Board of Directors' Meeting
9 December 2021

Agenda item	296/21			
Report	Integrated Performance Report			
Executive Lead	**Louise Barnett CEO**			
	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) 25.11.21, FPAC 30.11.21 and QSAC 24.11.21.			
Dependent upon (if applicable)**:**	N/A			
Executive summary:	This report provides the Board of Directors with an overview of the performance indicators of the Trust to the end of October 2021. Key performance measures are analysed over time to understand the variation-taking place and the level of assurance that can be inferred from the data. The indicators have been scrutinised by QSAC and FPAC. 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 provided at the front of the report. The Board of Directors are requested to **review** the content of this report.			
Appendices:	1. Key Performance Indicators reported where performance is in-line with plan/target. 2. Understanding SPC charts. 3..Glossary of terms .			
Lead Executive:				

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. The measures have been scrutinised by the relevant committees of the board and 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 dashboard identifies the scrutiny and governance route for each measure included in the report.
Where performance is in line with expected standards the measures are included in the appendix for completeness.
Performance trajectories aligned to the H2 plan and agreed local quality improvement strategy targets are included, with expected year-end position included in the dashboard.

The report is aligned to the Trust's functional domains and includes an overarching executive summary.

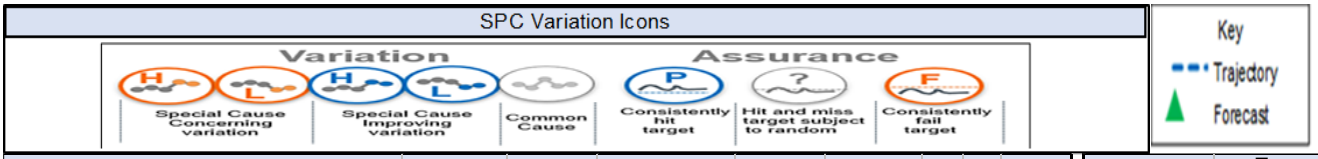
Contents

1. Executive Summary
Louise Barnett, Chief Executive

- There has continued to be a high prevalence of COVID-19 in the local community with an increase in the number of patients admitted to hospital with COVID-19. The (original) vaccination programme is continuing to perform well and is helping to reduce the direct relationship between community infections and the volume of hospitalisations (compared to earlier waves of the virus). We remain extremely vigilant as the increased admissions have consequences not only for our patients with COVID-19, but also on our ability to treat other patients and reduce our waiting lists.
- The month of October saw considerable operational pressures, particularly relating to some lengthy delays for patients accessing our emergency departments, and challenges around overall health system (and regional) capacity for urgent and emergency care services. We are working hard to address these challenges with system and regional partners, including reducing the number of patients in acute beds that are medically fit for discharge and supporting patients to be discharged earlier in the day where possible. The winter admission avoidance schemes starting in November should also provide additional capacity outside of the acute hospital setting, to ensure appropriate alternatives are in place for patients who might otherwise present at our Emergency Departments.
- During October, we worked with system partners to agree our activity plan for the remainder of the year. To offset the impact of internal constraints, we are planning to carry on providing additional elective capacity through the independent sector and in partnership with RJAH. We are delivering elective activity in accordance with our plans and are beginning to see reductions in waits for diagnostics and planned care. We recognise we have a long way to go to return to pre-COVID-19 waiting times and waiting list sizes, and further work is progressing to develop service options that re-build sustainable pathways for our patients.
- October has seen increased staffing challenges, linked to a rise in staff absences combined with an ongoing level of vacancies, which in aggregate exceed our 10% target. These challenges mean that we are more reliant on bank, locum and agency staffing to maintain our services. We are actively recruiting staff through a wide variety of different channels and are implementing a number of initiatives that aim to make SaTH a more attractive place to work, including increasing our flexible working arrangements.
- The financial position for the second half of 2021-22 is currently being finalised and will support the continuation of planned additional activity. The first half of 2021-22 saw the Trust broadly deliver the expected deficit plan, excluding the impact of changes to Elective Recovery Funding. In the first half of the year, the Trust also delivered its efficiency plan and underspent against its capital allocation.
- In November, we received a CQC report giving feedback on the recent inspections of a number of core services (urgent and emergency care, medical care, end of life and maternity) and, a well-led review. Whilst the Trust remains with an overall rating of Inadequate, the report recognises the significant improvements that have been

made across many areas with a number of areas moving from Inadequate to Requires Improvement or Good.

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	Aug 21	94.0	100	100			No		100
RAMI	QSAC	Sep 21	87.3	100	100			No		100
Infection										
HCAI - MSSA	QSAC	Oct 21	1		<2.3			No	14	28
HCAI - MRSA	QSAC	Oct 21	0	0	0			No	1	0
HCAI - C.Difficile	QSAC	Oct 21	4	<4.08	<2.5			Yes	18	30
HCAI - E-coli	QSAC	Oct 21	4	<10.17	<3.16			Yes	29	38
HCAI - Klebsiella	QSAC	Oct 21	0	2	<1			No	8	13
HCAI - Pseudomonas Aeruginosa	QSAC	Oct 21	0	<0.83	0			No	3	3
Patient harm										
Pressure Ulcers - Category 2 and above	QSAC	Oct 21	16		<13			Yes	87	152
Pressure Ulcers - Category 2 Per 1000 Bed Days	QSAC	Oct 21	0.73							tbc
VTE	QSAC	Sep 21	94.3%	95%	95%			Yes		95%
Falls - total	QSAC	Oct 21	127		<89			Yes	779	1074
Falls - per 1000 Bed Days	QSAC	Oct 21	5.86	6.60	<4.5			Yes	6.90	4.50
Falls - with Harm per 1000 Bed Days	QSAC	Oct 21	0.22	0.19	<0.17			Yes	0.10	0.17
Never Events	QSAC	Oct 21	1	0	0			Yes	1	0
Coroners Regulation 28s	QSAC	Oct 21	0		0			No	1	0
Serious Incidents	QSAC	Oct 21	9		N/A				59	57
Mixed Sex Breaches	QSAC	Oct 21	48	0	0			Yes	232	tbc
Patient Experience										
Complaints	QSAC	Oct 21	46		<56			No	419	672
Complaints Responded within agreed time	QSAC	Sep 21	46%	85%	85%			Yes		85%
Complaints Acknowldeged within agreed time	QSAC	Oct 21	100%		100%			No		100%
Compliments	QSAC	Oct 21	24 letters of thank you received.						289	tbc
Friends and Family Test	QSAC	Oct 21	97.2%	80%	80%			No	94.16%	80.00%
Maternity										
Smoking rate at Delivery	QSAC	Oct 21	9.8%	6.0%	6.0%			Yes	12.1%	6.0%
One to One Care In Labour	QSAC	Oct 21	99.7%	100.0%	100.0%			Yes	99.3%	100.0%
Delivery Suite Acuity	QSAC	Oct 21	50.0%	85.0%	85.0%			Yes		85.0%
Caesarean Sections rate of Robson Group 1 Delive	QSAC	Oct 21	12.2%	3.4%	3.4%			Yes	16.1%	3.4%
Caesarean Sections rate of Robson Group 2 Delive	QSAC	Oct 21	50.0%	42.0%	42.0%			Yes	43.2%	42.0%
Caesarean Sections rate of Robson Group 5 Delive	QSAC	Oct 21	85.7%	85.0%	85.0%			Yes	76.6%	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	Oct 21	6008		6732			Yes		6732
Total temporary staff -FTE	FPAC	Oct 21	691					Yes		tbc
Staff turnover rate (excludes junior doctors)	FPAC	Oct 21	1.1%	0.8%	0.75%			Yes	1.2%	0.8%
Sickness absence rate Excluding Covid Related	FPAC	Oct 21	5.7%		4.00%			Yes	5.0%	4%
Covid Related absence rate	FPAC	Oct 21	1.7%					Yes		
Agency Expenditure	FPAC	Oct 21	£2,639m	£2.860m	£2.860m			No	£18.302m	
Appraisal Rate	FPAC	Oct 21	84%	90%	90.0%			Yes		90%
Appraisal Rate (Medical Staff)	FPAC	Oct 21	89%	90%	90.0%			Yes		90%
Vacancies	FPAC	Oct 21	613 (10.2%)	<10%	<10%			Yes		<10%
Statutory and Mandatory Training	FPAC	Oct 21	85%	90%	90.0%			Yes		90%
Trust MCA – DOLS & MHA	FPAC	Oct 21	77%	90%	90%			Yes		90%
Safeguarding Adults - level 2	FPAC	Oct 21	88%	90%	90%			Yes		90%
Safeguarding Children – level 2	FPAC	Oct 21	90%	90%	90%			No		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	Oct 21	35033					Yes		tbc
RTT Waiting list -English	FPAC	Oct 21	31325		30806			Yes		27832
RTT Waiting list -Welsh	FPAC	Oct 21	3708					Yes		tbc
18 Week RTT % compliance -incomplete pathways	FPAC	Oct 21	57.2%	92%				Yes		
26 Week RTT % compliance -incomplete pathways	FPAC	Oct 21	71.0%	92%				Yes		
52+ Week breaches - Total	FPAC	Oct 21	2690	0				Yes		tbc
52+ Week breaches - English	FPAC	Oct 21	2432	0	2486			Yes		2108
52+Week breaches - Welsh	FPAC	Oct 21	258	0				Yes		tbc
78+ Week breaches - Total	FPAC	Oct 21	805	0				Yes		
78+ Week breaches - English	FPAC	Oct 21	733	0				Yes		
78+ Week breaches - Welsh	FPAC	Oct 21	72	0				Yes		
104+ Week breaches - Total	FPAC	Oct 21	35	0	42			Yes		74
104+ Week breaches - English	FPAC	Oct 21	31	0	38			Yes		71
104+ Week breaches - Welsh	FPAC	Oct 21	4	0	4			Yes		3
Cancer										
Cancer 2 week wait	FPAC	Sep-21	86.8%	93%	83%			Yes	83.7%	93%
Cancer 62 day compliance	FPAC	Sep-21	64.1%	85%	62%			Yes	66.9%	85%
Diagnostics										
Diagnostic % compliance 6 week waits	FPAC	Oct-21	64.4%	99%				Yes		tbc
DM01 Patients who have breached the standard	FPAC	Oct-21	4436	0	1254			Yes		tbc
Emergency Department										
ED - 4 Hour performance	FPAC	Oct-21	57.7%	95.0%	64%			Yes	65.1%	78%
ED - Ambulance handover > 60mins	FPAC	Oct-21	1052	0				Yes	4655	tbc
ED 4 Hour Performance - Minors	FPAC	Oct-21	88.9%	95%	95%			Yes	92.0%	95%
ED 4 Hour Performance - Majors	FPAC	Oct-21	29.7%	95%				Yes	40.4%	tbc
ED time to initial assessment (mins)	FPAC	Oct-21	43	15	15			Yes		15mins
12 hour ED trolley waits	FPAC	Oct-21	132	0	0			Yes	495	tbc
Total Emergency Admissions from A&E	FPAC	Oct-21	2938					Yes	20367	29744
% Patients seen within 15 minutes for initial assessr	FPAC	Oct-21	25.27%					Yes	42.9%	
Mean Time in ED Non Admitted (mins)	FPAC	Oct-21	238					Yes	207	
Mean Time in ED admitted (mins)	FPAC	Oct-21	566					Yes	433	
No. Of Patients who spend more than 12 Hours in E	FPAC	Oct-21	1057					Yes	4166	
12 Hours in ED Performance %	FPAC	Oct-21	8.20%					Yes	5%	
Hospital Occupancy and activity										
Bed Occupancy -G&A	FPAC	Oct-21	86.8%	92%	91%			Yes		92%
ED activity (total excluding planned returns)	FPAC	Oct-21	12888		12205			No	90637	148493
ED activity (type 1 &2)	FPAC	Oct-21	10861		10095			No	76431	123702
Total Non Elective Activity	FPAC	Oct-21	4940		5851			Yes	35377	65129
Outpatients Elective Total activity	FPAC	Oct-21	51698		48366			No	373129	565514
Total Elective IPDC activity	FPAC	Oct-21	5272		5225			No	37041	65183
Diagnostic Activity Total	FPAC	Oct-21	17519		15954			No		197619
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	Oct-21	(0.420)		1.700			Yes	18.182	1.700
Efficiency	FPAC	Oct-21	0.570		7.550			No	3.448	7.438
Income and Expenditure	FPAC	Oct-21	(1.645)		(9.590)			Yes	(7.411)	(9.590)
Cumulative Capital Expenditure	FPAC	Oct-21	2.103		39.159			Yes	7.135	39.159

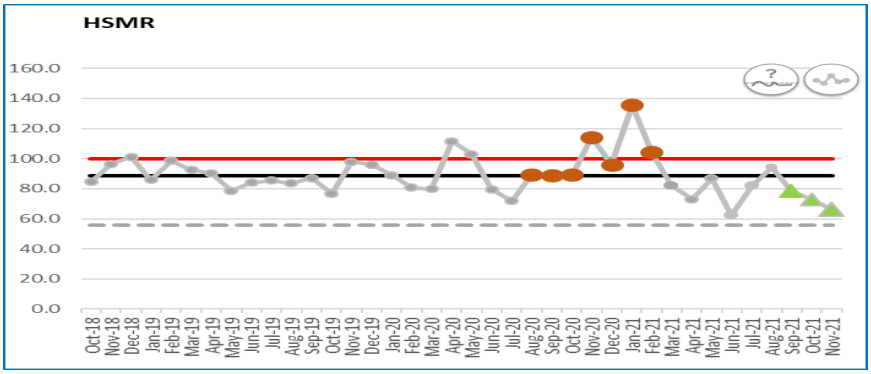
3. Quality Executive Summary
Hayley Flavell, DoN, Richard Steyn and John Jones Acting Medical Directors

- Mortality is reported via HSMR and RAMI. HSMR has been rebased and as expected remains below the accepted reference level of 100, as does RAMI. The conditions with the highest number of excess deaths are: urinary tract infections, pneumonia and acute and unspecified renal failure. Case review into these 3 conditions have been conducted and learning outcomes derived from the findings and used to determine whether any further audit is required. Both HMSR and RAMI exclude COVID-19 deaths from the indices.
- Following the work undertaken to ensure patients are not admitted to wards without a VTE assessment completed the delivery remains close to the target, with work progressing to improve compliance with the change continuing to embed the process in the Divisions.
- Our performance on all the Hospital Care Acquired Infections (HCAIs) remains better than the national standard set and with the exception of E.coli close to achieving the locally set improvement trajectory for the year. There have been no further cases of MRSA, Klebsiella or Pseudomonas Aeruginosa this month.
- There were 16 pressure ulcers (0.73 per 1000 beddays) last month. The increase in higher grade pressure ulcers, has resulted in additional actions being taken within the Medicine and Emergency Care Division and investigation of the 3 grade 3 ulcers reported on their wards. 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 127 reported this month. The number of falls is consistently higher than the improvement target, with 779 falls having occurred in the year to date (72.5% of the improvement target for the full year).The falls per 1000 bed days remains above the local stretch target for improvement, and the falls with harm per 1000 bed days has increased this month. Three of the falls with harm are subject to SI review this month.
- There were 9 serious incidents this month. These included a wrong site surgery never event, the first never event this year, which is being investigated and learning put in place to prevent a recurrence.
- There was a deterioration in mixed sex breaches this month with 48 reported. These are largely arising from delays to discharge from critical care units, although ward 32 accounted for 12 breaches which relates to segmentation of Covid-19 patients.
- The response time for concerns remains unsatisfactory at 46% for August, although improvement to 75% is forecast for September with the interventions starting to impact. This measure is currently reported two months in arrears due to the agreed extension to response times while the backlog is reduced. It is expected that this will return to the 30 day reporting standard and one month in arrears from early 2022. Trajectories for improvement have been set for each division and are being monitored weekly. The overall trajectory is slightly behind the expected recovery and so this is being closely managed to ensure delivery by the end of December 2021.
- Recruitment in midwifery is improving and it is expected this will have a positive impact on the delivery suite acuity level reported going forward. It is positive to note that the 1-2-1 care in labour has continued to be achieved over 99% of the time.
- There are no coroner section 28s to report this month.
- A CQC Well Led report has been issued during November, with the Trust overall rating of inadequate. This report recognises the progress made from the work undertaken and further work required to improve our services.

4. Quality Exception Reports – Harm

Mortality

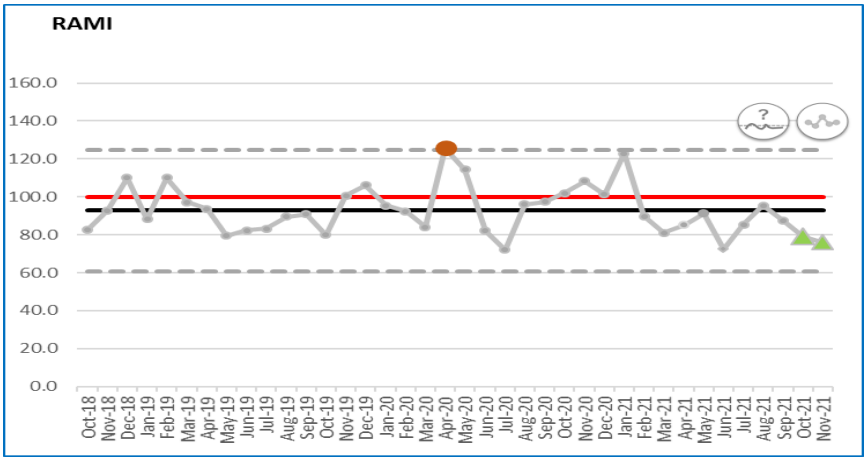
HSMR



August 2021 actual performance
94.03
Variance Type
Special Cause Improvement
Reference Level
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 HSMR model has now been rebased. As anticipated, the indicator has increased but remains below the reference level. Patients coded with a primary diagnosis of COVID-19 are excluded from HSMR.	No Dr Foster Imperial alerts have been received. The upward trend in excess deaths identified since Quarters 2 and 3 2020 for the conditions with the highest number of excess deaths identified within the HSMR indicator; urinary tract infections, pneumonia and acute and unspecified renal failure, has now improved. The trend for all 3 conditions seen on local CUSUM charts has flattened out. A higher HSMR at PRH for admissions on a Saturday versus the peer group remains under review.	Mortality reviews by senior clinicians have been undertaken for 32 cases of the 88 deaths identified between September 2020 and August 2021 where urinary tract infection was the primary diagnosis code. Analysis of this data shows that sepsis was evident in 72% of these cases. Further audit work is required to review this in greater detail in collaboration with the sepsis team to identify if the management of sepsis in these cases was optimum or whether there is any additional learning. Specific sepsis questions have been incorporated into the Mortality Screening tool currently in development with IT, which will help identify cases for mortality review moving forwards as well as assist ongoing sepsis improvement work. Mortality reviews have been undertaken for 101 out of 248 cases where pneumonia was identified as the primary diagnosis code between September 2020 and August 2021. This data is currently being reviewed to determine further audit work required. Mortality reviews have been undertaken for 38 cases out of a total 86 cases where acute and unspecified renal failure was identified as the primary diagnosis code between September 2020 and August 2021. This data is currently being reviewed to determine further audit work 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.

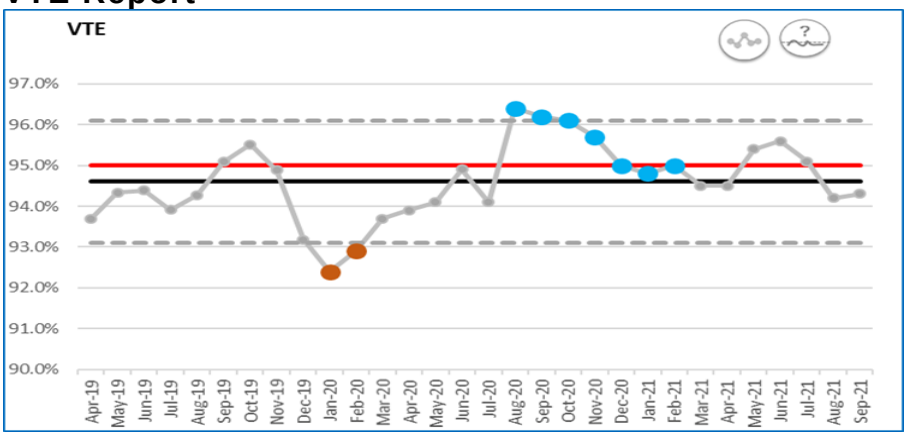
RAMI



September 2021 actual performance
87.29
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 reflecting the expected deaths within the Trust.	The Trust's RAMI position is better than the peer average. The RAMI indicator excludes COVID-19 patients.	The conditions with the highest number of excess deaths are consistent with the HSMR Mortality Indicator: urinary tract infections, pneumonia and acute and unspecified renal failure.	Actions in line with HSMR indicator.	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



September 2021 actual performance
94.3%
Variance Type
Common Cause
National Target
95%
Target / Plan Achievement
Delivery continues to be close to target

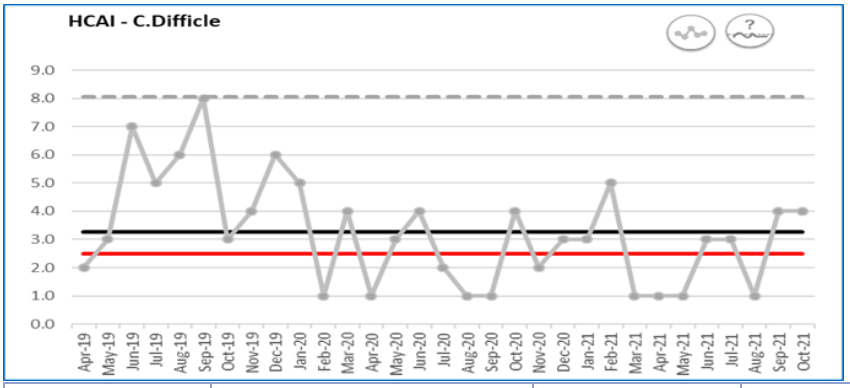
Background	What the Chart tells us	Issues	Actions	Mitigations
This is clinically important in order to protect inpatients from harm by early assessment of patient risk of venous thrombosis.	The graph is showing common cause variation post the intervention made in June 2021.	Performance improved following intervention in May/June 2021 but has varied around the target since this intervention.	Monitoring will continue to ensure the change in practice is embedded.	Divisional PRMs review performance by division.

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. The forecast for the year based on year to date performance shows all national standards being achieved:

HCAI	National threshold set	Local Improvement target	Year to date	Forecast to year end (straight line)
C.Difficile	49	30	18	31
E. coli	122	38	29	50
Pseudonomas.Aeruginosa	10	3	3	5
Klebsiella spp.	24	13	8	14

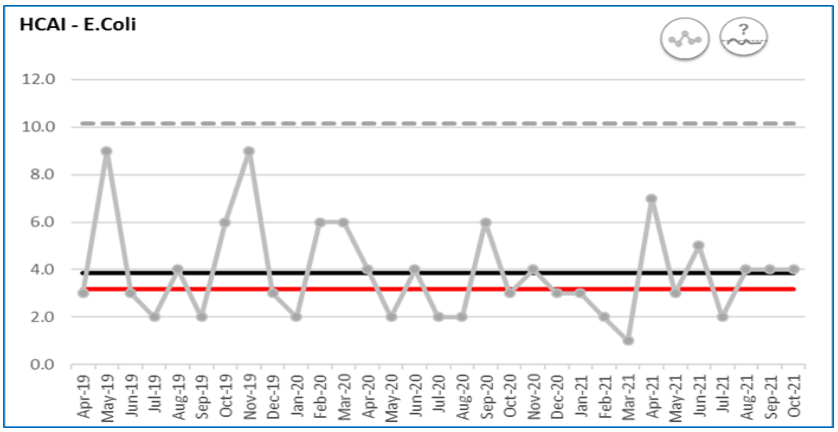
C-Difficile



October2021 actual performance
4
Variance Type
Common Cause
Local Standard
<ave.2.5pm
Target / Plan Achievement
Sustain or improve on 2020/21.

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. The National target has been set at 49.	There were 4 cases of C.Diff in October 2021. YTD there have been 18 cases against a target of no more than 17.5 by month 7. We are seeing common cause variation with the local improvement target being delivered in some months but not others. Overall performance is close to the improvement trajectory set.	There were 2 cases of C.Diff on Ward 22RE, these are being investigated and typing has been sent off to ascertain if this is an outbreak or a period of increased incidence.	RCAs being completed. Immediate actions in relation to ward 22RE include cleanliness of sanitary equipment. Ongoing actions from previous RCAs include: • Timely stool sample • Timely isolation • Completion of stool charts • Antimicrobial prescribing.	Redi-rooms to enable prompt isolation. Monitoring of cleaning schedules. Actions monitored via IPCOG.

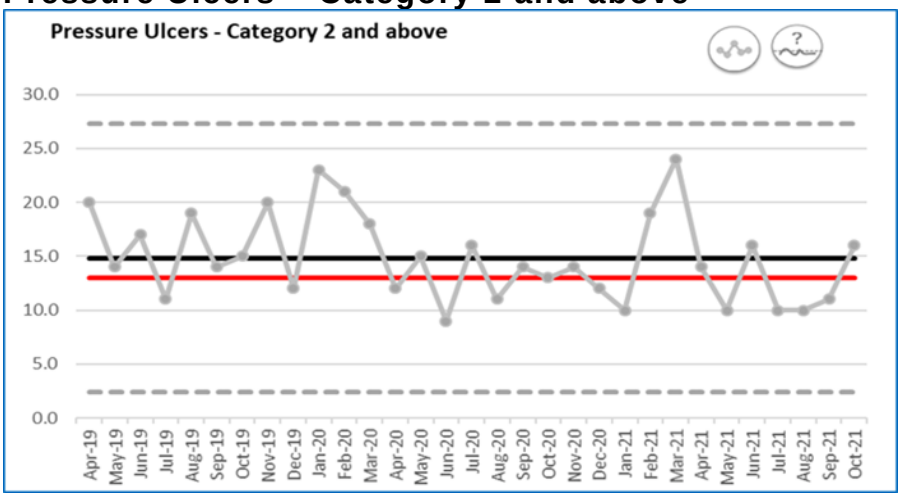
E-Coli



October 2021 actual performance
4
Variance Type
Common Cause
Local Standard
<ave.3.16pm
Target / Plan Achievement
Local target for 2021/22 of no more than 38 cases is unlikely to be delivered at the current run rate.

