedics
SDEC	Same Day Emergency Care
OSCE	Objective Structural Clinical Examination
MADT	Making A Difference Together
MTAC	Medical Technologies Advisory Committee
CNST	Clinical Negligence Scheme for Trusts
MCA	Mental Capacity Act
DOLS	Deprivation Of Liberty Safeguards
MHA	Mental Health Act
EQIA	Equality Impact Assessments
CRL	Capital Resource Limit
CT	Computerised Tomography
NEL	Non Elective
COO	Chief Operating Officer
IPDC	In patients and day cases
C.Section	Caesarean Section
IPC	Infection Prevention and Control
IPC Ops.	Infection Prevention and Control Operational Committee
RCA	Root Cause Analysis

VIP	Visual Infusion Phlebitis
NIQAM	Nurse investigation quality assurance meeting
TV	Tissue Viability
Q1	Quarter 1
HoNs	Head of Nursing
BP	Blood pressure
ITU	Intensive Therapy Unit
HDU	High Dependency Unit
CCU	Coronary Care Unit
SaTH	Shrewsbury and Telford Hospitals
RSH	Royal Shrewsbury Hospital
PRH	Princess Royal Hospital
RJAH	Robert Jones and Agnes Hunt Hospital
MEC	Medicine and Emergency Care
SAC	Surgery Anaesthetics and Cancer
CSS	Clinical Support Services
W&C	Women and Children
SATOD	Smoking at the onset of delivery
LMNS	Local maternity network
CCG	Clinical Commissioning Group
SMT	Senior Management Team
NICE	National Institute for Clinical Excellence
PPE	Personal Protective Equipment
LFT	Lateral Flow Test
HCSW	Health Care Support Worker
NHSEI	National Health Service England and NHS Improvement
Ed.	Education
A&E	Accident and Emergency
WMAS	West Midlands Ambulance Service
H1	April-September 2021 inclusive
ERF	Elective Recovery Fund
OPD	Outpatient Department
PIFU	Patient Initiated Follow Up
CT	Computed Tomography
MRI	Magnetic Resonance Imaging
PTL	Patient Targeted List
2ww	Two week waits
R	Routine
GP	General Practitioner
AGP	Aerosol-Generating Procedure
Exec	Executive
GI	Gastro-intestinal
MFFD	Medically fit for discharge
MD	Medical Director
CAMHS	Child and Adolescence Mental Health Service
DTA	Decision to Admit
HMT	Her Majesty’s Treasury
YTD	Year to Date
PID	Project Initiation Document
FYE	Full year effect
QOC	Quality Operations Committee
KPI	Key performance indicator
TOR	Terms of Reference
MVP	Maternity Voices Partnership
Q&A	Question and Answer
RN	Registered Nurse
MSK	Musculo-Skeletal

Appendix 3: Key Performance Indicators where performance is in line with plan/target set.

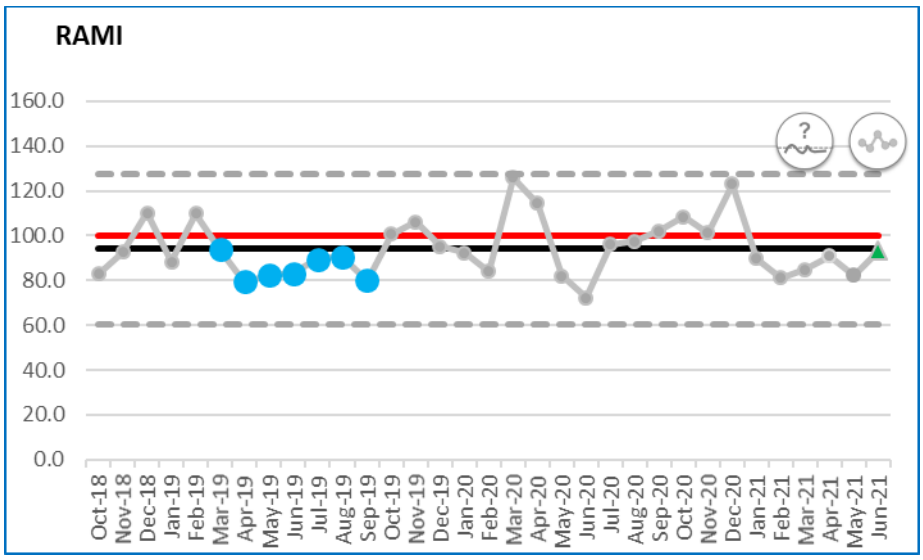
Mortality
HSMR



March 2021 actual performance
81.57
Variance Type
Common Cause
National Target
100
Target / Plan Achievement
Performance better than expected range

