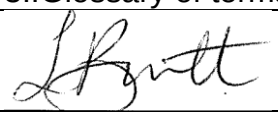
Board of Directors' Meeting
7 October 2021

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	246/21			
Report	Integrated Performance Report			
Executive Lead	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, CRR17, CRR19, CRR21, CRR22, CRR23, CRR27	
	For noting			
	For information			
	For consent			
Presented to:	SaTH Leadership Committee (Operational) 23.9.21., FPAC 28.9.21 and QSAC 29.9.21.			
Dependent upon (if applicable)**:**	N/A			
Executive summary:	This report provides the Board with an overview of the performance indicators of the Trust to the end of August 2021. Key performance measures are analysed over time to understand the variation taking place and the level of assurance that can be provided 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 executive summary is included at the front of the report and metrics reported under functional headings for: Quality, Workforce, Operations, Finance and Transformation.			
Appendices	1. Key Performance Indicators reported where performance is in-line with plan/target. 2. Understanding SPC charts 3..Glossary of terms			
				

Integrated Performance Report

Purpose

This report provides the Board with an overview of the quality of care and patient safety 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.

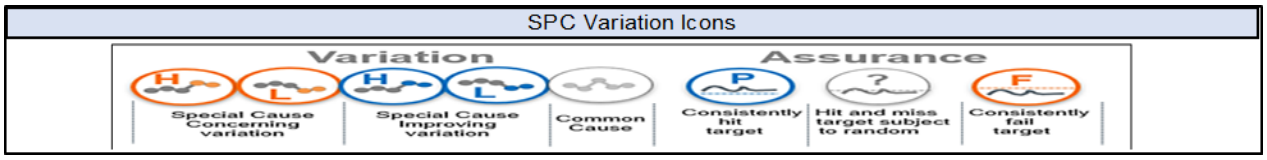
The report is aligned to the Trust's functional domains and includes an overarching executive summary. The measures relevant to the remit of the Quality and Safety and Finance and Performance committees are scrutinised by these committees ahead of the board.

Contents

1. Executive Summary
Louise Barnett, Chief Executive

- August has seen an increase in the prevalence and the number of patients admitted with COVID-19. Our vaccination programme performs well. One of the unfortunate consequences in August has been the impact on elective services, in particular the loss of our elective orthopaedic capacity at Princess Royal Hospital (PRH), and we are working with The Robert Jones & Agnes Hunt Orthopaedic Hospital (RJAH) to improve the availability of services for patients.
- During August, the CQC undertook a Well-Led inspection, as part of their wider inspection. We await the outcome of this visit.
- Feedback from our Friends and Family scores regarding the quality and standard of our catering is positive. We are also seeing continuing good scores for cleanliness.
- The focus on infection prevention and control as part of our Quality Improvement Strategy continues, with performance against expected standards being closely monitored..
- During August, our operational challenges have intensified with high levels of attendances and acuity in our emergency departments, delays to discharge for medically fit patients, referrals for Cancer services returning to pre-pandemic levels and longer waiting times for many of our patients waiting for out-patient consultations, diagnostic tests and elective surgery.
- We are continuing to work as part of the whole system to address the unscheduled care pressures and within SaTH are moving forward with the capital development of our emergency department in Shrewsbury so as to create a larger treatment area for our patients. The first phase of this is scheduled for completion in September.
- We are continuing to provide patient appointments virtually where possible, as well as restoring face-to-face consultations where virtual clinics are not suitable. We have an additional Vanguard theatre and recovery facility at PRH and have an additional CT and MRI scanner being installed. The CT scanner will be operational during October, and the MRI scanner will become operational as soon as recruitment for additional MRI Radiographers has been finalised.
- Our recovery of elective capacity has been affected by both the unscheduled and COVID-19 pressures combined with absences in our own staff. It is positive to see the number of new doctors taking up post during the month and the international recruitment recommencing. We have also been successful in recruiting midwives and look forward to them taking up post during September.
- Our income and expenditure has been adversely affected by the reduction in the elective recovery and the change in the Elective Recovery Framework (ERF) threshold introduced in July 2021. We are working to finalise our H2 activity plans and looking to balance the needs of our elective recovery with the increasing demands we may face over the winter months. Our efficiency plans show a positive variance in the year to date.
- Our Phase 2 Getting to Good plans are showing all 9 programmes making progress. Through this we are seeking to ensure our good work in Year 1 is embedded in our services to improve outcomes for our patients. We are working to review and strengthen actions in areas which are behind plan.

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	Jun 21	63.8	100	100			No		100
RAMI	QSAC	Jul 21	84.4	100	100			No		100
Infection										
HCAI - MSSA	QSAC	Aug 21	2		<2.3			No	11	28
HCAI - MRSA	QSAC	Aug 21	0	0	0			No	1	0
HCAI - C.Difficile	QSAC	Aug 21	1		<2.5			No	9	30
HCAI - E-coli	QSAC	Aug 21	4		<3.16			Yes	21	38
HCAI - Klebsiella	QSAC	Aug 21	1		<1			No	8	13
HCAI - Pseudomonas Aeruginosa	QSAC	Aug 21	0		0			No	3	3
Patient harm										
Pressure Ulcers - Category 2 and above	QSAC	Aug 21	10		<13			No	60	152
Pressure Ulcers - Category 2 Per 1000 Bed Days	QSAC	Aug 21	0.48							tbc
VTE	QSAC	Jul 21	95.1%	95%	95%			No		95%
Falls - total	QSAC	Aug 21	115		<89			Yes	534	1074
Falls - per 1000 Bed Days	QSAC	Aug 21	5.5	6.60	<4.5			Yes	4.79	4.50
Falls - with Harm per 1000 Bed Days	QSAC	Aug 21	0.19	0.19	<0.17			Yes	0.09	0.17
Never Events	QSAC	Aug 21	0	0	0			No	0	0
Coroners Regulation 28s	QSAC	Aug 21	0		0			No	1	0
Serious Incidents	QSAC	Aug 21	8		n/a				40	57
Mixed Sex Breaches	QSAC	Aug 21	29	0	0			Yes	154	tbc
Patient Experience										
Complaints	QSAC	Aug 21	63		<56			Yes	305	672
Complaints Responded within agreed time	QSAC	Jul 21	45%	85%	85%			Yes		85%
Complaints -Acknowldeged within agreed time	QSAC	Aug 21	100%		100%			No		100%
Friends and Family Test	QSAC	Aug 21	97.7%	80%	80%			No	93.4%	80%
Compliments	QSAC	Aug 21	31 letters of thank you received.						235	tbc
Maternity										
Smoking rate at Delivery	QSAC	Aug 21	12.4%	6.0%	6.0%			Yes	12.8%	6.0%
One to One Care In Labour	QSAC	Aug 21	99.3%	100.0%	100.0%			Yes	99.4%	100.0%
Delivery Suite Acuity	QSAC	Aug 21	57%	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
Activity										
WTE Employed**Contracted	FPAC	Aug 21	5805		6173			Yes	5805	6173
Total temporary staff -FTE	FPAC	Aug 21	676					Yes		tbc
Staff turnover rate (excludes junior doctors)	FPAC	Aug 21	1.4%	0.8%	0.75%			Yes	1.22%	0.8%
Sickness absence rate Excluding Covid Related	FPAC	Aug 21	5.2%		4.00%			Yes	4.71%	4%
Appraisal Rate	FPAC	Aug 21	87%	90%	90.0%			Yes		90%
Appraisal Rate (Medical Staff)	FPAC	Aug 21	89%	90%	90.0%			Yes		90%
Vacancies	FPAC	Jul 21	378	<10%	<10%			Yes		<10%
Statutory and Mandatory Training	FPAC	Aug 21	85%	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	Aug-21	34282 30779 (English)					Yes		26209 English
18 week RTT % compliance -incomplete pathways	FPAC	Aug-21	58.15 % (English Only)	92%				Yes		40% English
52 week breaches	FPAC	Aug-21	2755 2485 (English)	0				Yes		4156 English
Cancer										
Cancer 2 week wait	FPAC	Jul-21	81.7%	93%	93%			Yes	82.1%	93%
Cancer 62 day compliance	FPAC	Jul-21	67%	85%	85%			Yes	69.0%	85%
Diagnostics										
Diagnostic % compliance 6 week waits	FPAC	Aug-21	69.4%	99%				Yes		tbc
DM01 Patients who have breached the standard	FPAC	Aug-21	3168	0	1254			Yes		tbc
Emergency Department										
ED - 4 Hour performance	FPAC	Aug-21	60.8%	95.0%	73%			Yes	68.0%	78%
ED - Ambulance handover > 60mins	FPAC	Aug-21	686	0				Yes	2740	tbc
ED 4 Hour Performance - Minors	FPAC	Aug-21	90.8%	95%	95%			Yes	93.3%	95%
ED 4 Hour Performance - Majors	FPAC	Aug-21	34.8%	95%				Yes	44.0%	tbc
ED time to initial assessment (mins)	FPAC	Aug-21	32	15	15			Yes		15mins
12 hour ED trolley waits	FPAC	Aug-21	69	0	0			Yes	232	tbc
Total Emergency Admissions from A&E	FPAC	Aug-21	2922					n/a	14658	29744
Hospital Occupancy and activity										
Bed Occupancy -G&A	FPAC	Aug-21	85.9%	92%	92%			No		92%
ED activity (total excluding planned returns)	FPAC	Aug-21	12630		13297			Yes	64985	118403
ED activity (type 1 excluding planned returns)	FPAC	Aug-21	10632		10975			Yes	54739	tbc
Total Non Elective Activity	FPAC	Aug-21	5074		5623			Yes	25427	62349
Outpatients Elective Total activity	FPAC	Aug-21	47916		58650			Yes	266104	558021
Total Elective IPDC activity	FPAC	Aug-21	5251		6105			Yes	26463	58789
Diagnostic Activity Total	FPAC	Aug-21	16216		16500			Yes	84405	tbc
Finance - KPI		Latest month	Latest Value (£m)	National Standard for month	Plan for year (£m)	Perfomance	Assurance	Exception	Year to Date(£m)	Year End Planned Trajectory (£m)
Cash	FPAC	Aug 21	12.551		1.700			Yes	28.504	1.700
Efficiency	FPAC	Aug-21	0.41		2.400(H1)			Yes	2.315	2.400(H1)
Income and Expenditure	FPAC	Aug-21	(1.945)		(3.219)(H1)			Yes	(4.196)	(3.219)(H1)
Cumulative Capital Expenditure	FPAC	Aug-21	1.692		34.142			Yes	4.022	34.142

3. Quality Executive Summary
Hayley Flavell, DoN, Richard Steyn and John Jones Acting Medical Directors

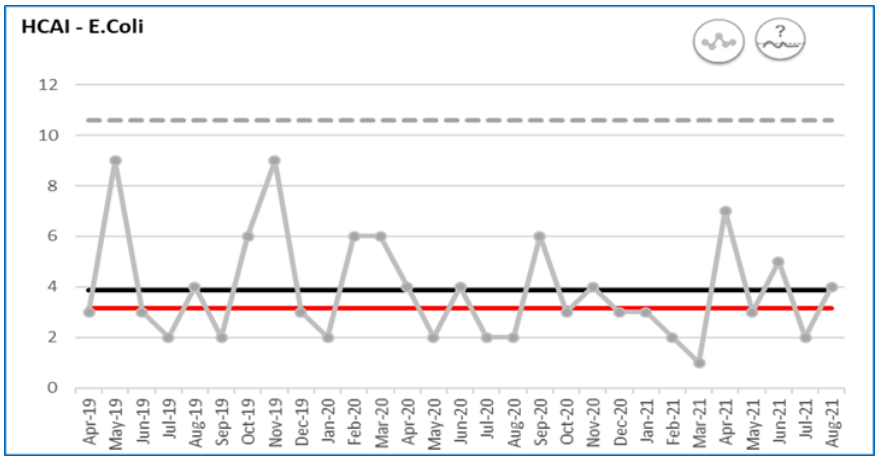
- Mortality indices remains better than the reference level of 100 and is forecast to continue to perform better than peers. Within the data a small improvement is noted in data related to Urinary Tract infections in quarter 1 of 2021-22 which may be associated with the work undertaken to improve the accuracy of coding. There is a slight increase in deaths related to septicaemia recorded.
- 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 improved. This improvement was sustained overall this month with good performance in the Surgical, Anaesthetic & Cancer and Women and Children's divisions. It is a concern that this was not achieved in the Medicine and Emergency Care Division.
- NHS England have published the contractual standards for 2021-22 in relation to minimising C.difficle and gram-negative bloodstream infections. Our performance to date shows we should achieve better than these standards. We are retaining our current stretch improvement targets. No further cases of MRSA are reported this month, however the incidence of E.coli is above the monthly standard set. MSSA and C.difficile remain on course to achieve better than the improvement trajectory for the year.
- Improvement is seen in the number (10) and rate of pressure ulcers (0.48 per 1000beddays) last month. The year to date performance suggests the improvement trajectory set internally for the year is on course to be delivered.
- The number of falls continues to remain an area of concern, with 115 reported this month. The number of falls is consistently higher than the improvement target, with 534 falls having occurred in the year to date (49.7% of the improvement target for the full year).The falls per 1000 bed days remains above the local stretch target for improvement, however the falls with harm per 1000 bed days is delivering at the national standard but not at the local stretch target this month.
- There were 8 serious incidents this month with a number of these reported in the Women and Children's Division. This division has 50% of the open SIs. No SIs are overdue for closure.
- There was an improvement in mixed sex breaches this month with 29 reported. These are largely arising from delays to discharge from critical care units.
- The response time for concerns remains unsatisfactory at 45% and is a further deterioration on performance. Trajectories for improvement have been set for each division and are being monitored weekly.
- 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. The continuing deterioration of performance of this measure and the volume of red flags are discussed at the maternity governance meetings to seek assurance that the trigger is appropriately responded to in a timely manner and the safety of patients in the delivery suite is maintained. Recruitment of midwives has been successful, once in post, performance is expected to improve.
- There are no never events or further section 28s to report this month.
- A CQC Well Led visit took place in August 2021. The outcome from this visit is awaited.

4. Quality Exception Reports – Harm

Hospital Acquired Infections-The national standard for the Trust performance on reportable infections has been received. Our local standards are more ambitious than the national expectations set out below:

	National threshold set	Local Improvement target	Year to date	Forecast to year end (straight line)
C.difficile	49	30	9	22
E.coli	122	38	21	50
P.aeruginosa	10	3	3	7
Klebsiella spp.	24	13	8	19

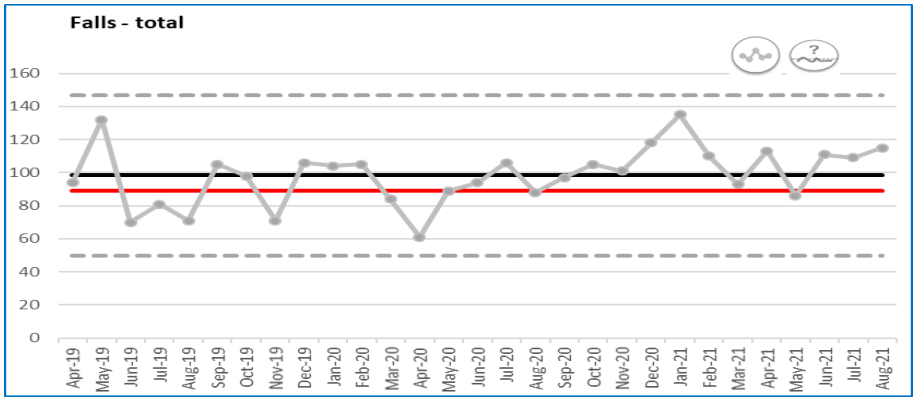
E-Coli



August 2021 actual performance
4
Variance Type
Common Cause
Local Standard
<ave.3.16pm
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 four cases of Ecoli bacteraemia in August 2021 that were taken post 48 hours of admission. The Trust has an internal improvement target of no more than 38 cases. The external target for 2021/2022 set by NHSE/I is no more than 122 cases.	In August, 2 cases were deemed to be device/intervention related In one case the source was considered to be a CAUTI, in the second case the source was considered to be a post-operative infection. The remaining two cases were considered to be urosepsis, but were not considered to be device related.	RCA are being undertaken on the two cases considered to be device/intervention related to establish any learning points • Improvement work in relation to catheter care include: • New catheter insertion and care plan to be embedded in clinical areas • Indwelling devices including catheters included on vitals • Matrons to monitor documentation around insertion. • Timely taking of samples discussed at governance meetings.	Cases where source is unknown or deemed to be device related have an RCA completed. catheter care monitored as part of the matrons monthly quality audits. Included in monthly IPC Divisional updates to IPC Ops Group. Catheter care monitored as part of the matrons monthly quality audits.

Falls

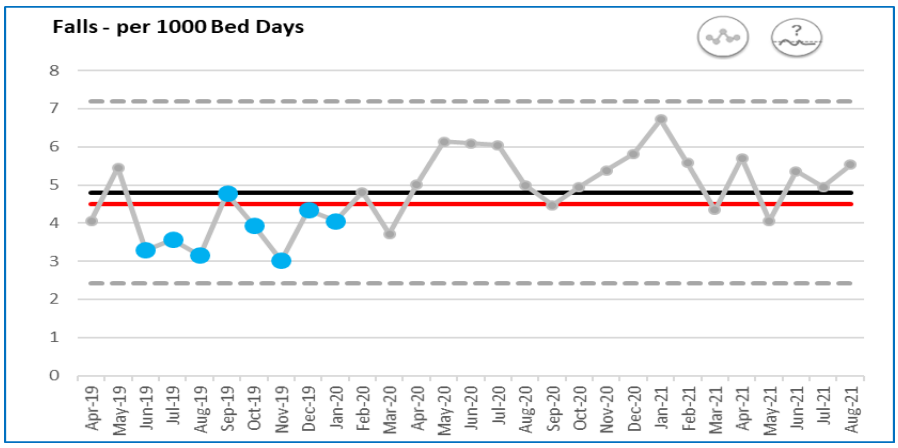


August 2021 actual performance
115
Variance Type
Common Cause
Local Target
89
Target / Plan Achievement
10% reduction on 20/21

Falls – Total per Division	Number Reported
Medical and Emergency Care	73
Surgical, Anaesthetics and Cancer	42

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 remains above the Trust improvement target. The year-end target for improvement (1074) is at risk with 534 falls reported in the first 5 months of the year.	Common themes in relation to falls includes: Lying and standing BP being recorded as part of assessment. Timely re-assessments on transfer to new ward and at least weekly or when condition changes. Neuro observations post fall as per Trust policy. Cohorting and bay tagging for patients at high risk of falls. Ensuring medication reviews are undertaken.	All falls are reviewed daily by Quality team, 96% at PRH and 91% at RSH had a falls risk assessment in place at time of fall, Overall 90% had a care plan in place and post falls documentation was completed correctly in 86% of falls reviewed. Feedback is provided to teams. Daily SQL report to ward managers to ensure lying and standing BP completed has shown improvements. Observations for unwitnessed falls monitored through daily reviews and reinforced with ward teams.	All falls are reviewed daily by the quality team to identify any gaps in pre or post falls care. Weekly falls meeting. Monthly audit of falls documentation as part of matrons quality audits. Learning from falls Sis shared at NIQAM.

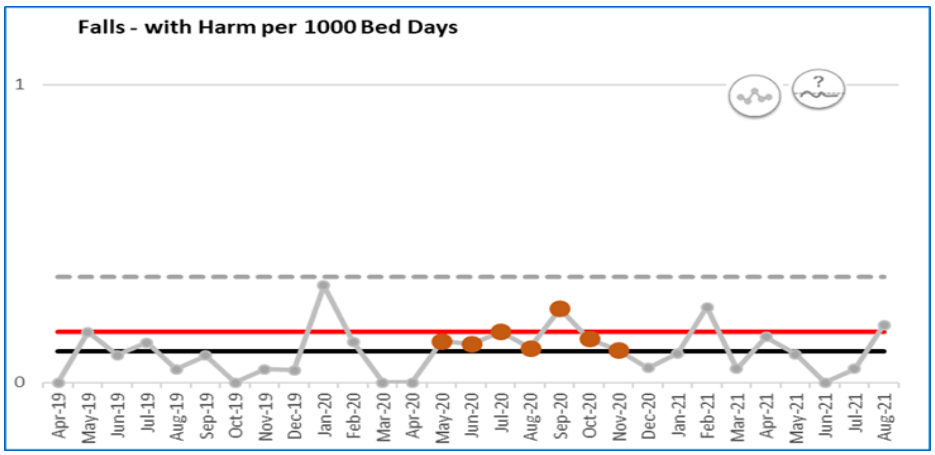
Falls – per 1000 Bed Days



August 2021 actual performance
5.53
Variance Type
Common Cause
Local Plan
4.5
National Standard
6.6
Target/ Plan achievement
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 was 1 fall resulting in moderate harm or above in August 2021.	A patient on Ward 25G fell and fractured their tibia.	Ongoing Falls improvement work continues As per falls exception report above.	As per falls exception report above.

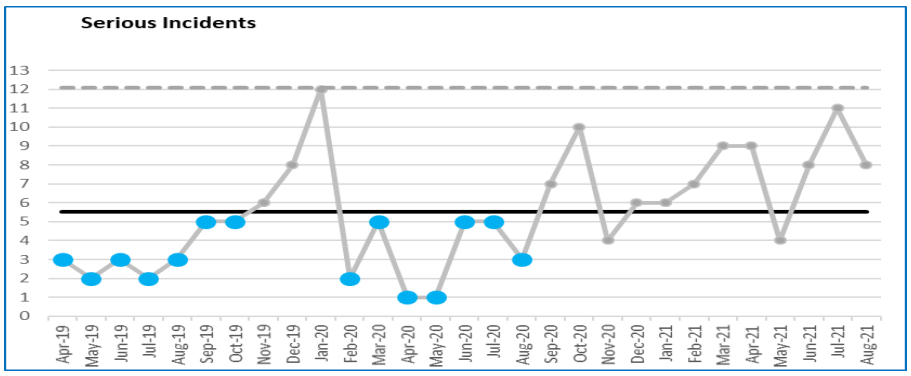
Falls – with Harm per 1000 Bed days



August 2021 actual performance
0.19
Variance Type
Common Cause
Local Target
0.17
National Standard
0.19
Target/ Plan achievement
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 remains above local improvement target but below national level.	As per falls exception report above.	As per falls exception report above.	As per falls exception report above.

Serious Incidents

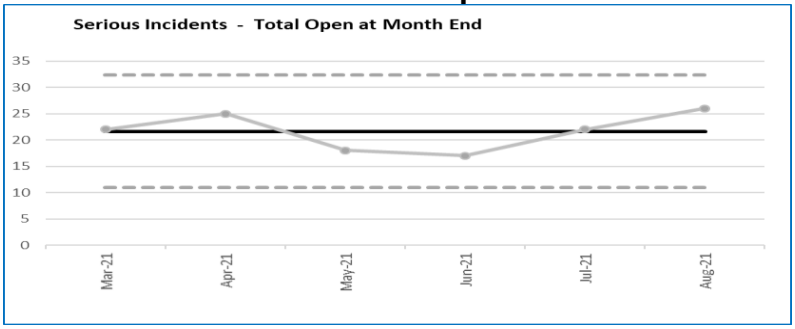


August 2021 actual performance
8
Variance Type
Common Cause
Local Standard
n/a
Target/ Plan achievement
n/a –seeking to encourage reporting of incidents

SI theme	Number Reported
Delayed diagnosis	1
Fall resulting in a fractured neck of femur	1
HCAI/IPC incident – Overarching Trust acquired COVID-19 deaths	1
Delayed diagnosis – Sickle Cell	1
Delayed diagnosis of DiGeorge syndrome (paediatric case)	1
Obstetric – Shoulder dystocia leading to Erb's Palsy	1
Obstetric – Ruptured uterus and major obstetric haemorrhage	1
Fall resulting in fractured tibia	1
Total	8

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.	July saw an increase in the reporting of Serious Incidents with a total of 11. There had been a reduction in August to a total of 8 SIs, for the same period in 2020, the Trust reported 3 SIs.	Over the coming months, COVID-19 related incidents such as delayed diagnosis due to access, issues/outbreaks and COVID-19 related deaths may 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.

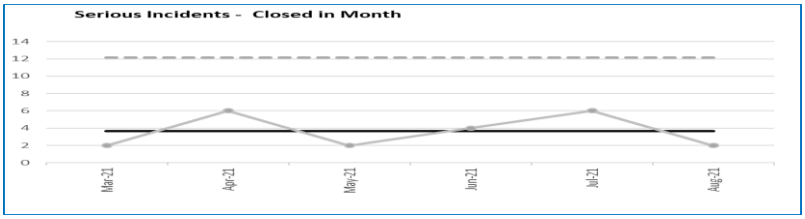
Serious Incidents – Total Open at Month End



SI – Total Open at Month End per Division	Number Reported
Medical and Emergency Care	7
Surgical, Anaesthetics and Cancer	4
Women and Children's	13
Clinical Support Services	1
Other – SaTH department	1
Total	**26**

Background	What the Chart tells us	Issues	Actions	Mitigations
Current number of open Serious Incidents.	Number of open SIs.	26 open SIs 23 within 60-day framework. 3 are awaiting final discussion and sign off (they have been to RALIG).	Monitoring of progress of investigation.	Weekly review of progress.

Serious Incidents – Closed in Month

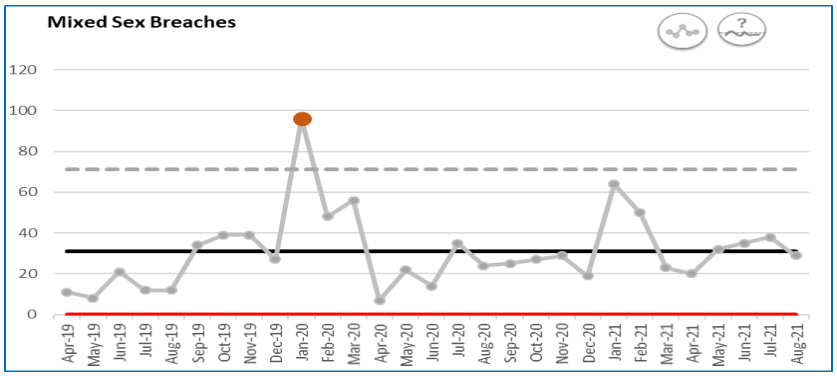


August 2021 actual performance
SATH
2

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 2 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.

5. Quality Exception Reports – Patient Experience

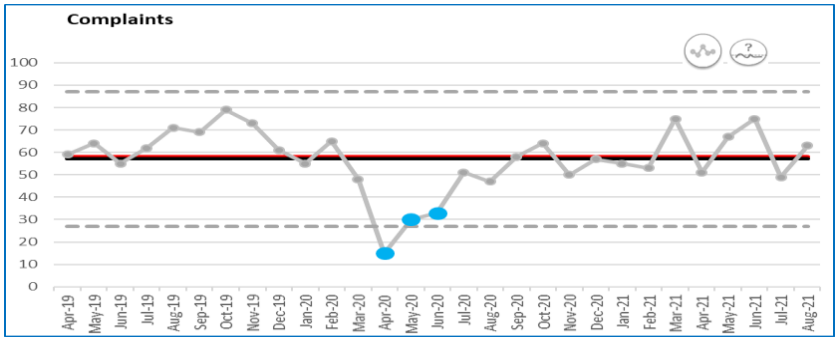
Mixed Sex Breaches Exception Report



August 2021 actual performance
29
Variance Type
Common Cause
National Target
0
Target/ Plan achievement
Continuing to breach this target.