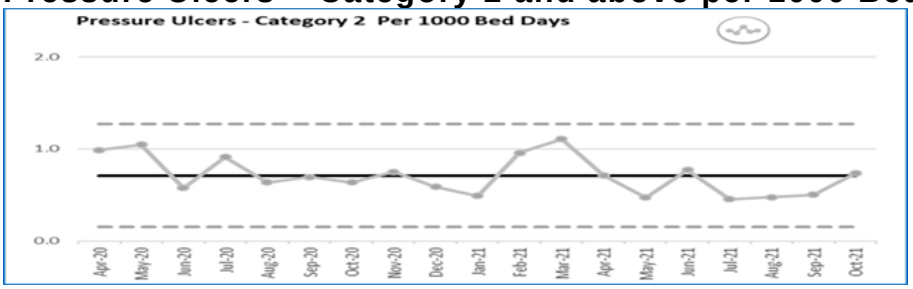
Background	What the Chart tells us	Issues	Actions	Mitigations
Reporting E. Coli bacteraemia has been a mandatory requirement since 2011.	There were 4 cases of post 48 hour E.coli bacteraemia in October 2021. YTD there have been 29 cases which is above the Trust internal target for this time in the year but well below the target set for the Trust by NHSE/I of no more than 122 cases for 2021/22.	The number of cases is below nationally set start but above the internal target.	All cases which are deemed to be device related or where the source of infection cannot be identified have an RCA completed. There is ongoing work being undertaken to ensure that the new catheter insertion documentation and catheter care plan is consistently used across the Trust, Further actions in relation to compliance with catheter care and improvement work to be discussed at the November nursing quality metrics meetings chaired by DON.	Catheter care is monitored via the monthly matron's quality assurance metrics audits, and high impact interventions audits.

Pressure Ulcers – Category 2 and above



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

Pressure Ulcers – Category 2 and above per 1000 Bed days



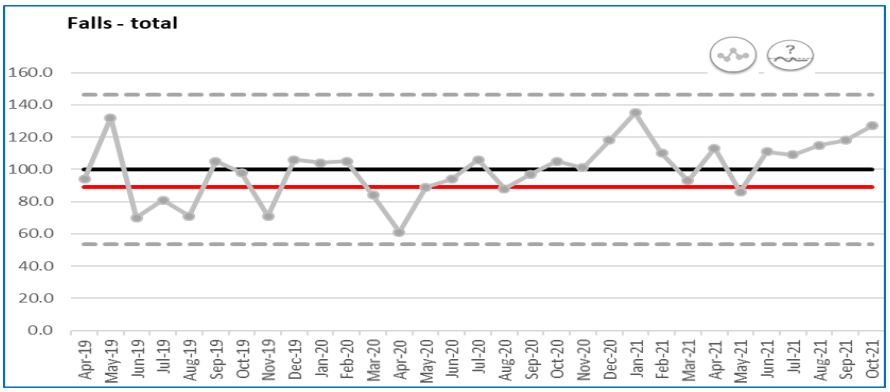
October 2021 actual performance
0.73
Variance Type
Common Cause
Local Standard
tbc

Pressure Ulcers – Total per Division	Number Reported
Medicine and Emergency Care	14
Surgery, Anaesthetics and Cancer	2

Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust aims to reduce the number of hospital acquired pressure ulcers.	There were 16 pressure ulcers in October. This is showing common cause variation, with the year to date position being in line with	There have been 4 Cat 3 pressure ulcers. These are higher level of harm and were all on the medical wards at	Ongoing improvement work based on the outcomes from the RCA investigations include: • Ensuring risk assessments are completed on admission but also when patients condition changes or weekly • Completion of MUST nutritional Tool • Mandated Tissue Viability training	All category 2 pressure ulcers and above have RCA investigation Those that meet the threshold for an SI are investigated and presented at NIQAM

	achievement of improvement target set locally.	RSH: Ward 27, 28, 22 RE and Ward 32.	• Additional support from TVN for areas with category 3 ulcers Senior nurse meeting in the medical division reviewed and agreed actions to ensure consistency in care, and accountability for that care.	Monthly matrons audits of assessments and documentation.

Falls

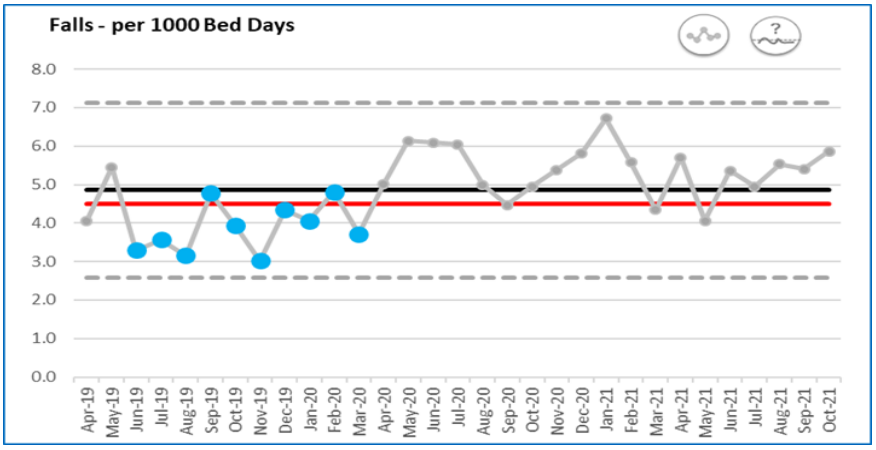


October 2021 actual performance
127
Variance Type
Common Cause
Local Target
<89
Target / Plan Achievement
10% reduction on 20/21

Falls – Total per Division	Number Reported
Medicine and Emergency Care	98
Surgery, Anaesthetics and Cancer	29

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 has increased during quarter 2 the chart continues to demonstrate common cause variation. The year to date performance suggests the year end improvement trajectory will not be achieved.	3 of the falls in October resulted in serious harm one patient sustaining a head injury Ward 26, one patient sustaining a head injury and subsequent death Ward 28 and one resulting in a fractured neck of femur Ward 32. There were a further 2 falls which resulted in moderate harm. Investigations are underway.	The 3 Serious harm cases in October have been reported as Serious Incidents and the investigations are in progress. Ongoing work continues in relation to ensuring: • All patients have a falls risk assessment on admission • Falls care plans in place for patients assessed as at risk of falls • Lying and standing BP completed • Falls reassessments completed weekly or when patient's condition changes • Post falls care bundle consistently applied.	Monitoring via monthly nursing metrics audits and discussed/actions agreed at monthly monitoring meetings. Baseline exemplar peer reviews. Falls steering group continues to meet monthly and monitors falls data, falls Sis and falls improvement work. All SI investigations reviewed at NIQAM and summary report of cases will now go to RALIG.

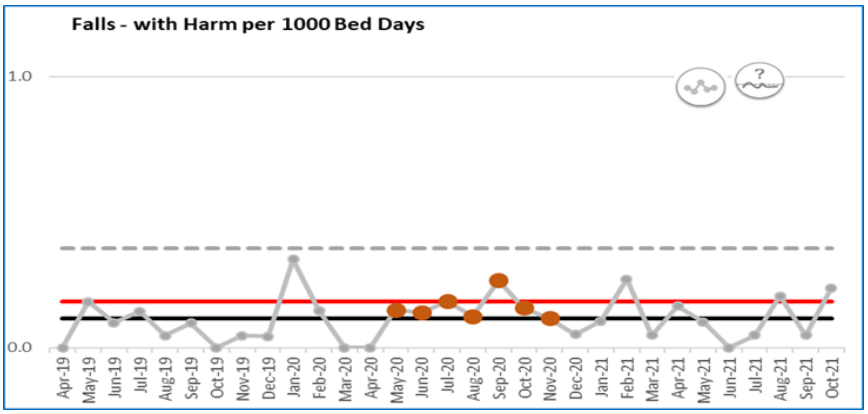
Falls – per 1000 Bed Days



October 2021 actual performance
5.86
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.	Falls per 1000 bed days increased during October 2021 from the previous month, remaining within common cause variation but worse than the local improvement target for the 5th consecutive month.	Falls per 1000 bed days remains worse than local trust target however; we are lower than national benchmark and some of our peer organisations.	As per Falls with harm report below.	As per Falls with harm report below.

Falls – with Harm per 1000 Bed days

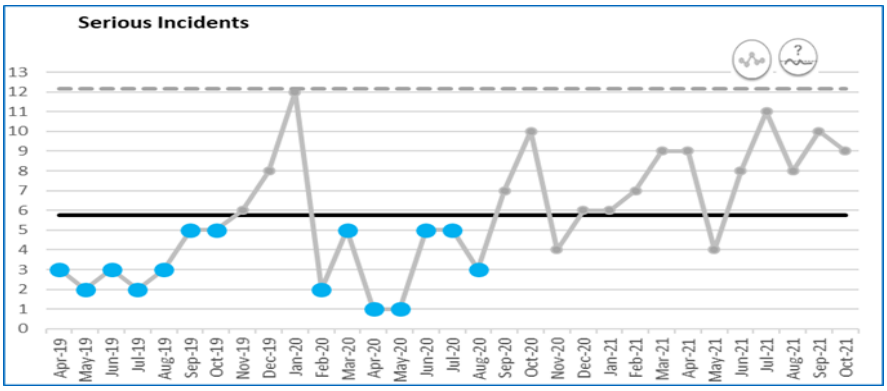


October 2021 actual performance
0.22
Variance Type
Common Cause
Local Target
0.17
National Standard
0.19
Target/ Plan achievement
Local Target set for 21/22

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 with harm per 1000 bed days decreased in the first quarter of 2021/22. For quarter 2, there has been a slight increase to 0.29. The current performance is worse than both national and	3 of the falls in October resulted in Serious Harm one patent sustaining a head injury Ward 26, one patient sustaining a head injury and subsequent death Ward 28 and one resulting in a fractured neck of femur Ward 32. There were a further 2 falls which resulted in moderate harm.	The 3 Serious harm cases in October have been reported as Serious Incidents and the investigations are in progress Ongoing work continues in relation to ensuring:: • All patients have a falls risk assessment on admission • Falls care plans in place for patients assessed as at risk of falls	Monitoring via monthly nursing metrics audits and discussed/actions agreed at monthly monitoring meetings. Baseline exemplar peer reviews. Falls steering group continues to meet monthly and monitors falls data, falls Sis and falls improvement work. All SI investigations reviewed at NIQAM and summary report of

	local expected standards.	Investigations are underway.	• Lying and standing BP completed Falls reassessments completed weekly or when patient's condition changes.	cases will now go to RALIG.

Serious Incidents

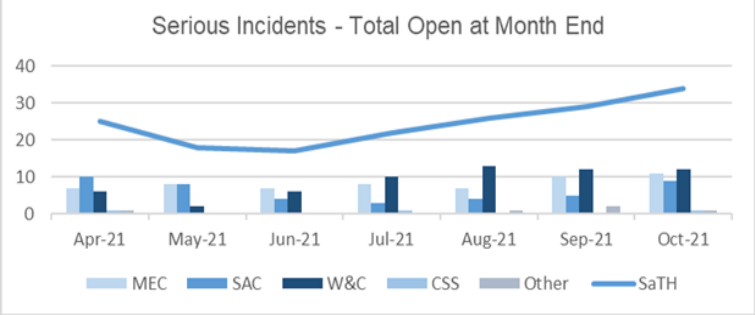


October 2021 actual performance
9
Variance Type
Common Cause
Local Standard
n/a
Target/ Plan achievement
n/a –seeking to encourage reporting of incidents

SI theme	Number Reported
Category 3 pressure ulcer (Ward 21)	1
Wrong site surgery (Never Event) - theatres	1
Medication error (Gentamicin) - SAU	1
Delayed diagnosis (Breast Cancer) – PRH OPD	1
Delayed diagnosis (Stroke management) – RSH ED	1
Diagnostic incident (mis-reporting of CT scan) RSH radiology	1
Fall resulting in a head injury (Ward 36)	1
Fall resulting in a head injury (Ward 28)	1
Fall resulting in a fractured neck of femur (Ward 32)	1
Total	**9**

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.	October saw a small decrease in the reporting of serious incidents with a total of 9 from 10 in September. There were 10 SIs reported for the same period in 2020.	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 be seen in reporting figures.	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.

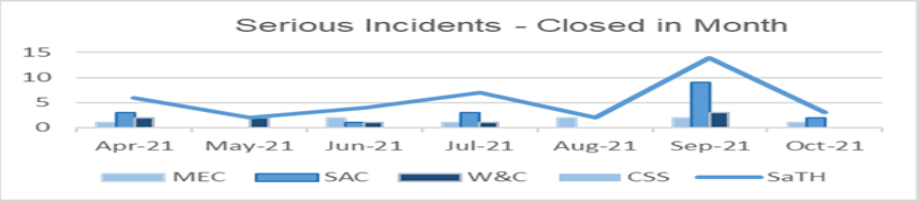
Serious Incidents – Total Open at Month End



SI – Total Open at Month End per Division	Number Reported
Medicine & Emergency Care	11
Surgery, Anaesthetics and Cancer	9
Women and Children's	1
Clinical Support Services	12
Other – SaTH department	1
Total	**34**

Background	What the Chart tells us	Issues	Actions	Mitigations
Current number of open serious incidents.	Number of open SIs.	There are currently 34 open SIs, 3 of which are being investigated by HSIB externally to the organisation. The number of open SIs is increasing but is consistent with a steady increase in reporting.	Monitoring of progress of investigation.	Weekly review of progress.

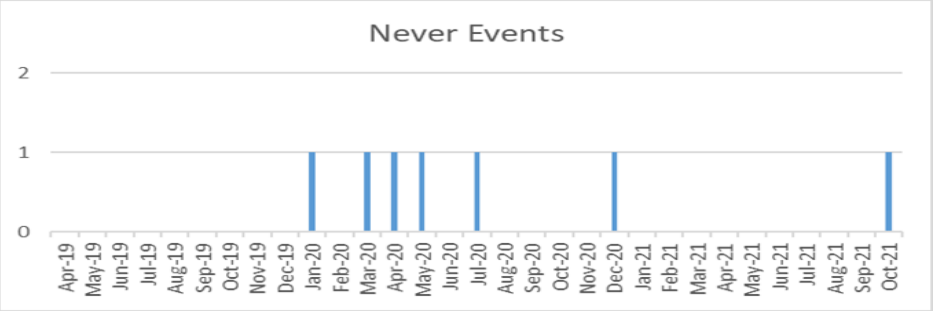
Serious Incidents – Closed in Month



October 2021 actual performance
SATH
3

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 3 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. Attain sustainable learning from incidents.	Weekly review of progress of investigations.

Never Events

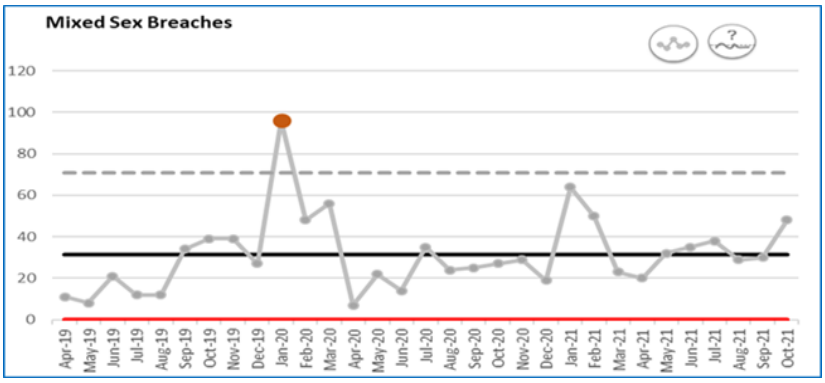


October 2021 actual performance
1
Variance Type
Special Cause
Local Standard
0
Target/ Plan achievement

Background	What the Chart tells us	Issues	Actions	Mitigations
Key patient safety measure.	One new Never Event has been reported in October.	Never Events pose a risk for the organisational reputation as well as potential harm to patients.	The investigation into the Never Event has been initiated.	A review of the processes linked to and information contained within to come in (TCI) forms has been initiated.

5. Quality Exception Reports – Patient Experience

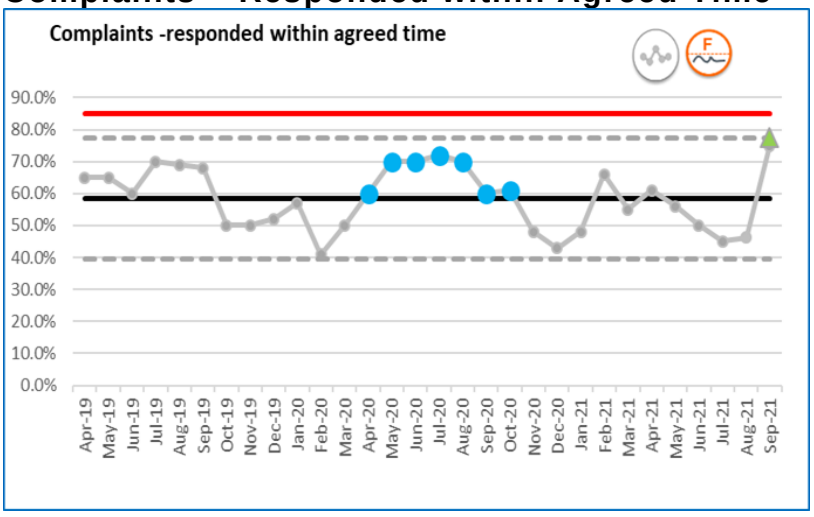
Mixed Sex Breaches Exception Report



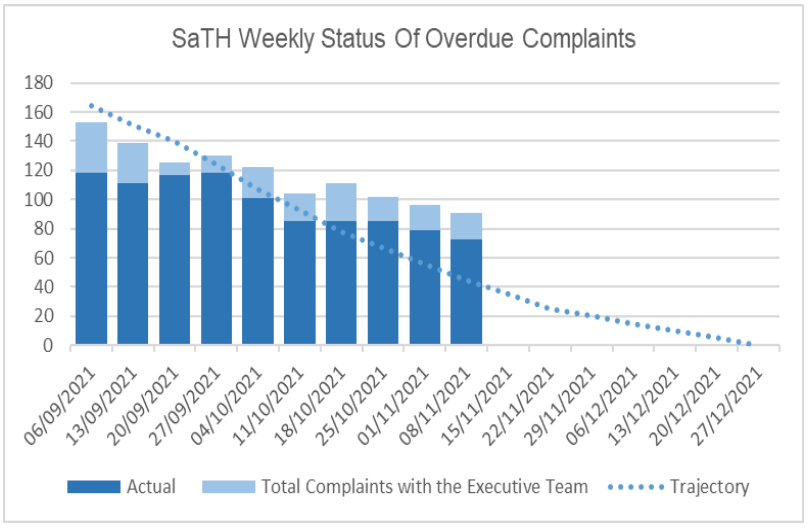
October 2021 actual performance
48
Variance Type
Common Cause
National Target
0
Target/ Plan achievement
Continuing to breach this target.

Location	Number of breaches	Additional Information
ITU / HDU (PRH)	5 Primary breaches	3 Medical and 2 Surgical
ITU / HDU (RSH)	31 Primary breaches	9 Medical and 22 Surgical
Ward 32	12 Primary breaches	

Complaints – Responded within Agreed Time



August 2021 actual performance	
46% (September Forecast 75%)	
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.	

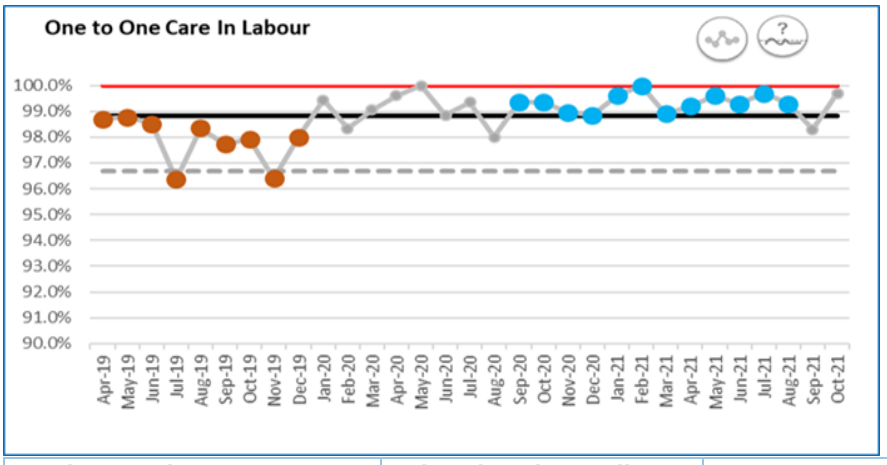


Overdue Complaints per Division	Number Reported
Medicine and Emergency Care	61
Surgical, Anaesthetics and Cancer	20
Women and Children's	8
Clinical Support Services	2
Total	**91**

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.	Numbers for August remain low, however the forecast figure for September shows significant improvement, indicating that measures taken are starting to impact.	Clinical pressures and access to records have created delays in divisions responding to complaints.	New processes have been put in place, and there is regular close monitoring of all open cases to support divisions in investigating and responding to complaints in a timely manner.	All complainants are kept updated about delays in their response.

6. Maternity Indicators

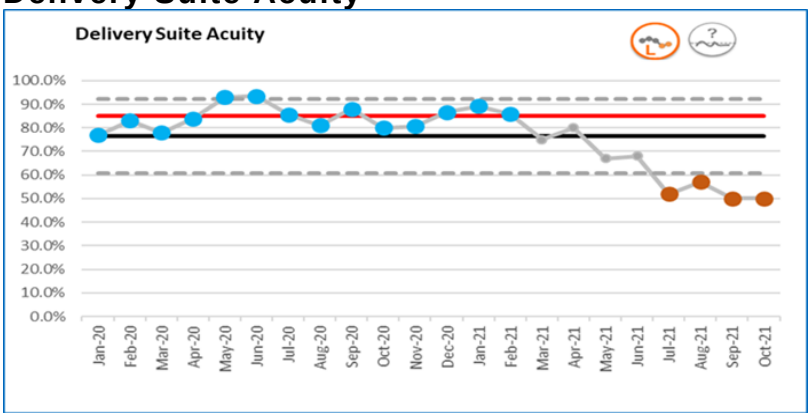
One to One Care in Labour



October 2021 actual performance
99.7%
Variance Type
Common Cause
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.	121 care has been consistently >99% since Sept 2020 demonstrating an improvement in the correct direction.	Staffing levels challenging due to vacancies, sickness and COVID-19 related absences.	Ongoing monitoring using acuity tool. Ongoing recruitment in progress.	Delivery suite coordinators manage acuity and SMT huddles twice daily. Escalation policy followed when required.

Delivery Suite Acuity



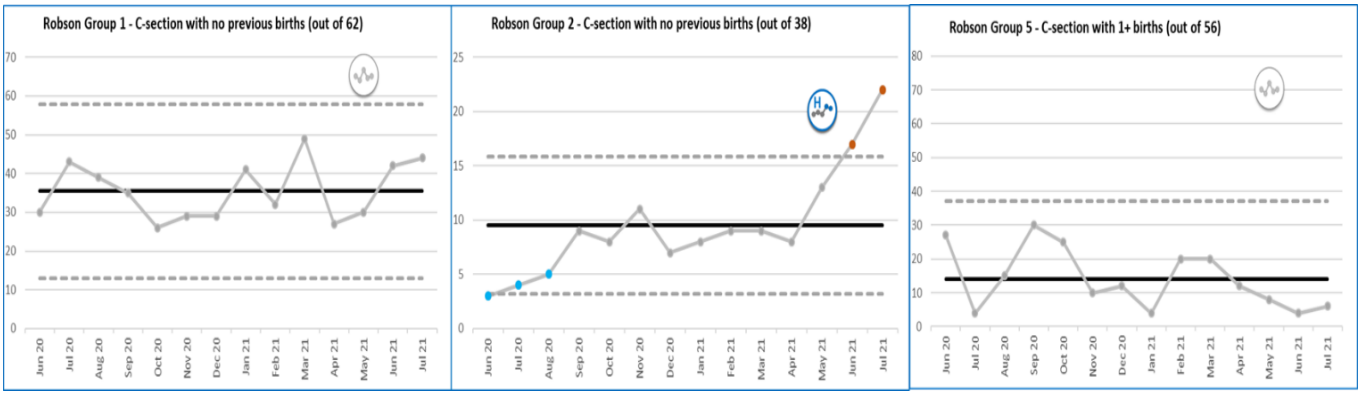
October 2021 actual performance
50%
Variance Type
Special Cause Concern
National Standard
85% (Birth Rate Plus)
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

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.	Workforce challenges have been ongoing since March 21.	Ongoing vacancies, Maternity Leave, secondments have caused imbalance in service provision on the delivery suite. Due to staffing challenges the midwifery led unit has been on divert intermittently since July.	10.8 WTE band 5 midwives commenced mid Sept.2021. Further 2.8 WTE band 5 midwives commence Nov.2021. Use of temporary staffing to support teams where possible. Additional hours for existing staff. Additional training provided on use of Birth Rate + acuity tool to have confidence in the data.	Use of SMT huddles to assess acuity across unit to maintain safety and deploy staff to areas in high acuity. Use of escalation policy to support teams and areas.

Caesarean Section

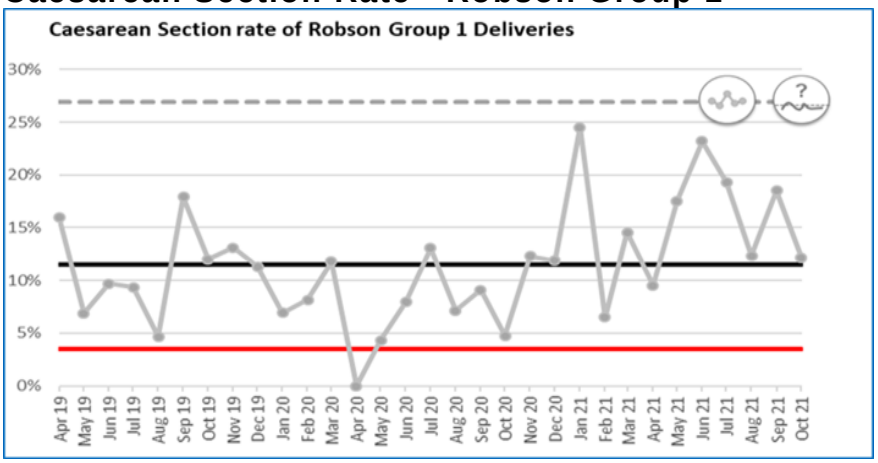
The Robson classification is recognised as a global standard for assessing, monitoring and comparing Caesarean section rates both within healthcare facilities and between them.
The system classifies all women into 10 mutually exclusive categorises using 5 obstetric characteristics.
Our benchmarking data reports on 3 Robson scores up to July 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.

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Robson group 1 c-section with no previous births	Jul 21	3.5%	6.3%			32
Robson group 2 c-section with no previous births	Jul 21	42.0%	44.2%			42
Robson group 5 c-section with 1+ previous births	Jul 21	85.0%	69.6%			91



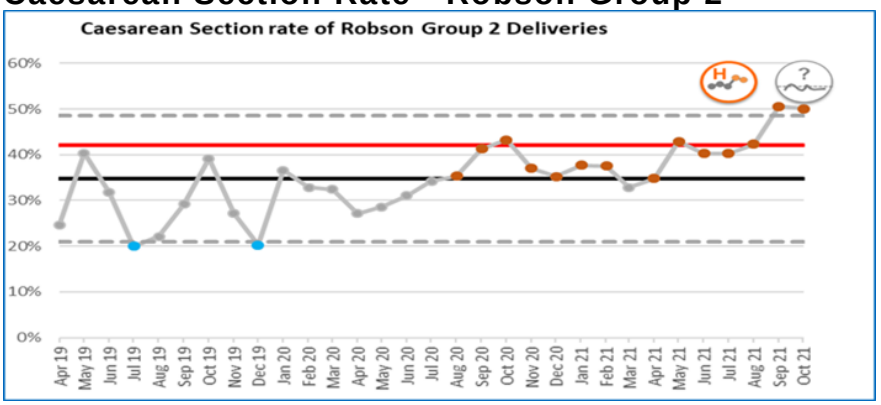
As these are new indicators they data quality is being clinically reviewed, while this work is completed the figures should be treated with caution.