Background	What the Chart tells us:	Issues	Actions	Mitigation
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 index in March 2021 was below 100 at 81.6, demonstrating performance in the better than expected range, although this index value is likely to increase when the HSMR model is rebased shortly. The graphs shows a higher forecast position for April and May 2021.	The Trust's HSMR index was higher than the peer in some months, notably November 2020 and January 2021, which correlates to the second wave of COVID-19 deaths. The longer-term trend for HSMR is in line with the peer and expected range for the 12 month period. The HSMR was higher than the peer at PRH. For deaths where the primary diagnosis has been recorded as COVID-19 these are excluded from HSMR, however of COVID-19 appears elsewhere in the spell or in a subsequent diagnosis then these deaths may be included in HSMR. The conditions with the highest number of 'excess deaths' are urinary tract infection, pneumonia, aspiration pneumonia and respiratory failure all of which were higher than the peer and increased from the previous report. The increased HSMR at PRH requires further analysis.	A review of coding accuracy and the recording of primary diagnosis for urinary tract infection patients has identified learning for both clinicians and coders. Findings have been shared at the Learning from Deaths group and specifically disseminated within the coding department. The sepsis team are working with clinicians to specifically address documentation of sepsis to further support this work. Further analysis is being undertaken to review mortality by site with a specific focus on days of the week.	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.

RAMI

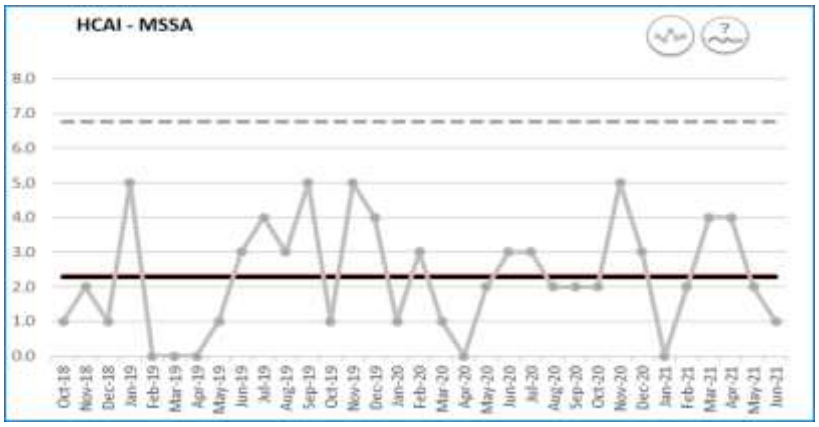


May 2021 actual performance
81.1
Variance Type
Common Cause
National Target
100
Target / Plan Achievement
Monthly variation means that the 100 reference level may not be delivered month on month

Background	What the Chart tells us:	Issues	Actions	Mitigation
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 comparable to 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 were pneumonia, urinary tract infection, acute and unspecified renal failure, and aspiration pneumonitis. All had increased from the previous year and, other than pneumonia were high compared to the peer.	All cases with a primary diagnosis of urinary tract infection have been reviewed for coding accuracy. 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. The sepsis team are working with clinicians to specifically address documentation of sepsis to further support this work. Initial analysis of the remaining conditions has taken place with the Coding Manager and these will be monitored over the coming months by both the Trust and CHKS.	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.