Location	Number of breaches	Additional Information
ITU / HDU (RSH)	18 Primary (3 Medical and 15 Surgical)	
ITU / HDU (PRH)	7 Primary (6 Medical and 1 Obstetric)	
CCU (PRH)	3 Primary	3 Secondary Breach
Ward 32	1 Primary	

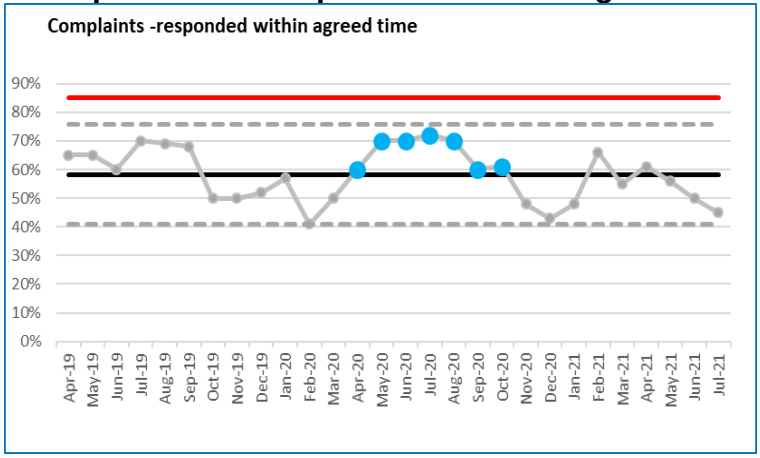
Complaints



August 2021 actual performance
63
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.	Numbers remain within common cause variation.	There has been a slight increase in complaints about appointments and waiting times, particularly within Gynaecology.	The Gynaecology Team are working to review all patients and ensure that they are correctly appointed, as well as considering how capacity can be increased.	

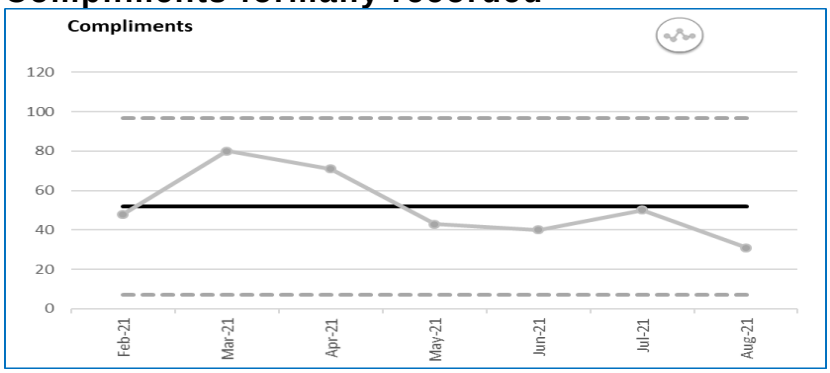
Complaints – Responded within Agreed Time



July 2021 actual performance	
45%	
Variance Type	
Common 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.	

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.	Response rates have dropped in all divisions. This is due to clinical pressures, and has been exacerbated by annual leave over the summer period.	Trajectories have been set for all divisions to clear the backlog and reach a sustainable position going forwards; this is being monitored on a weekly basis.	Regular updates to complainants Regular reviews of open cases to identify what is still needed from Divisions.

Compliments formally recorded

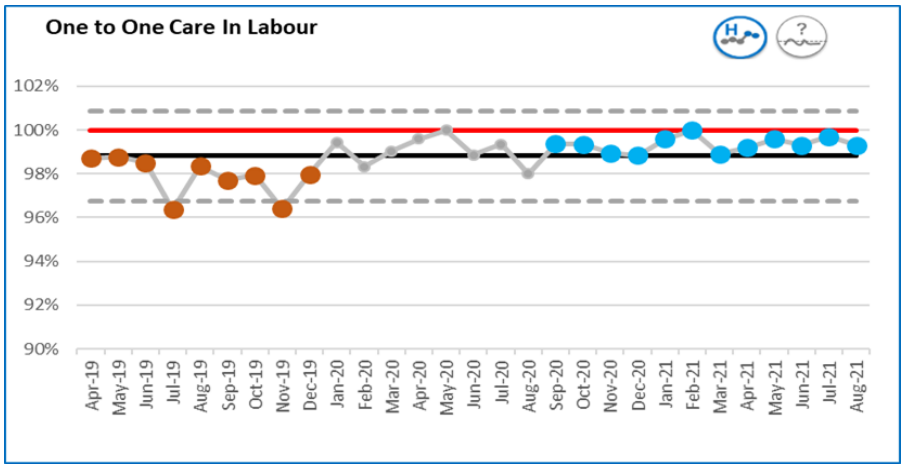


August 2021 actual performance	
SATH	
31	
Divisions	
Medicine & Emergency Care	11
Surgery, Anaesthetics & Cancer	7
Women & Children's	5
Clinical Support Services	1
Other	7

Background	What the Chart tells us:	Issues	Actions	Mitigations
By collecting data on positive feedback, the Trust will be able to identify well performing areas, and seek to spread good practice.	The number of compliments recorded has dropped, although it remains within common cause variation; it is thought that this is due to low reporting.	This is still a new system, and staff may not be aware of the need to log compliments.	Remind staff to use the Datix system to record positive feedback.	

6. Maternity Indicators

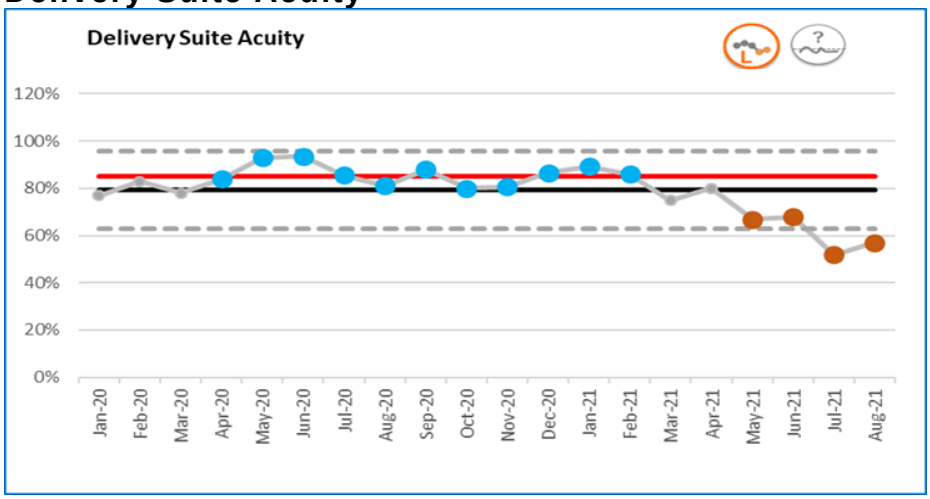
One to One Care in Labour



August 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. COVID-19 related isolations impacting staffing numbers further. A/L period on top of above pressures.	Acuity is managed by Delivery Suite coordinators and SMT huddles twice daily. Staff are redeployed once SMT huddles have been undertaken to maintain safety in areas of high acuity. Weekly SLT meetings to discuss weekly staffing challenges in place.	Incentivised bank shifts in place between 12th July end of July to improve staffing levels until vacancy rate improves. Consideration to evoking business continuity plans to support services. Escalating into daily site meetings for communication and information.

Delivery Suite Acuity



August 2021 actual performance
57%
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 5 months. This is Delivery Suite acuity only- not whole of inpatient areas.	High vacancy rate currently. Imbalance in staffing due to number of secondments in service. Some shifts unfilled across service due to vacancies, maternity leaves, COVID-19 related isolation and A/L period. Retention of staff challenging with a further 11.6 WTE new leavers identified.	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 across the whole unit. This data is data from Delivery Suite only at this time- work is ongoing to have oversight and report on whole inpatient area. Escalation used appropriately when required to maintain safe acuity across all areas. Recruitment ongoing, has been successful, with 20.6 WTE recruited midwives, due to be in post by mid/end of September. Continue to monitor	Twice daily SMT huddles in place to monitor safety and staff deployment across unit. Consideration for business continuity planning, look to proactively manage LT staffing challenges. Maternity Matrons reporting daily into Site meetings at 15.00 to communicate and inform when high acuity and staffing challenging.

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.

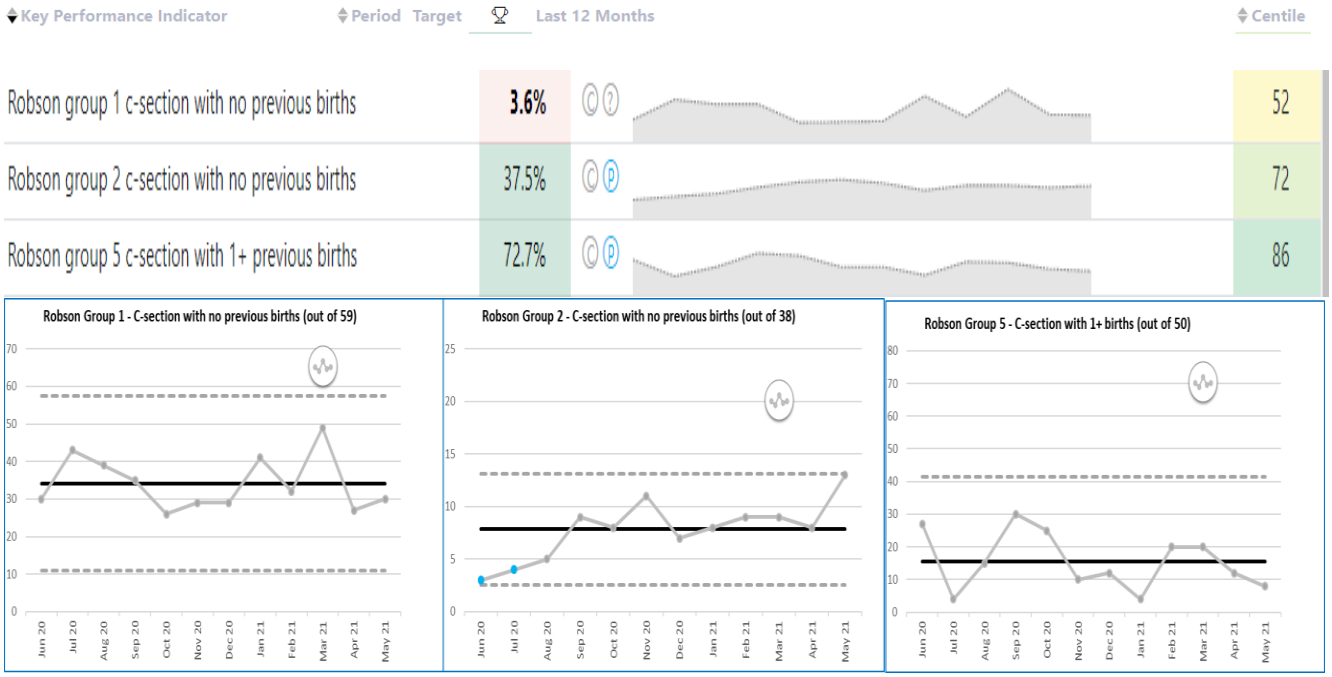
The system classifies all women into 10 mutually exclusive categorises using 5 obstetric characteristics.

Our benchmarking data reports on 3 Robson scores up to April 2021 and demonstrates performance as follows:

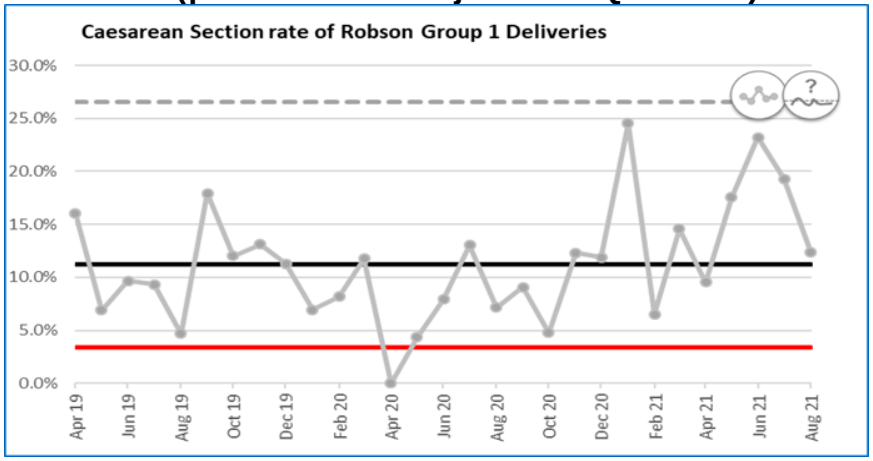
Women in Robson Group 1: having a caesarean section >37weeks with no previous births, spontaneous labour

Women in Robson Group 2: having a caesarean section>37weeks with no previous births and had either labour induced or delivered by C-section before labour

Women in Robson Group 5: having a caesarean section>37weeks with at least one previous birth by C-section.

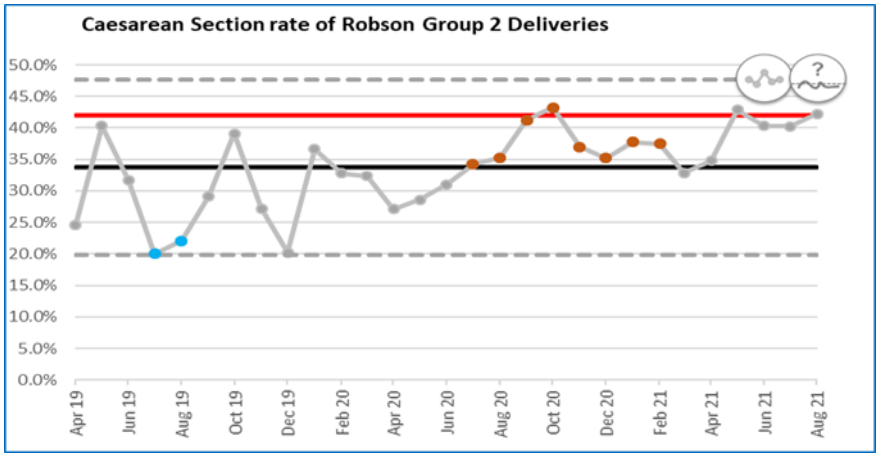


Caesarean Section Rate - Robson Group 1 Deliveries(provisional subject to DQ review)



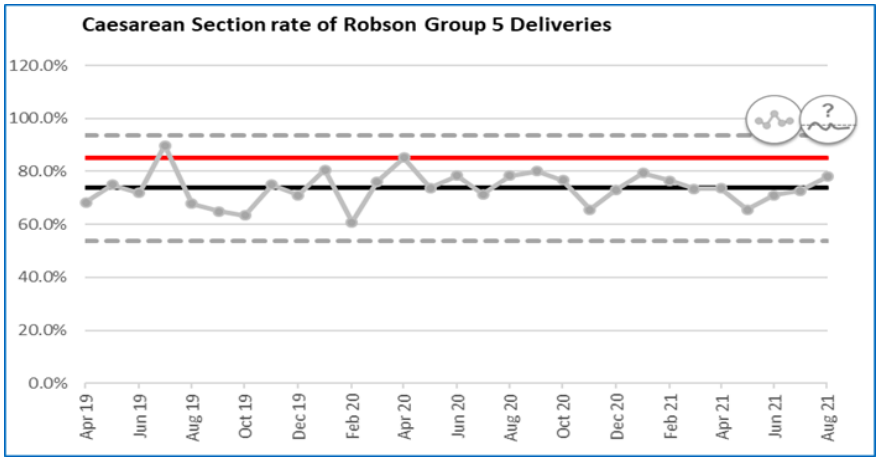
August 2021 actual performance
12.3%
Variance Type
Common Cause
Expected Range
3.4% (Public View)
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

Caesarean Section Rate - Robson Group 2 Deliveries



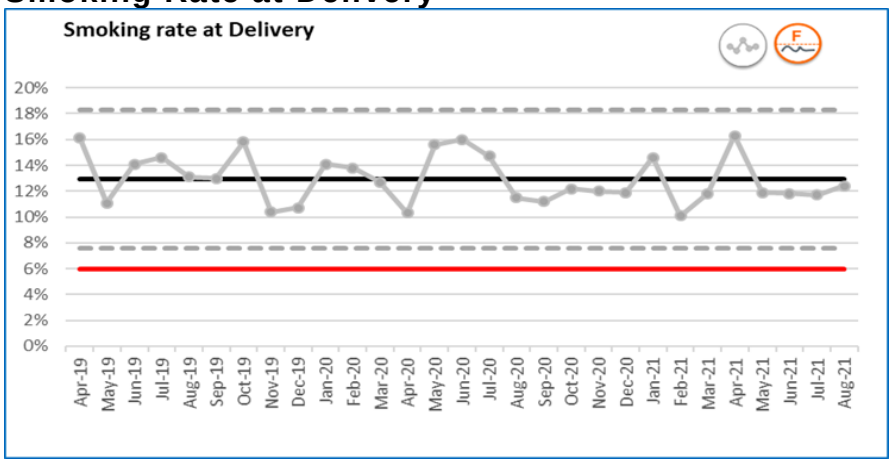
August 2021 actual performance
42.3%
Variance Type
Common Cause
Expected Range
42% (Public View)
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

Caesarean Section Rate - Robson Group 5 Deliveries



August 2021 actual performance
78%
Variance Type
Common Cause
Expected Range
85% (Public View)
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

Smoking Rate at Delivery



August 2021 actual performance
12.4%
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	Minimal change since previous month's data- rates consistent at	As in previous months, unable to support partners to quit at present.	Healthy Pregnancy Support Service (HPSS) will provide family support for smoking	Once again, government target may be difficult to

smoking at time of delivery has been set to 6% by March 2022. All pregnant smokers in Shropshire and Telford and Wrekin are referred to and supported by the Public Health Midwifery team based at PRH.	present across the county with no unexpected anomalous data. 2% higher than national average for SATOD and more than 6% higher than government target.	County services for general smoking cessation support are present in Telford and Wrekin but not present in Shropshire causing inequity In access to services. Areas of severe deprivation across county (some wards in top 10% nationally)-require targeted support due to social complexities.	cessation alongside other pressing health issues such as obesity in the form of weight management support. Deprived areas will be targeted to encourage access to visible services in the community. Adverts to recruit to team are now live.	achieve by March 2022, in view of the local demographic and current smoking rates.

7. Workforce Summary

Rhia Boyode, Director of People and Organisational Development.

- August was an exceptionally busy month for medical recruitment with the annual junior doctor induction-taking place.

- A total of 136 new doctors joined the Trust in with many others rotating internally.

- There were 19 bank appointments made in August, many of which are doctors in training who wish to continue working with SaTH after rotating to other Trusts within the West Midlands.

- Overall workforce growth has continued to increase however is below plan due to delays with the 2021 international recruitment programme. We expect to have another 84 nurses to arrive before Christmas and we are in the process of recruiting another 45 which we aim to recruit by February 2022.

- Overall vacancies reported in July was 378, the August position is being validated. Work is underway to review our staffing strategies which include how we use our existing staff efficiently (improved rostering), maximising temporary staff (higher volume at lower cost), supporting our international recruits and creating a more flexible workforce.

- 79 FTE leavers in August, which is above average for the previous 12 months. 33% (26FTE) of leavers in August had less than 12 months service. Interviews have taken place with staff who have left in their first year to provide a deep dive understanding of reasons for leaving. These include work life balance, relationships with colleagues or managers, promotion outside of the Trust and majority of reasons relating to personal circumstances. Work underway to ensure we support flexible working patterns including monitoring of roster approval times to promote better work-life balance.

- Mandatory training rate has reduced by 1% to 85% from last month and we have seen an increase in the number of staff not attending training following a booking. This reflects the increase in hospital site pressures and an increase in annual leave over August. There has been a 3% increase in Safeguarding Children Level 3, which is encouraging.

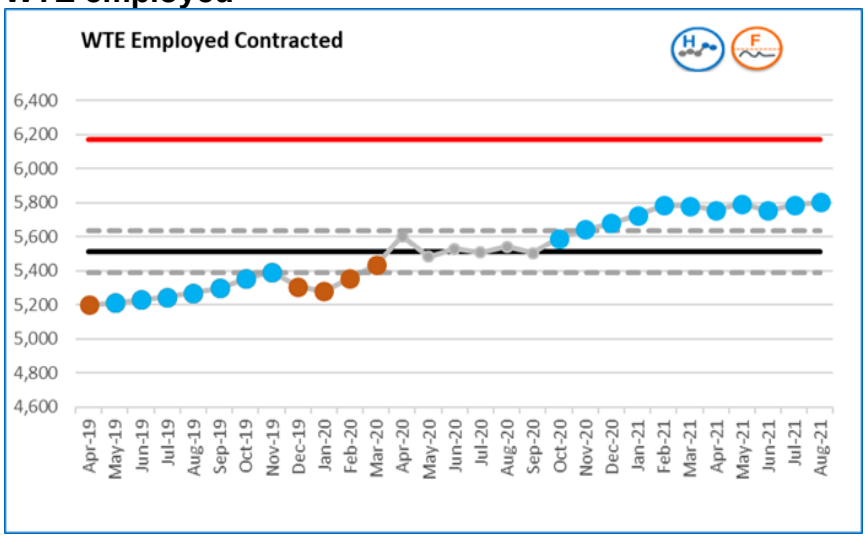
- New Learning Management System purchased with implementation started. Pilot in Maternity in October. E-Learning reminder emails continue to be generated and sent to all staff who are non-compliant.

- Appraisal rate maintained at 87%, which is the highest rate in the last 12 months. Focused support is being provided to the managers of any ward that is below target.

- COVID-19 related absence continue at high levels during August with increasing levels of staff testing positive and requiring to isolate due to members of the household testing positive. Non-COVID-19 sickness has increased to 5.2% in August and nursing and midwifery sickness is at the highest level for the previous 12 months.

- Lateral flow reporting rates have increased this month to 18%, reports now available showing managers which staff have returned results and to show rates for their teams and departments.

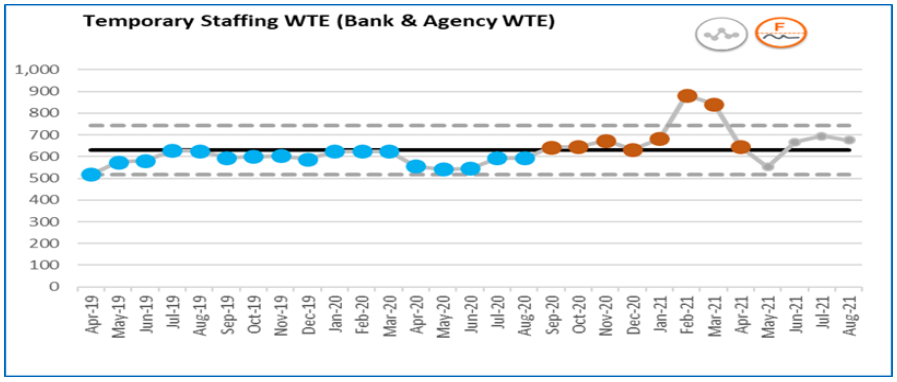
WTE employed



August 2021 actual performance
5805
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 2020, 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 along with higher overall levels of unavailability than planned.	Recruitment activity continues to increase staffing levels. Promote timely roster approvals to maximise opportunities for bank utilisation.	Utilisation of bank and agency staff to support workforce gaps.

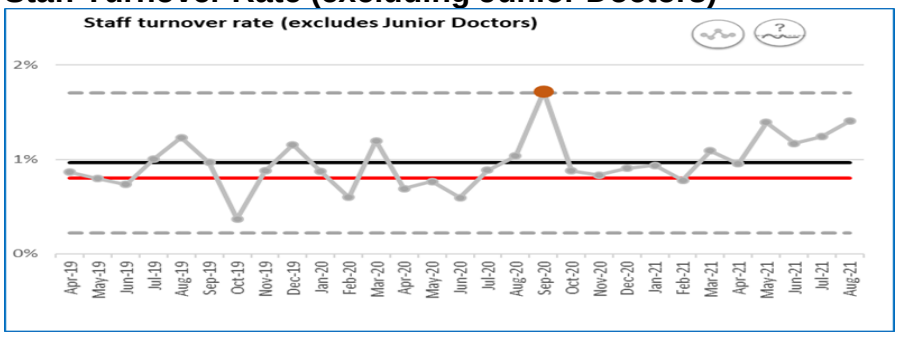
Temporary/ Agency Staffing



August 2021 actual performance
676
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 Aug21.	Staff absences attributed to both sickness (non-COVID-19) and COVID-19 related absence due to requirements to isolate 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 at risk areas. Progress with recruitment activities to increase substantive workforce including international nurses.

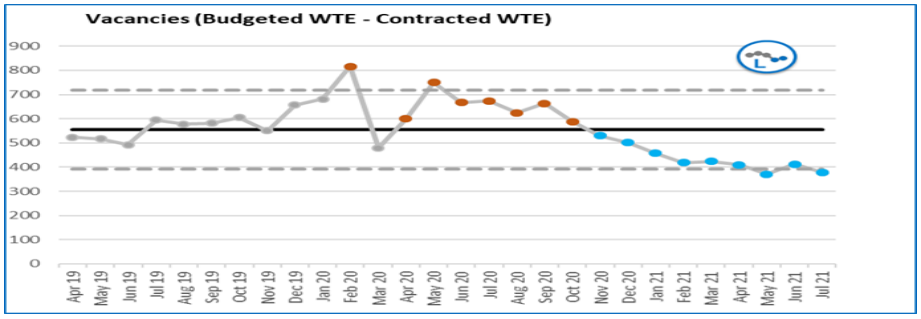
Staff Turnover Rate (excluding Junior Doctors)



August 2021 actual performance
1.4%
Variance Type
Common Cause
National Target
0.8%
Target / Plan Achievement
Target not achieved

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 Aug 21. However the last 4months have seen data points above the mean requiring on-going monitoring to reduce the risk of special cause.	79 FTE leavers in August, which is above average for the previous 12 months. 33% (26FTE) of leavers in August had less than 12 months service. 198FTE leavers over the last 12 months had less than 1 years' service with 32% (63FTE) of those leaving with a destination of no employment. 26% (44FTE) of leavers within nursing and midwifery staff group is due to work life balance. Work life balance remains the highest reason for leaving over the last 12 months with 18% (123FTE) of staff leaving for this reason.	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. Ongoing work to adopt recommendations within the NHS People Plan regarding supporting staff to adopt flexible working practices. Improvement initiatives to improve culture and work-life balance. Monitoring of roster approval times to promote better work-life balance.	Recruitment activity to help ensure minimal workforce gaps. Utilisation of temporary workforce to maintain suitable staffing levels.