Caesarean Section Rate - Robson Group 1



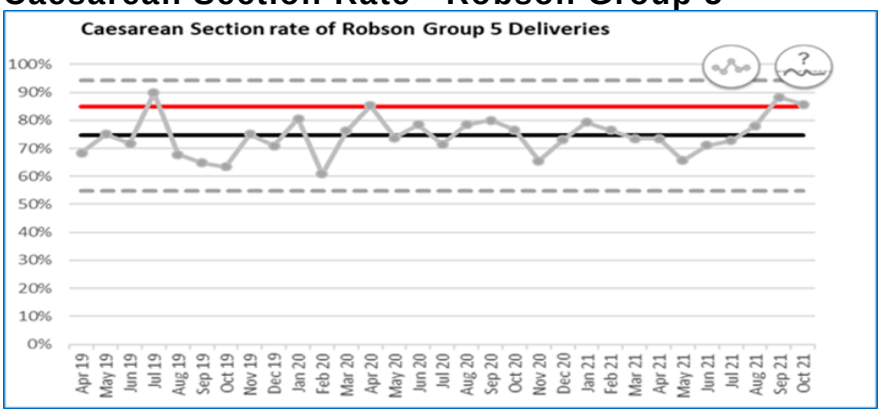
October 2021 actual performance
12.2%
Variance Type
Common Cause
Expected Range
3.4% (Public View)
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

Caesarean Section Rate - Robson Group 2



October 2021 actual performance
50%
Variance Type
Special Cause Concern
Expected Range
42% (Public View)
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

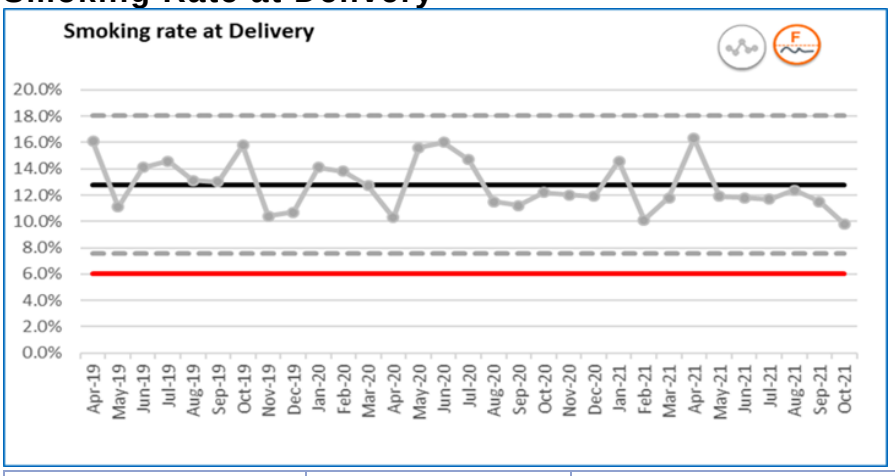
Caesarean Section Rate - Robson Group 5



October 2021 actual performance
85.7%
Variance Type
Common Cause
Expected Range
85% (Public View)
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

Background	What the Chart tells us:	Issues	Actions	Mitigations
SaTH Caesarean Section (CS) rate has traditionally been low. CS rates are rising nationally. They will be impacted by women's choices which we are committed to supporting and updated NICE guidance. CS now being reported in Robson Groups 1,2 and 5	The CS rate for Robson group 1 women would appear to be high against a background rate of 3.4% (as reported by Public View). Concerns re: accuracy of data input to Medway which will impact the group that each woman falls into.	Robson 1 rate can be influenced by patient choice. Accuracy of recording within previous maternity system. Changes in guidelines may result in higher levels of C.Section.	Current work is underway to manually validate the data for groups 1 and 2. Further work to reconcile the data that appears on Public View and our own dashboard is required. Introduction of Badgernet with staff training to support correct classification	Work being clinically-led and reported to the Maternity Governance meeting monthly

Smoking Rate at Delivery



October 2021 actual performance
9.8%
Variance Type
Common Cause
National Target
6% March 2022
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

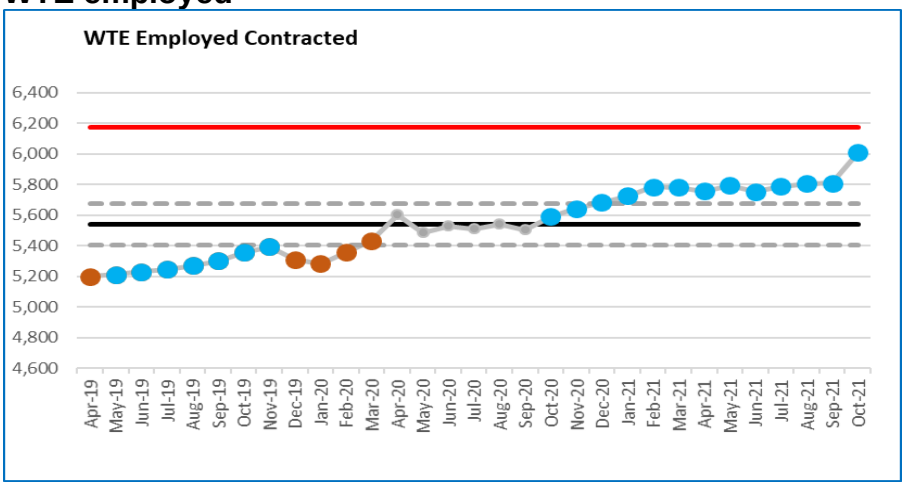
Background	What the Chart tells us:	Issues	Actions	Mitigations
The National SATOD government target for smoking at time of delivery has been set to 6% by March 2022. All pregnant smokers in Shropshire and Telford and Wrekin are referred to and supported by the Public Health Midwifery team based at PRH.	Further reduction in SATOD rates. Lowest monthly rate recorded by SATH. National average currently 9.5%-therefore current performance is showing improvement almost in line with national rates.	Awaiting new Healthy Pregnancy Support Service (HPSS) to launch. Launch date January 2022. Therefore, existing barriers still remain-areas of deprivation require targeted support and partner/wider-family support with smoking cessation still to be implemented.	Launch HPSS -service will include smoking cessation support, weight management, vaccination programme and service signposting for a holistic approach to public health maternity services.	Despite significant decline in SATOD rates, the 6% government target may still be unachievable by March 2022.

7. Workforce Summary
Rhia Boyode, Director of People and Organisational Development

- COVID-19 related absence (1.7%) continues to be at average levels during October with consistent levels of staff testing positive, averaging three per day.
- Lateral flow reporting rates have increased this month to 18%; reports are now available showing managers which staff have returned results, rates for their teams and departments.
- Overall, we are seeing higher non-COVID-19 absence levels than normally expected for this time of year. Absence rate of 5.7% equating to 338 whole time equivalent (WTE) staff. Absence levels attributed to causes mental health and conditions such as musculoskeletal, coughs, colds, and flu remain high. Sickness absence support delivered by our people advisory team is in place.
- Flu and COVID-19 booster programme is now up and running with current Flu uptake at 3401 staff (43.7%) and 4544 (58%) staff having received a booster vaccine.
- Statutory training has remained at 85% with non-attendance to training reduced to 26% from 35% last month. In August, we achieved 87% across the Trust for staff appraisals over the last two months this has reduced and is now at 84%.
- Staff leavers in October (62 WTE) is in line with the average number of leavers per month of 61WTE. Work life balance was the top leaving reason in October with 17% (11 WTE) of leavers. We are focussing on flexible working, with a programme now being developed. More information and support will be published across the Trust over the next month.

- October has been particularly challenging across our registered and unregistered nursing workforce with high levels of staff unavailability at 34%. This equates to an increase of 24WTE from the previous month. Both bank and agency usage has increased to support staff unavailability and there has been an increase in off framework usage (23 WTE staff used).
- Working with the ICS and NHS E/I we have and continue to validate our underlying position in respect of Trust vacancies. Based on recurrent budgets FYE which also includes our significant quality investments our vacancy position has increased to 613 WTE.
  This is a material shift and does include FYE investments, which have been updated in the ledger as part of budget setting processes. We have done this to support the Trust to recruit to vacancies despite posts being phased in at points in the future aligned to business cases. We recognise therefore further work is required to validate the true vacancy position in month considering these phased investments and expected start date. It is also important to note we do have a number of staff who remain in supernumery roles while training and are therefore while recruited to vacancies may not be fully operational in role for a short time. We also continue to review maternity and secondment adjustments, which may also be affecting the vacancy position.
- Vacancies and short-term sickness are the main reason for requests for temporary staffing together with the continued need for 1:1 care requiring additional Health Care Assistants (HCA) at short notice. The Trust has recently recruited an additional 60 HCAs to supplement our bank, which will help reduce the need to request agency HCAs. International nursing recruitment continues with 25 nurses joining in October 20 in November and 26 throughout December.
- The recruitment team have been working closely with our people system team to ensure all December junior doctor rotations have been processed. This will assist with set up of new medical rostering system.
- Recruitment events are planned for next month; these include an admin event, therapies, radiography, cleanliness technicians, theatres and an external event with The Jobs Fair Telford. In October, we have had 18 doctors start at the Trust. We currently have a number of doctors waiting to join the trust, including 10 clinical fellows, 14 SAS doctors and 14 consultants.
- Following our attendance at the BMJ live medical recruitment event we have received applications for our hard to fill roles such as Consultant Radiologist, Consultant Oral & Maxillofacial Surgeon and Consultant Neonatal Paediatrician.

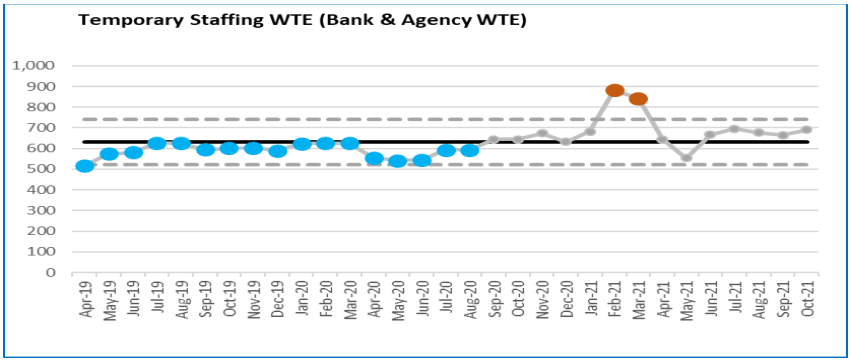
WTE employed



October 2021 actual performance
6008
Variance Type
Special Cause Improvement
Local Target
6732
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. Note increase post reconciliation exercise.	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.

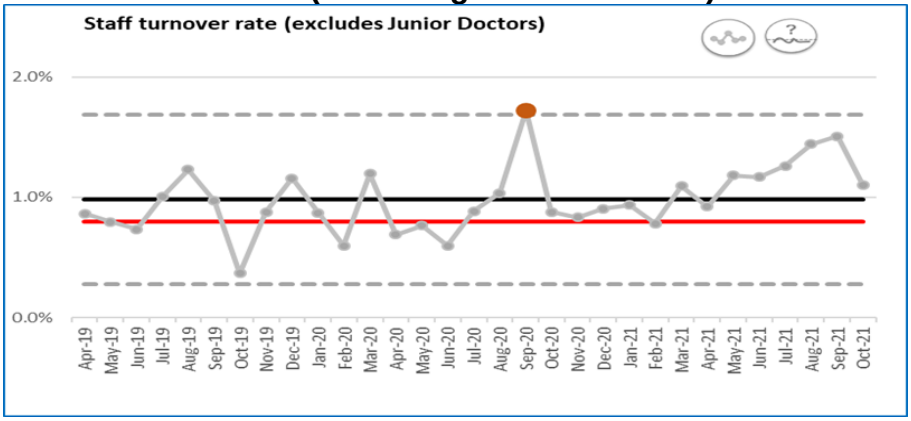
Temporary/ Agency Staffing



October 2021 actual performance
691
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-19-19) and COVID-19-19 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.

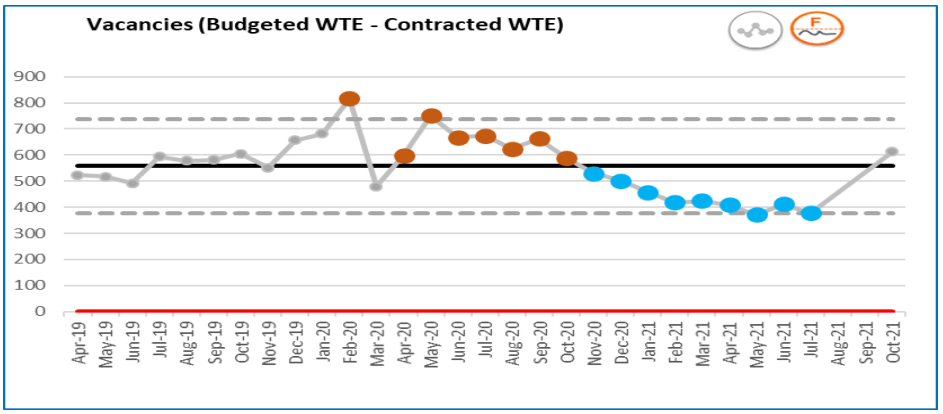
Staff Turnover Rate (excluding Junior Doctors)



October 2021 actual performance
1.10%
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.	Common cause variation continues between Oct 20 and Oct 21, with a reversal this month of the increase seen over the previous 5 consecutive months. This remains above the national target but close to the mean.	Staff leavers in October (62WTE) is in line with the average number of leavers per month of 61 WTE. Work life balance was the top leaving reason in October with 17% (11WTE) of leavers. Of leavers in October, 41% (10WTE) were from the additional clinical services staff group and had less than 2yrs services. Within the staff group Nursing and midwifery registered, work life balance remains the top reason for leaving over the last 12 months with 23% (44WTE) of leavers attributed to 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. Escalated bank rates in challenged areas.

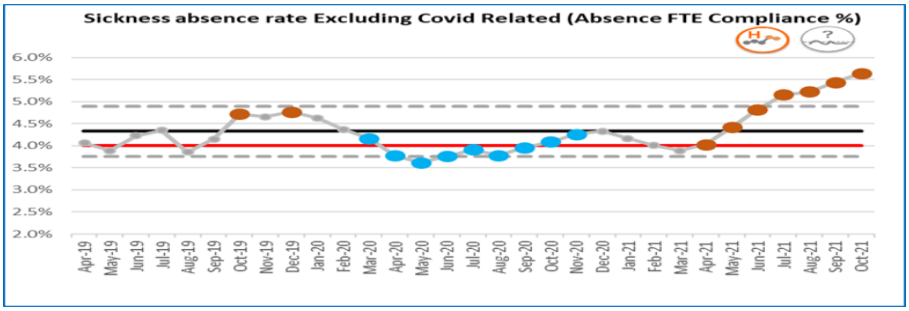
Vacancies



October 2021 actual performance
613 = 10.2%
Variance Type
Common Cause
National Target
<10%
Target / Plan Achievement
Note change post reconciliation work

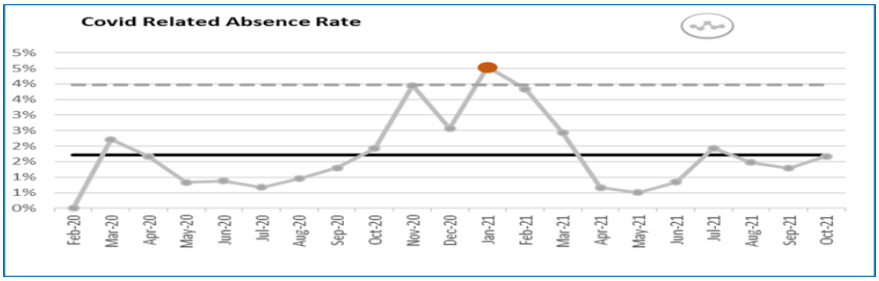
Background	What the Chart tells us	Issues	Actions	Mitigations
This is a measure of the gap between budgeted WTE and contracted WTE.	Following reconciliation of the budget to the contracted establishment there has been a material change in the number of vacancies reported this month. Further work is needed to refine this further.	The figures quoted does not yet take into account the number of supernumerary staff in post who are not yet fully operational. Further work is needed to consider the number of maternity leave vacancies being covered in our establishment. The phasing of the budgeted investments needs to be applied to the vacancy figures.	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. Continuation of the reconciliation of workforce and financial data to address the issues stated is expected to be completed over the next month to give a validated position for vacancies.	Recruitment activity continues to reduce workforce gaps. Use of temporary staff to cover vacant posts.

Sickness Absence



October 2021 actual performance
5.65%
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 WTE calendar days absent. COVID-19 related sickness and absence is not included.	Special cause concern from Apr21 – Oct21	Higher absence levels than normally expected for this time of year. Absence rate of 5.7% equating to 338WTE. Absence attributed to mental health continues to be high with 206 episodes equating to 97WTE in October. Absence levels attributed to other known causes musculoskeletal and cough, cold, flu remain high. Estates and facilities remains the staff group with the highest absence % at 8.2% (41WTE) with additional clinical services at 7.4% (87WTE) and nursing and midwifery at 6.3% (108WTE). Medical and Dental sickness remains at 4.1% (28WTE) and is significantly above 12 month average of 1.9% (14WTE).	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. Review unavailability rates to identify areas of risk.	Work with temporary staffing departments to ensure gaps can be filled with temporary workforce where necessary. Encourage bank uptake of shifts; escalated rates in challenged areas.

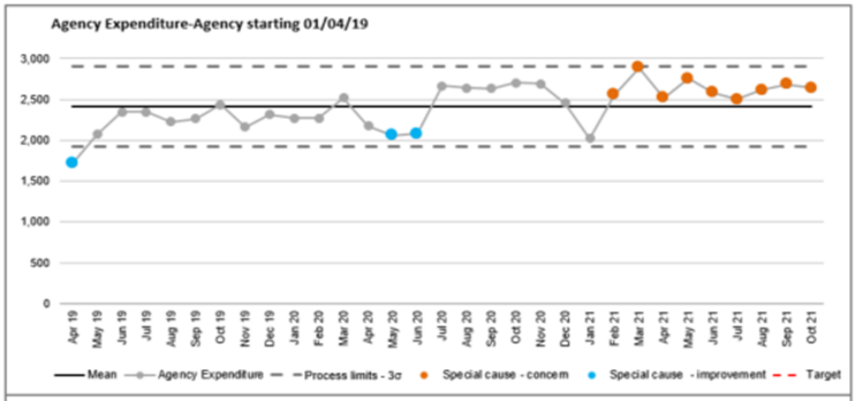


October 2021 actual performance
1.67%
Variance Type
Special Cause Concern
National Target
N/A

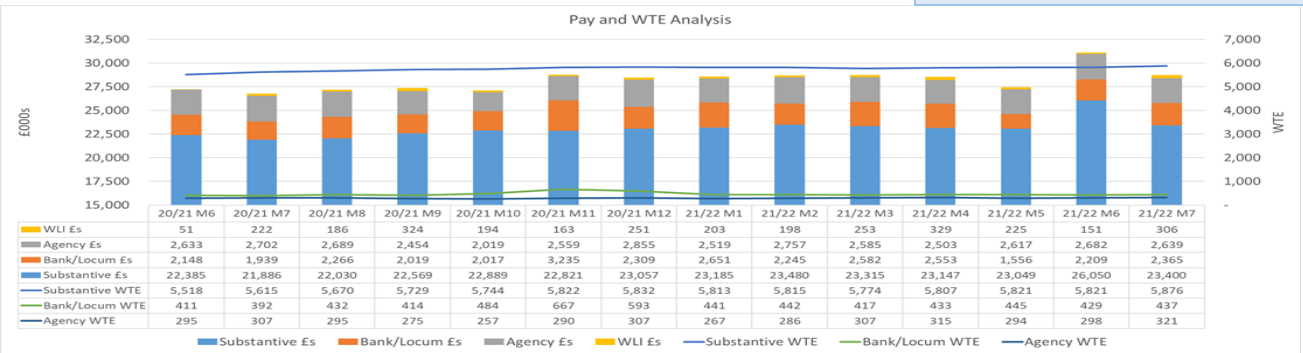
Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of staff COVID-19 sickness absence average per week and is the number of staff absent due to COVID-19 related sickness.	COVID-19 related absence shows normal variation between Feb 21 and Oct 21.	COVID-19 related absence continue at average levels during October with consistent levels of staff testing positive averaging 3 per day. Staff continue to isolate due to members of the household testing	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 including	Maintain social distancing; regular and timely staff testing; identification of positive cases and effective contact

		positive. COVID-19 related absences continue to add to staffing challenges.	promoting of booster jab and flu vaccine.	tracing. Continue risk assessments for staff identified as contacts.

Agency Expenditure



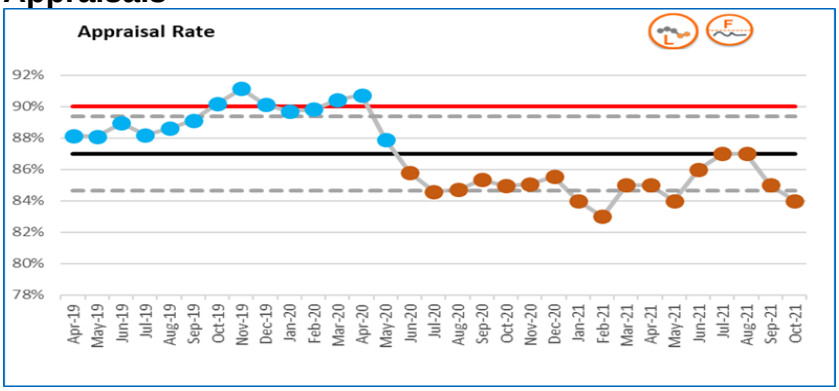
October 2021 actual performance	
£2,639m - £18.302m ytd	
Variance Type	
Special cause	
National Target	**SaTH Plan**
£2.860m	£2.860m
Target/ Plan achievement	
Favourable variance	



	20/21 M6	20/21 M7	20/21 M8	20/21 M9	20/21 M10	20/21 M11	20/21 M12	21/22 M1	21/22 M2	21/22 M3	21/22 M4	21/22 M5	21/22 M6	21/22 M7
WLI £s	51	222	186	324	194	163	251	203	198	253	329	225	151	306
Agency £s	2,633	2,702	2,689	2,454	2,019	2,559	2,855	2,519	2,757	2,585	2,503	2,617	2,682	2,639
Bank/Locum £s	2,148	1,939	2,266	2,019	2,017	3,235	2,309	2,651	2,245	2,582	2,553	1,556	2,209	2,365
Substantive £s	22,385	21,886	22,030	22,569	22,889	22,821	23,057	23,185	23,480	23,315	23,147	23,049	26,050	23,400
Substantive WTE	5,518	5,615	5,670	5,729	5,744	5,822	5,832	5,813	5,815	5,774	5,807	5,821	5,821	5,876
Bank/Locum WTE	411	392	432	414	484	667	593	441	442	417	433	445	429	437
Agency WTE	295	307	295	275	257	290	307	267	286	307	315	294	298	321

Background	What the Chart tells us:	Issues	Actions	Mitigations
Agency is a constituent element in the Trusts deficit plan over the period. The H1 agency plan has been set equivalent to Q3 20/21 spend. The H2 plan is still being finalised. The efficiency programme includes reduction in use of agency as we recruit a sustainable workforce.	Agency spend is significantly above the NHSEI ceiling, however this target needs to be updated to reflect the current regime. Agency costs were £2.639m in the month, which is slightly lower than previous month.	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). Action plan agreed to understand increase in HCSW agency usage.	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.