Hospital Acquired Infections

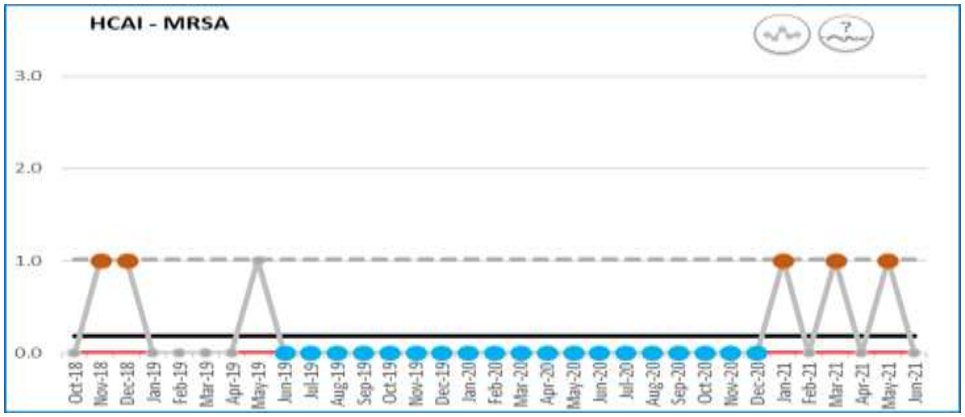
MSSA



June 2021 actual performance
1
Variance Type
Common Cause
Local Standard
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 was one case of post 48 hour MSSA Bacteraemia in June 2021 In Q1 there were 7 cases against a target of no more than 7 cases.	The case in June was not considered device related.	Previous RCA actions included ensuring use of catheter care plan and catheter insertion documentation. Staff reminded about correct labelling of blood cultures ANTT training to be delivered by CPE team.	Any cases where the cause of infection is unknown or is thought to be device related have an RCA completed Catheter documentation is audited through the monthly matrons quality audits.

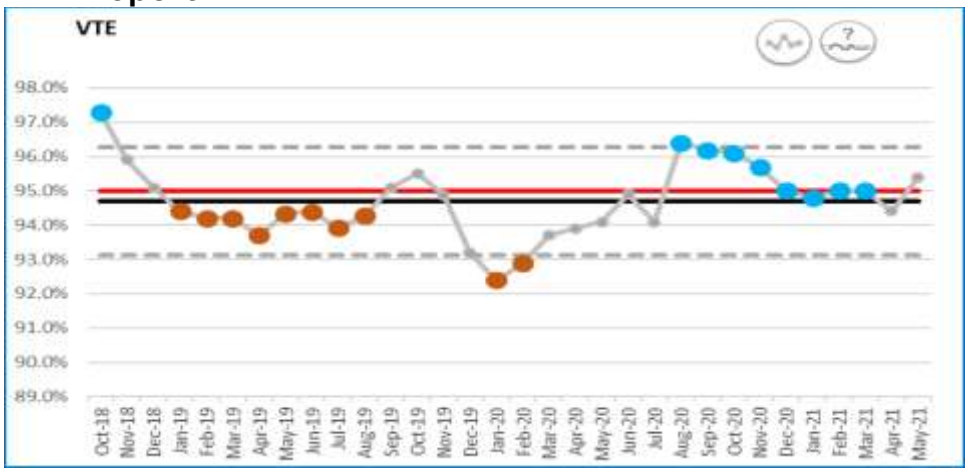
MRSA



June 2021 actual performance
0
Variance Type
Common cause
Local Standard
0
Target / Plan Achievement
0 infections for 21/22

Background	What the Chart tells us	Issues	Actions	Mitigation
The Target for all Acute Trusts is Zero cases of MRSA bacteraemia.	There were no cases in June 2021. There has been one case in Q1 (April to June 2021).	Previous cases highlighted issues with details of who took the sample not being documented and training for junior doctors.	Staff reminded to complete blood culture documentation correctly. Training for junior doctors implemented.	Monitored through IPC Operational Group.