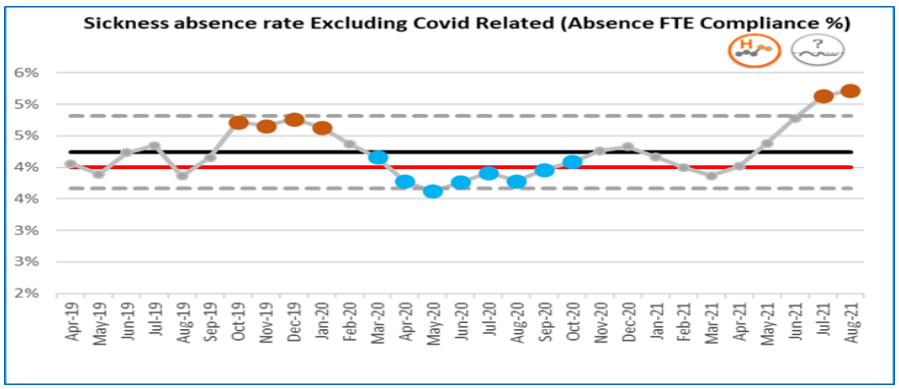
Vacancies



July 2021 actual perfrmance
378 (6.5%)
Variance Type
Special Cause
National Target
<10%
Target / Plan Achievement
Better than target level of performance

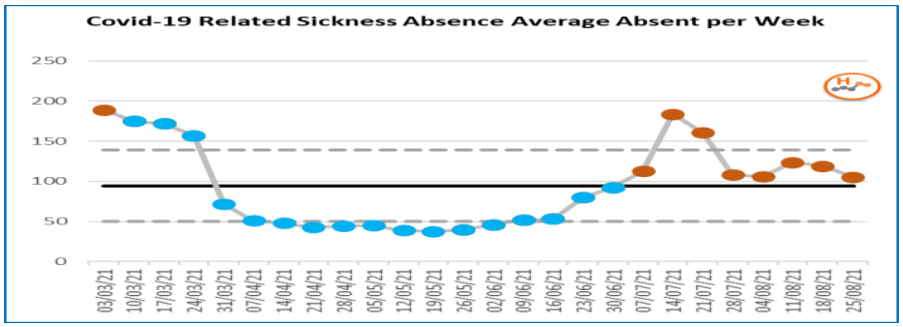
Background	What the Chart tells us	Issues	Actions	Mitigations
This is a measure of the gap between budgeted WTE and contracted WTE.	Special cause improvement between Nov20 – Jul21. August position being validated.	Shortfall in gap between contracted WTE and budgeted WTE continues to put pressure on bank and agency usage. Revised budget position received in Aug21 is being validated.	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. Review of fixed term working arrangements to support retention of staff and engage new recruits.	Recruitment activity continues to reduce workforce gaps. Use of temporary staff to cover vacant posts.

Sickness Absence



August 2021 actual performance
5.2%
Variance Type
Special Cause Concern
National Target
4%
Target / Plan Achievement
4%

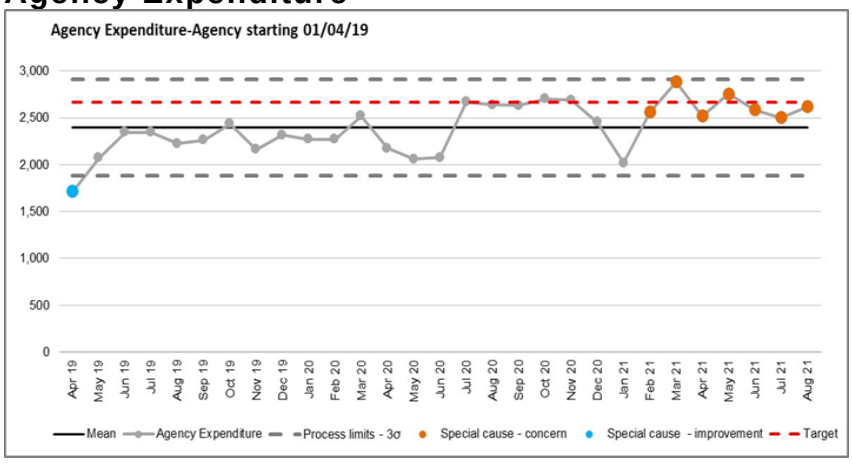
Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of staff sickness absence and is a % of FTE calendar days absent. COVID-19 related sickness and absence is not included.	Special cause improvement between Mar 20 and Nov 20 with common cause variation through Dec 20 to June 21. July 2021 saw special cause concern with an increase in the sickness absence reported which is continuing in August 2021.	Absence attributed to mental health continues to be high with 215 episodes equating to 101FTE in August. Absence levels attributed to other musculoskeletal, other known causes and gastrointestinal all remain high. Estates and facilities remains the staff group with the highest absence % at 8.9% (44FTE) with additional clinical services at 6.7% (77FTE) and nursing and midwifery at (103FTE) 6.1%. Nursing and midwifery sickness in August is at the highest level for the previous 12 months.	Continue to promote health and wellbeing initiatives. HR team supporting with welfare conversations. Care for you days to help provide additional respite and recognise efforts made by colleagues. Embedding of new employee wellbeing and attendance management policy. Work to highlight importance of return to work conversations.	Work with temporary staffing departments to ensure gaps can be filled with temporary workforce where necessary.



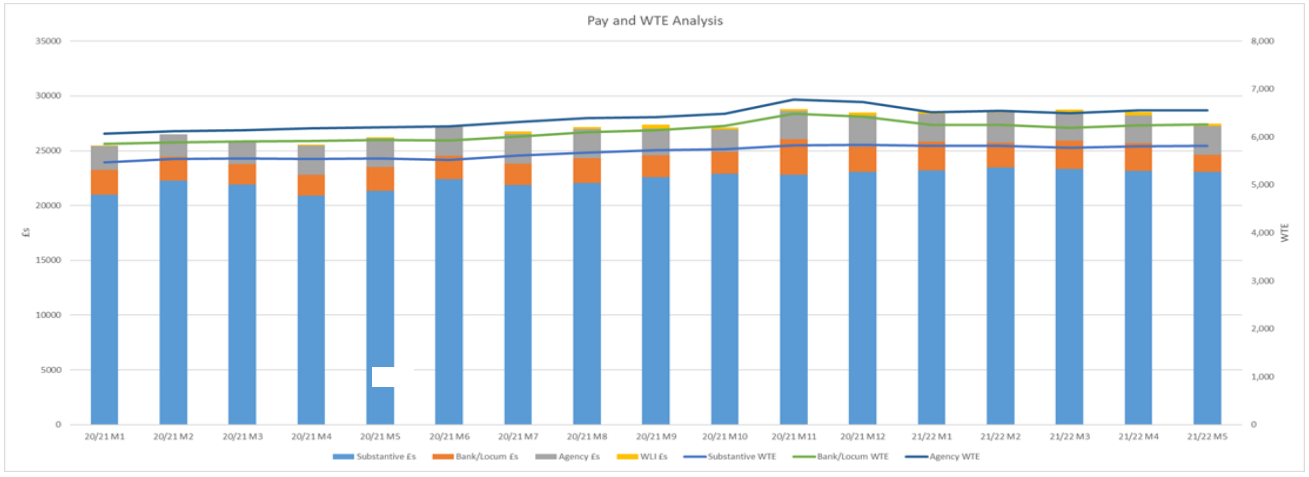
25th August 2021 actual performance
105
Variance Type
Special Cause Concern
National Target
N/A
Target / Plan Achievement

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 concern in August.	COVID-19 related absence continue at high levels during August with increasing levels of staff testing positive and requiring to isolate due to members of the household testing positive. Increase in COVID-19 related absences have presented additional staffing challenges.	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. Continue risk assessments for staff identified as contacts.

Agency Expenditure

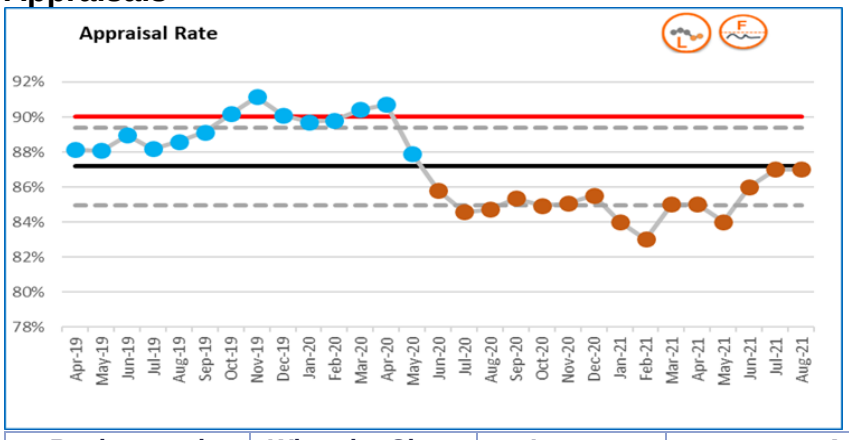


August 2021 actual performance	
£12.980m ytd spend	
Variance Type	
Underspend	
National Target	**SaTH Plan**
£2.860m	£2.860m
Target/ Plan achievement	
£0.473m favourable variance.	



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 this target needs to be updated to reflect the current regime. Agency costs were £2.616m in the month, in line with the Q1 average spend but slightly up on previous month which is due to increased Nursing costs in Medicine.	Due to workforce fragility the Trust is consistently overspent against its agency ceiling. There has been a significant increase in the use of agency Health Care Support Workers linked to an increase in acuity and 1:1 care.	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, 20/21 and 21/22. 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.

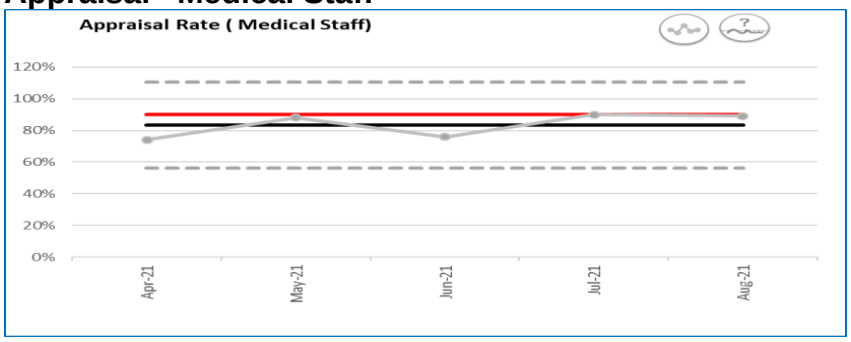
Appraisals



August 2021 actual performance
87% (89% Medical Staff)
Variance Type
Special Cause Concern
National Target
90%
Target / Plan Achievement
Below target level of performance

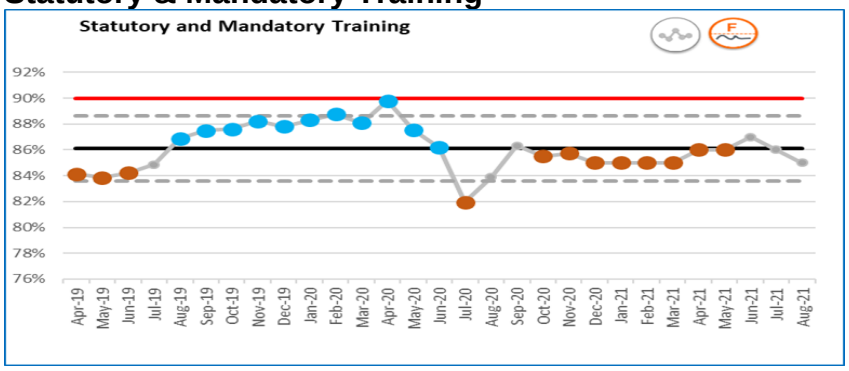
Background	What the Chart tells us:	Issues	Actions	Mitigations
The measure is a key indicator for patient safety in ensuring staff are compliant in having completed their annual appraisal.	The 90% target was achieved January to April 20 then started to drop and has remained below target, however, this month has risen to 87% 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. This support has been extended to further areas. 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 will continue to send 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.

Appraisal –Medical Staff



August 2021 actual performance
89%
Variance Type
Common Cause
National Target
90%
Target / Plan Achievement
90%

Statutory & Mandatory Training

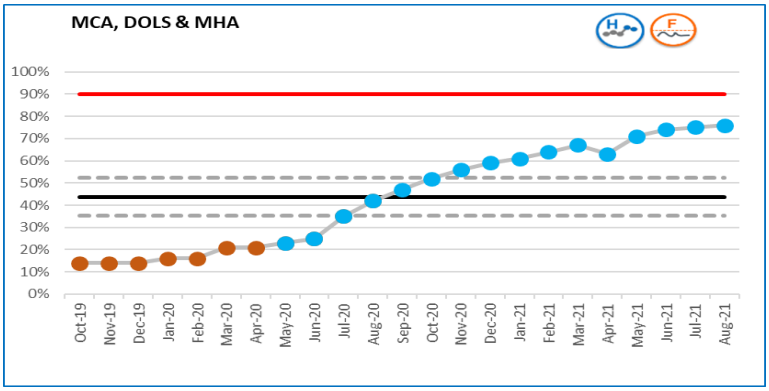


August 2021 actual performance
85%
Variance Type
Common Cause
National Target
90%
Target / Plan Achievement
The target is above the upper process limit

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
83%	**91%**	**80%**	**96%**	**87%**	**77%**	**75%**	**90%**	**80%**	**88%**

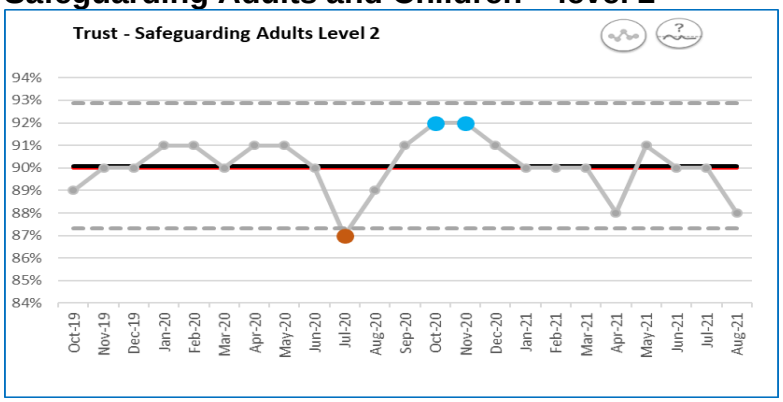
Background	What the Chart tells us:	Issues	Actions	Mitigations
The measure is a key indicator for patient safety in ensuring staff are compliant in having completed their training needs.	Dropped 1% to 85% from last month. 3% improvement in Safeguarding Children Level 3.	The DNA rate increased to 35% this month. CV-19 &, 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. Increased annual leave taken during August due to holiday season	Corporate Education is working with Care Groups to identify and reduce data conflicts. Corporate Education is supporting additional Ward/Dep managers to prioritise and schedule training completion and validate data within the report. New Learning Management System purchased – implementation started. Pilot in Maternity in October. E-Learning reminder email. Continue to be sent to all staff who are non-compliant. Corporate Education requested proxy facility to support remote e-learners effectively.	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

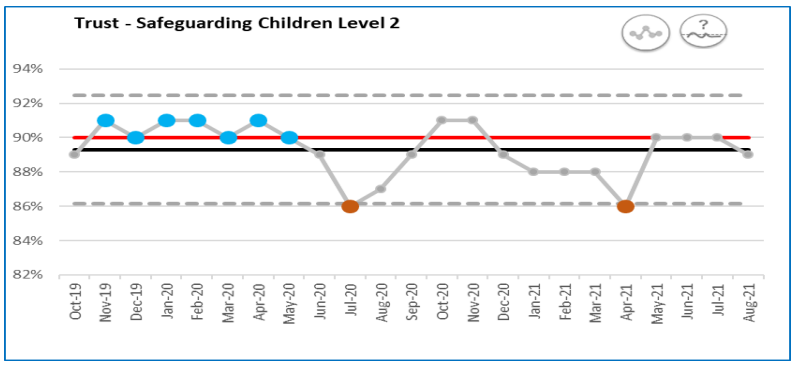


August 2021 actual performance
76%
Variance Type
Special Cause Improvement
National Target
90%
Target / Plan Achievement
Improvement trajectory in place to deliver at end of Q3

Safeguarding Adults and Children – level 2



August 2021 actual performance
88%
Variance Type
Common Cause
National Target
90%
Target Achievement
90%



August 2021 actual performance
89%
Variance Type
Common Cause
National Target
90%
Target Achievement
90%

8. Operational Summary

Nigel Lee, Chief Operating Officer

August continued the trend of being a busy month for urgent and emergency care activity, a challenging month for workforce availability and one where performance delivery was significantly pressured in both emergency and elective/cancer activity. The month also saw COVID-19 activity rise once again, and both sites maintained a COVID-19 ward for high risk and COVID-19 patients; this increased to 2 wards at RSH from the end of August. The inpatient numbers have been between 30-35, with between 3-7 COVID-19 positive patients in critical care.

Urgent care pressures dominated the Trust over the month; demand remained high and acuity of patients is also remaining high. Flow through the Emergency Departments (EDs) has been very pressured at times, due to volume of demand at peak periods, workforce pressures and flow to and out of wards on both sites. The RSH site has been especially pressured, with the age and acuity profile remaining high, but also the combination of medicine and surgery demand (RSH is our single emergency surgery centre).

The Trust has seen a high level of 12 hour breaches and ambulance handover delays as a result. The Trust has worked closely with the West Midlands Ambulance Service (WMAS) to

seek options to support more timely offload; in addition WMAS have cohorted patients (i.e. one crew taking responsibility for more than 1 patient), and this has been inside the ED. Patients have therefore been in a more comfortable environment, but have still been recorded as a delay. ED clinicians regularly review the patients waiting, and also prioritise with ambulance crews in order that clinically urgent patients are seen more swiftly.

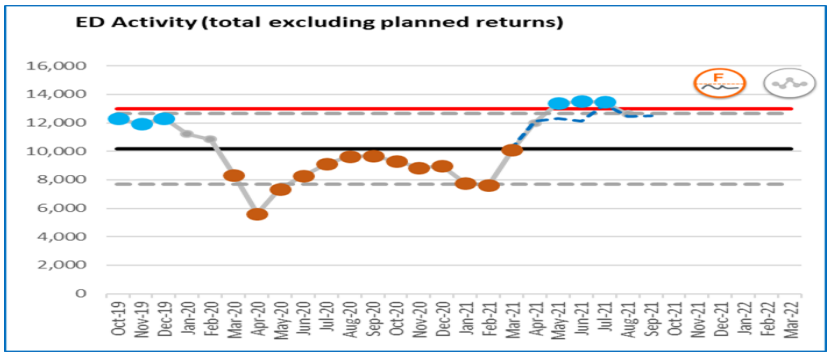
The Trust is also working across the health and care system on the whole system patient flow. Workforce and capacity pressures are a feature in many sections of the system, such as community services and domiciliary care. The number of patients who are medically fit but waiting for placements has risen, as has the length of time before the discharge is able to take place.

For elective activity, the Trust continues to clinically prioritise patients, including those requiring surgery. However, the urgent care demand has meant that elective inpatient orthopaedic activity has remained stepped down at Telford (with the Trust working jointly with Robert Jones and Agnes Hunt Orthopaedic Foundation Trust to pool inpatient orthopaedic activity and to prioritise together); similarly at Shrewsbury, the high priority elective cases (largely cancer cases) are now based in the Day Surgery Unit, meaning that both sites inpatient capacity is focused on supporting COVID-19 and Urgent Care. Daycase activity is managed through both sites, and the Vanguard integrated theatre and recovery unit will remain based at Telford. Additional capacity from insourcing and outsourcing has continued, and the system has developed a number of schemes for implementation for Q3 and 4, subject to the national planning and financial framework. The backlog of patients on RTT pathways continues to be closely monitored; whilst the numbers of patients >52 weeks remaining fairly stable, the numbers over 78 weeks (primarily on the lower priority admitted pathways) are still rising.

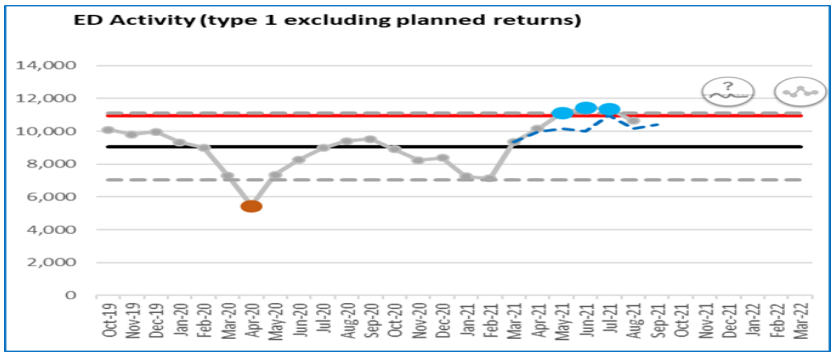
Our cancer pathways are also under significant pressure, with some specialist workforce challenges (such as Oncology) and also capacity pressures especially in imaging. Whilst CT activity in August was at 100% of the level delivered in 2019/20, this is not sufficient to meet the demand and to reduce backlogs; the Trust is introducing a new 'pod' with 1 MRI and 1 CT scanner in early September, but workforce constraints mean that this will begin to come on line in late October. In the meantime, the Trust is looking at the options for securing mobile CT capacity in Q3 (of note this scarce capacity has been managed at a national level since April).

The Trust is working to carefully plan for the next 6 months, to understand the likely forecast for COVID-19 impact, as well as RSV and flu, alongside managing the urgent care demand and optimise delivery of the cancer and other elective activity given the significant capacity and workforce constraints that we are balancing.

ED Activity



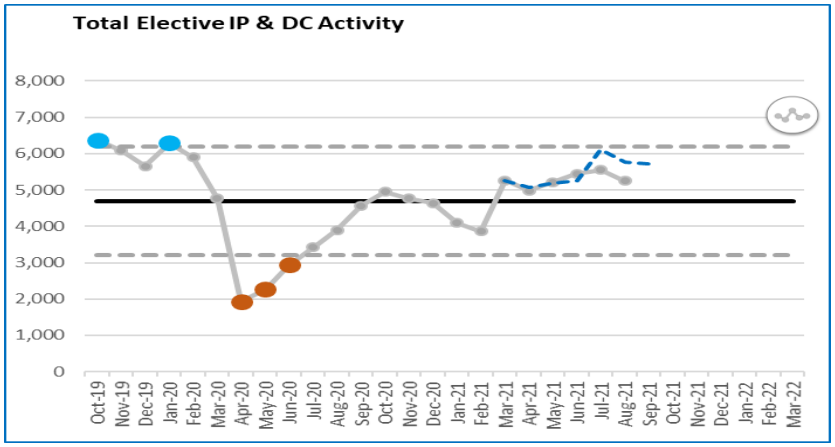
August 2021 actual performance
12630
Variance Type
Special Cause Improvement
Local Target
13297 (H1 Plan)
Target/ Plan achievement
Trajectory Based on H1 plan



August 2021 actual performance
10632
Variance Type
Special Cause Improvement
Local Target
10975 (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 year to date run rate is higher than planned and higher than the recovery trajectory, although slightly lower than the baseline 2019 figure reflected in the H1 plan for this particular month.	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 and Surge plan being developed. Admission avoidance scheme supported through system investment committee.

Elective IP & DC Activity v H1 recovery plan

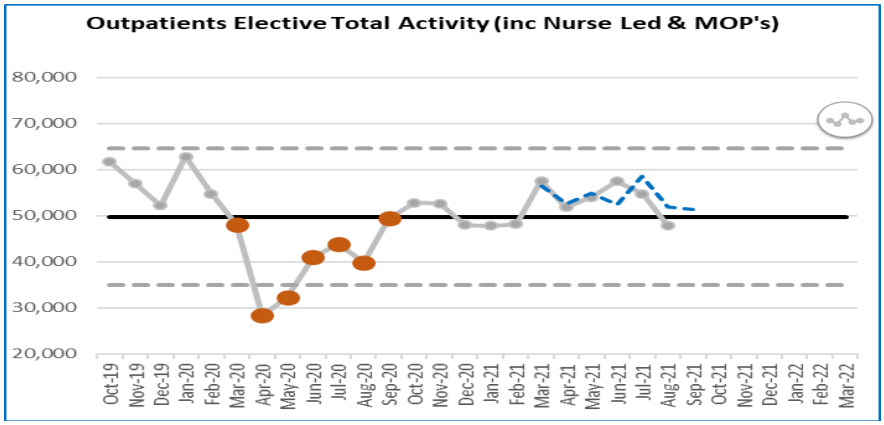


August 2021 actual performance
5251 (86.4% recovery) (IP 314, DC 4937)
Variance Type
Common Cause
National Target
National DC & IP 95%
Target/ Plan achievement
H1 86.4% achieved –above original target, below revised target introduced mid-July

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 July 2021	Performance is tracking is slightly below the H1 plan trajectory and remains lower than August 19/20.	Controlled drug key holders are an issue in theatre and extra substantive staffing are require to support this. Short notice cancellations by patients and the	Review lists to ensure optimising throughput of lists running Ensure 6-4-2 theatre	Patient clinically prioritised if lists need to be cancelled.

increased to 95% of the July 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). .	Elective IP plan was not delivered. The plan is below the threshold set and in-patients particularly remains an area of challenge. The Daycase activity was also lower than plan. Therefore, the combined elective activity was lower than plan.	inability to backfill due to swabbing. Staffing vacancies in theatre reducing the number of lists available. Bed capacity reduced with loss of orthopaedic elective beds on Ward 36 to medical patients.	meeting optimises utilisation of lists. Recruitment of theatre staff	

Outpatients Elective Total Activity

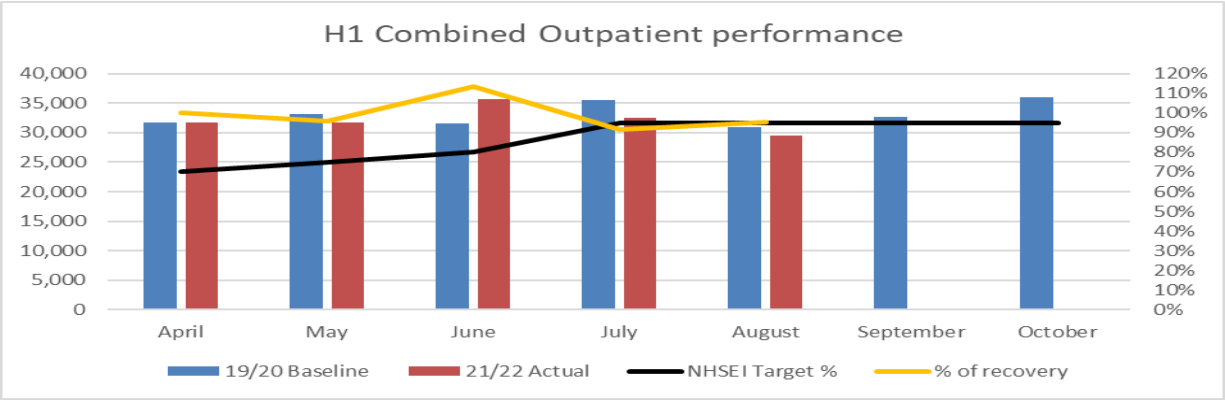


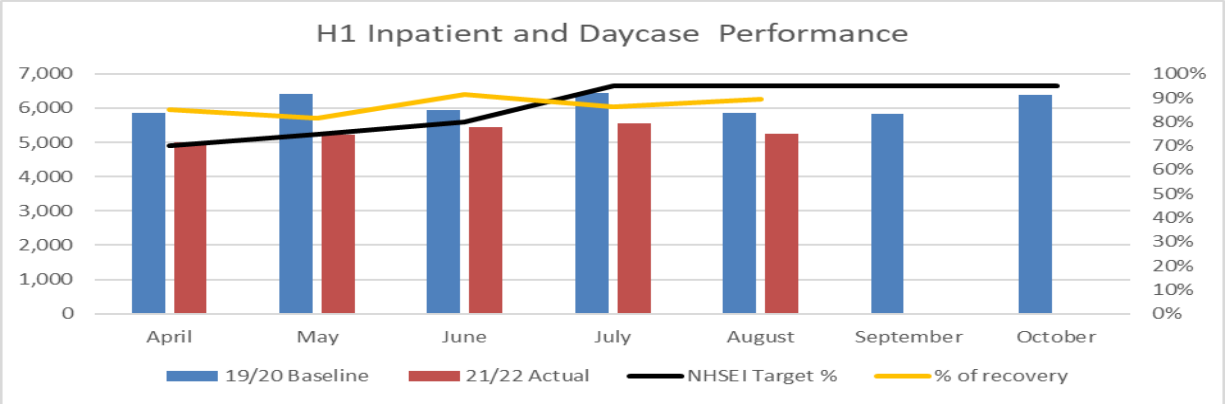
August 2021 actual performance
47916
Variance Type
Common Cause
Local Target
58650 (H1 plan)
Target/ Plan achievement
Aim to deliver H1 plan

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.	Activity below target and below plan.	The availability of outpatient capacity remains constrained due to staff leave and COVID-19 isolation. Staff absences due to self-isolation have some impact on lists running.	WLIs Bank staff to support outpatient staffing.	Patients prioritised in terms of clinical priority i.e. 2WW, urgent.