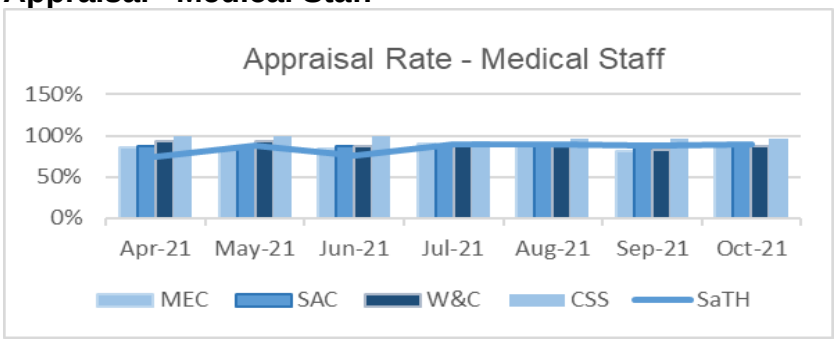
Appraisals



October 2021 actual performance
84%
Variance Type
Special Cause Concern
National Target
90%
Target / Plan Achievement
Below target level of performance

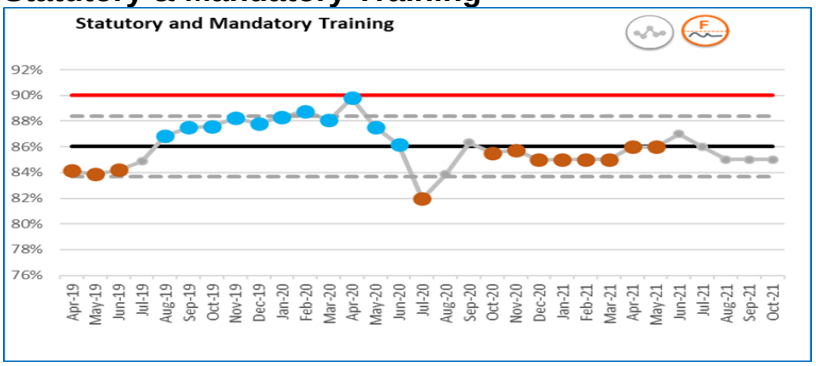
Background	What the Chart tells us:	Issues	Actions	Mitigations
The measure is a key indicator for patient safety in ensuring staff are compliant in having completed their annual appraisal.	The 90% target was achieved January to April 20 then started to drop. In August we achieved 87% this month but this has dropped 84% this month.	COVID-19, staffing constraints and service improvement has reduced ability of ward staff to have time to complete appraisals.	Focused support is being provided to the managers of any ward that is below target. This support has been extended to 1:1 advisor support for 70 wards/departments. 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 training sessions are available on the Training Diary.	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



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

Statutory & Mandatory Training

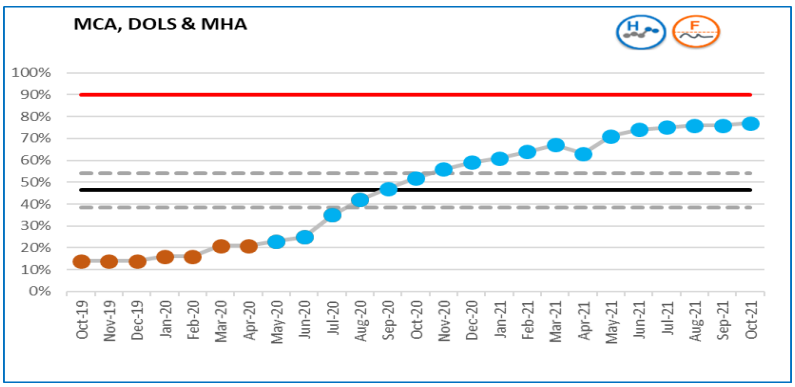


October 2021 actual performance
85% (Medical Staff – 78%)
Variance Type
Common Cause
National Target
90%
Target / Plan Achievement
The target is above the upper process limit

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%	92%	79%	96%	87%	76%	72%	90%	82%	88%

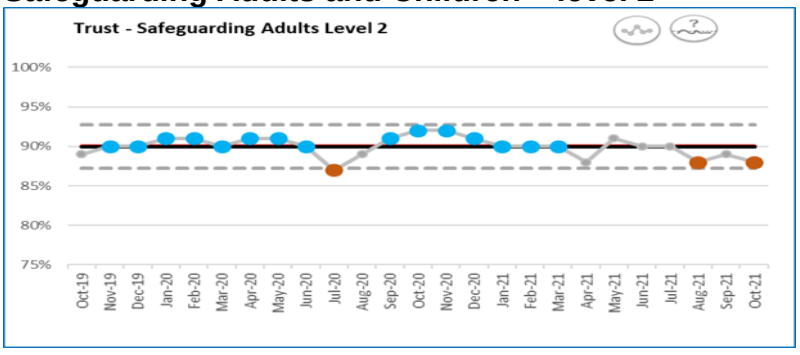
Background	What the Chart tells us:	Issues	Actions	Mitigations
The measure is a key indicator for patient safety in ensuring staff are compliant in having completed their training needs.	Remained 85% DNA % dropped to 26% from 35% last month. A further 2% increase in Information Governance & 2% increase in Prevent L3.	COVID-19 staffing constraints and service demands have reduced ability of wards to release staff for training. Poor IT literacy impacting on e-learning completion. Some data validation issues.	Corporate Education is working with Care Groups to identify and reduce data conflicts. Corporate education is supporting additional Ward/Dep managers with 1:1 Advisor support 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 emails continue to be sent to all staff who are non-compliant. Corporate Education requested proxy facility to support remote e-learners effectively. From September – at the request of MLT & Dr Srinivasan the SSU for Medical CPD has been developed. This should hopefully see an increase in the Medical Staff SSU %.	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



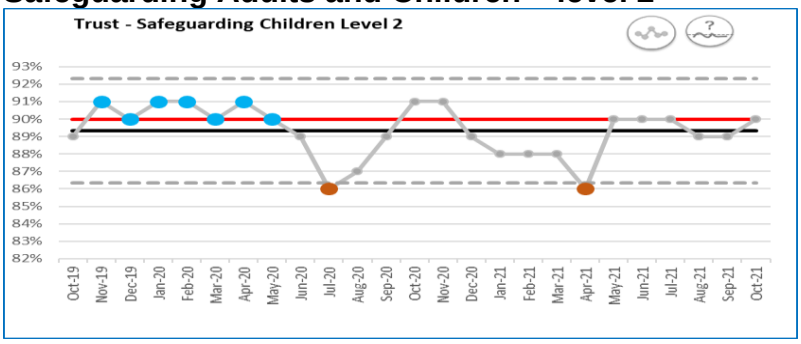
October 2021 actual performance
77%
Variance Type
Special Cause Improvement
National Target
90%
Target / Plan Achievement
Improvement trajectory in place to deliver at end of Q3

Safeguarding Adults and Children – level 2



October 2021 actual performance
88%
Variance Type
Special Cause Concern
National Target
90%
Target Achievement
90%

Safeguarding Adults and Children – level 2



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

8. Operational Summary
Nigel Lee, Chief Operating Officer

October continued to be a very challenging month, with significant pressure on Urgent and Emergency Care (UEC) as well as workforce pressures due to the COVID-19 related and other absence. As in September, the Trust continues to maintain some priority elective surgery on both sites, but this is limited by bed capacity and staffing; clinical prioritisation remains the core principle for planning, with very urgent and cancer surgery prioritised.

Within UEC, the pressures seen at both Emergency Departments (EDs) remain significant, with demand as well as acuity (severity of illness as well as complex comorbidities) remaining high. At times, this has resulted in both EDs being very busy, and ambulance handover delays have resulted. The Trust has seen some long waits, albeit mitigated by regular senior clinician checks on the patients, as well as cohorting being used on both sites (cohorting is supported by the ambulance service, with one crew monitoring a number of patients in a suitable location in the ED but importantly releasing other crews to attend to calls). We fully recognise the risk for the wider community as well as the risk across the hospital sites, and the Trust is continuing to look at all possible options to provide swifter offload and capacity internally. In parallel, work with ambulance services on pre-hospital pathways as well as with the developing capacity for 'Rapid Response' from community services are continuing, to support alternate pathways for patients wherever possible. And across the health & social care system, actions to increase capacity for rehab and home based care continue, although this also remains challenging due to national workforce pressures.

For elective and cancer services, the demand also remains high and similar pressures on workforce are also present. Demand for 'priority 2' surgery (including cancer) has increased and teams continue to focus on effective theatre lists for these patients. We are also maintaining the close link with Robert Jones & Agnes Hunt Orthopaedic Trust for the inpatient orthopaedic elective surgery, and during October expanded the range of private sector capacity that we will use during the second half of 2021/22. The level of cancer patients on the list over 62 days has reduced during the month, primarily due to the increased CT capacity, and this will continue through Q3 and Q4. For the wider elective backlog, whilst the number of patients over 52 weeks is fairly steady, the numbers reaching 78 weeks and up to 104 weeks is increasing; the Trust has a clear trajectory to minimise the number of patients waiting over 104 weeks at the end of March 2022 – the objective is no more than 74. We continue to seek options to reduce this further although many of the patients are very specialist in nature.

All forms of diagnostics remain a vital step in a patient pathway; the addition of a mobile CT scanner (based at PRH) to the existing mobile MRI is adding much needed capacity. Furthermore, the new imaging 'pod' at RSH, with 2 new scanners (one CT and one MRI) is starting to see their first patients; the capacity will increase as the staffing increases over the next few weeks. However, the diagnostic waiting list is also significant and as with patients requiring surgery, patients on a diagnostic waiting list are also clinically prioritised with the most urgent cases (such as patients needing urgent scans from EDs) as well as cancer pathways our highest priority.

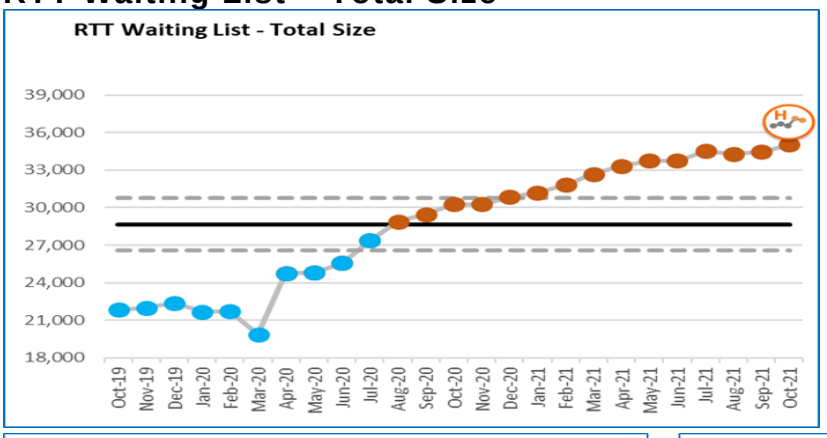
The Trust is working to carefully plan for the next 6 months, to understand the likely forecast for COVID-19 impact, as well as RSV and flu, alongside managing the urgent care demand and optimise delivery of the cancer and other elective activity given the significant capacity and workforce constraints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

Elective Care

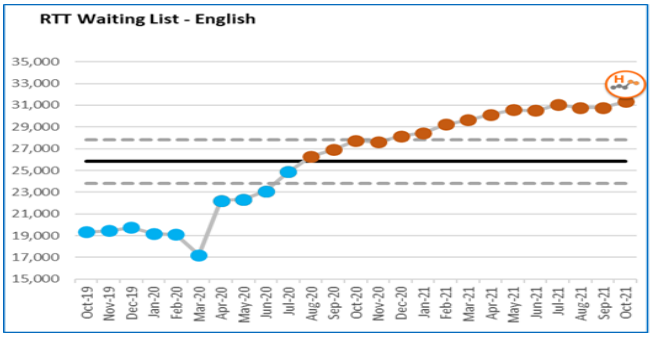
The H2 plan has been agreed for elective activity from October 2021-March 2022. The additional interventions are being supported and aim to deliver a positive impact on the volume of patients waiting for treatment, although not being sufficient to remove the backlog developed in a single year. The plan will be closely monitored both for activity delivered, aligned to each intervention and its impact on waiting times and waiting lists in line with the profile agreed to year end:

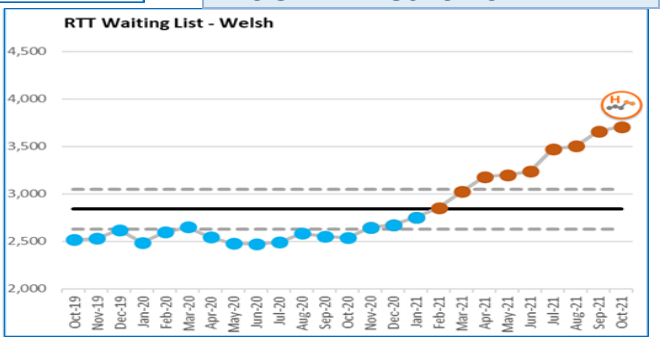
H2 plan	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
The number of incomplete RTT pathways (patients waiting to start treatment) of 52 weeks or more at the end of the reporting period	2486	2458	2451	2243	2159	2108
The number of incomplete RTT pathways (patients waiting to start treatment) of 104 weeks or more at the end of the reporting period	42	24	44	41	59	74
The total number of incomplete RTT pathways at the end of the reporting period (often referred to as the size of the RTT waiting list)	30806	30325	29614	28907	28260	27832

RTT Waiting List – Total Size



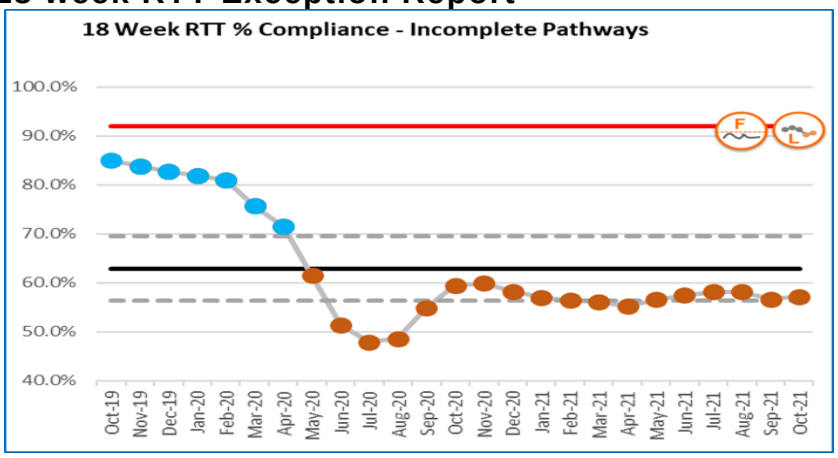
October 2021 actual performance
35033 (English 31325, Welsh 3708)
Variance Type
Special Cause Concern
Local Plan
27832 (English) by Mar 2022
Target / Plan Achievement
Overall plan dependant on Welsh ERF scheme



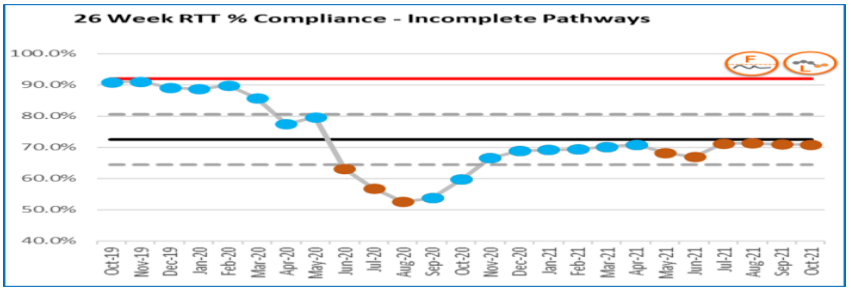


Background	What the Chart tells us	Issues	Actions	Mitigations
Total list size continues to increase because of the inability to treat clinically routine patients and close RTT pathways.	Continuation of the increase in the total waiting list size. With the interventions agreed in H2 it is expected that the waiting list size will start to reduce but remain at a higher level than pre-Covid-19 by March 2022.	Referrals returning to pre-COVID-19 levels especially in relation to cancer services. 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. Joint working with RJAH on orthopaedics and CT. Use of independent sector for additional capacity. Waiting list continues to be clinically prioritised for diagnostics and surgical procedures. Theatre staff recruitment continuing.	Need to address demand, outpatient transformation and Midlands's 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. Supernumerary theatre staff being trained to be operational over next 6months.

18 week RTT Exception Report



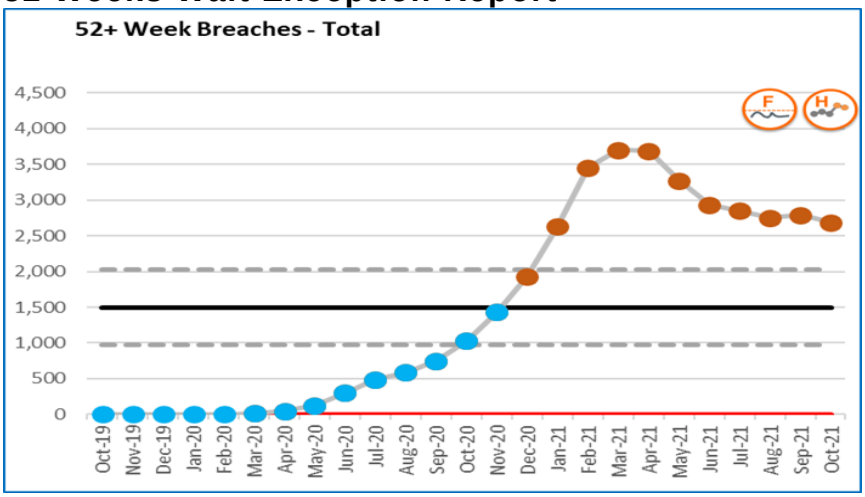
October 2021 actual performance
57.2%
Variance Type
Special Cause Concern
National Target
92%
Target / Plan Achievement
Due to the size of the backlog developed, the target will not be achieved. Local plan focuses on clinically prioritised patients.



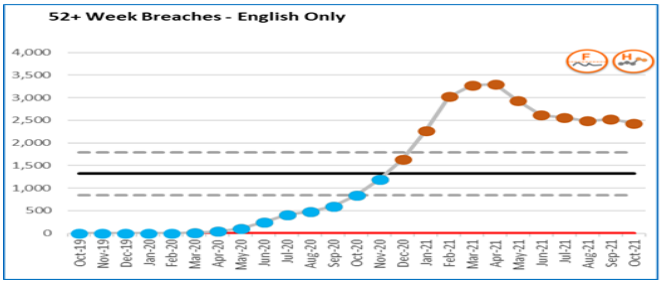
October 2021 actual performance
71%
Variance Type
Special Cause Concern
National Target
92%

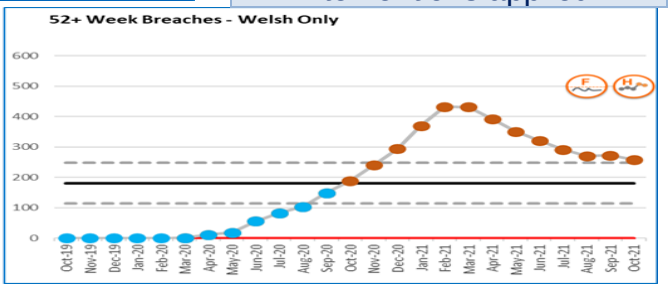
Background	What the Chart tells us	Issues	Actions	Mitigation
Headline performance against this measure has now stabilised (58.15% Aug compared to 57.48% at end July and 56.6% at end May 2021) but is well below the pre-pandemic performance.	Incomplete pathway appear to have stabilised at a level significantly below the national target. 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 urgent patients tend to wait in shorter time bands.	Limited outpatient capacity with 1m social distancing. Theatre capacity & staffing. COVID-19 & non COVID-19 absences. Increase in urgent demand. Inability to treat routines 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 IS support and insourcing capacity.	System elective and cancer meeting established. Modelling to inform system actions.

52 Weeks Wait Exception Report



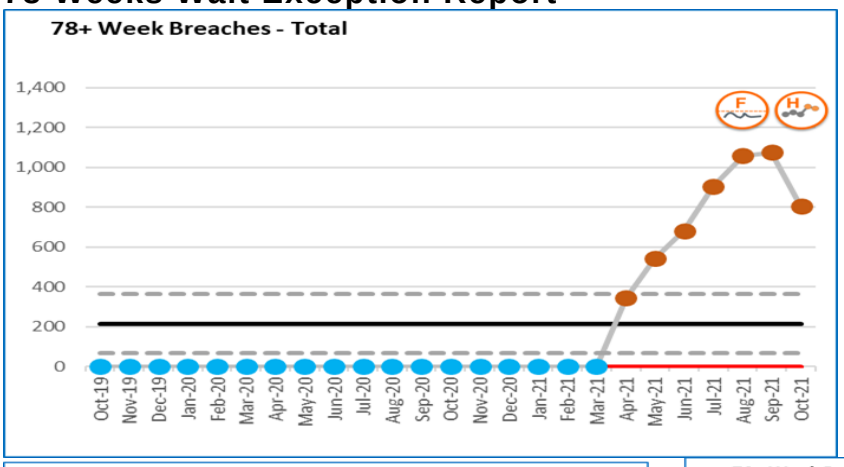
October 2021 actual performance	
2690 (English 2432, Welsh 258)	
Variance Type	
Special Cause Concern	
National Target	**Local Forecast**
0	2108
Target / Plan Achievement	
Local forecast developed aligned to the H2 plan post interventions applied.	



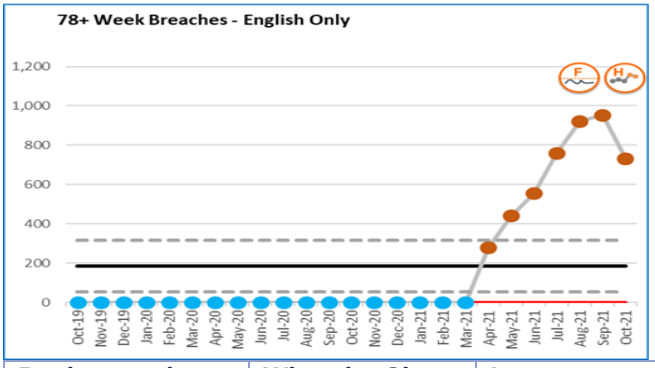


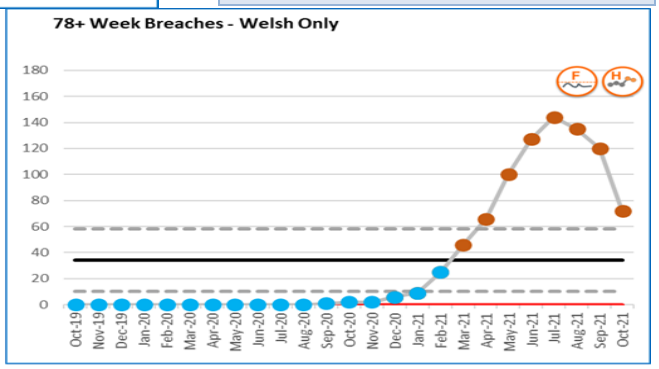
Background	What the Chart tells us	Issues	Actions	Mitigations
From a baseline position of zero pre-pandemic, the volume of patients waiting in excess of 52 weeks on an open RTT pathway has increased significantly. It reflects routine patients are not currently being able to be prioritised for treatment.	The reduction seen in over 52 weeks at present is forecast to be sustained with the additional interventions agreed in the H2 plan. The recovery will not be complete by March 2022 with 2108 patients forecast to be waiting over 52 weeks at year end.	Reduced theatre capacity and staffing vacancies. Urgent care bed pressures resulting in loss of elective beds. Focus on clinical priority patients and then longest waiting patients.	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 and other IS providers for Ophthalmology. Insourcing for additional capacity. Continue to date in chronological and clinical urgency.	Monitored by weekly RTT meeting & cancer performance meeting.

78 Weeks Wait Exception Report



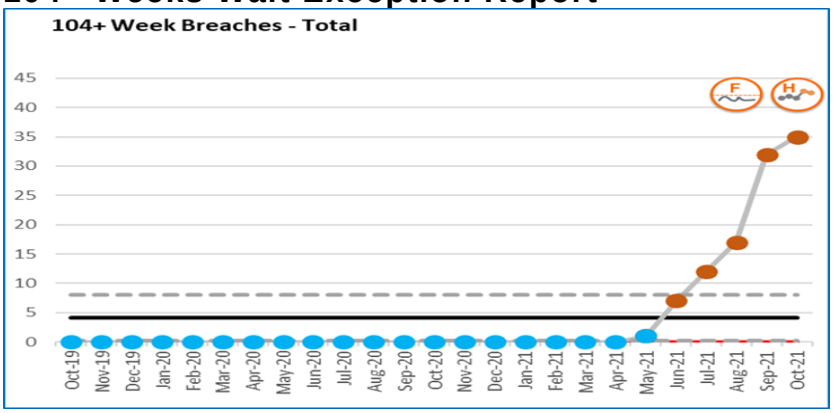
October 2021 actual performance	
805 (English 733, Welsh 72)	
Variance Type	
Special Cause Concern	
National Target	**Local Forecast**
0	tbc
Target / Plan Achievement	
The target will not be delivered in 21/22.	





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.	The proportion of these long waiting patients who are over 78 weeks has started to reduce as the additional interventions and recovery plans impact.	The volume of patients over 78weeks is related to the proportion of clinically urgent patients waiting and the unscheduled care demands reducing capacity for routine long waiting patients. A small number of patients are requesting not to return to service at this time.	Reduced theatre capacity and staffing vacancies being addressed through recruitment and overseas nursing. COVID-19 and non COVID-19 related absences are being closely monitored. Urgent care bed pressures resulting in loss of elective beds. Ring-fenced elective capacity retained in eye suite and Vanguard unit plus green pathways and additional IS capacity secured.	Monitored via weekly RTT meeting. H2 plan monitored through system and weekly divisional meetings.

104+ Weeks Wait Exception Report

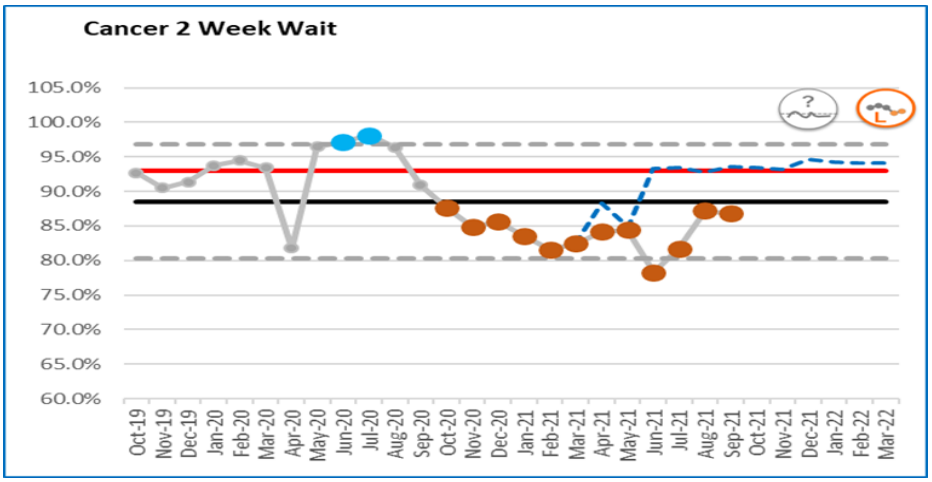


October 2021 actual performance	
35 (English 31, Welsh 4)	
Variance Type	
Special Cause Concern	
National Target	**Local Forecast**
0	74
Target / Plan Achievement	
H2 monthly trajectory	

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.	Number of 104+ week waiters is increasing.	Reduced theatre capacity and staffing vacancies. COVID-19 related staff absences. Level of non COVID-19 related sickness. 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.	Implementation of the H2 plan fully to maximise capacity and ensure 104 week patients are scheduled to treatment. This includes both additional internal activity, use of OPD transformation to enable virtual and face to face consultations, increased diagnostic capacity, insourcing and use of IS sector capacity, managing orthopaedic elective IPDC activity jointly with RJAH and use of the vanguard and eye suite for day surgery.	Monitored via weekly RTT meeting. Trajectory for 104 weeks monitored by region fortnightly and reported weekly.

Cancer

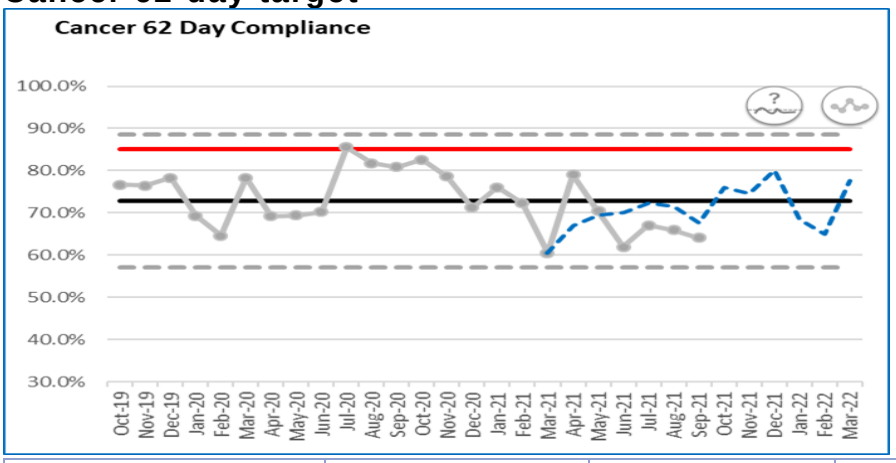
Cancer 2 week waits



September 2021 actual performance
86.8% (October Forecast 83.23 %)
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/Gynaecology service. Performance is currently below plan.	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.	Breast Pain only clinics to start in November, which will reduce the amount of 2WW Breast referrals. Gynaecology working on extra capacity.	Implementation of revised 2WW Breast Referral Proforma. Implementation of revised 2WW Gynaecology Proforma.