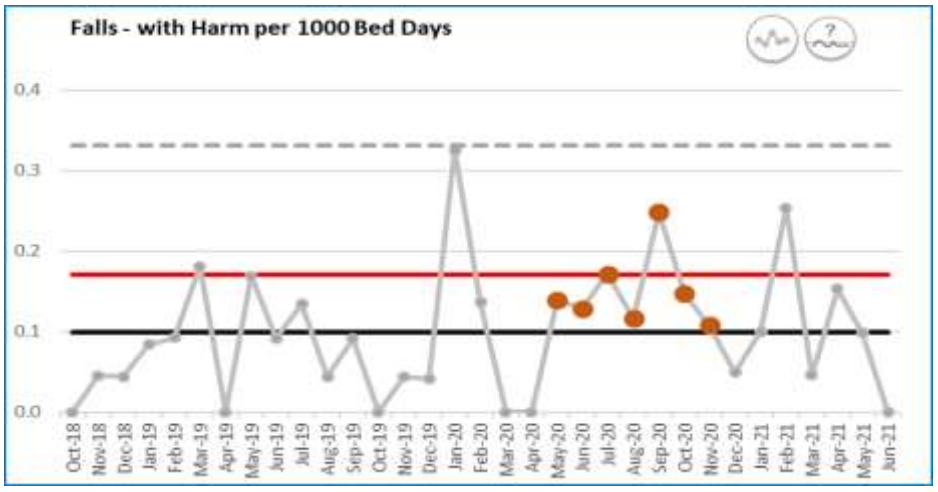
VTE Report



May 2021 actual performance
95.4%
Variance Type
Common Cause
National Target
95%
Target / Plan Achievement
Delivery 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.	Improvement with target delivered this month. The graph is showing common cause variation post the intervention made in June 2021.	Performance has improved following the intervention commenced in June.	Monitoring will continue to ensure this change in practice is embedded.	

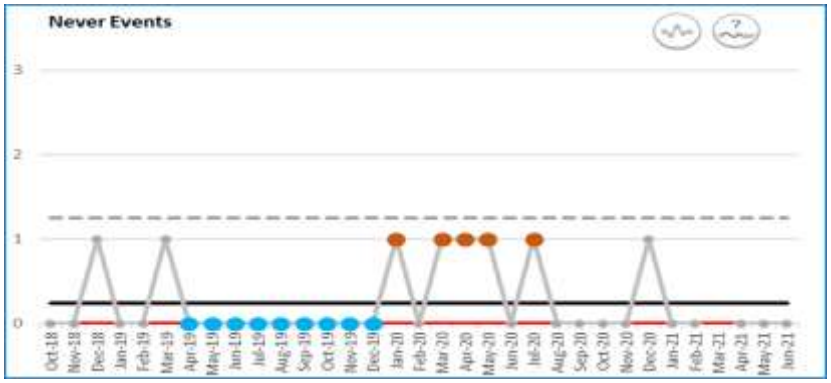
Falls – with Harm per 1000 Bed days



June 2021 actual performance
0.00
Variance Type
Common Cause
Local Target
0.17
National Standard
0.19
Target/ Plan achievement
New local Target set for 21/22

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 were no falls resulting in significant harm in June 2021.	As per Falls Slide.	As per Falls Slide.	As per Falls Slide.

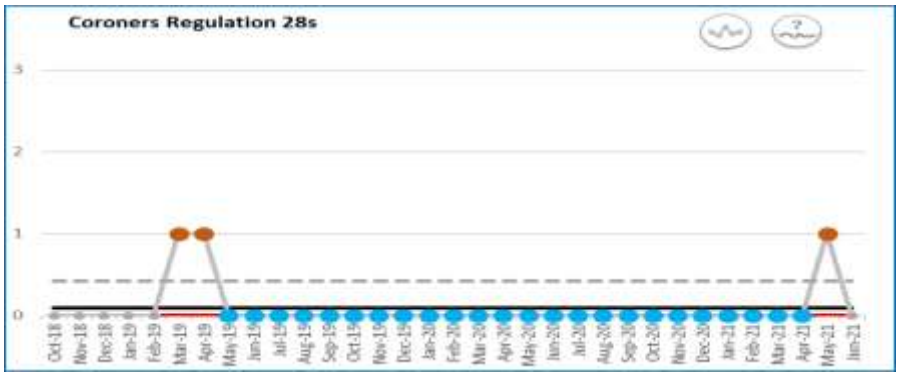
Never Events



June 2021 actual performance
0
Variance Type
Common cause
Local Standard
0
Target/ Plan achievement
.

Background	What the Chart tells us	Issues	Actions	Mitigations
Key patient safety measure.	No Never Events in June.			No actions.