From April 2021 – September 2021 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 2021 to reach 85% of the July 2019 activity by July 2021 and sustain this level in August and September. This threshold from July 2021and onwards has been increased by NHSEI to 95% of the July 2019 activity. Achievements above these thresholds are incentivised via the ERF scheme providing the other gateway 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 -August 2021 and the forecast for July – October 21. The diagnostic recovery plan is shown in the next section of the report.

The activity in August fell below our H1 plan and does not deliver the new the revised ERF threshold.



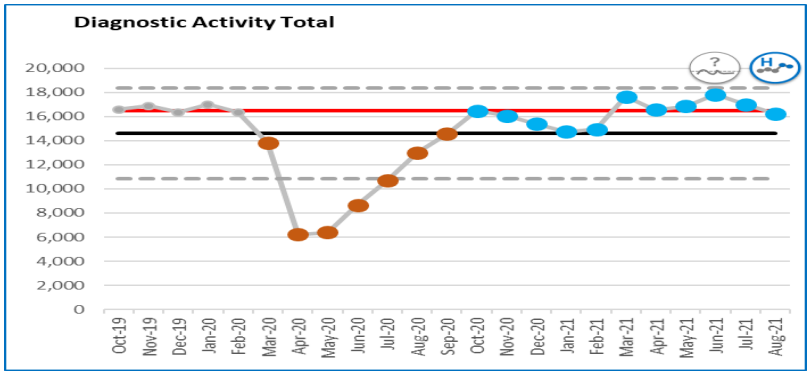


Diagnostics Recovery v H1 plan (national target is 70% April, 75% June, 80%, 95% July onwards of 2019-20 baseline).
Provisional activity data for August shows good recovery in a number of modalities, however this is not alone sufficient to meet demand and start to reduce the backlog of patients waiting for diagnostics:

Indicator Name	19/20 Baseline	21/22 Actual	21/22 Actual % of 19/20 Baselir
Diagnostic Tests - Magnetic Resonance Imaging	2375	2238	94.2%
Diagnostic Tests - Computed Tomography	5916	5922	100.1%
Diagnostic Tests - Non-Obstetric Ultrasound	5397	4783	88.6%
Diagnostic Tests - Colonoscopy	485	514	106.0%
Diagnostic Tests - Flexi Sigmoidoscopy	346	158	45.7%
Diagnostic Tests - Gastroscopy	544	592	108.8%
Diagnostic Tests - Cardiology - Echocardiography	724	1058	146.1%

It is noted that the clinical pathway to flexi-sigmoidoscopy has changed with FIT testing being introduced and so this service has been reconfigured to reflect the change and lower resulting demand and therefore the activity is not expected to need to be at 2019 levels with capacity shifted to support colonoscopy.

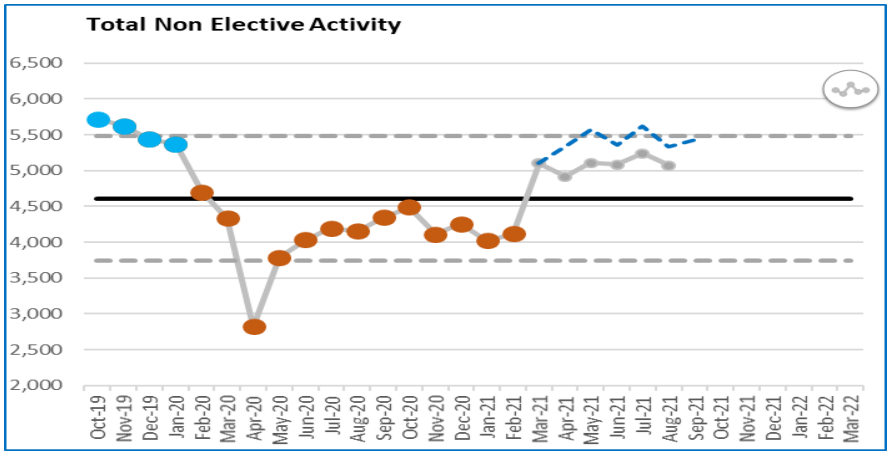
Diagnostics recovery



August 2021 actual performance
16216
Variance Type
Special Cause Improvement
Local Target
16500 (based on Apr-19-Feb-20 average)
Target/ Plan achievement
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 with performance close to the 2019-20 baseline.	Radiology activity continues to be significantly affected by staffing difficulties caused by vacancies, sickness and need to isolate. This has led to cancellation of lists, particularly in CT and MRI. This is reflected in DM01 performance, which has dropped for both CT and MRI. This is affecting cancer patients on treatment pathways with a growing surveillance backlog and increasing wait for initial diagnostic tests and results.	Appointment templates regularly updated to maximise available staff and capacity. Ongoing recruitment. Voluntary overtime. Dual-trained Radiographers being redeployed from MRI into CT to increase capacity. Recruitment of additional radiographers to staff the new CT and MRI scanners in the POD (4 wte recruited)	5 newly qualified Radiographers have started in post through July-August. Workload continues to be prioritised in terms of urgent and acuity. D values introduced and reported.

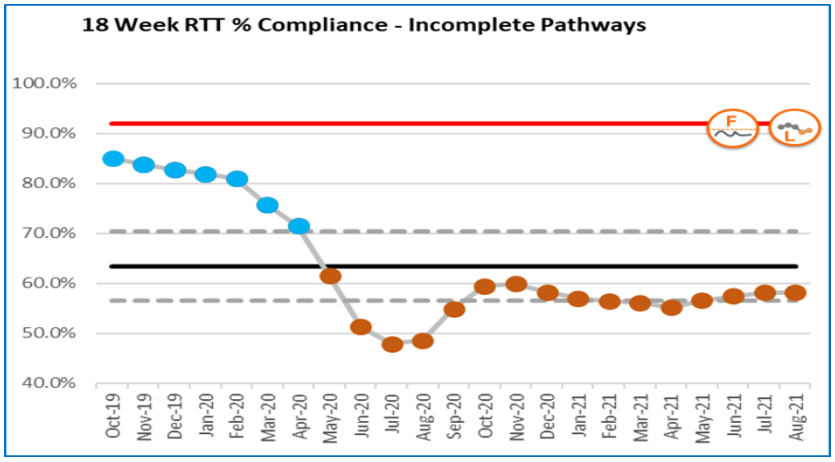
Non-Elective Activity



August 2021 actual performance
5074
Variance Type
Common Cause
Local Target
5623 (H1 plan)
Target/ Plan achievement
Demand is forecast 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.	Increase in non-elective activity across scheduled care. However, activity remains slightly lower than the 2019-20 baseline in the H1 plan and lower than the trajectory shown on the graph.	Increase in proportion of non-elective activity presenting via ED. Increase in time from MFFD to discharge, slightly increasing overall length of stay and resulting in flow issues within the sites. Increase in COVID-19 admissions and need to segment patients on both sites Anticipated increase in surgical emergencies	Dedicated CEPOD surgeon and list to support demand – clinical prioritised if needed by clinical teams. Elective capacity reduced to increase access to beds and segmentation of COVID-19 patients, with elective activity within day case unit.	See actions.

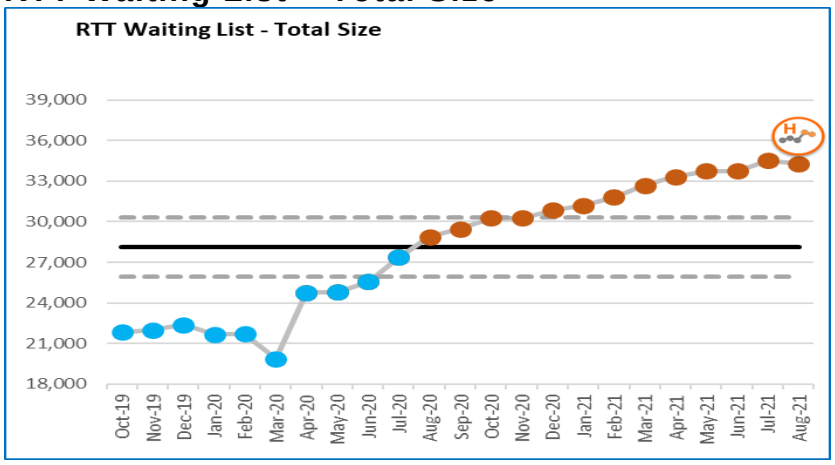
18 week RTT Exception Report



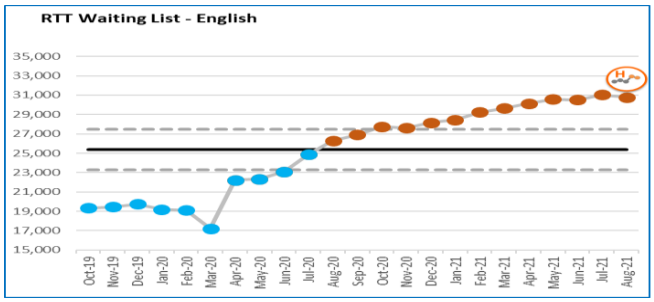
August 2021 actual performance
58.15%
Variance Type
Special Cause Concern
National Target
92%
Target / Plan Achievement
Due to the size of the backlog developed, the target will not be achieved. Local plan focuses on clinically prioritised patients.

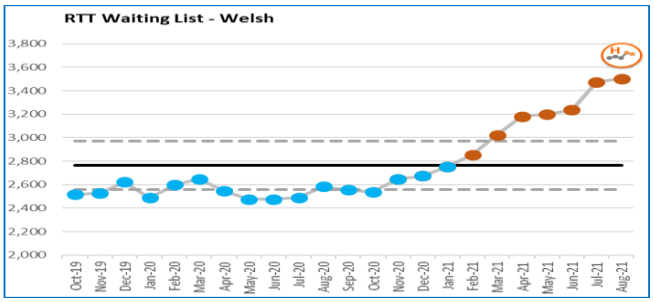
Background	What the Chart tells us	Issues	Actions	Mitigation
Headline performance against this measure has now stabilised (58.15% Aug compared to 57.48% at end July and 56.6% at end May 2021) but this compares to a much better performance with 18 week compliant pathways before the Pandemic commenced.	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. Urgent referrals rates including Cancer demand returning to pre COVID-19 rates, impacting on routine capacity. Total list size increased because of the inability to treat clinically routine patients and close RTT pathways.	Referral demand/ capacity monitored through Restore and recovery meeting and centre POD meetings Align additional capacity where possible. H2 plans developed including consideration of opportunities for IS support (subject to funding).	System elective and cancer meeting established. Modelling to inform system actions. As per actions

RTT Waiting List – Total Size



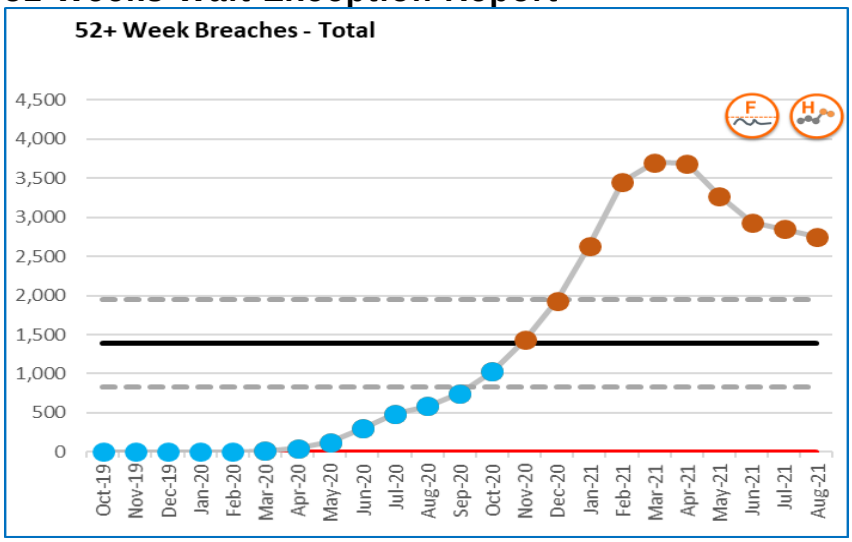
August 2021 actual performance
34282 (English 30779, Welsh 3503)
Variance Type
Special Cause Concern
Local Plan
26209 (English) by Mar 2022
Target / Plan Achievement
Overall plan dependant on Welsh ERF scheme confirmation



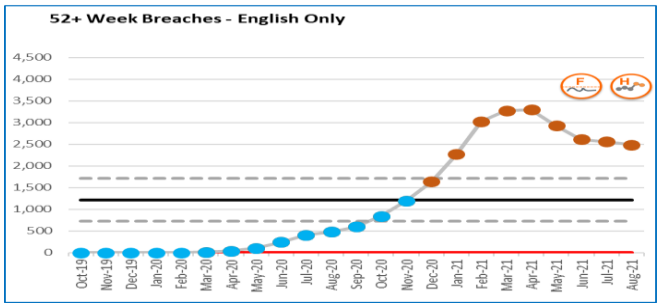


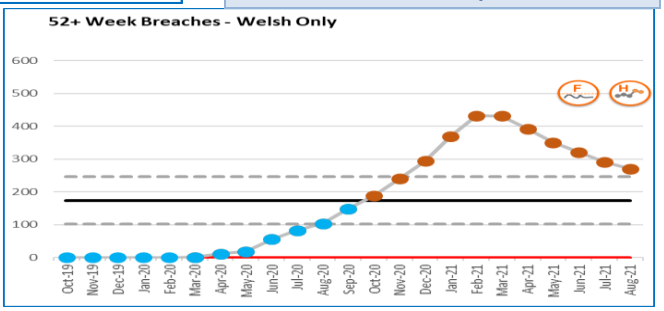
Background	What the Chart tells us	Issues	Actions	Mitigations
Total list size continues to increase because of the inability to treat clinically routine patients and close RTT pathways.	Continuation of the increase in the total waiting list size.	Increase in referrals. Patients converting from outpatient to inpatient/day cases as more patients being seen in OPD. Reduced capacity to treat patients due to staffing absences and vacancies, bed and clinic space restrictions and impact of increasing emergency demands.	Referral demand/ capacity monitored through Restore and recovery meeting and centre POD meetings Align additional capacity where possible. H2 demand and capacity refreshed. Focus on improving utilisation of capacity and recruitment to vacant posts. Use of insourcing to provide additional out of hours working.	Need to address demand, outpatient transformation and midlands elective care improvement programme as a system. Additional 32 beds to be available from Approx. April 2022 to mitigate some of the bed shortages may alleviate risk of loss of elective activity due to winter pressures.

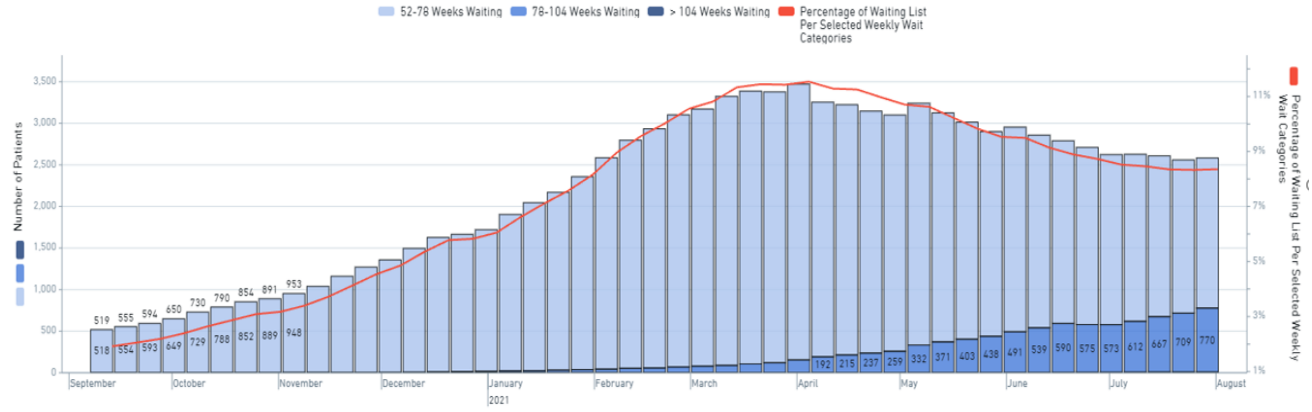
52 Weeks Wait Exception Report



August 2021 actual performance	
2755 (English 2485, Welsh 270)	
Variance Type	
Special Cause Concern	
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.	

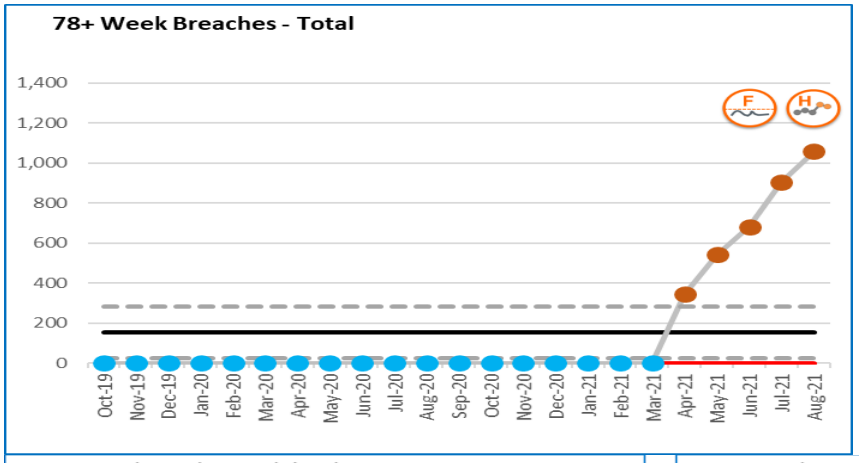




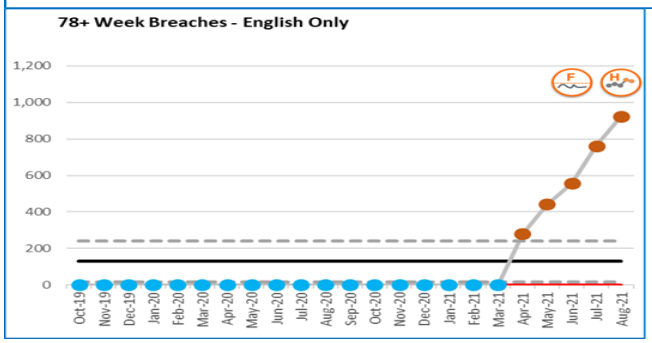


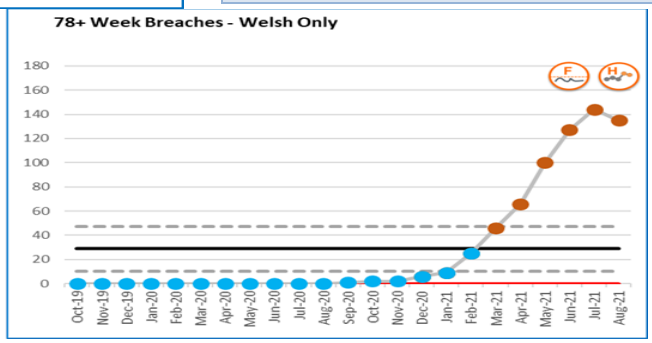
Background	What the Chart tells us	Issues	Actions	Mitigations
From a baseline position of zero pre-pandemic, the volume of patients waiting in excess of 52 weeks on an open RTT pathway has increased significantly. It continues to increase because routine patients are not currently being able to be prioritised 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.	Reduced theatre capacity and staffing vacancies. Urgent care bed pressures resulting in loss of elective beds. The volume of patients over 78weeks is continuing to increase	Clinical prioritisation of patients in terms of PL scores and monitoring patients over 52 and 78 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. Continue to date in chronological and clinical urgency	Monitored by weekly RTT meeting & cancer performance meeting.

78 Weeks Wait Exception Report



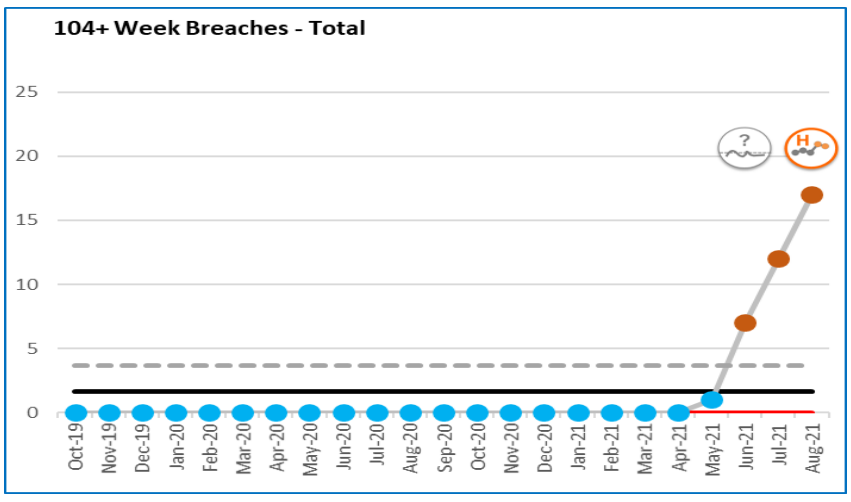
August 2021 actual performance	
1057 (English 922, Welsh 135)	
Variance Type	
Special Cause Concern	
National Target	**Local Forecast**
0	tbc
Target / Plan Achievement	
The target will not be delivered in 21/22...	





Background	What the Chart tells us:	Issues	Actions	Mitigations
From a baseline position of zero pre-April 21, the volume of patients waiting in excess of 78 weeks on an open RTT pathway has increased significantly. It continues to increase because routine patients are not currently being prioritised for treatment.	The proportion of these long waiting patients who are over 78 weeks is increasing,	The volume of patients over 78weeks is continuing to increase with a small number (c20) now over 104 weeks. A small number of patients are requesting not to return to service at this time.	Reduced theatre capacity and staffing vacancies. Urgent care bed pressures resulting in loss of elective beds.	Monitored via weekly RTT meeting

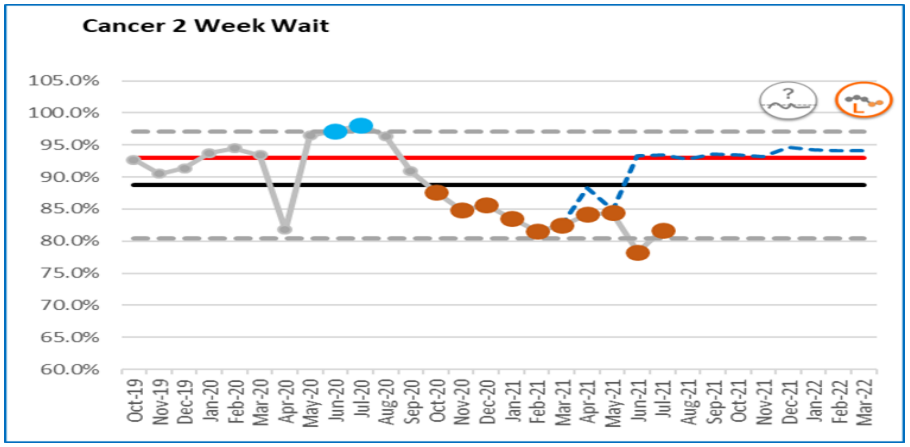
104+ Weeks Wait Exception Report



August 2021 actual performance	
17 (English 12, Welsh 5)	
Variance Type	
Special Cause Concern	
National Target	**Local Forecast**
0	85 (with support)
Target / Plan Achievement	
We will continue to strive to eliminate 104 week waits	

Background	What the Chart tells us:	Issues	Actions	Mitigations
From a baseline position of zero pre-April 21, the volume of patients waiting in excess of 104+ weeks on an open RTT pathway has increased. It continues to increase because routine patients are not currently being prioritised for treatment.	The proportion of these long waiting patients who are over 104+ weeks is increasing,	Reduced theatre capacity and staffing vacancies. Urgent care bed pressures resulting in loss of elective beds. The volume of patients over 104+ weeks is continuing to increase, with a small number of patients choosing to wait.	Clinical prioritisation of patients in terms of PL scores and monitoring patients over 52 and 78 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. Continue to date in chronological and clinical urgency.	Monitored via weekly RTT meeting. Trajectory for 104 weeks position submitted to region with indication of support required to reduce numbers.

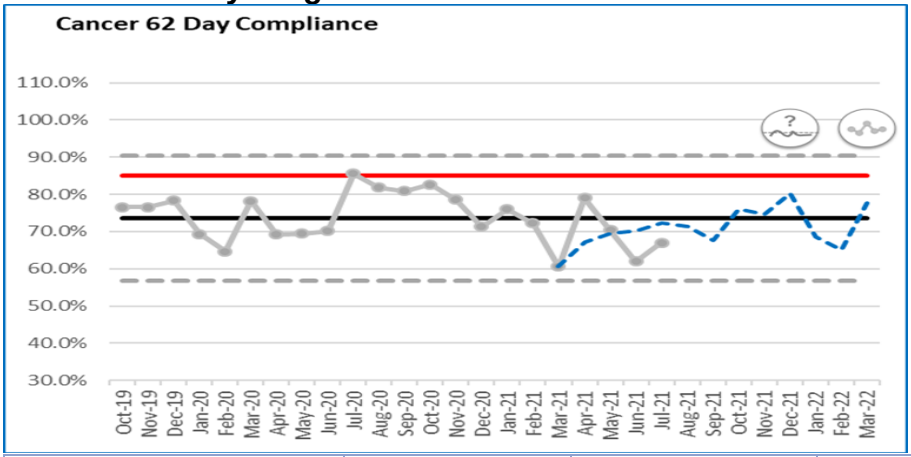
Cancer 2 week waits



July 2021 actual performance
81.7% (August forecast 92.8%)
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.	Capacity issues in the Breast specialty has impacted negatively on SaTH's overall 2WW performance. Gynaecology PMB patients to be seen in one stop only, which will cause breaches of 2WW, but improve the 28 day target.	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.	Implement ation of revised 2WW Breast Referral Proforma. Implement ation of revised 2WW Gynaecolo gy Proforma

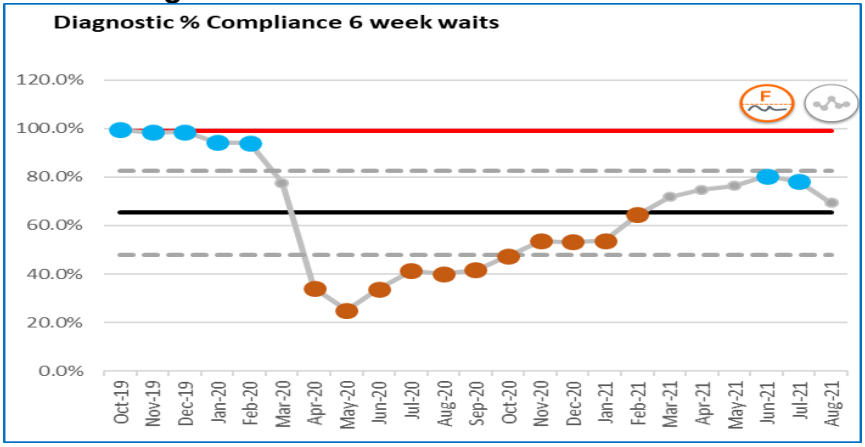
Cancer 62 day target



July 2021 actual performance
67.05% (August forecast 71.5%)
Variance Type
Common Cause
National Target
85%
Target / Plan Achievement
Performance worse than 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 only once since April 2019.	Capacity does not meet demand (diagnostics had significant issues even prior to COVID-19). Surgical capacity not back to pre COVID-19 levels. 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 Sept. 2021, with a view to have capacity ready in Oct 2021.	Cancer Performance and Assurance Meetings on going chaired by Deputy COO.