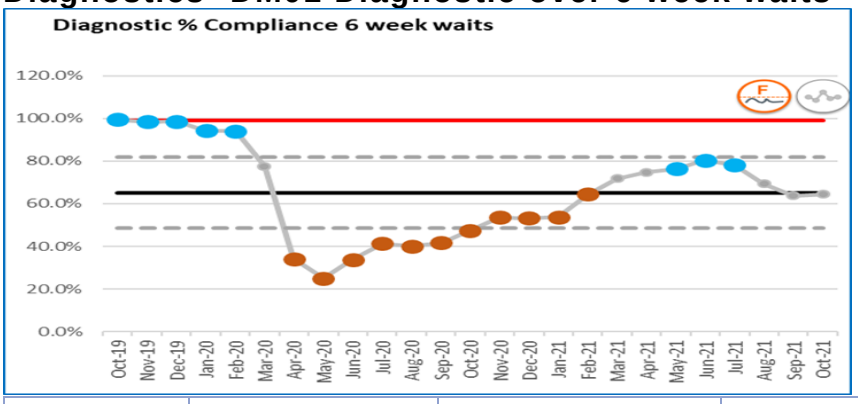
Cancer 62-day target



September 2021 actual performance
64.31% (October forecast 61.87%)
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 once since April 2019. Performance is also slightly worse than plan.	Capacity does not meet demand (diagnostics a significant issue 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 Aug 2021, with a view to have capacity ready in Oct 2021.	Cancer Performance and Assurance Meetings on going chaired by Deputy COO.

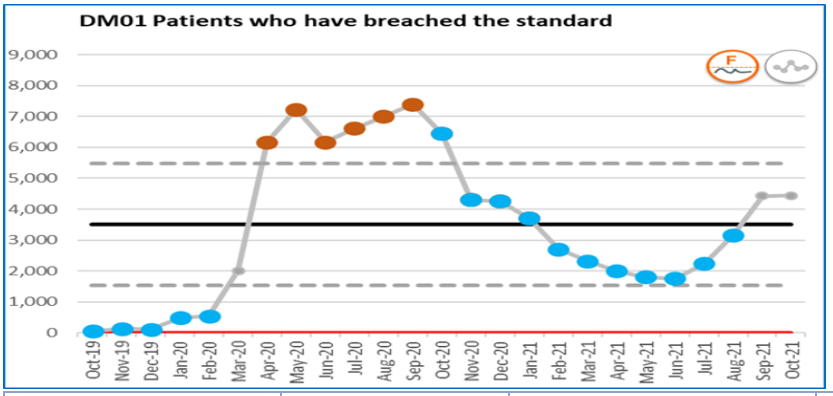
Diagnostics -DM01 Diagnostic over 6 week waits



October 2021 actual performance
64.4%
Variance Type
Common Cause
National Target
99%
Target / Plan Achievement
Recovery is forecast by March 2022 for CT.

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.	Improvement seen since February has not been sustained. CT recovery is forecast by end of March 2022 with the additional capacity coming on line.	Lack of capacity to meet demand due to ongoing COVID-19 working restrictions and staffing difficulties. Improvement seen through to May reversed with loss of mobile CT at end of May.	Return of mobile CT from 11th October will demonstrate improved performance over the next 2-3 months. Imaging Pod now on-line but limited use due to inability to fully staff the unit. Recruitment ongoing including appointment of overseas radiographers. Commenced TNE lists to create capacity in endoscopy.	Clinical prioritisation of appointments. Utilisation of all available mutual aid from RJAH and Nuffield.

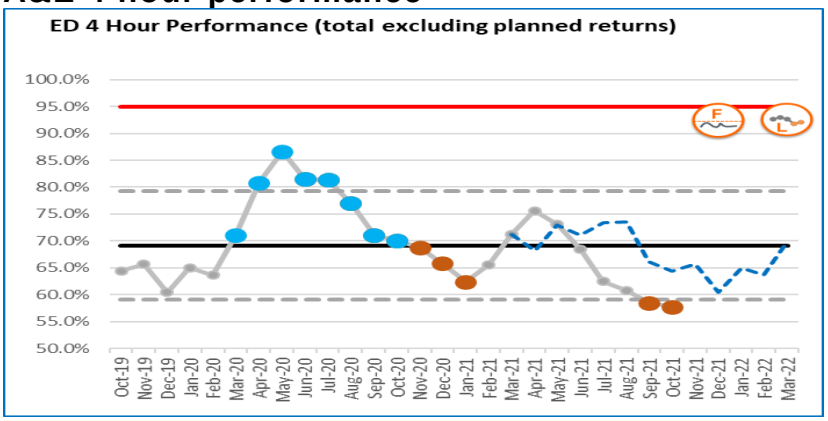
DM01 Patients who have breached the Standard



October 2021 actual performance
4436
Variance Type
Common Cause
National Target
0 - < 6weeks
Target / Plan Achievement
Forecast improvement by March 2022.

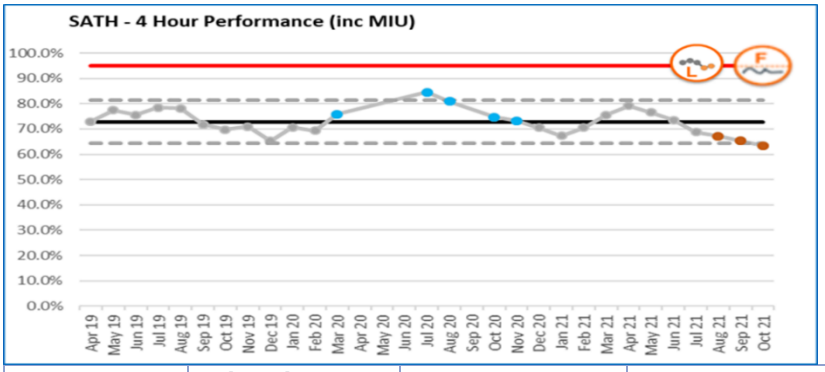
Background	What the Chart tells us	Issues	Actions	Mitigations
DM01 is the national standard for non-urgent diagnostics completed within 6 weeks of the referral. There must be no more than 1% of patients waiting longer than 6w.	Improved performance was seen through to June with a gradual worsening of performance since July 2021.	This change in performance correlates to the loss of the mobile CT scanner at the end of May 2021. The full effect took a couple of months to become evident. Compounding factor is ongoing staffing crisis, particularly affecting the cross-sectional team, reducing available capacity in CT and MRI.	Ongoing recruitment into cross sectional team. Approval of mobile CT business case saw the mobile return to site and commence scanning on 11th October. This should feed through into DM01 performance in the next 2-3 months.	Deployment of staff between CT and MRI to maximise capacity across both modalities. Review of appointment templates in line with scan times. Continue to prioritise appointments according to clinical urgency.

Emergency Department
A&E 4 hour performance



October performance
57.7%
Variance Type
Special Cause Concern
National Target
95%
SaTH Local Plan
64.4%
Target / Plan Achievement
Performance is worse than the improvement trajectory.

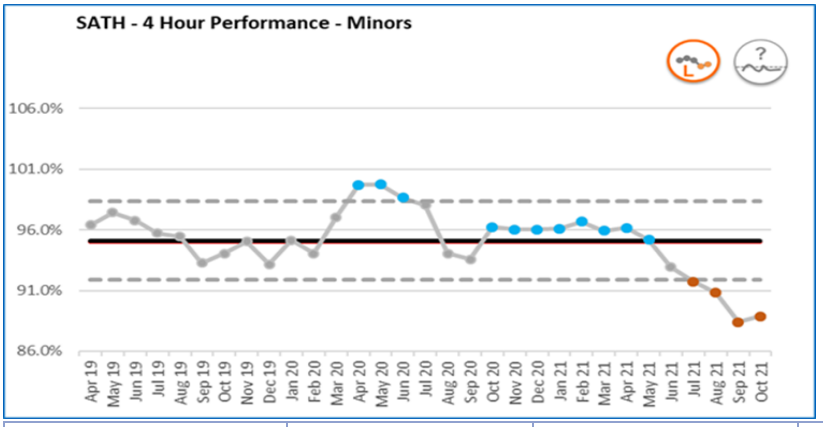
..... forecast



October 21 performance
63.4%
Variance Type
Special Cause Concern
National Target
95%
SaTH Local Plan
66.1%

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.	Flow out of ED restricted due to constraints associated with the different COVID-19 pathways and an overall lack of capacity as demonstrated within the Trust bed model, an increase in the number of MFFD patients and late in the day discharges.	Continued full use of SDEC for suitable patients. Focus on the reduction in MFFD patients occupying beds with system partners. Working with WMAS on conveyance improvements. Two-week improvement event held September to focus on medical wards at RSH so improve flow. Follow up actions agreed to ensure revised ward processes are embedded. Capital expansion of facilities in A&E at RSH to increase capacity to treat patients underway. Daily site meetings redesign to increase actions for improved timeliness of discharges. Winter schemes commenced across system to support admission avoidance and discharge planning.	System UEC action plan. Support from NHSEI on flow.

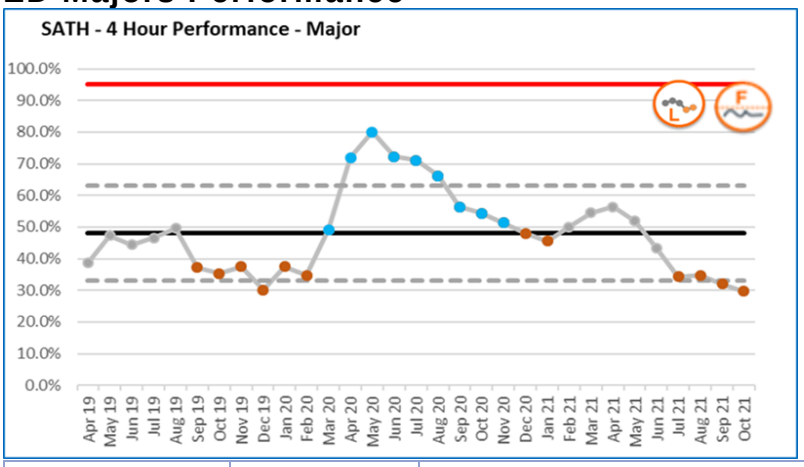
ED Minors Performance



October 2021 actual performance
88.9%
Variance Type
Special Cause Concern
National Target
95%
Target / Plan Achievement
The target cannot 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. Physical space in departments.	Continuing to address workforce issues. Working with NHS 111 to improve utilisation of booked appointment slots. WMAS working with Community Trust to use MIU capacity.	Patients assessed on clinical priority need.

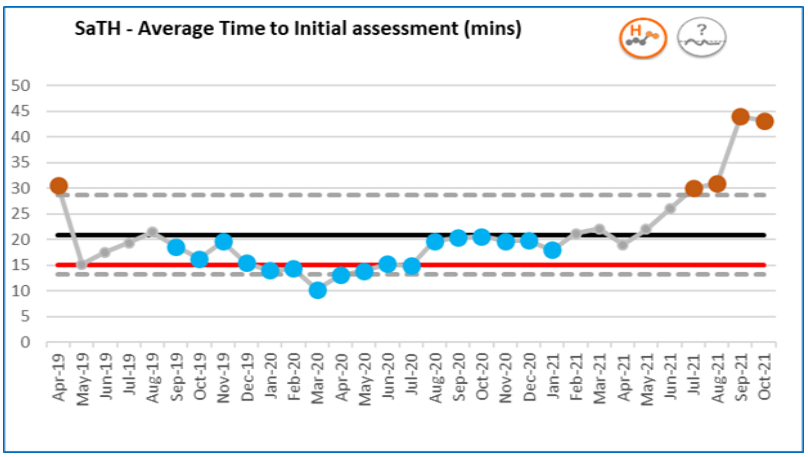
ED Majors Performance



October 2021 actual performance
29.7%
Variance Type
Special Cause Concern
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.

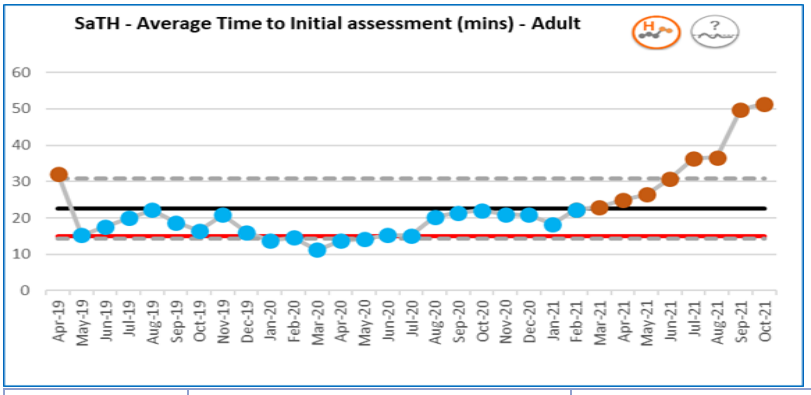
Background	What the Chart tells us	Issues	Actions	Mitigations
The national target is for all patients to be seen treated, admitted, transferred or discharged within 4 hours of arrival at the emergency department.	Deterioration in performance. Special cause variation.	Workforce constraints – sickness absence and COVID-19-19 isolation. Physical space in the department to enable patients to be accommodated. Flow from the department constrained by access to beds, including segmentation of COVID-19 and non COVID-19 routes and delays to discharge for medically fit patients.	Issue will resolve as workforce issues improve. Flow programme aims to reduce MFFD to time to discharge and improve access from ED to wards.	Patients assessed on clinical priority need.

ED –Time of Initial assessment (mins)



October 2021 actual performance
43 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

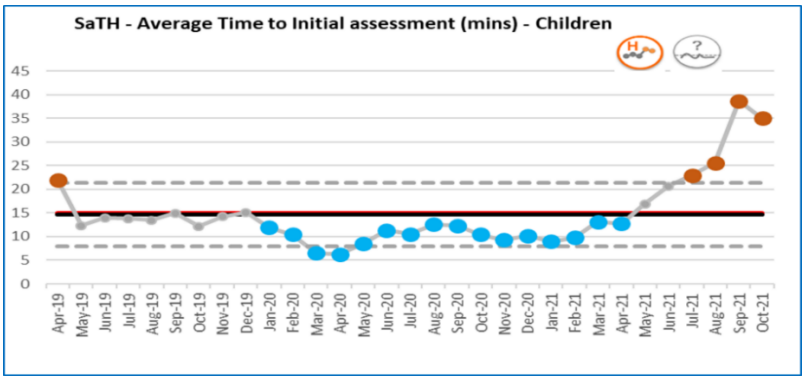
ED Time to Initial Assessment - Adult



October 2021 actual performance
51 Minutes
Variance Type
Special Cause Concern
National Target
15 Minutes
Target / Plan Achievement
Performance worse than target and 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.	Workforce and physical capacity constraints to meet the demand for both walk in and ambulance arrivals leads to bottleneck in departments.	Matrons focussing on restoration of initial assessment times – action plan developed, now in the process of being implemented.	ED assurance meeting chaired by COO.

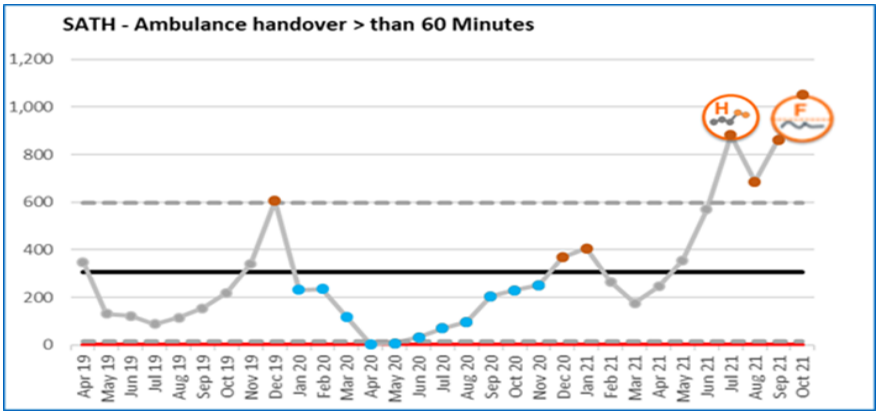
ED Time to Initial Assessment - Children



October 2021 actual performance
35 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	Increase in paediatric. 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. Occupancy and staffing levels on the paediatric ward has an impact upon flow through the department and workforce capacity to support paediatric patients as staff are re designated from streaming to care for patients.	Matrons focussing on restoration of initial assessment times, improvement plan developed, in the process of implementation. in a timely manner. Working with Community partners to reduce demand at ED Recruitment plan for paediatric trained nurse underway Review of space within both EDs to increase capacity.	ED assurance meeting chaired by COO.

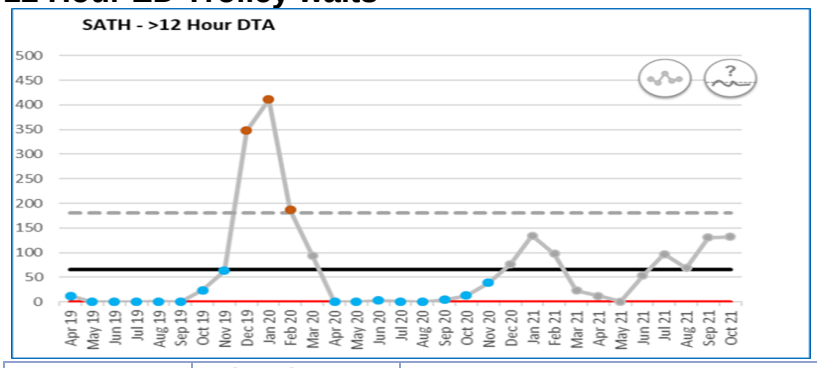
Ambulance handover> 60 Mins



October 2021 actual performance
1052
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 have not been able to open consistently to receive patients. Exit block associated with flow issues.	Discharge area on ward 22SS to facilitate early flow from ED Frailty area to be piloted on RSH site Direct access to surgical and medical SDEC from WMAS	System UEC action plan with oversight of established ambulance handover improvement group chaired by WMAS.

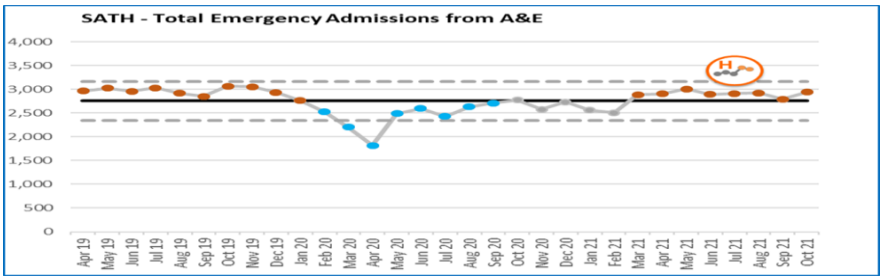
12 Hour ED Trolley waits



October 2021 actual performance
132
Variance Type
Common Cause
National Target
0
Target / Plan Achievement
Not achieved

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 especially in majors. There has been a significant increase in both the number and length of stay for MFFD patients which has impacted on flow from the departments. There is a known shortfall in medical bed capacity to meet demand. Increase in COVID-19 presentations has impacted on flow due to the necessity to segregate patients.	Improvement focus on morning discharges to release beds for admissions earlier in the day. Review of bed configuration to improve flow. Direct access to surgical SDEC commenced.	ED Safe Today processes in place to mitigate risk where possible within the department.

Total Emergency Admissions from A&E

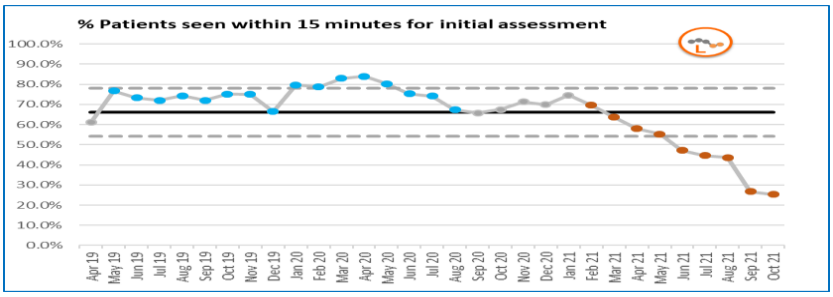


October 2021 actual performance
2938
Variance Type
Special Cause Concern
National Target
N/A

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.	Segmentation of patients continues to be necessary to ensure good IPC is maintained. Beds are required across elective and emergency care.	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.	System wide winter plan being implemented which include admission avoidance schemes.

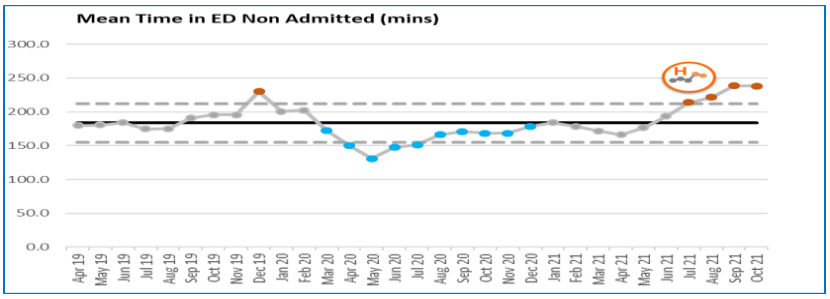
UEC metrics – shadow reporting

% Patients seen within 15 minutes for Initial Assessment



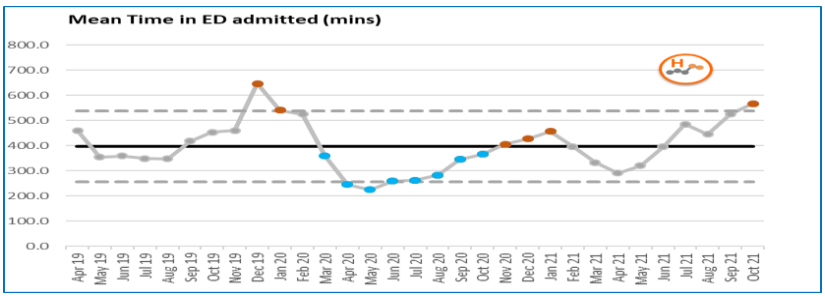
October 2021 actual performance
25.3%
Variance Type
Special Cause Concern
National Target
n/a

Mean Time in ED Non-Admitted (Minutes)



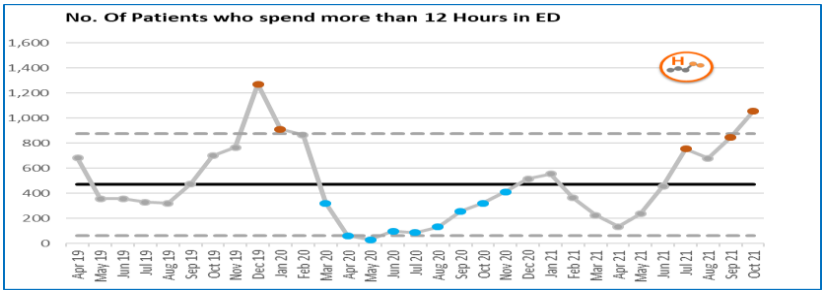
October 2021 actual performance
238
Variance Type
Special Cause Concern
National Target
n/a

Mean Time in ED Admitted (Minutes)



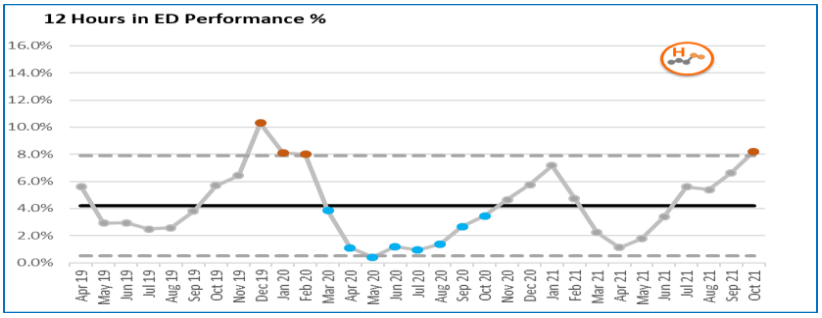
October 2021 actual performance
566
Variance Type
Special Cause Concern
National Target
n/a

Number of Patients who spend more than 12 hours in ED



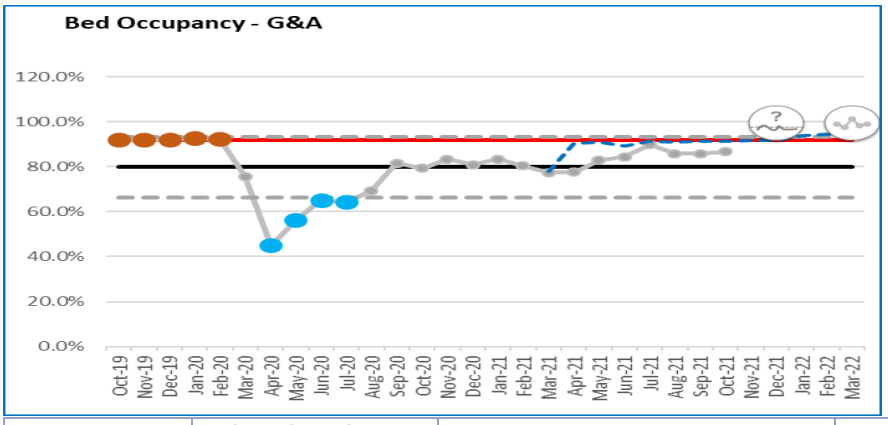
October 2021 actual performance
1057
Variance Type
Special Cause Concern
National Target
N/A

12 Hours in ED Performance %



October 2021 actual performance
8.2%
Variance Type
Special Cause Concern
National Target
N/A

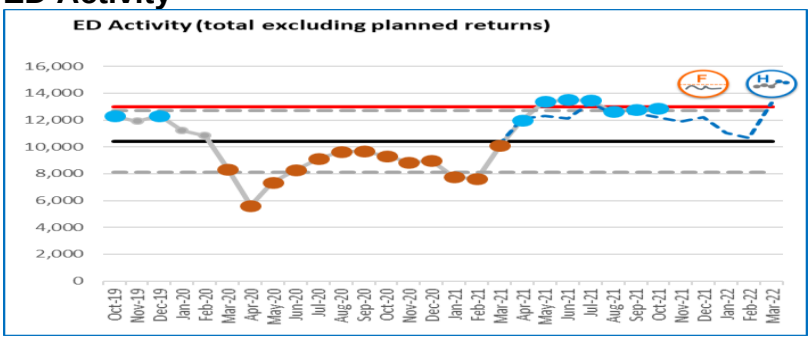
Hospital Occupancy and Activity
Bed Occupancy



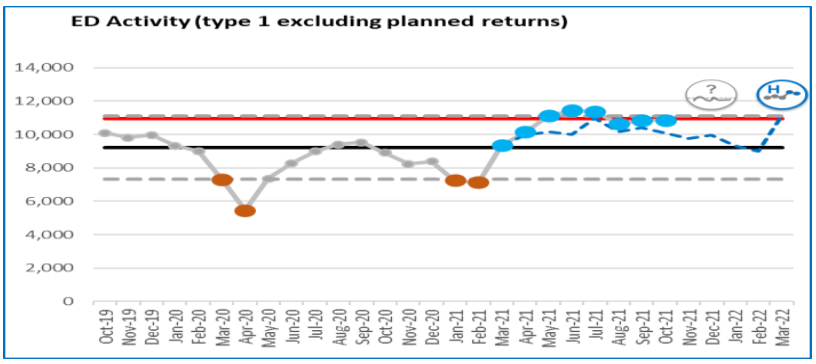
October 2021 actual performance
86.8%
Variance Type
Common Cause
Local Target
92%
Target / Plan Achievement
Occupancy slightly lower than pre-COVID-19

Background	What the Chart tells us	Issues	Actions	Mitigation
Bed occupancy is an important measure indicating the flow and capacity within the system.	Bed occupancy has increased overall, however the majority of the increase represents an increase in emergency non-COVID-19 admissions. Occupancy levels remain slightly below the pre-COVID-19 levels but close to the forecast position.	Segmentation of beds has created smaller bed pools and reduced flexibility. The increase in NEL occupancy has reduced capacity to restore elective activity.Re-allocation of beds to specialties means that some wards will have lower occupancy levels however their beds may not be clinically suitable to other specialty patients. Increase in MFFD times to discharge. Further work needed to mitigate against the forecast winter bed shortfall.	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 increase bed capacity earlier in the day. Bed modelling completed demonstrating underlying bed shortfall for winter 2021-22. Winter planning schemes being implemented to continue admission avoidance.	Additional 32 beds planned from April 2022.