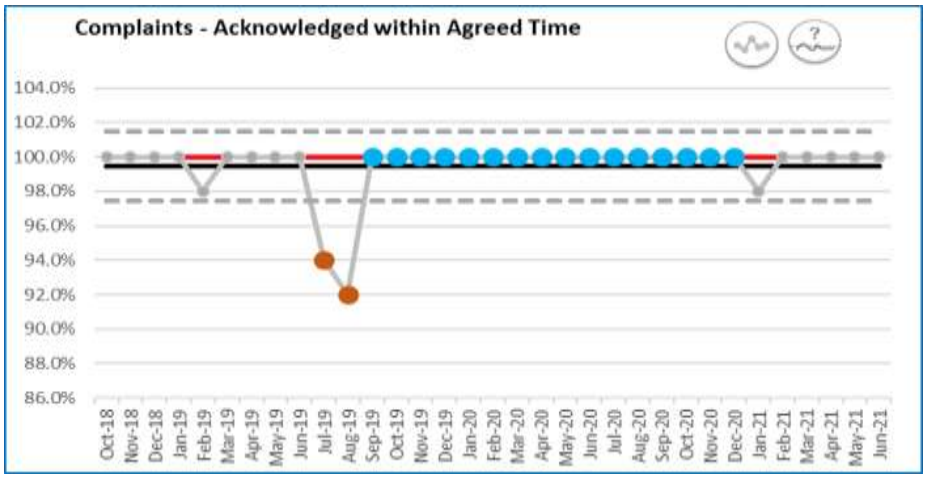
Coroner Regulation 28 Notices



June 2021 actual performance
0
Variance Type
Common cause
Local Standard
0
Target/ Plan achievement
Achieving target month on month.

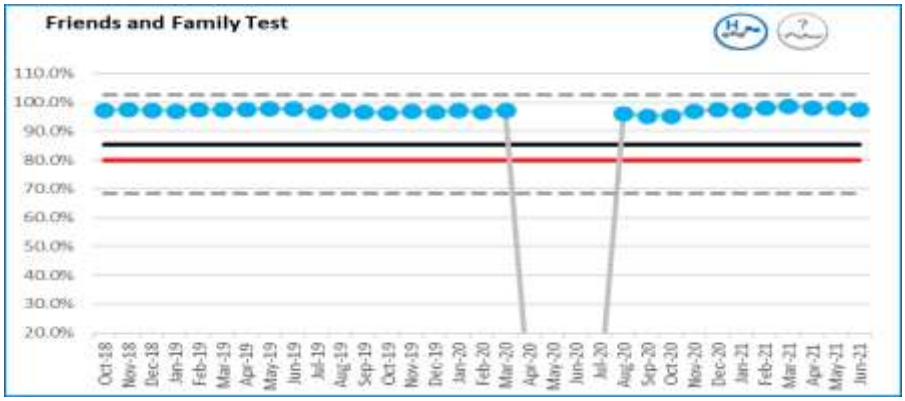
Background	What the Chart tells us	Issues	Actions	Mitigations
Key patient safety measure.	None reported in June.			

Complaints Acknowledged within agreed time



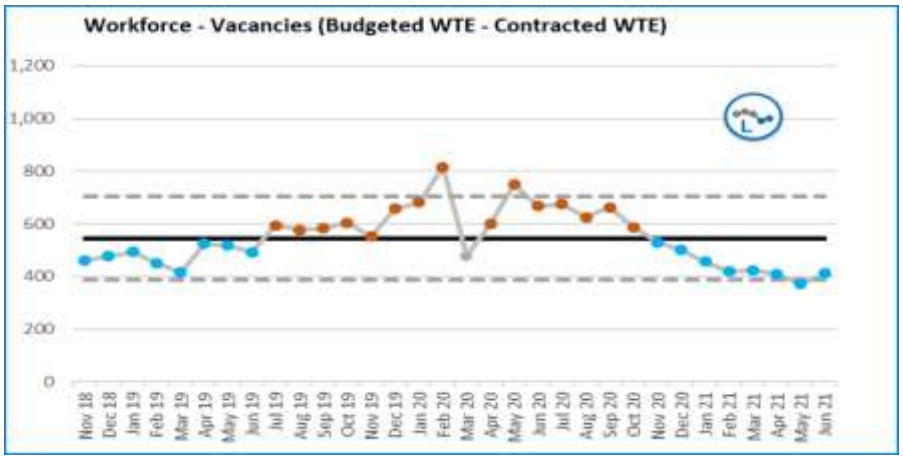
June 2021 actual performance
100% (93% within two days)
Variance Type
Normal variance
National Target
100%
Target/ Plan achievement
Target achieved consistently