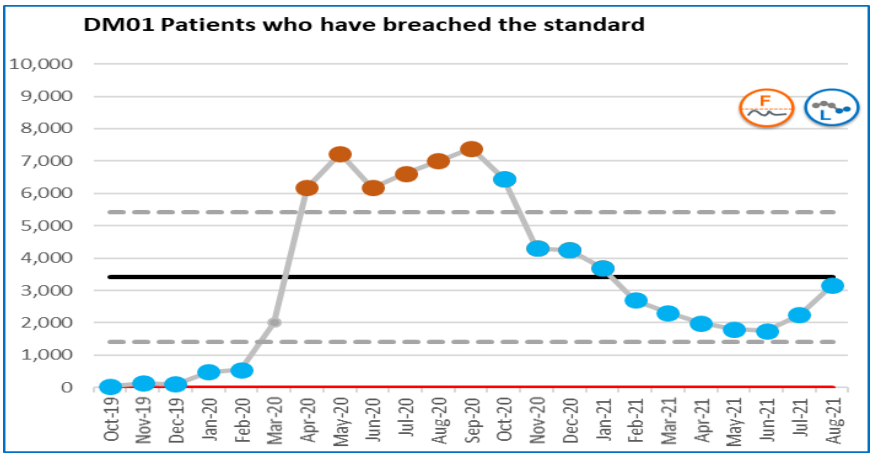
DM01 Diagnostic over 6 week waits



August 2021 actual performance
69.38%
Variance Type
Common Cause
National Target
99%
Target / Plan Achievement
Target will not be delivered with present capacity constraints

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 had improved. However August saw a deterioration with increased waits for CT.	Recovery space and the ability to maximise throughput. Delay start for TNE. Cancellation of activity due to staffing levels. Lack of mobile CT capacity	Awaiting risk assessment to be signed off. CT and MRI POD to start in October All diagnostic waits prioritised by D code with scheduling priority given to the most urgent cases. Mutual aid provided from RJAH	Additional CT mobile capacity requested from NHSE

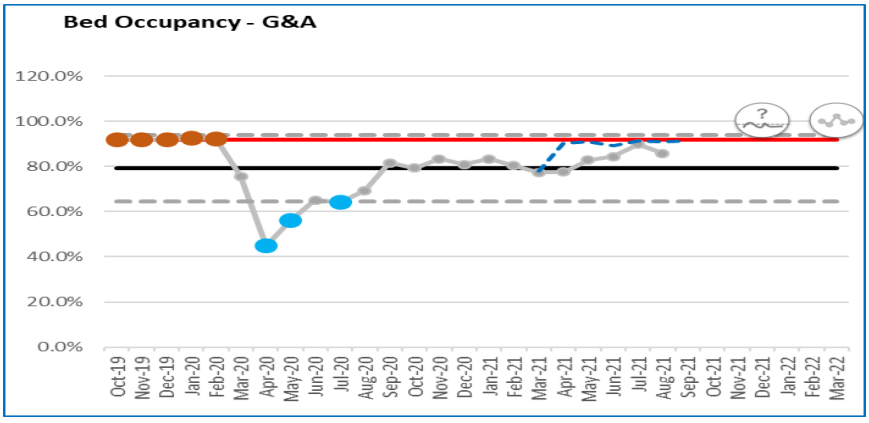
DM01 Patients who have breached the Standard



August 2021 actual performance
3168
Variance Type
Special Cause Improvement
National Target
0 - < 6weeks
Target / Plan Achievement
Deterioration in previous recovery noted

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 had improved since Oct.2020. The last two months have seen a reversal of this trend.	As per the operational guidance published in May 2021 overdue surveillances will now be moved to the active DM01 waiting list. CT capacity has reduced with removal of mobile from site Staffing capacity in CT and MRI Increased waits in audiology and cystoscopy contributing to the number of breaches	All diagnostics clinically prioritised with D codes and scheduled according to clinical priority. Staff recruitment continuing and CT/MRI pod on course for commissioning in Sept and operational from Oct	Additional staffed CT mobile to requested to return to site (NHSE managed)

Bed Occupancy

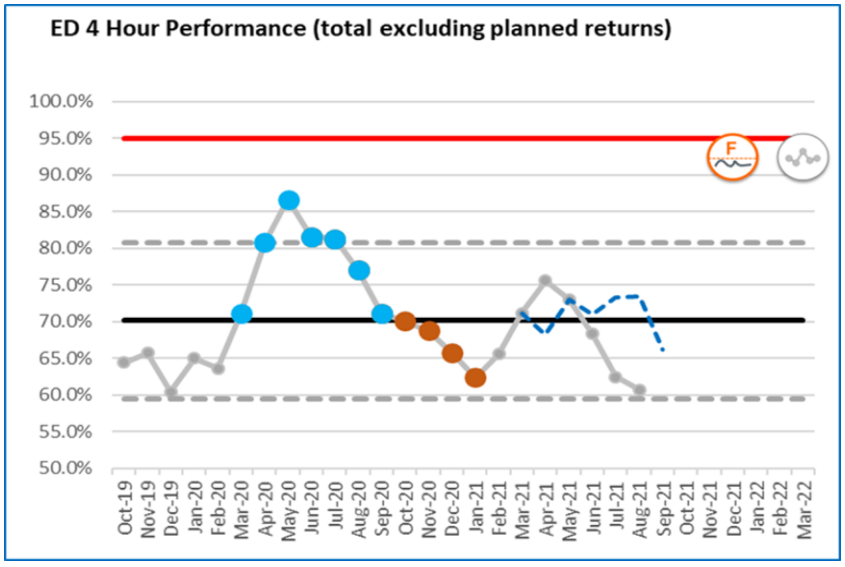


August 2021 actual performance
85.9%
Variance Type
Common Cause
Local Target
92%
Target / Plan Achievement
Occupancy continuing to be lower than pre-COVID-19

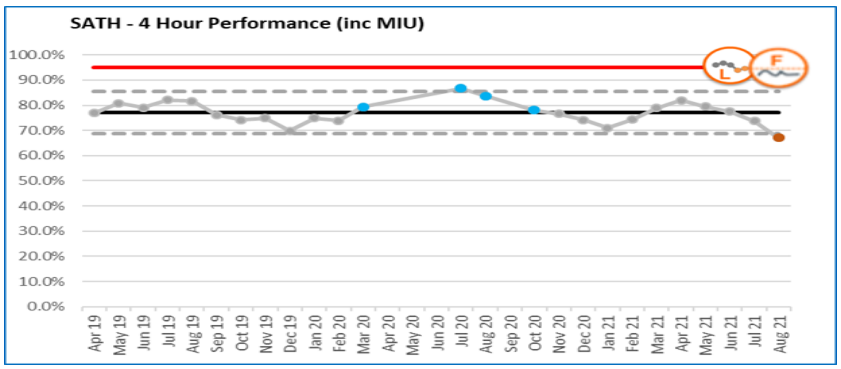
Background	What the Chart tells us	Issues	Actions	Mitigation
Bed occupancy is an important measure indicating the flow and	Bed occupancy has increased overall, however the majority of the increase represents an increase in emergency non-	Segmentation of beds has created smaller bed pools and reduced flexibility. The increase in NEL occupancy has reduced	Bed base re-allocated to increase capacity for COVID-19 patients while protecting cancer activity within the day surgery unit. Focus on flow and discharge pathways with partners to	Additional 32 beds subject to approval from Feb 2022 to reduce a portion of

capacity within the system.	COVID-19 admissions. Occupancy levels remain slightly below the pre-COVID-19 levels but close to the forecast position.	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. Increase in MFFD times to discharge. Further work needed to mitigate against the forecast winter bed shortfall.	increase bed capacity earlier in the day. Improvement fortnight at RSH planned from 13th Sept.2021 to improve Board rounds and discharge processes. Bed modelling completed demonstrating underlying bed shortfall for winter 2021-22. Winter planning and surge planning commenced and schemes under-development to continue admission avoidance. Impact assessment of system funded winter plans on beds to be completed and aligned to the current bed gap.	the forecast bed gap.

A&E 4 hour performance



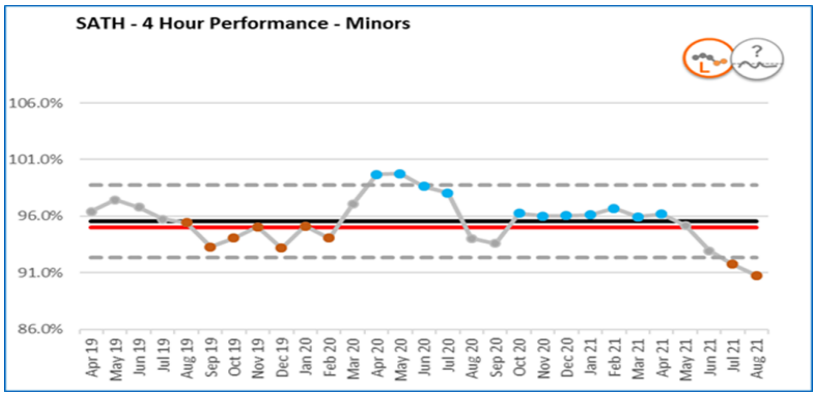
August performance
60.8%
Variance Type
Common Cause
National Target
95%
SaTH Local Plan
73.5%
Target / Plan Achievement
Performance is worse than the improvement trajectory set. The 95% target cannot be achieved. Trust is working with system partners towards delivery of 85%.



August 21 performance
67.2%
Variance Type
Special Cause Concern
National Target
95%
SaTH Local Plan
73.5%

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 however performance is currently below this plans trajectory.	Ambulance arrivals groups to certain times of the day adding to the in-day peaks in demand. Flow out of ED restricted due to constraints associated with the different COVID-19 pathways, 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. MD leading professional standards group for transfer of patients from A&E to ward beds. Two week improvement event in September to focus on medical wards at RSH so improve flow. Capital expansion of facilities in A&E at RSH to increase capacity to treat patients.	System UEC group. Support from NHSEI on flow.

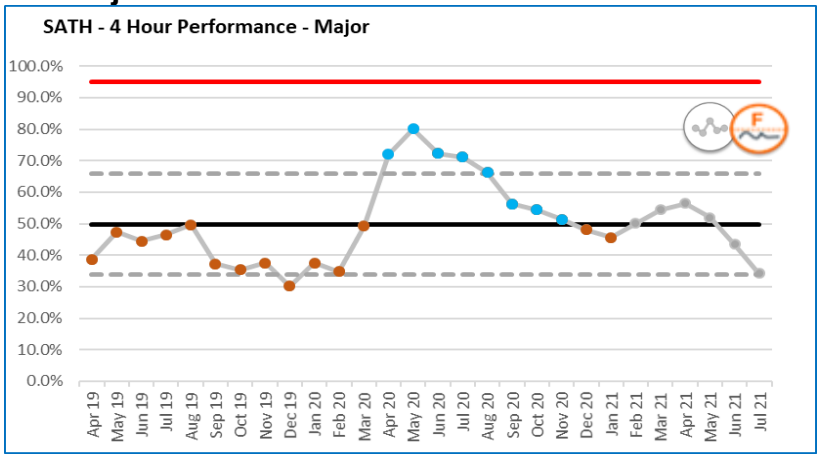
ED Minors Performance



August 2021 actual performance
90.76%
Variance Type
Special Cause Concern
National Target
95%
Target / Plan Achievement
The target being between the process limits will not be delivered reliably each month

Background	What the Chart tells us	Issues	Actions	Mitigations
Maintaining streaming between minor and major conditions will support delivery of the 4 hour standard for patients with more minor presentations.	Deterioration in performance. Special cause variation.	Workforce constraints – sickness absence and COVID-19 isolation.	Issue will resolve as workforce issues improve.	Patients assessed on clinical priority need.

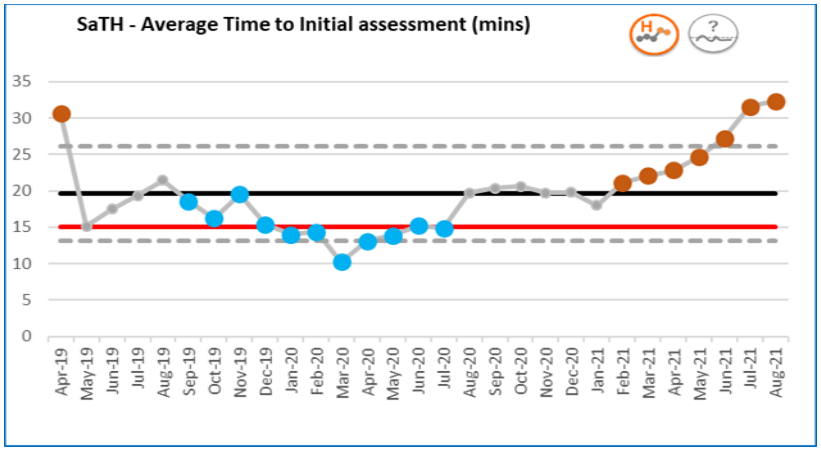
ED Majors Performance



August 2021 actual performance
34.7%
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.

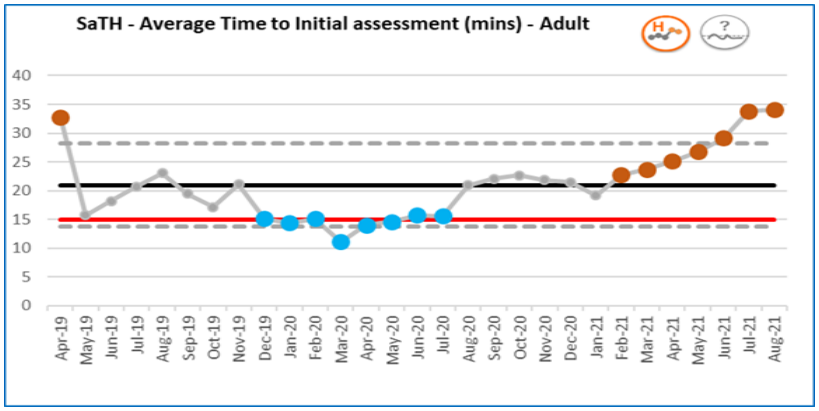
Background	What the Chart tells us	Issues	Actions	Mitigations
The national target is for all patients to be seen treated, admitted, transferred or discharged within 4 hours of arrival at the emergency department.	ED performance is forecast to continue to be below national target and is deteriorating, esp. in respect of majors. The A&E improvement plan has been developed and overall performance including MIU is in line with this plan.	Ambulance arrivals groups to certain times of the day adding to the in-day peaks in demand. Patients are being cared for within the ED majors area with some discharged from this area when recovered without admission to the ward areas. Flow out of ED restricted due to constraints associated with the different COVID-19 pathways, 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. MD leading professional standards group for transfer of patients from A&E to ward beds. Expansion of majors facility at RSH on course.	System UEC group. Support from NHSEI on flow.

ED –Time of Initial assessment (mins)



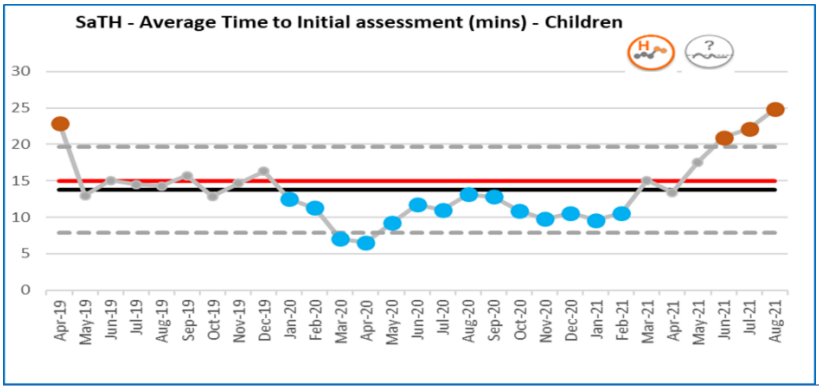
August 2021 actual performance
32 Minutes
Variance Type
Special Cause Concern
National Target
15 Minutes
Target / Plan Achievement
Performance has further deteriorated this month and is now above the upper process limit

ED Time to Initial Assessment - Adult



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

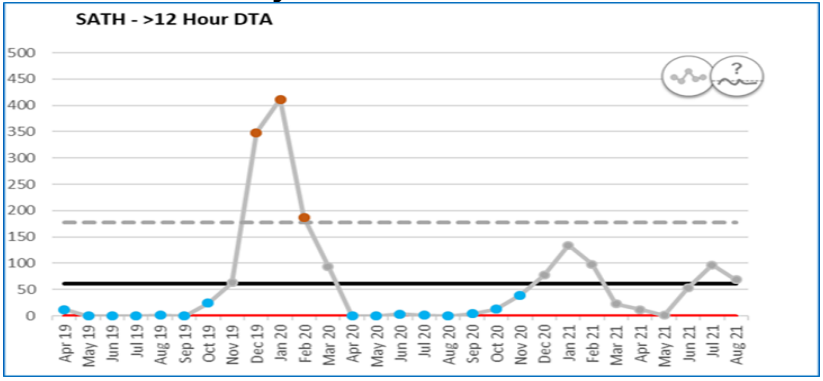
ED Time to Initial Assessment - Children



August 2021 actual performance
25 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 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.

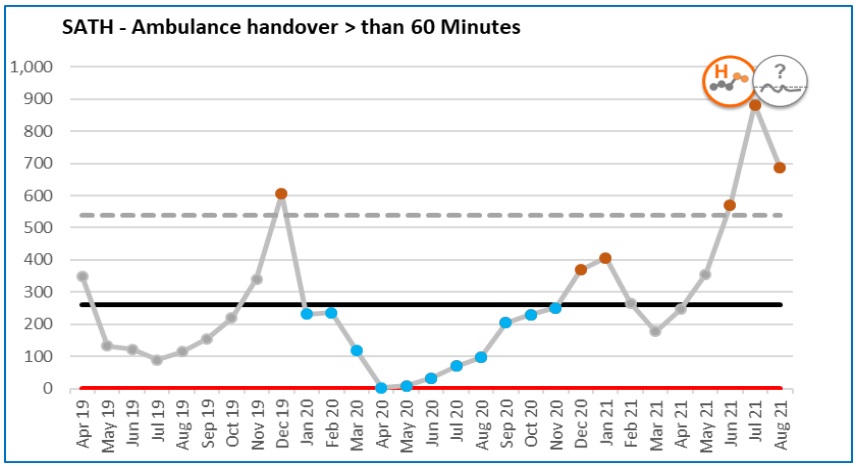
12 Hour ED Trolley waits



August 2021 actual performance
69
Variance Type
Common Cause
National Target
0
Target / Plan Achievement
The target was 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-May 2021 performance has deteriorated.	Increased volume of ED attenders esp. in majors. Flow of patients from ED to wards. Balance of provision of beds for elective recovery and urgent care admissions. Increase in COVID-19 presentations. Management of COVID-19 pathways and need to segregate leads to inefficiencies.	Bed modelling completed to inform winter planning. Improvement focus on morning discharges to release beds for admissions earlier in the day. Additional COVID-19 capacity opened with planning for further escalation underway.	Subject to final approval, 32 additional beds are expected to be available early next year. .

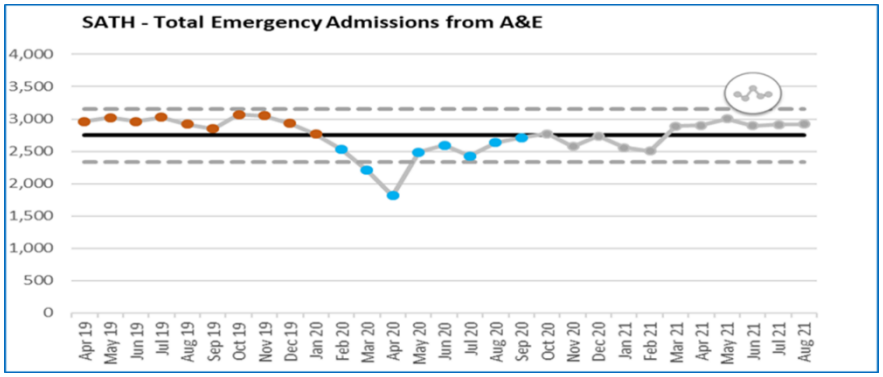
Ambulance handover> 60 Mins



August 2021 actual performance
686
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 and performance is showing special cause concern.	High volume of ambulance presentations with a large number presenting around the same time of day. The requirement to segregate patients arriving by COVID-19 pathway creates additional delays. Staffing of the departments has been challenging and has meant that some areas haven't been able to open consistently to receive patients.	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



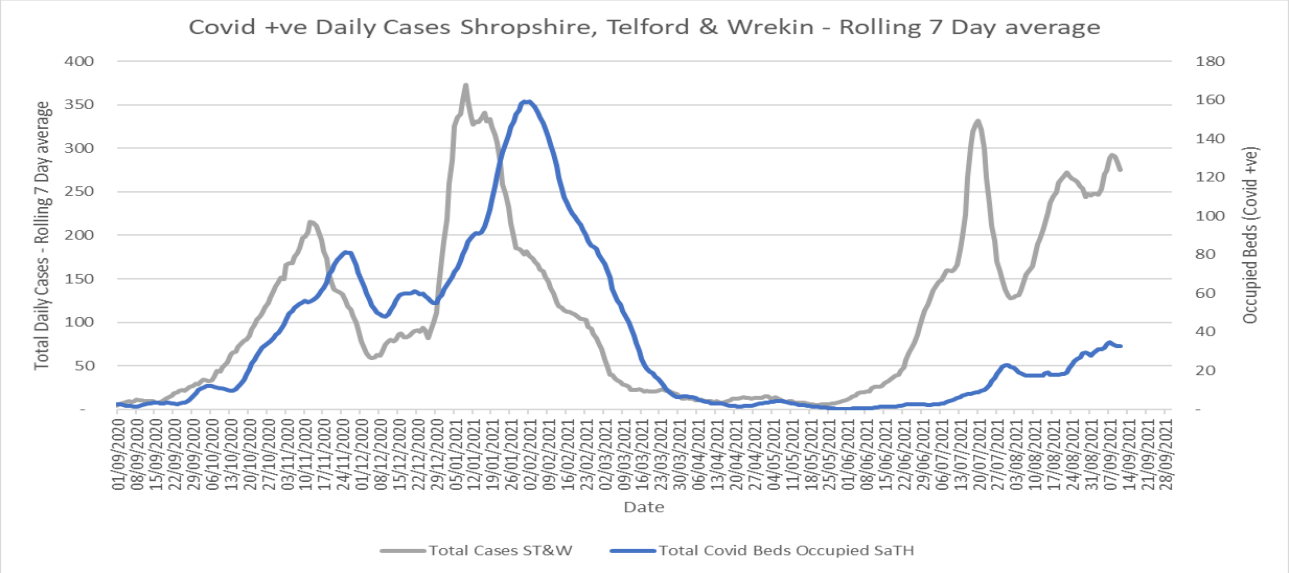
August 2021 actual performance
2922 (21.4%)
Variance Type
Common Cause
National Target
N/A
Target / Plan Achievement
N/A

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. The run rate for year to date is slightly higher than a straight 12th distribution would support. 49% of expected annual admissions via ED have been received in the first 5months of the year.	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.	Development of system wide winter plan

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 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 August and into September and increase in hospitalisations.

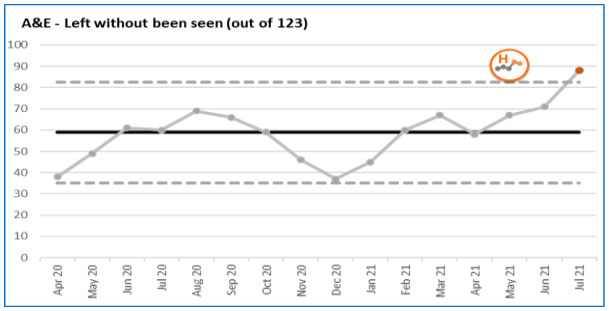


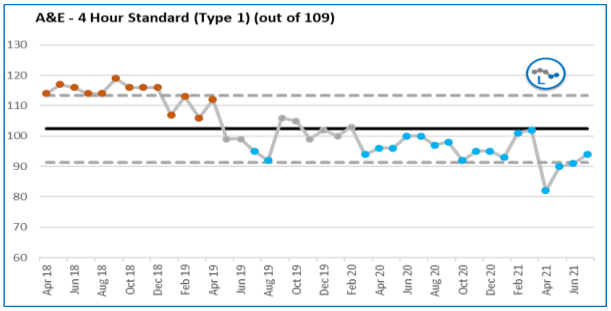
Operational Performance Benchmarking

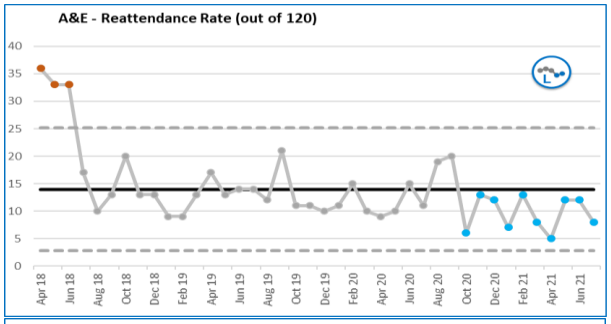
This table demonstrates the benchmarked position of the trust at a point in time compared to other English trusts reporting the same indicator. The icon shows the trend of ranking over time of the trust in relation to other trusts.