ED Activity



October 2021 actual performance
12888
Variance Type
Special Cause Improvement
Local Target
12205 (H2 Plan)
Target/ Plan achievement
Trajectory Based on H2 plan



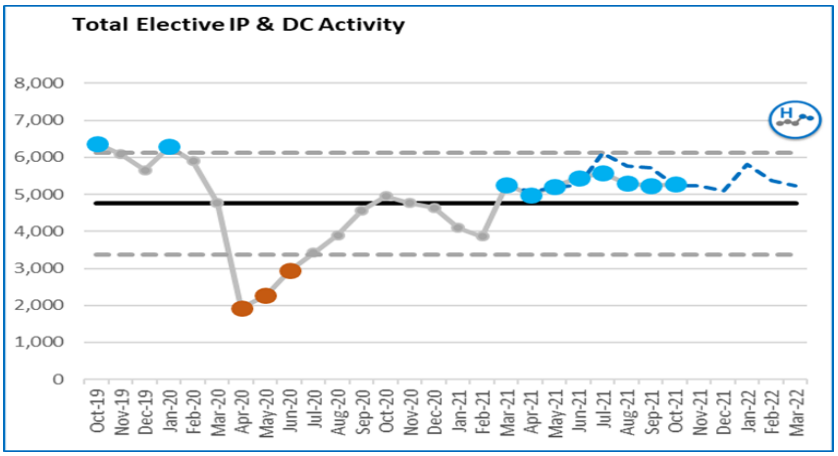
October 2021 actual performance
10861
Variance Type
Special Cause Improvement
Local Target
10095 (H2 Plan)
Target/ Plan achievement
Trajectory Based on H2 plan

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.	Flow out of ED restricted due to constraints associated with the different COVID-19 pathways and an overall lack of capacity as demonstrated within the Trust bed model, an increase in the number of MFFD patients and late in the day discharges.	Continued full use of SDEC for suitable patients. Focus on the reduction in MFFD patients occupying beds with system partners. Working with WMAS on conveyance improvements. Follow up actions agreed to ensure revised ward processes are embedded. Capital expansion of facilities in A&E at RSH to increase capacity to treat patients underway.	System UEC action plan. Support from NHSEI on flow.

Elective IP & DC Activity v H2 recovery plan

The H2 activity plan has been submitted to the system and includes activity provided by our core services and our additional internal interventions and use of the Nuffield Hospital. In addition to this plan the IS has been commissioned by the CCG to provide additional eye care, urology, and general surgery cases.

H2 plan	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
Total number of Specific Acute elective spells in the period	5225	5233	5098	5807	5368	5233
Total number of Specific Acute elective day case spells in the period	5034	5025	4908	5579	5141	5004
Total number of Specific Acute elective ordinary spells in the period	191	208	190	228	227	229

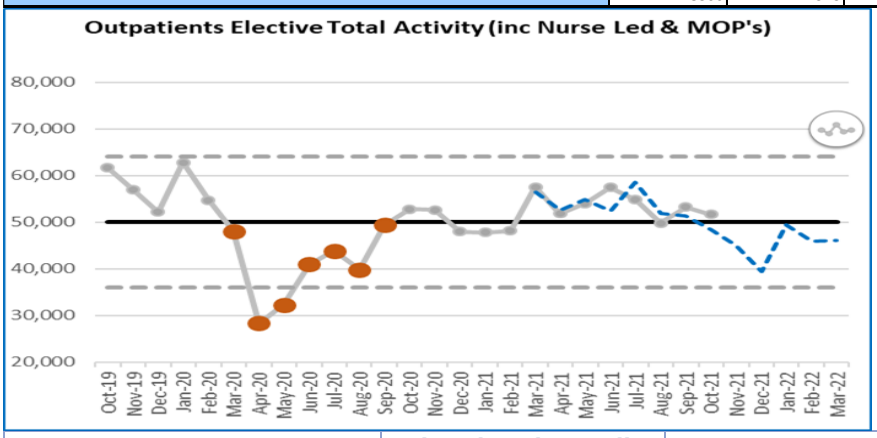


October 2021 actual performance	
5272 (Recovery 89.7%) (IP 281 , DC 4991)	
Variance Type	
Special Cause Improvement	
National Target	**Local Target**
95%	5225
Target/ Plan achievement	
Trajectory Based on H2 plan above	

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 trust has developed an activity plan for H2. This aims to optimise the internally available capacity to address urgent elective cases and to increase capacity via use of insourcing the Nuffield and RJAH to reduce the longest waits for routine surgery. .	Performance is tracking is slightly above the H2 plan trajectory but remains lower than September 19/20. Elective IP plan was delivered. The daycase activity was lower than plan. Therefore, the combined elective activity was slightly better than plan.	Controlled drug key holders remain an issue in theatre and extra substantive staffing are require to support this, limiting the additional insourcing activity that can be undertaken. Staffing vacancies in theatre reducing the number of lists available. Staff absences due to COVID-19 related – isolation, family. Bed capacity reduced with loss of orthopaedic elective beds on Ward 36 to medical patients. Initiation of the new IS patient transfers and ensuring effective communications in place to support patients.	Review lists to ensure optimising throughput of lists running. Ensure 6-4-2 theatre meeting and theatre list planning optimises utilisation of lists. Recruitment & retention of theatre staff. Full approval of ODP apprenticeship programme, trust agreed to go at risk this year. Establishing patient tracking and monitoring take up of IS capacity. Establishing additional internal lists. Optimisation of use of Vanguard. Optimising throughput within new IPC guidelines.	Patient clinically prioritised if lists need to be cancelled. Weekly RTT meetings to ensure long waiting patients validated and scheduled to available capacity. Fortnightly regional meetings to monitor progress against plan.

Outpatients Elective Total Activity –H2 plan

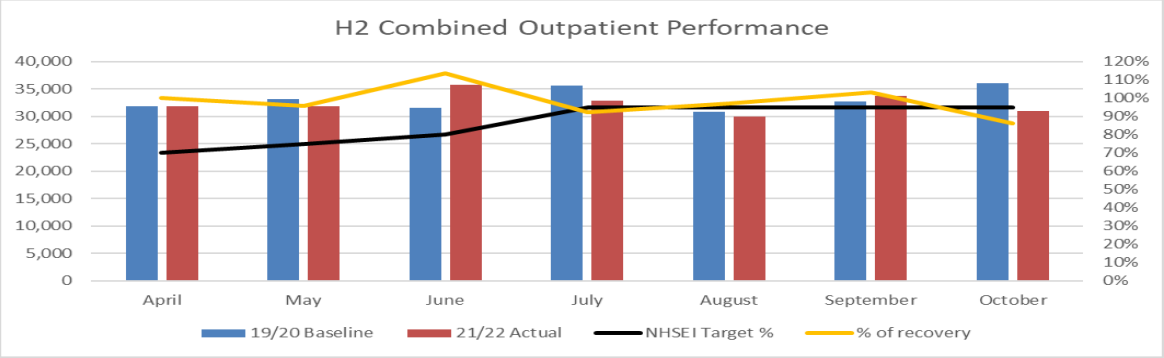
H2 plan	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
Total outpatient attendances (all TFC; consultant and non consultant led)	48366	44973	39355	49393	45937	46064

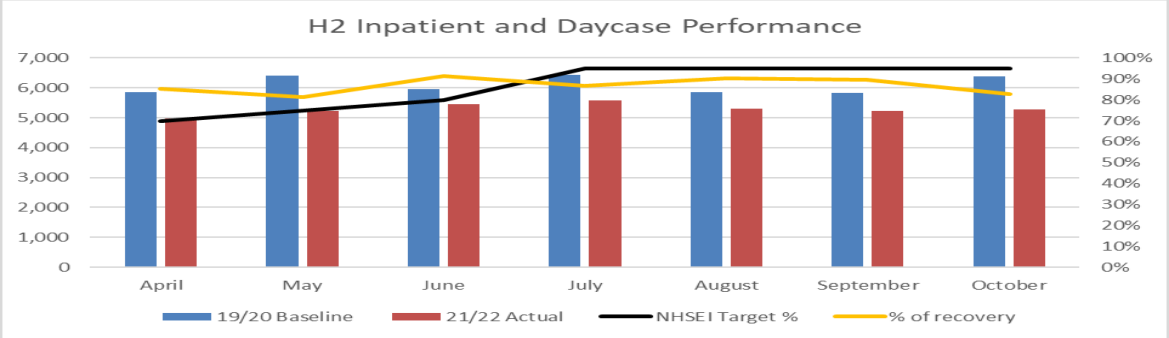


October 2021 actual performance
51698
Variance Type
Common Cause
Local Target
48366 (H2 plan)
Target/ Plan achievement
Aim to deliver H2 plan

Background	What the Chart tells us	Issues	Actions	Mitigation
The H2 activity plan aims to recover activity during Q3 and Q4 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 is slightly ahead of plan for October 2021.	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.	Waiting list initiatives being set up in accordance with the plan Bank staff to support outpatient staffing.	Patients prioritised in terms of clinical priority i.e. 2WW, urgent, longest wait.

The H1 elective recovery scheme has been revised for H2 and now considers the volume of closed RTT clocks compared to pathways closed in same month in 2019-20 rather than recovery of baseline activity. We are continuing to monitor activity levels for Outpatients, IPDC against the % of 19/20 baseline activity to assess the extent of service recovery. In addition we are closely tracking the additional H2 interventions and the impact of these on reducing the volume of routine patients waiting long periods for treatment. The tables and charts below show the actual positions for April - October 21. The diagnostic recovery plan is shown in the next section of the report.
The activity in October 2021 is part of the H2 plan and is in line with our plan, but remains below the 2019-20 baseline activity.





Diagnostics Recovery v plan (national target is 95% of 2019-20 baseline).
Activity data for October 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:

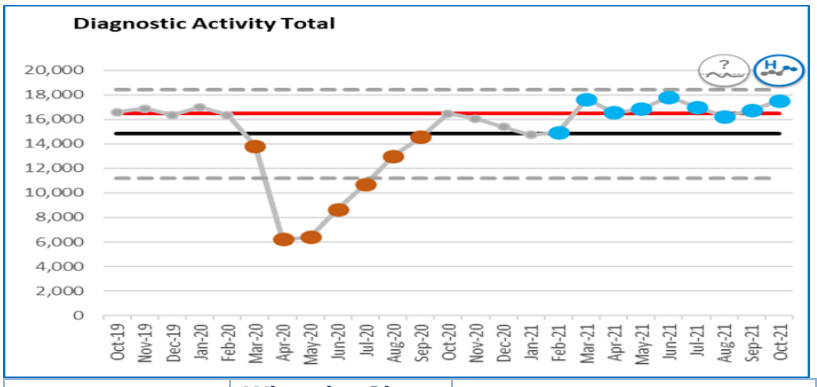
Indicator Name	19/20 Baseline	21/22 Actual	21/22 Actual % of 19/20 Baseline
Diagnostics Tests - Magnetic Resonance Imaging	2248	2083	92.66%
Diagnostics Tests - Computed Tomography	5868	6760	115.20%
Diagnostics Tests - Non-obstetric ultrasound	5598	5037	89.98%
Diagnostics Tests - Colonoscopy	475	595	125.26%
Diagnostics Tests - Flexi sigmoidoscopy	442	207	46.83%
Diagnostics Tests - Cystoscopy	278	354	127.34%
Diagnostics Tests - Gastroscopy	620	576	92.90%

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- H2 plan

The combined H2 activity plan for CT, MRI, NOUS, Colonoscopy, Flexi-sigmoidoscopy, gastroscopy and echocardiography is shown in the table below:

H2 plan	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
Total	15954	16714	19240	19358	17590	18423



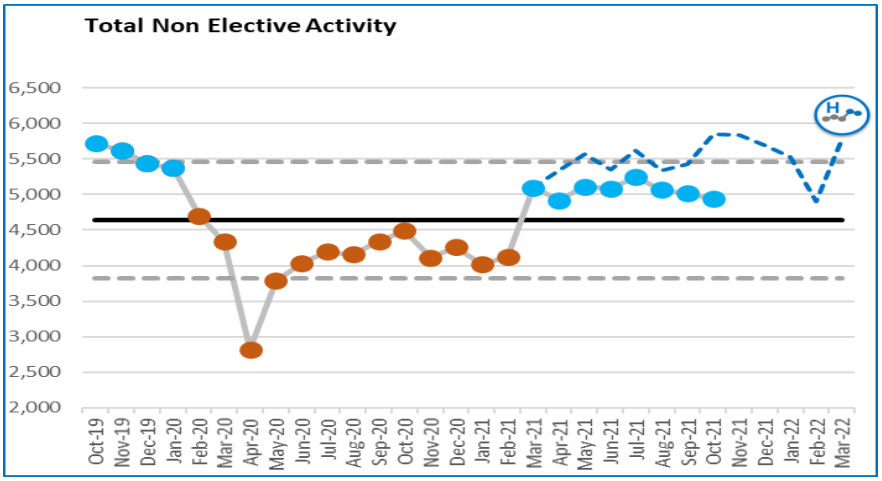
October 2021 actual performance
17,519
Variance Type
Special Cause Improvement
Local Target
197,619 for year, 15,954 Oct. 2021
Target/ Plan achievement
better than H2 plan

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 is comparable to pre-COVID-19 levels, even without full restoration of services, demonstrating the increasing demand for imaging overall. Fluctuating staffing levels due to vacancies, sickness and COVID-19 affects performance month on month. While activity looks good, we are still not able to meet the overall demand with increasing waiting lists and continued failure to meet DM01.	Review of appointment templates. Deployment of staff to maximise efficiency. Reliant on voluntary staff overtime. Continued use of agency Radiographers. Working with Medical Staffing to try and secure short-term locum Radiologists. Use of staffed mobile CT and MRI scanners.	Ongoing recruitment. International Radiographers expected to join SaTH in December and January. Recruitment of 3 additional Radiologists, expected to take up posts from December and into new year.

Non-Elective Activity

The H2 activity plan for non-elective admissions is shown in the table below:

H2 plan	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
Number of Specific Acute non-elective spells in the period	5851	5843	5697	5533	4908	5792



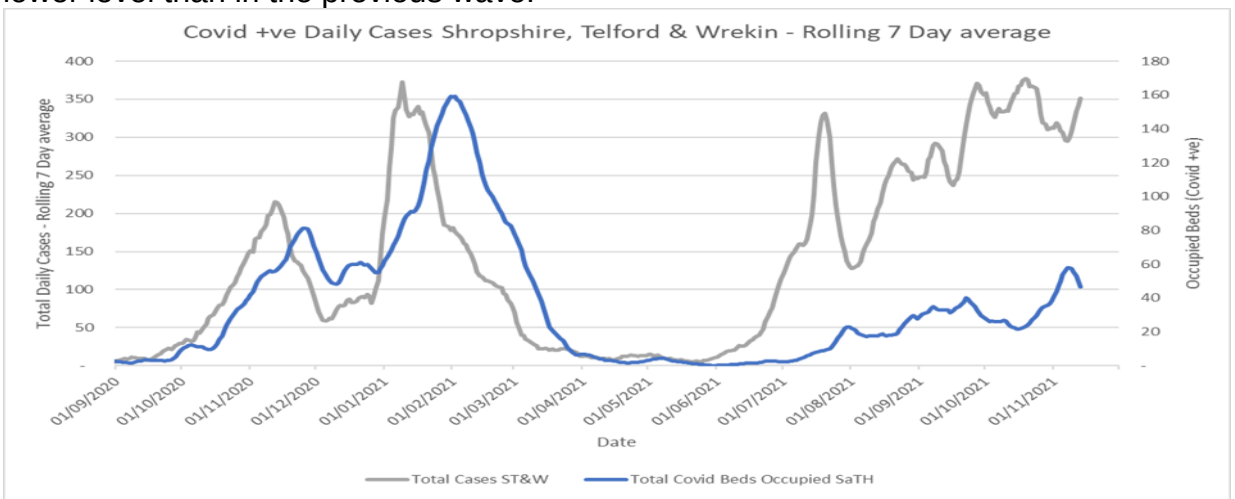
October 2021 actual performance
4940
Variance Type
Special Cause Improvement
Local Target
5851 (H2 plan)
Target/ Plan achievement
Demand is forecast to return to 19/20 baseline

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 and the level expected in the H2 plan.	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.

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 has continued during October and into November and is leading to increases in hospitalisations, albeit at a lower level than in the previous wave.



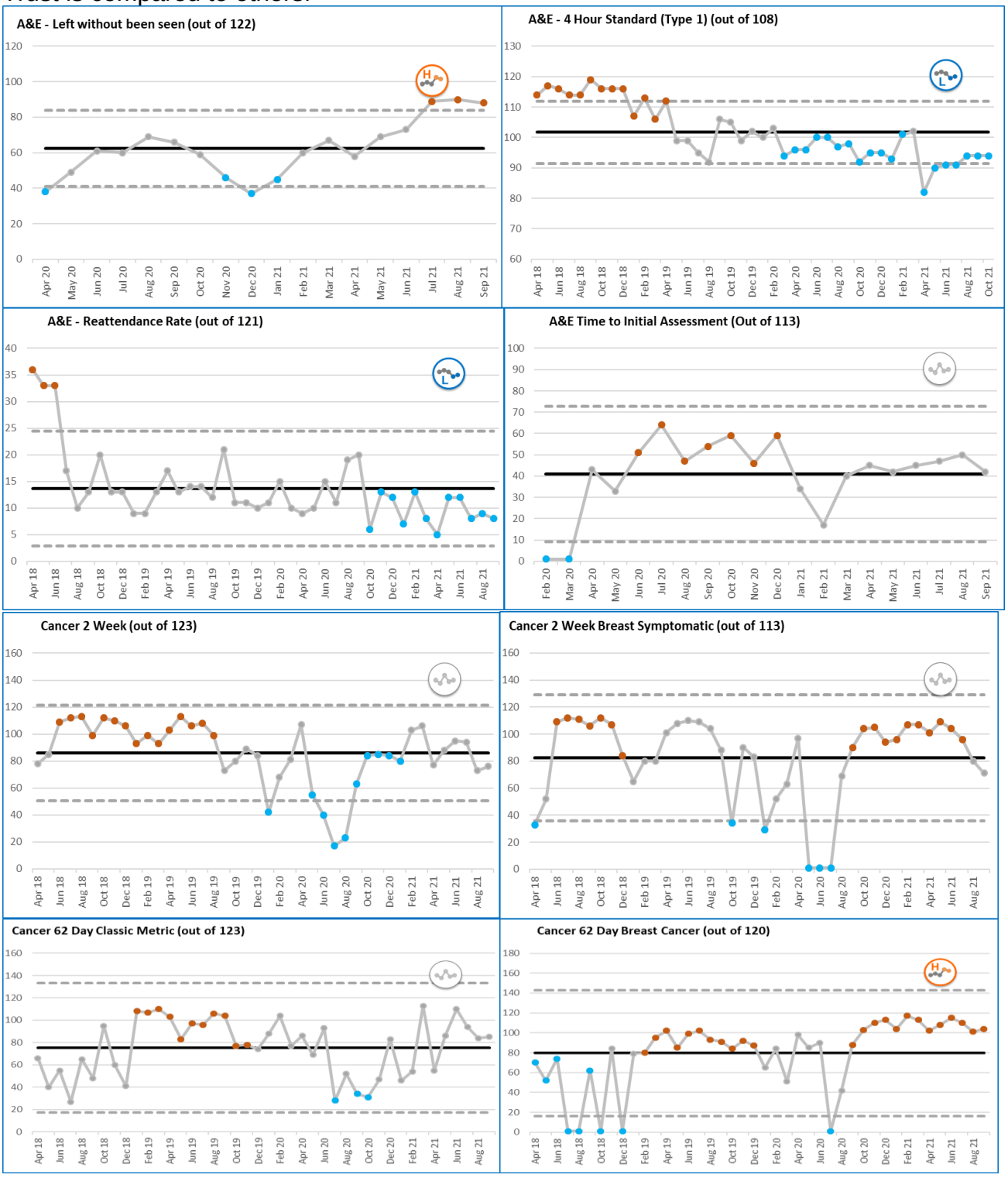
Operational Performance Benchmarking

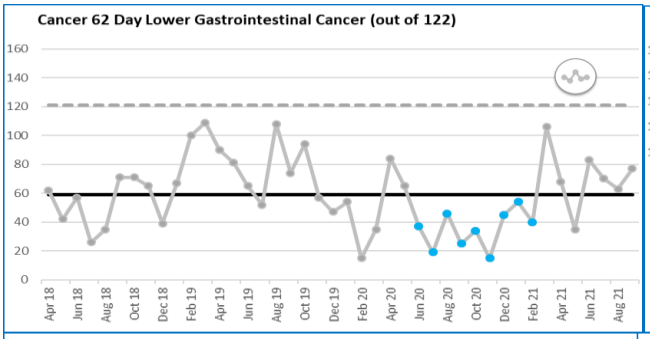
This table demonstrates the benchmarked position of the trust at a point in time compared to other English trusts reporting the same indicator. The icon shows the trend of ranking over time of the trust in relation to other trusts.

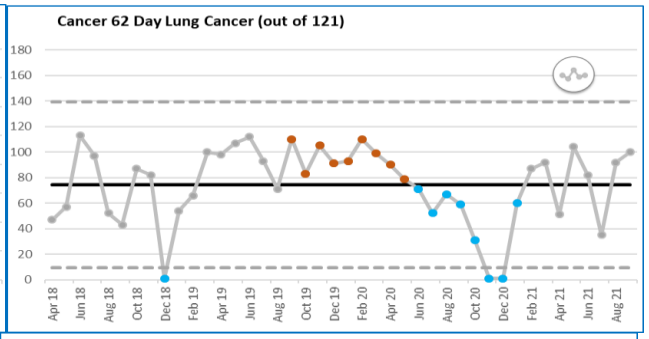
KPI	Latest month	Actual Performance Ranking	Performance	Lower process limit	Upper process limit
A&E - Left without been seen (out of 122)	Sep 21	88		41	84
A&E - 4 Hour Standard (Type 1) (out of 108)	Oct 21	94		91	112
A&E - Reattendance Rate (out of 121)	Sep 21	8		3	24
A&E Time to Initial Assessment (Out of 113)	Sep 21	42		9	73
Cancer 2 Week (out of 123)	Sep 21	76		50	121
Cancer 2 Week Breast Symptomatic (out of 113)	Sep 21	71		36	129
Cancer 62 Day Classic Metric (out of 123)	Sep 21	85		17	133
Cancer 62 Day Breast Cancer (out of 120)	Sep 21	104		16	143
Cancer 62 Day Lower Gastrointestinal Cancer (out of 122)	Sep 21	77		-3	121
Cancer 62 Day Lung Cancer (out of 121)	Sep 21	100		9	139
Cancer 62 Day Other Cancer (out 123)	Sep 21	101		-28	140
Cancer 62 Day Skin Cancer (out 114)	Sep 21	77		-25	138
Cancer 62 Day Urological Cancer (out of 122)	Sep 21	51		14	138
Diagnostic 6 Week Standard (out of 122)	Sep 21	97		34	97
Diagnostic 6 Week Standard - Cardiology : echocardiography (out of 122)	Sep 21	6		-6	42
Diagnostic 6 Week Standard - Audiology Assessments (out of 109)	Sep 21	88		11	100
Diagnostic 6 Week Standard - Urodynamics: pressures & flows (out of 103)	Sep 21	89		7	102
Diagnostic 6 Week Standard - Respiratory physiology : sleep studies (out of 93)	Sep 21	51		-25	98
Diagnostic 6 Week Standard - Magnetic Resonance Imaging (out of 121)	Sep 21	86		46	106
Diagnostic 6 Week Standard - Computed Tomography (out of 121)	Sep 21	118		26	118
Diagnostic 6 Week Standard - Non-obstetric ultrasound (out of 121)	Sep 21	91		83	119
Diagnostic 6 Week Standard - Colonoscopy (out of 122)	Sep 21	119		-3	85
Diagnostic 6 Week Standard - Flexi sigmoidoscopy (out of 122)	Sep 21	60		-6	91
Diagnostic 6 Week Standard - Cystoscopy (out of 118)	Sep 21	82		7	110
Diagnostic 6 Week Standard - Gastroscopy (out of 122)	Sep 21	91		4	78
RTT 52 Week Breach (out of 122)	Sep 21	92		66	85
RTT Incomplete 18 Week Standard – (out of 122)	Sep 21	108		47	84
RTT Incomplete 18 Week Standard Metric - Gynaecology (out of 120)	Sep 21	77		44	86
Total Time in A&E - Admitted (out of 106)	Sep 21	87		58	112
Total Time in A&E - Non - Admitted (out of 120)	Sep 21	61		32	75

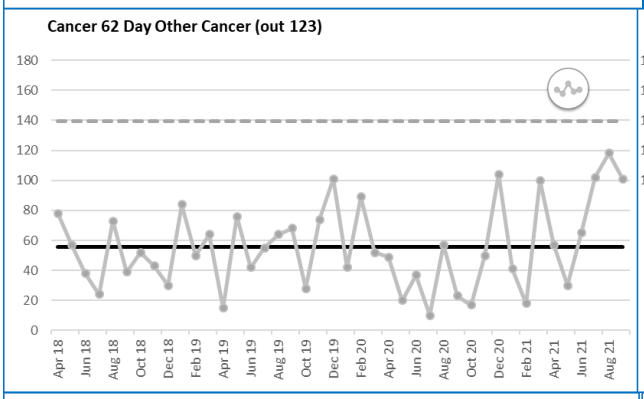
The SPC charts show the relative ranking of the Trust compared to other English trusts over time and so demonstrates the change in relative position compared to previous periods and

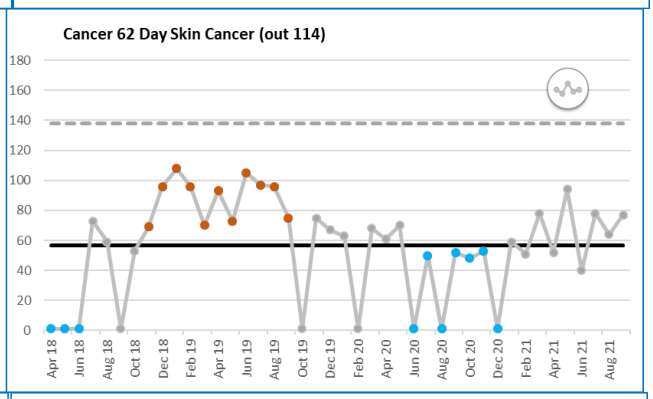
the variation in the Trust ranking. The lower the ranking the better the relative position of the Trust is compared to others.