Friends and Family Test



June 2021 actual performance
97.5%
Variance Type
Special cause improving
National Standard
85%
Target/ Plan achievement

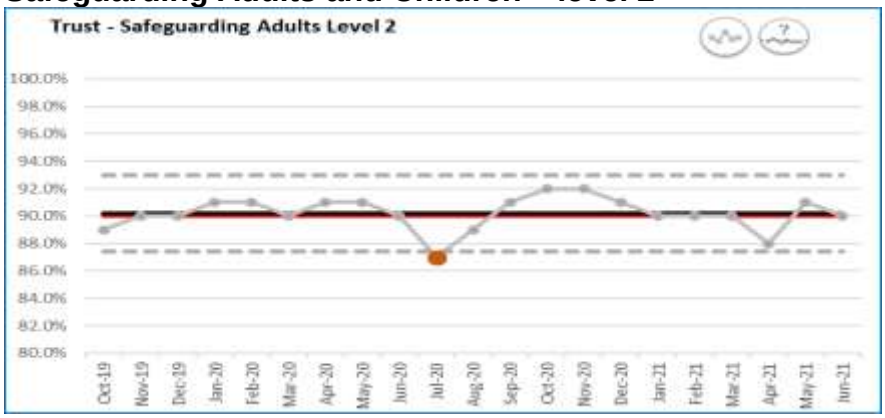
Vacancies



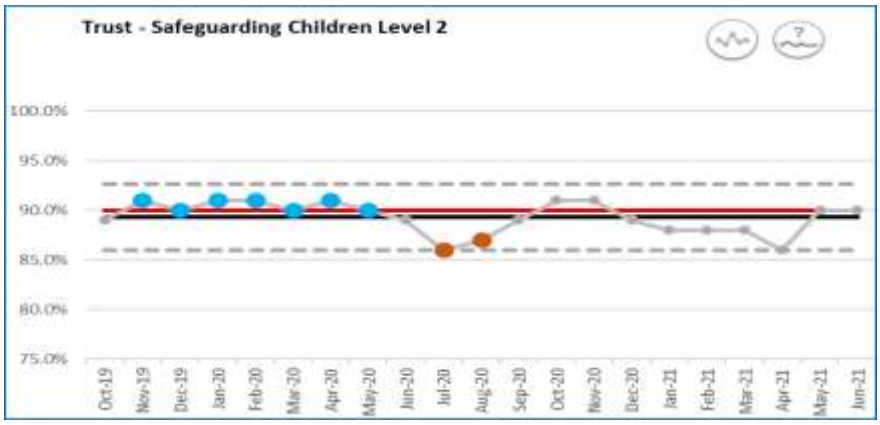
June 2021 actual performance
412=7%
Variance Type
Special Cause Improvement
National Target
<10%
Target / Plan Achievement
Better than target level of performance

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 Nov 20 and June 21.	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. Initiatives to help retain existing staff. Ongoing work to review vacancy gaps against temporary staffing usage to better understand workforce utilisation.	Recruitment activity continues to reduce workforce gaps. Use of temporary staff to cover vacant posts.

Safeguarding Adults and Children – level 2

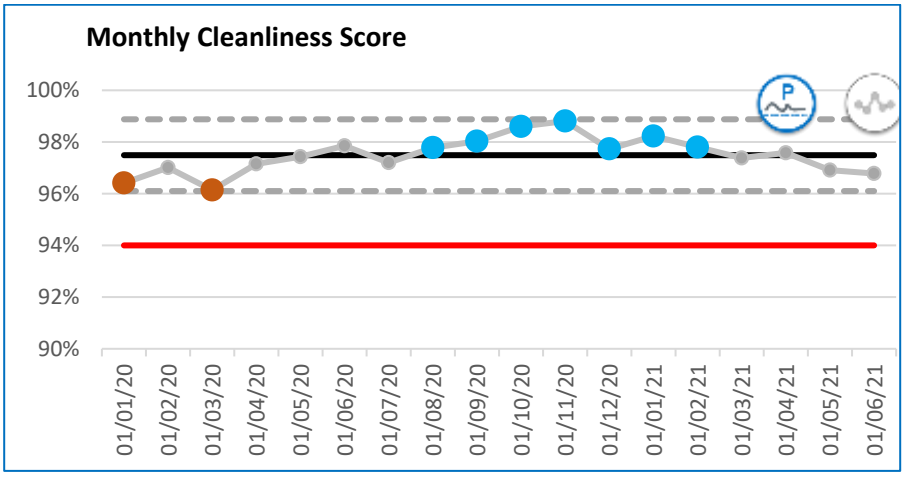


June 2021 actual performance
90%
Variance Type
Special Cause Improvement
National Target
90%
Target / Plan Achievement