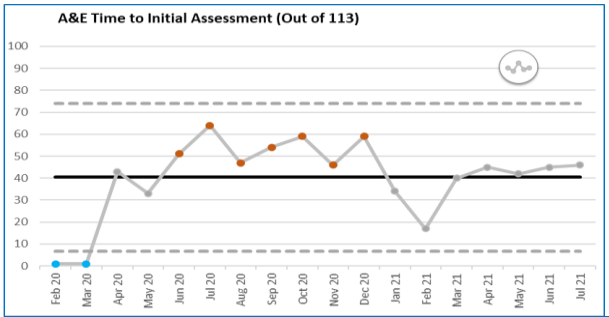
KPI	Latest month	Actual Performance Ranking	Performance	Lower process limit	Upper process limit
A&E – Left without been seen (out of 123)	Jul 21	88		35	83
A&E – 4 Hour Standard (Type 1) (out of 109)	Jul 21	94		91	113
A&E – Reattendance Rate (out of 120)	Jul 21	8		3	25
A&E Time to Initial Assessment (Out of 113)	Jul 21	46		7	74
Cancer 2 Week (out of 123)	Jul 21	94		51	122
Cancer 2 Week Breast Symptomatic (out of 113)	Jul 21	96		35	130
Cancer 62 Day Classic Metric (out of 123)	Jul 21	94		14	135
Cancer 62 Day Breast Cancer (out of 118)	Jul 21	110		13	144
Cancer 62 Day Lower Gastrointestinal Cancer (out of 123)	Jul 21	70		-5	122
Cancer 62 Day Lung Cancer (out of 120)	Jul 21	35		9	137
Cancer 62 Day Other Cancer (out 123)	Jul 21	102		-33	139
Cancer 62 Day Skin Cancer (out 114)	Jul 21	78		-28	140
Cancer 62 Day Urological Cancer (out of 122)	Jul 21	82		14	140
Diagnostic 6 Week Standard (out of 123)	Jul 21	65		34	95
Diagnostic 6 Week Standard – Cardiology : echocardiography (out of 123)	Jul 21	6		-6	43
Diagnostic 6 Week Standard – Audiology Assessments (out of 110)	Jul 21	62		9	99
Diagnostic 6 Week Standard – Urodynamics: pressures & flows (out of 103)	Jul 21	97		3	103
Diagnostic 6 Week Standard – Respiratory physiology : sleep studies (out of 9	Jul 21	1		-24	97
Diagnostic 6 Week Standard – Magnetic Resonance Imaging (out of 123)	Jul 21	72		45	107
Diagnostic 6 Week Standard – Computed Tomography (out of 123)	Jul 21	102		23	117
Diagnostic 6 Week Standard – Non-obstetric ultrasound (out of 123)	Jul 21	105		83	120
Diagnostic 6 Week Standard – Colonoscopy (out of 123)	Jul 21	48		-2	80
Diagnostic 6 Week Standard – Flexi sigmoidoscopy (out of 123)	Jul 21	52		-4	84
Diagnostic 6 Week Standard – Cystoscopy (out of 120)	Jul 21	98		17	99
Diagnostic 6 Week Standard – Gastroscopy (out of 123)	Jul 21	30		4	75
Emergency C-Section (out of 120)	May 21	26		-2	29
Booking Appointment Before 10 Weeks (out of 120)	May 21	86		52	114
Breast Feeding Initiation (out of 110)	May 21	52		22	63
Elective C-Section (out of 120)	May 21	58		-5	97
Instrumental Assistance (out of 120)	May 21	62		-12	109
Premature Birth Rate (out of 120)	May 21	95		-34	151
Skin to Skin Contact (out of 120)	May 21	52		26	78
Spontaneous Delivery (out of 120)	May 21	18		-5	26
RTT Incomplete 18 Week Standard Metric – Gynaecology (out of 121)	Jul 21	81		43	86
Robson Group 1 – C-section with no previous births (out of 59)	May 21	30		11	57
Robson Group 2 – C-section with no previous births (out of 38)	May 21	13		3	13
Robson Group 5 – C-section with 1+ births (out of 50)	May 21	8		-10	41

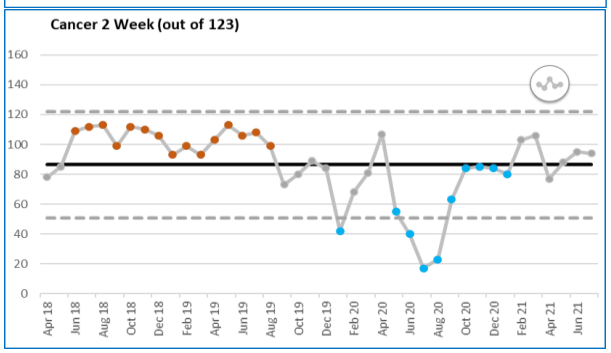
The SPC charts show the relative ranking of the Trust compared to other English trusts over time and so demonstrates the change in relative position compared to previous periods and the variation in the Trust ranking. The lower the ranking the better the relative position of the Trust is compared to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

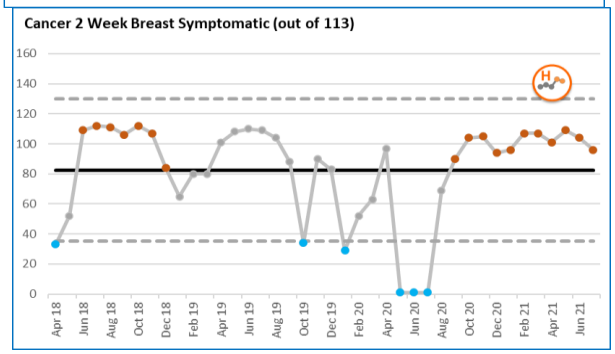


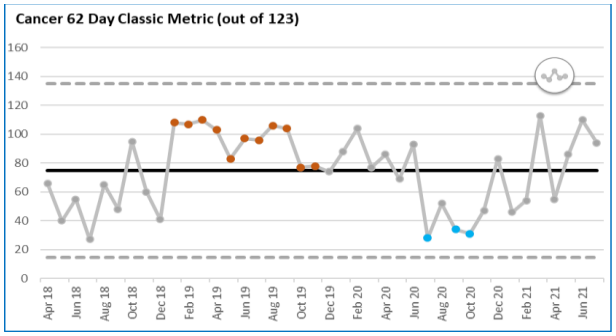


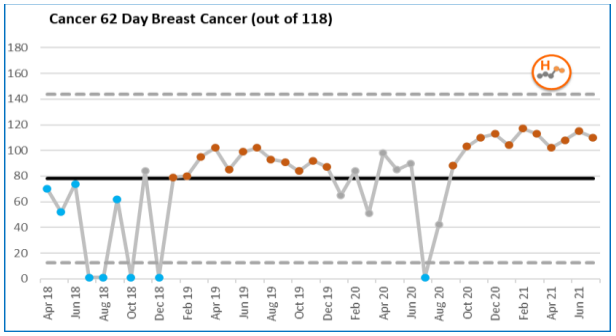


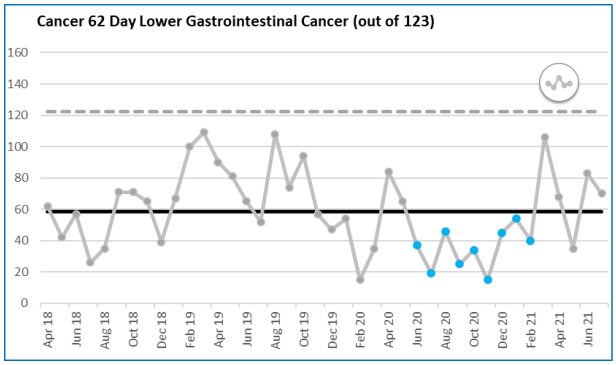


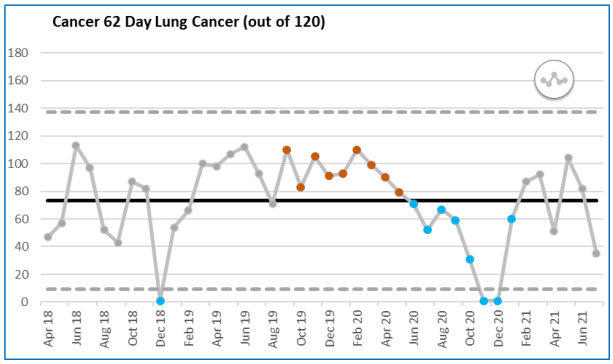


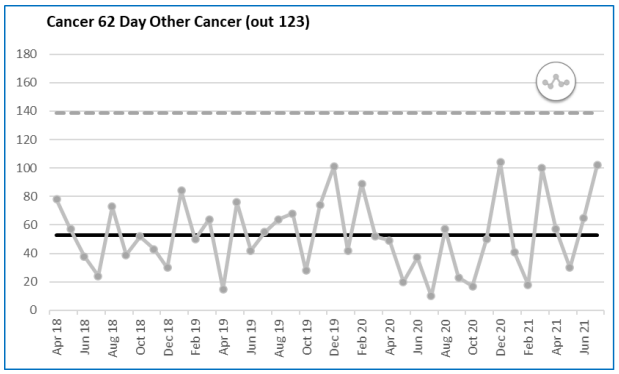


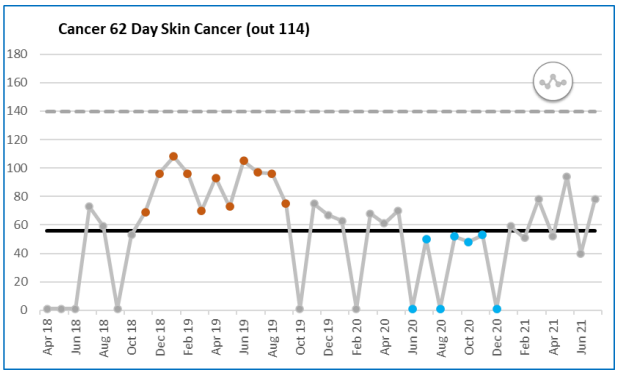


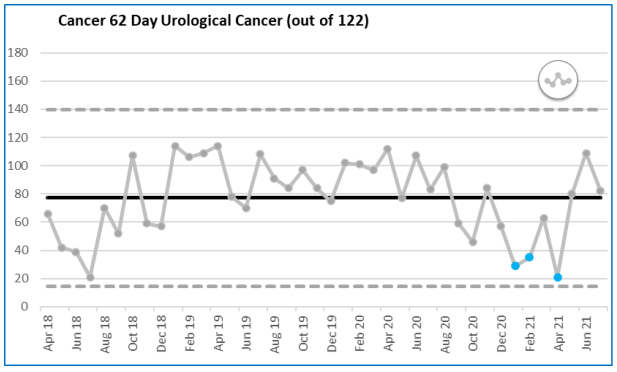


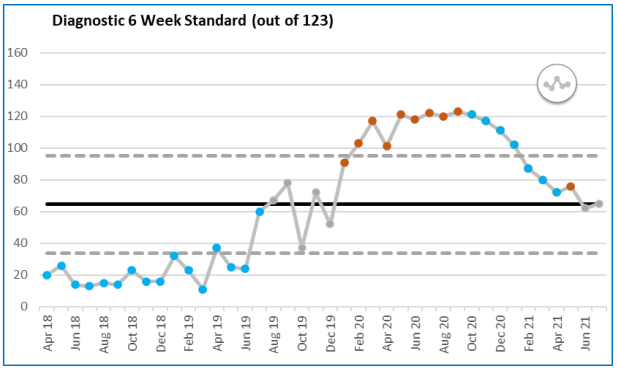


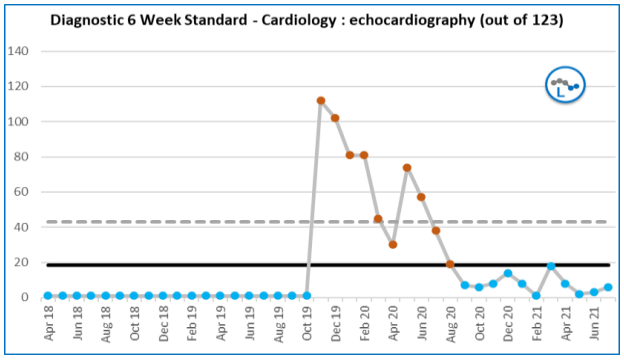


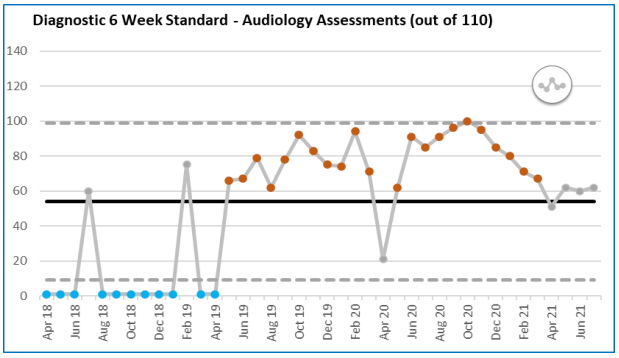

Cancer 62 Day Other Cancer (out 123)

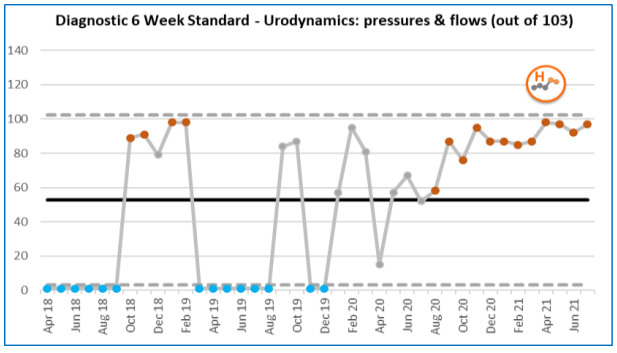

Cancer 62 Day Skin Cancer (out 114)

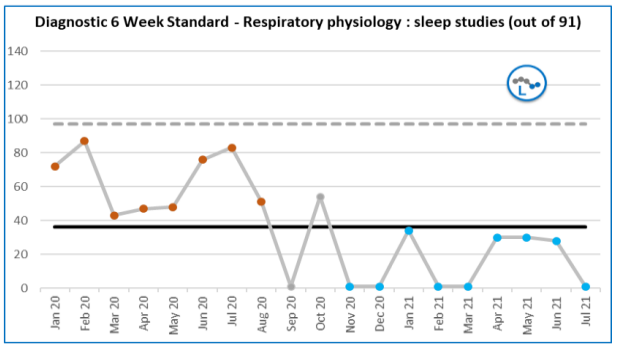

Cancer 62 Day Urological Cancer (out of 122)

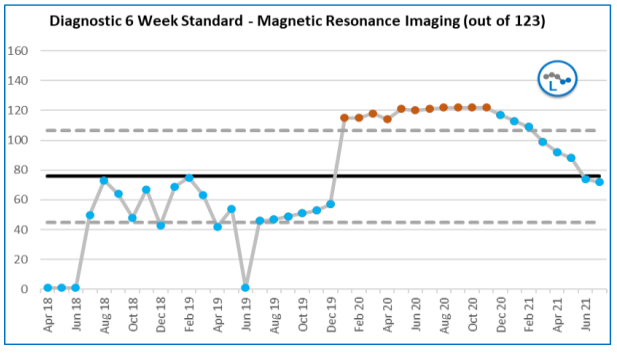

Diagnostic 6 Week Standard (out of 123)

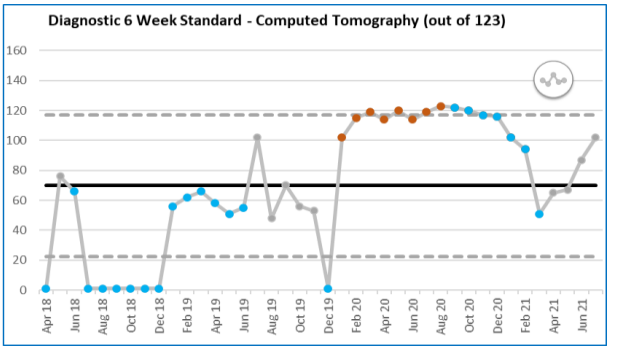

Diagnostic 6 Week Standard - Cardiology : echocardiography (out of 123)

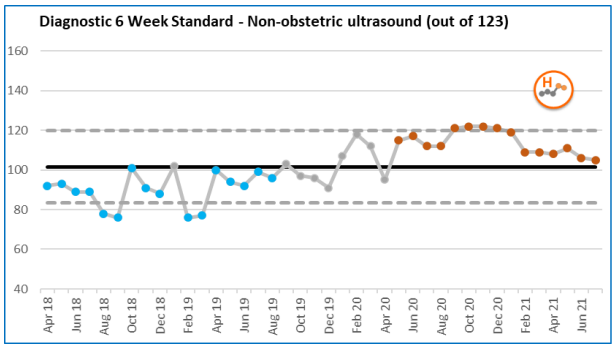

Diagnostic 6 Week Standard - Audiology Assessments (out of 110)


Diagnostic 6 Week Standard - Urodynamics: pressures & flows (out of 103)


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


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


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


Diagnostic 6 Week Standard - Non-obstetric ultrasound (out of 123)
160
140
120
100
80
60
40
Apr 18
Jun 18
Aug 18
Oct 18
Dec 18
Feb 19
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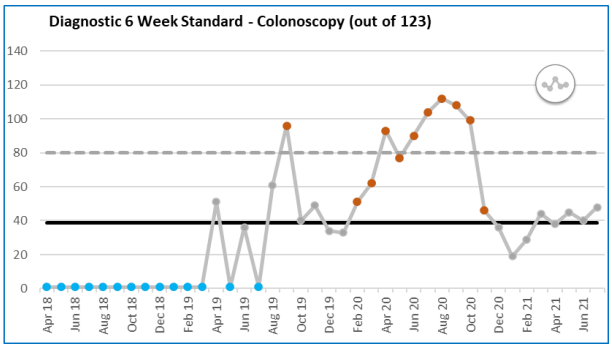
Jun 21


Diagnostic 6 Week Standard - Colonoscopy (out of 123)
140
120
100
80
60
40
20
0
Apr 18
Jun 18
Aug 18
Oct 18
Dec 18
Feb 19
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Feb 21
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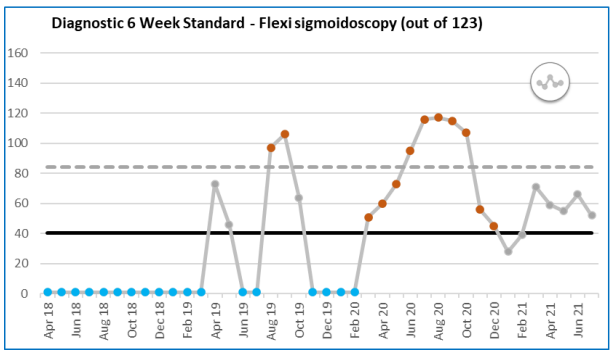
Jun 21


Diagnostic 6 Week Standard - Flexi sigmoidoscopy (out of 123)
160
140
120
100
80
60
40
20
0
Apr 18
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Dec 18
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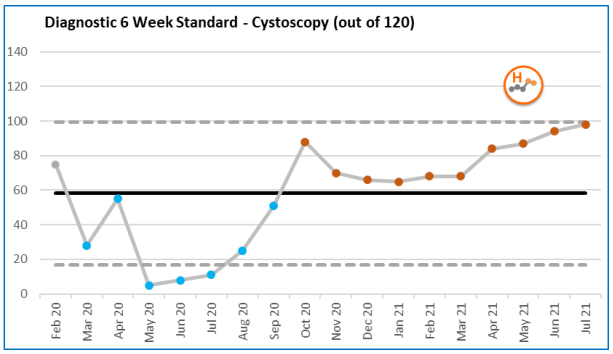
Jun 21


Diagnostic 6 Week Standard - Cystoscopy (out of 120)
140
120
100
80
60
40
20
0
Feb 20
Mar 20
Apr 20
May 20
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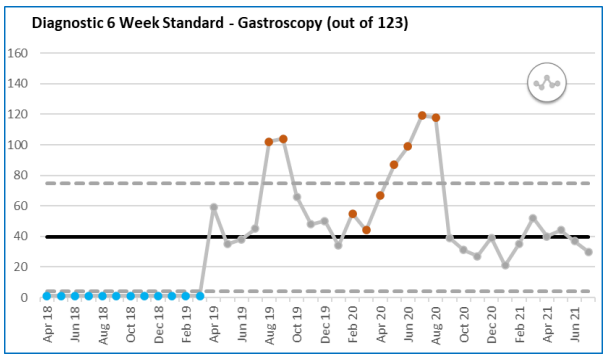
Jul 21


Diagnostic 6 Week Standard - Gastroscopy (out of 123)
160
140
120
100
80
60
40
20
0
Apr 18
Jun 18
Aug 18
Oct 18
Dec 18
Feb 19
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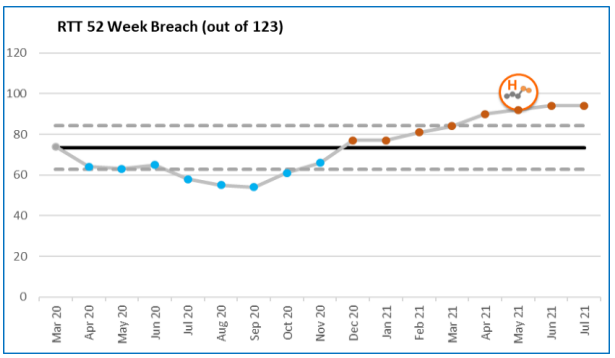
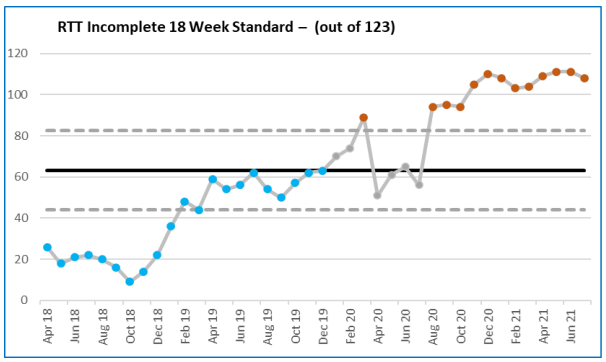
Feb 21
Apr 21
Jun 21


RTT 52 Week Breach (out of 123)
120
100
80
60
40
20
0
Mar 20
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21


RTT Incomplete 18 Week Standard – (out of 123)
120
100
80
60
40
20
0
Apr 18
Jun 18
Aug 18
Oct 18
Dec 18
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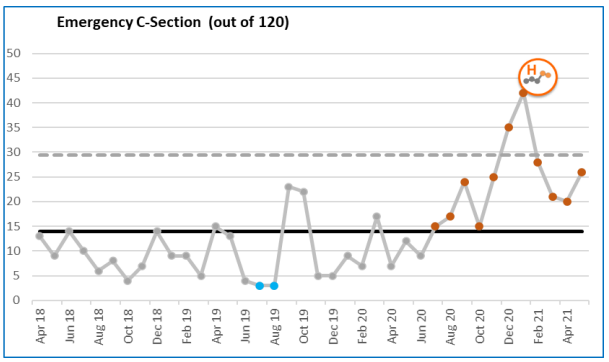
Jun 21


Emergency C-Section (out of 120)
50
45
40
35
30
25
20
15
10
5
0
Apr 18
Jun 18
Aug 18
Oct 18
Dec 18
Feb 19
Apr 19
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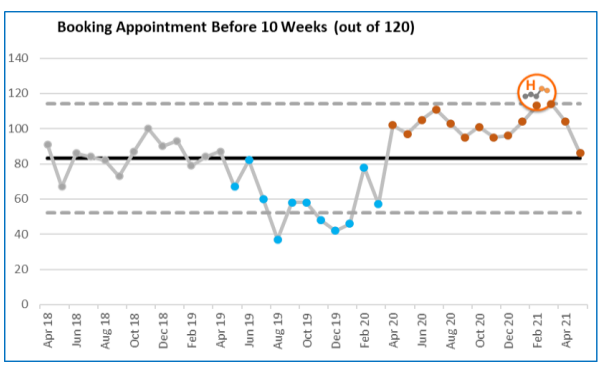
Feb 21
Apr 21


Booking Appointment Before 10 Weeks (out of 120)
140
120
100
80
60
40
20
0
Apr 18
Jun 18
Aug 18
Oct 18
Dec 18
Feb 19
Apr 19
Jun 19
Aug 19
Oct 19
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Feb 20
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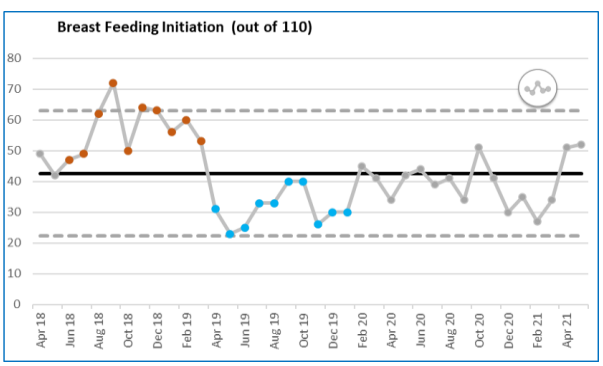
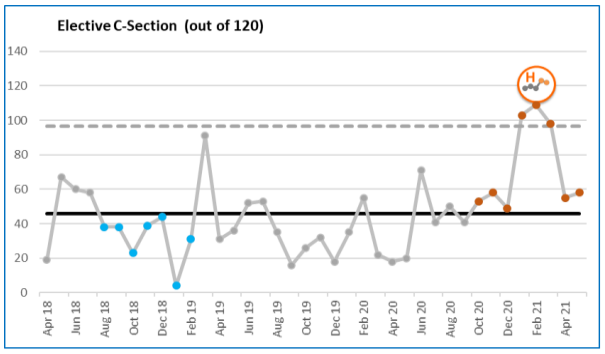
Oct 20
Dec 20
Feb 21
Apr 21


Breast Feeding Initiation (out of 110)
80
70
60
50
40
30
20
10
0
Apr 18
Jun 18
Aug 18
Oct 18
Dec 18
Feb 19
Apr 19
Jun 19
Aug 19
Oct 19
Dec 19
Feb 20
Apr 20
Jun 20
Aug 20
Oct 20
Dec 20
Feb 21
Apr 21


Elective C-Section (out of 120)
140
120
100
80
60
40
20
0
H
Apr 18
Jun 18
Aug 18
Oct 18
Dec 18
Feb 19
Apr 19
Jun 19
Aug 19
Oct 19
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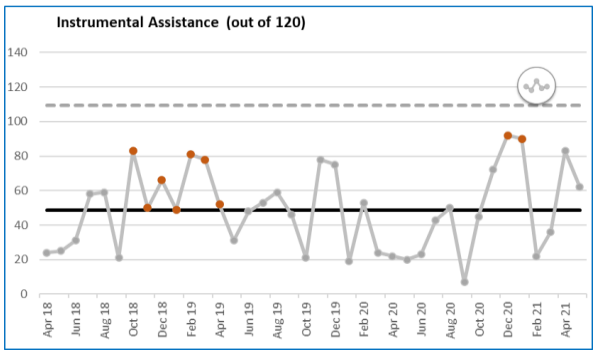
Oct 20
Dec 20
Feb 21
Apr 21


Instrumental Assistance (out of 120)
140
120
100
80
60
40
20
0
Apr 18
Jun 18
Aug 18
Oct 18
Dec 18
Feb 19
Apr 19
Jun 19
Aug 19
Oct 19
Dec 19
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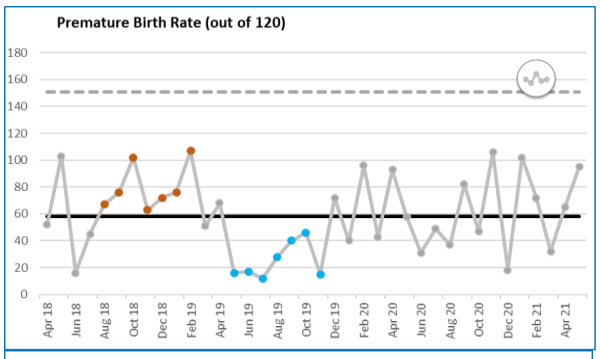
Aug 20
Oct 20
Dec 20
Feb 21
Apr 21


Premature Birth Rate (out of 120)
180
160
140
120
100
80
60
40
20
0
Apr 18
Jun 18
Aug 18
Oct 18
Dec 18
Feb 19
Apr 19
Jun 19
Aug 19
Oct 19
Dec 19
Feb 20
Apr 20
Jun 20
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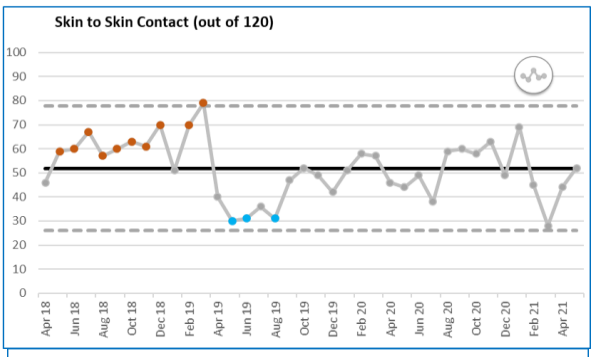
Oct 20
Dec 20
Feb 21
Apr 21