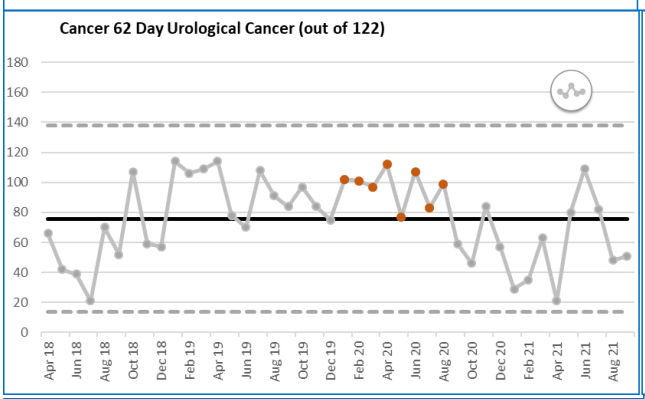


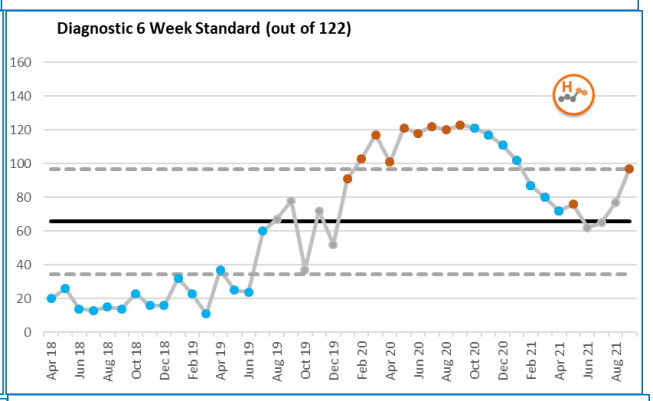

Cancer 62 Day Lower Gastrointestinal Cancer (out of 122)

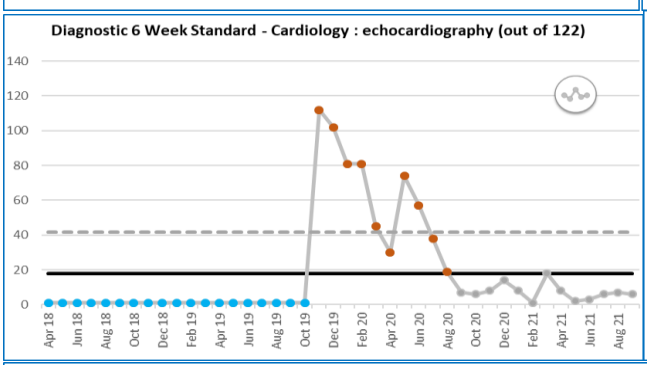

Cancer 62 Day Lung Cancer (out of 121)

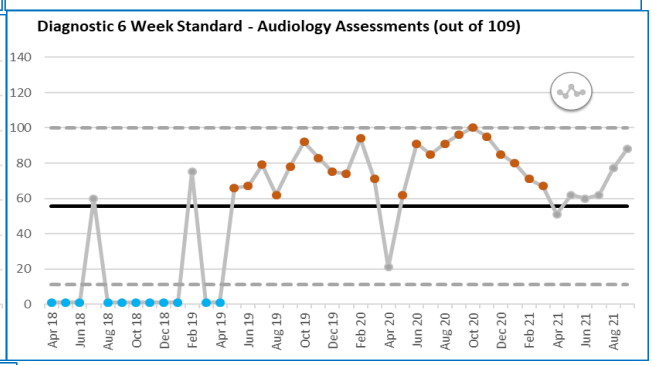

Cancer 62 Day Other Cancer (out 123)

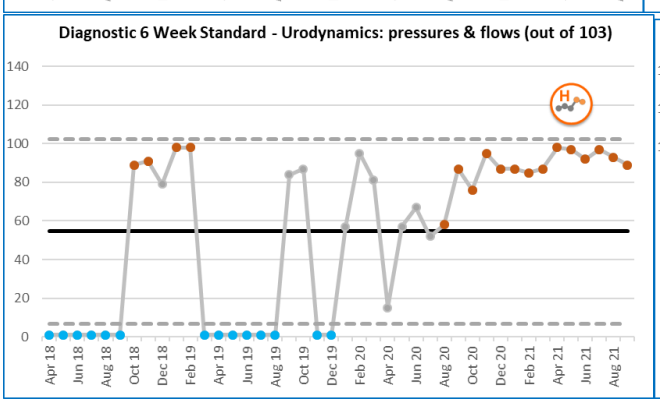

Cancer 62 Day Skin Cancer (out 114)

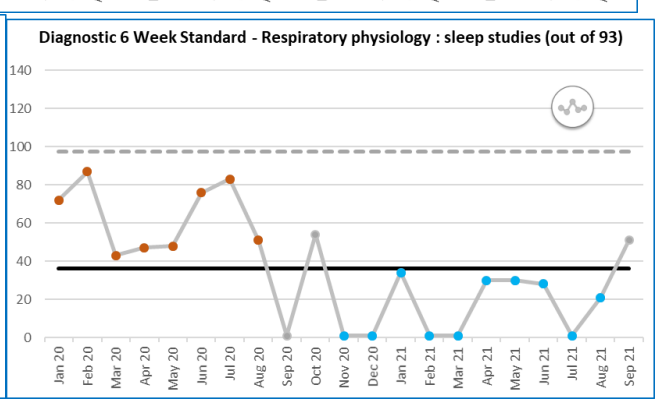

Cancer 62 Day Urological Cancer (out of 122)

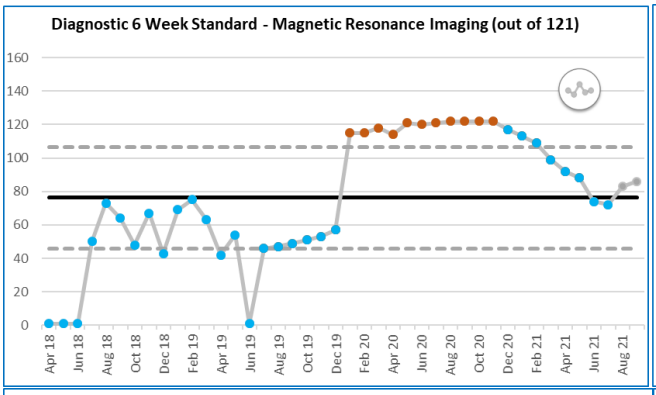

Diagnostic 6 Week Standard (out of 122)

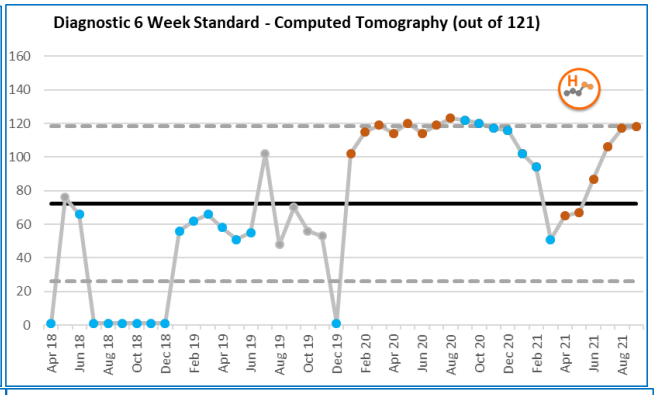

Diagnostic 6 Week Standard - Cardiology : echocardiography (out of 122)

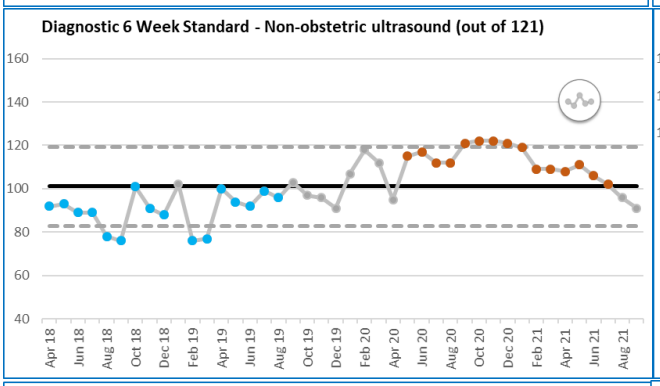

Diagnostic 6 Week Standard - Audiology Assessments (out of 109)

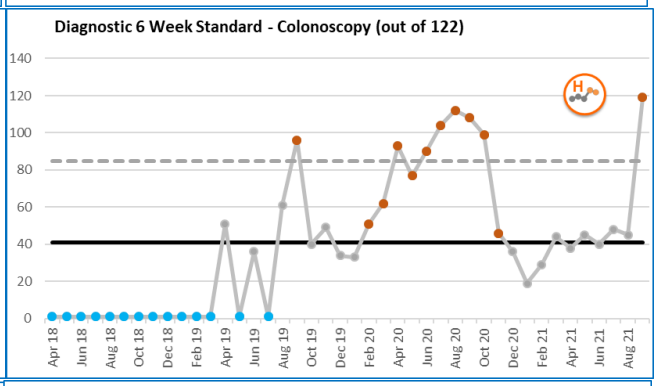

Diagnostic 6 Week Standard - Urodynamics: pressures & flows (out of 103)

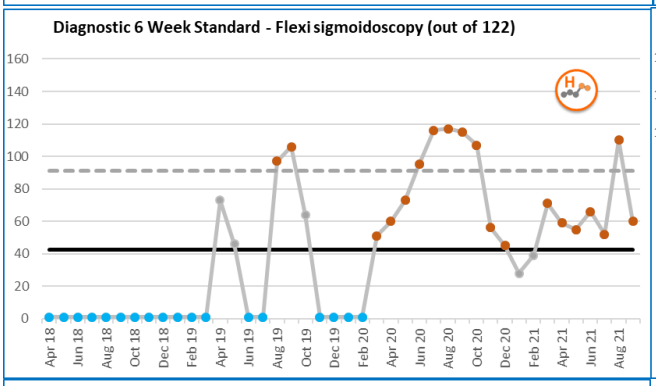

Diagnostic 6 Week Standard - Respiratory physiology : sleep studies (out of 93)

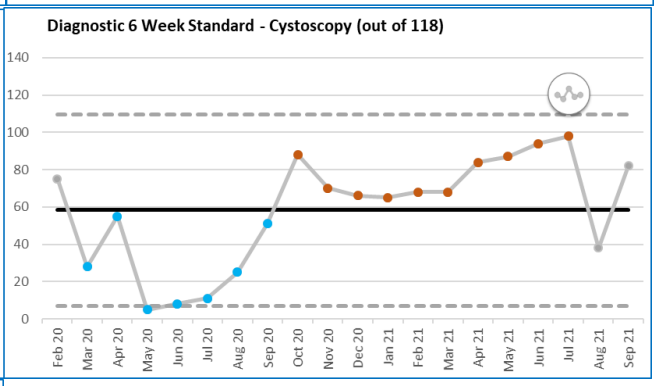

Diagnostic 6 Week Standard - Magnetic Resonance Imaging (out of 121)

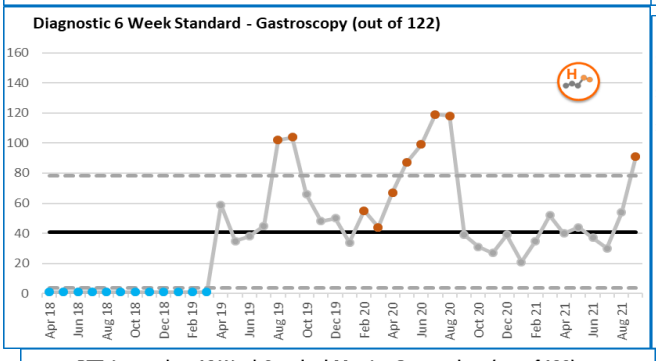

Diagnostic 6 Week Standard - Computed Tomography (out of 121)

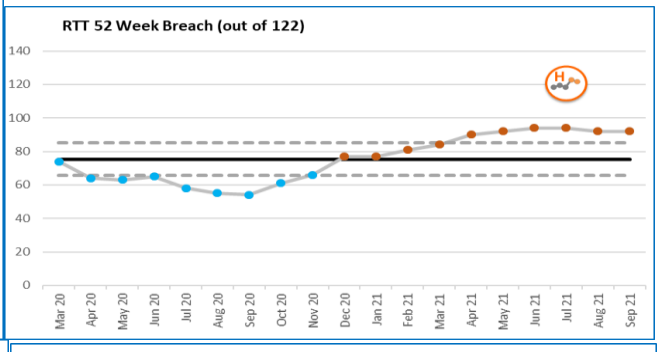

Diagnostic 6 Week Standard - Non-obstetric ultrasound (out of 121)

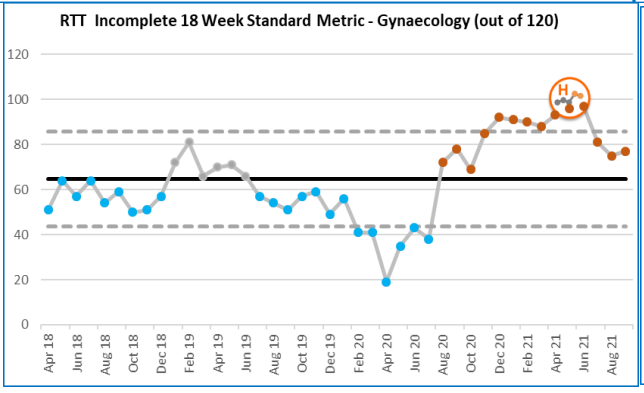

Diagnostic 6 Week Standard - Colonoscopy (out of 122)

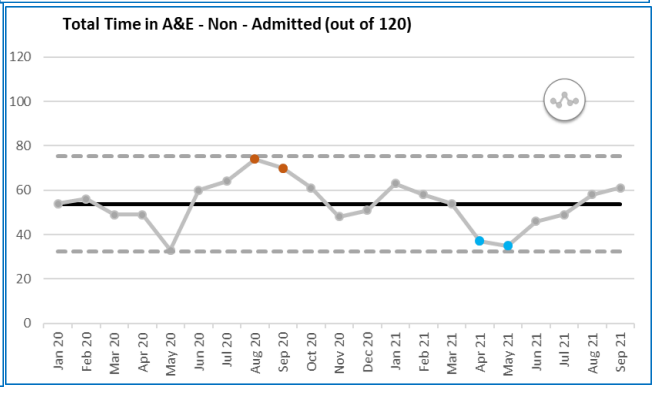

Diagnostic 6 Week Standard - Flexi sigmoidoscopy (out of 122)


Diagnostic 6 Week Standard - Cystoscopy (out of 118)


Diagnostic 6 Week Standard - Gastroscopy (out of 122)


RTT 52 Week Breach (out of 122)

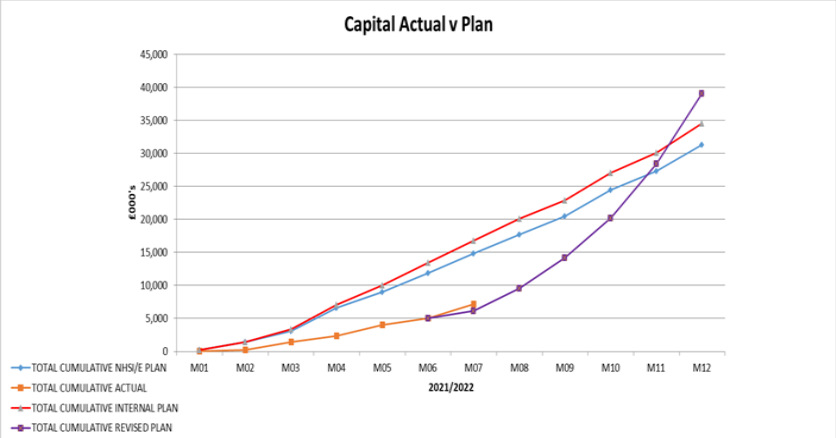

RTT Incomplete 18 Week Standard Metric - Gynaecology (out of 120)


Total Time in A&E - Non - Admitted (out of 120)

9. Finance Summary
Helen Troalen, Director of Finance

- The Trust recorded a deficit of £5.766m for the first 6 months (H1) and at the time of writing the plans for the final 6 months (H2) are still being finalised.
- The Trust's plan for H2 is to report a financial deficit of £3.824m, and when added to the H1 planned deficit becomes a £7.043m deficit for the full 12 month period. However, the forecast is to deliver a deficit of £9.590m which is accepted by the system and regulators and therefore will form the basis of the Trusts internal plan for the remainder of the year. This position assumes expenditure associated with the elective recovery programme is offset in full for the year by income.
- The plan will be matched to the actual financial position recorded for month 07 for national reporting purposes until the H2 plans have been submitted and approved during November.
- The Trust recorded a deficit of £1.645m during October, £7.412m cumulatively. This position includes a deficit recorded against the elective recovery fund of £0.696m during the month, £3.252m YTD. The Trust had agreement to proceed at risk ahead of the signed off H2 plan, and procured additional capacity to support elective and cancer recovery in October and November. The in-month position was broadly in line with the draft plan excluding the deficit linked to elective recovery.
- The Trust's deficit, excluding costs associated with elective recovery, was £0.949m in the month, £4.160m cumulatively. The in-month deficit was slightly higher than previous month due mainly to income reducing in line with the H2 system envelope, higher pay costs which have been offset in part by a lower level of operating expenses.
- The higher pay costs in the month are primarily due to increased nursing costs mainly linked to costs required to support non-elective operational pressures. Some of the increase is linked to the supernumerary impact of the newly recruited overseas nursing staff. Non pay costs were lower due to a lower level of elective theatre spend in the month.
- Additional funding continues to be available during H2 to support the on-going COVID-19 response but this will be at least 5% lower than the level of funding received during H1. £1.080m of expenditure directly associated with COVID-19 was incurred during the month, £7.918m YTD.
- £3.448m of efficiency savings have been delivered YTD which is broadly in line with plan although c43% has been delivered non-recurrently. The overall recurrent annual efficiency requirement is for £7.550m (1.6%), the Trust is currently forecasting to deliver £7.438m.
- The capital allocation for the Trust has increased mainly due to the inclusion of funding for Community Diagnostic Centre of £4.581m. Total capital spend YTD is £7.135m against a planned spend of £14.880m, this is a timing issue and the Trust is still forecasting to deliver the total capital programme for 2021/22 of £39.159m. Since month 7 reporting, the Trust has received confirmation of success in bids for additional capital investment through the targeted investment fund (TIF) (£7.098m) and TIF Digital (£0.800m) funding, these schemes will be included in future reporting.
- The Trust held a cash bank balance at the end of October of £18.182m.

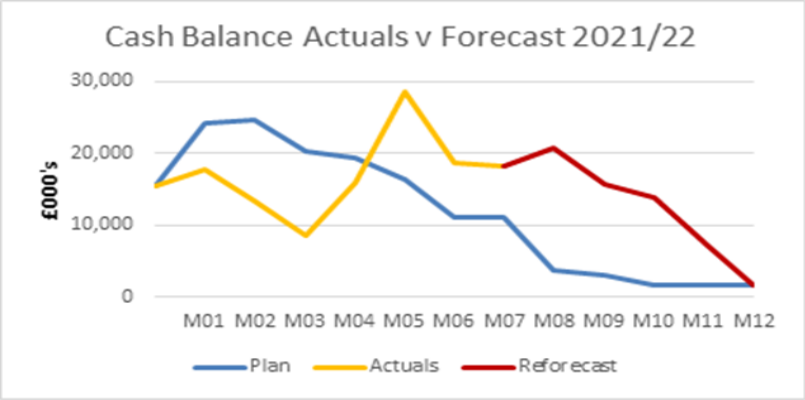
Capital Expenditure



October 2021 actual performance
Spend year to date is £7.135m
Variance Type
Underspend (against original NHSEI Plan)£7.745m
SaTH Plan 2021/22
£39.159m
Target/ Plan achievement
To meet the Trust's Capital Resource Limit (CRL) at year end.

Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust's total capital programme for 2021/22 as at month 07 has increased to £39.159m, following additional early drawdown for HTP professional fees of £0.040m and the inclusion of the Community Diagnostic Centre of £4.581m (previously Shropshire Community project). The Trust has been informed (after M07 reporting) that it has been successful in its bids for TIF funding of £7.098m for the modular ward and £0.800m for TIF Digital funding and will be included in M08 reporting onwards.	Within the capital plan submitted to NHSEI, the Trust forecast spend at month 07 of £14.880m. £7.135m has been expended giving an underspend of £7.745m to plan.	Capital expenditure to date is lower than projected. The Trust is forecasting that all capital allocations will be spent during 2021/22 although a detailed review of this forecast is being undertaken following the changes to the capital programme due to CDC and successful TIF bids. The expenditure, together with the commitments to date, total £20.591m, being just over 50% of the Capital Programme for the year. A revised capital plan was agreed at October's Capital Planning Group (CPG). Against this Plan of £6.157m at M07, the actual spend is £0.978m more.	Following agreement of revised capital plan at October's CPG, a further discussion will take place at November's CPG to agree schemes which can be brought forward from next financial year to cover any projected slippage in the 2021/22 Capital Programme.	No mitigations required.

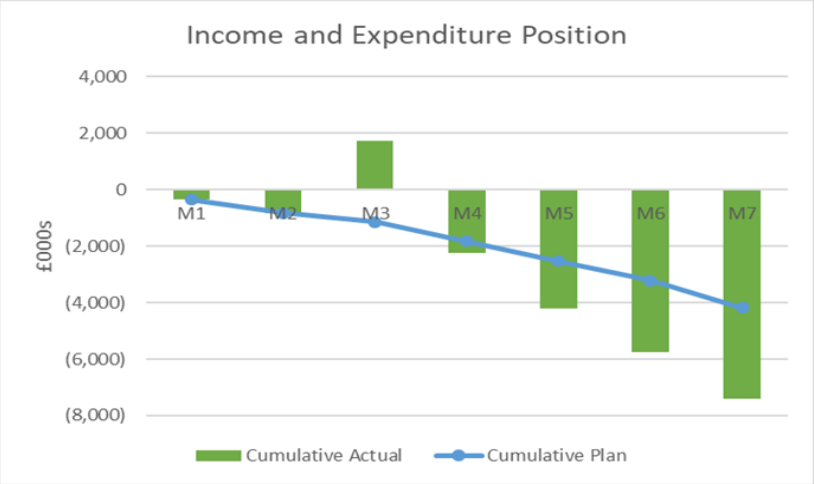
Cash



October 2021 actual performance	
£18.182m	
Variance Type	
Lower Cash Balance	
SaTH Original Forecast	**SaTH Rolling Forecast**
£11.152m	£25.149m
Target/ Plan achievement	
£6.967m lower Cash Balance than Rolling Forecast	

Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust has revised the cash flow forecast and is now based on average spend to date for the year, taking account of known variations and changes in working capital balances. The cash flow will be amended to reflect H2 plan when approved. The Trust reforecasts on a monthly basis.	The cash balance at the end of October was £18.182m (ledger balance of £18.093m due to reconciling items). This balance is in line with the M06 cash balance.	The Trust is not forecasting a requirement for cash support. The revised forecast currently projects a year end cash balance of £1.700m in line with the required minimum cash balance.	The Trust to undertake a review of the assumptions within the cash flow. Rolling monthly forecasting to continue. The cash flow will be reforecast based on H2 plan when approved.	No mitigations required.

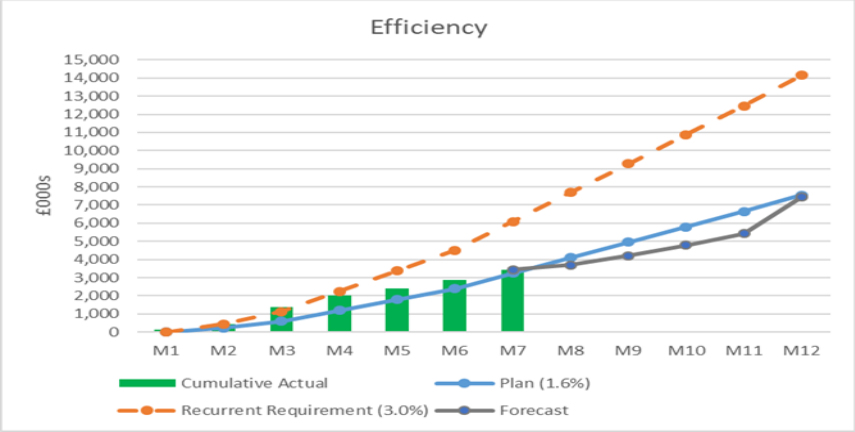
Income and Expenditure Position



October 2021 actual performance	
Income & Expenditure Position year to date (£7.412m)	
Variance Type	
Overspend to date (£3.229m)	
National Target	**SaTH Plan 2021/22**
(£0m)	(£9.590m)
Target/ Plan achievement	
£7.043m Adverse variance	

Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust continues to operate within a temporary finance regime for 2021/22. The STW system submitted a plan for H1 which was compliant with the H1 system funding received but with £6m of unmitigated risk. As part of this the Trusts plan was to deliver a deficit over the H1 period of £3.219m. This plan is compliant with the recurrent system sustainability plan. The H2 plan submission date is mid-November and at the time of writing the Trust has a H2 draft deficit plan of £3.824m making the full year draft plan £7.043m deficit. This assumes the full year overspend against ERF is offset in full by income.	The Trust recorded a net deficit of £1.645m in month, £7.412m after 7 months, £3.229m adverse to draft plan. This position however includes a £3.252m YTD overspend linked to the additional spend above income received against the ERF. Excluding this impact the financial position would be favourable to plan at the end of the period. The surplus delivered in month 03 was driven by an estimate of the ERF income achievement provided to the Trust by the system. Positive discussions are progressing with NHSE/I to potentially fund the full year ERF overspend which will be confirmed next month.	Operational pressures continue to increase cost and further limit the Trusts ability to recover elective activity. Efficiency savings are also compromised .	Discussions with STW partners ongoing around risk management arrangements.	Additional system savings/ underspend. Slippage against investments.

Efficiency



October 2021 actual performance	
Efficiency year to date is £3.448m	
Variance Type	
Over performance to date £0.278m	
National Target	**SaTH Plan 2021/22**
£0.000m	£7,550m
Target/ Plan achievement	
£0.278m favourable variance YTD	

Background	What the Chart tells us	Issues	Actions	Mitigations
A minimum of 1.6% in year recurrent savings are required to maintain financial stability across the system. However further savings are required to fund additional priority investments.	The Trust has delivered £3.448m of efficiency savings after 7 months, £0.278m ahead of plan. The challenge is that 57% 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, the current forecast is £7.438m.	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% in order to enable additional investments to be made. There is currently a heavy reliance on nursing workforce savings in the H2 forecast, which could be delayed.	Increased programme focus in H2 to progress the material efficiency schemes. Additional PMO support to the agency reduction programme planned.	Non-recurrent opportunities.