June 2021 actual performance
90%
Variance Type
Special Cause Improvement
National Target
90%
Target / Plan Achievement

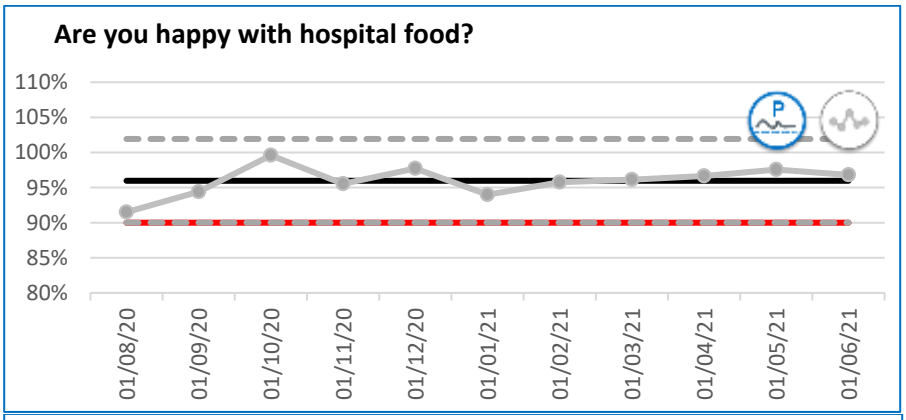
Monthly Cleanliness Score

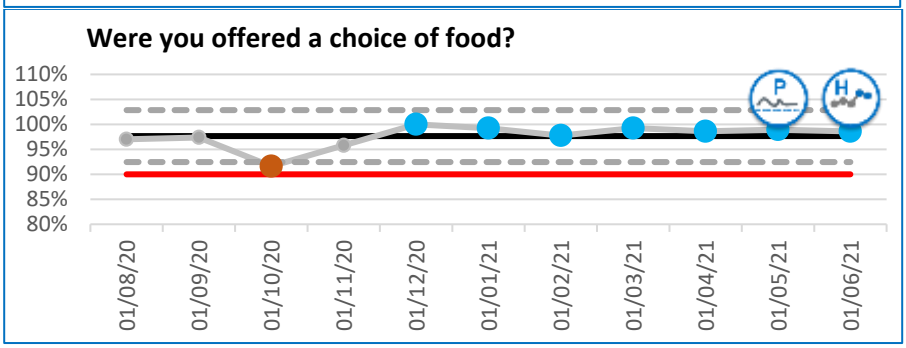


June 2021 actual performance	
96.8%	
Variance Type	
Common Cause	
National Target	**Local SaTH standard**
NA	94%
Target/ Plan achievement	
On target to achieve above local standard	

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.	Performing between the mean and the lower control limit with some slight common cause variation.	There are no concerns at present which should effect our ability to achieve the target however it is noted that the last 2 months have seen a slight decline in the scores which has taken them below the mean. The decline can be attributed to RSH scores and is a result of low staffing levels due to high sickness and vacancy rates. The reduction in scores are mainly on public circulation spaces and entrances.	Due to the recent difficulty in recruiting Cleanliness Technicians at RSH the team have tried to increase staffing levels through contractors and have recently worked with Temporary Staffing to engage with agencies too. This appears to be successful as we have several candidates to interview so the staffing levels should increase over the next few weeks. We have also employed a contractor to clean public corridors and entrances on evenings for the next couple of weeks while waiting for the agency staff to start work.	NA.

Monthly Patient Food Satisfaction Score





June 2021 actual performance	
96.8% for satisfaction with food and 98.6% for satisfaction with choice	
Variance Type	
Common Cause	
National Target	**Local SaTH standard**
NA	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 June 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.	NA.	NA.