Skin to Skin Contact (out of 120)
100
90
80
70
60
50
40
30
20
10
0
Apr 18
Jun 18
Aug 18
Oct 18
Dec 18
Feb 19
Apr 19
Jun 19
Aug 19
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Apr 20
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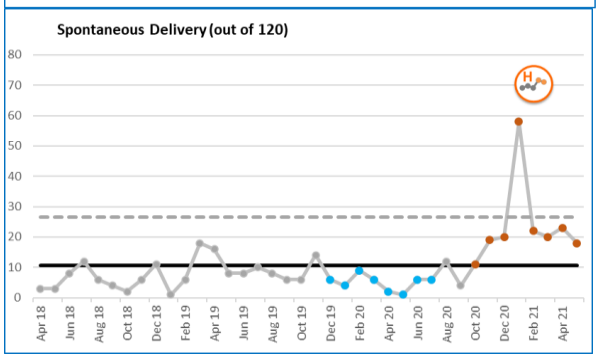
Dec 20
Feb 21
Apr 21


Spontaneous Delivery (out of 120)
80
70
60
50
40
30
20
10
0
H
Apr 18
Jun 18
Aug 18
Oct 18
Dec 18
Feb 19
Apr 19
Jun 19
Aug 19
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Feb 20
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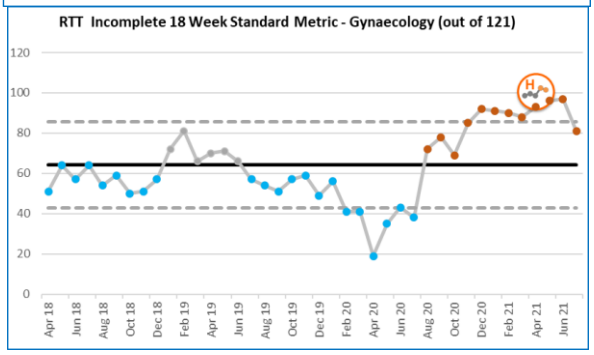
RTT Incomplete 18 Week Standard Metric - Gynaecology (out of 121)
120
100
80
60
40
20
0
H
Apr 18
Jun 18
Aug 18
Oct 18
Dec 18
Feb 19
Apr 19
Jun 19
Aug 19
Oct 19
Dec 19
Feb 20
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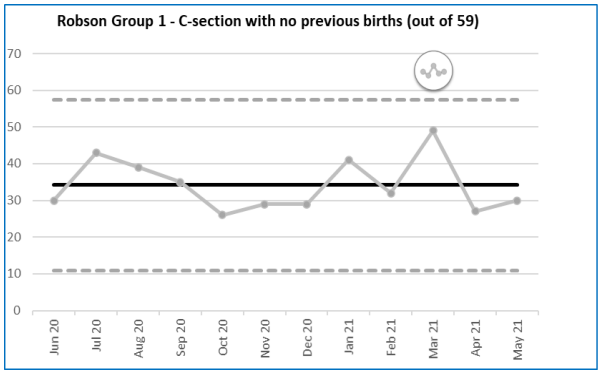
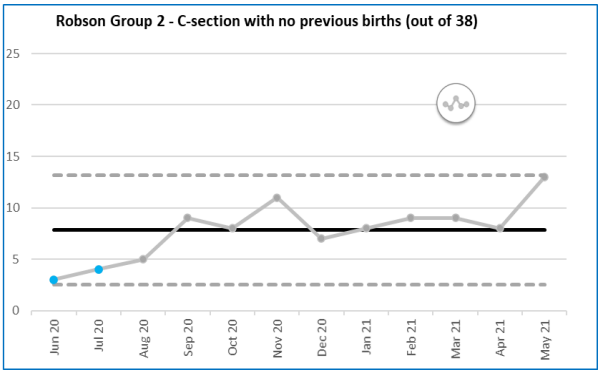
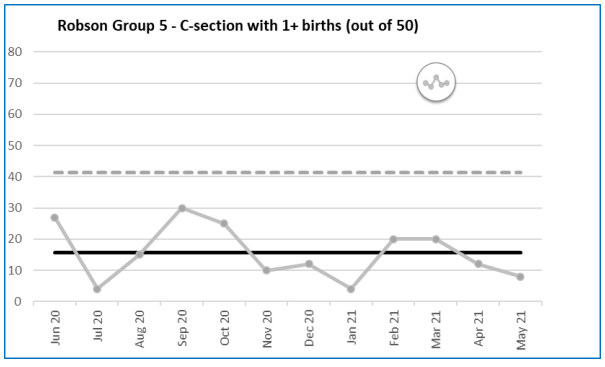
Dec 20
Feb 21
Apr 21
Jun 21


Robson Group 1 - C-section with no previous births (out of 59)
70
60
50
40
30
20
10
0
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21


Robson Group 2 - C-section with no previous births (out of 38)
25
20
15
10
5
0
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21


Robson Group 5 - C-section with 1+ births (out of 50)
80
70
60
50
40
30
20
10
0
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21

9.Finance Summary
Helen Troalen, Director of Finance

- The Trust reported a deficit of £4.196m after 5 months of the 2021/22 reporting period. This position is £1.672m adverse to the YTD plan, which continues to be driven by the impact of the delivery of the Elective Recovery Fund (ERF).

- The Trust has incurred £3.939m of expenditure cumulatively associated with the elective recovery programme with £2.215m of income estimated to be achieved YTD, leaving a shortfall of £1.724m. System leaders are aware of this pressure, largely driven by the change in the thresholds at short notice. To date no mitigation action has been requested by NHSE/I.

- Excluding the impact of the ERF, the Trusts YTD financial position is a deficit of £2.472m, which is £0.052m favourable to plan. A lower level of COVID-19 spend offsets an increase in costs linked to non-COVID-19 related activity.

- The Trust has £7.500m of additional funding YTD to support the ongoing COVID-19 response. Costs of £1.330m were incurred in the month, £5.815m cumulatively. The monthly spend continues to increase relative to the levels seen during Q1 which is largely due to a higher level of staff absence. The YTD COVID-19 spend is £1.685m lower than the plan. This position is offsetting overspends against non-COVID-19 related spend.

- Excluding the impact of the ICS related spend hosted by SaTH, the Trust's overall expenditure is £2.985m higher than the YTD plan. However, it is important to remember that the plan for H1 reflects the temporary financial regime and the high-level planning exercise undertaken, therefore an element of this variance will be driven by a planning variance.

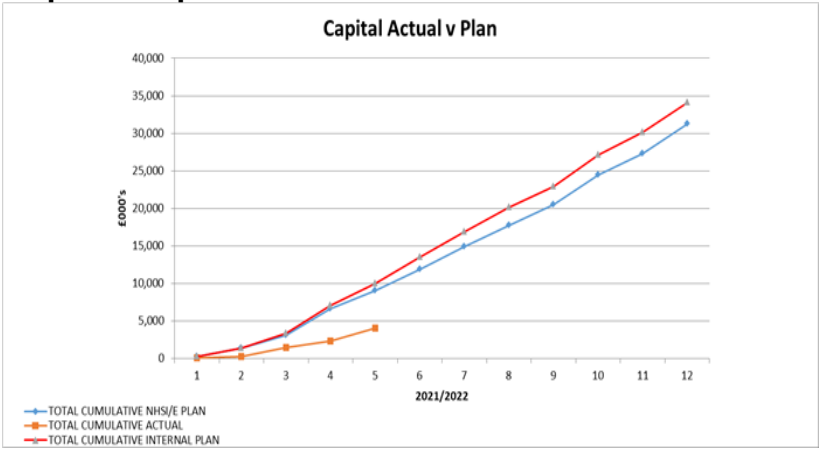
- The key expenditure pressures are driven mainly by a higher level of nursing reliance mainly seen on medical wards due in part to an increase in 1:1 care and in part to the supernumerary impact of the newly recruited overseas nurses. The key non-pay variances relate to the one-off set-up costs linked to the recently implemented endoscopy maintenance contract (£0.450m). The remaining expenditure variances are largely a consequence of additional spend linked to research & development and education & training all of which is covered in full by additional income.

- Efficiency savings of £2.405m have been delivered YTD (56% recurrent) against a plan of £1.800m, £0.605m favourable. The overall recurrent annual efficiency requirement is for £7.550m (1.6%) which the Trust is on track to deliver.

- Total capital spend YTD is £4.022m against a planned spend of £9.015m, this is a timing issue and the Trust is still forecasting to deliver the total capital programme for 2021/22 of £34.414m.

- The Trust held a cash balance at the end of August of £28.504m. The increase in cash within the month is due to receipt of system income year to date and reimbursement of COVID-19 top up.

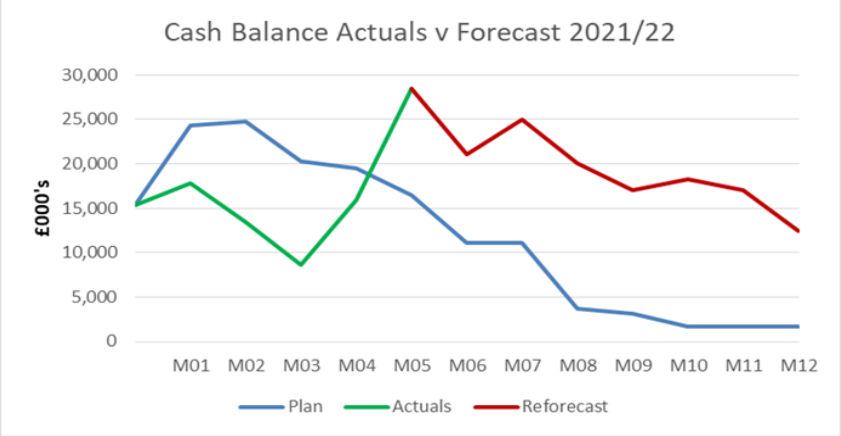
Capital Expenditure



August 2021 actual performance
Spend year to date is £4.022m
Variance Type
Underspend to date £4.993m
SaTH Plan 2021/22
£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 05 has increased to £34.414m, following confirmation of early drawdown for HTP professional fees.	Within the capital plan submitted to NHSEI, the Trust forecast spend at month 05 of £9.015m. Only £4.022m has been expended giving an underspend of £4.993m to plan.	Capital expenditure to date lower than projected. Detailed work to be undertaken during September to provide assurance of delivery of schemes within 2021/22.	The detailed Capital Programme is discussed at Capital Planning Group and it is expected that expenditure will shortly be incurred on the agreed projects.	No mitigations required.

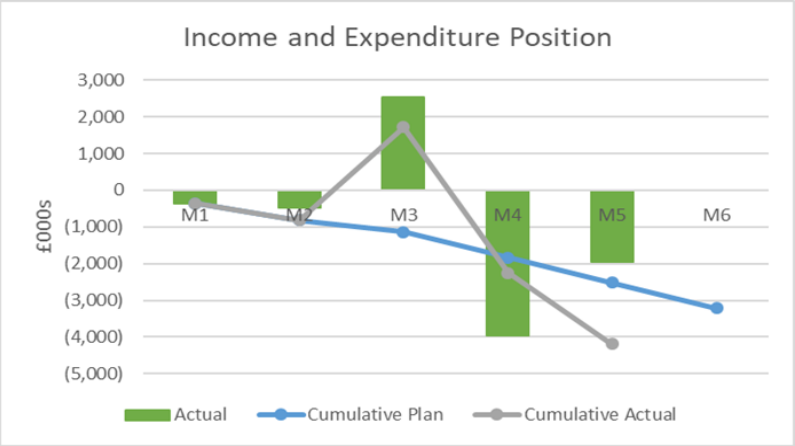
Cash



August 2021 actual performance	
£28.504m cash in Bank	
Variance Type	
Higher Cash Balance	
SaTH Original Forecast	**SaTH Rolling Forecast**
£16.516m	£27.534m
Target/ Plan achievement	
£1.150m higher Cash Balance than Rolling Forecast	

Background	What the Chart tells us	Issues	Actions	Mitigation
The Trust has revised the Cashflow forecasting and it is now based on a projected I&E deficit of £6.438m, which assumes that H2 outturn is the same as H1 Plan**.** The Trust reforecasts on a monthly basis taking account of actuals to date.	The cash balance at the end of August was £28.504m, which is £1.150m higher than the Trusts rolling Cashflow forecast. The increase in cash within the month is due to receipt of additional system income and the timing of the reimbursement of COVID-19 top up.	As the Trust has now revised the Cashflow based on a much lower deficit than the original modelling, there are no issues currently projected in terms of cash and the Trust is not forecasting a requirement for cash support. The forecast currently projects a year-end cash balance of £12.492m.	The Trust to undertake a review of the assumptions within the Cashflow. Rolling monthly forecasting to continue.	No mitigations required.

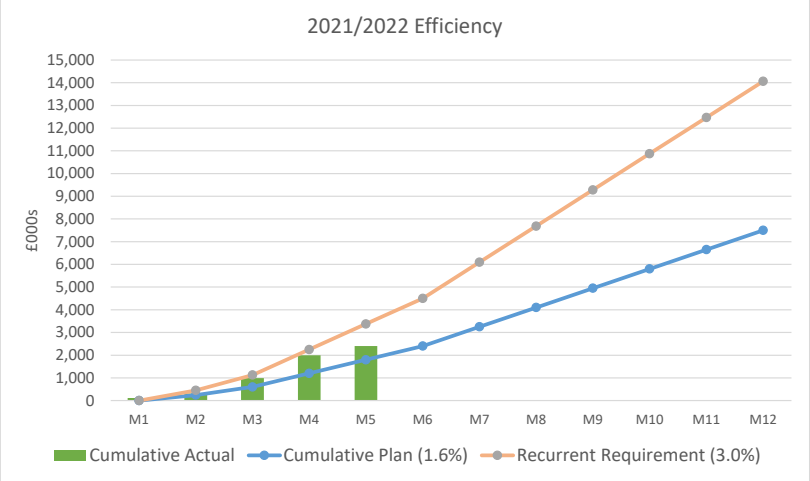
Income and Expenditure Position



August 2021 actual performance	
Income & Expenditure Position year to date (£4,196m)	
Variance Type	
Overspend to date	
National Target	**SaTH Plan 2021/22**
(£2,524m)	(£2,524m)
Target/ Plan achievement	
£0.421m unfavourable 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 2021/22 (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 £3.219m. This plan is compliant with the recurrent system sustainability plan.	The Trust recorded a net deficit of £1.945m in month, £4.196m YTD, £1.672m adverse to plan. This position includes a £1.724m YTD overspend linked to the additional capacity expected to be funded through the ERF. Partly due to a lower level of activity delivery and partly due to the unexpected change in the national thresholds from July. Excluding this impact the financial position would be £0.52m favourable to plan. The surplus delivered in month 03 was driven by an estimate of the ERF income achievement provided to the Trust by the system.	Cost pressure linked to the capacity expected to be funded through the ERF.	Mitigation plan agreed by System Leaders address ERF shortfall for H1.	Additional system savings/underspends Slippage against investment.

Efficiency



August 2021 actual performance
Income & Expenditure Position year to date £2,405m
Variance Type
Over performance to date
SaTH Plan 2021/22
£7,550m
Target/ Plan achievement
£0.605m favourable variance YTD

Background	What the Chart tells us	Issues	Actions	Mitigations
In order to achieve the £3.219m 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.	The Trust has delivered £2.405m of efficiency savings after 5 months, £0.605m ahead of plan. 56% of the savings delivered are recurrent so the focus is on increasing the level of recurrent savings over the remainder of the year. £7.550m (1.6%) of recurrent savings are required over the period.	Whist the Trust is ahead of plan YTD the level of recurrent savings need to be increased. There is also an accelerated need to identify efficiency savings beyond the 1.6% (estimated to be 3% depending on level of investments) in order to enable additional investments to be made.	Head of Efficiency commenced with the Trust. Efficiency group established in May. Finalise governance arrangements (SROs, PIDs etc.).	Non-recurrent opportunities.

10. Transformation
Helen Troalen Director of Finance

Following the principles laid out for Phase Two of Getting to Good, this section of the IPR summarises the progress on the 9 Programmes within the overarching Getting to Good programme. The full report of each programme of work is submitted to SLC-O.

Transformation Summary

The majority of the nine programmes within Getting to Good are progressing well. The Quality and Safety, Workforce, Leadership, Digital and Culture Programmes are all reporting their projects as being on track this period.

There is a recognition of exception that the Delivery of the Quality Strategy Project within the Quality and Safety Programme is reporting a status of reasonable. This is due to ongoing work to develop the communications plan for the Quality Strategy at a Trust wide level and the continuing engagement with the work-stream leads to develop delivery plans, this ongoing work will aim to mitigate any risk to delivery. Requests to move the delivery date from August 2021 to September and October 2021 respectively were made at the Operational Delivery Group on 8th September.

The Finances, Resources, and Operational Effectiveness programmes are both reporting a 50/50 status of their projects as reasonable and on track.

The Maternity Programme is currently at a status of reasonable and the governance programme is still in development.

There are no programmes or projects reporting as off track in this period, however the Governance Programme has not yet started.

The highest risks to delivery are within the following projects:

1. Restoration and Recovery: Lack of capacity in Radiology to meet the clinical demands for restoration and recovery of services post COVID-19 pandemic

2. Performance and Business Intelligence: There is a risk that focus on the work needed to implement the digital path products will limit the DWH capacity to automate existing reports.

Exceptions, Issues and Mitigations *(for projects with a status below 'On Track)*

There are four projects out of Twenty-Six currently reporting as reasonable. An explanation for this status is provided for each project below:

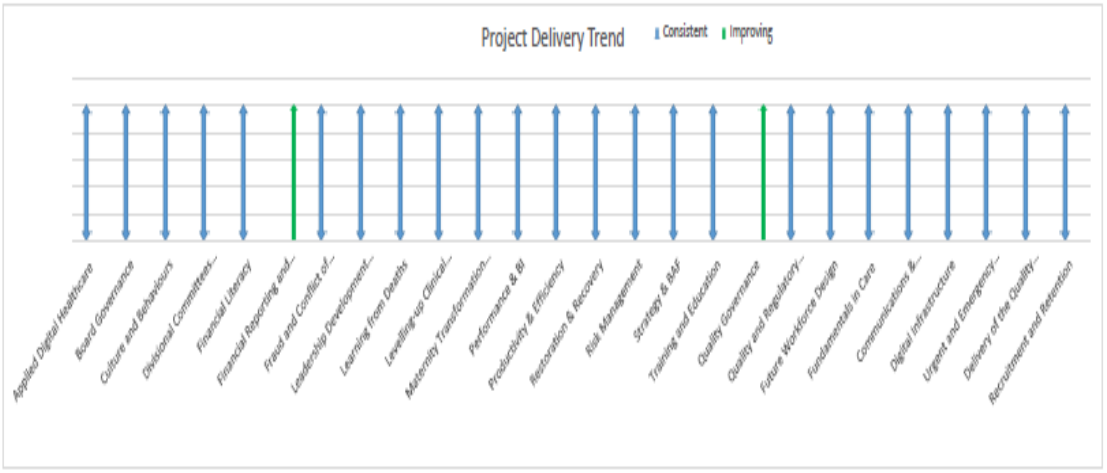
i. **Maternity**: A detailed review has been conducted of a number of Ockenden actions which highlighted significant progress in a number of areas. A number of actions will not be delivered by the original self-imposed deadline of October 2021 including those that are subject to 'external to the Trust' actions (e.g. agreement to a wider LMNS) and five obstetric anaesthetics actions, which now have a revised proposed date of March 2022.

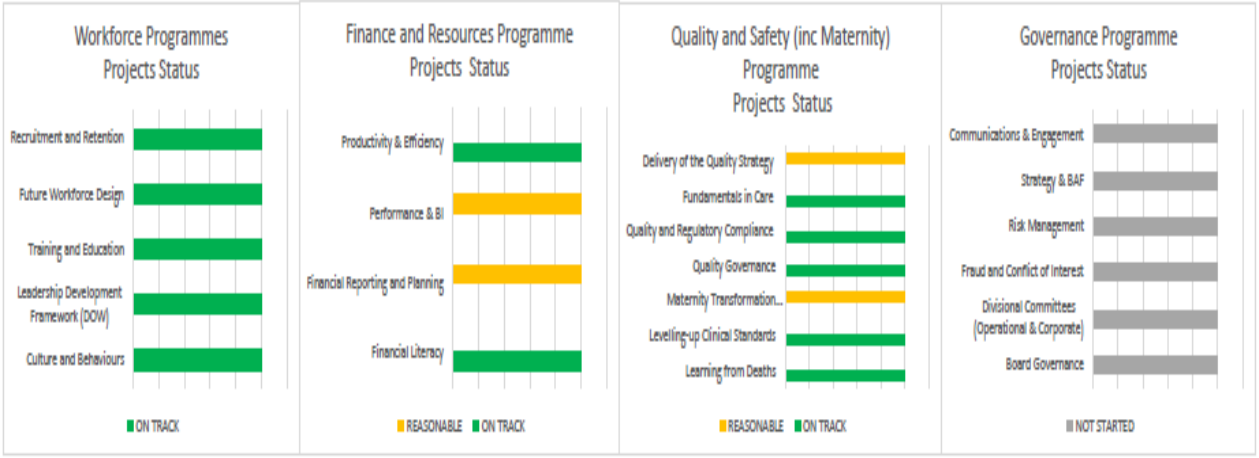
ii. **Restoration and Recovery:** The current major risks to delivery of the Restoration and Recovery project include an expected bed gap from October 21 which will have a significant impact and prevent the Trust from hitting the elective recovery targets. Another significant risk is the lack of skilled theatre staff roles; the succession planning for theatre staff roles is being picked up through Workforce Recruitment and Retention. In an effort to reduce and mitigate this risk, workforce colleagues are in discussion with HR teams across system partners for mutual aid for theatre staffing and radiology**.**

iii. **Financial Reporting and Planning:** The project has been scoped by the Senior Responsible Officer and work will continue with more detailed supporting action plans to be available in September 2021.

iv. **Performance and Business Intelligence**: Progress on STAR assurance of metrics has been affected by business as usual pressures within the Performance Team. This risk of delay is being mitigated by the recruitment of a fixed term post to support timely delivery of the InPhase product.

PMO Getting to Good Programme Dashboard - August 2021

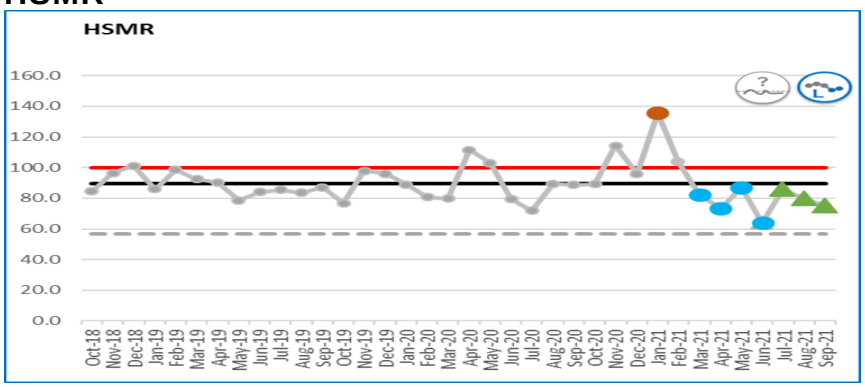




Appendix 1: KPIs performing in line with plan/target

Mortality

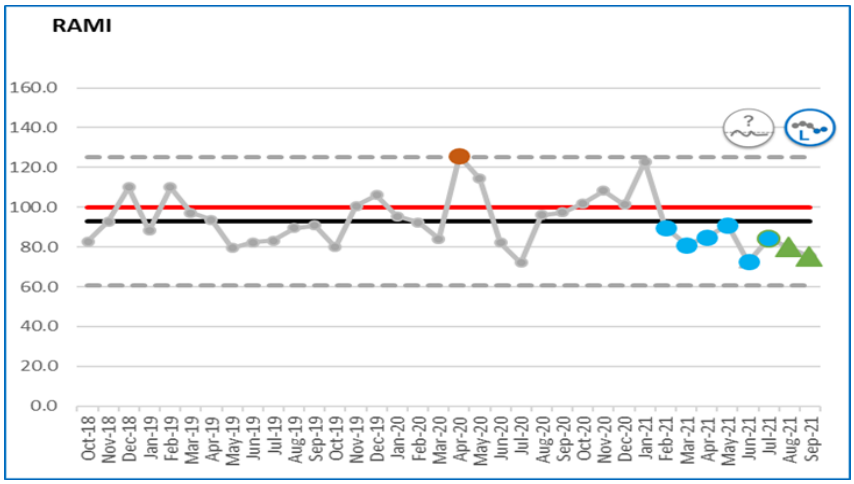
HSMR



June 2021 actual performance
63.77
Variance Type
Special Cause Improvement
National Target
100
Target / Plan Achievement
Performance better than expected range

Background	What the Chart tells us:	Issues	Actions	Mitigations
The Hospital Standardised Mortality Ratio (HSMR) is the quality indicator that measures whether the number of deaths across the hospital is higher or lower than expected.	The Trust's HSMR position is slightly lower than the peer average over the 12 month period to June 2021 although higher than the peer in November 2020 and January 2021 as noted last month. The longer term trend shows a similar pattern to the peer. Patients coded with a primary diagnosis of COVID-19 are excluded from HSMR.	Conditions where the number of deaths are higher than expected within the HSMR model are noted as urinary tract infections, pneumonia, acute and unspecified renal failure and aspiration pneumonitis. Whilst urinary tract infections continue to be identified on this list, some small improvement is noted over Q1 2021/22 and may be linked to work that has been undertaken to review the accuracy of coding for these patients. A slight upward trend is noted with septicaemia in both RAMI and HSMR data which may also correlate to this work, but will continue to be monitored. A higher HSMR at PRH on a Saturday versus the peer group is noted and remains under review.	Additional validation of deceased patients' records on completion of coding has been introduced to monitor the accuracy and consistency of data submitted. There is ongoing monitoring of the HSMR index relating to sepsis and review by sepsis team for any potential areas of concern which may be related to the upward trend in septicaemia.	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.

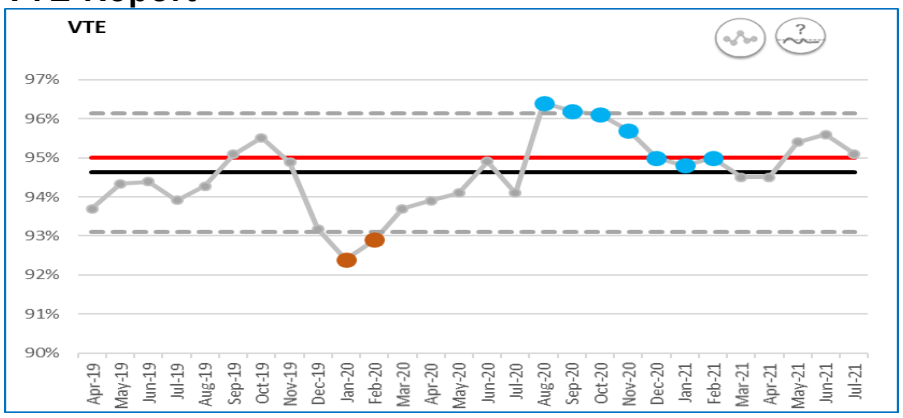
RAMI



July 2021 actual performance
84.42
Variance Type
Special Cause Improvement
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	Mitigations
The Risk Adjusted Mortality Index is a quality measure used to predict death within the organisation.	The Trust's RAMI position is below the peer average. In line with HSMR, the index is higher at Princess Royal Hospital but remains lower than the peer. The RAMI indicator excludes COVID-19 patients. Performance was negatively impacted due to the high crude mortality rate in January 2021 but has now improved.	In line with HSMR, the conditions with the highest number of 'excess deaths' (more deaths than expected within the RAMI model) over the last 12 month period to June 2021 are pneumonia, urinary tract infection, acute and unspecified renal failure and septicaemia.	Additional validation of deceased patient's records on completion of coding has been introduced to monitor the accuracy and consistency of data submitted. All conditions are being closely monitored and will be reviewed in more detail as required.	Mortality performance indicators are a standing agenda item at the monthly Learning from Deaths Group where all indicators that are above the expected range are discussed and appropriate action agreed.