10. Transformation Executive Summary
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.
Five of the nine programmes within Getting to Good are progressing with the following programmes reporting all of their projects as being on track this period.

- Quality and Safety
- Maternity
- Workforce
- Leadership
- Culture

The finance and resources programme continues to show progression with three out of four projects reporting as on track; however, a status of off track is being reported against the Performance and Business Intelligence Project. This is due to a delay in the delivery of an IPR Dashboard with the ability to drill down to ward level, caused by some discrepancies with hierarchy development in the system. Mitigation is in place with a meeting scheduled for 8th November, with assurance that this will enable completion of this key milestone. Three programmes are reporting one or more projects with a status of reasonable:

a) Digital Transformation
- Digital Infrastructure
- Applied Digital Healthcare.

b) Operational Effectiveness
- Restoration and Recovery
- UEC

c) Corporate Governance programme is reporting a reasonable status overall.

Exceptions and Mitigations (for projects with a status below On Track).

There are nine projects out of 26 currently reporting as reasonable. An explanation for this status is provided for each project below:

Urgent and Emergency Care (UEC): The planned rollout of Vitals 4.2 in September 2021 has been delayed owing to a serious functionality issue identified during the testing phase. This will also cause a delay in the planned implementation date of December 2021 for the Emergency Department Careflow system. The Digital Team are awaiting the updated timescales from the provider.

Restoration and Recovery: Theatres - Staff absence, including COVID-19 related absence and the impact of supernumerary staff on theatre capacity has resulted in a gap in theatre staffing and subsequently has resulted in the closure of four elective theatres across the two sites. In response, a theatre re-opening plan has been produced, together with a theatre efficiency and recovery plan. This plan has set revised targets for theatre efficiency and has refined the weekly 6-4-2 process.

Outpatient improvement - The weekly information indicates there has been a deterioration in performance, to mitigate this, an improvement plan is in place and is being monitored each week at the recovery group.

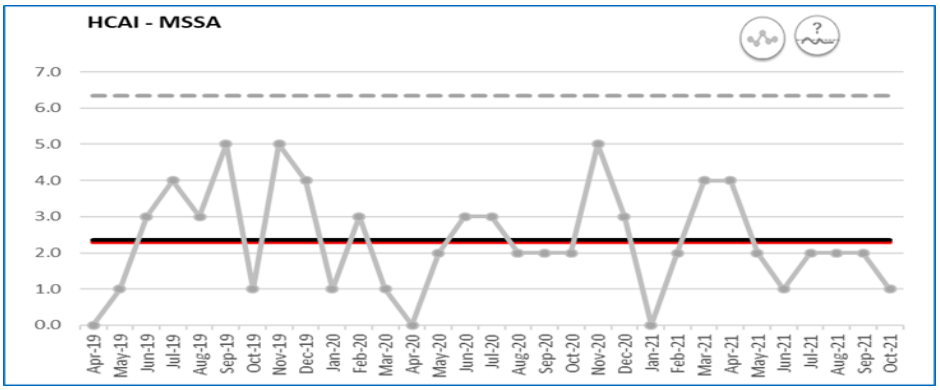
Applied Digital Healthcare: The agreement on appropriate clinical supervision from the acute trust for Virtual Ward patients poses a risk to delivery.

Digital Infrastructure: The planned rollout of Vitals 4.2 in September 2021 has been delayed owing to a serious functionality issue identified during the testing phase. The SRO is working closely with the provider to resolve this issue, with a possible revised go live date of November 2021, provided a fix is available within that timeframe. This will also cause a delay in the planned implementation date of December 2021 for the Emergency Department Careflow system.

Corporate Governance Programme, comprising of four projects: Board Assurance Framework (BAF), Communications and Engagement, Board Governance, Risk Management Anti-Fraud, Bribery and Corruption: These projects are reporting an improved status from not started to reasonable. Whilst the delivery plans for these projects are not yet defined, the transformation delivery partner will work with the Director of Governance and Communications to develop these during November 2021.

Appendix 1: Indicators performing in accordance with expectations.

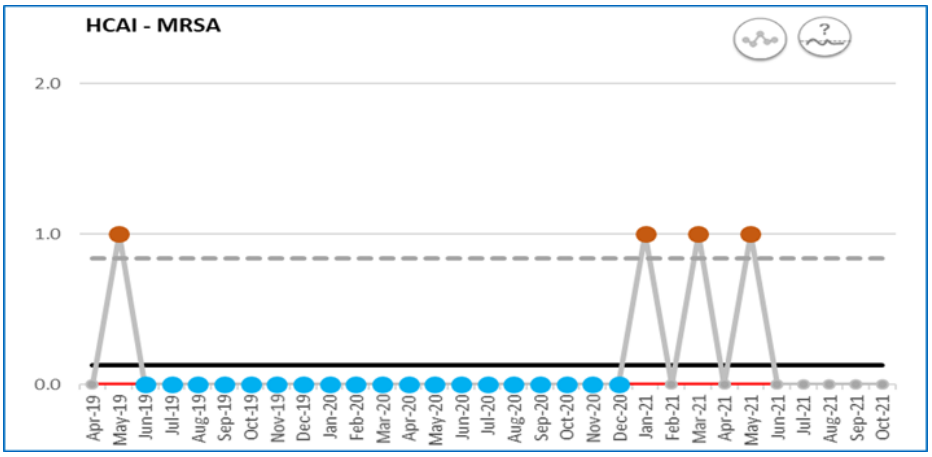
MSSA



October 2021 actual performance
1
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 1 case of post 48 hour MSSA Bacteraemia in October 2021. YTD there have been 14 cases against a Trust target for the year of no more than 28 cases. No NHSE/I target for MSSA cases has been set for the Trust, however performance is currently better than our internal improvement target.	All cases deemed to be device related have an RCA completed.	Aseptic non-touch technique training (ANTT) audit at PRH showed 91% compliance This audit is to also be undertaken at RSH.	The number of staff who have completed this training will be reported through the IPC Operational Group.

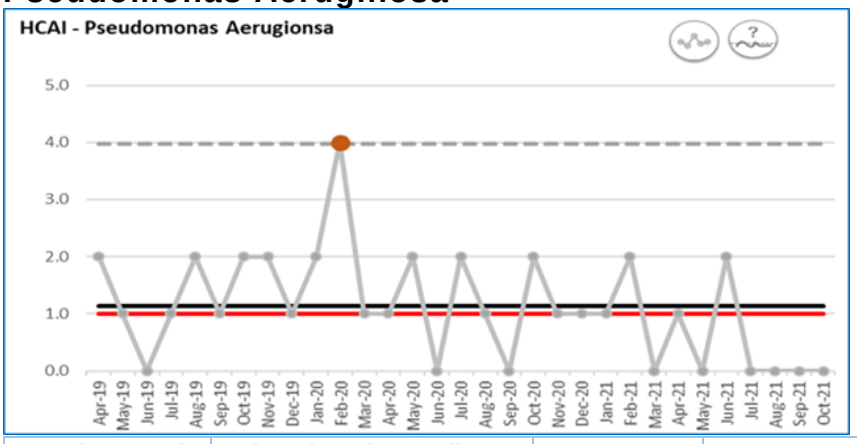
MRSA



October2021 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 since May 2021.	No new cases.	No new actions.	Monitored monthly through IPC Operational Committee.

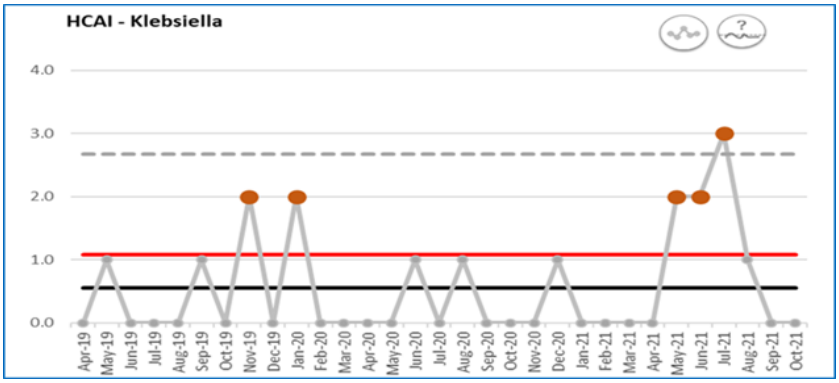
Pseudomonas Aeruginosa



October 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 October 2021. YTD there have been 3 cases all in Q1 National target set for Trust for 2021/22 is no more than 10 cases.	No new issues identified in October.	As for some of the other device related HCAIs associated with catheter associated urinary tract infections, the embedding of the use of the newly implemented catheter insertion document and catheter care plan continues across the Trust supported by the Quality Team.	Ongoing monitoring at IPCOG and Monthly metrics meetings.

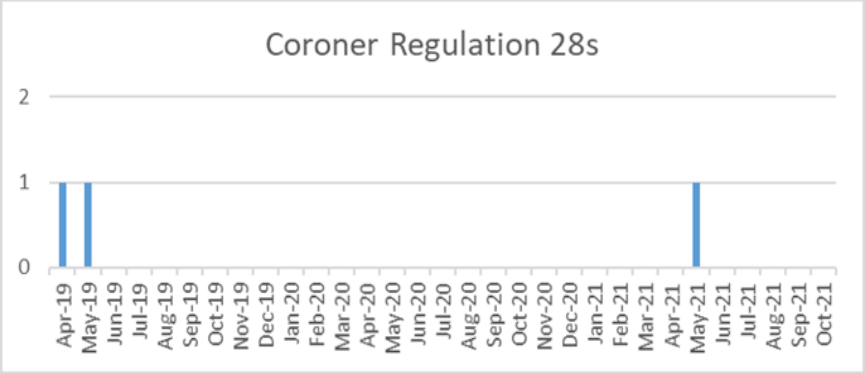
Klebsiella



October 2021 actual performance
0
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 were no cases of Klebsiella bacteraemia in October 2021. YTD there have been 8 cases of Klebsiella, which is slightly worse than the local Trust target but better than the NHSE/I target set for the Trust for 2021/22 of no more than 24 cases.	No issues in month	Ongoing actions to embed use of the catheter insertion documentation and catheter care plan ongoing.	Monitored at IPCOG and Monthly Metrics meetings.

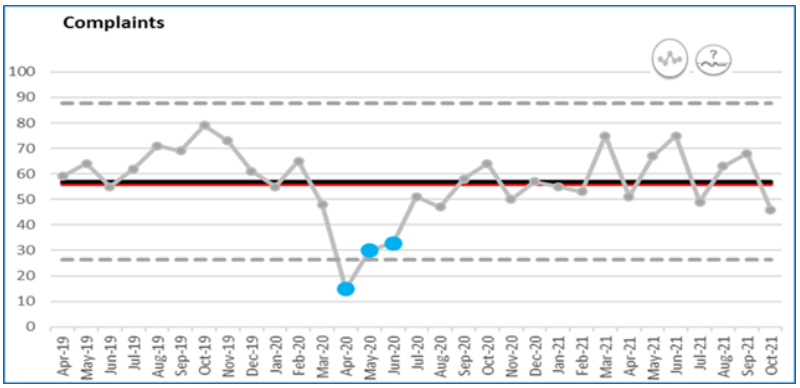
Coroner Regulation 28 Notices



October 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 October.	No Issues to report.	No Actions.	No Mitigations.

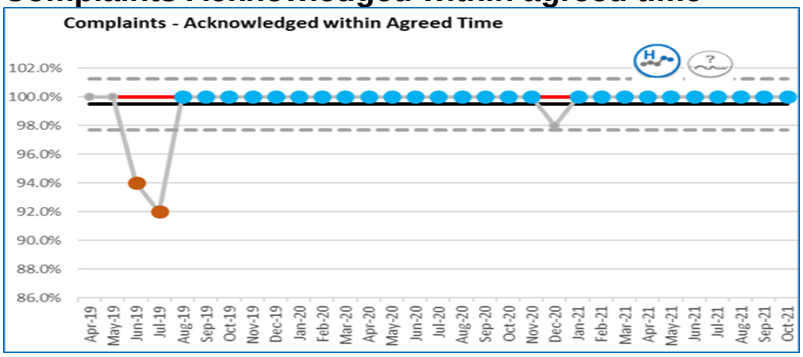
Complaints



October 2021 actual performance
46
Variance Type
Common Cause
SATH internal target
<56
Target/ Plan achievement
>10% reduction on 19/20 total complaints

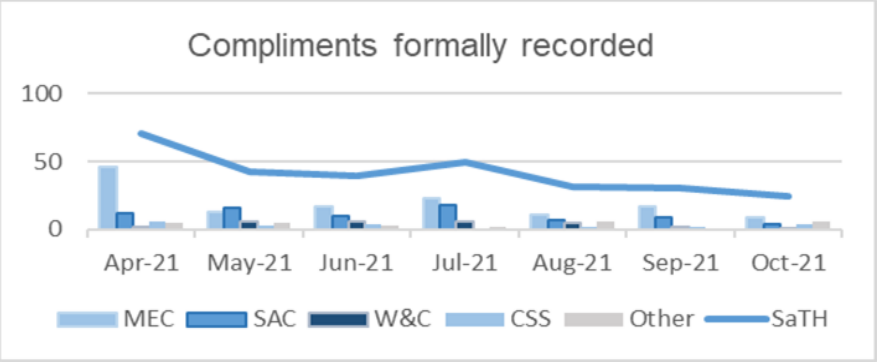
Background	What the Chart tells us	Issues	Actions	Mitigations
Complaints provide a valuable source of learning to the organisation.	Numbers remain within common cause variation.	There has been an increase in complaints relating to Ward 9.	This has been escalated and is being reviewed by the Division.	None.

Complaints Acknowledged within agreed time



October 2021 actual performance
100% (88% within two days)
Variance Type
Common Cause
National Target
100%
Target/ Plan achievement
Target achieved consistently

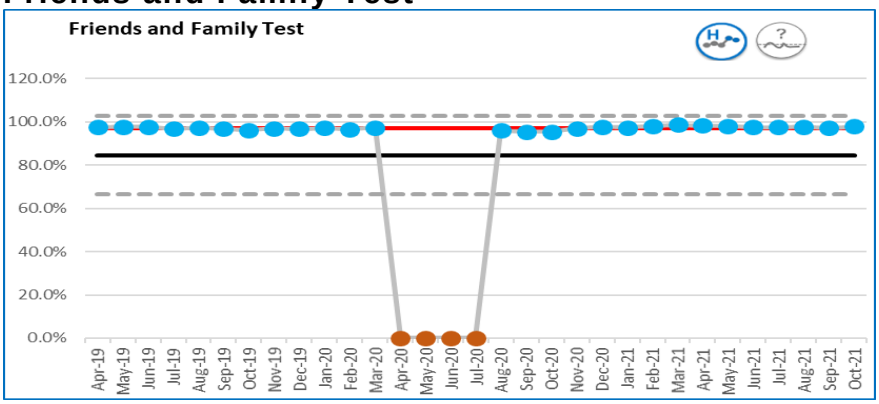
Compliments formally recorded



October 2021 actual performance
SATH
24
Divisions
MEC – 9
SAC - 4
W&C - 1
CSS – 4
Other - 6

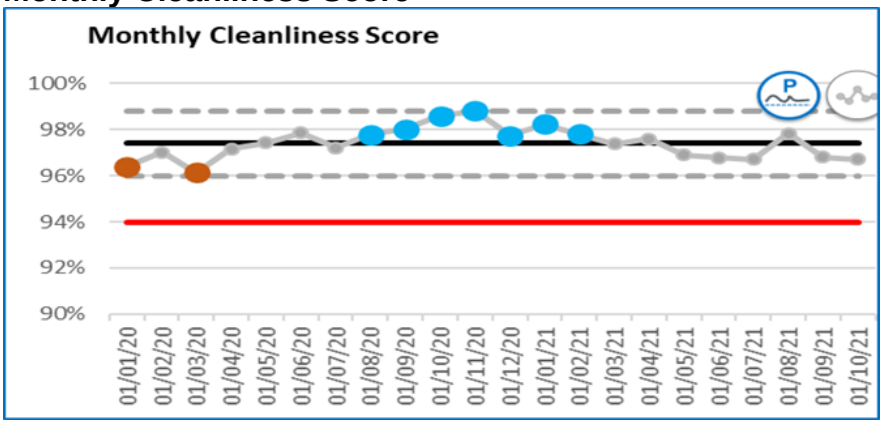
Background	What the Chart tells us:	Issues	Actions	Mitigations
By collecting data on positive feedback, the Trust will be able to identify well performing areas, and seek to spread good practice.	The number of compliments recorded has dropped, although it remains within common cause variation; it is thought that this is due to low recording of compliments received.	This is still a new system, and staff may not be aware of the need to log thank yous.	Remind staff to use the Datix system to record positive feedback.	None.

Friends and Family Test



October 2021 actual performance
97.2%
Variance Type
Special Cause
National Standard
85%
Target/ Plan achievement
Target achieved consistently

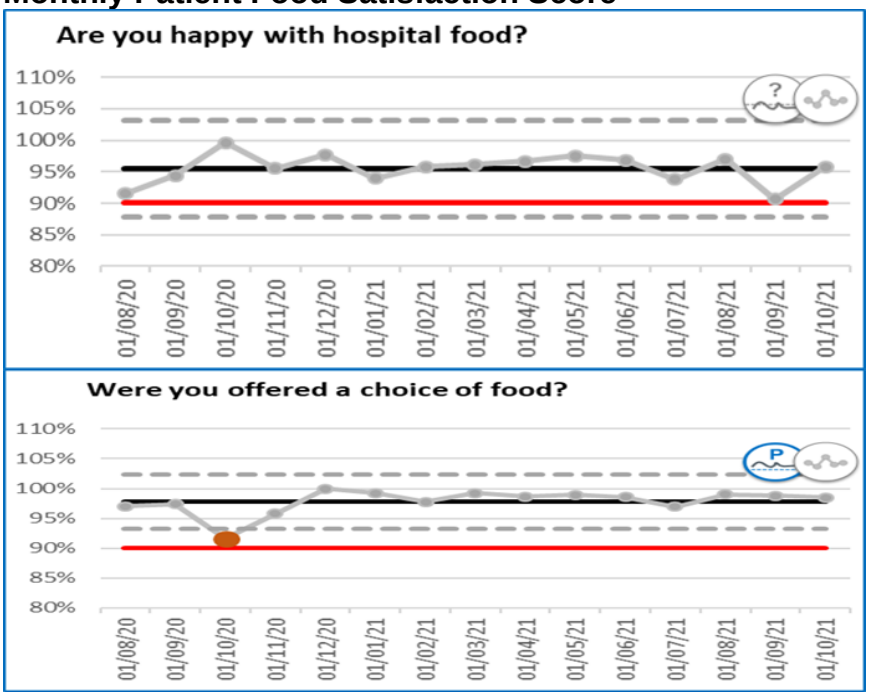
Monthly Cleanliness Score



October 2021 actual performance
96.7%
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 above the target with some slight common cause variation.	The cleanliness score over the last few months have seen a slight decline, which has taken them below the mean. There are continuing 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. An open day has been arranged for 26th November with interviews/employment checks on 29th November in order to fast track recruitment. An advertising campaign has been developed for Shropshire Star and Radio Shropshire and social media platforms will be used as well as traditional methods of reaching potential candidates.	Not applicable

Monthly Patient Food Satisfaction Score

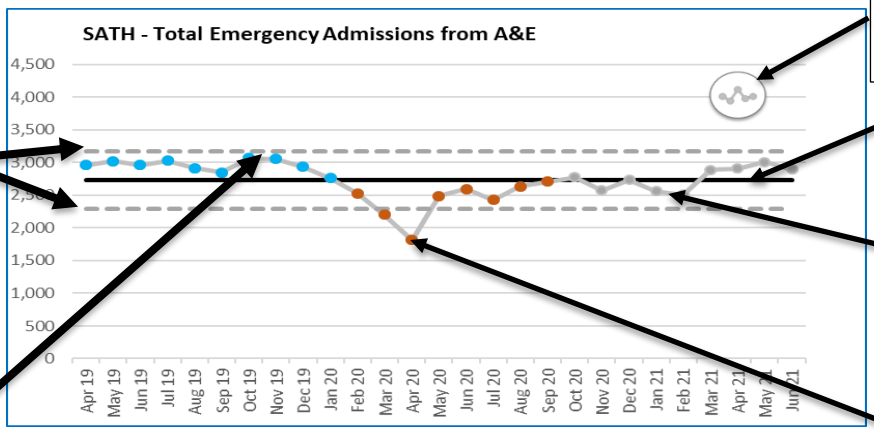


October 2021 actual performance
95.8% for satisfaction with food and 98.5% for satisfaction with choice.
Variance Type
Common Cause
Local SaTH standard
90%
Target/ Plan achievement
On target to achieve local standard

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 are both at the medium this month.	There are no concerns at present.	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.



Icon showing most recent point type of variation

Process limits – upper and lower

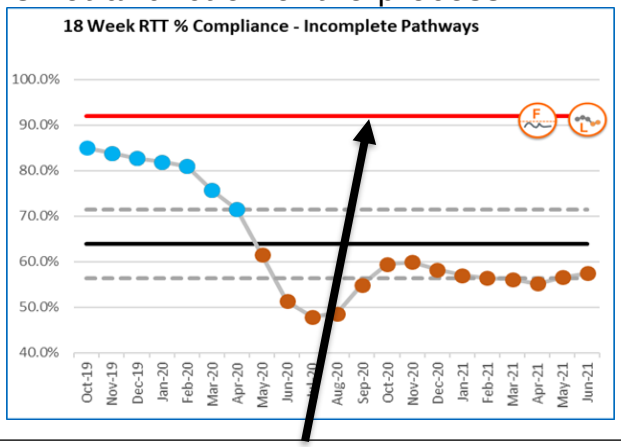
Mean or median line

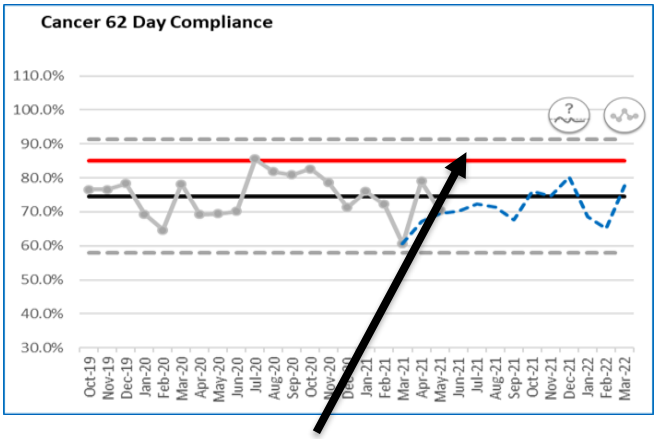
Common cause variation

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

Special cause variation – data point outside of the process limit

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





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

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

Appendix 3: Abbreviations used in IPR reports.

Term	Definition
2ww	Two week waits
A&E	Accident and Emergency
AGP	Aerosol-Generating Procedure
ANTT	Antiseptic Non-Touch Training
BAF	Board Assurance Framework
BP	Blood pressure
CAMHS	Child and Adolescence Mental Health Service
CCG	Clinical Commissioning Groups
CCU	Coronary Care Unit
C.Difficile	Clostridium Difficile
CNST	Clinical Negligence Scheme for Trusts
COO	Chief Operating Officer
CQC	Care Quality Commission
CRL	Capital Resource Limit
CRR	Corporate Risk Register
C.Section	Caesarean Section
CSS	Clinical Support Services
CT	Computerised Tomography
DMO1	Diagnostics Waiting Times and Activity
DOLS	Deprivation Of Liberty Safeguards
DTA	Decision to Admit
E.Coli	Escherichia Coli
Ed.	Education
ED	Emergency Department
EQIA	Equality Impact Assessments
ERF	Elective Recovery Fund
Exec	Executive
F&P	Finance and Performance
FTE	Full Time Equivalent
FYE	Full year effect
G2G	Getting to Good
GI	Gastro-intestinal
GP	General Practitioner
H1	April-September 2021 inclusive
H2	October2021-March 2022 inclusive
HCAI	Health Care Associated Infections
HCSW	Health Care Support Worker
HDU	High Dependency Unit
HMT	Her Majesty's Treasury
HoNs	Head of Nursing
HSMR	Hospital Standardised Mortality Rate
HTP	Hospital Transformation Programme
ICS	Integrated Care System
IPC	Infection Prevention Control
IPC Ops.	Infection Prevention and Control Operational Committee
IPDC	In patients and day cases
IPR	Integrated Performance Review
ITU	Intensive Therapy Unit
ITU/HDU	Intensive Therapy Unit / High Dependency Unit
KPI	Key performance indicator
LFT	Lateral Flow Test
LMNS	Local maternity network
MADT	Making A Difference Together
MCA	Mental Capacity Act

Term	Definition
MD	Medical Director
MEC	Medicine and Emergency Care
MFFD	Medically fit for discharge
MHA	Mental Health Act
MRI	Magnetic Resonance Imaging
MRSA	Methicillin- Sensitive Staphylococcus Aureus
MSK	Musculo-Skeletal
MSSA	Methicillin- Sensitive Staphylococcus Aureus
MTAC	Medical Technologies Advisory Committee
MVP	Maternity Voices Partnership
NEL	Non Elective
NHSEI	NHS England and NHS Improvement
NICE	National Institute for Clinical Excellence
NIQAM	Nurse investigation quality assurance meeting
OPD	Out Patient Department
OPOG	Organisational performance operational group
OSCE	Objective Structural Clinical Examination
PID	Project Initiation Document
PIFU	Patient Initiated follow up
PMO	Programme Management Office
POD	Point of Delivery
PPE	Personal Protective Equipment
PRH	Princess Royal Hospital
PTL	Patient Targeted List
Q1	Quarter 1
Q&A	Question and Answer
QOC	Quality Operations Committee
QSAC	Quality and Safety Assurance Committee
R	Routine
RAMI	Risk Adjusted Mortality Rate
RCA	Route Cause Analysis
RJAH	Robert Jones and Agnes Hunt Hospital
RN	Registered Nurse
RSH	Royal Shrewsbury Hospital
SAC	Surgery Anaesthetics and Cancer
SaTH	Shrewsbury and Telford Hospitals
SATOD	Smoking at the onset of delivery
SDEC	Same Day Emergency Care
SI	Serious Incidents
SMT	Senior Management Team
SOC	Strategic Outline Case
SRO's	Senior Responsible Officer
T&O	Trauma and Orthopaedics
TIF	Transformation Investment Fund
TOR	Terms of Reference
TV	Tissue Viability
UEC	Urgent and Emergency Care service
VIP	Visual Infusion Phlebitis
VTE	Venous Thromboembolism
W&C	Women and Children
WEB	Weekly Executive Briefing
WMAS	West Midlands Ambulance Service
WTE	Whole Time Equivalent
YTD	Year to Date