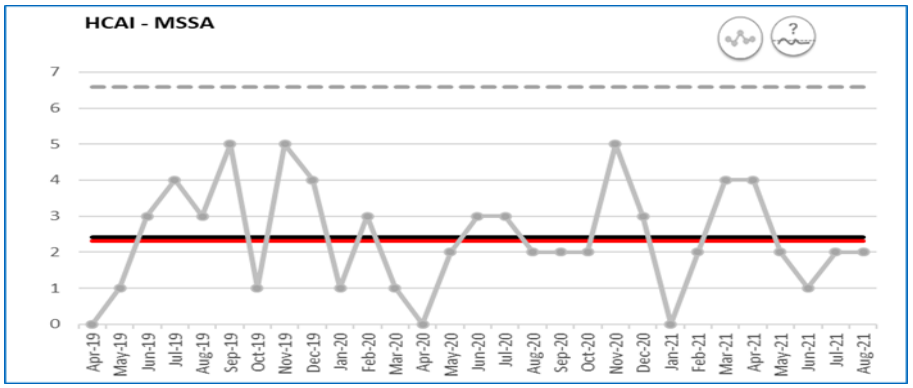
VTE Report



July 2021 actual performance
95.1%
Variance Type
Common Cause
National Target
95%
Target / Plan Achievement
Delivery continues to be close to target

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.	Divisional PRMs review performance by division.

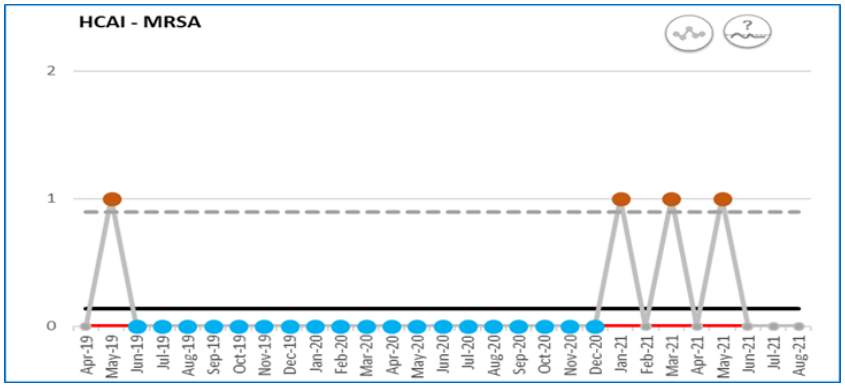
MSSA



August 2021 actual performance
2
Variance Type
Common Cause
Local Standard
<ave.2.3 per month
Target / Plan Achievement
<28 infections for 21/22

Background	What the Chart tells us	Issues	Actions	Mitigation
Reporting of MSSA bacteraemia is a mandatory requirement.	There were two cases of MSSA Bacteraemia in August 2021 that were taken post 48 hours of admission. YTD there have been 11 cases against a target for month 5 of no more than 11 cases and so performance is on course to deliver the year end stretch improvement set.	In the first case, the source was considered to be due to a Hickman line infection. In the second case, the source was considered to be a diabetic foot infection, therefore is not considered to be device or intervention related.	RCA is being undertaken on the 1st case to identify any learning points Ongoing actions from previous RCAs include: • 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.	RCA summary and actions from RCAs presented as part of Divisional updates monthly at IPC Ops Group. Any cases where the cause of infection is unknown or is thought to be device related continue to have an RCA completed. Catheter documentation is audited through the monthly matron's quality audits.

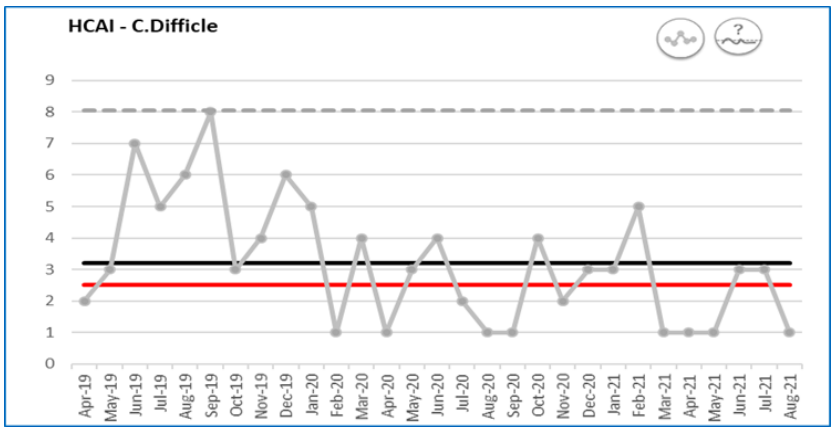
MRSA



August 2021 actual performance
0
Variance Type
Common Cause
Local Standard
0
Target / Plan Achievement
0 infections for 21/22 not achieved (1 infection in May)

Background	What the Chart tells us:	Issues	Actions	Mitigations
The Target for all Acute Trusts is Zero cases of MRSA bacteraemia.	There have been no MRSA Bacteraemia for 3 months.	Previous case in May 2021 was deemed to be a contaminant.	No new actions Actions from previous RCAs include: Staff reminded to complete blood culture documentation correctly. Training for junior doctors implemented.	Continue to monitor through IPC Ops Group.

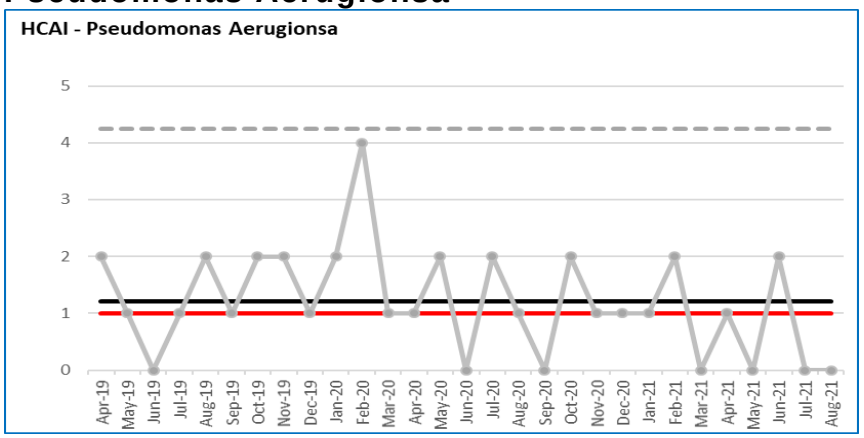
C-Difficile



August 2021 actual performance
1
Variance Type
Common Cause
Local Standard
<ave.2.5pm
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 was one case of C difficile attributed to the Trust in August 2021. This was a Pre 48 case, the patients had however been discharged from the Trust in the previous 28 days. Trust improvement target is no more than 30 cases. Target set for 2021/2022 by NHSE/I is no more than 49 cases. The Trust is on course to deliver its internal stretch target with 9 cases reported in the first 5 months of this year.	RCA on this case being undertaken to identify learning points.	Ongoing actions include: Timely obtain stool sample. Prompt isolation Anti-microbial prescribing.	Multi-disciplinary RCA completed on all cases of C.Difficile.

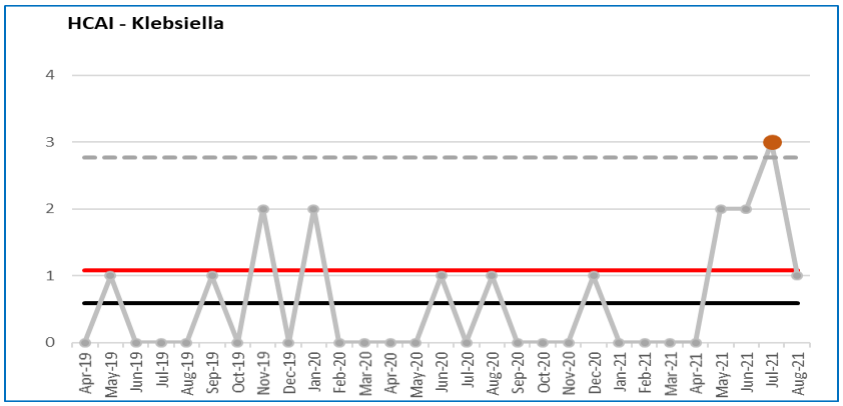
Pseudomonas Aeruglonsa



August 2021 actual performance	
0	
Variance Type	
Common Cause	
National Target	Local Standard
No more than 10 per annum	No more than 3 per annum
Target / Plan Achievement	
The local standard is ambitious and ytd 3 infections have occurred	

Background	What the Chart tells us	Issues	Actions	Mitigations
Reporting of Pseudomonas is a mandatory requirement.	There were no case of Pseudomonas bacteraemia in August 2021. YTD there have been 3 cases against a local improvement target of no cases. The Trust target set by BHSE/I for 2021/2022 is no more than 10 cases.	No new issues identified.	Ongoing improvement actions included: Ensuring 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.

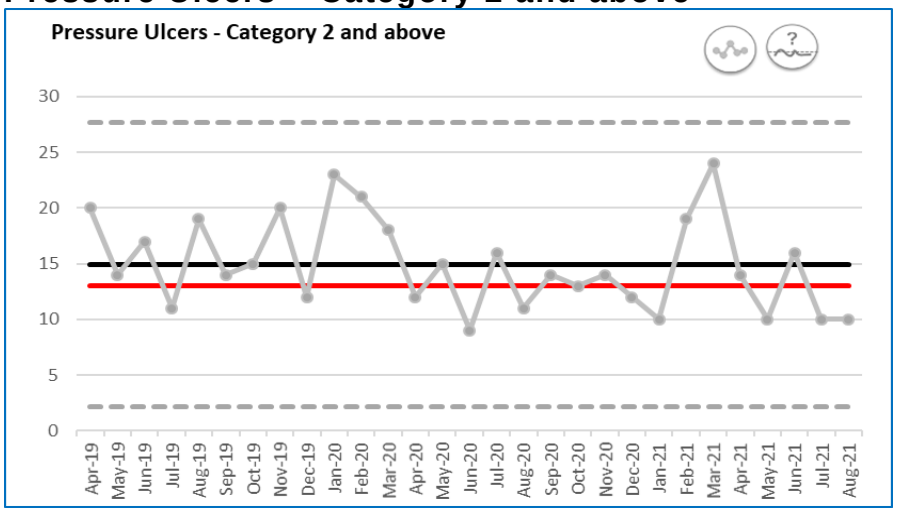
Klebsiella



August 2021 actual performance
1
Variance Type
Common Cause
Local Standard
<ave.1.1pm
Target/ Plan achievement
Sustain or improve on 2020/21

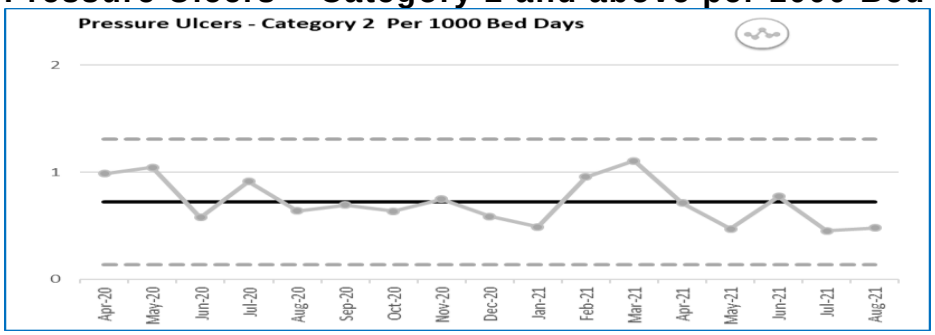
Background	What the Chart tells us	Issues	Actions	Mitigations
Reporting of Klebsiella is a mandatory requirement.	There was one case of post 48 hour Klebsiella Bacteraemia in August 2021 Trust improvement target of no more than 13 cases pa. Trust target set for 2021/2022 by NHSE/I is no more than 24 cases.	This case is currently being reviewed to establish the source.	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



August 2021 actual performance
10
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 – Category 2 and above per 1000 Bed days

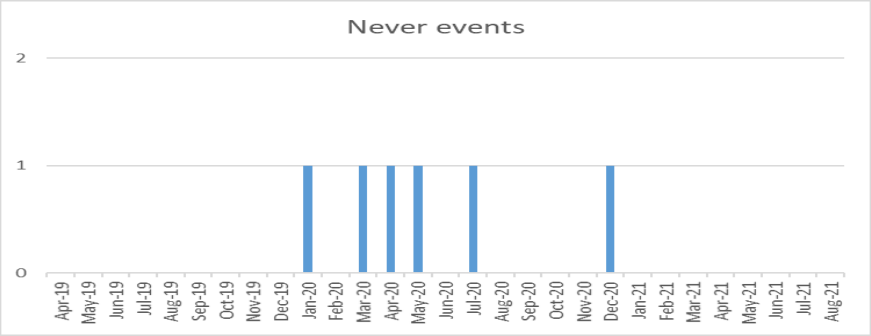


August 2021 actual performance
0.48
Variance Type
Common Cause
Local Standard
tbc

Pressure Ulcers – Total per Division	Number Reported
Medical and Emergency Care	9
Surgical, Anaesthetics and Cancer	1

Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust aims to reduce the number of hospital acquired pressure ulcers.	Acquired pressure ulcers were the same as in July with 10 reported across the Trust. The Trust is on course to deliver the year end improvement target internally set.	All of the pressure ulcers were category 2 with no reported category 3 or above for the month of August	Current SSKIN booklet revised and awaiting print, more streamlined layout with images of pressure ulcers to support nursing teams with correct categorisation. 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.

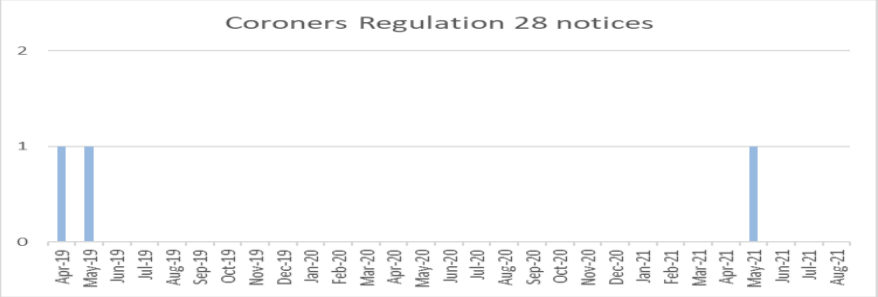
Never Events



August 2021 actual performance
0
Variance Type
Common Cause
Local Standard
0
Target/ Plan achievement
Achieving target

Background	What the Chart tells us	Issues	Actions	Mitigations
Key patient safety measure.	No Never Events in August.	No Issues to report.	No Actions.	No Mitigations.

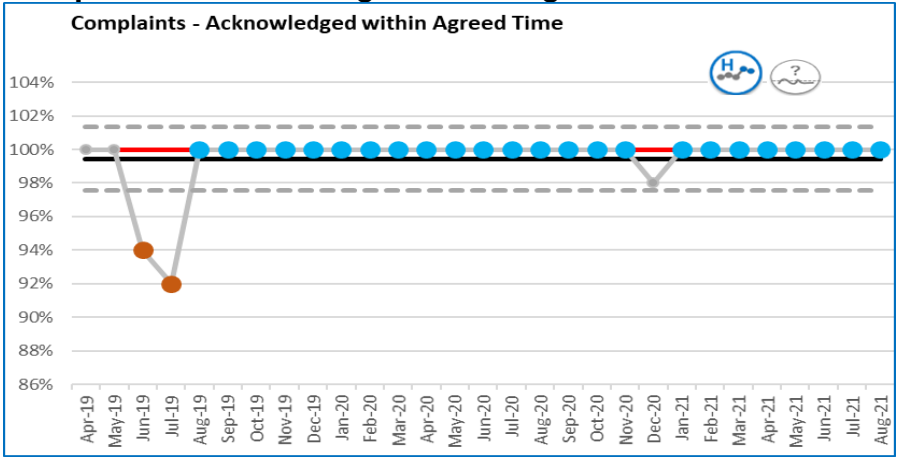
Coroner Regulation 28 Notices



August 2021 actual performance
0
Variance Type
Common Cause
Local Standard
0
Target/ Plan achievement
Achieving target

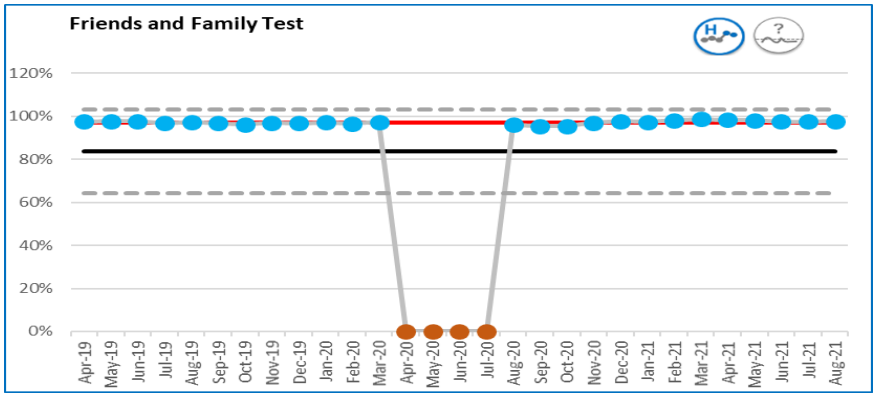
Background	What the Chart tells us	Issues	Actions	Mitigations
Key patient safety measure.	None reported in August.	No Issues to report.	No Actions.	No Mitigations.

Complaints Acknowledged within agreed time



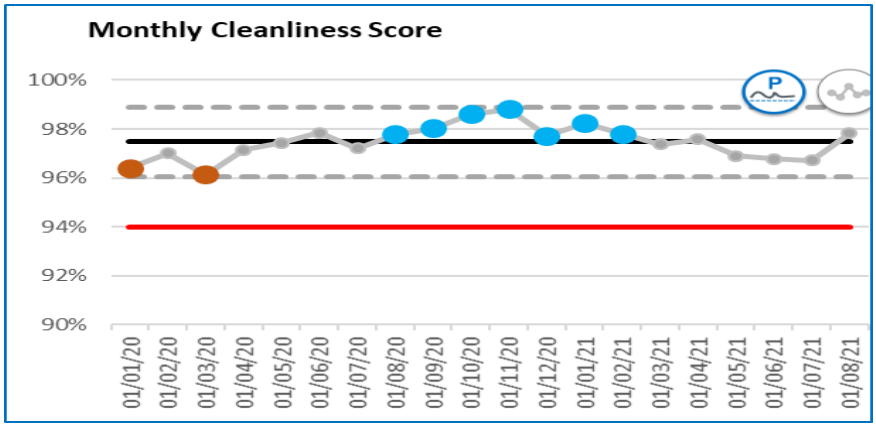
August 2021 actual performance
100% (89% within two days)
Variance Type
Common Cause
National Target
100%
Target/ Plan achievement
Target achieved consistently

Friends and Family Test



August 2021 actual performance
97.7%
Variance Type
Special Cause
National Standard
85%
Target/ Plan achievement
Target achieved consistently

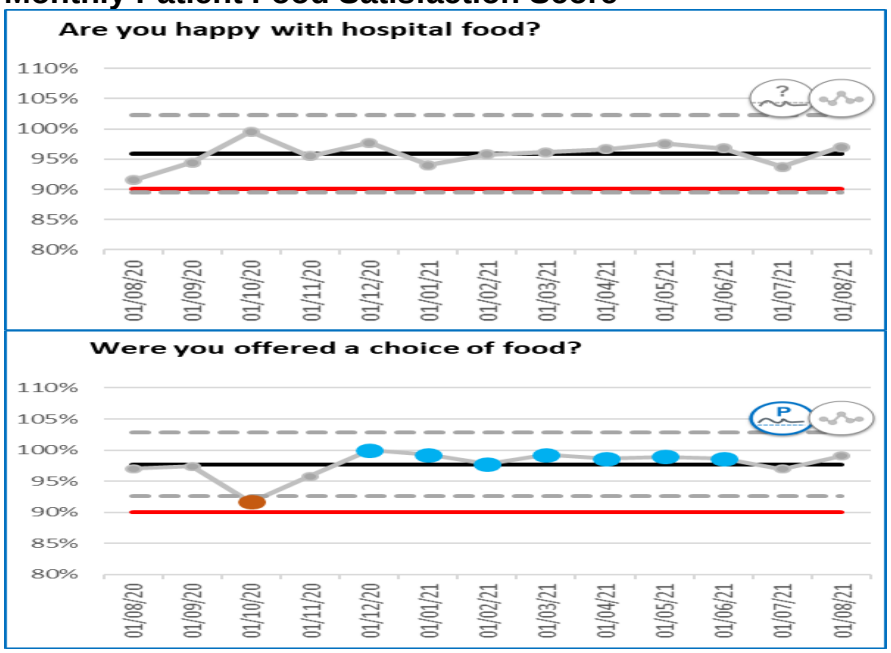
Monthly Cleanliness Score



August 2021 actual performance
97.8%
Variance Type
Common Cause
Local SaTH standard
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. Lower control limit is well above the target suggesting target performance will continue to be delivered	There cleanliness score over the last 3 months have seen a slight decline which has taken them below the mean. However this month has seen an increase that has taken the score above the mean. There are still issues at RSH who are struggling to recruit. Circulation spaces and public areas have reduced scores because low staffing levels has meant that clinical areas have to take priority.	Due to the difficulty in recruiting Cleanliness Technicians at RSH the Cleanliness Management Team are working with the Temporary Staffing and Recruitment Teams to get agency staff to help out short term and to improve levels of recruitment. It is intended to hold an open day with recruitment starting pre-employment checks on the day to speed up the process. The employment check process is being looked at to try and make it quicker and a revised advertising campaign is being developed and planned using social media platforms as well as traditional methods of reaching potential candidates.	Not applicable

Monthly Patient Food Satisfaction Score

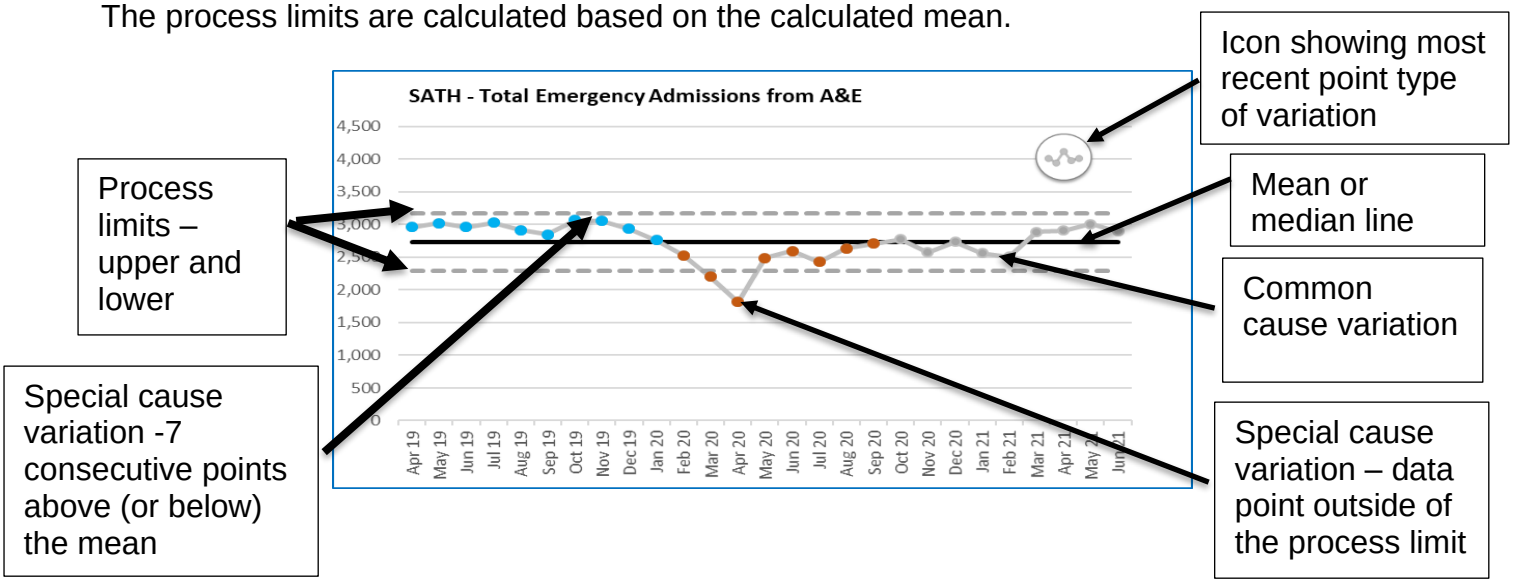


August 2021 actual performance
97.8% for satisfaction with food and 99.0% for satisfaction with choice.
Variance Type
Common Cause
Local SaTH standard
90%
Target/ Plan achievement
On target to achieve local standard

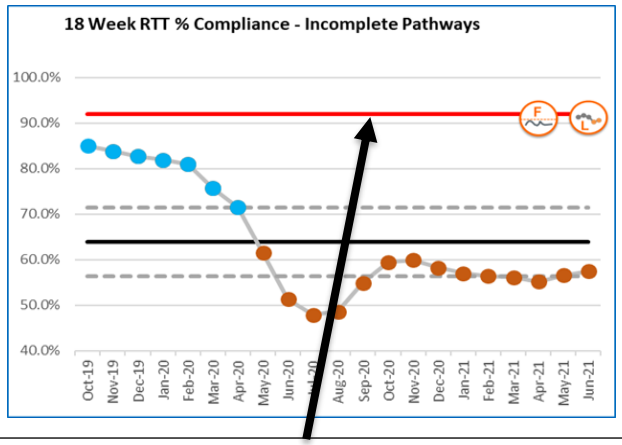
Background	What the Chart tells us:	Issues	Actions	Mitigations
This data is taken from the monthly Matron's Audit where 10 patients per month per ward are asked whether they are happy with the hospital food and the choice they were given.	There is common cause variation with both measures for hospital food and they remain within the upper and lower control limits. The score for being happy with hospital food has risen again 2% this month though it is not clear at this stage what has caused this.	There are no concerns at present which should effect our ability to achieve the target.	Not applicable.	Not applicable.

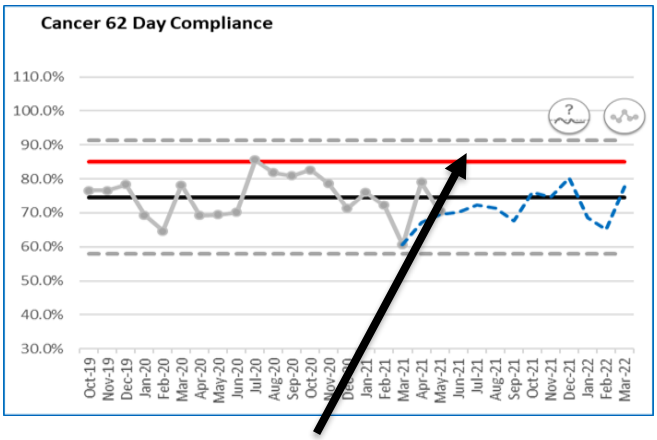
Appendix 2: Understanding Statistical control process charts in this report

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.



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





Appendix 3: 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's
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